Public Health Annual Report 2014 – Progress on recommendations 2015/16 **APPENDIX 1**

	ACTION	PROGRESS (RAG)	COMMENT - PROGRESS TO DATE AND NEXT STEPS	Updater
	KEY: Green – On track or completed; **Amber –** Off target; **Red –** Significantly off target; Grey – Missing information or status			
A: Fitness in young people				
A1	To create a social movement through encouraging a whole city collaborative cross-sector approach to physical activity through the Health and Wellbeing Board.	**GREEN** On target	Fitness in young people is covered through Active Nation / Southampton Gets Active and the Green Spaces consultation. Work continues to build on the 'One You' campaign encouraging the public to be responsible for their health and get more active. Currently testing a new PHE tool to assess ability to tackle childhood obesity in the city.	HWB / Bob Coates
A2	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.	**GREEN** On target	The integrated commissioning unit is working with health providers towards embedding the concept of Making Every Contact Count core within the all elements of the health workforce. The ICU is also working, with the support of the CSU and HEW, to develop a programme of education which supports the broader workforce (including Domiciliary Care, Community and Voluntary Sector) to deliver this approach and become the 'eyes and ears' of the system.	ICU
A3	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.	**AMBER**	Our PHD student (3yrs) is assessing physical activity levels in primary school children in the city and opportunities to increase physical activity levels in conjunction with schools. The outcomes from the analysis and recommendations will be reported to the HWBB.	Children's and Families / Jo Cassey
A4	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.	**AMBER**	The HWBB held a special meeting to feed into the proposals for the local plan submission. This specifically considered the implications of healthy and active environments and maximising use of green spaces. This engagement needs to continue to progress as part of the Health and Wellbeing Strategy inequalities approach. Future informal agenda item to be scheduled in May 2016.	HWBB
B: Building mental resilience in young people				
B1	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.	**GREEN** On target	The HeadStart bid, developed in partnership with schools and key stakeholders and through coproduction with young people, was submitted at the end of February 2016. The HWBB considered the draft submission in January 2016 and will receive the final submission in March. Subject to approval from the Big Lottery, HeadStart will be implemented in 3 tranches with 4 schools in each tranche except tranche 1 which will also include the two alternative schools, Polygon and Compass. Once all the schools have begun it is estimated that 1,038 young people will be accessing the	ICU / Katy Bartolomeo

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			HeadStart Universal Plus programmes per year and 12,526 10-16 year olds accessing the Universal HeadStart services. Overall, 735 pupils will be from non-transition years i.e. secondary school years 7-11, (children aged 11 to 16), with a focus on school years 8 and 9 (children aged 12-14). The outcomes we are seeking to achieve link to our mission and the national common measurement framework, using the key question: "Does the HeadStart Southampton programme raise happiness and mental wellbeing for children and young people aged 10-16 years of age living in Southampton City?"	
B2	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.	**GREEN** On target	The integrated prevention and early help offer for children and young people (pre birth to age 19 years) and their families in Southampton includes a strong emphasis on strengthening resilience and improving emotional health and wellbeing. There are three evidenced based pathways : ➢ parent support – including attachment, positive relationships, employment and journey out of poverty ➢ healthy lifestyles – including nutrition, exercise, sleep, safety, oral health, substance misuse and emotional wellbeing ➢ development and behavior – including speech & language development, physical, cognitive and behavioural development, social skills and school attendance	Debbie Chase / Donna Chapman
B3	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.	**GREEN**	The Be Well Strategy is currently being refreshed. The timescale on this should allow for the findings of Mental Health Matters, the local suicide audit and plan and publication of the Mental Health Taskforce Review to be included. Draft strategy to be presented to HWBB in May 2016.	Sally Denley
C: Southampton child health profile				
C1	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.	**AMBER**	A needs assessment is underway and IPAC hopes to meet to look at the report and recommendations in May 2016. A PHD student is also currently exploring the role of the GP in coordinating responses around injuries. Outcomes and recommendations will be reported to HWBB.	Public Health
C2	Injury prevention should be embedded	**GREEN**	Audit and research is undertaken by key partners working as part of the	Stephanie

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	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.	Ongoing	Better Care programme. Better Care has embedded some injury prevention programmes in key areas e.g. fragility fracture in the elderly	Ramsey / Bob Coates
C3	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.	**GREEN** On target	As the Hampshire Compact has evolved the Council have engaged in supporting Hampshire Fire and Rescue Service by developing more open and effective channels of communication and data sharing. Working towards joint principles of improving Health and Wellbeing. Youth interventions include: long term health conditions, low level self harm, improving self-esteem and increasing activity level Elderly interventions include: ill health and falls prevention.	HWBB / Bob Coates
D: Air quality in Southampton				
D1	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.	**AMBER**	Air Quality is covered in the Cabinet response to the Air Quality Inquiry and the subsequent Low Emissions Strategy which will be governed by the HWB Board. Work is underway to develop the Low Emissions Strategy, the draft implementation report is due for publication in March 2016. A Clean Air Strategy (CAS) is to be produced as public facing document setting out the range of activities SCC will pursue to deliver improvements. It is anticipated that a draft will be available for consultation late Summer 2016/17.	Debbie Chase
D2	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.	**GREEN** On target	Funding has been secured through the DEFRA Air Quality Capital Grant programme to develop a Clean Air Partnership. This includes development of webpages to support and communicate all activities in the Clean Air Strategy and inform businesses and the public on how they can contribute. These pages will be merged with the My Journey site and share the same branding. First pages are anticipated in June/July 2016 and will be developed in conjunction with the associated activities to improve air quality.	Steve Guppy/ Debbie Chase
D3	Stronger links with planning should be developed to ensure public health implications are considered in decision-making.	**GREEN** On target	Planning guidance is being developed to ensure the development control processes takes appropriate account of any air quality impacts and good design and best-practice measures are introduced to both reduce pollutant emissions and human exposure. The guidance will introduce the concept of damage costs to ensure the impacts can be quantified and mitigation measures are adequate. It will also provide standards for undertaking air	Steve Guppy/ Debbie Chase

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			quality assessments to ensure impacts are reported in an accurate and consistent way. It is anticipated that a draft will be available for consultation in June/July 2016 and can be introduced on an informal basis. By referencing it in the Air Quality Management Plan it can be adopted as advice and will gain further weight as the Local Plan review proceeds with the expectation that a final version will be adopted as a Supplementary Planning Document by Q3/4 2016/17	
E: Dementia and long term illness				
E1	NHS providers should ensure that people with dementia have appropriate physical health checks to manage the many health problems that are often present.	**GREEN** On target	Where a patient does not already have a care plan or an advanced care plan in place, it is expected that the GP practice will develop a care plan. A face-to-face care plan or advanced care plan review focuses on support needs of the patient and their carer. In particular the review will address the following key issues: • an appropriate physical, mental health and social review for the patient, • a record of the patients' wishes for the future, • communication and co-ordination arrangements with secondary care (if applicable), • identification of the patients' carer(s)	ICU / Stephanie Ramsey
E2	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.	**GREEN** On target	Southampton scrutiny inquiry 'Making Southampton a dementia friendly city' launched in September 2015, the inquiry has compiled a file of evidence from the contribution made by invited experts in the field, and this will be used to produce a final report of the inquiry. The inquiry has identified many areas of good practice, and will make recommendations of where, as a city, we could be doing more. The final report is due at the end of April 2016.	ICU / Stephanie Ramsey
E3	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.	**AMBER**	In line with Better Care Southampton, OPMH and Physical health teams continue to develop and deliver against joint integration plans, this includes a memorandum of understanding between SHFT and Solent NHS Trust. Integration plans and progress of delivery is being included in CRM process.	ICU / Stephanie Ramsey /
E4	GPs and primary care teams are encouraged to increase awareness of	**GREEN** Ongoing	A programme of regular communication with GP practices providing information and access to a range of resources included GP Tutorial	CCG / Sue Robinson

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	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.		OPMH – Dementia. This provided primary care with summary information in a number of areas: • Identification of patients at clinical risk of Dementia • Guide to overlapping symptoms of depression and dementia, other physical health problems causing delirium. This has resulted in significant progress to improve our diagnosis rate, resulting in more people having access to information, services and support. The current diagnosis rate in the city as at January 2016 is reported at 71% of the expected prevalence having received a diagnosis, and above the national average. The Over 75 nurses proactively contact patients who do not often see their GP, and encourage assessment should they show signs of memory loss. Due to changes in the follow up system there is now more capacity for early assessment in the memory clinic.	
F: High blood pressure: A global health threat				
F1	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.	**GREEN** Ongoing	4,289 health checks were completed by GP practices in the period April 2014 to March 2015. However, many people found to have a raised BP on a health check will not be hypertensive. They should then have further measurements, either ABPM (ambulatory BP monitoring) over 24 hours, or home BP monitoring, ideally twice daily readings for a week, to confirm or refute the diagnosis. GP Clinical software will automatically flag an alert during a consultation when a patient has not had their BP recorded for five years, reminding the clinician to check the BP. Diagnosis of hypertension has increased from 10.83% to 10.87% in 2014/15, which equates to more than 1,000 additional people diagnosed. However, it is estimated that hypertension is still underdiagnosed in the city and work continues to increase detection rates.	CCG / Sue Robinson / Bob Coates
F2	General Practices are encouraged to take action to increase the proportion of patients that achieve target BP control on their chronic disease registers.	**GREEN** Ongoing	Practices continue to be incentivised through the Quality and Outcomes Framework to maintain good B/P control in patients with chronic conditions and the general population over 45 years. 96.89% of patients over 45 years had a B/P recorded between April 2014 and March 2015, an increase of 8.15% on the previous year. Across all chronic conditions monitored through QOF, the level of B/P control is being maintained, with 87.75% of patients with a record of B/P	CCG / Sue Robinson

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			within the target range, a small increase of 0.32% on the previous year.	
F3	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.	**GREEN** Ongoing	The CCG has commissioned the Stroke Association to undertake Stroke prevention and awareness work. During 2015 a number of "Know your Blood Pressure" events took place together with Stroke prevention and awareness presentations to a number of organisations and audiences e.g. Mencap, Solent students, Sure Start, residents associations. The CCG has supported the British Heart Foundation's campaigns via internal communications and via social media. There has also been some promotion of local pharmacy health checks. This will form part of the 'One You' campaign in early summer 2016.	Dawn Buck / Paddy O'Shea
F4	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.	**GREEN** Ongoing	Many GP practices have an accessible B/P machine in their waiting room for patient use. Portable B/P machines are available to loan from some practices for short term home use. All practices are able to refer patients for 24 hour BP monitoring, which is very helpful in making an accurate diagnosis of hypertension.	CCG / Sue Robinson
G: Tackling health inequalities in Southampton				
G1	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.	**AMBER**	Health Inequalities has been considered by the Health Inequalities Reference Group and will be a key theme for updating the JSNA and Health and Wellbeing Strategy. As part of the approach it is proposed that a Health Inequalities Action Plan is developed to ensure a coordinated approach across the city.	HWB
G2	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	**AMBER**	Health Inequalities has been considered by the Health Inequalities Reference Group and will be a key theme for updating the JSNA and Health and Wellbeing Strategy. As part of the approach it is proposed that a Health Inequalities Action Plan is developed to ensure a coordinated approach across the city.	HWB

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	have the most impact in the short to medium term, based on findings in this report.			
G3	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.	**GREEN** On target	CCG Operating plan for 2015/16 identifies key priorities and actions for reducing inequalities including implementation of National Audit Office Health Inequities report recommendations such as increasing prescribing of drugs to control blood pressure, to reduce cholesterol and increasing anticoagulant therapy in atrial fibrillation. New Diabetes service model being implemented with majority of care (80% patients) being delivered in primary care, with support from specialist community diabetes service to improve blood sugar control in diabetes. Focussed work on implementing Parity of esteem programme, including use of CQUIN payments. Priorities under development for 2016/17. We are working on a local improvement scheme, aimed at supporting practices in caring for patients living in the most deprived LSOAs. The six cluster areas in the City are encouraged to develop locality plans which reflect the needs of their community, to inform commissioning strategy.	CCG – Sue Robinson / ICU - Stephanie Ramsey
G4	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.	**GREEN** On target	Health Inequalities has been considered by the Health Inequalities Reference Group and will be a key theme for updating the JSNA and Health and Wellbeing Strategy. As part of the approach it is proposed that a Health Inequalities Action Plan is developed to ensure a coordinated approach across the city. The outcomes from the Fairness Commission that relate to the health system will also feed into this.	HWB