Southend-on-Sea
Joint Adult Prevention Strategy
2016-2021

Contents

"Invest in prevention, not remediation.
Invest in flourishing lives, not in correcting problems after they appear."
'Professor James Heckman Nobel Laureate'

Foreword

I am delighted to introduce the Joint Adult Prevention Strategy for Southend-on-Sea 2016-2021. This strategy is focused on the adult population of the Borough. It sets out our ambition to reshape the landscape of Southend through preventing illness and disease to avoid the need for costly treatment and care.

We know that a quarter of the population of Southend-on-Sea live within the most deprived 30% of all areas in England. These people suffer worse health outcomes than people living in our more affluent areas. Men in the most deprived areas of Southend live 11.1 years less than men in the most affluent areas of Southend, for women this figure is 10 years. I am determined to redress this inequality.

We know that the biggest challenges to health and wellbeing in the 21st century are related to risks from diseases and conditions that we can do something about. These include cardiovascular disease, cancer, hypertension, obesity and lifestyle related dementia. By taking positive action to address modifiable risk factors for these conditions, we hope to create an environment in Southend where everyone can achieve their full potential.

I am clear we must change how we do things. Prevention ‘at scale’ is the only way to secure our communities health and tackle the siginficant inequalities that exist in some areas. We will provide greater access to information and advice to help people better manage their own health lifestyle risks. We will coordinate our programme of prevention to link with the programme of redevelopment and regeneration of the Borough.

My ultimate aim is to make Southend-on-Sea one of the healthiest towns in England by 2020. The implementation of this strategy will be pivotal in achieving this objective.

I recommend this Joint Prevention Strategy to you as one of the key vehicles that will help to improve the health and wellbeing of our local residents.

Councillor Lesley Salter
Portfolio Holder for Adults, Health and Social Care, and
Chair of Southend Health and Wellbeing Board

1.0 Our Vision

For Southend to be a Borough which promotes partnership working to improve the health and quality of life for individuals, families and communities, by moving the focus from ill health and disease to prevention and wellbeing.

Mission

Our mission is to enable Southend residents to live longer healthier lives. Local people will be able to take control and avoid or effectively manage issues that impact negatively on their health and wellbeing. Adults with a pre-existing health issue will be:

- Active partners with their care providers
- Able to problem solve and make changes
- Able to manage thinking and behaviours positively
- Able to access information and support that is useful for them

Strategic aims

To help us achieve our vision, we will use our influence and resources to deliver the following key strategic aims:

- To focus action to embed prevention in all policies
  We will look at transforming the way individuals and organisations recognise the importance of the prevention agenda, so that preventing illness and disease is at the forefront of local policy planning and commissioning.

- To improve access to high quality information, advice and signposting.
  We will create a communication and social marketing programme that provides helpful up-to-date advice and information to signpost people to where to access support.

- To support people to increase their sense of control and resilience in their lives by enabling them to effectively self-manage their condition.

  We will provide people with the necessary skills, knowledge and confidence to self-manage their long term conditions.

- To promote specific action to improve health & wellbeing.
  We will provide improved access to healthy lifestyle services.

- To prevent, reduce and delay the use of health or care services.
  We will support people to remain independent and reduce the need for hospital admissions or care home placement.

This strategy focuses on adults aged 18+ who are resident in the Borough .The specific priority areas for enhanced prevention are:

- Older people aged 65+
- People with learning disabilities
- Adults with mental health problems
- Physical disability (including sensory impairment)
- Carers
- People with chronic long term conditions

2.0 Introduction

The Southend health and social care system faces significant challenges. The population is getting older and frailer and there are more adults living with chronic long term health conditions such as diabetes, cardiovascular and respiratory disease. Added to these factors is the impact of fiscal austerity.

The NHS and publicly funded adult social care accounted for £157bn of public spending across the UK in 2015/16. This is equivalent to 8.4% of gross domestic product (GDP) or £1 in every £5 of government spending (1). Although national government made a commitment in 2015 to increase funding for the NHS by £8bn by 2020/21, there has been no equivalent commitment for adult social care, even though the pressures within the social care system are growing at a faster rate than pressures on health care. By 2020/21, it is estimated that 43.4% of national government spending will be allocated to older people and health services.

Locally Southend Clinical Commissioning Group has operated within a tight financial allocation over the last two years and their financial position is challenged particularly with issues within the acute hospital sector. There are also significant financial challenges for Southend-on-Sea Borough Council which has had to make financial savings of £56 million since 2011/12. Further cuts will be required in future years, totalling £33 million from 2016- 2019.

In order to prevent the system from becoming unsustainable, both health and social care will need to work in radically different ways than they did in the past. A key solution is to move ‘upstream’ and focus on prevention. This Joint Adult Prevention Strategy describes how the Southend health and care system will work in partnership to empower and engage individuals and communities to stay healthier for longer. It describes a fundamental shift from providing services that respond to a person’s ill health and care needs as they arise to a proactive model of services which aim to reduce, prevent and delay the onset of ill health and loss of independence.

There is good evidence that the introduction of large scale self-management interventions result in measureable benefits, particularly in terms of population health gain and reduced commissioning costs (2,3).

2.1 Definition of prevention

The term 'prevention' refers to a variety of measures taken to improve or maintain the health status of an individual or group of people. Prevention in the context of this strategy refers to any intervention or action that prevents, reduces or delays deterioration in the health of adults resident in Southend.

Prevention is often broken down into three general approaches: primary, secondary and tertiary prevention:

Primary prevention: measures to prevent ill health and promote wellbeing

Primary prevention is defined as interventions aimed at individuals who have no current particular health or social care support needs. The aim of primary prevention is to help people avoid developing needs for care and support by maintaining independence, good health and promoting wellbeing. Interventions include: providing universal access to good quality information and advice, supporting safer neighbourhoods, promoting healthy and active lifestyles.

Secondary prevention: measures to identify those at increased risk of poor health or wellbeing and intervene early

Secondary prevention refers to interventions aimed at individuals who are at risk of developing needs, where the provision of services, resources or facilities may help slow down any further deterioration. Screening or case finding may be used to identify those individuals most likely to benefit from targeted services. Examples include; NHS Health Checks and postural stability programmes for falls.

Tertiary prevention: Measures that delay or minimise the impact of existing health conditions

Tertiary prevention refers to interventions aimed at minimising the impact of disability or further deterioration in people with existing health condition or complex care and support needs, including supporting people to regain skills and reduce need where possible. Action is taken to manage any adverse event that could trigger entry into a high cost service, which could include admission into hospital or residential/nursing care. Examples include re-ablement and support to people with serious mental health problems.

Preventative activity will only reduce demand within the health and care system, if interventions and outcomes are focussed on decreasing the gap between healthy life expectancy and life expectancy. Most strategies fail to achieve their

ambitions as they often establish new systems that do not take account of local need and pathways. The Southend Joint Adult Prevention strategy uses a placed based approach and existing systems to deliver preventative interventions at scale.

2.2 The case for prevention

People are living for longer than ever before – since 2002, life expectancy has been increasing year on year in Southend. However, the years lived in good health have not seen the same rate of increase. This means that many people will be living longer lives, but with more years of ill health or disability.

Population projections suggest that there will be an increase in the numbers in all older age groups from age 65 and over, both nationally and locally. With this increasing longevity there is also a noticeable increase in morbidity from long term conditions and disabilities within these age groups that causes concern. This increase also leads to increased pressure on health and care services.

2.3 The local population

Southend-on-Sea has an estimated population of 177,990 people, of which 18.9% are aged 65 and over - higher than the England average of 17.6%.

The overall life expectancy for men and women in Southend is similar to the England average (79.2 years men, 82.9 years women). Tables 1 and 2 provide 3 year rolling averages for healthy life expectancy in Southend and England, for males and females in the period 2009 to 2013.

Life expectancy is an estimate of the average expected life span, based on the current patterns of mortality; healthy life expectancy is an estimate of the years of life that will be spent in good health (illness free).

Table 1 Life Expectancy and Healthy Life Expectancy for Males and Females Southend

Year	Males		Females	
	Life Expectancy	Healthy Life expectancy	Life Expectancy	Healthy Life expectancy
2009-11	78.7	63	82.4	64.6
2010-12	79.7	64.1	82.6	64.9
2011-13	79.8	62.6	82.9	64.6

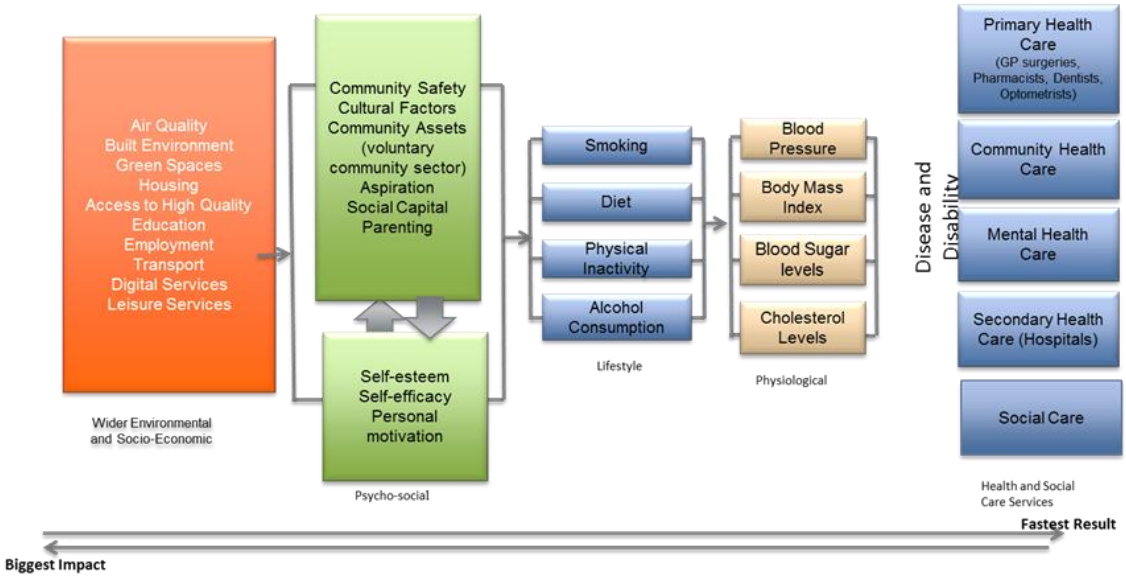
Table 2 Life Expectancy and Healthy Life Expectancy for Males and Females England

Year	Males		Females	
	Life Expectancy	Healthy Life expectancy	Life Expectancy	Healthy Life expectancy
2009-11	78.9	63.2	82.9	64.2
2010-12	79.2	63.4	83	64.1
2011-13	79.4	63.3	83.1	63.9

Life expectancy varies from population to population, men and women living in the most disadvantaged areas of Southend have a life expectancy 11.1 years and 10 years respectively, lower than men and women in the most affluent areas of Southend. We know that areas with high levels of deprivation have increased death rates attributable to conditions such as cardiovascular diseases, cancers, respiratory disease (3). Therefore any preventative action we take locally, must also address disadvantage and inequality (3,4).

Between 2012-2014, 1483 Southend-on-Sea residents died prematurely (before age 75) as a result of a condition that could have been prevented (335.1 deaths per 100,000 population). This high rate of premature deaths ranks Southend 67 out of 150 upper tier local authorities for premature mortality in England. Figure 1 shows the potential interaction of a range of risk factors on population health and wellbeing.

Figure 1 Interplay of risk factors on population health



3.0 The Context for Prevention

3.1 National policy

There are a number of statutory prevention related duties the Council and its partners are required to deliver. The Care Act 2014 places a duty on local authorities to provide or arrange for the provision of interventions, facilities or resources that contribute to preventing or delaying the development of care and support needs by adults. Local authorities must also contribute towards preventing or delaying the development of support needs by carers in their area.

The Five Year Forward View is the new plan setting out NHS policy for the next 5 years. This plan establishes a new vision for the English health and social care system (2). It envisages an integrated, flexible localised system, able to collaborate and respond rapidly to address the key issues impacting on the health of local people. The key thread within the Forward View is the prevention of disease and disability. This Five Year Forward View recognises the sustainability of the NHS, and economic prosperity of the country, depends on a radical upgrade in the manner in which people are supported to live healthier lives.

The current increase in the burden of avoidable illness and disease on the health and social care system in England was predicted in 2002 by Sir Derek Wanless (3).

The Wanless report warned of severe consequences for the Health and Social Care system unless there was a concerted effort focussed on prevention. This report identified 3 possible scenarios:

- ***Slow uptake*** –no change in the level of public engagement: life expectancy rises by the lowest amount in all three scenarios and the health status of the population is constant or deteriorates. The health and social care economy is relatively unresponsive with low rates of technology uptake and low productivity.

- ***Solid progress*** – people become more engaged in relation to their health: life expectancy rises considerably, health status improves and people have confidence in the primary care system and use it more appropriately. High rates of technology uptake and more efficient use of resources

- ***Fully engaged*** – levels of public engagement in relation to their health are high: life expectancy increases go beyond current forecasts, health status improves dramatically and people are confident in the system and demand high quality care. There is a high response and use of technology, particularly in relation to disease prevention. Use of resources is more efficient.

Wanless estimated the fully engaged would scenario would result in savings of up to £30bn, but he warned statutory organisations responsible for protecting and improving the public health, needed to take radical steps to fully engage the public in preventative endeavours.

The alternative to the fully engaged scenario was a rise in health inequalities, more illness and disease and higher costs for the NHS and Social care. The Five Year Forward View is a recognition the fully engaged scenario proposed by Wanless has not been achieved.

Other strategic drivers also advocate a greater focus on prevention. The Care Act 2014 and Health and Social Care Act 2012 place statutory duties on local authorities and their partners to take action to protect and improve the health of the population.

At a local level, the Southend Health and Wellbeing Board through its Health and Wellbeing Strategy, holds local partners to account for the way in which they deliver improved health outcomes for local residents. The Southend Health and Wellbeing Strategy, has 3 broad impact goals, underpinned by 9 wider ambitions to improve population health.

Impact Goals:

a) Increased physical activity (prevention)
b) Increased aspiration and opportunity (addressing inequality)
c) Increased personal responsibility and participation (sustainability)

Ambitions:

A positive start in life	Promoting healthy lifestyles	Improving mental wellbeing
A safer population	Living independently	Active and healthy ageing
Protecting health	Housing	Maximising opportunities

3.2 Sustainability and Transformation Plans (STP)

The Five Year Forward View has required NHS organisations to engage with local authorities and other partners to produce two separate but connected plans:

- Five year Sustainability and Transformation Plan (STP) - this is place-based and will drive the Five Year Forward View
- One year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP.

Prevention and early intervention is a key theme within STPs. These plans place an emphasis on system wide place based approaches to deliver better and more efficient health and care services. They require action to transform the environments where people live and work, as opposed to simply focussing on a particular behaviour do. This prevention strategy will help deliver the Southend locality aspirations for the South and Mid Essex Sustainability Transformation Plan. It will provide a vehicle for collaboration to deliver evidence based prevention across the NHS, social care, voluntary and community interface in Southend.

3.3 The extent of the problem

The main consumers of health care are older people. Nationally it is estimated the number of people of pension age will increase from a base of 12.4 million in

mid-2014, to 16.5 million by mid-2039 (9). There is good evidence that people aged 65 and over from lower occupational income groups, have higher levels of physical, psychological and overall frailty than the more affluent (5). Meeting the needs of these people as they move into old age poses a considerable challenge in Southend.

Southend-on-Sea has an estimated population of 177,990 people, of which 18.9% are aged 65 and over. This figure is higher than the average for England where 17.6% of the population are aged 65 and over. Over 87,000 Southend residents are aged between 40-85. This means there are a significant number of older adults in the borough, who may require preventative support to maintain or improve their health status at some stage during their life.
In the period 2012 to 2014, the premature mortality rate in Southend residents attributable to cardiovascular diseases, was significantly higher than the England average. There were 85.6 deaths per 100,000 population in Southend, compared to 75.7 deaths per 100,000 population in England.

The premature death rate associated with preventable cancers in the same period, was 87.1 per 100,000 population Southend, compared with 83 per 100,000 for England. Increasing levels of physical activity within the population; improving diets through reducing the amounts of sugar and salt consumed; increasing fruit and vegetable consumption and maintaining a healthy weight, are simple but effective ways to reduce a person's risk of adverse events related to cardiovascular disease and preventable cancers (5).

Prevention can also help to reduce deaths from respiratory disease which is another key issue impacting on the health of local people. In 2012 to 2014, the death rate from respiratory disease was 17.7 per 100,000 population in Southend, compared with 17.8 per 100,000 population in England. Helping people stop smoking, taking action to improve air quality will help to reduce the impact of respiratory disease. Working with vulnerable people to keep their homes warm in winter and increasing the uptake of seasonal influenza vaccination in those at risk will also help to reduce preventable deaths from respiratory disease.

The other major indicator of note is the number of older people aged 80 and over suffering a hip fracture. Falling and associated hip fractures, pose a major challenge in England. Treatment and care costs are in the region of £2 billion each year. The average cost of a single hip fracture is in the region of £28,000 over a 2 year period. Only 1 in 3 older people who suffer a hip fracture return to their former levels of independence and 1 in 3 will need to leave their own home and move into long-term care.

In the period 2012 to 2014, the rate of hip fracture for this age group in Southend was 1,822 per 100,000 population. This rate is significantly higher than the England average (4). Future projections suggest a 243% increase in costs associated with the treatment and care of people suffering a hip fracture. It is estimated these costs will increase to £5.6 billion by 2033 (10).

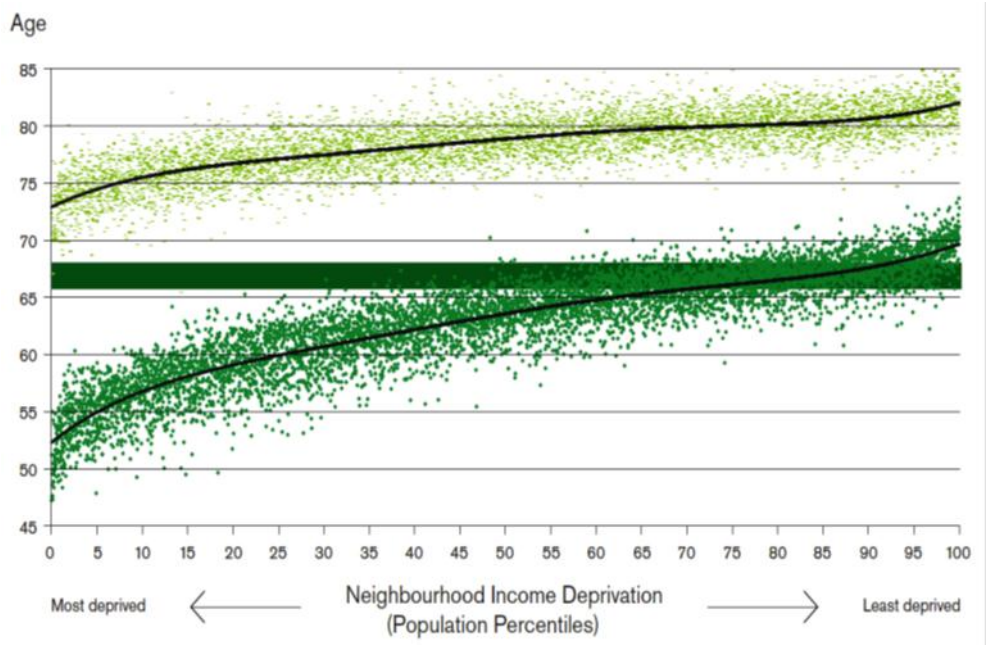
Prevention has an extremely important role to play to reduce the human and financial costs associated with hip fractures. Simple measures such as screening and identifying those at greatest risk of falling and taking steps to improve bone health through increasing weight bearing and physical activity can have a positive impact on reducing the number of people suffering a hip fracture.

3.4 Non communicable diseases

There is evidence to suggest that the increase in the prevalence of non-communicable diseases, such as diabetes, hypertension and cardiovascular conditions, may result in healthy life expectancy not keeping pace with current increases in life expectancy (4). This finding reinforces strong evidence of the relationship between socio-economic status and ill health in later life.

The Marmot review into healthy inequalities in England identified that people living in the poorest neighbourhoods; will on average die 7 years earlier than people living in the richest neighbourhoods (5). Figure 2 provides an overview of this inequality.

Figure 2 Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999–2003

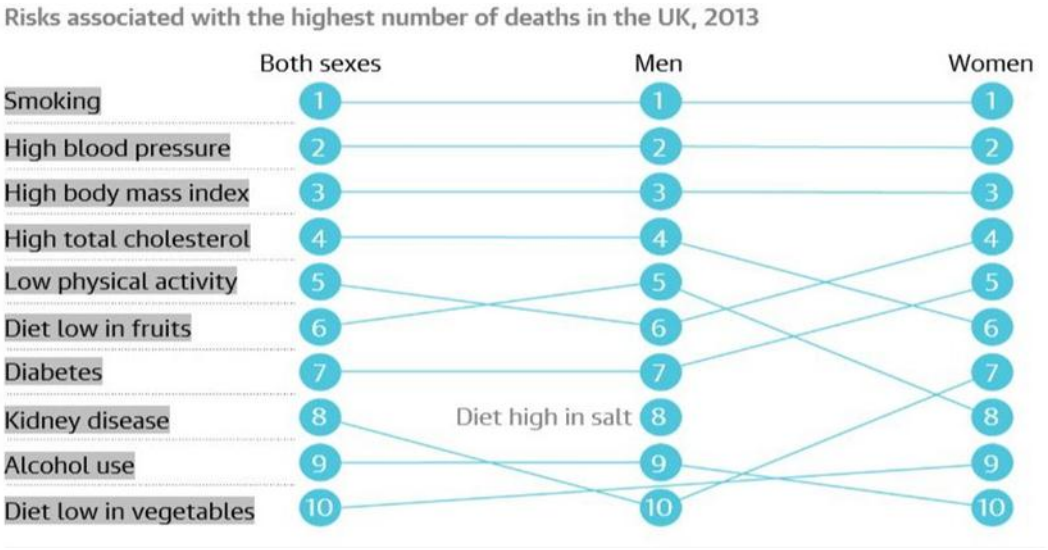


Source: Marmot Review Fair Society Healthy Lives 2010

Key:
- Life expectancy
- DFLE
- Pension age increase 2026–2046

In order to be successful, we need to focus on what will provide most benefit for our population. The recent update to the Global Burden of Diseases Study, found tobacco smoking, high blood pressure and obesity to be the risk factors attributable for **most mortality** in the UK (5). Figure 3 provides an overview of these risks and their ranking in terms of causing deaths for men and women in the UK.

Figure 3 Risks associated with the highest number of deaths in the UK, in 2013



Source: Global Burden of Disease Survey 2015

High blood pressure (blood pressure reading over 140/90mmHg) is one of the leading risk factors for premature death and disability. This condition can lead to stroke, heart attack, heart failure, chronic kidney disease and dementia. The average cost to health and social care commissioners of managing a person who has had stroke, is £12,000 initially and £6,000 every subsequent year.

There are 28,300 **people diagnosed** with hypertension living in Southend. This is well below the estimate of 47,700 people who are believed to have hypertension living in the Borough, which is significantly higher than the England average (8).

Of those diagnosed with hypertension, 22,300 have their condition effectively controlled. The number of people who are controlled is significantly lower than the England average (8). People from the most deprived areas are 30% more likely than the least-deprived to have hypertension. Southend ranks 184 out of 326 local authorities for negative lifestyle behaviours that increases the risk of hypertension. The total cost of prescriptions to treat hypertension was £620,000 in 2014/15 alone. At a cost of £3.98 per item, the Southend costs were 90p per item more than the average cost for England. Addressing this issue by

diagnosing and supporting people to effectively manage their high blood pressure is a local priority.

Over 670,000 people are thought to be living with dementia in England. Care and treatment costs are in the region of £19 billion each year. The cost of treating and managing people with dementia is higher than the costs of treating cancer, stroke or heart disease. Nationally over 550,000 people are caring for someone living with dementia and 1 in 3 people are expected to have to care for a person with dementia in their lifetime. Poor lifestyle can also trigger vascular dementia which account for 20% of all dementia cases diagnosed. Within Southend the number of people recorded on GP disease registers having with dementia as a proportion of the number of people **estimated** to have dementia locally was 68.49%. This figure is lower than the England average and significantly lower than 10 similar comparable areas to Southend (68.71% and 72.44% respectively).

The impact of chronic long term conditions (LTCs) on the Southend population is a major concern. Southend has an older population than the England average and one that is ageing faster. Thirty-one per cent of Southend residents report having at least 1 long term condition. There are also more people in Southend living with three or more LTCs (12.9%, compared to the national average of 10.5%). People with a multiple LTCs are more likely to have complex needs and require intensive health and care support. The average national annual cost to provide care and support to someone with a single LTC is around £1,000. This rises to £3,000 for someone with two conditions and £8,000 for people with three or more conditions. This is borne out by the evidence that suggests people with LTCs account for 70% of health and care spend nationally (11).

There is clear evidence that addressing lifestyle risk factors in the Southend population will help to reduce the impact of non-communicable diseases on the local health and care system.

3.5 What works

Interventions focussed on improving the key determinants of health and addressing wider environmental and socio-economic factors, will have the greatest impact on the life course and reduce health inequalities over the long term. Action to address modifiable risk factors related to non-communicable diseases, will improve health outcomes (categorised under lifestyle and physiological factors) but need to be delivered in a joined up way. This means prevention must be built into all aspects of service planning in Southend preferably through a placed based approach.

There is good evidence that taking **proportionate** action to support people with low or moderate risk factors is a more effective and efficient way to improve the health of the whole population over time. Everyone has different capabilities which will influence the way they respond to challenges to their health and

wellbeing. Interventions need to be tailored to enable people to take as much control of their treatment and care as possible. Those at greater risk of an adverse event should receive more support. Those who are able to support themselves should be given the tools to do so. The latter group may be supported to self-care by being signposted to information and advice, or through further intervention such as referral for lifestyle support.

Southend has the capacity to make this major change. There are dedicated professionals, working alongside equally dedicated and well established community groups and organisations. Southend residents are responsive when motivated. They want to make a positive difference to improve their health and that of their community.

All the required strategic enablers are available to take forward a place based approach to industrialising prevention in Southend. There is a single upper tier local authority, coterminous with one Clinical Commissioning Group. Southend is a health and social care integrated pilot area, with joint commissioning arrangements overseen by a strong partnership. There is a strong history of collaboration between commissioning and provider organisations.

4.0 Links with other local strategies

This Prevention Strategy does not aim to replicate the work of existing key plans. It does however aim to align local current and future initiatives to deliver an industrial scale, placed based prevention approach in Southend-on-Sea. The main local drivers for change are set out in Table 2:

Table 2: Key local strategies and interventions through which the objectives of this Joint Adult Prevention Strategy will be achieved (list is not exhaustive)

System Redesign	Population Focus	Wellbeing Interventions	Commissioning
Southend Community Recovery Pathway	Older People's Strategy	Lifestyle Service	LA Commissioning
Southend Complex Care Work stream	Dementia Strategy	Obesity Strategy	NHS Commissioning
Social Care Redesign	Carers Strategy	Physical Activity Strategy	Joint Commissioning
End of Life Strategy	Falls Prevention Strategy	Parks and Green Spaces Strategy	
Digital Strategy	Housing Strategy		
Sustainability Transformation Plans	Mental Health Strategy		

5.0 Delivering the strategy

5.1 Implementation, monitoring and evaluation

Within Southend there are a number of forums and strategic groups to enable effective delivery of health and social care interventions. In terms of prevention, the Southend Health and Wellbeing Strategy provides the overall direction of travel. Operationally, system leaders within Southend work collaboratively to facilitate the local delivery of programmes.

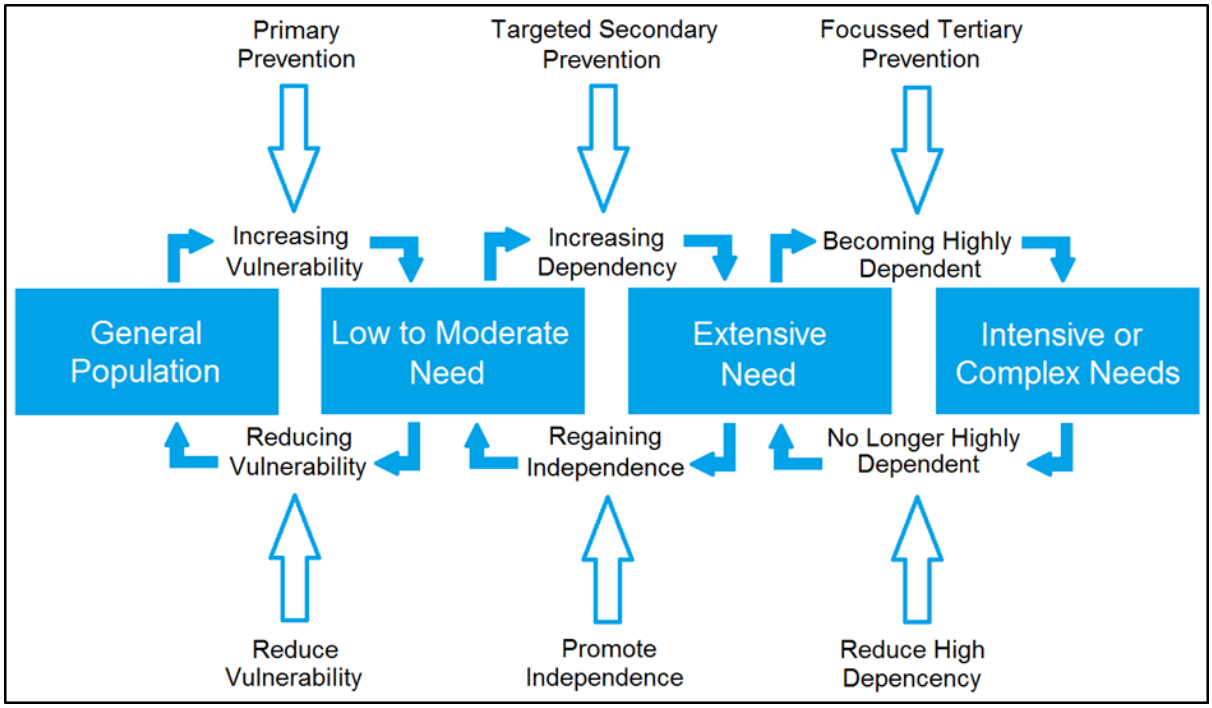
One key intervention that may prove to be a 'game changer' for prevention locally is the commissioning of a Southend Healthy Lifestyle Service. This service provides a single gateway for all locally commissioned preventative interventions. It enables individuals to access support and self-care options to meet their own particular needs. The Southend Healthy Lifestyle Service also facilitates access to interventions available from local Southend third sector providers and voluntary organisations.

Local primary care practitioners have expressed a desire for access to more holistic preventative interventions. The Southend Healthy Lifestyle Service will provide this crucial bridge between primary care and other settings. Social care practitioners will also able to access this service. These colleagues often identify people who are in need of support and are best placed to signpost or refer individuals according to need.

The Southend Healthy Lifestyle Service aims to help deliver the vision of a place based approach to prevention. It sits alongside key local programmes, including the Southend Community Recovery Pathway (core programme with the Southend Health and Social Care Transformation Programme). It fully supports secondary prevention. GPs will be able to utilise their expertise in particular targeted case finding and refer at risk individuals to the Lifestyle Service for in-depth, supported interventions.

Figure 4 provides an overview of how prevention can be used to support people at risk of an adverse health event, or who have already have a health issue, regain independence.

Figure 4 Opportunities to deliver prevention to promote independence



5.2 Innovation

In order to achieve the strategic shift to prevention focussed placed based commissioning within Southend, there needs to be a radical rethink of the way we do things.

There are real opportunities to harness technology to improve outcomes for local people. Southend is aligned with new technology providers through its 'Med Tech' partnership with Anglia Ruskin University. It has developed a Digital Strategy and is in the process of implementing a 'Smart Cities' programme that will revolutionise the way local people and those living and working in the Borough, access information, advice and support.

The regeneration of Southend offers the chance to 'design in' prevention opportunities within the local infrastructure. One example is the 'Queensway' regeneration project. This major building project, offers the chance to radically change the physical environment of the Borough, embedding prevention into the physical landscape of Southend.

To get 'full engagement' from the Southend community, we need to harness the power of local people. We have to empower them to take steps to improve their physical and mental health. To do this we propose to identify local 'Prevention Champions' and train them appropriately so they can support their community, friends and family, to improve their health and future life chances. There should be no shortage of volunteers to take up these roles. Elected members are an

obvious choice to become Prevention Champions given their direct contact with local people, but there are many who could be trained to build local capacity and capability. This approach also aligns with the aspiration of NHS Southend Clinical Commissioning Group to increase local case management for people with long term conditions.

There are a range of actions that will help to improve population outcomes within Southend. The following areas are those the evidence suggests are most effective in terms of reducing or delaying the impact of adverse events. It is important to note these actions focus on people at risk (as detailed in the prevention strategy scope) as opposed to the general adult population of Southend-on-Sea.

5.3 Key priority areas

Key Area 1: **Proactively support lifestyle behaviour change in adults with specific long term conditions (LTCs)**

- Roll out and use of patient activation measures in primary care.
- Increase the number of people living with chronic long term health conditions who access the Southend Healthy Life Style Service.
- Develop a local cadre of prevention champions trained in ***Making Every Contact Count*** behavioural change methodology.
- Increase the proportion of Southend adults (specifically those with a long term chronic health condition, physical disability, mental health) who regularly undertake the recommended weekly levels of physical activity.
- Reduce the proportion of the Southend adult population who are deemed to be overweight and obese.(in particular women of child bearing age)
- Continue to support the work to decrease tobacco use in Southend.
- Decrease excessive alcohol use in Southend.
- Deliver a targeted social marketing programme targeted at risk behaviours to facilitate lifestyle change.
- Use digital technology to improve access to health promotion, information and advice for people who are at risk of or recovering from an adverse event that has impacted on their health.

Key Area 2: Creating community capacity and enhancing community resilience.

- Improve support to carers so they feel they are able to cope more effectively with their caring responsibilities.

- Increase and improve interventions to address social isolation and loneliness in older people, people living with disabilities and carers.

- Supporting people with a long term condition to feel independent and in control of their own condition.

- Support local employers to improve and maintain the mental and physical health of employees.

- Increase the number of volunteers in Southend who are able to actively support people with long term chronic health conditions.

- Continue to address risk factors related to suicide and deaths undetermined

Key Area 3: Improve early detection and treatment of risk factors related to non-communicable diseases

- Increase the number of individuals diagnosed with:
  - Hypertension
  - Atrial fibrillation
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Diabetes
  - Osteoporosis (fragility fracture risk)

Appropriate treatment and management plans are in place to support these individuals in line with best practice guidance for each condition

- Use outreach services to make NHS Health Checks more accessible for the most vulnerable and harder to reach groups within the population.

- Increase uptake of learning disability health checks in primary care.

- Improve detection of risk factors liable to cause deterioration of physical and mental health status in frail older people.

- Reduce the ratio of expected to diagnosed dementia patients on GP primary care registers.

5.4 High level prevention indicators

In order to deliver the aspirations of this strategy we will:

- Consolidate a performance matrix to capture the contribution of existing strategies to health improvement outcomes
- Establish mechanisms to inform the inclusion of specific prevention outcomes within all future strategies/programmes within Southend

These two tasks are currently being taken forward. An outline action plan is set out in Appendix 1 that will be used to inform delivery of strategy outcomes. This plan is subject to regular revision in line with the dynamic nature of the Southend Health and Social Care Transformation Programme. The following section sets out an initial range of indicators across the 3 domains of prevention that will be subject to regular review and update.

Indicator	Source
Smoking prevalence (Smoking in Pregnancy)	Public Health Outcomes Framework (PHOF)
Percentage of physically inactive adults	PHOF
Excess weight in adults (Maternal Obesity)	Public Health England
Alcohol related hospital admissions	PHOF
Flu vaccination coverage, adults aged 65+ and those in defined “at risk groups”	INFORM, Public Health England
Percentage of adults eating 5 portions of fruit and vegetables each day	Active People Survey

Secondary Prevention Indicators

Indicator	Source
Health Checks Delivered	Local commissioned providers
LD Health Checks Delivered	Quality Outcomes Framework (QOF)
Number of patients who have had their activation levels monitored	Local Source (SBC PH)
Incidence of stroke	PHOF
% of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA2DS2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more)	QOF
Completeness of Hypertension registers	QOF
% of patients on QOF Hypertension register	QOF

with a blood pressure recorded in the preceding 12 months is <=150/90	
% of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis	QOF
% of adult carers who have as much social contact as they would like	PHOF
Completeness of COPD registers	QOF
The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March	QOF

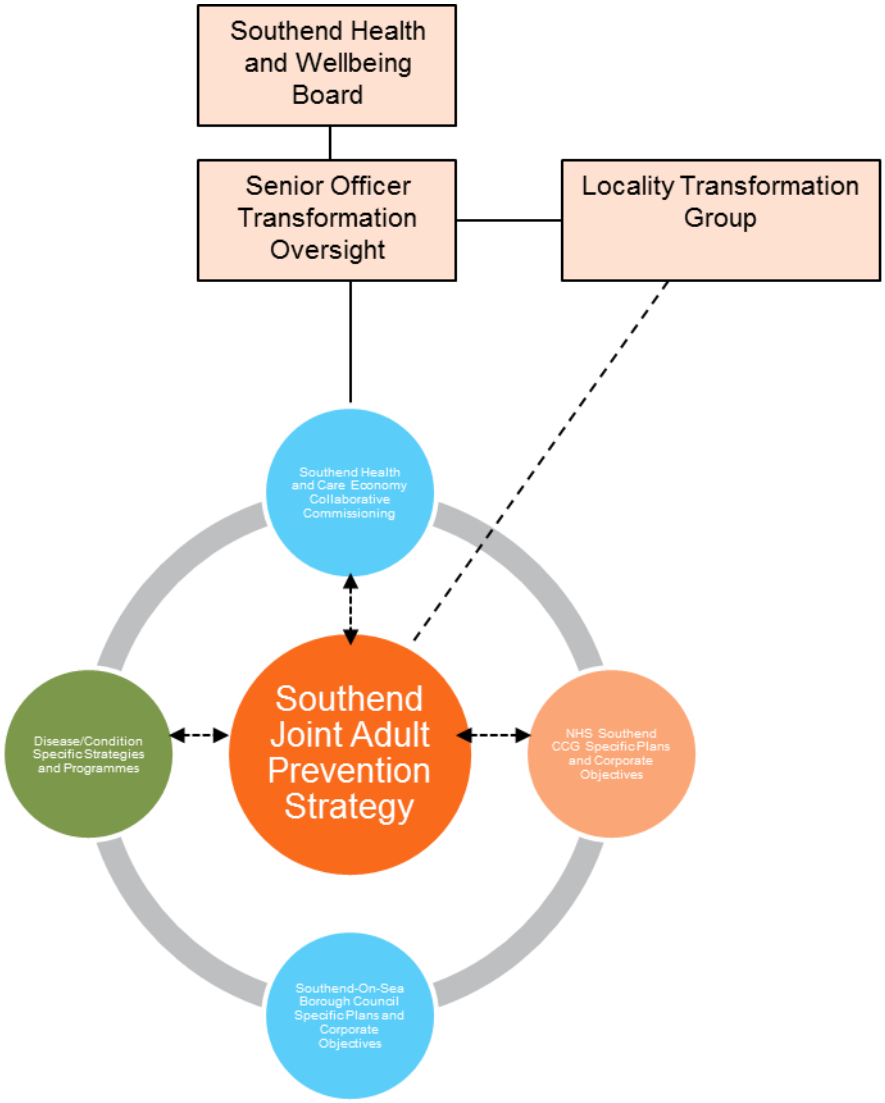
Tertiary Prevention Indicators

Indicator	Source
Number and rate of falls in population aged 65+	PHOF
Number and rate of falls resulting in fractured neck of femur as Primary Diagnosis in population aged 65+	PHOF
% of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken	QOF
% of stroke discharges that result in Early Supported Discharge	NHSSCCG/SBC
Completeness of GP COPD registers	QOF
Rate of unplanned hospital admissions for those ages 75+	PHOF
% of population in SBC funded registered care	SBC
% of clients self-caring following reablement	SBC
% of adults with a learning disability who live in stable and appropriate accommodation	SBC
Gap in employment rate between those with a learning disability and the overall employment rate	SBC
% of adults in contact with secondary mental health services who live in stable and appropriate accommodation	SBC
Gap in employment rate between those in contact with secondary mental health services and the overall employment rate	SBC

5.5 Oversight

Figure 5 provides an illustration of the relationship between this prevention and strategy and the Southend health and care economy. This diagram is subject to revision in line with pending changes to local governance arrangements within the Southend health and care economy.

Figure 5 Oversight arrangements



5.6 Summary

The Wanless ‘fully engaged’ scenario may take some time to achieve in Southend. Being able to contain demand at current levels and maintaining the status quo might be desirable in some cases. We will know we have made a difference when health and care costs reduce and demand for interventions reduce substantially overtime.

The action plan at Appendix 1 sets out the high-level prevention outcomes to be delivered throughout the lifetime of the Southend Joint Adult Prevention Strategy. Responsibility for delivering condition specific outcomes rests with the relevant strategy and associated local delivery mechanisms. For example, the Southend Physical Activity Strategy is the vehicle that will take forward actions related to increasing the rate of physical activity in at risk groups; the Southend Carers strategy, actions related to improving outcomes for carers.

Further debate is required to align the key outcomes that are set out in the partnership strategies referenced in this prevention strategy. This work is on-going. There is a need to be pragmatic and take account of the changing population needs and local priorities. The following section sets out how we will monitor the progress of the deliverables set out in this prevention strategy.

5.7 Southend Joint Adult Prevention Strategy Action Plan

	Key Area 1: Proactively support lifestyle behaviour change in adults with specific long term conditions (LTCs)				
Action	**Outcome**	**Specific Actions**	**How it will be measured**	**Lead Organisation**	**Timescale**
1	Rollout use of patient activation measures in primary care (increase the ability of people to self-manage)	All GP Practices to use patient activation measures for routine assessment (annual reviews) with people LTC's People at low activation (1&2) to be referred appropriately for self-management support) Increase the number of people moving from activation levels 1&2 to level 3 or 4 by 10% each year for the period of the strategy (baseline to be established)	Primary Care Coding PH Audit/performance monitoring SBC-PH contract monitoring - KPI	NHS Southend CCG –SBC PH NHS Southend CCG –SBC PH	April 2017 April 2017
2	Increase the ability of people living with chronic long term health conditions to self-management	Increase referrals the Southend Healthy Lifestyle Service (at least 3600 people with LTC referred per annum)	Primary Care (Southend Community Recovery Pathway)	NHS Southend CCG, SBC Social Care, SBC-PH	2017-2020
3	Develop a local cadre of prevention champions trained in ***Making Every Contact Count*** behavioural change methodology.	Identify, train and establish a network of local Southend voluntary prevention champions Every GP practice to have an assigned prevention lead responsible for supporting the practice to improve health of people with identified LTCs in each practice.	SBC-PH audit	SBC – PH and NHS Southend CCG	2016-2020

Action	Outcome	Specific Actions	How it will be measured	Lead Organisation	Timescale
4	Increase the proportion of Southend adults (specifically those with a long term chronic health condition, physical disability, mental health) who are regularly undertake the recommended weekly levels of physical activity	Southend physical activity strategy to develop specific baseline and target with interventions for people with LTC's and mental health problems	Active People Survey	SBC PH and SBC Department of Place	2016-2021
5	Reduce the proportion of the Southend adult population who are deemed to be overweight and obese	Implement the Southend Obesity Strategy	Public Health Outcomes Framework	SBC and NHS Southend CCG	2016-2021
6	Continue to decrease tobacco use in Southend	Implement Southend Tobacco control policy Increase number of local businesses in Southend Public Health Responsibility Deal signing up to tobacco control pledge	Local Audit	SBC –PH, SBC Department Place	2016-2021
7	Decrease excessive alcohol use in Southend	Reduce number of people alcohol related hospital admissions for Southend residents Increase identification of excessive alcohol intake in persons aged 40-74 through use of brief interventions following NHS Health Checks	Public Health Outcomes Framework	SBC – PH , SBC DACT, NHS Southend CCG	2016-2021
8	Deliver a social marketing programme targeted at risk behaviours to facilitate lifestyle change	Segment local at risk population (LTC) deliver social marketing programmes to support referrals to Southend Healthy Lifestyle Service	Programme evaluation	SBC - PH	2016-2018

9	Use digital technology to improve access to health promotion, information and advice for people who are at risk of or recovering from an adverse event that has impacted on their health	Implement Public Health Elements of Southend Digital Strategy	Audit TBC	SBC-PH, SBC Place Department	2016-2021
	Key area 2. Creating community capacity and enhancing community resilience				
Action	**Outcome**	**Specific Actions**	**How it will be measured**	**Lead Organisation**	**Timescale**
10	Improve support to carers so they feel they are able to cope more effectively with their caring responsibilities	Improved and more varied respite for the cared for	Carers survey	SBC Department for People/ Southend Carers Forum	2016-2018
11	Increase and improve interventions to address social isolation and loneliness in older people, people living with disabilities and carers	Develop capacity and capability to support lonely and social isolated older people Network (volunteers). Engage with volunteers and user led groups to discuss how they can help with improving interventions which address social isolation.	Take up of the opportunities provided Customer feedback	SBC Department for People/ Southend Carers Forum	2016-2018
12	Increase social connectivity and befriending	Develop local community resilience and local peer networks. Use learning from C2 community development programme to develop local community capacity. Focus on using strengths-based assessments and care planning, which concentrate on individual abilities and community assets, rather	Customer feedback/ SBC-KPI SBC - KPI	SBC Peoples Department	2016-2018

		than an approach that overly focuses on deficits and provision to meet need.			
Action	**Outcome**	**Specific Actions**	**How it will be measured**	**Lead Organisation**	**Timescale**
13	Establish network of Local Southend Prevention Champions	Work with council community development team to Identify and train local voluntary Prevention Champions to link with local communities and specific target groups	Evaluation criteria will feed into Connect metrics. Social Return on Investment also under consideration	SBC-PH – Vol Orgs	March 2017
14	Support people with a long term conditions to feel independent and in control of their own health	People with LTC able to access local self-management courses and opportunities	GP Survey	SBC PH- NHS Southend CCG	2020
15	Increase the number of people with respiratory conditions (COPD, asthma) who have a seasonal influenza vaccination	Work with primary care teams and NHS England to increase influenza uptake in at risk groups Reduce the rate (100,000) of people with respiratory conditions (COPD, Asthma) admitted to hospital	Inform returns	NHS Southend CCG/ NHS England	2018
16	Support local employers to improve and maintain, the mental and physical health of employees	Continue to support employers signed up to the Southend Public Health responsibility deal and increase the number of new local employers signed up to Southend Public Health Responsibility deal (by a minimum of 10% each year	PH Performance monitoring Employment Support Allowance Claimants	SBC- PH	2020

Action	Outcome	Specific Actions	How it will be measured	Lead Organisation	Timescale
	Key area 3: Improve early detection and treatment of risk factors related to Non-Communicable Diseases				
17	Increase the number of patients diagnosed with hypertension by at least 19%	Increase opportunistic testing of blood pressure within primary care (GP and pharmacy), the Southend Get Healthy Service IHLS and the wider community Improve the uptake of the NHS Health check in 40-74 year olds to at least 75% of those offered a check (at least 200 new cases of hypertension identified) All people referred to Southend Get Healthy Lifestyle Service to have their BP taken. (Appropriate referrals made/action taken for all those identified)	QOF IHLS KPI PH contract monitoring and PHOF PH -Performance monitoring	NHSE/NHS Southend CCG - PH SBC – PH SBC -PH	April 2018 April 2018 July 2016
18	Improve the care of those already diagnosed with hypertension	9200 people with hypertension to have BP measured within appropriate range (150/90) Support adherence to treatment and lifestyle by increasing self-monitoring of BP	QOF audit	NHSE/NHS Southend CCG NHS Southend CCG	April 2018 April 2020
19	Improve the detection of atrial fibrillation (AF) to match that of comparator CCGs	Targeted action within primary care to identify AF (actions currently being scoped. Measure will be confirmed when finalised)	QOF	NHSE/NHS Southend CCG	April 2020

Action	Outcome	Specific Actions	How it will be measured	Lead Organisation	Timescale
20	Improve the care of those already diagnosed with atrial fibrillation,	All patients with AF who could benefit from anticoagulants are offered treatment. (baseline 2015/16 QOF)	QOF	NHSE/NHS Southend CCG	April 2020
21	Increase uptake of learning disability health checks in primary care	At least 80% of people identified with a learning disability (LD) to receive LD health check People with LD are appropriately referred for lifestyle intervention to address risk factors related to non-communicable disease	QOF PH Contract monitoring	NHS Southend CCG SBC-PH	April 2020
22	Prevent the onset of type 2 diabetes in people at risk of the condition	100 people access the Southend diabetes prevention programme	PH contract monitoring	NHS Southend CCG/SBC PH	September 2017
23	Improve the prevention and detections management of those with diabetes.	Increase the uptake of the NHS health check to 75% (at least 51 new cases of type 2 diabetes identified)	PH contract monitoring	NHS Southend CCG/SBC – PH	April 2017
24	Improve the management of type 2 diabetes	Increase proportion of patients with optimal treatment to national good practice levels	QOF	NHSE/ NHS Southend CCG	April 2020

Action	Outcome	Specific Actions	How it will be measured	Lead Organisation	Timescale
25	Improve the management of those diagnosed with COPD	Support people with COPD to stop smoking (% to be determined) Improve coverage of flu vaccination for those with COPD (baseline 2015/16)	QOF NHSE Flu returns	NHS Southend - CCG SBC-PH	April 2017 April 2017
26	Use outreach to make NHS Health Checks more accessible for the most vulnerable and harder to reach groups within the population	Percentage of people from routine and manual groups who receive an NHS Health Check through the outreach service (at least 800 people checked through outreach service)	SBC-PH and PHOF	SBC - PH	April 2017
27	Increase diagnosis of dementia	Reduce the ratio between expected and diagnosed dementia prevalence in GP primary care dementia registers (baseline 2015/16)	QOF	NHS Southend CCG	April 2020
28	Support older adults to achieve a healthy lifestyle to delay the onset of frailty	Increase throughput of older adults at risk of frailty to Southend Healthy Lifestyle Service to 20% by 2020. Support frailer adults to self-manage and address risk lifestyle behaviours including: stop smoking, physical inactivity, improve their diet, maintain a healthy weight, and reduce alcohol intake. Current baseline 2015/16 is 16% of service users are over 60	SBC PH contracting	SBC-PH	April 2020

Action	Outcome	Specific Actions	How it will be measured	Lead Organisation	Timescale
29	Prevent falls and fragility fractures in older people	Increase number of older people who receive falls risk assessment in primary care (specifically those with cognitive impairment) by 10% each year (107 additional referrals by 2018) (2016 baseline 510) Increase referral of older people at high risk of falls to community falls service/postural stability service Increase assessment and treatment of older people at risk of fragility fractures by 15% (referral baseline into community postural stability service 389 (58 additional referrals per year) 2015/16/ community falls service baseline in 2015/16 510 (77 additional referrals per year)	QOF/SBC PH Contracting	SBC-PH	April 2018

QOF: Quality outcome framework for General Practice in contracts PHOF: Public Health Outcome Framework KPI: Key Performance Indicator

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