Hampshire and Isle of Wight

Southampton City Five Year Health and Care Strategy 2020-2025

Progress update – November 2022

Southampton City Health & Care Strategy

2020-2025

Our vision

"A healthy city where everyone thrives"

Our goals

- Reducing **inequalities** and addressing **deprivation**
- Working with people to build **resilient communities** and **live independently**
- Improving **earlier help, care and support**
- Tackling the city's **biggest killers**
- Improving **mental and emotional** wellbeing
- Improving **joined-up, whole-person care**

Our priorities

Start Well

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

Live Well

People will achieve and maintain a sense of wellbeing by leading a healthy lifestyle supported by resilient communities

Age Well

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

Die Well

People are supported to ensure the last stages of their life happen in the best possible circumstances, receiving the right help at the right time from the right people

Our two cross-cutting programmes and three key enablers:

- Primary Care
- Urgent & Emergency Care
- Digital
- Workforce
- Estates

Hampshire and Isle of Wight

Start Well Progress Update

November 2022

Reminder of our five year vision for Start Well

Start Well

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

In five years time, we want children and young people in Southampton to:

- Live happy, healthy lives, with good levels of physical and mental wellbeing
- Be safe at home and in the community, with Southampton being a child-friendly, family focussed city.
- Have good levels of educational attainment, fulfil their potential and go on to successful opportunities in adulthood.
- Live in communities which are resilient, engaged and prepared for the future.

Start Well – Original Roadmap & Progress to date

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

Year 1 2020/21

- Year of the Child
- Early Help locality model
- Local foster care offer expanded
- Two mental health support teams in schools established
- Phoenix specialist family service goes live
- Implementation of children's psychiatric liaison service

Year 2 2021/22

- Children's Hospital at Home service goes live
- Expansion of mental health support teams in schools and a whole school approach to mental health and wellbeing
- Employment and training opportunities expanded for young people
- Development of local residential provision

Year 3 2022/23

- 0-25 year service offer in place
- Expansion of mental health support teams in schools
- Employment and training opportunities further expanded for young people

What have we done?

- **Child Friendly** City – Southampton now formally onboarded onto UNICEF UK programme (1st South Coast city in UK), 1st children's mayor appointed, rights based practice already influencing local strategies, e.g. Domestic Abuse, Prevention & Early Help and Safe City Strategies. 2200+ children and young people engaged
- **Reconfiguration of Children's Services into localities, strengthening Early Help and Young People's Services** – locality based Children and Family First service (Early Help) launched April 2021; new locality based **Young People's Service** launched Autumn 2022
- Development of **SEND early help offer** – roll out of parenting support into localities, Autism in Schools project extended to a further 10 schools (in addition to original 5)
- **Children's Hospital at Home** service went live Spring 2022: worked with 545 CYP from Apr-Oct-22 of which 92% continued to be managed in the community
- **Mental Health Support teams in schools** established – covering 90% of city's school population by end 2022/23 – and rolling out whole school approach to emotional and mental wellbeing
- **Children's psychiatric liaison** service in hospital is fully operational weekdays 9am – 10pm, 9am – 5pm weekends. Under 10% of CYP they have seen have required onwards admission to wards
- Appointment of **Preparing for Adulthood Champion** to improve transition planning
- **Phoenix Service**. The first community of Pause women is coming to a close. All 19 women successfully maintained relationships with professionals. The 2nd community of women began in September. Therapeutic pathway provided by Yellow Door has been very successful
- **Multidisciplinary Teams around Schools** – 3 pilots established

What are we still planning?

- Ongoing development towards a **Child Friendly City** – moving through 3-stage process of Discovery, Development and Implementation, with key priorities established by Dec 22 which will be the focus of 3-5 years Delivery Phase
- Development of a single point of access for **Early Intervention Mental Health support** across the City, aligned to the Children's Resource Hub
- Development of **local residential provision** including a short stay crisis/assessment unit (go live Q3 23/24) and expansion of local **foster care** offer and **Supported Lodgings**
- Improved support offer to vulnerable young people and **care leavers** to improve housing and employment outcomes
- Development of information and guidance on employment and housing to support young people **Preparing for Adulthood** and development of an extended offer of support and activities in the community – Transition Fayre planned for March 23

Key points – Children and Young people

- 20/21 Smoking at time of delivery (10%) remains higher than England (9%) but percentage decreasing overall trend
- Low birth weight (2020) significantly increased from previous years and now significantly higher than England average. Breastfeeding prevalence at 6-8 weeks after birth increasing and higher than national average (53% vs. 45%)
- Excess weight in 4/5 years old and 10/11 years old higher than England (20/21) and with a steeper overall increase
- Looked after children rate similar 2019 to 2021, higher than national but gap reducing. School readiness following national increases and MMR vaccination (age 2) recent years significantly higher and increasing overall trend vs. national decline
- Teenage conception decreased overall at a faster rate than nationally over last 15 years, despite significantly higher than England in 2020 (2018 and 2019 was statistically similar)
- Children in relative low income families, consistently significantly higher than England (20/21) and gap getting worse
- Hospital admissions caused by unintentional and deliberate injuries in children under 15 years lowest rate in last 10 years (20/21)
- Hospital admissions for mental health conditions reducing but still significantly higher than England average (20/21)
- 16-17 year olds not in education, employment or training has been rising and is significantly higher than England average and worse than most of our comparators (2020)

Key points – Children and Young people

Five Year Health and Care Strategy Scorecard

November 2022

Better Care Southampton
working together to make a difference

NHS
Hampshire, Southampton and Isle of Wight
Clinical Commissioning Group

Priority area	Measure	Unit	Latest period	Southampton Sparkline	Southampton value	England value	ONS (n=12) Comparator Ranking (1 is worse, worst third in pink)	Significance compared to England value
Children & Young People/Early years	Smoking status at time of delivery (Female)	%	2021/22		9.7	9.1	6	Higher
	Low birthweight of full term babies	%	2020		3.8	2.9	2	Significantly Higher
	Breastfeeding prevalence at 6-8 weeks after birth - current method	%	2021/22		53.4	49.3	4 of 7	Significantly Higher
	Population vaccination coverage - MMR for one dose (2 years old)	%	2021/22		91.7	89.2	8	Significantly Higher
	Population vaccination coverage - Dtap / IPV / Hib (2 years old)	%	2021/22		94.5	93.0	9	Significantly Higher
	Child excess weight in 4-5 year olds	%	2021/22		22.4	22.3	5	Higher
	Child excess weight in 10-11 year olds	%	2021/22		39.8	37.8	7	Significantly higher
	Hospital admissions caused by unintentional &deliberate injuries in ch	per 10,000	2020/21		65.0	75.7	9	Significantly Lower
	Hospital admissions for mental health conditions (<18 yrs)	per 100,000	2020/21		115.8	87.5	3	Significantly Higher
	Under 18s conception rate / 1,000 (Female)	per 1,000	2020		20.7	13.0	2	Significantly Higher
	Children looked after	per 10,000	2021		96.0	67.0	3	Significantly Higher
	Children in relative low income families (under 16s)	%	2020/21		22.2	18.5	6	Significantly Higher
	Children attaining 5 or more GCSEs - Average attainment 8 score	Mean Score	2020/21		46.9	50.9	3	Significantly Lower
	16-17 year olds not in education, employment or training (NEET)	%	2020		7.6	5.5	4	Significantly Higher
	First time entrants to the youth justice system	per 100,000	2021		174.7	146.9	7	Higher

Inequalities – Children and Young People

Comparing the most deprived 20% of Southampton to the least deprived 20%, outcomes for children and young people show inequalities:

Mothers smoking at booking

4.1x higher

Breastfeeding at initial check

1.4x lower

Mental Health/Psychosocial conditions (per 1k children)

1.5x higher

Healthy weight

1.1x lower for Year R children

1.2x lower for Year 6 children

Child poverty

3.7x higher

Average Attainment 8 Score

1.3x Lower

Youth Violent Crime (per 1k children)

3.2x higher

Drug use (per 1k children)

7.8x higher

Alcohol use (per 1k children)

5.1x higher

Children experiencing neglect or abuse (per 1k children)

4.9x higher

Looked after children

4.1x higher

Note: Uses local deprivation quintiles

2022/23 Proposed Priority Areas for Focus & Rationale

Reducing childhood obesity

- Remains a challenge – particularly worsening between Year R and Year 6 – particularly during the pandemic years
- Local City Strategy recently published
- This is a key area requiring a focussed whole system effort – healthy eating, physical activity, attitudes to food, access to affordable healthy foods are key themes which extend far beyond traditional health services

Improving children and young people's emotional and mental wellbeing

- Mental health is everyone's business – all partners have a contribution to make
- A person's mental health will have a significant impact on all aspects of their life and ability to achieve positive outcomes for themselves and their families
- A whole family approach is key to promoting positive mental health and identifying and responding to risk factors – all services have a part to play in this and more can be done jointly between children and adult services
- This is an area that has particularly worsened during the pandemic as evidenced by increasing referrals to specialist CAMHS & rising numbers of young people in crisis

Improving outcomes in the Early years (First 1001 Days of Life)

- Health and wellbeing in the first years of a person's life, particularly from conception until 5 years of age, has a significant impact into adolescence and adulthood. Giving every child the best start in life is endorsed as the most important recommendation for reducing health inequalities in the Marmot Review as it can break the links between early disadvantage and poor outcomes later on
- Good Start in Life is one of the key priorities in the Children & Young People's Plan and identified by the HWBB as its key priority for 22/23
- This is an area that all services and partners can contribute to

What are the challenges for Start Well?

Upcoming challenges	Key actions
Increasing demand in referrals, waiting lists and waiting times	▪ Strengthening Early Help and prevention ▪ Multiagency approaches to identifying and managing vulnerable families
Workforce	▪ Joint recruitment campaigns – whole city approach to making Southampton a good place to work ▪ Health and wellbeing of staff ▪ Collaborative working with providers in staff retention ▪ Continued exploration/evaluation/use of digital/different ways of working ▪ Joint training programmes, e.g. Emotional Wellbeing workforce development programme
Improving IT infrastructure	▪ Exploration of opportunities with new CareDirector system ▪ Exploration of CHIE – greater application in children's services
Capacity of the voluntary sector	▪ Work with the voluntary sector to understand pressures ▪ Support in identifying alternative funding streams

Hampshire and Isle of Wight

Live Well
Progress Update

November 2022

Reminder of our five year vision

Live Well

People will achieve and maintain a sense of wellbeing by leading a healthy lifestyle supported by resilient communities

In five years time, we want people in Southampton to:

- Live healthier, for longer
- Be happy in life and feel supported by their family, friends and local community
- Live independently and feel confident to take care of their own health and wellbeing
- Live in a city which is fully accessible.

Live Well – Original Roadmap

Year 1 2020/21

- **Lung Health Checks** fully implemented to increase the early detection and survivorship of cancer
- Patients will be able to receive a **definitive cancer diagnosis** within 28 days of referral
- **Cervical screening** implemented at more flexible timings
- Community **Cardiology and Respiratory** service developed
- Psychology therapy support available for people with cardiovascular or gastrointestinal conditions
- Development of an **Integrated Diabetes Service** that will be measured on improving outcomes for patients living with diabetes
- Introduce risk stratification to identify individuals with a **learning disability** who have the greatest need
- Expand portfolio of **housing options** for those with a learning disability/mental health need
- Implement **"The Lighthouse"** community based facility to support those experiencing a mental health crisis
- Pilot a complex nurse worker in **Homeless Healthcare** to work with people with complex needs, including mental health refocus in 201/22 as return to BA following redirected work to support homeless population during Covid.
- Review best practice models for mental health services accessed by **rough sleepers**

Year 2 2021/22

- New Southampton **Alcohol** strategy launched
- All patients have access to **on-line and video consultations** for their GP surgery
- Every person diagnosed with cancer will have access to **personalised care,** including a care plan and health and wellbeing information and support
- **Follow up support** for people who are worried their cancer may have recurred will be in place
- New **heart failure** and breathlessness services developed
- People with a **mental health** condition will be able to access digitally enabled therapy
- **Therapeutic care** from inpatient mental health services will be improved
- Produce a proposal for an effective mental health pathway for **rough sleepers** to access integrated holistic, long term care and support, service options emerging in development - ongoing

Year 3 2022/23

- Community **Cardiology and Respiratory** service fully in place
- Implement new mental health services for **rough sleepers**
- Every person diagnosed with cancer will have access t **personalised care,** including a care plan and health and wellbeing information and support
- **Follow up support** for people who are worried their cancer may have recurred will be in place

Live Well – Progress to date

What have we done?

Tackling the city's biggest killers

- **Cancer services** showing continued delivery of **Faster Diagnosis** standard
- **Cancer screening** work underway to increase uptake of **cervical screening in women with learning difficulties and severe mental illness and prostate self referral**
- Work with providers to increase uptake of **Faecal Immunochemical Testing** for all new Lower Gastrointestinal referrals in line with national guidance
- **Wessex Cancer Alliance** working with communities to **improve early detection of cancer**
- **Targeted Lung Health Check programme** for earlier detection lung cancer (55–74 year olds) has invited 22,829 patients for lung health check, completed 7,791 & identified 132 lung cancers (76% stage 1). Programme will be expanding to Totton and Eastleigh in 2023
- Increased access to **psychological therapies**, including those with Long Term Conditions
- **Diabetes – new integrated service** launched in June 2022 in 3 PCN areas, and **WISDOM programme** further developed with primary care to improve Diabetes management
- **Heart Disease** – provided **additional equipment** (blood pressure and portable ECG monitoring devices) to GPs to support the early detection of Atrial **Fibrillation.** Secured £11k additional funding to pilot Activate Your Heart online cardiac rehab training and also to expand the digital Heart Failure service

Supporting the most vulnerable

- **I**ncreased sustainable **housing options for people with Learning Disabilities**
- **Risk Stratification pilot for people with LD** completed and being used to shape service provision
- Achievement of 'exemplary' quality mark for Southampton **Mental Health Individual Placement and Support Service** (210 people reached).
- Hub and Spoke model for **Adult Eating Disorders** established with Eating Disorders Hub and Adult Eating Disorders Local Incentive Scheme.
- New PCN based **Enhanced Primary Care Mental Health** roles, delivering evidence based individual and group interventions
- Development of **Southampton Mental Health Network and Southampton Mental Illness Lived Experience (SMILE) Network**
- Additional **Mental Health support for Rough Sleepers**
- Introduction of **Early Intervention in Psychosis cannabis prevention peer-led group** providing support and psychoeducation
- **Gambling Harm** Clinic launch in Southampton with expansion plans across ICS
- Expansion of the ICS Wide **Mental Health Rapid Response** vehicle and dedicated Mental Health crisis care liaison lead in South Central Ambulance
- New **Suicide and Bereavement Support** Service
- Mobilisation of new **IAPT** contract, re-design of service provision to localities and integrated working with Enhanced Primary Care Mental Health Teams
- Increase in provision of **Memory Cafes** in the city and delivery of Dementia Navigation
- Development of a second **Lighthouse** in Bitterne.
- Recommissioning of **Housing Related Support Services** incl development of new Housing First offer
- Recommissioning of **Domestic and Sexual Abuse services**
- Increasing the number **of NHS Health checks** completed by GP practices since Covid-19
- **Sexual health needs assessment**

Live Well – Progress to date

What are we still planning to do?

Tackling the city's biggest killers

- **More smokefree services** and settings
- New SCC tobacco, alcohol and drugs strategy in development to run 2023 – 2027.
- Engaging with ICB clinical workstreams to deliver **improvements in Ophthalmology, ENT, Gynaecology, Urology, Orthopaedics and General surgery**
- Maximise use of **Faecal Immunochemical Testing** to detect bowel cancer
- Working with the WCA to deliver **cancer** programmes and plans including the **Rapid Investigation Service** to support faster diagnosis and Right By You to support personalised care
- Work with **UHSFT to evaluate and support the Heart Failure Service** to build upon established digital pathway
- **Respiratory** - **easier-to-access diagnostics and consumables outside of hospital,** and develop an ICS breathlessness pathway
- **Embed the new Diabetes Integrated service** and work with Solent NHS Trust and PCNs to improve achievement of key treatment targets (blood pressure, blood sugar and cholesterol) for people with Diabetes
- **Eye health – additional capacity in primary care optical practice** to reduce pressure on the eye hospital, improving treatment times and patient experience

Supporting the most vulnerable

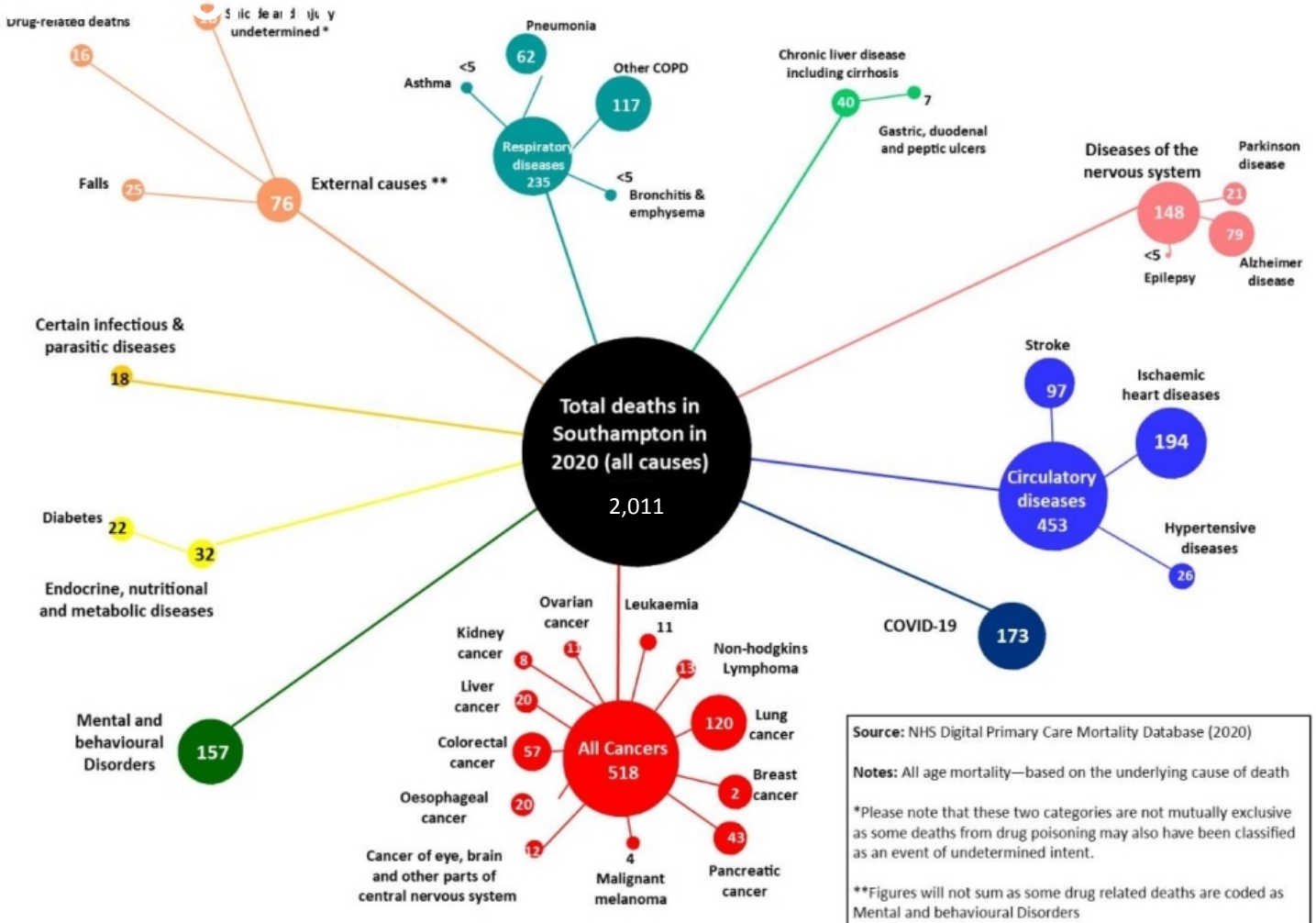
- Coproduction of **Inclusive Lives** –a new model of support which promotes opportunities for employment, skills development, travel, community activities, advice & information for people with LD
- **Sex Workers outreach service** to support health and wellbeing of women selling sex on the street
- Ongoing implementation of **Suicide Prevention strategy,** including digital development of SHOUT to increase digital access to people in mental health crisis
- Improved **housing and support for people with Severe mental illness,** including completion of Mental Health Housing Needs Assessment and Market Position Statement
- Continue to **support people with learning disabilities to live more independently** - 58 new tenancies planned over the next 2 years, primarily apartment style accommodation plus additional homes that support complex needs
- Development of **MH services for 16 – 25** year olds, involving local statutory, voluntary and service user organisations
- Complete
- Launch Southampton **MH grant giving scheme** to strengthen VCSE growth and building community assets, development of Saints by you Side programme for men, and Mayfield Nurseries horticultural therapy programme.
- Broadening the MH offer within PCNs (carer support, housing, employment alongside the social prescriber role).
- Delivery of evidenced based multi-modality model and pathways for adults with **personality disorder and complex trauma.**

Key points – Adults

- Smoking prevalence – data quality issues with 2020 figure; true value likely to be between 2019 & 2020 figures – improving picture but still higher than England average
- Alcohol hospital admissions – data impacted by changes in coding – rate still significantly higher than England average and our comparators
- All Cancer screening significantly lower than England average and most of our peers
- Premature deaths from all causes significantly higher than England average – cancers also significantly higher than our comparators
- Adults with LD in paid employment significantly lower than England average and our peers, though this has improved since the 19/20 position & is now 3.9%

Priority area	Measure	Unit	Latest period	Southampton Sparkline	Southampton value	England value	ONS Comparator Ranking (1 out of 12 is worse, worst third in pink)	Significance compared to England value
Adults	Smoking Prevalence in adults (18+) - current smokers (APS)	%	2020		11.8	12.1	8	Lower
			2019		16.8	13.9		Significantly Higher
	Alcohol-specific emergency admissions	per 100,000	2020/21		2275.8	586.6	1	Significantly Higher
	Intentional self-harm emergency admissions	per 100,000	2020/21		383.1	181.2	1	Significantly Higher
	COPD emergency admissions	per 100,000	2019/20		677.0	415.1	3	Significantly Higher
	Major diabetic lower-limb amputations	per 10,000	2017/18 - 19/20		9.6	8.1	5 of 11 CCG	Higher
	Breast cancer screening	%	2021		53.5	64.1	1	Significantly Lower
	Cervical cancer screening - aged 25 to 49 years old	%	2021		59.3	68.0	1	Significantly Lower
	Cervical cancer screening - aged 50 to 64 years old	%	2021		69.3	74.7	2	Significantly Lower
	Bowel cancer screening	%	2021		61.8	65.2	5	Significantly Lower
	Premature deaths - all causes (Under 75)	per 100,000	2018 - 20		390.0	336.5	6	Significantly Higher
	Premature deaths - cancer (Under 75)	per 100,000	2017 - 19		158.0	129.2	2	Significantly Higher
	Premature deaths - cardiovascular disease (Under 75)	per 100,000	2017 - 19		80.8	70.4	5	Significantly Higher
	Premature deaths - respiratory disease (Under 75)	per 100,000	2017 - 19		44.4	33.6	4	Significantly Higher
	Life expectancy at birth (Male)	Years	2018 - 20		78.3	79.4	5	Significantly Lower
	Life expectancy at birth (Female)	Years	2018 - 20		82.5	83.1	7	Significantly Lower
	Depression and anxiety prevalence - Depression	%	2020/21		12.4	12.3	5th highest	Higher
	Adults with learning disability having a GP health check	%	2018/19		57.7	52.3	10 of 11	Significantly Higher
	Adults with learning disability in paid employment	%	2019/20		2.9	5.6	1 of 11	Significantly Lower
	Persons detained under the Mental Health Act (of those known to services)	%	2019/20 Q2		1.1	1.0	7 of 11 CCG	Higher
	People with long term Mental Health problems - QOF serious mental illness	%	2020/21		1.1	1.0	2	Higher
	Percentage of people aged 16-64 in employment	%	2021/22		74.3	75.4	5	Lower
	Homelessness - households in temporary accommodation	per 1,000	2020/21		1.6	4.0	7	Significantly Lower
	Homelessness - households owed a duty under the Homelessness Reduction Act	per 1,000	2020/21		12.1	11.3	7	Significantly Lower
	Violent crime - hospital admissions for violence (incl. sexual)	per 100,000	2018/19 - 20/21		64.4	41.9	3	Significantly Higher
	Violent crime - violence offences per 1,000	per 1,000	2021/22		57.9	34.9	1st highest	Significantly Higher
	Violent crime - sexual offences per 1,000	per 1,000	2021/22		4.9	3.0	1st highest	Significantly Higher

Mortality – Underlying causes of deaths



Source: NHS Digital Primary Care Mortality Database (2020)

Notes: All age mortality—based on the underlying cause of death

*Please note that these two categories are not mutually exclusive as some deaths from drug poisoning may also have been classified as an event of undetermined intent.

**Figures will not sum as some drug related deaths are coded as Mental and behavioural Disorders

Inequalities - Mortality

southampton dataobservatory

In the most deprived quintile compared to the least…

All Causes

All age mortality

1.5x higher

Premature (u75) mortality

2.0x higher

2018 to 2020

Cancer

All age mortality

1.4x higher

Premature (u75) mortality

1.5x higher

2015 to 2017

Circulatory Disease

All age mortality

1.3x higher

Premature (u75) mortality

1.9x higher

2015 to 2017

COPD

All age mortality

2.9x higher

2015 to 2017

Note: Uses local deprivation quintiles

Live Well – 2022/23 Proposed Priorities for Focus & Rationale

Improving Mental Health & Tackling loneliness

- Mental health is everyone's business – all partners have a contribution to make
- A whole family approach is key to promoting positive mental health and identifying and responding to risk factors
- This is an area that has particularly worsened during the pandemic as evidenced by increasing referrals, higher rates of hospital admission and depression compared to the England average and our comparators
- Risk factors for poor mental wellbeing include physical inactivity, tobacco, alcohol and drugs. We Can Be Active strategy and the tobacco, alcohol and drugs priority will support mental wellbeing

Improving life chances for the most vulnerable, tackling inequalities

- People with learning disabilities and mental health problems are particularly at risk of poor outcomes. Premature mortality rates are higher than the general population. They are less likely to be living in good accommodation and accessing paid employment (only 3.9% of people with LD are in employment compared to 4.8% England average).
- People living in the 20% most deprived wards suffer from significantly worse health – 2.9 times more likely to get COPD, 1.4 times more likely to get cancer
- There are opportunities at place to work together and with partners across sectors such as housing, employment & communities to address the wider determinants of health and improve life chances for these groups

Reduce harm from tobacco, alcohol and drugs

- Tobacco, alcohol and drugs are major contributors to premature deaths and health inequalities – Southampton's rate of premature deaths is significantly higher than the England average (particularly cancer, cardiovascular & respiratory illness)
- Cancer and circulatory disease are the biggest causes of death in Southampton
- Smoking rates in Southampton remain high compared to the national average and correlate with deprivation.
- Alcohol harm is significantly higher than England average and worse than our comparators
- Populations who would benefit from more prevention and support include pregnant women, people with severe mental illness and children exposed to harm from adults.
- A place based approach to tobacco, alcohol and drugs has the potential to significantly improve health. The forthcoming SCC tobacco, alcohol and drugs strategy has a health in all policies approach. The NHS Long Term Plan promotes a smokefree NHS too.

What are the challenges for Live Well?

Upcoming challenges	Key actions
Recovery from COVID period	▪ Continue with communications/ other campaigns to encourage people to attend appointments. ▪ Continue to prioritise elective activity/reducing waiting lists ▪ Continue to prioritise elective activity/reducing waiting lists
Prioritising Public Health during period of change	▪ Improved monitoring of impact of Public Health investment ▪ Optimise NHS Long Term Plan emphasis on prevention and data quality, and new funding. Smoking cessation high impact intervention. ▪ Optimise role of public sector as anchor organisations ▪ Build on covid community engagement
Workforce	▪ ICS wide HR workforce development ▪ Continue to promote health and wellbeing of staff ▪ Continued exploration/evaluation/use of digital/different ways of working
Increased demand on mental health services	▪ Strengthening Early Help and prevention ▪ Additional crisis investment – Lighthouse on East of city ▪ Additional investment to reduce waiting lists ▪ Improve pathways and support for people with co-occurring alcohol and drug use disorders
Housing stock for independent living for all single vulnerable adults	▪ Proactive work with developers to identify opportunities for new developments ▪ Use of SCC housing stock and land options where appropriate ▪ Partnering with ICS on schemes where beneficial
Community and voluntary sector market	▪ Proactive work with market – co-production of new models of support ▪ Transition arrangements which support development of the market

Hampshire and Isle of Wight

Age Well
Progress Update

November 2022

Reminder of our five year vision

Age Well

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

In five years time, we want people in Southampton to:

- Be able to maintain their health, wellbeing and independence into old age, stay living in their own homes and feel part of their local communities.
- Be supported to recover from illness in their own home wherever possible and only go to or stay in hospital when needs can't be met in the community.
- Be supported by collaborative and integrated working between health, social care and housing support.
- Be able to access the right support, at the right time, in the right place, as close to home as possible.
- Feel in control of their health and wellbeing, be part of any decision about their care and have the information and support they need to understand and make choices.

Age Well – Original Roadmap and Progress to date

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

Year 1 2020/21

- Integrated community teams, 'One Team', across Southampton – beginning to operate
- Enhanced healthcare teams supporting all residential and nursing homes across the city
- Community navigators (social prescribers) in place across Primary Care
- Exercise classes in place for people at risk of falling
- More dementia friendly spaces in place
- Extra Care housing scheme at Potters Court opens
- Risk stratification rolled out to tackle inequalities and case manage people with the greatest needs
- Multiagency services at the hospital front door – with a 'Home First' principle

Year 2 2021/22

- Care technology support becoming the norm in enabling people to maintain their independence
- Health and care professionals using single care plans enabled through technology
- Single intermediate care team operating across hospital, community & primary care

Year 3 2022/23

- Integrated community transport service in place
- More intergenerational opportunities and older people volunteering
- Further increase in Extra Care homes available
- Health and care professionals across all sectors, including care homes and home care providers making active use of single care plans to share information and use technology to seek rapid advice from each other
- Enhanced healthcare teams providing support to extra care housing

What have we done?

- Age Well Strategy in place
- Extra Care housing scheme at Potters Court opened
- Carers Strategy launched
- Transformation of discharge process and roll out of Discharge to Assess at scale
- Establishment of community Health & Care Single Point of Access coordinating hospital discharge
- Advice, support & workforce development to the social care market– including the roll out of care technology (Restore 2) and introduction of Trusted Assessors reducing delays in hospital discharge
- Delivery of Virtual Ward service to approx. 360 individual patients enabling additional capacity for earlier supported discharge and alternatives to admission.
- Expanded Urgent Community Response service with 88% seen within 2 hours
- Continued development of One Team/Integrated Care Teams with 4 out of 6 PCNs having a maturing approach in place.

What are we still planning?

- Review of the Discharge to Assess process, building on what has worked, learning from what hasn't and ensuring its future financial sustainability
- Development of a fully integrated Transfer of Care Hub to support both discharge and people in crisis in the community
- Continued development of community health & care capacity to meet increasing complexity of need
- Re-procurement of a new model of short term recovery & assessment beds and expansion of reablement offer to enable more people to maintain/regain their independence
- Workforce development, recruitment and retention across health and care
- Increasing Virtual Wards utilisation and preparation for expansion in year 2
- Promoting Urgent Response Service access, particularly to under 80 yr. olds
- Further embedding the One Team model and proactive case management work.
- Embedding digital opportunities e.g. CHIE digital Interoperability, use of Care Technology
- Procurement of an integrated community transport solution
- Continued development of community navigation and community development
- Implementation of We Can Be Active strategy (all age) and forthcoming SCC Tobacco, Alcohol and Drugs Strategy

Performance against key measures

- Hospital admissions related to Injuries due to falls in adults aged 65+ significantly higher than England average and our peers, although has reduced in recent years
- Permanent admissions to residential care has been decreasing but still significantly higher than England average and most of our comparators
- Suicide rates amongst males aged 65+ higher than England average and worse amongst our comparators, though have been reducing
- Deaths from respiratory disease significantly higher than England average and our comparators
- Life expectancy lower for both men and women than England average
- Adults living in income deprived households significantly higher than England average
- New fuel poverty measure show those living in fuel poverty is lower than the national average

Priority area	Measure	Unit	Time period	Southampton Sparkline	Southampton value	England value	ONS (n=12) Comparator Ranking (1 is worse, worst third in pink)	Significance compared to England value
Older people	Dementia: QOF prevalence (all ages)	%	2020/21		0.5	0.7	12 / Lowest	Lower
	Dementia emergency hospital admissions	per 100,000	2019/20		5507.0	3517.0	1	Significantly Higher
	Injuries due to falls in people aged 65+ years (Persons)	per 100,000	2020/21		2919.0	2023.0	2	Significantly Higher
	Injuries due to falls in people aged 65+ years (Male)	per 100,000	2019/20		2659.4	1667.3	2	Significantly Higher
	Injuries due to falls in people aged 65+ years (Female)	per 100,000	2019/20		3092.8	2284.8	3	Significantly Higher
	Adults using social care who receive self-directed support, and those using direct	%	2020/21		90.9	91.6	5	Lower
	Permanent admissions to residential and nursing care homes per 100,000 aged 65+	per 100,000	2020/21		701.0	498.0	4	Significantly Higher
	Excess winter deaths (85+ years)	%	2019 - 20		7.0	20.8	12	Lower
	Suicide rate (65 years+) - Males	per 100,000	2013-17		19.2	12.4	1	Higher
	Suicide rate (65 years+) - Females	per 100,000	-	Data unavailable	N/A	N/A	-	Not compared
	Deaths from respiratory disease (65 years+) - mortality rate	per 100,000	2020		624.1	495.3	2	Significantly Lower
	Deaths from cardiovascular disease (65 years+) - mortality rate	per 100,000	2020		1076.9	1007.0	4	Higher
	Life expectancy at 65 years (Male)	Years	2018 - 20		17.9	18.7	5	Significantly Lower
	Life expectancy at 65 years (Female)	Years	2018 - 20		20.7	21.1	8	Significantly Lower
	Adults living in income-deprived households (60 years+)	%	2019		17.3	14.2	6	Significantly Higher
	New Fuel poverty (low income, low energy efficiency methodology)	%	2020		12.5	13.2	9	Lower

Age Well – 2022/23 Proposed Priorities for Focus & Rationale

Proactive Care Approach

- Opportunities to develop a refreshed understanding of Public health challenges for our older population and build on the successes of Population Health Management
- Work has already commenced on a One Team approach and integrated care – there are opportunities to build on this, focusing on the areas identified and successes
- We are well placed as a city to promote partnership working between integrated care and CVSE
- Significant opportunity to roll out prevention and early intervention

What are the key challenges for Age Well?

Upcoming challenges	Key actions
Move to virtual/remote offers – ensuring older people who may have less access to digital means continue to have access	▪ Range of offers considered – ▪ Phone, IT and where Covid safe, face to face ▪ Proactive approach for the most vulnerable people in receipt of services ▪ Promotion of the community hub, to provider volunteer support with key areas e.g. food and medication delivery
Economic impact on individuals	▪ Advice and guidance offer available in an accessible manner to this group.
Access to health provision	▪ Review of GP coding ▪ Consideration of risk to this client group during restoration planning
Older persons physical activity and well being.	▪ Implement We Can Be Active Strategy and action plan

Hampshire and Isle of Wight

Die Well
Progress Update

November 2022

Reminder of our five year vision

Die Well

People are supported to ensure the last stages of their life happen in the best possible circumstances, receiving the right help at the right time from the right people

What do we want to be different in five years' time?:

- More people will be supported to stay at home when they experience a decline in their health within their last years of life.
- There will be equality in provision of end of life care across all socioeconomic backgrounds.
- More people will achieve their preferred place of care and death.
- Early identification and end of life discussions will be the norm; more people will be describing their end of life wishes and preferences.
- There will be local, compassionate communities who are confident to talk about and support friends and neighbours who may be experiencing death and dying.
- Proactive, personalised care planning to help people to consider their end of life wishes and options for a Personal Health Budget will be the norm
- More palliative care patients will have continuity of care and support across all health and care settings.
- Bereavement care will improve the involvement, support and care for all those important to the dying person.

Die Well – Original Road Map & Progress to Date

Year 1
2021/22

- **24/7 coordination centre** with access to rapid response 24 hour advice, support and home visits
- Development of **end of life champions**, linking with primary care and communities
- **Bereavement services** expanded
- Review the provision of access to end of life services for professionals and the families of **children at or approaching end of life**

Year 2
2022/23

- **Nurse-led unit** in place at Countess Mountbatten Hospice
- **Independent hospice provision** in place for Southampton
- Everyone in a care home is identified on an **end of life register** with an **advanced care plan** in place
- **End of life training** available to home care staff
- Work with children's services and families to design local **end of life services for families and children**

Year 3
2023/24

- Development of an **end of life schools programme**

Year 4
2024/25

- **Children's end of life care** services in place
- Bank of end of life children's home care /sitting service

What have we done?

- 24/7 telephone helpline implemented for patients, their families and professionals providing a central point of contact
- Access to rapid response 24 hour advice and support
- Offer of bereavement care extended beyond patients & families known to Mountbatten and bereavement support offer to all residential care home staff
- Virtual End of Life training available to all external providers and Six Steps education programme in residential and nursing homes
- Virtual day care group offering exercise, bereavement support, support for people with fatigue and breathlessness
- Hospice@Home service developed – including the function previously known as palliative care support worker
- Implementation of Nurse Led Beds
- Bereavement support project for Care Home Staff taking into consideration the impact of the pandemic

What are we still planning?

- Implement End of Life register and early identification of people who are in the last 3 years of life
- Roll out and increase uptake of CHC Fast Track/rapidly deteriorating personal health budgets and work to increase numbers of personalised care and support plans for all patients who are EOL
- Work to ensure end of EOL services meet the needs of specific groups e.g. LD, dementia, children and homelessness

Performance against key measures

- Data for this workstream is limited by what is readily available and so has focussed on place of death – consideration will need to be given to additional metrics in future, e.g. uptake of personal budgets, early identification of people on End of Life Register
- Percentage of deaths that occur in usual place of residence (all ages) has been increasing but is below the England average – this is similar for cancers, dementia and circulatory diseases but respiratory deaths in usual place of residence are slightly higher than the England average

Priority area	Measure	Unit	Time period	Southampton Sparkline	Southampton value	England value	ONS (n=12) Comparator Ranking (1 is worse, worst third in pink)	Significance compared to England value
Healthy settings	% of deaths that occur in hospital (all ages)	%	2021		43.0	44.0	6	Lower
	% of deaths that occur in care homes (all ages)	%	2021		18.4	20.2	8	Lower
	% of deaths that occur at home (all ages)	%	2021		29.0	28.7	5	Higher
	% of deaths that occur in usual place of residence (all ages)	%	2017		42.5	46.6	3rd highest	Significantly Lower
	% of deaths that occur in usual place of residence - cancer (all ages)	%	2016		42.9	44.5	7th highest	Lower
	% of deaths that occur in usual place of residence - circulatory disease (all ages)	%	2016		43.9	44.8	8th highest	Lower
	% of deaths that occur in usual place of residence - respiratory disease (all ages)	%	2016		33.3	32.2	6th highest	Higher
	% of deaths that occur in usual place of residence - dementia and Alzheimer's (65+)	%	2019		67.8	70.3	9th highest	Lower

Die Well – Proposed Priorities for Focus & Rationale

Early identification of people at End of Life

- By identifying people earlier, we can improve outcomes for both them and their families, enabling people to plan and make choices and exercise greater control over where they die
- There are opportunities, working with the Age Well and Live Well programmes and through the One Teams approach, to promote early identification of people who may be in their last 3 years of life.
- There are opportunities to establish an end of Life register with partners
- As a system, through the most appropriate approach, we can promote anticipatory care planning for those entering the last 3 years of life

Promote accessibility of End of Life care for all

- There are certain groups who do not have good access to end of life care and support.
- Working with partners at place, we have the opportunity to promote accessibility of End of Life support for groups who find it more difficult to access care and support, e.g.
- people experiencing Homelessness
- people living with a learning disability
- people living with dementia

Out of Hospital End of Life Care Co-ordination

- We can improve end of life outcomes by better coordinating care in the community
- By working with PCNs, UHS, CCG, CHC, NHS Solent, Adult Social Care and Mountbatten Hampshire (MH) we could expedite referrals for people who are rapidly deteriorating and coordinate and communicate care across the system for these people

Hampshire and Isle of Wight

Forward View Priorities

November 2022

Forward View Priorities – remainder 2022/23 & 2023/24

Summary of our Top Priorities going forward

1. Healthy Weight for all ages
2. Improved Mental health and Wellbeing for all ages
3. Improved outcomes in the Early Years
4. Better life chances for the most vulnerable
5. Reduce harm from tobacco, alcohol and drugs
6. Providing proactive integrated care/Early Intervention
7. Better End of life care and planning

What will make the difference?

1. A stronger focus on tackling poverty
2. Support residents and staff to benefit from healthier lives, including healthy weight, good mental health and being free from the harms of tobacco, alcohol and drugs
3. Tackling Inequalities – knowing and working with our communities and the people in them
4. Continued focus on joined up, early intervention

Our collective commitments (for discussion..)

1. Targeting employment opportunities to care leavers, people with MH problems and people with learning disabilities
2. Purchasing more locally and for social benefit
3. Commitment to deliver a number of whole city campaigns, working with local communities
4. City wide sign up to Healthy Weight declaration
5. Smokefree NHS and Settings
6. Adoption of Health in all Policies (inc transport, housing)
7. Healthy High Five and Healthy Early Years Award rolled out to all schools
8. City wide adoption of trauma informed practice
9. Implementation of Population Health Management across the city
10. Rolling out the One Team approach, including co-location of staff, in partnership with local communities
11. Maximising the use of our collective public sector estate to promote the health and wellbeing of local communities

COMMITMENT 1: Targeting employment opportunities to care leavers, people with MH problems and people with learning disabilities DRAFT

Commitment Overview

Supporting people with health conditions/disadvantages who want to move into work or stay in work, and targeting employment opportunities for; care leavers, young adults, people with a mental health condition, people with learning disabilities, a substance misuse disorder, offenders, a Musculo-skeletal condition (MSK), social housing tenants, people aged 50+ and people who are economically inactive.

- Employment rates are lowest among disabled people, with only 51.3% in work, (81.4% non-disabled people in work). 54% have a mental health or MSK condition as their main health condition
- Almost 9 in 10 disabled people that are out of work are economically inactive
- Unemployment is bad for health and wellbeing, and is linked with increased risks of mortality and morbidity *Health matters: health and work, 31 January 2019, Public Health England,* *Health matters: health and work - GOV.UK (www.gov.uk)*
- The UK economic inactivity rate was estimated at 21.6%, which is 1.4 percentage points higher than before the pandemic Employment in the UK - Office for National Statistics (ons.gov.uk), 2022. In 2022 there were 600.000 more people out of work than before the pandemic began. This is explained by higher 'economic inactivity' driven by more older people leaving work and more people out of work with long-term health conditions *WORKING FOR THE FUTURE Launch Report for the Commission on the Future of Employment Support, November 2022,* *Working for the Future - Launch Report.pdf (employment-studies.co.uk)*
- Increases in economic inactivity were also driven by those aged 50 to 64 years, accounting for over 55% of the increase in economic inactivity during the pandemic Movements out of work for those aged over 50 years since the start of the coronavirus pandemic and Employment in the UK - Office for National Statistics (ons.gov.uk), 2022

Key Stakeholders

- Department for Work and Pensions (DWP)
- Southern Health (SH)
- Integrated Commissioning Unit
- Wellbeing and Housing Directorate (SCC)
- Children and Learning Directorate (SCC)
- Place Directorate (SCC)
- Keele University
- Southampton University Health Trust (SUHT)
- Department for Education (DfE)
- Department for Levelling Up, Housing and Communities (DLUHC)
- Education and Skills Funding Agency (ESFA)
- Steps 2 Wellbeing Southampton and Dorset (IAPT)
- No Limits (Southampton)
- Princes Trust
- Solent MIND

Current State Detail our current position

- Disabled people are 2.5 times more likely to be out of work than non-disabled people
- Deprived areas, ex-industrial and coastal areas tend to have fewer jobs in growth industries and more jobs in industries at risk of decline. *WORKING FOR THE FUTURE (As above)*
- 10.8% of Southampton's economically active population have either no or low qualifications (NVQ Level 1 or below) Economic assessment (southampton.gov.uk)
- 20.1% of children in Southampton aged under 16 are in low income families, compared to the national average of 17.0% Deprivation and poverty (southampton.gov.uk)
- The employment rates for disabled people with autism was 21.7%, severe or specific learning difficulties 26.5%, mental illness or other nervous disorders 33.3%, epilepsy 34.2% and progressive illnesses 35.8% had employment rates which were significantly lower than the employment rate for the disabled population 53.6% Outcomes for disabled people in the UK - Office for National Statistics (ons.gov.uk), 2020
- 20% - 30% of people with an offending history have a learning difficulty, learning disability or neuro diverse condition (Hughes et al, 2017)
- In Southampton there are approximately 32,000 economically inactive residents (June 2022, ONS) of whom 10,100 want a job
- In October 2022 there were approximately 28,000 working age people in Southampton claiming Universal Credit in the City. Approx 16,000 were workless and 12,000 in low paid work Microsoft Power BI
- Only *17% of ex-offenders* manage to get a job within a year of release. Ex-offenders who get a job after prison are up to *9 percentage points* less likely to reoffend Employing prisoners and ex-offenders - GOV.UK (www.gov.uk), 2020
- Around half (52%) of working-age people who live in social housing are not working. Only 10% of this population can be classified as unemployed. A much larger group of 40% is economically inactive - more than half of this cohort are long-term sick or disabled, and a further 34% are carers. With a further 4% being temporarily sick, a total of 88% of social housing tenants are economically inactive due to barriers such as illness, disability or caring responsibilities. Worklessness and social housing: a look behind the numbers | Housing Network | The Guardian
- 40% of care leavers (19, 20 and 21 years of age in 2016) were not in employment, education or training compared to 14% of all 19, 20 and 21 year olds Supporting Care Leavers (youthemployment.org.uk)
- Adult Social Care Outcomes Framework (ASCOF) October 2022 Southampton. Employment of people with a Learning Disability with an SCC care package increased to 3.7%. England average (2020/21 5.1%)
- The unemployment rate for 16–24 year olds was 9.8% (September 2022) – general unemployment rate in England was 3.6% Youth unemployment statistics - House of Commons Library (parliament.uk)

Future State Highlight the desired changes

- Support current cohorts of people into training, employment (and monitor/record metrics)
- (Note; there is little local data to use to set targets for each cohort)
- Secure sufficient funding (external and Council) to maintain employment support to the target cohorts of residents
- Stretch – secure funding to offer support to people who are economically inactive (with a health condition) into employment

COMMITMENT 1ctd: Targeting employment opportunities to care leavers, people with MH problems and people with learning disabilities DRAFT

Risks

- All funding for the Employment Support Team and the Adult and Community Learning Team is grant funded/commissioned (No SCC General fund). Projects tend to start/stop regularly and not be restarted until a funder commission's an intervention
- Interventions/projects are dependent on funders priorities and the availability of public funding
- STEP project targeted at NEETS concluding March 2023
- Retaining staff/colleagues who can develop and draft effective bids for funding is challenging
- Unsustainable growth in demand and complexity of need as the economy slips into recession
- The scale of residents with low/no qualifications is too significant to address with current levels of resources
- The Economically Inactive population in the City is growing and its scale too significant to support with current resources
- The unemployment rate for people with health conditions tends to rise faster than the corresponding general rate of unemployment. Current Bank of England estimates suggest general unemployment may double by 2024

Assumptions

- No further 'lockdowns'
- Funding for projects/commissions is not withdrawn or reduced due to public sector financial pressures
- There are new opportunities to apply for funding/commissions in 2023
- Integration with colleagues/projects in other services, directorates and organisations will continue to be maintained, and ideally expand

Benefits

- Maintaining (and increasing!) employment support for some of our city's most disadvantaged people in 2023/24. Targets; 1,000 people supported, 400 supported into paid work, and 500 supported to complete employment related learning/training
- Delivering a full offer of Adult and Community Learning (ACL), including Multiply (Basic Maths skills) for residents wanting to achieve basic/entry level learning. Target for 2022/23 3,500 learners

Measures

- Maintaining (and increasing!) employment support for some of our city's most disadvantaged people in 2023/24. Targets; 1,000 people supported, 400 supported into paid work, and 500 supported to complete employment related learning/training in 2023
- Delivering a full offer of Adult and Community Learning (ACL), including Multiply (Basic Maths skills) for residents wanting to achieve basic/entry level learning. Target for 2022/23 3,500 learners

Actions	Action Owner	Deadline
Support 400 people in the target cohorts into paid employment each year	**JC**	**Ongoing**
Support 500 people in the target cohorts into training each year	**JC**	**Ongoing**
Support 3,500 people into basic skills/entry level learning each year	**JC**	**Ongoing**
Secure sufficient funding (external and Council) to maintain employment support to the target cohorts of residents	**JC**	**Ongoing**
Secure funding to offer people who are economically inactive (with a health condition) into employment	**JC**	**Ongoing**
Link with colleagues to report on employment rates for people with a Local Authority care package and a Learning Disability (ASOF data)	JC	Ongoing
Link with colleagues to report on employment rates for young adults who are NEET (Note STEP project concluding March 2023, after which no bespoke employment support)	JC	Ongoing
Link with colleagues to report on employment rates for people who are Care Leavers (Note STEP project concluding March 2023, after which no bespoke employment support other than from Pathways Team)	JC	Ongoing
Determine and scope employment support requirements from DWP regarding UK Shared Prosperity Fund delivery – economically inactive cohort	**JC**	**Ongoing**

Dependencies	**Workforce**:	**Digital:**	**Estates**:	**Finance**:
	Workforce – 32fte	strong presence using social media to support people, engage with people and promote events	Integrated use of public spaces and public sector buildings	as above

Dependencies	
	• Public Health – increasing employment and the health benefits associated with being in paid work • Anti-poverty – Referrals from Household Support Fund and similar initiatives. Reducing the numbers in receipt of State out of work Benefits • Community Engagement – working with others to deliver community based employment and learning support • Economic Development/Skills – Reduce the economically inactive population in the City, and increase the number of people ready to work. Increasing the basic skills of residents • Estates – co-locating and integrating with other teams/services/organisations to deliver seamless one-stop provision

COMMITMENT 2: Purchasing more locally and for social benefit

DRAFT

Commitment Overview

Key Stakeholders

Current State Detail our current position

Future State Highlight the desired changes

IN DEVELOPMENT

Risks

Assumptions

Benefits Numerically quantifiable, if possible!

Measures

Actions

Action	Action owner	Deadline

Any Dependencies?	Workforce:	Digital:	Estates:	Finance:

COMMITMENT 3: Joined up city campaigns on health and care

DRAFT

Commitment Overview

Rationale – linking up communications across health and care to run a series of internal and external health and wellbeing campaigns
Aims – to ensure residents are equipped with the information they need to improve their health and ultimately improve health outcomes.
Purpose – promote good mental health and wellbeing, reduce harm from drug and alcohol use, support people to achieve a healthy weight and to stop smoking.

Key Stakeholders:

Tom Sheppard	HIOW Integrated Care Board
Jess Brimble	Southampton City Council
Communication leads	UHS, Solent NHS Trust, Southern Health, Healthwatch, SVS
Community engagement leads	UHS, Solent NHS Trust, Southern Health, Healthwatch, SVS
Public health leads	Southampton City Council

Current State: current position

Communications team working on health and care projects operate separately with loose joint working arrangements. Communications leads from Southampton City Council, the Integrated Care Board, NHS providers and some voluntary/charity sector organisations meet fortnightly to share information on campaigns and identify areas for joint working.
Campaigns are run and implemented by individual leads within an organisation with a commitment from other leads to share content through existing channels.

Future State: desired changes

- Jointly owned internal and external communications plans with focus on:
  - Increasing the number of children with healthy weight, including promotion of the Healthy Weight Declaration
  - Reducing smoking prevalence and promotion of the NHS Smokefree Pledge
  - Improving mental health and wellbeing
  - Reducing harm from drug and alcohol consumption/related admissions to ED
- An agreed and implemented health and care communications grid/plan/strategy/approach for Southampton, aligned with the priorities of the Southampton Health and Care Strategy for Southampton (2020-2025)
- Regular reporting to the Health and Care Board, evaluating success and reach of campaign, highlighting areas requiring further focus and resource, and providing an overview of upcoming campaigns
- Organisations bringing campaign resources together, and with communities, to increase reach and impact

Benefits:

- Greater reach and impact of communications campaigns
- Greater oversight at board level

Measures:

- Regular evaluation and reporting of process and output measures – to be determined

Actions

	Action owner	Deadline
Joint communications approach to be developed with key stakeholders, and governance and accountability within the ICB and each separate organisation agreed.	Jess Brimble / Tom Sheppard	January 2023
Communications plan to be approved by Health and Care Board	Jess Brimble / Tom Sheppard	April 2023
Quarterly communications report to be provided to the board	Jess Brimble / Tom Sheppard	April 2023
Health and care communications forward plan to be in place	Jess Brimble / Tom Sheppard	June 2023

Risks:

- Significant financial constraints across all organisations
- Organisational boundaries and capacity
- Turnover of staff

Assumptions:

Existing resources will continue and be available as a collective fund
Strong links between board members and their respective communications leads
Partners all support priority areas identified in the Health and Care Strategy

Any Dependencies?	Workforce:	Digital:	Estates:

COMMITMENT 4: City wide sign up to Healthy Weight declaration

DRAFT

Commitment Overview

In 2022 Southampton city council committed to the Local Authority Declaration on Healthy Weight (Healthy Weight Declaration-HWD). The commitments support a Healthy Weight Environment through system-wide leadership and cultural and organisational change
Rationale To support a whole systems approach for creating a healthy weight environment in Southampton
Aims – System-wide leadership for the development and implementation of policies which promote a healthy weight environment
Purpose –Reducing childhood and adult obesity and associated harms and inequalities

Key Stakeholders:

- Southampton City Council
- NHS Trusts, PCNs, GP Practices and other health and care providers
- Universities
- Business leaders
- Wessex Cancer Alliance

Current State: Detail our current position

The National Child Measurement Programme data for 2020/21 showed an unprecedented increase in childhood obesity (for Reception year and year 6 pupils) during the COVID-19 lockdown. The most recent data for 2021/22 show that prevalence of overweight and obesity in year R (22.1%) has returned to pre-pandemic levels but among year 6 pupils (39.4%) the prevalence is higher than pre-pandemic levels. Approximately 65.0% of the adult population is overweight or obese. As part of work to prevent obesity Southampton City Council support the adoption of the HWD to shift the focus to the systemic causes of obesity. The HWD consists of 16 (+2) commitments to create a healthy weight environment grouped into five categories:
1.Strategic system leadership
2.Commercial determinants
3.Health promoting infrastructures and environments
4.Organisational change and cultural shift
5.Monitoring and evaluation
Some commitments are LA focussed but those prioritised here would benefit from system-wide leadership

Future State:

- A change in **system intent** clearly articulated by system leaders: the systemic causes of obesity are acknowledged and addressed, and a shift away from a solely individualised focus on changing behaviour
- A change in **system design** to enable this shift in culture: policies, contracts and best practice standards will be in place with appropriate data and governance throughout the system
- A change in monitoring to identify and **strengthen what works**
- Targeted support/training/campaigns are least likely to lead to system change if not supported by a shift in system intent and design

Risks:

- Cost of living crisis, decrease in affordability of healthy food, inflation, staff food insecurity (using food banks with limited choice), fuel costs
- Reduction in revenue and income through amended contracts to reduce promotion of HFSS foods and drinks
- Buy-in and engagement for seemingly counter-intuitive actions dealing with the causes and not directly with the problem (obesity)
- Operational pressures on providers

Assumptions:

Culture change is a priority

Benefits:

- Reduced exposure to high fat, fat, sugar (HFSS) foods and drinks marketing across the city
- Active travel embedded across organisations
- Increase in availability and promotion of healthy affordable food
- Improved access to fresh drinking water

Measures:

↑No. contracts limiting promotion of HFSS foods and drinks
↓No. of marketing campaigns (across the city) promoting HFSS
↑No. of policies in place enabling active travel and increasing availability of affordable healthy food
↑No. of accessible drinking water points. ↓No. in single use plastic waste

Actions	Action owner	Dead line
1.Implement the Local Authority HWD as part of a long-term, 'systems-wide approach' to obesity; 2. Advocate plans that promote a preventative approach to encouraging a healthier weight with local partners, identified as part of a 'place-based system' (e.g. Integrated Care System); 3. Support action at national level to help local authorities promote healthy weight and reduce health inequalities in our communities (this includes preventing weight stigma and weight bias);	RT TBC TBC	
8. Protect our children from inappropriate marketing by the food and drink industry such as advertising and marketing in close proximity to schools; 'giveaways' and promotions within schools; at events on local authority and partner controlled sites;	TBC	
12. Review contracts and provision at public events, in all public buildings, facilities and 'via' providers to make healthier foods and drinks more available, convenient and affordable and limit access to high-calorie, low-nutrient foods and drinks (this should be applied to public institutions & scrutiny given to any new contracts for food & drink provision, where possible); 13. Increase public access to fresh drinking water on controlled sites; (keeping single use plastics to a minimum) and encouraging re-useable bottle refills;	Events /Contracts teams TBC	
14.Develop an organisational approach to enable and promote active travel for staff, patients & visitors, whilst providing staff with opportunities to be physically active where possible (e.g. promoting stair use, standing desks, cycle to work/school schemes); 15. Promote the health and well-being of staff by creating a culture and ethos that promotes understanding of healthy weight, supporting staff to eat well and move more;	TBC TBC	

Any Dependencies?			
	Workforce: HR (staff focussed actions). Contract teams (internal and external contracts). Procurement, estates, campaigns and health in all policies	**Corporate:** Policy development and governance processes across different organisations	**Estates**: supportive facilities to enable active travel, access to fresh drinking water

COMMITMENT 5: Smokefree NHS

DRAFT

Commitment Overview

- Rationale – High harm, effective interventions not yet fully implemented. NHS Long Term Plan for inpatients and maternity to treat dependency by March 2024. Added benefit if all provider settings smokefree.
- Aim – **All NHS Trusts deliver NHS Long Term Plan by March 2024.** Also, providers work towards smokefree, with frontline clinicians delivering Very Brief Advice (Ask, Advise, Act), NHS Smokefree Pledge and campaigns. SCC continues Local Government Declaration and implements new Tobacco, Alcohol & Drugs Strategy.
- Purpose – Reduce health inequalities, improve health, use a health in all policies approach to tobacco.

Key Stakeholders:

UHS Hospitals NHS Foundation Trust	Southampton City Council
Southern Health NHS Foundation Trust	Southampton Health & Wellbeing Bd
Solent NHS Foundation Trust	HIoW Integrated Care Board
Local Maternity & Neonatal System	Southampton Smokefree Solutions
PCNs, GP practices, pharmacies	Providers outside NHS

Current State: current position

- c34k smokers in Southampton. Higher rate than England, similar to comparators. Nationally half smokers die from smoking. Half gap in life expectancy most-least deprived areas.
- Trusts working towards NHS LTP for inpatients (including mental health) and maternity.
- Southampton Smokefree Solutions (SSS) commissioned by SCC to support providers. SCC also commission treatment in PCNs, maternity, pharmacies, UHS.
- SCC signed Local Government Declaration on Tobacco Control 2013, with a new strategy from 2023. Central PCN first PCN in the country to sign the NHS Smokefree Pledge.
- No other NHS organisation in Southampton yet publicly pledged to be smokefree.

Future State: desired changes

- NHS Long Term Plan commitment met by March 2024 to deliver improved tobacco dependency treatment for people during pregnancy or inpatient admissions (acute or mental health).
- As many NHS Providers as possible are smokefree and signed up to the NHS Smokefree Pledge.
- SCC continues with the Local Government Declaration and new Tobacco strategy, including improving community tobacco dependency support for people with drug and alcohol use disorders and/or who are homeless too.

Benefits:

- NHS LTP implemented: more people treated for tobacco dependency
- Settings smokefree
- Contribution to reduced smoking rates

Measures:

- No. people treated and quit rate
- No. settings smokefree (& NHS Pledge)
- Smoking prevalence

Risks:

- Funding– insufficient & short term.
- Short-term workforce
- IT infrastructure and data reporting
- Competing pressures & priorities

Assumptions:

- NHS Long Term Plan funding due in 2023/24 – single year, not likely to meet full costs
- No NHS Long Term funding after 23/24 expected

Actions	Action owner	Deadline
Trusts share their current NHS LTP delivery plans with ICB.	Trust SROs	Jan 2023
Trusts provide monthly progress reports & data headlines	Trust SROs	Jan 2023
NHS LTP review & business case to HIoW/Place ICB for 24/25	Trusts, ICB	June 2023
SCC & ICU reviews best use of public health grant for tobacco dependency treatment to inform 24/25 onwards – initial report	DPH/ICU	June 2023
As many NHS organisations as possible sign NHS Smokefree Pledge and promote being smokefree. Earlier sign up welcomed.	SROs	March 2024
SCC implement new Tobacco, Alcohol & Drugs Strategy 2023-2027.	Cabinet Member/DPH	2027

Any Dependencies?			
	Workforce: Yes – tobacco treatment advisors, wider health & care frontline workforce	**Digital:** Yes – recording in patient records and reporting to NHS England and others, local evaluation	**Estates**: Yes – smokefree estates

COMMITMENT 6: Adoption of Health in All Policies

DRAFT

Commitment Overview

Health and health inequality considerations will be integrated and articulated in all policies approach across sectors in the City

Rationale – population health and health inequalities in Southampton are influenced by a wide range of factors, with the wider determinants (social, economic and physical environment) estimated to drive around half of health outcomes. These factors are driven by wider policy making decisions with variable explicit consideration of health. If system partners consistently consider health in every aspect of their work, the social, educational, employment, commercial and environmental conditions for Residents of Southampton can improve, in turn improving population health and reducing health inequalities
Aims – to develop knowledge and embed systems, structures and support that increase consideration of health impacts in policy and decision making
Purpose – to place an additional lens on strategy and operations that will enable improved health and health equity at place level

Key Stakeholders:

Southampton City Council
Universities
Primary care
Secondary care
Community care and mental health

Current State: current position

The Public Health team at Southampton City Council is currently scoping a health in all policies approach towards its own strategic and operational activity. The team are researching options to increase positive impact on the wider determinants of health within the organisation and to develop tools and governance to embed consideration of health and health inequalities in wider policy and decision making. This sits alongside work to increase the impact of large organisations anchored to the City as employers, purchasers, building owners and environmental impactors (other Health and Care Strategy commitments).

Future State: desired changes

- Health and health inequalities are consistently effectively integrated and articulated in policy and decision making in the city
- Good practice examples are known and shared
- Policy and decision makers are confident and supported in their consideration of health and health inequalities impacts

Benefits:

- Improved health and wellbeing and reduced health inequalities (further definition required in scoping phase)

Measures:

- Number of policies influenced by explicit consideration of health impact

Risks:

- Lack of strategic engagement and commitment to delivery of population health outcomes and reduction of health inequalities
- Lack of capacity to lead
- Impact of commissioning review

Assumptions:

- Health and care partners can significantly influence policy and decision making in the City

Actions	Action owner	Deadline
Research Health in All Policies good practice examples and evidence base to provide recommendations for local programme, including governance	MW	Feb 2023
Identify examples of good practice to share and celebrate	MW	Feb 2023
Agree structures and support required in policy and decision making		
Pilot and test tools in policy and decision making		
Agree supportive model to scale across Southampton health and care partners		

Any Dependencies?	Workforce:	Digital:	Estates:

COMMITMENT 7: Healthy High Five and Healthy Early Years Award rolled out to all schools

DRAFT

Commitment Overview

Key Stakeholders

Current State Detail our current position

Future State Highlight the desired changes

Risks

Assumptions

Actions

Action	Action owner	Deadline

Benefits Numerically quantifiable, if possible!

Measures

Any Dependencies?	Workforce:	Digital:	Estates:	Finance:

COMMITMENT 8: City wide adoption of trauma informed practice

DRAFT

Commitment Overview

Key Stakeholders

Current State Detail our current position

Future State Highlight the desired changes

Risks

Assumptions

Benefits Numerically quantifiable, if possible!

Measures

Actions

Action	Action owner	Deadline

Any Dependencies?	Workforce:	Digital:	Estates:	Finance:

COMMITMENT 9: Population Health Management

DRAFT

Commitment Overview

Population Health is an approach aimed at improving the entire population. It is about improving the physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities within and across a defined population. It includes action to reduce the occurrence of ill-health, including addressing wider determinants of health, and requires working with communities and partner agencies.

Population Health Management improves population health by data driven planning and delivery of proactive care to achieve maximum impact. It includes segmentation, stratification and impactabilty modelling to identify local 'at risk' cohorts - and, in turn, designing and targeting interventions to prevent ill-health and to improve care and support for people with ongoing health conditions and reducing unwarranted variations in outcomes. There are five overall aims of Population Health Management:

1. Enhance the experience of care
2. Improve the health and well being of the population
3. Reduce per capita cost of health care and improve productivity
4. Address health and care inequalities
5. Increase the well-being and engagement of the workforce

Southampton's commitment is to develop the infrastructure, intelligence and interventions to achieve a system wide, outcome focus, driven by need in considering the whole life course from addressing the wider determinants of health to early intervention, primary, secondary, tertiary disease prevention and inequalities in health at

- An individual level
- Neighbourhood level
- Place level and
- Across the HIoW Integrated Care System

Key Stakeholders (indicative)

- Patients, Carers and Communities
- Workforce
- Primary Care
- Mental Health Care Agencies
- Community Care
- Secondary Care
- Public Health
- Local Authority
- Social Care
- Housing
- Environmental Agencies
- Education
- Fire, Police, Lifeguard
- Southampton Health and Care Partnership
- HIoW Place areas
- Comms and Engagement

Current State

The current challenges facing health and care are:

- Reactive response – crisis driven
- Chronic skilled staff workforce shortages, poor retention and declining wellbeing
- Ageing population
- Primary Care in crisis
- Delayed patient presentation
- Diagnostic capacity
- Inadequate space and deteriorating estates
- Insufficient funding
- Interoperability and sharing of information
- Dependent population

Physical structures within the NHS working and being held to account, independently
Increased increase in demand across all settings of health, care and voluntary sector
Inequality of service provision leading to health inequalities across populations.

Future State

Normal practice will be to work as a collective to realise Southampton's Place strategic vision by addressing:

- Proactive preventative approach
- Health inequalities by taking action
- Using data driven insights and evidence of best practice to inform targeted interventions which improved the health and well being of specific populations and cohorts
- Making informed judgements, not just relying on the analytics
- Prioritising the collective resources to the best impact
- Acting together – the NHS, Local Authority, Public services, Voluntary Care Sector, Communities, activists and local people. Creating partnership of equals.
- Achieving practical tangible improvements for people and communities.

COMMITMENT 9 ctd: Population Health Management

DRAFT

Risks

Culture

Working collective as a system as opposed to independent organisations

Ability to pool resources against competing priorities

System capabilities an availability

- Business analytic/data skills to provide impactability analysis
- Coding/algorithms which can be used by all partners
- Patient level costing to support actuarial modelling
- Ability to translate different organisational currencies (i.e. viewing populations through eyes of each organisation)
- Benefits realisation skills and evaluation knowledges
- Research skills

Workforce capacity

People time and commitment required is significant in set up processes of programme/project.

Assumptions

- No further lockdowns
- Resource is available
- "Buy In" for PHM exists across the system
- Pressures in system do not derail work programme
- Resources will be available to realise end product
- Skill set available to support PCNs in adopting PHM approach

Benefits

The benefits of Population Health Management include better health outcomes with reduced care gaps and real-time monitoring.

The following are the key advantages:

- Improved quality of care while reducing costs
- Improved care for patients with chronic and costly conditions by monitoring
- Real-time access and closed gaps in care along with patient-centric view
- Better clinical outcomes
- Improved distribution of health
- Improved experience for patients, carers and communities

Measures

Relational to strategic plan, PHM Programme, projects and benefits sought

Actions (Milestones)	Action owner	Dead line
Infrastructure • Set up a leadership team and governance structure representative of all parts of Southampton and capable of making decisions for the wellbeing of the population • Agree decision-making framework which underpins and drives the strategic vision of Southampton Place. • Onboard 22-week programme of PHM for Place and Southampton PCNs • Have clearly defined, common population definitions across Southampton for each the geographical levels (system, place and neighbourhood, individual) • Make sure there is clear Information Governance (IG) set up across Southampton supported by HIoW ICS • Be clear and understand the data sets that are available across the system and how they can be used	ST	March 2023
Intelligence • Understand the specific needs of the local population, the impact of wider determinants and to explore gaps in care and unwarranted variation, through e.g. segmentation • Identify high and emerging risk groups most amenable to interventions and target them through tools such as risk stratification and impactability models • Size the opportunity and conduct system modelling to understand impact on financial risks and incentives	ST	Ongoing
Interventions • Design care models and interventions based on evidence to target priority patient groups and implementation plans, making a clear and compelling case for change with contributing resources agreed at all tiers • Define key indicators and outcomes to be measured and evaluated for success • Map and model workforce changes to determine gaps and new role definitions • Implement interventions and care models • Evaluate impact against agreed indicators and outcomes, and whether any changes are needed to be made (going back to understanding the needs of the populations	ST	Ongoing

Any Dependencies?	**Workforce**:	**Digital:**	**Estates**:	**Finance**:
	workforce capacity particular workforce skills work across existing boundaries	Onboarding of digital information to healthe-intent platform Shared coding Interoperability		Utilisation of funding across a system not by organisation

COMMITMENT 10: The One Team approach

DRAFT

Commitment Overview

Promote a pro-active integrated approach for the city which enables the delivery of effective person centred care that meets the needs of our most complex client groups in as timely and efficient manner as possible.
Aims – To create a 'One Team' partnership involving health, social care and voluntary sector organisation which will deliver responsive, integrated, co-ordinate, and inclusive patient centre care.
Purpose – Patient Statement 'My care is planned with people who work together to understand me and my carer(s), puts me in control and co-ordinates and delivers services to achieve my best outcomes'

Key Stakeholders

- Primary Care – including ARRS Roles
- Community and Voluntary Sector including community navigation
- Adult Social Care
  - Link with localities work
  - Community Independence Teams
  - Reablement
- Acute Care - particularly front and back door teams

Community Health providers

- Solent – community nursing, case management and community independence service
- SHFT – Community mental health teams.
- SMS – Community Wellbeing team
- Solent – UCR team

Current State Detail our current position

PCNs working with One Team clinical lead and stakeholders to build the approach around identified cohorts.

- Bitterne: High Intensity Users of urgent care and heart failure.
- Living Well: High Intensity Users of urgent care and patients with respiratory disease.
- Woolston& Chartwell: LD with complexity.
- TOFS/St Peters: responsive holistic approach for patients needs living with persistent pain
- Central: reviewing/developing proactive case management for a cohort tbd. .
- North: palliative care and end of life planning.
- West: reviewing/developing proactive case management for a cohort tbd.

Continued development of the model to promote the following outputs

- One team promotes the delivery of the PHM approach and Proactive Care model.
- Promotes integrated approach to assessment for our most complex individuals
- Increase the use of effective anticipatory care plans
- Promotes efficient transfers of care Improve co-ordination of care across all agencies
- Patients care for in their place of choice for longer.
- Joint care and management protocols in place

Risks

- Risk of impact on pace of implementation as a result of workforce challenges in providers and primary care
- Volume of national requirements on care agencies impacting on ability to deliver the One Team approach

Assumptions

- Alignment between One Team development and SCC Localities work.
- Ongoing funding and recruitment of coordinator role and clinical lead.
- All agencies are supportive of the One Team approach

Benefits

- Improved health and wellbeing of target population
- Reduction in health inequalities for target population
- Patient/workforce Statements – qualitative
- ACP national metrics
- One Team individual project metrics

Measures

- Increase in the utilisation of anticipatory care plans/escalation plans – national ACP DES metrics
- NEL reduction for target population – contributary rather than causal needs explaining

Actions

Action	Action owner	Deadline
Clinical leadership support for PCNs – guidance and facilitation to support development of approach and alignment with test of Proactive Case Management.	SS	31/12/2022
Finalisation of MOU for coordinator post with Solent having agreed financial arrangements.	ST/MFC	01/12/2022
Clarify, test and embed the MDT element of Proactive Case Management as part of one team approach	MFC	31/03/2023
Clarify and implement with community Health Providers and ASC/LA the one team approach which aligns with SCC localities model	MFC	31/03/2023

Any Dependencies?	**Workforce**:	**Digital:**	**Estates**:	**Finance**:
	Capacity, skills and transition of workforce Data analysis capacity	Interoperability of care planning templates Evaluation and analysis capability	Colocation issues may arise	Funding of roles to deliver and support One Team ACP DES funding, Primary Care may choose not to utilise if for this project and therefore would require further financial input.

Commitment 10: One Team Logic Model

Southampton

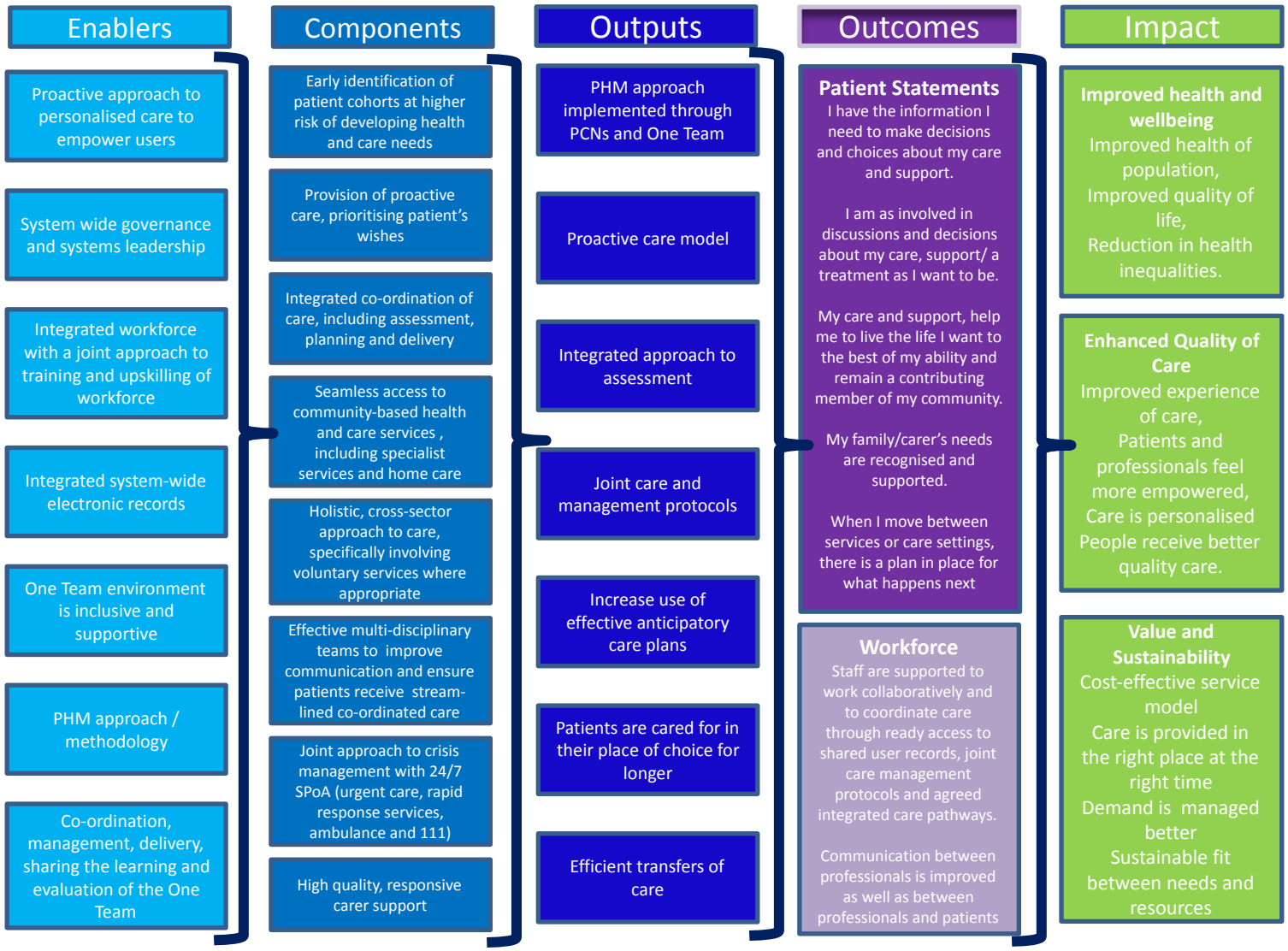
Vision

To create “One Team” partnerships involving health, social care and voluntary sectors, which will deliver responsive, integrated, co-ordinated, and inclusive patient centred care

Patient’s statement

“My care is planned with people who work together to understand me and my carer(s), puts me in control and co-ordinates and delivers services to achieve my best outcomes”

Commitment 10: One Team Logic Model - Southampton



COMMITMENT 11: Maximising the use of our collective public sector estate to promote the health and wellbeing of local communities

DRAFT

Commitment Overview

Key Stakeholders

Current State Detail our current position

Future State Highlight the desired changes

Risks

Assumptions

Benefits Numerically quantifiable, if possible!

Measures

Actions

Action	Action owner	Deadline

Any Dependencies?	Workforce:	Digital:	Estates:	Finance:

Hampshire and Isle of Wight

Other project areas of work in progress supporting the programmes

Update: November 2022

Start Well

NHS
Hampshire and Isle of Wight

ICS/ PLACE	PROJECT	DESCRIPTION	TIMEFRAME Start Date	End Date	IMPACT DESCRIPTION
Place	0-19 Prevention & Early Help Service including Family Hubs	Implementation of recommendations to improve Healthy Child Programme Performance, strengthen the integration locality model & development of Family Hubs	Apr-22	Mar-23	Improved HCP performance Increased Breast feeding Better parenting support & attachment Improved early childhood MH outcomes
Place	Youth Offer	Development of an enhanced and more joined up locality based youth offer, aligned to the new Young People's Service	Jul-22	Jan-24	Improved outcomes for Young people (employment, education & training, reduced homelessness, reduced crime)
ICS	Supporting children with long term conditions	Development of paediatric dietetic service and community epilepsy service (subject to business case and additional investment)		Mar-23	improved outcomes for children with LTCs (reduce NEL admissions, mortality rates, improve school attendance)
ICS	Health support to schools	Review and develop consistent needs led nursing and therapy support into schools	Apr-22	Mar-24	Increased inclusion, attendance and attainment
Place	Early intervention children's mental health	Roll out of Mental Health Support Teams in Schools, developing the early MH offer in localities, Healthy Early Years Award in schools and other settings, reprocurement of counselling services	Apr-22	Mar-23	More CYP supported earlier, reduced pressure on CAMHS and other statutory services, improved education outcomes
ICS	Eating Disorder Services for Children and YP	Work with service to expand the team to meet need and develop ARFID pathway	Apr-22	Mar-23	Achievement of national KPIs for CYP Eating Disorder access & NICE guidance
Place	Improving MH Crisis Support for CYP	Expansion of Psychiatric Liaison offer (7 days and evenings) & intensive community based support, particularly development of BRS crisis offer and short stay therapeutic assessment unit	Apr-22	Jul-23	Reduction in hospital admissions, ED attendances & residential placement.
Place	Remodelling of Jigsaw Service	Review and remodel specialist support for children with complex learning disabilities	Apr-22	Apr-23	Improved health, education and social care outcomes, improved family/placement stability, improved attendance & attainment
Place	Development of children's short break offer	Development of short breaks to address gaps in provision, in particular for children with neurodiversity and challenging behaviour	Apr-22	Mar-23	Improved family/placement stability, reduction out of area and residential placements
Place	Development of Neurodiversity offer for children & families	Roll out of parenting and peer led support in localities, development of resource offer, development of sensory offer, implementation Autism in Schools project	Apr-22	Mar-23	improved understanding of neurodiversity, inclusive settings, improved co-production with parents/families
Place	Sufficiency Strategy refresh	Review and development of accommodation options for children looked after, care leavers and vulnerable young people at risk of homelessness to meet need	Apr-22	Mar-23	Clear identification of need, provision and gaps leading to provision to meet gaps and improved outcomes: - care leavers in suitable accommodation - reduction in youth homelessness - more care leavers and young people in employment, further education and training - more children looked after able to maintain contact with family and friends in their local area (where appropriate) - more children looked after supported to remain in a family and to achieve permanency
D22	Children's Homes	Development of local in-house children's home provision	Apr-22	Mar-25	Improved outcomes for children looked after: - more children looked after able to maintain contact with family and friends in their local area (where appropriate) - more children looked after supported to return to a family setting and to achieve permanency - avoidance of long term residential provision where possible/appropriate - improved life outcomes for CLA
D22	Early Help	Development of Family Hub model across the city and more integrated early intervention and support	Apr-22	Mar-25	Improved outcomes for children in the early years - first 1001 days Improved uptake of Healthy Child Programme mandated checks Improved public health outcomes - breastfeeding rates, healthy weight, more smoke free families including in pregnancy Improved school readiness Improved emotional and mental health, attachment
D22	Young People's Services	Establishment of a new Young People's Service in the city	Apr-22	Mar-23	Improved outcomes for young people: - reduction in First Time Entrants to Youth Justice System - Improved mental and emotional health - more young people in education, training and employment - more young people in suitable housing/reduced homelessness - reduction substance use

Live Well

NHS
Hampshire and Isle of Wight

ICS/ PLACE	PROJECT	DESCRIPTION	TIMEFRAME Start Date	End Date	IMPACT DESCRIPTION
Place	Strategic review of Primary Care model	Review PC model and build recommendations for transformation and development	Sep-22	Jan-23	More resilient PC model which improved access and better meets the needs of our diverse community
Place	Increase Learning Disabilities AHC and ACP	Work with all practices to maximise uptake of LD AHC and ACP - form network, identify and share best practice, identify and progress initiative to increase uptake	Aug-22	Mar-23	Increased uptake and associated improvements in health outcomes for people with LD living in the city
Place	PCN Tackling health inequalities service	Support PCNs to develop and embed service to tackle health inequalities in-line with the DES	Apr-22	Mar-23	Improving Health Outcomes for cohorts facing health inequalities
Place	PCN Cardio Vascular Disease Prevention service	Support PCNs to ensure they are delivering on the CVD prevention service requirements	Apr-22	Mar-23	To improve the outcome for Southampton CVD patients
Place	PCN Personalised Care	Support PCNs to ensure they are delivering on the Personalised Care service within the PCN DES	Apr-22	Mar-23	Increase in number of patients receiving appropriate personalised care
Place	PCN DES Cancer QI	Work with and support PCNs to ensure they are meeting requirements of DES in relation to Cancer	Sep-22	Mar-23	Improved diagnosis and referral leading to better outcomes for patients
Place	PCN proactive social prescribing	Work with PCNs to develop proactive social prescribing services	Sep-22	Mar-23	Proactive social prescribing services will be available across the city for identified vulnerable cohorts reducing their reliance on the health system
Place	Care leavers & vulnerable YP's accommodation	Reprocurement of semi independent post 16 accommodation services and review of care leavers accommodation needs	Apr-22	Mar-23	More care leavers in suitable accommodation, reduced costs, improved outcomes for care leavers
Place	Support for Sex Workers	Business case for a sustainable service to support health and care needs of sex workers	Jul-22	Mar-23	Sustainable service, improved health outcomes, e.g. sexual health infections, pregnancies, substance misuse, MH problems. Reduced pressure on other services, e.g ASC, police
Place	Support for Hoarders	Development of sustainable service to support health and wellbeing of hoarders	Apr-22	Mar-23	Service sustained, improved health outcomes, reduced pressure on other services
Place	Smoking cessation	Commissioning and implementation of smoke free support services, targeting populations and settings for MH, LD and homelessness	Apr-22	Mar-23	Reduction in smoking rates and associated health conditions
Place	Weight management	Development of weight management support, including recommissioning of tier 2 services, implementation of liraglutide pathway in specialist service and improved access and choice of specialist bariatric services	Apr-22	Mar-23	Reduction in people who are overweight or obese
Place	Sexual Health Service developments	Review and development of commissioning intentions for future specialist sexual health services	Apr-22	Mar-23	Improved uptake of screening and treatment of STIs
Place	LD housing project	Development of more supported living options, enabling more people to maximise their independence. More efficient use of accommodation including management of voids and support hours.	Apr-22	Dec-23	Improved independence, improved fit for purpose accommodation, reduced costs & savings, more people with LD in suitable housing
Place	Inclusive Lives project	Development of new inclusive lives offer for people with LD and in time MH problems, to include support with employment/training, digital opportunities, transport and engaging in meaningful community activities. To include piloting new approaches with young people preparing for adulthood and Safe Places Scheme	Apr-22	Aug-23	More adults with LD and MH problems in employment, improved uptake annual health checks, more adults with LD feeling safe, supported & included. Improved uptake direct payments
Place	Review of respite for adults with LD	Review and future plans for respite provision, including future of Kentish Road	Apr-22	Mar-23	Delivery of broader & more equitable respite offer that meets need. More people able to access support they need. Greater cost effectiveness/savings
ICS	No wrong door	Delivery of new models of integrate primary and community care for adults and older adults with severe mental illnesses through the Adult Community Transformation programme	Apr-22	Mar-23	Increase in number of people with SMI who are in paid employment, settled accommodation and having a full annual physical health check

Live Well

Hampshire and Isle of Wight

ICS/ PLACE	PROJECT	DESCRIPTION	TIMEFRAME Start Date	End Date	IMPACT DESCRIPTION
Place	Housing for people with SMI	Working across the ICU to develop an approach which fits the needs for housing and support provision for people living with SMI.	Oct-22	Sep-23	Impact on recovery pathway for people living with SMI
Place	Mental health network and service user network	Review the newly implemented mental health and service user network to inform commissioning intentions	Oct-22	Mar-23	clarify of network reach and recommendations for future provision
Place	Enhancement of substance use disorder services	Working public health utilise OHID funding to promote a broadening and deepening of the substance use disorder services	Jul-22	Mar-24	more people successful in their recovery - including those successfully completing treatment for opiate, non-opiate and alcohol use.
Place	Co-occurring conditions	Revision of pathway for integrated working between mental health services and substance use disorder services.	Jun-22	Mar-23	impact and evaluation as part of the project
ICS	HIOW Green Capacity	Development of ICB wide Green Capacity Strategy Reviewing options to use existing budgets to deliver greater case mix/ complexity through reducing variation and increasing productivity Development of ICB wide proposals for development of 2 Treatment Centre sites Roll out of new multi-speciality elective hub in Winchester site in 23/24, operating at full capacity by 24/25 – ringfenced capacity for hip and knee replacements and a range of urology and ENT day case procedures. Development of elective activity coordination hub (EACH) to support green pathway sites and relationships with independent sector Innovation around how use IS capacity Link to Review of Tier Two capacity and provision	Sep-22	?	Achievement of national targets re elective capacity, waiting times etc. esp. in terms of HVLC activity. Ensuring right elective capacity in line with LDS and ICB population needs. Multi-million pound contracts with IS and Trusts.
ICS	Cancer - Prevention and Screening	Projects include: S7A screening project – multiple pathway project to restore/ improve screening uptake, actions defined by NHSE. Prostate self referral –pathway project for men aged 50-80 enabling self-referral and filter tests Prostate Black African/Caribbean screening – case finding pathway project in Southampton inviting Black men over 45 to complete questionnaire, get PSA checked. Aim to roll out more widely. Cervical screening – initiative to improve accessibility for women with a learning disability, or whose first language isn't English, working with PHE, Macmillan, primary care. LIS – Prevention & Earlier Diagnosis Local Improvement Scheme, working with PCNs and Cancer Research UK Breast lump self referral – expansion of project trialled in N&M following evaluation	Jan-22	Ongoing	Improved prevention and screening
ICS	Cancer - Earlier, Faster Diagnosis	Projects include: Rapid Investigation Service project – implementation/ development of rapid diagnostic centres to deliver faster and earlier diagnosis. Evaluation informing business case for future funding. Targeted Lung Health Check programme for ex/current smokers over 55 in Southampton. NHSE funded pilot, rolling out to Eastleigh/Totton in Jan 2023. Est. could the early detection rate of lung cancers 28% (2017) to 44% by 2024 FIT Testing – bowel pathway initiative to increase uptake of FIT tests for patients requiring 2ww colorectal referral. Implement 2ww teledermatology Direct access CT screening – pilot programme for patients >60 enabling GP direct access to CT for pancreatic cancer.	Feb-22	Ongoing	Earlier, Faster Diagnosis of cancer
ICS	Ophthalmology - Integrated Digital Solutions	Work includes: Implementation of digital improvements, addressing a number of IT integration issues in line with ICS approach including: Improving integration with GP systems to enable direct Optometrist referrals without GP input Implementing IT solution in UHS which enables electronic letters to be sent to primary care, smooth discharge of patients to community services and escalation to eye unit. Addressing current issues with Ophthalmology correspondence, e.g. unclear medication recommendations/actions for primary care, delays caused by batching, use of acronyms.	Apr-22	Ongoing	Increase elective activity, organise/ deliver services to maximise productivity, reduce waiting times, reduce risks around patient harm, avoid potential legal costs/ claims

Age Well

NHS
Hampshire and Isle of Wight

ICS/ PLACE	PROJECT	DESCRIPTION	TIMEFRAME Start Date	TIMEFRAME End Date	IMPACT DESCRIPTION
Place	PCN EHCH	Support PCNs o fully delivered on EHCH and ensure integration with city wide service in City	Sep-22	Mar-23	Reduction in admission, enable earlier discharge, in date ACPs
Place	Discharge model	Whole system review and development of hospital discharge model	Apr-22	Mar-23	More timely discharge, more people supported to maintain their independence for longer, reduced costs long term care, frees up elective capacity
Place	Home First	Development of an integrated Urgent Community Response, rehab and reablement and Virtual Ward model for the city.	Apr-22	Mar-23	Promotion of admission avoidance and contribution to timely discharge.
Place	One Team Development	Embedding the One Team as business as usual for core community services in partnership with PCNs	Apr-22	Mar-23	Delivery of anticipatory care planning which promotes independence and ability for people to remain as home for as long as possible.
Place	Community wellbeing and anticipatory care	Review of community wellbeing offer in the context of anticipatory care planning. Information future options.	Jul-22	Mar-23	Options clear for ICS decision making.
Place	Community transport	Scope and develop proposals for community transport which bring together hospital discharge, dial-a-ride and shopmobility. Scope will include consideration of wider service inclusion - related areas e.g. day services.	May-22	Mar-23	Project initiation document to inform
Place	Implementation of the carers strategies	Implementation of the city's carer strategies which promotes improved identification of carers, stronger carer voice and broadening of the support offer.	Apr-22	Mar-23	increase in the number of carers known to services and accessing support to sustain their informal caring role
Place	Promotion of prevention and early intervention	Development of prevention and early intervention offer through codesign future model for community solutions, Advice Information and Guidance and related services.	Sep-22	Aug-23	increased access to community assets and management of low level need.
Place	OPMH crisis	Development of an OPMH crisis model which will inform commissioning and provider future action	Oct-22	Mar-23	Accelerate the planning towards providing an integrated approach to crisis care for OPMH and URS

Die Well

NHS
Hampshire and Isle of Wight

ICS/ PLACE	PROJECT	DESCRIPTION	TIMEFRAME Start Date	End Date	IMPACT DESCRIPTION
ICS	Improving end of life care for children	Review and develop services	Jun-22	Mar-23	Improved end of life experience, more children supported to die in place of choice
Place	Promoting access to end of life support	Promoting early identification of people in the last three years of life and access to end of life provision for those who need it.	Dec-22	Mar-23	Timely anticipatory care planning which in turns improves access to services at the end of life.
Place	Improving out of hospital EOL and Palliative Care	Review current out of hospital EOL and Palliative care support workers service (care@home), including fast track patients, to ensure that care provided out of hospital is consistent, reliable and implemented in a timely manner.	Nov-22	Mar-23	Ensuring fast track patients are provided the care they require quickly and facilitating discharge of these patients out of hospital and into the community. Also ensuring that the cost of the service is providing what is contractually agree.
ICS	Personalised care for EOL & Palliative care patients	Exploring the implementation of PHB's for EOL patients and the importance of personalised care and support plans for all patients under the EOL & Palliative care service.	Apr-22	Mar-23	Providing greater personalised, flexible and increased level of choice of care for EOL and Palliative care patients to ensure their last weeks/days of life are as good as possible.
Place	Improving access to hard to reach groups who are EOL	Scoping current access arrangements for individuals with LD, dementia or who are Homeless.	Jan-23	Mar-23	Ensuring individuals in these hard to reach groups are also able to access EOL & Palliative care within the context/setting of their choice.
Place	EOL education and training model to other health and care providers	Evaluate the impact of one off training programmes e.g. ASC and working with provider to develop a more meaningful report to measure the impact of training	Jan-23	Mar-23	To upskill workers in health and social care settings, to be able to provide excellent quality EOL care to residents and patients alike.