Southampton's Joint Health and Wellbeing Strategy

Gaining Healthier Lives in a Healthier City

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

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

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.

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.

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.

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

- 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.

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

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

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

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

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

	• 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

	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	

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.

- 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.

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 2.6(ii)

	independence and improving quality of life	
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		

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.

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