

Wiltshire's

Joint Health and Wellbeing Strategy

Post consultation draft for approval
by the Health and Wellbeing Board

Contents

What is the Joint Health and Wellbeing Strategy for Wiltshire?	Page 3
What will success look like?	Page 3
How long does the strategy last?	Page 4
Reading this document	Page 5
Theme: Prevention	Page 6
Theme: Engagement	Page 9
Theme: Independence	Page 10
Theme: Safeguarding	Page 12
Glossary	Page 13
Appendix 1: Key documents and organisational plans	Page 15
Appendix 2: Summary of UK National Outcomes Frameworks	Page 16

What is the Joint Health and Wellbeing Strategy for Wiltshire?

It is about working together in Wiltshire so that people have the support they need to live longer, healthier lives. Working together means collaboration between organisations but it also involves the population of Wiltshire playing an active part in its own wellbeing.

Throughout our lives all of us want to live healthily and independently; to have our needs listened to and to be kept safe from avoidable harm. We think that these are healthy ambitions and that services in Wiltshire should be set up to support this. This applies whether we are young or old.

We have looked long and hard at the evidence on health and wellbeing in Wiltshire¹. By and large this is a cause for celebration; most people in Wiltshire are living longer lives than ever before. However, the same evidence also shows us a number of issues which individuals and agencies cannot always tackle alone – such as unhealthy lifestyles; a rise in illnesses, such as dementia, as people live longer; and the need to give help to those that are at particular risk of ill health.

Working together, all of us can offer something important to deal with these challenges.

Organisations already have their own business plans² which set out the services that they are providing and how they aim to make things fairer. Families, friends and neighbours also provide help in local communities across Wiltshire, alongside the wider voluntary and community sector, which is invaluable. We want to see more of this and will support people to do more for themselves, and each other, and to take responsibility for their health and wellbeing whether they are young or old.

So this strategy is not about taking action on everything at once. Instead, it sets out the main areas where working together will be vital for making a real difference in people's lives. This includes important issues such as making sure the right help is on hand when leaving hospital and offering support to allow people to live in their own homes for longer.

The Wiltshire-wide response (including that of Wiltshire Council) on improving the health of the public and providing care to children and adults will be in line with the themes and actions shown in this document. As will the work of the Clinical Commissioning Group (the organisation led by a group of GPs, responsible for buying the healthcare we need) and NHS England (the national body responsible for sourcing specialist healthcare, including the services provided to patients by GPs). Joint commissioning plans will be developed to provide more detail on how the outcomes will be delivered.

What will success look like?

The four main things we want to achieve for the people of Wiltshire are:

1. Living for longer;
2. Living healthily for longer, and enjoying a good quality of life;
3. Living independently for longer;
4. Living fairly, reducing the higher levels of ill health faced by some less well-off communities.

¹ Set out in the Health and Wellbeing Chapter of Wiltshire's Joint Strategic Assessment

² A list of some of the key documents here is included in Appendix 1.

To deliver this, GPs, social workers, health visitors, nurses and other frontline professionals will be working more closely together to provide a seamless service to carers, families and individuals. This aim will also be considered in workforce development strategies.

Better ways of getting help, such as over the phone (telecare) or by putting different services in the same place will also be looked at.

And the different organisations will plan and buy more of their services together to make sure people get the joined-up support they need.

Wiltshire's Health and Wellbeing Board* will be responsible for making this happen. The members of the Board will work with other local partners such as the Local Nature Partnership, housing providers, Wiltshire Probation Trust, schools, the Voluntary and Community Sector and Area Boards to influence other key services that affect health. The link between housing, planning and development and the health of the community is also recognised; given that physical and mental wellbeing depend on a broad range of characteristics including facilities for active travel, public transport and green spaces.

When making decisions, the Board will bear in mind the potential effects on vulnerable groups. The Board will also receive regular reports on the progress that is being made using measures developed nationally³ as well as some local measures where these are appropriate. These are shown against each of the ambitions in this document.

How long does the strategy last?

This strategy begins in September 2013 and sets out the ambitions which agencies will be working together to meet over the next few years and the actions needed to achieve these.

We will look at it again in 12 months time (and as and when needed) to make sure the right areas are still covered. We will also be listening to communities and service users across Wiltshire (working with the new Healthwatch Wiltshire) to make certain your views and experiences on joint working are used to change things for the better.

Signed: The Members of Wiltshire's Health and Wellbeing Board*

*Wiltshire's Health and Wellbeing Board members work together to understand Wiltshire's needs, agree local priorities and encourage commissioners (those responsible for designing and paying for services) to work in a more joined up way. The Board is chaired by the Leader of Wiltshire Council, Cllr Jane Scott OBE. The Board also involves patient representatives (through Healthwatch Wiltshire) and brings these together with local commissioners from health, public health, the police and children and adults' social care sectors. By working in this way the Board aims to significantly strengthen the democratic basis of decisions, as well as offering a way of involving local people.

³ These include the [NHS Outcome Framework](#) (NHSOF), [Adult Social Care Outcome Framework \(ASCOF\)](#) and [Public Health Outcome Frameworks](#) (PHOF) and the views of the [Children and Young People's Health Outcomes Forum](#). These are summarised in Appendix 2.

Reading this document

The diagram below illustrates how the key **themes** (Prevention, Independence, Engagement and Safeguarding) in Wiltshire’s Joint Health and Wellbeing Strategy are looked at for each stage of our lives.

For each of these themes, ‘**Healthy Ambitions**’ are provided. These are what we want the people of Wiltshire to experience. Alongside the Healthy Ambitions are shown the joint actions that will be taking place to help achieve them.

Although not a hard and fast rule, the joint actions at the start of each theme tend to be those most relevant to early life and those later on more relevant to other stages of life. Some of the actions will be relevant across all life stages.

Life stage				
Theme: I will be...		Starting Well Developing Well (inc. Pre-natal, Pre-school & School)	Living Well Working Well (inc. Adulthood)	Ageing Well (inc. Retirement & Old Age)
	Supported to live healthily (Prevention)	Joint Action →		
	Listened to and involved (Engagement)	Joint Action →		
	Supported to live independently (Independence)	Joint Action →		
	Kept safe from avoidable harm (Safeguarding)	Joint Action →		

Taken together, the actions will provide the right healthcare for you, with you and near you.

As explained above, the outcomes of the actions will be measured using indicators from the Public Health Outcomes Framework (**PHOF**); the Adult Social Care Outcomes Framework (**ASCOF**) and the NHS Outcomes Framework (**NHSOF**).

Theme: I will be supported to live healthily (Prevention)

Healthy ambition	Joint activity	Outcome measure
I will get the best start in life	<p>Further development of integrated working between children’s centres, health visitors and midwives (to support mother and child)</p> <p>National Healthy Child programme Air Quality Strategy</p>	<ul style="list-style-type: none"> • Infant mortality (NHSOF 1.6i) • Children in poverty (PHOF 1.1) • Low birth weight of term babies (PHOF 2.1) • Breastfeeding (PHOF 2.2) • Smoking status of mother (PHOF 2.3) • Child development at 2 years (PHOF 2.5)
I eat well and get enough exercise; and have access to a range of opportunities for physical activity, including outdoors	<p>Early Years Healthy Eating programme and Healthy Schools programme (inc. Forest Schools)</p> <p>Child Obesity and Adult Obesity Pathways implementation; Free child swimming in school holidays and leisure services promotion Local measures to promote walking and cycling and active travel (e.g. Bike It Plus and Walking Challenge; sustainable transport planning and school/ workplace travel plans) Provision of green space close to where people live</p> <p>Active health programme providing referrals for particular groups Green Gym scheme Support conservation volunteering Support communities to develop healthy lifestyle initiatives Air Quality Strategy</p>	<ul style="list-style-type: none"> • Excess weight in 4-5 and 10-11 year olds (PHOF 2.6) • Tooth decay in children aged 5 (PHOF 4.2) • Use of green space for exercise/ health reasons (PHOF 1.16) • Excess weight in adults (PHOF 2.12) • Proportion of physically active and inactive adults (PHOF 2.13)
I make informed decisions about alcohol, cigarettes and drugs	<p>Risky behaviour training Healthy Schools Programme ASSIST (A Stop Smoking In School Trial) intervention with schools</p> <p>Information provision Stop smoking service</p> <p>Stop smoking service to specifically target people with long term conditions and who are on surgical lists with stop smoking support</p>	<ul style="list-style-type: none"> • Alcohol related admissions to hospital (PHOF 2.18) • Smoking prevalence of 15yr olds (PHOF 2.9) • Adult smoking prevalence (PHOF 2.14) • Alcohol related admissions (PHOF 2.18)
I make informed decisions in relationships	<p>Risky behaviour training Healthy Schools Programme Multiagency drop in centres Sexual health clinics Screening programmes</p>	<ul style="list-style-type: none"> • Under 18 conceptions (PHOF 2.4) • Chlamydia diagnoses of 15-24yr olds (PHOF 3.2)

Theme: I will be supported to live healthily (Prevention)

Healthy ambition	Joint activity	Outcome measure
<p>I can access the emotional support I need</p>	<p>Anti-bullying and counselling services Peer mentoring groups</p> <p>Sharing information on case referrals</p> <p>Suicide and self harm prevention strategy including:</p> <ul style="list-style-type: none"> • Appropriate and timely crisis intervention teams • Proactive primary care based mental health liaison services • Recovery services <p>Promote positive mental health – five ways to mental health: Connect; Be active; Take notice; Keep learning; Give.</p> <p>Wiltshire Wildlife Trust wellbeing project or similar opportunities with the Local Nature Partnership. Debt/ financial capability advice.</p> <p>Information sharing protocol (including with police on Anti-Social Behaviour and vulnerable people)</p>	<ul style="list-style-type: none"> • Number of reported instances of bullying by children • Children feel safe • Pupil absence (PHOF 1.3) • Emotional wellbeing of looked after children (PHOF 2.8) • Suicide (PHOF 4.10) • Hospital admissions as a result of self harm (PHOF 2.10) • Excess under 75 mortality in adults with mental illness (PHOF 4.9 and NHSOF 1.5)
<p>If I have served my country in the armed forces, my family and I will be able to access appropriate support</p>	<p>Military Civilian Integration Partnership ensures appropriate contractual arrangements with service providers for military personnel to access services</p> <p>Wiltshire Veterans' Action Plan</p>	<ul style="list-style-type: none"> • Health outcomes for service and ex-service personnel based in Wiltshire
<p>My house is a warm and safe place for me to live</p>	<p>Promotion of Warm and Well initiative</p> <p>Affordable warmth strategy Adaptations to climate change</p> <p>Falls and bone health strategy, including care pathways and integrated community teams</p> <p>Improved awareness of falls prevention and osteoporosis management.</p> <p>Integrated community equipment service (including home adaptations)</p>	<ul style="list-style-type: none"> • Fuel poverty (PHOF 1.17) • Excess winter deaths (PHOF 4.15) • Falls and injuries in the over 65s (PHOF 2.24) • The proportion of patients recovering to their previous level of mobility at 30 and 120 days (NHSOF 3.5)

Theme: I will be supported to live healthily (Prevention)

Healthy ambition	Joint activity	Outcome measure
<p>If I get seriously ill, problems will be spotted early and I will be supported to live a long healthy life</p>	<p>Increase early diagnosis and delivery of health checks programme Improve cancer screening coverage Improve access to chemotherapy in the community Improve quality of life for cancer survivors Improve timely and early diagnosis of dementia and post diagnostic support</p> <p>Improve timely and early diagnosis of diabetes, renal and other high impact diseases</p> <p>Step up beds to provide short term support when needed</p> <p>Community based transport and seamless health and social care services</p> <p>Care coordination plans for those with any or a combination of long term conditions. Risk stratification approach.</p>	<ul style="list-style-type: none"> • Cancer diagnosed at stage 1 and 2 (PHOF 2.19) • Mortality from causes considered preventable (PHOF 4.3) • Mortality from all cardiovascular diseases (PHOF 4.4) • Mortality from cancer (PHOF 4.5) <ul style="list-style-type: none"> • Reduced time spent in hospital by people with long term conditions (NHSOF 2.3) <ul style="list-style-type: none"> • Proportion of people feeling supported to manage their condition (NHSOF 2.1)

Theme: I will be listened to and involved (Engagement)		
Healthy ambition	Joint activity	Outcome measures
As a child I will be offered opportunities, with my parents and carers, to participate in the development of services	Use of Children and Young Peoples Services Participation and Involvement Strategy Coordinated multiagency consultation and sharing of findings	<ul style="list-style-type: none"> Local evaluation from users
I can help commission care and support services for adults of working age	Co-production of care and support services, e.g. with Wiltshire's user led organisations, strategic action groups or tenants groups. Use of Wiltshire Voices, engagement with advocacy and user networks, and support for community-led activities such as stroke clubs.	<ul style="list-style-type: none"> ?Healthwatch Wiltshire? satisfaction measure?
It is easy to find out what help is available	Communication and signposting services Improved information and advice about self care.	<ul style="list-style-type: none"> The proportion of people who use services and carers, who find it easy to find information about services (ASCOF 3D)
I make the important decisions on my care and support	Person-centred assessments, support plans and reviews Timely future planning for people with dementia	<ul style="list-style-type: none"> The proportion of people who use services who have control over their daily life (ASCOF 1B) The proportion of carers who report that they have been included or consulted in discussions about the person they care for (ASCOF 3C) H2LAH Survey questions
I care for someone and I am involved in decisions about their care	Support for advocacy through Carers Voice, Wiltshire Carers Action Group, Carer involvement networks and other organisations	<ul style="list-style-type: none"> The proportion of carers who report that they have been included or consulted in discussions about the person they care for (ASCOF 3C)
I know what the Council will pay towards my care and support	Personal budgets and direct payments	<ul style="list-style-type: none"> Proportion of people using social care who receive self-directed support, and those receiving direct payments (ASCOF 1C)
At the end of my life I can decide where I want to die	End of life planning and coordination Appropriate support to care homes to improve end of life care.	<ul style="list-style-type: none"> Numbers dying in setting of choice Numbers with end of life plans (NHSOF 4.6)

Theme: I will be supported to live independently (Independence)		
Healthy ambition	Joint activity	Outcome measures
Regardless of my background, I will be supported to achieve my potential	<p>Joined up work between children's centres and community health services and schools.</p> <p>Early identification of difficulties that could make children and young people vulnerable to underachievement and then providing signposting or direct support. Financial education.</p> <p>Joined up services for special educational needs and disabled children and young people (0-25 yrs old); and transition into adulthood.</p> <p>Integrated commissioning across health, social care and education, together with development of personal budgets</p>	<ul style="list-style-type: none"> • School readiness (PHOF 1.2) • % of all children achieving at Foundation Stage Profile, Key Stage 2 and 4 results compared to % children from vulnerable groups achieving at Foundation Stage Profile, Key Stage 2 and 4 results. • 16-18yr olds not in education, employment or training (PHOF 1.5) • Health related quality of life for carers (NHSOF 2.4) • Reported experience of parents and carers
I can arrange my own care and support if I want to	<p>Direct payments</p> <p>Pilot personal health budgets</p> <p>Improved information and advice about self care</p>	<ul style="list-style-type: none"> • Proportion of people using social care who receive self-directed support, and those receiving direct payments (ASCOF 1C)
I have the opportunity and support needed to work or volunteer my time	<p>Employment support services, including for those with a long term condition</p> <p>Promote healthy workplaces for those with mental health issues</p> <p>Support for voluntary service</p>	<ul style="list-style-type: none"> • Proportion of adults with learning disabilities in paid employment • Proportion of adults in contact with secondary mental health services in paid employment (ASCOF 1E, 1F) • Employment for those with a long term health condition including those with a learning difficulty or mental illness. Sickness absence rate. (PHOF 1.8 and 1.9, NHSOF 2.5 and 2.2)
My support helps me stay in control of my life	<p>Rehabilitation, education, advocacy and support programmes for those with long term conditions (including dementia)</p> <p>Active health and health trainer programmes. Wiltshire Wildlife Trust wellbeing project and/ or similar opportunities.</p> <p>Learning disabilities services</p> <p>Increasing access to services in the community (GPs, NHS Dentistry) and exploring co-location of services in community campuses</p>	<ul style="list-style-type: none"> • The proportion of people who use services who have control over their daily life (ASCOF 1B) • Proportion of people who feel supported to manage their condition (NHSOF 2.1) • Reduced time spent in hospital by people with long term conditions (NHSOF 2.3) • Improving access to primary care (GP and dental) services (NHSOF 4.4)

Theme: I will be supported to live independently (Independence)		
Healthy ambition	Joint activity	Outcome measures
I use care services and my quality of life is good	<p>Quality assurance on safeguarding policies and procedures</p> <p>Good neighbour scheme Bridging the gap initiative Multi sensory arts projects</p>	<ul style="list-style-type: none"> • Social care-related quality of life (ASCOF 1A) • Self-reported wellbeing (PHOF 2.23) • Health related quality of life for older people (PHOF 4.13) • Social isolation (PHOF 1.18/ ASCOF 1I)
I care for someone else and my quality of life is good	<p>Active support network for carers (including young carers) Employment, volunteering and training opportunities for carers GP “Investors in carers” scheme Information and guidance for carers provided within a single handbook Financial & benefits advice for carers Carer personalised breaks Advocacy for Carers Emergency and crisis support for carers (Emergency Card Service)</p>	<ul style="list-style-type: none"> • Carer-reported quality of life (ASCOF 1D and NHSOF 2.4)
I get help so that I can live in my own home instead of moving to a care home.	<p>“Moving Out” initiative</p> <p>Mental health awareness training for housing professionals. Early identification of people with mental health issues at risk of losing their tenancy.</p> <p>Dementia friendly communities</p> <p>Delayed transfer of care measures including extra care facilities</p> <p>Integrated community equipment service (including home adaptations). Telehealth and telecare.</p> <p>Access to financial advice and support</p> <p>Help to live at home ongoing support and active ageing support</p>	<ul style="list-style-type: none"> • Proportion of adults with learning disabilities who live in their own home or with their family • Proportion of adults in contact with secondary mental health services living independently, with or without support (ASCOF 1G, 1H, 2A) • People with mental illness or disability in settled accommodation (PHOF 1.6) • Permanent admissions to residential and nursing care homes, per 1,000 population • Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital, into reablement/ rehabilitation services (ASCOF 2A, 2B and NHSOF 3.6) • Help to live at home O24
I get help quickly at times of crisis, for example, if I need help to leave hospital	<p>Help to live at home initial support plans; Starr beds – scheme for step up and step down care Seamless working between NHS, social care and mental health services to reduce delayed transfers of care. Health gain agreement.</p>	<ul style="list-style-type: none"> • Help to live at home performance reports

Theme: I will be kept safe from avoidable harm (Keeping Safe)		
Healthy ambition	Joint activity	Outcome measures
As a child, I live, study and play in a safe environment	Child injury prevention initiatives Road danger reduction initiatives	<ul style="list-style-type: none"> Hospital admissions caused by deliberate and unintentional injuries in under 18s (PHOF 2.7)
As a child, my family and carers will be offered support to look after me	Carer, family and parenting support services Use of the child assessment framework and taking on the “lead professional role” Engage in “team around the child” activity	<ul style="list-style-type: none"> Number of active Common Assessment Frameworks (CAFs) for children and young people Children and young people and their families, reports on the outcomes of interventions
As a child, when domestic violence, mental health issues or parental substance misuse occurs, the impact on my family will be minimised as far as possible.	Hidden Harm initiative Joined up working between children and adult services to deliver a “think family” (early intervention) approach	<ul style="list-style-type: none"> Reduced number of domestic violence incidents reported where children and young people are present Pupil absence (PHOF 1.3)
As a child, I am able to remain with my family when it is safe to do so and protected from abuse and exploitation	Implementation of “Working Together” guidance, including engagement with Local Safeguarding Children Board, and relevant safeguarding meetings	<ul style="list-style-type: none"> Rate per 10,000 CYP on child protection plans or in care
If I suffer from domestic abuse, my needs are understood and I am offered the right support	Staff are trained and appropriate domestic abuse policies are in place for all agencies	<ul style="list-style-type: none"> Domestic abuse (PHOF 1.11)
If I have misused substances such as alcohol or drugs I will be supported into treatment and sustained recovery	Early intervention and support for employment, training and housing services	<ul style="list-style-type: none"> Successful completion of drug treatment and detection of drug use in offenders (PHOF 2.15 and 2.16)
My support helps me stay safe but doesn’t stop me living how I want to	Health and social care services work	<ul style="list-style-type: none"> The proportion of people who use services, who say that those services have made them feel safe and secure (ASCOF 4B)
If someone tries to harm me, it is investigated sensitively and quickly	Safe guarding policies, procedures and training Proportionate investigation of abuse-allegations	<ul style="list-style-type: none"> The proportion of people who use services who feel safe (ASCOF 4A)
I feel safe	Victim support and other emotional wellbeing support	<ul style="list-style-type: none"> Older people’s perceptions of community safety (PHOF 1.19)

Glossary

Joint Strategic Assessment / Joint Strategic Needs Assessment (JSA/ JSNA)

Joint Strategic Needs Assessment describes a process that identifies current and future health and wellbeing needs in light of existing services and informs future service planning taking into account evidence of effectiveness. Joint Strategic Needs Assessment identifies 'the big picture', in terms of the health and wellbeing needs and inequalities of a local population. In Wiltshire, this information is set out in the Health and Wellbeing Chapter of the Joint Strategic Assessment – a document which looks wider than Health and Wellbeing issues.

Clinical Commissioning Group (CCG)

Clinical Commissioning Groups are groups of GPs that will, from April 2013, be responsible for designing local health services in England. They will do this by commissioning or buying health and care services including: Elective hospital care; Rehabilitation care; Urgent and emergency care; Most community health services; Mental health and learning disability services.

National Health Service Commissioning Board (NHS CB)

The NHS CB's overarching role is to ensure that the NHS delivers better outcomes for patients within its available resources. The NHS CB will play a vital role in providing national leadership for improving outcomes and driving up the quality of care. It will fulfil this role through its leadership on delivering the NHS Outcomes Framework, supported by its accountability framework for clinical commissioning groups, its framework for choice and competition and its framework for emergency planning and resilience.

Health and Wellbeing Board (Wiltshire)

Wiltshire's Health and Wellbeing Board members work together to understand Wiltshire's needs, agree local priorities and encourage commissioners (those responsible for designing and paying for health and social care services) to work in a more joined up way.

Outcome Framework

Broadly speaking, 'outcomes' means 'results'. The NHS Outcomes Framework (NHS OF) sets out the results that the work of the NHS will be measured on. The Public Health Outcomes Framework (PHOF) and Adult Social Care Outcomes Framework (ASCOF) measure the results of work in those areas.

Healthwatch Wiltshire

Healthwatch Wiltshire is the consumer champion for users of health and social care services in Wiltshire. It builds on existing responsibilities to promote patient and public involvement, and to seek views on services which can be fed back into local commissioning; it will have rights to enter and view provider services, and be able to comment on changes to local services. It also has functions and funding for advocacy and supporting individuals to exercise choice. It can report concerns about the quality of local health and social care services to HealthWatch England who will be able to recommend that the Care Quality Commission takes action.

Joint Health and Wellbeing Strategy

This document, which outlines the priorities for joint working between health and social care organisations in Wiltshire.

Healthy Ambition

In this document, the 'healthy ambitions' are what we want the people of Wiltshire to experience. Joint activity to deliver these healthy ambitions is set out alongside these.

Prevention

Activities to prevent illness such as routine check-ups, immunizations, patient counseling, and screenings.

Independence

Managing everyday living skills to maximise ability, taking account of the support available and needed.

Engagement

A general term that may be translated as "involvement" or "participation".

Safeguarding

The process of protecting people from abuse or neglect, preventing impairment of their health and development, and ensuring they are living in circumstances consistent with the provision of safe and effective care.

Local Nature Partnership

The partnership in Wiltshire and Swindon that brings together a diverse range of individuals, businesses and organisations to create a vision and plan of action of how the natural environment can be taken into account in decision-making.

Help to Live at Home

The Help to Live at Home is a range of services that have been developed in Wiltshire to support independent living and pay providers on enabling people to live independently.

Appendix 1

Key documents and organisational plans

JSA Health and Wellbeing Priorities (this includes reference to the full range of documents relied upon and links to the resources available):

www.intelligencenetwork.org.uk/health/jsa-hwb/

Wiltshire Public Health Business Plan 2012/13:

<http://www.wiltshire.nhs.uk>

NHS Wiltshire Strategic Framework 2009-14:

<http://www.wiltshire.nhs.uk/Corporate/About-Us/Our-plans-and-priorities.htm>

Local Account for Wiltshire (Adult Social Care):

www.wiltshire.gov.uk

Wiltshire Children and Young People's Plan:

<http://www.wiltshirepathways.org/>

Wiltshire's Clinical Commissioning Group 'clear and credible plan':

<http://www.wiltshire.nhs.uk/Corporate/ccg.htm>

Help to Live at Home in Wiltshire

<http://www.wiltshire.gov.uk/healthandsocialcare/adultcare/helptoliveathome.htm>

Community-led planning events – discussion and actions on health and wellbeing issues:
Community Area Managers

Wiltshire Council [Housing Strategy](#)

Wiltshire Council [Volunteering Strategy and Action Plan](#)

Wiltshire Council [VCS Strategy](#)

Wiltshire Council [Safer Communities](#) and Safeguarding Strategy

Lives not services - from the Local Agreement for Wiltshire (old):

<http://www.wiltshire.gov.uk/council/wiltshirefamilyofpartnershipsworkingtogether/localagreemntforwiltshire.htm>

Local Transport Plan 3

<http://www.wiltshire.gov.uk/council/howthecouncilworks/plansstrategiespolicies/transportpoliciesandstrategies/localtransportplan3.htm>

Wiltshire Cycling Strategy; Wiltshire Walking Strategy; Wiltshire Green Infrastructure Strategy/policy; Wiltshire Obesity Strategy – update, Wiltshire Alcohol Strategy, Countryside Access Improvement Plan: www.wiltshire.gov.uk.

NICE guidance on physical activity via JSA chapter: <http://tinyurl.com/hwjisa160>

Appendix 2

Summary of UK national outcomes frameworks

<p>1 Preventing people from dying prematurely</p> <p>Overarching indicators</p> <p>1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare i Adults ii Children and young people 1b Life expectancy at 75 i Males ii Females</p> <p>Improvement areas</p> <p>Reducing premature mortality from the major causes of death 1.1 Under 75 mortality rate from cardiovascular disease* (PHOF 4.4) 1.2 Under 75 mortality rate from respiratory disease* (PHOF 4.7) 1.3 Under 75 mortality rate from liver disease* (PHOF 4.6) 1.4 Under 75 mortality rate from cancer* (PHOF 4.5) i One- and ii Five-year survival from all cancers iii One- and iv Five-year survival from breast, lung and colorectal cancer</p> <p>Reducing premature death in people with serious mental illness 1.5 Excess under 75 mortality rate in adults with serious mental illness* (PHOF 4.9)</p> <p>Reducing deaths in babies and young children 1.6 i Infant mortality* (PHOF 4.1) ii Neonatal mortality and stillbirths iii Five year survival from all cancers in children</p> <p>Reducing premature death in people with a learning disability 1.7 Excess under 60 mortality rate in adults with a learning disability</p>	<p>3 Helping people to recover from episodes of ill health or following injury</p> <p>Overarching indicators</p> <p>3a Emergency admissions for acute conditions that should not usually require hospital admission 3b Emergency readmissions within 30 days of discharge from hospital* (PHOF 4.11)</p> <p>Improvement areas</p> <p>Improving outcomes from planned treatments 3.1 Total health gain as assessed by patients for elective procedures i Hip replacement ii Knee replacement iii Craniotomy iv Varicose veins v Psychological therapies</p> <p>Preventing lower respiratory tract infections (LRTI) in children from becoming serious 3.2 Emergency admissions for children with LRTI</p> <p>Improving recovery from injuries and trauma 3.3 Proportion of people who recover from major trauma</p> <p>Improving recovery from stroke 3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months</p> <p>Improving recovery from fragility fractures 3.5 Proportion of patients recovering to their previous levels of mobility/walking ability at 1, 30 and 120 days</p> <p>Helping older people to recover their independence after illness or injury 3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation service*** (ASCOF 3B) ii Proportion offered rehabilitation following discharge from acute or community hospital</p>	<p>4 Ensuring that people have a positive experience of care</p> <p>Overarching indicators</p> <p>4a Patient experience of primary care i GP services ii GP Out of Hours services iii NHS Dental Services 4b Patient experience of hospital care 4c Friends and family list</p> <p>Improvement areas</p> <p>Improving people's experience of outpatient care 4.1 Patient experience of outpatient services</p> <p>Improving hospitals' responsiveness to personal needs 4.2 Responsiveness to in-patients' personal needs</p> <p>Improving people's experience of accident and emergency services 4.3 Patient experience of A&E services</p> <p>Improving access to primary care services 4.4 Access to GP services and ii NHS dental services</p> <p>Improving women and their families' experience of maternity services 4.5 Women's experience of maternity services</p> <p>Improving the experience of care for people at the end of their lives 4.6 Bereaved carers' views on the quality of care in the last 3 months of life</p> <p>Improving experience of healthcare for people with mental illness 4.7 Patient experience of community mental health services</p> <p>Improving children and young people's experience of healthcare 4.8 An indicator is under development</p> <p>Improving people's experience of integrated care 4.9 An indicator is under development*** (ASCOF 3E)</p>	<p>2 Enhancing quality of life for people with long-term conditions</p> <p>Overarching indicator</p> <p>2 Health-related quality of life for people with long-term conditions** (ASCOF 1A)</p> <p>Improvement areas</p> <p>Ensuring people feel supported to manage their condition 2.1 Proportion of people feeling supported to manage their condition**</p> <p>Improving functional ability in people with long-term conditions 2.2 Employment of people with long-term conditions*** (ASCOF 1E, PHOF 1.8)</p> <p>Reducing time spent in hospital by people with long-term conditions 2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 18s</p> <p>Enhancing quality of life for carers 2.4 Health-related quality of life for carers** (ASCOF 1D)</p> <p>Enhancing quality of life for people with mental illness 2.5 Employment of people with mental illness*** (ASCOF 1F & PHOF 1.8)</p> <p>Enhancing quality of life for people with dementia 2.6 i Estimated diagnosis rate for people with dementia* (PHOF 4.10) ii A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life*** (ASCOF 2E)</p>	<p>NHS Outcomes Framework 2013/14 at a glance</p> <p>Alignment across the Health and Social Care System</p> <ul style="list-style-type: none"> * Indicator shared with Public Health Outcomes Framework (PHOF) ** Indicator complementary with Adult Social Care Outcomes Framework (ASCOF) *** Indicator shared with Adult Social Care Outcomes Framework **** Indicator complementary with Adult Social Care Outcomes Framework and Public Health Outcomes Framework <p><i>Indicators in italics are placeholders, pending development or identification</i></p>	<p>5 Treating and caring for people in a safe environment and protect them from avoidable harm</p> <p>Overarching indicators</p> <p>5a Patient safety incidents reported 5b Safety incidents involving severe harm or death 5c Hospital deaths attributable to problems in care</p> <p>Improvement areas</p> <p>Reducing the incidence of avoidable harm 5.1 Incidence of hospital-acute venous thromboembolism (VTE) 5.2 Incidence of healthcare associated infection (HCAI) i MRSA ii C. difficile</p> <p>5.3 Incidence of newly-acquired category 2, 3 and 4 pressure ulcers 5.4 Incidence of medication errors causing serious harm</p> <p>Improving the safety of maternity services 5.5 Admission of full-term babies to neonatal care</p> <p>Delivering safe care to children in acute settings 5.6 Incidence of harm to children due to 'failure to monitor'</p>
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Adult Social Care Outcomes Framework 2013/14 at a glance

<p>2 Delaying and reducing the need for care and support</p>	<p>Overarching measure</p> <p>2A. Permanent admissions to residential and nursing care homes, per 1,000 population</p> <p>Outcome measures</p> <p>Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs.</p> <p>Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services.</p> <p>2B. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services ** (NHSOF 3.6)</p> <p>New measure for 2014/15: 2D. The outcomes of short-term services: sequel to service. New placeholder 2E: Effectiveness of reablement services</p> <p>When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence.</p> <p>2C. Delayed transfers of care from hospital, and those which are attributable to adult social care</p> <p>New placeholder 2F: Dementia - a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life. ** (NHSOF 2.6f)</p>
<p>1 Enhancing quality of life for people with care and support needs</p>	<p>Overarching measure</p> <p>1A. Social care-related quality of life * (NHSOF 2)</p> <p>Outcome measures</p> <p>People manage their own support as much as they wish, so that are in control of what, how and when support is delivered to match their needs.</p> <p>1B. Proportion of people who use services who have control over their daily life To be revised from 2014/15: 1C. Proportion of people using social care who receive self-directed support, and those receiving direct payments</p> <p>Carers can balance their caring roles and maintain their desired quality of life.</p> <p>1D. Carer-reported quality of life * (NHSOF 2.4)</p> <p>People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation.</p> <p>1E. Proportion of adults with a learning disability in paid employment *** (PHOF 1.8, NHSOF 2.2)</p> <p>1F. Proportion of adults in contact with secondary mental health services in paid employment ** (PHOF 1.6, NHSOF 2.5)</p> <p>1G. Proportion of adults with a learning disability who live in their own home or with their family ** (PHOF 1.6)</p> <p>1H. Proportion of adults in contact with secondary mental health services living independently, with or without support ** (PHOF 1.6)</p> <p>New measure for 2013/14: 1I. Proportion of people who use services and their carers, who reported that they had as much social contact as they would like. ** (PHOF 1.18)</p>
<p>4 Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm</p>	<p>Overarching measure</p> <p>4A. The proportion of people who use services who feel safe * (PHOF 1.19)</p> <p>Outcome measures</p> <p>Everyone enjoys physical safety and feels secure. People are free from physical and emotional abuse, harassment, neglect and self-harm. People are protected as far as possible from avoidable harm, disease and injuries. People are supported to plan ahead and have the freedom to manage risks the way that they wish.</p> <p>4B. The proportion of people who use services who say that those services have made them feel safe and secure</p> <p>New placeholder 4C: Proportion of completed safeguarding referrals where people report they feel safe</p>
<p>3 Ensuring that people have a positive experience of care and support</p>	<p>Overarching measure</p> <p>People who use social care and their carers are satisfied with their experience of care and support services.</p> <p>3A. Overall satisfaction of people who use services with their care and support</p> <p>3B. Overall satisfaction of carers with social services New placeholder 3E: Improving people's experience of integrated care ** (NHS OF 4.9)</p> <p>Outcome measures</p> <p>Carers feel that they are respected as equal partners throughout the care process.</p> <p>3C. The proportion of carers who report that they have been included or consulted in discussions about the person they care for</p> <p>People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.</p> <p>3D. The proportion of people who use services and carers who find it easy to find information about support</p> <p>People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual. This information can be taken from the Adult Social Care Survey and used for analysis at the local level.</p>
<p>Aligning across the Health and Care System</p>	<p>* Indicator complementary ** Indicator shared *** Indicator complementary with the Public Health Outcomes Framework and the NHS Outcomes Framework</p> <p>Shared indicators: The same indicator is included in each outcomes framework, reflecting a shared role in making progress Complementary indicators: A similar indicator is included in each outcomes framework and these look at the same issue</p>

Public Health Outcomes Framework 2013–2016

At a glance (Autumn 2012)

VISION

To improve and protect the nation's health and wellbeing and improve the health of the poorest fastest.

Outcome measures

- Outcome 1) Increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life
- Outcome 2) Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities)

Alignment across the Health and Care System

- Indicator shared with the NHS Outcomes Framework.
- Complementary to indicators in the NHS Outcomes Framework
- Indicator shared with the Adult Social Care Outcomes Framework
- Complementary to indicators in the Adult Social Care Outcomes Framework
- Indicators in *italics* are placeholders, pending development or identification

1 Improving the wider determinants of health

Objective
Improvements against wider factors which affect health and wellbeing and health inequalities

- Indicators**
- Children in poverty
 - School readiness (Placeholder)
 - Pupil absence
 - First time entrants to the youth justice system
 - 16-18 year olds not in education, employment or training
 - Adults with a learning disability/in contact with secondary mental health services who live in stable and appropriate accommodation (ASCOF 1G and 1H)
 - People in prison who have a mental illness or a significant mental illness (Placeholder)
 - Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services † (NHSOF 2.2) †† (NHSOF 1E) ††† (NHSOF 2.4) †††† (NHSOF 1F)
 - Sickness absence rate
 - Killed and seriously injured casualties on England's roads
 - Domestic abuse (Placeholder)
 - Violent crime (including sexual violence)
 - Re-offending levels
 - The percentage of the population affected by noise
 - Statutory homelessness
 - Utilisation of outdoor space for exercise/health reasons
 - Fuel poverty (Placeholder)
 - Social isolation (Placeholder) † (ASCOF 1I)
 - Older people's perception of community safety (Placeholder) †† (ASCOF 4A)

2 Health improvement

Objective
People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

- Indicators**
- Low birth weight of term babies
 - Breastfeeding
 - Smoking status at time of delivery
 - Under 18 conceptions
 - Child development at 2-2½ years (Placeholder)
 - Excess weight in 4-5 and 10-11 year olds
 - Hospital admissions caused by unintentional and deliberate injuries in under 18s
 - Emotional well-being of looked after children
 - Smoking prevalence – 15 year olds (Placeholder)
 - Self-harm (Placeholder)
 - Diet
 - Excess weight in adults
 - Proportion of physically active and inactive adults
 - Smoking prevalence – adults (over 18s)
 - Successful completion of drug treatment
 - People entering prison with substance dependence issues who are previously not known to community treatment
 - Recorded diabetes
 - Alcohol-related admissions to hospital (Placeholder)
 - Cancer diagnosed at stage 1 and 2
 - Cancer screening coverage
 - Access to non-cancer screening programmes
 - Take up of the NHS Health Check programme – by those eligible
 - Self-reported well-being
 - Injuries due to falls in people aged 65 and over

3 Health protection

Objective
The population's health is protected from major incidents and other threats, whilst reducing health inequalities

- Indicators**
- Fraction of mortality attributable to particulate air pollution
 - Chlamydia diagnoses (15-24 year olds)
 - Population vaccination coverage
 - People presenting with HIV at a late stage of infection
 - Treatment completion for Tuberculosis (TB)
 - Public sector organisations with a board approved sustainable development management plan
 - Comprehensive, agreed inter-agency plans for responding to public health incidents and emergencies (Placeholder)

4 Healthcare public health and preventing premature mortality

Objective
Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities

- Indicators**
- Infant mortality* (NHSOF 1.6)
 - Tooth decay in children aged 5
 - Mortality rate from causes considered preventable** (NHSOF 1a)
 - Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)* (NHSOF 1.1)
 - Under 75 mortality rate from cancer* (NHSOF 1.4)
 - Under 75 mortality rate from liver disease* (NHSOF 1.3)
 - Under 75 mortality rate from respiratory diseases* (NHSOF 1.2)
 - Mortality rate from infectious and parasitic diseases
 - Excess under 75 mortality rate in adults with serious mental illness* (NHSOF 1.4)
 - Suicide rate
 - Emergency readmissions within 30 days of discharge from hospital* (NHSOF 3b)
 - Preventable sight loss
 - Health-related quality of life for older people (Placeholder)
 - Hip fractures in people aged 65 and over
 - Excess winter deaths
 - Estimated diagnosis rate for people with dementia* (NHSOF 2.6)

Information about Wiltshire Council services can be made available on request in other languages including BSL and formats such as large print and audio.

Please contact the council by telephone 0300 456 0100, by textphone 01225 712500, or email customerservices@wiltshire.gov.uk

Wiltshire Clinical Commissioning Group can be contacted by telephone on 01380 728899 or email communications.wiltshireccg@nhs.net