JOINT HEALTH AND WELLBEING STRATEGY

LEAD		OBJECTIVES *(what we are seeking to do)*	ACTIONS	OUTCOME *(what we are seeking to achieve)*	PERFORMANCE *(outcome measures)*
STARTING WELL	Children's Trust / CHCG	**Provide strategic support and co-operation so that the Children and Young Peoples Plan can be delivered**	To develop and implement an autism Strategy for Children	Agree care pathway for children with support needs	Improved outcomes for children with autism to be identified and agreed by Child Health Commissioning Group
	Children's Trust / Child Health Commissioning Group		Develop and implement a joint strategy (CCG, Children's Services, Schools and Therapy providers) to deliver a sustainable, fair and transparent model of high quality, integrated therapy support in all parts of the county	Address inequalities identified in needs assessment and improve equity of access to Therapy Services	CYPP - Priority 3 E: Early years & foundation stage speech therapy Improved outcomes for children (an specific measures?)
	Children's Trust / CHCG		Review and improve access to Child and Adolescent Mental Health Service (CAMHS) particularly for vulnerable groups such as children in care	Improvement in waiting times and service interventions	Improved outcome for children with young people to be identified and agreed by Child Health Commissioning Group
	Transition Programme Board		Develop a Transition Programme Board and implement programme plan	Implement an improvement plan to review delivery to enable smooth transition from Children's to Adult orientated support	Increasing numbers of young people with a transition plan and transition arrangements in place
LIVING WELL	Public Health Group	**Reduction in diagnosed illness and death from alcohol attributable disease at all ages**	Revise and implement DAAT led Drug and Alcohol Strategy to inform commissioning across all HWB partners	Fewer people drinking harmful amounts of alcohol - evidence based value led approach Continued reduction in Drug and alcohol measures	PHO: 2.18 Alcohol related admissions Rate of alcohol attributable deaths
		Reduction in diagnosed illness and death from tobacco attributable disease at all ages	Link smoking cessation services with NHS healthchecks Implementation of key messages from localised strategic approach Ensuring COPD/CHD/cancer prevention effective and evidence based	Fewer people starting to smoke and more people quit smoking tobacco	PHO:2.9 smoking prevalence - 15years PHO: 2.14 smoking prevalence - adults
		Reduction year on year in the rise of obesity	Implement key strategic wins Increasing mobility/energetic mobility	Fewer children and adults are overweight or obese	PHO:1.16 Utilisation of outdoor space for exercise/health reasons PHO: 2.6 excess weight children PHO: 2.12 Excess weight adults PHO:2.13 proportion of physically active and inactive adults
		Support delivery of 'No Health Without Mental Health' - *more people have good mental health*	Develop and deliver a partnership Mental Wellbeing Strategy that enables mental wellbeing to be a key part of every aspect of business delivery	More people, including professionals have a better understanding of how they can protect their mental own wellbeing	PHO: 2.23 Self-reported well-being PHO:2.10 self harm PHO:4.10 suicide reduction trend
		Increase early detection of HIV and Chlamydia and reduce teenage pregnancy	Ensure that integrated sexual health service for young people continues via CYPP	CYPP outcomes achieved	PHO: 3.4 people presenting with HIV late stage PHO: 2.4 under 18 conceptions - reduce teenage pregnancy PHO: 3.2 Chlamydia diagnosis CYPP - Priority 2 H & I - teenage pregnancy and sexual health
		Continue to protect the health of the population of Hampshire from communicable and non-communicable environmental hazards	Health protection task finish group advises Public Health Group of on-going issues, assurance of commissioning of services as necessary	Surge capacity available Improvement in herd immunity Reduction in avoidable infections (HCAIs) Address PH LA duties for community infection prevention and control Effects on seasonal mortality Oversight of screening and immunisation programmes	PHO: 2.20 cancer screening coverage PHO:2.21 access to non-cancer screening programmes PHO:3.3 population vaccination coverage PHO:3.5 treatment completion for TB PHO:3.7 comprehensive, agreed interagency plans fro responding to public health incidents PHO:4.8 mortality from infectious and parasitic diseases PHO: 4.15 excess winter deaths
		Enable appropriate use of unscheduled healthcare services for people of all ages, as described in all CCG plans support cost effective healthcare	Combine A&E use age data across the main A&E units used by citizens of Hampshire to confirm age-range use by time of day/day of week Work with CCG/NHS England colleagues to support local communications in line with NHS England A&E	Reduction in inappropriate A&E use as identified through routine audits all the main A&E units used by citizens of Hampshire meeting their performance and quality criteria - this reads across to performance also	All the main A&E units used by citizens of Hampshire meeting their performance and quality criteria

			work being led nationally including social media approaches identify and plan for evidence based alternative healthcare access for people unwilling or unable to access GP services during their working day		
AGEING WELL	Integrated Commissioning Group	**Close the prevalence gap in long term conditions within the Hampshire population**	Develop and implement a Hampshire wide blueprint to reduce variation and improve the quality of life of people with long term conditions	Reduce unplanned admissions to hospital Increase self care and self management	NHSO: 2.2 Ensuring people feel supported to manage their condition NHSO: 2.2 Improved functional ability in people with long term conditions NHSO: 2.3i Reducing time spent in hospital for people with long term conditions (unplanned)
		Meet the National Dementia Challenge	Refresh and implement Older Persons Mental Health Strategy	Increase earlier diagnosis Reduce avoidable admission and reduced length of stay for people with dementia Reduction in prescribed antipsychotic medication Increase the levels of support in mainstream public and provide sector services	PHO: 4.16/NHSO/CCGO:26i Estimated diagnosis rate for people with dementia ASCO: 2F dementia - a measure of the effectiveness of post-diagnosis care in sustaining independence
		Fewer People Falling and suffering the consequences	Agree Hampshire Falls Prevention and Bone Health Strategy, implementation plan and refreshed falls pathways	More people are identified earlier and receive effective intervention that reduces harm from falling	PHO: 2.24 Injuries due to falls in people aged 65 and over PHO:4.14/SCO 2F Hip factures in people aged 65 and over NHSO: 3.5 proportion of patients recovering to their previous levels of mobility /walking ability at i) 30 and ii) 120 days QOF: OST 1,2,3
		Reductions in acute hospital stays when patients are medically able to leave	Develop a Hampshire wide blueprint to improve discharge management through adequate and appropriate support Commission appropriate models of reablement Commission speedy and efficient eligibility assessment of NHS Continuing Health Care	Fewer people stay in hospital when they could safely be at home Reduced length of stay in hospital Reduction in delayed transfer of care	CCGO/ NHSO 2.3i: reducing time in hospital ASCO: 2C delayed transfers of care NHSO: 3.6 ii proportion offered rehabilitation following discharge from hospital ASCO 2E: effectiveness of reablement NHSO: 3b/ PHOF 4.11 Emergency readmissions within 30 days of discharge form hospital
		More people helped to stay at home safely for longer and reduce social isolation	Redesign and deliver primary and community based services so they are a viable alternative to hospital care through integrated community provision, care coordination / case management and integrated care teams	Reduce admission rate to hospital and care homes Reduction in re-admission rates Reduce social isolation and loneliness	ASCO: 2B NHSO: 3.6i / proportion of older people (65+) who were still at home 91days after discharge form hospital NHSO: 3a Emergency admissions for acute conditions that should not usually require admissions NHSO: 3b/ PHOF 4.11 Emergency readmissions within 30 days of discharge form hospital PHO:1.18/ ASCO1I Social isolation
		Reduce premature death in people with learning disabilities	Refresh and implement the Learning Disability Partnership Strategy including: Review and revise the model of assessment and treatment against need especially for people with complex needs. Develop and commission age appropriate services Implement Autism Strategy	Increased registered numbers of people on the health record (current 38%) Increased health checks for people with learning disabilities Reduced numbers of people in treatment and assessment units Reduced long term residential care	ASCO: 1G proportion of adults with learning disabilities living in their own home or with family ASCO 1H/ PHO: 1.6 Adults with learning disabilities in contact with MH services who live in stable and appropriate accommodation NHSO: reducing death in people with a learning disability
		Personalised support for both carers and those they support so as to reduce carer breakdown	Implement a joint carers strategy that supports carers to maintain their health and wellbeing : Early identification of carers Increases carer health checks	Reduction in breakdown in packages of care due to carers being unable to cope More carers have health checks Carers balance their caring roles and maintain their quality of life	NHSO: 2.4 Health related quality of life for carers ASCO:1I / PHO: 1.18 proportion of people who use services and their carers, who reported that they had as much social contact as they would like ASCO/NHSO 2.4: 1D Carer-reported quality of life
HEALTHEIR COMMUNITIES	Health and Wellbeing District Forum	**Improve access to information and advice**	Mapping what is going on already Identifying needs and gaps District level actions to address local issues	Increase availability of appropriate information and advice to improve peoples health and wellbeing	Increased use of information and advice Evaluation of a number of campaigns such as Hitting the Cold spots
		Working with communities and groups to reduce health inequalities and improve health outcomes	Identified geographic areas and groups through need assessment(s) Implement evidence based programmes	Identified geographic areas and groups through need assessment(s) Implement evidence based programmes	Health outcomes of people living in identified areas using indicators used in the three other areas
		Reduce the personal, social and public service costs of families with complex needs	Identification of families at risk and development, commissioning and delivery of Local Delivery Strategies	Prevent the escalation of 530 families per year with complex needs	Using cohort group: Reduction in levels of anti-social behaviour Children consistently attending school Parents in work or benefiting from training opportunities