Feedback by 30 September 2012

Gaining Healthier Lives in a Healthier City

Southampton Joint Health and Wellbeing Strategy

Consultative Draft July 2012

NHS
Southampton City Clinical Commissioning Group

SOUTHAMPTON CITY COUNCIL ®

Contents Page

Southampton's Joint Health and Wellbeing Strategy

Gaining Healthier Lives in a Healthier City

Forward

From the Cabinet Member for Communities, Southampton City Council and the Chair of the Clinical Commissioning Group (CCG).

We are delighted to be able to introduce this draft Health and Wellbeing Strategy for Southampton. The Health and Social Care Act 2012 requires Local Authorities and Clinical Commissioning Groups to jointly produce a strategy. The Department of Health advises that our strategy should not try to solve everything, but should take a strategic overview on how to address the key issues identified in our Joint Strategic Needs Assessment (JSNA) including tackling the worst inequalities. The Department of Health also advises that the strategy should concentrate on an achievable amount. That is why the strategy identifies six priority areas for action. Issues that are not referred to in this document are not unimportant. We have tried to identify the priority areas for this first joint strategy based on those needs where we really believe we can work together to improve the health of our citizens and have a positive impact on health inequalities.

We want it to provide a process through which all organisations, services and local people can help determine the priorities we should be focussing on to improve the health and quality of life of local people. The six key priority areas proposed will support improving health from cradle to older age.

We want your views on whether we have identified the right priorities and actions. Along with other cities, Southampton faces financial challenges and we need to make sure we make robust decisions about where we focus local action. We want local organisations and local citizens to have their say in making these decisions and to become part of the solution to address them.

We have set out our ambitions based on the evidence we have available on local needs in the City and are keen to hear your views and welcome comments to improve the strategy through this consultation process.

Councillor Jacqui Rayment

Dr Steve Townsend

Section One – Background and Local Context

Introduction

The promotion of health and wellbeing across Southampton City requires collective effort across a range of services and activities including those affecting the wider determinants of health (such as housing, education, transport, environment and economic regeneration) clinical and care services, community interventions, the voluntary sector and the business sector. This draft Joint Health and Wellbeing Strategy provides an overarching framework for action across the City for the period 2013 - 2016. This will require collective actions across a range of agencies, including the Local Authority, Clinical Commissioning Group (CCG) and local arm of the NHS Commissioning Board. It proposes the priority areas for action to improve health and wellbeing for local communities based on the needs identified in Southampton's Joint Strategic Needs Assessment (JSNA).

Consultation on this draft strategy will support the Health and Wellbeing Board in fostering commitment, involvement and collective effort to improving the health and wellbeing of those who live and work across the City.

The cornerstone of our decision making – Southampton City's Joint Strategic Needs Assessment (JSNA)

What is the JSNA?

Southampton City's JSNA includes a huge wealth of information, intelligence and analysis from a number of different sources that cover the health and wellbeing of the population.
http://www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/jsna2011/

This information is shared between local organisations, key stakeholders and is made available to the public. It provides those planning, commissioning and delivering services across the city with a common and consistent evidence base which supports the identification of gaps in services and priority areas for improvement and action.

Specific challenges highlighted in the JSNA include:

- Demographic pressures, especially the growth in the city's birth rate (around 35% in seven years)
- The increasing proportion of older people and accompanying increase in dementia
- Deprivation and children in poverty – the city is ranked the fifth most deprived local authority in the South East and 81st out of the 326 local authorities in England
- The increase in unhealthy lifestyles leading to preventable diseases
- The need to ensure high quality services for specific care groups, including those living with mental ill health, physically disabilities and learning disabilities
- The need to ensure that provider services are joined up and seamless to create robust care pathways for a 'whole person' approach
- The need to support carers to care and the need for volunteering
- Work and worklessness and the impact on mental health
- Recognising the impact on health of wider determinants (housing, transport and economic regeneration)

Nine key overarching themes to improve health and wellbeing in Southampton City were identified through stakeholder and public consultation as part of the JSNA development:

- Economic wellbeing
- Mental health
- Early years and parenting
- Taking responsibility for your health
- Long-term conditions- maximising the quality of life
- More people living longer
- Creating a healthy environment
- Safeguarding children and vulnerable adults
- Protecting people from health threats

Key Priorities

This strategy proposes six priority areas to focus local action and ensure best outcomes from our combined efforts.

Priority 1: Early Years and Childhood – sustaining work to support vulnerable families with young children

Priority 2: Adolescence and Young Adulthood – taking action to reduce the harm to individuals and society caused by misuse of alcohol and drugs

Priority 3: Working Age Adults – working with employers and local education providers to support people into employment and prevent people falling out of employment due to ill health

Priority 4: Helping People Grow Old and Stay Well

Priority 5: Reducing admissions to hospital from preventable causes of both physical and mental ill health

Priority 6: Improving housing options and conditions for people in the city to support healthy lifestyles

A whole range of on-going work continues outside of this strategy to address the wider determinants of health, delivered through mainstream services the voluntary sector and communities (e.g. transport, housing, economic development and mainstream health and social care service provision).

Key Principles

Southampton's Joint Health and Wellbeing Strategy is underpinned by six key underlying principles:

A. **Adopts a Life Course approach** (cradle to grave) – action to improve health and wellbeing and tackle inequalities must start before birth and continue throughout childhood and into adult life and later years. For this reason our strategy recognises the importance of giving children the best start in life and strengthening the role of ill health prevention throughout the life-course journey is a high priority.

B. **Needs driven** – it takes account of the current and future health and social care needs of the entire population (based on the JSNA).

C. **Mobilises local assets** – it enables the city's Health and Wellbeing Board and wider stakeholders across the city to look beyond identified *needs* to mobilise local *assets* (including those of the local community itself). Consultation question four at the end of each section will help identify local community-based assets to support delivery.

D. **Addresses inequalities** – within the City by addressing the wider determinants of health including poor housing, worklessness, community safety and economic regeneration.

E. **Maximises collaborative working** – to secure best outcomes from working together across the member organisations of the health and wellbeing board, key stakeholders and local people across the city

F. **Determines focused priorities to maximise outcomes** – the strategy prioritises the issues requiring the greatest attention and as part of the consultation process will work with key stakeholders across the city to identify what success will look like against key priority actions.

Section Two – Key Priorities for Action

Priority 1 – Sustaining work to support vulnerable families with young children

Rationale

Good health and wellbeing outcomes in early years have a major impact on the future health and emotional and economic wellbeing of individuals throughout their life course. The city's early years population continues to grow and there is a need to achieve the best possible outcomes for children under five years.

The majority of children and young people who enjoy good outcomes do so without the support of targeted or specialist support services, but through the care of their parents or other carers as part of family life. For many of those children who are at risk of poor outcomes, targeted and specialist services find that parents and carers are less able to provide children and young people with the support, guidance, challenge and resilience they need to enjoy good outcomes.

Whilst there is a strong correlation between socio-economic status and education and parenting skills, the situations which place challenges upon parents are complex and varied. Closer working between professionals in different services has confirmed the importance of the role that services can play in building the capacity of families to develop and make better use of their own resources to overcome the challenges that make them vulnerable to poor health and well-being outcomes.

Health and wellbeing needs of looked-after children also represent a key priority for this population group. The effectiveness of a variety of programmes, most notably integrated working between health and social care professionals in Sure Start Children's Centres and targeted programmes such as the Family Nurse Partnership, has confirmed the need to help parents and carers to recognise and address the contribution that they make to their children's health and wellbeing.

Local Evidence from the JSNA	What we will do
Child Poverty • 12,575 children live in poverty in the city; 28% compared to 21% in England (in some wards of high deprivation this is around 50%) • 385 children (0-17 years) were in local authority care (March 2011)	• Improve take-up of benefit entitlements • Undertake a Child Poverty Needs Assessment and develop a local action plan/strategy to tackle child poverty • Build parents self esteem, confidence and skills through volunteering and training pathways in Children's Centres • Support with helping parents into employment e.g. though sustained input from Job Centre Plus advisors • Meet the particular needs of looked-after children and young people, including those from black and minority ethnic backgrounds, unaccompanied asylum seekers, and those who have disabilities
Healthy Pregnancy • Increase the number of pregnant women accessing antenatal care before the twelfth completed week of pregnancy • Maintain the offer of choice for place of birth and promote a higher normal delivery rate • To promote best outcomes, enhanced support is needed during pregnancy up until the child reaches school age • Mothers smoking during pregnancy has reduced	• Sustain the delivery of the Healthy Child Programme, ensuring that every mother and child receives the health and development support they need, when they need it and to increase the routine promotion and uptake of the Healthy Start Scheme across the city • Sustain and build on the good practice of integrated working already achieved across the city (e.g. through Sure Start Children's Centres, midwifery service for

Local Evidence from the JSNA	What we will do
from 24% to 20%. Mothers who smoke are at higher risk of having premature and low birth weight infants • Mental ill health during pregnancy and early motherhood, or 'perinatal mental illness', is a serious public health issue. In Southampton postnatal depression rates are 10% with moderate to severe depression affecting 3-5% (104 to 173 women per year)	teenage parents under 18 years and family support workers as part of the heath visiting service) • Continually improve maternity services – implement recommendations from the review undertaken in January 2011 • Sustain and further develop the Family Nurse Partnership to improve outcomes for teenage mothers • Implement the on-going development of the Health Visiting Service including the increase in workforce by 2015
Maternity Services and Breastfeeding • Caesarean section rates in the city are 22.7%, which is an increase of 2.3 percentage points on the previous year (UHS births and bookings data). Caesarean birth rates are significantly lower within the most deprived areas compared to the rest of the city, although the gap is narrowing • Breastfeeding rates are indicating a steady increase and are now at 75.3% with greatest success in areas of higher deprivation	• Action is needed to sustain and increase the rate of normal births (currently around 60%) • Maintain breastfeeding rates so that more women continue to breastfeed at 6-8 weeks and beyond
Child Dental Health • Children's dental health in the city is poor when compared to the England average (42% of children aged 5 years with decayed missing or filled teeth compared to 38% for England) • The number of children requiring dental extractions under a general anaesthetic is unacceptably high at around 500 a year	• Sustain targeted oral health programmes in schools and nurseries across the city
Tackling Childhood Obesity • Almost 24% of children in reception classes are overweight and this increases to almost 32% by year 6 (10 years of age) • 9.5% of children in reception classes are classified as obese and this increases to 19.6% by year 6 • Of those who are obese in reception classes, 64% remain obese in year 6	• Implement the recommendations and actions detailed within the Fit 4 Life (tackling obesity) Strategy for Southampton • Improve support and engagement of women as they become pregnant in terms of good nutrition and activity in order to prevent and reduce levels of obesity in pregnancy • Provide support for children and their families to address levels of weight management, in line with the Fit for Life Weight Management Care Pathways and continue to engage providers through the Healthy Early Years Award scheme • Support schools where there is a greater prevalence of obesity to take a whole school approach to ensure an ethos and environment exists that encourages being active and eating well • Increase the proportion of children that take part in up to 5 hours of good quality PE or physical activity per week both within schools and in the wider community • Take actions to ensuring the physical environment in local areas helps to

Local Evidence from the JSNA	What we will do
	promote walking, cycling and safe local recreation and play
Emotional Health and Wellbeing • 53% of children enjoy good relationships with their family and friends in Southampton compared to 56% national average • The emotional wellbeing of children in care is also lower than the national average (as calculated through the strengths and difficulties questionnaire) • Based on a prevalence rate of 15%, an estimated 6,385 children and young people will experience a mental health problem in the city, according to the CAMHS Needs Assessment (2010)	• Promote positive mental health and wellbeing through activity in schools • Ensure the engagement of children and young people in CAMHS services continues to meet their needs at the earliest possible opportunity (assessment of effectiveness of local CAMHS resulted in them achieving maximum score)
Reducing Teenage Pregnancy and Support for Teenage Parents • Southampton's under 18 conception rate was 49.2 per 1000 females aged 15 to 17 years old (2009) • Southampton's under 16 conception rate remains significantly higher than national and regional comparators, although the gap is narrowing • Outcomes for teenage mothers continue to improve year on year – in 2011/12, 58.7% of young people under 19 years were breastfeeding, 7.2% had a previous live birth and 9.6% had a low birth weight baby.	Implement the Children and Young People's Trust strategy for reducing teenage conceptions (March 2012). Key actions include: • Continued provision of high quality sex and relationships education in all secondary schools (including health and well-being drop-in services in secondary school and FE college settings) • Sustain targeted work with young people at risk of early pregnancy/parenthood (e.g. prevention and inclusion, safeguarding services) • Sustain provision of supported accommodation for teenage parents and young families • Continue provision of the full range of maternity services, including those currently jointly commissioned for dedicated teenage parent case loading (under 18s) • Continue support into employment – Job Centre Plus • Monitor uptake and provision for teenage parents of full learning curriculum for school-aged teenage parents – with dedicated and tailored provision from 14-16, 16-19 years and beyond • Sustain parenting, Early Years and CAMHS focused work to support relationship skills and interventions for vulnerable teenage parents

Consultation Questions

1. Do you agree with the 'What we will do' actions in this section? If not, why not?
2. Which four actions do you consider the highest priority?
3. Are there any other actions or recommendations that should be included in this section? If yes, what are they and why? Are there any you think that are not strategic priorities?
4. Can you identify ways in which your organisation, sector or community might help to take forward the recommendations/actions in this section?
5. Do you have any other comments?

Priority 2 – Taking action to reduce the harm to individuals and society caused by misuse of alcohol and drugs

Rationale

Alcohol

Excessive alcohol consumption is impacting negatively on the city's population in a number of ways including health, mortality, and crime. Misuse of alcohol costs the NHS £2.7 billion per annum and puts strain on emergency department resources, police services, and other support agencies as well as the abuse and violence suffered by staff in many of these settings.

- The direct standardised rate of alcohol-attributable deaths amongst males in Southampton was 35.7 per 100,000 in 2009-10
- The direct standardised rate of alcohol attributable deaths among females shows an increasing trend at 26.3 per 100,000 in 2009-10
- The rate of alcohol-specific admissions amongst under 18s is significantly higher in Southampton, at 122.5 per 100,000 population, compared with 64.5 for England as a whole.

Drug Misuse

In common with the rest of the region, drug misuse prevalence is apparently highest among the 25-35 year age group. However, the use of so-called "recreational" drugs is reported to be growing within the under 18 age group and also the 18-25 age range, with an increasing number of individuals presenting at the open access services for assistance with stimulant and "legal high" usage.

Local Evidence from the JSNA	What we will do
• Alcohol specific admissions to the Emergency Department (ED) for under 18s in Southampton are high compared to the national average (122.5 per 100,000 compared to 64.5 for England) • To tackle alcohol harm and prevent damage to health and wellbeing, there is a need to broaden the base of alcohol treatment services by investing more in early intervention services that achieve sustained change in relation to our local drinking culture and behaviour • The government seeks to re-focus drug treatment services on the need to plan for Recovery and Re-integration, thus improving the rate of planned exits from treatment. This increases the need to improve treatment pathways (including abstinence), access to mutual aid groups and support for families and carers of service users • The shared care protocol for drug services needs to be implemented in order to ensure there is improved clinical governance and leadership by senior clinicians • City agencies need to increase collaboration across the health and social care system to foster a culture of joint investment, commissioning and integrated service delivery • Young people in Southampton are demonstrating problematic substance use at age	• Develop better understanding of young people's use of alcohol by undertaking further surveys across the city • Implement awareness/public education campaigns around alcohol and substance misuse e.g. Buzz without Booze campaign • Maintain existing schemes to address underage drinking and associated behaviours (through a programme of test purchasing of alcohol to control underage sales) • Develop wider awareness amongst health and social care practitioners to ensure engagement of patients on alcohol issues and application of risk assessment tools • Develop and expand the current services in Southampton through partnership working approaches that develop "wrap around services" (including housing and access to education, employment and training) and link health, social care, housing, leisure, night-time activities and criminal justice to include tacking alcohol and substance abuse in young offenders • Increase numbers accessing both drug and alcohol services with increasing numbers achieving recovery from alcohol or other drugs

15 and too few young people receive support through young people's substance misuse treatment services • To tackle the impact drug use has on the city there is a need to develop robust prevention around the spread of blood borne viruses (BBV) • In Southampton there are over 11,500 dependent drinkers and approximately 2,000 problematic drug users. These individuals will need to access treatment that offers a focus on recovery and reintegration back into their communities • Treatment needs to incorporate a stepped care approach, through commissioned services, in partnership with primary care and acute hospital settings	• Improve the percentage of people staying in treatment and achieving abstinence • Encourage take up of personalised services for drug and alcohol treatment • Enhanced liaison across services over shared clients and review the dual diagnosis protocol • Improve performance management with a focus on data compliance /monitoring • Review drug treatment services available to young people to ensure a best value, high quality treatment system which is reflective of young people's drug use • Work together with local agencies to help address the detrimental effects of parents' problem drug and alcohol use upon their children • Build abstinence and recovery as the central theme for all clients accessing treatment • Increase the range of interventions for crack cocaine users and stimulant users in effective treatment • Refocus services on recovery and helping people regain control of their lives, including returning to employment and achieving stable accommodation • Develop an appropriate suite of abstinence and harm reduction services for blood borne viruses

Consultation Questions

1. Do you agree with the 'What we will do' actions in this section? If not, why not?
2. Which four actions do you consider the highest priority?
3. Are there any other actions or recommendations that should be included in this section? If yes, what are they and why. Are there any you think that are not strategic priorities?
4. Can you identify ways in which your organisation, sector or community might help to take forward the recommendations/actions in this section?
5. Do you have any other comments?

Priority 3 – Working with employers and local education providers to support people into employment and prevent people falling out of employment due to ill health

Rationale

The relationship between employment status, income and health is well documented. National research clearly identifies the link between poverty and health. Health inequalities associated with class, income or deprivation are pervasive and can be found in all aspects of health, from infant death to the risk of mental ill-health. Men aged 25-64 from routine or manual backgrounds are twice as likely to die as those from managerial or professional backgrounds.

An estimated 2,000 households in the city do not have a bank account and around 16,000 households have no home contents insurance. Around 6,500 households are without affordable credit and approximately 1,800 people use loan sharks. Also financial abuse is high and it is estimated that 1.2% of older UK residents have experienced financial abuse by a friend, relative or care worker since reaching the age of 65 years.

The economic recession has had a marked impact on Southampton and its residents. The average house price is nearly eight-times the average annual salary for residents. In November 2011, there were a total of 19,300 claimants of out of work benefits in the city, 11.3% of the working age population. This compares with a rate of 8.6% for the South East region.

In 2010 the average weekly gross earnings for a full-time employee who lives in Southampton were estimated at £452.20. This compares poorly to Portsmouth and Hampshire, where the average earnings are £480.20 and £540.70 respectively.

There are 5,690 people aged 16-64 claiming job seekers allowance in Southampton and 2,503 notified vacancies for April 2012. This is a rate of 2.27 people per job. The priorities identified below aim to maximise the opportunities to help promote health and wellbeing to the working age population across the city by working with local employers, improving economic wellbeing and helping young people into employment.

Local Evidence from the JSNA	What we will do
Helping Young People into Employment • There is a need to sustain the number of 16 year olds progressing into education and training	To maximise the proportion of young people who are on track to achieve good levels of economic wellbeing there is a need to: • Broaden learning opportunities for 14-19 year olds through apprenticeships, diplomas, GCSEs and 'A' Levels so that Southampton outcomes catch up and surpass levels elsewhere • Reduce the number and level of young people not in education, employment and/or training to much lower levels that compare more favourably with similar cities • Understand the housing and accommodation pressures upon young people better so that appropriate provision can be put in place, particularly for the most vulnerable
Improving Economic Wellbeing • The key issues to improving economic wellbeing are: o tackling worklessness	To improve the economic wellbeing of the population, especially those most vulnerable, there is a need to: • Ensure that people can stay in or return to

Local Evidence from the JSNA	What we will do
o improving skills and employability o promoting financial inclusion o mitigating poverty o maximising incomes • It will be important to support key developments in the city that make it more attractive to residents and businesses and ensure these maximise their potential to reduce disadvantage • The partner organisations of the Health and Wellbeing Board have an important part to play in encouraging economic development to reduce the levels of deprivation and its associated health and social care consequences	work as soon as possible e.g. through the appropriate use of the 'Fit Note' • Ensure that those who do stop working because of illness or a health condition access advice and support that enables them to get back to work sooner, claim appropriate benefits or rethink their future job prospects • Extend benefit take up/welfare rights campaigns and other anti-poverty initiatives • Ensure that those who have been off sick for a significant length of time are helped back into training and/or employment in a timely way • Ensure that the range of initiatives to improve economic wellbeing through employment and skills across all sectors of the population are coordinated for maximum benefit/effect
Employment and Mental Health • People with mental health problems often have fewer qualifications, and find it harder to both obtain secure and stay in work. Mental health problems are the most common reason for incapacity benefits claims (replaced by employment and support allowance in 2008 for new claimants) – around 43% of the 2.6 million people on long-term health-related benefits have a mental or behavioural disorder as their primary condition • The highest proportion of incapacity benefit claims are for mental and behavioural disorders. These claimants represent a significant proportion of total out-of-work claimants in Southampton • Sickness absence due to mental health problems costs the UK economy £8.4 billion a year and also results in £15.1 billion in reduced productivity	To ensure that the appropriate mental health services are provided for patients and preventative measures are taken, there is a need to: • Improve access to employment for people with mental health problems • Identify opportunities and services to improve access to work for people with mental health problems • Ensure early access to psychological therapy/services which help people retain and return to employment • Work with other agencies to develop an anti-stigma campaign as part of the national campaign – Time to Change • Work with employers to ensure they have policies and procedures in place to support positive mental health • Adopt a public health approach in the development of strategies which promote mental wellbeing for the whole population including activities which reduce health inequalities and which promote good mental health in the workplace

Consultation Questions

1. Do you agree with the 'What we will do' actions in this section? If not, why not?
2. Which four actions do you consider the highest priority?
3. Are there any other actions or recommendations that should be included in this section? If yes, what are they and why? Are there any you think that are not strategic priorities?
4. Can you identify ways in which your organisation, sector or community might help to take forward the recommendations/actions in this section?
5. Do you have any other comments?

Priority 4 - Helping people grow old and stay well

Rationale

Average life expectancy in Southampton is increasing. The fastest growing sector of the population is that aged 65 years and over with a projected increase of 14% between 2010 and 2017, whilst the number of people over 85 years is forecast to grow from 5,200 to 6,000, an increase of over 15%.

However, people on lower incomes living in the most deprived areas in the city have shorter lives than those in the more affluent areas, with premature deaths (under age 75) 62.5% higher and increasing. The life expectancy of men is lower by 3.5 years and widening, and for women by 1.4 years and narrowing, against the population living in more affluent areas in the city.

Many older person households are living in poverty, including fuel poverty where a household is spending more than 10% of its income on fuel to maintain a warm home. This is closely related to ill health and increased risk of death.

Caring is a role that many older people take on or require. Maintaining the health and wellbeing of carers is a key challenge for the city. Demands for social care and wider support are increasing as the population ages and ill health and disability increases as a consequence.

The priorities identified include the aim to support older people to:

- stay healthy and actively involved in their communities for as long as possible, thus helping prevent, reduce or delay the need for more specialist care services;
- effectively regain as much independence as possible when this has been lost through accident or illness, and to re-engage within their community;
- access the information and the means to take more control over their health and care arrangements, and have more choice over services when there is a continuing need for such services.

Abuse of older people is a hidden and often ignored problem in society, and many older people are too frightened to report its presence or may be unaware that it is happening. Locally, the reporting of abuse against older people and other vulnerable adults has increased significantly in the last few years. It is likely that this is the result of increased awareness amongst both professionals and the public, but it is not known whether prevalence of abuse is increasing simultaneously. Safeguarding of vulnerable adults and ensuring the quality of the care that they receive is an important priority.

Each year about 460,000 people die in England and around 1,790 residents in Southampton (3 year average). End of life care is about enabling people to live their life to the end with dignity and having their choices respected. Not all people will be able to plan for their death, but for a majority of people planned end of life care has enabled them to experience a peaceful and dignified death.

Local Evidence from the JSNA	What we will do
Poverty and Deprivation in Later Years • The older population living in Southampton faces substantial poverty. There are seven areas in the city where Income Deprivation affecting Older People is in the worst 10% for England. These are mainly clustered in the central areas of the city (with the exception of Weston) • Mosaic data shows that 3,863 households consist of deprived, very elderly single pensioners living in council owned, purpose built accommodation • 46% of homeowners over 85 live in non-decent housing compared to an England average of over 50%	Action is needed to continue delivering programmes and partnership working designed to reduce fuel poverty, specifically focusing on: • Promoting take-up of “Warm Front” grants to those eligible for them and the Warm Home Discounts offered by "the big six" energy companies • Encouraging more households with a person over 70 years to take up the Government’s free loft and cavity wall insulation benefit • Targeting older people who live in rented and owner-occupied accommodation with

Local Evidence from the JSNA	What we will do
• In the winter of 2008/09, an estimated 113 people died in Southampton because of cold weather, with frail, elderly women thought to be at greatest risk • National research indicates a third of all pensioner households entitled to Pension Credit and two-fifths entitled to Council Tax Benefit do not claim it	no central heating • Improving the multi-agency referral process • Establishing effective mechanisms for delivering the Green Deal when it is launched in October 2012 • Providing recognition, respect and support for carers to enable them to maintain their caring role and retain their health and wellbeing, including economic wellbeing • Develop a sustainable and diverse community-based support system that best utilises people's skills to help themselves and each other. For example, encompassing quality information and advice (including financial advice), active community groups, peer networks and opportunities to contribute including volunteering, training and employment options
End of Life Care • In 2010 there were 1,713 deaths registered in Southampton's resident population and of these cancer was responsible for 29.6%, coronary heart disease 13.4% and circulatory diseases 8.8%. Around 59.3% of these deaths occurred in an acute hospital setting, 11.2% in a nursing/care home and 23.6% in the individual's own home • By working collaboratively across the city with GPs, specialist palliative care teams, community teams, care homes, University Hospital Southampton Foundation Trust and social services, progress is being made to identify people who may be approaching the end of their lives to ensure, generally within the last year of life, their care at this crucial time is planned • Locality registers and advance care planning can help support people to express their wishes. For example, people's wishes around resuscitation, preferred place of care/death	To better support people at end of life care action is needed to: • Increase public awareness and discussion around death and dying • Enable more people to express their preferences for care through advance care planning • Assess the population need for end of life care services more robustly • Map current provision, to ensure that the Gold Standard Framework and Liverpool Care Pathway are incorporated and audited in hospitals • Extend palliative care to other diseases besides cancer • Ensure access to physical, psychological, social and spiritual care • Establish an end of life care register accessible to all appropriate service providers (e.g. Out of Hours Service) • Establish a single point of access for the co-ordination of services • Have timely bereavement counselling available
Dignity and Safeguarding • The Government's ambition for promoting greater independence and choice is through social care reform, making personalisation the cornerstone of change where every person is enabled to exercise choice and control over their care and support • The political commitment as a result of this is the 'personal budget': a transparent allocation of social care resources to eligible individuals which are managed either by the council, by another organisation or paid as a direct payment or a mixture of both	In order to support the increasing numbers of people living longer in Southampton, action is needed to ensure as many people as possible are able to live as independent and active lives as possible in their own homes. Specific action is needed to: • Target resources so that personal budgets are available to all eligible social care clients by March 2014 • Enhance service user involvement in planning Action is needed to support people live more

Local Evidence from the JSNA	What we will do
• The agenda has safeguarding implications combined with the management of potential risk. A core part of a personalised system is an effective and established way of enabling people to make supported decisions built on appropriate safeguarding arrangements • Safeguarding policies have resulted in experience and learning that must be built into the transformation process in public services. At the heart of this transformation is the need to recognise that, for the most part, organisations and professionals do not need to make decisions for people – it is time they had real, informed choices. But with that may come greater risk of harm and abuse (No Secrets Review, 2008) • To provide confidence that the city's most vulnerable adults are safe from abuse, or other harm there is a need to address safeguarding issues from an equalities perspective. The issues involved in not reporting harm need to be looked at in culturally sensitive ways • It will also be necessary to address the recommendation of the Law Commission Review of Social Care (2011) for lowering the threshold for safeguarding action. Should these be implemented locally, the demands placed on the health and social care system will increase	independently through: • An emphasis on re-ablement services • Cost-effective telehealth and telecare • Training and recruiting 500 additional care workers by 2015 • Increased support for carers • Timely discharge from hospital to appropriate accommodation of choice • Timely access to equipment to support moves from hospitals and acute settings to home care seven days a week • Develop the prevention agenda • Ensure that vulnerable adults in hospital/care homes have their nutritional needs met Further action on safeguarding should include: • Education for all care staff (including those in primary care teams) • Learning from and acting on recommendations from any Serious Case Review • Develop quality assurance processes which ensure services are safe, of good quality and which people can have confidence in accessing

Consultation Questions

1. Do you agree with the 'What we will do' actions in this section? If not, why not?
2. Which four actions do you consider the highest priority?
3. Are there any other actions or recommendations that should be included in this section? If yes, what are they and why? Are there any you think that are not strategic priorities?
4. Can you identify ways in which your organisation, sector or community might help to take forward the recommendations/actions in this section?
5. Do you have any other comments?

Priority 5 – Reducing admissions to hospital from preventable causes of both mental and physical ill health

Rationale

The numbers of people with long term conditions requiring health and social care solutions is increasing and set to grow, now representing 30% of the population but utilising 70% of NHS and Social Care resources. For example one third of people over 65 years will die with dementia and 25% of hospital beds are occupied by someone with dementia as part of the diagnosis.

National and local evidence identifies the need to shift services towards proactive identification and management of individuals "at risk" to reduce the number of unscheduled admissions for acute care or residential /nursing care usage by increasing the independence of individuals and carers. This care transcends organisational boundaries of social care, primary and community care and hospital care. Increasing numbers of people have more than one long term condition yet face an increasingly fragmented specialised response.

As the proportion of older people in the population increases, the management of long term conditions will make a growing contribution to the overall burden of disease. As people become more burdened with disease, there is often a requirement for more social care support. Treatment of these conditions is costly both to the NHS and to society, however the condition and their complications are often preventable.

Long term conditions are one of the major health challenges in the UK. For example diabetes is the fastest growing chronic condition in the UK, with one new case diagnosed every 3 minutes, and yet for the majority of patients this is entirely preventable or can be delayed. Cancer can also be seen as a long term but curable condition. Indeed nationally there are over 1.6 million people who have survived cancer and we want them to remain cancer free.

There are also opportunities for providing better support for people with physical, sensory and learning disabilities to enable them to live more independently. Over time the ageing profile of the city is likely to increase the number of people living with disabilities, as people tend to pick up disabilities through injury or degenerative conditions as they get older.

Finally it is important to try and ensure that people who are admitted to hospital for whatever reason are not exposed to further health risks e.g. from healthcare acquired infections.

Local Evidence from the JSNA	What we will do
Prevention of Hospital Admissions from Conditions Amendable to Health Care • An estimated 22% of adults smoke in the city • An estimated 22% of adults are obese • An estimated 20.5% of adults participate in the recommended levels of physical activity per week, this is higher than the England average and influenced by our large numbers of young people • Over 11,000 people are diagnosed with diabetes, however 14,000 people (a crude rate of 6.4%) are estimated to be living with this disease • GP figures show 4,573 people have a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) 1.7%, although modelling suggests 8,723 or 3.55%	• Continue to invest in the prevention of long term conditions. Sustain prevention programmes around smoking, obesity and physical activity and cardiovascular disease. Support the NHS Health Checks programme • Support development of integrated community teams and personalised care approach to support individuals with long term conditions to pharmacists to make appropriate self-management/care plans

Local Evidence from the JSNA	What we will do
Long Term Conditions • There is a need to ensure that long term care needs are identified as early as possible and that appropriate care provision is in place to meet these needs. Everyone with a long term condition should be provided with their own personalised care plan • Individual care plans can enable different agencies to anticipate/ co-ordinate people's needs more effectively and invest in more Medication Use Reviews to increase the benefits of good prescribing by GPs and community pharmacies, for people with long term conditions and complex medications • Services should be designed so that they take account of the increase in most long term conditions as people get older. Better co-ordination or integration of different health and social care groups for the planning and delivery of care • Better data sharing is required across health and social care IT systems to improve efficiency and outcomes (with appropriate data security) via Hampshire Health Record and the Common Assessment Framework (CAF) project	To better support people with long term conditions and proactively manage diseases action is needed to: • Detect earlier those at risk and improve control to minimize effects of disease and reduce complications • Provide an annual health check for carers who look after a relative at home to help promote their health and wellbeing • Ensure effective case management of long term conditions to reduce the need for hospital admission and improve overall health • Provide more person-centred care closer to home by expanding high quality integrated provision • Ensure better continuity of carers for social care, helping to increase people's confidence in their care and reducing stress • More effective medicines management • Increase use of telehealth and telecare
Learning Disabilities • Local healthcare organisations should collect data and information necessary to allow people with learning disabilities to be identified by the health service and track pathways of care • Family members and other carers should be involved as a matter of course as partners in the provision of treatment and care. Providers should ensure that reasonable adjustments are made to enable and support carers to do this effectively • An understanding of the reasons for inequalities in health and social care outcomes for people with learning disabilities is also needed. Improved primary care awareness and training through primary care learning disability registers would enable more accurate understanding and better planning of resources to meet these needs	To better support people with learning disabilities, action is needed to: • Identify people with learning disabilities to ensure their needs are identified and addressed • Ensure comprehensive implementation across GP practices of annual physical health checks • Ensure that information systems are capable of identifying and recording people with learning disabilities • Develop specialist services to sustain and support people in their local community, avoiding unnecessary admission or re-admission to hospital or out of area placements • Put plans in place that meet the needs of people with learning disabilities who are aging (older adult services) • Raise awareness of the risk of premature avoidable death of people with learning disabilities, and to promote sustainable good practice in local assessment, management and evaluation of services
Cancer • Need to improve public information and health promotion about lifestyle choices/risk factors, including smoking, diet, alcohol consumption, exercise and exposure to ultra violet radiation • Need to improve the uptake of cancer screening	To prevent cancer and improve health outcomes of those living with cancer action is needed to: • Improve the uptake/participation in prevention programmes around lifestyle risk factors • Continue to offer the HPV vaccine to Year 8 girls and link this information to the cervical screening programme

Local Evidence from the JSNA	What we will do
	• Increase the number of women participating in breast and cervical screening programmes in the city • Increase the number of men and women aged 60 to 74 participating in the bowel screening programme from 60% to over 70% by 2013/14 • Improve understanding of the barriers to cancer screening programmes and why some people choose not to be screened • Ensure that all people with a suspected cancer have their first outpatient appointment at a hospital within two weeks of seeing their GP • Improve access to radiotherapy treatment
Healthcare Acquired Infection • Continuing emphasis needs to be placed on the health economy wide efforts to tackle healthcare acquired infections which remain a significant public, professional and political concern	• Ensure all providers in primary, community and secondary care implement high standards of infection control to minimise risk
Sensory Impairment • Eye health is a public health priority and the importance of regular sight tests should be promoted. It is important to ensure that eye disease is detected early in all communities, especially minority ethnic groups • Improvements are needed to ensure that diabetic patients are better enabled to access screening • There is equally a need to ensure early diagnosis and early intervention with hearing aids and specialist support including: o Appropriate number of teachers of deaf children to meet their education and communication development needs o Access to a comprehensive range of services to prevent hearing loss	To improve visual health and reduce health inequalities and social exclusion, there is a need to: • Increase awareness of eye health amongst children, their families and carers • Improve the diabetic retinal screening programme to consistently meet national standards • Provide access to the best treatment options on the NHS • Enhance the inclusion, participation and independence of people with sight loss To improve hearing and reduce deafness and social exclusion action is needed to: • Sustain investment in the newborn hearing screening programme care pathways so that children and families receive prompt treatment and support from health and education teachers of the deaf • Improve the quality, effectiveness and efficiency of services to mitigate deafness • Increase choice for patients and ensure a better experience of care through greater responsiveness to people's needs

Consultation Questions

1. Do you agree with the 'What we will do' actions in this section? If not, why not?
2. Which four actions do you consider the highest priority?
3. Are there any other actions or recommendations that should be included in this section? If yes what are they and why? Are there any you think that are not strategic priorities?
4. Can you identify ways in which your organisation, sector or community might help to take forward the recommendations/actions in this section?
5. Do you have any other comments?

Priority 6 – Improving housing options and conditions for people in the city to support healthy lifestyles

Rationale

In March 2010 a report jointly produced by the Association of Retained Council Housing (ARCH) and the Association for Public Service Excellence (APSE) reinforced the message that housing is a fundamental human need. It identified that the availability, existence and condition of homes has a direct impact on health and wellbeing, educational attainment, employment opportunities, and safety. Housing is therefore essential to create safe, sustainable cohesive and thriving places where people want to live and enjoy life.

24% of all homes in the city are privately rented (over twice the national average) of which over 7,000 are Homes in Multiple Occupation (HMO). 38% (over 28,000) of privately owned and rented homes do not meet the Decent Homes Standard, of which 8,500 are occupied by vulnerable people. The total cost of dealing with unsafe private housing is estimated at £111m. Older properties (pre-1919) and privately rented homes are generally in the worst condition. To enable people to live independent lives and remain in their family homes there is a need for around 3,900 adaptations for disabled people at an estimated cost of £21m.

As a result of comparatively lower household incomes and associated higher levels of deprivation and poverty, 23% of all homes in the city are in the social housing sector of which over 17,000 are in the ownership and management of the City Council. Over 98% of Council properties currently meet the Decent Homes standard. The Council has a significant number of homes in deprived areas - five Local Super Output Area's (LSOA's) in the top 10% most deprived in the country. The Council also has over 3,300 properties specifically designated for older people, but demand continues to exceed supply available as a result of our ageing population.

The Council has over 14,000 households on its housing waiting list and whilst the Council lets about 1,600 properties a year they receive on average 400 new applications each month. The average wait for a one-bed property is seven years and the average wait for a three-bed house is six to seven years. Therefore the City has about 2,000 overcrowded households within social housing. Overcrowding has detrimental affects on health and wellbeing. In 2011/12 over 1,500 homeless households were assessed with the majority being supported to maintain their accommodation. However 250 single homeless people are seen each month by the Street Homeless Prevention Team (SHPT) and on average 10 to 12 rough sleepers are found on outreach each week and a much higher number "sofa surf" (sleep at friend's homes). Homelessness drastically shortens life expectancy and increases people's vulnerability.

Nationally rising fuel prices are forcing more families into fuel poverty which detrimentally affects infant weight gain, hospital admission rates, mental ill health and increased mortality especially in vulnerable people.

Local Evidence from the JSNA	What we will do
Housing • Fuel Poverty – over 7,000 Council tenants currently heat their homes through a landlord heating system which uses electricity and is not controlled by the tenant • Benefit dependency – over 60% of Council tenants are in receipt of some housing benefit to help meet their housing costs – 24.2% of the working age population in Weston claim out of work benefit (38% in Weston Shore) compared to a city average of 13.2%	• Deliver housing investment schemes that tackle the hardest to heat properties in the city to improve insulation and heating options for residents • Give as many tenants as possible control over their own heating • Monitor stock condition data and ensure investment is targeted at the homes with the greatest need in particular those properties that are cold or damp • Provide information, advice and guidance to tenants who currently rely on housing

Local Evidence from the JSNA	What we will do
	benefit to help mitigate the impacts on their household income as a result of the introduction of Universal Credit • Develop skills and employment initiatives that support tenants to develop pathways out of dependency and into employment
Homelessness and Prevention • The average life expectancy of a homeless man in the UK is 47 years and woman just 43 years o Where the needs of homeless people are known around 30% have drug problems, 48% alcohol problems and 30% mental health problems o The homeless healthcare team has between 400 to 500 people on its GP list at any one time o Over 1500 households were assessed in 2011/12 with the majority being supported to resolve their housing needs o 250 people are seen each month by the SHPT and on average 10 people sleep rough each week	• Provide a holistic homelessness prevention service that supports people to make independent choices about their housing future • Work with the housing providers across the city to maximise options for housing for those people in highest need • Work with the voluntary and supported housing sectors and the Homeless Healthcare team to ensure that provision in the city can meet the needs of the most challenging people to safeguard both their housing and health needs
Addressing poor housing conditions in the private sector • 38% (over 28,000) of privately owned and rented homes do not meet the Decent Homes Standard • Approximately 7,000 houses in the city are classified as HMO's. Less than 500 are currently licensed and many contain breaches of the Housing Health & Safety Rating System (HHSRS) • 46% of homeowners over 85 live in non-decent housing	• Affordable thermal improvements to deliver more efficient heating and better insulation are being made available to the private housing sector now and the 'Green Deal' will commence this autumn • Consult on the introduction of an Additional Licensing scheme for all HMO's in the city to help ensure the conditions in the private rented sector are improved and poor or inadequate housing is eradicated • Provide a Handyman service to older residents in the City to support small scale improvements to private homes and help alleviate risks
Housing in Older Age • In 2011 1,287 people in Southampton (0.5%) were on the dementia register and between 2010 and 2017 those over the age of 65 in the city is predicted to increase by 14% • One third of people over 65 will die with dementia and 25% of hospital beds are occupied by someone with dementia as part of the diagnosis • In 2009/10 249 people were admitted to hospital for a broken hip	• Provide a wide range of housing and support options for older people including supported housing, floating support and assisted technologies to help people stay independent for longer • Refurbish and remodel a supported housing scheme within the city to help meet the housing and care needs of residents with dementia without the need to resort to residential care • Develop local hubs of support and care in the city with high quality, well trained staff including promotion of dementia friendly communities with activities and interactions for people with dementia in the wider community • Promote health and active older age through a programme of activities provided by dedicated Activity

Local Evidence from the JSNA	What we will do
	Coordinators which helps promote movement, healthy eating and health information • Continue to run programmes and initiatives to support falls awareness and design out areas of trips, slips and falls within our older person communities • Provide opportunities for older people to engage in volunteering and intergenerational activities to support active engagement and well being

Consultation Questions

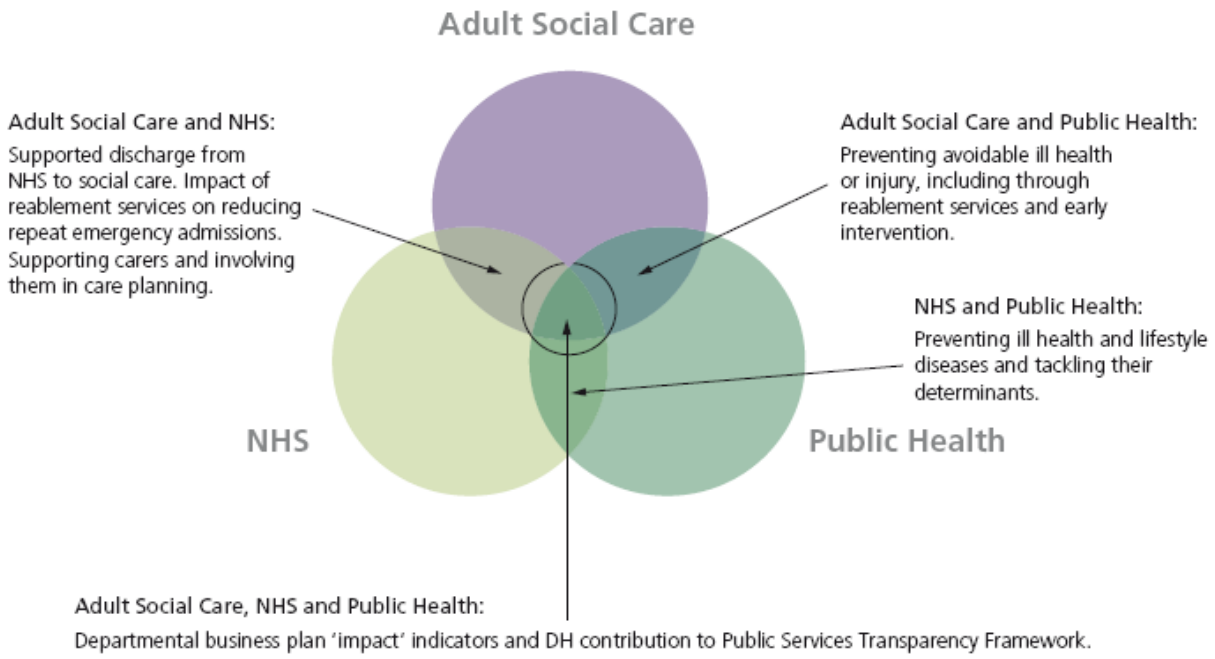
1. Do you agree with the 'What we will do' actions in this section? If not, why not?
2. Which four actions do you consider the highest priority?
3. Are there any other actions or recommendations that should be included in this section? If yes, what are they and why? Are there any you think that are not strategic priorities?
4. Can you identify ways in which your organisation, sector or community might help to take forward the recommendations/actions in this section?
5. Do you have any other comments?

Section Three – How will we measure success?

It is proposed that during the consultation process views will be sought on the actions proposed for the six priorities outlined above. It is also intended that as we talk to groups and organisations views will be sought as part of the consultation process about the most appropriate outcome measures which would enable us collectively to measure success.

Local outcome measures will draw from the national frameworks (NHS, Adult Social Care and Public Health and the Children's Outcomes Framework anticipated later in 2012) and additional local measures will be developed for those actions which fall outside the scope of the national outcomes frameworks.

Figure 1. Overlapping National Frameworks



Section Four – Developing Annual Action Plans and developing Health and Wellbeing

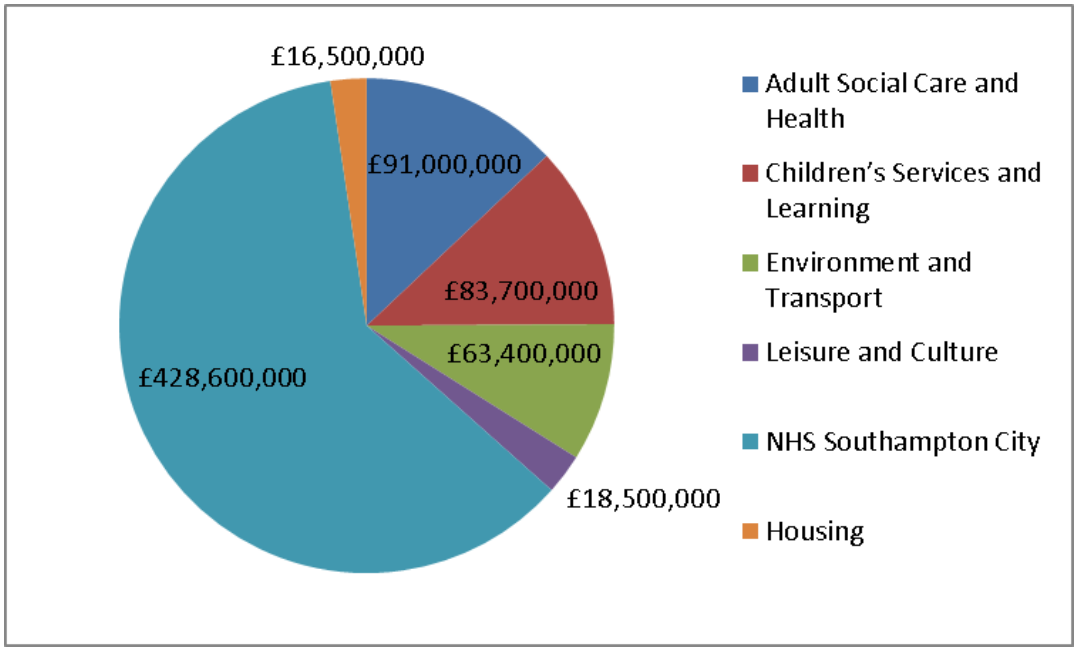
It is proposed that for each year of the strategy annual action plans will be developed. These will include measurable, focussed actions for each of the six priority areas. The national outcome framework will be drawn on to define local priorities, baseline measurements and proposed outcome targets, and other measures will be developed as required.

The partner agencies of the Health and Wellbeing Board will be jointly accountable for the delivery of this strategy and the development and implementation of the annual delivery plans. These delivery plans will comprise short, medium and long term objectives and ascribe specific leads for implementation and accountability.

It is proposed that joint strategic solutions will be brokered and agreed by health and wellbeing partners with agreement on annual investment to support strategy and delivery through the Board.

The total resource available for all service areas in the city is summarised below in Figure 2. :

Figure 2. Indicative budget for health and wellbeing from which all agencies are working towards savings targets



Section Five – Next Steps/Consultation

Section 193 (5) of the Health and Social Care 2012 requires that local Healthwatch and the people living and working in the area must be involved in the preparation of the joint health and wellbeing strategy. Until local Healthwatch is established in April 2013 work can be undertaken with the Local Involvement Network (LINk). Section 193 (3) requires consideration of the extent to which the needs could be met more effectively by the making of arrangements under section 75 of the National Health Service Act 2006 (joint working arrangements). Therefore it is essential that effective consultation and arrangements are supported to engage as many professional stakeholders as possible.

A detailed consultation plan and brief executive summary of the strategy will be developed to support the engagement process between the end of July and October 2012. This draft strategy is being published on the council and clinical commissioning group websites, with an automated feedback form. This can be access at:
http://www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/jsna2011/jhws/
Alternatively, you can send your response to the address on the back page of this report, or email to jhws@scpct.nhs.uk. Printed copies are also available on request.

Section Six – Conclusion

This is the consultative draft of Southampton City's first Joint Health and Wellbeing strategy. It is proposed that consultation up to October 2012 will enable a wide range of stakeholders to amend and adapt both priority areas and priorities for action.

The final strategy will go to the November 2012 meeting of Southampton's Health and Wellbeing board for approval, prior to the final decisions being taken by the Southampton City Council Cabinet and the Southampton City Clinical Commissioning Group board in December 2012. The strategy priorities and proposed actions are intended to shape and inform the commissioning intentions and business planning processes of constituent member agencies for the period 2013 to 2016.

Appendix 1

Southampton's Health and Wellbeing Strategy Consultation Questionnaire

Please give us some details about yourself

Your Name----------
Your organisation (if applicable)----------
Your email or postal address----------

Question 1 Have we identified the right priorities for Southampton City? Priority 1: Early Years and Childhood – sustaining work to support vulnerable families with young children **Yes/No** Priority 2: Adolescence and young adulthood – taking action to reduce the harm to individuals and society caused by misuse of alcohol and drugs **Yes/No** Priority 3: Working age adults – working with employers and local education providers to support people into employment and prevent people falling out of employment due to ill health **Yes/No** Priority 4: Helping people grow old and stay well **Yes/No** Priority 5: Reducing admissions to hospital from preventable causes of both physical and mental ill health **Yes/No** Priority 6: Improving housing options and conditions for people in the city to support healthy lifestyles **Yes/No** If you have answered No, what would you like to include/ replace?
Question 2. Which actions do you consider the most important for each of the six priorities?
Question 3. Are there any other actions or recommendations that should be included in this strategy? If yes, what are they and why?
Question 4. Can you identify ways in which your organisation, sector or community might help to take forward the recommendations/actions in this strategy? **Do you have any other comments on actions/recommendations'? (*please continue on another sheet if required*)**

Please feedback by 30 September 2012 using one of the following methods:
http://www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/jsna2011/jhws/

Email to jhws@scpct.nhs.uk

Post your questionnaire to:
Emma Wynn-Mackenzie
Business and Planning Manager
Public Health
Lower Ground Floor
Municipal Block – East
Civic Centre
Southampton
SO14 7LT

http://www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/jsna2011/jhws/