Public Document Pack

Health and Wellbeing Board

Wednesday, 19th June, 2019 at 5.30 pm

Committee Room 1 - Civic Centre

This meeting is open to the public

Members

To be appointed at Cabinet on 18 June 2019

Rob Kurn – Healthwatch
Hilary Brooks – Service Director, Children and Families Services
Stephanie Ramsay – Director of Quality and Integration
Dr J Horsley – Director of Public Health
Dr M Kelsey – Clinical Commissioning Group
Vacancy – NHS England Wessex Local Area Team

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BACKGROUND AND RELEVANT INFORMATION

Purpose of the Board

The purpose of the Southampton Health and Wellbeing Board is:

- To bring together Southampton City Council and key NHS commissioners to improve the health and wellbeing of citizens, thereby helping them live their lives to the full, and to reduce health inequalities;
- To ensure that all activity across partner organisations supports positive health outcomes for local people and keeps them safe.
- To hold partner organisations to account for the oversight of related commissioning strategies and plans.
- To have oversight of the environmental factors that impact on health, and to influence the City Council, its partners and Regulators to support a healthy environment for people who live and work in Southampton

Responsibilities

The Board is responsible for developing mechanisms to undertake the duties of the Health and Wellbeing Board, in particular

- Promoting joint commissioning and integrated delivery of services;
- Acting as the lead commissioning vehicle for designated service areas;
- Ensuring an up to date JSNA and other appropriate assessments are in place
- Ensuring the development of a Health and Wellbeing Strategy for Southampton and monitoring its delivery.
- Oversight and assessment of the effectiveness of local public involvement in health, public health and care services
- Ensuring the system for partnership working is working effectively between health and care services and systems, and the work of other partnerships which contribute to health and wellbeing outcomes for local people.
- Testing the local framework for commissioning for:
    - Health care
    - Social care
    - Public health services
    - Ensuring safety in improving health and wellbeing outcomes

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

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

The Southampton City Council Strategy (2016-2020) is a key document and sets out the four key outcomes that make up our vision.

- Southampton has strong and sustainable economic growth
- Children and young people get a good start in life
- People in Southampton live safe, healthy, independent livesSouthampton is an attractive modern City, where people are proud to live and work

Fire Procedure – In the event of a fire or other emergency, a continuous alarm will sound and you will be advised, by officers of the Council, of what action to take

Access – Access is available for disabled people. Please contact the Democratic Support Officer who will help to make any necessary arrangements.

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.

Dates of Meetings: Municipal Year 2019/20

2019	
19 June	
18 December	

CONDUCT OF MEETING

BUSINESS TO BE DISCUSSED
Only those items listed on the attached agenda may be considered at this meeting.

PROCEDURE / 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.

RULES OF PROCEDURE
The meeting is governed by the Executive Procedure Rules as set out in Part 4 of the Council's Constitution.

QUORUM
The minimum number of appointed Members required to be in attendance to hold the meeting is 3 who will include at least one Elected Member, a member from Health and Healthwatch.

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.

AGENDA

1 ELECTION OF CHAIR

To elect a Chair for the 2019-2020 municipal year.

2 ELECTION OF VICE-CHAIR

To elect a Vice-Chair for the 2019-2020 municipal year.

3 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

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

4 STATEMENT FROM THE CHAIR

5 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.

6 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 19 December 2018 and to deal with any matters arising, attached.

7 SOUTHAMPTON CITY FIVE YEAR HEALTH & CARE STRATEGY

Report of the Director of Quality and Integration detailing the update of the Southampton City Five Year Health & Care Strategy.

8 BETTER CARE END OF YEAR REPORT

Report of the Director of Quality and Integration providing an overview of performance in 2018/19 against Southampton's Better Care programme and pooled fund, including the iBCF (improved Better Care Fund), and highlighting priorities for 2019/20.

9 JOINT STRATEGIC NEEDS ASSESSMENT UPDATE

Report of Director of Public Health providing an update on the Southampton Joint Strategic Needs Assessment and the Health and Wellbeing Strategy Scorecard.

Tuesday, 11 June 2019 Director of Legal and Governance

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HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 19 DECEMBER 2018

Present: Councillors Shields (Chair), Taggart and Murphy
Rob Kurn, Hilary Brooks, Jason Horsley and Dr Mark Kelsey (Vice-Chair)

Apologies: Councillor Dr Paffey, Councillor Fielker, Dr Mearns and Stephanie Ramsey

8. **APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)**

Apologies were received from Councillor Fielker, Councillor Dr Paffey, Dr Mearns and Stephanie Ramsey.

The Board noted that Carol Binns, Statutory Director Adult Social Care, had retired and had been replaced by Stephanie Ramsey, Interim Designated Director Adult Services.

The Board further noted that Dr Mearns was no longer the representative from NHS England Wessex Local Area Team and that a replacement member would be sought.

9. **DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS**

Councillor Shields declared a personal interest in that he was a Council appointed representative of the Clinical Commissioning Group and remained in the meeting and took part in the consideration and determinations of items on the agenda.

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

RESOLVED that the minutes of the meeting held on 20 June 2018 be approved and signed as a correct record.

11. **HEALTH AND WELLBEING STRATEGY ANNUAL REVIEW**

The Board received and noted the report of the Director of Public Health outlining progress against the Health and Wellbeing Strategy 2017-25.

The Board discussed some of the prevalent points arising from the tabled Scorecard and noted that although Southampton scored worse than the national average in many areas, many factors were improving.

12. **DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT**

The Board considered the report of the Director of Public Health detailing the annual report for 2017.

The Board agreed the following modified recommendations:

RESOLVED that

(i) The report be noted; and
(ii) The report be promoted throughout the city to enable its contents to be incorporated into other key strategies including the Local Plan.

DECISION-MAKER:		**HEALTH & WELLBEING BOARD**		
SUBJECT:		**SOUTHAMPTON CITY FIVE YEAR HEALTH AND CARE STRATEGY**		
DATE OF DECISION:		**19 JUNE 2019**		
REPORT OF:		**JAMES RIMMER, MANAGING DIRECTOR, NHS SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP**		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Clare Young**	**Tel:**	
	E-mail:	**clare.young4@nhs.net**		
Director	**Name:**	**James Rimmer**	**Tel:**	
	E-mail:	**james.rimmer3@nhs.net**		

STATEMENT OF CONFIDENTIALITY		
None		
BRIEF SUMMARY		
This draft strategic plan sets out a high level view of the challenges we face and proposes a framework to guide the activities of all partners over the next five years (see appendix 1).		
The strategic framework has been co-produced with health and care partners across the city. Following a discussion at the Southampton System Chiefs Group on 24 May 2019, John Richards has written to all system partners (see appendix 2) asking that the strategy is taken through the appropriate governance processes in each organisation.		
RECOMMENDATIONS:		
	(i)	That the Health & Wellbeing Board considers and provides feedback on the draft strategy.
REASONS FOR REPORT RECOMMENDATIONS		
1.	To inform the Health and Wellbeing Board of the current draft of the five year strategic plan. This follows a previous update in September 2018.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	Not applicable	
DETAIL (Including consultation carried out)		
3.	Work started during the summer of 2018 on the preparation of a new five year strategy for health and care in the City. This involved detailed analysis into the health and wellbeing of the population, linked to deprivation and service use. In discussions with partners, it was agreed to develop a response to these needs that goes beyond the NHS into social care and wider, which can be owned by all of our partners in the City. It remains,	

	nonetheless, a subset of the wider ten year strategy for health and wellbeing led by the Health and Wellbeing Board.
4.	The new draft strategy, shared with the Health & Wellbeing Board in Appendix 1, incorporates feedback from: • Joint Commissioning Board (JCB) • Southampton System Chiefs Group • Southampton Connect • Better Care Steering Board • Health Overview and Scrutiny Panel (HOSP)
5.	We have held two partnership conferences on the theme of the emerging strategy, on 29 March and 8 May 2019. A community engagement event was held on 20 November 2018 to support increased public participation in the development of the strategy. Alongside this, opportunities have been taken to share information and invite discussion of the emerging plans with Healthwatch, the CCG Patients' Forum, Southampton Voluntary Services (SVS) and a wide variety of other community groups. Public involvement will be an ongoing feature of the way we work.
6.	The strategy in its current draft form was endorsed by the CCG's Governing Body on 22 May 2019. Following this, John Richards, former CCG Chief Executive Officer, wrote to all partner organisations involved in the formation of the draft strategy to secure the support of their boards and their commitment to its implementation. A copy of this letter is made available to the Panel in Appendix Two
7.	At this time the draft strategy sets out the challenges which require addressing. We will now proceed, subject to support from partners, to incorporate further details on how those challenges will be addressed and how improvements will be delivered over the next five years into the final version of the strategy.
RESOURCE IMPLICATIONS	
Capital/Revenue	
8.	Not applicable.
Property/Other	
9.	Not applicable.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
10.	Not applicable.
Other Legal Implications:	
11.	None.
RISK MANAGEMENT IMPLICATIONS	
12.	None.
POLICY FRAMEWORK IMPLICATIONS	
13.	Not applicable.

KEY DECISION?	**No**
WARDS/COMMUNITIES AFFECTED:	**ALL**
SUPPORTING DOCUMENTATION	
Appendices	
1.	**TRANSFORMING HEALTH AND CARE OUTCOMES FOR THE PEOPLE OF SOUTHAMPTON: OUR FIVE YEAR STRATEGIC PLAN 2019–2023**
2.	**LETTER FROM JOHN RICHARDS TO SYSTEM PARTNERS**

Documents In Members' Rooms

1.	**None**
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.	**No**
Data Protection Impact Assessment	
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out.	**No**
Other Background Documents None **Other Background documents available for inspection at: Not applicable.**	

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.		

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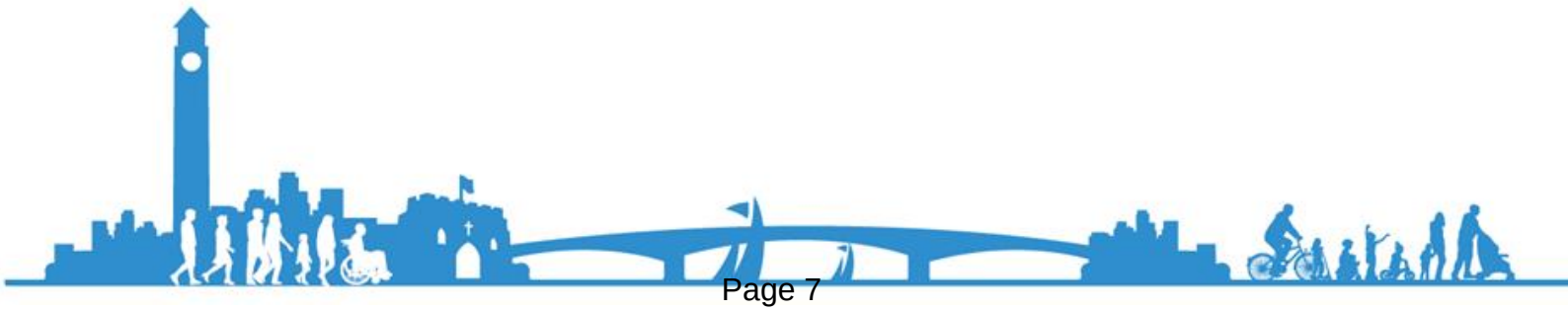
Transforming health and care outcomes for the people of Southampton

Our five year strategic plan
2019–2023



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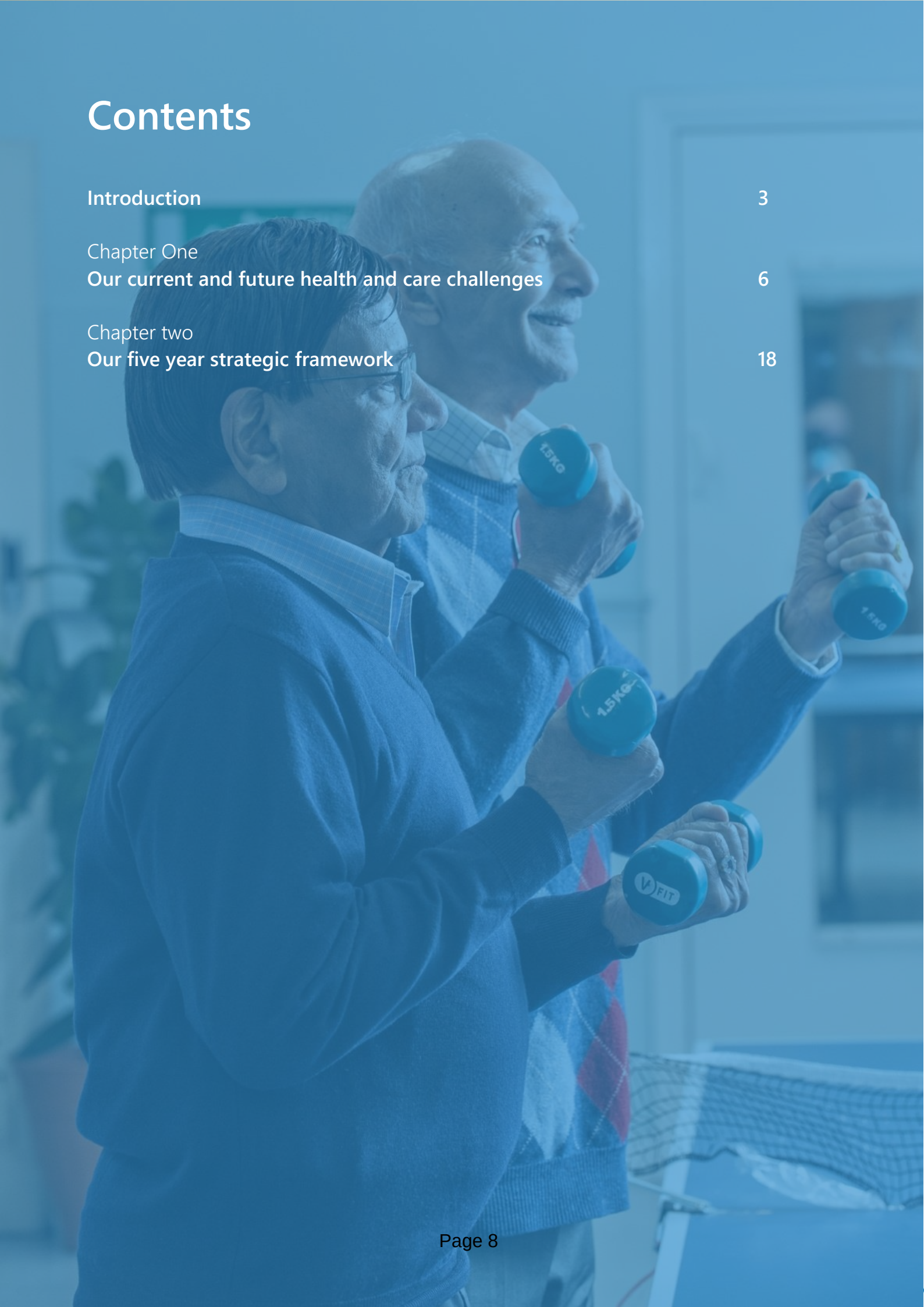


Introducing our five year strategic plan

Work started during the summer of 2018 on the preparation of a new five year strategy for health and care in the City. This involved detailed analysis into the health and wellbeing of the population, linked to deprivation and service use. In discussion with partners, it was agreed to develop a response to these needs that goes beyond the NHS into social care and wider, which can be owned by all of our partners in the City. It remains, nonetheless, a subset of the wider ten year strategy for health and wellbeing led by the Health and Wellbeing Board.

In early 2019, the NHS Long Term Plan (LTP) was published and it has been agreed that Southampton's strategic plan should also be the City's contribution to the wider Hampshire and Isle of Wight five year response to the LTP which is due later in Autumn.

Our strategic plan sets out a high level view of the challenges we face and proposes a framework to guide the activities of all partners over the next five years.

The strategic framework is summarised on page 20, including our proposed vision, goals, mission, programmes and enablers, and principles of working together. These have been widely supported and developed by partners.

The framework incorporates feedback from various system-wide bodies including:

- Health and Wellbeing Board
- Joint Commissioning Board (JCB)
- Southampton System Chiefs Group
- Southampton Connect
- Better Care Steering Board
- Health Overview and Scrutiny Panel (HOSP)

We have held two partnership conferences on the theme of the emerging strategy, on 29 March and 8 May 2019.

A community engagement event was held on 20 November 2018 to support increased public participation in the development of the strategy. Alongside this, opportunities have been taken to share information and invite discussion of the emerging plans with Healthwatch, the CCG Patients' Forum, Southampton Voluntary Services (SVS) and a wide variety of other community groups. Public involvement will be an ongoing feature of the way we work.

Looking back

2018/19 was the final year of the CCG's five year strategy and, similarly, of our two year operational plan. Since summer 2018, we have been undertaking a stocktake of our position and reviewing the outcomes and prospects for our population.

First, we reviewed the outcomes of our CCG strategy published in 2014. There were eight outcome indicators we set:

- Improved patient safety and user experience
- Reduced inequalities in life expectancy
- Reduced avoidable emergency admissions*
- More older people living independently (91 days after reablement)*
- Fewer permanent admissions to nursing and residential homes*
- Fewer delayed transfers of care*
- Reduced injuries dues to falls in people aged over 65*
- 20% productivity improvement in elective care

*Outcomes marked with an asterisk were also outcomes we specified in the Better Care Plan

The results of our stocktake were mostly positive. We considered whether we had done what we said we were going to do, if not why not, and what had we learned in the process.

Whilst we have done relatively well on our own terms as a CCG, we wanted to focus on our challenges as a City.

We looked at what had happened to our population over the last few years. We were able to review how deprivation across the city has affected health, such as disease prevalence, and utilisation of healthcare services in the city (for example, emergency hospital admissions). This revealed a stark picture of growing inequalities across the city and gaps in life expectancy.

We also reconfirmed that the City performs poorly by comparison with our statistical neighbours and nationally. For example, Southampton is ranked second worst of our 10 comparator CCGs and 35th worst out of all 201 CCGs in terms of inequalities in the rates of emergency admissions for certain urgent care sensitive conditions. This gives us a powerful indicator of where we need to focus over the next few years.

The analysis into rates of emergency admissions is particularly useful as an indicator of need (assuming people are only admitted to hospital as emergencies if they are seriously unwell) as opposed to demand (which may be influenced by the convenience of access, for example, to A&E). We found that the most deprived areas of the city were also the places with the highest rates of emergency admissions. These admissions are probably a good indicator of where we are failing to prevent ill health or to provide planned care interventions that could have avoided an emergency admission.

Thus, if we can target what we do to focus on improving access to prevention and earlier, planned intervention in these areas of the city, we may reduce the inequalities gap and improve health outcomes overall.

Our analysis also enabled us to see at a detailed population level how varied health and healthcare usage is across the City. We were able to break down admissions by age, gender and ethnicity for different health conditions (e.g. cardiac, respiratory, diabetes and mental health). This analysis provides each of the six health and care clusters with rich data about the particular challenges for their local populations.

We have also been able to look at population and long term conditions projections for the period ahead to help predict future healthcare demand, and demand for social care.

Broadening the scope

It has become apparent that to understand what is happening to our population in the city, we need to look wider than just health. The picture of increased deprivation and its palpable impact on health, and of widening inequalities between different communities, raises challenges about the resilience of the population as a whole. It also means we have to take a system-wide perspective in our plan for the next five years.

First, this plan has to be a plan for social care too. It is true that the quality and capacity of social care provision has an important impact on the health service. It is also argued that whilst initiatives to fund directly, or transfer funding

from the NHS to social care, have tended to be focussed on initiatives to get people home from hospital, this may have skewed social care priorities. This means that the years of reductions to local government funding of social care have cut even deeper into the provision of 'core' social care which helps to keep people healthy and independent.

But social care is not just there to support the NHS. It has a huge value in its own right as part of the fabric, the social solidarity, of society as a whole.

Evidence suggests there has been a serious deterioration in the mental and emotional wellbeing of people living in the City, whereby mental wellbeing is now increasingly a factor in people's presenting needs across every aspect of healthcare. So, the plan has to be a plan for health and wellbeing.

Furthermore, we know that communities themselves, and wider civil society (including police, fire and rescue, probation, education, employment support, housing and so on) have a huge role to play in the determinants of health and wellbeing. The plan has to be relevant to and owned by communities and partners right across the City as a whole.

The NHS often struggles to comprehend the meaning of 'place', assuming instead our health planning is all about hospitals and healthcare institutions. This would be to miss the point on so many levels. This is why we are passionate about our One City approach: the importance of engaging, mobilising and galvanising a wide range of partners including citizens themselves, to develop and be part of implementing the plan for the next five years and beyond.

Looking Forward

This has generated some constructive discussions with our health and care partners and a shared intention to develop a new five year strategy for health and care in the city as a whole. At the end of March 2019, we held a partnership conference to take stock of our emerging city strategy and to invite partners to own and commit to its development.

In January 2019, we received the new Long Term Plan from NHS England which has been prepared in response to the Prime Minister's announcement in May 2018 of a five year funding settlement of £20 billion in return for which it is clear that the Government expects to see NHS provider finances restored to balance, NHS Constitution standards performance recovered, and other improvements.

Alongside the development of the new five year strategy for the city as whole, we agreed that 2019/20 would be the right time to also review the CCG's primary care strategy. With the recent publication of the new GP contract, including ambitious plans for investing in new workforce and the development of primary care networks (PCNs), primary care development will be a major focus this year.

The October 2018 Planning Letter sets out the expectation that local areas will prepare their five year plans during the first half of 2019, due in Autumn.

2019/20 begins the new period in our work to improve health and wellbeing in the city.

Chapter One

Our Current and Future Health and Care Challenges

Deprivation & Health Inequalities in Southampton

Deprivation

The Index of Multiple Deprivation (IMD) measures deprivation for small areas at a neighbourhood level. In Southampton, there are 148 small neighbourhoods, of which each has a deprivation ranking.

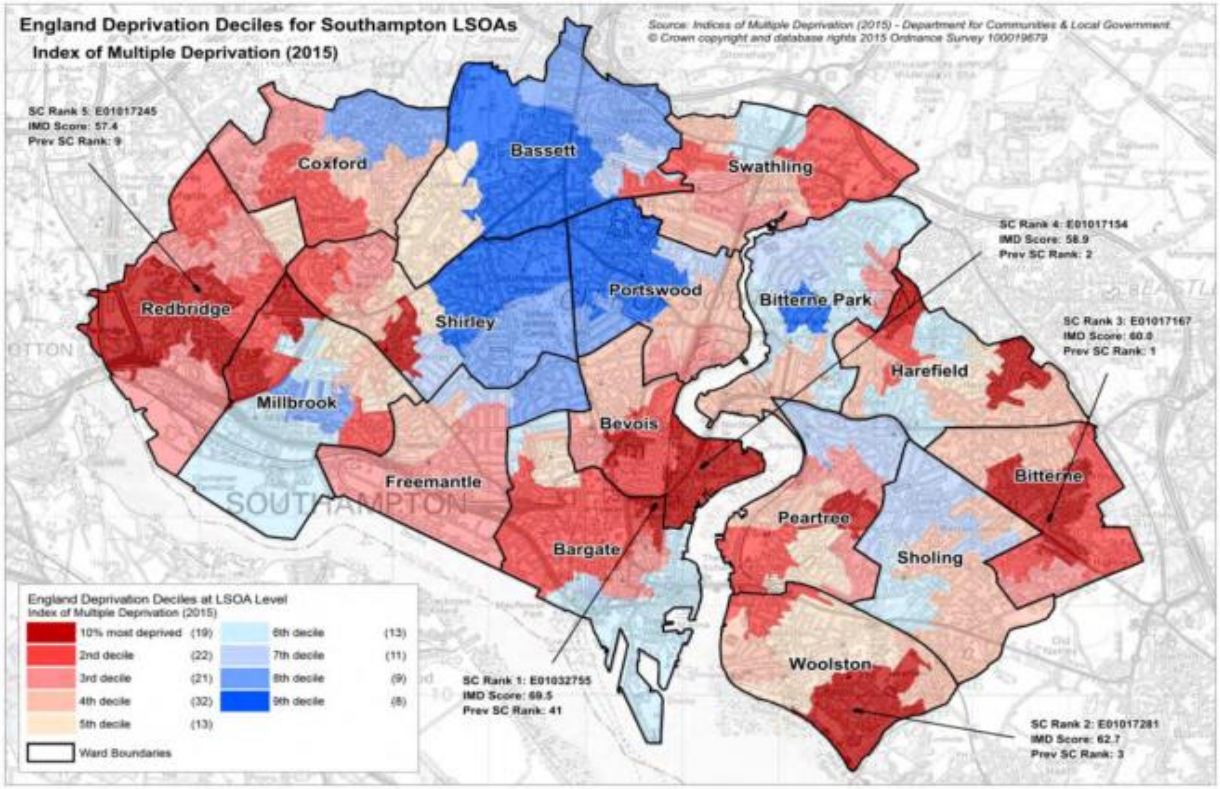
The map below show levels of deprivation across the city. The darker shades of red indicate areas in Southampton which fall into the 10 per cent most deprived neighbourhoods nationally. The darker shades of blue indicate areas in Southampton which fall into the least deprived neighbourhoods nationally.

In Southampton, 19 of the 148 neighbourhoods fall into the 10 per cent most deprived neighbourhoods nationally.

Overall, Southampton is ranked the 54th most deprived local authority out of 326 local authorities in England.

There is a common misconception that deprivation means how affluent an area is. To some extent this is true, however the IMD measures seven domains which contribute to deprivation (weightings in percentages):

- Income (22.5 per cent)
- Employment (22.5 per cent)
- Education (13.5 per cent)
- Health (13.5 per cent)
- Crime (9.3 per cent)
- Barriers to housing and services (9.3 per cent)
- Living environment (9.3 per cent)



Health Inequalities

"Inequalities are a matter of life and death, of health and sickness, of wellbeing and misery. The fact that in England today people in different social circumstances experience avoidable differences in health, well-being and length of life is, quite simply, unfair. Creating a fairer society is fundamental to improving the health of the whole population and ensuring a fairer distribution of good health. Inequalities in health arise because of inequalities in society – in the conditions in which people are born, grow, live, work, and age."
The Marmot Review, 2010

In Southampton, deprivation and health inequalities are inextricably linked – inequalities in health result from inequalities in society. In a fair society, health outcomes would be equal for people living in the most and least deprived areas of the city. However, there is a social gradient in health – the lower a person's social position, the worse his or her health. The existence of health inequalities in Southampton means that the right of our residents to the highest attainable standard of physical and mental health is not being enjoyed equally across the population.

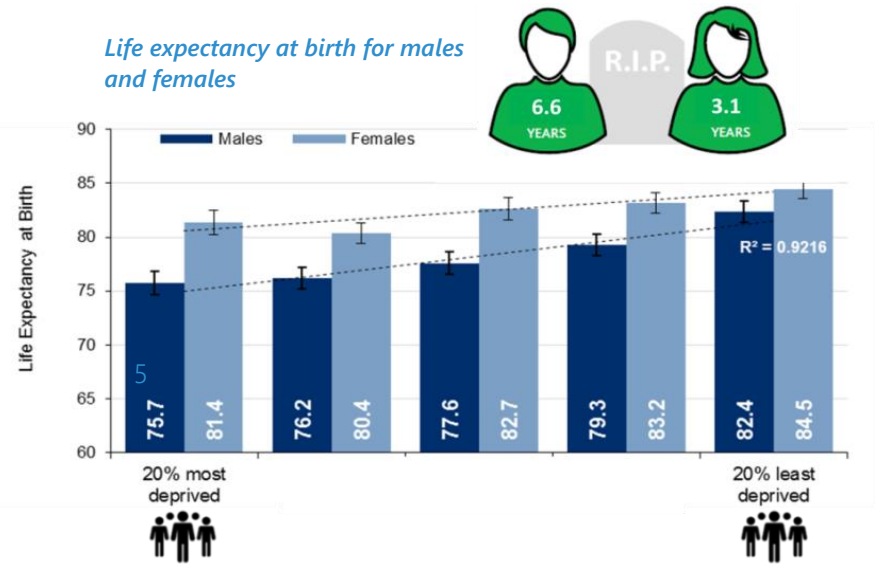
The social gradient in heath in Southampton is demonstrated in the following graphs which show that inequalities in health are related to inequalities in social status.

Inequalities in Life Expectancy

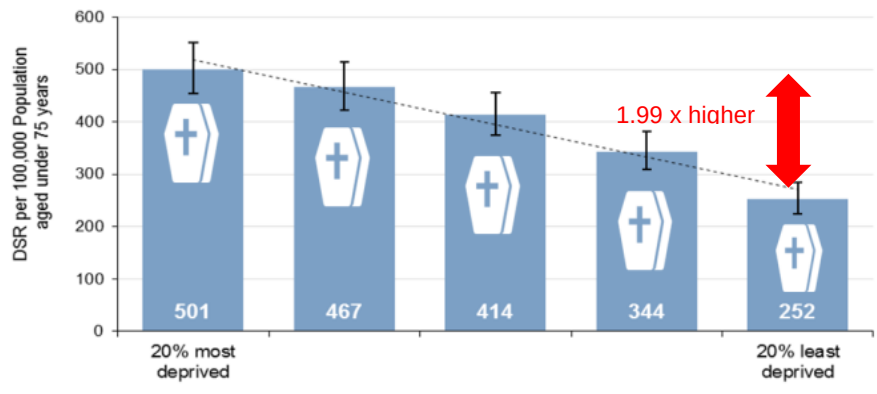
In Southampton, people living in the most deprived areas of the city **die earlier** than those living in the least deprived areas. Males living in the most deprived areas of the city are likely to die 6.5 years earlier than males living in the less deprived areas of the city. Females living in the most deprived areas of the city are likely to die 3.1 years earlier than females living in the less deprived areas of the city.

Premature deaths (defined as deaths under the age of 75 years) from all causes are twice as high in the most deprived areas of the city than the least deprived areas of the city.

Life expectancy at birth for males and females



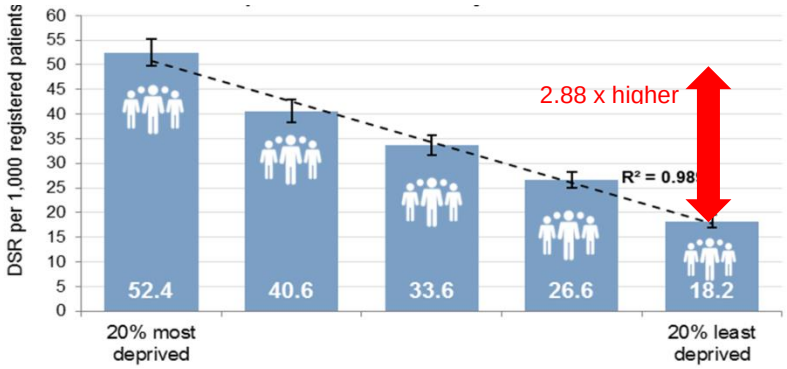
Premature deaths from all causes



Inequalities in Long Term Conditions

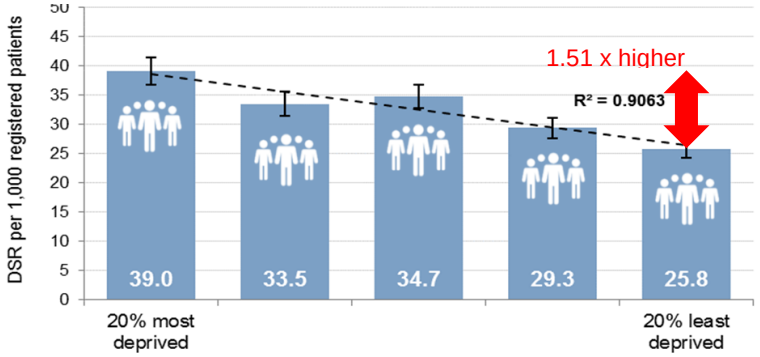
Prevalence of Chronic Obstructive Pulmonary Disease (COPD) is nearly three times higher in the most deprived areas of the city compared to the least deprived areas.

Chronic Obstructive Pulmonary Disease (COPD) Prevalence



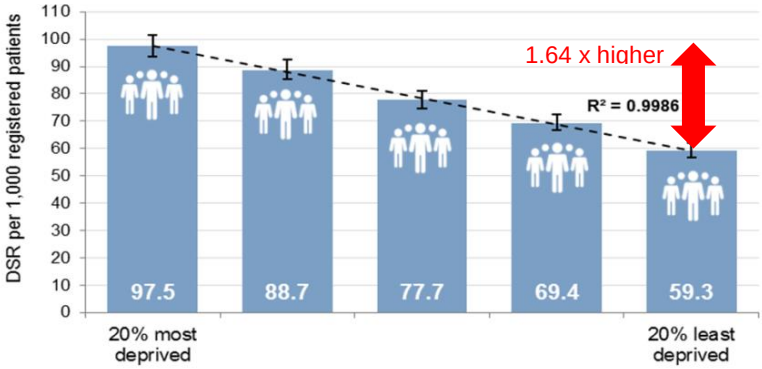
Prevalence of Coronary Heart Disease (CHD) is one and a half times higher in the most deprived areas of the city compared to the least deprived areas.

Coronary Heart Disease (CHD) Prevalence



Prevalence of Diabetes is over one and a half times higher in the most deprived areas of the city compared to the least deprived areas.

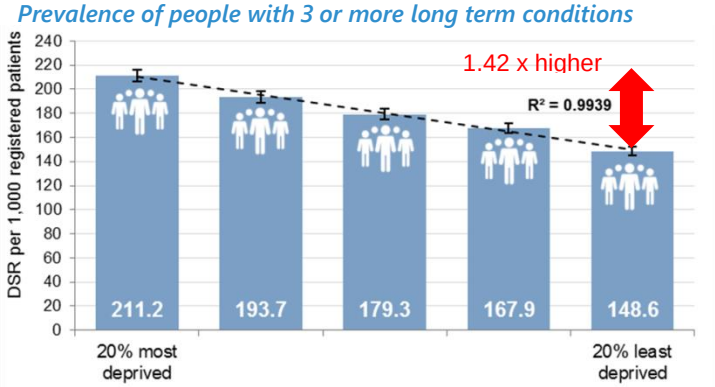
Diabetes Prevalence



Inequalities in Multi-morbidity

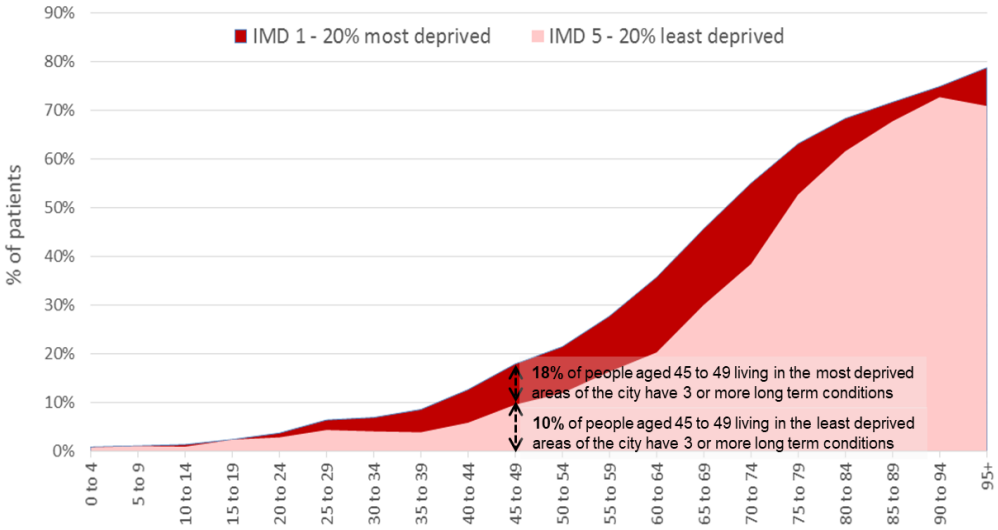
The prevalence of people living with multiple long term conditions (multi-morbidity) is higher in the most deprived areas of the city compared to the least deprived areas. For example, prevalence of people with three or more long term conditions is nearly one and a half times higher in the most deprived areas of the city compared to the least deprived areas.

Prevalence of people with 3 or more long term conditions



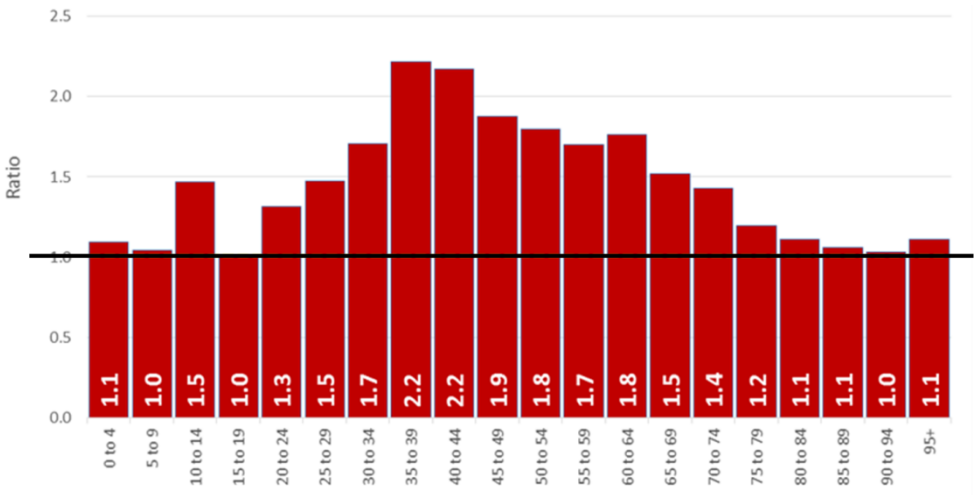
This graph shows the proportion of people in Southampton with three or more long term conditions, by age group. Importantly, it shows the proportions by deprivation group. For example, 10% of people aged 45 to 49 living in the least deprived areas of the city have three or more long term conditions, compared to 18% in the most deprived areas.

Proportion of people with 3 or more long term conditions, by age group



This graph demonstrates a similar trend. It shows how many times higher the prevalence is for people living in Southampton with three or more long term conditions in the most deprived compared to the least deprived areas. For example, it shows that for the 35 to 39 year old age group, prevalence of multi-morbidity is more than two times (x2.2) higher in the most deprived areas of the city compared to the least deprived areas.

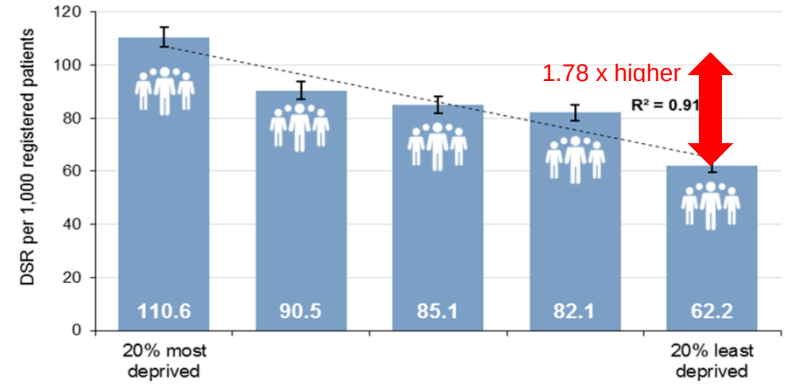
Proportion of people with 3 or more long term conditions, by age group: how many times higher in the most deprived areas of the city



Inequalities in Mental Health

Prevalence of Depression is nearly two times higher in the most deprived areas of the city compared to the least deprived areas.

Depression Prevalence



Prevalence of Schizophrenia is nearly three times higher in the most deprived areas of the city compared to the least deprived areas.

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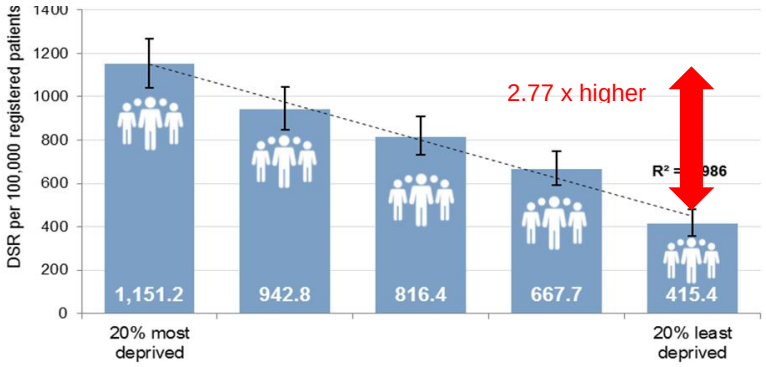
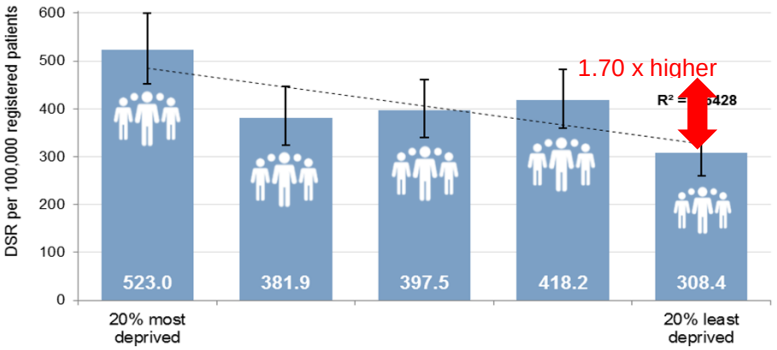
Schizophrenia Prevalence



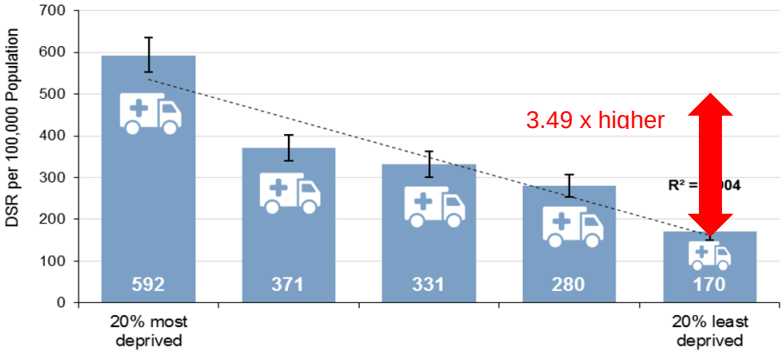
Prevalence of Bipolar Disorder is nearly two times higher in the most deprived areas of the city compared to the least deprived areas.

Bipolar Prevalence



Emergency admissions as a result of intentional self-harm are three and a half times higher in the most deprived areas of the city compared to the least deprived areas.

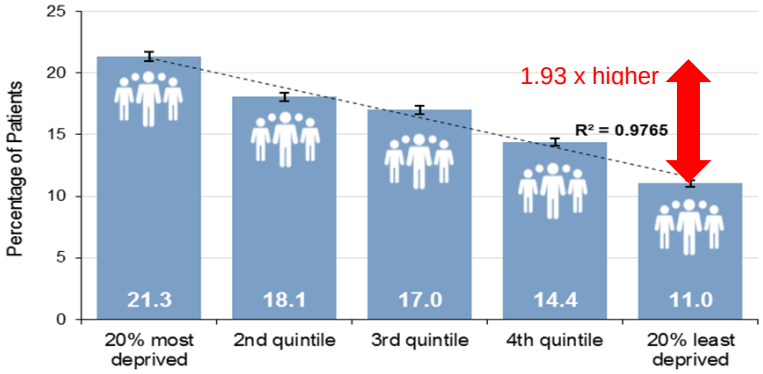
Intentional self-harm emergency admissions



Inequalities in Health Behaviours

Prevalence of Smoking is nearly two times higher in the most deprived areas of the city compared to the least deprived areas.

Smoking Prevalence



Prevalence of inactivity is over two and a half times higher in the most deprived areas of the city compared to the least deprived areas.

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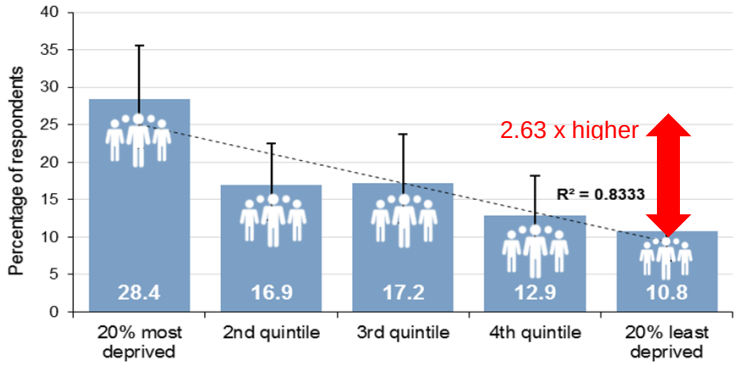
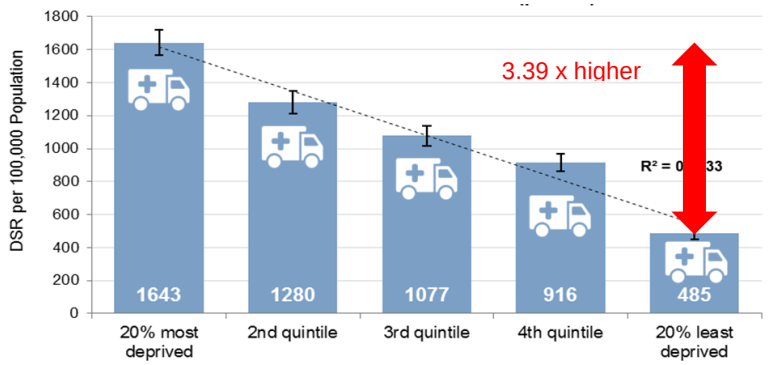
Inactivity Prevalence



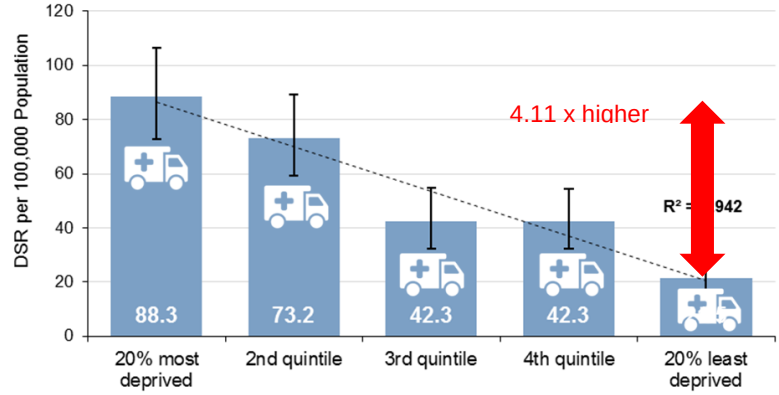
Emergency admissions from alcohol-specific conditions is nearly three and a half times higher in the most deprived areas of the city compared to the least deprived areas.

Emergency admissions from alcohol-specific conditions



Emergency admissions as a result of poisoning from illicit drugs are over four times higher in the most deprived areas of the city compared to the least deprived areas.

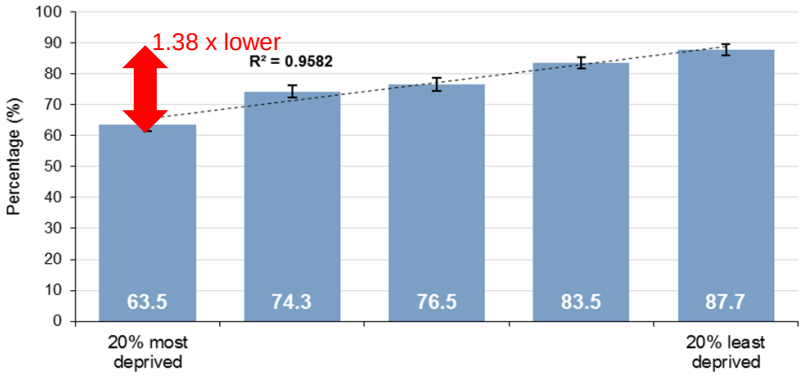
Emergency admissions from poisoning of illicit drugs



Inequalities in Healthy Start in Life

Prevalence of mothers breastfeeding is almost one and a half times lower in the most deprived areas of the city compared to the least deprived areas.

Breastfeeding Prevalence



Prevalence of mothers smoking during pregnancy is over four times higher in the most deprived areas of the city compared to the least deprived areas.

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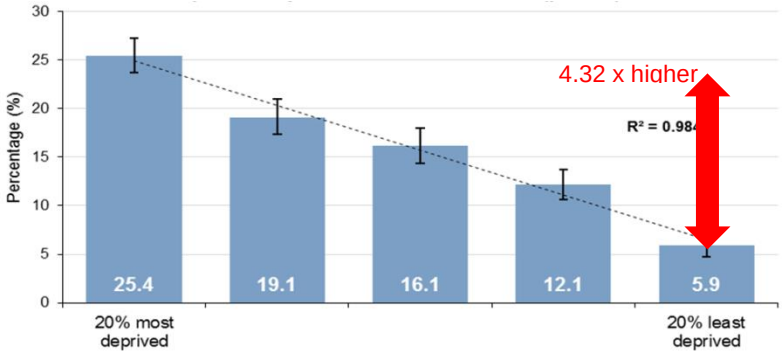
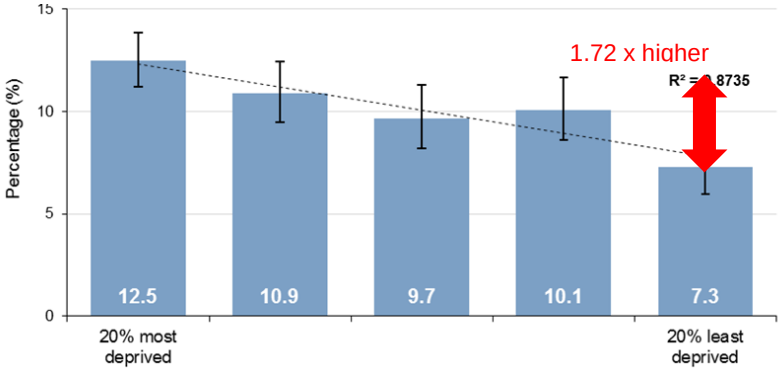
Smoking during Pregnancy Prevalence



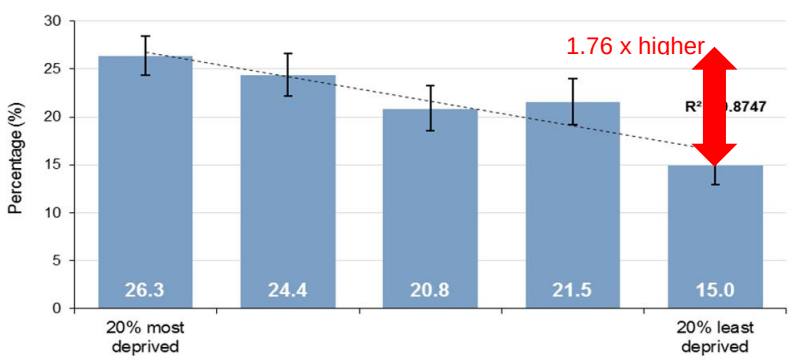
Prevalence of children considered to be obese in Year R is nearly two times higher in the most deprived areas of the city compared to the least deprived areas.

Year R Obesity Prevalence



Prevalence of children considered to be obese in Year 6 is nearly two times higher in the most deprived areas of the city compared to the least deprived areas.

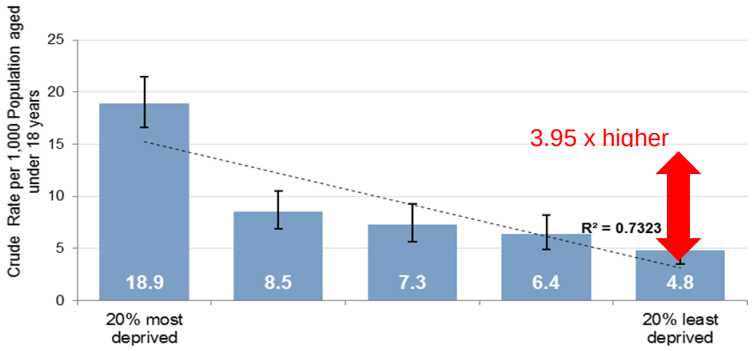
Year 6 Obesity Prevalence



Inequalities in Wider Determinants of Health

The rate of looked after children (children in care) is nearly four times higher in the most deprived areas of the city compared to the least deprived areas.

Rate of looked after children



Prevalence of children living in poverty is nearly five times higher in the most deprived areas of the city compared to the least deprived areas.

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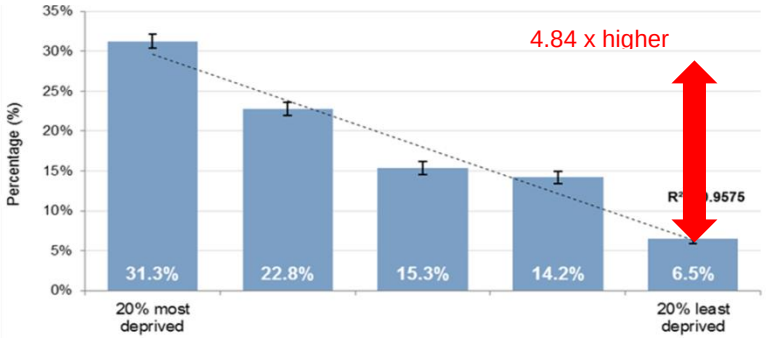
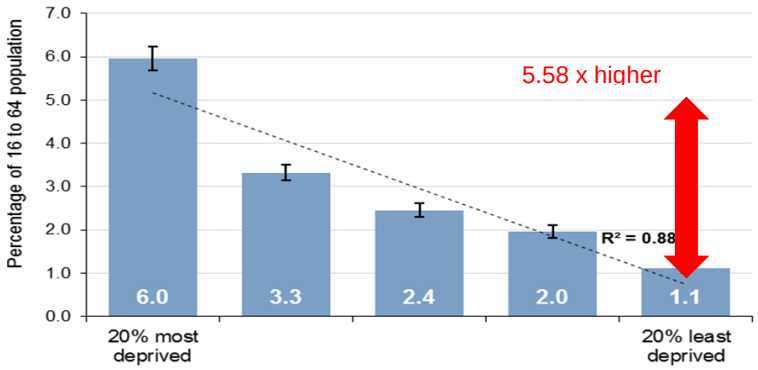
Children living in poverty



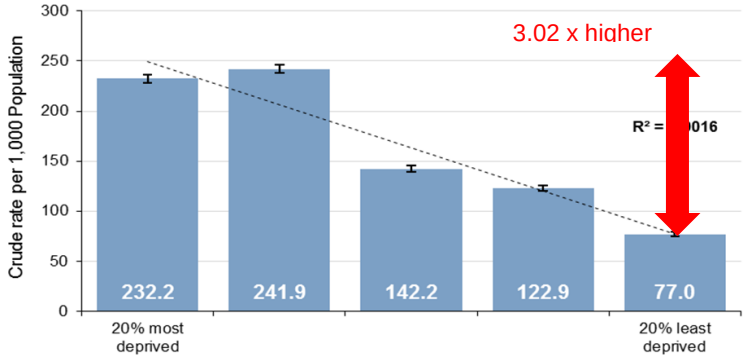
Prevalence of people claiming out of work benefits is five and a half times higher in the most deprived areas of the city compared to the least deprived areas.

Claimants of out of work benefits (aged 16 to 64)



Prevalence of police recorded crime is three times higher in the most deprived areas of the city compared to the least deprived areas.

Police recorded crime

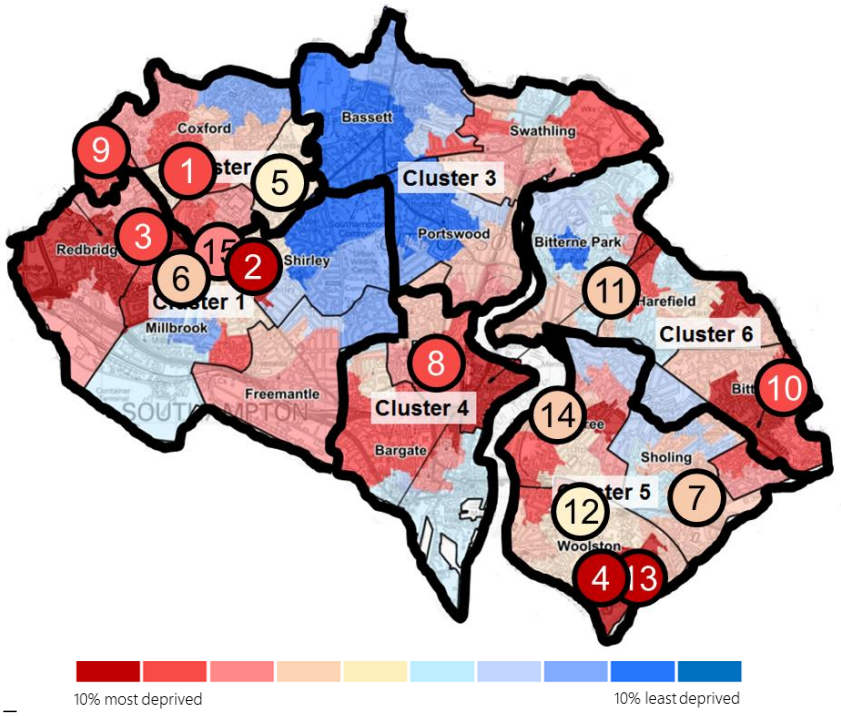


How is deprivation affecting healthcare usage?

In Southampton, there is a strong link between deprivation and rates of urgent healthcare usage. We have found that areas of the highest deprivation are also the places with the highest rates of emergency admissions.

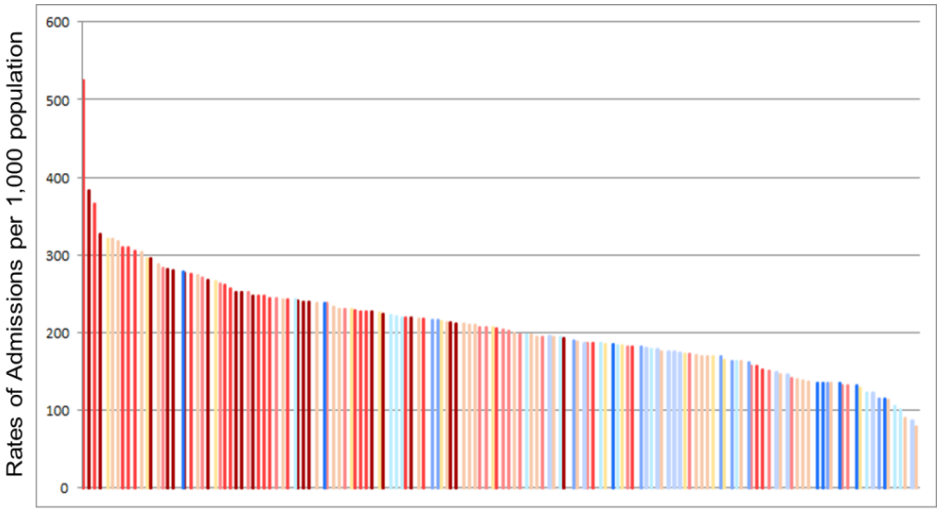
The map on this page shows the 15 neighbourhoods in the city with the highest rates of emergency admissions per 1,000 population. The graph then shows the rates of emergency admissions for all 148 neighbourhoods in Southampton – this shows that the more deprived areas of the city have (red shades) have higher rates of emergency admissions than the less deprived areas of the city (blue shades).

The analysis is particularly useful as an indicator of need (assuming people are only admitted to hospital as emergencies if they are seriously unwell) as opposed to demand (which may be influenced by the convenience of living close to the hospital).



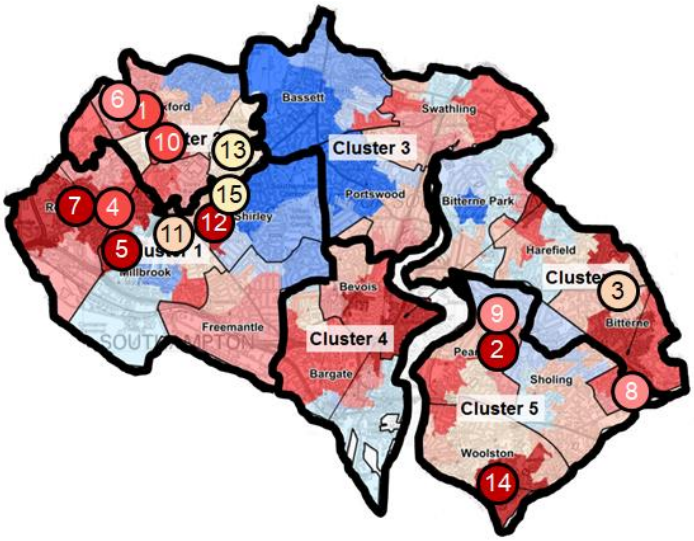
This analysis is also a good indicator of where we our local health and care system is failing to prevent ill health or to provide planned care interventions that could have avoided an emergency admission.

Thus, if we can target what we do to focus on improving access to prevention and earlier, planned intervention in these places, we may reduce the inequalities gap and improve health outcomes overall.

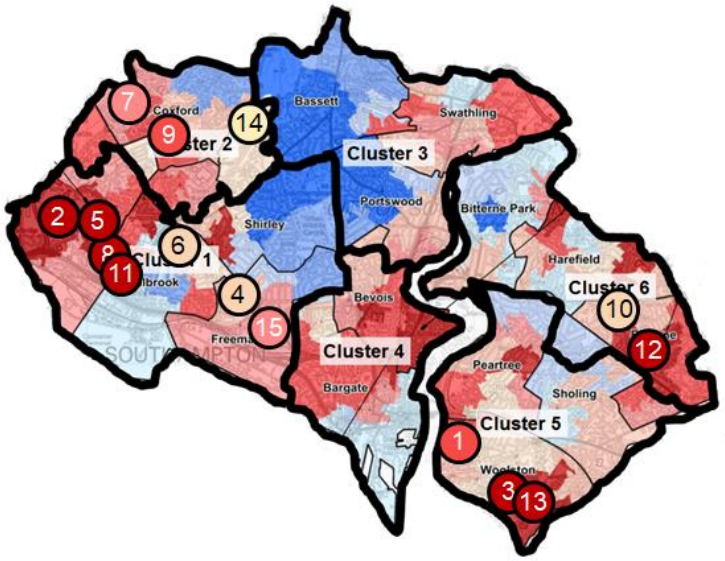


Our analysis has also enabled us see which areas of the city have the highest rates of emergency admission for certain conditions. A few examples are shown below and show a similar trend that the highest rates of emergency admissions are from more deprived areas of the city.

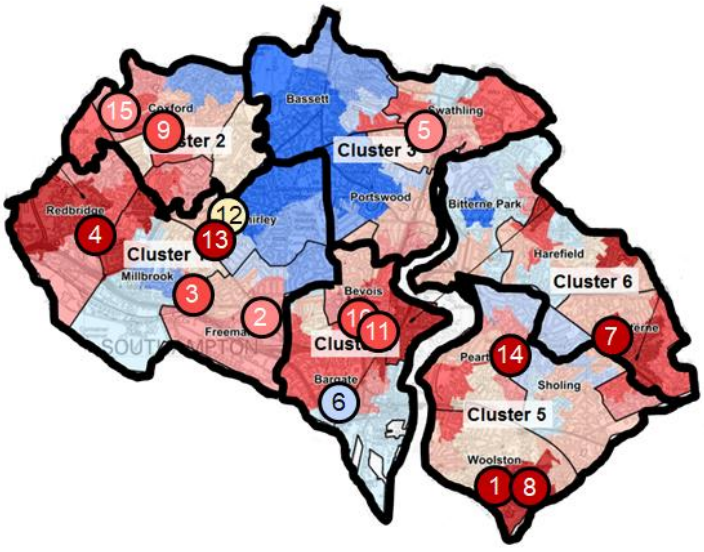
Emergency Admissions for Chronic Obstructive Pulmonary Disease (COPD)



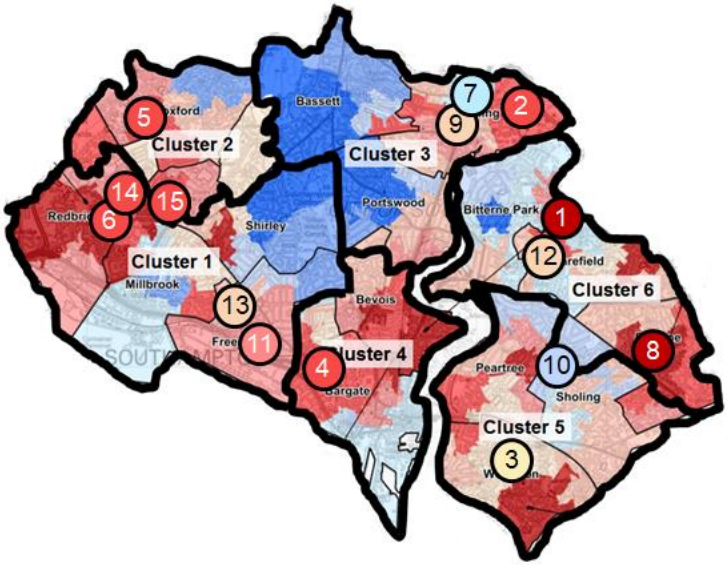
Emergency Admissions for Abdominal Pain



Emergency Admissions for Acute Mental Health Crisis



Emergency Admissions for Cellulitis



Future Health and Care Challenges

Population growth

In Southampton, it is estimated that between 2018 and 2024, the city could have 12,300 more residents. This is equivalent to a 4.8 per cent increase.

By age group:

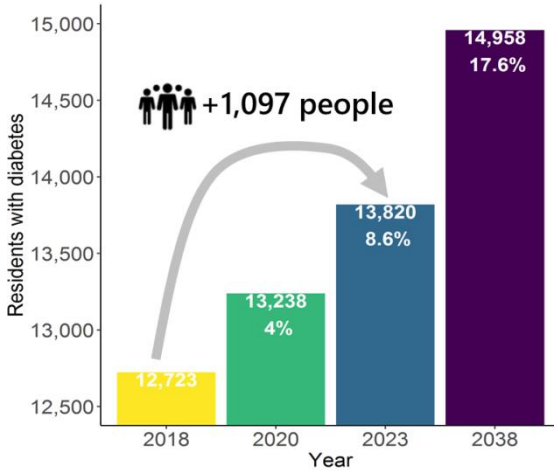
2,730 more children and young people (5.5 per cent increase)

4,530 more working age adults aged between 18 and 64 (2.7 per cent increase)

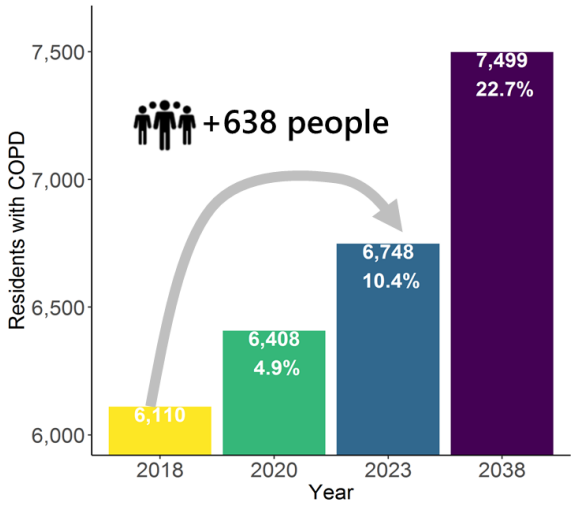
5,030 more older people aged over 65 (14.5% increase)

The age group with the biggest percentage increase will be the older population, and we know that a growing and ageing population will add more pressure onto the city's health and care services.

1,097 more people with diabetes



638 more people with COPD

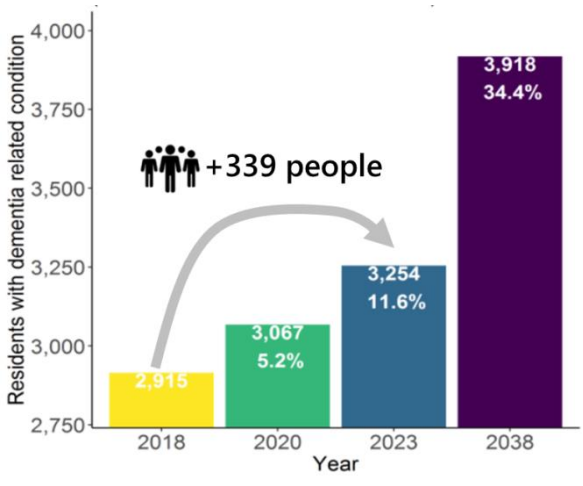


Long term conditions

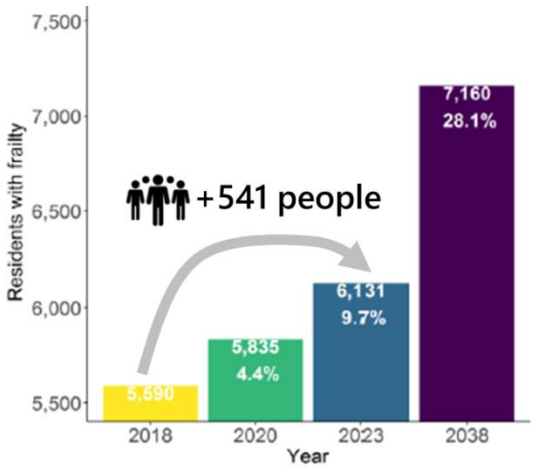
By combining population estimates with current trends in long term conditions, we have been able to forecast increases in long term conditions for our population.

The graphs show the forecast increases in the number of residents with long term conditions, against a baseline of 2018.

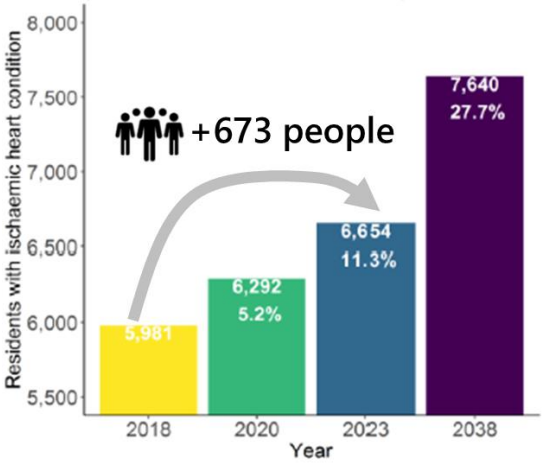
339 more people with dementia



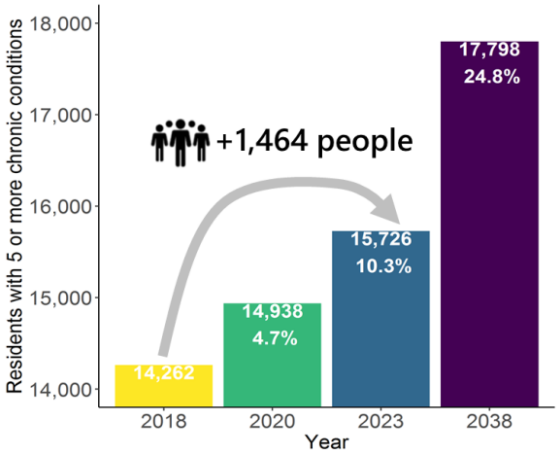
541 more people with frailty



673 more people with coronary heart disease



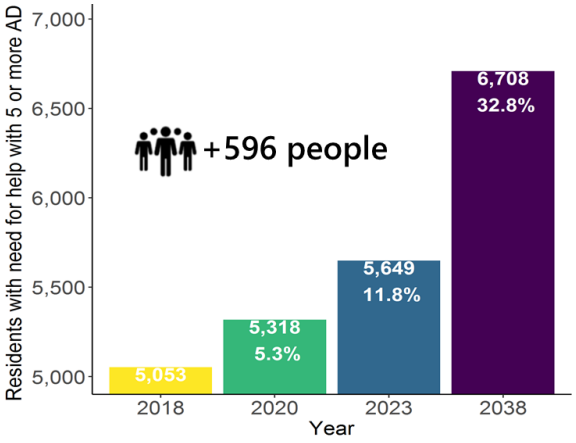
1,464 more people with five of more long term conditions



Adult social care

By combining population estimates with current trends in adult social care demand, we have been able to forecast increases in people needing adult social care support.

The number of people needing home care support with five or more activities of daily living (such as bathing, using the stairs, getting dressed) is estimated to increase by 596 people between 2018 and 2023.



Chapter Two

Our five year strategic framework

Transforming health and care outcomes for the people of Southampton

Our five year strategic framework (2019-2023)

Our Vision

One city, our city, a healthy Southampton where everyone thrives

Our Goals

- **Reduce health inequalities and confront deprivation**
- **A strong start in life for children and young people**
- **Tackle the city's three 'big killers': Cancer, Circulatory diseases and Respiratory diseases**
- **Improve whole-person care**
- **Improve mental and emotional wellbeing**
- **Build resourceful communities**
- **Reduce variation in quality and productivity**

Our Mission

Effective system partnerships delivering safe, sustainable, coordinated care with the people of Southampton

Our Goals

Reduce health inequalities and confront deprivation. Whilst most of the wider determinants of health are beyond the scope of health and care services, the data we now have about the distribution and characteristics of social deprivation across the City means we can get much more scientific about the way we target our limited resources to where they can have the maximum benefit.

A strong start in life for children and young people. Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. We want Southampton to be a city where children and young people get a strong start in life, are able to fulfil their potential and become successful adults who are engaged in their communities.

Tackle the city's three 'big killers'. In Southampton, the three big killers – cancer, circulatory diseases and respiratory diseases – account for most deaths. The Department of Health estimates that two thirds of premature deaths among under-75s in England are preventable. We want to take stronger action on improving prevention and encouraging healthy lifestyle changes to reduce smoking, obesity and alcohol consumption.

Improve whole-person care. In Southampton, by age 45-49 a quarter of our population have two or more long term conditions. Multi-morbidity is higher in the most deprived areas of the city. This means that our services need to fundamentally change, from treating single illnesses, towards supporting people in a more joined up way to live with their long term conditions.

Improve mental and emotional wellbeing. This is summed up well by the phrase, 'No Health Without Mental Health'. Mental health services are a high priority. Beyond this. mental and emotional wellbeing is demonstrably now such an all pervasive issue that our approach has to be about recognising the mental health dimension of everything we do and seeing it as an indispensable part of every interaction that health and care professionals, and citizens have with each other.

Build Resourceful Communities. This is about 'Getting Behind People'. Individuals and communities have 'agency' and are willing and able to help themselves; the job of public services might be more about 'standing behind. For example, in 2014/15, the residents of Newtown mobilised themselves to stop 'Immigration Street', but the support of every part of the public sector and business community (Southampton Connect) made them feel strong enough to make it happen.

Reduce variation in quality and productivity. Tackling unwarranted variation to improve outcomes and achieving excellence in quality of care.

Better Care Southampton

Our aim is to further enable the delivery of the One City vision: specifically a place-based approach that is fully inclusive of City partners, not just the NHS. This is about partnership, not structure. It is also easy to overlook the obvious and to assume the existence of an implicit consensus means that improvement and change will happen. Just because 'Better Care' is the bedrock of our established approach, we need to be realistic about how much remains to be done to achieve its aims.

Integration is one of those terms so overused that we are at risk of losing its meaning. We also need to recognise that integration is only a means to an end, not an end in itself.

The Southampton integration vision has evolved and is well established locally, characterised by strong and inclusive partnerships built painstakingly over several years. It is essentially very simple, based on Better Care, which has given us a strong sense of united purpose around care that is joined up and co-produced with people.

The original 2014 Better Care Southampton plan was based on the notion of integrated person centred care, with outcomes for people derived from the national 'I statements' and structured around a 'three legged stool' concept:

- cluster based teams, embedded in communities, of integrated primary, community, social and mental health care
- integrated discharge, rehabilitation and reablement (realised in 2016 by the creation of the Urgent Response Service)
- building community capacity

This has shaped our work programme ever since.

The compelling case for integration hinges in the fact that the City has 123,000 people (46%) living with a long term condition. Whilst multi-morbidity increases substantially with age, this is not just a problem of old age. By the age of 45, half the population has at least one long term condition. This means that our services need to fundamentally change, from treating single illnesses towards prevention and early intervention outside of hospital, but also towards supporting people in a more joined up way to live with their long term conditions.

We see integration as a means to improve people's outcomes, not an end in itself. No-one has to participate, but neither do they have a veto. Our approach is about working together effectively rather than pursuit of organisational goals. Similarly we do not feel constrained by any particular contractual tools and inter-organisational arrangements may be facilitated by both informal and formal arrangements to manage risk and express accountability in the interests of the people of the city

Integration is not the same thing as collaboration, neither does it equate to the absence of competition or an end to procurement. Some legal changes to competition requirements might be helpful but even the Health and Social Care Act 2012 already places on all parties a duty to provide services 'in an integrated way'.

Better Care Southampton

Better Care has evolved since 2014 from a programme into an all-pervading approach. Thus, at the heart of our strategy is the Better Care Southampton Programme, which has three main areas of focus:

- **Promoting independence and wellbeing**
- **Timely and appropriate access to care and support**
- **Proactively joining up care across health and social care, physical and mental health and primary and secondary care.**

Workstreams:

- Maternity
- Sexual Health and Teenage Pregnancy
- Improving outcomes for children with SEND
- Prevention & early help for children & families
- Addressing the needs of high intensity users (HIUs)
- Transforming Care for people with Learning Disabilities
- Community Solutions
- Housing related support and homelessness
- Personal health budgets
- Implementing the city's frailty model
- Enhanced Health Support in Care Homes (EHCH)
- Supporting appropriate timely discharge & out of hospital model
- Home Care
- Housing with Care
- End of Life and Complex Care

Start Well

Children and young people get the best start in life, providing the foundation to ensure they are able to achieve the best opportunities and keep as healthy and well as possible throughout their lives.

Live Well

Individuals and communities thrive and are resilient with access to health and care services, good jobs, affordable housing, leisure activities, lifelong training, education and learning.

Age Well

People are able to live independently in their own homes with appropriate care and support to maintain and develop their social and community networks.

Die Well

Supporting people to have the best opportunities in their last years of life, by reconceptualising death and dying to be part of the norm by discussing and capturing end of life wishes.

Our Programmes & Enablers

A key next step in evolving the strategic plan will be the development of high level plans for each programme. Currently, the programme descriptors and workstreams below are draft.

Behaviour Change & Prevention

Encourage people to make healthier lifestyle choices and drive reductions in demand on health and care services caused by smoking, alcohol and obesity

- Smoking
- Alcohol
- Obesity

Primary Care

Build a model of general practice that will be the strong, effective and sustainable foundation of our integrated health and social care system

- Access
- High quality and sustainable services
- Collaboration

Social Care

Work with individuals, their carers and wider communities in a more inclusive way to promote independence, focussing on strengths as opposed to a deficit model

- TBC

Mental Health

Improve mental wellbeing and provide support at the right time to avoid people getting into crisis

- Adult mental health
- Child and adolescent mental health
- Crisis care
- Dementia
- Suicide

Cancer & Long Term Conditions

Increase earlier detection and treatment of cancer, and transform clinical pathways to improve productivity and provide care closer to home

- Cancer prevention & earlier diagnosis
- Long term conditions pathways

Urgent & Emergency Care

Redesign and strengthen the urgent and emergency care system to ensure that patients receive the right care in the right place, first time

- NHS 111 development
- Urgent treatment centre
- Emergency response (999)
- Same Day Emergency Care (SDEC)
- Eye A&E & minor eye conditions service (MECS)

People & Workforce

Training health and care staff together so that they develop common approaches, and focusing on behaviours and attitudes just as much as skills. Thus enabling Healthy Conversations, both with people and between professionals.

Digital

Interoperable, integrated IT with innovative digital solutions which enable proactive care, better access, better coordination and modern care

- People powered
- Connected systems, shared information
- Digital-first access

Estates

Ensure we have the right type of buildings (size, configuration, flexibility, cost) in the right locations across Southampton

- TBC

Working together to transform outcomes

Our mission

Effective system partnerships delivering safe, sustainable, coordinated care with the people of Southampton.

Health and care organisations in the city have committed to work together to deliver the strategy. The vision we share for health and care in the city has evolved out of strong and inclusive partnerships between commissioners, providers, communities and citizens, built painstakingly over a number of years.

How we'll work

- **Promoting independence.** Supporting self-care and strengths-based approaches.
- **Co-production.** Communicating and engaging with residents and encouraging participation.
- **Population health management.** Understanding our population and planning for the future.
- **Simplifying processes.** In other words, a complete reversal of a 'gatekeeping' approach to services, instead stripping out the steps that add no value to the 'patient/client'. Thus, 'right place, right contact, first time', enabling better productivity and efficiency in service provision.
- **Moving from urgent care, to planned care.** By putting better anticipatory care in place, we spend less time reacting to a problem and more time preventing it.
- **Tackling unwarranted variation.** Actively using benchmarking tools like Public Health Fingertips, Dr Foster, RightCare and Getting it Right First Time (GIRFT) to improve outcomes.
- **Getting the basics right.** Working in partnership is not a substitute for successful, efficient, well run organisations.
- **Financial Strategy, based on the following principles:**
  - Good planning, not heroic assumptions.
  - Risk reduction, not risk transfer. Reducing system cost, not cost shunting. Also, improving payment mechanisms but recognising they are not the answer.
  - Investment in change: recognising that change costs money and has to be funded.

Our values

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Southampton City Clinical Commissioning Group

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Dr Nick Broughton, Chief Executive, SHFT
Will Hancock, Chief Executive, SCAS
Dr Nigel Jones, Chief Executive, SMS
Jo Ash, Chief Executive, SVS
Sandeep Sesodia, Chair, Southampton Connect

29th May 2019

Dear Colleague,

Transforming Health and Care for the People of Southampton:
Our five year strategic plan 2019-2023

Further to our recent discussion at Southampton System Chiefs, I am writing to share with you the current version of our draft strategy for the City which we have developed in partnership. This version has been developed following the partnership conferences held on 29 March and 8 May. I would like to thank you all for the contributions you have made to getting us to this point.

I should be most grateful if you would now ensure that this document is taken through the appropriate internal governance processes to ensure your organisation owns the approach and is able to approve the strategic framework set out in Chapter 2.

The CCG Board considered the strategy at its meeting on 22 May and I have been asked to write to our key partners accordingly. The covering paper for the CCG Board is also attached for your information.

We will also need to consider how best to secure the buy-in of other key partners, including schools, communities, independent providers of social care and the wider voluntary sector. This could be a topic for Southampton Connect to consider.

Clearly, there is still further work needed to develop high level plans, a roadmap and supporting documents (such as the primary care and social care plans, for example). Once the high level plans for each segment have been developed, the system will then need to look at how best to ensure oversight of delivery. I believe that we should ensure that such oversight is streamlined and unbureaucratic, as annual operating plans will contain specific actions and resource plans for implementation. I want to thank you in advance for the contributions your organisation will make to these and, of course to the successful delivery of the strategy.

We intend this strategy for Southampton will be a key component of the overall Hampshire and Isle of Wight response later this year to the NHS Long Term Plan, and hope you will be able to join me in commending this approach to our STP colleagues.

We would be most grateful to receive your confirmation that the strategy has been considered by your Board and interested to receive any feedback. Please link with Clare Young to close this loop: clare.young4@nhs.net

With best wishes,

Yours sincerely

John Richards

Cc:
David French, David Noyes, Barry Day, Richard Crouch, Jane Hayward, Richard Samuel, Lena Samuels. Maggie Macisaac, Cllr Chris Hammond, Cllr Lorna Fielker, Cllr Dave Shields, Cllr Darren Paffey. Heather Hauschild.

Encs; covering paper and strategy document from 22 May board.

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DECISION-MAKER:		**HEALTH AND WELLBEING BOARD**		
SUBJECT:		**BETTER CARE END OF YEAR REPORT**		
DATE OF DECISION:		**19 JUNE 2019**		
REPORT OF:		**DIRECTOR OF QUALITY AND INTEGRATION**		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Donna Chapman**	Tel:	023 80296004
	E-mail:	**d.chapman1@nhs.net**		
Director	**Name:**	**Stephanie Ramsey**	Tel:	023 80296941
	E-mail:	**Stephanie.Ramsey@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
Not Applicable.

BRIEF SUMMARY
This report provides an overview of performance in 2018/19 against Southampton's Better Care programme and pooled fund, including the iBCF (improved Better Care Fund), and highlights priorities for 2019/20.

RECOMMENDATIONS:		
	(i)	To note 2018/19 performance against Southampton's Better Care programme and spend against the pooled budget, including the iBCF.
	(ii)	To note the priorities for 2019/20.

REASONS FOR REPORT RECOMMENDATIONS	
1.	The Health and Wellbeing Board (HWBB) is responsible for overseeing the Better Care pooled fund in each Local Authority area. In Southampton, this responsibility has been delegated to the Joint Commissioning Board (JCB) from the Health and Wellbeing Board (HWBB). The JCB reviews progress against the Better Care programme and pooled budget on a quarterly basis and an end of year report is presented to the HWBB.
2.	At the point of writing this report, national planning guidance for 2019/20 is still outstanding following publication of the national Policy Framework on 10 April 2019. However verbal intelligence from the LGA and NHSE is that 2019/20 will be seen as a transitional year whilst the national review of the Better Care Fund is concluded and the current spending period comes to an end. Changes to the planning guidance in 2019/20 are expected to be limited. There will be no change to the four national conditions: (i) Plans to be jointly agreed (ii) NHS contribution to adult social care to be maintained in line with the uplift to CCG Minimum Contribution (iii) Agreement to invest in NHS commissioned out-of-hospital services, which may include 7-day services and adult social care (iv) Managing Transfers of Care: A clear plan for improved integrated services at the interface between health and social care that reduces Delayed Transfers of Care (DToC), encompassing the High Impact Change Model for Managing Transfers of Care. As part of this all Health and Wellbeing Boards adopt the centrally-set expectations for reducing or maintaining rates of DToC during 2019-20 into their BCF plans.

	The main changes are expected to be: • A one year plan (as opposed to two years) • A requirement to include the Adult Social Care Winter pressure funding in the Better Care pooled fund • A stronger emphasis on integrating housing, housing adaptations and equipment services into the plans for integration.
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
	NOT APPLICABLE
DETAIL (Including consultation carried out)	
1.	**Overview** Southampton's Better Care Plan aims to achieve the following vision: • To put **individuals and families at the centre of their care and support**, meeting needs in a holistic way • To provide the **right care and support, in the right place, at the right time** • To make **optimum use of the health and care resources** available in the community • To **intervene earlier** and build resilience in order to secure better outcomes by providing more coordinated, proactive services. • To **focus on prevention and early intervention** to support people to retain and regain their independence It is a programme of whole system transformational change which is based around 3 key building blocks: • **Implementing person centred, local, integrated health and social care**. This includes harnessing the assets within communities and the power of individuals in improving their own health and wellbeing. It also includes health, social care, housing and voluntary sector teams coming together to proactively identify those people most in need in the local area and plan and deliver care and support in a more joined up and personalised way. • **Joining up Rehabilitation and Reablement, hospital discharge teams and other city wide services into integrated health and social care teams**. • **Building capacity** across the system to promote and support people to maintain their independence for as long as possible. This includes promoting self management approaches and supporting the role of carers. It also includes developing the capacity of the voluntary and community sector to meet lower level needs in local communities, as well as investing in the home care sector to enable more people to continue living in their own homes. Southampton's 5 key priorities as identified in the 2017-19 Better Care Plan are set out below: • Further expansion of the integration agenda across the full life-course • Continue to strengthen prevention and early intervention • Further shift the balance of care out of hospital and other bed based settings into the community • Development of the community and voluntary sector • Development of new organisational models which better support the delivery of integrated care and support, along with new contractual and commissioning models which enable and incentivise the new ways of working The **Better Care Fund** pools resources from both the CCG and Local Authority to support

the delivery of the Better Care Programme. In 2018/19 this totalled £111.5M (£74.5M from the CCG and £37M from the Council), making Southampton one of the country's top ten authorities for pooling an amount way beyond its national requirement which was £16.177M, demonstrating its commitment to integrating health and social care at scale.

Southampton's Better Care Fund is made up of the following schemes:

1. Supporting Carers
2. Local integrated services (clusters)
3. Integrated Rehabilitation and Reablement and Hospital Discharge
4. Promoting Care Technology
5. Prevention and Early Intervention
6. Learning Disability Integration
7. Promoting uptake of Direct Payments
8. Transforming Long Term Care
9. Integrated provision for children with SEND
10. Integrated health and social care provision for children with complex behavioural & emotional needs

2. **2018/19 Performance**

The table below provides the year end position for the key Better Care national metrics.

Metric	Year End Performance against Plan	Year End Performance against previous year
Non Elective Hospital Admissions	8% above plan	3% increase
• Children	-	6% increase
• Working age adults	-	2% increase
• Older People	-	4% increase
• Non Elective Hospital Admissions resulting from Falls Injuries	20% above plan	9% increase
Delayed Transfers of Care (DTOC)		
• Rate (this is the % beds occupied by a delayed discharge as a % of all available beds for Southampton. The national NHSE target is 3.5%)	4.8% against a target of 3.5%. Split by provider Trust: - UHS: 5.5% - Solent: 2.3% - Southern Health: 3.6%	4.8% compared to 5.4% in 17/18
• Average Daily Delays (this is the average number of patients delayed each day across Southampton LA area. Southampton's daily target is 26.6)	38.6 against target of 26.6	Not available
• Rate of Average Daily Delays per 100,000 over 18 population (Southampton's target is 13.2 per 100,000)	16.2 compared to target of 13.2	Not available
Permanent Admissions to Care Homes	8% above plan	6% increase

3. **Performance Commentary**

- **Permanent admissions to residential and nursing homes:** A high number of people whose capital has depleted, and so are no longer self funding, in the first 6 months of the year has resulted in an increase in the proportion of Council funded permanent admissions. This has contributed to the increase in the figures as has an increase in nursing home admissions.
- **Delayed transfers of care (DTOC):** There are two key national measures for DTOC – the national 3.5% target (% beds occupied by a delayed discharge as a % of total

beds available) which is the NHS England measure reported at Acute Hospital Trust level; and the rate of average daily delays which is used by Local Government (Southampton's expected rate for 18/19 being 13.2 per 100,000 over 18 population which equates to 26.6 average daily delays). DTOC is measured across the whole system and so locally the daily target has been split as follows:

- UHS – 19.98 average daily delays
- Solent – 2.66 average daily delays
- Southern Health – 4.0 average daily delays

The national target is split by responsibility as follows:

- NHS – 11.3 daily delays
- Adult Social care – 11.0 daily delays
- Both (joint NHS and social care responsibility) – 4.4 daily delays

The beginning of 2018/19 saw an increase in the DTOC rate. Although the DTOC rate has been reducing since September, it still remains significantly above where it should be and above that of our comparator authorities. Figure 1 at Appendix 1 shows performance against the 26.6 daily target for Southampton as a whole and split by NHS, Social Care and "Both" delays.

Figure 2 at Appendix 1 shows the rate for the daily average delays per 100,000 over 18 population and how Southampton compares to the national average and other Local Authorities.

Performance against the 3.5% target by year end was 4.8% for the system as a whole (5.5% for UHS; 2.3% for Solent and 3.6% for Southern Health).

- The main challenges resulting in delays are:
  - Increasing levels of complexity amongst patients being discharged.
  - Sourcing complex "double up" care packages.
  - Sourcing care home placements particularly for patients with dementia but also in relation to response times for assessment by the homes
  - Sourcing care for patients with low level health needs such as collar care
  - Flow in NHS rehabilitation beds whereby difficulties in sourcing home care prevent patients from moving on and thereby create a bottleneck in the pathway
- However, despite the DTOC rate being higher than plan in 2018/19, the number of delayed days this year to date are at a very similar level to the number this time last year (1% lower) and overall, there has been a steady reduction in DTOC over the past 2 years. In order to understand what more it needs to do in order to improve, the CCG and SCC therefore requested a peer review of DTOC which took place on 30 April 2019, coordinated by the LGA. Key feedback from this review is currently being implemented and includes:
  - Strengthening senior oversight and leadership by ensuring that there is a regular focus on DTOC performance at the monthly Better Care Steering Board meetings
  - Strengthening reporting processes and accountability so that on any one day performance can be tracked against each of the 3 discharge pathways ("simple" which is the responsibility of the hospital; "supported" which is the responsibility of Rehab and Reablement and "enhanced/complex" which is the responsibility of the Integrated Discharge Bureau)
  - Organisation of a system wide workshop for 21 June with Hampshire colleagues to take a fresh look at the 8 High Impact Change Model (using the latest reviewed guidance from the LGA) for improving discharge and flow and identify key improvement areas for focus

- Refresh of the DTOC action plan to include priorities identified from above workshop plus:
    - Continuing to mainstream discharge to assess and home first principles.
    - Improving planning at the hospital front door to assess needs, direct people to the most appropriate setting, avoid admission where possible, commence early discharge planning.
    - Continuing to increase the supply of home care to meet greater levels of complexity and address gaps e.g. people with low level health needs whilst engaging the social care market and voluntary sector more in our transformation work.
    - Improving hospital processes for organising discharge/"getting the basics right" – e.g. timely and reliable transport and provision of medication and equipment, timely transfer of patient notes and consistent application of the Complex Discharge policy, particularly in relation to early discharge planning.
    - Working towards 7 day discharge.

- **Non Elective (NEL) admissions:** For 2018/19 NEL admissions were 8% above target and, despite holding growth for the majority of the year, ended the year 3% higher than 17/18. This was due to high rates of admissions in the last 3 months of the year coupled with unprecedented increases in Emergency Department (ED) attendances, particularly amongst children and over 65s. The majority of the increase has been in short stay admissions (less than one day) – 13% increase compared to previous year for children and 12% for over 65s. This is shown in Figure 3 of Appendix 1.
- In comparison longer admissions of one day or more only increased by 2% for both children and over 65s.
- Growth in short stay admissions (less than one day) remains a particular challenge. Work is ongoing with UHS, Solent and Adult Social Care to develop rapid pathways from the hospital front door back into the community where hospital stay is avoidable; however under current coding rules, any stay in hospital (be it only for a few hours) will be counted as an admission.
- Short stay NEL admissions in the working age population on the other hand were 1% lower than the previous year; the following have helped to reduce admissions for this age group:
    - Changes to the pathway for low risk chest pain patients.
    - Reductions in admissions amongst high intensity users - this has included the introduction of an ambulance demand practitioner targeting cohorts of patients with frequent urgent care activity (which is demonstrating reductions in ambulance call outs) and the implementation of an intensive support scheme focussed on people in the inner city with very complex health and social care needs.
- With regard to falls related admissions amongst older people which were 20% above target and 9% higher than last year, a detailed review of activity has been undertaken in 18/19 to identify areas on which to focus improvement. The following developments have been agreed for 2019/20 funded by the CCG:
    - Implementation of a telecare pilot specifically targeting people identified as being at high risk of falling in their own homes (which is where the majority of falls occur) to provide falls prevention equipment as well as a 24 hour responder service to prevent people remaining on the floor for long periods of time (identified as a key reason for admission)
    - Introduction of a clinician from the Urgent Response Service into the South Central Ambulance Service call centre with knowledge of the local pathways and services in order to support the call handlers with identifying alternatives to hospital conveyance (identified as a missed opportunity).

	➢ Re-procurement of a city wide falls exercise service ➢ Additional investment into the Community Independence Service to increase the capacity for falls assessments to ensure that people are compliant with their medication, exercising appropriately and making other lifestyle changes that could prevent a fall
4.	**Key Developments in 2018/19** Below is a summary of some of the key developments in 2018/19 against each of the 18/19 Better Care priorities. • **Priority 1: More rapid expansion of the integration agenda across the full life-course, building on the city's model of person centred integrated care** ➢ Implementation of an **integrated 0-19 Early Help Service**, bringing together NHS employed public health nurses (Health Visitors and School Nurses), the Council's Children's Centres and Family Matters teams to form an integrated offer delivered across three localities. Work has commenced to further strengthen and extend the teams by devolving some city wide services down to localities, including social workers. The Council has been successful in a bid to become a research partner with the national What Works Centre for Children's Social Care which is funding 6 **social workers to work in 3 school clusters** across the city from February 2019 which will test the benefit of bringing social work closer to schools and children and families. ➢ A Better Care Programme Manager was appointed in May 2018 to support integration at an operational level and a number of key building blocks are now in place including: - Detailed population profiles to inform each locality's understanding of their local population and setting of local priorities. - Local Solution Groups which bring together community and voluntary sector partners with statutory services to map the wider community provision and work together to identify future creative solutions to meeting local need. - Commenced pilot of social work hubs • **Priority 2: A much stronger focus on prevention and early intervention** ➢ Implementation of the new **Southampton Living Well Service** which commenced in April 2018 and is transforming the way we provide older people's day care into a more person centred, community focussed model. The provider of this service is co-producing an activity offer with service users and will establish an affiliate scheme with local activity groups/organisations which will significantly increase the number and range of activities being offered outside of the traditional day care setting. ➢ Establishment of an integrated **Information, Advice and Guidance** Service. In the first year of the contract for every £1 invested into the service approximately £4 is returned in benefit to the clients who use the service (e.g. through savings in bills, increased access to benefits, consumer advice etc) ➢ Development of the **Falls Exercise** offer which is now operating across the whole city. • **Priority 3: A more radical shift in the balance of care away from bed based provisions and into the community** ➢ Implementation of the national **High Impact Change Model for hospital discharge and flow**. Discharge to Assess (D2A) for discharge pathway 2 (people requiring reablement or some level of additional support in their own homes) is now mainstreamed for all people leaving hospital (UHS as well as the

community hospitals RSH and Snowden). There is evidence that discharge to assess and reablement for this group is reducing the need for ongoing care. Between January 2018 and January 2019, 947 people left the service having been on the reablement pathway of whom 500 had no further care needs at the end of their reablement period (53%). Specific data for patients discharged from the RSH shows that of those requiring ongoing care, 20% had reduced needs.

A D2A pilot for the more complex group of people leaving hospital on Discharge Pathway 3 has also been piloted in 2018/19. An evaluation of this pilot has shown that those patients/clients who have accessed the D2A scheme have shorter lengths of hospital stay (on average the D2A group had an average length of stay 27 days less than those patients/clients who were offered D2A but declined).

- Implementation of the **Crisis Lounge** to provide a safe space in the community for people in mental health crisis, diverting unnecessary ED attendances. This is now operating 24/7.
- Further roll out of **IAPT** (Improving Access to Psychological Therapies) in the community to support more people with lower level mental health needs.
- Successful piloting of the **Enhanced Health in Care Homes** model with 15 residential care homes across the city has demonstrated a significant impact on reducing Emergency Department (ED) attendances and Non elective hospital admissions (NEL). Overall it would appear that ED attendances have reduced by 48%, Ambulance Call outs by 57% and NEL hospital admissions by 38% across the 15 targeted homes over a 16 month period. The pilot has also helped to build positive relations between commissioners, health services and these homes. As a result, the CCG are now rolling this out city wide.
- Continued **work with the care home market to develop capacity to meet increasing levels of complexity.** This has included encouraging care homes to increase complexity of care by identifying current capabilities, and the training and skills development required to meet future needs. SCC and CCG are also looking into options to contract for capital investment in nursing homes in return for bed spaces at a reduced rate.
- Successful re-procurement of the **Home Care Framework** and continued expansion throughout the year of the hours available to respond to increasing demand. The new framework which went live in April 2019 builds on the lessons and challenges of the previous framework. A key feature of the new Home Care model is to have appointed lead providers for each of the city's Better Care clusters to better coordinate care on the ground, model the new ways of person centred, strengths based working and ensure strong linkages with other services as part of our overall integrated model. The lead providers will have a greater responsibility in working in partnership with other health care providers in their cluster, including acute and community hospitals, GP surgeries and social care teams.

- **Priority 4: Significant growth in the community and voluntary sector**
  - Development of plans for a new **Community Solutions Service** which will provide an infrastructure to support Community Development and roll out Community Navigation across the city. This is now being procured and will be in place by the Autumn of 2019/20.
- **Priority 5: Develop new models of care which better support and develop new contractual and commissioning models which enable and incentivise the new ways of working**
  - Embedding the use of **care technology in Adult Social Care;** although there is still some way to go, referrals have increased over 2018/19 and referral routes have been opened up to promote greater usage, e.g. to the Lifeskills team and

Homegroup to allow for more supported living clients with learning disabilities to be referred for Connected Care assessment.

- Development of an **integrated team for adults with learning disabilities**, which brings together Council, Southern Health and CCG staff. An integrated Service Manager commenced in post in September.
- Establishment of the **Joint Commissioning Board** which brings together senior decision makers from across the CCG and Council to determine commissioning strategy

5. **Impact of the iBCF**

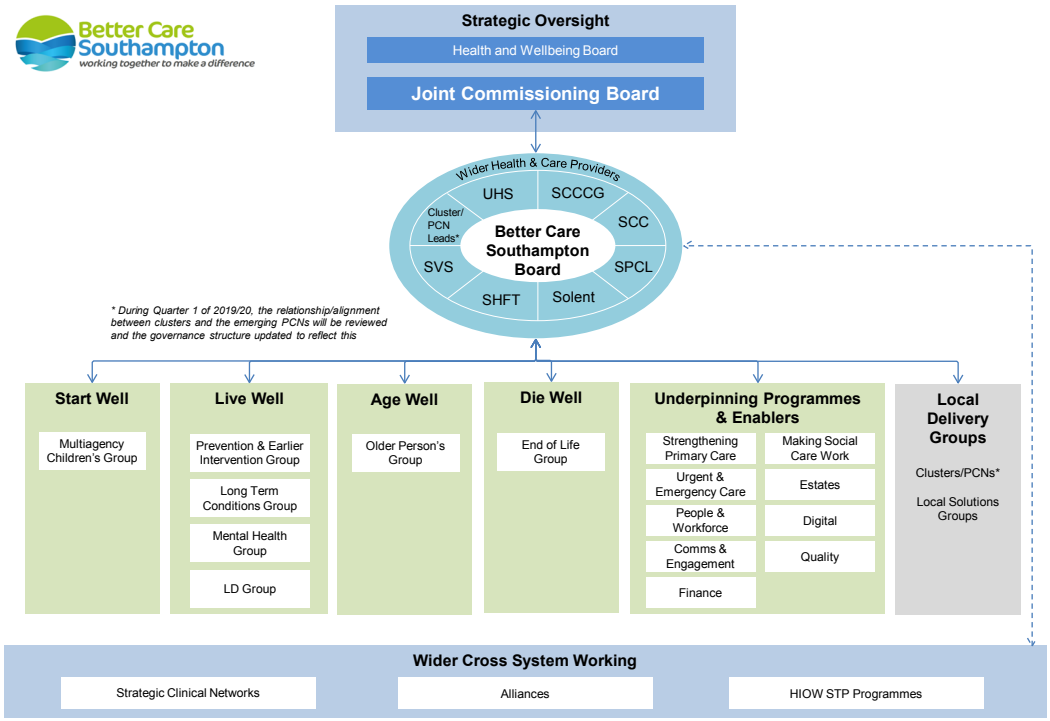
A number of the achievements outlined above have been supported by the iBCF national fixed term (April 2017 – March 2020) grant funding which is part of the overall pooled fund. In 2018/19 the total value of the iBCF was £4.85M, which included a carry forward from 2017/18 of £1.68M. This has been allocated as follows:

Scheme	2018/19 Spend	Impact
Establish a dedicated Direct Payments Team	£0.24M	• 120 new people in receipt of a direct payment (although this increase is not mirrored in the overall figures as a number of people have ceased their DP)
Care Technology Coordinator Post	£0.05M	• Provision of care technology has become more embedded for Adult Social Care. 1207 referrals in total during 18/19 compared to 854 in 17/18 and 584 in 16/17 and 276 referrals from integrated/health teams in 18/19 compared to 203 in 17/18. Referrals have visibly increased since the appointment of the coordinator in October 2017. • Conversions have remained stable (54.4% in 17/18 and 54.5% in 18/19) • Benefits tracking process implemented • Supported launch of telecare falls pilot
Weston Court replacement / respite care scheme	£0.31M	• Provision of a new respite service at Weston Court since Jan 2018 for adults with learning disabilities • 23 individuals receiving respite at service and 760 nights provided to date (up to March 2019) – which has enabled individuals to remain living in their family home. This has included provision of extended respite stays for five individuals due to family emergencies who might otherwise have ended up in residential provision
Expanded 7 day social care operation in the hospital discharge team	£0.10M	• 7 day working in the Hospital Discharge Team has meant that delays relating to assessment by the social care team have been significantly reduced.
Speeding up hospital discharge for people with complex needs	£0.35M	• This funding has been used to implement D2A for all clients discharged from the community hospitals (RSH and Snowden) with additional support needs in their own homes, mirroring the process at UHS. 809 patients have been discharged onto this pathway between April 2018 and January 2019 (on average 89 a month). Of these approx. 38% go on to require no further care and, of those needing ongoing care, approx. 20% have a reduction in their care needs. • The funding has also been used to pilot a D2A scheme for those more complex patients coming out of UHS on pathway 3 (i.e. those who are likely to need a nursing home placement). As already highlighted above, data from the pilot has shown that there is a reduction in the number of delayed days in

			hospital for those patients/clients receiving D2A.
	Meeting increased demand and complexity	£2.00M	• Reduction of Adult Social care cost pressure
	Stabilising the provider market	£0.32M	• 100 additional home care hours a week purchased from the Retainer • Employment of Service Development Officer and successful re-procurement of city wide Home Care Framework, whilst also managing business as usual
	Extra Nursing Home Capacity for complex needs	£0.11M	• Appointment of a Service Development post which has led on negotiations with the care home sector to increase access to affordable bed spaces (approx. 50 bed spaces) and encourage and support homes to meet increased levels of complexity • Commissioning of a land options appraisal which has identified land available in the city that would be of the size that could support either extra care developments (large plots of land) or supported living developments (smaller units). This work is the first time the city has provided this level and quality of information, and is being used to underpin investment strategies – both for LA money and for private development resources.
	Additional social work capacity in new community based social wellbeing service	£0.10M	• Additional capacity to meet need
	Additional social work capacity in new integrated learning disability service	£0.11M	• Additional capacity to meet need
	Additional social work capacity to review care needs in accordance with the Care Act 2014	£0.03M	• Additional capacity to meet need
	To be carried forward to 19/20	£1.10M	
	TOTAL	£4.85M	

6. **2019/20 Better Care Programme**

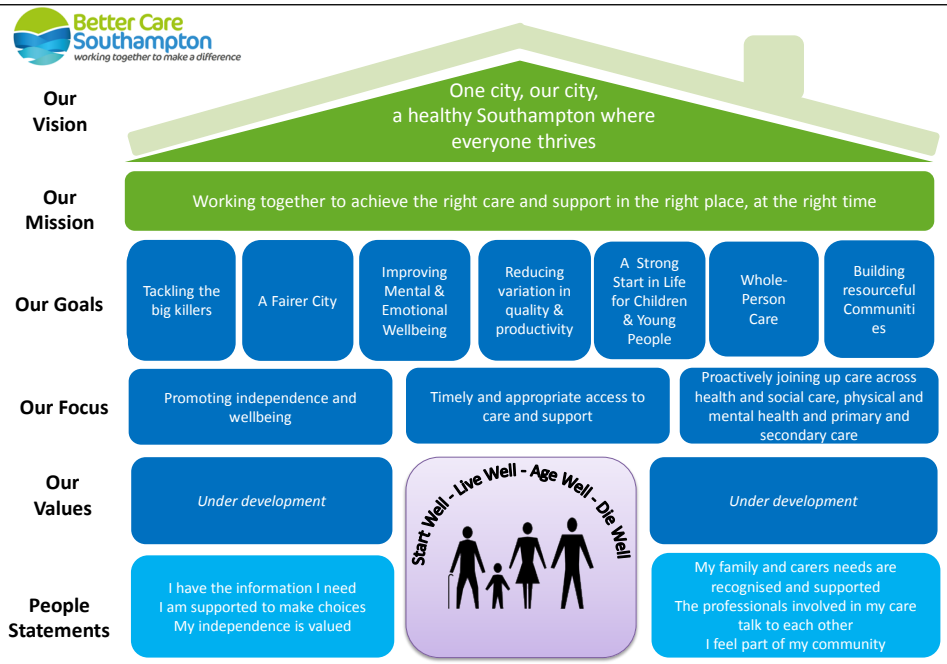
In the light of the city's new 5 Year Health and Care Plan (2019 – 2024), the governance structure for Better Care has been reviewed. The new governance structure will be presented to Joint Commissioning Board on 20 June for approval and is shown below:



The main changes to the governance are:

- A move to 3 localities (as opposed to 6 clusters) to enable better alignment with Primary Care Networks (PCNs) and local health and care delivery structures, where localities of 80,000 – 100,000 populations provide a footprint which offers better economies of scale for organising services around than 6 clusters of 30,000 – 50,000 could offer. This does not preclude working at sub-locality/neighbourhood level where it makes sense to do so.
- Inclusion of the locality leads on the Better Care Steering Board to strengthen connectivity between strategic planning and local service delivery.
- Restructure and rationalisation of the Better Care Steering Board subgroups to align with the life course approach used in the 5 Year Health and Care Plan: start well, live well, age well, die well.

The vision for Better Care has also been refreshed to mirror the 5 Year Health and Care strategy:



Underpinning the delivery of the 5 year plan, 3 key areas of focus have been identified for Better Care:

- Promoting independence and wellbeing
- Timely and appropriate access to care and support as close to home as possible
- Proactively joining up care across health and social care, physical and mental health, primary and secondary care.

The following actions are being taken forward in 2019/20:

Focus	Actions
Promoting independence and wellbeing	• Implement the next stage of the falls prevention strategy. • Further development of strengths based approach in adult social care and wider team • Procurement of the new Community Solutions Service to provide an infrastructure to support growth in the community and voluntary sector and community navigation to better link people into the support that is available in their local communities • Further expansion of Extra Care Housing with the development of 80 new bed spaces at Potters Court which will open in 2020 plus development of further proposals • Development of supported housing options for people with learning disabilities and implementation of new housing related support services for children and adults
Timely and appropriate access to care and support as close to home as possible	• Continuing to embed the High Impact Change Model for Hospital Discharge with a particular focus on strengthening the 3 hospital discharge pathways, work with the care home sector to improve hospital discharge and increasing weekend discharges. • Rolling out the Enhanced Health in Care Homes model city wide • Implementation of the new Home Care framework • Continue to work with the nursing home sector to increase capacity and availability of affordable bed spaces for Southampton clients with increased levels of complexity. • Implementation of Southampton's Frailty model, designed in 2018/19,

	to manage higher levels of acuity in the community, e.g. IV medication and strengthen multidisciplinary working at the hospital front door to ensure that people are directed in a timely way to the best setting for supporting their needs, wherever possible in their own homes • Continue to maximise opportunities for using care technology to improve access to health and care and support people's independence. • Continue to increase access to Improving Access to Psychological Therapies (IAPT), including for people with long term conditions • Continue to develop mental health crisis response for adults and children, developing intensive home treatment as an alternative to inpatient care
Proactively joining up care across health and social care, physical and mental health, primary and secondary care.	• Continue to join up health and care across physical and mental health at a locality level with a particular focus on implementing integrated locality health and social care teams for vulnerable adults and continuing to develop the integrated team for adults with learning disabilities. • Continue to implement the extended locality team model for 0-19 Prevention and Early Help Services to manage greater risk in the community, including joint work with Adult Services to ensure a whole family approach - whilst also integrating specialist health, care and education services to better support young people with complex social/emotional/ behavioural needs in the community, reducing numbers entering care or being placed out of area. • Development of a more integrated model of equipment, housing, adaptations and related services • Explore alternative contracting approaches which better support system wide working to a set of common outcomes

RESOURCE IMPLICATIONS

Revenue

7. **2018/19**

The total value of the pooled fund for 2018/19 was £111.50M. Total spend was £111.90M which represents a percentage variance against budget of 0.38%.

The main area of overspend was in the Learning Disabilities Scheme (£0.98M). This is due to an increase in complexity of client care. This overspend was offset to an extent by underspends in other schemes, primarily:

- Integrated Rehab and Reablement and Hospital Discharge where there was an under spend of £0.13M, mainly related to staff vacancies (that are now being recruited to).
- Prevention and Early Intervention where there was an under spend of £0.52M due to contract savings within day care commissioning and housing related support.
- The Children's multiagency Building Resilience Service (BRS) where there was an underspend of £0.12M which is related to staff vacancies (now being recruited to)

Financial performance against each Scheme is monitored on a monthly basis by the Better Care Finance and Performance Group.

8. **2019/20 Spend Plan**

The total Better Care Fund for 2019/20 will be £115.7M, split as follows between the schemes:

Scheme	2019/20 Budget
1. Supporting Carers	£ 1.46M
2. Cluster working	£53.96M
3. Integrated Rehabilitation and Reablement and Hospital Discharge	£17.14M
4. Promoting Care Technology	£ 0.05M
5. Prevention and Early Intervention	£ 7.61M
6. Learning Disability Integration	£28.48M

7.	Promoting uptake of Direct Payments	£ 0.25M
8.	Transforming Long Term Care	£ 0.12M
9.	Integrated provision for children with SEND	£ 1.20M
10.	Integrated health and social care provision for children with complex behavioural & emotional needs	£ 1.27M
11.	Disabled Facilities Capital Grant	£ 2.22M
12.	Additional Social Work Capacity	£ 0.31M
13.	Joint Equipment Store	£ 1.65M

It should be noted that, with the exception of the IBCF, all funding in the Better Care pooled fund is committed to existing service provision.

Property/Other

9. There are no specific property implications arising from the Better Care pooled fund.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

10. The legal framework for the Better Care Pooled Fund derives from the amended NHS Act 2006, which requires that in each Local Authority area the Fund is transferred into one or more pooled budgets, established under Section 75, and that plans are approved by NHS England in consultation with DH and DCLG. The Act also gives NHS England powers to attach additional conditions to the payment of the Better Care Fund to ensure that the policy framework is delivered through local plans. For 2019/20, NHS England has set the following conditions:

- Plans to be jointly agreed
- NHS contribution to adult social care to be maintained in line with the uplift to CCG Minimum Contribution
- Agreement to invest in NHS commissioned out-of-hospital services, which may include 7-day services and adult social care
- Managing Transfers of Care: A clear plan for improved integrated services at the interface between health and social care that reduces Delayed Transfers of Care (DToC), encompassing the High Impact Change Model for Managing Transfers of Care. As part of this all Health and Wellbeing Boards adopt the centrally-set expectations for reducing or maintaining rates of DToC during 2019-20 into their BCF plans.

Southampton is compliant with all four of these conditions.

Other Legal Implications:

11. None

CONFLICT OF INTEREST IMPLICATIOINS

12. None

RISK MANAGEMENT IMPLICATIONS

13. Risks on specific Better Care Fund Schemes are monitored on a monthly basis. Key risks and issues for the Better Care Programme overall are summarised below:

- **Capacity of the care market** to meet increasing needs and support additional schemes to improve discharge - To mitigate this, the ICU is working proactively with the care market and utilising alternative mechanisms such as retainers and block contracts to provide increased stability.
- **Resilience in the voluntary sector** and ability to respond to new ways of working - A number of mitigating actions are being taken including: various procurement options being considered to make best use of local market and encourage innovation; support to local agencies also being considered as part of the developments; proactive review of any bidding opportunities.

POLICY FRAMEWORK IMPLICATIONS

14.	Southampton's Better Care Programme supports the delivery of outcomes in the Council Strategy (particularly the priority outcomes that "People in Southampton live safe, healthy and independent lives" and "Children get a good start in life") and the CCG Operating Plan, which in turn complement the delivery of the local HIOW STP, NHS 5 Year Forward View, Care Act 2014 and 5 Year Health and Care Plan.
15.	Southampton's Better Care Plan also supports the delivery of Southampton's Health and Wellbeing Strategy 2017 - 2025 which sets out the following 4 priorities: • People in Southampton live active, safe and independent lives and manage their own health and wellbeing • Inequalities in health outcomes and access to health and care services 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

KEY DECISION?	**Not Applicable - No decision required – Briefing only**
WARDS/COMMUNITIES AFFECTED:	**All**
SUPPORTING DOCUMENTATION	
Appendices	
1.	Performance Charts

Documents In Members' Rooms

1.	None
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.	**No – EIAs will be conducted as required at an individual project level**
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	**No – PIAs will be conducted as required at an individual project level**
Other Background Documents **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**	

Appendix 1

Better Care End of Year Report

Performance Charts

Figure 1

The charts below show performance against the 26.6 daily target for Southampton as a whole and split by NHS, Social Care and “Both” delays:

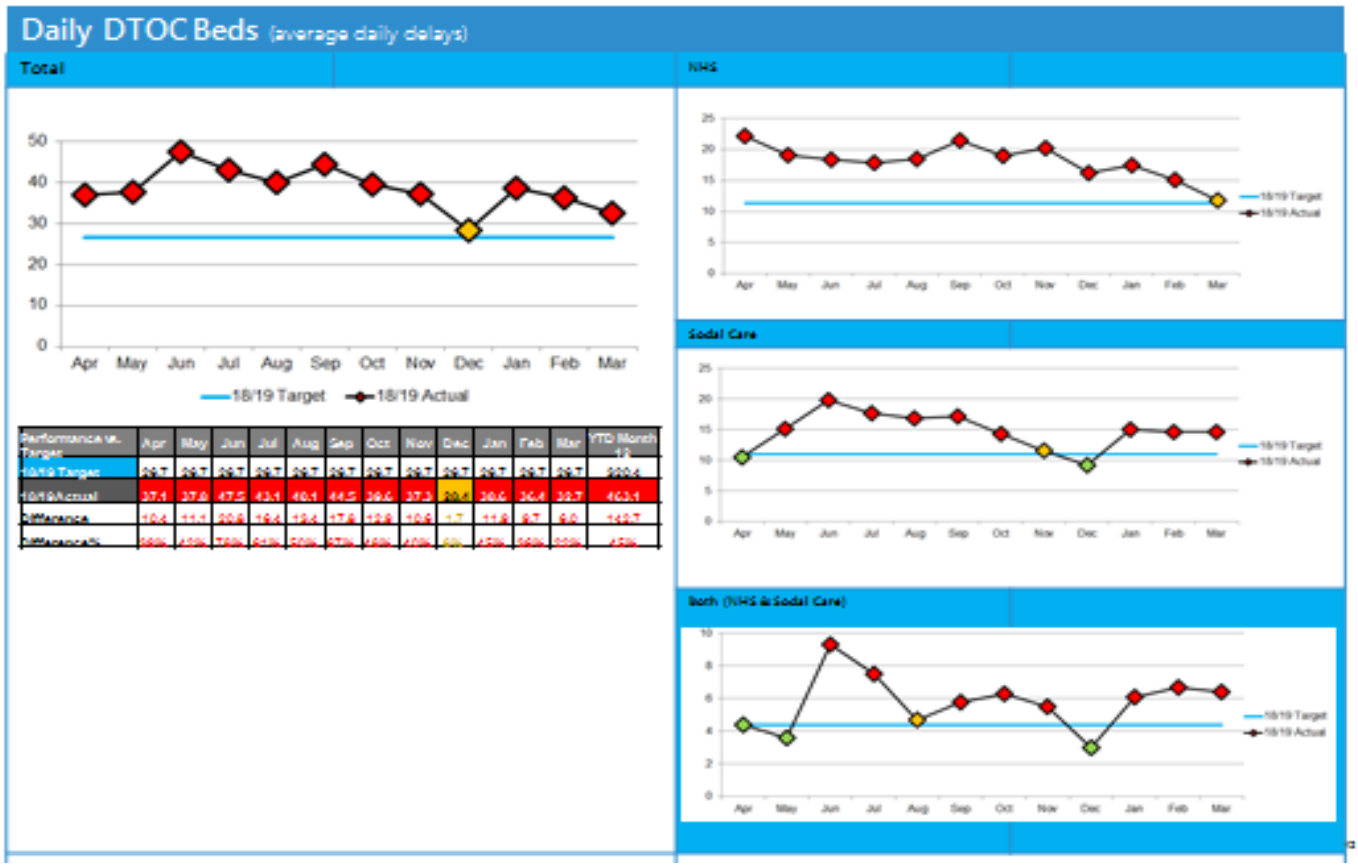


Figure 2

The charts below show the rate for the daily average delays per 100,000 over 18 population and how Southampton compares to the national average and other Local Authorities:

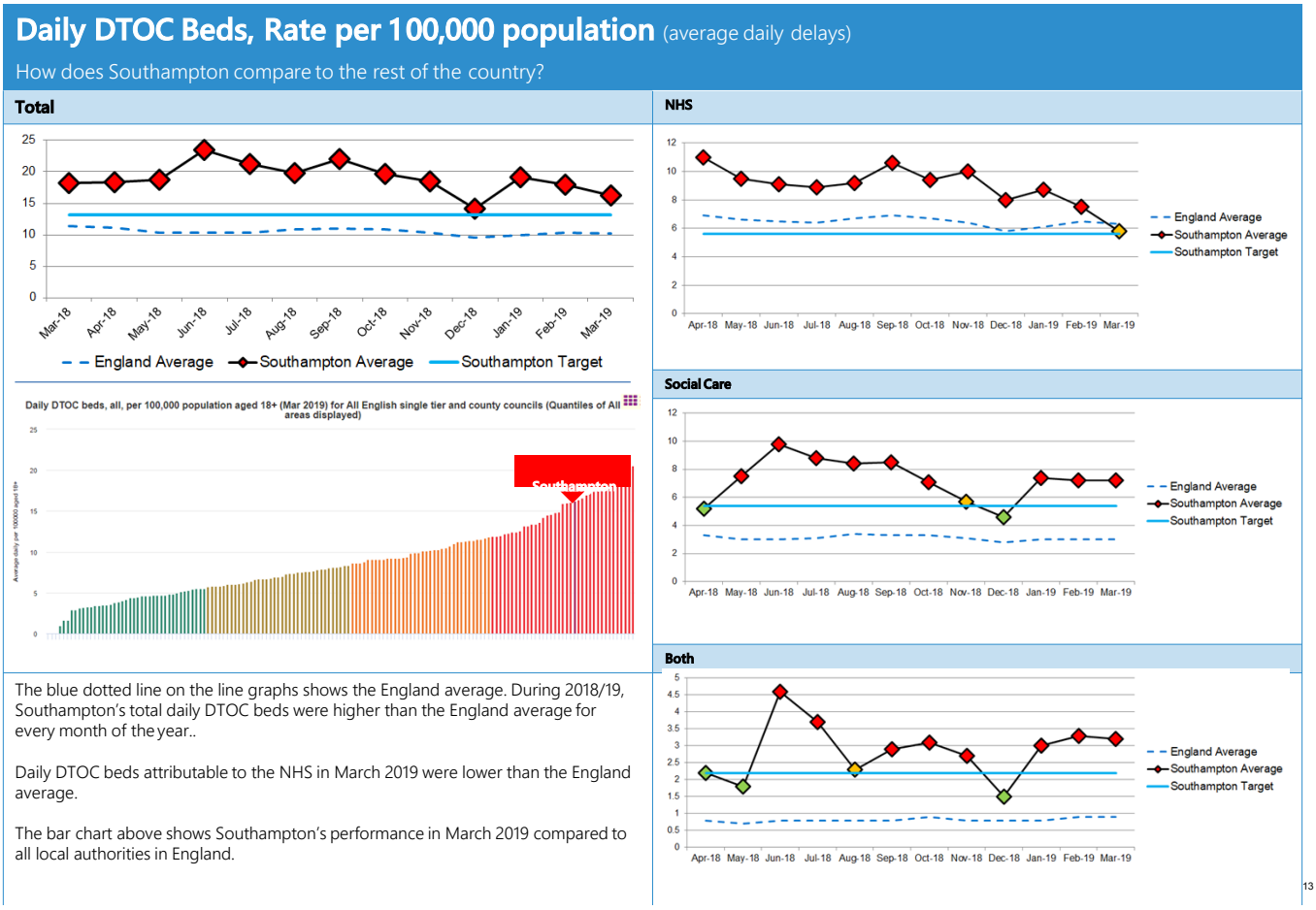
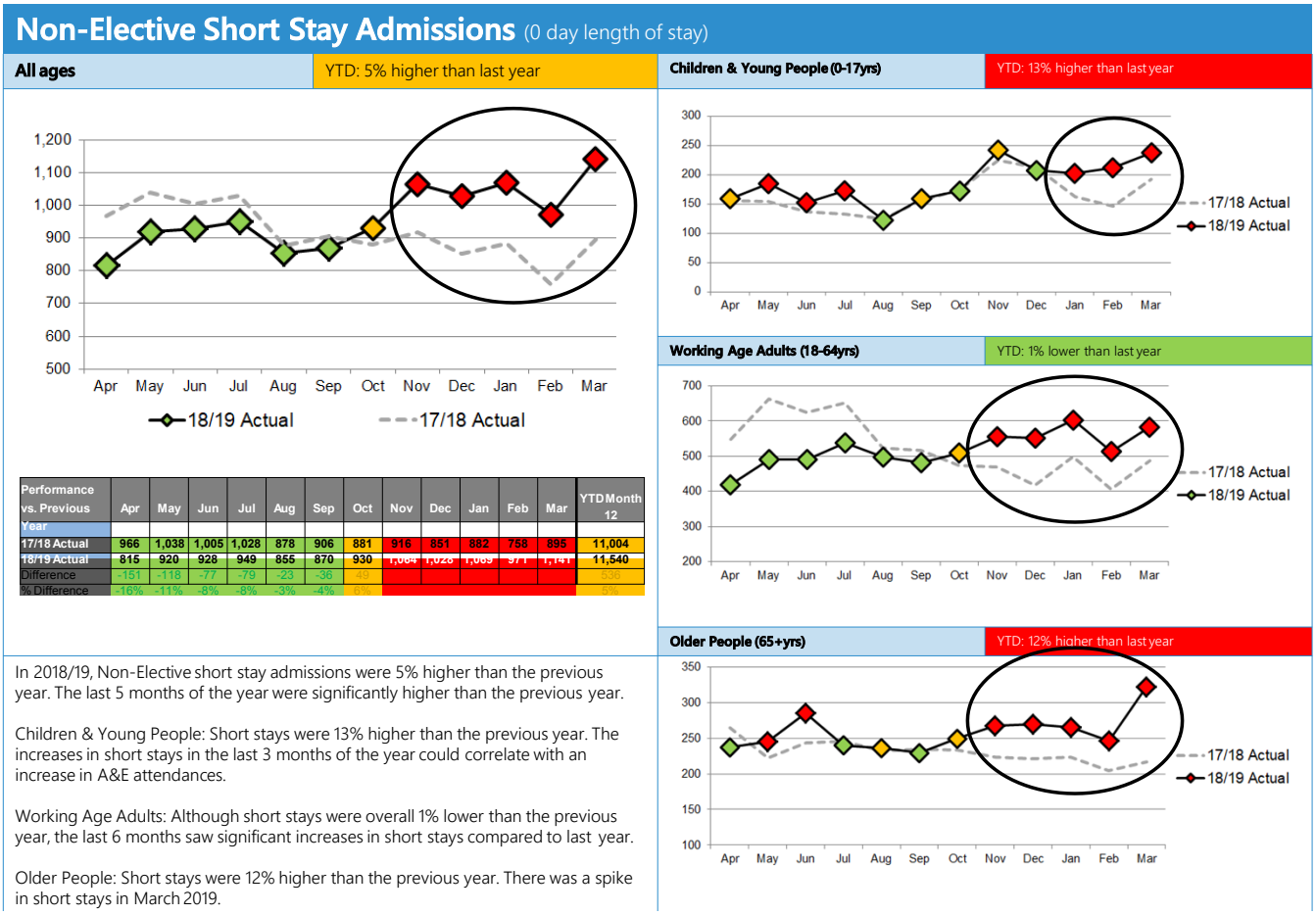


Figure 3

The majority of the increase has been in short stay admissions (less than one day) – 13% increase compared to previous year for children and 12% for over 65s. This is shown in the charts below:



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DECISION-MAKER:		**HEALTH AND WELLBEING BOARD**		
SUBJECT:		**JOINT STRATEGIC NEEDS ASSESSMENT UPDATE**		
DATE OF DECISION:		**19 JUNE 2019**		
REPORT OF:		**THE DIRECTOR OF PUBLIC HEALTH**		
CONTACT DETAILS				
AUTHOR:	**Name:**	Dan King	Tel:	023 8083 2493
	E-mail:	dan.king@southampton.gov.uk		
Director	**Name:**	Jason Horsley	Tel:	023 8083 3818
	E-mail:	jason.horsley@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY		
Not applicable		
BRIEF SUMMARY		
This paper provides an update on Southampton's Joint Strategic Needs Assessment, the work of the Strategic Analysis Steering Group (SASG) and the progress towards the delivery of a Single Needs Assessment (SNA) for the city through the Southampton Data Observatory. It also includes an update on the latest Health and Wellbeing Strategy Scorecard.		
RECOMMENDATIONS:		
	(i)	The Health and Wellbeing Board note the latest JSNA update and new Southampton Data Observatory website.
	(ii)	The Health and Wellbeing Board note the updated Health and Wellbeing Strategy Scorecard.
REASONS FOR REPORT RECOMMENDATIONS		
1.	For information only	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	None	
DETAIL (Including consultation carried out)		
3.	Under the Health and Social Care Act 2012 local Health and Wellbeing Boards are responsible for producing a Joint Strategic Needs Assessment (JSNA). The JSNA looks at the current and future health and care needs of the local populations to inform and guide the planning and commissioning of health, wellbeing and social care services within a local authority area.	
4.	The JSNA supports Health and Wellbeing Boards and other stakeholders to consider wider factors that impact on their communities' health and wellbeing, and local assets that can help to improve outcomes and reduce inequalities. Local areas are free to undertake JSNAs in a way best suited to their local circumstances; there is no template or format that must be used and no mandatory data set to be included.	
5.	Southampton City Council and the Southampton Health and Wellbeing Board recognise the importance of evidence based decision making, using evidence	

	and data from a range of sources including wider determinants of health. We have therefore moved away from the traditional JSNA and are now incorporating the JSNA into a single “all purpose” needs assessment framework, which also includes the Safe City Strategic Assessment, Economic Assessment and Pharmaceutical Needs Assessment (PNA). This vision was previously presented and agreed by the Health & Wellbeing Board.
	Single Needs Assessment and Southampton Data Observatory
6.	A new Southampton Data Observatory website has been developed to host the new Single Needs Assessment, with all content available as an online resource. The new website is hosted at https://data.southampton.gov.uk/ and will replace the JSNA currently hosted at www.publichealth.southampton.gov.uk
7.	The new data observatory has been developed based on user feedback and in consultation with members of the Southampton Strategic Analysis Steering Group (SASG). As previously presented to the Health and Wellbeing Board, the website is structured by topic to improve navigation and to make it more intuitive for users to find what they need. From the homepage the user is presented with 8 topics; population, health (JSNA), economy, place, community safety, children & young people, needs assessments and data and resources. Within each of these sections the user is able to access and download key facts, intelligence briefings, datasets, summary slide packs, city profiles and detailed needs assessments. The user is also signposted to resources developed elsewhere (i.e. PHE Fingertips tools), so it is a ‘one-stop shop’ for data and intelligence on Southampton. Users should be able to navigate seamlessly through the website using similar functionality to that used on the Office of National Statistics (ONS) website.
8.	It was originally envisaged the website would go live late 2018, but was delayed due to technical resources being prioritised elsewhere. However, the site is now live and is going through a user testing period before being formally launched during the summer.
	Strategic Analysis Steering Group (SASG)
9.	In June 2018, the Health and Wellbeing Board were informed that the Strategic Analysis Steering Group (SASG) had been formed help set the strategic direction of the SNA and other strategic analysis, ensuring it is fit for purpose and informs evidence based decision making. This is the forum for partners to influence the analytical work programme, ensuring it is informed by organisational priorities, the commissioning and strategy cycle and business need.
10.	The steering group is made up of representatives from different areas, such as the CCG, Public Health, Voluntary Sector, Children’s and Adult Services, ICU and Strategy and Policy. Their participation and input ensures the analytical work programme is continually informed by a variety of partners and their respective priorities and business need.
11.	As well as the development of the new Southampton Data Observatory website, over the last 12 months the SASG have prioritised and overseen work on a number of analytical projects including: • Homelessness Needs Assessment to inform the new Homelessness Prevention Strategy for the city

	• Modelling future prevalence of long term health conditions and demand for adult social care • Electoral (health) ward profiles • Smoking intelligence briefing • Community Safety Strategic Assessment update • Economic Development analysis update • Update to mental health and sexual health data compendiums • Learning Disabilities Needs Assessment (ongoing) • Domestic Violence Needs Assessment (ongoing) • Health inequalities analysis • Support for the new Health and Social Care Strategy
	Health and Wellbeing Scorecard
12.	We know that improvements in health outcomes can take years to achieve at a population level, and that no one action will contribute to improving health across the city. The strategy therefore includes a number of measures from the Public Health Outcomes Framework (PHOF), which will be monitored over the 8 years of the strategy. Appendix 1 provides a scorecard outlining the current position, regional, national and statistical comparators, and recent trends for each measure. Southampton continues to face challenges in relation to health outcomes, but has seen some improvements from the previous years. These include: • Under 75 mortality from cardiovascular disease and respiratory diseases reduced in 2015-17 for both males and females. However, both rates for males continue to be significantly higher than the national average. • The rate of looked after children has continued to decrease in Southampton, from 120 per 10,000 in 2016, to 104 per 10,000 in 2018; although this is still significantly higher than the national average. • Southampton's under 18 years contraception rate has decreased from 31.7 per 1,000 population in 2016 to 26.3 per 1,000 population in 2016. • Adult (18+) smoking prevalence has fallen for the second year running, from 20.5% in 2015 to 17.4% in 2017. However, it is still higher than the national average of 14.9%.
13.	However, there are still some areas for improvement, and include: • Both life expectancy and health life expectancy have fallen for males and females in the last 12 months. Female healthy life expectancy in particular has fallen from 63.1 to 61 years and is now significantly lower than the England average. • Under 75 mortality from liver disease considered preventable has increased from 17.5 per 100,000 population in 2014-16 to 21.2 per 100,000 population in 2015-17. • Smoking status at time of delivery has increased from 13.8% to 14.4% in 2017/18. • Child excess weight in 10-11 year olds has increased from 34.9% 2016/17 to 37.4% in 2017/18. • Southampton continues to be the 2nd worst for injuries due to falls in people aged 65+ compared to it ONS comparator areas and the rate has continued to rise.

	An overview of the health of Southampton's population will be presented to the Health and Wellbeing Board at the meeting on 19th June.
RESOURCE IMPLICATIONS	
Capital/Revenue	
14.	None
Property/Other	
15.	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
16.	None
Other Legal Implications:	
17.	None
RISK MANAGEMENT IMPLICATIONS	
18.	None
POLICY FRAMEWORK IMPLICATIONS	
19.	None

KEY DECISION?	**No**	
WARDS/COMMUNITIES AFFECTED:	All	
SUPPORTING DOCUMENTATION		
Appendices		
1.	Health and Wellbeing Strategy Scorecard	

Documents In Members' Rooms

1.	None	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.		**No**
Data Protection Impact Assessment		
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out.		**No**
Other Background Documents **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	

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Health and Wellbeing Scorecard

May 2019

Comparison with England:	Significantly Worse	Worse (but not sig)	Similar	Better (but not sig)	Significantly Better
England Ranking Quintile:	20% Worst	2nd	3rd	4th	20% Best

Priority area	Measure	Unit	Latest Period	Southampton sparkline	Southampton value	England Value	Comparison with England	ONS Comparator Ranking (12 LAs) (1 = worst)	England LA Ranking (1 = worst)*	Updated May 2019	Updated February/March 2019	Updated 2018	Direction of travel comparison with ghost rank of last time: Comparator ranking direction of travel	ONS Comparator Ranking (12 LAs) (1 = worst)	England ranking direction of travel	England LA Ranking (1 = worst)*
Overarching	Life expectancy at birth (Male)	Years	2015-17		78.3	79.6	Significantly lower	6	45			*	↑	5	↓	49
	Life expectancy at birth (Female)	Years	2015-17		82.4	83.1	Significantly lower	8	56			*	↓	9	↓	68
	Life expectancy at 65 years (Male)	Years	2015-17		17.9	18.8	Significantly lower	5	40		*	*	↑	4	↑	37
	Life expectancy at 65 years (Female)	Years	2015-17		20.6	21.1	Significantly lower	7	53		*	*	↓	8	↓	64
	Healthy Life Expectancy at birth (Male)	Years	2015-17		61.4	63.4	Significantly lower	5	53		*	*	↓	8	↓	64
	Healthy Life Expectancy at birth (Female)	Years	2015-17		61.0	63.8	Significantly lower	6	46		*	*	↓	9	↓	74
	Under 75 years mortality rate from cardiovascular disease (Male)	per 100,000	2015-17		120.9	101.3	Significantly higher	5	41 of 149			*	↑	3	↑	35 of 149
	Under 75 years mortality rate from cardiovascular disease (Female)	per 100,000	2015-17		43.8	45.2	Lower	9	89 of 149			*	↔	9	↑	81 of 149
	Under 75 years mortality rate from respiratory disease (Male)	per 100,000	2015-17		56.8	39.9	Significantly higher	2	23 of 149			*	↔	2	↑	12 of 149
	Under 75 years mortality rate from respiratory disease (Female)	per 100,000	2015-17		34.5	29.0	Lower	7	51 of 148			*	↑	5	↑	37 of 149
	Mortality rate from causes considered preventable (Male)	per 100,000	2015-17		296.7	228.6	Significantly higher	2	21			*	↓	3	↓	22
	Mortality rate from causes considered preventable (Female)	per 100,000	2015-17		160.7	137.7	Significantly higher	4	38			*	↓	6	↓	57

Priority area	Measure	Unit	Latest Period	Southampton sparkline	Southampton value	England Value	Comparison with England	ONS Comparator Ranking (12 LAs) (1 = worst)	England LA Ranking (1 = worst)*	Updated May 2019	Updated February/March 2019	Updated 2018	Comparator ranking direction of travel	ONS Comparator Ranking (12 LAs) (1 = worst)	England ranking direction of travel	England LA Ranking (1 = worst)*
Children & Young People/Early years	Smoking status at time of delivery	%	2017/18		14.4	10.8	Significantly higher	2	40 of 149		*		↓	3	↔	39 of 149
	Breastfeeding prevalence at 6-8 weeks after birth	%	2016/17	Not available	Not available	Not available	Not available	Not available	Not available			*				
	Child excess weight in 4-5 year olds	%	2017/18		23.3	22.4	Higher	6	59 of 148			*	↓	7	↓	65
	Child excess weight in 10-11 year olds	%	2017/18		37.4	34.3	Significantly higher	4	48 of 148			*	↓	6	↓	77
	Population vaccination coverage – MMR for one dose (2 years old)	%	2017/18		93.9	91.2	Significantly higher	10	118 of 149			*	↑	9	↑	109 of 149
	Looked after children rate	per 10,000	2017/18		103.8	63.6	Significantly higher	2	16 of 150	*		*	↔	2	↑	11
	School readiness: Good level of development at the end of reception	%	2017/18		71.0	71.5	Lower	9	67 of 151		*	*	↑	7	↓	87
	School readiness: Year 1 pupils achieving the expected level in the phonics screening check	%	2017/18		81.7	82.5	Lower	7	49 of 150		*	*	↓	10	↓	82
	Children in low income families (under 16s)	%	2016		20.1	17.0	Significantly higher	7	53		*	*	↔	7	↓	57
	Hospital admissions from unintentional & deliberate injuries (0-14 yrs)	per 10,000	2017/18		115.8	96.4	Significantly higher	6	37 of 150		*	*	↓	10	↓	59 of 148
	Under 18 years conception rate	per 1,000	2017		26.3	17.8	Significantly higher	3	18 of 150	*		*	↔	3	↑	7

Priority area	Measure	Unit	Latest Period	Southampton sparkline	Southampton value	England Value	Comparison with England	ONS Comparator Ranking (12 LAs) (1 = worst)	England LA Ranking (1 = worst)*	Updated May 2019	Updated February/March 2019	Updated 2018	Comparator ranking direction of travel	ONS Comparator Ranking (12 LAs) (1 = worst)	England ranking direction of travel	England LA Ranking (1 = worst)*
Adults	Smoking prevalence in adults	%	2017		17.4	14.9	Higher	2	34 of 150			*		3		
	Suicide rate	per 100,000	2015-17		13.3	9.6	Significantly higher	3	13 of 149			*	↑	1	↑	6 of 149
	Depression recorded prevalence	%	2017/18		10.1	9.9	Similar	5	66 of 151		*	*	↔	5	↓	68 of 151
	Injuries due to falls in people aged 65+ (Persons)	per 100,000	2017/18		3249.3	2170.4	Significantly higher	2	5 of 150	*		*	↔	2	↔	5 of 148
	Injuries due to falls in people aged 65+ years (Male)	per 100,000	2017/18		2865.4	1775.1	Significantly higher	1	2 of 150	*		*	↓	2	↓	5 of 148
	Injuries due to falls in people aged 65+ years (Female)	per 100,000	2017/18		3523.3	2453.4	Significantly higher	2	6 of 150	*		*	↑	1	↑	4 of 148
	HIV late diagnosis	%	2014-16		55.2	40.1	Higher	1	16 of 145							
	Under 75 years mortality rate for liver disease considered preventable	per 100,000	2015-17		21.2	16.3	Significantly higher	4	34 of 150			*	↓	7		
	TB incidence (3 year average)	per 100,000	2015-17		12.2	9.9	Higher	4	48			*	↓	8		

Priority area	Measure	Unit	Latest Period	Southampton sparkline	Southampton value	England Value	Comparison with England	ONS Comparator Ranking (12 LAs) (1 = worst)	England LA Ranking (1 = worst)*	Updated May 2019	Updated February/March 2019	Updated 2018	Comparator ranking direction of travel	ONS Comparator Ranking (12 LAs) (1 = worst)	England ranking direction of travel	England LA Ranking (1 = worst)*
Healthy settings	Fraction of mortality attributable to particulate air pollution	%	2017		5.8	5.1	Higher	2	41		*	*	↓	3	↓	42
	Percentage of people aged 16-64 years in employment	%	2017/18		74.7	75.2	Significantly lower	5	67 of 151			*	↔	5		45
	Excess winter deaths index (Persons)	Ratio	Aug 2014-Jul 2017		20.4	21.1	Lower	7	79 of 150			*	↓	12	↓	112
	Excess winter deaths index (Male)	Ratio	Aug 2014-Jul 2017		19.4	18.1	Higher	4	63 of 150			*	↓	12	↓	116
	Excess winter deaths index (Female)	Ratio	Aug 2014-Jul 2017		21.3	23.9	Lower	10	104 of 150			*	↑	8	↑	88

** Ranking is out of 152 Upper Tier Local Authorities unless otherwise stated*

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