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Shadow Health and Wellbeing Board

Wednesday, 23rd January, 2013
at 5.30 pm

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Rayment, Cabinet Member for Communities
Councillor Bogle, Cabinet Member for Children's Services
Councillor Stevens, Cabinet Member for Adult Services
Councillor Baillie, Opposition Member
Councillor Turner, Opposition Member
Dr S Townsend, Clinical Commisioning Group
Dr S Ward, SHIP PCT Cluster
Mr H Dymond, Local Health Watch
Mr C Webster, Director of Children's Services
Ms M Geary, Director of Health and Adult Social Services
Dr A Mortimore, Director of Public Health

Contacts
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BACKGROUND AND RELEVANT INFORMATION

Purpose of the Board
The purpose of the Southampton Shadow 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

Southampton City Council's Seven Priorities

- More jobs for local people
- More local people who are well educated and skilled
- A better and safer place in which to live and invest
- Better protection for children and young people
- Support for the most vulnerable people and families
- Reducing health inequalities
- Reshaping the Council for the future

Responsibilities
The shadow board is responsible for developing mechanisms to undertake the duties to be placed on the health and wellbeing board from April 2013, 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 turn off your mobile telephone whilst in 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

Proposed Municipal Year Dates

2012	2013
21 November	23 January
	27 March
	29 May
	31 July
	25 September
	27 November

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

CONDUCT OF MEETING

BUSINESS TO BE DISCUSSED

Only those items listed on the attached agenda may be considered at this meeting.

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 one third of the membership

DISCLOSURE OF INTERESTS

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

DISCLOSURE OF INTEREST

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

DISCLOSABLE PERSONAL 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 fo 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 a, '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 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.

3 STATEMENT FROM THE CHAIR

4 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 21st November 2012 and to deal with any matters arising, attached.

5 JOINT HEALTH AND WELLBEING STRATEGY REVISED DRAFT

To consider the report of the Director of Public Health seeking approval of a revised Joint Health and Wellbeing Draft Strategy document and recommendation of the final strategy document to the City Council Cabinet and the Clinical Commissioning Group Executive for adoption, attached.

6 111 NON EMERGENCY SERVICE

To consider the report of the Commissioning Manager Unscheduled Care Southampton and South West Clinical Commissioning Group detailing the scope of the 111 Service, key elements of the implementation plan and the way in which it is likely to impact on other elements of unscheduled care across the system, attached.

7 REDUCING UNSCHEDULED ADMISSIONS - MENTAL HEALTH SUPPORT

To consider the report of the Joint Associate Director of Strategic Commissioning detailing the current provision of mental health services, links between physical and mental health and local initiatives designed to improve support for local people with mental health illnesses which would lessen the demand for unscheduled emergency treatment, attached.

Tuesday, 15 January 2013 Head of Legal, HR and Democratic Services

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SHADOW HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 21 NOVEMBER 2012

Present: Councillors Rayment, Bogle, Stevens, Baillie, Turner, Dr S Townsend, Mr H Dymond, Mr C Webster, Ms M Geary and Dr A Mortimore

Apologies: Councillors Dr S Ward

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

To approve and sign as a correct record the Minutes of the meetings held on 19th September 2012 and to deal with any matters arising, attached.

8. **REDUCING ADMISSIONS TO HOSPITAL FROM PREVENTABLE CAUSES OF PHYSICAL AND MENTAL ILL HEALTH**

The Shadow Health and Wellbeing Board considered the report of the Chair, Clinical Commissioning Group detailing how the Southampton City Clinical Commissioning Group would reduce avoidable admissions by improving the management of long term conditions and developing ways of increasing care available in the community.

The CCG had outlined its approach to achieving a healthy and sustainable system within its Clinical Commissioning Strategy 2012-17 and prioritised the following:-

- Gain more control within the system recognising that the way patients accessed services in the present system was too random and variable. More systematic arrangements were needed to drive up quality.
- Focus service redesign work on strategic priorities in mental health, early years and care for older people. The management of long term conditions in cardiovascular health, lung health, diabetes and mental health would be centred on improving care pathways, including self care, integrated care management and complex needs, but also recognised the links across pathways so that improving one would potentially help with the others.
- bringing it all together through the transformational approach of Integrated Person-Centred Care

The Board supported in principle the approaches that had been suggested and made the following points:-

- Concern that members of the public would perceive the approach as a way of saving money rather than being in the interest of the patient, therefore it may be useful to use different terminology and to have an educational/publicity programme in place as part of delivery. “Care Closer to Home” was suggested as an alternative description.
- Carers were often elderly and caution was needed in relation to pressures on carers and that this process was not about preventing admissions that needed to be.
- That the report contained limited information on mental health support and the impact of the introduction of 111 services.

- Was there confidence that GP's could provide the quality of care that would be needed?
- The Portsmouth Programme of target sessions to deliver training, peer reviews and identify steps to improve practice delivery which it was noted Southampton GP's were keen to see introduced.
- That as part of the role of the Health and Wellbeing Board a way to track lessons learnt was needed, a quarterly report was suggested.

RESOLVED

i. That the areas of priority be supported;

ii. That detailed consideration be given at the January meeting of the Health and Wellbeing Board to the subjects of improving mental health support and the arrangements for implementing and operating the new 111 service and the ways in which they could contribute to reducing hospital admissions; and that the appropriate representatives of Hampshire Constabulary be invited to attend; and

iii. That a reporting system be developed to provide progress updates to the Health and Wellbeing Board.

9. **SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP PROGRESS TOWARDS AUTHORISATION**

The Shadow Health and Wellbeing Board received and noted the report of the Chair, Clinical Commissioning Group detailing progress towards the Clinical Commissioning Authorisation.

The Board noted that Southampton City Clinical Commissioning Group was currently functioning in Shadow format and was working towards Authorisation by March 2013 and would be in Wave 4 with the requirement for initial documents to be submitted on 1st November 2012 and a site visit on 14th December 2012.

The Clinical Commissioning Group had 37 constituent member GP practices working in three localities; East, West and Central serving a registered population of 265,000 with a delegated budget for 2012/13 of about £340 million. It was noted that their mission was to:

"To become an organisation that was focused on our communities, striving to make healthcare decisions relevant to those we served. We would engage meaningfully with patients and the public to seek greater ownership of and personal responsibility for health choices to achieve our goal of a healthy City for all."

The SHIP PCT Cluster would remain the Accountable organisation for 2012/13, however PCT's would cease in April 2013 when the NHS Commissioning Board local teams, wider role for Public Health England and Commissioning Support Organisations would commence.

The Board noted that Southampton were well ahead of other areas nationally in that there were good working relationships with the NHS and the Local Authority in place.

10. **JOINT HEALTH AND WELLBEING STRATEGY**

The Shadow Health and Wellbeing Board considered the report of the Director of Public Health detailing the post workshop which took place at an informal meeting of the

Health and Wellbeing Board in November which provided for a further re-shape of the strategy taking account of stakeholder and public feedback from the consultation draft.

The Board particularly noted the revised outcomes of the informal workshop which recommended the following:-

- Consensus on the issues covered which had been endorsed by the wider consultation.
- Reduce the strategy from five priorities to three themes:
  - Theme 1 Building resilience and prevention to achieve better health and wellbeing to combine aspects of Priority 3 (work) and 5 housing
  - Theme 2 will be Best start in life
  - Theme 3 will be Ageing and living well
- The actions that emerged from the three themes needed to be
  - Achievable in number and realistic given budgetary constraints
  - Actions needed to stretch/transform outcomes
- That Director's re-look at sections and actions to be included for the next revision of the strategy.
- That the Board hold partners to account regarding delivery of health and wellbeing actions and outcomes.

RESOLVED

i. That the strategy be revised to take account of the comments raised; and
ii. That the three key themes be approved.

11. **JOINT COMMISSIONING STRATEGY**

The Shadow Health and Wellbeing Board considered the report of the Chair, Clinical Commissioning Group detailing the progress towards a joint commissioning strategy which had been developed on the experiences of many years of partnership work between health and social care across the City of Southampton.

The Board noted that joint commissioning had initially started with pooled budgets, using Health Act flexibilities for mental health, substance misuse and learning disabilities and joint appointments for managers to lead the work on behalf of both organisations. In 2009 work was further strengthened when the Primary Care Trust and Southampton City Council moved to a formal alignment of commissioning for Adult Health and Social Care Services with the appointment of an Associate Director to discharge leadership for both organisations.

The Board also noted that recently Southampton City Council and Southampton City Clinical Commissioning Group had confirmed their commitment to continuing with joint commissioning arrangements within the newly restructured NHS arrangements and the wish to explore opportunities for developing this further. A Joint and Integrated Commissioning Board comprising of the Clinical Commissioning Group Chair, Accountable Officer and Elected Members and Directors from the City Council were

developing proposals based on the report to further develop Joint Commissioning including the development of a shared team.

The Board noted that The Joint Commissioning Framework set out how the organisations would commission together and outlined the areas of focus for Integrated Commissioning and the organisational and governance structures required to support effective and safe implementation.

The Board made the following points:-

- It was important for the Board to track and receive detail around the provision of person centred care in order that they could challenge and act as the critical friend where necessary.
- There were three priorities that had been identified within the strategy; it was suggested that these should mirror the three themes of the Joint Health and Wellbeing Strategy for consistency.
- That an implementation programme with timelines needed to be in place as this would change the way in which business was conducted.
- That there should be a briefing for all Members of the City Council on this strategy.

RESOLVED

i. That the principles for joint integrated commissioning outlined in the strategy be approved;
ii. That the necessary steps be taken to ensure that the actions contained in the final version of the Joint Health and Wellbeing Strategy were reflected in future years' commissioning plans; and
iii. That the implementation of the Strategy be supported.**PROPOSED CONTENT OF REGULATIONS FOR HEALTH AND WELLBEING BOARDS**

The Shadow Health and Wellbeing Board received and noted the report of the Director of Public Health detailing a publication from the Department of Health outlining draft regulations that were proposed to be laid before Parliament in January 2013 and come into force on 1st April 2013 governing the operation of Health and Wellbeing Boards.

The Board noted that the creation of Health and Wellbeing Boards as a Committee of the Local Authority did not align with the current legislation dealing with the appointments of Committees.

The Board noted that the following areas were proposed to be clarified within the new regulations:-

- Establishment of sub-committees and delegation
- Voting restrictions
- Political proportionality requirements
- Disqualification for membership
- Application of a code of conduct and declarations of interest
- Application of transparency provisions.

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DECISION-MAKER:		SHADOW HEALTH AND WELLBEING BOARD		
SUBJECT:		JOINT HEALTH AND WELLBEING STRATEGY – REVISED DRAFT		
DATE OF DECISION:		23rd JANUARY 2013		
REPORT OF:		DIRECTOR OF PUBLIC HEALTH		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Martin Day**	**Tel:**	**023 80917831**
	E-mail:	**Martin.day@southampton.gov.uk**		
Director	**Name:**	**Dr Andrew Mortimore**	**Tel:**	**023 80833204**
	E-mail:	**andrew.mortimore@southampton.gov.uk**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

The Joint Health and Wellbeing Strategy for Southampton will set out a key priorities to improve health and wellbeing for people living in Southampton and to reduce health inequalities. At its meeting on 21st November the Board received feedback from the consultation undertaken on the draft strategy and identified 3 themes for the strategy that actions would be aligned against. A revised draft strategy document is now presented to the board for approval, which will then be circulated to those who participated in the consultation. The Board will then recommend the final strategy document to the City Council Cabinet and the Clinical Commissioning Group Executive for adoption.

RECOMMENDATIONS:

(i) That the revised draft joint health and wellbeing strategy be approved;

(ii) That the text of the revised draft strategy be circulated to stakeholders and the public who had responded to the consultation together with a summary explanation of the changes made in the light of the consultation responses.

REASONS FOR REPORT RECOMMENDATIONS

1. To move forward with the development of the first joint health and wellbeing strategy and to ensure that stakeholders and individuals who responded to the consultation process are informed of the key changes made to the strategy in the light of the comments received.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None

DETAIL (Including consultation carried out)

3. The Health and Social Act 2012 places a duty on health and wellbeing boards to produce a joint health and wellbeing strategy, which must be adopted by the local authority and each clinical commissioning group in the local authority area, and which the local authority must publish.

4. A draft consultation strategy was approved by the shadow health and wellbeing board at its meeting on 13th June 2012. Following this a 3 month period of consultation and engagement was undertaken with stakeholders and the general public. At its meeting on 21st November the board considered a summary of the comments from the consultation exercise, and following a subsequent informal discussion concluded the strategy should be structured around the following themes:

   - Building resilience and prevention to achieve better health and wellbeing
   - Best start in life
   - Ageing and living well

5. The strategy has now been re-drafted around these themes and a revised document is attached at Appendix 1. Each theme has a number of actions that will deliver improvements to health and wellbeing and reduce health inequalities and measures have been identified, mainly from the national outcomes frameworks, against which progress can be tracked.

6. The Board is now asked to approve the revised strategy document. It is suggested that the revised document is then circulated to those who took part in the consultation and engagement. Then at its meeting on 27th March the Board will recommend the strategy for approval to both the City Council Cabinet and the Clinical Commissioning Group Executive.

RESOURCE IMPLICATIONS

Capital/Revenue

7. The resources for delivering the actions set out in the Joint Health and Wellbeing Strategy will be determined through the annual city council and CCG commissioning and budget cycles. Publication of the strategy will be met from existing budgets.

Property/Other

8. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

9. The duty to produce a joint health and wellbeing strategy is set out in section 193 of the Health and Social Care Act 2012.

Other Legal Implications:

10. None.

POLICY FRAMEWORK IMPLICATIONS

11. None.

KEY DECISION? Yes

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Southampton Joint Health and Wellbeing Strategy – Revised draft

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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Southampton's Joint Health and Wellbeing Strategy

Gaining Healthier Lives in a Healthier City

DRAFT

2013-2016

Revised Draft

January 2013

SOUTHAMPTON CITY COUNCIL

NHS Southampton City

NHS Southampton City Clinical Commissioning Group

Southampton's Joint Health and Wellbeing Strategy
Gaining Healthier Lives in a Healthier City

Contents

DRAFT

Southampton's Joint Health and Wellbeing Strategy
Gaining Healthier Lives in a Healthier City

Foreword

To be inserted following HWB approval of final draft plan

DRAFT

From the Cabinet Member for Communities, Southampton City Council and the Chair of the Clinical Commissioning Group (CCG).

Councillor Jacqui Rayment

Dr Steve Townsend

Section One – Background and Local Context

Introduction

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

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

Specific challenges highlighted in the JSNA include:

- Demographic pressures, especially the growth in the city's birth rate (around 35% in seven years)
- The increasing proportion of older people and accompanying increase in dementia
- Deprivation and children in poverty – the city is ranked the fifth most deprived local authority in the South East and 81st out of the 326 local authorities in England
- The increase in unhealthy lifestyles leading to preventable diseases
- The need to ensure high quality services for specific care groups, including those living with mental ill health, physical disabilities and learning disabilities
- The need to ensure that provider services are joined up and seamless to create robust care pathways for a 'whole person' approach
- The need to support carers to care and the need for volunteering
- Work and worklessness and the impact on mental health
- Recognising the impact on health of wider determinants (education, housing, transport and economic regeneration)

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

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Consultation

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

- Presentations to and debates at a number of key partnerships, including the GP Forum, Southampton Connect, the Children and Young People Trust Board and Southampton Safeguarding Children Board
- Public workshop sessions hosted by Southampton Local Involvement Network (LINk)
- Opportunities for on-line feedback on both the city council and PCT websites

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

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

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

The actions in the strategy are stratified into 3 themes:

- Building resilience and prevention to achieve better health and wellbeing
- Best start in life
- Ageing and living well

Using these 3 themes, actions can be linked back to the needs identified in the JSNA. They will secure a life course approach to improve health and wellbeing and provide a means of reducing health inequalities. They also provide scope for improved joint working across health and care systems, and the opportunity to develop a shared ambition and vision of success.

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

How we will ensure that things are improving

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

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

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Section Two – Key Themes to Deliver Change

Theme 1 – Building resilience and prevention to achieve better health and wellbeing

Why this is important

Developing a focus on health improvement priorities is essential to helping people improve their lifestyle and to reduce suffering from a series of long-term conditions over time. The consequences of smoking, alcohol and obesity have serious implications for individuals and are placing growing demands on health and care systems. Easy access to improvement and prevention programmes are key to improving quality of life for people affected and to reducing the number of cases of serious illness associated with them.

Work and housing have major impacts on health and wellbeing. The relationship between employment status, income and health is well documented with research clearly identifying links between poverty and health. Men aged 25-64 from routine or manual backgrounds are twice as likely to die as those from managerial or professional backgrounds. Sickness absence due to mental health problems costs the UK economy £8.4 billion a year and also results in £15.1 billion in reduced productivity. The evidence for 'good' work benefitting physical and mental health and well-being, is strong. Work can be therapeutic and can reverse the adverse health effects of unemployment. That is true for healthy people of working age, for many disabled people, for most people with common health problems and for long-term unemployed and those on prolonged sickness absence. In Southampton, the highest proportion of incapacity benefit claims are for mental health problems.

People living in poor quality or overcrowded housing tend to have poorer health. Appropriate adaptations can help people with disabilities live independently at home for longer which maintains physical and mental wellbeing for longer. Whilst the council and social landlords have invested in improving the quality of their properties to meet decent homes standards, there is a significant proportion of privately owned and privately rented homes that fail to reach this standard.

Key Information from the Joint Strategic Needs Assessment

- 22.3% of adults smoke in the city compared to 21.2% nationally
- £12-13m is spent in Southampton every year treating smoking-related illnesses
- 22% of adults are obese, as are 11% of children in the reception year at schools and 20.5% by year 6
- Hospital admissions for under 18s alcohol specific admissions is 111.8 per 100,000, which is 80% above the national average
- 23% of all homes in the city are in the social housing sector and over 17,000 of these are owned and managed by the council
- Southampton has over twice the national average of privately rented homes (24%) of which over 7,000 are Homes in Multiple Occupation
- Over 28,000 privately owned and rented homes (38% of the total) do not meet the Decent Homes Standard. 8,500 of these homes are occupied by vulnerable people

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- 250 single homeless people are seen each month by the Street Homeless Prevention Team
- The highest proportion of incapacity benefit claims are for mental health problems.

What we will do:

Smoking and Tobacco Control

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

Obesity and Physical Activity

- Identify and implement options that address the wider determinants of health and support healthy lifestyle behaviours leading to improved diet and physical activity in key target groups e.g. health promoting workplaces, breastfeeding friendly environments, healthy early years and childcare settings
- Support a range of initiatives and services that are effective in preventing and managing overweight and obesity in our high risk populations as part of the implementation of local weight management care pathways for children, young people and adults.

Alcohol and Drugs

- Work together with local agencies to help address the detrimental effects of adults' problem drug and alcohol use, particularly that of parents
- Sustain and expand public education initiatives that raise awareness around alcohol and substance misuse and maintain existing schemes to address underage drinking and associated behaviours
- Develop and expand the current services in Southampton through partnership working approaches that develop 'wrap around' services' (including housing and access to Education, Employment and Training) and link health, social care, housing, leisure, night-time activities and criminal justice to include tacking alcohol and substance abuse in young offenders
- Increase numbers accessing both drug and alcohol services with increasing numbers achieving recovery from alcohol or other drugs
- Review drug treatment services available to young people to ensure a best value, high quality treatment system which is reflective of young people's drug use
- Increase the range of interventions for crack cocaine users and stimulant users in effective treatment
- Develop an appropriate suite of abstinence and harm reduction services for blood borne viruses.

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Housing

- Ensure that people have access to good quality, energy efficient housing that is both affordable and meets their needs. The priorities below aim to maximise the opportunities to help promote health and wellbeing to the working age population across the city by working with local employers, improving economic wellbeing and helping young people into employment.
- Provide a holistic homelessness prevention service that supports people to make independent choices about their housing future
- Work with the voluntary and supported housing sectors and the Homeless Healthcare Team to ensure that provision in the city can meet the needs of the most challenging people to safeguard both their housing and health needs
- Consult on the introduction of 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 eradicated
- Develop local hubs of support and care in the city with high quality, well trained staff including promotion of dementia friendly communities with activities and interactions for people with dementia in the wider community
- Support falls awareness and design out areas of trips, slips and falls within council older person accommodation

Workplace Health

- Implement a programme of work to support employers to improve the health and wellbeing of their workforce through recognised good practice at work; improve the support for those stopping work due to sickness to get them back into work sooner or to rethink their future job prospects.
- 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)
- Promote and develop the 'Time to Change' campaign to reduce the stigma of mental health in the workplace

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

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

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

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Improved support for dementia in local settings	• Effectiveness of post-diagnosis care in sustaining independence and improving quality of life	ASC 2F / NHS 2.6i
Reduce risk of falls	• Fall and fall injuries in over 65s	PH 2.24
Workplace Health		
Support to employers	• Number of working days lost due to sickness absence • Rate of fit notes issued per quarter	PH 19ii PH 19iii
Helping vulnerable people into work	• Adults with LD in employment • Adults in contact with secondary mental health services in paid employment	ASC 1E ASC 1H
Reduce stigma of mental health in the workplace	• Adults in contact with secondary mental health services in paid employment	ASC 1H

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Theme 2 – Best start in life

Why this is important

Good outcomes in the early years, childhood and adolescence are a strong predictor of the health and wellbeing experiences of individuals throughout their life course. Most children and young people receive all the love, care and opportunities they need from their families supported by local community services to achieve success. However, too many children and young people have needs beyond the ability, capacity and, too often, willingness of their families and/or universal community based services to overcome. At these times more specialist services are needed.
Help can take many forms and usually involves elements of challenge as well as support. Its purpose is always to enhance the skills, resources, capacity and positive resilience of individuals, families and communities so that children and young people get the best possible start in life.

Over the last 10 – 15 years there has been significant research into the type of support that is most effective in improving outcomes and addressing inequalities. At the forefront of these have been studies in neuroscience, early attachment, parent/child interaction, early education and effective school and post-16 experiences. The evidence base from these studies has led to a number of policy developments, some resource intensive, including:

- The initiation of the Sure Start Children's Centre programme,
- the Family Nurse Partnership,
- the health visiting Call to Action initiative,
- the project to deliver free early education and child care places to vulnerable two year olds,
- the development of evidenced based parenting programmes
- the 'pupil premium'
- school-to-school partnerships
- sex and relationship curricula
- on-site school and college sexual health 'drop in' clinics
- the emphasis on whole family approaches including the Families Matter ("Troubled Families") initiative.

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

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

Key Information from the Joint Strategic Needs Assessment

- The child population (0-18 years) in Southampton is 51,284, 16,156 of whom are under 5, 28,965 of school age 5-16 and 6,163 aged 17-18. The pre-school population has seen a particular increase in recent years owing to the rising birth rate – a 36% increase in births over the last 8 years.
- There are 12,575 children living in poverty in the city which is 27.5% of

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Southampton's child population compared to 21.3% in England (in some wards of the city, this figure is as high as 42%).

- 14.1% of school children do not have English as their first language.
- There are approximately 460 children living in the care of the local authority at any one time.
- 42% of 5 year olds in Southampton have decayed, missing or filled teeth compared to 38% for England. (Based on 2006 dental survey)
- The number of mothers smoking in pregnancy have reduced but the overall figure of 19.4% is still too high. (Southampton postcode, UHSFT provider, 2011/12)
- Almost 24% of children in reception classes are overweight and 32% in year 6 classes. 9.6% of children are classified as obese in reception classes and 19.6% in year 6. (2010/11 figures)
- Southampton's under 18 conception rate was 49.2 per 1000 females aged 15-17 years in 2010 compared to an England rate of 35.4 and 42.5 for the city's ONS comparators.
- Southampton's alcohol specific related hospital admissions crude rate was 111.8 per 100,000 under 18s, this is significantly higher compared to the England rate of 61.8.
- Whilst breastfeeding initiation rates have consistently remained at around 75% over the past 4 years, maintenance of breastfeeding at 6-8 weeks remains an on going challenge at currently 47.2%.

Existing plans

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

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

What we will do

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

- Oversight of the development and implementation of an integrated commissioning approach for all key partners, particularly the local authority and NHS Southampton. This approach will help ensure the alignment of the work of all partnerships and networks, including that of the Children and

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Young People's Trust , linked to the national outcomes frameworks.

- Strengthening and promoting the links between agencies and services so that improved outcomes for children and young people can be enabled and delivered by the Trust even more effectively
- Identification of ways to mobilise the city's business sector, community groups and community representatives to help build community capacity and resilience so that the health and wellbeing needs of children, young people and families are met.
- Champion the work of the Trust to continue to raise learning standards generally, and particularly to broaden learning opportunities for 14-19 year olds through apprenticeships, diplomas, GCSEs and 'A' Levels so that Southampton outcomes catch up and surpass levels elsewhere

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

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

Priority	Measure	Outcomes Framework Reference / Local Measure
Promoting Health and Wellbeing	• Low birth weight	PH 2.1
	• Breastfeeding rates at 6-12 weeks	PH 2.2
	• Mothers smoking in pregnancy	PH 2.3
	• Percentage of children immunised by their second birthday for DTaP/IPV/Hib	TBC
	• Children in poverty	PH 1.1
	• Healthy weight at YearR and Year 6	PH 2.6
	• Tooth decay in children aged 5	PH 4.2
	• Chlamydia diagnosis rates	PH 3.2
	• Smoking prevalence – 15 year olds	PH 2.9
	• Teenage pregnancy rates	PH 2.4
	• Alcohol related admissions (under 18 year olds)	PH 2.18
	• Numbers of young people in treatment for substance misuse?	TBC

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	• Numbers in treatment for CAMHS?	TBC
Promote learning, achieving and aspiring for all	• Foundation Stage (age 5) Foundation Stage Progress: good attainment (Readiness for school) • Key Stage 1 (age 7) Level 2+ attainment in Reading, Writing and Maths (separately) • Key Stage 2 (age 11) Level 4+ attainment in English and Maths (combined) • Key Stage 4 (age 16) 5+GCSEs or equivalents at A*-C (including English and Maths) • Percentage of parents getting their 1st preference in school place (all phases) • Percentage of total absence from school • The attainment gap for vulnerable Southampton children and young people (FSM, SEN, CLA, EAL) from Early Years Foundation Stage to Key Stage 4 • Percentage of young people NEET • Sure Start / early years take-up / payment by results • Exclusion from school (fixed term and permanent) • EBacc attainment • Level 3 attainment at age 19	TBC TBC TBC TBC TBC TBC TBC TBC TBC TBC TBC TBC
Keeping children safe from harm, abuse and neglect	• First time entrants to the youth justice system • Percentage of Initial Assessments carried	PH 1.4

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	out within 10 days • The timeliness of initial child protection work for vulnerable children • Percentage of Children Looked After with a permanence plan in place • Care leavers in suitable accommodation • Numbers of troubled families supported by local agencies and numbers supported in turnaround (rewarded) • Levels of prevention work; e.g. through PreCAF / CAF • Adoption (levels and timescales) • Social care quality assurance audit outcomes • Young offenders in suitable accommodation • Rate of Child Protection Plans against comparators • Rate of Children in Need against comparators • Rate of Children Looked After against comparators • Hospital admissions caused by unintentional and deliberate injury	

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Theme 3 – Ageing and Living Well

Why this is important

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

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

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

Key information from the Joint Strategic Needs Assessment

- The number of people over 85 in the City is forecast to grow from 5,200-6,000 between 2010 and 2017 – an increase of over 15%.
- In the wealthiest part of Southampton, in Bassett, a man can expect to live to 80.6 and women 84.0 years, while a few kilometres away in Bitterne, one of the cities poorer wards, life expectancy is 75.3 and 79.9 years for males and females respectively. These differences in life expectancy of 5.3 and 4.1 years respectively for men and women are significant.
- The numbers of people with long term conditions requiring health and social care solutions is increasing and set to grow, now representing 30% of the population but utilising 70% of NHS and Social Care resources. For example one third of people over 65 years will die with dementia and 25% of hospital beds are occupied by someone with dementia as part of the diagnosis.
- There are 7 areas in the city were Income Deprivation Affecting Older People is in the worst 10% for England, they are mainly clustered in the central areas of the city with the exception of Weston
- It is estimated that in the winter of 2008/09, 113 people died in Southampton because of cold weather. In the UK, frail, elderly women are the most vulnerable group
- In 2010/11 2,500 people had been identified as suffering from dementia. Of those, 2/3 live in the community, and 1/3 live in care homes.
- The number of hip replacements performed increased by 31.9% over 5 years from 2004/05 to 2008/09, while in the same period the number of knee replacements performed increased by 16.3%.
- 202 people per 1,000 aged 65 or over received adult social care services, compared with an England average of 123.5 per 1,000.

- During 2010/11 adult social care services undertook the following activities.
    - 9,222 people received community care
    - 837 people were supported into permanent residential care
    - 410 people were supported into nursing care
    - 3,659 new people were assessed
    - 2,047 new people received services

What we will do

Tackling poverty

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

Prevention and earlier intervention

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

Being 'person' centred and not 'disease' centred

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

Care of long-term conditions, including cancer and dementia

- Work with GPs to more accurately achieve earlier diagnosis of those most at risk of experiencing dementia
- More support for people with dementia to remain in their own homes for as long as it is safe for them to do so
- The development of extra-care services for people with long term conditions and those with dementia.
- Launching a new approach to provision of equipment which encourages better access and information for individuals able to fund themselves and improves the timelines of response to those requiring equipment to maintain their independence.

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- Raising awareness amongst all care and health staff about appropriate care for people with dementia and about mental capacity issues
- Work with the Clinical Commissioning Group and providers of social care to raise the standard of medicines management across the health and care system.
- To prevent cancer and improve health outcomes of those living with cancer action will be taken to improve understanding amongst the public about the signs and symptoms of cancer and encourage early checks with their GP.

Improve the response to learning disabilities

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

End of life care

- Increase public awareness and discussion around death and dying
- Map current provision to ensure that appropriate national care pathways are incorporated and audited in hospitals and the community
- Extend palliative care to other diseases besides cancer and ensure access to physical, psychological, social and spiritual care.
- Establish an end of life care register accessible to all appropriate service providers (e.g. Out of Hours Service)
- Have timely bereavement counselling available.

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

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

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

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	independence and improving quality of life	2.6(ii)
Staff awareness about dementia	To be developed	Local measure
Developing extra care services	• At home 91 days after hospital discharge	ASC 2B
Provision of equipment	• At home 91 days after hospital discharge • Control over daily life	ASC 2B ASC 1B
Improving medicine management	• Prescribing rates for anti-dementia drugs • Prescribing rates for antipsychotic drugs in dementia • Medication reviews for patients	NHS 4.4 (i)
Cancer – screening and treatment	• Under 75 mortality rate from cancer	NHS 1.4 (i) and (ii) / PH 4.5
Improving the response to Learning Disabilities		
Annual health checks for people with learning disabilities	• Client satisfaction • Take up of learning disability health check	ASC 3A
Co-ordination and promotion of services	• Adults with LD living in own home or with family	ASC 1G
Improving employment	• Proportion of adults with LD in employment	ASC 1E
LDPB involved in shaping improvements	• Client satisfaction	ASC 3A
End of life care		
Awareness and discussions around death and dying	• Bereaved carers view of quality of care in last 3 months of life • Numbers of patients on appropriate recognised care pathways	NHS 4.6 Local measure
Use of appropriate national care pathways		
Extension of palliative care to other conditions		
End of life care register		
Availability of bereavement counselling		

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Section 3

Conclusions

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

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

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

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Southampton Shadow Health and Wellbeing Board Members

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

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DECISION-MAKER:		SHADOW HEALTH AND WELLBEING BOARD		
SUBJECT:		111 NON-EMERGENCY SERVICE		
DATE OF DECISION:		23rd JANUARY 2013		
REPORT OF:		COMMISSIONING MANAGER UNSCHEDULED CARE SOUTHAMPTON & SW CLINICAL COMMISSIONING GROUP		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Ann Penfold**	**Tel:**	**023 80296018**
	E-mail:	ann.penfold@hampshire.nhs.uk		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

The Health and Wellbeing Board examined initiatives to reduce unscheduled hospital admissions at its meeting in November 2012. One of the measures referred to in that report was the introduction of the new 111 non-emergency service. The Board indicated it wished to examine the details and capacity of the service in greater detail. This report outlines the scope of 111, the key elements in the implementation plan, and the way it is likely to impact on other elements of unscheduled care across the system.

RECOMMENDATIONS:

(i) That the Health and Wellbeing Board notes the arrangements for implementing the 111 service, and identifies any instances where the introduction of 111 might provide opportunities for joining up service elements and take pressure off other parts of the unscheduled care system

(ii) That the Health and Wellbeing Board reviews the operation of the 111 service after its first year of operation

REASONS FOR REPORT RECOMMENDATIONS

1. To respond to the Board's decision at its previous meeting to examine the 111 service in greater detail and assess its impact on other elements of the unscheduled care system.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None

DETAIL (Including consultation carried out)

The new 111 service

3. As set out in the "Equality and Excellence: Liberating the NHS", (DH publication 2010), the Government is committed to developing a coherent 24/7 urgent care service in every area of England, that makes sense to

patients when they have to make choices about their care, and in order to drive integration of services. To help deliver this, the new NHS 111 telephone number is being made available.

4. The NHS 111 service has been successfully piloted in a number of Primary Care Trusts (PCTs) and is now being rolled out nationally. Strategic Health Authorities (SHAs) have been tasked with ensuring that full coverage is achieved by April 2013 in accordance with the national NHS 111 Service Specification. SHIP Board of Clinical Commissioners (BoCC) agreed in October 2011 to commence with a programme of work to commission a NHS 111 mainland Hampshire service. CCGs are taking a lead on ensuring the availability of a comprehensive Directory of Skills and Services (DoSS) and associated referral protocols to underpin the delivery of NHS 111

5. The provision of a memorable three digit telephone number – NHS 111 – with a national brand and agreed service standards will make it easier for the public to make best use of care services. The aims of the NHS 111 Service in Hampshire are to:

- Provide call handling, clinical assessment and appropriate referral to other NHS services for NHS 111 calls in a defined geographic area;
- Provide consistent clinical assessment of patient needs at the first point of contact;
- Integrate with a directory of locally available services to enable patients to be directed to the right service following clinical assessment;
- Promote improved integration with other service providers to allow the forwarding of information and booking of appointments;
- Provide improved management information and intelligence regarding the demand and usage of non-emergency healthcare services enabling evidence based commissioning and proactive support to be offered to specific patient groups;
- Get people to the right service first time, including self-care where appropriate;
- Improve the public experience accessing healthcare;
- Reduce health inequalities by improving access;
- Provide Commissioners with management information regarding usage of services

- Enable greater use in the future of digital access channels reducing the need for telephone contact.

6. The aim of the NHS 111 Service is to ;
   - improve the efficiency of the urgent and emergency healthcare system by connecting patients to the right service in the right place, first time, thereby reducing the number of 999 incidents, and the number of attendances to Accident and Emergency (A&E);
   - improve patient and carer experience by providing clear, easy access to more integrated services;
   - provide a modern, efficient entry point to the NHS focused on patient needs and supporting the use of more cost-effective channels;
   - enable the commissioning of more effective and productive healthcare services that are tuned to meet patient needs, thereby reducing duplication and waste in the system;
   - Provide commissioners with management information regarding the usage of services

Implementation timetable and key milestones

7. The 111 service is set to go live during January 2013, and the key milestones are set out below:

   - The Department of Health will test the service for the SHIP area on week commencing 15th January 2013

   - On 22nd January the Department of Health are expected to fully authorise the SCAS service as 111 accredited; Just prior to that date NHSDirect staff will TUPE transfer into the SCAS call centre (they will be fully trained on Pathways in advance);

   - The new soft launch takes place on 22nd January 2013

   - On the 22nd January NHUC Out of Hours services will hook up to the 111 service for call handling / clinical triage, going live approximately 6.00 p.m. that day

   - NHSDirect calls will cease on 22nd January and the SHIP 111 service will become fully 24/7.

   Portsmouth City CCG will lead on behalf of the 111 and Portsmouth Health Ltd / HDOCs Out of Hours commissions. A managed transfer for future commissioner arrangements is taking place, involving working closely with Portsmouth City CCG leads,

Projected service volumes and capacity

8. Service volumes were based on the streamlining of a number of services, including Out of hours numbers, dental helpline numbers and NHS Direct, therefore a number of planning assumptions were made in order to develop the activity profile for the NHS SHIP 111 Service.

(i) That there will be less first contacts into Out of Hours(OOH) services given that 111 will be the OOH call handling service and a proportion of call dispositions are expected to be 'self-care' or visit pharmacy for over the counter(OTC) treatments

(ii) That there will be overall less OOH visits and /or surgery attendances but conversion rates of contacts will be higher: given that 111 will be the call handling service a proportion of calls will be 'self-care' or visit pharmacy for OTC treatments etc, but calls that are referred into OOH after assessment and triage through 111 are more likely require attendance / visit.

(iii) That there will be less overall A&E attendances: both minor and standard attendances are expected to reduce as a result of increase in referral to GP in hours / Pharmacy and / or self-care alternatives

(iv) That there will be more patients being referred to attend MIUs, Walk In Centres (being referred away from A&E / OOH and Ambulance service providers) as a result of appropriate disposition via assessment and triage by the NHS Pathways and DoSS

(v) That there will be an overall increase in referrals through to community and mental health services as a result of the 111 assessment and triage of patients using the Pathways / DoSS procedure.

(vi) That there will be a reduction in Category C calls (not serious or immediately life threatening) handled by Ambulance Services as a result of the availability of the alternative 111 non urgent call lines: calls will go through 111 and be dealt with via the assessment and triage through the NHS Pathways and DoSS procedure

(vii) That there will be a reduction in each acute health system of NEL admissions as a result of the overall reduction in referrals through the urgent pathway.

(viii) That there will be an increase in patients being seen or having a telephone consultation within in hours GP practices as a result of the 111 assessments and triage.

(ix) That there will be a reduction in NHS Direct calls / no more calls into NHSD (final termination date to be determined)

(x) That the calls currently being dealt with by the Dental helpline and Emergency Dental Services out of hours will be handled by the NHS 111 contract provider

(xi) That a proportion of GP Urgent calls into Ambulance for onward conveyance to Acutes will be redirected into community and mental health by contacting 111 professional help line.

9. The contract was tendered on the basis of a core number of contacts on a cost and volume basis with incentive payments for the achievement of performance goals set out in the contract, these performance goals are related to a threshold on calls transferred to 999, a threshold on callers advised to attend the A & E Department and increasing self-care advise.

The core activity for SHIP is set out below

Year 1 Nos	Year 2 Nos	Year 3 Nos	Year 4 Nos	Year 5 Nos
378,000 to 558,000	381,780 to 563,580	385,598 to 569,216	389,454 to 574,908	393,348 to 580,657

Plans for promoting the service

10. NHS 111 is National programme, the promotion of which is centrally controlled and incremental. This will be locally supported through the communications team.

Key risks identified affecting successful delivery, implementation and success of the 111 Service

11. If the core programme team are affected by the impact of the new structures and are slotted into new substantive roles before February 2013, there is a risk that core programme team will not be available to assist with the final stages of mobilisation. Actions are underway to transfer skills, knowledge and learning to all CCG commissioners.

If there is no permanent ongoing management of the DOSS following dissolution of SHIP PCT cluster, risk that DOSS will become inoperable for the 111 service. To mitigate this risk, a job description for DOSS lead has been developed and will be submitted to CSU for grading.

Measures that can identify whether the service has avoided admission to hospital

12. NHS 111 is an enabler in the unscheduled care system and key to the success of NHS 111 is an up to date and accurate Directory of Skills and Services(DOSS), the provider will be able to interrogate the DOSS and provide valuable information regarding dispositions arising through the use of

the pathways software and what services were available to refer patient to. This will enable commissioners to identify gaps in provisions and commission from an informed position.

The DOSS has been developed locally in partnership with providers to ensure accuracy, the ranking system available as a function of the DOSS has been configured to ensure patients are referred to the appropriate service for their needs.

RESOURCE IMPLICATIONS

Capital/Revenue

13. The cost to the NHS of the Service for Hampshire, dependent on volume of activity will be between £4m and £6m per year. There are no costs falling on the council.

Property/Other

14. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

15. The health and wellbeing board's powers to consider issues which impact on health and wellbeing of the population are set out in sections 194 – 196 of the Health and Social Care Act 2012.

Other Legal Implications:

16. None.

POLICY FRAMEWORK IMPLICATIONS

17. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

	None

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)
	None	

DECISION-MAKER:	SHADOW HEALTH AND WELLBEING BOARD
SUBJECT:	REDUCING UNSCHEDULED ADMISSIONS – MENTAL HEALTH SUPPORT
DATE OF DECISION:	23rd JANUARY 2013
REPORT OF:	JOINT ASSOCIATE DIRECTOR OF STRATEGIC COMMISSIONING
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

The Health and Wellbeing Board received a report in November 2012 regarding initiatives to reduce hospital admissions from preventable causes of both physical and mental ill health. The report outlined a variety of approaches to improving care for older people, people with alcohol problems and children, including emergency and urgent care services.

The Health and Wellbeing Board requested further information on improving mental health support in order to contribute to this programme. This report now describes the current provision of mental health services, examines the links between physical and mental health, and highlights some of the local initiatives designed to improve support for local people with mental health illnesses and which would lessen the demand for unscheduled emergency treatment.

RECOMMENDATIONS:

(i) That further opportunities for partnership working continue to be explored and developed, recognising that in the current financial climate the importance of a co-ordinated approach and the avoidance of duplication to achieve the best possible outcomes.

REASONS FOR REPORT RECOMMENDATIONS

1. To enable the Health and Wellbeing Board to set a baseline of information on mental health support.

DETAIL (Including consultation carried out)

2. **Mental Illness in Southampton**

In 2010/11 the City GPs recorded 24,163 patients on depression registers giving a crude prevalence rate of 9.1% for the city. This compares to the national average of 8.8%. In 2010/11 there were 2,585 people on Southampton GP's serious mental illness registers (includes schizophrenia, bipolar disorder and other psychoses). Over the 2008/10 period there were 77 deaths by suicide and undetermined injury to Southampton residents. In Southampton, the number of people presenting to hospital as a result of self harm has been rising year on year, from 562 in 2007/08 to 860 in 2009/10.

3. **Local Mental Health Provision**

A range of specialist services are commissioned from Southern Health Foundation Trust (SHFT) for people with serious mental health conditions. These services are provided in partnership with the City Council under

section 75 arrangements. This provides an integrated health and social care service which maximises efficiency and reduces risk. These services are organised into the following functions:

- Access and Assessment and Team – this is a single point of referral for all services and it is operational 24 hours a day, 7 days a week. This team provides assessment and brief interventions (time limited interventions which will resolve the presenting problem) This team also includes the Approved Mental Health Practitioner (AMHP) service, social workers who undertake additional training in order to undertake actions under the Mental Health Act including compulsory admissions.
- Community treatment Team – providing long term treatment through a range of different interventions and care planning. This team includes specialist approaches to people who are experiencing a first episode psychosis and an assertive outreach function for people who are difficult to engage.
- Inpatient Treatment services – these services are primarily provided at Antelope House, a specialist psychiatric unit which is on the Royal South Hants Site. There are 2 wards each consisting of 20 beds, 1 male and 1 female. Each ward also has an emergency bed. There is also a challenging behaviour unit called Abbey Ward which has 10 beds. This was previously a separate unit based in Netley. Antelope House also has a Psychiatric Intensive Care Unit (PICU) with 10 beds.
- Hospital at Home Service – this is also part of the Inpatient Treatment service and provides care to people in their own home who would otherwise need an admission to hospital. The service provides high intensity services which are tailored to the needs of the individual and their carers. This is a new service which has been operational for about a year and which is providing an effective alternative. The service manages between 20 to 26 individuals per month.
- Inpatient Rehabilitation Services – this service consists of 18 beds, 6 of which are purchased by NHS Hampshire for their residents, and a rehabilitation Team. The aim of this service is to enable people to regain skills in order to achieve maximum independence. In Southampton there has traditionally been an over reliance on inpatient rehabilitation but the number of beds has been reduced in recent years in favour of community based services which is more reflective of best practice. This service will need to be reviewed again in order to continue the shift towards maximising independence and Recovery.

- 136 Suite – this is a facility which provides a ‘place of safety’ for people detained by the Police in a public place. Section 136 of the Mental Health Act enables the Police to detain someone in order for them to have access to an assessment. Additional places of safety are the acute hospital and the police station. It is considered best

practice for people to be taken to a specialist 136 suite but there are occasions when this is not suitable – when someone needs medical attention or when someone is violent for example. Locally there are have been too many people going to police stations though there are a number of initiatives and local interest groups working to improve this *and recent figures show significant improvement.*

- Psychiatric Liaison Service – based at the acute hospital this service offers specialist assessment and input for people presenting with mental health problems. There are separate teams for adults and older people. These services were recently reviewed and it is acknowledged that additional and better co-ordinated services are needed to address the significant need. The adult service is commissioned by University Hospital of Southampton Foundation Trust (UHSFT) whilst the older persons service is commissioned by the CCG

In addition to services provided by statutory agencies there are a number of services provided by the voluntary sector which also support people to achieve as much independence as possible. These include :

- Natalie House – a 10 bedded high care residential unit which accommodates people for a maximum of 12 months. This service provides for people who cannot be discharge from straight from hospital into the community. The aim of the service is to enable people to move to more independent accommodation
- A range of Supported Accommodation providing low level support either in group homes or individual units.
- Floating Support Services – low level support to enable people to maintain their own tenancies.

People suffering from stress, anxiety and depression, who do not meet the criteria for specialist services, can be referred to the Steps To Wellbeing Service. This is provided by Dorset University Foundation Trust, who offer an evidenced based Cognitive Behavioural Therapy (CBT) Service. A range of interventions including self-help, supported self-help and individual therapies are provided.

4. Links between Physical and Mental Health

The prevalence of mental health conditions is particularly high amongst acute hospital inpatients. National evidence suggests that patient admitted to an acute setting have a 28 per cent chance of also having a diagnosable psychiatric disorder. A further 41 per cent have sub-clinical symptoms of anxiety and depression.

People with long-term physical illness are three to four times more likely to

have a mental illness than a healthy member of the population. Chronic physical illness can have a life-changing effect on an individual's wellbeing, functional capability and quality of life. Depression and/or anxiety disorders (as either a cause or a consequence of the physical illness) may exacerbate the perceived severity of the physical symptoms and add to the person's distress, resulting in increased use of healthcare services and poorer outcomes. For example:

- People who have suffered a heart attack have a 30% chance of developing depression (Davies et al 2004).
- Depression is common among people who suffer from diabetes. It has been estimated that almost 25% of people with diabetes also experience depression, with people with diabetes being two to three times more likely to suffer from depression than the general population
- COPD accounts for as many as one in eight medical admissions. Emergency admissions are also common, owing to a combination of acute exacerbations and increased incidence of panic attacks.
- Between 30% and 45% of patients attending chronic pain clinics are estimated to be clinically depressed. Patients with chronic pain are also likely to have a high degree of health anxiety about their pain
- The prevalence of post-stroke depression has been estimated to be as high as 61%.

Elderly patients are at high risk for depression and cognitive disorders, the latter of which can be chronic (as in dementia) or acute (as in delirium). Delirium is amongst the most common complications in the hospitalisation of older people and national recommendations advise that;

- Routine cognitive assessment in unwell older people would improve detection rates
- Better systems of routine care, delirium could be prevented in at least a third of patients

National reports highlight that dementia is a predictor of a higher probability of inappropriate or delayed discharge. An increased length of stay is reflected locally in benchmarking 'Balance of Care' data undertaken by NHS Hampshire suggests that 50% of dementia in general hospitals is unrecognised.

Research published by DEMOS reported that people with dementia are deteriorating whilst in hospital; they experience a worsening of symptoms of dementia and the development of physical health problems. It is also reported that 'every day in hospital the chance of being prescribed unnecessary antipsychotics or entering a care home increases'

People who self-harm also represent significant need. During a nine-month period to 30th April 11 to 31st January 12, a total of 623 people visited the USHFT Emergency Department for self-harm and according to USHFT

data, 24% of the top 50 adult attendees (April 10 –March 11) were identified as having self-harm related admissions.

28% (176) of patients visiting ED for self-harm were admitted to a hospital bed.

5. Local response

The information above demonstrates a clear link between mental and physical health and an urgent need to strengthen both the provision of mental health care to people with physical illness and the quality of physical health care provided to people with mental health problems. Traditionally this link has not been well developed With under-diagnosis of mental health problems in people accessing general health services and the physical health of people with mental health problems being poorly addressed.

Hospital liaison services can improve care and bring cost savings by allowing patients to be discharged earlier if their mental health needs can be addressed and by reducing rates of readmission. An effective liaison service therefore can improve health and save money. A number of pieces of work using pilot approaches and payment incentives have been developed to address these issues:

- Psychiatric Liaison CQUIN – the national incentive scheme which is built into NHS contracts is being used to pilot an enhanced service following a review of current arrangements. The aim is to provide increased training to staff in acute services to identify mental health conditions, improved access to specialist assessment including better contact times, a proactive approach to referral onto community teams, improved pathways between acute and community care and identification of service gaps. The pilot will roll out over the next 12 months and findings will be used to inform future commissioning.
- Long Term Conditions Project – this is a scheme which aims to increase the capacity of community staff in identifying people suffering from stress, anxiety and depression and to enable them to provide low level interventions and self-management techniques and referral on to more specialist services where necessary. This project is being evaluated by Southampton University with the aim of identifying whether outcomes of physical health conditions can be improved by psychological approaches.
- Dementia Challenge project - Southampton has been awarded funds from a national grant to improve dementia services in the acute hospital. The award was for 280K to be spent by April 2014. The project aims to Increase the understanding of dementia across the workforce through a significant training programme, improve the quality of the physical environment so that disorientation is reduced, implement person centred care approaches, reduce the use of antipsychotics and improve pathways of care including the interface between health and social care.

- Increased access to psychological therapies for older people and people with long term conditions – it is preferable that people with common mental health problems such as stress and depression are referred for treatment as soon as possible. In addition to acute and specialist based services we are therefore targeting staff working with people newly diagnosed through GP's, community services, alcohol and substance misuse services. This is being addressed through a variety of methods including training, joint working and out-reach clinics. We are also able to compare recovery rates for different groups in order to develop adapted approaches.

Actions to improve the mental health of the whole population as a preventative measure which we believe will also impact on physical health outcomes. A local strategy 'Be Well' launched in October 2012, which is in line with the national mental health strategy 'No Health Without Mental Health', is based on the principle that good mental health and resilience is fundamental to our physical health, relationships, education, work and achieving our full potential.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

6. None. The report is supplying addition information requested at the previous meeting and not seeking a specific decision from the Health and Wellbeing Board.

RESOURCE IMPLICATIONS

Capital/Revenue

7. The Department Of health requires the Local Authority and PCT to undertake a financial mapping exercise on an annual basis. This is used to identify investment against priority areas. The 2011/12 mapping indicates a combined total of £37,543, 000 invested in adult mental health services. Investment in 2012/13 is 4.9m for the Local authority and 33,3m from the PCT.

Property/Other

8. None.

LEGAL IMPLICATIONS

Statutory Power to undertake the proposals in the report:

9. There is a statutory requirement to identify and fund services to meet assessed need within our eligibility criteria under the Community Care Act 1993. There is a statutory requirement to provide services under the Mental Health Acts 1983 and 2007.

Other Legal Implications:

10. None.

POLICY FRAMEWORK IMPLICATIONS

11. Prevention is a theme in the draft Joint Health and Wellbeing Strategy which will be adopted in for 2013/14. Good mental health services contribute to a range of health and wellbeing targets across all age ranges and helps people

to live as independently as possible.

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SUPPORTING DOCUMENTATION

Non-confidential appendices are in the Members' Rooms and can be accessed on-line

Appendices

1.	None

Documents In Members' Rooms

1.	None

Integrated Impact Assessment

Do the implications/subject/recommendations in the report require an Integrated Impact Assessment to be carried out.	No

Other Background Documents

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

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

WARDS/COMMUNITIES AFFECTED:	All

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