Southampton City Five Year Health and Care Strategy 2020-2025

Update for 2023/24

Southampton City Health and Care Strategy

2020-2025

Our vision

A healthy Southampton where *everyone* thrives

Our goals

Reducing **inequalities** and confronting **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

Five key enabling priorities:

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

Approach to 2023/24 Work Programme

The following slides provide an update on the Five-Year Health and Care Strategy 2023-2025, on the high priority areas for each of the 4 Workstreams: Start Well, Live Well, Age Well, Die Well for the Health and Care Partnership Board.

The key areas of focus are defined as those which:

- Require a **whole system approach** – all partners will have a contribution to make
- Will make a **significant impact** on the health and wellbeing of people in Southampton
- Address **key issues** that the city has been struggling to grapple with

As in previous years, the 2023/24 work programme will not attempt to repeat all the other plans that are in existence (e.g. Health & Wellbeing Strategy, Children & Young People's Plan, Mental Health Transformation Plans, Age Well Strategy and single agency plans). Instead, it will acknowledge and add value to these by bringing a collective focus to a few key areas where a more joined up approach across the system is needed to address a key issue

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.

Key points – Children and Young people

- **Smoking at time of delivery** (11%) **higher** but not **significantly** than England (10%). Previous years significantly higher. Recent years show **Southampton** percentage **decreasing faster** rate **than nationally.**
- **Breastfeeding** prevalence at 6-8 weeks after birth **increasing** and **higher** than **national** average (53% vs. 45%)
- **Excess weight** in 4/5 years old significantly higher and 10/11 years old higher than England and with a steeper overall increase, (see slide 27) 2020/21 uses local data as published data for all local authorities unavailable due to insufficient pandemic-related coverage
- **Children Looked After rate** similar 2019 to 2021, **higher than England** 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 and **gap getting worse**
- Hospital admissions caused by **unintentional and deliberate injuries** in **children** under 15 years **lowest rate** in last 10 years

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
Children & Young People/Early years	Smoking status at time of delivery (Female)	%	2020/21		10.7	9.6	5	Higher
	Breastfeeding prevalence at 6-8 weeks after birth - current method	%	2020/21		53.4	47.6	2 of 5	Significantly higher
	Child excess weight in 4-5 year olds	%	2020/21		32.7	27.7	Insufficient data	Significantly higher
	Child excess weight in 10-11 year olds	%	2020/21		41.0	40.9	Insufficient data	Higher
	Population vaccination coverage - MMR for one dose (2 years old)	%	2020/21		93.7	90.3	8	Higher
	Children looked after	per 10,000	2021		96.0	67.0	3	Significantly higher
	School readiness: Good level of development at the end of reception	%	2018/19		71.1	71.8	9	Lower
	School readiness: Year 1 pupils achieving the expected level in the phonics screening check	%	2018/19		82.1	81.8	10	Higher
	Children in relative low income families (under 16s)	%	2020/21		22.2	18.5	6	Significantly higher
	Hospital admissions caused by unintentional &deliberate injuries in children (aged 0-14 yrs)	per 10,000	2020/21		65.0	75.7	9	Significantly Lower
	Under 18s conception rate / 1,000 (Female)	per 1,000	2020		20.7	13.0	2	Significantly higher

Inequalities – Children and Young

Comparing outcomes for children and young people in the most deprived 20% of Southampton to the least deprived 20%, illustrates the inequality gap in the city.

Mothers smoking at booking

4.1x higher

Breastfeeding at initial check

1.4x lower

Child poverty

3.7x higher

Healthy weight

1.1x lower for Year R children

1.2x lower for Year 6 children

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

Mental Health/ Psychosocial condition (per 1k children)

1.5x higher

Note: Uses local deprivation quintiles

Start Well – Original Roadmap

Year	What we said we were going to do in the strategy
Year 1 2022/21	• **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
Year 4 2023/24	• **Family Hubs** offer rolled out across the city in line with the Government Best Start for Life vision with focus on tackling inequalities • Improved support for young people with **SEND/additional needs** preparing for adulthood • Improved short break offer for children with SEND and parenting support in place for families of **children with Neurodiversity** of all ages • **MH Support Team** offer rolled out to all mainstream primary, secondary and colleges and home educated pupils • Development of Southampton Children and Young People's **Mental Health Crisis Resolution and Home Treatment Team** • Improved mental health support to **children in care and vulnerable young people**, and the professionals working with them • Launch of **BeeWell survey** within secondary schools • Southampton officially launches as a **Child Friendly City** • **Development of Young Southampton** – an alliance of voluntary and community sector organisations supporting young people

Start Well – Progress to date

What have we done in the last 12 months?

- Developed **Family Hub offer** (7 Family Hubs) including recruitment of Perinatal MH practitioners, implementation of breastfeeding rooms and peer champions in all Family Hubs and roll out of parenting support (26 parenting courses)
- UHS has adopted **UNICEF Baby Friendly Initiative** to support breastfeeding
- Implementation of **Kooth on-line** counselling service for 11-25year olds
- New counselling contract with **No Limits** - increased capacity for young people 0-18
- **Emotional health training** programme piloted in Southampton with the Anna Freud Centre – 500 staff and volunteers have signed up
- Implementation of a new **Preparing for Adulthood (PFA)** Assessment Team in the Council to provide more timely assessment and pilot of a PFA community navigation service to support young people access the support and activities available in their communities. Development of an Employment Guide. Transition Fair run by Re:minds in March 23.
- Sign up to the Local Authority **Declaration for Healthy Weight**
- **Autism in Schools programme** rolled out to 15 schools in Southampton
- Early Bird, Early Bird Plus, Cygnet and New Forest **Parenting Programmes** introduced across the city for parents of children with Neurodiversity
- **Early LifeLab** programme rolled out to all primary schools
- Expanded range of SEND friendly and **inclusive holiday programmes** in the city (HAF)
- Completion of **Discovery and Development phases of UNICEF Child Friendly City**

What are we planning in the next 12 months

- Officially **launch Child Friendly City** in November 2023
- Roll out of **#Beewell Health and Care** survey to all secondary schools from Sept 23
- Completion of refurbishment and mobilisation of Westwood Short Stay residential unit to support children at risk of hospital admission or long term residential care
- Recommissioning of **short breaks for children with SEND**, broadening the offer of support, particularly for those at the medium level of need and with neurodiversity
- Roll out **Autism in Schools programme** to all schools and colleges in the city
- **Further develop Family Hubs,** embedding Perinatal MH practitioners, rolling out PEEP training to support parents help their child's development and learning pre-school
- **Remodel the 5-19 Public Health Nursing Service** – focus on national High Impact areas
- Roll out **MH Support Teams** to 10 remaining primary schools in Southampton
- Implement the new **CAMHS support offer to children** looked after and vulnerable young people and the professionals who work with them
- Continue to improve support for **young people preparing for adulthood** – implementation of new mental health access coordination service, Improved support to vulnerable young people and care leavers to access housing and employment
- Develop an **all-age neurodivergent strategy** along with piloting a new **Autism Hub**
- Embed expanded **community mental health crisis support** covering evenings and weekends
- Development of sustainable model of assessment and support for **children with neurodiversity,** including potential roll out of Neurodiversity profiling tool in the city

Impact

- Reduced hospital admissions for children with mental health issues since introduction of acute psychiatric liaison offer – from 47% pre 2022 to 27% in 23/24
- Reduced short stay hospital admissions for common acute childhood illness by 17% since introduction of Hospital at Home Service
- During 2022/23 28% of mothers stopped smoking during pregnancy reducing the overall percentage to 9.6%, only slightly above the national average of 9.1%
- 81% of babies breastfed in Southampton at 7-10 days are still breastfeeding at 6-8 weeks which puts Southampton above the national average
- More to do:
  - Referrals into specialist CAMHS continue to rise and Waiting list for for Autism/ADHD assessments continue to rise
  - Outcomes for young people with additional needs preparing for adulthood have still to improve (e.g. those not in employment, education and training)
  - Impact on percentage of children with healthy weight – too early to tell

Reminder of our five year vision for Live Well

Live Well

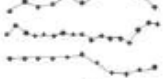
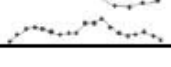
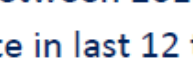
People will achieve and maintain a sense of wellbeing by leading a healthy lifestyle supported by resilient communities

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.

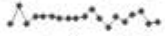
Key points – Adults

- **Smoking prevalence** in adults **decreasing** overall, 2019 data (16.8%) significantly higher than England (13.9%), 2020 has cautionary flag around data collection, true value is expected to lie between 2019 and 2020 values
- **Suicide rate** (2019-21 9.5 per 100k) **similar to England** and lowest rate in last 12 three-year pooled periods, however **coroner** hearings and **registered** dates may have been **delayed** due to **COVID-19**.
- Local **depression prevalence** (12.4%) has **increased** similarly **along** with **national** rates (12.3%) for 2020/21
- Under 75 mortality from **preventable liver disease**, data 2016-18 & 2017-19 **highest since 2001-03**, **significantly higher** than **England**
- **HIV late diagnosis** in people first diagnosed with HIV in the UK, now 37% continues with a 4th consecutive 3 year pooled period **lower** than **national average** (43%)
- **TB incidence locally** (9.8 per 100k) **significantly higher** than England (8.6 per 100k) and **lowest** since 2001-03
- **Injuries due to falls** in those aged 65+ **increasing overall** whilst **England average** remained **stable**, pandemic period saw falls locally and nationally decline in line with stay-at-home/social distancing compliance

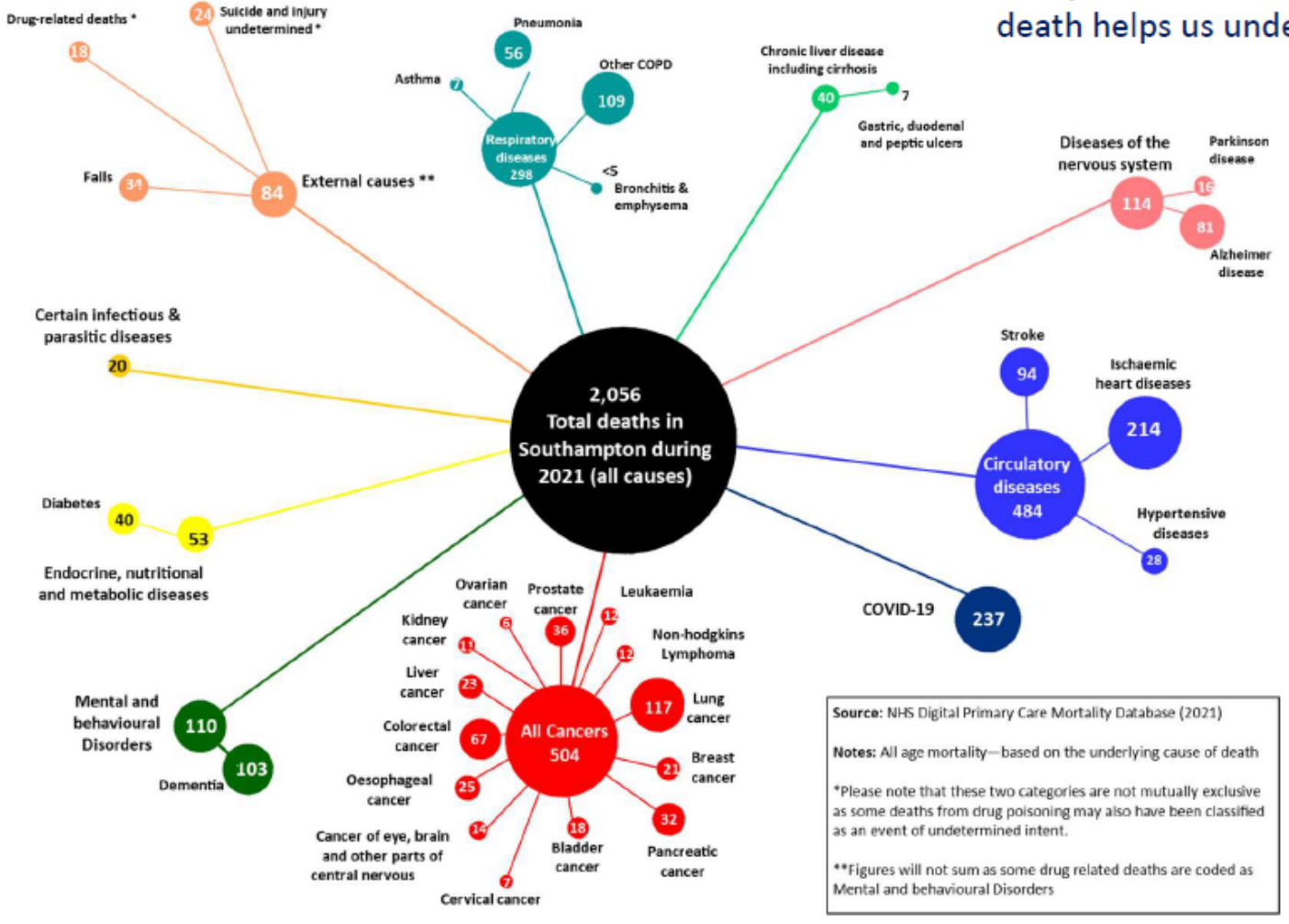
Priority area	Measure	Unit	Time period	Southampton Sparkline	Southampton value	England value	ONS (n=12) Comparator Ranking (1 is worse, worst third in pink)	Significance compared to England value
Adults	Smoking Prevalence in adults (18+) - current smokers (APS)	%	2020		11.8	12.1	8	Lower
			2019		16.8	13.9	3	Significantly higher
	Suicide rate (age 10+ years)	per 100,000	2019 - 21		9.5	10.4	11	Lower
	Depression: Recorded prevalence (aged 18+)	%	2020/21		12.4	12.3	4	Higher
	Injuries due to falls in people aged 65+ (Persons)	per 100,000	2020/21		2918.6	2023.0	2	Significantly higher
	Injuries due to falls in people aged 65+ years (Male)	per 100,000	2020/21		2659.4	1667.3	2	Significantly higher
	Injuries due to falls in people aged 65+ years (Female)	per 100,000	2020/21		3092.8	2284.8	3	Significantly higher
	Under 75 mortality rate from liver disease considered preventable (2019 defn)	per 100,000	2017 - 19		23.2	16.7	3	Significantly higher
	HIV late diagnosis in people first diagnosed with HIV in the UK	%	2019 - 21		37.3	43.4	10	Lower
	TB incidence (3 year average)	per 100,000	2018 - 20		9.8	8.0	3	Higher

Key points – Healthy settings

- 2020 saw fraction of **mortality attributable to particulate air pollution higher** than **England average** (6.3 versus 5.6%)
- **Excess winter deaths not significantly different** to **England average** and follows national warm/cold winter trends. The data has not be revised at local authority level for Winter 2020 to 2021 which nationally showed a growth of excess winter deaths driven by the large number of coronavirus (COVID-19) deaths in the non-winter months of 2020 (April to July) and the winter months of 2021 (December to March).
- Data for **people in employment** to end of March 2021 saw Southampton significantly higher than England, however the impact of COVID-19 has since seen significant increases and also sub-city variation (see slides on benefits in Covid Impact Assessment section)

Priority area	Measure		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	Fraction of mortality attributable to particulate air pollution (new method)	%	2020		6.3	5.6	2	Not comparable
	Percentage of people aged 16-64 in employment	%	2020/21		80.0	75.1	11	Significantly Higher
	Excess winter deaths index (Persons)	Ratio	Aug 2019 - Jul 2021		7.4	17.4	11	Lower
	Excess winter deaths index (Male)	Ratio	Aug 2019 - Jul 2021		11.0	17.5	11	Lower
	Excess winter deaths index (Female)	Ratio	Aug 2019 - Jul 2021		3.6	17.3	11	Lower

Some causes of deaths are more common than others.



Source: NHS Digital Primary Care Mortality Database (2021)

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

Analysis of the **trends, patterns** and **comparisons** for cause of death helps us understand **priorities** for **health** and **wellbeing**

Comparing proportions of **deaths by cause** with proportions of **years of life lost by cause** shows which groups impact younger people disproportionately:

External causes account for **4.1% of deaths** in **2021** but **14.5% of years of life lost.**

Suicide and injury undetermined are the **largest** part of this accounting for **3.1% of deaths** and **7.4% of year of life lost**

Drug related deaths account for **0.9% of deaths** in 2021 and **5.3% of year of life lost**

Liver disease (incl. cirrhosis) is the underlying cause for **1.9% of deaths** and **6.3% of years lost**

Inequalities - Mortality

In the most deprived quintile compared to the least…

All Causes

All age mortality

1.4x higher

Premature (u75) mortality

2.0x higher

Cancer

All age mortality

1.4x higher

Premature (u75) mortality

1.5x higher

Circulatory Disease

All age mortality

1.3x higher

Premature (u75) mortality

1.9x higher

COPD

All age mortality

2.9x higher

Note: Uses local deprivation quintiles

Live Well – Original Roadmap

Year	What we said we were going to do in the strategy
Year 1 2022/21	• **Lung health checks** fully implemented to increase the early detection and survivorship of lung cancer • Patients will be able to receive a **definitive cancer diagnosis** within 28 days of referral • Community **Cardiology and Respiratory** service developed • Psychological therapy support available for people with cardiovascular or gastrointestinal conditions • Development of **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 • 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 and **Therapeutic care** from inpatient MH services will be improved • Implement an effective mental health pathway for **rough sleepers** to access integrated holistic care, long term care and support
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 **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
Year 4 2023/24	• Implementation of **16-25 mental health pathway** to support young people preparing for adulthood, including co-produced Mental Health online resource. • **Community Mental Health Transformation:** broadening the offer within PCNs to include support for social determinants of mental health (carer support, housing, employment alongside the social prescriber role). • Increased uptake of **Serious Mental Illness physical health check** and access to physical activity/behavioural change offer • Development of **supported housing strategy** for people with Mental Health issues. • Expand access to NHS Talking Therapies (previously known as Improving Access to Psychological Therapies - IAPT) • Proactive care for **people with long term conditions**, with focus on Heart Failure, Cardiac Rehabilitation and Breathlessness (incl. diagnosis of COPD and asthma • Increase **Diabetes** education (NDPP) uptake targeting at risk groups and review transition pathway from children to adult services • Reduce **Tobacco Dependence** through targeted work with PCNs, maternity, homeless settings, mental health and acute inpatient settings. • Continuation of services to reduce number of **rough sleepers** through additional government funding. • Improve the quality and quantity of **Learning Disability Annual Health Checks** and Plans (including improved access to cancer screening) • Pilot a **Neurodiversity** Hub providing advice and support

Live Well – Progress to date

What have we done in the last 12 months?

- Reduced **Tobacco Dependence** through commissioned Smokefree Southampton Solutions service, PCNs, maternity and homeless settings.
- Continuation of services to reduce number of **rough sleepers**
- Reviewed **sexual health** services, re-procurement of service.
- Recommissioned **Domestic Violence**
- Commissioned a **Housing First** service
- More **supported living** properties for adults with learning disabilities and MH needs.
- Launched **new Integrated Diabetes** service in 2022
- Achievement of **'exemplary' quality mark for Southampton Mental Health Individual Placement and Support Service**
- Development of **16-25 Mental Health pathways**.
- Development of new **PCN based Enhanced Primary Care Mental Health roles**, delivering evidence based individual and group intervention in Primary Care settings.
- Embedded integrated working between Primary Care, IAPT, secondary care services
- Introduction of **Serious Mental Illness physical health check** facilitator to support Primary Care and provision of point of care testing technology in every GP Practice.
- Completed **Mental Health Housing Needs Assessment** & Market Position Statement
- Launched Southampton **MH grant giving scheme**, Saints by you Side programme for men, Mayfield Nurseries horticultural therapy programme.
- 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
- **Gambling Harm Clinic** launch in Southampton
- Development of a **second Lighthouse in Bitterne**
- New **Suicide and Bereavement Support Service (Amparo)** and ICS Wide Mental Health Digital development of SHOUT, linked back to the 111 Mental Health Triage.
- Developed easy-read guidance for **cancer screening**
- Improved use of **learning disabilities housing** stock in the city

Impact

- 60% of people experiencing 1st episode **psychosis** treated within 2 weeks of referral
- 7 more adults with **LD** supported to move from residential care into supported living
- Referral target achieved for **Diabetes** education programme – 6703 people referred
- Employment - 210 people accessed **MH Individual Placement** and Support Service
- People with **LD in paid employment** increased from a low of 2.9% during Covid, to 4.4%
- Improved use of **housing stock -** void rates reduced from 17% in 21/22 to current rate of 3%
- **Smoking** prevalence in adults decreasing overall
- **Suicide** rate reducing
- More to do:
  - **Cancer, CVD and Respiratory disease** - prevalence much higher in most deprived areas
  - Uptake of **LD health checks** remains below target, poorer health & wellbeing outcomes
  - Local **depression** prevalence increased

What are we planning in the next 12 months?

- Target **tobacco dependency** support in deprived areas and those facing inequalities (mental health, homeless) by training more front-line staff in behaviour change interventions.
- Mobilise new **Integrated Reproductive Sexual Health Service** (IRSHS) across HIOW
- Development of an **Early Intervention and Prevention strategy**
- Continue to improve **proactive and preventative care for people with long term conditions,** focusing on Heart Failure, Cardiac Rehab, Breathlessness
- Continue to increase **Diabetes education** (NDPP) uptake through community engagement officer, offering non-English language programmes, and pilot of hospital referrals
- Implementation of **16-25 mental health pathway**.
- Co-produce offer for people with **co-occurring MH issues and substance use** disorder
- Continue to increase uptake **of Serious Mental Illness physical health check**
- Development of **supported housing strategy for people with MH issues**
- Increase access to NHS **Talking Therapies**
- **Inclusive Lives procurement**: inclusive, strengths-based care & support for people with LD
- Improve uptake of Learning Disability Annual Health Check
- Deliver 29 new **Supported Living tenancies** for adults with learning disabilities
- Maximise use of Faecal Immunochemical Testing to detect **bowel cancer**

Mental Health Case Studies

Mental Health Case Studies

Improved patient experience and outcomes - case studies

Case Studies

SMI physical health outreach and Point Of Care technology

- 63 year old agoraphobic gentleman on SMI register
- Referred for SMI physical health check by surgery due to attempts to contact
- Invite letter sent and contacted by patient who consented to visit by SMI health facilitator
- Visited patient at home and SMI health check completed
- Blood test identified onset of diabetes
- CWT HCA supporting gentleman with new diagnosis, self-management including use of glucometer
- Reassurance and advice around medications/treatments provided
- Ongoing support with referrals to other services, including accessing dentist and optician

Integrated working between Enhanced Primary Care Mental Health team and PCN social prescribers

- Patient referred by social prescriber
- Presented with Low mood, anxiety, ruminating thoughts, suicidal ideation and self harm
- Assessed within 5 days and offered brief intervention 6 sessions. Included psychoeducation and developing coping skills and strategies. Used online self-help resources and guided interventions workbooks
- Positive feedback from patient as anxiety lessened and able to resume activities; avoided medication

Early detection and support to avoid step up to secondary care

- Patient had diagnosis of Bi-Polar who was experiencing a manic phase of her illness, referred by GP to EPCMHT
- Triaged on the day and prevented full relapse, early detection and avoided secondary services
- Medication advice and guidance and support from nurse ensured deterioration managed and did not escalate
- Positive feedback from patient and family due to timely response, support to family and less disruption to family life

Peer Recovery Workers

- Recovery peer worker supported patient in peer recovery group
- Presentation; highly anxious, social phobia and reduced level of functioning
- Outcome; able to attend group and looking at voluntary work
- Positive feedback 'I would like to thank peer worker and NHS for wisdom and support for giving me light at end of tunnel and could not imagine this prior to treatment'

Reminder of our five year vision for Age Well

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.

Performance against key measures

- Hospital admissions relat**ed 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**

Priority Area	Measure	ID	Units	Latest data	Southampton Value	England Value	Significance compared to Engand
Older People	Dementia: QOF prevalence (all ages)	247	%	2020/21	0.5	0.7	Lower
	Emergency hospital admissions due to falls in people aged 65 + (female)	22401	per 100,000	2021/22	3,418.0	2,360.0	Significantly Higher
	Emergency hospital admissions due to falls in people aged 65 + (male)	22401	per 100,000	2021/22	2,915.2	1,749.6	Significantly Higher
	Emergency hospital admissions due to falls in people aged 65 + (persons)	22401	per 100,000	2021/22	3,186.8	2,099.9	Significantly Higher
	Life expectancy at 65 (female)	91102	Years	2021	40.9	41.9	Lower
	Life expectancy at 65 (male)	91102	Years	2021	34.6	36.9	Lower
	Mortality rate from all cardiovascular diseases, ages 65+ yrs	92718	per 100,000 65+	2021	1,179.3	1,021.4	Significantly Higher
	Mortality rate from respiratory disease, ages 65+ yrs	92725	per 100,000 65+	2021	568.0	440.8	Significantly Higher
	Older people in poverty: Income deprivation affecting older people index (IDAOPI)	93279	%	2019	17.3	14.2	Significantly Higher
	Percentage of people aged 65+ using social care who receive self-direct payments	92729	%	2021/22	94.3	93.2	Higher
	Permanent admissons to residential and nursing care home per 100,000 aged 65+	1194	per 100,000	2021/22	644.5	538.5	Significantly Higher
	Suicide crude rate 65+ years: per 100,000 (5 year average) (male)	91430	per 100,000	2013-17	19.2	12.4	Higher
	Winter mortality index (age 85+)	90361	Ratio	Aug 2019 - Jul 2021	7.4	17.4	Lower

Age Well – Original Roadmap

Year	What we said we were going to do in the strategy
Year 1 2022/21	• **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 • Multi-agency 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**
Year 4 2023/24	• Full range of **community support activities** on offer • **Age Well friendly City** • **People actively managing their health**, utilising technology, self-managed care plans with easy access to information, advice and guidance • Integrated community teams working across localities utilising population management tools – delivering strengths based, joined up, proactive care and support • **Mental Health support** fully embedded in the locality team offer • More people **supported to stay at home/maintain their independence** for as long as possible – stronger focus on getting people back home after a hospital stay • **Care Homes proactively managing the health needs** of their residents

Age Well –Progress to date

What have we done in the last 12 months?

- A **reablement business case** and subsequent improvement groups have been developed
- The **Joint Equipment Store** has increased the amount of DFG activity and minor works it undertakes which reduces unnecessary assessment and promotes timeliness.
- Continued "One Team" pilot, informing development of Integrated Neighbourhood Teams
- The **Virtual Ward** model has further developed and is operating at an optimum level.
- Roll out of **Enhanced Health in Care Homes** support delivered by PCN's across the city.
- Southampton **Dementia Festival** showcasing information on support opportunities for those people living with dementia, their family and carers; Re-commissioning of Dementia Friendly Southampton bringing together community groups, charities, businesses and residents & Increase in provision of Memory Cafes
- **Increased occupancy of extra care schemes** (to 94%) and review of need bandings to enable gradual increase in the complexity of need that can be met within extra care.
- Support for **adult social care workforce** around recruitment, retention and training
- A new **Market Position Statement** for older person care services.
- Publication of **market sustainability plan** based on the cost of care exercise
- Re-procurement and increased **market diversity in home care**, with 29 new providers joining the Home Care Platform
- **Transfer of Care Hub** set up to support hospital discharge – promoting home first approach
- **Care technology** rolled out across Virtual Wards and Care Homes promoting independence.

What are we planning in the next 12 months?

- Operationalise the reablement business case increasing **reablement to community referrals**
- Develop a more **integrated** whole system approach to **proactive joined up local care and support**, including greater use of care technology to help people maintain independence
- Reset **Carers Strategy** in line with contextual change in the city
- Further maximise opportunities to use the **DFG** to better support people's independence
- Continued review and development of **discharge to assess model**
- Revisit the **Falls Strategy** to ensure it is aligned strategically.
- Continued development of **community navigation**, taking referrals from the Adult Social Care front door
- Implement learning from Hampshire and Isle of Wight ICB **Dementia group** to develop a recovery plan to achieve Dementia Diagnosis targets
- Develop plans for **Older Persons Mental Health** community based support including crisis and in reach into Nursing Homes
- Confirm commissioning intentions regarding future use of **RSH** site for adult social care
- Implement new banding system for extra care as part of re-tender
- Continued workforce support to the market with a more specific focus on the **personal assistant market** (for those with direct payments).
- Implement and monitor new **hospital discharge community navigation** service
- Re-tendering existing extra care schemes through the Home Care Platform
- Concluding a review of the community transport offer in the City

Impact

- Over 95% people now discharged "home first" from hospital supporting a more strengths based, independence promoting approach
- More to do:
  - Hospital admissions in relation to falls remain very high
  - Permanent admissions to residential homes for people aged 65+ remain high
  - High rates of avoidable unplanned hospital admissions
  - High rates of suicide amongst males 65+

Reminder of our five year vision for Die Well

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 no disparity in access to and provision of end of life care across the Southampton geography.
- More people will achieve their preferred place of care and death where this is practical to do so.
- 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 available?
- More palliative care and end of life 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.

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	ID	Units	Latest data	Southampton	England	Significance compared to Engand
Die Well	Deaths in usual place of residence: People with dementia (aged 65+) (Persons)	91887	%	2019	67.8	70.3	Similar
	Percentage of deaths that occur at home (persons)	93476	%	2021	29.0	28.7	Similar
	Percentage of deaths that occur in care homes (persons)	93475	%	2021	18.4	20.2	Similar
	Percentage of deaths that occur in hospital (persons)	93474	%	2021	43.0	44.0	Similar

Die Well – Original Roadmap

Year	What we said we were going to do in the strategy
Year 1 2022/21	• **24/7 coordination centre** with access to rapid response 24 hours 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 2021/22	• **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 advance care place 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 2022/23	• Development of an **end-of-life school's programme**
Year 4 2023/24	• Childrens end-of-life care services in place with bank of **end-of-life children's home care/sitting service** • Continued development of **24/7 end of life Care Coordination Centre** • **Improved hospital discharge processes** to support more people to **die in the place of their choice** • Increased ea**rly identification of people at end of life** to support more proactive care planning • **Improved bereavement support** • **Addressing inequalities in access to end of life** care (e.g. people with learning disabilities, homeless people)

Die Well – Progress to date

What have we done in the last 12 months?

- **Palliative Care Support Workers** are now part of the care coordination centre, which is run 24/7 by Mountbatten Hampshire
- A **discharge facilitator** is now in place working across UHS and the hospice inpatient unit. The main focus on this role is to facilitate quicker fast track discharges from hospital.
- Two **nurse led respite beds** are now in place and have been working well for the past 12 months.
- An intensive **communications programme** with stakeholders i.e. Primary Care, Acute, Social prescribers, 111, 999 (paramedics) to raise awareness of the breadth of end of life and palliative care (EOL&P) services available in Southampton and the importance of early referral to the EOL&P care service.
- Opened a **social space** for the general public based at Mountbatten Hampshire which includes a café/restaurant and supports those feeling socially isolated.
- Roll out of a time limited/funded programme to **deliver bereavement and wellbeing support to residential and nursing home staff in Southampton** following impact of Covid19. This has led to a direct reduction in sickness for the care homes who engaged.
- Increase in the numbers of **nurse prescribers** within Mountbatten Hampshire, which aims to reduce the impact on Primary Care, 111 etc to prescribe drugs.
- Development of an **end of life care coordination register** in conjunction with key stakeholders.
- Embedded **spiritual care** as mandatory training for all Mountbatten staff
- Mountbatten Hampshire employed an **LD nurse** to support patients and families with a diagnosis of a LD who are EOL and to be a point of reference for staff.
- The **Southampton Homeless and substance user's forum** has been reinstated and training needs for staff identified for this cohort, supported by a tailored education programme. Includes shadowing in hostels and at Mountbatten.

Impact

- Percentage of **deaths that occur in usual place of residence** has been increasing – reduction in deaths in hospital
- More people being **identified earlier** for support in the community – Mountbatten's community case load has grown from <500 in April 2020 to 1,400 in June 2023
- More to do:
  - **Deaths in usual place of residence** lower than England average for dementia
  - **Bereavement support**

What are we planning in the next 12 months?

- **Developing a broader spiritual care offer**, pre and post bereavement, which includes working with local clergy to identify a resource of all faiths.
- **Training of teachers** in bereavement support providing psychological skills.
- **Partnerships between adult and children's EOL services** to support Children and Young Adults in transition (in conjunction with ICB).
- End of life provider and care homes, to strengthen **collaborative working** and increase the number of end of life patients registered with Advance Care Plans (ACP)
- Explore how **personal health budgets** might be implemented for those fast track patients

Health and Care Commitments supporting workstream priorities

Start Well

- **Strengthening Early Help through integrated local support in communities (1st 1001 days)**
- **Improving Emotional & Mental health of children & families through earlier intervention & promotion of positive MH**
- Increase opportunities for all young people & particularly the most vulnerable, in education, housing, employment, training
- Improve outcomes for children with SEND
- **Promoting healthy weight – to include City wide roll out of Healthy High Five & Healthy Early years Award**

Live Well

- **Reduce harm from tobacco, alcohol and drugs**
- **Improve the life chances of the most vulnerable, in particular people with MH problems, LD & other disadvantages & reduce inequalities, through improved opportunities for housing, employment & training**
- **Improving mental health & tackling loneliness**
- Improving cancer screening & early identification
- Improving outcomes for people with diabetes
- **Promoting healthy weight**

Commitments

All partners are signed up to the following commitments in support of each of the workstream priorities to address the city's cross cutting issues & challenges:

1. A "**one team**" locality based approach which brings health & care teams together with local communities, informed by population health management, to proactively identify & support children, families & adults
2. A **Trauma informed** workforce
3. **Whole city campaigns** targeted at healthy weight, smoking, mental health & harm from drug and alcohol
4. An **Infrastructure** which promotes health & wellbeing:
    - Health in all Policies
    - Sign up to Healthy Weight declaration
    - Recruitment practice that targets opportunities towards vulnerable groups
    - Purchasing locally for social benefit
    - Smoke free settings
    - One public estate

Age Well

- Improving support to enable people to maintain their health, wellbeing and independence into old age
- Support more people to receive the right services at the right time & in the right place, through proactive, integrated support, embedded in local communities
- **Improve mental health, emotional wellbeing & tackle loneliness**
- Improve identification of and support for carers

Die Well

- **Early identification of people at End of Life to improve outcomes through proactive personalised care planning**
- Promote accessibility & equality of End of Life care for everyone, with a particular focus on groups who have poorer outcomes, e.g. homeless, people with LD, dementia
- Improve Out of Hospital End of Life Care Co-ordination

Health and Care Commitments

Workstream	Progress to date
A Trauma Informed workforce	Southampton Trauma Informed Practice (TIP) strategy developed TIP working group set up to communicate and inform delivery of TIP across the city Working with all partners in Southampton to sign up to the development of a Trauma informed workforce. TIP training framework for all organisations in development A mapped landscape of provision underway within the city to support those who have experienced trauma and diversity.
Whole City Campaigns	Partners working together to commit resources to a series of joint whole city comms campaigns targeted at healthy weight, smoking, mental health & harm from drug and alcohol. Progress to date includes: • Joint campaign being prepared and led by Southern Health NHS Foundation Trust on suicide prevention • Joint work to support smoke free programme, partnering with University Hospital Southampton NHS Foundation Trust. • Process in place for agreeing joint work within fortnightly Southampton comms group meetings • ICB drafting Southampton place achievements and successes, for consideration to use internally or externally as appropriate
Pro-active Integrated Neighbour -hood Teams	Southampton Primary and Local Care Transformation Delivery Group (PLCTD) set up with members from all agencies, NHS, social care and third sector. The group has set out its objectives and work is underway to design and deliver • Southampton Neighbourhood Operating Model • Pro-active Case Management - Integrated Neighbourhood Team • Acute Infection Hub/Same Day Access across primary care • Urgent Care Response in the community • Virtual Wards, Telemedicine

Health and Care Commitments

Workstream	Progress to date
Health and Wellbeing Infrastructure	**Health in all policies (HiaP)** HiAP Progress includes: • Development of a new Tobacco, Alcohol and Drugs Strategy with significant involvement from teams across the council. • Scoping of a whole systems approach towards the food environment in Southampton. • Adoption of the Prevention Concordat for Better Mental Health, and development of a multi-agency partnership group of teams and organisations which influence the wider determinants of mental health and wellbeing in Southampton. Development of a commitment for all partners to sign up to embedding health promoting activities within their organisations which include HiaP, Healthy Weight declaration, recruitment practice that targets opportunities towards vulnerable groups, smokefree settings, purchasing locally for social benefit and utilising public estate. **Recruitment practice – vulnerable groups** On track to support 400 people in target cohorts into paid employment each and to support up to 500 into training. Securing funding remains a challenge to continue with the work. Skills Team and Adult Learning Team budgets stabilised SCC and DWP Partnership agreement finalised, focussing on: • Unemployed Young People aged 18-24 • Unemployed people with health conditions and disabilities • Unemployed people with a Secondary mental health condition and people recovering from substance/alcohol misuse • Unemployed and workless people aged over 50 • Commissioned support to young people at risk of NEET (Aged 15/16) = project being drafted **One public estate** Working with all partners and agencies to make best use of public estate, including the co-location of workforce, support for communities and reduction of environmental impact.

Common Challenges across all Workstreams

Challenges	Key actions
Increasing demand and complexity of need	• Strengthening early help and prevention • Maintain clear understanding of current and future need forecasts • Work with the market to adapt provision to meet those needs
Workforce shortages (across health and care sector)	• Joint recruitment campaigns – whole city approach to making Southampton a good place to work • Collaborative working with providers in staff retention • Continued exploration/evaluation/use of digital/different ways of working • International recruitment • Peer Support Worker expansion programmes • Development of new roles promoting career progression e.g. clinical support workers, advanced practitioner programme
Financial pressures across the system	• Continued focus on Value for Money, identification of opportunities for streamlining provision, achieving efficiencies, reducing duplication • Greater use of care technology and digital resources • Balance of preventative work versus crisis care
Community and Voluntary Sector - Impact of cost of living pressures	• Working with the VCSE to develop infrastructure and support to attract external sources of funding, fund raising, sharing of resources – Young Southampton, Health and Care Alliance
Estate	• Commissioners and providers to work together to maximise utilisation across services and communities • Review opportunities for SCC as Social Landlord to develop housing for vulnerable groups e.g. rough sleepers, people with LD
Strategic and financial context rapidly changing	• Ensure that our strategic vision is relatable and realistic • Ensure that we engage actively with partners, other systems and patients/service users and their families
Economic impact on individuals – increasing deprivation	• Targeting provision to those most vulnerable populations/areas of deprivation • Strengthening the early help and prevention offer
Care provider sustainability	• Monitor impact of cost of living on care provider sustainability (both operational and financial) with consideration of this within 2024/25 uplifts. • Work with Skills for Care and Hampshire Care Association to identify support available to care market