COMMISSIONING STRATEGY FOR WELLBEING

DRAFT

Northern, Eastern and Western Devon Clinical Commissioning Group

PLYMOUTH CITY COUNCIL

Part: I

DOCUMENT CONTROL

Version	Date	Author	Change Ref	Pages Affected
1.0	080914	Sarah Lees / Dave Schwartz	-	-
1.1	011014	Sarah Lees / Dave Schwartz	Removal of substance misuse/ offending/mental health/ homelessness and transitions services	Across document
1.2	151014	Sarah Lees / Dave Schwartz	Incorporation of Katy Shorten input	Across document
1.3	261114	Sarah Lees / Dave Schwartz	Refinement of document through feedback from ODPH + updating latest needs data	Across document
1.4	031214	Sarah Lees / Dave Schwartz	Refinement of document through feedback	Across document
1.5	161214	Sarah Lees / Dave Schwartz	Further refinement	Across document
1.6	231214	Sarah Lees / Dave Schwartz	Wellbeing definition & action plan	Relevant pages
1.7	170205	Sarah Lees / Dave Schwartz	Redraft following initial consultation with LA and CCG colleagues	Across document

QUALITY REVIEWERS: (General QA and accuracy)

Name	Position	Signature	Date

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Name	Position	Date

CONSULTATION PATHWAY:

NAME

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1.0 EXECUTIVE SUMMARY

This Commissioning Strategy supports transformative change through creating a significantly enhanced focus on prevention at a population level as well as through targeted approaches. It supports healthy and happy communities in Plymouth by supporting and utilising social networks, increasing investment in public health and putting health and wellbeing at the heart of everything we do. It covers people of all ages across the whole life journey.

The Strategy drives forward a step change in how we will support and improve people's capacity to live healthy and happy lives and in doing so reduce the level of health inequality across the city. It does so by setting out the framework into which, over time, an increased proportion of investment from the whole health and social care system will be focused on prevention. Through targeting this investment in evidence based interventions this approach will improve outcomes for more people and so reduce pressure on services in the city. This approach will support value for money and produce efficiencies.

A successful strategy will:

- Improve the well-being and health of the people of Plymouth through increasing the capacity of individuals, families and communities to meet the challenges of everyday life
- Deliver stronger, safer more inclusive communities which will reduce demand and increase assets
- Reduce the number of preventable deaths in the city
- Reduce health inequality in the city
- Enable individuals, families and communities to be empowered to make decisions and influence decisions regarding their wellbeing and health including decisions regarding services they may need to use
- Enable key stakeholders including local communities to actively join in a shared process of system and service design
- Over time reduce the spend on high cost intensive interventions for the City

The Strategy will have at its heart the use of the 4-4-54 construct. This is known in Plymouth as 'Thrive'. This approach will tackle the key 4 behaviours that contribute to the 4 key illnesses that cause 54% of all deaths in the city. Focusing on these four behaviours will have the biggest impact on well-being and health across the city, and reduce the pressure on the wider health and social care system

The Strategy describes five key elements to a wellbeing system (with Thrive as the focus) into which the commissioning intentions sit. These elements area:

- Comprehensive advice, information and advocacy
- Strong safe communities and social capital (community networks and resources)
- Health promotion and healthy lifestyle choices
- Low level preventative support
- Emotional wellbeing and mental health

Commissioning intentions linked to these elements within a wellbeing system are set out for the first year.

Whilst the benefits of improving wellbeing are high so is the challenge. The health of people in Plymouth is varied compared with the England average. Deprivation is higher than average and an estimated 21.6% (11,335) children live in poverty. Life expectancy for both men and women is lower than the England average. Life expectancy is 7.9 years lower for men and 5.8 years lower for women in the most deprived areas of Plymouth than in the least deprived areas.

Out of the 32 health indicators presented in the Annual Health Profile, produced by Public Health England, Plymouth has 17 that are significantly worse than the English average.

Over the years many approaches have been taken to address the health inequalities in Plymouth. Whilst these have seen some success, inequalities still persist. What this tells us is that we must work differently as partners and leaders if we want to significantly reduce health inequalities.

The Health and Social Care Act 2012 provides new and exciting opportunities to work across health and social care and address the key issues that undermine the health and wellbeing people in Plymouth. In Plymouth we are implementing a single commissioning process and a single budget to work from that integrates the Health and Social Care agenda.

In Michael Marmot's landmark report, 'Fair Society Healthy Lives', he states, "The extent of people's participation in their communities and the added control over their lives that this brings has the potential to contribute to their psychosocial well-being and, as a result, to other health outcomes". We will be seeking to create an environment that builds social capital and facilitates co-production between commissioners, services and communities.

The opportunities provided through the Health and Social Care Act 2012 and the enhanced drive to engage with local communities is the key to how we work differently and this Strategy sets out our programme for improving health and wellbeing in that context.

2. INTRODUCTION

2.1 Background – Strategic Challenge

Public Sector organisations across the country are facing unprecedented challenges and pressures due to rising demography, increasing complexity of need and the requirement to deliver better services with less public resource. Plymouth and Devon also face a particular financial challenge because of the local demography, the historic pattern of provision and pockets of deprivation and entrenched health inequalities. Until recently the complexity and scale of our system-wide challenge has been difficult to understand and local organisations have, as a result, focussed mainly on meeting their own challenges. A lot of this work has been successful and this has delivered much that is good right across our system. However we know that this existing good practice will not be enough to meet the current challenge. This means a new imperative for joint and collaborative working across all the organisations that commission and deliver health and wellbeing in our area.

Recognising these challenges and within the context of a system's leadership approach Plymouth Health and Wellbeing Board has agreed a vision that by 2016 we will have developed an integrated whole system of health and care based around the following elements:

Integrated Commissioning: Building on co-location and existing joint commissioning arrangements the focus will be to establish a single commissioning function, the development of integrated commissioning strategies and pooling of budgets.

Integrated Health and Care Services: Focus on developing an integrated provider function stretching across health and social care providing the right care at the right time in the right place; and an emphasis on those who would benefit most from person centred care such as intensive users of services and those who cross organisational boundaries

Integrated system of health and wellbeing: A focus on developing joined up population based, public health, preventative and early intervention strategies; and based on an asset based approach focusing on increasing the capacity and assets of people and place

2.2 An Integrated Commissioning Response

In order to meet the challenges facing Plymouth, New Devon CCG and Plymouth City Council have agreed to develop a single commissioning function working towards jointly approved commissioning strategies and pooled budgets.

The primary driver of this is to streamline service delivery and provision with the aim of improving outcomes for individuals and value for money. Integrated commissioning must deliver integrated wellbeing.

To support this strategic aim 4 commissioning strategies have been developed that stretch across the spectrum of early years, health, social care, and wellbeing need in Plymouth.

Figure 1

These co-dependent Commissioning Strategies aim to move the balance of care towards prevention in order to improve life chances, manage demand and improve health outcomes. Specific aims of this systems approach includes;

- Provide and enable brilliant services that strive to exceed customer expectations
- People will receive the right care, at the right time in the right place.
- Improve pathways and transitions
- Help people take control of their lives and communities.
- Children, young people and adults are safe and confident in their communities.
- People are treated with dignity and respect.
- Prioritise prevention
- Sustainable Health and Wellbeing System
- Improve System Performance

2.3 Purpose of the Strategy

Each strategy describes the current and projected need in Plymouth, as well as the local and national strategic context that the future system will need to address / respond to. They also describe current provision how the existing system is performing.

This then builds into a vision of Plymouth's future system over a 5 year period, and details of how commissioners in Plymouth will achieve this through a series of annual implementation plans setting out and signalling to the market commissioning priorities, and how the impact of these will be measured across the system.

2.4 Implementation and Action

System Design Groups against each strategy will drive the implementation of the identified commissioning priorities within each strategy.

2.5 Finance

Table 1 provides an overview of how the current commissioning budgets in scope for integration are currently spread across the system.

Full detail on the existing resources allocated within each strategy area is provided in the 'current provision' section.

Table1

Strategy Area	Approximate total spend	% of spend in each Strategy area
Children and Young People	£27,150,102	6.72%
Wellbeing	£20,752,235*	15.03%
Community Care	£119,742,637	29.62%
Complex Care	£196,616,072	48.64%
TOTAL	**£404,261,046**	

An additional £40 million of prescribing spend is currently being linked to the Wellbeing Strategy but further discussions need to take place to determine the best place to hold this budget and the implications in doing so

2.6 Principles for the commissioning of services to deliver well-being outcomes

- The focus will be on those issues likely to have the biggest positive impact on the whole system
- Services designed to incorporate and utilise community assets
- Co-produced with key stakeholders including service users and communities
- Services that empower people and communities to improve and maintain their own health and wellbeing
- Services commissioned to meet need across the whole life journey in line with the Marmot Review
- Services commissioned using high quality public health intelligence and delivering evidence based support and intervention

- Where needs cluster together (two or more needs that are often interdependent) then options appraisals on the commissioning approach will always include alliance contracting
- Services that have effective and seamless links and pathways including in and out of the community system, complex system and the children and young people's system
- Recognition that services need to be designed with families in mind
- Relevant services need to support transition for young people from children services to adult services
- Child protection and safeguarding is integral to system and service design
- Safeguarding adults at risk (vulnerable adults) is integral to system and service design
- Services need to be designed to meet an increasingly diverse population

2.7 Definition of Wellbeing

There are many descriptions and definitions of wellbeing. Plymouth's Health and Wellbeing Board recognised that people have different views of what it means to them personally and for their communities. The Board adopted a holistic view of health and wellbeing based on four broad and wholly interrelated and co-dependent components;

The Mind ; including mental health and wellbeing, happiness, personal growth, development and learning

The Body ; including physical health and wellbeing, having the best start in life, growing and ageing well, having access to good jobs, homes and health services

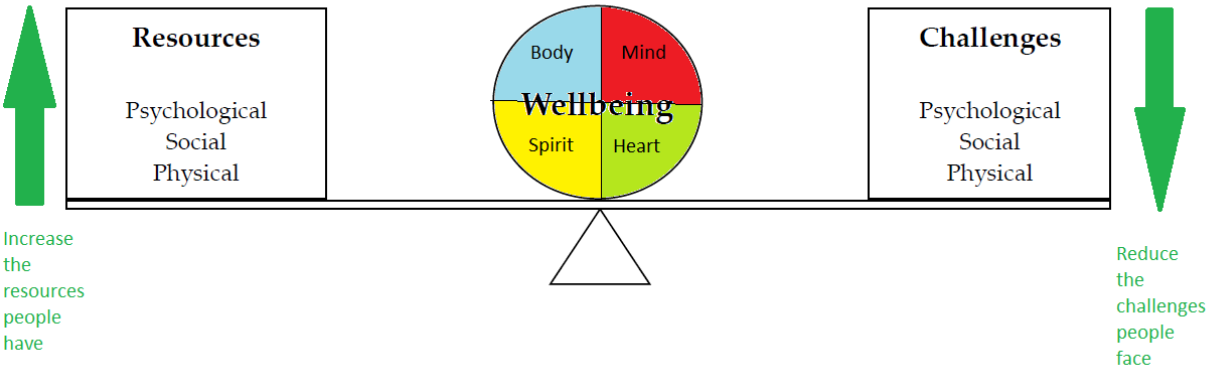
The Heart : including social health and wellbeing, having good friendships, loved and valued, valuing others and engaging with the world around us

The Spirit : including a sense of community, of meaning in life, a sense of belonging and of making a difference

In seeking a definition of wellbeing that is universally applicable, easily understood and yet conveys the multi-faceted nature of wellbeing, the following definition[1] will be used. This definition sees wellbeing as the balance point between and individual's resource pool and the challenges that they face. In the diagram below, the circle representing wellbeing can be seen to be in balance, at the centre of the see-saw. Balance or equilibrium is achieved when the resources of the individual are able to meet the challenges that they face. When individuals have more challenges than resources, the see-saw dips, along with their wellbeing. A lack of challenge for an individual would equally cause a dip in wellbeing. This represents a dynamic definition of wellbeing and reflects the human preference to return to a set point of wellbeing that is defined by the individual. The Health and Wellbeing Board definition can be incorporated into this diagrammatic representation if the circle of wellbeing is made up of four quadrants of mind, body heart and spirit.

[1] Dodge, R., Daly, A., Huyton, J., & Sanders, L. (2012). The challenge of defining wellbeing. *International Journal of Wellbeing, 2*(3), 222-235. doi:10.5502/ijw.v2i3.4

Figure 2



In the context of this commissioning strategy, services that support wellbeing will be aiming to build an individual's capacity to meet the challenges they face in their lives and also contribute to a wider approach of addressing the determinants of health and wellbeing by reducing unacceptable challenges that people face e.g. poor quality housing. The scope of this commissioning strategy includes a wide range of public health services, such as health improvement, smoking cessation and sexual health promotion.

Services for children and young people that can be described as universal / preventative are covered within the accompanying Commissioning Strategy for Children and Young People.

2.8 Scope

Services covered by the Strategy include those that:

- empower people to maintain and improve their own health and wellbeing
- build active and supportive networks among people within communities (social capital)
- enable individuals, families and communities to meet a range of challenges they may experience in their lives
- provide low level support to help enable people to stay in their homes safely in their community

3.0 NEEDS ASSESSMENT

Further data, including data at a sub-city level, as well as the definitions clarifying the use of the data can be found among the suite of Joint Strategic Needs Assessment (JSNA) reports held on Plymouth City Council's JSNA web site[2]

PLYMOUTH'S DEMOGRAPHY

3.1 The population

Plymouth's population has grown by over 15,000 people (an increase of 6.4%) from 2002 to 2012 (mid-year population estimates shown in Table 1). All six localities have increased in population size, with the largest percentage increase in the South West (12.1%) and South East (12.0%) localities. The smallest percentage increase occurred in Plymstock (1.9%).

Table 2: Mid-year population estimates (all ages) for Plymouth localities and Plymouth, 2002-2012

Year	Central & North East	North West	Plympton	Plymstock	South East	South West	Plymouth
2002	49.727	51.805	29.301	24.234	35.118	52.365	242.550
2004	49.699	51.841	29.438	24.235	35.850	52.974	244.037
2006	50.316	52.180	29.345	24.545	37.554	55.238	249.178
2008	50.864	52.307	29.656	24.698	38.426	56.537	252.488
2010	50.855	52.261	29.747	24.680	39.063	57.621	254.227
2012	51.488	53.779	30.029	24.687	39.342	58.701	258.026
% change	3.5%	3.8%	2.5%	1.9%	12.0%	12.1%	6.4%

Source: Office for National Statistics

It is estimated that Plymouth's population will increase by over 16,000 by 2030 (Table 2). The largest increase will be seen in 75+ year olds (54.6%), whilst it is estimated there will be a 5.2% reduction in the 30-64 year old population.

Table 3: Sub-national population projections by age group, 2012-2030

Age group	2012	2015	2020	2025	2030	% change
Under 18	50.912	51.482	53.645	55.241	55.102	8.2%
18-29	52.613	53.779	53.169	52.133	54.820	4.2%
30-64	111.026	109.880	109.002	107.814	105.247	-5.2%
65-74	23.367	24.964	25.584	25.569	28.205	20.7%
75+	20.108	21.210	23.904	28.511	31.091	54.6%
90+	2.119	2.296	2.700	3.475	4.432	109.2%
All ages	258.026	261.315	265.304	269.268	274.466	6.4%

Source: Office for National Statistics

[2] www.plymouth.gov.uk/homepage/socialcareandhealth/publichealth/healthandwellbeingboard/jsna.htm

3.2 'Protected Characteristics' (Equality Act 2010)

The Equality Act 2010 sets out nine personal characteristics that are protected by the law:[3] These are, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, Religion or belief, sex, sexual orientation

3.3 Age

As outlined in 3.1, Plymouth currently has a population of 258,026 (Table 1). Due to an estimated 35,000 to 40,000 students residing in the city, the proportion of 18-24 year olds (13.2%) is higher than that found regionally (8.8%) and nationally (9.3%). The proportion of the working-age (16-64 year old) population (65.7%) is higher than that regionally (62.1%) and nationally (64.1%). The city has the third lowest percentage of people 75 years and over, and the eighth lowest percentage of children and young people (under 18) of the 16 Southwest county and unitary authorities (2012).

3.4 Disability

According to the 2011 Census, 10.0% of Plymouth residents reported having a long-term health problem or disability that limits their day-to-day activities a lot and has lasted, or is expected to last, at least 12 months (including problems related to old age). The national value was 8.3%.

According to the 2011 Census, 46.0% of Plymouth residents reported their general health as 'very good'; this increased to 79.5% when also including those who reported their health as 'good'. In England 81.4% of people reported their general health as either 'very good' or 'good'. Plymouth's combined value is therefore nearly two percentage points lower than the national average.

3.5 Faith, religion or belief

According to the 2011 Census, Christianity is the most common religion in Plymouth. 32.9% of the Plymouth population stated they had no religion. Those following Hinduism, Buddhism, Judaism or Sikhism combined totalled less than 1.0%. 0.5% of the population had a current religion, such as Paganism or Spiritualism.

3.6 Gender - including marriage, pregnancy and maternity

Overall, 50.5% of Plymouth's population is female. According to the 2011 Census, of those aged 16 and over 90,765 (42.9%) people are married. There were 3,418 live births in 2012. The number of births has increased annually from 2,547 in 2001, except in 2011 when the number was the same as 2010 (3,280 births in each year).

3.7 Gender reassignment

In 2010, it was estimated nationally that the number of gender variant people presenting for treatment was around 12,500. Of these, around 7,500 have undergone transition. The median age for treatment for gender variation is 42 years. There is no precise number of the trans-gender population in Plymouth.

3.8 Race

There is relatively little ethnic diversity in Plymouth. According to the 2011 Census, 96.1% of Plymouth's population considered themselves White British. This is significantly higher than the England average (79.8%). Plymouth has lower percentages of residents within each ethnic group compared with the national average. However, despite the small numbers, Plymouth has a rapidly rising BME population which has doubled since the 2001 census. The main ethnic

3 http://www.equalityhumanrights.com/private-and-public-sector-guidance/guidance-all/protected-characteristics

minorities in Plymouth are the Polish (0.7%; just over 1,900) and the Chinese (0.5%; just over 1,200).

3.9 Sexual Orientation - including Civil Partnership

There were 21 Civil Partnership Formations in Plymouth in 2010, 24 in 2011, and 30 in 2012. 5,190 (2.5%) of people in Plymouth are separated and still either legally married or legally in a same-sex civil partnership. There is also no precise local data on numbers of Lesbian, Gay and Bi-sexual (LGB) people in Plymouth but it is nationally estimated at 5.0% to 7.0%. This would mean that approximately 13,300 people aged 16 years and over in Plymouth are LGB.

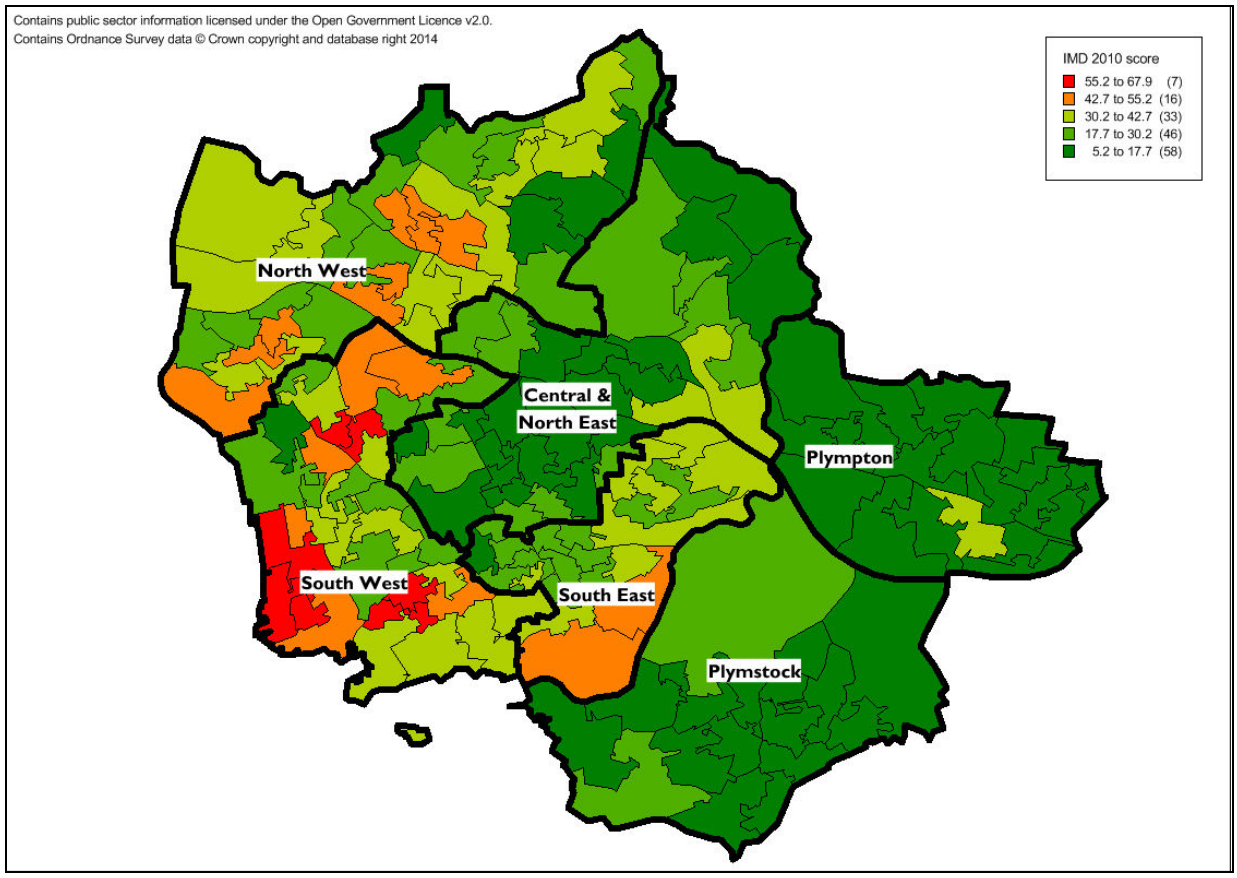
In summary

Key challenges for Plymouth are that there is expected to be a significant increase in the number of people living beyond 75; there are higher levels of long term health problems or disability when compared nationally; there are lower levels of reported good or very good health when compared nationally and there is a growing and diverse BME population.

3.10 Deprivation

The English Indices of Deprivation 2010 use 38 separate indicators to calculate the Index of Multiple Deprivation 2010 (IMD 2010). The IMD 2010 score is calculated for every Lower Super Output Area (LSOA) in England. LSOAs typically have a population of around 1,500.

Figure 3: Index of Multiple Deprivation (IMD) 2010 scores by locality and Lower Super Output Area (LSOA) within Plymouth. Higher scores reflect higher levels of deprivation.



Source: Department for Communities and Local Government

According to their relative level of deprivation, Plymouth is ranked 72 out of 326 (1=most deprived; 326=least deprived). This places Plymouth just above the bottom 20% of local authorities in England. In comparison, Salford was ranked 18, Bristol 79, and Newcastle-upon-Tyne 150. Out of 32,482 LSOAs in England, Plymouth has two in the 4% most deprived, two in the 3% most deprived, two in the 2% most deprived and one in the 1% most deprived in the country.

Separate analysis has been carried out by the Public Health Team in Plymouth City Council to identify the most or least deprived localities in the city. Table 3 sets out the findings. The locality with the highest score (i.e. the most deprived) is the South West, with the North West and South East localities also scoring highly. The locality with the lowest score (i.e. the least deprived) is Plymstock, followed by Plympton and Central & North East localities.

Table 4: Index of Multiple Deprivation (IMD) 2010 score by locality

Locality	IMD 2010 SCORE
Central & North East	16.4
North West	32.1
Plympton	12.1
Plymstock	11.4
South East	28.5
South West	39.7
Plymouth	25.6

Source: Produced by the Public Health Team, Plymouth City Council, from Department for Communities and Local Government data

In summary Plymouth is one of the more deprived areas in the country. There is a significant national and international evidence base that demonstrates the impact of deprivation across a wide range of measures covering wellbeing and health. Michael Marmot's report 'Fair Society Healthy Lives' provides a comprehensive overview of this for England and he reported:

- There is a social gradient in health – the lower a person's social position, the worse his or her health.
- In England, the many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life.

OVERVIEW OF PLYMOUTH

3.11 Introduction

The Health Profiles published by Public Health England (PHE) provide an overview of the general health of the local population. They present a set of key indicators that, through comparison with other areas and with the national average, can highlight potential problems locally. They are designed to help local government and health services identify problems and decide how to tackle them to improve health and reduce health inequalities. Figure 4 sets out Plymouth's Health Profile for 2014. A summary of selected indicators is provided below Figure 4.

3.12 Public Health England's Health Profile for Plymouth 2014

Figure 4: General health profile for Plymouth 2014

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Health Summary for Plymouth

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

Regional average^ | England Average | England Worst | England Best | 25th Percentile | 75th Percentile | England Range

Domain	Indicator	Local No Per Year	Local value	Eng value	Eng worst	Eng best
Our communities	1 Deprivation	67,594	26.2	20.4	83.6	0.0
	2 Children in poverty (under 16s)	10,140	22.4	20.6	43.6	6.4
	3 Statutory homelessness	92	0.8	2.4	33.2	0.0
	4 GCSE achieved (5A*-C inc. Eng & Maths)	1,727	60.8	60.8	38.1	81.9
	5 Violent crime (violence offences)	4,585	17.9	10.6	27.1	3.3
	6 Long term unemployment	1,471	8.7	9.9	32.6	1.3
Children's and young people's health	7 Smoking status at time of delivery	564	16.7	12.7	30.8	2.3
	8 Breastfeeding initiation	2,327	69.1	73.9	40.8	94.7
	9 Obese children (Year 6)	392	17.5	18.9	27.3	10.1
	10 Alcohol-specific hospital stays (under 18)	43	84.7	44.9	126.7	11.9
	11 Under 18 conceptions	167	39.5	27.7	52.0	8.8
Adults' health and lifestyle	12 Smoking prevalence	n/a	24.0	19.5	30.1	8.4
	13 Percentage of physically active adults	n/a	59.2	56.0	43.8	68.5
	14 Obese adults	n/a	24.7	23.0	35.2	11.2
	15 Excess weight in adults	399	60.0	63.8	75.9	45.9
Disease and poor health	16 Incidence of malignant melanoma	53	20.7	14.8	31.8	3.6
	17 Hospital stays for self-harm	623	229.2	188.0	596.0	50.4
	18 Hospital stays for alcohol related harm	1,752	708	637	1,121	365
	19 Drug misuse	2,372	13.9	8.6	26.3	0.8
	20 Recorded diabetes	12,188	5.5	6.0	8.7	3.5
	21 Incidence of TB	5	5.9	15.1	112.3	0.0
	22 Acute sexually transmitted infections	2,281	889	804	3,210	162
	23 Hip fractures in people aged 65 and over	280	592	568	828	403
Life expectancy and causes of death	24 Excess winter deaths (three year)	142	19.5	16.5	32.1	-3.0
	25 Life expectancy at birth (Male)	n/a	78.3	79.2	74.0	82.9
	26 Life expectancy at birth (Female)	n/a	82.1	83.0	79.5	86.6
	27 Infant mortality	14	4.1	4.1	7.5	0.7
	28 Smoking related deaths	457	342	292	480	172
	29 Suicide rate	27	10.8	8.5		
	30 Under 75 mortality rate: cardiovascular	174	86.3	81.1	144.7	37.4
	31 Under 75 mortality rate: cancer	336	166	146	213	106
	32 Killed and seriously injured on roads	65	25.3	40.5	116.3	11.3

Indicator Notes

1 % people in this area living in 20% most deprived areas in England, 2010 2 % children (under 16) in families receiving means-tested benefits & low income, 2011 3 Crude rate per 1,000 households, 2012/13 4 % key stage 4, 2012/13 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2012/13 6 Crude rate per 1,000 population aged 16-64, 2013 7 % of women who smoke at time of delivery, 2012/13 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery, 2012/13 9 % school children in Year 6 (age 10-11), 2012/13 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2010/11 to 2012/13 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2012 12 % adults aged 18 and over, 2012 13 % adults achieving at least 150 mins physical activity per week, 2012 14 % adults classified as obese, Active People Survey 2012 15 % adults classified as overweight or obese, Active People Survey 2012 16 Directly age standardised rate per 100,000 population, aged under 75, 2009-2011 17 Directly age sex standardised rate per 100,000 population, 2012/13 18 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2012/13 19 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2010/11 20 % people on GP registers with a recorded diagnosis of diabetes 2012/13 21 Crude rate per 100,000 population, 2010-2012 22 Crude rate per 100,000 population, 2012 (chlamydia screening coverage may influence rate) 23 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over, 2012/13 24 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.09-31.07.12 25 At birth, 2010-2012 26 At birth, 2010-2012 27 Rate per 1,000 live births, 2010-2012 28 Directly age standardised rate per 100,000 population aged 35 and over, 2010-2012 29 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2010-2012 30 Directly age standardised rate per 100,000 population aged under 75, 2010-2012 31 Directly age standardised rate per 100,000 population aged under 75, 2010-2012 32 Rate per 100,000 population, 2010-2012 ^ "Regional" refers to the former government regions.

More information is available at www.healthprofiles.info Please send any enquiries to healthprofiles@phe.gov.uk

Out of the 32 health indicators presented in the Annual Health Profile (2014), produced by Public Health England, Plymouth has 17 that are significantly worse than England.

Table 5. Regional centre comparisons of health profiles (n=11)

		Number of significantly worse measures out of 32
1	Bournemouth	9
2	Brighton and Hove	12
	Bristol	12
3	Sheffield	14
4	Leeds	16
5	Plymouth	17
	Southampton	17
6	Newcastle upon Tyne	18
7	Portsmouth	20
8	Liverpool	21
9	Salford	22

Plymouth and Southampton are placed in the middle of our comparator regional centres with just over 50% of all the measures being significantly worse than the England average

Selected indicators where Plymouth's value is 'better' than the England average:

- Statutory homelessness
- People diagnosed with diabetes
- Road injuries and deaths
- Long-term unemployment
- Incidence of TB

Selected indicators where Plymouth's value is 'worse' than the England average:

- Under 18 conceptions
- Alcohol and drug misuse
- Adults smoking
- Sexually transmitted infections
- Incidence of malignant melanoma
- Early deaths from cancer

Selected indicators where Plymouth's value is 'not significantly different' to the England average:

- Obese children (Year 6)
- Obese / excess weight in adults
- Physically active adults
- Infant deaths
- Early deaths from heart disease and stroke
- Hip fractures in people aged 65 and over

3.13 Housing

There are over 114,000 dwellings in Plymouth with most of the city's housing stock being in the private sector. Plymouth has lower than average levels of home ownership, but greater amounts of private rented housing.

Table 6: Number of differing types of dwellings and proportion of total housing stock in Plymouth with a comparison with England

Owner occupied 64,998 dwellings	Plymouth 59.5%; England 64.2%
Privately rented 21,095 dwellings	Plymouth 20.2%; England 16.8%
Social housing 22,026 dwellings	Plymouth 19.3%; England 17.7%
Living rent-free 1,188 dwellings	Plymouth 1.1%; England 1.3%

Table 7: Housing Conditions in Plymouth 2010/11

Tenure	Non decent (%)	Category 1 hazard (%)	Disrepair (%)	Thermal comfort (%)	Fuel poverty (%)
Owner	32.0	19.3	8.5	13.0	12.9
Privately rented	37.2	26.1	19.0	20.1	18.4
Social housing	24.8	11.5	4.4	10.2	13.5

Housing conditions in Plymouth are worst in the private rented sector.

There is a clear link in Plymouth between the areas of worst housing condition and the areas of high deprivation and greatest health inequalities.

The most common Category 1 Hazard failure across the private sector is excess cold followed by falls on stairs and falls on the level, contributing to the poor health and well-being of residents and generating significant NHS and care costs.

There is an urgent need to improve housing conditions across the private sector, but notably private rented housing, which has the worst conditions across all sectors, as illustrated below:
8,208 non decent private rented dwellings.
5,758 private rented dwellings with Category 1 Hazards.
4,192 private rented dwellings with disrepair (Decent Homes Standard).
4,435 private rented dwellings failing thermal comfort (Decent Homes Standard).
4,060 private rented dwellings (households) in fuel poverty.

There are high levels of overcrowding in Plymouth. Of the 9,671 households currently registered for social housing through Devon Home Choice (DHC) 1,951 (20%) lack one bedroom and 190 (2%) lack two bedrooms.

3.14 Unemployment and under employment

In 2012 Plymouth's real level of unemployment was estimated at 9.8% of the working age residents, around 17,000 individuals.[4] Furthermore, 'under-employment' is comparatively high in Plymouth, reflecting the rise in part-time working and too few suitable full-time job opportunities being created. Between October 2010 and September 2011, there were 16,000 under-employed people in Plymouth, equating to 13.6% of the workforce.

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3.15 Crime

Despite the increase recorded in 2011/12 there is an overall decreasing trend in Plymouth's crime rate. There were 21,175 crimes recorded in 2009/10 compared to 18,425 in 2012/13 (a reduction of 2,750 or 13%)

Incidents of anti-social behaviour recorded by Devon and Cornwall Police were 40.1 per 1,000 Plymouth residents (2012/13). This is a decrease of 28% from 2011/12.[5]

There were a total of 6,092 domestic abuse incidents in 2012/13. This is a 5% increase (309 incidents) since 2011/12. Of these incidents 33% resulted in a crime being recorded. [6]

In 2012/13 the rate of violence with injury (offences including grievous bodily harm, actual bodily harm and malicious wounding) was 10.0 crimes per 1,000 population (a reduction of 173 crimes (6%) on 2011/12). Of these, 31% were domestic abuse related[7]

3.16 Carers

In England and Wales, there are around 5.4 million people providing unpaid care for an ill, frail or disabled family member or friend. Using data from the 2011 Census, there were 27,247 of these carers in Plymouth. This was a 13% increase on the 2001 census. The majority (57.3%) provided 1-19 hours of care per week but nearly 30% (7,566 individuals) were committing over 50 hours.[8]

ASSESSING NEED: PUBLIC HEALTH INDICATORS RELATED TO WELLBEING .

3.17 Introduction

This section provides more detailed examination of the different health needs of the population on a locality basis but with regards to public health indicators related specifically to wellbeing.

Table 8.

Indicator	Central & North East	North West	Plympton	Plymstock	South East	South West	Plymouth
Teenage pregnancy (rate per 1,000 women)	20.3	42.6	23.0	13.3	30.9	64.4	35.5
Smoking in pregnancy (%)	7.4	22.7	7.3	8.4	17.7	20.8	16.1
Parents who smoke (%)	17.7	29.5	9.2	16.1	32.9	35.9	26.2
Parents who misuse drugs (%)	1.0	4.3	0.8	0.8	2.5	3.7	2.7
Parents who misuse alcohol (%)	0.8	3.1	0.7	0.7	2.1	2.4	2.0
Depressed/mentally ill parents (%)	9.1	17.4	9.4	16.1	18.7	16.2	14.8
Social isolation (%)	2.3	4.2	1.8	4.2	7.8	8.8	5.3
Accident admissions (0-4 year olds) (rate per 1,000 pop)	12.4	20.9	21.6	10.2	27.8	21.6	19.6
Accident admissions (5- 14 year olds) (rate per 1,000 pop)	8.9	13.7	6.8	7.4	13.4	10.8	10.6

5 Strategic Assessment (Crime and Disorder) 2012/13
6 Strategic Assessment (Crime and Disorder) 2012/13
7 Strategic Assessment (Crime and Disorder) 2012/13
8 2011 Census

Accident admissions (15-24 year olds) (rate per 1,000 pop)	9.7	15.0	9.5	10.1	7.9	15.8	11.4
Emergency circulatory admissions (all ages) (rate per 10,000 pop)	107.7	132.1	88.4	100.9	139.4	124.0	116.2
Emergency circulatory admissions (under 75s) (rate per 10,000 pop)	60.2	76.4	45.1	55.2	77.7	81.6	67.7
Admissions from falls (65 years and over) (rate per 10,000 pop)	227.0	208.3	228.7	221.4	250.3	206.8	219.9
Admissions from falls (75 years and over) (rate per 10,000 pop)	388.0	363.8	382.9	380.1	417.2	381.7	381.7
Substance misuse (rate per 10,000 pop)	37.1	76.6	27.6	23.5	101.9	161.0	81.0
Mental health contacts (rate per 10,000 pop)	263.6	320.8	255.8	270.0	303.5	413.5	315.4
Self-harm admissions (rate per 10,000 pop)	29.8	64.8	32.0	19.3	78.5	96.5	53.0
Smoking status (GP referrals) (%)	13.9	22.5	11.9	12.1	21.1	26.5	18.9
Adult obesity (GP referrals) (%)	28.9	36.6	30.7	28.1	31.8	33.0	32.0
High blood pressure (GP referrals) (%)	16.5	17.4	14.4	16.1	12.7	16.5	16.3
One or more risk factors (smoking, obesity, high blood pressure) (%)	49.0	60.2	49.1	46.8	53.6	59.1	53.9
Incidences of melanoma (rate per 100,000 pop)	80.6	59.0	101.3	73.7	69.5	56.1	X
Cancer mortality (under 75s) (rate per 10,000 pop)	12.7	17.1	14.0	17.2	15.2	20.4	16.2

3.18 Teenage pregnancy

Information regarding Plymouth's teenage conception rate at the locality level is not available nationally and is therefore obtained via Plymouth Hospitals NHS Trust. As a consequence, direct comparisons with national statistics are not possible but local data provide a useful proxy. In 2013, Plymouth's conception rate was 35.5 per 1,000 women aged 15-17 years. Conception rates vary considerably across the city with the South West consistently having the highest rate except for 2009 and 2011. The locality with the lowest rate in 2013 was Plymstock. All areas have seen a decrease in conception rates since 2004, with the exception of Plympton.

3.19 Smoking in pregnancy

In 2013, 16.1% of mothers reported that they were smoking at the time of delivery. This equates to a reduction of 6.7 percentage points since 2005. The proportion of mothers smoking in pregnancy is unevenly distributed across the city, with the highest proportion found in the North West (22.7%), South West (20.8%) and South East localities (17.7%). The lowest proportion was in Plympton (7.3%), Central & North East (7.4%) and Plymstock (8.4%). The proportion of mothers smoking in pregnancy has fallen across all the localities except for Plymstock where it increased by 1.4 percentage points.

3.20 Parents who smoke

According to the 2014 survey of health visitor caseloads, 26.2% of parents with children aged less than five years currently smoke. This represents a reduction of 8.3 percentage points since 2002. The distribution of parents who smoke is uneven across the city with a higher percentage found in the South West (35.9%), South East (32.9%) and North West localities

(29.5%). The South West has reduced by 13.9 percentage points compared to Central & North East reducing by 1.8 percentage points since 2002.

3.21 Parents who misuse drugs

The survey of health visitor caseloads suggests that a small proportion (2.7% in 2014) of parents with young children misuse drugs and that this has increased slightly over the period 2002 to 2014.. The distribution across the city shows a higher percentage of parents misusing drugs in the North West (4.3%) and South West localities (3.7%). All localities except for the South West have had an increase in percentage points since 2002; South West has had a reduction of 1.1 percentage points. Anecdotal evidence from the Public Health Team, Plymouth City Council, suggests that these figures and those for alcohol below, may underreport the true position and so the data should be interpreted with caution.

3.22 Parents who misuse alcohol

The survey of health visitor caseloads suggests that a small proportion of parents with young children misuse alcohol and that this proportion has fallen slightly from 2002 to 2014. In 2014, 2.0% of families with young children misused alcohol. The distribution of parents who misuse drugs is higher in the North West (3.1%). All the localities except for the North West and Plympton have reduced percentage points; North West has increased by 0.7 percentage points.

3.23 Depressed or mentally ill parents

The survey of health visitor caseloads suggests that 14.8% of parents with young children were considered to be depressed or mentally ill in 2014; a reduction of 1.3 percentage points since 2002. In 2014, the distribution of depressed or mentally ill parents is uneven across the city, with higher proportions found in South East (18.7%) and the North West (17.4%) compared to Central & North West (9.1%) and Plympton (9.4%). The locality which has had the greatest reduction in percentage points was the South West (7.9%), while Plymstock has increased by 7.6 percentage points in the period 2002-14.

3.24 Social isolation within families

Social isolation has been shown repeatedly to prospectively predict mortality and serious morbidity both in general population samples and in individuals with established morbidity, especially coronary heart disease. The survey of health visitor caseloads suggests that 5.3% of parents with young children were considered to be socially isolated in 2014.

3.25 Emergency admissions in children and young people (unintentional and deliberate)

The crude rate of emergency admissions for unintentional and deliberate injuries in children aged 0-4 years per 1,000 population has gone up by 1.3 from 2007-08 to 2012-13. The distribution of admissions is unevenly distributed across the city, with the South East having a rate of 27.8 per 1,000 population in 2012-13 compared to Plymstock with a rate of 10.2 per 1,000 population

The crude rate of emergency admissions for unintentional and deliberate injuries in children aged 5-14 years has decreased by 1.1 from 2007-08 to 2012-13. The rate of admission is unevenly distributed across the city, with the North West having a rate of 13.7 per 1,000 population in 2012-13 compared to Plympton with a rate of 6.8 per 1,000 population.

3.26 Emergency admissions for circulatory diseases

The hospital admission rate for circulatory diseases has increased by 10.0 per 10,000 population since 2008-09. The South East locality has the highest rate of admissions (139.4 per 10,000 population) compared to Plympton (88.4 per 10,000 population).

The rate of hospital admissions for circulatory diseases in the under 75s has increased by 2.7 per 10,000 population since 2008-09. The South West has the highest rate of hospital admissions (81.6 per 10,000 population) compared to Plympton which has the lowest rate (45.1 per 10,000 population).

3.27 Hospital admissions for falls in adults aged 65 and over

The rate of hospital admissions for falls in adults aged ≥65 increased by 31.6 per 10,000 population from 2008-09 to 2012-13. All six localities have seen an increase in the rate of admissions due to falls since 2008-09. For 2012-13, the South East locality had the highest rate of admissions (250.3 per 10,000 population) compared to the South West locality which had the lowest rate (206.8 per 10,000 population).

During the period 2008-09 to 2012-13, the rate of hospital admissions for falls in adults aged ≥75 increased in Plymouth by 62.8 per 10,000 population. All six localities have seen an increase in the rate of admissions since 2008-09, especially in Plymstock, although the locality with the highest rate was the South East (417.2 per 10,000 population).

3.28 Alcohol-related hospital admissions (all ages)

The rate of alcohol-related hospital admissions in Plymouth has remained static since 2010-11 The rate remains significantly higher than for England.

3.29 Substance misuse (all ages)

Substance misuse is recorded by agencies commissioned by the Office of the Director of Public Health, Plymouth City Council. In 2012-13, substance misuse was unevenly distributed across the city with the highest rate of clients living in the South West locality (161.0 per 10,000 population) and the lowest rate of clients living in Plymstock locality (23.5 per 10,000 population).

3.30 Estimates of population with specific mental health problems

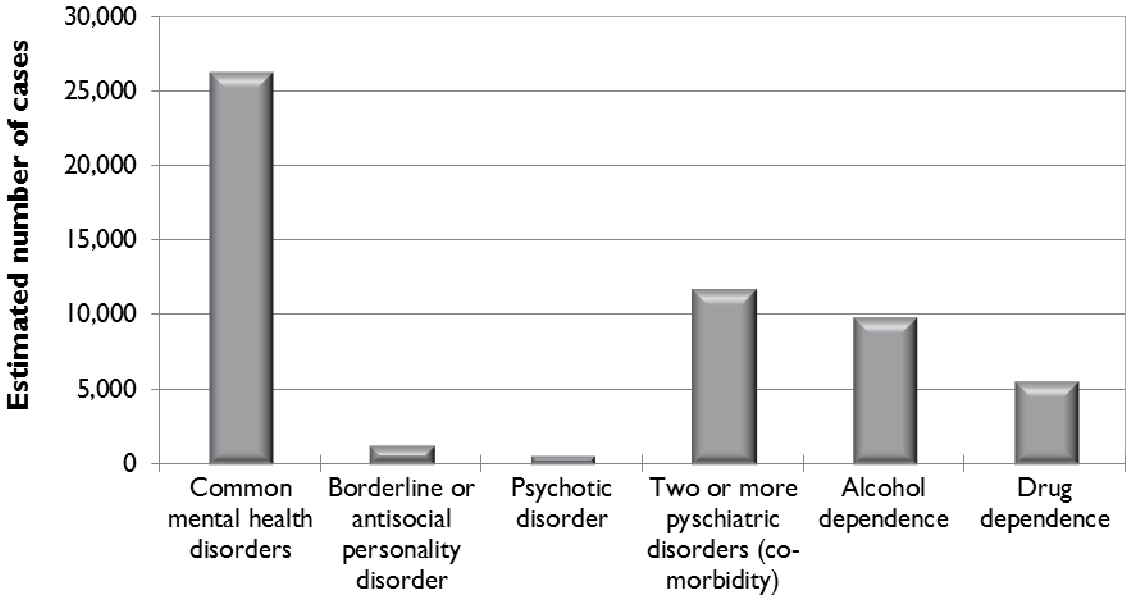
The number of males and females with specific mental health problems (common mental disorder, borderline personality disorder, antisocial personality disorder, psychotic disorder and two or more psychiatric disorders) is expected to increase, with females predicted to have a higher prevalence than males by 2020.

Contacts with the mental health service (a contact is defined as accessing the service for a spell of treatment; a person could have multiple contacts per spell) were unevenly distributed across the city in 2012-13. The South West locality had a crude rate of 413.5 contacts per 10,000 population compared to Plympton with a crude rate of 255.8 contacts per 10,000 population.

The graph below is produced by Public Health England and is from indicators calculated by taking some measure of mental health need. The two used are rates of hospital admission and the proportion of people rated as having a mental health problem in general population surveys.

Figure 5

Estimated 2014 prevalence of mental health problems in 18-64 year olds in Plymouth



The graph demonstrates that common mental health problems, including depression, anxiety and obsessive-compulsive disorder, constitute the greatest proportion of the mental health burden in Plymouth. Drug and alcohol dependence; as well as psychiatric co-morbidity are also very significant.

The mental health needs of Plymouth are estimated to be over 20% higher than would be expected for a city this size, indicating that the City has a high burden of mental ill health[9]

3.31 Hospital admissions for self-harm

The rate of hospital admissions for self-harm, has increased in Plymouth by 4.6 since 2008-09. For 2012-13, admissions were unevenly distributed across the city, with the South West locality having the highest rate of admissions (35.1 per 10,000 population) compared to Plymstock with the lowest (11.6 per 10,000 population).

3.32 Dementia

The estimated number of people with dementia in Plymouth is predicted to reduce for the 65-69 age group but increase in the over 69s by 2020. For the period 2014 to 2020 this increase is estimated to be 513 (from 2957 in 2014 to 3470 in 2020)[10].

The younger age groups (30-64 year olds) are not predicted to change over time.

9 North East Public Health Observatory. MINI and NPMS Needs Indices Data. http://www.mentalhealthobservatory.org.uk/mho/mini (accessed 2 January 2012)

10 Projecting Older People Population Information System (POPPI). www.poppi.org.uk (sourced 17 February 2015)

3.33 Long-term conditions (diabetes, respiratory problems, circulatory diseases, dermatological issues)

The prevalence of diabetes in Plymouth adults (aged ≥16 years) is predicted to increase by 1.1% by 2030 which is slightly less than the figure for England

The prevalence of circulatory diseases in Plymouth adults (aged ≥16 years) is similar to the prevalence for England. For Plymouth, the observed prevalence is less than the estimated prevalence.

The prevalence of Chronic Obstructive Pulmonary Disease (COPD) for the NEW Devon Clinical Commissioning Group (CCG) area is similar to England's average which is under the expected prevalence.

3.34 Smoking status, obesity and blood pressure (based on GP referrals)

The following sections on smoking status, obesity and blood pressure are based on data recorded at time of patient referral to Plymouth Hospitals NHS Trust (for any reason) by General Practitioners (GPs) in Plymouth.

The proportion of patients being referred (for any reason) who smoke in Plymouth, has decreased by 2.1 percentage points from 2010-11 to 2012-13. The locality with the largest proportion of smokers is the South West (26.5%) whilst Plympton has the smallest proportion (11.9%)

The proportion of patients being referred (for any reason) who were obese increased by 0.9 percentage points from 2010-11 to 2012-13. The locality with the largest proportion of obese patients is the North West (36.6%), compared to Plymstock which has the smallest proportion (11.9%).

The proportion of referred patients also experiencing high blood pressure has decreased by 0.3 percentage points from 2010-11 to 2012-13. The localities with the highest proportion of patients with high blood pressure are North West and Plympton (17.4% respectively). In the South East, 12.7% of referrals were for patients who were also experiencing high blood pressure.

3.35 Skin cancer incidence

The incidence of new cases of melanoma in adults in Plymouth (aged ≥16 years) has increased by 48 per 100,000 population from 2007-09 (426 cases) to 2010-12 (474 cases). This is due to a rise in the incidence of new cases of melanoma in males from 2007-09 (198 cases) to 2010-12 (268 cases). Females have seen a reduction in incidence from 2007-09 (228 cases) to 2010-12 (206 cases). For males, the incidence rate is higher in the less deprived localities (Central & North East, Plympton, and Plymstock). For females, the incidence rate is fairly similar across the localities

3.36 Cancer mortality in the under 75s

The directly age-standardised cancer mortality rate for persons aged <75 years per 10,000 population has fallen over the period 2003 to 2012 to 16.2 per 10,000 population in 2012. From 2003 to 2012, the mortality rate in the city fell by 3.2 deaths per 10,000 population. Mortality rates are unevenly distributed across the city, with the South West consistently recording the highest mortality rate and the lowest mortality rate typically in Plympton.

3.37 Predicting future demand

Since 2003 following the 'Mackay vision' Plymouth has aspired to grow to a city in excess of 300,000 population by 2026.

The Office for National Statistics (ONS)[11] projects the total population of Plymouth to reach 271,800 by 2021. This trajectory would not result in Plymouth reaching its target of 300,000 residents by 2026.

To support this ambition the city's Adopted Core Strategy 2007 identifies a housing target of 17,250 new dwellings over the period 2006-21 and a further 7,250 dwellings in the period 2021-26. Much of this development is focused on new housing developments at Plymstock Quarry; the Northern Corridor and regeneration in areas of high deprivation. Sherford New Town will also provide dwellings as the town becomes established.

By 2021 ONS projects growth in the 0-9 age group of 15.1% and continued growth in the 20-29 age group. The 65 years and over age group will grow by 14.7% and will account for 18.0% of Plymouth's total population. An aging population will put pressure on Plymouth's public services, supported housing, and adult social care in particular.[12] In particular the over 75's age-group is predicted to rise from 20,472 in 2013 to 24,731 in 2021.[13]

In line with an increasing population we will also expect to see an increase in the City's BME population. There is a wide diversity to the current BME population and if this profile continues it will also provide challenges in ensuring that access to our services are fair and equitable.

There will clearly be an increase in pressure on health and wellbeing services required by an increasing population and whilst these developments will be linked to increased income generation for the city intelligent, 'smart' use of resources will need to be applied to ensure positive outcomes and efficient services.

3.38 Consultation feedback

During 2013 the Plymouth Fairness Commission set up the 'Summer of Listening'. This was a process whereby local people and other stakeholders were able to tell the Commission what issues they thought were fair and unfair in Plymouth. The following reflect feedback on areas seen as unfair and relevant to this strategy:

- low wages in Plymouth compared to the high cost of living
- personal impact of unemployment and benefit cuts
- lack of affordable homes to buy
- high rents and a lack of suitable social housing
- lack of support for those with a mental health condition
- access to mental health and rehabilitation services
- vulnerability of some older people
- high cost of public transport in the city
- access to healthcare and dentistry
- affordable healthy food
- leisure activities for disabled people and certain ethnic groups
- alcohol and drug-related abusive and anti-social behaviour
- racism and discrimination
- barriers to involvement in community activities
- limited opportunities for community engagement

11 ONS Subnational Population Projections, Interim 2011-based
12 ONS Subnational Population Projections, Interim 2011-based
13 Interim 2011-based subnational population projections, persons by single year of age for local authorities in England (ZIP 3964Kb)
http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Sub-national+Population+Projections

- lack of clear routes for participation in local matters and decision making
- health inequalities
- obesity

The following reflect relevant areas recognised as doing well - fair:

- the opportunity to access adult learning with good support for individuals
- social housing allocation system and the investment in new build properties to tackle the problems of poor quality housing
- good healthcare provision
- availability and affordability of public transport schemes
- the breadth of volunteering and citizen engagement opportunities
- community improvement programmes
- abusive and anti-social behaviour, a number of respondents felt that issues are dealt with promptly
- positive response to abusive and anti-social behaviour

The feedback from stakeholders including local people and local groups bring into focus issues of fairness of access to services and support. They also reflect some of the challenges to peoples resilience and hence issues that can affect a person's wellbeing e.g. mental health, racism and discrimination, impact of unemployment etc. The feedback also reinforces the need for involvement in and the importance of community based activity, effective community engagement and participation in local decision making / issues. Assets linked to volunteering and citizen engagement are noted as are community improvement programmes and support available for those in adult learning.

In response to identifying commissioning intentions as part of the NEW Devon CCG Transforming Community Services programme the key issues identified by local people were written as 'I' statements:

- "I want the services I value now to be strengthened"
- "I want no barriers to care caused by geographic, regulatory or any other kind of boundary."
- "I want services that support me to manage my situation in life not just my condition"
- "I want the information I need to make healthy choices and stay healthy"
- "I want what my carer does to be recognised and for them to have the support they need to have a full, healthy life of their own"
- "I want to be able to get to my community services at times that are convenient for me"
- "I want to be able to have services provided in lots of different places not just health centres"
- "I want to be able to talk to healthcare providers when I need to."
- "I want to tell my story once - share my information with colleagues"
- "I want to be able to use new technology to help me manage my own health"
- "I want to continue to get the services I value that are provided by the voluntary sector"
- "I want to be able to get to the services in my community"

These statements support the need for people to be enabled to have choice and control over their lives across all of their lives stages including end of life. They reflect the need to have high quality advice and information available; accessible services and support that is local and centred on meeting a person's holistic needs. In developing a 'Wellbeing Strategy' with a strong prevention focus these

statements also support the need for co-design of services and building community capacity through the voluntary and community sector.

3.6 Needs Assessment Summary

The health of people in Plymouth is generally worse than the England average. In the city there are higher than average levels of deprivation, with more than 50% of residents being in the 2 most deprived socio-economic quintiles. The inequality in health that is driven by social inequalities and is demonstrated in the fact that there is a 7.9 year gap in life expectancy in men and a 5.8 year gap in life expectancy of women in Plymouth between the least and the most deprived groups.

Poor health behaviours cluster in the more deprived socio-economic groups and this also drives health inequalities. In Plymouth there are higher than average numbers of people who smoke and hence higher proportion of smoking related deaths. There are higher levels of alcohol-related ill health, higher levels of drug misuse.

Health in Plymouth is significantly worse than England as measured on 17/32 health indicators in the annual Health Profile. In relation to the 11 Regional Centre comparator areas, Plymouth is 5th= with Southampton in terms of health profile indicators. Mental health in Plymouth is also poor, demonstrated by the fact that common mental health problems are estimated to be 20% higher than would be expected for the demographic and economic make up of the City.

In Plymouth the population is broadly similar to national average, although there are considerably more young adults in age 20-29, attributable largely to the student population in the city. There is a small but rapidly growing black and minority ethnic population in the city and in the last 10 years there has been significant growth in the very young 0-4 years. Overall our population is an ageing one and growth in 65+ age groups is broadly in line with national average. These are the main population characteristics relevant to impact on health and wellbeing needs.

The levels of deprivation that exist in Plymouth drive the on-going challenge to tackling the resulting health and social inequalities and represent a major challenge to improving the health of the population as a whole. The new approach to health inequalities proposed in the city (4-4-54) will work over the next 10 years to address this by focusing on the 4 behaviours that drive health inequalities in the city – poor diet, lack of exercise, tobacco use and excess alcohol consumption.

Table 9

Demographic	• Increasing population size • Increasing older population over 75 • Increasing number and diversity of BME population
Deprivation	• Plymouth is ranked 72 out of 326 in terms of deprivation (1=most deprived; 326=least deprived) • There are higher levels of long term health problems or disability when compared nationally; there are lower levels of reported good or very good health when compared nationally
Determinants	• Clear social gradient in health which shows life expectancy is 7.9 years lower for men and 5.8 years lower for women in the most deprived areas of Plymouth than in the least deprived areas • Housing conditions in Plymouth are worst in the private rented sector with 37.2% categorised as non-decent • Under-employment' is comparatively high in Plymouth.

Need: Areas where we are reported as being significantly higher than England in the Health Summary for Plymouth	• Under 18 conceptions • Alcohol and drug misuse • Adults smoking • Sexually transmitted infections • Incidence of malignant melanoma • Early deaths from cancer • Violent crime - of which local data reports 31% of which linked to domestic abuse
Need - Additional	• Mental health need estimated as being 20% higher than what would be expected for a city with our population • Increase in the rate of hospital admissions for self-harm • Increase in the rate of hospital admissions for circulatory diseases • Increase in hospital admissions for falls in adults aged 65 and over • Increase in dementia in the over 69s by 2020

4.0 STRATEGIC CONTEXT

4.1 National

Health and Social Care Act 2012

Sets out the legislative framework to enable integrated health and social care delivery

Healthy Lives Healthy People 2010

The Governments strategy for public health in England stated, 'We need a new approach that empowers individuals to make healthy choices and gives communities the tools to address their own, particular needs'.

Fair Society, Healthy Lives[14]

Sir Michael Marmot's report sets out a life course framework for tackling the wider social determinants of health. The approach aims to build people's self-esteem, confidence and resilience right from infancy – with stronger support for early years.

A Call to Action: Commissioning for Prevention'[15]

NHS England and Public Health England state, "Commissioning for prevention is one potentially transformative change that CCGs can make, together with Health and Wellbeing Boards and their other local partners. Implemented systematically, the evidence suggests prevention programmes can be important enablers for reducing acute activity and capacity over the medium term".

The Five Year Forward View[16]

Sets out how the NHS needs to change. The authors state, 'The first argument we make in this Forward View is that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. Twelve years ago Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences.'

[14] Marmot, M. (2010) Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010, www.marmotreview.org
15 NHS England & Public Health England (2013) A Call to Action: Commissioning for Prevention
16 NHS England; Public Health England; Health Education England; Trust Development Authority; Care Quality Commission; Monitor (2014) Five Year Forward View

4.2 Local

Creating the Conditions for Fairness (2014): The Plymouth Fairness Commission Final Report

This report sets out recommendations focused at both the national and local level that will create a fairer Plymouth. The Fairness Commission asked all local organisations named in the report to provide their response and commitment to delivery of attributed recommendations and initial estimates of timetables by the end of June 2014. In responding to this challenge the Health and Wellbeing Board stated that they will now 'ensure that the Commissioning Strategies from NEW Devon CCG, Plymouth City Council and other agencies are integrated, budgets are pooled and the Fairness Commission recommendations are addressed in the strategies developed and implemented'.

Health and Wellbeing Strategy (2014) Plymouth Health and Wellbeing Board

The Joint Health and Wellbeing Strategy is intended to inform commissioning decisions across local services such that they are focused on the needs of service users and communities, and tackle the factors that impact upon health and wellbeing across service boundaries. Underpinned by the Marmot review the Strategy recognises that health and wellbeing must be addressed across the whole life course. In line with the Marmot review the Strategy aims to:

- Give every child the best start to life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy sustainable places and communities
- Strengthen the role and impact of ill health protection

The Plymouth Plan – How Plymouth Will be a Healthy City (in development)

The Plymouth Plan is a single holistic plan setting out the direction for the City up to 2031. It brings together all the key strategies and plans for the city into one coherent document. It does so because the interdependencies of these strategies and plans are key to transforming the City. The section on health recognises that over the course of the Plymouth Plan period demographic changes and increasing complexity of need will continue to put pressure on all vital front-line services. The challenge for the public sector is to meet the volume and complexity of demand with decreasing resource. A focus on prevention is evidenced to reduce the burden of disease and consequently reduce demand on front-line services. The Plymouth Plan will show how partners and services from across the city can achieve this aspiration.

PCC Corporate Plan – The Brilliant Co-operative Council

On its adoption of a new Corporate Plan in July 2013, the council set the ambition to become a Brilliant Co-operative Council, in spite of decreasing resources. This 'Plan on a Page' commits the Council to achieving stretching objectives with measurable outcomes, and also sets out a Cooperative vision for the Council, creating a value-driven framework for the way that it will operate as well as the outcomes that it is committed to achieve.

Thrive Plymouth (4-4-54): Framework for addressing health inequalities

Cabinet approved this framework and the supporting action plan to address health inequalities in the city in November 2014. Thrive Plymouth (4-4-54) will be delivered through a new Plymouth Health and Wellbeing Collaborative of multiple partner organisations in the city. In summary, poor diet, lack

of physical activity, tobacco use and excess alcohol consumption are risk factors for coronary heart disease, stroke, cancers and respiratory problems which together contribute to 54% of deaths in Plymouth. Changing these four behaviours would help prevent these four diseases and reduce the number of deaths due to those chronic diseases.

NHS Futures: Prevention - Outline Business Case

This strand of the NHS Futures Programme aims to reduce the overall demand on the health system by promoting healthier lifestyles straight away and commissioning for prevention starting in 2015/16. The recommended option for the Prevention Plymouth strand of the Programme was Option1.This was to achieve a reduction in the overall demand on the health system by increasing the health of the Plymouth population focusing on three workstreams (a) being born; (b) living and (c) ageing. Key to the delivery of this would be the 4-4-54 construct (see page 30)

Transforming Care in Devon and Plymouth: Five Year Strategic Plan, (2014) CF01 NEW Devon CCG

This Strategic Plan states that, 'By 2019, healthy people will be living healthy lives in healthy communities. Services will be joined up and delivered in a flexible way. Resources will follow need. More care will be provided in the community'. Healthy living and wellbeing is cited as one of the key elements to the model of care recognising that interventions 'focus on preventing ill health and social factors such as isolation in the first place, focused on those most at risk – where the returns are greatest in terms of quality benefits for patients and service users and the reduction in demand (and cost) along the care pathway'.

In this framework NEW Devon CCG state they 'will work with its partners to commission services that contribute to the delivery of the Joint Health and Wellbeing Strategy'. The framework sets out the key CCG intentions.

Integrated, personal and sustainable: Community Services for the 21st Century; A strategic framework (2014) NEW Devon CCG

The strategic framework sets out to design future services to meet people's needs whilst continuing to improve quality, efficiency and effectiveness of community services and to build on the many skills and talents of staff delivering them. It also sets out to achieve this change through co-production. That is working with partners, providers and communities to transform these services together.

The strategic intentions of the Western Locality are underpinned by:

- coordination and integration
- a pathway approach
- personalisation and self-management
- shifting care to a home based setting wherever possible
- prevention of ill health
- the key role of carers

For patients, Integrated Health and Social Care provision promotes:

- Greater choice and control over the care and support received
- Timely support in a crisis and support to recover
- Care provided closer to home and in communities
- Reduced health inequalities, high quality services and safe from abuse.

- The right care, in the right place at the right time

Examples of current Plymouth Strategies, Commissioning Plans and other key documents supporting the scope of this Commissioning Strategy:

- Addressing health inequalities in Plymouth: 4-4-54 Action Plan
- Carers Strategy 2014-18
- Charter for Older People (2012)
- Dementia Strategy 2014-15,
- Domestic Abuse Commissioning Plan 2012-2019,
- Healthy people living healthy lives in healthy communities CF01 NEW Devon CCG Commissioning Framework 2014 – 2016
- Housing Plan 2012-2017 Plymouth City Council
- How do we make Plymouth a healthier city? (2014) Plymouth Plan Topic Paper Health and Wellbeing
- Our (Plymouth City Council) Commitment to Equality and Diversity (2014)
- A Mental Health Commissioning Strategy for Devon, Plymouth and Torbay 2014-2017
- Plymouth Aquatics Strategy 2010 -2020
- Plymouth's Healthy Lives for Healthy Weight Action Plan (in development)
- Plymouth Mental Health Network Strategy – Whole Life Whole Systems
- Plymouth Mental Health and Wellbeing Promotion Action Plan strategy
- Plymouth Suicide Prevention Action Plan (in development)
- Promote Responsibility, Minimise Harm. A Strategic Alcohol Plan for Plymouth 2013-18
- Transforming Community Services: Proposed Commissioning Intentions for the Western Locality Your Health, Your Future, Your Say (2014) NEW Devon CCG

4.3 Key legislation

Health & Social Care Act 2012

The Health and Social Care Act 2012 contains a number of provisions to enable the NHS, local government and other sectors, to improve patient outcomes through more effective and co-ordinated working within the context of economic austerity. The Act provides the basis for better collaboration, partnership working and integration across local government and the NHS at all levels. The Act identifies Clinical Commissioning Groups (CCGs) as being best placed to promote integration given their knowledge of patient needs, and the commissioning power to design new services around these needs. This is endorsed by early findings from the Department of Health's 16 Integrated Care Pilots (evaluated independently in the RAND report, 2012) which suggest that GPs in particular are taking on responsibility not only for the individual patient but also for that person's journey through the system

The Social Value Act (2012)

Requires all public bodies to consider how the services they commission and procure might improve the economic, social and environmental wellbeing of the community. 'Social value' involves looking beyond the price of the individual contract and considering the social impact on the community when the contract is awarded.

Care Act 2014

The Care Act 2014 creates a single modern piece of law for adult care and support in England. The reforms introduce significant new duties on Local Authorities and consequently will involve significant change to finances, processes and people.

The Act rebalances the focus of care and support and makes explicit the need to promote wellbeing and prevention rather than intervening only at points of crisis. Fundamental to these new duties will be the role of communities and social networks. There is a requirement that local authorities must promote wellbeing when carrying out any of their care and support functions in respect of a person.

The Care Act insures that people will have clearer information and advice to help them navigate the care system and a more diverse, high quality range of support to choose from to meet their needs.

Duties also include additional responsibility for assessment. This includes:

- Carers – the Act also included the need to supply services if the carer is eligible
- All adults regardless of need/support or regardless of financial resources.

Funding reforms will introduce a national minimum eligibility threshold, a cap on care costs, the introduction of Independent Personal Budgets, the maintenance of Care Accounts and a universal Deferred Payment Scheme.

The Act states that 'local authorities must promote wellbeing when carrying out any of their care and support functions in respect of a person'. In this context the Act describes wellbeing as relating to the following areas:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over day-to-day life (including over care and support provided and the way it is provided)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal relationships
- suitability of living accommodation
- the individual's contribution to society

This 'wellbeing principle' applies in all cases where a local authority is carrying out a care and support function, or making a decision in respect of the person. In this context the promotion of wellbeing is also central to the commissioning strategies covering community care and complex care and this can be seen to be complementary to the activity in scope of this Strategy. In this way wellbeing will be promoted at a population and sub-population level through this strategy and also promoted when an individual is in need of a service providing care and support including at end of life through the complementary strategies. The principle also applies to those caring for an individual.

4.4 Evidence based / good practice

4,4,1 This strategy will incorporate good practice and build on an evidence base to improve the health and social care outcomes of people in Plymouth. The following good practice resources, research and data can be accessed by health and social care professionals and commissioners:

- Social Care Institute for Excellence (SCIE) – http://www.hscic.gov.uk/
- National Institute for Health and Care Excellence (NICE) - http://www.nice.org.uk/
- The Health and Social Care Information Centre (HSCIC) - http://www.hscic.gov.uk/
- NHS Improving Quality (NHS IQ) - http://www.nhsiq.nhs.uk/

- Ofsted (Office for Standards in Education, Children's Services and Skills) - http://www.ofsted.gov.uk/
- Care Quality Commission (CQC) - http://www.cqc.org.uk/
- Health & Care Professions Council (HCPC) - http://www.hpc-uk.org/
- Health & Safety Executive (HSE) - http://www.hse.gov.uk/index.htm

4.4.2 THRIVE

Oxford Health Alliance (OxHA) developed the concept of 3 four 50 in response to global concerns about chronic diseases. This construct reflects the observation that there are three risk factors to health that together contribute to four chronic diseases which, in turn, contribute to more than 50% of preventable deaths worldwide. These diseases are:

- Cancer
- Coronory Heart disease
- Stroke
- Chronic obstructive pulmonary disease (COPD)

This focus on chronic diseases is appropriate as they are now the major cause of death and disability worldwide, having surpassed infectious diseases and injuries. By focusing on changing behaviours that can lead to the development of these diseases there is likely to be a reduction in the number of people who experience them with consequent benefit to the individual, family, community and public purse. Using this construct with the Plymouth data leads to the 4-4-54 numbers.

4.4.3Think Local Act Personal and Public Health England published a framework for Health and Wellbeing Boards in 2014 entitled, Developing the Power of Strong, Inclusive Communities. Evidence cited reflected a growing evidence base that shows:

- Low levels of social integration and loneliness significantly increase mortality whilst people with stronger networks are healthier and happier
- Social networks are consistently and positively associated with reduced illness and death rates
- The most significant difference between people with mental ill health and people without mental ill health is social participation. Social relationships can also reduce the risk of depression.
- Areas with poor social capital experience higher rates of cardiovascular disease in general and recurrence of acute coronary syndrome, in particular among lower level income individuals
- For older people, volunteering is associated with 'more positive effect and more meaning in life'
- Areas with stronger social networks experience less crime and delinquency
- Neighbourhood watch can reduce crime by 16-26%
- The time credits organisation Spice documented a 17% reduction in crime following the introduction of a timebank scheme in local youth groups

5.0 CURRENT PROVISION

5.1 Strategic overview

There has, up to now, not been a wellbeing system defined. A wide range of provision reflects services that have been commissioned in line with strategies, commissioning plans and business cases focusing on specific priorities that include a universal or preventative offer supporting wellbeing.

The existing approach has meant that differing commissioners utilising different budgets and commissioning processes have created 'artificial' structures that can mean unnecessary duplication can take place; service users have to repeat their story to access services; and service users on pathways linking differing services often do not experience this as seamless and timely. Importantly no coherent evidence based approach to population level prevention has been strategically agreed and delivered by all the key stakeholders across the city.

Outcomes in this context for the person have too often been shaped by more of a' silo' approach to service and system design which does not place the service user at the centre of the range of services they require and the outcomes they are needing.

There has always been ambition to design services that work better together within and across systems and progress has been made. However the current categories that we've commissioned against (see table 9) has not enabled us to maximise the potential to create a coherent system for wellbeing.

Currently, investment in universal and preventative services has been primarily met by the local authority.

5.2 Existing service provision

Currently there is a wide range of services that have been identified as supporting wellbeing. These services include the following:

Table 10

Current Categories	Examples
Universal / Social Capital	Advice and information ; Time-banking; Advocacy Services; Healthwatch; Carers Support; Learning, Physical and Sensory Disability Support, Counselling; Health Improvement Services; Primary Care Enhanced Services; Health Checks; GPs with Special Interest; Sexual health and prevention and promotion services; Community Contraception Services; GUM Services; Library Services; Stop Smoking Service; Community Gyms; Life Centre/ Brickfields/LIDO/Mount Wise Pools/ Plympton Pool; Community Health in Keyham;
Enabling and Floating Support	Home from Hospital; Telecare Alarm Monitoring; Dementia Support; Floating Support; Befriending; Carers Support; domestic abuse; homeless information, advice and support; mental health support;
Sheltered Housing	Information, advice and support; provision of sheltered housing;

These services are delivered by over 60 providers (not including Primary Health Practices and Pharmacies) with around 40 coming from the independent, voluntary and community sector.

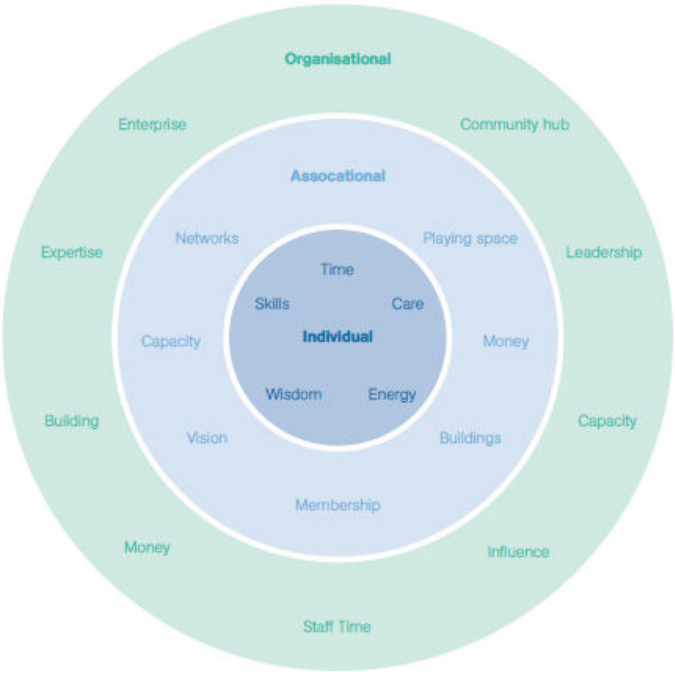
Services generally perform well against the measures in their contracts but this service performance is not always reflected in improvements in key outcomes for the city or in reducing inequality across the city.

Whilst there has been some investment in developing social capital this has been limited. Current commissioning practices have not facilitated a strategic approach to developing social capital and community self-help to support wellbeing.

5.3 Community asset mapping

Asset mapping will be utilised to determine existing informal provision, assets and resources that people have access to in the community. A co-production approach will improve the understanding of local needs and assets and will be part of the wider needs assessment work carried out across the four strategies. The asset maps would then support the formally procured services as part of the long-term commissioning strategies (Adapted from *Commissioning for Outcomes and Co-production: A practical Guide for Local Authorities, NEF 2014*). An example of the wide range of assets that could be included in the mapping exercise is presented in figure 1 below.

Figure 6 Asset Mapping



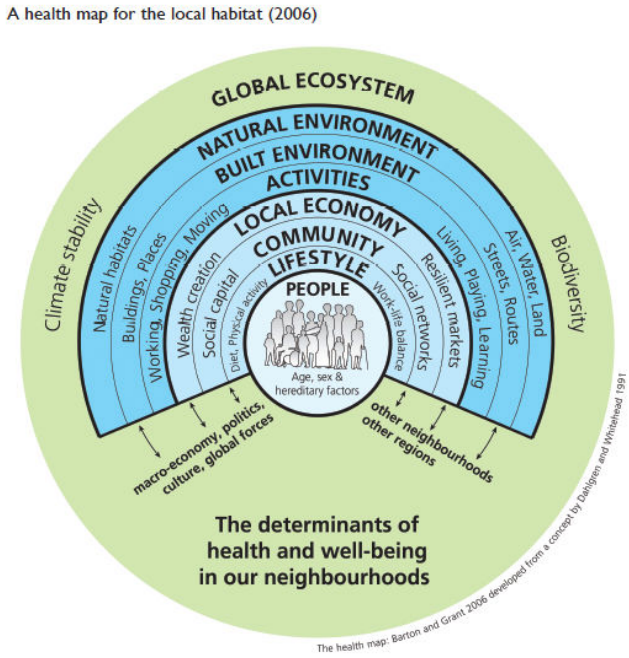
Source: Commissioning for Outcomes and Co-production: A practical Guide for Local Authorities, NEF 2014. Adapted from Foot, J. and Hopkins T. (2012). The Collaborative. (n.d.) Our Vision. The Collaborative: London. Retrieved from http://lembethcollaborative.org.uk/about/our-vision.

6.0 THE FUTURE 'WELLBEING' SYSTEM MODEL

6.1 Health Map and the Wellbeing System

Work by the Kings Fund identified that health is determined by a complex interaction between individual characteristics, lifestyle and the physical, social and economic environment. The Health Map illustrated below details how many different factors influence people's health. Most experts agree that these 'broad determinates of health' are more important than health care in ensuring a healthy population.

Figure 7 Health Map



The Health Map places services in scope of this strategy within this wider system. These services focus on the people, lifestyle and community domains. Ensuring a strategic approach to improving wellbeing will create an environment within which decisions focusing on the wider determinants of health and wellbeing will be made with the aim of supporting the impact of the services in scope of this commissioning strategy and so maximise outcomes for individuals, families, communities and the city as a whole.

The approach must therefore ensure that improving wellbeing is integrated into strategic objectives and policies in respect of each of the domains set out: Natural Environment, Built Environment, Activities (such as shopping, transport and employment), Local Economy, Community, Lifestyle and People. Therefore the Health Map sets out our 'wellbeing system'.

The services in scope of this strategy will provide a universal and preventative offer and be designed to (1) target those issues that have the biggest impact on well-being across the city and (2) build capacity within communities (social capital) with the aim of supporting the development of healthy and happy communities in Plymouth, and reduce the pressure on the wider health and social care system.

The services that will be commissioned directly through this strategy will sit alongside a range of other key stakeholder contributions who also commission prevention services that support wellbeing. For example:

- NHS England commission Primary Health Care that plays a key role in preventing ill health and detecting ill health
- NHS England commission a range of immunisation and screening programmes that prevent ill health
- The Police Crime Commissioner PoCC invests in activity (much of which will sit alongside activity described in the Community Strategy) that includes some prevention work. This investment is used to support the commissioning intentions of Safer Plymouth.
- Plymouth City Council and NEW CCG through the accompanying Integrated Strategies have a duty under the Care Act to promote wellbeing of the people these Strategies are intended

to reach (through the wellbeing principle). In doing so 'promoting wellbeing' will not just be something 'siloed' within this Strategy but an offer that is integrated across the whole system of health and social care. For example the promotion of wellbeing for people at the 'end of life' and their carers will be a core offer. This Strategy will focus on delivering whole or targeted population level interventions.
- The Children and Young Peoples Commissioning Strategy will also include activity that supports the wellbeing of children, young people and families e.g. Health Visitors, Family Support.

For services and support that are not currently commissioned by the local authority, CCG, NHS England and the Police Crime Commissioner:

- Schools contribute significantly to the City's wellbeing through prevention activity that supports the wellbeing of their school population
- Business' contribute significantly to the City's wellbeing through running programmes to help improve the wellbeing of their employees
- The University's contribute significantly to the City's wellbeing through prevention activity that supports the wellbeing of their University population

Finally, the voluntary and community sector deliver commissioned services or services and support that is funded through charitable grant making bodies or services and support that is truly voluntarily based.

- The voluntary and community sector provide a wealth of services and support, that reflects local (neighbourhood) need and is a key enabler of local social capital and community self-help

6.2 Wellbeing Interdependencies
Maximising the relationship between stakeholders and their interdependencies to have an effective 'wellbeing system'

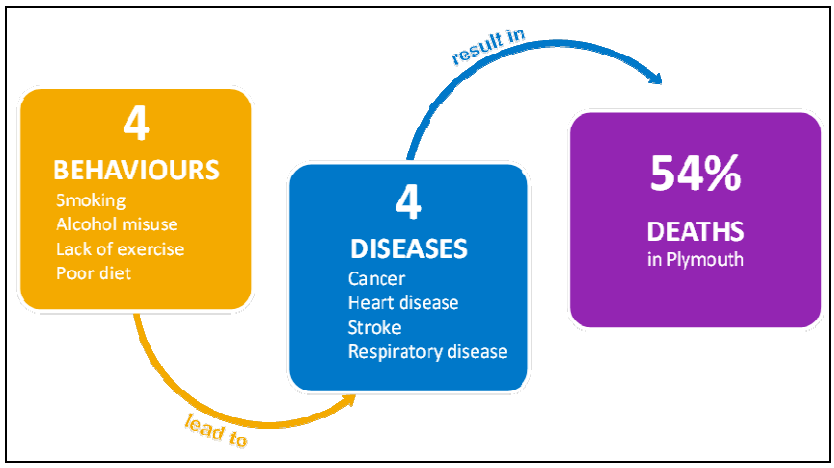
It is vital that at both a strategic level and on a service design and delivery level effective links are made with the appropriate stakeholders noted above. Opportunities to work in partnership, co-commission and joint work must be taken forward to maximise the use of resources and impact. Pathways described or that will be developed in support of the accompanying Strategies should where appropriate link to the activity that is developed through this Strategy enabling universal and preventative interventions to be accessible to anyone at any point within the system.

Central in this approach should be the strong emphasis given to building social capital and community self-help, and engaging in co-design activities with local communities. This will ensure a co-produced system that will maximise investment and local assets.

6.3 Thrive

The Strategy will drive forward a population level prevention programme through Thrive Plymouth (4-4-54) to tackle the four key behaviours that impact on four key diseases and contribute to 54% of all deaths in Plymouth.

Figure 8 Thrive Plymouth; 4-4-54



Thrive is not based on the delivery of commissioned services alone but through enabling social change through for example influencing key stakeholders, providing accessible advice and information to populations to change behaviours and supporting patient activation to help them achieve choice and control.

Commissioned services will deliver a range of high quality, evidence based interventions and include an enhanced focus on the key behaviours that contribute to risk factors for coronary heart disease, stroke, cancers and respiratory problems. These behaviours are poor diet, lack of exercise, tobacco use and excess alcohol consumption. Changing these four behaviours would help prevent these four diseases and reduce the number of deaths due to those chronic diseases.

6.4 Integrated Commissioning Model – Wellbeing

Currently there is a high spend on specialist care and in comparison a limited focus (and relatively limited resourcing) of preventative services. Over the lifetime of this and the accompanying strategies there will be a shift in the amount of investment and proportion of investment toward improving and promoting wellbeing and community based support.

Prevention is recognised through a range of evidence and policy drivers as key in reducing pressure at the complex and intensive end of provision as well supporting savings across the whole system.

Over time the system should not see a decrease in the proportion of investment supporting wellbeing through prevention activity as a proportion of investment across the whole system. Indeed the proportion of investment spent on prevention as a percentage of the total spend on health and social care should increase over the five years of the Integrated Commissioning Strategies. There is a good evidence base for the impact or preventative approaches. For example NHS England cites the following:

- 42% of the mortality decrease from Coronary Heart Disease between 1981 and 2000 was attributable to medical and surgical treatments, whilst about 58% was attributable to the

change in risk factors—showing that preventative interventions can have a significant impact over the medium term[17]

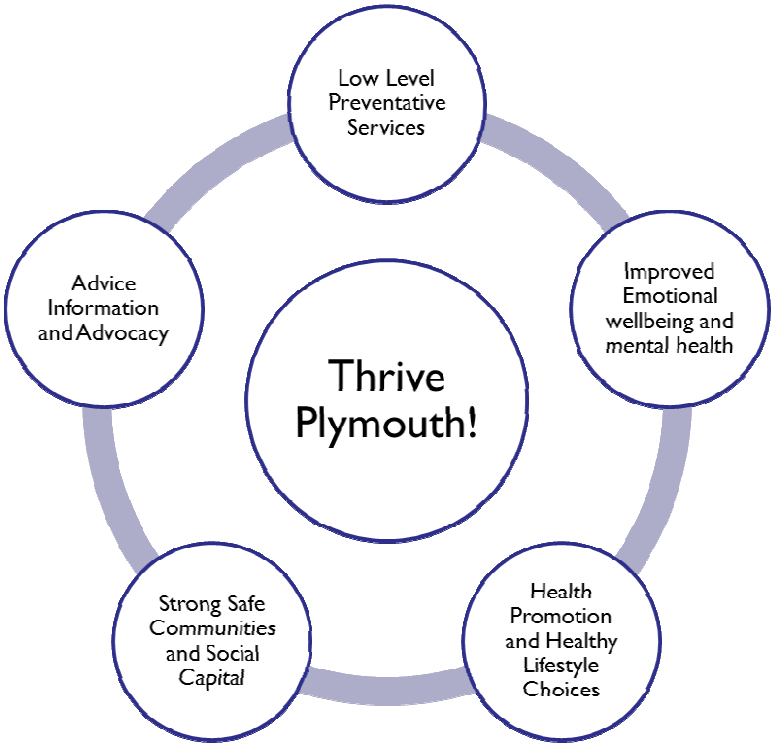
- For every £1 spent on preventative action £8 can be saved with families with conduct disorder[18]
- For every £1 spent on preventative action £18 can be saved on psychosis[19]
- For every £1 spent on preventative action £12can be saved with primary care[20]

Increasing the proportion of funding for wellbeing as a percentage of the whole of the Health and Wellbeing system and then investing this in evidence base interventions should save potential future spend.

This should be further supported through building social capital and self-help.

Commissioning framework for Wellbeing

Figure 9



Thrive is the central population focused approach to reducing health inequality in the city that will reduce preventable deaths, improve lifestyle behaviour and in time reduce the overall spend in the system. All the additional elements of the commissioning framework contribute to Thrive but require a specific focus in line with the City's Strategic ambition and the needs identified.

17 Kelly, M.P. and Capewell, S. (2004) Briefing paper: Relative contributions of changes in risk factors and treatmentto the reduction in coronary heart disease mortality. Health Development Agency

18 Campbell, C.A., Hahn, R.A., Elder, R., Brewer, R., Chattopadhyay, S., Fielding, J., Naimi, T.S., Toomey, T., Lawrence, B. and Cook Middleton, J. (2009) The Effectiveness of Limiting Alcohol Outlet Density as a means of reducing excessive alcohol intake. American Jounral of Preventative Medicine 37 (6) pp. 556 -569

19 Jebb, S.A., Ahern, A.L., Olson, A.D., Aston, L.M., Holzapfel, C., Stoll, J., Amann-Gassner, U., Simpson, A.E., Fuller, N.R., Pearson, S., Lau, N.S., Mander, A.P., Hauner, H. and Caterson, I.D. (2011) Primary care referral to a commercial provider for weight loss- treatment versus standard care: a randomised controlled trial. The Lancet 378 (98) pp.1485-1492

20 Jolly, K., Lewis, A., Beach, J., Denley, J., Adab, P., Deeks, J.J., Daley, A. and Aveyard, P. (2011) Comparison of range
of commercial or primary care led weight reduction programmes with minimal intervention control for weight lossin obesity: Lighten up randomised control unit. British Medical Journal 3 (343)

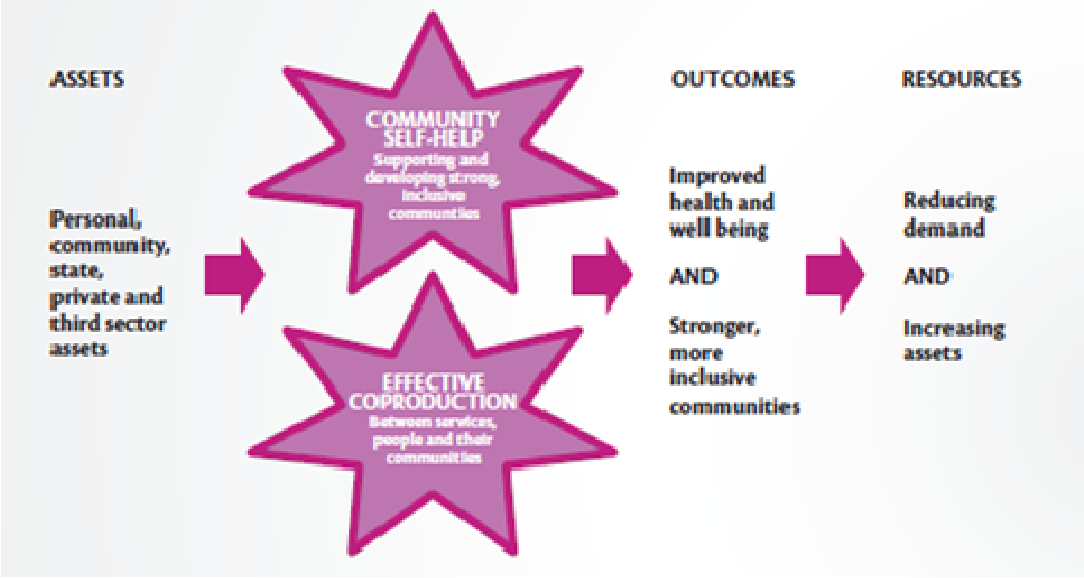
Key elements identified to support the wellbeing system in scope of this strategy:

6.4.1 Strong safe communities and social capital

In his report, Fair Society Healthy Lives, Michael Marmot states 'The extent of people's participation in their communities and the added control over their lives that this brings has the potential to contribute to their psychosocial well-being and, as a result, to other health outcomes. It is vital to build social capital at a local level to ensure that policies are both owned by those most affected and are shaped by their experiences.'

Building social capital and community self-help will be a key strand to the Strategy. Supporting community development approaches will enable local communities to build social capital and also design services with key stakeholders. The Strategy needs to raise the profile of this area and will require improved understanding of community based assets in place and more detailed work on the investment requirements to facilitate building on our current level to achieve a step-change in community engagement and participation.

Figure 10



Think Local Act Personal & Public Health England 2014

6.4.2 Advice, Information and Advocacy

High quality, accessible advice, information and advocacy, to support choice and control by individuals, families and communities. This also supports patient activation and will ensure that individuals and populations have access to independent support to ensure people know their rights or how they can challenge or clarify decisions made which affect their wellbeing. These are key building blocks to ensuring that people are enabled and empowered to be make decisions to improve their wellbeing and their health.

6.4.3 Health Promotion and Healthy Lifestyle Choices

Health promotion enables people and communities to be healthier. Delivered through a range of services and settings these activities can include screening and active engagement with people to develop improved lifestyle choices. Provision of evidence based information and knowledge along

with access to a range of activities or an offer that supports improved health e.g. community gymnasium.

6.4.4 Improved emotional well-being and mental health

Helping people build the resilience to challenges they face is critical. This is not just about what services there are available but what social capital can offer. Taken together more resilient people are able to cope better with life including those with many forms of mental illness . Improving the emotional wellbeing and mental health of individuals, families and communities is also recognised as a key cross cutting component to all aspects of improving wellbeing.

6.4.5 Low level preventative services

The needs data identified the following as areas that need a specific focus:

- Sexually transmitted diseases
- Violent crime and domestic abuse
- Falls by older people

These areas will require a specific focus at both a whole population level and targeted population level.

Some of the services and the offer developed will also work with people with multiple need and complexity. Access to wellbeing strategy commissioned services from community and complex commissioned services as well as services designed for children and young people will ensure wellbeing is addressed at all levels of need across the City and across the whole life course.

6.5 Available Resources

The current approximate commissioning budget against each service element is described in the table below.

Table 11

System element	Approximate current budget
Advice information and advocacy	£3,070,828
Low level preventative services	£3,773,422
Improved emotional wellbeing and mental health	£106,858
Health promotion and health lifestyle choices	£12,425,383
Strong safe communities and social capital	£1,375,744
Total	£20,752,235

An additional £40 million of prescribing spend is currently being linked to the Wellbeing Strategy but further discussions need to take place to determine the best place to hold this budget and the implications in doing so

6.6 Measuring Future System Performance

The following outcome performance indicators have been identified as key to measuring how this strategy contributes to improvements across the whole health, wellbeing and social care system in Plymouth. These will form part of a comprehensive performance dashboard that will be used to monitor an overview of the system.

Table 12

Indicator	National	Plymouth	Impact on system – why is this a measure?	Trajectory
PHOF 2.12 Excess weight adults	63.8%	60%	Measures against THRIVE - People lead healthier lives for longer delaying need for care and support service in the 'community' and 'complex' strategies	
PHOF 2.13ii Adults classed as inactive	28.9%	34%		
PHOF 2.14 Smoking prevalence in adults	18.4%	24.5%		
Social isolation: % of adult carers who have as much social contact as they would like	41.3%	36.5%		
Wellbeing Indicator	TBC	TBC	Key measure for wellbeing for the city. Further discussion to take place on using ONS measure and / or local wellbeing measure based on the Plymouth Wellbeing Survey	

7.0 COMMISSIONING INTENTIONS

DRAFT Initial Implementation timetable 2015/16

Table 14

System element	Commissioning Activity	Key Outcome	Lead Commissioner	Timeframe
THRIVE	Delivery of 4-4-54 Action Plan to address health inequality in the city	Reduce the number of preventable deaths	PCC / CCG	Annual Review
Comprehensive advice, information and advocacy offer	Advice and Information *Commission Advice and Information provision in response to the Care Act and Welfare Reform and in support of patient self-management (including financial information and advice and financial inclusion work)*	Improved wellbeing through exercising choice and control Improved wellbeing through patient activation Improved wellbeing for Carers	PCC / CCG	September 2015
	Advocacy Services *Implementation of new Advocacy Services contract for the City*	New contract commences safely and effectively	PCC / CCG	Review September 2015
Strong, Safe Communities and Social Capital	Building social capital and community self help *Develop a strategic approach to how PCC/CCG will actively support the building of social capital and community self-help through community development approaches and then deliver approach*	Improve the wider determinants of health Maximise volunteering for health and wellbeing Joint Strategic Needs and Assets Assessment Improved support networks Improved trust and neighbourliness Being active and having influence Living together and respect	PCC / CCG	Benchmark outcomes by March 2016 and then Annual review to monitor

	Strategic review of services supporting Safer Plymouth objectives and in scope of wellbeing to support maximising outcomes *Review to be undertaken to (1) ensure flexibility in system to commission in response to emerging or fast moving issues; and (2) to explore how to maximise outcomes through links across wellbeing system e.g. violent crime and domestic abuse Findings to be incorporated onto planning and commissioning decisions*	System has capability to support targeted prevention that aim to mitigate fast moving, new or emerging challenges Reduce crime	PCC / CCG (note link to Police Crime Commissioner)	December 2016
	Improve the poor condition and management of private sector housing that affects the health of residents, and results in higher health and care costs *Build on the work underway to enhance the approach*	• Reduction in the % of private rented accommodation that is classified as non-decent • Reduction in the % of private rented accommodation that is classified as having a category 1 hazard • Reduction in the % of private rented accommodation that is classified as being in disrepair • Improve in the % of private rented accommodation with regard to their thermal comfort rating • Reduction in the % of private rented accommodation that is classified as having a high level of fuel poverty	PCC / CCG	
	Implement Dementia Friendly City Action Plan 2015/16	Increased diagnosis rates People live well with Dementia	PCC	March 2016

Health promotion & healthy lifestyle choices	Develop Primary Care co-commissioning with Area Team *Review any current co-commissioning with Area Team and agree scope and scale of possible future co-commissioning to support well being*	Co-commissioning framework agreed to maximise health promotion and healthy lifestyle choices	CCG / PCC (NHS England)	December 2015
	Develop Physical Activity Commissioning Plan	Services commissioned in line with Plan	PCC / CCG	March 2016
	Build on existing offer to commission an older persons falls prevention programme	Reduction in number of older people presenting to Hospital following (1)an initial fall (2) a subsequent fall	PCC / CCG	March 2016
Low level preventative support	Strategic review of low level preventative services to ensure a sustained impact on improving wellbeing and reducing pressure on the wider health and social care system *Review of range of services currently commissioned to determine alignment with Strategic priorities and impact on improving wellbeing including mental health. Inform commissioning intentions for 2016 +*	Reduce or delay the need for care and support Review of range of services currently commissioned to determine alignment with Strategic priorities and impact on improving wellbeing	PCC / CCG	December 2015
	Undertake comprehensive sexual health needs assessment to inform future commissioning and system design	Reduction in rate of sexually transmitted infections Under under conceptions	PCC / CCG	March 2016
Improved emotional wellbeing and mental health	Build community / neighbourhood capability and capacity to support people with mental health needs	More people with mental health needs participate in their local community	PCC / CCG	March 2016
	Promote awareness of mental health need across system with a strong emphasis on tackling stigma			