Healthier Lives in a Healthier City

Southampton's Joint Health and Wellbeing Strategy

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SOUTHAMPTON CITY COUNCIL

NHS Southampton City

NHS Southampton City Clinical Commissioning Group

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Foreword

We are delighted to introduce this new Joint Health and Wellbeing Strategy for Southampton. It sets out a strategic vision for improving the health of people of in the city and reducing health inequalities. The strategy will inform commissioning plans for the Council and Southampton City Clinical Commissioning Group (CCG) over the coming years.

The process of developing this strategy has been ably supported by our fellow shadow Health and Wellbeing Board members, together with a substantial number of council and CCG colleagues.

We undertook a substantial consultation exercise in the summer and autumn of 2012 to generate a city-wide discussion on what the most important issues were to include in this document. We have been heartily encouraged by the number of individuals and organisations who responded and produced some thought provoking and challenging comments and observations. Consideration of the responses received has resulted in the final strategy document looking substantially different to the consultation document. We would like to place on record our thanks to everyone who responded during the consultation. Your input has really helped to shape the final strategy and made it both more robust and more realistic.

There are a number of major challenges to improving the health and wellbeing of our citizens set out in subsequent pages. The strategy contains challenges to individuals to take responsibility for their own lifestyles that can have major impacts on health, as well as looking to ensure there is adequate care, treatment and support for the most vulnerable members of our society.

Delivering the results needed to meet these challenges will require commitment not only from the Council and the CCG, but also from NHS provider trusts, social care providers, and the host of voluntary organisations who operate in the city. This strategy now provides the overarching framework for action and delivering change. We hope you will identify with it and support us in making sure it delivers our ambition.

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Dr Steve Townsend
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Section One – Background and Local Context

Introduction

This Joint Health and Wellbeing Strategy sets out how Southampton City Council, Southampton City Clinical Commissioning Group (CCG) and the NHS Commissioning Board plan to take action to address the key health and wellbeing needs of the city over a 3 year period beginning in 2013/14. The strategy was developed through Southampton's Shadow Health and Wellbeing Board, and has been adopted by both the Council and the CCG.

The content of the strategy has been informed by the Joint Strategic Needs Assessment (JSNA) and through conversations and feedback with stakeholders and the public. The Joint Strategic Needs Assessment is a process undertaken jointly by the City Council and the former Southampton City Primary Care Trust (PCT) where data on the health of people living in Southampton, their care needs and a number of the key wider determinants that affect health and wellbeing (including housing and employment) are collated, analysed and published. The JSNA is a web-based resource that is periodically updated as new data become available. It can be viewed at
http://www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/jsna2011/?locale=en

Specific challenges highlighted in the JSNA include:

- Demographic pressures, especially the growth in the city's birth rate (around 35% in seven years. Please see data under Theme 2 – Best Start in Life on page 12)
- 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, physical 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 stresses and worklessness and the impact on mental health
- Recognising the impact on health of wider determinants (education, poor housing, transport and economic regeneration)

Southampton is in the fortunate position of having operated an effective Health and Wellbeing Partnership for a number of years. This situation provides a strong base from which the statutory Health and Wellbeing Board can launch and deliver its new responsibilities. The former Health and Wellbeing Partnership also produced a Strategy. Learning from that process will be utilised in the delivery of this joint health and wellbeing strategy.

Consultation

A period of consultation and engagement took place over the summer and early autumn of 2012 on a draft Joint Health and Wellbeing Strategy document. The consultation process included:

- Presentations to and debates at a number of key partnerships, including the GP Forum, Southampton Connect, the Children and Young People Trust Board, Southampton Safeguarding Children Board and a detailed workshop session with the Health Overview and Scrutiny Panel
- Public workshop sessions hosted by Southampton Local Involvement Network (LINk)
- Opportunities for on-line feedback on the City Council and PCT websites

Whilst a number of comments were specific to one issue or service, there were several comments made by a significant number of responders and these have been incorporated into this final strategy. These include the views that:

- There were too many proposals for actions in the draft strategy - so the final strategy now contains fewer and more significant proposals, and those that can be classed as "work as normal" have been omitted
- In these times of economic constraint, it was important that the strategy should be realistic and achievable – so an assessment has been undertaken to ensure that funding has been identified for those actions set out in this strategy
- Focus on preventative measures is vital as a means of reducing demand in the future – so prevention is now included as the first theme of this strategy
- It is vital that measures are developed to measure the success and impact of the strategy – so where possible the actions are aligned to the relevant national outcomes frameworks. Where there is no suitable measure in the framework, then a local indicator has been identified

Three Key Themes for Southampton's Joint Health and Wellbeing Strategy

The actions in the strategy are grouped into three themes:

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

Using these three themes, actions can be linked to the needs identified in the JSNA. They will secure a life course approach to improve health and wellbeing and provide a means of reducing health inequalities. They also provide scope for improved joint working across health and care systems, which develop a shared ambition and vision of success.

The following sections now consider each of these themes in turn. Key data from the JSNA are used to highlight the underlying issues and challenges, and then the actions the strategy will deliver are listed. Finally, the measures that will be used to record the impact the strategy is making are tabulated.

How we will ensure that things are improving

The Government has developed a range of national outcomes frameworks, which have placed a greater emphasis on the use of shared and complementary indicators that highlight shared responsibilities and goals. Those for the NHS, public health and adult social care are now in place, and a framework for children is currently under development. Overlaps across outcomes frameworks recognise the joint responsibilities for contributing to outcomes that different parts of the system can deliver. The Government believes that use of the outcomes framework will provide robust and comparable information, which show how far the system is delivering better outcomes for patients and users, allowing local partners to compare their performance against others.

The strategy shows which outcome measures will be used to measure progress in the actions to be delivered by this strategy.

Section Two – Key Themes to Deliver Change

Theme 1 – Building resilience and preventative measures to achieve better health and wellbeing

Why this is important

Developing a focus on health improvement priorities is essential to help people improve their lifestyles and to reduce suffering from many long-term conditions. The consequences of smoking, alcohol abuse and obesity have serious implications for individuals and are placing growing demands on health and care (and legal) systems and society as a whole. Easy access to improvement and prevention programmes are key to improving quality of life for people affected and to reducing associated serious illnesses.

Work and housing have major impacts on health and wellbeing. The relationship between employment status, income and health is well known with research clearly identifying links between poverty and health. Men aged 25-64 from manual backgrounds are twice as likely to die earlier than those from managerial or professional backgrounds. 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. The evidence for 'good' work benefitting physical and mental health and wellbeing is strong. Work can be therapeutic and can reverse the adverse health effects of unemployment. This is true for healthy people of working age; for many disabled people; for most people with common health problems and for the long-term unemployed and those on prolonged sickness absence.

People living in poor quality or overcrowded housing tend to have poorer health. Appropriate adaptations can help people with disabilities live independently at home which maintains physical and mental wellbeing for longer. Whilst the Council and social landlords have invested in improving the quality of their properties to meet decent homes standards, there is a significant proportion of privately owned and privately rented homes that fail to reach those standards. Public transport is a key enabler for accessing health services, and the Health Overview and Scrutiny Panel is undertaking an important study of public transport access to Southampton General Hospital.

One in four people will have a mental health problem at some time in their lives. People can be more vulnerable to common mental health problems if they have poor physical health, are isolated, in debt or poor housing. There are a number of lifestyle factors that can improve mental wellbeing. These include eating healthily, exercising, having a network of friends and family, drinking in moderation and not misusing drugs. Actions are necessary to promote good mental health and wellbeing in the community; reduce the number of people with common mental health problems, and lessen the stigma and discrimination associated with mental ill health.

Key information from the Joint Strategic Needs Assessment

- 22.3% of adults in the city smoke compared to 21.2% nationally
- £12-13m is spent in Southampton every year treating smoking-related illnesses
- 22% of adults are obese, as are 9% of children in the reception year at schools and 18.9% by year 6
- Hospital admissions for under 18s alcohol specific admissions is 111.8 per 100,000, which is 80% above the national average
- Around 22,900 homes in the city are social rented accommodation and 16,600 of these are owned and managed by the Council
- Southampton has 24,500 privately rented homes of which over 7,000 are Homes in Multiple Occupation (HMO)
- Over 28,000 privately owned and rented homes (38% of the total) do not meet the Decent Homes Standard. 8,500 of these homes are occupied by vulnerable people
- 250 single homeless people are seen each month by the Street Homeless Prevention Team
- The highest proportion of incapacity benefit claims are for mental health problems

What we will do

Smoking and Tobacco Control

- Develop and implement a comprehensive Tobacco Control Plan for the City in conjunction with the Police and Customs, which tackles prevention, provision of smoking cessation support, illicit supply of cheap smuggled tobacco, implementation of tobacco control policies at a local level
- Sustain implementation of the national NHS Health Check programme across the City to support early detection/screening for cardiovascular disease and to tackle lifestyle risk factors

Obesity and Physical Activity

- Identify and implement options determining better health and support healthy lifestyle behaviours leading to improved diet and physical activity in key target groups e.g. health promoting workplaces, breastfeeding friendly environments, healthy early years and childcare settings
- Support initiatives and services that are effective in preventing and managing overweight and obesity in our high risk individuals in the children, young people and adults sectors

Alcohol and Drugs

- Work together with local agencies to reduce detrimental effects of adults' problem drug and alcohol use, particularly parents
- Sustain and expand public education initiatives that raise awareness around alcohol and substance misuse and maintain existing schemes that address underage drinking and associated behaviours, including in school settings
- 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 tackling alcohol and substance abuse in the young
- Increase numbers accessing both drug and alcohol services. This will enhance numbers achieving recovery from alcohol or other drugs
- Review drug treatment services available, particularly to young people to ensure a best value, high quality treatment system reflective of their drug use patterns
- Increase the range of effective treatment interventions for crack cocaine and stimulant users
- Develop an appropriate suite of abstinence and harm reduction services for blood borne viruses, such as HIV etc.

Housing

- Endeavour to help people to have access to good quality, energy efficient housing that is both affordable and meets their needs. The priorities below aim to provide opportunities to help promote health and wellbeing in the working age population across the city by working with local employers, improving economic wellbeing and helping particularly young people into employment
- Provide a comprehensive homelessness service that supports people to make independent choices about their housing future
- Work with the voluntary and supported housing sectors and the Homeless Healthcare Team to ensure that provision in the city meets the needs of the most challenging people to safeguard both their housing and health needs and reduce the impact on the general population
- Having an additional Licensing scheme for all HMOs in the city to help ensure the conditions in the private rented sector are improved and poor or inadequate housing is brought up to acceptable standards
- Develop local hubs for quality support and care in the city, for example dementia friendly facilities with support activities and interactions for people with dementia from the wider community
- Raise awareness of falls and reduce or prevent trips, slips and falls within Council older people's accommodation. Good design can do much in this sector

Workplace Health

- Implement a programme of work to support employers in improving the health and wellbeing of their workforce through recognised good practice at work; improve the support for those stopping work due to sickness to get them back into work sooner or to rethink their future job prospects. Harassment and bullying need preventative policies
- Support more vulnerable people into good quality work, such as young people, carers and people with learning disabilities, mental health and long term health conditions and disabilities
- Promote and develop the 'Time to Change' campaign to reduce the stigma of mental illness in the workplace

Mental Health

- Adopt a public health approach in the development of strategies which promote wellbeing for the whole population including activities which reduce health inequalities and which promote good mental health across the city
- Ensure early access to psychological therapy/services, such as counselling

and talk, which help people remain in or return to employment
- Develop and implement a suicide prevention strategy across the city

How we measure the impact of the actions set out in this section

The table below shows the outcome framework measures which will be used to track progress on the priorities set out in this section.

Priority	Measure	Outcomes Framework Reference / Local Measure
Smoking and tobacco control		
Implement Tobacco Control Plan NHS Health Checks	• Smoking prevalence • Smoking status • Mortality from respiratory diseases	PH 2.0 PH 2.3 PH 4.7 / NHS 1.2
Obesity and physical activity		
Supporting healthy lifestyles Local weight management care pathways	• Diet • Excess weight in adults • Mortality from cardiovascular diseases • Utilisation of green space for exercise / health reasons	PH 2.11 PH2.12 PH 4.4 / NHS 1.1 PH 1.16
Alcohol and drugs		
Education and awareness Wrap around services Increase number in and completing treatment Review drug treatment services for young people Increase range of interventions for stimulant and crack cocaine users Reduce risk from blood borne viruses	• Alcohol-related admission to hospital • Mortality from liver disease	PH 2.18 PH 4.6 / NHS 1.3
Housing		
Helping young people into employment	• Under 25s unemployment	
Home insulation	• Fuel poverty • Excess winter deaths	PH1.17 PH 4.15
Homelessness prevention	• People with mental illness and/or disability in settled accommodation	PH 1.6
	• Homelessness acceptances	PH 1.15i
	• Households in temporary accommodation	PH 1.15ii

Homeless healthcare	• People with mental illness and/or disability in settled accommodation	PH 1.6
Improved support for dementia in local settings	• Effectiveness of post-diagnosis care in sustaining independence and improving quality of life	ASC 2F / NHS 2.6i
Reduce risk of falls	• Fall and fall injuries in over 65s	PH 2.24
Workplace Health		
Support to employers	• Number of working days lost due to sickness absence	PH 19ii
	• Rate of fit notes issued per quarter	PH 19iii
Helping vulnerable people into work	• Adults with LD in employment	ASC 1E
	• Adults in contact with secondary mental health services in paid employment	ASC 1H
Reduce stigma of mental health in the workplace	• Adults in contact with secondary mental health services in paid employment	ASC 1H
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 across the city	
	• Ensure early access to “talking therapies” and services which help people retain and return to employment	
	• Develop and implement a suicide prevention strategy across the city	

Theme 2 – Best start in life

Why this is important

Good outcomes in the early years, childhood and adolescence are a strong predictor of the health and wellbeing experiences of individuals throughout their life course. Most children and young people receive the love, care and opportunities they need from their families supported by local community services. However, too many children and young people have needs beyond the ability, capacity and sometimes willingness of their families and/or community-based services to overcome. At these times more specialist services are needed.

Help can take many forms but usually involves elements of challenge as well as support. Its purpose is always to enhance the skills, resources, capacity and positive resilience of individuals, families and communities so that children and young people get the best possible start in life.

Over the last 10–15 years there has been significant, well-conducted scientific research into the type of support that is most effective in improving outcomes and addressing inequalities. Evidence from these studies has led to a number of policy developments including:

- The initiation of the Sure Start Children's Centre programme
- The Family Nurse Partnership
- The health visiting "Call to Action" initiative
- The project to deliver free early education and child care places to vulnerable two year olds
- The development of evidence based parenting programmes
- The "Pupil Premium" (additional funding given to schools so they can support disadvantaged pupils)
- School-to-school partnerships
- Sex and relationship curricula
- On-site school and college sexual health 'drop in' clinics
- The emphasis on whole family approaches including the Families Matter ("Troubled Families") initiative

In addition, a number of significant recent reports, including those produced by Frank Field MP (child and young people's health) and Professor Eileen Munro (safeguarding of children and young people), have reinforced the continuing needs to:

- Shift resources from crisis intervention to prevention
- Improve co-ordination between practitioners, services and agencies in all sectors
- Develop effective and consistent processes for identifying emergent needs and providing early help

The Children and Families Bill 2013 sets out in Part 3 the new system for ensuring that the needs of children and young people aged 0 to 25 with special educational needs and disabilities are identified in a timely way through a multi-agency integrated assessment. The current special educational needs statements will be replaced by

Education, Health and Care Plans and that will be a statutory responsibility for the local authority and CCG to jointly commission services to assess and meet the needs of children and young people with SEND.

Existing plans

The Southampton Children and Young People's Trust (CYPT) Board brings together all key statutory and non-statutory partners from across the city. These include: Southampton City Council, NHS Southampton, schools, colleges, Jobcentre Plus, Hampshire Constabulary, Southampton Council of Faiths and the city's Voluntary Sector to ensure the coordinated delivery of positive outcomes for children and young people. The CYPT Board has developed and works to a set of outcome measures for covering pre-birth, the early years, childhood and adolescence. These measures align closely with national outcomes frameworks or their equivalent for the NHS, Social Care, Public Health and Education, and are organised according to three strategic priorities:

1. To promote health and wellbeing
2. To promote learning, achieving and aspiring for all
3. To keep children safe from harm, abuse and neglect

Key information from the Joint Strategic Needs Assessment

- The child population (0-18 years) in Southampton is 51,284, 16,156 of whom are under 5, 28,965 of school age 5-16 and 6,163 aged 17-18. The pre-school population has seen a particular increase in recent years owing to the rising birth rate – a 36% increase in births over the last 8 years
- There are 12,575 children living in poverty in the city which is 27.5% of Southampton's child population compared to 21.3% in England (in some wards of the city, this figure is as high as 42%)
- 14.1% of school children do not have English as their first language
- There are approximately 460 children living in the care of the local authority at any one time
- 42% of 5 year olds in Southampton have decayed, missing or filled teeth compared to 38% for England. (Based on 2006 dental survey)
- The number of mothers smoking in pregnancy has reduced but the overall figure of 19.4% is still high. (Southampton postcode, UHSFT provider, 2011/12)
- Almost 23% of children in reception classes are overweight and 34% in year 6 classes. 9% of children are classified as obese in reception classes and 18.9% in year 6. (2011/12 figures)
- Southampton's under 18 conception rate was 49.2 per 1000 females aged 15-17 years in 2010 compared to an England rate of 35.4 and 42.5 for the city's ONS comparators
- Southampton's alcohol specific related hospital admissions crude rate was 111.8 per 100,000 under 18s, this is significantly higher compared to the England rate of 61.8
- Whilst breastfeeding initiation rates have consistently remained at around 75% over the past 4 years, maintenance of breastfeeding at 6-8 weeks remains an on going challenge at currently 47.2%

What we will do

The Children and Young People's Trust (CYPT) has developed a local outcomes framework. This sets out its strategic priorities and actions to deliver key outcomes for the city's children and young people. These are outlined below.

Giving every child the best start in life

- Develop and deliver early learning for 2 year olds who are disadvantaged
- Develop an integrated early years service incorporating children's centre provision, family and parenting support services and the Healthy Child Programme
- Develop health visiting and maternity services to achieve optimum health outcomes in the early years and tackle inequalities
- Continue to develop high class education provision, raise attainment faster than comparator cities and improve school attendance rates where they are low

Intervening early when problems occur

- Develop an integrated assessment process for all types of needs which identifies them early and facilitates a holistic multiagency approach to providing good quality education, health and care services
- Shift the focus of provision and resources towards prevention, ensuring that the workforce at all levels and across all agencies is equipped with the skills and knowledge to identify needs and intervene early in situations of risk
- Develop and maintain a stable, skilled, high calibre and experienced safeguarding workforce which is well managed and supported

Supporting children, young people and their families with additional needs

- Increase personalisation and choice through implementation of a core offer and personal budgets, building on the learning from the Government-sponsored SEN and Disability Pathfinder
- Narrow the gap in attainments and outcomes for children with SEN and disabilities, increasing their aspirations, skills and qualifications
- Improve outcomes for children looked-after by the Council (corporate parent) building on the findings from the Integrated Ofsted/CQC inspection
- Develop holistic approaches to support and challenge for the most vulnerable families in the city through the Families Matter programme

Supporting young people to become healthy, responsible adults

- Develop Raising Participation Age support for schools and colleges
- Redesign substance misuse treatment services for young people to improve uptake and compliance with treatment
- Continue to improve sexual health and reduce teenage conceptions through delivery of the Children and Young People's Trust reducing teenage pregnancy strategy
- Make sure young people leaving care are well supported to achieve their aspirations and become independent, self-reliant citizens

The prime role of the Health and Wellbeing Board in relation to ensuring the best start in life will be to support the Children and Young People's Trust in fulfilling the plans outlined in its 'strategic priorities and actions' outcomes framework. The

Board's support will include:

- Oversight of the development and implementation of an integrated commissioning approach for all key partners, particularly the local authority and NHS Southampton. This approach will help ensure the aligning of the work of all partnerships and networks, including that of the Children and Young People's Trust, based on the national outcomes frameworks
- Strengthening and promoting the links between agencies and services so that improved outcomes for children and young people can be enabled and delivered by the Trust even more effectively
- Identification of ways to mobilise the city's business sector, community groups and their representatives to help build community capacity and resilience so that the health and wellbeing needs of children, young people and families are met
- Champion the work of the Trust to continue to raise learning standards generally, and particularly 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

How we measure the impact of the actions set out in this section

The table below shows the measures which will be used to track progress on the priorities set out in this section. Where measures are local, 2013/14 targets are included. For other local measures baseline information against which targets can be set will be reviewed.

Priority	Measure	Outcomes Framework Reference / Local Measure
Promoting Health and Wellbeing		
	• Low birth weight	PH 2.1
	• Breastfeeding rates at 6-12 weeks	PH 2.2
	• Mothers smoking in pregnancy	PH 2.3
	• Percentage of children immunised by their second birthday for DTaP/IPV/Hib	Local measure CSLCPI16. 2013/14 target 95%
	• Children in poverty	PH 1.1
	• Healthy weight at Year R and Year 6	PH 2.6
	• Tooth decay in children aged 5	PH 4.2
	• Chlamydia diagnosis rates	PH 3.2
	• Smoking prevalence – 15 year olds	PH 2.9

	• Teenage pregnancy rates	PH 2.4
	• Alcohol related admissions (under 18 year olds	PH 2.18
	• Numbers of young people in treatment for substance misuse	Local Indicator - review and establish baseline and target.
	• Numbers of children and young adults treatment for mental health	Local Indicator - review and establish baseline and target.
Promote learning, achieving and aspiring for all		
	• Foundation Stage (age 5) Foundation Stage Progress: good attainment (Readiness for school	CSLCPI4. 2013/14 target 77%
	• Key Stage 1 (age 7) Level 2+ attainment in Reading	CSLCPI6. 2013/14 target 94%
	• Key Stage 1 (age 7) Level 2+ attainment in Writing	CSLCPI7. 2013/14 target 91%
	• Key Stage 1 (age 7) Level 2+ attainment in Maths	CSLCPI8. 2013/14 target 95%
	• Key Stage 2 (age 11) Level 4+ attainment in English and Maths (combined)	CSLCPI10. 2013/14 target 87%
	• Key Stage 4 (age 16) 5+GCSEs or equivalents at A*-C (including English and Maths)	CSLCPI11. 2013/14 target 68%
	• EBacc attainment	Local measure – review and establish baseline and targets
	• Percentage of parents getting their 1st preference in school place (all phases)	CSLCPI14. 2013/14 target 85%
	• The attainment gap for vulnerable Southampton children and young people (FSM, SEN, CLA, EAL) from Early Years Foundation Stage to Key Stage 4	CSLCPI12. 2013/14 target 14/16
	• Percentage of total absence from school	CSLCPI5. 2013/14 target 5.9%
	• Exclusion from school (fixed term and permanent)	Local measure – review and establish baseline and targets
	• Percentage of young	Local measure –

	people NEET	review and establish baseline and targets
	• Children's Centres sustained contact with families in greatest need	Local measure – review and establish baseline and targets
	• Children's Centres – families in greatest need accessing evidence based parenting programmes.	Local measure – review and establish baseline and targets
	• Early Years - percentage of 3 and 4 year olds accessing early years provision	Local measure – review and establish baseline and targets
	• Level 3 attainment at age 19	Local measure – review and establish baseline and targets
Keeping children safe from harm, abuse and neglect		
	• Percentage of Social Care Initial Assessments carried out within 10 days	CSLCPI3. 2013/14 target 95%
	• The timeliness of initial child protection work for vulnerable children	CSLCPI1. 2013/14 target 90%
	• Percentage of Children Looked After with a permanence plan in place	CSLCPI2. 2013/14 target 95%
	• Care leavers in suitable accommodation	Local measure – review and establish baseline and targets
	• Numbers of 'Families Matter' families supported by local agencies and numbers supported in turnaround (rewarded)	Local measure – review and establish baseline and targets
	• Adoption (rate and timescales)	Local measure – review and establish baseline and targets
	• Social care quality assurance audit outcomes • accommodation	Local measure – review and establish baseline and targets
	• Rate of Child Protection Plans against comparators	Local measure – review and establish baseline and targets
	• Rate of Children in Need against comparators	Local measure – review and establish baseline and targets
	• Rate of Children Looked After against comparators	Local measure – review and establish baseline and targets

	• Hospital admissions caused by unintentional and deliberate injury	Local measure – review and establish baseline and targets
	• First time entrants to the youth justice system	CSLCPI113. 2013/14 target 900 (number per 100,000)
	• Young offenders in suitable accommodation	Local measure – review and establish baseline and targets

Theme 3 – Living and Ageing Well

Why this is important

Southampton is following the national trend in that life expectancy continues to increase. It is important that people not only live longer but retain their health and independence for as long as possible. The two are linked. The evidence is that people who retain more control over their lives and remain as independent as they can be stay healthier for longer.

More people are living longer with long-term conditions. A long-term condition is defined as something that cannot be cured at present, but can be controlled by medication and/or other therapies. The scope of the term has increased. Traditionally it included conditions such as chronic lung conditions and heart failure. However, it now includes cancer (because improvements in treatment mean many patients with cancer can survive for some years), chronic mental illness, and some conditions which have been ill-defined by medical science such as chronic fatigue syndrome.

People tend to develop long-term conditions as they become older, and frequently feature more than a single disease process. This means that models of care developed around single diseases may be unsatisfactory, and social care and medical care must be more adaptable to match these challenges.

Key information from the Joint Strategic Needs Assessment

- The number of people over 85 in the City is forecast to grow from 5,200-6,000 between 2010 and 2017 – an increase of over 15%
- In Bassett, the wealthiest part of Southampton, a man can expect to live to 80.6 and women 84.0 years, while a few kilometres away in Bitterne, one of the cities poorer wards, life expectancy is 75.3 and 79.9 years for males and females. These differences in life expectancy of 5.3 and 4.1 years respectively for men and women are significant
- 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 they utilise 70% of NHS and Social Care resources. For example one third of people over 65 years will die with a diagnosis that includes dementia and 25% of hospital beds are occupied by someone with dementia as part of the diagnosis
- There are 7 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
- It is estimated that in the winter of 2008/09, 113 people died in Southampton because of cold weather. In the UK, frail, elderly women are the most vulnerable group
- In 2010/11 2,500 people had been identified as suffering from dementia. Of those, 2/3 live in the community, and 1/3 live in care homes
- The number of hip replacements performed increased by 31.9% over 5 years from 2004/05 to 2008/09, while in the same period the number of knee

replacements performed increased by 16.3%
- 202 people per 1,000 aged 65 or over received adult social care services, compared with an England average of 123.5 per 1,000
- During 2010/11 adult social care services undertook the following activities:
  - 9,222 people received community care
  - 837 people were supported into permanent residential care
  - 410 people were supported into nursing care
  - 3,659 new people were assessed
  - 2,047 new people received services

What we will do

Tackling poverty

- Make the most of existing services (voluntary, public and private sector) that offer free or discounted access to leisure, learning, transport and care
- Support the development and use of information advice assistance to help people to maximise their income, ensure winter warmth and improve their quality of life

Prevention and earlier intervention

- Offer an annual health check to carers and promote support networks for carers across the City
- Review tele-care and tele-health services in the City, re-shape and re-launch these so that local people are more aware of the ways in which they can use technology to retain their independence
- Extend re-ablement services so that people can help to regain their confidence and skills after an illness or mental health breakdown
- Promote healthy, active lifestyles through a dedicated team of Activity Coordinators

Being 'person' centred and not 'disease' centred

- Increasing the number of people who can say how best to spend the money allocated for their health and care, either through direct payments or personal health/care budgets
- Joining up health and social care services so that the number of assessments is reduced and a person's experience of moving between professionals is much smoother and less fragmented
- Developing a shared understanding of how best to support people to retain their independence and make changes to practice which improve the achievement of this objective
- Promotion of a focus on recovery rather than simply procedures for admission avoidance and/or hospital discharge when people need any form of secondary care

Care of long-term conditions, including cancer and dementia

- To ensure that the enduring issues for people living with long-term conditions are recognised and that they are supported in the management of their conditions.
- Work with GPs to more accurately achieve earlier diagnosis of those most at risk of experiencing dementia

- More support for people with dementia to remain in their own homes for as long as it is safe for them to do so
- The development of extra-care services for people with long term conditions and those with dementia
- Launching a new approach to provision of aids and adaptations which encourage better access and information for individuals able to fund themselves and improves response times to those requiring equipment to maintain their independence
- Raising awareness amongst all care and health staff about appropriate responses for people with dementia, mental capacity issues including deprivation of liberty guidelines and protocols
- Work with the Clinical Commissioning Group and providers of social care to raise the standard of medicines management across the health and care system
- To improve health outcomes of those living with cancer action will be taken to improve understanding amongst the public about the signs and symptoms of cancer and encourage early checks with their GP

Improve the response to learning disabilities

- Work with the Clinical Commissioning Group to ensure the implementation across GP practices of annual health and dental checks for people with learning disabilities
- Better coordinate and promote services which support people with learning disabilities and their carers across the City
- Encourage partners within the Health and Wellbeing Board to lead by example and produce plans for improving employment of people with learning difficulties
- Involve the Learning Disability Partnership Board which includes people with learning disabilities in the City in shaping all improvements

End of life care

- Increase public awareness and discussion around death and dying
- Map current provision to ensure that appropriate national care pathways are incorporated and audited in hospitals and the community
- Extend palliative care to other diseases besides cancer and 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)
- Have timely bereavement counselling available

How we measure the impact of the actions set out in this section

The table below shows the outcome framework measures which will be used to track progress on the priorities set out in this section

Priority	Measure	Outcomes Framework Reference / Local Measure
Tackling Poverty		
Use of and access to	To be developed	Local measure

services		
Advice to maximise income, warmth and quality of life	To be developed	Local measure
Prevention and earlier intervention		
Carer's health check	• Carers who received health checks • Carer reported quality of life	Local measure ASC 1D
Tele-care and tele-heath	• Control over daily life	ASC 1B
Re-ablement services	• At home 91 days after hospital discharge	ASC 2B
Promoting healthy lifestyles	• Excess weight in adults • Physically active adults • Recorded diabetes • Alcohol-related hospital admissions	PH 2.12 PH 2.13 PH 2.17 PH 2.18
Person-centred approach	• Control over daily life	ASC 1B
Direct payments or personal health/care budgets	• Self-directed support • Self directed support at end of period • Direct payments	ASC 1C(i) Local ASC 1C(ii)
Reducing number of separate assessments and improving patient experience across systems	• Overall satisfaction with care	ASC 3A
Retaining independence	• Permanent admissions to residential and nursing homes	ASC 2A
Focus on recovery	• At home 91 days after hospital discharge • Delayed discharges	ASC 2B ASC 2C
Dementia, Cancer and Long-term Conditions		
Early diagnosis of dementia	• Diagnosis rate	PH 4.16
	• Prescription rates for anti-dementia drugs	
	• Prescription rates of anti-psychotic drugs to patients with dementia	
Support for dementia	• Sustaining independence and improving quality of life	ASC 2F/ NHS 2.6(ii)
Staff awareness about dementia	To be developed	Local measure
Developing extra care services	• At home 91 days after hospital discharge	ASC 2B
Provision of equipment	• At home 91 days after hospital discharge • Control over daily life	ASC 2B

		ASC 1B
Improving medicine management	• Prescribing rates for anti-dementia drugs • Prescribing rates for antipsychotic drugs in dementia • Medication reviews for patients	NHS 4.4 (i)
Cancer – screening and treatment	• Under 75 mortality rate from cancer	NHS 1.4 (i) and (ii) / PH 4.5
Improving the response to Learning Disabilities		
Annual health checks for people with learning disabilities	• Client satisfaction • Take up of learning disability health check	ASC 3A
Co-ordination and promotion of services	• Adults with LD living in own home or with family	ASC 1G
Improving employment	• Proportion of adults with LD in employment	ASC 1E
LDPB involved in shaping improvements	• Client satisfaction	ASC 3A
End of life care		
Awareness and discussions around death and dying	• Bereaved carers view of quality of care in last 3 months of life • Numbers of patients on appropriate recognised care pathways	NHS 4.6 Local measure
Use of appropriate national care pathways		
Extension of palliative care to other conditions		
End of life care register		
Availability of bereavement counselling		

Section 3 – Conclusion

This strategy sets out an ambition to deliver real improvements to health and wellbeing and a reduction in health inequalities at a time of great challenge for both local government and the NHS. Whilst some of the challenges identified in the JSNA will respond to shorter term actions, others will take a generation or more to change. The health and wellbeing board will need to maintain a focus across the varying timeframes relating to different actions set out in this strategy. National circumstances are affecting the health and wellbeing of individuals in a variety of ways, and demand for services and support are likely to rise in the short term. If the board can secure the delivery of the preventative actions set out in this strategy, then there should be scope to reduce demand for some of the high cost treatments and support over a period of time. This should enable more people to live healthier, more active and more fulfilling lives, and provide a greater proportion of resources to support the most vulnerable and needy people living in Southampton.

Both the Council and the CCG are committed to joint commissioning where appropriate as a means of improving the quality of services to users and make commissioning and services more efficient.

The Health and Wellbeing Board will recommend the strategy to the Southampton City Council Cabinet and Southampton City Clinical Commissioning Group and it will be adopted by both organisations. Action plans will be developed to support the delivery of the outcomes, and the Health and Wellbeing Board will review the outcome measures at least annually.

Southampton Shadow Health and Wellbeing Board Members as at 27th March 2013

Councillor Jacqui Rayment (Chair) Cabinet Member for Communities		**Dr Steve Townsend (Vice-Chair)** Southampton City CCG Chair	
Councillor Sarah Bogle Cabinet Member for Children's Services		**Councillor Matthew Stevens** Cabinet Member for Adult Services	
Councillor Peter Baillie Conservative Group Member		**Councillor Maureen Turner** Liberal Democrat Group Member	
Harry Dymond Chair, Southampton LINk		**Dr Stuart Ward** National Commissioning Board Representative	
Dr Andrew Mortimore Director of Public Health		**Margaret Geary** Director of Health and Adult Social Care	
Clive Webster Director of Children's Services