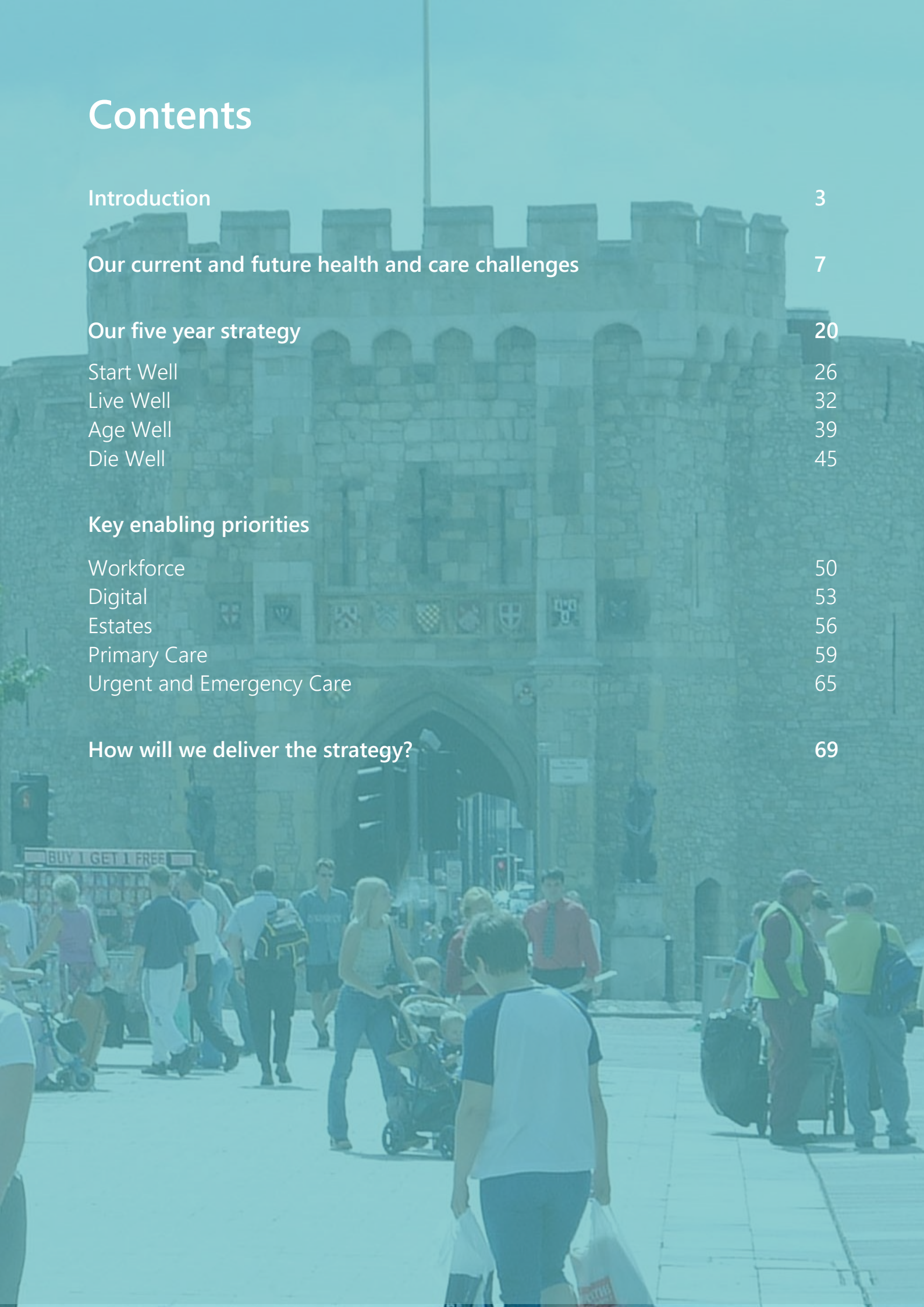
Southampton City Health and Care Strategy

2020-2025

A healthy city where everyone thrives

Contents



Introduction

Southampton is a vibrant, historic waterfront city with a diverse population, a strong growing economy and high quality health and care services. Despite this, health and wellbeing outcomes are not as good for some of our residents as they could be.

Southampton is ranked the 55th most deprived local authority area in England and 13% of neighbourhoods in the city fall within the 10% most deprived nationally (IMD 2019).

In Southampton, people living in the most deprived areas of the city have poorer outcomes than those living in the least deprived areas of the city. This means that the right of our residents to the highest standard of health and wellbeing is not being enjoyed equally across Southampton.

Deprivation and inequalities in health outcomes are linked; inequalities in health can arise from inequalities in society – in the conditions in which people are born, grow, live, work, and age.

We therefore need to take action which goes beyond just health and the NHS. We need a collective response across NHS organisations, the Local Authority and voluntary organisations to tackle these challenges together.

We are not starting from scratch. Over several years, these organisations in the city have already been building strong partnerships to improve services, outcomes and experience for the people of Southampton. This includes significant work already undertaken through the city's Better Care programme.

We are committed to continuing our 'one city' place-based approach; working together to improve health and care outcomes for the population of Southampton that we serve. We have a shared vision, a case for change that we all endorse and a strategy to deliver improvement.

Our strategy is based on making continuous improvement over a number of years to meet our shared vision, 'a healthy Southampton where everyone thrives'. To achieve it will take time and it is something we need to do together.

COVID-19 update: *This strategy was developed, and was due to be launched, before the COVID-19 pandemic. The strategy already focuses on tackling the same health inequalities that the pandemic has exacerbated. People who experienced worse health before COVID-19 are most likely to be adversely affected by COVID-19 from the infection and also through isolation, overcrowding, uncertainty and financial hardship, among others. The commitments in the strategy are more important than ever. The swift, collaborative and innovative response to the pandemic in Southampton and across Hampshire and Isle of Wight gives us much to build on. We will continue to refine our work in light of the latest knowledge about COVID-19.*

How does the Strategy align with other plans?

Hampshire and Isle of Wight Sustainability and Transformation Partnership (STP) Plan

In 2016, NHS and local government organisations came together in 44 areas across England to develop proposals to improve health and care. They formed new partnerships – Sustainability and Transformation Partnerships (STPs) – to

agree strategy and priorities, allocate resources and deliver transformation for a population across a larger geographical footprint.

Southampton is part of the Hampshire and Isle of Wight STP.

During the summer of 2018, the Prime Minister set out a funding settlement for the NHS in England for the next five years. In return, NHS England was asked to develop a Long Term Plan for the future of the service.

Following this, every STP in England was requested to translate the NHS Long Term Plan into a local one, and in November 2019 the Hampshire and Isle of Wight STP finalised its long term Strategic Delivery Plan.

Southampton's Health and Care Strategy is aligned to the priorities of the Hampshire and Isle of Wight STP plan and the NHS Long Term Plan, however it is focused on addressing the health and care needs specific to the population of Southampton.

Southampton City Health and Wellbeing Strategy

Health and Wellbeing Boards (HWBs) were established in councils with adult social care responsibilities in 2013. Our Southampton City HWB produces a joint strategic needs assessment (JSNA) for Southampton. The JSNA provides a wide source of information and data for health, care and wellbeing planning and commissioning and informs Southampton's Health and Wellbeing Strategy (2017-2025). This sets out the vision, priorities and action agreed at the HWB to improve the health, care and wellbeing of local communities and reduce inequalities for all ages.

The vision of the Southampton Health and Wellbeing Strategy is that Southampton has a culture and environment that promotes and supports health and wellbeing for all. It is ensuring that work is prioritised and plans are in place to mitigate the causes of the wider

determinants of health and wellbeing across social, environmental and economic aspects, such as jobs and housing.

The Southampton City Health and Care Strategy is a subset of the wider Health and Wellbeing Strategy.

Southampton City Local Plan and Green City Charter

The Local Plan is the long term planning policy framework for the city which guides and controls future development for addressing housing needs and other economic, social and environmental priorities, and a platform for local people to shape their surroundings.

It ensures that growth is managed and sets out rules about what can be built and where. Importantly, it also makes sure that it doesn't just deliver houses or work spaces but all the things people need to live and work; school places, health services, transport networks, open spaces, quality environments and retail, leisure and community facilities.

The Local Plan is in the process of being refreshed, providing an important opportunity to strengthen future planning for health and wellbeing in the city.

Alongside the Local Plan, the Council has launched the Green City Charter, with a vision to 'make Southampton a cleaner, greener, healthier and more sustainable city'.

Through the Charter, Southampton will be a better place for current and future generations that is prepared for the challenges presented by climate change.

Southampton COVID-19 Local Outbreak Plan

Local Authorities are required to have local outbreak control plans. The plan describes how Southampton City Council will work with partners to minimise the spread of COVID-19 infection, and identify and control local flare ups of the virus as quickly as possible.

Our Current and Future Health and Care Challenges

Deprivation and inequalities

Social deprivation

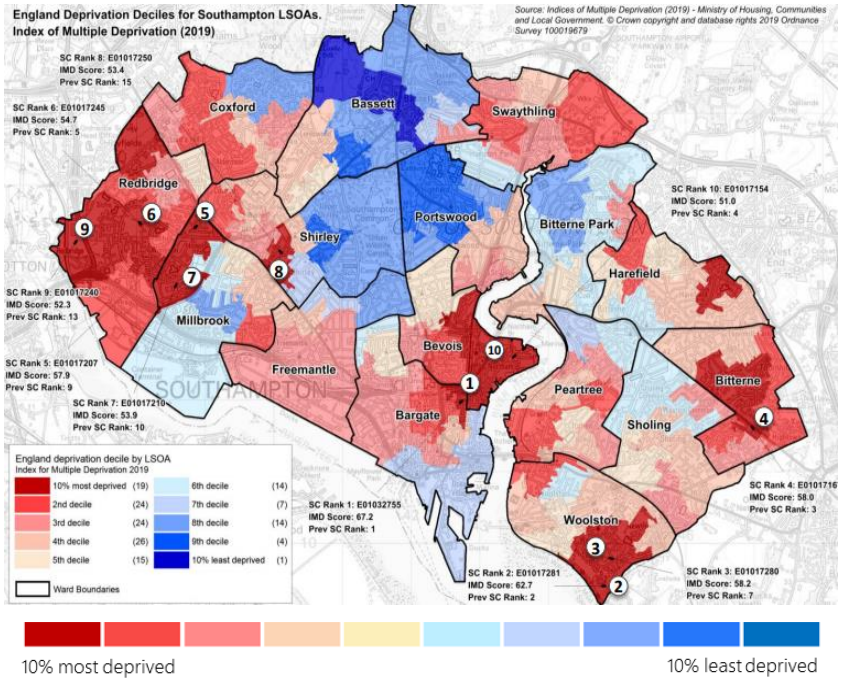
The Index of Multiple Deprivation (IMD) measures deprivation for small areas at a neighbourhood level. There is a common misconception that deprivation means how affluent an area is. To some extent this is true, however the IMD measures multiple factors which contribute to deprivation, such as income, employment, health and education.

The map below shows levels of deprivation across the city, with the ten most deprived neighbourhoods numbered 1 to 10. The darker shades of red indicate areas in Southampton which fall into the 10% most deprived neighbourhoods nationally. The darker shades of blue indicate areas in Southampton which fall into the 10% least deprived neighbourhoods nationally.

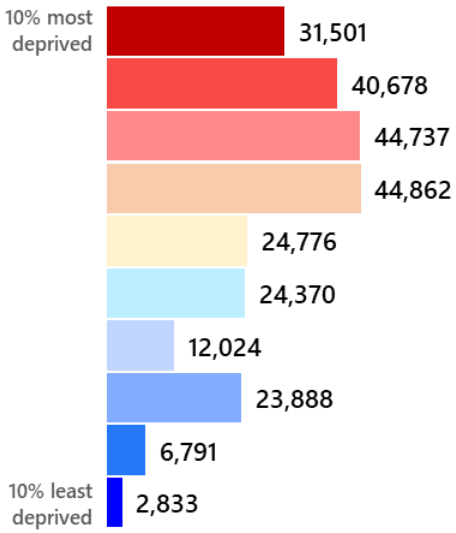
In Southampton, 19 of the 148 neighbourhoods fall into the 10% most deprived neighbourhoods nationally. Overall, Southampton is ranked the 55th most deprived local authority area in England (IMD 2019).

The chart shows the estimated number of Southampton residents in each deprivation decile. **Over 45% of Southampton's population live within the 30% most deprived neighbourhoods nationally (117,000 people).** At the other end of the scale, 13% of Southampton's population live within the 30% least deprived neighbourhoods nationally (33,500 people).

Southampton's neighbourhood deprivation rankings



Number of Southampton residents living in each deprivation decile

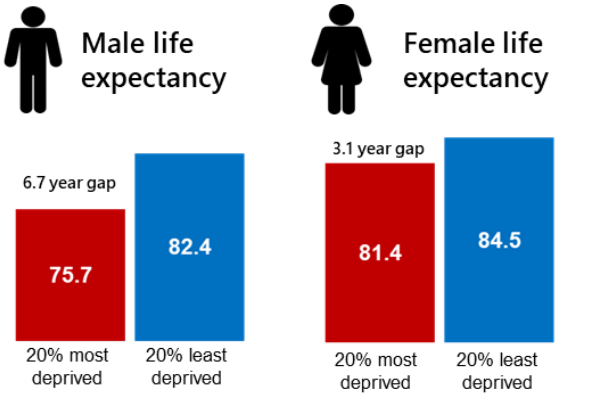


Inequalities across the life course

"Inequalities are a matter of life and death, of health and sickness, of wellbeing and misery. The fact that in England today people in different social circumstances experience avoidable differences in health, well-being and length of life is, quite simply, unfair. Creating a fairer society is fundamental to improving the health of the whole population and ensuring a fairer distribution of good health." The Marmot Review, 2010

A key indicator which shows inequality across the population is life expectancy. In Southampton, people living in the most deprived areas of the city die earlier than those living in the least deprived areas. Males living in the most deprived areas of the city are likely to die 6.7 years earlier than males living in the less deprived areas of the city. Females living in the most deprived areas of the city are likely to die 3.1 years earlier than females in the less deprived areas of the city.

Differences in life expectancy in Southampton



Evidence of how inequalities are leading to differing outcomes in Southampton over the course of a person's life is shown below. Differences are shown as a multiple, in terms of how many times higher ('x' higher) or how many times lower ('x' lower) the differences are. For example, teenage pregnancies are 3.1 times higher in the most deprived neighbourhoods in the city compared to the least deprived.

Pregnancy and Early Years

- 3.1x higher — Teenage pregnancy
- 4.3x higher — Smoking during pregnancy
- 1.6x higher — Low birth weight of full term babies
- 1.4x lower — Breastfeeding prevalence

Children and Young People

- 4.0x higher — Looked after children
- 4.8x higher — Children living in poverty
- 1.7x higher — Child obesity (Year R)
- 1.8x higher — Child Obesity (Year 6)

Working Age Adults and Older People

- 1.9x higher — Smoking
- 3.4x higher — Alcohol emergency hospital admissions
- 2.9x higher — COPD prevalence
- 1.5x higher — Coronary Heart Disease prevalence
- 1.8x higher — Depression prevalence
- 5.6x higher — Claimants of out of work benefits
- 2.0x higher — Premature deaths from all causes
- 1.5x higher — Premature deaths from Cancer
- 2.6x higher — Physical inactivity
- 4.1x higher — Drug poisoning emergency hospital admissions
- 1.6x higher — Diabetes prevalence
- 1.4x higher — People who have 3 or more long term health conditions
- 3.5x higher — Intentional self-harm emergency hospital admissions
- 3.8x higher — Violent crime and sexual offences
- 1.9x higher — Premature deaths from Circulatory diseases
- 2.9x higher — Deaths from COPD

Key

- 20% most deprived neighbourhoods in Southampton
- 20% least deprived neighbourhoods in Southampton

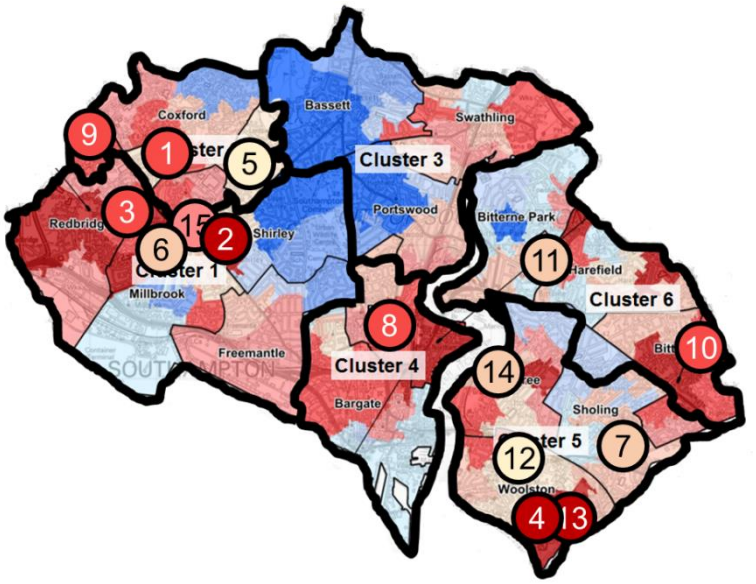
How is social deprivation in Southampton affecting healthcare usage?

In Southampton, there is a strong link between deprivation and rates of urgent healthcare usage. We have found that the neighbourhoods with highest deprivation are also the neighbourhoods with the highest rates of emergency admissions.

The map on this page shows the 15 neighbourhoods in the city with the highest rates of emergency hospital admissions (per 1,000 population).

It is a useful indicator of where our local health and care system could be failing to prevent ill health or to provide planned care interventions that could have avoided an emergency admission.

Areas with highest rates of emergency hospital admissions

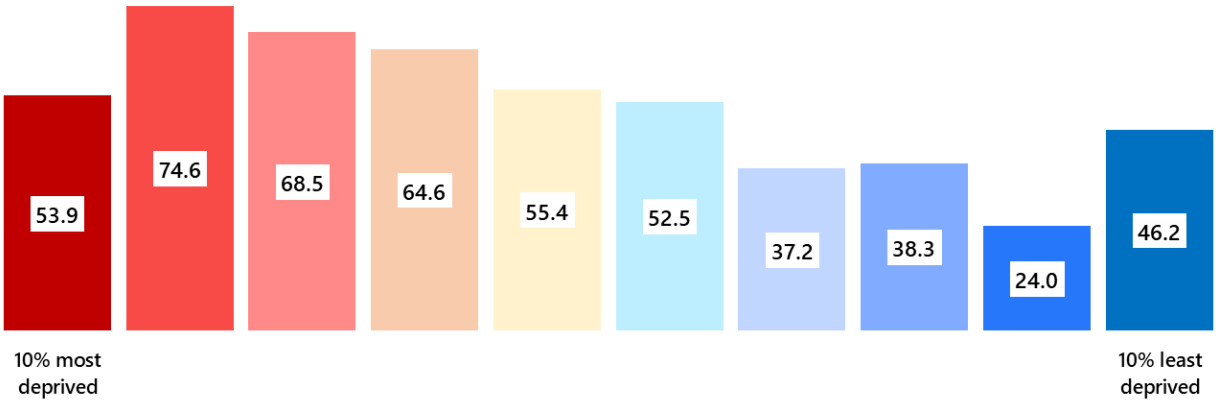


Consequently, if we can target what we do to focus on improving access to prevention and earlier, planned intervention in parts of the city, we may reduce the inequalities gap and improve health outcomes overall.

How is social deprivation in Southampton affecting social care usage?

Similar to healthcare, there is a strong link between deprivation and rates of social care usage. An example is shown below. The graph shows the rates of home care users (aged 65 and over, per 1,000 population) across the city and which deprivation decile they live in. In general, there are higher rates of home care users in the more deprived areas of the city than the less deprived areas of the city.

Rate of home care users in Southampton aged 65 and over, per 1,000 population, by deprivation decile



Protected characteristics and inequality

In addition to social deprivation, there is potential for individuals to experience inequality relating to protected characteristics.

Race and ethnicity

Southampton is an ethnically diverse city:

- **22.3% of Southampton's residents are from an ethnic group other than White British**, compared to 20.2% nationally (2011 Census).
- **Southampton has residents from over 55 different countries who between them speak 153 different languages** (2011 Census).
- Across Southampton, there is a wide variation in diversity; in Bevois ward, over half of residents (54.5%) are from an ethnic group other than White British compared to 6.8% in Sholing (2011 Census).
- **7,522 households (7.7%) in Southampton contain no one who speaks English as their main language**, compared to 4.4% nationally. Just under 12% of Southampton's resident population do not speak English as their main language, and this rises to nearly 24% in residents aged 25 to 34. The most common main language other than English is Polish, accounting for 3.6% of the total population.

People from black and minority ethnic (BAME) groups tend to have poorer socioeconomic circumstances, leading to poorer health outcomes. In addition, some communities may face barriers to accessing health and care services, for example because of cultural and language barriers.

Disability (physical and mental)

- **Disability-free life expectancy at birth for males in Southampton is 59.6 years**, compared to 62.9 nationally (2016-18). **Disability-free life expectancy at birth for females in Southampton is 58.2 years**, compared to 61.9 nationally (2016-18).
- **Around 200 children in Southampton in need due to disability or illness** (2018).
- **Around 123,000 people in Southampton have a long-term health condition** (such as diabetes, heart disease, epilepsy, breathing problems etc.). Over half of these people have two or more conditions for which they need ongoing support.
- **610 adults with a learning disability in Southampton receive long-term support from the local authority** (2018/19)
- **3.9% of supported working age adults with a learning disability in paid employment**, compared to 5.9% nationally (2018/19).
- **13.5% of people aged 16 years and over in Southampton have a long-term mental health problem**, compared to 9.9% nationally (2018/19).

Compared with the general population, people with severe mental illnesses are at substantially higher risk of long-term physical health conditions. Despite suffering greater ill health, people with a learning disability, autism or both often experience poorer access to healthcare. Older people, especially those with a disability and/or multiple or complex long-term physical health conditions and/or dementia, are likely to face barriers when accessing services, poorer health outcomes or poorer experience.

Religion or beliefs

- According to the 2011 Census, **51.5% of Southampton's population reported their religion to be Christian**, compared to just under 60% in England.
- **The second largest religion in Southampton is Islam**. In 2011, 4.2% of Southampton's population were Muslim, although there was significant variation; in Bevois ward this proportion rises to 19.5% of the population, followed by 9.6% in Bargate. The smallest Muslim population live in Sholing Ward (0.7%).

Age

Please refer to the earlier section on inequalities across the life course.

Other protected characteristics

There is currently no best source of information for sexual orientation and gender reassignment in Southampton.

Carers

- **The most common age of a carer living in Southampton is between 35 and 65 years**.
- From the 2011 Census, **over 20,000 family members and friends living in Southampton provide unpaid care**.
- The actual number of carers living in Southampton is estimated to be over 30,000 people (calculated as 12.5% of the population).
- The 2011 Census has also shown us that in Southampton, most carers provide between 1 and 19 hours of care per week; however, almost one quarter of Southampton's carers provide over 50 hours per week of care and support.
- Carers live in all areas of Southampton, although in the 2011 Census, more carers have been identified (over 1,400 each) in the wards of Bitterne, Coxford, Harefield, Peartree, Redbridge and Sholing.

Carers are twice as likely to suffer from poor health compared to the general population, primarily due to a lack of information and support, finance concerns, stress and social isolation. Young carers say they feel invisible and often in distress, with up to 40% nationally reporting mental health problems arising from their experience of caring (NHS Long Term Plan).

How does Southampton compare to England and similar areas?

The previous sections looked at how outcomes compare across Southampton. The tables below show how outcomes in Southampton compare to the England average and the peer average (areas similar to Southampton). In some instances, Southampton has worse outcomes compared to both the England average and the peer average.

	Comparison to the England average	Comparison to the peer average (similar areas)	Latest data
Children and Young People			
Teenage pregnancies	Worse	Worse	2017
Smoking during pregnancy	Worse	Worse	2017/18
Low birth weight of full term babies	Similar	Better	2017
Breastfeeding prevalence	Similar	Better	2016/17
Looked after children	Worse	Worse	2018
Children living in poverty	Worse	Similar	2016
Year R child obesity	Worse	Similar	2017/18
Year 6 child obesity	Worse	Worse	2017/18
16-17 year olds not in education, employment or training (NEET)	Worse	Worse	2018
First time entrants to the youth justice system	Worse	Worse	2017
Children attaining 5 or more GCSEs	Worse	Similar	2015/16
Adults			
Life expectancy (males)	Worse	Similar	2016-18
Life expectancy (females)	Worse	Similar	2016-18
Premature deaths – all causes	Worse	Better	2016-18
Premature deaths – cancer	Worse	Similar	2016-18
Premature deaths – cardiovascular diseases	Worse	Better	2016-18
Premature deaths – respiratory diseases	Worse	Similar	2016-18
Breast cancer screening	Worse	Similar	2019
Cervical cancer screening	Worse	Worse	2019
Bowel cancer screening	Worse	Worse	2019
Smoking prevalence	Worse	Similar	2017/18
Alcohol-specific emergency admissions	Worse	Worse	2018/19
Intentional self-harm emergency admissions	Worse	Worse	2018/19
COPD emergency admissions	Worse	Worse	2017/18
Major diabetic lower-limb amputations	Worse	Worse	2015/16 – 17/18
Depression and anxiety prevalence	Worse	Similar	2016/17
Adults with learning disability having a GP health check	Similar	Better	2017/18
Adults with learning disability in paid employment	Worse	Similar	2017/18
Persons detained under the Mental Health Act	Similar	Better	2019/20 Q2
People with long term Mental Health problems	Worse	Similar	2019
People in employment (aged 16-64)	Similar	Better	2018/19
Homelessness	Worse	Better	2017/18
Violent crime	Worse	Worse	2018/19

	Comparison to the England average	Comparison to the peer average (similar areas)	Latest data
Older People			
Excess winter deaths (85 years+)	Worse	Similar	Aug 17 – Jul 18
Suicide rate (65 years+)	Worse	Worse	2013-17
Deaths from respiratory disease (65 years+)	Worse	Worse	2016-18
Deaths from cardiovascular disease (65 years+)	Worse	Worse	2016-18
Households experiencing fuel poverty	Similar	Similar	2017
Adults living in income-deprived households (60 years+)	Worse	Better	2013
Dementia emergency hospital admissions	Worse	Worse	2017/18
Falls-related emergency hospital admissions (65 years+)	Worse	Worse	2018/19
Adults using social care who receive self-directed support, and those using direct payments (65 years+)	Worse	Worse	2018/19
End of Life			
% of deaths that occur in hospital (all ages)	Higher	Higher	2018
% of deaths that occur in care homes (all ages)	Lower	Lower	2018
% of deaths that occur at home (all ages)	Similar	Similar	2018
% of deaths in usual place of residence (all ages)	Lower	Lower	2017
% of deaths in usual place of residence - cancer (all ages)	Similar	Similar	2016
% of deaths in usual place of residence - circulatory disease (all ages)	Similar	Similar	2016
% of deaths in usual place of residence - respiratory disease (all ages)	Similar	Similar	2016
% of deaths in usual place of residence - dementia and Alzheimer's (all ages)	Lower	Lower	2015

Public Health England, Public Health Profiles, https://fingertips.phe.org.uk

	Worse than England/Worse than Peers
	Similar to England/Similar to Peers
	Better than England/Better than Peers

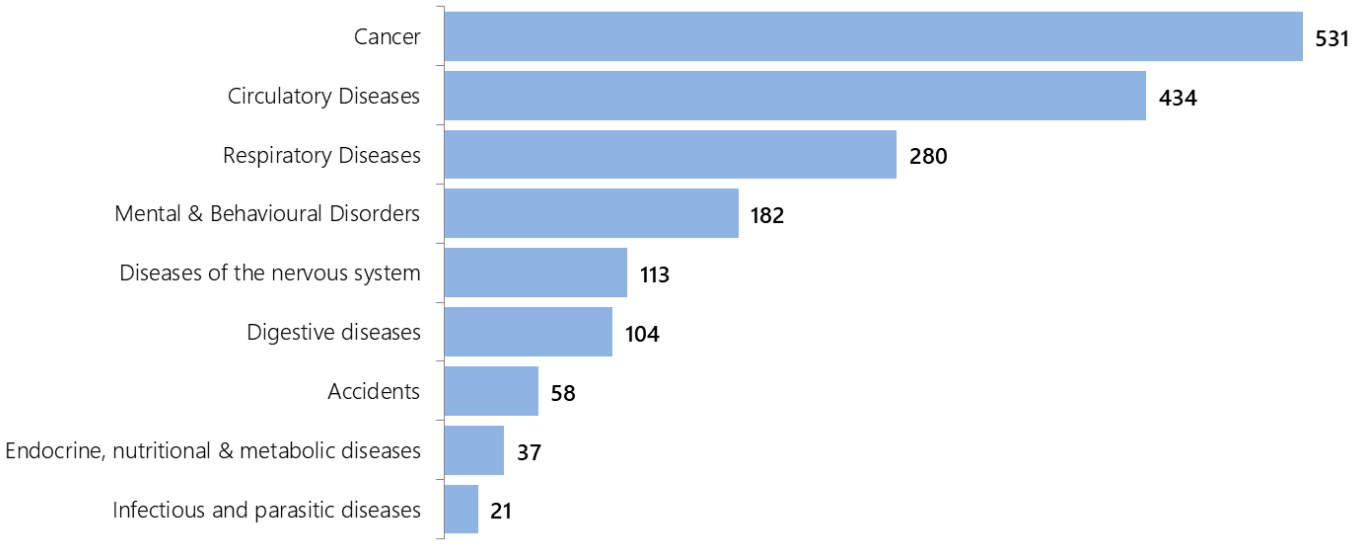
Blue colour coding is used for indicators where it cannot be determined whether a higher or lower value to the England/Peer average represents good or poor performance.

The three ‘big killers’ in Southampton

In Southampton, the three biggest causes of death are:

1. Cancer
2. Circulatory Diseases
3. Respiratory Diseases

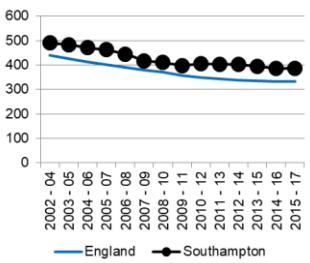
Causes of death in Southampton (2017)



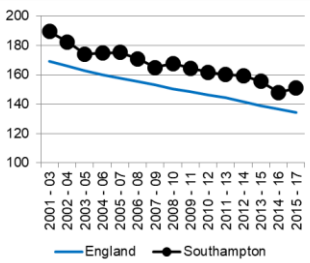
An important indicator to look at is deaths under the age of 75 years, known as ‘early’ or ‘premature’ deaths. The graphs below show the rate of early deaths in Southampton compared to the England average. Despite Southampton’s early death rate falling over the last two decades, it is still significantly higher than the England average.

Early/premature deaths (people aged under 75) Rate per 100,000 population

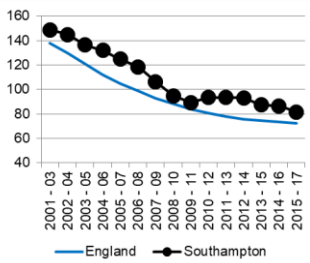
All causes



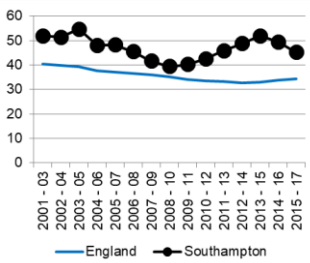
Cancer



Cardiovascular



Respiratory



Future Health and Care Challenges

Population growth

In Southampton, it is estimated that between 2018 and 2024, the city could have 12,300 more residents. This is equivalent to an almost 5% increase.

2,730 more children and young people (5.5% increase)

4,530 more working age adults aged between 18 and 64 (2.7% increase)

5,030 more older people aged over 65 (14.5% increase)

The age group with the biggest percentage increase will be the older population, and we know that a growing and ageing population will add more pressure onto the city's health and care services.

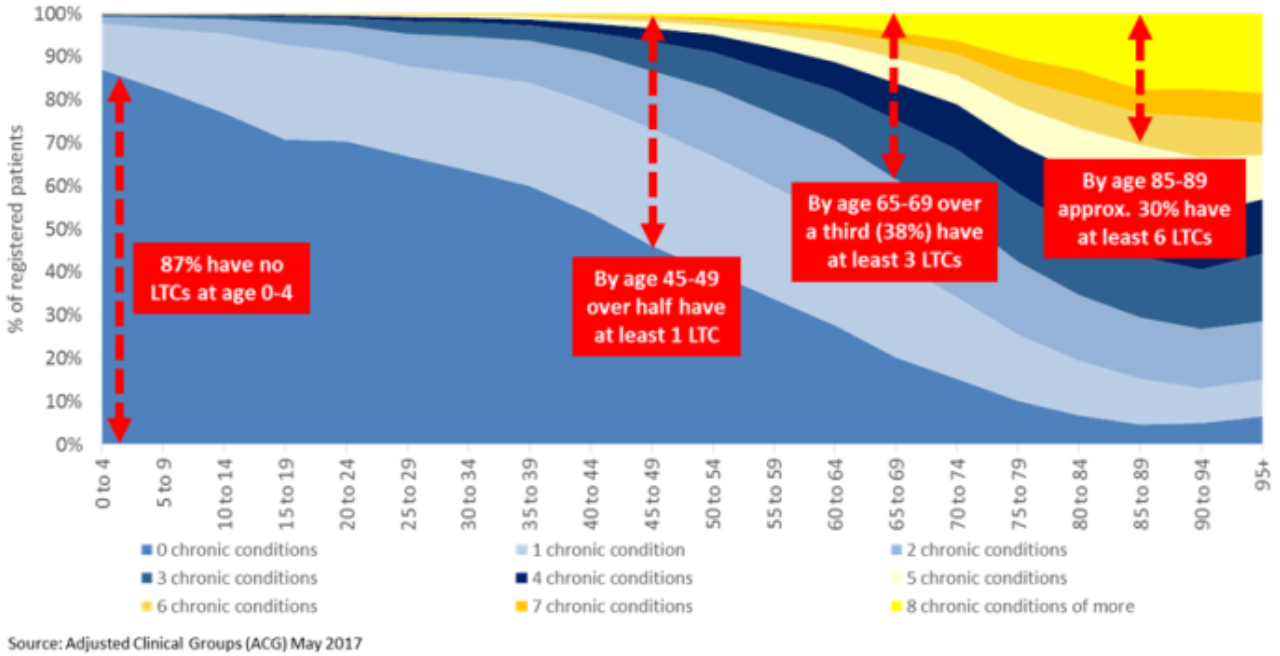
Long term conditions

Long term conditions, or chronic diseases, are those for which there is currently no cure and are managed with drugs and other treatment, such as diabetes, chronic obstructive pulmonary disease (COPD), arthritis and hypertension.

Long term conditions in Southampton are more prevalent in older people – the graph below shows that approximately 30% of older people aged 85-89 have at least 6 long term conditions.

However, long term conditions are also becoming more prevalent in Southampton's working age adult population. By age 45-49, at least half of this population have at least one long term condition. We also know that long term conditions are more prevalent in people living in the more deprived areas of the city.

Number of long term conditions by age band (Southampton residents)



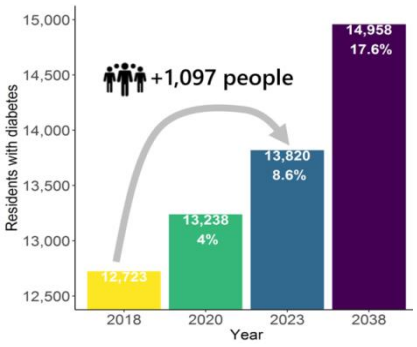
Source: Adjusted Clinical Groups (ACG) May 2017

By combining population estimates with current trends in long term conditions, we have been able to forecast increases in long term conditions for our population. Increases in the prevalence of these conditions will add further pressure onto the city's health and care services.

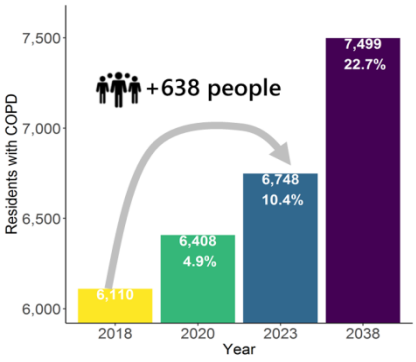
The graphs below show the forecast increases in the number of residents with long term conditions, against a baseline of 2018.

Estimated future increases in people in Southampton living with long term conditions (2018 to 2023)

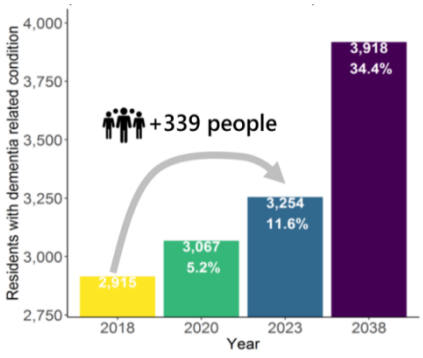
Diabetes



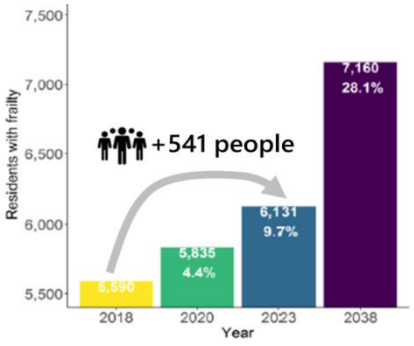
COPD



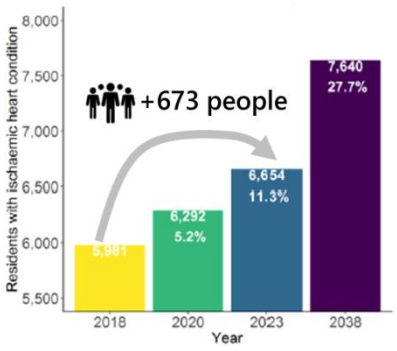
Dementia



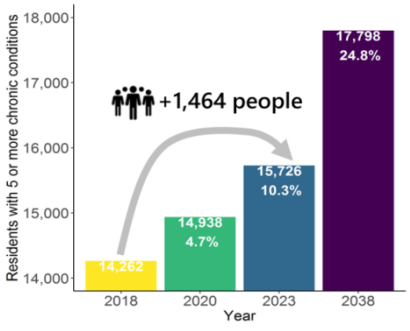
Frailty



Coronary Heart Disease



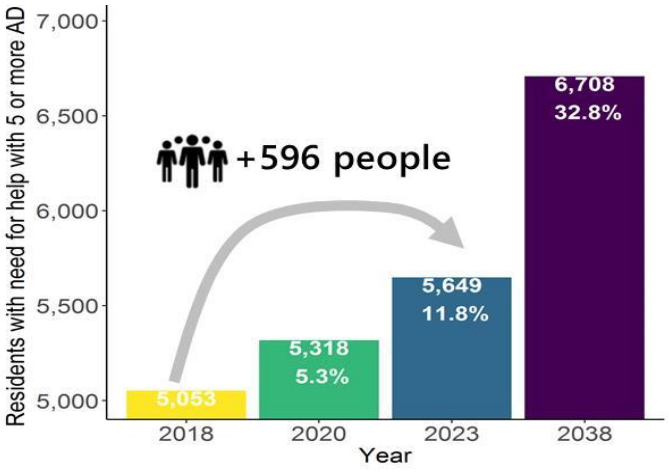
5 or more long term conditions



Adult social care

By combining population estimates with current trends in adult social care demand, we have also been able to forecast increases in people needing adult social care support. The number of people needing home care support with five or more activities of daily living (such as bathing, using the stairs, getting dressed) is estimated to increase by 596 people (11.8%) between 2018 and 2023.

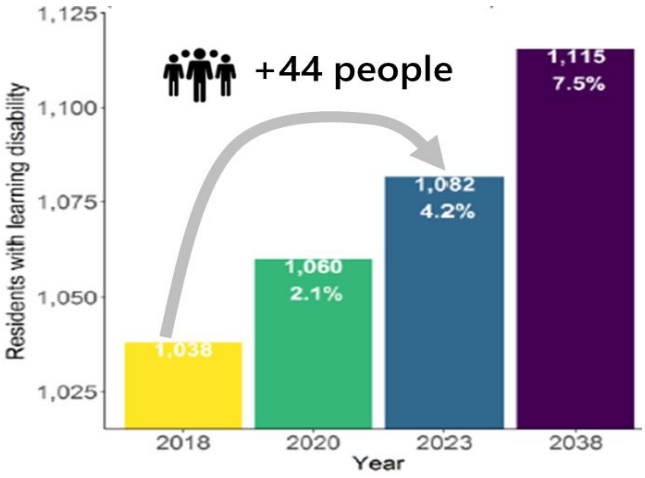
Estimated future increases in people in Southampton needing home care support (2018 to 2023)



Learning disabilities

We have also been able to forecast increases in people with a learning disability. Between 2018 and 2023, the number of people with a learning disability is estimated to increase by 44 people (4.2%).

Estimated future increases in people in with a learning disability (2018 to 2023)



COVID-19 Impact

COVID-19 illness and death

People with pre-existing and serious conditions are more vulnerable to serious illness and death from COVID-19.

- Of the 33,841 deaths that occurred in March and April 2020 involving COVID-19 in England and Wales, 30,577 (90.4%) had at least one pre-existing condition, while 3,264 (9.6%) had none (ONS).
- Males had a significantly higher rate of death due to COVID-19; the age-standardised mortality rate (ASMR) for males in England was 781.9 deaths per 100,000 males compared with 439.0 deaths per 100,000 females (ONS).
- Research is underway to better understand why BAME groups are over-represented in deaths from COVID-19 (likely factors include deprivation, geography at ward level, occupation and that some BAME groups are at higher risk of some underlying health conditions).

In addition, although all age groups are at risk of contracting COVID-19, older people face significant risk of developing severe illness if they contract the disease due to physiological changes that come with aging and potential underlying health conditions.

- In April 2020 in England and Wales, 91% of deaths from COVID-19 were in people aged 65 years or over (ONS).
- In April 2020 in England, dementia and Alzheimer's disease was the most common main pre-existing condition found among deaths involving COVID-19 and was involved in 6,887 deaths; 20.4% of all deaths involving COVID-19 (ONS).

Mental Health

Social distancing and the impacts of lockdown will (for many) exacerbate existing conditions such anxiety and depression, and create "new" mental health needs. There is a high risk that social distancing may turn into 'social isolation' for those without a strong network of family and friends and a way to connect to others outside the home (known higher risk groups are men, older people and those that live

alone). Financial stress, being out of work, and "juggling" work and family life, and sudden loss of loved ones (bereavement) will also be contributing to mental health stress. A summary of the mental health impacts of COVID-19 across the life course is shown below.

Mental Health impacts of COVID-19 across the life course

	Pre-Term	0-5 Years	School Years	Working Age Adults	Old Age
Key issues to consider	• Anxiety about impact of COVID on baby • Financial worries • Anxiety about delivery and access to care • Isolation	• Coping with significant changes to routine • Isolation from friends • Impact of parental stress and coping on child	• School progress and exams • Boredom • Anxiety or depression or other MH problems • Isolation from friends • Impact of parental stress	• Balancing work and home • Being out of work • Carer Stress • Anxiety about measures and family or dependents or children • Financial Worry • Isolation	• Isolation and disruption of routine • Anxiety from dependent on services • Financial worry • Fear about impact of COVID if infected
Staff/ Vols	Cumulative load of stress from significant changes. Traumatic incidents. Isolation from work colleagues. Having to manage working from home. Potential bullying from or to others as part of not coping				
Loss	**Loss of loved ones dying may be particularly severe and grieving disrupted because of inability to do normal grieving rites eg as be physically close to dying person, have usual funeral rites, attend funeral etc**				
Specific Issues	**Impact of delayed diagnoses and treatment (eg chronic conditions,surgery, people living in pain)**. Suicide and self harm risk for most at risk populations. Members of faith communities may feel disconnected during closure of premises. Domestic abuse may be issues across lifecourse. Drug and Alcohol issues .People reliant on foodbanks or on low incomes or self employed may have additional stress.				

Physical Health

The lockdown has been positive for many adults' physical health (and an opportunity to encourage positive behaviour change), though has been negative for others.

- People at higher risk of doing less physical activity are those that are isolated, which can lead to more sedentary behaviours.
- People living in areas of deprivation are likely to consume poorer quality diets and the impact of the pandemic on income and job security is likely to exacerbate the situation leading to both food insecurity and consumption of an energy dense diet low in nutrients among those at greatest risk. Poor quality diet is a risk factor for a range of chronic conditions including diabetes, hypertension, cardiovascular disease and some cancers and is also a risk factor for obesity.
- As a consequence of self-isolation, older people may lack access to nutritious food, basic supplies, money, and medicines to support their physical health and social care.

Vulnerability

There is thought to be a high level of "hidden" need in as a result of the pandemic and lockdown measures, including domestic violence and abuse and drug and alcohol use. These, with mental health needs in parents, will be impacting on the wellbeing of children and young people. As well as being clinically more vulnerable to the symptoms of COVID-19, older people can also be vulnerable from a social perspective; they are more likely to be the victims of scams for example. However, there is also a risk that given their "clinically vulnerable status" to COVID-19, old age is presented as a condition of frailty and vulnerability, when we want to empower older people

Our five year strategy

2020-2025

Southampton City Health and Care Strategy

2020-2025

Our vision

A healthy Southampton where *everyone* thrives

The vision we share in Southampton is about enabling everyone to live long, healthy and happy lives, with the greatest possible independence.

We will do this by:

- Reducing **inequalities** and confronting **deprivation**
- Improving **mental and emotional** wellbeing
- Tackling the city's **biggest killers**
- Improving **earlier help, care and support**
- Working with people to build **resilient communities** and **live independently**
- Improving **joined-up, whole-person care**

Our priorities

We want to improve outcomes for the whole population, right across the main life stages, from birth to death. Our strategy will therefore take a life course approach, focusing on the following priorities:

Start Well

Children and young people get the best start in life, are able to achieve the best opportunities and keep as healthy and well as possible throughout their lives

Live Well

People enjoy and are able to maintain a sense of wellbeing and good health, supported by resilient communities

Age Well

People are able to live independently in their own homes with appropriate care and support to maintain and develop their social and community networks

Die Well

People are supported to ensure the last stages of their life happen in the best possible circumstances, receiving the right help at the right time from the right people

Five key enabling priorities span the whole strategy, across all life stages:

Digital	Workforce	Estates	Primary Care	Urgent & Emergency Care

What do we mean by Start Well, Live Well, Age Well and Die Well?

Start Well

- I feel happy and safe
- I have green and open spaces I can visit or play in and am able to walk or cycle to and from places
- I feel like I can influence my own future
- I feel like I belong

Live Well

- I can take care of my own health and wellbeing and am able to manage the challenges life may give me
- I lead a happy, fulfilling and purposeful life
- I feel supported by my family, friends and local community

Age Well

- I can take care of my own health and wellbeing and am able to manage the challenges life may throw at me
- I have the information I need and I'm supported to understand and make choices
- I lead a happy, fulfilling and purposeful life
- I can continue to do what matters to me and be the person I want to be
- I am in control of my physical and mental health
- My family's/carer's needs are recognised and supported
- I feel a valued and respected member of my community

Die Well

- I will be asked for my end of life wishes and will be able to die, where practically possible, in my preferred place of care
- I know that when I die, this will happen in the best possible circumstances
- My family, friends and all those important to me will be supported throughout my end of life journey and if needed after my death.

Our key ambitions

By 2025, we will:

Start Well

- ↓ Reduce the percentage of mothers smoking during pregnancy
- ↓ Reduce the rate of teenage pregnancies
- ↑ Increase the percentage of mother's breastfeeding 6-8 weeks post birth
- ↓ Reduce the rate of looked after children
- ↑ Increase the percentage of care leavers in suitable accommodation
- ↓ Reduce the percentage of children in Year R and Year 6 with excess weight
- ↑ Increase the percentage uptake of healthy child mandated immunisations and health checks
- ↑ Increase the percentage of children achieving a good level of development at the end of reception
- ↑ Increase the percentage of children reporting positive mental health at Year 7
- ↓ Reduce the rate of first time entrants to the youth justice system
- ↓ Reduce the percentage of 16-17 year olds not in education, employment or training (NEET)

Live Well

- ↑ Increase healthy life expectancy
- ↓ Reduce the gap in life expectancy between the most and least deprived areas of the city
- ↓ Reduce smoking prevalence in adults
- ↓ Reduce the percentage of adults who are physically inactive and/or obese
- ↓ Reduce alcohol-related mortality
- ↓ Eliminate all inappropriate out of area mental health placements
- ↓ Reduce the rate of suicides
- ↑ Increase the percentage of adults with a learning disability living in settled accommodation
- ↑ Increase the percentage of cancers being diagnosed at an earlier stage
- ↓ Reduce early deaths from cardiovascular disease and respiratory disease
- ↑ Increase the number of social prescribing referrals
- ↑ Increase the number of people being referred to the national diabetes prevention programme

Age Well

- ↑ Increase the number of older people with a personalised care and support plan
- ↓ Reduce the number of older people being referred for adult social care
- ↓ Reduce the rate of emergency hospital admissions, including readmissions
- ↓ Reduce the rate of older people having discharge delays from hospital (delayed transfers of care)
- ↑ Increase the percentage of older people receiving reablement care after hospital discharge
- ↓ Reduce permanent inappropriate admissions into residential care
- ↑ Increase the number of carers having a carer assessment and receiving appropriate support
- ↑ Increase access for older people with a common mental illness to psychological therapies
- ↑ Increase the number of volunteers supported to find a volunteering opportunity
- ↓ Reduce the percentage of older people reporting that they feel lonely

Die Well

- ↑ Increase the percentage of people in the last 3 years of life who are registered on a local end of life register
- ↑ Increase the percentage of people who have, or are offered, a personal health budget towards end of life (fast-track)
- ↓ Reduce the average number of patients per month who die in hospital whilst being delayed to be discharged
- ↓ Reduce the percentage of older people who die within 7 days of an emergency hospital admission
- ↓ Reduce the percentage of older people who die within 14 days of an emergency hospital admission

Digital

- ↑ Increase the number of people using care technology
- ↑ Increase the percentage of people accessing services digitally
- ↑ Increase the percentage of people electronically managing appointments
- ↑ Increase the number of people using self-management apps, such as MyCOPD
- ↑ Increase the use of single care plans
- ↑ Increase the number of patients using MyMedicalRecord

Workforce

- ↓ Reduce clinical staff turnover rates in the first 12 months of employment
- ↓ Reduce non-clinical staff turnover rates in the first 12 months of employment
- ↓ Reduce vacancy rates

Estates

- ↑ Increase extra care housing
- ↑ Increase key worker housing
- ↑ Increase older people rehabilitation bed capacity
- ↑ Increase general intensive care unit capacity
- ↑ Increase operating theatre capacity

Primary Care

- ↑ Increase the number of primary care appointments per 1,000 patients
- ↑ Increase the uptake of digital access, such as video consultations and e-consultations
- ↑ Increase the number of patients directly booking primary care appointments via NHS 111
- ↑ Increase the number of social prescribing referrals

Urgent and Emergency Care

- ↑ Increase the percentage of patients whose needs are addressed through a single call to NHS 111
- ↓ Reduce the percentage of patients advised to attend ED following a call to NHS 111
- ↑ Increase the percentage of emergency hospital admissions receiving same day emergency care
- ↑ Sustain achievement of new urgent and emergency care standards

During 2020, we will work up quantified performance targets for a smaller set of key metrics which will be monitored and reported on a tri-annual basis at the Better Care Southampton Board. Other metrics will be monitored elsewhere. Additional metrics may also be brought in over the next five years, depending on emerging priorities, such as from COVID-19.

Start Well

Start Well

Children and young people get the best start in life, are able to achieve the best opportunities and keep as healthy and well as possible throughout their lives

What do we want to be different in five years' time?

We want children and young people in Southampton to:

- Live happy, healthy lives, with good levels of physical and mental wellbeing.
- Be safe at home and in the community, with Southampton being a child-friendly, family focused city.
- Have good levels of educational attainment, fulfil their potential and go on to successful opportunities in adulthood.
- Live in communities which are resilient, engaged and prepared for the future.

How will we do this?

Reducing inequalities and confronting deprivation

We want to address the impact of inequalities and child poverty through the city's strategies and policies whilst also breaking the cycle for future generations. We will:

- Implement the extended **Early Help Locality Model,** building skills, confidence and capacity to hold more risk in Early Help, strengthening the advice, information and guidance offer and increasing outreach support to families with pre-school children.
- Improve the uptake of **early years education** offer.
- Use tools such as **adverse childhood experiences** (ACEs) to identify those children most at risk of poor outcomes and use this intelligence to target services to reduce their impact through childhood, adolescence and into adult life.
- Implement the city's **Teenage Pregnancy** Action Plan.
- Expand **long-acting reversible contraception** services in maternity and primary care.
- Improve birth outcomes by **promoting healthy pregnancies**, including smoking cessation support.
- Implement the **Phoenix specialist family service** that will provide an intensive programme of support and work with women in Southampton who have experienced, or are at risk of, repeated pregnancies that result in children needing to be removed from their care.

- Strengthen early help services for **children with Special Education Needs and Disabilities** (SEND) and their families.
- Develop an inclusive educational offer, implementing the **school improvement and attendance action plan** and reconfigure specialist educational provisions to meet local need.
- Through the **Safe City Partnership**, support delivery of preventative health work and targeted interventions to implement the Domestic and Sexual Abuse strategy and reduce serious violence involving young people in line with the Youth violence reduction strategy.
- Improve outcomes for **looked after children and care leavers** through:
  - Developing the **foster care** offer to ensure a greater mix of foster care placements which reflect the needs of the city.
  - Expanding the range of **good quality local placements** available to enable more children, where appropriate, to remain within the city.
  - Improve access to good **housing and employment options** for care leavers within the city.

Tackling the city's biggest killers

A healthy pregnancy and childhood are key enablers to achieving good health in later life. By embedding positive health behaviours in childhood, such as healthy eating and physical activity, life chances in adulthood can be improved. We will:

- Increase **play, physical activity** and positive youth opportunities.
- Improve uptake of **Healthy Early Years Award and Healthy High 5 Award** in schools.
- Ensure that the refresh of the council's Local Plan (the plan for the future development of the city) supports health and wellbeing, including **restrictions on fast food** planning applications near schools.
- Reduce **risky behaviours** by delivering the city's Sexual health improvement Plan, Alcohol Strategy and Healthy Weight Strategy.
- Continue to promote the development of **healthy settings**.
- Improve the quality of care for children with **long term conditions** such as asthma, epilepsy and diabetes and their transition to adulthood.
- Ensure that there is a strong focus on **promoting good health in the first 1,000 days of a child's life** as this is a critical phase during which the foundations of a child's development are laid, including:
  - Promoting uptake and continuation of **breastfeeding**.
  - Promoting **smoking cessation/smoke free homes** amongst pregnant women and parents.
  - Continuing to ensure good uptake of **childhood immunisations**.
- Develop a robust and sustainable **hospital at home** service to support the care of children with acute childhood illness outside of hospital with access to expert paediatric advice and rapid clinic access.

Improving mental and emotional wellbeing

One in eight 5-19 year olds have at least one mental disorder; suicide is the biggest killer of young people in the UK; 50% of mental health problems are established by age 14 and 75% by age 24. Improving children and young people's mental health and wellbeing is a whole system effort which relies on strong partnership working. We will:

- Increase access to **perinatal mental health** services up to 24 months after birth, including support to partners.
- Implement **mental health support teams in schools and colleges** and promote a whole school approach to mental health and wellbeing across Southampton.
- Improve assessment and support for children with a **learning disability and neuro-diversity**.
- Promote **social and emotional resilience** and embed prevention and early intervention across the system.
- Improve services for children and young people with **eating disorders**.
- Improve **access** – 'no wrong door'.
- Ensure that mental health services are **accessible to the most vulnerable**.
- Work together to better meet the needs of young people with **complex social, emotional and behavioural needs**.
- Improve **crisis care** pathways for children in mental health crisis and improve access to specialist mental health treatment and support.
- Inform and support and the implementation of the **Southampton Suicide Prevention Plan**.

Supporting people to build resilient communities and live independently

We want to develop a 'Child Friendly Southampton' where the aspirations, needs and rights of children are a central part of public policies, place-shaping and decision-making and ensure children and young people in Southampton have an active role as part of their communities and have the best possible start in life, whatever their circumstances. We will:

- Delivery of the **Year of the Child 2020**: bringing together the city's businesses, arts and cultural venues, voluntary and community organisations, and practitioners who work with children to provide a year-long programme of consultative and celebratory events.
- Develop **intergenerational activities**, recognising the positive contribution that children and young people make to the city.

Improving earlier help, care and support

All children and young people should have a good start in life. Early help and prevention is about building protective factors and reducing harm at the earliest stage so children and young people have the best opportunities to thrive. We will work together with parents, families, carers and communities to do this, providing the right help at the right time. We will:

- Implement the extended **Early Help Locality model**, strengthening advice, information and guidance and outreach support to families with pre-school children, enabling them to receive the right support at the right time in their communities.
- Develop the **Early Help Hub** as a single route into early help and expand the community/voluntary sector offer.
- Strengthen **support to families in the early years**, including action to promote early communication (speech and language).
- Strengthen the **parenting** offer.
- Expand the options and support available to young people, including those with SEND, for further **education & training, employment, independent living and social inclusion**.
- Support **continuity of care** for pregnant women by implementing case-holding.
- Increase information and support in the community on **management of common childhood illness**.
- Improve the **transition** for young people with additional needs into adulthood, including giving them control over their own personal health budgets to meet

Improving joined-up, whole-person care

The needs of children and families are best met if they are considered in the round with health, care and education working together in a child/family centred way. We will:

- Continue to work in partnership across the Local Authority, NHS and Voluntary/ Community sectors to build a **strong, joined-up service** offer based on restorative principles and a whole family approach.
- Develop **peer support** models.
- Empower children and families to have more **choice and control**.

What is our roadmap?

Year 1
2020/21

- **Year of the Child**
- **Early Help locality model** extended
- Local **foster care offer** expanded
- Two **mental health support teams** in schools established
- **Phoenix specialist family service** goes live
- Implementation of **children's psychiatric liaison service**
- **Care pathways implemented** for all mental health presentations and will be hosted on the Healthier Together website.

Year 2
2021/22

- **Children's Hospital at Home** service goes live
- Expansion of **mental health support teams in schools** and a whole school approach to mental health and wellbeing
- **Employment and training opportunities** expanded for young people
- **Perinatal mental health services** expanded for women and partners up to 24 months post-natal
- Pilot a **whole school approach to mental wellbeing**
- Development of **local residential** provision

Year 3
2022/23

- **0-25 year service** offer in place
- Expansion of **mental health support teams in schools**
- **Employment and training opportunities** further expanded for young people

Year 4
2023/24

- **24/7 mental health crisis provision** for children and young people that combines crisis assessment, brief response and intensive home treatment functions
- Comprehensive offer for 0-25 year olds that spans across **mental health services for young people and adults**

Year 5
2024/25

- Progress towards halving **still births, neonatal deaths and maternal deaths**

Live Well

Live Well

People enjoy and are able to maintain a sense of wellbeing and good health, supported by resilient communities

What do we want to be different in five years' time?

We want people in Southampton to:

- Live healthier, for longer
- Be happy in life and feel supported by their family, friends and local community
- Live independently and feel confident to take care of their own health and wellbeing
- Live in a city which is fully accessible

How will we do this?

Reducing inequalities and confronting deprivation

- Improve **equality, diversity and inclusion** across all services and settings.
- Population health management systems will enable health and care staff to **identify people most at risk of ill health and identify areas of the city where health inequalities are greatest** – this will ensure that resources can be targeted at people with the greatest need.
- Improve **access to appointments in general practice**, such as evening and weekend appointments, and longer appointments for people with multiple long term health conditions.
- For people with a **learning disability or severe mental illness**, improve the uptake of annual health checks and cancer screening.
- Improve **uptake of cancer screening** in areas of the city with the lowest uptake rates, and focus on vulnerable groups. Undertake community engagement to raise the profile of cancer screening.
- Improve uptake of **immunisations and vaccinations** in areas of the city with the lowest uptake rates, and focus on vulnerable groups.
- Improve access to advice, treatment and support to anyone concerned by their, or someone else's, use of **drugs or alcohol** to help them overcome the impact and improve their lives.
- Ensure access to services that improve **sexual health** outcomes for everyone.
- Reduce the number of **rough sleepers**.

- Explore different ways to help those sleeping on the streets and those who are **homeless** to access a range of service and accommodation options.
- Reduce the health inequalities of the **homeless** population through increased access to healthcare and accommodation.

Tackling the city's biggest killers

- Implement a new **stop smoking support and development team** and deliver the city's tobacco control plan.
- All **patients at hospital will be asked if they smoke** and all smokers are offered support and advice to quit.
- Support patients to **improve their health before undergoing major surgery**, to help them recover better, such as by being more active.
- Implement the city's **physical activity and sports strategy**, including active places, active communities and active every day.
- Improve people's awareness of and understanding of the health risks associated with drinking too much **alcohol**.
- Increase the number of people successfully completing treatment and not re-presenting for **alcohol, opiates and non-opiates**.
- Continued **Alcohol** care team support at University Hospital Southampton, supported by community substance use disorder services.
- Promote **'making every contact count'**, where all health and care staff, when the opportunity arises, have a brief conversation with an individual to encourage changes in their behaviour that have a positive effect on their health and wellbeing.
- Embed **prevention of risk factors** including smoking, alcohol, obesity and physical activity in all health and care pathways so that all patients will receive a brief intervention or be signposted to appropriate support.
- Increase coverage and effectiveness of **cancer screening** services, including:
  - Increasing the uptake of Faecal Immunochemical Testing (FIT), helping to **detect colorectal cancer as quickly as possible**.
  - Implementing the Targeted Lung Health Check programme to **detect lung cancer** in 55–74 year olds at an earlier stage.
  - Implementing the **cancer Faster Diagnosis Standard**, resulting in patients receiving either a positive or negative diagnosis of cancer within 28 days.
- Implement **cardiovascular disease prevention and detection** programmes within primary care, including increasing the number of people at risk of stroke on anti-coagulation drugs.
- Expand **Cardio-Pulmonary Rehabilitation** to increase the number of patients being offered and accessing rehabilitation.
- Expansion of **community respiratory services** to improve earlier diagnosis, management and treatment of all respiratory disorders.

- Increase **diabetes risk detection** and the number of people offered and completing the Diabetes Prevention Programme and Structured Education Programmes
- Ensure that the refresh of the council's Local Plan (the plan for the future development of the city) supports health and wellbeing, including **green city and healthy environments**.
- Encourage and support **healthy settings** across the city, such as healthy workplaces, healthy living pharmacies, healthy universities and healthy homes.
- Develop proposals to improve the **local food environment**. including tackling diet related ill-health and food poverty, transforming catering and procurement, reducing food waste and promoting a sustainable and vibrant food economy.

Improving mental and emotional wellbeing

- Implement "The Lighthouse" – a new community based facility that will support individuals in a recovery-focused way to manage their **mental health crisis**.
- Increase access to specialist community **perinatal mental health services** with extended periods of care from pre-conception to 24 months after birth.
- Improve access to **psychological therapy**, including expanding psychological therapy and wellbeing support for people with a **long term health condition**.
- Implement national guidance to improve outcomes for **people with co-occurring mental health and substance use conditions**, through the development and implementation of a strategic plan.
- Develop the **attention deficit hyperactivity disorder (ADHD)** pathway to provide integrated support for those with frequently occurring mental health co-morbidities and substance use conditions.
- Improve the uptake of **physical health checks** for people with SMI.
- Deliver a new model of **integrated primary and community care** for adults with serious mental illness (SMI).
- Increase access to Individual placement support (IPS) to **support people with SMI to find employment**.
- Improve 24/7 community based **crisis response and intensive home treatment service** to help prevent people being unnecessarily admitted into hospital.
- Inform and support the implementation of the **Suicide Prevention Plan** and the Hampshire and Isle of Wight STP Suicide Prevention programme, which includes action on self-harm, primary care, bereavement services and workplace health.
- Increased access to mental health services for **rough sleepers**.
- City-wide tackling of **mental health anti-stigma**, through communications, campaigns and events, and through supporting the Time to Change partnership.

Supporting people to build resilient communities and live independently

- Build opportunities, through volunteering and So Linked, to **help more people to access support and activities in the community**.
- Promote relationships between GP practices and voluntary and community groups to increase **social prescribing**.
- Maximise the use of **care technology**, to support people to self-manage their conditions and live independently.
- Link people up to support already available in their own families and communities.
- Ensure that **carers** have the help and support they need.
- Provide **short term, tailored social care** support to keep people independent in their own homes.
- Support younger generations to **prepare for older age**.
- **City of Culture** – improve overall wellbeing through cultural development and opportunities.
- Support adults to live independently through appropriate and accessible **housing options** with varying levels of flexible support.
- Work with people to **plan ahead** so they can prevent problems from getting worse and stay independent, reducing the likelihood of needing long term social care.
- Enable more individuals with **learning disabilities** to access community resources, volunteering, employment or other meaningful activities.
- Ensure **housing for people with learning disabilities** it is fit for future needs.
- Explore opportunities to apply for **Disabled Facilities Grants (DFG) for supported living housing adaptations** which will enable people with learning disabilities to live more independently, including improving fire safety.

Improving earlier help, care and support

- Develop easy access to **advice and information**.
- Ensure that **carers** feel supported and receive the help they need.
- Implement **e-consultations and video consultations** into all GP practices.
- Commission an increased range of health services from community **pharmacies**.
- **NHS 111 is the main gateway** used by patients to urgent care.
- Develop **clinical assessment within NHS 111** to include a wide range of clinical expertise so more people get the help and advice they need on a single call.
- Communication and education for patients and communities on **'choose well' and 'stay well'**, to enable patients and carers to make informed decisions about the services they choose.

Improving joined-up, whole-person care

- Implement new models of **person-centred care for people with long term conditions**, such as longer appointments with a named GP or alternative clinician.
- Improve IT systems interoperability across GP practices to **improve access to information and patient records** to support assessment.
- Ensuring people have more **choice and control** about their care, such as making personal health budgets available to a greater range of people.
- Implement **personalised care for everyone diagnosed with cancer** to ensure they have a needs assessment, a care plan, wellbeing information and support.

What is our roadmap?

Year 1 2020/21	▪ **Lung Health Checks** national pilot fully implemented to increase the early detection and survivorship of lung cancer ▪ All patients have access to **on-line and video consultations** for their GP surgery ▪ People with a **mental health** condition will be offered a range of self-management apps, digital consultations and digitally enabled therapy ▪ Transformation of **Outpatient Cardiology and Respiratory** services and develop community diagnostics focused on earlier diagnosis of disease. ▪ Psychological therapy support available for people with cardiovascular or gastrointestinal conditions ▪ Development of an **Integrated Diabetes Service** that will be measured on improving outcomes for patients living with diabetes ▪ Introduce risk stratification to identify individuals with a **learning disability** who have the greatest need ▪ Expand portfolio of **housing options** for those with a learning disability/mental health need ▪ Implement "**The Lighthouse**" community based facility to support those experiencing a mental health crisis ▪ Pilot an enhanced service in **Homeless Healthcare** to work with people with complex needs, including mental health ▪ Review best practice models for mental health services accessed by **rough sleepers**
Year 2 2021/22	▪ Patients will be able to receive a **definitive cancer diagnosis** within 28 days of referral ▪ **Cervical screening** implemented at more flexible timings ▪ New Southampton **Drugs, Alcohol and Tobacco** Strategy launched ▪ People with **Cardio-respiratory** disorders including breathlessness will be diagnosed and managed in the community. ▪ People with a **mental health** condition will be able to access digitally-enabled therapy ▪ **Therapeutic care** from inpatient mental health services will be improved ▪ Produce a proposal for an effective mental health pathway for **rough sleepers** to access integrated holistic, long term care and support
Year 3 2022/23	▪ Community **Cardiology and Respiratory** service fully in place ▪ Implement new mental health services for **rough sleepers** ▪ Every person diagnosed with cancer will have access **to personalised care**, including a care plan and health and wellbeing information and support ▪ **Follow-up support** for people who are worried their cancer may have recurred will be in place -
Year 4 2023/24	▪ Visibly improved **healthier food environment** in NHS and other public sector settings in Southampton
Year 5 2024/25	▪ 150 new **supported living tenancies** in place for adults with learning disabilities.

Age Well

Age Well

People are able to live independently in their own homes with appropriate care and support to maintain and develop their social and community networks

What do we want to be different in five years' time?

We want older people in Southampton to:

- Be able to maintain their health, wellbeing and independence into old age, stay living in their own homes and feel part of their local communities.
- Be supported to recover from illness in their own home wherever possible and only go to or stay in hospital when needs can't be met in the community.
- Be supported by collaborative and integrated working between health, social care and housing support.
- Be able to access the right support, at the right time, in the right place, as close to home as possible.
- Feel in control of their health and wellbeing, be part of any decision about their care and have the information and support they need to understand and make choices.

How will we do this?

Reducing inequalities and confronting deprivation

Health and care outcomes are poorer in parts of city with higher levels of deprivation. 19% of older people aged 60 years+ in Southampton live in poverty. Older people are more vulnerable to fuel poverty which impacts on their ability to keep their homes warm and enable them to keep healthy. They are also more susceptible to poor nutrition, as well as COVID-19. We will:

- Develop **community based support and activities** across the city.
- Development of integrated **community transport** services to reduce isolation and improve engagement in community activities.
- Work as a city to provide **good quality housing and warm homes**.
- Improve **access to appointments in general practice**, such as longer appointments for people with multiple long term health conditions.
- Develop an **Eat Well** offer across the city, ensuring that older people receive nutritious food.
- Population health management systems will enable health and care staff to **identify people most at risk of ill health and identify areas of the city where health inequalities are greatest** – this will ensure that resources can be targeted at people with the greatest need.
- Promote an approach to services which works for this population, including virtual and face to face methods.

Tackling the city's biggest killers

As with all age groups, how people choose to live their life remains vitally important to improving and maintaining health and wellbeing throughout older age. This includes being active, eating a healthy diet, maintaining a healthy weight, being smoke-free, and not exceeding the recommended limits for alcohol intake. We want to promote the importance of healthy lifestyles and early identification and screening. We will:

- Promote **healthy ageing**, including healthy eating, physical activity, smoking cessation and reducing alcohol consumption.
- Ensure that the **design of our neighbourhoods** positively influences physical activity levels, travel patterns, and social connectivity
- Support **self-management** to maintain active and healthy ageing in both physical and mental health.
- Continue to promote the uptake of **immunisations**, including the seasonal flu vaccination.
- Increase coverage and effectiveness of cancer screening services, including:
  - Increasing the uptake of Faecal Immunochemical Testing (FIT), helping to **detect colorectal cancer as quickly as possible**.
  - Implementing the Targeted Lung Health Check programme to **detect lung cancer** in 55–74 year olds at an earlier stage.
  - Implementing the **cancer Faster Diagnosis Standard**, resulting in patients receiving either a positive or negative diagnosis of cancer within 28 days.
- Improve access to **faster diagnostics.**
- Increase **diabetes risk detection** and the number of people offered and completing the Diabetes Prevention Programme and Structured Education Programmes.
- Expand **community respiratory services** to support the management and treatment of all respiratory disorders.
- Expand **Pulmonary Rehabilitation** to increase the number of patients with respiratory diseases being offered and accessing rehabilitation.
- Implement **cardiovascular disease prevention and detection** programmes within primary care, including increasing the number of people at risk of stroke on anti-coagulation drugs.
- Review and expand **Cardiac Rehabilitation**.

Improving mental and emotional wellbeing

As we grow older, it is just as important to look after our mental health as well as our physical health. Retirement, physical disability, loss of independence and bereavement are just some of the major life changes people may encounter as they get older. Having a network of friends and family, feeling valued, keeping active and having a purpose are just as important as access to good support and specialist services. We will:

- Tackle **loneliness** by creating opportunities for connection and encouraging people to participate and get involved, such as through volunteering, developing communities and neighbourhood support and promoting opportunities for creative intergenerational approaches and activities.
- Increase public education to reduce the risk of **dementia** and further develop dementia friendly communities.
- Improve **earlier diagnosis of dementia** and ensure people receive appropriate support and education.
- Improve support for **carers**.
- Improve access for older people to **psychological therapies** in steps to wellbeing and specialist services.
- The Older Person's Mental Health team will work more effectively with the Dementia crisis team to **prevent or delay admissions** and support family and carers at home.
- Improve **mental health support to care homes and nursing homes**.

Supporting people to build resilient communities and live independently

Older adults have significant skills and experience to contribute to society. We know that giving, using skills, and learning also helps increase people's self-esteem, encourages social interaction, and gives people hope and purpose. We will:

- Expand and make best use of **retirement and Extra Care housing** to support people's independence.
- Develop a **community transport service** to make it easier for older people to get around the city.
- Increase the proportion of people being offered and receiving **rehabilitation and reablement care** to support recovery and help people maintain their independence.
- Promote use of **equipment, care technology and assistive technology** to support people's independence.
- Develop a broad offer of **community based support and activities** that enable more people to both access and be part of delivering support and activities in their local community, building on older people's opportunities for volunteering, peer support, being experts by experience.
- Ensure **carers** feel supported and receive the care they need
- Simplify and streamline '**hospital to home**' pathways to ensure timely discharge from hospital and maximise opportunities for reablement.

Improving earlier help, care and support

Prevention and early intervention is key to ageing well. This includes working with younger populations, employers and the education sector to promote health and wellbeing, promoting available support and resources to enable people to think ahead, including in planning their finances and effectively communicating the impact of changing behaviours before reaching old age. We will:

- Develop a work programme to encourage and support local employers to promote employee health and wellbeing, support employees to prepare for retirement and to be **age friendly employers**.
- Promote **phased retirement** and **volunteering** opportunities.
- Empower **people approaching older age** to make positive choices for their health.
- Develop and promote and **physical activity** and active ageing.
- Implement **enhanced healthcare support** into to all residential and nursing homes in Southampton, providing dedicated clinical support to homes with assessment and care planning, responsive advice and support.
- Implement **risk stratification** approaches and **anticipatory care planning** to promote proactive care.

Improving joined-up, whole-person care

Healthy ageing needs to be supported by environments, opportunities and services that enable people to live well for as many years as possible, and that can adapt to the changing needs of people at different times in their lives. Moreover, service users have told us that they want the professionals involved in their care to talk to each other. Our aim is that health, social care, housing, transport, community and voluntary sector support will be delivered in a seamless and joined up way, around the needs of the individual. We will:

- Develop **local health and social care teams** which bring together physical and mental health, NHS, housing and social care across statutory and non-statutory sectors, to provide coordinated, person-centred proactive care and support for people.
- Promote integrated **care planning and sharing of information** across health and social care to support high quality, proactive, joined-up care and support.
- Continue to build high quality capacity within the community, in particular **home care and nursing home** provision.
- Develop **multiagency services at the hospital front door**, enabling more people to be supported to return home quicker (same day emergency care).
- Develop services available **seven days a week**.

What is our roadmap?

Year 1 2020/21	▪ **Integrated community teams, 'One Team',** across Southampton – bringing together physical health services, mental health services and social care –beginning to operate ▪ **Enhanced healthcare teams** supporting all residential and nursing homes across the city ▪ **Community navigators** (social prescribers) in place across Primary Care ▪ **Exercise classes** in place for people at risk of falling ▪ More **dementia friendly spaces** in place ▪ **Extra Care housing** scheme at Potters Court opens ▪ **Risk stratification** rolled out to tackle inequalities and case manage people with the greatest needs ▪ **Multiagency services at the hospital front door – with a 'Home First' principle**
Year 2 2021/22	▪ **Care technology** support becoming the norm in enabling people to maintain their independence ▪ Health and care professionals using **single care plans** enabled through technology ▪ **Single intermediate care team** operating across hospital, community & primary care
Year 3 2022/23	▪ Integrated **community transport service** in place ▪ More **intergenerational opportunities** and older people volunteering ▪ Further increase in **Extra Care homes** available ▪ Health and care professionals across all sectors, including care homes and home care providers making active use of **single care plans** to share information and use **technology** to seek rapid advice from each other ▪ **Enhanced healthcare teams** providing support to extra care housing
Year 4 2023/24	▪ Southampton is an **Ageing Well friendly city** ▪ **People actively managing their health** and enabled through **technology** to make appointments, manage their own care plan and seek advice directly from health and care professionals ▪ **Mental health support** including psychological therapies fully embedded in local teams ▪ **Care homes** proactively managing health needs of their residents, seeking support from health and social care professionals where necessary through technology ▪ **New inpatient rehabilitation wing** at Western Community Hospital expected to open (subject to approval of Full Business Case)

Die Well

Die Well

People are supported to ensure the last stages of their life happen in the best possible circumstances, receiving the right help at the right time from the right people

What do we want to be different in five years' time?

- More people will be supported to stay at home when they experience a decline in their health within their last years of life.
- There will be equality in provision of end of life care across all socioeconomic backgrounds.
- More people will achieve their preferred place of care and death.
- Early identification and end of life discussions will be the norm; more people will be describing their end of life wishes and preferences.
- There will be local compassionate communities who are confident to talk about and support friends and neighbours who may be experiencing death and dying.
- Proactive, personalised care planning to help people to consider their end of life wishes and options for a Personal Health Budget will be the norm
- More palliative care patients will have continuity of care and support across all health and care settings.
- Bereavement care will improve the support and care for all those important to the dying person.

How will we do this?

Reducing inequalities and confronting deprivation

- Support **more people to achieve their preferred place of care and death**.
- **Equitable** provision of end of life care and services available to all.
- Develop staff to **support people who are less able to self-advocate their own care**, such as people with a learning disability.
- Explore providing **end of life hospice care for children** and a hospice at home service.
- Improve **access to hospice services** including community support, day services and inpatient facilities if or when required.

Improving mental and emotional wellbeing

- Support people to be clear about **what to expect** as they approach and reach the end of their life.
- Holistic needs assessments will **consider the person's wellbeing, psychological, spiritual and health and social care needs**.
- **Carers** will be offered a holistic needs assessment to identify what practical and emotional support can be provided.
- Involving, supporting and caring for **all people** important to the dying person is also recognised as a key foundation of good end of life care.
- Launch a **new bereavement and psychological service**.
- Develop a process to **assess families post bereavement** at day 21.

Supporting people to build resilient communities and live independently

- Offer **Personal Health Budgets** (PHBs) for people in their last 12 weeks of life, to give people more choice and control around their end of life care.
- Develop a strategy to **engage and raise public and community awarenes and attitude of death and dying**.
- **Volunteers** will be recruited, trained and developed to help support individuals, their families and communities.
- Support and **encourage local communities to provide compassionate and practical help**, pre and post bereavement.
- Engage and involve local communities and places of worship in the development and **co-design of the local hospice to be an integral part of the community**.
- Encourage schools to support the development of an **end of life programme for schools and colleges.**

Improving earlier help, care and support

- **Early identification of people thought to be within their last three years of life** with a focus on older and frailer people and those with life limiting conditions, and those who may not, because of their condition, be able to communicate their end of life wishes in the future.
- All appropriate individuals in a care home will be on an **end of life register** and will have an advanced care plan discussion.
- Regular monitoring of people on the end of life register to provide **timely intervention** when required.
- Implement **proactive, personalised care planning** to support individuals to consider their end of life wishes early on in their illness or frailty.
- Improve **hospital discharge fast-track** processes to enable people at the end of their life to die in their place of choice.
- Improve **responsiveness within the community** to support individuals at the end of life and avoid unnecessary hospital admissions.
- Provide support to individuals, their families/carers in times of **crisis**.
- **24/7 help and support line and rapid, responsive support** for people in their own homes.
- People will have access to **timely pain control** and management of their symptoms.

Improving joined-up, whole-person care

- Develop and implement an effective **out of hospital end of life care coordination** service to allow more people to achieve their preferred place of care and death.
- **Train and develop the workforce** within the home care and residential home services to provide continuity of care.
- Use **Personalised Care and Support Plans**, or **Advance Care Planning**, to capture end of life care wishes.
- Develop a **workforce** which is confident and competent to discuss and capture end of life wishes.
- Proactive working **partnerships between the NHS, social care, voluntary sector, charities and local communities**.

What is our roadmap?

Year 1 2020/21	▪ **Independent hospice provision** in place for Southampton ▪ **24/7 coordination centre** with access to rapid response 24 hour advice and support ▪ Review the provision of access to end of life services for professionals and the families of **children at or approaching end of life**
Year 2 2021/22	▪ **Nurse-led unit** in place at Countess Mountbatten Hospice ▪ **24/7 access to rapid response** 24 hour advice, support and home visits ▪ **Bereavement services** expanded ▪ Development of **end of life champions**, linking with primary care and communities ▪ **End of life training** available to home care staff
Year 3 2022/23	▪ Development of an **end of life schools programme** ▪ Everyone in a care home is identified on an **end of life register** with an **advanced care plan** in place ▪ Work with children's services and families to design local **end of life services for families and children**
Year 4 2023/24	▪ **Children's end of life care** services in place

Key Enabling Priorities

Workforce

The overarching aim of the workforce plan is to support an effective system of organisations, teams and roles that can sustain population health and wellbeing through the provision of safe, high quality, and effective services. This will include a number of key areas with a clear plan to focus on the workforce needs of tomorrow, today. This will look like a skilled, sustainable, equal and diverse workforce which can respond to the changing environment in which we live and work, and can respond to the demand within the city. The scope of roles, services and organisations included within this vision is broad, encompassing all key areas of health and care delivery in the city.

What do we want to be different in five years' time?

- Southampton is a '**Great Place to Work**' in health, care and wider wellbeing services.
- A more **diverse, equal and inclusive** workforce and culture that reflects and understands the people of Southampton that we serve.
- Southampton is a place where people choose to **volunteer** and are supported to do so.
- An effective system of **organisations, teams and roles** that can sustain population health and prevent ill health through the provision of safe, high quality, and effective services.
- A **skilled and sustainable workforce** which can respond to the changing environment in which we live and work and responds to the demand picture within the city.
- **Talent management and leadership** practices create a workforce that is highly engaged and empowered to deliver the best possible care for the population of Southampton.
- Empowering **leaders**, who care and truly inspire.
- Partnerships and systems leadership that develop an **open and transparent culture** focused on continuous learning, innovation and improvement. These partnerships will be across health, care, wellbeing and the voluntary, community and social enterprise (VCSE) sector.
- High levels of **trust and engagement** among staff, community members and partners.
- An **employment experience** which works for employees, clients and our organisations alike.

How will we do this?

Planning the workforce needs of tomorrow today	• Understand our future population demand and identify the workforce impact. • Develop plans which meet future population demand, including; – Identification of new roles – Multi-skilling of staff.

	– Flexible patterns of working across services/organisations. – Ensure healthy conversations (Making Every Contact Count (MECC)) are embedded in all job descriptions. – Ensure the workforce reflects the diversity of the city it serves.
Building a diverse, equal and inclusive workforce and culture	• Work with partners to ensure a detailed equality analysis assessment of our workforce and use the findings to build a workforce equality, diversity and inclusion action plan.
Creating a great place to work	• Develop a shared vision, values and behaviours for the city's workforce. • Promote health and care career development opportunities, work experience and internships across the system and within educational institutions. • Include consideration of the needs of the Community, Voluntary and 3rd sector of care provision within the programme of work.
Developing an employment experience which works	• An employment experience which works for employees, clients and our organisations alike. Holding at the centre a focus on asset or strengths-based approaches to delivery across all sectors, promoting personalisation and self-care as standard. • Collaborative procurement of apprenticeships with educational institutions/system-wide relationships with non-pay levy organisations. • Implement an internal communications plan to ensure a consistent approach across organisations. • Implement value based appraisals and support structures.
Attracting and developing talent	• Talent management and leadership practices to create a workforce that is highly engaged and empowered to deliver the best possible care for the population of Southampton. • Develop a joint induction offer. • Align the recruitment and retention strategy and leadership competency framework with future workforce priorities. • Create a register of staff qualifications and skills, identifying underutilised skills and how these could be used across the system and support vacancy gaps. • Implement a communications plan, promoting Southampton as a great place to work in health and care.
Developing empowering leaders	• Developing empowering leaders, who care and truly inspire (Leadership Development) • Share promotion opportunities and approaches for hard to recruit/ bespoke roles. • Enable promotion and redeployment opportunities across the system. • Develop leadership networks which fit the needs of the system, including localities, Primary Care Networks and other specialist areas.

Creating an agile learning approach to our workforce	• Create career optimisation pathways across health and care roles. • Develop and implement competency frameworks to support new roles or changing roles. • Multidisciplinary/agency training and development of core behaviours and new ways of working. • Upskill staff with digital skills to work with people in different ways. • Alignment of terms, conditions and pay across health and care.

What is our roadmap?

Year 1
2020/21

- Leadership network developed
- Joint education programmes scoped, trialled and implemented
- Work with partners to ensure that workforce equality analysis assessment completed and actions identified
- Leadership induction – development of content and a city wide approach
- Development of staff stories and case studies that support the promotion of Southampton being a great place to work
- Communications support – support employee brand and culture development

Year 2
2021/22

- Oversight of actions identified from the workforce equality analysis assessment.
- Review organisational requirements related to Terms and Conditions
- Consideration of the needs of the Community, Voluntary and 3rd sector of care provision within the programme of work
- Review apprenticeship programme opportunities
- New roles and competency development
- Develop and trial flexible roles and employment opportunities
- Communications support - implement a communications plan which promotes Southampton as a great place to work in health and care

Year 3
2022/23

- Oversight of actions identified from the workforce equality analysis assessment.
- Modern workforce planning in place that supports the shift to place based delivery
- New (joint) recruitment approach developed and implemented
- Offer work experience / internships across the system and promote within educational institutions

Year 4
2023/24

- Develop a shared vision, values and behaviours for the city's workforce.
- Value based appraisals and support structures implemented

Digital

What do we want to be different in five years' time?

We want people to be able to:

- Participate fully in their care using digital services.
- Live better with long term conditions.
- Feel empowered to take control of their care.
- Save time through accessing their services digitally.

We want health and care staff to be able to:

- Offer a more personalised experience to service users.
- Access vital information about their service users at the point of contact which they need it most.
- Record information about their service users and trust that it will be readily available to others involved in their care.
- Work seamlessly across organisations.

We want the health and care system to be able to:

- Share information seamlessly.
- Be at the forefront of using digital technology.
- Plan ahead using the information available.

How will we do this?

Make best use of new technologies	• Implement 'digital-first' access into all GP practices to enable patients to receive greater choice and an improved experience. • Increase the uptake and breadth of supported self-management apps to enable patients to take greater control of their conditions. • Expand the use of MyMedicalRecord at University Hospital Southampton to enable patients to manage their healthcare online, reduce the need for hospital visits, connect with their care team and receive information from the hospital digitally as opposed to paper. • Offer MyMaternityRecord to all pregnant women so that they have a digital record as opposed to a paper record, which also enables them to message their midwife/clinical support team. • Implementation of innovative digital devices, such as wearable and mobile devices. • Improve digital messaging within integrated teams.

	• Provide greater patient choice in terms of remote consultations, such as video consultations (where clinically appropriate).
Digital inclusion and enablement	• Spread of digital technology into non-digitised organisations, such as care homes, home care providers and people's homes. • Maximise the use of the NHS App and other quality applications. • Enable patients to manage their appointments online, order repeat prescriptions online and view their medical records. • Introduce a digital strategy for safeguarding. • Work with organisations to improve their digital maturity. • With support from the voluntary sector, work on a digital literacy/inclusion project for patients to ensure that we provide help to patients to access their digital record or use video consulting. • Make sure no-one gets left behind.
Development and collaboration of infrastructure	• Improve access to Wi-Fi in health and care settings. • Ensure the hardware and software available to front line staff is of an appropriate standard to meet their needs. • Enable 'plug in and go' flexible working and networks to support Multi-Disciplinary Team working across Southampton. • Utilise common infrastructure for team working, such as cloud-based solutions and Office 365.
Make best use of population health analytics	• Ensure population health systems are available to integrated teams and primary care networks (PCNs). These will support risk stratification of patients and identification of inequalities in health outcomes. • Enriching data collection to include determinants of health. • Education of health teams – use of data and data quality.
Exchange and use of data and information	• Develop the Care and Health Information Exchange (CHIE) to improve the breadth and depth of information that is shared. • Communicate and embed the use of CHIE. • Develop integrated Patient Held Digital records to promote 'Digital First' access and empowerment of patients. • Improve sharing of digital imaging between healthcare providers.

What is our roadmap?

Year 1
2020/21

- Patients will have online access to their full record
- Patients will be given access online to correspondence
- Every pregnant woman will be offered a digital maternity record instead of a paper record
- Patients will be able to have a virtual appointment at University Hospital Southampton, if clinically appropriate.
- Spread of digital technology into non-digitised organisations e.g. care homes, home care providers and people's homes
- Maximise the use of the NHS app and the apps library
- Introduce a digital strategy for safeguarding
- Implementing joint patient activation programme
- Population health tools to support PCNs with identifying the needs of their population
- Aligning of clinical and digital strategies
- Gap analysis of data flows
- Evaluate Primary Care Digital Exemplars

Year 2
2021/22

- Improve pathways through Implementation of devices and innovation – wearable and mobile devices
- Patients will have the right to online and video consultation by April 2021 so we will ensure pathways are 'digital first' or digitally enabled where possible
- All parents will have a choice of a paper or digital Redbook for their new babies
- Spread of digital technology into non-digitised organisations e.g. care homes, home care providers and people's home
- Maximise digital inclusion through training and education
- Implementing joint patient activation programme
- All staff working in the community will have access to mobile digital services

Year 3
2022/23

- Improve pathways through Implementation of devices and innovation – wearable and mobile devices
- Spread of digital technology into non-digitised organisations e.g. care homes, home care providers and people's home
- Maximise digital inclusion through training and education
- Implementing joint patient activation programme

Year 4
2023/24

- Improve pathways through Implementation of devices and innovation – wearable and mobile devices
- All women will have their own digital maternity records
- Spread of digital technology into non-digitised organisations e.g. care homes, home care providers and people's home
- Maximise digital inclusion through training and education
- Implementing joint patient activation programme

Estates

The COVID-19 pandemic could potentially have a significant long-term impact on how existing healthcare buildings are used and how new buildings are designed. At the time of writing (August 2020) the implications are still to be fully understood. However, initial learning from 2020 suggests that there will be a requirement for enhanced infection prevention and control measures (e.g. social distancing) to be designed into our buildings, along with additional and flexible capacity so that health and care services can respond swiftly and effectively to any resurgence of COVID-19 or similar, highly contagious viruses.

The intentions for the health and care estate that are summarised in the following section need to be read against a backdrop of the need to apply the experience of the pandemic and the impact of COVID-19.

What do we want to be different in five years' time?

- The **network of buildings delivering integrated primary and community care** will have been substantially reshaped, underpinned by a long-term investment plan.
- Substantial progress will have been made in **transforming the Royal South Hants Hospital (RSH) campus** into a community-facing health and wellbeing campus.
- **Older people rehabilitation wards** will have been relocated to a new £19.5m facility on the site of an unused ward at the Western Community Hospital.
- **University Hospital Southampton's** current capital investment programme will have been delivered, including a new Children's Emergency Department, General Intensive Care Unit (ICU), expanded theatre capacity, and additional diagnostic capacity.
- **Countess Mountbatten Hospital** will have been operating the city's life-limiting illness service for five years and across that period significant investment will have been made in the building to ensure that it conforms to current and changing service requirements.
- Support the "**Southampton aims to be the UKs most accessible city by 2050**" initiative, such as ensuring dementia friendly buildings and improving access for people with disabilities.
- The **Local Plan** will be guiding and controlling development for addressing housing needs and other economic, social and environmental priorities. It will be developing health-promoting spaces and places for everyone across the life-course, reflecting the built and natural environment as a wider determinant of health.
- Alongside the Local Plan, the **Green City Charter** will be helping to make Southampton a cleaner, greener, healthier and more sustainable city' for current and future generations.

How will we do this?

Royal South Hants Hospital Campus Optimisation	• The RSH Campus Optimisation project has been established to ensure best use is made of land and buildings at this large community hospital in the city centre. • It aims to ensure best use is made of good quality buildings on the site and that old/unused and increasingly costly buildings are vacated. • Land released to be used to establish Housing with Care, Specialist Nursing Home, Key Worker Housing, expanded car parking
Western Community Hospital Campus Optimisation	• This project links directly with the RSH Campus Project and aims to ensure best use is made of land and buildings on the Western Campus (Western Community Hospital, Adelaide Health Centre, Taplins, Radio Broadcast Building). • Key component is the construction of a new 50-bed Older People Rehab wing on the site of a redundant ward. Project also includes remodelling of the Adelaide Health Centre and the Radio Broadcast Building to enable collocation of Solent and Southern Health teams in the West Southampton Locality. Car parking will also be improved through more active management and land optimisation.
Locality Hubs and primary care estate optimisation	• A key component of this workstream is a feasibility study to develop a "Community Hub" in Bitterne District Centre. Aim is to re-provide the current Bitterne Leisure Centre and Bitterne Library alongside a primary and community health services in a brand new building embedded in the District Centre to support regeneration of the main shopping precinct in Bitterne. • In a linked project, primary care estate (currently 38 sites across the city) is being reviewed and a prioritised investment plan will be established to support Primary Care Networks and the delivery of the Health and Care Strategy. The Investment Plan is expected to include the development of Hubs to support integrated care in the Central Locality and in the West Locality.
Extra Care Housing	• The City Council has calculated that Southampton has a demand for 400-500 additional Housing with Care units over the next 10 years. Mix of renting and shared ownership is envisaged. • Housing with Care enables people to remain independent in their own homes into old age and reduces demand for Care Home accommodation and has been shown to reduce unplanned admissions to acute care and reduce demand for primary care. • This workstream links to the RSH Campus Optimisation Project which will deliver c100 units of Housing with Care at this site.
Key Worker Housing	• This workstream also links to the RSH workstream where the proposed development of up to 70 units of Key Worker Housing is an important

	part of the optimisation work. The aim of the workstream is to find opportunities to establish Key Worker Housing on public sector land across the city. There has already been significant interaction with the Workforce Programme given the important contribution Key Worker Housing can make in addressing recruitment and retention challenges.
NHS Provider Trust Estate Strategies	• University Hospital Southampton, Southern Health, and Solent have organisation-specific estate strategies and plans that have been developed to support their clinical strategies and cost improvement programmes. Common themes include: major infrastructure investment to support commissioned services; dealing with backlog maintenance; ensuring efficient use of space, reconfiguration of estate to support agile working and co-location of teams; investments to improve energy efficiency and sustainability.
One Public Estate and Local Plan development	• Health partners in Southampton are members of the Southampton City One Public Estate Board and we will continue to play an active role in ensuring best use of all public sector real estate across the city. There is already extensive shared use of buildings and we will seek opportunities to utilise other public sector buildings and provide accommodation for other public sector bodies. • Southampton City Council has recently initiated a refresh of the Local Plan for the next 15-year period. A close working relationship with the City Council Planners will be maintained – especially in the development of the Health Infrastructure Study. A Section 106/CIL Protocol is in development and will be implemented once agreed.

What is our roadmap?

Year 1 2020/21	▪ Completion of Primary Care Estates Reviews. ▪ Completion of site masterplan for Southampton General Hospital campus. ▪ Opening of Children's ED, Southampton General Hospital. ▪ Provide input into the development of the Local Plan. ▪ Opening of new general intensive care unit with additional 7 beds and new 27 bed oncology ward at University Hospital Southampton.
Year 2 2021/22	▪ Opening of new general intensive care unit with additional 7 beds at Southampton General Hospital.
Year 3 2022/23	▪ Opening of additional operating theatres and inter-operative MRI facility at Southampton General Hospital.
Year 4 2023/24	▪ Completion and opening of new older people Rehab wing at Western. ▪ Vacation of Brambles Wing at RSH. ▪ Commencement of vacation of Fanshawe Wing at RSH.

Primary Care

Primary Care is at the foundation of our health services. In 2019 our city's GP practices delivered around 1.4 million appointments per year, offering advice, assessment, treatment and referral to specialist services for people at all stages of their lives. This works out as an average of 4.6 appointments per person per year for everyone registered with a Southampton GP practice.

Our vision is for strong high quality Primary Care services that improve healthcare for all, especially those who experience inequitable health outcomes, by keeping people healthy, preventing illness, facilitating recovery and supporting people's management of their long term conditions. The city's primary care services will be universally accessible, comprehensive and adaptable.

Over the next five years, Primary Care services must transform to meet current challenges associated with changing demand, workforce supply and market forces. During this time of change it is important that we strive to maintain the fundamental and tested benefits of these services including, but not limited to, personalised family care, patient choice and GP clinical leadership.

Primary Care services in Southampton responded strongly to the COVID-19 pandemic and whilst this has affected progress of some programmes over the first part of 2020/21, it has also accelerated others – including, for example, the availability and uptake of video consultations and e-consultations. We will harness this momentum and take stock of our priorities in the wake of the COVID-19 pandemic and the legacy of its impact on our communities, clinicians and services in the city.

The development of Primary Care Networks (PCNs) presents a major opportunity which will deliver improved outcomes for patients through more sustainable and resilient Primary Care services.

What do we want to be different in five years' time?

- Improved outcomes and experience for patients through more **timely access to the right information, advice and services** to meet individual needs.
- Wider **range of services tailored to patient and population needs** provided at practice, Primary Care Network (PCN) and city levels, including improved access to appropriate 24/7 urgent care and longer appointments for patients with long term conditions.
- **Sustainable and resilient GP practices** that gain strength through collaboration within their Primary Care Networks and their close partnerships with other heath and care providers and local voluntary organisations.

- A **Primary Care workforce** led by GPs and made up of a wider range of trained professionals and specialist clinicians working at practice, PCN and city levels. Higher levels of job satisfaction among people working in Primary Care.
- **Population health management systems** to support targeting of individualised person centred care planning and informing service planning for local communities.
- Primary Care **clinical leadership** at the heart of local Integrated Care Teams, coordinating care for people with more complex needs, maintaining people's independence and avoiding unnecessary hospitalisation or admission into long term care wherever possible.
- Advances in **IT systems** enabling more effective sharing of patient records to support assessments and enabling many more patients to access services digitally, e.g. via their smartphones.
- Effective **estate** with Locality "hubs" in district centres hosting a range of services and open 8am till 8pm, 7 days per week plus the right number of more local neighbourhood surgeries to support access and choice.

How will we do this?

Improve access to Primary Care	• Implement 'digital-first' access for all. • Implement new models of person centred care for people with long term conditions, such as longer appointments with a named GP/clinician. • Implement new models of "at scale" urgent care through co-production with PCNs at City, Locality/PCN and practice levels. • Implement Integrated Urgent Care services, including "111 First" and delivery of our local Clinical Assessment Services. • Commission an increased range of services from community pharmacies.
Improve the quality and sustainability of primary care	• Foster GP and other healthcare professional development. • Build resilience into the general practice business model. • Provide tailored support to practices experiencing challenges. • Work with NHS England and Public Health England to improve uptake of immunisations. vaccinations and cancer screening.
Digitally-enabled primary care	• Build on the momentum gained through our local response to the COVID-19 pandemic to further promote the uptake of e-consultations and video consultations. • Implement population health management systems to support PCNs to understand their population's greatest health needs, support resource planning and identify priorities to improve outcomes. • Promote utilisation of the NHS App.

	• Invest in IT and digital access, including better interoperability of clinical systems • Improve systems interoperability across GP practices to improve access to information / patient records to support assessment.
Integrated, networked primary care	• Commission and develop Primary Care Networks (PCNs). • Promote relationships between practices and voluntary and community groups to increase social prescribing. • Develop highly integrated care, such as for people with multiple conditions and/or frailty, via integrated teams aligned to PCNs. • Implement leadership and organisational development programmes for primary care and PCNs • Commission new primary care and network services that reduce inequalities, deliver better outcomes and patient experience and avoid unnecessary hospitalisation. • Promote collaboration and efficiencies across practices, such as sharing of back-office functions. • Further develop models of delivery for Primary Care at scale.
Workforce and skills	• Develop a primary care workforce action plan to improve recruitment and retention. • Support professional development of practice nurses and other members of the wider primary care workforce. • Develop GPs as clinical leads within practices/PCNs. • Support practices and PCNs to develop strong skill mixes in the workforce.
Fit-for-purpose, modern estate	• Phased planning of primary care estate solutions on locality by locality basis • Deliver locality resource centres in district centres, which will host 7 day urgent care and network services. • Rationalisation of sites which are sub-optimal and investment in estate fit for the future • Maintain and develop new estate solutions to ensure access in key sub-locality sites and areas of deprivation.

What is our five year roadmap?

Year 1
2020/21

- Growing range of Primary Care services tailored to individual and population needs
- Improved understanding of how primary care is doing and further development of menu of support for struggling practices
- PCNs are supported in their organisational development and recruitment of new workforce by CCG and other system stakeholders
- Development of workforce plans to sustain new models of care – including for additional PCN roles
- Establishment of Integrated care teams configured around PCNs
- Commissioning of local improvement schemes to align with PCNs and Investment and Impact fund
- Stocktake of Primary Care response to COVID-19 pandemic, reprioritisation of work programmes and seizing momentum to further embed new ways of working (e.g. e-consultations and video consultations)
- PCNs becoming more established in neighbourhood, city and wider arrangements for partnership governance, planning and integrated service delivery
- Mobilisation of new population health management tools
- All practices operate active patient participation groups or other suitable public engagement arrangements
- Review of Primary Care estates and access outlines plans for future to facilitate high quality, sustainable models of care

Year 2
2021/22

- Improvements in access to Primary Care services and patient experience through advancements including digital and telephony solutions
- Practices more routinely collaborating via Primary Care Networks to support resilience
- PCNs in year three and becoming more established in role to lead planning and coordination of care for their populations
- Implementation of new workforce plans and recruitment and retention programmes including rotational posts
- Further development of Integrated Care Teams with strong Primary Care clinical leadership
- Integrated Urgent Care (IUC) with Clinical Assessment Service (CAS) embedded with primary care and with full access to primary health records
- Exploration of roles of community pharmacies within PCNs and commissioning of additional services
- Full deployment of population health management at PCN level to support planning and care delivery
- PCN engagement with communities and beginning to make use of wider assets
- Improvements in Primary Care estate to support new out-of-hospital care models

Year 3 2022/23	▪ Significant improvements in outcomes for patients with complex needs though highly integrated care teams working optimally at PCN level ▪ PCNs in year four and becoming the main investment and delivery vehicle for investment in out-of-hospital services. ▪ Integrated workforce across PCNs & other partners delivering integrated out-of-hospital service models ▪ New models of access to urgent and same-day primary care services 24/7 delivered at PCN and city level and integrated with IUC and local CAS ▪ PCN Clinical Directors providing clinical leadership for planning and delivery of services at Integrated Care System, city and PCN levels ▪ Advanced deployment of population health management support delivery and inform future commissioning ▪ Single clinical system and/or advanced levels of interoperability to support sharing of records between city practices and other relevant urgent care and community services ▪ Delivery of one or more Locality hubs based in district centres, with access to a wider range of health and care services from 8am till 8pm, 7 days per week
Year 4 2023/24	▪ Patients experiencing high levels of satisfaction relating to access to and experience of Primary Care services in the city ▪ Highly developed workforce model across Primary Care and out-of-hospital services including appropriate mix of skills and professionals to meet diverse needs ▪ Improved recruitment, retention, development opportunities job satisfaction in general practice and other out-of-hospital care settings ▪ PCNs in year five and taking a lead role in the coordination of urgent care ▪ Advanced deployment of population health management to support delivery and inform future commissioning ▪ PCNs working in formal partnerships with the local voluntary and community sector to promote health and tackle inequalities ▪ Evaluation and further development of new models of access to urgent and on-day primary care services 24/7 ▪ Delivery of one or more Locality hubs based in district centres, with access to a wider range of health and care services from 8am till 8pm, 7 days per week

Year 5
2024/25

- Comprehensive, consistently high quality and sustainable primary care services forming the foundation for a transformed health and care services for the city
- Improved health outcomes and reduced health inequalities through effective population health management and locally sensitive service delivery
- Resilient Practices routinely collaborating via PCNs and with other partners and with enhanced levels of community ownership
- Embedded application of population health management arrangements driving the planning of care at individual, PCN, city and Integrated Care System levels
- Further co-production with PCNs to develop advanced models of out-of-hospital models for urgent, planned and integrated care
- Significant number of patients accessing Primary Care services and being supported in self-management through advanced digital services
- Locality hubs in all of the city's district centres, with access to a wider range of health and care services from 8am till 8pm, 7 days per week

Urgent and Emergency Care

What do we want to be different in five years' time?

- **Primary Care (in its widest sense) and the Urgent Treatment Centre (UTC)** are at the heart of the response to demand in the city for urgent, but not life threatening, illness and injury.
- **NHS 111 Clinical Assessment Service** (CAS) is an integral part of the local response to urgent care demand.
- **Think 111 First** – NHS 111 is the main gateway used for patients to accessing urgent care, with robust community pathways available with direct booking and triaging patients to the Emergency Department (ED) where clinically appropriate.
- Timely **ambulance response** according to clinical need, with skilled paramedics treating more patients at home, or conveying to appropriate services outside of hospital.
- **Improvements to pathways**, such as direct admissions straight to ward for patients who do not need to go via the Emergency Department (ED).
- Easy access to **advice and guidance** and decision support to reduce ED attendances and emergency hospital admissions.
- Effective urgent and emergency care pathways and 'front door' at UHS which **maximises management of people outside of hospital** where appropriate, and provides responsive specialist urgent care services to manage people who need acute hospital care, including Same Day Emergency Care (SDEC) and acute frailty service.
- A highly skilled, flexible and sufficiently resourced urgent and emergency care **workforce** across the local system.
- Sustained **flow through and out of hospital** and a reduction in delayed discharges.

How will we do this?

Pre-hospital urgent care

Prevention, communications and right place first time	• Promote 'Think 111 First' to support managing more patients through advice, and directly booking into services if needed. • Additional 111/CAS capacity to increase the number of patients triaged and managed outside of ED. • Communication and education for patients and communities on 'choose well' and 'stay well', to help people make informed decisions about the services they choose.

	• Promote uptake of vaccinations in eligible "at risk" populations, including children and young people. • Promote the Wessex Healthier Together website and similar digital resources to help people make informed decisions about the services they chose for children. • Develop South West Hants Connect – Direct access to specialist advice and guidance via an app to support GPs, paramedics and other clinicians in deciding next steps for patients requiring admission or management outside of hospital
Integrated Urgent Care (IUC), incorporating NHS111	• Integration of NHS 111 call centre and 111-online within the IUC so that NHS 111 is the main gateway to urgent care.
Enhanced and Urgent access to Primary Care Services and Urgent Treatment Centre	• Providers, Primary Care including PCNs work together to coordinate seamless patient pathways and manage more urgent patients. • NHS 111 CAS integrated into local urgent care response. • UTC as a key and integral part of urgent care delivery. • Increase the use of digital technologies to improve access to urgent primary care.
Ambulance pathways	• Develop pathways to reduce ED conveyance, including use of the community Urgent Response Service and direct admission pathways in to the hospital for patients who require conveyance but do not need to go via ED. • Increase the use of digital enablers to support pathways and clinical decision making. • Eliminate hospital handover delays, keeping ambulances available and on the road to help further improve response times • Improve ambulance access to patient care plans so that more patients can be managed outside of hospital.

In-hospital urgent care

Paediatric front door	• Improve access to early assessment and diversion to appropriate community services for children and young people in mental health crisis. • Implement "Hospital at Home" care models that better support the care of acute illness in children at home, in primary care and community settings through improved access to expert paediatric advice, rapid access clinics and better support for safe discharge.
Same Day Emergency Care (SDEC) and acute frailty	• Increase the proportion of acute admissions discharged on the same day of attendance. • Early identification of patients in ED suitable for SDEC and acute frailty. • Direct admission to SDEC and frailty pathways.

Internal ED processes	• Development of pathways to increase the number of patients actively 'pulled' from ED as early as possible, or signposted directly to the admitting unit. • Staff mix models future-proofed and adapted to meet changing needs • Deliver 'choose well' brief interventions to educate patients who could have accessed an alternative service.
Effective discharge and flow, hospital to home	• Simplify and streamline 'hospital to home' pathways to ensure timely discharge. • Maximise the use of capacity within the community and increase proactive 'pull' of patients from hospital by community services. • Embed 8 High Impact Changes to support effective discharge and flow • Sustained reduction of CHC full assessments in acute setting to <15% • Increase uptake of reablement to support recovery outside of hospital

What is our roadmap?

Year 1 2020/21	▪ NHS 111 Think First. ▪ Procurement of Integrated Urgent Care (IUC) ▪ Implementation of "Hospital at Home" care models ▪ Development of improved pathways for young people in mental health crisis, and improved community capacity to assess and support needs ▪ Improved pathways to reduce ED attendances and emergency admissions ▪ Develop and embed community discharge hub to support safe, timely and effective discharge ▪ Sustained delivery of all Seven Day Service Clinical Standards ▪ Improved digital clinical solutions
Year 2 2021/22	▪ Roll out of full IUC ▪ Implement new urgent and emergency care standards ▪ Local NHS 111 CAS as part of local urgent care services
Year 3 2022/23	▪ Evaluation and development point for full alignment of the Enhanced and Urgent Primary Care Service (EUPCS) and the Urgent Treatment Centre (UTC) for future procurement ▪ Patient and community engagement to inform development of future care models
Year 4 2023/24	▪ PCNs taking a lead role in the coordination of urgent care ▪ Evaluation and further development of new models of access to urgent and on-day primary care services 24/7 ▪ Evaluation and extension/re-procurement of Enhanced Urgent Primary Care Service

How will we deliver?

How will we deliver?

Implementing our strategy

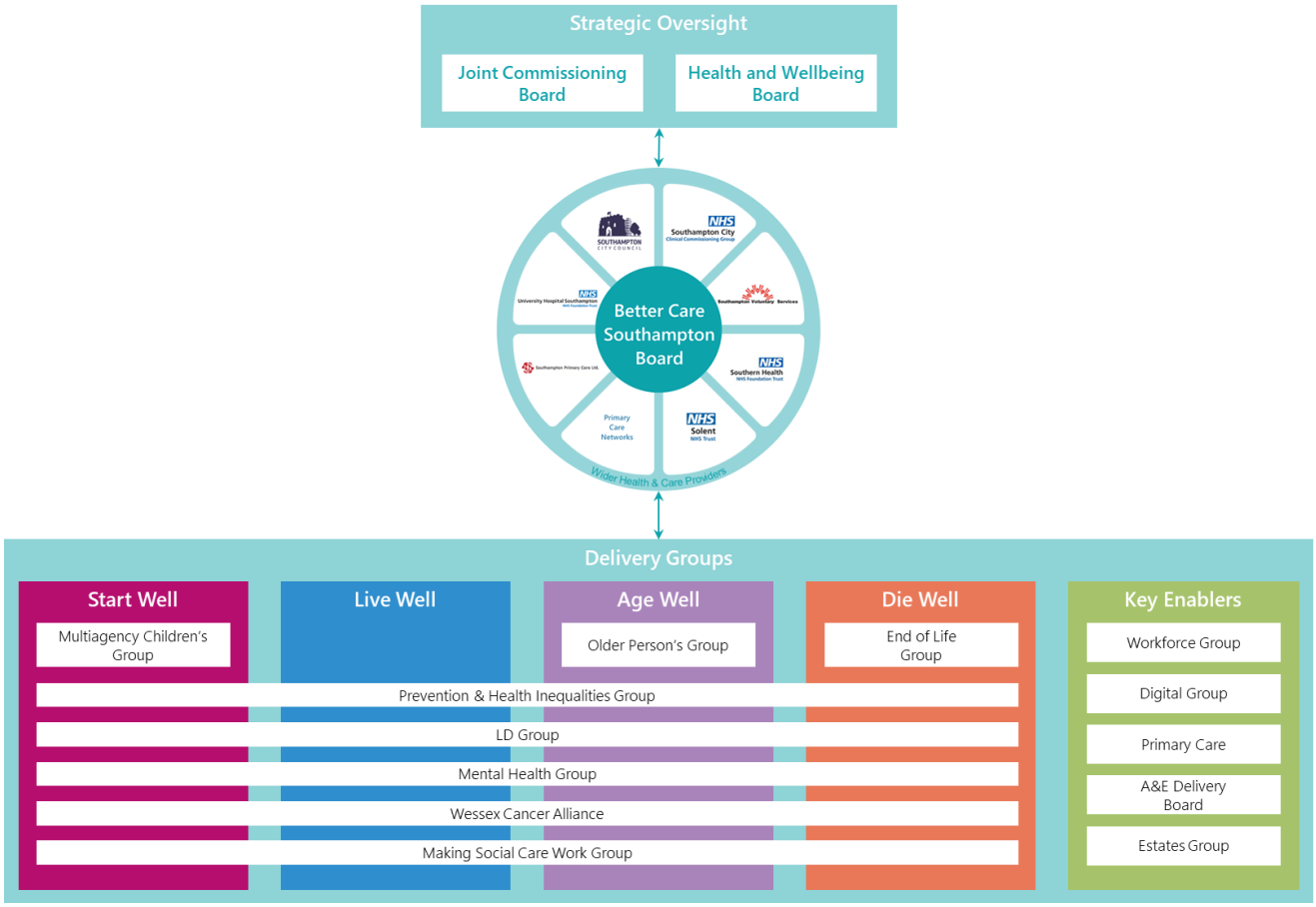
Underpinning our strategy, detailed plans have been developed for each of our key workstreams, setting out the scope, objectives, key milestones and interdependencies with other workstreams. The detailed plans are live documents and will continue to be reviewed and updated throughout the duration of the strategy. Each of the workstreams also has an associated delivery group. These groups own the detailed plans and act as the main driving force to implement the strategy.

How will delivery be monitored?

It is crucial that the strategy does not remain a simple statement of intent, but a continuing process of monitoring, challenge and review. It cannot remain a static document, but a way of continually assessing whether the approach being taken is appropriate and sufficient to secure our vision.

As part of this, a robust strategy delivery and governance structure is in place.

Strategy Delivery and Governance Structure



Delivery Groups

Each delivery group is responsible for delivering change. The detailed plans owned by the delivery groups will provide a reference point for the Better Care Southampton Board to keep planned delivery on track. The delivery groups will report progress to the Better Care Southampton Board on a termly (four month) basis and are responsible for monitoring and reporting delivery against the outcome metrics/key performance indicators (KPIs) for their workstreams.

Better Care Southampton Board

The Better Care Southampton Board membership includes senior representatives from key health and care organisations across the city, including the voluntary sector. The purpose of the Board is to set strategic direction and oversee the successful delivery of the strategy. The Board will hold the delivery groups to account for delivering the agreed plans and outcomes, and will help to remove barriers to progress. Progress will be regularly reviewed to ensure that actions not only remain on track and anticipated key outcomes can be fully realised, but that the delivery plan is updated with new actions and measures as appropriate. A range of health and care outcome indicators will be monitored to inform whether the interventions in the strategy are having an impact.

The Better Care Southampton Board is accountable to both the Joint Commissioning Board and the Health and Wellbeing Board.

Joint Commissioning Board

The Joint Commissioning Board (JCB) acts as the single health and care commissioning body for the city of Southampton and a single point for decision making. The JCB membership includes the main commissioners of health and care services in the city; NHS Southampton City Clinical Commissioning Group and Southampton City Council. The JCB ensures effective collaboration, assurance, oversight and good governance arrangements to ensure achievement of the city's health and care strategic objectives. The JCB will enable continued engagement and momentum of the strategy and will assist with resolving any delivery issues which cannot be resolved by the Better Care Southampton Board.

Health and Wellbeing Board

The Health and Wellbeing Board (HWB) acts as a formal committee of Southampton City Council, charged with promoting greater integration and partnership between the NHS, public health and local government. The HWB includes representatives from health, social services and public health to decide what the main public health needs of Southampton are, and to determine how best to meet them in an integrated and holistic manner. It has a statutory duty to encourage the integrated delivery of health and social care to advance the health and wellbeing of people in Southampton and provides oversight of the local health and care system. It will therefore have ongoing oversight of the Southampton City Health and Care Strategy.

How will we work together?

We will:

- At all times act in the best interests of the health and care system and of the population we serve.
- Operate as a single Southampton 'place-based' health and care system based on partnerships, not structure.
- Set priorities for the use of public funding for health and care and get the best value for the 'Southampton Pound'.
- Ensure resources across the health and care system are prioritised and organised in a joined up way to achieve outcomes.
- Invest in transformation.
- Work across the health and care system to minimise clinical, organisational and financial risk.
- Continuously review and prioritise plans based on their alignment to our shared vision and priorities, creating a culture of learning and improvement.
- Collaborate with wider system planning and developments as part of the larger population footprint of Hampshire and Isle of Wight.

Engaging and involving local people

We want local people to play their part in decisions about local health and care, which is why we are committed to involving and engaging our population as we implement this strategy. The success of this strategy will depend on open engagement and involvement of service users, patients, carers, partners and other key stakeholders.

Over the next five years, we will continue to engage with local people and collect insight and feedback, to help us to continually improve our services and create a healthy Southampton where everyone thrives.