Public Document Pack

HEALTH OVERVIEW AND SCRUTINY PANEL

Thursday, 23rd February, 2017
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Conference Room 3 and 4 - Civic Centre

This meeting is open to the public

Members

Councillor Bogle (Chair)
Councillor P Baillie
Councillor Houghton
Councillor Mintoff
Councillor Noon
Councillor Savage
Councillor White

Contacts

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PUBLIC INFORMATION

Role of Health Overview Scrutiny Panel (Terms of Reference)

The Health Overview and Scrutiny Panel will have six scheduled meetings per year with additional meetings organised as required.

- To discharge all responsibilities of the Council for health overview and scrutiny, whether as a statutory duty or through the exercise of a power, including subject to formal guidance being issued from the Department of health, the referral of issues to the Secretary of State.
- To undertake the scrutiny of Social Care issues in the City unless they are forward plan items. In such circumstances members of the Health Overview and Scrutiny Panel will be invited to the relevant Overview and Scrutiny Management Committee meeting where they are discussed.
- To develop and agree the annual health and social care scrutiny work programme.
- To scrutinise the development and implementation of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy developed by the Health and Wellbeing Board.
- To respond to proposals and consultations from NHS bodies in respect of substantial variations in service provision and any other major health consultation exercises.
- Liaise with the Southampton LINk and its successor body "Healthwatch" and to respond to any matters brought to the attention of overview and scrutiny by the Southampton LINk and its successor body "Healthwatch"
- Provide a vehicle for the City Council's Overview and Scrutiny Management Committee to refer recommendations arising from panel enquiries relating to the City's health, care and well-being to Southampton's LINk and its successor body "Healthwatch" for further monitoring.
- To consider Councillor Calls for Action for health and social care matters.
- To provide the membership of any joint committee established to respond to formal consultations by an NHS body on an issue which impacts the residents of more than one overview and scrutiny committee area.

Mobile Telephones: - Please switch your mobile telephones to silent whilst in the meeting.

Use of Social Media: - The Council supports the video or audio recording of meetings open to the public, for either live or subsequent broadcast. However, if, in the Chair's opinion, a person filming or recording a meeting or taking photographs is interrupting proceedings or causing a disturbance, under the Council's Standing Orders the person can be ordered to stop their activity, or to leave the meeting. By entering the meeting room you are consenting to being recorded and to the use of those images and recordings for broadcasting and or/training purposes. The meeting may be recorded by the press or members of the public.
Any person or organisation filming, recording or broadcasting any meeting of the Council is responsible for any claims or other liability resulting from them doing so.
Details of the Council's Guidance on the recording of meetings is available on the Council's website.

Public Representations
At the discretion of the Chair, members of the public may address the meeting on any report included on the agenda in which they have a relevant interest. Any member of the public wishing to address the meeting should advise the Democratic Support Officer (DSO) whose contact details are on the front sheet of the agenda.

Smoking policy – the Council operates a no-smoking policy in all civic buildings.

COUNCIL'S PRIORITIES:

- Jobs for local people
- Prevention and early intervention
- Protecting vulnerable people
- Affordable housing
- Services for all
- City pride
- A sustainable Council

CONDUCT OF MEETING

The general role and terms of reference for the Overview and Scrutiny Management Committee, together with those for all Scrutiny Panels, are set out in Part 2 (Article 6) of the Council's Constitution, and their particular roles are set out in Part 4 (Overview and Scrutiny Procedure Rules of the Constitution.

Business to be discussed
Only those items listed on the attached agenda may be considered at this meeting.

Rules of Procedure
The meeting is governed by the Council Procedure Rules as set out in Part 4 of the Constitution.

Quorum
The minimum number of appointed Members required to be in attendance to hold the meeting is 3.

DISCLOSURE OF INTERESTS

Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "Disclosable Pecuniary Interest" or "Other Interest" they may have in relation to matters for consideration on this Agenda.

DISCLOSABLE PECUNIARY INTERESTS

A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:

(i) Any employment, office, trade, profession or vocation carried on for profit or gain.

(ii) Sponsorship:

Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.

(iv) Any beneficial interest in land which is within the area of Southampton.

(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.

(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.

(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

a) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or

b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class.

Other Interests

A Member must regard himself or herself as having an, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

Any body to which they have been appointed or nominated by Southampton City Council
Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

Any body whose principal purpose includes the influence of public opinion or policy

Principles of Decision Making

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the "rationality" or "taking leave of your senses" principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, 'live now, pay later' and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

Dates of Meetings: Municipal Year 2016/2017

2016	2017
30 June	18 January
25 August	23 February
27 October	27 April
22 December	

AGENDA

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

To note any changes in membership of the Panel made in accordance with Council Procedure Rule 4.3.

2 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Democratic Support Officer.

3 DECLARATIONS OF SCRUTINY INTEREST

Members are invited to declare any prior participation in any decision taken by a Committee, Sub-Committee, or Panel of the Council on the agenda and being scrutinised at this meeting.

4 DECLARATION OF PARTY POLITICAL WHIP

Members are invited to declare the application of any party political whip on any matter on the agenda and being scrutinised at this meeting.

5 STATEMENT FROM THE CHAIR

6 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

(Pages 1 - 8)

To approve and sign as a correct record the minutes of the meetings held on 19th December 2016 and 18th January 2017 and to deal with any matters arising, attached.

7 EMERGENCY DEPARTMENT PERFORMANCE

(Pages 9 - 16)

Report of the Chief Executive, University Hospital Southampton Foundation Trust, providing the Panel with an update on the performance of the Emergency Department at Southampton General Hospital.

8 UPDATE ON DISCHARGES FROM UNIVERSITY HOSPITAL SOUTHAMPTON

(Pages 17 - 22)

Report of the Chief Executive of University Hospital Southampton and the Acting Service Director – Adults, Housing and Communities, providing the Panel with an update on discharges from University Hospital Southampton.

9 DRAFT HEALTH AND WELLBEING STRATEGY (2017-2025)
(Pages 23 - 46)

Report of the Director of Public Health seeking comments and feedback on the draft Health and Wellbeing Strategy 2017-2025.

10 UPDATE ON THE IMPLEMENTATION OF SOUTHAMPTON CITY FOOT CARE PATHWAY
(Pages 47 - 58)

Report of the Director of Quality and Integration providing the Panel with an update on the implementation of the Foot Care Pathway.

Wednesday, 15 February 2017 SERVICE DIRECTOR, LEGAL AND GOVERNANCE

To consider the minutes of meetings held on 19th December 2016 and 18th January 2017.

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SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 19 DECEMBER 2016

Present: Councillors Bogle (Chair), P Baillie, Houghton, Mintoff, Noon, Savage and White

Also In Attendance Councillor Shields - Cabinet Member for Health and Sustainable Living

13. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**

RESOLVED: that the minutes for the Panel meeting on 27 October 2016 be approved and signed as a correct record.

14. **HAMPSHIRE AND ISLE OF WIGHT SUSTAINABILITY AND TRANSFORMATION PLAN: DELIVERY PLAN**

The Panel considered a report detailing the delivery plan for the Hampshire and the Isle of Wight (HIOW) Sustainability and Transformation Plan (STP) that was submitted to NHS England and NHS Improvement for consideration.

Richard Samuel (Chief Officer of the Fareham and Gosport Clinical Commissioning Group (CCG) and lead on the development of the Sustainable Transformation Plan), John Richards (Chief Executive Officer, NHS Southampton City CCG) and Councillor Shields (Cabinet Member for Health and Sustainable Living) Jane Freeland (Southampton Keep Our NHS Public) were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of matters and concerns including:

- the range and scope of the plan;
    - it was noted that the Plan was a for a period of five years and had been brought together with all of the partners within the local health system. The Plan would build upon best practice developed across the area such as Better Care Southampton.
- the developing consultation process;
    - it was recognised that as the plan was still being developed and that there would be a need for consultation with a range of groups and organisations such as health and wellbeing boards and local healthwatch groups.
- the decision making process;
    - in response to questions it was noted that there were no formal decision making powers being assigned to one body in the development of Sustainable Transformation Plan. It was noted that the aims and goals of the Plan were being developed in dialogue with the stakeholders and that each of the individual organisations. It was noted that each of the organisations involved had been asked to develop their own local operating plan that would feed into the aims and goals of the Plan as a whole.

- the flexibility of the Plan to cope with future demands on the local health system;
    - it was noted that the Plan was aimed to alleviate pressures that were growing both nationally and locally within the health system. However, it was acknowledged that there were considerable demands on both the recruitment of staff and in relation to the demands on adult social care.

RESOLVED that the Panel noted the challenges and aspirations of the Sustainable Transformation Plan set out in the report and would continue review and monitor the development of the Plan.

15. **SOLENT NHS TRUST CQC REPORT**

The Panel considered the report of Chief Executive – Solent NHS Trust providing a summary of the key findings from the inspection and outlines the approach the Trust will follow to address the issues raised in the Care Quality Commission reports.

Mandy Rayani (Chief Nurse) and Alex Whitfield (Chief Operating Officer) were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of matters and concerns including:

- that the Trust had been rated as requiring improvement by the Care Quality Commission (CQC);
    - it was noted that the CQC report had indicated that there were areas of the Trust, including some of the services in Southampton, that had been rated as outstanding. That the result was an overall judgement of the Trust. It was also noted that action had commenced to address the concerns raised by the CQC following the inspection.
- why some services in the Portsmouth area had outperformed the same services in the Southampton area;
    - It was noted that the management of the children and adolescent mental health services (CAMHS) had been structured in different ways and that this led to information being recorded differently. It was explained that steps had been implemented to resolve this including the redesign of various templates to more clearly indicate that the required information had been considered and recorded. In addition it was noted that the Trust had also reviewed its staff structure within this area in order to ensure consistency of care.
- concern was raised that the Trust was not learning from serious incidents;
    - assurance was given by the Trust that the CQC had found no issues in the Trust's ability to learn from serious incident or its leadership.

RESOLVED that the Panel noted the report and would continue to monitor the performance of the Trust and that the item would return at a future meeting.

16. **MENTAL HEALTH MATTERS**

The Panel considered the report of the Director of Quality and Integration updating the Panel on the progress of the Mental Health Matters programme following the briefing in March 2016.

Katy Bartolomeo (Senior Commissioner - Mental Health, Integrated Commissioning Unit) , John Richards (Chief Executive Officer, NHS Southampton City CCG) Jo Hannigan and Penny Turpin (members of the public) were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of matters and concerns including:

- Why the plan for children and young people and adults within the City were at different stages;
    - It was noted that the scope for adult mental health matters had been broadened and further developed to include a wider patient group. It was noted that additional funding had been received for the provision of care for children and young people to enable certain actions to be expedited.
- The potential effects of the Sustainable Transport Plan (STP) on the development of the Mental Health Matters plan;
    - It was noted that both plans shared the same aims and goals and that the Mental Health Matters plan had been developed alongside partner organisations and would therefore fit into the STP.
- Concerns were raised by members of the public relating to appropriate care pathways for young people with autism and the recently published green paper that indicated potential changes were forthcoming to who was directly responsible for the care of young people withcare needs;
    - The Panel noted that officers were reviewing the green paper. It was also noted that officers recognised the importance of early identification of autism and that the Plan would reflect this.

RESOLVED that the Panel noted the report and welcomed the extra investment into the area requesting that the matter be brought back to Panel at future meeting.

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SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 18 JANUARY 2017

Present: Councillors Bogle (Chair), P Baillie, Houghton, Mintoff, Noon and Savage

Apologies: Councillor White

In Attendance: Cabinet Member for Health and Sustainability – Councillor Dave Shields

17. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**

RESOLVED: that consideration of the minutes for the Panel meeting on 19 December 2016 be considered at a future meeting.

18. **HEALTH AND CARE BUDGET PROPOSALS - 2017/2018**

The Panel considered the report of the Chair of the Health Overview and Scrutiny Panel setting out the health and care proposal for the 2017-2018 municipal year, for discussion.

John Richards (Chief Executive Officer, NHS Southampton City CCG), Stephanie Ramsey (Director of Quality and Integration), Paul Juan (Acting Service Director Adults, Housing and Communities), Councillor Dave Shields (Cabinet Member for Health and Sustainable Living), and Abelardo Clariana-Piga (Southampton Keep Our NHS Public) were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of matters and concerns including:

- the lack of alignment with the financial systems within the Council and the health service;
- the need to ensure that proposals should be:
    - properly planned for;
    - assessed; and
    - realistic;
- the requirement for a health impact assessment for all proposed savings;
- the dangers of displacing the costs of a service, and the ultimate escalation of the financial burden to both the Council and its partners, in the health system locally, that the proposed reductions would have.

RESOLVED that the Panel agreed that the Chair of the Panel be requested to co-ordinate and collate an official response to the Council's budget consultation. It was agreed that this would clearly set out concerns raised at the meeting in regard to:

- the displacement of costs to other organisations within the local health system;
- the potential for escalating costs that cuts relating to prevention would have;

- the scale and pace of the proposed changes, in particular changes to the provision of substance misuse prevention, where the Panel were concerned that a saving had been identified with no clear plan to address this shortfall; and
- the need for health impact assessments and the inclusion, within the existing impact assessments, of the potential cost implications the proposals could have on the public sector in Southampton

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		EMERGENCY DEPARTMENT PERFORMANCE		
DATE OF DECISION:		23 FEBRUARY 2017		
REPORT OF:		CHIEF EXECUTIVE, UNIVERSITY HOSPITAL SOUTHAMPTON		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Jane Hayward**	**Tel:**	**023 8120 6060**
	E-mail:	**Jane.Hayward@uhs.nhs.uk**		
Director	**Name:**	**Fiona Dalton, Chief Executive UHS**	**Tel:**	**023 8120 6060**
	E-mail:	**fiona.dalton@uhs.nhs.uk**		

STATEMENT OF CONFIDENTIALITY

None

BRIEF SUMMARY

The University Hospital Southampton Foundation Trust and system partners will update the committee on the latest Emergency Department performance.

RECOMMENDATIONS:

	(i)	That the Panel notes the report and following discussions agree any issues that may need to be brought forward to a future HOSP meeting.

REASONS FOR REPORT RECOMMENDATIONS

1.	At the request of the Chair of the Panel.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2.	None.

DETAIL (Including consultation carried out)

3.	Attached as Appendix 1 is an update on emergency flow within University Hospital Southampton. The Panel are requested to note the good progress that has been made within the hospital and that UHS's performance in 2016/17 has exceeded the performance in 2015/16 in every month, except June, November, and December and in every month when compared to 2014/15. However, the Trust is yet to meet the target of 95%.

RESOURCE IMPLICATIONS

Capital/Revenue

4.	N/A

Property/Other

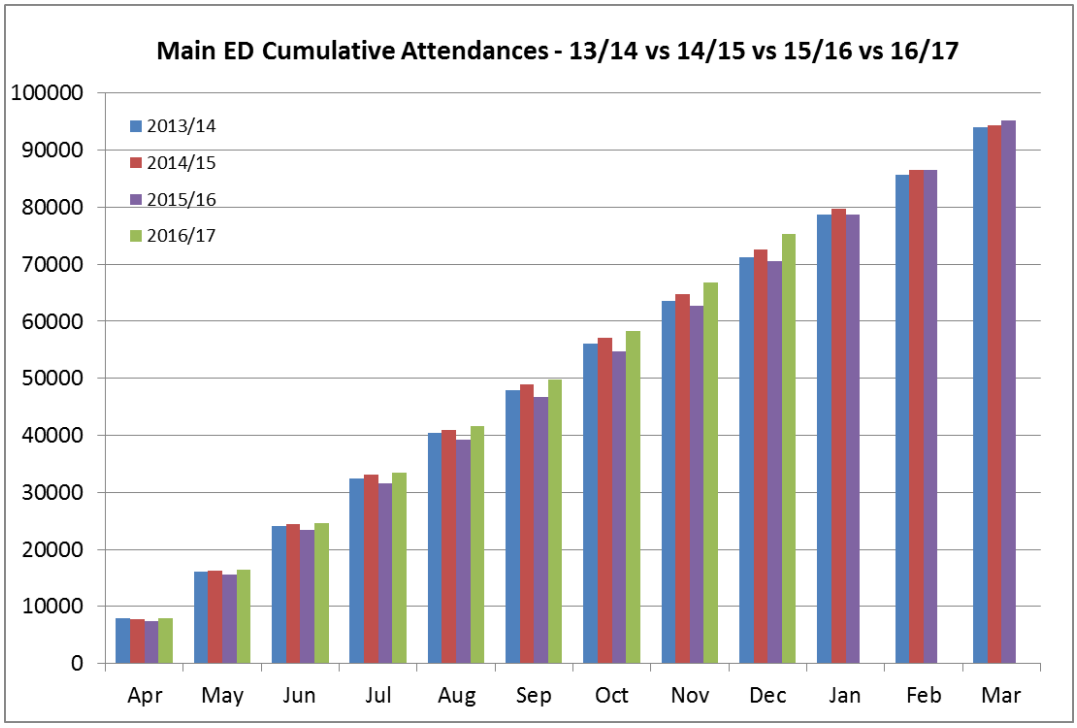
5.	N/A

LEGAL IMPLICATIONS			
Statutory power to undertake proposals in the report:			
6.	The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.		
Other Legal Implications:			
7.	N/A		
POLICY FRAMEWORK IMPLICATIONS			
8.	N/A		
KEY DECISION	N/A		
WARDS/COMMUNITIES AFFECTED:	N/A		
SUPPORTING DOCUMENTATION			
Appendices			
1.	Update on Emergency Flow in University Hospital Southampton		
Documents In Members' Rooms			
1.	None		
Equality Impact Assessment			
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.		No	
Privacy Impact Assessment			
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.		No	
Other Background Documents **Equality Impact Assessment and Other Background documents available for inspection at:**			
Title of Background Paper(s)		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)	
1.	None		

Update on Emergency Flow in University Hospital Southampton

Activity

The table below shows the demand for Main ED (ie excluding Minor Injuries Unit and Eye Casualty) over the current and previous 3 financial years:



Year-on-year monthly ED attendances are up for each month in 2016/17 when compared to 2015. This increase in demand has equated to approximately 7% growth in attendances and reflects the national picture of increasing attendance to the ED. However, it is also important to acknowledge the activity seen by Eye Casualty has increased. The table in Appendix 1 shows the same data but for Eye Casualty.

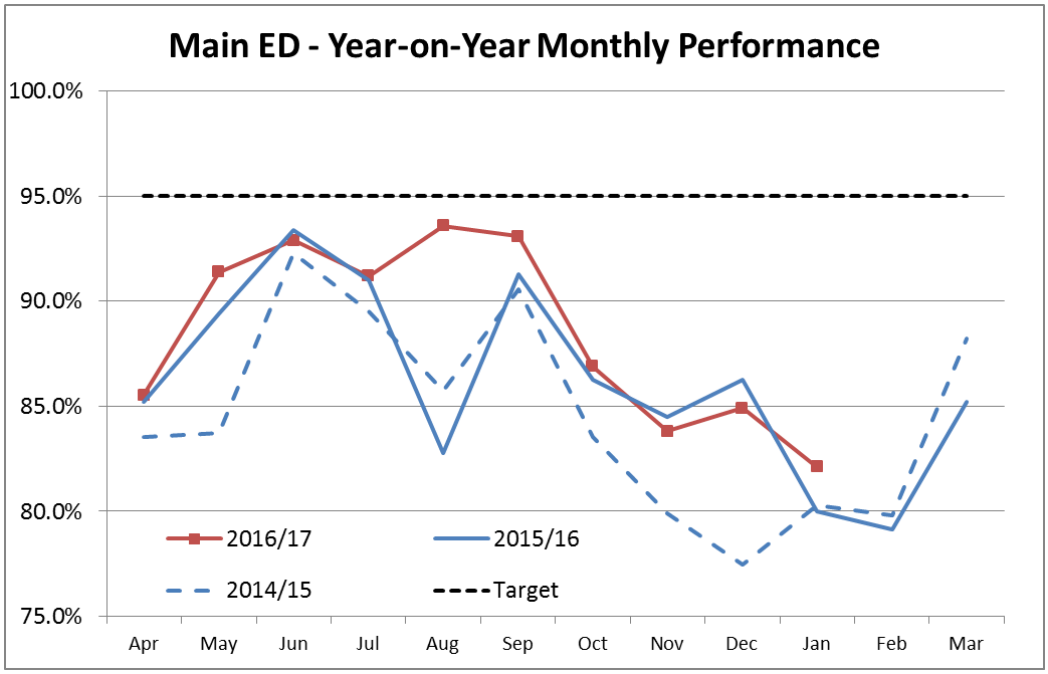
Performance

The four-hour Emergency Department target states that at least 95% of patients attending the department must be seen, treated, and admitted or discharged in under four hours.

The performance by Main ED against the 95% target for can be seen on the table below, along with the 95th centile, mean and median treatment times:

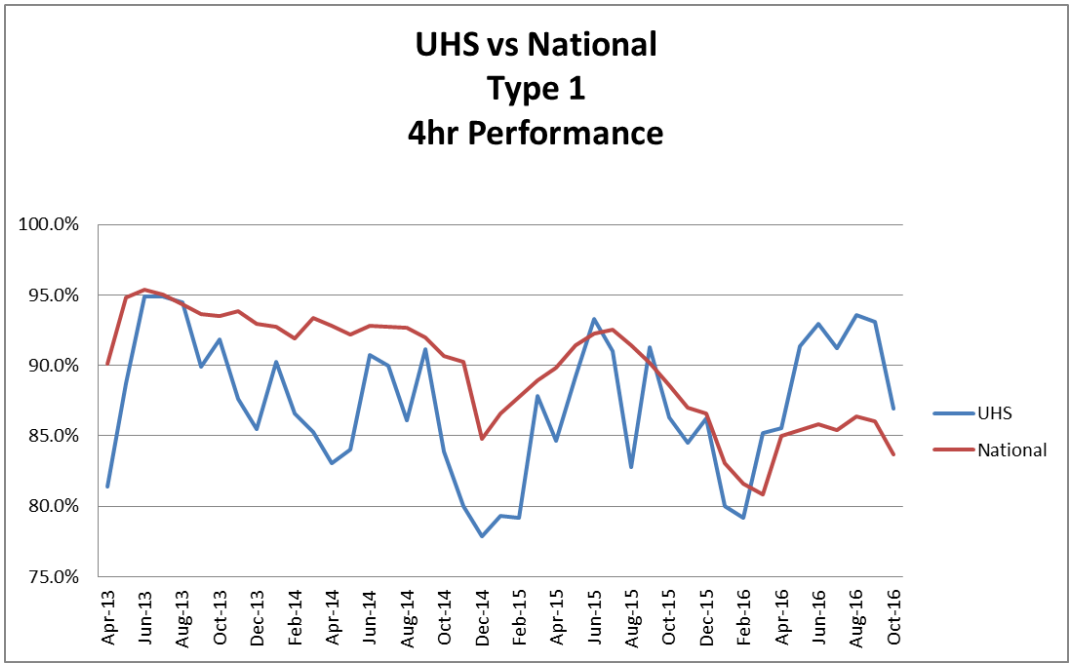
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Performance: Main ED	2015/16	85.2%	89.4%	93.4%	91.0%	82.8%	91.3%	86.3%	84.5%	86.3%	80.0%	79.2%	85.2%
	2016/17	85.5%	91.4%	92.9%	91.2%	93.6%	93.1%	86.9%	83.8%	84.9%	82.1%		
Performance: Main & Eye ED Combined	2015/16	87.6%	91.0%	94.5%	92.5%	85.6%	92.7%	88.5%	86.9%	88.4%	82.8%	82.5%	87.5%
	2016/17	87.8%	92.7%	94.0%	92.5%	94.6%	94.1%	88.8%	85.9%	86.9%	84.4%		
Wait: 95th Centile (Main ED)	2015/16	07:28	06:11	04:55	05:33	07:13	05:29	06:20	06:40	06:18	07:19	08:04	06:51
	2016/17	07:14	05:19	05:09	05:32	05:02	05:01	06:54	06:45	06:34	08:04		
Wait: Mean (Main ED)	2015/16	03:21	03:11	02:58	03:04	03:27	03:07	03:17	03:23	03:18	03:32	03:38	03:24
	2016/17	03:21	03:07	03:04	03:11	02:41	02:26	03:20	03:30	03:26	03:39		
Wait: Median (Main ED)	2015/16	03:11	03:11	03:03	03:09	03:22	03:12	03:19	03:24	03:21	03:29	03:24	03:21
	2016/17	03:15	03:15	03:10	03:17	03:07	03:12	03:15	03:04	03:21	03:26		

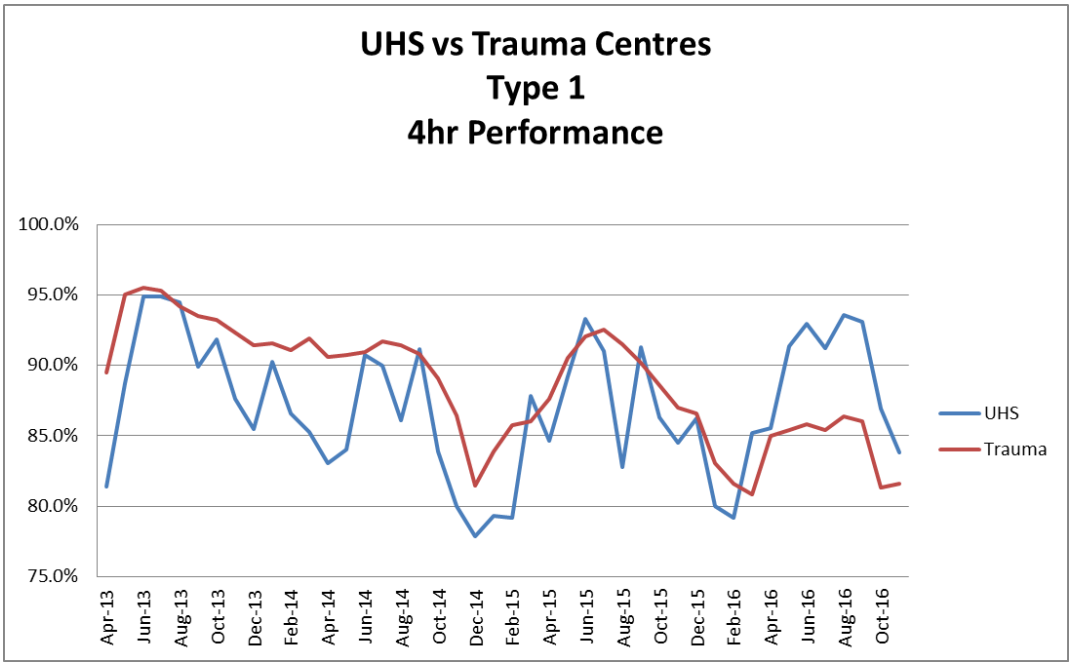
For the first half of 2016-17 performance has improved over 2015-16 most notably in August. However, from month 7 performance has not been sustained in every month as pressure on hospital beds has increased due to a rise in emergency admissions.



Performance in comparison

Despite the increase in attendances to ED, UHS continues to perform well when compared to similar Trusts and the national position. The graphs below track UHS ED Type 1 (i.e. excluding Minor Injuries Unit and Eye Casualty) Performance against the 4 hour target and demonstrate that UHS has fared better than the national position for the previous eight consecutive months. Similarly, when compared to other NHS Trauma Centres, UHS has continued to perform better than its peers. National benchmarking data is reported in arrears therefore the data represented in the graphs reflects the most recently published position.





Next Steps

The Trust has an agreed action plan in place. A monthly monitoring meeting is in place with the CCGs and a fortnightly internal meeting chaired by Fiona Dalton.

The action plan focuses on 5 key areas:

- Ensuring there are clear admission pathways that fast track patients into beds
- Enhancing the skills of the nursing team to allow more independent decision making
- Reviewing the skills and competencies of the shift leaders
- Increasing Home before Lunch to increase flow
- Ensuring there is a robust plan for August when the new junior teams start and special event planning.

Reductions in delayed transfers of care are not included within the plan itself but undoubtedly have made the biggest difference in the most recent months. November and the first half of December were some of the worst months ever recorded for delayed transfers of care but the second half of December has been one of the best. Focused work in partnership with the Clinical Commissioning Groups in reducing delayed transfers of care is on-going and will remain a priority for the Trust. Going forward the focus will remain on improving the 'Home before Lunch' figures and a continued collaborative approach with specialties in rapidly identifying patients requiring an admission and fast tracking these patients to wards.

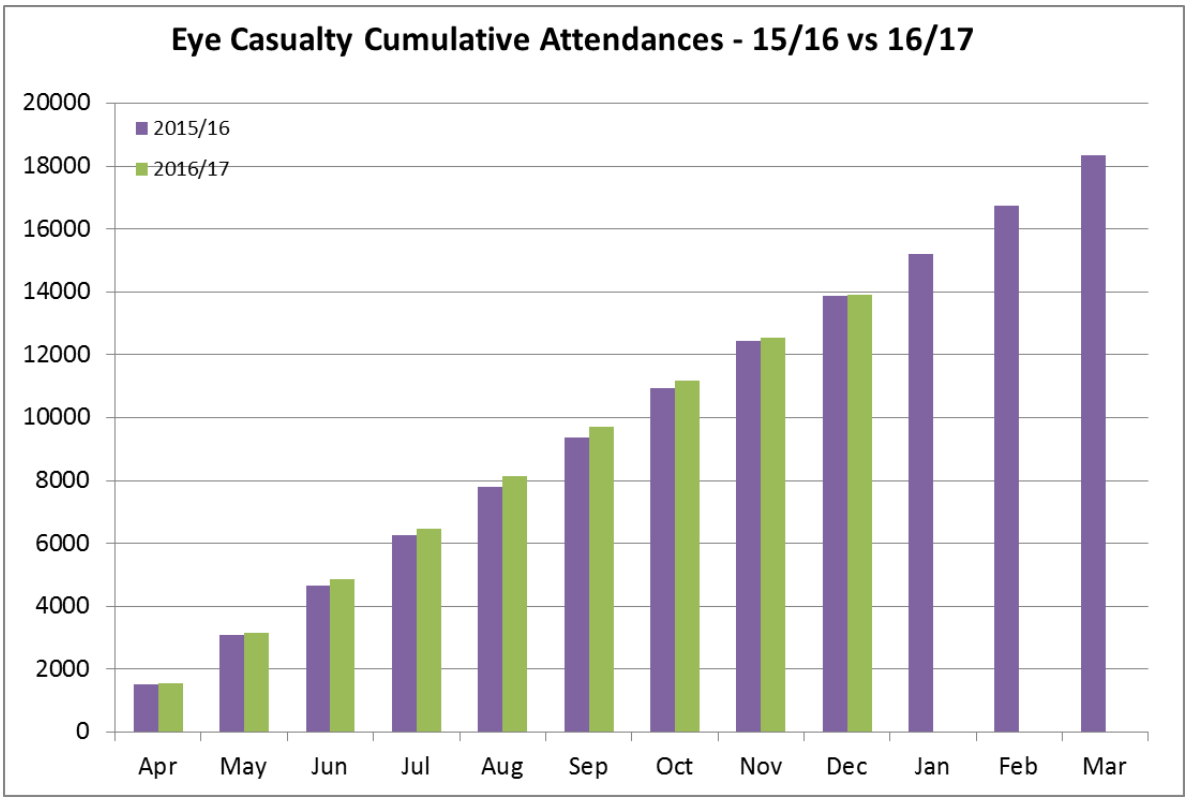
Conclusions

In the past 9 months the ED has seen sustained and unprecedented rises in attendance levels. The latest data demonstrates that attendances are continuing to increase with month-on-month growth rates reaching 7%. Despite the October to December positions being below the recovery trajectory for the month, the year-to-date performance has remained ahead of expectation. When ranked against all providers according to the yearly overall Type 1 performance UHS demonstrates a pattern of continual improvement rising from 135th out of 144 providers in 2013-14 to 42nd out of 144 as of

October 2016. And when compared to Major Trauma Centres UHS ranked 9th out of the 11 Major Trauma Centres that deal with both paediatric and adult patients in 2013-14 but as of October 2016 UHS is now 3rd out of the 11 similar Major Trauma Centres. Even with the increasing trend in demand the Trust is continuing to work to improve ED performance against the 4hr target on a year-on-year basis.

Emergency pathway metrics

Eye Casualty Attendances



Activity in Eye ED has not seen the same increases in demand as main ED as cumulative attendance is up by less than .5%.

NB: In April 2015, a change was made in the way in which Eye ED attendances are counted and was applied retrospectively to 2014/15 data to aid with trend monitoring. This resulted in a reduction in the total number of attendances reported and had an impact of approximately 0.5% to the Trust's combined overall ED performance. Data is not presented in this chart for years prior to 2014/15 as it would not be comparable.

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		UPDATE ON DISCHARGES FROM UNIVERSITY HOSPITAL SOUTHAMPTON		
DATE OF DECISION:		23 FEBRUARY 2017		
REPORT OF:		CHIEF EXECUTIVE, UNIVERSITY HOSPITAL SOUTHAMPTON AND THE ACTING SERVICE DIRECTOR, ADULTS, HOUSING AND COMMUNITIES, SOUTHAMPTON CITY COUNCIL		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Jane Hayward** **Sharon Stewart**	**Tel:**	**023 8079 6241** **023 8083 2660**
	E-mail:	**Jane.Hayward@uhs.nhs.uk** **sharon.stewart@southampton.gov.uk**		
Director	**Name:**	**Fiona Dalton, Chief Executive, UHS** **Paul Juan, Acting Service Director – Adults, Housing and Communities, SCC**	**Tel:**	**023 8077 7222** **023 8083 2530**
	E-mail:	**fiona.dalton@uhs.nhs.uk** **Paul.juan@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY
The University Hospital Southampton Foundation Trust and representatives from Adult Social Care at Southampton City Council will update the committee on progress being made reducing complex discharges in the Hospital.

RECOMMENDATIONS:		
	(i)	The Panel is asked to note the positive work which has been undertaken across the system since HOSP last considered this matter and the improvements which have been made.
	(ii)	The Panel is asked to note the specific issues of domiciliary care and increasing funding pressures.

REASONS FOR REPORT RECOMMENDATIONS	
1.	At the request of the Panel.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
2.	None

DETAIL (Including consultation carried out)	
3.	Following discussion at the 19 January 2016 meeting of the HOSP the Panel requested an update on discharges from University Hospital Southampton at the February 2017 meeting.
4.	Attached as Appendix 1 is an update on discharges from University Hospital

	Southampton that identifies the current position and the steps that are being taken to improve performance across the system.
RESOURCE IMPLICATIONS	
Capital/Revenue	
5.	Not applicable
Property/Other	
6.	Not applicable
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
7.	The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006.
Other Legal Implications:	
8.	Not applicable
POLICY FRAMEWORK IMPLICATIONS	
9.	None

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices	
1.	Update on discharges from University Hospital Southampton
Documents In Members' Rooms	
1.	None

Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.	No
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)	
1.	None	

Update on Discharges from University Hospital Southampton – February 2017

Southampton City Council Health Overview and Scrutiny Panel

Introduction

Our last update in January 2016 discussed a considerable body of work that had been undertaken internally within the Trust and externally in collaboration with commissioners, community providers and the councils in relation to discharge and centred around the three pathways outlined in *Figure 1*. This work, a local and national priority, is essential for the successful running of the hospital and to deliver high quality, safe NHS care for the population of Southampton.

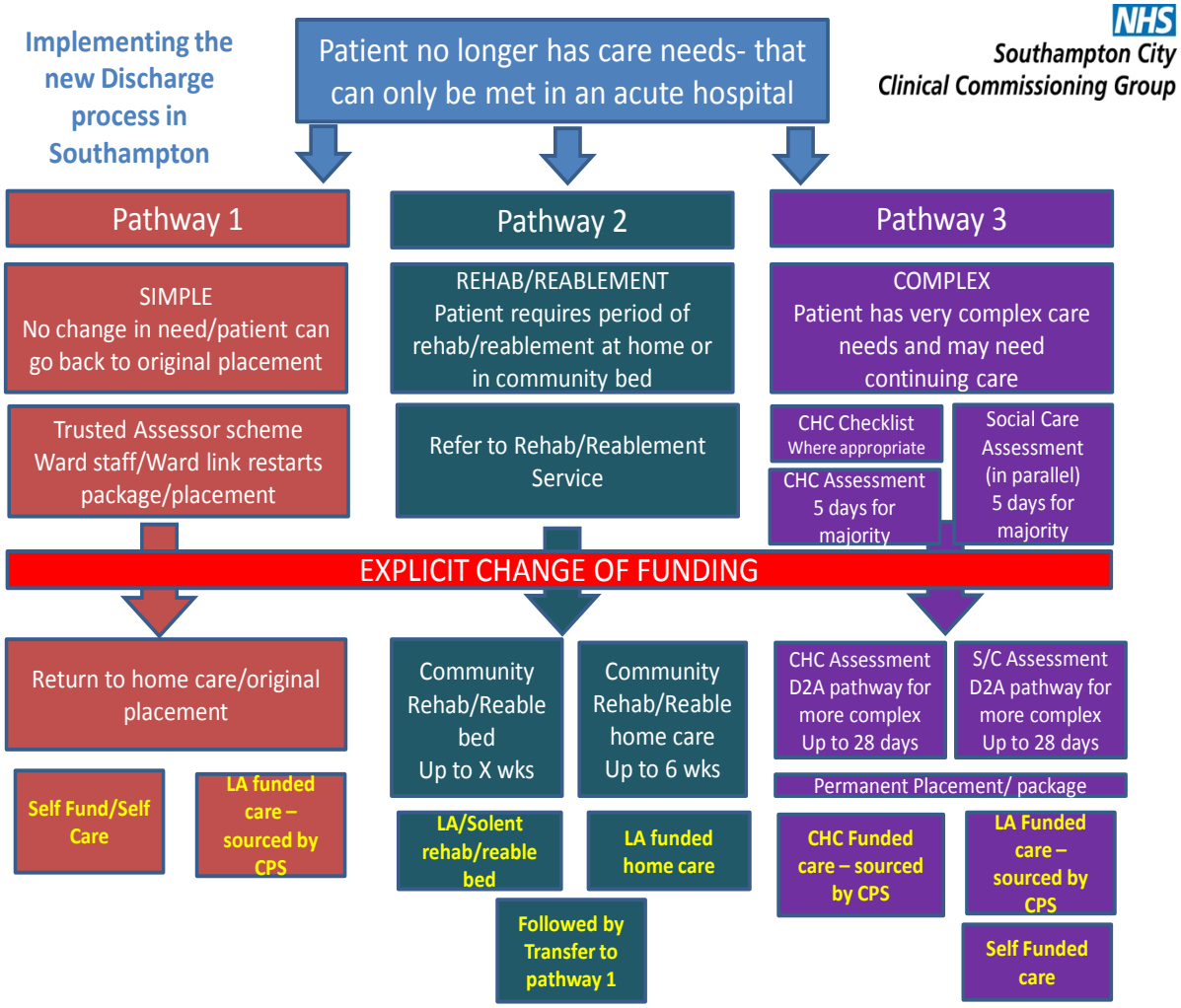


Figure 1: discharge pathways out of hospital

Details of work undertaken / ongoing

a) Agreed recovery trajectories with Southampton and West Hampshire Clinical Commissioning Groups for Delayed Transfer of Care (trajectory in Annex)

- Reduce the system Delayed Transfers of Care rate to 6.5% by March 2017
- Reduce the system Delayed Transfers of Care rate to 3.5% by March 2018

b) Ongoing development of the UHS discharge team and Integrated Discharge Bureau

- Development of Discharge Officer team to co-ordinate and case manage the discharge of complex patients in clinical ward areas
- Employment of integrated discharge bureau manager
- Embedding of new discharge IT systems and new Social care act compliant system
- Ongoing trust wide education

c) Development of processes within the Emergency Department and Acute Medical Unit

- Plan discharge from admission
- Rapid turnaround of patients who don't need hospital admission / only need short admission
- Investment in resource and Frailty service
  - Nursing, therapy and geriatrician input
  - Closer co-ordination with community services

d) Development of systems within the hospital to support flow

- Electronic Patient Status At a Glance (ward white) boards
- Red and green days
- 'Stay active' campaign trust priority for 2017

e) Development of processes to enable UHS staff to discharge patients down pathway 1 / simple pathway without the involvement of social care

- Trusted assessment agreements in place
- Training due to start within the next month with full roll out Spring 2017

f) Successful roll out of Supported pathway in conjunction with Solent NHS trust

- Discharge to assess scheme increased capacity to 22 patients per week with significant long term benefits to patients in terms of better independence and to the system in terms of the correct prescription of long term care (approximate 1/3 reduction in home care)
- Reconfiguration of Royal South Hants to support better flow into non-acute step down beds
- Further investment from Southampton City Clinical Commissioning Group in year 2017/18 and national recognition from NHS England.

Continuing healthcare (CHC) processes

The trust has worked closely with the CCG to refine processes both in terms of putting fewer patients through CHC and the speed in which this happens. This has been partially successful but a combination of increased admissions, increased complexity and unexpected staff shortages has resulted in deterioration in performance. In the immediate term UHS has used internal and locum staff to increase capacity. In the longer term the health system plans to perform a higher number of CHC assessments in the community: either prior to admission or on a discharge to assess basis. This is increasingly mandated by NHS-England.

Time to wait for domiciliary care

This is the major issue for the national and local system. Delays in sourcing packages of care reach crisis points especially over holiday periods and in winter months. This impacts patients leaving the General Hospital and also those in the RSH and the effectiveness of the supported discharge to assess pathway. This is the major priority for the Southampton Health and Social care system.

Time to wait for rehabilitation beds

Flow into rehabilitation beds at the Royal South Hants has improved considerably and associated waits are usually no more than a few days. This is expected to improve further as the supported pathway attracts more investment from the CCG and as the domiciliary care market is strengthened. This will enable the RSH to take a greater volume of patients and better support UHS Delayed Transfers of Care.

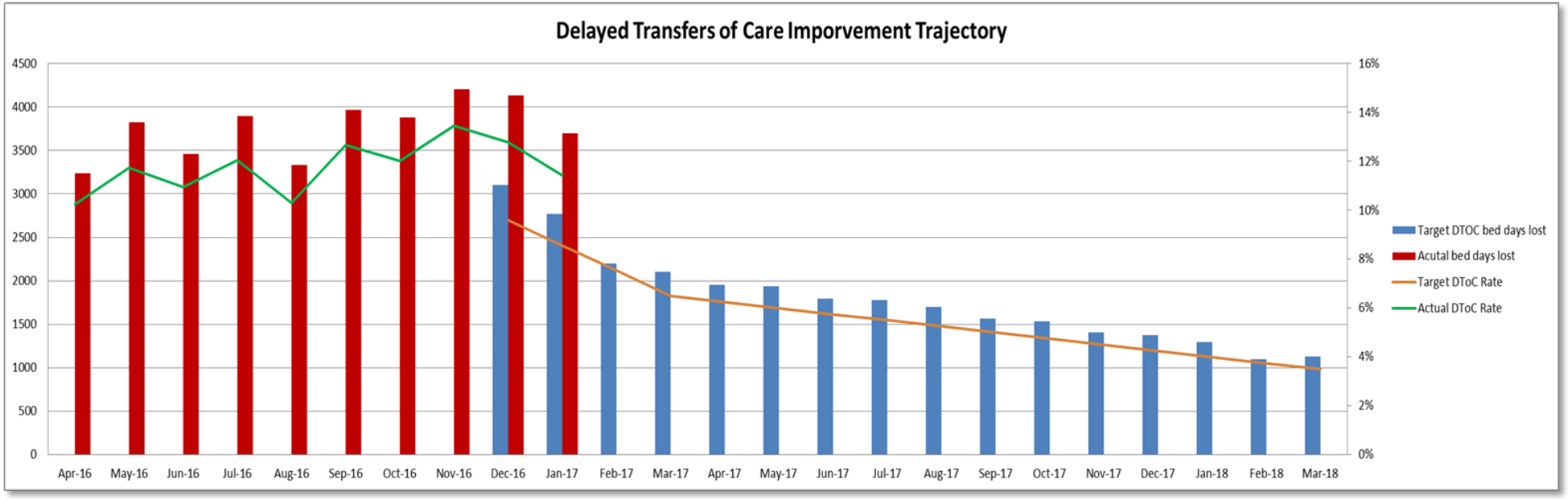
Conclusion

Good progress has been made in many areas towards improving safe and timely discharge from hospital - the joint work we have put in is starting to show its results in terms of the increasing numbers of discharges and operational position at the hospital relative to the regional and national picture. We continue to develop the system complex discharge action plan in response to challenges as they arise.

The Panel should be aware that there are still significant risks and challenges as we move forward. Major pressures are a consequence of increased admission rates, increased frailty within the population and ongoing crises within the domiciliary care market.

UHS is very aware of the serious financial challenges that face local authorities. We are very concerned that if these are translated into reductions in front line social service provision, this will directly impact upon patients delayed in hospital. Therefore, we are pleased to note that locum positions are being recruited to permanently to stabilise the workforce.

Annex


Delayed Transfers of Care Imporvement Trajectory
4500
4000
3500
3000
2500
2000
1500
1000
500
0
16%
14%
12%
10%
8%
6%
4%
2%
0%
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
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Apr-17
May-17
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Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Target DTOC bed days lost
Acutal bed days lost
Target DToC Rate
Actual DToC Rate

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		DRAFT HEALTH AND WELLBEING STRATEGY (2017-2025)		
DATE OF DECISION:		25 FEBRUARY 2017		
REPORT OF:		DIRECTOR OF PUBLIC HEALTH		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Dr Debbie Chase** **Consultant in Public Health**	**Tel:**	**023 8083 3694**
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	E-mail:	**Jason.Horsley@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY

N/A

BRIEF SUMMARY

Health and wellbeing is important to everyone in Southampton, whether they live, work or learn in the city. The Joint Health and Wellbeing Strategy for Southampton sets out the strategic vision for improving the health and reducing health inequalities in the city.

Southampton's current Health and Wellbeing Strategy was published in March 2013 and the refreshed strategy will run from 2017 to 2025. It sets out a vision for Southampton to have a culture and environment which promotes and supports health and wellbeing for all. It includes the outcomes to achieve over the next eight years and is based on evidence from the Joint Strategic Needs Assessment. The strategy will be supported by a number of more detailed strategies and action plans.

RECOMMENDATIONS:

(i)	That the Health Overview and Scrutiny Panel considers and provides any comments and feedback on the draft Health and Wellbeing Strategy 2017-2025.

REASONS FOR REPORT RECOMMENDATIONS

1.	Local Authorities and Clinical Commissioning Groups (CCGs) have equal and joint statutory duties to prepare a Health and Wellbeing Strategy that sets out how they plan to work together with local partners to meet health and care needs identified in the Joint Strategic Needs Assessment (JSNA).
2.	This strategy sets out a vision for improving health and wellbeing for all and reducing health inequalities in Southampton, as well as how partners across the city can work together to achieve these outcomes.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3.	The Health and Wellbeing Strategy is a statutory requirement; therefore, there is no alternative option.

DETAIL (Including consultation carried out)	
	Background
4.	Southampton is a thriving city with enormous growth potential, however health outcomes are poorer than in other areas in the south east and the city's characteristics relating to poverty and deprivation present challenges. For instance, the under 75 mortality rate from all cardiovascular diseases has remained high whilst the England average has reduced. The suicide rate is also twice that of the England average, increasing since 2009-11, and smoking prevalence and alcohol related problems in adults are also higher than England average.
5.	Southampton's population demographic is relatively young compared with the England average. Children in the city have high levels of physical inactivity and obesity and tooth decay is also much higher than the England average. Children and young people have identified mental health as a key issue.
6.	Lifestyle choices, socio-economic status and level of deprivation aside, there are environmental factors that significantly contribute to poor health in Southampton. For example, exposure to air pollution increases the risk of deaths from cardiovascular and respiratory conditions and is a significant health issue for Southampton, with 6.2% of deaths attributable to long term exposure to air pollution in 2010.
7.	Action is required to create a culture and environment that supports people to make healthy choices for themselves, their families and communities; stay well and independent and manage their own health and wellbeing; and access care which is joined up and tailored to meet the needs of the individual when they need it. The draft health and Wellbeing Strategy sets out a vision for partners across the city to work together to address these challenges and improve health and wellbeing outcomes for residents.
	Developing the Strategy
8.	The draft Health and Wellbeing Strategy has been developed using evidence of population need described JSNA, and engagement with residents and stakeholders to gain an understanding of their views on health and wellbeing.
9.	Engagement for the proposed strategy took place throughout March and April 2016, with over 900 residents participating in a survey on health outcomes. The majority of residents (70%) assessed their health as being good or very good. Mobility problems, cancer, mood/contentment and money were highlighted by residents as their greatest health and wellbeing concerns for the future.
10.	In addition, an early draft of the Health and Wellbeing Strategy was published in May 2016 in order to invite public and professional input. In total, 161 people responded. Engagement exercises and discussion sessions were also held with Healthwatch, People's Panel members (two events), and Sure Start Centre customers. The results of this engagement were fed back to Southampton City Council, the Clinical Commissioning Group and the Health and Wellbeing Board, and have been used to inform the latest update of the draft strategy.

	Outcomes and themes
11.	Southampton's previous strategy set out 64 actions to improve health in Southampton under three themes: (1) Building resilience and using preventative measures to achieve better health and wellbeing, (2) best start in life and (3) living and ageing well. In the final review of progress against these actions in 2015/16, 95% of commitments had been achieved or were underway.
12.	The proposed draft Health and Wellbeing Strategy has a vision that, over the next eight years, Southampton has a culture and environment that promotes and supports health and wellbeing for all. The ambition is to significantly improve health and wellbeing outcomes and reduce health inequalities in Southampton by 2025.
13.	The strategy includes four themes: • People in Southampton live active, safe and independent lives and manage their own health and wellbeing • Inequalities in health outcomes are reduced. • Southampton is a healthy place to live and work with strong, active communities • People in Southampton have improved health experiences as a result of high quality, integrated services.
14.	Progress in delivering this eight year strategy will be assessed periodically. Measures are described within the strategy and most are included within the national public health outcome framework.
15.	The Health and Wellbeing Strategy sits within a framework of other strategies and plans across the local health and care system. These set out the actions required to achieve our long term goals. Progress against these plans will be reported to the Southampton Health and Wellbeing Board on a regular basis and longer term outcomes will be monitored through the Joint Strategic Needs Assessment.
16.	The strategic intent set out in the draft strategy aligns with: • Southampton Connect City Strategy priorities (2015-2025), particularly the priority "Healthier and safer communities". • Southampton City Council Strategy priorities (2016-2020) in the Council Strategy, particularly the outcome "People in Southampton live safe, healthy, independent lives". • Southampton City Clinical Commissioning Group five year strategic plan (2014-2019), and Two Year Operational Plan (2017-2019).
RESOURCE IMPLICATIONS	
Capital/Revenue	
17.	There are no resource or financial implications at this stage. The strategy will inform commissioning of health and care services.
Property/Other	
18.	None
LEGAL IMPLICATIONS	

Statutory power to undertake proposals in the report:		
19.	Local Authorities and Clinical Commissioning Groups (CCGs) have equal and joint statutory duties to prepare a Health and Wellbeing Strategy under powers outlined in the Local Government and Public Involvement in Health Act 2007 section 116A (as amended by the Health and Social Care Act 2012 section 193).	
Other Legal Implications:		
20.	None	
POLICY FRAMEWORK IMPLICATIONS		
21.	The proposed Health and Wellbeing Strategy (2017-2025) is listed as a core strategy in Southampton City Council's Policy Framework Part 2 Articles 4.01. The delivery of the Health and Wellbeing Strategy also contributes to the priorities and outcomes set out in the Southampton City Strategy 2015-2025 and the Southampton City Council Strategy 2017-2020.	
KEY DECISION?	Yes	
WARDS/COMMUNITIES AFFECTED:	All	
SUPPORTING DOCUMENTATION		
Appendices		
1.	Draft Health and Wellbeing Strategy	
2.	Draft Health and Wellbeing Strategy Background Document	
Documents In Members' Rooms		
1.	None	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.		No
Privacy Impact Assessment		
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.		No
Other Background Documents Joint Strategic Needs Assessment: **Equality Impact Assessment and Other Background documents available for inspection at:**		
Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)	
1.	None	

Draft Health and Wellbeing Strategy 2017-2025

Appendix 1

Our vision is that Southampton has a culture and environment that promotes and supports health and wellbeing for all

Our ambition is to significantly improve health & wellbeing outcomes and reduce citywide health inequalities in Southampton by 2025.

This Strategy sets out the outcomes that Southampton Health and Wellbeing Board wants to achieve over the next eight years. These outcomes will be achieved by working with partners across the city, and with Southampton's residents and diverse communities.

Southampton's Health and Wellbeing Board is a statutory partnership and a committee of the Council which brings together the city's health and social care commissioners, including Southampton City Clinical Commissioning Group, Southampton City Council and NHS England. The Board has oversight of health and wellbeing in the City. Its role is to develop joint priorities for local commissioning to ensure delivery of the right outcomes, and to provide advice, assistance or other support to improve the health and wellbeing of the city's diverse communities.

The Health and Wellbeing Board is committed to working together with the people of Southampton to improve the health and wellbeing of residents. At a time of increasing demand on services and pressures on funding, it is even more important to make sure the city is a healthy place by supporting people to take responsibility for their health, and that services are delivered as efficiently as possible, targeting them towards those people who need the most help.

Key facts about Southampton

- 247,569 people live in Southampton, and this is expected to grow by nearly 5% by 2022, to 259,615.
- There are around 98,000 households in the city – with 51% owner occupiers and 25% living in privately rented homes.
- 34,557 people aged 65+ live in the city, and this is expected to increase by 12% by 2022. By 65, about a third of people have at least 3 chronic conditions.
- 53,928 children and young people live in the city, and this is expected to increase by 5.9 % by 2022.
- There are 2 universities and around 40,000 students living in the city.
- 30,250 residents live in the 10% most deprived areas of the city
- 22.4% of Southampton residents are non-white British, of which 14% are Black or Minority Ethnic.
- Around 55% of Southampton residents exercise regularly, doing at least 150 minutes of physical activity per week.
- Life expectancy in the city is 83.1 years for women 78.2 years for men, with variances across different parts of the city.
- Health and Wellbeing Board partners spend around £450 million per year on health and care services in the city.

What do we want to achieve?	Why is this important?
People in Southampton live active, safe and independent lives and manage their own health and wellbeing	We want to support more people to choose active and healthy lifestyles. When people take responsibility for their own health and the health of their children through positive lifestyle changes, this improves their wellbeing, prevents ill health and helps them to stay independent in their own homes and communities for longer.
Inequalities in health outcomes are reduced.	Health and wellbeing outcomes are very different for men, women and different communities in Southampton, and there are significant health inequalities in our city. We want to improve the health and wellbeing of all residents and reduce inequalities so that everyone, and especially vulnerable children and adults, has increased opportunities and a better quality of life.
Southampton is a healthy place to live and work with strong, active communities	Being healthy and well for a lifetime involves much more than good health and social care services. Many different things impact on health and wellbeing, like housing, jobs, leisure, sport and access to open spaces, education, health services and transport. We want Southampton to be a healthy place, with healthy workplaces and communities which are strong and resourceful, making best use of their community assets.
People in Southampton have improved health experiences as a result of high quality, integrated services	We want to make sure people get high quality support when and where they need it. This means making sure services are designed around the needs of people, and that residents are involved in the design and delivery of services to improve their experiences of integrated services. We want to focus on prevention and early help, and deliver services that are accessible and coordinated so that people receive joined up, seamless care. Integrating services across health and social care also means that all health and wellbeing partners can work more effectively and efficiently together, so that resources and assets are used where they are needed most.

Our challenges

- Health inequalities are a big challenge in the city. Men in the least deprived areas live 8 years longer than in the most deprived; for women the difference is 4.7 years.
- 6,050 people are claiming health related employment benefits (ESA and Incapacity Benefit) - 3.5% of the working population.22.7% of children under 16 in Southampton live in poverty – higher than the England average of 18.6% - and this is linked to poor health outcomes.
- Southampton children and young people are more likely to be admitted to hospital for mental health conditions than the national average.
- Children in the city have high levels of obesity, poor dental health and admission to hospital for injuries.
- The city has high numbers of Looked After Children in comparison to many other cities.
- Although life expectancy is increasing, as people are living longer more of them are living with complex needs.
- 20.4% of people in Southampton smoke (16.9% in England). The rate is significantly higher in the most deprived areas.
- Almost two thirds (62.6%) of adults in Southampton are classified overweight or obese.
- The rate of deaths relating to drug poisoning is 5.1 per 100,000 population (2013-2015), higher than the England average of 3.9 per 100,0000.
- Alcohol specific hospital admissions have increased significantly since 2010 and in 2014/15 there were 1,060 admissions.
- There is growing evidence of the impact of social isolation and loneliness on health.
- Although Southampton has significantly reduced the rates of teenage conceptions from 47.4 per 1,000 teenagers (aged 15-17) in 2011 to 29.0 in 2014, it remains above the England average.
- Nearly 10,000 households are estimated to experience fuel poverty in Southampton.
- Air pollution is a significant health issue for Southampton, with 6.2% of deaths attributable to air pollution in 2010. Long term exposure to air pollution increases the risk of deaths from cardiovascular and respiratory conditions.

What do residents say? *(Research undertaken 2016, 900 respondents)*

- The majority of residents (70%) self-assessed their health as being good or very good.
- Mobility problems, cancer, mood/contentment and money are their greatest health and wellbeing concerns for the future.
- Residents are already doing things to be healthier such as not smoking, eating healthily and limiting alcohol consumption.
- Fewer residents told us that they make use of helplines and websites, talk to friends and family about their concerns or attend health checks / screenings.
- Some of the things residents said they could do to be more healthy include:

- Having a better work life balance and going to more social venues
- De-stressing regularly and getting better sleep
- Doing more volunteering
- Being able to exercise more

Key points from the City Survey 2016:

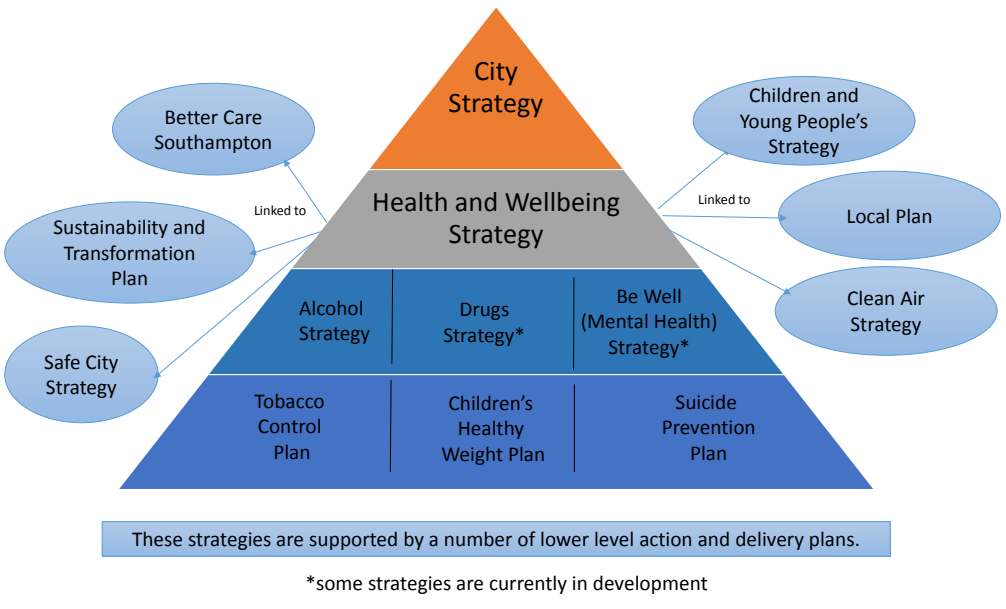
- 75% of residents felt they were in good health
- 40% felt lonely or somewhat lonely
- 39% felt people in their neighbourhood pull together to improve things
- 21% of people had few or no friends or relatives they could rely on

	What are we going to do?	Lead organisation
People in Southampton live active, safe and independent lives and manage their own health and wellbeing	• Encourage and promote healthier lifestyle choices and behaviour, with a focus on smoking, alcohol / substance misuse, healthy weigh, and physical activity including walking and cycling more. • Encourage and promote healthy relationships and wellbeing of individuals of all ages, carers and families, particularly for those at risk of harm and the most vulnerable groups through increasing early help and support. • Support people to be more independent in their own home and through access to their local community, making best use of digital tools including Telecare. • Ensure that information and advice is coordinated and accessible. • Prioritise and promote mental health and wellbeing as being equally important as physical health. • Increase access to appropriate mental health services as early as possible and when they are needed. • Make every contact count by ensuring all agencies are able to identify individual needs and respond /refer to services as appropriate. • Promote access to immunisation and population screening programmes.	•
Inequalities in health outcomes are reduced.	• Reduce the health inequalities gap between the most deprived and least deprived neighbourhoods in the city using the evidence of what works in the Marmot review of Health Inequalities. • Take action to improve men's health to reduce the difference between male and female life expectancy through community based initiatives to deliver behaviour change. • Reduce inequalities in early childhood development by ensuring good provision of maternity services, childcare, parenting and early years support. • Work with schools to improve healthy lifestyle choices and mental wellbeing and reduce adolescent risk taking in children and young people. • Target access to advice and navigation to services to those who are most at risk and in need, to improve their health outcomes. • Ensure that health inequalities are taken into account in policy development, commissioning and service delivery. • Provide support to help people access and sustain quality jobs, targeting those who are long term unemployed or with families.	•
Southampton is a healthy place to live and work with strong, active communities	• Support development of community networks, making best use of digital technology, community assets and open spaces. • Improve housing standards and reduce illness and avoidable deaths related to fuel poverty. • Develop an understanding of, and response to, social isolation and loneliness in the city. • Work with city planners to ensure health is reflected in policy making and delivery. • Deliver a cleaner environment through a clean air zone with vehicle access restrictions to the city. • Work with employers to improve workplace wellbeing through healthier work places.	•
People in Southampton have improved health experiences as a result of high quality, integrated services	• Improve health outcomes for residents, at a lower cost, through integration and joint working across all health and Council services. • Prioritise investment in and embed a prevention and early intervention approach to health and wellbeing across the city. • Deliver a common approach to planning care tailored to the needs of the individual or family. • Deliver the right care, at the right time, in the right place by working as locally as possible and shifting the balance of care out of hospital to community providers. • Maximise opportunities for prevention and early intervention through making every contact with services count.	•

Our principles:

1. Promote prevention and early help.
2. Work with residents and communities to:
   - Jointly plan, design and deliver services
   - Develop resilience
   - Make it easier for people to make healthy choices.
3. Deliver services that:
   - Are designed with residents
   - Are proportionate to the level of need
   - Are accessible to vulnerable groups
   - Are personalised, safe, effective and value for money
   - Give equal priority to physical and mental health.
4. Consider health in all policies.

The Health and Wellbeing Strategy is supported by a number of citywide strategies and action plans:



How will we measure success?

The Public Health Outcomes Framework is a comprehensive list of desired outcomes and indicators that help measure how well public health and wellbeing is being improved and protected in an area. The Health and Wellbeing Board will focus on a selection of these indicators that a) require the most improvement and b) will best indicate progress towards the outcomes in this strategy.

Priority area	Measure		
Overarching	Life expectancy at birth	Life expectancy at 65 years	Healthy Life Expectancy at birth
	Under 75 years mortality rate from cardiovascular disease	Under 75 years mortality rate from respiratory disease	Mortality rate from causes considered preventable
Children & Young People/Early years	Smoking status at time of delivery	Breastfeeding prevalence at 6-8 weeks after birth	Child excess weight in 4-5 and 10-11 year olds
	Population vaccination coverage – MMR for one dose (2 years old)	Looked after children rate	School readiness
	Children in low income families (under 16s)	Hospital admissions caused by unintentional and deliberate injuries (0-14 years)	Under 18 years conception rate
Adults	Smoking prevalence in adults	Suicide rate	Depression recorded prevalence
	Injuries due to falls in people aged 65 years and over	HIV late diagnosis	Under 75 years mortality rate for liver disease considered preventable
	TB incidence (3 year average)		
Healthy settings	Fraction of mortality attributable to particulate air pollution	Percentage of people aged 16-64 years in employment	Excess winter deaths index

The full Public Health Outcomes Framework can be found at http://www.phoutcomes.info/

HEALTH AND WELLBEING STRATEGY 2017-2025: Background document

Our vision is that Southampton has a culture and environment that promotes and supports health and wellbeing for all

Our ambition is to significantly improve health and wellbeing outcomes and reduce citywide health inequalities in Southampton by 2025.

1. Introduction

Health and wellbeing is important to everyone in Southampton, whether they live, work or learn in the city. It is about much more than the absence of illness or disease. It is about being able to lead fulfilling lives, and be actively engaged in families and communities.

The Southampton Health and Wellbeing Board are committed to working together with the people of Southampton to improve the health and wellbeing of residents. At a time of increasing demand on services and pressures on funding, it is even more important to make sure the City is a healthy place, that local people are able to take responsibility for their health and that of their families and communities, and that services are delivered as efficiently as possible, and targeted towards those people who need the most help.

Our Joint Strategic Needs Assessment (JSNA)[1] shows that the health of people living in Southampton continues to improve. We are living longer, deaths from heart disease and stroke are falling and cancer survival rates are improving. However, not all of these extra years of life are lived in good health or free from disability. Lifestyle related diseases are placing an increasing burden on our health and care system. There has also been limited progress in narrowing the health gap between the wealthy and those who are on low incomes. Furthermore, many health indicators in childhood show that we are not yet succeeding in our aim to give every young person the best possible start in life.

The Joint Health and Wellbeing Strategy (2017-25) for Southampton sets out the strategic vision for improving the health and reducing health inequalities in the city. The strategy identifies the long term outcomes we want to achieve for Southampton over the next eight years and the evidence base for achieving them. It is based on evidence of population need described in the Joint Strategic Needs Assessment.

The Health and Wellbeing Strategy will provide a bridge between plans produced by the local health and care system and other plans developed elsewhere that impact on the city's health and wellbeing. These will set out the actions required to achieve our long term goals. Progress against these plans will be reported to the Southampton Health and Wellbeing Board on a regular basis and longer term outcomes will be monitored through the Joint Strategic Needs Assessment.

[1] Southampton's JSNA can be accessed at: http://www.publichealth.southampton.gov.uk/HealthIntelligence/JSNA/

Our ambition **is to significantly improve health and wellbeing outcomes and reduce citywide health inequalities in Southampton by 2025.**

In order to achieve this, action will be required to create a culture and environment that empowers people to make healthy choices for themselves, their families and communities; stay well and independent and manage their own health and wellbeing; and access care which is joined up and tailored to meet the needs of the individual when they need it.

Our vision is that over the next 8 years Southampton grows and develops as a city with a culture and environment that promotes and supports health and wellbeing for all.

2. Health in Southampton

2.1 Southampton Population

Southampton is the largest city in Hampshire. It is a diverse city with a resident population of 247,569 comprising over 98,000 households, 53,928 children and young people, 53,000 residents who are not white British (22.4%) and over 40,000 students. The population of Southampton is predicted to rise by nearly 5% by 2022 to 259,600, with the over 65s and under 15s populations projected to increase by approximately 12% and 5.9% respectively. The GP registered population of Southampton is larger; 276,250.

Whilst Southampton is a thriving city with enormous growth potential associated with the affluent south, health outcomes are poorer than other areas in the south east and the city's characteristics relating to poverty and deprivation present challenges. The Index of Multiple Deprivation 2015 (IMD 2015) illustrates how Southampton has become relatively and absolutely more deprived since 2010. Based on average deprivation score, Southampton is now ranked 67th (where 1 is the most deprived) out of 326 local authorities in the country, compared to its previous position of 81st in 2010.

Over the past decade there has been an increase in life expectancy for both male and females, in keeping with national trends. However, life expectancy in Southampton City is significantly lower than the England average for males and most recent data suggest a decline. Healthy life expectancy in Southampton is similar to the England average for both males and females and remains fairly unchanged since recording began 5 years ago.

In terms of mortality, encouragingly our infant mortality rate is similar to the England average. Furthermore, the potential years of life lost due to premature mortality has fallen from 496.8 to 484.6 (2012-14), but continues to be significantly worse than England. The under 75 mortality rate from all cardiovascular diseases has remained stubbornly high whilst the England average has reduced. Alarmingly, the suicide rate is twice that of the England average, increasing since 2009-11. Infection rates are reducing and vaccination rates are high. However, HIV and TB remain key infection risk priorities for the city.

Health inequalities are a big challenge in the city. Men in the least deprived areas live 8 years longer than in the most deprived; for women the difference is 4.7 years. Although people are living longer, increases in healthy life expectancy are not keeping pace with gains in life expectancy, particularly at older ages and there are increasing numbers of people in Southampton living with complex needs. The main causes of mortality in Southampton are cancer and circulatory disease (including heart disease and stroke). 86,000 residents in the city

have a long term condition; half of these having multiple conditions. Inequalities in healthy life expectancy are even greater than those for life expectancy.

Children and adults in the city have high levels of physical inactivity and obesity. Tooth decay is much higher than the England average in children in Southampton and smoking prevalence and alcohol related problems in adults are also higher than England average. Unhealthy behaviours are known to cluster in populations. While higher socioeconomic groups have to some extent changed their health behaviour, this is not true of people living in the lower socio-economic groups. This is reflected in the city's smoking prevalence rates which are significantly higher in those with the greatest deprivation.

Lifestyle choices, socio-economic status and level of deprivation aside, there are environmental factors that significantly contribute to poor health in Southampton. For example, exposure to air pollution increases the risk of deaths from cardiovascular and respiratory conditions and is a significant health issue for the industrial Port City of Southampton, with 6.2% of deaths attributable to long term exposure to air pollution in 2010. The overall health impact across the life course is much greater and areas of high air pollution tend to coincide with areas of high deprivation. In terms of housing, standards and degree of fuel poverty have a significant impact on health and wellbeing. This is particularly important for Southampton because a high proportion of housing is landlord owned and about 10,000 householders live in fuel poverty.

2.2 Our Challenges

Southampton has a young demographic compared to the England average. Although Southampton's birth rate is projected to remain steady until 2022, a previous increase in birth rate continues to place increasing demands upon a whole range of both universal services. Since 2002, the city experienced a 42% rise in the level of new births. From 2011 onwards this trend has fallen and stabilised, with a total of 3,207 babies were born in Southampton in 2013. Health outcomes can vary by ethnicity and language may create a barrier to service access. 30.2% of school aged children are an ethnicity other than White British compared to 22.3% for all ages and the most prevalent language spoken as a first language second to English in schools is Polish.

Southampton's deprivation profile and wider determinants of health have a large impact on health inequalities. Over 22% of children in our city live in low income families, this is significantly worse than the national average. Despite this, the strategic focus to ensure children have a good start in life has ensured that children accessing early years settings progress well and achieve a good level of development at the end of Reception; similar to the national average. Teenage pregnancy rates are strongly linked to deprivation and our teenage pregnancy rate is significantly higher than the national average, but is reducing from 47.4 per 1,000 teenagers (aged 15-17) in 2011 to 29.0 in 2014 in line with the national trend.

GCSE attainment 2016 in Southampton schools has shown an improvement from the previous year and we have seen a decline in pupil absence and the number of first time entrants to the youth justice system. Nonetheless, rates are significantly worse than the national average. The hospital admissions rate for violent crime rate is high, almost double that of the national average and the rate of looked after children is 75% higher than the national average. Mental health hospital admissions, both for adults and children and young people are high, as is the hospital admission rate for self-harm. All of these factors have a major impact on future health and life chances.

In 2016 the over 65 population made up 14% of the Southampton population (34,600 people). This is a smaller proportion of the population than in many other areas of the country, however still an important group in terms of need and demand for services. The older population is projected to grow more than any other group in Southampton over the next few years and the proportion of the total Southampton population over 65 will also increase. Given changing demographics, it is important that the health and care system in and around Southampton adapts to meet the changing and growing needs of the population and has a focus on promoting healthy ageing.

Encouragingly, smoking prevalence in adults in Southampton reduced from 21.5% to 20.4% between 2013 and 2015 but remains significantly above the England average of 16.9% and the under 75 mortality rate from respiratory disease remains above the England average. Furthermore, 15% of pregnant women in Southampton are recorded as smoking at time of delivery, this is almost 30% higher than the national average.

More than 30,000 Southampton residents drink alcohol at levels that increase their risk of physical and mental harm, with a further 10,000 drinking at levels that place them at significantly higher risk of long term disease. Admission episodes for alcohol-related conditions are far higher than the England average and have shown no sign of decline since the last Health and Wellbeing Strategy (70.9 compared to 64.1 per 100,000). Under 75 mortality rate from liver disease also remains higher than the England average.

Lifestyle issue	Prevalence (%)	Number in Southampton
Smoking – children and young people*	11.7	1,128
Smoking – adults**	20.4	40,325
Alcohol – regular drinking in young people*	5.0	482
Alcohol – increasing or higher risk adults**	23.4	46,029
Physical inactivity - children and young people*	74.1	7,145
Physical inactivity – adults**	30.5	59,996
Overweight (including obese) - Year R**	22.8	637
Overweight (including obese) - Year 6**	34.6	2,162
Obesity - Year R**	8.7	242
Obesity - Year 6 **	20.8	450
Overweight (including obese) – adults**	62.2	122,352
Obesity – adults**	24.1	47,406
*Data taken from the What About YOUth survey which is completed by 15 year olds – population numbers calculated using population aged 14-17. Physical inactivity - children and young people measured as % of Southampton 15 year olds who are physically active for less than one hour per day seven days a week is.**Public Health Outcomes Framework[2] indicator Population numbers based on ONS 2014 Mid-Year Population Estimates		

The City's financial challenge is that there is a significant funding gap for local health and social care services of £70 million over the next five years (estimate as of 2016/17). In addition, primary care is undergoing significant change in service provision as a result of increasing

[2] Public Health Outcomes Framework http://www.phoutcomes.info/

demand and reduction in capacity. There is a clear need to empower people to stay well; provide high quality, sustainable health and care to everyone who needs it; and deliver consistent and affordable care to all of our population. Furthermore, there is a need to ensure that Southampton is a healthy place, encouraging and supporting healthy behaviours through living, working and learning within healthy environments.

3. Health and Wellbeing Board in Southampton

Southampton's Health and Wellbeing Board is a statutory partnership and a committee of the Council which brings together the city's health and social care commissioners, including Southampton City Clinical Commissioning Group, Southampton City Council and NHS England. The Board has an oversight of health and wellbeing in the City. Its role is to develop joint priorities for local commissioning to ensure delivery of the right outcomes, and to provide advice, assistance or other support to improve the health and wellbeing of the city's diverse communities.

The Chair of the Health and Wellbeing Board is the Cabinet Member for Health and Sustainable Living and the Deputy Chair is Southampton City CCG's Chair. Membership includes Cabinet Members for Housing and Adult Care; Children's Social Care; and Education and Skills; as well as the Southampton City Council's Director of Public Health; Director of Housing, Director of Adults and Communities; Director of Children Services; the joint Council/CGG Director of Quality and Integration; the Chief Officer of Southampton CCG and the Healthwatch Southampton Manager.

There is a strong history of partnership working to improve health in the city. Southampton had operated an effective Health and Wellbeing Partnership for a number of years before the Health and Wellbeing Board became a statutory requirement in 2013. Southampton's last Health and Wellbeing Strategy was published in March 2013. The former Health and Wellbeing Partnership produced a Strategy previously. This new strategy builds on learning from these strategies and the strong links between partners in the city.

3.1 Purpose of the Health and Wellbeing Strategy

Local Authorities and Clinical Commissioning Groups (CCGs) have equal and joint statutory duties to prepare a Health and Wellbeing Strategy that sets out how they plan to work together with local partners to meet health and care needs identified in the Joint Strategic Needs Assessment (JSNA) and to improve the health and wellbeing of the local community and reduce inequalities for all ages.

It is an overarching strategy which provides the future strategic direction for health and care in the city, setting out our priorities and how we will work together. The strategy sits within a framework of other strategies and plans across the local health and care system and other plans that impact on the city's health and wellbeing. These will set out the actions required to achieve our long term goals. Progress against these plans will be reported to the Southampton Health and Wellbeing Board on a regular basis and longer term outcomes will be monitored through the Joint Strategic Needs Assessment

The Southampton Health and Wellbeing Board's strategic intent aligns with:

Southampton Connect City Strategy priorities (2015-2025)[3] for economic growth with social responsibility, skills and employment and healthier and safer communities.

Southampton City Council Strategy priorities (2016-2020)[4] which are: Southampton has strong and sustainable economic growth, children and young people get a good start in life, people in Southampton lead safe, healthy and independent lives and Southampton is an attractive modern City where people are proud to live and work.

Southampton City Clinical Commissioning Group (5 year strategic plan 2014-2019)[5] vision of a healthy Southampton for all with the following 5 goals: Make care safer, make care fairer, improve productivity (achieve more with less), shift the balance (integrate health and care services) and delivering sustainable finances.

The Hampshire and Isle of Wight Sustainability and Transformation Plan which has the following priorities: to develop new models of integrated care, Solent Acute Alliance, Mental Health Alliance, effective patient flow and discharge and prevention at scale and is the route to deliver the **NHS Five Year Forward View**[6] which sets out the shared ambition to improve health, quality or care and efficiency within the resources given to local health and care systems by Parliament. This triple aim will only be achieved through local health and care organisations working together in partnership with the active involvement of patients, stakeholders, clinicians and staff.

NHS Southampton City CCG Two Year Operational Plan (2017-19) which sets out plans to make Southampton a healthy city for all and supports the delivery of the Hampshire and Isle of Wight Sustainability and Transformation Plan.

3.2 What's happened since the last strategy

Southampton's previous strategy set out 64 actions to improve health in Southampton under three themes:

- Building resilience and using preventative measures to achieve better health and wellbeing
- Best start in life
- Living and ageing well

In the final review of progress against these actions in 2015/16, 95% of commitments had been achieved or were underway. Teenage pregnancies are reducing, mental health awareness has increased through City wide campaigns as has end of life care planning. From the perspective of service redesign, Better Care Southampton has been implemented: £60 million of health and care budgets have been pooled and six GP 'clusters' established to improve local services.

Areas identified as not meeting targets were:

[3] http://www.southampton.gov.uk/Images/Southampton-City-Strategy-15-25_tcm63-387730.pdf

[4] http://www.southampton.gov.uk/Images/Council-strategy-2016-20_tcm63-387729.pdf

[5] http://www.southamptoncityccg.nhs.uk/search?term=five+year+strategic+plan&search=Search+me&searchType=all

[6] https://www.england.nhs.uk/ourwork/futurenhs/

- Continue to develop high class education provision, raise attainment faster than comparator cities and improve school attendance rates where they are low.
- Establish an end of life care register accessible to all appropriate service providers (e.g. Out of Hours Service)

Eight areas were amber rated, having progressed but not meeting targets. These commitments have been reviewed and where still relevant have been incorporated in to this new strategy.

Residents views on health and wellbeing priorities

Southampton City Council engaged with residents and stakeholders to gain an understanding of their views on health and wellbeing. The intention was to gather data which relates to attitudes and behaviours, as this type of data is not collected in the more comprehensive Joint Strategic Needs Assessment (JSNA). Engagement took place throughout March and April 2016.

The agreed approach for engagement was to use an online survey, with paper versions available on request. In addition, a council officer attended five Sure Start Children's Centre sessions across the city to talk to parents, which also provided them with the opportunity to complete the survey.

In addition, the council held resident workshops, collated comments through a 'post-box' in Central Library and held a session with voluntary sector representatives to gather broader views from service providers and voluntary groups on key issues for the city. As a result of the engagement the council engaged with over 950 stakeholders through the various opportunities, as mentioned above.

Over 900 residents took part in the survey. Mobility problems and cancer were the most chosen concern by respondents, 29% and 28% respectively. In joint third, mood/ contentment and money received 24% of responses, and was chosen more often than other health concerns such as heart conditions (16%), lung/ breathing problems (13%) and diabetes (9%).

The majority of respondents (70%) assessed their own health as being good or very good. The majority of respondents shared that they currently do not smoke, they eat healthily and attend regular dental check-ups. However, respondents were less likely to talk to friends and family about concerns and make use of advice websites and helplines.

The results showed comments relating to time constraints (34% of the 553 responses) for example, being busy with work, caring for others and raising children, were the most common reasons that prevent people from improving their health and wellbeing. Respondents felt exercise (17% of the 546 responses) would help improve their health and wellbeing. This was closely followed by 15% of responses which fell within the support category, for example providing advice or groups to help.

During the workshops residents focused on healthy behaviours. Participants shared a wide range of healthy things they do now, which included taking part in a wide range of physical activity, eating healthily and attending regular health screenings. Participants felt they could do more healthy things, such as getting a better work life balance, doing more exercise and de-stressing

regularly. They also felt that the lack of ambition and motivation, lack of role models and money and finances all prevent people from behaving more healthily.

The post-box activity provided people with an opportunity to share their health and wellbeing views 'on the go'. Some of the thoughts shared which related to things they could do to be healthier, included: increased physical activity, taking care of mental wellbeing and eating healthier.

The engagement session with the voluntary sector provided representatives with the opportunity to share their ideas on key priorities for the city. Their suggestions included: healthy environments (including the workplace), mental health, aspiration and budgeting.

4. Purpose of strategy

Health and wellbeing is important to everyone in Southampton, whether they live, work or learn in the city. Our strategy is a call to action to both improve health for all and reduce health inequalities in Southampton.

Our vision is that Southampton has a culture and environment that promotes and supports health and wellbeing for all

Our ambition is to significantly improve health and wellbeing outcomes and reduce citywide health inequalities in Southampton by 2025.

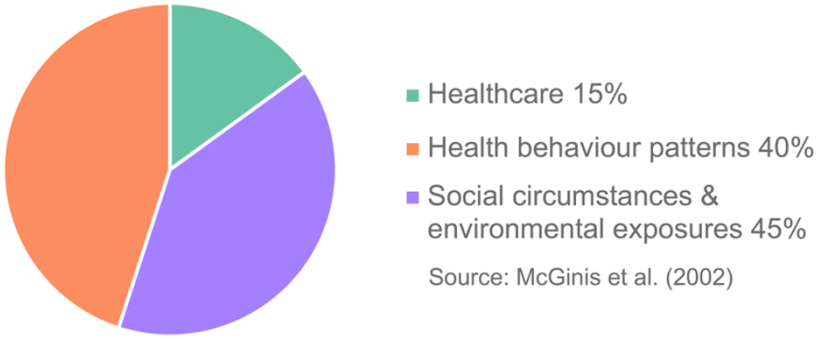
Our strategy takes a life course approach, and is underpinned by the following principles:

1. Promote prevention and early intervention
2. Work with residents and communities to:
    - Jointly plan, design, and deliver services
    - Develop resilience
    - Make it easier for people to make healthy choices
3. Deliver services that:
    - Are proportionate to the level of need
    - Are accessible to vulnerable groups
    - Are personalised, safe, effective and best value for money
    - Give equal priority to physical and mental health
4. Consider health in All Policies

5. What outcomes do we want to achieve

As a population we're living longer but spending more years in ill-health. Many factors combine together to affect the health of individuals and communities. Our health is determined by where we live, the environment and community around us, our education, employment and income level as well as genetics and lifestyle choices and access and use of health and care services.

Model of relative contributions of the determinants of health



This model shows that action is required to improve the environment around us and change health behaviours as well as deliver high quality health and care in order to improve health and wellbeing.

A review of the evidence together with stakeholder and public engagement undertaken in 2016 identified four strategic themes which will enable us to achieve our vision that Southampton grows and develops as a city with a culture and environment that promotes and supports health and wellbeing for all and some key principles for their delivery.

Our four strategic themes:

1. Inequalities in health outcomes and access to health and care services are reduced.
2. Southampton is a healthy place to live and work with strong, active communities.
3. People in Southampton live active, safe and independent lives and manage their own health and wellbeing.
4. People in Southampton have improved health experiences as a result of high quality, integrated services.

The Health and Wellbeing Strategy will provide a bridge between plans produced by the local health and care system and other plans developed elsewhere that impact on the city's health and wellbeing. These will set out the actions required to achieve our long term goals. Progress against these plans will be reported to the Southampton Health and Wellbeing Board on a regular basis and longer term outcomes will be monitored through the Joint Strategic Needs Assessment.

5.1 Inequalities in health outcomes and access to health and care services are reduced.

Why this is important

Health and wellbeing outcomes are very different for men, women and different communities in Southampton, and there are significant health inequalities in our city. We want to improve the health and wellbeing of all residents and reduce inequalities so that everyone, and especially vulnerable children and adults, has increased opportunities and a better quality of life.

What the evidence tells us

The conditions in which people are born, grow, live, work and age have profound influence on health and inequalities in health in childhood, working age and older age. The lower a person's

social and economic status, the poorer their health is likely to be. Health inequalities arise from a complex interaction of many factors, such as housing, income, education, social isolation and disability, all of which are strongly affected by economic and social status. Action on health inequalities requires action across all the social determinants of health, including education, occupation, income, home and community. The greatest reductions in health inequalities can be achieved through providing support proportionate to level of need.

The Marmot Review "'Fair Society Healthy Lives"[7] was a comprehensive review of the evidence and an assessment of what actions are likely to be most effective in reducing health inequalities in the short, medium and long term in England. Six key policy areas were proposed, with a set of actions for each.

The six areas are:

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

A series of evidence briefings[8] has been produced by University College London Institute of Health Equity to show where greatest gains in reducing health inequalities can be achieved based on the policy objectives set out in the Marmot Review. In light of these reviews and accumulating evidence of increasing health inequalities in Southampton, a Health Inequalities framework was produced in July 2015.

What we are going to do

Our actions to reduce health inequalities will include:

- Reduce the health inequalities gap between the most deprived and least deprived neighbourhoods in the city through a community based approach that is proportionate to level of need
- Take action to improve men's health to reduce the difference between male and female life expectancy through community based initiatives to deliver behaviour change. Reduce inequalities in early child development by ensuring good provision of maternity services, childcare, parenting and early years support.
- Work with schools to improve healthy lifestyle choices and mental wellbeing and reduce adolescent risk taking in children and young people.
- Target access to advice and navigation to services to those who are most at risk and in need, to improve their health outcomes.

[7] 'Fair Society Healthy Lives' (The Marmot Review) 2010
http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
[8] Local Action on Health Inequalities Series – Overview, UCL Institute of Health Equity
http://www.instituteofhealthequity.org/projects/local-action-on-health-inequalities-series-overview

- Ensure that health inequalities are taken into account in policy development, commissioning and service delivery.
- Provide support to help people access and sustain quality jobs, targeting those who are long term unemployed or with families.

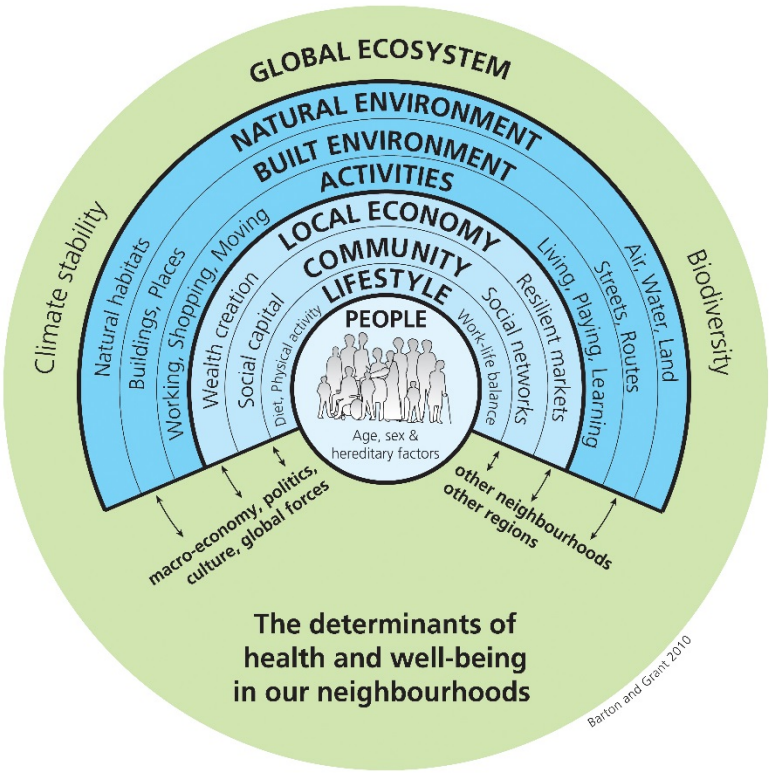
5.2 Southampton is a healthy place to live and work with strong, active communities.

Why this is important

Being healthy and well for a lifetime includes much more than good health and social care services. Many different things impact on health and wellbeing, like housing, jobs, leisure and sport and access to open spaces, education, and transport as well as the neighbourhood and community we live in.

We want Southampton to be a healthy place to live and work with health promoting assets and strong and active communities.

What the evidence tells us



Evidence shows that addressing the social determinants of health requires innovative solutions and a new way of thinking about policy. Health in All Policies (HiAP) is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas[9]. HiAP is based on the

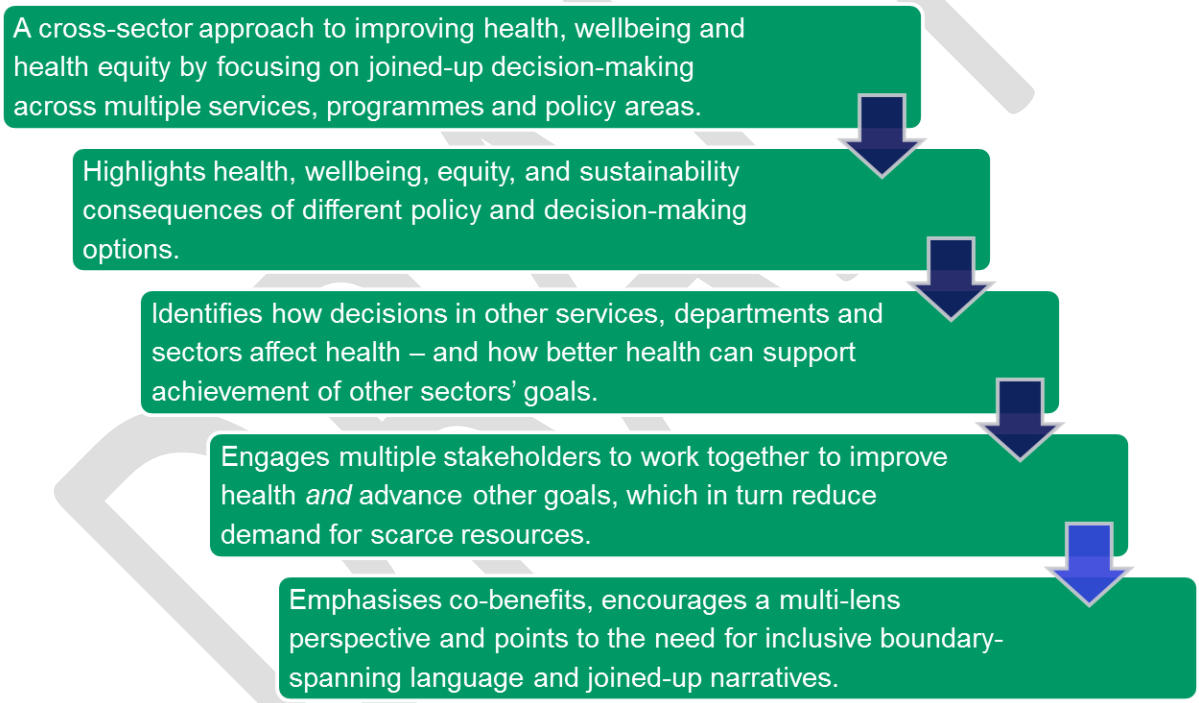
[9] Health in All Policies – evidence based approach to tackle health inequalities.: http://www.local.gov.uk/documents/10180/7632544/1.4+Health+in+ALL+policies_WEB.PDF/b21cf56f-403e-45c4-8a29-2c96df48acdb

recognition that our greatest health challenges for example, non-communicable diseases, health inequities and inequalities, climate change and spiralling health care costs are highly complex and often linked through the social determinants of health.

HiAP ideally starts with the policy area (e.g. economic development policy or transport policy) not with a public health issue. This encourages thinking about the range of potential direct and indirect benefits/risks for health that can be created from that policy. The figure below recommends actions and outcomes from delivery of health in all policies.

Healthy policies will support the development of healthy places to live, work and learn. Coupled to this is the need for community action to improve health, mental resilience and resilience to act in the event of extreme conditions e.g. gritting of icy paths.

How Health in All Policies works



What we are going to do

We will take action to improve the social, economic and environmental conditions that influence the health of individuals and communities in Southampton and adopt a Health in all Policies approach.

Actions will include:

- Support and develop community networks, making best use of digital technology, community assets and open spaces.
- Improve housing standards and reduce illness and avoidable deaths related to fuel poverty.
- Develop an understanding of, and response to, social isolation and loneliness in the city.

- Work with city planners to ensure health is reflected in policy making and delivery.
- Deliver a cleaner environment through a clean air zone with vehicle access restrictions to the city.
- Work with employers to improve workplace wellbeing through healthier work places.

5.3 People in Southampton live active, safe and independent lives and manage their own health and wellbeing

Why this is important

We want to support more people to choose healthy lifestyles. When people take responsibility for their own health and the health of their children through positive lifestyle changes, this improves their wellbeing, prevents ill health and helps them to stay independent in their own homes and communities for longer.

What the evidence tells us

We want to prevent avoidable deaths, ensure that people are supported to stay well for longer, are able to live active, safe and independent lives and manage their own health and wellbeing. To achieve this requires an understanding of the burden of disease in the population and evidence based interventions to reduce this burden.

In 2014, nearly a quarter of all deaths (23%) in England and Wales were from causes considered potentially avoidable through timely and effective healthcare or public health interventions[10]. In adults the leading causes of avoidable death are cancer and heart disease, whilst the leading causes of avoidable deaths in children and young people include complications during childbirth accidental injuries, suicides and self-inflicted injuries. The highest number of avoidable deaths in children and young people were from accidental injuries (14%; 195 out of the 1,443 avoidable deaths in this age group). Injuries can also be the cause of life changing and life long disability.

The burden of disease in a population can be measured in different ways: Years of Life Lost (YLL), Years Lived with Disability (YLD), and Disability Adjusted Life Years (DALY) which takes in to account the years of potential life lost due to premature mortality and the years of productive life lost due to disability.

40% of disability adjusted life years lost are caused by lifestyle risk factors[11] and there is good evidence that many early deaths and ill health could be prevented or delayed if people made healthier lifestyle choices[12]. The Wanless Report Securing Good Health for the Whole Population[13] outlined a position in the future in which levels of public engagement with health are high, and the use of preventive and primary care services are optimised, helping people to

[10] Avoidable mortality in England and Wales: 2014 https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/avoidablemortalityinenglandandwales/2014

[11] Global Burden of Disease Study 2010 https://www.healthdata.org/sites/default/files/files/country_profiles/GBD/ihme_gbd_country_report_united_kingdom.pdf

[12] Kings Fund Improving the Public's Health http://www.kingsfund.org.uk/publications/improving-publics-health

[13] Securing Good Health for the Whole Population Derek Wanless 2004 http://webarchive.nationalarchives.gov.uk/+/http:/www.hm-treasury.gov.uk/media/D/3/Wanless04_summary.pdf

stay healthy. This 'fully engaged' scenario requires changes in behaviours and their social, economic and environmental context to be at the heart of all disease prevention strategies.

The data shows that mental health and wellbeing are also important, with depression and anxiety causing a high burden of disease in the population and suicide accounting for a high number years of life lost, particularly in men. Mental and physical wellbeing are closely linked; people with poor physical health are at higher risk of experiencing mental health problems and people with poor mental health are more likely to have poor physical health. People with mental health problems are more likely to smoke, be overweight, use drugs and drink alcohol to excess, have a disrupted education, be unemployed, take time off work, fall into poverty, and be over-represented in the criminal justice system. It is therefore crucial that mental health is given equal priority to physical health in order to improve health and reduce inequalities in the population.

There are a range of evidence based interventions that can help improve the health of the population and reduce health and care service demand[14]. These are shown in the table below.

Evidence based interventions to achieve behaviour change and reduce service demand

Lifestyle risk	**Evidence based intervention**
Alcohol	Alcohol care teams in acute hospitals Alcohol identification and brief advice
Tobacco	Assessment, very brief advice and referral in hospitals Behaviour change support to help smokers stop
Diet and obesity	Weight management services Polices and interventions to tackle the obesogenic environment including promoting healthier food and drink choices and increasing physical activity opportunities
Health and work	Implement holistic workplace wellbeing programmes Individual placement and support
CVD secondary prevention	Reduce the incidence of avoidable AF-related strokes Improve management for patients with high blood pressure
Diabetes	Healthier You: the NHS Diabetes Prevention Programme Encourage uptake of structured education in diabetes
Falls and muscoskeletal health	Musculoskeletal physiotherapy: patient self-referral Establish fracture liaison services
Physical activity	Deliver effective brief advice on physical activity in clinical care Promoting and increasing active travel
Mental health	Improving perinatal mental health services Smoke free mental health trusts and quitting support
Sexual health	Improve access to long-acting reversible contraceptives Increasing uptake of HIV testing
Dementia	Raise public awareness about reducing the risk of dementia
Maternity and early years	Screen and refer women who smoke during pregnancy Implement programmes that increase access to fluorides
Drugs	Review prescriptions of medicines liable to dependence

[14] Local Health and Care Planning: Menu of preventative interventions, Public Health England 2016 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/565944/Local_health_and_care_planning_menu_of_preventative_interventions.pdf

Antimicrobial resistance	Reducing inappropriate prescribing of antibiotics

What are we going to do

Actions will include:

- Encourage and promote healthier lifestyle choices and behaviour, with a focus on smoking, alcohol / substance misuse, physical activity, and a healthy weight.
- Encourage and promote healthy relationships and wellbeing of individuals of all ages, carers and families, particularly for those at risk of harm and the most vulnerable groups through increasing early help and support.
- Support people to be more independent in their own home and through access to their local community, making best use of digital tools including Telecare.
- Ensure that information and advice is co-ordinated and accessible.
- Prioritise and promote mental health and wellbeing as being equally important as physical health.
- Increase access to appropriate mental health services as early as possible and when they are needed.
- Make every contact count by ensuring all agencies are able to identify individual needs and respond /refer to services as appropriate.
- Promote access to immunisation and population screening programmes.

5.4 People in Southampton have improved health experiences as a result of high quality, integrated services

Why this is important

We want to make sure people get high quality support when and where they need it. This means making sure services are designed around the needs of people, with a focus on prevention and early intervention and that they are accessible and coordinated so that people receive joined up, seamless care. Integrating services across health and social care also means that all health and wellbeing partners can work more effectively and efficiently together, so that resources and assets are used where they are needed most.

What the evidence tells us

The Better Care Southampton vision is to transform the delivery of care in Southampton through the jointly led CCG and City Council Better Care programme so that it is fully integrated across health and care, delivered as locally as possible and person centred. People will be at the heart of their care, fully engaged and supported where necessary by high quality integrated local and connected communities of services to maintain or retain their independence, health and wellbeing. Neighbourhoods and local communities will have a recognised and valued role in supporting people and there will be a much stronger focus on prevention and early intervention.

The overall aims for integrated care in Southampton are:

- Putting people at the centre of their care, meeting needs in a holistic way
- Providing the right care, in the right place at the right time, and enabling people to stay in their own homes for as long as possible

- Making optimum use of the health and care resources available in the community, reducing duplication and closing gaps, doing things once wherever appropriate
- Intervening earlier in order to secure better outcomes by providing more coordinated, proactive services

What we are going to do

The key priorities are:

- Improve health outcomes for residents, at a lower cost, through integration and joint working across all health and Council services.
- Prioritise investment and embed a prevention and early intervention approach to health and wellbeing across the city.
- Deliver a common approach to planning care tailored to the needs of the individual or family.
- Deliver the right care, at the right time, in the right place by working as locally as possible and shifting the balance of care out of hospital to community providers.
- Maximise opportunities for prevention and early intervention through making every contact with services count.

6. How we will measure success

Success in delivering our 8 year vision will be monitored through high level outcomes included in the Public Health Outcomes Framework and our local Joint Strategic Needs Assessment. These are shown in the framework below

Outcome: Health Inequalities within Southampton are reduced in 5 years and the Southampton City average is equivalent to the national average in 8 years PHOF: Public Health Outcome Framework		
Priority area	**Outcome**	**Measure**
	Life expectancy at birth (males and females)	**PHOF 0.1ii**
Overarching	Life expectancy at 65 years (males and females)	**PHOF 0.1ii**
	Healthy Life Expectancy at birth (males and females)	**PHOF 0.1i**
	Under 75 years mortality rate from cardiovascular disease (males, females and persons)	**PHOF 4.04**
	Under 75 years mortality rate from respiratory disease (males, females and persons)	**PHOF 4.07**
	Mortality rate from causes considered preventable (males, females and persons)	**PHOF 4.03**
Early years	Smoking status at time of delivery	**PHOF 2.03**
	Breastfeeding prevalence at 6-8 weeks after birth	**PHOF 2.02**
	Child excess weight in 4-5 and 10-11 year olds	**PHOF 2.06**
	Population vaccination coverage – MMR for one dose (2 years old)	**PHOF 3.03**
	Looked after children: rate per 10,000 <18 population[15]	**Local Authority/Department for**

[15] Available in PHE Child Health Profile https://fingertips.phe.org.uk/search/looked%20af#page/3/gid/1/pat/6/par/E12000008/ati/102/are/E06000045/iid/90401/age/173/sex/4

		Education
	School readiness at the end of reception	**PHOF 1.02i**
Children & Young People	Children in low income families (under 16s)	**PHOF 1.01ii**
	Hospital admissions caused by unintentional and deliberate injuries (0-14 years)	**PHOF 2.07i**
	Under 18 years conception rate	**PHOF 2.04**
	GCSE achieved 5A*-C including English & Maths	**Department of Education (in Child Health Profile)**
Adults	Smoking prevalence in adults	**PHOF 2.14**
	Suicide rate	**PHOF 4.10**
	Depression recorded prevalence	
	Injuries due to falls in people aged 65 years and over	**PHOF 2.24**
	People presenting with HIV at a late stage of infection	**PHOF 3.04**
	TB incidence (3 year average)	
	Under 75 years mortality rate for liver disease considered preventable	**PHOF 4.06**
Healthy settings	Fraction of mortality attributable to particulate air pollution	**PHOF 3.01**
	Percentage of people aged 16-64 years in employment	**PHOF 1.08**
	Excess winter deaths index (persons)	**PHOF 4.15**

Developmental outcomes

There two outcomes that are important to improve in Southampton but are not currently monitored consistently and/or benchmarked against other areas. These outcomes will be reviewed on a bi-annual basis to determine opportunity for measurement in the future.

- Loneliness and social isolation
- Corporate parenting – health indicators

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		UPDATE ON THE IMPLEMENTATION OF SOUTHAMPTON CITY FOOT CARE PATHWAY		
DATE OF DECISION:		23 FEBRUARY 2017		
REPORT OF:		DIRECTOR OF QUALITY AND INTEGRATION		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Georgina Cunningham**	**Tel:**	**023 80725607**
	E-mail:	**Georgina.Cunningham@southamptoncityccg.nhs.uk**		
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STATEMENT OF CONFIDENTIALITY

None

BRIEF SUMMARY

As part of the overall Diabetes Improvement programme set out in the Diabetes Strategy 2013-16, NHS Southampton CCG implemented a new Foot Care Pathway from April 2016. The outline of the pathway and need for change was presented at HOSP in January 2016 with the recommendation that an update be presented in twelve months' time.

This paper provides an update based on the monitoring recommendations established in March 2016 by HOSP and the Podiatry Service Review Report for the period April 2016 to end September 2016 (Quarter 1 & Quarter 2). A verbal up-date for the period October to December 2016 will be available at the meeting if required.

RECOMMENDATIONS:

	(i)	That progress of the new Foot Care Pathway be noted
	(ii)	The Panel identifies any issues it may require further information/updates on.

REASONS FOR REPORT RECOMMENDATIONS

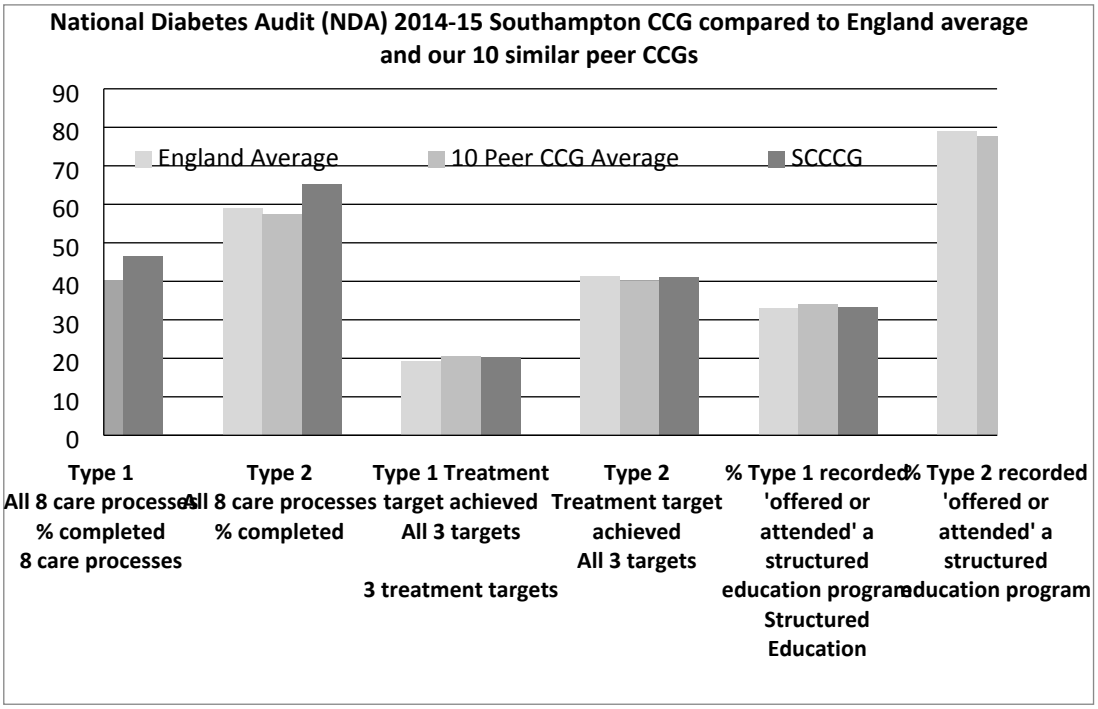
1.	To enable the Health Overview and Scrutiny Panel to examine key health issues.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2.	None

DETAIL (Including consultation carried out)

	Background - Diabetes
3.	In Southampton Diabetes has been a priority improvement area since 2013. As at April 2016, 12,497 people registered at GP practices in the city have a diagnosis of Diabetes, 5.3% of the adult GP registered population. Since 2013 the city has seen a 5.4% increase in the number of those diagnosed with Diabetes and it is likely that given the growing prevalence of obesity in the city that the number of those diagnosed with Diabetes will continue to grow.
4.	Actions set out in the Southampton City CCG Diabetes Strategy 2013-2016

	have been achieved in the last three years which has included new investment for a local insulin pump service, a new Foot Care Pathway which includes combined clinics, Multidisciplinary team working and a Diabetes Foot Protection Team, plus investment in Primary Care through quality improvement schemes. A summary of the achievements and outcomes of the Diabetes Strategy and three year plan is attached as Appendix 1.
5.	The city has also seen improvements in diabetes patient outcomes for 9 key care processes and treatment targets since 2011/12 when the city was reported to be in the bottom 25% of all CCGs in England and Wales. **Table One:** 
6.	The City now compares well against the average for England and its ten peer CCGs. However, further improvement is required in the up-take of Patient Structured Education. The CCG's Two Year Operational Plan (2017-19) sets outs key actions for Diabetes Prevention which includes the improvement of the up-take of Patient Structured Education; implementation of the National Diabetes Prevention Programme; continued improvement of Treatment Targets and the enhancement of Self- Management linked to the personalisation of care for Long Term Conditions.
	Background – Foot Care Pathway
7.	Every patient with diabetes has an annual review undertaken at their GP surgery, most commonly by the practice nurse. As part of this annual review, the feet of each patient are examined and assessed. By doing this, the foot risk is identified and will be discussed with the patient. There are three levels of risk: • Low risk – managed in Primary Care • Increased / moderate risk – referred to NHS Solent Podiatry • High Risk – referred to NHS Solent Podiatry
8.	The majority of patients with diabetes, 70% will have a low risk of developing foot complications related to their diabetes, 20% will be a medium risk, 5%

	will be at high risk with a further 5% having active foot disease and Ulceration.
9.	The vast majority of diabetic amputations (85%) begin with a single ulcer. Diabetic foot ulcers require rapid and specialist support and can deteriorate rapidly. Good, joined up care delivered in a timely manner can ultimately prevent an acute hospital admission and an amputation. The survival rate following an amputation is poor, with approximately 50% survival after five years. Average life expectancy is reduced by 14 years, even in those with predominantly neuropathic disease.
10.	Southampton is particularly challenged by diabetes foot outcomes, as the following table demonstrates: **Table Two:**

Extracted data from PHE Diabetes Foot Care Profile	Hospital foot care activity (April '10 to Mar '13) **Published Mar 2014**		Hospital foot care activity (April '11 to Mar '14) **Published June 2015**		Hospital foot care activity (April '12 to Mar '15) **Published Aug 2016**	
	SCCCG	England avg.	SCCCG	England avg.	SCCCG	England avg.
Amputations per 1,000 people aged 17+ with diabetes	4.2% (137)	2.6%	4.3% (148)	2.6%	4.6% (165)	2.6%
Major amputations per 1,000 people aged 17+ with diabetes	1.0% (32)	0.9%	0.8% (28)	0.8%	0.8% (30)	0.8%
Minor amputations per 1,000 people aged 17+ with diabetes	3.2% (105)	1.7%	3.5% (120)	1.8%	3.8% (135)	1.8%

11.	It is important when reviewing the headlines about amputations to understand the context, for example the numbers of amputations undertaken, identified by the numbers in the brackets, over the period of time. Key observations are: • Major amputations are similar to the national average for England • Minor amputations are significantly higher than the national average for England Compared to our closest peer CCG, Portsmouth, the overall amputation rate is higher in Southampton by 0.6%. However, Southampton's rate for major amputations is lower at 0.8% compared to 1.2% in Portsmouth but the city's minor amputation rate is higher at 3.8% compared to 2.8% in Portsmouth.
	The New Foot Care Pathway
12.	To improve Diabetic Foot outcomes in Southampton a new foot care

	pathway commenced from 1st April 2016. It aims to meet the needs of those at low risk, medium to high risk and those with acute foot disease and ulceration, with the implementation of a community Diabetes Foot Protection Team (DFPT) and new Combined Foot Care Clinics and Multi-Disciplinary Team (MDT) delivered at the hospital. It will: • Improve management in primary care to support patients who are at low risk to self-manage better and maintain their low risk status • Through the implementation of the DFPT - Improve access to more responsive and timely care, greater patient satisfaction • Prevention of foot disease and improved management of ulceration to prevent further complication • Improved access to expert assessment and intervention through MDT and Combined Foot Care clinics • Reduction in major and minor amputations over the next 3 years • Improved outcomes for the city Please see Appendix 2 for a copy of the current foot care pathway.
	Total Contact Casting (TCC-EZ)
13.	Diabetic Foot Ulcers traditionally take 12 months to heal. To heal diabetic foot ulceration, appropriate offloading needs to be offered and used. There are two types of offloading devices available and recommended by NICE: **A non- removable device (which is worn 24 hours per day for 6-8 weeks)** • NICE NG 19 recommends non-removable offloading devices that reduce peak plantar pressures and redistribute pressure from the ulceration site in patients with acute foot problems (NICE, 2015). • Clinical evidence of the use of Total Contact Casting (TCC-EZ) demonstrates a healing rate of 86% at 8 weeks compared to an average healing rate of 52 weeks with conventional therapy **Removable device** • By their nature these devices (Air cast boots, Draco shoes, cast shoes etc.) can be removed so patient compliance is a major factor. • Whilst these devices can help they are more palliative in their approach as they can keep a wound static, but the risks of an open wound remain e.g. infection.
14.	Southampton City CCG has also commissioned for the provision of TCC-EZ locally which started in September 2016 for an initial 12 month period, pending review and evaluation to determine continuation of funding. This additional provision will help to further improve outcomes for those with Diabetes foot complications.
15.	The SCCCG Diabetes Development group, which meets bi-monthly, receives reports and feedback from the NHS Solent Trust lead Podiatrist on the progress of the new foot care pathway. Quarterly Service Review meetings are also undertaken with University Hospital Southampton NHS Trust, who delivers the combined foot care clinics and MDT and report on activity against the agreed performance indicators.
	Diabetic Foot MDT
16.	The Diabetic Foot Multi-Disciplinary Team (DFMDT) started in April 2016

	and is hosted at UHS within Victoria House Outpatients. The DF MDT clinic runs two clinics per week, a Tuesday PM and Friday PM which provides 14 appointments per week. The DFMDT is the top end of the Diabetic Foot Pathway. The frequency of DFMDT clinics are at present dependent on room availability within Victoria House. The clinics comprise of the following staff: • Clinics on a Tuesday are delivered by the UHS Consultant Diabetologist and the NHS Solent Lead Podiatrist. • Clinics on a Friday are delivered by the UHS Consultant Diabetologist and the NHS Solent Lead Podiatrist, UHS Vascular Surgeons and a Vascular Surgical Care Practitioner. In addition to the 7 slots for Southampton CCG on a Friday, and to enable the Vascular teams input, there are three additional slots per Friday (12 a month on average) for West Hampshire CCG patients.
17.	Referrals come through Podiatry SPA and the patient caseload in the DFMDT consists of the following four types of patients: • New Diabetic foot ulceration presentation from Primary care as per Diabetic Foot pathway. • Chronic diabetic foot ulcer within Podiatry caseload that is: o Non healing within 6/52 despite specialist podiatrist intervention o Ulcers that are penetrating to tendon, capsule or bone (Texas grade 2 and 3). o Those that are complicated by recurrent infections – such as osteomyelitis (Texas Grade B and D) • Charcot - Sudden onset hot, swollen neuropathic foot , with sudden change in shape of foot • Follow up of a diabetes patient admitted to hospital due to a foot condition under vascular and needing review in the MDT before returning to community services.
18.	Comprehensive management plans are communicated via letter to the patients GP and recorded on the NHS Solent IT system for future reference by the Podiatry team.
19.	In the period April to September 2017 88 patients have been seen, comprising of 66 new referrals and 12 follow-up appointments. There have been seven DNA appointments all of which were followed up and re-booked. This level of activity is under plan for the year to date however it is anticipated that activity will grow in quarter three as the pathway fully imbeds and more referrals are generated by Primary Care into the Podiatry service.
20.	Activity will continue to be monitored to ensure that the level of patients accessing the service increases in the remaining two quarters of the year. Depending on the outcome a review of the pathway may need to be undertaken.
21.	In addition there is a “virtual MDT” as all members of the team (UHS and Solent) are available to coordinate admission to UHS for those patients who

	become systemically unwell or who have limb threating foot disease that need urgent vascular intervention and would be unsafe to wait for an outpatient MDT appointment.
22.	To support the delivery of the MDT, the NHS Solent Podiatry team have added two additional clinics per week (Monday and Wednesday) that run as a step up / step down from the MDT clinic. This provides capacity for an additional 21 appointments per week so that the care plan identified via the MDT can be delivered. Within these clinics they offer: • Infection management via the 4 PGD and access to independent prescriber • Provision of appropriate non removable offloading device – TCC-EZ • Clinical advice to wider team for swab and X ray results • Advanced wound care • On-going education to the patient • Making Every Contact Count (MECC).
	Outcomes
23.	A key feature of the new pathway is to prevent non elective admissions with a preference to shift activity where possible from a non-elective episode to an elective or the prevention of any admission. During the period of April to September 2016 there have been 14 elective admissions as a result of those being seen by the MDT and 8 non elective admissions. One admission was for a major amputation, the others for minor amputations and IV antibiotics to prevent spreading of infection. The overall improvement of a reduction in amputation rates for the city is not anticipated until 2018/19.
24.	The implementation of the new foot care pathway required the discharge of low risk patients from the Podiatry service. Neither SCCCG nor NHS Solent has received any formal complaints from patients about the change in service provision.
25.	Any patient concerns have been promptly addressed by the Podiatry Team who has explained through either face to face contact or over the telephone why the changes have been made and patients have been able to fully understand and accept the change.
26.	GP and health care professionals were fully engaged in the development and changes made to service provision through the robust communication provided and sharing of the service criteria. All GP concerns raised at the time that the new pathway was implemented were again addressed promptly by the Lead Podiatrist and resolved.
	Quality improvements
27.	**Education -** Within quarters 1 and 2, there has been several key education events that have been delivered by the NHS Solent Podiatry team: • Diabetes UK supported patient education session 'Putting Feet First (April 2016) 45 attended • Diabetes UK support profession education session (Oct 2016) – 80 registered and 56 attended • Education session delivered to the Southampton CCG Pharmacists LPG : 28 attended • Education session delivered to the Nurses link advisors at UHS – 18

	staff attended • Education session to local Southampton Diabetes UK patient group on pathway - 25 Patients attended • Education event to the three Solent GP practice patient group - 32 patients attended • Solent Podiatry team update on pathway A patient engagement event was also held on Sunday 15th January at two Sikh temples in the city supported by the UHS Consultant Diabetologist and the NHS Solent Lead Podiatrist. Positive feedback has been received following the events.
	Patient experience
28.	In quarter 1 and 2, patient and staff feedback about the MDT has been positive. Examples of patient feedback: *"I saw a patient in clinic on Tuesday at the RSH (12:20) who had been referred by me to the MDT, she has expressed her gratitude for the service and care she has received. She is full of praise for the attention she received and the wound has responded well to the interventions recommended*" "*Re patient MR.P, I would like to let you know that he thanked me for referring him into the MDT team at Victoria House. He said he was so pleased with the treatment he got there, how nice and thorough everyone was with him and it was good to know everyone was doing all they could for him".*
29.	Clinical staff are reporting that they find the MDT plans are clear and are thankful that there is now a clear pathway for the acute foot to be seen in a timely manner.
	Future Developments
30.	The following developments are planned: • Alternative accommodation for clinics to be sort at UHS • Full audit of the impact of the DFMDT long term • Orthotist to start to attend the clinics • SystmOne access is nearly there for the UHS team • Links are developing with orthopaedics • Podiatry staff and others will be rotated trough the DFMDT to give resilience to the DFMDT • Explore need for Psychological support for these complex patients such as Intentional Peer Support and the Recovery Approach. Peer support is a term that covers a range of different relationships and can form traditional diagnosis-based support groups where people with similar experiences give and received support from each other.
RESOURCE IMPLICATIONS	
Capital/Revenue	
31.	CCG investment has been made
Property/Other	
32.	N/A

LEGAL IMPLICATIONS		
Statutory power to undertake proposals in the report:		
33.	N/A	
Other Legal Implications:		
34.	N/A	
POLICY FRAMEWORK IMPLICATIONS		
35.	N/A	
KEY DECISION?	No	
WARDS/COMMUNITIES AFFECTED:	All	

SUPPORTING DOCUMENTATION		
Appendices		
1.	Summary of the achievements and outcomes of the Diabetes Strategy and three year plan.	
2.	Southampton City Foot Care Pathway	
Documents In Members' Rooms		
1.	None	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.		No
Privacy Impact Assessment		
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.		No
Other Background Documents **Equality Impact Assessment and Other Background documents available for inspection at: Appendices 1&2**		
Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)	
1.	None	

Summary of achievements and outcomes of the Diabetes Strategy and three year plan

Diabetes Strategy Plan	Achievement / Outcomes
Year One:	
Establish our expectations of Acute Care Providers (predominantly UHSFT) by clearly defining what services they are expected to deliver particularly with regard pre-conception advice, foot care and general ward care. This must be evidence based and robust outcomes monitoring must be established, so we must determine what we expect the outcomes to be. (i.e. reduction in hospital stay, fewer hospital follow ups etc.)	• New Acute Hospital Diabetes Care service spec implemented with clearly defined service objectives, KPIs and reporting requirements (from April 14) • Quarterly service review meetings established (from April 14) • Enhanced pathway for pre-conception care (May 16) • Implementation of new combined foot care clinics with access to MDT (From April 2016) • Reduction in the number of admissions and the cost of these admissions since 2013/14. • No reduction in Follow-up appointments (13/14 466, 14/15 451, 15/16 486)
Review the current contract for Solent podiatry and community diabetes education and support services. Clarify contractual requirements and ensure they are delivering what is currently expected. This will require specific measurable outcomes to be defined and monitored.	• New Community service specification implemented to reflect change in service delivery. It clearly defines scope of service and service objectives (April 2016)
Develop and implement a local insulin pump service	• New IPT service started April 14
Set up a city wide Diabetic network to coordinate communication, education and review of services	• Stakeholder Workshop held 2nd October 2013 to give an up-date on progress to date on the Diabetes Improvement Programme and to also determine 'What would a good Diabetes Network look like' • Options explored on establishing a Network but lacked support, local stakeholders concluded that the facilitation of a Network should not be through the CCG – no further action was taken.
Specific locality based projects (CEPA) looking at a. Accessible structured patient education and opportunities to maximise self-care b. A Multidisciplinary foot care service that fully supports practices c. Improving primary care professional education d. A practice based stocktake to clarify the current situation	• A Self-management summary report and a IT resources for Self-Management were produced to support Primary Care and the aims of the DAS • Foot Care pathway development and commissioned from April 2016 • DAS supported the access to professional education • Stocktake was completed
Development of a model for a primary care led integrated service model based on the above work which clearly defines the roles of each organisation and the emphasis is on primary care coordination of community based care. This will be foundational in determining the commissioning of services for 2014/15.	New model of diabetes integrated care developed and implemented June 14 this included the implementation of the Diabetes Accreditation Scheme for Primary Care which started 1st October 2015

Year Two:	
Robust and active monitoring of Acute/Community Contracts – this will require Primary Care to be monitoring outcomes referrals and admissions to secondary care	• CCG Service review meetings established • Diabetes Development Group established June 14 • Clinical Reference Group established January 15
Establish a process / network which can monitor outcomes and cost of the services.	As above
Mobilisation of Insulin Pump service	Service was quick to mobilise from April 14
Delivery of new arrangements for out of hospital care with clear roles and responsibilities and mechanisms for integrative care established	• New model of diabetes integrated care provides specialist support in primary care
Year Three:	
Delivery of new integrated service • 80% of patients managed via practice based co-ordinated care • 90% of patients availed themselves of educational opportunities • 100% of healthcare staff with responsibility for diabetes care demonstrated improved knowledge and confidence	• The focus on primary care led care continues and the PC Stock Take in 2013 found that a large proportion of patients were being managed solely in PC. • 2014-15 NDA reported 33% of those with Type 1 'offered and attended' structured education programme and 74.8% with Type 2. Whist the Type 1 percentage is the same as the average for England, the Type 2 achievement is less than the England average of 78.9%. Further work needs to be undertaken to ensure that GP system records the attendance of structured education. • This has not been measured however the Diabetes Accreditation Scheme which aimed improve practice based knowledge and skills provided evidence that between Oct 14 to Oct 15 674 hours of training had been undertaken, the target was 198 hours.

DIABETES FOOT REFERRAL PATHWAY
(Increased and High Risk) Southampton CCG March 2016

Foot assessed as "AT INCREASED or HIGH RISK" NICE 2015
Diabetes Foot Assessment Score >10 refer

DIABETIC FOOT ULCER
(Foot ulcer = below malleoli)
New ulcer / Non healing / Infected / abscess refer ASAP

If mild to moderate infection refer and:
- Initiate Empirical antibiotics (HIOW Antibiotics Guidelines)
- Deep wound swab

HOT SWOLLEN NEUROPATHIC FOOT (Suspect CHARCOT) refer
Features may include:
- Pain on walking when usually neuropathic
- Recent minor trauma
- Adequate blood supply

Solent Podiatry Service
Single Point of Access (SPA)
Fanshaw Wing,
Royal South Hants Hospital,
Southampton, SO14 0YG
Referral by letter or fax
Fax: 02380825283
Tel: 03003002011

Referral form with Diabetes Foot Assessment (DFA) GP Summary letter with details including full foot neuro & vascular assessment / infection status / diabetes control

Diabetic foot clinical advice from a Podiatrist is available from Monday to Friday 9am-2pm on:
07733303711

SEVERE INFECTION – ADMIT
- Patient systemically unwell
- Spreading infection despite antibiotics
- Deep abscess

Admission to UHS
02381208999

ACUTE CRITICAL ISCHAEMIA
Features include the following:
- Discoloration of toes (pale, dusky, black)
- Signs of necrosis
- Rest pain (often at night)
- Cold
- Diminished / absent pulses

Vascular Team
02381208803
Rapid Access clinic runs weekly for urgent cases
Referral by letter / fax / telephone as indicated by the patient's condition

Why is it important to refer promptly?
- The risk of a lower extremity amputation in a person with diabetes is more than 20 x that of a person without diabetes and 95% of all non-traumatic amputations start with a foot ulcer
- Good diabetes control will improve healing and outcomes
- Ensure patient has appropriate footwear, doesn't smoke and understands the implications of diabetes