HEALTH AND WELLBEING STRATEGY 2013-16: COMMITMENTS - PROGRESS REPORT Q4 2015/16

	ACTION	PROGRESS (RAG)	COMMENT	Updater
	KEY: Green – On track or completed; Amber – Off target; Red – Significantly off target; Grey – Missing information or status N/A			
THEME 1: BUILDING RESILIENCE AND USING PREVENTATIVE MEASURES TO ACHIEVE BETTER HEALTH AND WELLBEING				
Smoking and Tobacco Control				
1.	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, and implementation of tobacco control policies at a local level.	**GREEN**	Tobacco control plan in place and implemented for 2014-15. Smoking cessation services also commissioned. Review of plan undertaken and used to inform for 2015-16 refresh. Trading Standards have moved to Hampshire County Council, this raises concerns over the impact of tobacco control in the city. Working with Hampshire commissioners to develop a Southampton inclusive approach e.g. Helpline, Roadshow.	Public Health, Dr. Bob Coates
2.	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.	**GREEN**	NHS Health Checks programme implemented across the City as well as additional opportunistic outreach work targeted at key groups within the population to address potential health inequalities. In 2014/15 99% of eligible population were invited for health checks (over 11,000 invitations). Uptake has increased to 40%. 2015/16 year end data is not yet available.	Public Health, Dr. Bob Coates
Obesity and Physical Activity				
3.	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.	**GREEN**	A range of activities and services are available to support healthy lifestyle behaviours. These are accessible for children, families and adults and include activities in key settings such as workplaces, early years and schools. The public health nursing service (school nursing) was recommissioned for 1 April 2015. New service specification has a specific focus on healthy weight. The breastfeeding action plan has been developed, with progress monitored by the 0-5 year working group (under the 0-19 commissioning group). Health improvement plan in maternity services specification monitored at maternity trust board meetings.	Public Health, Dr. Bob Coates
4.	Support initiatives and services that are effective in preventing and managing overweight and	**GREEN**	Initiatives and services for children, young people and adults to prevent obesity and manage their weight are supported. Additional insight work is being undertaken to better understand further needs of key target groups.	Public Health, Dr. Bob Coates

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	obesity in our high risk individuals in the children, young people and adults sectors.		Commissioned insight work for obesity in pregnancy to be available by March 2016 to inform future service delivery. Other targeted work with families and is continuing. Health trainer service provide one to one support and weight management groups for those who want to lose weight. All of these services are targeted to the most deprived Each of the services are reviewed annually	
Alcohol and Drugs				
5.	Work together with local agencies to reduce detrimental effects of adults' problem drug and alcohol use, particularly parents.	**GREEN**	New Integrated Substance Misuse Services (SMS) were commissioned from December 2014 and have been subject to a comprehensive redesign process. There are now four main contracts, with a Young People's substance misuse service dealing with young people aged 11-24 years inclusive. Service providers work in partnership in order to deliver holistic treatment pathways across the City. All clients have a treatment plan (focussed on recovery) and issues relating to safeguarding children are addressed proactively. Additional training on substance misuse has been targeted at social workers working with vulnerable adults and children. Service providers work closely with local agencies including police, probation, Youth Offending services, children and adult safeguarding services, JobCentre Plus, Liaison and Diversion Service, CAMHS and adult mental health services, as well as a wide range of other voluntary services targeted at people with a substance misuse problem and their carers. Although national performance reports still show a reduction in performance based on the previous rolling year's data, live information from provider services shows that the number of successful completions for adults is improving steadily.	Public Health, Dr. Bob Coates
6.	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.	**GREEN**	The younger persons' SMS has been newly commissioned with No Limits. The enables the delivery of comprehensive school and college based campaigns with access to confidential advice and individual treatment planning, where appropriate. The Healthy Southampton communications plan has prioritised alcohol campaigns for 2015 and identified additional resources to support awareness raising. Other examples include Dry January, Take 2, and the Know your number from the Academic Science Network. No Limits undertake the school education programme, 'Buzz'. This is now part of the annual campaign calendar with our communications team. It is difficult to evaluate the impact of these campaigns directly, however, a sustained and consistent message is evidence based approach.	Public Health, Dr. Bob Coates

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7.	Develop and expand the current services 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.	**GREEN**	The new service model for both young people (YP) and adults is designed to enable a multi-disciplinary and multi-agency response to the needs of service users. Effective partnership working with a wide range of statutory and voluntary organisations is given a high priority. This builds upon the established partnership and educational activities that the Young People's substance misuse service (DASH) had previously developed. Since the new service commenced in December 2014, DASH has expanded its offer to young people to include not only engagement at schools and colleges, but has developed in-reach into Southampton University to address the issues of recreational drug and alcohol use amongst the young adult student population and is hoping to develop a similar relationship with Solent University. The service has also expanded its ability to offer meaningful activity and skills based opportunities to young people to build confidence and develop pro-active approaches to finding employment and training opportunities. The service works closely with a range of partners and agencies in order to develop and provide wrap around services, promoting young people's health services and working closely with the Safe City Partnership, police and probation services in order to tackle the problems associated with drug and alcohol problems in the young.	Public Health, Dr. Bob Coates
8.	Increase numbers accessing both drug and alcohol services. This will enhance numbers achieving recovery from alcohol or other drugs.	**AMBER**	Following the redesign of the substance misuse services and what has proved to be a challenging implementation period, we have seen a reduction in the number of service users accessing treatment, particularly alcohol users. Whilst we have seen some reductions in numbers accessing treatment, within some age ranges, nationally, it is felt that there are local issues that must be resolved. Part of the reason for this is that more service users who require an alcohol brief intervention are being seen as part of the "open access" service which means that they are not uploaded onto the National Drug Treatment and Monitoring System and therefore numbers appear to have reduced. In addition, the decision was taken for the Alcohol Specialist Nurse team not to upload onto NDTMS as they did not have compatible IT systems and the types of interventions they are providing do not form part of the national minimum data set. This has also led to a slight apparent reduction in numbers. However, it should be noted that national figures involve a "time lag" based on a rolling year data, which means that performance reports are still being	Public Health, Dr. Bob Coates

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			affected by data from the previous treatment services. Live information received from the current service providers is showing signs of improvement and treatment providers have improvement plans in place which are being monitored by commissioners and senior managers from the Integrated Commissioning Unit. Overall, the number of alcohol services users aged over 50 has risen by 44%, but fallen by 34% for 16-24 year-olds. This is thought to reflect the general downward trend in young people's drinking, although younger groups have always been less likely to access treatment.	
9.	Review drug treatment services, particularly to young people to ensure a value, high quality treatment system reflective of their drug use patterns.	**GREEN**	The new service was implemented following the review.	Public Health, Dr. Bob Coates
10.	Increase the range of effective treatment interventions for crack cocaine and stimulant users.	**GREEN**	Whilst numbers in treatment (as above) for people presenting with concerns around their use if non-opiate drugs are also in need of improvement, taking into consideration the limitations in NDTMS reporting (as above), we do continue to see services offering an increasingly wide range of interventions, individual work, group work and diversionary activities that are suitable for people presenting with issues around their non-opiate drug use. The most recent (Q3 201516) Diagnostic Outcomes Monitoring Report (DOMES) received from NDTMS indicates Abstinence and reliably improved rates at 6 months review are either well within the expected range or nearly at the expected range • Cocaine abstinence rates (6 month review) = 50% (expected range 9.2% - 100%) • Crack abstinence rates (6 month review) = 15.4% (expected range 18.6% - 48.2%) Clearly there is still work to be done to support improvement in these and other measures. The commissioning team are working closely with the providers to ensure improvements are made.	Public Health, Dr. Bob Coates
11.	Develop an appropriate suite of abstinence and harm reduction services for blood borne viruses (BBV), such as HIV etc.	**GREEN**	Needle exchange, BBV screening, and access to new hepatitis treatments was in the top quintile of performance nationally last year. A programme of enhanced HIV surveillance has been agreed with the CCG and Integrated Commissioning team.	Public Health, Dr. Bob Coates

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Housing				
12.	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.	**GREEN**	The Homelessness Prevention Strategy for 2013-2018 is in place and outlines our approach to tackling homelessness. It demonstrates a commitment to build on our experience to provide a comprehensive service that tackles homelessness in Southampton. The strategy focuses on early intervention and prevention where possible and assisting people in need.	Housing, Liz Slater
13.	Provide a comprehensive homelessness service that supports people to make independent choices about their housing future.	**GREEN**		
14.	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.	**GREEN** (On Target)	• The HRS review has commenced and successfully aligned all current contracts to end as of March 31st 2017, allowing the full scope of HRS to be considered in a unified way. • Project group has been set up and starting to monitor the projects progress • Engagement events for Adults and YP have been scheduled for 14th March and 30th March 2016 respectively • While maintaining an overview across all HRS services, there is a dedicated focus on each of the following areas; CYP, Adults and Older persons • Work has commenced on researching a wide range of literature relating to HRS including strategies (local & national), legislation (include current Housing & Planning reform Bill), research and other good practice information as sourced. • Reviews of current services have commenced and will inform final report	ICU, Donna Chapman/ Sandy Jerrim

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15.	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.	**GREEN**	Southampton City Council introduced an additional HMO Licensing scheme in four wards (Bevois, Bargate, Portswood and Swaythling) in July 2013. The scheme is working to improve management and conditions in HMOs and reduce the impact on the communities. The scheme was extended in October 2015 to include Freemantle, Shirley, Bassett and Millbrook wards. There is insufficient evidence of poorly managed HMO's in other parts of the city to legally extend the scheme further, however, a Government consultation is currently underway to consider implementing a national mandatory HMO scheme.	Regulatory & City Services, Mitch Sanders
16.	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.	**GREEN** On target	All mental health services are currently being reviewed and this will lead to a new model of service for all groups including people with dementia and their carers, with initial proposals due for consideration late Spring 2016. A key feature emerging in the review is the need to link with Better Care initiatives to provide holistic seamless services. The need for local services/hub is now part of the work to develop community solutions to support people in their own homes and localities in a number of different ways. A special City Council Inquiry Panel will be looking at the situation for people with dementia and their carers in Southampton, it will assess how the city is progressing and will also identify further actions needed in making Southampton a dementia friendly city using the recognised framework developed by the Alzheimer's Society. Actions will be progressed throughout the inquiry period (September 2015 – March 2016), starting with an application 'working to become dementia-friendly'. A carers support service has recently been procured which offers support to those caring for people with dementia.	ICU, Amanda Luker
17.	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.	**GREEN**	This is being progressed as a key Better Care programme target. A falls action plan is in place with all agencies committed to delivering key actions. A new exercise class programme is being piloted with a local voluntary sector organisation and other partners to reduce repeat falls. A new falls liaison pathway has also been introduced between UHS and Solent NHS Trust to reduce repeat falls. Specific work is being undertaken with nursing homes to introduce "falls champions" to prevent trips, slips and falls. A publicity week is also planned in September to raise awareness of falls and how to prevent them.	ICU, Donna Chapman

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Workplace Health				
18.	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.	**GREEN**	National Workplace Wellbeing Charter implemented through the Well & Working programme, supporting a range of employers to improve the health and wellbeing of their workforce. Work undertaken to better understand the issues around Fit Note and to address the worklessness agenda for those with a health condition. Every review will be assessing the value for money and opportunities for achieving further access across Hampshire.	ICU, Stephanie Ramsey
19.	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.	**AMBER**	The Solent Jobs Pilot completed at the end of December 2015 with 25% of participants supported into work, 5% over target. The second stage of the Programme has still been delayed by ESF funding processes and we are not expecting approval until March 2016. The City Deal Youth Programme is now underway and 3 key workers are now working in Early Help teams and Youth Offending and Pathways services to provide advice and support to the most vulnerable NEET young people. 72 young people have been supported since mid-August (start of the programme) and 34 have had a positive outcome in relation to employment, education or training. A PID has been taken to the Commissioning Board to develop an integrated employment support service with health and social care services. The project group has been established and is due to report with recommendations for commissioning by summer 2016. This commitment is amber due only to the delay by the ESF funding processes.	Skills & Regeneration, Kathryn Rankin
20.	Promote and develop the 'Time to Change' campaign to reduce the stigma of mental illness in the workplace.	**GREEN**	Successful Citywide anti-stigma campaign undertaken for two weeks in October which included: • 5K park run, • Time to Change pop up village event in Guildhall Square with a recovery choir, local health services, charities over 450 people were held on mental health, • Further work to be undertaken at the Health and Wellbeing board for organisations to sign up to a mental health pledge.	Public health, Sally Denley

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Mental Health				
21.	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.	**GREEN**	The public mental health Be Well strategy has been refreshed and due to be presented for approval by HWBB in May 2016. The majority of the ten pledges have been met.	Public health, Sally Denley
22.	Ensure early access to psychological therapy/services, such as counselling and talk, which help people remain in or return to employment.	**GREEN**	Access to Southampton Steps to Wellbeing (National Improving Access to Psychological Therapies (IAPT) scheme) has met the national ambition for the proportion of people who have received psychological therapies.	ICU, Amanda Luker
23.	Develop and implement a suicide prevention strategy across the city.	**GREEN**	The evidence obtained by the Southampton Suicide audit undertaken jointly with the Coroner's Office will inform a local Public Health Prevention Plan for Southampton. This will be rolled out as part of the Be Well Strategy refresh, following input from Mental Health matters. Safe care approaches to suicide prevention in the CQUIN scheme; includes review and adaptation of risk assessment. By rolling out 'connecting with people' training for clinicians and USI Suicide Prevention Training together with Mental Health First Aid we aim to make Southampton a suicide safer city.	Public Health, Sally Denley; ICU, Amanda Luker
THEME 2: BEST START IN LIFE				
Giving every child the best start in life				
24.	Develop and deliver early learning for 2 year olds who are disadvantaged.	**AMBER**	The 2014-2015 Southampton Childcare Sufficiency Assessment highlighted that where sufficient capacity has not been developed the necessary plans should be in place to achieve this by September 2015. This has been achieved across the city except in the Thornhill area where suitable premises have still not been identified and all existing local provision has already been expanded to the limit. Take up of places increased from 67% to 70% since the Autumn term 2015. More data and intelligence in relation to the best approach to increase take up is informing outreach work and telephone contact with families. Multi agency training held in February 2016 on how to positively promote the offer to parents. Further information from the DfE expected to	Children and Families Services, Sue Thompson

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			continue to increase uptake.	
25.	Develop an integrated early years' service incorporating children's centre provision, family and parenting support services and the Healthy Child Programme.	**GREEN**	With commissioning responsibility for Public Health Nursing services (health visiting and family nurse partnership) moving to the local authority (Public health) in October 2015, work has been underway to explore a more integrated 0-5 year old offer. We are aiming to implement a virtual model of integration with joint management teams comprising health visiting, children's centres and midwifery leadership from July 2015 to achieve greater integration of resources and alignment of health, education and social care performance indicators and outcomes. At the same time, we plan to undertake a review of MASH and Early Help services to inform the future direction of travel, with a view to potentially working towards an integrated 0-19 offer based around localities.	ICU, Donna Chapman
26.	Develop health visiting and maternity services to achieve optimum health outcomes in the early years and tackle inequalities.	**GREEN**	Work continues with Solent NHS Trust, NHS England and University Hospital Southampton Foundation Trust (UHSFT) to improve outcomes in the early years and tackle inequalities. For Maternity Services, this has been negotiated as part of the 2015/16 Service Specification held by the CCG which includes specific reference to key public health priorities, in particular smoking cessation (including the universal implementation of Carbon monoxide monitoring), healthy weight, healthy start, mental health and breast feeding. Work is underway to ensure that the new Maternity Payment by Results tariff is driving a stronger focus on tackling inequalities. For health visiting, the Council is working closely with NHS England (current commissioner) to improve outcomes in the early years, with reference to the 6 high impact areas described by NHSE. This will be further supported by the integrated 0-5 offer described above.	ICU, Donna Chapman
27.	Continue to develop high class education provision, raise attainment faster than comparator cities and improve school attendance rates where they are low.	**RED**	The percentage of primary and secondary schools judged good or outstanding by Ofsted is currently 84.6%, a ranking of 64th in 152 local authorities nationally; this is a cause for optimism. At 17.8%, nearly a fifth of these are graded outstanding. These figures comprise 88.5% of primary schools judged good or better, including 21.2% graded outstanding. 75% of secondary schools currently judged good or better, with 8.3% graded outstanding. KS2: 1% below national average KS4: 6% below national average KS5: 13.3% below national average point score In June 2015 the 'School Attendance Action Plan Group' was formed and has	Children and Families Services, Kim Drake

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		RED	been meeting on a regular every month since. It aims to develop a shared purpose and vision citywide to improve school attendance and raise attainment throughout our schools. Furthermore, it aims to co-ordinate a consistent, collaborative approach to improve school attendance within the City. It is a vehicle for sharing good practice with others, discussing and exploring current issues that are affecting absence and updating policies, procedures and processes to accommodate the ever changing landscape and reasons for absence from school. Representatives from schools, academies, health, police, youth offending service, education services, social care services, early help and external partners attend. Agencies work together to disseminate the message, and to ensure improved school attendance is high on the agenda throughout the City. Work is also expanding into other areas and we have already engaged and shared our message with governors. An invitation to speak to the chamber of commerce, in April 2016, to engage business in the drive to improve attendance and attainment, along with regular local truancy sweeps, in collaboration with the police, are underway. Improving school attendance is everybody's business and this is the message to the City of Southampton & its partners. There are also consequences for those parents/carers who continually fail to send their children to school regularly, despite our collective intervention.	
Intervening early when problems occur				
28.	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.	GREEN	This is a key element of the Better Care programme and implementation of the cluster interagency team model. Six clusters have been established, based around GP practice populations, bringing together health, social care, housing and voluntary staff. The clusters are at varying stages of development but a core principle for all is the use of risk stratification tools to identify people at most risk and shared assessment and care planning. These principles are also being applied for children and their families, where use of the Universal Help Assessment and Family Help Assessment tools are being used by Children's Centres, school nursing, Early Help and the MASH. Work is also underway to explore a more integrated approach to bringing together the 2-3 year old assessments of the Healthy Child Programme and Early Years Foundation Stage. Integrated process established for safeguarding set up through the MASH (Multi-agency safeguarding hub), Early Help teams and scrutiny of services via the section 11 audit process.	ICU, Donna Chapman

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29.	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.	**GREEN**	This is a key element of the 0-19 Prevention and Early Intervention Strategy which has 5 key strands: • Implementation of a core parenting offer and family support; • Better use of data, information and intelligence across the system to identify gaps, provide information to staff and families on what is available and share evidence based interventions; • Community engagement and development of capacity within the voluntary and community sector to better meet need at an earlier stage; • Interagency workforce development and training to support prevention • Early intervention and inclusive integrated services. Significant progress has been made in implementing the parenting offer for 0-5s and a parenting toolkit has been launched with schools to support development of the 5-14 years offer. Different models for strengthening engagement of the community/voluntary sector have been explored through the Delivering Differently and Headstart initiatives and will be further supported through the Prevention and Early Intervention Strategy. Further work required on interagency workforce development and equipping staff with skills and knowledge to identify needs and intervene at a much earlier stage. The Better Care Programme has its own workforce development project being rolled out in 2015/16. This will focus on NHS / Council staff in addition to nursing home and domiciliary care staff. Better Care will lead to prevention and early intervention and initial work has commenced on developing a plan for health and social care outcomes.	ICU, Donna Chapman
30.	Develop and maintain a stable, skilled, high calibre and experienced safeguarding workforce which is well managed and supported.	**GREEN**	The Safeguarding Adults Team is fully staffed, apart from a 0.67 FTE Investigator post, which is vacant pending recruitment. In terms of the skill set within the team, it is recognised that there are areas where more specific expertise is needed. This includes Learning Disabilities and Mental Health and actions are being taken to develop these skill areas. The final area for development is the need to broaden the professional vocational base of team members. The team is almost exclusively staffed by colleagues from a Social Care/Work background and would benefit from having staff with a broader professional background (probation/working with offenders etc.) This will be a future objective, to be a multi-agency service.	Adult Social Care, Derek Law

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Supporting children, young people and their families with additional needs				
31.	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.	**GREEN**	An integrated 0-25 service is being developed across education, health and social care. This includes the integration of Council and Solent NHS Trust staff within a single service structure and the development of a strong person-centred ethos. The SEND offer is published on the Southampton Information Directory and provides information about what is available and how to access services. A revised Impartial Information and Advice Service is being commissioned to meet the requirements of the Children and Family Act.	ICU, Donna Chapman
32.	Narrow the gap in attainments and outcomes for children with SEN and disabilities, increasing their aspirations, skills and qualifications.	**AMBER**	Current work to create a more nuanced set of performance indicators with Education, Health & Care via the SEND Partnership Board will further support targeted activity in narrowing gaps between this vulnerable groups of children & YP and their peers. Agreed regional benchmarking indicators will be incorporated into the SEND dataset to enable comparisons and opportunities to learn from others to improve outcomes.	Children and Families Services, Jo Cassey
33.	Improve outcomes for children looked-after by the Council (corporate parent) building on the findings from the Integrated Ofsted/CQC inspection.	**GREEN** On target	An OFSTED Action Plan is in place. A performance board meet monthly to audit, continually monitor and ascertain where improvements need to be made. A diagnostic of all LAC has identified several cohorts of children for whom permanency plans can be progressed faster. Due to this 100 children are planned to move out of care in the next year.	Children and Families Services, Christine Robertson
34.	Develop holistic approaches to support and challenge for the most vulnerable families in the city through the Families Matter programme.	**GREEN**	Phase 1 completed with 100% families turned around, Southampton ranked 7 of 152 local authorities. Phase 2 commenced in Summer 2015/16 is based on a new set of criteria and families. Links with new families are being established.	Children and Families Services, Simon McKenzie
Supporting young people to become healthy, responsible adults				
35.	Develop Raising Participation Age support for schools and colleges.	**GREEN**	Raising Participation Age has been implemented effectively with schools.	Children and Families Services, Jo Cassey
36.	Redesign substance misuse treatment services for young people to improve uptake and compliance with treatment.	**GREEN**	Procurement and redesign completed in Dec 2014.	Public Health, Bob Coates

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37.	Continue to improve sexual health and reduce teenage conceptions through delivery of the Children and Young People's Trust reducing teenage pregnancy strategy.	**GREEN**	Teenage pregnancy city wide event held in October 2014. Sexual health strategy developed and intentions reviewed quarterly by sexual health steering group. Teenage pregnancy is a key strategic priority. Teenage pregnancy action plan currently being updated, with assurance of delivery from the 0-19 commissioning group.	ICU, Donna Chapman
38.	Make sure young people leaving care are well supported to achieve their aspirations and become independent, self-reliant citizens.	**GREEN** On Target	Latest validated data indicates that there are 127 care leavers over the age of 18 years worked with by the Service. The trend over 5 years contrasts with a 184 in Quarter 1 2012/13 and evidences a significant reduction in the cohort. Corporate Parenting and Participation: The role of elected members has developed significantly within the City since July 2014. The Children and Families Scrutiny Panel led by Elected Members robustly examines the work and performance of services and outcomes for children and young people in the City and includes a targeted focus upon children in care and care leavers. Participation: Services are designed to involve children and young people in participation and engagement activities require greater coordination over the year ahead. Further creative approaches to building capacity are being applied in this area which practically empowers and supports children and young people to input into consultative, decision-making and delivery mechanisms including the Corporate Parenting Committee. A new Children and Families Participation Officer has been appointed to bring out the voice of the child. Employment, Education and Training: There has been significant progress in outcomes and data collection for this group of young people and some additional externally funded resources are now available to work with the Pathways team to improve outcomes further. The City Deal Youth Programme Manager, now in post, will take a lead in co-ordinating effort across different agencies and teams to maximise NEET results for these young people. Care Leavers "in touch" and in suitable accommodation: The city has developed a strategic approach to finding and accessing suitable accommodation for young care leavers and a wide range of options are available including a "staying put" offer for care leavers to continue to reside with their current foster carer(s). Steps have been taken to improve the joint working between the Care Leavers/Pathways Team and the Housing Needs Team. Health assessments for looked after children have been significantly improved	Children and Families Services, Robert South

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			over the past 12 months in both timeliness and quality. This is rigorously monitored and maintained through the partnership of agencies and processes put in place to establish these improvements. Solent NHS Trust and the Local Authority also need to deliver similar improvements in relation to immunisations and dental checks for children in care. This progress has also impacted positively upon the older children/young people as they leave care.	
Theme 3 – Ageing and Living Well				
Tackling poverty				
39.	Make the most of existing services (voluntary, public and private sector) that offer free or discounted access to leisure, learning, transport and care.	AMBER	Public Health attended a physical activity lecture in February 2016 led by Active Nation on their new strategy Sporting Future published in December 2015. The strategy has outcomes for health, economic development and community development. Further discussions to take place on how to embed the framework. This work will be included in the Public Health team business plan.	Public Health
40.	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.	GREEN	Additional advice provision has been made available in the city in response to welfare reforms. Training for staff has been provided on debt awareness. The funding for Local Welfare Provision, which has supported people in crisis since April 2013, is ending in March 2016. The Welfare Monitoring Group have aimed to support people through the Welfare Reforms changes and have achieved a sustainable solution for affordable loans has been secured with the Credit Union. Southampton are progressing the Fairness Commission's report will take forward these issues where possible. In particular, the following recommendations will look to tackle issues of debt and fair access to welfare entitlement in the city: • Promoting and providing learning modules for debt and money management in schools and colleges. • Developing and implementing a programme to increase awareness of and fair access to welfare entitlements, particularly linked to key life-transition points. The Southampton Information Directory signposts people to key services. Significant work has been undertaken to coordinate advice services through the Southampton Advice Services Alliance (SASA) which was established following a successful bid for funding. This has resulted in the establishment of an advice portal and cross-agency specialist advice. The funding has now	Skills & Regeneration, Sara Crawford

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			ceased, although funding has been secured for the specialist advice worker to continue. Work is underway to agree a way forward for the alliance into the future. In July 2015 the HWBB supported the Southampton Warmth for All Partnership (SWAP) to ensure City wide partnership working to address public health, energy efficiency and fuel poverty concerns, especially in the development of bids for future funding. Work on this is continuing. The Fuel Poverty Strategy has been published to work alongside this.	
Prevention and earlier intervention				
41.	Offer an annual health check to carers and promote support networks for carers across the City.	AMBER	The process for health checks being offered to carers will be reviewed with local carer and primary care services to establish how they will be offered in the future. As part of this work discussions are taking place in the next few months, with proposals to be outlined in Autumn 2016.	ICU, Sandy Jerrim
42.	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.	GREEN	Plans being developed under oversight of Health and Social Care System Chief Officers. Diagnostics have been completed and the project has now been implemented.	ICU, Sandy Jerrim
43.	Extend re-ablement services so that people can help to regain their confidence and skills after an illness.	GREEN	The integrated rehabilitation and reablement service is designed to intervene rapidly and early when people are at risk of crisis, nursing or rest home or hospital care or are ready to discharge from hospital care back into the community. The service dovetails with the developing cluster teams to promote simple, integrated and shared care pathways for clients and patients. On target.	ICU, Jamie Schofield
44.	Promote healthy, active lifestyles through a dedicated team of Activity Coordinators.	GREEN	Through programmes such as health trainers and My Journey residents and visitors are encouraged and supported to be more physically active.	Public Health, Dr Bob Coates
Being 'person' centred and not 'disease' centred				
45.	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	GREEN	Adult Social Care Direct Payment performance is improving, with 40 additional recipients in 2015/16. The rate has increased to 18.1%; although this is below the target of 22.1% for 2015/16 due to increasing number of eligible service users. Spectrum CIL has been commissioned to provide additional support to individuals as part of a pilot aimed at further increasing uptake.	Adult Social Care, Paul Juan

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	health/care budgets.			
46.	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.	AMBER	Service functions related to crisis response, rehabilitation, reablement and hospital discharge will be integrated with pooled funding arrangements, single management, referral, governance, planning and performance arrangements to ensure greater fluidity and shared responsibility. The programme is being undertaken in 3 phases: Phase 1. Integration of existing SCC and SCCCG Teams working on hospital discharge, rehabilitation and reablement. Phase 2. Redirecting resources from Brownhill House to further support and grow Phase 1. All consultation complete and approval received to proceed. Implementation underway and alternative provision being sought. Phase 3. Develop out of hospital pathways that ensure timely discharge from hospital again freeing up resources through a reduction in occupied excess bed days. Again these resources will be used to support and grow the functions inherent in Phase 1. The detail of the 'out of hospital' pathways are currently being developed.	ICU, Jamie Schofield
47.	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.	AMBER	This is a key area of focus of the three Better Care principles. A fundamental element of this is the recommissioning of the long term care pathways and self-management approach. The review of behaviour change will also have an impact. Examples of work underway include: Age UK are piloting Person Centre Planning in three GP practice for people with long-term conditions. Two GP practices are running pilots for the over 50's who use alcohol with long-term conditions. Also piloting with Spectrum community navigation, with workshops being held June 2015. Southampton Advice Services Alliance (SASA) have developed the advice and information website.	ICU, Moraig Forest –Charde
48.	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.	GREEN	The integrated crisis response, rehabilitation, reablement and hospital discharge provision will focus on promoting independence by having a community cluster focus at all time, developing self-management planning, involvement in risk stratification processes, developing city wide single care planning and information sharing processes and protocols. Focusing on reconditioning pathways in the tender for behaviour change.	ICU, Moraig Forest-Charde

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Care of long-term conditions, including cancer and dementia				
49.	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	**GREEN**	The Better Care Programme aims to address needs of individuals, especially vulnerable older adults. The focus is explicitly on Long Term Conditions and frailty. BCP is in its second year of roll –out. The programme benefits from "pooled" health and social care funding and is given high priority by partner organisations. Prevention and early intervention work relating to the behaviour change review is underway and will have an impact.	Public Health, Bob Coates; ICU, Stephanie Ramsey
50.	Work with GPs to more accurately achieve earlier diagnosis of those most at risk of experiencing dementia	**GREEN**	Focused work undertaken with Primary Care during 2014/15 has resulted in an increased diagnosis rate, preliminary March 2015 data 65%, which is an increase of 10.5% from the March 2014 position. This data will be updated as part of the next phase of the JSNA refresh.	ICU, Amanda Luker
51.	More support for people with dementia to remain in their own homes for as long as it is safe for them to do so.	**GREEN**	Services promoting social inclusion to those living with dementia, working with individuals and families to review and establish self-management goals within a personal programme. Working with the voluntary sector and community settings to improve the health and wellbeing of people living with dementia and to reduce loneliness and social isolation, by participating in a range of activities.	ICU, Amanda Luker
52.	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.	**GREEN**	Extra care provision at Graylings available for individuals with dementia. An innovative project has been running for some time and is being expanded featuring GPS technology to help people with dementia who are at risk of becoming lost and confused in the community. The evaluation of this project is expected in the Summer 2016. This now sits within a range of areas: the wider Better Care agenda; Person centred Planning, Personal Budgets, JES, telecare and telehealth and the Prevention and Early Intervention portfolios. Launched joint equipment store and retail mobility facilities.	ICU / Amanda Luker; Chrissie Dawson
53.	Raising awareness amongst all care and health staff about appropriate responses for people with dementia, mental capacity issues including deprivation of	**GREEN**	NHSE mandate that 80% of front facing staff should receive dementia awareness training. Community Trust has developed a bespoke e-learning package to deliver tier 1 training, and currently reviewing tier 2 and 3 training. An Acute Trust Dementia Strategy is now in place, and linked to the Trust education plan.	ICU, Amanda Luker

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	liberty guidelines and protocols.		VIP training with 5 dementia modules being offered, with additional module being developed. MIND have raised awareness of IMCA/DoLS within hospitals and regularly link closely with residential homes.	
54.	Work with the Clinical Commissioning Group and providers of social care to raise the standard of medicines management across the health and care system.	**GREEN**	Public health advise on medicines evaluation and prescribing policy (across SW Hampshire). CQC and CCG Clinical Governance monitor quality of medicines management. The CCG medicines management team have a comprehensive programme to improve the safety and effectiveness and medicines management.	Public Health, Dr. Bob Coates.
55.	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.	**GREEN**	Public Health have worked with Public Health England, the Saints Foundation and NHS England on cancer awareness programmes including ‘Blood in pee’ and the ‘lung cancer awareness’ programmes. These proved to be effective in increasing the number of diagnoses.	Public Health, Dr. Bob Coates.
Improve the response to learning disabilities				
56.	Work with the Clinical Commissioning Group to ensure the implementation across GP practices of annual health and dental checks for people with learning disabilities.	**GREEN**	A city wide plan has been developed covering, engagement with GPs, Wessex AT, Southern Health, LDPB, Choices Advocacy, people with learning disabilities and their carers. Implementation is planned to reach 50% within 2015/16. More work needs to continue on increasing take up. The Primary Care Joint Committee meeting on 14th January 2016 received an update regarding the Annual Health Checks. Four practices have not signed up to the LD DES which potentially leaves approximately 100 patients not receiving their annual checks. 420 patients have received a coded health check (out of 1,148 - as at the time of the meeting). A reminder has gone out the practices about completing the health checks with their patients. The CCG are undertaking a re-engagement exercise currently, with a view to making stronger improvements in 2016/17. This will also look at the quality of the health checks. The CCG is considering a procurement route for the service from other practices (to cover the surgeries who have not signed up to the DES), as well as picking up any under activity. A working group is established to develop the proposal. Feedback has	ICU, Kate Dench

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			been established from the Learning Disability Partnership Board and there is strong link into the group on further developments. It has also been suggested a “disability friendly” award is set up to encourage practices. Regarding dental checks, there are some key actions that commissioners have undertaken to make improvements in dental services. The Community LD Health team share the Dental Passport when working with patients and carers. Additionally, dental checks are well incorporated into the clinical pathways set up for high risk groups (e.g. challenging behaviour). This is further enhanced within the newly let Domiciliary Care Framework so that all home care providers can support individuals with their dental health (based on their support plan). NHS England commissioned specialist dental services that are well established; feedback is positive regarding the use of these services.	
57.	Better coordinate and promote services which support people with learning disabilities and their carers across the City.	**GREEN**	The online Southampton Information Directory (SID) has been developed to include information about all services available and how they can be accessed. Carers in Southampton services are being promoted widely. Advocacy services have been re-commissioned with a strong emphasis in supporting people with learning disabilities.	ICU, Kate Dench
58.	Encourage partners within the Health and Wellbeing Board to lead by example and produce plans for improving employment of people with learning difficulties.	**GREEN**	Further analysis is required to assess whether partner plans are in place and their effectiveness. The Prevention and Early Intervention work stream received a PID from the Head of Skills and Regeneration in order to progress the development of a business case to establish strengthened employment support for the city’s most vulnerable groups including people with learning disabilities. Key partners across Health and Social care are supportive of progressing this work. Linked to the Learning Disabilities Housing Project a fixed term part time post has been commissioned from City Limits to engage a group of individuals in employment options. This starts in April 2016 and is expected to last for 12 months.	ICU, Kate Dench
59.	Involve the Learning Disability Partnership Board which includes people with learning disabilities in the City in shaping all improvements.	**GREEN**	The Partnership board regularly requests and receives information from the council, CCG and other partners about current service developments and is in involved in shaping them. The Learning Disability Partnership Board has agreed from 16/17 there will be six priority areas for the board, which are: 1. Health	ICU, Kate Dench

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			2. Employment 3. Community Inclusion 4. Independence 5. Carers 6. Person centred approaches/quality Recent examples of how the board have shaped service developments include: Further development of the Learning Disability Annual Health Check so that there is a mechanism within the city for all people with learning disabilities to access their annual health check (this is in progress). Understanding how the Quality and Safeguarding Team work, work has been undertaken to inform a quality audit tool that can be used in Day Services. Choice's Advocacy have also agreed to explore with Busy People and the Quality Team how we can their expertise in a 'quality checker' role. This is in development.	
End of life care				
60.	Increase public awareness and discussion around death and dying.	**GREEN**	Southampton, in conjunction with Health Education Wessex, provided information and awareness sessions through community groups (for Southampton it was Carers Together). Their remit was to develop teaching and training to raise awareness of EOL care planning amongst voluntary organisations and their members.	ICU, Chrissie Dawson/ Carole Binns
61.	Map current provision to ensure that appropriate national care pathways are incorporated and audited in hospitals and the community.	**AMBER**	Southampton are represented nationally to ensure national directives are implemented. Providers have developed and implemented an 'individualised care plan for the last days and hours of life' based on the Achieving Priorities of Care recommendations. End of Life Care Plans are audited through acute hospitals which includes the review of 'do not attempt cardio pulmonary resuscitation' (DNACPR) processes. The AMBER care bundle (a guide for clinicians), which identifies and supports people to achieve their preferred wishes at the EOL, has been rolled out in our acute hospital. The Transform Programme aims to improve the quality of end of life care within acute hospitals, enabling more people to be supported to live and die well in their preferred place. The programme focuses on both the quality of care provided by acute hospitals, as well as the important role acute hospitals	ICU, Chrissie Dawson

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			have, as one of many organisations that may provide care for people who are approaching end of life. End of life care includes care for people in their last years, months and days of life as well as care after death. Developing an end of life 'rapid response' model with acute and community providers to provide support to patients, their families and carers to achieve their preferred place of care/death.	
62.	Extend palliative care to other diseases besides cancer and ensure access to physical, psychological, social and spiritual care.	**Green**	Countess Mountbatten House was successful in a Department of Health grant to improve the facilities at the hospice, the refurbishment included appropriate surroundings to extend care for people with a non-cancer diagnosis approaching EOL, as a result the hospice has seen an increase in the number of people with a non-malignancy receiving care.	Chrissie Dawson
63.	Establish an end of life care register accessible to all appropriate service providers (e.g. Out of Hours Service).	RED	This has slipped for Southampton (and SHIP) as the preferred IT platform has been superseded by the Hampshire Health Record (HHR), with the timescales for the End of Life plans for the end of summer 2015. The EOL care plans which are produced by GP's and Solent Community Teams are uploaded to the HHR as documents under the EOL Care Planning folder. The CCG has commissioned graphnet, the IT supplier of HHR, to develop an automated care plan format which will include all the elements required under EPACCS (Tina has been involved in this). The new care plan formats, which are called CareCentric+ are due to become operational in September this year. They need to go through a period of testing and trialling. This work will also feed into the pan-Hampshire work to develop an interoperability platform under the CHIP Programme. Governance Structures and business cases of the development of this are underway. Dr Mark Kelsey CCG clinical lead is also the lead for the HHR/CHIP. Sean Dawtry is the rep from SCC on this programme.	ICU / Chrissie Dawson
64.	Have timely bereavement counselling available.	AMBER	Family member/carers receive an initial contact from the provider who cared for their deceased relative, with signposting to appropriate services as required. Work is continuing with providers and the voluntary sector to ensure feedback from the national VOICES survey is considered going forward. Bereavement support is provided for in-patients and their families/carers at Countess Mountbatten Hospice. Wider bereavement support is being considered in line with the EOL strategy refresh and developed in conjunction with bereavement charities.	ICU / Chrissie Dawson