Public Document Pack

Health and Wellbeing Board

Wednesday, 14th March, 2018 at 5.30 pm

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Lewzey
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 M Kelsey – Clinical Commissioning Group
Vacant – NHS England Wessex Local Area Team

Contacts
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Senior Democratic Support Officer
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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 17th January 2018 and to deal with any matters arising, attached.

5 PHARMACEUTICAL NEEDS ASSESSMENT

Report of Director of Public Health - outlining pharmaceutical needs assessment.

6 CHILDREN'S HEALTHY WEIGHT PLAN

Report of the Director of Public Health outlining children's healthy weight plan.

7 PHYSICAL ACTIVITY AND SPORTS PLAN

Report by the Director of Public Health outlining Physical Activity and Sports Plan.

8 BETTER CARE PLAN RESPONSIBILITY

Report of the Director of Quality and Integration outlining Better Care Plan Responsibility.

9 HEALTH AND WELLBEING BOARD FREQUENCY

Report of the Director of Public Health outlining the Health and Wellbeing Board frequency.

Tuesday, 6 March 2018 Service Director, Legal and Governance

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HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 17 JANUARY 2018

Present: Councillors Shields (Chair) and Taggart
Harry Dymond, Carole Binns, Dr Mark Kelsey and Dr Elizabeth Mearns

Apologies: Hilary Brooks and Dr Jason Horsley

21. **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.

Dr Kelsey declared a personal interest in that he was a member of the Clinical Commissioning Group Governing Body and remained in the meeting and took part in the consideration and determinations of items on the agenda.

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

RESOLVED: that the minutes of the meeting held on 18th October 2017 be approved and signed as a correct record.

23. **LOCAL SAFEGUARDING CHILDREN BOARD ANNUAL REPORT**

The Board received and noted the report of the Independent Chair of the Local Safeguarding Children Board (LSCB) presenting the Local Safeguarding Children Board Annual Report 2016-17. Keith Makin, Independent Chair was in attendance and with the consent of the Chair addressed the meeting.

The Board noted that the LSCB was moving forward during a period of national uncertainty with regard to the “Wood” Review of LSCB’s albeit the LSCB locally had unanimously agreed that it should continue in its current structure. The review would also require Child Death Overview Panels to cover a specified population number which would mean the Pan Hants arrangement would need to be re-established which the LSCB locally welcomed given they had not agreed with the current arrangement that had been put into place following the previous Pan Hants arrangement.

The Board also noted that the LSCB had provided a focus on Child Sexual Exploitation, Missing Home/School, Modern Slavery, Gangs and Esafety over the last year and continued to work alongside the Safeguarding Adults Board to ensure a “think family” approach.

24. **PHARMACEUTICAL NEEDS ASSESSMENT CONSULTATION FEEDBACK**

The Board received and noted the report of the Director of Public detailing the Pharmaceutical Needs Assessment Consultation which had taken place from 23rd October to 22nd December 2017. The consultation had identified six questions and the Board noted the summary of responses to these which had been provided over 53 responses, 8 of which were from professional stakeholders and 45 from members of the public.

The Board noted that through the consultation it had also been highlighted that longer term commissioned services needed to be better planned and that a lot of work currently being provided within a pharmacy environment was not resourced and did require review which would be responsibility of both the CCG and NHS England.

25. **ALCOHOL STRATEGY UPDATE**

The Board received and noted the report of the Director of Public Health providing an update on the progress made in implementing the Southampton Alcohol Strategy 2017-20.

26. **DRUGS STRATEGY UPDATE**

The Board received and noted the report of the Director of Public Health providing an update of the progress made in implementing the Drugs Strategy 2017-20.

DECISION-MAKER:		**HEALTH AND WELLBEING BOARD**		
SUBJECT:		**PHARMACEUTICAL NEEDS ASSESSMENT**		
DATE OF DECISION:		**14th MARCH 2018**		
REPORT OF:		**DIRECTOR OF PUBLIC HEALTH**		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Claire Currie, Consultant in Public Health**	**Tel:**	**023 9284 1714**
	E-mail:	**claire.currie@portsmouthcc.gov.uk**		
Director	**Name:**	**Dr Jason Horsley, Director of Public Health**	**Tel:**	**023 8083 3818**
	E-mail:	**jason.horsley@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY		
NOT APPLICABLE		
BRIEF SUMMARY		
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). It must be published every three years. A paper was brought to the Health and Wellbeing Board (HWB) on 18th October 2017 where the draft PNA was approved for consultation and on 17th January 2018 where the consultation findings were discussed.		
This paper presents the final Southampton PNA 2018 (appendix 1) and seeks approval of the report for publication on 1st April 2018.		
RECOMMENDATIONS:		
	(i)	The Health and Wellbeing Board is asked to approve the final Pharmaceutical Needs Assessment (PNA) for publication on 1st April 2018.
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 ran from Monday 23rd October to Friday 22nd December 2017.	
3.	The PNA concludes that in Southampton 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.
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
4.	None
DETAIL (Including consultation carried out)	
5.	The conclusion of the Southampton PNA 2018 is based on the following data: • 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. • 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. • 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. • All pharmacies provide the full range of essential pharmaceutical services. • There is good provision of advanced services across the city. • There are a range of enhanced and locally commissioned services delivered in 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.
RESOURCE IMPLICATIONS	
Capital/Revenue	
6.	None
Property/Other	
7.	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
8.	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")
9.	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.
10.	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:	
11.	None
RISK MANAGEMENT IMPLICATIONS	
12.	None
POLICY FRAMEWORK IMPLICATIONS	
13.	None

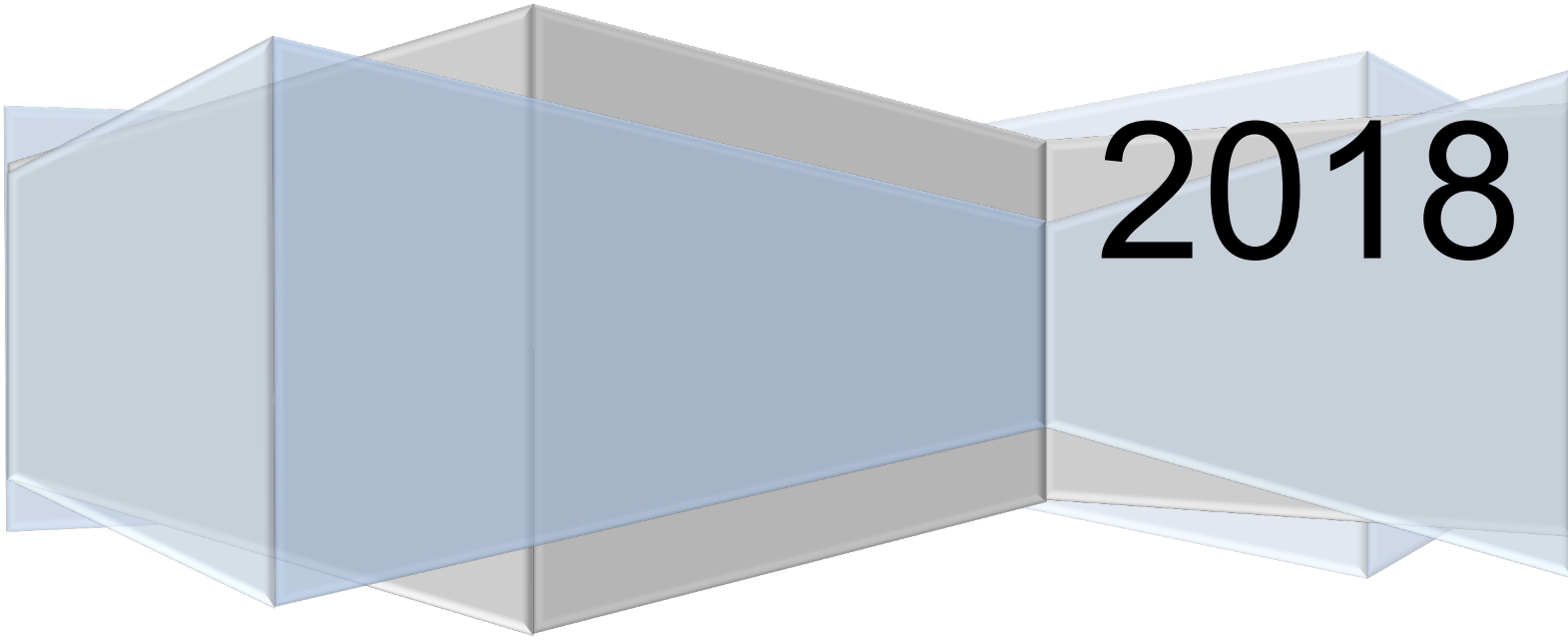
KEY DECISION?	**N/A**
WARDS/COMMUNITIES AFFECTED:	**All wards**
SUPPORTING DOCUMENTATION	
Appendices	
1.	**Southampton PNA 2018 (including Equality and Safety Impact Assessment)**

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.		

Southampton Pharmaceutical Needs Assessment



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 gaps in the provision.

In Southampton 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 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 had representation from key stakeholders and reports to the Joint Director of Public Health for Portsmouth City Council and Southampton City Council.

The group oversaw 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 included 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 was used to identify any gaps of pharmaceutical provision within the locality. A draft consultation document completed in line with national guidance and approved by the steering group and Director of Public Health.

Stage 4: Draft PNA

The draft PNA was shared with the Health and Wellbeing Board in October 2017 prior to consultation.

Stage 5: Consultation

A consultation in line with the statutory requirements was held from Monday 23rd October to Friday 22nd December 2017.

Stage 6: Review of consultation responses

The steering group considered the comments received in response to the consultation. A report on the information gathered in the consultation can be found in Appendix C. Minor amendments have been made in light of the consultation.

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.

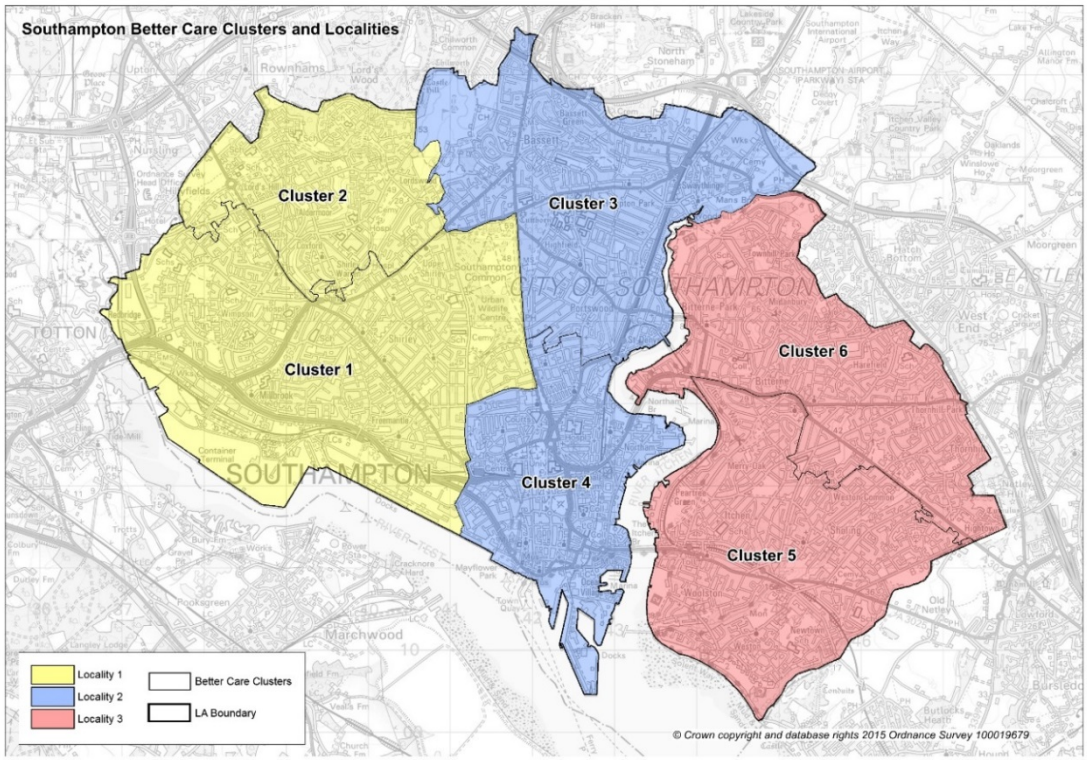


Figure 1. Southampton Better Care Clusters and localities

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

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. Hampshire residents may also choose to use 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.

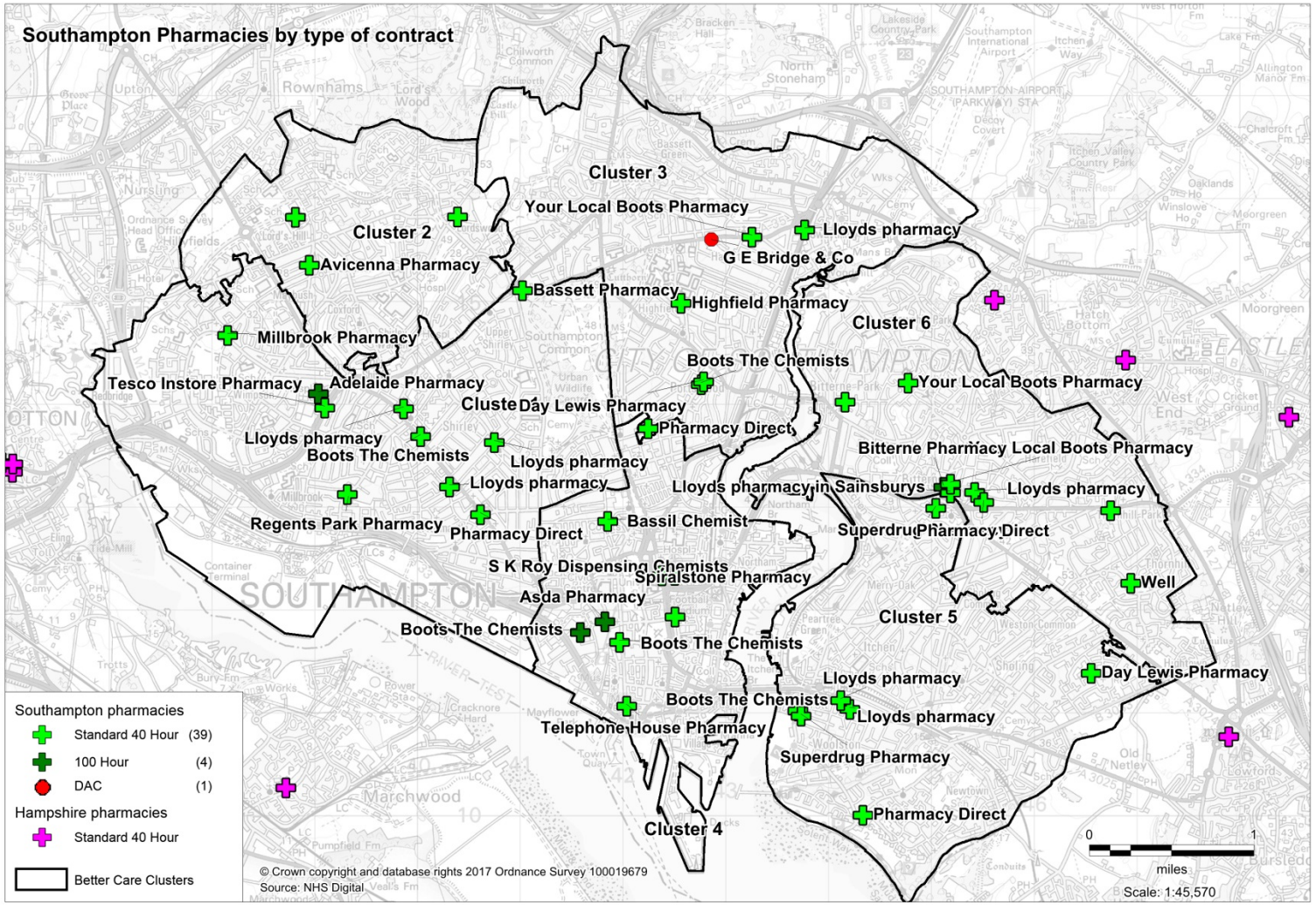


Figure 2. The map detailing the location of Pharmaceutical Service providers in Southampton; and the nearest providers outside the city (Sept 2017)

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.

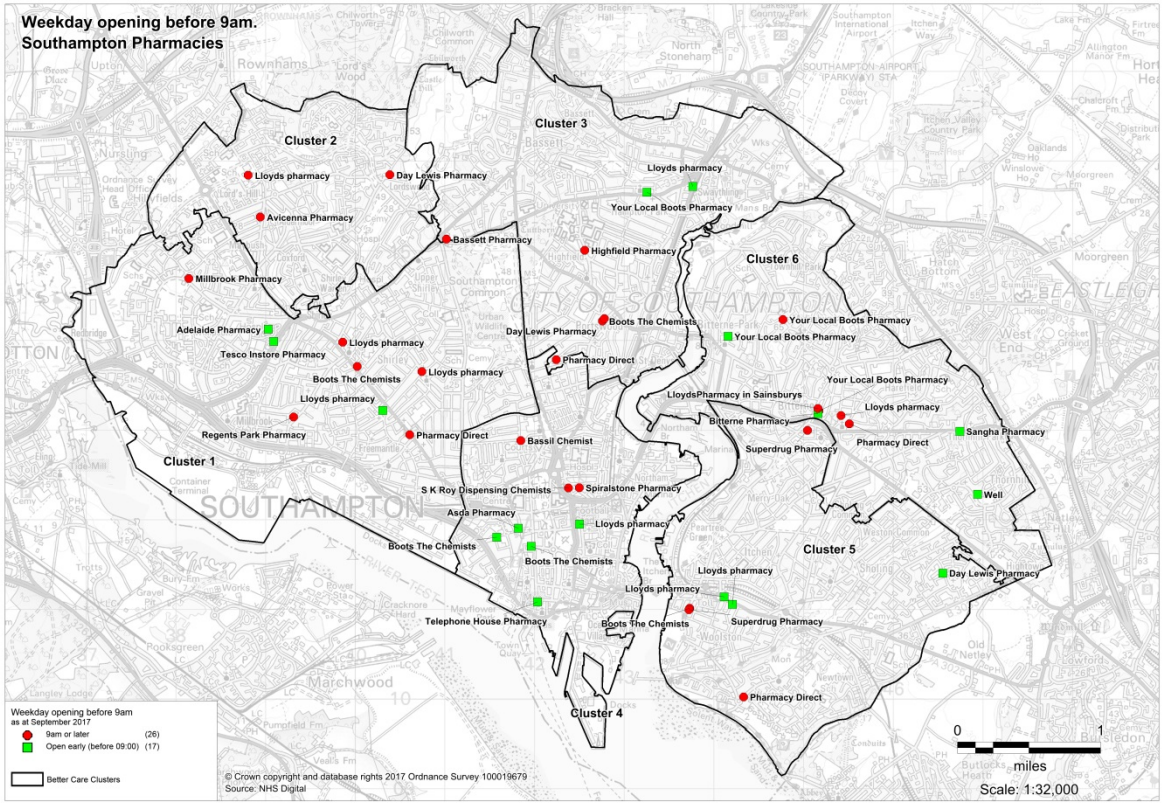


Figure 3. Map of weekday morning opening times for community pharmacies in Southampton, as at September 2017

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.

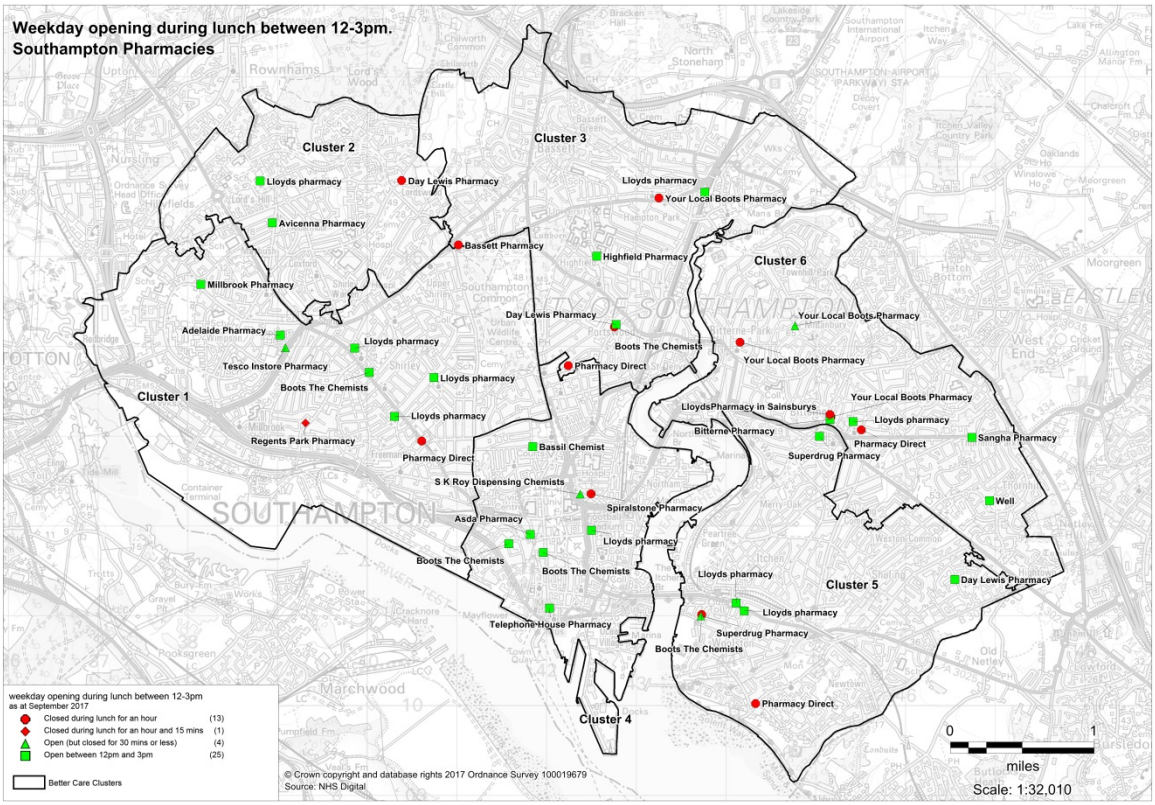


Figure 4. Map of weekday lunchtime opening times for community pharmacies in Southampton, as at September 2017

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.

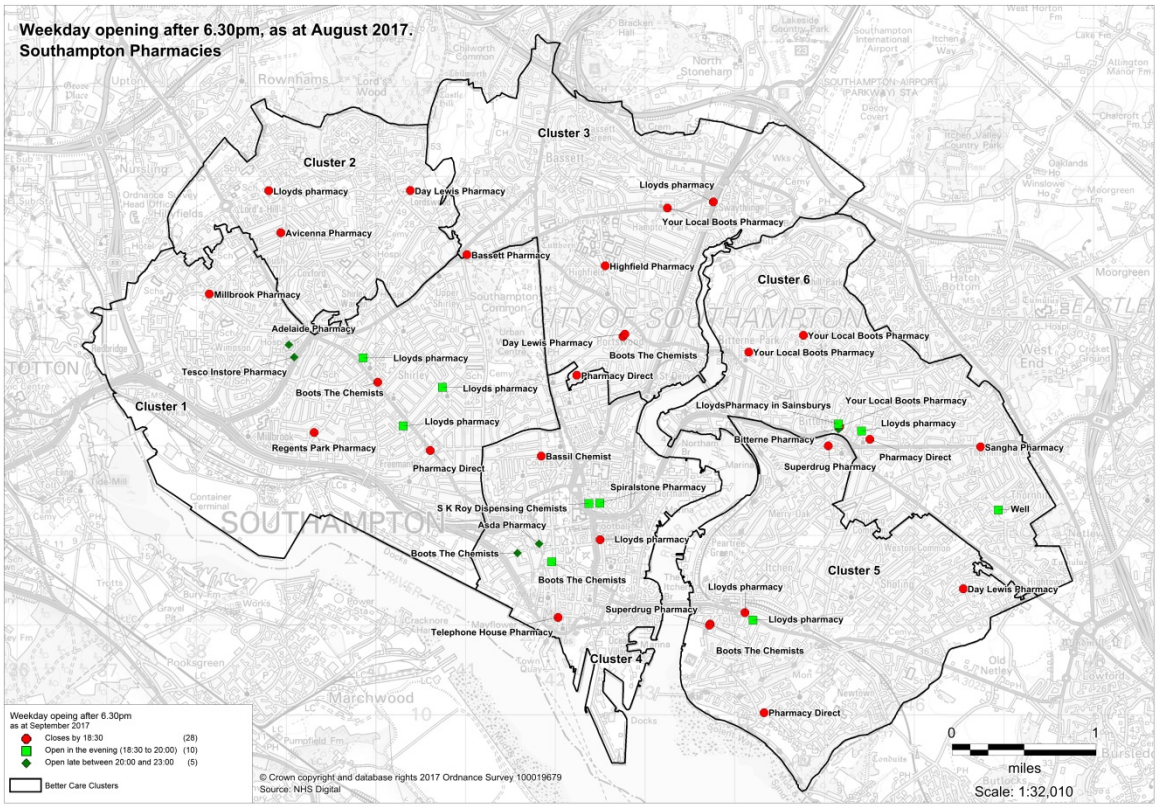


Figure 5. Map of weekday evening opening times for community pharmacies in Southampton, as at September 2017

7.1.6 Saturday opening

The majority of community pharmacies 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.

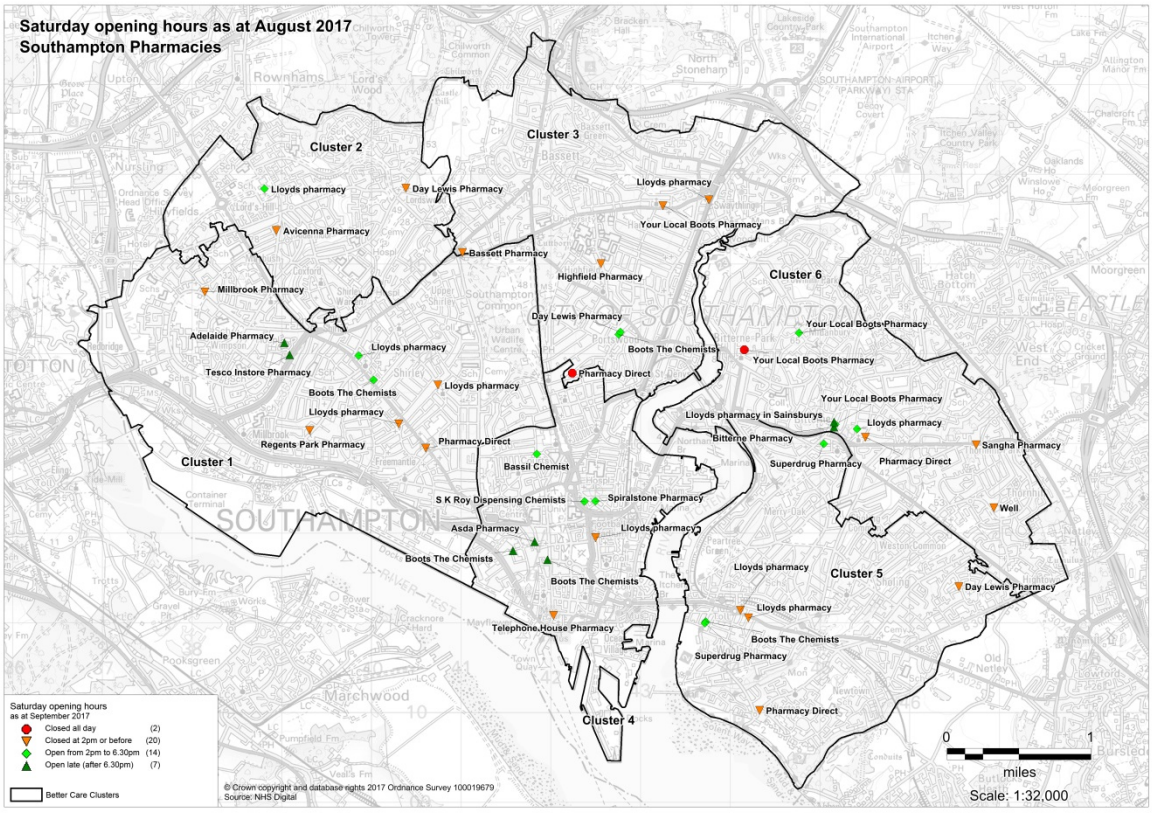


Figure 6. Map of Saturday opening times for community pharmacies in Southampton, as at September 2017

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.

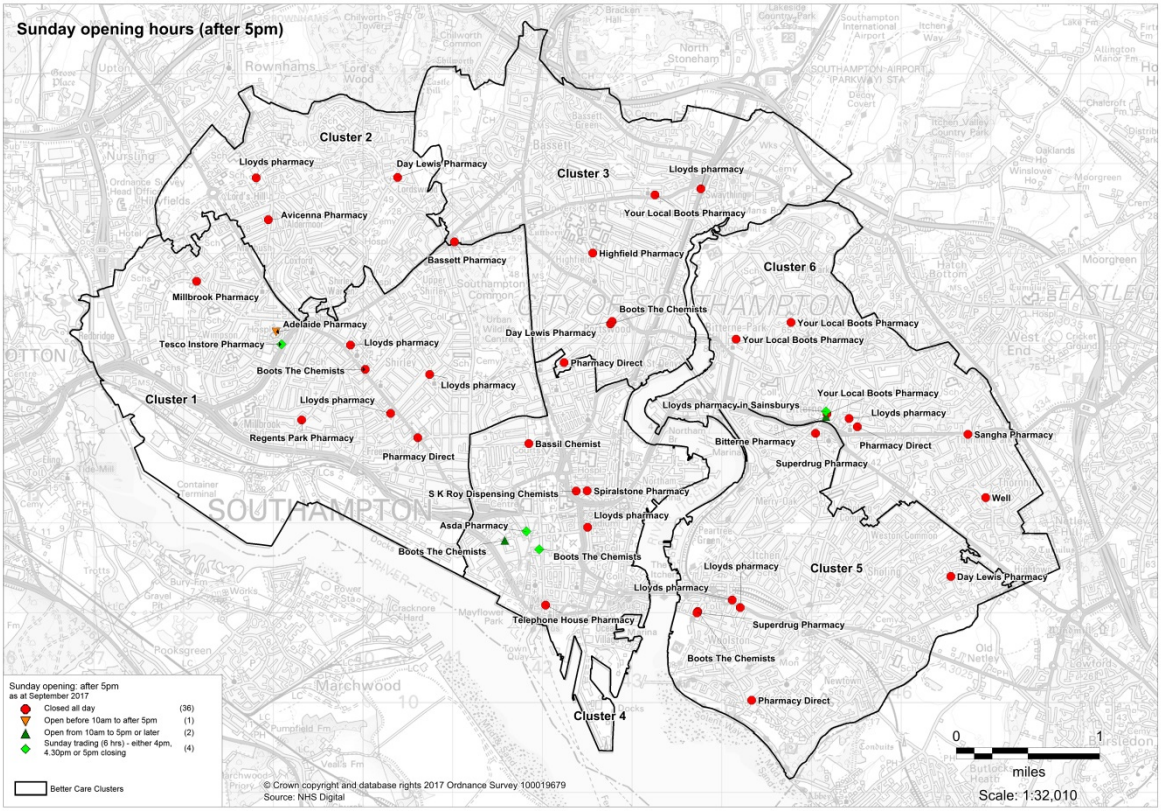


Figure 7. Map of Sunday opening times for community pharmacies in Southampton, as at September 2017

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

7.1.9.1 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.

7.1.9.2 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).

7.1.9.3 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.

7.1.9.4 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.

7.1.9.5 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).

7.1.9.6 Proximity to GP Practices

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

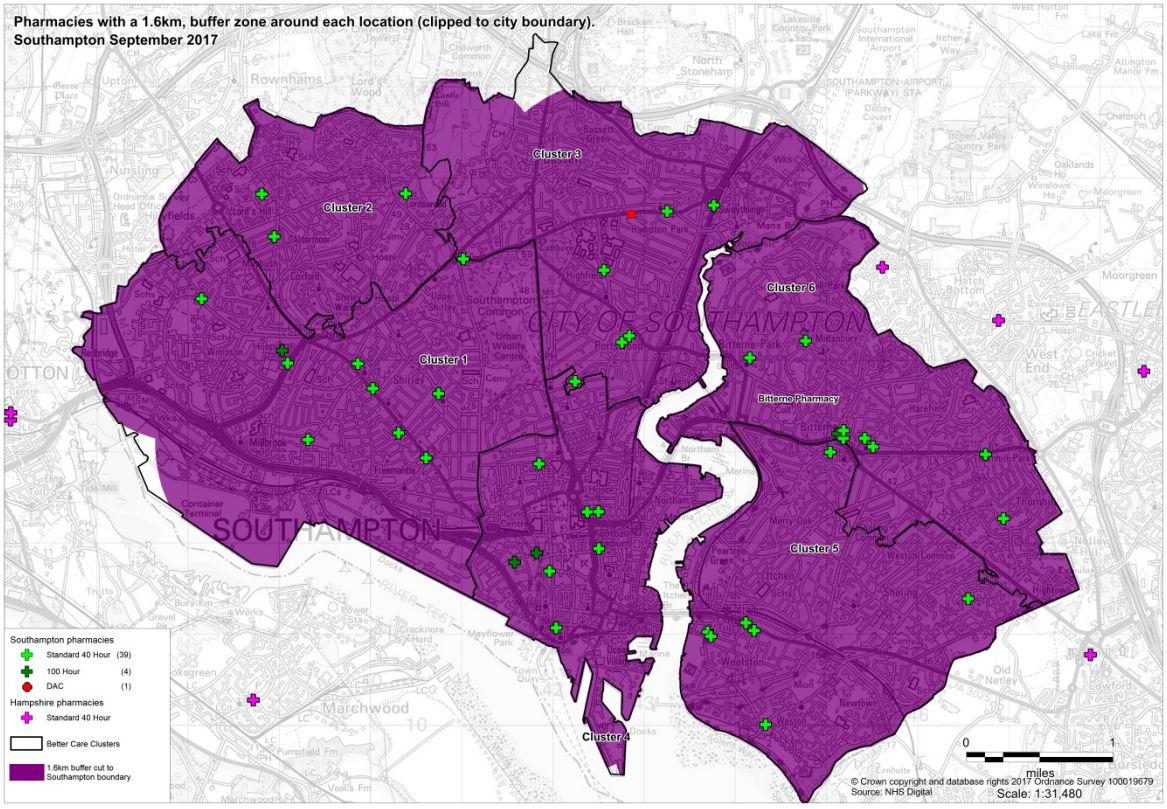


Figure 8. Map of pharmacies with a 1.6km straight line buffer zone (purple), Southampton.

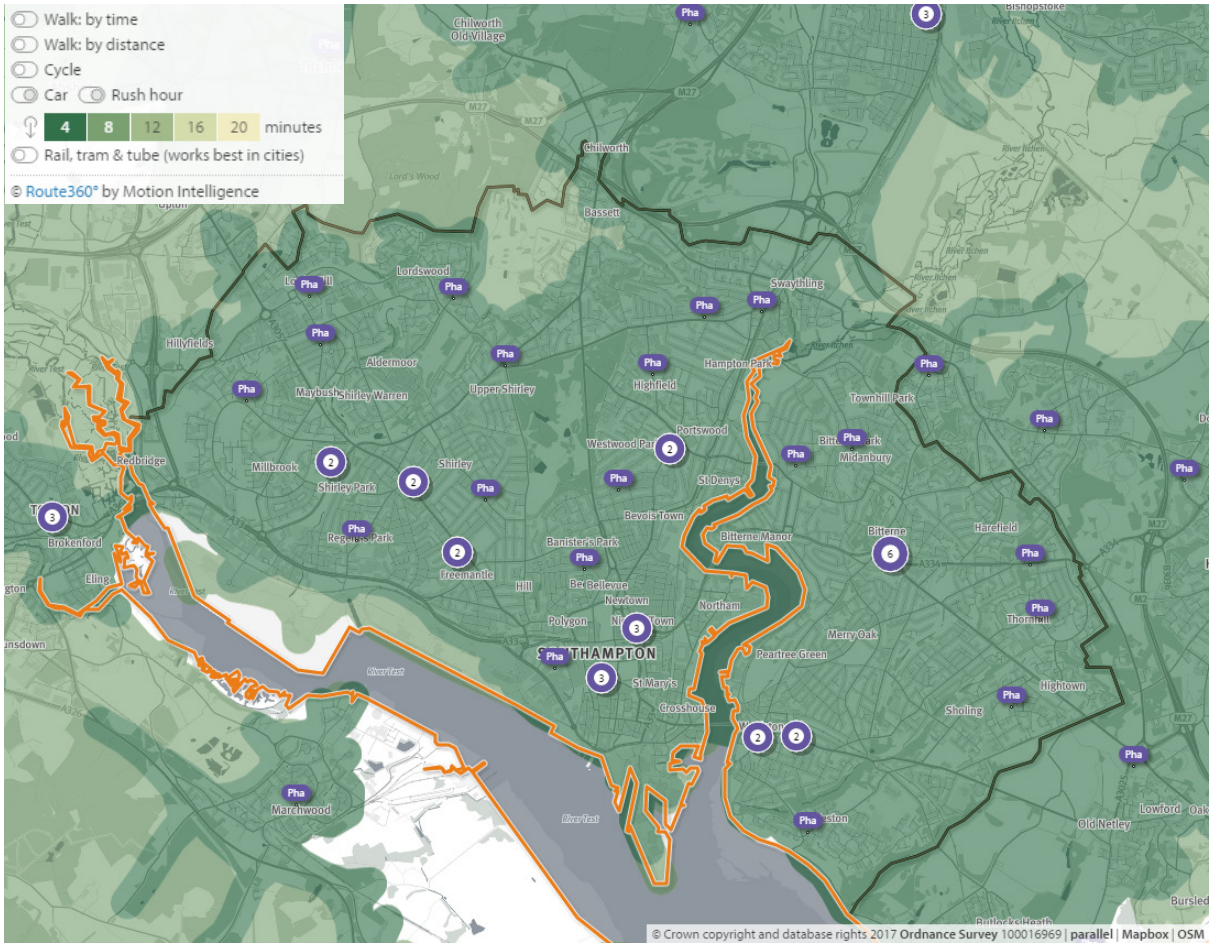


Figure 9. Map of drive times in rush hour from pharmacies (excluding distance selling) in Southampton and outside of the local authority boundary. Source: SHAPE place, Public Health England.

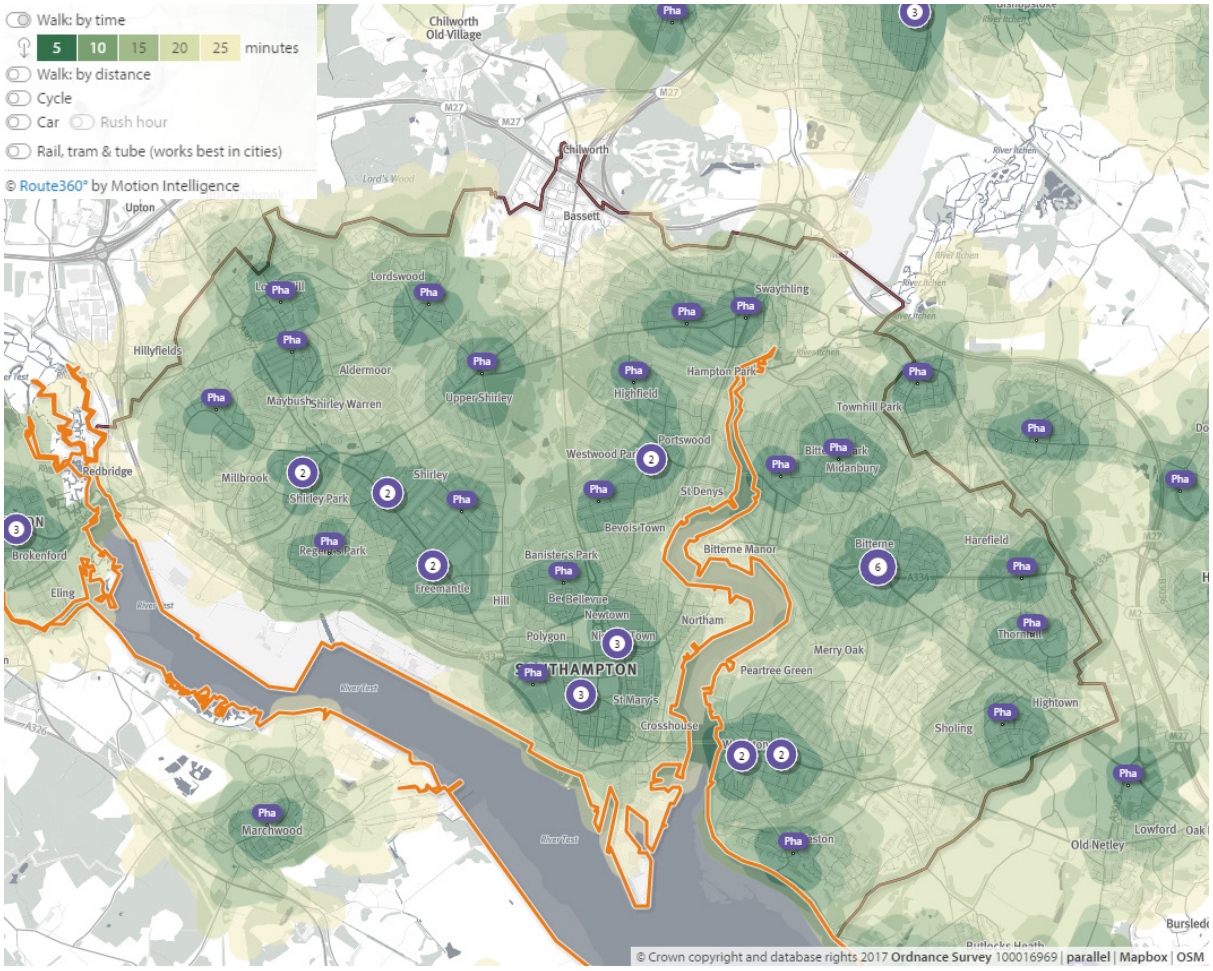


Figure 10. Map of walking times (5-25 minutes) from pharmacies in Southampton (excluding distance selling) and outside of the local authority boundary. Source: SHAPE place, Public Health England.

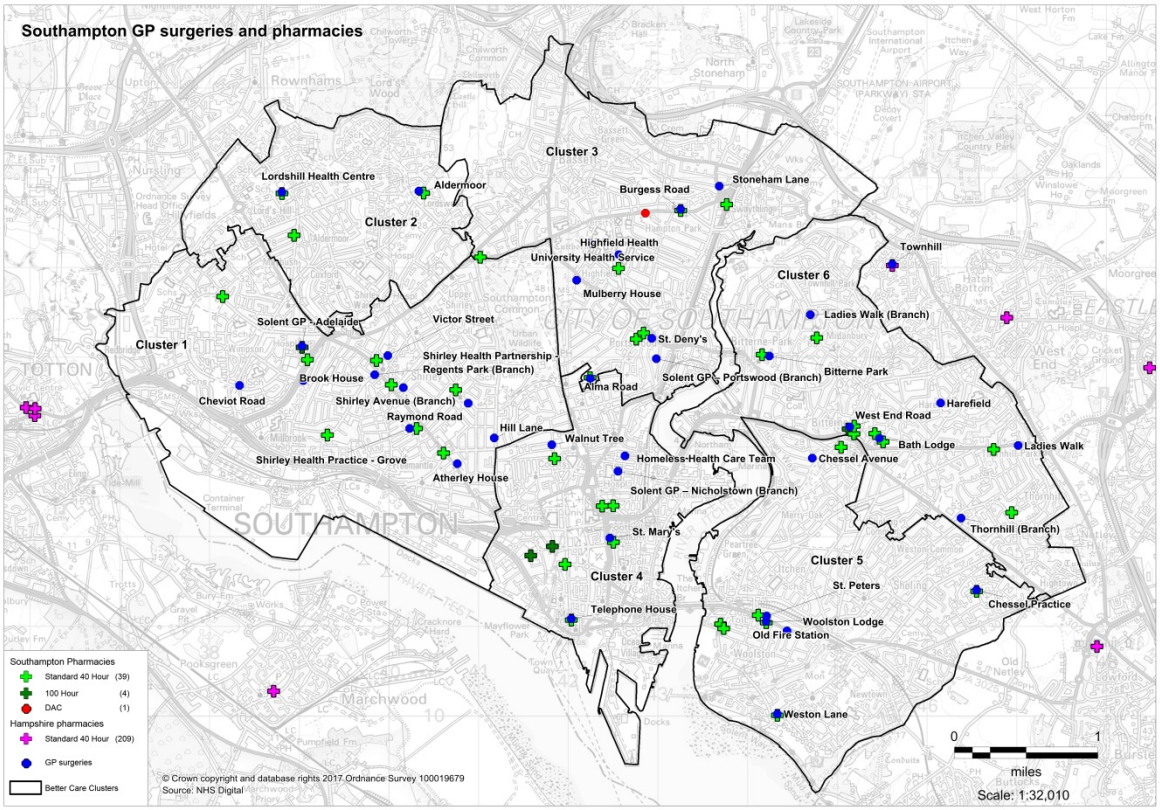


Figure 11. Map of GP surgeries proximity to pharmacies in Southampton (September 2017).

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 September 2018. It began operating in Southampton in January 2018. 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	The majority of 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 recognised that a wide variety of languages are spoken within

[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

	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.
Out of hours service	Voluntary opening by one or two pharmacies has ensured sufficient pharmaceutical services for major bank holidays.
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	The majority of prescribing is met by GPs.
Service 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.

7.4.8 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.

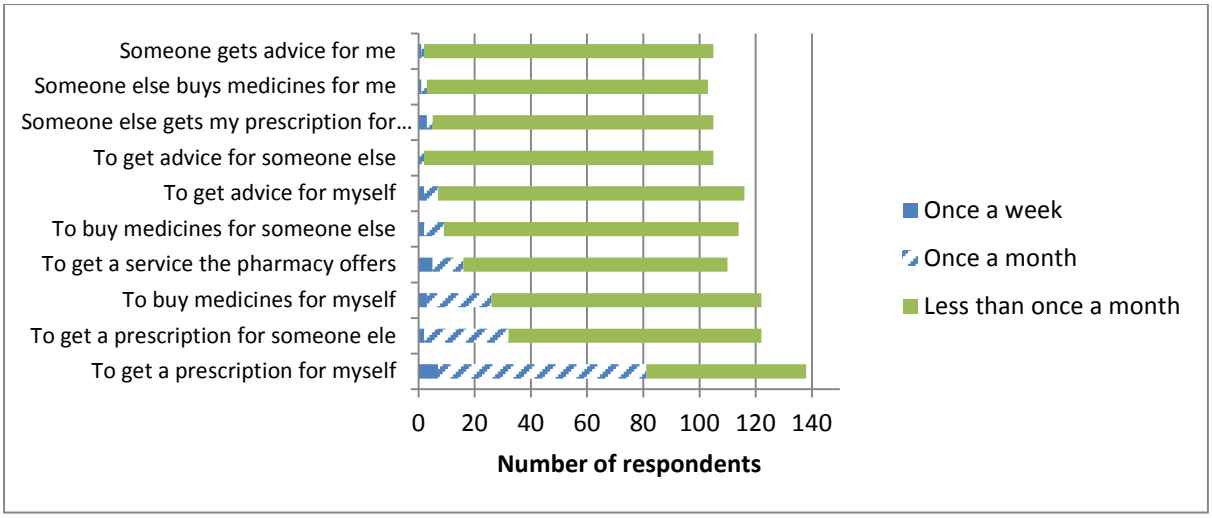


Figure 12. Reason and frequency given by survey respondents for using a community pharmacy

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	40.4%	37.7%	22.0%	
and noon	90	84	49	223
Between noon	38.8%	36.7%	24.5%	
and 2pm	57	54	36	147
Between 2pm	41.9%	35.5%	22.7%	
and 5pm	72	61	39	172
Between 5pm	49.2%	29.8%	21.0%	
and 8pm	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

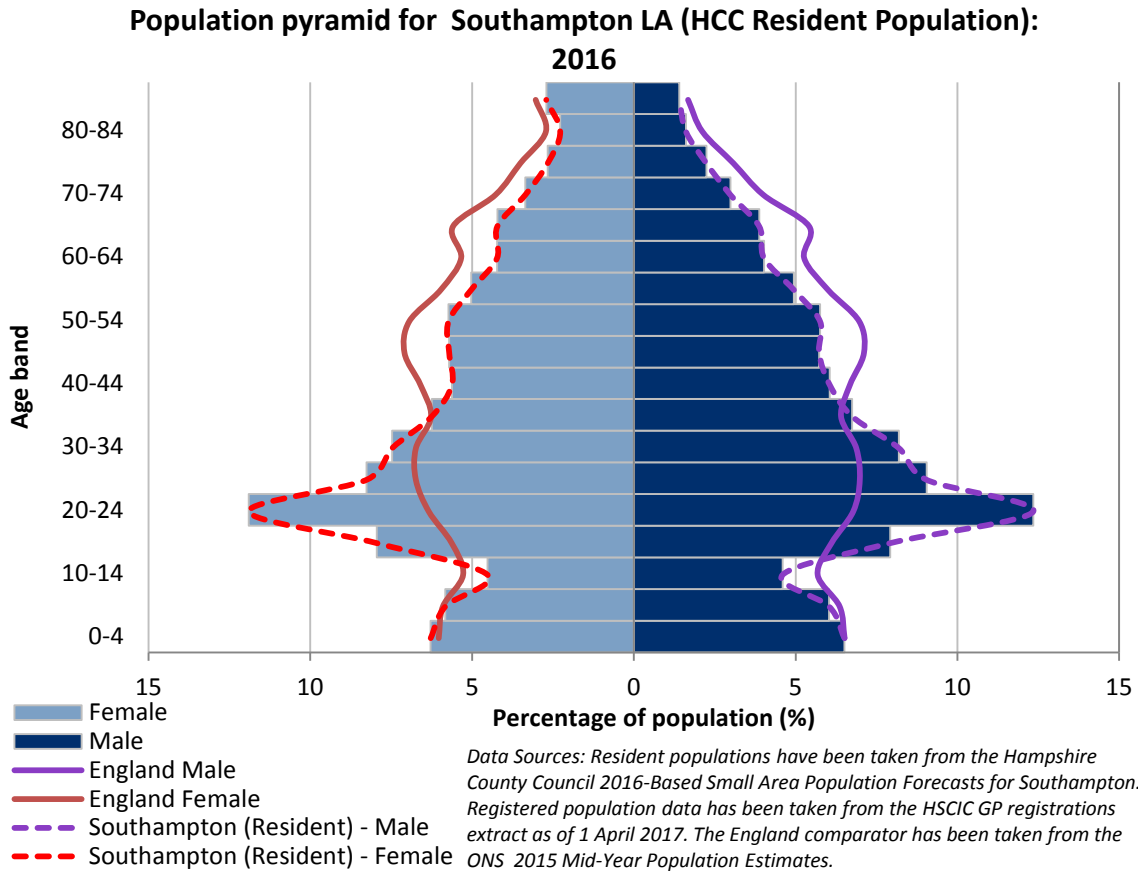
Table 7. Information on healthy living being offered by community pharmacies and Heatlhy Living Pharmacy status as reported by survey respondents

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

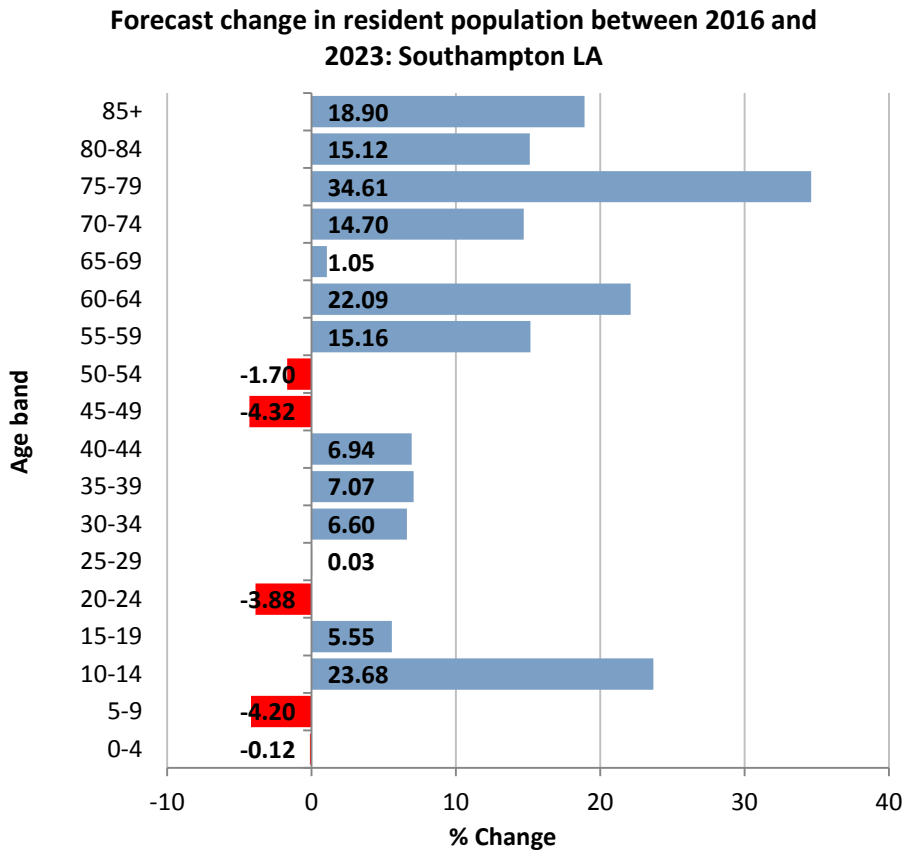
There are many uncertainties around current and future population numbers. The Southampton JSNA currently uses data produced by Hampshire county council (HCC) which incorporates the results of the 2011 Census. Hampshire County Council's small area population forecasts (SAPF) are based on the planned 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]

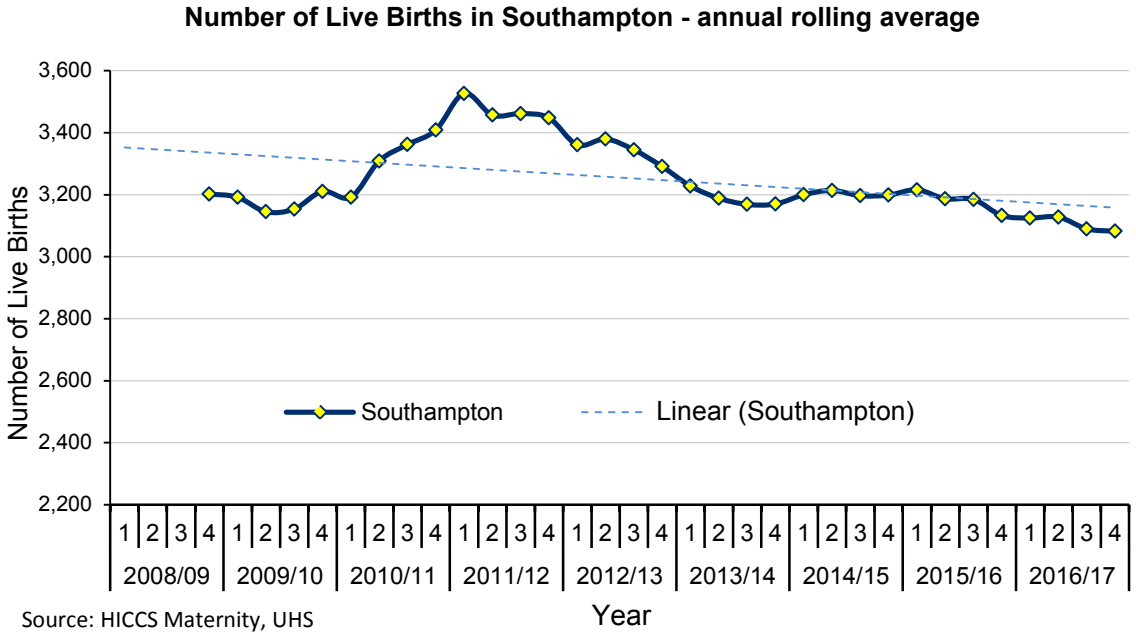
Longer term projections, based on past trends, predict a 38% increase in over 65s in Southampton between 2010 and 2035 with the number of residents in the city aged over 85 reaching 8,500 by 2035.[20]

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.

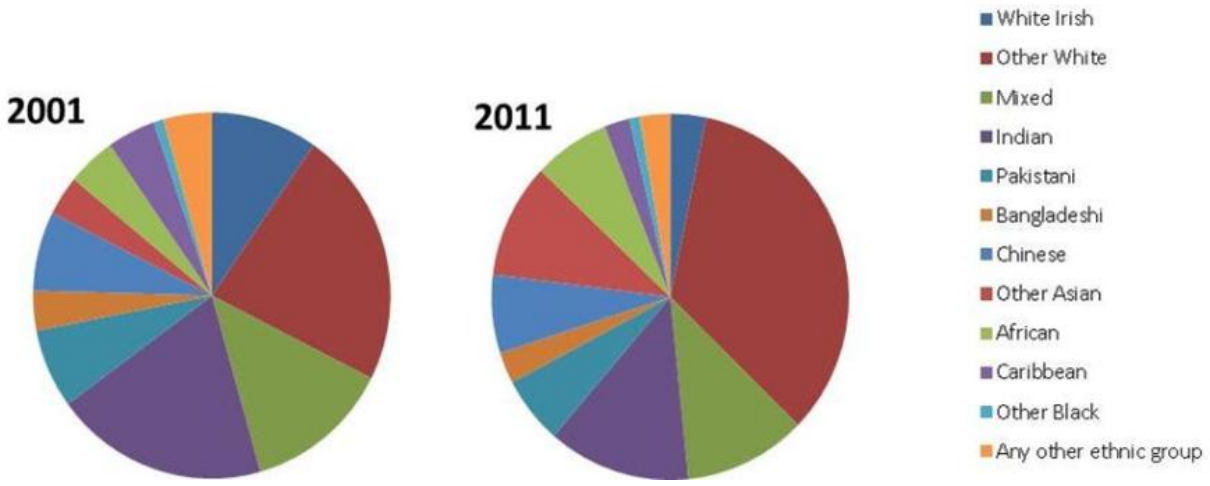
In 2015, the general fertility rate for Southampton by electoral ward ranged from 92.9 births per 1000 females aged 15 to 44 years in Redbridge to 32.9 births per 1000 females aged 15 to 44 years in Swaythling.

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.

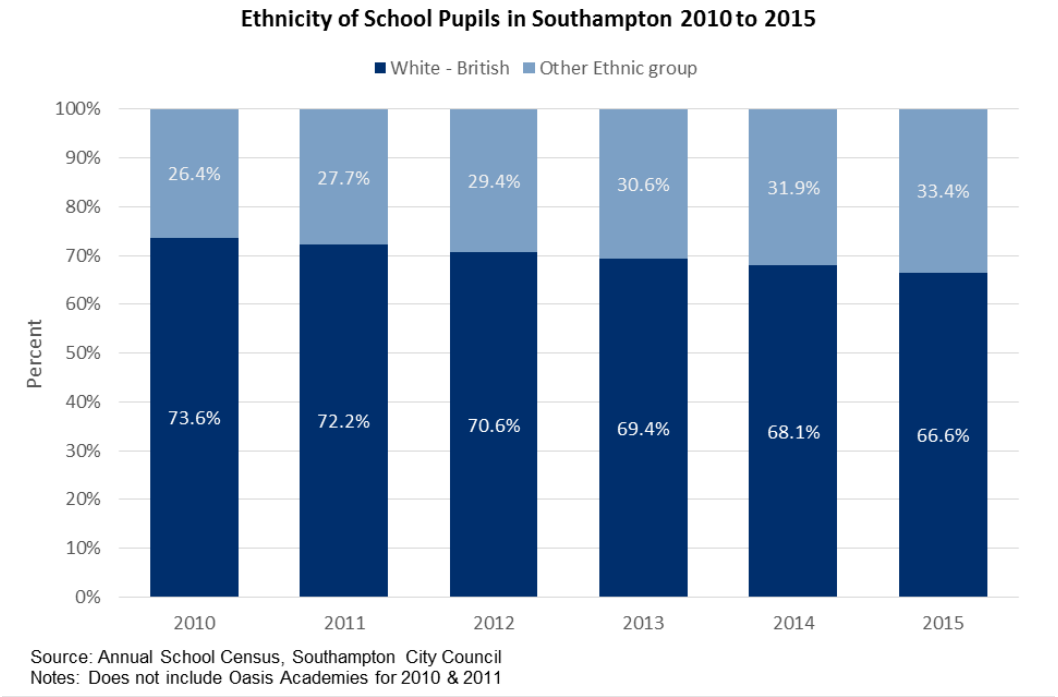
Based on results from the 2011 Census, Southampton now has residents from over 55 different countries who between them speak 153 different languages. In the 2011 Census 77.7% of residents recorded their ethnicity as white-British, which is a decrease of 11% from 2001. The pie charts in Figure 16 show 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.

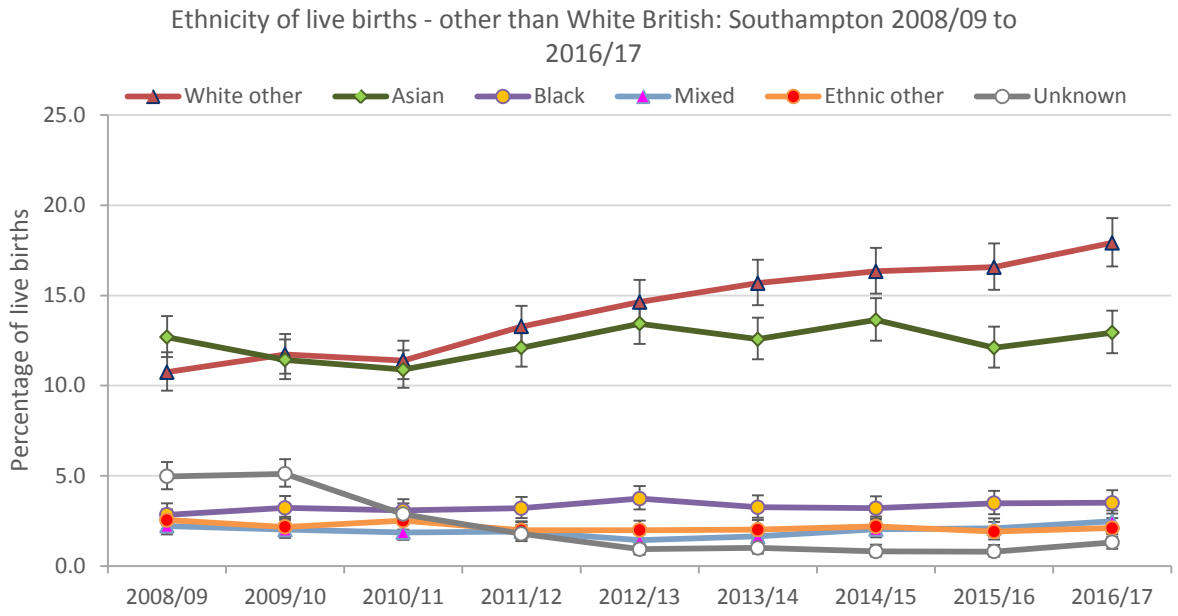


Southampton has a higher proportion of households where no-one has English as their main language (7.7% compared to 4.4% nationally). There are 7,522 households in the city that fall into this category. The school census in 2012 found that 14.1% of school pupils had a

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



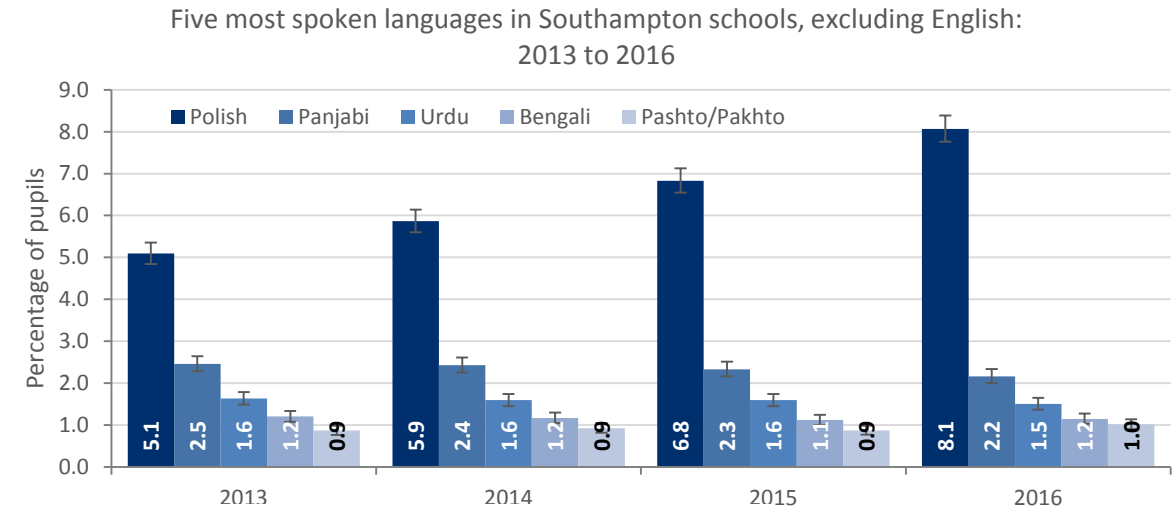
Source: UHS Midwifery database, Southampton CCG

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

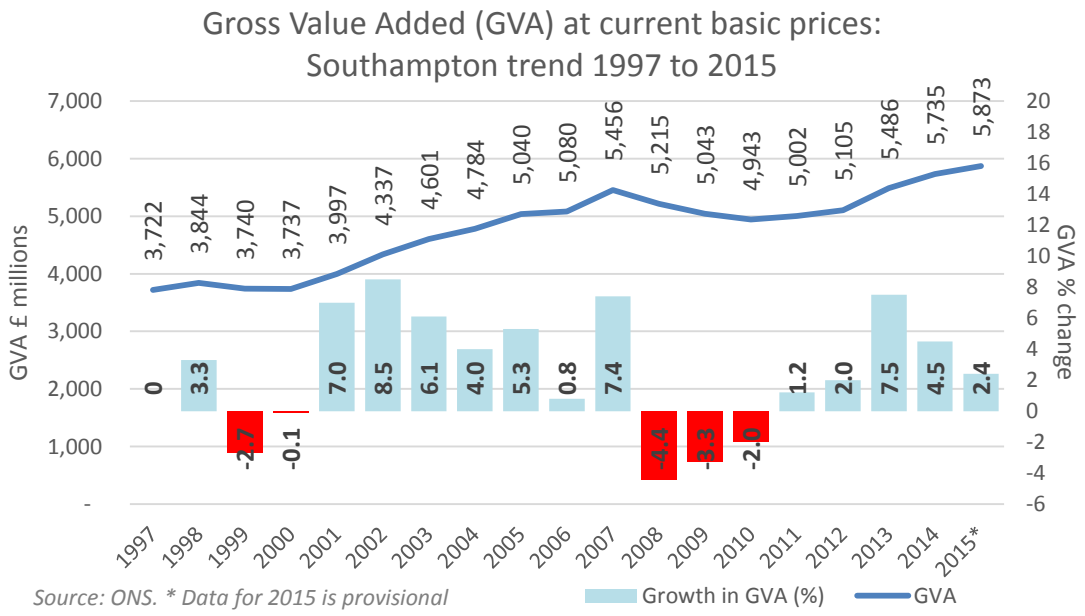
Since 2004, economic migration from Eastern Europe has contributed to the development and sustainability of many business activities, thereby bringing in greater richness and diversity to city life. Strong community relations over many decades have contributed to maintaining cohesiveness. Long term international 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:

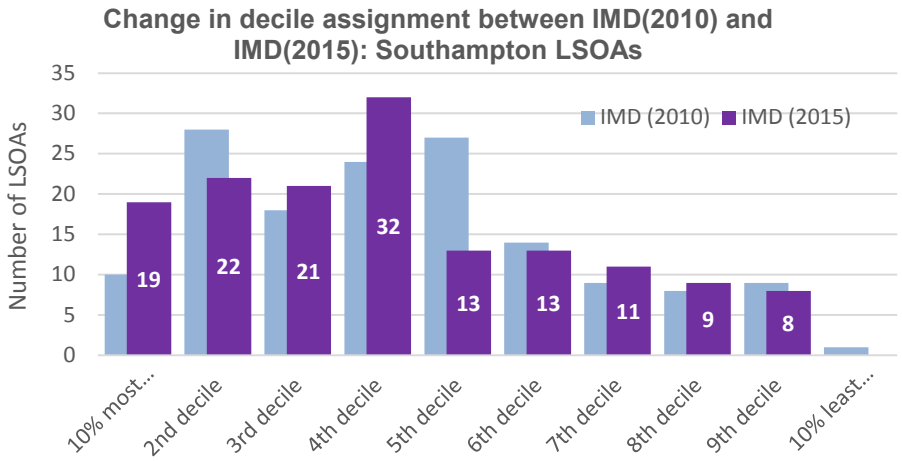
- Lidl Regional Distribution Centre with an investment of around £50M
- 1,620 new residential units at Centenary Quay and 350 at Meridian Waterside.
- 525 student residential units in Portswood (former B&Q site) and 350 at City Gateway.
- Higher educational facilities at the Southampton Marine and Maritime 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

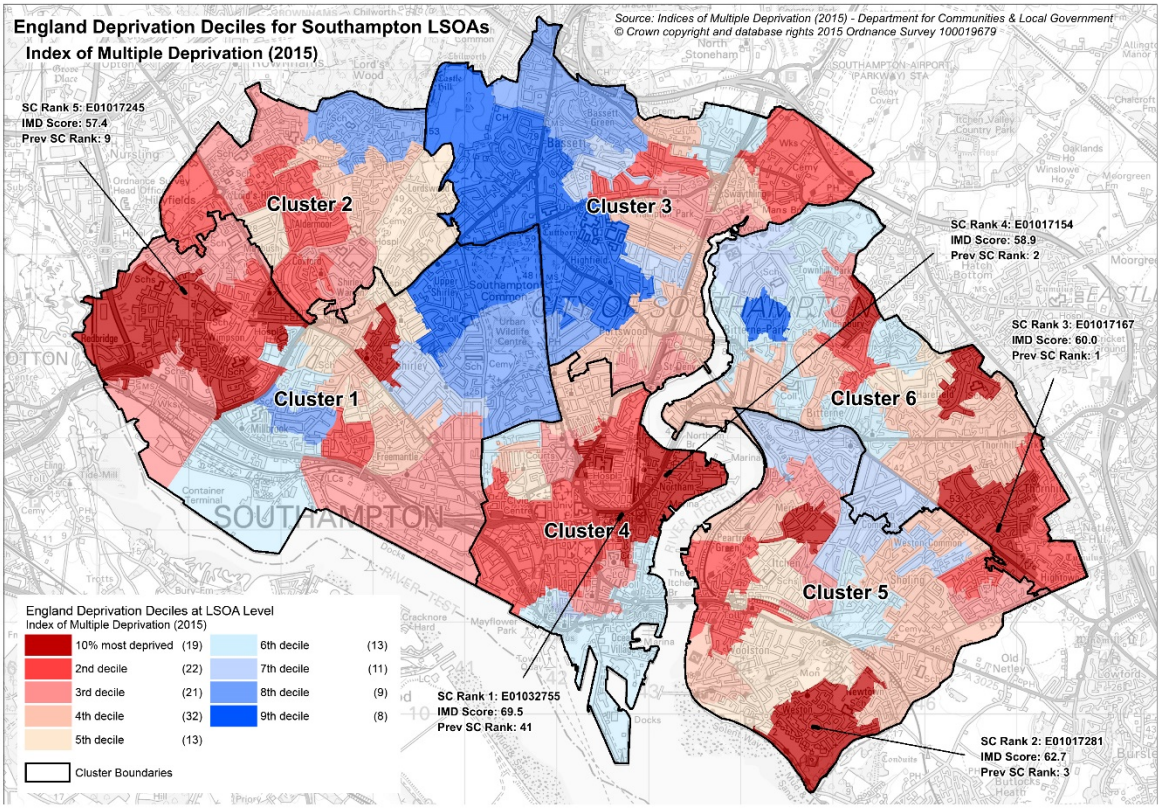


Source: DCLG. Note: IMD (2010) data is based on PHE rebased figures for 2011 LSOAs

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

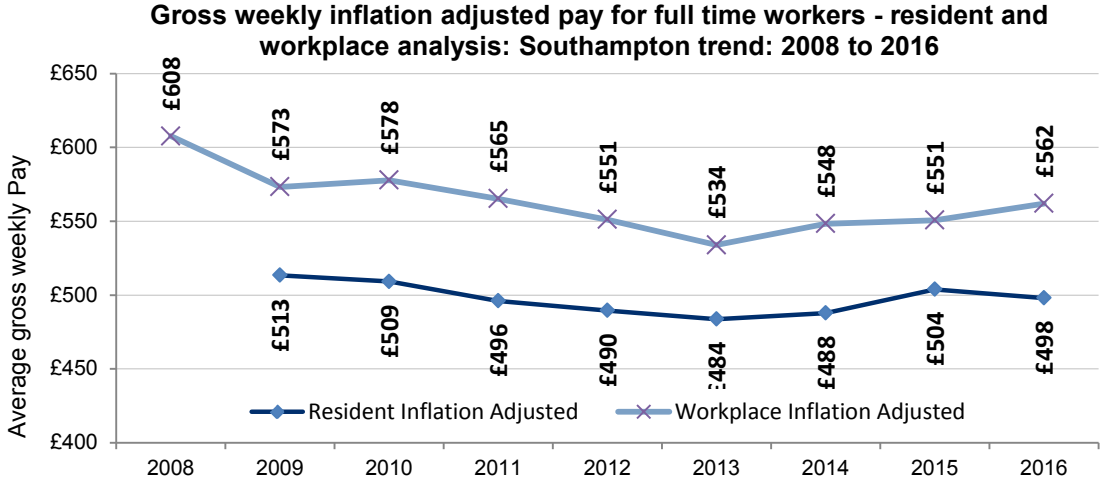
of 16.2%, and broken down into electoral ward level ranges from 11.1% in Bassett ward to 38.0% in Bevois ward.[29]

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

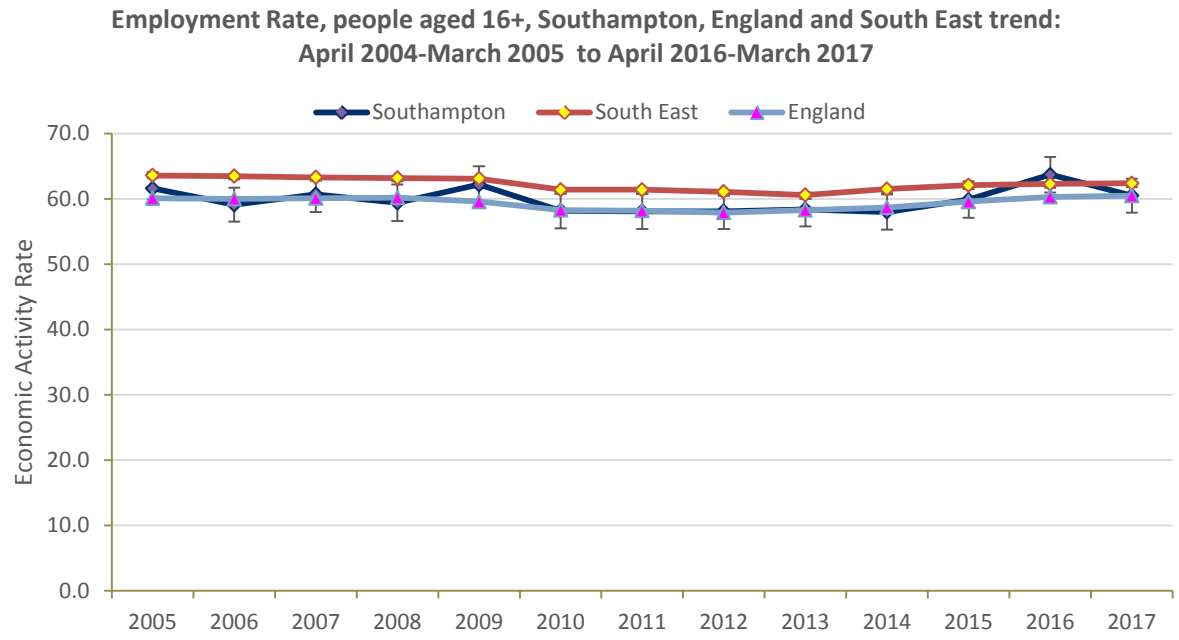
Levels of pay for jobs located in Southampton are now higher than the England average and the highest on offer amongst the city's statistical neighbours. Southampton is home to large businesses requiring higher skilled workers, as well as hosting university workers and graduates. Southampton is a net 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.

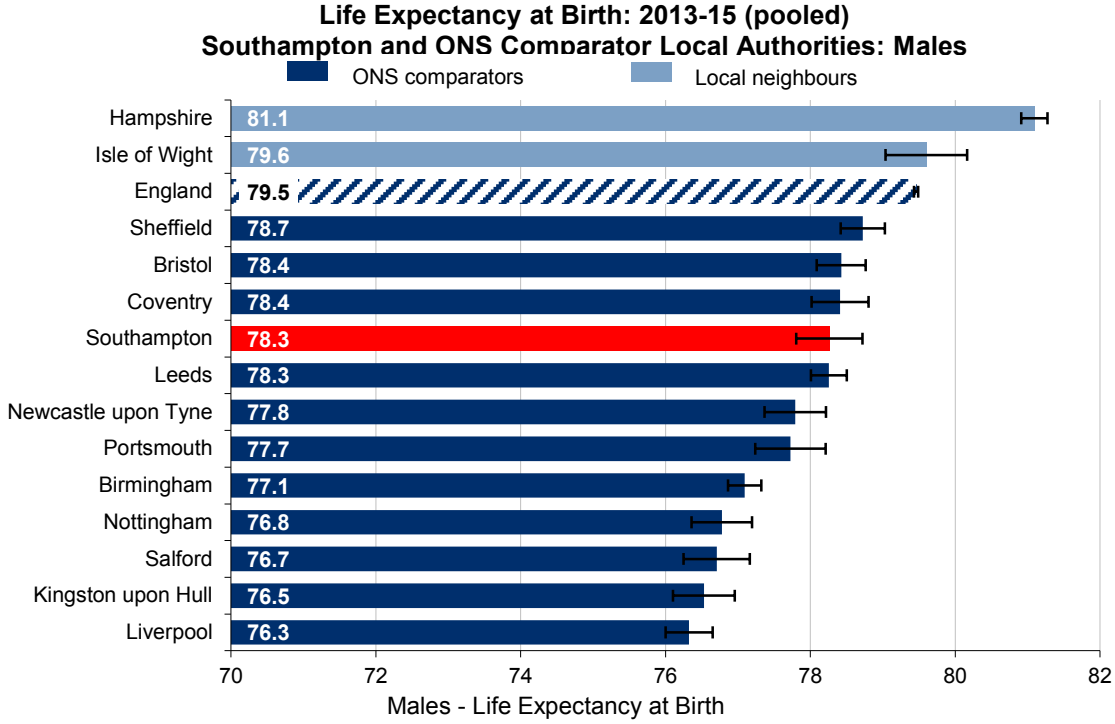
[37] February 2010 http://www.marmotreview.org/

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)

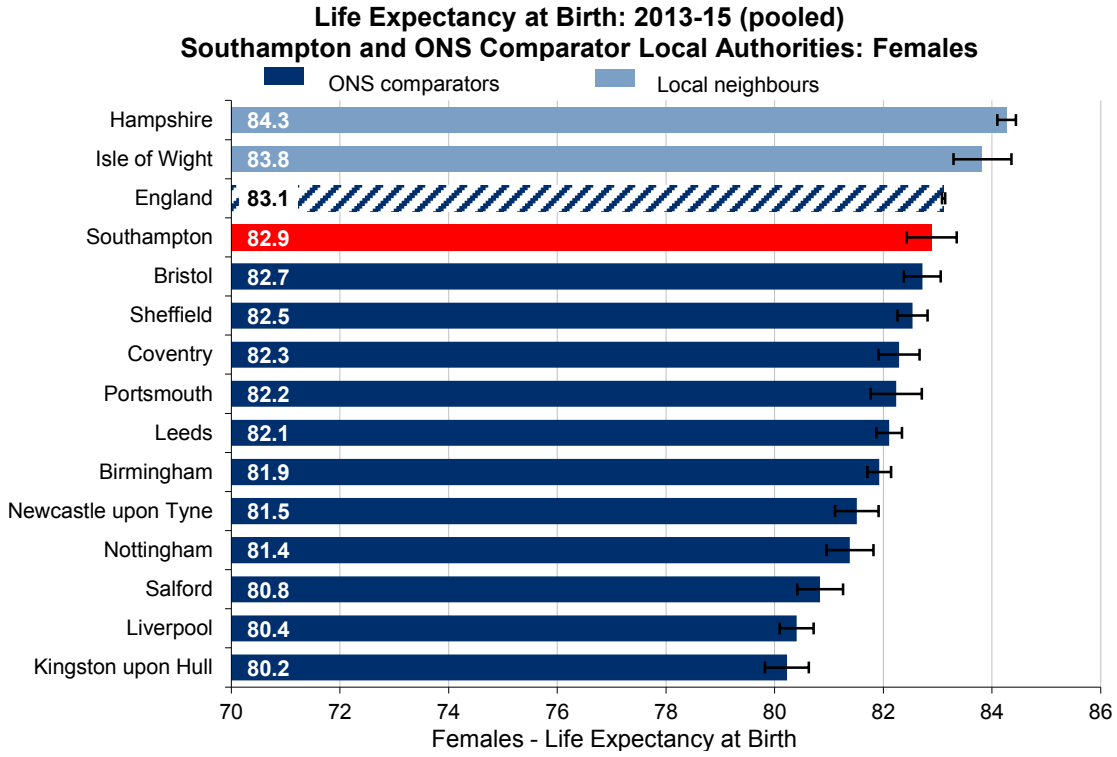
Figure 25



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.

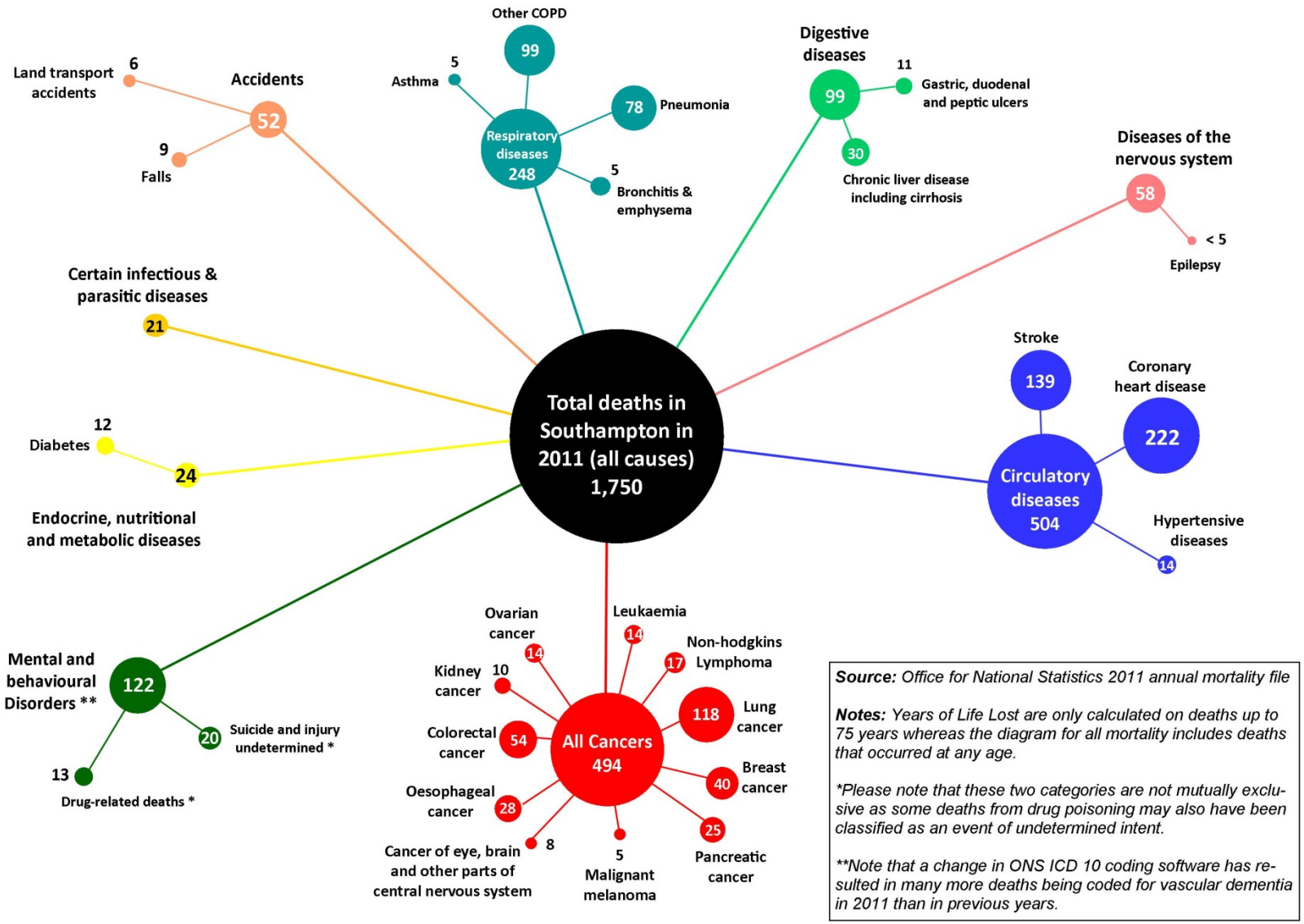
In 2013/15, the number of years of healthy life expectancy for males are significantly lower and for females are lower but not significantly in Southampton (60.9 years and 63.2 years respectively) compared to England (63.4 years and 64.1 years respectively).

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.*

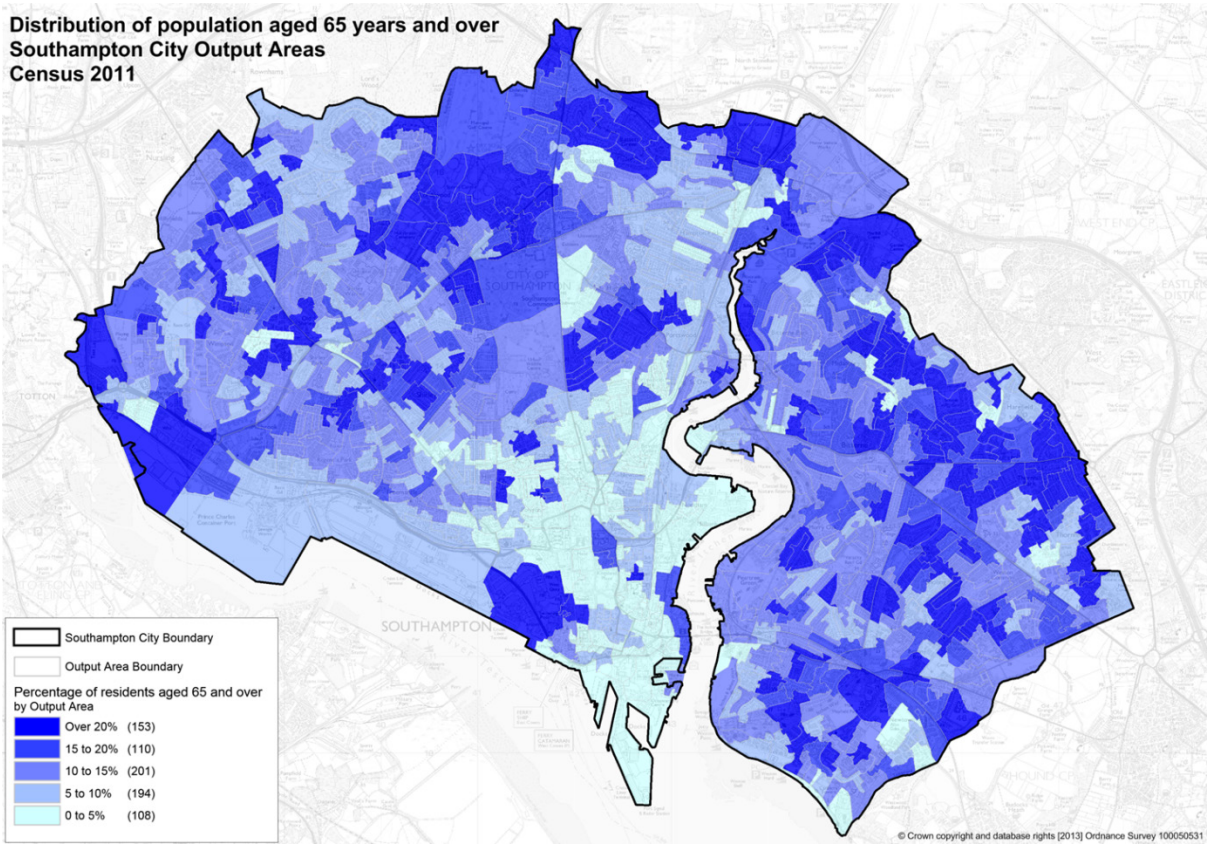
**Please note that these two categories are not mutually exclusive as some deaths from drug poisoning may also have been classified as an event of undetermined intent.*

***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

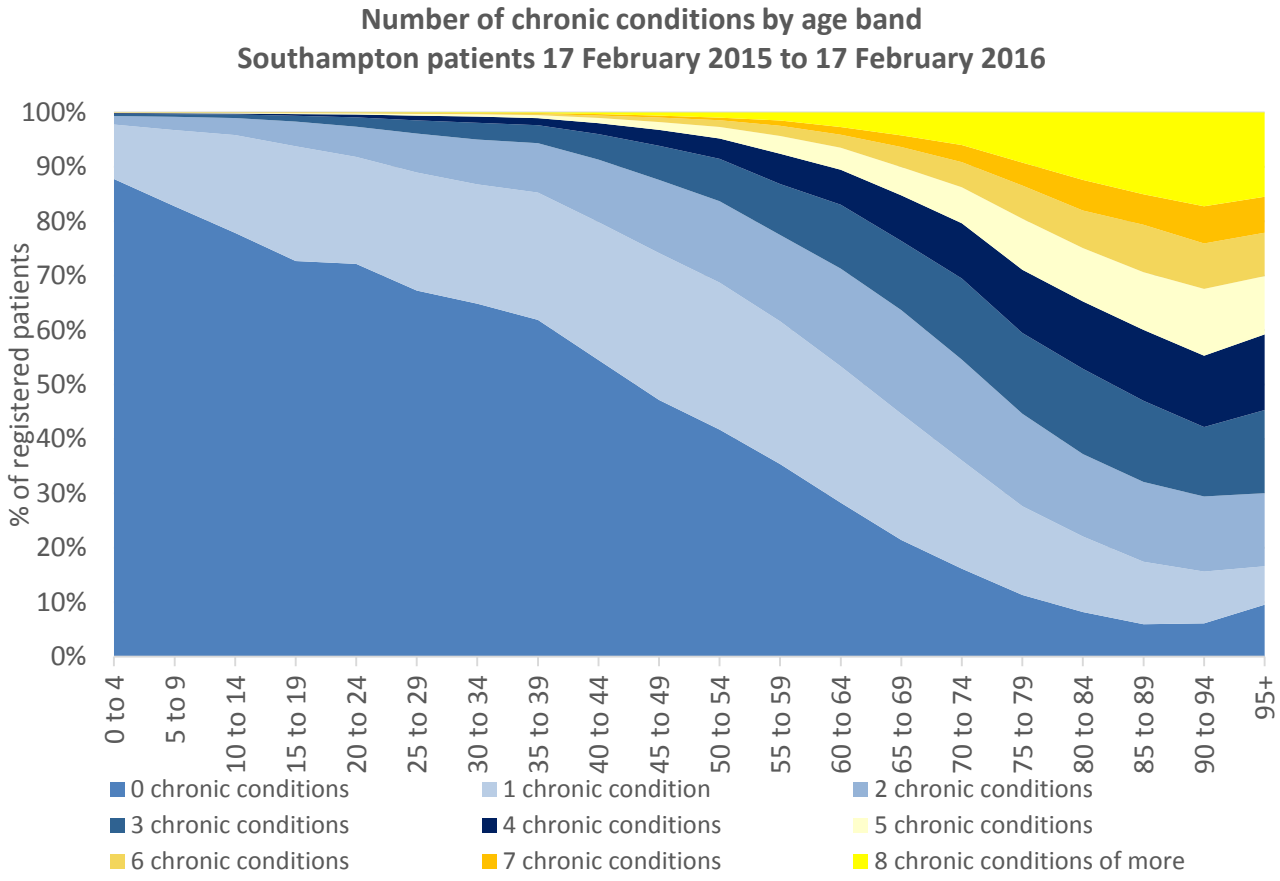
- rate of deaths from Cancer among people aged 65 years and over;
- rate of deaths from Respiratory disease among people aged 65 years and over;
- population vaccination coverage - Flu (aged 65+);
- preventable sight loss - age related macular degeneration (AMD);
- and hip fractures in people aged 65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

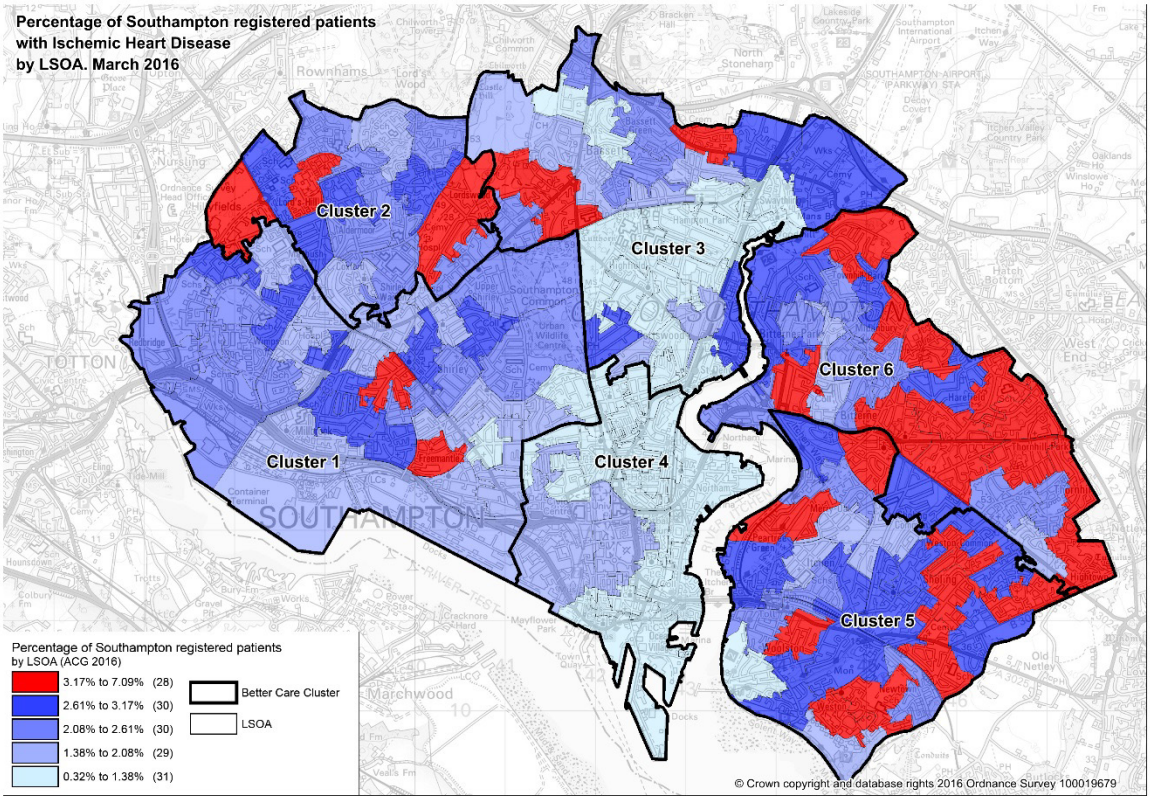
More recent modelled estimates focus on the age group 55 to 79 year old. In 2015 the estimated prevalence for this age group in Southampton was 8.1% equating to 3,740 55 to 79 year old with CHD.[42]

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%.

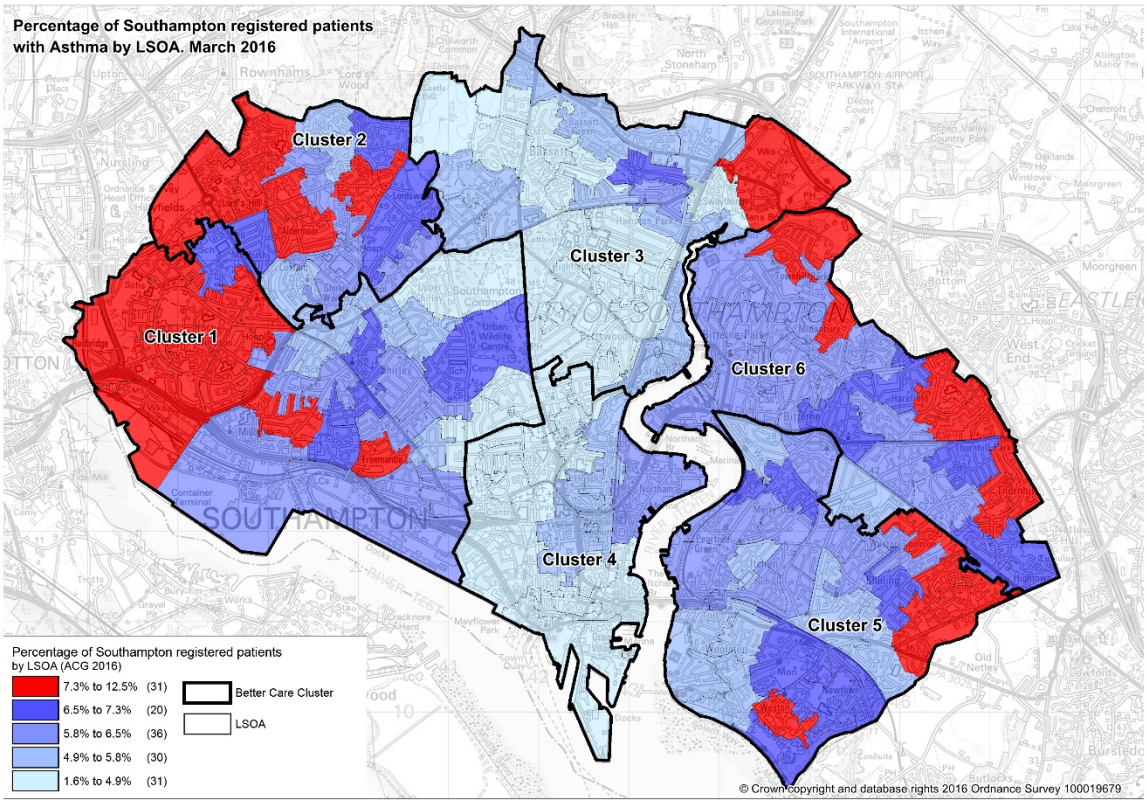
Public Health England investigated this this to be underestimate and have modelled for Southampton 2015/16 expected prevalence of AF to be 1.9% of registered patients, however this estimate is based on assuming Southampton's population structure and related attributes remain similar to that used in the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

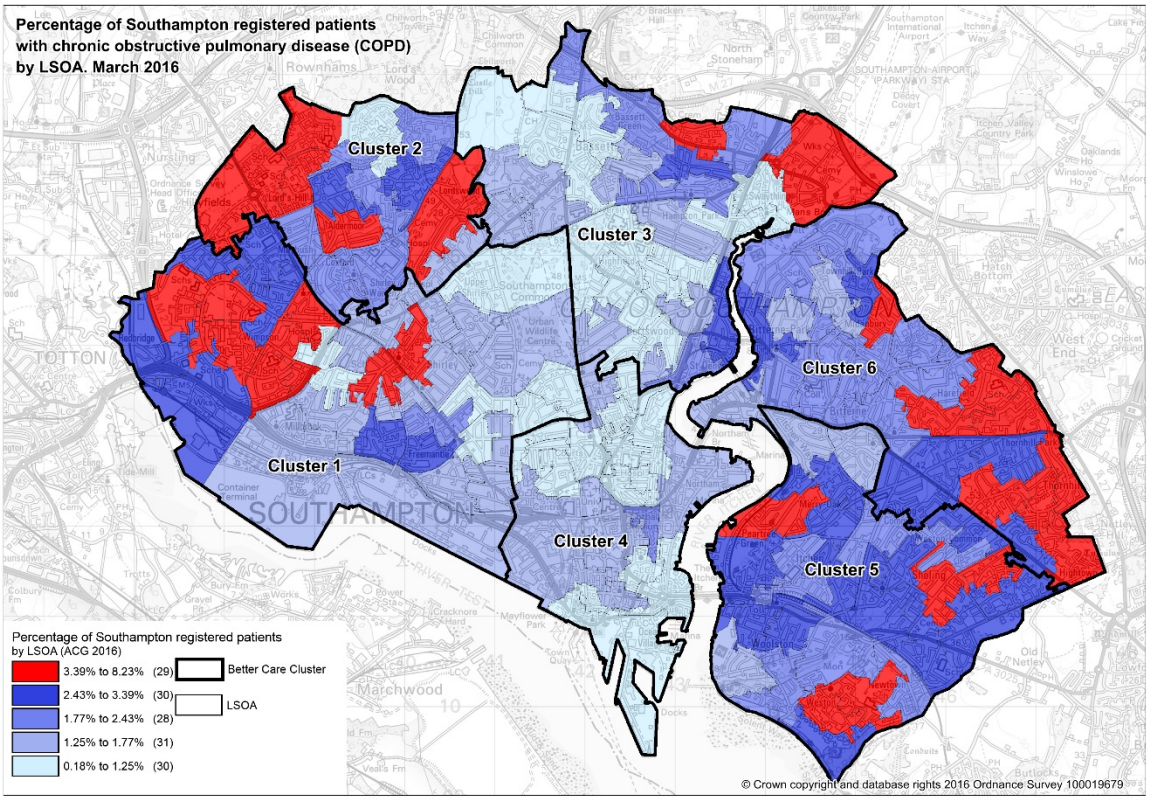


9.8.4.7 Chronic obstructive pulmonary disease (COPD)

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

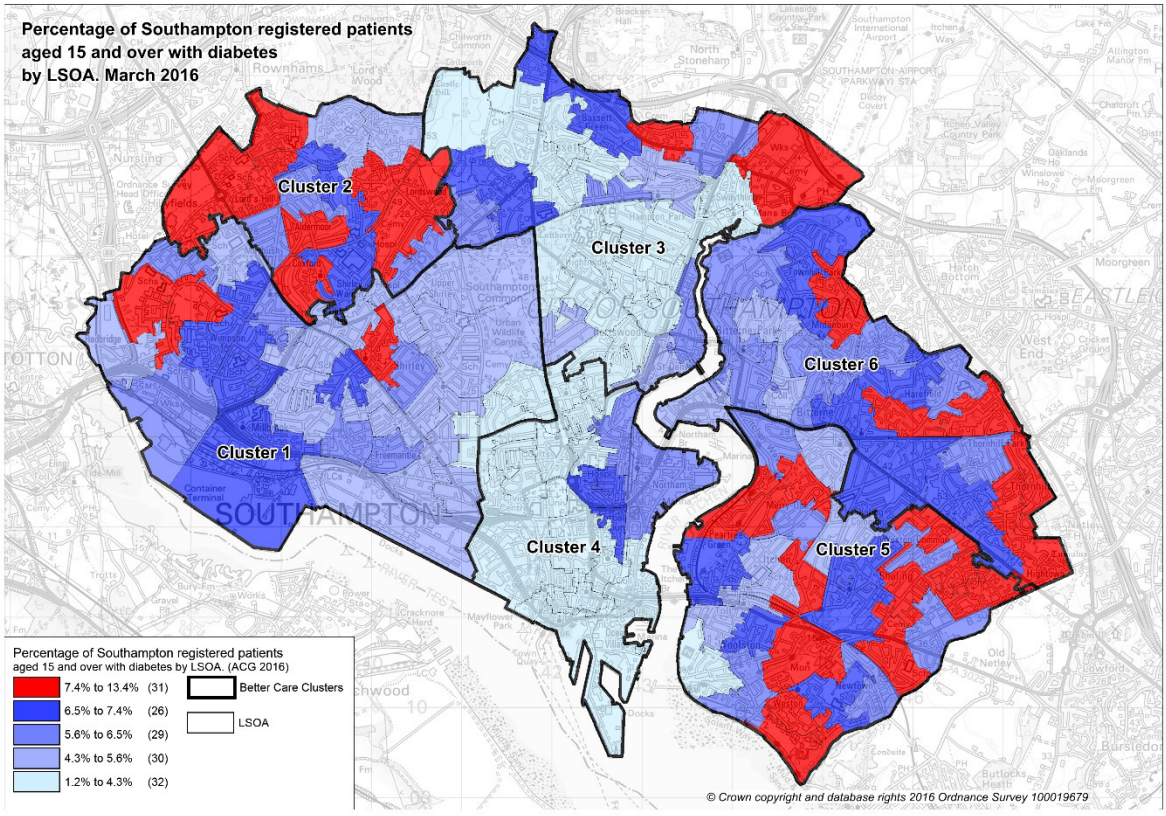
In March 2016 GP QOF data showed 6,777 people on GP disease registers with chronic kidney disease (CKD). The prevalence of diagnosed CKD amongst people aged 18 years and over in Southampton is 3.0% (compared to 4.0% in the CCG Cluster comparator group) although this varies from 0.2% to 5.5% by Southampton 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%).

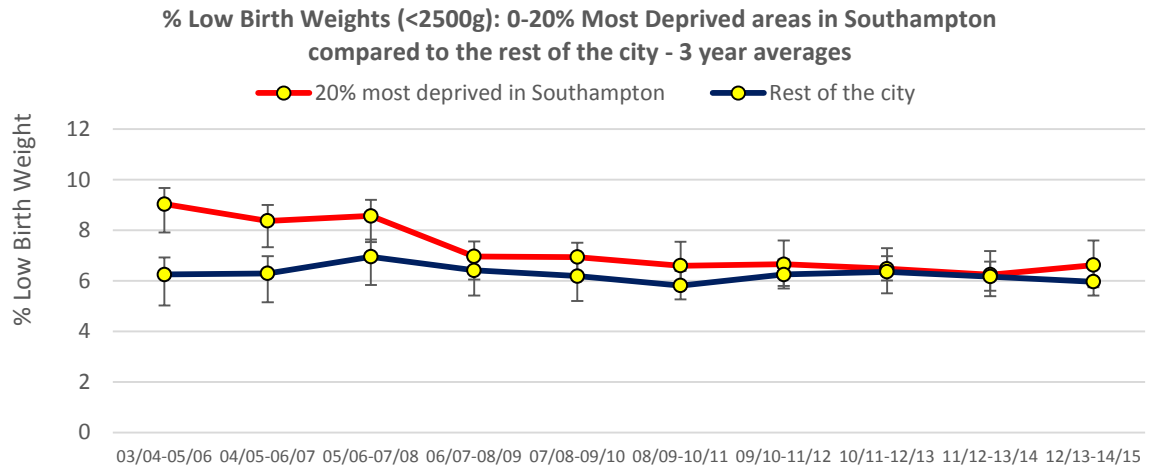
9.10 Parenting, childhood and adolescence

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.

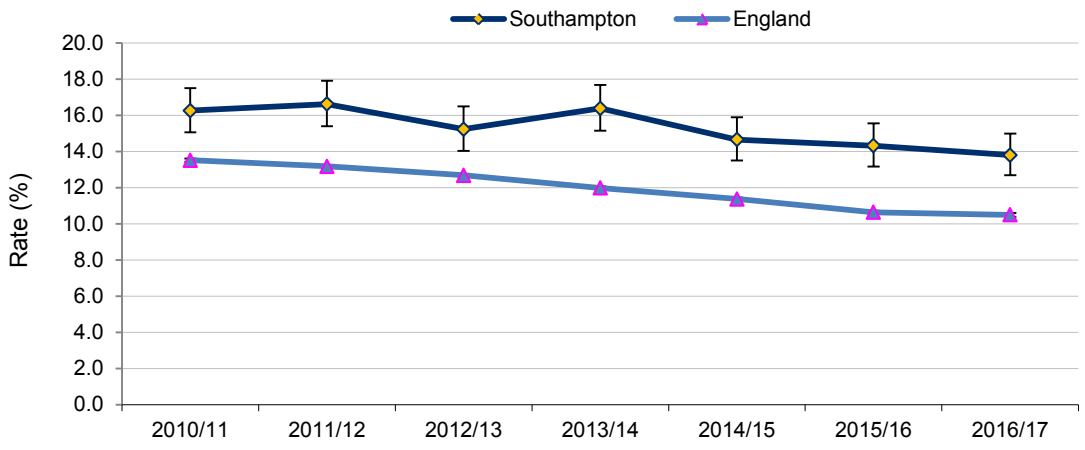
Caesarean birth rates are significantly lower within the most deprived areas compared to the rest of the city, although the gap is narrowing. Whilst there is some variability in the percentage of babies born by caesarean section across the city's areas, none are significantly different from the Southampton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

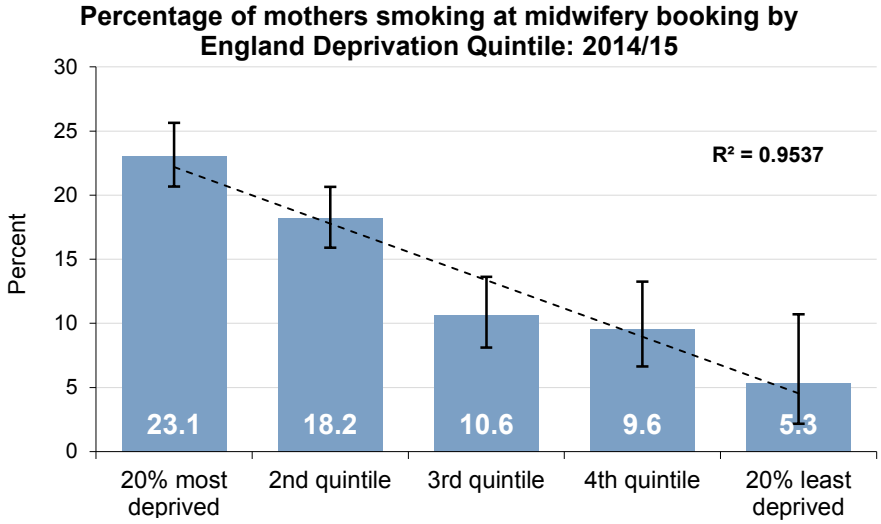


Sources: Copyright © 2017. Health and Social Care Information Centre, Lifestyles Statistics.

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



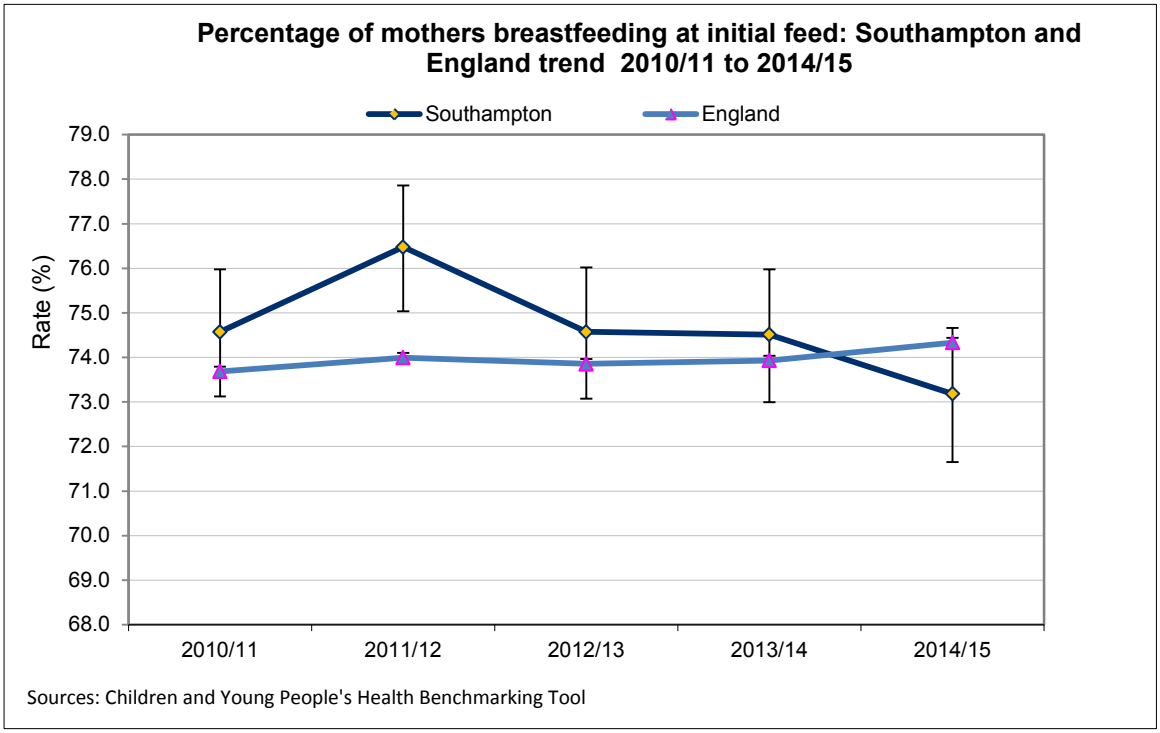
Sources: UHS Midwifery database: Southampton CCG

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.

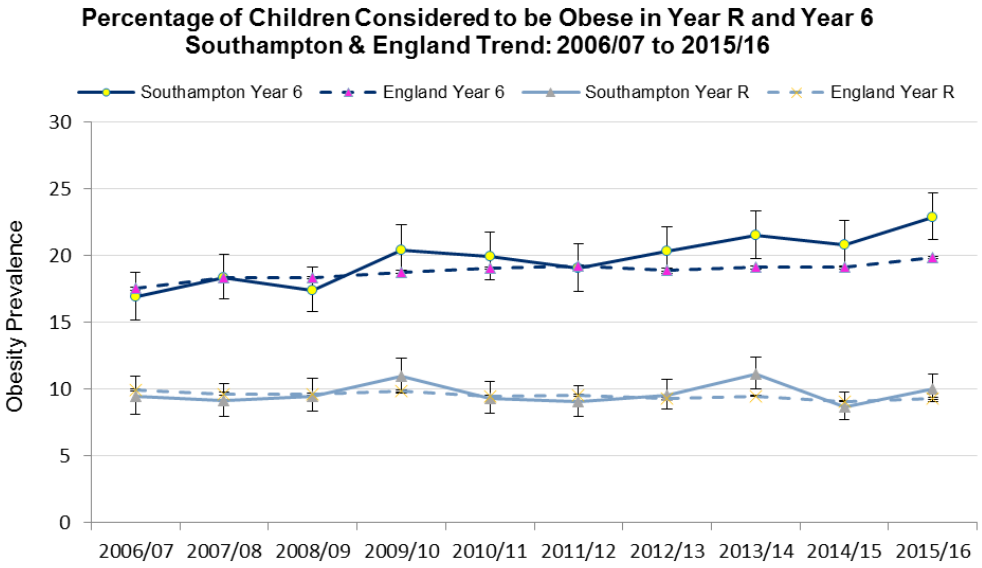
Dental extractions are also more common amongst children from the more deprived areas of Southampton. There is a large gap in the rate of children with teeth extracted under general anaesthetic between the highest and lowest deprivation quintiles over both years. Each GA extraction for school-aged children 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).

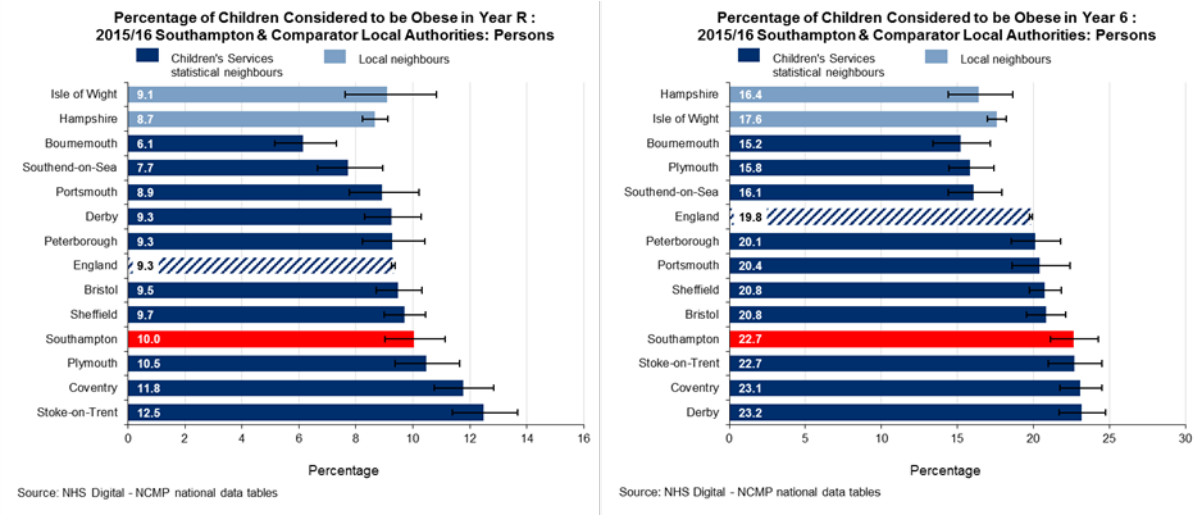
Similar to the national picture, overweight and obesity prevalence is significantly higher in Year 6 compared to Year R. In Southampton, the prevalence of obesity for Year 6 children has increased from 20.8% in 2014/15 to 22.9% in 2015/16, but because of the relatively wide confidence intervals associated 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

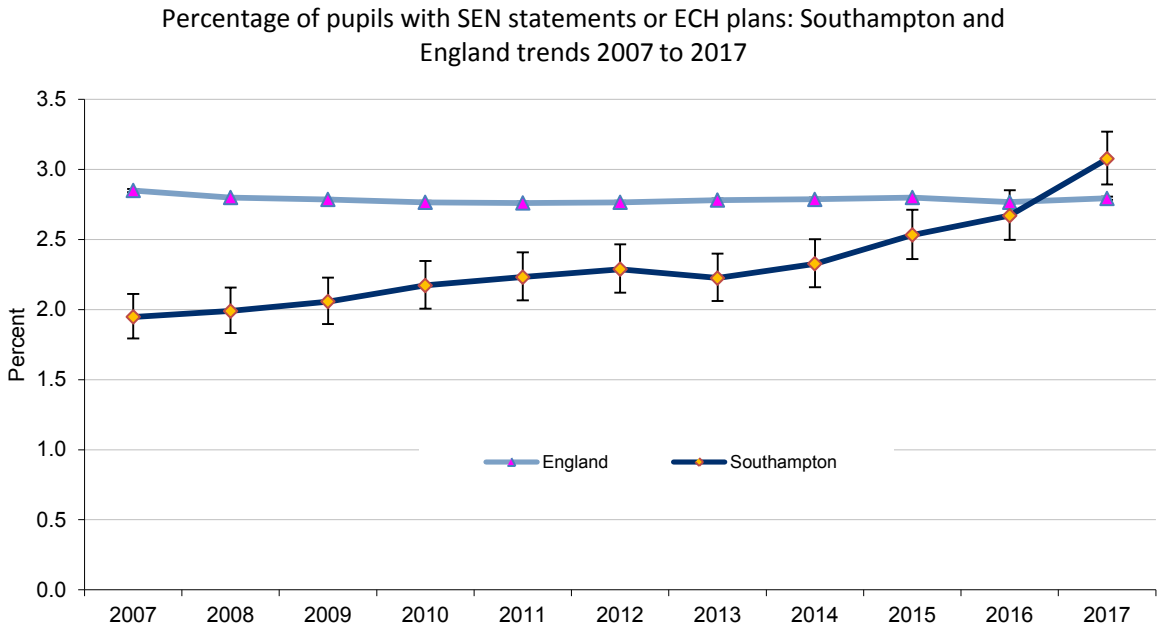


A longitudinal analysis of the ten years of data available locally shows that over 70% of children classified as overweight in Year 6 were previously of a healthy weight at 4-5 years of age. This proportion increased significantly (at the 95% confidence level) from 66.5% in 2012/13 to 77.4% in 2014/15, 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)

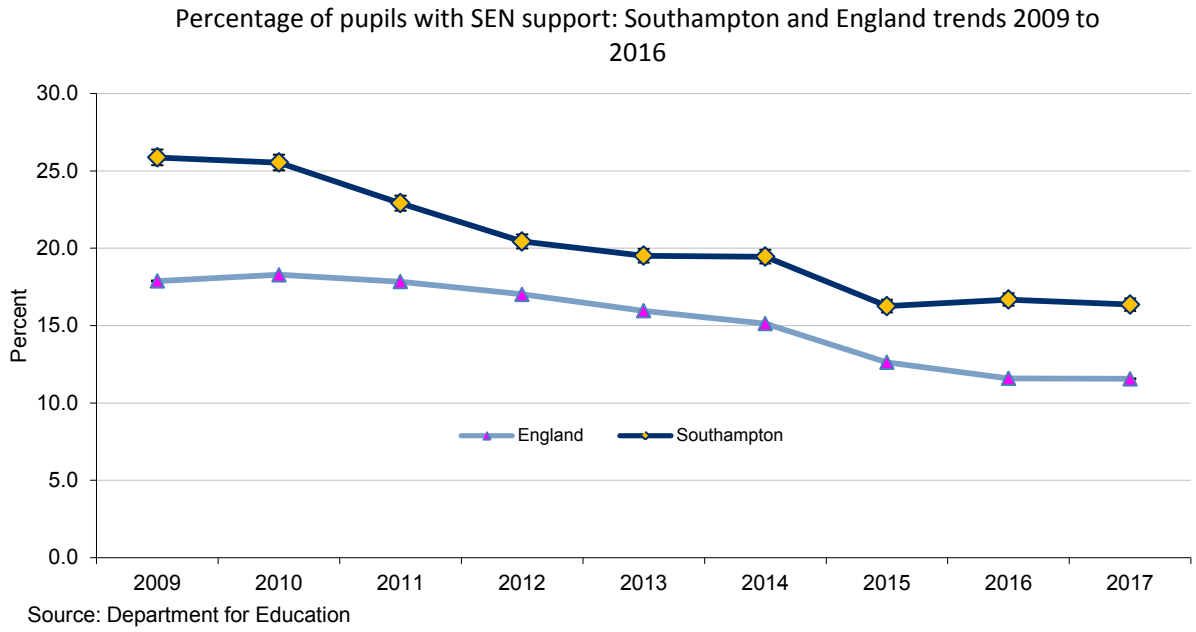
Latest data from the Department for Education (DfE) shows there to be over 6,000 children in the city with SEND; 860 with Statements or Education, Health or Care Plans (EHC). Historically, Southampton has had a lower level of pupils with SEN Statements or EHC Plans than the national average and most 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

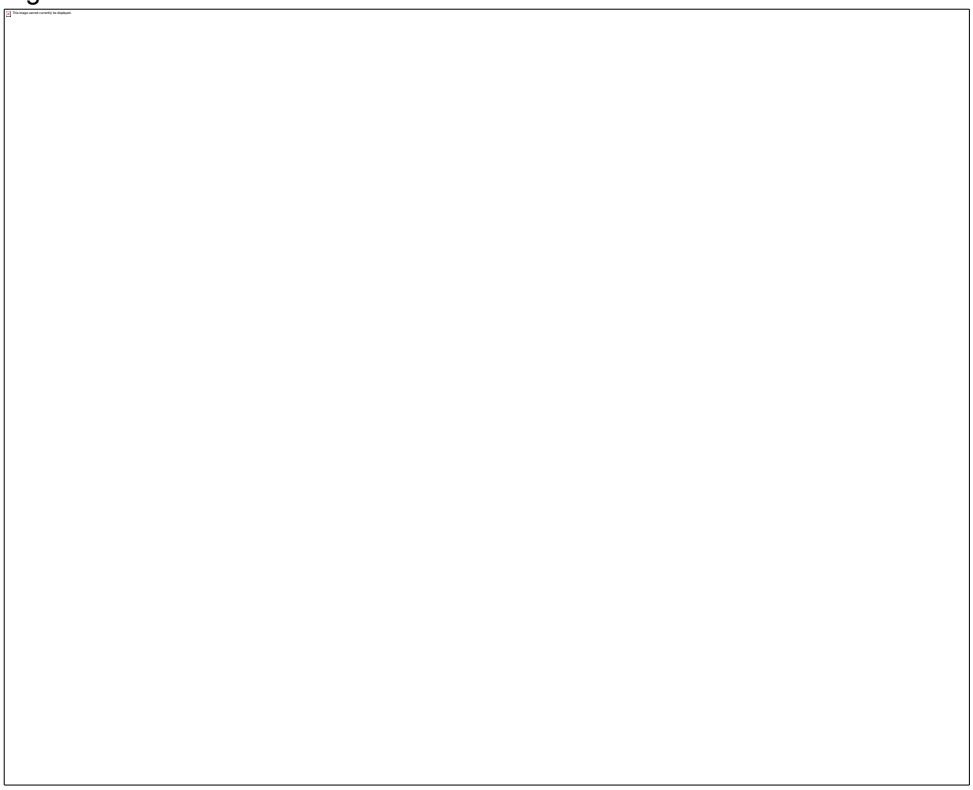
Figure 41



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



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

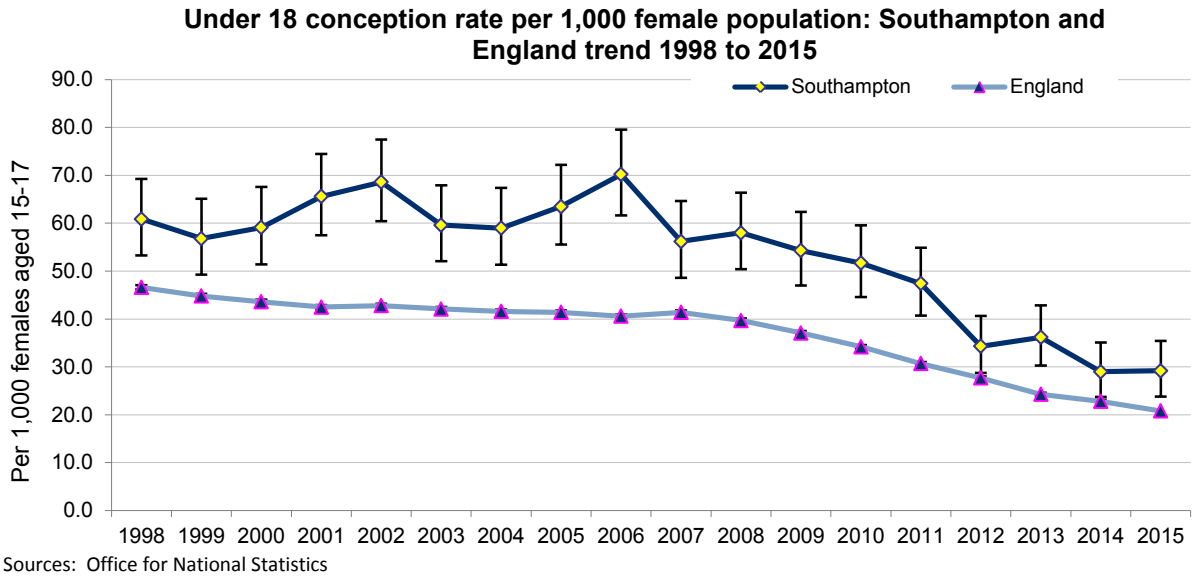
Setting	Area	Total Pupils	Statements or EHC plans		SEN support		Total pupils with SEN	
			Number	%	Number	%	Number	%
Primary	Southampton	20,331	339	1.7	3,621	16.1	3,621	17.8
	South East	724,988	10,584	1.5	81,699	11.3	92,283	12.7
	England	4,689,658	62,390	1.3	570,714	12.2	633,104	13.5
Secondary	Southampton	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.

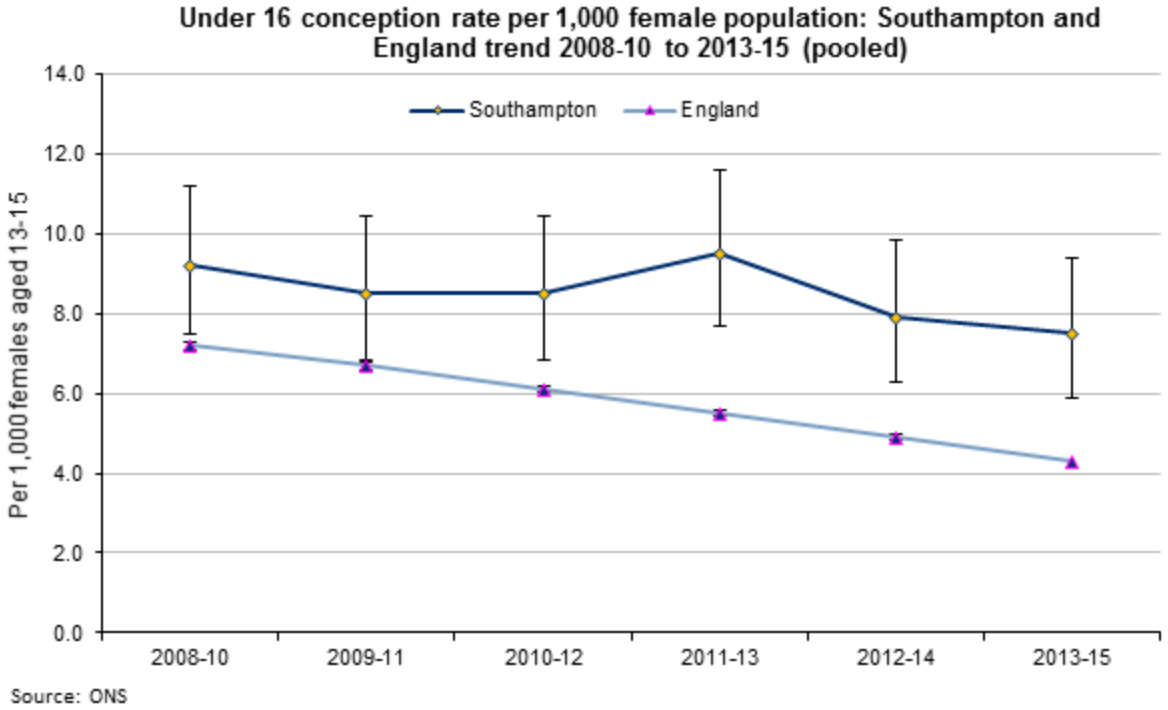
Figure 43



Sources: Office for National Statistics

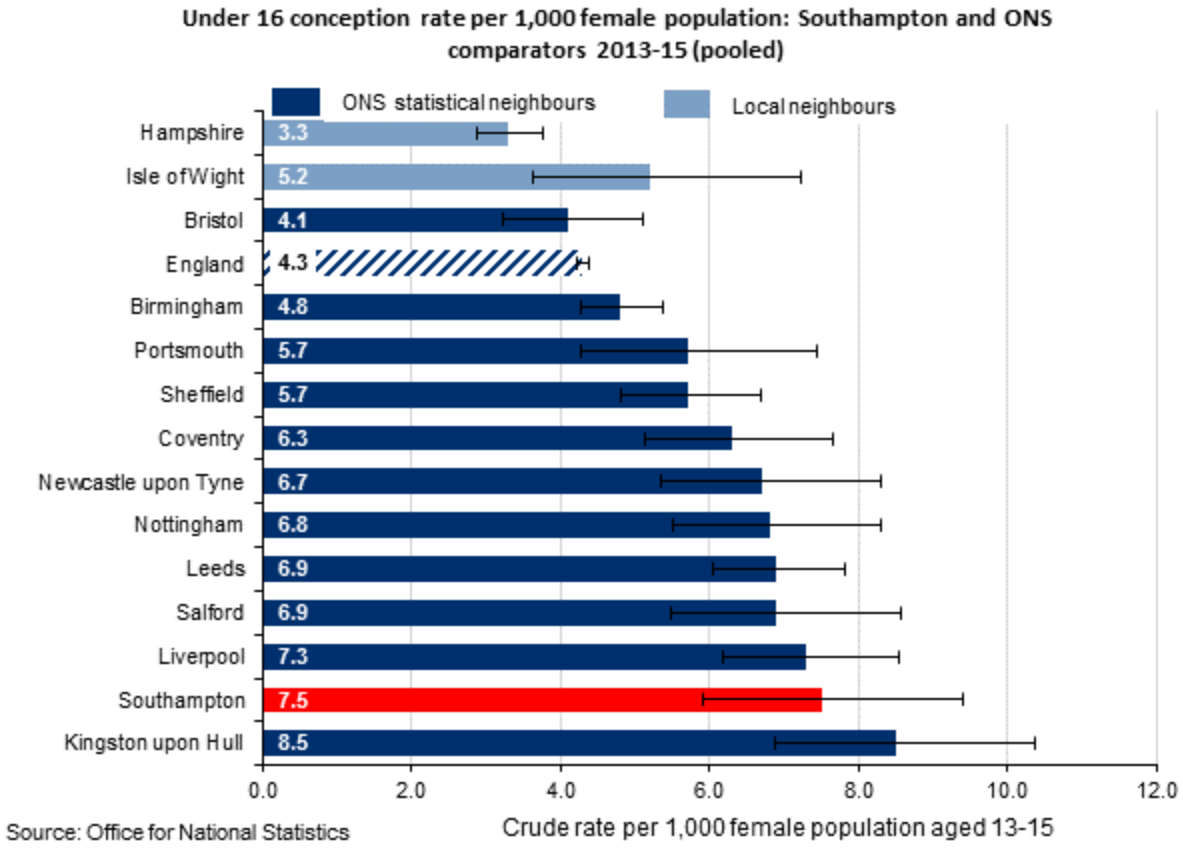
In the 2013-15 period there were 75 conceptions amongst girls aged under 16. This is important in demonstrating that many of these conceptions were both unplanned and unwanted, and therefore might have been prevented through effective Sex and Relationships Education support and better access to contraception 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 $\mu g/m^3$ which is higher than the England average of 8.3 $\mu g/m^3$. 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.

[83] Strategic Housing Land Availability Assessment, Southampton City Council, accessed via http://www.southampton.gov.uk/planning/planning-policy/research-evidence-base/shlaa.aspx

10 Gaps in provision

10.1 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.

10.2 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.

11 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.

12 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.

13 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

14 Appendix C: Consultation report

Consultation Requirements

The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 sets out detailed requirements for the consultation process including a specified list of stakeholders that must be consulted at least once.

Publication of draft PNA

The draft PNA and the associated questionnaires were published on the Southampton City Council website. Printed copies were available on request.

Consultation period

There is a minimum requirement of 60 days for consultation process. Local formal consultation started on Monday 23rd October 2017 and closed on Friday 22nd December 2017.

Consultation Activities

Consultation questions

The short set of questions used for the consultation of the Portsmouth PNA 2015 was used (with minor amendments). For each question there was an opportunity for respondents to add free text comments to expand on their views.

Consultation with professional stakeholders

All professional stakeholders as specified in the Regulations were contacted by email by Monday 23rd October 2017. 'Read' receipts of these emails have been retained.

All contractor pharmacies within the city were contacted by a message on PharmOutcomes (software system used by pharmacies) and by email on 23rd October 2017 giving details of the consultation process.

Consultation with the public

The public consultation was supported by the Southampton City Council (SCC), Healthwatch Southampton and Southampton City Clinical Commissioning Group (CCG).

The SCC insights and communications team used social media such as Twitter and Facebook to promote the consultation. The PNA consultation for Southampton was shared with residents using Southampton's City Council's digital communication channels. The surveys were hosted on the Southampton City Council website on both the News and 'Have Your Say' consultation pages. The links to the pages were shared with over 13,000 subscribers to the council's Stay Connected email update service, with residents on social media including Facebook and Twitter and via partners in the health and voluntary sector.

The CCG publicised the consultation through distributing leaflets at a range of locations in the city and at various community events. The consultation was also discussed as part of the CCG Communications and Engagement reference group meeting on 22nd November 2017.

Healthwatch Southampton publicised the consultation via their website, in their newsletter (distributed to approx. 400 individuals), and using social media channels (Facebook and Twitter).

Response

The HWB appreciates the time given by members of the public and professional stakeholders to complete this consultation exercise. Fifty-three responses to the consultation were made - eight responses from professional stakeholders and 45 responses from members of the public.

Summary
Consultation findings showed satisfaction with the PNA. Comments will be addressed in the PNA but there will be no notable changes to the document before formal publication on 1st April 2018.

Responses
The summary of the responses to each question are listed below. Comments relating to specific pharmacies have been dealt with separately from the PNA by forwarding to the relevant person and will be followed up appropriately.

1. Has the purpose of the pharmaceutical needs assessment been explained clearly?

75.0% (6/8) of professional stakeholders strongly agreed or agreed that the purpose of the PNA had been clearly explained (two chose not to respond).

93.3% (42/45) members of the public who responded strongly agreed, agreed or were neutral that the purpose of the PNA had been clearly explained (three chose not to respond).

There were no additional comments given in response to this question.

Table 1. Summary of responses to consultation question one

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Did not respond	Total
Public	4	26	12			3	45
Professional	1	5				2	8

2. Do you know of any relevant information that we have not included that may affect the conclusion of this document?

75.0% (6/8) of professional stakeholders did not know of any further relevant information that should have been included that would affect the document's conclusions (two chose not to respond). There were no comments from professional stakeholders.

75.6% (34/42) members of the public who responded did not know of any further relevant information that should have been included that would affect the document's conclusions (nine chose not to respond). Of the two respondents to the survey who stated there was further relevant information, only one additional comment was provided regarding the quality of service at a specific pharmacy which does not change the conclusions of the draft PNA (See question 6 response to comments regarding 'quality of service').

Table 2. Summary of responses to consultation question two

	Yes	No	Did not respond	Total
Public	2	34	9	45
Professional		6	2	8

3. From the information in the pharmaceutical needs assessment and my personal experience, I believe the pharmaceutical needs of myself (or my patients and/or the people I represent) are being met.

75.0% (6/8) of professional stakeholders strongly agreed, agreed or were neutral that the pharmaceutical needs of local residents were being met (two chose not to respond). There were no comments from professional stakeholders.

55.6% (25/45) members of the public who responded strongly agreed, agreed or were neutral that the pharmaceutical needs of local residents were being met (five (11.1%) disagreed and another 15 (33.3%) chose not to respond). Of the five respondents to the survey for members of the public who stated that pharmaceutical needs were not being met, there was only one written comment provided relating to a specific pharmacy suggesting that the premises should be expanded to ease demand from the local GP practice. This is beyond the scope of the PNA and does not change the conclusions. See question 5 response to comments regarding 'capacity'.

Table 3. Summary of responses to consultation question three

	Yes*	Neither agree or disagree	No**	Did not respond	Total
Public	19	6	5	15	45
Professional	5	1		2	8

*For professional stakeholder survey these were strongly agree or agree responses
**For professional stakeholder survey these were strongly disagree or disagree responses

4. From the information in the pharmaceutical needs assessment and my personal experience, I believe that my future pharmaceutical needs for myself (or my patients and/or the people I represent) for the next four years are being met.

75.0% (6/8) of professional stakeholders strongly agreed, agreed or were neutral that the pharmaceutical needs of local residents are likely to be met over the next four years (two chose not to respond). There were no written comments from professional stakeholders.

4.4% (2/45) members of the public who responded strongly agreed or agreed that the pharmaceutical needs of local residents are likely to be met over the next four years (43 chose not to respond). There were six written comments from members of the public. Four comments commented upon accessibility (two general comments and two relating to needs of the respondents), one comment related to stock levels of medications and one related to timeliness of filling monthly repeat prescriptions. These comments have been considered under the themes of access and quality of service alongside responses to question 6, but do not change the conclusions of the draft PNA.

Table 4. Summary of responses to consultation question four

	Yes*	Neither agree or disagree	No**	Did not respond	Total
Public	2			43	45
Professional	5	1		2	8

*For both surveys these were strongly agree or agree responses
**For both surveys these were strongly disagree or disagree responses

5. Do you think there is a need for additional pharmacy sites within Southampton?

62.5% (5/8) of professional stakeholders disagreed or were neutral that there is a need for additional pharmacy sites in Southampton. One agreed there is a need (no reason given) and two chose not to respond.

53.3% (24/45) members of the public strongly disagreed, disagreed or were neutral that there is a need for additional pharmacy sites in Southampton (another 13 (28.9%) chose not to respond). Eight (17.8%) respondents to the public survey considered there to be a need for additional pharmacy sites. There were nineteen written comments from members of the

public with nine indicating sufficient pharmacy sites and ten indicating a need for more. Where the rationale for this response was expanded upon, reasons related to three themes of access, capacity and quality of services. These comments do not change the conclusions of the draft PNA. These were:

Access
- Acknowledgement that for those that do not have a car access may be more difficult (2 comments)
- Access in mornings and evenings to accommodate those who work during working day (1 comment)
- Pharmacies are located in the wrong places (1 comment)

See question 6 response to comments regarding 'access'.

Capacity
- Current pharmacies being unable to cope with demand (1 comment)
- The wait is too long to be served (1 comment)

These comments indicate potential issues regarding capacity within specific pharmacies. It is not clear whether these concerns relate to particular times of day, or at particular sites in the city. The PNA aimed to consider average dispensing workload of pharmacies in Southampton compared to Wessex and England (PNA section 7.2.1). The average numbers of prescription items dispensed each month per pharmacy was similar to Wessex and slightly higher than the England average. Managing workload is for individual pharmacies to manage and therefore, these comments do not provide a sufficient basis to deem there to be a need for more pharmacies within Southampton.

Quality of service
- Pharmacies do not always have medications in stock (1 comment)
- Concern that a number of pharmacies do not provide service efficiently (1 comment)
- General concern re quality of service at a particular pharmacy (1 comment)

See question 6 response to comments regarding 'quality of service'.

- No reason given (1 response)

Table 5. Summary of responses to consultation question five

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Did not respond	Total
Public	5	3	13	10	1	13	45
Professional		1	3	1	1	2	8

6. Do you have any further comments you would like to make about pharmaceutical services in Southampton? This can include good or bad experiences, any concerns, questions or just general comments you might have.

Four comments were from professional stakeholders.

Comment
We believe that participation in the NHS Urgent Medicine Supply Advanced Service would improve patient access to medicines during the out of hours period, and would improve convenience for patients, with fewer referrals from 111 to the Out of Hours Service providers.
Response
NHS Urgent Medicine Supply Advanced Service (NUMSAS) has now started in Southampton, from 8th January 2018 and accepts referrals from NHS 111. This was not stated in the consultation draft and has since been updated. NUMSAS is being run as a

national pilot project which is due to finish at Easter 2018. It is also worth noting that the Pharmacy Urgent Repeat Medicine service (PNA section 7.4.1) is led by NHS England Wessex Area Team and enables supply of repeat medications where needed urgently. This programme is reported to be working well.

Comment
We could not identify from the needs assessment whether there are plans to widen the availability of naloxone for overdoses caused by heroin and other opiates
Response
Naloxone is available through the drug treatment service in Southampton within an inclusive approach to individuals not engaged in drug treatment. The provision of naloxone through other settings, including pharmacies, will be kept under review.

Comment
We do not agree that there will be an increase in demand for internet services that would necessitate the establishment of a Distance Selling Pharmacy (DSP). DSPs must cover the whole country, and several already exist. Community Pharmacies are already providing delivery services that sufficiently cater for the housebound. Although a delivery service is not a pharmaceutical service, and would therefore not usually be referred to in this assessment, we feel it is an important point to note.
Response
In the 2013 Regulations, DSPs are the only exemption category from the current market entry regulations. Therefore, the use of the PNA for market entry does not apply to distance selling pharmacies. Consideration to DSPs have been included in the PNA as they contribute to the overall pharmaceutical provision of an area (although, as has recognised in the comment made, activity is not solely located to the area in which a DSP is based).

Comment
The PNA needs to acknowledge that Hampshire residents may use services in Southampton in particular Out of Hours
Response
Text will be amended to acknowledge more explicitly that Hampshire residents can choose to use pharmacies located in Southampton.

There were sixteen written comments from members of the public to this question.
Other relevant comments in questions above (six comments given in response to question four, giving a total of 24 comments) have also been considered here. These have been categorised into themes of access and quality of service. Four comments specifically stated that the respondent had nothing further to add. One comment was praise for a particular pharmacist.

Access
There were seven comments which related to access. Four comments highlighted that access was more difficult on Sundays, early mornings, evenings, late nights and bank holidays. One comment stated that pharmacies should be co-located with GP practices to reduce inefficiency in the number of trips individuals make to both services (with regards to both time spent and environmental impact). Another comment stated the need for local services and one person stated that a pharmacy was not accessible to them within walking distance.

The PNA identified that many pharmacies in Southampton are open before 9am, over lunchtime, in the evenings and at weekends (PNA section 7). Information about bank holiday opening is also included. It is recognised that access will be more limited outside of core working hours, however, opening hours are at the discretion of each individual pharmacy.

The pharmaceutical services outside of core working times are considered satisfactory in Southampton. There are provisions in the Regulations for relocation of community pharmacies. It is beyond the remit of this PNA to influence location of services.

Quality of service
There were eleven comments relating to quality of service.

Five comments raised individual issues experienced with specific pharmacies. Three of these responses included an indication that the individual now use a different pharmacy as a consequence. Another comment was a general comment pointed to 'poor quality' services and another expressing long waits to have a prescription dispensed. These comments highlighted areas outside the remit of the PNA and have been forwarded to the relevant person and will be followed up appropriately.

One comment related to variability in how pharmacies use the Electronic Prescription service which allows paperless transmissions of prescriptions to pharmacies. The comment indicated that some pharmacies access what has been sent through once a day with prescriptions not being ready to collect in a timely way. This comment is outside the remit of the PNA. However, it may be useful to note that NHS Southampton City CCG is actively providing support to pharmacies (as well as GP practices) to share good practice in the use of electronic repeat dispensing services. This feedback is helpful to inform understanding of how this scheme is working.

Two comments related to medicines frequently being out of stock and a further one comment highlighting medications were not available in a timely way (although it was unclear whether this was a stock issue, or something else). This comment is outside the remit of the PNA. However, it may be useful to note that with a huge number of prescription items dispensed, there will be some occasions when medicines are unavailable which can either be due to a national supply issue or to pharmacy stock levels and ordering processes. The CCG continues to work with GP practices and pharmacies to improve communication with patients and to ensure an alternative medicine is made available when appropriate.

15 Appendix D: Equality and Safety Impact Assessment

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	Southampton Pharmaceutical Needs Assessment 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 Southampton, 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 PNA has made specific reference to a range of groups.	

Potential Positive Impacts	
The PNA describes provision of pharmaceutical services including locally commissioned services and their role in promoting health and wellbeing of the people of Southampton. The 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	February 2018
Approved by Senior Manager	Jason Horsley Joint Director of Public Health
Date	February 2018

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. Distance Selling Pharmacies registered outside of Southampton provide additional choice and increases accessibility to older adults who may have limited mobility.	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 selling pharmacies also provide additional choice and	N/A

Impact Assessment	Details of Impact	Possible Solutions
	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 PNA.	N/A
Religion or Belief	No specific impact has been identified from this PNA. The General Pharmaceutical Council has published guidance to clarify that while a pharmacist may be unwilling to provide a particular service due to religious reasons or personal values and beliefs, they should take steps to make sure the person asking for care is at the centre of their decision-making, so that they are able to access the service they need in a timely manner.	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

DECISION-MAKER:		**Health & Wellbeing Board**		
SUBJECT:		**Children and Young Peoples Healthy Weight Plan**		
DATE OF DECISION:		**14 March 2018**		
REPORT OF:		**Director of Public Health**		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Ravita Taheem, Senior Public Health Practitioner**	**Tel:**	**023 80 833020**
	E-mail:	**ravita.taheem@southampton.gov.uk**		
Director	**Name:**	**Jason Horsley, Director of Public Health**	**Tel:**	**023 80 83 2028**
	E-mail:	**Jason.horsley@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
NOT APPLICABLE

BRIEF SUMMARY

The Children and Young People's Healthy Weight Plan 2017-2022 sets out a blueprint for the prevention and management of childhood obesity in Southampton. It is clear that no one intervention, organisation or sector alone can tackle childhood obesity. Instead a range of actions are required across different organisations and sectors which make healthy choices easier for the population.

This plan has been developed with key partners, and outlines a range of important actions, including environmental measures (such as restriction of hot food takeaways around schools), organisational practices (including developing active travel plans) as well as individual level behaviour change, all aimed at increasing the proportion of healthy weight children and young people in the city. This briefing provides a brief summary of the Children and Young People's Healthy Weight Plan in order to support final approval by the Health and Wellbeing Board.

RECOMMENDATIONS:

	(i)	To consider and approve the Children and Young People's Healthy Weight Plan.

REASONS FOR REPORT RECOMMENDATIONS

1.	In Southampton 23.2% of children in year R (5 year olds) are either overweight or obese (England average 22.6%). Among year 6 pupils (11 year olds) levels of overweight and obesity increase to 35.0% (England average 34.2%,data from the National Child Measurement Programme for 2016/17). Levels of overweight and obesity among year R pupils have remained stable over time but for year 6 pupils levels have steadily increased. Among adults in Southampton 62.6% are either overweight or obese (Southampton Health Profile, 2017). Obesity in childhood is associated with reduced academic performance, low self-esteem, school absence, bone and joint problems, high cholesterol and type 2 diabetes, as well as obesity and premature mortality in adulthood. The council has a significant role to play in influencing the

	development of a healthy weight environment in the city and can encourage partnerships and new ways of working to tackle the issue.
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
2.	To not have a Children and Young People's Healthy Weight Plan which may lead to the number of young people becoming either overweight or obese, increasing the likelihood of health risks such as bone and joint problems, high cholesterol and type 2 diabetes, as well as premature mortality in adulthood.
DETAIL (Including consultation carried out)	
3.	The Children and Young People's Healthy Weight Plan was developed with multiple partner organisations across the city. This included representatives from Planning, Transport, Education, Health sector, Leisure and Community sector. It aims to halt the rise in obesity and to increase the proportion of children having a healthy weight by 5% over the next few years. This is an ambitious target, but if achieved, could have positive effects on a wide range of outcomes including educational attainment, physical and mental health.
4.	The 4 priorities of the Children and Young People's Healthy Weight Plan (Place, Settings, Targeted Prevention and Treatment) aim to initiate action at a variety of levels to; 1) create a healthy weight environment through work with the Planning and Transport departments, 2) influence settings such as schools, early years and workplaces to create a health promoting culture, 3) ensure activities aimed at prevention target those at risk, and 4) make sure those identified as having excess weight through the National Child Measurement Programme have the support they need towards achieving a healthier weight.
5.	Traditional approaches to tackling obesity point the responsibility to the individual and focus on encouraging individual level behaviour change. However, the environment, limited choice and other constraints can make it difficult to make changes at this level. Due to the scale of the issue, the proportion of children and young people affected and at risk of developing obesity, a population level approach is crucial.
6.	This plan allows us to move towards a "whole systems" approach to tackling childhood obesity. It also provides a platform to continue to engage schools, businesses and other sectors with the agenda.
Next Steps	
7.	The Children and Young People's Healthy Weight Plan has been approved by CMT and is awaiting final approval from the Health and Wellbeing Board. After this point, delivery will be led by the Children and Young People's Healthy Weight Partnership, which is the group of stakeholders that came together to develop the plan. This group will meet twice a year providing assurance on delivery to the 0-19 prevention and early help group (which sits under the Health and Wellbeing Board).The Health and Wellbeing Board will have overall oversight for the delivery of the plan.
RESOURCE IMPLICATIONS	
8.	None
Capital/Revenue	
9.	None

Property/Other	
10.	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
11.	**N/A**
Other Legal Implications:	
12.	**N/A**
RISK MANAGEMENT IMPLICATIONS	
13.	None
POLICY FRAMEWORK IMPLICATIONS	
14.	The Children's Healthy Weight Plan will support the outcomes set out in the Health and wellbeing Strategy 2017-2025.

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	All wards
SUPPORTING DOCUMENTATION	
Appendices	
1.	**Children and Young People's Healthy Weight Plan**

Documents In Members' Rooms

1.	
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.		

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CHILDREN AND YOUNG PEOPLE'S HEALTHY WEIGHT PLAN 2017- 2022

Southampton City Council

About Childhood Obesity

Causes

The causes of obesity are complex; social circumstances, family background, educational background, food skills and lack of opportunities to be active can all contribute.

These factors vary but at the core is energy balance, which is the balance between what we eat and how much physical activity we do.

Tackling the issue

We know that childhood obesity is an issue both locally and nationally

We have learned that the issue cannot be addressed by a single organisation or by a single intervention. Action is needed across all sectors and organisations.

Our vision

Our vision is that Southampton is a city where children and young people have happy, healthy, active lives where healthy choices are the easy choices.

The aim is to create a "healthy weight" environment where healthy choices are the easy choices for children; as well as ensuring early intervention targets those in greatest need.

This 5 year plan outlines steps towards achieving this vision.

How is Childhood Obesity Measured?

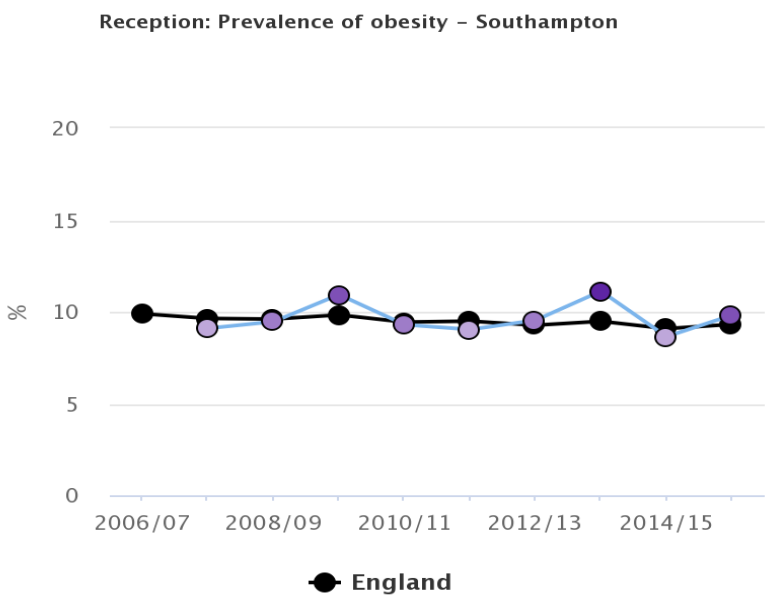
The National Child Measurement Programme (NCMP)

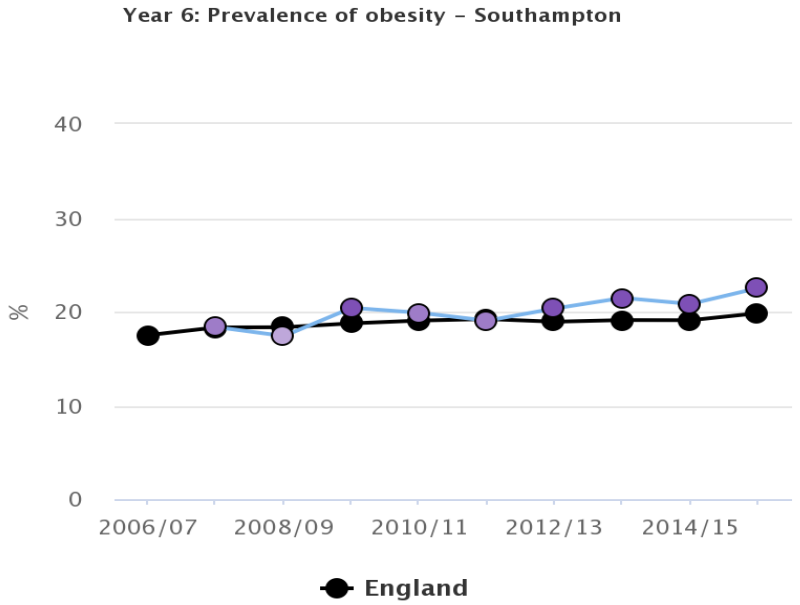
What?	How?	Reference
Measures year R and year 6 pupils annually	Each child is assigned a BMI centile, taking into account height, weight gender and age	Using the British 1990 child growth reference (UK90) to assign each child a BMI centile

For the assessment each child is then placed in one of four categories:

- Underweight: less than 2nd centile
- Healthy weight: between 2nd - 91th centile
- Overweight: more than or equivalent to 91st centile
- Very overweight : (obese) more than or equivalent to 98th centile

Scale of the Problem in Southampton

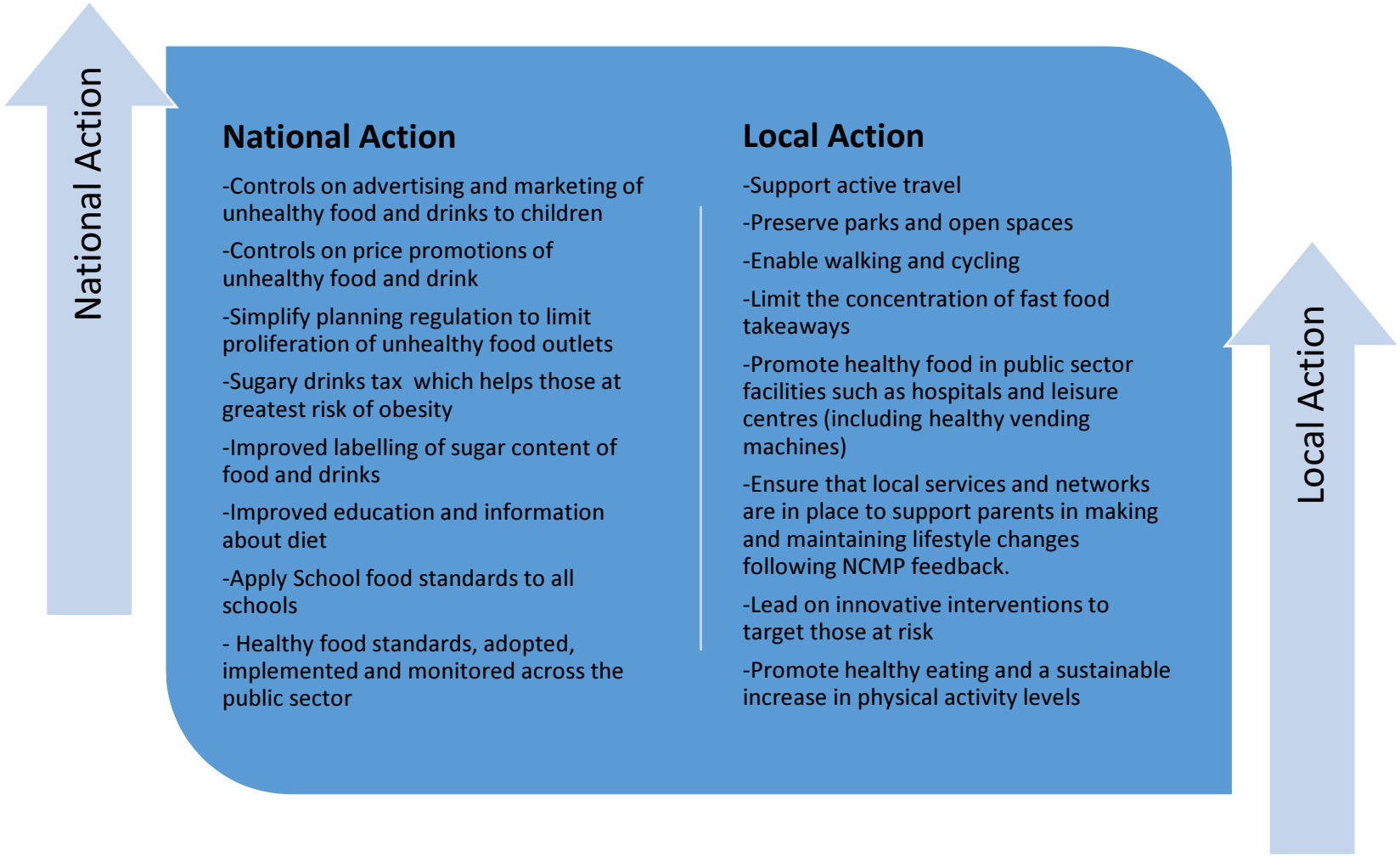




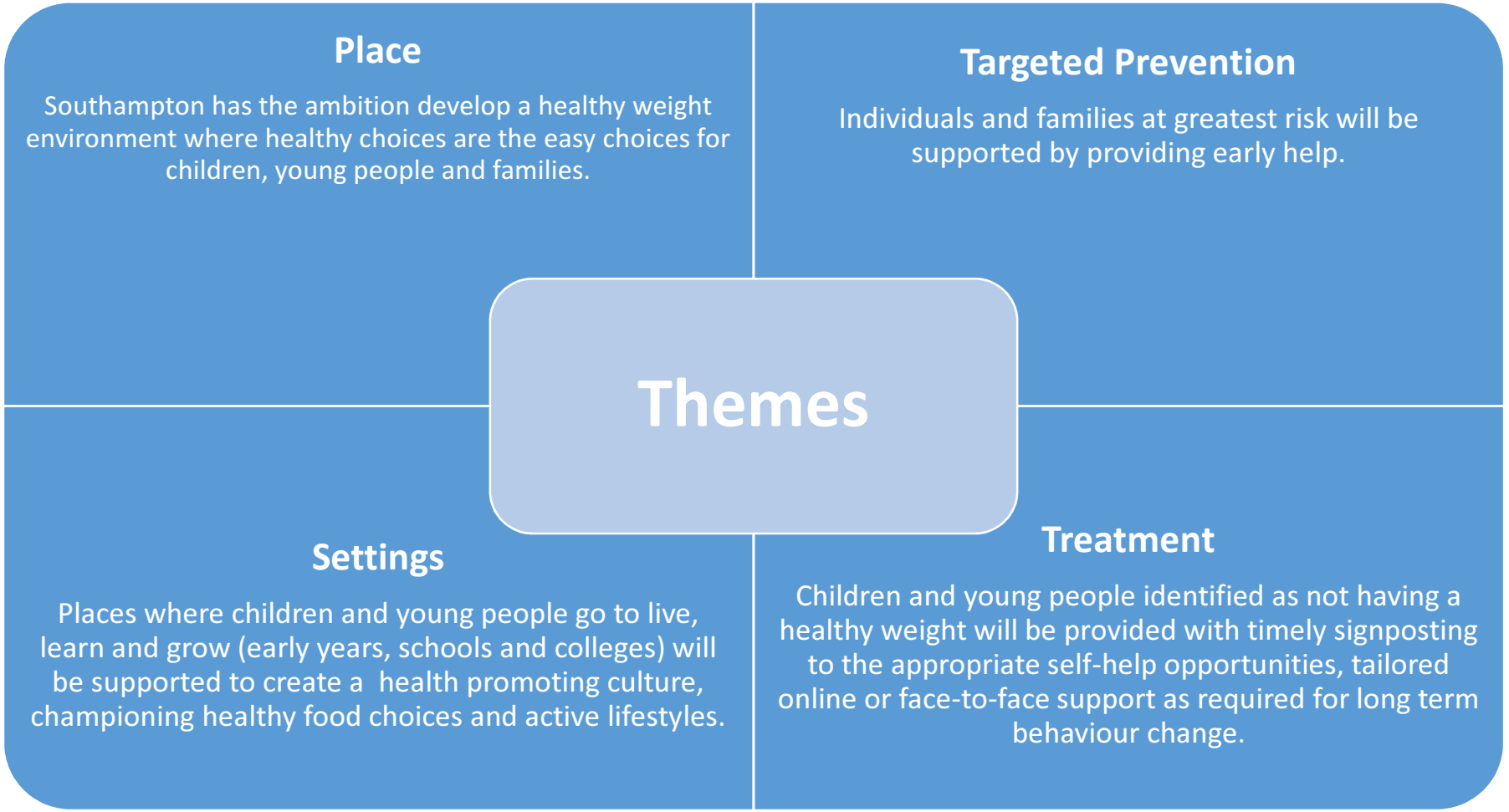
- Obesity in year R is similar to the England average. In 2016/17 23.2% of year R children are overweight or obese (England average 22.6%)
- Obesity in year 6 levels are higher than England and levels are increasing. In 2016/17 35% of year 6 Children are overweight or obese (England average 34.2%)
- Only 47.8% of young people age 15 meet their 5-a-day (England average 52.4%)

- Obesity is associated with poorer mental health and lower educational attainment.
- 40% children obese in year 6 were a healthy weight in year R
- Breast feeding initiation rates in Southampton is 73.2%, (England average 74.3%)
- Childhood obesity is strongly linked to deprivation

Actions are Required at National and Local Levels



Our Priorities



A Call to Action

- The outcomes set out in this plan will only be achieved in partnership with a range of sectors including local businesses.
- This is a call to local businesses and partners to pledge a contribution and measure the changes that result.
- Whether this is through partners applying for funding for a local target groups to sustainably increase physical activity levels.
- Or local businesses improving their cycle storage or outside space to encourage walking.
- Share your success: https://www.southampton.gov.uk/health-social-care/children/healthy-weight/

Action plan- Place

Action	Linked programme	Lead	Y1	Y2	Y3	Y4	Y5	Output	S
Map childhood obesity data so that activities to promote physical activity, active travel and healthy food choices can be targeted to areas, communities and groups in greatest need.	NCMP briefing	Public Health/ Intelligence team	Format of maps agreed Updated annual NCMP briefings with maps produced and disseminated		Included as part of child growth briefing- ongoing →			Annual child growth briefing, with mapped NCMP data	
Ensure principles of planning for healthy weight environments are embedded in the new Local Plan.	Local Plan	Planning /Public Health	Principles of Healthy weight environment included and approved as part of draft Local plan		Draft plan finalised			New Local Plan with principles of Healthy weight environment embedded	
Work with the Planning team to implement restrictions on new takeaways near secondary schools.	Local Plan	Planning/ Public Health	Restriction on takeaways approved as part of draft Local plan					Restrictions included in Local Plan	
Implement internal space standards for new dwellings (to ensure adequate kitchen and dining space)	Local Plan	Planning	Draft local plan to include internal space standards		Internal space standards adopted			Standards adopted and implemented	
Re-examine existing cycle parking standards and improve cycling routes in the city. Review the cycle parking and cycle parking standards for new developments to ensure good quality, safe and secure cycle parking is available locally. Improve pedestrian and cycle routes to address gaps in provision and prioritising areas of greatest deprivation.	Transport Plan, Cycle Strategy 2016-2026	Transport Planning	New standards for cycle parking in new developments agreed, annual programme for cycle parking Improved cycle routes/ facilities as outlined in the Cycle strategy					Adoption Parking Standards SPD Increase in cycle parking in city centre	
Implement interventions to maximise access to and use of green and public spaces, with projects focussing on the most at risk communities to achieve a measurable increase in the use of green and other public space.	Town Plan Green space Strategy	Transport, Public Health, Parks and greenspaces	Funding in place for pilot(s) Green space identified and project agreed Project delivered and evaluated			Funding sought to replicate successful measures in other target areas, activities replicated and evaluated		Evaluation complete Successful measures in place and replicated	

Action plan-Place

Action	Linked programme	Lead	Y1	Y2	Y3	Y4	Y5	Output	S
Work with businesses and partners to promote city wide initiatives/campaigns which promote sustainable increase in physical activity (PA) , makes use of green/open spaces and promotes healthy food choices	HWB plan	Comms Public Health Open Spaces/ Transport	Campaigns calendar planned Regular campaigns promoting healthy choices and active lives			→	→	Annual comms plan includes promotion of sustainable PA and local open spaces	
Work with Active Travel to promote projects and interventions targeting at risk groups and communities through workplaces and schools in priority areas as identified through NCMP and relevant mapping data.	Active Travel	Transport /Public Health	Funding in place, Identify and engage with priority communities, through workplaces and schools			Evaluate activities and findings disseminated		Active travel plans adopted among priority communities and schools	
Put in place procurement mechanisms that promote and enable a healthy weight environment. Through contracts, agreements and the Social Value Act.	Contracts	Integrated Commissioning unit (ICU)			Resource in place Amendments made to core contracts All providers meet guidelines set out in Healthier More Sustainable Catering principles toolkit			Increased number of contracts promoting and enabling a healthy weight environment	
Work with local universities to evaluate the impact of actions to strengthen the evidence base. Including developing the local evidence base for interventions to improve the food environment around schools and children's centres.	HWB plan	Public Health/ MRC Life course Epidemiology Unit, University of Southampton	Southampton focussed research shared with key boards including HWB Local evidence base routinely shared and disseminated among stakeholders					Southampton focussed research shared with key boards including HWB Local evidence base routinely shared and disseminated among stakeholders	
Review of the local food system to establish how the local food environment could be influenced to ensure healthy choices are the easy choices for families in Southampton	To be developed	Public Health	Scope out food systems review to identify priorities for the review		Funding in place Local food system review commissioned			Report findings disseminated	

Action plan -Settings

Action	Linked programme	Lead	Y1	Y2	Y3	Y4	Y5	Output	S
To influence school leadership and governing body to champion health and wellbeing and provide a clear strategic vision. This may include developing guidance on using pupil premiums to promote health promoting curriculums and activities, which also seek to improve pupil attainment and tackle obesity.	0-19s (Health Improvement) Public Health Energise Me	0-19s Board			Funding/resource in place Guidance developed Guidance piloted Final guidance in place and disseminated.			Increase in school engagement with refreshed Healthy Schools offer.	
Develop a refreshed Healthy Schools offer with schools and other partners to ensure schools are offered relevant support and expertise to address their priorities towards being a healthy setting (healthy school and colleges).	0-19s (Health Improvement)	Public Health, ICU	0-19 health improvement contract in place New healthy school offer developed and piloted		New offer rolled out			Annual increase in schools engaged with new healthy school. Offer evaluated and amended as required.	
Develop refreshed Healthy Early Years Award offer to maximise engagement with early years and childcare settings so that providers are offered relevant support and expertise to address their priorities towards being a healthy setting.	0-19s (Health Improvement)	Public Health, ICU	0-19 health improvement contract in place New Healthy Early Years offer piloted and evaluated And rolled out			→	→	Annual increase in schools engaged with Healthy Early Years Award. Programme evaluated	
Encourage all schools to adopt the School Food Standards for school food.	0-19s (Health Improvement)	0-19s Board Public Health PH School Nursing			Funding in place Survey of food provision Schools Promotion of SFT via Healthy Schools			All schools meet the SFT standards	
Support workplaces to enable them to create a health promoting culture which champions healthy lifestyle choices, through providing an online offer to include signposting resources, case studies, activities and local support.	Well and Working	Public Health	Workplace wellbeing programme promoted widely Local businesses demonstrate commitment to workforce health					Increased number of workplaces engaged in improving workplace health	

Action plan- Settings

Action	Linked programme	Lead	Y1	Y2	Y3	Y4	Y5	Output	S
Improved communications, signposting and networking opportunities between providers and schools/education and health to enable settings to access SCC funded and wider services/programmes which address their priorities.	CYPHWP	0-19s Board CYPHWP PH School Nursing	Biannual updates Regular promotion of activities through CYPHWP		Piloting and uptake of support and services among local schools			Healthy Schools offer in place Schools signposted to relevant support including training	
Support education professionals in the development of age and stage appropriate teaching and learning activities for children/young people during curriculum time, including PSHE and PE provision. Support teachers as part of science curriculum by encouraging participation in LifeLab (secondary schools) and Early LifeLab (primary schools).	PSHE Network LifeLab	PSHE network Wessex Education Network Behaviour Change providers	2022-ongoing		Funding/resource in place Needs assessment completed with PSHE network and activities addressing healthy lifestyle choices developed and implemented			PSHE network has access to and delivers activities addressing healthy choices and obesity	
Support activities which encourage joint work with housing associations to reinforce school/community/home based initiatives promoting healthy lifestyles.	To be developed	Public Health CYPHWP (Children and Young people's Healthy weight Partnership)	Work force access to MECC and other relevant training	Funding/resource in place. With Housing sector pilot a range of activities for families promoting healthier lifestyles. Housing supporting families with healthier lifestyles through range of mechanisms/activities				Housing sector leading/piloting activities promoting healthy lifestyles	
Work with local businesses to contribute to the Children and Young Peoples Healthy weight plan by pledging an action to enable healthy active lifestyle choices among staff, clients and service users	HWB plan	Public Health	Web page developed Pledges made by a variety of organisations Pledges implemented		→	→	→	Web page in place with pledges from local businesses	
Create opportunities for innovative programmes/projects/activities promoting healthy settings.	0-19 Health improvement Workplace wellbeing Charter	0-19s Board CYPHWP Public Health ICU Partners ?SVS	Providers supported to seek funding/resource for innovative projects Projects piloted and evaluated Reports with recommendation produced and disseminated			Programmes evaluated and findings shared		Programmes piloted and evaluated and findings disseminated	

Action plan- Targeted Prevention

Action	Linked programme	Lead	Y1	Y2	Y3	Y4	Y5	Output	S
Promote self-help and adult behaviour change services, to ensure women thinking about starting a family can access weight management support	Behaviour change service	Maternity services and Primary care/ Adult behaviour change service	Behaviour change service in place Promoted through range of mediums		→	→	→	Increase in proportion of women of child-bearing age accessing support/self-help resources	
Enable women identified as obese in pregnancy to access the local behaviour change support services including self- help and one-to-one support as required.	Behaviour Change Service	Maternity services	Behaviour change service in place. Routine referral mechanism developed and implemented		→	→	→	Routine referral mechanism in place to behaviour change service for pregnant women identified as obese in pregnancy	
Work with partners to promote projects and interventions which support families and young people to improve food choice, targeting groups most at risk (including families matter, foster carers and Sure Start centres). Through early years settings, communities, schools and colleges.	0-19 service (Health Improvement)	SCC (Public Health, ICU, Early Help team)/ Children & Young People's Healthy Weight Partnership/ Active Travel	Funding in place. Range of programmes in place for target communities Range of community lead programmes piloted and evaluated.			Successful programmes supported to seek funding to scale up		Programmes in place to promote healthy food choices for families	
Work with partners, including leisure providers and local businesses to promote opportunities and projects which achieve a sustainable increase in physical activity among, families with young children, school aged children and young people, targeting those in greatest need (including families matter, foster carers and Sure Start centres).	0-19 service (Health Improvement)	Public Health CYPHWP Active Travel Other partners	Funding in place for programmes aimed at target communities		Programmes evaluated. Successful programmes supported to seek funding to scale up	→	→	Programmes in place to support increased physical activity among target groups	

Action plan- Targeted Prevention

Action	Linked programme	Lead	Y1	Y2	Y3	Y4	Y5	Output	S
Work with partners to expand the Youth Health Champion programme- to train more peer mentors in secondary schools to promote healthy eating and physical activity at their schools and among their peers.	LifeLab	Public Health LifeLab CYPHWP	LifeLab led Youth Health Champions training pilot completed		Youth Health Champions training rolled out			YHC Programme available to all secondary schools in Southampton	
Develop capacity of the 0-19 workforce supporting families and young people (including Sure Start Children's Centres, Families matter, fostering/adoption services) in using Making Every Conversation Count (MECC) and Healthy Conversation Skills	0-19 Service Behaviour Change Service	Public Health Behaviour Change service	Training providers (Behaviour change service in place)	Trained promoted among 0-19 workforce				Trained staff competently using MECC and Healthy Conversation skills	
Develop capacity among workforces supporting families and young people (including Sure Start Children's Centres, Families matter, fostering/adoption services), in delivering hands-on/practical activities to support families to eat healthily on a budget and being an active family in a way which is attainable, attractive, healthy and fun.	0-19 service (Health Improvement)	Public Health ICU	Training provider in place and training provided- monitored through ICU		0-19 workforce leading activities to measurable increase healthy choices			Increased number of children and families accessing activities promoting healthy eating	

Action plan -Treatment

Action	Linked programme	Lead	Y1	Y2	Y3	Y4	Y5		S
A co-ordinated tier 1 offer (signposting and self-help resources for healthy lifestyles and weight management) to include a central point where individuals and families can access information about universally available national and local resources to support weight management.		Public Health School Nursing Adult behaviour change service	Behaviour change service in place	Online hub developed	Online hub in place	→	→	Online hub developed and accessible	
A strong stakeholder network to provide an opportunity for organisations to promote discuss projects and share resources to meet local needs and ensure projects/activities targets children and families effectively.	Public Health	Children and Young people's Healthy weight Partnership	Twice yearly implementation meetings for Children and Young people's Healthy weight Partnership established	→	→	→	→	Bi-annual network meetings established	
Review of NCMP feedback letters to increase uptake of support offered at tier 2.	0-19s Service	Public Health School Nursing	Revised NCMP letter piloted, finalised and implemented		Increase in uptake of support among families with obese children			Annual increase in uptake of support	
Conduct insight work among families to understand facilitators and barriers for take up of community based healthy lifestyle and weight management support (tier 2).	0-19s Service	Public Health/Public Health School Nursing	Resource in place Commissioning of Insight work Final report and recommendation produced and disseminated at CYP HWP			→	→	Final report and recommendation produced and disseminated at CYP HWP	
Use findings from insight work to inform the NCMP feedback letter for children with excess weight and inform the development/ of support available to families and children in the community. Ensure support meets the needs identified and addresses issues such as self-esteem and body image.	0-19 Service	Public Health Public Health School Nursing	Amended NCMP letter Dissemination of insight report Adapted community programmes based on findings		Increase in uptake of support post NCMP feedback, including School Nurse led support and community/voluntary sector led programmes.			Adapted community programmes based on findings. Increase in uptake of support post NCMP feedback	

	Status (S)
	Deliverable through existing plans
	Deliverable within existing resources- require embedding in work plans/programmes
	Additional resources required

Action Plan Measures

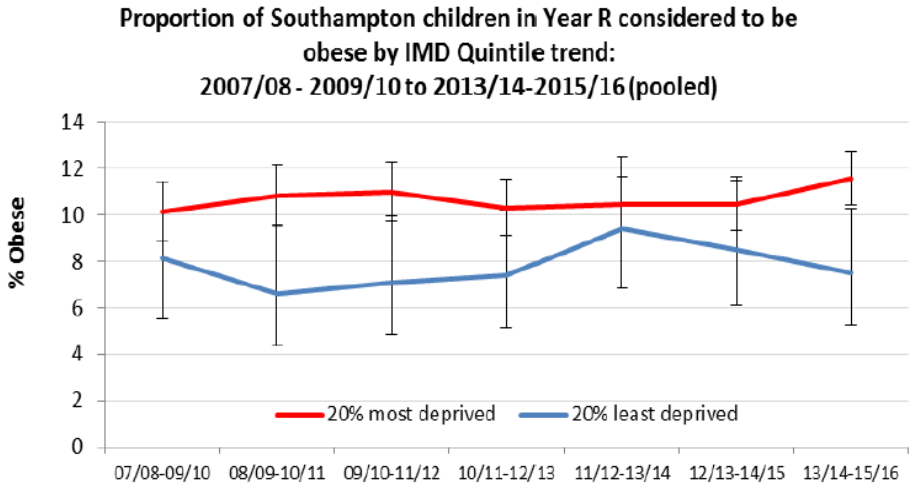
Measures	Baseline (Southampton) 2015/16	England 2015/16	Target	2017-2019	2020-2021	2022
5% more new mums breast feeding	73.2%	74.3%	78.2%	74.3% 37 more*	76.2% 97 more*	78.2% 167 more*
5% more pupils with healthy weight at year R	77.0%	76.9%	82.0%	79% 63 more*	81% 126 more*	82% 158 more*
5% more pupils with a healthy weight at year 6	61.8%	64.5%	66.8%	63.8% 45 more*	65.8% 90 more*	66.8% 112 more*
4% increase in 15 year olds achieving 5-a-day	47.8%	52.4%	57.8%	52.8%	55.0%	57.8%
60 more settings (early years, school, colleges and workplaces) engaged in work to create a healthy setting	10	-	70	20	50	70
100 new businesses pledging an action to enable healthier choices	0	-	100	30	70	100

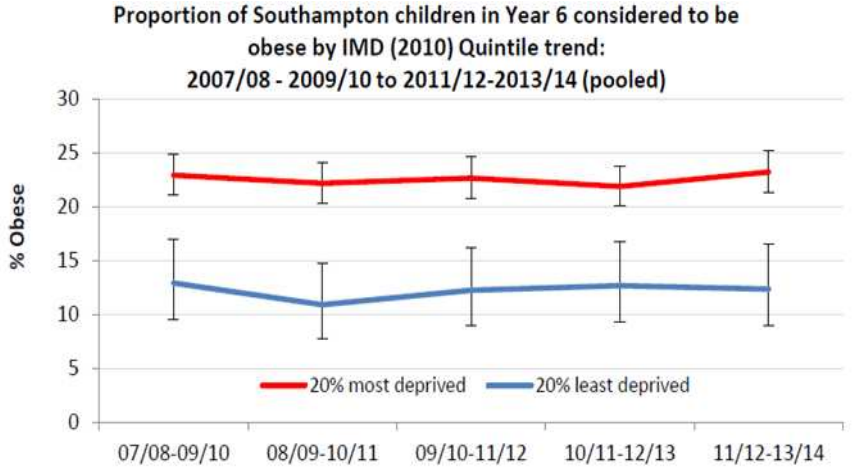
Further Information

- Consequences of Childhood Obesity
- Childhood Obesity and deprivation

Consequences of Childhood Obesity

Childhood Obesity is Associated with Deprivation





Data notes: *Data has been taken from the validated NCMP national dataset. Only data for children resident in Southampton (but attending a Southampton school) is shown and therefore may not exactly match other locally or nationally published figures.*

Obesity levels are consistently higher in children from the most deprived areas for year R and year 6

DECISION-MAKER:		**Health & Wellbeing Board**		
SUBJECT:		**Draft Physical Activity & Sports Plan**		
DATE OF DECISION:		**14 March 2018**		
REPORT OF:		**Director of Public Health**		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Ravita Taheem, Senior Public Health Practitioner**	**Tel:**	**023 80 83 3020**
	E-mail:	**Ravita.taheem@southampton.gov.uk**		
Director	**Name:**	**Jason Horsley, Director of Public Health**	**Tel:**	**023 80 83 2028**
	E-mail:	**Jason.horsley@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
NOT APPLICABLE

BRIEF SUMMARY
A new 5 year Physical Activity & Sports Plan is being developed to support the Health and Wellbeing Strategy and align with a number of other council strategies such as the Children and Young People's Strategy, the Clean Air Strategy and the Cycling strategy. The plan takes forward national priorities as outlined in the UK government's strategy Sporting Future (2015), which set out a plan to invest in people who are least active. The aim of Southampton's Physical Activity & Sports Plan is to make physical activity a normal part of life for all and actively support excluded, inactive groups to increase participation in physical activity.

RECOMMENDATIONS:		
	(i)	To review and provide feedback on the draft Physical Activity & Sports Plan.

REASONS FOR REPORT RECOMMENDATIONS	
1.	Technology has continued to have an effect on physical activity and energy expenditure since the industrial revolution. Overall there has been a trend of a reduction in occupational physical activity and an increase in leisure time physical activity. Physical inactivity is the fourth leading modifiable risk factor for death in high income countries. With an increasing prevalence of long-term conditions such as hypertension, diabetes and coronary heart disease it is important to consider how participation in physical activity can be increased, particularly among those who are inactive.
.2.	As well as health benefits, environments that encourage physical activity can also have social benefits such as reduced loneliness and a stronger sense of community. Environmental benefits include carbon dioxide emissions and reduction in air pollution. Economic benefits can be gained through creating a more attractive walking environment, which can increase footfall and trade, reduce maintenance and infrastructure costs and raise land value.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
3.	To not have a Physical Activity & Sports Plan, however this may lead to people being less active and at risk of the health conditions outlined above. Moreover, this would also impact environmental and economic objectives for the city.
DETAIL (Including consultation carried out)	
4.	The new five year Physical Activity & Sports Plan is being jointly developed with Public Health, Planning, Transport, Open spaces, Capital Assets and a range of external stakeholders from Leisure/sport, Health and voluntary sectors. The plan aligns with the Health and Wellbeing Strategy and aims to increase participation in physical activity for all and actively support excluded and inactive groups.
5.	Current figures for adults (19+) who achieve 150+minutes per week (65.6%) in Southampton are similar to the England average (64.9%), therefore approximately 35% of the adult population are not meeting the guidelines for physical activity. The proportion of adults classed as inactive in Southampton is 22.3% and in England is 22.4%.
6.	The plan includes a target of a 5% decrease in the proportion of residents achieving less than 30 minutes per week (a person doing this level of activity is classed as inactive). Achieving this target will mean that by 2022 about 8,325 fewer residents (aged 19+) will be classed as inactive.
7.	Particular groups are likely to be considerably less active than the general population, including children and young people, people with long term conditions and disabilities and those from lower socio economic groups; as well as those from under-represented groups such as BME and LGBT communities. The national aspiration is more people taking part in physical activity with a faster rate of change in inactive and under-represented groups.
8.	The plan will take account of the national priorities as outlined in the UK government's strategy Sporting Future (2015), which set out a strategy to invest in people who are least active (including women, girls, older people, people with disabilities and those from lower socio economic groups).
9.	Aligning Southampton's new Physical Activity & Sports Plan to national priorities whilst also addressing local needs will put SCC and partners in a strong position to access external funding such as the Sport England grants.
10.	The plan has been jointly developed with Public Health, Planning, Transport, Open spaces, Capital Assets and a range of external stakeholders from Leisure/sport, Health and voluntary sectors.
Priorities	
11.	The aim of Southampton's Physical Activity & Sports Plan is to increase participation in physical activity or "get everybody in Southampton more active and make tackling inactivity a priority". The draft plan has 3 themes outlined below: 1. Active Places- The availability of green/open spaces, environments and facilities that encourage physical activity supports people to live healthy, independent lives. 2. Active Communities- Improving participation in physical activity raises

	aspiration, creates community cohesion and builds city pride. 3. Active Everyday- Being physically active everyday provides lifelong health benefits. Schools, colleges and workplaces are crucial to embed physical activity habits into daily routines.
RESOURCE IMPLICATIONS N/A	
Capital/Revenue	
13.	None
Property/Other	
14.	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
15.	N/A
Other Legal Implications:	
16.	N/A
RISK MANAGEMENT IMPLICATIONS	
17.	None
POLICY FRAMEWORK IMPLICATIONS	
18.	The draft Physical Activity & Sports Plan will support the outcomes set out in the Health and wellbeing Strategy 2017-2025.

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	All wards
SUPPORTING DOCUMENTATION	
Appendices	
1.	**Draft Physical Activity & Sports Plan**

Documents In Members' Rooms

1.	
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.		

Draft Physical Activity & Sports Action Plan 2017-2022

Agenda Item 7

Appendix 1

A city of opportunity where everyone thrives

SOUTHAMPTON CITY COUNCIL

About the plan

A city of opportunity and our aspiration

A city of opportunity

In Southampton there are very many opportunities to be active in the community.

The city hosts an annual cycle ride, the third largest park run in the country, a half marathon, free family activities in local parks and there are a number of indoor and outdoor sports facilities.

A shift in focus

Recent trends show that inactivity has increased

National guidance points to a need to shift focus to communities, groups and individuals who are inactive to get them active.

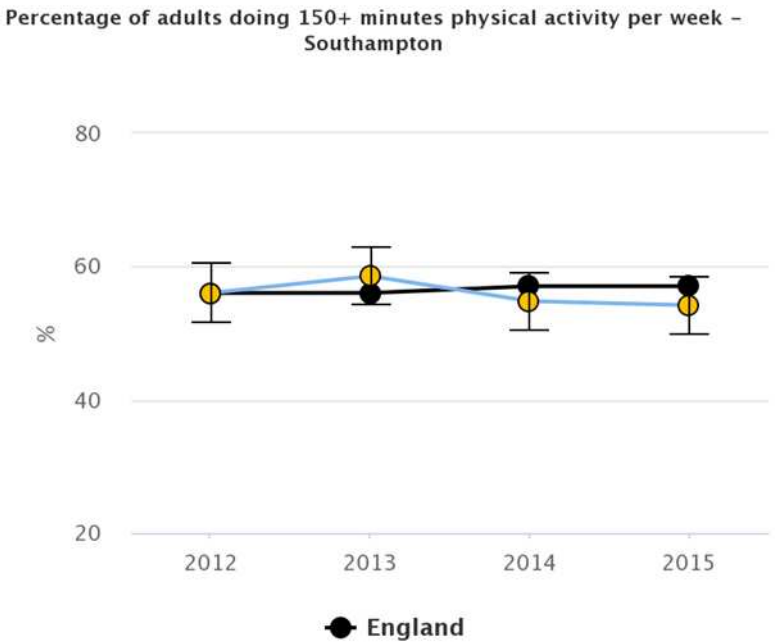
This shift won't occur overnight but embedding it into new and existing programmes (delivered by the council and its partners) will help to make physical activity the norm

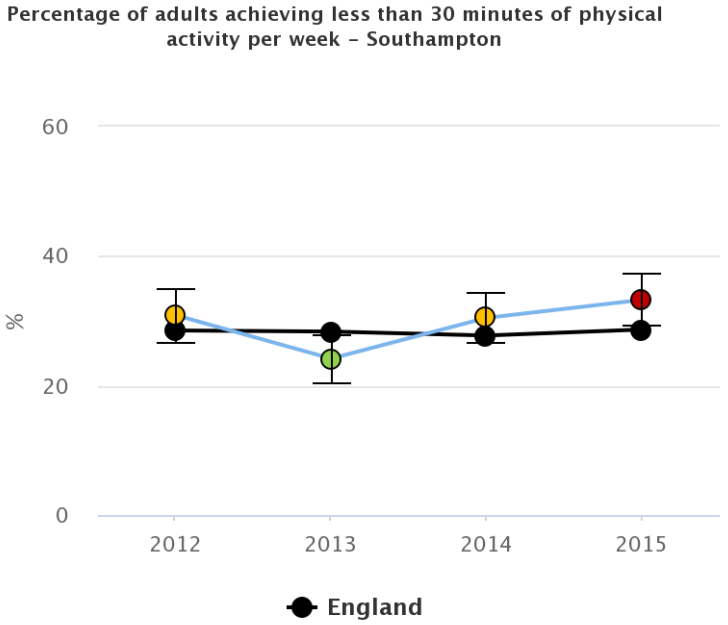
Our aspiration

We will aim to make physical activity a normal part of life for all and actively support excluded, inactive groups to increase participation in physical activity.

This 5 year plan sets out how such a vision will broadly be achieved.

Current Physical Activity Levels in Southampton





- **In Southampton 33.2% of adults are inactive** (do less than 30 minutes per week) compared to 28.7% in England.
- 54.2% adults in Southampton do at least 150 minutes of activity per week this is similar to the England average (57.0%).
- Physical activity levels in children are not routinely measured, nationally it is estimated that of 5-15 year olds only 23% boys and 20% girls met the physical activity guidelines.

- Inactivity increases with age, with a greater proportion of older age groups classed as inactive compared to younger groups.
- Overall physical activity is lower among women compared to men.
- People from Asian, Black and Chinese backgrounds are more likely to be inactive than the white and mixed ethnic groups

The data is taken from the Active People Survey. The way that population physical activity levels are measured changed in 2017. This has changed to the Active Lives Survey. This means it will not be possible to look back at trends. However this year's figures from the Active Lives Survey will be used a s a baseline for the Physical activity Plan.

Targeting Less Active Groups

- **Among some groups physical inactivity levels are high and there is some evidence of a worsening trend, these are women, people with limiting illness or disability and children and young people.**

- **National data shows:**
  - Levels of inactivity increase with age, with a greater proportion of older age groups classed as inactive compared to young people.
  - In addition people from, lower socioeconomic groups and underrepresented e.g. BAME backgrounds are more likely to be inactive

Target groups:

Children and Young People	Lower socioeconomic groups	BAME groups	People with long term conditions/disabilities

A Framework for Action

Three themes

Active Places- The availability of green/open spaces, environments and facilities that encourage physical activity supports people to live healthy, independent lives.	•More residents using open spaces within the city. •Residents have access to local facilities (including sports facilities) that suit their needs and aspirations •Barriers to physical activity are minimised
Active Communities- Improving participation in physical activity raises aspiration, creates community cohesion and builds city pride.	•Local and national opportunities for physical activity are championed to connect people with the opportunities that meet their needs. •Local needs are understood and communities are encouraged to develop local solutions.
Active Everyday- Being physically active everyday provides lifelong health benefits. Schools, colleges and workplaces are crucial to embed physical activity habits into daily routines.	•Positive attitudes and behaviours to physical activity are created from an early age. •Positive physical activity habits are embedded in everyday life

Action Plan- Active Places

Outcome	Action	Lead	Activities						Status
			Y1	Y2	Y3	Y4	Y5	Output	
More residents using open spaces within the city.	Promote improved connectivity and access to key destinations within and outside of the city centre for walking and cycling. ***Aligns with Cycling Strategy and Clean Air Strategy.***	Planning Strategic Transport	Cycling routes align with cycle strategy →					Improved connectivity and walkways	
	Improve the pedestrian environment, safety and accessibility in the city. Develop a network of legible "Active Routes" that are integrated with the existing Legible Cities wayfinding and the emerging Legible Cycling wayfinding. .	Strategic Transport Tree team	Routes agreed and funding secured to improve key active routes in the city →					Improved connectivity and walkways	
	Enable inactive communities and groups to safely make use of grey spaces through facilitated street closures.*	Transport in partnership with Southampton University	Roads identified Temporary Traffic orders agreed Street play activity delivered and evaluated		Metamorphosis project year 3	Metamorphosis project completed and evaluated		8-10 street closures delivered Evaluation disseminated	
	Build on other opportunities which promote physical activity, play and active travel.* ***Aligns with Metamorphosis project, delivered through European funding and Clean Air Plan***	Public Health Transport Community sector partners	Support community led street closures, simplify processes for street closures where possible Pilot community/partner led street closures for play and physical activity Promote street play among target communities		Evaluate pilots	Promote opportunities across the city among target communities		Increase in applications for community led street play to 10 per year	
	Explore opportunities to access green spaces and playing fields (owned by local schools and other partners) for use by local residents outside of school hours. Focussing on those with benches, toilets, lighting, physical access to appeal to inactive people.	Public Health Green Spaces team Community sector partners	Pilot area /school(s) agreed	Funding/resource in place Project plan agreed	Project delivery and monitoring		Project evaluation Explore opportunities for scaling up	Pilot delivered Evaluation shared Other pilot schools identified	

Action Plan- Active Places

Outcome	Action	Lead	Activities						Status
			Y1	Y2	Y3	Y4	Y5	Output	
Residents have access to local facilities that suit their needs and aspirations	Review available local public indoor and outdoor facilities (including sports facilities) to identify priorities for improvement.	Contracts Capital Assets	Review of Playing Pitch Strategy Identify priority facility improvements		Work with national governing bodies to identify and secure funding and develop a programme		Implementation of priority improvement programme	Completion of pitch playing strategy	
	Work with partners to identify facilities which can increase activity among target inactive groups and develop programmes to increase engagement with physical activity.	Public Health Energise Me	Work with national governing bodies and other partners to identify and secure funding to develop programmes using local facilities		Implement the programme(s)		Evaluate programme(s)	Minimum 2 programmes implemented and evaluated	
Barriers to physical activity are minimised	Work with local planners to review planning applications and planning policies to enable increased physical activity among residents and minimise barriers to physical activity for all age groups and abilities (including older residents and those with mobility problems). This may include planning policies influencing green space, play facilities for children and young people and places to rest for older people).	Planning Economic Growth Transport Public Health	Draft local plan reviewed and recommendations submitted Amendments discussed and finalised		Local plan finalised	→		Local plan finalised referencing proactive promotion of physical activity opportunities	
	Promote and incentivise physical activity by 'park and walk/cycle' opportunities in the city. ***Aligns with the Clean Air Strategy, Car Parking Plan and Local Transport Plan.**	Strategic Transport	SCC Car Parking Plan to include reducing city centre car parking and variable pricing strategy to promote underutilised edge of centre parking. "Park & Walk" & "Park & Cycle" can support this Plan and specific campaigns developed through My Journey to promote physical activity benefits.					SCC Car Parking Plan in Place and uptake of edge of centre parking monitored	

Action Plan- Active Communities

Outcome	Action	Lead	Activities						Status
			Y1	Y2	Y3	Y4	Y5	Output	
Local and national opportunities for physical activity are championed to connect people with the opportunities that meet their needs.	Improve event/campaign messages to increase awareness of opportunities to be active , among target inactive groups. This includes local green/blue/open spaces, Smart Cities Card, local and national events and campaigns.	Communications Active Nation Transport/My Journey Community sector partners	Review of key selected events/campaigns promoting physical activity and how they target inactive groups. Plan developed to improve promotion to target inactive groups		Deliver plan for selected events/campaigns Monitor progress		Successful methods of engaging target inactive communities embedded	Comms plans agreed with added focus targeting inactive people integrated into annual plans	
	Support interventions and activities led by partners (including communities, voluntary sector, health, housing, leisure providers) that target inactive groups. Activities could include, social prescribing, family friendly and play activities (such as creating a Park Lives project legacy) Active Ability programme, Living Well for older people, walking, cycling and volunteering.	Active Nation Voluntary Sector Public Health comms Community sector partners	Intervention/activities routinely promoted to increase awareness among target groups		→		→	Annual increase in uptake of opportunities among target groups	
	A point of contact established for existing and new community groups interested in developing local physical activity opportunities in their neighbourhoods.	Pubic Health Communications Community Development Community sector partners	Resource/funding in place Point of contact and process of support agreed		Community led programmes and initiatives supported within funded capacity		Findings shared as part of provider stakeholder network	Minimum of three community led groups/event supported annually	
	Promote and incentivise opportunities for volunteering through physical activity, to encourage a sense and culture of community service. Activities could include led walks, cycling, litter picking, group allotments and community gardening.	Communications Sustrans Community sector partners ICU	Volunteers in place and trained Volunteers delivering relevant activities to target groups. Monitoring in place Pilot activities evaluated Findings disseminated Updates provided to stakeholder network			Ongoing support of volunteer programmes to promote physical activity		Funding in place Project plan agreed & delivered X volunteers trained & actively promoting physical activity	
	Promote existing technologies and apps that have been evaluated and quality assured (e.g. by Public Health England) to promote physical activity among target groups. E.g. couch to 5k.	Communications Public Health Community sector partners Transport	Quality assured technologies and apps routinely promoted among target groups		→		→	Free quality assured apps/ tech routinely promoted alongside relevant activities/ campaigns/events	

Action Plan- Active Communities

Outcome	Action	Lead	Activities						Status
			Y1	Y2	Y3	Y4	Y5	Outputs	
Local needs are understood and communities are encouraged to develop local solutions.	Undertake insight work to understand the barriers to physical activity among inactive target groups and work with partners and local networks to explore innovative ways to increase participation.	Community sector partners Public Health University of Southampton	Seek resource (such as research students) or funding Prioritise target groups Insight work undertaken Reports produced		Insights used to inform relevant funding applications and projects		→	Minimum of 3 insight reports (s)completed and shared with stakeholders	
	Develop a local network of existing providers and partners to share monitoring and evaluation information and insights from target groups to improve the delivery of new and existing programmes	Community sector partners Public Health Energise Me	Agree plan for physical activity focus for the existing SHL affiliate network Meetings at least twice a year to include monitoring and implementation of physical activity plan, sharing projects, evaluations and insights		→			Plan agreed with SHL Minimum of 2 meetings annually Strong network in place	
	Gain a commitment from partners to develop collaborative funding applications based on local need to increase physical activity levels among target groups. Develop and support partnerships with a variety of sectors (including private, voluntary and higher education sectors) which promote health and wellbeing.	Public Health ICU Transport Community sector partners	Funding opportunities routinely identified and shared with partners		→			Minimum of 2 expressions of interest for funding submitted annually	

Action Plan- Active Everyday

Outcome	Action	Lead	Activities						Status
			Y1	Y2	Y3	Y4	Y5	Output	
Positive attitudes and behaviours to physical activity are created from an early age.	Support initiatives which integrate physical activity throughout the curriculum, including innovative programmes, teacher training initiatives and events.	LifeLab (lead) and the Early LifeLab programme Children's Services Public Health Solent University Community sector partners	Early LifeLab trial Programmes to train and develop capacity for teachers in place		→	→	Interim Monitoring information and outcomes shared	Measurable increase in promotion of physical activity in the curriculum of participating schools	
	Work with settings including early years and schools to maximise opportunities for physical activity during the school day. Work with partners to promote school based campaigns and initiatives to increase physical activity, such as the Daily Mile, Golden Mile, and other programmes which embed health and physical activity into the school day.	ICU Public Health ICU/PH school nursing Energise Me Public Health Comms	Early Years and Schools settings initiatives pilots completed and embedded into contracts Plan and deliver programme of promotion for Golden Mile and Daily Mile initiative		Programmes evaluated and finalised →		Ongoing monitoring Ongoing monitoring	50% early years settings achieved HEYA. Increase in schools and enabling physical activity in school/work time Annual increase in primary schools piloting Golden Mile or Daily Mile. Minimum of 20 schools engaged	
	Support schools to make effective use of the Primary Premium to increase quality of PE and school activity	Energise Me Solent University Public Health	Develop guidance for schools on the most effective way to use the Primary Premium		→	→	→	Increase in pupils doing 30 minutes a day at school	
	Work with workplaces to maximise opportunities for physical activity during the work day. Encourage the adoption of campaigns and initiatives rate such as the workplace challenge to embed health and physical activity into a school/work day.	Public Health	Work place health programme reviewed. Recommendations shared		Programme in place to improve workforce health including physical activity with ongoing monitoring			Increase in workplaces enabling workforce to be physical activity in work time	

Action Plan- Active Everyday

Outcome	Action	Lead	Activities						Status
			Y1	Y2	Y3	Y4	Y5	Outputs	
Positive physical activity habits are embedded in everyday life.	Promote training, including MECC and other opportunities to develop capacity among staff working with target groups at GP surgeries (e.g. through GP Champion training), supporting Looked After Children, Job Centres, libraries and community centres to empower and enable vulnerable groups to sustainably increase participation in physical activity.	Public Health ICU Community sector partners Energise Me	Training communication s plan in place	No. and type of staff trained reported annually as part of behaviour change contract	→	→	→	Annual increase in uptake of MECC and healthy conversations training	
	To deliver Active Travel and My Journey Southampton to support inactive groups, enabling active travel to schools and work places ***Aligns with the Cycling Strategy***	Transport My Journey	Funding/ resource in place to target inactive groups with My Journey and Active Travel		Pilot programme in place and delivered		Pilot evaluated and results dissemina ted to relevant partners	Annual increase in proportion of inactive groups/individ uals engaged in active travel	
	Embed health including physical activity in all SCC strategies, policies and contracts. This will include a focus on measurably increasing physical activity among inactive groups ***Aligns with Health & Wellbeing Strategy***	Strategy ICU Public Health Contracts	To be completed when all policies and contracts are reviewed		→	→	→	Measurable increase in policies with health and physical activity outcomes embedded	

Monitoring the Action Plan

Success will be measured by the RAG rating included in the plan as well as the key outcome measures.

- A decrease in the proportion of residents achieving less than 30 minutes per week (a person doing this level of activity is classed as inactive).
    - Achieving this target will mean that by 2022 about 8,325 fewer residents (aged 19+) will be classed as inactive
- An increase in the proportion of residents achieving 150+ minutes per week.
- Increase number of physical activity events/campaigns promoted to those who are inactive
- Increase number of volunteers promoting and supporting various forms of physical activity in their communities.
- Monitoring of physical activity in children and young people when data becomes available in 2019

Key outcome measures						
Description	Baseline	England	Target	2017-2019	2020-2021	2022
5% decrease in proportion of inactive residents	22.4%	22.3%	17.4%	20.4%	18.4%	17.4%
5% increase in proportion of active residents	65.6%	64.9%	70.6%	67.6%	69.6%	70.6%
Minimum number of annual physical activity events/campaigns promoted to those who are inactive	0	-	10	5	8	10
Increase in total number of volunteers promoting and supporting various forms of physical activity in their communities.	0	-	95	80	95	95

The way that population physical activity levels are measured changed in 2017. This has changed from the Active Peoples Survey to the Active Lives Survey (for adults aged 19 and over). This means it will not be possible to look back at trends. However this year's figures from the Active Lives Survey will be used as a baseline for the Physical Activity Plan.

Further reference information

- **Chief Medical Officer's guidelines for physical activity**
- **The benefits of physical activity for health, communities and the environment**
- **Current physical activity levels in Southampton**

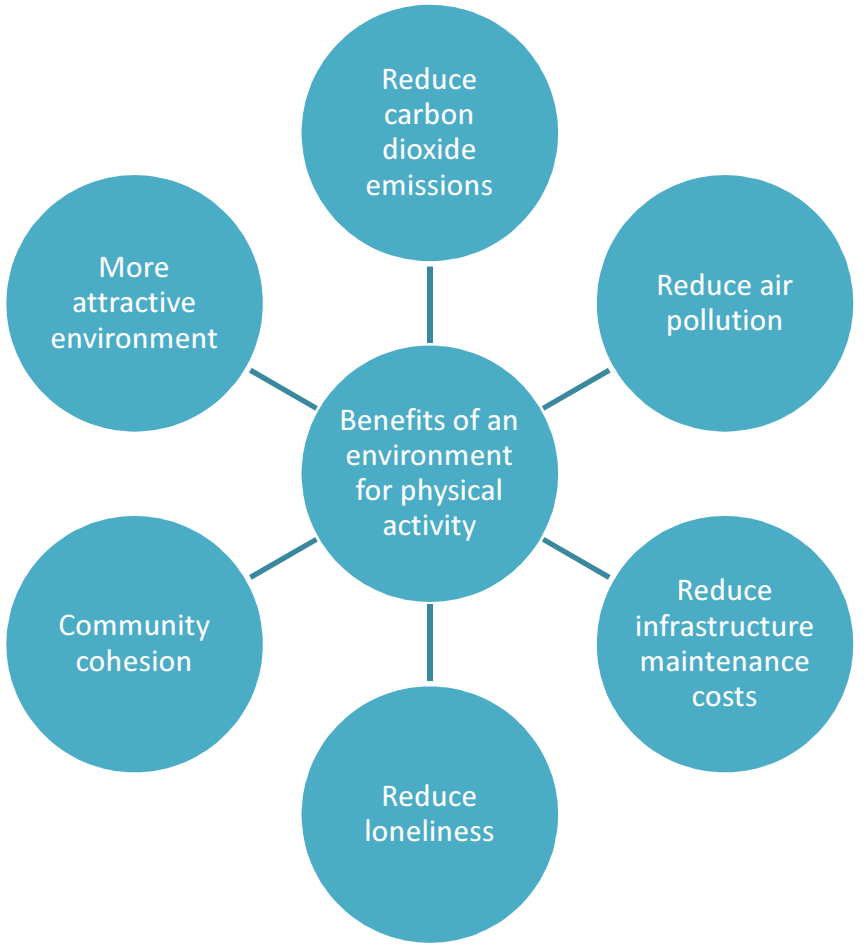
Chief Medical Officer's Physical Activity Guidelines

0-5 YEAR OLDS	•Physical activity should be encouraged from birth, particularly through floor-based play and water-based activities in safe environments. •Children of pre-school age who are capable of walking unaided should be physically active daily for at least 180 minutes (3 hours), spread throughout the day •All under 5s should minimise the amount of time spent being sedentary (being restrained or sitting) for extended periods (except time spent sleeping).
CHILDREN AND YOUNG PEOPLE (5–18 years)	•All children and young people should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day. •Vigorous intensity activities, including those that strengthen muscle and bone, should be incorporated at least three days a week. •All children and young people should minimise the amount of time spent being sedentary (sitting) for extended periods.
ADULTS (19–64 years)	•Adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week. • Alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous intensity activity. • Adults should also undertake physical activity to improve muscle strength on at least two days a week. • All adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

Physical activity includes active travel, physical activity undertaken at home, such as heavy housework, activity undertaken in some occupations and activities and sports undertaken in leisure time

Benefits of physical activity

Health, communities and the environment



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DECISION-MAKER:		**HEALTH AND WELLBEING BOARD**		
SUBJECT:		**BETTER CARE PLAN RESPONSIBILITY**		
DATE OF DECISION:		**14TH MARCH 2018**		
REPORT OF:		**DIRECTOR OF PUBLIC HEALTH**		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Donna Chapman – Associate Director System Redesign**	**Tel:**	**023 8029 6004**
	E-mail:	**d.chapman1@nhs.net**		
Director	**Name:**	**Stephanie Ramsey - Director of Quality and Integration**	**Tel:**	**023 8029 6941**
	E-mail:	**stephanie.ramsey1@nhs.net**		

STATEMENT OF CONFIDENTIALITY		
NOT APPLICABLE		
BRIEF SUMMARY		
This report sets out a proposal to formally delegate responsibility for Better Care from the Health and Wellbeing Board to the Joint Commissioning Board. The establishment of a Joint Commissioning Board was agreed by Cabinet and Council in July 2017 to ensure effective collaboration, assurance, oversight and good governance across the integrated commissioning arrangements between Southampton City Council and Southampton City CCG.		
In order to enable the Joint Commissioning Board to fulfil its duties as set out in its Terms of Reference, the Health and Wellbeing Board is required to delegate responsibility for Better Care to the new Board.		
RECOMMENDATIONS:		
	(i)	To delegate responsibility for Better Care from the Health and Wellbeing Board to the Joint Commissioning Board.
REASONS FOR REPORT RECOMMENDATIONS		
1.	A Cabinet decision was made in July 2017 to establish a new Joint Commissioning Board for Southampton. The decision to establish the new Board included the delegation of powers to undertake joint commissioning functions for the city. In order to effectively undertake this role the new Board will also require the delegation of some of the responsibilities for Better Care currently within the remit of the Health and Wellbeing Board.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	To retain responsibility for Better Care within the Health and Wellbeing Board. This option has been rejected as it would undermine the intentions of the Joint Commissioning Board as set out to Cabinet in July 2017.	
DETAIL (Including consultation carried out)		
3.	The establishment of the Southampton Joint Commissioning Board was agreed by Cabinet and Council in July 2017. This included a delegated	

	authority to undertake joint commissioning functions that are executive functions within agreed budgets to individual members of the Board.
4.	The Joint Commissioning Board is now in place, and has the role of ensuring effective collaboration, assurance, oversight and good governance across the integrated commissioning arrangements for health and care between Southampton City Council and Southampton City CCG. The scope of the integrated commissioning arrangements broadly mirror those areas of health and care commissioning covered by the Better Care Fund S75, plus other existing partnership agreements/shared funding arrangements.
5.	The Terms of Reference for the Joint Commissioning Board state that the Health and Wellbeing Board will delegate responsibility for Better Care to the Board, and the Board will be accountable to the Health and Wellbeing Board for this element.
6.	This paper proposes that responsibility for the delivery of integrated commissioning and the Better Care Plan for Southampton is formally delegated to the Joint Commissioning Board.
7.	The Joint Commissioning Board will be accountable to the Health and Wellbeing Board, and in line with the duties set out in the Health and Social Care Act 2012, will report to the Health and Wellbeing Board on a regular basis on the Better Care Plan.
RESOURCE IMPLICATIONS	
Capital/Revenue	
8.	None
Property/Other	
9.	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
10.	Health and Social Care Act 2012 sets out responsibilities for Health and Wellbeing Boards.
11.	Children and Families Act 2014 – emphasises that a local authority in England and its partner commissioning bodies must make arrangements ("joint commissioning arrangements") about the education, health and care provision to be secured.
12.	Care Act 2014 establishes requirement for integration of care and health by 2020.
13.	NHS Five Year Forward View 2014 which outlines the future direction for the NHS which requires new partnerships in how care is delivered breaking down barriers between health and social care with more integrated approaches and with patients having far greater control over their own care.
Other Legal Implications:	
14.	There is no requirement to amend the Terms of Reference for the Health and Wellbeing Board.
RISK MANAGEMENT IMPLICATIONS	
15.	**None**
POLICY FRAMEWORK IMPLICATIONS	

16.	**None**

KEY DECISION?	**No**	
WARDS/COMMUNITIES AFFECTED:		**All**
SUPPORTING DOCUMENTATION		
Appendices		
1.	Shared Commissioning Between Southampton City Council And Southampton City Clinical Commissioning Group Cabinet and Council paper	
2.	Terms of Reference for the Joint Commissioning Board	

Documents In Members' Rooms

1.		
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.		

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DECISION-MAKER:		**CABINET** **COUNCIL**		
SUBJECT:		**SHARED COMMISSIONING BETWEEN SOUTHAMPTON CITY COUNCIL AND SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP**		
DATE OF DECISION:		**18 JULY 2017** **19 JULY 2017**		
REPORT OF:		**THE LEADER OF THE COUNCIL**		
		CONTACT DETAILS		
AUTHOR:	**Name:**	**Sarita Riley, Service Lead, Legal Services** **Stephanie Ramsey, Director Quality and Integration**	**Tel:**	**023 80833218** **023 80296941**
	E-mail:	**Sarita.Riley@southampton.gov.uk** **Stephanie.Ramsey@southampton.gov.uk**		
Director	**Name:**	**Dawn Baxendale, Chief Executive** **John Richards, Chief Executive**	**Tel:**	**023 80834428** **023 80296923**
	E-mail:	**Dawn.Baxendale@southampton.gov.uk** **John.Richards@nhs.net**		

STATEMENT OF CONFIDENTIALITY
None.

BRIEF SUMMARY
This report recommends further integration between health and social care in the city through the establishment of a Joint Commissioning Board to make joint decisions on behalf of the Council and CCG on certain agreed functions related to health and care. This will be in line with best practice and give Southampton a leading edge as there is an emerging consensus, both nationally and locally, about the opportunity to improve outcomes through a unified approach to health and care planning and funding (commissioning). To contribute towards this it is proposed to build on the existing integrated commissioning arrangements by establishing a new Joint Commissioning Board which would have delegated powers from Council/Cabinet and the CCG General Assembly/ Governing Body to make joint decisions on behalf of the Council and CCG on certain functions related to health and care. It is proposed that the scope of the integrated commissioning arrangements will broadly mirror those areas of health and care commissioning covered by the Better Care Fund S75 plus other existing partnership agreements/shared funding arrangements.

RECOMMENDATIONS:		
	CABINET:	
	(i)	To approve the establishment of a Joint Commissioning Board between the Council and Southampton City Clinical Commissioning Group to undertake Executive functions within the Boards proposed Terms of Reference.
	(ii)	To delegate authority to undertake joint commissioning functions that are executive functions within agreed budgets to individual members of the Board (Officers and Members as appropriate) acting at Board meetings within the procedures set out in the terms of reference.
	COUNCIL:	
	(i)	To approve the establishment of a Joint Commissioning Board between the Council and Southampton City Clinical Commissioning Group to undertake non-executive functions within the Boards proposed Terms of Reference.
	(ii)	To delegate authority to undertake joint commissioning functions that are non-executive functions within agreed budgets to individual members of the Board (Officers and Members as appropriate) acting at Board meetings within the procedures set out in the terms of reference.
	(iii)	To authorise the Service Director: Legal and Governance following consultation with the Leader, Group Leaders, the Chief Strategy Officer and the Director: Quality and Integration to make all necessary changes to the Council's Constitution to give effect to the establishment of the Board and decision making arrangements, including but not limited to changes to the Executive Scheme of Delegation, Officer Scheme of Delegation, Member and Officer Codes of Conduct, Partnership Protocols, Financial and Contract Procedure Rules, decision making protocols and standards and the creation of an Inter Authority Agreement, information sharing and information governance protocols, conflict resolution procedures and protocols as well as terms of reference for any new Board established.
REASONS FOR REPORT RECOMMENDATIONS		
1.	There is an opportunity to strengthen existing joint commissioning arrangements to achieve the level and pace of service change and integration needed to meet current and future challenges. This will enable both organisations to provide the seamless health and care which residents need and to meet quality and sustainability challenges. The current governance structures require changes for both organisations to be able to implement the necessary changes jointly and at pace.	
2.	National direction, such as Integration and Better Care Fund Policy Framework 2017, requires integration between health and care services. Success measures for such are being developed nationally and the Care Quality Commission has the remit to carry out targeted reviews.	
3.	Nationally there is an expectation that full integration of health and social care will be implemented by 2020. Southampton is ideally placed to increase the pace and depth of integrated commissioning, with its asset of co-terminosity between health and local government; its track record of delivering benefits through integration, its existing integrated commissioning functions and good working relationships. A shared	

	ambition for change has been agreed between SCC Cabinet and the Clinical Commissioning Group (CCG) Governing Body: '*Commissioning together for health and wellbeing will allow us to push further and faster towards our aim of completely transforming the delivery of health and care in Southampton so that it is better integrated, delivered as locally as possible, person centred and with an emphasis on prevention and intervening early to prevent escalation'.*
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
4.	Eight options were rigorously tested against a range of (weighted) financial and non-financial assessment criteria. They included: • Resident and patient outcomes: increasing resident and patient benefits through maximising new commissioning possibilities • System efficiency and sustainability :financial benefit through making savings for both organisations; effective decision making; ease of deliverability • Accountability: democratic accountability; strategic alignment of priorities for both organisations; legal and regulatory compliance.
5.	The options considered and rejected during this first stage were to: • do nothing • continue with or reverse current arrangements • joint commissioning by a Combined Authority. These were rejected on the basis of an agreed scoring criteria which comprised ranking the weighted benefit criteria; through this process it was ascertained that these options did not deliver the same benefits as other options.
6.	Four shortlisted options were analysed further to assess their benefits in terms of : • Strategy (i.e. which option has the greatest potential to drive service innovation, provider integration and ultimately maximise benefits for citizens and patients) • Governance (i.e. which option has the structures, powers and duties to maximise integration, whilst minimising complexity and the possibility of legal challenge) • Financial (i.e. balance of pooled and aligned budgets for each option).
7.	As a result of further assessment an additional three options were rejected at this stage: • Joint commissioning hosted by either the CCG or Council • Commissioning overseen by the Health and Wellbeing Board (H&WB). This was rejected as the Health and Wellbeing Board is a sub-committee of Council, not the Executive and as such cannot legally exercise Executive powers. The H&WB has statutory functions wider than the scope of shared commissioning as well as statutory membership which would impact on the balance of the proposed new board as the members have particular voting rights in law. The current H&WB advisory / scrutiny role could also be lost from the system. • Establishing a Regulation 10 committee as allowed within a Section 75 agreement (an agreement made under section 75 of National Health Services Act 2006 between a local authority and an NHS body in England). This was rejected as it would limit decision making to pooled budget items only and not areas where budgets are aligned rather than formally pooled.
DETAIL (Including consultation carried out)	
8.	The proposal is to establish a Joint Commissioning Board to be accountable for

	effective collaboration, assurance, oversight and good governance across the integrated commissioning arrangements for health and care between Southampton City Council and Southampton City CCG. This would demonstrate a commitment to genuine joint working and provide a body constituted with executive powers jointly accountable to Cabinet/Council and the CCG Governing Body/General Assembly. This change will enable greater transparency as meetings will be held in public and reduce complexity in decision making,
9.	The Board will approve and monitor the development and implementation of a publicly available, annual Integrated Commissioning Plan; ensure objectives and targets are met, outcomes achieved for residents and patients and that commissioning arrangements align with the partners' financial and business planning cycles.
10.	This Board would replace the Commissioning Partnership Board which oversees the work of integrated commissioning. The Commissioning Partnership Board make recommendations for key decisions to the Council's Cabinet and CCG Governing Body. It has no delegated decision making power and its role is to ensure effective collaboration, alignment and assurance across the integrated commissioning arrangements between Southampton City Council and Southampton City CCG. The Board also ensures that priorities identified by the Health and Wellbeing Board are met. The proposal in this report is to further strengthen integrated commissioning by delegating some decision making to the members of a Joint Commissioning Board, once strategic direction has been set by Council and CCG Governing Body. This will include the delegation of some of the responsibilities for Better Care currently within the remit of the Health and Wellbeing Board.
	Scope
11.	The proposed scope of the integrated commissioning arrangements will be limited to agreed elements of health and care commissioning. A large majority will be areas already included in the well-established Better Care Fund Section 75 agreement between the council and the CCG. It will also include other existing partnership agreements and shared funding arrangements. This includes services such as integrated rehabilitation, reablement and discharge services, support services for carers, care technology, joint equipment service, mental health and integrated services for children with complex health needs. A detailed breakdown is attached at Appendix 1. At the start, it is proposed that the Joint Commissioning Board will be responsible for an initial budget of at least £105M. The services included within this budget will form part of the budget process for both organisations and still be required to contribute to the efficiency and savings programmes. The remit of this Board will be to recommend savings to contribute to these programmes. The Joint Commissioning Board will be responsible for delivering agreed savings, many of which will be inter related across social care and health, such as with integrated rehabilitation and reablement.
12.	There will also be services in scope for consideration by the Board where the commissioning responsibility/ decision making remains solely with the City Council or the CCG but the use of funding is aligned to deliver a jointly agreed strategy. This could include Respite and short breaks or transformation of Children and Adolescent Mental Health Services (CAMHS). In addition there will be other areas to consider together that help both organisations achieve agreed outcomes, such as bids for funding.
13.	It would be the responsibility of the Board to: • assess and manage any liabilities or risks reported in relation to each of the Better Care pooled fund schemes

	• monitor financial contributions of the Council and the CCG and make recommendations regarding future financial contributions • receive and sign off all Better Care Fund performance reports for approval and submission to NHS England • provide the Council/Cabinet and CCG Governing Body with an annual review of the S75 Better Care Partnership Agreement arrangements.
	Governance
14.	The council's representation on the Joint Commissioning Board will be made through executive appointments of 3 Cabinet Members, similar to the membership of the Health and Wellbeing Board. The CCG will similarly nominate 3 members from the CCG Governing Body. The proposal is that there will be delegated decision making to individual members of the Board with appropriate safeguards limiting the exercise of their delegations to circumstances in which consensus can be achieved at the Board meetings. The Council's Cabinet and the CCG Governing Body may grant delegated authority (with any appropriate caveats) to those of its members or officers participating in the Board to make decisions on their behalf, whilst retaining overall responsibility for the decision made by those members or officers. It would therefore be the individual member or officer who had the delegated authority to make a decision rather than the Joint Commissioning Board itself (unless under S75 lead commissioning arrangements).
15.	As the Board will, through its member's delegated decisions, be exercising Executive functions, the following requirements would apply: • set published meeting dates, to provide advance information on the Council's Forward Plan (28 days before any decision)) and CCG's governance arrangements • written reports containing specified information that must be published a set period in advance (5 working days before meeting date) • hold meetings in public (proposed to commence from April 2018) • restrictions on taking confidential decisions unless a period of notice (28 days) has been given • requirements around recording and publishing decisions • 'standstill period' following decisions during which 'Call In' can be exercised by the council's Overview and Scrutiny arrangements.
16.	The council's legal advice is that this is a tried and tested method of governance that is legally the most robust to achieve. It also requires less change constitutionally and will be easier to manage administratively.
17.	Under this proposal Executive Members or Officers attending the Board would require delegated powers to enable them to make decisions following consultation with the collective Board. This could be achieved by amending the Executive Procedure Rules and Officer Scheme of delegation in the Council's constitution together with consequential amendments to Financial Procedure Rules and Access to Information Procedure Rules. Such changes would need to go through the constitutional change process and be approved by Full Council.
18.	The draft Terms of Reference is attached at Appendix 1 and includes the scope. The Board would require a consensus between the two organisations prior to any delegated decisions being taken. Consensus will be demonstrated by a show of hands. It is important that given the nature of the decisions, securing the support of both partners will be critical to the success of this Board. In those circumstances where consensus cannot be reached, it is proposed that the matter would be deferred for further consideration by the parties to be reconsidered after discussions between the Chair

	and respective partner lead. Functions outside the decision making scope of the Board, but related to health and social care will be discussed for information only at the Board, with the considerations and any recommendations of the Board formally minuted. Items will then be referred to the relevant decision maker (e.g. CCG Governing Body, Council).
	Benefits
19.	Shared commissioning enables achievement of a shared vision e.g. a shared focus on prevention and early intervention and community solutions to promote independence & a shared commitment to realise it. This is alongside the ability to share risks and benefits associated with implementation of the shared vision, enabling us to do the "right thing" without unfairly disadvantaging or advantaging one organisation and to commission against a single agreed set of common outcomes and priorities – making best use of resources. The opportunity to share data on needs and good practice evidence leads to more intelligent commissioning and to develop more innovative solutions to meet people's needs in the round (as opposed to commissioning in silos for people's "health" versus "social" needs) which leads to improved outcomes for people. Bringing together health, public health and social care resources and stripping out duplication had already led to savings and efficiencies. A stronger governance process will facilitate the commissioning of a more joined up health and care system,
20.	Integrated commissioning has already achieved savings across both organisations covering a range of services which include in 2016/17, Adult Social Care - £2.4M, Public Health - £1M and the CCG - £3M. Integrated commissioning arrangements have been highlighted as a particular strength in recent inspections, e.g. SEND and delivered improved outcomes and made positive benefits such as: • redesign of an integrated Rehabilitation and Reablement Service which has reduced admissions to residential and nursing homes (16% lower than the plan in 2016/17) • collaborative work with the home care market promoting an increase in over 1,500 hours per week • focus on quality in care home provision limiting the need for lengthy cautions or suspensions from placement; • 50% increase in carers identified, engaged and in receipt of services • complete redesign of all age mental health services undertaken – Mental Health matters – and additional investment identified for CAMHS and adult mental health services • six new supported living schemes have been created providing 28 new tenancies for people with learning disabilities
21.	Ten benefit criteria of integrating commissioning were identified to be used as part of the options analysis including: • Using integrated commissioning to drive provider integration and service innovation. It is through these innovations that integrated commissioning has the greatest potential to benefit citizens and patients. • Improving the efficiency of commissioned services. This includes both streamlining process and reducing duplication and variation. This is particularly relevant for services / providers working across both commissioning organisations. • Increasing the effectiveness of commissioning – across the whole of the commissioning cycle. Combining the knowledge, expertise and (importantly) authority and leaderships of both organisations (clinical and democratic) has the potential to significantly increase the effectiveness of commissioning across the city.

22.	Financial benefits from integrated commissioning will be delivered in a number of ways including: • Economies of scale and benefits accruing from integrated services • Enhanced market and local economic development arising from more opportunities to invest at scale in health and care private, social enterprise and voluntary and community provision. • Agreed efficiency savings arise from better understanding of activity, unit costs and reduced variation.
	Consultation and engagement
23.	A Steering Group with representatives from the council's Cabinet and lead officers and executive officers from the CCG Governing body reviewed the outcomes from the options appraisal as well as feedback from one to one interview discussions with Members, clinicians and stakeholders. Feedback which has been reflected in the final proposal in this report, included: • do not want to move backwards and undo progress made by integrated commissioning (ICU) • agreed further integration is the correct direction of travel, to deliver better outcomes for citizens and financial stability • current governance structures constrain the pace and quality of decisions. • enabling cultural differences between the organisations to be narrowed through mutual trust whilst retaining control within each organisation. • define 'red lines' – the areas of control that would need to remain for the council and the CCG. • need to define clear metrics for further integration – the measures of success and the degree to which each option can achieve these and selection by Parliament for Southampton to be one of a handful of councils to test this.

RESOURCE IMPLICATIONS

Capital/Revenue

24. The current 2017/18 value of the Better Care Section 75 pooled budget resources is:

Scheme	CCG £'000	SCC £'000	Total £'000
Carers	1,240	134	**1,374**
Clusters	47,026	2,212	**49,238**
Rehab & Reablement	10,543	4,551	**15,094**
Capital		1,882	**1,882**
Joint Equipment Store	798	803	**1,601**
Telecare		250	**250**
Direct Payments		500	**500**
Long Term Care		2,750	**2,750**
Integrated Care Teams	9,894	16,414	**26,308**
Prevention & Early Intervention		6,199	**6,199**
Total	**69,501**	**35,695**	**105,196**

CCG Savings (QIPP) schemes impacted by Integrated Commissioning:	
Working Age Adults Non-Elective Admissions	548
Older people falls and Ambulatory Care Sensitive admiss	61
Rehab/Supported discharge	702
Case Management	1,013
	2,324

Property/Other

25. Not applicable

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

26. Children and Families Act 2014 – emphasises that a local authority in England and its partner commissioning bodies must make arrangements ("joint commissioning arrangements") about the education, health and care provision to be secured

27. Care Act 2014 establishes requirement for integration of care and health by 2020

NHS Five Year Forward View 2014 which outlines the future direction for the NHS which requires new partnerships in how care is delivered breaking down barriers between health and social care with more integrated approaches and with patients having far greater control over their own care

Other Legal Implications:

28. Changes will be required to the Executive Scheme of Delegation, Officer Scheme of Delegation, Member and Officer Codes of Conduct, Partnership Protocols, Financial and contract procedure Rules, Decision making protocols and standards and the creation of an Inter Authority Agreement, information sharing and information governance protocols, conflict resolution procedures and protocols as well as terms of reference for any new Board established. Changes will only be made following consultation with the Leader and Group Leaders. Changes to Financial Procedure

	Rules will at this time be limited to authorising an increase in individual Cabinet Member authority to spend up to £2M and only when all 3 Cabinet Members on the Board are in agreement.
POLICY FRAMEWORK IMPLICATIONS	
29.	The scope of integrated commissioning fully supports the achievement of priorities in the Council Strategy, and in particular, children and young people in Southampton get a good start in life, people in Southampton to live safe, healthy, independent lives. These are also the basis of the Southampton Better Care plan. They also form the core of the CCG operating plan and Southampton City Local Delivery System Plan 2017-19 where key priorities include: • Prevention and Earlier intervention – deliver a radical upgrade in prevention, early intervention and self-care • Better Care Southampton • Mental health – improve the quality, capacity and access to mental health services • Children and maternity – improve local services for children, young people and women.
30.	Integration and Better Care Fund Policy Framework 2017 – local areas have to set out in Better Care Fund returns for 2017-19 how they expect to progress to further integration by 2020. Policy Framework has been developed by the Department of Health (DH), Department for Communities and Local Government (DCLG), Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), and NHS England.
31.	The proposals above help the city to realise the Local Government Association's eight principles for effective health and care commissioning.

KEY DECISION?	Yes	
WARDS/COMMUNITIES AFFECTED:	All	
SUPPORTING DOCUMENTATION		
Appendices		
1.	Draft terms of Reference including the scope	
Documents In Members' Rooms		
1.	None	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessments (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.		Yes/No
Other Background Documents **Equality Impact Assessment and 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.		
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Appendix 1

DRAFT Terms of Reference for the Joint Commissioning Board

1. Introduction

1.1. Southampton City Council and Southampton City Clinical Commissioning Group have developed a shared ambition for change *'Integrated Health and Wellbeing Commissioning allows the city to push further and faster towards our aim of completely transforming the delivery of care in Southampton, so that it is better integrated, delivered as locally as possible, person centred and with an emphasis on prevention and intervening early to prevent escalation'.* For the purpose of these Terms of Reference, Health and Wellbeing is defined as Health and Care services outlined in the scope Annex A.

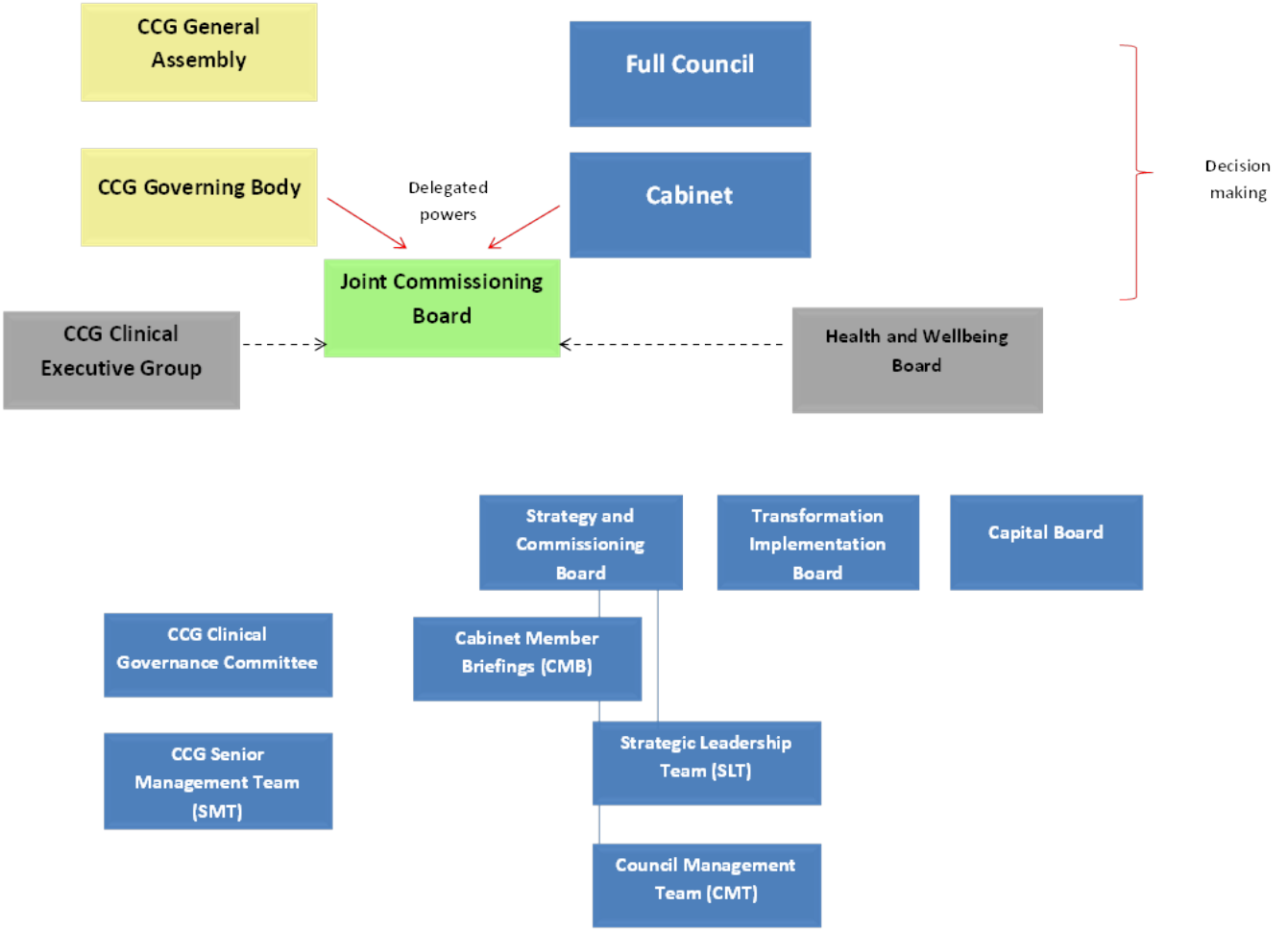
If we are to realise this vision and meet the challenges we face then we will need to

- Act as one for the city by
  - developing and delivery a single view of the city's needs and how we can ensure they are best met
  - aligning and allocating our collective resources to achieve prioritised outcomes
  - working for the whole population
- Support people to become more independent and do things for themselves by changing the relationship between citizens and services
- Be innovative and have an appetite for risk to make the change
- Make the most of new opportunities and powers
- Build on our existing good work
- Ensure that the system is financially sustainable and flexible enough to meet current and future challenges.

1.2. There are a number of benefits from integrated commissioning that have been grouped under three broad headings

1. **Using integrated commissioning to drive provider integration and service innovation**. It is through these innovations that integrated commissioning has the greatest potential to benefit citizens and patients.
2. **Improving the efficiency of commissioned services**. This includes both streamlining process and reducing duplication and variation. This is particularly relevant for services/providers working across both commissioning organisations.
3. **Increasing the effectiveness of commissioning – across the whole of the commissioning cycle.** Combining the knowledge, expertise and importantly authority and leaderships of both organisation (clinical and democratic) has the potential to significantly increase the effectiveness of commissioning across the City.

1.3. The Council and CCG have therefore established a Joint Commissioning Board to commission health and social care in the City of Southampton. It will encourage collaborative planning, ensure achievement of strategic objectives and provide assurance to the governing bodies of the partners of the integrated commissioning fund on the progress and outcomes of the work of the integrated commissioning function. The Joint Commissioning Board hereafter will be referred to as the Board



1.4. The Board will act as the single health and wellbeing commissioning body for the City of Southampton and a single point for decision makers. The Board will convene and exercise their functions following consensus / consultation with each other on those functions as defined in Annex A. This includes those areas of health and social care commissioning covered by the Better Care Fund Section 75.

1.5. The CCG Governing Body and SCC Cabinet may grant delegated authority (with any appropriate caveats) to those of its members or officers participating in the Board to make decisions on their behalf, whilst retaining overall responsibility for the decision made by those members or officers. It is therefore the individual member or officer who has the delegated authority to make a decision rather than the Joint Commissioning Board itself.

1.6. It is proposed that the scope of the integrated commissioning arrangements overseen by the new Board will be broadly as described below.

1.7. The Board will have oversight of all schemes established under the Better Care Section 75 and other remaining Partnership Agreements which in some cases may have their own specific Partnership Board, under the NHS Health Act 2006 flexibilities, and Local Government Act 1972 (s.113). This will include shadow monitoring of schemes under development and scrutinising their suitability for future inclusion in the BCF Partnership Agreement or other Partnership Agreements. A list of the schemes

included and planned for the Better Care Section 75 Partnership Agreement can be found at Appendix A.

1.8. The Board has been established to ensure effective collaboration, assurance, oversight and good governance across the integrated commissioning arrangements between Southampton City Council and Southampton City CCG.

1.9. As such, the Board will develop and oversee the programme of work to be delivered by the Integrated Commissioning Unit and review and define the integrated commissioning governance arrangements between the two bodies.

1.10. The Board will monitor the performance of the integrated commissioning function and ensure that it delivers the statutory and regulatory obligation of the partners of the Better Care Fund.

1.11. Evidence based commissioning will be key to achieving our vision and the Board will be informed and driven by needs assessment, market analysis, user experiences, consultation and engagement.

2. Scope

2.1. The scope of the Board will cover joint NHS and City Council services commissioned by the Integrated Commissioning Unit. The scope is outlined in Annex A.

2.2. The Board may, where appropriate, develop a wider range of services subject to final approval of the CCG Governing Body and Council

2.3. Subject to the agreement of the CCG Governing Body and the Council, the Board membership may be amended to include any other partner who jointly commissions with the City Council or Southampton City Clinical Commissioning Group and other agency representatives may be co-opted as necessary.

3. Role and Objectives

3.1. To agree shared commissioning priorities for the Council and CCG based on where a partnership approach will improve outcomes and promote greater efficiencies.

3.2. To approve and monitor the development and implementation of the Integrated Commissioning Plan to ensure it meets agreed priorities, objectives, savings and performance targets and aligns commissioning arrangements with partners' financial and business planning cycles.

3.3. To ensure that all commissioning decisions are made in line with the principles set out in the Integrated Commissioning Strategy.

3.4. To monitor the financial plans and financial performance of the integrated commissioning function, including forecasts for the year.

3.5. To ensure compliance with any specific reporting requirements associated with the formal pooled fund described in the Section 75 agreement.

3.6. To ensure compliance with rules and restrictions associated with any other blocks of funding, including specific grant funding.

3.7. To ensure management response to risks identified and the assurances against them regarding the integrated commissioning function.

3.8. To agree, subject to the financial decision making limits of the council and the CCG, all financial planning commitments across areas of integrated commissioning responsibility for pooled or non-pooled budgetary provision.

3.9. To receive and consider reports on service development, budget monitoring, audit and inspection reports in relation to those services which are the subject of formal partnership arrangements.

3.10. To set priorities for and review the performance of the Integrated Commissioning Unit on behalf of Southampton City Council and Southampton City CCG.

3.11. To seek assurance on the quality and safety of commissioned services in relation to key performance indicators and standards. Where performance is outside of expected threshold to receive exception reports.

3.12. To provide system leadership and direction to the staff of the integrated commissioning function.

3.13. To promote quality and identify how the health and wellbeing strategic intentions and priorities of partners will be supported and enabled through integrated commissioning.

3.14. To maintain oversight of the s.113 arrangements between the two organisations.

4. Better Care Section 75 Partnership Agreement

4.1 With specific reference to the Better Care Section 75 Partnership Agreement, the Joint Commissioning Board:

4.2 Shall oversee and review the schemes established under the Better Care S75 Partnership Agreement, ensuring adherence to the relevant legislation and protocols in the development of Partnership Agreements have been followed.

4.3 Shall receive, review and approve Business Cases for new pooled fund schemes to be established under the Better Care Section 75 Partnership Agreement (with reference to the respective Schemes of Delegation).

4.4 Shall receive and review quarterly reports on each Better Care pooled fund scheme on the exercise of the partnership arrangements. These reports shall include details of:

- Annual forward financial plans setting out the projected annual spend
- Review of the operation of each scheme covering:
  - evaluation of performance against agreed performance measures targets and priorities and future targets and priorities;
  - quality of service delivery and how the arrangements benefit and meet the needs of client groups;
  - any service changes proposed;
  - any shared learning and opportunities for joint training;
  - assurance that monitoring and evaluation processes take account of statutory guidance and policy directives pertaining to quality standards, best value and audit arrangements of the Council and the CCG.

4.5 Shall ensure the Services provided under each scheme are meeting the needs of the service users and their carers.

4.6 Shall ensure that commissioning decisions are the result of the wide ranging consultation and discussion with the key people involved in all aspects of the function of delivering joined up health and social care.

4.7 Shall encourage and ensure that service providers work collaboratively with service users, other providers and commissioners and that it is promoted through positive design of payment packages and risk and benefit share arrangements into commissioning contracts.

4.8 Shall ensure that commissioners listen to service users and providers and respond supportively to ideas to make services more effective for the user and more responsive to needs.

4.9 Shall assess and manage any liabilities or risks reported in relation to each of the Better Care pooled fund schemes and act upon these at the earliest opportunity and monitor their impact throughout the delivery of the services. This shall include consideration of proposed changes to the services and funding and how these may impact on each organisation.

4.10 Shall monitor financial contributions of the Council and the CCG and make recommendations regarding future financial contributions.

4.11 Shall provide the Council and CCG with an annual review report and forward plan of the S75 Better Care Partnership Agreement arrangements, incorporating financial and activity performance, risks, benefits and evidence of improvements for service users.

5. Risk Sharing principles

5.1. The pooled budget arrangements will be managed in such a way as to avoid destabilising either organisation.

5.2. Each organisation will retain responsibility for dealing with any deficit it has at the start of the pooled budget arrangement.

5.3. Each organisation will strive to achieve a balanced budget within the pooled budget.

5.4. The statutory requirements of each organisation must be maintained.

5.5. The pooled budget will contain a mechanism for dealing with significant changes to the funding or statutory responsibilities of either organisation that effect the areas on scope of the pooled budget arrangement.

5.6. The mechanism should be transparent and as simple as possible.

5.7. Both organisations will develop an appropriate Inter Authority Agreement (IAA) to include a financial management agreement which will feed into the corporate governance arrangements of each partner organisation and provide robust management information.

5.8. Both organisations will agree a mechanism for the early identification of potential in year under or over spends and for remedial actions to be put into place.

6. Governance and Reporting

6.1. The Board will be accountable to the Council's Cabinet and / or Council as appropriate and the CCG Governing Body. It will work in partnership with the Health and Wellbeing Board and the CCG Clinical Executive Group.

6.2. The Board will need to demonstrate contribution to the Health and Wellbeing Strategy outcomes

6.3. The Board will need to be informed by the JSNA, needs assessments, market analysis and feedback from consultation and engagement with residents and patients.

6.4. The Board will meet monthly and be minuted. Where items require decision by a Member or Officer of the Council the requirements of the Local Government Act 2000 in relation to publication of Forward Plans, Agendas, reports and Decision Notices will be fully complied with.

6.5. At least one meeting each quarter will be dedicated to reviewing the performance of the Better Care S75 Partnership Agreement, undertaking those responsibilities as set out in above.

6.6. The Board shall be entitled to call a meeting, at any time, outside of the agreed meetings schedule, for any purpose, subject to compliance with any statutory requirements in relation to decision making under the Local Government Acts and CCG Constitution.

6.7. All minutes and papers from the Board will be reported to the CCG Governing Body and made available to Council's Cabinet.

6.8. Agendas will be jointly agreed in line with the Forward Plan and will need to be circulated at least 5 working days in advance of the meeting. All new agenda items are subject to agreement of the Chair or Vice Chair. Where a decision of the Council (Member or Officer) is required at a Board meeting then the requirements of the Local Government Act 2000 and Access to Information regulations must be adhered to (publication of notice of key decisions 28 days in advance, publication of reports 5 clear working days in advance, formal decision Notice signed by decision maker and Proper Officer (Democratic Services must attend for this purpose for these items). Decisions that are 'key decisions' within the meaning of the Local Government Act 2000 are subject to the Council's 'call-in' procedures and cannot be implemented until the time for call-in has expired or the matter has been dealt with in accordance with Overview & Scrutiny Procedure Rules.

6.9. The agendas, minutes, decision notices and briefing papers of the meetings of this Board are subject to the provisions of the Freedom of Information Act 2000, the Environmental Information Regulations and the Data Protection Act 1998. If the Chair concludes that specific issues are exempt from publication and should not be made available under the terms of the Freedom of Information Act, a Part 2 meeting of the Board shall be convened to consider them.

6.10. Part 2 meetings have to be notified 28 days in advance of the meeting and reasons for excluding the public included on the report / agenda item or the decision cannot be taken. There are limited urgency provisions but these require prior consent from the chair of the Health Overview and Scrutiny Panel.

6.11. Meetings of the Board shall be advertised in advance on the calendar of meetings of the CCG Governing Body and Council and shall, unless notice of consideration of an excluded item has been given, shall be open to the public to attend from April 2018.

6.12. The Chair will invite questions or statements by members of the public on matters pertaining to that agenda at the beginning of the meeting.

6.13. Administrative support for the Board will be a shared responsibility although agenda publication etc. will be undertaken by the Council.

6.14. The Health and Wellbeing Board will delegate responsibility for Better Care to the Board and the Board will be accountable to the Health and Wellbeing Board for this element.

7. Membership

7.1. The council's representation on the Joint Commissioning Board will be 3 Cabinet Members made through executive appointments, similar to the membership of the Health and Wellbeing Board. The CCG will similarly nominate 3 members from the CCG Governing Body. Both partner organisations will agree a scheme for the appointment of substitute members or nominated deputies at the inaugural meeting of the Board.

7.2. **Other attendees**

- Key senior managers from the Council and the CCG as required.
- The relevant commissioning lead for each of the pooled budgets under the S75 Better Care Partnership Agreement will attend as appropriate the quarterly meetings to present the performance report for the S75 Partnership Agreement.

7.3. The Chair will be a politician from the council or a member from the CCG Governing Body who will rotate on an agreed basis. The Vice Chair of the Board will be from the alternate partner organisation.

8. Quorum, Decision Making and Voting

8.1. The Board will require consensus prior to any delegated decisions being taken; consensus will be demonstrated by a show of hands. It is important that given the nature of the decisions, securing the support of both partners will be critical to the success of this Board. The Board will be quorate if there are at least 4 members in attendance with a minimum of 2 from each.

8.2. In those circumstances where consensus cannot be reached, the matter will be deferred for further consideration by the parties and will be reconsidered after discussions between the Chair and respective partner lead.

8.3. Schemes of Delegation to City Council Members and Council Officers shall be amended to reflect that decisions should not be taken under delegation and should stand either deferred to a future meeting or referred back to the parent body where a consensus of those present do not support the decision proposed. The Chair of the Board shall consult those present before deferring the decision or directing that it be referred back to each partner organisation.

8.4. Legally, it is not possible to have a mechanism that requires individual decision makers to exercise their decision making function in accordance with the will of a majority or quorum of a Board. Any individual decision maker must consider any decision on its

merits as a whole in accordance with established decision making principles. The process for seeking the support of the Board prior to exercising any delegation meets a requirement in the Scheme of Delegation to limit the power to exercise that delegation to situations only where the support of the Board is demonstrated.

8.5. Functions outside the decision making scope of the Board, but related to health and social care will be discussed for information only at the Board, with the considerations and any recommendations of the Board formally minuted. Items will then be referred to the relevant decision maker (e.g. CCG Governing Body, Council).

9. Dispute Resolution

9.1. If disputes relating to the Better Care Section 75 Partnership Agreement arise then the Dispute Resolution process within that will be followed. Otherwise any matter of dispute will be referred for further discussion by the Leader of the Council and Chair on behalf of the CCG before referring back to the Board for further consideration. It is recognised that as the desire is to reach agreement on any matter by consensus that if this is not reached that matter may not move forward. There will be no formal and binding external arbitration procedure.

10. Scrutiny

10.1 Decisions of members of the Joint Commissioning Board will be subject to formal scrutiny normally undertaken by the Health Overview and Scrutiny Panel, on behalf of the Council and Call in. Health scrutiny is a fundamental way by which democratically elected councillors are able to voice the views of their constituents, and hold NHS bodies and health service providers to account. In Southampton the Health Overview and Scrutiny Panel undertakes the scrutiny of health and adult social care. The Panel meets every 2 months. However, there may be some major decisions may be considered by the council's Overview and Scrutiny Management Committee.

11. Conflict of Interests

11.1. The Board will be bound by the Standing Orders/Standing Financial instructions and Codes of Conduct of both parent bodies. Declaration of interests will need to be declared annually and at each meeting of the Board in line with the agenda. Depending on the topic under discussion and the nature of the conflict of interest appropriate action will be taken and recorded in the minutes

12. Variation

12.1. The parent bodies may agree from time to time to modify, extend or restrict the remit of the Board.

12.2. The Terms of Reference will be reviewed in March 2018 or sooner at the request of the Chair or Vice Chair.

Annex A

Integrated Commissioning – Potential scope

1. For the first year, it is proposed that the scope of the integrated commissioning arrangements overseen by the new Board will be broadly mirror those areas of health and social care commissioning covered by the Better Care Fund Section 75.

2. As is currently the case, the assumption is that some of the services in scope will be jointly funded and jointly commissioned under a S75 or S256/76 arrangement (primarily through the Better Care Fund S75 Agreement).

3. However there will also be services in scope for which the commissioning responsibility/ decision making remains solely with the CCG or City Council but the funding is aligned to deliver a jointly agreed strategy.

4. Beyond this, there could be areas of shared commissioning where the Council and CCG will want to discuss and share information about relevant commissioning intentions, budget and spend. The Board could also consider bids that are of joint interest. These 3 categories are described below:
   - Jointly commissioned/funded services
   - Single agency commissioning aligned under a jointly agreed strategy
   - Other areas relevant for the achievement of the outcomes

<u>Jointly commissioned/funded services</u>

5. These will be services currently in scope for the 2017/19 Better Care Fund S75 agreement. In addition, the scope will include other existing partnership agreements/shared funding arrangements:
   - Integrated Services within the established 6 Better Care Clusters: Community health services for adults (Community Nursing, Continence, Podiatry, Community Wellbeing Services, Community specialist services for people with long term conditions, case management, Palliative Care, community navigation, Community Adult Mental Health Services and IAPT (Improving access to psychological therapies) , Adult Long Term Social Care Teams)
   - Support Services for Carers
   - Integrated rehabilitation, reablement and discharge services (including the Hospital Discharge Team, Discharge to Assess, residential reablement and extra care, Falls Assessments)
   - Care Technology
   - Prevention and Early Intervention services – Behaviour Change, Older Person's Offer, Information, Advice and Guidance
   - Integrated Learning Disabilities provision (placements)
   - Direct Payments Support services
   - Transformation of Long Term Care provision (Adult Social Care additional/improved BCF funding to support transformation of Extra Care and conversion of a Residential Unit to Nursing Care as well as stabilising the Domiciliary Care and Care Home market)
   - Joint Equipment Service, Wheelchair Service, Orthotics and Disabled Facilities Grant
   - Integrated services for children with complex health needs (specifically Building Resilience Service and SEND integrated health and social care team).

Single agency commissioning aligned under a jointly agreed strategy

6. This would mean that commissioning responsibility/ decision making remains solely with the CCG or City Council but the funding is aligned to deliver a jointly agreed strategy. This could include:
    - Long Term Care provision (including domiciliary care, nursing and residential CHC and social care packages) – aligned to Better Care strategy
    - 0-19 prevention and Early Help, CAMHS, Community midwifery – aligned to 0-19 prevention and early help strategy/CAMHS Transformation
    - Sexual health (integrated level 3 service, voluntary and primary care prevention services, termination of pregnancies, vasectomies) – aligned to Sexual Health and Reproductive Strategy
    - Substance Misuse Services – aligned to Substance Misuse Strategy
    - Respite and Short Breaks – aligned to Replacement Care Strategy, services for children, e.g. Edge of care, Family Drugs and Alcohol Court, Looked After Children, Safeguarding – aligned to children's strategy
    - Community development (definition to be agreed)

Benefits

7. The scope will increase the ability of both organisations to:
    - Realise a shared vision – e.g. a shared focus on prevention and early intervention and community solutions to promote independence & a shared commitment to realise it
    - Share risks and benefits associated with implementation of the shared vision, enabling us to do the "right thing" without unfairly disadvantaging or advantaging one organisation
    - Commission against a single agreed set of common outcomes and priorities – making best use of resources
    - Share needs data and good practice evidence – leading to more intelligent commissioning
    - Develop more innovative solutions to meet people's needs in the round (as opposed to commissioning in silos for people's "health" versus "social" needs – leading to improved outcomes for people
    - Bring together health, public health and social care resources and strip out duplication – leading to savings and efficiencies
    - Commission a more joined up health and care system, developing together whole pathways from prevention to care - fewer gaps
    - Enable providers to develop more innovative integrated pathways and organisational models – leading to less fragmentation
    - Shape and develop primary medical care as part of the integrated health and social care system
    - Better understand and manage demand through greater influence over assessment and review processes

DECISION-MAKER:		**HEALTH AND WELLBEING BOARD**		
SUBJECT:		**HEALTH AND WELLBEING BOARD FREQUENCY**		
DATE OF DECISION:		**14TH MARCH 2018**		
REPORT OF:		**DIRECTOR OF PUBLIC HEALTH**		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Felicity Ridgway** **Service Lead – Policy, Partnerships and Strategic Planning**	**Tel:**	**023 8083 3310**
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STATEMENT OF CONFIDENTIALITY		
NOT APPLICABLE		
BRIEF SUMMARY		
This report sets out a proposal for the Health and Wellbeing Board to review the frequency of meetings, following the establishment of the Joint Commissioning Board. The establishment of a Joint Commissioning Board was agreed by Cabinet and Council in July 2017 to ensure effective collaboration, assurance, oversight and good governance across the integrated commissioning arrangements between Southampton City Council and Southampton City CCG.		
RECOMMENDATIONS:		
	(i)	To review the frequency of Health and Wellbeing Board meetings.
	(ii)	To agree that the frequency of the Health and Wellbeing Board will be confirmed as part of the Council's Constitutional Review at the May AGM.
REASONS FOR REPORT RECOMMENDATIONS		
1.	The Health and Wellbeing Board's function (as set out by the Department of Health) is "to build strong and effective partnerships, which improve the commissioning and delivery of services across NHS and local government, leading in turn to improved health and wellbeing for local people".	
2.	In Southampton, much of this function will now be led by the Joint Commissioning Board whose purpose is "to be accountable for effective collaboration, assurance, oversight and good governance across the integrated commissioning arrangements for health and care between Southampton City Council and Southampton City CCG". There is therefore a need to review the current arrangements for the Health and Wellbeing Board.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		

3.	To not review or reduce the frequency of Health and Wellbeing Board meetings. This has been considered and rejected as the statutory duties of the Health and Wellbeing Board can be met with less meetings.
DETAIL (Including consultation carried out)	
4.	The establishment of the Southampton Joint Commissioning Board was agreed by Cabinet and Council in July 2017. The Joint Commissioning Board is now in place, and has the role of ensuring effective collaboration, assurance, oversight and good governance across the integrated commissioning arrangements for health and care between Southampton City Council and Southampton City CCG. The scope of the integrated commissioning arrangements broadly mirror those areas of health and care commissioning covered by the Better Care Fund S75, plus other existing partnership agreements/shared funding arrangements. Therefore, the new commissioning arrangements for the city through the Joint Commissioning Board have an impact on the role of the Health and Wellbeing Board.
5.	As part of the agreement to set up a Joint Commissioning Board, it was agreed that the Health and Wellbeing Board should be reviewed, to ensure that that its role is clear alongside the Joint Commissioning Board. This review should also consider the frequency of the meetings.
6.	The Health and Wellbeing Board currently meets 6 times per year, bimonthly. The proposal is to reduce the frequency of meetings of the Health and Wellbeing Board now that the Joint Commissioning Board has been established.
7.	Subject to agreement of the Health and Wellbeing Board, the Chair will review the appropriate frequency of future Health and Wellbeing Board meetings, and confirm the frequency at the Council's AGM in May 2018 as part of the Council's Annual Constitutional Review. In making this assessment, the Chair will take into account and ensure that all statutory functions of the Health and Wellbeing Board are met.
RESOURCE IMPLICATIONS	
Capital/Revenue	
8.	None
Property/Other	
9.	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
10.	The Health and Social Care Act 2012 contains a number of duties that the Health and Wellbeing Board must meet: a) To encourage integrated working commissioners of health and social care services b) To prepare and publish the Joint Strategic Needs Assessment c) To prepare and publish the Health and Wellbeing Strategy d) To assess needs for pharmaceutical services in its area and publish a statement (Pharmaceutical Needs Assessment) e) To consider and advise the CCG on whether the Better Care Plan has taken account of the Health and Wellbeing Strategy

	f) To review the extent to which the CCG has contributed to the Health and Wellbeing Strategy.
11.	The Health and Wellbeing Board also have a duty to make a representation to NHS England on consolidation applications of community pharmacies in its area (i.e. where pharmacy businesses on two or more sites propose to consolidate to a single existing site). This duty was delegated to the Director of Public Health in a decision of the Board 26th July 2017, and the Director of Public Health will raise any consolidation applications with the Board as required.
Other Legal Implications:	
12.	The Terms of Reference for the Health and Wellbeing Board do not set out the frequency of the meetings, and therefore no changes to the Terms of Reference are required.
RISK MANAGEMENT IMPLICATIONS	
13.	**None**
POLICY FRAMEWORK IMPLICATIONS	
14.	**None**

KEY DECISION?	**No**
WARDS/COMMUNITIES AFFECTED:	**All**
SUPPORTING DOCUMENTATION	
Appendices	
1.	

Documents In Members' Rooms

1.	
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.		

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