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Health and Wellbeing Board

Wednesday, 29th July, 2015 at 5.30 pm

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Shields
Councillor Jeffery
Councillor White
Councillor Lewzey
Councillor Chamberlain

Rob Kurn – Healthwatch
Hilary Brooks – Interim Head of Service
Dr A Mortimore – Director of Public Health
Dr S Robinson – Clinical Commissioning Group
Dr E Mearns – NHS England Wessex Local Area Team

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BACKGROUND AND RELEVANT INFORMATION

Purpose of the Board

The purpose of the Southampton Health and Wellbeing Board is:

- To bring together Southampton City Council and key NHS commissioners to improve the health and wellbeing of citizens, thereby helping them live their lives to the full, and to reduce health inequalities;
- To ensure that all activity across partner organisations supports positive health outcomes for local people and keeps them safe.
- To hold partner organisations to account for the oversight of related commissioning strategies and plans.
- To have oversight of the environmental factors that impact on health, and to influence the City Council, its partners and Regulators to support a healthy environment for people who live and work in Southampton

Responsibilities

The Board is responsible for developing mechanisms to undertake the duties of the Health and Wellbeing Board, in particular

- Promoting joint commissioning and integrated delivery of services;
- Acting as the lead commissioning vehicle for designated service areas;
- Ensuring an up to date JSNA and other appropriate assessments are in place
- Ensuring the development of a Health and Wellbeing Strategy for Southampton and monitoring its delivery.
- Oversight and assessment of the effectiveness of local public involvement in health, public health and care services
- Ensuring the system for partnership working is working effectively between health and care services and systems, and the work of other partnerships which contribute to health and wellbeing outcomes for local people.
- Testing the local framework for commissioning for:
    - Health care
    - Social care
    - Public health services
    - Ensuring safety in improving health and wellbeing outcomes

Smoking policy – The Council operates a no-smoking policy in all civic buildings.

Mobile Telephones:- Please switch your mobile telephones to silent whilst in the meeting

Southampton City Council's Priorities:

- Jobs for local people
- Prevention and early intervention
- Protecting vulnerable people
- Affordable housing
- Services for all
- City pride
- A sustainable Council

Use of Social Media:- The Council supports the video or audio recording of meetings open to the public, for either live or subsequent broadcast. However, if, in the Chair's opinion, a person filming or recording a meeting or taking photographs is interrupting proceedings or causing a disturbance, under the Council's Standing Orders the person can be ordered to stop their activity, or to leave the meeting.

Fire Procedure – In the event of a fire or other emergency, a continuous alarm will sound and you will be advised, by officers of the Council, of what action to take

Access – Access is available for disabled people. Please contact the Democratic Support Officer who will help to make any necessary arrangements.

Dates of Meetings: Municipal Year 2015/16

2015	2016
29 July	27 January
30 September	23 March
4 November	

CONDUCT OF MEETING

BUSINESS TO BE DISCUSSED
Only those items listed on the attached agenda may be considered at this meeting.

PROCEDURE / PUBLIC REPRESENTATIONS
At the discretion of the Chair, members of the public may address the meeting on any report included on the agenda in which they have a relevant interest. Any member of the public wishing to address the meeting should advise the Democratic Support Officer (DSO) whose contact details are on the front sheet of the agenda.

RULES OF PROCEDURE
The meeting is governed by the Executive Procedure Rules as set out in Part 4 of the Council's Constitution.

QUORUM
The minimum number of appointed Members required to be in attendance to hold the meeting is 3 who will include at least one Elected Member, a member from Health and Healthwatch.

DISCLOSURE OF INTERESTS

Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "Disclosable Pecuniary Interest" or "Other Interest" they may have in relation to matters for consideration on this Agenda.

DISCLOSABLE PECUNIARY INTERESTS

A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:

(i) Any employment, office, trade, profession or vocation carried on for profit or gain.
(ii) Sponsorship:
Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.
(iv) Any beneficial interest in land which is within the area of Southampton.
(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.
(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.
(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

a) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or
b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class

Other Interests

A Member must regard himself or herself as having an, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

Any body to which they have been appointed or nominated by Southampton City Council

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

Any body whose principal purpose includes the influence of public opinion or policy

Principles of Decision Making

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the "rationality" or "taking leave of your senses" principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, 'live now, pay later' and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

AGENDA

Agendas and papers are now available via the Council's Website

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

To note any changes in membership of the Board made in accordance with Council Procedure Rule 4.3.

2 ELECTION OF CHAIR AND VICE-CHAIR

To elect a Chair and Vice-Chair for the 2015/16 Municipal Year.

3 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Democratic Support Officer.

4 STATEMENT FROM THE CHAIR

5 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 25th March, 2015 and to deal with any matters arising, attached.

6 HOUSING AND HEALTH IN SOUTHAMPTON

Report of the Director of Public Health detailing the health impact and opportunities to improve health through joined up housing related approaches, attached.

7 DRAFT HEALTH INEQUALITIES FRAMEWORK

Report of the Director of Public Health detailing the draft Health Inequalities Framework, attached.

8 INTEGRATED COMMISSIONING WORK PROGRAMME 2015/16

Report of the Director of Quality and Integration detailing the Integrated Commissioning Work Programme 2015/16, attached.

9 BETTER CARE SOUTHAMPTON PROGRESS AND PERFORMANCE

Report of the Director of Quality and Integration detailing progress and performance of

Better Care Southampton, attached.

10 PERFORMANCE UPDATE

Report of the Chair of the Health and Wellbeing Board detailing a performance update, attached.

11 SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP (SCCCG) QUALITY PREMIUM

Report of Southampton City Clinical Commissioning Group GP Board Representative, detailing the Southampton City CCGs Quality Premium, attached.

Tuesday, 21 July 2015 Head of Legal and Democratic Services

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 25 MARCH 2015

Present: Councillors Baillie, Lewzey, Shields (Chair) and Chamberlain
Alison Elliott, Dr Andrew Mortimore, Dr Steve Townsend (Vice Chair) and Rob Kurn

Also in Attendance: Councillor Payne – Cabinet Member for Housing and Sustainability
Stephanie Ramsey - Director of Quality and Integration, Southampton City Clinical Commissioning Group (CCG)
John Richards – Chief Executive, NHS Southampton Clinical Commissioning Group
Matthew Harrison – Commissioner, Integrated Commissioning Unit
Richard Pearce – Carer
Mike Stonehouse, Self Advocate
Alex Whitfield – Chief Operating Officer, Solent NHS Trust

38. **APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)**

The Board noted the apologies of Councillor Jeffery.

The Board further noted the following changes in membership which would become effective from 1 April 2015:-

Dr Sue Robinson replacing Dr Steve Townsend, Clinical Commissioning Group
Dr Elizabeth Mearns replacing Dr Stewart Ward, NHS England Wessex Local Area Team

39. **DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS**

Councillor Shields declared a personal interest in that he was a Council appointed representative of Solent NHS Trust and remained in the meeting and took part in the consideration and determination of items on the agenda.

Councillor Lewzey declared a personal interest in that he was a Council appointed representative of Southern Health NHS Foundation Trust and remained in the meeting and took part in the consideration and determination of items on the agenda.

40. **STATEMENT FROM THE CHAIR**

The Chair made a statement in accordance with accepted practice and passed a vote of thanks to Dr Steve Townsend, Dr Stuart Ward, Councillor Baillie and Martin Day for their professionalism and efficiency over the past few years and wished them well for the future.

41. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**

RESOLVED that the Minutes of the Meeting held on 28 January 2015 be approved and signed as a correct record.

Matters Arising:-

Minute No 36 (Page 5) – Improving Access to General Practice and Innovation in Primary Care – The Prime Minister's Challenge Fund – to date there had been no announcement on the outcome of the bid for the Prime Minister's Challenge Fund.

42. **2014 JOINT HEALTH AND SOCIAL CARE LEARNING DISABILITIES SELF-ASSESSMENT FRAMEWORK**

The Board considered the report of the Director of Quality and Integration, Southampton City Clinical Commissioning Group (CCG) detailing the second Joint Health and Social Care Learning Disabilities Self-Assessment Framework (the "SAF") return.

The Board received a presentation from Matthew Harrison, Commissioner, Integrated Commissioning Unit. Richard Pearce, Carer and Mike Stonehouse, Self Advocate were present and with the consent of the Chair, addressed the meeting.

The Board noted the following:-

- the Self Assessment Framework (SAF) assisted services, commissioners, people with learning disabilities and their families to identify what was working well and what required improvement; and
- the SAF comprised of two comprehensive sections "data collation" and "self-assessment against nationally agreed measures";
  current assessments were :-
  - Staying Healthy – red (less effective);
  - Keeping Safe – amber (effective);
  - Living Well – amber (effective).

The Board noted the following comments from Richard Pearce and Mike Stonehouse:-

- there was a lack of information and communication when individuals with learning disabilities transferred from Children's Services to Adult Services;
- individuals with learning difficulties were treated with respect and looked after reasonably well but there was not enough support for carers;
- 95% of people with learning disabilities were unemployed and there was insufficient funding for supported employment opportunities;
- transport for people with learning difficulties was reasonably helpful and effective but could be improved;
- many carers found it difficult to communicate with the Council in terms of their needs and could not comprehend the complicated financial letters relating to care packages sent out by the Council;
- there were still many carers who had not had a carer's assessment and those who had, still had not been informed of the outcome of the assessment; and

- communication between the different services was very poor;

RESOLVED:

(i) that the actions identified within the Action Plan be noted, including areas which had been self-assessed as "less effective";
(ii) that a further report providing details on the progress of the actions set out in the SAF be submitted to the Health and Wellbeing Board in 12 months;
(iii) that a report providing information on employment issues for people with learning disabilities be submitted to a future meeting; and
(iv) that the concerns relating to complicated financial letters, supported employment opportunities and carers' assessments would be investigated by officers as a matter of priority.

43. **NHS FIVE YEAR FORWARD VIEW: NEW MODELS OF CARE**

The Board considered the report of the Chief Executive, Clinical Commissioning Group (CCG) detailing the NHS Five Year Forward View: New Models of Care.

The Board received a presentation from Alex Whitfield, Chief Operating Officer, Solent NHS Trust providing information on the Southampton City Vanguard Bid for a Southampton Multispecialty Community Provider (MCP).

The Board noted the following:-

- the NHS Five Year Forward View identified the following themes to be addressed:-
  - Health and Wellbeing – which required a radical upgrade in prevention;
  - Care and Quality – which required new models of care; and
  - Funding – which required efficiency and investment.
- the Vanguard bid for a Southampton MCP had been shortlisted but had not accepted. If the bid had been accepted it would have enabled Southampton access to a share of the £200M fund announced in NHS England allocations;
- the bid underpinned Southampton's model of integrated care as set out in the Southampton Better Care programme and was strategically sound and widely supported;
- the overriding vision was to join up care for each and every unique person in the City requiring care;
- one team would meet the community health and social care needs of people living in geographically defined communities within Southampton; and
- the future model would be based on key pathways which were proactive, routine and urgent rather than the current model which was based on organisational providers and the MCP would be the single team providing an individual's integrated community health and social care requirements; and

RESOLVED:-

(i) that the proposed approach of the NHS Five Year Forward View : New Models of Care and the opportunities and barriers to be managed in moving forward with the Better Care vision be noted; and

(ii) that the partners involved with the further development of the Five Year Forward View be supported.

44. DEPARTMENT OF PUBLIC HEALTH ANNUAL PLAN 2014

The Board considered the report of the Director of Public Health detailing the Public Health Annual Report 2014.

The Board noted the following:-

- the Director of Public Health had a statutory duty under the NHS Act 2006 to provide an annual report;
- the theme of the report provided a foundation for better health in the future, covering issues around the fitness of young people, mental health problems, environmental factors, air quality and healthy lifestyles and concluded with the health inequalities that existed in Southampton which necessitated significant improvement; and
- that the first bullet-pointed recommendation in the Department of Public Health Annual Plan 2014 on Page 64,under 1.3 Recommendations be changed as follows: “The Health and Wellbeing Board should create a social movement through encouraging a whole city collaborative cross-sector approach to physical activity”.

RESOLVED:-

(i) that the Public Health Annual Report be welcomed and implications for future work of the Board be considered;
(ii) that the persistent health inequalities detailed in the report be considered and a prioritised plan of evidence-based actions that would make the biggest contribution at local level to reduce these be agreed; and
(iii) the recommendations made in the Director of Public Health’s Annual Report be considered in detail at the meeting on 29 July 2015.

45. HOUSING AND HEALTH FUEL POVERTY PLAN 2014-2017

The Board considered the report of the Director of Public Health providing details of the Housing and Health Fuel Poverty Plan 2014-2017.

The Board noted the following:-

- the Southampton Warmth for All Partnership (SWAP) was a multi-agency response to the issue of fuel poverty led by Public Health;
- an estimated 9.7% of households in Southampton suffered from fuel poverty and had below average income with above average expenditure on fuel to keep warm;
- current housing stock being built in the City was of good quality with insulation, but the quality of housing stock in the 1960’s/1970’s was inferior;
- people’s health was detrimentally affected by cold temperatures which caused respiratory illness, symptoms of arthritis (decreased mobility) and affected mental and social health;

- SWAP had agreed a three year action plan (2013-2016) to tackle fuel poverty in Southampton and annual progress reports would be submitted to the Health and Wellbeing Board with key achievements and challenges set out in the Public Health Annual Report; and
- good quality housing was a crucial factor in reducing fuel poverty and it was essential that the Cabinet Member for Housing and Sustainability was involved in the process.

RESOLVED:-

(i) that the potential impact and ambition of the Fuel Poverty Plan be noted and methods of additional support be identified; and
(ii) that the scope for the housing and health report to be submitted to the meeting on 29 July 2015, be agreed.

46. **BETTER CARE SOUTHAMPTON IMPLEMENTATION**

The Board considered the report of the Director of Quality and Integration, Southampton City Clinical Commissioning Group (CCG) detailing progress on the implementation of Better Care Southampton.

The Board noted the following:-

- the final Better Care Southampton Plan had been approved following the Nationally Consistent Assurance Review, which meant that Southampton could progress with full implementation of the Plan;
- the Integrated Commissioning Board (ICB) had reviewed the Section 75 Agreement and this would be finalised before 31 March 2015; the ICB would oversee the effective management and performance of the overall Partnership Agreement and each of the individual schemes within it on behalf of the CCG and Southampton City Council;
- cluster development was moving forward and the development of integrated care in Southampton was focused around six cluster areas;
- one of the key streams in the Better Care Plan was integrated rehabilitation and reablement which had the objective of integrating resources that facilitated rapid crisis response, timely hospital discharges and included preventative and recovery focused rehabilitation and reablement;
- the Community Solutions Group managed and co-ordinated the delivery of increased community involvement to support the Better Care agenda and Housing Community Solutions had been of great help in establishing this Group;
- the involvement of the voluntary sector was important as it would provide feedback on how Better Care was working in the City;
- General Practitioners (GP's) were under a great deal of pressure as they were having to take on additional work and change their way of working with the added pressure of a recruitment crisis and subsequent shortage of GP's; and
- the social care work force still had to be engaged and there was a need for a different skill set; and
- a rolling Project Assurance Report scrutinised the work being undertaken by Better Care and provided a progress summary.

RESOLVED

(i) that progress with the implementation of Better Care Southampton be noted;
(ii) that progress with the finalisation of Section 75 of the National Health Service Act 2006 Partnership Agreement Pooled Fund be supported and Southampton's ambition to achieve integration at scale be noted; and
(iii) that a report on workforce development be submitted to a future meeting.

DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		HOUSING AND HEALTH IN SOUTHAMPTON		
DATE OF DECISION:		29 JULY 2015		
REPORT OF:		DIRECTOR OF PUBLIC HEALTH		
CONTACT DETAILS				
LEAD AUTHOR:	**Name:**	**Debbie Chase**	**Tel:**	**023 80833694**
	E-mail:	**Debbie.Chase@southampton.gov.uk**		
Director	**Name:**	**Andrew Mortimore**	**Tel:**	**023 80833204**
	E-mail:	**Andrew.Mortimore@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
None.

BRIEF SUMMARY

The Health and Wellbeing Board endorsed the Housing and Health Fuel Poverty Plan at their March meeting. In recognition of the impact of housing on health, the Board requested a report describing health impact and opportunities to improve health through joined up housing related approaches (Appendix 1).

RECOMMENDATIONS:

(i) To acknowledge the broad range of housing related services currently operating in the city and support the recommendations of the paper, these are:

a) Align strategic intentions for housing and health under HWBB and ensure a strategic approach to provision of housing services for those who are most vulnerable i.e. needs based rather than self-referral.

b) Protect housing initiatives that are working well, where possible, seek to evaluate the impact of local existing and new approaches on health and social care resource use and well-being.

c) Support the Health Overview and Scrutiny Panel recommendations on homelessness.

d) Extend the HMO licensing scheme to all HMOs across the City to ensure conditions in the private rented sector are improved.

e) Support strategies to encourage behaviour change and early intervention to reduce demand for social housing and adaptations.

f) Exploration of the use of Social Return On Investment approaches to determine future health and well-being

priorities for the city.

g) Support the Southampton Warmth for All Partnership (SWAP) to ensure City wide partnership working on this agenda, especially in the development of bids for future funding.

h) Align the work of SWAP with the Better Care Programme Framework and engage the Integrated Care Board on fuel poverty agenda and potential for developing a warmth on prescription scheme.

REASONS FOR REPORT RECOMMENDATIONS

1. Recommendations were made by the housing and health writing group in light of the evidence, national guidance and strategic intent, local developments and future funding opportunities.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. The paper is for information and discussion; it represents the beginning of a new way of working. Alternative options and priority groups for funding may be identified through future consultation with housing association providers and community representatives.

DETAIL (Including consultation carried out)

3. Following the Housing And Health Fuel Poverty Plan 2014-2017 reported to the Health and Wellbeing Board on 25th March 2015 the Board agreed to receive the report on housing and health at its next formal meeting on July 29th 2015.

4. It was agreed that the paper will cover:

Overview of housing in the City

- The housing stock in the City including tenure, age, type, location.
- Residential homes, housing with care.

Housing quality

- What the condition is of homes in both the public and private sector.
- Making homes accessible for people with disabilities, now and in the future.
- Assessment of the impact on the health and wellbeing of residents.

Strategic overview

- National strategic approach.
- Overview of related local strategies, plans and services

This will include: Housing strategy, empty properties, regulation in the private rented sector, planning, performance and City Plan and Better Care Fund.

Housing availability

- Homelessness (including outcome of recent member led enquiry into single homeless people)
- Allocation of social housing
- Overcrowding

Housing needs

- Needs of residents now and in the medium term.

5. The Housing and Health Report, attached at Appendix 1, submits the key evidence to the Board, including:

- The link between housing and health
- National guidance and local housing related strategies
- Current initiatives and case studies
- Return on investment as an approach to assess local value
- Recommendations to improve health

6. Evidence of health impact and inequalities is strongest in relation to cold and damp homes. The attached report focuses on this aspect.

7. Contributions to the report came from a range of different services and organisations. The writing group is listed on page 34 of the report. In addition Rob Kurn (HealthWatch), Peter Bennie (AgeUK) and Sara Crawford (Chair of the Anti-Poverty network) were also consulted.

8. The Board is asked to consider the evidence, conclusions and recommendations to acknowledge the broad range of housing related services currently operating in the city and support the 8 recommendations, as set out on pages 33-34 of the report.

RESOURCE IMPLICATIONS

Capital/Revenue

9. Future bidding opportunities for other capital and revenue resources are highly likely. To ensure quality bids, it will be important to prioritise release of staff from organisations to develop these.

Property/Other

10. There are no property implications.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

11. The principal aim of the report is to promote wellbeing and reduce impact of poor housing on the health of Southampton Residents; as required by the Care Act 2014. Other legislation including the Housing Act 2004 would be relevant for specific elements, initiatives and work programmes.

Other Legal Implications:

12. There are no other legal implications.

POLICY FRAMEWORK IMPLICATIONS

13. Nationally, the Government has set a fuel poverty target within the National Fuel Poverty Strategy. Locally, the report has drawn from the following:

- Southampton Health and Well-being Strategy
- The Housing Strategy 2011-2015
- Southampton Green City Strategy
- Homelessness prevention strategy
- Better Care
- The Fuel Poverty Plan 2014-17

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	All wards.

SUPPORTING DOCUMENTATION

Appendices

1.	Housing and health in Southampton

Documents In Members' Rooms

	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out?	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)

Housing and Health in Southampton Report

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2 Impact on health
6 Strategic overview
8 Southampton's Strategic Approach
10 Housing needs, standards and availability
21 Determinants of housing need
21 Current local schemes and return on investment
31 Conclusions and recommendations

Annexes

1. **HOSP homelessness recommendations**
2. **Local case studies**

INTRODUCTION

1 The purpose of this report is to describe:

(1) The link between housing and health,
(2) Housing related strategies and initiatives to tackle poor health and
(3) Future opportunities in light of recent national strategic direction and funding opportunities

2 Good quality homes in decent neighbourhoods enable people to live safe, healthy and happy lives. Housing standards (including the need for adaptations to keep people in their own homes for longer), homelessness and fuel poverty[1] have a major impact on the health and well-being of our local population.

3 The UK has the highest rate of deaths due to cold homes because of poor quality, inefficient housing. It has one of the most poorly insulated housing stocks in Western Europe. Fuel poverty is associated with cold homes, being driven by household income, cost of energy and the energy efficiency of the home. One in ten households are in fuel poverty yet almost half of all households in fuel poverty are in work. Fuel poverty has been made worse by rising energy bills (up 128% from 2003 to 2013) and households in the most energy inefficient properties now have to spend up to £1,700 extra a year to heat their homes to a suitable level.

[1] Fuel poverty definition: A household is considered to be in fuel poverty if:
- they have required fuel costs that are above average (the national median level)
- were they to spend that amount they would be left with a residual income below the official poverty line

IMPACT ON HEALTH

4 The majority of evidence on housing and health is in relation to the impact of cold homes.

5 The World Health Organisation estimates that 30% of Excess Winter Deaths are due to people living in cold homes. These deaths could be prevented if people were kept warm during the winter months. Over 25,000 people die per annum in UK as a result of living in cold temperatures mainly due to poorly heated homes. We have seen a small increase in excess winter deaths in Southampton over the past 4 years compared to a slight reduction for England (figure1). In 2012/13 there were 100 excess winter deaths in Southampton (table 1).

Figure 1 Excess Winter Deaths index for Southampton and England 2006 to 2013

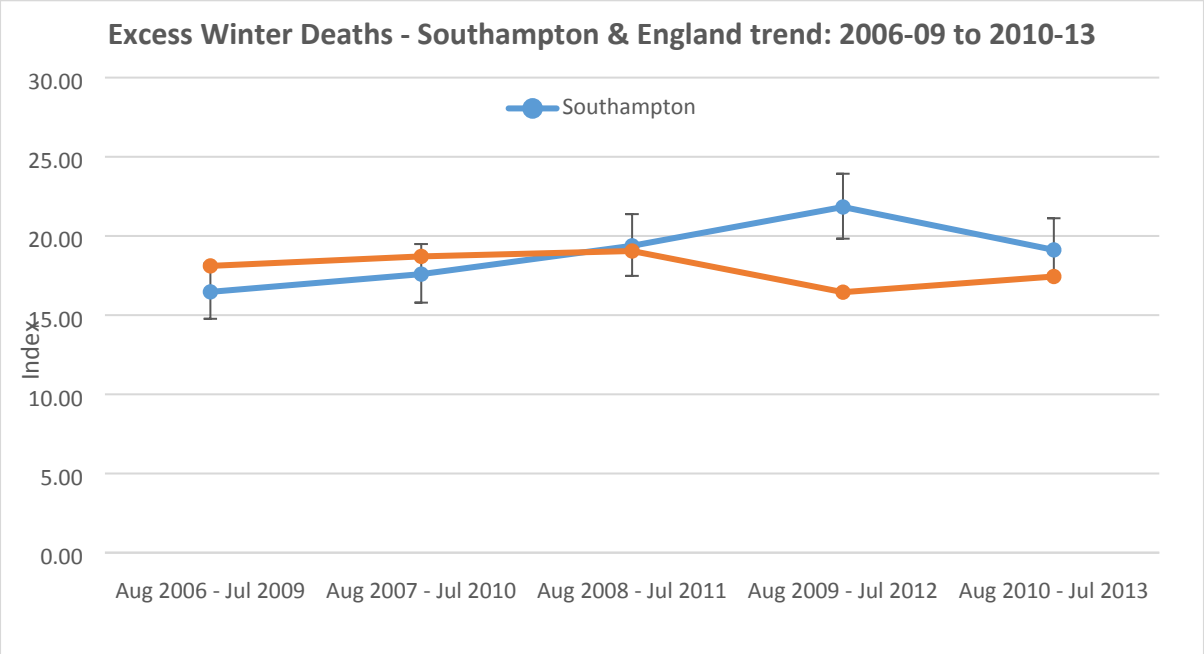


Table 1 Number of excess winter deaths in Southampton per annum

Period	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12	2012/13
EWD	80	130	110	80	90	130	100	120	100

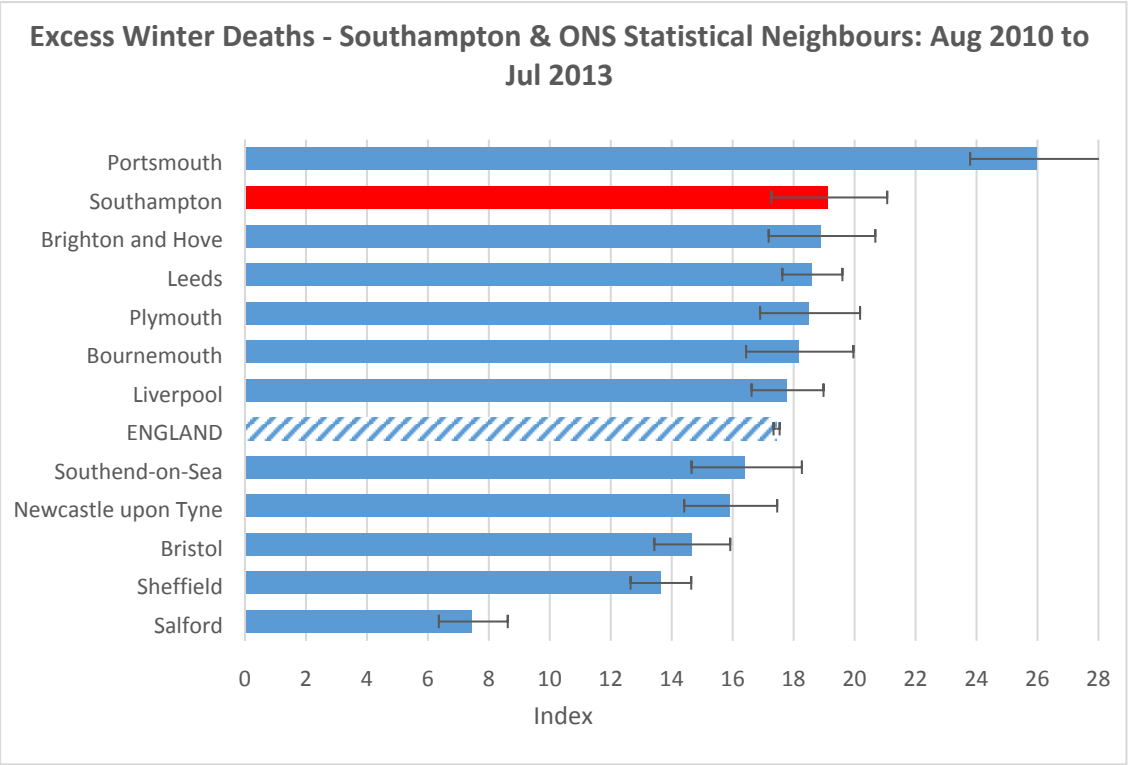


Figure 2 above shows that Southampton has the second highest excess winter deaths rate (expressed as an index for deaths from 2010 to 2013) compared with statistical neighbours.

The table below shows number of deaths within the winter by health condition and the percentage increase in these deaths in the winter as opposed to the rest of the year. As can be seen from the table, the largest increase in deaths is in the older age groups.

Table 2: Mortality by month of death, Winter months (December to March) verses Rest of year (April to November)

Type	Age group	Total deaths	Winter months	Rest of year	% increase
Cardiovascular diseases	All age	4505	1650	2855	13.5%
	Aged 35 to 64	558	197	361	8.4%
	Aged 65 and over	3926	1444	2482	14.1%
	Aged 75 and over	3291	1214	2077	14.5%
Coronary heart disease or stroke	Aged 35 to 64	411	141	270	4.3%
All-cause mortality	Aged 75 and over	10,222	3,859	6,363	17.6%

Source: ONS Mortality data. Pooled 2006 to 2013

Beyond an increase in winter deaths, cold homes affect health in other ways. Further evidence of the impact on health is shown in box 1 below.

BOX 1: Health impact of the cold (ref UCL)

Respiratory problems

- GP visits for respiratory tract infections increase by up to 19% for every one degree drop in mean temperature below 5°C
- People with asthma are two to three times more likely to live in cold and damp household conditions than non-asthmatics

Circulatory problems

- Deaths from cardiovascular disease in England 22.9% higher in winter months than the average for other times for the year.

Mental health

- Evaluation of the government's Warm Front scheme found increases in room temperature were associated with reduced likelihood of experiencing depression and anxiety.
- Young people living in cold homes more likely to be at risk of multiple mental health symptoms, experiencing four or more negative mental health symptoms.
- 28% of young people lacking affordable warmth at risk of multiple mental health symptoms, compared with just 4% of young people living in sufficiently warm homes.
- A significant proportion (10%) of children living in cold homes reported feeling unhappy compared with 2% of children living in warm homes

Children and young people

- Children growing up in poor housing conditions (including cold living conditions) were more likely than others to experience mental health problems, such as depression and anxiety; more likely to experience slower physical growth and cognitive development; and had higher risks of respiratory problems, long term ill-health and disability
- Children living in cold, damp and mouldy homes have been found to be between 1.5 and 3 times more likely to develop symptoms of asthma than children living in warm and dry homes.

Older people

- One study examined residents aged over 65 across the London Borough of Newham and hospital admissions for respiratory diagnosis, ranking these against the Fuel Poverty Index (FPI). The study found the FPI to be a predictor of hospital admittance
- Cold homes have been associated with lower strength and dexterity and exacerbated symptoms of arthritis, which can increase the risk of falls and unintentional injury.

Wider determinants of health

- Research has found an association between cold homes and poor educational performance among children, partly due to higher rates of sickness and absence from school.
- Children living in cold homes were more likely to lack an adequate and quiet environment to carry out homework.
- A systematic review looking at housing improvements and socio-economic outcomes indicates that improvements in the warmth of the home could reduce absences from work, which is likely to have a positive impact on work-related health.

Cost

Estimates of the health care costs of poor housing are as follows:

- Poor housing costs the NHS at least £2.5 billion per annum in treating people with illnesses directly linked to living in cold, damp and dangerous homes[1]
- Treating children and young people injured by accidents in the home costs A&E departments in UK around £146 million per annum[1]
- Among over 65s, falls and fractures account for 4 million hospital bed days in England per annum costing £2bn[1]

Number of vulnerable people in fuel poverty in Southampton

In Southampton, there were 9,889 households in fuel poverty in 2012. Estimates of the number of vulnerable people who are in fuel poverty within Southampton is shown below.

Table 3 Estimate of number of people living in fuel poverty

Population group	Southampton	Estimated number living in fuel poverty*	Proportion
Asthma	26,245	2,656	10.1%
COPD	5,215	487	9.3%
Depression	27,595	2,697	9.8%
Ischemic Heart Disease (IHD) or Congestive Heart Failure	41,944	4,236	10.1%
Asthma & depression	3,750	363	9.7%
IHD & depression	1,171	112	9.5%
IHD and COPD	949	90	9.5%
COPD and depression	1,272	119	9.4%
Children aged 0-17	47,887	4,837	10.1%
Aged 65 and over	32,194	2,946	9.1%

Source: Adjusted Clinical Groups 2013, Mid Year Estimate 2013, Fuel poverty data DECC 2012. Includes patients who have been diagnosed but are not on medication or patients that have been diagnosed and are on a prescription.

* Compared proportion of households in fuel poverty in Southampton, with the number of people with each area. To give an estimated number of people living in fuel poverty

It is important to note that this estimate is a comparison of the proportion of households in fuel poverty with the number of people within an area. On this basis, Almost 1 in 10 people in all vulnerable groups are living in fuel poverty in Southampton.

STRATEGIC OVERVIEW

6 The Government has set a fuel poverty target within the National Fuel Poverty Strategy: to ensure that as many fuel poor homes as is reasonably practicable achieve a minimum energy efficiency standard of band C by 2030[2]. The principles of this approach are to prioritise the most severely fuel poor, and deploy cost-effective policies while having regard for the most vulnerable.

7 Alongside the national strategy, the Department of Energy and Climate Change (DECC) is making up to £3 million of funding available for new fuel poverty pilots to encourage innovation. Up to £1 million of funding will be made available immediately to scale up a selection of local 'warmth-on-prescription' projects to help people who face health risks because of the cold. Up to another £2 million will support local fuel poverty innovation over the next year.

8 A previous and current policy enabler is the Green Deal. This was introduced in 2012. The scheme allows households to pay for some or all of the improvements over time through additional costs on their energy bill. The Energy Company Obligation, introduced in 2013, places a legal obligation on the main energy suppliers to deliver subsidised energy efficiency improvements to low income households to enable them to heat their homes to a comfortable thermal level. Other schemes such as the warm home discount scheme, big energy saving scheme, winter fuel payment and cold weather payment were subsequently introduced to support the vulnerable and those on low income. The future of such schemes, including the Green Deal, is uncertain.

9 The Cold Weather Plan for England is a framework for protecting the population of England from harm to health from cold weather[3]. It aims to prevent major avoidable effects of cold weather on people's health by alerting them to the negative effects and enabling them to prepare and respond appropriately.

10 Health based recommendations have been described in the Health Equity Evidence Review on tackling fuel poverty and cold home related health problems to improve health outcomes and reduce inequalities and NICE guidelines (March 2015) on reducing the risk of death and ill health associated with living in a cold home[4,5]. These recommendations are described in box 2.

Box 2: The Health Equity Evidence Review:

- Acknowledges important role of Health and wellbeing boards in collaborating and working with other parts of the local authority, other stakeholders and local organisations including primary care and clinical commissioning groups to drive improvements.
- Recommends the UK Health Forum's fuel poverty guide as a resource for action that can be taken by partners to reduce fuel poverty

NICE guidelines (March 2015):

- HWBB should include the health consequences of living in a cold home in the joint strategic needs assessment process and develop a strategy to address the health consequences of cold homes
- Ensure that there is a single point of contact health and housing referral service to help vulnerable people living in cold homes
- Provide tailored solutions via the single point-of-contact health and housing referral service for people living in cold homes. Solutions should take account of the language and reading ability of recipients
- Identify people at risk of ill health from living in a cold home
- Make every contact count by assessing the heating needs of people who use primary health and home care services
- Non-health and social care workers who visit people at home should assess their heating needs
- Discharge vulnerable people from health or social care settings to a warm home
- Train health and social care practitioners to help people whose homes may be too cold
- Train housing professionals and faith and voluntary sector workers to help people whose homes may be too cold for their health and wellbeing
- Train heating engineers, meter installers and those providing building insulation to help vulnerable people at home
- Raise awareness among practitioners and the public about how to keep warm at home
- Ensure buildings meet ventilation and other building and trading standards

SOUTHAMPTON'S STRATEGIC APPROACH

11 The current Southampton health and well-being strategy[6] makes the following recommendations in relation to housing:

1. Endeavour to help people to have access to good quality, energy efficient housing that is both affordable and meets their needs.
2. Provide a comprehensive homelessness service that supports people to make independent choices about their housing future
3. Work with the voluntary and supported housing sectors and the Homeless Healthcare Team to ensure that provision in the city meets the needs of the most challenging people to safeguard both their housing and health needs and reduce the impact on the general population
4. Having an additional Licensing scheme for all HMOs in the city to help ensure the conditions in the private rented sector are improved and poor or inadequate housing is brought up to acceptable standards
5. Develop local hubs for quality support and care in the city, for example dementia friendly facilities with support activities and interactions for people with dementia from the wider community
6. Raise awareness of falls and reduce or prevent trips, slips and falls within Council older people's accommodation.

12 The Health and Well-Being Strategy is scheduled for update in 2016.

13 There are a number of local strategies and plans that have an impact on health through the link with housing.

Housing Strategy

15 The Housing Strategy 2011-2015 'Homes for Growth' Strategy Context Paper has the strategic objective of maximising homes for the city so that the right mix of housing will support economic growth[7]. The vision is for housing to work towards attracting more jobs for local people, securing more investment in the city and delivering high quality, low cost services that meet customer needs.

16 The strategy promotes home ownership and encourages community sustainability. There is a focus on improving existing homes and transforming neighbourhoods, particularly through the estate regeneration programme, energy efficiency, tackling fuel poverty and improving poor housing conditions in the private sector. The Southampton Homes Standard has been agreed with tenants and leaseholds to ensure all homes are: Safe, wind and weather tight, warm and will use as small an energy footprint as possible, have reasonably modern facilities inside the home and well maintained communal facilities. Southampton has a target to deliver new 16,300 homes over the period 2006-2026.

17 The recent fairness commission set a recommendation to increase the availability of affordable and good quality housing through short and long term creative housing solutions.

Low Carbon City strategy

18 The residential sector contributes 27% of UK carbon emissions. It is widely acknowledged that we cannot meet our climate change targets without addressing emissions from our homes.

19 The Southampton Green City Strategy outlines the city council's vision for a low carbon city[8]. It sets out the key target to reduce carbon emissions by 40% by 2020 and 80% by 2040. Plans for housing within its existing stock, new developments and through the regeneration programmes help to deliver this target and tackle fuel poverty.

Homelessness prevention strategy

20 Homelessness is the most acute form of housing need. The city has a homelessness prevention strategy (2013/18) backed by a range of agencies including the voluntary sector[9]. The objectives are to: 1. Prevent homelessness, 2. Maximise the number of available homes in the city to all sectors of the community including homeless people, 3. Provide good quality accommodation with support for short periods only, in order to enable successful move on and maintenance of a settled home and 4. Improve positive outcomes for homeless people or people at risk of homelessness.

Recommendations from the recent Health and Overview Scrutiny Panel on homelessness are shown in appendix 1.

Fuel Poverty Plan

21 The Southampton Warmth for all Partnership (SWAP) is a multi-agency response to the issue of fuel poverty, led by Public Health. This key partnership includes statutory services and third sector organisations and aims to raise awareness of fuel poverty and coordinate action to alleviate it. The partnership has been operating for almost 15 years and more recently has a core membership from Public Health (SCC), Environmental Health (SCC), Housing Services (SCC) the Environment Centre and Age UK Southampton. It has produced a fuel poverty plan[17].

Better Care

22 Better Care is about joining up care around individuals so they are seamless, co-ordinated and give patients/service users a better experience. There are several services provided by the city council and the NHS whose sole aim is to support recovery from an illness or injury. Staying as independent as possible for as long as possible is a key priority for many older people in the city[18].

23 Targets for Better Care are:

- Reducing admissions to residential care

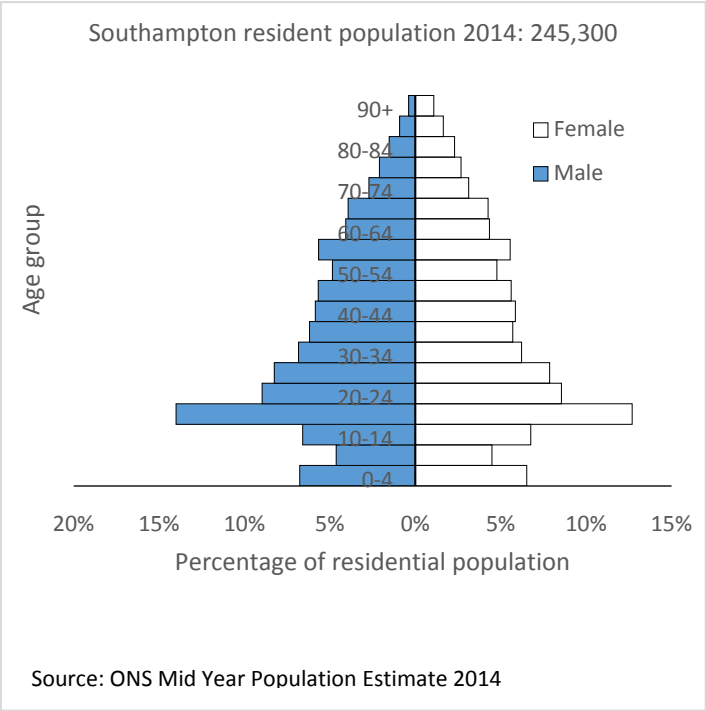
- Reducing hospital admissions through integrated care services
- Reducing falls with injury in the over 65 year population
- Reducing readmissions
- Reduced Delayed Transfers of Care from acute hospitals
- Risk Stratification
- Case Management
- Single Care Plans accessible across health & social care system, which are person centred
- Single case coordination for most complex
- Self-Management
- Telecare/telemedicine
- Prevention agenda
- Information & advice
- Support to change behaviour/take action
- Personalisation of services individual social and health budgets
- Integrated rehabilitation/reablement a rapid response services to promote independence and improve discharge

HOUSING NEEDS, STANDARDS AND AVAILABILITY

Demography

24 There are 242,100 residents in Southampton, 52,900 with an ethnic origin other than White British (2011 Census). Figure 3 shows the age breakdown for our population. There are approximately 47,000 students. The employment rate is 69.3% and unemployment rate 6.7%. The median gross annual pay for residents of Southampton is £24,913 based on the 2014 Annual Survey of Hours and Earnings, this compares to the England median gross pay of £27,500.

Figure 3 – Residential population 2014



25 The city is growing, between 2013 and 2017 the population is forecast to increase by 35,800 people (14.8%). Compared to 15.5% in England and 17.3% in the South East region. The 20-29 age range, who traditionally form new households requiring homes, will grow by 12.6%. The 30-44 age group, the main economically active and moving group also shows a rise of 3%. 15,000 residents live in the city's top 5 priority areas (LSOAs).

Poverty within the City

26 Although Southampton is a relatively prosperous city, there are areas of significant deprivation. We have a higher percentage of residents claiming key 'out of work' benefits than the regional average (9.1% compared to 6.8% for the South East) and 'in-work poverty' is a growing issue - 20% of households are receiving housing or council tax benefit; well above the national average[19].

27 Nearly a quarter of children (23.4%) live in poverty compared to a regional average of 13.6% and a national average of 19.2% and this figure rises to over 40% for our most deprived wards. In relation to income deprivation affecting older people, the city has seven areas that fall into the 10% most deprived in England.

28 The national programme of welfare reforms has been underway since 2010. It has brought changes to a range of working age benefits including housing, health and disability, crisis support and tax credits. The changes have affected in-work and out-of-work claimants. The Centre for Economic and Social Inclusion (CESI) has predicted the overall financial impact to Southampton for 2015/16 will be a loss of £53 million compared to if the

reforms had not been implemented; affecting 34,157 households with an average loss of £1,551 per year.

29 For housing, the Housing Benefit Size Criteria ('Bedroom Tax'/ 'Spare Room Subsidy) has affected social housing tenants (1612 households in the city were affected in 2014/15). Households within the private rented sector have also been affected by recent changes. Local Housing Allowance (LHA) rates now only cover the 30th percentile. This is pushing claimants into often poorer quality housing. In 2012, the age threshold for the shared accommodation rate of LHA was increased from 25 to 35 years. This means single claimants up to the age of 35 now have their LHA based on a room in a shared property rather than a self-contained one bedroom property and this creates demand for Houses in Multiple Occupation (HMO) type accommodation.

30 Fuel poverty is a significant issue in the city. During 2014/15, Southampton Local Welfare Provision accepted over 900 referrals for emergency utility top-ups (key meters) from local agencies. Funding for this has been reduced significantly will cease at the end of March 2016.

Overview of housing in the city

31 Southampton has an estimated 104,000 homes providing accommodation to 245,300 (mid-year estimate 2014), of which 53% are owner occupied, 24% are privately rented, 17% are local authority and 6% are housing association. The city has over twice the national average of privately rented accommodation (11% nationally) and below the average number of owner occupied homes (71% nationally).

32 The proportion of privately rented homes is higher in Southampton than other comparable local authorities for example Portsmouth has 18%, Brighton and Hove 23% and Bournemouth 22%. All of which are on the south coast with universities.

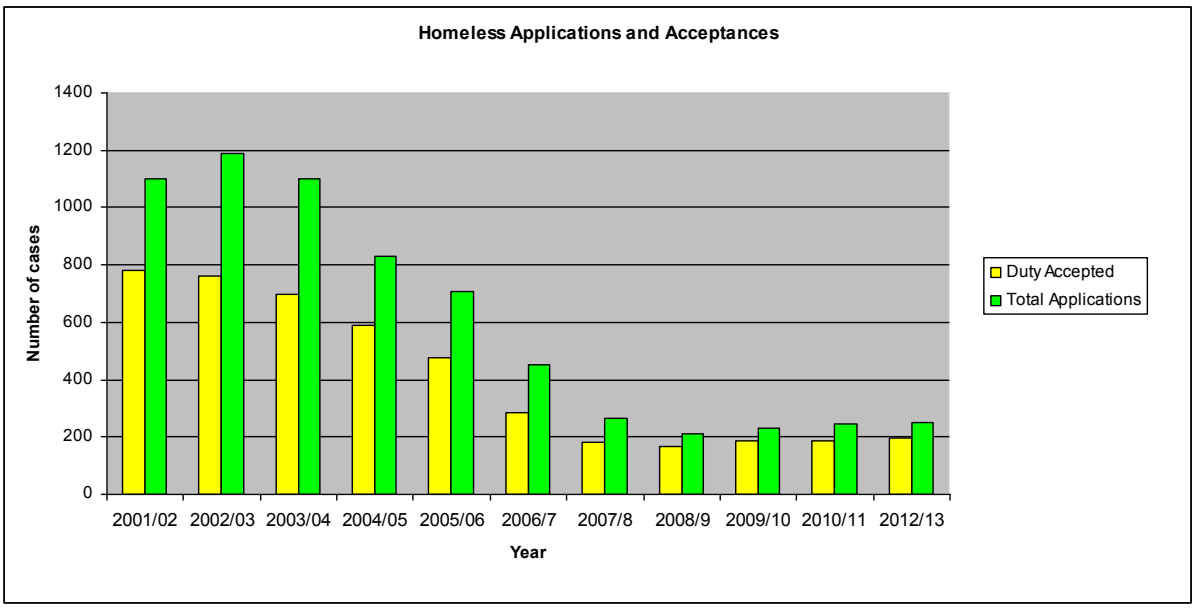
33 The South Hampshire Strategic Housing Market Assessment 2014 quotes a standard house price of £216,815 with 41.6% 3 bed, 26.6% 2 bed (Census 2011). The average cost of a home in the city has risen by 140% since 1999. Entry level private rent for 3 bed households is £825 and £675 for 2 bed households per annum. The estimated proportion of households unable to afford market housing without subsidy is 51.4%. The survey estimates that the 4,008 households (4%) are unsuitable.

Homelessness

34 There has been a 50% increase in the number of recorded homelessness preventions from 2008 to 2013. In 2008 the number of households prevented from becoming homeless was 902, but five years later this increased to 1486 cases (2013). Whilst homeless acceptances have increased nationally by 20% over the last four years, in Southampton this has been restricted to 10%.

Figure 4 below shows the number of homeless applications and acceptances in Southampton from 2001/02 to 2012/13.

Figure 4 Statutory homeless statistics



35 The number of individuals found rough sleeping on weekly outreach sessions was 8 in 2011/12 increasing to 9 in 2014/15.

Housing standards and conditions affecting health

36 Of the council stock, 99% met the Government's Decent Homes Standard (1st April 2011) and the council is the largest landlord in the south with over 18,000 properties let to households including tenants and leaseholders. A large scale stock condition survey carried out in 2008 showed that 38% (28,400) of all private homes did not meet the Decent Homes Standard, of which 8,500 are occupied by vulnerable people. 16,000 fail to meet the standard because of poor insulation and heating and 14,000 because of one or more serious housing hazards – the most common are excess cold, falls (especially in owner occupied homes) and fire (especially in privately rented homes). The total cost of dealing with this is estimated at £111M.

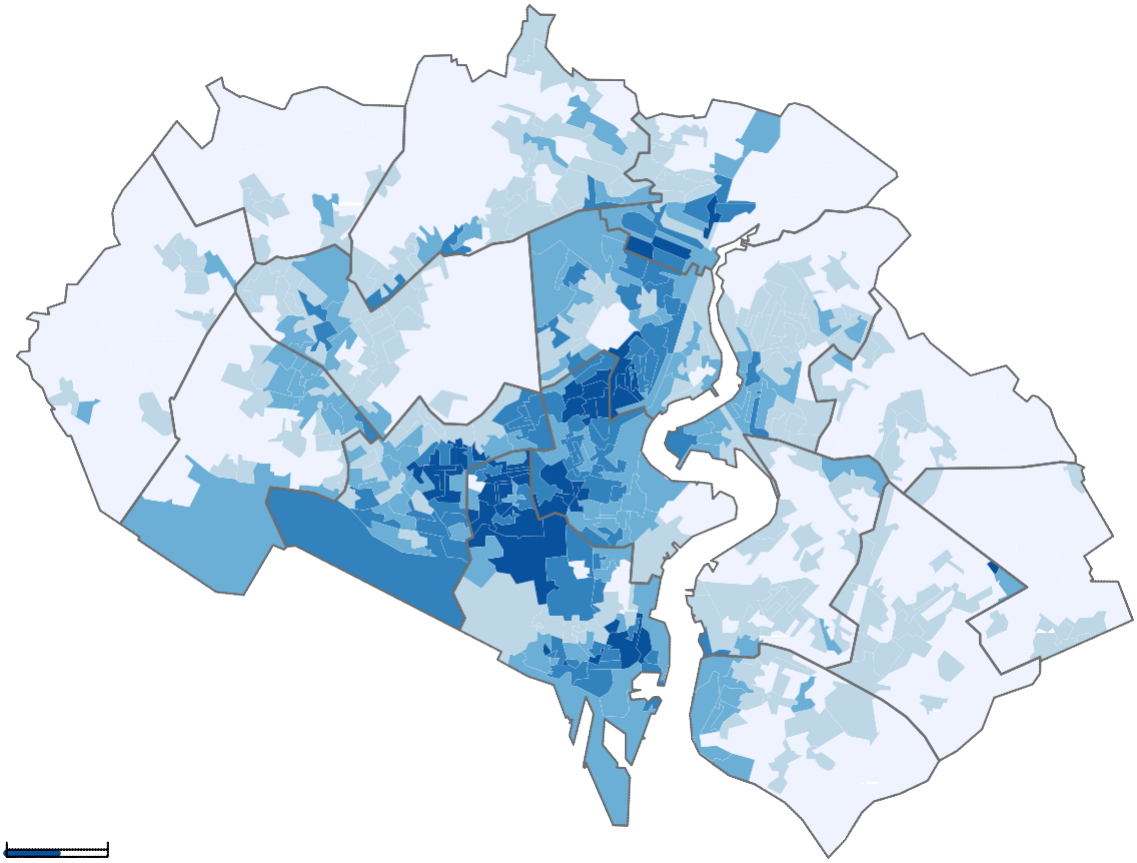
37 Older properties (pre-1919) and privately rented homes are generally in the worst condition. There is an estimated need for 3,900 adaptations for disabled people, at an estimated cost of £21M. Research suggests that the most effective use of council resources to improve private homes is to target energy efficiency and adaptations in all private homes and to focus on those privately rented properties in the worst condition.

38 Poor private housing is more concentrated in Bevois, Bargate and Portswood wards. 14,000 private homes have a serious housing hazard, with a quarter of homes built before 1919 and a quarter of privately rented homes having a

hazard that is likely to result in harm that needs medical treatment. The cost of dealing with a serious hazard is estimated at £5,000, rising to an average of £19,000 for more comprehensive repairs.

39 In terms of energy efficiency, the average SAP rating is 51 (equivalent to energy rating band E on a scale of A to G). There is the potential to improve energy efficiency in 95% of private homes and there remain 7,000 homes with a dangerously low SAP rating of under 35 and an estimated 6,000 vulnerable households in fuel poverty. There are similar levels across owner occupied and privately rented homes however the numbers of households in fuel poverty is forecast to rise with increasing energy costs and the effects of other fiscal and economic factors. The private rented stock is spread across the city and details from the 2011 Census show the spread as in Figure 5.

Figure 5: Tenure (Private rented: Private landlord or letting agency)



1.1 Percentage

	under 13.2
	13.2 to 27.9
	27.9 to 44.8
	44.8 to 63.1
	Over 63.1

Variable ID – KS402EW0015.

Houses in Multiple Occupation in Southampton

40 The council administers a mandatory licensing scheme for HMOs of three storeys and above occupied by five or more unrelated people. This helps ensure that minimum safety and management standards are met in these properties. New powers will allow the council to protect family homes and control where houses in multiple occupation (HMOs) are permitted by using an Article 4 Direction to control HMOs (rented homes where three or more unrelated people live.) This means it will be able to refuse new HMOs in any one area in the future. Article 4 powers allow local authorities to implement strict planning rules in specific areas of cities or towns. In this instance landlords would have to obtain planning permission before turning homes into rented HMOs.

41 There are about 7,000 Houses in Multiple Occupation (HMOs) of all types (9.3% of private sector dwellings), of which 444 of the largest have been licensed. There are an estimated 130 licensable HMOs that continue to operate without a licence. These are not spread evenly across the city but there are areas of very high density, moderate density and low density as well as areas where there are not believed to be HMOs.

42 The national average proportion of private dwellings that are HMOs is 2% (EHCS). Southampton has a higher HMO rate than Portsmouth (5.9%) and Bournemouth (7.3%) but the rate is less than that in Brighton and Hove (20%).

Social housing

43 Southampton operates a Housing Register and Choice Based Lettings system called Homebid. This is a list of households who want to move into or between homes owned by the city council and participating housing associations. There are 11673 households waiting for a social rented home. The current breakdown by size of property households are waiting for is shown in table 4 below. As can be seen from the table, the majority of households are awaiting studio accommodation, followed by two and three bed homes.

Table 4 Households awaiting a social rented home

Over 60's	1689
Studios	4328
1 Beds	585
2 Beds	2436
3 Beds	1562
4 Beds	390
5+ Beds	66
Unknown	617
Total	11673

44 There were 1900 households who were housed into social housing (2014/15) which is both council and registered providers' vacancies. Of these 380 were households who we had accepted as being homeless. Demand is far greater than supply and the average waiting time is in excess of 5 years. Families needing larger 3 + bedroomed accommodation wait usually 6-7 years.

45 The CORE dataset (2013-2014) of letting and sales of social housing in England provides information on tenancy. The majority of tenants in social housing in Southampton have fixed term tenancy of 5 years (60% of tenants). In 62% of homes, head of the household is female (compared to 59% in England) with 34% single adult and 24% lone parent households. 31% not seeking work (23% working full time, 18% working part time, 16% job seekers and 8% long term sick/disabled). 85% are White British. The average weekly

income of Southampton City Council tenants is £254. As would be expected, the highest concentration of SCC housing stock is in areas of greatest deprivation within the city.

Care and nursing homes

46 Southampton currently has 11 nursing homes and 46 care and residential homes. These facilities provide a total of 1457 beds, with the smallest facility providing accommodation for 3 residents and the largest having 104 beds. The average size is 17 beds for Care Homes and 61 for Nursing Homes. Most beds within the city are privately owned and managed. BUPA is the largest provider in terms of nursing beds managing 241 beds within the city and a further 124 beds at centres that lie on the periphery of the city but into which both the CCG and SCC place clients.

47 There are 2 residential homes which are Southampton City Council run properties – Holcroft House and Brownhill House, the third property Woodside is currently in the process of closing. This means that the council provide for up to 71 clients within their properties; less than 5% of health or social care beds within the city are located within council run facilities.

48 Of concern is the state of the properties offered as health & social care client funded facilities. While some of the large nursing, and in one case residential care facilities, are provided within purpose built facilities these are the minority. The majority of properties used are mid to late Victorian or early 20th century houses which have undergone significant alterations. The majority of these 'old' properties are in need of refurbishment to make them 'fit for purpose'. Within the CQC regulated work mechanism there is no specific review of whether a home/facility meets energy efficiencies or are 'fit for purpose'.

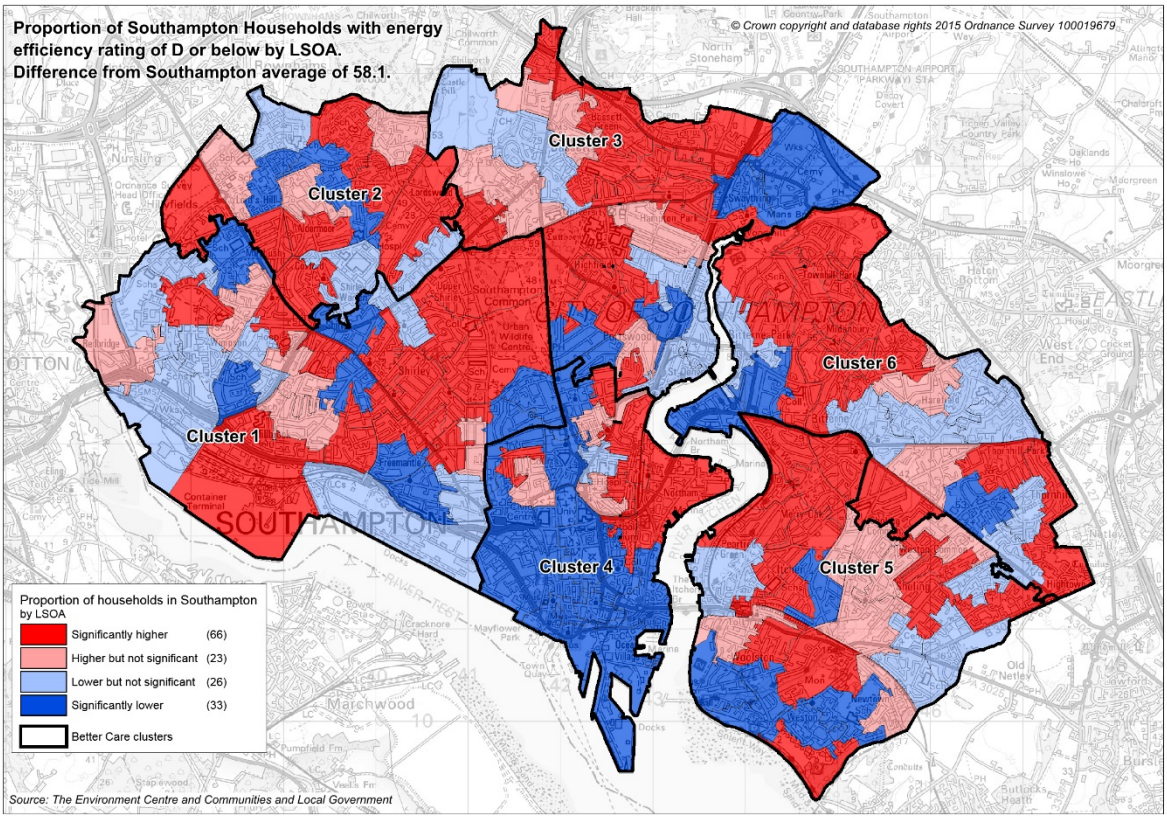
49 From the perspective of health and safety legislation, the Fire & Rescue service and Environmental Health (in terms of kitchen facilities) monitor adherence to requirements. A significant number of our homes into which we place residents of Southampton are reliant on shared toilet and bathing facilities. A significant piece of legislation which refers to the environment of a care or nursing home is Health and Safety in Care Homes HSG220 (2nd edition) Published 2014. This work covers additional requirements such as equipment safety; general environment; incident reporting and Infection Prevention and Control among many. All the sections of this work is tied to specific legislation which relates to varying aspects of health & safety.

50 As indicated earlier many of the properties used as care facilities are adapted from housing stock and therefore the inclusion of a suitable size laundry facility is a challenge. Having a well laid out laundry with correct clean dirty flows is essential in reducing the risk of cross-contamination of the environment; it is essential that when a property is being registered as a care facility that this is a requirement.

Mapping of household energy efficiency ratings

51 Of 104,000 properties within the city, 50,000 properties have energy efficiency ratings. Of these 50,000 properties, 42% (21,055 properties) have been graded A to C and 58% (29,149 properties) graded D to E. The map below shows, of those properties with an energy efficiency rating, the proportion of households in graded D-G within each Lower Super Output Area that have ratings higher (worse) and lower (better) than the average D-G energy efficiency rating for the city.

Figure 6 Proportion of households with energy efficiency ratings of D or below



52 The highest proportion of properties with the lowest energy efficiency ratings (significantly worse than the average for D-G rated properties across the city) is in a number of areas across the city (shown in red) including Shirley, Millbrook, Bevois, Swaythling, Bitterne Park and Peartree.

Mapping of fuel poverty

Figure 7 below shows households living in fuel poverty within Southampton. As can be seen, the greatest density of households with the highest level of fuel poverty are located in central Southampton, mainly within Portswood, Bevois and Swaythling wards (located in clusters 3 and 4).

Figure 7 Southampton households living in fuel poverty 2012 by the Better Care Fund primary care clusters

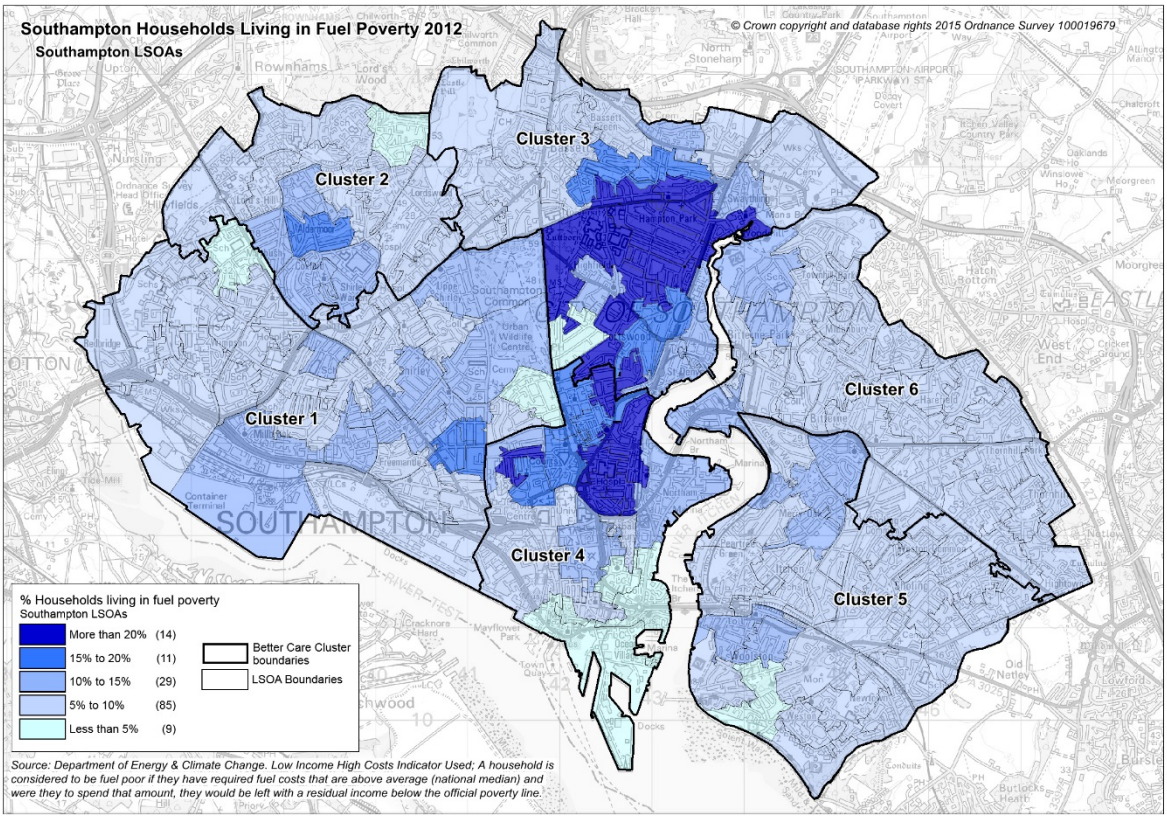
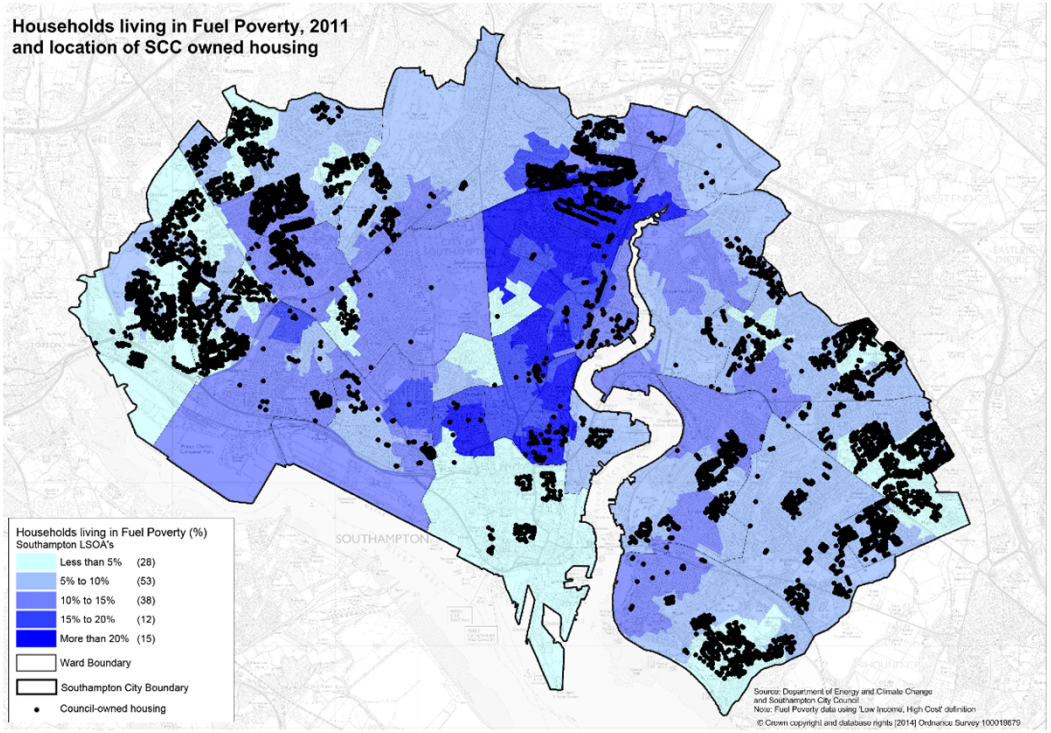
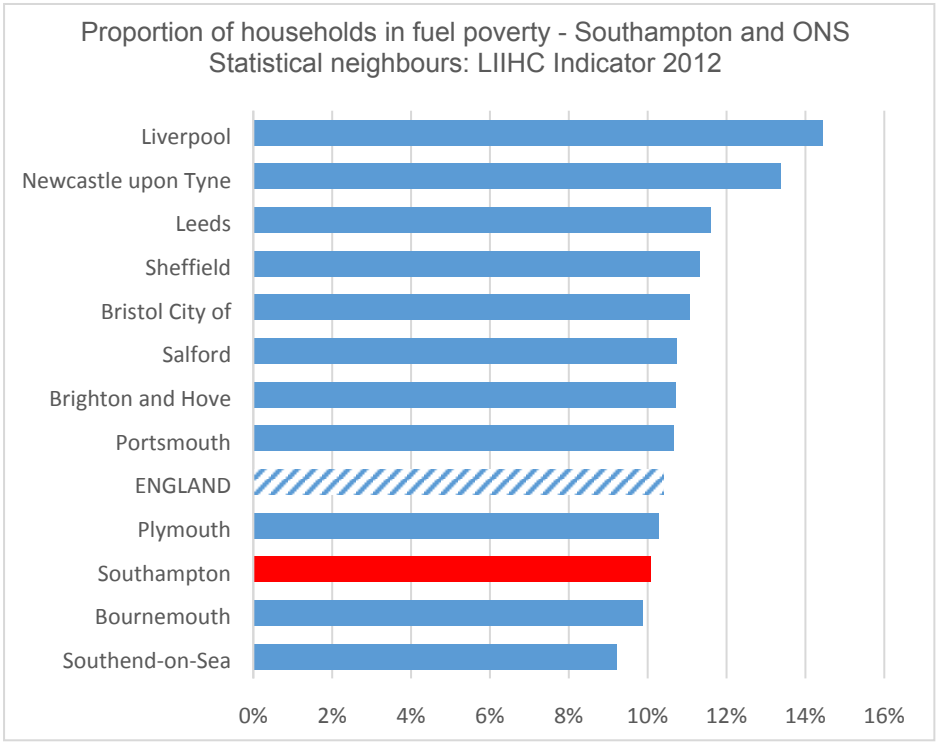


Figure 8 below shows concentrations of SCC owned housing (and levels of fuel poverty). As can be seen, there isn't an association between fuel poverty and degree of social housing provided through SCC in Southampton. At an area level, there is no association between fuel poverty levels and deprivation.

Figure 8 Southampton households living in fuel poverty and location of SCC owned housing 2011



Southampton has a lower proportion of households in fuel poverty than the England average (figure 9). In comparison with our statistical neighbours, Southampton is 10th of 12 areas in relation to fuel poverty.



53 A significant population growth is forecasted in the over 65 age group in Southampton, with an increase of 13,500 people (+ 43.8%) over a period up to 2033. There is a need to plan housing, support and care solutions which will enable people to live independently. The effective adaptations in people's homes are an important part of this planning.

54 The need for a range of housing with support options have been identified through the Supporting People and other health and social care strategies. These identify the support and care required across the spectrum of needs including; young people, people with physical disabilities, people with learning disabilities, people with mental health problems and people fleeing domestic violence. This could be in their own homes or in hostels, sheltered housing or other specialised supported housing. However, there is a need to ensure housing and social care requirements are fully aligned so that the city is able to meet needs in the longer term.

55 There are a range of different needs to respond to including:

- Short-term/emergency responses – particularly for people who are homeless
- Adapted housing – for those with disabilities and mobility issues
- Medium term options – for people who may remain vulnerable
- Longer term options – particularly for older people, those with learning disabilities, people with mental health problems, and those with long term conditions and disabilities.

56 The Supporting People Programme assists over 6,000 people in Southampton providing a variety of services which offer the opportunity to improve quality of life and a stable environment to enable greater independence for vulnerable residents.

57 The Extra care housing provision supports independent living by providing onsite care and support. There are two purpose built schemes of extra care for the elderly, one in the east provided by Saxon Weald HA called Rosebrook Court, and one in the West owned by SCC housing; Manston Court. SCC care alarm service is also providing support for older people to live in their own homes and developing new initiatives such as telecare.

Adaptations:

58 These are provided in both SCC owned homes and private homes in the city. There is a £1.2 million programme to complete adaptations in private homes in the city, this is funded through the Better Care Fund. Funding provision is means tested and provides a maximum of £30,000 per household. The aim is to provide for 120 homes per annum. The programme is delivered in accordance with the Housing Grants, Construction and Regeneration Act 1996.

59 Last year the average age of applicants was 64 (although there has been a steady increase in the number of applications for children). The average grant was £6,400 and the average time taken from assessing need to completing the installation was 8 months. More referrals are received for level access showers and stair lifts than any other type of adaptation.

DETERMINANTS OF HOUSING NEED

60 There are longer tem measures that can be taken to reduce demand for social housing, reduce need for adaptations and enable people to afford and continue to live in a home that meets their needs.

Poverty

61 Reduction in poverty and increase in employment and training opportunities, particularly for young people is crucial in reducing social housing need and enabling people to live in the homes that meet their needs. Continued economic development within the city is clearly the driver with a focus on provision of higher level jobs for residents. Linked to this is the need for a good quality education.

Prevention and early intervention

62 Ensuring children have the best start in life, promoting and enabling individual lifestyle choices to reduce consumption of sugar, take physical exercise, stop smoking and reduce alcohol intake, all contribute to reducing the need for housing support and adaptations as a result of lifestyle factors. Public health programmes and services aim to promote health and protect against risk to health.

City planning

63 Ensuring the development of a healthy city with sufficient green space, walking and cycling routes and reduction in road transport. A city with local shops and health services within easy walking distance.

LOCAL SCHEMES AND SOCIAL RETURN ON INVESTMENT

64 This section of the report highlights some of the local schemes in place to support health through housing related initiatives and some initial calculations of return on investment. Case studies describing the impact of initiatives on individuals' lives in Southampton are shown in appendix 2.

Local Schemes

STOP the cold (Advice line funded until March 2016)

65 STOP the cold provides practical advice and support through a freephone advice line, contact number and webpages. It enables referrals to complimentary projects including Local Welfare Provision Service, Money Matters and Green Deal Assessments (115 completed so far). In 2014-15, 306

Southampton residents were supported through the advice line and 'STOP the cold' was promoted at over 70 local meetings and events.

Local Welfare Provision Service (LWPS) (closed – short term continuation)

66 LWPS (Officially closed April 2015 but we are continuing to run the service in the short term). This is a free, confidential service available to working age clients of any tenure type, focussing on those who meet LWP criteria and are struggling to keep warm or pay their bills. The scheme supports clients with: Home energy efficiency, energy efficiency grants and finance options, draught-proofing (and materials), heating and hot water controls and dealing with condensation and mould. Advice and information is provided by home visits, phone, email, post and at drop-ins. 127 households have been helped (estimated 188 adults and 90 children).

Money Matters (Due to close September 2015)

67 This is a partnership project with Age UK Southampton aiming to support older people all around Southampton helping to 'put more money in their pockets'. The service provides a friendly and confidential home visit service, with advice and practical help on keeping warm and well, saving energy and managing gas and electric bills, household budgeting and benefit entitlements and applications

68 The final report for Money Matters is imminent. To date tEC have undertaken 220 home visits either with the Age UK Southampton office or on their own. The current total for increased benefits through the Money Matters Project is £485,687. The funding to pay for the project from Comic Relief is just under £200,000

Southampton Warmth for all (Scottish Power People Energy Trust – begins September 2015)

69 The aim is to reach out to vulnerable households in Southampton to provide advice and practical help with home energy, helping to keep people warm and lift them out of fuel poverty. The services will be made available to low income households with young children or other vulnerabilities due to ill health or disability, and will largely be targeted at people in private rented accommodation.

Social Return on Investment

70 Some of the many local initiatives in place to provide decent housing, adaptations and enable warm homes have been assessed to determine social return on investment.

71 Social Return on Investment covers two aspects:

- Actual Cashable Savings and;
- The impact on people

72 There are a number of approaches that can be used to assess return on investment, four of these are described below. This section assesses the impact of local approaches using four methods. **Calculations described are examples should be considered with caution. Validation of estimates and assumptions is required.**

Community Energy Saving Programme Project (CESP) and other energy efficiency works:

73 The CESP Project delivered extensive energy improvements to 520 properties to the five tower blocks in International Way in Weston (Oslo Towers, Havre Towers, Hampton Towers, Copenhagen Towers and Rotterdam Towers), an area of high deprivation measured by the Indices of Multiple Deprivation (IMD). The project was funded by a £6.2M Grant from the CESP via British Gas. Rotterdam Towers was initially excluded from the CESP works and was later funded separately from the Energy Company Obligation (ECO) part of Ofgem for an identical programme of work. An additional £3M was added to this budget by Southampton City Council

74 The Ofgem target was to reduce fuel bills for residents by an average of one third. The project has met and extended this target by reducing fuel bills by an average of 60%. Before the project average fuel bills were £1000 p.a. for a two bedroom property. Following the project average fuel bills are now £400 p.a. for a two bedroom property. This gives households an average £600 per year saving, with a large reduction in energy use and significant improvements in thermal comfort. In some one bedroom properties for example, residents do not have to put their heating on at all because their flat is now warm enough all year round as a result of significantly better insulation.

75 Additionally 107 properties in Farringford Road in Thornhill, have received EWI (External Wall Insulation), around 150 - 200 properties have received CWI (Cavity Wall Insulation) or loft upgrades and approximately 30 properties have received fuel switching systems. This is estimated to save an average of £500 per year on heating bills assuming a move from a Band D to Band C.

76 Since April 2010, a further 2,900 properties have benefitted from either a new A grade efficiency gas boiler or heat exchanger; split between c2,400 gas boilers and c500 heat exchangers. The gas boilers installed are more energy efficient than those replaced and the heat exchangers are linked to a district heating system.

77 Based on Energy Saving Trust figures for low income homes, the estimated annual fuel savings after installing a new A rated condensing boiler are

between £145 p.a. (for a mid floor flat) and £570 (detached house); depending on the types of different property; assuming that the old boiler is rated at under 70%. If we average this out this amounts to an average of £325 per year.

78 If we take the average fuel costs per year and multiply it by the number of properties receiving improvements, we find the estimated average fuel costs representing cashable savings to our tenants.

Table 5 Return on Investment for tenants as a result of housing improvement programmes

Stakeholder	Input	Output	Outcome
SCC Tenant	520 properties benefitting from energy improvements in CESP Project	Average fuel savings £600 p.a.	520 x £600 = £312,000 cash saving p.a.
SCC Tenant	337 properties benefitting from EWI / CWI / loft upgrade / heat exchangers	Average fuel savings £500 p.a. (from A Fuel Poverty Strategy for England March 2015)	337 x £500 = £168,500 p.a.
SCC Tenant	2,900 properties benefitting from new boiler exchange / heat exchanger	Average fuel saving £325 p.a. (From Energy Savings Trust)	2,900 x £325 = £942,500 cash saving p.a.
Total	3757 properties	Average Savings £475 p.a.	£1,423,000 p.a.

Cross Benefit Savings to NHS: Cashable Savings

79 The Housing Health and Safety Rating System (HHSRS) is a government risk-based evaluation tool to help local authorities identify and protect against potential risks and hazards to health and safety from any deficiencies identified in dwellings. It was introduced under the Housing Act 2004 and applies to residential properties in England and Wales.

80 BRE (Building Research Establishment) an independent and impartial housing consultancy have devised a calculator that uses the HHSRS to calculate the risk of hazards and the costs averted to the NHS following improvement work. BRE have consolidated the risks of certain hazards to high risk groups (e.g.

falls and the over 65's) and brought together all NHS costs to average them out across four categories; from Class I (the most serious to Class IV the least serious).

81 The average NHS costs are:

Class 1 £50,000

Class 2 £20,000

Class 3 £1,500

Class 4 £100

82 The online calculator focuses on six specific hazards (Excess Cold, Crowding and Spacing, Damp, Entry by Intruders, Level Falls and Stair Falls) and can be found here www.cieh.org/library/knowledge/housing/**HHSRS**_cost_**calculator**.xls

83 Using the Calculator, it is possible to estimate the risks, numbers of cases averted and the NHS cost savings by inputting the number of properties that have received interventions into the calculator.

84 We can assess the impact of scenarios, for instance:

- Approximately 3757 households receiving interventions to mitigate excess cold hazard and damp (520 households from CESP, 337 households with CWI / EWI / loft upgrade / fuel switching and 2,900 households receiving new boiler exchange / heat exchanger)
- 6,468 properties receiving new bathrooms and / or kitchens that mitigate the risk of falls on the Level

Table 6 Return on investment – assessment of cash savings to NHS of interventions

Measure	Number	Benefit	Cash Savings p.a. NHS
HHSRS Calculator: 3757 households receiving energy improvements			
BRE HHSRS Calculator Cost Excess Cold Class I Hazard Over 65's (most serious harm – e.g. EWD)	Risk: 1 in 1013	4 cases per year averted	£200,000
BRE HHSRS Calculator Class II	Risk: Less	N/A	N/A

Hazard: Excess Cold (Over 65's)	than 1		
BRE HHSRS Calculator Class III Hazard: Excess Cold (Over 65's)	Risk: 1 in 1488	3 cases per year averted	£4,500
BRE HHSRS Calculator Class IV Hazard (least serious): Excess Cold (Over 65's)	Risk: 1 in 757	5 cases per year averted	£500
Total		**12 cases per year averted**	**£205,000**
BRE HHSRS Calculator Class I - III Hazards: Damp (Under 14's)	Risk: Less than 1	N/A	N/A
BRE HHSRS Calculator Class IV Hazard (Least Serious): Damp (under 14's)	Risk: 1 in 629	6 cases averted per year	£600
BRE HHRS Calculator: 6,468 properties receiving new kitchens and / or bathrooms			
BRE HHSRS Calculator Class I Hazard (Most Serious): Falls on the level (Over 60's)	Risk: Less than 1	N/A	N/A
BRE HHSRS Calculator Class II Hazard: Level Falls (Over 60's)	Risk: 1 in 1800	4 cases averted per year	£80,000
BRE HHSRS Calculator Class III Hazard: Level Falls (Over 60's)	Risk: 1 in 570	11 cases averted per year	£16,500
BRE HHSRS Calculator Class IV Hazard: Level Falls (Over 60's)	Risk: 1 in 309	21 cases per year averted	£2,100
BRE HHSRS Calculator All Hazards Level Falls: Total	**Risk: 1 in 180**	**36 cases per year averted**	**£98,600**
HHSRS Grand Total: All hazards NHS Savings		**54 Cases per year averted**	**£304,200 p.a.**

Health and Wellbeing:

85 Regional and National Statistics: Evaluation from Warm Front scheme and Scottish CHP Evaluation

- Two thirds of participants reported increased comfort
- 20% reported less minor illnesses during the winter
- 24.5% reported feeling more relaxed and content
- 55.1% reported feeling better and 26.5% reported better mood and temperature
- 24.5% reported easing of chronic conditions such as arthritis
- 10% of householders felt more and better quality of food could be purchased due to cost savings
- 20% reported improved cooking (Gilbertson et al “Home is where the Hearth is: Grant recipients’ views of England’s home energy schemes” Warm Front 2006)

Table 7 Estimated impact of a warm front scheme on the health and well-being of Southampton City Council Tenants

Outcome: Subjective measure out of 3,800 households	Measure from Warm Front and Scottish CHP Evaluation	SCC CESP	SCC Boiler / heat exchange	EWI / CWI	Total
Self reported increased comfort	33%	343 households	957 households	125.4 households	1425.4 households
Less minor illnesses during Winter	20%	104 households	580 households	76 households	760 households
Feeling more relaxed / content	24.5%	127 households	710.5 households	93.1 households	930.6 households
Feeling better (health)	55.1%	287 households	1597.9 households	209.3 households	2094.2 households
Better Mood and temperature	26.5%	138 households	768.5 households	100.7 households	1007.2 households
Easing of chronic conditions e.g. arthritis	24.5%	127 households	710.5 households	93.1 households	930.6 households
Reported improved cooking	20%	104 households	580 households	76 households	760 households

Wellbeing Valuation: HACT Calculator

86 The HACT calculator is a useful guide for Housing Providers to put an economic value on wellbeing following investment. It includes a Wellbeing Calculator to calculate social impact on data following an intervention and an easy read explanation of how to turn qualitative survey data into robust quantifiable data

How Social Value is calculated:

87 The results of four large national surveys (British Crime Survey, Taking Part survey, British Household Survey and Understanding Society survey) were analysed to isolate the effect of a particular factor on the average person's wellbeing. Analysis is then used to find the monetary equivalent that this is equivalent to. Together these datasets comprise tracked information of over 100K households and individuals. As a lot of this information comes from households or individuals who are interviewed on regular timescales; it is possible to measure, identify and isolate the factors that matter with regards to improving wellbeing or worsening it.

88 Based on the HACT calculator values; the following outputs might apply to these interventions:

Improved Health:

89 Health: Secondary data suggests that residents who have benefitted from energy efficiency improvements and have warmer households experience better self-reported health as a result (e.g. Warm Front and Scottish CHP evaluation suggests that 55.1% feel better and 20% report fewer winter illness.)

90 The measure of improvement using the HACT Calculator is going from self-reported poor or neutral health to 'Excellent' or 'Good' in the last 12 months 'compared with people your own age'. We do not know how many households who would report poor or neutral health, however we could make a conservative assumption that 10% of households would report someone living in the household reporting this, which would apply to 376 households (and more people).

Improved mental health:

91 Wellbeing / mental health: We know from secondary data that being in a warm home makes a significant improvement to mental health following energy improvements; with significant improvements to better mood and feeling more relaxed / content (26.5% and 24.5% respectively – Warm Front and Scottish CHP data) and there is an inverse relationship between the likelihood of avoiding anxiety or depression and bedroom temperatures – residents with bedroom temperatures of 21C are 50% less likely to suffer anxiety or depression than those with temperatures of 15C.

92 If we used the interim data unknown function on the HACT calculator of 10% we could make the conservative assumption that 10% of these households would experience relief from depression or anxiety. This would equate to 94 households and is equivalent to a HACT calculator value of £36,766 per individual per year. This would equate to a total value of £2,527,065 per year with the deadweight for Health (set at 27%) deducted.

Improved Financial Inclusion:

93 We know that energy improvements have made a significant average saving for our tenants. This is actual cash money that they have saved. As a result we can use HACT calculator values to estimate the wellbeing return that it generates.

94 **Financial Comfort:** Financial comfort, that of self-reported living 'comfortably' or 'doing alright' is rated at £8917 per individual per year. As we do not have the actual data to see how many households have moved from a negative or neutral value to a positive value, we assume that 10% of the 3757 households would report being comfortable following improvements that is rated at £8917 per individual per year that equates to £2,707,740 per year.

95 **Ability to Save Regularly**: HACT calculator rates the value of being able to save 'regularly' or from 'time-to-time' as £2155 per individual per year. As we do not have the data to show how many households had moved from a negative or neutral response we estimate that 10% of the 3757 households are now able to save regularly or from time-to-time as a result of the cost savings. This generates a benefit of £678,894.

Benefit of new kitchens and / or bathrooms:

96 In addition to the benefits of energy improvements; there are also wellbeing benefits from the households that have received new bathrooms and / or kitchens. This is slightly harder to apply as the HACT calculator questions do not exactly match the outcomes. The nearest outcome that might apply is the question; "Do you have enough money to keep your home in a decent state of decoration?" under Financial Inclusion.

97 While this does not meet exactly the data; the value of financial inclusion seems to best match an attempt to calculate the wellbeing received from having a new bathroom and / or kitchen. In this case a new bathroom and / or kitchen is essentially a significant financial benefit in keeping a home in a decent state of decoration to households in receipt of this.

98 With the caveat that this does not exactly meet HACT calculator values; we can attempt to estimate the wellbeing value of this. Using the HACT calculator value that rates this as £5326 per individual per year; we assume 10% of the total value of the 6468 households receiving new kitchens and / or bathrooms moving from a neutral or negative response to a positive response which would be £3,138,213 per year.

Table 8 Wellbeing value of measures using the HACT calculator

Measure	Households affected	Measure £ per individual	Benefit we can apply	Wellbeing Value (
HACT Calculator: Improved Health	10% of 3757 households (approx.)	£20,141	10% Unknown Value	£546,581
HACT Calculator: Relief from depression or anxiety	940 households (25% of 3757 households)	£36,766	10% Unknown Value	£2,527,065
HACT Calculator: Financial Comfort	3757 households	£8917	10% Unknown Value	£2,707,740
HACT Calculator: Ability to save regularly	3757 households	£2155	10% Unknown Value	£678,894
HACT Calculator: Enough money to keep house in decent state of decoration	6468 households	£5326	10% Unknown Value	£3,138,213
Total				£9,598,493

CONCLUSIONS AND RECOMMENDATIONS

99 Southampton's population is forecast to grow in number, with an increasing proportion of people living for longer with long term health conditions, a continued high level of deprivation (within the South East region) and a relatively young demographic with a high proportion of large families. This combination of population factors makes it particularly important that City wide strategies to ensure good quality housing, both private and social, are preserved and further developed. Furthermore, with recent welfare reforms and the economic climate, it is crucial that we ensure vulnerable people have a safe place to stay.

100 Determinants of housing need are poverty and coupled to this, education and consequent employment prospects. Housing is expensive and wages are low in Southampton compared with national estimates. Poverty is an increasing issue, with one quarter of children now living in poverty across the city. It is important that the links between education, employability, health and housing are well recognised and form a key part of the strategic approach to the provision and quality of homes.

101 Decent housing standards have been achieved for 99% of Southampton's social housing stock. However, over half of Southampton's housing stock is owner occupied and a quarter landlord owned. This is where energy efficiency ratings are lower, fewer households meet decent housing standards and there are a high number of houses of multiple occupancy. Older buildings are particularly at risk. Most of the care homes in our City are older buildings.

102 Evidence on the impact of housing on health is strongest in relation to cold and damp homes; with one third of excess winter deaths resulting from people living in cold homes. To reduce the risk of excess winter mortality and further poor health and well-being outcomes, we need to reduce the number of cold and damp homes across the City. This can be achieved through raising energy efficiency ratings in private dwellings in line with national targets. Previous local initiatives have been provided through self-referral. To ensure equity, in future we need to prioritise energy efficiency initiatives those people in greatest need i.e. for households where vulnerable people reside.

103 Comparison of areas in Southampton with a high proportion of households in fuel poverty against those with low energy efficiency rates does not suggest a direct relationship. If we simply target those areas in Southampton with lower energy efficiency ratings we will not reach the highest number of households in fuel poverty. It is therefore important that we triangulate energy efficiency, fuel poverty and health data to identify our priority areas. Linkage with the integrated care teams will ensure that we can direct efforts to vulnerable households. Primary Care Cluster areas 3 and 4 have the highest proportion of households in fuel poverty.

104 Poor housing comes at a substantial cost to individuals, the health and social care sector and essentially the economy. Return on investment approaches

have begun to assess the financial impact of housing initiatives. Four approaches were described in this report, with financial benefits to our population of estimated at over £1m for social housing improvement programmes, a conservative estimate of over £300K for the health sector in reducing health hazards and well-being benefits for over 2,000 households as a result of energy efficiency measures.

105 There is a lack of research and regulation relating to fuel poverty and cold home-related ill health in the private rented sector. Evidence of reducing fuel poverty is associated with improving the energy efficiency of the home (and finding best value energy tariffs) so that it can be heated to an adequate temperature for a lower cost. We need to ensure that future initiatives in Southampton are also assessed in relation to impact on well-being and potential reductions in health and social care costs.

106 We need to maintain housing initiatives in Southampton that are working well, with a focus on protecting the most vulnerable in our population i.e. homeless, young people coming out of the care system, families with young children living in poverty and older people (supporting independent living). Expansion and further development of the HMO licensing scheme is an important approach to ensure decent housing standards.

107 Opportunities to bring new funds into the city to tackle fuel poverty are arising as a result of the publication of the National Fuel Strategy and voluntary redress agreements between OFGEM and energy companies. It is likely that these bidding rounds will centre on health impact with a focus on links between local government and the health sector. The warmth on prescription scheme is an important aspect. It is unclear whether the Green Deal will continue. To preserve current initiatives and set up new ventures, City partnerships need to mobilise swiftly to capitalise on these opportunities.

108 In Southampton, we should align our fuel poverty initiatives with the Better Care Programme integrated care teams to ensure a strong link with health. Networks of care navigators could be trained to both raise awareness and provide support when needed. Further to this, we should expand the ‘making every contact count’ approach, such that heating engineers, health workers, police, fire and safety, churches and Council of Faiths and other agencies are aware of support that is available should they come in contact with someone in fuel poverty. In addition, we should expand the network of agencies receiving extreme temperature emergency alerts to ensure those at risk are protected at times of greatest need. Lastly, we need local awareness campaigns to ensure the public understand and can readily take advantage of low energy tariffs.

Recommendations:

109 The recommendations from this report are:

1. Align strategic intentions for housing and health under HWBB and ensure a strategic approach to provision of housing services for those who are most vulnerable i.e. needs based rather than self-referral

2. Protect housing initiatives that are working well, where possible, seek to evaluate the impact of local existing and new approaches on health and social care resource use and well-being

3. Support the Health Overview and Scrutiny Panel recommendations on homelessness

4. Extend the HMO licensing scheme to all HMOs across the City to ensure conditions in the private rented sector are improved

5. Support strategies to encourage behaviour change and early intervention to reduce demand for social housing and adaptations

6. Exploration of the use of Social Return On Investment approaches to determine future health and well-being priorities for the city

7. Support the Southampton Warmth for All Partnership (SWAP) to ensure City wide partnership working on this agenda, especially in the development of bids for future funding

8. Align the work of SWAP with the Better Care Programme Framework and engage the Integrated Care Board on fuel poverty agenda and potential for developing a warmth on prescription scheme

110 Report working group members included:

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Janet Hawkins, Interim Regulatory Services Manager SCC
Liz Slater, Housing Needs Manager SCC
Sherree Stanley Conroy, Housing Delivery and Renewal Manager SCC
Adam Goulden, CEO, the Environment Centre
Adrian Littlemore, Senior Commissioning Manager, Integrated Commissioning Unit
Julia Kennedy, Business research and analysis officer SCC
Dan King, Vanella Mead, Public Health Strategic Analysis SCC

With information and review from: Rob Kurn Healthwatch Southampton, Peter Bennie Age UK, Sara Crawford Chair of the Anti-Poverty network

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ANNEXE 1

HOSP INQUIRY RECOMMENDATIONS: THE IMPACT OF HOMELESSNESS AND POOR HOUSING ON THE HEALTH OF SINGLE PEOPLE:

Please note *highlighted recommendations denote the Panel's priorities.

i.	The Homelessness Prevention Strategy continues to support city-wide commitment for continued funding of the existing flexible and innovative partnership model of homelessness in the city.
i.	**Commissioners undertake a feasibility study including a cost/benefit analysis, with providers, to consider whether a more intensive 'Housing First' model could provide the relatively small number but high cost entrenched homeless clients a potential route into sustainable and settled accommodation.***
i.	**The Housing Strategy continues to prioritise an increase in affordable single person accommodation across the city, including new developments.**
v.	Links are maintained and strengthened between homelessness prevention and employment projects such as City Limits and the new City Deal to increase the skills and employment opportunities for homeless and vulnerably housed individuals.
v.	**Continue to build relationships with landlords to raise awareness and common understanding of the issues and barriers of homeless tenancies and increase social letting with relevant support agencies. This includes bringing together the current range of city approaches for social lettings to the private sector housing rental market.***
i.	**Raise awareness of good practice and successful outcomes in homelessness prevention services as a means of reducing the stigma for homeless clients and encourage wider partnership involvement of other agencies including the Police and National Health Services including GPs and the University Hospital Southampton Trust.***
i.	**Expand the partnership to wider health services to reduce inequalities for homeless people services through delivering a comprehensive framework of preventative and integrated services.***
i.	**Raise the awareness of healthcare professionals of the role of homeless healthcare provider case workers and the value of their support of the single homeless, particularly through advocacy.***
x.	Maintain an overview of the cost benefit of key valued services within the city's Homelessness model, including the Homeless Health Care Team and dedicated specialist services supporting substance misuse and mental health problems.
x.	Consider outcomes from the Southampton Healthwatch review of GP registration and continue to work with GPs to improve access and integration

	to support homeless clients to move on from homeless health care to primary care services.
i.	The Homelessness Strategy Steering Group continue to support commissioners as they progress towards an evidence-based and outcome-focussed commissioning model so that the case for changes in policy and practice can be evidenced.
i.	**Children and Family Services continue to prioritise the Multi-Agency Safeguarding Hub (MASH) and Early Help Team to ensure children in need are not falling through the gaps.***
xiii	Children in Care continue to be a priority, particularly in preparing those in care to lead an independent life and that care leavers have access to suitable accommodation and maximise opportunities for employment, education and training.*
xiv.	Homelessness Services work with National Probation Trust and the Hampshire Community Rehabilitation to support more pre-release planning to ensure emergency bed spaces are being used appropriately.
xv.	**Commissioners of Homelessness services should consider the option of providing a 'dry' environment within the homelessness prevention model in the City to support those who want to become or stay sober.***
xvi.	**Homelessness providers and commissioners should work towards developing 'psychologically informed environments' in hostels and develop a staff training programme as appropriate. Partnerships between the psychological support from the University of Southampton and local housing providers are essential to achieving this.***
xvii.	**Undertake a fundamental review of Mental Health services for the city, specifically including improving access to behaviour therapies for homeless clients and considering raising the age for transition for young people into adult services to 24 years in line with the thresholds for the Integrated Substance Misuse Service. Early intervention should be prioritised alongside improving access to services from primary to acute care to ultimately reduce and better manage demand.***
xviii.	**Investigate opportunities to reduce barriers and provide incentives for Houses in Multiple Occupation (HMOs) to be used for homeless clients.***
xix.	Expand training on homelessness services / welfare services to community first responders and primary care services e.g. Hampshire Police, Ambulance Services, GPs and community nurses
x.	**Regulatory Services undertake an evidence based review of the effectiveness of the HMO licensing scheme to ensure that standards of quality are maintained for all private sector tenants in the city and to support the decision making process for whether to expand the scheme to other wards in the city. It should be recognised that those who have been homeless will be moving on into the lower cost / quality end of the market where risks to their health remain high.***
i.	**Regulatory Services consider options to undertake a new stock**

	condition survey to gain a better understanding of the quality of the city's private housing stock and establish mechanisms and resources to secure an up to date survey at least every 6 years.*
i.	Integrated Drug and Alcohol Substance misuse service to report to the Health Overview and Scrutiny Panel on how changes to service delivery will support homeless people more effectively, particularly in relation to raising the age of transition into adult services.
i.	Continue to monitor homelessness trends and impacts of Welfare Reforms on homeless people to enable an evidence based response to adapt the Local Welfare Provision where necessary and report the impacts of Welfare Reforms to commissioners, the Jobcentre Plus and the Department of Work and Pensions.
v.	The Homelessness Strategy Steering Group review the number, use and awareness of emergency weekend bed schedule for adults and especially for young homeless referrals and discharge from hospital or custody.
v.	Homelessness commissioners undertake a city-wide review of valued services which may come under threat due to lack of funding. Immediate consideration should be given to determine their value to the city's Homelessness Model and health outcomes for individuals for The Two Saints Day Centre and 'Breathing Space' project and the Vulnerable Adult Support Team in the University Hospital Southampton NHS Trust's Emergency Department.

Annexe 2 Case studies 2014-15 from Southampton

Mr F and family – Local Welfare Provision Service (LWPS)

Mr F, 40+ years, from Southampton spoke to us at a drop-in session about his condemned boiler at risk of gas leak and carbon monoxide poisoning, which he was unable to replace due to the family's financial circumstances. There was a particular safety concern because of his two teenage children and two children under 5 living there and a health concern of no heating or hot water with young children and Mr F's own health issues: COPD, asthma, arthritis and recent knee replacement affecting his mobility.

Advisors visited and discovered further issues including draughty windows and front door, damp and mould problems, fuel debt, fire safety and home security concerns and a leaking toilet, contributing to higher water meter charges.

Following the visit SCC agreed to fund a boiler replacement for the family, and this work was coordinated between the advisors, HP+ and the approved contractor. The family also received additional follow up from the advisors regarding the other issues identified: draught-proofing provided for windows, doors and radiators, advice on minimising condensation and preventing mould, referrals for smoke alarms, carbon monoxide monitor, spyhole and other home security measures, information and application forms for applying for Warm Home Discount and clearing utility debts and signposting to BwC contractors for fixing water leaks.

Mr F was extremely grateful for this help and the immediate impact it had on their lives:

'I just wanted to say thank you for all the help you have given me and my family, we had the boiler installed this week and never thought it would all happen so quickly, we are really happy and it is such a weight off our minds to know we don't have to worry about it breaking or leaking anymore... this has been a positive change for us, we were in a difficult place when we met you and now through all of your help we can get on with our lives and look to the future... we have put up some of the draught-proofing you gave us, but to be honest getting this new boiler has inspired us to tidy up and redecorate inside the house'.

Ms M – LWPS

Single parent of four children aged between 3 and 19, and victim of domestic abuse, referred to us as her boiler was broken and she was unable to fund a repair, so had no heating or hot water and was boiling water in the kettle and saucepans to wash her young children. Ms M receives Income Support, Disability Living Allowance as she has limited mobility and agoraphobia, Child Tax Credits and Housing Benefit and was on a debt management plan with consolidated debts of £5399 from legal aid costs.

Based on her circumstances the tEC advisor made a referral for a boiler repair through SCC discretionary funding and for delivery of emergency temporary heater from SSJ HP+. At the visit Ms M was also given advice on reducing energy and water usage and on preventing condensation and mould, which was an issue by the front door, on a bedroom wall and in the loft. The tEC advisor completed a £140 Warm Home Discount application on Ms M's behalf and provided a carbon

monoxide detector as Ms M is not always able to afford a Gas Safety Check and boiler service.

Due to ageing, draughty double glazing, Ms M was provided with rubber seal draught-proofing strips, door brushes and curtain lining material and fixings. Following a successful application Ms M's boiler repair was fully funded.

Miss F – LWPS

50+ year old lady with mental health issues, living alone and receiving Employment and Support Allowance referred to us because she had recently moved into a private rented property for the first time and was unsure how to set up bills and heating controls.

At the visit the tEC advisor phoned the existing energy supplier to provide meter readings, switched Ms F to a better fixed tariff, saving her about £200/year, made arrangements for her to pay by monthly Direct Debit and applied for the £140 Warm Home Discount for her. The advisor explained to Ms F how the programmer on her boiler worked, set up heating and hot water timings that worked best for her routine and adjusted her thermostat and radiator valves to the most efficient settings.

Ms F was also using a second-hand gas heater, so the tEC advisor explained to her the additional costs of secondary heating compared to gas central heating and provided her with a carbon monoxide detector for additional gas safety. During the visit the advisor discussed tips for reducing energy and water usage, explained her assessed water tariff and how to prevent condensation and mould developing in the future.

As the flat was quite cold and draughty, Ms F was provided with reflective radiator panels to keep heat in the room, rubber seal draught-proofing tape for her windows and front door, as well as a door brush and letter box cover and step-by-step guidance of how to fit them.

Mrs A – Money Matters

80+ year old homeowner contacted us as her boiler was broken and she had no central heating, hot water or secondary heating. Mrs A receives Pension Credit and Council Tax Benefit, has been undergoing treatment for cancer, has asthma and incontinence, which all reduce her mobility and prevent her from leaving her home.

Under the Money Matters project tEC referred her to HP+ for emergency heating and due to her financial circumstances and health needs applied to SCC discretionary fund for her boiler to be assessed for repair or replacement.

At the Money Matters home visit it was also identified that Mrs A was eligible for her energy supplier's Priority Service Register, for Southern Water's WaterSure tariff due to her incontinence and had £3104 fuel debt from an increased heating need during her cancer treatment and using more expensive electric heating over gas central heating.

A tEC advisor spoke to Mrs A's energy supplier on her behalf, arranged for her to join the Priority Services Register and receive large print bills that were easier

for her to read, confirmed she was eligible for the £140 Warm Home Discount, arranged more manageable monthly Direct Debit payments and put debt repayments on hold whilst an application was made to their Charitable Trust to reduce the fuel debt.

The tEC advisor helped Mrs A complete the Charitable Trust application, as well as the WaterSure tariff application, which capped Mrs A's water bills, saving her over £100/year. Additionally Mrs A was provided with predicted running costs of electric heating and gas central heating to encourage her to change her energy habits and contact details for Buy with Confidence contractors to fix a blocked toilet.

Through our partnership with Age UK for this project a successful application was made for Mrs A to receive Attendance Allowance, increasing her income by £54.45/week, consequently she became eligible for full Council Tax Reduction, saving an additional £20/month and looking at her finances we identified she was paying for incontinence products when she would be able to get them on prescription for free, saving about £30/month.

Finally, Mrs A's application for boiler replacement was successful and she had a new boiler installed fully funded at a value of £2010.

Mrs A was very appreciative of the help and said

"I just wanted to say thank you, you've all been so helpful, ever since I contacted Age UK everything has moved so quickly, with my boiler and my electricity. Laura spent such a long time on the phone to Npower, I would have given up, but she was so good. And I am so grateful."

Mr & Mrs P Money Matters

Mr and Mrs P were referred to the project by their daughter as they were facing real financial distress. Having previously run their own business which went bust, they now have serious mortgage arrears and fuel debt and had been referred to the food bank by their local vicar. They had also been repeat victims of burglary. They had lived in their house for a very long time and were now in serious danger of losing it and both of them have poor health (Mrs P has Alzheimer's and Mr P has arthritis in his back and most of his joints).

We supported them to improve the energy efficiency of their home by providing draft proofing materials and advice about effective use of their heating controls. They were also added to the fuel providers Priority Services register to access free gas safety checks. We supported them to apply for a grant to address their fuel debt.

We also gave the daughter information about grants for people that had worked in their trade that might help with other home improvements such as replacing the old rotting window frames and mending the leaky roof in the kitchen. A referrals were made to: (1) the Blue Lamp trust for home security advice and to fit window locks for free, (2) the Handy Person service to mend dripping taps which was increasing their water bills and (3) the Hampshire Fire Service to supply smoke alarms and provide a home fire safety check.

As Mr P had very poor mobility we referred them for an occupational therapy assessment for aids and adaptations. Through our support to maximize benefits their income has increased by over £13,500 per year.

The family says… they are overwhelmed by all the wide ranging help that we were able to give and that they can now afford to buy food, pay their bills and also most crucially manage the mortgage repayments and so not have to leave their beloved home.

Mrs A

Mrs A is a lively 80+ year old, but with poor health as she suffers from respiratory illness as well as mobility issues and is on a very low income. She had contacted Money Matters in January when her boiler had broken. She had previously called in a boiler engineer that she had found in the Thompson Local and he had been out to her home and charged her £100 but the boiler was still broken.

Our first action was to organise emergency heating for her. A brief assessment identified that Mrs A was eligible for the Local Authority boiler replacement funding and she was referred to this scheme.

Mrs A also had a large debt with her fuel supplier which she had incurred during a period when she had been treated for cancer and one of her sons had sadly passed away and she had found it difficult to cope. The fuel provider was trying to insist that she pay the debt off at such a rate that it would have swallowed half her already low income. We helped negotiate with the company to put a stop on the repayments pending the outcome of an application to BGET for a grant to pay off the debt which is around £3100. Mrs A's poor health meant that she needed to use a lot of water and her water bills were high.

We supported her to apply to Southern Water's Watersure tarrif which will save her £100 per year. Mrs A was unaware that she was eligible to claim further benefits because of her long term health condition and we helped her to make a successful application for Attendance Allowance and this has increased her income by £2831 per year.

Her son had recently become unemployed and had moved in with her and this had reduced the amount of Council Tax Reduction that she was eligible for. As she now receives the Attendance Allowance, the Council Tax Reduction rules means that the son will now be disregarded and she will get full Council Tax Reduction which will be an extra £200 per year. We also helped her to report the heating engineer from the directory to Trading Standards and advised her about the 'Buy with Confidence' for future use.

Mrs A had her new boiler installed within a month of contacting us and was extremely happy with all the other help and support that the Project was able to provide and she described the extra money as

Mrs A said….'Pennies from Heaven'.

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DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		DRAFT HEALTH INEQUALITIES FRAMEWORK		
DATE OF DECISION:		29 JULY 2015		
REPORT OF:		DIRECTOR OF PUBLIC HEALTH		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Noreen Kickham**	**Tel:**	**023 803738**
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	E-mail:	**Andrew.Mortimore@southampton.gov.uk**		
STATEMENT OF CONFIDENTIALITY				
None.				

BRIEF SUMMARY

The Health and Wellbeing Board agreed at the formal Board meeting in March 2015 that further work be undertaken to identify priorities to tackle health inequalities in the City. This report outlines the recommendations from the Reference Group and draft Health Inequalities Framework.

RECOMMENDATIONS:

(i) To consider and agree the following recommendations to support the further development of the Health Inequalities Framework.

a) Development of Consultation and Engagement Process as part of Health and Wellbeing Strategy Development.
b) Assign accountability and develop implementation plan for high impact actions.
c) Development of Community Resilience Theme.
d) Health equality proof commissioning and policy development across Health and Wellbeing Board partner agencies.

REASONS FOR REPORT RECOMMENDATIONS

1. The draft Health Inequalities Framework has been developed to support the next iteration of the Joint Health and Wellbeing Strategy. It proposes core themes for action to address health inequalities in the City. The recommendations proposed in the Framework provide a focus for next steps in the process. They include the development of a wider consultation process and stakeholder engagement in determining priority areas for action.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

3. Draft Framework produced as pre-consultation phase prior to development and consultation on Health and Wellbeing Strategy in Autumn 2015.

4. The Draft Health Inequalities Framework attached to this report has been developed by the Health Inequalities Reference Group. The Group was established to progress a short life project to identify the principles, themes and priority actions to tackle the persistent social gradient in health outcomes in the City.

5. The Group has met on 3 occasions and the Draft Framework attached proposes:

   - Core Principles to underpin action on health inequalities
   - Core Themes for action. These reflect the social determinants of health and a focus on ill health prevention.

   Preliminary High Impact Actions to tackle health inequalities.

6. The recommendations are proposed by the Reference Group to support the further development of the Health Inequalities Framework.

Recommendation 1 – Development of Consultation and Engagement Process as part of Health and Wellbeing Strategy Development.

7. It is proposed that a partner and key stakeholder consultation process is developed and implemented in early Autumn 2015 to :

   - Support consensus building on key principles/core themes and progress discussion to agree high impact actions.
   - Expand the picture of current activity underway across core themes.
   - Implement consultation with local population (community/voluntary groups and wider population).
   - Inform the focus of the next iteration of the Joint Health and Wellbeing Strategy.

Recommendation 2 – Assign accountability and develop implementation plan for high impact actions.

8. It is proposed that as part of the consultation process and agreement on high impact actions the following are identified.

   - Lead agency and accountable officers.
   - Definition and work up of delivery plan and “success” metrics for each action area (with agreed reporting mechanism and timescales to Health and Wellbeing Board)

Recommendation 3 – Development of Community Resilience Theme

9. It is proposed that further work be undertaken to develop a comprehensive picture of activity underway across the City. This would support the development of a collective approach to increasing community resilience and tackling loneliness and social isolation.

Recommendation 4 – Health equality proof commissioning and policy developme across Health and Wellbeing Board partner agencies.

10. It is proposed that a common approach is developed by Joint Health and Wellbeing Board partners to support the following:

    - Health equity proofing policy

Implementation of health inequality as a core theme for application of the Social Value Act (2012) as part of commissioning and procurement processes.

RESOURCE IMPLICATIONS

Capital/Revenue

11. None

Property/Other

12. N/A

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

13. N/A

Other Legal Implications:

14. N/A

POLICY FRAMEWORK IMPLICATIONS

15. None

KEY DECISION?	No (Joint Health & Wellbeing Board will determine future work as part of Joint Health & Wellbeing Strategy development)
WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Appendices

1.	Draft Southampton Inequalities Framework

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)

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Healthy Southampton

Draft - Health Inequalities Framework

Southampton – A Healthy and Fair City

Draft Report – July 2015 of the
Health Inequalities Reference Group:

Councillor Paul Lewzey (Chair)
Noreen Kickham - Consultant in Public Health
Rob Kurn – Deputy Chief Executive, Southampton Voluntary Services
Carole Binns – Associate Director, Integrated Commissioning Unit
Alex Whitfield - Chief Operating Officer, Solent NHS Trust (representative from Southampton's Fairness Commission)

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Introduction

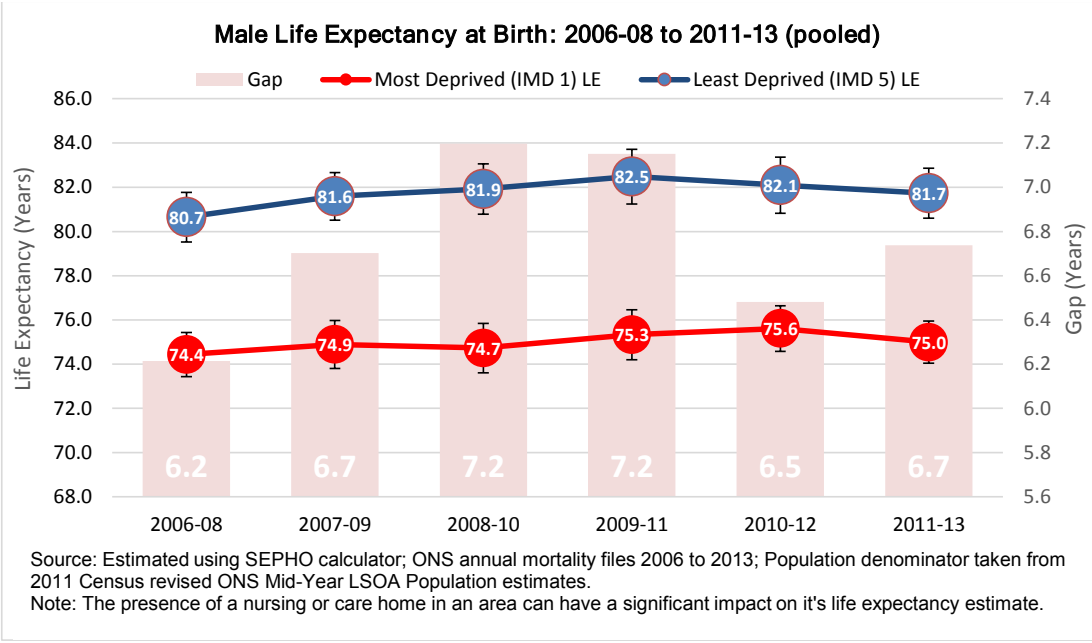
1. The Draft Health Inequalities framework has been developed by the Health Inequalities Reference Group on behalf of the Health and Wellbeing Board. The Group was established as a "short life" group and has met on 3 occasions since its establishment at the end of April 2015. This framework is intended as a platform from which consultation and engagement on action on health inequalities can be progressed. The Group's Terms of Reference are outlined in Appendix A.

2. The overarching aim of the Group was to develop a health inequalities framework which would provide the cornerstone of the next iteration of Southampton's Joint Health and Wellbeing Strategy (due for publication in April 2016).The model and priorities proposed below are designed to support the development and consultation process for the Strategy during Autumn 2015.

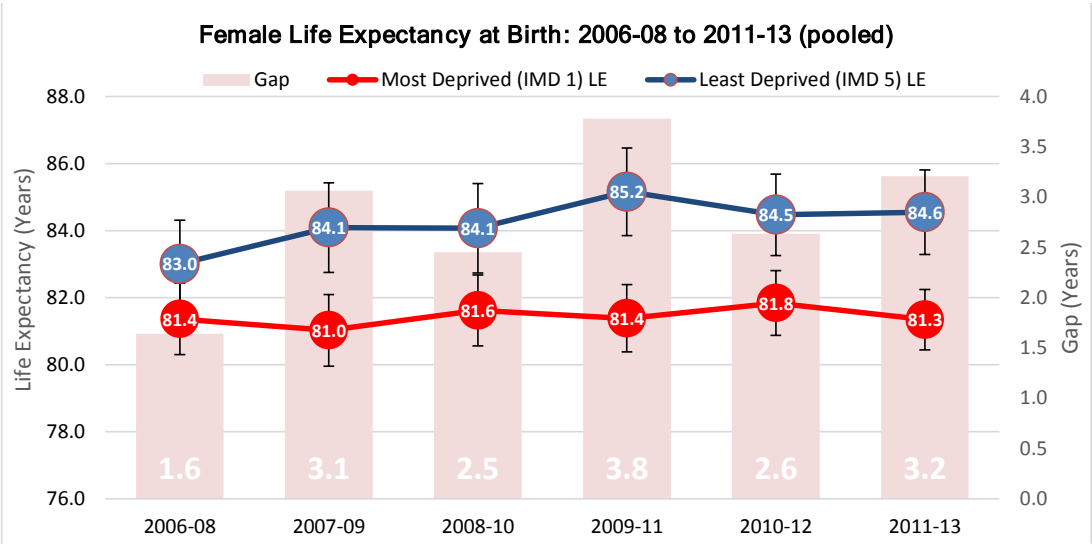
Background Context – Health Inequalities in Southampton

3. Over recent years Health Inequalities have persisted between the most deprived and least deprived populations in the City. The current status of Health Inequalities in the City has been outlined comprehensively in two City publications : **the Director of Public Health's Annual Health Report 2014 and the briefing report, Health Inequalities in Southampton City – Analysis of Trends (Refresh November 2014)** [1,2]**.** The Health and Wellbeing Board has received presentations on both of these data sources. They present a picture of consistent and persistent health inequalities in the City. The findings from these reports informed the Health and Wellbeing Board's decision to progress a more focused piece of work which would propose priority themes and actions to address health inequalities in the City.

4. For illustrative purposes the figures on Male and Female life expectancy between the least and most deprived populations in the City are outlined below. These have been taken from the Health Inequalities Briefing (November 2014) and present a picture of consistent and enduring inequality between the richest and the poorest in the City.



Source: Estimated using SEPHO calculator; ONS annual mortality files 2006 to 2013; Population denominator taken from 2011 Census revised ONS Mid-Year LSOA Population estimates.
Note: The presence of a nursing or care home in an area can have a significant impact on it's life expectancy estimate.



Source: Estimated using SEPHO calculator; ONS annual mortality files 2006 to 2013; Population denominator taken from 2011 Census revised ONS Mid-Year LSOA Population estimates.
Note: The presence of a nursing or care home in an area can have a significant impact on it's life expectancy estimate.

5. In summary, the analysis of local data indicates that health inequalities between the most deprived and least deprived areas of Southampton are consistent over time and for some indicators are actually widening. This data has provided impetus and urgency for the Joint Health and Wellbeing Board to determine a focus on sustaining and focusing collective effort on tackling health inequalities.

Southampton Health Inequalities Framework – Key Principles

What works in tackling health inequalities – National evidence base

4 The Health Inequalities Reference Group has drawn extensively on national sources of effectiveness evidence including work undertaken by the Institute of Health Equity at University College London and the reviews undertaken by the Kings Fund [3,4]**.** The national strategy Fair Lives, Healthy Society published in 2010 provided a substantial evidence base to support and inform actions at national government and local government level to tackle health inequalities. This work was further developed for a local government audience with the publication in Autumn 2014 of a suite of evidence based briefings. The proposed Southampton Framework is underpinned by this comprehensive national evidence base.

Southampton Framework - Key Principles

5. The Reference Group propose that the Framework should be underpinned by 8 key principles:

a) **Take evidence – informed action**: the process of determining priorities and designing and modifying local action should be underpinned by evidence of effectiveness.

b) **Use a life course approach:** local action that recognises and responds to health needs and inequalities at different stages of life can help prevent the accumulation of disadvantage through life.

c) **Apply proportionate universalism**: proportionate universalism recognises the social gradient, aiming to improve the health of everyone but with a greater focus on those with the greatest need and the worst health outcomes.

d) **Work with local communities:** working with local communities to tackle health inequalities is essential in order to ensure that attempts to tackle health inequalities are relevant to local need and draw on local assets within local populations and communities.

e) **Aim for health equity in all activities**: working across all partner organizations on the Joint Health and Wellbeing Board and wider sectors in the City to ensure consideration of impact on health equity underpins key processes (Commissioning and procurement, policy impact assessments, employment and other local processes).

f) **Inter-sectoral Collaboration**: ensure that the decision making on local priorities to tackle health inequalities and development of local action is underpinned by a collaborative approach across statutory and non-statutory agencies, voluntary and community groups to secure maximum agreement and sanction.

g) **Ensure impact and learn from successes and failures:** ensure monitoring and evaluation of local action underpins delivery and that successes and failures are shared to increase the local understanding of what works.

h) **Aim for continuity and sustainability**: action to tackle health inequalities should be supported by a long term approach to planning and delivery.

Southampton Framework – Identification of Core Themes

Methodology – How the themes were identified

6. The Reference Group applied a twofold approach to support the identification of core themes for action:

- Scoping and analysis of the evidence base on what works to tackle health inequalities and the local data analysis on health inequalities in Southampton
- Engagement and discussion with lead officers from the City Council and Clinical Commissioning Group to provide examples of current activity and to raise awareness of the emerging shape of the Framework

Rapid Evidence Review

7. The development of this framework has drawn on the substantial body of work undertaken by the Institute of Health Equity at University College London. The national Review on health Inequalities Fair Lives, Healthy Society published in 2010 [3] provided a comprehensive picture of the causes of health inequality in England. It proposed an evidence based approach which tackles the social determinants of health alongside ill health prevention. It concluded that to tackle health inequalities action would be needed across six policy areas:

- Give every child the best start in life
- Enable all children, young people and adults to maximize their
- capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and
- communities
- Strengthen the role and impact of ill health prevention

8 In November 2014 the IHE team published briefings to further focus and direct action at local government level to tackle health inequalities. The briefings proposed the following themes for action across the life course:

Institute of Health Equity – Local Authority Health Inequality Briefings (November 2014) [5-16]

- Good Quality parenting
- Improving Home to School Transition
- Building Children and young people's resilience in schools
- Reducing the number of young people not in employment,
- education or training (NEET)
- Adult Learning Services
- Workplace interventions to improve health and wellbeing
- Increasing employment opportunities and retention for people
- with a long term condition or disability and older people
- Fuel Poverty and cold home related problems
- Access to green spaces

9. This evidence base was reviewed and applied to support the definition of core themes for the Southampton Framework. It has also focused the early stage dialogue and engagement undertaken with lead officers in the City Council and the Clinical Commissioning Group.

Engagement with Lead Officers in Local Authority and Clinical Commissioning Group

10. The Reference Group agreed early on in its discussions that alongside the review of evidence, the process of developing the draft Health Inequalities Framework should also include direct engagement and dialogue with those officers leading on the core themes. Brief meetings were held with a total of 16 officers of the City Council and Clinical Commissioning Group (a list of officers consulted and job roles is attached in Appendix B).

11. These brief meetings enabled the following:

    - Early dialogue and consensus building on the proposed focus of health inequalities for the next Joint Health and Wellbeing Strategy and early "heads up" on the proposed engagement and consultation process during autumn 2015.

    - Capture of headline examples of current action aligned with the evidence of effectiveness across the core themes.

12. In the Next Steps section of this document (Section 7) a recommendation to further build on and expand officer participation in the sanction and further development of the Health Inequalities Framework is proposed.

Core Themes of Southampton's Health Inequality Framework

13. The Health Inequalities Reference Group has identified 6 core themes to support and focus action on health inequalities in the City.

Core Themes – Health Inequalities Framework

a) **Early Life Interventions – Give every child the best start**: to include a focus on Good Parenting programmes, Improving School Transitions, Building children and young people's resilience in schools.

b) **Skills Development – enable all children, young people and adults to maximize capabilities:** to include a focus on reducing the number of young people not in employment, education or training (NEET) and adult learning.

c) **Employment and Work – create access to fair employment, good work for all and promote the living wage**: to include a focus on workplace interventions to improve health and wellbeing, increasing employment opportunities and retention for people with a long term condition or disability and older people.

d) **Healthy Environment** – **create and develop healthy and sustainable places and communities:** to include a focus on fuel poverty, improving access to green spaces.

e) **Ill Health Prevention** – **strengthening the role and impact of ill health prevention:** to include a focus on early intervention/prevention, chronic disease management, tackling the key lifestyle risk factors, improving the health of vulnerable groups and promoting the physical health of people with a mental health condition and those with a learning disability.

f) **Resilient Communities – building resilient communities, tackling loneliness and social isolation:** with a whole population approach and proportionate focus on vulnerable groups and communities.

14. Outlined below in summary format for each theme are:
    - Headline messages drawn from the evidence of what works to tackle health inequalities
    - Examples of business case/return on investment information
    - Examples of local action currently underway in the City linked to each theme.

15. The Examples of Business Case and Return on Investment information outlined below have been drawn substantially from the reviews undertaken by the Institute of Health Equity and the Kings Fund [4,17] and local work undertaken on return on investment in the Public Health Team. [18]

16. It is proposed that the Autumn 2015 consultation process will enable "core theme" based discussion with lead officers, wider stakeholders and community groups to further expand the intelligence around current action and support priority setting of actions (See Section 7).

Core Theme 1 – Early Life Interventions – Give Every Child the Best Start

Headline Messages from Effectiveness Evidence - What works	Examples of Business case/Return on Investment	Examples of local Action
Promotion of good maternal/parental and child health: addressing healthy behaviours and lifestyle risk factors (promotion of positive mental health, aiming for fewer women who smoke, drink and take drugs during pregnancy, promotion of healthy weight and breast feeding and promotion of the health of the child (in line with public health priorities in Healthy Child programme – to include focus on healthy eating/good nutrition and promotion of oral health) **Good Parenting Interventions:** **-** Universal provision of parenting programmes aiming to promote secure attachment, positive engagement between parent and child and promotion of improved cognitive, social and emotional ,	- Family nurse partnership programme has been evaluated positively in the US – benefit-cost ratios fall in range of 3:1 to 5:1. In the UK context a social-cost ratio of 1.94 has been calculated per £1 spent - Report for UNICEF UK found that moderate increases in breastfeeding translate into potential cost savings for the NHS and tens of thousands of fewer hospital admissions and GP consultations - Social benefit to cost ratio of a range of programmes (from Early Intervention Foundation) found to be beneficial – including: Incredible Years Parent Training, Parent Child Interaction therapy, Targeted Reading interventions - Evidence from the US (Seattle Social Development Project) –	- Universal delivery of Healthy Child programme across the City (Maternity and Health Visiting) - Range of parenting support initiatives/programmes across the City including Early Years/Childrens Centre programmes - Family Nurse Partnership programme being implemented as targeted intervention with teenage mothers - Troubled Families programme – provision targeted to cohort with highest complexity of need - Scoping exercise of community support groups in the City underway to establish resources to support community capacity building for families - Early Years provision and health improvement/prevention initiatives (eg. Smoke Free Homes, Healthy Start Scheme, Breast Feeding initiative

language and physical health outcomes - Targeted delivery of parenting programmes to improve outcomes in specific population groups (eg. Teenage mothers/vulnerable communities) **Improving the home to school transition:** **-** Promotion of good transition practices, to include: focus on the whole child, implementation of a variety of practices to support transition eg. open days, information sessions ,one to one support (implementation of multiple approaches found to be particularly beneficial for those at risk of poor transition) - Provision of targeted support for at risk groups such as looked after children - Implementation of strong, joined up linking schemes between pre school/nursery programmes and curriculum combined with strong leadership and commitment to	targeting youths to increase bonding to school and family as a protective measure against school failure, delinquency, teen pregnancy and violence. Overall benefit to cost-ratio is $1.92 for every $1 spent -Parenting programmes to prevent conduct disorder pay back £8 over six years for every £1 invested - Meta –analysis of parenting programmes that improve maternal mental health indicates cost effectiveness. If health visitors identify and treat post-natal depression that improves productivity and leads to cost savings in the medium to short term - National Institute of Health and Clinical excellence has identified whole school approaches to preventing bullying and its health consequences as cost effective - School based obesity programmes have been estimated to have a cost benefit ratio of 7:1	- Joint working well established between childrens centres and schools to support delivery of good transition practice - Headstart Big Lottery Fulfilling Lives programme for 10-14 year olds pilot phase implementation underway (Initiative aimed at increasing resilience and positive outcomes) - Healthy Schools/School Enhancement programme supported in the City as a means of promoting a “whole school” approach to improving health outcomes - Early Intervention Joint Commissioning Strategy (Pre-birth- 19 yrs) developed to support long term planning and prioritisation process for early years to young adulthood (focus includes promotion of good maternal and child health, promotion of good parenting outcomes through targeted support and focus on securing good transitions for children and building resilient families, children and young people) - Teenage Pregnancy Action Plan being updated and “deep dive” analysis of data around teenage pregnancies in the City being undertaken to further inform planning and targeting of support

transition interventions from school leadership teams - Implementation of integrated, proactive approach to identify needs of those at risk of poor transition and with special educational needs across agencies (pre school, health, school leads) to mitigate against poor attendance **Building Children and Young People's Resilience in Schools** **-** Implementation of sustained interventions to promote positive achievements including: academic performance, number of years spent in school and increased attendance levels. - Promotion of positive school experiences including engagement, enjoyment and success in sports, arts and music can help increase resilience and confidence in children - Promoting healthy behaviours through a "whole school" approach to address: smoking, taking drugs, sexual behaviour, drinking alcohol, tackling obesity/increasing physical	- Effective smoking prevention in schools has been estimated to have a cost benefit ratio of over 15:1 over a lifetime - Every £1 spent preventing teenage pregnancy saves £11 in healthcare costs - Reducing truancy can produce a saving of £1318 per year per child, and reducing exclusion can save £9748 in public value benefits (89% of which goes to local authorities)	- Future in Mind initiative being implemented (focus on child and adolescent mental health promotion)

activity - Programmes to promote emotional resilience in schools as a means of increasing pupils self esteem and resilience (to include :addressing transition to secondary school, promoting anti-bullying, promoting peer to peer support and involvement of parents and carers)		

Core Theme 2 Skills Development – Enable all children, young people and adults to maximize capabilities

Headline Messages from Effectiveness Evidence – What works	Examples of business case/Return on Investment	Examples of local Action
Reduce the number of young people not in employment, education or training (NEET): - Early intervention programmes to prevent vulnerable young people becoming NEET including targeted support to those at risk to support successful move from education to training and employment - Effective interventions in school environment include: recognising achievements in general skills and those that increase employability, managing transitions, minimising or preventing exclusions (These actions to involve working with families and communities, rather than just with children and should be universal, but targeted proportionately to those in greater need of support) - Offer courses to increase employability (literacy, numeracy	- Estimated that each 16-18 NEET will have cost £56,000 over their lifetime based on welfare costs, lost tax and national insurance contributions and small costs in the health and criminal justice systems. - Programme for children at risk of becoming NEET in a school in Salford was evaluated by the Audit Commission - found scheme would become cost neutral if it helped 8 out of the 31 young people involved . If all of them didn't become NEET savings were estimated at £250, 000 - £4k support to a teenage mother on interventions that enable her to move into work would be repaid 20 times over through increased tax	- City Deal Youth Programme being implemented across the City (also covering Portsmouth): Focus is on vulnerable young people (16-24 yrs)in transition from education to employment. Aims and objectives of the programme include: to reduce NEET rate (particularly among vulnerable cohort – programme will measure outcomes for those up to 25) It aims to provide co-ordinated, systematic information advice and guidance service. This will include key worker support to enable young people to progress into training and employment. Programme will provide a hub for information and activity for youth employment and training. It will also work with local employers to increase training and employment opportunities - Programme implementation began in April 2015 (aim is to identify, work with and track 750 vulnerable young people across 2 cities)

and communication skills and which include accreditation to improve confidence and self belief) - Provide good staff training and awareness raising to ensure those at risk are identified and supported - Implement a planned approach to maximise opportunities through commissioning and delivery of services to increase apprenticeship opportunities	contributions over lifetime and estimated to result in reduction of public service costs by £200,000	
Adult Learning Services: **-** Adoption of a lifecourse approach to address different needs at different stages of life - Promotion of adult learning opportunities to those in greatest need (social gradient around need – participation is lower amongst those with lower literacy and numeracy levels) **-** Interventions and courses through adult learning to prevent/address poor educational outcomes (to include Family literacy programmes) - Collaborative approaches across agencies to work with	-Increasing skills through adult learning is cost effective – fiscal benefits due to increased taxation revenue as a result of an increase in skills are estimated to be between £83 and £787 per annum as a result of an increase from below Level 2 training to Level 2 and between £513 and £1391 as a result of an increase from level 2 to 3. - Lifetime benefits to individuals and the economy show that return on investment is £21.60 for every £1 invested	- Commissioned programme of adult learning across the City (annual cycle of approx. 20 providers) - Approx. 5,000 adult learners across the City and service Ofsted Rated: Good - Strategic framework for commissioning of learning opportunities developed - Well established Employment, Skills and Learning partnership in the City - Programme in the City through Job Centre Plus available for upskilling JSA claimants who are over 50 yrs (lone parents a priority)

vulnerable/hard to reach groups (eg. Joint working between commissioners of services and Job Centres) - Design and implementation of programmes to address needs of those who find re-engaging with learning stressful and aim to tackle deep seated barriers to employment (embed literacy and numeracy into vocational programmes) - Work with local employers to encourage workplaces to deliver learning and training in universally proportionate way - Engage the community (development of Community Learning Champion schemes)	at Level 1 courses for those aged 19-24	

Core Theme 3 – Employment and Work – create access to fair employment, good work for all and promote the living wage

Headline Messages from Effectiveness Evidence – What works	Examples of business case/Return on Investment	Examples of local Action
Workplace Interventions to improve health and wellbeing: **-** Promote greater participation in decision making by employees - Implementation of health behaviour change programmes in the workplace setting can be effective - Provision of in work training and development for workforce - Implementation of interventions to reduce workplace stress and improve mental health at work (including line management training, provision of flexibility in employment) **Working with Employers to promote good quality work:** - Evidence that local authorities can work with employers to promote good quality work	**-** A range of behaviour change/employee wellness programmes in workplaces have been found to return £2-£10 for every £1 spent -An independent review of health and work in 2008 estimated that the total economic costs of sickness absence and worklessness associated with working age ill health, to industry, employers, NHS, government and the economy as a whole to be over £100bn per year - Estimated cost of mental health problems to the economy is £30-40bn, arising from lost productivity from people with mental health problems and costs of care - Individual placement and support programmes are estimated to be cost effective (eg. Kent supported	- Southampton Programme developed to implement Workplace Charter locally - Links established with local workplaces and business organisations and first cohort of businesses (4 Workplaces) have participated and worked through pilot scheme requirements - National organisation Health at Work commissioned to develop the quality assurance framework for the Southampton programme - City Council is working on elements of the Charter for its workforce - Linkage with health improvement programmes and services being established to support workplaces in delivery of health and wellbeing initiatives - Southampton Fairness Commission recommendations to be reported shortly (understood to include reference to promotion of Living Wage) - City Deal Programme includes specific initiative to provide support to long term unemployed with long term conditions to get back into employment. Pilot phase has begun with focus on working with 100 unemployed people across Southampton and

(advice role of local authority, alongside enforcement/employer legal obligations, promotion of partnership working across agencies and sectors) - Application of commissioning and procurement leverage through application of Social Value Act 2012 offers opportunity to promote good quality work, improved working conditions (Application of Health and Safety Executive Stress Management standards) **- Living Wage:** ways of promoting the living wage include – leading by as example as major employer, utilisation of innovative ways for implementing living wage by integrating into commissioning and procurement processes, use existing partnerships to develop support for the living wage **Increasing Employment**	employment programme estimated to cost £9910 per person, 88% of the cost of a day service place – potential saving of £1290 to local authority - Better Health at Work Award (scheme previously generated through Primary Care Trust collaboration) evaluated reduction in sickness absence of 0.007-1.1 days for every £1 invested - Getting back into employment increases the likelihood of reporting improved health (from poor to good) almost threefold, and boosts quality of life almost twofold - Unemployment increases the risk of fatal or non-fatal cardiovascular disease and all-cause mortality by between 1.5 and 2.5 times - Business in the Community has estimated that its programme of getting disadvantaged groups ”Ready for Work” provides more than £3 in benefits for every £1 spent over 5 years (associated savings include reduction in homelessness, benefits and	Portsmouth. Evaluation of pilot will inform core programme. Work also being progressed during pilot phase to work with employers across the patch to raise awareness of the programme and identify training and placement opportunities.

opportunities and retention for people with long term conditions, disability and older people: - Local government can raise employer awareness of national measures aimed at increasing access and retention among vulnerable groups (Access to Work, Equality Act) - Targeted support to prevent people from leaving work due to health problems is vital (Health and Work interventions and application of Fit Note designed to support employees on long term sick leave back into work) - Fit for work service pilots – key message is the availability of quick access to holistic , initial assessment, ongoing case management as route to improve management of LTC - Support for people with mental health problems – National Time to Change programme addresses stigma through campaigns (some	healthcare)	

positive evaluation). Individual placement and support (IPS) is well established “place then train” method to get unemployed people with severe mental health problems into work (Scheme evaluation positive) - Range of employer approaches evaluated as likely to increase employment opportunities and retention among older people including measures to promote fair recruitment, equal training opportunities, flexible working, phased retirement and succession planning		

Core Theme 4 – Healthy Environment – create and develop healthy and sustainable places and communities

Headline Messages from Effectiveness Evidence – What works	Examples of Business case/Return on Investment	Examples of local Action
Fuel Poverty: - Promotion and implementation of schemes aiming to improve energy efficiency of housing (eg. Green Deal 2012 and Energy Company Obligation 2013) - Development and implementation of Cold Weather Plan at local government level - Interventions to include: schemes supporting improvement in energy efficiency of homes, provision of advice on energy saving methods and how to reduce costs - Joined up, pan agency approach at locality level to identify those at risk to implement schemes raising awareness of benefits advice, home repairs/improvements schemes and targeted monitoring and support of individuals at risk of cold home related ill health as part of Cold Weather Plan implementation	- Poor housing conditions cost the NHS an estimated £2.5bn per year. This includes costs accrued by primary care services, treatment costs, hospital stays and outpatient visits - Affordable Warmth Access referral Mechanism – a cost benefit analysis was conducted on 52 household interventions and analysed the impact of warmer housing on the quality of life, The cost of the 52 interventions was estimated to be £88,800 – the evaluation identified a benefit-cost ratio of 6.8:1 - Living in cold housing is associated with poor health outcomes and an increased risk of morbidity and mortality for all age groups. Age UK (2012) estimated an annual cost to the NHS in England of £1.36bn (excluding social care costs)	- Fuel Poverty Action Plan 2014-17 developed. Includes 5 strands of work : - Redefining the Challenge (researching the impact of the new definition of fuel poverty) - Improving Energy Efficiency (supporting programmes that improve energy efficiency across all housing tenures) - Maximising Income (Ensuring those in fuel poverty have opportunities to work and get the right benefits) - Ensuring Cheaper Energy (Making sure that fuel poor households get the best deals on their energy bills) - Changing Behaviours (ensuring that fuel poor households have access to and act on best advice and information) Annual Reports on the delivery of the plan will be made to the Health and Wellbeing Board. The SWAP will provide ongoing monitoring of implementation. **Wider work on the links between**

		Housing and Health is being progressed and outline paper will be presented to the Health and Wellbeing Board in July.
Improving Access to Green Spaces: - Increase use of good quality green space for all social groups (to include community engagement/awareness raising of availability and potential use of areas to promote health improvement and social cohesion/community involvement) - Create new areas of green space and improve the quality of existing green spaces (to include developing new areas of green space in neighbourhoods where there is little green space or improving quality to increase access/utilisation)	- In 2007 physical inactivity estimated to cost the NHS somewhere between £1bn and £1.8bn - Walking for Health programmes evaluated as cost effective - Green gym schemes evaluated as effective (evaluation of Green Gym project between 2005 to 2009 indicated that for every £1 invested , £2.55 will be saved in reduction in treating physical inactivity related illness - "high standard" spatial planning is likely to return £50, £168 and £50 for planning interventions that promote walking, cycling and insulating homes respectively for every £1 invested - Increasing access to parks and open spaces could reduce costs in treating obesity and impact on improving mental health	- Strategic planning of green spaces being linked into Local Plan development. Timeline includes consultation on Issues and Options, Draft Plan developed by Autumn 2016 (Final Plan 2017-2036) - Range of initiatives underway aimed at increasing and promoting access and use of existing green spaces. Examples include: - Friends of Parks Groups - Green Spaces Strategy - Play area development/promotion - Sports facilities planning (planned development of Playing Pitch Strategy) - Links with delivery of Local Transport Plan and the promotion of walking and cycling and My Journey initiative (part of sustainable transport agenda) - Opportunities to develop closer links between green infrastructure development and promotion with Health and Wellbeing agenda

Air Quality (including promotion of active/safe travel) **-** Development of common policies to reduce scale and impact of climate change (Promotion of active travel, interventions to reduce carbon based pollution) **-** Promotion of cycling and walking as forms of travel and recreation (replacing car journeys)	**-** Investing in a range of practical air quality improvements is likely to return on average a benefit of £620 for every £100 spent - Costs of transport induced poor air quality, ill health and road accidents estimated to exceed £40bn per year – getting one more child to walk or cycle to school could pay back as much as £768 or £539 respectively in health benefits, NHS costs, productivity gains and reductions in air pollution	- Air Quality Action Plan in place (review undertaken as part of recent Air Quality Inquiry) - My Journey scheme implementation - Air Alert scheme in place (over 200 subscribing to Alerts) - Travel plan development (schools and employers)

Core Theme 5 - Ill Health Prevention – Strengthening the role and impact of ill health prevention

Headline Messages from Effectiveness Evidence – What works	Examples of business case/Return on Investment	Examples of local Action
Prioritise prevention and early intervention: Interventions to tackle the health related conditions linked to the Big Four unhealthy behaviours: smoking, obesity, physical inactivity and excessive alcohol consumption throughout the life course **Early detection and chronic disease management :** **-** Early detection and management of risk factors linked to long term /chronic conditions (eg. cardiovascular disease, diabetes and cancer).[19] **Proportionate focus on specific populations and vulnerable groups:** **-** Target delivery of prevention activity across the population with a proportionate focus on the most deprived communities - Prioritise interventions to address the physical health and health behaviour risk factors of people with a mental health condition (in line with national Parity of Esteem programme) and people with a learning disability . [20,21]	- Nationally unhealthy lifestyles cost the UK billions of pounds every year: Smoking £5.2 bn, Obesity £4.2bn, alcohol £3.5bn, physical inactivity £1.1bn **-**Estimated tackling the "big four" modifiable risk factors (smoking, obesity, physical activity and alcohol) would provide return on investment. Estimated annual costs to Southampton: - Smoking - £12-13m -Obesity - £4.5m -Alcohol - £12m -Vascular and coronary heart disease - £9.1m - Growing evidence to show supporting self care leads to: improved health and quality of life, rise in patient satisfaction, positive impact on use of services (fewer primary care consultations and reduced demand on seconday care). National annual cost savings of £250m are estimated as a result of increasing self	- Tobacco Control Plan developed for the City (ongoing implementation and monitoring) - Smoking Cessation Services provided across the City by Specialist Service and wider primary/community providers (GP practices and Community Pharmacy) - Health Trainers Service commissioned to support behaviour change and address key lifestyle risk factors (focus on deprived/vulnerable communities) - Physical Activity promotion (including Exercise on Referral scheme and promotion of Let's Get Moving programme) - Weight Management Service for adults - Implementation of Health Checks programme to support early detection and intervention to tackle risk factors for cardiovascular disease - Health Improvement and Behaviour Change Services including Healthy Early Years Award scheme and Healthy Schools Enhancement Scheme.

Promotion of self care: - Support people with chronic/long term conditions to secure maximum health and capacity through self care and good disease management. - Promote opportunities to develop social capital through peer support, mentoring (see core theme 6) **Promotion of uptake of Screening screening programmes** **-** Targeted interventions to promote public awareness and early intervention to those communities and vulnerable groups where screening uptake is low and delayed presentation may be of particular concern [22] (to include tackling social gradient in screening uptake/access by BME communities and access/uptake for people with a learning disability or mental health problem)[19]	care (locally this is estimated as potential savings of £957,584)	- Development of Prevention and Early Intervention Strategy underway to determine commissioning and delivery priorities to support primary, secondary and tertiary prevention - Clinical Commissioning Group (CCG) 5 year Strategic Plan (2014-2019) includes a key theme on reducing health inequalities and promotion of self care through delivery of Better Care programme - CCG plan indicates commitment to address 5 most cost effective high impact interventions (National Audit Office recommendations). These include: interventions to tackle blood pressure control, reduce cholesterol, improve blood sugar control in diabetes

Core Theme 6 – Resilient Communities, Tackling Loneliness and the Development of Social Capital

Headline Messages from Effectiveness Evidence – What works	Examples of business case/Return on Investment	Examples of local Action
Community Resilience: **-**Implementation of community – centred approaches for health and wellbeing that seek to mobilise assets (across capital resources, people skills and capacity) promote equity and increase people's control over their health and lives [23] **Development of Social Support/Networks:** **-** Promotion of schemes that sustain social support/networks and target vulnerable groups (eg. Vulnerable older people, people with long term conditions/disability) enhance health and wellbeing outcomes **Promotion of Befriending and Health Volunteering Programmes** **-** Health volunteering programmes evaluated as effective for service users, volunteers and wider community (eg. Community Health Champion programmes)	**-** Social support evaluated as important enabler in promoting recovery from illness and increasing resilience - Large scale international study indicating over 7 year period those with adequate social relationships had 50% greater survival rate compared with individuals with poor social relationships - Evidence of return from health volunteering programmes – for every £1 spent estimated returns of between £4 and £10 (British Red Cross volunteers shown to generate savings equivalent to 3 and half times their costs - Befriending services have been estimated to pay back around £3.75 in reduced mental health service spending and improvements in health for every £1 spent.	-New 'Community Navigator role for staff operating in 6 local cluster groups to enable promotion of retention and creation of supportive links for people at risk of hospital / care or discharge from hospital and their carers / families, with promotion of this approach with staff groups – in place and developing -Integration of representatives from voluntary and community sector into leadership teams in cluster groups to promote and enable use of voluntary and community resources to support patients, carers and families – in place and developing -Promotion of 'Joint Strategic Assets Assessment' to enable identification and deployment of voluntary and community resources, with provision of information about them. Identification of gaps in provision – under development, needing more work

		-Identification of and use of potential new sources of capital funding at City, Cluster and Neighbourhood/ community / interest group scale – under development and needing more work -Enhancement of co-working between range of groups working to promote the Better Care Fund approach across the city – beginning and needing more work

Health Equity Proofing Policy development and Commissioning

17. The integration of health inequalities as a key consideration in local policy development and commissioning processes is proposed as a priority.

18. Application of the Public Services (Social Value) Act 2012 provides an opportunity to apply systematic consideration of the impact on health inequalities of commissioning processes. Social value is described as "the benefit to the community from a commissioning/procurement process over and above the direct purchasing of goods, services and outcomes"[21]. All English public bodies under the jurisdiction of the Westminster Government are required to comply with the Act.

19. The Act came into force end of January 2013. It requires public bodies to consider how the services they commission and procure might improve the economic, social and environmental well-being of an area. The Act applies to contracts for public services which are over the EU threshold and includes all public service markets, from health and housing to transport and waste. Commissioners are required to factor social value in at the pre-procurement phase, allowing them to embed social value in the design of the service from the outset.

20. The development of a Health Inequalities Framework for the City provides the opportunity to develop an explicit, health equity proofing approach to the application of the Act through commissioning and procurement processes. It is proposed that a consistent approach to health equity proofing is developed to maximise opportunities to tackle health inequalities in the City(Section 7). This approach is proposed as a high impact, long term enabler for the delivery of the Framework.

Preliminary High Impact Actions

21. In this "short life" project the Health Inequalities Reference Group has identified principles and core themes to inform and structure interventions across the City aimed at tackling health inequalities. It is proposed that action needs to be sustained across all of the core themes to support reduction in the medium to long term. The table below provides a qualitative description of impacts on health outcomes as a result of implementing action on core themes across the life course proposed in this framework. It uses a high, medium to low evaluation across 4 impact criteria. This has been adapted from an approach developed in some work undertaken by the Kings Fund.[4]

Impacts of Actions across Core Themes

Area	Scale of Problem in relation to Public Health	Strength of Evidence	Impact on Health	Speed of Impact (Short/Medium/ Long Term)	Contribution to reducing inequalities (High, Medium, Low)
Early Life Interventions	High	High	High	Medium	High
Skills Development	High	High	High	Short/Medium	High
Employment and work	High	High	High	Medium	High
Healthy Environment	High	High	High	Medium/long	High
Ill Health Prevention	High	High	High	Short/Medium	High
Resilient Communities	High	Medium	Medium	Medium/long	Medium

To further focus deliberations on preliminary actions the Health Inequalities Reference Group has attempted to identify high impact actions as a focus for priority action within each core theme. These are identified in the table below and qualitative criteria have been applied to assess high, medium and low impacts. It is proposed the Autumn 2015 consultation process on the next Joint Health and Wellbeing Strategy will support stakeholder debate and discussion to determine priority actions.

Preliminary High Impact Actions

Initiative/ Intervention	Strength of Evidence	Lead Agency	Potential Impact	Priority	Implementation Status (Current activity/new action)
Good Parenting Programmes (to include interventions/ programmes offered in children centres and through Healthy Child programme	High	City Council/Health	High	High	Current activity underway – focus to be sustained in areas/populations with high needs to support reduction in health inequalities
Family Nurse Partnership (targeting vulnerable families/teenage mothers)	High	City Council/Health	High	High	Current programme delivery
Implementation of City Deal Programmes to increase skills and employment (Youth programme and initiative targeting those with long term conditions)	High	City Council	High	High	Current activity – with opportunity to evaluate through pilot programmes underway

Workplace Health and Wellbeing (Implementation of workplace charter scheme)	High	City Council	Medium/High	High	Current activity – opportunity to expand coverage post evaluation of early phase implementation - 4 Businesses participating
Headstart (increasing resilience in young people – implementation and evaluation of pilot programme)	High	City Council	High	High	Pilot phase of programme underway – early phase evaluation to inform wider roll-out
Early Detection and management of cardiovascular disease (proportionate application of programmes to most deprived communities, those with mental health conditions and those with a learning disability)	High	City Council and Health (with a focus on delivery through the Health Checks Programme and Primary Care provision)	High	High	Opportunity to evaluate uptake/coverage of current Health Check Programme to support planning/implementation of proportionate, targeted programme to vulnerable populations
Behaviour change programmes to tackle big four lifestyle risk factors – Smoking, Obesity, Physical Activity and Alcohol (to include a settings based approach eg. Healthy	High/ Medium	City Council	Medium/High	High	Current programmes underway – opportunity to review and target delivery proportionately to tackle health inequalities through commissioning process

Early Years, Healthy Schools, Healthy Workplaces and community Health Trainers and promotion of Green Spaces in the City)					
Implementation of targeted, proportionate Smoking Cessation Programmes (with a focus on most deprived communities with highest prevalence/poorest health outcomes and those with mental health conditions)	High	City Council	High	High	Current universal programme underway with some targeted interventions/programmes (eg. Pregnant women) – Opportunity to proportionately target service provision to communities/specific vulnerable groups to tackle health inequalities
Development / Implementation of joined up/multi-agency community resilience/tackling loneliness interventions (to support health maintainence /improvement and self	Medium (Developing evidence base)	City Council/Health (Joint Development)	Medium	High	Work underway through interagency work on community resilience/tackling loneliness as an enabler supporting health maintenance and self care (eg. Community Solutions Group scoping strategic plan and current activity).

care)					
Healthy Environment – to include delivery of Fuel Poverty Plan and Air Quality Plan to support improvement of health outcomes in the City	High	City Council	High (particularly in relation to reduction of excess winter deaths and cold related ill health)	High	Fuel Poverty and Air Quality plans developed and interventions being implemented

Recommendations for Next Steps

22. The following recommendations are proposed by the Reference Group to support the further development of the Health Inequalities Framework.

Recommendation 1 – Development of Consultation and Engagement Process as part of Joint Health and Wellbeing Strategy Development

23. It is proposed that a partner and key stakeholder consultation process is developed and implemented in early Autumn 2015 to:
    - Support consensus building on key principles/core themes and progress discussion to agree high impact actions
    - Expand the picture of current activity underway across core themes
    - Implement consultation with local population (community/voluntary groups and wider population)
    - Inform the focus of the next iteration of the Joint Health and Wellbeing Strategy

Recommendation 2 – Assign accountability and develop implementation plan for high impact actions

24. It is proposed that as part of the consultation process and agreement on high impact actions the following are identified:
    - Lead agency and accountable officers
    - Definition and work up of delivery plan and "success" metrics for each action area (with agreed reporting mechanism and timescales to Health and Wellbeing Board)

Recommendation 3 – Development of Community Resilience Theme

25. It is proposed that further work be undertaken to develop a comprehensive picture of activity underway across the City. This would support the development of a collective approach to increasing community resilience and tackling loneliness and social isolation.

Recommendation 4 – Health equity proof commissioning and policy development across Health and Wellbeing Board partner agencies

26. It is proposed that a common approach is developed by Joint Health and Wellbeing Board partners to support the following:
    - Health equity proofing of policy
    - Implementation of health inequality as a core theme for application of the Social Value Act (2012) as part of commissioning and procurement processes

ANNEXE A

Health Inequalities Reference Group Terms

Terms of Reference

- To identify areas for local action to reduce health inequalities, based on the early intervention themes identified by Public Health England / Institute of Health Equity:
    - Early life interventions
    - Education
    - Employment
    - Ensuring a healthy standard of living for all
    - Healthy environment
- To consider health inequalities issues identified by the Southampton Fairness Commission.
- To consider the impact of mental health issues on health inequalities within the context of Parity of Esteem.
- To identify areas for local action on health inequalities, based on evidence of what health services can contribute to reducing health inequalities:
- To assess the financial consequences for health and care systems if no progress is made on reducing health inequalities.
- To identify opportunities available to improve health and wellbeing and reduce health inequalities using powers set out in the Public Services (Social Value) Act 2012.
- To identify where and how the work of the integrated commissioning unit is contributing to reducing health inequalities.
- To identify key projects and work strands that may impact on health inequalities being undertaken by key strategic partnerships in the city.
- To recommend a mechanism whereby, under the leadership of the Health and Wellbeing Board, health and health inequalities will be integrated into all key policies and strategies of the City Council, Southampton City CCG, and other strategic city partnerships.
- To recommend ways of engaging local communities on health inequality priorities
- To identify health inequalities that need to be prioritised when the Joint Health and Wellbeing Strategy is refreshed in 2016, and to recommend any specific actions that should be considered for inclusion in the next iteration of the Joint Health and Wellbeing Strategy.
- To report the outcomes and findings of the Reference Group to the Health and Wellbeing Board by July 2015.

April 2015

ANNEXE B

List of Officers engaged to date (July 2015) as part of Framework Development Process

Donna Chapman – Associate Director
Debbie Chase – Consultant in Public Health
Sara Crawford – Improvement Manager
Jenny Davies – Acting Consultant (Senior Specialist) in Public Health
Tim Davis – Senior Commissioner, Healthy Lives
Denise Edghill – Head of Skills, Regeneration and Partnerships
Robert Hardy – Interim Head of 0-25 Service
Mike Harris – Head of Leisure, Planning and Transport
Lindsay McCulloch – Planning Ecologist
Andrew Mortimore – Director of Public Health
Stephanie Ramsey – Director of Quality and Integration (Southampton City Clinical Commissioning Group and Southampton City Council)
Kathryn Rankin – City Deal Programme Manager
John Richards – Chief Officer – Southampton Clinical Commissioning Group
Mitch Sanders – Head of Regulatory and City Services
Graham Tuck – Planning Policy Group Leader
Nick Yeats – Landscape and Development Manager

ANNEXE C

References

1. Southampton City Council, Director of Public Health: Public Health Annual Report (2014)
2. Southampton City Council, Public Health Intelligence Team: Health Inequalities in Southampton City: Analysis of Trends (November 2014)
3. The Marmot Review: Fair Society, Healthy Lives – Strategic Review of Health Inequalities in England post-2010
4. Kings Fund (Authors David Buck and Sara Gregory): Ideas that change healthcare – Nine key areas that can improve public health and reduce inequalities (2013)
5. UCL Institute of Health Equity: Good Quality Parenting Programmes (Health equity briefing 1a: September 2014)
6. UCL Institute of Health Equity: Improving the home to school transition (Health equity briefing 1b : September 2014)
7. UCL Institute of Health Equity: Building children and young people's resilience in schools (Health equity briefing 2: September 2014)
8. UCL Institute of Health Equity: Reducing the number of young people not in employment, education or training (NEET) – (Health equity briefing 3: September 2014)
9. UCL Institute of Health Equity: Adult Learning Services (Health equity briefing 4: September 2014).
10. UCL Institute of Health Equity: Workplace interventions to improve health and wellbeing (Health equity briefing 5a: September 2014)
11. UCL Institute of Health Equity: Working with local employers to promote good quality work (Health equity briefing 5b: September 2014)
12. UCL Institute of Health Equity: Increasing employment opportunities and retention for people with a long term condition or disability (Health equity briefing 5c: September 2014)
13. UCL Institute of Health Equity: Increasing employment opportunities and retention for older people (Health equity briefing 5d: September 2014)
14. UCL Institute of Health Equity: Health Inequalities and the Living Wage (Health equity briefing 6: September 2014)
15. UCL Institute of Health Equity: Fuel Poverty and cold home related health problems (Health equity briefing 7: September 2014)
16. UCL Institute of Health Equity: Improving access to green spaces (Health equity briefing 8: September 2014)
17. UCL Institute of Health Equity: Understanding the economics of investments in the social determinants of health (September 2014)
18. NHS Southampton City : Public Health Briefing Note: The case for preventative healthcare in Southampton (November 2010)
19. Department of Health: Systematically Addressing Health Inequalities (June 2008)
20. Improving Health and Lives, Learning Disabilities Observatory, Royal College of General Practitioners, Royal College of Psychiatrists: Improving the Health and Wellbeing of People with Learning

Disabilities: An Evidence-Based Commissioning Guide for Clinical Commissioning Groups (October 2012)
21. HM Government: No Health without Mental Health – A cross government mental health outcomes strategy for people of all ages (February 2011)
22. NHS: National Cancer Action Team and National Cancer Equality Initiative : Briefing paper on practical action to reduce inequalities in cancer (2012)
23. Public Health England and NHS England: A guide to community – centred approaches for health and wellbeing (Briefing) – (February 2015)
24. HM Government: The Public Services (Social Value) Act 2012: One Year On (January 2014)

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DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		INTEGRATED COMMISSIONING WORK PROGRAMME 2015/16		
DATE OF DECISION:		29 JULY 2015		
REPORT OF:		DIRECTOR OF QUALITY AND INTEGRATION		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Stephanie Ramsey**	**Tel:**	**023 80296004**
	E-mail:	**Stephanie. Ramsey @southamptoncityccg.nhs.uk**		
Director	**Name:**	**Dawn Baxendale** **John Richards**	**Tel:**	**023 80** **023 80 296923**
	E-mail:	**Dawn.Baxendale@southampton.gov.uk** **john.richards@southamptoncityccg.nhs.uk**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

This report sets out the key commissioning themes and work programme for the Integrated Commissioning Unit for 2015/16. It informs the Health and Wellbeing Board of the key activities to enable the Board to ascertain how it wishes to engage in areas of strategic importance to influence the next iteration of the Health and Wellbeing Strategy and priorities for updating the Joint Strategic Needs Assessment.

The priorities for 2015/16 for the ICU are based on the Health and Wellbeing Strategy, Better Care priorities and national targets required of Council and Southampton City Clinical Commissioning group. Key commissioning themes of work for the ICU are:

- Early Intervention and prevention – developing an integrated early intervention and prevention offer for adults and young people, children and families
- Improving outcomes for people with Learning disabilities
- Improving outcomes for people with Mental health problems
- Improving outcomes for children and young people
- Delivering Integrated Care (Better Care)

RECOMMENDATIONS :

(i) To note the priorities for Integrated Commissioning for 2015/16 and consider how the Health and Wellbeing Board will engage with areas of strategic importance to its own work programme.

REASONS FOR REPORT RECOMMENDATIONS

1. The ICU priorities identified are based on the Health and Wellbeing Strategy, Better Care plan and national targets required of Council and Southampton City Clinical Commissioning group. Priorities have been identified and signed off by the Commissioning Partnership Board based on strategic need, impact and cost effectiveness.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

1. Not applicable. The ICU's work programme is set and monitored by the Commissioning Partnership Board and may be adapted in year should alternative priorities emerge.

DETAIL (Including consultation carried out)

Background

2. The Council and Southampton City Clinical Commissioning group (CCG) are committed to Integrated Commissioning and have established an Integrated Commissioning unit (ICU) to take this forward. The ICU undertakes all parts of the commissioning cycle (needs analysis, planning, commissioning strategy, service specification, market development, procurement, contract monitoring, quality assurance and review) working across health and social care to develop an integrated service offer for local people.

3. This approach is embodied within the city's Better Care plan and is supported through the Pooled budget for Better Care which was established in April 2015 through a Section 75 Partnership agreement.

4. From 1 April 2015 Local Authorities and CCGs are required to establish a pooled fund under Section 75 of the NHS Act 2006 for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authority. Southampton City has taken a more holistic approach to health and social care and aims to fund and commission it in that way. It has therefore gone beyond the minimum national requirement to pool health and social care resources and chosen to pool a significantly greater amount of its budgets.

5. In 2015/16 this comes to £62m health and social care funding. The ambition is to encompass in time all services that fit within the scope of the Better Care model, including some services for children and young people, eventually bringing the total pooled fund to in excess of £130m. Approval to proceed with the pooled fund has been given by Health and Wellbeing Board, Full Council and Clinical Commissioning group Governing body.

6. The ICU reports to the Commissioning Partnership Board (CPB) which oversees the integrated commissioning agenda for the Council and CCG. The CPB comprises the Chief Executives of the Council and CCG, Director of Public Health, GP Governing Board member, Cabinet member, Chief Finance Officers and lead Directors from the council and CCG. This Board is also the Partnership Board for the Better Care pooled budget. The Health & Wellbeing Board provides high level oversight of these arrangements, ensuring that partnership arrangements are effective and that plans are robust and both ambitious and realistic in their aspiration.

7. The ICU was established in December 2013 to:
    - Pool capabilities and purchasing power across the Council and CCG, so that both organisations can exercise much greater control over what they need, buy, at what price and at the right level of quality.
    - Realigning spend to the outcomes required – take a whole SCC/CCG perspective, regardless of the current budget arrangements

- Commission so everything “works together” – achieve better outcomes for identified groups of people through joint working during the whole commissioning cycle and therefore providing a more joined-up service for these groups
- Provide a mechanism for influencing the market at scale across health and social care
- Deliver against national targets and new legislation requirements

8. Key drivers for this were to address need in the round and improve outcomes, including reducing health inequalities and improving life expectancy. The aim is to be able to develop services to intervene earlier, be more proactive and to shift balance of care from acute to community settings. To support the development of integrated provision and to promote independence by increasing the numbers of people living independently and using self-management approaches. All of this being achieved with a focus on managing within reducing resources and ensuring delivery of high quality care and support to a diverse population.

9. Key commissioning themes of work for the ICU for 15/16 are:

- Early Intervention and prevention – developing an integrated early intervention and prevention offer for adults and young people, children and families
- Improving outcomes for people with Learning disabilities
- Improving outcomes for people with Mental health problems
- Improving outcomes for children and young people
- Delivering Integrated Care (Better Care)

Details of the schemes included in these and progress so far are included in Appendix 1. Below is a summary of some of the key pieces of work.

Early Intervention and Prevention

9. This programme of work aims to place more emphasis on prevention and early intervention in order to support people to maintain their independence and delay their need for formal care, a strategic aim for both the CCG and City Council.

10. This involves reviewing the current resources and services commissioned or funded and how a shift might be achieved. The aim is to refocus towards maintaining independence and good health and promoting wellbeing, including the creation of supportive and safer neighbourhoods/communities and combating loneliness.

11. The programme will also look at ways to identify people at risk and how to halt or slow down any deterioration, and actively seek to improve their situation. This also aligns closely with the better care programme.

12. The work is at an early stage but areas identified as potential priorities are advice and information services, developing strong resilient communities, promoting access to accommodation and helping people to gain and maintain employment.

People with Learning disabilities - Complex Housing Project

13. The purpose of this project is to increase the quality, capacity and number of

supported living environments for adults (primarily those with learning disabilities) living in Southampton (for whom the city council or CCG are responsible). This will support service users to be more independent.

People with Mental Health Problems – Mental Health Review

14. The ICU is currently undertaking a review of mental health services which will conclude towards the end of the year. There is further work and consultation taking place but key themes are already emerging. In line with national and local priorities, we are looking to ensure services are recovery orientated and that people have maximum choice and control of their own care and treatment. There has, and will continue to be, an emphasis on people accessing services in community settings and on employment being the norm for people with mental health conditions who are of working age.

15. The review will involve all services and is not age specific. We will be looking at how to align mental health services with other priority areas including Better Care and initiatives such as Headstart, researching best practice and learning from others, consulting with a wide range of agencies and service users and carers and undertaking financial modelling to design a model within the resources available.

Improving Outcomes for Children and Young People

16. The focus of the ICU's commissioning programme of work for children and young people is on developing a Child & Family centred local integrated service offer, Integrated specialist support and building community capacity to support prevention and early intervention.

17. At the universal and targeted level, work is in progress to integrate services organised around 3 localities (East, West, Central Southampton), each aligned to 2 of the Better Care clusters. The 3 integrated teams will work closely with partners including schools and primary care services in each locality. The first phase of development commences this summer with the establishment of enhanced early childhood leadership teams comprising maternity, health visiting and children's centres. The teams will work together on creating local priorities and business plans against citywide templates. Support for families will be enhanced by combining and aligning assessment processes.

18. Second and subsequent phases of development are intended to include integrated locality management structures and co-location of services 0-19 years across health visiting, children's centres, school nursing and Early Help teams and will be linked to future commissioning plans for health visiting and school nursing.

19. Work is also in progress to integrate systems and processes (and in some cases teams) that focus on meeting statutory requirements and more specialist needs to deliver a more coordinated service to children, young people and families which meets their needs in the round. In particular, this includes:

    - Statutory processes for looked after children - the City Council looked after children services and Solent looked after children health team have been working together over the last 12 months to improve communication and join up processes to improve performance against statutory response times for new into care assessments and reviews. This is part of a wider programme for improving the health response to

looked after children. Consideration is also being given to co-location of the health and social care teams.

- Development of an integrated 0-25 SEND offer across Education, Health and Social Care which includes the statutory assessment and plan pathway as one amongst a range of options that enable families to meet the needs of their child, young person or young adult.

Sexual health review

20. The ICU working with Public Health has undertaken a Sexual Health needs assessment, consulting widely, and developed commissioning intentions for sexual health services. The approach is to work collaboratively with neighbouring local authorities and CCGs to jointly procure integrated specialist Contraception, Sexual Health and GUM Services starting no later than April 2018.

21. In the interim period, the Council and CCG are working with the existing provider of the integrated Level 3 service to deliver a transformation programme to meet local priorities and achieve economies of scale and maximum value for money, at the same time as re-procuring Level 2 services (GP and Pharmacy based) during 2015/16 for a new contractual framework from 1 April 2016.

22. A key area of focus for sexual health will be on developing our approach to sexual health promotion and behaviour change, creating appropriate capacity within the commissioned services for effective interventions around sexual and reproductive health and a leadership role to the wider system to ensure a collective, cohesive approach across the council, schools, colleges, public health nursing, primary care and community settings.

Delivering Integrated Care (Better Care)

23. Extensive work has been undertaken by the Council working in partnership with the CCG and other stakeholders to develop Southampton's Better Care Plan, under the leadership of the Health and Wellbeing Board. The ICU is supporting the implementation of this vision to completely transform the delivery of care in Southampton so that it is better integrated across health and social care, delivered as locally as possible and person centred.

23.. The current main scheme's and work in progress are:

1. Local person centred coordinated care (clusters) - integrated multidisciplinary cluster teams providing integrated risk stratification, care coordination, planning, 7 day working.
2. Integrated discharge, reablement and rehabilitation service, including greater use of telecare/telehealth. This scheme is aimed at helping people to maintain their independence at home, in the community, intervening quickly where required to prevent deterioration, as well as supporting people's recovery and reablement following a period of illness
3. Community solutions and prevention - this scheme is aimed at building on and developing local community assets and supporting people and families to find their own solutions.
4. Supporting carers – this scheme recognises the important role that

carers have in supporting older people and those with multiple long term conditions in the community and supports the overall model and ambitions of local person centred coordinated care.

5. Developing the market for placements and packages and further integrating approaches – this includes work to develop the market to provide greater opportunity and choice, encourage a recovery/ reablement focus and support people to remain as independent as they can be in their own homes.

24. This is being developed further to include adults, children and those with learning disabilities or mental health issues**.**

25. In addition, a number of contracts have been recently developed or changed in support of the above agenda. These are currently being implemented including:

- Public Health nursing 5-19 (school nursing service) – new contract in place from April 2015
- Substance misuse – new contract in place from January 2015
- Domiciliary Care – new contract in place from April 2015
- Carers service – new contract in place from
- Advocacy service

Provider Relationships

26. A key aspect of the ICU work is Provider Relationships and priorities include:

- Developing and implementing a care placement service
  - Agreeing new processes across commissioning and operational functions for the purchasing of individual packages of care
  - Identifying opportunities to increase the practice of 'intelligent' purchasing across CCG/ SCC
  - Undertaking targeted work with providers of high cost/ high volume care to deliver savings
- Developing a strategic and systematic approach to the management of contractual commitments across adults and children's health and social care and seeking further opportunities to rationalise and consolidate contractual obligations
- Developing the market
  - Gaining a comprehensive understanding of the relationship between the supply and demand for local care/ support, and identifying market failures/ priority areas of spend where purchasing power must increase
  - Engaging proactively with the market to increase the diversity of local supply, co-produce alternatives to traditional care service models, and expand the local capacity of service models which provide better value for money
  - Developing a rolling programme of thematically focused and segmented market position statements
- Ensuring the market is fit to effectively respond

Quality

27.. Quality underlies all of the work undertaken to ensure :

- Care is safer for everyone whatever the care setting
- People always have good outcomes from services
- People always have a good experience from services

Governance

28. The detailed work of the ICU is overseen by the Commissioning Partnership Board which has Chief Officer, Director, Cabinet member, clinical and lay member representation. Formal decisions remain with SCC and CCG governance routes

RESOURCE IMPLICATIONS

Capital/Revenue

29. Current targeted savings to be achieved by the ICU for 2015/16 are £6,992m, approximately 50/50 split across SCC and CCG

30. The minimum requirement for the Better Care Fund in 2015/16 is £15.325M Revenue and £1.526M Capital. The majority is existing funding sources included within either the Council or CCG 2014/15 budget. Pooled budget for 2015/16 is £61m. It should be noted that it is the commissioning budgets for services that are being pooled and that the services themselves and the associated staff will remain managed and employed as they are currently

Property/Other

31. Not applicable

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

32. Section 75 of the National Health Service Act 2006

Other Legal Implications:

33. The Health and Social Care Act 2012 places a duty on Health and Wellbeing Boards to encourage and support integrated working.

POLICY FRAMEWORK IMPLICATIONS

34. The priorities identified are wholly consistent with the Council's Health and Wellbeing Strategy and other policy framework strategies and plans.

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Integrated Commissioning Unit 15/16 priorities

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out?	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

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Integrated Commissioning Project Updates

Project/Programme	Lead	RAG: Prev Mth	RAG: Current Mth	Summary Narrative	Date Updated
A. Early Intervention and prevention – Adults					
1. Early intervention and prevention strategy /framework					
i Development of strategic framework to guide/support early intervention/prevention agenda, clarifying priorities for development	Sandy Jerrim Chrissie Dawson	G	A	A number of contracts are coming up for renewal and would fit well into this programme. Further discussion required to identify links with other corporate work programmes and transformation projects and to gain agreement on scope of this work.	Jul-15
ii Preparation for Behaviour Change Procurement		A	A	Awaiting update on where behaviour change will sit within the overall PEI programme of works. To develop proposal on behaviour change model including focus on every contact counts. Scoping work commencing with Capita and Publc health	
2. Long term conditions – COPD Review of COPD future service model	Chrissie Dawson / Georgina Cunningham	G	G	Review not yet complete. Aim to complete by mid-June this continues to be progressed, awaiting more info. FOI data received being collated to inform review.	Jul-15
3. Heart Failure Review of Heart failure future service model	Moraig Forrest Chard	G	G	Project underway in May 15, with Project steering group in place and first meeting complete. Aim is to complete by end of August to inform commissioning decisions and 30th of September letter	Jun-15
4. Diabetes					
i Diabetes Delivery of Diabetes foot care model to reduce non elective admissions and amputations	Chrissie Dawson / Georgina Cunningham	A	A	Outline business case presented to SMT in June. Direction of travel agreed pending further detail on type and volume of low risk podiatry activity that will be removed from service (to create capacity to implement footcare pathway) and where this activity will fall in future. CCG to discuss with Health Overview and Scrutiny. CCG has formally written to Solent requesting this information. Response received SOlent now working through additional information as requested.	Jul-15
ii Embed diabetes service model		A	A	Evaluation of Diabetes Accreditation Scheme to commence July 2015, prevailing issues regarding pathways to be resolved through the Clinical Reference Group. Finding of 6 month review to be presented to the PMCJCC in August	

Project/Programme	Lead	RAG: Prev Mth	RAG: Current Mth	Summary Narrative	Date Updated
5. Flu and Pneumonia Improve uptake of vaccine	Chrissie Dawson	G	G	Adverse publicity around the effectiveness of the flu vaccine against the strain in winter 2014/15 may impact on uptake. Pork gelatine substance ingredient in nasal spray goes against some cultural beliefs impacting on uptake for children in some BME communities. Progress continues to be monitored against detailed action plan, there is a natural lull in the project due to this being a seasonal programme, however steps have been put in place to ensure all avenues have been considered for the effectiveness of the project	Jul-15
6. End of life care	Chrissie Dawson	G	G	Awaiting outcome of meetings with WHCCG and UHS. Meeting regarding revising model has been booked in June. Meeting convened between UHS, WHCCG & SCCCG, agreed there needs to be a focus on developing a strategy to support the vision of integrated, equitable EOL care. Principles document shared with UHS, engagement commenced with primary care and Solent to review the whole pathway	Jul-15
B. Learning Disability					
1. Complex housing and support for those with Learning Disabilities	Kate Dench	A	A	Improved progress as a result of ICU input into Disabilities Housing Panel and good joint work with operational teams, with tracking of savings and outcomes. Meeting held with voluntary sector to support further engagement to move clients into appropriate housing.	Jun-15
C. Mental Health (all ages)					
1. Mental Health review	Katy Bartolomeo/ Jackie Hall	A	A	Service review discussions with providers have begun and the team is developing new models to be discussed with providers during the initial consultation	Jun-15
D. Early Intervention/Prevention - Young People, Children and Families					
1. Sexual health review					
i Teenage pregnancy Action Plan	Tim Davis	G	G	Completion of Deep Dive audit - broadly on track, though review findings have posed new questions that may require ongoing further work. Self assessment of current SRE provision is taking longer than anticipated to progress due to limited capacity in the PSHE networks, which are entirely dependent upon voluntary input from PSHE/SRE lead Teachers in schools. Approach agreed with primary and secondary networks in June. Health promotion team updating the pro - likely to be July due to focus of PSHE teacher leads in schools on SATs (Primary) and GCSEs (Secondary). TP action plan to be updated shortly.	Jun-15

Project/Programme	Lead	RAG: Prev Mth	RAG: Current Mth	Summary Narrative	Date Updated
ii Sexual Health Service Improvement		A	A	Contract exemption has been granted. Participation in transformation programme with Solent, Hampshire and Portsmouth started. More work needed with CCG SH commissioner engagement. Commissioning intentions signed off with ICU MT. Review of Locally Commissioned Services (LCS) and No Limits service complete. Delay on some of the communication around completed work and preparatory audit work around shaping professional development priorities for wider workforce around awareness of sexual health services.	
I Develop integrated model of HV/Children's Centres to achieve efficiencies and support early intervention strategy	Tim Davis/Sue Thompson	A	A	On track for transfer of Public Health 0-4 nursing contract to City Council on 1 October 2015. Exemption granted to extend contract to 31 March 2017. Phase 1 virtual integration to be achieved by July (integrated HV/Children's Centres/Midwifery) leadership teams. Ongoing discussions regarding future scope of integration. To include joint review of MASH and Early help model to inform future plans for integration of HV, Children's Centres and Early Help teams across 0-19 pathway. Decision made that early years will continue as stand alone team .	Jun-15
ii. Mainstreaming of Caseloading Maternity contract		A	G		
iii. Recommissioning of oral health contract		A	A	Contract team currently working to clarify contract status and extension. Options in discussion with focus on integrating into 0-4 HCP. Due to report end June. Recommendations likely to include splitting elements of provision. Potential joint procurement for epidemiology surveys with Portsmouth	
3. Domestic Violence	Sandy Jerrim	G	G		Jul-15
4. Child health services model	Tim Davis/Phil Lovegrove	A	A	Collaboration around acute paediatric care has been agreed as a priority for the South West System network group comprising Commissioners, CCG Clinical Leads and service/clinical representation from UHS and Solent Child and Family Services. Regular meetings are in diaries. Separate meetings to progress the future shape of the COAST service are ongoing and the service has proposed a new model and achieved success in recruitment. Priority areas for review include: joint appointments between providers, integrated model of paediatric nursing, acute time limited illness pathway (implementing recommendations from SCN) and review of where services are delivered.	Jun-15

Project/Programme	Lead	RAG: Prev Mth	RAG: Current Mth	Summary Narrative	Date Updated
5. SEND 0-25					
i Design and implement integrated health, education and social care service	Donna Chapman/ Jamie Schofield	A	A	New model of service for integrating health and social care (0-18) in the 0-25 SEND service offer agreed and staff consultation complete. Implementation underway. Partnership Board overseeing development with broad representation from children's and adult services, health, LA and Voluntary Sector. Discussions now focussing on post 16 offer. Working group being established.	Jun-15
ii Review and procure Impartial Advice and Support service		G	G		
6. Ofsted action plan					
i Ensure effective advocacy/independent Visitor service	Sam Ray	G	G	Service review completed. Additional budget has been identified to double the hours available to the advocate service to ensure that children looked after are offered a service via the statutory review process. IV service being developed via contract monitoring.	Jun-15
ii Strengthen voice of child – Children in Care Council (Contracts)		G	G	Funding for an additional Young People In Care Council (YPICC) informal meeting for those aged 14+ years to allow more time for involvement and development activity. In addition, there are now 4 meetings each month for the Junior Children in Care council (aged 5-13 years) across the city. This has strengthened the voice of the child by increasing the opportunities for children and young people to participate.	
iii Review and improve housing support to vulnerable yp and care leavers		G	G	Contracts have been negotiated until 2016. There is a need to recommission services following the outcome of the needs assessment to ensure that care leavers and vulnerable young people's needs are met.	
1. Integrated discharge/rehabilitation/reablement	Jamie Schofield	R	R	It is aimed to take both phases forward for Cabinet approval to consult in August 2015.	Jun-15
2.Better Care implementation					
i Implementation of Cluster development to achieve BCF targets	Moraig Forrest-Charde / Adrian Littlemore	G	G	All elements progressing, noting that the time lines for cluster development and SPA business case are being challenged by the level of commitment which provider organisations can achieve at this time.	Jun-15
ii Development of Community solutions, e.g. community navigator role		G	G	Actions on track. Need to align work of Community Solutions group with Community/Behaviour Change investment review and Care Act Implementation.	

Project/Programme	Lead	RAG: Prev Mth	RAG: Current Mth	Summary Narrative	Date Updated
3. Community teams					
i Development of sustainable model of community nursing	Adrian Littlemore / Moraig Forrest-Charde	A	A	Actions on track. Service capacity being closely monitored.	Jun-15
ii Development of sustainable and clear offer of community geriatricians		A	A	Specification agreed with clinical leads, final agreement through contractual arrangements being undertaken in June	
4. Falls					
i Falls Implement and monitor effectiveness of exercise classes and new fracture pathway	Adrian Littlemore	A	A	Solent University confirm they are not able to incorporate delivery of falls exercise programme as part of degree courses. Business Case for 2016/17 to be developed to provide an economically viable model, involving Active Nation. Business Case to be developed by Sept 15. Funding available for existing service to end April 16. Risk of classes ceasing if funding subsidy not identified.	Jun-15
ii Implement action plan and CQUIN		G	G	Actions on Track.	
5. Tier 3 Weight management	Chrissie Dawson	G	G	ITT closes on 30 June. Moderation panel arranged. Procurement timescales being followed.	Jun-15
F. Quality					
1. Personal health budgets/direct payments - children and adults (CCG only)	Mike Cooke	G	G	Some minor slippage in milestone d. but additional resource identified/redirected to address this and expected to be on track by end July 15. Overall, actions remain either completed ahead of deadline or on track. However, will continue to remain subject to operational pressures from range of imperatives such as safeguarding and delivery of exceptionally challenging QIPP target	Jun-15

Project/Programme	Lead	RAG: Prev Mth	RAG: Current Mth	Summary Narrative	Date Updated
2.Nursing homes	Lindsay Rugman	A	A	The nursing homes in Southampton City (and our close Hampshire Borders Homes) have been identified as needing support and development in a range of areas. The project aims to support the nursing home managers to drive up standards of care, empower the managers to challenge poor practice within their own service, build sustainably and promote inclusion within their peer group. This support is offered in the following ways: Leadership skills and staff development Sourcing out free/cost effective/standardised training Development and sustainability of a nursing home mangers peer support group Medicines reconciliation and the Green Bag scheme Supporting NH's to work with the hospital to promote safe discharges Linking in with Vol Orgs, Training Providers and the hospital to build capacity. Linking in with Soton Uni to encourage uptake of student placement scheme/	Jun-15
3. CCG Quality Premium	Carol Alstrom		0	Milestones not agreed yet	May-15
4. Quality criteria for day care and respite provision	Carol Alstrom			Milestones not agreed yet	
G. Provider Relations					
1. Cost avoidance - Care Placement Service	Jeanette Clarke	G	G	New framework is not yet at full capacity, however all support is now being sourced through the new provider framework. All contracts for successful existing providers have been amended from 20/4/15. Majority of new domiciliary and residential/nursing support is now being sourced through the Care Placement Service. CPS team is successfully negotiating and reducing costs of residential and nursing placements that are being sourced.	Jun-15
2.High Cost placement review	Kevin Butler	A	A	Project on track to secure identified savings target	Jul-15
3. Review of IFA placements/costs	Jeanette Clarke	G	G	IPA Contracts progressing but work has been superseded by urgent requirement for residential contracts. Some discrepancies in contract costs and invoice amounts identified and some savings identified. Children's placement service went 'live' at beginning of June	Jun-15
4. Market position statements development	Foizul Islam	A	A	Extension agreed to engage housing managers before final draft	Jun-15

Project/Programme	Lead	RAG: Prev Mth	RAG: Current Mth	Summary Narrative	Date Updated
5. Dom Care tender implementation	Matthew Waters	G	G	On target for achieving both transfers and savings, and for achieving the dates for all transfers. In addition, considering the use of all the available Lots to ensure the most effective use of dom care in the city, and the best way to maximise savings while achieving good quality.	Jun-15
6. Carers	Sandy Jerrim	G	G	Soft launch 1st June 2015 with Carer Partnership group established (involves providers, ASC and commissioners). Key challenges will be worked through as the service is developed (e.g clear criteria around replacement care, respite etc, process and access to direct payments)	Jul-15
7. Supporting people in the community/ individualised model of care	Foizul Islam/ Sandy Jerrim	A	A	Awaiting day / respite needs review to ascertain whether commissioning actions are required	Jun-15
8. Review contracts for efficiencies	Matthew Waters/Aleks Burlinson	G	G	To utilise the Contract Life Cycle Management Committee to enable further savings opportunities to be identified.	Jun-15

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DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		BETTER CARE SOUTHAMPTON PROGRESS AND PERFORMANCE		
DATE OF DECISION:		29 JULY 2015		
REPORT OF:		DIRECTOR OF QUALITY AND INTEGRATION		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Stephanie Ramsey**	**Tel:**	**023 8029 6004**
	E-mail:	**Stephanie. Ramsey @southamptoncityccg.nhs.uk**		
Director	**Name:**	**Dawn Baxendale** **John Richards**	**Tel:**	**023 8083 2602** **023 8029 6923**
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STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

Over the last 18 months extensive work has been undertaken by the City Council working in partnership with Southampton City CCG and other stakeholders to develop Southampton's Better Care Plan, under the leadership of the Health and Wellbeing Board. The final plan was signed off by the Health and Wellbeing Board, Chief Executive of the City Council and Chief Operating Officer of the CCG on 19th September 2014 and submitted to Ministers. This has been approved following the Nationally Consistent Assurance Review which identified no areas of high risk within the plan and means that Southampton can now progress with full implementation of its plan. This includes the establishment of a Better Care pooled fund by 1 April 2015.

The Board will receive a brief presentation to consider progress towards implementation and performance to date of Better Care Southampton.

RECOMMENDATIONS :

(i) To note the progress with implementation and performance of Better Care Southampton.

REASONS FOR REPORT RECOMMENDATIONS

1. From 1 April 2015 Local Authorities and CCGs are required to establish a pooled fund under Section 75 of the NHS Act 2006 for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authority.

2. Southampton City has taken a more holistic approach to health and social care and proposes to fund and commission it in that way. The ambition is to encompass all services that fit within the scope of the Better Care model, eventually bringing together approximately £132m into the pooled fund. Approval to proceed with the pooled fund has been given by Health and Wellbeing Board, Full Council and Clinical Commissioning group Governing body.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. To pool only the minimum - this has been rejected on the basis that Southampton's Better Care Plan seeks to achieve a fully integrated model of health and social care. In order to achieve this ambitious transformation, it is considered necessary to bring together all of those health and social care resources associated with this vision and commission services in a fully integrated way, which is focussed on people's outcomes and needs in their entirety, as opposed to their health or social care in isolation.

DETAIL (Including consultation carried out)

Implementation of Better Care Southampton

4. Southampton's vision for Better Care is to completely transform the delivery of care in Southampton so that it is better integrated across health and social care, delivered as locally as possible and person centred. People will be at the heart of their care, fully engaged and supported where necessary by high quality integrated local and connected communities of services to maintain or retain their independence, health and wellbeing.

5. Neighbourhoods and local communities will have a recognised and valued role in supporting people and there will be a much stronger focus on prevention and early intervention. The overall aims are:
   - Putting people at the centre of their care, meeting needs in a holistic way.
   - Providing the right care, in the right place at the right time, and enabling people to stay in their own homes for as long as possible.
   - Making optimum use of the health and care resources available in the community, reducing duplication and closing gaps, doing things once wherever appropriate.
   - Intervening earlier in order to secure better outcomes by providing more coordinated, proactive services.

6. Southampton's plan has the following main schemes and work is in progress with each:
   i. Local person centred coordinated care (clusters) - integrated multidisciplinary cluster teams providing integrated risk stratification, care coordination, planning, 7-day working.
   ii. Integrated discharge, reablement and rehabilitation service, including greater use of telecare/telehealth. This scheme is aimed at helping people to maintain their independence at home, in the community, intervening quickly where required to prevent deterioration, as well as supporting people's recovery and reablement following a period of illness
   iii. Community solutions and prevention - this scheme is aimed at building on and developing local community assets and supporting people and families to find their own solutions.
   iv. Supporting carers – this scheme recognises the important role that carers have in supporting older people and those with multiple long term conditions in the community and supports the overall model and ambitions of local person centred coordinated care.
   v. Developing the market for placements and packages and further integrating approaches – this includes work to develop the market to provide greater opportunity and choice, encourage a recovery/

reablement focus and support people to remain as independent as they can be in their own homes.

7. The Health and Wellbeing Board will be given a presentation on the progress of implementation and performance of Better Care Southampton.

8 The Health and Wellbeing Board is asked to note the progress for implementation and Performance of Better Care Southampton. The Board may also wish to consider if there are any areas of work where they would like more detailed information.

RESOURCE IMPLICATIONS

Capital/Revenue

10. The minimum requirement for the Better Care Fund in 2015/16 is £15.325M Revenue and £1.526M Capital. The majority is existing funding sources included within either the Council or CCG 2014/15 budget. This funding is not new to the Health and Social Care system. However, under the conditions of the Better Care Fund, additional funding of £600,000 from within the pool will be provided to help meet the new responsibilities of the Council required by the Care Act 2014. This funding will come from the existing NHS resource and will therefore be a pressure to the CCG.

11. It is planned to place three of the five schemes into the pool from 1st April 2015. These schemes will incorporate approximately a further £45m of funding from the Council and the CCG bringing the total planned pool for 2015/16 to £61m. Currently £3.4m of the additional £45m is within an existing joint funding arrangement between SCC and SCCCG under a S75, S76 or S256 agreement. The funding for the first three schemes entering into a pooled fund arrangement will be Council £5.3m, (9%) and CCG £55.5m (91%). It should be noted that all figures in this report are based on 2014/15 budgeted levels for both the Council and CCG. The equivalent budgets for 2015/16, except for the minimum BCF provision, may vary subject to the relevant budget approvals for each organisation.

12. It should be noted that it is the commissioning budgets for services that are being pooled and that the services themselves and the associated staff will remain managed and employed as they are currently. Therefore the recommendations in this report have no TUPE implications.

Property/Other

13. The proposal should not have any property implications as it relates to commissioning functions. Any changes made to any service funded through the pooled fund which may have property implications will be subject to a separate report.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

14. Section 75 of the National Health Service Act 2006

The pooled fund agreement will cover governance and technical aspects including accountability, financial reporting and the handling of overspends, underspends and savings requirements.

Other Legal Implications:

15. The Health and Social Care Act 2012 places a duty on Health and Wellbeing Boards to encourage and support integrated working.

POLICY FRAMEWORK IMPLICATIONS

16. The decision sought is wholly consistent with the Council's Health and Wellbeing Strategy and other policy framework strategies and plans.

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	None.
2.	

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out?	Yes

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		PERFORMANCE UPDATE		
DATE OF DECISION:		29 JULY 2015		
REPORT OF:		CHAIR OF THE HEALTH AND WELLBEING BOARD		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Dottie Goble**	**Tel:**	**023 8083 3317**
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STATEMENT OF CONFIDENTIALITY
None.

BRIEF SUMMARY

This report highlights progress against the commitments in the Health and Wellbeing Strategy 2013 – 2016. It also introduces a draft Health and Wellbeing Performance Scorecard to enable the Board to assess the outcomes for key health priorities across the city and address areas requiring further action. The commitments and performance scorecard will form the basis for monitoring future priorities and improvement outcomes for the Board. Performance against Better Care Southampton is reported in a separate report to the meeting.

RECOMMENDATIONS:

(i) To note the progress against the commitments in the Health and Wellbeing Strategy 2013 – 2016.

(ii) To agree further actions to be taken to progress the commitments in the Health and Wellbeing Strategy 2013 - 2016, with a particular focus on the actions that are significantly off target (red).

(iii) To consider the draft Health and Wellbeing Scorecard, recommend any changes to the measures for improvement or attention of the Board and agree future reporting mechanisms.

REASONS FOR REPORT RECOMMENDATIONS

1. The Health and Wellbeing Board sets the strategic direction for commissioning in the City. It is also responsible for developing the Health and Wellbeing Strategy. Performance and action monitoring is an important part of this process.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

3. The Health and Wellbeing Board has developed from a shadow to formal status and is now a well-established partnership. An important element of assessing the effectiveness and success of the partnership is to consider performance against key outcome measures and achievement of the commitments in the Health and Wellbeing Strategy 2013 – 16. Effective

performance monitoring will also ensure that a focus is maintained on the areas for improvement and influence future priorities and commitments for the Health and Wellbeing Strategy

4. Progress against the Health and Wellbeing Strategy 2013 – 16 commitments are attached at Appendix 1.

5. Overall, of the 64 commitments set out in the Strategy 28 are on target or complete (green) and 30 are ongoing but off target (amber). It is encouraging to see 90% of commitments have been achieved or are underway. These commitments are being achieved through working with a range of partners. The commitments will continue to develop and provide a focus for potential actions within the next Health and Wellbeing Strategy.

6. There are 5 commitments which are significantly off target (red). These are:

Theme 1: Building resilience and using preventive measures to achieve better health and wellbeing:

8. Increase numbers accessing both drug and alcohol services. This will enhance numbers achieving recovery from alcohol or other drugs.

Theme 2: Best start in life:

27. Continue to develop high class education provision, raise attainment faster than comparator cities and improve school attendance rates where they are low.

Theme 3: Ageing and Living Well Theme:

39. Make the most of existing services (voluntary, public and private sector) that offer free or discounted access to leisure, learning, transport and care.
58. Encourage partners within the Health and Wellbeing Board to lead by example and produce plans for improving employment of people with learning difficulties.
63. Establish an end of life care register accessible to all appropriate service providers (e.g. Out of Hours Service).

7. The Board are asked to consider the progress against the Health and Wellbeing Strategy commitments and agree any further action that should be taken by partners. The Board should particularly focus on the red measures highlighted above. The Board may also wish to consider the overall achievement of Theme 3: Ageing and Living Well theme, where 70% of the commitments (18 out of 26) are either off target (15 amber) or significantly off target (3 red)).

8. The Draft Health and Wellbeing Performance Scorecard is attached at Appendix 2.

9. The measures selected for the Board to focus on are drawn from national health data sources including the Public Health, National Health Service and Adult Social Care Frameworks. They also reflect the measures set out in key strategies, reports and plans for the city. These include:

- City Strategy 2015 - 2025
- Council Strategy 2014 - 2017
- Health and Wellbeing Strategy 2013 - 2016
- Public Health Annual Report 2014
- Southampton Better Care Plan
- Health Inequalities report (a separate agenda item at this meeting)

10. It should be noted that this scorecard is not a 'balanced scorecard' but seeks to identify those areas of focus for improvement and priority for the Board. In selecting key measures from the Health and Wellbeing Strategy that are currently not comparing well to others, it will also serve to support the Board consider priorities for improvement for the Joint Strategic Needs Assessment to inform the next Health and Wellbeing Strategy.

11. It is proposed that the Health and Wellbeing Performance Scorecard is reported on a quarterly basis to the Board. Although a number of the measures are only reported on an annual basis they may be published at different times of the year and it is important that the Board remain aware of key performance issues.

12. In developing the draft Health and Wellbeing Board Performance Scorecard an assessment was made of the health and social care related measures being reported elsewhere. Where appropriate, the Board will work with others other boards, panels and partnerships e.g. Southampton Connect, Safe City Partnership, Employment, Skills and Learning Partnership, the Integrated Commissioning Partnership Board and the Local Children and Adult Safeguarding Boards to consider additional performance measures by exception.

13. The Health and Wellbeing Board are asked to consider the proposed draft Health and Wellbeing Performance Scorecard and recommend any changes to the measures for improvement or attention of the Board. The Board are also asked to agree future performance reporting mechanisms.

RESOURCE IMPLICATIONS

Capital/Revenue

14. The achievement of commitments and improved outcomes will be achieved within existing partner resources or pooling of partner budgets through the Better Care Plan and other similar initiatives in the future.

Property/Other

15. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

16. The duty to undertake health overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000. The Health and Social Care Act 2012 required Health and Being Boards to act in the best interest of improving the health of an area.

Other Legal Implications:

17. None

POLICY FRAMEWORK IMPLICATIONS

18. The Health and Wellbeing Board Performance Scorecard and Health and Wellbeing Action Plan will be used as evidence for consideration for the next iteration of the Health and Wellbeing Strategy.

KEY DECISION?	No	
WARDS/COMMUNITIES AFFECTED:	All	
SUPPORTING DOCUMENTATION		
Appendices		
1.	Progress against the Health and Wellbeing Strategy 2013 – 2016 Commitments	
2.	Draft Health and Wellbeing Performance Scorecard	
Documents In Members' Rooms		
1.	Health and Wellbeing Strategy 2013 - 2016	
2.		
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out?		No
Other Background Documents **Equality Impact Assessment and Other Background documents available for inspection at:**		
Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)	
1.		
2.		

JOINT HEALTH AND WELLBEING STRATEGY COMMITMENTS - PROGRESS TRACKER REPORT 2013/14 AND 2014/15

	ACTION	PROGRESS (RAG)	COMMENT	Updater
	KEY: Green – On track or completed; Amber – Off target; Red – Significantly off target; Grey – Missing information or status N/A			
THEME 1: BUILDING RESILIENCE AND USING PREVENTATIVE MEASURES TO ACHIEVE BETTER HEALTH AND WELLBEING				
Smoking and Tobacco Control				
1.	Develop and implement a comprehensive Tobacco Control Plan for the City in conjunction with the Police and Customs, which tackles prevention, provision of smoking cessation support, illicit supply of cheap smuggled tobacco, and implementation of tobacco control policies at a local level.	GREEN	Tobacco control plan in place and implemented for 2014-15. Smoking cessation services also commissioned. Review of plan being undertaken and used to inform for 2015-16 refresh.	Public Health
2.	Sustain implementation of the national NHS Health Check programme across the City to support early detection/screening for cardiovascular disease and to tackle lifestyle risk factors.	GREEN	NHS Health Checks programme implemented across the City as well as additional opportunistic outreach work targeted at key groups within the population to address potential health inequalities. In 2014/15 99% of eligible population were invited for health checks (over 11,000 invitations). Uptake has increased to 40%.	Public Health
Obesity and Physical Activity				
3.	Identify and implement options determining better health and support healthy lifestyle behaviours leading to improved diet and physical activity in key target groups e.g. health promoting workplaces, breastfeeding friendly environments, healthy early years and childcare settings.	GREEN	A range of activities and services are available to support healthy lifestyle behaviours. These are accessible for children, families and adults and include activities in key settings such as workplaces, early years and schools. The public health nursing service (school nursing) has been commissioned for 1 April 2015. New service specification has a specific focus on healthy weight. The breastfeeding action plan has been developed, with progress monitored by the 0-5 year working group (under the 0-19 commissioning group). Health improvement plan in maternity services specification monitored at maternity trust board meetings.	Public Health
4.	Support initiatives and services that are effective in preventing and managing overweight and obesity in our high risk individuals in the	GREEN	Initiatives and services for children, young people and adults to prevent obesity and manage their weight are supported. Additional insight work being undertaken to better understand further needs of key target groups.	Public Health

	ACTION	PROGRESS (RAG)	COMMENT	Updater
	KEY: Green – On track or completed**;** **Amber –** Off target**;** **Red –** Significantly off target; Grey – Missing information or status N/A			
	children, young people and adults sectors.			
Alcohol and Drugs				
5.	Work together with local agencies to reduce detrimental effects of adults' problem drug and alcohol use, particularly parents.	AMBER	New Integrated Substance Misuse Service (SMS) has been commissioned from November 2014, stratified for younger persons and adults. This has created a new relationship between local agencies in the NHS, voluntary and commercial sector. A specific focus on parents has not yet been achieved, as the mobilisation of the new service model has taken precedence.	Bob Coates
6.	Sustain and expand public education initiatives that raise awareness around alcohol and substance misuse and maintain existing schemes that address underage drinking and associated behaviours, including in school settings.	GREEN	The younger persons SMS has been newly commissioned with No Limits. The enables the delivery of comprehensive school and college based campaigns with access to confidential advice and individual treatment planning, where appropriate. The Healthy Southampton communications plan has prioritised alcohol campaigns for 2015 and identified additional resources to support awareness raising.	Bob Coates
7.	Develop and expand the current services through partnership working approaches that develop 'wrap around' services' (including housing and access to Education, Employment and Training) and link health, social care, housing, leisure, night-time activities and criminal justice to include tackling alcohol and substance abuse in the young.	AMBER	The new service model for young people (YP) and adults is designed to enable a multi-disciplinary and multi-agency response to the needs of YP. It is well positioned in the city to enable effective partnership working with initiatives in the night time economy (NTE) and Youth Offending Team (YOT) programmes. The service has only recently been established and therefore has not had long to build/embed the crucial relationships.	Bob Coates
8.	Increase numbers accessing both drug and alcohol services. This will enhance numbers achieving recovery from alcohol or other drugs.	**RED**	Local problems with IT interoperability, coupled with a "switch off" with the national SMS data system (NDTMS) mean there is no access to benchmarking or the usual datasets over the last two quarters. The issues were discussed and solutions agreed at the DAAT partnership meeting in April 2015. These local and national issues will mean this remains a challenge now and in the foreseeable future.	Bob Coates
9.	Review drug treatment services, particularly to young people to ensure a value, high quality treatment system	GREEN	The new service was implemented following the review.	Bob Coates

	ACTION	PROGRESS (RAG)	COMMENT	Updater
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	reflective of their drug use patterns.			
10.	Increase the range of effective treatment interventions for crack cocaine and stimulant users.	GREEN	The last available data on treatment outcomes in this group was encouraging.	Bob Coates
11.	Develop an appropriate suite of abstinence and harm reduction services for blood borne viruses (BBV), such as HIV etc.	GREEN	Needle exchange, BBV screening, and access to new hepatitis treatments was in the top quintile of performance nationally last year. A programme of enhanced HIV surveillance has been agreed with the CCG and Integrated Commissioning team.	Bob Coates
Housing				
12.	Endeavour to help people to have access to good quality, energy efficient housing that is both affordable and meets their needs. The priorities below aim to provide opportunities to help promote health and wellbeing in the working age population across the city by working with local employers, improving economic wellbeing and helping particularly young people into employment.	GREEN	The homelessness Prevention Strategy for 2013-2018 is the third strategy to tackle homelessness. It demonstrates a commitment to build on our experience to provide a comprehensive service that tackles homelessness in Southampton. The strategy focuses on early intervention and prevention where possible and assisting people in need.	Liz Slater
13.	Provide a comprehensive homelessness service that supports people to make independent choices about their housing future.			
14.	Work with the voluntary and supported housing sectors and the Homeless Healthcare Team to ensure that provision in the city meets the needs of the most challenging people to safeguard both their housing and health needs and reduce the impact on the general population.	AMBER	Significant work underway in relation to care leavers and homeless young people. Action plan in place to address Ofsted recommendations and proactively working with providers to implement changes which support a stronger focus on care leavers, a move away from properties of multiple occupation, improved processes and joint working with children's services. Also exploring the possibility of a more targeted resource and support for the most challenging young people.	Donna Chapman

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15.	Having an additional Licensing scheme for all HMOs in the city to help ensure the conditions in the private rented sector are improved and poor or inadequate housing is brought up to acceptable standards.	GREEN	Southampton City Council introduced an additional HMO Licensing scheme in four wards (Bevois, Bargate, Portswood and Swaythling) in July 2013. The scheme is working to improve management and conditions in HMOs and reduce the impact on the communities. Consideration is currently being given to extend the scheme to include Freemantle, Shirley, Bassett and Millbrook wards. The statutory consultation period has ended and subject to due process the new scheme will commence in October 2015.There is insufficient evidence of poorly managed HMO's in other parts of the city to legally extend the scheme further.	Mitch Sanders
16.	Develop local hubs for quality support and care in the city, for example dementia friendly facilities with support activities and interactions for people with dementia from the wider community.	AMBER	Working together for a 'Dementia Friendly City' being progressed. Dementia awareness sessions have been delivered to Primary Care reception teams, with the dementia friendly surgeries project moving to implementation stage. CCG/SCC working with local charities, voluntary and community groups to provide more support in the community to help people live well with dementia and connect those living with dementia with their community.	Amanda Luker
17.	Raise awareness of falls and reduce or prevent trips, slips and falls within Council older people's accommodation. Good design can do much in this sector.	GREEN	This is being progressed as a key Better Care programme target. A falls action plan is in place with all agencies committed to delivering key actions. A new exercise class programme is being piloted with a local voluntary sector organisation and other partners to reduce repeat falls. A new falls liaison pathway has also been introduced between UHS and Solent NHS Trust to reduce repeat falls. Specific work is being undertaken with nursing homes to introduce "falls champions" to prevent trips, slips and falls. A publicity week is also planned in September to raise awareness of falls and how to prevent them.	Donna Chapman
Workplace Health				
18.	Implement a programme of work to support employers in improving the health and wellbeing of their workforce through recognised good practice at work; improve the support for those stopping work due to sickness to get them back into work sooner or to rethink their future job	AMBER	National Workplace Wellbeing Charter implemented through the Well & Working programme. Supporting a range of employers to improve the health and wellbeing of their workforce. Some work undertaken to better understand the issues around Fit Note. Work being undertaken to address the worklessness agenda for those with a health condition.	Public Health

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	KEY: Green – On track or completed**;** **Amber –** Off target**;** **Red –** Significantly off target; Grey – Missing information or status N/A			
	prospects. Harassment and bullying need preventative policies.			
19.	Support more vulnerable people into good quality work, such as young people, carers and people with learning disabilities, mental health and long term health conditions and disabilities.	AMBER	Southampton and Portsmouth City Councils entered in to the City Deal agreement with government in November 2013, and a key element of this was the provision of additional resources to improve employment services for adults with health conditions and young NEETs. Some of this resource (dependent on EU funds) was delayed, leading to a late start with the programmes. The Youth Programme is now underway and a coordinated response to dealing with NEETs has been agreed and is being implemented. A pilot project, seeking to integrate health and employment services for adults with health conditions has started with 100 people to test the approach and assumptions for this innovative initiative before the main City Deal programme starts in early 2016. Outcomes will be reported to the HWB.	Kathryn Rankin
20.	Promote and develop the 'Time to Change' campaign to reduce the stigma of mental illness in the workplace.	AMBER	A Time to Change planning event is taking place on 27 June to inform and get buy in from local stakeholders. If all interested parties sign up we should have a citywide anti-stigma campaign in October.	Sally Denley
Mental Health				
21.	Adopt a public health approach in the development of strategies which promote wellbeing for the whole population including activities which reduce health inequalities and which promote good mental health across the city.	AMBER	The public mental health Be Well strategy is due for a refresh by the end of the year. The majority of the ten pledges have been met. However, the issue of service user involvement remains a concern.	Sally Denley
22.	Ensure early access to psychological therapy/services, such as counselling and talk, which help people remain in or return to employment.	GREEN	Access to Southampton Steps to Wellbeing (National Improving Access to Psychological Therapies (IAPT) scheme) has met the national ambition for the proportion of people who have received psychological therapies.	Amanda Luker
23.	Develop and implement a suicide prevention strategy across the city.	AMBER	The evidence obtained by the Southampton Suicide audit undertaken jointly with the Coroner's Office will inform a local Public Health Prevention Plan for Southampton. This will be rolled out as part of the Be Well Strategy refresh.	Sally Denley/ Amanda Luker

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			Safe care approaches to suicide prevention in the CQUIN scheme; includes review and adaptation of risk assessment. By rolling out 'connecting with people' training for clinicians and USI Suicide Prevention Training together with Mental Health First Aid we aim to make Southampton a suicide safer city.	
THEME 2: BEST START IN LIFE				
Giving every child the best start in life				
24.	Develop and deliver early learning for 2 year olds who are disadvantaged.	AMBER	The 2014-2015 Southampton Childcare Sufficiency Assessment shows that where sufficient capacity has not been developed there are the necessary plans in place to achieve this by September 2015. The exception to this is in the Thornhill area where, as yet, suitable premises have not been identified and all existing local provision has already been expanded to the limit. Take up of places is currently at 59% of entitled children (current HMRC estimate of total number of children entitled is 1430) which is low in comparison to our statistical neighbours and slightly below the national average. This is despite a comprehensive communications plan and follow up with families. Investigation of other authorities' approaches suggests that more outreach to families is needed to proactively support take up of places. There is currently minimal additional capacity within children's centres to do this. We are looking at more effective use of current capacity and the possibility of extending the outreach contract which is supported from the 2 year old trajectory funding. The funding is available until November 2015.	Sue Thompson
25.	Develop an integrated early years service incorporating children's centre provision, family and parenting support services and the Healthy Child Programme.	GREEN	With commissioning responsibility for Public Health Nursing services (health visiting and family nurse partnership) moving to the local authority (Public health) in October 2015, work has been underway to explore a more integrated 0-5 year old offer. We are aiming to implement a virtual model of integration with joint management teams comprising health visiting, children's centres and midwifery leadership from July 2015 to achieve greater integration of resources and alignment of health, education and social care performance indicators and outcomes. At the same time, we plan to undertake a review of MASH and Early Help services to inform the future direction of travel, with a view to potentially working towards an integrated 0-19 offer based around localities.	Donna Chapman

	ACTION	PROGRESS (RAG)	COMMENT	Updater
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26.	Develop health visiting and maternity services to achieve optimum health outcomes in the early years and tackle inequalities.	GREEN	Work continues with Solent NHS Trust, NHS England and University Hospital Southampton Foundation Trust (UHSFT) to improve outcomes in the early years and tackle inequalities. For Maternity Services, this has been negotiated as part of the 2015/16 Service Specification held by the CCG which includes specific reference to key public health priorities, in particular smoking cessation (including the universal implementation of Carbon monoxide monitoring), healthy weight, healthy start, mental health and breast feeding. Work is underway to ensure that the new Maternity Payment by Results tariff is driving a stronger focus on tackling inequalities. For health visiting, the Council is working closely with NHS England (current commissioner) to improve outcomes in the early years, with reference to the 6 high impact areas described by NHSE. This will be further supported by the integrated 0-5 offer described above.	Donna Chapman
27.	Continue to develop high class education provision, raise attainment faster than comparator cities and improve school attendance rates where they are low.	**RED**	2013/2014 early years foundation stage is above the national average, whilst Key Stage 2 performance is just above average and GCSE attainment (5+ A*-C grades including English and Maths) is 5% points below the England national average. Overall attendance (5%) is just below the national average (4.5%). Work continues on a school by school basis with Education Welfare Officers and the School Improvement Team to raise attainment levels and standards in schools. The work also links to the Families Matter Programme. 2014/15 results will be available in August and reported to the next Children's Scrutiny Panel.	Robert Hardy
Intervening early when problems occur				
28.	Develop an integrated assessment process for all types of needs which identifies them early and facilitates a holistic multiagency approach to providing good quality education, health and care services.	AMBER	This is a key element of the Better Care programme and implementation of the cluster interagency team model. Six clusters have been established, based around GP practice populations, bringing together health, social care, housing and voluntary staff. The clusters are at varying stages of development but a core principle for all is the use of risk stratification tools to identify people at most risk and shared assessment and care planning. These principles are also being applied for children and their families, where use of the Universal Help Assessment and Family Help Assessment tools are being used by Children's Centres, school nursing, Early Help and the MASH. Work is also underway to explore a more integrated approach to bringing together the 2-3 year old assessments of the Healthy Child	Public Health

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			Programme and Early Years Foundation Stage. Integrated process established for safeguarding set up through the MASH (Multi-agency safeguarding hub), Early Help teams and scrutiny of services via the section 11 audit process.	
29.	Shift the focus of provision and resources towards prevention, ensuring that the workforce at all levels and across all agencies is equipped with the skills and knowledge to identify needs and intervene early in situations of risk.	AMBER	This is a key element of the 0-19 Prevention and Early Intervention Strategy which has 5 key strands: • Implementation of a core parenting offer and family support; • Better use of data, information and intelligence across the system to identify gaps, provide information to staff and families on what is available and share evidence based interventions; • Community engagement and development of capacity within the voluntary and community sector to better meet need at an earlier stage; • Interagency workforce development and training to support prevention • Early intervention and inclusive integrated services. Significant progress has been made in implementing the parenting offer for 0-5s and a parenting toolkit has been launched with schools to support development of the 5-14 years offer. Different models for strengthening engagement of the community/voluntary sector have been explored through the Delivering Differently and Headstart initiatives and will be further supported through the Prevention and Early Intervention Strategy. Further work required on interagency workforce development and equipping staff with skills and knowledge to identify needs and intervene at a much earlier stage. The Better Care Programme has its own workforce development project being rolled out in 2015/16. This will focus on NHS / Council staff in addition to nursing home and domiciliary care staff. Better Care will lead to prevention and early intervention and initial work has commenced on developing a plan for health and social care outcomes.	Public Health
30.	Develop and maintain a stable, skilled, high calibre and experienced safeguarding workforce which is well managed and supported.	AMBER	A workforce strategy is being delivered to improve the recruitment and retention of safeguarding staff. Analysis of its effectiveness is ongoing.	Mark Howell/ Hillary Brooks
Supporting children, young people and their families with additional needs				
31.	Increase personalisation and choice through implementation of a core offer	GREEN	An integrated 0-25 service is being developed across education, health and social care. This includes the integration of Council and Solent NHS	

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	and personal budgets, building on the learning from the Government-sponsored SEN and Disability Pathfinder.		Trust staff within a single service structure and the development of a strong person-centred ethos. The SEND offer is published on the Southampton Information Directory and provides information about what is available and how to access services. A revised Impartial Information and Advice Service is being commissioned to meet the requirements of the Children and Family Act.	
32.	Narrow the gap in attainments and outcomes for children with SEN and disabilities, increasing their aspirations, skills and qualifications.	N/A	SEND plans are developed on an individual basis for each child and will be implemented within the individuals Education and Health Care Plan. This matter is currently difficult to report against. A regional report is being undertaken by Portsmouth to develop potential SEND future benchmarks.	Hillary Brooks
33.	Improve outcomes for children looked-after by the Council (corporate parent) building on the findings from the Integrated Ofsted/CQC inspection.	AMBER	An OFSTED Action Plan and performance monitoring is in place. The outcomes for children are continually monitored to ascertain where improvements need to be made.	Hillary Brooks
34.	Develop holistic approaches to support and challenge for the most vulnerable families in the city through the Families Matter programme.	GREY	To be updated.	Christine Robertson
Supporting young people to become healthy, responsible adults				
35.	Develop Raising Participation Age support for schools and colleges.	GREEN	Raising Participation Age has been implemented effectively with schools.	Robert Hardy
36.	Redesign substance misuse treatment services for young people to improve uptake and compliance with treatment.	GREEN	Procurement and redesign completed in Dec 2014.	Bob Coates
37.	Continue to improve sexual health and reduce teenage conceptions through delivery of the Children and Young People's Trust reducing teenage pregnancy strategy.	GREEN	Teenage pregnancy city wide event held in October 2014. Sexual health strategy developed and intentions reviewed quarterly by sexual health steering group. Teenage pregnancy is a key strategic priority. Teenage pregnancy action plan currently being updated, with assurance of delivery from the 0-19 commissioning group.	Donna Chapman
38.	Make sure young people leaving care are well supported to achieve their aspirations and become independent, self-reliant citizens.	AMBER	A care leavers action plan is in place and monitored. Improvements have been seen for care leavers in terms of NEETs and accommodation, however, our performance are both worse than the national average and work continues to assess potential improvements on an individual basis.	Hillary Brooks
Theme 3 – Ageing and Living Well				

	ACTION	PROGRESS (RAG)	COMMENT	Updater
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Tackling poverty				
39.	Make the most of existing services (voluntary, public and private sector) that offer free or discounted access to leisure, learning, transport and care.	RED	Southampton Gets Active is working to develop a plan to increase active participation in sport and recreation. Further partnership work is needed to assess where potential free or discounted services are on offer and promoted more widely.	Andrew Mortimore
40.	Support the development and use of information advice assistance to help people to maximise their income, ensure winter warmth and improve their quality of life.	AMBER	Additional advice provision has been made available in the city in response to welfare reforms. The city has developed and Fuel Poverty Plan and continues to work with 'The Environment Centre' to offer a one stop shop service to the general public for any affordable warmth/fuel poverty related enquires.	Sara Crawford
Prevention and earlier intervention				
41.	Offer an annual health check to carers and promote support networks for carers across the City.	GREEN	New services were commissioned to promote and develop support networks for carers across the City. This has been extended to include provision of carer assessments.	Sandy Jerrim
42.	Review tele-care and tele-health services in the City, re-shape and re-launch these so that local people are more aware of the ways in which they can use technology to retain their independence.	AMBER	Plans being developed under oversight of Health and Social Care System Chief Officers.	Sandy Jerrim
43.	Extend re-ablement services so that people can help to regain their confidence and skills after an illness or mental health breakdown.	AMBER	The integrated rehabilitation and reablement service designed to intervene rapidly and early when people are at risk of crisis, nursing or rest home or hospital care or are ready to discharge from hospital care back into the community. The service dovetails with the developing cluster teams to promote simple, integrated and shared care pathways for clients and patients.	Jamie Schofield
44.	Promote healthy, active lifestyles through a dedicated team of Activity Coordinators.	GREEN	Through programmes such as health trainers and My Journey residents and visitors are encouraged and supported to be more physically active.	Andrew Mortimore
Being 'person' centred and not 'disease' centred				
45.	Increasing the number of people who can say how best to spend the money allocated for their health and care, either through direct payments or personal health/care budgets.	AMBER	Focussed work on increasing direct payments uptake. Personal health budgets offer integrated / normal continuing healthcare pathways with expectations and plans to deliver a minimum notional budget for all clients that the CCG fund before the end of the financial year. Further refinement and development progressing to refine and	Mike Cooke

	ACTION	PROGRESS (RAG)	COMMENT	Updater
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			maximise the robustness of the personal health budget offering.	
46.	Joining up health and social care services so that the number of assessments is reduced and a person's experience of moving between professionals is much smoother and less fragmented.	AMBER	Service functions related to crisis response, rehabilitation, reablement and hospital discharge will be integrated with pooled funding arrangements, single management, referral, governance, planning and performance arrangements to ensure greater fluidity and shared responsibility.	Jamie Schofield
47.	Developing a shared understanding of how best to support people to retain their independence and make changes to practice which improve the achievement of this objective.	AMBER	Age UK are piloting Person Centre Planning in three GP practice for people with long-term conditions. Two GP practices are running pilots for the over 50's who use alcohol with long-term conditions. Also piloting with Spectrum community navigation, with workshops being held June 2015. Southampton Advice Services Alliance (SASA) have developed the advice and information website.	Carole Binns
48.	Promotion of a focus on recovery rather than simply procedures for admission avoidance and/or hospital discharge when people need any form of secondary care.	AMBER	The integrated crisis response, rehabilitation, reablement and hospital discharge provision will focus on promoting independence by having a community cluster focus at all time, developing self-management planning, involvement in risk stratification processes, developing city wide single care planning and information sharing processes and protocols,	Carole Binns
Care of long-term conditions, including cancer and dementia				
49.	To ensure that the enduring issues for people living with long-term conditions are recognised and that they are supported in the management of their conditions	AMBER	The Better Care Programme is aims to address needs of individuals, especially vulnerable older adults. Workstreams are underway for a number of long-term conditions to improve pathways and all have a key focus on self-management and improved quality of life.	Bob Coates
50.	Work with GPs to more accurately achieve earlier diagnosis of those most at risk of experiencing dementia	GREEN	Focused work undertaken with Primary Care during 2014/15 has resulted in an increased diagnosis rate, preliminary March 2015 data 65%, which is an increase of 10.5% from the March 2014 position.	Amanda Luker
51.	More support for people with dementia to remain in their own homes for as long as it is safe for them to do so.	GREEN	Services promoting social inclusion to those living with dementia, working with individuals and families to review and establish self-management goals within a personal programme. Working with the voluntary sector and community settings to improve the health and wellbeing of people living with dementai and to reduce loneliness and social isolation, by participating in a range of activities.	Amanda Luker

	ACTION	PROGRESS (RAG)	COMMENT	Updater
	KEY: Green – On track or completed; Amber – Off target; Red – Significantly off target; Grey – Missing information or status N/A			
52.	The development of extra-care services for people with long term conditions and those with dementia Launching a new approach to provision of aids and adaptations which encourage better access and information for individuals able to fund themselves and improves response times to those requiring equipment to maintain their independence.	AMBER	Extra care provision at Graylings available for individuals with dementia. An innovative project is running until August 2015 featuring GPS technology to help people with dementia who are at risk of becoming lost and confused in the community. This now sits within a range of areas: the wider Better Care agenda; Person centred Planning, Personal Budgets, JES, telecare and telehealth and the Prevention and Early Intervention portfolios. *To add further commentary from SCC in relation to equipment and adaptations*	Amanda Luker Chrissie Dawson SCC
53.	Raising awareness amongst all care and health staff about appropriate responses for people with dementia, mental capacity issues including deprivation of liberty guidelines and protocols.	GREEN	NHSE mandate that 80% of front facing staff should receive dementia awareness training. Community Trust has developed a bespoke e-learning package to deliver tier 1 training, and currently reviewing tier 2 and 3 training. An Acute Trust Dementia Strategy is now in place, and linked to the Trust education plan. VIP training with 5 dementia modules being offered, with additional module being developed. MIND have raised awareness of IMCA/DoLS within hospitals and regularly link closely with residential homes.	Amanda Luker
54.	Work with the Clinical Commissioning Group and providers of social care to raise the standard of medicines management across the health and care system.	AMBER	Public health provide advice on medicines, evaluation and prescribing policy. CQC and CCG Clinical Governance monitor quality of medicines management.	Bob Coates. (Julia Bowey and Liz Bere)
55.	To improve health outcomes of those living with cancer action will be taken to improve understanding amongst the public about the signs and symptoms of cancer and encourage early checks with their GP.	GREEN	We worked with Public Health England and NHS England on cancer awareness programmes including 'Blood in pee' and the 'lung cancer awareness' programmes.	Bob Coates
Improve the response to learning disabilities				
56.	Work with the Clinical Commissioning Group to ensure the implementation across GP practices of annual health	AMBER	30-37% of people with learning disability on the GP registers have had a annual health check. A city wide plan has been developed covering, engagement with GPs, Wessex AT, Southern Health, LDPB, Choices	Kate Dench

	ACTION	PROGRESS (RAG)	COMMENT	Updater
	KEY: Green – On track or completed; **Amber –** Off target; **Red –** Significantly off target; Grey – Missing information or status N/A			
	and dental checks for people with learning disabilities.		Advocacy, people with learning disabilities and their carers. Implementation is planned to reach 50% within 2015/16.	
57.	Better coordinate and promote services which support people with learning disabilities and their carers across the City.	GREEN	The online Southampton Information Directory (SID) has been developed to include information about all services available and how they can be accessed. Carers in Southampton services are being promoted widely. Advocacy services have been re-commissioned with a strong emphasis in supporting people with learning disabilities.	Kate Dench
58.	Encourage partners within the Health and Wellbeing Board to lead by example and produce plans for improving employment of people with learning difficulties.	RED	Further analysis is required to assess whether partner plans are in place and their effectiveness.	Kate Dench
59.	Involve the Learning Disability Partnership Board which includes people with learning disabilities in the City in shaping all improvements.	GREEN	The Partnership board regularly requests and receives information from the council, CCG and other partners about current service developments and is in involved in shaping them.	Kate Dench
End of life care				
60.	Increase public awareness and discussion around death and dying.	AMBER	Southampton, in conjunction with health Education Wessex, provided information and awareness sessions through community groups (for Southampton it was Carers Together). Their remit was to develop teaching and training to raise awareness of EOL care planning amongst voluntary organisations and their members.	Chrissie Dawson
61.	Map current provision to ensure that appropriate national care pathways are incorporated and audited in hospitals and the community.	AMBER	Southampton are represented nationally to ensure national directives are implemented, e.g. following the demise of the LCP, we have developed and implemented an 'individualised care plan for the last days and hours of life' based on the 5 Key Priorities of Care document. DNACPR is audited in acute hospitals with adherence to the recent Tracey judgement AMBER care bundle to identify and support people to achieve their preferred wishes at the EOL (rolled out in acute hospital). The Transform programme - enabling more people to be supported to live and die well in their preferred place.	Chrissie Dawson
62.	Extend palliative care to other diseases besides cancer and ensure	AMBER	Countess Mountbatten House was successful in a DOH grant to improve the facilities at the hospice, the refurbishment included appropriate	Chrissie Dawson

	ACTION	PROGRESS (RAG)	COMMENT	Updater
	KEY: Green – On track or completed**;** **Amber –** Off target**;** **Red –** Significantly off target; Grey – Missing information or status N/A			
	access to physical, psychological, social and spiritual care.		surroundings to care for people with a non-cancer diagnosis approaching EOL, as a result CMH has seen an increase in the number of people with a non-malignancy receiving care.	
63.	Establish an end of life care register accessible to all appropriate service providers (e.g. Out of Hours Service).	RED	This has slipped for Southampton (and SHIP) as the preferred IT platform has been superseded by the Hampshire Health Record, with the timescales for the End of Life plans for the end of summer 2015.	Chrissie Dawson
64.	Have timely bereavement counselling available.	AMBER	Family member/carers receive an initial contact from provider who cared for deceased with signposting to appropriate services as required. SCCCG is continuing to work with providers and the voluntary sector to ensure feedback from the national VOICES survey is considered going forward.	Chrissie Dawson

Appendix 2

Measure	STATUS	Scorecard / data source	Theme / issue	Service area responsible	Frequency
% people who use services who have control over their daily life	3rd quartile	ASCOF	Independence	Adult Social Care	Annual
Proportion of adults in contact with secondary mental health services in paid employment	**4th quartile**	ASCOF ASC Scorecard	Mental health	Adult Social Care	Annual
Permanent admissions to residential and nursing homes per 100,000 population	**4th quartile**	ASCOF People Scorecard ASC Scorecard	Placement and packages	ICU	Monthly
Proportion of Older people (65+) who were still at home 91 days after discharge from hospital into reablement and rehabilitation services (effectiveness of the service)	3rd quartile	ASCOF People Scorecard ASC Scorecard	Rehabilitation & Reablement	ICU	Monthly
Whole system delayed days for transfers of care from hospital per 100,000 population	**Red**	ASCOF ASC Scorecard	Rehabilitation & Reablement	ICU	Monthly
Outcome measure for dementia - tbd	TBC - see proxy options below	ASCOF	Dementia	adult social care	
Dementia proxy: % recorded dementia against the estimated diagnosis in the population	Potential proxy measure for dementia				
Prevalence rate for depression	Potential proxy measure for dementia				
Non elective admissions (cumulative)	Green	People Scorecard	Rehab & Reablement	Integrated Care	Monthly
0.1i - Healthy life expectancy at birth	**Male Red (F = Amber**	PHOF Overarching indicators	Life expectancy	PHOF	Annual
0.1ii - Life expectancy at 65	**Red**	PHOF Overarching indicators	Life expectancy	PHOF	Annual
0.1ii - Life expectancy at birth	**Male Red (F = Amber**	PHOF Overarching indicators	Life expectancy	PHOF	Annual
1.01ii - Children in poverty (under 16s)	**Red**	PHOF Wider determinants of health	Child poverty	PHOF	Annual
1.15ii statutory homelessness - Reduction in number of households in temporary accommodation	Green	PHOF Wider determinants of health	Housing	PHOF	Annual
1.16 - Utilisation of outdoor space for exercise/health reasons	Amber	PHOF Wider determinants of health	Obesity and physical activity	PHOF	Annual
1.17 - Fuel Poverty	Green	PHOF Wider determinants of health	Housing	PHOF	Annual
2.01 - Low birth weight of term babies	Amber	PHOF Health improvement	Best start in life	PHOF	Annual
2.02ii - Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth	**Red**	PHOF Health improvement	Best start in life	PHOF	Annual
2.03 - Smoking status at time of delivery	**Red**	PHOF Health improvement	Best start in life	PHOF	Annual
2.06i - excess weight in 4-5 and 10-11 year olds - 4-5 year olds	**Red**	PHOF Health improvement	Child obesity	PHOF	Annual
2.06ii - excess weight in 4-5 and 10-11 year olds - 10-11 year olds	**Red**	PHOF Health improvement	Child obesity	PHOF	Annual
2.07i Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	**Red**	PHOF Health improvement	Child wellbeing and safeguarding	PHOF	Annual
2.12 - excess weight in Adults	Amber	PHOF Health improvement	Adult obesity / physical activity	PHOF	Annual
2.13i - Percentage of physically active and inactive adults - active adults	Amber	PHOF Health improvement	physical activity	PHOF	Annual
2.14 - Smoking Prevalence	Red	PHOF Health improvement	Smoking	PHOF	Annual
2.17 - Recorded diabetes	Above average	PHOF Health improvement	Obesity and physical activity	PHOF	Annual
2.18 Alcohol-related admission to hospital	**Red (F=Amber)**	PHOF Health improvement	Substance misuse	PHOF	Annual

Measure	STATUS	Scorecard / data source	Theme / issue	Service area responsible	Frequency
2.24i injuries due to falls in people aged 65 and over (persons)	Red	PHOF Health improvement	Falls	PHOF	Monthly
3.01 Fraction of mortality attributable to particulate air pollution	N/A	PHOF Health protection	Air pollution	PHOF	Annual
3.02ii - Chlamydia detection rate (15-24 year olds) - CTAD	Red	PHOF Health protection	STDs	PHOF	Monthly
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old)	Green	PHOF Health protection	Vaccination	PHOF	Annual
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old)	Green	PHOF Health protection	Vaccination	PHOF	Annual
4.02 - Tooth decay in children aged 5	Red	PHOF Healthcare and premature mortality	Child health	PHOF	Annual
4.03 Mortality rate from preventable causes per 100,000 population	Red	PHOF Healthcare and premature mortality	Preventable causes	PHOF	Annual
4.04i - Under 75 mortality rate from all cardiovascular diseases	Red	PHOF Healthcare and premature mortality	Cardiovascualar	PHOF	Annual
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Red	PHOF Healthcare and premature mortality	Cardiovascualar	PHOF	Annual
4.05i - Under 75 mortality rate from cancer	Red	PHOF Healthcare and premature mortality	Cancer	PHOF	Annual
4.05ii Under 75 mortality rate from cancer considered preventable	Red M&F = A	PHOF Healthcare and premature mortality	Cancer	PHOF	Annual
4.06i - Under 75 mortality rate from liver disease	Amber M=Red	PHOF Healthcare and premature mortality	Liver disease	PHOF	Annual
4.06ii - Under 75 mortality rate from liver disease considered preventable	Amber M=Red	PHOF Healthcare and premature mortality	Liver disaease	PHOF	Annual
4.07i - Under 75 mortality rate from respiratory disease	Red F = A	PHOF Healthcare and premature mortality	Respiratory	PHOF	Annual
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	Red	PHOF Healthcare and premature mortality	Respiratory	PHOF	Annual
4.10 - Suicide rate	Red M=A; F Data too small	PHOF Healthcare and premature mortality	Suicide	PHOF	Annual
4.15i - excess Winter Deaths index (Single year, all ages)	Amber	PHOF Healthcare and premature mortality	Ageing well	PHOF	Annual

DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP (SCCCG) QUALITY PREMIUM		
DATE OF DECISION:		29 JULY 2015		
REPORT OF:		SCCCG GP BOARD REPRESENTATIVE		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Dorota Goble**	**Tel:**	**023 8083 3317**
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STATEMENT OF CONFIDENTIALITY
None.

BRIEF SUMMARY

As part of the planning process for 2015/16, Clinical Commissioning Groups (CCGs) need the approval of local Health and Wellbeing Boards and NHS England for a number of measures that they will be held accountable for in the coming year. The deadline for submission was 14th May 2015 and therefore did not tie in with the last formal meeting. Approval was given by the chair and vice chair outside of the meeting and the Board is now asked to formally ratify the Southampton City CCGs Quality Premium.

RECOMMENDATIONS:

(i) To consider the Southampton City CCGs Quality Premium and approve proposals for 2015/16, particularly in relation to:

- Urgent and Emergency Care – overall worth 30% of quality premium
- Mental Health – overall worth 30% of quality premium
- Local priority measures – 10% each of quality premium
  - Maternal smoking at delivery
  - Total health gain as assessed by patients for elective groin hernia procedures.

REASONS FOR REPORT RECOMMENDATIONS

1. As part of the planning process for 2015/16, Clinical Commissioning Groups (CCGs) need the approval of local Health and Wellbeing Boards and NHS England for a number of measures that CCGs will be held accountable for in the coming year.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

3. As part of the planning process for 2015/16, Clinical Commissioning Groups need the approval of local Health and Wellbeing Boards and NHS England for a number of measures that CCGs will be held accountable for in the coming year. This

paper sets out the measures and justification for Southampton CCG's submission. These have been approved by the CCG Senior Management Team.

4. The 2015/16 Quality Premium (QP) guidance asks CCGs to choose from a menu of Urgent and Emergency Care and Mental Health measures and identify two local measures; approval is being sought via the HWBB Chairman's delegated authority.

Urgent and Emergency Care

5. **Avoidable emergency admissions composite measure - a reduction or zero % change over 4 years 2012/13 to 2015/16 – total 30% of QP**

6 **Rationale for submission:**

There has been a 4.86% reduction since 2012/13 to 2014/15 and it is felt that the % change target for 2015/16 can be achieved.

7. The remaining two measures and rationale for not selecting these is detailed below:

1. Delayed Transfers of Care which are an NHS Responsibility – Local authority performance in 2014/15 is below target by 12%. NHS England threshold requests a reduction but have not yet stipulated level and we cannot be confident of making an unspecified level of reduction on 2014/15 outturn.
2. Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays - Current data indicates that CCG has good performance and it may be difficult to achieve further improvement.

Mental Health

8. **Reduction in the number of patients attending an A&E department for mental health-related needs who wait more than four hours to be treated and discharged, or admitted, together with a defined improvement in the coding of patients attending A&E – total 30% of QP**

9. **Rationale for submission:**

This measure relates to National CQUIN 8a - valid diagnosis code target 85% and collaboration to reduce re-attendance rates. The University Hospital Southampton (UHS) agree in principle to national CQUIN 8a and 8b and discussions in progress to achieve final agreement. The UHS will need to sign up to both CQUIN and stretch target of 90%. UHS improved Psychiatric Liaison service for A&E to 7 days per week 09:00 - 24:00 is in place. Both CQUIN and Liaison service will support delivery of the targets.

10. The remaining three measures and rationale for not selecting these is detailed below:

1. Reduction in the number of people with serious mental illness who are currently smokers - Delays in General Practice Extraction Service (GPES) reporting have resulted in delay in this data being available.
2. Increase in the proportion of adults in contact with secondary mental health services who are in paid employment - Data collection and data quality issues make setting baseline and monitoring difficult and unreliable.
3. Health related quality of life for long term mental health condition - Relevant information is not available on the GP Survey.

Local Priority Measures

11. As part of the planning process, two local priorities can be agreed by each CCG with their local Health and Wellbeing Board and NHS England. The following are

proposed as the local priorities for Southampton City CCG:

Maternal smoking at delivery

12. This measure is in the worst quintile in 2013/14 in national rankings. It is a key contributor to public health poor outcomes in Southampton. The 2014/15 outturn is estimated to be 14.7%. This is based on national reporting from Q1-Q3 and UHS reporting for Q4.

14. The 2015/16 proposed trajectory is 14%. The reduction is based upon reversing the upward trajectory, with associated work programmes with midwifery services and the wider Public Health England.

Total health gain as assessed by patients for elective groin hernia procedures.

15. This measure is in the second worst quintile in 2013/14 in National rankings. The latest total health gain as at September 2014 is reported at 0.026.

16. The proposed trajectory to March 2016 is to make improvement to 0.030 (15%). This is based upon continuation of the change in technique at the Independent Sector Treatment Centre (ISTC) at the Royal South Hants Hospital and ensuring that maximum number of records are reported nationally.

17. The SCCCG is seeking agreement to the choices and distribution of the total % premium for the following measures:

- Urgent and Emergency Care – overall worth 30% of quality premium
- Mental Health – overall worth 30% of quality premium
- 2 local priority measures – 10% each of quality premium

18. It should be noted that there are 2 further mandatory measures which make up the remaining element of the quality premium:

- Reducing potential lives lost through causes amenable to healthcare - 10% of quality premium
- Improving antibiotic prescribing in primary and acute care - 10% of quality premium

RESOURCE IMPLICATIONS

Capital/Revenue

19. Achievement of these targets will be achieved within existing commissioning budgets.

Property/Other

20. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

21. The duty to undertake health overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000. The Health and Social Care Act 2012 required Health and Being Boards to act in the best interest of improving the health of an area.

Other Legal Implications:

12. None.

POLICY FRAMEWORK IMPLICATIONS

13. None.

KEY DECISION?	No	
WARDS/COMMUNITIES AFFECTED:	All	
SUPPORTING DOCUMENTATION		
Appendices		
1.	None	
2.		
Documents In Members' Rooms		
1.	None	
2.		
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out?		No
Other Background Documents **Equality Impact Assessment and Other Background documents available for inspection at:**		
Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)	
1.		
2.		