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Health and Wellbeing Board

Wednesday, 25th March, 2015 at 5.30 pm

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Shields (Chair)
Councillor Jeffery
Councillor Baillie
Councillor Lewzey
Councillor Chamberlain

Rob Kurn – Healthwatch
Alison Elliott – Director, People
Dr A Mortimore – Director of Public Health
Dr S Townsend – Clinical Commissioning Group (Vice Chair)
Dr S Ward – NHS England Wessex Local Area Team

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BACKGROUND AND RELEVANT INFORMATION

Purpose of the Board

The purpose of the Southampton Health and Wellbeing Board is:

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

Responsibilities

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

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

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

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

Southampton City Council's Priorities:

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

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

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

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

Dates of Meetings: Municipal Year 2014/15

2014	2015
14 May	28 January
30 July	25 March
1 October	
3 December	

CONDUCT OF MEETING

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

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

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

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

DISCLOSURE OF INTERESTS

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

DISCLOSABLE PECUNIARY INTERESTS

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

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

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

Other Interests

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

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

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

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

Principles of Decision Making

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

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

In exercising discretion, the decision maker must:

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

AGENDA

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

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

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

2 STATEMENT FROM THE CHAIR

3 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

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

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

4 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the Minutes of the Meeting held on 28 January 2015 and to deal with any matters arising, attached.

5 2014 JOINT HEALTH AND SOCIAL CARE LEARNING DISABILITIES SELF-ASSESSMENT FRAMEWORK

Report of the Director of Quality and Integration, Southampton City Clinical Commissioning Group detailing the second Joint Health and Social Care Learning Disabilities Self-Assessment Framework (the 'SAF') return, attached.

6 NHS FIVE YEAR FORWARD VIEW: NEW MODELS OF CARE

Report of the Chief Executive, Southampton City Clinical Commissioning Group detailing the NHS Five Year Forward View: New Models of Care for information and comment, attached.

7 DEPARTMENT OF PUBLIC HEALTH ANNUAL PLAN 2014

Report of the Director of Public Health detailing the Public Health Annual Plan 2014 for information and comment, attached.

8 HOUSING AND HEALTH FUEL POVERTY PLAN 2014-2017

Report of the Director of Public Health detailing the Housing and Health Fuel Poverty Plan 2014-2017 for information and comment, attached.

9 BETTER CARE SOUTHAMPTON IMPLEMENTATION

Report of the Director of Quality and Integration, Southampton City Clinical Commissioning Group detailing progress on the implementation of Better Care Southampton for information and comment, attached.

TUESDAY, 17 MARCH 2015 HEAD OF LEGAL AND DEMOCRATIC SERVICES

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 28 JANUARY 2015

Present: Councillors Baillie, Lewzey, Shields (Chair) and Chamberlain, Dr Steve Townsend (Vice-Chair), Dr Stuart Ward and Rob Kurn, Stephanie Ramsey and Dr Bob Coates

Also in Attendance Paul Burns – Primary Care Commissioning (PCC)
Ros Cassy – Southampton Keep our NHS Public (SKONP)
Sue Dewhirst – Public Health England, Wessex
John Richards – Chief Executive, NHS Southampton Clinical Commissioning Group

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

The Board noted the apologies of Councillor Jeffery, Dr Andrew Mortimore and Alison Elliott. The Board further noted that Dr Bob Coates and Stephanie Ramsey were in attendance and represented Dr Andrew Mortimore and Alison Elliott respectively.

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

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

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

30. **STATEMENT FROM THE CHAIR**

The Chair made a statement in accordance with accepted practice and informed Board Members that the Guidance relating to the NHS's "5-Year Vision" had been published and a paper providing details would be submitted to the March 2015 Meeting.

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

RESOLVED that the Minutes of the Meeting held on 3 December 2014 be approved and signed as a correct record.

Matters Arising:-

- Minute No 24 (Page 13 and 14) – Health Overview and Scrutiny Panel Inquiry Report : The Impact of Housing and Homelessness on the Health of Single People – the report had been submitted to the Cabinet Meeting on 20 January 2015 and it was noted that 18 of the 25 recommendations had been approved.
- Minute No 26 (Page 15 and 16) – Better Care Southampton Update – a workshop had been held today providing details on how officers could communicate with members of the public and how service users could access the facilities being provided. It was noted that Healthwatch would have a large

role to play in communicating with the public with regard to the Better Care Plan and its services.

- Minute No 27 (Page 16) – Care Act 2014 – an update report would be submitted to the March 2015 Meeting.

32. **PHARMACEUTICAL NEEDS ASSESSMENT (PNA)**

The Board considered the report of the Director of Public Health providing details of the Post-Consultation Pharmaceutical Needs Assessment (PNA) for approval.

The Board noted the following:-

- the statutory 60 day Consultation had closed on 18 December 2014 and the majority of responses received were supportive of the draft PNA. The limited comments offered provided no reason to alter the conclusions of the final PNA;
- the final PNA document required to be published by 1 April 2015 and would be refreshed on a 3-yearly basis;
- the PNA linked closely to the Joint Strategic Needs Assessment (JSNA) and whilst the JSNA focussed on the general health needs of Southampton's population, the PNA focussed on how those health needs could be met by Pharmaceutical Services;
- NHS England were the commissioners of Pharmaceutical Services and would utilise the PNA document as a tool to provide a strong and resilient service;
- that all Pharmacies should provide the same core services; and
- that patients were being encouraged to seek advice from Pharmacists rather than attending an A and E Unit.

RESOLVED:-

(i) that the responses recommended by the PNA Steering Group to points raised in the Consultation be endorsed and the Consultation Report be approved;

(ii) that the Post-Consultation Pharmaceutical Needs Assessment be approved and adopted by the Board for publication on 1 April 2015;

(iii) that authority be delegated to the Director of Public Health following consultation with the Chair and Vice-Chair of the Board to make any drafting or other changes necessary, including any amendments recommended by the Health and Wellbeing Board; and

(iv) that following publication of the PNA, authority be delegated to the Director of Public Health to publish any supplementary statements required by NHS Pharmaceutical Services and local Pharmaceutical Services Regulations (2013), to reflect any minor changes.

33. **SOUTHAMPTON LOCAL PLAN FOR THE BETTER CARE FUND : POOLED FUND DEVELOPMENT**

The Board considered the report of the Director of Quality and Integration, Integrated Commissioning Unit providing an update on the development of Southampton's Local Plan Better Care Pooled Fund.

The Board noted the following:-

- that the total Pooled Fund would be broken down into a number of smaller Pooled Funds, each with their own hosting arrangements and specifications, but under the umbrella of the overall Section 75 Partnership Agreement;
- that from April 2015 the following schemes would be phased in:-
  - Clusters (local person centred co-ordinated care);
  - Supporting Carers; and
  - Integrated Discharge, Reablement and Rehabilitation; and

  the following schemes would be phased in at a later date:-
  - Placements and Packages; and
  - Community Solutions and Prevention.
- that the Integrated Commissioning Board would oversee the effective management and performance of the overall Partnership Agreement and each of the individual Schemes within it on behalf of the Clinical Commissioning Group and Southampton City Council;
- that Southampton's Better Care Plan was designed to achieve its targets by agencies working together as a team providing early intervention to reduce incidents and future needs; the workforce would require to be flexible and willing to work together with trust being a crucial factor;
- political continuity was important and it was vital that all major parties supported the Better Care Plan.

RESOLVED:-

(i) that the decision made by Cabinet on 20 January 2015 and the CCG Governing Body today to establish a Pooled Fund for implementation of the Better Care Plan be welcomed;

(ii) that the Board supported the Council and the CCG Governing Body's approval of entering into a S75 National Health Service Act 2006 Partnership Agreement and that the minimum statutory requirement to pool £15.325m Revenue and £1.526m Capital be noted;

(iii) that the Board supported the Council and the CCG Governing Body's approval of exceeding the minimum requirement to pool up to the total value of the first three schemes identified in Section 13 of this report (Cluster Development, Supporting Carers and Integrated Discharge, Reablement and Rehabilitation) from 1 April 2015 and that Southampton's ambition to achieve integration at a total cost of approximately £61m be noted;

(iv) that the Board supported the Council and the CCG Governing Body's approval of the addition of the remaining budgets included within Section 13 of this report into the Pooled Fund as and when appropriate, bringing the total value to approximately £132m;

(v) that officers be requested to circulate a summary of the decisions made by the Integrated Commissioning Board in respect of the Pooled Fund to Board Members; and

(vi) that officers be requested to circulate the Better Care Fund Newsletter to Board Members.

34. **FEEDBACK FROM THE MENTAL HEALTH MATTERS ROUND TABLE EVENT, 4TH DECEMBER 2014**

The Board considered the report of the Senior Commissioner for Mental Health Services providing an overview of the first Mental Health Matters Event held on 4 December 2014.

The Board noted the following:-

- the Mental Health Matters Round Table Event highlighted key issues and challenges facing service users, commissioners and providers of Mental Health Services and explored the future of mental health in the City;
- that despite representation from service users and the Southampton Service User Network at the Event, more engagement with stakeholders was required; and
- Wessex Strategic Clinical Networks and the Clinical Senate were holding a Conference "Valuing Mental and Physical Health Equally in Wessex on delivering Parity of Esteem and the Crisis Care Concordat in Wessex" on 9 March 2015 at the Novotel Hotel, Southampton.

RESOLVED:-

(i) that the report be noted;
(ii) that Councillor Lewzey and Rob Kurn be elected as the Health and Wellbeing Board's Champions for mental health;
(iii) that the contribution by Southampton Connect in championing the issue of mental health to ensure its development into a cross cutting theme in the City Plan be acknowledged and welcomed; and
(iv) that the establishment of a Crisis Care Concordat Steering Group across Hampshire be welcomed and appropriate representation from the Steering Group be engaged in future Health and Wellbeing discussions on improving mental health in the City.

35. **HEALTHY SOUTHAMPTON BRANDING**

The Board considered the report of the Director of Public Health and received a presentation providing details of the "Healthy Southampton" Branding.

The Board noted the following:-

- that the World Health Organisation's definition of health was "a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity". The "Healthy Southampton" Branding could therefore provide a process for identifying work supported by this wide definition of health;
- "Healthy Southampton" encompassed the aspirations of the Health and Wellbeing Board and the logo would act as a visual anchor for the public facing work that the Board would be pursuing in the future; and
- as it was important to maintain control of the "Healthy Southampton" Brand it would be appropriate for the Health and Wellbeing Board to be the gatekeeper and maintain parameters for its use.

RESOLVED that the "Healthy Southampton" Branding as presented to the Board be adopted for use in the Health and Wellbeing Board's publications and activities.

36. **IMPROVING ACCESS TO GENERAL PRACTICE AND INNOVATION IN PRIMARY CARE - THE PRIME MINISTER'S CHALLENGE FUND**

The Board received and noted the report of the Chair, Southampton Clinical Commissioning Group providing details of a bid made by a Federation of Southampton GP Practices seeking funding from the Prime Minister's Challenge Fund for improving access to General Practice and stimulating innovative ways of providing Primary Care.

The Board noted the following:-

- that the first tranche of £50 million had been awarded last year and a group of six Southampton Practices had submitted a bid which had reached the national shortlist but had not been successful; and
- a Federation of a large number of Southampton GP Practices had been set up in 2014 and had put forward a bid for the second tranche of £100 million which had been announced in October 2014. The outcome of the bid would be known during February 2015.

RESOLVED:-

(i) that the report be noted; and
(ii) that the Board be informed of the outcome of the bid made by Southampton's Federation of GP Practices.

37. **MONITORING PROGRESS OF THE JOINT HEALTH AND WELLBEING STRATEGY**

The Board received and noted the report of the Director of Public Heath providing details of arrangements for monitoring and refreshing the current Joint Health and Wellbeing Strategy.

The Board noted the following:-

- a report providing information on the progress made in delivering the Joint Health and Wellbeing Strategy would be submitted to the March 2015 Meeting;
- that the view of the Board was that the Joint Health and Wellbeing Strategy should not be refreshed until the intentions of the Government in office following the General Election in May 2015 were known; and
- that the refreshed Joint Health and Wellbeing Strategy should address some of the health inequalities that had shown little improvement over the past decade.

RESOLVED that the report be noted.

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DECISION-MAKER:	HEALTH AND WELLBEING BOARD			
SUBJECT:	2014 JOINT HEALTH AND SOCIAL CARE LEARNING DISABILITIES SELF-ASSESSMENT FRAMEWORK			
DATE OF DECISION:	25TH MARCH 2015			
REPORT OF:	DIRECTOR OF QUALITY AND INTEGRATION SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP (CCG			
CONTACT DETAILS				
AUTHOR:	**Name:**	**Kate Dench**	**Tel:**	
	E-mail:	**Kate.dench@southampton.gov.uk**		
Director	**Name:**	**Alison Elliott, Director of People** **John Richards, Chief Executive**	**Tel:**	**023 8083 2602** **023 8029 6923**
	E-mail:	**Alison.Elliott@southampton.gov.uk** **John.Richards@southamptoncityccg.nhs.uk**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

This report informs the Health and Wellbeing Board of the second Joint Health and Social Care Learning Disabilities Self-Assessment Framework (the 'SAF') return.

The Learning Disability Health Self-Assessment began being used in England in 2007/8 and has become an important guide for the NHS and Local Authorities. It has helped them to recognise the overall needs, experience and wishes of young people and adults with learning disabilities and their carers. This has made it easier to bring these perspectives into the tasks of determining local commissioning priorities and monitoring of services.

The Framework has helped to improve services for young people with learning disability in many parts of the country by raising awareness of their health needs, driving increased health and Local Authority resources and improving interagency co-ordination. However, the events at Winterbourne View and subsequent investigations have demonstrated there is still much to be done. As a result of this, the *Transforming Care* report and the *Winterbourne Review Concordat* agreed to implement a joint health and social care self-assessment framework. It has been designed so that it becomes the main source of intelligence and data on learning disability in future years.

The SAF is showing that Southampton is effective in many areas but there are still significant areas of improvement especially in uptake of screening and ensuring timeliness of reviews.

RECOMMENDATIONS:

(i) To note the actions identified within the Action Plan (Appendix 1) and that there are areas which have been self-assessed as 'less effective' at this stage.

(ii) That a further report on progress of the actions set out in the SAF be brought back to the Health and Wellbeing Board in 12 months.

REASONS FOR REPORT RECOMMENDATIONS

1. As part of the governance arrangements, requested by Public Health England - Improving Health and Lives (IHAL) there is a requirement to present the assessment to Southampton's Health and Wellbeing Board, with a carer and self-advocate involved in that presentation.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None. The Department of Health has indicated it expects Health and Wellbeing Boards to be confident that the right leadership and infrastructure is in place to secure delivery of the actions required.

DETAIL (Including consultation carried out)

3. The framework has been further refreshed for 2014. The format for the SAF questions is broadly unchanged from 2013 and it has the same three sections with nine measures in each. The definitions and guidance have been revised mainly to make them clearer. In two questions the self-assessment framework specifically asks for direct views of carers and/or self-advocates. Previously 'shared stories' were part of the return. This element has been stopped in order to lean the process. IHAL will also be assessing two measures via national data returns (cancer screening and annual health checks). The aim is to ensure that the information collected will support action that improves outcomes for people with learning disabilities and their families.

4. The framework provides a single, consistent way of identifying the challenges in caring for the needs of people with learning disabilities, and documenting the extent to which the shared goals of providing care are met. Locally, this will help Learning Disability Partnership Boards, Health and Wellbeing Boards, Clinical Commissioning Groups (CCGs) and Local Authorities (LAs) to identify the priorities, levers and opportunities to improve care and tackle health and social care inequalities in their areas. It should also provide a sound evidence base against which to monitor progress.

5. Findings from the SAF will be used both locally and nationally.
   IHAL will publish a national themed analysis. The findings will also be reported to ADASS National Executive and Ministerial Programme Board, which includes NHSE leads with family carer (National Valuing Families Forum) and self-advocate (National Forum) representatives, on the progress in providing services in every part of the country to meet the aspirations of *Healthcare for All* and of *Transforming care: A National Response to Winterbourne View*. Locally, it will be used to inform:
   1. Joint Strategic Needs Assessment (JSNA)
   2. Health and Wellbeing Strategy
   3. Commissioning intentions/strategy
   4. Winterbourne improvement joint plans, including ongoing work regarding Southampton's Challenging Behaviour Policy Statement.
   5. Learning Disability Partnership Board work programmes

   The organisational arrangements of the new SAF will retain at its heart the principles of engaging with people with learning disability, their families and carers and of strengthening their voice. The governance arrangements set out below are designed to support this.

6. The governance structure is designed to facilitate local arrangements for reporting, planning and action. It is assumed that local authorities, through their Health and Wellbeing Boards, will provide the central leadership. IHAL will add their data to the overall SAF and give each local area a final rating (based on a RAG score), by mid-February 2015.

7. The SAF now comprises two comprehensive sections which needed to be completed and submitted to Public Health England by the end of January 2015. These are:
   • Data collation
   • Self-assessment against nationally agreed measures

   The following section gives an outline of each area and our initial findings from the assessment. The SAF is intended to be an up to date stock take of our local service. When it comes to performance numbers clear time frames were specified. In most cases this is either March 2014 or (if it is a snapshot question) March 31st 2014. But for the SAF questions (the 27 measures), which do not specifically specify a timeframe, we respond about our current position.

8. <u>Data collation</u>
   As part of the SAF framework we are required to collate a comprehensive and a wide range of data. There is now a combined data pull from local information, in Southampton's case we undertake a Miquest report, and IHAL will take Southampton's remaining data from routine statistical returns.

   This covers the following sections:

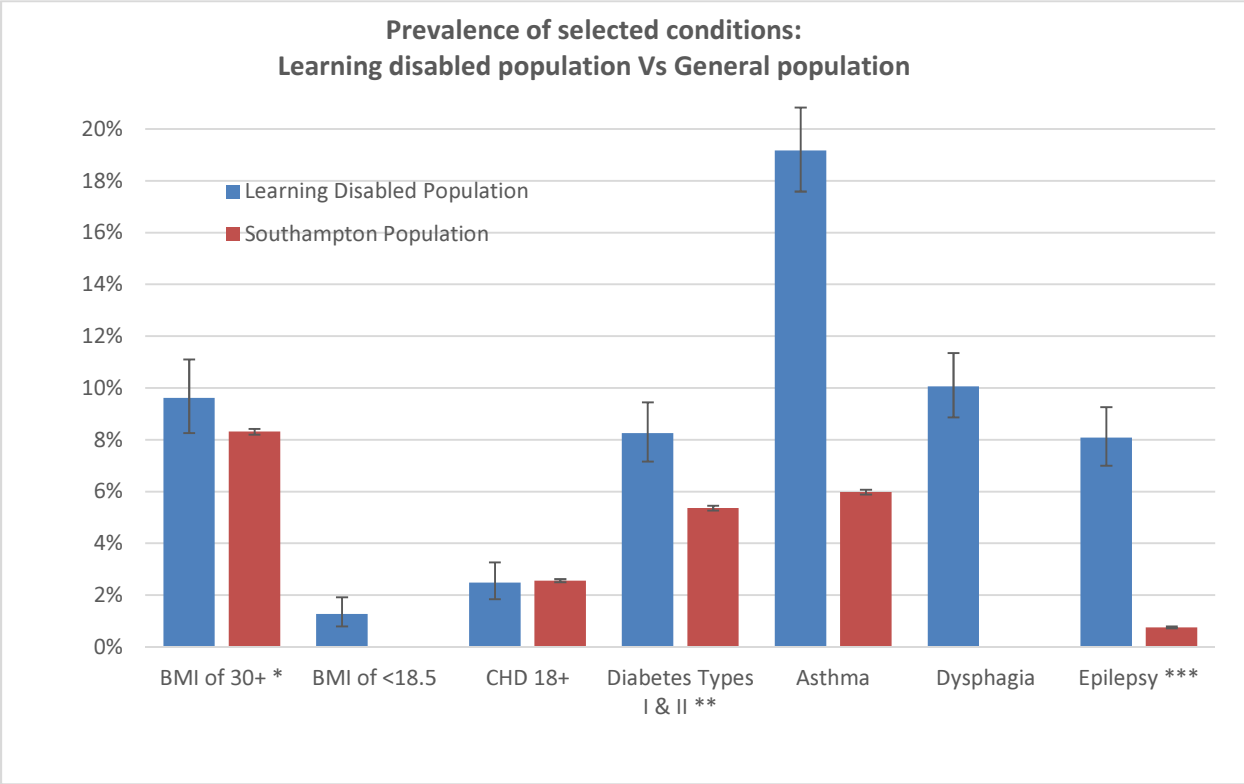
   - Demographics - Healthcare and health needs (such as numbers of people known to GP's)
   - Cancer screening
   - Wider health (e.g. BMI/diabetes/asthma/epilepsy)
   - Those in inpatient services, continuing healthcare and those with challenging behaviour
   - Mortality
   - Inclusion and where I live (e.g. employment and housing);
   - Children and young people in transition

   Completing the SAF meant gathering a large amount of data, however, due to the refreshed approach from IHAL this process has been leaner this year.

   Headlines from data collection for the Health and Wellbeing Board to note are:

   - 2,326 people with a learning disability are identified on GP registers. These are: 184 0-13 year olds; 134 14 – 17 year olds, 792 18-34 year olds, 1,046 35 – 64 year olds, 170 65 years and over. 166 of these people also have either profound or complex needs.

- The prevalence of epilepsy, asthma and diabetes shows significantly higher proportions for people with learning disabilities than the general population. The graph below shows a comparison for these measures.



- 103 people with learning disabilities are in receipt of Continuing Healthcare
- 41 adults with a learning disability, known to the council, were in paid employment and 46 in some form of voluntary work.

9. <u>Self-assessment against nationally agreed measures (SAF)</u>

As part of the SAF we were required to self-assess ourselves against 27 measures using a RAG 'Traffic Light' system. These are aligned to various outcome frameworks – Adult Social Care Outcomes Framework (ASCOF), Public Health Outcomes Framework (PHOF), National Health Service Outcomes Framework (NHSOF), Winterbourne View Concordat and Health Equalities Framework (HEF). These nationally agreed outcome frameworks and policies were used as the evidence base for the three broad areas in the SAF, which are:

- Section A – Staying Healthy
- Section B – Keeping Safe
- Section C – Living Well

The SAF action plan demonstrates that plans are in place to continue delivering change and improvements in the commissioning and delivery of care for people with learning disabilities to address health inequalities and achieve comparable health outcomes.

Each of the domain areas has a range of performance measures against which there are three possible assessment outcomes:

	Less Effective
	Effective
	Exceeds requirements

Section A – Staying Healthy

This asks questions about making sure people with learning disabilities can be as healthy as everyone else. It includes questions about making sure we have the right information about people, health action plans are in place, annual health checks occur and how we assess that people are being supported to manage their own health. It also asks questions whether universal or mainstream health services are making reasonable adjustments.

Comparing the RAG rating from 2013/14 with 2014/15; four of the nine standards maintained the same rating, three improved and two are now supplied by IHAL so a comparison is not possible. None of the standards in Section A became less effective.

The three standards which have an improved rating all moved from amber to green, they are:

- Learning Disability registers now reflect prevalence data and are stratified in every required dataset (Standard A1). This was achieved and prevalence reports will be updated annually.
- Primary care notification of LD status to other healthcare providers (A6). There is a system in place to enable this and evidence that both an individual's capacity and consent are inherent to the system.
- A Learning Disability liaison function is in place (A7). There is a work plan in place for LD liaison nurses in order to gain formal reporting to leadership boards.

Section B – Keeping Safe

This section looks at safeguarding and quality. Making sure that we design, commission and provide services which give people the support they need close to home and which are in line with well-established best practice. This was highlighted in the Winterbourne Review Concordat.

Comparing the RAG rating from 2013/14 with 2014/15; five of the nine standards maintained the same rating, three improved and one became less effective.

The three standards which improved were:

- Services commissioned for people with a learning disability have annual service and contract reviews (B2). This improved from red to amber because all services now have annual contract reviews. Further development of quality assurance indicators and executive board level reporting is planned so that a green rating can be achieved.
- Up to date commissioning strategies and impact assessments are in place and are clear about how they will address the needs of those with learning disabilities (B7). This moved from amber to green as clear progress had been made.
- There is evidence that providers change practice as a result of feedback from complaints and whistle blowing (B8). This moved from amber to green as clear progress had been made.

The standard which became less effective was:

- Family carers and people with a learning disability agree that providers treat people with compassion, dignity and respect (B6). This moved from green to amber and was based on feedback from self-advocacy and LD groups in the City

who felt that there were areas of good practice however also improvements in access, communication and workforce which should be made so that services are more consistent in how people are treated

Section C – Living Well

This section is about inclusion, being a respected and valued part of society and leading fulfilling and rewarding lives. People with learning disabilities and their family carers deserve an equal opportunity with the rest of the population to fulfil their lives as equal citizens of our nation safe from crime and intolerance.

Comparing the RAG rating from 2013/14 with 2014/15; one of the nine standards improved, seven became less effective and one is not comparable as it was removed from the 2014/15 SAF.

The standard which improved moved from red to green, this was:

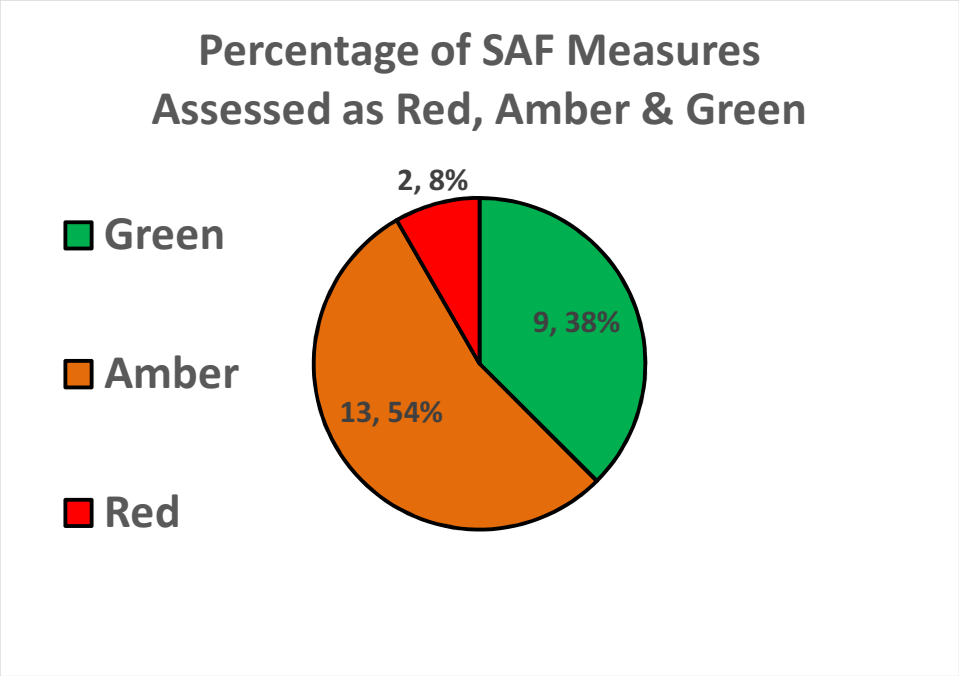
- There is a monitored strategy, service pathways and multi-agency involvement across education, health and social care in relation to transition from children to adult's services (C6). The reason for this is the implementation of a 0-25 years SEND (Special Educational Needs and Disability) service which includes adult social care staff seconded into the team. A task and finish group has been set up to lead recommissioning of post 16 health services related to SEND.

The standards which became less effective all moved from green to amber. They were:

- Effective joint working across health and social care (C1). Progress against this has moved forward with the Better Care programme however there is still progress to be made around developing fully integrated teams.
- Access to local amenities and transport (C2), arts and culture (C3), sport and leisure (C4). The LD Partnership Board felt that there were areas of good practice such as the range of arts and culture on offer but that in order to access these there is often an over-reliance on support staff. If services were further improved, people could access these with less support. There remains an issue for those with the most complex needs in the City accessing mainstream services.
- Supporting people with learning disabilities into employment (C5). The guidance on this standard was clarified for the 2014/15 return making clear that a green rating should be given where there is a clear and published strategy for supporting people with learning disabilities into employment. This work is in progress but not completed yet so the standard was rated as amber.
- People with learning disability and family carers are involved in service planning and decision making (C7). This was rated amber after discussion with the LD Partnership Board and self-advocacy groups who felt there were areas of good practice however co-production was not yet embedded as common practice across all services.
- Carer satisfaction rating (C8). The guidance for this standard was updated for the 2014/15 return and family carers felt that an amber rating was most appropriate given that there were some areas of good practice but still further development needed in other areas such as the experience of going to the GP. The carers commissioning group will be responsible for actioning these areas to improve the satisfaction rating.

The detailed SAF shows there were a number of measures (8%) where our position was assessed as less effective (red). Our responses and evidence to 54% of the questions

were identified as effective (amber), and 38% were considered as exceeding requirements (green). This is shown visually in the chart below:



Further work will be required to continue to drive up service standards, as identified in the SAF Action Plan (Appendix 1).

10 The Learning Disabilities Partnership Board will have formal feedback and update progress events throughout 2015. Health is a regular topic at the Board, and therefore regular updates will be given to outline progress. Quarterly updates will be tabled at the Integrated Care Board.

RESOURCE IMPLICATIONS

Capital/Revenue

11. N/A

Property/Other

12 None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

13. Equality Act 2010

14. The Care Act 2014 requires local authorities to prepare for implementation of the Act in April 2015 and April 2016. The Act places a number of duties and responsibilities on Local Authorities regarding commissioning appropriate services. Local Authorities must ensure their commissioning practices and the services delivered on their behalf comply with the requirements of the Equality Act 2010 and should encourage service that respond to the fluctuations and changes in people's care and support needs.

Other Legal Implications:
15. None.

POLICY FRAMEWORK IMPLICATIONS
16. None.
KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Learning Disabilities Joint Health and Social Care Action Plan 2015

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	

SAF	What the measure involves	How 'green' is rated	RAG Rating	2014 Baseline	Improvement plan in place	KPI (15/16)	Lead/Group Responsible
Section A - Staying Healthy							
A1	LD QOF register in primary care	Learning Disability data is stratified in every required data set (e.g. age / complexity / Autism diagnosis / BME)	Green	Learning Disability Registers reflect prevalence data and are now stratified in every required data set (e.g. age / complexity).	No required	Continue to pull prevalence reports (suggested annual).	LD Health Group
A2	Long Term Health Conditions: People with learning disability are accessing disease prevention, health screening and health promotion in each of the following health areas: Obesity, Diabetes, Cardio vascular disease and Epilepsy	Compare treatment and outcomes for all four health conditions between people with learning disabilities and others in: the area and at local GP level.	Amber	Comparative data for some of the health areas listed in the descriptor available at AT/CCG/Practice level	Channelling data is required from all systems to ensure benchmarking good practice.	Process established to benchmark	LD Health Group Wessex AT
A3	Annual Health Checks and Annual Health Check Registers	IHAL are undertaking this and will provide local authorities and CCGs with a figure.	IHAL to provide	Registers not validated since set up. **30-37%** of people with learning disability on the GP DES Register had an annual health check.	A city wide plan is in development covering, engagement with GPs, Wessex AT, Southern Health, LDPB, Choices Advocacy and LD population/carers.	Registers will be validated by close of Qtr 4 15/16 Implementation to reach 50% (Amber) within 15/16.	LD Health Group Wessex AT
A4	Health Action Plans are generated at the time of Annual Health Checks	70% or more of Annual Health Checks generate specific health	Red	39% of patients who have had an assessment have a	Template shared with all practices. CQUIN undertaken from	Southern health to visit all 33 practices signed	LD Health Group Wessex AT

	(AHC) in primary care and these include a small number of health improving activities.	improvements (Health Action Plan)		health action plan. An audit is being carried out to review the quality of these plans. Unclear whether plans are being generated at the time of health checks and if these are aligned.	Southern Health – identified that no practices had an easy read action plan.	up to LD DES and work with them to embed the easy read health action plan.	
A5	Comparative data for national cancer screening programmes for people with learning disability vs. similar age cohort of non-learning disabled population in each health screening area for: a) Cervical screening b) Breast screening c) Bowel Screening (as applicable)	IHAL are undertaking this and will provide local authorities and CCGs with a figure.	IHAL to provide	Numbers completed and comparative data in place. Limited evidence to suggest scrutinised exception reporting and evidence of reasonably adjusted services	Comparative data shows marked differences in uptake; therefore screening programmes need to demonstrate reasonable adjustments. A programme regarding improved coding. Accountability issues to be resolved.	Wessex AT to identify KPI	LD Health Group Wessex AT
A6	Primary care communication of learning disability status to other healthcare providers	Secondary care and other healthcare providers can evidence that they have a system for identifying LD status on referrals based upon the LD identification in primary care and acting on any reasonable adjustments suggested. There is evidence that both an individual's capacity and consent are inherent to the system employed	Green	There is evidence of an AT/CCG wide system for ensuring LD status and suggested reasonable adjustments if required, are included in referrals. There is evidence that both an individual's capacity and consent are inherent to the system employed	To be raised at Locality meetings with GPs to raise awareness for the need to pass information to providers. Quarterly contract meetings to monitor progress.	Review of secondary system and identification of good practice guidance to services to be disseminated.	Carol Alstrom (Quality Associate Director ICU) Clinical Governance Board (CGB)

A7	Learning disability liaison function or equivalent process in acute setting	Designated learning disability function in place or equivalent process, aligned with known learning disability activity data in the provider sites and there is broader assurance through executive board leadership and formal reporting / monitoring routes	Green	Designated learning disability liaison function in place and details of the provider sites covered has been submitted. Providers are not yet using known activity data to effectively employ LD liaison function against demand.	There is a work plan in place for Health Facilitation/Hospital Liaison Nurses for Learning Disabilities, in order to gain formal reporting. This measure to be discussed at UHS and SHFT CQRM to ensure board leadership.	Annual rolling programme to demonstrate board leadership.	Carol Alstrom (Quality Associate Director ICU) Clinical Governance Board
A8	Reasonable adjustments in primary care: NHS commissioned primary and community care * Dentistry * Optometry * Community Pharmacy * Podiatry This measure is about universal services NOT those services specifically commissioned for people with a learning Disability.	All people with learning disability accessing/using services are known and patient experience is captured. All of these services are able to provide evidence of reasonable adjustments and plans for service improvement.	Amber	Services commissioned by the CCG (maternity and podiatry) are able to provide evidence of reasonable adjustments and plans for service improvements. NHS England commissioned services do not have specific contractual requirements.	Reasonable adjustment work will be taken forward in 2015/16 contracts. CQUIN being worked up to cover patient experience Where relevant some work will be taken across Hampshire and Portsmouth area with Wessex AT. A programme with carers to be put in place regarding reasonable adjustments in services.	CQRM to hold all providers to account in 15/16 to ensure all areas have clear action plans.	LD Health Group
A9	Offender Health & the Criminal Justice System	Local Commissioners have and act on data about the numbers /prevalence of people with a learning disability in the CJS. Local commissioners have are working with regional, specialist prison health	Amber	There is ongoing communication with specialist prison health commissioners. Processes in place to ensure prisoners and youth offenders with LD are offered a health action plan.	Work ongoing around developing the LD forensic pathway and implementation of the Green Light Toolkit.	Hampshire Probation Trust KPI - Reduction of the differential in successful completion of orders between offenders who have a learning	HTP Equalities Consultation Panel LD Health Group

		commissioners Good information on health needs of people with LD in local prisons /wider criminal justice system and a clear plan on how needs can be met. Prisoners and young offenders with LD have had an annual health check which generates a health action plan, or are scheduled to have one within 6 months. Evidence of 100% of all care packages including personal budgets reviewed at least annually.		LD screening questionnaires used in police and health. Probation have own screening tools.		difficulty and those who do not.	
Section B- Keeping Safe							
B1	Individual health and social care packages for people with learning disability, across all life stages, are reviewed regularly.	Evidence of 100% of all care packages including personal budgets reviewed within the 12 months are covered by this self-assessment	Red	85% of health packages have had an annual review. 47% of social care packages received a review in 2014. There are 177 reviews currently in progress.	There is a plan in place, for social care, co-working with the review project, identifying outstanding reviews, and ensuring recruitment in progressed to ensure full resource in place to undertake the reviews.	100% of reviews to be completed in 15/16	Mark Howell (SCC HoS) Carol Alstrom (Quality Associate Director ICU)
B2	Contract Compliance Assurance – For services primarily commissioned for people with a learning	Evidence of 100% of health and social care commissioned services for people with learning	Amber	All services have annual quality reviews. Lead commissioning managers are identified	A new Individual Service Contract has been developed for all placements (SCC).	% of commissioned services with contract reviews	Carol Alstrom (Quality Associate Director ICU)

	disability and their family carers.	disability have: - had full scheduled annual contract and service reviews. - Demonstrate a diverse range of indicators and outcomes supporting quality assurance Evidence that the number regularly reviewed is reported at executive board level in both health & social care		for each contract and the monitoring of reviews will be overseen by the contract development and monitoring committee with outcomes reported as performance indicator to CCG and LA exec board level.	SCCCG (Continuing Healthcare) are reviewing service contracts in line with new home care tender. The ICU Scorecard, including Quality elements will report to IC Board and other relevant bodies' such as SSAB this will include the number of services reviewed	per annum. % of contract reviewed services with additional requirements. Levels are currently being agreed by Leads.	Provider Relationships Associate Director
B3	Monitor Assurances: Assurances given regularly in Monitor Risk Assessment Framework for Foundation Trusts	Commissioners review monitor returns and review actual evidence used by Foundation Trusts in agreeing ratings Evidence that commissioners are aware of and working with non-foundation trusts in their progress towards monitor compliance.	Green	The quality and safeguarding team work with health providers regarding their monitor returns.	Achieved. CQRM will ensure ongoing monitoring. This will be overseen by SCCCG Clinical Governance Committee and Governing Body/SCCCG Executive Board.	This requirement to be formally written into contracts for FT/Non FT and major private providers quality schedules.	Carol Alstrom (Quality Associate Director ICU)
B4	Assurance of safeguarding for people with learning disability in **all** provided services and support.	Evidence of robust, transparent and sustainable governance arrangements in place in all statutory organisations including Local Safeguarding Adults Board(s), Health & Well-Being Boards and Clinical	Green	There is evidence of robust, transparent and sustainable governance arrangements in place in all statutory organisations including SSAB, HWBB and CCG Executive Board. The provider can	The SSAB will ensure ongoing monitoring.	100% of services demonstrating compliance with CQC outcome 7	SSAB

Page 20		Commissioning Executive Boards The provider can demonstrate delivery of Safeguarding adults within the current Statutory Accountability and Assurance Framework includes people with learning disabilities. This assurance is gained using DH Safeguarding Adults Assurance (SAAF) framework or equivalent. Every learning disability provider service have assured their board and others that quality, safety and safeguarding for people with learning disabilities is a clinical and strategic priority within all services. Key lessons from national reviews are included. There is evidence of active provider forum work addressing the learning disability agenda		demonstrate delivery of Safeguarding adults within the current Statutory Accountability and Assurance Framework includes people with learning disabilities. This assurance is gained using DH Safeguarding Adults Assurance (SAAF) framework or equivalent Every learning disability provider service have assured their board and others that quality, safety and safeguarding for people with learning disabilities is a clinical and strategic priority within all services. Key lessons from national reviews are included. There is evidence of active provider forum work addressing the learning disability agenda through residential and domiciliary care forum as well as the LDPB. An independent chair has been appointed to the			

				SSAB.			
B5	Involvement of self-advocates and carers in training and recruitment	LD specific services: evidence of all services involving people with learning disability and families in recruitment/ training. Commissioners of universal services can provide evidence of contracting for LD awareness training (e.g. as part of Disability Equality training)	Amber	In place for universal health providers as part of their mandatory training requirements. There are areas of good practice within the city that will be built upon. Some residential and homecare providers employ people with learning disabilities and carers to undertake their training.	Provider forums will seek to address how self advocates are engaged more proactively in training and recruitment and contractual requirements will be further enhances as contracts are reviewed.	100% of services evidence involvement of users and families in recruitment, training and monitoring during QA visits. 100% of services have completed reviews of universal provision and have plans in place to ensure reasonable adjustments are achieved	Provider Relationships Associate Director ICU Carol Alstrom - Quality Associate Director ICU
B6	Compassion, dignity and respect. To be answered by self advocates and family carers.	Family carers and people with a learning disability agree that all providers treat people with compassion, dignity and respect.	Amber	Feedback provided by 'Busy People' a Southampton self advocacy group and the LD carers groups. Areas of good practice were identified however improvements across services were identified.	Ongoing monitoring in place for all contracts using good practice e.g. service audits, Dignity in Care work. Social Value Act used prominently within tendering processes.	100% of services evidence organisational values reflected in day to day work practices, with clear commitment to involvement of users and dignity being	Provider Relationships Associate Director

						promoted.	
B7	Commissioning strategy impact assessments. Commissioning strategies for support, care and housing is the subject of Impact Assessments and are clear about how they will address the needs and support requirements of people with Learning Disabilities.	Up to date commissioning strategies and impact assessments are in place.	Green	All commissioning strategies most have completed impact assessment. This is carries out as standard.	Commissioning Strategies and work stream areas identify EQI. The LDPB (which has 50% of people with LD sitting on this) inputs on commissioning strategies and associated equality impact assessments, these are shared via the LDPB website. Experts by Experience to considered.	90% of all EIA's to be up loaded to LDPB website with repeat agenda item at LDPB for review/challeng e.	System Redesign Associate Directors Carol Alstrom - Quality Associate Director ICU
B8	Commissioners can demonstrate that all providers change practice as a result of feedback from complaints and Whistle blowing experience.	90% or more of commissioned services can demonstrate improvements, based on the use of feedback from people who use services (e.g. complaints, surveys and quality checking). There is evidence of effective use of a Whistle-blowing policy where appropriate.	Green	In place for 100% of health providers. Good evidence that providers respond to complaints and whistle blowing positively. The CCG have worked proactively with commissioned services. There are good examples of where services have invited the complainant to board. Complaints leaflets are produced in easy read format.	Providers will be requested to demonstrate that they are changing their practice, based on the feedback from the service users. Monitoring to record this to be put in place so that at least 90% of providers show this under service review/monitoring. Staff surveys' also to be used more formally to gain intelligence.	100% of service reviews evidence changes in practice based on complaints/whist le blowing.	Carol Alstrom - Quality Associate Director ICU

B9	Mental Capacity Act & Deprivation of Liberty Safeguards. Appropriate use of the MCA and DoLS.	Commissioners can evidence that all relevant providers have well understood policies in relation to the MCA and DoLS in place and routinely monitor their implementation.	Green	All appropriate providers have well understood policies in place and routinely monitor implementation of these in relation to, the Mental Capacity Act (including restraint, consent and deprivation of liberty). The provider can evidence action taken to improve and embed practice where necessary. This is identified and monitored through contract review processes and SSAB.	Maintain good practice. Develop register of providers checked for compliance against MCA.	Breaches of MCA and DOLS to be reported – expectation no breaches in any providers	Carol Alstrom - Quality Associate Director ICU
Section C – Living Well							
	Effective joint working across health and social care.	There are well functioning formal partnership agreements and arrangements between health and social care organisations. There is clear evidence of pooled budgets or pooled budget arrangements, joint commissioning structures, intentions, monitoring and reporting arrangements.	Amber	Joint commissioning strategy and pooled budgets operate within the city. Better Care Southampton is supporting the joint agenda to meet needs across the city. There is no integrated team at present.	Plans to further develop partnership agreements will be processed through Southampton's Better Care Fund work area.	Number of jointly commissioned services. Review and agreement re Integrated Team arrangements.	Integrated Commissioning Unit Board
C2	Local amenities and transport	Extensive and equitably geographically distributed examples of people with learning disability having access to reasonably	Amber	Evidence from LDPB is that services are making reasonable adjustments and reviewing how to support people with	Needs to be a better plan regarding how transport is managed in the city.	Number of training sessions delivered to transport	LDPB

		adjusted local transport services, changing places and safe places (or similar schemes) in public venues and evidence that such schemes are communicated effectively.		learning disabilities.	Training regarding reasonable adjustments for bus companies by people with LD being developed. Safe places launched and updated, work currently being undertaken to include info on training for providers and council staff (KPI) Meetings with police to monitor scheme. Continue to build on existing good practice.	agencies by people with learning disabilities Number of people being trained in Safer Places.	
C3	Arts and culture	Extensive and equitable distributed examples of people with learning disabilities having access to reasonably adjusted facilities and services that enable them to participate fully e.g. cinema, music venues, theatre, festivals and that the accessibility of such events and venues are communicated effectively.	Amber	This measure was asked at the LDPB. People felt there was a good range of arts and culture on offer. However there is sometimes an over reliance on support staff in order to help people. If services were further improved, people could access these with less support. Example is autism friendly cinema and theatre screenings.	Continue to build on existing good practice.	Numbers of new arts and culture facilities promoting reasonable adjustments in their services.	LDPB
C4	Sport & leisure	Extensive and equitably geographically distributed examples of people with	Amber	This question was asked at the LDPB. Similar to access to arts and	Continue to build on existing good practice. Active Nation	Numbers of new sports and leisure facilities	LDPB

		learning disability having access to reasonably adjusted facilities and services that enable them to participate fully e.g. local parks, leisure centres, swimming pools, walking groups. Designated participation facilitators with learning disability expertise etc. and evidence that such facilities and services are communicated effectively.		culture, they felt there was a good range however an over reliance on support staff which could be reduced if services were improved.	developing a range of sport and leisure activities.	promoting reasonable adjustments in their services.	
C5	Supporting people with learning disability into and in employment	Clear published local strategy for supporting people with learning disabilities into paid employment. Relevant data is available and collected and shows the strategy is achieving its aims.	Amber	Employment workplan has identified key actions for supporting adjustments with the LD population. 127 clients supported by City Limits with 41 in paid employment. New 'job club' has started with the Job Centre and working with a self advocate from Choices Advocacy.	Work is in progress to ensure that all vulnerable groups access employment more effectively within the city (ICU Employment Plan drafted). Implementation of employment advisor for people with complex learning disabilities approved.	Numbers of adults in employment against national and regional benchmarks.	LDPB System Redesign Associate Director in liaison with City Deal.
C6	Transition to Adulthood. Preparing for adulthood in Education, Health & Social Care.	There is a monitored strategy, service pathways and multi-agency involvement across education, health and social care. There is evidence of clear preparing for adulthood	Green	The integrated SEND service has adult social care staff seconded into it to co-work transition cases from Q4 2014/15. Joint task and finish group established to lead re-commissioning	Ongoing development of the SEND 0-25 service and joint tasks and finish group to lead on re-commissioning of post 16 health services.	Qtr 2 2017 is the national requirement of 100% of children currently with statements to have been	Childrens Transformation Programme

		services or functions that have joint health and social care scrutiny and ownership across children and adult services.		of post 16 health services related to the SEND service.		transferred to EHC Plans.	
C7	People with learning disability and family carers are involved in service planning and decision making.	Clear evidence of co-production in universal services and learning disability services. The commissioners use this to inform commissioning practice.	Amber	LDPB meeting is co-produced and attended by commissioners. There are a number of forums across the city that people with learning disabilities are actively involved with, e.g. Consult & Challenge, health Inequalities Group. Self advocacy groups proactively seek to influence how services are delivered.	Continue to build on existing good practice.	Co-production embedded as common practice across all services (not just specialist LD).	LDPB
	Carer satisfaction rating. To be answered by family carers.	Most carers are satisfied that their needs were being met.	Amber	There are some positive themed areas but some areas that require further work.	Carers commissioning group to action areas identified as needing further work.	Increase in the proportion of carers who report that they have been included or consulted in discussions about the person they care for.	Carers Commissioning Group LDPB

DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		NHS FIVE YEAR FORWARD VIEW: NEW MODELS OF CARE		
DATE OF DECISION:		25 MARCH 2015		
REPORT OF:		CHIEF EXECUTIVE, CLINICAL COMMISSIONING GROUP (CCG)		
CONTACT DETAILS				
AUTHOR:	**Name:**	**John Richards**	**Tel:**	**02380 725637**
	E-mail:	**John.Richards@southamptoncityccg.nhs.uk**		
Director	**Name:**	**John Richards**	**Tel:**	**02380 725637**
	E-mail:	**John.Richards@southamptoncityccg.nhs.uk**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

The NHS Five Year Forward View (FYFV) was published by NHS England and the other national bodies in October 2015. It identifies three themes or gaps that must be addressed and are interlinked:

- Health and wellbeing – requiring a radical upgrade in prevention
- Care and quality – requiring new models of care
- Funding – requiring efficiency and investment

This paper addresses the second theme and provides the Health and Wellbeing Board with an update on development work in Southampton. The expression of interest attached at Appendix 1 was prepared at very short notice and submitted to the national team on 9 February as part of the Vanguard/Forerunners scheme that would have enabled access to a share of the £200M fund announced in NHS England allocations. It was shortlisted and a team from Southampton presented to the final selection panel on 3 March. The proposal describes a City-wide integrated model encompassing primary care, community health services, social services, voluntary sector and mental health services. It does not assume a single organisational entity.

RECOMMENDATIONS:

(i) Health and Wellbeing Board is invited to discuss the merits and drawbacks of the proposed approach, how it fits with our Better Care vision, and the opportunities and barriers to be managed in moving things forward.

(ii) The Board is invited to express its support to the partners involved in developing the proposal further.

REASONS FOR REPORT RECOMMENDATIONS

1. Despite not being selected as one of the nationally funded Vanguards, the proposal is strategically sound and widely supported. The proposals are perfectly aligned with the Board's Better Care Plan and represent an imaginative step forward towards purposeful implementation of a model of provision that will enable delivery at scale and pace, provided that they are wholeheartedly embraced and driven through to realisation

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. The present fragmented range of out of hospital services are a product of history and happenstance. There are gaps and overlaps which militate against the most efficient and effective delivery of joined up care. The proposals represent a collaborative approach to changing provision. The proposals should be viewed alongside alternative organisational approaches under discussion such as the emerging practice federation, options for providing social services, the Foundation Trust programme and so on.

DETAIL

3. The detail of the proposal is set out in appendix 1

RESOURCE IMPLICATIONS

Capital/Revenue

4. None at this stage.

Property/Other

5. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

6. Not required at this stage.

Other Legal Implications:

7. None

POLICY FRAMEWORK IMPLICATIONS

8. Align with Health and Wellbeing Strategy and Better Care Plans.

KEY DECISION? Yes

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Forward View into Action: expression of interest in the national Vanguard programme

Documents In Members' Rooms

1.	None

Equality Impact Assessment

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

Other Background Documents

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

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

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Appendix 1

Forward View into Action: expression of interest in the National Vanguard Programme

Q1. Who is making the application?
(What is the entity or partnership that is applying? Interested areas may want to list wider partnerships in place, e.g. with the voluntary sector. Please include the name and contact details of a single senior person best able to field queries about the application.)

Solent NHS Trust are leading the bid submission with the full support and engagement of ***Southampton City Council,*** a number of additional independent ***GP practices in the city, Southampton Voluntary Services***, ***University Hospitals Southampton NHS Foundation Trust, Southern Health NHS Foundation Trust,*** and ***Southampton City CCG.***

The bid underpins Southampton's model of integrated care as set out in Southampton Better Care and described through the eyes of Joan, a fictional character developed to illustrate our ambition for integrated care in Southampton. Joan and her family represent each and every unique person in our city, needing our care. We all share a vision and aspiration to ***join up care for Joan, her children and grandchildren.***

Additional stakeholders who have encouraged the creation of an MCP in Southampton include:

- ***The Southampton City Health and Wellbeing Board.*** The chair, Dave Shields asked us to include this quote , *"As chair of Southampton's Health & Wellbeing Board I am delighted to support this Vanguard bid for a Southampton MCP as it embraces our bold ambitions for the city as set out in our Better Care Fund programme. Local Councillors - from across political groupings - are really enthusiastic about Better Care Southampton and the approach being promoted in this bid will really help to address many of our challenges."*

- ***NHS England***
- ***The Local Medical Committee*** "The LMC would be happy to support a Vanguard bid in Southampton."
- ***The Trust Development Authority*** support Solent NHS Trust leading a submission to the Vanguard Programme.
- ***Southampton Healthwatch***

The team who have developed this bid consist of a number of influential clinicians and professionals in the city including but not limited to:

- Dr Cliff Howells, GP and Clinical Director of Solent NHS Trust Primary Care service line.

- Dr David Paynton, GP and National Clinical Lead for the RCGP's Centre for Commissioning.
- Dr Hayden Kirk, Consultant Physiotherapist and Clinical Director of Solent NHS Trust Adults Services Southampton service line.
- Alex Whitfield, Chief Operating Officer, Solent NHS Trust
- Alison Elliott, Director of People, Southampton City Council
- Jo Ash, Chief Executive of Southampton Voluntary Services
- Dr Steve Townsend, GP and Clinical Chair, Southampton City CCG
- John Richards, Chief Officer, Southampton City CCG
- And many other partners.

The single senior person best able to field queries about the application is Sue Harriman, Chief Executive of Solent NHS Trust.

Q2. What are you trying to do?
(Please outline your main objectives, and the principal changes you are planning to make to change the delivery of care. What will it look like for your local community and for your staff?)

Joining it up for Joan, her children and grandchildren.

Our overriding vision is to join up care for each and every unique person in our city needing our care, as represented by Joan, her children and her grandchildren

One team will meet the ***community health and social care needs*** of people living in ***geographically defined communities*** within the city of Southampton.

The MCP will deliver cradle to grave, integrated community health and social care to ***all 250,000 people in Southampton city***, managed in clusters centred around GP practices, accelerating and expanding on the vision of Southampton Better Care.

The challenge is to develop systems of care, which ***improve the health, and wellbeing of a population*** and are sensitive to clinical and social demand rather than supply led. To achieve this we will create a governance framework, which ***incentivises innovation and integration of community services*** and supports the local population to optimise ***their health and well being***.

For Joan, her children and grandchildren the MCP will be a ***single team who provide all their integrated community health and social care needs.***

For children, we will provide health visiting, public health nursing, CAMHS services, community paediatrics, community nursing, children's social care services, children's centres and Early Help, and our innovative children's admission avoidance service (COAST); all through integrated teams.

For adults, the MCP will be the single team to provide community nursing, adult social care, community rehabilitation inpatient facilities, reablement, rapid response services to prevent unnecessary hospital admissions and rapid discharge services to support people to return home quickly from an acute episode. Adult and older people's mental health expertise will be within the community networks integrated with physical health teams, social care teams and voluntary services. ***The MCP will include community geriatricians, psychiatrists and rehabilitation consultants***.

For citizens of any age, the MCP will provide primary care services, long term condition management and public health promotion through GPs, specialist sexual health teams, health promotion teams and public health nursing teams. ***There will be a focus on prevention, early intervention and creative solutions.***

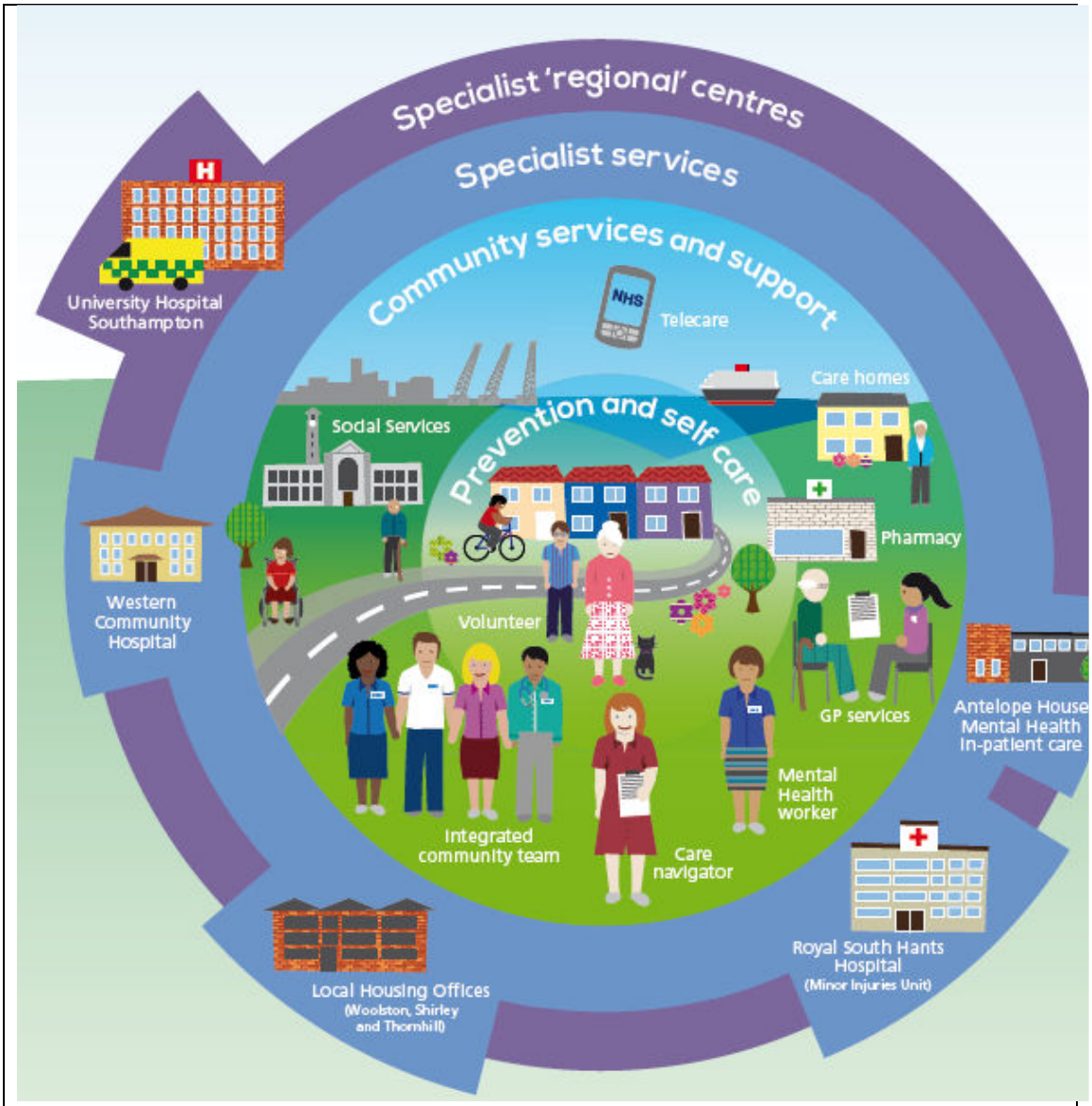
The vision is that there are ***no gaps*** between services or organisations, and ***no duplication*** for services or for individuals. Individuals are ***risk stratified*** using appropriate tools which will include ***ACG and frailty index tools as well as risk based assessments of children and families at risk.*** These are then clinically validated and personalised care plans developed, based on need. There will be a ***single shared care plan*** for an individual rather than numerous plans held by different agencies.

A key objective is to be able to improve the care that the public sector is able to provide, despite the ever increasing pressures on public sector finances. We will meet the needs of the city population ***making the best use of the city pound.***

For staff, their predominant team will be their ***geographical local team*** who they work with to care for their local population. They will continue to receive professional support and expertise through a matrix structure, but they will work for a locality.

For some specialist services, such as epilepsy specialist nursing or specialist neuro rehab therapists – the resource will be managed on a city wide basis with named contacts or sessions in each locality.

For the city there will be sufficient resource to support ***capacity building such that voluntary organisations*** can help to deliver integrated services through a range of community development models. We will also harness the role and contribution of ***individual volunteers*** including linking them to the geographical clusters.



Q3. Which model(s) are you pursuing? *(of the four described)*

Southampton city is pursing the ***Multi-Speciality Community Provider (MCP)*** model.

The Five Year Forward View and the Dalton Review both describe a visionary plan for transforming the provision of integrated care. All the partners in Southampton city see this as a way of strengthening integrated community care, accelerating Better Care Southampton and ensuring sustainability of primary and community providers to ***continue to support the out of hospital models and choice for patients and citizens***. Solent NHS Trust was one of the first community and mental health trusts to receive a new style CQC inspection, having been supported by the TDA to move to FT status. The CQC commended the trust for the high quality, compassionate care provided and the trust was supported to continue on the FT journey. However, the vision of an MCP has encouraged the trust to explore other organisational forms, including a social enterprise model, embedded in the community. Supporting the vanguard bid for Southampton city would enable national bodies to explore alternative options for trusts which are delayed within the FT

pipeline.

Solent NHS Trust is unusual in that it ***directly provides primary care***. The current list size is 14,000, spread across the West, Central and East areas of the city. One of the practices provides care for the homeless population in the city through the Homeless Healthcare Practice. There are plans in progress to directly support GMS practices in the city which will increase this to 30,000 in 2015 and likely to be ***over 50,000 by April 2016***. This growth will come by partnering and supporting practices to stay sustainable through an innovative sub contracting commercial model.

The Trust also provides ***community care, community inpatient wards, consultant paediatricians and geriatricians, CAMHS services and public health services***. Combining this with ***additional primary care practices working in partnership***, with ***social care and with adult and older people's mental health*** services, as well as ***voluntary and community organisations*** will allow the creation of a strong and innovative MCP for the city.

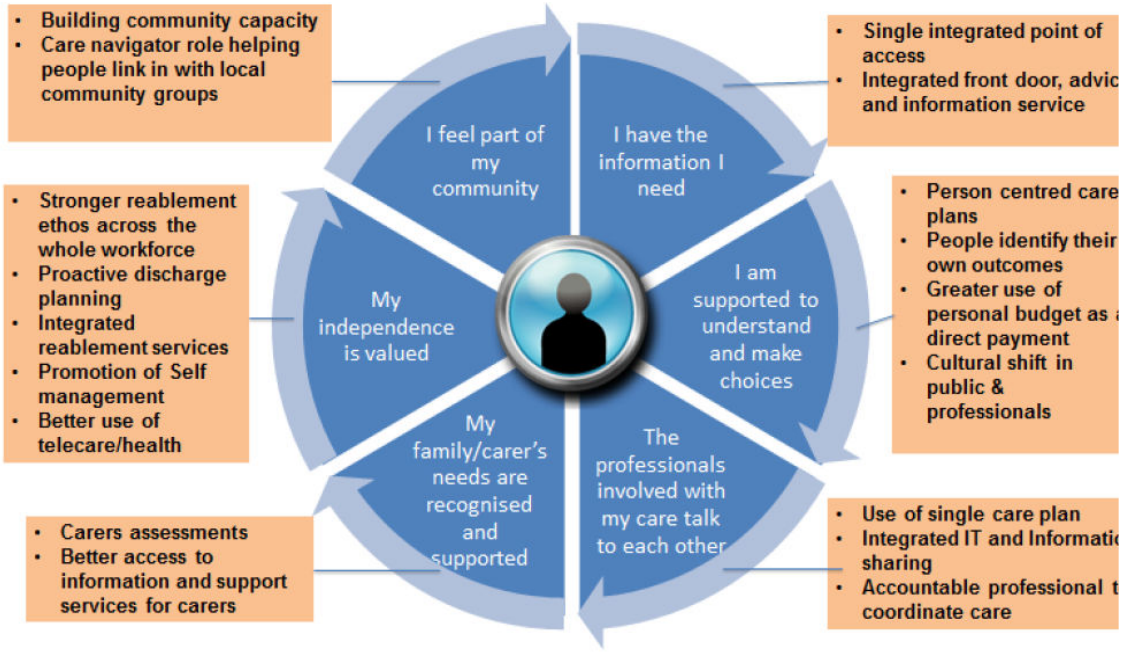
Southern Health NHS FT provides ***adult and older people's mental health*** services in the city and is fully signed up to bringing these into the MCP through partnership models. University Hospitals Southampton, who provide secondary and tertiary acute care in the city will support the MCP through the ongoing development of ***joined up pathways for long term conditions***. Southampton city council brings ***social care, housing*** and young people's ***education and training services*** into the MCP model.

Southampton has a diverse population both in terms of age, ethnicity and wealth. It is a multicultural city which is small enough to be able to run city wide services and diverse enough to benefit from locality specific teams. It has the huge benefit of being ***a unitary authority with a co-terminus local authority, CCG and community healthcare provider. Southampton Voluntary Services*** is a well-established co-ordinator of voluntary and community organisations. The city has its challenges with higher levels of worklessness, teenage pregnancy, mental health issues, domestic violence and isolation, than many of its statistical neighbours. The Health and Well Being Board are entirely supportive of an integrated health, social and community model in the city, as evidenced by the very ambitious Better Care Programme. ***It is an ideal city to trial the Multi-Speciality Community Provider model.***

Q4. Where have you got to?
(Please summarise the main concrete steps or achievements you have already made towards developing the new care model locally, e.g. progress made in 2014.)

Southampton city has already committed £62m to Better Care Southampton and has a stated aim to put ***over £130m of health and social care spend*** into a pooled fund be managed on behalf of the Council and CCG by the integrated commissioning unit. This puts the city into one of the ***top 10***

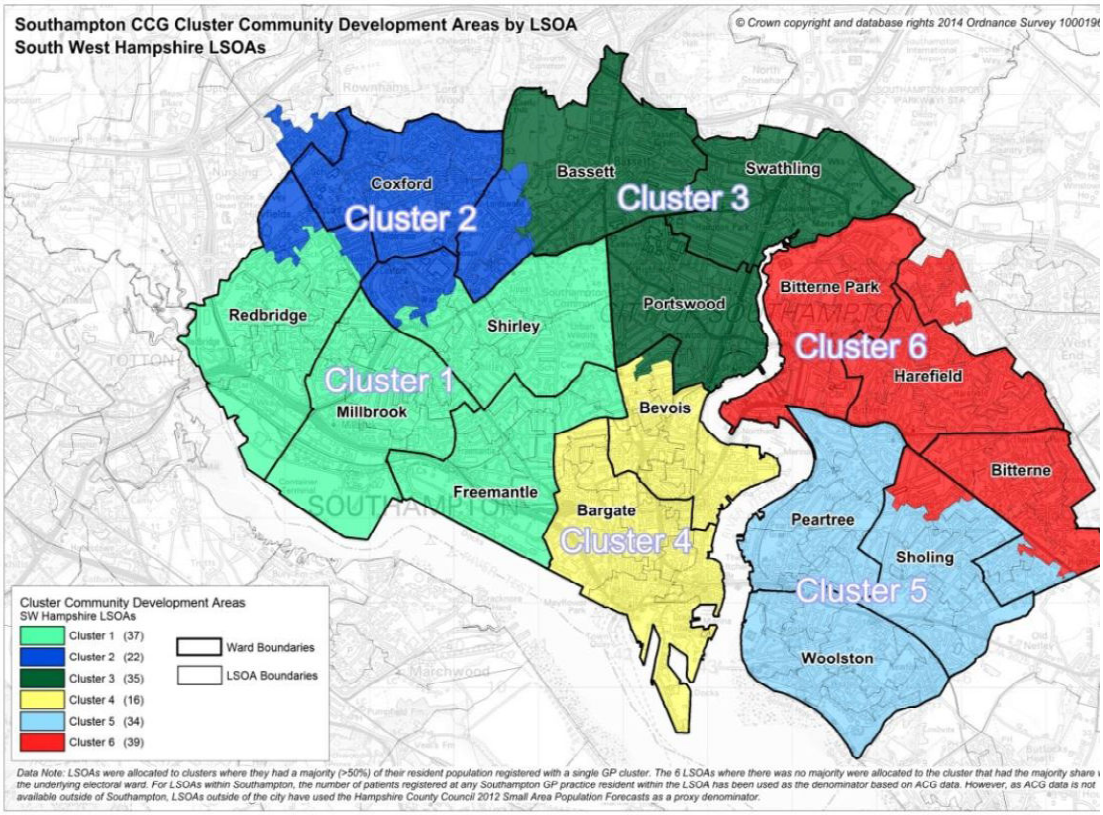
communities in the country and is significantly beyond the minimum required. The integrated commissioning unit was established in 2014 and is already commissioning pathways across health and social care. Southampton has been recognised nationally as having one of the most ambitious Better Care plans which has been created from a well-developed consensus in the city to deliver integrated health and social care services on a locality basis. This is the central plank of the CCG's 5 year plan.



The Better Care Southampton vision has three main aims which will be accelerated and broadened, through this programme.

i) cluster based teams, embedded in communities, of integrated primary, community, social and mental health care;

The clusters have been identified and widely consulted on. The map below shows the Southampton city clusters for Better Care Southampton. ***The team development activities*** have started within these clusters and ***governance processes are being established.*** The clusters, as shown, will be the smallest geographical entity with a dedicated team. For some services, care will be managed across two clusters, in larger localities, and for other, more specialist services, care will be managed across the city as a whole. By building up from a smaller cluster, services will be able to wrap around Joan, her children and grandchildren, while not losing the benefit of scale on a city wide basis, where that is beneficial.



ii) ***integrated discharge, rehab and reablement***

This brings together health and social care community and inpatient rehab and reablement alongside rapid response and crisis services. The implementation has started and will be further accelerated if we are successful in achieving vanguard status.

iii) building community capacity

Pilots are underway to demonstrate the effectiveness of ***community navigators*** and ***building community capital and resilience.*** All of our services recognise the importance of enabling and supporting the community to deliver services with us.

Primary Care: Solent NHS Trust are in a unique position of already directly running four APMS GP practices in the city, and providing highly skilled staff into two other practices. We provide ***8-8, 7 day a week*** services involving multi-disciplinary teams where advanced nurse practitioners and mental health nurses support GPs and practice nurses. We are also in the advanced stages of delivering ***an innovative model to ensure the sustainability of a large GMS practice*** by using the NHS trust to underpin and support the primary care services. This has the support of NHS England and the Local Medical Committee who see it as a way of delivering sustainable primary care in the future. We have won NHSE Innovation funding to deliver a new service delivery model for all our patients, and separately for ***GP and practice nurse workforce development***. Our vision is to further develop this existing primary care provision by using this model to support other practices and by working in partnership with independent partnerships. As the MCP develops a variety

of primary care models will be included, from direct provision, through integrated support and networked partnership working. This will be supported by the CCG who are moving to ***co-commissioning of primary care in April 2015*** and full delegation by April 2016. The Solent primary care practices are already moving to the concept of ***Care Planning embedded in your practice***, as described through the RCGP's Rose's story

Community Healthcare and Social Services: These teams have worked closely together for a number of years and have recently explored the Plymouth model of community healthcare. As part of the BCF, ***the crisis response, rehabilitation and reablement teams within Solent NHS Trust and Southampton City Council are in the process of fully integrating*** under a single management team. Southampton City Council and the CCG have just been through a procurement process to transform the ***domiciliary care market in the city*** which will ensure sustainable domiciliary care providers are ***commissioned on a cluster basis*** and able to support the implementation of the MCP. Solent community nursing and rehabilitation teams are already organised around the geographical localities. A number of integrated models are already delivered between Solent NHS Trust and Southampton City Council for children's services including children with special educational needs and disabilities and children aged under 5 years, through children's centres.

Voluntary and Community Services. Southampton Voluntary Services is an umbrella organisation for nearly 500 voluntary and community organisations across the city. They are a well established part of ***integrated care programmes in the city***. The voluntary sector have a long history of success in community projects including the Thornhill Plus You Project, West Itchen Trust and Age Concern providing care navigation in GP practices. The ***city faith groups*** also provide support for individuals and communities and are involved in locality teams. A number of pathways deliver integrated care, provided by local and national voluntary organisations, and current sub-contracting of voluntary sector providers. There is scope to extend this through ***innovative contracting relationships and procurement strategies for the voluntary sector*** as part of the wider system development.

Mental Health Services: Solent NHS Trust provides CAMHS services in the city and has plans to bring these into more integrated and holistic children's services. Southern NHS Foundation Trust provides ***adult and older people's mental health*** services and is fully supported of bringing them into a city MCP in order to better integrate care around people. Solent and Southern have already started a project to bring older people's mental health services into ***jointly managed teams on a locality basis*** in the city using shared buildings.

Children's Services: Southampton will be one of the first systems to integrate the MARAC and MASH to more quickly identify children and families at risk of domestic abuse or safeguarding concerns. This is an example of integration of services for the benefit of families, and closer joint working with statutory partners like the police.

A single IT system. Solent has procured TPP Systm1 as the new clinical record system for all the community health services in the city. This is the same system that a large number of primary care practices in the city use. A significant number of other practices use EMIS which can interface with TPP Systm1. This IT platform will create ***a single care record*** across a significant number of primary care practices and all of community health care by October 2015. This will enable each patient to have a single care plan. In addition, ***the Hampshire Health record (HHR) provides a single record*** for patients across the acute hospital, primary, community, mental health and social care. The HHR is well established and is being expanded to include even more information. The information governance challenges surrounding shared data have been resolved within the city. The IT innovations also includes ongoing investment in ***telemedicine and telecare,*** and the joining up of health and social care maximises the benefit of recent investment in a city council ***single point of access*** to support telecare systems.

Urgent Care System and interface with the acute hospital. Southampton City has a well-established process for investing in support for urgent care. The community teams provide ***hospital in-reach teams*** who work in the acute hospital pulling patients out. Solent provides a ***Community Emergency Department Team*** (CEDT) who turn patients round at the front door. The acute and community geriatricians have established a collaborative locality working model which ensures that the acute geriatric beds mirror their community localities. This ensures that an individual geriatrician always looks after patients from the same city locality and as a result has developed very strong relationships with the patients, GPs and community health and social care teams in that locality. The experience from this model of cross organisational locality working will look to be replicated with further community and secondary care specialities across the MCP.

Long term condition pathways exist across the acute / community sector including for diabetic care, respiratory and COPD conditions and paediatrics.

Carers are a crucial part of the plans for integrated community based care in the city. The city council, voluntary sector and healthcare providers have committed plans to improve the support available for carers across the city. We also recognise that not all carers are living locally but some provide care at a distance and need different support mechanisms. ***Young carers are a particular area of focus*** and Southampton Voluntary Services have well established support services for this vulnerable group.

Workforce Development. Solent have been working with ***Health Education Wessex*** to plan for the workforce of the future. We know that we will need more staff capable of working in a multi-speciality way, working across the boundaries of traditional professional groups and comfortable with providing community based care as an alternative to acute hospital admissions. These staff will need to be less task based and more client focused, more proactive and less reactive and happy trusting assessments from their colleagues. This will need ***a shift in training programmes*** for clinicians where more time is spent in community settings than has historically been the case. Solent GP

practices are also developing models of ***career development for GPs***. This includes supporting GPSi's with specialisms in geriatrics and paediatrics as well as mental health and long term conditions. The MCP will give a strong foundation for these development opportunities. ***The integrated locality teams will provide training and development opportunities for the workforce of the future.***

Q5. Where do you think you could get to by April 2016?
(Please describe the changes, realistically, that could be achieved by then.)

A Southampton Task Force will programme manage the implementation of the MCP through 2015 and 2016. This will be governed by the ***Southampton City Accountable Officers*** who have a well-established relationship and meet regularly. An MCP Board will be established during 2015/16 with representation from the various providers involved and this will, in effect, be a shadow board for a full MCP launch in 2016/17. ***Established co-production groups*** will help validate and inform the implementation with representation from patients, community groups, employees and the voluntary sector. There is a group called the ***Can Do group*** which is the existing implementation forum for Better Care Southampton and this will be a key programme management group for the MCP.

By April 2016, our ambition is to have ***one team working in each identified community***. In every locality in the city, this team will include community health and social care teams for children and adults wrapped around clusters of GP practices. The teams will also include voluntary sector organisations and mental health services. Other local authority functions such as housing, homelessness, employment and training services may also be operating as part of the cluster teams or with strong links into those teams. Members of these teams will be ***co-located within their locality*** where possible and working to a ***single locality leader***. We will run a single induction process for staff in these teams and will have locality leadership in place in each cluster with all staff having either a full employment contract into the locality team, or else an honorary contract to the team. We will have in place a Capability Maturity Model to evaluate the maturity of each cluster team. This is ambitious and challenging but with support from the vanguard programme we are confident we could be achieving most of this by April 2016.

The locality teams will be using all the community resources available to deliver great joined up care to Joan, her children and grandchildren. This could include the postmen and refuse men alerting the local team if they are concerned about a resident; the domiciliary care worker who visits Joan referring to the mental health nurses if Joan's dementia seems to be deteriorating; the housing officer contacting the local church if a young mum seems to be struggling. ***It is about an interconnected network of statutory and community organisations working together to support great outcomes all underpinned by a strong multi-speciality community provider.***

Primary Care in the city will be on a more sustainable basis with more practices supported to work 8-8, 7 days a week with ***innovative workforce models***, using pharmacists, advanced nurse practitioners and mental health

nurses as part of the practice teams.

Care planning will be in place for everyone with one or more long term condition and these plans will empower individuals and promote health and wellbeing and support self-management. ***One care plan for one person.***

For patients with long term conditions, we will build on the existing strong community / acute relationships and put in place additional pathways, for example for chest pain and IV management. These will provide seamless care for patients with long term conditions. Ideas like a mobile medic will be piloted. Acute clinicians will come out of the hospital more often to deliver care in community settings, and community teams will continue their presence in the acute hospital ensuring that people are turned round quickly at the front door when they can be, and discharged home as soon as they are medically ready for discharge. ***The MCP will give us the right clinical and financial governance structures to deliver care in a different way***

A City Charter will be in place, which provides a framework for how the clusters operate and defines the core principles /strategy that each cluster must adopt. This will ensure that local autonomy is complemented by city wide consistency where that is beneficial.

The engagement process over 2015/16 allows ***organisational involvement to grow over time*** and allows any general practices not involved in April 2015, for example, to join over individually appropriately timescales. Organisational form change will follow the functional changes as appropriate.

Work will focus in each community on three key pathways.

- Urgent care
- Routine care
- Proactive care

Current model based on organisational provider

Future model based on key pathways

Urgent

Primary Care

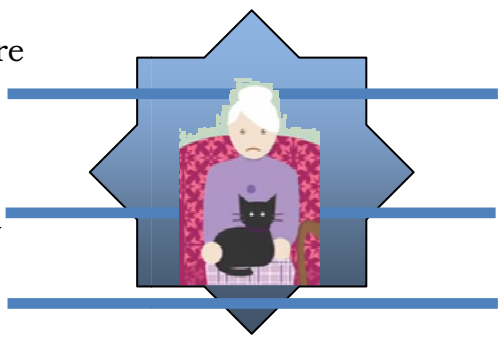
Social Care

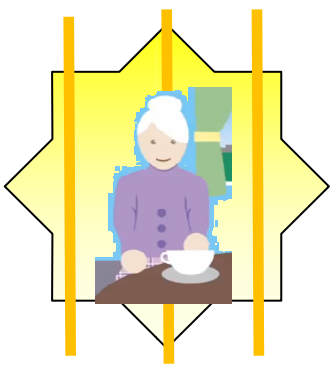
Community Health care

Community &

Proactive

Routine





Voluntary sector

By April 2016 we will expect to be in a position to ***operate to a capitated contract for 16/17*** whereby commissioners provide capitated funding using Person Based Resource Allocation (PBRA) or similar methodology and the MCP directly provides, sub contracts or partners with, other community based health and social care within Southampton. We would hope to shadow run some elements of capitated contracts in 15/16.

Personal budgets and direct commissioning of personal care packages for children and adults will have progressed significantly. Community capital will have increased so that local communities provide some of the personally commissioned support through voluntary and community organisations.

Information and data will be integrated between some of the partners by April 2016 so that data can drive predictive action planning to better prepare for operational and strategic challenges. Analysis of what works best will be simpler because of the shared data systems. ***Full integration of data and optimal use of Hampshire Health Record*** will continue into 2016/17.

Estates will be an enabler of integrated locality based care. The city has the usual mix of poor quality, old estate and newer, excellent quality estate. The MCP will support primary care practices with their estates challenges and create health hubs around practices, or in existing community assets.

Carers will be better supported. There will be a strong focus on recognising carers and their needs in their own right when delivering integrated health and social care to people. The MCP will support those with caring responsibilities to remain mentally and physically well by developing systems to identify carers earlier and signpost to local support services. Young carers and carers who are not local to their loved one will also be supported by the locality teams. Carers will be valued as important members of the community teams.

Metrics. By April 2016 we will be seeing real traction on key metrics which demonstrate improving patient centred care. These metrics will include the Southampton Better Care metrics: ***reducing non-elective admissions, reducing delayed transfers of care, reducing permanent admissions to care homes and reducing injuries due to falls.*** In addition there will be metrics supporting improved care for children, working age adults and families.

By 2016 all service specifications for services commissioned by the city council or the CCG will reflect the cluster model and ***every commissioning contract will be based around clusters.***

By April 2016, Southampton city will have a growing reputation for ***high quality, cost effective, seamlessly integrated health and social care*** – where Joan, her children and grandchildren do not have to repeat themselves, where they are empowered to live healthy and happy lives and the public and

community sector supports them to fulfil their potential whether they are 9 or 99.

As we move into 2016/17 and beyond, the ambition is for that the strong, effective, well governed MCP will be able to include more of the outpatient activity from the acute hospital, by working with acute colleagues to join up acute pathways with community teams. This might lead to a development into a PACS model over time. The range of services could also expand to include police, fire, education, local community pharmacies, employment and training services – all linked to the clusters.

Q6. What do you want from a structured national programme?

(Aside from potential investment and recognition: i.e. what other specific support is sought?)

Southampton city is committed to implementation of an MCP and being part of a structured national programme will enable the implementation to happen faster by being ***part of a learning community***, where we can share ideas and solutions with others who are pursuing the same ambition. We are particularly interested in robust ***evaluation methods and models*** so that the outcomes of this programme can be rigorously measured. We want to develop a rigorous methodology which enables us to monitor our own progress and measure success so we know when we have made a real difference to care for Joan, her children and grandchildren.

Support to allow the innovations demonstrated in Southampton to be ***shared more widely through the UK*** and for Southampton to learn from other systems.

Support for the ***commercial models for capitated contracts*** and the data analysis required for successful management of these contracts.

Solent are already well progressed in implementing an innovative model ***to support a large GMS GP practice*** to be sustainable and support for the ***legal and commercial frameworks*** for this model would be useful. We would also appreciate facilitation support for bringing the remaining GP practices into the model. CCG co-commissioning will enable the CCG to design contracts aligned to the strategy but there are a handful of practices where there will still be work to do in getting hearts and minds entirely behind the vision.

A key requirement of a successful MCP will be the efficient use of estates in the community. Southampton MCP would appreciate support in implementing ***the estates strategy including for primary care premises*** especially in terms of developing cost effective financing options, to fully meet the health and wellbeing needs of the city.

IT development is well underway in the city with the Hampshire Health Record well established and TPP Systm1 used by a number of primary and community services. However, there is still much that could be done, and

national support in developing fully integrated care records across health and social care would go a long way to increasing integration of services.

The Southampton city model is brought in partnership with Southampton Voluntary Services and a structured national programme enables ***national charities to formulate an approach for integrating with models*** like this which could be replicated elsewhere.

Work has already started with Health Education Wessex on the workforce changes needed to support this model, but ***help on workforce design and development***, learning from innovative programmes elsewhere in the country, would enable the MCP to move faster.

National support will allow greater investment in management support to enhance and complement the existing system wide team enabling Southampton city to reach our goals more quickly – delivering ***truly joined up care for Joan by April 2016***.

Please send the completed form to the New Care Models Team (england.fiveyearview@nhs.net) by **9 February 2015**.

DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		PUBLIC HEALTH ANNUAL REPORT 2014		
DATE OF DECISION:		25 MARCH 2015		
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 80833738**
	E-mail:	**andrew.mortimore@southampton.gov.uk**		
STATEMENT OF CONFIDENTIALITY				

None.

BRIEF SUMMARY

The Director of Public Health has a duty under the NHS Act 2006 to write an annual report on the health of the local population and the local authority has a duty to publish it. The content and structure of the report is to be decided locally.

RECOMMENDATIONS:

(i) That the Health and Wellbeing Board welcomes the Public Health Annual Report and considers the implications for the future work of the Board.

(ii) That the Health and Wellbeing Board considers the persisting health inequalities that are described in the Report and agrees to develop a prioritised plan of evidence-based actions that will make the biggest contribution at local level to reducing these.

REASONS FOR REPORT RECOMMENDATIONS

1. The purpose of the Director of Public Health's Annual Report is to make an assessment of the health of the local population and make recommendations on key actions that would lead to an improvement in the population's health.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

3. This is the second report since Public Health leadership and responsibilities transferred from the NHS back to local government on 1st April 2013. In it the Director of Public Health reports on the state of Southampton's health, underlying trends and some of the future challenges that the City faces, and makes recommendations for how health can be improved.

4. There is a wide range of information in our Joint Strategic Needs Assessment (JSNA) that helps us understand the health of people in Southampton. This resource is regularly updated and paints a picture of

what life is like in Southampton and what the health challenges are. The full JSNA is a web-based resource and can be found at ww.publichealth.southampton.gov.uk/jsna. As well as data and analysis, there are mapping tools and summaries which enable a detailed picture to be built up on a wide range of topics.

5. The Public Health Annual Report highlights a number of key issues facing the City and aims to help set the agenda and accelerate progress in improving health. This year we are making the online version of the Report a more useful resource, and will be publishing a series of papers on the topics selected each year with links to the more detailed data in the JSNA and elsewhere, as well as summaries, presentations and other resources. We are aiming to engage more widely and ensure that everyone who can make a contribution to improving health is able to do so.

6. We are becoming less physically active as a society, and the risks of a sedentary lifestyle affect our young people as it is in childhood that behaviours begin to be established. Most young people are not as active as they need to be for good health, and we look at why this is and what can be done to improve fitness levels.

7. One in ten children have a mental health problem at some point, and half of all adult mental ill health starts before the age of 15. Children from the poorest households are three times more likely to have a mental health problem. There are many challenges that young people face by the time they get into their teens, and building mental resilience – the ability to 'bounce back' - helps to reduce the risks and increase life chances. The second chapter looks at how this can happen and the specific opportunities that the City has with its Big Lottery funded HeadStart programme.

8. Environmental factors have a major impact on health. Accidents cause injuries that can have a devastating impact on mobility and on physical and mental wellbeing. The third chapter looks at the wide range of accidents and injuries that can occur across the life-course, and what can be done to prevent many of them and reduce their impact.

9. We can easily take the air that we breathe for granted. Poor air quality can be the cause of significant health problems affecting people of all ages. Recent reports have highlighted that this is a problem in Southampton, where expected improvements in air quality have not yet been achieved. The fourth chapter of this year's report explains the ways in which poor air quality causes disease and worsens health problems, particularly in those who are vulnerable, with long term exposure contributing to over 100 deaths in adults every year. Measures to reduce exposure to vehicle emissions lie at the heart of improving the situation – technology and innovation can only go so far, and we need fewer car journeys and to encourage more people to walking and cycle.

10. Dementia is less common in people with healthy lifestyles. The risk of dementia, however, increases with age, and it is estimated that only half of

those with the condition are currently diagnosed. Most people with dementia will have other long term conditions such as high blood pressure, heart disease, diabetes and depression. There is limited scope for effective treatment, so the main focus remains on early diagnosis, care and support.

11. Hypertension (high blood pressure) is a major public health challenge as it is a risk factor for disease, particularly heart disease and stroke, and contributes to 13% of all deaths. Just over 25,000 adults in Southampton are known to have hypertension, but almost as many are estimated to have high blood pressure that has not yet been diagnosed. The issue is explored in detail in a chapter that emphasises the importance of managing lifestyle factors and encourages opportunistic testing, increasing the uptake of NHS Health Checks and raising public awareness.

12. The final section of the Report looks again at the health inequalities that exist in Southampton. We reported on this topic in 2009, but despite a focus over the last decade on reducing these inequalities, the health gap between those who are well off and those who are the poorest has not significantly reduced. The chapter explores the reasons for this, and what more can be done to tackle the issue. A prioritised plan of evidence-based actions that will make the biggest contribution at local level is needed. The Health and Wellbeing Board has a key role to play in providing strategic leadership and coordination if we are to make real difference.

RESOURCE IMPLICATIONS

Capital/Revenue

13. None

Property/Other

14. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

15. Section 73B(5) & (6) of the NHS Act 2006, inserted by section 31 of the Health and Social Care Act 2012.

Other Legal Implications:

16. None

POLICY FRAMEWORK IMPLICATIONS

17. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Appendices

1.	Public Health Annual Report 2014

Documents In Members' Rooms

1.	None.

Equality Impact Assessment

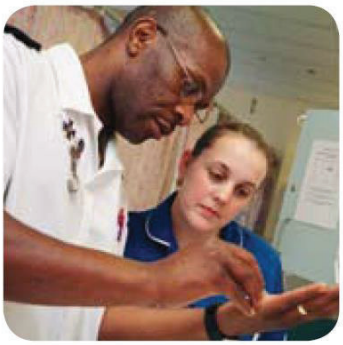
Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out?	No

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.	

SOUTHAMPTON CITY COUNCIL



Health in Southampton 2014

Laying the foundations for future generations

Report from the Public Health Director for Southampton

Southampton City Public Health Annual Report 2014

Contents

Finding out more about the health of Southampton

As well as publishing an Annual Report and a Joint Strategic Needs Assessment (JSNA), we also produce a number of other resources that help build up a more detailed picture of health in Southampton. The back catalogue of annual reports is available on our website; these give an in-depth analysis of a range of topics that remain current in our City. We also publish briefing notes which are a comprehensive look at topics such as child growth, inequalities and sexual health. We produce profiles of the sixteen electoral wards in the city; these are available as an interactive mapping tool on our website.

Please visit our website to access any of these resources:

www.publichealth.southampton.gov.uk

Acknowledgements

Many thanks to Dan King and Debbie Chase for editing this report and to the following members of the public health team for their contributions: Bob Coates, Ginny Cranshaw, Jennifer Davies, Parvin Damani, Martin Day, Nicola Duffield, Tim Davis, Ravita Taheem, Sally Denley and Robin Poole.

Special thanks also to guest contributors Helen Cruickshank, Steve Guppy, Liz Taylor and Lee Tillyer.

Preface

This is my second report since Public Health leadership and responsibilities transferred from the NHS back to Councils on 1st April 2013. In it I report on the state of Southampton's health, underlying trends and some of the future challenges that we face, and make recommendations for how health can be improved.

The health of people living in Southampton continues to improve. We are living longer, deaths from heart disease and stroke are falling and cancer survival rates are improving. However, not all of these extra years of life are lived in good health or free from disability. Some health indicators in childhood show that we are not yet succeeding in our aim to give every young person the best possible start in life. There has also been limited progress in narrowing the health gap between the wealthy and those who are on low incomes, and many challenges remain or have increased in significance.

In this report we look again at the extent of the health differences between those who are well-off and those on low incomes, and the limited progress that has been made in reducing the gap. More can and must be done, based on good evidence of what works.

We also explore a range of issues that will help to lay the foundations for better health for future generations. Improving the public's health and tackling these challenges can only be done by working in partnership across our City, and my recommendations aim to show how together we can make Southampton *"a healthier city - a place which is safe and healthy and where people thrive"*.

Dr Andrew Mortimore
Director of Public Health
Southampton City Council
March 2015

Introduction

If Southampton is to become a healthier City, we need to know what our current health outcomes are, trends over time, how we compare with similar cities and what the evidence suggests will make the biggest difference if we want to improve.

There is a wide range of information in our Joint Strategic Needs Assessment (JSNA) that helps us understand the health of people in Southampton. This resource is regularly updated and paints a picture of what life is like in Southampton and what the health challenges are. The full JSNA is a web-based resource and can be found at www.publichealth.southampton.gov.uk/jsna. As well as data and analysis, there are mapping tools and summaries which enable a detailed picture to be built up on a wide range of topics.

The Public Health Annual Report highlights a number of key issues facing the City and aims to help set the agenda and accelerate progress in improving health. This year we are making the online version of the Report a more useful resource; Full technical briefings on the this year's selected topics are published along with links to further information in the JSNA and elsewhere, as well as topic summaries, city profiles and other resources. We are aiming to engage more widely and ensure that everyone who can make a contribution to improving health is able to do so.

We are becoming less physically active as a society, and the risks of a sedentary lifestyle affect our young people as it is in childhood that behaviours begin to be established. Most young people are not as active as they need to be for good health, and we look at why this is and what can be done to improve fitness levels.

One in ten children have a mental health problem at some point, and half of all adult mental ill health starts before the age of 15. Children from the poorest households are three times more likely to have a mental health problem. There are many challenges that young people face by the time they get into their teens, and building mental resilience – the ability to 'bounce back' - helps to reduce the risks and increase life chances. The second chapter looks at how this can happen and the specific opportunities that the City has with its Big Lottery funded HeadStart programme.

Environmental factors have a major impact on health. Accidents cause injuries that can have a devastating impact on mobility and on physical and mental wellbeing. The third chapter looks at the wide range of accidents and injuries that can occur across the life-course, and what can be done to prevent many of them and reduce their impact.

We can easily take the air that we breathe for granted. Poor air quality can be the cause of significant health problems affecting people of all ages. Recent reports have highlighted that this is a problem in Southampton, where expected improvements in air quality have not yet been achieved. The fourth chapter of this year's report explains the ways in which poor air quality causes disease and worsens health problems, particularly in those who are vulnerable, with long term exposure contributing to

over 100 deaths in adults every year. Measures to reduce exposure to vehicle emissions lie at the heart of improving the situation – technology and innovation can only go so far, and we need fewer car journeys and to encourage more people to walk and cycle.

Dementia is less common in people with healthy lifestyles. The risk of dementia, however, increases with age, and it is estimated that only half of those with the condition are currently diagnosed. Most people with dementia will have other long term conditions such as high blood pressure, heart disease, diabetes and depression. There is limited scope for effective treatment, so the main focus remains on early diagnosis, care and support.

Hypertension (high blood pressure) is a major public health challenge as it is a risk factor for disease, particularly heart disease and stroke, and contributes to 13% of all deaths. Just over 25,000 adults in Southampton are known to have hypertension, but almost as many are estimated to have high blood pressure that have not yet been diagnosed. The issue is explored in detail in a chapter that emphasises the importance of managing lifestyle factors and encourages opportunistic testing, increasing the uptake of NHS Health Checks and raising public awareness.

The final section of the Report looks again at the health inequalities that exist in Southampton. We reported on this topic in 2009, but despite a focus over the last decade on reducing these inequalities, the health gap between those who are well off and those who are the poorest has not significantly reduced. The chapter explores the reasons for this, and what more can be done to tackle the issue. A prioritised plan of evidence-based actions that will make the biggest contribution at the local level is needed. The Health and Wellbeing Board has a key role to play in providing strategic leadership and coordination if we are to make a real difference.

1. Fitness in young people

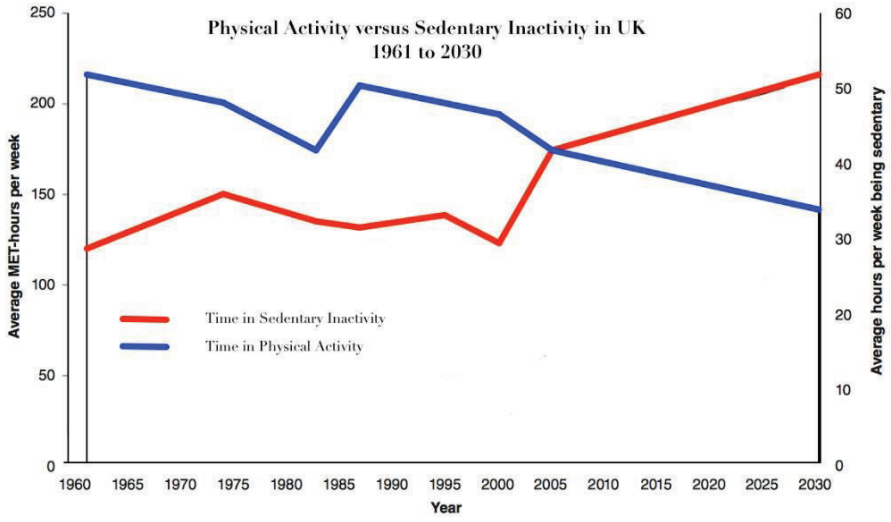
1.1 Why is this issue important?

Regular physical activity can reduce the risk of many chronic conditions including coronary heart disease, stroke, type 2 diabetes, cancer, obesity, mental health problems and musculoskeletal conditions. Even relatively small increases in physical activity are associated with some protection against chronic diseases and an improved quality of life. These benefits can deliver cost savings for health and social care services. However, the benefits of physical activity extend further to improved productivity in the workplace, reduced congestion and pollution through active travel, and healthy development of children and young people[1].

In addition, evidence indicates that there are risks of sedentary behaviour for all age groups, with associations being observed between sedentary behaviour and overweight and obesity, and some research also suggesting that sedentary behaviour is independently associated with all-cause mortality, type 2 diabetes, some types of cancer and metabolic dysfunction. These relationships are independent of the level of overall physical activity. For example, spending large amounts of time being sedentary may increase the risk of some health outcomes, even among people who are active at the recommended levels.

Although humans evolved to move, it has taken less than a hundred years for our behaviours to change to such an extent that physical activity is no longer something that most of us do on a daily basis. Thanks to modern society, the invention of the motorcar and screen based leisure and working activities, we no longer perceive or perform physical activity as a necessity, which poses many health related risks.

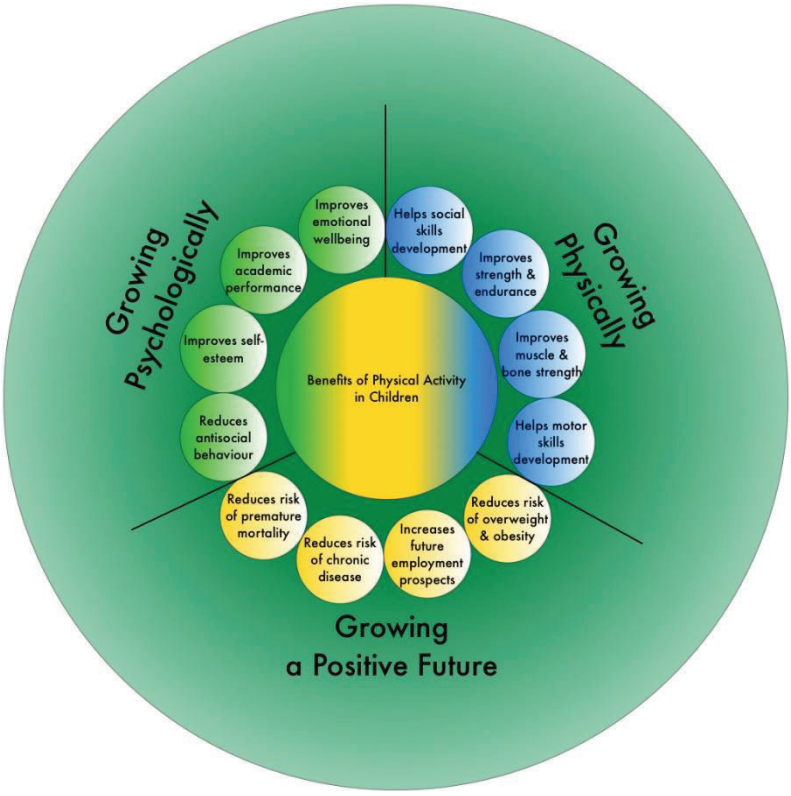
Figure 1: Physical Activity versus Sedentary Inactivity UK (actual to 2005, modelled to 2030)[2]



Physical activity data, collected in the UK as part of the Health Survey for England, Active People Survey, National Travel Survey, General Household Survey and National Diet and Nutrition Survey was compiled to show trends in how we have become less physically active and more sedentary[2]. The study modelled the likely future trends up to 2030, which are illustrated in figure 1. The physical activity is shown as average MET-hours per week. A MET is a 'Metabolic Equivalent' or a universal unit of physical activity energy expenditure allowing different activities to be compared. In figure 1 the MET-hours is a composite measure of active leisure, active transport, occupational and domestic physical activity. This evidence highlights there has been a shift from physical activity to a more sedentary existence in the UK and is likely to continue.

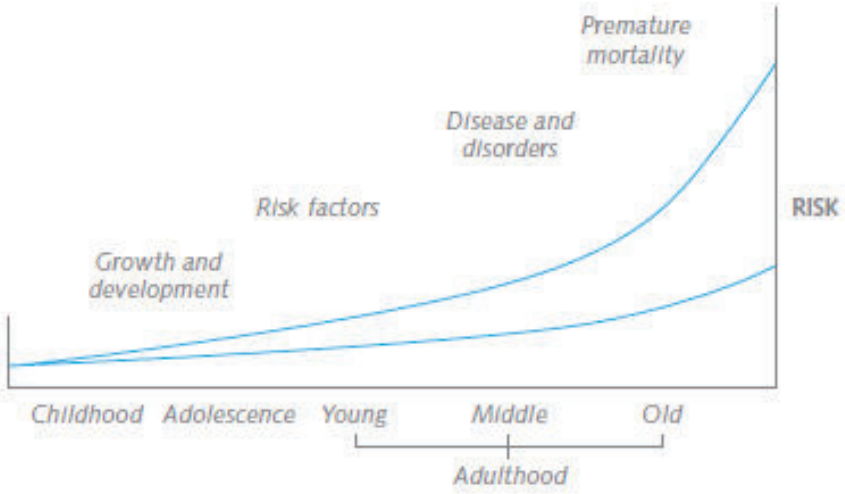
The estimated direct cost of physical inactivity to the NHS across the UK is £1.06 billion[1]. Inactivity also creates costs for the wider economy, through sickness absence and through the premature death of productive individuals. It also increases costs for individuals and for their carers. In England, the costs of lost productivity have been estimated at £5.5 billion per year from sickness absence and £1 billion per year from the premature death of people of working age. Children and young people who become more active will *immediately* benefit from enhanced physical strength and endurance, improvement in mental wellbeing, enhanced academic performance and reduced absenteeism through ill health from school and college. They develop better social skills through active play and can use physical activity as a displacement for anti-social and criminal behaviour. In the medium to longer term, more physically active children are less likely to become overweight or obese. Benefits of physical activity in children are shown in figure 2 below.

Figure 2: Benefits of physical activity in children



Although it is not until adulthood and older age that the increase in morbidity and premature mortality is seen, the exposure to risk through inactivity begins in childhood and behaviours established in the early years are predictive of patterns of behaviour in adulthood. Indeed, the strength of the relationship between physical activity and health outcomes persists throughout people's lives, highlighting the potential health gains that could be achieved if more people become more active throughout the life-course. Figure 3 below shows a hypothetical model showing the difference in risk with the top line representing those who are inactive and bottom line those who are active[1].

Figure 3: Key stages of disease development throughout the life course



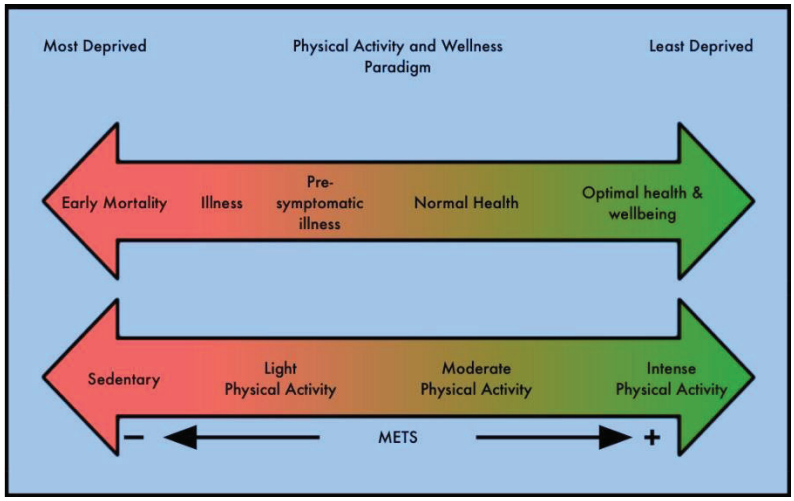
For our children and young people being physically active is an investment in their own and future generations since a cultural shift to a more active society will be passed onto their offspring and it will become embedded in the very fabric of life. Future generations can also benefit from inheriting a more sustainable existence where a more active society has reduced health and social care costs, a significantly reduced carbon footprint and greater social cohesion.

Long-term, active children will grow into adults with improved bone strength and cardiovascular health and the enhanced achievements at school lead to better jobs and houses. They will on average live longer than children who are not physically active. In the UK, physical inactivity is the fourth leading risk factor for death after tobacco use, high blood pressure, and obesity[3]. There is a three year life-expectancy difference between people who are physically inactive and those that do even a small amount of physical activity demonstrating that any shift away from sedentary behaviour is advantageous. Figure 4 below shows a conceptual continuum between sedentary behaviour and physical activity and how this can also link to a gradient between early mortality and optimal health and wellbeing.

Although any reduction in inactivity can be beneficial, for optimising health benefits, the Chief Medical Officer currently recommends that once children can walk they are encouraged to have 180 minutes or more of activity every day up until the age of 5 years, after which being active for a minimum of 60 minutes every day is recommended until adulthood.

Data from the Health Survey for England 2012 suggests that approximately only 10% of under 5 year olds meet the current recommendations for physical activity whilst 21% boys and 16% girls aged 5-15 achieved one hour or more of moderately intensive exercise each day. Older children are less active than younger children, with 24% of 5-7 year olds achieving the recommendations, but only 14% in 13-15 year olds.

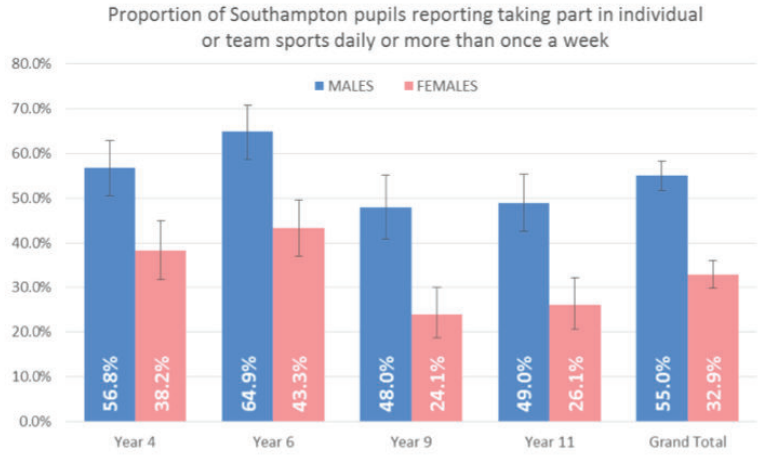
Figure 4



Currently data is not routinely collected in Southampton. It was last collected as part of the discontinued 'PE and Sport Survey' in 2009/10, where 57% of children self-reported achievement of three hours or more physical activity each week (based on previous national recommendations), whether as part of PE or outside school.

A school pupil attitude survey was undertaken in December 2012 amongst children in Years 4, 6, 9 and 11 across the City. The response rate was about 24% of all pupils and was underrepresented by children living in the most deprived areas. A number of measures of physical activity and sedentary behaviour were recorded including method of getting to school, enjoyment of physical activity and number of days taking part in individual or team sports. The bar graph in figure 5 below shows data from children involved in some sort of sport on two or more days per week by age and gender.

Figure 5

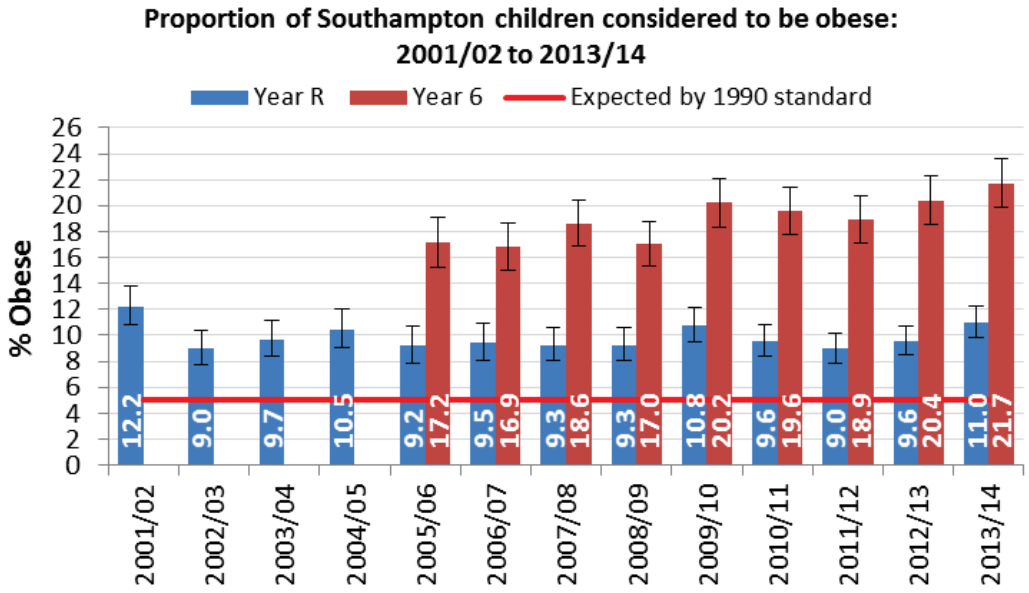


The drop off in sport participation between Years 4/6 and Years 9/11 is evident for both boys and girls. However, a statistically significant higher proportion of boys take part in sport (at least twice a week) compared to girls in all year groups, with almost twice as many boys taking part compared to girls in Years 9 and 11. The full report on the pupil survey can be found at the following link (http://www.publichealth.southampton.gov.uk/HealthIntelligence/Briefings.aspx).

It is apparent that children in Southampton, just as in the rest of the country, are not meeting the current recommendations for physical activity, and as a result, are not fulfilling their potential to live long and healthy lives. There is also likely to be significant health inequalities in relation to physical inactivity according to income, gender, age, ethnicity and disability.

Whilst physical activity is not the whole answer to addressing the high prevalence of overweight and obesity in children, it is an important component of the energy balance between calories consumed and calories expended. Studies have shown that children who are more active are more likely to have a healthy body weight. In England, children have been measured at reception age (4-5 year olds) and year 6 (10-11 year olds) since 2005 as part of the National Childhood Measurement Programme. Figure 6 below shows the proportion of children considered to be obese in Southampton and how this has changed with time.

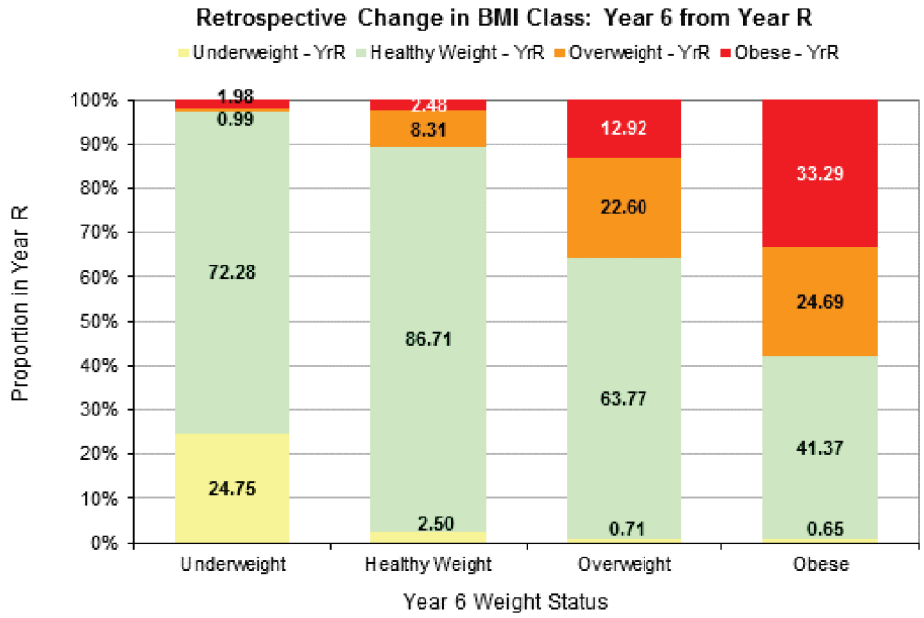
Figure 6



In Southampton in 2013/14, approximately 1 in 4 reception aged children were measured as being overweight and 1 in 10 obese. In year 6 children, 1 in 3 were overweight and 1 in 5 obese. Body mass changes between reception age and year 6 are not exclusively in the direction of weight gain but the majority are as can be seen from figure 7 below. This bar chart shows that around 40% of children who are obese by year 6 were previously a healthy weight in reception year, and that the majority of healthy weight children in year 6 were those having been healthy weight in reception year with less than 3% having transitioned from obesity to healthy weight during that time. Clearly there is an

opportunity to do something to change the momentum of this weight gain as children begin to go to school. Becoming more physically active may represent part of the answer.

Figure 7: Change in BMI classification in the same children between Year R and Year 6



Children from the most deprived areas are significantly more likely to be overweight or obese compared to children from the least deprived areas. This may offer an opportunity to target physical activity interventions towards those most in need in order to reduce health inequalities, although as the work of Marmot suggests, addressing issues across the entire socioeconomic gradient is important albeit in a proportionate way[4].

1.2 What can be done?

It is clear we need to do something *now* to reverse the current trend in physical inactivity as the potential benefits to the individual and society are significant. To achieve this does not necessarily mean encouraging people to join gyms or start playing a sport. Physical activity encompasses everyday activities such as active travel, occupational activity, housework; recreation activities such as walking, cycling, active play, dance; and sport through formal and informal activities. It is therefore about *everybody being active, everyday, doing everyday things*. The aim is to create a normality where we combine all these different forms of physical activity and reduce the length of time we spend being inactive. This includes designing our physical environments including cities, parks & open spaces and buildings to make being active easier.

'Everybody Active, Every Day' provides the evidence base of what works and hence a framework for action to address physical activity in both adults and children[5]. A good example of what can be achieved comes from Finland, which when faced with the highest incidence of heart disease forty years ago invested in physical activity across the entire life-course. Deaths from cardiovascular disease

were reduced by 65% by addressing nutrition, tobacco use and physical activity simultaneously. *Persistence* and *collaboration* were believed to be key ingredients to effective change and should form the principles of work we do to address the issue in Southampton.

Before children are old enough to attend school, encouraging unstructured active play is an essential element of activity becoming an everyday part of life. Research in Southampton has highlighted the importance of maternal physical activity in getting children more active and the importance of this activity being fairly vigorous in under five year olds in order to maintain healthy weight[6]. Ensuring good advice for parents during pregnancy and in the early years of their children's lives can help them to form good activity habits.

Parents of school-aged children have a responsibility to encourage them to be physically active in the evenings and at weekends and to limit the length of time spent having small screen recreation such as watching television, playing computer games, browsing the internet or using their smart phones. A rule of thumb is that limiting this sedentary behaviour to two hours maximum each day can help to encourage children to reach the recommended levels of physical activity. National programmes such as the 'Change4life' campaigns can help to deliver messages to parents of school aged children[7]. Active parents are associated with active children and to be effective campaigns should be targeted at whole families.

Schools themselves represent an excellent opportunity for a holistic approach to becoming physically active and evidence supports this. This can include physical education, classroom activities, afterschool sports, and promoting active travel for their school commute.

Transitions between schools or on leaving school sometimes act as barriers to continuing participation in sport. Ensuring whole school approaches to physical activity can also help children during these transitions. The National Institute for Health and Care Excellence (NICE) also recommends school physical activity facilities as being available for extended hours during the days and at weekends[8].

Afterschool clubs and youth clubs can offer children and young people wonderful opportunities for being physically active in an enjoyable, socially supportive environment. Additionally, ensuring good access to safe outdoor spaces such as parks and play areas is an important part of optimising the built environment to make everyday activity easy for children. Evidence suggests that living close to parks and play areas can increase the amount of physical activity in children[9]. Guidance from NICE on interventions to promote physical activity in children includes recommendations to actively promote public parks and facilities and ensure they are safe. Actively promoting the many good park facilities we have within the city should be considered to help get more children more active[8].

Collaborative working across council sectors to ensure that every transport, planning and development decision considers the impact on physical activity for children and young people, building environments that are safe for cyclists and make walking easier are further key ingredients to making everybody active, every day. This also means continuing to build partnerships with community

organisations and other stakeholders who share a common vision and can contribute towards making activity the norm.

What is currently being done in the city?

In order to achieve and sustain behaviour change, the evidence suggests that there is a need to target interventions at an individual/family, organisational and community level.

Individual level interventions

At an individual level there are a wide range of activities and services operating across the city that engage children and young people in active play and physical activity. These are promoted on the Active Southampton website through directories of services.

Active Southampton is Southampton's Sport and Physical Activity Alliance (SPAA) and is a partnership of organisations who promote sport and physical activity across the whole city. The Partnership acts as a single voice and 'one stop shop' for the planning and co-ordination of sport and physical activity within Southampton. The forum facilitates and supports a wide range of different activities and schemes for children locally (see website for details http://activesouthampton.co.uk/). These include Street Sport, Hampshire Games and Sportivate in addition to those listed in the directories.

Skyrides also come to Southampton, allowing children and their parents to ride in traffic free routes to gain valuable experience and have fun cycling. Parkrun takes place every week in Southampton common. This is a timed 5 kilometre run with hundreds of people taking part each week including many older children and teenagers.

The new Public Health School Nursing Service has a remit of addressing the wider health improvement agenda through both individual level support as well supporting schools in a whole school approach to a range of lifestyle issues.

Organisational level interventions

The city council's 'My Journey' initiative, in collaboration with the cycling charity Sustrans, works closely with schools to promote active travel during the journey to school in a programme called 'Bike It' as well as a STARS programme that works with schools taking a whole school approach to physical activity.

A piece of work was undertaken in conjunction with Southampton Solent University during 2013-14 to better understand the extent and nature of physical activity-specific interventions within the city's schools with a particular focus on priority areas, to identify what is currently being done and what works. This highlighted a lack of programmes designed specifically to increase physical activity over and above existing PE lessons.

In the previous Fit4Life (tackling obesity) Strategy (2009-13), Southampton schools were tasked with having a comprehensive physical activity policy and ensuring two hours per week of structured physical education within existing funding from the School Sports Partnership. This specific funding stream has since ended in conjunction with the end of data collection on physical activity within schools. It is not clear locally whether schools have developed physical activity policies. However, schools do have to teach physical education as part of the national curriculum and the minimum two hours structured physical activity is one of the requirements for schools meeting National Healthy School Status.

Schools continue to be supported to work towards the Healthy Schools Enhanced Model (Pioneer) and those choosing to focus on physical activity and/or obesity work closely with the Healthy Schools team to achieve measureable changes in children's behaviours and patterns of activity and/or diet.

Sure Start Children Centres in Southampton continue to be a valuable resource for parents and carers with young children and hence are a key setting for intervention. As such Children Centres as well as other providers of early years care are encouraged to engage with the city-wide Healthy Early Years Award which sets recommended standards for settings in terms of both physical activity/play and nutrition. Many of the city's children centres are either working towards or have already achieved these standards.

Community level interventions

'Making Every Contact Count' (MECC) is a programme being rolled out to the workforce from various sectors of the city. It is an evidence-based healthy conversation skills teaching that allows staff to make more impact in enabling change in people's behaviours. The key is that people already have the solution towards making positive changes in their own lives or the lives of their children and MECC can help them to unlock their own resources. It has great potential to deliver behaviour change around physical activity by widening the workforce trained in using it.

The physical environment is important in enabling and supporting behaviour change, whether this is the quality and quantity of open and green spaces, cycle lanes, walkability of the environment, transport infrastructure, leisure facilities, play areas/equipment etc. There is joint working across the council to integrate the evidence base in terms of promotion of physical activity within transport and planning programmes and policies.

1.3 Recommendations

In line with the recent Public Health England publication, 'Everybody Active, Every Day' (2014), the key recommendations for action from the Director of Public Health are:

1. To create a social movement through encouraging a whole city *collaborative* cross-sector approach to physical activity through the Health and Wellbeing Board.
2. Commissioners and those planning services to ensure *persistence* and consistence of key messages by rolling out 'Making Every Contact Count' to the wider health workforce and beyond.
3. The Council to ensure good quality physical activity data is collected locally in school-aged children in order to monitor and evaluate the success of any work done.
4. The Health and Wellbeing Board to ensure physical activity is considered as part of the planning process for the city through championing the continued development of active environments and use of existing green spaces.

1.4 References

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2. Building mental resilience in young people

2.1 Why is this issue important?

There are just over 58,000 children and young people living in Southampton, with over one quarter living in poverty. We know that the physical and mental health of children and their life chances are strongly linked to deprivation. Within our child health profile, Southampton is significantly worse than England for 11 of the 32 indicators, this includes a high rate of looked after children, teenage pregnancy and hospital admissions for mental health conditions (see appendix 1).

We also know that it is important to prevent the development and accumulation of ill-health at the earliest stage possible. Some 50% of adult mental illness (excluding dementia) starts before age 15, and 75% by age 18[1]. Children and young people from the poorest households are three times more likely to have a mental health problem than those growing up in better-off homes. Furthermore, mental health problems in childhood and adolescence in the UK result in increased costs of between £11,030 and £59,130 per child annually[1].

Building mental resilience can help reduce the risk of future mental health problems and support young people in making important life choices. Adolescence is a time of life-changing decision-making. Choices about education, occupation and childbearing during the teenage years can have profound impacts on subsequent life chances, while behaviours that predicate future health; such as diet, exercise, sexual activity and psychoactive substance use, develop during adolescence.

What is mental resilience and what is the link with health?

Mental resilience is the capability to 'bounce back' from adverse experiences, and succeed despite adversity. Although resilience reflects individual personality traits, it is also shaped by experiences, opportunities and relationships. Exposure to risk factors is more likely to lead to vulnerability, whereas protective factors lead to increased resilience. Protective factors include achievement and attainment at school, successful transitions, good relationships with parents, teachers and peers, a supportive school environment, and community social capital, resources, services and connectedness. Conversely, risk factors are the opposite of many of these features e.g. low achievement at school or neglectful or unsupportive family relationships[2].

Resilience is dynamic, it can accumulate and develop (or reduce) over time. Changes in resilience over the life course are likely to be related to the experiences of individuals, families and communities and wider social, economic and political factors. Even highly resilient individuals cannot overcome all adversity, such as severe abuse and neglect or living with multiple adversities such as poverty, parental mental illness and having little social support[2].

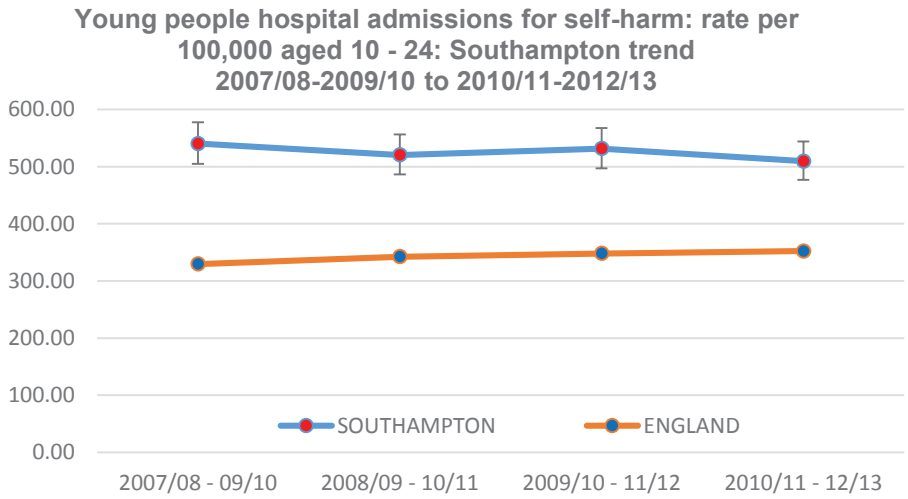
Evidence suggests that mental resilience in early life helps to protect against risky health behaviour, improve academic results, develop skills to increase employability, increase mental wellbeing and enable quicker and better recovery from illness[2].

What is the situation in our City?

Our City's Joint Strategic Needs Assessment shows that nearly 5,500 of our children and young people have mental health problems, two thirds with conduct disorders. The estimated need for children with moderately severe problems requiring attention from professionals trained in mental health (Tier 2) is 3,590 children and young people.

The directly standardised hospital admission rate as a result of self-harm for children aged 10 to 24 years in Southampton is 400.9 per 100,000 (2012/13). Our rate is significantly higher than England, and has remained similar from 2007/08 to 2012/13. Crude rates of hospital admissions are shown in figure 1 below.

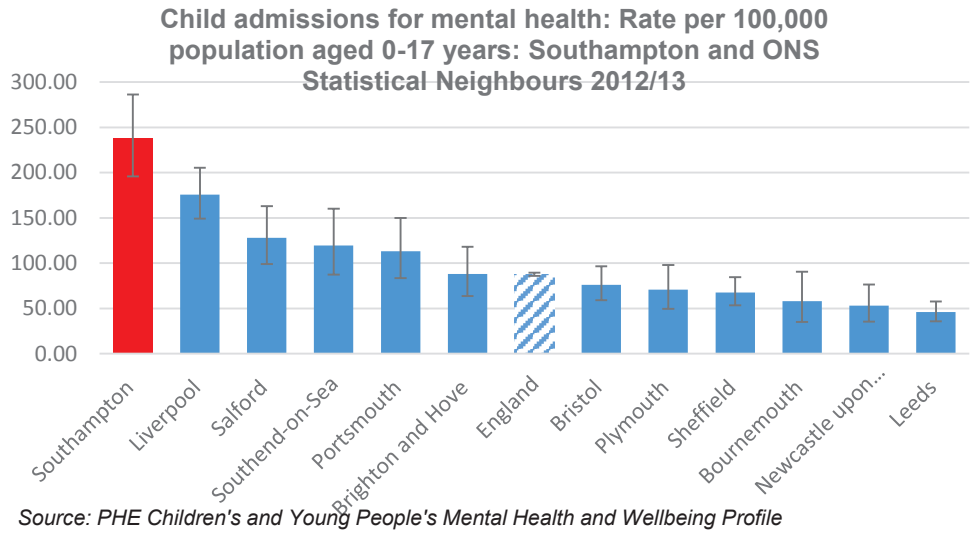
Figure 1:



Source: PHE Children's and Young People's Mental Health and Wellbeing Profile

Similarly, Southampton City has a significantly higher rate for mental health hospital admissions, with a crude rate of 238 per 100,000 (aged 0-17 years) in 2012/13. As can be seen from figure 2, Southampton had a higher rate of mental health admissions in 2012/13 than all our statistical neighbours. It is important to note that this higher rate has been attributed to variations in hospital admission policies between acute trusts.

Figure 2:

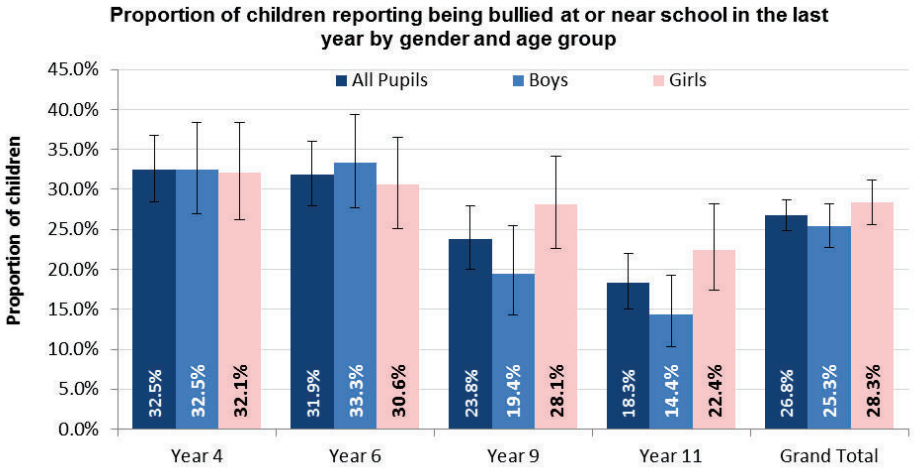


Source: PHE Children's and Young People's Mental Health and Wellbeing Profile

Information and data from Southampton schools, voluntary services and our Child and Adolescent Mental Health Service (CAMHS) describes a lack of support at lower levels of mental health need. Emotional and mental health need accounts for 37% of school nursing referrals. Most importantly, these issues are also echoed by young people themselves within local workshops and focus groups.

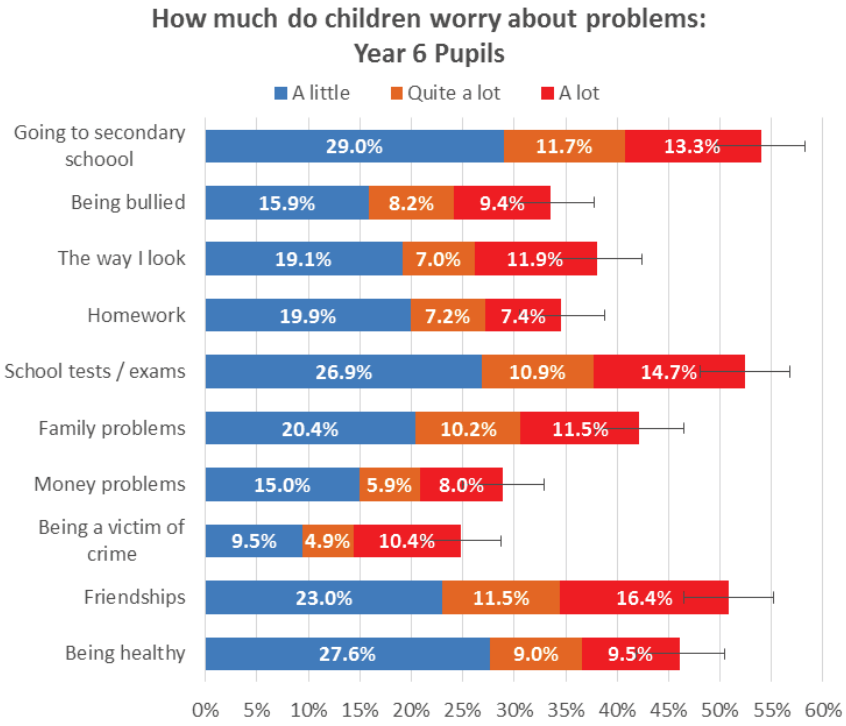
Our latest school pupil attitude survey was undertaken in December 2012 amongst children in Years 4, 6, 9 and 11 across the City. The response rate was about 24% of all pupils, although a low response, the characteristics of pupils completing the survey were similar to age specific demographics. However, there was an underrepresentation of responses from pupils living in the most deprived areas of Southampton (particularly for Year 4). Survey responses suggested that 1 in 4 pupils (26.8%) had been bullied in the past 12 months and this declined with age (from 32.5% in Year 4 to 18.3% in Year 11). Figure 3 shows the proportion of children being bullied at or near school in the last year by gender and age group.

Figure 3:



The proportion of pupils reporting being afraid of going to school due to bullying was slightly higher (28.3%), this might suggest that perceptions of potential bullying may further raise anxieties. Pupils were also asked about where they felt safe; sadly 2.3% (43 students surveyed) reported feeling unsafe or very unsafe in their own homes, with the highest being in the Year 4 cohort (3.7%). Children were also asked about their 'worries'. Figure 4 below shows the 'worries' identified by pupils in Year 6. The highest proportion of children expressed 'worries' on going to secondary school, school tests/exams and friendships.

Figure 4



In general, the proportion of pupils worrying about most problems increased with age, the exception being bullying. The largest increase in 'worries' from Year 4 to Year 11 were in relation to school tests/exams (36% vs 71.3%), the way they look (32.2% vs 58.8%) and being healthy (40.7% vs 64.1%).

2.2 What can be done?

There is good evidence about what works to build protective factors and reduce risk factors to promote wellbeing, and some evidence on building resilience[2]. Some examples at different levels of intervention are highlighted in the table below. Of note, research consistently emphasises that, in nearly all cases, children cannot build resilience without love, support and positive relationships, most crucially with their family.

Level of intervention	Examples
Individual	Seattle social development project, SEAL (UK) (whole school approach), social and emotional learning programmes (US), building emotional resilience in schools, Deny Scotland (transition programme), strengthening families programme
Interpersonal	Effective parenting and good parent-child relationships Links between parents and schools e.g. Families and Schools Together, Place2Be Teachers support in schools e.g. YoungMinds in schools, skills for life programme Friends e.g. peer mentoring in schools
School and community	Whole school approach - Health Promoting schools

NICE has modelled the cost-effectiveness of whole school approaches to prevent bullying and victimisation and found that where these interventions were successful, the cost per QALY was £9,600. However, there was a significant range in the efficacy of programmes[2].

Taking action on resilience can reduce costs in other areas e.g. reducing truancy can produce a saving of £1,318 per year per child, and reducing exclusion can save £9,748 in public value benefits, 89% of which goes to local authorities[1].

What have we done locally?

In 2014/15, through a £500,000 award from the Big Lottery HeadStart Programme, children and young people aged 10-14 years in specific areas across the City will have access to a range of skills development opportunities and fun activities to help raise their mental resilience.

The purpose of the programme is to raise young people's aspirations through a 'whole school' approach to building mental resilience; making sure that the child/young person, and everyone around that child/young person, is skilled up to deal with life's challenges at the earliest stage possible. The programme also provides additional support for those with higher level mental health needs (but not at the level of referral to the child and adolescent mental health service).

The Southampton HeadStart programme has a number of components:

- Emotional First Aid training for professionals, parents and peers in secondary schools
- Mindfulness in primary schools
- Counselling in secondary schools for children/young people at higher levels of risk
- A transition programme from primary to secondary schools
- Community based arts, drama and music activities
- Digital champions to support safer social media use
- Youth leadership programme
- Targeted support programmes for young carers and children/young people exposed to domestic violence

In addition, two young apprentices have been appointed to lead on youth engagement within the programme.

This programme supports the City's strategic aim; to be an early intervention City. The HeadStart Programme offers a key opportunity to develop the foundations of commissioning to raise children and young peoples' resilience and that of their families through a community of practice approach. The learning will also inform the ongoing development of our BeWell Strategy and commissioning priorities for a range of children and young people's services. The Big Lottery have offered an opportunity for funding over an additional 5 years to further develop this programme and make it sustainable.

Alongside this programme, the local Youth Offending Team are leading a restorative practice project. This project aims to prevent and solve conflict at an early stage. Over Spring/Summer 2015, the team will be working with a small number of Southampton's secondary schools, and feeder primary schools, not included within the HeadStart programme. This project offers the potential to not only build resilience in children and young people at higher risk but also reduce school exclusions and criminal activity.

What more can we do?

The Local Authority is currently responsible for commissioning leadership of the Healthy Child Programme 5-19 years via the school nursing service. This service has very recently been re-commissioned (now known as the Public Health Nursing Programme) with an emphasis on raising mental resilience and taking a community based approach. The service will begin in April 2015. Furthermore, responsibility for the healthy child programme pre-birth-5 years (excluding maternity services) will become a local authority responsibility from October 2015. This offers both opportunities to better align the whole programme from pre-birth to 19 years and put an emphasis on raising mental resilience at a family and community level at an earlier stage.

Strong evidence from the Early Years Foundation suggests that resilience development should begin with parenting programmes for families with children under the age of 3 years, and indeed support at time of pregnancy, to have the greatest impact on life chances. A parenting offer is currently being developed that builds on current assets within the City.

2.3 Recommendations:

1. The HeadStart Strategy Group should make the whole school approach a central component of the HeadStart bid for 5 year funding, strengthening the community of practice and making it sustainable.
2. Building mental resilience should be a component of family and child health strategic plans and commissioning intentions from pregnancy to 19 years to raise health and wellbeing via the Children's Transformation Board.
3. Building mental resilience should form part of a wider approach to strengthen community resilience, health and well-being via the Be Well (mental health promotion) strategy.

2.4 References:

1. Department of Health (2013) *Chief Medical Officers Annual report 2013.* [Online] Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/351629/Annual_report_2013_1.pdf

2. Public Health England (2014) *Local Action to Reduce Health Inequalities - Building Children and Young People's resilience in schools.* [Online] Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/355770/Briefing2_Resilience_in_schools_health_inequalities.pdf

3. Public Health England (2014) *Children and Young People's Mental Health Profile.* [Online] Available from: http://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh

Appendix 1

Southampton Child Health Profile — March 2014

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.

- Significantly worse than England average
- Significantly better than England average
- Not significantly different
- Regional average

25th percentile — England average — 75th percentile

	Indicator	Local no.	Local value	Eng. ave.	Eng. worst	Eng. best
Premature mortality	1 Infant mortality	14	4.1	4.3	7.7	1.3
	2 Child mortality rate (1-17 years)	4	7.8	12.5	21.7	4.0
Health protection	3 MMR vaccination for one dose (2 years)	3,320	94.1	92.3	77.4	98.4
	4 Dtap / IPV / Hib vaccination (2 years)	3,422	97.0	96.3	81.9	99.4
	5 Children in care immunisations	255	85.0	83.2	0.0	100.0
	6 Acute sexually transmitted infections (including chlamydia)	1,459	30.2	34.4	89.1	14.1
Wider determinants of ill health	7 Children achieving a good level of development at the end of reception	1,512	50.8	51.7	27.7	69.0
	8 GCSEs achieved (5 A*-C inc. English and maths)	1,210	58.1	60.8	43.7	80.2
	9 GCSEs achieved (5 A*-C inc. English and maths) for children in care	-	-	15.3	0.0	41.7
	10 16-18 year olds not in education, employment or training	430	6.3	5.8	10.5	2.0
	11 First time entrants to the youth justice system	182	968.2	537.0	1,426.6	150.7
	12 Children in poverty (under 16 years)	10,640	25.9	20.6	43.6	6.9
	13 Family homelessness	173	1.7	1.7	9.5	0.1
	14 Children in care	480	104	60	166	20
	15 Children killed or seriously injured in road traffic accidents	15	35.5	20.7	45.6	6.3
Health improvement	16 Low birthweight of all babies	230	6.7	7.3	10.2	4.2
	17 Obese children (4-5 years)	266	9.5	9.3	14.8	5.7
	18 Obese children (10-11 years)	403	20.3	18.9	27.5	12.3
	19 Children with one or more decayed, missing or filled teeth	-	29.9	27.9	53.2	12.5
	20 Under 18 conceptions	170	47.4	30.7	58.1	9.4
	21 Teenage mothers	51	1.6	1.2	3.1	0.2
	22 Hospital admissions due to alcohol specific conditions	35	75.8	42.7	113.5	14.6
	23 Hospital admissions due to substance misuse (15-24 years)	35	78.9	75.2	218.4	25.4
Prevention of ill health	24 Smoking status at time of delivery	512	15.2	12.7	30.8	2.3
	25 Breastfeeding initiation	2,505	74.6	73.9	40.8	94.7
	26 Breastfeeding prevalence at 6-8 weeks after birth	1,441	43.5	47.2	17.5	83.3
	27 A&E attendances (0-4 years)	6,209	400.2	510.8	1,861.3	214.4
	28 Hospital admissions caused by injuries in children (0-14 years)	514	130.0	103.8	191.3	61.7
	29 Hospital admissions caused by injuries in young people (15-24 years)	682	141.2	130.7	277.3	63.8
	30 Hospital admissions for asthma (under 19 years)	111	221.4	221.4	591.9	63.4
	31 Hospital admissions for mental health conditions	112	238.0	87.6	434.8	28.7
	32 Hospital admissions as a result of self-harm (10-24 years)	271	400.9	346.3	1,152.4	82.4

Notes and definitions - Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box.

1 Mortality rate per 1,000 live births (age under 1 year), 2010-2012
2 Directly standardised rate per 100,000 children age 1-17 years, 2010-2012
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2012/13
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2012/13
5 % children in care with up-to-date immunisations, 2013
6 Acute STI diagnoses per 1,000 population aged 15-24 years, 2012
7 % children achieving a good level of development within Early Years Foundation Stage Profile, 2012/13
8 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2012/13
9 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2013 (provisional)
10 % not in education, employment or training as a proportion of total age 16-18 year olds known to local authority, 2012
11 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2012
12 % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2011
13 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2012/13
14 Rate of children looked after at 31 March per 10,000 population aged under 18, 2013
15 Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2010-2012
16 Percentage of live and stillbirths weighing less than 2,500 grams, 2012
17 % school children in Reception year classified as obese, 2012/13
18 % school children in Year 6 classified as obese, 2012/13
19 % children aged 5 years with one or more decayed, missing or filled teeth, 2011/12
20 Under 18 conception rate per 1,000 females age 15-17 years, 2011
21 % of delivery episodes where the mother is aged less than 18 years, 2012/13
22 Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions, 2010/11-2012/13
23 Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse, 2010/11-2012/13
24 % of mothers smoking at time of delivery, 2012/13
25 % of mothers initiating breastfeeding, 2012/13
26 % of mothers breastfeeding at 6-8 weeks, 2012/13
27 Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2011/12
28 Crude rate per 10,000 (age 0-14 years) for emergency hospital admissions following injury, 2012/13
29 Crude rate per 10,000 (age 15-24 years) for emergency hospital admissions following injury, 2012/13
30 Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma, 2012/13
31 Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health, 2012/13
32 Directly standardised rate per 100,000 (age 10-24 years) for hospital admissions for self-harm, 2012/13

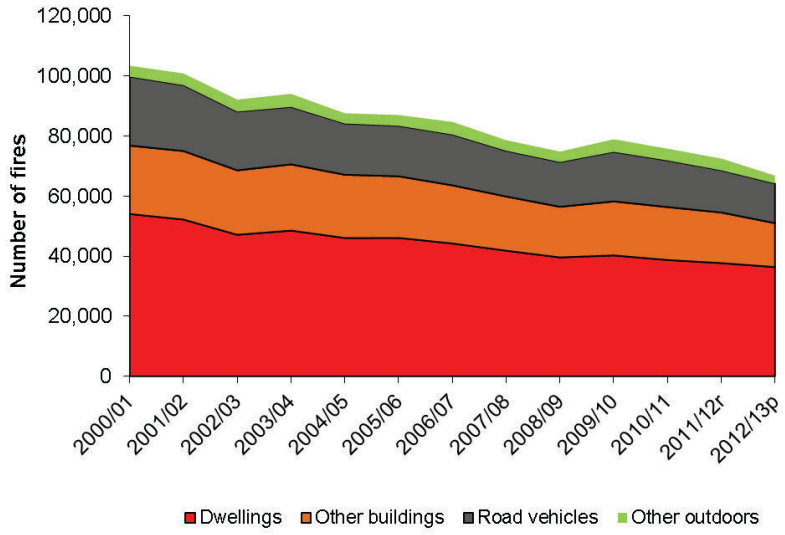
3. Accident prevention

3.1 Why is this issue important?

Accidents cause injuries that impact on population health, affecting people throughout the life course. The frequency of accidents is variable, and the extent of injury (morbidity and mortality) is significant. Prevention of accidents remains a priority for health and social care organisations, who otherwise have to provide rehabilitation and care services for people who may have enduring problems caused by accidents. Injury compensation schemes cost society £billions, and NHS clinical compensation claims continue to increase in value, in some cases costing £millions for a single claim.

Accident prevention can be cost effective whilst also improving health and tackling health inequalities. Health and social care agencies need to ensure effective action targeting accident prevention, by working with a range of agencies and in different community settings. The Fire Service is an agency that has effectively reduced the number of fires and the injuries (death and disability) that occurs as a result. Figure 1 shows how the number of fires in different settings have reduced between 2000 and 2013. This level of preventative action is sufficient for the fire service to re-model its operational systems, investing more in prevention activities and less on firefighting and damage limitation. The NHS and social care, by contrast, are reacting to ever increasing demands on care, and in terms of accidents and injuries, the need is increasing, not falling, suggesting an even more important role for prevention.

Figure 1 – The number of fires by setting 2000 to 2013



(Source: Fire Statistics for Great Britain 2014. DCLG)

This reduction in fires has accompanied a fall in mortality. In 2012-13, there were 350 fire-related deaths in Britain, 47 fewer than in 2011-12 and lower than in any year in the last fifty years. The highest number of fatalities recorded was 967 in 1985-86. There were 10,300 non-fatal casualties in fires in Britain in 2012-13, 10 per cent and 32 per cent lower compared to the previous year and ten years before respectively.

Impact on health

The spine chart shown in figure 2 below provides a dashboard of information on accidents and injury as it impacts on the population of Southampton. The red circles indicate where the city is significantly worse than the England average.

Figure 2 – Mortality and admissions caused by injury

..	Indicator	Number	Rate or %	England A...	England Lowest	Current Performance	England Highest
General Injuries							
...	Deaths from unintentional injury, 2008-2010 (co...	127	13.3	15.2	4.9		29
...	Years of life lost (under 75s) from unintentional inj...	1497	21.8	35.0	0		95.6
...	Hospital admissions due to unintentional injury ca...	3583	1,312.8	1007.7	494.2		1,742.5
...	Hospital admissions due to unintentional injury (in...	2817	1,085	888.6	418.4		1,628.6
...	Hospital stays over 3 days due to unintentional inj...	910	316.2	326.3	222.8		513.2
...	'Serious' unintentional injuries likely to require ho...	527	168	148.3	105.7		232.5
...	Children (under 18) hospital admissions due to inj...	679	156.8	124.3	69.7		235.1
...	Infants (under 5) hospital admissions due to injury...	281	194	143.2	57.6		353.3
...	Older people (75s and over) hospital admissions d...	844	528.1	480.8	213.6		844.7

With 127 deaths over 3 years, Southampton has a relatively low death rate compared to the England average, and fewer potential years of life lost from injuries. Almost all the other measures in this chart indicate activities that are higher (worse) than the England average, suggesting a higher rate of moderate to severe injuries requiring a hospital stay. This is also true for the under 5's and over 75's. The resource implications of this are significant; falls amongst the over 75's cost the NHS approximately £2.3 billion. The fragility of bones in older people gives rise to an increased fracture risk, and this translates into a higher rate of fractures, even when a fall is only low impact. Figure 3 shows the gradual but significant increase in hospital admissions due to a fall resulting in injury for Southampton CCG patients between 2008-09 and 2012-13.

Figure 3

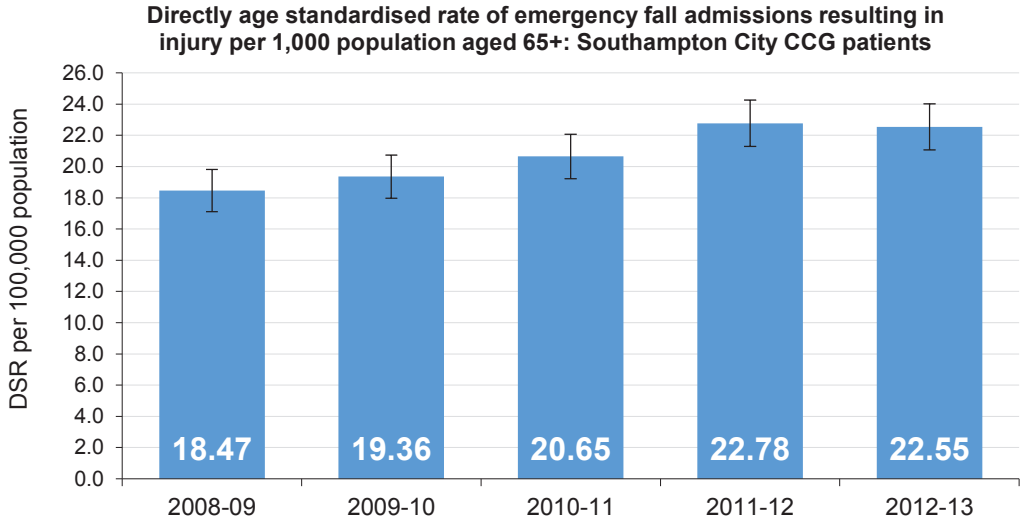
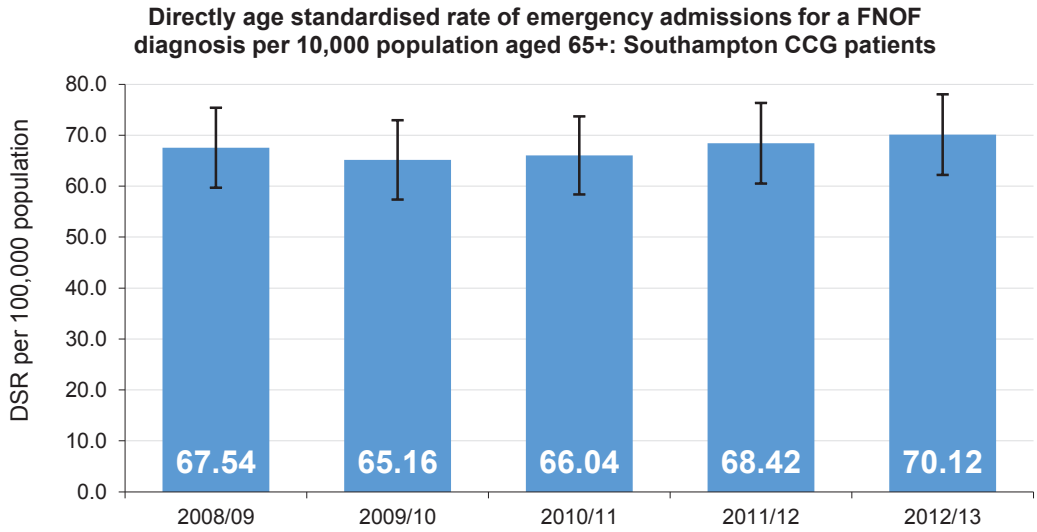
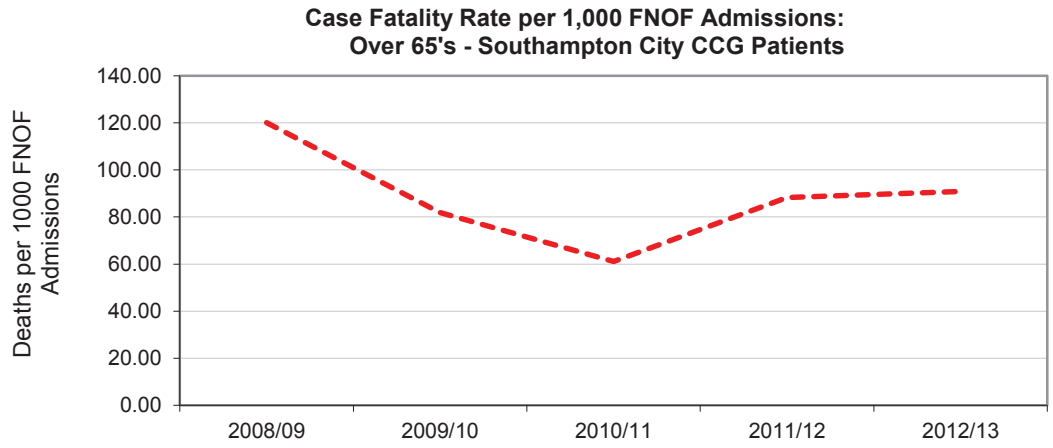


Figure 4



Treatment involves an orthopaedic pin and plate, or a hip joint replacement, followed by early mobilisation. Mortality among older patients following a FNOF can be high, illustrating the frailty of the patients who experience these types of injury. The trend in mortality caused by FNOF amongst Southampton CCG patients has been variable. In 2012/13, the case fatality rate for Southampton CCG patients was 90.9 per 1,000 admissions (approximately 9%), but has varied from 6% to 12% since 2008/09 (see figure 5).

Figure 5



Subsequent fear of falling may lead to loss of confidence and significant anxiety in older people. Full recovery from a fall complicated by a fracture can take many months, and confidence may take longer to restore. Prompt diagnosis, hospital admission and emergency surgery can secure the best clinical outcome. Missed fractures and surgical delays beyond 24 hours are associated with poorer outcomes following fractured NOF, and higher use of residential and nursing homes.

Risk factors for injury relate to the extremes of age, risk taking behaviours, and the environment in which we live. Socio-economic deprivation and poor housing increases risk of accidents and injury. This is especially the case among homeless children and adults. Design features can play a major part in reducing accidents, for example in the provision of safer play areas in parks, and careful design and repair of pavements and road crossings, care safety features, and home adaptations.

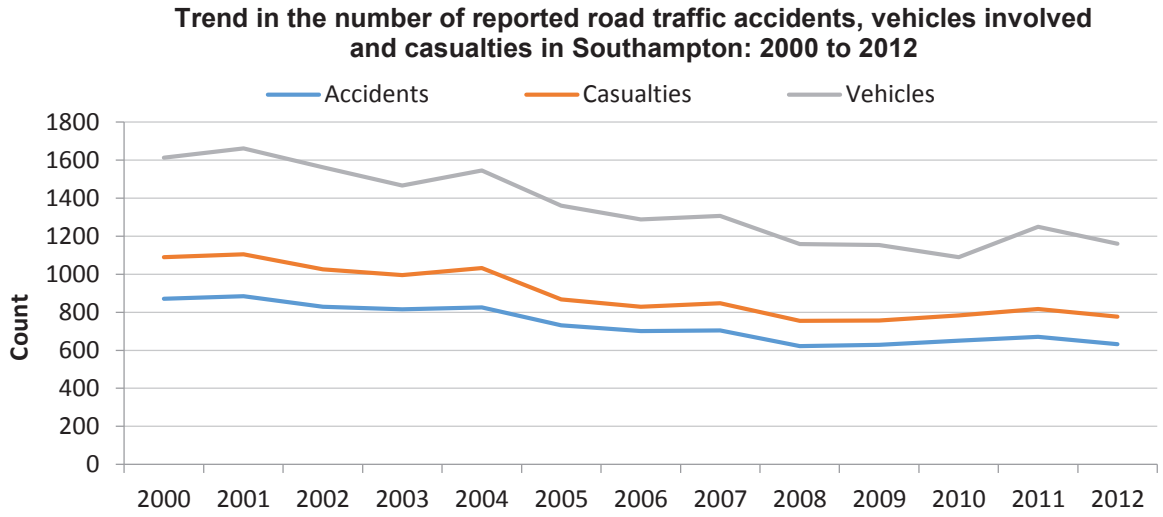
Figure 6 – Deaths and admissions resulting from falls

..	Indicator	Number	Rate or %	England A...	England Lowest	Current Performance	England Highest
Falls							
...	Deaths from unintentional fall, 2008-2010 (combi...	22	2.6	3.8	0		13.1
...	Hospital admissions due to fall injuries, 2010/11	1602	567.5	498.3	265.3		928.6
...	65s and over hospital admissions due to falls, 20...	1453	3,344.4	2475.3	1,259.4		4,844.4
...	65s and over hospital admissions due to fall injuri...	822	1,899.9	1641.6	899.7		3,126.8
...	Infant (under 5) hospital admissions due to fall inj...	269	64	54.8	23.1		144.9
...	Fall injuries on/from different height hospital admis...	251	101.8	89.3	42.9		165.9
...	Infant (under 5) fall injuries on/from height hospita...	55	13.1	12.4	3.3		30.8

This spine chart in figure 6 benchmarks injury from falls for Southampton residents against the national average. Infant admissions (under 5 years) following falls are approximately 20% higher locally than the national average, but overall mortality is below the national mean. Falls can cause fractures, but bones are resilient in childhood, and can withstand more trauma than osteoporotic bones in the older patient. "Greenstick" fractures can result from injury in children and tend to heal rapidly.

Other causes of injury in childhood include burns, scalds and head injuries, and these are relatively common. Severe injuries, such as those resulting from road traffic accidents, fires and severe burns, or head trauma, can cause death or very serious disability (such as head injury with marked cognitive and behavioural problems). However, this is less common than the frequent but less serious minor injuries. Trends in road traffic accidents are illustrated in figure 7 below, illustrating a convincing reduction in the number of collisions, casualties and vehicles involved. This charts another success story and show-cases variability of accidental injury and how effective prevention can be. However, one disappointment in these statistics is the growing proportion of more serious injuries resulting from road traffic accidents, which has risen from 10% in 2000-02 to 16% in 2010-12; a statistically significant increase.

Figure 7

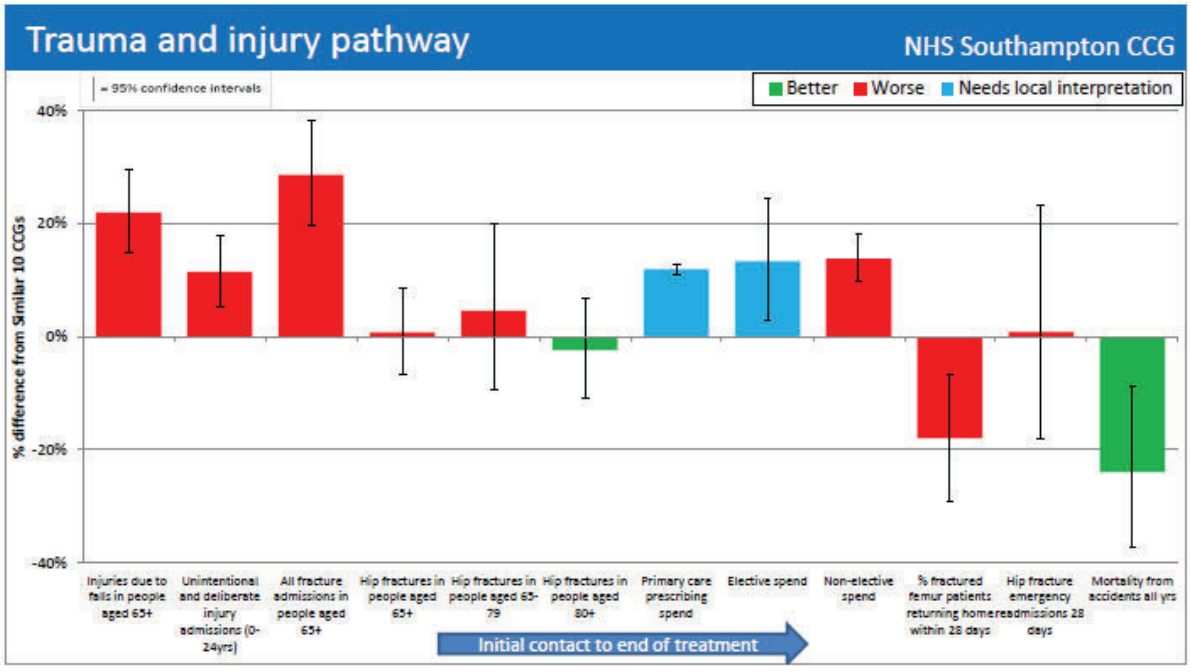


Note: This analysis is based on the standard STATS19 dataset supplied by the Police. This dataset includes all road accidents where human death or personal injury has occurred on the Highway and has been notified to the police within 30 days of occurrence, and in which one or more vehicles have been involved. The data relates to accidents occuring within the Southampton City boundary.

3.2 What can be done?

A selection of indicators are presented following the course of a trauma and injury pathway. This has been analysed for the local clinical commissioning group (CCG) in Southampton. Each indicator is shown as the percentage difference from the average of 10 most similar CCGs. The indicators are colour coded as 'better' (green) or 'worse' (red) values than the peers' districts and shown in figure 8 below.

Figure 8



Our comparator CCGs for the injury pathway are:

- NHS Portsmouth CCG
- NHS Leeds West CCG
- NHS Norwich CCG
- NHS Bristol CCG
- NHS South Manchester CCG
- NHS Brighton & Hove CCG
- NHS Hull CCG
- NHS Nottingham City CCG
- NHS Canterbury and Coastal CCG
- NHS North Durham CCG

The pathway chart summarises information on accidents and injuries. The overview shows a higher rate of injuries due to falls in people 65+ (22% higher than other "comparator" areas), and a 10% rise in unintentional and deliberate injuries in people 0-24 years. The raised injury rate is reflected by a 30% higher spend on fracture admissions to hospital for the over 65's. One positive indicator is a slightly lower fracture rate in people over 80 yrs. The higher activity in hospital is, not surprisingly, associated with higher emergency and non-emergency spending. GP spending on medicines used in this area is also higher. This may be a positive indicator suggesting use of protective medication such as treatments for osteoporosis, for example.

From a preventative perspective, these indicators suggest we are dealing with high demand, and the population is experiencing a higher than average rate of accidents and injury. A high spend on fractures in older people and intentional and unintentional injuries in younger people is the consequence. This summary agrees with the other data presented in this report, and points to the need for greater efforts to prevent accidental injury.

What more can we do?

Injuries are preventable and injury prevention should be an important public health concern. However, efforts can be hampered both by the will to make injury prevention a priority at local level and lack of access to useful data. Efforts to understand prevention and programmes of care in Southampton have been intensified this year, by creation of an injury prevention advisory committee (IPAC). The work has started by mapping activities across different local agencies, and inviting input and members from different agencies in the city. This is work in progress, but expert advice from the group should underpin and help formulate a city wide injury prevention programme. The group aim to reduce the morbidity and mortality caused by injuries, through an approach which encompasses both the creation of safer environments and improved awareness, knowledge and skills within the population and agencies.

The "Better Care" programme is a joint programme combining resources and aligning efforts to integrate health and social care. Part of this comprehensive programme will target fallers' services and drive to reduce injury and related hospital admissions. The programme aims to reduce demands on the emergency department and make a much needed reduction in hospital admissions for older people. For this to succeed, the rising trend in accidental injury and hospital admissions will have to be reversed. A first step in pursuing this programme involves auditing the faller's service as part of a national initiative lead by PH England. Another approach to evaluation and research into this area is beginning with two new PhD research initiatives in our area. These complementary studies should provide us with more detailed analyses of faller's services and the systems of care in the city.

Finally, another initiative is just beginning with Hampshire Fire services to develop new ways of working together to create safe, healthy and active communities across Hampshire. This will take the form of a compact across all of Hampshire to enable us to work more effectively together to deliver services to the people in our community. If we can capitalise on the methods and systems used by the fire service to move from fire-fighting to prevention, and apply that to a wider injury prevention agenda, then both health and social care could start to turn the rising tide of injuries, reduce demand on the emergency care system and improve health and social care outcomes and inequalities in this area.

3.3 Recommendations:

1. The Injury Prevention Advisory Committee (IPAC) should continue its work and produce a prioritised plan so more effective approaches to injury prevention across the city can be commissioned.

2. Injury prevention should be embedded into the Better Care Programme by creating better intelligence to improve understanding of accidents and injury prevention across the city, through service audits and research studies.

3. The Council is encouraged to sign up to the compact with Hampshire Fire & Rescue, to enable closer working and collaboration with fire services, which could help boost efforts to prevent injuries.

3.4 References:

DCLG (2014) *Fire Statistics for Britain.* [Online] Available from: https://www.gov.uk/government/organisations/department-for-communities-and-local-government/about/statistics

NICE (2011) *NICE Clinical Guideline 124: The management of hip fracture in adults.* [Online] Available from: https://www.nice.org.uk/guidance/cg124

ROSPA & PHE (2014) *Delivering accident prevention at the local level in the new public health system. A joint ROSPA and Public Health England publication.* [Online] Available from: http://www.rospa.com/about/currentcampaigns/publichealth/delivering-accident-prevention.aspx

4. Air quality in Southampton

4.1 Why is this issue important?

Air pollution is a significant health issue for Southampton City, disproportionately affecting our most vulnerable members of society. European legislation sets out a number of requirements to control outdoor levels of pollutants. Local Authorities have a responsibility under Local Air Quality Management legislation to review air quality. Southampton currently has ten Air Quality Management Areas declared, each one as a result of the annual mean for nitrogen dioxide (NO_2) exceeding the limit value of 40 µg/m^3.

What is air pollution and what is its effect on health?

In the UK, air pollutants are mainly products of motor vehicle traffic combustion especially from diesel vehicles. Pollutants known to have effects on health are particles, sulphur dioxide, oxides of nitrogen, carbon monoxide and ozone. In a good state of health, short term exposure to moderate levels of air pollution is unlikely to have any serious short term effects. Short term exposure to high levels of air pollutants can cause a range of adverse effects such as exacerbations of asthma, effects on lung function and consequent increases in hospital admissions for respiratory and cardiovascular conditions[1].

Long term exposure to air pollution does increase the risk of deaths from cardiovascular and respiratory conditions, including lung cancer and existing lung and heart conditions. Chronic effects can be triggers of new disease, worsen severity of disease through increase in symptoms or accelerate progression of disease over time. Children, the elderly and people with lung or heart conditions are more susceptible to the health effects of air pollution. People with coronary artery disease are at greater risk of being affected by air pollution, especially particles, than people without such disease. Coronary artery disease, which can remain undetected, is common in older people[1].

Evidence of the long term effects of air pollution are most closely associated with levels of fine particulate matter (PM2.5). Just 18 µg/m^3 PM2.5 could be responsible for an average loss of life expectancy from birth of around 2-20 months (average of 7-8 months). This compares to an estimate of around 7 years if all the population were smokers (Department of Health, 2001). There is no evidence for a threshold below which health effects would not be expected. For NO_2, studies have shown that both day to day variations and long term exposure to NO_2 are associated with mortality and morbidity.

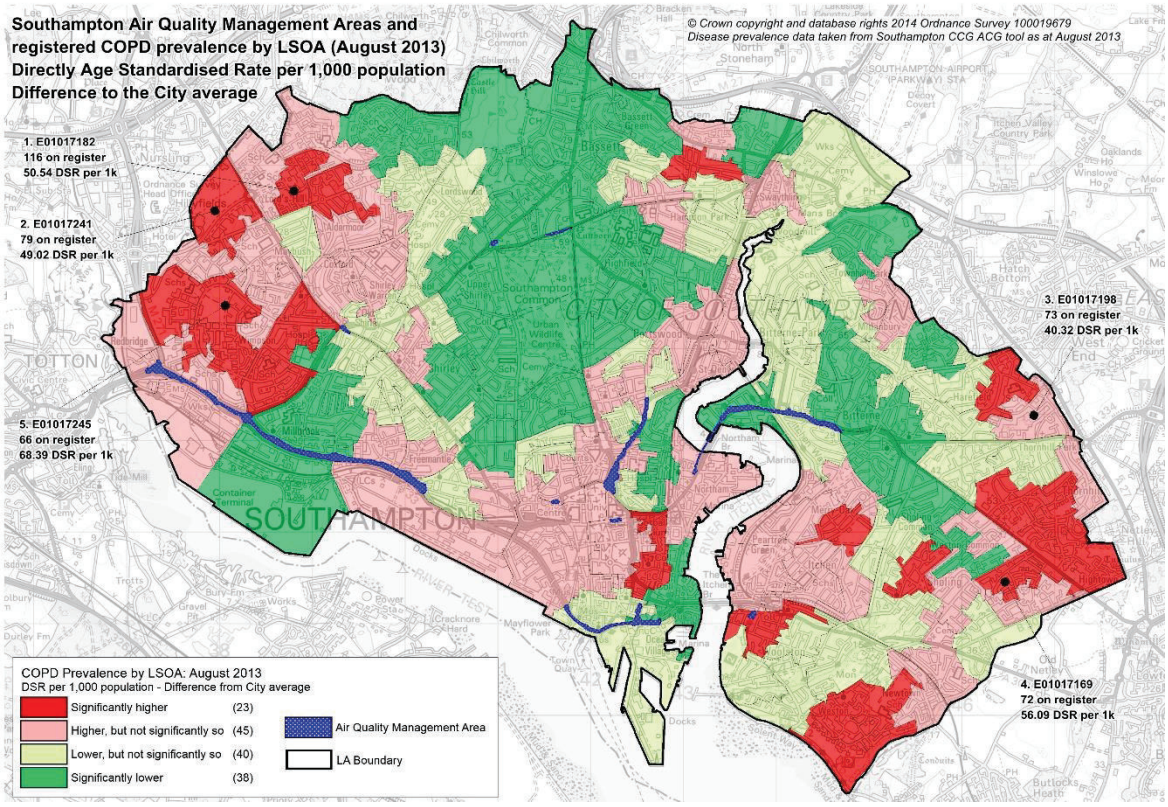
The public health benefit of a 1µg/m3 reduction in national average PM2.5 concentration is estimated as being an increase in average life-expectancy of around 20 days (range 3 to 40 days)[2]. It is likely that, compared with factors affecting individuals such as smoking, diet and lack of exercise, air pollution has a health impact similar to that of passive smoking. Department of Transport estimate that health impact from motorised transport for the UK is estimated at £10 billion. The cost to Southampton is estimated at £50 million.

What is the situation in our City?

Modelled estimates of mortality attributable to long term exposure to air pollution i.e. annual average concentrations of fine particulate matter (PM2.5) have been published by Public Health England[3]. These suggests that 6.2% of deaths in 2010 were attributable to air pollution, with long-term exposure contributing 110 deaths amongst those aged 25 years and over and 1,280 life years lost.

Since 2010, Southampton's estimated fraction of mortality attributable to particulate air pollution has declined, from 6.2% to 5.7%. This is in line with a national decrease. 2012 figures show that Southampton's fraction of mortality attributable to particulate air pollution is worse than both the England and South East average of 5.1%. Local cities are also rated better than Southampton, for example Portsmouth 5.3%, Brighton and Hove 5.0%, Oxfordshire 5.1%, Bristol 5.2% and Bournemouth 4.1%.

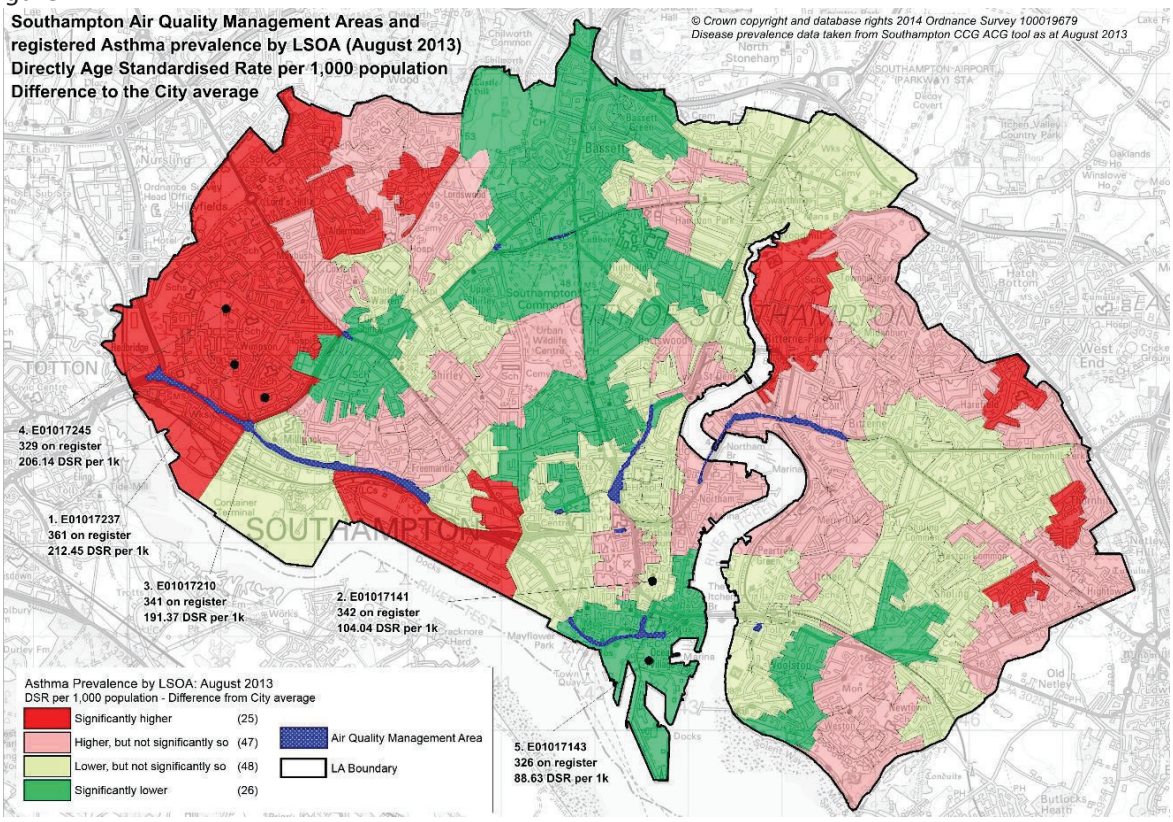
Figure 1



Mapping of Chronic Obstructive Pulmonary Disease hospital admissions, asthma hospital admissions and cardiovascular hospital admissions against air quality management areas in Southampton City show close correlation. Those areas in Southampton with the highest pollution levels are also areas where hospital admissions for these indications are highest. These are also areas of significant deprivation and where we would expect health outcomes to be worse. As previously described, air pollution exacerbates pre-existing conditions. Mapping of Chronic Obstructive Pulmonary Disease and asthma prevalence against air quality management areas also shows some degree of correlation (see

figures 1 & 2). Opportunities to monitor air quality in areas were respiratory disease prevalence is high would be of benefit.

Figure 2



4.2 What can be done?

Public Health England has offered proposals on ways that Local Authorities can improve air quality[1], these are:

- Encouraging schemes like ECOSTARS that recognises excellent levels of environmental and energy saving performance for vehicles that operate within their area
- Introducing intelligent transport systems that maximise efficiency of the highway network and also provide real time information to enable better informed travel choices
- Incorporating air quality into planning considerations for new developments and refurbishments
- Promoting energy efficient and sustainable transport to residents and businesses

What have we done locally?

Work has already been undertaken within the City to raise awareness when air pollution levels are high. The air alert service enables people who are more vulnerable to air pollution to manage the health impact in the event of high pollution levels. This service is free and open to all. There are currently 277 subscribers and 126 air alerts have been issued since June 2010. City air quality actions have focused on transport related projects to improve the efficiency of the road network and reduce congestion.

Recent findings from a study of the City's Western approach suggest that emissions from road transport are the most significant contributor, however emissions from the Port are far more significant than previously understood. A City wide Low Emission Strategy (LES) is being developed. A working group from departments across the council has been established to promote the delivery of existing initiatives and identify new ones. A City-wide emission reduction strategy will be developed for passenger cars, freight, buses and taxis.

What more can we do?

Air pollution is one of a number of risks for heart and lung disease. Stopping smoking has the largest impact on preventing risk and nearly one quarter of people within Southampton still smoke. Increased walking and cycling, and consequent reduced car travel, would not only reduce risk through reduction in air pollution, it would also benefit health through people being more physically active. Reducing road traffic would also reduce the number of road traffic accidents. There were 387 people 'killed and seriously injured on roads' from 2010-2012 (an average of 129 per year) in Southampton City.

Active travel

Southampton has adopted recommendations from the national Active Travel Strategy published by the Department for Transport and Department of Health through its 'My Journey' initiatives. As an example, 100% of schools in Southampton have school travel plans in place, aided by 'My Journey' including the development of STARS and Bike It programmes. This enables schools to encourage children and their parents to cycle or walk to school instead of driving.

The council's 'Cycle to Prosperity' scheme hopes to increase cycling levels in the population from 3% to 18% within 10 years. A 10 year cycling strategy has been produced in association with Sustrans to increase the provisions for cyclists throughout the city and make it safer to cycle. Cleaner buses are being introduced into Southampton and the city was awarded £632,700 from the Clean Bus Technology Fund to fund 37 buses with Flywheel technology, which will reduce pollution levels coming from buses.

Air Quality Scrutiny Inquiry – Port and planning

A local Air Quality Scrutiny Inquiry is currently ongoing. Council led approaches and public health impact described above were highlighted as an important part of the Inquiry. In addition, representatives from the Port described the benefits of their vehicle booking system in reducing the number of vehicles entering the Port at unspecified times, the increasing number of containers carried by rail rather than road and trailing of new compressed gas powered straddle carriers. DP world emission targets are driving these initiatives.

Planning decisions have also been considered. Local Plan Review policy states that planning permission will be refused: (i) where the effect of the proposal would contribute significantly to the exceedance of the National Air Quality Strategy Standards; or (ii) where the proposal would be materially affected by existing and continuous poor air quality. This only applies in AQMAs. A Local Plan Review has been initiated to re-evaluate the air quality policy. This could potentially include landscaping and transport issues; further mitigating against air pollution health risk.

Air Quality Scrutiny Inquiry – resident's views

A residents survey undertaken in August 2014 on air quality showed that air quality is important to Southampton residents (298 responses from across the City). 44% of respondents felt that cars are the main contributor to air quality, with HGVs (20%) second most common response and industry (10%) and shipping/ ports (10%) third most common. 59% of the 294 respondents felt air quality in the city has worsened in recent years, whereas in contrast, 4% felt it had improved. Suggestions for improvement included better public transport, park and ride, improving cycling routes, lowering speed limits, planting more trees, having a low emission zone and redirecting and restricting HGVs.

Individual responsibility for health

Individuals must take responsibility for their own health and that of their families and communities to mitigate against the health risk of air pollution. By ensuring that young children are active, walking and cycling to school, we can set the norm for a lifetime of making healthy choices that not only benefit individual's health but also that of the community at large. It is important that, as adults, we act as role models to the younger generations in taking this responsibility. We need to reduce the number of journeys we make by car to make this happen.

4.3 Recommendations:

1. There is a need for joined up strategic intent on combating air pollution, sustainable development and encouraging people to walk and cycle. The Low Emission Strategy should provide the direction for this vision and be governed by the Health & Wellbeing Board.
2. To improve public awareness, a clearer Council webpage should inform on progress since the last Air Quality Action Plan; Stronger promotion of Council's efforts is needed in a more 'public friendly' way to tackle air pollution.
3. Stronger links with planning should be developed to ensure public health implications are considered in decision-making.

4.4 References

1. Department for Environment, Food and Rural Affairs briefing. *Air quality: Public Health Impacts and Local Actions*. [Online] Available from: http://laqm.defra.gov.uk/documents/air_quality_note_v7a-(3).pdf

2. Committee on Medical Effects of Air Pollutants (2010) *The mortality effects of long-term exposure to particulate air pollution in the United Kingdom. A report by the Committee on Medical Effects of Air Pollutants.* [Online] Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/304641/COMEAP_mortality_effects_of_long_term_exposure.pdf

3. Public Health England (2014) *Report on local mortality associated with particulate air pollution.* [Online] Available from: https://www.gov.uk/government/news/estimates-of-mortality-in-local-authority-areas-associated-with-air-pollution

5. Dementia and long term conditions

5.1 Why is this issue important?

Dementia covers a number of different conditions. Alzheimer's disease (AD) is the most common form, increasing in prevalence during retirement years, affecting women in their 90's five times more than men. Some types of AD have a strong genetic component, and onset may occur in middle age in affected families. Vascular dementia (VD) occurs in 10-15% of demented patients, and is equally distributed between men and women. Dementia with Lewy body changes (a change in brain structure) is less common, and it is associated with Parkinson's disease and some distinctive changes to sleep patterns. Chronic alcohol abuse can be associated with memory loss and dementia, the effects on the brain being partly due to alcohol poisoning and partly mediated by abnormal thiamine metabolism. Dementia is a progressive condition that may deteriorate gradually or in sudden steps (especially where a vascular cause is present). In many people, the type of dementia may be a mixture of AD and VD.

Mild cognitive impairment (MCI) is more common than dementia in older people, and in a significant proportion of people, this condition does not progress. Some clinicians are reluctant to make an early diagnosis of dementia, fearing that it may be confused with MCI, which has a better prognosis. The importance of making an accurate diagnosis and planning health and social care to meet the needs of people with dementia has been stressed over the past two years in a drive to improve the quality of care for people affected by dementia.

The risk of dementia increases with age and so does the risk of other long term conditions. Therefore, it is no surprise to see patterns of multi-morbidity (the presence of multiple chronic conditions) in people with dementia. Indeed, some dementias develop as a result of other conditions, for example vascular dementia following on from vascular disease (i.e. after a stroke). Hypertension is present in over half of people with a diagnosis of dementia. Due to the nature of dementia and the way it can affect memory, thinking and communication, and the way that specialist services are often set up to address only one condition, there may be particular challenges in delivering appropriate, holistic care for someone with dementia and multi-morbid conditions.

Some of the potential challenges that occur include:

- People with dementia may not be able to clearly report and describe symptoms
- Getting a diagnosis for a multi-morbid condition may take longer when dementia is already present
- New symptoms may be attributed to dementia with other conditions remaining undiagnosed (diagnostic overshadowing).
- The interplay of conditions may exacerbate symptoms – for example hearing or visual impairment might increase confusion and disorientation for someone with dementia
- Hospital stays may be longer for people with dementia and some admissions may be avoided.

Our understanding of the number of people living with dementia in Southampton is limited by the rate of diagnosis; it is thought that currently only about half of all people with dementia are diagnosed. Figure 1 shows the difference between the recorded number of people with dementia in Southampton (from primary care databases) and the best estimate of the true number (from expert opinion).[1] [2]

Figure 1

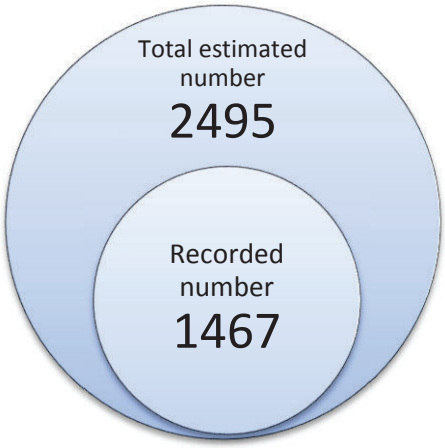
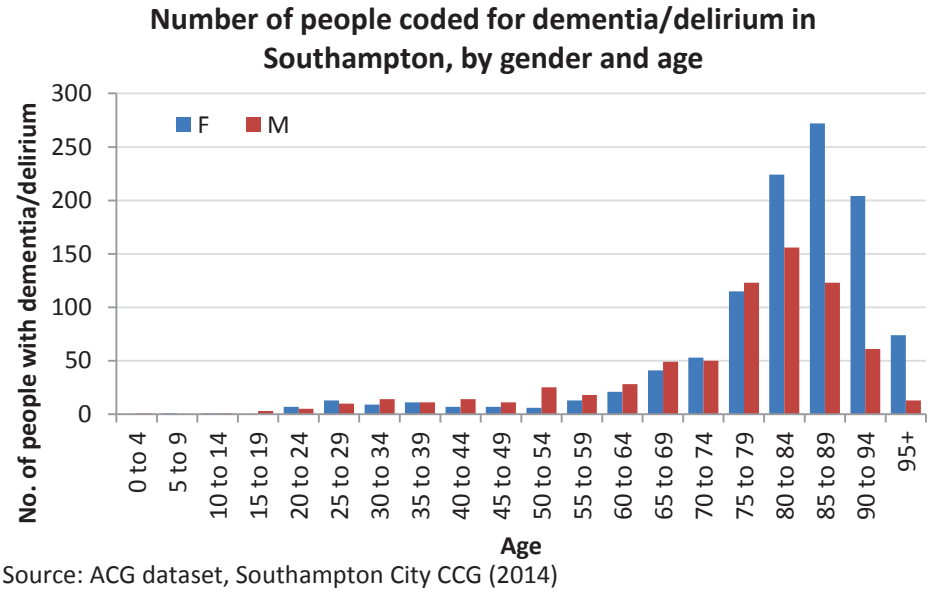


Figure 2 shows the age profile of people diagnosed with dementia and delirium in Southampton, with numbers peaking in men in the 80 to 84 age group, and women in the 85 to 89 age group. The increased prevalence of dementia in older women is clearly illustrated.

Figure 2



Source: ACG dataset, Southampton City CCG (2014)

[1] Alzheimer's Society (2014). Dementia UK: Update.
http://alzheimers.org.uk/site/scripts/download_info.php?downloadID=1490

[2] Quality Outcomes Framework, (2013/14)
http://www.hscic.gov.uk/searchcatalogue?productid=16273&pubdate=OCT%2c2014&sort=Relevance&size=10&page=1#top

The conventional data sources which are used to estimate the prevalence of dementia do not provide us with any information about the other conditions which may be present. For this, we need to look to other data sources. One of the sources we have used in Southampton to try and understand multi-morbidity in dementia is the Adjusted Clinical Groups (ACG) tool[3]. Although the ACG tool is not specific to dementia, as the clinical grouping also includes delirium (as can be seen by the presence of the diagnostic group in younger age groups in Figure 2), this tool can give us a useful insight into the other conditions that people with dementia also live with.

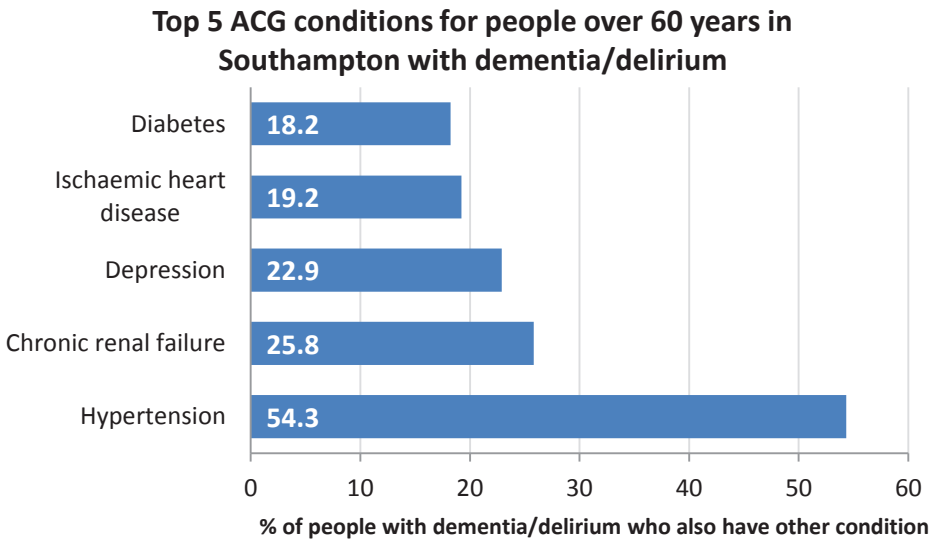
In Southampton, people with dementia are more likely to have at least one other ACG condition than have dementia alone. In fact, 83% of people with dementia also have at least one other long term condition (Figure 3).

Figure 3

Dementia and co-existing ACG conditions	
Dementia only	17%
Dementia plus one other condition	22%
Dementia plus two other conditions	21%
Dementia plus 3 or more conditions	40%

Figure 4 shows the most common comorbidities for people diagnosed with dementia in Southampton. The most common is hypertension, affecting over half of all individuals, followed by chronic renal failure (25.8%) and depression (22.9%).

Figure 4



Source: ACG dataset, Southampton City CCG

[3] ACG is a risk stratification tool which uses primary and secondary care data to build datasets around 20 long term conditions: rheumatoid arthritis, low back pain, persistent asthma, chronic renal failure, congestive heart failure, COPD, depression, diabetes, disorders of lipid metabolism, hypertension, ischaemic heart disease, age related macular degeneration, bipolar disorder, glaucoma, hyperthyroidism, immunosuppression, osteoporosis, Parkinson's disease, schizophrenia, seizure disorder.

5.2 What can be done?

Making a diagnosis of dementia can take time, and distinguishing from MCI and a progressive dementia may take a number of months or even years. GPs and experts in memory clinics are responsible for diagnosis and longer term management of diagnosed cases. With only limited scope for effective treatment, there are a few drugs that have some impact on the disease. Cholinesterase inhibitors and, to a lesser extent, memantine, are used in the early stages of disease to manage symptoms but there is limited evidence of an effect on the natural history of the disease. Many other medications, including sedatives and mood stabilisers tend to worsen cognitive functioning or in the case of major tranquillisers, may cause major problems. The main focus still remains on diagnosis, care, and support, for both the person affected and their carer, and managing co-morbidities that are present (including anxiety, depression, or agitation, alongside physical conditions such as diabetes, hypertension or incontinence).

Dementia developments in recent years

The local Council and Clinical Commissioning Group (CCG) have made commitments to supporting residents to live well with dementia. Additional funding was allocated in 2014/15 to support interventions, aimed at improving the health and wellbeing of people living with dementia, and reducing loneliness and social isolation by encouraging participation in a range of activities:

- **Volunteer led walking group:** aimed at younger people, with meeting points at local cafes to help normalise dementia within our communities and provide opportunities for regular physical activity.
- **Art classes led by teaching staff**: resulting in an exhibition of art work created which will also have a positive impact on raising awareness and reducing stigma across the city.
- **Seafaring memories group:** which will provide individuals with an opportunity to talk about their working lives and hobbies; men are often more comfortable reminiscing about things they have experienced in the past.
- **Partnership with the Community Farm** in Southampton. Regular opportunities for individuals to enjoy the outdoors, connect with the natural environment and take part in a range of supported practical tasks and activities; this also provides opportunities for individuals to obtain healthy home grown food.
- **Ethnic Minority awareness raising project:** Working with community leaders, faith groups, health and wellbeing professionals and other agencies about cultural differences and attitudes to memory loss held by some ethnic minority communities.

It is estimated that between 2012 and 2020, there will be an increase of almost 20% in people aged over 65 years with dementia in Southampton[4]. With an ageing population projected to increase the number of people with dementia, health and social care services need to be responsive to the changing demographics in order to meet the needs of local people. This means not only preparedness

[4] Projecting Older People Population Information System (POPPI) www.poppi.org.uk

for treating and caring for people with dementia, but also considering co-existing conditions which may add extra complexity. The quality standards for dementia published by the National Institute for Health and Care Excellence (NICE) support a personalised approach that enables people with dementia to access services that help maintain their physical and mental health and wellbeing[5]. It is important that people with dementia have equitable access to services which care for their physical health. If dementia and co-existing conditions are managed effectively and according to individual needs, there are clear benefits for improving the quality of life for people with dementia and their carers, and also potential cost savings from preventing hospital or residential admissions or shortening the stay.

5.3 Recommendations:

1. NHS providers should ensure that people with dementia have appropriate physical health checks to manage the many health problems that are often present.
2. All service providers should aim to create dementia friendly services to enable people with dementia and their carers to feel confident about accessing support for all their physical health needs.
3. Commissioners should work with service providers to minimise the number of different services that people with dementia need to access to receive care for their physical and mental health.
4. GPs and primary care teams are encouraged to increase awareness of early signs of dementia, to manage risk factors that exacerbate dementia symptoms, and to exclude other diseases that may mimic dementia (such as hypothyroidism or depression in older people, for example). Early referral to specialist memory clinics helps refine the diagnostic subgroups, plan management and optimise care for dementia patients and their carers.

5.4 References:

Alzheimer's Society (2014). *Dementia UK: Update*. [Online] Available from: http://alzheimers.org.uk/site/scripts/download_info.php?downloadID=1490

HSCIC (2014) *Quality Outcomes Framework, (2013/14).* [Online] Available from: http://www.hscic.gov.uk/searchcatalogue?productid=16273&pubdate=OCT%2c2014&sort=Relevance&size=10&page=1#top

NICE (2010) *Dementia quality standard (June 2010)*. [Online] Available from: www.nice.org.uk

NICE (2013) *Quality standard for supporting people to live well with dementia (April 2013).* [Online] Available from: www.nice.org.uk

Oxford Brookes University (2014) *Projecting Older People Population Information System (POPPI)*. [Online] Available from: www.poppi.org.uk

[5] Dementia quality standard (June 2010) and Quality standard for supporting people to live well with dementia (April 2013). Available at www.nice.org.uk

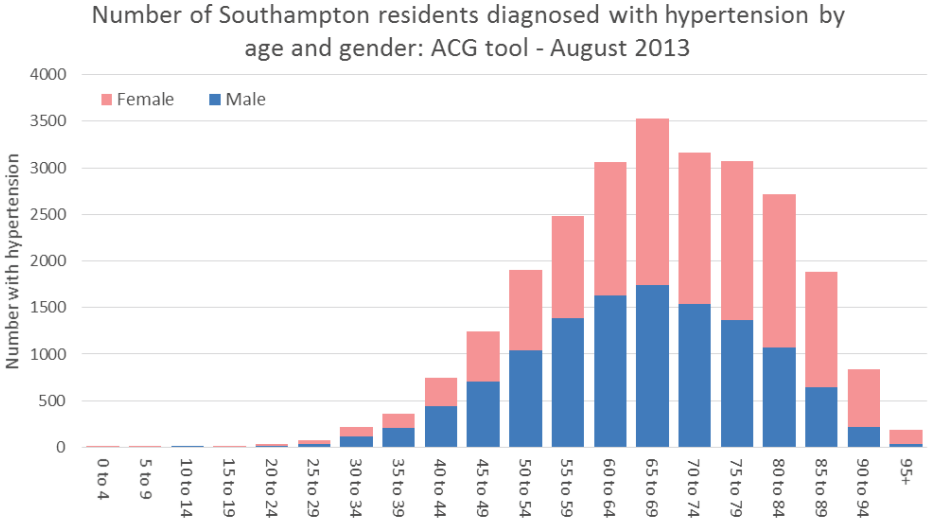
6. High blood pressure (hypertension): A local and global health threat

6.1 Why is this issue important?

Hypertension (or raised blood pressure) is a major public health challenge. It is a key factor in living longer and healthier lives. Mild or moderately raised blood pressure (BP) is very common, especially in retirement age, causes few symptoms, and can easily go unnoticed. It is simple to measure, and can be diagnosed in pharmacies and GP surgeries. Low cost automated BP equipment is widely available and used by some patients, while more sophisticated 24 hour BP monitoring helps us understand BP variability through the day and night. Despite ready access to BP measuring equipment, and the widespread nature of the problem, a significant proportion of people with raised BP remain undiagnosed. The distribution of blood pressure across any population is a continuum, with no sharp cut-off between those who have normal and those with raised blood pressure. Blood pressure is measured as systolic and diastolic pressure. The unit of blood pressure measurement is the height of a column of mercury used in old fashioned blood pressure machines. Average blood pressure for an adult is in the region of 120/80 mmHg. High blood pressure is usually diagnosed as measurements above 140/90 mmHg. A lower threshold for diagnosing high blood pressure is needed for children and younger people.

Hypertension prevalence rises with age: 7.4% in ages 19-24, rising to 44% in those aged 55 to 64, and 72% over 75 years. It is more common in socio-economically deprived areas, prevalence reaching 34% compared to 26% in the least deprived communities. Men are affected more than women, while black African and black Caribbean ethnic groups are also at high risk. Public Health England (PHE) estimates we have 7,660,010 people in England (2012/13) with recorded high blood pressure. Local GP data identify 25,532 people in Southampton with Hypertension, 10.4% of registered patients. Figure 1 below illustrates the distribution of these patients by age and gender. More men have high blood pressure up to retirement age, then women predominate due to their longer life expectancy.

Figure 1:

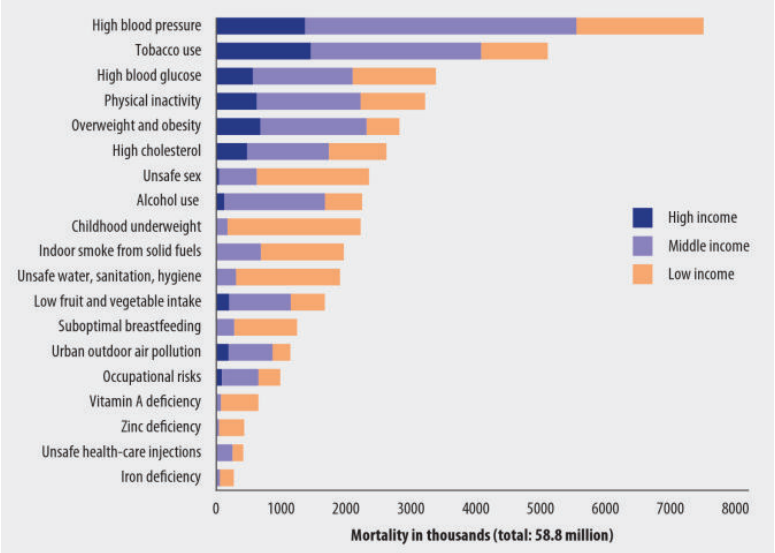


Blood pressure depends on factors such as cardiac output, elasticity of blood vessels and circulating volume of blood. Hormones and autonomic nerves also modulate BP, which has a circadian rhythm (low readings in the night, higher in the day). A rise in BP occurs just before waking, and increases occur in the daytime as a response to stress, or strenuous exercise, for example lifting heavy loads. People live with mild or moderate hypertension for many years, but if untreated, the cumulative risk of complications increases with time.

Effects on health

The Global Burden of Disease Study charts 235 causes of death, and examined the effects of 67 risk factors. Hypertension now stands out clearly as the leading global risk factor for disease; it causes death, major challenges to healthcare, and costs millions in prescribing costs and lost productivity. Hypertension is a risk factor for ischaemic heart disease and stroke. Estimates suggest 7.5 million deaths are caused by raised BP (13% of all deaths). Hypertension was thought to be a greater problem in developed countries, but this has changed recently, with increased impact recognised on low and medium income countries (see figure 2). Estimates in England suggest 4,458 deaths in England (2010) were caused by hypertension. This is probably an underestimate because hypertension is often classified as a "contributing factor" rather than underlying cause of death.

Figure 2: Risk factors vs global mortality

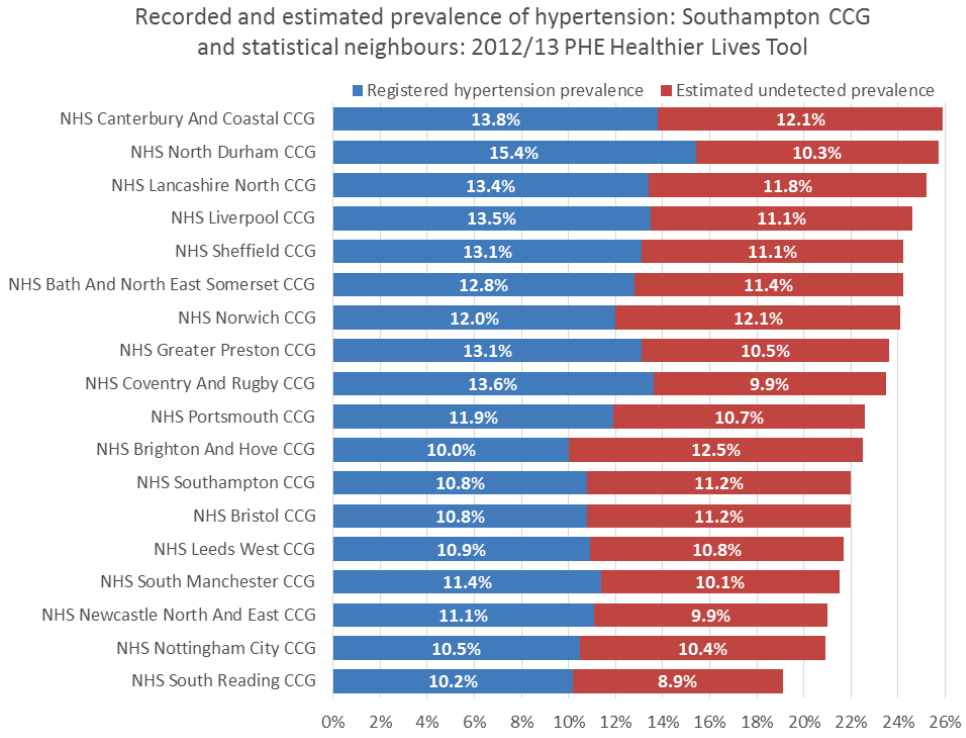


The vascular health effects (risk) of high blood pressure can be estimated using a simple formula: The risk doubles for each increase of 20/10 mmHg of BP, starting as low as 115/75 mmHg. In addition to coronary heart diseases and stroke, complications of raised blood pressure include heart failure, peripheral vascular disease, kidney damage, and visual impairment. Vascular risk increases as multiple risk factors become combined. In this case, it is the combined risk of raised cholesterol, high blood sugar, smoking, obesity, and physical inactivity that interact with raised blood pressure to create high cardiovascular risk. These all feature in the risk factors that contribute to the highest global mortality statistics.

Prevention of high blood pressure and avoidance of other vascular risk factors can reduce the burden of cardiovascular disease (CVD). In this respect population health trends in the UK are encouraging, with good progress made over recent decades, with significant falls in CVD mortality. The UK had some of the highest levels of CVD in the world, and the rate of reduction is among the fastest improvement in developed countries. This improvement was driven by changes in lifestyle, less tobacco use, and lower cholesterol intake. Lower population salt intake and increased use of potassium rich food can also have a direct effect on reducing BP at population level, while reducing or stopping alcohol intake can improve an individual's BP. Challenges remain, with early diagnosis, monitoring, and effective management of high BP being far from optimal, with a large number of people undiagnosed or unable to attain BP control effectively.

Prevalence of high blood pressure is measurable at the level of GP practices. Figure 3 shows the GP records alongside the estimated prevalence of hypertension. This suggests that only 48.5% of the estimated number of people with hypertension are on GP practice registers in Southampton. Approximately half the people with hypertension in the city are yet to be diagnosed and effectively treated. Similar challenges exist across the country, as can be seen in figure 3.

Figure 3:

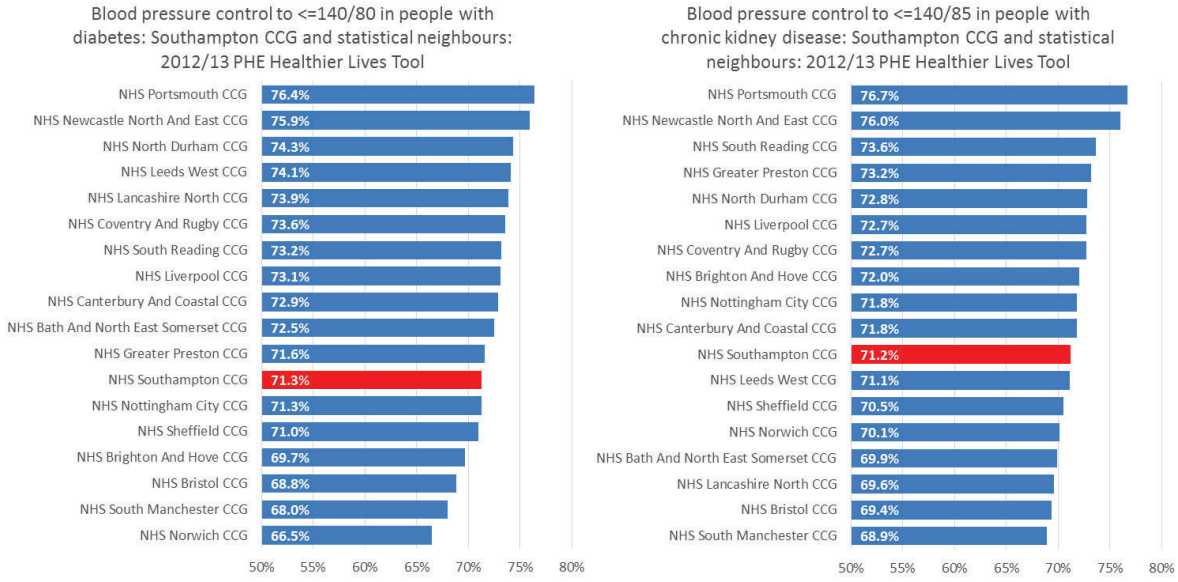


The estimated prevalence of high blood pressure varies from 7.9 to 29.7 % across the GP practices in Southampton, with the low prevalence recorded in university practices that cater for younger persons. Monitoring of BP compares well with national data, with all but one local practice displaying BP records within the last 9 months at or above 82% of patients with known high BP. Vascular health checks have been achieved in between 60% and 100%. This is a wide range of performance, but is consistent with the national standard.

Managing hypertension effectively is especially important in people with diabetes or chronic kidney disease, because both conditions worsen rapidly if BP is poorly controlled, and vascular risk increases disproportionately. Malignant hypertension, a rare form of hypertension, rapidly leads to end organ damage, causing a medical emergency or death. A sudden rise in pressures to 180/110 or more can occur in malignant or accelerated hypertension.

Figure 4 shows the blood pressure control for diabetes and chronic kidney disease patients for Southampton and similar CCGs. BP control $\leq$ 140/80 is important in diabetes because the kidneys and eyes can be especially sensitive to raised BP. Good control is recorded in just over 70% of patients on the local diabetes registers. A similar level of BP control is achieved in people with chronic kidney disease. The best performance across Clinical Commissioning Groups (CCGs) achieved control in approximately 77%, a target we should aspire to across Southampton.

Figure 4: % patients with BP controlled (diabetes and chronic kidney disease)



Hypertension causes a lot of long lasting disability, in the form of stroke survivors, chronic heart failure, and other forms of vascular disease, including vascular dementia in which the brain function deteriorates due to loss of blood supply. Without a concerted effort addressing the prevention, diagnosis, treatment, and control of hypertension, the global pandemic of cardiovascular disease will continue. Southampton's population is affected by hypertension as much as any other developed region in Europe, and still faces the same challenges when we set out to reduce the negative impact on health outcomes.

6.2 What can be done?

Under diagnosis of hypertension remains a problem, so opportunistic test and re-testing is required to find as much undiagnosed hypertension in the population as possible. There is no population screening programme for hypertension, so opportunistic tests and active case finding has to be encouraged. GP datasets and patient registers provide intelligence on the distribution of hypertension among their patients, as well as information on the effect of treatment on BP control, and should continue to be used to drive up case ascertainment and entry on to GP registers.

In 2013, there were 7.5 million people on GP lists in England alone with hypertension. An estimated 5 million probably have undiagnosed hypertension. Health surveys suggest that the prevalence of hypertension has been stable between 2005 and 2011, but as the GP registers have increased numbers with diagnosed hypertension from 11.3 to 13.7% of the population, it is reasonable to assume there are fewer undiagnosed cases these days.

Most patients with hypertension are diagnosed and managed by GPs and practice nurses. A smaller number have more severe or drug resistant hypertension, and may have care from both GPs and hospital teams. High blood pressure is an especially difficult challenge on kidney units, where the majority of patients have moderate to severe high blood pressure which may be hard to control.

At diagnosis, lifestyle factors are usually managed carefully, especially weight management, smoking cessation, reducing salt intake, avoiding excess alcohol (which elevates blood pressure) and diabetes tests are done. Anti-hypertensive medications are usually required in moderate or severe high blood pressure, but in milder cases, monitoring and lifestyle change is usually tried first. Long term monitoring is needed because BP may rise over time, and other risk factors, such as diabetes may become obvious later on. Some patients respond to a single drug to lower BP, while others may have to take two, three or more types of BP lowering drug to gain control. Some find the side effects of BP tablets hard to cope with, and given the asymptomatic nature of raised BP, this can give rise to treatment failure. Fortunately, the range of BP lowering agents is quite broad, and they have different side effect profiles so most doctors and pharmacists can devise a treatment regimen patients can accept.

Clearly, the progress made with improving the detection of high BP needs to continue by encouraging the population to access BP checks when offered, and to make use of the many opportunities to have BP measured in pharmacies and GP practices. Similarly, the testing of BP in health checks and visits to the GP or hospital should be systematically undertaken and recorded by clinicians.

6.3 Recommendations:

1. GP practices and other providers of health checks need to use every opportunity to improve the diagnosis of hypertension in the general population, reducing any delay before effective treatment is initiated.
2. General Practices are encouraged to take action to increase the proportion of patients that achieve target BP control on their chronic disease registers.
3. The Health Services and other partners should take every opportunity to raise public awareness of the high prevalence of high blood pressure, where to access BP measurements, and how modification of lifestyle can reduce the risk of cardiovascular complications.
4. Low cost home BP monitoring is widely available and affordable, it provides useful information, and helps reassure people that their BP is under control. Steps should be taken to ensure accurate measurement technique and regular recalibration of the equipment used. This option may not suit all individuals, and can cause undue anxiety, so we recommend people discuss this option with their GP. Useful online information can be found at: http://www.bloodpressureuk.org/BloodPressureandyou/Homemonitoring

6.4 References:

WHO, DCO & WHD (2013) *A Global Brief on Hypertension. Silent killer, global public health crisis.*

WHO (2014) *Global Health Risks: Mortality and Burden of Disease attributable to selected major risks.*

7. Tackling health inequalities in Southampton

7.1 Why is this issue important?

People enjoy different levels of health and have always done so. The fact that health is distributed unequally in society and that those who are less well-off tend to have poorer health is a challenge for all those who are concerned about fairness and social justice. Health inequalities exist and are persisting in Southampton, as elsewhere, despite a focus over the last decade on reducing them. This chapter explores the reasons for this, and what more can be done to tackle this issue.

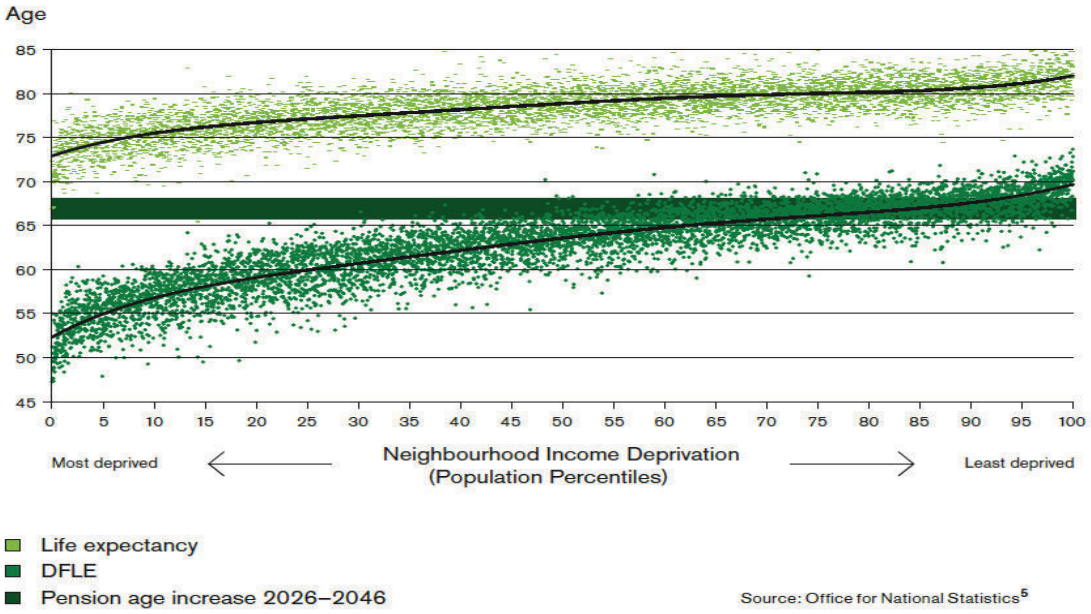
What causes health inequalities?

The Acheson Report published in 1998[1] provided the focus for action on health inequalities in England for more than a decade, and underpinned the national inequalities strategy. The Marmot Review in 2010 set out to reassess the extent of health inequalities and the evidence to underpin future policy and action, and to advise on objectives and measures for tackling the issue. The review team's work continues and subsequent reports provide guidance and tools for both national and local level planning.

The Review Team's key findings and recommendations were:

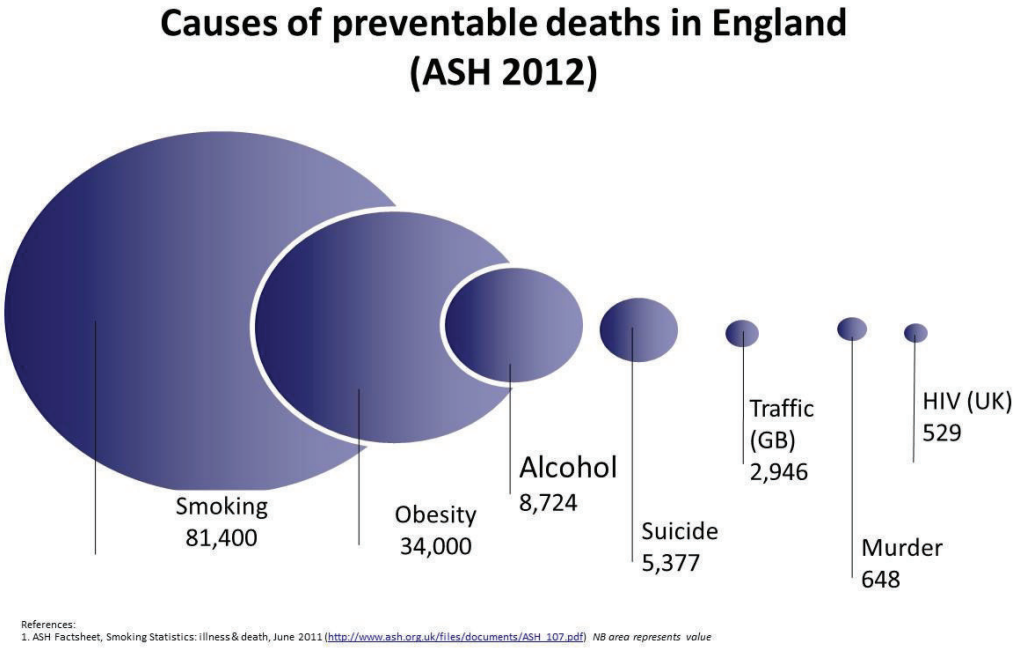
- People living in the poorest neighbourhoods in England will on average die seven years earlier than people living in the richest neighbourhoods.
- People living in poorer areas not only die sooner, but spend more of their lives with disability - an average total difference of 17 years (see figure 1).
- The Review highlights the social gradient of health inequalities - put simply, the lower a person's social and economic status, the poorer their health is likely to be.
- Health inequalities arise from a complex interaction of many factors - housing, income, education, social isolation, disability - all of which are strongly affected by economic and social status.
- Health inequalities are largely preventable. Not only is there a strong social justice case for addressing health inequalities, there is also a pressing economic case. It is estimated that the annual cost of health inequalities is between £36 billion to £40 billion through lost taxes, welfare payments and costs to the NHS.
- Action on health inequalities requires action across all the social determinants of health, including education, occupation, income, home and community.

Figure 1: Life expectancy and disability-free life expectancy at birth by neighbourhood income level, England (1999-2003)



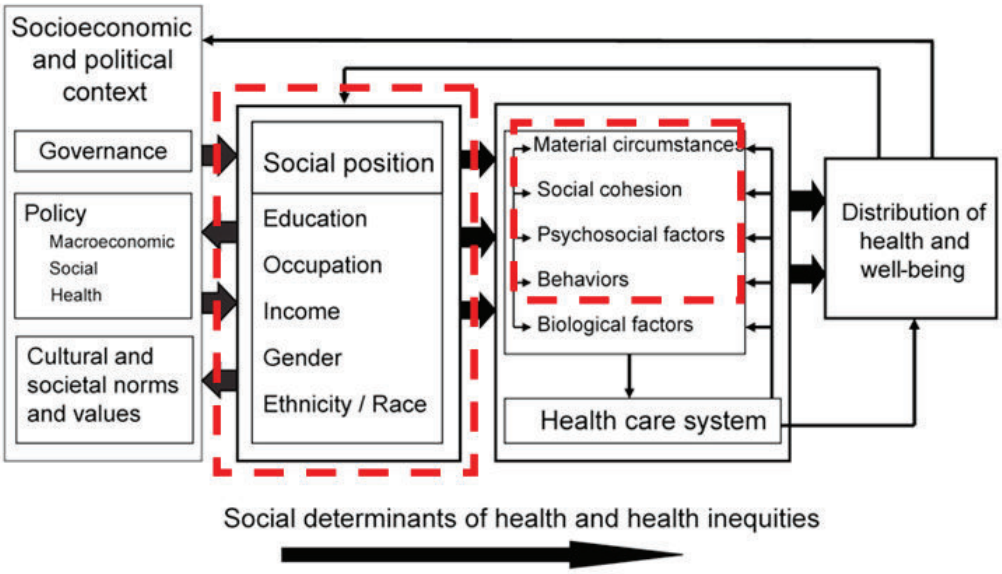
Lifestyle risk factors such as smoking, obesity, excess alcohol consumption, unhealthy diets and lack of exercise are well understood as key contributors to the major disease burden in England. Smoking is still by far the biggest contributor to premature death in England and, as smoking is more common among those on lower incomes, it continues to be a major factor underlying health inequalities (see figure 2).

Figure 2: Causes of preventable deaths in England (ASH, 2012)[2]



Social determinants of health are also recognised as exerting a key impact on health outcomes. The Marmot Review reinforces a social determinants model of health inequalities and endorses a conceptual framework of health proposed by the World Health Organisation (WHO) shown in figure 3 below. The WHO commission on the social determinants of health proposes that the distribution of health and wellbeing is caused by material circumstances, social cohesion, psychosocial factors, behaviours and biological factors.

Figure 3: Commission on Social Determinants of Health Conceptual Framework (WHO 2008)[3]

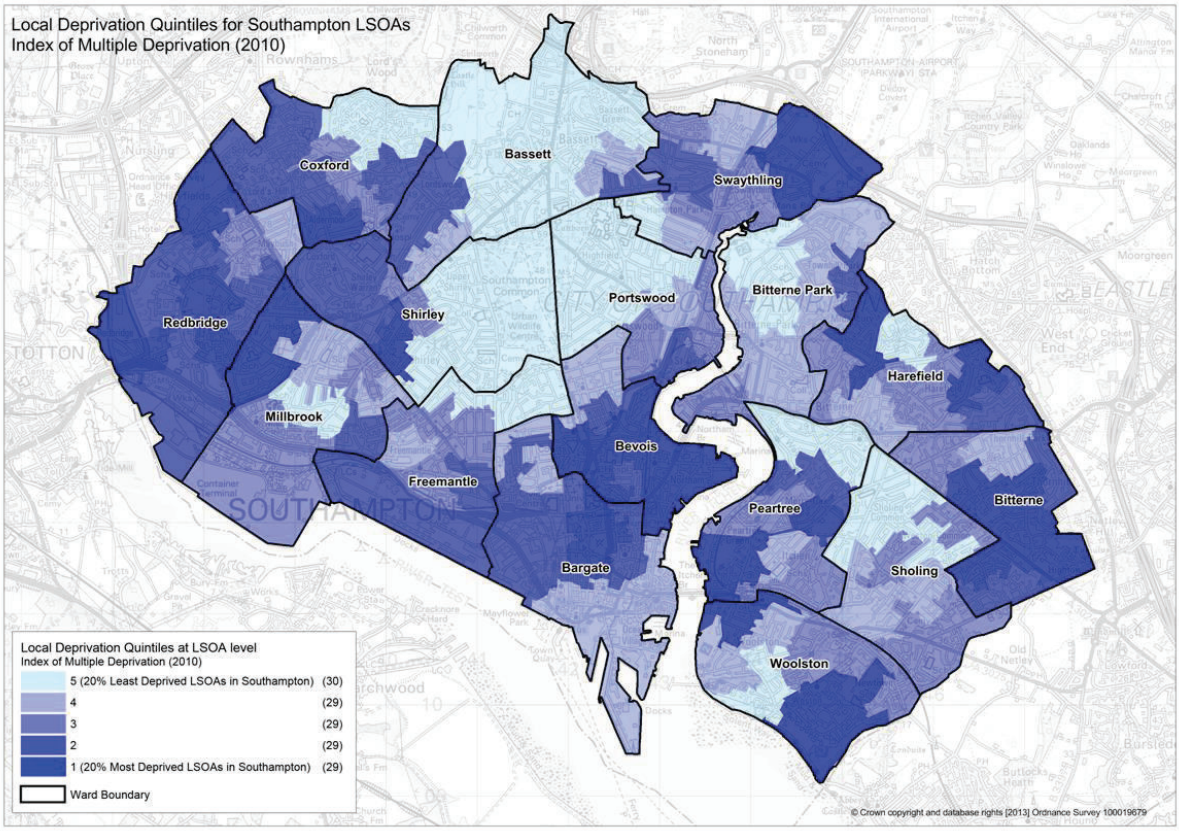


What is the situation in our City?

In the past we have based our analysis of inequalities in Southampton on comparisons of the health of people living in eleven areas defined as "priority for action" in the City's Neighbourhood Renewal Strategy. These were described in the 2009 Report of the Director of Public Health. The Report showed that up until 2007 there had been little progress in reducing the gap between the 40% of Southampton people living in relatively disadvantaged circumstances and those who were better off, despite overall health improving.

Recognising that all our neighbourhoods have a mix of communities and living circumstances, we now compare and contrast the health inequalities that exist between the 20% most deprived neighbourhoods in Southampton and the 20% least deprived. These neighbourhoods have been defined in terms of Lower Super Output Areas (LSOAs). The 20% most and least deprived LSOAs (referred to as the most and least deprived quintiles) were identified using the Index of Deprivation 2010 (ID2010)[4]. Figure 4 shows a map of deprivation quintiles in the city against geographical boundaries.

Figure 4: Local deprivation quintiles for Southampton LSOAs



A separate Briefing Note, *Health Inequalities in Southampton City: Analysis of Trends (November 2014)*[5], provides a detailed assessment of a range of measures of health, examines the differences and gradients that exist and the changes that have taken place over the past five years. It also gives details of the methods that have been used. The key findings are summarised in figure 5 below. The tables show three things: the size of the difference in health between the worst-off 20% and the most affluent; whether the health indicator is improving for those who are worst-off; and, whether the gap in health is narrowing.

Figure 5: Summary: Progress towards narrowing the gap

Please note that although this table provides a summary of the inequalities in the city, it only provides a snapshot in time. Readers are advised to refer to the graphs contained throughout this report for a more thorough representation of whether the inequalities gap is narrowing or not.

Current Gap Key	Improving Key	Narrowing Key
Most deprived significantly worse	Significantly worse than baseline	Gap has widened (significance not measured)
Most deprived worse but not significantly so	Worse than baseline but not significantly so	Gap has narrowed (significance not measured)
Most deprived better but not significantly so	Better than baseline but not significantly so	
Most deprived significantly better	Significantly better than baseline	

Life Expectancy and Mortality Indicators			
Measure	Current Gap - Most deprived vs. least (2011-13)	Have the most deprived areas improved between 2006-08 and 2011-13?	Has the inequality gap narrowed between 2006-08 and 2011-13?
Life expectancy for males	6.7 yrs lower	↑ 0.6 yrs	0.5 yrs ←→
Life expectancy for females	3.2 yrs lower	↓ 0.1 yrs	1.6 yrs ←→
All cause, all age mortality	1.36 x higher	↓ 1.4%	9.5% ←→
Male All cause, all age mortality	1.50 x higher	↓ 3.4%	10.0% ←→
Female All cause, all age mortality	1.23 x higher	↑ 0.8%	11.8% ←→
Premature (u75) all cause mortality	1.95 x higher	↓ 8.4%	1.8% →←
Male Premature (u75) all cause mortality	2.10 x higher	↓ 10.7%	27.0% →←
Female Premature (u75) all cause mortality	1.77 x higher	↓ 3.8%	23.6% ←→
All circulatory disease mortality	1.26 x higher	↓ 10.6%	4.2% ←→
Male All circulatory disease mortality	1.42 x higher	↓ 12.8%	7.0% ←→
Female All circulatory disease mortality	1.10 x higher	↓ 7.6%	5.6% ←→
Premature (u75) circulatory disease mortality	2.20 x higher	↓ 28.0%	20.7% →←
Male Premature (u75) circulatory disease mortality	2.30 x higher	↓ 28.7%	75.8% →←
Female Premature (u75) circulatory disease mortality	2.10 x higher	↓ 23.4%	46.1% ←→
All cancer mortality	1.42 x higher	↑ 6.0%	12.9% ←→
Male All cancer mortality	1.43 x higher	↓ 2.3%	13.8% ←→
Female All cancer mortality	1.39 x higher	↑ 13.8%	15.3% ←→
Premature (u75) cancer mortality	1.57 x higher	↑ 4.9%	14.8% ←→
Male Premature (u75) cancer mortality	1.63 x higher	↑ 1.2%	4.5% ←→
Female Premature (u75) cancer mortality	1.50 x higher	↑ 9.6%	24.3% ←→
COPD mortality	2.25 x higher	↑ 3.7%	42.2% →←
Male COPD mortality	2.23 x higher	↓ 4.2%	20.4% →←
Female COPD mortality	2.57 x higher	↑ 23.9%	43.9% →←

Hospital Procedure Indicators			
Measure	Current Gap - Most deprived vs. least (2012)	Have the most deprived areas improved between 2007 and 2012?	Has the inequality gap narrowed between 2007 and 2012?
Ratio of CHD Invasive Procedures to U75 CHD Mortality	2.16 x lower	↓ 18.64%	62.7% ←→

Maternity and Child Health Indicators			
Measure	Current Gap - Most deprived vs. least (2013/14)	Have the most deprived areas improved between 2008/09 and 2013/14?	Has the inequality gap narrowed between 2008/09 and 2013/14?
Proportion of mothers smoking at midwifery booking	3.85 x higher	↓ 2.1%	0.2% ←→
Proportion of mothers breastfeeding at initial feed	1.36 x lower	↑ 0.9%	0.1% →←

Measure	Current Gap - Most deprived vs. least (2011-13)	Have the most deprived areas improved between 2006-08 and 2011-13?	Has the inequality gap narrowed between 2006-08 and 2011-13?
Proportion of births weighing less than 2500g	1.33 x higher	↑ 0.4%	0.5% ←→

Measure	Current Gap - Most deprived vs. least (11/12-13/14)	Have the most deprived areas improved between 06/07-08/09 and 11/12-13/14?	Has the inequality gap narrowed between 06/07-08/09 and 11/12-13/14?
Proportion of reception children classified as obese	1.57 x higher	↑ 1.7%	2.2% ←→
Proportion of year 6 children classified as obese	1.53 x higher	↑ 2.0%	1.0% ←→

Access to Smoking Cessation Services			
Measure	Current Gap - Most deprived vs. least (2013/14)	Have the most deprived areas improved between 2009/10 and 2013/14?	Has the inequality gap narrowed between 2009/10 and 2013/14?
Crude rate of smoking quit attempts per 10k pop (18+)	4.36 x higher	↓ 54.2%	136.5% ←→ *
Proportion of smokers successfully quitting at 4 weeks	1.26 x higher	↓ 20.8%	16.7% →←

Cancer Incidence Indicators			
Measure	Current Gap - Most deprived vs. least (2010-12)	Are the most deprived areas improving compared to baseline (2002-04)?	Has the inequality gap narrowed from baseline (2002-04)?
All cancer incidence DSR	1.16 x higher	↑ 3.9%	6.3% →←
Male all cancer incidence DSR	1.15 x higher	↓ 4.5%	11.4% →←
Female all cancer incidence DSR	1.17 x higher	↑ 10.3%	3.5% →←
Measure	**Current Gap - Most deprived vs. least (2008-12)**	**Are the most deprived areas improving compared to baseline (2002-06)?**	**Has the inequality gap narrowed from baseline (2002-06)?**
Colorectal cancer incidence DSR	1.27 x higher	↑ 21.0%	24.3% ←→
Lung cancer incidence DSR	2.12 x higher	↑ 8.1%	2.1% ←→
Male lung cancer incidence DSR	1.99 x higher	↑ 8.1%	23.4% ←→
Female lung cancer incidence DSR	2.21 x higher	↑ 3.0%	36.3% →←
Breast cancer incidence DSR	0.93 x lower	↓ 2.0%	10.6% →←

The key messages from this detailed analysis are:

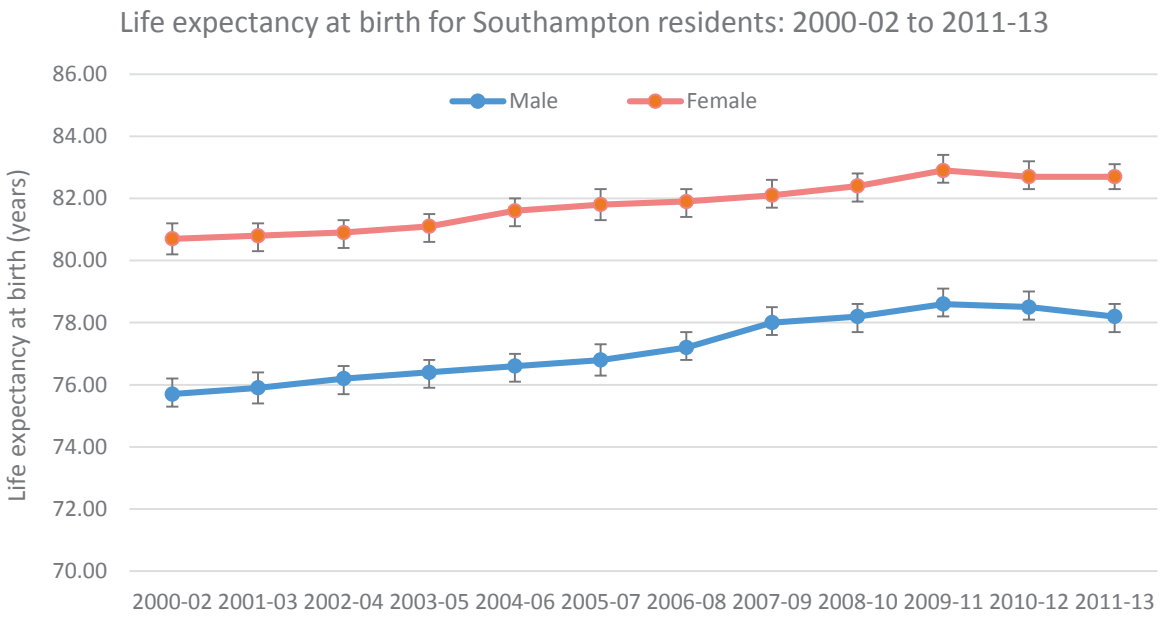
- *If you are in the 20% less well-off areas, you are twice as likely to die before reaching 75*
- *… and more than twice as likely to die from heart disease or a stroke*
- *Early deaths from cancer and lung disease are also much more common*
- *For men in particular it seems that, even if you are less well-off, life expectancy is improving*
- *BUT … for most of the things we are tracking, we are not showing that the gap is reducing*

It is important to recognise that overall heath has improved over the last decade, and this was described in some detail in the 2011 Annual Report[6]. Life expectancy has increased, deaths from heart disease and stroke have continued to fall and cancer survival has improved. Our new analysis confirms this overall trend.

Life expectancy is a good overall measure, and this has increased for both men and women, as illustrated in figure 6.

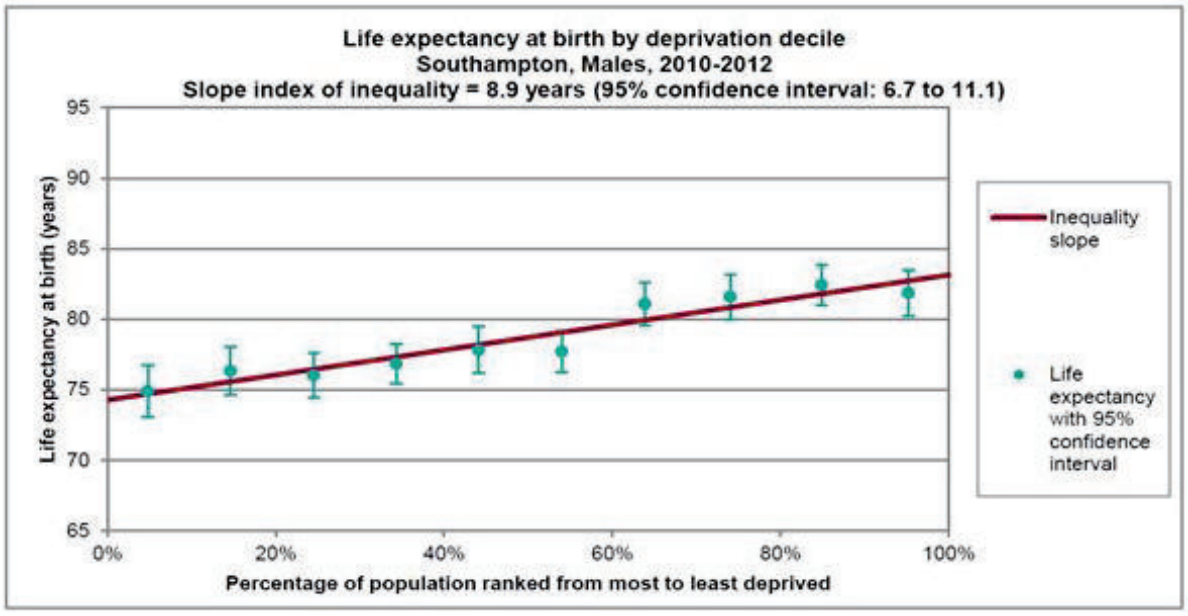
However, a significant life expectancy gradient remains. Figure 7 shows how, for men, there is nearly a ten year difference accounted for by deprivation.

Figure 6: Life expectancy at birth in Southampton



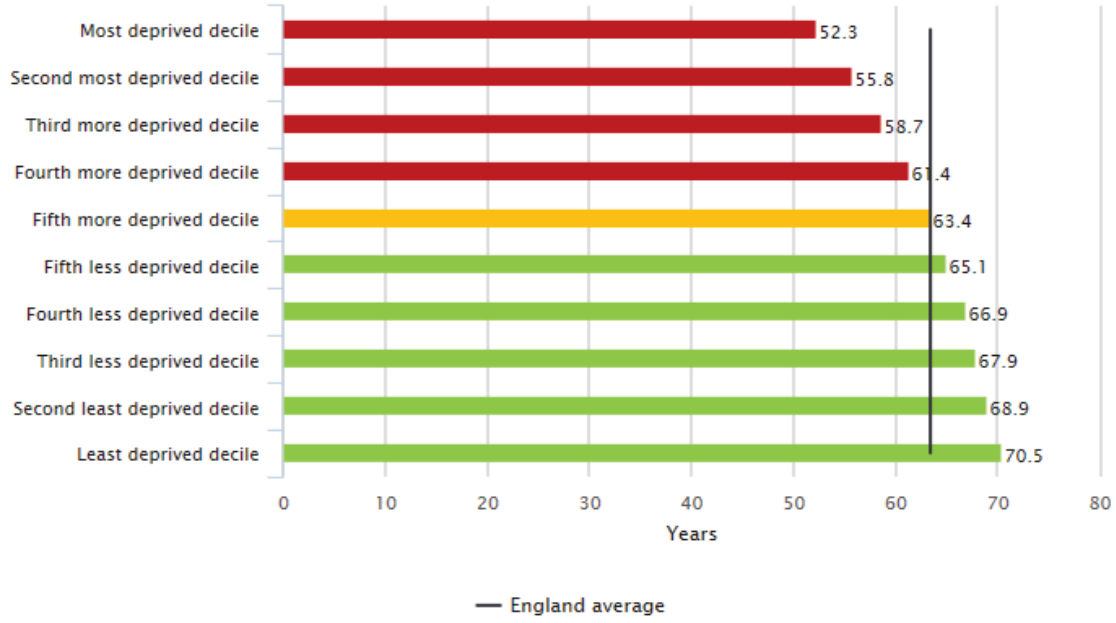
Source: PHE Public Health Outcomes Framework

Figure 7: Slope Index of Inequality



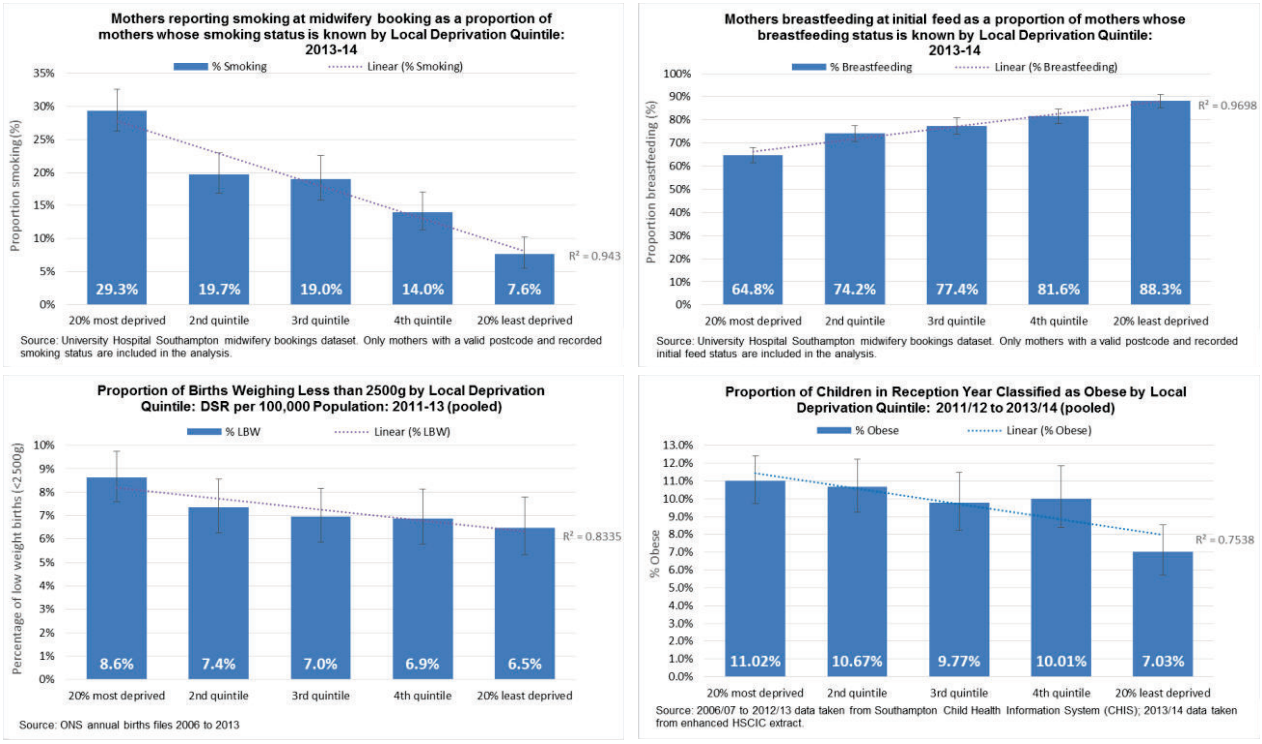
Healthy life expectancy (HLE) is an estimate of how many years people might live in a 'healthy' state. HLE is a key summary measure of a population's health. Men in Southampton have the second lowest HLE in the South East (61.3 years), and there is a very marked difference depending on socio-economic circumstances. Figure 8 shows that the most affluent 10% can expect to enjoy more than 18 extra years of healthy life than the 10% least well-off.

Figure 8: Male Healthy Life Expectancy by deprivation decile (IMD 2010), Southampton (2010-12)



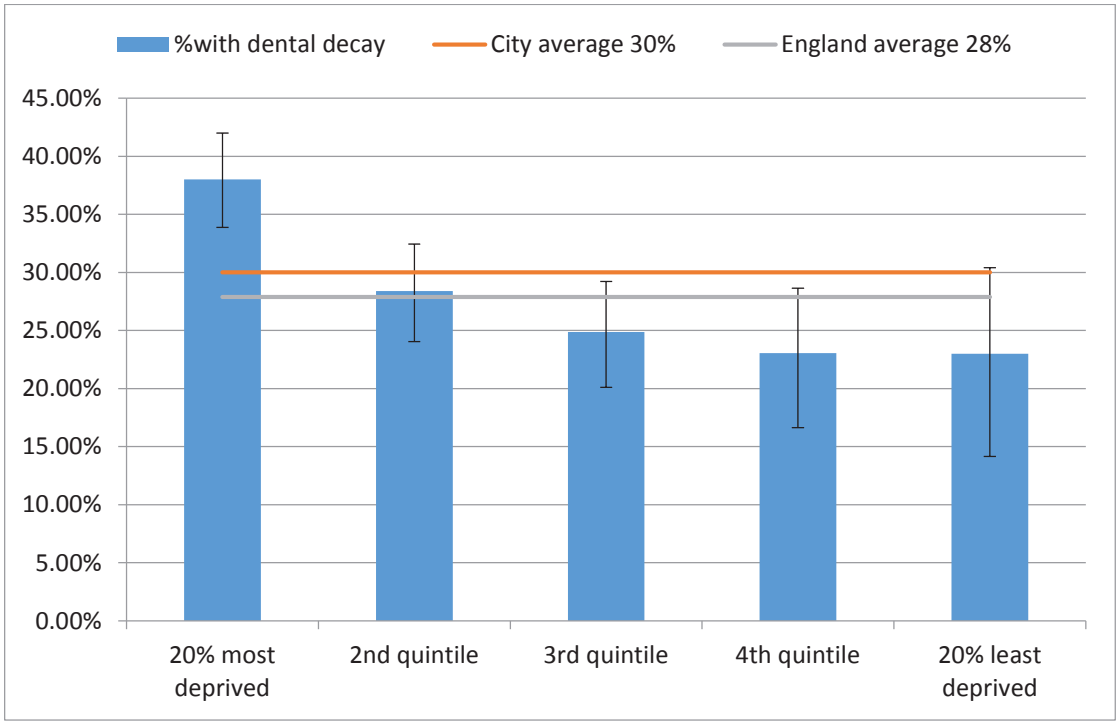
The Briefing Note explored a range of health data for the city and demonstrates a number of very striking differences that relate to deprivation. Figure 9 shows some important indicators of children's start in life. A smoke-free pregnancy reduces the risk of low birth weight, and breast feeding contributes benefits throughout early childhood, including setting the course for being a healthy weight.

Figure 9



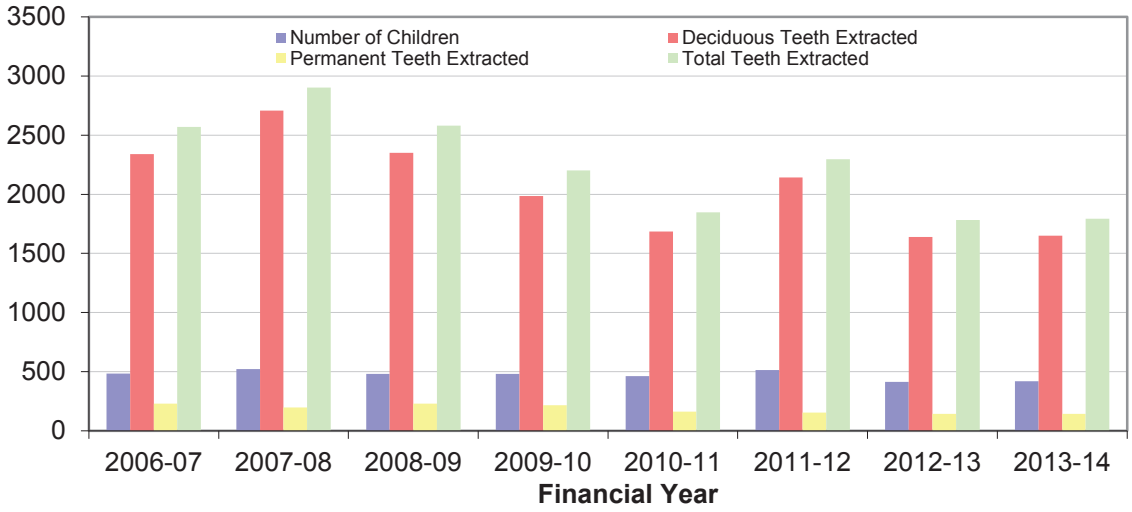
In addition, good oral health is particularly important for young children as they are just learning to speak and socialise, and a varied healthy diet is essential for development and achievement of their potential. Poor oral health results in pain and distress, which is undesirable particularly in early childhood. Child dental health surveys indicate that children in Southampton have poorer oral health than many other areas in the country. In the last survey of five-year-old children, around 30% of Southampton children had experience of dental decay (England = 27.9%). Figure 10 below shows the distribution of dental decay experience by deprivation quintile, with 38% of children in the most deprived quintile experiencing dental decay compared to 23% in the least deprived – an inequality gap of 15%.

Figure 10: Proportion of 5-year old children resident in Southampton with experience of dental decay by IMD (2010) deprivation quintile: 2011/12



Dental treatment can sometimes involve removing badly decayed teeth under a general anaesthesia (GA). Dental GAs are the main reason for children being admitted to hospital. Over 400 children are admitted each year in Southampton. Most of these children will be from the most disadvantaged backgrounds. Figure 11 indicates the trend over the last seven years. On average this would involve two to three visits which accounts for around 1,000 days off school, not taking account of the impact on parents'/ carers' time off work, sleepless nights and pain and distress to the child.

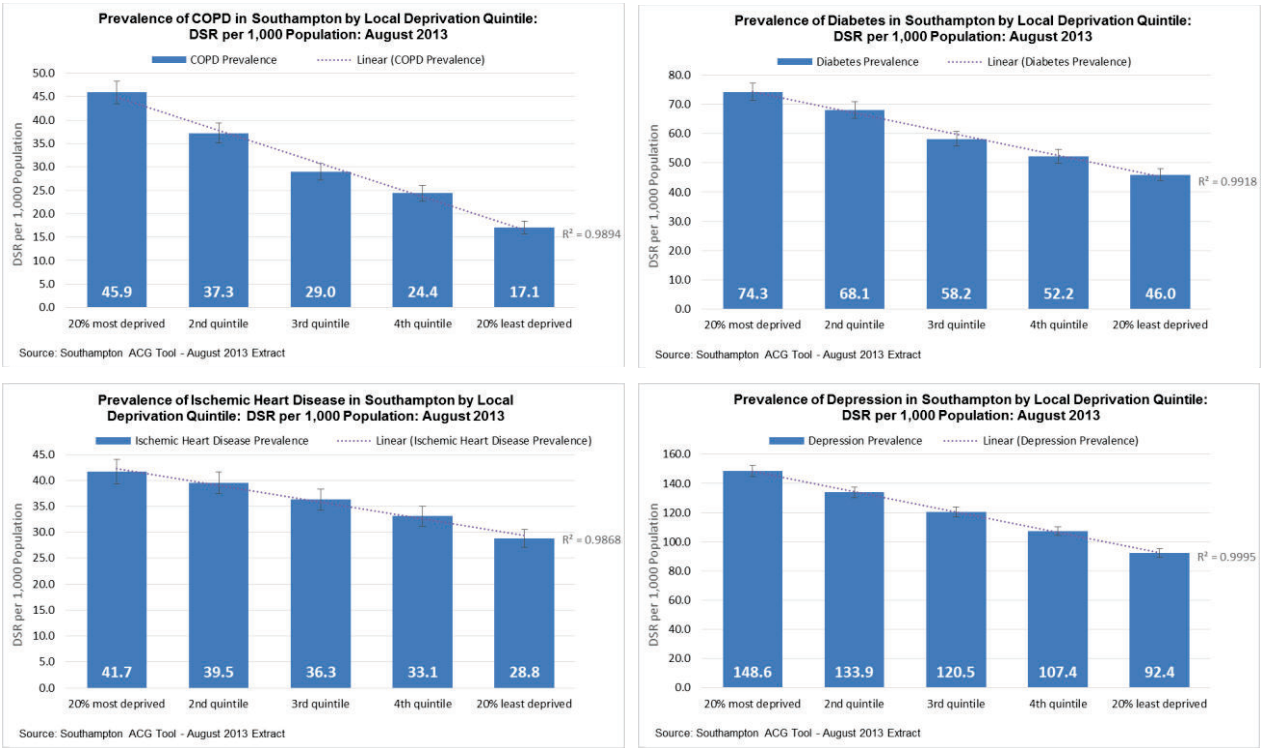
Figure 11: GA Extractions for Children in Southampton: 2006/07 - 2013/14



Sources: ONS Mid-Year Population Forecasts, Extraction data from NHS Solent Trust.

Amongst adults, even more striking gradients exist when looking at a number of chronic illness, such as lung disease (COPD), diabetes, heart disease and depression, as illustrated in Figure 12.

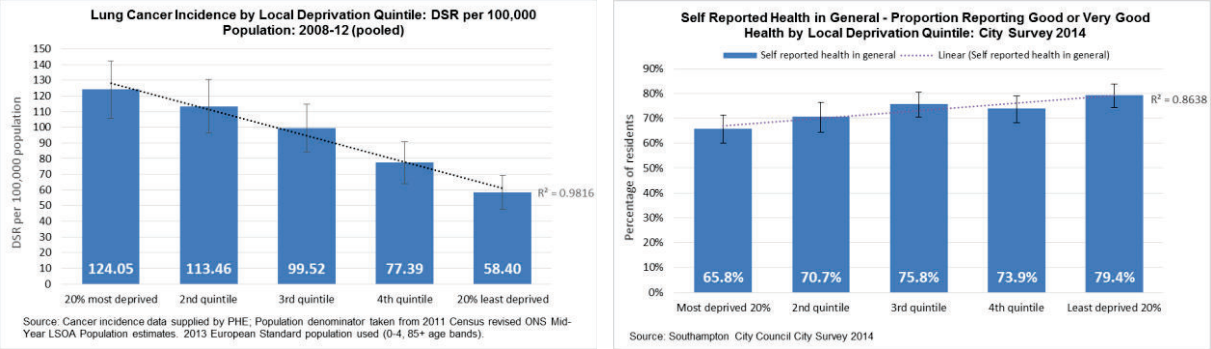
Figure 12



People in the least well-off group are over four times more likely to have one or more long term health conditions.

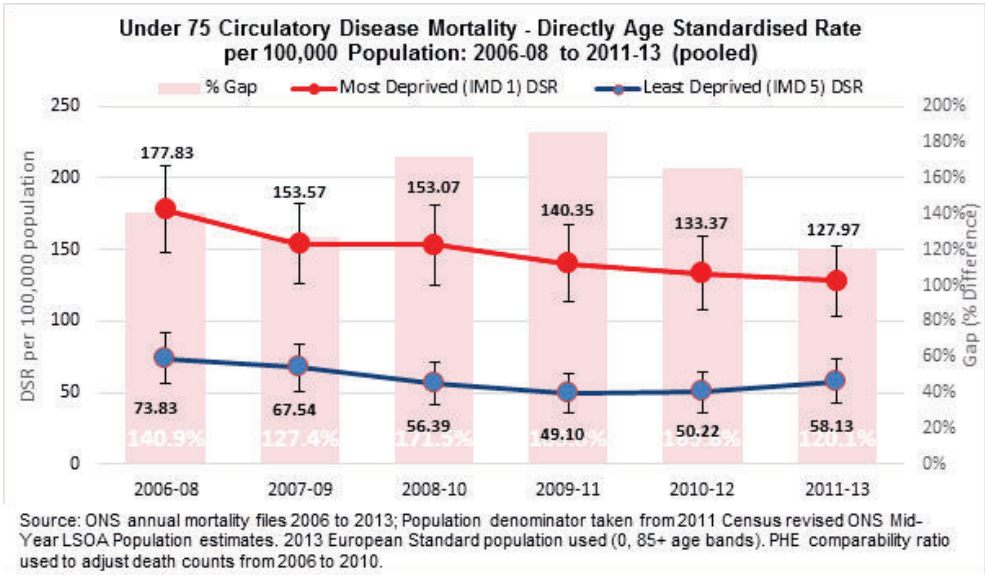
The Briefing Note shows how cancer is more common in those who are less well off, with the exception of breast cancer. Lung cancer is markedly more common, and data from the 2014 City Survey also illustrates how the reduction of smoking rates is lagging behind, with the smoking rates double those of the 20% least deprived. Unless smoking and other unhealthy lifestyles reduce among those less well-off, health inequalities will persist for a future generation.

Figure 13



As the trend data in Figure 5 illustrated, there is no clear pattern of gap narrowing from the measures that have been analysed. For many indicators the trend is an improving one for both the least well-off and the best-off, but the gap is persisting. For example, early deaths from heart disease and stroke have been falling for several decades. The recent local data shows that this trend is continuing, but the rate remains over twice as high in the 20% most deprived (Figure 14).

Figure 14



7.2 What can be done?

The opportunity to make changes and adopt healthier lifestyles is in itself affected by a broader set of circumstances, most importantly the amount of control people have in their lives. The Marmot Review team carried out a comprehensive review of the evidence and an assessment of what actions are likely to be most effective in reducing health inequalities in the short, medium and long term. Six key policy areas were proposed, with a set of actions for each.

Policy objective A – Give every child the best start in life

- Reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills.
- Ensure high quality maternity services, parenting programmes, childcare and early years education to meet need across the social gradient.
- Build the resilience and wellbeing of young children across the social gradient.

Policy objective B – Enable all children, young people and adults to maximise their capabilities and have control over their lives

- Reduce the social gradient in skills and qualifications.
- Ensure that schools, families and communities work in partnership to reduce the gradient in health, well-being and resilience of children and young people.
- Improve the access and use of quality life-long learning across the social gradient.

Policy objective C – Create fair employment and good work for all

- Improve access to good jobs and reduce long-term unemployment across the social gradient.
- Make it easier for people who are disadvantaged in the labour market to obtain and keep work.
- Improve quality of jobs across the social gradient.

Policy objective D – Ensure a healthy standard of living for all

- Establish a minimum income for health.
- Reduce the social gradient in the standard of living through progressive taxation and other fiscal policies.
- Reduce the cliff edges faced by people moving between benefits and work.

Policy objective E - Create and develop healthy and sustainable places and communities

- Develop common policies to reduce the scale and impact of climate change and health inequalities.
- Improve community capital and reduce social isolation across the social gradient.

Policy objective F – Strengthen the role and impact of ill-health prevention

- Prioritise prevention and early detection of those conditions most strongly related to health inequalities.
- Increase availability of long-term and sustainable funding in ill health prevention across the social gradient.

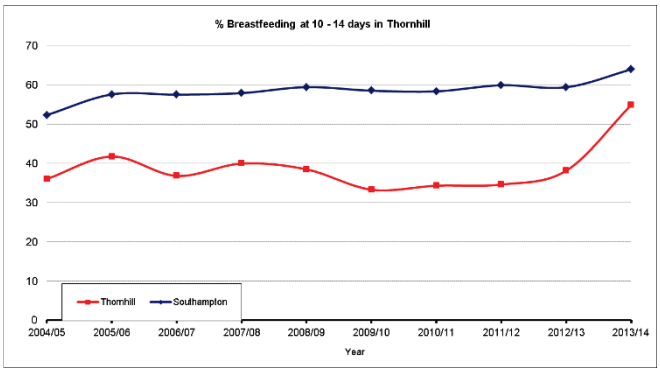
Policy objective F focuses on the key role of prevention in reducing health inequalities. It recommends that investment in prevention and health promotion is prioritised across government departments to reduce the social gradient. It proposes the implementation of evidence-based programmes of preventative interventions that are effective across the social gradient and cites in particular the need for sustained action on smoking, alcohol and obesity.

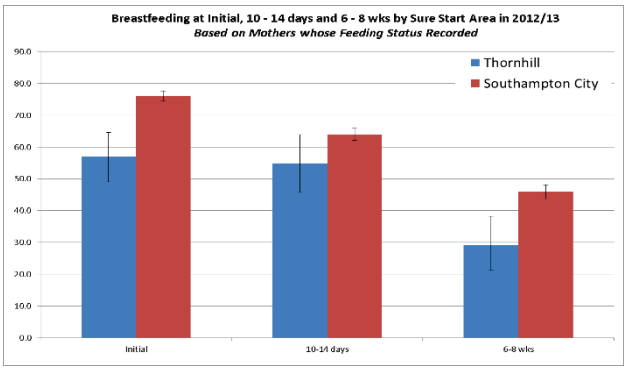
What have we done locally?

Local health improvements, particularly those in disadvantaged groups, have come as a result of a range of local and national initiatives. Adult smoking rates have fallen from 36% to 22% over a decade, in part due to the provision of local stop smoking services, increasingly targeted to reach people on low incomes. But national campaigns and Smoke Free legislation have helped to de-normalise smoking. The number of children smoking (8%) is half the rate five years ago, and efforts to prevent young people being recruited as the next generation of nicotine addict need to be stepped up. The ban on smoking in cars carrying children and plain packaging will be the national next steps towards a Smoke Free future.

The rise in childhood obesity has slowed, in part due to local initiatives to raise awareness of the problem, promote healthy eating in childcare and school settings, and increase opportunities for physical activity. Through the work of Southampton's Children's centres and the local Health Trainers programme these initiatives have targeted higher needs groups and taken increasingly holistic approaches to supporting individuals and families to make changes. More recently, intensive work by the midwives and health visitors in the East of the City has enabled more mothers in Thornhill to breastfeed, an area with traditionally low rates (see Figure 15).

Figure 15: Breast feeding in Thornhill Sure Start area, 2012/13





As shown previously in figure 11, the number of GA dental extractions amongst children in Southampton is very high. Data from Dudley (Southampton's closest equivalent fluoridated area) indicates that in 2008-9 there were 40 children in Dudley requiring this procedure, compared to 481 in Southampton. This gives an indication of the impact of water fluoridation on the oral health of children and why, from a public health perspective, this intervention continues to be recommended as both effective and safe, and to protect the most vulnerable of the City's children.

The water fluoridation scheme for Southampton is currently not being implemented as it does not have the support of the Council. Efforts to improve children's oral health continue, following best practice. There are currently around 800 children in 15 school settings participating in supervised tooth-brushing programmes. These are being expanded to include all Early Year's settings over the next year. The programme also includes recommendations for health eating and encouraging parents to take children to a dentist regularly.

Drugs and alcohol services have been enabling more people to tackle problematic use, while developing innovative approaches to prevent use and misuse in the first place, some of which have been described in previous Public Health Annual Reports.

Cancer and other screening programmes run by the NHS help detect health problems earlier, when treatment is likely to be more successful. Immunisation has reduced the burden of infectious diseases, particularly in childhood, and the national programme continues to offer new vaccinations as evidence for cost-effectiveness emerges. While immunisation rates have been good in recent years, variations in coverage need further evaluation, as more of those from high needs areas or groups are likely to be missing out. Screening uptakes need to be similarly reviewed.

Better management of long-term conditions, and ensuring that those least well-off are accessing the services they need, will improve outcomes and add life to years as well as years to life. Each year, the Public Health Annual Report focuses on different groups of illnesses and makes recommendations on how population outcomes can be improved. This year's report looks at hypertension and dementia.

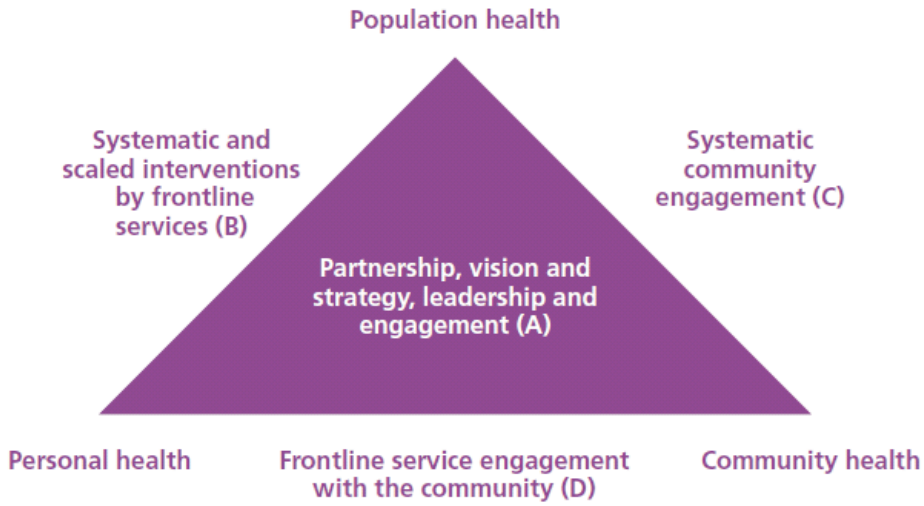
Actions on wider determinants such as improving housing conditions, community safety, skills development and employment opportunities, neighbourhood regeneration, and improved transport infrastructure have undoubtedly improved the lives of many people. While we have many successes to celebrate, many of which have been described in previous reports, the City would benefit from a more systematic and better co-ordinated approach.

What more can we do?

The final report of the Strategic Review of Health Inequalities in England post-2010 has provided best evidence to support both national and local action. It is informing the direction of national strategy. At a local level the recommendations provide the opportunity for Southampton City Council and its partners to review commissioning of health and wellbeing activity across the city to ensure best evidence is implemented and best outcomes secured to reduce health inequalities.

Unless a more systematic and consistent approach is adopted across the city, the inequalities in health that are described in this report are likely to continue. The local focus has to be on those measures for which there is strong evidence that they will make the most difference. The 2009 Public Health Annual Report set out advice developed by the National Support Team for Health Inequalities. A whole systems approach was recommended, with interventions at whole population, community and personal health level. Success, based on experience in deprived areas in England, depends on four key factors, summarised in Figure 16:

Figure 16: Producing percentage change at population level

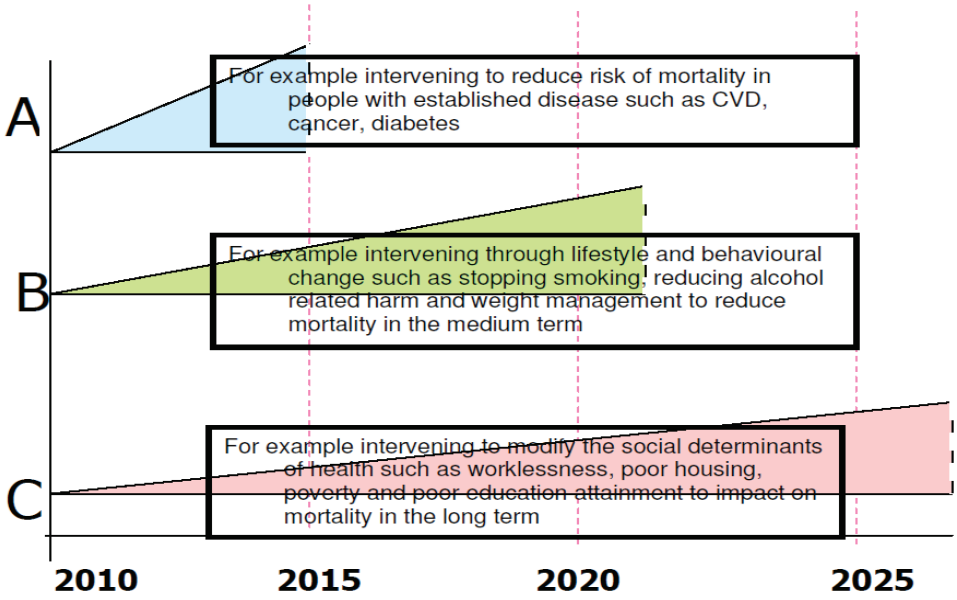


(Source: Chris Bentley, Health Inequalities Support Team)

A. The whole system must be driven by committed leadership fostering engagement, effective local strategic partnership and a locally owned, coherent vision and strategy.
B. Interventions must be provided effectively with system and scale by frontline services proactively pursuing health outcomes.
C. Community development should be addressed in a systematic way, rather than ad hoc, targeting engagement and support to the weakest and least capable of responding alone.
D. A range of processes should connect frontline services into the heart of communities, reaching out to "seldom seen, seldom heard" groups and individuals.

This approach can succeed, but not overnight. It is important to recognise that different interventions take different lengths of time to have their impact on a populations health and their gap-narrowing effect, as illustrated in Figure 17.

Figure 17: Health inequalities –different gestation times for interventions[7]



However, tackling key public health challenges with a broad range of approaches over many years can bring a range of benefits to society as a whole. For example, obesity reduces life expectancy by three years, on average, and severe obesity by eight to ten years. It is more common in those living in deprived areas and, like many public health challenges, there is no silver bullet that will halt its rise and reduce the multiple health harms it causes. The evidence shows that a whole system, partnership approach is required, and the benefits of tackling this societal challenge will have wide-reaching impacts, as illustrated in Figure 18.

Figure 18: Impact of actions to reduce obesity[8]

In the new, post-2013 health and social care system, Health and Wellbeing Boards are well placed to lead on developing a local vision and a determined whole-system approach to narrowing the health gap.

In developing such an approach local areas such as Southampton can benefit from newly published evidence reviews and equity briefings from Public Health England and the UCL Institute of Health Equity. These include evidence, practical points and case studies on approaches and actions that can be taken by local authorities on a range of issues to reduce health inequalities, and cover 9 topic areas as summarised in figure 19 below[9]:

Figure 19

	Health equity evidence reviews	Health equity briefings
Early intervention	1. Good quality parenting programmes and the home to school transition	1a. Good quality parenting programmes
		1b. Improving the home to school transition.
Education	2. Building children and young people's resilience in schools	2. Building children and young people's resilience in schools
	3. Reducing the number of young people not in employment, education or training (NEET)	3. Reducing the number of young people not in employment, education or training (NEET)
	4. Adult learning services	4. Adult learning services
Employment	5. Increasing employment opportunities and improving workplace health	5a. Workplace interventions to improve health and wellbeing
		5b. Working with local employers to promote good quality work
		5c. Increasing employment opportunities and retention for people with a long-term health condition or disability
		5d. Increasing employment opportunities and retention for older people
Ensuring a healthy living standard for all	6. Health inequalities and the living wage	6. Health inequalities and the living wage
Healthy environment	7. Fuel poverty and cold home-related health problems	7. Fuel poverty and cold home-related health problems
	8. Improving access to green spaces	8. Improving access to green spaces
	Implementation and impact: health equity briefings	
	9. Understanding the economics of investments in the social determinants of health	10. Tackling health inequalities through action on the social determinants of health: lessons from experience

Southampton City Council has established a Fairness Commission to investigate and report on what can be done to create a fairer City. Issues of social justice will be highlighted and the Commission's recommendations, due in early 2015, will create a springboard for the Health and Wellbeing to launch a fresh approach to narrowing the health gap.

Elsewhere in England, some councils and their partners are looking at how obligations under the Social Value Act (2012) can contribute to this agenda. The Act requires public sector organisations to consider how to increase local economic, social and environmental benefits when spending money on goods and services. Other councils are looking at ways of ensuring that health and reducing health inequalities are included as objectives in all their policies.

Despite the challenging financial situation faced by all public sector organisations, there are many opportunities and approaches that should be explored to tackle the health inequalities that persist in Southampton.

7.3 Recommendations:

1. Based on the best evidence available, the City's Health and Wellbeing Board should develop a city-wide targeted programme of actions to tackle health inequalities due to wider social and environmental factors affecting the public's health.

2. The Health and Wellbeing Board should make specific recommendations on urgent, high priority actions to be taken by the Council and the local NHS that will have the most impact in the short to medium term, based on findings in this report.

3. The local NHS, led by the Clinical Commissioning Group, should assess health inequalities that could be reduced by health service interventions, and develop deliverable plans to reduce these.

4. The Health and Wellbeing Board should use the opportunity of its next five-year strategy to prioritise actions that will reduce inequalities, improve overall health and create a fairer Southampton.

7.4 References

1. Department of Health (1998) *The Acheson Report: Independent Inquiry into Health Inequalities*

2. Action on Smoking & Health (2012) *ASH Factsheet: Smoking Statistics – Illness & Deaths* [Online] Available from: http://www.ash.org.uk/files/documents/ASH_107.pdf

3. Commission on Social Determinants of Health, World Health Organisation (2008) *Closing the gap in a generation: Health equity through action on the social determinants of health – Final Report*

4. Department for Communities & Local Government (2011) *English Indices of Deprivation 2010.* [Online] Available from: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2010

5. King, D. (2014) *Health Inequalities in Southampton City: Analysis of Trends.* [Online] Available from: http://www.publichealth.southampton.gov.uk/HealthIntelligence/Briefings.aspx

6. NHS Southampton City (2011) *Health in Southampton 2011: Report from the Public Health Director for Southampton.* [Online] Available from: http://www.publichealth.southampton.gov.uk/healthintelligence/phar.aspx

7. Department of Health (2011) *Health Inequalities National Support Team: Priority actions based upon best practice that could impact inequalities in mortality and life expectancy in the short term.* [Online] Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215329/dh_130949.pdf

8. Public Health England (2015) *Making the case for tackling obesity – why invest?* [Online] Available from: http://www.noo.org.uk/slide_sets

9. UCL Institute of Health Equity & Public Health England (2014) *Local Action on Health Inequalities: Introduction to a series of evidence papers* [Online] Available from: http://www.instituteofhealthequity.org/projects/local-action-on-health-inequalities-series-overview

RESIDENT POPULATION, 2013

Population resident in Southampton City

Age band	Male	Female	Persons	%
0-4	8,342	7,865	16,207	6.7%
5-14	12,486	11,879	24,365	10.1%
15-24	25,253	23,038	48,291	19.9%
25-49	44,673	41,077	85,750	35.4%
50-64	17,833	17,501	35,334	14.6%
65-74	8,117	8,650	16,767	6.9%
75-84	4,521	6,125	10,646	4.4%
85+	1,583	3,198	4,781	2.0%
Total	122,808	119,333	242,141	100%

Source: Office for National Statistics Mid-Year Population Estimates 2013, © Crown Copyright.

REGISTERED POPULATION, 2014

Population registered with Southampton City GPs

Age band	Male	Female	Persons	%
0-4	8,791	8,063	16,854	6.3%
5-14	13,978	13,306	27,284	10.1%
15-24	22,856	23,447	46,303	17.2%
25-49	53,987	46,843	100,830	37.5%
50-64	21,661	19,778	41,439	15.4%
65-74	9,519	9,850	19,369	7.2%
75-84	5,150	6,451	11,601	4.3%
85+	1,813	3,460	5,273	2.0%
Total	137,755	131,198	268,953	100%

Source: Health & Social Care Information Centre (HSCIC), October 2014

BIRTHS

General Fertility Rate and Number of Births

	2010	2011	2012	2013
Live births per 1,000 women aged 15-44				
Southampton	57.0	63.4	60.2	57.5
South East	64.4	63.8	64.5	61.3
England	65.5	64.2	64.9	62.2
Number of live births				
Southampton	3,448	3,550	3,420	3,284

Source: Office for National Statistics, Mid-year population estimates and Vital Statistics table VS1. © Crown Copyright.

TEENAGE CONCEPTIONS

	2009	2010	2011	2012
No. of conceptions to girls aged under 18				
Southampton	188	181	170	129
Under 18 conception rate per 1,000 girls aged 15-17				
Southampton	54.3	51.7	47.4	34.3
South East	29.9	28.0	26.1	23.2
England	37.1	34.2	30.7	27.7

Source: Office for National Statistics, © Crown Copyright.

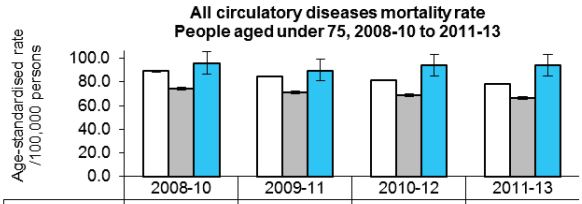
INFANT MORTALITY*

	2008-10	2009-11	2010-12
Number of deaths (in 3 year period)			
Southampton	54	44	43
South East	1,171	1,137	1,103
England	9,001	8,771	8,505
Mortality per 1,000 live births			
Southampton	5.4	4.3	4.1
South East	3.7	3.6	3.4
England	4.4	4.3	4.1

* Deaths of infants aged under 1 year

Source: Office for National Statistics. © Crown Copyright.

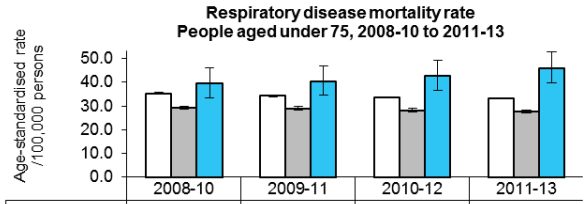
CIRCULATORY DISEASE



	2008-10	2009-11	2010-12	2011-13
England	89.0	84.4	81.1	78.2
South East	74.3	71.1	68.6	66.3
Southampton	95.4	89.7	93.8	93.8
Average number of deaths per year				
Southampton	138	132	139	141

Source: Public Health England PHOF. © Crown Copyright.

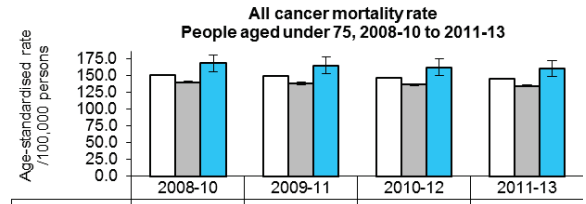
RESPIRATORY DISEASE



	2008-10	2009-11	2010-12	2011-13
England	35.3	34.2	33.5	33.2
South East	29.2	28.9	28.2	27.6
Southampton	39.4	40.3	42.6	45.8
Average number of deaths per year				
Southampton	55	57	61	68

Source: Public Health England PHOF. © Crown Copyright.

CANCER



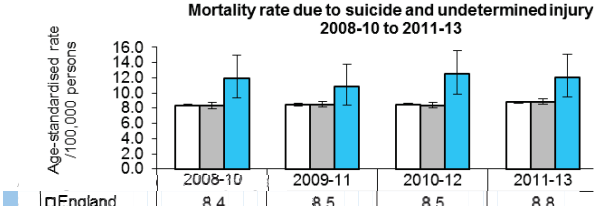
	2008-10	2009-11	2010-12	2011-13
England	150.6	148.5	146.5	144.4
South East	140.0	138.0	136.0	134.0
Southampton	167.7	164.5	161.6	159.9

LIVER DISEASE

	2008-10	2009-11	2010-12	2011-13
England	17.9	18.0	18.0	17.9
South East	14.2	14.3	14.3	14.9
Southampton	22.4	21.9	20.5	21.6
Average number of deaths per year				
Southampton	35	35	32	35

Source: Public Health England PHOF. © Crown Copyright.

SUICIDE



	2008-10	2009-11	2010-12	2011-13
England	8.4	8.5	8.5	8.8
South East	8.3	8.5	8.4	8.8
Southampton	11.9	10.9	12.5	12.1
Average number of deaths per year				
Southampton	26	23	28	27

Source: Public Health England PHOF. © Crown Copyright.

A Pocket Profile

The Health of the People of Southampton City 2014

Contact

Public Health Southampton
Civic Centre
1st Floor
Municipal Block – West
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Southampton
SO14 7LT

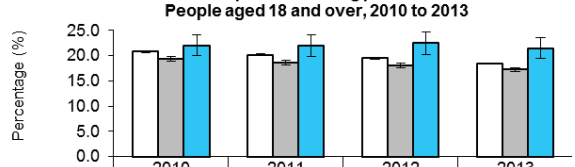
Email: dan.king@southampton.gov.uk

For more health information please visit our website:
www.publichealth.southampton.gov.uk

FOR LARGE PRINT VERSION
023 80 832493

SMOKING

Self-reported smoking prevalence
People aged 18 and over, 2010 to 2013



	2010	2011	2012	2013
England	20.8	20.2	19.5	18.4
South East	19.4	18.7	18.0	17.2
Southampton	22.0	21.9	22.5	21.5

Integrated Household Survey. Analysed by Department of Health and published by Public Health England (PHOF). © Crown Copyright.

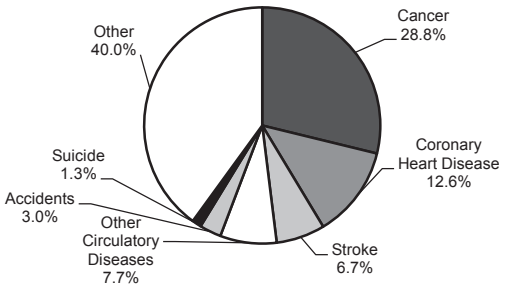
LIFE EXPECTANCY

		Males	Females
Life Expectancy at Birth (years) 2010-12	Southampton	78.5	82.7
	South East	80.3	83.8
	England	79.2	83.0
		Males	**Females**
Healthy Life Expectancy at Birth (years) 2010-12	Southampton	61.3	63.6
	South East	65.8	67.1
	England	63.4	64.1

Life expectancy is an estimate of the number of years a new-born baby could expect to live if they experienced that area's mortality rates throughout their life. Healthy life expectancy is the number of years they could expect to live in good health based on current morbidity and mortality rates. Public Health England (PHOF). © Crown Copyright.

MAJOR CAUSES OF DEATH

Southampton Residents 2013 (No. of deaths = 1,888)



Source: Office for National Statistics, Vital Statistics VS3 © Crown

JOBS AND UNEMPLOYMENT

Job Seekers Claimant count (as % of 16-64 resident population)

	Southampton	South East	England
Dec 2014	1.5	1.2	1.9
Sep 2014	1.7	1.3	2.1
Jun 2014	1.9	1.4	2.4
Mar 2014	2.4	1.8	2.8
Dec 2013	2.7	1.8	2.8

Jobs Density (no. of filled jobs per working age resident)

	Southampton	South East	England
2012	0.73	0.81	0.79

Source: National Statistics (www.nomisweb.co.uk)
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INDEX OF DEPRIVATION 2010

Ranking of the worst 5 Super Output Areas (SOAs) out of 146 SOAs in Southampton for overall score and each domain

Domain	E01017167 Bitterne	E01017154 Bevois	E01017281 Woolston	E01017207 Millbrook	E01017163 Bitterne	E01017240 Redbridge	E01017280 Woolston	E01017161 Bevois	E01017140 Bargate	E01017137 Bargate	E01017210 Millbrook	E01017237 Redbridge	E01017274 Woolston	E01017145 Bassett	E01017148 Bassett	E01017142 Bargate	E01017257 Sholing	E01017146 Bassett	E01017139 Bargate	E01017227 Portswood	E01017218 Peartree	E01017189 Freemantle	E01017225 Peartree	E01017160 Bevois
Overall IMD Score	1	2	3	4	5																			
Income	2	3	1	4	5																			
Employment	2	3	1			4	5																	
Health		3	1					2	4	5														
Education	1				5						2	3	4											
Housing/Access														1	2	3	4	5						
Crime	1			4						2	3								5					
Environment																				1	2	3	4	5

Also within the 10% most deprived SOAs in England

Source: Index of Deprivation 2010. Department for Communities and Local Government.

EDUCATIONAL ATTAINMENT

	10/11	11/12	12/13	13/14
Southampton				
KS2 English	79	83	86	89
KS2 Mathematics	80	83	85	87
5+ GCSEs A*-C	51.7	54.4	58.1	49.8
England				
KS2 English	82	85	87	88
KS2 Mathematics	80	84	85	86
5+ GCSEs A*-C	59.0	59.4	59.2	52.6

KS2 = % of children gaining at least level 4 at Key Stage 2
GCSEs = % of 15 yr olds gaining 5+ GCSE/GNVQ grades A*-C inc English and Maths
Source: Dept. for Education www.education.gov.uk. © Crown copyright

HEALTH IN SOUTHAMPTON CITY

This Pocket Profile summarises the most recent comparative indicators of the health of residents of Southampton.

We have compared Southampton to the South East Region and with the England average.

We hope you find this profile useful and welcome your comments.

Dan King
Head of Public Health Intelligence

Andrew Mortimore
Director of Public Health

DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		HOUSING AND HEALTH – FUEL POVERTY PLAN		
DATE OF DECISION:		MARCH 2015		
REPORT OF:		DIRECTOR OF PUBLIC HEALTH		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Debbie Chase & Janet Hawkins**	**Tel:**	**023 808333738**
	E-mail:	**debbie.chase@southampton.gov.uk** **janet.hawkins@southampton.gov.uk**		
Director	**Name:**	**Andrew Mortimore**	**Tel:**	**023 80833738**
	E-mail:	**andrew.mortimore@southampton.gov.uk**		
STATEMENT OF CONFIDENTIALITY				
None.				

BRIEF SUMMARY

The quality of a home has a substantial impact on health. A warm, dry and secure home is associated with better health. In addition to basic housing requirements, other factors that improve wellbeing include location/neighbourhood, adaptations for disabilities, proximity to primary health services as well as security of tenure in rented homes. The Building Research Establishment (BRE) has calculated that poor housing costs the NHS at least £600 million each year.

This briefing highlights the impact of fuel poverty in Southampton. It sets out local issues, partnership work and an action plan to tackle fuel poverty in our City. In addition, this briefing provides the scope for a paper to be presented to the Board in June 2015 looking at Housing and Health in a broader context and the opportunities arising from the National Fuel Strategy.

RECOMMENDATIONS:

(i) That the Board considers the potential impact and ambition of the Fuel Poverty Plan (Appendix 1) and identifies methods in which additional support could be mobilised.

(ii) That the Board agrees the scope for the paper on housing and health as described in this briefing, to be presented to the Board in July 2015.

REASONS FOR REPORT RECOMMENDATIONS

1. To endorse the Fuel Poverty Plan and seek direction on requirements for the proposed report on housing and health.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

3. Fuel poverty is a distinct and serious problem in Southampton, An estimated 9.7% households in the City meet the definition; they have below average income and above average expenditure on fuel to keep warm. In 2012 there were 124 excess winter deaths in Southampton.

4. The Southampton Warmth for All Partnership (SWAP) is a multi-agency response to the issue of fuel poverty, led by Public Health. This key partnership includes statutory services and third sector organisations and aims to raise awareness of fuel poverty and coordinate action to alleviate it. The partnership has been operating for almost 15 years and more recently has a core membership from Public Health (SCC), Environmental Health (SCC), Housing Services (SCC), the Environment Centre and Age UK Southampton. The group have found it a challenge to sustain engagement with colleagues in health and social care services.

5. SWAP have had many successes:
   (i) Raising awareness with services and partners who visit people in their home (community, voluntary and statutory services); each year a fuel poverty checklist is updated and distributed as a prompt.
   (ii) Providing advice services to help residents to better understand their energy costs and manage these.
   (iii) Delivering physical improvements to homes through initiatives such as Warm Front, Cocoon, Heat Seekers etc.
   (iv) Bidding for resources to deliver services and provide support, for example successful bids were made to the Department of Health as part of their 'Warm Home Health People Fund' and two successive bids to provide practical support for residents.

6. The Fuel Poverty Plan builds on the successes of the previous strategy approved in 2004 and aims to 'reduce health inequalities associated with fuel poverty, to reduce the number of deaths caused by cold homes and improve the quality of life of people living in fuel poverty'. The plan has been developed by SWAP and has been presented and approved by Southampton City Council's Sustainability Board in 2014. The plan can be found in Appendix one.

7. The Plan sets out the complexity of issues in Southampton and compares this with the national picture, the focus is on delivering a range of practical actions with demonstrable improvements. Included within is a three year action plan where each partner organisation has committed to contribute and these actions will be monitored and reported. The action plan has key themes:
   - Redefining the challenge (researching the impact of the new definition).
   - Improving energy efficiency (supporting improvement across all tenures).
   - Maximising income.

- Ensuring cheaper energy (best deal on energy bills).
- Changing behaviours (fuel poor households have access to and act on best advice).

8. The targets are challenging and depend on the effective partnerships already in place to be achieved. The funding for energy efficiency improvements has become complex and challenging. This together with maintaining the ability to bid for funding streams to complete work identified in the action plan requires sufficient resources and priority in terms of officer time.

9. In March 2015, the Government published 'Cutting the cost of keeping warm: a fuel poverty strategy for England'. This sets out the Governments priorities for tackling fuel poverty whilst recognising that there are many factors affecting a household's ability to keep warm in their home. The key outcomes are:
    - Progress against milestones (to ensure that as many fuel poor homes as reasonably practicable) achieve an energy rating of band C or above).
    - Increased comfort.
    - Improved health and wellbeing.
    - Improved partnership.
    - Improved evidence base and understanding.
    - Improved targeting.
    - Lower carbon emissions.

10. The full impact of the national strategy needs to be assessed locally. There will be opportunities to bid for additional funding to support delivery of innovative and creative schemes including boilers on prescriptions.

11. The design, quality and standard of homes have a measurable impact on physical and mental health. As such housing was identified as an important social determinant of health in the Marmot Strategic Review of Health Inequalities and a number of housing related factors are included within the Public Health Outcomes Framework for England.

12. The proposed paper that will be presented to the Board in June 2015 will cover:

Overview of housing in the City
- Put into context the housing stock in the City including tenure, age, type, location.
- Residential homes, housing with care.

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

Strategic overview

- National strategic approach.
- Overview of related local strategies, plans and services
  This will include: Housing strategy, empty properties, regulation in the private rented sector, planning, performance and City Plan and Better Care Fund.

Housing availability

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

Housing needs

- Needs of residents now and in the medium term.

RESOURCE IMPLICATIONS

Capital/Revenue

13. None.

Property/Other

14. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

15. 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

1.	Southampton Warmth for All Partnership. Fuel Poverty Plan 2014-2017 'Warm homes for health' June 2014.

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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Fuel Poverty Plan 2014 – 2017

"Warm Homes for Health"

This plan includes:

- The Impact of Fuel Poverty
- Patterns of Excess Winter Deaths
- Location of Vulnerable Groups and Action Plan

June 2014

Southampton Warmth for All Partnership

Contents

Aim

To reduce health inequalities associated with fuel poverty, to reduce the number of deaths caused by cold homes, and improve the quality of life of people living in fuel poverty.

Background

Climate change is one of the biggest global public health threats this century (Cosello et al 2009). It presents risks to the health of the UK population, particularly to the most vulnerable, as well as to the effective delivery of public health, the National Health Service (NHS) and social care services (DEFRA 2012). Fuel Poverty is where a household cannot keep adequately warm at reasonable cost given their income. The definition of fuel poverty was changed in July 2013 by the Government (Department of Energy and Climate Change) which makes this updated plan very timely.

This Fuel Poverty Plan is presented against the background not only of climate change but of the most fundamental reforms to the welfare system for 60 years. The Government's stated aim is to produce a simpler, fairer benefits system and to ensure that 'work pays'.

The changes, which primarily affect people of working age, will mean that from April 2013:

- Many Social Housing tenants will see their Housing Benefit reduced if they are occupying accommodation with an excess of bedrooms for the household needs
- Many working age claimants in receipt of income-related benefits will be required to pay a proportion of their Council Tax
- Many working age households will have their weekly benefits capped to a level of £350 per week for single claimants and £500 per week for couples/lone parents
- Responsibility for Community Care Grants and Crisis Loans, currently the responsibility of the DWP Social Fund scheme will devolve to Local Authority administration through Local Welfare Provision.

Between October 2013 and 2017 Universal Credit will be introduced, eventually resulting in most claimants receiving calendar monthly benefit payments in arrears. These will include an element for rent where appropriate and it will be the responsibility of the claimant to pay this direct to the landlord.

The city council, in partnership with health and other agencies, will address fuel poverty in Southampton and report on progress through the Health and Wellbeing Board.

Addressing fuel poverty links with some key national plans, including:

- The National Adaptation Plan (Defra) which focuses on making the country resilient to a changing climate – references are made to the Cold Weather Plan for England and the Home Energy Conservation Act
- The Department of Energy and Climate Change (DECC) Fuel Poverty a Framework for Future Action (2013)

Also the Public Health Outcomes Framework (2012) which includes:

- Improving the wider determinants of health – narrowing health inequalities
- Health improvement – behaviour change and lifestyle factors
- Health protection – disease prevention
- Healthcare public health and improving premature mortality

And locally with:

- Southampton's Joint Health and Wellbeing Strategy (2013)
- Southampton's Joint Strategic Needs Assessment.
- Southampton City Councils Low Carbon City Strategy
- Southampton City Council Housing Strategy 2011-15

Fuel Poverty in Southampton

Fuel poverty is a distinct and serious problem in Southampton and although the number of households increased between 2006 and 2008 but fell between 2009 and 2011 the number is likely to increase in the future because of rising energy costs. Fuel poverty is associated with excess winter deaths, of which there were an estimated 100 excess deaths in Southampton during the winters of 2010/11.

The Southampton Warmth for all Partnership (SWAP) has worked effectively in partnership to deliver a range of initiatives to tackle fuel poverty. Despite a climate of diminishing resources, there are the additional challenges of welfare reform and the implementation of the Green Deal and Energy Company Obligation (ECO) to be met and these have coincided with the ending of other subsidies for energy efficiency improvements.

This plan builds on the successes of the previous strategy, approved in 2004.

Key successes under the previous strategy include:

- Sustaining a strong partnership for coordinating activities – SWAP
- 3,900 households removed from fuel poverty (not including council tenants)
- Energy efficiency initiatives; including several thousand privately owned and rented homes insulated through the Warm Front scheme, insulating private rented homes, Cocoon and Heatseekers schemes.
- Two successful bids to the Department Health's Warm Homes, Healthy People Fund. Funding was used to establish the STOP the cold project, which reinvigorated a partnership approach with the voluntary sector, developed a clearly defined brand and streamlined communication and referral routes, while enabling practical assistance during times of severe weather
- Activities to maximise income – including the council's Moneytree publication

The STOP the Cold project has achieved the following objectives to date:

- Improved knowledge among community, voluntary and statutory services and organisations about the help and assistance available for all residents, with a focus on older and vulnerable people to keep warm in the city
- Increased awareness city-wide about the effects of the cold weather on older and vulnerable people through a local media campaign (local radio adverts, information in local newspapers, social media, websites etc.)
- Targeted assistance to identified older single people
- The completion of a programme of home visits to complete 'warm home' checks and linking with other services as needed including checking the customers are on a suitable tariff with their energy supplier
- The distribution of information packs with room thermometers and thermal clothing to older people in the city through volunteers, the Handyperson Service, lunch clubs, carers etc.

- Provided practical support through the council-funded Handyperson Service (provided under contract by the Society of St. James) and the loaning of oil filled radiators to households without heating
- Work with partners to maximise household income and where possible apply for funding to assist with fuel bills
- Repair or replacement of broken, energy inefficient boilers for low income households
- Loft clearance assistance to enable improved insulation
- Work with others to deliver warm meals and food essentials during periods of extreme cold

Further information is available in the STOP the Cold evaluation report which can be downloaded at www.environmentcentre.com

This plan has been developed with the following partners:

- Dr Debbie Chase, Consultant in Public Health, Southampton City Council, Chair of the Southampton Warmth for All Partnership (previously Dr Graham Watkinson)
- Paul Juan, Regulatory Services Manager, Southampton City Council
- Southampton Warmth for All Partnership (SWAP)
  - Nicola Butler, Operations Director, Society of St James
  - Eileen Downes, Senior Worker Community Training, Sure Start
  - Mary Carnegie, Advice and Information Coordinator, Age UK Southampton
  - Helen Farley, Principle Project Manager, the Environment Centre (tEC)
  - Adam Goulden, Senior Manager, the Environment Centre (tEC)
  - Janet Hawkins, Team Leader, Regulatory Services, Southampton City Council.
  - Alan Laney, Partner Support Manager, Department for Work and Pensions
  - Eva Richmond, Money Matters Project Officer, Age UK Southampton
- Rebecca Wilkinson, Head of Public Health Information and JSNA Manager, Southampton City Council
- Southampton Housing Partnership (including private and social landlords)

Contact: Paul Juan, Southampton City Council
Email: Paul.juan@southampton.gov.uk

Fuel Poverty and its Impact on Health

Research carried out in Southampton in 2002 and 2008 (large scale sample surveys of housing conditions) showed that fuel poverty dropped over these six years from an estimated 9,900 to 6,000 vulnerable households. This does not include householders living in council housing.

However, the Department for Energy and Climate Change (DECC) defines a household as fuel poor if it needs to spend more than 10% of its income on fuel to maintain an adequate standard of warmth – normally 21 degrees for main living room and 18 degrees for all other occupied rooms. According to this definition, fuel poverty levels in Southampton have generally been above the regional averages but below the English average since 2006 (Table 1).

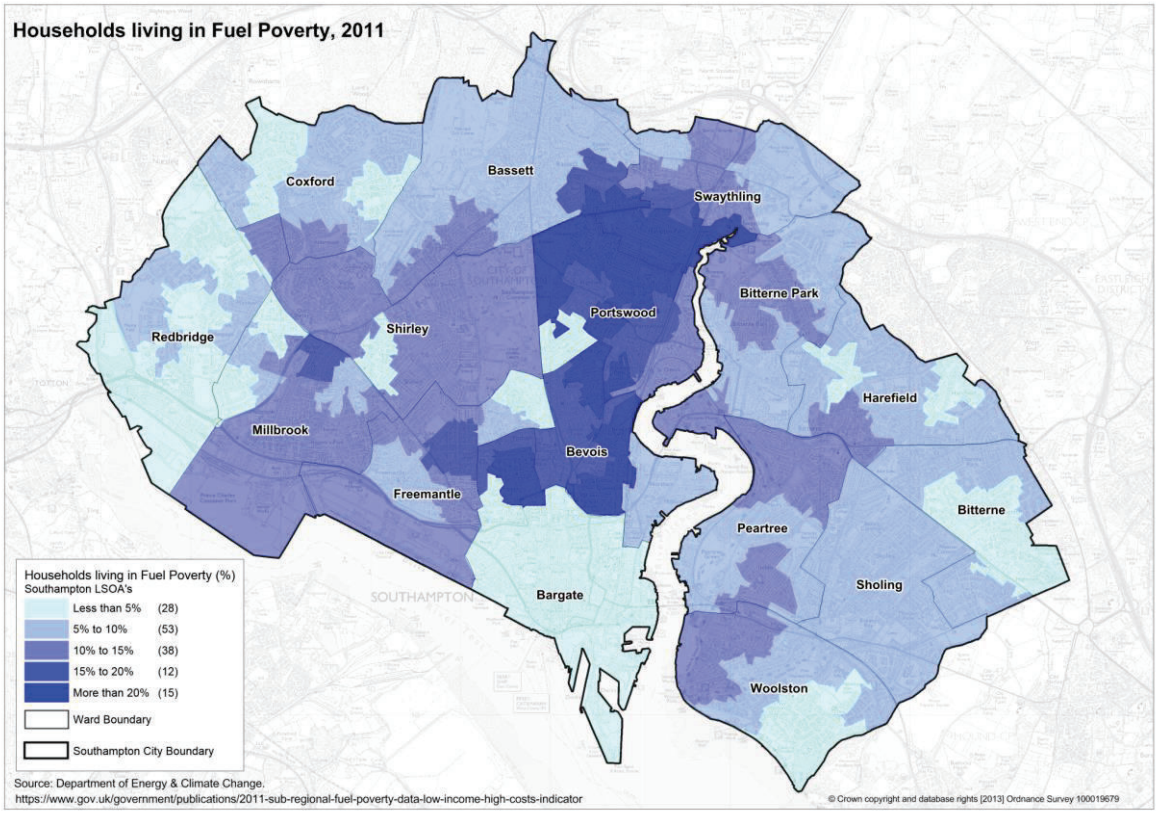
In 2011, an estimated 9.7% of the total number of 98,254 households in Southampton was in fuel poverty. This represented a total of 9,531 households.

Table 1: The estimated numbers of fuel poor households in Southampton.

Year	Estimated number of Southampton households	Estimated number of Southampton households in fuel poverty (FP)	% of Southampton households in FP	Average % of Hampshire county households FP	Average % of South East households in FP	Average % of English households in FP
2006	92,976	9,055	9.7	8.1	8.5	11.5
2008	97,191	10,419	10.7	9.5	9.9	15.6
2009	98,074	12,448	12.7	11.5	11.8	18.4
2010	97,726	11,592	11.9	10.7	11.5	16.4
2011	98,254	9,531	9.7	9.3	10.3	14.6

Map 1 shows the areas within the city with the highest proportions of households in fuel poverty.

Map 1: Households living in Fuel Poverty, 2011

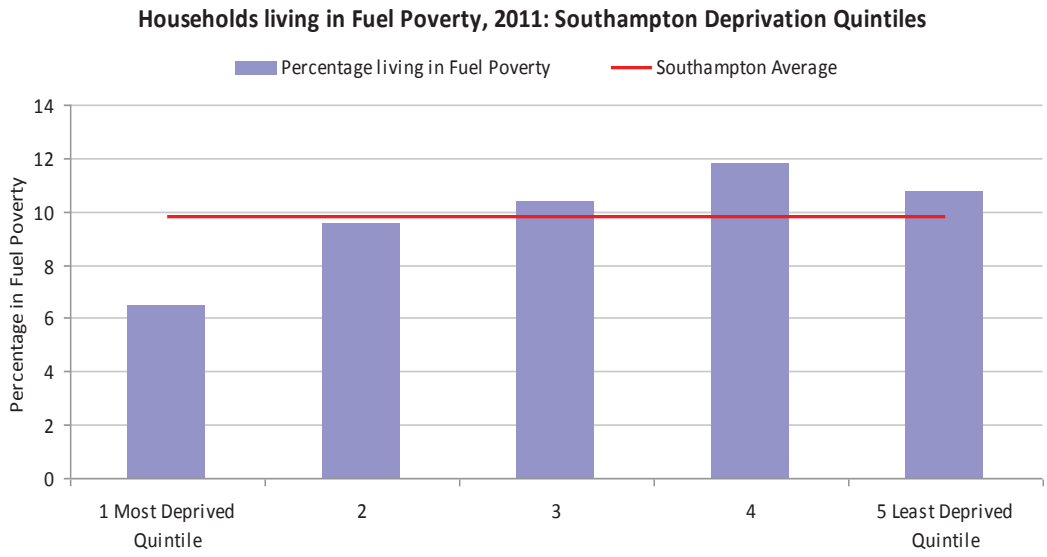


The energy efficiency of private homes has improved and the average SAP[1] rating is 51 (equivalent to energy efficiency rating band E on a scale of A to G). However, the survey carried out by the council in 2008 showed that there is the potential to improve the energy efficiency in 95% of private homes and there remain 7,000 homes with a dangerously low SAP rating of under 35. The survey found that there were similar levels of fuel poverty across Southampton's owner occupied and privately rented homes.

The chart show the relationship between fuel poverty and deprivation in Southampton, the fact that fuel poverty rates appear lower in the most deprived areas is related to the energy efficiency measures within the social housing stock.

[1] SAP (Standard Assessment Procedure) is a standardised measure of the energy efficiency of a building

Chart 1: Households living in Fuel Poverty, 2011: Southampton Deprivation Quintiles



Source: Department of Energy and Climate Change

The council previously reported progress against National Indicator (NI) 187, which has now been discontinued. This measured the proportion of vulnerable households living in energy efficient housing across all tenures (in 2009/10 this was 35%) and the proportion of vulnerable households living in housing with very poor energy efficiency (in 2009/10 this was 9%).

How the cold affects health

In older people, a one degree lowering of living room temperature is associated with a rise of 1.3 mmHg blood pressure, due to cold extremities and lowered core body temperature. Increases in blood pressure, along with increased blood viscosity, caused by mild skin surface cooling, increases the risk of strokes and heart attacks.

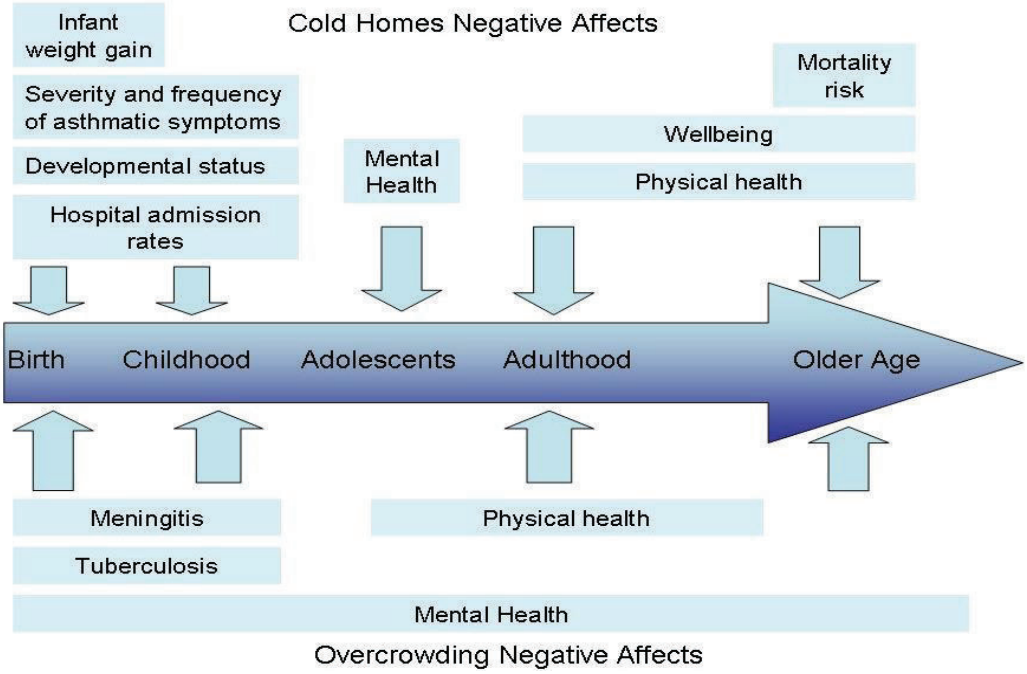
Cold air affects the normal protective function of the respiratory tract, with increased broncho-constriction, mucus production and reduced mucus clearance. Cold, damp houses also promote mould growth, which increases the risk of respiratory infections.

Although cold weather is clearly a factor in excess deaths, Scandinavian countries do not have the same pattern of excess winter deaths. The excess winter deaths in the UK are related to factors which affect how warm a house is, for example, energy efficiency and insulation, central heating and household income. There is a 20% difference in excess winter deaths between the coldest and warmest homes. Table 2 illustrates the health effects experienced by those living in temperatures below the recommended 16-21 degrees (18 and over in living areas).

Table 2: Effect of temperature on health

Indoor Temperature	Effect on Health
21°C	Recommended living room temperature
18°C	Minimum temperature with no health risk, though may feel cold
Under 16°C	Resistance to respiratory diseases may be diminished
9 – 12°C	Increased blood pressure and risk of cardiovascular disease
5°C	High risk of hypothermia

Figure 1: The Health Impacts of Cold Homes and Fuel Poverty (Marmot Review Team 2011)



Cardio-vascular disease

- Cause over 30,000 excess winter deaths each year nationally
- The cold increases blood pressure
- A 1 degree lowering of living room temperature is associated with a rise of 1.3 mmHg blood pressure
- A rise in blood pressure during the cold increases the risk of heart attacks and strokes

Respiratory Illness

- Cause around 20,000 excess winter deaths each year (nationally)
- The cold lowers resistance to respiratory infections
- Coldness impairs lung function and can trigger broncho-constriction in asthma and COPD
- Dampness is associated with cold houses; damp increases mould growths which can cause asthma and respiratory infections
- Home energy improvements have decreased school sickness by 80% in children with asthma or recurrent respiratory infections

Mobility and increase falls and non-intentional injuries

- Symptoms of arthritis become worse in cold damp houses
- Strength and dexterity decrease as temperatures drop, increasing the risk of non-intentional injuries
- A cold house increases the risk of falls in the elderly

Mental and social health

- Damp, cold housing is associated with an increase in mental health problems
- Some people become socially isolated as they are reluctant to invite friends round to a cold house
- In cold homes where only one room is heated, it is difficult for children to do homework, affecting educational and long term work and health opportunities

In 2012/13 there were:

- 13,800 people registered with Southampton GPs as having depression
- 1,376 people registered with their GP as having dementia
- 2,758 people registered with their GP as having a severe and enduring mental illness (schizophrenia, bipolar disorder and other psychoses)

Not everyone who has a mental health problem is registered with a GP or has a diagnosis so the true figures are likely to be significantly higher.

The Be Well Mental Health and Wellbeing Strategy (2012) is the Southampton City response to “No Health without Mental Health”, a cross government strategy for people of all ages. The Southampton strategy is available at: http://www.publichealth.southampton.gov.uk/

Fuel Poverty and Excess Winter Mortality in Southampton

It is estimated that during winter 2012, 124 people died in Southampton from illnesses related to the cold. The problem is not unique to Southampton, it exists across the UK, but locally we are working to reduce the number of excess winter deaths because many can be prevented by encouraging people to take simple actions to improve the warmth of their homes.

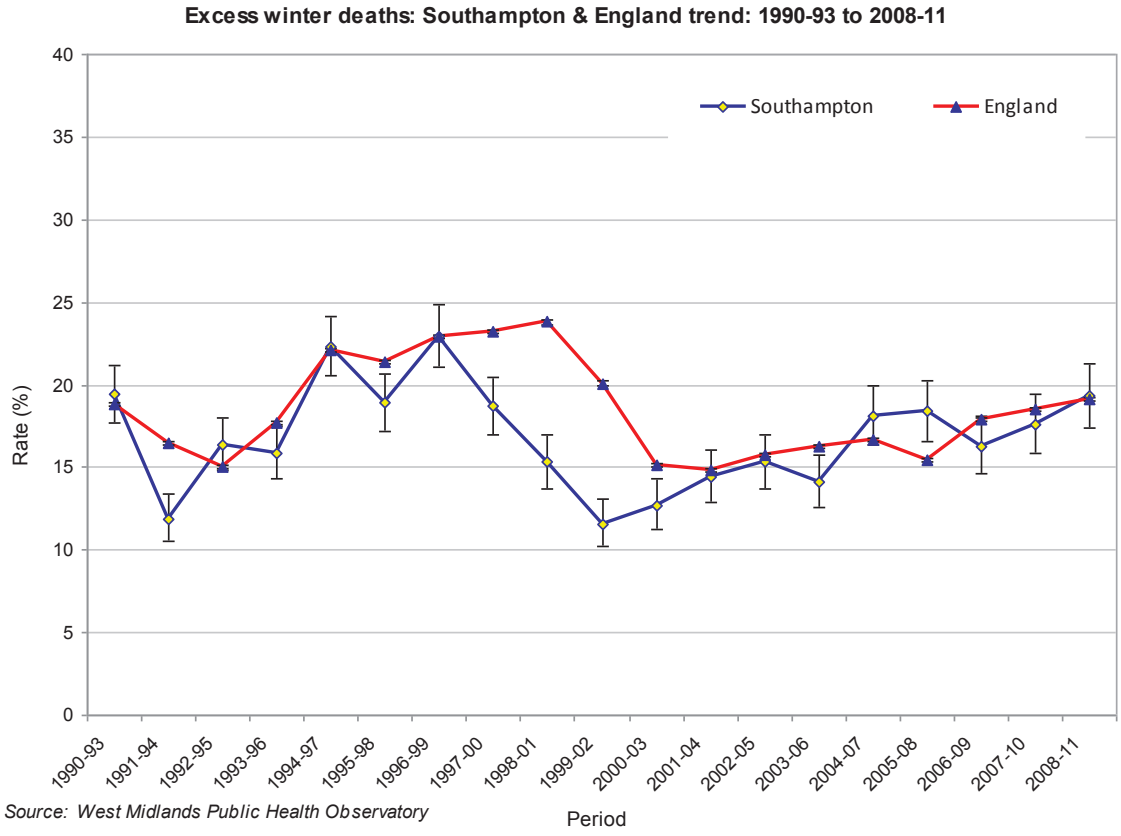
Excess winter mortality is the term which describes the higher number of deaths that occur in winter than in the summer.

Table 3: Excess Winter Mortality 2001-2012

Region	Excess Winter Mortality (number of deaths) over the winter ending in:											
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Southampton	20	70	150	60	80	130	110	80	90	130	100	124
South East England	4,560	3,770	3,750	3,990	6,150	7,650	3,210	6,710	7,680	3,150	4,140	3,670

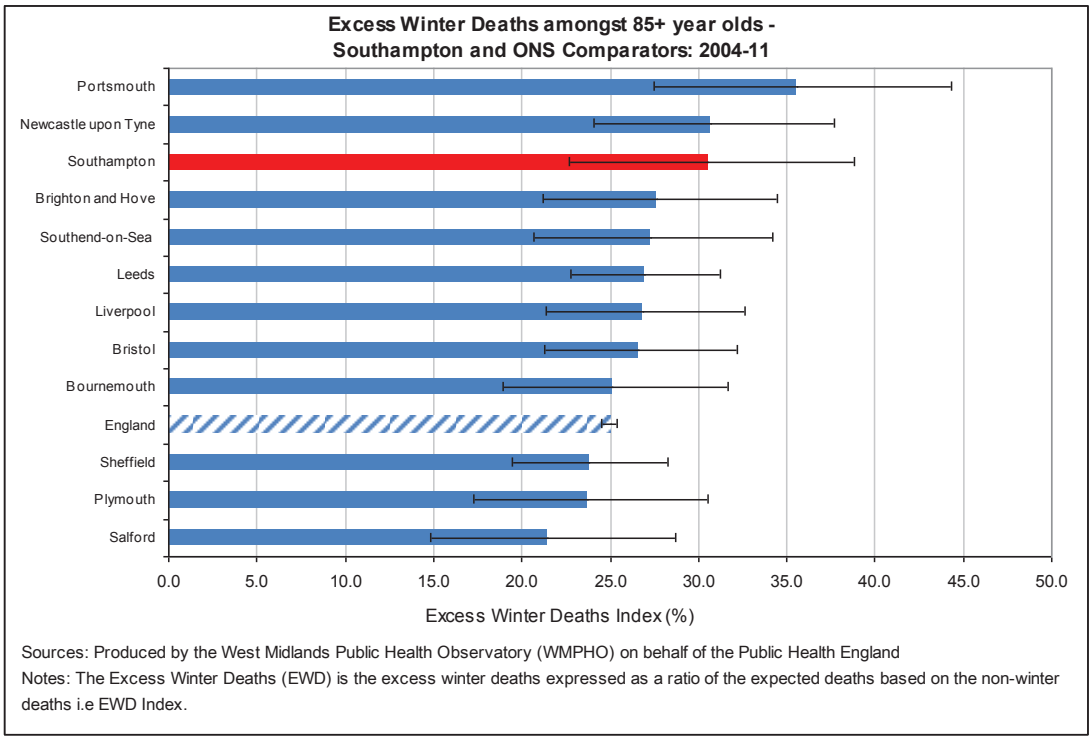
Public Health Outcomes Framework www.phoutcomes.info

Figure 2: Excess Winter Deaths 1990-93 to 2009-12 Southampton and England



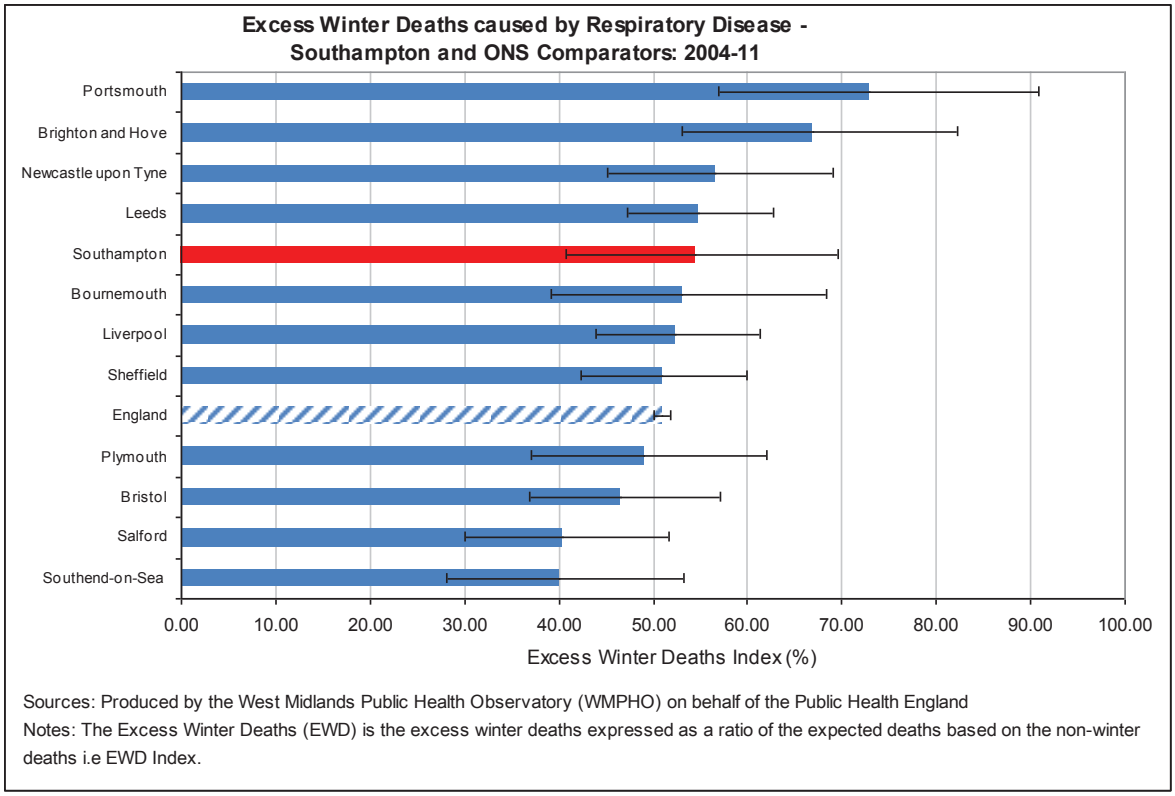
Source: West Midlands Public Health Observatory

Figure 3: Excess Winter Deaths amongst 85+ year olds in Southampton with ONS Comparators 2004-11



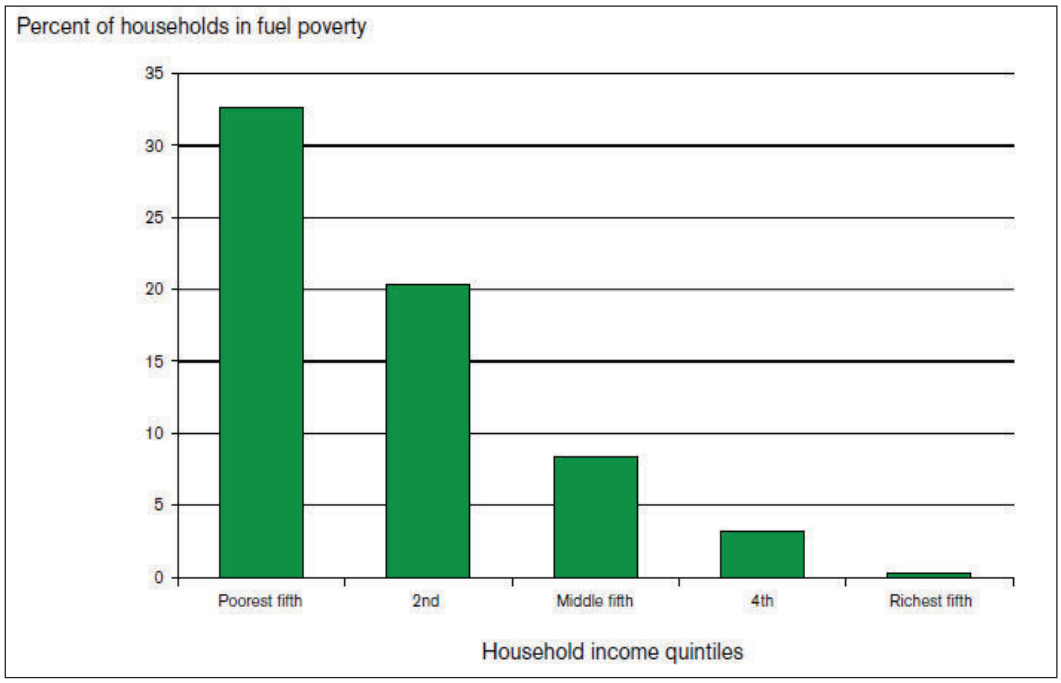
Sources: Produced by the West Midlands Public Health Observatory (WMPHO) on behalf of the Public Health England
Notes: The Excess Winter Deaths (EWD) is the excess winter deaths expressed as a ratio of the expected deaths based on the non-winter deaths i.e EWD Index.

Figure 4: Excess Winter Deaths caused by Respiratory Disease – Southampton and ONS Comparators 2004-11



Sources: Produced by the West Midlands Public Health Observatory (WMPHO) on behalf of the Public Health England
Notes: The Excess Winter Deaths (EWD) is the excess winter deaths expressed as a ratio of the expected deaths based on the non-winter deaths i.e EWD Index.

Figure 5: Percentage of households in fuel poverty by household income (Marmot 2011)



Potential Increased Efficiency and Savings

When simple measures are taken to improve housing conditions and increase ability to pay for energy, highly significant improvement can be measured post-intervention:

- Results in fewer days off work due to ill-health by 38%
- Improves children's educational achievements; reduces self-reported days off school by 50%
- Reduces depression by 50%
- Improves self-rated health by 50%
- Results in fewer visits to a general practitioner by 27%(Howden-Chapman et al 2007)
- Home energy improvements have also been seen a decrease in school sickness in children with asthma or recurrent respiratory infections by 80% (Somerville et al 2000)

The annual cost to the NHS of treating winter-related disease due to cold private housing is £859 million. Investing £1 in keeping homes warm saved the NHS 42 pence in health costs in 2009.

Monetising Health Impacts

Typically, the government uses cost-benefit analysis to assess the economic impact of fuel poverty policies, where the overall impact is expressed in terms of a net present value (NPV). However, these NPV values do not currently measure health impacts. This is because we do not yet have a robust methodology for measuring the improved health outcomes that can result from policies.

A New Definition of Fuel Poverty

In 2011, the DECC started using a new definition of fuel poverty called 'low income, high costs' which is the one recommended by Professor John Hills of the London School of Economics (LSE) following his independent review. Under this a household would be defined as fuel poor if they have fuel costs that are above the average (national median) and were they to spend that amount they would be left with a residual income below the official poverty line. The following table uses this new definition.

Table 5: Households in Fuel Poverty by new definition, 2011

Year	Estimated number of SCC households	Estimated number of SCC households in fuel poverty (FP)	% of SCC households in FP	Average % of Hampshire county households in FP	Average % of South East households in FP	Average % of English households in FP
2011	98,254	9,629	9.8	7.6	8.2	10.9

The rationale for changing the definition is that the previous one could capture some rich households while overlooking others that are struggling with their energy costs. The new definition focuses attention on households with low incomes and high energy costs and has been welcomed by the SWAP.

The data presented earlier in this plan use the previous definition of fuel poverty, but the action plan confirms SWAP's commitment to understanding how the new definition affects Southampton and its fuel poor households to ensure that resources are directed in the best way.

The Fuel Poverty Review concluded that fuel poverty was a long term, structural and complex problem. The government has stated that a focus on eradication is therefore inappropriate given the nature of the problem. Instead, it has proposed a target that will focus on improving the energy efficiency of the homes of the fuel poor, providing for a more sensible measure of progress in tackling the problem.

The government has set out further details of its revised approach in a Framework for Action Document, which will become effective when the Energy Bill currently before Parliament receives Royal Assent. The document is available online at https://www.gov.uk/government/publications/fuel-poverty-a-framework-for-future-action

SWAP will keep this under review during the life of this plan and will align its objectives and action plan to this new approach as further details and guidance are released.

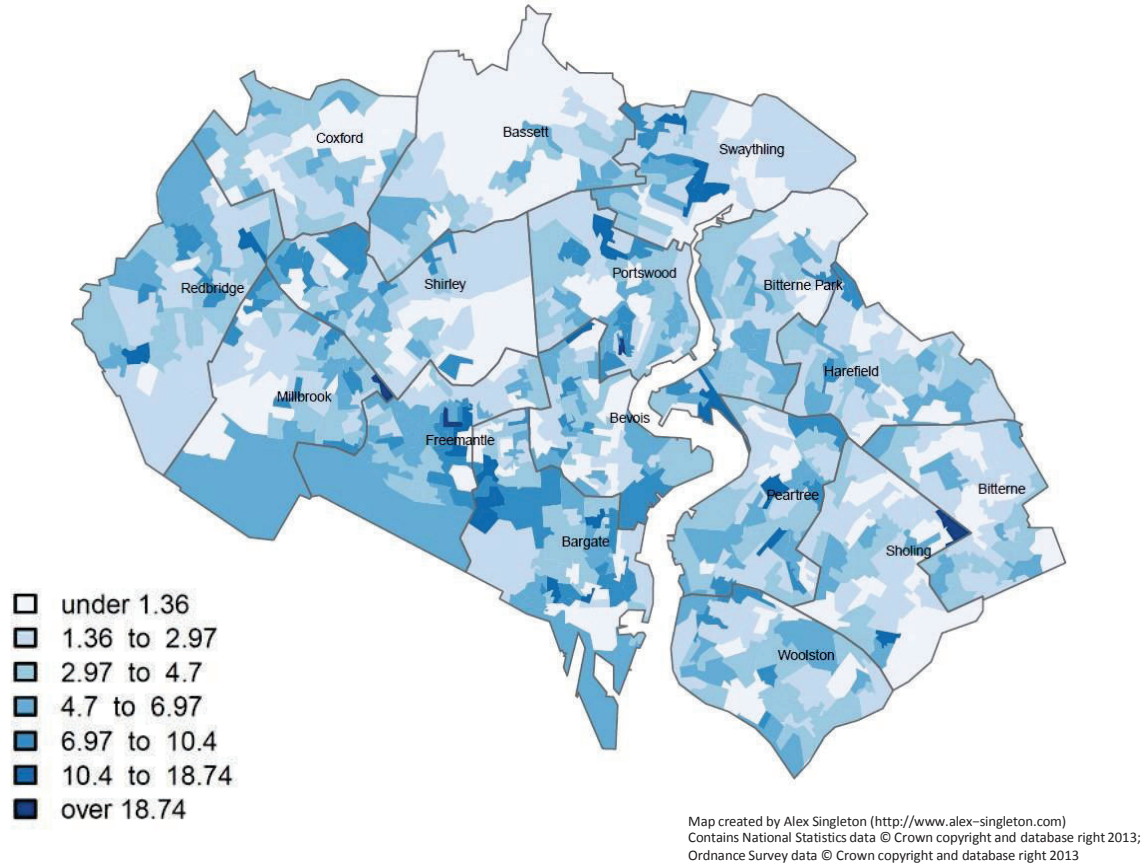
In the meantime, the strategic approach set out by the SWAP is likely to be broadly consistent with the government's emerging framework and will help to coordinate and direct resources to Southampton's fuel poor households as soon as possible. There is likely to be a greater emphasis on improving energy efficiency in the future, which SWAP is supporting through the Solent Green Deal for owner-occupied and

privately rented homes. The council has now procured a long term partner to deliver Energy Company Obligation (ECO) funded schemes in its own housing stock.

Although tenants of registered providers of affordable housing (housing associations) may access the Solent Green Deal, many of them have their own energy efficiency improvement programmes underway or planned.

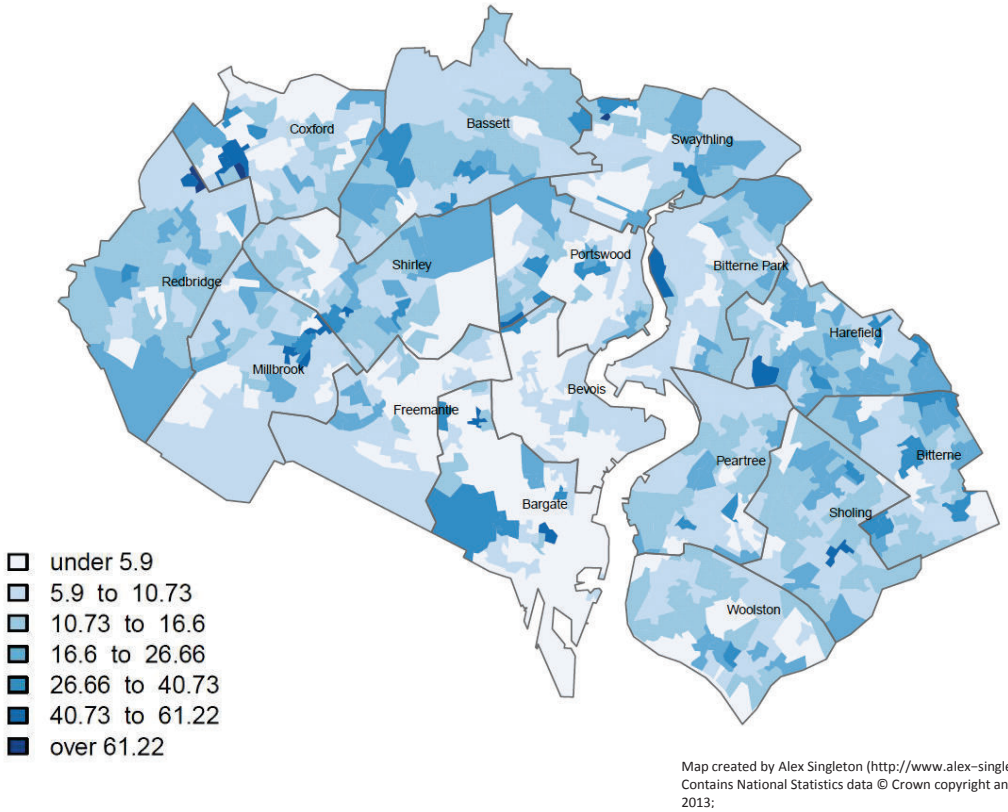
Addressing Fuel Poverty in Southampton

Map 2: Percentage of households with no central heating in Southampton



Map created by Alex Singleton (http://www.alex-singleton.com)
Contains National Statistics data © Crown copyright and database right 2013;
Ordnance Survey data © Crown copyright and database right 2013

Map 3: Percentage of households comprised of one person aged 65+ (Output Areas in Southampton)

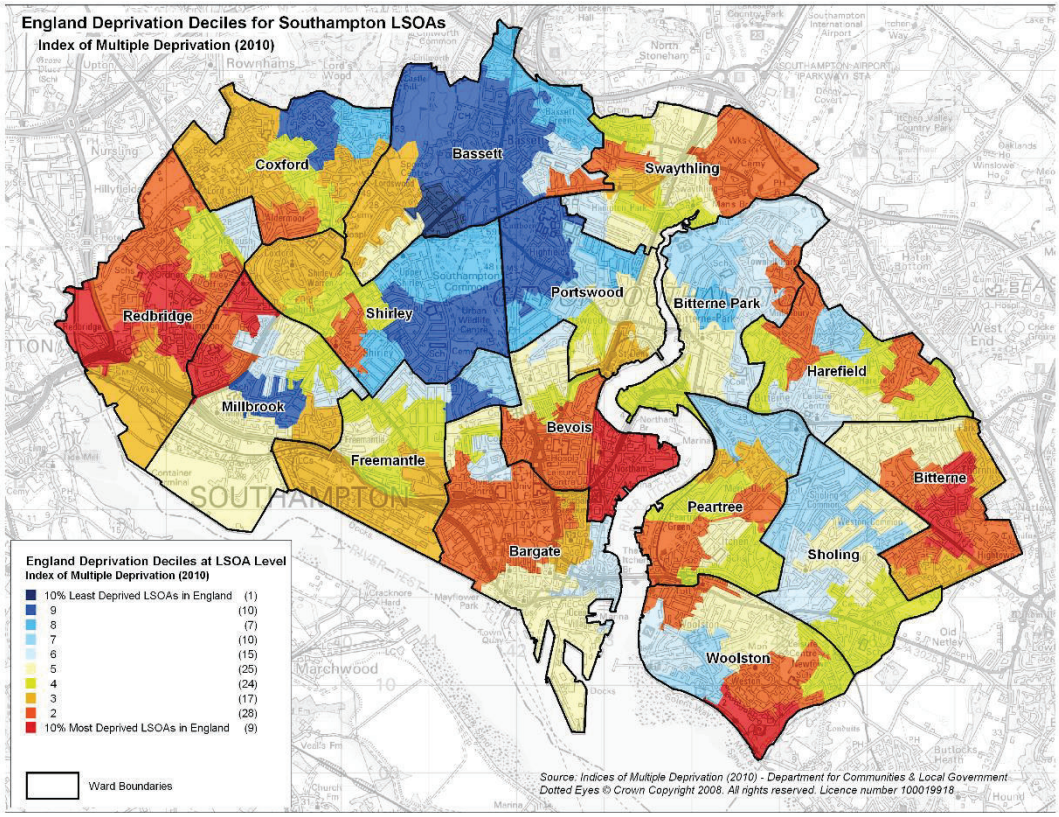


Map created by Alex Singleton (http://www.alex-singleton.com)
Contains National Statistics data © Crown copyright and database right 2013;

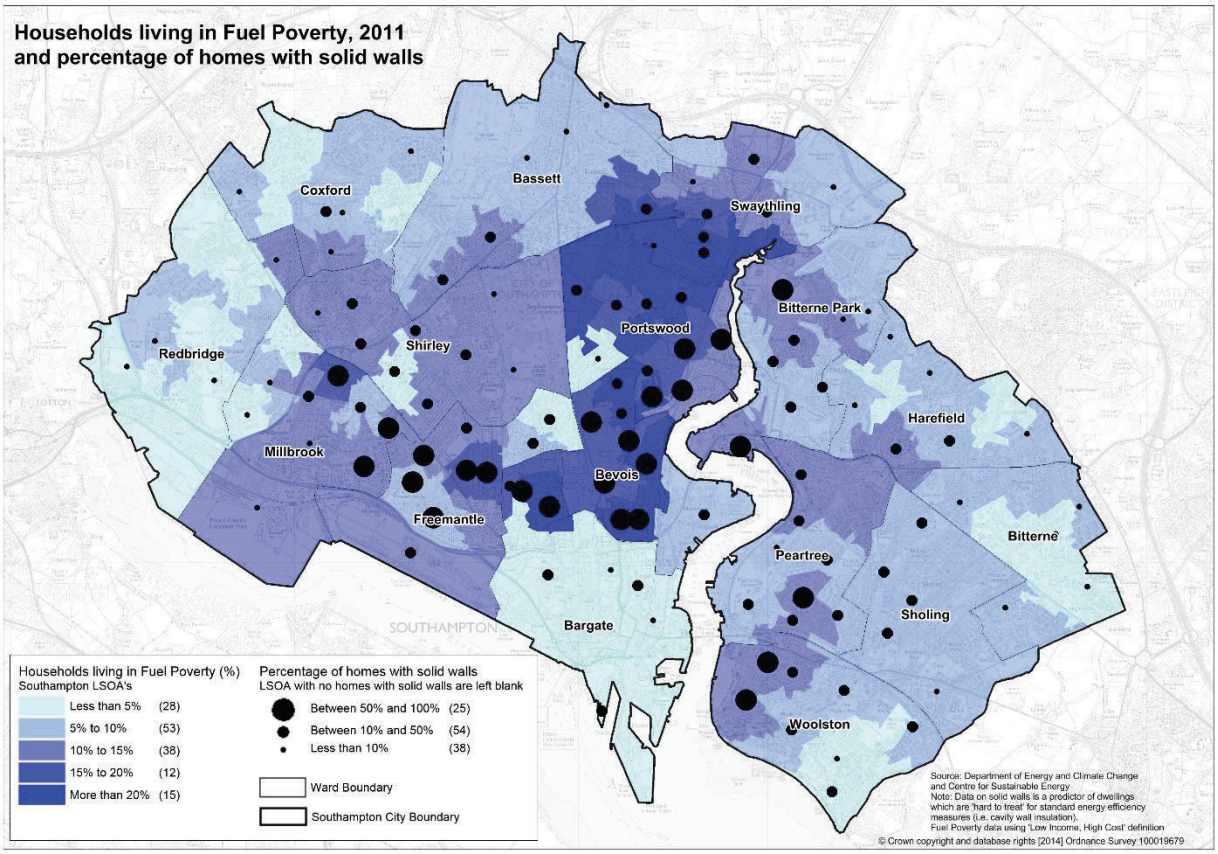
Table 4: Number and percentage of homes with various types of central heating or no central heating

Central Heating	Southampton		England	
	Value	Percent	Value	Percent
All categories: Type of central heating in household	98,254	100.0	22,063,368	100.0
No central heating	3,686	3.8	594,561	2.7
Gas central heating	69,221	70.5	17,386,813	78.8
Electric central heating (including storage heaters)	19,158	19.5	1,828,589	8.3
Oil central heating	117	0.1	848,145	3.8
Solid fuel central heating (e.g. wood, coal)	118	0.1	149,694	0.7
Other type of central heating	2,095	3.0	357,916	1.6
Two or more types of central heating	3,049	3.1	897,650	4.1

Map 4: Index of Multiple Deprivation 2010: Lower Super Output Areas in Southampton



Map 5: Map showing the percentage of households in fuel poverty 2011 and the percentage of homes with solid walls



District Energy in Southampton

What is District Energy?

District Energy using Combined Heat and Power (CHP) involves the local generation of electricity whilst using the heat which would normally be wasted to provide heat for a heating or cooling network. Steam and/or hot water is produced and distributed in insulated pipe work to individual buildings for space heating, domestic hot water or air conditioning. As a result, the buildings served by the system do not require individual boilers or chillers. DE heat and power can be provided using a number of fuel sources including gas or biomass and makes the conversion from fossil-fuel heating to renewable heating much simpler. For example, waste heat from industrial processes (such as distilleries and breweries) can be used to heat homes and businesses. Schemes may also incorporate other low and zero carbon technologies such as fuel cells, biomass, solar thermal, heat pumps, high-efficiency gas-fired boilers, and in Southampton's case, deep geothermal energy.

District energy provides the opportunity for significant cost savings and reduced CO_2 emissions and is considered by Government as a key solution to delivering low carbon energy in areas with high heat demand such as apartment blocks, schools, hospitals, commercial centres and public sector estates. Such energy schemes could also help reduce the council's heat deficit budget (estimated at £1.4 million per year). It can be an essential way of generating affordable warmth and reducing levels of fuel poverty in homes.

Local energy generation, including district energy, can play an important part in meeting Home Energy Conservation Act requirements, whilst also incorporating other energy efficiency measures such as insulation and other heating measures where appropriate, making the best use of financial incentive schemes such as the Renewable Heat Incentive and ECO.

What are its benefits?

The majority of the UK's electricity is supplied by large-scale power stations that reject up to 60% of their fuels' energy as waste heat. If this waste heat was to be captured, it could meet the UK's entire heating and hot water energy needs. Whilst improving the sustainability of large scale power stations is vital, there is an increasing need to focus on the role that smaller scale decentralised energy generation could play. In addition to efficiency savings, CHP-led district heating provides resilience and security of supply to existing and prospective occupiers in the city and due to its greater efficiency, CHP systems can deliver heat at prices below that of gas and still be financially viable.

A large proportion of the council's housing stock in the city uses electricity as the principal means of providing heating and hot water. These heating systems are inefficient, costly to run and generate relatively high amounts of CO_2. Providing cheaper energy and improved energy efficiency would help to overcome fuel poverty, particularly in those areas of the city occupied by the most vulnerable. For example, the council procured £5 million worth of energy for heating for its tenants

in council-owned flats in 2011/12. Current economic conditions combined with energy price rises mean that many home owners and private or social landlord tenants are finding it more and more difficult to meet the cost of heating and lighting their homes. Although residents will inevitably be subject to future energy price rises, direct energy schemes provide the scope to fix prices below market rates to offer a degree of protection. Gas required as a fuel for a CHP engine can be purchased in bulk at a commercial rate that is much cheaper than the domestic alternative.

District energy schemes are seen to be the most cost effective and efficient ways to deliver heat and hot water in areas of high building density and demonstrate the following benefits:

- Helping to tackle fuel poverty by providing residents with more control over current and future energy costs
- Improving building performance and reducing long term maintenance and replacement costs for alternative heating systems
- Producing a potential revenue stream for the scheme owner
- Reducing CO_2 levels on a whole lifecycle basis

What are we trying to achieve in Southampton?

There are significant opportunities to achieve energy cost reductions from the council's building stock and to support similar achievements in the city's commercial sector. This can be realised through the generation of low carbon electricity and/or heat on a district or community level as an energy supplier, by making use of existing energy sources alongside the delivery of energy efficiency retrofitting programmes.

The council is seeking to supply district energy (including the possibility of private wire) to pre-selected areas of the city using CHP and other forms of low carbon and renewable technologies.

The Thornhill area of the city is considered to be the best starting point for developing a direct energy scheme in conjunction with ECO energy efficiency improvements and is the first phase in the expansion of direct energy throughout the city. It forms part of a much wider energy efficiency programme in the council's housing stock with plans to deliver direct energy in Weston, Northam, Shirley, Lordshill, Millbrook and Redbridge.

District Energy and SWAP

SWAP will be an ambassador for the scheme and ensure the strategic health and wellbeing advantages are captured.

Working in Partnership

The aim and objectives of this plan will only be realised with successful and effective partnership working. SWAP is aware that there are a number of different organisations in the city that are working with residents who are either experiencing or at risk of experiencing fuel poverty.

Raising and maintaining the profile of fuel poverty is therefore important. This, together with training opportunities and access to advice, information and support, would seek to reinforce the key messages of this plan.

The role of health, social care and other professionals in addressing fuel poverty

Many health, social care and other professionals are in a unique position to make a difference for people experiencing fuel poverty. Many health professionals have regular contact and often visit patients in their homes, especially older people and families with young children, who are at greater risk of fuel poverty. They are more likely to be aware of which are the colder homes, but it is their position of trust by their patients and clients which means that any advice offered is more likely to be accepted.

There are four types of help available for residents:

- Advice on achieving a warm home
- Reducing fuel bills
- Tackling low household incomes
- Referral to specialist advice about grant subsidies and other programmes for home energy efficiency improvements, such as the Green Deal and ECO

The core STOP the Cold service is funded by the council to offer a single point of contact for receiving referrals for people who are experiencing or are vulnerable to fuel poverty, for specialist advice and information on assistance that is available. In some cases, a home visit can be arranged as part of separate grant-funded programmes.

Contact details and a health checklist of fuel poverty can be found in Appendix 1 and 2 respectively.

Action Plan

Fuel Poverty Plan - Actions and Solutions

The SWAP has agreed the following three year action plan (2013-2016) to tackle fuel poverty in Southampton. Annual progress reports will be made to Southampton's Health and Wellbeing Board and the key achievements and challenges will be set out in the Public Health Annual Report. The Action Plan will be kept under review at quarterly SWAP meetings.

Theme 1: Redefining the Challenge
Researching the impact of the new definition of fuel poverty

Ref	Action	Outcomes	Success measure	Resources	Target dates	Lead
1A	Establish specialist working group to collate all available data on fuel poverty and examine the impact of the new definition in Southampton	Working group established; new definition understood; research undertaken to define problem scoped; directory of available data compiled	SWAP receives a report from the specialist working group, with maps showing relative levels of fuel poverty in Southampton, using the new definition	Colleagues' time; IT	30.09.2013: group established 31.03.2014: final report	Public Health
1B	Demonstrate the value of addressing fuel poverty in terms of money saved by health, social care etc.	Data available for use in funding bids etc. to support fuel poverty initiatives	Using HIDEEM^ model & QALY* measures to quantify cost savings. See supporting document	Colleagues' time; IT	01.04.2014: group established 01.09.2014: final report	Public Health

^Health Impact of Domestic Energy Efficiency Measures
*Quality Adjusted Life Years

Theme 2: Improving Energy Efficiency
Supporting programmes that improve energy efficiency across all housing tenures

Ref	Action	Outcomes	Success measure	Resources	Target dates	Lead
2A	Procure a long term strategic partner to deliver ECO funded improvements to the council's own housing stock	Significant investment in improving energy efficiency of the council's own housing stock, which is typically located in areas of multiple deprivation	The energy efficiency of 2,000 council homes located in areas of multiple deprivation improved	Housing Capital Programme; ECO funding; project management	31.12.2013: Long term strategic partner appointed 31.03.2015: 2,000 homes improved	Southampton City Council
2B	Train two Green Deal Advisors to facilitate access by Southampton's residents to the Solent Green Deal[2] and ECO	Green Deal Advisors accredited to deliver assessments, which are the gateway to Green Deal and ECO	Two Green Deal Advisors trained, enabling them to carry out assessments and ensuring quality advice; Number of assessments completed TBA.	PUSH* grant; STOP the cold funding; Solent Green Deal	31.12.2013: First advisor trained 30.06.2014: advisor trained TBC for number of assessments to be completed	The Environment Centre
2C	Promote the Solent Green Deal as a solution to funding	Owner occupiers and people renting privately	Number of Green Deals completed, TBA	Solent Green Deal marketing budget; ECO	31.12.2016	Southampton City Council

[2] The Solent Green Deal is Southampton City Council's recommended Green Deal Scheme and was established by the council using government funding and in partnership with Portsmouth City Council and Eastleigh Borough Council in June 2013. The Green Deal enables energy efficiency and renewables to be installed for no upfront cost, within a highly regulated quality assurance framework. Energy Company Obligation (ECO) subsidy is also available for fuel poor households and for hard to treat homes. www.solentgreendeal.org.uk
*Partnership for Urban South Hampshire

Ref	Action	Outcomes	Success measure	Resources	Target dates	Lead
	energy efficiency improvements	are living in homes that can be kept warm for a reasonable cost		subsidy from the Solent Green Deal Providers; money saved from reduced energy bills		
2D	Replacement of broken energy inefficient boilers of fuel poor households on very low incomes	Reduced energy use to maintain safe temperatures for very vulnerable owner occupiers. Maximise ECO HHCRO* funding.	Assistance provided to enable 25 boilers to be replaced. Number of people helped to be removed from fuel poverty.	Southampton City Council Capital Funding	31.03.2015	Southampton City Council
2E	Draught proofing or other energy efficiency work through Money Matters[3] and Energy Action Southampton[4]	Increased awareness and uptake of energy efficiency measures	335 home visits (clients over 60 – to increase awareness of energy efficiency) & signpost to appropriate sources of help 6 DIY workshops and 3 community presentations 110 Measures	Comic Relief, Scottish Power People Energy Trust & tEC funding. ECO and Green Deal funding for measures where appropriate.	31.10.2015: home visits completed 30.04.2014: draught proofing measures completed	The Environment Centre

[3] Money Matter is available until October 2015
[4] Energy Action Southampton is available until April 2014
*Home Heating Cost Reduction Obligation

Ref	Action	Outcomes	Success measure	Resources	Target dates	Lead
			installed £3,240 savings arising from draught proofing measures installed (per year)[5] 12.96 tonnes CO_2 savings arising from draught proofing measures installed[6]			
2F	Energy efficiency work carried out by Handyperson service under contract	Increased awareness and uptake of energy efficiency measures	Energy saving measures installed in 30 homes. Distribute oil filled radiators as needed.	Handyperson service and provision of oil filled radiators.	31.03.2015	Southampton City Council and Society of St James.
2G	Landlords enforcement where needed	Improve thermal efficiency of private rented homes.	Monitor and report number of improvements made as a result of enforcement interventions. Analyse the effectiveness of HHSRS* and local statistical evidence and achieving affordable warmth in	Resources to develop and promote initiatives to landlords. Colleagues' time; IT	Ongoing	Southampton City Council

[5] Based on Energy Saving Trust figures for 2012: £30 per year per household saved by draught proofing doors/windows.
[6] Based on Energy Saving Trust figures for 2012: 120 kg CO_2 per year per household saved by draught proofing doors/windows.
*Housing Health and Safety Rating System

Ref	Action	Outcomes	Success measure	Resources	Target dates	Lead
			private rented homes. Identify opportunities to work with private landlords to understand barriers etc. and develop actions to address these.			
2H	Link additional licensing scheme with other energy efficiency and ECO initiatives	Increase awareness among private landlords.	Increase in number of ECO/Green Deals in private rented home. Target TBA.	Resources to develop and promote initiatives to landlords Colleagues' time; IT	31.03.2014: Comms plan developed 31.03.2015: Comms plan delivery	Southampton City Council
2I	New build properties – code for sustainable homes level 4/use of Community Infrastructure Levy/Allowable Solutions	Higher energy efficiency reduces likelihood of fuel poverty as less energy needed.	Develop closer working with services responsible to raise profile of fuel poverty; influence where possible and identify success measures to support the plan.	Colleagues' time	Ongoing	Southampton City Council (Planning)

Theme 3: Maximising Income
Ensuring that those in fuel poverty have opportunities to work and get the right benefits

Ref	Action	Outcomes	Success measure	Resources	Target dates	Lead
3A	Identify opportunities to increase income for vulnerable residents	Complete home visits for vulnerable people where appropriate, advise on winter fuel payments, cold weather etc.	Monitor and report the enhanced level of income as an annual increase	Colleagues' time; IT	31.03.2015	Department for Work and Pensions
3B	Money Matters programme – focus on maximising benefit income for older people	Increased take-up of benefits for older people	100 beneficiaries of home visits per year 75% of eligible people apply for benefits	Comic Relief funding (Sept 2012- Sept 2015)	30.09.2015	Age UK, Southampton
3C	Internal training/ signposting	tEC staff with up to date knowledge of welfare reform & benefit information	Referrals to DWP home visit service and Job Centre Plus	DWP, tEC Advice line service & Money Matters home visits	31.12.2016	The Environment Centre

Theme 4: Ensuring Cheaper Energy (including District Energy)
Making sure that fuel poor households get the best deals on their energy bills

Ref	Action	Outcomes	Success measure	Resources	Target dates	Lead
4A	Promoting Hampshire County Council's "Switch Hampshire" scheme[7]	Residents benefit from the best value energy tariffs	Monitor the number of households that have signed up and then opted to switch for Switch Hampshire	Marketing budget; colleagues' time, tEC Advisors	31.12.2016	Southampton City Council
4B	Energy bill checks through Money Matters project	Reduced outgoings on energy bills	Monitor fuel poor households with increased knowledge of the benefits of tariff switching and savings estimated.			The Environment Centre; Age UK, Southampton
4C	Extend District Energy network in two areas of multiple deprivation	Reduced-cost heating available for more residents	Successful schemes developed and implemented; increase in residents accessing service	Investment to develop infrastructure and connections to homes/ thermal efficiency of homes. Colleague's time; IT.	Ongoing	Southampton City Council
4D	Promoting solar PV/ micro generation to	Residents are able to access free, impartial	Increase the number of enquiries into renewable	tEC Advisors, colleagues' time; IT. Resources		the Environment Centre,

[7] Switch Hampshire is a collective switching scheme for energy bills, which uses the combined purchasing power of Hampshire residents to secure the best energy tariff. Further information is available online at www.hants.gov.uk/switch

Ref	Action	Outcomes	Success measure	Resources	Target dates	Lead
	Southampton residents	advice on micro generation.	technologies for domestic usage	for promotional work		Southampton City Council
4E	Access grant funding for assisted connections to gas network	Assisting vulnerable households off mains gas to connect to the network	Monitor referrals to Southern Gas Networks	Staff time Southern Gas Networks & SCC data	Ongoing	the Environment Centre
4F	Cold weather payments/winter fuel payments/ Warm Home Discount – advice and information to ensure all eligible discounts from energy companies are obtained	Increased numbers of vulnerable households accessing financial support during cold weather periods, reduced outgoings on bills	Monitor and report number of referrals to the relevant schemes	tEC Advisors, Age UK Money Matters funded through Comic Relief	Ongoing	the Environment Centre to coordinate through Stop the Cold Advice Line etc. Age UK Money Matters

Theme 5: Changing Behaviours
Ensuring that fuel poor households have access to and act on the best advice and information

Ref	Action	Outcomes	Success measure	Resources	Target dates	Lead
5A	Sustain the provision of a local single point of referral for advice and information on improving energy efficiency and tackling fuel poverty	STOP the Cold freephone helpline provided	1,500 number of calls per annum handled by advice line; referrals made resulting in achieving measures including ECO/Green Deal completions.	Grant from Southampton City Council	Annual monitoring	Southampton City Council
5B	Distribute an updated fuel poverty information card to health and social care professionals working in Southampton and all council staff and other agencies (including fire and Blue Lamp Trust) who are visiting people at home	More referrals made by health, social care and other professionals following identification of fuel poor households or those at risk or being in fuel poverty	System developed to monitor and report number of referrals	Colleagues' time; IT Resources to develop and distribute cards.	Annual monitoring	Southampton City Council with the Clinical Commissioning Group (CCG)
5E	Referral on hospital discharge and ensuring hospital discharge teams engaged	Increased awareness among health staff of services to enable effective	System developed to monitor and report number of referrals	Colleagues' time; IT	31.03 2015	Southampton City Council with the Clinical Commissioning Group (Integrated

Ref	Action	Outcomes	Success measure	Resources	Target dates	Lead
		referrals.				Commissioning Unit)
5F	Identify opportunities for external grant funding and bid for funds that support fuel poverty strategic objectives	Increased resources for fuel poverty work in Southampton	Maximise opportunities by reviewing bids and identifying priorities. Dependant on funding opportunities.	Colleagues' time	Annually	Southampton City Council with the Environment Centre

References and Further Information

Costello A, Abbas M, Allen A, Ball S, Bell S, Bellamy R et al., 2009. 'Managing the health effects of climate change'. London: The Lancet, Vol 373, no. 9676, pp.1693—733

Fuel Poverty: Changing the framework for measurement – the government response, Department of Energy and Climate Change (July 2013) https://www.gov.uk/government/consultations/fuel-poverty-changing-the-framework-for-measurement

The National Adaptation Programme Making the country resilient to a changing climate. (July 2013) www.gov.uk/defra

The Fuel Poverty Review, John Hills (March 2012) https://www.gov.uk/government/publications/final-report-of-the-fuel-poverty-review

Useful Links

Public Health England Cold Weather Plan (published after the Southampton plan was completed) https://www.gov.uk/government/publications/cold-weather-plan-for-england-2013

UK Climate Change Risk Assessment: Government Report https://www.gov.uk/government/publications/uk-climate-change-risk-assessment-government-report

Southampton's Joint Strategic Needs Assessment (JSNA) http://www.publichealth.southampton.gov.uk/HealthIntelligence/JSNA/default.aspx

New Public Health Outcomes Framework https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency

Marmot Review Team (2011) The Health Impacts of Cold Homes and Fuel Poverty. Friends of the Earth and Marmot Review Team. http://www.instituteofhealthequity.org/projects/the-health-impacts-of-cold-homes-and-fuel-poverty

Joseph Rowntree Foundation: Climate change and communities http://www.jrf.org.uk/work/workarea/climate-change-and-social-justice

Appendices

Appendix 1: Contact details of agencies which provide advice, grants for home improvements, and support agencies for those on low incomes

STOP the Cold helpline – 0800 804 8601

The main point of contact for energy efficiency and fuel poverty enquiries in Southampton is the STOP the Cold advice line, provided by the Environment Centre and funded by Southampton City Council.

Solent Green Deal – 0800 052 2242

The Green Deal is a nationwide Government initiative to enable homeowners and tenants to make energy efficient improvements to their homes with no initial installation costs. The expected savings made on energy bills will always be equal to or greater than the cost of the work. There will also be additional help for those most in need, such as the vulnerable, those on low incomes and those with homes that are expensive to improve.

Environmental Health Housing Team – 023 8083 3006 (option 5)

Southampton City Council's Environmental Health Housing Team provides a range of services aimed at improving the city's private sector housing stock. These include both enforcement action to tackle unsafe housing and disrepair as well as dealing with landlords who fail to tackle cold.

Housing Advice – 023 8083 2254

Southampton City Council Housing Advice team provides a specialist housing advice service for people with housing related problems. The emphasis of the work of the team is on the prevention of homelessness, the promotion of good tenancy relations, and the enforcement of legislation to prevent harassment and illegal eviction.

Welfare Rights – 023 8083 2339

Southampton City Council Welfare Rights Unit is a small specialist team with the Housing and Welfare Advice Service. Their primary objective is to contribute to the Council's Anti-Poverty Strategy by maximising the take-up of Social Security benefits, and by stabilising the financial circumstances of residents in the city who live on low incomes. The work of the unit is split into 4 main areas; Benefits Advice, Money Advice, Awareness and take up campaigns and Welfare rights training.

Local Pension Service – 0845 6060 265

Our aim is to combat poverty and promote security and independence for todays and future pensioners by delivering a holistic community based service to customers in a variety of locations across Southampton, working in partnership with

other organisations in the statutory and voluntary sector to provide a first class customer service. Provides personal advice and assists in identifying benefits which older people are eligible for.

Handyperson Service – 0800 085 4802

The Handy Person Service (HP+) provides a maintenance and repair service for older vulnerable and other vulnerable people living in the city in their own privately owned/rented accommodation. The service is generally available free of charge to people in receipt of one of the qualifying benefits but also provides the service at very low cost to those not receiving these benefits. The aim of HP+ is to enable older people to stay living independently in their own homes by offering an easy to access service that responds quickly to day to day property maintenance issues, therefore reducing the stress and anxiety that these issues can often cause. HP+ also works in close partnership with other services to ensure that other support needs of individuals that are not being met can be addressed appropriately.

The service is now available to vulnerable families with children under the age 5 living in the property. If the family is in receipt of one of the qualifying benefits, the service is free but is also available at low-cost to vulnerable families not in receipt of these benefits.

HP+ undertakes minor repairs, maintenance and adaptations that would not normally be eligible for financial assistance from the City Council or other providers. The service is available to residents living within the Southampton local authority boundary.

Age UK Southampton (including Money Matters) – 023 8036 8636

Age UK Southampton provides a wide range of services for older people in Southampton. This includes Information and Advice on everything effecting older people including how to stay warm, benefits advice, etc. Age UK Southampton Money Matters Project is a home visiting service helping older people to access benefits, improve energy efficiency and manage fuel bills.

Appendix 2: Southampton Affordable Warmth Checklist

SOUTHAMPTON AFFORDABLE WARMTH CHECKLIST 2013

This checklist may help you identify Fuel Poverty in a client's home, and take the appropriate action.

What you notice in your client's home

- The home is too cold, draughty or smells damp
- No visible source of heating
- Only portable appliances for heating such as bottled gas heaters or electric fires
- Ventilators have been blocked up
- Curtains closed during the day to keep the heat in
- Signs of damp or mould, such as mould patches round windows and in corners, and water laying on windowsills
- Mainly living in one room

What your client tells you

- Their home is too cold or draughty
- Fuel bills are high or they owe money for fuel
- They have had a prepayment meter installed
- They may stay in bed to keep warm
- They use a hot water bottle to keep warm
- They may want to stay in hospital to keep warm

Increased vulnerability to the cold

- Older people
- Children
- Disabled people
- Those with long term medical conditions

Diseases and conditions related to cold homes

- Worsening of existing conditions in the winter
- Strokes
- Chronic bronchitis and emphysema
- Asthma
- Falls and accidents
- Depression

What you can do

- Call **0800 804 8601*** for the Environment Centre's advice line for information on home improvement opportunities, energy advice, healthy lifestyle, and debt and benefit advice. * Monday to Friday 9 until 5pm.

For council or Housing Association tenants, refer them to their landlord for improvements.

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DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		BETTER CARE SOUTHAMPTON IMPLEMENTATION		
DATE OF DECISION:		25TH MARCH 2015		
REPORT OF:		DIRECTOR OF QUALITY AND INTEGRATION, SOUTHAMPTON CITY CLINICIAL COMMISSIONING GROUP (CCG)		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Stephanie Ramsey**	**Tel:**	**023 80296004**
	E-mail:	**Stephanie. Ramsey @southamptoncityccg.nhs.uk**		
Director	**Name:**	**Alison Elliott** **John Richards**	**Tel:**	**023 80832602** **023 80296923**
	E-mail:	**alison.elliott@southampton.gov.uk** **john.richards@southamptoncityccg.nhs.uk**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

Over the last 12 months extensive work has been undertaken by the City Council working in partnership with Southampton City CCG and other stakeholders to develop Southampton's Better Care Plan, under the leadership of the Health and Wellbeing Board. The final plan was signed off by the Health and Wellbeing Board, Chief Executive of the City Council and Chief Operating Officer of the CCG on 19 September 2014 and submitted to Ministers. This has been approved following the Nationally Consistent Assurance Review which identified no areas of high risk within the plan and means that Southampton can now progress with full implementation of its plan. This includes the establishment of a Better Care pooled fund by 1 April 2015.

This report summarises some of the progress towards implementation of Better Care Southampton.

RECOMMENDATIONS :

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

(ii) To support the progress by the Council and Southampton City CCG with finalisation of S75 of the National Health Service Act 2006 Partnership Agreement Pooled Fund, noting Southampton's ambition to achieve integration at scale

REASONS FOR REPORT RECOMMENDATIONS

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

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

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

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

DETAIL (Including consultation carried out)

Implementation of Better Care Southampton

4 Southampton's vision for Better Care is to completely transform the delivery of care in Southampton so that it is better integrated across health and social care, delivered as locally as possible and person centred. People will be at the heart of their care, fully engaged and supported where necessary by high quality integrated local and connected communities of services to maintain or retain their independence, health and wellbeing. Neighbourhoods and local communities will have a recognised and valued role in supporting people and there will be a much stronger focus on prevention and early intervention.
The overall aims are:

- Putting people at the centre of their care, meeting needs in a holistic way.
- Providing the right care, in the right place at the right time, and enabling people to stay in their own homes for as long as possible.
- Making optimum use of the health and care resources available in the community, reducing duplication and closing gaps, doing things once wherever appropriate.
- Intervening earlier in order to secure better outcomes by providing more coordinated, proactive services.

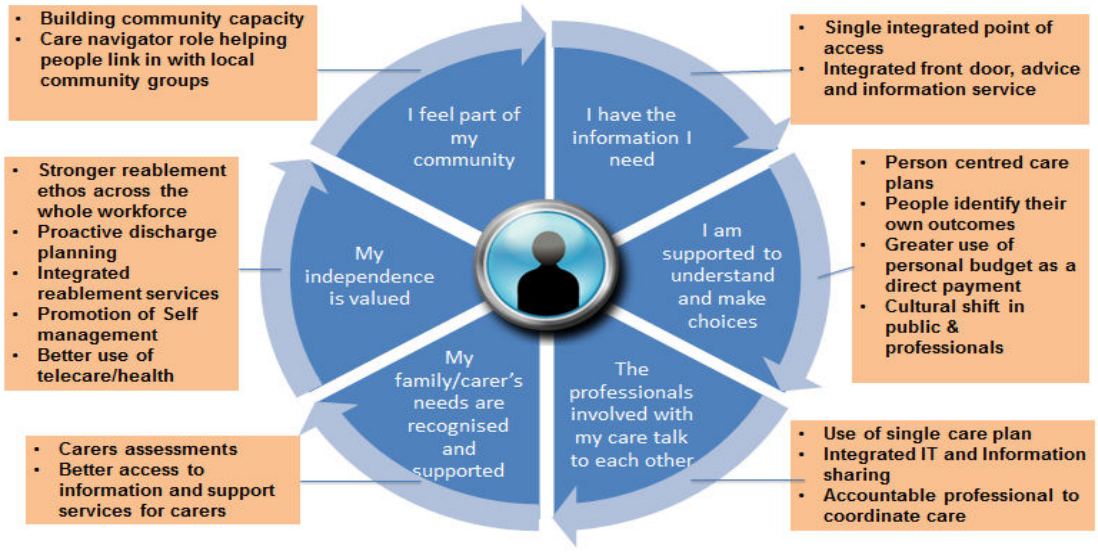
5 Southampton's plan has the following main schemes and work is in progress with each:

1. Local person centred coordinated care (clusters) - integrated multidisciplinary cluster teams providing integrated risk stratification, care coordination, planning, and 7 day working.
2. Integrated discharge, reablement and rehabilitation service, including greater use of telecare/telehealth. This scheme is aimed at helping people to maintain their independence at home, in the community, intervening quickly where required to prevent deterioration, as well as supporting people’s recovery and reablement following a period of illness.

3. Community solutions and prevention - this scheme is aimed at building on and developing local community assets and supporting people and families to find their own solutions.
4. Supporting carers – this scheme recognises the important role that carers have in supporting older people and those with multiple long term conditions in the community and supports the overall model and ambitions of local person centred coordinated care.
5. Developing the market for placements and packages and further integrating approaches – this includes work to develop the market to provide greater opportunity and choice, encourage a recovery/ reablement focus and support people to remain as independent as they can be in their own homes.

Appendix 1 outlines the progress of work within the Better Care newsletter. This is used to communicate progress to a wide range of stakeholders

6 The diagram below illustrates what the system will look like from the perspective of an individual and the work in progress to achieve this:



7 **Cluster Development**

Development of integrated care in Southampton is focused around six cluster areas. To support implementation, leadership groups are now working in all six, formed from community health providers, adult social care, supported housing and voluntary sector organisations. These groups have developed a cluster specific implementation plan, resulting in six plans now being in place to underpin the city wide approach. These early plans include real time actions towards integrating care for the frail elderly and people with complex needs as a result of having a number of long term conditions.

The primary areas of focus are as follows:

- Integration of care planning between community and primary care providers (cluster 5).
- Development of cluster need and service profiles (city wide – starting in cluster 3, 4 and 5).
- Focus around the specific registered practice population, where extraordinary need identified (cluster 4 and 6).
- Development of shared agreement of those most vulnerable in each cluster, providing a primary focus for integrated care development (city wide – starting in cluster 1, 2 and 4).

Over the coming 3 months the city wide group will being the process of engaging with a wider group of services, i.e. those more primary supporting adult population. These will include: learning disability services; adult mental health services; substance misuse services; and IAPT (Improving Access to Psychological Therapy). This will initially start from a city wide view before moving into cluster development discussions.

8 **Integrated rehabilitation and reablement**

The aim is to integrate resources that facilitate rapid crisis response, timely hospital discharge and preventative and recovery focused rehabilitation and reablement. This will be achieved through working alongside families/carers and community clusters to:

- undertake community rehabilitation and falls prevention activity.
- assess and coordinate safe discharge of people from hospital back into their communities.
- collectively intervene early and rapidly responding to crisis situations in a coordinated and flexible manner thus helping to avoid unnecessary acute hospital, residential and nursing home care or complex home packages.

A new service specification is in place and service providers are working together to integrate services with a completion date by July 2015.

9 **Community solutions and prevention**

The Community Solutions group oversees and coordinates the delivery of increased community involvement to support the Better Care agenda. The work plan for the coming year includes:

- mapping community resources at a cluster level against identified needs. Community leaders will be encouraged to upload information about their group on either Placebook, SID (Southampton Information Directory) or the Knowledge Hub.
- Community Navigation pilots have commenced Falls Exercise Classes due to commence developed by a consortium led by Age UK and involving Solent University (Sports Sciences), Active Options and Southampton City Housing .
- Southampton is involved in piloting Person Centred Planning for people

with long term conditions. £20,000 has been awarded by NHS England Patients In Control Programme. Age UK is starting to lead the work linking into a small number of GP practices. Early outcomes from the work will be reported in March 2015.

- Nicholstown Surgery in partnership with Age UK have been developing links with local ethnic minority groups to explore how individuals can be supported to self-manage their long term condition (see project evaluation).
- Southampton is involved in a national pilot scheme designed to change the way services are commissioned and delivered, with the involvement of local residents. The Our Place scheme which is underway in the Shirley and Freemantle area has started to engage the community to understand their concerns and priorities. One of the key areas identified is the need to improve the health and wellbeing of older people in the community.

As part of the development of clusters and integrated team developments, a coproduction process is being proposed, which will involve users, carers and voluntary sector organisations, together with statutory services. The aim is to review information emerging regarding the needs of the population in a cluster area, identify common priorities and develop a cross community/organisation action plan which will be delivered and supported by the cluster leadership teams; information which will be used is as follows:

10 **Market Development**

New domiciliary care contracts will come into place on the 1st April increasing reliability and quality of these packages of care.

11 **Performance**

Southampton's Better Care Plan has been designed to achieve the following key targets:

- To reduce unplanned hospital admissions - by 2% year on year over the next 5 years (2014 – 2019). Rate per 100,000 population.
- To reduce permanent admissions to residential and nursing homes - by 12.3% in per capita terms over 2014/15 and sustain and improve on this in subsequent years, bringing Southampton in line first with its statistical neighbours and then the national average. *65 years and over, per 100,000 population* To reduce readmissions by increasing the percentage of older people still at home 91 days post discharge into reablement services - to achieve 90% in 2015/16.
- To reduce delayed transfers of care and therefore excess bed days - by 3 per day in 15/16 which equates to an approximate 10% reduction. *Delayed days, per 100,000 population, average per month, aged 18+.*
- To reduce injuries due to falls - by 12.5% by the end of 2014/15 and sustain and improve on this in subsequent years. *65 years and over.*

Year to date progress is that performance is on target for the reduction in non-elective admissions and permanent admissions to residential and nursing homes Please see Appendix 2.

12 **Development of the Pooled Fund**

Southampton City's Better Care Fund Plan seeks to pool all budgets associated with health and social care services for older people and those with long term conditions to deliver a fully integrated provision centred around the needs of individuals. Pooling these budgets at scale will minimise overlap/gaps in service delivery, increase efficiency, improve value for money and ensure that services are designed to meet the needs of service users. It will enable radical redesign of services around the user regardless of whether their needs are mainly social or health.

The Integrated Commissioning Board (ICB) of the City Council and CCG which oversees all integrated commissioning arrangements between the two organisations has been overseeing the development of the pooled fund, in consultation with City Council and CCG legal representatives and finance. The Board have reviewed the Section 75 agreement and this will be finalised before 31st March 2015. The Partnership Agreement has duration of 3 years with a 3 month notice period for variation, unless otherwise agreed by the ICB. The ICB will oversee the effective management and performance of the overall Partnership Agreement and each of the individual Schemes within it on behalf of the CCG and City Council.

RESOURCE IMPLICATIONS

Capital/Revenue

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

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

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

Property/Other

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

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

17 Section 75 of the National Health Service Act 2006
The pooled fund agreement will cover governance and technical aspects including accountability, financial reporting and the handling of overspends, underspends and savings requirements.

Other Legal Implications:

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

POLICY FRAMEWORK IMPLICATIONS

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

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Southampton City Better Care Plan
2.	Pooled budgets and the Better Care Fund Guidance, October 2014 (The Chartered Institute of Public Finance and Accountancy)

Documents In Members' Rooms

1.	None

Equality Impact Assessment

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

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

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

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February/March 2015 / @NHSSotonCityCCG / www.southamptoncityccg.nhs.uk

Welcome - from Dr Sue Robinson and Councillor David Shields

Happy New Year! The countdown is now on to April 1st when the Better Care Fund is formally launched and the Care Act comes into force.

This second Better Care Southampton Update continues to chart our progress, bringing you news and views from the people and organisations joining up our care.

It was great to see lots of you at our Better Care Southampton TARGET event recently. This event was attended by GPs, practice staff and stakeholders from across health, social care and the voluntary sector. It was a really good opportunity for us to share our progress to date and to get GPs and primary care teams involved in the next steps for Better Care.

You will see in this edition stories of joint initiatives, updates on the part primary care are playing in the development of joined up working and a view from the community outlining what Better Care Southampton means for one local voluntary organisation. We also shine our spotlight on the invaluable contribution that housing is making to joining up care. All of this together with a host of other updates really shows the breadth of what Better Care Southampton is setting out to achieve.

With our Better Care plan now having the national seal of approval we are ideally placed to make the necessary changes to join up health, care and the voluntary sector and provide a better and more intuitive service for local people. Looking to the future we need to think more about mental health and the Health and Wellbeing Board hosted a round table event before Christmas to start this discussion.

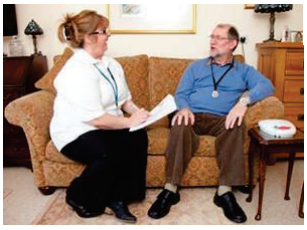
We have also now completed the complex process of establishing the pooled fund – the joint budget which will include money from the City Council and Clinical Commissioning Group budgets. The Health and Wellbeing Board initially discussed this, beginning the approval process for the finances that will support Better Care Southampton. This was followed by a City Council

Cabinet meeting and CCG Governing Body meeting where all gave the fund, which will initially be over £60m, the green light. The Full Council also approved the fund, marking the final formal approval. This is an important development and will give us the financial stability we need to move forward with confidence.

As the momentum for Better Care Southampton increases so does the amount of news we have to share. We will continue to keep you posted via these updates and if you have any comments or questions then please get in touch – email info.bettercare@southamptoncityccg.nhs.uk **and we will do our very best to help.**

Dr Sue Robinson, lead GP for Better Care Southampton and Cllr David Shields, Chair of the Health and Wellbeing Board

Better Care Spotlight



This new feature gives us a chance to look at an area in more detail and get the low down on the contribution it is making to joining up health and care services. This month we are throwing the spotlight on housing and will look at how it can make a difference to patient care.

Jean Brown, Supported Services Manager at Southampton City Council, is passionate about the involvement of housing in joining up health and social care. She has seen first hand from her experiences as part of the 'demonstrator site' pilot (which concluded last year), the extra skills and insight her staff can bring to GPs, social workers, community nurses and more.

Click here to read the interview.

A view from the community

Phil Williams, Health and Wellbeing Development Officer with Age UK Southampton, tells us about the work they are doing to help join up care in the city.

"We at Age UK are very excited about the possibilities afforded by Better Care Southampton to improve the range and type of services delivered to local older people. We are working hard to ensure our services are part of a joined up approach and have realigned them to meet the needs of Better Care Southampton. Introducing community/care navigators to provide initial and ongoing person-centred needs assessment and support planning is a key part of our work.

This is a nationally proven model that uses a combination of paid-for and volunteer navigators to reduce avoidable hospital admissions and GP visits and help cut delayed hospital discharge and premature residential care referrals.

In the future, we see ourselves working with the whole system to enable navigators to co-locate across the city in hospitals, GP surgeries and community venues, all working in a person-centred way to support behaviour change and help individuals improve

their quality of life.

We have long sought a more structured, effective and coordinated way of working with health and social care; Better Care Southampton enables us to contribute community and voluntary sector resources in a way that makes a genuine and sustainable difference to the quality of life for the city's older population. Better Care fits really well with our own holistic and proactive approach to identifying and addressing people's needs – for us Better Care offers the potential for a better quality of life."

Is getting animated about care planning the key for GPs?

The Royal College of GPs (RCGP) are getting animated about care planning in a bid to communicate the benefits of joined up working to busy GPs.

We at Better Care Southampton think their animation is great, so please take a look. It's only three minutes long yet it provides some real food for thought.

The RCGP say: "Care planning could be the solution to so many problems that GPs are facing in trying to provide high quality care to our patients with long term conditions. Yet still it is under-used, largely because it can be a difficult concept to understand. We have launched an excellent video animation that explains the process and what can be achieved when care planning is properly implemented."

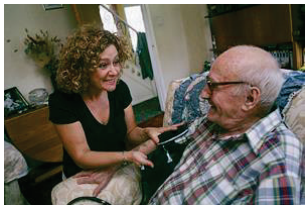
Let us know what you think - info.bettercare@southamptoncityccg.nhs.uk

Your views on shaping Better Care - You said, We did!

Following on from our last Better Care newsletter, please click here to view the progress we have been making on the four work streams in the Better Care programme. Each has a key role in tackling our main health and wellbeing challenges through joined up care. The four work streams are this year focussing on frail elderly across these areas:

1. Rapid response, rehab and reablement
2. Integrated Care – Cluster Development
3. Community Solutions
4. Enablers

Update on – the Community Navigator



Last month we gave a full update on what the new community navigators will do (click here if you missed it).

As reported, the aim is to commission community organisations to provide our community navigators, with several organisations operating in the city having been given the opportunity to submit proposals outlining how they would make this role work.

Proposals were received by the end of December and have now been evaluated.

We are very pleased to be able to announce that SPECTRUM Centre for Independent Living (www.SPECTRUMCIL.co.uk) have been selected to begin the work of developing community navigators. The idea is for the work in these areas to be evaluated over the next 18 months with a view to rolling out across the city.

SPECTRUM will begin by working with partners to develop the initial approach to this new and exciting role. The areas which will form the early focus for this work are Shirley, Freemantle, Weston and Woolston (Cluster 1 and Cluster 5) with the aim of promoting and developing the role more widely across the city in the longer term.

Ian Loynes, Chief Executive of SPECTRUM said: "We are absolutely delighted to have been selected to provide this valuable role. We think community navigators will make a real difference to patients and service users and will help them gain access to a broad range of services offered by voluntary and charitable organisations in the community. We feel it is a great chance to make a tangible difference to the health and wellbeing of local people."

It is anticipated that the first community navigators will take up their posts by early spring when they can begin making a difference helping bridge the gap between care services and community groups. Watch this space for further updates.

The care provider perspective

Steve Smith from Solent NHS Trust answers key questions about the 'Case Manager' role.

What is the point of having a Case Manager?
One of the aims of Better Care Southampton is to have a holistic model of care – focusing on the whole person and not looking at each individual health issue separately. The case manager role will act as a vital part of this approach and will be a key element of our integrated Community Nursing Team, as well as being linked with the wider Community Health Teams.
Click here for the full interview

Personalised care for over 75s - update

As reported in our last issue, the introduction of the new practice based nurses for elderly patients as part of the 'Everyone Counts' initiative is now underway. The role of the elderly care nurse is to reduce the need for long term care by proactively identifying those at risk earlier to ensure they get the right support at the right time.

This initiative, closely linked to our Better Care work, requires Clinical Commissioning Groups (CCGs) to set aside £5 per patient to implement improvements in care for patients over 75. In the city, each locality developed their own proposals about how best to make this happen. Find out more and hear from Lisa Lucas, a local Elderly Care Nurse from Burgess Road Surgery about her early impressions.

Working together for a dementia friendly city

We want a dementia friendly city and we will work together to achieve it!

That's the message from NHS Southampton City Clinical Commissioning Group (CCG) and Southampton City Council as they join together with local charities, voluntary and community groups to provide more support in the community to help people in Southampton live well with dementia this winter and beyond.

The initiative, set up by the CCG and council, aims to develop support in the community for people with dementia and has seen several support groups established by charities across the city. Everything from art classes to gardening groups, to walking groups and Singing for the Brain® - all proven to improve wellbeing and connect those living with dementia with their community are now running - and to much acclaim!

Stephanie Ramsey, Chief Nurse and Director of Quality and Integration for the CCG and City Council said: "Dementia is a very real issue in our community and I am delighted to be part of such a great joint project to provide much needed support.

"62% of people with dementia say they are lonely and 47% say they don't feel part of their local community. We are determined to improve these statistics, especially over the colder months which can often be a difficult time for those living alone.

These groups are being delivered by local charities that can provide expert support giving those with dementia and their carers the chance to talk to others and make a positive impact on their day to day life."

Gary Marsh, Group Coordinator from the local office of the Alzheimer's Society added: "We are really pleased to join with our partners in health and the local authority and delighted that the groups we have set up are already making positive differences to people in Southampton – from walking groups and art classes to a seafaring memory group to encourage local people to share memories about their maritime lives and hobbies, all the groups are playing their part in tackling dementia and the isolation that

can go with it."

Other local support includes opportunities for people with dementia to enjoy the outdoors at a community farm and reducing stigma of memory loss held by some ethnic minorities and using technology help stimulate and encourage reminiscing.

For further information about the groups please email us at info.bettercare@southamptoncityccg.nhs.uk.

Integrated Commissioning Unit update

The Integrated Commissioning Unit (ICU) is the name given to the growing department of people employed jointly by Southampton City Council and NHS Southampton City CCG with a remit of jointly planning and buying health and care services.

Director of Integration and Quality, Stephanie Ramsey, herself a joint appointment, said: "The ICU is vital in our work to join up services. For truly joined up services the starting point is commissioning – developing the right specifications and contracts to ensure services can be delivered seamlessly."

Find out more about the ICU and the projects they are currently working on.

Care plans to be viewed by all

An exiting new project to upload all existing urgent and anticipatory care plans to the electronic Hampshire Health Record (HHR) has now begun.

This will enable the same care plan to be seen by health and care staff from a variety of organisations. It means that frontline staff from GPs and community staff to the ambulance service and acute sector can now all see plans to inform how they care for people - making life simpler. **Find out more**

Working together for your care:

SOUTHAMPTON CITY COUNCIL

NHS Southampton City Clinical Commissioning Group

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Trust Headquarters
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Phone: 02380 296904
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Better Care Fund

Project Assurance Report

February 2015

Clare Young – Southampton CCG Programme Management Office (PMO)

Better Care Fund Progress Summary — February

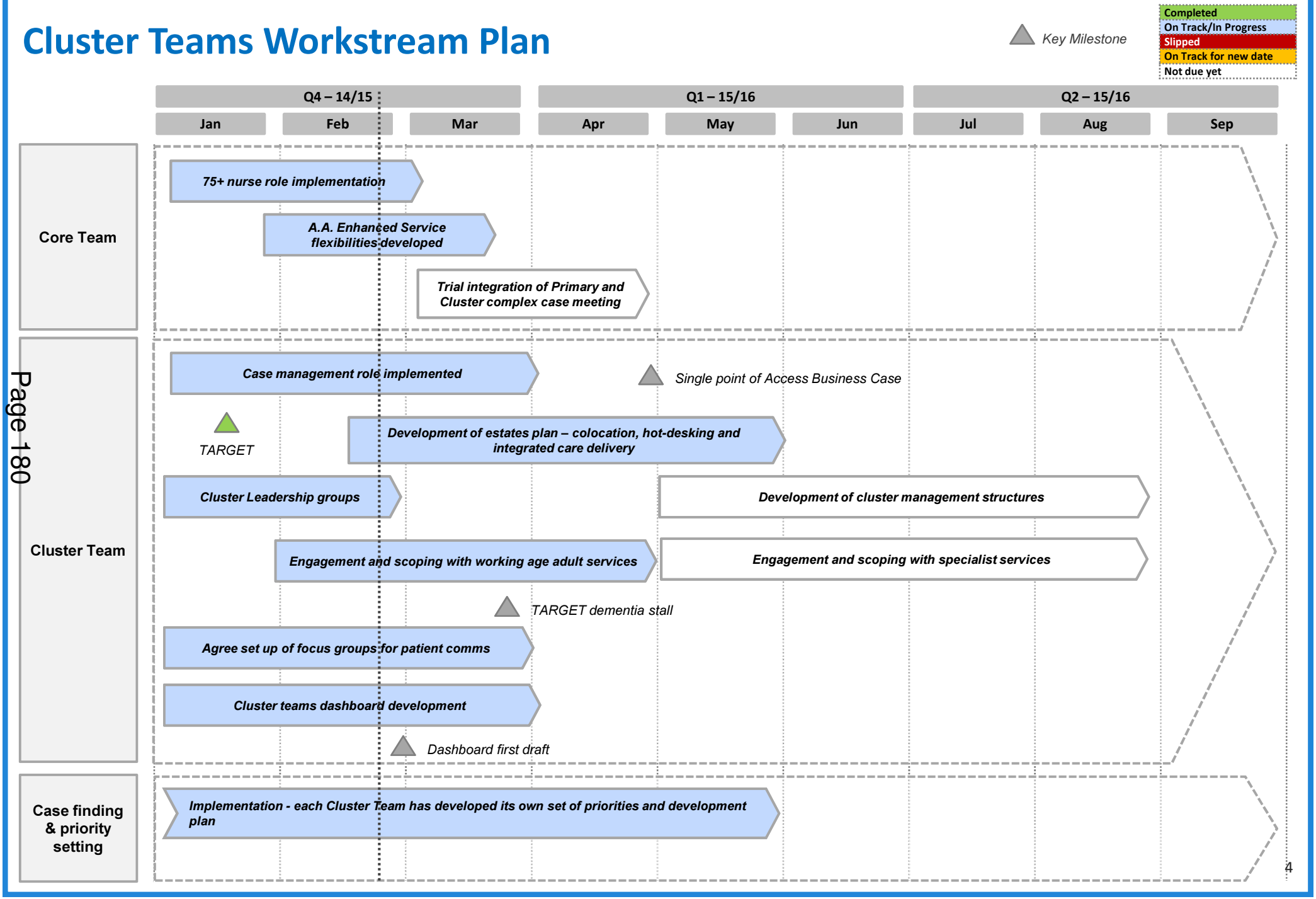
Workstream	Last Month's Status	This Month's Status	Looking Back… *What's happened over the last month?*	Looking Forward… *What's happening over the next couple of months?*	Date
Cluster Teams	**Green**	**Green**	✓ TARGET event completed 21st Jan ✓ Started to explore the future state for cluster teams ✓ Started to expand involvement with services related to working age adults ✓ '10 plus 1' action plan in place and actions built into milestones	• Cluster teams dashboard draft in progress – acute completed • Single point of access PID – presentation to ICB	**End Feb**
				• Agree set up of focus groups for patient communications • TARGET session with dementia stall • Implementation of Community Navigator	**March**
				• Development of cluster plans • Voluntary sector involvement in cluster development • Involvement of working age adults	**Ongoing**
Rehabilitation, Reablement & Hospital Discharge	**Amber**	**Amber**	✓ Monthly meetings have begun with providers ✓ New geriatric fracture clinic for over 75's in place ✓ Exploring kite mark for exercise activity in the city, based on work in Derbyshire	• R&R Phase 1 implementation consultation – slippage from Feb to Mar due to delay in providers pulling together a plan and model	**March**
				• Exercise service operational – slipped from Feb to April. Leaflets and transport to be resolved.	**April**
				• Potential for falls data on HHR is being investigated	**TBC**
Building Community Capacity	**Amber**	**Green**	✓ Domiciliary care mobilisation commenced ✓ Additional domiciliary care resource in place ✓ TLAP funding awarded ✓ Implementation plan for Community Navigator completed ✓ Community solutions group has identified leads to link into cluster leadership group	• Domiciliary care mobilisation	**Feb - May**
				• Work with CSU to recruit project resource to begin working with experts to develop workforce development programme	**March**
				• Community solutions group actively mapping resource (part of Southampton Information Directory)	**Ongoing**
Infrastructure & Inter-dependencies	**Amber**	**Amber**	✓ Revisited branding for the BCF, such as more supporting statements ✓ Rehab & Reablement service spec issued to providers ✓ Advertising GP clinical leads at cluster level	• Shared care plans – Phase 1, upload existing care plans to HHR • TPP extract • Cluster teams service specs issued to providers • Commence exploring estates plan	**End Feb**
				• BCF comms plan to be reviewed • Workshop to revise IT programme plan and priorities with operational stakeholders	**March**
				• Sign off partnership agreement	**End March**

Better Care Fund Progress Summary

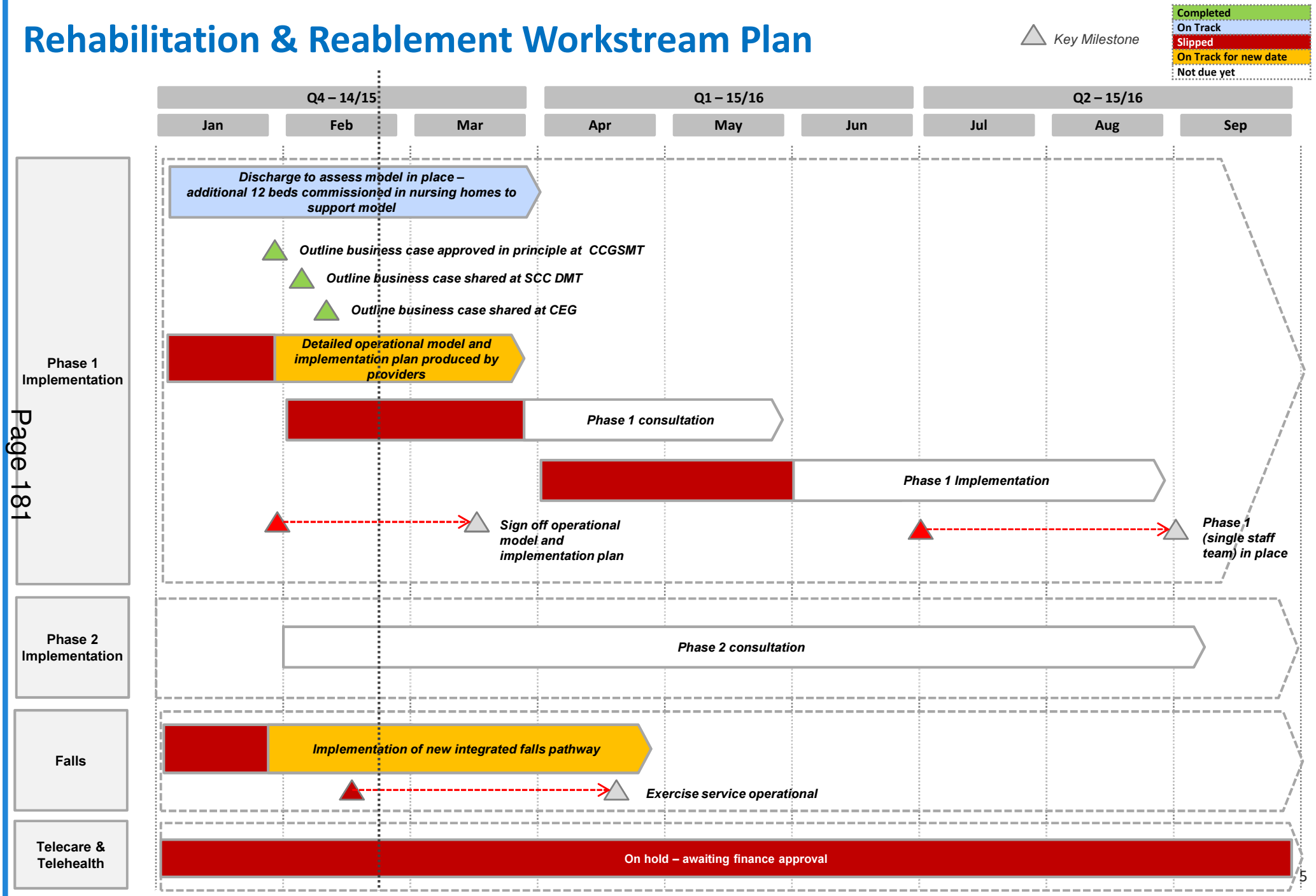
KPI Scorecard

Metric	Target	Activity		Finance	
		In month Performance	YTD Performance	In month Performance	YTD Performance
Reduction in Non Elective Admissions *Rate per 100,000 population*	2% year on year reduction	Off-Target	On-Target	Off-Target	Off-Target
Reduction in permanent admissions to residential and nursing homes *65 years and over, per 100,000 population*	12.3% reduction over 2014/15	On-Target	On-Target	Decline in residential home cost, increase in nursing home cost. Cost per person has increased by 5% since April 2014.	
Reduction in Delayed Transfers of Care (DToC) *Delayed days, per 100,000 population, average per month, aged 18+*	894 monthly average by Dec 2014	Off-Target	Off-Target	*Finance not available for this metric*	
Reduction in injuries due to falls *65 years and over*	12.5% reduction per week, by end of 2014/15	Off-Target	Off-Target	*Finance not available for this metric*	

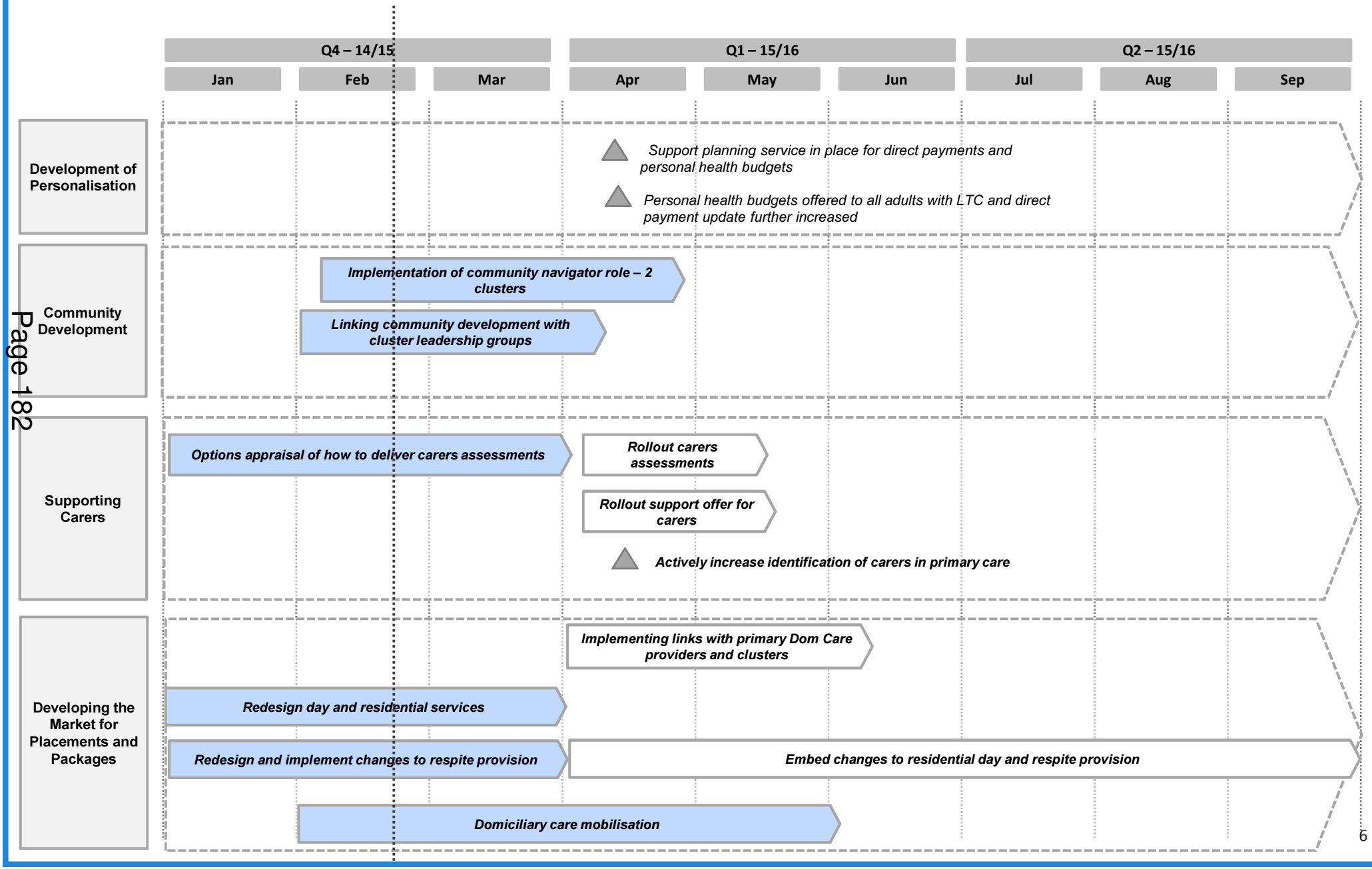
Cluster Teams Workstream Plan



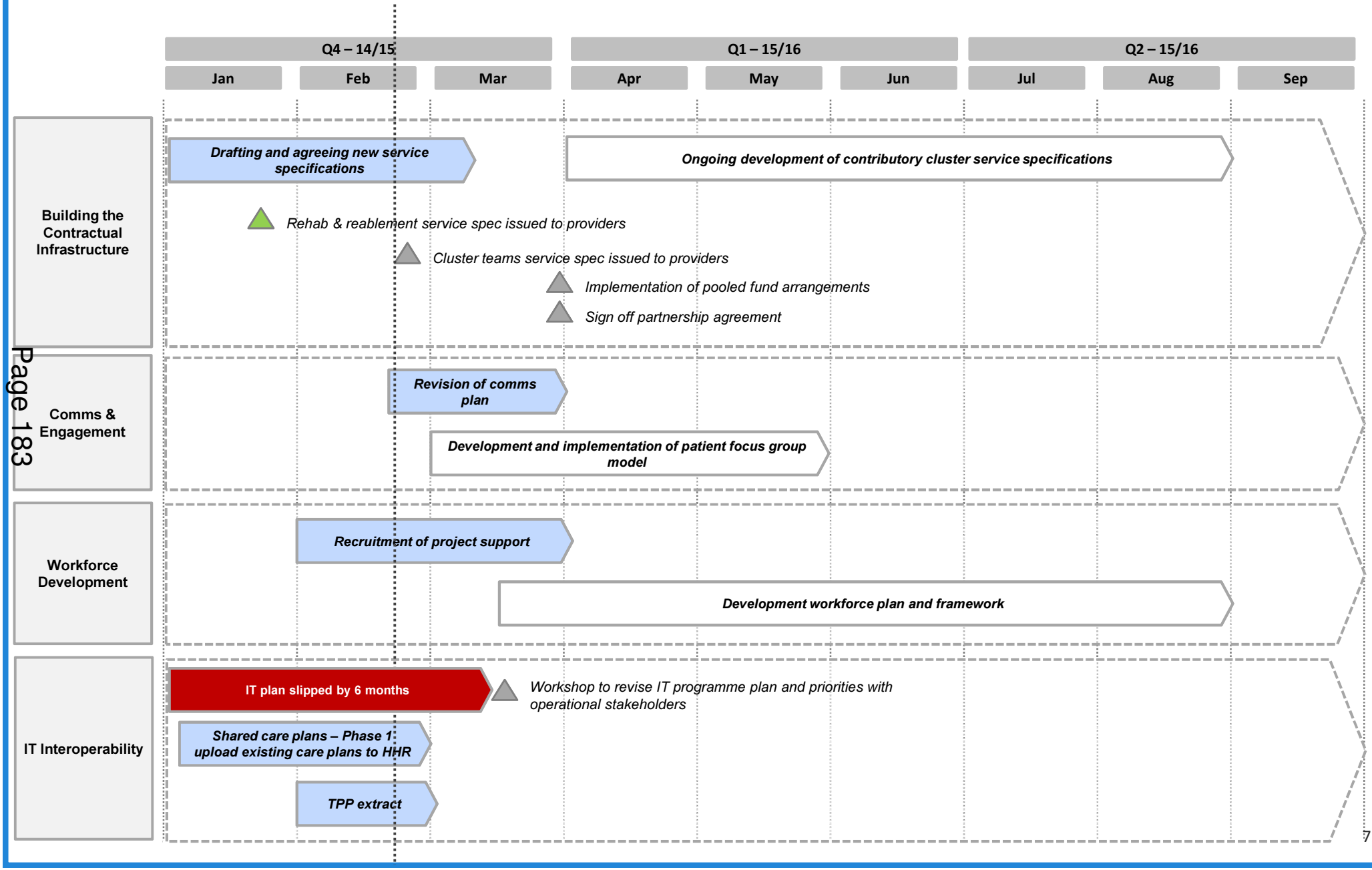
Rehabilitation & Reablement Workstream Plan



Building Community Capacity Workstream Plan



Infrastructure & Interdependencies Workstream Plan



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