Public Document Pack

Health and Wellbeing Board

Wednesday, 18th October, 2017
at 5.30 pm

Committee Rooms 1 and 2 - Civic Centre

This meeting is open to the public

Members

Councillor Jordan
Councillor Payne
Councillor Paffey
Councillor Shields
Councillor Taggart

Rob Kurn – Healthwatch
Hilary Brooks – Service Director, Children and Families Services
Carole Binns – Designated Director Adult Services
Dr J Horsley – Director of Public Health
Dr S Robinson – Clinical Commissioning Group
Vacant – NHS England Wessex Local Area Team

Contacts
Claire Heather
Senior Democratic Support Officer
Tel: 023 8083 2412
Email: claire.heather@southampton.gov.uk

BACKGROUND AND RELEVANT INFORMATION

Purpose of the Board

The purpose of the Southampton Health and Wellbeing Board is:

- To bring together Southampton City Council and key NHS commissioners to improve the health and wellbeing of citizens, thereby helping them live their lives to the full, and to reduce health inequalities;
- To ensure that all activity across partner organisations supports positive health outcomes for local people and keeps them safe.
- To hold partner organisations to account for the oversight of related commissioning strategies and plans.
- To have oversight of the environmental factors that impact on health, and to influence the City Council, its partners and Regulators to support a healthy environment for people who live and work in Southampton

Responsibilities

The Board is responsible for developing mechanisms to undertake the duties of the Health and Wellbeing Board, in particular

- Promoting joint commissioning and integrated delivery of services;
- Acting as the lead commissioning vehicle for designated service areas;
- Ensuring an up to date JSNA and other appropriate assessments are in place
- Ensuring the development of a Health and Wellbeing Strategy for Southampton and monitoring its delivery.
- Oversight and assessment of the effectiveness of local public involvement in health, public health and care services
- Ensuring the system for partnership working is working effectively between health and care services and systems, and the work of other partnerships which contribute to health and wellbeing outcomes for local people.
- Testing the local framework for commissioning for:
    - Health care
    - Social care
    - Public health services
    - Ensuring safety in improving health and wellbeing outcomes

Smoking policy – The Council operates a no-smoking policy in all civic buildings.

Mobile Telephones:- Please switch your mobile telephones to silent whilst in the meeting

The Southampton City Council Strategy (2016-2020) is a key document and sets out the four key outcomes that make up our vision.

- Southampton has strong and sustainable economic growth
- Children and young people get a good start in life
- People in Southampton live safe, healthy, independent livesSouthampton is an attractive modern City, where people are proud to live and work

Fire Procedure – In the event of a fire or other emergency, a continuous alarm will sound and you will be advised, by officers of the Council, of what action to take

Access – Access is available for disabled people. Please contact the Democratic Support Officer who will help to make any necessary arrangements.

Use of Social Media:- The Council supports the video or audio recording of meetings open to the public, for either live or subsequent broadcast. However, if, in the Chair's opinion, a person filming or recording a meeting or taking photographs is interrupting proceedings or causing a disturbance, under the Council's Standing Orders the person can be ordered to stop their activity, or to leave the meeting. By entering the meeting room you are consenting to being recorded and to the use of those images and recordings for broadcasting and or/training purposes. The meeting may be recorded by the press or members of the public. Any person or organisation filming, recording or broadcasting any meeting of the Council is responsible for any claims or other liability resulting from them doing so.

Details of the Council's Guidance on the recording of meetings is available on the Council's website.

Dates of Meetings: Municipal Year 2017/18

2017	2018
28th June	17th January
26 July	14 March
18 October	4 April

CONDUCT OF MEETING

BUSINESS TO BE DISCUSSED
Only those items listed on the attached agenda may be considered at this meeting.

PROCEDURE / PUBLIC REPRESENTATIONS
At the discretion of the Chair, members of the public may address the meeting on any report included on the agenda in which they have a relevant interest. Any member of the public wishing to address the meeting should advise the Democratic Support Officer (DSO) whose contact details are on the front sheet of the agenda.

RULES OF PROCEDURE
The meeting is governed by the Executive Procedure Rules as set out in Part 4 of the Council's Constitution.

QUORUM
The minimum number of appointed Members required to be in attendance to hold the meeting is 3 who will include at least one Elected Member, a member from Health and Healthwatch.

DISCLOSURE OF INTERESTS

Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "Disclosable Pecuniary Interest" or "Other Interest" they may have in relation to matters for consideration on this Agenda.

DISCLOSABLE PECUNIARY INTERESTS

A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:

(i) Any employment, office, trade, profession or vocation carried on for profit or gain.
(ii) Sponsorship:
Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.
(iv) Any beneficial interest in land which is within the area of Southampton.
(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.
(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.
(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

a) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or
b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class

Other Interests

A Member must regard himself or herself as having an, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

Any body to which they have been appointed or nominated by Southampton City Council

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

Any body whose principal purpose includes the influence of public opinion or policy

Principles of Decision Making

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the "rationality" or "taking leave of your senses" principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, 'live now, pay later' and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

AGENDA

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

To note any changes in membership of the Board made in accordance with Council Procedure Rule 4.3.

2 STATEMENT FROM THE CHAIR

3 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Democratic Support Officer.

4 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 26th July 2017 and to deal with any matters arising, attached.

5 LOCAL SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2016-17

Report of the Service Director, Children and Families updating the Board on the Local Safeguarding Children Board Annual Report 2016-17.

6 PHARMACEUTICAL NEEDS ASSESSMENT CONSULTATION

Report of the Director of Public Health presenting the draft Pharmaceutical Needs Assessment and seeking approval for wider consultation.

7 INFLUENZA VACCINATION UPTAKE

Report of the Director of Public Health updating the Board on the latest information regarding influenza vaccination.

Tuesday, 10 October 2017 Service Director, Legal and Governance

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HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 26 JULY 2017

Present: Councillors Lewzey, Payne and Shields (Chair)
Dr Sue Robinson, Rob Kurn, Jason Horsley and Paul Juan (representing Carole Binns)

Apologies: Councillors Dr Paffey and Taggart
Hilary Brooks and Carole Binns

7. **ELECTION OF CHAIR**

RESOLVED: that Councillor Shields be elected as Chair for the 2017/2018 Municipal Year.

8. **ELECTION OF VICE-CHAIR**

RESOLVED: that Dr S Robinson be elected as Vice-Chair for the 2017/2018 Municipal Year.

9. **DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS**

Councillor Shields declared a personal interest in that he was a Council appointed representative of the Clinical Commissioning Group and remained in the meeting and took part in the consideration and determinations of items on the agenda.

Councillor Lewzey declared a personal interest in that he was a Council appointed representative of Southern Health NHS Foundation Trust and remained in the meeting and took part in the consideration and determinations of items on the agenda.

Councillor Payne declared a personal interest in that he was a Council appointed representative of Solent NHS Trust and remained in the meeting and took part in the consideration and determinations of items on the agenda.

10. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**

RESOLVED: that the minutes of the meeting held on 28th June 2017 be approved and signed as a correct record.

Matters Arising

Minute 3 – Drugs Strategy 2017-2020
The Board noted that the strategy had now been published. In addition it was noted that the national drug strategy had been published within the last few days and Southampton's was in line with this and in fact more ambitious.

11. **PHARMACY CONSOLIDATION APPLICATION PROCEDURE**

The Board considered the report of the Director of Public Health regarding a proposed procedure for responses to pharmacy consolidation applications. The Board had a statutory duty to make representation within 45 days to NHS England on consolidation applications of community pharmacies in its area. The proposed procedure would formulate a process for responding to a consolidation application of community pharmacies that fell outside of the scheduled meetings of the Health and Wellbeing Board.

The Board expressed concern as to the representative of the Clinical Commissioning Group not being specified and recommended that it should be the Primary Care Team and also to the lack of criteria around "potentially/more contentious applications.

In light of the concerns expressed above the Board proposed revised recommendations as follows:-

RESOLVED:

(i) That the Director of Public Health electronically circulate all applications for consolidation to the following stakeholders within 14 calendar days of receipt:-
- Cabinet Member for Health and Sustainable Living
- Relevant Ward Members
- Primary Care Team, Clinical Commissioning Group
- Public Health Team, SCC
- Planning Policy Team, SCC
- Chair of the Health Overview and Scrutiny Panel, SCC
- Healthwatch Southampton

(ii) That stakeholders feedback any concerns relating to "contentious" applications within 14 calendar days of the information being circulated;

(iii) That authority be delegated to the Director of Public Health following consultation with the Chair of the Health and Wellbeing Board to determine all applications for pharmacy consolidation taking account of any feedback relating to "contentious" applications and make representation to NHS England accordingly.

12. **BETTER CARE SOUTHAMPTON PLAN 2017/19**

The Board considered the report of the Director of Quality and Integrated Commissioning detailing the 2017-2019 Better Care Plan. The Board noted that the national guidance had now been published and the requirement was still for the Plan to be submitted by September 2017.

The Board particularly noted the following key points in the national guidance:-

- Greater emphasis on reducing delayed transfers of care than in previous years;
- A dashboard showing how areas were performing against a range of metrics across the NHS Social Care Interface;

- Targeted CQC reviews to examine performance in the areas with the worst outcomes. It was noted that Southampton was not part of the first tranche of 12; however a further tranche of 8 would be announced later in the year;
- Consideration of a review in November 2017 of 2018-19 budget allocations of the social care funding provided at Spring Budget 2017 for areas that were poorly performing.

The Board noted that the priorities identified within the plan remained the same however actions had been updated as a result of the national guidance.

The Board acknowledged all the hard work that had gone into developing the Plan and thanked those involved.

RESOLVED:

(i) That the draft Better Care Southampton Plan for 2017-19, the priorities and performance targets be endorsed;

(ii) That the final version of the plan be approved for sign off following consultation with the Chair and Vice-Chair of the Health and Wellbeing Board by the national submission deadline of 11th September 2017; and

(iii) That the Chair of the Health and Wellbeing Board and the Clinical Commissioning Group ensure that the 3 local MP's were fully briefed on all the challenges contained within the Better Care Southampton Plan 2017-2019.

13. ACCEPTANCE OF ADULT SOCIAL CARE GRANT

The Board considered the report of the Service Director; Adults, Housing and Communities regarding the Adult Social Care Grant. The Board noted that they were required to ratify proposals for spending a one-off Government grant of £4.98m in 2017/18 for the purposes of meeting adult social care needs, reducing pressures on the NHS and stabilising the social care provider market.

The Board acknowledged all the hard work that had gone into developing the proposals and thanked those involved.

RESOLVED: that expenditure of £4.981, 651 in 2017/18 on schemes as detailed in appendix 1 of the report be ratified in accordance with the grant conditions, financial procedure rules and the governance arrangements for Southampton's Better Care Fund.

14. SHARED COMMISSIONING BETWEEN SOUTHAMPTON CITY COUNCIL AND SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP

The Board received and noted the report of the Director of Quality and Integrated Commissioning detailing shared commissioning between Southampton City Council and Southampton City Clinical Commissioning Group which had been approved by Full Council on 19th July and the Clinical Commissioning Group on 26th July.

The Board noted that the arrangement strengthened existing integrated commissioning arrangements in the City but would impact on the role of the Health and Wellbeing Board going forward which would require review.

DECISION-MAKER:		Health and Wellbeing Board		
SUBJECT:		LSCB Annual Report 2016 – 17		
DATE OF DECISION:		18th October 2017		
REPORT OF:		Service Director, Children and Families		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Emma Gilhespy**	**Tel:**	**023 80 832959**
	E-mail:	**Emma.Gilhespy@southampton.gov.uk**		
Director	**Name:**	**Hilary Brooks**	**Tel:**	**023 80 834899**
	E-mail:	**Hilary.Brooks@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY		
Not applicable		
BRIEF SUMMARY		
The attached report is the LSCB Annual Report to cover the period 2016–17. It is being shared with this Board for information and for noting.		
RECOMMENDATIONS:		
	(i)	That the Health & Wellbeing Board notes and welcomes the LSCB annual report.
REASONS FOR REPORT RECOMMENDATIONS		
1.	Report is being brought for information.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
3.	None.	
DETAIL (Including consultation carried out)		
4.	See attached report.	
RESOURCE IMPLICATIONS		
Capital/Revenue		
5.	None.	
Property/Other		
6.	None.	
LEGAL IMPLICATIONS		
Statutory power to undertake proposals in the report:		
7.	See attached report.	
Other Legal Implications:		
8.	None.	
RISK MANAGEMENT IMPLICATIONS		
9.	None.	

POLICY FRAMEWORK IMPLICATIONS			
10.	None.		
KEY DECISION?	**No**		
WARDS/COMMUNITIES AFFECTED:		**All**	
SUPPORTING DOCUMENTATION			
Appendices			
1.	Local Safeguarding Children Board Annual Report 2016-17		

Documents In Members' Rooms

1.	None	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.		**No**
Privacy Impact Assessment		
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.		**No**
Other Background Documents **Other Background documents available for inspection at:**		
Title of Background Paper(s)	**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**	
1.	None.	

LSCB
Southampton
Local
Safeguarding
Children Board

Annual Report

2016 - 17

CONTENTS

Keith Makin's Intro

The Local Safeguarding Children Board has been working hard in 2016-17, in spite of decreasing resources. As this report exemplifies, we have undertaken a variety of pieces of work to ensure that the welfare of children and young people remains paramount in the City of Southampton.

The Board is moving forward during a period of national uncertainty with regard to the Wood Review of LSCBs, whilst sitting in unanimous agreement that the Board should continue in its current structure. Future recommendations will be considered when required.

We are well aware of the increasing demand placed on agencies both financially and physically and are therefore extremely grateful for the consistent work and engagement that the LSCB receives. Partnership working within Southampton has been a strength identified in numerous inspections and reviews and we continue to see this evidenced regularly.

As detailed in the report below, the LSCB completed a partnership review around an emotional and physical neglect case in 2016. Learning is still being reviewed and shared via training and briefings. It has also assisted with the more in-depth work that the Board has been undertaking through its Neglect Assurance Sub Group and Neglect Task and Finish Group. I took on the role of Chair for this sub group and am very impressed by the City's desire and aspiration to work together and improve the outcomes for children who are at risk of neglect. We will be in a position to report back on a great deal of positive work around this issue in the 2017 – 18 Annual Report.

As a Board, we regularly monitor and reflect on challenges made between agencies and by the Board through our quarterly challenge log (http://southamptonlscb.co.uk/about/whatdowedo/). During 2016 – 17, there were a total of 45 challenges made through our main Board meetings, Executive Group and our Sub Groups. I believe that this activity highlights the importance of the Safeguarding Board's work and demonstrates its effectiveness in drawing out key issues and themes that may require more attention.

The Board agreed it's priorities for the year. These are:

- Ensure safeguarding is a whole city theme
- Manage and monitor the impact of austerity measures, increasing demand and changes to service provision on safeguarding outcomes for children and young people.
- Coordinate and quality assure responses to prevent and disrupt the exploitation and victimisation of children and young people
- Embed key learning from case reviews (including SCR's) and audits into local practice
- Ensure a focus on building resilience and raising the aspirations of children and young people in Southampton.

These themes will continue until 2018, as we believe that they are still relevant and we wish to keep our efforts consistent in order to make a robust and lasting impact.

We receive regular updates on sub group work through our reports to the Executive Board and have therefore seen some excellent work taking place. Included in this is the work of our recently developed Education Task and Finish Group. This was established in order to respond to identified gaps in safeguarding issues in schools. During the last year, this group has had oversight of a new child protection policy guidance document, new Elective Home Education processes and a new method for capturing children missing from education data regularly. We have also worked alongside the Local Authority Education Service to develop a 'Safeguarding in Schools' self-evaluation audit. This is aligned to the 'Keeping Children Safe in Education' 2017 DfE Guidance and responses will be reviewed by the Board annually; putting us in a much stronger position with regard to having a full picture of safeguarding within Southampton's schools.

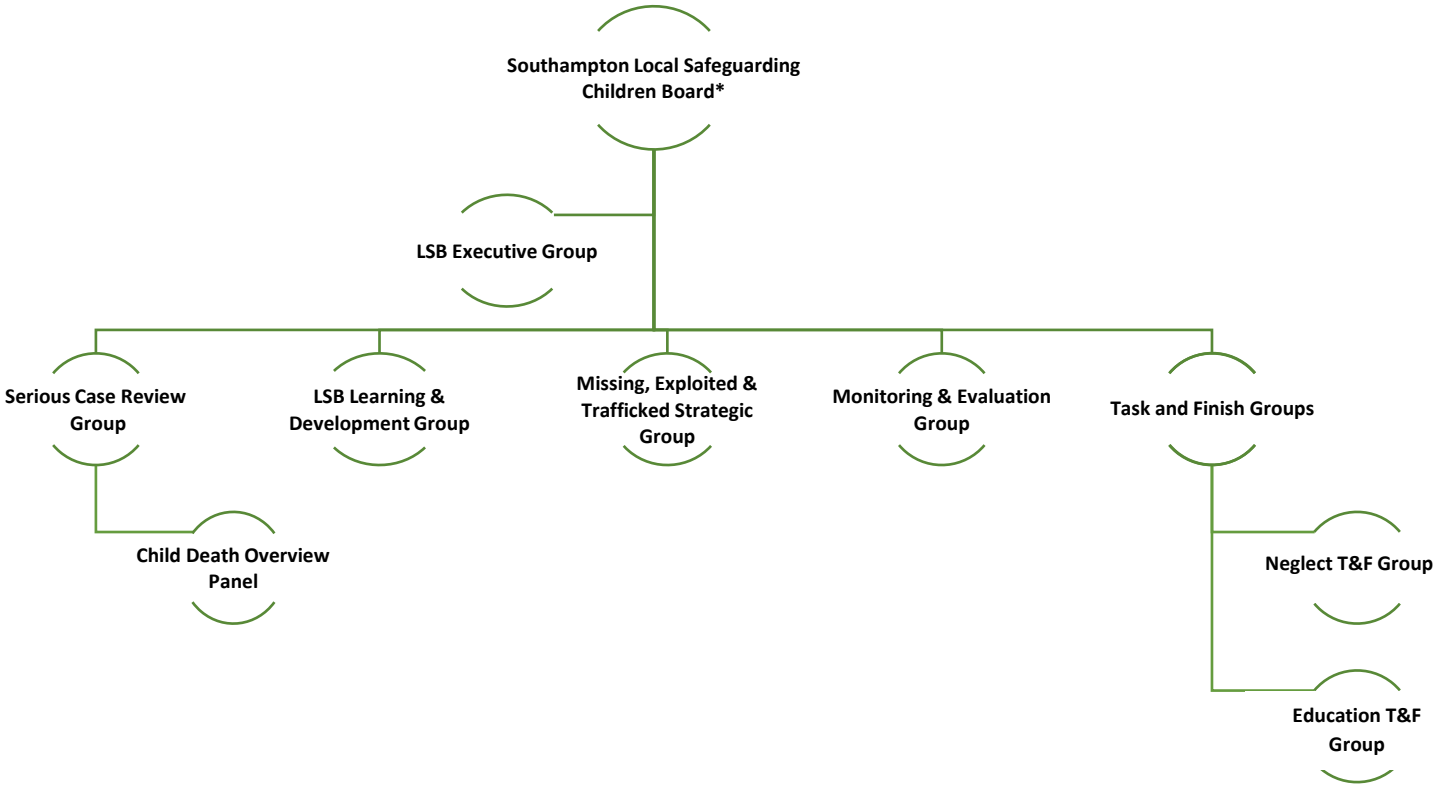
Within the last year, there have been numerous changes to the Children and Families Service's Front Door Arrangements. Professionals and members of the public are now able to reach a Social Worker and discuss any concerns they may have in a much speedier and more direct way. The Board welcomed these changes and was in favour of lessening the bureaucracy and delay at this crucial point in Child Protection. We are already seeing the impact that this has had, with our number of Children on a Child Protection Plan steadily decreasing and our number of Looked after Children lowering to 542 at the end of Q4, as opposed to a high of 611 in Q1. This has been lowering consistently each quarter. The Board has been seeking regular assurance and updates, to ensure that this reduction is safe and appropriate and we will continue to do so.

Each year we work with our Board partners to ensure that our meetings are relevant and efficient. We adapted the style of Board meetings in response to feedback that agendas were too full and that there was not enough time for discussion and group work. Our agendas are now themed and attendees are given time to reflect on what we have heard during the meeting and work in groups to think of new and creative ways to improve things in the City. So far, these discussions have led to the creation of bimonthly multi agency professional's sessions, which will be focussed on improving communication and on the welfare of staff and the implementation of a joint LSCB and LSAB session to review cross-area working and 'think family' issues. This is due to take place in 2017-18. The new style of meeting feels more collaborative and creative and I am excited to see what else is developed here in the future.

Finally I would like to express my thanks to the LSCB partner agencies for their hard work and continued commitment to improving the lives and wellbeing of children in Southampton.

What is an LSCB?

Southampton Local Safeguarding Children Board (LSCB) is a statutory body that leads on keeping children safe and ensuring their wellbeing in Southampton. The LSCB must also continually check that what is done in Southampton to safeguard children works. For example, we try to make sure that the procedures we publish are clear and help staff and volunteers know what to do when they are worried about a child, or that staff and volunteers receive the training they need to undertake their roles. We focus our attention and efforts on a range of agreed priorities taken forward by 'sub groups' and occasionally issues focussed 'task and finish' groups of the main LSCB. During the year 2016 – 17, our **structure chart** looked like this:



This report will detail the work carried out by these subgroups and will discuss their impact in relation to LSCB themes and objectives.

The Team

Southampton LSCB is chaired by Keith Makin and is supported by a joint Safeguarding Children and Adults Board Team. This consists of a manager, two coordinators, an information analyst and an administrator. The amalgamation of support for both Safeguarding Boards has enabled a consistent and robust 'think family' approach to all of our work.

Funding for these posts is covered by LSCB and LSAB joint pooled budget arrangements. LSCB's funding is set out below.

Finances

LSCB partners agreed to the following contributions to cover 2016 – 17:

Board Partner Agency	Contribution 2016 - 17
Southampton City Council	**£81,224**
Southampton City CCG	**£33,724**
Hampshire Constabulary	**£13,297**
National Probation Service	**£1,329**
Hampshire & IOW Community Rehabilitation Company	**£1,329**
CAFCASS	**£550**
Total:	**£131,453**

In addition to this, Board partners contributed a supplementary amount for learning and development, totalling £20,144. This funds the multi agency Level 3 Working Together to Safeguard Level 3 Training and allows us to commission independent trainers for specific courses and workshops as and when required.

Business Planning

In February 2016, the LSCB met for a 'Business Planning Day'. This gave the Board a chance to review the 2015 – 18 Business Plan (this can be viewed here or by visiting www.southamptonlscb.co.uk), ensuring its relevance and updating where appropriate. It was also a chance to consider setting new priorities and themes for the year ahead.

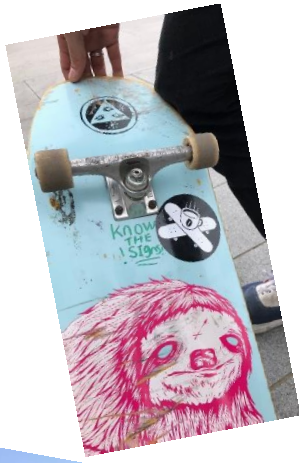
The priorities set for 2015 – 18 remained the same and are as follows:

3 Year Priorities:	
1.	Ensure safeguarding is a whole city theme
2.	Manage and monitor the impact of austerity measures, increasing demand and changes to service provision on safeguarding outcomes for children and young people.
3.	Coordinate and quality assure responses to prevent and disrupt the exploitation and victimisation of children and young people
4.	Embed key learning from case reviews (including SCR's) and audits into local practice
5.	Ensure a focus on building resilience and raising the aspirations of children and young people in Southampton.

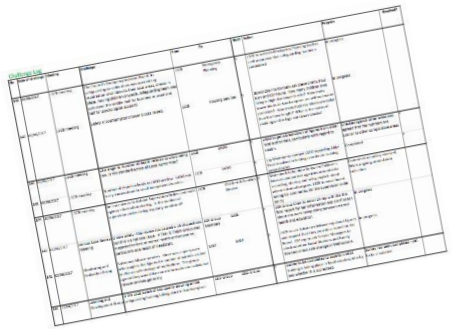
Throughout 2016 – 17, the LSCB tailored its activity to ensure that these priorities remained our key focus. A summary of work undertaken is below:

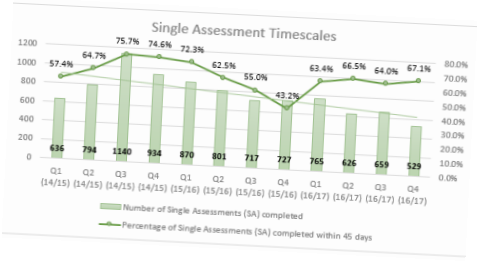
Ensure safeguarding is a whole city theme

- Community engagement strategy in place
- Annual Conference – Neglect
- Community engagement activity:
  - Child Safety Week
  - CSE Awareness Day
  - Online Safety Day
  - Make Safe Campaign
  - Time to Talk (online based)
- Set up a Diversity Advisory Group
- Monthly professionals' survey
- Quarterly newsletters
- 3 x's lay members – linking directly with community and voluntary groups



Manage and monitor the impact of austerity measures, increasing demand and changes to service provision on safeguarding outcomes for children and young people.

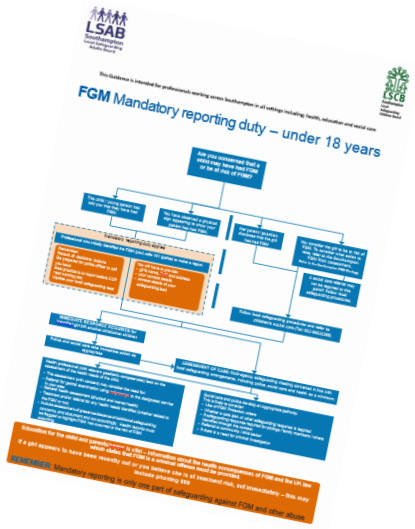


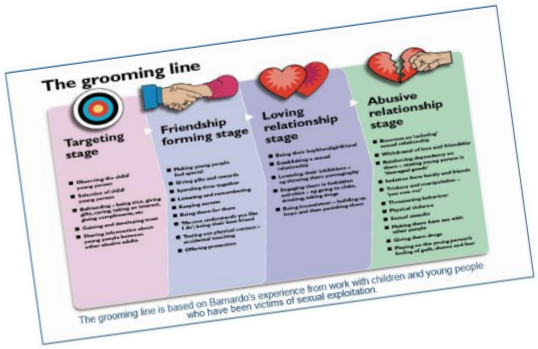


- Regular multi agency audit programme
- Updated the methodology for Section 11 Audits
- Quarterly challenge log reviewed by LSCB and updated to website quarterly
- LSCB main meetings are themed to enable regular assurance on each agreed theme
- Partnership Board Chairs' meeting in Southampton attended by LSCB Chair
- Trends and timescales monitored on multi agency dataset

Coordinate and quality assure responses to prevent and disrupt the exploitation and victimisation of children and young people

- Missing Exploited and Trafficked (MET) Audits
- MET group activity
- Make Safe Campaign
- Specific training for taxi drivers
- MET dataset reviewed quarterly
- Quarterly half day CSE training
- 4LSCB (4 local LSCB areas) renewal of FGM flow chart





Embed key learning from case reviews (including SCR's) and audits into local practice

- Quarterly oversight of multi agency case review action plans
- Multi agency audit schedule
- Training programme influenced by emerging themes from case reviews and audits
- Multi agency audit action plan monitored quarterly
- Workshops on audit findings e.g. JTAI Audits
- Education Task and Finish Group – initiated in response to SCR findings
- Neglect Task and Finish Group – initiated in response to SCR findings
- Section 156 Schools Safeguarding Audits

Ensure a focus on building resilience and raising the aspirations of children and young people in Southampton.

- Education Task and Finish Group set up to focus on:
  - Elective Home Education
  - SEND
  - Children Missing from Education
  - Alternative Provision
  - Virtual School
- School attainment and NEET figures reviewed by LSCB annually
- All audit activity includes a focus on the voice of the child
- Neglect task and finish group initiated in order to review the toolkit, strategy and policy
- Online safety and CSE awareness campaigns
- Public endorsement of the NSPCC Speak Up, Stay Safe campaign

At the business planning day in February 2016 the Board agreed four themes for 2016/17. These represent four key safeguarding areas in Southampton that require a multi agency focus. The themes are:

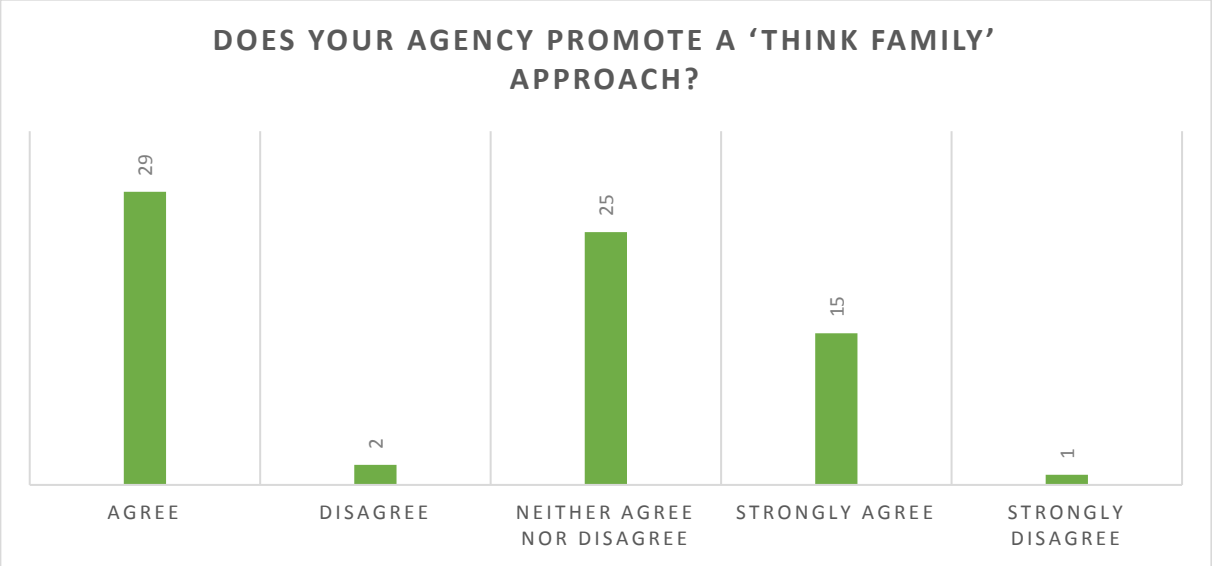
LSCB Themes:	
1.	Develop responses to encourage a 'think family' approach where there is adult mental health, substance / alcohol use and domestic abuse and this is impacting on childrens' safety
2.	Improve identification and responses to neglect of children in Southampton
3.	Focus on improving safety and outcomes for vulnerable children including; • Looked after Children • Those at risk of going missing, being exploited or trafficked (MET)
4.	Improve communication between services at senior and practitioner level

Over the last year the LSCB sub groups have sought to address each of the above themes as follows:

1. **Develop responses to encourage a think family approach where there is adult mental health, substance/alcohol use and domestic abuse and this is impacting on a child's safety.**

a. A 'think family' themed Board meeting took place in July 2016. Relevant Board member agencies and services (Children & Families Service, Hampshire Constabulary, Domestic Violence service, Substance Misuse service and SCC Housing Services) provided an update as to how their service area was using the 'think family' approach and data was provided from each which is fed into this report.

b. The Board also conducted a 'think family' professionals survey in June 2016 to raise awareness of the approach and find out if professionals on the ground felt that it was being used. When asked whether their own agency promoted a 'think family' approach, we received the following results:



Further findings from this survey were shared with Board and the Learning and Development Group for further action.

c. The LSCB Serious Case Review Group received feedback on all adult social care case review actions to ensure that these were being carried forward. 80% of their actions were signed off by the group during the year.

d. Adult Services submitted a Section 11 report in July 2016. Feedback to the service included:
'Ensure a service wide awareness of the 4LSCB policies and procedures' and
'Add a statement to the Section 11 stating that adult's social care staff know how to refer to MASH'

e. The LSCB has received regular updates on the MASH, including the changes to the front door process. This has also included regular feedback and assurance on the introduction of the MARAC/MASH process.

f. The Board coordinated four adult mental health multi agency workshops and three substance and alcohol misuse workshops across the year. In total, these were attended by 144 professionals. Both sessions were attended by both children's and adult focussed practitioners and feedback is consistently good.

g. Quarterly joint Safeguarding Boards newsletter to share learning from audits and case reviews (both local and national). The Boards team published five newsletters in 2016 – 17.

h. The Safeguarding Boards Team has joined up work across LSCB and LSAB where appropriate:
- Learning and Development Group
- Community engagement and awareness

What is left to do?

The LSCB Business Plan incorporates the following actions which endeavour to further this work across the next year:

- Develop a training offering for disability and for child mental health
- Enhance our method of sharing learning from case reviews and audits such as 6 step briefings, online videos and increased numbers of workshops
- Review the Joint Working Protocol and facilitate the creation of a Southampton 'local' version of this document
- Deliver a joint audit with LSAB on transition from children's services to adult services, with a focus on mental health

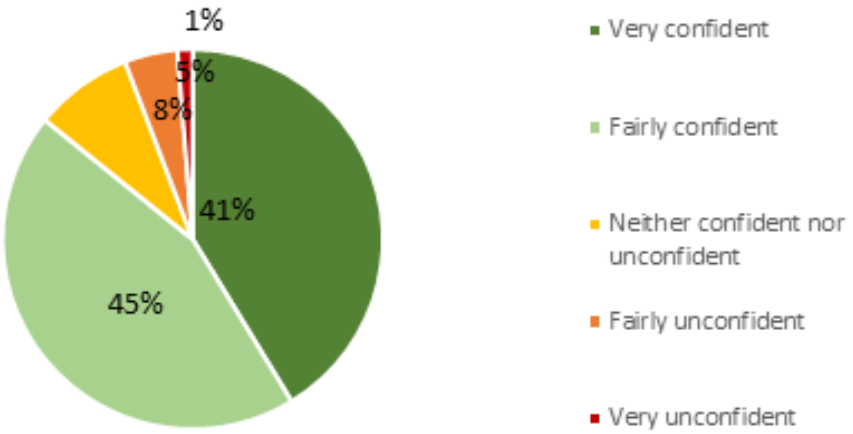
2. Improve identification and responses to neglect of children in Southampton

a. A themed meeting on 'Neglect' took place in October 2016. Assurance was sought from Children's Social Care, Police, Education, Health/CCG and Housing. Information taken to Board included excellent feedback from Housing on how they have rolled out the Neglect Toolkit to their staff and have offered extra training on the issue.

b. The Board has established a Neglect Assurance Group to look at coordinating action in this priority area strategically. This is attended by a large number of agencies including the Police, Social Care, Education, Health, and Voluntary Sector and is chaired by the Independent Chair of the LSCB.

c. In addition to this, a multi agency neglect task and finish group has been developed. This is chaired by a local secondary school head teacher and exists to agree a new city-wide neglect definition, refresh the Neglect Strategy in the City and renew the Neglect Toolkit.

d. The Board conducted a professionals' survey on 'Neglect' in October 2016. When asked 'To what extent do you feel confident in recognising and responding to child neglect?', the response was:



Further findings from this survey were shared with Board and the Learning and Development Group for further action.

e. Quarterly multi agency half day workshops titled 'An Introduction to Neglect' are offered and funded by the LSCB. An external expert trainer has been commissioned to deliver this training in order to ensure a high standard and an independent view. We have run 4 courses over this annual report year with a total of 91 multi agency attendees.

f. The Board have coordinated focussed activities during Safeguarding Week (June 2016) to raise awareness of 'what to do if you are worried about a child' – focussing on neglect indicators. The Board engaged with over 400 people during the week.

g. The LSCB and the LSAB delivered a joint conference in December 2016 titled 'Recognising Neglect, A Shared Responsibility'. This was attended by approx. 175 multi agency professionals. It also promoted the 'Think Family' approach to neglect, focussing on both neglect in children and self-neglect in adults.

What is left to do?

The LSCB Business Plan incorporates the following actions which endeavour to further this work across the next year:

- Multi agency definition of neglect to be agreed
- Multi agency revision of neglect strategy to be finalised
- Neglect toolkit to be refreshed in line with the updates to threshold
- JTAI Audit of Neglect to take place in 2017 – 18
- Develop a dataset to understand the extent of neglect
- Explore methods of enabling peer challenge in cases of neglect in terms of thresholds

3. Focus on improving the safety and outcomes for Looked after Children and children at risk of going missing, being exploited or trafficked.

a. A themed meeting on improving outcomes for 'Looked after Children' and 'at risk of going missing, being exploited and trafficked' took place in December 2016. The Board received information from Children and Families Service, Health Providers, Education, police, the National Probation Service and Community Rehabilitation Company on these themes. This included an update from University Hospitals Southampton NHS Foundation Trust on how they have improved staff awareness of their missing and absconding policy and how they run simulations to ensure staff remain vigilant.

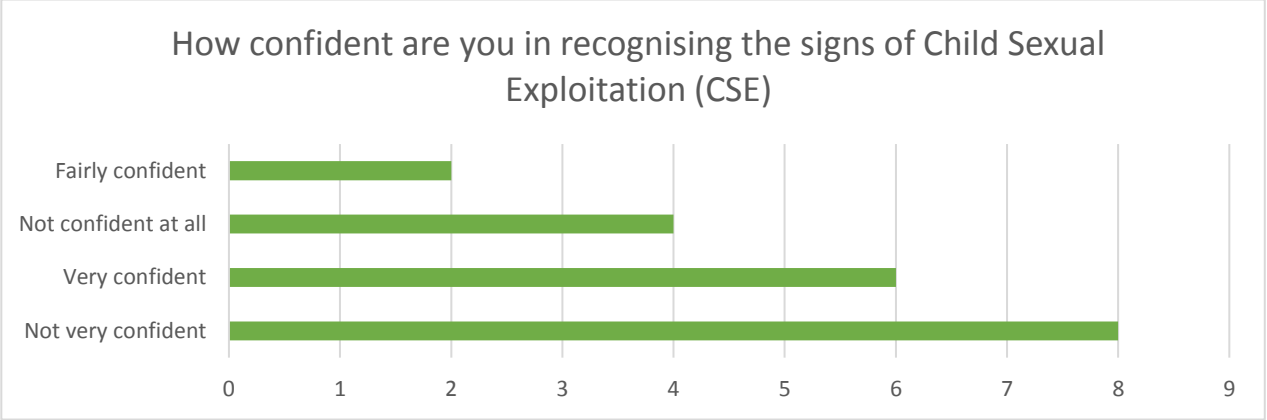
b. The Board also received assurance from the Local Authority of plans to safely address the number of Looked after Children. Southampton Children and Families Service adopted a new Front Door Approach, have planned a staff transformation and have amended the Threshold Document. The LSCB had oversight of all of these changes and challenged as appropriate to ensure that the safety and welfare of the child was always paramount. The Board was broadly in favour of the planned changes to the service and is continuously kept up the date with progress.

c. The LSCB dataset includes Looked after Children data, including annual attainment levels at all school levels and further and higher education. This is reviewed by the Monitoring and Evaluation Sub Group and the Main Board.

d. The Missing, Exploited and Trafficked Sub Group carries out quarterly audits on key themes, to ensure a quality multi agency response in this area. The first audit reviewed Looked after Children that are placed out of area. Recommendations included reviewing any existing arrangements for a child placed out of area who is believe to be at risk of going missing or being exploited, to ensure that this has been properly risk assessed, ensuring geographical, social and environmental factors are considered in planning and assessing suitability of placement and continuing and developing local professional development in this area.

e. The Missing, Exploited and Trafficked Sub Group review a quarterly dataset which is MET specific. Key feedback from this is shared with the LSCB Executive Group on a regular basis.

f. In April 2016, we carried out a professional's survey on Missing, Exploited and Trafficked' issues. When we asked 'How confident are you in recognising the signs of Child Sexual Exploitation (CSE)?', we received the following response:



Further findings from this survey were shared with the Board and the Learning and Development Group for further action.

What is left to do?

The LSCB Business Plan incorporates the following actions which endeavour to further this work across the next year:

- Improve links between Corporate Parenting Committee and LSCB
- Ensure that Education have a detailed action plan to address attendance rates and attainment – where information demonstrates 'gap' against national averages and priority groups including CLA.
- Seek the views of children and young people in designing work to raise aspirations and build resilience in this area.

- Work with key stakeholders including schools and Social Care to ensure a strategic and quality response to online safety issues.
- Deliver a thematic review to include an audit of recent cases where peer to peer online exploitation or abuse was alleged.
- Develop a system to monitor and quality assure foster carers and independent fostering agencies used by Southampton.

4. Improve communication between services at senior and practitioner level

a. In March 2017, the Board held a themed meeting on 'communication'. Assurance was sought from Children and Families Service (including Education and Early Help), Hampshire Constabulary, National Probation Trust, Community Rehabilitation Company, CCG and other Health providers. Board discussion led to an agreement to run monthly multi agency sessions for staff to come together and discuss key themes and issues that are arising in front line work. These will be aimed at improving relationships and communication across partners and will be rolled out in 2017 – 18.

b. The Board has developed its methods of communication with multi agency professionals in order to convey key messages and hear their views. This has been achieved through the use of staff surveys, focus groups, Weekly Wednesday Workshops, newsletters and social media.

c. The Board has regular communication with other key partnerships including LSAB, Safe City Partnership, Health and Wellbeing Board and Scrutiny Panels, regarding issues of concern. This is largely through the Chair's attendance at a quarterly Partnership Chair's Meeting.

d. The 4LSCB online policies and procedures are updated on a six monthly basis. Briefings are sent out to highlight these changes either via specific email or through the LSCB newsletter.

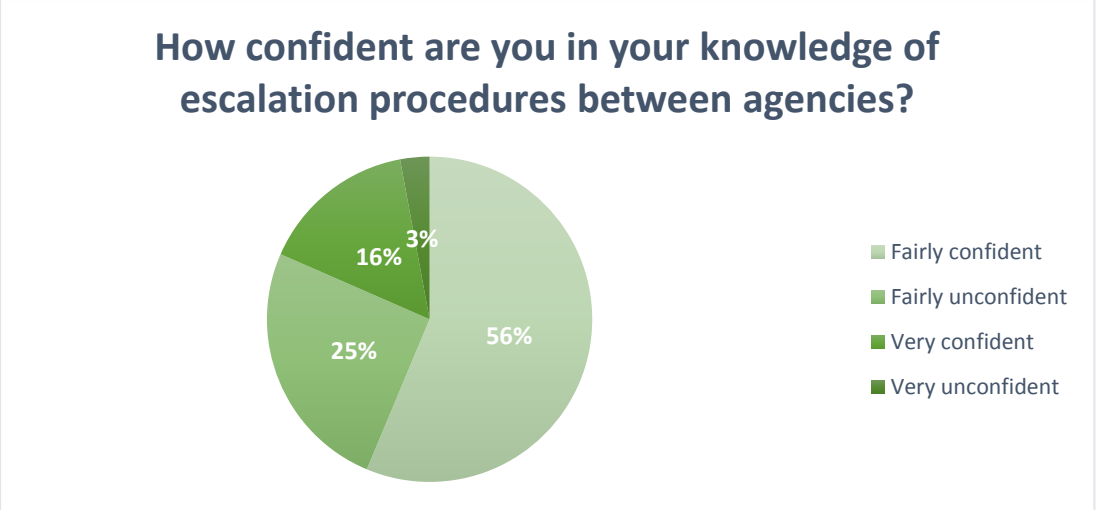
e. The Monitoring and Evaluation Group has linked with Education leads to develop a safeguarding audit tool for schools. This is so the Board can gain assurance regarding safeguarding responses and it includes duties under Section 156 of Education Act. The LSCB Chair and Education leads delivered a joint workshop with Head Teachers in order to build communications and introduce the new tool. Results will be reviewed by the Monitoring and Evaluation Group in 2017 – 18.

f. The Board has delivered a number of audits to seek assurance of current quality of practice in the following issues:

    - Neglect
    - Missing, Exploited and Trafficked cases
    - Female Genital Mutilation
    - Domestic Violence – JTAI

    All learning and improvement from these audits is monitored by the Monitoring and Evaluation Group.

g. In November 2016, the Board carried out a professional's survey on communication. When asked 'How confident are you in your knowledge of escalation procedures between agencies?' staff reported the following:



Further findings from this survey were shared with Board and the Learning and Development Group for further action.

What is left to do?

The LSCB Business Plan incorporates the following actions which endeavour to further this work across the next year:

- Review the results from the Education safeguarding self-assessments and ensure process is robust
- Deliver audits as per agreed audit schedule
- Work with Board members to ensure the needs of diverse communities are met when responding to safeguarding concerns
- Embed a process for multi agency professionals to come together and discuss a variety of topics in relation to safeguarding

Throughout this annual report year, the Board has heard examples of excellent work taking place across a number of agencies regarding these themes. New and innovative ideas have also been developed such as improving communication through multi agency practitioner workshops and the implementation of an annual safeguarding assessment tool for schools.

However as portrayed above, there is still room for improvement and further work to be achieved. The Board continues to monitor this closely and is regularly involved in or kept up to date with progress on these matters.

Learning and Improvement –

LSCB Case Reviews

There were no Serious Case Reviews completed during the year 2016 – 17. The Board received one report from a partnership review which involved the long-term neglect of two siblings. This piece of work significantly informed the work that has since been carried out by the Neglect Assurance Group. Learning from this review is being consistently shared through the quarterly 'Introduction to Neglect' training course that is available to multi agency professionals. All actions are also being monitored by the Serious Case Review Group on a quarterly basis.

There have been a number of reviews underway during this annual report year; 'The Allegations against Foster Carers' Serious Case Review which originally commenced in 2012 but had to be paused due to criminal proceedings. This review was able to continue in August 2016. The report is expected to be shared with the Board in December 2017.

The LSCB commissioned a thematic report on online safety, following the tragic suicides of two teenagers in 2015. These were both thought to be linked to online bullying, peer to peer abuse and the significance of self-harm. The final report has been written and shared with the Board. Learning is due to be shared with head teachers and then the wider workforce in early 2017/18. The LSCB has also chosen online safety to be the theme of the Annual Conference in November 2017. Any action deriving from this report will be regularly monitored by the Serious Case Review Group.

Three further case reviews were agreed in 2016 – 17:

- A partnership review regarding two children who have suffered emotional and physical neglect. The multi agency panel is in place for this case and a report is expected towards the end of 2017-18.
- 2 Serious Case Reviews, both involving the tragic death of young children. Criminal investigations have meant that parts of these reviews are halted but multi agency panels are in place and reports are likely to go to Board in 2018/19.

The following are key themes that we see consistently within our case review learning:

- The importance of **chronologies -** Knowing the history of a case to inform current practice can prevent future harm – it is vital that the services involved with families and individuals know what has happened in the past. Keep up to date chronologies for cases where there are risks, find out what other services know, this will help identify current risks or harm
- **'Trigger Trio'** - Domestic violence, substance misuse and mental health issues - high risk of serious harm or death for all adults and children involved. The risk of harm is greatly increased when these issues are seen together. This includes risks to victims and perpetrators of domestic violence as well as children involved.
- **Escalation** – Safeguarding is your business until the individual is safe – If a professional is unhappy with the outcome of a meeting, conference or referral, they are responsible for escalating this as appropriate. This may take a number of attempts but learning demonstrates that it is essential to keep these cases on the radar rather than accepting an outcome that one may disagree with.

- Good **communication** between agencies – Professionals and agencies can only act on the information that they are aware of. It is important for professionals to have a good understanding of information sharing and ensure that this is adhered to whenever appropriate.
- The importance of the **voice of the child –** Thinking about what life is like for that child and seeing the world through their eyes. Learning shows that it is easy to get distracted by the parents and their issues and to forget about the lived experience of the children in that household.
- Regular and effective **supervision -** plays a key role in supporting practitioners to identify and manage risks by providing an opportunity to discuss even seemingly 'stable' or 'low risk' cases with more experienced practitioners. Again this review identified an overreliance on staff to recognise the need for treatment review or case discussion which potentially increased the risk to clients in receipt of long-term care.
- **Use your instincts!** Don't just take what you hear from people (workers or clients) on face value, show 'inquisitive enquiry', ask where you are concerned, find out what you need to know and use this to inform what happens next.

Once a case review has been written, the lead author will form recommendations. The multi agency partnership will use these to create an action plan, in order to address these. The LSCB Serious Case Review Group have oversight of these plans and reviews them quarterly. If all are agreed that an action has been achieved, this is turned to 'green', signed off and removed from the plan. At the end of the financial year 2016 – 17, there were 30 outstanding actions on the plan. This is in comparison with the end of the financial year in 2015 – 16 where there were 46 outstanding. However, this isn't a direct comparison as there were a number of new actions added throughout the year.

Outstanding actions include themes such as ensuring current chronologies are kept, used and analysed robustly, attendance at conferences is audited and escalated where appropriate, spot checking and auditing GP READ codes with individual GP practices and considering how information on vulnerable tenants is kept within Housing.

The LSCB is planning to enhance the way in which it shares learning from case reviews in the future. There will be a learning package offered for each case which will include:

- Regular learning workshops
- 6-step briefing documents on each case
- A learning video recorded by the lead reviewer or a relevant professional (to be accessed via the LSCB website)

Child Death Overview Panel (CDOP)

First, Southampton LSCB and CDOP would like to send deepest sympathies to any families affected. During 2016 – 17, Southampton CDOP reviewed 17 of the 26 notified deaths, leaving 6 outstanding (this is due to pending information and these are scheduled for review early in 2017 – 18). This is a significantly larger total of reviewed cases in comparison to the 9 reviewed in 2015 – 16, due to the fact that CDOP now reviews pre-24 week deaths and a backlog of cases from the disbanding of the 4LSCB CDOP was carried over in 2016 – 17.

The CDOP process is a national requirement to categorise the death. The category does not necessarily reflect the registered cause of death. The CDOP process requires the panel to categorise the deaths and report these back to the DfE annually. It is worth noting that the category agreed does not necessarily reflect the registered cause of death. 59% (10) of the deaths were neonatal, whereas 24% were due to Chromosomal, genetic and congenital anomalies and 17% were due to malignancy. 16 of the 17 cases were expected. In reviewing deaths, CDOP members consider whether there were any contributory factors known to be associated with increased risk which could be modified to reduce the risk of future deaths. This does not mean that removing these factors would have prevented the death. 4 of the 17 deaths reviewed had modifiable factors leaving 13 that did not.

10 of the children that Southampton reviewed were male and 7 were female. There were 15 deaths reviewed in which a Statutory Order and a child protection plan had not been in place at all in the child's life and 2 where the status for both was unknown. None of the children were known to be asylum seekers.

Staffing issues – Southampton has spent this year embedding the CDOP process and agreeing systems and efficient ways of working. The meetings are always well attended and the group benefits from the expertise of a neonatal consultant and the Designated Doctor for child deaths, in addition to a Public Health lead and safeguarding leads from various services in the City.

The CDOP Group has met 6 times throughout the year. They formerly met quarterly but there were a number of extra meetings held in order to catch up with previous backlog.

Trends, issues and actions arising from Southampton cases:

- Southampton has not noticed any trends across the cases that have been reviewed.
- As mentioned above, the majority of deaths were neonatal and expected.
- The issue of language barriers within services offered to new parents arose from cases reviewed. The Hospital Service took an action to review this internally and to ensure that all services are accessible for all. There is a piece of work outstanding for all Boards to double check this in their own areas.
- Another issue that was raised within CDOP cases and thereafter discussed with Public Health is the importance of offering the flu vaccine to all who may be vulnerable, regardless of any other secondary health needs.
- Southampton has written to the Ambulance Service to ensure that the algorithm of the 111 service is appropriate and will result in an ambulance dispatch where required.
- It was bought to the CDOP Group's attention that some staff who are involved in the Rapid Response process are finding it distressing, as they often knew the child personally. This issue has been discussed across the 4 LSCB areas and it has been agreed that attendance at these meetings should fall under management responsibility, or should allow practitioners to have their manager attend for support. Hampshire LSCB are working on producing leaflets for schools who take part in this process and have agreed to share these with the other areas.

Southampton CDOP is aware of pending national changes with regard to the way in which it operates and is preparing for alternative methods of reviewing child deaths in the local area. This may be through linking with other health agencies or with other geographical areas.

Section 11s

The LSCB has a structure in place to receive reviews from key services in Southampton who have a duty under Section 11 of the Children Act 2004. This places a duty on a range of organisations to ensure their functions and any services that they contract out to others are discharged regarding the need to safeguard and promote the welfare of children.

The LSCB Monitoring and Evaluation Group reviewed 16 full Section 11 reviews from partner agencies during this year. These include:

Southampton City Council:

- Children & Family Services; including early help, social care, education & early years
- Youth Offending Service
- Adults Services
- Housing Services
- Licensing
- Sport, leisure and culture services
- Public Health

- CAFCASS (Child and Family Court Advisory Support Services)
- Hampshire Constabulary
- Hampshire Probation Trust
- Community Rehabilitation Company
- Home Office – Border Force
- NHS (including Southampton City Clinical Commissioning Group, Solent NHS Trust, University Hospitals (Southampton) NHS Trust, Southern Health)
- Jubilee Sailing Trust (update requested by the Chair).

The Board also requested a full Section 11 from Southampton Football Club, following on from the national issues highlighted in the media regarding a former coach. This was scheduled and took place in Q2 of 17 / 18.

The following are key areas for development that were raised in more than three submissions throughout the year:

- All staff in our organisation are able to access the 4LSCB on-line inter-agency child protection procedures. Staff are aware of the procedures and use them appropriately

- Staff are clear about the circumstances in which a referral to MASH is necessary

- Records are kept of staff that have completed safeguarding training, including the dates and details

- Staff are made aware of who is the designated lead for safeguarding within our organisation

The Monitoring and Evaluation Group were able to assist with queries where appropriate and referred to the appropriate people if required. Examples of follow up actions include a senior manager from Children

and Families Service attending a team meeting in Licensing, to talk through the referral process, details of all available safeguarding training shared with National Probation Service for use within their teams and more regular 4LSCB briefing document being devised by LSCB Team, in order to raise awareness.

The process for Section 11 auditing has now changed. This is to assist the agencies that work across a number of local LSCB areas (Hampshire, Portsmouth and Isle of Wight) and to avoid duplication. Cross-area agencies now submit one Section 11 to a multi agency, multi-area panel once a year. All local Section 11s are received by a Southampton panel once a year. All feedback is shared and analysed by the Monitoring and Evaluation Group.

Multi agency Audits

Joint Target Area Inspection – Children Living with Domestic Abuse (Dry run)

This audit was undertaken to improve local understanding of case work in light of the current Joint Thematic Area Inspection theme, examining how local partners, including local authorities, police and probation, and health services, work together to protect children living with domestic abuse.

Seven cases were picked (as would be during an inspection). Cases were cross referenced across Children's Social Care and IDVA case systems. Three of these were high risk cases and four lower risk. The children fell across Children in Need, Child Protection, Children with Disability and Looked after Children areas. The ages of the children ranged from pre-birth to late teens.

Agencies contributing to the audit included: Children and Families; Police; Housing; IDVA; Southern Health; Solent NHS; Cafcass; Yellow Door; the Youth Offending Service. Unfortunately, there was no feedback from the National Probation Service or General Practitioners.

Regarding impact of agency involvement: of the seven cases: Two high risk IDVA cases had ongoing risks identified; but, these were being managed through the service and with partners; Risk of DV appeared to have reduced in one IDVA case; Risk of DA appeared static in two lower risk cases, subject to CIN and CP planning; Risk of DA appeared to have reduced in the other two cases.

Core procedures for high risk cases appear to be robust (based on evidence from evidence from MARAC-MASH, IDVA, CP, and police risk management). However, partners appeared to articulate that information sharing and partnership wasn't as clear around lower risk DA. Raising professional awareness around the 'trigger trio' (domestic violence, mental health, substance and alcohol misuse) and understanding the impact of ongoing coercive control on families. In addition, inconsistent critical analysis of the impact of current and historic DA by professionals was another theme.

Auditors from across the participating organisations attended two workshops to discuss the results in February and March 2017. Next steps identified by auditors at these workshops were:

- Consideration preparation for future JTAI – 'dry run' audit and case study activity. Contact lists for participating organisations.
- Consider how to get adult mental health involved in CP / DV processes and provide robust risk assessments to inform good practice and decision making.
- Will take strengths back to the team.
- Analyse audit feedback as part of commissioning cycle.
- Findings will be shared with staff and volunteers.

- Findings will be shared at team meetings
- Information about practice pathway and training will be shared.
- Need to be more consistent in respect of lower risk DA cases. Raise training opportunities across housing.
- IDVA to be contacted for all YOS cases. Training information and feedback from workshop to be shared with practitioners.

The Monitoring and Evaluation Group have oversight of this audit and its actions.

Missing Exploited and Trafficked – Looked After Children Placed Out of Area

This audit is the first thematic audit being delivered by Southampton LSCB Missing Exploited and Trafficked (MET) Strategic Group. Overarching terms of reference for audits of this kind were agreed by the MET Strategic Group who also determined the membership of the Audit Team for this theme. Membership of the Audit Team consisted of:

- Detective Inspector from Hampshire Police, Public Protection Team
- CSE Advance Practitioner from Southampton City Council Children's Services
- Barnardo's Missing / CSE Service lead
- Health (School Nursing and Sexual Health)
- LSCB Manager & Assistant
- Senior Probation Officer, National Probation Service
- Virtual School Head Teacher, Southampton City Council
- Housing Coordinator, Southampton City Council

The aim of this audit is to establish the success and quality of multi agency partnership working in relation to looked after children placed out of area that are at risk of going missing, being exploited and/or being trafficked, especially focussing on

- Level and quality of multi agency partners involvement
- Success in intervention improving outcomes for the young person/s safety and wellbeing
- Experience and views of young people and their families as relevant
- How the intervention has impacted on the quality of life for the child/young person
- Whether appropriate assessments have been carried out and pathways have been followed
- The success of disruption and prevention methods
- Identification of any key learning themes for further action

The Audit Team planned and delivered the audit work, they agreed;

- Audit topic – Children Looked After Placed Out of Area at risk of Child Sexual Exploitation
- Process to be employed – individual research & group discussion using an agreed audit tool
- Case number and source of cases – 3 cases of children looked after out of area that were at risk during these placements of going missing, and CSE. It was also agreed that other 'people of concern' would be shared in order that full searches of probation and police files could be carried out.
- Contact with family / young people and professionals involved – it was agreed that the children along with the carers or agencies responsible for the children during out of area placements would be contacted via lead professionals involved in the case.
- Meeting dates / deadlines for completion of each stage – 2 planning and 2 audit meetings took place during February – March 2016

- Author of overview report to detail findings and recommendations – this was agreed as the LSCB Manager on this occasion
- Timescale for completion and feedback to the MET strategic group – aim to feedback initial findings to the May 2016 meeting

Overview of findings:

- The Audit Team acknowledge that these cases were often being responded to prior to the Goldstone Team and CSE Hub developments. All three cases were deemed to require improvement (RI) by the audit team in terms of quality of interventions and outcomes for the children, and it was felt that with this more recent work, more opportunities exist for multi agency responses earlier in the experiences of children
- Statutory work and planning had taken place in line with procedures that were known by the audit team; however the value of multi agency information was not evident, despite often being available. This would have improved the quality of responses and potentially enabled more timely and appropriate interventions for the three children
- Planning and preparation for placements was not always thorough enough to provide the quality that could be expected. For example, this was often single or dual agency limited to the children's services leads and provider of the placement. Information in the wider network could have informed carers / providers of risks and helped to manage risks during placements that were known for the children
- Emergency placements were evident in these cases – the speed and urgency for these was seen as influencing the above
- In addition, although statutory work was undertaken, relevant agency handover to placement areas was not always apparent – possibly as a result of the lack of involvement in placement planning. For example, conversations from the 'home area' police force to 'out of area' police force, which may have informed decisions about placement, did not take place.
- Placements were not informed by the assessment of CSE risks and issues particular to the child – this would have provided more quality and potentially longer and more stable placements for the children involved
- Earlier identification of CSE risks in cases (prior to being accommodated) were missed in these cases
- Language used to describe risks and issues of concern – in terms of the responsibility for abuse experienced and CSE / missing episodes being on the child.
- Guidance for lead professionals informing those, such as the fostering team who are arranging placements for cases where CSE was a risk (whether emergency or not) was not easily available to the audit team

The MET Strategic Group are due to carry out quarterly multi agency audits around specific issues within the MET agenda. The next audit to be carried out will be focussed on children who go missing. This will commence in early 2017 – 18.

All recommendations and actions from the MET audits are discussed at the Strategic Group meetings and a rolling action plan is monitored quarterly. The Monitoring and Evaluation Sub Group also have an oversight of this activity.

Future Audit Schedule 2017 - 18:

Quarter	Month	LSCB Audit
1	Apr 17	MET: Children who go missing
	May 17	JTAI: Children living with neglect MET: Children who go missing
	Jun 17	JTAI: Children living with neglect MET: Children who go missing
2	Jul 17	JTAI: Children living with neglect MET: Children who go missing
	Sep 17	Transition from Children to Adult Services Core group audit
3	Oct 17	
	Nov 17	
4	Jan 18	JTAI: Interfamilial sexual abuse JTAI: Interfamilial sexual abuse

Southampton's Children

Changes to Continuum of Need and Thresholds

In December 2016, the LSCB approved changes to the existing continuum of need document and threshold. The new continuum introduces four levels of intervention, replacing the existing three, making a clear delineation between prevention and early help & activity requiring a statutory social work response.

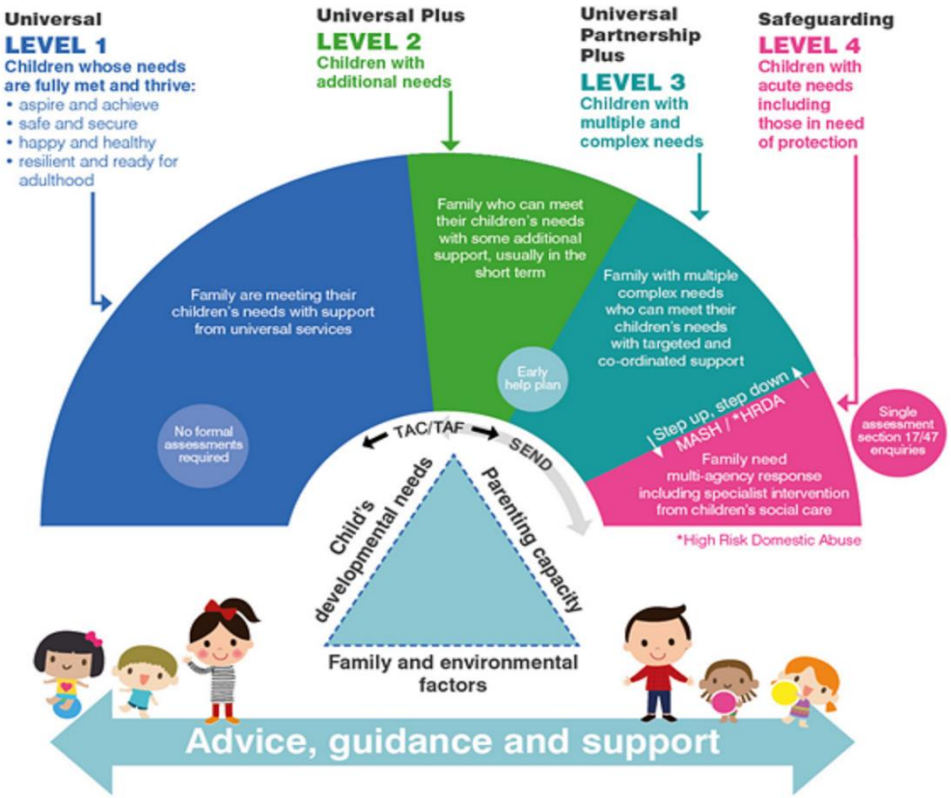
The four levels are:

Level 1 (Universal) – Children whose needs are fully met and thrive

Level 2 (Universal Plus) – Children with additional needs

Level 3 (Universal Partnership Plus) Children with multiple complex problems and additional needs

Level 4 (Safeguarding) Children with acute needs including those in need of protection



This model introduces strength based language encouraging practitioners to think about what a family **can** do. The continuum is complimented by the introduction of a new Early Help Assessment and Plan, replacing the Universal Help Assessment, with refreshed LSCB web pages and supporting guidance.

Alongside the introduction of the new continuum, the 'Front Door' to Social Care was redesigned, following review and consultation from Professor David Thorpe. This was in response to Social Workers carrying high caseloads and rates per 10, 000 of Child in Need and Looked After Children that placed SCC as a significant outlier in relation to national and regional comparators.

Following on from the review by Professor Thorpe, there were no proposed changes to current multi agency MASH arrangements, which were noted to be safeguarding children well. However, this was to be augmented through process redesign and adopting a new way of working using a single number to call, as a central point of first response. This would enable professionals to be accessed directly through a dedicated team of skilled and experienced social workers whenever someone may want to discuss worries they have about a child.

With no need to complete a written referral, it was intended that this approach would promote improved decision-making and joint working relationships.

Whist referring agencies can provide supporting written information and receive a written record of their referral, this new process will ensure that only the most vulnerable children at the greatest risk are assessed by a social worker.

Allowing for a greater emphasis on quality rather than volume, there would be an increased professional social work rigour aided by improved workflow management processes, scrutiny of live data through weekly case review meetings and live supervision of staff undertaking this work.

The LSCB was wholly in favour of these changes and offered its support in its multi agency implementation. To read more about these changes, please visit www.southamptonlscb.co.uk.

Demographics

The information analysed in the section that follows has been selected from a data set presented at each main LSCB meeting during 2014-15. Statistical Neighbour and National Average figures have been used where available and appropriate to provide comparison.

The current population of Southampton is 254,275 based on the Mid-Year Estimate (MYE) 2016 of which 129,879 are male and 124,396 are female. 62,448 are under 19 and usually resident in Southampton, equating to 24.8% of the population. (Population Pyramid Tool: 2017)

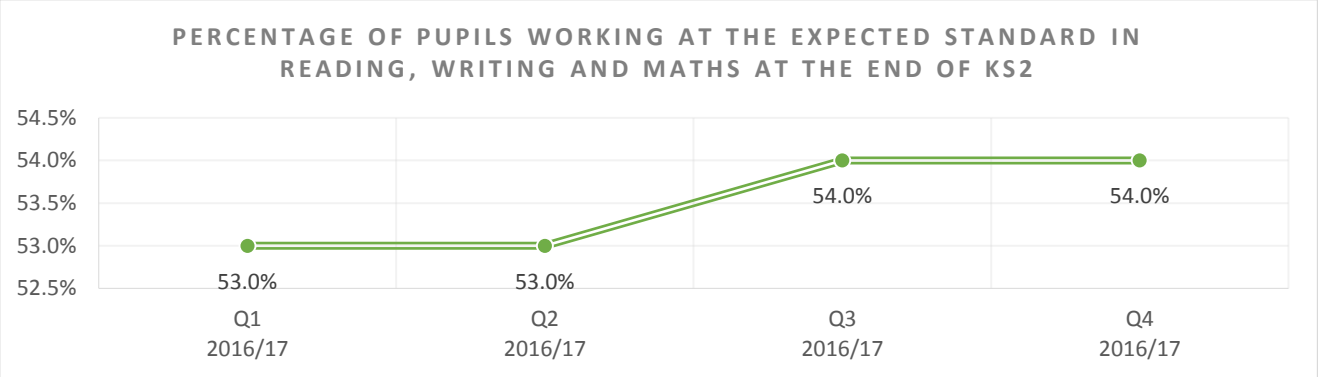
Children and young people from ethnic groups account for 19.7% of all children living in Southampton. The largest ethnic groups of children and young people in the area are Asian or British Asian (2011 Census).

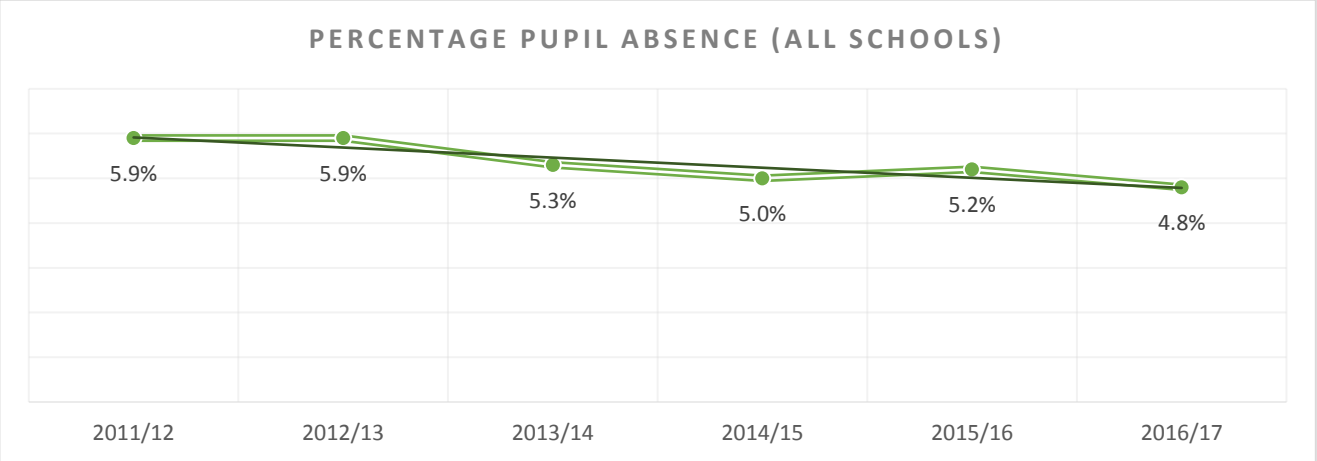
The LSCB receives details of the Child Health Profile for the city as this is published each year by Public Health England. The full report is available via www.chimat.org.uk –the headlines this year for Southampton are as follows:

- 33.7% of school children are from a minority ethnic group.

- The health and wellbeing of children in Southampton is generally worse than the England average.
- Infant and child mortality rates are similar to the England average.
- The level of child poverty is worse than the England average with 23.4% of children aged under 16 years living in poverty.
- The rate of family homelessness is better than the England average.
- 9.8% of children aged 4-5 years and 22.5% of children aged 10-11 years are classified as obese.
- Local areas should aim to have at least 95% of children immunised in order to give protection both to the individual child and the overall population. For children aged 2, the MMR immunisation rate is 94.9% and the diphtheria, tetanus, polio, pertussis and Hib immunisation rate is 97.1%.
- 33.7% of five year olds had one or more decayed, filled or missing teeth. This was higher than the England average. The recent hospital admission rate for dental caries (decay or cavities) in children aged under 5 years is lower than the England average.

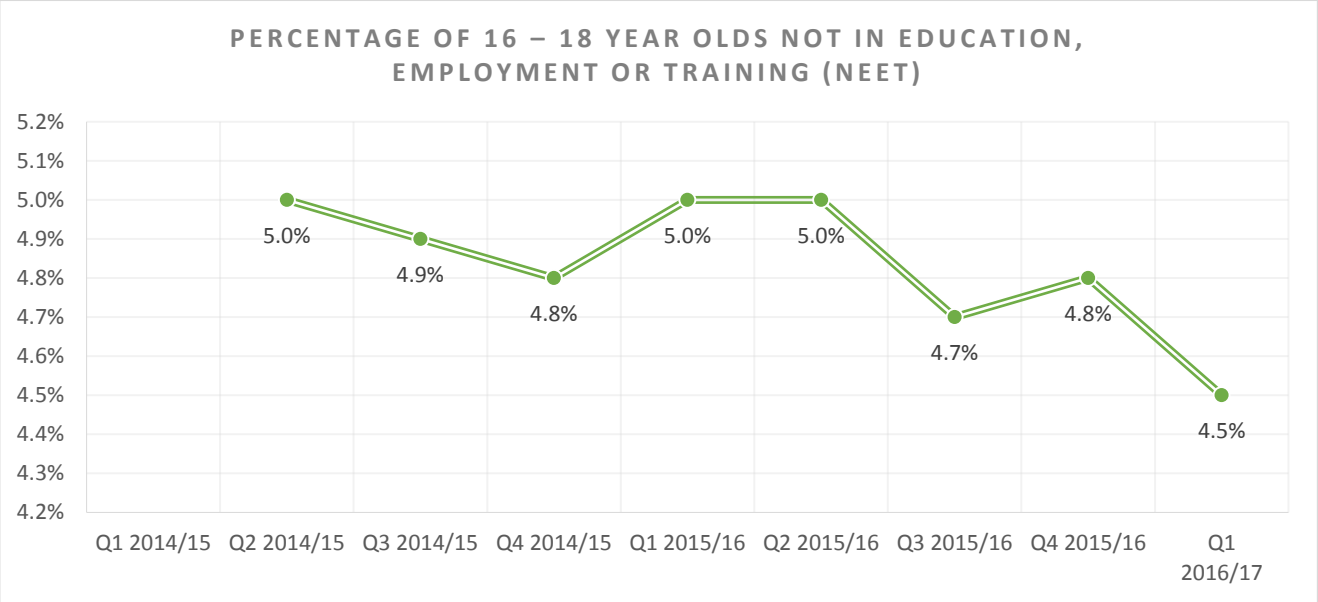
Our Children:



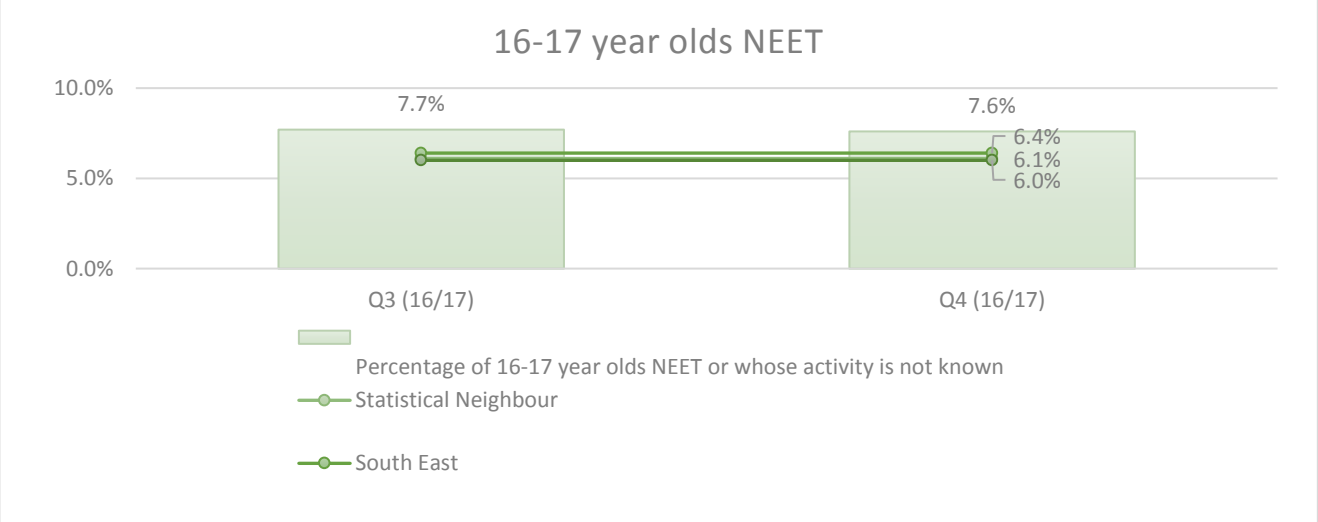


Overall there is a decrease in the percentage of pupil absence across all schools in Southampton. Education data reflects that Southampton is able to demonstrate a trend for improvement in respect of Special Schools, for example, meaning our performance is now an improvement on national averages. The trends

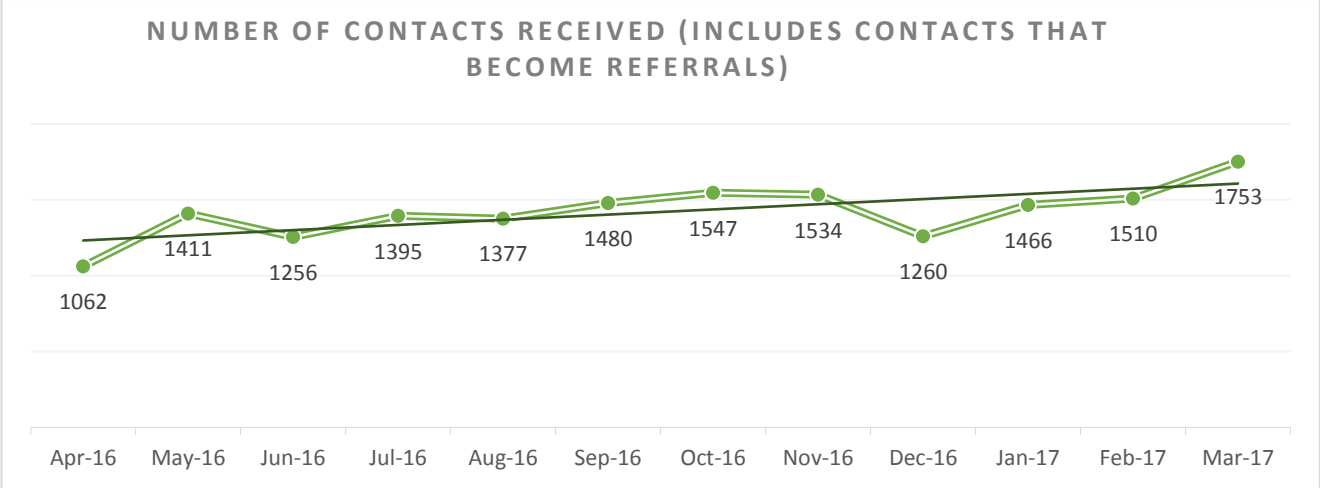
point towards a similar milestone being achieved for both Primary and Secondary Schools. Authorised absence accounts for a substantial proportion of Southampton's overall absence total - we are developing a focus through the school Led, Attendance Action Group to focus in particular on the causes of sickness related absence.



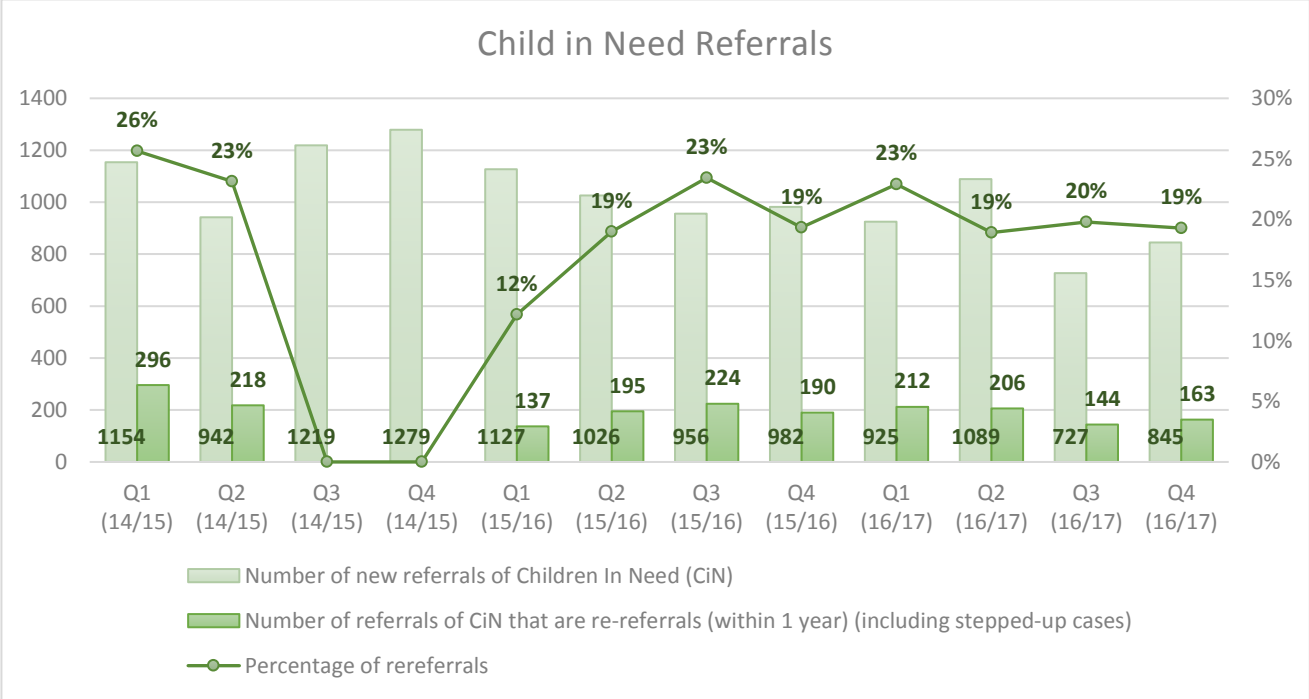
The measure has changed from 16-18 year olds NEET to 16 – 17 year olds NEET however, prior to the change one can see the decreasing trend in the NEET figure.



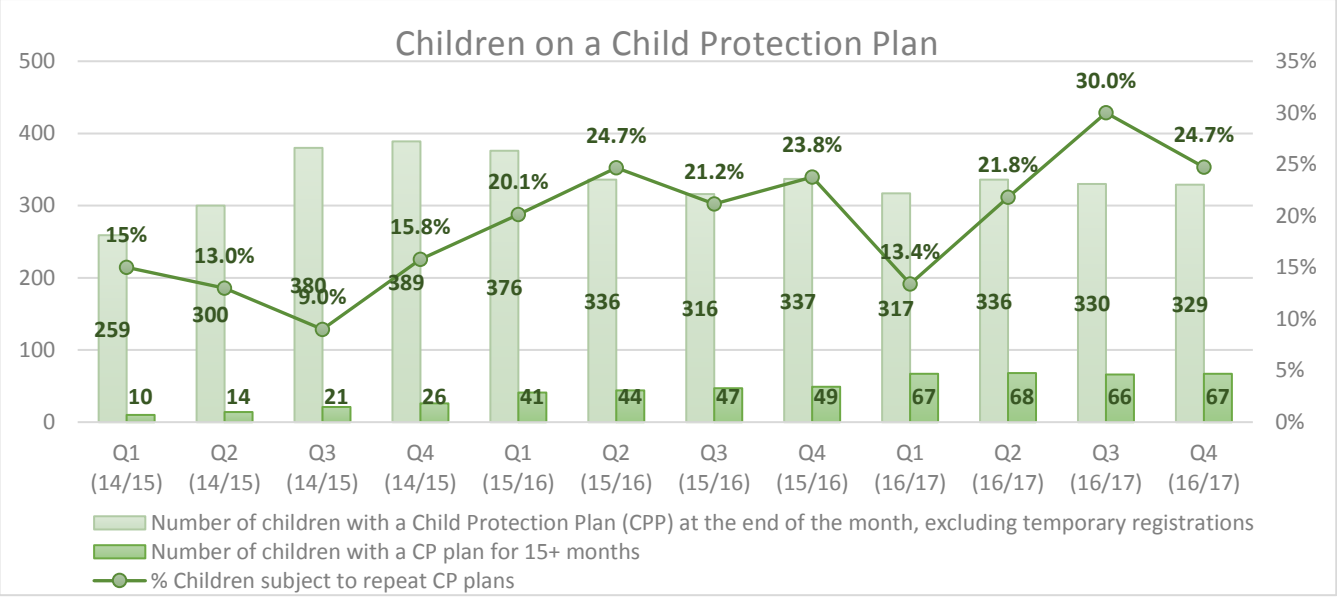
Children's and Families' Services have reflected that National NEET reporting has now changed to only include 16-17 year olds (as opposed to 16-18) and to also incorporate 'unknowns'. Whilst Southampton continues to perform well in relation to the NEET element alone against core cities and stat neighbours, our ranking has reduced (i) because we were previously relatively outperforming on 18 year olds that are now not in scope and (ii) we have a slightly higher level of 'unknowns'. Both of these factors are being addressed through (i) re-focussing on younger age group and (ii) new approaches to tracking.



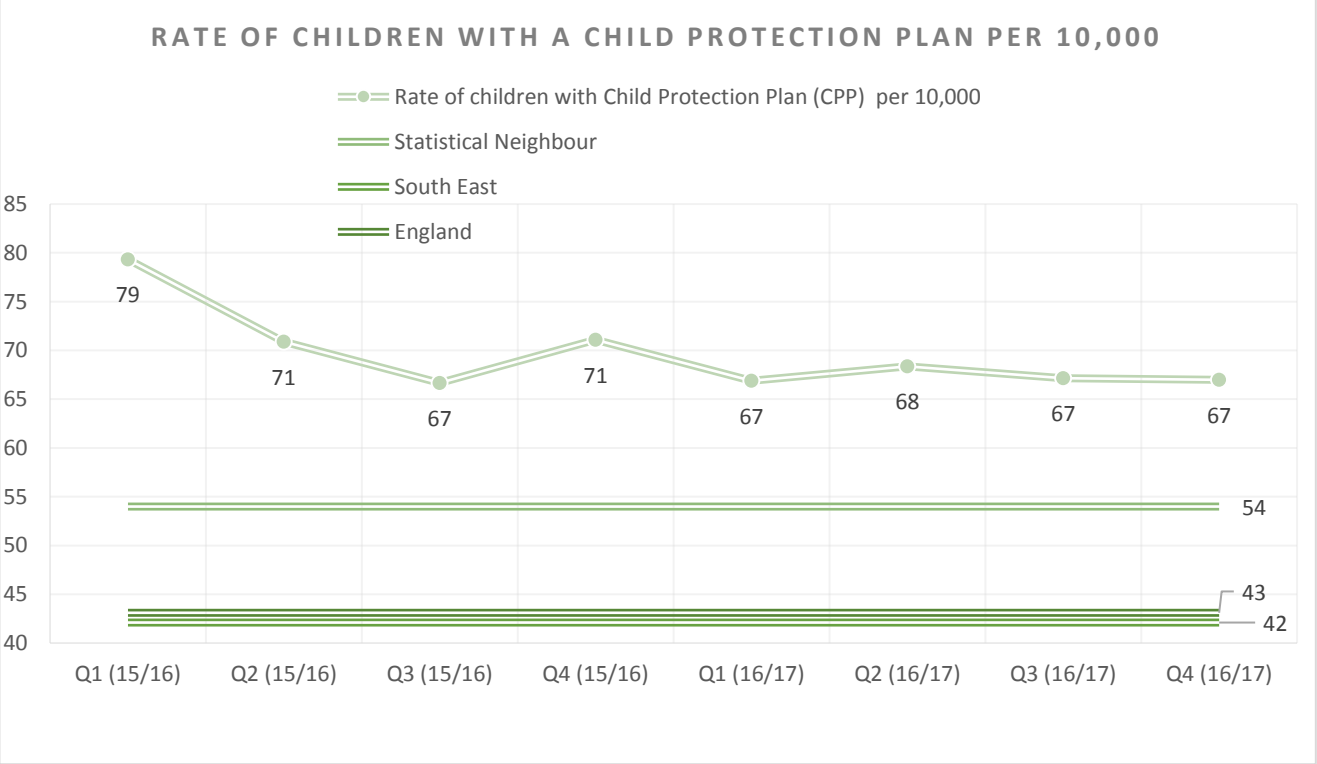
This year has seen an increase in the number of contacts coming to MASH. There was a 65.0% increase in contacts form April 2016 to March 2017. Commentary from the team reflects that an increase in referrals is anticipated given the new front door process. Throughout the year, 1361 referrals became Section 47 enquiries.



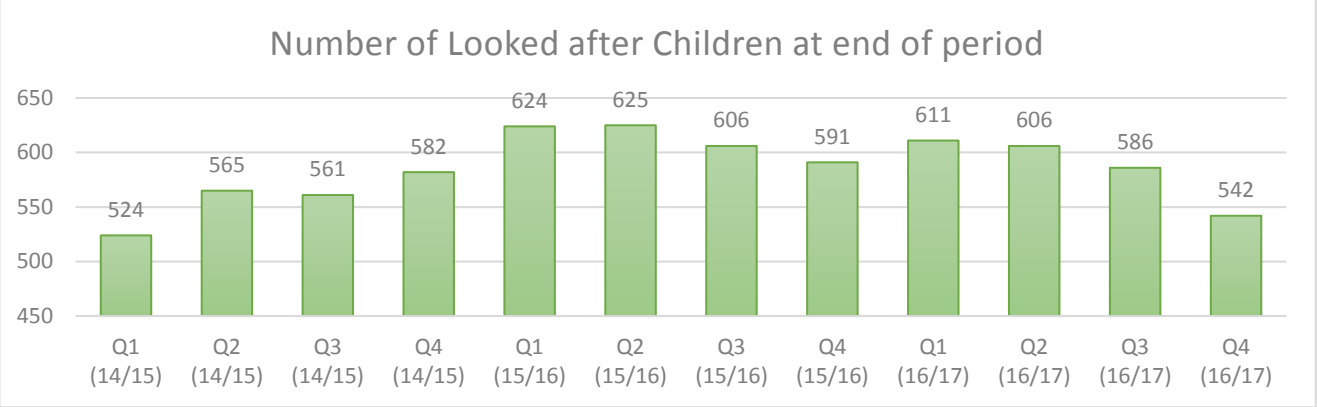
In 2016/17 there were 3595 Child In Need Referrals. There has been a decrease in the number of Child In Need Referrals as in 2015/16 and 2014/15 there were 4091 and 4594 contacts respectively. A 10.9% decrease from 2014/15 to 2015/16 and a 12.1% decrease in Child In Need Referrals from 2015/16 to 2016/17. Over the last 7 quarters, form quarter 2 (15/16) to quarter 4 (16/17) there have been significant fluctuations in the number of referrals from quarter to quarter. Over this same period the number of referrals within a 12 month period has oscillated between 19% and 23%.



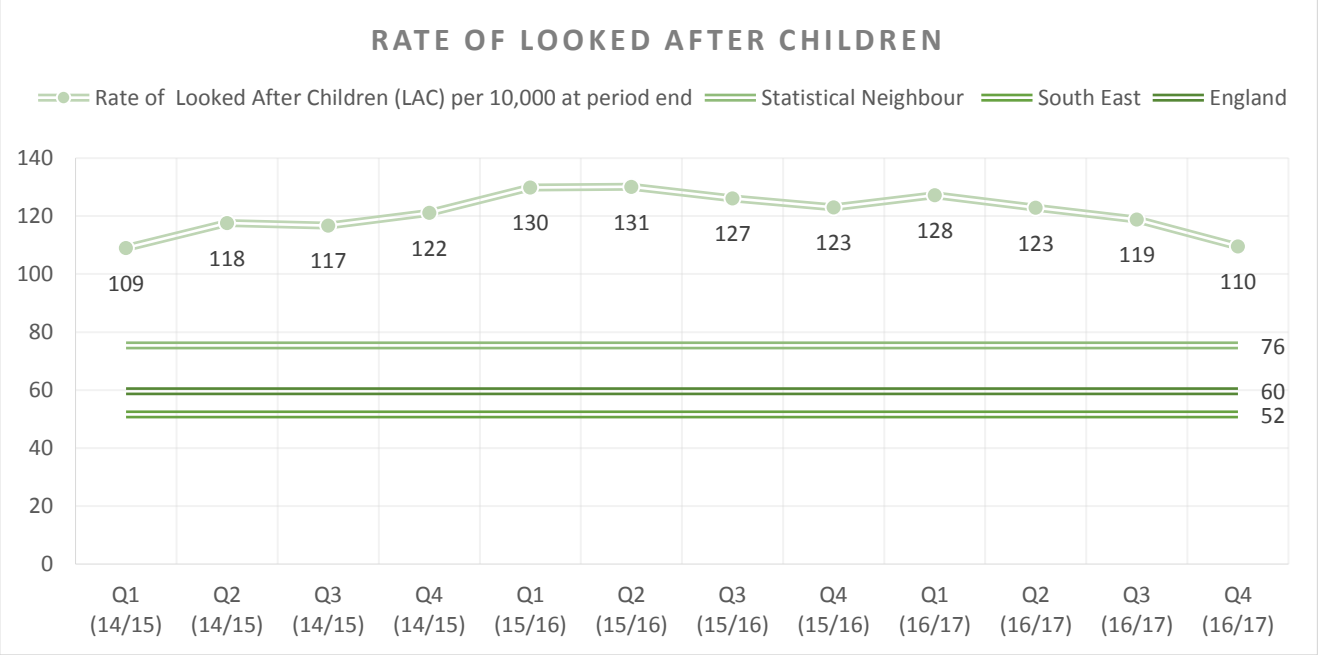
The number of children on a Child Protection Plan has fluctuated steadily between 337 and 316 between quarter 2 (15/16) and quarter 4 (16/17). However, over this same period the number of children on a Child Protection Plan for 15+ months has increased from 44 to 68. In addition the percentage of children that are on a repeat Child Protection Plan is increasing overall.



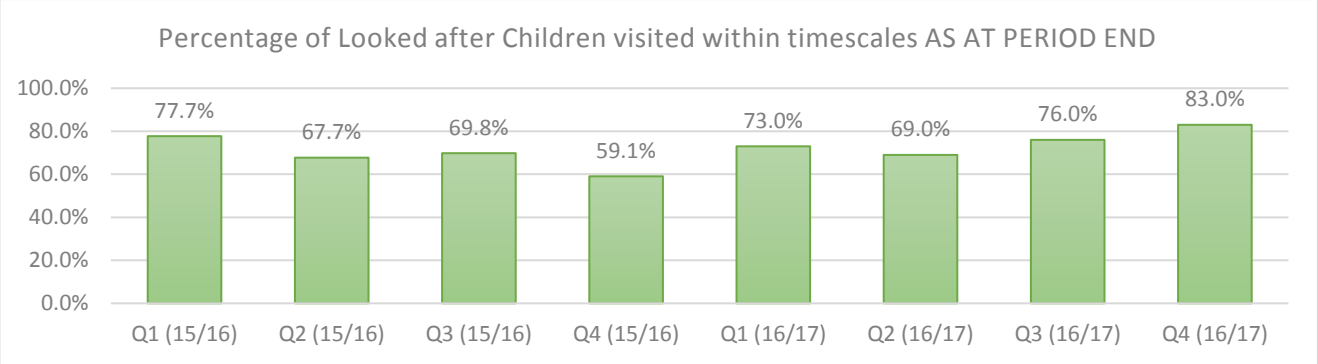
The rate of Children on a Child Protection Plan has not changed significantly across 2016/17. Southampton's rate (67) is significantly higher than the statistical neighbour rate (54) and is significantly higher than the South East (42) and national (43) rates.



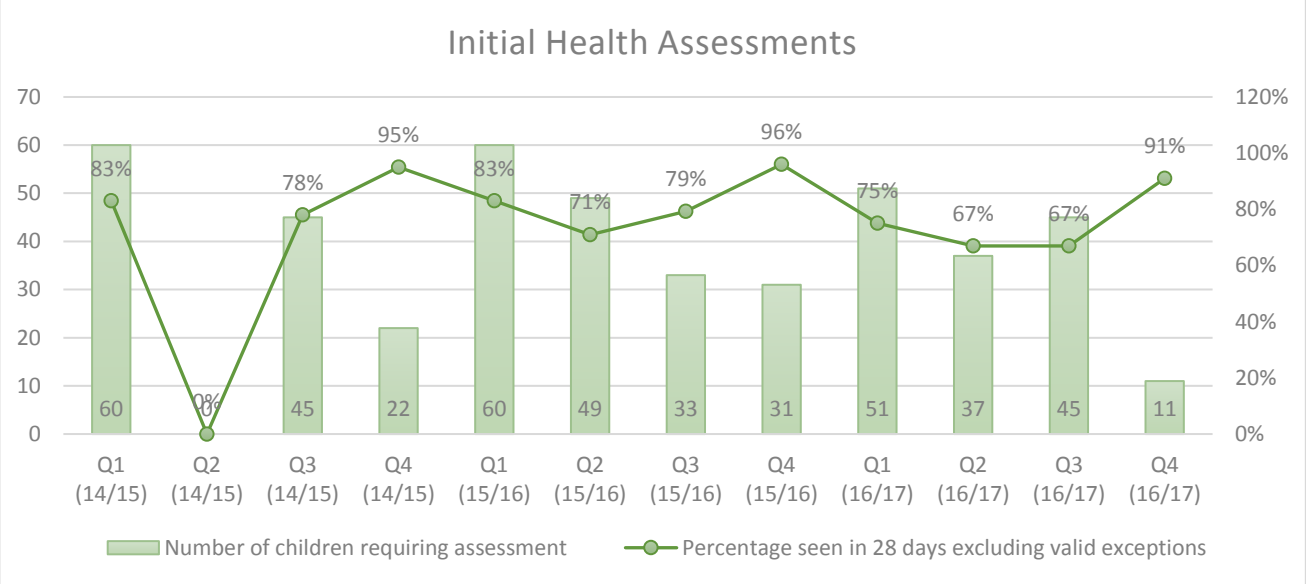
In 2016/17 the number of Looked after Children has decreased significantly by 11.3%. The figure is now at its lowest since quarter 1 2014/15. Children and Families' Services reflect: significant decrease in looked after numbers which is linked to the work of our dedicated LAC reduction plan, focussed work around looked after children in the service and close monitoring of all LAC arrangements. This is a combination of reunification planning for those in care where appropriate, permanence planning for those who need to remain in care and ensuring all possible options have been explored prior to considering a child being accommodated. It is expected that the number will fluctuate as the service needs to prioritise the safety of children at risk of harm in the care of their parents and this can be unpredictable at times.



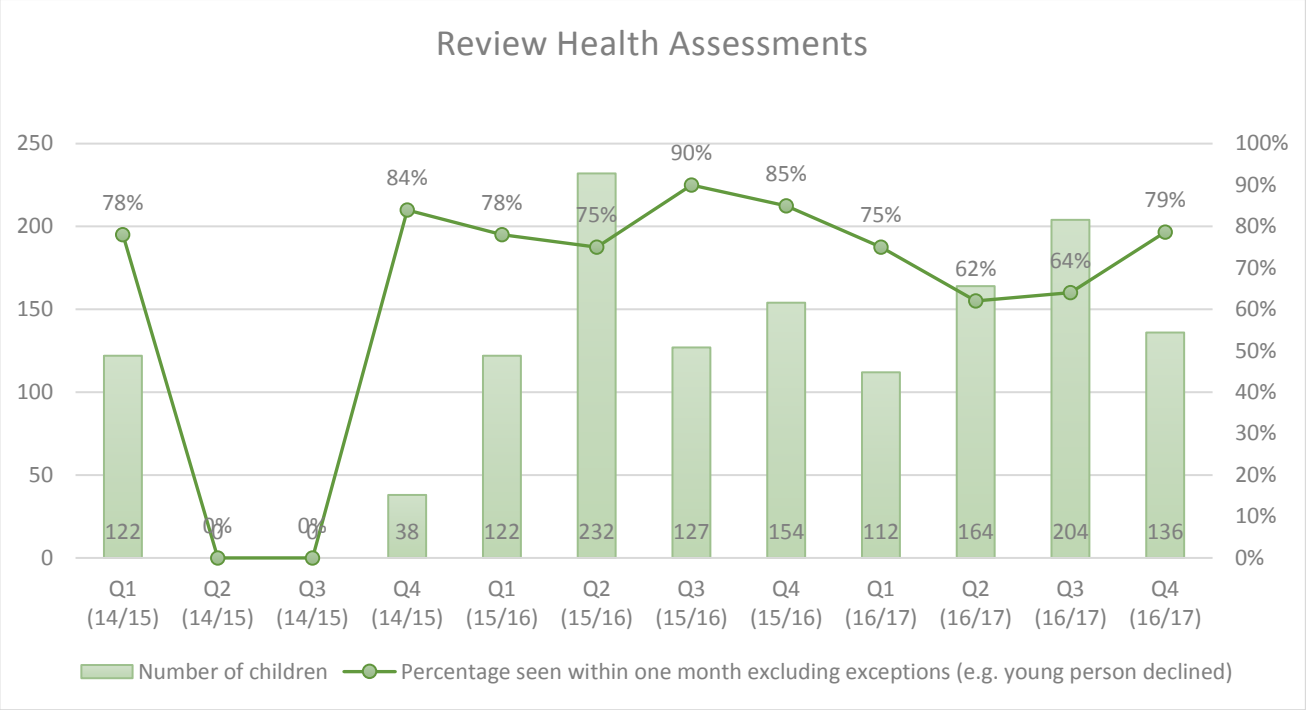
The rate of Looked after Children has shown a reducing trend across 2016/17. Southampton's rate (110) is significantly higher than the statistical neighbour rate (76) and is significantly higher than the South East (52) and national (60) rates



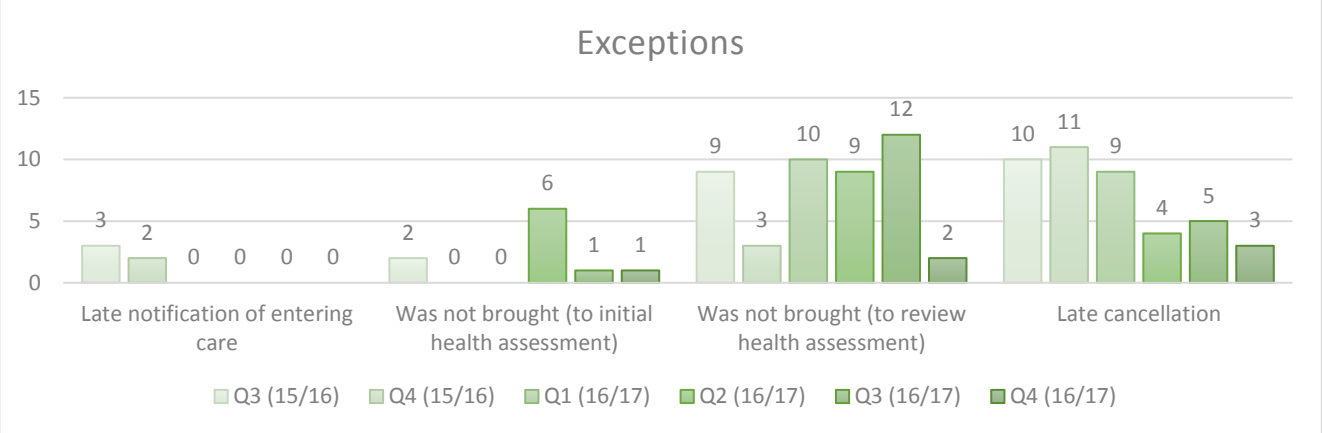
2016/17 has seen an improvement in the number of Looked after Children that have been visited within timescales. Quarter 4 (16/17) has seen the highest percentage over the last two years.



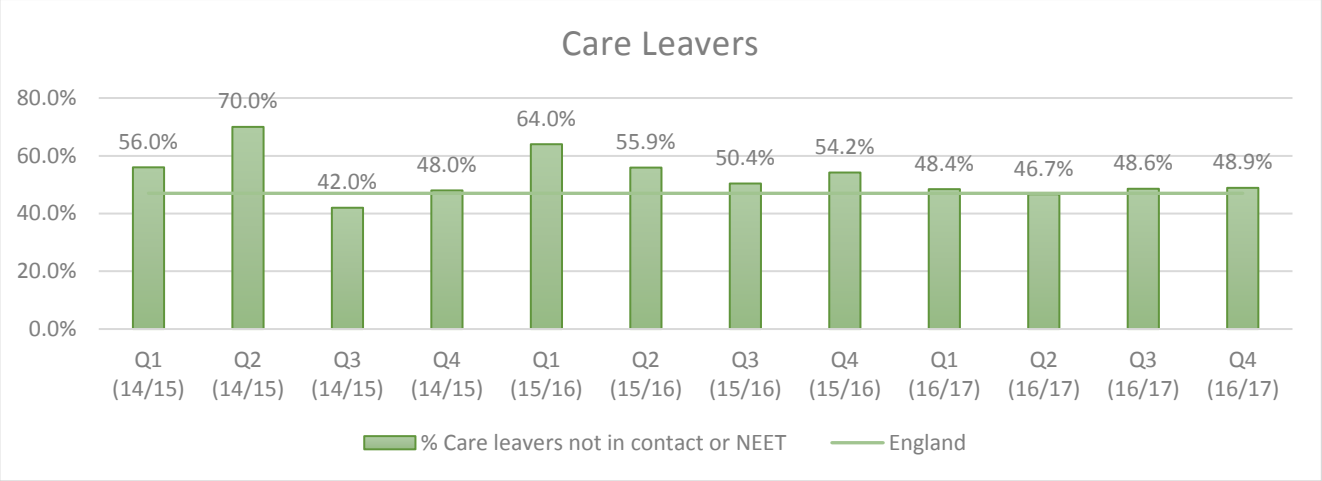
The percentage of children having their initial health assessments within timescale decreased to 67% over Quarters 2 and 3 but increased in Q4.



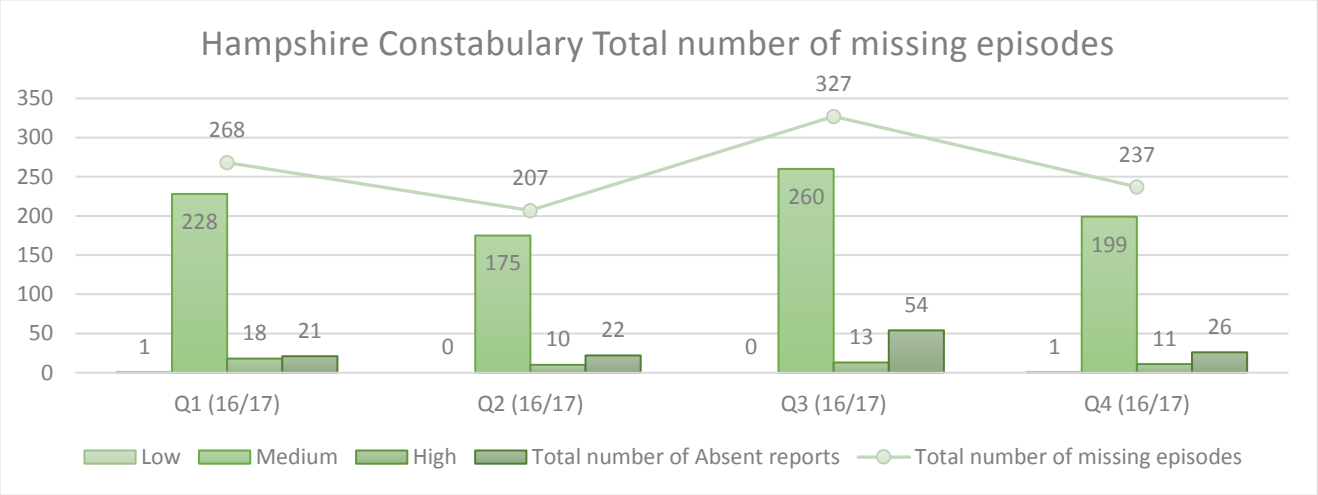
As with the initial health assessments, there was a dip in the number of Looked after Children having their review health assessments within timescales. However, at the end of 2016/17 the percentage having assessments within timescales was at its highest for the year.



The figure above shows the exceptions for Looked after Children's health assessments. There were no late notifications of entering care and the number of late cancellations has decreased compared to last year. The number of 'Was Not Brought' to initial health assessments has decreased over the year however, the number of 'Was Not Brought' for review health assessments remained high through the year. It is worth noting that the 'Was Not Brought' figure also includes children who refuse to attend.



The number of Care Leavers not in contact or not in employment, education or training has decreased in 2016/17 as compared to previous years. This year the percentage has not changed significantly.



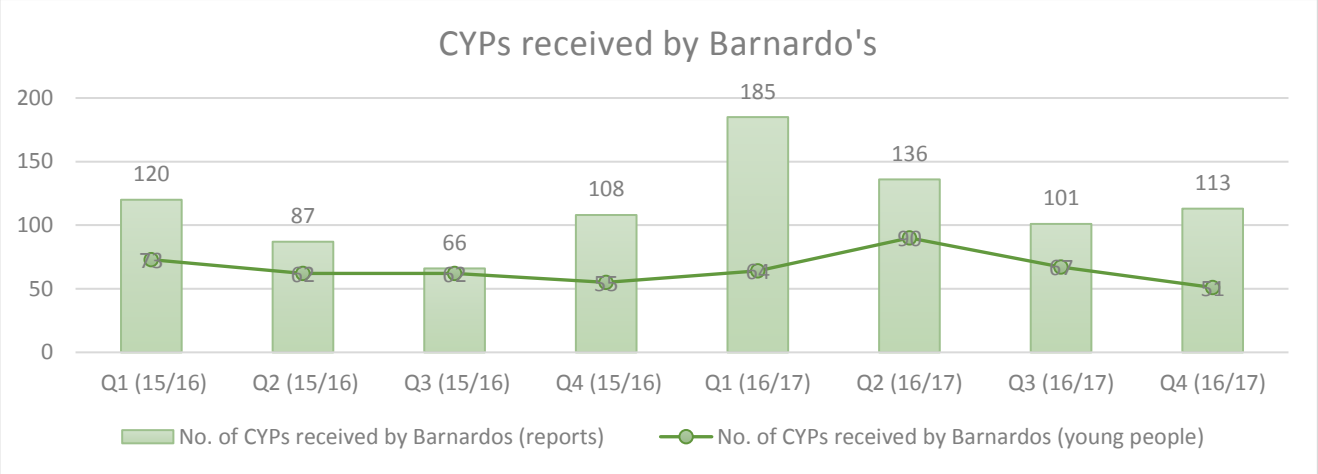
During the course of 2016/17 the Hampshire Constabulary have reported a total of 1039 missing episodes. The risk category of these missing episodes can be broken down as follows:

High risk: 52 (5.0%)

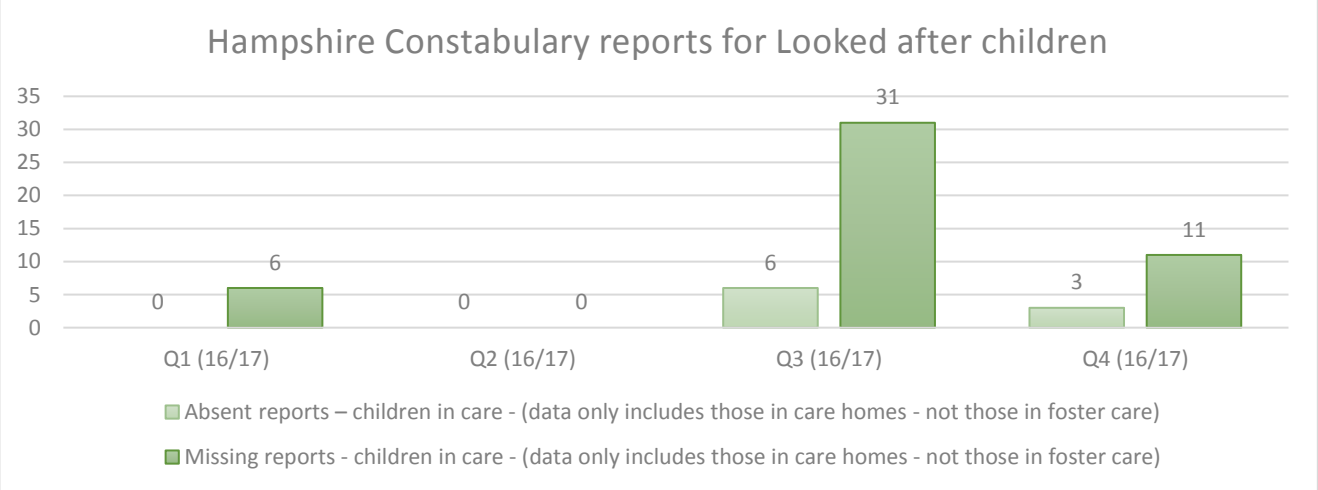
Medium risk: 862 (83.0%)

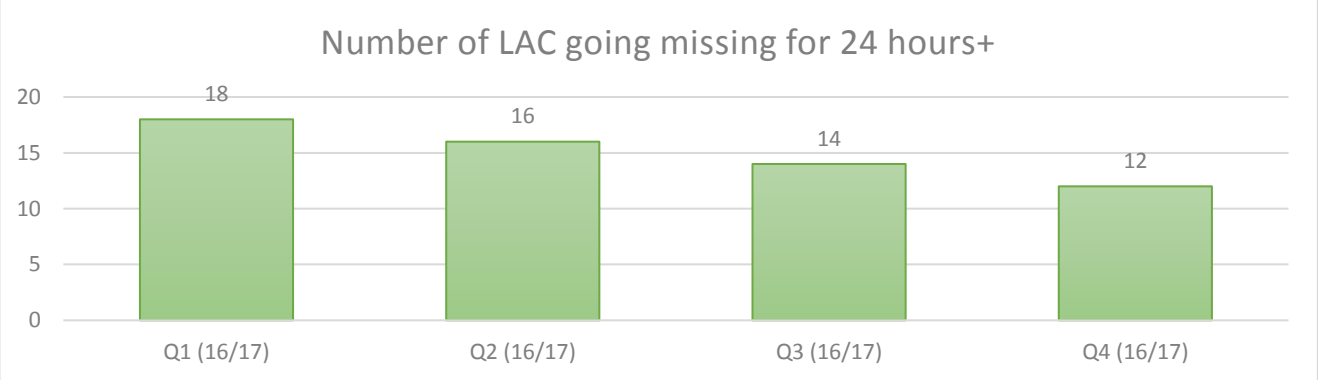
Low risk: 2 (0.2%)

Absent reports: 123 (11.8%)



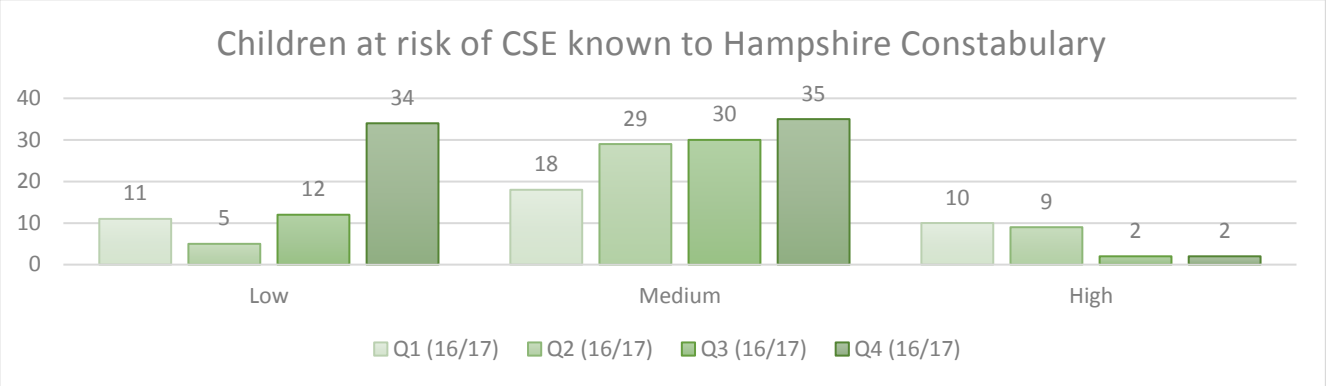
The number of missing reports received by Barnardo's amounted to 535 for 2016/17. From the graph above one can see that in some cases multiple missing episodes can correspond to one young person. The number of missing episodes and missing reports fluctuates significantly on a quarterly basis and no particular trend can be observed.





Hampshire Constabulary has seen a significant decrease in the number of missing reports for Looked After Children in care homes. The number of absent reports has also decreased since last quarter. Quarter 3 does have an unusually large number of missing and absent reports as compared to quarters 1, 2 and 4.

Children and Families' Services have reflected that there is a steady decline in our missing LAC. Managers receive a daily missing report and monitor the young people closely.



The number of children and young people known to be at risk of CSE by Hampshire Constabulary has gradually increased across the year. For each quarter, the figure is as follows:

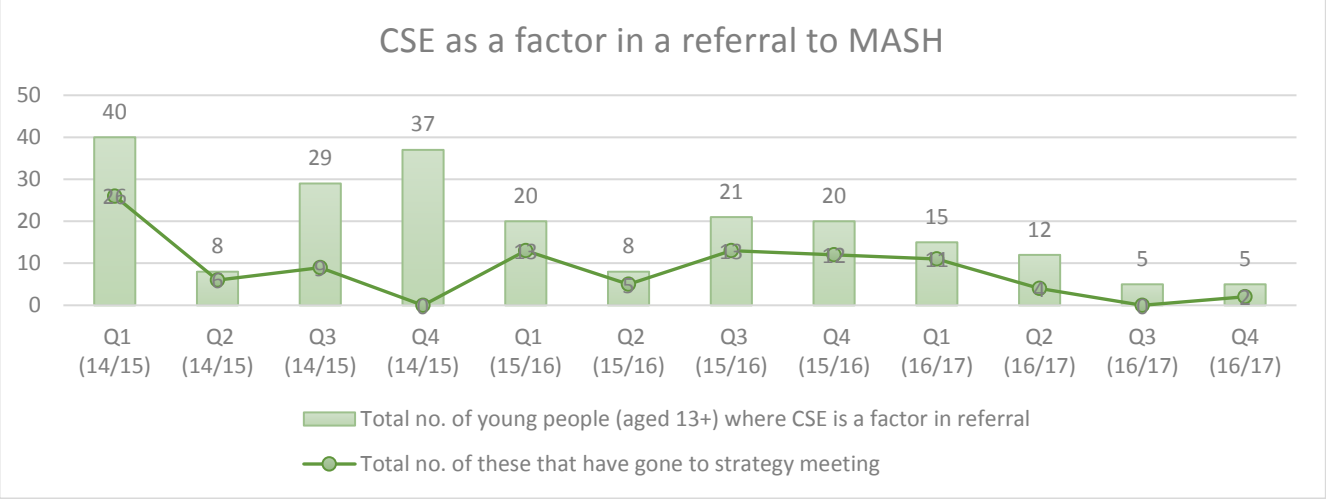
Quarter 1: 39

Quarter 2: 43

Quarter 3: 44

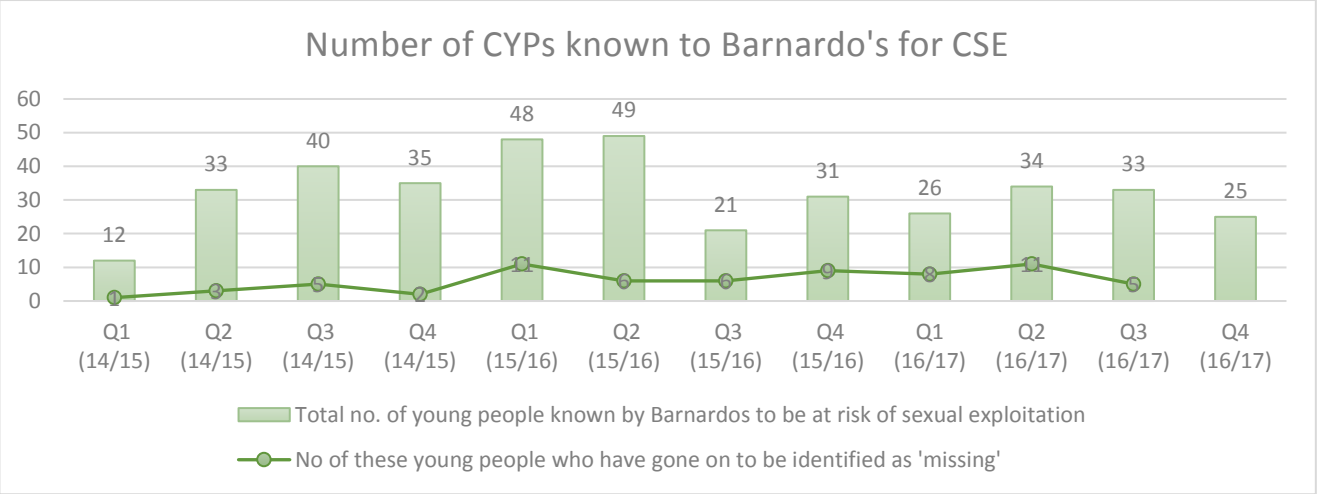
Quarter 4: 71

The majority of these children and young people are of medium risk of CSE.



Children and Families' Services have reflected that "This is a figure that can fluctuate month on month, though there was a recording issue in Dec/Jan. This has now been rectified. There has been work undertaken over the past 18 months to deliver CSE awareness raising workshops across the city to a range of organisations, resulting in a more accurate understanding of CSE in the city.

Alongside this, the MET Operational Group has identified that the majority of young people where CSE is a factor and where a strategy discussion has been recorded are already open cases to Children's Social Care so would not be measured for this scorecard.



The number of young people open to Barnardo's U-Turn service has fluctuated steadily between 21 and 34 since Quarter 3 (2015/16).

Between January 2015 and Q4 2016/17, no new referrals were sent in to Barnardo's for Trafficking. Over that period of time Barnardo's worked with two young people. However, two new referrals were sent in in Q4, one to the new Independent Child Trafficking Advocacy Service and the other in to the existing service.

We continue to offer training on MET issues to ensure that frontline staff are kept fully aware of the signs and indicators. Clear referral processes are also in place.

The Board closely monitors the above actions quarterly to ensure that we are aware of any trends and gaps that may need addressing by a multi agency forum.

In addition to quality assurance, the Board works to engage the community and young people. We also offer a range of training to professionals. Details of this activity is below.

Other Board Activity -

Community Engagement

Throughout the year, the Board has organised or been a part of a number of community engagement activities. This is to try and raise awareness and the importance of safeguarding with the general public and to share resources. Examples of activities undertaken are below:

Safeguarding Week – June 2016

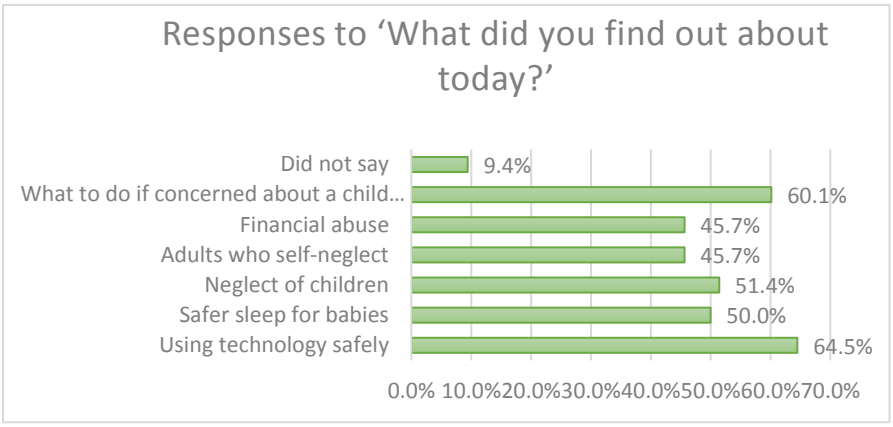
The Week coincided with the Child Accident Prevention Trust's (CAPT) Child Safety Week, the theme for 2016 was - 'Turn off technology for safety'. This event was joined with the LSAB to ensure a 'think family' approach and to make it relevant for all.

Local themes were:

- **Monday** –Child Safety Week 'Turn of technology for safety' launch
- **Tuesday** – Safe sleep for babies
- **Wednesday** – Recognising and responding to self-neglect in adults and neglect in children
- **Thursday** – Financial abuse (adults focussed)
- **Friday** –Raising awareness of what to do if you think somebody is at risk of harm or abuse

On three of the days within the week we went out with the Local Authority trailer at different locations and worked with partner agencies to engage with over 400 families and individuals to promote the key messages.

Evaluations received from 138 members of the public told us the following:



Imagine the Future – July 2016

On 12 July 2016 the second 'Imagine the Future' event took place, supported by the LSCB. This event is the only one of its kind which takes place on a ferry and is designed and led by young people, for young people. Three workshops took place and these were designed and run by students from local colleges. 250 school children attended and took part in workshops which were 'My Life Online' (looking at online safety and issues),'Looking after Yourself' (looking at self-care and wellbeing for young people) and 'Burst the Stigma!' which looked at destigmatising mental health issues and peer support.

The event took place on a red funnel ferry cruising from Southampton to the Isle of Wight and back and gave many young people their first opportunity to get out on the water. The other organisations supporting it were Red Funnel Ferries, Southampton Connect, Southampton Clinical Commissioning Group, Southampton Education Forum, and Hearing Dogs for the Deaf. It was a great opportunity to find out more about what mattered to young people in Southampton and enable the Board to incorporate

this into its work. The issue of online safety in particular has been an ongoing theme in the Board's work and will be the theme of the Safeguarding Boards Annual Conference in 2017.

Online Safety Day – February 2017

This year the Local Safeguarding Children Board promoted Safer Internet Day which took place on Tuesday 7th February 2017 with the theme 'Be the change: unite for a better internet'.

Online safety is a worrying issue that seems to be increasingly apparent locally, as well as nationally. Not only does it cover topics such as online bullying and grooming, it can also be used to glamourize and promote self-harm and other dangerous/ illegal activities.

As part of our push to raise awareness of key internet safety issues, we promoted the use of the 'Safer Internet Day' education packs within schools/settings in Southampton. These are national resources and have been tailored for ages 5-7, 7-11, 11-14, 14-18 and parents and carers. Packs included:

- Lesson plan
- Assembly presentation and script
- Play script
- Quick activities
- Whole school or community activities
- Poster

The LSCB also promoted the day via the following methods:

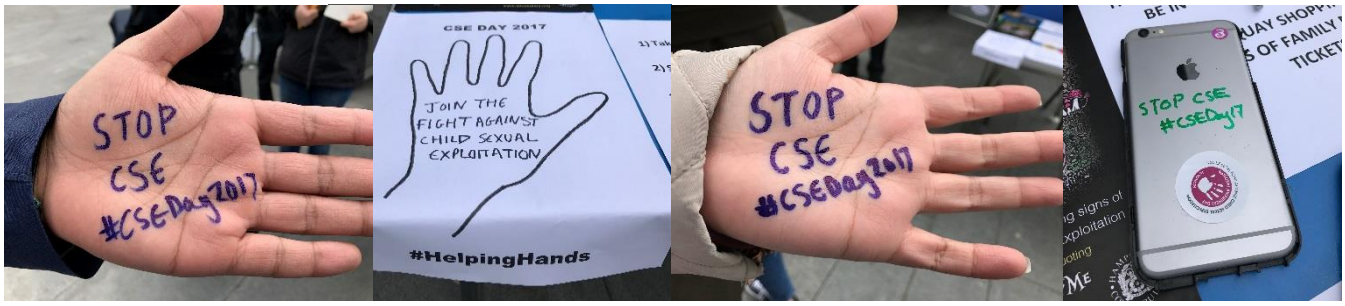
- Displaying a range of useful resources in the Southampton Civic Centre reception between 6th – 10th February 17
- Sharing important messages via social media throughout the week

CSE Awareness Day – March 2017

Southampton LSCB worked with Children and Families Service, The Police and Barnardos to deliver an awareness raising session on National CSE Awareness Day.

We had a trailer filled with resources parked in Southampton's Guildhall Square from 9am – 1.30pm on the day and we had a constant stream of professionals from each of the aforementioned agencies speaking to members of the public.

We engaged with community members and asked them to have a picture with their pledge for CSE Awareness Day
We also shared key messages via our Social Media pages.



Voice of the child

As the LSCB's Communication Strategy states, we want to ensure that the views of children and young people, their parents and carers and adults at risk themselves and the wider community are heard and their feedback used to improve safeguarding of Southampton's children and adults at risk.

Our aim is to ensure that those we communicate with understand how to keep children, young people and adults at risk safe and are able to recognise and know what to do where they suspect individuals or groups may be at risk of harm.

The Children Act 1989 and 2004 recognises children as citizens with the right to be heard and requires that when working with children in need, their wishes and feelings should be ascertained and used to inform making decisions. The Children and Families Act 2014 section 19 requires that children, young people and families should be involved in decision making at every level of the system. Working Together 2015 states that one of the key principles for effective safeguarding arrangements in a local area is to

take a child centred approach: 'for services to be effective they should be based on a clear understanding of the needs and views of children'.

Throughout the year, the LSCB has been keen to hear young people's views in a variety of ways. Examples of this activity is below:

a. Looked after Child Case Study at LSCB meeting

A young person attended the meeting to share his experience as a Looked after Child. As a 14 year old he went missing from home. Mum had abusive boyfriends and his lifestyle was very chaotic. He got into bad ways, went missing and got arrested. He was eventually placed into care and moved around a lot. He feels he had a messed up view as to what was right and wrong. His social worker became inspirational to him and told him things could get better. At 16 he moved into supported living, he was then rushed into the adult homeless unit quickly and he described it as horrific, he had felt safe in children's homes but felt very vulnerable in adult hostels. He was exposed to the wrong influences and became addicted to heroin, he was involved with the wrong people at the wrong time.

He wanted the LSCB to know that it is dangerous to rush young people into that adult situation. Drug use is a major concern. He came out the other side, his support worker used a unique approach, and took him to favourite places where he felt comfortable, shops, open spaces. He has been clean from drugs for 3 1/2 years and it has been almost 3 years from when he was last arrested.

When the Board asked if there was anything that he felt could have helped him earlier in his youth, he stated that he thought Police could be 'more human' when responding to young, troubled people. He said that he needed someone to talk to and someone to help him understand the way he was expressing himself. The Children and Families representative pledged to take the learning from this back to the service and speak to Social Workers such as workers taking young people to shops and open spaces. We are very grateful to this young person for giving up his time and telling his story!

b. Case Studies at Neglect Annual Conference

At the Safeguarding Boards Annual Conference in December 2016 on neglect, delegates heard three case studies from service users and professionals. One case study, which was read out by the Youth Participation Officer (SCC) was about '*Freddy*', a young boy who had suffered emotional and physical neglect since birth.

In the afternoon, attendees heard directly from a parent who told her story of self-neglect, the impact of this on the children and how she is now overcoming these issues.

These thought provoking case study were used to set the scene for the morning and afternoon sessions and helped participants to understand the far reaching impact of neglect on children and young people.

c. Youth led workshop at Neglect Annual Conference - *'Neglect: A day in the life'*

The NSPCC participation group led a workshop which offered a chance to think and talk about how children and young people experience neglect throughout the day through the eyes of a child/young person. The workshop focussed on what that child/young person sees, thinks and feels, as well as the impacts of neglect at different times of the day.

The session was delivered by four members of Southampton's NSPCC Participation Group. This is a group of young people that regularly meet to discuss issues relevant to the NSPCC's work with children and families. They are able to give views and opinions that as adults and professionals we often don't think of, or overlook, and give us relevance to what is going on in the lives of young people.

This was one of the most successful aspects of the conference and was seen to be extremely thought provoking and interactive.

d. Youth 'Safeguarding' Survey

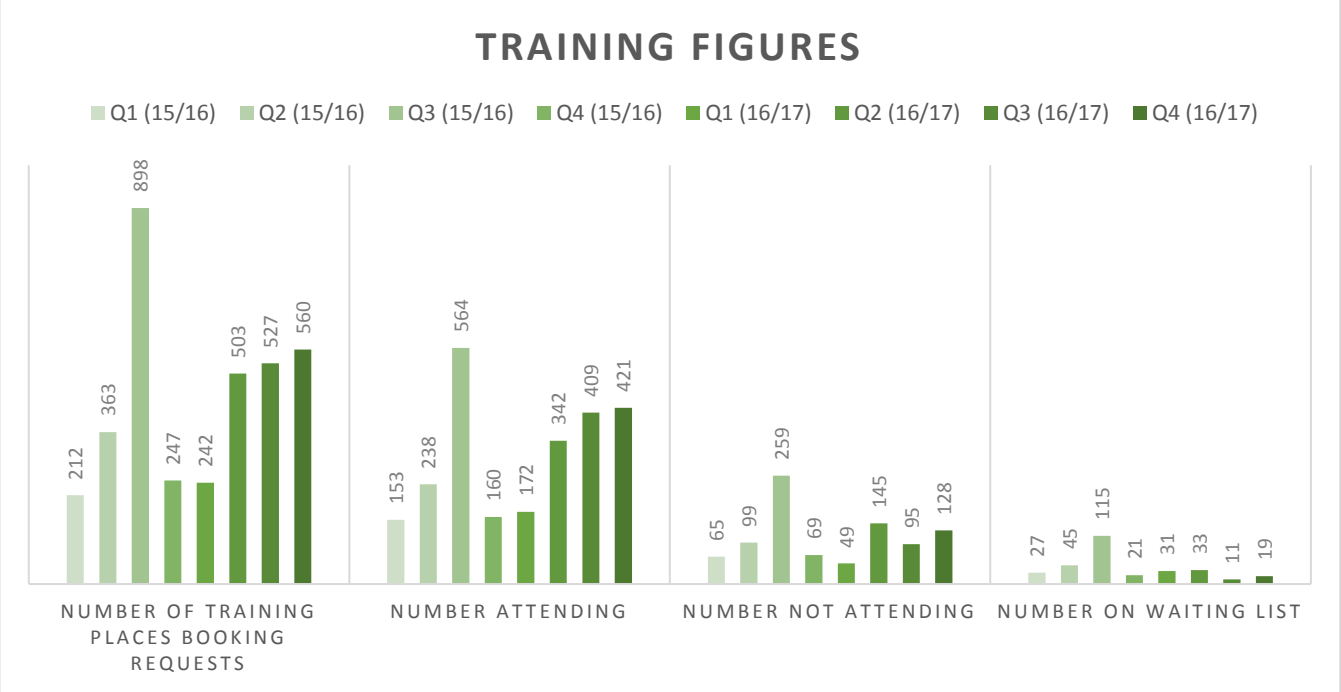
We asked a range of young people in Southampton 'what does Safeguarding mean to you?' Below is an example of feedback that was received:

This was fed back to the LSCB at the Business Planning Day in March 2017 by the Youth Participation Worker (SCC). They also shared a video made by the Children in Care Council about their experiences of being in care and about how it has impacted them within their life, since becoming care leavers. This had a great impact and served as an effective reminder of what the Board exists to do and how we all work together to improve the welfare and quality of life for our City's young people. This video directly drove a number of new additions to the Business Plan for 2017 – 18, including a more detailed assurance of Foster Carer procedures in the City.

Training

The Safeguarding Board has been delivering an agreed programme of Weekly Wednesday Workshops, Level 3 Safeguarding Training and other 'ad hoc' half day workshops for the last year.

Below is a summary of all attendance at LSCB training, broken down by quarter.



Wednesday Workshops:

Total number of Weekly Wednesday Workshops: **33**
Total number of attendees: **424**

Examples of workshops offered:

- Working with interpreters
- Youth Justice
- Universal Credit
- Fabricated and induced illness
- CSE and BAME communities
- Recognising physical injuries
- Child Abuse Investigation Team
- Working with families affected by suicide

Our most attended workshops were:

- Working with interpreters
- Recognising physical injuries
- Child abuse investigation team
- Working with GPs

Working Together to Safeguard Children and Young People Level 3 Training:

Total number of Working Together to Safeguard Children and Young People 2 day courses: **6**
2 day course total number of attendees: **137**

Total number of Working Together to Safeguard Children and Young People Refresher Courses: **6**
Refresher course total number of attendees: **77**

Half Day Workshops:

Total number of half day workshops: **13**
Total number of attendees: **329**

Half Day Workshop Topics:

- Substance and Alcohol Misuse
- An Introduction to Child Sexual Exploitation
- An Introduction to Neglect
- Adult Mental Health

Below is an example of feedback received in all types of LSCB training:

LSCB Membership

Agency	Position
Independent Chair	Independent Chair
Southampton City Council	Director of C&F Director of Housing, Adults & Communities
Hampshire Constabulary	Detective Supt Public Protection
Hampshire Probation	Director of Portsmouth/Southampton LDU
Community Rehabilitation Company	Director of Portsmouth/Southampton
Southampton City Clinical Commissioning Group	Director of Quality and Integration/Executive Nurse
NHS England (Wessex)	Director of Nursing
University Hospitals Southampton NHS Foundation Trust	Director of Nursing and Organisational Development
Solent NHS Trust	Operations Director (Children's Services)
Southern Health Foundation Trust	Director of Children and Families Division and Safeguarding Lead
South Central Ambulance Service	Assistant Director of Quality
CAFCASS	Senior Service Manager
Primary School Rep	Primary Heads Conference Representative Headteacher Compass School
Secondary School Rep	Secondary Schools Conference Representative

Agency	Position
Special Schools Rep	Special Schools Conference Representative
Further Education Rep	Further Education Representative
Voluntary & Community Sector	SVS
Legal advisor	SCC Legal
Designated Health Professional	Designated Nurse Designated Doctor
Principal Social Worker	Principal Social Worker
Director of Public Health	Consultant in Public Health
Lead Member for Children's Services	Lead Member
LSCB Business Unit	Board Manager Business Coordinator
LSCB Lay Member	LAY Member

Contact Information

Southampton Local Safeguarding Children Board

Tel 023 8083 2995

Email lscb@southampton.gov.uk

www.southamptonlscb.co.uk

Southampton Local Safeguarding Children Board

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DECISION-MAKER:		**HEALTH AND WELLBEING BOARD**		
SUBJECT:		**PHARMACEUTICAL NEEDS ASSESSMENT CONSULTATION**		
DATE OF DECISION:		**18th OCTOBER 2017**		
REPORT OF:		**DIRECTOR OF PUBLIC HEALTH**		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Claire Currie**	**Tel:**	**023 9284 1714**
	E-mail:	**claire.currie@portsmouthcc.gov.uk**		
Director	**Name:**	**Dr Jason Horsley**	**Tel:**	**023 8083 3818**
	E-mail:	**jason.horsley@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY

NOT APPLICABLE

BRIEF SUMMARY

1.1 The Health and Wellbeing Board has a statutory responsibility to publish a statement of the needs for pharmaceutical services of the population in its area, referred to as a Pharmaceutical Needs Assessment (PNA). A paper was brought to the Health and Wellbeing Board (HWB) on 29th March 2017 where the plan for refreshing the Southampton PNA was approved.

1.2 The regulations state that the HWB must undertake a consultation on the content of the PNA and it must run for minimum of 60 days. This paper presents the draft Southampton PNA (appendix 1) and seeks approval of the report for consultation from 23rd October to 22nd December 2017. It also seeks approval for the steering group to respond to consultations of PNA's from neighbouring areas on behalf of the HWB where the Southampton HWB is a statutory consultee and to ask the HWB to note the response.

RECOMMENDATIONS:

	(i)	The Health and Wellbeing Board approves the Draft Southampton Pharmaceutical Needs Assessment (PNA) report for consultation from 23rd October to 22nd December 2017.
	(ii)	The Health and Wellbeing Board approves that the steering group respond to consultations of PNA's from neighbouring areas on behalf of the HWB where the Southampton HWB is a statutory consultee and ask the HWB to note the response.

REASONS FOR REPORT RECOMMENDATIONS

1.	The PNA is a report on the local needs for pharmaceutical services. It is used to identify gaps in current services or improvements that could be made to current or future service provision. The specific content of the PNA is set out in schedule 1 of the NHS (Pharmaceutical & Local Pharmaceutical Services) Regulations 2013. It is a statutory requirement for the Health and Wellbeing Board to publish a revised assessment within three years of its previous PNA. The refreshed Southampton PNA must be published on 1st April 2018.

2.	There is a regulatory duty (NHS (Pharmaceutical & Local Pharmaceutical Services) Regulations 2013 No 349: Part 2: Reg 8) to have a 60 day consultation about the contents of the assessment it is making. As part of the Southampton PNA refresh, the consultation is planned to run from Monday 23rd October to Friday 22nd December 2017.
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
3.	None
DETAIL (Including consultation carried out)	
4.	*What is a PNA and what should it contain?* PNAs are relevant when deciding if new pharmacies are needed, in response to applications by businesses, including independent owners and large pharmacy companies. Applications are contested by applicants and existing NHS contractors and can be open to legal challenge if not handled properly. They also inform commissioning decisions by local commissioning bodies. The content of PNAs is set out in Schedule 1 to the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. • A statement of the pharmaceutical services provided that are necessary to meet needs in the area; • A statement of the pharmaceutical services that have been identified by the Health and Wellbeing Board (HWB) that are needed in the area, and are not provided (gaps in provision); • A statement of the other services which are provided, which are not needed, but which have secured improvements or better access to pharmaceutical services in the area; • A statement of the services that the HWB has identified as not being provided, but which would, if they were to be provided, secure improvements or better access to pharmaceutical services in the area; • A statement of other NHS services provided by a local authority, the NHS Commissioning Board (NHS England), a Clinical Commissioning Group (CCG) or an NHS Trust, which affect the needs for pharmaceutical services; • An explanation of how the assessment has been carried out (including how the consultation was carried out); and • A map of providers of pharmaceutical services.
5.	*What is the requirement for consultation?* There is a regulatory duty to have a 60 day consultation about the contents of the assessment it is making. As part of the Southampton PNA refresh, the consultation is planned to run from Monday 23rd October to Friday 22nd December 2017. According to the Regulations, the following must be consulted: • Local Pharmaceutical Committee for its area • Local Medical Committee in its area • Any persons on the pharmaceutical lists and any dispensing doctors

	list for its area; • Any local pharmaceutical service pharmacy in its area with whom the NHS England has made arrangements for the provision of any local pharmaceutical services; • Local Healthwatch and any other patient, consumer or community group which in the opinion of the Health and Wellbeing Board has an interest in the provision of pharmaceutical services in its area • Any NHS Trust or NHS Foundation Trust in the area • NHS England • Any neighbouring Health & Wellbeing Board
6.	*Proposed timetable* After the end of the consultation on 22nd December 2017, comments will be considered and the final document will be presented to the HWB in early 2018 in advance of formal publication on 1st April 2018. • 18th October: To request approval of draft PNA from HWB for consultation • 23rd October: Formal 60 day consultation starts. • 22nd December: Formal 60 day consultation ends. • Write report on consultation and make changes to draft PNA. • February 2018: Present final draft PNA to HWB. • Make final changes based on HWB feedback. 1st April 2018: Final PNA published on website.
7.	*What does the draft Southampton PNA conclude?* In Southampton, at the current time, there are 43 community pharmacies and one dispensing appliance contractor. Since the previous PNA, one community pharmacy has been removed from the pharmaceutical list (on 1st September 2017) as the result of a consolidation application. The Health and Wellbeing Board consider the location, number, distribution and choice of pharmaceutical services serving the Southampton residents to meet the needs of the population. The Health and Wellbeing Board also consider that there is currently no identified need for improvements and better access to pharmaceutical services in Southampton. The basis for these conclusions are given in the draft report and summarised in the executive summary (appendix 1).
RESOURCE IMPLICATIONS	
Capital/Revenue	
8.	None
Property/Other	
9.	None
LEGAL IMPLICATIONS	

Statutory power to undertake proposals in the report:	
10.	There is a statutory duty requiring the Health and Wellbeing Board to undertake and publish this needs assessment under section 128A of the National Health Service Act 2006 and regulations made under that section, namely the National Health Service (Pharmaceutical & Local Pharmaceutical Services) Regulations 2013 ("the 2013 Regulations").
11.	Regulations 3 to 9 and Schedule 1 of the 2013 Regulations set out the detailed requirements as to the content of needs assessments and the manner in which the assessment is to be made and published.
12.	Regulation 8 of the 2013 Regulations, in particular, prescribes those specified persons who must be consulted about the content of the assessment and the manner in which they must be consulted about specified matters.
Other Legal Implications:	
13.	None
RISK MANAGEMENT IMPLICATIONS	
14.	None
POLICY FRAMEWORK IMPLICATIONS	
15.	None

KEY DECISION?	**No**
WARDS/COMMUNITIES AFFECTED:	**All**

SUPPORTING DOCUMENTATION

Appendices	
1.	Enc. 1 for Pharmaceutical Needs Assessment draft approval for consultation – PNA draft
2.	Enc. 2 for Pharmaceutical Needs Assessment draft approval for consultation – Equality and Safety Impact Assessment

Documents In Members' Rooms

1.	None
Equality Impact Assessment	

Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.	**Yes**
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	**No**

Other Background Documents
Other Background documents available for inspection at:

Title of Background Paper(s)	**Relevant Paragraph of the Access to Information Procedure Rules /**

		Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

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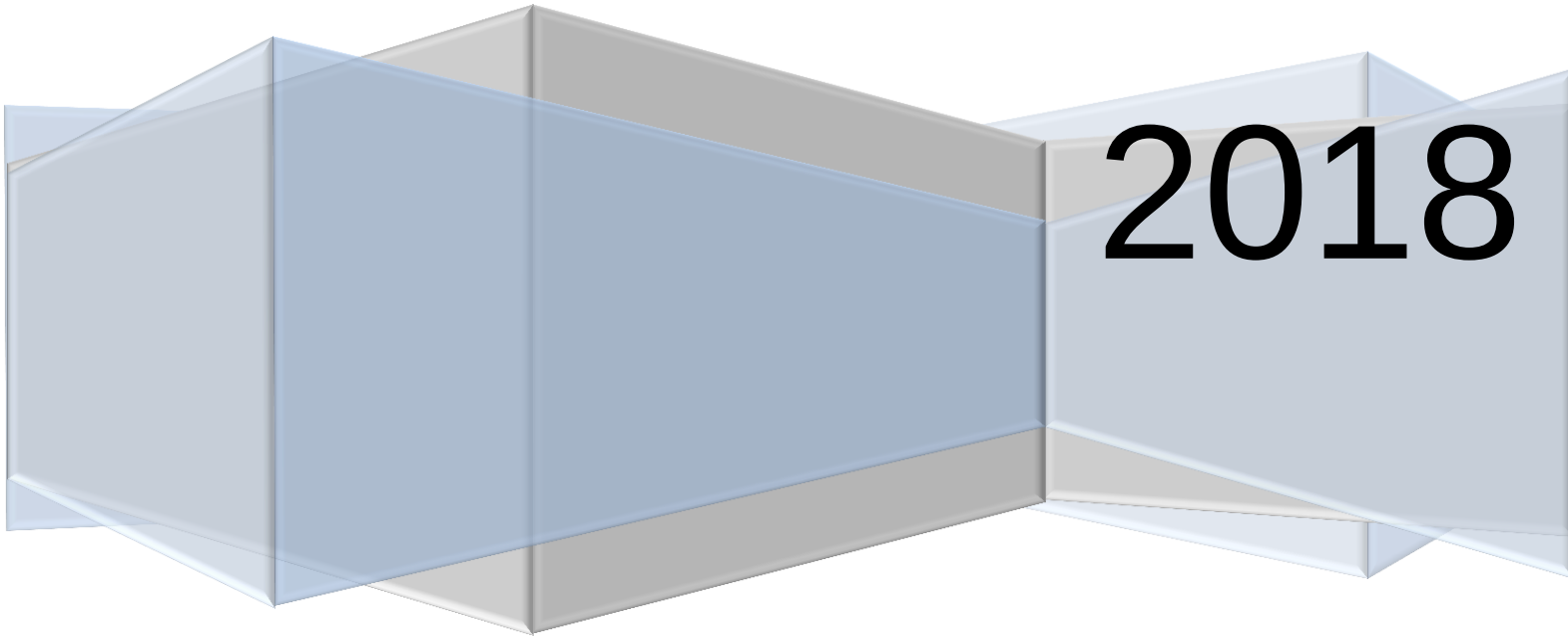
Southampton Pharmaceutical Needs Assessment
Draft report for consultation



2 Executive Summary

The statutory Pharmaceutical Needs Assessment (PNA) is a statement of current pharmaceutical services provided in the local area, assesses whether or not the pharmaceutical services provision is satisfactory for the local population and identifies any perceived gaps in the provision.

In Southampton, at 1st October 2017, there are 43 community pharmacies and one dispensing appliance contractor.

The Health and Wellbeing Board consider the location, number, distribution and choice of pharmaceutical services serving the Southampton residents to meet the needs of the population. The Health and Wellbeing Board also consider that there is currently no identified need for improvements and better access to pharmaceutical services in Southampton.

In particular, this is based on:

- Almost all of the Southampton population is within a 1.6km straight line distance of a community pharmacy (section 5.1.1.1).
- A good geographical spread of community pharmacies across the city (section 6.7).
- There being 18 community pharmacies per 100,000 Southampton population, which is very similar to the average for Wessex and is broadly in line with the national average (section 7.2.1).
- Over 99% of the Southampton population are within a 20 minute walk of a community pharmacy (section 5.1.1.5).
- Just over nine in every 10 (92.3%) respondents to a public survey said it took 15 minutes or less to get to a community pharmacy (section 8).
- Consideration of opening hours from early morning, through lunchtimes and late into the evening as well as weekend opening (section 7.1.1).
- Four 100 hour pharmacies, supplementary hours in other Southampton community pharmacies as well as provision in a neighbouring Health and Wellbeing Board area provide improvements and better access which meets the needs of Southampton residents (section 6).
- All pharmacies provide the full range of essential pharmaceutical services (section 7.2).
- There is good provision of advanced services across the city (section 7.3).
- There are a range of enhanced and locally commissioned services delivered in the city (section 7.4).
- A large proportion of community pharmacies providing a delivery service to residents, including housebound patients (section 7.1.10).
- There will not be substantial changes in population areas, nor major development, which can be anticipated during the three-year lifespan of this PNA, which would warrant the need for additional pharmaceutical services. Smaller changes would be managed by existing providers. (Sections 9.4.2 and 9.2).

3 Introduction

3.1 Definition and purpose of the PNA

The statutory Pharmaceutical Needs Assessment (PNA) is a statement of current pharmaceutical services provided in the local area, assesses whether or not the pharmaceutical services provision is satisfactory for the local population and identifies any perceived gaps in the provision.

It is a key commissioning tool that will be used to inform and support the future commissioning of pharmaceutical services in Southampton. If a person (a pharmacist, a dispenser of appliances or in some circumstances and normally in rural areas, a General Medical Practitioner (GP)) wants to provide pharmaceutical services, they are required to apply to the NHS to be included on the pharmaceutical list. The PNA will be used by NHS England, as a basis for making decisions, when applications are received to enter or amend the entry on the list of pharmaceutical service providers within the Health and Well Being Board area. This includes to:

- Determine market entry of new NHS pharmaceutical service providers
- Determine relocation or change of business premises of existing pharmaceutical service providers.
- Determine changes of pharmaceutical services provided by any current individual pharmaceutical services provider. It may also be used by Southampton City Council and NHS Southampton City Clinical Commissioning Group (CCG) to inform local commissioning decisions.

3.2 Historical and Legal Background

The Health Act 2009[1] sets out the minimum standards for PNAs and the use of PNAs as the basis for determining market entry to NHS pharmaceutical services provision. The Regulations came into force in May 2010 and required Primary Care Trusts (PCTs) to develop and publish their first PNA under these Regulations by 1 February 2011.

The Health and Social Care Act 2012[2] brought about major reforms to the NHS. From April 2013, PCTs were abolished and their duties transferred to other organisations. Responsibility for developing, updating and publishing a local PNA was transferred to Health and Wellbeing Boards. In addition this Act also transferred the responsibility of using the PNA as the basis for determining market entry to a pharmaceutical list and dispensing doctor list from the PCT to NHS England.

The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013[3] set out the legislative basis for developing and updating PNAs. The National Health Service (Pharmaceutical and Local Pharmaceutical Services (Amendment

[1] National Health Service Act 2009 available at http://www.legislation.gov.uk/ukpga/2009/21/contents

[2] Health and Social Care Act 2012 available at http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

[3] The NHS (Pharmaceutical Services and Local Pharmaceutical Regulations) 2013 available at http://www.legislation.gov.uk/uksi/2013/349/contents/made

and Transitional Provision) Regulations 2014[4] have been published to amend these regulations following a report published by the Joint Committee on statutory instruments. More recently, The NHS (Pharmaceutical and Local Pharmaceutical Services) (Amendment) Regulations 2016 were published.

The first PNA to be produced by the Southampton Health and Wellbeing Board was published on 1st April 2015 to comply with these regulations. The regulations state that each Health and Wellbeing Board must publish a revised statement within three years of it previous publications and this document has been produced to satisfy this requirement.

4 Process for producing the Pharmaceutical Needs Assessment

The PNA has been undertaken in line with the requirements of the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 under the guidance of the PNA steering group.

The Southampton PNA 2018 has been in development from April 2017 until its official publication on April 1st 2018. Reflecting the arrangement for a joint steering group to oversee development of the PNA for Portsmouth and for Southampton (producing two separate PNAs), the structure of the Portsmouth PNA published in 2015 has been used as the basis for the Southampton PNA 2018 and the work from its authors is gratefully acknowledged. The process has had many steps; the key stages are outlined below.

Stage 1: Formation of a steering group

A joint steering group formed to oversee the development of each of the PNAs for Portsmouth and Southampton cities.

The group has representation from key stakeholders and reports to the Joint Director of Public Health for Portsmouth City Council and Southampton City Council.

The group oversees the development of the PNA and ensures that the PNA conforms to the relevant regulation and statutory requirements on behalf of the Health and Wellbeing Board.

Key stakeholders include representation from Southampton City Council, NHS Southampton City CCG, NHS England Wessex Area Team, Local Pharmaceutical Committee and Healthwatch Southampton.

Stage 2: Collation of information and data

The Joint Strategic Needs Assessment for Southampton has been extensively used to give an overview of major health and wellbeing needs of the local population.

Every existing community pharmacy in Southampton was invited to complete a detailed questionnaire about their services to inform the development of the PNA. This survey was open from 7th June until 14th August 2017. Data held by NHS England Wessex Area

[4] The National Health Service (Pharmaceutical and Local Pharmaceutical Services) (Amendment and Transitional Provision) Regulations available at http://www.legislation.gov.uk/uksi/2014/417/contents/made

Team was also used to inform the Southampton picture of local pharmaceutical provision, including data on delivery of advanced services. National and locally held statistics have been examined to determine levels of activity in delivering current services.

A public survey was open for responses from 7th June until 28th July 2017 to gather views about pharmaceutical services in the city. This survey was hosted on Southampton City Council's website and promoted through various local channels including social media. This was based on and acknowledges the survey used to inform the Southampton PNA in 2015.

Expertise and advice has also been sought from Southampton City Council Planning and Communications departments.

Stage 3: Analysis

Analysis of the information collated to identify any gaps of pharmaceutical provision within the locality. Draft consultation document completed in line with national guidance and approved by the steering group and Director of Public Health.

Stage 4: Draft PNA

Draft PNA shared with the Health and Wellbeing Board in October 2017 prior to consultation.

Stage 5: Consultation

A stakeholder consultation to meet the stated requirements will be held from October 2017 to December 2017. *(A detailed consultation description will be published as an additional section to this draft after the consultation*)

Stage 6: Review of consultation responses

Collation of responses to consultation and consideration of the comments will be made by the steering group and the PNA will be reviewed and amended at this stage in light of this consultation exercise. *(This will be published as an additional section to this draft.)*

Stage 7: Publication

The final document will be presented to the Health and Wellbeing Board for approval before the planned publication of the PNA by 1st April 2018.

5 Introduction

Southampton is on the south coast of England and is the largest city in Hampshire and in the south east, outside London. It is a diverse city with a population of 254,275 people comprising 104,951 households, 60,083 children and young people aged (0-19 years), 53,000 residents who are not white British and approximately 43,000 students. The population of Southampton is predicted to rise by nearly 5.5% by 2023, with the over 65s and under 15s populations projected to increase by approximately 15% and 5% respectively.

The over 65s population is projected to increase by 15% by 2023; this ageing population will have an increasing impact on demand for health and social care services in the city. Poor lifestyles also continue to hold back health improvement in Southampton, with smoking prevalence, childhood obesity (in Year 6) and alcohol-related hospital admissions in particular, being significantly higher than the national average. This is all influenced and compounded by poor living circumstances (wider determinants) such as deprivation, which are lowering life chances. Inequalities in health and wellbeing outcomes are clearly evident in the city and there is no evidence that this inequality gap is narrowing.

5.1 The Southampton Locality

Until the abolition of the Southampton City Primary Care Trust in March 2013, the city was divided into areas based upon groups of GP practices that worked together in ‘localities’ (consisting of two ’Better Care Clusters)’ to manage and commission services relevant to their area (Figure 1). These are no longer used in the CCG, but are still referred to in the JSNA as a way of segmenting the city. The below historic map is illustrative of that former division and included here for reference purposes. This PNA has not divided the city into localities but considered Southampton as a whole for the purpose of pharmaceutical services.

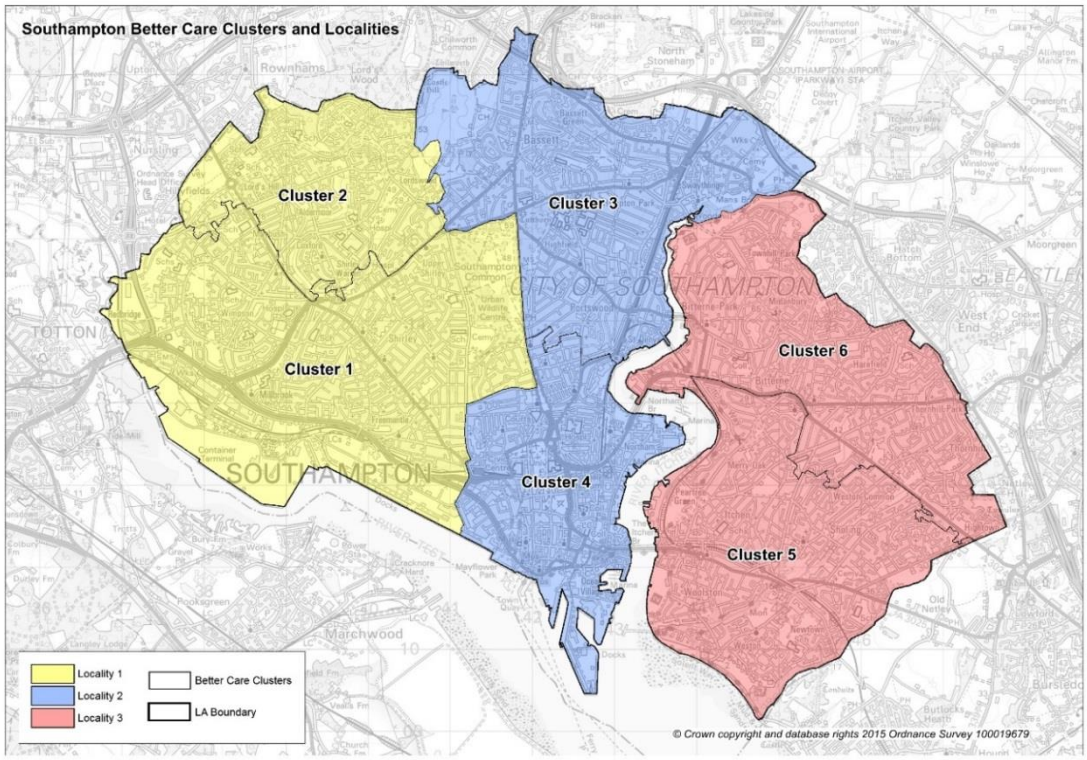


Figure 1. Southampton Better Care Clusters and localities

Other NHS services can affect the need for pharmaceutical services. These include hospital and community services as follows.

There are four hospital sites in Southampton:

- Southampton General Hospital (SGH), part of University Hospital Southampton NHS Foundation Trust, provides a range of services including through the Emergency Department, outpatient clinics and specialist services.
- Princess Anne Hospital (PAH), part of University Hospital Southampton NHS Foundation Trust, provides services including maternity care, fetal and maternal medicine services and breast screening.
- Southampton Children's Hospital (SCH), part of University Hospital Southampton NHS Foundation Trust, is a major centre for specialist paediatric services in the south of England.
- The Royal South Hants Hospital (RSH) provides a wide range of outpatient, day and inpatient surgical operations, diagnostic procedures and sexual health services. Some services are provided by Care UK and others by University Hospital Southampton NHS Foundation Trust. The sexual health services are provided through Solent NHS Trust. A minor injuries unit (MIU) which offers treatment, advice and information on a range of minor injuries is located on this site.

Patients attending these, on either an inpatient or outpatient basis, may require prescriptions to be dispensed. There are three hospital pharmacies providing services; an inpatient pharmacy serving patients at SGH, PAH and SCH, a pharmacy for outpatients located at SGH and the third pharmacy is located at RSH. These pharmacies are operated by UHS Pharmaceutical Service.

NHS Southampton CCG had 30 member GP practices at August 2017[5]. The GP out of hours service is provided by UHS Pharmaceutical Service. There are 36 NHS dental practices providing NHS dental services and 15 opticians in the Southampton City Health and Wellbeing Board area[6]. A behaviour change service ("Southampton Healthy Living") commissioned by Southampton City Council supports individuals with smoking, alcohol and weight management issues.

[5] NHS Choices; NHS Southampton CCG; accessed via http://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=89740
[6] NHS England Area Team; personal communication on 2nd October 2017

6. Current Pharmaceutical Services

NHS Act 2006[7] sets out the definition for pharmaceutical services.

6.1 Community Pharmacy

At 1st October 2017, Southampton has 43 community pharmacies providing NHS services. The pharmacies are distributed across the city predominantly in shopping and residential areas. These pharmacies can be divided into pharmacies providing a minimum of 40 hours of NHS pharmaceutical services each week and those providing 100 hours of NHS pharmaceutical services per week. Since the previous PNA, one community pharmacy has been removed from the pharmaceutical list (on 1st September 2017) as the result of a consolidation application.

There are 39 pharmacies providing '40 core hours' of service and 4 pharmacies providing '100 core hours' of service. The majority of 40 hour pharmacies choose to open for longer and these additional hours are referred to as supplementary hours.

6.2 Distance Selling Pharmacies

Southampton has no distance-selling pharmacies. Distance selling pharmacies provide services solely to customers who do not attend the premises, for example internet services only. However, Southampton residents may choose to have their prescriptions dispensed from any pharmacy across the country including distance selling pharmacies. This trend is anticipated to increase, in line with other internet shopping trends, particularly as more electronic prescriptions are produced by prescribers.

6.3 Dispensing Doctor

None of the GP practices in Southampton are on a dispensing doctor list. GP practices can only apply for consent to dispense in rural areas. This facility is available to patients who live at a distance of more than one mile from pharmacy premises. Southampton is a totally urban area and the conditions for such an application would not arise.

6.4 Local Pharmaceutical Services Scheme

Southampton has no Local Pharmaceutical Services pharmacies (LPS). These are pharmacies that provide a service tailored to specific local requirements. A typical example would be for very rural areas where a pharmacy opening to provide pharmaceutical services would not be financially viable without this type of arrangement. Again due to the urban nature of Southampton with a wide distribution of pharmacies the conditions for this type of application to the pharmaceutical list cannot be identified.

6.5 Dispensing Appliance Contractor

Southampton has one dispensing appliance contractor (DAC). This type of contractor only supplies appliances e.g. stoma care products (rather than medicines). Many prescriptions for specialist appliances are dispensed by specialist appliance contractors, located across the country and provide delivery services. All pharmacies within the city are also able to dispense appliances.

[7] http://www.legislation.gov.uk/ukpga/2006/41/contents

6.6 Pharmacies close to Southampton boundaries

Consideration has been taken of pharmacies providing pharmaceutical services just outside the Southampton City boundary. The city is located on the south coast and is surrounded by Hampshire. The New Forest National Park is situated to the west of the city and a major motorway, the M27, is located along the northern boundary of the city area as well as Southampton Airport.

Examining dispensing data shows that some prescriptions prescribed by Southampton GPs are dispensed in the surrounding areas of Totton to the west of the city and Hedge End, Hamble, West End and Bursledon to the east of the city. These are within the Hampshire Health and Wellbeing Board area.

Generally these pharmacies located on the boundaries are providing additional choice for people residing in Southampton but they do not provide additional pharmaceutical services, e.g. a greater range of opening hours or services, compared to pharmacies located within Southampton.

6.7 Pharmaceutical Needs assessment map

The PNA requires a map that shows all current pharmaceutical service providers. Figure 2 is the designated map as required by paragraph 7 of Schedule 1 of the 2013 Regulations. This map will be updated, during the lifetime of this PNA, when pharmacy premises open, close or relocate. This map shows the locations of the 43 community pharmacies and one dispensing appliance contractor.

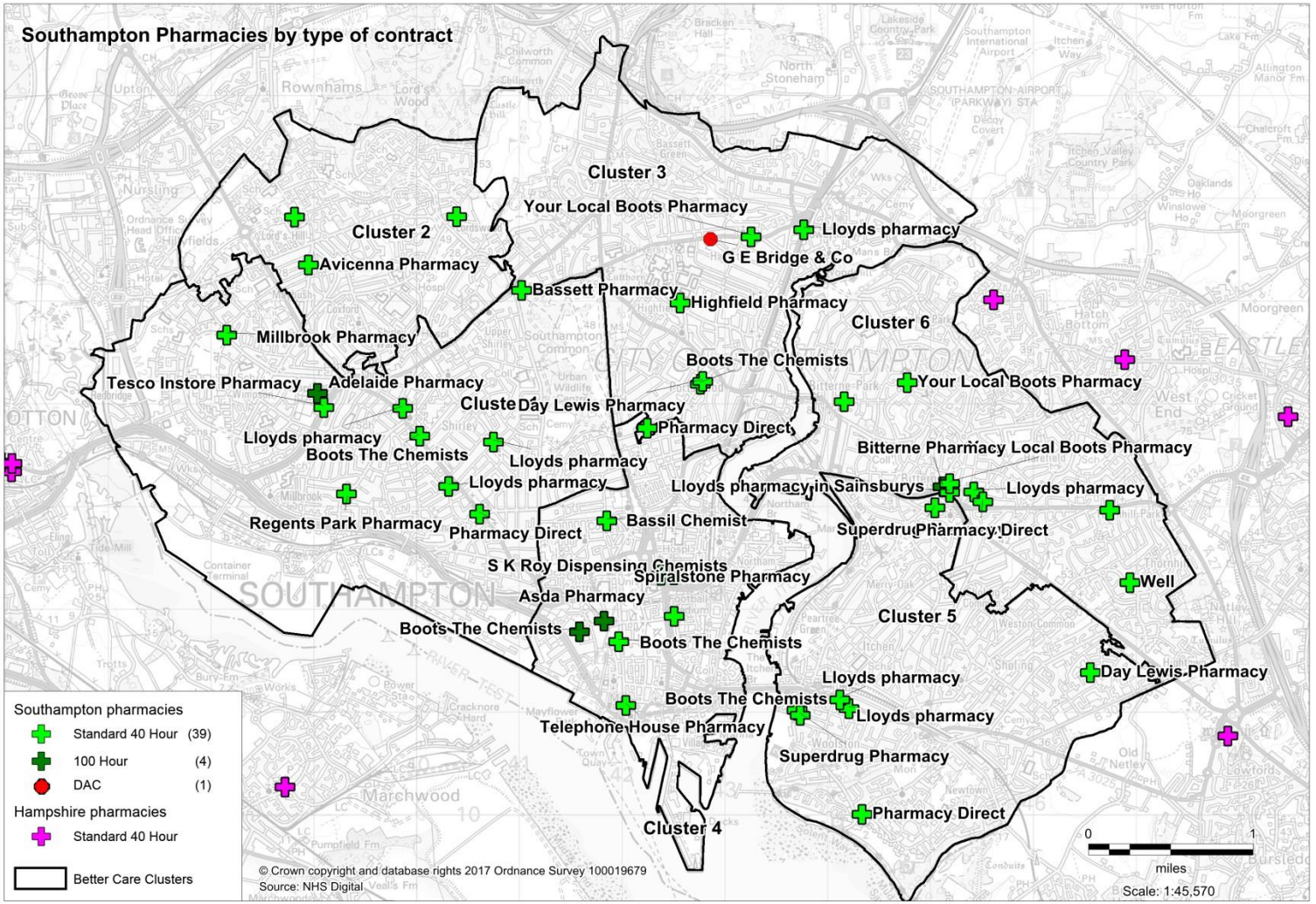


Figure 2. The map detailing the location of Pharmaceutical Service providers in Southampton; and the nearest providers outside the city (Sept 2017)

7. NHS Pharmaceutical Services

The PNA has considered the general accessibility to all pharmaceutical services.

The NHS regulations have split Pharmaceutical services into Essential Services, Advanced Services and Enhanced Services. The delivery and access to each of these services levels is considered within this PNA.

7.1 Access to Pharmaceutical Services[8]

7.1.1 Opening hours

The opening hours used in this section are based on the total opening hours (both 'core' and 'supplementary' hours) as held by NHS England for July 2017. This is based on the 43 community pharmacies in the city at 1st October 2017. The removal of one contractor from the pharmaceutical list did not change these opening hours. Details of individual pharmacy opening times can be found on the NHS Choices website[9].

Many pharmacies that provide a minimum of '40 core hours' of NHS pharmaceutical service also extend these hours of service, opening into the evening and/ or opening on Saturday afternoon and Sunday. This gives a broad range of opening hours for the pharmacies located across the city.

7.1.2 100 hour core hour of service pharmacies

There are four '100 hour pharmacies' in the city which opened using the 'necessary or expedient' test under the 2005 exemptions to the market entry system. These pharmacies provide 100 core hours per week of pharmaceutical services. They have given Southampton residents greater access to pharmaceutical services by extending opening hours both in the morning and late into the evening plus extended weekend coverage. These pharmacies meet an identified need for pharmaceutical services for both 'out of hours' dispensing services and for the general population who wish to seek professional help for health and lifestyle advice, treating minor ailments and conditions that may be managed by self-care.

[8] Public Health data held following PNA questionnaire/ data collection from Portsmouth pharmacies June 2014
[9] NHS Choices website - available at http://www.nhs.uk/Pages/HomePage.aspx

7.1.3 Opening hours Morning

For early morning access seventeen pharmacies open before 9am on weekdays. There is good geographical spread across the city of pharmacies with early opening.

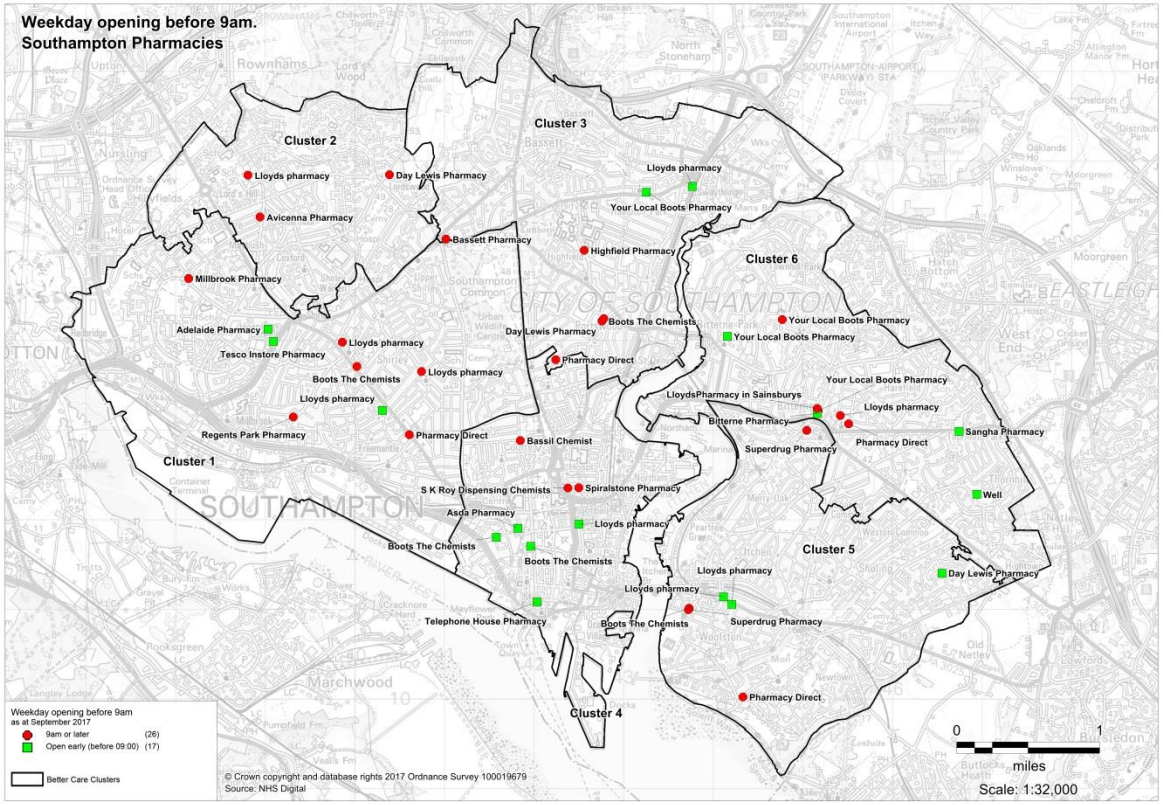


Figure 3. Map of weekday morning opening times for community pharmacies in Southampton, as at July 2017

7.1.4 Opening Hours Lunchtime

There is access to NHS pharmaceutical services throughout the lunch period (12pm to 3pm) in twenty-five local pharmacies. Thirteen pharmacies are closed for one hour during lunch, and a further one pharmacy for up to an hour and 15 minutes. The remaining four pharmacies are closed for 30 minutes or less.

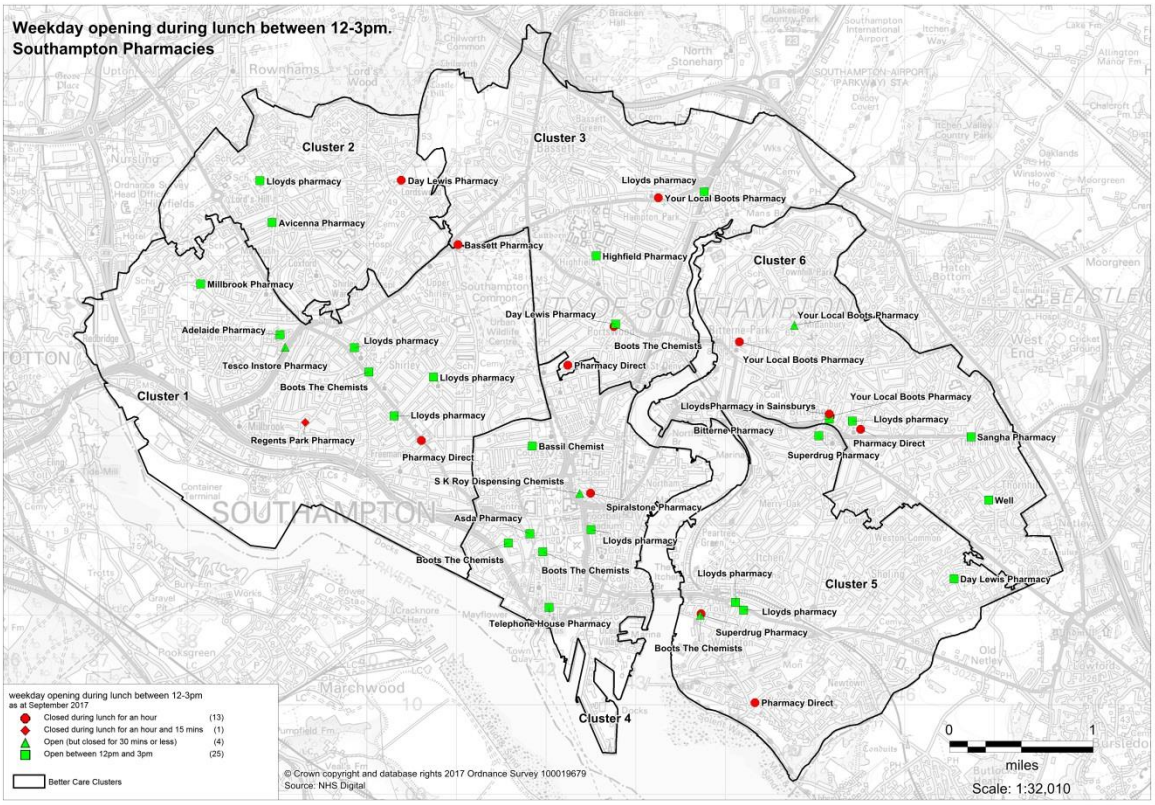


Figure 4. Map of weekday lunchtime opening times for community pharmacies in Southampton, as at July 2017

7.1.5 Opening Hours Evening

Five pharmacies are open late in the evening between 8pm and 11pm. Another ten pharmacies are open between 6.30pm and 8pm. The remaining twenty-eight are closed by 6.30pm.

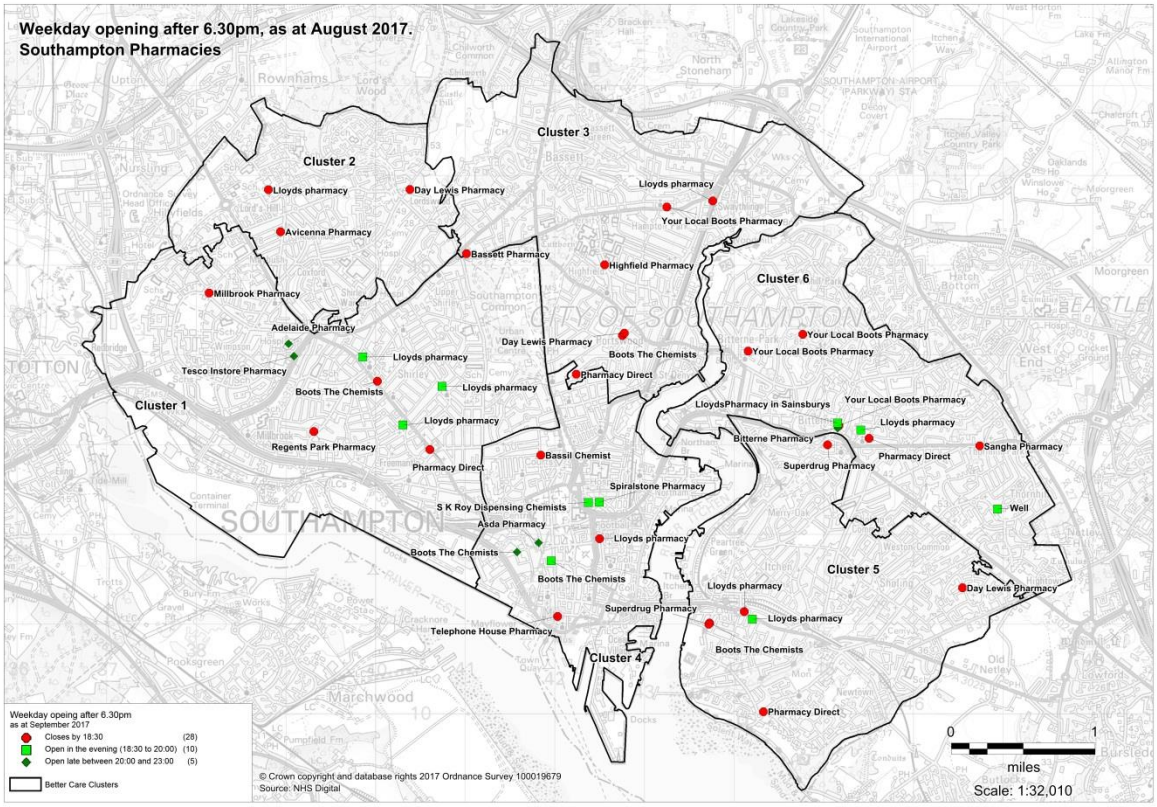


Figure 5. Map of weekday evening opening times for community pharmacies in Southampton, as at July 2017

7.1.6 Saturday opening

The majority of GP practices are open for at least a part of the day on a Saturday with only two pharmacies closed all day. Twenty pharmacies close at 2pm or before, fourteen are open during the hours of 2pm to 6.30pm and seven are open after 6.30pm.

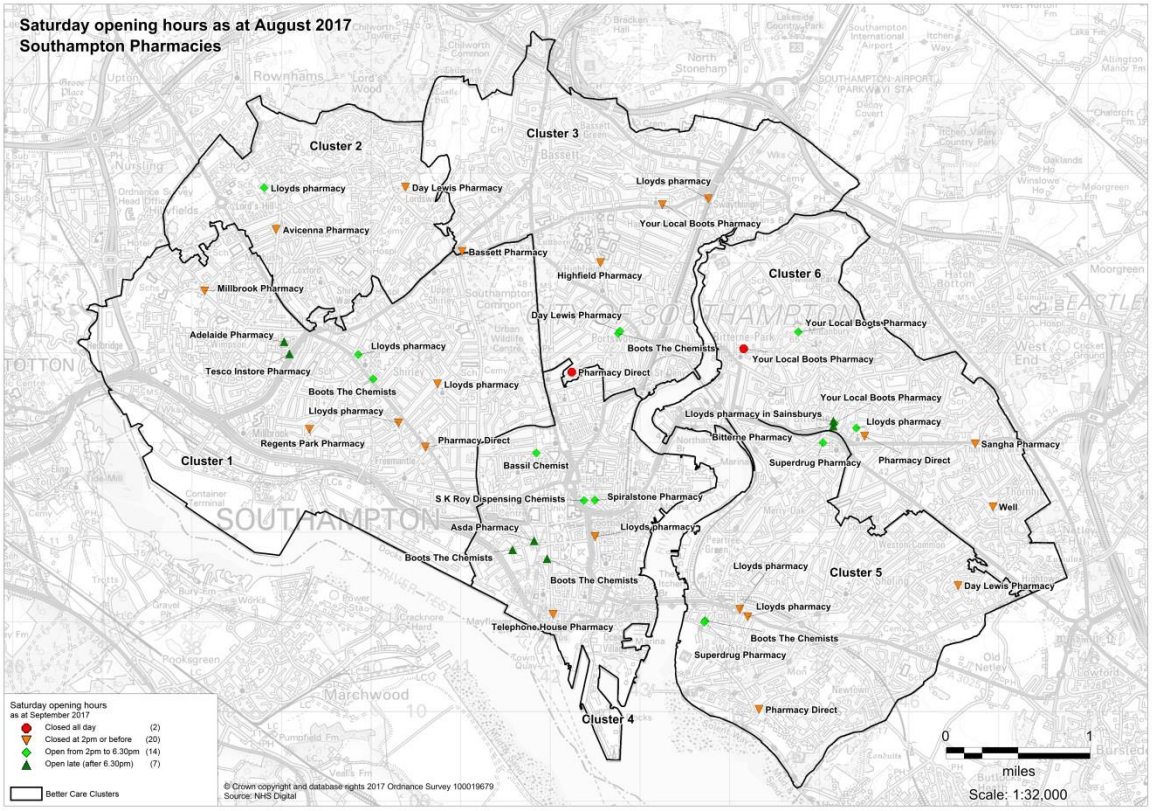


Figure 6. Map of Saturday opening times for community pharmacies in Southampton, as at July 2017

7.1.7 Sunday opening

Seven pharmacies are open regularly on a Sunday. For four of these pharmacies the Sunday trading laws limit opening times to six hours only with typical closing times being 4pm, 4.30pm or 5pm. Two pharmacies open from 10am to 5pm or later and the remaining one pharmacy is open before 10am to after 5pm.

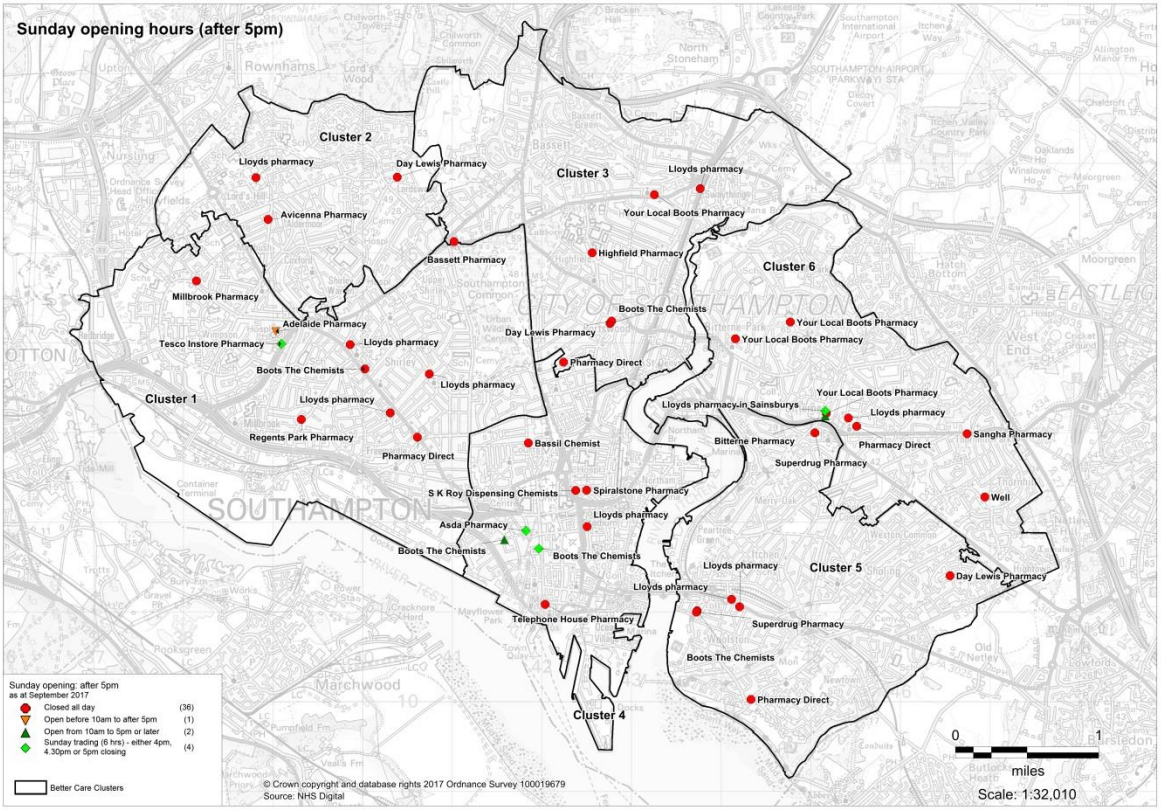


Figure 7. Map of Sunday opening times for community pharmacies in Southampton, as at July 2017

7.1.8 Bank Holiday

Community pharmacies are not required to open on bank holidays. For major bank holiday such as Christmas Day and Easter Sunday, voluntary opening by a small number of pharmacies has ensured sufficient pharmaceutical services for the city to enable urgent prescriptions to be dispensed and self-care remedies to be purchased. NHS England can direct pharmacies to open on bank holidays if required and NHS England have a rota of pharmacies for opening on Christmas Day and Easter Sunday.

Details of opening times for these holidays are published on the NHS Choices website and are usually available on the NHS Southampton City CCG website.

There is also a GP out of hours service provided by UHS Pharmaceutical service.

The Emergency Duty Pharmacist (EDP) is available when Community Pharmacy Contractors are closed (accessible by the GP out of hours service and the community nursing service), currently, this is normally:

- Midnight to 8am Mon-Sat
- 5pm Sunday – 8am Monday
- 5pm on Public Holiday – 8am next working day
- Christmas Day All Day
- Boxing Day All Day
- New Year’s Day All Day
- Easter Sunday All Day

7.1.9 Access Distance

5.1.1.1 Pharmacies with buffer zone of 1.6km

All pharmacy locations within Southampton with a buffer zone of 1.6km Euclidean distance (straight line) demonstrates that the Southampton population can access a pharmacy within 1.6km (approximately one mile) or less from almost all parts of the city (assuming it's possible to travel in a straight line) (Figure 8). The small area in the west of cluster 1 shown in Figure 8 to be outside the 1.6km buffer zone is sufficiently covered by pharmaceutical provision in Totton. The area on the northern edge of the city in cluster 3 shown in Figure 8 to be outside the 1.6km buffer zone is also just beyond the 1.6km distance from the nearest pharmacy in Hampshire (Asda in Chandler's Ford). This is a very small area in one of the least deprived areas of the city which has good access to a pharmacy by car (section 5.1.1.2). There is considered to be sufficient access to pharmaceutical services to meet the needs of these residents.

5.1.1.2 Driving

In 'rush hour' in Southampton (normal speed limits but taking into account junctions, crossings and traffic lights with the additional congestion data and road density analysis), a pharmacy in Southampton should still be accessible within a four minute drive for most parts of the city, with only a few small areas with low residential density being an eight minute drive or more from a pharmacy (Figure 9).

5.1.1.3 Cycling

Seventy-six percent of the Southampton population are within a four minute cycle ride of a pharmacy; and 99% of the population are within an eight minute cycle ride - this assumes a cycle speed of 15km per hour (kph) or 9.3 miles per hour (mph). This of course assumes all people have access to a bike and can ride a bike; nevertheless for those that do have access and can ride a bike it assumes that cycling to a pharmacy is a reasonable option.

5.1.1.4 Public Transport (Rail in particular)

Residential areas of Southampton are well covered by bus stops and bus routes; therefore access to pharmacies in Southampton are well served. There are also eight railway stations in Southampton and 99% of the Southampton population are within a 20 minute rail journey of a pharmacy. In addition, Southampton is well served with 24 hour taxi services at prices not too dissimilar to bus and rail prices.

5.1.1.5 Walking

Over 99% of the population can reach a pharmacy in Southampton within a 20 minute walk (assuming the average walking speed is 3.1 mph) and this is especially the case in the more densely populated areas of Southampton. Nearly 40% of the Southampton population is within a five minute walk of a pharmacy. The total Southampton population is within a 25 minute walk of a pharmacy (Figure 10).

5.1.1.6 Proximity to GP Practices

The location of GP surgeries are in relative proximity to a pharmacy (Figure 11).

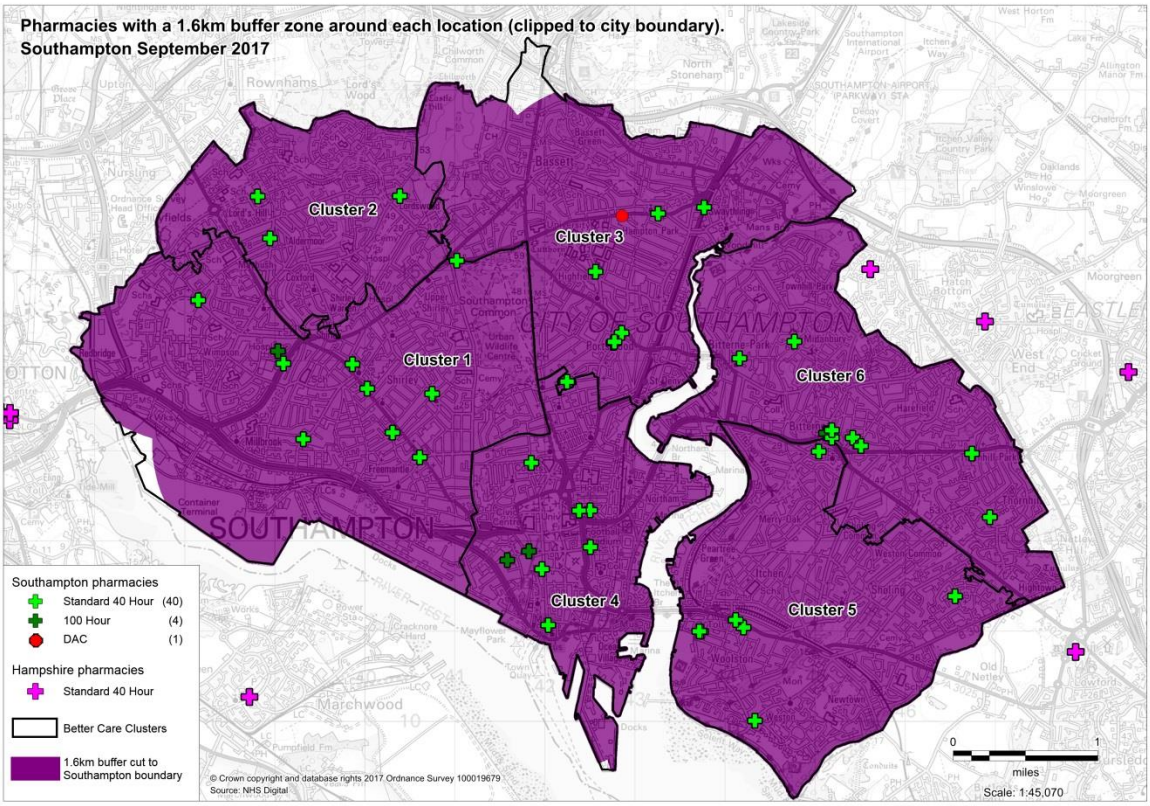


Figure 8. Map of pharmacies with a 1.6km straight line buffer zone (purple), Southampton.

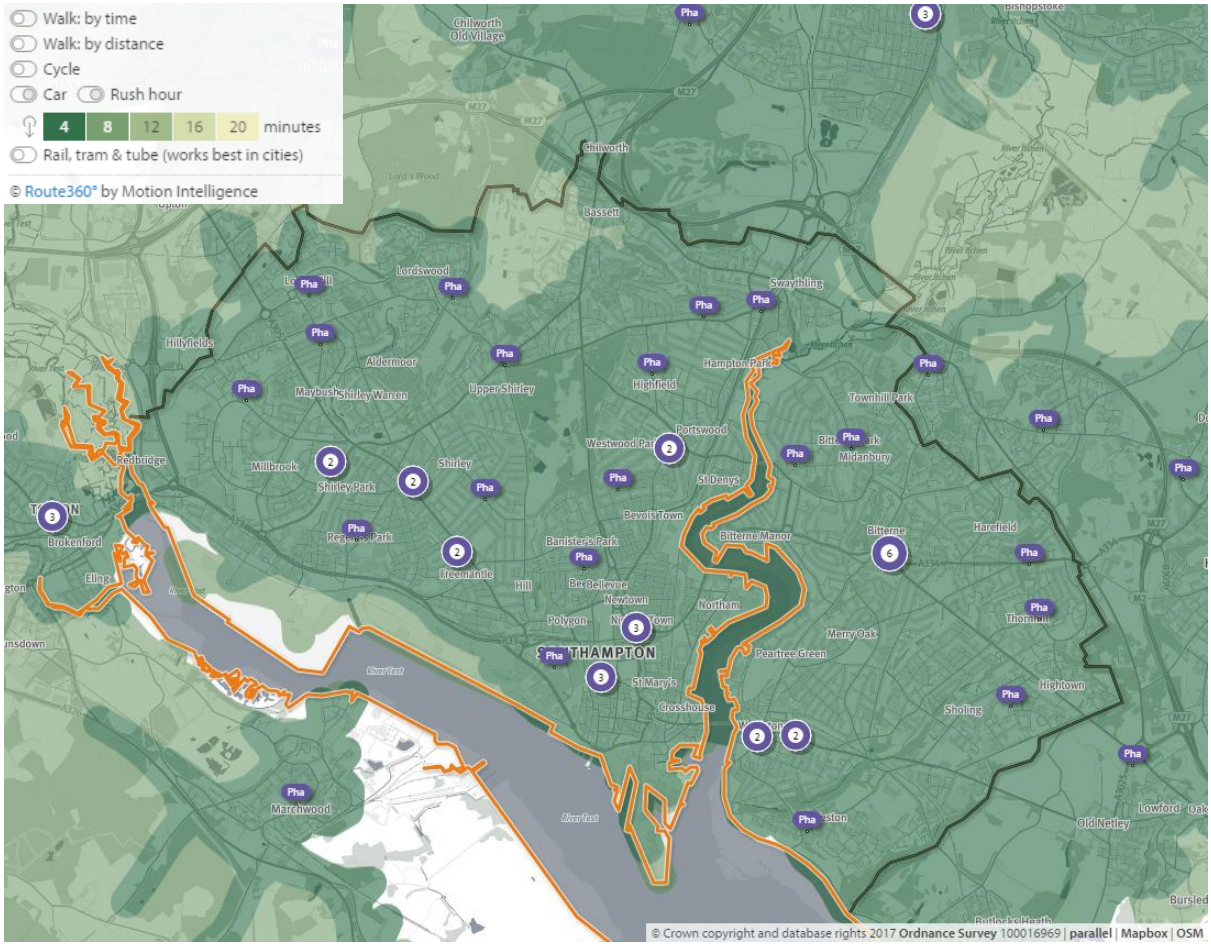


Figure 9. Map of drive times in rush hour from pharmacies (excluding distance selling) in Southampton and outside of the local authority boundary. Source: SHAPE place, Public Health England.

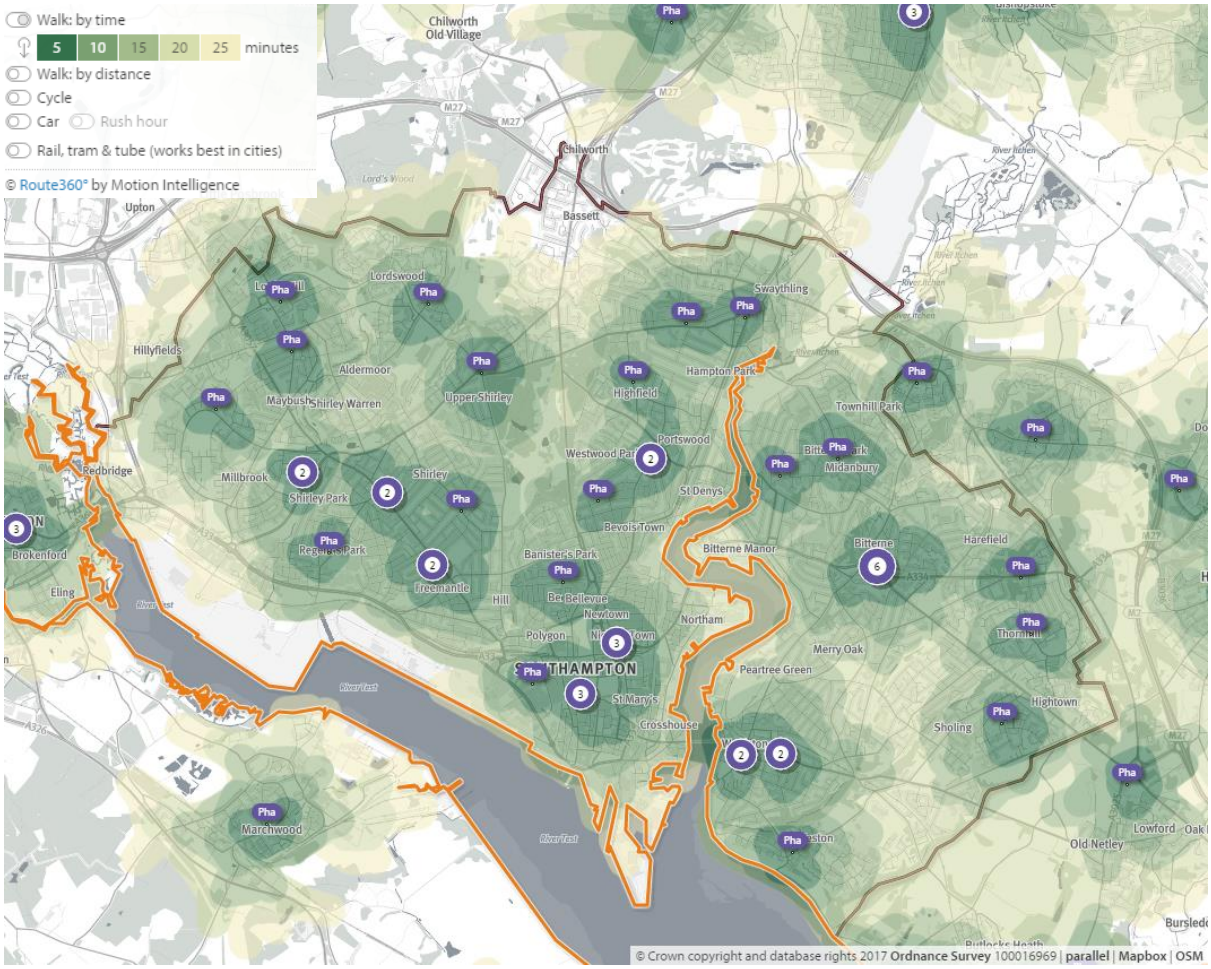


Figure 10. Map of walking times (5-25 minutes) from pharmacies in Southampton (excluding distance selling) and outside of the local authority boundary. Source: SHAPE place, Public Health England.

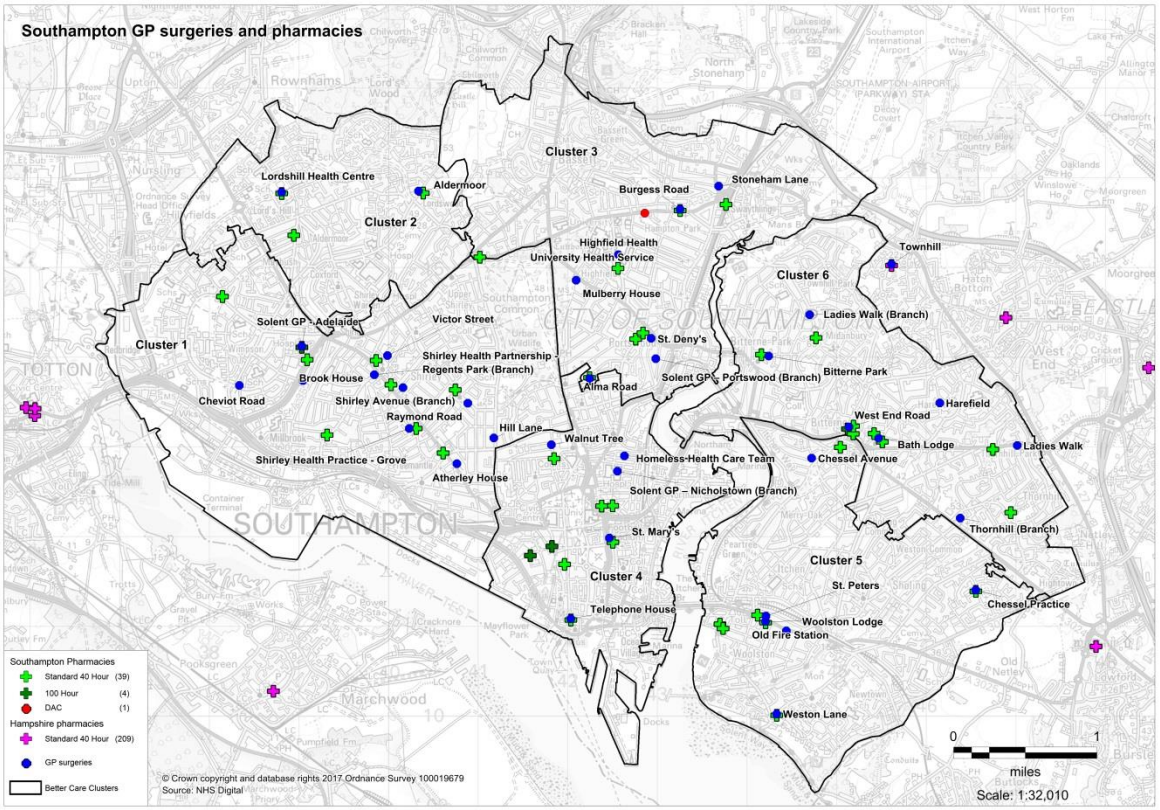


Figure 11. Map of GP surgeries proximity to pharmacies in Southampton (September 2017).

7.1.10 Access for residents with additional needs

The contractor questionnaire was issued to all community pharmacies and the DAC in Southampton and was open from 7th June until 14th August 2017. This resulted in 31 responses.

Housebound

The survey of pharmacies indicated that 96.8% (30/31) of pharmacies who responded will collect prescriptions from GP practices across the city. The majority, 27, of pharmacies stated they provide a delivery service to residents. 24 pharmacies said that they provide this free of charge, providing a service to housebound patients and others.

All pharmacies can give telephone advice to housebound and other residents.

Equality Act

Businesses and health care professionals have responsibility under the Equality Act to make reasonable adjustment to their services to facilitate access by people affected by disability. For pharmacy this is part of their terms of service. Typical examples of adjustments for premises adjustments include wheelchair/ buggy ramps, doors sufficiently wide to allow wheel chairs, consultation rooms with wheelchair access and hearing aid loops. Typical examples of amendments to services include collection of prescriptions; home delivery of prescriptions and other goods from pharmacy; adding easy opening lids to medicine bottles; large print labels; provision of compliance charts and other aids to help use eye drops and inhalers.

Access Languages

The pharmacy workforce in Southampton embraces a range of nationalities and cultural backgrounds. The recent survey showed that 27 different languages were spoken from amongst Southampton staff. It is not unusual for residents who are from other countries and cultures to seek out services from a pharmacy that speaks their native language.

These were the languages identified from individual pharmacies:

Arabic	German	Polish	Telugu
Bengali	Gujarati	Punjabi	Turkish
Cantonese	Hindi	Romanian	Urdu
Czech	Italian	Russian	
English	Latvian	Slovak	
Farsi	Mandarin	Somali	
Filipino	Nigerian	Spanish	
French	Pashto	Swahili	

7.2 Essential Services

Essential Pharmaceutical services are provided by all community pharmacies and cover those services that any member of the public would anticipate receiving from a community pharmacy on the high street. They include:

- dispensing prescription medicines and appliances
- repeat dispensing and electronic prescribing services
- disposal of unwanted medicines
- providing support for self-care
- promoting healthy lifestyles
- signposting
- clinical governance.

7.2.1 Dispensing NHS prescriptions

A range of nationally[10] and locally available statistics[11] has been researched to determine whether there is sufficient capacity within Southampton pharmacies to dispense prescriptions generated within the city.

In 2016-2017 there were 3,849,300 items prescribed by Southampton GPs dispensed across the country. 98% of these prescription items are dispensed through less than 100 sites. Further analysis of these 100 sites shows that:

- 92% of these prescriptions are dispensed within Southampton community pharmacies;
- 4% are dispensed in the surrounding area e.g. Totton, Hedge End, Hamble, West End and Bursledon;
- 2% are personally administered items, which are bought in and used by the GP practice e.g. vaccinations;
- 0.4% dispensed by specialist appliance suppliers;
- 0.65% dispensed by distance selling pharmacies.

Density of pharmacies

Based on the number of community pharmacies on the pharmaceutical list at 31st March 2017, Table 1 shows that Southampton had 18 pharmacies per 100,000 population compared to 19 per 100,000 for the Wessex region. This is slightly fewer than for the rest of England but remains unchanged following the removal of one contractor from the pharmaceutical list following a consolidation application which took effect from 1st September 2017. The average numbers of prescription item dispensed each month per pharmacy was similar to Wessex and slightly higher than the England average. Overall, this demonstrates that the number of pharmacies and their dispensing work load is broadly in line with national averages.

[10] NHS Business services
[11] Epact data held by NHS Southampton CCG for April 2016-March2017

	Number of community pharmacies	Prescription items dispensed per month	Population Mid 2015 [12]	Pharmacies per 100,000 population	Average number of dispensed items per pharmacy per month
ENGLAND	11,688	82,940,000	54,786,327	21	7,096
WESSEX	511	3,752,000	2,762,546	19	7,342
Southampton (CCG)	44	320,775	249,537	18	7,290

Table 1. Community pharmacies on a pharmaceutical list at 31 March 2017 (prior to consolidation application which took effect from 1st September 2017), prescription items dispensed per month and population by NHS England Region 2015-16[13]

7.2.2 Repeat Prescribing and Electronic Prescription Service

All GP practices and pharmacies in the city are enabled to dispense in accordance with the Electronic Prescription services and all actively participate in the programme. NHS Southampton City CCG is actively encouraging the uptake of both electronic prescribing and electronic repeat dispensing services by providing specialist support to GP practices and pharmacies. These services can be beneficial to patients by reducing the number of visits they make to their GP practice to collect routine prescriptions for long term conditions.

The latest statistics from NHS England demonstrate the success of these programmes (Table 2).

January – March 2017 Percentage of all items prescribed as electronic prescribing as a proportion of all prescription items.[i]	
England	53.86%
Southampton	56.83%
April 2016 – March 2017 Percentage of all electronic prescription service items prescribed as electronic repeat dispensing	
England	12.18%
Southampton	3.16%

Table 2. Items prescribed as electronic prescribing items in Southampton and England

Other Essential Services including disposal of unwanted medicines; providing support for self-care; promotion of healthy lifestyles; signposting and clinical governance are provided by all pharmacies in the city.

7.3 Advanced Services

There are six advanced services that may be provided by any community pharmacy as long as they meet the necessary requirement to deliver the service and are on the pharmaceutical list.

- Medicines Use Review (MUR)
- New Medicine Service (NMS)
- Appliance Use Reviews (AUR)

[12] Source: ONS Mid-2015 Population Estimates for Clinical Commissioning Groups in England, by single year of age, Persons (National Statistics)

[13] Sources: NHS Prescription Services part of the NHS Business Services Authority

4 Population data - Office of National Statistics (2011 mid-year Estimates based on 2011 census)

- Stoma Appliance Customisation (SAC)
- Flu Vaccination Service
- NHS Urgent Medicine Supply Advanced Service (NUMSAS)

7.3.1 Medicine Use Reviews

Medicine Use Review (MUR) and prescription intervention service allows accredited pharmacists to undertake structured adherence review with patients on multiple medicines, particular for those receiving medicines for long term conditions. The service helps patients understand their therapy, the best time to take the medicine, discussion about side-effects and adherence with the prescribed regimen, which may identify any problems the patient is experiencing along with possible solutions. The number of MURs is capped at 400 per pharmacy.

For April 2016 - March 2017, NHS England data show all 44 pharmacies in Southampton were accredited to deliver the MUR service. The average for the city was 322 MURs per pharmacy at a rate of 3.7 MURs per 1000 items dispensed.

7.3.2 New Medicine Service

The service provides support for people, with long-term conditions and who have newly been prescribed a medicine. The aim of the services is to help improve medicines adherence; it is initially focused on particular patient groups and conditions; asthma and COPD, diabetes (Type 2), antiplatelet /anticoagulant therapy and hypertension.

For April 2016 - March 2017, NHS England data show 35 of the 44 pharmacies (80%) were accredited to deliver the New Medicine Service for these patient groups providing 3,626 provisions of service. The average for the city was 82 per pharmacy.

7.3.3 Appliance Use Reviews

Appliance Use Reviews (AURs) can be carried out by a pharmacist or a specialist nurse in the pharmacy or at the patient's home. AURs should improve the patient's knowledge and use of any listed appliances that include stoma care products.

NHS England data shows little activity is recorded for this service. The contractor questionnaire issued to all community pharmacies and the DAC in Southampton had 31 responses. Two of these responses reported the pharmacy to provide the AUR service and one reported they would soon be providing the service. It is recognised that the AUR service is for a limited number of patients. Many GP practices have provided information to patients eligible to receive these services about appliance reviews carried out by pharmacy or by specialist nurses offering appliance reviews within a patient's own home. Patients have good access to these services.

7.3.4 Stoma Customisation Services

Stoma customisation services aim to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste. This service is for a very limited number of patients, many of whom may access this service from specialist appliance contractors located outside the city, who operate a mail order service. Patients have a good choice of providers for this specialised service. These patients may also access specialist nurse services.

For April 2016 - March 2017, NHS England data show eight pharmacies were accredited to provide this service in the city.

7.3.5 Flu Vaccination Service

The seasonal influenza vaccination programme aims to protect those who are most at risk of serious illness or death should they develop influenza, by offering protection against the most prevalent strains of influenza virus. This advanced service aims to support an effective vaccination programme in England by building capacity of community pharmacies as an alternative to general practice and improving convenience for eligible patients to access flu vaccinations.

For April 2016 - March 2017, NHS England data show 37 of the 44 pharmacies (84%) were accredited to deliver flu vaccinations although 35 delivered the service. A total of 3,628 vaccinations were given during this time period. The average number of flu vaccinations for the city was 82 per pharmacy.

7.3.6 NHS Urgent Medicine Supply Advanced Service

The NHS Urgent Medicine Supply Advanced Service (NUMSAS) is running in some areas of the country as a pilot service until end March 2018. It is not yet operating in Southampton. It is a service that manages a referral from NHS 111 to a community pharmacy because they need urgent access to a medicine or appliance that they have been previously prescribed on an NHS prescription, enabling access to medicines or appliances out of hours.

7.4 Enhanced and other locally commissioned services

Enhanced services are listed in the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013[14] and the provision in Southampton is summarised below.

Service	How this need is met
No specifically commissioned service	
Anticoagulant Monitoring	This service is available through a local commissioning arrangement with GP practices.
Care Home service	This is not currently commissioned in Southampton. However, is likely to become available through a local commissioning arrangement with GP practices during 2017/18.
Disease specific medicines management service	Training opportunities to increase knowledge about local clinical pathways is provided through a varied range of educational and information resources for all health staff within the locality.
Gluten free food supply service	Available via GP prescription.
Independent prescribing service	This service is not required at this time from community pharmacies as the need for prescribing is met by GPs.
Home delivery service	There is a widespread voluntary service provided by local community pharmacies which meets this need.
Language access service	NHSE commission translation services on behalf of Wessex in GP practices and pharmacies when required. However it is

[14]Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/193012/2013-03-12_-_Advanced_and_Enhanced_Directions_2013_e-sig.pdf

	recognised that a wide variety of languages are spoken within Southampton pharmacies and residents may choose to use a particular pharmacy for that reason.
Medication review service	The MUR service meets the need for medication reviews at this time.
Medicines assessment and compliance support	The MUR and NMS meet the need for medicines assessment and compliance support at this time.
Prescriber support service	Pharmacists working in GP practices are an emerging role nationally.
Schools service	This service is not required at this time from community pharmacies.
Stop Smoking Service	To ensure a consistent approach, to start during 2017/18, pharmacies will be reimbursed for referring individuals to stop smoking support through the behaviour change service commissioned by Southampton City Council.
Supplementary Prescribing Service	This service is not required at this time from community pharmacies as the need for prescribing is met by GPs.
Service commissioned by NHS England Wessex Area Team	
Out of hours service	Pharmacy Urgent Repeat Medicine Service (PURMs) is commissioned by NHS England Wessex Area Team
Emergency supply	Pharmacy Urgent Repeat Medicine Service (PURMs) is commissioned by NHS England Wessex Area Team. In addition, see detail in the previous section regarding the NHS Urgent Medicine Supply Advanced Service (NUMSAS).
Service commissioned by NHS Southampton City CCG	
Minor ailment service	Commissioned by NHS Southampton City CCG
On demand availability of specialist drugs	Palliative care drugs service commissioned by NHS Southampton City CCG
Service commissioned by Southampton City Council, Public Health	
Needle and Syringe Exchange Service	Commissioned by Southampton City Council, Public Health
Patient Group Direction service (not related to public health services)	Emergency Hormonal Contraception (via a PGD) is commissioned by Southampton City Council, Public Health
Screening Service	NHS Health Checks are commissioned by Southampton City Council, Public Health
Other service not named in the Regulations	A supervised consumption service is commissioned by Southampton City Council, Public Health

7.4.1 Pharmacy Urgent Repeat Medicine Service

This is a locally commissioned service that allows participating pharmacies to make emergency supplies (which are usually private transactions) at NHS expense. Normal prescription charges apply unless the patient is exempt in accordance with the NHS Charges for Drugs and Appliances Regulations. The pharmacist will only make a supply where they deem that the patient has immediate need for the medicine and that it is impractical to obtain a prescription without undue delay. In 2017/18, thirty-eight community pharmacies were accredited to provide this service.

7.4.2 Minor ailment service

Minor ailments are defined as common or self-limiting or uncomplicated conditions which can be managed without medical intervention. The management of patients with minor self-

limiting conditions, impacts significantly upon GP workload. The situation is most acute where patients do not pay prescription charges and may not have the resources to seek alternatives to a prescription from their GP. It is estimated that one in five GP consultations are for minor ailments and by reducing the time spent managing these conditions would enable them to focus on more complex cases.

A minor ailments scheme has been in place within Southampton for two years. The scheme started as a pilot project and had good spread across the city. The public are encouraged to use this scheme especially to relieve pressure on other services within the healthcare system over the winter period. The service is available in all areas of the city and now covers 26 conditions. In 2017/18, twenty pharmacies were taking part in the scheme.

7.4.3 Palliative Care Service

Drugs used for palliative care reasons can be required at short notice and are not items which are routinely stocked at all community pharmacies. This scheme aids accessibility to these drugs for individuals who are being cared for in community settings. In 2017/18, seven community pharmacies were accredited to provide this service.

7.4.4 Needle and Syringe Exchange Service

Needle Exchange services for injecting drug users are a crucial component in providing a comprehensive harm reduction programme. These schemes prevent blood born viral infections within the illicit drug addiction community. In 2017/18, six pharmacies provided Needle Exchange services.

7.4.5 Emergency Hormonal Contraception

The supply of Emergency Hormonal Contraception was available free through 41 of the community pharmacies with contracts in Southampton in 2017/18. During 2017/18 this service will become available to only those aged under 25 years as this is where the greatest need is and to encourage use of Long Acting Reversible Contraception (LARC).

7.4.6 NHS Health Checks

NHS Health Checks were launched as a national programme in April 2009. The check is offered to residents who are aged between the ages of 40 and 74, once every five years, to assess risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk. Pharmacies offering the service proactively targets patients. A pharmacist also visits a gym on a regular basis to offer a check to gym-goers. In 2017/18, eight pharmacies had a contract to offer this service alongside all of the GP practices in the city. Having a pharmacy service offers residents more choice and access.

7.4.7 Supervised consumption

Methadone and buprenorphine (oral formulations), using flexible dosing regimens, are used for maintenance therapy in the management of opioid dependence, as part of a programme of supportive care. To aid compliance, administration of these medications can be supervised which also provides routine and structure for the client in helping to promote a move away from chaotic and risky behaviour. In 2017/18, the current supervised scheme was contracted to run through 12 pharmacies.

5.1.2 TCAM (Transfer of Care around Medicines)

Community pharmacy and hospital pharmacy colleagues in Southampton have been working together with Wessex Academic Health Science Network (AHSN) to improve care for recently discharged patients where it is thought there would be potential benefit of a further intervention. TCAM was a new service in Southampton in September 2017. It aims to ensure patients receive appropriate support from their community pharmacist soon after leaving University Hospital Southampton NHS Foundation Trust.

Hospital pharmacists will use PharmOutcomes (a secure software system) to refer patients nearing discharge to the patients chosen local community pharmacy. A member of the community pharmacy team will then contact the patient ideally within three days to arrange for them to come in for a consultation. This visit may then result in the completion of a Medicines Use Review, New Medicine Service and/or other suitable services; such as repeat dispensing, home delivery, stop smoking, flu vaccination. Evidence has shown real benefits to patients receiving such interventions through reduced readmission rates back into hospital and improved health outcomes[15].

7.5 Healthy Living Pharmacies

The Healthy Living Pharmacy (HLP) framework is a tiered commissioning framework aimed at achieving consistent delivery of a broad range of high quality services through community pharmacies to meet local need, improving the health and wellbeing of the local population and helping to reduce health inequalities[16].

The Department of Health (DH) introduced a Quality Payments Scheme as part of the Community Pharmacy Contractual Framework in 2017/18. HLP status is included in this scheme.

The 31 respondents to the contractor questionnaire identified whether they were regarded as a Healthy Living Pharmacy (HLP). Four reported having achieved HLP status with the remainder working towards HLP status (Table 3).

Healthy Living Pharmacy	Total
Yes	4 (12.9%)
Working towards HLP status which will be achieved by 1st April 2018	21 (67.7%)
Working towards HLP status but will not be achieved by 1st April 2018	5 (16.1%)
Not working towards HLP status	1 (3.2%)

Table 3. Healthy Living Pharmacy status reported by community pharmacies in Southampton, at July 2017

[15] Robinson, S; Hospital e-referral initiative boosts post-discharge MURs in community pharmacies; The Pharmaceutical Journal (2015); accessed via http://www.pharmaceutical-journal.com/your-rps/hospital-e-referral-initiative-boosts-post-discharge-murs-in-community-pharmacies/20068940.article?adfesuccess=1

[16] PSNC; Healthy Living Pharmacies accessed via http://psnc.org.uk/services-commissioning/locally-commissioned-services/healthy-living-pharmacies/

8. Public engagement

The public survey which gathered views about pharmaceutical services in the city received 205 responses. Of the total, 143 had complete responses (i.e. all questions were seen although answers may have been skipped for some) for which the results are presented here.

Residents from all areas of the city were represented in the survey with SO17 having the lowest number of responses.

The age profile of respondents is given in Table 4. Over three-quarters of respondents (76.9%) were 45 years of age and over. Approximately two-thirds of respondents were female (65.4%).

Table 4. Age profile of respondents to the public survey

Age	Number of respondents
Under 16	0
16-24 years	2
25-34 years	10
35-44 years	16
45-54 years	22
55-64 years	27
65 years and over	61
Unknown	5
Total	143

Other respondent information included:

- Nearly nine in every ten respondents (88.1%) identified themselves as White British.
- Almost half (47.6%) of respondents identified themselves to be retired and over a fifth of respondents (22.4%) were in full-time employment.
- 13 (9.1%) respondents identified themselves to be registered as disabled and a further 23 (16.1%) identified themselves to be disabled but unregistered.
- More than one in every seven (14.7%) respondents identified themselves to be a formal or informal carer.

Most respondents (90.9%) reported using the same pharmacy all or most of the time. The reason and frequency given for using a pharmacy is shown in Figure 12. Of those who indicated how frequently they get a prescription for themselves, almost six in every ten (58.7% of 138) stated using pharmacies at least once a month. Of those who indicated how frequently they get a prescription for someone else, just over a quarter (26.2%) stated using pharmacies for this reason at least once a month.

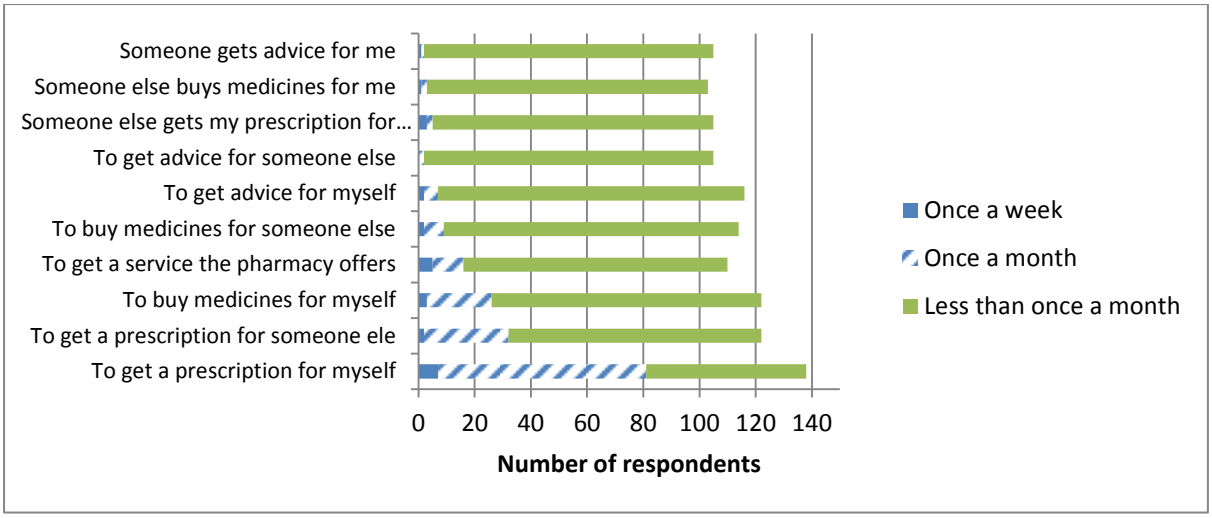


Figure 12. Reason and frequency given by survey respondents for using a community pharmacy

When asked if there is a more convenient or closer pharmacy that for some reason they didn't use, 49 (34.3%) responses said 'Yes', citing the following as reasons for not doing so (respondents were able to select more than one reason):

- The service is too slow (24 responses)
- It is not easy to park (17 responses)
- I have had a bad experience in the past (16 responses)
- They don't have what I need in stock (15 responses)
- It is not open when I need it (8 responses)
- There is not enough privacy (5 responses)
- It is not wheelchair / buggy friendly (0 responses)

When accessing the pharmacy themselves, 46 respondents (32.2%) said it took less than five minutes with 86 respondents (60.1%) reporting it took between 5 and 15 minutes. Overall, getting to a pharmacy was deemed easy by almost three-quarters of respondents (72.7%) and difficult by only a small number. Six in every ten (59.4%) respondents reported walking to the pharmacy with almost another third (32.2%) using a car and only 4.9% using a bus.

The most convenient time for the respondents to use a phamacy is during standard working hours of 9am to 5pm. The evening period until 8pm is also popular with a lesser number of people identifying late evening and early morning (before 9am) as convenient. Respondents were invited to select all the time slots which were most convenient for them Table 5.

	Normal weekday	Saturday	Sunday	Total respondents
Before 9am	49.4%	31.8%	18.8%	
	42	27	16	85
Between 9am and noon	40.4%	37.7%	22.0%	
	90	84	49	223
Between noon and 2pm	38.8%	36.7%	24.5%	
	57	54	36	147
Between 2pm and 5pm	41.9%	35.5%	22.7%	
	72	61	39	172
Between 5pm and 8pm	49.2%	29.8%	21.0%	
	61	37	26	124
After 8pm	45.2%	31.5%	23.3%	
	33	23	17	73

Table 5. Times reported as being convenient to se a community pharmacy by survey respondents

When six in ten respondents could not access their usual pharmacy (61.4% of 88 who responded to the question) they went to another. The majority of the remainder waited until that pharmacy was open (26.1%). In order to access information on the pharmacy, such as opening times and services, searching the Internet was reported as the most common source.

The knowledge of respondents in respect of services offered by community pharmacies varied, with the availability of flu vaccination and home delivery services the most widely recognsied (61.1% of 131 and 60.0% of 125 respondents respectively) Table 6. A comparatively small proportion had used these services. The service which had been used by the largest number of respondents was the medicines review service (16.2% of 130).

	I know they offer this service	I didn't know this service was on offer	I have used this service	Total
Flu vaccination	61.1%	34.4%	4.6%	131
Home delivery	60.0%	36.8%	3.2%	125
Medicine reviews	42.3%	41.5%	16.2%	130
Heart health check ups	39.5%	59.7%	0.8%	129
Treatment for minor ailments	38.9%	58.7%	2.4%	126
Morning after pill	35.8%	61.0%	3.3%	123
Cholesterol check ups	35.7%	64.3%	0.0%	129
Disposal of injecting equipment	23.0%	76.2%	0.8%	122

Table 6. Knowledge of services offered by community pharmacies reported by survey respondents

Half (50.0%) of respondents felt the pharmacy they visit offered information on heatlhy living Table 7. The term 'Healthy Living Pharmacy' seemed to be less familiar to respondents with nine in every ten respondents not knowing whether the pharmacy they visit was accredited.

	Yes	No	Don't know	Total
Is information on healthy living offered at the pharmacy?	50.0% (71)	0.7% (1)	49.3% (70)	142
Is the pharmacy Healthy Living Pharmacy accredited?	8.5% (12)	0.7% (1)	90.8% (129)	142

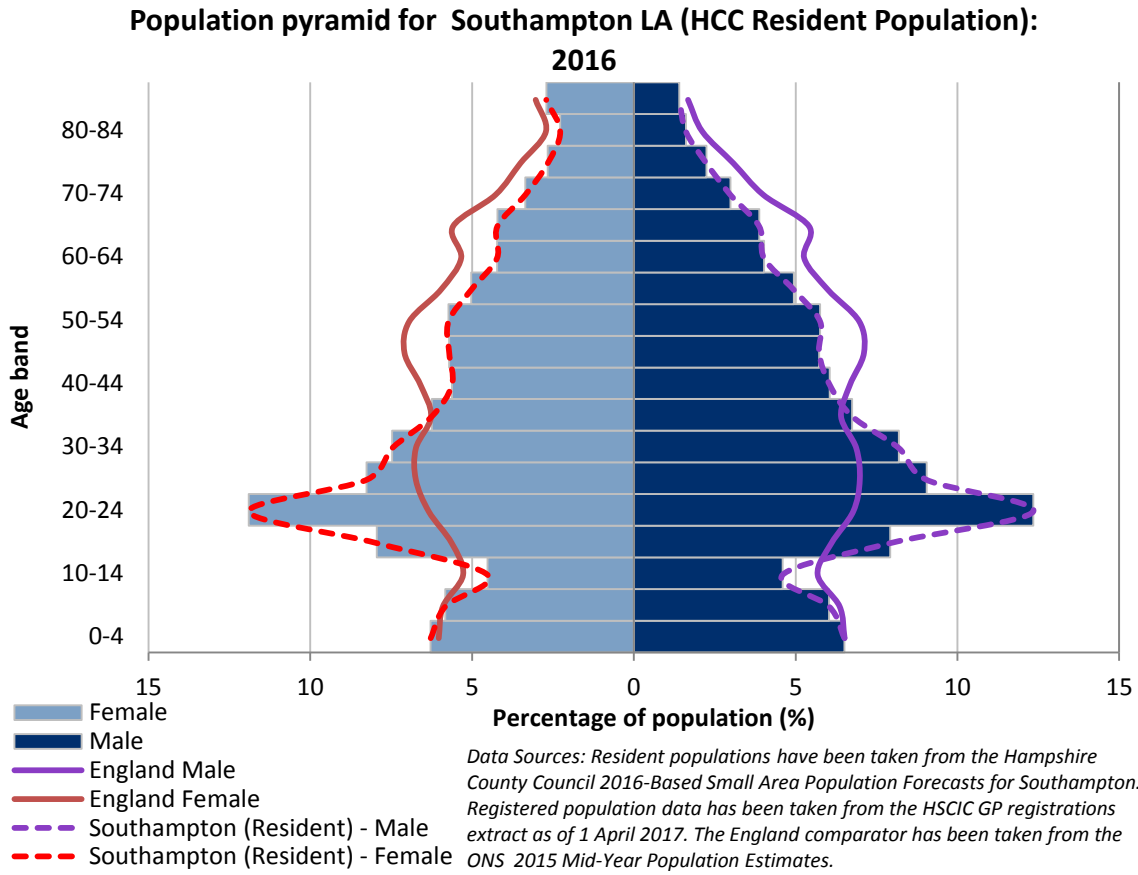
Table 7. Information on healthy living being offered by community pharmacies and Heatlhy Living Pharmacy status as reported by survey respondents

9. Population and demography

9.1 Population

In 2016, the resident population of Southampton is estimated to be to be 251,565 (HCC SAPF) with 282,455 (HSCIC) people registered with GP practices in April 2017. The population pyramid shown below illustrates how the profile of Southampton's population differs from the national average. This is because of the large number of students in Southampton; 20% of Southampton's population is aged between 15 and 24 years, compared to just 12.4% nationally.[17]

Figure 13.



Data Sources: Resident populations have been taken from the Hampshire County Council 2016-Based Small Area Population Forecasts for Southampton. Registered population data has been taken from the HSCIC GP registrations extract as of 1 April 2017. The England comparator has been taken from the ONS 2015 Mid-Year Population Estimates.

[17] Southampton JSNA. August 2017

9.2 Population forecasts

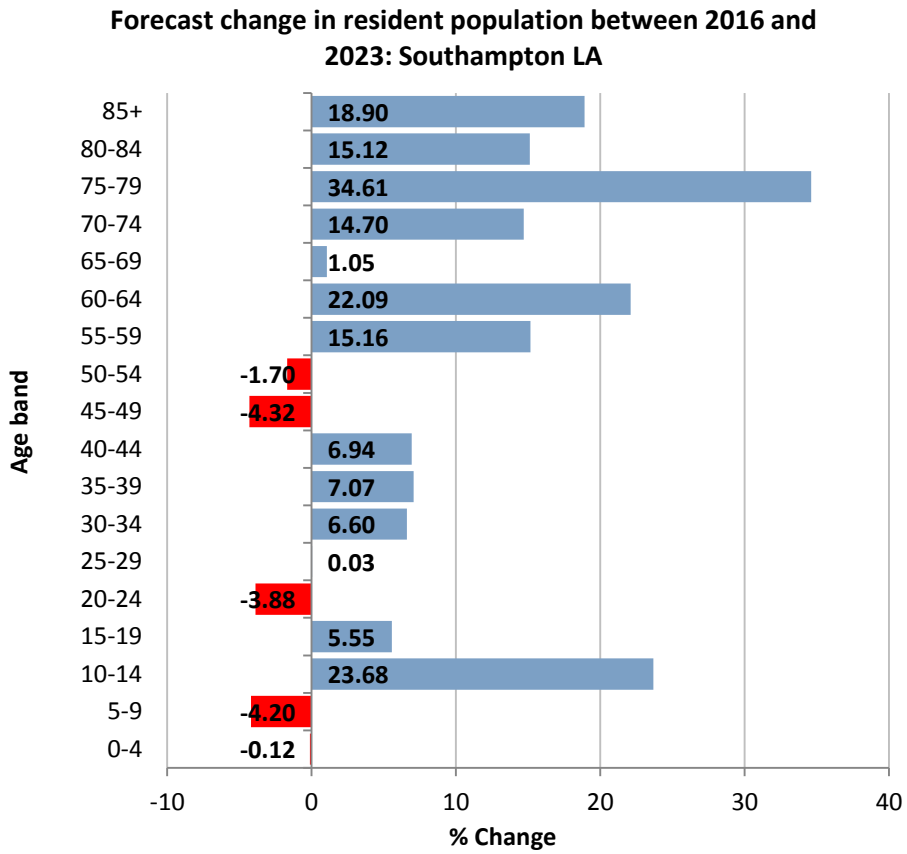
There are many uncertainties around current and future population numbers. The Southampton JSNA currently uses data produced by Hampshire county council (HCC) which incorporates the results of the 2011 Census. Hampshire County Council's small area population forecasts (SAPF) are based on the planned completions of residential dwellings in Southampton, which predict an increase in dwellings of 6,672 (6.4%) between 2016 and 2023. The largest growth in dwellings is predicted to be in Bargate (2,497 dwellings; 26.2%), followed by Woolston (1,014 dwellings; 15%) and Bevois (639 dwellings; 9.3%).

The increase in dwellings across Southampton translates to a population increase of 13,911 (5.5%) between 2016 and 2023. Within the city, the largest growth is predicted to be in Bargate (5,039 people; 21.8%) followed by Woolston (2,311; 15%). Bitterne is predicted to have a loss of approximately 200 or 1.3% of people over the same period.

The older population is projected to grow proportionally more than any other group in Southampton over the next few years (Figure 14.). The over 65 population is set to increase by nearly 5% between 2016 and 2023, with the over 85 population set to increase by nearly 19%. Importantly the proportion of the population of working age is set to increase by only 5% potentially influencing productivity and the skill pool of the resident workforce. It may also have an impact on the informal and community care available to the changing population structure. The chart below shows how the age of population is expected to change up to 2023.[18]

[18] Hampshire County Environment Department's 2016-based Southampton Small Area Population Forecasts

Figure 14.



Data Sources: Hampshire County Council 2016-Based Southampton Small Area Population Forecasts

Life expectancy in Southampton is 78.3 years for males and 82.9 years for females compared to the England averages of 79.5 and 83.1 respectively (2013-15). In addition, although people are living longer, it is often with multiple long term conditions and an extended period of poor health and/or disability. The over 65s population is projected to increase by 15% by 2023 from 34,320 to 39,435 including the number of people over 85 years is forecast to grow from 5,150 to 6,120 , an increase of 19%; this ageing population will have an increasing impact on demand for health and social care services in the city.[19]

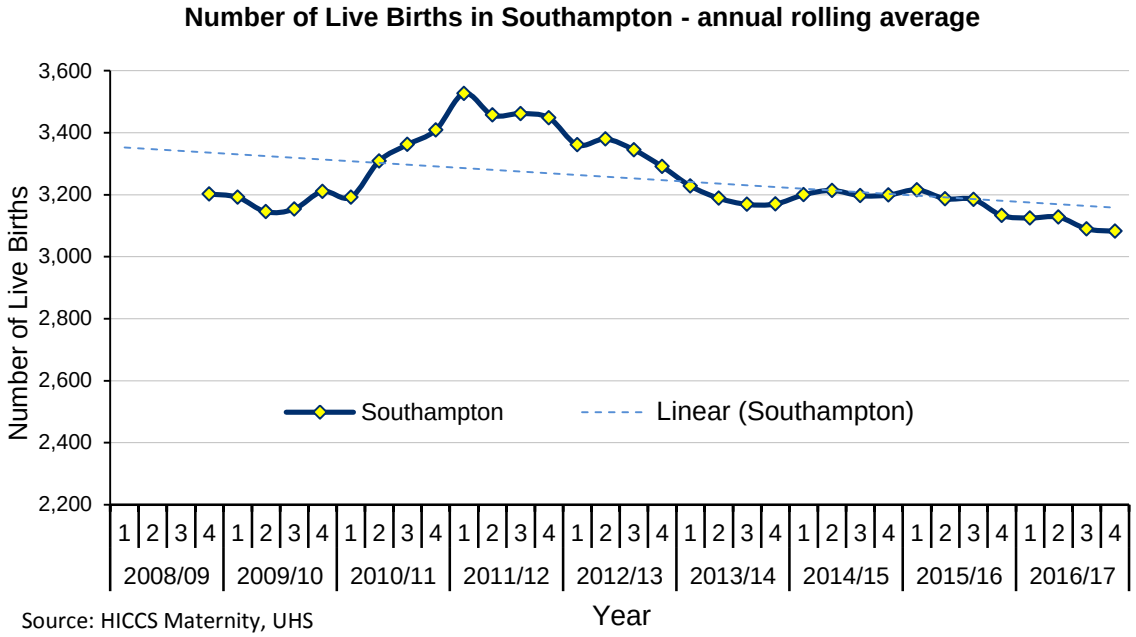
Longer term projections, based on past trends, predict a 38% increase in over 65s in Southampton between 2010 and 2035 with the number of residents in the city aged over 85 reaching 8,500 by 2035.[20]

According to the HCC forecasts, the number of 0-4 year olds will decrease by 0.1% between 2016 and 2023. Local monitoring of births at Southampton University Trust (SUHT) reveals that births have fallen by -3.7% between 2008/09 and 2016/17, although recent data

[19] Hampshire County Environment Department's 2016-based Southampton Small Area Population Forecasts
[20] Office for National Statistics (ONS) subnational population projections. Published 23 May 2016

suggests this may be levelling off (Figure 15). This suggests that, the HCC methodology may be overestimating fertility in Southampton.

Figure 15



Source: HICCS Maternity, UHS

Between 2003 and 2011 general fertility rates in the city have increased from 49.3 to 63.4 per 1000 females aged 15 to 44 years and between 2011 and 2015 general fertility rates in the city have decreased from 63.4 to 56.1 per 1000 females aged 15-44 to 53.2 per 1000 females.

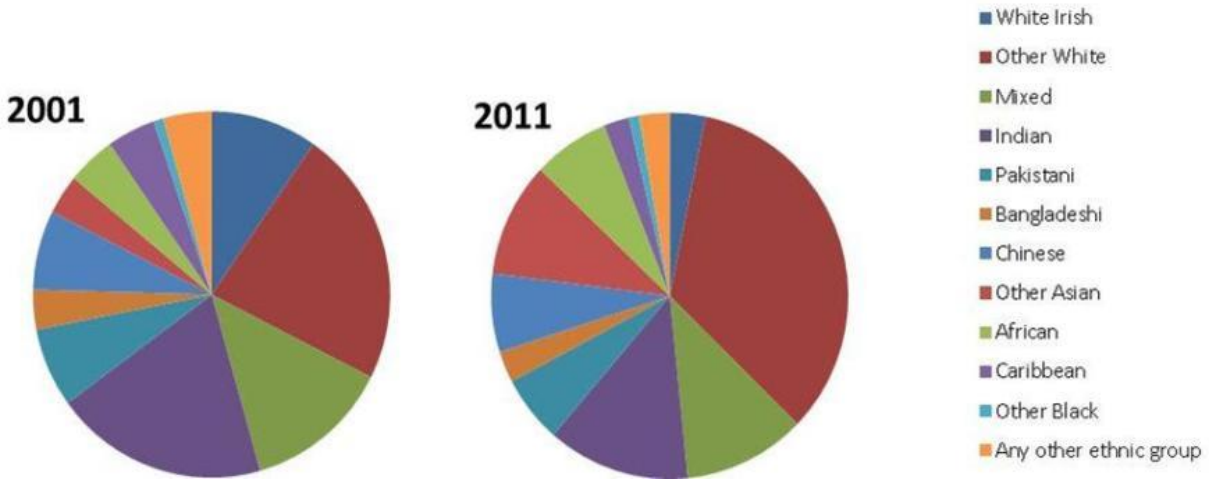
In 2015, the general fertility rate for Southampton by electoral ward ranged from 92.9 births per 1000 females aged 15 to 44 years in Redbridge to 32.9 births per 1000 females aged 15 to 44 years in Swaythling.

9.3 Ethnicity, migration, language and religion

Since 2004, high levels of economic migration from Eastern Europe have contributed to the development and sustainability of many business activities, thereby bringing in greater richness and diversity to city life. Strong community relations over many decades have contributed to maintaining cohesiveness. Long-term international migration up to the end of June 2015 shows that Southampton has more international incomers than leavers (5,350 compared to 1,820). There is also a high level of internal migration, with 16,100 people arriving and 16,900 leaving over the same period.

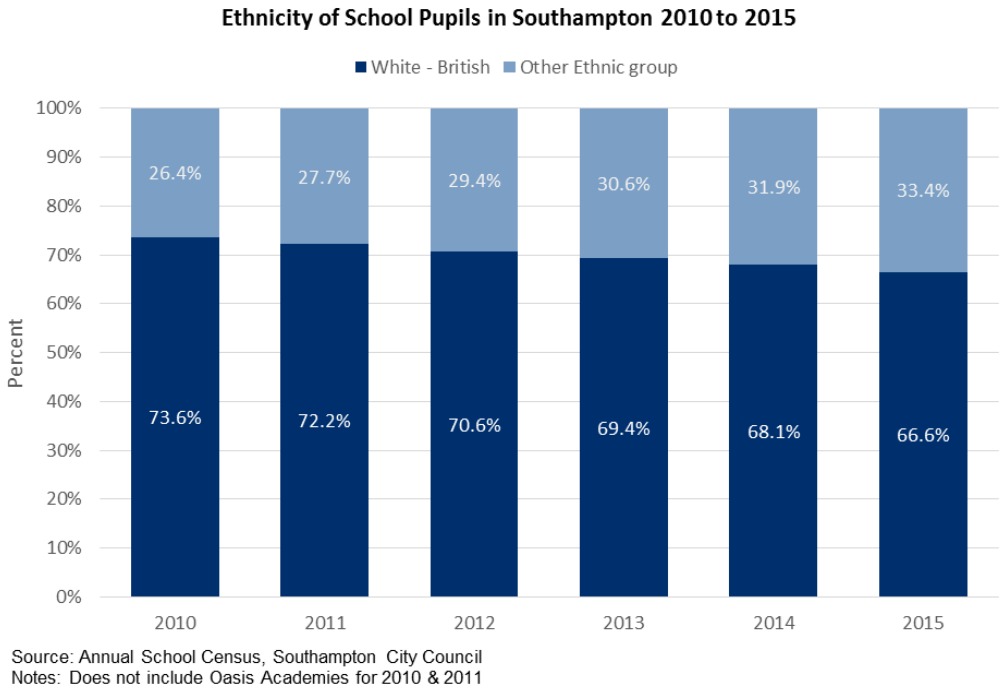
Based on results from the 2011 Census, Southampton now has residents from over 55 different countries who between them speak 153 different languages. In the 2011 Census 77.7% of residents recorded their ethnicity as white-British, which is a decrease of 11% from 2001. The pie charts in Figure 16 show that the biggest change has been in the 'Other White' population (which includes migrants from Europe) as this has increased in last 10 years by over 200% (from 5,519 to 17,461).

Figure 16. Ethnicity of resident population reported in the 2001 and 2011 census



Within Southampton, there is a wide variation in diversity; in Bevois ward, over half of residents (55.4%) are from an ethnic group other than White British compared to 7.6% in Sholing. The annual school census in Southampton in 2015 revealed that 33.4% of pupils were from an ethnic group other than White British. This has increased from 26.4% in 2010 (Figure 17).

Figure 17.

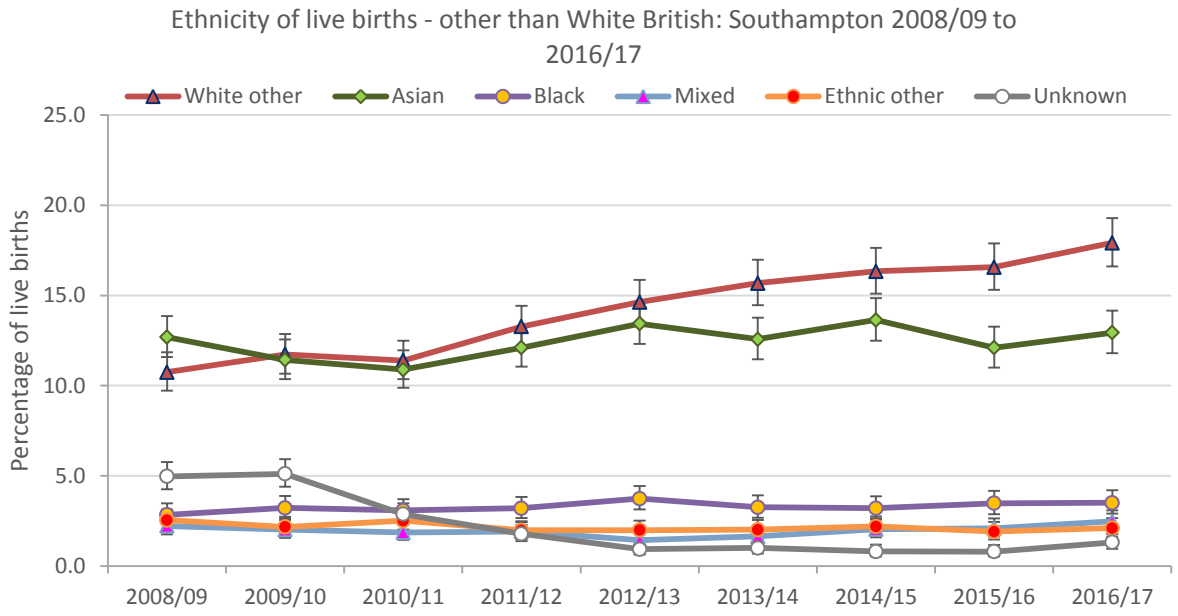


Southampton has a higher proportion of households where no-one has English as their main language (7.7% compared to 4.4% nationally). There are 7,522 households in the city that fall into this category. The school census in 2012 found that 14.1% of school pupils had a

first language other than English; a rise from 8.4% in 2007. In 2007 there were 427 pupils whose first language was Polish but by 2012 this had risen to 1,282[21].

In 2016/17, nearly 39% of live births in Southampton (where ethnicity was known) were non-White British or Irish. Trends in ethnicity of live births show the 'Other White' background has risen most significantly in recent years; from 10.7% (2008/09) to 17.9% (2016/17), see Figure 18. In 2011 17.6% of Southampton residents were born outside UK, compared to 13.8% for England.

Figure 18



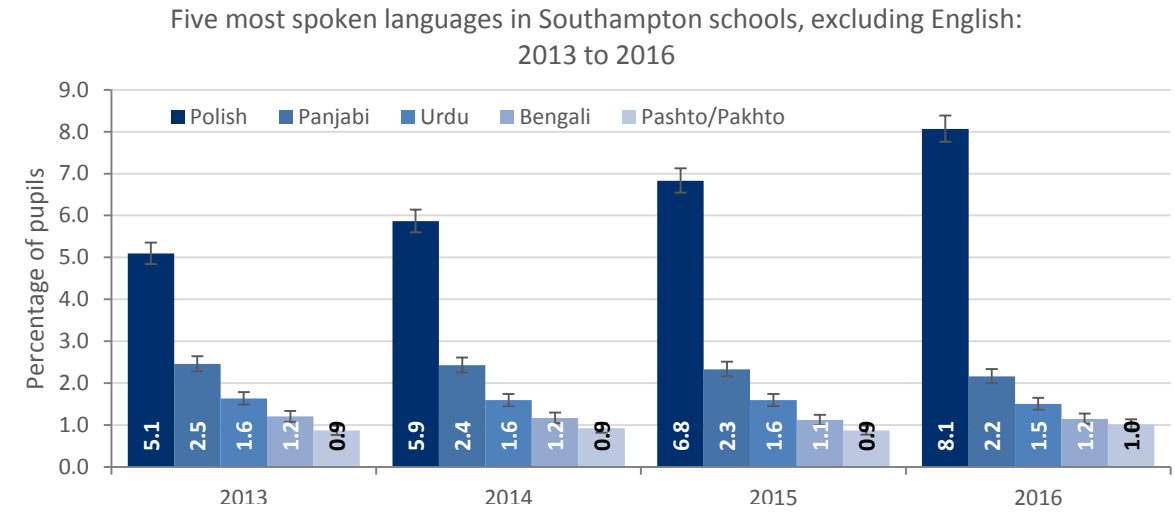
Source: UHS Midwifery database, Southampton CCG

Just under 71% of Southampton residents hold a UK passport, 17.4% hold no passport and 6.5% hold an EU passport. Of the 41,651 people not born in the UK, over 58% have lived here for more than 5 years. Just over 31% of those people born outside the UK are aged 25 to 34 (2011 Census).

In Southampton 7,522 or 7.7% of households have no one in them who speaks English as their main language, compared to 4.4% nationally. In Southampton schools, 7,870 (26.4%) pupils were reported to have a first language other than English. Figure 19 illustrates the main languages (excluding English) spoken by Southampton pupils. In 2013 there were 1,442 (5.1%) pupils whose first language was Polish by 2016, this had risen to 2,405 (8.1%).

[21] Southampton JSNA. September 2014

Figure 19



Sources: Southampton City Council Children's Data Team

The following statistics in Table 8 for self-reported religion of Southampton residents are taken from the 2011 Census.

Table 8. Self reported religion of Southampton residents

Religion	Number	Percentage
Christian	122,018	51.5
No religion	79,379	33.5
Religion not stated	16,710	7.1
Muslim	9,903	4.2
Sikh	3,476	1.5
Hindu	2,482	1.0
Buddhist	1,331	0.6
Other religions	1,329	0.6
Jewish	254	0.1

9.4 Socio-economic factors and measures of deprivation

9.4.1 Southampton's local economy

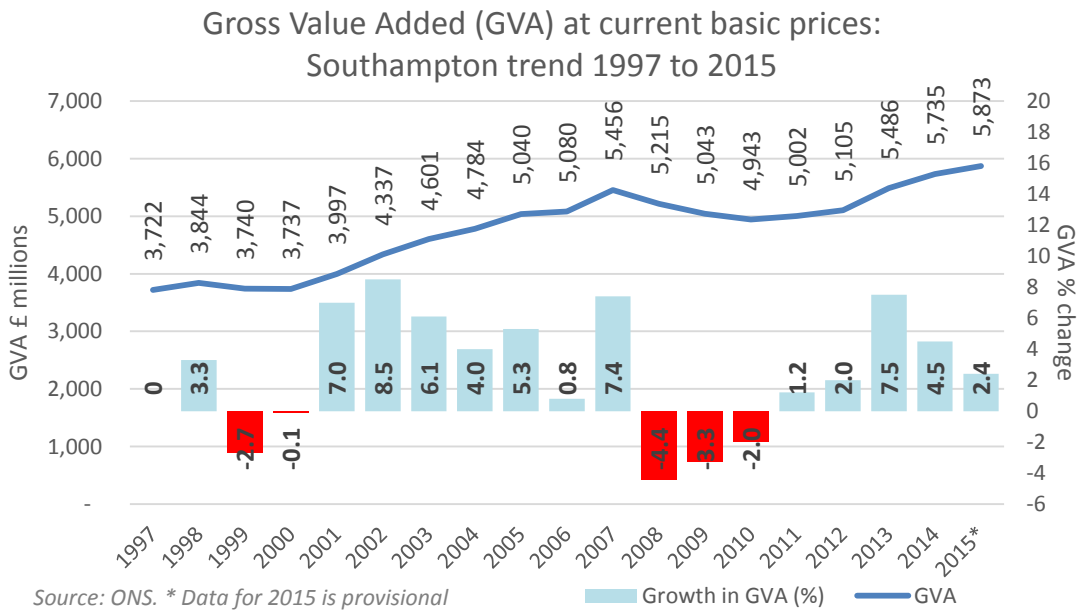
Since 2004, economic migration from Eastern Europe has contributed to the development and sustainability of many business activities, thereby bringing in greater richness and diversity to city life. Strong community relations over many decades have contributed to maintaining cohesiveness. Long term international migration up to the end of June 2015 shows that Southampton has more international incomers than leavers (5,300 compared to 1,800). There is also a high level of internal migration, with 16,100 people arriving and 16,900 leaving over the same period.[22] Based on results from the 2011 Census, Southampton now has residents from over 55 different countries who between them speak 153 different languages.[23] 12% of the population do not have English as a main language; 80% of these can speak good English, 17% can't speak it well and 3% can't speak English at all.[24]

The city contains a major deep sea port which hosts the largest cruise passenger operation in the UK and is Europe's leading turnaround cruise port (1.8 million passengers in 2015). It is also the UK's number one vehicle handling port (820,000 vehicles every year) and the UK's most productive container port.[25] Major employers include the council, the NHS, the University of Southampton and Southampton Solent University, Carnival, Old Mutual Wealth and DP World (container port). The city has 4 million visitors a year for retail and leisure activities and its night time economy has grown in recent years.

In 2015, the Southampton economy was worth £5.9 billion and contributed 12.3% to the Hampshire Economic Area economy (£48 billion) and 2.4% to the overall South East England economy (£249 billion).[26] Southampton was particularly affected by the 2008 economic crisis and subsequent recession. Overall, the local economy shrunk from £5.5 billion in 2007 to £4.9 billion in 2010; a fall of 9.4%. In comparison over the same period, the overall Hampshire Economic Area economy grew by 4.4% and national economy by 3.3%. However, since 2010 the economy in Southampton has recovered dramatically, with Gross Value Added (GVA) rising steadily from a low of £4.9 billion to £5.9 billion in 2015, an overall increase of 18.8%. In fact, since 2010, the Southampton economy has grown at an annual rate of 3.8%, which is higher than the overall Hampshire Economic Area (2.9%) and similar to the England and South East averages (3.9%). These changes are illustrated in Figure 20.

[22] ONS Migration ending June 2015
[23] Southampton City Council (2015) Children's Data Team
[24] ONS 2011 Census
[25] Associated British Ports Website (2017) http://www.abports.co.uk/Our_Locations/Southampton/
[26] ONS (2016) Regional Gross Value Added (Income Approach) 1997 to 2015: December 2016

Figure 20



9.4.2 Major regeneration projects

Southampton has many regeneration projects recently completed or underway. Within the city centre, brownfield regeneration specialists; Inland Homes, will be developing the 350 homes and a new park at Itchen Riverside. 300 apartments are being built through the redevelopment of the Fruit and Vegetable Market with Hampshire and Regional Property Group, and also over 1,000 homes at the former Vosper site at Centenary Quay through Crest Nicholson. 1,000 new properties have been developed via the City Centre Masterplan since 2012/13.

Southampton's £90 million new leisure and dining hub with a landmark 10 screen cinema over 20 restaurants and a new high quality public plaza for the city supported by the Government's Regional Growth Fund opened in December 2016. This includes a new public square in front of the city's historical medieval walls.

The new Cultural Quarter, building on SeaCity and O2, has brought significant investment, cultural and economic benefits, which since 2013 has included the £40 million new development of Studio 144 Arts Centre with Grosvenor Developments. New restaurants and bars have boosted the growing night-time economy.

The potential behind Southampton's globally-important university base is being maximised, including through the relocation of Lloyds Register with the University of Southampton as part of the £120M largest University/Private sector development in the UK; the £100M redevelopment of Southampton Solent University campus and the £25M National Cancer Immunology development with the University of Southampton.

The transformation of the city is not restricted to the city centre alone. In the wider city, the council has facilitated the following, creating around 3,000 jobs per year for local people:

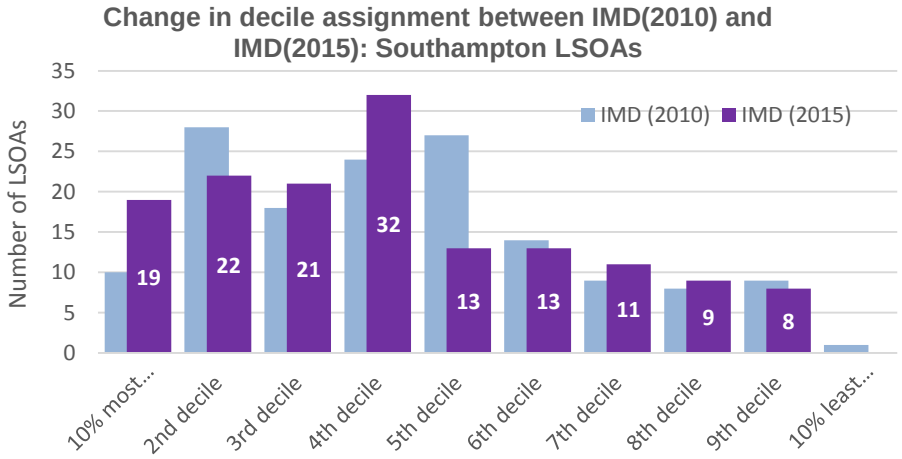
- Lidl Regional Distribution Centre with an investment of around £50M
- 1,620 new residential units at Centenary Quay and 350 at Meridian Waterside.
- 525 student residential units in Portswood (former B&Q site) and 350 at City Gateway.
- Higher educational facilities at the Southampton Marine and Maritime Institute, and the Mountbatten and Life Sciences buildings at Southampton University.
- Retail and commercial facilities at Weston Shopping Parade, Hinkler Place and Inchcape.
- Swift redevelopment of the Ford site which closed in July 2013. The units under construction have already been let to a mixture of industrial and logistics companies, creating 600 jobs.

Public realm and highways improvements with Balfour Beatty develop include the £5M development of the train station as the gateway to the city, and the £13M Platform Road, which links the nationally economically important docks connecting the UK to worldwide and the Far East in particular.

9.4.3 Overall Deprivation

Whilst the city has achieved significant growth in the last few years in line with the affluent south, the city's characteristics relating to poverty and deprivation present challenges more in common with other urban areas across the country with high levels of deprivation. The Index of Multiple Deprivation 2015 (IMD 2015) illustrates how Southampton has become relatively and absolutely more deprived since 2010. Based on average deprivation score, Southampton is now ranked 67th (where 1 is the most deprived) out of 326 local authorities, compared to its previous position of 81st in 2010. Southampton now has 19 Lower Super Output Areas (previously 10) within the 10% most deprived in England and zero in the 10% least deprived (previously 1) as Figure 21 shows.

Figure 21

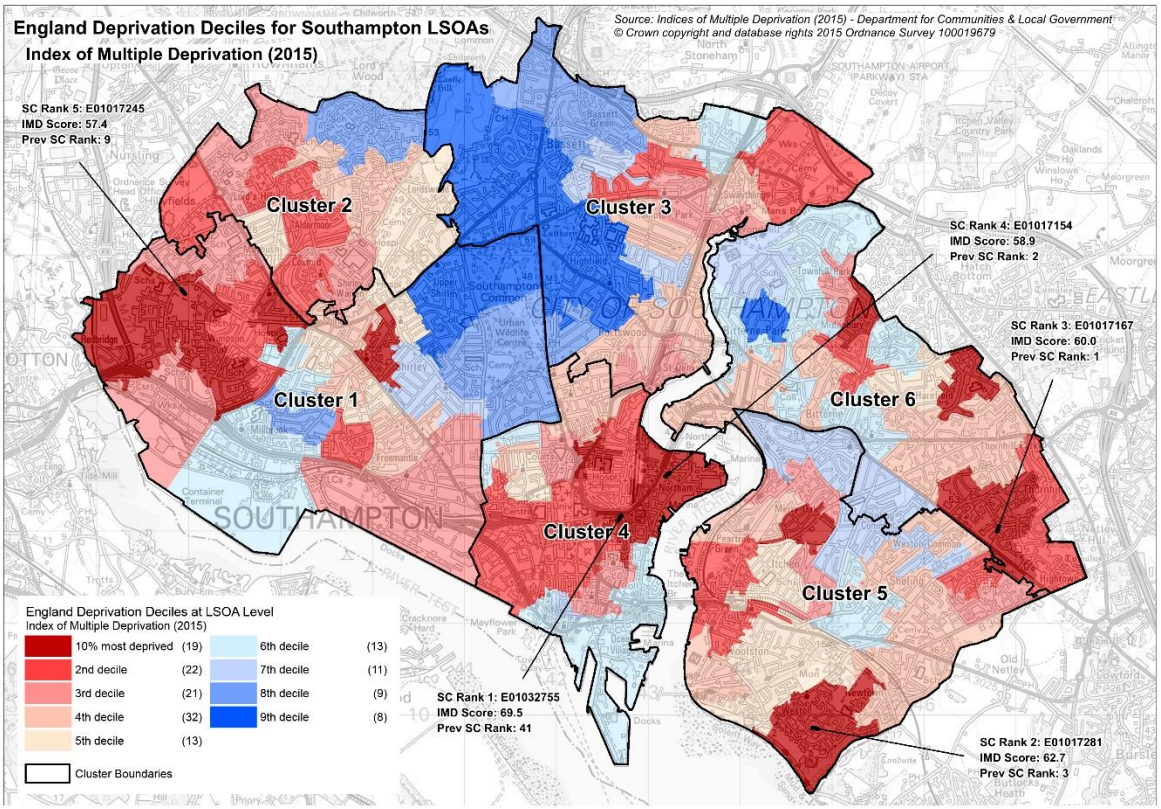


Source: DCLG. Note: IMD (2010) data is based on PHE rebased figures for 2011 LSOAs

The IMD is based on the concept that deprivation consists of more than just poverty. Poverty is not having enough money to get by on where as deprivation refers to a general lack of resources and opportunities. The IMD brings together a range of indicators which cover specific aspects of deprivation. These indicators are aggregated into seven domains which are then weighted and combined to create the overall IMD. The majority of the data underpinning the IMD 2015 is from 2012/13. The 7 domains are: income; employment; education, skills & training; health; crime; barriers to housing and services; and living environment. The IMD cannot show how deprived an area is. It can be used to identify if one area is more deprived - but not by how much. For example if an area has a rank of 40 it is not necessarily half as deprived as a place with the rank of 20. It also cannot be used to identity deprived people or to measure real change in deprivation over time.

As noted at the beginning of this section, deprivation is a significant issue in Southampton and is a wider determinant of health outcomes. The following map (Figure 22) shows how the lower super output areas (LSOA) in Southampton score on the index of multiple deprivation (IMD) scale. Better health outcomes are expected in those areas shaded in blue (the darker the blue, the better the outcomes), and poorer health outcomes are expected in those areas shaded in red, with the worst outcomes expected in those areas shaded in the darkest red.

Figure 22.



9.4.4 Income Deprivation

Income deprivation (ID 2015) is a subset of IMD 2015 looks at people living in income-deprived households as a percentage of the population. The Income Deprivation Domain measures the proportion of the population in an area experiencing deprivation relating to low income. The definition of low income used includes both those people that are out-of-work, and those that are in work but who have low earnings (and who satisfy the respective means tests).

ID 2015 estimated 37,000 Southampton residents experienced income deprivation – 15.4% of Southampton residents - significantly higher than England percentage of 14.6%. At electoral ward level the percentages for this measure, ranges from 7.7% in Bassett ward to 27.0% in Bitterne ward.

9.4.5 Children affected by deprivation

Child poverty is a challenging issue for society. The Marmot Review (2010)[27] suggests there is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults. Reducing the numbers of children who experience poverty should improve these adult health outcomes and increase healthy life expectancy.

In 2014, nearly 1 in 4 children in Southampton were living in child poverty. This is defined as children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income) for under 16 year olds only.

In Southampton, the percentage of children living in child poverty decreased from 28.4% in 2009 to 22.7% in 2013, but increased again in 2014 (23.4%), consistently remaining higher than the percentage for England . In 2014, the proportion of children living in child poverty, ranged at ward level from over 1 in 3 children in Bitterne Ward (35.6%) to 1 in 8 in Bitterne Park Ward (12.7%).[28]

9.4.6 Older people affected by deprivation

Older people are one of the most vulnerable groups in society. Another subset of IMD 2015 is Income Deprivation Affecting Older People Index (IDAOPI) which measured the proportion of all adults aged 60 or over living in income deprived households as a percentage of all adults aged 60 or over.

An estimated 8,100 adults aged 60 and over live in income-deprived households, equating to 19.2% of older people. This percentage is significantly higher than the national percentage

[27] Marmot M "Fair Society Healthy Lives" (The Marmot Review) 2010, http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

[28] Income deprivation 2015 via Local Health Profiles, Public Health England www.localhealth.org.uk

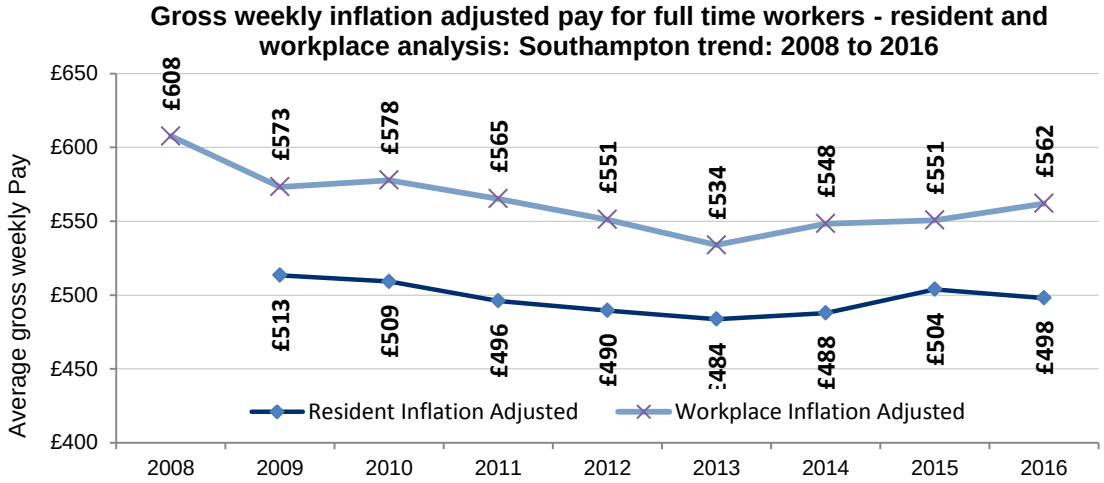
of 16.2%, and broken down into electoral ward level ranges from 11.1% in Bassett ward to 38.0% in Bevois ward.[29]

9.4.7 Unemployment, employment, education and training

Unemployment among adults of working age in Southampton has fallen over the last few years in line with national trends, with the number of people claiming Job Seeker's Allowance and Universal Credit in Southampton remaining fairly stable over the last 12 months at around 1.6% (June 2017),[30] whilst those claiming out of work benefits have fallen from 9% in November 2014 to 8.2% in November 2016.[31]

As illustrated in Figure 23, after adjusting for inflation, weekly pay for Southampton residents and workers has increased in 'real' terms since 2013 following a period of steady decline from 2008.[32] This is due to a combination of growth in average earnings and the continued relatively low level of inflation. However, adjusted for inflation, earnings are not yet back to their peak in 2008, and weekly earnings for residents fell slightly in 2016 by -1.2% in 'real' terms (workplace earnings increased by 2.1%).

Figure 23



Source: Annual Survey of Hours and Earnings, ONS Crown Copyright

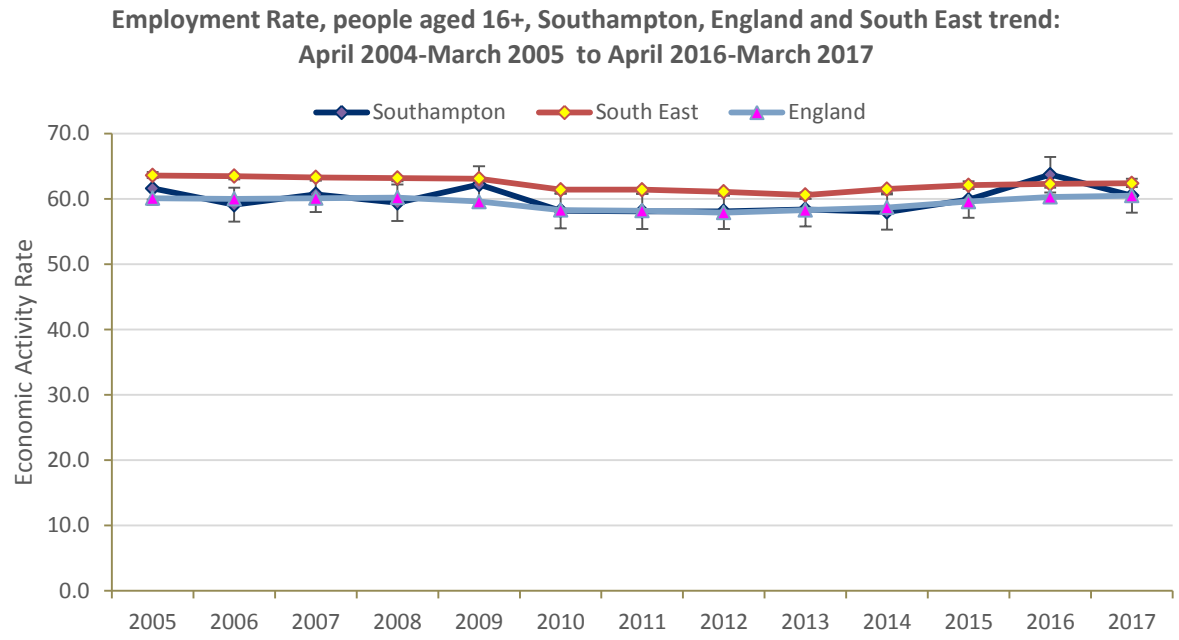
Levels of pay for jobs located in Southampton are now higher than the England average and the highest on offer amongst the city's statistical neighbours. Southampton is home to large businesses requiring higher skilled workers, as well as hosting university workers and graduates. Southampton is a net importer of workers and has a relatively high proportion of highly qualified workers relative to its resident population. However, the relatively high levels of income available to workers in the city is not directly reflected in the economic wellbeing of Southampton residents. There continues to be an income inequality gap between those

[29] Income deprivation Affecting Older People Index 2015 via Local Health Profiles, Public Health England www.localhealth.org.uk
[30] Nomis (experimental) - counts the number of people claiming JSA and Universal Credit who are out of work
[31] Benefit Claimants Working Age Group ONS 2016
[32] ONS(2016) Annual Survey of Hours and Earnings (ASHE) adjusted using the Consumer Prices Index of Inflation

resident in the city and those working in the city, with weekly earnings for workers approximately 13% higher than for residents. The average house price in Southampton (£204,469) is nearly 8 times the average annual salary for residents (£26,425).

The chart below (Figure 24) shows that in the financial years from April 2004 to March 2017 (except 2015/16 when Southampton's employment rate was significantly higher), the employment rate in Southampton fluctuates but remains statistically similar to the England average[33].

Figure 24



Source: Annual Population Survey, Office for National Statistics

In July 2017, there were people claiming 3,110 jobseekers allowance in the city. This translates to 1.8% unemployed people in Southampton[34]. This is slightly lower but not significantly than the national percentage (1.9%).

Education and training for young people improve employment opportunities. In 2015/16, 53.0% of Southampton pupils achieve 5 or more GCSE grades A*-C (including English and Mathematics), this was significantly lower than the national percentage (57.8%).
In 2015, the percentage of Southampton's young people aged 16-18 years not in education, employment or training (NEET) was 4.7%, and this was higher but not significantly than the rate for England (4.2%). The rates for Southampton and England has decreased annually since 2011.

[33] Annual Population Survey, Office for National Statistics
[34] Nomis –Job Seekers Allowance claimants and notified job vacancies as at July 2017 Southampton.

9.5 Housing

9.5.1 Household composition

The 2011 Census revealed lots about the way people live in Southampton, including collecting information on household composition (Table 9). As expected from having a large student population, Southampton has a higher proportion of single (never married) residents than nationally (33.3% compared with 25.8%). Southampton has 10,249 widowed residents and 17,184 who are single through separation or divorce. There are 11,283 households in Southampton consisting of older people living alone and 416 people in a registered same-sex civil partnership.

In 2011, there were 6,918 lone parent families in Southampton with dependent children. Of these, 46.8% were not in employment (compared to 40.5% nationally) and the vast majority were female (over 91%).

Table 9. Marital status for Southampton residents, 2011

Marital status for Southampton residents	Number	Percentage
Single (never married or never registered a same-sex civil partnership)	88,491	45.3
Married	72,324	37.0
In a registered same-sex civil partnership	416	0.2
Separated (but still legally married or still legally in a same-sex civil partnership)	5,141	2.6
Divorced or formerly in a same-sex civil partnership which is now legally dissolved	17,827	9.1
Widowed or surviving partner from a same-sex civil partnership	11,335	5.8

The 2011 Census data also showed Southampton has a higher proportion of families that are large (3+ children) than the national average.

9.5.2 Housing stock

In 2016, there are an estimated 104,660 homes in Southampton[35], the details of which are shown in Table 10.

[35] Department for Communities and Local Government Live tables on dwelling stock (including vacants) https://www.gov.uk/government/statistical-data-sets/live-tables-on-dwelling-stock-including-vacants

Table 10. Profile of housing stock in Southampton, 2016

Tenure	Number	Percentage of total (Southampton)	Percentage of total (National)
Local Authority (incl. owned by other LAs)	16,420	15.7%	6.8%
Private Registered Provider providers of social housing (includes Housing Associations)	7,650	7.3%	10.5%
Other public sector	0	0.0%	0.2%
Private sector	80,590	77.0%	82.5%
Total (all housing)	104,660	100.0%	100.0%

In 2016, the proportion of housing stock in Southampton that was local authority owned, was twice the national average.

The Southampton Housing Strategy 2011-2015: 'Homes for growth' set out the city's priorities of maximising homes for the city, improving homes transforming neighbourhoods, and providing extra support for those who it. Since 2011, 2,600 new homes have been delivered including 1,475 new affordable and sustainable homes. Agreed planning permission has been given for an additional 4,133 dwellings. Estate regeneration projects including Hinkler Road, Laxton Close, Exford Avenue and Cumbrian Way have been undertaken.

More people have been helped to stay in their homes for longer with over 5,600 adaptions to homes since 2011 and over the last 20 years Southampton City Council have brought back more than 2,000 empty homes into use. Licensing has been introduced for Houses in Multiple Occupancy (HMOs) to raise standards and mitigate the impacts of HMOs on the city. Future plans include ensuring all applicable Houses in Multiple Occupancy (HMOs) are licensed, to ensure that residents' health and safety is protected.[36]

9.6 Crime and Disorder

Hampshire Constabulary recorded a 19% increase in recorded crime in 2015/16, compared to an 8% increase recorded nationally and an 8% increase recorded in 2014/15. These increases continue to be driven, at least in part, by changes in recording and reporting practices by Hampshire Constabulary. A comparison of the last six months of 2015/16 with the same period last year (after data integrity changes had been introduced) reveals smaller increase of 5.6%.

The rise in recorded crime has not led to a commensurate rise in calls for service and resident perceptions crime levels remains similar to two years ago, whilst the independent Crime Survey for England & Wales indicates that, in real terms, crime continues to fall.

[36] Southampton City Council Housing Strategy 2016-2025 http://www.southampton.gov.uk/Images/Housing-strategy-06-16-27049_tcm63-386907.pdf

Domestic burglary levels have decreased and this is largely attributable to a sharp reduction in burglaries from multi-occupancy student premises in areas such as Portswood (60% reduction in 2015/16), as a result of increased neighbourhood patrols, proactive engagement with the student population and the arrest and remand of one of the most prolific burglars of student premises in February 2015.

In contrast non-domestic burglary has continued to rise, with a 12% increase recorded in 2015/16; Southampton now has the highest rate amongst its comparator areas. Offences include high value commercial breaks by organised crime groups, offences committed to fund drug habits, and those committed by juvenile offenders, typically shed breaks targeting machinery, tools and bicycles.

There has been a 15% reduction overall in the number of recorded anti-social behaviour offences in 2015/16. Despite this improvement, anti-social behaviour continues to be raised as a priority for neighbourhood policing teams across the city and incorporates the main concerns highlighted in the 2016 residents' survey. Particular concerns relate to youth nuisance, motorbike nuisance, street drinking and street begging. Public Space Protection Orders (PSPOs) were introduced in April 2016 giving further powers to the police to tackle street drinking and begging.

A total of 492 incidents of hate crime were recorded by Police in Southampton in 2015/16; an increase of just over 11.5% on the previous year, although this is less than the national average of 19%.

The recent increase in recorded sexual offences has continued in 2015/16, with the number of rapes increasing by 9% and other sexual offences by 42%. Although these increases are considerably smaller than those reported last year, Southampton has a rate significantly higher than the national average and has the second highest rate amongst its comparator areas. Some of this is due to increased disclosure amongst domestic abuse victims following improved risk assessment procedures implemented by Hampshire Constabulary; one in three non-recent reports are now domestic in nature.

The recorded violent crime rate in Southampton continued to rise (by 45%) in 2015/16, with rates significantly higher than all comparator areas except Southampton. There has also been a 42% increase in reported knife crime in 2015/16 compared to a 10% rise nationally. Rates of violent crime continue to be highest in the city centre, where the night time economy continues to act as a driver for these offences. Alcohol-related violent crime continued to rise overall in 2015/16, although recent monthly data indicates that the trend is beginning to level off and may be beginning to fall. This is supported by a fall in both the number of assault presentations to the Emergency Department and in the number of clients visiting the ICE Bus per night in the last 12 months.

There was a 53% rise in domestic violent crimes reported in 2015/16, with a 7% increase in the number of high risk MARAC (Multi-Agency Risk Assessment Conference) referrals. Southampton has the third highest MARAC referral rate amongst comparator areas and over twice the national average, although repeat cases continue to be low. In contrast, the number of arrests and charges for DVA offences fell by 18%.

Police recorded drug offences has continued to fall (by 29%) in 2015/16, much faster than the national average. However, drug-related violence continues to be an issue in Southampton, rising by nearly 13% over the same period.

9.7 General health needs of Southampton

In Southampton the JSNA is a comprehensive online resource. It aims to identify the 'big picture' for health and wellbeing through analysis of a wide range of data sets and through stakeholder and public engagement.

Maintaining a needs assessment is a dynamic iterative process rather than a product and builds on the first JSNA, published in 2008. The local data compendium lies at the heart of that process. The data will be used to inform future commissioning decisions and spending priorities. The data compendium will be regularly updated with current data during the lifetime of this second JSNA as new data sets and analysis become available. The JSNA also integrates the six key recommendations from Sir Michael Marmot's report *Fair Society Healthy Lives*[37], probably the most important evidence based commentary on health for a generation.

All references to the JSNA within this document are to the version that was available on the Public Health Southampton website as of August 2017.

The first chapter in this PNA has already introduced the context demographics of Southampton's population. The second chapter explores the data around life expectancy and mortality for Southampton's residents and also keys aspects of residents' long term conditions and ill health. Taking Responsibility for Health theme of the JSNA is split into four distinct topics; 'smoking', 'obesity', 'sexual health' and 'alcohol & drugs', which is the corresponding third chapter in this needs assessment. 'Parenting, childhood and adolescence' chapter summarises the health needs and services for children and young people in Southampton as the fourth chapter and a key priority for the city. The fifth chapter 'Protecting the Population' covers key environmental exposures, safeguarding and health protection needs from communicable diseases for Southampton residents. Then this needs section culminates in summarising the needs relating to inequalities and key population groups in the sixth chapter.

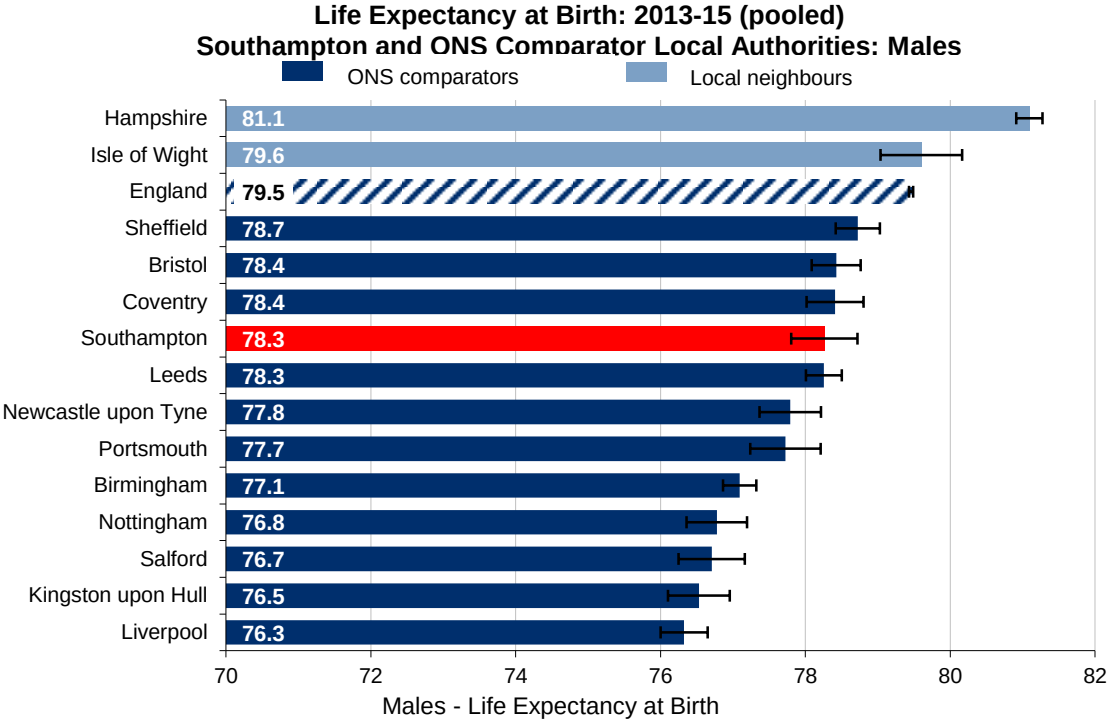
[37] February 2010 http://www.marmotreview.org/

9.8 Life Expectancy and Mortality

9.8.1 Life expectancy

Life expectancy is the number of years a baby born today would expect to live were he or she to experience the particular areas age-specific mortality rates for that time period throughout his or her life. In 2013/15, male life expectancy was 78.3 years; significantly lower than England (79.5 years), but similar to many of Southampton's ONS comparators. (Figure 25)

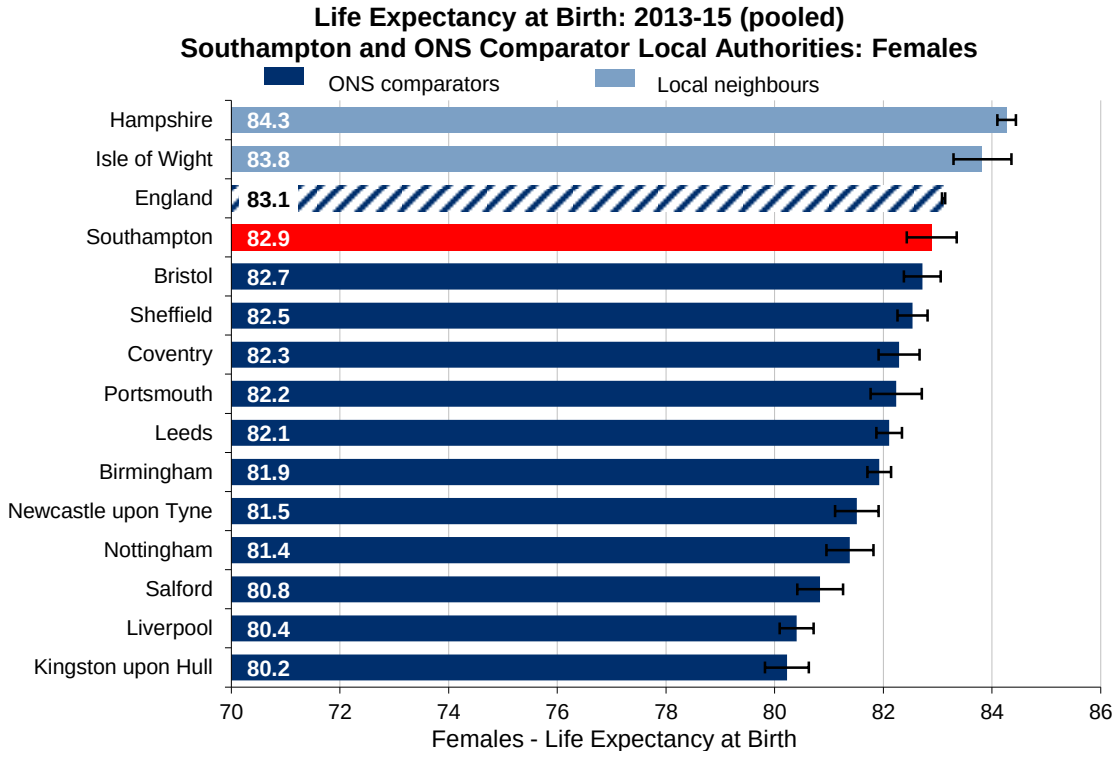
Figure 25



Source: Public Health England - Public Health Outcomes Framework (PHOF) http://www.phoutcomes.info/

In 2013/15, female life expectancy at birth was improving (82.9 years); similar to England (83.1 years) and the highest amongst Southampton's ONS comparator group (Figure 26).

Figure 26



Source: Public Health England - Public Health Outcomes Framework (PHOF) http://www.phoutcomes.info/

Life expectancy at birth has increased steadily for both males and females over the last decade however there is deprivation-based inequality. In 2013-15 for males in Southampton's most deprived quintile (20% of Lower Super Output Areas) is 7.7 years shorter than in the least deprived quintile. The gap for females in Southampton is 3.7 years.

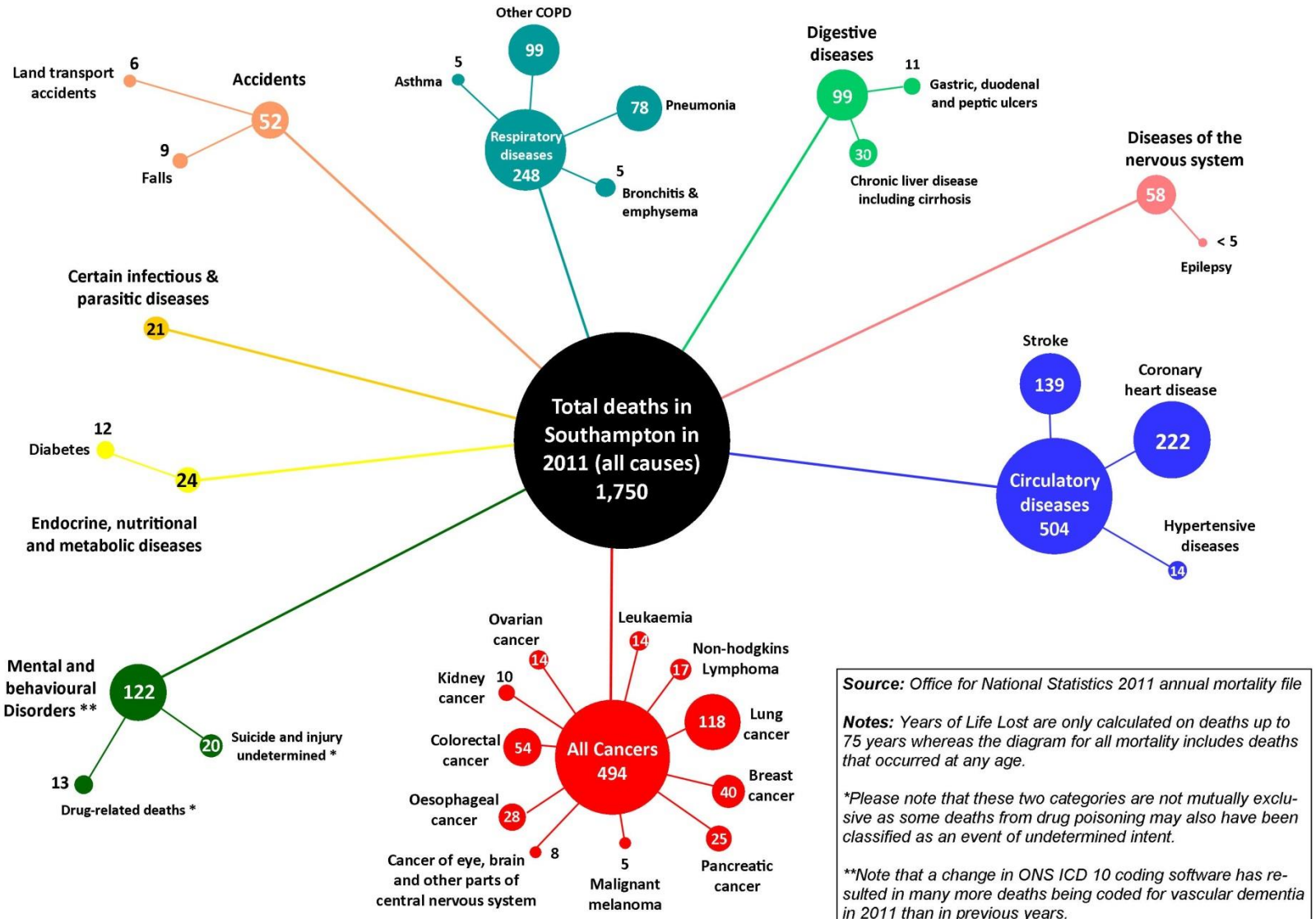
In 2013/15, the number of years of healthy life expectancy for males are significantly lower and for females are lower but not significantly in Southampton (60.9 years and 63.2 years respectively) compared to England (63.4 years and 64.1 years respectively).

Disability free life expectancy highlights inequality in the average number of years a person could expect to live free of an illness or health problem that limits their daily activities. The number of years of disability-free life expectancy at birth for both males and females males and females are lower, but not significantly in Southampton (61.4 years and 62.9 years respectively) compared to England (63.2 years and 63.3 years respectively).
Many long term health conditions increase markedly with age; consequently the effect of the aging population on the prevalence of these diseases in Southampton is significant.

9.8.2 Mortality

In 2015 there were 1,826 deaths registered in Southampton's resident population and of these cancer was responsible for 27.0%, coronary heart disease 11.8%, stroke 4.7% and other circulatory diseases 8.6%. Around 54.8% of these deaths occurred in an acute hospital setting, 17.7% in a nursing/care home and 25.0% in the individuals own home.

The diagram overleaf illustrates the main causes of death for Southampton residents as defined by the International Classification of Diseases v10 (ICD-10).



Source: *Office for National Statistics 2011 annual mortality file*

Notes: *Years of Life Lost are only calculated on deaths up to 75 years whereas the diagram for all mortality includes deaths that occurred at any age.*

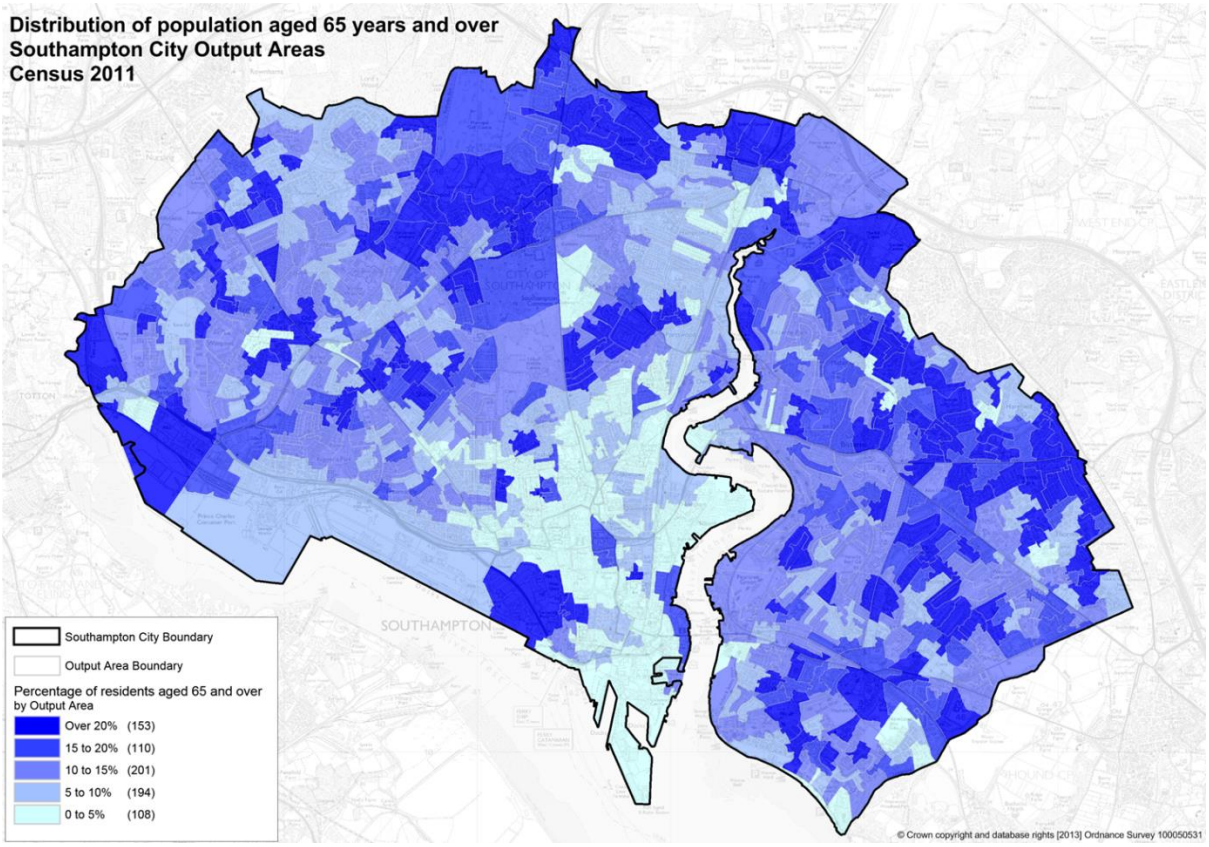
**Please note that these two categories are not mutually exclusive as some deaths from drug poisoning may also have been classified as an event of undetermined intent.*

***Note that a change in ONS ICD 10 coding software has resulted in many more deaths being coded for vascular dementia in 2011 than in previous years.*

9.8.3 Ageing population and chronic conditions

The ageing population is a local and national concern. The 2011 Census recorded 30,800 residents in Southampton aged over 65 years. The map below (Figure 27) shows the distribution of these older people across the city. The proportions are lower in the central areas of the city where there is a large student population.

Figure 27



More recent projections for 2017 from Census 2011 based Hampshire Small Area Population Forecast 2016) estimate there are 34,929 residents aged 65 years and over.

The Older People's Health and Wellbeing profile produced by the Public Health England (PHE)[38] provides a useful snap shot of indicators at local authority level. It shows that older people in Southampton are having significantly worse than the England average outcomes for several key indicators:

- male life expectancy at aged 65 years;
- percentage of deaths in usual place of residence among people aged 65 years and over;
- permanent admissions to residential and nursing care homes per 100,000 aged 65 years and over;
- percentage of people aged 65+ receiving winter fuel payments

[38]Public Health England https://fingertips.phe.org.uk/profile/older-people-health

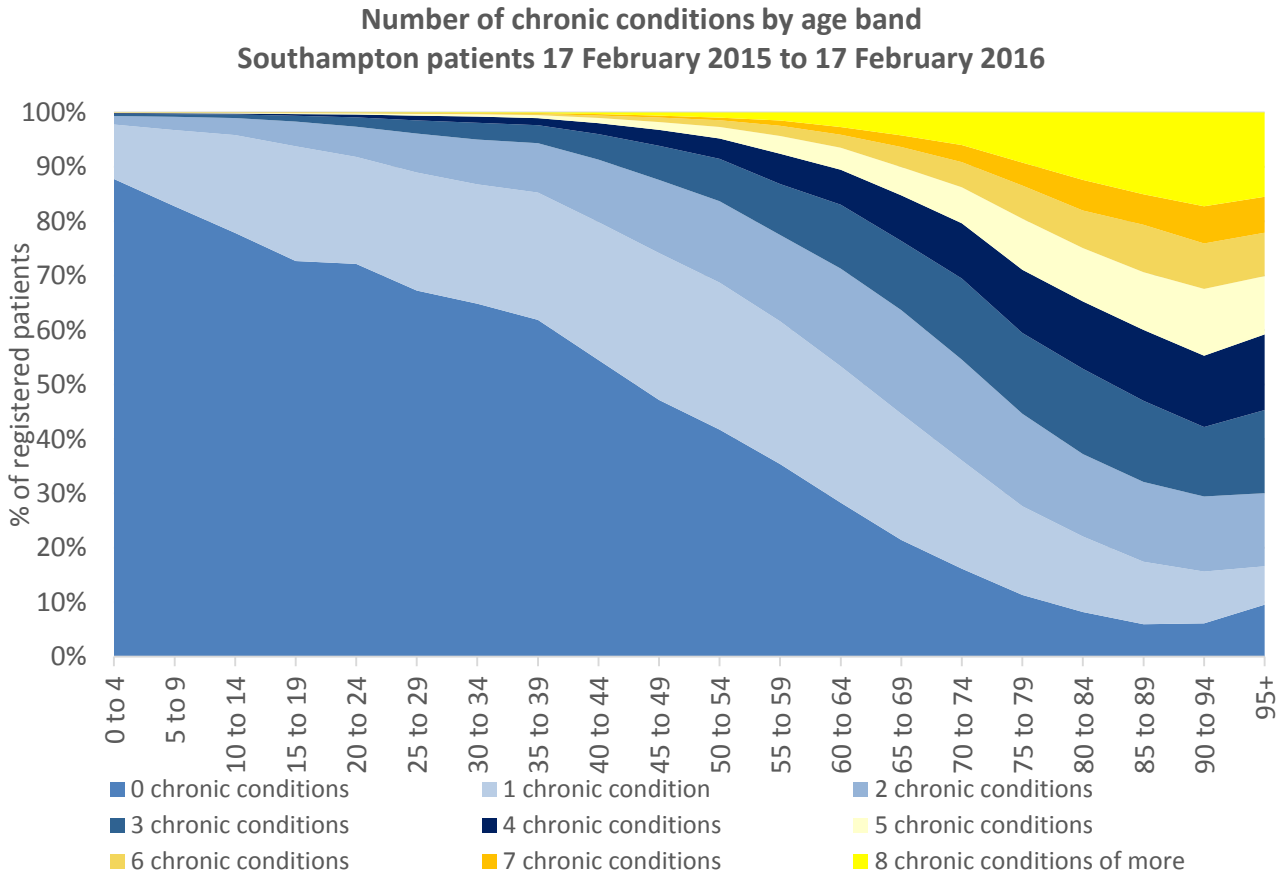
- rate of deaths from Cancer among people aged 65 years and over;
- rate of deaths from Respiratory disease among people aged 65 years and over;
- population vaccination coverage - Flu (aged 65+);
- preventable sight loss - age related macular degeneration (AMD);
- and hip fractures in people aged 65 and over.

Long term conditions in later life tend to become more frequent and complex, requiring more reactive and proactive health and social care.

Figure 28 illustrates the growing importance of effectively managing long term conditions (LTCs) as the population grows older. The number of LTCs increase with age, making care more complex and costly. Figure 28 was produced using the Adjusted Clinical Groups (ACG) tool. The ACG definition of chronic conditions: "An alteration in the structures or functions of the body that is likely to last longer than 12 months and is likely to have a negative impact on health or functional status."

For nearly 90% of Southampton's 0 to 4 year olds, they have no chronic conditions. The main conditions for the remainder are asthma, cleft lip and palette and developmental disorders (language delay etc.). When aged 40-44 years of age, half of Southampton's residents will have at least one LTC and when aged around 65-69 years, a third have at least three LTCs. As the population increases so does the multi-morbidities and at age 85-89 years approx. a quarter have at least six LTCs. The projected increase of 5,117 Southampton residents aged 65 years and over, between 2016 to 2023 and the long term social care clients 65+ forecast to grow from 1,775 in 2016 to 2,092 in 2023.

Figure 29



Source: Adjusted Clinical Groups (ACG) March 2016

9.8.4 Long Term Conditions and Ill Health

9.8.4.1 Cancer

In 2015 there were 1,826 deaths in Southampton and 27.1% of these were caused by cancer. This is statistically similar to the percentage of cancer deaths nationally (27.4%).

New cases of cancer are measured using an age standardised incidence rate (per 100,000 population). In 2014, the rate of incidence of all cancers in England is 608.3 per 100,000 population all ages but in Southampton it is higher still at 647.5 per 100,000 population all ages.

In 2012/14, incidence rates for Southampton registered patients of all ages for all cancers excluding skin cancers other than malignant melanoma, was significantly higher for persons and males, and higher but not significantly compared to the rates for England. The all age incidence rate for breast cancer (females), colorectal cancer (persons) and prostate cancer of Southampton GP registered patients of all ages are lower but not significantly so than the England averages.

In the periods 2007/09 to 2013/15, lung cancer rates of Southampton registered patient have been significantly higher than the national average. In 2013/15 the rate was 103.7 registrations per 100,000 population all ages compared to the England average of 78.9 per 100,000. The incidence of malignant melanoma for Southampton registered patients for 2010/12, 2011/13 and 2012/14 have been significantly higher than the England average.

In March 2016 there were 4,795 people diagnosed and on GP disease registers (1.7%) living with cancer in Southampton - the prevalence nationally is 2.4%.

Premature mortality measures unfulfilled life expectancy. It measures the early deaths in people aged under 75 years. This is important because deaths of younger people are often preventable.

In 2013/15, the premature mortality rate from cancer for Southampton was 155 deaths per 100,000 population under 75 years – this was significantly higher than the rate for England (138 per 100,000 population under 75 years old.

In 2012-14, all age mortality rates of colorectal cancer, breast and prostate in Southampton are not significantly different from the England average, although mortality for all cancer (excluding non-malignant melanoma) for persons, males and females, and lung cancer rates are significantly higher.

Lung cancer is the second most common cancer (after skin cancer) in England and Wales, with an estimated 44,500 new cases being diagnosed every year. It is the most common cause of cancer-related death in both men and women.[39] Lung cancer continues to be one of the most common cancers in Southampton. In 2015 there were 493 deaths from cancer amongst city residents and of these 120 were caused by lung cancer. In Southampton in 2013-15, there were 104 lung cancer registrations per 100,000 population, significantly higher than the incidence rate for England (79 registrations per 100,000 population). The 2013/15 lung cancer incidence rate for Southampton is the highest among the increasing incidence overall trend since 2007/09.

Also in 2013-15, Southampton had a significantly higher rate of smoking-attributable deaths in persons aged 35+ years compared to England and deaths from chronic pulmonary disease (2013-15).

Bowel cancer is the second most common cause of cancer death following lung cancer, around 1 in 20 people develop bowel cancer. Almost 18 out of 20 cases of bowel cancer in the UK are diagnosed in people over the age of 60 and 12 out of 20 cases will survive their cancer for 5 years or more.

In 2015 there were 49 deaths in the city from colorectal cancer. In 2008 the Bowel Cancer Screening Programme was introduced for 60 to 69 year olds in the City and extended to

[39] NHS Choices. www.nhs.uk/conditions/cancer-of-the-lung/pages/introduction.aspx?url=pages/what-is-it.aspx

include people up to 74 years of age in 2010. This programme offers screening every two years to men and women within this age group.[40]

In March 2016, 14,894 Southampton GP registered patients (around 54.5%) had taken up this offer, and in 2015/16 for 60-69 year olds uptake varies between 23% and 62% across GP practice populations. Work is being undertaken to encourage those elements of the population to take up this screening offer to enable earlier diagnosis and treatment.

In April 2016, two-thirds (67.6%) of Southampton females GP registered patients aged 50 to 70 years old eligible for breast cancer screening had been screened within the previous 3 years, and varies between 53% and 78% across GP practice populations. The uptake in Southampton is significantly lower than the national uptake percentage (69.8%).

Every year, 3,000 women are diagnosed with cervical cancer in the UK and sadly, just under 1,000 die. It is a disease that mainly affects sexually active women aged between 30 and 45 years old. 99.7% of cervical cancers are due to persistent HPV infection. The introduction in 2008 of a vaccine against human papilloma virus (HPV) for teenage girls promises to markedly reduce the incidence of this disease in the future.[41]

The uptake of this vaccine in the City has been good. In 2015/16, 91.5% of Year 8 girls received the first vaccination and 89.2% their second vaccination and completed this programme. The uptake across England was 87.0% and 85.1% respectively. The national benchmark for the first dose and both doses is 90% uptake.

Currently, cervical screening samples are examined under a microscope to look for abnormal cells that could go on to develop into cancer, a new testing process is now being rolled out across England over the next few years to test screening samples for HPV first, rather than after, cytology.

In 2011-13, Southampton's incidence of malignant melanoma was 30 registrations per 100,000 persons of all ages; the incidence rate was highest in males than females but not significantly. The Southampton incidence rate for persons and males was significantly higher than the rate for England.

9.8.4.2 Coronary heart disease (CHD)

In 2015/16, there were 6,455 people on CHD registers in Southampton giving a crude prevalence rate of 2.4%. The 2011 modelled estimate of CHD is higher at 9,822 giving a crude rate of 3.9%.

[40] NHS Choices: Bowel Screening http://www.nhs.uk/Conditions/bowel-cancer-screening/Pages/Introduction.aspx
[41] NHS Choices: Cervical Screening http://www.nhs.uk/conditions/Cancer-of-the-cervix/Pages/Introduction.aspx

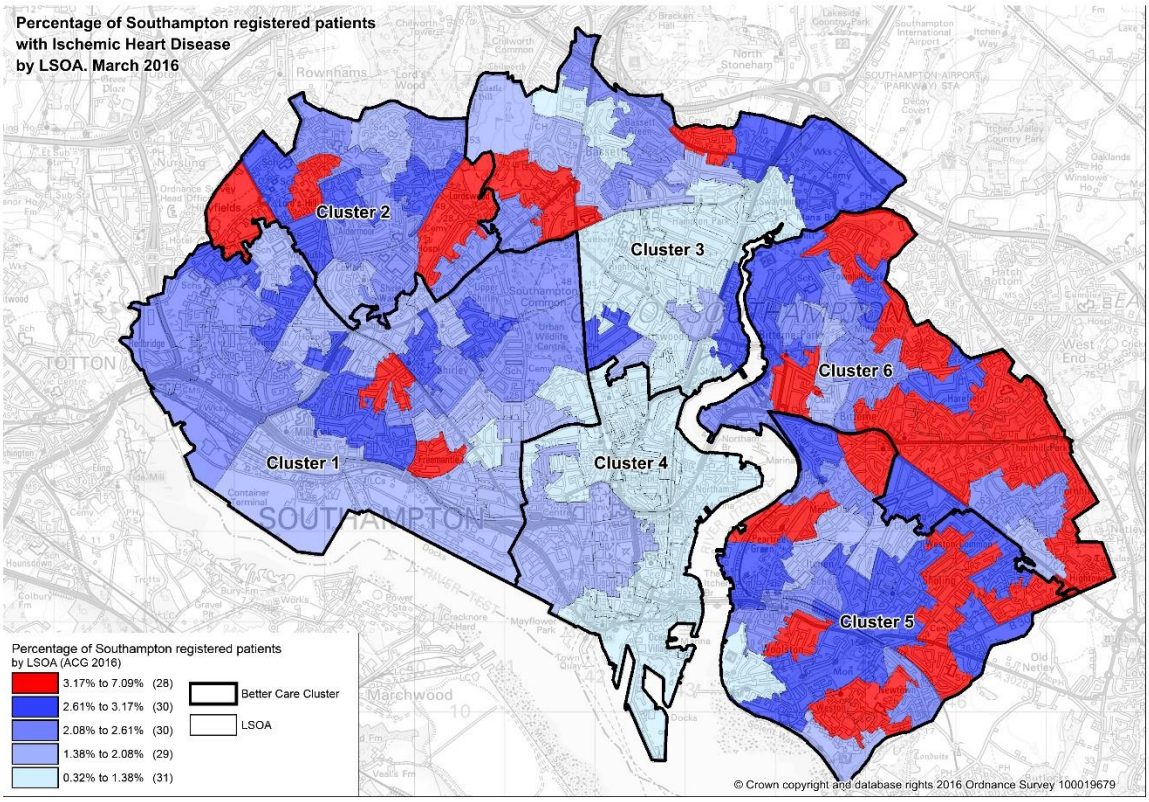
More recent modelled estimates focus on the age group 55 to 79 year old. In 2015 the estimated prevalence for this age group in Southampton was 8.1% equating to 3,740 55 to 79 year old with CHD.[42]

It should however be noted that as with any modelling, there are various caveats about the assumptions that have gone into it. There are assumptions of the model about the underlying population structure (e.g. age/gender composition) and relationships to explanatory variables remaining similar.

In 2015/16, NHS Southampton CCG had 338 admissions per 100,000 population of all ages, significantly less than the national average (528 admissions per 100,000), however the premature mortality rate from coronary heart disease for Southampton residents was significantly higher than the rate for England (48 deaths per 100,000 compared to 41 deaths per 100,000 respectively). Coronary heart disease was the main cause of death for 11.8% of Southampton deaths in 2015.

The following map (Figure 30) was produced using data from the ACG tool showing the highest and lowest recorded prevalence for Ischemic Heart Disease.

Figure 30



[42] Estimates modelled from the Whitehall II study (PHE Fingertips) applied to Hampshire 2015-based Small Area Population Forecasts

9.8.4.3 Stroke

In 2016, stroke was the main cause of death for 4.7% of Southampton deaths, this was significantly than the proportion nationally (6.6%). Stroke also causes a disproportionate amount of disability. Many strokes are preventable, with primary prevention offering the greatest potential for achieving benefits in value for money.

In 2015/16, all aged stroke admissions was higher but not significantly for NHS Southampton CCG compared to England (176 admissions per 100,000 population compared to 173 admissions per 100,000 respectively).

In March 2016 GP QOF data showed 4,056 people being cared for with stroke or transient ischaemic attacks. The most recent modelled estimated for 55 to 79 year olds, 3.8% will have suffered a stroke around 1,750 people.[43] Please note there are a range of caveats around modelling which assumes the population distribution by age, gender, ethnicity, diabetic status, smoking status, BMI, resident deprivation score and levels of physical activity remain the same as the modelling study population.

9.8.4.4 Hypertension

Hypertension or high blood pressure contributes to cardiovascular disease (CVD), strokes, renal disease, vascular disease including aortic aneurysms, and yet shows few, if any symptoms until the disease is advanced.

In March 2016 there were 29,613 people on hypertension registers in Southampton, giving a raw prevalence of 10.7%. However, the most current modelled estimate[44] of hypertension predicts an estimated prevalence across the city of diagnosed hypertension of 16.2% (around 33,580 adults aged 16+) and undiagnosed hypertension of 10.7% (around 22,072 adults aged 16+). Please note, these models assume Southampton's population structure and related characteristics (age, gender, ethnicity, and deprivation) remain similar to that of the model.

9.8.4.5 Atrial fibrillation (AF)

AF is recognised as a key risk factor for stroke and is the most common form of cardiac arrhythmia which is more prevalent in older age. Early detection of AF with treatment reduces the likelihood and severity of stroke.

[43] Estimates modelled from the Whitehall II study (PHE Fingertips) applied to Hampshire 2015-based Small Area Population Forecasts
[44] Estimates modelled from the Whitehall II study (PHE Fingertips) applied to Hampshire 2015-based Small Area Population Forecasts

In March 2016 GP quality and outcomes framework (QOF) data showed 3,642 people registered with AF which equates to a raw prevalence rate of 1.3% against a national raw prevalence rate of 1.7%.

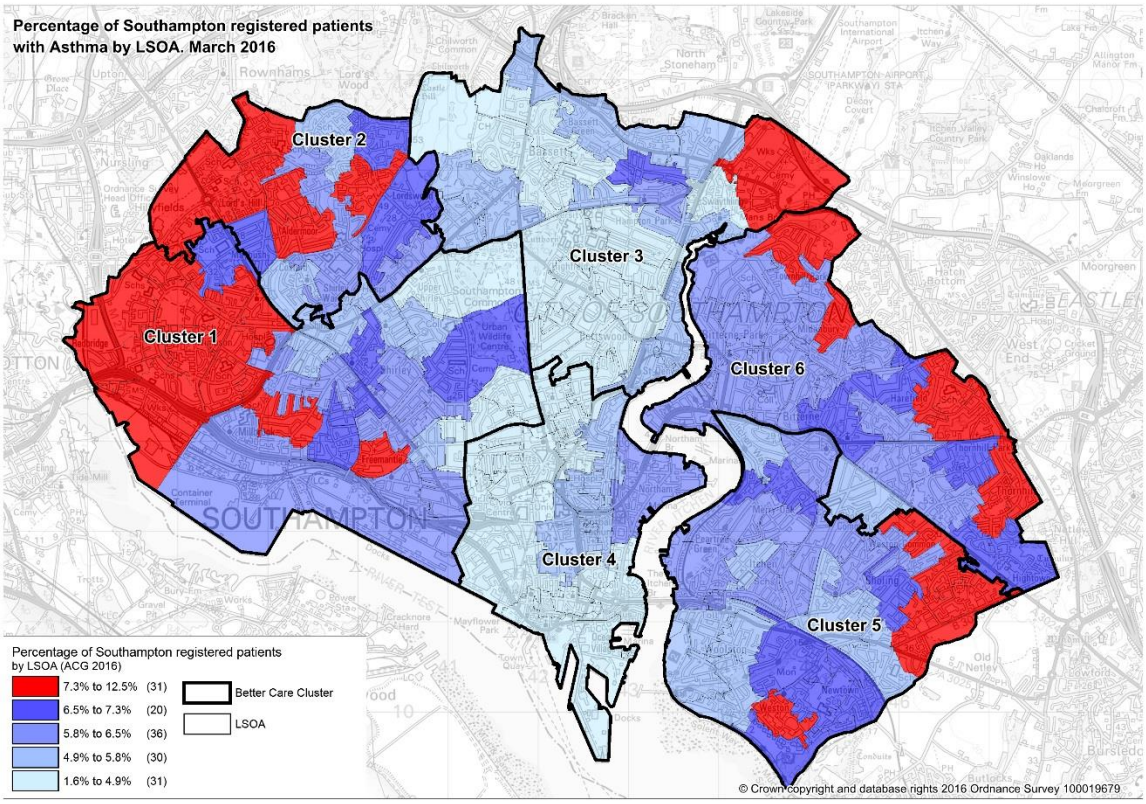
Public Health England investigated this this to be underestimate and have modelled for Southampton 2015/16 expected prevalence of AF to be 1.9% of registered patients, however this estimate is based on assuming Southampton's population structure and related attributes remain similar to that used in the model.

9.8.4.6 Asthma

In 2015/16 there were 16,164 people on GP asthma registers in Southampton giving a crude prevalence rate of 5.8% which is not significantly different from the national average of 5.9%. However, in previous years rates in Southampton were significantly higher than nationally and, it is only since 2008/09 that the gap has closed.

Figure 31 uses data from the ACG tool showing the highest and lowest recorded prevalence of asthma among Southampton's GP registered patients.

Figure 31

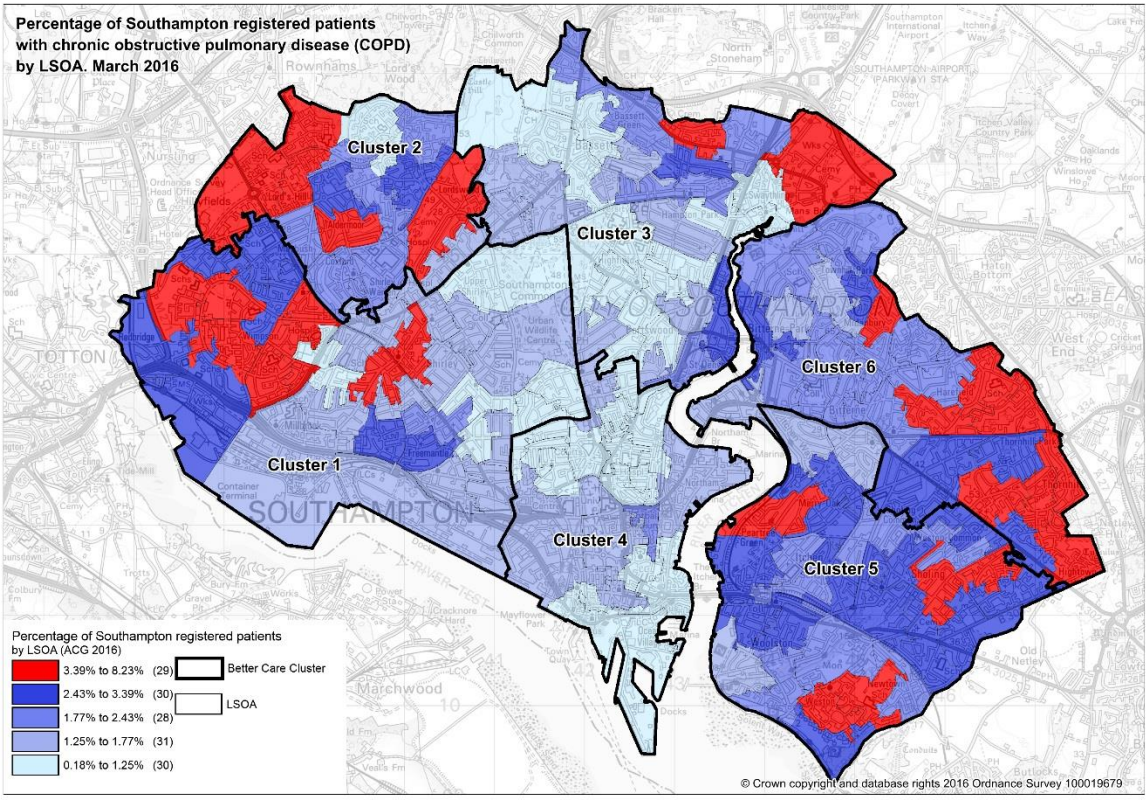


9.8.4.7 Chronic obstructive pulmonary disease (COPD)

In March 2016 there were 5,592 people on QOF COPD registers in Southampton. This represents a crude prevalence rate of 2.0% which is significantly higher than the England rate (1.9%) and about average compared to Southampton's CCG cluster peers (2.0%).

The range of the recorded prevalence of COPD for Southampton GP registered patients can be seen in Figure 32 which produced using data from the ACG tool.

Figure 32



However, there is a disparity between disease prevalence estimates from large surveys, in particular the Health Survey for England, and the number of patients diagnosed and registered in QOF. The most current modelled estimate[45] of COPD predicts an estimated prevalence across the city of 2.5% equating to 6,170 Southampton residents.

It should however be noted that as with any modelling, including those described earlier, it comes with various caveats about the assumptions that have gone into it. For example for practices with a population that significantly differs from a 'typical' population the assumptions of the model may not apply and discrepancies may occur, and the proportions by age, gender and other significant explanatory variables (smoking status and IMD) remains similar to the study population used in the model.

[45] Estimates modelled from the Imperial College London study (PHE Fingertips) applied to Hampshire Small Area Population Forecasts

9.8.4.8 Kidney disease

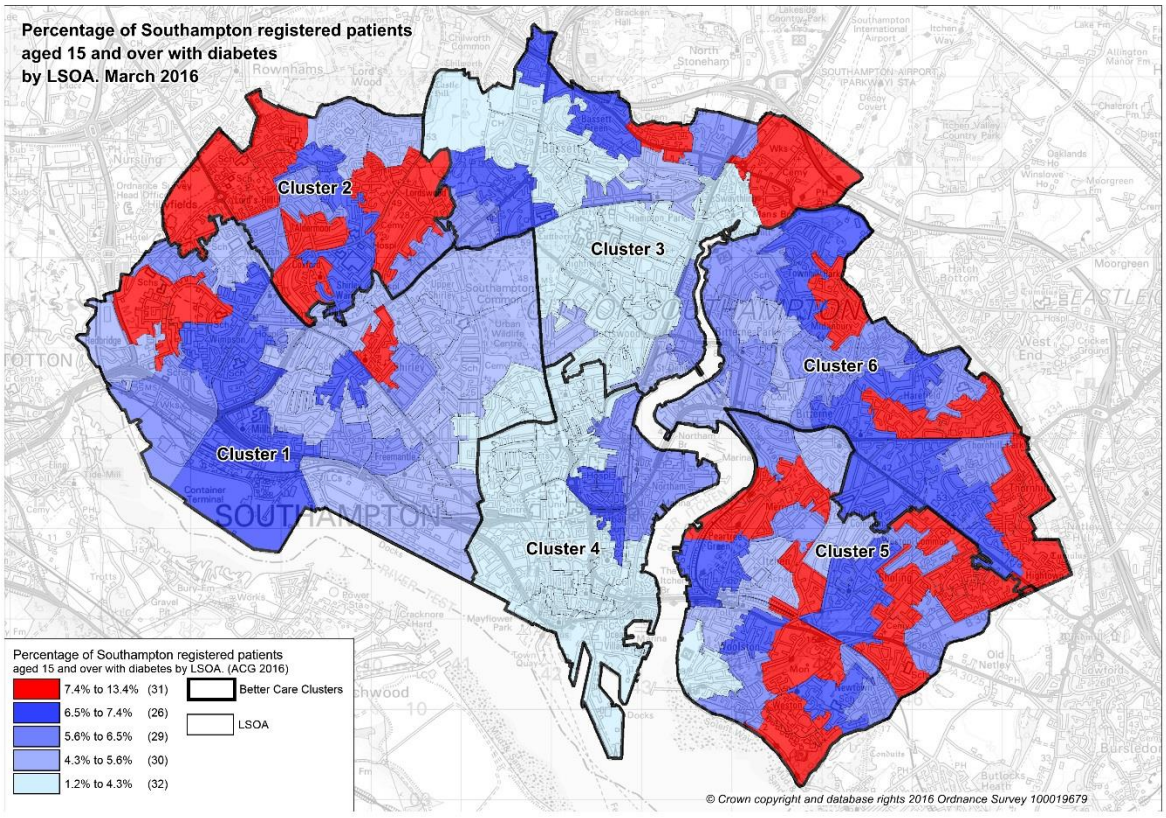
In March 2016 GP QOF data showed 6,777 people on GP disease registers with chronic kidney disease (CKD). The prevalence of diagnosed CKD amongst people aged 18 years and over in Southampton is 3.0% (compared to 4.0% in the CCG Cluster comparator group) although this varies from 0.2% to 5.5% by Southampton GP practices. This variation between practices will include differences in underlying risk factors including practice population and thresholds for CKD testing. In general CKD increases markedly with age, with the most common risk factors are cardiovascular disease, hypertension and diabetes. These often coexist with other factors such as obesity, coming from a lower socioeconomic group and from a minority ethnic group, particularly Black and Asian.

9.8.4.9 Diabetes

In 2015/16 there were 12,497 people on GP diabetes registers in Southampton which gives a crude prevalence rate of 5.5%, significantly lower than the England rate of 6.5%. Much diabetes is undiagnosed and modelled estimates of the true underlying prevalence put the total burden in the city at nearly 16,422 people (a crude rate of 7.3%).

Figure 33 was produced using data from the ACG tool showing the highest and lowest recorded prevalence of diabetes for Southampton's GP registered population.

Figure 33



Modelled estimates predict the prevalence of diabetes is set to increase, applying this to a growing population, by 2035, Southampton's diabetic population is estimated to be 7.1% or

around 14,405 people in 2015 will grow to 7.9% or 18,166 in 2035 (assuming no change in the underlying population of age, sex and ethnicity, levels of excess weight and physical inactivity).

PHE's National Cardiovascular Intelligence Network have produced a model for forecasting diabetes prevalence based on different levels of increases or decreases of obesity. The greatest increase is based on the 2015 level of obesity increases by 5% every 5 years, resulting in an increase in the diabetes prevalence to 8.6% in 2035 giving 19,800 people with diabetes in the city.

Poor diabetic foot care can result in lower limb amputations in diabetic patients. In 2015/16 of the 12,497 Southampton diabetic GP registered patients, 1 in 5 (around 2,583 or 21%) had no record of attending a foot examination with a 'foot complication' risk classification. This varies between GP populations ranging from 8% to 46%. However as described previously, there are potentially an additional 4,000 people in the city unware of the importance of foot care with their undiagnosed diabetes increase their risk of ulceration, reduced sensation/circulation and potential lower limb amputation.

In terms of other long-term conditions for diabetic patients, the ACG tool profiled diabetic patients the most common co-morbidities, showing a proportion of Southampton diabetic patients will also depression (22%), hyperlipidemia (18%), asthma (15%), chronic renal failure (14%), IHD (14%) and COPD (8%).

9.8.4.10 Sight loss

Diabetic retinopathy or diabetic eye disease is the leading cause of preventable sight loss in working age people in the UK and early detection through screening halves the risk of blindness.

In 2015/16, Southampton's rate of rate of sight loss due to diabetic eye disease in those aged 12 years and over is 10.3 per 100,000 population. This is significantly higher than the rate for England (2.3 per 100,000).

Age related macular degeneration (AMD) and glaucoma are the two other types of eye disease which can result in blindness or partial sight if not diagnosed and treated in time. Southampton's rate of AMD are also significantly higher compared to England (155 per 100,000 aged 65+ compared to 114 per 100,000 aged 65+ respectively). Southampton's rate of preventable sight loss due to glaucoma is lower but not significantly to the rate for England (12.2 per 1000,000 aged 40+ compared to 12.8 per 100,000 aged 40+ respectively)

Sight impaired (SI) and severe sight impairment (SSI) replace the terms partially sighted and blind for registration purposes. In March 2014, there were 620 registered blind people (SSI) (over half, n=315, were aged over and 75 years and over) and 715 registered partially sighted (SI) people known to the city council (of which 3 out of 5 are aged 75 years and over) , making a total of 1,335 people. In 2014, one in three of those registered as either SSI or SI, had additional physical disabilities. The data is collected every three years and the latest will be published in December 2017.

In February 2017, 221 Southampton residents (0.1%) were registered for Disability Living Allowance with the main disabling condition recorded as 'blindness'. Of these residents registered with 'blindness' as their main disabling condition, 22 people were aged under 16 years, 125 people were aged 16 to 64 years old and 64 people were aged 65 year and over.[46]

9.8.4.11 Hearing loss and deafness

Infants in Southampton have their hearing checked within hours of birth through the newborn infant screening programme (98.8% in 2015/16).

Since 2010, the number of people registered deaf or hard of hearing has not been published. In 2010, the number of adults registered as deaf in Southampton was 290 people and as hard of hearing was 1,025 people. The 2015/16 GP patient survey estimates 3.7% of the GP registered population reporting deafness or severe hearing loss, which is around 7,700 people.[47]

In February 2017, 157 Southampton residents were registered for Disability Living Allowance with the main disabling condition recorded as 'deafness'. Of these residents registered with 'deafness' as their main disabling condition, 40 people were aged under 16 years, 79 people were aged 16 to 64 years old and 33 people were aged 65 years and over.[48]

Modelling from PANSI/POPPI predict there are 5,053 Southampton residents aged 18-64 and 14,601 residents aged 65 years and over predicted to have a moderate or severe, or profound hearing impairment, by age, and this is projected to increase to 5,398 and 21,455 by 2035.[49]

9.8.4.12 Levels of disability among children and young people

In February 2017, data on disability living allowance claimants amongst the under 16 years old shows that 1,830 Southampton children receive DLA. Forty-four per cent (around 800 children) of those receiving DLA had their main disabling condition classed as 'learning difficulties'. Hyperkinetic Syndrome, also known as ADHD, was the second most common diagnosed main disabling condition for 245 children (13.4% of DLA recipients aged under 16 year old)[50]. Two hundred and forty children (n=240) shared the third most common main disabling condition; Behavioural Disorder.

Data on children and young people with Special Education Needs is covered in Chapter 4.

[46] DLA Entitlement (Count) Department for Work and Pensions
[47] Disease and risk factor prevalence, PHE Fingertips
[48] DLA Entitlement (Count) Department for Work and Pensions
[49] Projecting Older People Population Information System (POPPI) and Projecting Adult Needs and Service Information (PANSI), Oxford Brookes University
[50] DLA Entitlement (Count) Department for Work and Pensions

9.8.4.13 Levels of disability among adults

The number of adults aged 18 to 64 with physical disabilities receiving services in 2013/14 was 1,145. This is a rate of 707 adults per 100,000 population aged 18 to 64 years. [51]

In February 2017, there were 4,351 Southampton residents aged 16 to 64 years receiving Disability Living Allowance (DLA). One in six, around 730 adults aged 16 to 64 were classified as receiving DLA for the main disabling condition of psychosis, which was the most common. The next most common disabling condition was learning difficulties (n=667, 15.3%). Around 380 adults were receiving DLA for arthritis, which was the third most common main disabling condition (8.7%).[52]

Estimates and projections of the number of disabled people in the city have been produced using national prevalence rates applied to local population data; these suggest in 2017 there may be around 11,500 working-age adults with a moderate physical disability and a further 3,200 with a serious physical disability living in Southampton. By 2035 there are projected to be over 15,800 adults of working age with a moderate or serious physical disability in Southampton.[53]

In February 2017, 2,352 adults aged 65 years and over were receiving DLA. The most common main disabling condition was arthritis, accounting for 30.2% of those aged 65 years and over in receipt of DLA (n=764). Disease of the Muscles, Bones or Joints (6.9%, n=175) was the second the main disabling condition and Back Pain was the third (6.8%, n=173). This shows physically disabling conditions are more prolific in older adults compared to working age adults receiving DLA. [54]

Modelling by POPPI estimates in 2017, there are 6,291 people aged 65 and over unable to manage at least one mobility activity on their own, (This estimate is adjusted for the underlying age and gender distribution). Activities include: going out of doors and walking down the road; getting up and down stairs; getting around the house on the level; getting to the toilet; getting in and out of bed. This is predicted to increase to 9,122 Southampton residents aged 65 and over by 2035.[55]

9.8.4.14 Human immunodeficiency virus (HIV)

In 2015, 353 Southampton residents (2.15 per 1,000 population aged 15 to 59) are accessing HIV care. In 2015, 85 more individuals were accessing HIV care compared to 2010, an increase of 32%.

Late diagnosis of HIV is associated with a ten-fold increase in risk of death in the first year of diagnosis compared to those diagnosed early. In 2013/15, of those Southampton residents diagnosed with HIV, 45.5% had a late diagnosis, this is compared to 40.1% nationally.

[51] RAP P1 via PHE Fingertips
[52] DLA Entitlement (Count) Department for Work and Pensions
[53] Projecting Adult Needs and Service Information (PANSI), Oxford Brookes University
[54] DLA Entitlement (Count) Department for Work and Pensions
[55] Projecting Older People Population Information System (POPPI), Oxford Brookes University

9.8.4.15 Mental health and neurological conditions

There is no good health without good mental health and this is important across the life-course. Early intervention is at the heart of the Government's approach to improving outcomes for children and families. This is set out clearly in the public health White Paper Healthy Lives, Healthy People,[56] and the mental health strategy No Health without Mental Health[57] as well as the recommendations of Graham Allen's review of early intervention[58]. No Health without Mental Health, the Government mental health strategy was published in 2011. It states that mental health is everyone's business – individuals, families, employers, educators and communities all need to play their part.

9.8.4.16.1 Children and Young People

The Children and Young People's Mental Health and Wellbeing profile estimated prevalence rates and adjusted by age, gender and socio-economic classification (NS-SeC of household reference person). the 2015 local population estimates for the estimated prevalence for children and young people aged 5-16 years in Southampton of mental health disorders, was 2,960 (9.8%); for emotional disorders, 1,123 (3.7%); conduct disorders 1,827 (6%) and hyperkinetic disorders 500 (1.6%).

The estimated need for Tier 1 services for Children and Young people aged under 17 years is 10%[59] to 15%[60] and Tier 2 services is 7%[47 48]. Applying this to the 2016- based Hampshire Small Area Forecasts, in 2017 there is estimated level of need for Tier 1 services for 25,400 to 38,100 children and young people aged under 17 year olds and the estimated need for children with moderately severe problems requiring attention from professionals trained in mental health (Tier 2 services) around 17,800 child and young people resident in Southampton. The relative child deprivation in Southampton compared to England means these crude estimates of prevalence and service need are likely to underestimate the actual level of local need.

Intervening as early as possible can help to prevent those early indicators of problems occurring or escalating and there is compelling evidence of the cost benefit of early intervention using evidence-based programmes and methods for Specialist CAMHs, adult mental health services and society.

Emotional well-being is important in minimising the risk of children and young people making poor choices in relation to their long term well-being. The percentage of 15 year olds who have positive satisfaction with life among 15 year olds in Southampton is significantly lower

[56] Department of Health. Healthy Lives, Healthy People: our strategy for public health in England 2010 https://www.gov.uk/government/publications/healthy-lives-healthy-people-our-strategy-for-public-health-in-england
[57] Department of Health The mental health strategy for England 2011 https://www.gov.uk/government/publications/the-mental-health-strategy-for-england
[58] Cabinet Office and Department for Work and Pensions, Early intervention: the next steps 2011 https://www.gov.uk/government/publications/early-intervention-the-next-steps--2
[59] Campion J and Fitch C. (2013) Guidance for commissioning public mental health services, p. 33. http://www.jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf
[60] Kurtz Z. (1996) Treating Children Well: a guide to using the evidence base in commissioning and managing services for the mental health of children and young people

than the national average (57.2% compared to 63.8%) and the mean score Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) for Southampton's 15 year olds taken part in the What About YOUth (WAY) survey 2014/15 was significantly lower than the national average (46.0 compared to 47.6).[61]

Future in Mind is the government's vision to promote, protect and improve the mental health and wellbeing of children and young people. Promoting resilience, prevention and early intervention is one of the five themes of the vision and are fundamental to delivering the Children's mental Health and Wellbeing transformation outcomes for Southampton. The Strategic Transformation Plan for improving the health and wellbeing of children and young people across the Wessex region recognises the importance of schools in supporting young people's resilience and wellbeing.

Between April 2016 and August 2017 there were nearly 2000 referrals to Children and Adolescent Mental Health Service (CAMHS) in Southampton. Around 25% of these referrals didn't meet the criteria for CAMHS support and were therefore not accepted. These figures show a gap between the level of support schools and other universal services feel they can provide and the lower threshold of support agencies CAMHS can offer. There are numerous plans and service areas being developed by Southampton CCG and CC along with other stakeholders to promote wellbeing and build resilience, to help address this gap including an early intervention team sat within our core CAMHS service, increased investment in community provision of counselling and peer support and development of mental health training to professionals within universal services.

Self-harm and suicide among young people are extremely important issues. Many psychiatric problems, including borderline personality disorder, depression, bipolar disorder, schizophrenia, and drug and alcohol use disorders, are associated with self-harm. Self-harm increases the likelihood of a person eventually dying by suicide by between 50 and 100 times that of the rest of the population in a 12-month period.[62]

The 2014 Adult Psychiatric Morbidity Survey (APMS 2014) found one in four 16 to 24 year old women (25.7%) reported having self-harmed at some point; about twice the rate for men in this age group (9.7%). Estimates for Southampton for 2017 equate to 6,055 women and 2,410 men aged 16 to 24 years having self-harmed at some point.[63]

In 2015/16, Southampton had a significantly higher rate of emergency hospital admissions for self-harm for children and young people aged 10 to 24 years than England (559 per 100,000 population aged 10 to 24 years compared to 431 per 100,000 population aged 10 to 24 years).

[61] Public Health England, Children and Young People's Mental Health and Wellbeing https://fingertips.phe.org.uk/profile-group/child-health/profile/cypmh
[62] Self-harm in over 8s: long-term management https://www.nice.org.uk/guidance/cg133
[63] NHS Digital. NatCen Social research Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 http://content.digital.nhs.uk/catalogue/PUB21748 applied to the Hampshire County Council 2016-based Small Area Population Forecast

9.8.4.16.2 Adults

Common mental health disorders (CMDs) or common mental health problems (CMHP) are mental health conditions that cause marked emotional distress and interfere with daily function – including different types of depression and anxiety, and include obsessive compulsive disorder. The Adult Psychiatric Morbidity Survey 2014 categorises mixed anxiety and depressive disorder; generalised anxiety disorder; depressive episode; all phobias; obsessive compulsive disorder; and panic disorder as common mental health disorders. The AMPS 2014 found one in five (20.7%) women are affected by common mental disorders and one in eight men (13.2%) males and assuming the prevalence rate remains the same; in 2017 17,380 Southampton women and 11,900 Southampton men aged 16 to 64 year old are estimated to be affected by CMDs.[64] This is projected to increase to 17,740 women and 12,290 men by 2023.

(Note: these are crude estimates based on national estimated prevalence and more complex modeling adjusting for additional risk factors e.g. age and ethnicity would have provided more tailored estimates).

In 2015/16, compared to England, Southampton CCG had a significantly higher prevalence of people recorded with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses (2,989 people—1.1% of people of all ages, significantly higher compared to 0.9% in England).

In 2015/16, 18,492 people registered with their GP as having depression (with a diagnosis since 2006). This gives a crude prevalence rate of 8.3% (with the range at GP Practice level from 2.2% to 15.1%) which is the same as the figure for England (8.3%) and lower than Southampton's CCG cluster group average.

Not everyone who has a mental health problem is registered with a GP or has a diagnosis so the true figure is likely to be significantly higher.

In 2015/16, the GP patient survey estimated Southampton had a prevalence of long term mental health problems among the GP population of 7.5%, this was significantly higher than the national prevalence (5.2%).

The prevalence of CMDs/CMHPs are influenced by social determinants. Poor and disadvantaged people suffer disproportionately more CMHPs. The more debt people have, the more likely they are to have some form of mental health problem. CMHPs lead to reduced income and employment, which entrenches poverty and increases the risk of mental health problems. High rates of CMHPs are associated with low educational attainment. The Mental Health and Wellbeing JSNA profile show Southampton has higher rates compared to England for related risk factors, including: smoking at time of delivery; child poverty for those aged under 16 years old; excess weight for Year 6 children, looked after children; children in need due to abuse, neglect or family dysfunction, pupils with behavioural, emotional and social support needs; violent crime (including sexual violence),

[64] NHS Digital. NatCen Social research Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 http://content.digital.nhs.uk/catalogue/PUB21748 applied to the Hampshire County Council 2016-based Small Area Population Forecast

crime deprivation adult current smokers in adults. These topics are covered in other sections of this document.

Evidence shows work was generally good for both physical and mental health and wellbeing across society. In 2015/16, the gap in the employment rate for those in contact with secondary mental health services and the overall employment rate in Southampton was 75.1 percentage points, this is significantly worse than the gap nationally (67.2 percentage points). In 2015/16 the point gap in the employment rate between those with a long-term health condition and the overall employment rate was significantly lower in Southampton than the national gap (20.0 percentage points compared to 29.6 percentage points). For Southampton's residents with a learning disability point gap in their employment rate and the overall employment was 69.5 points, lower than the national gap (68.1 percentage points).

Prevention and treatment of CMDs/CMHPs should follow the stepped model of care, where the most effective yet least resource intensive form of support is provided in the first instance. At the higher steps of the model, treatment for identified CMHPs should be provided by Improving Access to Psychological Therapies (IAPT) services. In January – March 2017, 100% Southampton of patients referred to IAPT were seen within 6 weeks, compared to a national average of 89.9%. The Five Year Forward View for Mental Health guidance recommends at least 75% of people referred to IAPT services should start treatment within 6 weeks. In Q3 2016/17, Southampton had a significantly higher rate (quarterly) beginning IAPT treatment per 100,000 population aged 18 years and over than England. (591 per 100,000 compared to 547 per 100,000). For the same quarter, Southampton had a higher but not significantly rate (quarterly) for completing IAPT treatment (at least 2 appointments) per 100,000 population aged 18 years and over. (322 per 100,000 compared to 317 per 100,000).

In 2015/16, Southampton had a significantly higher rate of emergency hospital admissions for self-harm (all ages) than England (347.2 per 100,000 population compared to 196.5 per 100,000 population).

The APMS 2014 survey found a fifth of adults (20.6%) reported that they had thought of taking their own life at some point. Applying this prevalence to the Southampton adult population (aged 16 years and over), in 2017 an estimated 43,065 adults had had suicidal thoughts within their lifetime; this number is projected to increase to 44,950 adults in 2023.[65]

In 2013/15, Southampton's suicide and mortality from injury undetermined directly age standardised rate (DSR) aged 15 and over (14.4 per 100,000 population) significantly higher than England (10.1 per 100,000 population). The rate of suicide and mortality from injury undetermined for males is significantly higher than the rate for females, locally and nationally.

[65] NHS Digital. NatCen Social research Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 http://content.digital.nhs.uk/catalogue/PUB21748 applied to the Hampshire County Council 2016-based Small Area Population Forecast

9.8.5.16.3 Older people

Dementia is one of the main causes of disability in later life ahead of cancer, CVD and stroke. Data from GP QOF registers shows that in March 2016 there were 1627 people with diagnosed dementia, although the actual number of sufferers is likely to be higher. In September 2016, the recorded prevalence in dementia for Southampton GP registered patients aged 65 years and over was 4.38% (n=5,173) this was higher but not significantly than the national average of 4.31%

The number of people with neurological conditions is likely to grow sharply in the next two decades due to improved survival rates, improved general health care and infection control, increased longevity and improved diagnostic techniques.

The prevalence of dementia is closely associated with age and gender. As discussed in Chapter 1, the proportion of people aged 65+ years is estimated to increase by nearly 5% between 2016 and 2023. POPP estimates the number of people aged 65 and over predicted to have dementia In Southampton to be 2,450 in 2017 and set to increase to around 2,810 in 2025 and 3,710 in 2035.

In 2015/16, the rate of emergency inpatient hospital admissions of people (aged 65+ years) with a mention of dementia was 2,388 per 100,000 population aged 65+. This was lower but not significantly than the rate for England (3,387 per 100,000 population aged 65+ years).

9.9 Taking responsibility for health

The ‘Taking Responsibility for Health’ theme of Southampton’s JSNA is split into four distinct topics; 'smoking', 'obesity', 'sexual health' and 'alcohol & drugs'.

9.9.1 Smoking

Although smoking prevalence has decreased nationally, a wide disparity still exists across regions and Southampton compares less favourably both to the region and the country as a whole, making smoking a public health priority. In 2015/16, the prevalence of smoking among GP registered patients is in the city is 21.5%, significantly higher compared to the national average of 18.1%. In 2015/16, 14.3% of pregnant women in the city smoke at the time of delivery. This is significantly higher compared to the national average of 10.6%, putting both their own health, and the health of their baby, at risk. In addition, in 2016 the smoking rates are higher (but not significantly) among the city’s routine and manual workers with rates of 29.5% in Southampton compared to 26.5% nationally.

Men living in Southampton have significantly lower healthy life expectancy than the national average (60.9 years compared with 63.4 years), and smoking is one of the main causes for this. In 2013 to 2015, more people die from smoking attributable deaths in Southampton than the national average (353.7 per 100,000 population, compared to 283.5 per 100,000 in England). Deaths from lung cancer and chronic obstructive pulmonary disease are also

higher than the national average, and more people are admitted to our hospitals with smoking related illnesses.

Smoking causes a considerable burden for our health services, impacting on primary care and also increasing the number of hospital admissions, especially in the winter months. In 2015/16, 1,782 per 100,000 admissions to hospital were directly attributable to smoking. The cost per capita of smoking attributable hospital admissions for Southampton in 2011/12 was estimated to be £5.05 million. To try to reduce the significant economic burden of smoking on local NHS services, there is local investment in the improving fitness for surgery programme, which is an initiative that provides help to people to stop smoking for 4 weeks before having non-urgent (elective) surgery. There is also a need to ensure that smoking cessation is integrated into clinical pathways.

In 2015/16, the number of successful quitters (CO validated) at 4 weeks was 1,757 per 100,000 smokers aged 16+, this was lower but not significantly than the national rate of 1,854 per 100,000 smokers age 16+.

9.9.2 Excess weight and physical activity

In 2013/15, 62.6% of Southampton's adults are estimated to be overweight or obese which is lower but not significantly from the national average of 64.8%. However, in 2015/16 the proportion of adults recorded as obese on GP registers in the city is 8.7% which is significantly lower than the England average of 9.5%. However in 2015/16 physical activity amongst adults in Southampton is the same as national levels 65.4% and higher than most of the city's Office of National Statistics (ONS) peers.

The link between lack of physical activity and poor health outcomes is well documented. In 2015/16, 62 of Southampton's 74 schools were engaged with the Pioneer Healthy Schools Award scheme. Twenty-three schools achieved a level of the Pioneer Award Status between 2010/11 and 2015/16. The long-term approach of the Pioneer award scheme is to embed behaviour change, which is achieved over varying time scales, generally between 1 and 2 years.

The majority of children and young people are offered two hours of high-quality PE and sport a week, and all Southampton schools have travel plans. The percentage of children not travelling to school by car is increasing.

Active transport has benefits for health in terms of reducing the risk of chronic disease such as coronary heart disease or stroke and improving mental health and well-being. In 2014/15, the Active People Survey found in 79.0% of Southampton residents do 10 minutes walking at least once per week (lower than the national percentage 80.6%), but more Southampton residents (53.1%) do 10 minutes walking at least five times a week – higher than the national percentage (50.6%).

A similar pattern is reflected amongst Southampton residents who cycle. Fewer Southampton adults cycle at least once a week (12.4% of Southampton residents compared to 14.7% nationally), and of those who are more physically active, more Southampton adults (4.8%) cycle at least three times a week compared to the national average (4.4%).

9.9.3 Sexually transmitted infections (STIs)

In 2016, a total of 3,051 acute STIs were diagnosed in Southampton residents, with the distribution varying considerably across the city (1,223 per 100,000 population significantly higher compared to the England average 750 per 100,000 population). The most commonly diagnosed STI was chlamydia, followed by anogenital warts and herpes.

Of the 3,051 acute STIs diagnosed in Southampton in 2016:

- 56% were in people aged 24 years and under
- 9% were in people born outside of Europe
- 14% were in cases where people described the sexual orientation recorded as gay or bisexual or men who have sex with men (MSM),

In Southampton, an estimated 6.7% (7.1% nationally) of women and 8.7% (9.3% nationally) of men presenting with an acute STI at a genitourinary medicine (GUM) clinic during the 5 year period from 2010 to 2015 were re-infected with a new STI within 12 months became re-infected with an acute STI within twelve months.

In Southampton 20% of the population is aged between 15 and 24 years, compared to 12% in England. Forecasting tools predict that by 2023, the size of the 20 to 24 age group will decrease by up to 4% in Southampton, but even so, this group will still represent the largest proportion of the population. As this younger age group is most susceptible to STIs, strategic planning must take population projections into account.

The highest rate of STI diagnoses in Southampton is in the 15 to 24 age group. This is likely to reflect not only a greater burden of infections in this age group due to more frequent unprotected sex but also higher ascertainment due to targeted testing of young people. Since the full scale implementation of the National Chlamydia Screening Programme (NCSP) for 15-24 year olds in 2008, diagnosis rates of chlamydia have also increased in men and women.

In 2015, Southampton has the 36th highest rate (out of 326 local authorities in England) of new STIs excluding chlamydia diagnoses in 15-24 year olds; with a rate of 1013.5 per 100,000 residents (compared to 815 per 100,000 in England). In 2013 - 2016, Southampton was achieving in excess of the national target of 2,300 diagnoses per 100,000.

9.9.4 Alcohol and drug misuse

The 2014 What about YOUth survey estimates that 63.3% of 15 year olds in Southampton have ever had an alcoholic drink and 5% of this age group report being regular drinkers. These figures are not significantly higher than the national average. Southampton has two large Universities hosting over 30,000 students in the city. Some children and young people drink at levels which bring them into contact with emergency healthcare. The ICE bus or ‘In Case of Emergency’ bus is an innovative initiative to reduce the burden of alcohol-related attendances at University Hospital Southampton Emergency Department during the peak hours (1000 to 0400 hours) of the Night Time Economy in Southampton City Centre. It was implemented in 2009 and since then has offered an important service offering welfare

support and acute medical care to vulnerable people during most Saturday nights in the city. Thirty percent of ICE bus clients between 2013/14 to 2015/16 were either in drink or intoxicated and 64% are aged 18 to 24 years olds.

Alcohol can be directly or indirectly implicated in hospital admissions. When someone is admitted due to a condition wholly attributable to alcohol, it is termed an alcohol-specific admission. The 2015/16 rate of hospital admissions for all ages and those aged under 18 years for alcohol-specific conditions was significantly higher for Southampton's persons, males and females than the rates for England.

Alcohol-related hospital admissions includes all the cases of alcohol-specific hospital admissions and those in which alcohol is known to play a part. The indicator uses two measures; broad and narrow. The broad measure covers main diagnosis or any secondary diagnosis was attributable to alcohol, and the narrow where the main diagnosis was attributable to alcohol or the secondary diagnosis was alcohol related. The broad measure assesses the burden on community and health services better than the narrow measure. In 2015/16, under the broad measure, the rate of admission episodes for alcohol-related conditions for Southampton's males and females (all ages) was significantly higher than the rate for England.

In 2015/16, using the narrow measure the rate of admission episodes for alcohol-related conditions (all ages) for person and males was significantly higher, and for females higher bit not significantly than the rates for England.

In 2015/16 Southampton also has higher rates than the national average for:

- Admission episodes for alcohol-related unintentional injuries conditions (Narrow), persons and males
- Admission episodes for mental and behavioural disorders due to use of alcohol condition (Narrow), persons and males
- Admission episodes for intentional self-poisoning by and exposure to alcohol condition (Narrow), persons, males and females
- Admission episodes for mental and behavioural disorders due to use of alcohol condition (Broad) persons, males and females
- Admission episodes for alcoholic liver disease condition (Broad), persons)

More men in Southampton are dying because of alcohol than the national average, this figure has been consistent for the last 5 three year periods; between 2013-15 there were 78 deaths specifically due to alcohol in Southampton; 63 in males and 15 in females.

In 2016, Southampton had a significantly higher rate (177.3 per 100,000 working age population) of claimants of benefits with alcohol misuse as the main disabling condition compared to the national average (132.8 per 100,000 working age population).

In 2015, there were 737 clients resident to Southampton in treatment for opiate use, 43 clients had successful completion of drug treatment for opiate users (5.8%). The percentage was lower but not significantly than England (6.7%). In 2015, 23.8% (53 people) of

Southampton's residents receiving treatment for non-opiate drug use was successful which was significantly lower than the rate for England.

In 2015/16, 36.5% of Southampton adults with substance misuse treatment need successfully engaged in community-based structured treatment following release from prison. This was significantly higher than the rate for England (30.3%).

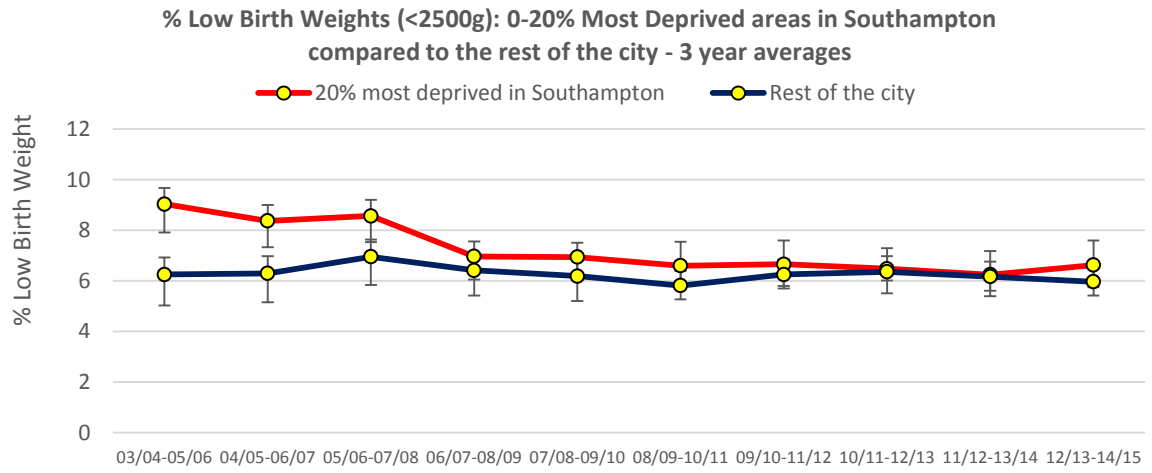
9.10 Parenting, childhood and adolescence

9.10.1 Low birth weight

Low birth weight among infants is strongly linked to poorer outcomes for children as they get older. It is associated with infant mortality and is predictive of educational achievement, disability and diabetes1, stroke and heart disease risk in adults. In 2015, the rate of low birth weight babies born at term (babies with a recorded birth weight of less than 2,500 grams and a gestational age of at least 37 complete weeks) in Southampton is 2.5% of all births; similar to the England average of 2.5%. This has been decreasing slowly overall since 2010.

The decline in low birth weight has been more rapid in those parts of the city with the highest levels of economic deprivation where case-loading midwifery teams are based. The rate has declined significantly in the most deprived 20% of Southampton from 8.6% to 6.6% over the same time period and a narrowing of the gap compared to the rest of the city from 1.6 percentage points to 0.6 percentage points (Figure 34). Whilst there is some variability in the percentage of babies born at a low birth weight across the Sure Start areas, none are significantly different from the city average.

Figure 34



9.10.2 Levels of caesarean versus normal births

Variations in the level of caesarean births relate more to the effective use of resources than need. The proportion of total births that were normal deliveries in 2014/15 was 59.4%. The proportion that were caesarean section was 23.4%, the same as the previous year (SUHT) births and bookings data). To ensure good use of resources there is a drive to reduce unnecessarily high levels of caesarean assisted deliveries.

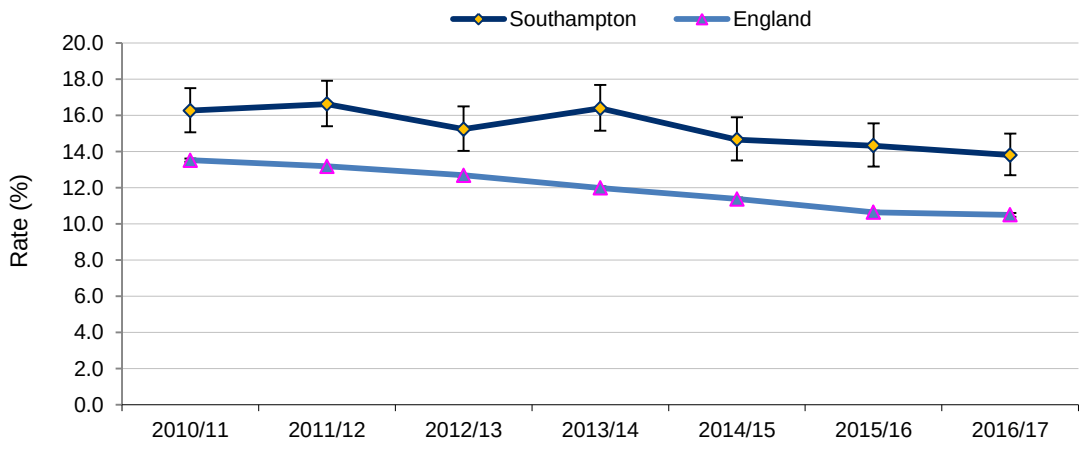
Caesarean birth rates are significantly lower within the most deprived areas compared to the rest of the city, although the gap is narrowing. Whilst there is some variability in the percentage of babies born by caesarean section across the city's areas, none are significantly different from the Southampton average.

9.10.3 Smoking during pregnancy

Smoking during pregnancy is strongly associated with a number of health problems for new born children. There is evidence to suggest that the number of mothers smoking at midwifery booking has reduced significantly from 24.3% in the 2003/04 - 2005/06 period to 18.0% in the 2012/13 - 2014/15 period. There are differences between ethnic communities, with 'White British' mothers having smoking rates significantly higher than the city average. Sure Start data shows that in the 2012/13 - 2014/15 period, 7.4% of mothers who smoked at the time of midwifery booking had a premature baby, which is significantly higher than 4.4% who did not smoke. In addition, 8.4% of women who smoked at the time of midwifery booking had a low birth weight baby; significantly higher than 4.3% of births to non-smoking mothers. Low birth weight often results in more intensive medical care, higher morbidity and delayed development in childhood. While data (Figure 35) shows that nationally 10.5% of women are still smoking at the time of delivery, the rate in Southampton, despite movement in the right direction, was still considerably higher than this at 13.8% in 2015/16.

Figure 35

Percentage of mothers smoking at delivery: Southampton and England trend: 2010/11 to 2016/17

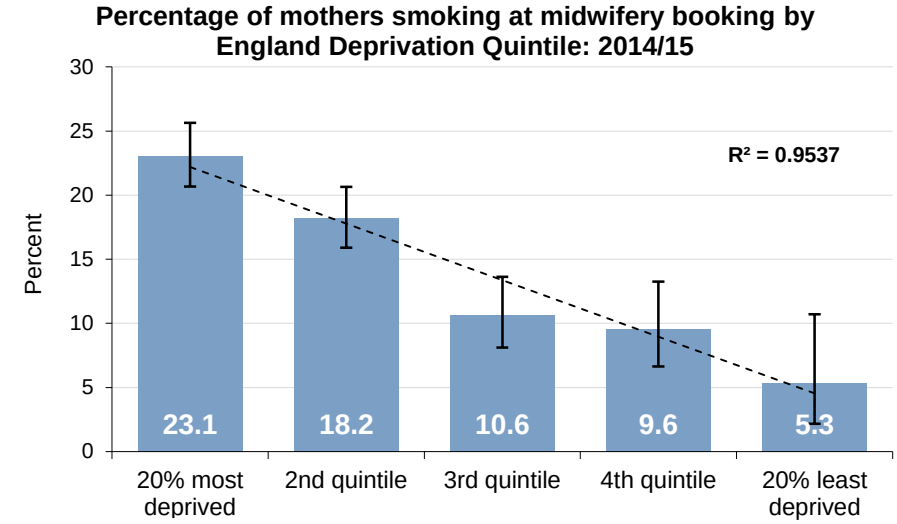


Sources: Copyright © 2017. Health and Social Care Information Centre, Lifestyles Statistics.

The poorer you are and the more disadvantaged, the more likely to you are to smoke and consequently suffer smoking-related disease and premature death. Research shows nationally pregnant women from routine and manual occupations are much more likely to smoke and to have done so during pregnancy than those from professional and managerial occupations (20% compared to 4%)[66]

Figure 36 demonstrates the wide disparity across the city with significantly higher rates of smoking at midwifery booking in the most deprived areas of the city compared to the least deprived.

Figure 36



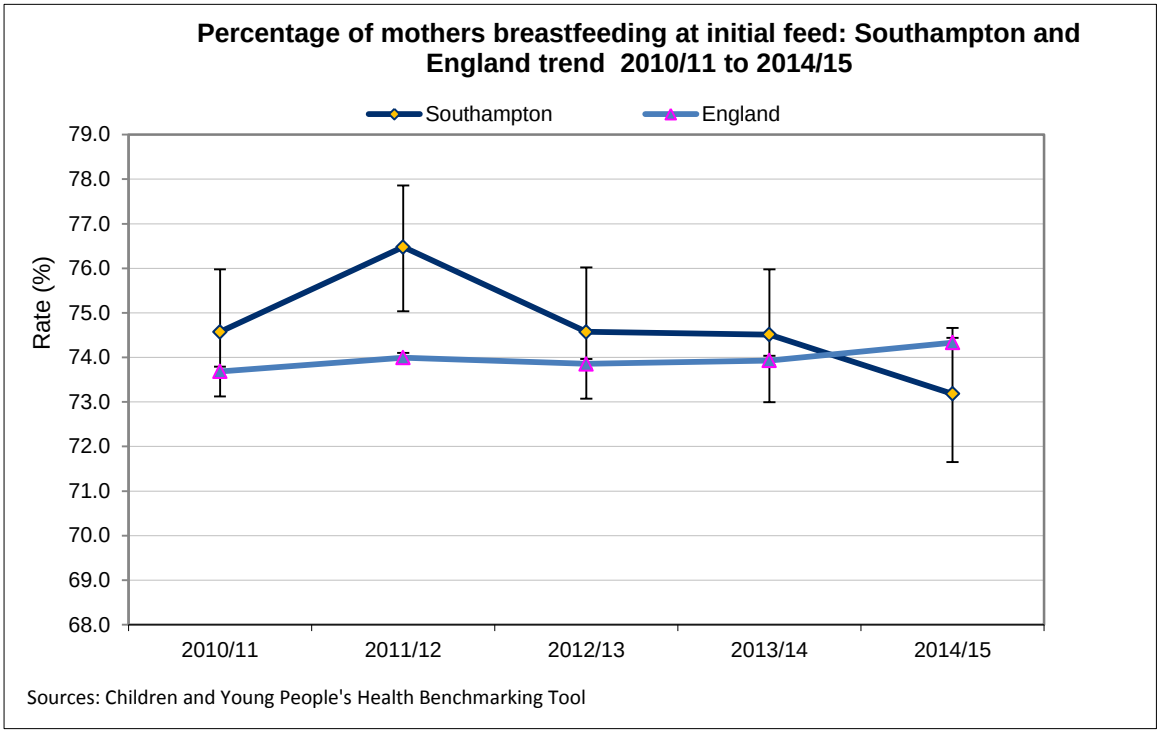
Sources: UHS Midwifery database: Southampton CCG

9.10.4 Breastfeeding initiation and maintenance

Year on year there has been a slight decrease in the number of mothers initiating breastfeeding in Southampton from 76.5% in the 2011/12 period to 73.2 % in the 2014/15 period (Figure 37). The challenge is now to maintain breastfeeding after the neonatal period so that more women continue to breastfeed at 6-8 weeks and beyond.

[66] McAndrew F, Thompson J, Fellows L et al (2012) Infant Feeding Survey 2010. A survey conducted on behalf of the Information Centre for Health and Social Care. Leeds: The Information Centre for Health and Social Care. http://digital.nhs.uk/catalogue/PUB08694/Infant-Feeding-Survey-2010-Consolidated-Report.pdf

Figure 37



In 2013/14, 44.3% of women still breastfed at 6-8 weeks, slightly lower than the England average of 47.2% over the same time period. Mothers living in areas of higher deprivation are less likely to initiate breastfeeding and are likely to breastfeed for a shorter duration compared to mothers living in areas of low deprivation.

In Southampton a local target has been set to reach 50% of new mother's breastfeeding at 6-8 weeks, however data quality issues for Southampton's data for 2014/15 and 2015/16 make it difficult measure meeting this challenge.

9.10.5 Child dental/oral health

Dental decay is largely preventable. Dental decay is also the main reason for children to be admitted to hospital. General Anaesthetic (GA) in a hospital may be needed to either fill or extract teeth in young children as they are often unable to cooperate, particularly if they are in pain. Good oral health is even more important in children than adults as they are just learning to speak and socialise and for whom a varied healthy diet is essential for development and achievement of potential. Poor oral health results in pain and distress, which is undesirable particularly in young children. Rates of children's dental health in the city are poor compared to many other areas in the country. In the most recent dental health survey of 5 year olds conducted in 2012, 30% of just over 2,700 Southampton children surveyed had decayed, missing or filled teeth (dmft) compared to 27.9% in England. Dental decay is experienced differently across levels of deprivation within the city; in 2011/12, 38% of children living in the 20% most deprived areas experienced dental decay compared to 23% of those living in the least deprived – an inequality gap of 15%.

Local data collected as part of the 2014-15 dental survey of Year 1 children, showed that a total of 644 (27.5%) needed to see a dentist due to dental concerns. The number and rate of children in Southampton who had teeth extracted under GA increased across all ages between 2013/14 and 2014/15. In 2013/14 there were 396 children in the city (a rate of 8.0 per 1000 residents) who had 1,677 teeth extracted. This increased to 493 children (9.8 per 1000) in 2014/15 (an increase of 24.5%) who had 2,248 teeth extracted between them. This includes 162 children aged 0-5 years in 2013/14 increasing to 191 in 2014/15 (an increase of 17.9%). The median number of teeth extracted per child remained at 4 over both years.

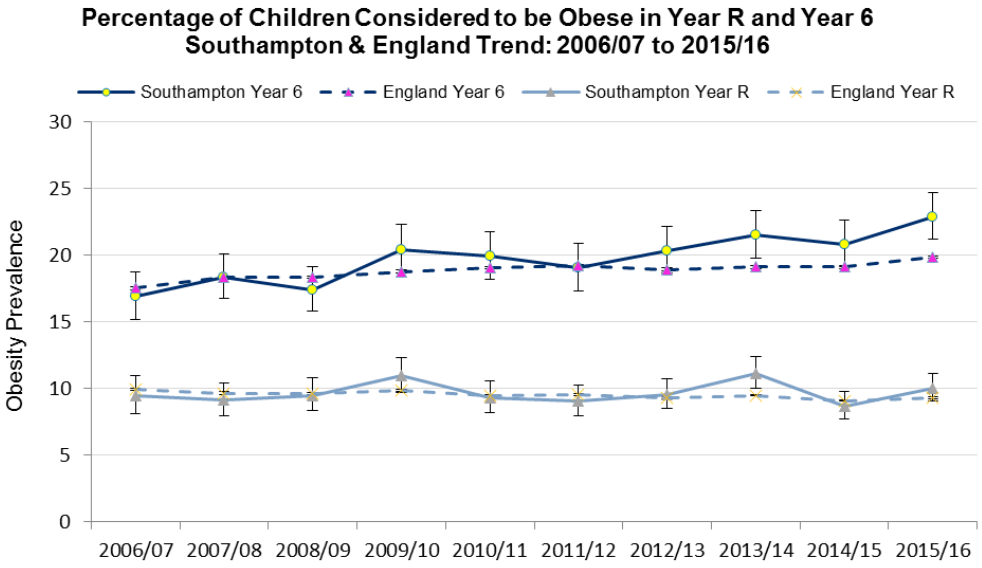
Dental extractions are also more common amongst children from the more deprived areas of Southampton. There is a large gap in the rate of children with teeth extracted under general anaesthetic between the highest and lowest deprivation quintiles over both years. Each GA extraction for school-aged children will potentially result in five missed sessions from school (one session for the presentation to dentist, one session for the GA pre-assessment clinic, one session for the day of extraction, one day for recovery on the following day and one session for post assessment). In reality there are likely to be more sessions missed for sickness days associated with toothache and for recovery time from the procedure. Additionally, parents/carers may need to take leave from work to take children to the various appointments. Using an estimate of five missed school sessions missed, GA dental extractions would have accounted for 1510 missed sessions in Southampton amongst 6-17 year olds in 2014-15.

9.10.6 Childhood obesity

Obesity in childhood is closely linked to obesity in adulthood and with a wide range of poor long term physical and mental health outcomes related to poor diet and low levels of physical activity. According to the most recent results from the National Child Measurement Programme (NCMP) from 2015/16, 12.5% of children in reception classes are overweight and a further 10.0% obese (i.e. 22.6% above normal weight). The prevalence of obesity has increased slightly from the previous year (10.0% compared to 8.7%), but the long term trend is relatively stable (Figure 38).

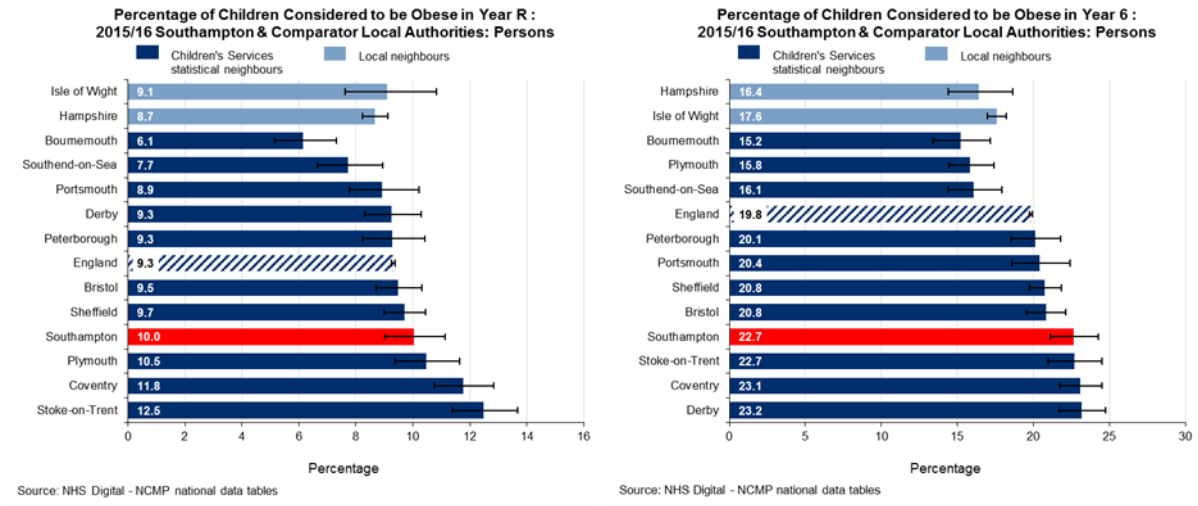
Similar to the national picture, overweight and obesity prevalence is significantly higher in Year 6 compared to Year R. In Southampton, the prevalence of obesity for Year 6 children has increased from 20.8% in 2014/15 to 22.9% in 2015/16, but because of the relatively wide confidence intervals associated with these rates, this change is not statistically significant. Levels of obesity in Year 6 have not reached the target of 16.5% set in the Local Area Agreement and the trend appears to be an increasing one. Results from the 2015/16 NCMP show that 14.3% of Southampton children in Year 6 classes are overweight (i.e. 37.0% above normal weight). Figure 26 and 27 show the trend and benchmark the prevalence of obesity respectively for Year R and Year 6 children.

Figure 38



Sources: NCMP validated dataset supplied by NOO, Southampton CHIS & NHS Digital NCMP national data tables (http://www.content.digital.nhs.uk/catalogue/PUB22269)

Figure 39

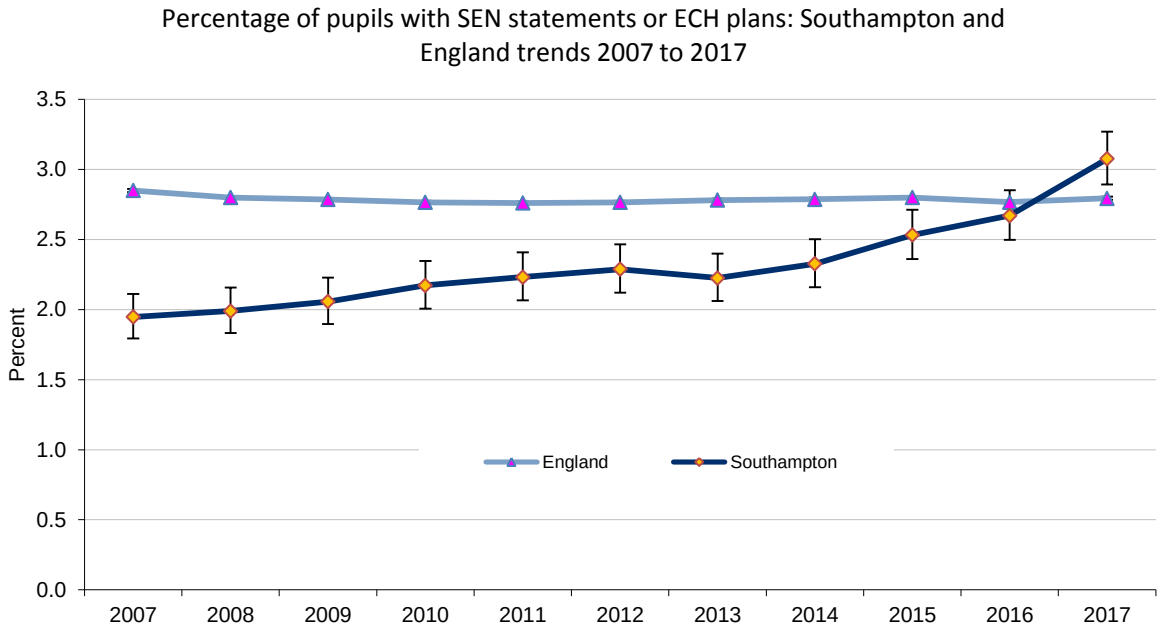


A longitudinal analysis of the ten years of data available locally shows that over 70% of children classified as overweight in Year 6 were previously of a healthy weight at 4-5 years of age. This proportion increased significantly (at the 95% confidence level) from 66.5% in 2012/13 to 77.4% in 2014/15, although the latest data for 2015/16 shows a reduction to 69.1%. Approximately 40% of children classified as obese in Year 6 were recorded as of healthy weight in Year R over the latest three school years examined, 2013/14 to 2015/16 (pooled). This suggests that although obesity in Year R is a significant risk factor for obesity in Year 6, interventions focused solely on children who were classified as obese in Year R only have the potential to reduce the level of obesity in Year 6 by around a third at most.

9.10.7 Children & Young People with special education needs (SEN)

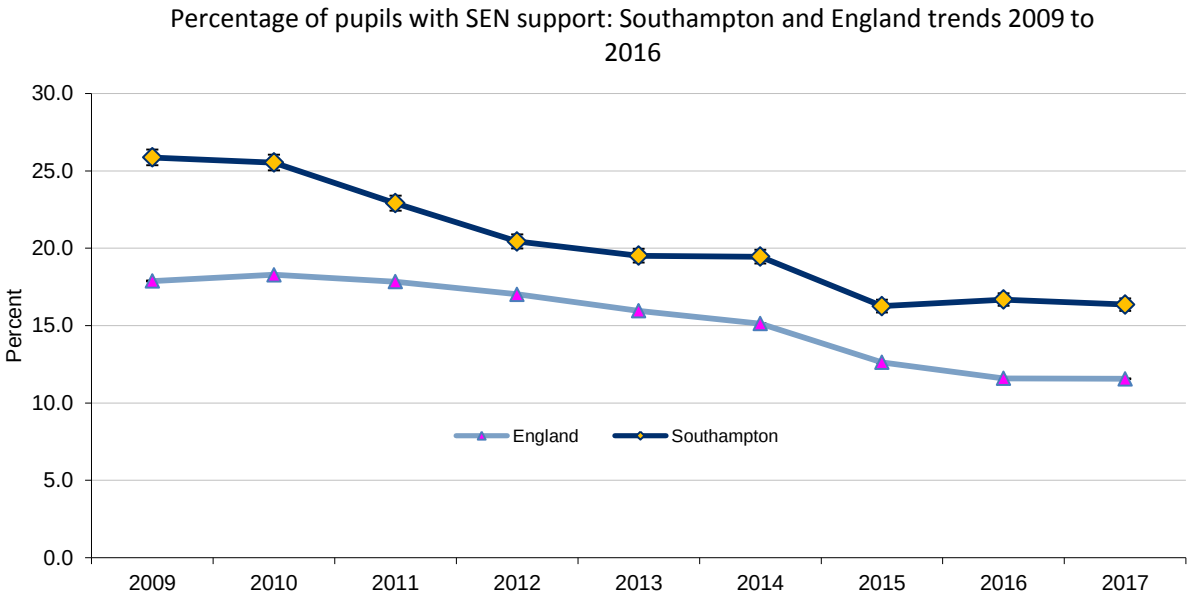
Latest data from the Department for Education (DfE) shows there to be over 6,000 children in the city with SEND; 860 with Statements or Education, Health or Care Plans (EHC). Historically, Southampton has had a lower level of pupils with SEN Statements or EHC Plans than the national average and most Statistical Neighbours. However, there has been a statistically significant increase from 2.1% of children in 2009 to 3.1% in 2017 when the percentage for Southampton was significantly higher than the rate for England (Figure 40 and 41). This is to be expected and is likely due to the implementation of clearer assessment criteria and pathways in the city.

Figure 40



Source: Department for Education

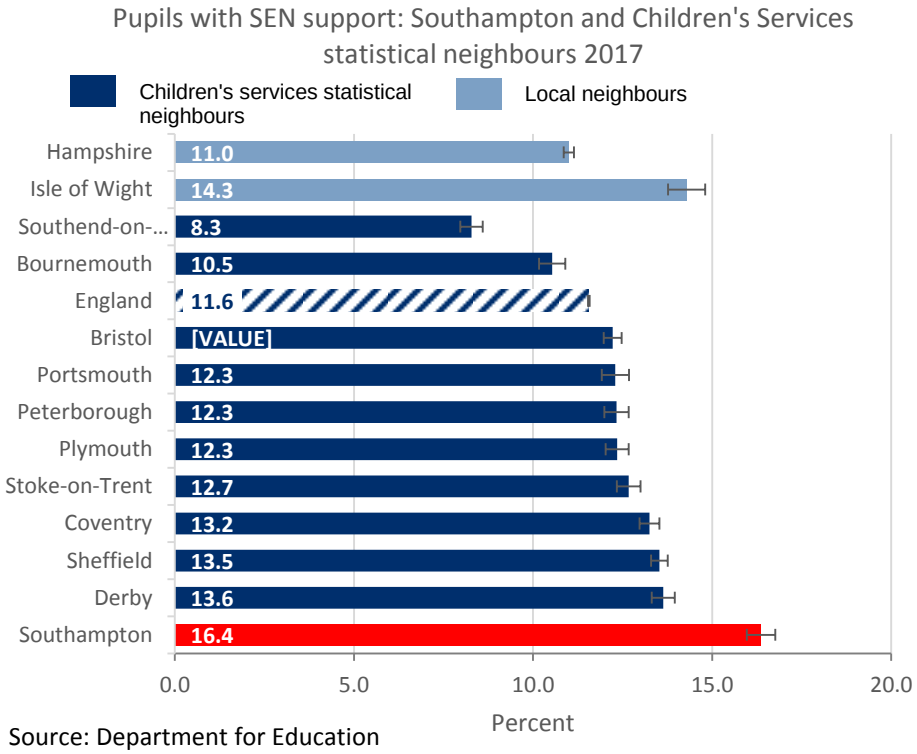
Figure 41



Source: Department for Education

Southampton has a higher level of pupils requiring SEN support than all of its statistical neighbours and the national average (Figure 42). Work is currently being undertaken in collaboration with Southampton Inclusion Partnership (SIP) to support accurate identification of pupils requiring SEN support, due to concerns of historic over-identification

Figure 42



Source: Department for Education

Schools census data from January 2016 illustrates the extent of SEND across primary and secondary cohorts (Table 1). This data is a 'snapshot' so the percentages are slightly different from the data presented previously. However, it shows that Southampton has higher levels than national and regional averages.

Table 11. EHCP / SEN in Primary and Secondary School cohorts – January 2017

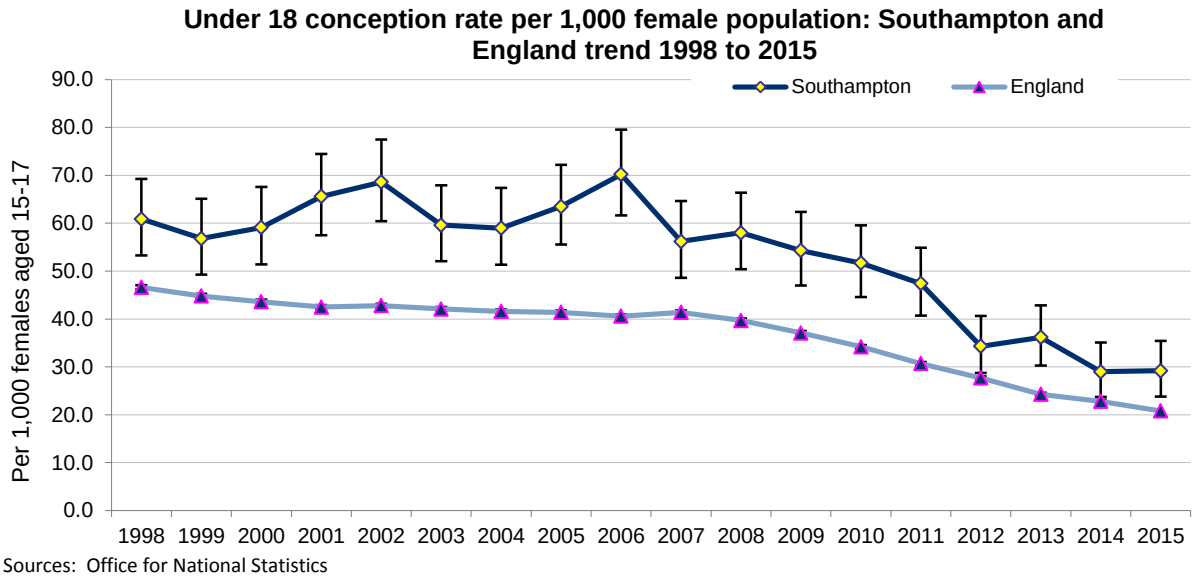
Setting	Area	Total Pupils	Statements or EHC plans		SEN support		Total pupils with SEN	
			Number	%	Number	%	Number	%
Primary	Southampton	20,331	339	1.7	3,621	16.1	3,621	17.8
	South East	724,988	10,584	1.5	81,699	11.3	92,283	12.7
	England	4,689,658	62,390	1.3	570,714	12.2	633,104	13.5
Secondary	Southampton	10,149	130	1.3	1,734	171	1,864	18.4
	South East	504,728	8,147	1.6	52,096	10.3	60,243	11.9
	England	3,223,089	55,867	1.7	345,139	10.7	399,006	12.4

Within Southampton there are three main areas of identified primary special educational needs; Moderate Learning Difficulty; Speech, Language and Communication and Social, Emotional and Mental Health. The level of Social, Emotional and Mental Health needs are the primary need for one in five pupils in the City, highlighting the importance of improving emotional wellbeing provision and access to CAMHS services for children and young People.

9.10.8 Teenage pregnancy

Teenage pregnancy has long been regarded as a proxy indicator for wider evidence of low aspirations, and social and education disengagement. Southampton's 2015 under 18 conception rate was 29.2 per 1,000 females aged 15-17 years old. This equates to approximately 2.9% of the under 18 female population conceiving in 2014 (99 young women). Figure 43 below shows that the Southampton rate has been consistently higher than the national rate since the 1998-2000 baseline, and although the rate in Southampton has fallen by over 50% since 1998, it still remains significantly higher than the national average.

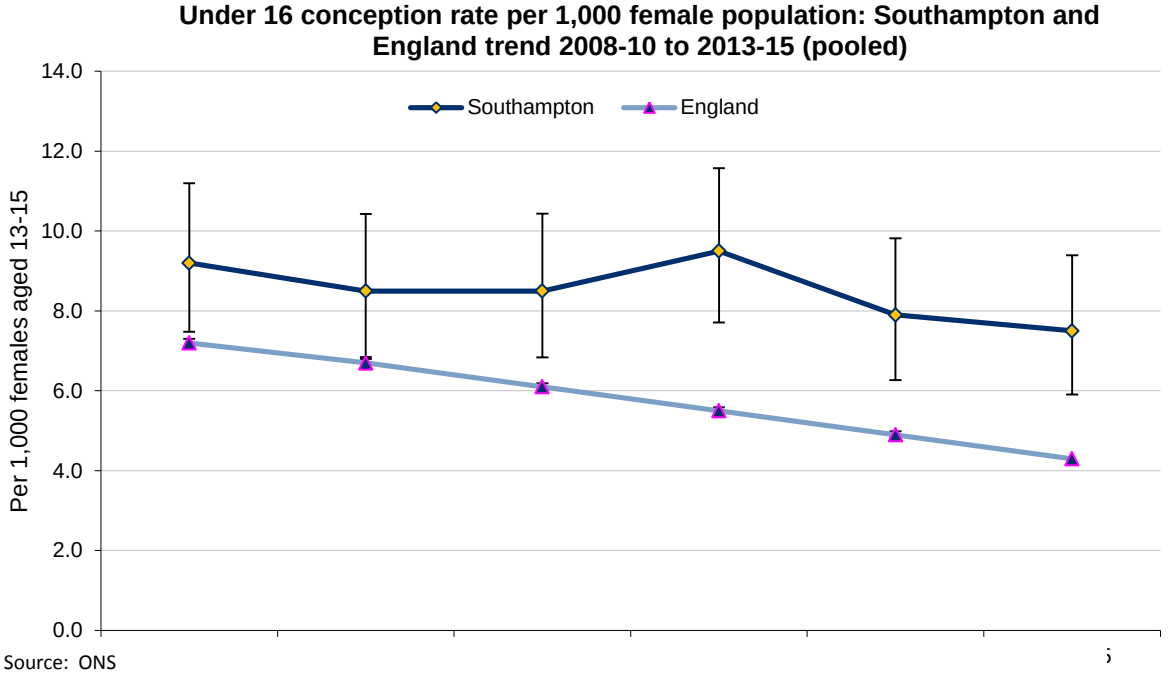
Figure 43



Sources: Office for National Statistics

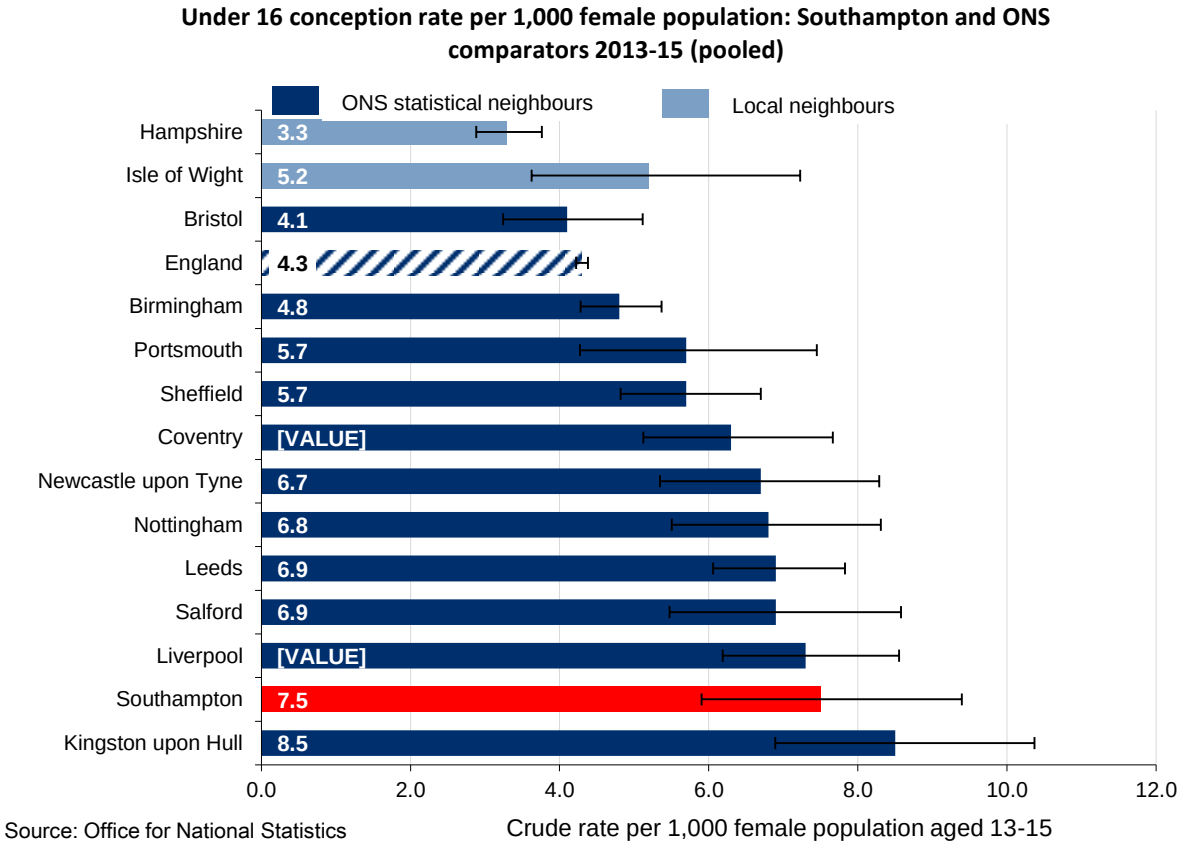
In the 2013-15 period there were 75 conceptions amongst girls aged under 16. This is important in demonstrating that many of these conceptions were both unplanned and unwanted, and therefore might have been prevented through effective Sex and Relationships Education support and better access to contraception and sexual health provision. Southampton's under 16 conception rate remains significantly higher than national average (7.5 per 1,000 compared with 4.3 for England over the three year period 2013 to 2015) and third highest amongst comparator areas. (Figure 44 & 45)

Figure 44



Source: ONS

Figure 45



9.10.9 Termination of pregnancy

In Southampton 965 abortions were carried out in 2016, this is a crude rate of 16.4 per 1,000. This rate is lower than the England average but not significantly so. In the city, 78.9% of NHS abortions are performed under 10 weeks gestation; this is lower but not significantly compared to the England average of 80.8%. Southampton has a lower rate of repeat abortions compared to England for all ages (35.8% compared to the national average of 38.4%).

9.10.10 Misuse of alcohol and other substances by young people

Results from the 2014 What about YOUth survey indicate that 11.7% of Southampton 15 year olds currently smoke, 8.3% smoke regularly, 13.4% have ever tried cannabis and 21.4% have tried e-cigarettes. All of these figures are significantly higher than the national average.

The same survey estimates that 63.3% of 15 year olds in Southampton have ever had an alcoholic drink and 5% of this age group report being regular drinkers. These figures are not significantly higher than the national average.

Modelling has found that key groups of vulnerable young people who typically demonstrate higher levels of risk-taking behaviour are under-represented in treatment services e.g. (young offenders, children looked after, young people with emotional and mental health issues, young people not attending school). Consultation with providers and service users found that services working with these young people lack the skills to be able to identify, assess and screen young people around their substance misuse. Partnership working to effectively support young people needs further development.

9.11 Protecting the Population

9.11.1 Environmental exposures

Prior to the mid-1980s asbestos was widely used in the ship-building industry. Exposure to asbestos is the leading cause of a cancer called mesothelioma which can affect the tissues covering the lungs or the abdomen. Southampton's ship-building heritage means that we need to be aware of this possible risk even though mesothelioma is a relatively rare cancer. Southampton is included within ten geographical areas of Great Britain with the highest male mesothelioma death rates for the period 1981-2015 (355 deaths for Southampton male residents. These areas include other prime ship-building locations of the last 40 years; Barron-in-Furness, West Dunbartonshire, North and South Tyneside, Southampton, Plymouth, Medway, Hartlepool, Medway and Eastleigh.[67]

ONS Mortality data shows over the period 2012-16, there were an average of 14 deaths per year to Southampton residents from mesothelioma.

Poor air quality is a significant public health issue. Particulate matter ($PM_{2.5}$) has a significant contributory role in human all-cause mortality and in particular in cardiopulmonary mortality. Southampton's level of $PM_{2.5}$ is 9.2 µg/m^3 which is higher than the England average of 8.3 µg/m^3. Southampton level has decreased annually between 2011 and 2015 but has remained higher than the England average. In 2015, the estimated fraction of all-cause adult mortality attributable to anthropogenic particulate air pollution (measured as fine particulate matter, PM2.5) for Southampton was 5.2% higher than the percentage for England (4.7%). The fraction of mortality attributable to particulate air pollution has fallen over time in line with the particulate levels.

9.11.2 Safeguarding for children and vulnerable adults

In Southampton, the intention remains to ensure that every child and young person has the best opportunity to be kept safe from harm, abuse and neglect.

Thresholds and referral processes have been thoroughly reviewed and improved to ensure that more referrals are appropriate and that timely interventions are made. However, the

[67] Health and Safety Executive, Mesothelioma mortality in Great Britain 1981-2015 (2017) http://www.hse.gov.uk/statistics/causdis/mesothelioma/mesoarea1981to2015.pdf

levels of children and young people who are subject to safeguarding support either as children in need, children and young people in care, or subject to a Child Protection are higher than national levels. A child in need is one who has been referred to children's social care services, and who has been assessed, usually through an initial assessment, to be in need of social care services. In 2015/16, the rate of children in need was 1453.9 per 10,000 children, over double the national rate of 1453.9 per 10,000 children.

Section 47 inquiries are undertaken when children are at risk of significant harm. In 2011, the Southampton Section 47 protocol was developed by a multiagency group and launched to ensure agencies such as Police, social care and health services are well co-ordinated. NHS providers in Southampton have specialist safeguarding / child protection teams to ensure the best possible outcomes for children. In 2015/16 the rate of Child Protection Investigations (Section 47 enquiries) was 384.1 per 10,000 children aged under 18 years, again more than double the national rate 147.5 per 10,000 children.

In 2015/16 Southampton's rate of looked after children was 120.0 per 10,000 population aged under 18 year. Southampton's rate is twice the nation rate and follows an annual increasing trend whereas the national rate has remain constant at 60 per 10,000 population aged under 18 years for the last four years. In 2016, the rate of children who started to be looked after due to abuse or neglect was significantly higher in Southampton 33.6 per 10,000 children aged under 18 years compared to the rate for England (14.9 per 10,000 children aged under 18 years old).

Bullying has a strong effect on the mental health of those bullied, and can often damage their outcomes in other areas of life and even lead to suicide amongst the worst affected and most vulnerable. The What About YOUth? Survey 2014/15 found a higher, but not significantly percentage of 15 year olds in Southampton (56.7%) had been bullied in the past couple of months compared to the national percentage (55.0%).

Injuries are a source of harm for children and a leading cause of hospitalisation and represent a major cause of premature mortality for children and young people. In 2015/16, for children and young children resident to Southampton the crude hospital admission rates for unintentional and deliberate injuries were not significantly different to the England rate for those aged 0-14 years - local crude rate was 111 admissions per 10,000 persons aged 0-14 years (468 hospital admissions) and those aged 0-4 years - local crude rate was 132 admissions per 10,000 persons aged 0-4 years (218 hospital admissions). However for those aged 15-24 years, the local crude rate was 163 admissions per 10,000 persons aged 15-24 years) (816 hospital admissions), significantly higher than the national rate of 134.1 per 10,000 persons aged 15-24 years.

Vulnerable adults include adults in contact with secondary mental health services and adults with a learning disability. Living in settled accommodation improves their safety and reducing their risk of social exclusion. Maintaining settled accommodation and providing social care in this environment promotes personalisation and quality of life, prevents the need to readmit people into hospital or more costly residential care and ensures a positive experience of social care.

In 2015/16, the percentage of adults in contact with secondary mental health services who live in stable and appropriate accommodation in Southampton was 19.8%, this is significantly lower than the England average of 58.6%. The percentages by gender for males and females were also significantly worse when compared to the national average. In 2015/16, the percentage of adults with a learning disability who live in stable and appropriate accommodation in Southampton was 19.8%, this is significantly lower than the England average of 58.6%. By gender, again Southampton's percentages were significantly worse for males and for females.

9.11.3 Health protection from communicable diseases

Health protection includes (but is not confined to) communicable disease, environmental health hazards/contamination and extreme weather conditions. As Southampton is a port city there are particular threats to health posed by the large scale movements of goods and people through the port.

Pharmacies have a role in the overall antibiotic stewardship activity taking place across the country, in offering vaccinations such as for seasonal influenza, and in some areas may be playing a role in Blood Borne Virus (BBV) testing using dry blood spot tests.

9.11.3.1 Tuberculosis (TB)

Cases of TB in Southampton have started to fall. In 2013-15, the rate per 100,000 population of new TB notifications in Southampton was 12.5. This is lowest rate since pre 2007-09, the rate peaked in 2011-13 with 18.3 new cases per 100,000 population. In 2014, 80% of drug sensitive TB cases had completed a full course of treatment by 12 months. Thus was significantly lower than the national percentage of 84.4%, however in 2013, 90.9% of Southampton drug sensitive TB cases had completed treatment, higher but not significantly than the national rate of 85.4%. Since 2004, the number of cases completing treatment has ranged annually of between 13 and 41.

9.11.3.2 Hepatitis C

Public Health England has produced a tool for estimating the prevalence of Hepatitis C in a local population based on national rates[68]. Using this tool, there are an estimated 606 people living in Southampton with Hepatitis C virus. The Health protection team received between 45-66 new reports of Hepatitis C infections amongst Southampton city residents per year over the last five years.

[68] https://www.gov.uk/government/publications/hepatitis-c-commissioning-template-for-estimating-disease-prevalence

9.11.3.3 Healthcare associated infections (HCAI)

Between April 2015 and March 2017 there were less than 6 cases of meticillin-resistant *staphylococcus aureusis* (MRSA) amongst the population registered with GPs in Southampton.[69]

During April 2016 to March 2017 there were, 42 cases of *clostridium difficile* amongst people registered with Southampton GPs.[70]

E.coli bacteraemia cases continue to see a year on year increase in Southampton and is in keeping with the national trend although Southampton CCG is amongst the ten CCGs nationally with the lowest crude rate of this infection.[71]

9.11.3.4 Vaccine preventable disease

Nationally, mumps is most commonly seen amongst University students and adolescents. This is not unusual as transmission is usually fueled by close contact, for example in halls of residence, events and parties. Although most cases occur either in unvaccinated or incompletely vaccinated individuals, mumps in fully vaccinated individuals can occur, due to waning immunity. Since 2013 however, there hasn't been an outbreak of mumps affecting students in Universities and schools in Southampton although there have been reports elsewhere in the country. Since 2013, an average of 40 cases/year were notified by GPs in Southampton residents with only an average of 10 cases/year being confirmed. Mumps activity tends to be cyclical with peaks occurring every four to five years.

There have been no confirmed cases of Rubella in Southampton or in Hampshire since 2012. Rubella incidence in the country remains very low.

In Southampton the number of confirmed and suspected pertussis cases was only around 5 per year in 2010 and 2011 rising to 46 in 2012. With the introduction of pertussis vaccine for pregnant women, and the associated awareness increasing, numbers appear to be falling again in 2013.

Since 2010, there have been two confirmed cases of Measles in Southampton residents. Both occurred in 2016 amongst unvaccinated individuals. While this appears encouraging, measles remains a highly infectious illness and reports of outbreaks affecting older children/ adolescents continue to be reported in the UK and in Europe.

9.11.3.5 Pandemic flu

The UK is planning for the worst case scenario in terms of pandemic flu, which would see a clinical attack rate of 50% amongst the population. Of those affected 2.5% of the population may die as a result. Extrapolating these figures to Southampton's 2017 population would mean an estimated 127,027 people could become symptomatic and 6,351 people could die.

[69] Public Health England. MRSA bacteraemia: annual data https://www.gov.uk/government/statistics/mrsa-bacteraemia-annual-data
[70] Public Health England. Clostridium difficile infection: annual data https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data
[71] Communicable Disease Control, Public Health England (Wessex)

9.11.3.6 Port health

As noted earlier the port hosts the largest cruise passenger operation in the UK and is Europe's leading turnaround cruise port (1.8 million passengers in 2015). It is also the UK's number one vehicle handling port (820,000 vehicles every year) and the UK's most productive container port. Food and people now travel over far greater distances than ever before, creating the conditions necessary for widespread and rapidly occurring outbreaks of disease. Infectious diseases such as cholera persist and return, and recent decades have shown an unprecedented rate of emergence of new zoonoses within the UK.

It is anticipated that container volumes and shipping movements will continue to grow but accurate projections are somewhat difficult in the current economic climate. It is also anticipated that the number and details of intervention will also increase in line with the effects of climate change, food fraud and adulteration which have clear implications for food production, food security and food safety. Southampton city council continually assesses resource threats and requirements and delivery outcomes.

9.12 Inequalities and specific needs for key population groups

The following patient groups and potential needs have been identified as living within the HWB's area:

9.12.1 University Students

As mentioned earlier, approximately 43,000 students live in the city. There are a number of health aspects during this transition period for young people. The mostly commonly associated with students are:

- Mumps
- Chlamydia testing
- Meningitis
- Contraception, including EHC provision
- Mental health problems are more common among students than the general population

In addition, students may need support managing pre-existing or long-term conditions such as diabetes, asthma, epilepsy, eczema and/or mental health problems, previously managed for the majority in a home environment.

9.12.2 Carers

Carers are a critical, and often under-recognised and under-valued resource in caring for vulnerable people. The 2011 Census revealed that in Southampton, 8.6% (or 1 in 12) of the population provides some form of unpaid care, ranging from 1 hour per week to over 50

hours per week. This represents 20,263 people in the city. There is no significant difference in the proportion of people providing unpaid care in 2011 compared to 2001. The proportion of the population who are carers was lower in Southampton than in all its ONS peers, apart from Southampton.

Of those who provide care in Southampton, most provide 1-19 hours per week. Almost a quarter of carers provide 50 hours of care or more each week. The number of people providing 50 hours or more of care has increased marginally, but significantly, in Southampton since 2001 from 1.9% of the population to 2%. This is equivalent to 4,802 people.

In 2014/15, Southampton's carers had lower but not significantly, level of satisfaction with social services than the national average (37.0% compared to 41.2%). In 2014/15, 62.6% of carers reported that they have been included or consulted in discussion about the person they care for, this was significantly lower than the national percentage (72.3%). In 2015/16, 55.1% of social care users and carers felt they had as much social contact as they would like, this is significantly higher than the national average (45.4%).

Many carers administer medicines for the person they care for as well as request/purchase equipment or aids for the home to support the care they provide.

9.12.3 Disability

9.12.3.1 People with learning disabilities

In 2015/16, there were 1,271 Southampton registered patients aged 18 and over on the learning disabilities register (0.46% of registered patients – the same prevalence as England). In 2015/16, there were 544 working age (18-64 years) Southampton residents receiving long-term support during the year with a primary support reason of learning disability support. People with learning disabilities have differing and often complex health care needs leading to increased prescribing and risk of polypharmacy. It is estimated that the prevalence of epilepsy is 15% in people with a mild learning disability and 30% in those with a severe learning disability and people with a learning disability may have a lifestyle that increases their risk of developing diabetes, e.g., poor diet and lack of physical activity. They may also be prescribed medicines that increase the risk of diabetes, e.g., antipsychotics. As a consequence the treatment regimens of people with a learning disability can be complex, involving several different prescribers with medicines frequently used outside their product license.[72]

[72] Royal Pharmaceutical Society, Learning disabilities; Medicines Optimisation. https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Policy/learning-disability-mo-article-160324.pdf

9.12.3.2 Adults with autistic spectrum conditions

A local estimate of the prevalence of autistic spectrum conditions (ASC adults aged 16 years and over in Southampton was produced using national prevalence estimates derived from the 2014 Adult Psychiatric Morbidity Survey. In 2017, it is estimated living in Southampton there are 119,300 males (1.1% of male population) and 21,198 females (0.2% of the female population) aged 16 years and over who would screen positive for autism spectrum conditions.[73]

9.12.4 Lesbian, gay, bisexual and transgender community

9.12.4.1 Sexual orientation

Data from the ONS Integrated Household Survey in 2015 found 1.7% of adults surveyed identified themselves as gay, lesbian or bisexual (LGB). In Southampton this would equate to 4,280 adults identifying as gay, lesbian or bisexual. The survey found a larger proportion of men stating they were gay (2.0%) compared to women (1.5%). The largest percentage among any age group is in the 16 to 24 age group with 3.3% identifying as LGB in 2015. This would equate to 1,590 16 to 24 year olds in Southampton identifying as gay, lesbian or bisexual.[74]

Specific issues for this population group include: gay or lesbian individuals may be possible targets for hate crime; mental illness, such as depression and anxiety, is more common amongst lesbian, gay and bisexual people and research has shown that lesbian women tend to drink more alcohol than straight women and gay men and lesbians generally take more drugs and are more likely to smoke than heterosexuals.

9.12.4.2 Transgender

Trans is an umbrella term used to describe people whose lives appear to conflict with the gender norms of society, whether this is in their clothing, in presenting themselves or undergoing hormone treatment and surgery. Being trans does not imply any specific sexual orientation. Some people consider being trans a very private matter and also subject to prejudice and harassment. ONS does not produce estimates of the number of trans for a range of reasons including infringement on people's human rights.

There is no reliable information regarding the size of the trans population in the UK. Recent estimates suggest that 0.6% to 1% of adults may experience some degree of gender variance (around 1,510 to 2,520 Southampton residents) and at some stage, about 0.2% (around 500 Southampton residents) may undergo transition. According to GIRES, 60% of those presenting with gender dysphoria actually underwent transition; of these 80% were

[73] NHS Digital. NatCen Social research Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 http://content.digital.nhs.uk/catalogue/PUB21748 applied to the Hampshire County Council 2016-based Small Area Population Forecast

[74] ONS, Experimental Official Statistics on sexual identity in the UK in 2015 by region, sex, age, marital status, ethnicity and NS-SEC. https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2015

assigned as boys at birth (now trans women) and 20% as girls (now trans men). Gender variant people present for treatment at any age. The median age is 42.[75]

The adults who present emerge from a large, mainly invisible, reservoir of people, who experience some degree of gender variance. GIRES estimate a prevalence of 600 per 100,000 which would equate to 1,440 people in Southampton. Other research by GIRES found that in those who had personal experience of transgender healthcare found that rates of mental ill health were high, and also agreeing with Brighton and Hove's recent Trans Needs Assessment found transgender individuals can face discrimination and harassment; they may be possible targets for hate crime.

9.12.5 Age

Mental health needs by age were explored in section 2.2.15, the health needs of Southampton's children were highlighted in Chapter 4.

- Health issues tend to be greater amongst the very young and the very old
- The number of chronic conditions increases with age: data from 12 GP practices in Southampton was analysed showing that 85% of people aged 65+ have at least one chronic condition and 30% of them have more than four (amongst the over 85's the equivalent figures are 93% and 47%).
- In 2013/14, a higher rate of older people (aged 65 year and over) in Southampton rely on input from social services than is the case nationally (17,457 per 100, 000 compared with 9,781 per 100,000).

9.12.6 Ethnicity, migration, language and religion

Cultural difference can affect health and wellbeing:

- Ethnic differences in health are most marked in the areas of mental wellbeing, cancer, heart disease, HIV, TB and diabetes.
- An increase in the number of older BME people is likely to lead to a greater need for provision of culturally sensitive social care and palliative care.
- BME populations and religious groups may face discrimination and harassment and may be possible targets for hate crime
- Migrants may have limited health literacy to spoken and written information that is not in their first language
- Possible link with 'honour based violence' which is a type of domestic violence motivated by the notion of honour and occurs in those communities where the honour concept is linked to the expected behaviours of families and individuals.
- Female genital mutilation is related to cultural, religious and social factors within families

[75]GIRES. The Number of Gender Variant People in the UK - Update 2011. GIRES; 2011

9.12.7 Gender

- Male healthy life expectancy in Southampton is 60.9 years which is significantly lower than the national average of 63.4 years.
- Inequalities in health are also greater for men in the city; there is a difference in life expectancy of 7.7 years for men from the most deprived 20% compared to those from the least deprived (the gap for women is 3.7 years).
- Domestic violence (mainly against women) is an issue in Southampton. In the last two years 450 referrals have been made to Multi Agency Risk Assessment Conferences because victims are at high risk of serious injury or death.

9.12.8 Port workers and visitors

Southampton is a port city where the threat of communicable diseases posed by the large scale movements of goods and people through the port needs to be monitored. 1.2 million TEU (Twenty Equivalent Unit) container movements of cargo, over 79,000 shipping movements and 170 cruise ship arrivals annually require a range of diverse environmental health control functions from Southampton Port Health Services.

9.12.9 Veterans

In common with other areas of the country, routinely collected local data for veterans in Southampton are extremely limited. Consequently for the Southampton veterans' health needs assessment[76] national data was used. The following data are taken from the veterans' health needs assessment dated September 2012.

Applying estimates of the national veteran population obtained from survey data from the Annual Population Survey 2014[77] to the HCC SAPF gives an estimated 18,782 veterans living in the city. Most veterans are estimated to be in the older age groups, with 32% aged 55-74 years old, and 22% aged 75-84 years.

The RBL found the ex-Service population is elderly and declining in size. Unsurprisingly, given the age profile of the ex-Service community, many of the most common difficulties experienced are those faced by many elderly people more generally: problems getting around, and feeling exhausted and socially isolated.

The RBL report suggests that between 2014 and 2030, the UK veteran population will reduce from 10% of the UK population to 6%. Although the overall number of veterans is projected to decline, the proportion of veterans aged 85 years and over is projected to increase. This is likely to be a reflection of the last veterans of the National Service cohort moving through the age profile, as well as increasing longer life expectancy within the UK population as a whole. However, there are increased proportions in age groups 16-24 years and 25-34 years due to the majority of personnel leaving the Armed Forces each year being in the younger age groups. There is also an unquantified impact of reductions in overall Service numbers which may lead to personnel leaving sooner than expected. The health

[76] http://www.publichealth.southampton.gov.uk/Images/Veterans'%20Needs%20Assessment%20May'12.pdf
[77] The UK ex-Service community: A Household Survey 2014, Royal British Legion http://www.britishlegion.org.uk/get-involved/campaign/public-policy-and-research/the-uk-ex-service-community-a-household-survey/ applied to Hampshire County Environment Department's 2016-based Southampton Small Area Population Forecasts

needs of younger veterans are likely to differ significantly from those in older age groups for example within the ex-Service community 16-34 year olds, particularly veterans and those who live alone, report a number of issues around debt, employment and transition, and a significant proportion have caring responsibilities..

[78]In March 2017, 767 people were in receipt of an occupational pension under the Armed Forces Pension Scheme. The largest proportions of these veterans live in SO16 and SO19 which are the postcode districts covering the West and East/South localities in Southampton. These localities include some of the city's most deprived areas. These two postcode districts also contained the majority of the 390 people in receipt of a war disablement pension (68 and 66 respectively).

A recent review of health and social factors affecting veterans suggest that overall the health of the veteran population is comparable to that of the UK's general population[79]. A study by the RBL in 2014[80] includes self-reported health information from veterans and the wider ex-service community (including dependents) found the top ten difficulties to be for the following conditions:

- Getting around outside the home
- Feeling depressed
- Exhaustion/pain
- Getting around inside the home
- Loneliness
- Bereavement
- Poor bladder control
- House/garden maintenance
- Not enough money for day-to-day living
- Not enough money to buy/replace items need

Veterans aged 16-64 are more likely than the general population of the same age to report a long-term illness that limits their activities (24% vs 13%).
This includes:

- Depression – 10% vs 6%
- Back problems – 14% vs 7%
- Problems with legs and feet – 15% vs 7%
- Problems with arms – 9% vs 5%
- Heart problems – 12% vs 7%
- Diabetes – 6% vs 3%
- Difficulty hearing – 6% vs 2%, and
- Difficulty seeing – 5% vs 1%

One in ten of the ex-Service community reports feeling depressed and this peaks at 14% of those aged 35-64 also one in six reports some relationship or isolation difficult,. The most reported physical self-care difficulty is exhaustion and pain, reported by almost one in ten, followed by poor bladder control, reported by slightly fewer. Both problems are,

[78] Location of armed forces pension and compensation recipients: 2017 Ministry of Defence https://www.gov.uk/government/statistics/location-of-armed-forces-pension-and-compensation-recipients-2017
[79] Fear N, Wood D, Wessely S for the Department of Health. *Health and social outcomes and health services experiences of UK military veterans - a summary of the evidence.* London: November 2009. Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113749.pdf
[80] The UK ex-Service community: A Household Survey 2014, Royal British Legion http://www.britishlegion.org.uk/get-involved/campaign/public-policy-and-research/the-uk-ex-service-community-a-household-survey/

unsurprisingly, slightly more prevalent among those with a long-term illness or disability. Poor bladder control is more likely to be reported by those aged 75-94 (one in ten), but reports of exhaustion and pain peak at age 45-54 (13%). Compared with the adult population of England and Wales, the ex-Service community is more likely to have some caring responsibility. The difference is greatest for those aged 16-34, so this difference is not explained by the older age profile of the ex-Service community. In total, 23% of those aged 16-64 have a caring responsibility, compared with 12% nationally.

9.12.10 Homelessness

In Southampton city, the statutory homelessness rate was 1.47 per 1,000 households (2015/16), a decrease from 1.85 per 1,000 households the previous year. This compares to a rate of 2.52 per 1,000 households in England in 2015/16 (with the previous year's rate of 2.40 per 1,000). Southampton's statutory homeless rate is lower than 10 ONS peers and higher than two ONS peers.[81]

The average life expectancy for homeless women is 43 years old and for homeless men is 47 years old. Drug and alcohol abuse are particularly common causes of death among the homeless population, accounting for just over a third of all deaths, and homeless people is nine time more likely to commit suicide than the general population.[82]

Southampton's homelessness prevention strategy 2013/18 highlights that the impact of the recession on homelessness has not yet been fully realised in Southampton, partly due to the relatively low local house values and low interest rates. It notes a significant decline in homelessness applications and acceptances from 2003-2009 as a result of increased homelessness prevention and improved housing options for people at risk. It also describes the impact of homelessness rise since 2009 on households with dependent children. There has been a 68% increase in the number of households with dependent children accepted as homeless since that time. The figures for other priority need groups have either remained static or continued to fall since 2009.

[81] Public Health Outcomes Framework, www.phoutcomes.org
[82] NHS Choices. Behind the Headlines (2011) https://www.nhs.uk/news/lifestyle-and-exercise/homeless-die-30-years-younger-than-average/

9 Potential future need

9.2 Housing developments

The Strategic Housing Land Availability Assessment (SHLAA)[83] for Southampton indicates where housing developments are likely to occur. This indicates that during 2018-22 (which spans the lifetime of this PNA), 3,900 new dwellings are anticipated in the city. This is taken into account by the Hampshire County Council population forecasts used in section 9.1.

Also, as described in section 9.4.2, urban in-fill is anticipated to be a substantial source of housing supply. There is also major growth anticipated concentrated in the city centre across various sites, ongoing major development at centenary quay in Woolston and a range of council estate regeneration schemes.

The potential increase in pharmaceutical services is expected to be met within existing provision.

9.3 GP extended opening

Southampton is part of the second wave of sites selected in March 2015 to help improve access to general practice and stimulate innovative ways of providing primary care services. This pilot is providing extended opening of GP practices from 6:30pm to 9pm on weekdays, from 8am to 4pm on a Saturday and from 8am to 2pm on a Sunday. The service is provided from six hubs across the city, with only three open at any one time. The hubs have GPs, Advanced Nurse Practitioners and Healthcare Assistants providing same day and routine appointments. Many GP consultations result in a prescription being issued. Community pharmacies within Southampton offer good access through supplementary hours and four 100 hour pharmacies which have, to date, met any increased demand from pharmaceutical services that GP extended opening may have had.

10 Consultation

A full description of consultation activities to be completed post the consultation period

11 Responses from the consultation

A description of the responses received from consultation and the response from the strategy group. To be completed in January 2018.

[83] Strategic Housing Land Availability Assessment, Southampton City Council, accessed via http://www.southampton.gov.uk/planning/planning-policy/research-evidence-base/shlaa.aspx

12 Gaps in provision

13.1 Necessary services

The Health and Wellbeing Board consider the location, number, distribution and choice of pharmaceutical services serving Southampton residents to meet the needs of the population.

In particular, this is based on:

- Almost all of the Southampton population is within a 1.6km straight line distance of a community pharmacy.
- A good geographical spread of community pharmacies across the city and within communities experiencing greatest deprivation.
- There being 18 community pharmacies per 100,000 Southampton population, which is very similar to the average for Wessex and is broadly in line with the national average.
- Over 99% of the Southampton population are within a 20 minute walk of a community pharmacy.
- Just over nine in every 10 (92.3%) respondents to a public survey said it took 15 minutes or less to get to a community pharmacy.
- Consideration of opening hours from early morning, through lunchtimes and late into the evening as well as weekend opening.
- All pharmacies provide the full range of essential pharmaceutical services
- There is good provision of advanced services across the city.
- A large proportion of community pharmacies providing a delivery service to residents, including housebound patients.
- There will not be substantial changes in population areas, nor major development, which can be anticipated during the three-year lifespan of this PNA, which would warrant the need for additional pharmaceutical services. Smaller changes would be managed by existing providers.

13.2 Improvements and better access

The Health and Wellbeing Board consider that there is currently no identified need for improvements and better access to pharmaceutical services in Southampton.

In particular, this is based on:

- Four 100 hour pharmacies, supplementary hours in other Southampton community pharmacies as well as provision in a neighbouring Health and Wellbeing Board area provide improvements and better access which meets the needs of Southampton residents.
- This current provision is expected to continue to meet any increase in need as a result of further increase in extended hours of opening by GP practices or known planned developments.
- There is good provision of advanced services across the city.
- There are a range of enhanced and locally commissioned services delivered in the city.

14 Conclusion

The Health and Wellbeing Board consider has considered the provision of pharmaceutical provision in Southampton and concludes:

- The current need for pharmaceutical services is met by the existing providers on the pharmaceutical list.
- There will not be substantial changes in population areas, nor major development, during the three-year lifespan of this PNA, which would warrant the need for additional pharmaceutical services. Smaller changes would be managed by existing providers.
- Southampton residents can use pharmaceutical services offered by distance selling pharmacies which provide improved access and greater choice.
- There is good coverage across the city of Advanced, Enhanced and locally commissioned services in place.
- The Health and Wellbeing Board has not identified any specific improvements or better access that could be met by an additional pharmaceutical services provider at this time.
- Future improvements or better access will be met by the current pharmaceutical service providers.

15 Appendix A: Terms of Reference

Pharmaceutical Needs Assessment Steering Group

Terms of Reference

The Pharmaceutical Needs Assessment (PNA) is a legal duty of the Health and Wellbeing Board (HWB). The HWB is required to publish the revised PNA for its area by 1st April 2018. The PNA is used by NHS England to make decisions on which NHS funded pharmaceutical services need to be provided in the local area. Failure to publish a robust PNA, which has been produced in line with requirements of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 could lead to legal challenges, particularly as the local PNA is central to making decisions about new pharmacy openings. The steering group is preparing this document on behalf of the Director of Public Health for presentation to the HWB.

Purpose:
The steering group will:-

- Oversee the development and publication of a separate PNA for Southampton City Council (PCC) and Southampton City Council (SCC)
- Agree a project plan and timetable for the development of the PNAs and ensure representation of the full range of stakeholders
- Agree the format and content of the PNAs
- Ensure that the PNAs reflects any future needs for, or improvement or better access to, pharmaceutical services as will be required by the local population
- Ensure the PNAs meets the requirements of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013
- Ensure the PNAs fulfils its statutory duties for consultation for the PNA
- Ensure publication of the PNAs within the required timescale
- Ensure the PNAs comply with requirements of each local authority to ensure authorisation by the respective HWB.

Membership
The membership of the steering group is as follows:-

Southampton City Council

Claire Currie (Chair)	Public Health Consultant (on behalf of PCC and SCC)
James Hawkins	Specialist Public Health Intelligence Analyst
Janet Byng	Public Health Team Administrator

Southampton City Council

Dan King	Service Lead – Intelligence and Strategic Analysis

NHS Southampton Clinical Commissioning Group

Janet Bowhill	Pharmaceutical Adviser

NHS Southampton City Clinical Commissioning Group

Sue Lawton	Locality Lead Pharmacist for West / Community Pharmacy Development Manager

Hampshire and Isle of White Local Pharmaceutical Committee

Paul Bennett (until June 2017)	Chief Officer
Debby Crockford (from July 2017)	

NHS England Wessex Local Area team

Leslie Riggs	Interim Contracts Manager (Pharmacy and Optometry), NHS England (Wessex)

Healthwatch representatives

Siobhain McCurrach (Southampton)	Project Manager, Learning Links
Rob Kurn (Southampton)	Healthwatch Southampton Manager

An agreed deputy may be used where the named member of the group is unable to attend.

Other staff members/stakeholders may be invited to attend meetings for the purpose of providing advice and/or clarification to the group.

Where there are discussions in the steering group specific to one City Council, only those members representing the City in question may take part.

Declarations of interest

Members must declare any pecuniary or personal interest in any business on the agenda for it to be formally recorded in the minutes of the meeting.

Meetings

All meetings will have an agenda and minutes. The frequency of the meetings will be determined by the chair of the group in line with the development of the PNA.

Accountability and reporting

The PNA steering group will be accountable to the Southampton Health and Wellbeing Board and separately to the Southampton Health and Wellbeing Board for the PNA being developed for the respective areas. The PNA steering group will report on progress on a three monthly frequency or as required by the Health and Wellbeing Board.

The pre-consultation drafts and the final draft PNAs will be presented to their respective Health and Wellbeing Board for approval.

16 Appendix B: Policy context

Pharmacies have a major role to play in helping improve the public's health, with 1.6 million people visiting a pharmacy each day[84]. There were approximately 12,000 community pharmacies in England (2065) and 79% of people have visited a pharmacy at least once in the last 12 months.

Pharmacists are experts in the use of medicines to treat disease and are an appropriate first point of contact for dealing with an array of health concerns. Pharmacists work within a code of ethics that requires them to continuously develop their professional knowledge and competence relevant to their field of practice. Pharmacists are responsible for the supply of most medicines available to the public. They advise the public and other professionals on the safe and effective selection and use of medicines and other health-related matters. Pharmacies provide a range of services in the heart of neighbourhood communities where they are within reach of the people who need them most – poorer people, older people and people with a disability or chronic condition.

The role of community pharmacy is evolving. Distance selling pharmacies are providing greater choice and accessibility for the public to pharmaceutical services. They are also changing the community pharmacy provision from the traditional high street provision.

Published in April 2016, the General Practice Forward View set out a vision to improve patient care and access, and invest in new ways of providing primary care. The General Practice Forward View committed to over £100m of investment to support an extra 1,500 pharmacists to work in general practice by 2020/21. This is in addition to over 490 pharmacists already working across approximately 650 GP practices as part of a pilot, launched in July 2015.

Pharmacists working as part of the general practice team aim to resolve day-to-day medicine issues and consult with and treat patients directly. This includes providing extra help to manage long-term conditions, provide advice for those on multiple medications, improving the quality of care and ensuring patient safety.

In August 2016 the Community Pharmacy Forward View was published by PSNC and Pharmacy Voice, with the support of the RPS English Pharmacy Board which set out the ambition for the sector. It focused on three key roles:

- As the facilitator of personalised care for people with long-term conditions;
- As the trusted, convenient first port of call for episodic healthcare advice and treatment; and
- As the neighbourhood health and wellbeing hub.

For 2017/18, The Department of Health (DH) introduced a Quality Payments Scheme as part of the Community Pharmacy Contractual Framework. This scheme involves payments being made to community pharmacy contractors meeting certain gateway and quality criteria. Achieving Healthy Living Pharmacy status is included in these criteria.

[84] Local Government Association; The community pharmacy offer for improving the public's health https://www.local.gov.uk/sites/default/files/documents/community-pharmacy-offer--9b3.pdf

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SOUTHAMPTON CITY COUNCIL

Equality and Safety Impact Assessment

The **Public Sector Equality Duty** (Section 149 of the Equality Act) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people carrying out their activities.

The Equality Duty supports good decision making – it encourages public bodies to be more efficient and effective by understanding how different people will be affected by their activities, so that their policies and services are appropriate and accessible to all and meet different people's needs. The Council's Equality and Safety Impact Assessment (ESIA) includes an assessment of the community safety impact assessment to comply with section 17 of the Crime and Disorder Act and will enable the Council to better understand the potential impact of the budget proposals and consider mitigating action.

Name or Brief Description of Proposal	Draft Pharmaceutical Needs Assessment for Southampton, 2018
Brief Service Profile (including number of customers)	
A Pharmaceutical Needs Assessment (PNA) is a statement of current pharmaceutical services provided in the local area. It also assesses whether or not the pharmaceutical services provision is satisfactory for the local population and identifies and perceived gaps in the provision. The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for developing an updating PNAs. It is a statutory requirement for the Health and Wellbeing Board to publish a revised assessment within three years of its previous PNA. The refreshed Southampton PNA must be published on 1st April 2018.	
Summary of Impact and Issues	
The PNA reflects the current and future needs for pharmaceutical services. This affects the residents of Portsmouth, people who work and study in the city and partner NHS organisations including NHS Southampton City Clinical Commissioning Group, Southampton University Hospitals NHS Foundation Trust, GP practices and the existing community pharmacy network. This PNA refreshes the previous assessment published on 1st April 2015. Access to high quality pharmaceutical services is particularly relevant for those taking medicines, typically people suffering from long term conditions and disproportionately affect those in ill-health and older adults. There is no specific impact on any one group. Everyone may need access to pharmaceutical services in the city. The draft PNA has made specific reference to a range of groups.	

This Equality and Safety Impact Assessment will be updated once the consultation phase has been completed.	
Potential Positive Impacts	
The draft PNA describes provision of pharmaceutical services including locally commissioned services and their role in promoting health and wellbeing of the people of Southampton. The draft PNA has been developed to ensure a good range of pharmaceutical services may be accessed by the local population of Southampton. Many services have been identified and their beneficial impact on health and wellbeing described.	
Responsible Service Manager	Claire Currie Consultant in Public Health, Portsmouth City Council
Date	October 2017
Approved by Senior Manager	Jason Horsley Joint Director of Public Health
Date	October 2017

Potential Impact

Impact Assessment	Details of Impact	Possible Solutions
Age	This PNA identified good provision of services for all ages. Medicines use increases with age. The majority of older adults will be taking at least one regular prescription medicine. All pharmacy contractors were asked about their services that would support older adults. These services include prescription collection and home delivery of medicines. Distance selling pharmacies also provide additional choice and increases accessibility to older adults some of whom may have limited mobility. Adjustments to the dispending process include easy open containers and large print labels.	N/A
Disability	This PNA identified good provision of people with disabilities. Pharmacy contractors were asked to describe adjustments they make in their service for this group. This included wheelchair access into premises and consulting rooms. During the data collection process it was confirmed that the majority of pharmacies in the city offer a prescription collection service and free home delivery service providing a service to housebound patients and others. Distance	N/A

Impact Assessment	Details of Impact	Possible Solutions
	selling pharmacies also provide additional choice and increases accessibility to individuals with disabilities who may have limited mobility.	
Gender Reassignment	No specific impact has been identified from this PNA.	N/A
Marriage and Civil Partnership	No specific impact has been identified from this PNA.	N/A
Pregnancy and Maternity	No specific impact has been identified from this PNA. Community pharmacies can provide an important source of advice for minor ailments for conditions such as constipation which can commonly occur in pregnancy. For women planning pregnancy, access to a community pharmacy for advice can also be important.	N/A
Race	No specific impact on a particular group has been identified from this PNA. Higher prevalence of some health conditions is associated with particular ethnic groups. Questions were asked about languages spoken by pharmacy staff which have been summarised in the draft PNA.	N/A
Religion or Belief	No specific impact has been identified from this PNA.	N/A
Gender	No specific impact for either men or women has been identified from this PNA. Life expectancy of men is lower than that for women in Southampton and nationally.	N/A
Sexual Orientation	No specific impact has been identified from this PNA.	N/A
Community Safety	No specific impact has been identified from this PNA.	N/A
Poverty	No specific impact has been identified from this PNA. Areas of deprivation have been described and considered in light of pharmaceutical provision.	N/A
Other Significant Impacts	No additional impacts identified. Reference to services beneficial to carers have been made within the document.	N/A

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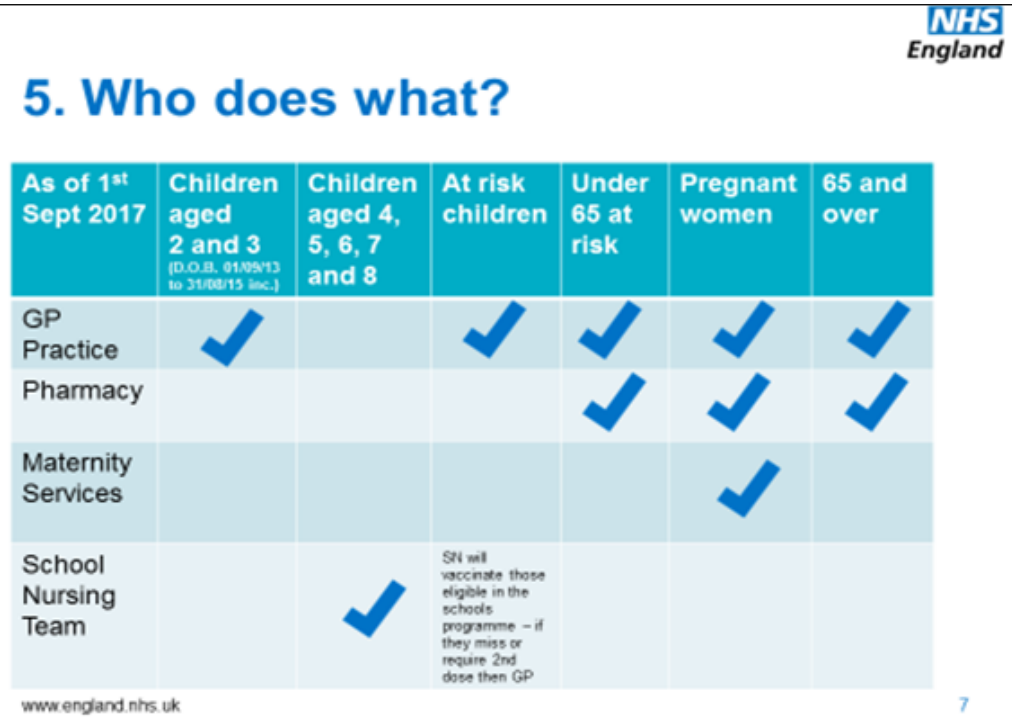
DECISION-MAKER:		**Health and Wellbeing Board**		
SUBJECT:		**Influenza Vaccination Uptake**		
DATE OF DECISION:		**18th October 2017**		
REPORT OF:		**Director of Public Health**		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Debbie Chase**	**Tel:**	**023 8083 3694**
	E-mail:	**debbie.chase@southampton.gov.uk**		
Director	**Name:**	**Dr Jason Horsley**	**Tel:**	**023 8083 3818**
	E-mail:	**Jason.Horsley@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY		
None.		
BRIEF SUMMARY		
The Health and Wellbeing Board are asked to receive a briefing for their information on local preparedness for influenza and the steps being taken by partners to increase uptake of vaccination, especially by those who are most vulnerable.		
RECOMMENDATIONS:		
	(i)	That the Health and Wellbeing Board notes the report.
REASONS FOR REPORT RECOMMENDATIONS		
1.	For information only.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	None.	
DETAIL (Including consultation carried out)		
	Background	
3.	Influenza infection (flu) is highly transmissible and can cause a spectrum of illness from mild to severe, even among people who are previously well. In good health with rest and fluids, it usually clears up within a week. However, flu can be more severe in certain people, such as: • Anyone aged 65 and over • Pregnant women • Children and adults with an underlying health condition (such as long-term heart or respiratory disease) • Children and adults with weakened immune systems Anyone in these risk groups is more likely to develop potentially serious complications of flu, such as pneumonia (a lung infection).	
4.	Pandemic flu represents the highest risk on the national risk register of civil emergencies (hazards, disease, accidents and societal risks); with highest health impact and likelihood of occurring in the next 5 years. Flu pandemics happen when a unique flu virus evolves that few people (if any) are immune	

	to. There are important differences between 'ordinary' seasonal flu of the kind that happens in winter, and pandemic flu. In a pandemic, the new virus will spread quickly and cause more serious illness in a large proportion of the population, due to the lack of immunity. There is a high probability of a flu pandemic occurring, but it is impossible to predict when, or exactly what it would be like.
5.	The most recent pandemic flu outbreak was an H1N1 strain ('Swine flu') in 2009 which caused at least 18,500 deaths worldwide. In 1918 another variant of the same H1N1 strain ('Spanish flu') killed over 50 million people globally. However, other flu strains exist with pandemic potential, such as H5N1 ('avian or bird flu'). This strain caused several hundred human deaths in South East Asia in 1996.
6.	Insight on the type of flu strain that could be most prevalent in the northern hemisphere this winter comes from surveillance of strains circulating in the southern hemisphere six months prior. This year, the dominant flu sub-type in the southern hemisphere has been A(H3). This sub-strain is similar to that experienced in the northern hemisphere last winter, with older more vulnerable people being affected most.
	The NHS Flu Vaccination programme 2017/18
7.	For Winter 2017/18, the NHS flu vaccine will protect against three types of flu virus: • A/H1N1 – the strain of flu that caused the swine flu pandemic in 2009 • A/H3N2 – a strain of flu that mainly affects the elderly and people with risk factors like a long term health condition. This year's vaccine will contain an A/Hong Kong/4801/2014 H3N2-like virus • Influenza B – a strain of flu that particularly affects children. This year's vaccine will contain B/Brisbane/60/2008-like virus • The nasal spray flu vaccine and some injected vaccines also offer protection against a fourth B strain of virus, which in 2017/18 is the B/Phuket/3073/2013-like virus.
8.	Flu vaccination is available every year on the NHS to help protect adults and children at risk of flu and its complications. This winter (2017/18) the injected flu vaccine will be made available to: Adults over the age of 18 at risk of flu (including everyone aged 65 and over), pregnant women and children aged six months to two years at risk of flu. The flu vaccine is routinely given on the NHS as an annual nasal spray to children aged two and three plus children in reception class and school years one, two, three and four (year 4 is a new addition for this winter season) and children aged two to 17 years at a particular risk of flu. The NHS England slide below shows where the flu vaccine is administered for each population group. Vaccination uptake rates for Winter 2016/17 in the Wessex region are shown in appendix 1 and 2.



	Business case for staff flu vaccination programmes
9.	Flu outbreaks in health care settings have occurred when large numbers of key frontline staff are unvaccinated. Healthcare staff vaccination programmes can both protect staff and vulnerable people in their care. The World Health Organisation recommends healthcare workers should be vaccinated against influenza. However, in Southampton 2016/17 healthcare workers flu vaccination coverage was 53.5%, lower than the England average (63.2%) and below the 75% national target for healthcare staff vaccination.
10.	A systematic review provides the best evidence on the cost-effectiveness of vaccinating healthcare workers[1]: • The cost per person for flu vaccination programmes targeting healthcare workers including promotion is approximately £7 • In the worst case scenario campaigns to vaccinate healthcare workers cost £400 per quality adjusted life-year (QALY) gained. This is significantly below the NICE threshold of £20,000 per QALY so it is cost-effective. • The return on investment is £12 for every £1 spent. This has been calculated in terms of costs saved from mortality and morbidity in high risk contacts as well as absenteeism from work.
	National campaign
11.	NHS England run an annual flu vaccination campaign. This year's programme comes under the 'stay well' campaign. This year's objective is to ensure that people who are most at-risk of preventable emergency admission to hospital are aware of and, wherever possible, are motivated to take those actions that may avoid admission this winter. Our local campaign will align with the national theme.
12.	The national flu vaccination campaign will run from 9th October to 29th October 2017. NHS England will be seeking to increase flu vaccination uptake in risk groups, people over 65 years and frontline healthcare workers. Similar to last winter, a CQUIN incentive has been attached to the frontline healthcare worker programme with the aim of achieving at least 70% uptake.

13.	All local General Practices were sent an information pack in August explaining this year's vaccination programme and uptake rates for 2016/17 by practice and more recently a flu readiness survey. NHS England recommends that heads of Public Health, Chief Executives and Council Directors promote flu vaccination to further improve uptake. Public Health England will be sending a survey to care homes to better understand reasons for low staff vaccination uptake and to encourage improvement.
	Local arrangements
14.	Our local flu campaign will run alongside, and be complimentary to the national campaign. As in previous years, it will be led jointly by Southampton City CCG and SCC. The campaign started on 9th October, and will progress on to 'keep warm, keep well' messages, promoting infectious disease prevention 'catch it, bin it, kill it' and our Southampton Healthy Home programme.
15.	Partnership working across the Solent enables a co-ordinated and intelligence based approach to improving flu vaccination uptake locally. The NHS England led Solent vaccination and immunisation group meets on a monthly basis and will prioritise action to reduce the impact of influenza during the flu season: September 2017-February 2018. Attendance includes representatives from public health SCC and PCC, CCG, Primary care, NHS Solent, Southern NHS Trust, the Universities, Local Pharmaceutical Committee and Local Medical Committee.
16.	The Solent Vaccination and Immunisation Group has proposed the following to improve uptake locally in Winter 2017/18: 1. Better joint working with the acute and third sector to identify opportunities for increasing uptake e.g. opportunistically offering vaccination at clinics and meetings 2. Promote staff vaccination in GP surgeries 3. Explore opportunity to target vulnerable individuals in deprived areas via housing officers and health visitors 4. CCGs to provide flu vaccination uptake data for individuals with learning disabilities (as last year) 5. A guide called 'healthy living mosques' has been developed in conjunction with colleagues in Birmingham and will support local communities in decision making. **6.** Encourage care providers (care, residential, nursing home and domiciliary) to promote, and provide, flu vaccination for their frontline workers with business cases.
RESOURCE IMPLICATIONS	
Capital/Revenue	
	None.
Property/Other	
	None.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	

	None – report is for information only.
Other Legal Implications:	
	None.
RISK MANAGEMENT IMPLICATIONS	
	None – report is for information only.
POLICY FRAMEWORK IMPLICATIONS	
	None – report is for information only.
KEY DECISION?	**No**
WARDS/COMMUNITIES AFFECTED:	**All**
SUPPORTING DOCUMENTATION	
Appendices	
1.	NHS flu vaccine uptake rates in 2016/17 by eligible group across the Wessex region
2.	NHS flu vaccine uptake rates for healthcare staff in 2016/17 across the Wessex region

Documents In Members' Rooms

1.	None.
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.	**No**
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	**No**
Other Background Documents **Other Background documents available for inspection at: Public Health, Civic Centre, Southampton**	

References		**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.	Burls A, Jordan R, Barton P, Olowokure B, Wake B, Albon E, et al. Vaccinating healthcare workers against influenza to protect the vulnerable – Is it a good use of healthcare resources?: A systematic review of evidence and an economic evaluation. Vaccine. 2006;24(19)4212-21.	

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Appendix 1 **NHS flu vaccine uptake rates in 2016/17 by eligible group across the Wessex region**

At Risk Groups	Over 65	Under 65 At Risk	Pregnant Women	Chronic Heart Disease	Chronic Respiratory Disease	Chronic Kidney Disease	Chronic Liver Disease	Diabetes	Immuno-suppression	Chronic Neurological Disease	Asplenia
NHS NORTH HAMPSHIRE CCG	70.9	49	46.7	46.7	48.7	52	39.3	61	52.3	51.7	36.1
NHS FAREHAM AND GOSPORT CCG	73.1	52.6	52.1	49.2	52.1	57.8	47.1	64.3	57.4	52.6	43.1
NHS ISLE OF WIGHT CCG	66.6	44.6	35.9	42.3	42.7	50.5	32.9	61.3	47.5	47.7	34
NHS PORTSMOUTH CCG	72.8	49.5	54.2	46.6	50.5	54.4	43.4	65.3	50.3	51	40.8
NHS SOUTH EASTERN HAMPSHIRE CCG	75	55.2	53	56.3	55.3	60.6	53.3	68.4	61.1	56.1	46.3
NHS SOUTHAMPTON CCG	72.7	49.8	42.9	47.1	50.4	55.5	46.4	64.9	55.6	50.2	39.2
NHS WEST HAMPSHIRE CCG	73.1	52.4	49.1	49.5	52.3	58.8	47.6	66.3	58	53.1	45.8
NHS DORSET CCG	70.2	46.7	44.2	46.4	46.9	50.7	38.2	62.5	50.2	48.6	38.4
NHS NORTH EAST HAMPSHIRE AND FARNHAM CCG	73.3	53.1	52.3	51.1	51.4	55.9	47.9	69.9	56.2	52.2	44.6
WESSEX	**71.7**	**49.9**	**47.7**	**48.2**	**49.8**	**54.2**	**43.3**	**64.7**	**54.2**	**51.1**	**41.1**
ENGLAND	**70.4**	**48.7**	**44.8**								

Children - GP Provided	2 Year Olds	3 Year Olds	4 Year Olds
NHS NORTH HAMPSHIRE CCG	39.4	44	34.5
NHS FAREHAM AND GOSPORT CCG	49.5	48.1	40.8
NHS ISLE OF WIGHT CCG	31.3	35.8	30.2
NHS PORTSMOUTH CCG	41.2	47.1	32.2
NHS SOUTH EASTERN HAMPSHIRE CCG	42.7	48.5	37.9
NHS SOUTHAMPTON CCG	35.4	38.9	29.9
NHS WEST HAMPSHIRE CCG	50.3	53.6	44.3
NHS DORSET CCG	43.9	44.6	37.1
NHS NORTH EAST HAMPSHIRE AND FARNHAM CCG	48.7	50.4	40.2
WESSEX	**43.7**	**46.6**	**37.4**
ENGLAND	**38.9**	**41.5**	**33.9**

Key:

	Target Achieved
	Childrens Upper Target Achieved

Targets:

Over 65s	75%
Under 65s	55%
Pregnant	55%
Staff	75%
Children	40-65%

Children - Schools Programme	Year 1	Year 2	Year 3
BOURNEMOUTH LOCAL AUTHORITY	58	54	50.1
POOLE LOCAL AUTHORITY	61.8	59.5	55.7
PORTSMOUTH LOCAL AUTHORITY	69.9	67.8	63.9
SOUTHAMPTON LOCAL AUTHORITY	62.3	59.8	58.1
ISLE OF WIGHT LOCAL AUTHORITY	58	50.4	43.2
DORSET LOCAL AUTHORITY	63.8	59	57.7
HAMPSHIRE LOCAL AUTHORITY	74.1	72.1	69
WESSEX	68.7	65.9	62.8
ENGLAND	57.6	55.3	53.3

Appendix 2 **NHS flu vaccine uptake rates for healthcare staff in 2016/17 across the Wessex region**

GP Practice Staff	Uptake
NHS NORTH HAMPSHIRE CCG	60.2
NHS FAREHAM AND GOSPORT CCG	64.2
NHS ISLE OF WIGHT CCG	50.7
NHS PORTSMOUTH CCG	53.5
NHS SOUTH EASTERN HAMPSHIRE CCG	60.2
NHS SOUTHAMPTON CCG	67.1
NHS WEST HAMPSHIRE CCG	64.6
NHS DORSET CCG	58.4
NHS NORTH EAST HAMPSHIRE AND FARNHAM CCG	65.9
WESSEX	60.7

Trusts	Uptake
SOLENT NHS TRUST	51.1
ISLE OF WIGHT NHS TRUST	46.5
DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	59.5
POOLE HOSPITAL NHS FOUNDATION TRUST	80.8
DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	34.1
THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST	70.9
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	53.4
PORTSMOUTH HOSPITALS NHS TRUST	65.9
HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	80.8
SOUTHERN HEALTH NHS FOUNDATION TRUST	34.1
WESSEX	**58.1**
ENGLAND	**63**

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