Public Document Pack

# Health and Wellbeing Board

**Tuesday 18 January 2022**
**at 5.30 pm**

**Please note: This will be a virtual meeting, a link to which is available on Southampton City Council's website.**

**In light of the current Covid Omicrom variant surge this meeting will now be held virtually via Microsoft Teams. As a matter of law to be a legally constituted meeting it must be held physically. As it is not considered reasonable to do that at the moment it is being treated as a consultation meeting. Council officers will then take decisions under delegated powers to decide on matters on the committee's agenda after having due regard to the committee's views and recommendations.**

This meeting is open to the public

**Members**

Councillor P Baillie

Councillor Fielker

Councillor Stead

Councillor Streets

Councillor White

Debbie Chase – Director Of Public Health

Guy Van Dichele - Executive Director Wellbeing (Health and Adults)

Robert Henderson – Executive Director Wellbeing (Children and Learning)

Rob Kurn – Healthwatch

Dr Shahed Ahmad - Medical Director,Hampshire Thames Valley, NHS England South East Region

Dr Sarah Young - NHS Southampton Clinical Commissioning Group,

**Contacts**
Pat Wood
Democratic Support Officer
Tel: 07385 416481
Email: pat.wood@southampton.gov.uk

## BACKGROUND AND RELEVANT INFORMATION

### Purpose of the Board

The purpose of the Southampton Health and Wellbeing Board is:

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

**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

**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.

**Southampton: Corporate Plan 2020-2025** sets out the four key outcomes:

- Communities, culture & homes - Celebrating the diversity of cultures within Southampton; enhancing our cultural and historical offer and using these to help transform our communities.
- Green City - Providing a sustainable, clean, healthy and safe environment for everyone. Nurturing green spaces and embracing our waterfront.
- Place shaping - Delivering a city for future generations. Using data, insight and vision to meet the current and future needs of the city.
- Wellbeing - Start well, live well, age well, die well; working with other partners and other services to make sure that customers get the right help at the right time

**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; and Ensuring safety in improving health and wellbeing outcomes

**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 2021/2022**

| |
|---|
| 1 September 2021 |
| 15 December 2021 |
| 2 March 2022 |

## 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 6th October 2021 and to deal with any matters arising, attached.

## 5 PHARMACEUTICAL NEEDS ASSESSMENT REFRESH

Report of the Cabinet Member for Health and Adult Social Care detailing the process to deliver the Board's statutory requirement to publish a Pharmaceutical Needs Assessment for Southampton

## 6 COVID-19 HEALTH IMPACT ASSESSMENT

Report of the Cabinet Member for Health and Adult Social Care outlining the impact of the COVID-19 pandemic on the health of the Southampton population

## 7 HEALTH AND WELLBEING BOARD MEMBERSHIP

Report of the Cabinet Member for Health and Adult Social Care seeking views on the future membership of the Health and Wellbeing Board

## 8 BID TO BECOME UK CITY OF CULTURE 2025

To provide the Health and Wellbeing board with an overview of the process to become UK City of Culture 2025 and the work associated with this.

## 9 PROPOSAL TO CREATE A NEW COMBINED TOBACCO, ALCOHOL AND DRUGS STRATEGY

Report of the Cabinet Member for Health and Adult Social Care seeking approval to proceed with the development of a new 5-year Tobacco, Alcohol and Drugs strategy

## 10 BETTER CARE FUND NARRATIVE PLAN AND TEMPLATE 2021/2022

Better Care Fund narrative plan and template submitted to HWBB for sign off as required by the policy and planning guidance published on the 30th of September 2021. Delegated authority provided by the Chair, as per guidance, to allow submission on the 16th of November ahead of HWBB.

Tuesday, 7 December 2021 Service Director – Legal and Business Operations

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HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 6 OCTOBER 2021

Present: Councillors P Baillie, Fielker, Streets, Stead and White
Rob Kurn, Debbie Chase, Robert Henderson, Guy Van-Dichele and Dr Sarah Young

10. **APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)**

The Board noted that Councillors P Baillie, Fielker, Stead, Streets and White were appointed as members of the Board at Cabinet on 15 June 2021.

11. **ELECTION OF CHAIR AND VICE-CHAIR**

**RESOLVED**

(i) that Councillor White be elected as Chair for the Municipal Year 2021/22; and
(ii) that Councillor Fielker be elected as Vice-Chair for the Municipal Year 2021/22.

12. **STATEMENT FROM THE CHAIR**

The Chair explained the need for the meeting to be held virtually due to key officers having Covid and as a committee under the LGA 1972 it was caught by the court ruling earlier this year ie it can only make decisions in person. Therefore any decision taken at the meeting would need to be ratified at the next scheduled Health and Wellbeing Board meeting.

The Chair read a briefing paper explaining the role of the Health and Wellbeing Board and stating that the Southampton Covid 19 Local Outbreak Engagement Board was now included in its remit.

The Chair stated that an extra meeting would be required in March 2022 to take account of the Pharmaceutical Needs Assessment and it was agreed that this would be scheduled for 2 March 2022.

It was acknowledged that there was a need to review the membership of the Board. It was agreed that a report would be brought to the December 2021 meeting which would also clarify the quorum and the need for multiple people in each area to ensure any future meeting was quorate.

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

**RESOLVED** that the minutes of the Health and Wellbeing Board meeting held on 17 June 2020 and the Local Outbreak Engagement Board meeting held on 7 June 2021 be approved and signed as a correct record.

14. **COVID-19 UPDATE AND HEALTH IMPACT**

The Board received and noted the report of the Cabinet Member for Health and Adult Social Care outlining activity in response to Covid 19 and the impact of the pandemic on health.

The Board heard that the Covid booster programme was about to start in the city and encouraged everyone to take up the offer of a vaccination. It was acknowledged how well agencies and voluntary sectors had worked during the past 18 months.

It was agreed that a report would be brought to the December 2021 Board meeting outlining the covid impact on other aspects of health and highlighting what had gone well/not so well to allow learning for the best way forward. There was a request that the report showed the population growth in the city and also the impact of long covid.

15. **HEALTH AND WELLBEING STRATEGY UPDATE**

The Board considered the report of the Cabinet Member for Health and Adult Social Care outlining progress against the Health and Wellbeing Strategy 2017-2025.

It was acknowledged that in refreshing the strategy, it was important to be data driven and focussed on a few priorities, such as the health of children, rather than spreading the work too thinly.

**RESOLVED**

(i) That progress against the Health and Wellbeing Strategy, including the current dashboard of outcomes, be noted;
(ii) That the Board re-commit to the promotion and implementation of the strategy;
(iii) That the Board scale up work to embed Health in all policies and to optimise the role of Anchor institutions, including role modelling good practice for staff health and wellbeing, to address longer term health inequalities across the city; and
(iv) That the Board continue a multi-faceted approach to reducing health inequalities and improving health. Other high-impact priorities for the next year were Covid 19 response and recovery, protecting a good start in life, all age mental health and reducing smoking prevalence.

16. **HEALTH AND CARE SYSTEM CHANGES - UPDATE ON THE DEVELOPMENT OF HAMPSHIRE AND ISLE OF WIGHT INTEGRATED CARE SYSTEM**

The Board considered the report of the Managing Director, Hampshire, Southampton and Isle of Wight CCG (Southampton) providing an update on the development of Hampshire and the Isle of Wight Integrated Care System (ICS). By April 2022 the new ICS would be a legal entity and would bring together NHS Commissioners, providers, local authorities and other local partners across a geographical area to achieve collective planning of health and care services to meet the needs of the population.

The Board wished to use the H&WBB to achieve transformation and to build on the existing strong base line.

**RESOLVED**

(i) That progress against the development of the Hampshire and Isle of Wight Integrated Care System be noted; and
(ii) That progress on the proposed Place based governance be noted and that comments raised at the meeting contribute to the model development.

17. **SOUTHAMPTON SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2019-20**

The Board noted the Southampton Safeguarding Adults Board Annual Report 2019/20 which was attached to the agenda for information only.

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| **DECISION-MAKER:** | **Health and Wellbeing Board** |
| **SUBJECT:** | **Pharmaceutical Needs Assessment** |
| **DATE OF DECISION:** | **15 December 2021** |
| **REPORT OF:** | **Cabinet Member for Health and Adult Social Care** |



| **CONTACT DETAILS** | | | | |
|---|---|---|---|---|
| **Executive Director** | **Title** | **Executive Director, Wellbeing (Health & Adults)** | | |
| | **Name:** | **Guy Van Dichele** | Tel: | 023 80 |
| | **E-mail** | **Guy.VanDichele@southampton.gov.uk** | | |
| **Author**: | **Title** | **Consultant in Public Health** | | |
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| **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). This briefing defines what is needed to do this and the steps we are taking to ensure this is in place. | | |
| **RECOMMENDATIONS:** | | |
| | (i) | To note the report |
| **REASONS FOR REPORT RECOMMENDATIONS** | | |
| 1. | To receive a briefing on the Pharmaceutical Needs Assessment which will be undertaken in 2021-22. | |
| **ALTERNATIVE OPTIONS CONSIDERED AND REJECTED** | | |
| 2. | None | |
| **DETAIL (Including consultation carried out)** | | |
| 3. | Access to a pharmacy has an impact on health. Pharmacies are essential for the supply of medications to the population, but also may offer a wide range of other services in the community that promote health, from medication reviews to smoking cessation services. Pharmacies are independent businesses, commissioned by NHS England. | |
| | **What is a PNA and what should it contain?** | |
| 4. | A 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 any perceived gaps in the provision. Once published the PNA will be used by NHS England to assist in responding to applications for opening of additional pharmacies, relocation of premises and amendments to opening hours or pharmaceutical services. | |

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| 5. | The content of PNAs is set out in Schedule 1 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. This states that the PNA must contain:<br>• A statement of the pharmaceutical services provided that are necessary to meet needs in the area<br>• A statement of the pharmaceutical services that have been identified by the HWB as needed in the area, but are not provided (i.e. gaps in provision)<br>• A statement of the other services which are provided, which are not needed, but which have secured improvements or better access to the pharmaceutical services in the area<br>• A statement of the services that the HWB has identified as not being provided, but which would, if they were to be provided, secure improvements or better access to pharmaceutical services in the area<br>• A statement of other NHS services provided by a local authority, the NHS Commissioning Board (NHS England), a Clinical Commissioning Group (CCG) or an NHS Trust, which affect the needs for pharmaceutical services<br>• An explanation of how the assessment has been carried out (including how the consultation was carried out); and<br>• A map of providers of pharmaceutical services.<br><br>These statements will be underpinned by an analysis of the latest data on needs and demography in the city, which will largely be taken from Southampton's JSNA and data observatory but will be reproduced within the PNA document.<br>The PNA will also be accompanied by an Equality Impact Assessment. |
| 6. | Following publication of a PNA, there is an ongoing obligation that the HWB must assess whether pharmacy consolidations (where one pharmacy is bought out by another, and one site closes or reduces its service) create gaps in the provision of pharmaceutical services. There is government guidance published in 2021 outlining this process to support the HWB. |
| | **What is the process for preparing a PNA?** |
| 7. | Development of the draft PNA will be guided by a steering group, led by a consultant in public health, which includes representatives from NHS England and the Local Pharmaceutical Committee (now known as Community Pharmacy South Central). The steering group will be joint across Southampton, Portsmouth, Hampshire and the Isle of Wight as all four authorities need to produce a PNA to the same timescale.<br>Engagement with local CCG representatives and with Southampton's Healthwatch will be done outside of the HIOW steering group.<br>A small working group of Public Health officers and analysts will map current pharmacy supply and services against data from the JSNA (included within the Southampton Data Observatory) and use this information to draft the PNA document. |
| 8. | There is also a duty (NHS (Pharmaceutical and LPS) Regulations 2013 No 349: Part 2: Reg 8) to have a 60-day consultation during the process, ideally on a draft document. This consultation must include pharmacies, dispensing |

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| | pharmacies, Healthwatch, NHS trusts, NHSE, Neighbouring HWBs, the Local Pharmaceutical Committee, and the Local Medical Committee. |
| 9. | Previous experience suggests 9-12 months is needed for the entire process. The Department of Health and Social Care have stated there is a requirement to have a refreshed document published by 1st October 2022.<br>We will be sharing resources and knowledge across Southampton, Portsmouth, Hampshire and IOW to benefit from economies of scale. |
| | **Will this be straightforward?** |
| 10. | We are hoping the refresh process for the PNA will be relatively straightforward. However, as this contains a 60-day consultation and the associated structures, there is little flexibility on timelines. This structure provides clear guidance on the project and its requirements. Additionally, there are a number of developments within pharmaceutical services that may have an impact on future pharmacy provision. |
| | **Proposed timetable** |
| 11. | **2021**<br>November: Development of contractor questionnaire. Existing data (Observatory, Census, Housing etc.) gathering begins. First steering group meeting. Equalities Impact Assessment begins. Contractor questionnaire distributed.<br>December: Existing data gathering ends, write up begins. Collation of contractor questionnaire results. HWB briefed on process<br><br>**2022**<br>January: Equalities Impact Assessment ends. Draft PNA document written.<br>February: Steering groups meets to approve draft. PNA ready to be taken to HWB.<br>March: HWB approves draft PNA.<br>April 1st: 60-day consultation on draft begins (finishing 31st May)<br>June: Draft PNA taken to local groups for comments.<br>July: Steering Group meet to approve responses, PNA redrafted.<br>August: Statement added to PNA responding to consultation<br>September: HWB approves completed PNA. |
| **RESOURCE IMPLICATIONS** | |
| **Capital/Revenue** | |
| 12. | None |
| **Property/Other** | |
| 13. | None |
| **LEGAL IMPLICATIONS** | |
| **Statutory power to undertake proposals in the report:** | |
| 14. | There is a legal duty to undertake this work as part of the NHS (Pharmaceutical & LPS) Regulations 2013, which result from the amended Health Act 2009. |

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| **Other Legal Implications:** | |
| 15. | None |
| **RISK MANAGEMENT IMPLICATIONS** | |
| 16. | None |
| **POLICY FRAMEWORK IMPLICATIONS** | |
| 17. | None |
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| **KEY DECISION?** | **No** |
| **WARDS/COMMUNITIES AFFECTED:** | All |
| SUPPORTING DOCUMENTATION | |
| **Appendices** | |
| | None |

**Documents In Members' Rooms**

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| | None |
| **Equality Impact Assessment** | |
| **Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.** | **Yes** |
| **Data Protection Impact Assessment** | |
| **Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out.** | **No** |
| **Other Background Documents**<br>**Other Background documents available for inspection at: N/A** | |

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| **Title of Background Paper(s)** | | **Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)** |
| | None | |

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| **DECISION-MAKER:** | **Health and Wellbeing Board** |
| **SUBJECT:** | **COVID-19 Health Impact Assessment** |
| **DATE OF DECISION:** | **15 December 2021** |
| **REPORT OF:** | **Cabinet Member for Health and Adult Social Care** |



| **CONTACT DETAILS** | | | | |
|---|---|---|---|---|
| **Executive Director** | **Title** | **Executive Director, Wellbeing (Health & Adults)** | | |
| | **Name:** | **Guy Van Dichele** | Tel: | |
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| **Author**: | **Title** | **Consultant in Public Health** | | |
| | **Name:** | **Robin Poole** | Tel: | |
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| **STATEMENT OF CONFIDENTIALITY** |
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| None |

**BRIEF SUMMARY**


A COVID-19 Health Impact Assessment has been conducted to highlight emerging direct and indirect health impacts of the pandemic on people living in Southampton. The assessment takes the form of a slide set which is accessible as a separate attachment. The disproportionate impact of direct COVID-19 health effects across different population groups are not yet fully understood nor the scale and impact of the indirect health effects such as delays in diagnoses, elective care, and management of long-term conditions. This also includes the detrimental economic and educational effects known to be powerful wider determinants of health.

This health impact assessment will be used to inform and support prioritisation of specific actions within the Southampton health and wellbeing strategy. Through our learning from local data, evidence and insight, we can ensure that we are doing as much as we can with the resources available to protect and improve the health and wellbeing of the residents of Southampton in COVID-19 recovery over the months and years to come.

Key Points

- Southampton is an ethnically diverse city, with significant pockets of deprivation, and a high burden of chronic disease.
- Clinical vulnerability to COVID-19 infection, vulnerability to acquiring infection, and vulnerability to the impact of policy decisions on managing the pandemic are likely to have been experienced differently across the city.
- Highest age-standardised COVID-19 mortality can be seen in some of our most deprived neighbourhoods. Comparing the 20% most deprived with the 20% least, there are significantly higher age-standardised case rates and hospitalisations in those living in most deprived neighbourhoods across the city.

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| • Existing health inequalities are likely to have been exacerbated by the pandemic but the evidence for this is yet to be fully realised including what the long-term impacts might be.<br>• The direct impacts of COVID-19 infection on health are captured by hospital admissions and deaths; these direct effects are likely to have been experienced differently across different segments of the population. The same is likely to be true for indirect health impacts such as delays in diagnoses or management of long-term conditions and elective care. Evidence for the scale and distribution of these impacts will take time to emerge.<br>• Effects on the wider determinants of health are most evident on the economic and educational impacts; the long-term consequences of these impacts on health and wellbeing are uncertain<br>• There was an increase in the proportion of the working age population who claimed universal credit and in the overall claimant count due to the pandemic response; so far only the claimant count has begun to reduce as the restrictions have eased and the economy has opened up again | | |
| **RECOMMENDATIONS:** | | |
| | (i) | To acknowledge the significant impact of the COVID-19 pandemic on the health of Southampton residents |
| | (ii) | To accept the findings of this initial assessment and recognise that many indirect health impacts are yet to be fully realised including the longer-term impact from the negative economic and educational effects of the pandemic |
| | (iii) | To review the Board's strategy for health and wellbeing in Southampton in light of the findings and to prioritise key areas as highlighted |
| | (iv) | To recommend that the impact of COVID-19 should continue to be assessed as part of the regular Joint Strategic Needs Assessment updates |
| | (v) | To consider how we can best learn more about the lived experiences of Southampton residents across the course of the pandemic to help add depth and greater understanding to what the data is telling us |
| **REASONS FOR REPORT RECOMMENDATIONS** | | |
| 1. | We are in the infancy of our understanding about the direct and indirect impacts of the COVID-19 pandemic on Southampton but they are likely to be substantial. It is important that we recognise what we currently know and continue to monitor data to better understand some of the medium and long-term effects. We can use these early insights to help inform any review of the health and wellbeing strategy. | |
| **ALTERNATIVE OPTIONS CONSIDERED AND REJECTED** | | |
| 2. | N/A | |
| **DETAIL (Including consultation carried out)** | | |
| | **Rationale and objectives** | |
| 3. | The direct health impacts of the coronavirus pandemic on Southampton can be seen from the number of COVID-19 cases, hospitalisations and deaths | |

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| | that have occurred in our city residents over the last 18 months. The indirect health impact from the measures required to control the virus and the way in which different groups of people may have been disproportionately affected requires more detailed investigation. This includes understanding more about where the wider determinants of health have been negatively impacted such as in education and employment/income. |
| 4. | This health impact assessment aims to review what we know so far about the direct and indirect impacts of the pandemic on health in Southampton across different populations, geographic areas and sectors. Where data is available, it aims to explore how health changed against a pre-covid baseline, and how the city responded to the challenge of supporting its residents. Finally, it aims to understand where the city could focus its collective recovery effort to improve health and address health inequalities as we build back fairer and learn to live with COVID-19. |
| | **Methods** |
| 5. | Between August and October 2021, members of the Data, Intelligence and Insight team worked closely with members of the Public Health team to collect and analyse a wide selection of data to inform our understanding of the direct and indirect effects of the pandemic. Local data was included where this was available although many likely impacts can be extrapolated from national findings. Local data used included case rates, hospitalisations, deaths, vaccination, benefit claimants, employment support scheme usage, educational cases and outbreaks, air quality, SCC service indicators and local resident survey results. Impact assessments of COVID-19 from other geographic areas and sectors were also reviewed. |
| 6. | The impact of COVID-19 on some subpopulation groups in Southampton cannot be fully realised at the current time and where there are gaps in our understanding, we need to build further assessments into our future work. For example, understanding the disproportionate impact of COVID-19 on people from minority ethnic groups will only be better understood when the 2021 Census data becomes available next year to understand changes in our population over the last 10 years. |
| 7. | This assessment should be read against these caveats. It will be updated on an ongoing basis as new data are published. |
| | **Key findings** |
| 8. | All parts of Southampton society were affected by the pandemic, either directly by contracting COVID-19 or indirectly through its wider effects, but effects were not felt equally across the city. Modelling of clinical vulnerability to severe infection, vulnerability to acquiring infection, and vulnerability to the policy decisions used to control the pandemic show how many of the already most deprived neighbourhoods were most likely to be most impacted by COVID-19. |
| 9. | There are likely to be short, medium, and long-term impacts of the pandemic. The full impact is still not known and will not be known for many years to come and at present it is not possible to know what the medium and long-term effects will be. |
| 10. | Direct health impacts: |

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| | • There have been 37,919 confirmed cases of COVID-19 and 444 covid-related deaths in people living in Southampton as of the 25th November 2021, and on the 23rd November there were 76 patients in University Hospital Southampton with COVID-19 including 13 requiring ventilation. Age-standardised COVID-19 hospitalisation admission rates are currently only available until May 2021 which showed a higher rate in Southampton residents compared to Hampshire, the South-East and England. In total there were 1,158 COVID-19 hospital admissions in Southampton from the start of the pandemic to May 2021. Age-standardised COVID-19 mortality rates between March 2020 and April 2021 shows Southampton was similar to Portsmouth and the South East average, significantly lower than the England average, but significantly higher than Hampshire and the Isle of Wight.<br>• Comparing the period of the pandemic from March 2020 to October 2021 there were 289 excess deaths than the equivalent average time period from 2015-19. This is less than the total number of COVID-19 related deaths suggesting on average some of these COVID-19 related deaths would have been likely to have occurred for other reasons in the absence of COVID-19 during this period of time.<br>• Southampton's average weekly infection rate from February 2020 to October 2021 was 461 per 100,000 population, which was higher than the South-East (448) and England (414) averages and lower than Hampshire (536). Average weekly infection rate in the Isle of Wight was 423 and Portsmouth 411 per 100,000.<br>• There is evidence of inequality in COVID-19 mortality, with those disproportionately affected including:<br>o People living in some of the most deprived neighbourhoods in Southampton (Southampton data)<br>o People from minority ethnic groups (national data)<br>o Older people including those living in care homes (Southampton data)<br>o Males (Southampton data)<br>o People with existing illness (national data) which disproportionately affects people living in more deprived neighbourhoods and from ethnic minority backgrounds<br>o People with learning disabilities (national data)<br>• Between 3% and 11.7% of people infected with COVID-19 go on to suffer Long Covid with symptoms following a suspected or confirmed case of COVID-19 infection that last more than 12 weeks (national data) |
| 11. | Indirect health impacts:<br>• Impact on health and care system, with long waiting lists for elective care and referrals, variability in access to face-to-face healthcare consultations, deteriorating health conditions and deconditioning (national data)<br>• Displacement of usual societal activities by COVID-19 response, with reduction in some types of support for vulnerable people (especially face to face support) (Southampton and national data)<br>• Impact of non-pharmaceutical interventions (NPIs) e.g. lockdowns, social distancing, self-isolation, business closure, suspension of schooling for most pupils etc (Southampton and national data) which |

| | |
|---|---|
| | affected people's mental health and wellbeing, economic and educational experiences. |
| 12. | There was evidence of inequalities in almost every aspect assessed and people who were already disadvantaged felt the negative effects more. Some groups were not able to adhere as closely as others to the recommended measures to reduce their risk of infection. It is likely that inequalities in Southampton have widened as a result of the pandemic. |
| 13. | The impact of the pandemic also affected people's ability to lead healthy lives, with reported reductions in healthy eating and physical activity in some groups, and increased consumption of alcohol and drugs and alcohol-related harm (national data). |
| 14. | Effects on health were mostly negative. However, there were some positives:<br>• An increase in healthy behaviour in some populations e.g. quitting smoking (national data)<br>• People reported that they valued clean air and used and valued green spaces more (Southampton data)<br>• Strengthened community support, connectivity and assets (Southampton data)<br>• Southampton's vulnerable population is now more easily identified for the future through e.g. the shielding list (Southampton data) |
| | **Looking to the future and recovery** |
| | Opportunities |
| 15. | • Capitalise on the renewed attention on health inequalities, public health and the importance of physical and mental wellbeing for society<br>• The pandemic has shown how closely health can be related to the economy which supports the Health in All Policies approach<br>• To build upon community engagement using new and refreshed partnerships and new ways of working to build capacity<br>• Use key learning from the pandemic response and strong partnerships that have developed to prepare for any future pandemic<br>• There are now clear areas to inform the HWB strategy going forward |
| | Priorities for the HWB's strategy |
| 16. | In terms of continuing to protect the public from covid-19 infection it is crucial that we:<br>• continue with vaccination, contact tracing strategies and preventative measures to reduce risk of covid-19 transmission and consequences<br>• continue to work through community engagement and targeted/general communications to help people learn to live with covid-19 and continue to understand how risk can be reduced<br><br>To ensure that the HWB strategy supports COVID-19 recovery, the recommendation is that we continue to, and amplify, our approach to reducing health inequalities in Southampton, using the 'build back fairer' framework to inform approach. These 'build back fairer' principles are already included within our strategy:<br><br>1. Reducing inequalities in early years |

| | |
|---|---|
| | 2. Reducing inequalities in education<br><br>3. Build back fairer for children and young people<br><br>4. Creating fair employment and good work for all<br><br>5. Ensuring a healthy standard of living for all<br><br>6. Creating and developing healthy and sustainable places and communities<br><br>7. Strengthening the role and impact of ill health prevention<br><br>The HWB agreed at their last meeting to prioritise giving children and young people the best start in life, this aligns with the first 3 principles above and clearly principles 4 to 7 will enable children and young people to have the best start in life. |
| **RESOURCE IMPLICATIONS** | |
| **Capital/Revenue** | |
| 17. | None |
| **Property/Other** | |
| 18. | None |
| **LEGAL IMPLICATIONS** | |
| **Statutory power to undertake proposals in the report:** | |
| 19. | Health and Social Care Act 2012 |
| **Other Legal Implications:** | |
| 20. | None |
| **RISK MANAGEMENT IMPLICATIONS** | |
| 21. | None |
| **POLICY FRAMEWORK IMPLICATIONS** | |
| 22. | None |

| | | |
|---|---|---|
| **KEY DECISION?** | **No** | |
| **WARDS/COMMUNITIES AFFECTED:** | | All |
| SUPPORTING DOCUMENTATION | | |
| **Appendices** | | |
| 1. | Southampton COVID-19 Health Impact Assessment PDF | |

**Documents In Members' Rooms**

| | |
|---|---|
| | None |

| | |
|---|---|
| **Equality Impact Assessment** | |
| **Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.** | **No** |
| **Data Protection Impact Assessment** | |
| **Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out.** | **No** |
| **Other Background Documents**<br>**Other Background documents available for inspection at: N/A** | |

| | | |
|---|---|---|
| **Title of Background Paper(s)** | | **Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)** |
| | None | |

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# COVID-19 Impact Assessment

## Southampton – 1st December 2021

Public Health and Data, Intelligence & Insight Team

# Key Findings

- Southampton is an ethnically diverse city, with significant pockets of deprivation, and a high burden of chronic disease.

- Clinical vulnerability to COVID-19 infection, vulnerability to acquiring infection, and vulnerability to the impact of policy decisions on managing the pandemic are likely to have been experienced differently across the city.

- Higher age-standardised COVID-19 mortality can be seen in some of our most deprived neighbourhoods. Comparing the 20% most deprived with the 20% least, there are significantly higher age-standardised case rates and hospitalisations in those most deprived living across the city.

- Existing health inequalities are likely to have been exacerbated by the pandemic but the evidence for this is yet to be fully realised including what the long-term impacts might be.

- The direct impacts of COVID-19 infection on health are captured by hospital admissions and deaths; these direct effects are likely to have been experienced differently across different segments of the population. The same is likely to be true for indirect health impacts such as delays in diagnoses or management of long-term conditions and elective care. Evidence for the scale and distribution of these impacts will take time to emerge.

- Effects on the wider determinants of health are most evident on the economic and educational impacts; the long-term consequences of these impacts on health and wellbeing are uncertain.

# Contents

## Introduction

This section provides a summary of Southampton's demographic and health baselines pre-covid, and a summary of COVID-19 cases, hospitalisations and deaths in the city. It describes how the conditions in which people are born, grow, live, work and age affect health and how this is likely to have affected how the city was impacted by the pandemic.

## Healthy People

The impact of COVID-19 has been felt differently in different groups of people in Southampton. This section explores which groups were affected more than others, why that might be the case, and how different groups were supported. It also considers the extent to which different groups were able to take steps to protect themselves from infection and from the wider effects of COVID-19 e.g. testing, vaccination, self-isolation etc. There are a limited number of characteristics available within the current case data to fully understand who has been most impacted by COVID-19 infection, hospitalisation and death in the city. For example, our case data does not contain data about pre-existing conditions like heart disease, respiratory disease and diabetes, or other clinical vulnerabilities and occupation.

## Healthy Living

This section describes how the pandemic affected people's ability to lead healthy lives.

## Healthy Places

This section summarises how the impact of the pandemic was felt in different parts and sectors of the city: wards, deprivation, environmental issues and crime

## Conclusions: looking to the future and recovery

As more data becomes available, we will be able to better understand the impacts of the COVID-19 pandemic in Southampton. Already we can see a disproportionate affect in those living in the most deprived neighbourhoods both in the direct and indirect health impacts. Where we have relied on national data for England/UK, it is important to remember that Southampton has higher deprivation on average than England, so the effects of COVID-19 may be even greater. Impacts may be further amplified when we are able to better understand variation in impacts across ethnicity when the 2021 Census data becomes available.

In almost every area, inequalities in the effects of COVID-19 are evident, with groups who were already disadvantaged suffering more. In general, the least deprived were protected from the worst effects of the pandemic.

The ability for people to lead healthy lives and enhance their wellbeing was also affected.

**Who were most affected?**

- People living with deprivation and illness, those of older age and those from ethnic minority groups and other vulnerable populations – people who in many cases had no choices about how they could respond to the pandemic
- Children and young people's lives including educational disruption with long-term effects not yet quantifiable

# Introduction

This section provides a summary of Southampton's demographic and health baselines pre-covid, and a summary of COVID-19 cases, hospitalisations and deaths in the city. It describes how the conditions in which people are born, grow, live, work and age affect health and how this is likely to have affected how the city was impacted by the pandemic.

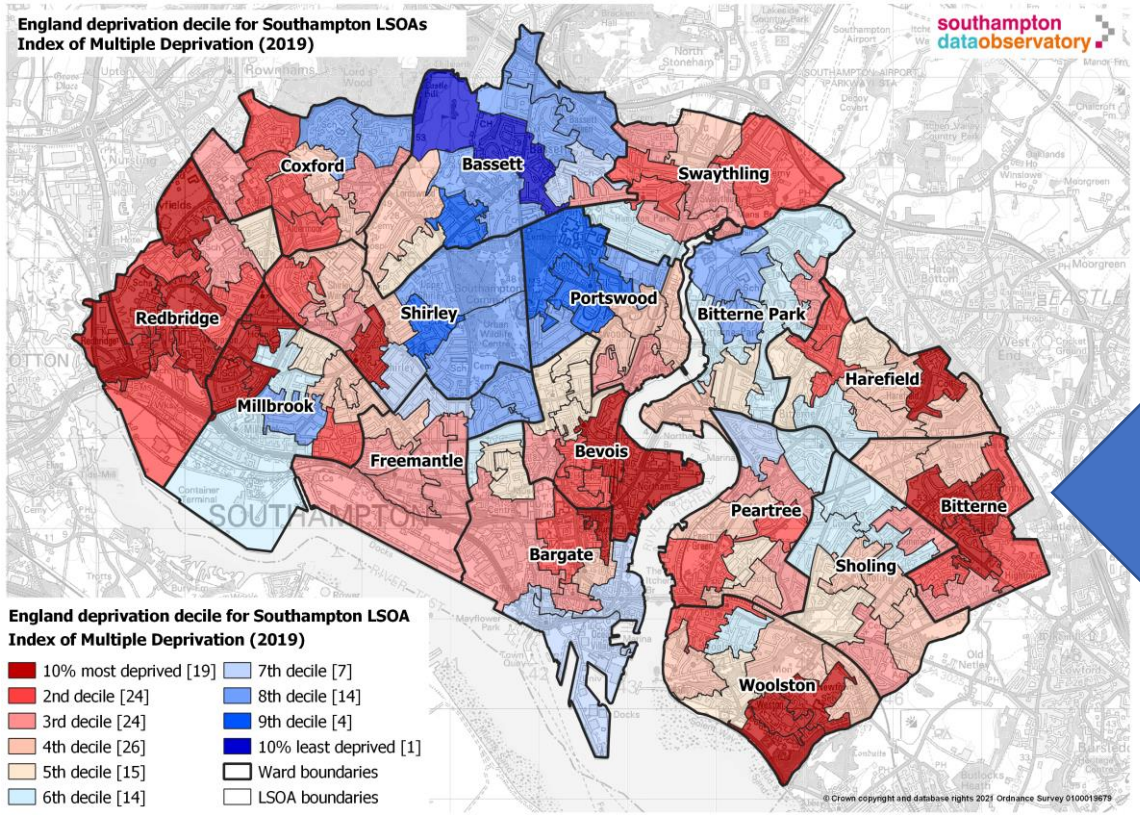
# Southampton population and deprivation

The impact of COVID-19 will be felt very differently from local authority to local authority because of differences in local demography and because the conditions in which people live affect how healthy they are and how vulnerable they are to COVID-19.

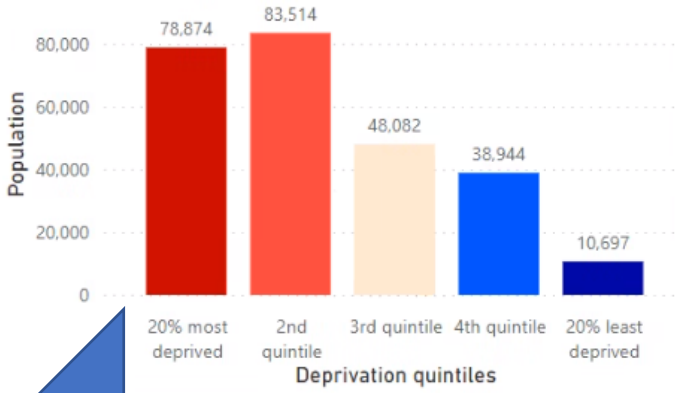
Southampton has an estimated population of **260,111** residents, of which **132,501** (50.9%) are **male** and **127,610** (49.1%) are **female** (2020).

Southampton has a relatively young population compared to geographic neighbours with higher rates of **deprivation**, **diversity** and pre-existing **disease**. A shift towards an ageing population has been forecast for the city.

Deprivation is generally associated with poor health outcomes.




**Southampton population estimates for England IMD quintiles: 2020**



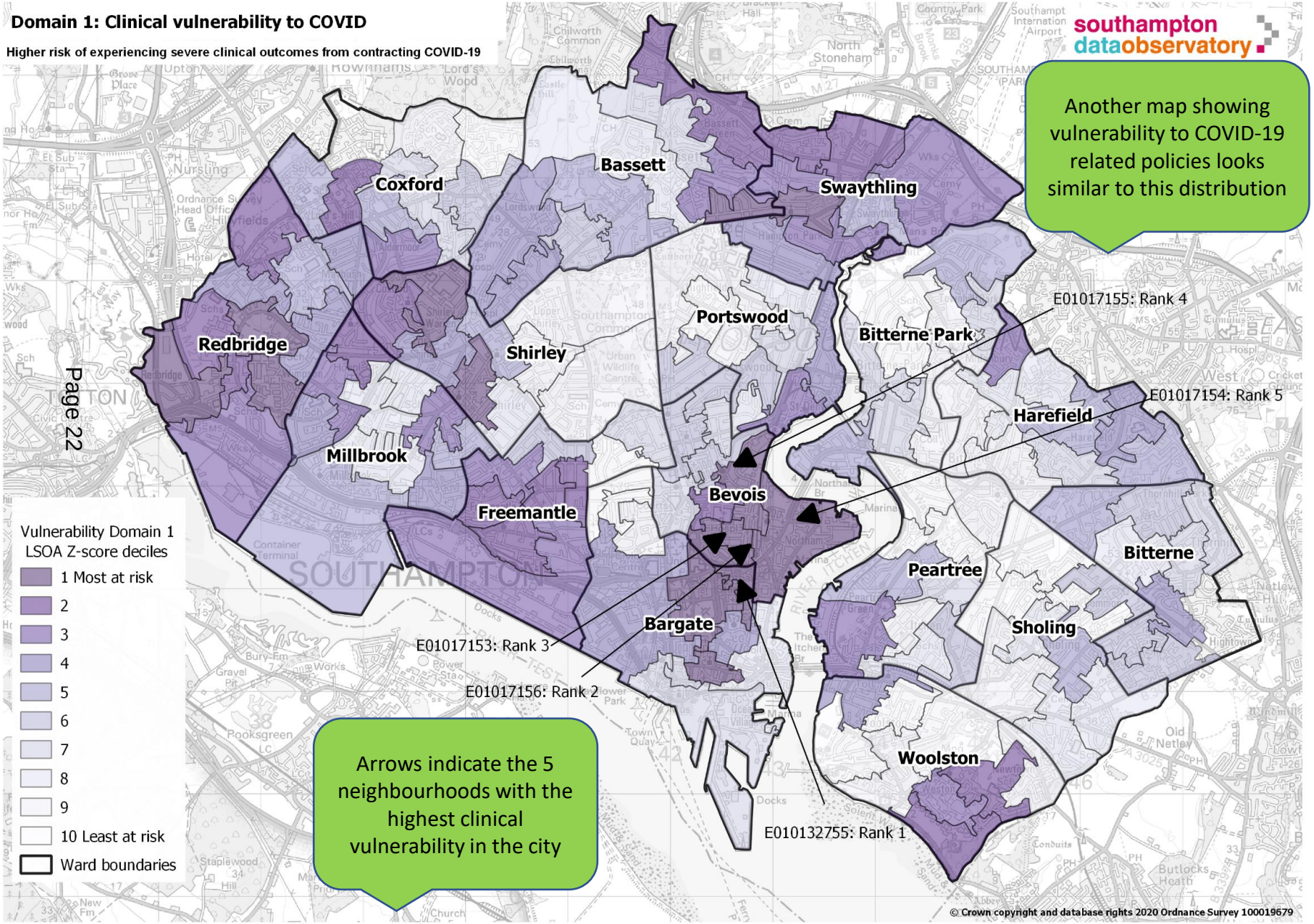

This map shows how deprivation is distributed across different neighbourhoods in the city with red areas experiencing much higher deprivation compared to blue areas.

The Index of Multiple Deprivation consists of 7 domains including income, employment, health and disability, education, crime, housing and living environment.

Southampton is ranked the 55th (previously 54th) most deprived out of 317 local authorities in England.

28% of Southampton's population live in neighbourhoods within the 20% most deprived nationally Southampton is ranked 3rd worst in the country for crime deprivation and is in the worst 20% of local authorities for 5 other deprivation domains.

# Clinical Vulnerability to COVID-19



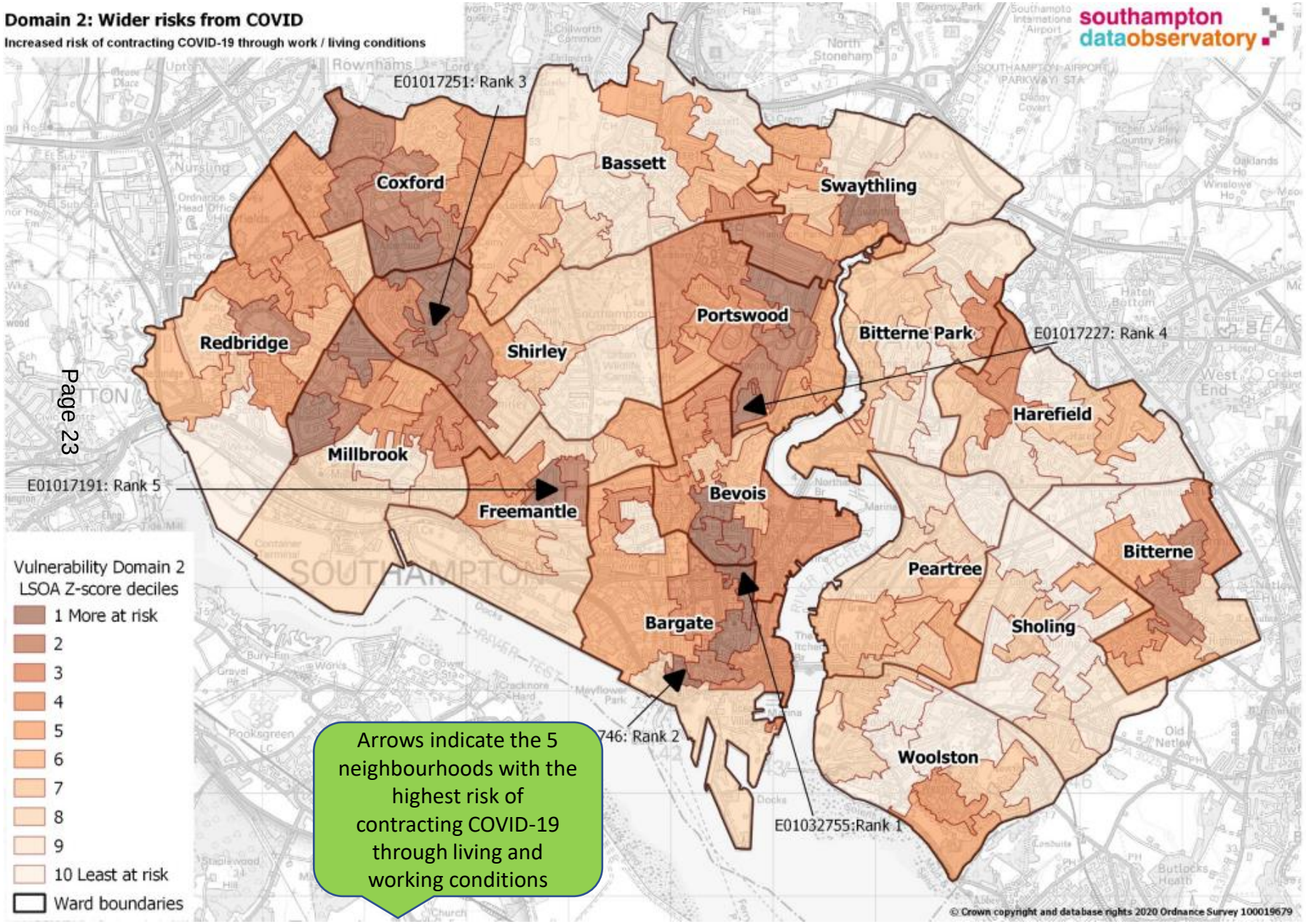

## Clinical vulnerability to COVID

Higher risk of experiencing severe outcomes from contracting COVID-19

- Male (%)
- Older age (% 70+ per LSOA)
- BAME (%)
- Clinical risk factors < 70s from CSU*
- Deprivation score

This map shows how clinical vulnerability to severe outcomes from COVID-19 is distributed across the city using an index comprising the factors in the table. There are pockets of the city with very vulnerable populations to severe disease and death from COVID-19

# Wider risks for exposure to COVID-19 infection




## Wider risks from COVID

Increased risk of contracting COVID-19 through work / living conditions

- Working in human health and social work activities (%)
- Working in Education (%)
- Working in transport and Storage (%)
- Overcrowded housing (%)
- High population density (%)

This map shows how risk of exposure to COVID-19 is distributed across the city. There are pockets of the city with populations more vulnerable to risk of contracting COVID-19 through living and working conditions

# Infections for Public Slides

Last updated 1 December 2021

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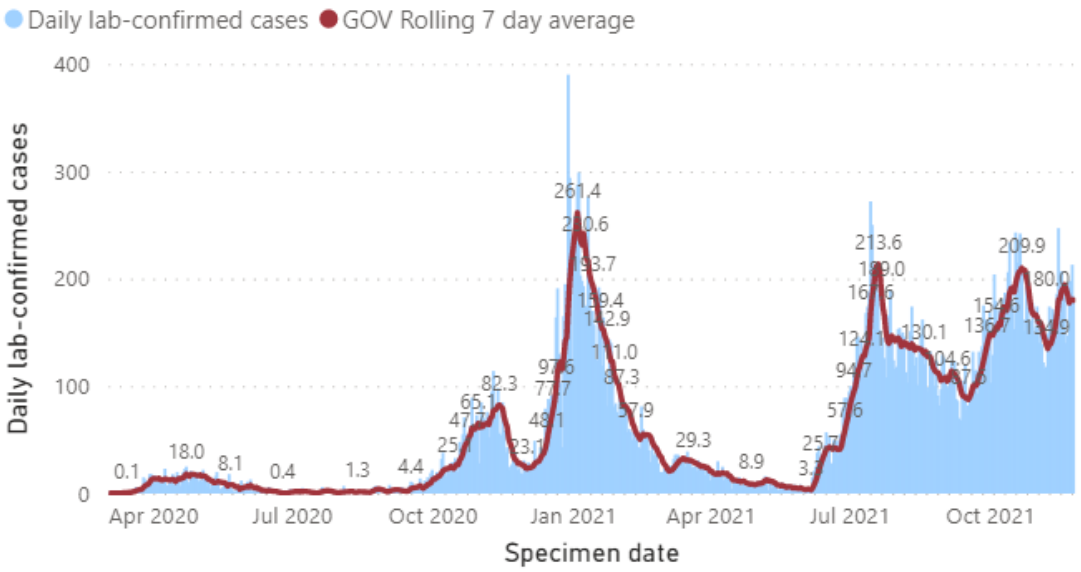
## GOV.UK Published Cases

| Cases in last 7 days | Change in last 7 days | Average cases per day (last 7 days) | Data up to |
|---|---|---|---|
| 1260 | -74 | 180.0 | 25/11/2021 |

Select date range: 30/01/2020 – 25/11/2021

Cases for selected dates: 37919

Number of COVID-19 cases per day and 7-day rolling average in Southampton for selected dates




There have been **37,919 confirmed cases** of COVID-19 in **Southampton** (includes both pillar 1 and 2 cases). There were **1260 confirmed cases** in the **last 7 days**, which is **a reduction** of **74** compared to the **previous 7 days.**

Data is correct at time of publication, but is subject to change due to reporting delays and corrections. Therefore, any changes in the number of infections should be **interpreted alongside overall trends**, as there will be daily fluctuations. It is more important to consider any **sustained increases or decreases** that may occur.

The chart to the left shows the **daily number of confirmed cases** and the **7 day moving average** (to smooth out fluctuations) in Southampton.

# Weekly Infection Rates – for public slides

Last updated 1 December 2021

## What is coming?

27/11/2021

Southampton 7 day infection rate per 100k

**464.9**

South East 7 day infection rate per 100k

**565.4**

England 7 day infection rate per 100k

**430.8**



## Southampton COVID-19 Data Dashboard

Select dates (last date drives rates below and charts to the right)

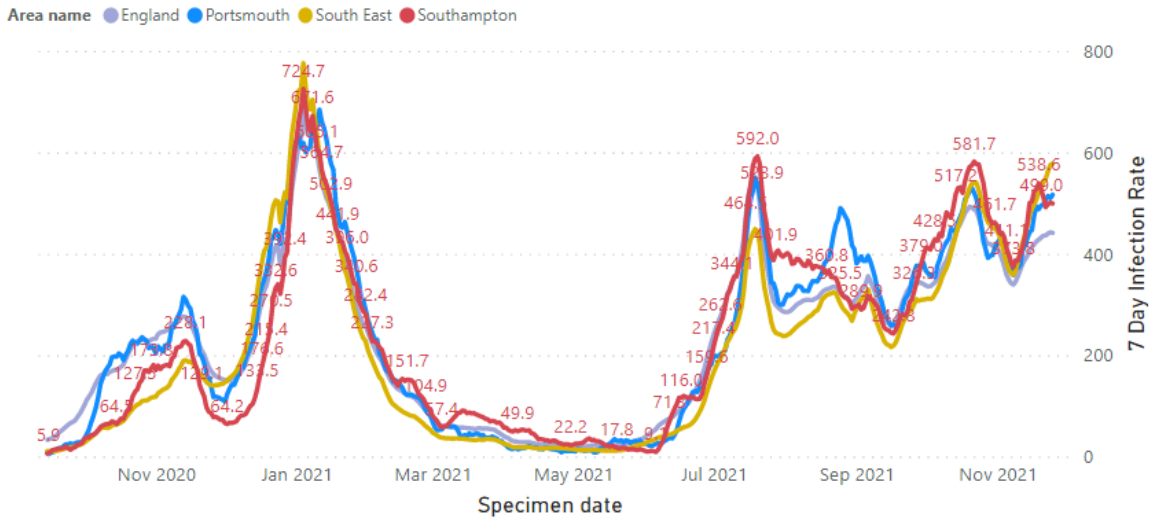
15/09/2020 — 25/11/2021

Area name (CTRL to select multiple)

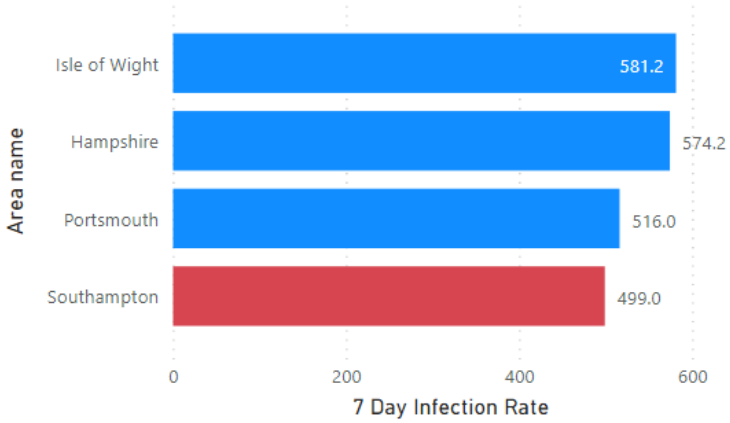
Multiple selections

| Southampton 7 day infection rate per 100k | South East 7 day infection rate per 100k | England 7 day infection rate per 100k |
|---|---|---|
| 499.0 | 577.8 | 441.1 |

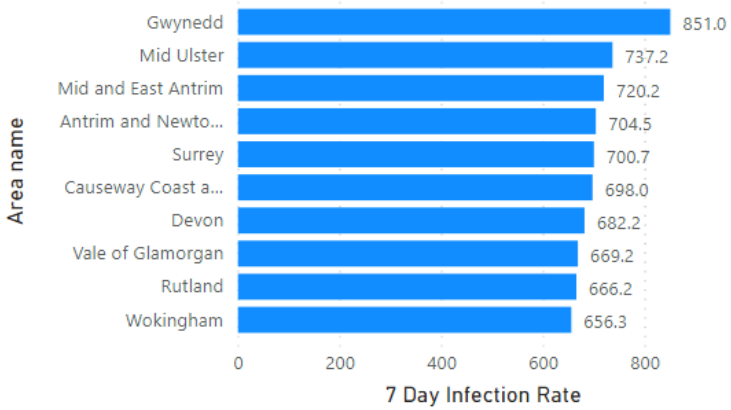
COVID-19 7-day rolling case rate per 100,000 population




Infection rate per 100,000 population: HIOW LAs




Infection rate per 100,000 population: TOP TEN LAs



# University Hospital Southampton Admissions

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## Patients admitted

21 November

**5**

Total admissions over the last 7 days

**40**

## Patients in hospital

23 November

**76**

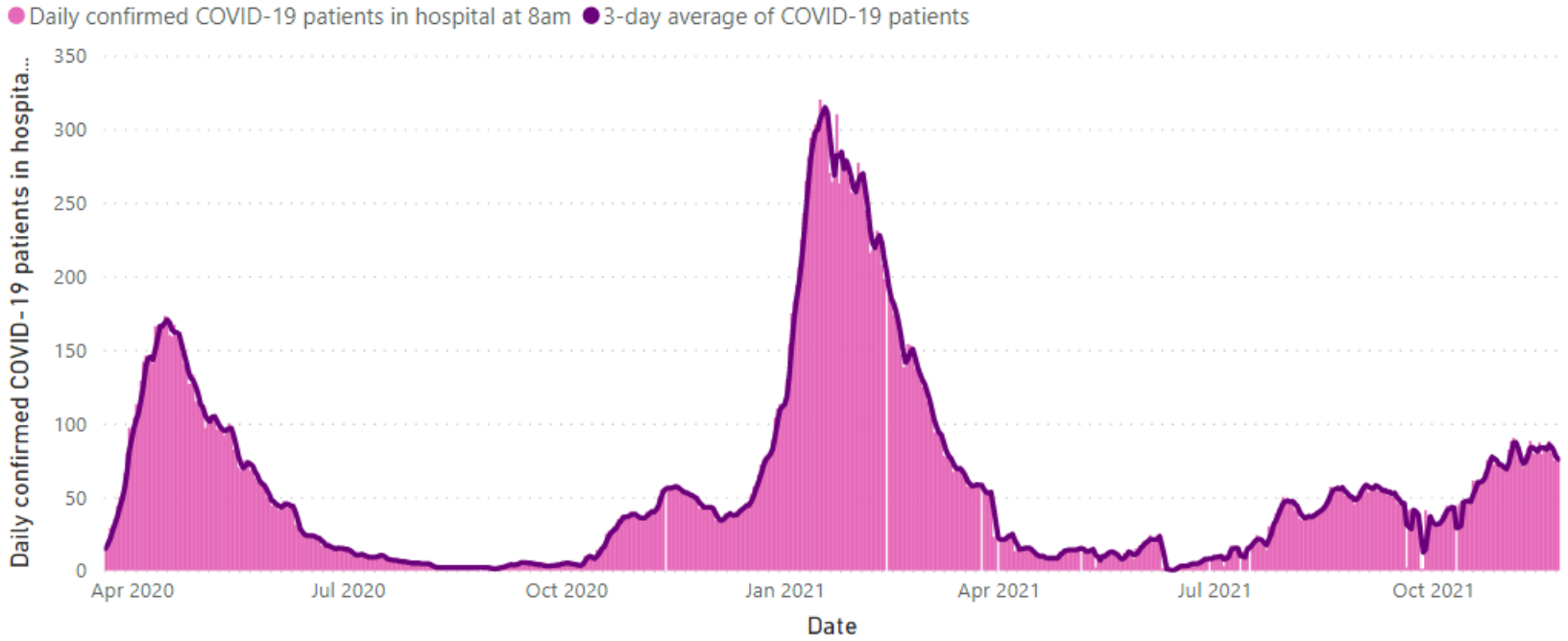
## Patients on ventilation

23 November

**13**

There were **76** COVID-19 patients on the **23 November**, which is **a decrease** of **-3** compared with the previous week. The admissions data relates to the patients of University Hospital Southampton so doesn't just include Southampton residents.

University Hospital Southampton COVID-19 daily confirmed COVID-19 patients in hospital at 8am




19/03/2020 23/11/2021

# COVID-19 related deaths

Includes deaths up to 19 November, all deaths registered up to 27 November

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| Total COVID related deaths | | Hospital | Community | | COVID Deaths during the week to 19 November | Change in deaths from previous week |
|---|---|---|---|---|---|---|
| 444 | of which | 300 | 144 | (105 of which in care homes) | 4 | +1 |

## COVID-19 deaths

There have been a total of **444** COVID-19 related resident deaths in Southampton. There was **4** COVID-19 related deaths in the most recent week, which is **an increase** of **+1** when compared to the previous week.

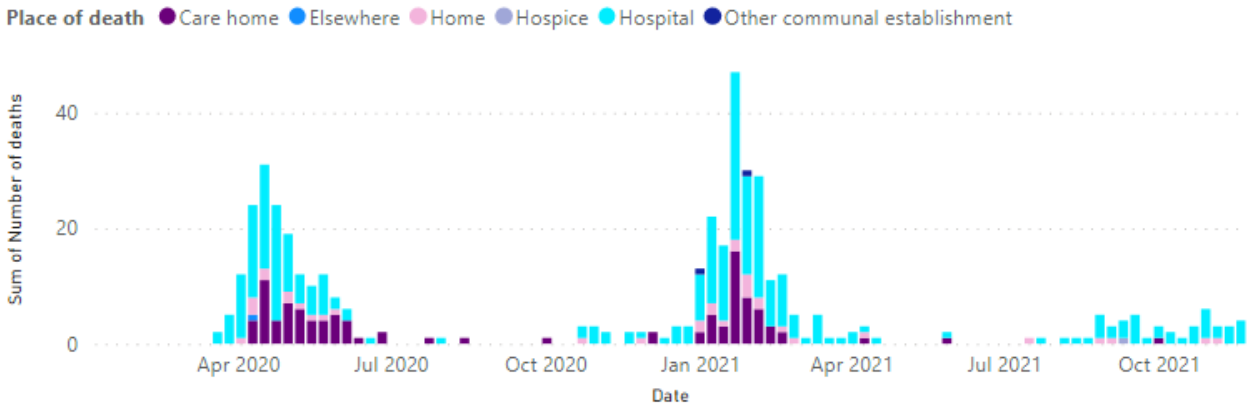
The chart to the rights shows the number of COVID-19 related deaths by week and setting.

Latest data shows that there was **5 COVID-19** related deaths in **University Hospital Southampton** (UHS) between the 17th November up to 23rd November. This data is different from that published by ONS as it doesn't necessarily include Southampton residents, only those who have died at UHS.

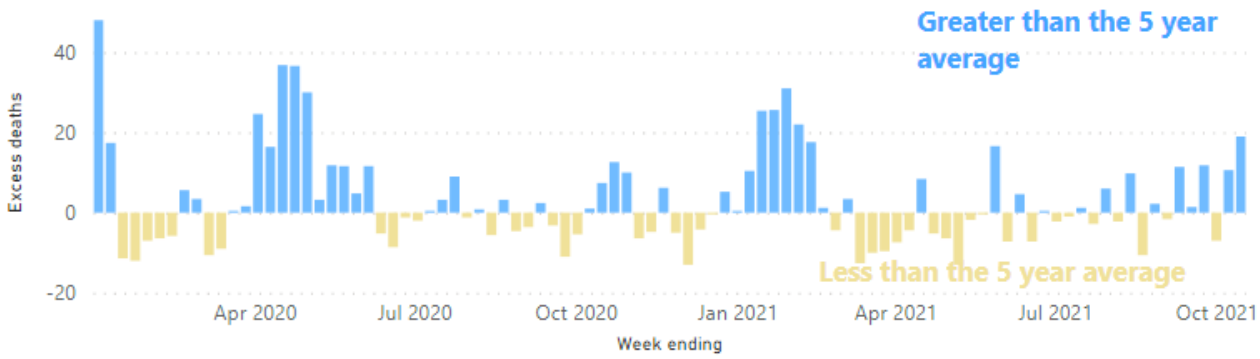
## Excess deaths (COVID and non-COVID)

In Southampton, **resident deaths** are now at **higher levels** compared to previous years as shown in the graph to the right. This shows the death occurrence by week compared to the average deaths count, by week, for the years 2015 to 2019.

Deaths by week and place of occurrence



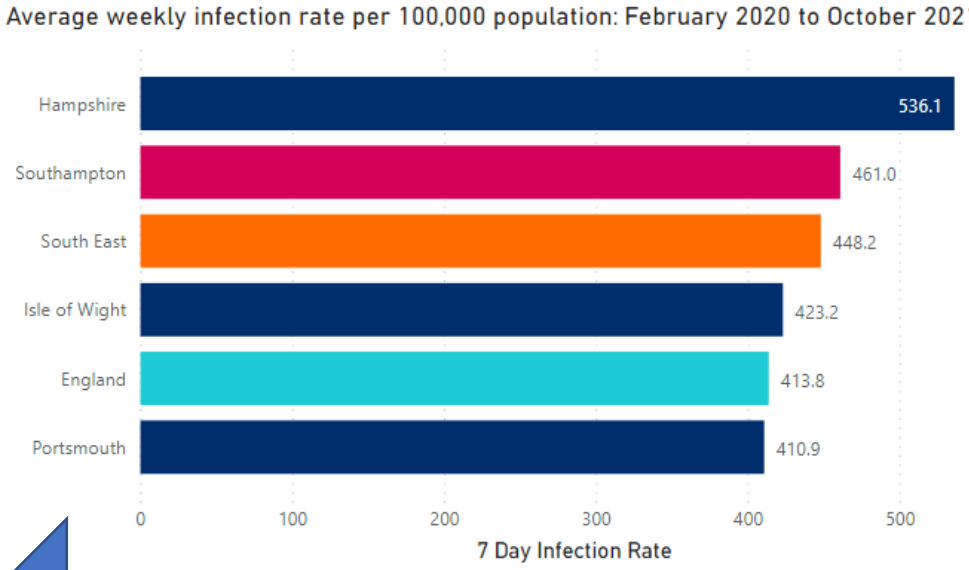

Excess deaths by week



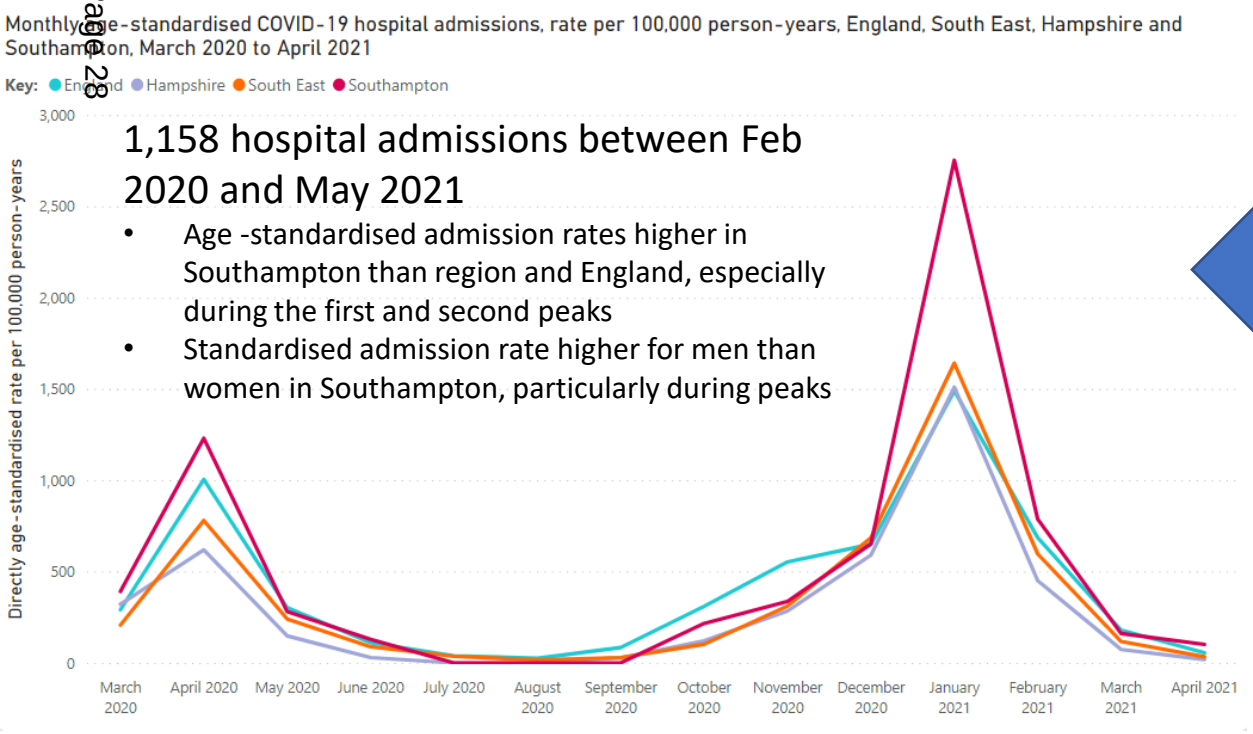

*Please note: data correct at time of publication, but may be revised in future weeks due to reporting delays*

# Southampton COVID-19 infections and hospitalisations

This chart shows that as an average we have had a higher case rate than the Isle of Wight, Portsmouth, and the South-East and England average. Only Hampshire has had a higher average weekly case rate compared to Southampton. However, Southampton case rates have been similar to our geographic neighbours across the entire course of the pandemic.






1,158 hospital admissions between Feb 2020 and May 2021

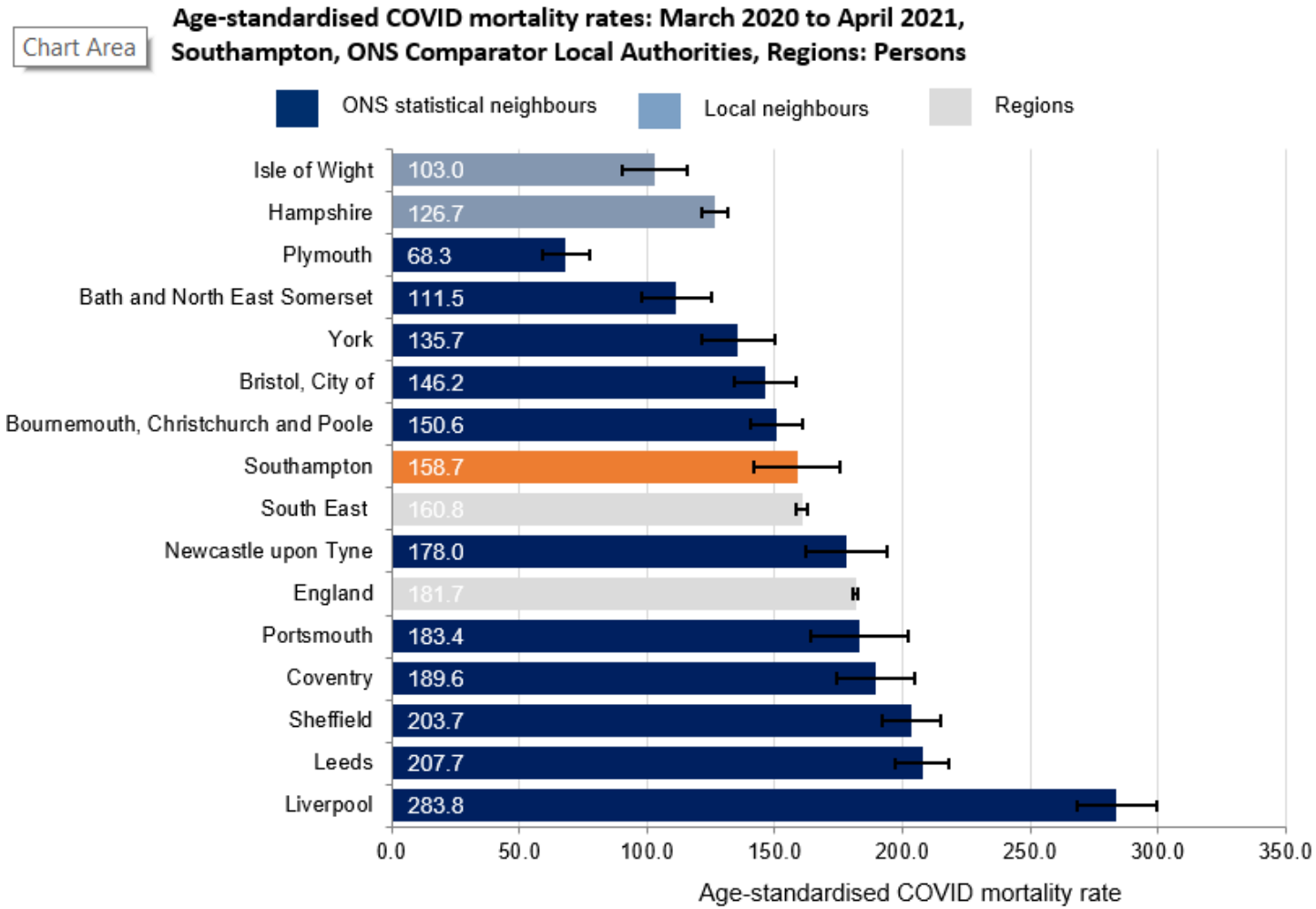
- Age -standardised admission rates higher in Southampton than region and England, especially during the first and second peaks
- Standardised admission rate higher for men than women in Southampton, particularly during peaks

There were 1,158 COVID-19 hospital admissions from the start of the pandemic up to May 2021. Age-standardised admissions show that Southampton had a higher rate of hospitalisations compared to Hampshire, and the South-East and England averages.

The first case of novel coronavirus was officially recorded in Southampton on 15 March 2020

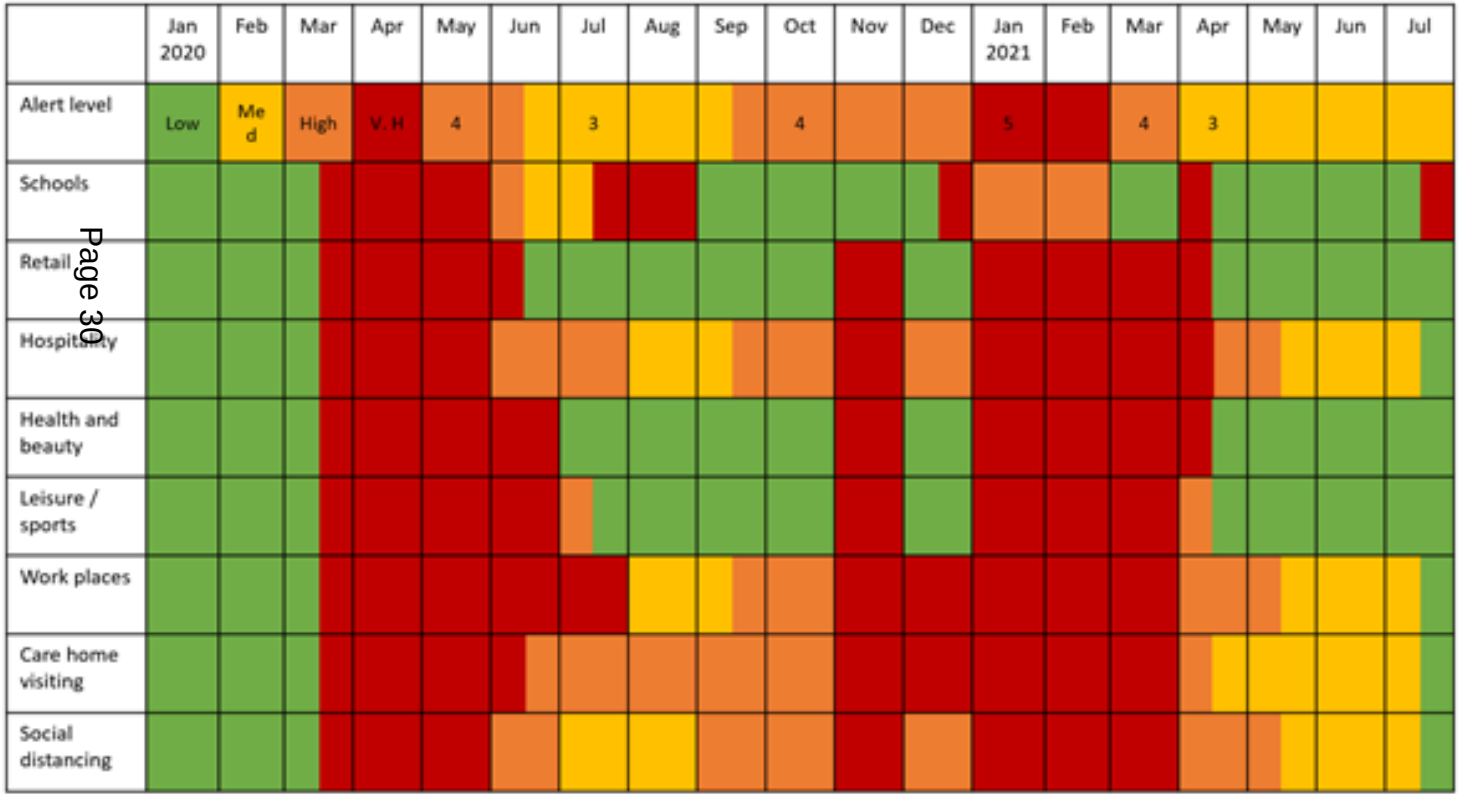
# Southampton COVID-19 mortality

This chart shows that age-standardised COVID-19 mortality rates in Southampton, between March 2020 and April 2021, were similar to Portsmouth and the South East average, significantly lower than the England average, but significantly higher than Hampshire and the Isle of Wight. Southampton was similar or fared better than a lot of its statistical comparators (cities with similar population characteristicss)



# National policy decisions and wider impacts

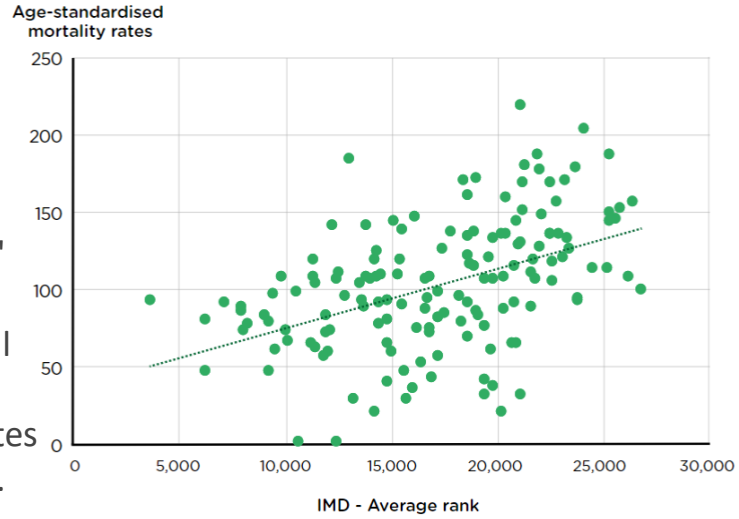
The direct impacts on health from COVID-19 infection can be seen in case rates, hospitalisations and mortality. Indirect impacts include the displacement in management of long-term conditions, elective care, and delays in diagnosis as well as the deconditioning of people during lockdowns and the effect on mental health and wellbeing. The scale of the impact on Southampton residents is yet to be fully understood. Indirect impacts of the pandemic on the wider determinants of health will likely result from the negative effects on employment and education.




This chart shows how different sectors of the economy were affected by national policy restrictions at different stages of the pandemic

Government policy decisions to reduce transmission of the virus through lockdowns, school closures, restrictions on movement and how people interacted, were successful in leading to reduced case numbers, hospitalisations and deaths.

Age-standardised COVID-19 mortality rates (per 100,000) for March to July 2020 and IMD average rank, upper tier local authorities in England



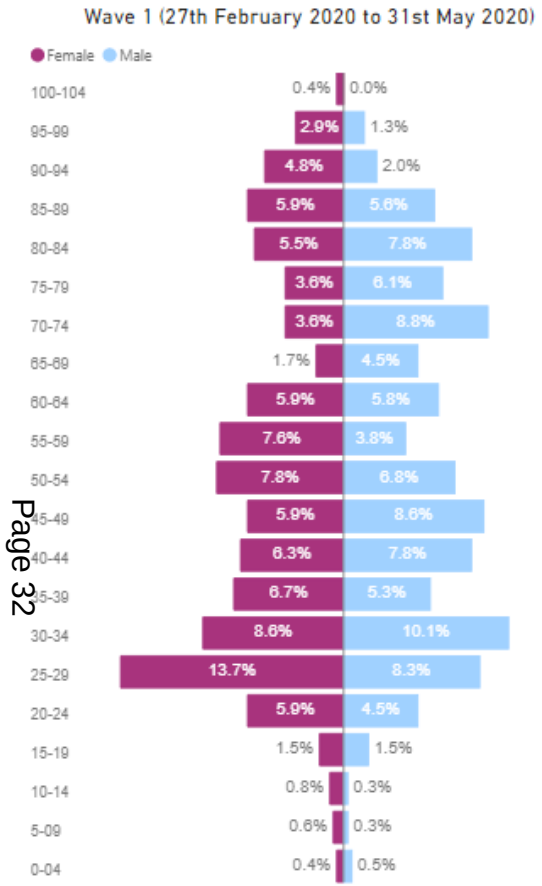

'Build Back Fairer: The COVID-19 Marmot Review' reported that more deprived local authorities had higher mortality rates in March-July 2020.

**Build Back Fairer:** The COVID-19 Marmot Review
The Pandemic, Socioeconomic and Health Inequalities in England

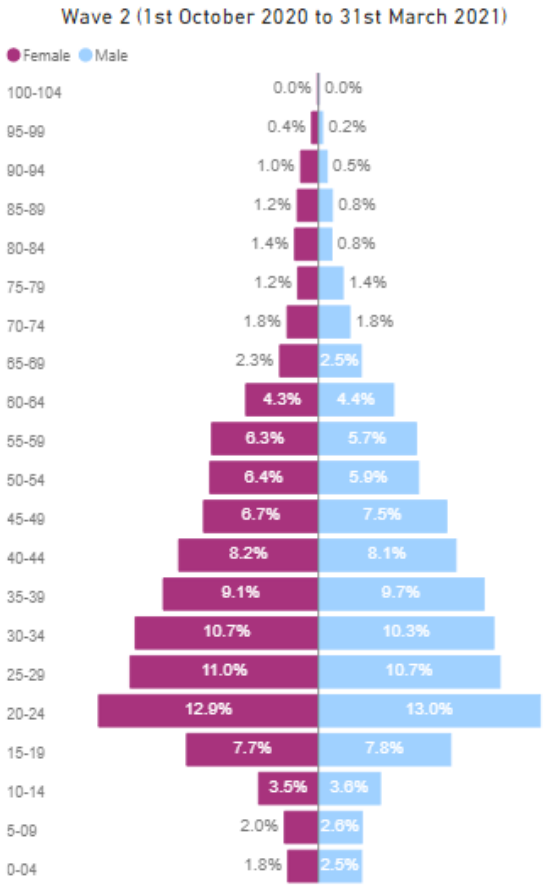
# Healthy People

The impact of COVID-19 has been felt differently in different groups of people in Southampton. This section explores which groups were affected more than others, why that might be the case, and how different groups were supported.  It also considers the extent to which different groups were able to take steps to protect themselves from infection and from the wider effects of COVID-19 e.g. testing, vaccination, self-isolation etc. There are a limited number of characteristics available within the current case data to fully understand who has been most impacted by COVID-19 infection, hospitalisation and death in the city. For example, our case data does not contain data about pre-existing conditions like heart disease, respiratory disease and diabetes, or other clinical vulnerabilities and occupation.

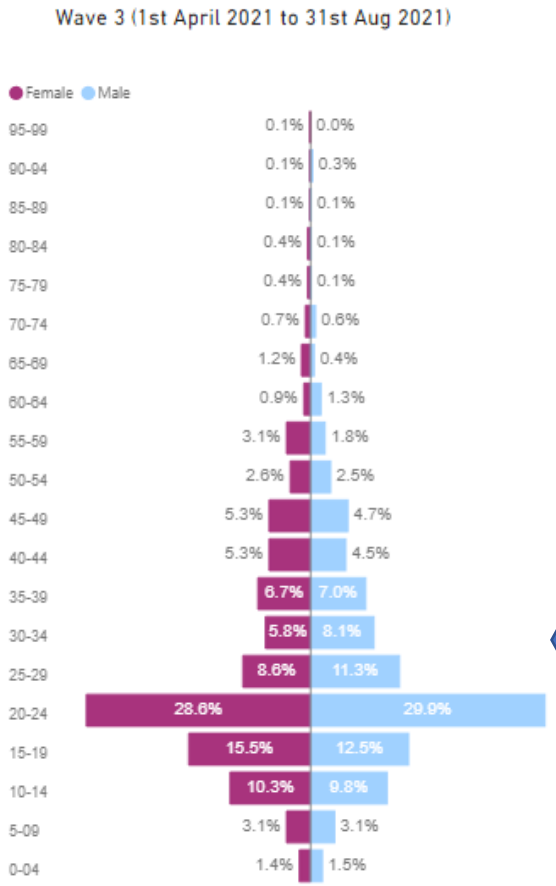
# Cases by age and wave of the pandemic




874 recorded cases




13,239 recorded cases




19,268 recorded cases

**Testing was not widely available in wave 1 and the total number of recorded cases is likely to be a fraction of true cases in the community**

These population pyramids show distribution of cases by age for the three waves of the pandemic in the UK. Older age groups are at the top and younger age groups at the bottom. Importantly there was a shift in proportion of cases away from older age groups due to a mixture of restrictions including shielding advice, vaccinations and personal behaviours to reduce risk.

# Mortality Demographics – Age & Gender

Last updated 17 September 2021

March 2020 to September 2021

**Total Deaths**

417

of which

**Male**

239

57%

**Female**

178

43%

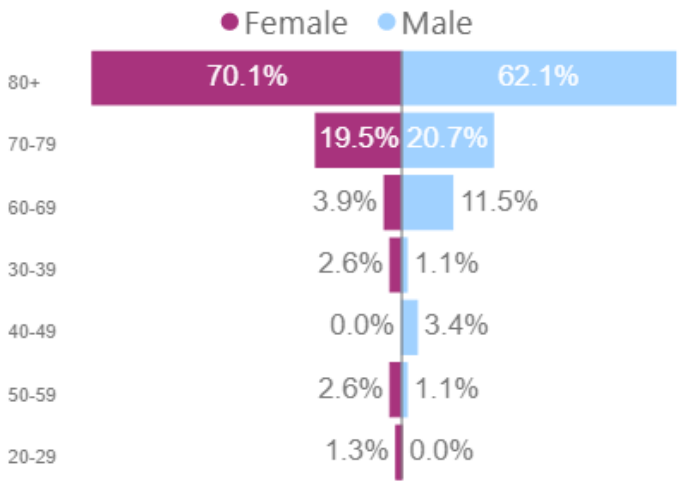
**Median Age**

83

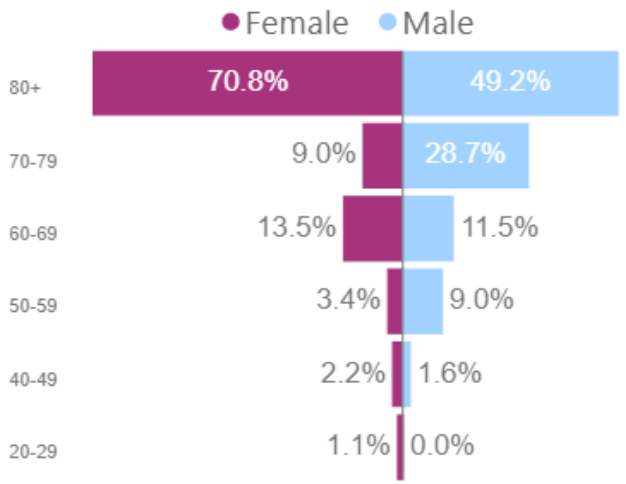
These charts show the distribution of COVID-19 deaths across age groups across the three waves of the pandemic. Age is the one of the greatest risk factors for COVID-19 mortality.



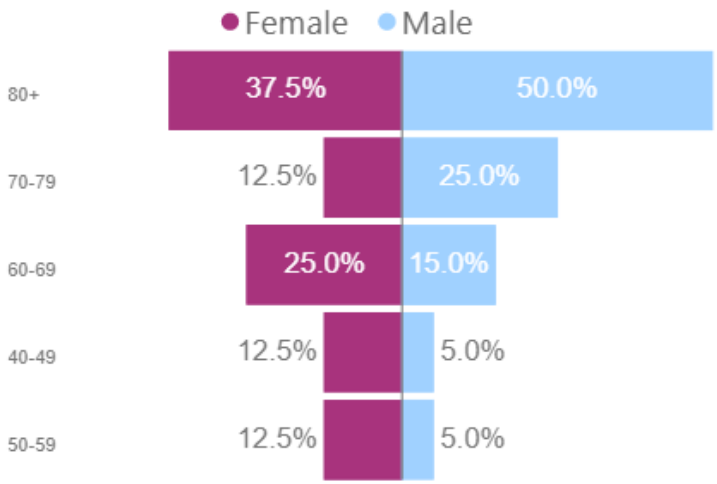
**Percentage of deaths by age band and gender: Southampton residents. Wave 1 (21st March 2020 to 12th June 2020)**



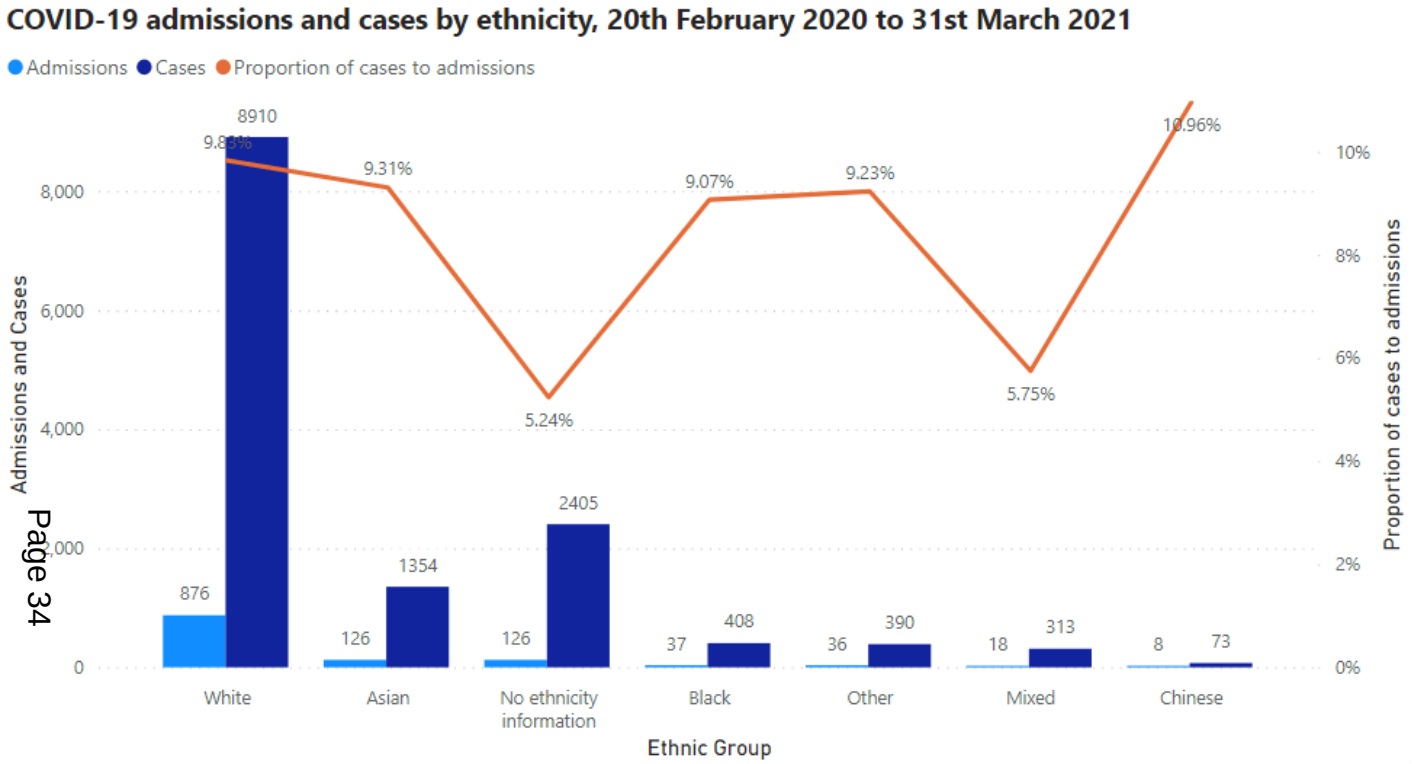

**Percentage of deaths by age band and gender: Southampton residents (wave 2: 24th October 2020 to 18th March 2021)**

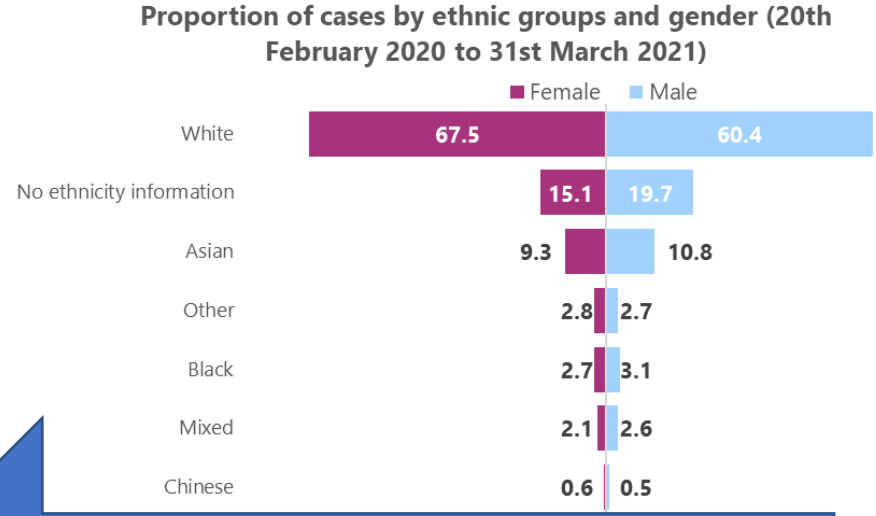



**Percentage of deaths by age band and gender: Southampton residents (wave 3: 1st April 2021 to 30th September 2021)**



# Impact of COVID-19 on different ethnic groups




This chart shows number of cases (dark blue), hospitalisations (light blue), and a case to hospitalisation % (orange) which shows that severity of infection may have been more equally experienced across many of the ethnic groups.

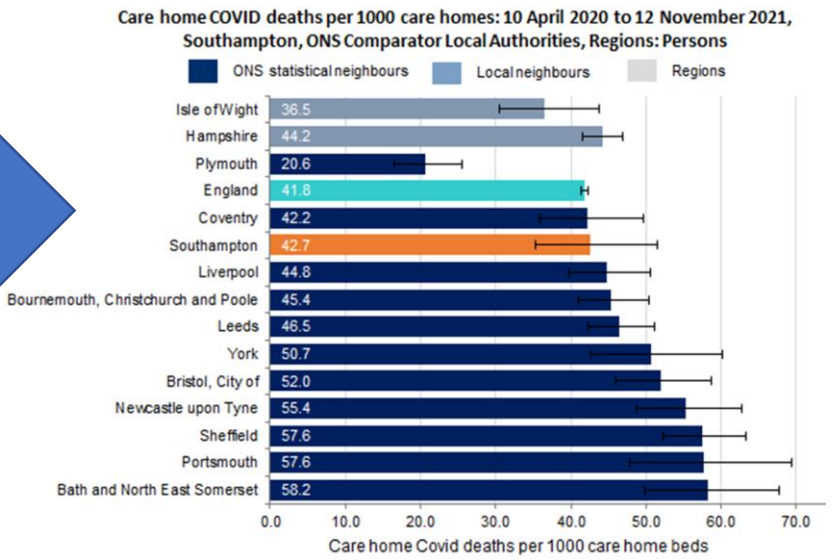
- The disproportionate negative effect of the pandemic on people from ethnic minority groups is well documented
- When the 2021 Census data becomes available next year we will be able to more accurately understand how rates of infection and hospitalisation have been experienced differently across ethnicities
- Ethnicity is not yet routinely available in mortality data for city residents and the disproportionate effect across ethnicities is likely to be similar to national data
- ONS data has shown that during the first wave people from all ethnic minority groups had higher rates of death involving COVID-19 compared with the White British population; 2.6-3.7 times greater for Black African, 1.9-3.0 for Bangladeshi, 1.8-2.7 for Black Caribbean and 2.0-2.2 for Pakistani ethnic groups. The gap reduced for most ethnic minority background in the second wave except Bangladeshi groups which increased to 4.1-5.0 times. A genetic variation has been identified which doubles risk of respiratory failure from COVID-19 and is more common in people from South Asian ethnic groups.

# Care home COVID-19 deaths

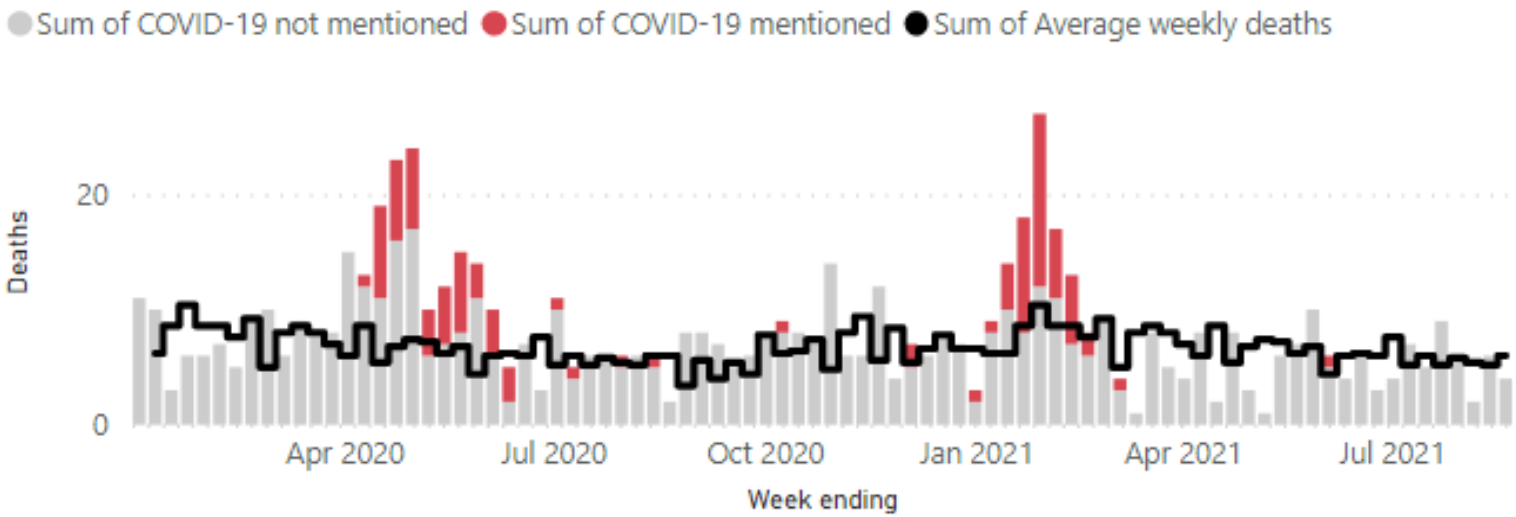
People living in Southampton care homes have been disproportionately affected by COVID-19, with 105 (24%) of all deaths occurring in care homes.

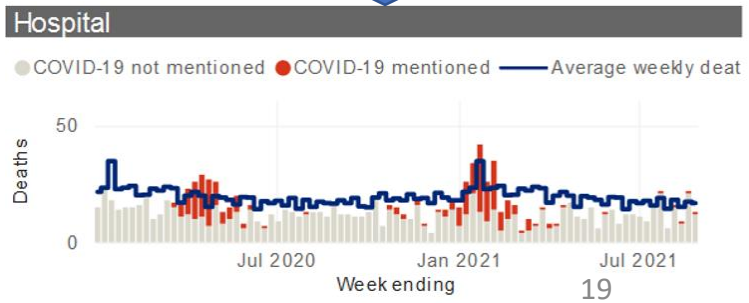
This chart shows COVID-19 related and non-COVID-19 deaths in care homes across the course of the pandemic and compared to average deaths in 2015-2019. There were an excess of non-COVID-19 deaths during the peak of the first and second wave suggesting unrecognised COVID-19 deaths or changes in the way patients were managed across the whole system as a result of the pandemic

This chart shows that compared to the national average Southampton had a higher (but not significantly) rate of care home COVID-19 deaths and 3rd lowest amongst our 12 ONS local authority comparator group




In hospitals excess deaths were COVID-19 related during peaks and there was lower than average non-COVID-19 deaths in hospital at other stages of the pandemic



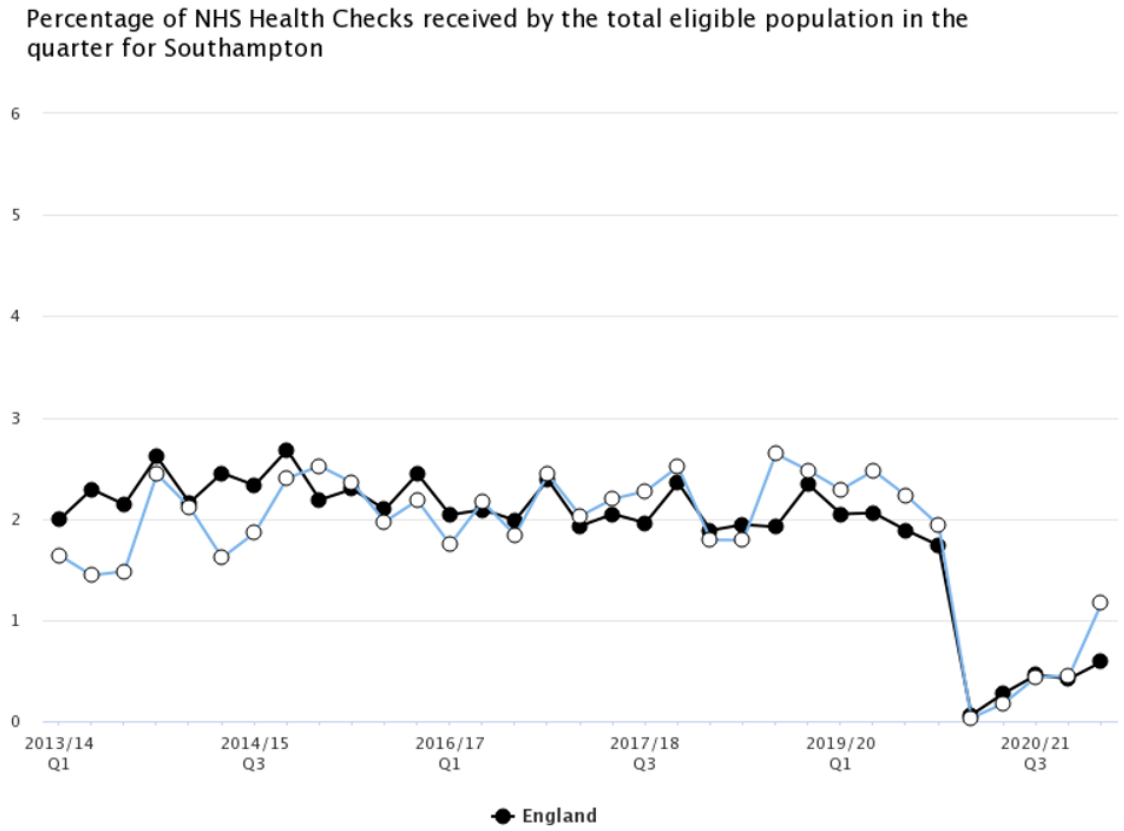
# Impact on mortality and morbidity

**Excess deaths:** Between 20/03/2020 to 15/10/2021 Southampton has had 3,165 deaths, 10% (289) more deaths when compared to the 2015-19 average (2,876).

**Visits to A&E** fell by 57%  in England in April 2020 compared to the previous year.

**Waiting lists:**  Analysis by the Health Foundation found that "6 million fewer people completed elective care pathways between January 2020 and July 2021 than would have been expected based on pre-pandemic numbers."  And  "access to elective treatment fell further in the most socioeconomically deprived areas of England between January 2020 and July 2021 than in less deprived areas." [Elective care: how has COVID-19 affected the waiting list? (health.org.uk)]

This chart shows how health checks were suspended when the pandemic first began and have now restarted but activity is still below pre-pandemic levels




Using national data, we can estimate that in Southampton the reduction in NHS Health Checks from March 2020 to March 2022 could mean that:

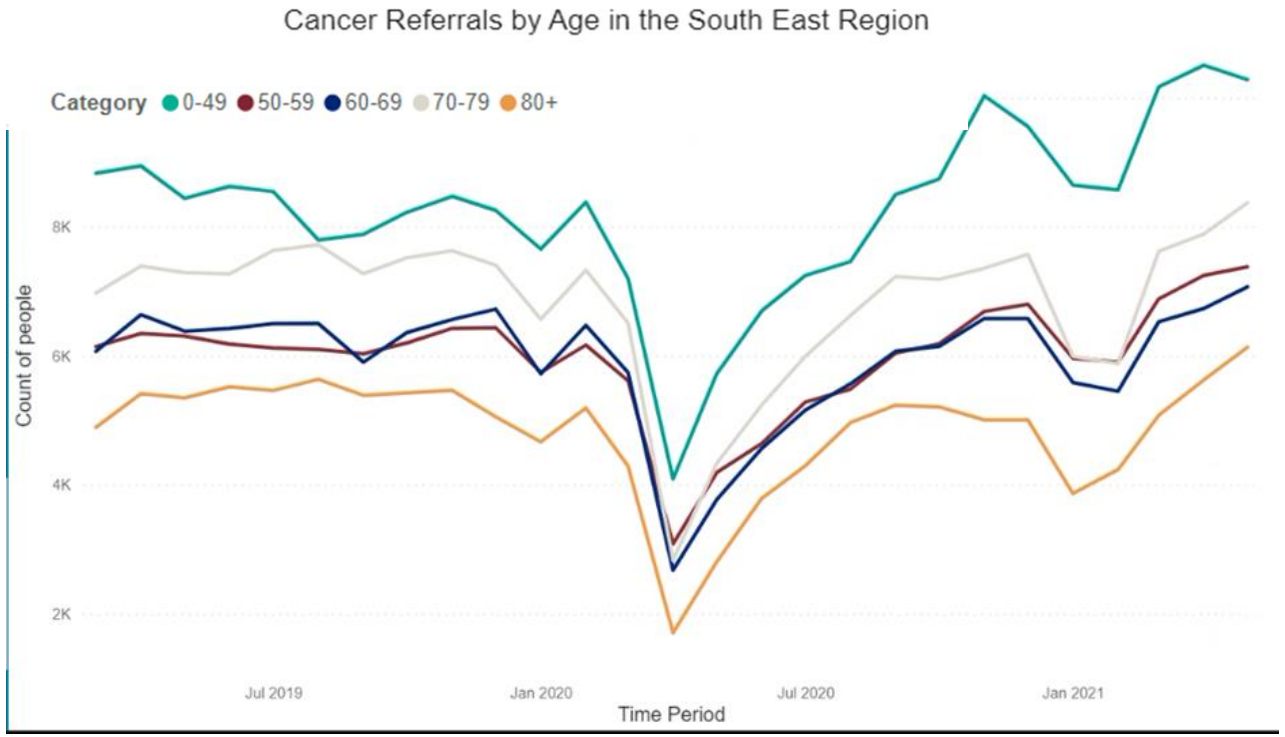
- 192-256 individuals might be diagnosed with hypertension at a later point than they would have been
- 38-96 individuals might be diagnosed with type 2 diabetes at a later point than they would have been
- 770-1,283 individuals at high risk of cardiovascular disease in the next 10 years have not yet been identified as they otherwise would have

# Impact on mortality and morbidity

The pandemic has affected people with **existing illness** in many ways:

- People with a pre-existing illness were more likely to experience severe outcomes from COVID-19
- Reduction in access to care, including monitoring and treatment due to suspension of clinics, elective surgery and support networks
- Suspension of normal care to enable greater capacity for COVID-19 patients
- Concern about potential infection or adding pressure to the NHS led some patients to stay away from healthcare
- Impact of the move to online consultations (and the speed with which this was done) in primary care may have affected accessibility, particularly for chronic disease management
- Difficulties accessing treatments due to reduced transport opportunities
- Suspension of clinical trials
- Contracting COVID-19 may have exacerbated existing illness
- Physical deconditioning due to impact on daily life
- Reduced opportunities to diagnose disease early for example though NHS health checks which were suspended across the country during earlier parts of the pandemic






Source: COVID-19 Cancer Equity Data Pack produced by Cancer Alliance Data, Evidence and Analysis Service (CADEAS) and PHE NCRAS.

**Taken together, it is likely that the pandemic will lead to earlier deaths, long waiting lists for treatment and a greater burden of illness in society. Gathering evidence for some of these impacts will take time.**

This chart shows that during periods of restrictions/peaks of pandemic waves there were drops in the number of cancer referrals across all age groups in the South East, with periods of recovery in between

# Clinically extremely vulnerable (CEV) people

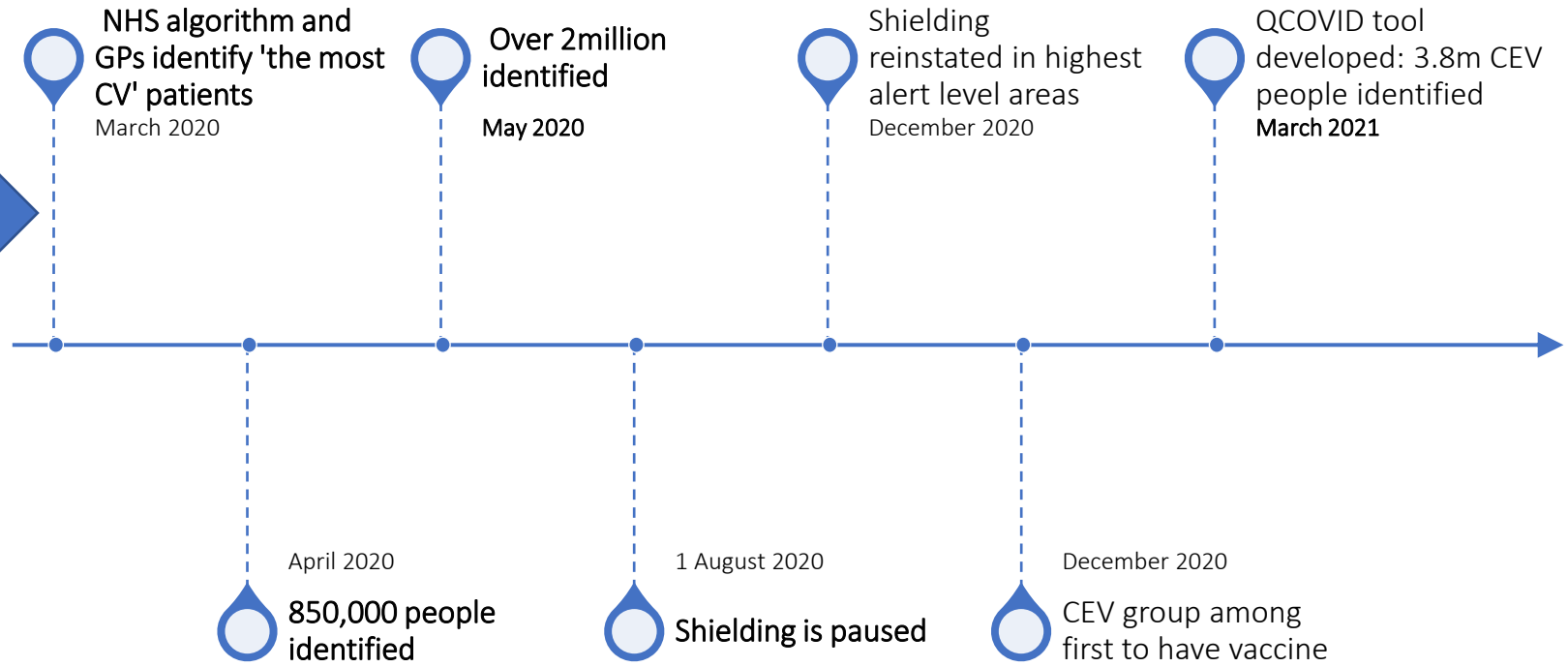
Those identified as CEV were asked to take more stringent measures to protect themselves from infection. 'Shielding' included not going to work, remaining at home other than to seek medical care and avoiding contact with anyone outside their household. There were 14,965 people in Southampton in the shielding list which is 5.92% of the population.

The direct effects of infection on this group of CEV people living in Southampton is yet to be fully understood and how effective the shielding policy was in protecting the most vulnerable

**England - 3.7 million (6.6%)**
**Hampshire, IOW and Southampton - 6.05%**
**Southampton - 14,965 5.92%**



This chart shows the timeline for Shielding. At stages of the pandemic shielding was paused, the eligibility list was increased when there was a composite tool applied to patient lists, and now shielding has been permanently discontinued due to the success of the vaccine programme




Assessing the impact of COVID-19 on the clinically extremely vulnerable population
October 2021

The Health Foundation

"the COVID-19 pandemic resulted in a substantial burden of severe infection and mortality among the clinically extremely vulnerable population"

# Ability to adhere to protective measures

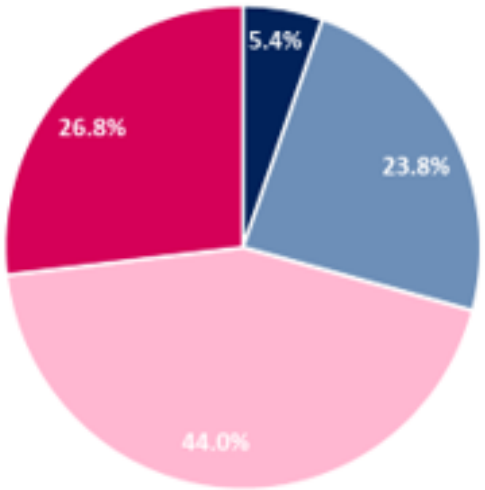
Regular symptom-free testing using lateral flow devices helps to identify infection at the earliest opportunity before symptoms begin or in those who may have no symptoms but who could still spread the infection. It helps to limit the transmission of infection especially when mixing with other people in social situations, educational and work settings.

We asked residents about their testing frequency in the 6th residents survey in August 2021

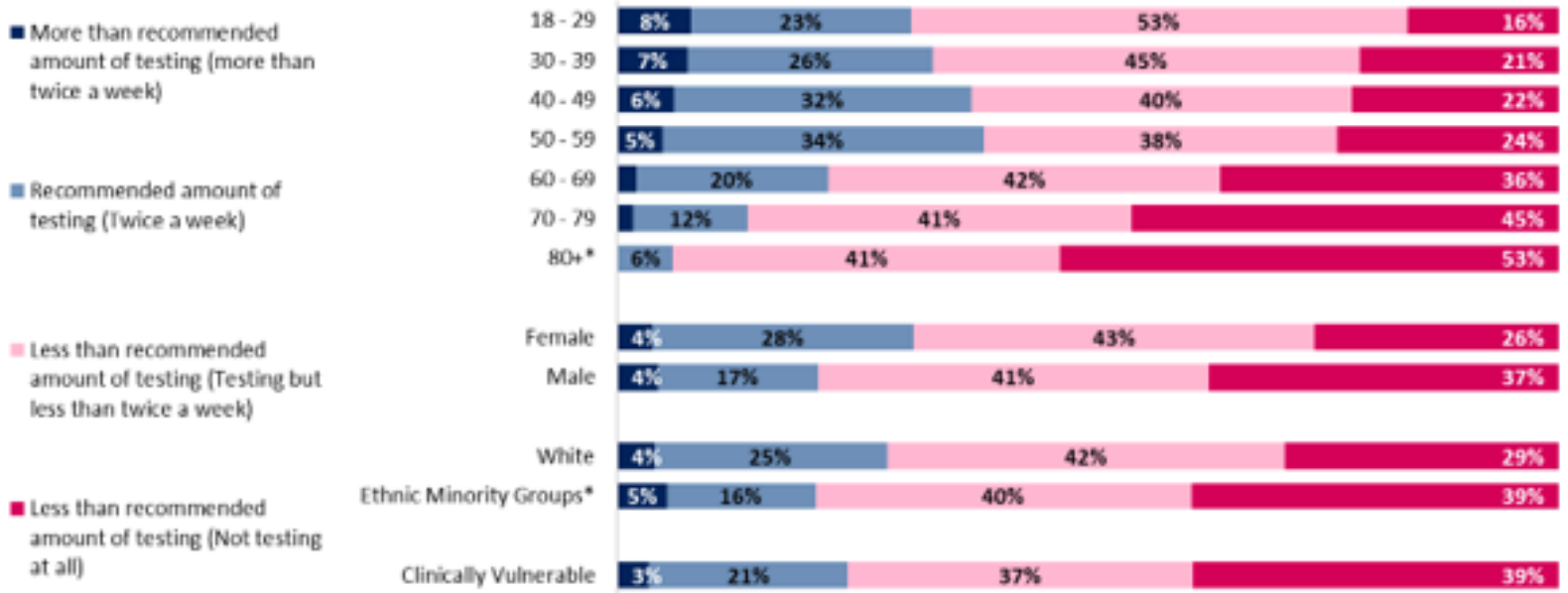
***Roughly how often do you use your symptom-free testing kit?***

This chart shows the frequency of symptom-free testing; older people aged over 60 years, males, people from ethnic minority backgrounds and clinically extremely vulnerable tended to test less often than average for the city

***Overall:***




***Broken down by demographics:***



# Vaccination coverage: Priority group 1-9

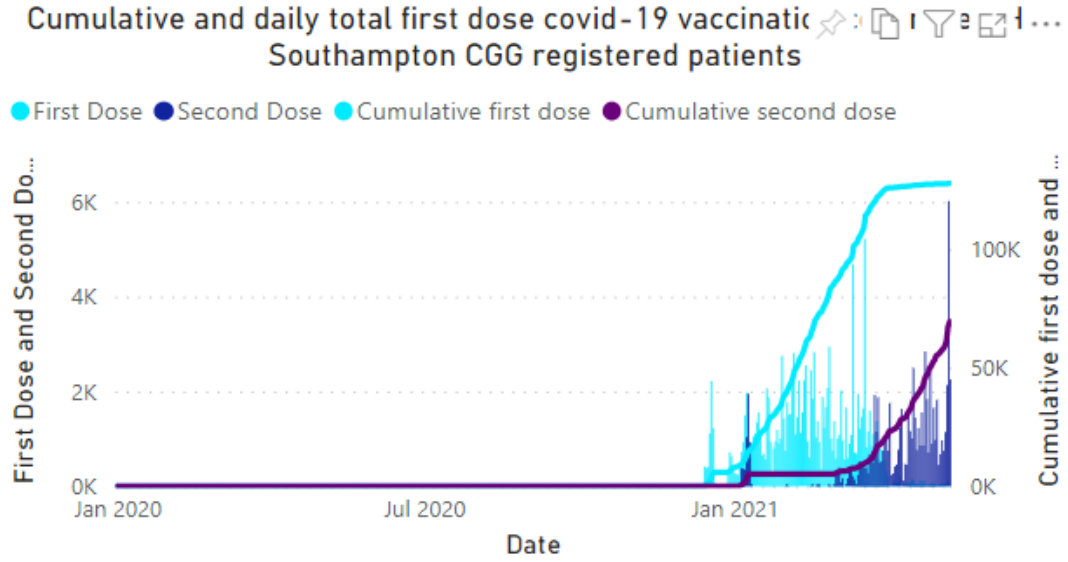
Source: National Immunisation Management System (NIMS)

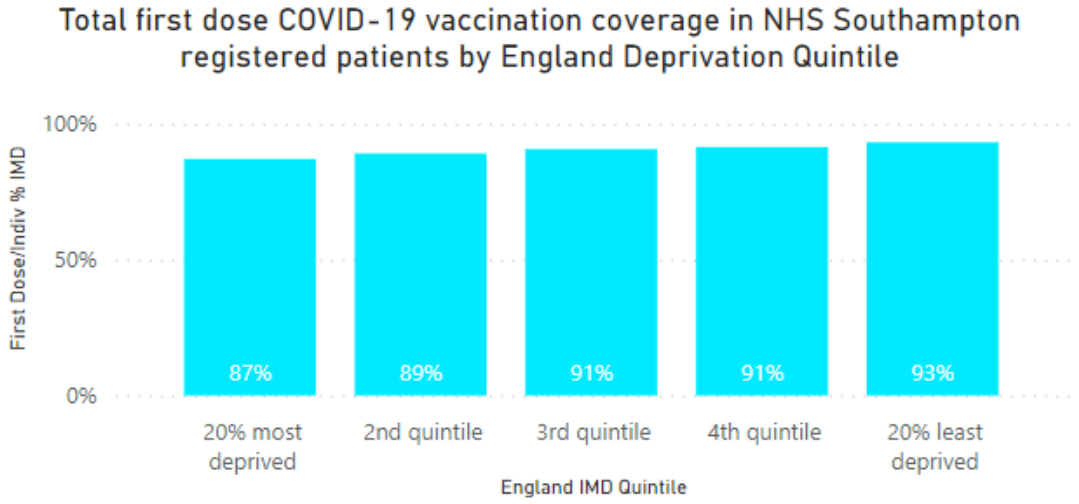
## Summary table

| Grouping | Individuals | First Dose | First Dose/Indiv % | Second Dose | Second Dose/Indiv % |
|---|---|---|---|---|---|
| Age 70 + | 27,081 | 25,760 | 95.12% | 25,527 | 94.26% |
| NHS and social care Worker | 8,381 | 7,981 | 95.23% | 7,718 | 92.09% |
| Clinically Extremely Vulnerable | 15,684 | 14,542 | 92.72% | 14,154 | 90.24% |
| Carers - Other | 2,042 | 1,876 | 91.87% | 1,816 | 88.93% |
| Age 50 - 69 | 57,078 | 49,854 | 87.34% | 48,680 | 85.29% |
| COVID19 at risk | 35,519 | 30,649 | 86.29% | 29,130 | 82.01% |
| Carers - DWP | 4,013 | 3,231 | 80.51% | 2,973 | 74.08% |
| **Total** | **149,798** | **133,893** | **89.38%** | **129,998** | **86.78%** |

**Across those cohorts at highest risk of death from COVID-19 infection there has been inequality in uptake across people from different ethnic minority groups ranging from 71% to 93% for first dose uptake**

This chart shows first dose vaccine uptake by deprivation and highlights an average 6% lower uptake between those living in the most deprived neighbourhoods in the city compared to the least deprived



# Test and Trace: Service Demand

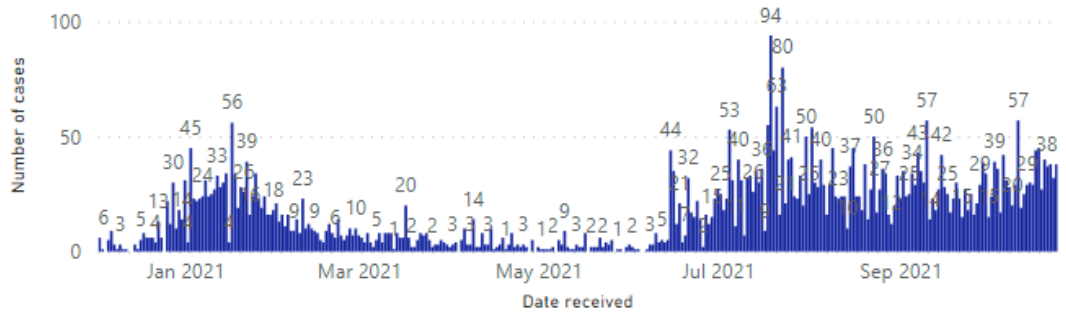
03/12/2020 24/10/2021

**28384**
Positive cases in Southampton

**5510**
Positive cases referred to ST&T

**19.47%**
Percentage of cases referred to ST&T

## Cases referred to ST&T by day



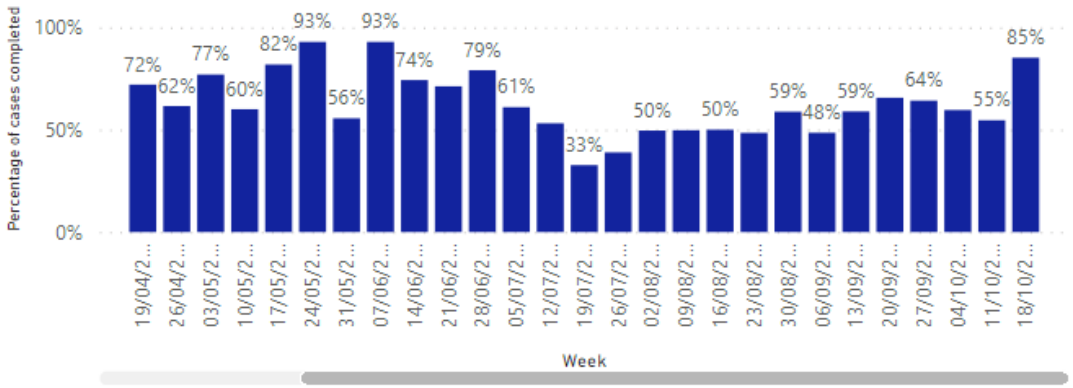

## Case status

| Case status | Number of cases | Percentage of cases |
|---|---|---|
| Referred back to National Test and Trace | 55 | 1.0% |
| In progress | 140 | 2.5% |
| Follow up failed - reached | 552 | 9.9% |
| Follow up failed - not reached | 1778 | 32.0% |
| Completed | 2994 | 53.8% |
| **Total** | **5510** | **99.2%** |

**Southampton local Test & Trace receives details for people who have tested positive with PCR and who have not responded to digital or telephone contact from the national NHS Test & Trace service within the first 28 hours so that further attempts to provide support and advice and carry out contact tracing can be made**

This chart shows some people are less likely to engage with Southampton local Test & Trace to receive advice about self-isolation requirements and help with contact tracing and this has worsened overtime

## Percentage of completed cases



# Ability to adhere to protective measures

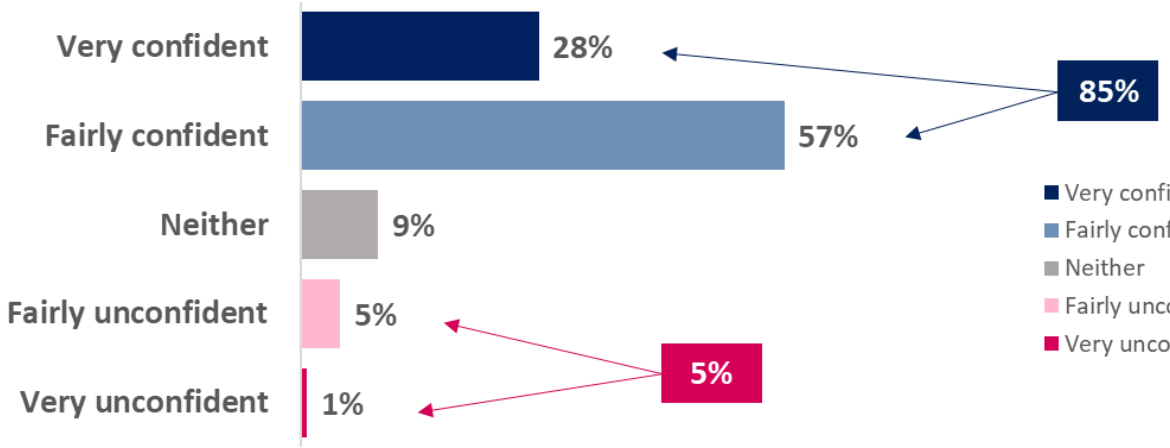
Understanding guidance and restrictions throughout different stages of the pandemic has been a challenge for all of us due to how quickly the situation was changing. In November 2020 we asked our residents how confident they were in understanding the current rules and guidance in the 4th COVID-19 resident survey.

This chart shows that confidence was generally very high but younger age groups, minority ethnic groups and parents were least confident in understanding COVID-19 rules and guidance compared to other groups

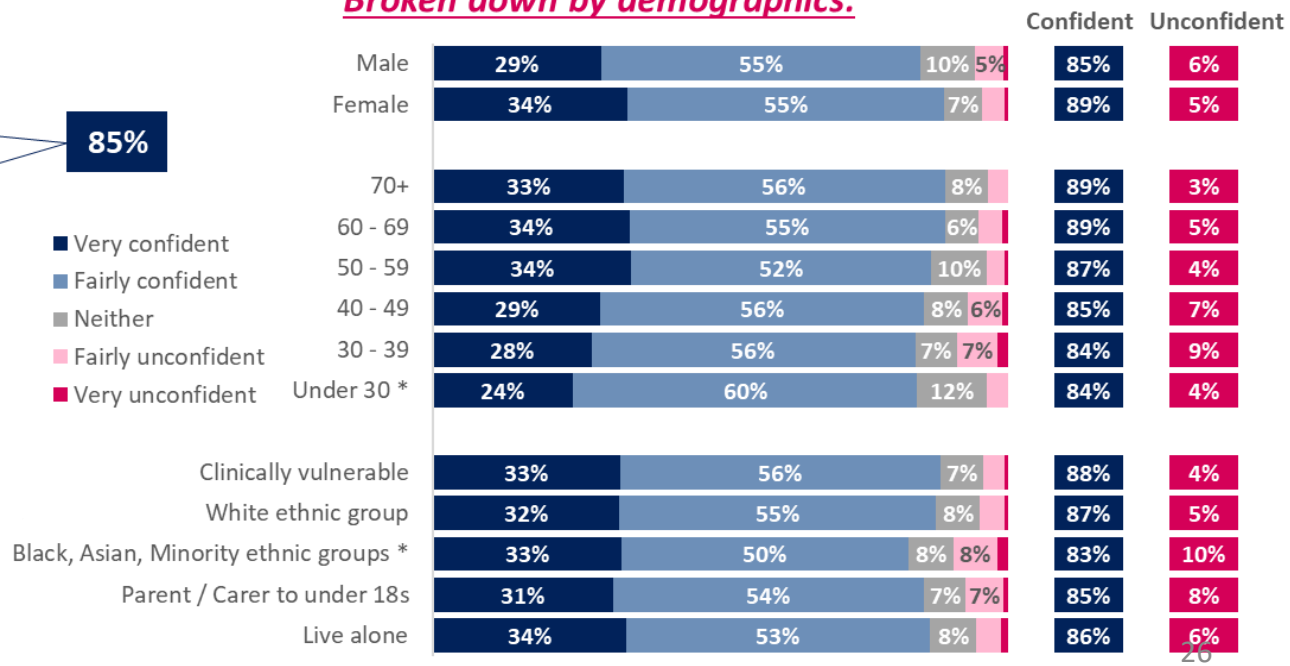
**Question: How confident are you that you understand the current rules and guidance?**



***Overall:***




***Broken down by demographics:***

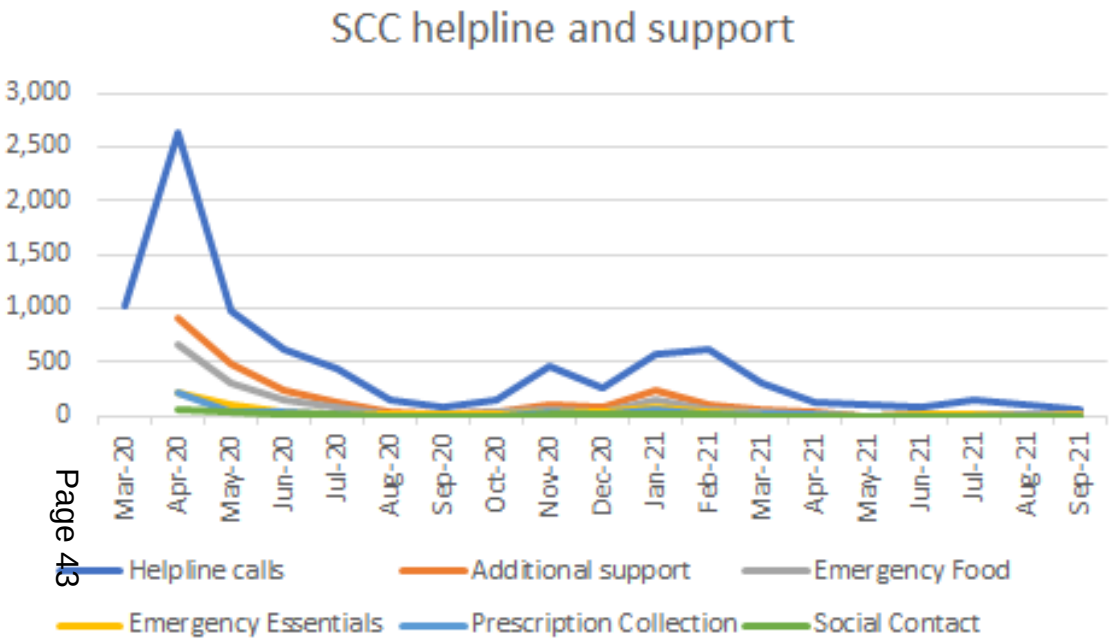



***Comparison to previous surveys:***

July: 80% November: 85% (Those that said very or fairly confident)

* Small sample size – fewer than 100 respondents

# Supporting vulnerable groups in Southampton




This chart shows that support has been sought at all stages of the pandemic but with peaks in calls to the SCC helpline and other support have mirrored the waves of infection in the city

COVID-19 Community Champions

Future Communities

Community Cohesion Forum

Community Participatory Action Research

Engagement Leads Network

A small selection of SCC community support and engagement groups



**Self-isolation support payments**
From 9th October 20 to 14th October 21
4742 applications

| Scheme | Successful | Paid |
|---|---|---|
| Main | 829 | £414,500 |
| Discretionary | 298 | £149,000 |


SCM Basics Banks: vouchers used
Jan 2020 – October 2021

Southampton City Mission

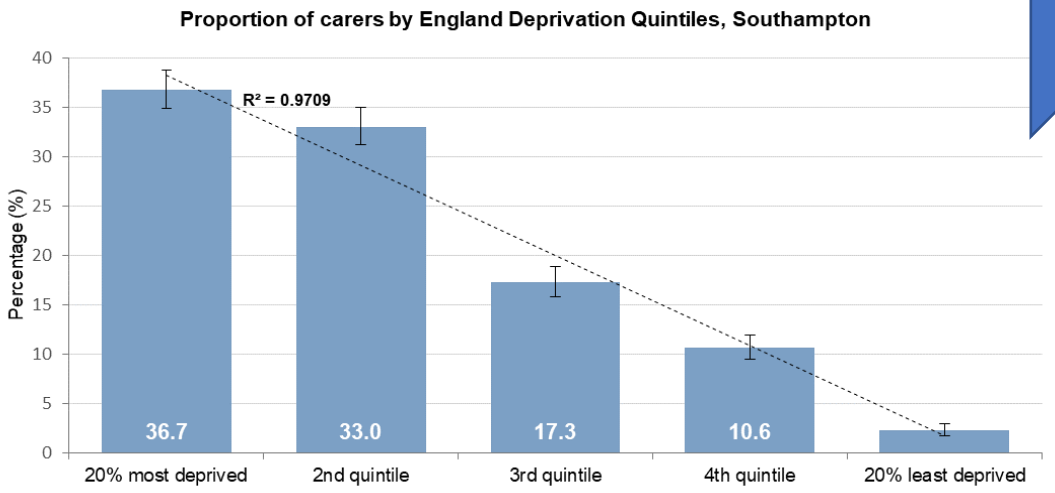
28.4%

Number of times SCM fed people – increase between 2019 & 2020

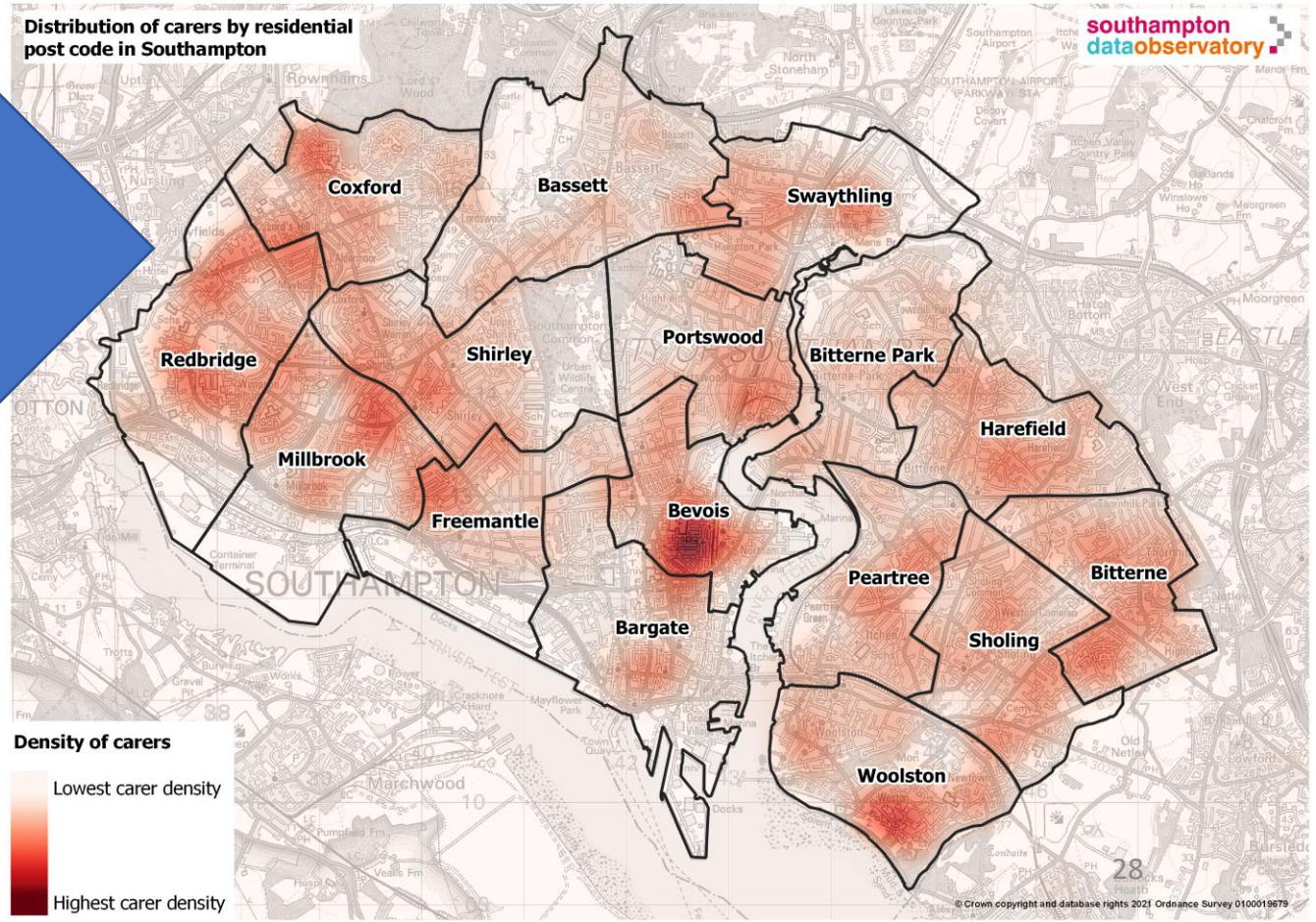
# Vulnerable groups in Southampton: carers

In Southampton, the burden of caring falls more heavily on those who live in deprived areas. During the pandemic, carers were less able to provide the support that was required due to lockdowns and restrictions on movement (especially in the early weeks when it was unclear what was permitted under national guidance), illness, closure of services and support etc. 'Carers in Southampton' told us that there were large increases in traffic on their webpages that provided advice about assisted shopping, food banks and food services, hospital ward numbers and LD passport, free legal advice, mobility aids and emergency plans. There was a sustained uplift in use of Carers in Southampton's online referral and self-referral forms. We also know that carers are more likely to suffer from poor health and their needs will have been exacerbated by the pandemic.

This map shows a snapshot from early 2021 of carers by place of residence in Southampton: Much greater proportions of carers live in areas considered to be in the 20%/40% most deprived in the country. Main hotspots of carers living centrally in Bevois, in Bitterne and Woolston in the east, and in a stretch from Freemantle to Redbridge across the western localities. These are similar neighbourhoods with high levels of clinical vulnerability to COVID-19 and vulnerability to the policy measures to control the spread of infection




Source: Carers in Southampton (2021)



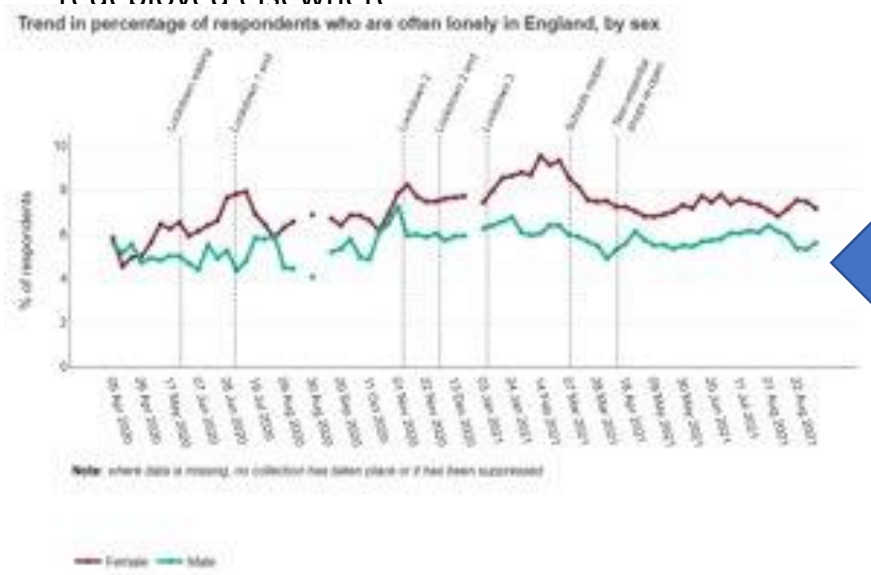
# Vulnerable groups in Southampton

**People with learning disabilities**

A national PHE report from November 2020 found that deaths from COVID-19 in people with learning disabilities were much higher than the general population (up to 6.3 times higher when adjusting for age and gender). The direct impact of COVID-19 on people with learning disabilities living in Southampton requires further analysis.

A Local Government Association report from 2021 listed the following additional impacts:

- COVID-19 restrictions affected routines, support and occupational activity which may have limited people's independence
- Increased risk of physical complications due to COVID-19 infection
- Reduced access to healthcare and physical health reviews, potential for delayed presentation
- Increased risk of mental health difficulties and challenging behaviour
- Increased risk of abuse/neglect
- Increased strain on families and carers, especially if support or respite care suspended
- Specialist staff trained to work with people with learning disabilities may have been redeployed elsewhere




This national PHE survey data shows trends in the number of females and males reporting loneliness over the pandemic in England

**LGBTQ population**

Data for Southampton residents is not available and there is little national data on the impact on the LGBTQ population. However, a 2021 survey report written by an organisation called Switchboard in partnership with Brighton and Hove City Council found that during the pandemic:

- 74% of LGBTQ respondents reported feeling depressed and anxious; 33% had considered suicide
- 68% felt lonely and isolated
- 40% used alcohol and drugs to manage their mental health
- 22% were living in an unsafe situation
- 24% could not access support when they needed it

The UN Development Programme also said that LGBTQ+ people are:

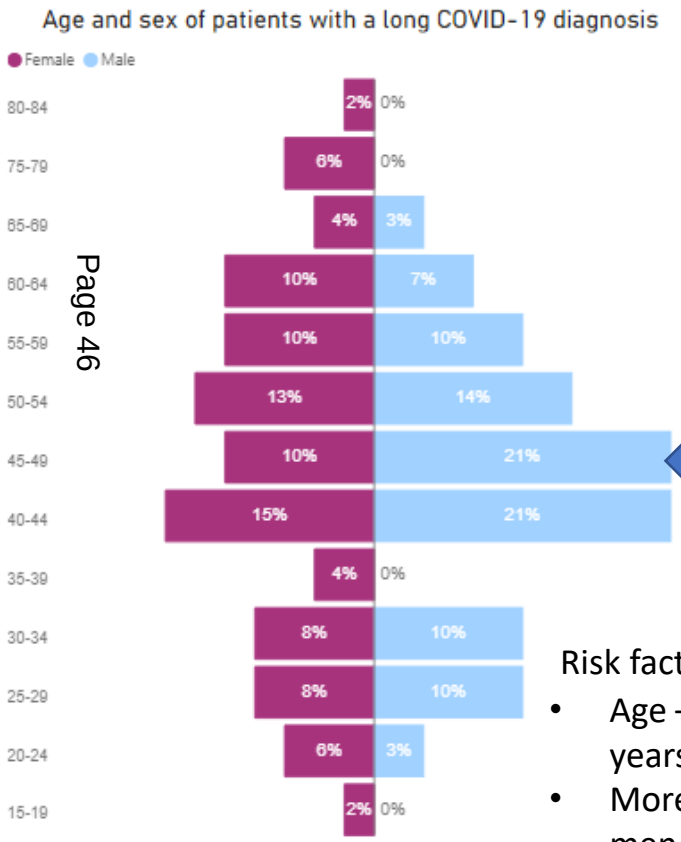
- Less likely to seek medical help or access vital services
- More likely to work in the informal sector with poor access to sick pay

**Homeless Population**

The direct impact of COVID-19 on people experiencing homelessness in Southampton requires further analysis. This population are vulnerable to exposure to the virus such as when sharing accommodation and have a high burden of pre-existing conditions which can put them at greater risk of severe infection. SCC has supported a reduction in risk of transmission in homeless hostels through provision of vaccination and regular testing.

# Long covid

Long Covid is an umbrella term that includes symptoms lasting more than 4 weeks (on-going symptomatic COVID-19) and more than 12 weeks (post-COVID-19 syndrome) that develop during or following an infection consistent with COVID-19. A recent ONS study put UK prevalence at between 3% and 11.7% of people who have had a COVID-19 infection and had symptoms at 12 weeks. The impact on people living in Southampton requires further analysis but is likely to mirror the national picture.




This chart shows distribution of people with a read code for long COVID-19 in a snapshot of Southampton GP data with COVID-19 diagnoses between January and April 2021 (48 females, 29 males total)

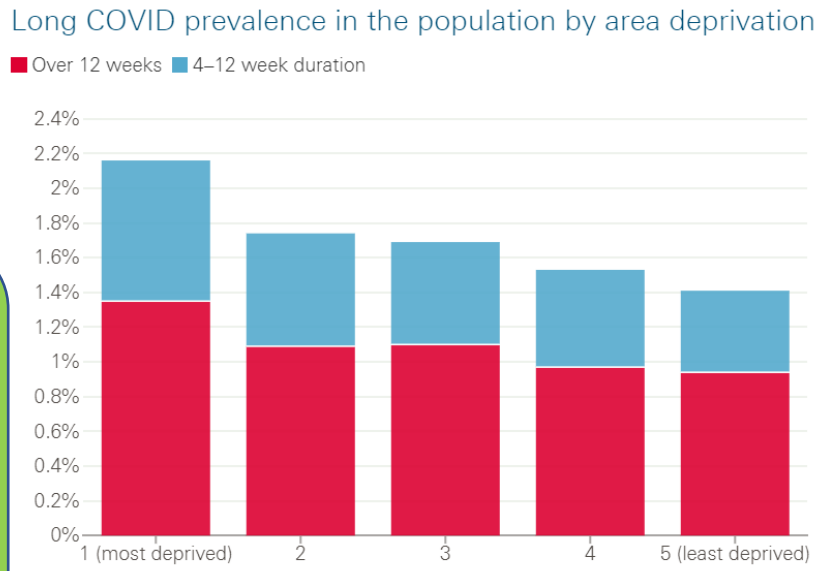
Common symptoms include fatigue, breathlessness, headaches, joint and muscle pain, chest tightness/pain, sleeping problems, memory and concentration difficulties and persistent cough. The long-term course of Long Covid is unclear but symptoms can last for over a year and be debilitating, impacting on people's ability to work and care for others. This has implications for health and social care and for the local economy.

There is a Long Covid service at UHS accepting referrals from general practice.

Risk factors for Long Covid include:

- Age – highest prevalence in 35-69 years
- More women are affected than men
- Deprivation
- Working in health and social care
- Pre-existing health conditions

**Long Covid can be a debilitating disease that impacts on people's ability to go about daily activities, which has important implications for health and social care and the local economy.**




The Health Foundation © 2021

Source: Source: ONS, Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK: 1 April 2021. The data is based on self-reported long COVID status based on a follow-up to a positive test in the ONS infection survey after four weeks.

# Business Vulnerability Index

| Area | Mobility - Retail and Recreation percent change from baseline (average 16/03/20 to 21/06/21) | Coronavirus Job Retention Scheme (Average take-up rate July 2020 to May 2021) | Self-Employment Income Support Scheme (Average take-up rate Grant 1 to 4) | Vulnerable Industry (per 1,000 business) | Vulnerable business size (per 1,000 business) | Claimant Count Rate (Increase between Feb 2020 and Feb 2021 - proportion of residents aged 16-64) | Sum of Z-Score | Z-Score Ranking (1 = most vulnerable) |
|---|---|---|---|---|---|---|---|---|
| **England** | | **12.6** | **67.4** | **119.5** | **896.8** | **3.5** | | |
| South East | | 12.5 | 65.3 | 110.3 | 902.5 | 3.2 | | |
| **Southampton** | **-51.3** | **11.5** | **70.6** | **112.7** | **911.0** | **3.7** | **0.71** | 6 |
| Newcastle upon Tyne | -55.3 | 13.2 | 69.2 | 192.1 | 849.8 | 3.7 | -0.13 | 7 |
| Liverpool | -47.5 | 12.6 | 72.5 | 160.3 | 881.1 | 4.1 | 3.15 | 3 |
| York | -45.6 | 13.2 | 67.3 | 165.0 | 874.6 | 2.2 | -1.12 | 9 |
| Sheffield | -47.4 | 11.5 | 70.8 | 147.1 | 866.9 | 3.2 | -1.05 | 8 |
| Leeds | -48.5 | 11.7 | 68.3 | 119.9 | 881.7 | 3.6 | -1.23 | 10 |
| Coventry | -42.1 | 11.5 | 69.6 | 113.6 | 895.8 | 3.6 | 0.77 | 5 |
| Portsmouth | -44.2 | 12.8 | 73.4 | 160.6 | 888.7 | 3.9 | 4.46 | 2 |
| Isle of Wight | -30.6 | 14.9 | 64.5 | 204.6 | 864.4 | 3.6 | 4.81 | 1 |
| Hampshire | -41.0 | 11.6 | 63.9 | 98.6 | 893.3 | 2.7 | -3.17 | 12 |
| Bath and North East Somerset | -53.2 | 13.6 | 63.0 | 136.6 | 887.6 | 2.1 | -3.65 | 14 |
| Bournemouth, Christchurch and Pool | -40.7 | 13.9 | 67.7 | 126.7 | 887.1 | 3.6 | 2.23 | 4 |
| Bristol | -52.8 | 11.7 | 67.1 | 135.9 | 879.7 | 3.5 | -1.99 | 11 |
| Plymouth | -44.8 | 10.2 | 69.5 | 153.0 | 867.2 | 2.5 | -3.23 | 13 |

Significantly less vulnerable compared to England average
Less vulnerable but not significantly compared to England average
Similar vulnerability compared to England average
More vulnerable but not significantly compared to England average
Significantly more vulnerable compared to England average

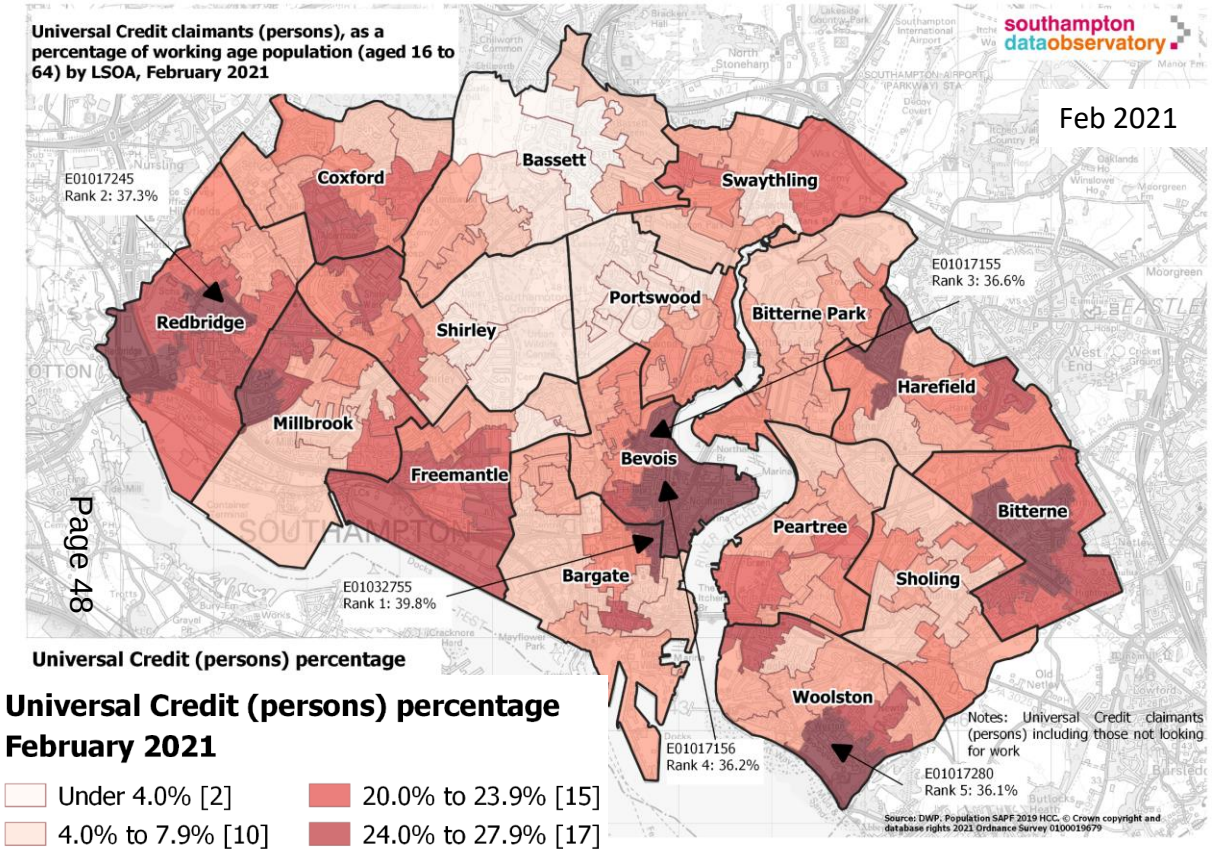
These six measures were identified as key business vulnerabilities

The tartan rug compares Southampton and ONS Comparators to national averages, significance assessed using 95% confidence intervals

Overall, businesses in **Southampton** deemed to be **sixth most vulnerable** out of 14 comparators - the higher rate of small businesses and greater proportion of SEISS take-up highlighted in Southampton

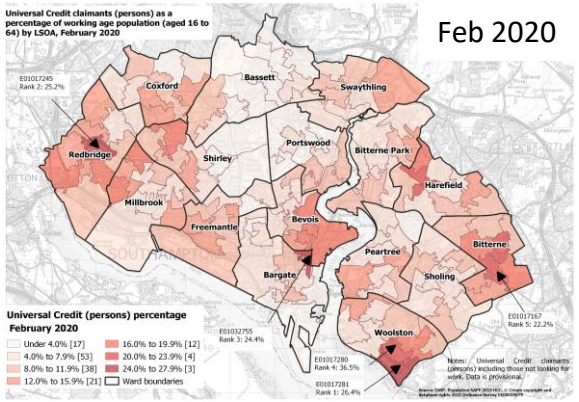
Local authorities with more vulnerable industries and therefore greater increase in claimant counts and take-up of the CJRS and SEISS appear to be more vulnerable – particularly the Isle of Wight, Portsmouth, Liverpool and Bournemouth, Christchurch & Poole

# Impact on benefits: Universal Credit



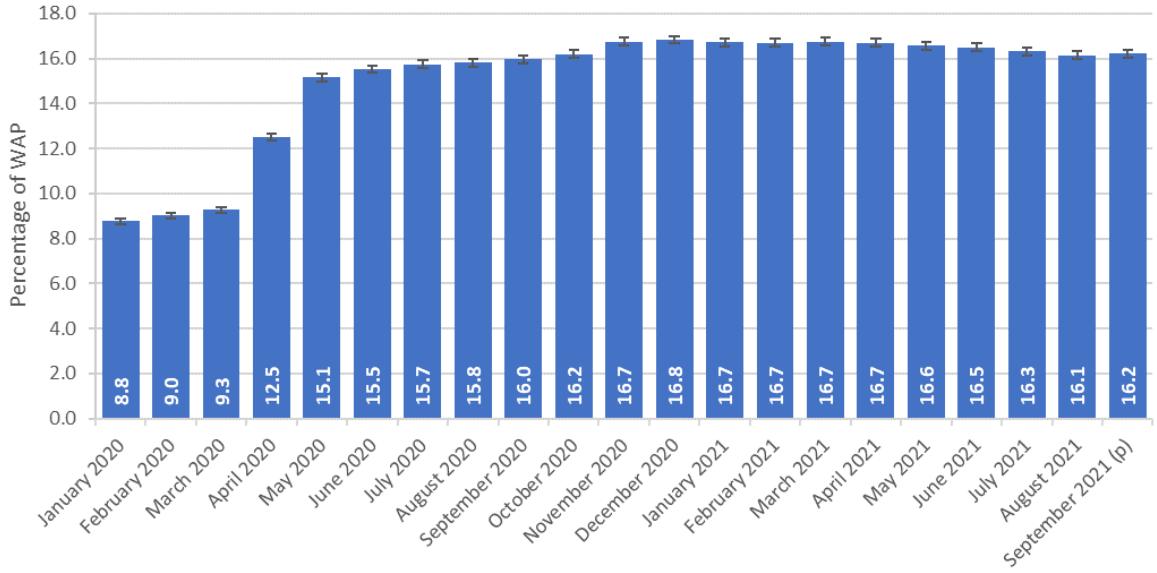



**The greatest increases in Universal Credit claimants were in the most deprived areas of the city risking widening of inequalities**




This map shows the distribution of the population claiming universal credit in Feb 2021 which had increased from a city average of 8.8% in Feb 2020 to 16.7% in Feb 2021 and remains over 16% to date

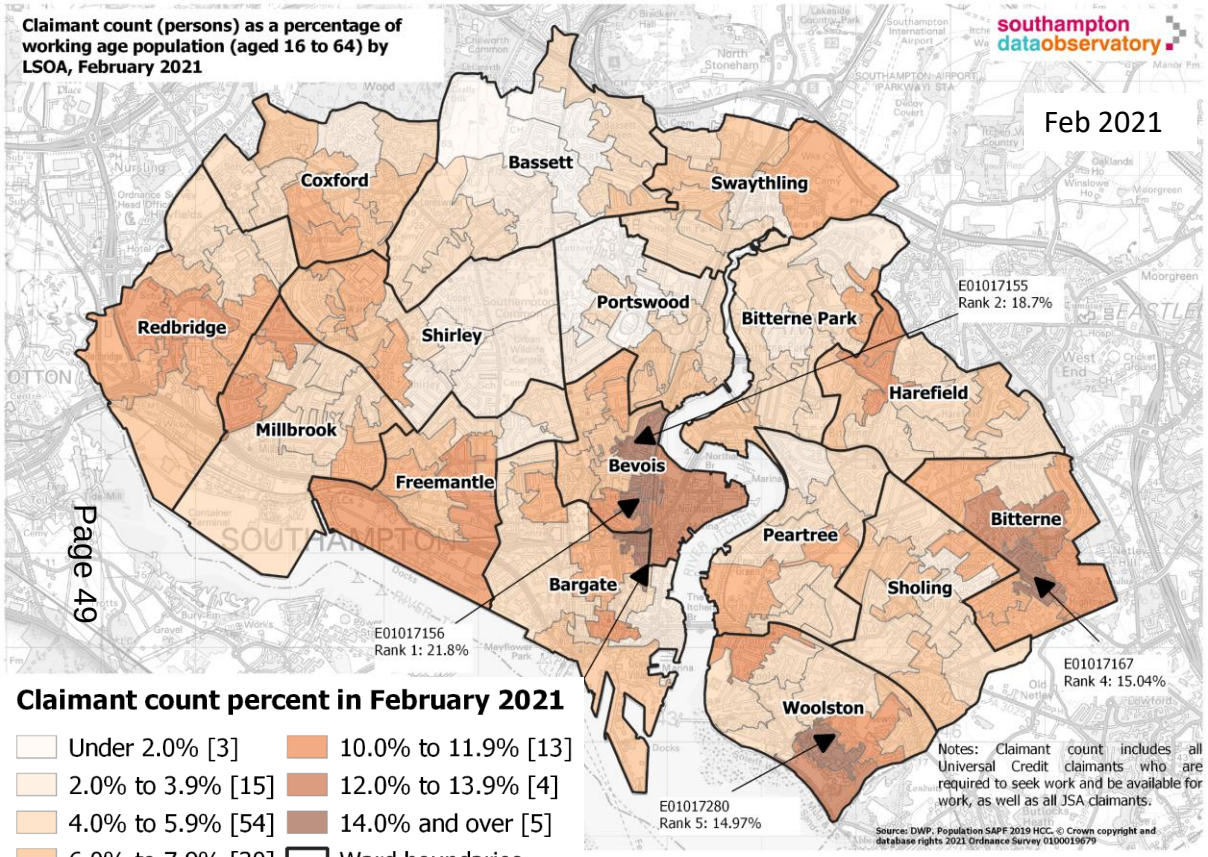
People on Universal Credit (total): Southampton January 2020 to September 2021 (p) percentage of working age population (WAP) [1]




Source: DWP 2021 (via Stat-Xplore). (p)-provisional

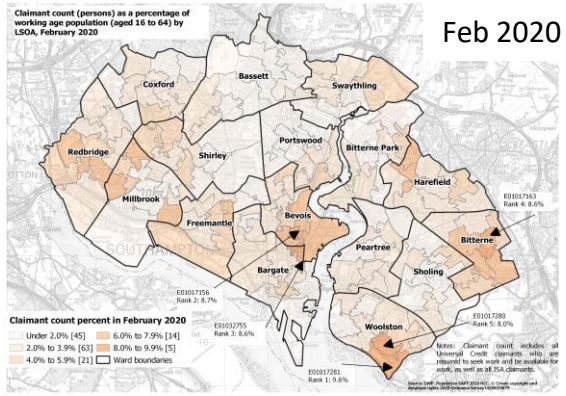
[1] Population - WAP Feb 2020 to March 2021 - HCC SAPF 2019. WAP from April 2021 - HCC SAPF 2020

# Impact on benefits: Claimant Count



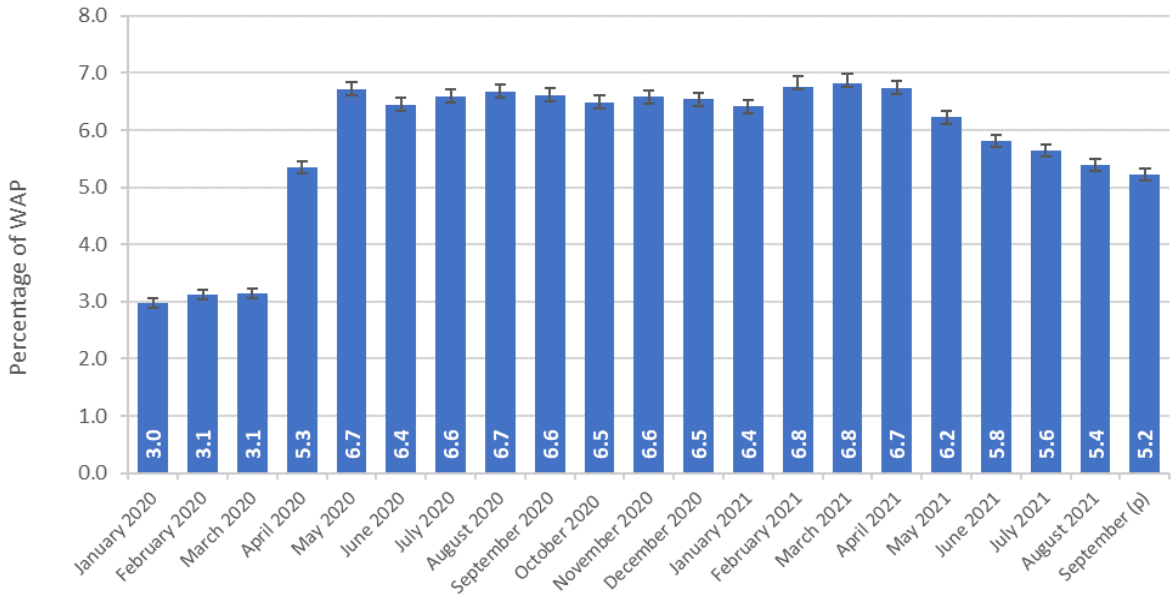



**The greatest increases in claimant counts were in the most deprived areas of the city risking widening of inequalities; Southampton had a higher rate of claimant counts than the South-East and England average**




This map shows the distribution of the population claiming benefits in Feb 2021 which had increased from a city average of 3.0% in Feb 2020 to 6.8% in Feb 2021 and rhas only recently started to fall since the easing of restrictions

Claimant Count: Southampton January 2020 to September 2021 (p). Percentage of working age population (WAP) [1]

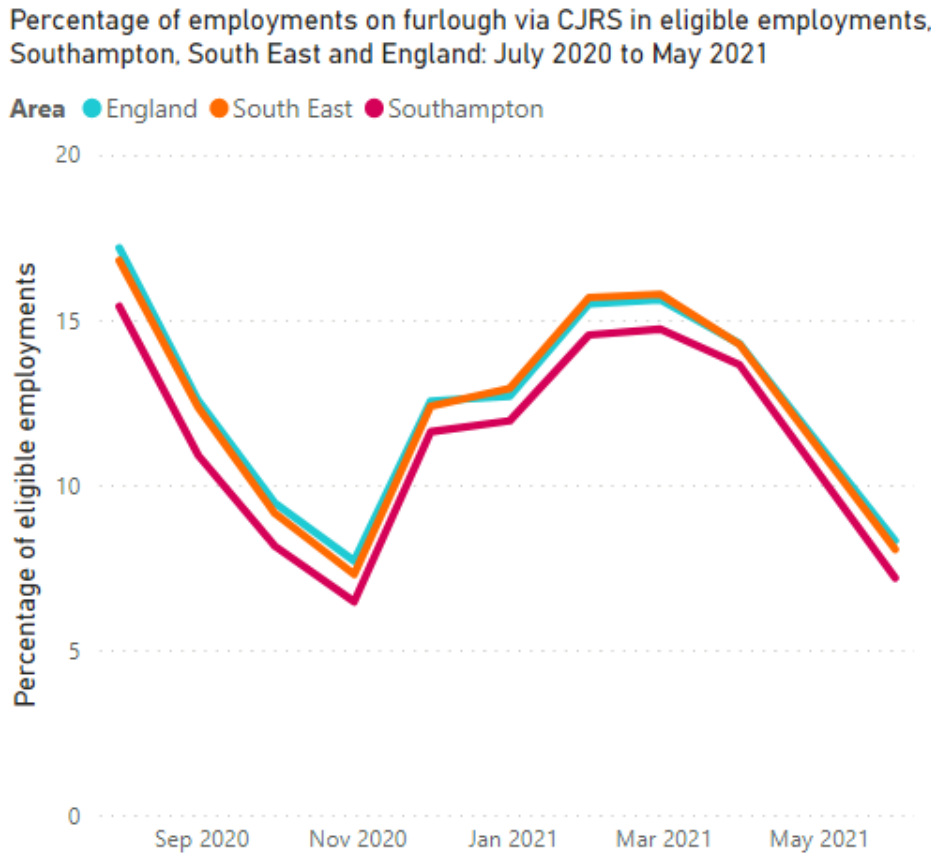



Source: DWP 2021 (via NOMIS). (p)-provisional

[1] Population - WAP Feb 2020 to March 2021 - HCC SAPF 2019. WAP from April 2021 - HCC SAPF 2020

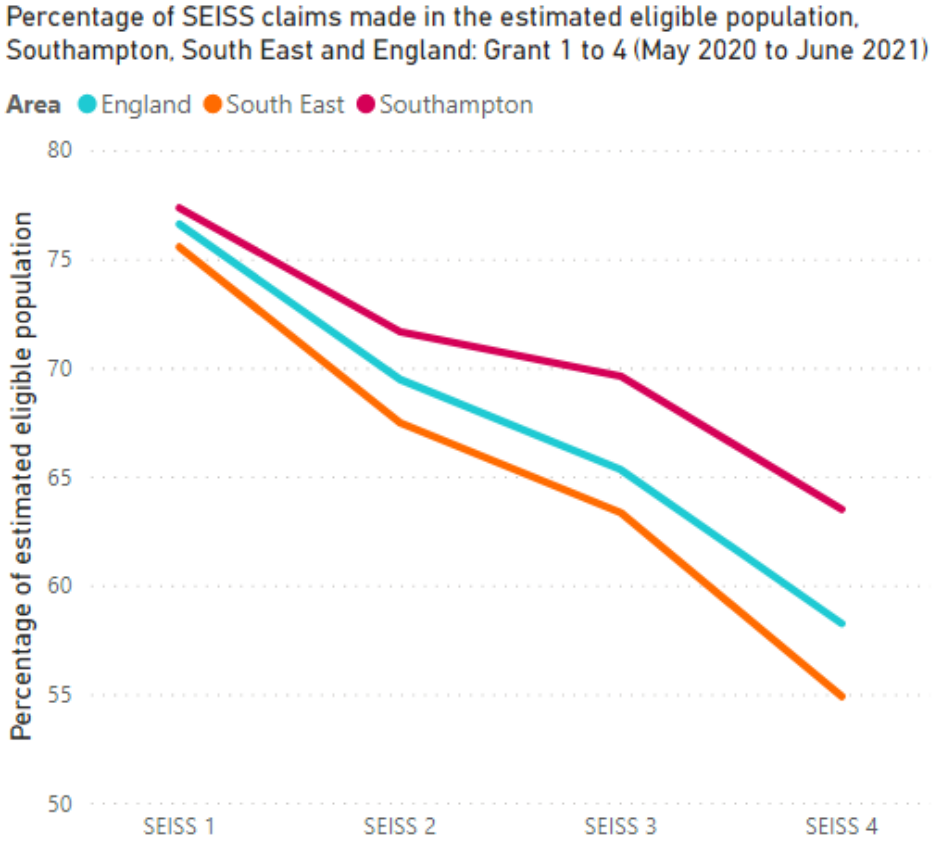
# Impact on employment

## Coronavirus Job Retention Scheme (CJRS) - Furlough




There was a lesser uptake in the CJRS in Southampton than England and South-East overall, but followed a similar trend throughout the pandemic, indicating that restrictions had similar impacts on our businesses

## Self Employment Income Support Scheme (SEISS)



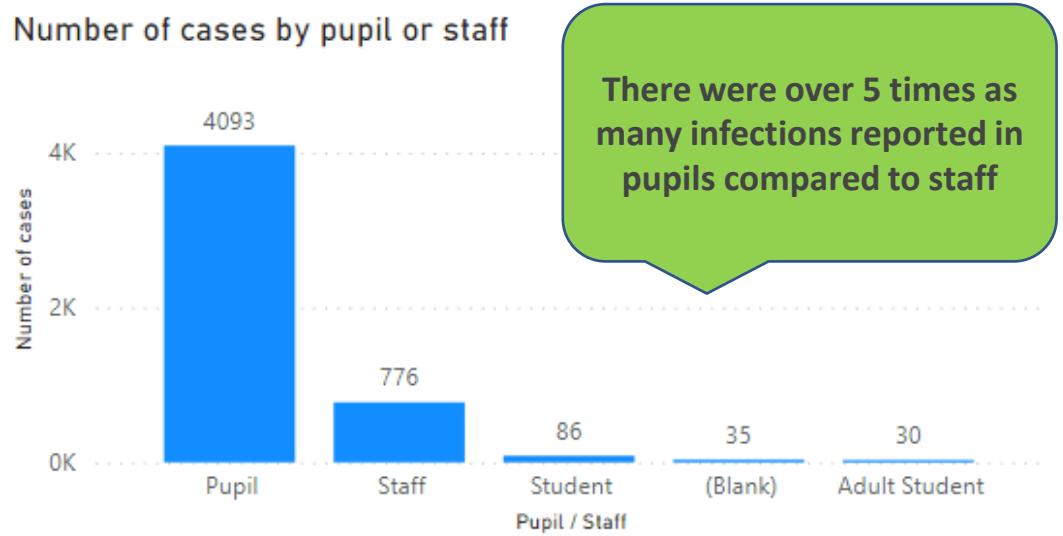

There was a greater proportion of SEISS claims in Southampton than England and South-East, plus slower decline over time through the second, third and fourth schemes possibly indicating that the self-employed in Southampton were more vulnerable during the pandemic

# Impact on education

The pandemic has had an enormous impact on education with schooling hugely disrupted and vulnerable children most affected. Published data on the impact on attainment outcomes is not yet available but national estimates of the potential impact include:

- each day of individual pupil absence results in around 0.3% to 0.4% of a standard deviation reduction in attainment
- an overall impact of between 6% to 10% of a standard deviation reduction in attainment due to time out of school in the 2019 and 2020 academic year

Other impacts of school closures include emerging learning difficulties missed, mental health deterioration, reduced physical activity, safeguarding opportunities missed, negative impact of additional time spent online (exposure to inappropriate content, digital dependency etc), disruption to vaccination programmes, reduced access to services, free school meals, extended periods of remote learning leading to poorer educational outcomes.




There were over 5 times as many infections reported in pupils compared to staff

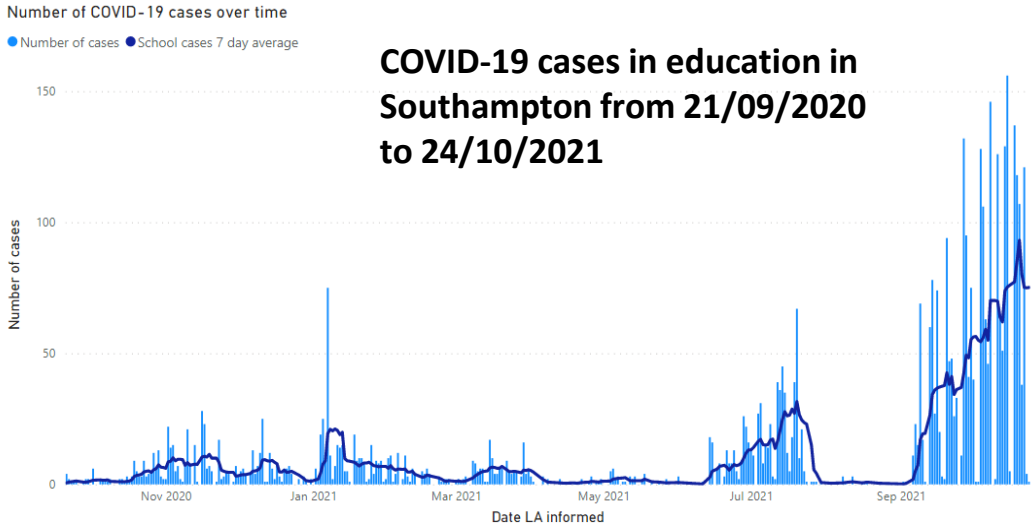
**4382** Total number of cases

**24,311** Number of Pupils who have isolated

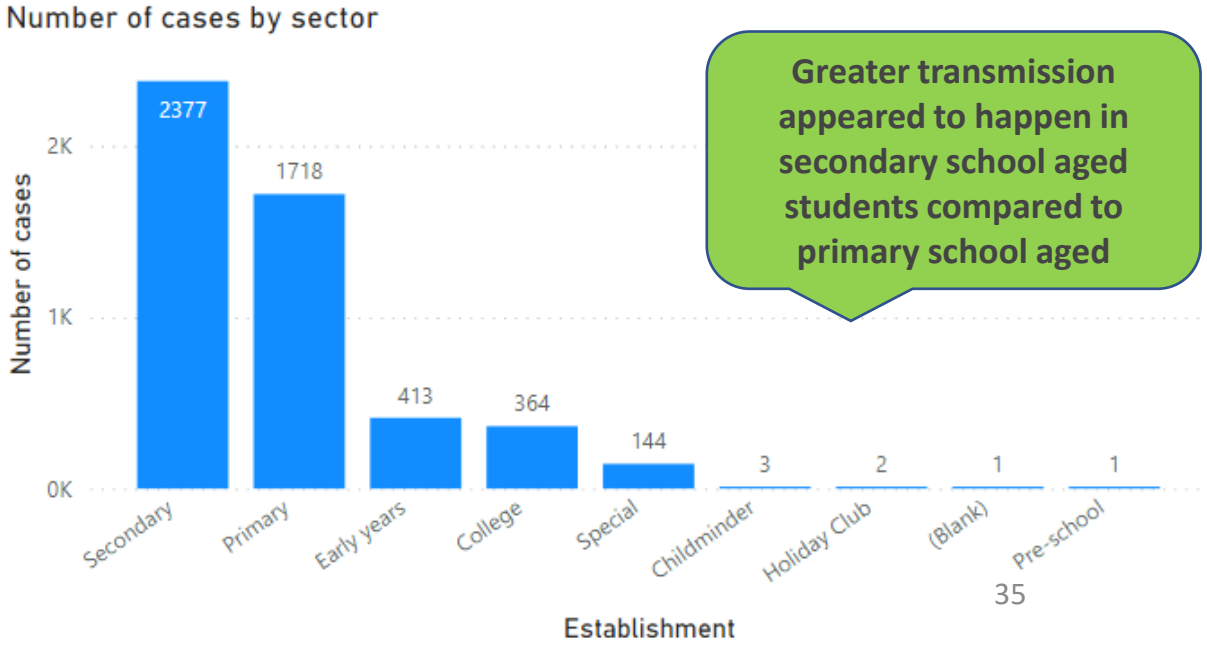
**2,567** Number of Staff who have isolated

**90** Closed Settings

**48%** Percentage of cases with a positive LRF




**COVID-19 cases in education in Southampton from 21/09/2020 to 24/10/2021**




Greater transmission appeared to happen in secondary school aged students compared to primary school aged

# Healthy Living

This section describes how the pandemic affected people's ability to lead healthy lives.

# Impact on healthy weight

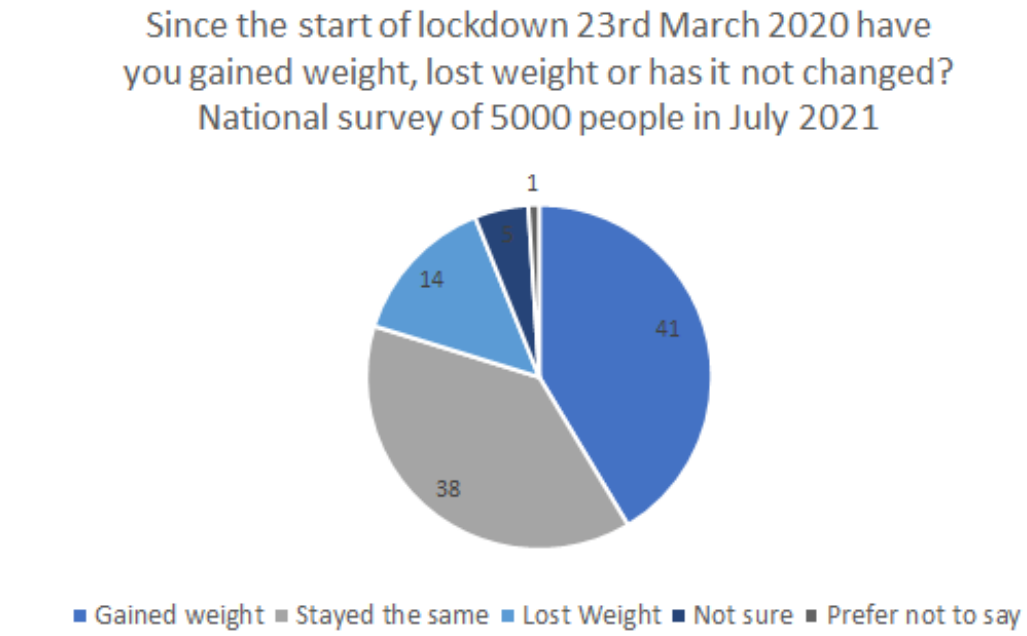
Local data on how the pandemic has affected healthy weight behaviour and outcomes is not yet available. However, we do know there has been a reduction in people accessing weight management services in Southampton. There is likely to have been an impact on people's weight through changes in e.g. eating habits and the way we work.

Childhood obesity prevalence nationally has increased since 2019/20, with the National Child Measurement Programme reporting:

- In Reception, obesity prevalence has increased - 9.9% in 2019/20 to 14.4% in 2020/21
- In Year 6, obesity prevalence has increased - 21.0% in 2019/20 to 25.5% in 2020/21
- Boys have a higher obesity prevalence than girls for both age groups
- Children living in the most deprived areas were more than twice as likely to be obese than those living in the least deprived areas

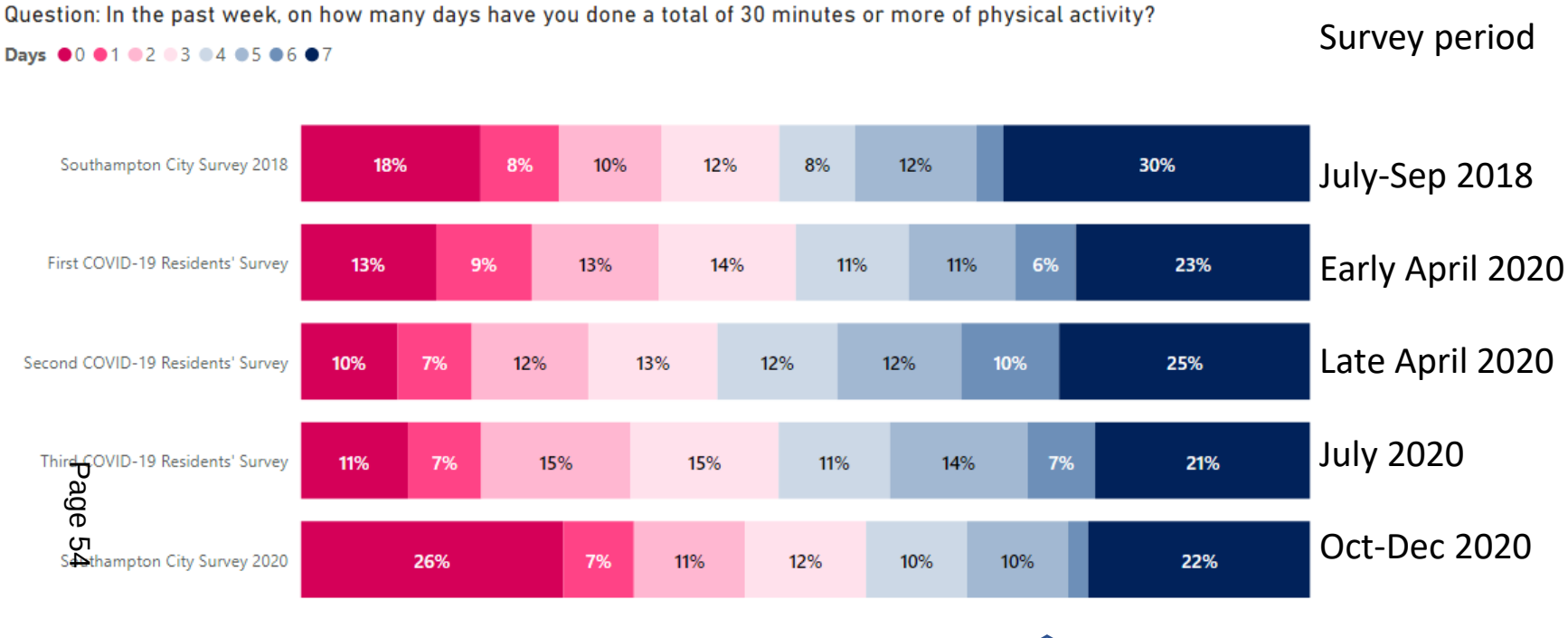


**The PHE national survey Better Health and PHE obesity campaign: attitudinal survey data published July 2021 found that 41% of adults in England said they had put on weight since the start of Lockdown in March 2020 and that on average 4.1kg (over half a stone) was gained by those who said they had put on weight. Where weight was gained, nearly half who responded said unhealthy eating habits were the main reasons.**




This chart shows the percentage of respondents by self-reported changes in weight since March 2020 to July 2021 and shows 41% gained weight, 38% stayed the same, and 14% lost weight.

# Impact on physical activity




**Southampton residents self-reported physical activity levels were reasonably consistent across the course of the pandemic. Variation may also be influenced by season.**

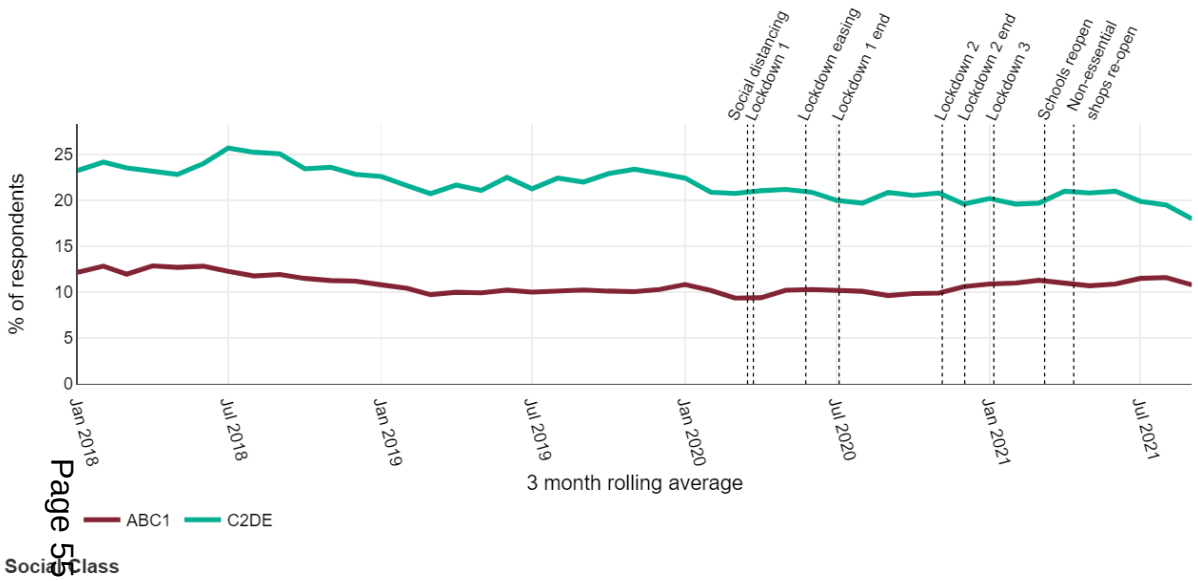
This chart shows a time series of Southampton resident survey responses to the question on number of days achieving 30 minutes or more of physical activity; blue indicates higher and pink lower number of days when this was achieved

## National data: Sport England April 2021

"The majority of physically active adults in England managed to maintain their habits despite the challenges of the coronavirus (Covid-19) pandemic, according to our latest Active Lives Adult Survey... However, the first eight months of coronavirus restrictions, as well as the storms that had a huge impact on outdoor activity in early 2020, also led to a worrying increase in the number of people who were inactive – doing less than 30 minutes of activity a week or nothing at all... Not all groups or demographics were affected equally though, with women, young people aged 16-24, over 75s, disabled people and people with long-term health conditions, and those from Black, Asian, and other minority ethnic backgrounds most negatively impacted beyond the initial lockdown period."

# Impact on smoking

**Prevalence of cigarette smoking (STS) in England by social class**




**Social Class**

**ABC1:** higher and intermediate managerial, administrative and professional workers, supervisory, clerical and junior managerial, administrative and professional workers, **C2DE:** skilled manual workers, semi-skilled and unskilled manual workers, people on long term state benefits, casual and lowest grade workers, unemployed with state benefits (including pension) only

Source: Smoking Toolkit Study, UCL, www.smokinginengland.info

Data from [Wider Impacts of COVID-19 (phe.gov.uk)]

**This chart shows a small narrowing of the gap between social classes in the prevalence of smoking, with a small decline in smoking in manual and casual workers and people on long term state benefits**

## YouGov/ASH June 2020

- 4.6% of respondents gave up smoking due to COVID-19 in the previous 4m
- 7.4% gave up for other reasons
- Estimated 1million quit during the first lockdown

## Addiction study First lockdown

- Increased smoking prevalence in ages 18-34
- Increased quit attempts in ages 18-34
- Increased successful cessation in ages 18-34

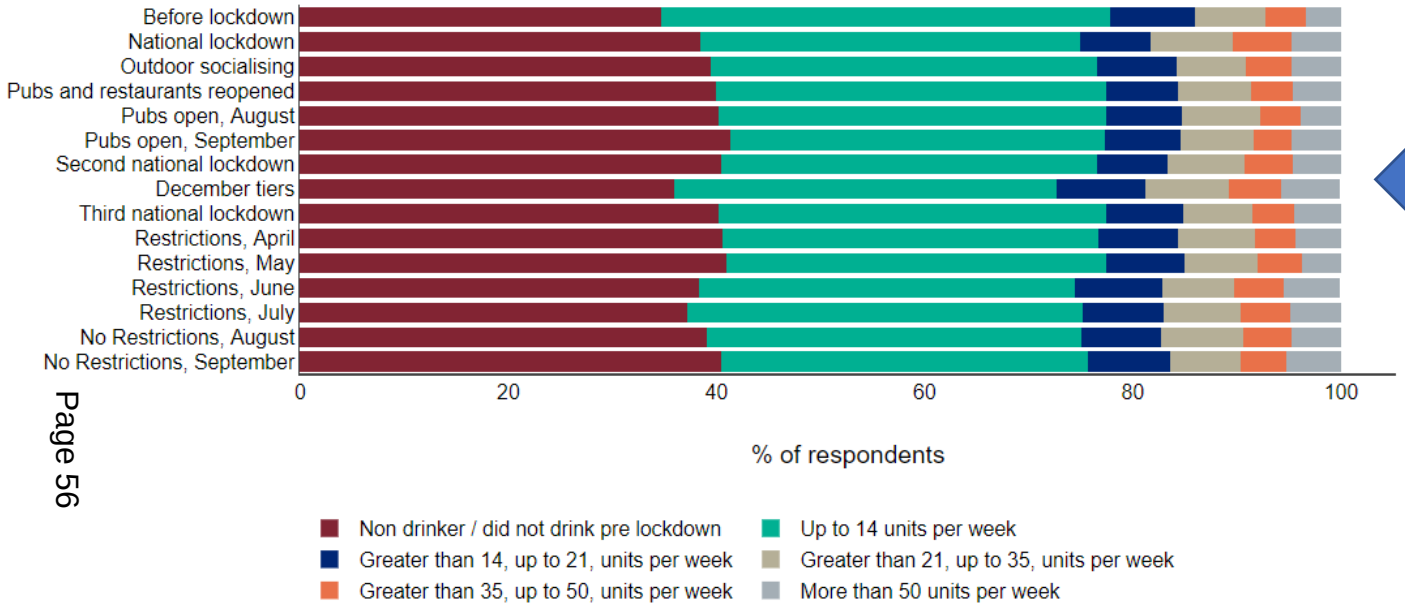
## Smoking at the time of delivery

- 9.6% of women were smokers at time of delivery in 2020-21 – an 0.8 percentage point decrease from 2019-20 (10.4%), but still above the current national ambition of 6% or less

National data shows a mixed picture of increased quitting in the early phase of the pandemic but more younger people taking up smoking. Up to September 2020, there were marginally more people who reported smoking more during lockdown than people who reported smoking less. Just under 50% of people said they were smoking about the same amount.

# Impact on use of drugs and alcohol

**Percentage of respondents aged 18+ years who consumed each of the unit groupings during a typical week in England**




This chart suggests that there were not huge shifts in drinking behaviour as a result of the pandemic. However, high risk drinking increased during lockdowns and this rate of consumption has not returned to pre-pandemic levels. The number of people not drinking any alcohol has increased over the period of the pandemic.

Data from [Wider Impacts of COVID-19 (phe.gov.uk)]

**Use of local services in Southampton (National Drug Treatment Monitoring System)**

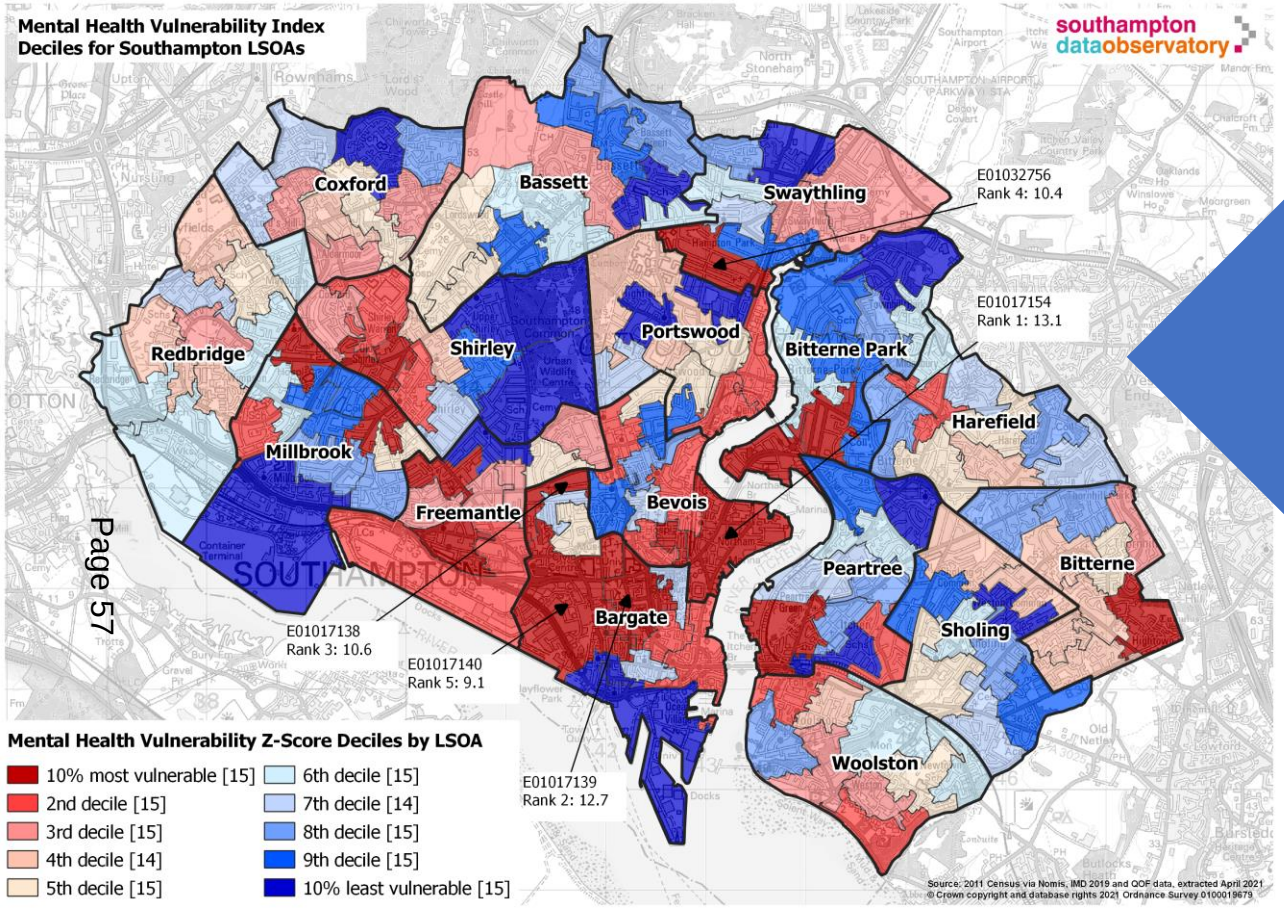
People who use opiates accessing treatment/ support

People who use alcohol acessing treatment/ support

The Global Drugs Survey found that between May and June 2020 in the UK there was an increase in consumption of cannabis, prescription benzodiazepines and prescription opioids. There was a reduction in cocaine use, MDMA and ketamine.

**National data is not conclusive but there are indications that high risk drinking increased over periods of lockdown. There was also an increase in consumption of some types of drugs but a reduction in use of stimulants. Locally, the number of people using opiates who access treatment and support increased, but there was a decrease in the number of people using alcohol who accessed treatment and support .**

# Impact on adult mental health




This map shows the areas in Southampton whose residents are more likely to have vulnerable mental health because of restrictions put in place during the COVID-19 pandemic. The most vulnerable areas are in the more deprived parts of the city centre and areas with more students. Vulnerability is less widespread in the east and west of Southampton, although there are clusters of more vulnerable areas, especially in more deprived areas in eastern and western wards.

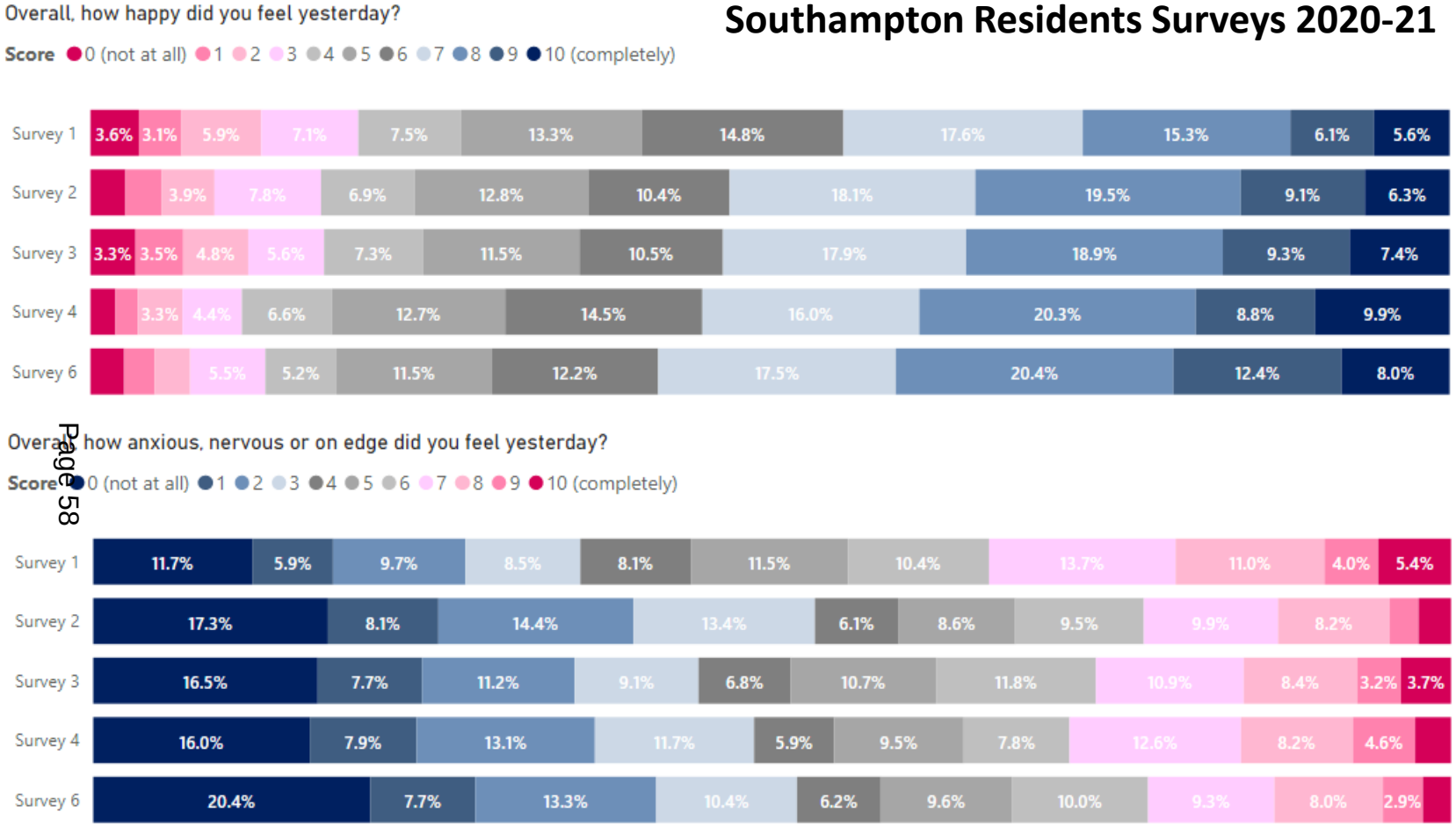
**Southampton residents were already vulnerable to mental health difficulties before the pandemic. Existing mental health difficulties are likely to have been exacerbated due to isolation from family and friends, bereavement, anxiety about infection and effects on others/wider society, financial and employment concern and reduced access to treatment and support. National data shows a mixed picture of periods of deterioration in mental health coinciding with lockdowns, followed by recovery in some indicators.**

**National data**

A PHE national surveillance report found 'deteriorations in mental health and wellbeing between March and May 2020, followed by a period of improvement from July, stabilising at levels comparable to before the pandemic between August and September... More recent evidence suggests that there was a second deterioration in population mental health and wellbeing between October 2020 and February 2021, followed by a period of recovery.' However, data from ONS indicates higher proportions of adults reporting low self-worth during the period of the pandemic compared to a 2019 baseline.

# Wellbeing across the pandemic

## Southampton Residents Surveys 2020-21




**These charts suggest that people's happiness and anxiety levels in Southampton changed over time. Happiness increased over time, particularly when compared with the early stages of the pandemic. Anxiety levels fluctuated more but lower levels were reported in the most recent survey (August 2021)**

Dates of Southampton Residents Surveys:
1st: Early April 2020; 2nd: Late April 2020; 3rd July 2020; 4th November 2020, 5th: February 2021*; 6th: August 2021

** the 5th survey did not replicate these questions*

# Impact on children and young people's mental health

Pre-pandemic, across England the number of children and young people (CYP) experiencing mental health difficulties was increasing.
An NHS England survey of CYP in July 2020 found that:

- the number of children with probable mental health disorders had increased from 10.8% in 2017 to 16% in 2020
- CYP with a probable mental disorder were more likely to say that lockdown had made their life worse than CYP unlikely to have a MH disorder

**The number of CYP experiencing mental health difficulties was increasing pre-pandemic, but COVID-19 has exacerbated this. Local CAMHS has seen a sharp rise in demand between 2020 and 2021**

**Southampton City Children and Young People's Emotional and Mental Health Wellbeing Plan: 2021 – 2024** found evidence that COVID-19 and related interventions, such as social distancing and stay at home guidance including school and early years setting closures, have likely had a negative effect on some children and young people's mental health and wellbeing.

Southampton City Children and Young People's Emotional and Mental Health Wellbeing Plan: 2021 - 2024

The Plan anticipates MH needs as a result of Covid-19 to include:

- Increase in crisis presentations including self-harm
- Increase in complexity of cases presenting to CAMHS
- Higher volume of mental health difficulties including depression, behavioural difficulties and family relationship challenges
- Increased anxiety e.g. due to lockdown/virus fears, transition back to school, separation anxiety
- Worries about exam cancellation and moving into next phase of education
- Increase in mental health presentations will have a negative impact on wider family
- Increased incidents of domestic abuse, and child abuse due to family/parental stress
- Increased number and severity of eating disorders
- Bereavement and loss
- Increase in violent crime – impact on mental health and aspirations

| Impact on local CAMHS April-June 2021 compared to April-June 2020 | |
|---|---|
| Referrals | 87% increase compared with same 2019 period (370 increasing to 690) |
| Eating disorder caseload | 138% increase since 2020 (37 in May 2020 increasing to 88 in July 2021) |
| A&E psychiatric presentations aged 12-17 yrs | 48% increase compared with same 2019 period (83 increasing to 123) |

# Impact on children and young people's mental health

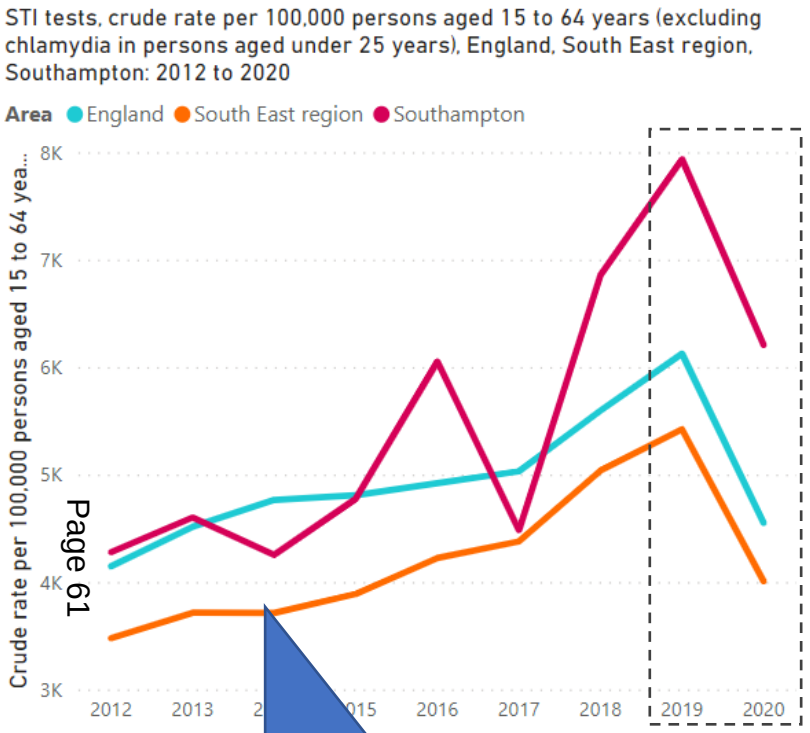
**No Limits** carried out a survey of 462 Southampton and Hampshire children and young people aged 8-25yrs between November 2020-January 2021 [New-Normal-Report-.pdf (nolimitshelp.org.uk)]

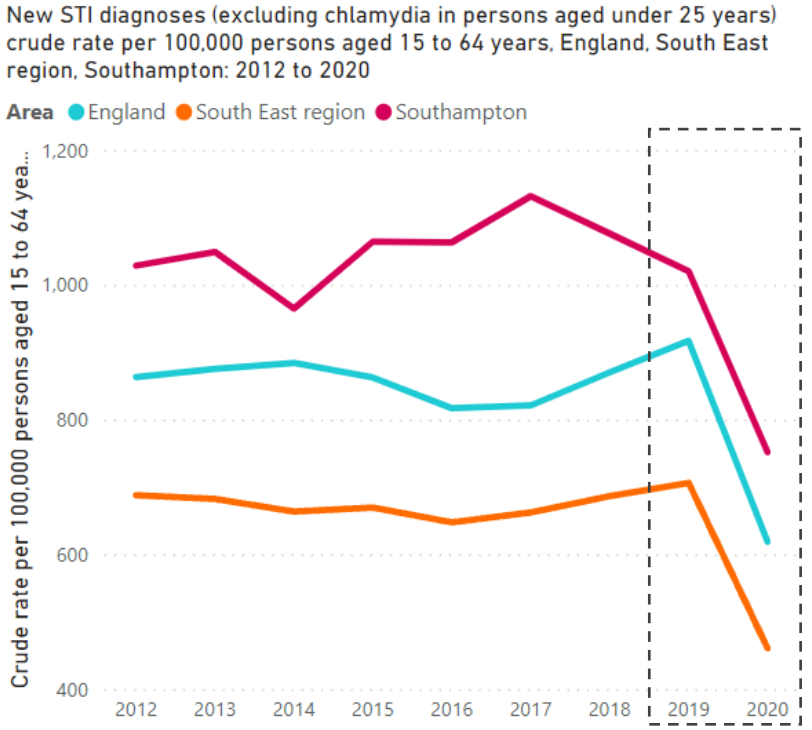

Wordcloud showing the issues that worried children and young people about going back to the new normal – from No Limits survey

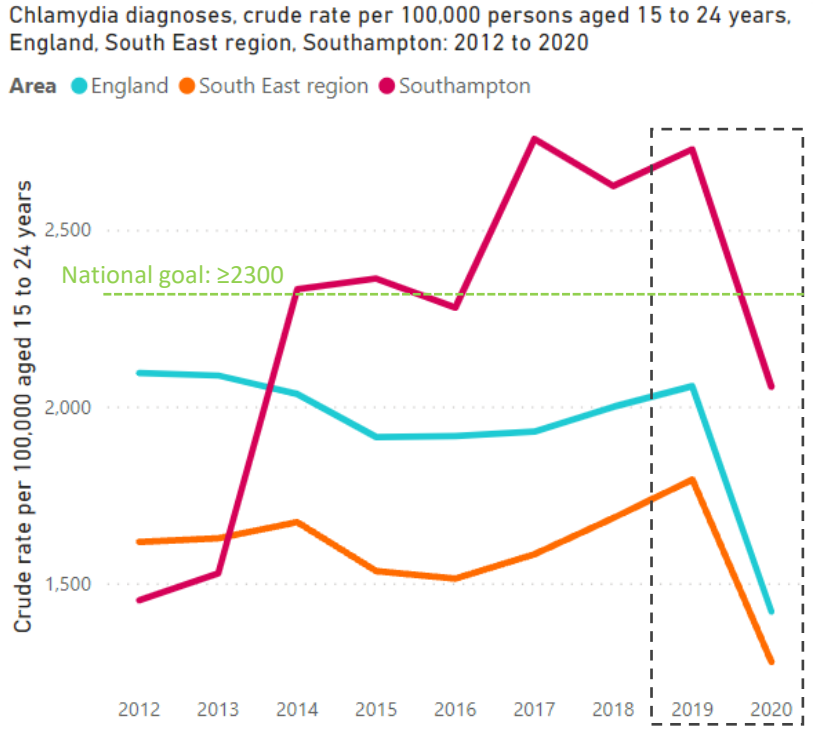
- 1 in 3 children and young people reported that their mental health got worse or continued to get worse when returning to school in the autumn.
- 82% of all young people aged 15+ are worrying about their long-term future.
- Almost two thirds of young people are worrying about: their mental health.
- 81% of young adults are worried about not having enough money to live on
- 36% of girls and young women feel they needed more support in returning to school, college or work compared with 24% of boys and young men.
- 10% of young people felt they had nowhere to go for support with their emotional or mental wellbeing

**COVID-19 has affected the social and emotional development of children and young people, as well as their education. Children and young people in Southampton report negative impacts of the pandemic on their mental health. They are worried about their own mental health and about the future**

# Impact on Sexual Health






**These charts show a sharp decline in STI testing, STI diagnoses and chlamydia diagnoses between 2019 and 2020 across Southampton, the South East and England**

Sexual health services across England were reconfigured as part of the national response to COVID-19. As noted in a national PHE report, between March and May 2020 there was a reduction in consultations, in testing capacity and in diagnoses.

*"There is a critical need to evaluate the impact of these changes on health inequalities, as hepatitis C virus, HIV and many STIs predominantly affect socially disadvantaged and/or marginalised groups who already experience poor health outcomes, including people who inject drugs and experience homelessness, and certain black and Asian ethnic minorities."*

[COVID-19: impact on STIs, HIV and viral hepatitis, 2020 report (publishing.service.gov.uk)]

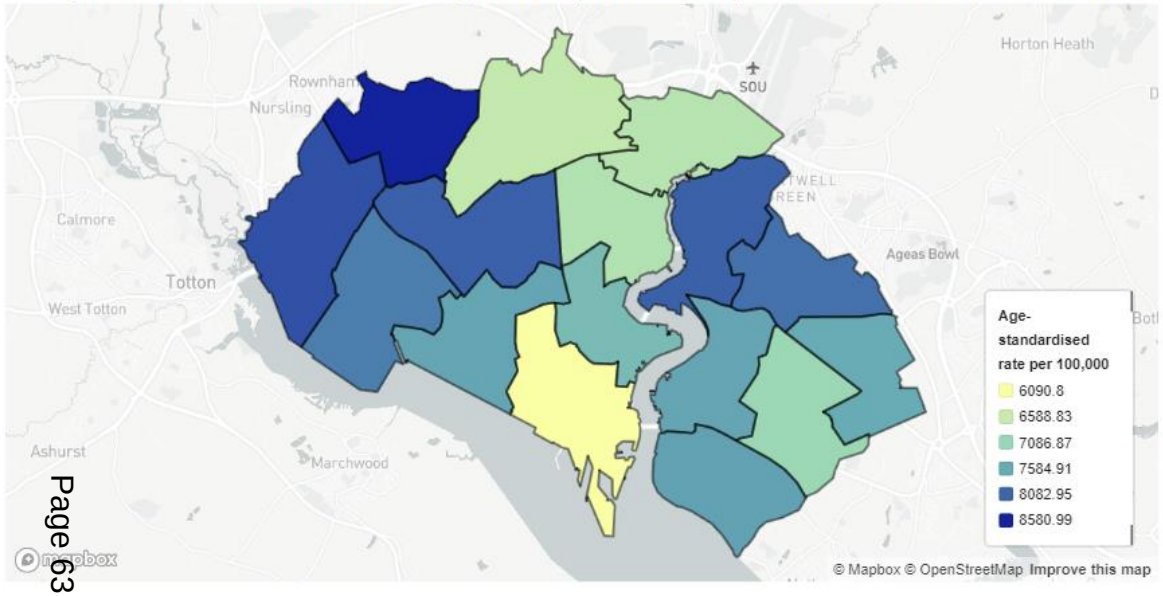
**Although testing and diagnosis in sexual health reduced during the first lockdown, it is difficult to draw conclusions about the health impact and whether this was due to reduced sexual activity, lack of access or a combination of the two. The impact will become clearer over time and may reveal a widening of inequality.**

# Healthy Places

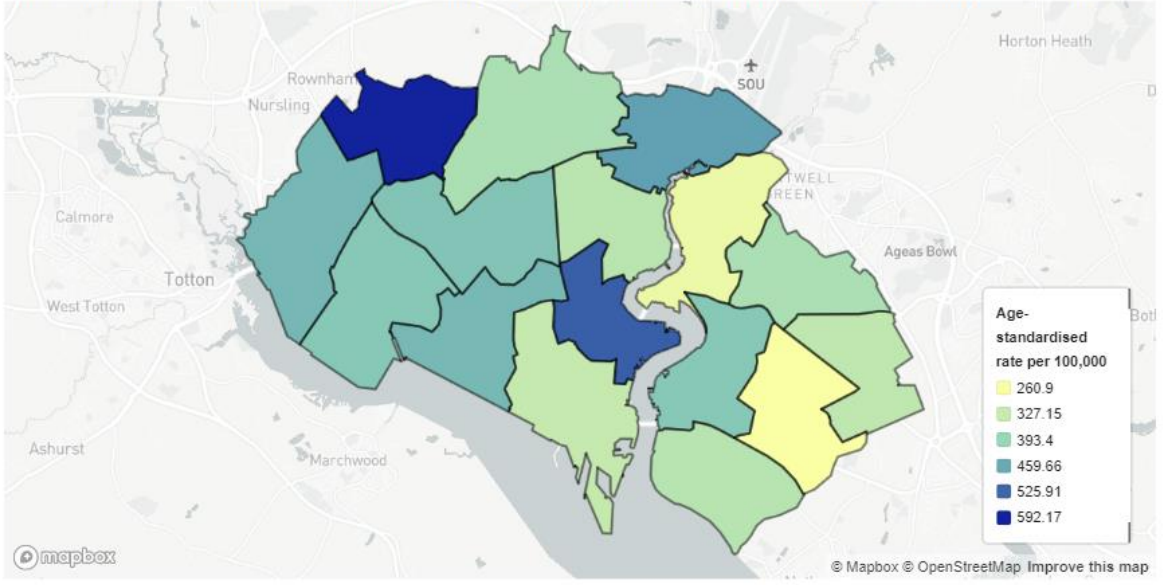
This section summarises how the impact of the pandemic was felt in different parts and sectors of the city: wards, deprivation, environmental issues and crime

# Impact by city ward

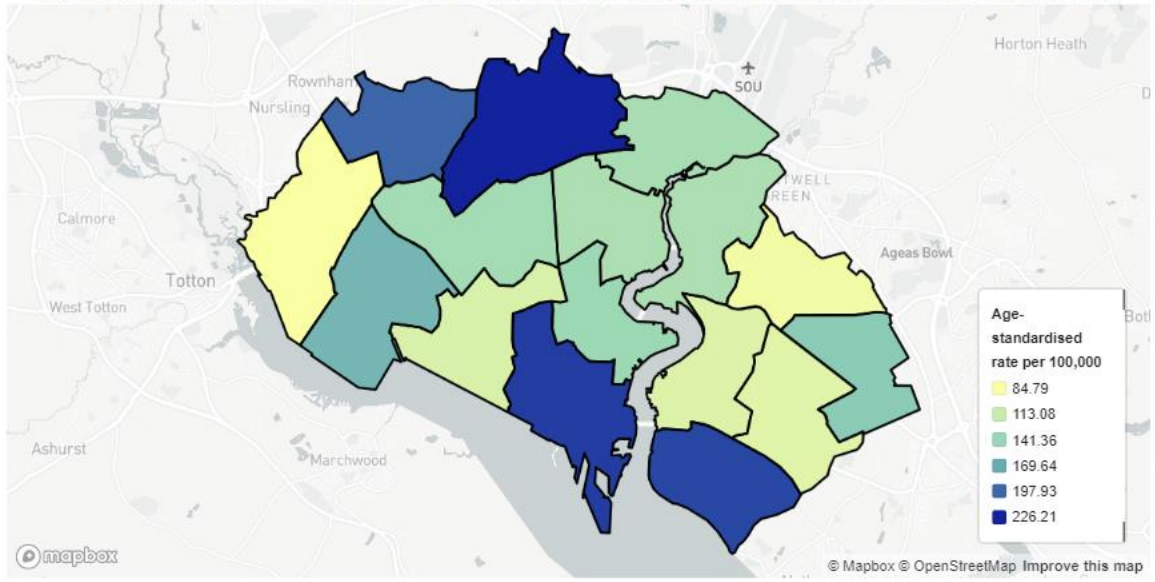
Age-standardised COVID-19 infections, rate per 100,000 persons, Southampton wards: March 2020 to October 2021




Age-standardised COVID-19 hospital admissions, rate per 100,000 persons, Southampton wards: January 2020 to May 2021




Age-standardised COVID-19 mortalities, rate per 100,000 persons, Southampton wards: March 2020 to September 2021




**Infections (March 2020 to October 2021):**

- Portswood, Bargate, Bassett and Swaythling showed significantly lower standardised infection rates than the city average (7,465 per 100,000)
- Millbrook, Bitterne Park, Redbridge, Harefield, Shirley and Coxford showed significantly higher infection rates than the city average (7,465 per 100,000)

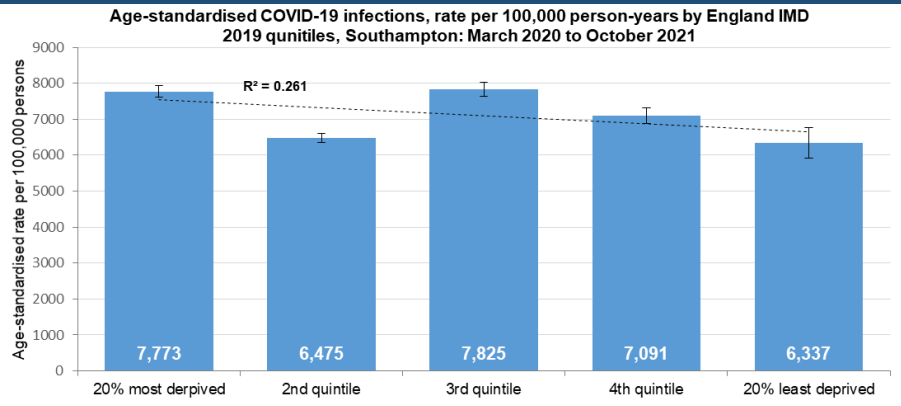
**Hospital Admissions (January 2020 to May 2021):**

- Sholing and Bittenre Park showed significantly lower standardised hospital admission rates than the city average (394 per 100,000)
- Coxford showed a significantly higher standardised hospital admission rate than the city average (394 per 100,000)

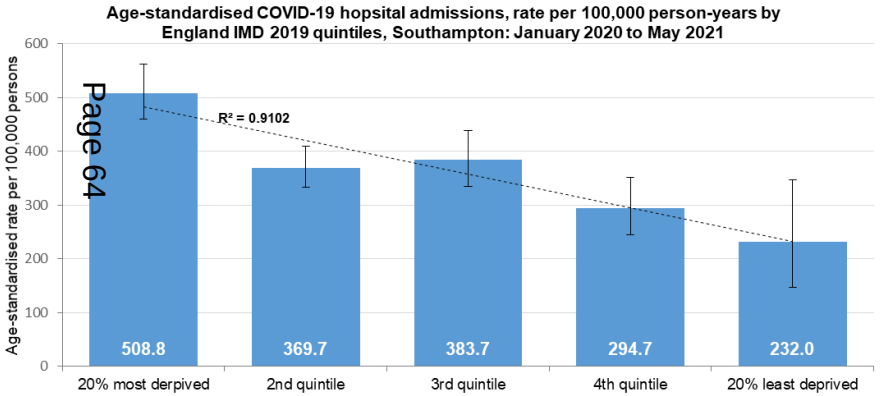
**Mortalities (March 2020 to September 2021):**

- Bassett showed a significantly higher standardised mortality rate than the city average (144 per 100,000)

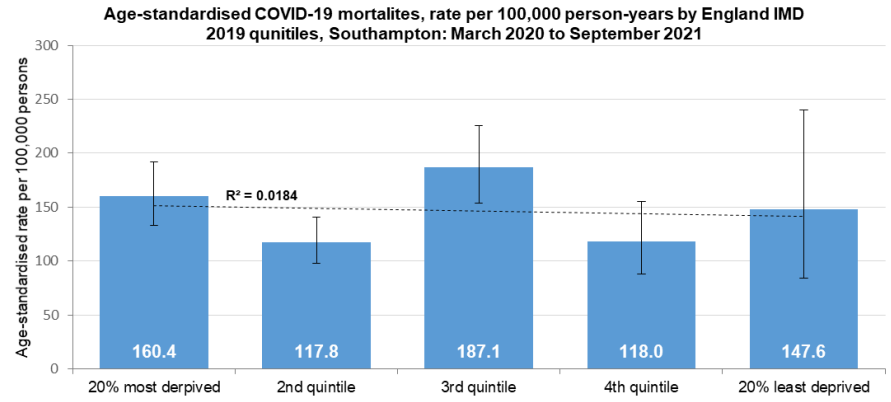
# Impact by deprivation




Source: NHS Digital & HCC SAPF (2020)




Source: SUS PbR Inpatients from South, Central & West CSU, extracted June 2021 & HCC SAPF (2020)




Source: Primary Care Mortality Database - NHS Digital & HCC SAPF 2020

These charts show age-standardised rates of infections, hospital admissions and deaths across different time periods based on data availability. Overall there are no clear gradients across all deprivation quintiles from COVID-19 infections and mortalities, although a trend in hospital admissions is more apparent. There are significant differences in case rates and hospital admissions when comparing those living in the 20% most deprived neighbourhoods with those living in the 20% least deprived with higher rates in the most deprived; for COVID-19 deaths this difference is not statistically significant. Given national trends, these gaps in deprivation may have been wider during the peaks of the pandemic.

**National and regional data via the CHIME tool suggests that a deprivation gap did exist between standardised rates of mortality and hospital admissions – especially during the first and second peaks; there were lesser differences in infection rates across deprivation during most of the pandemic.**

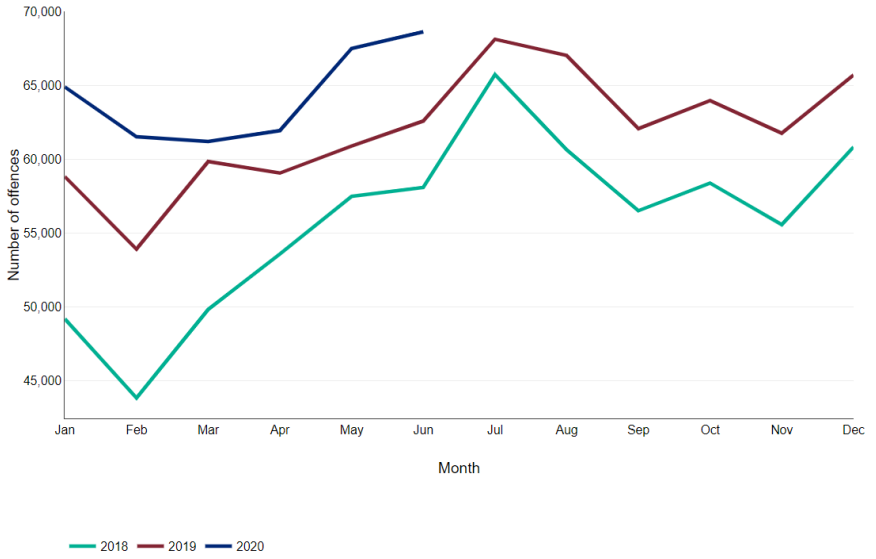
# Impact on crime and safety: domestic abuse

The Office for National Statistics reported an increase in demand for domestic abuse victim support services, including a **65% increase in calls and contacts logged by the National Domestic Abuse Helpline** between April and June 2020, compared with the first three months of the year.

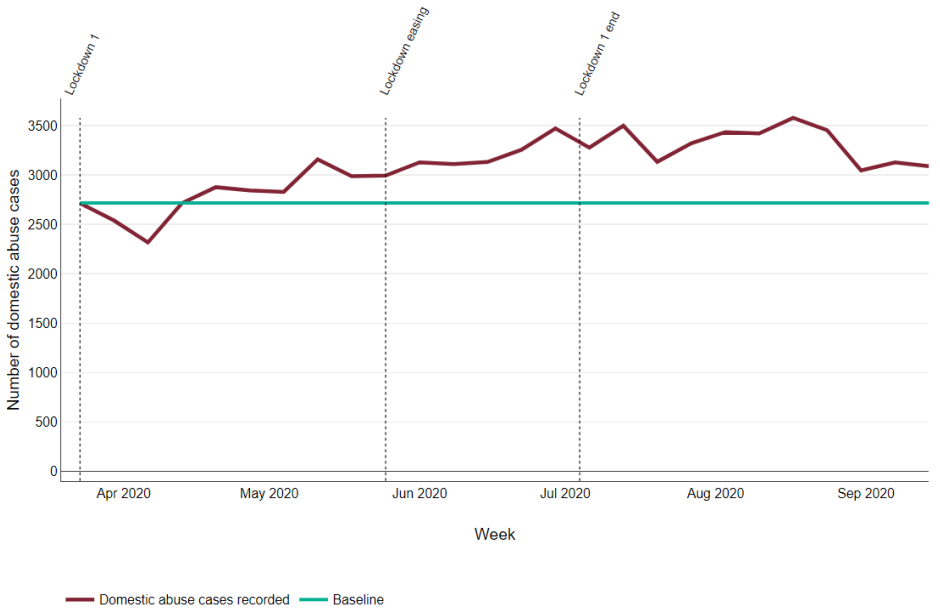
**Several national indicators suggest that rates of domestic abuse increased during the early period of the pandemic and the first lockdown. Contributing factors may have included restricted movement out of the home, increased unemployment/furlough, financial and emotional stress, and reduced access to support. As we move towards recovery it will be important to enable access to support services for those affected.**

There were 4,804 recorded domestic flagged crimes in Southampton during 2020/21, which is a 2.6% increase compared to the previous year. It is important to emphasise that domestic abuse is a 'hidden' crime and therefore police recorded crime figures only provide a partial picture.

**Total number of offences (excluding fraud) flagged as domestic abuse-related, by month, January 2018 to June 2020, England and Wales (excluding Greater Manchester Police)**




**Weekly number of domestic abuse cases recorded in Victim Support's case management system**

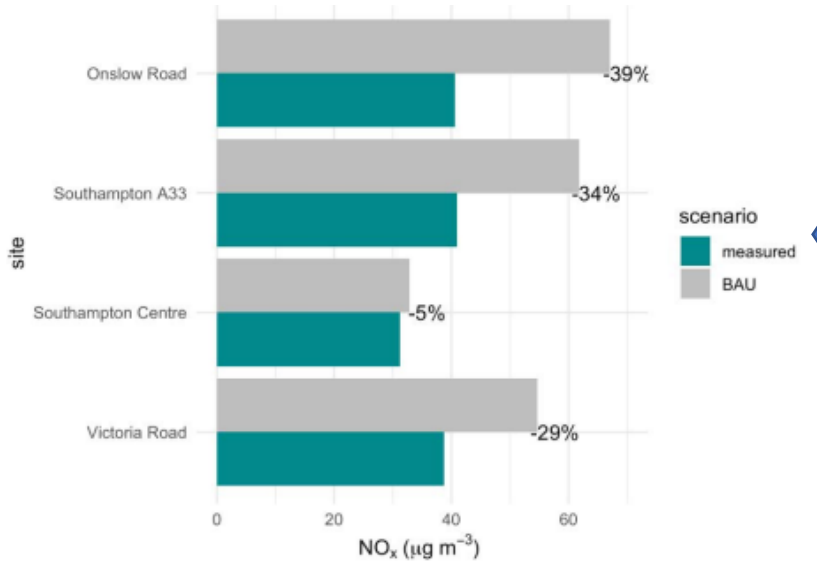



**These charts of national data show an increase in domestic abuse-related offences in the early part of 2020, higher than previous years (Home Office data) and a higher number of domestic abuse cases logged between May 2020 and September 2020 compared to March 2020 baseline (Victim Support data)**

# Impact on environment: air quality

Southampton City Council undertook an air quality analysis during the first lockdown, March – June 2020, which found:

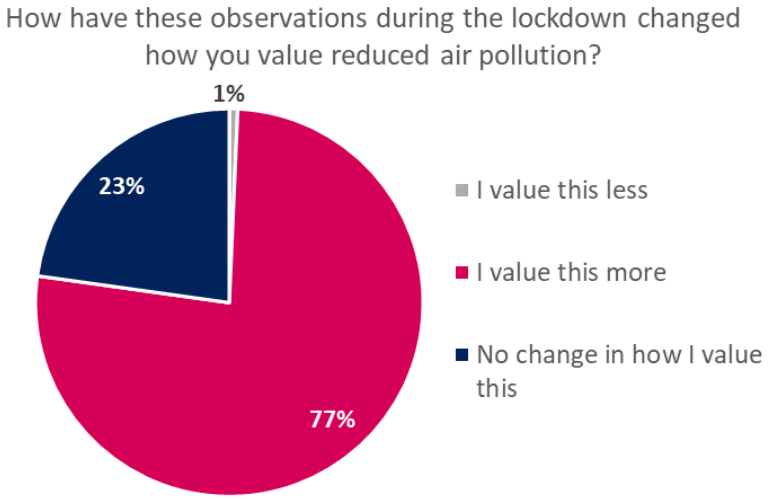
- Road traffic levels declined rapidly following the introduction of government restrictions and guidelines
- Nitrogen Oxide (NOx) levels were on average a third lower at roadside sites during lockdown compared to business as usual
- Nitrogen Dioxide ($NO_2$) levels were on average 12% lower at roadside sites during lockdown compared to business as usual
- Particulate matter (PM) increased during lockdown, but Southampton PM concentration is influenced by wind, wood burning, industrial activity and windblown contributions from outside of Southampton
- Weather had a larger effect on pollutant concentrations than emissions themselves during lockdown




**There was a reduction in average roadside NOx levels during lockdown compared to business as usual (BAU)**

We asked residents about air pollution in the third resident's survey (July 2020):

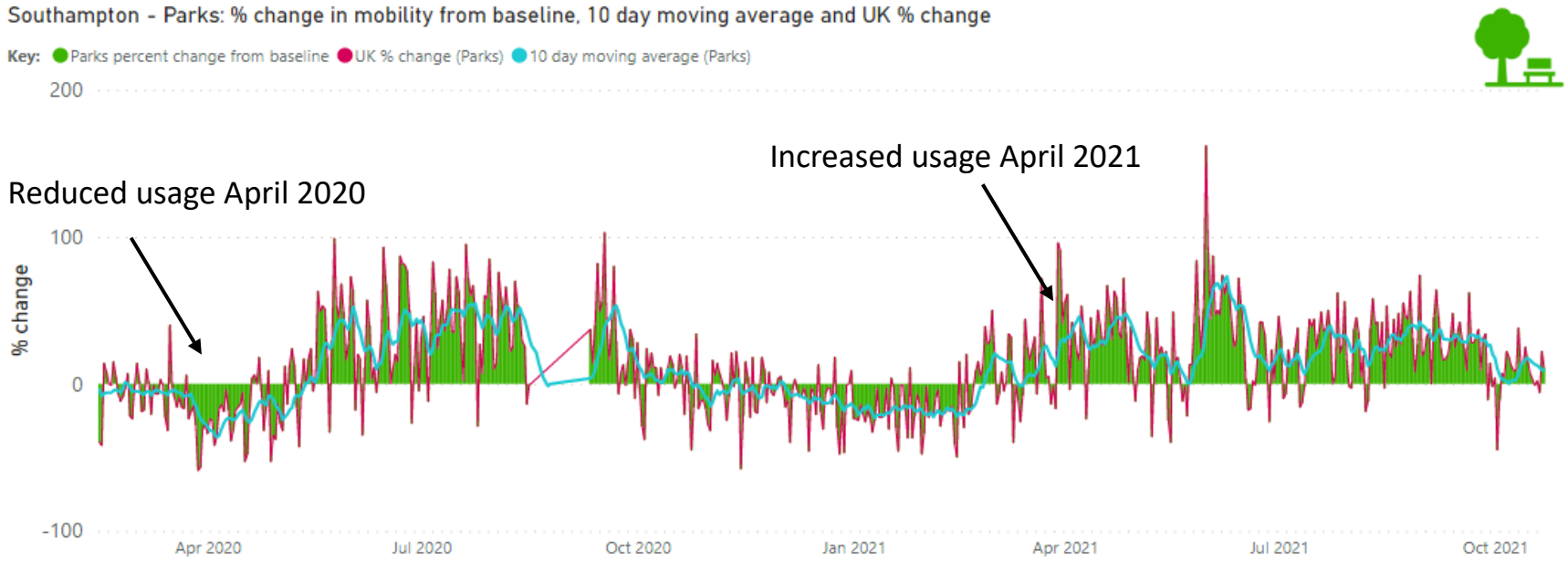
77% of respondents reported valuing reduced air pollution more




**The first lockdown benefited air quality in Southampton with reduced traffic and roadside emissions and residents reported that they valued improved air quality more. Although lockdown volumes of traffic cannot be maintained, there is scope to substantially reduce emissions with reduced traffic levels.**

# Impact on environment: use of green spaces

This chart of Google mobility data indicates that residents' use of parks fluctuated with the seasons but was affected by the COVID-19 restrictions especially in the first lockdown

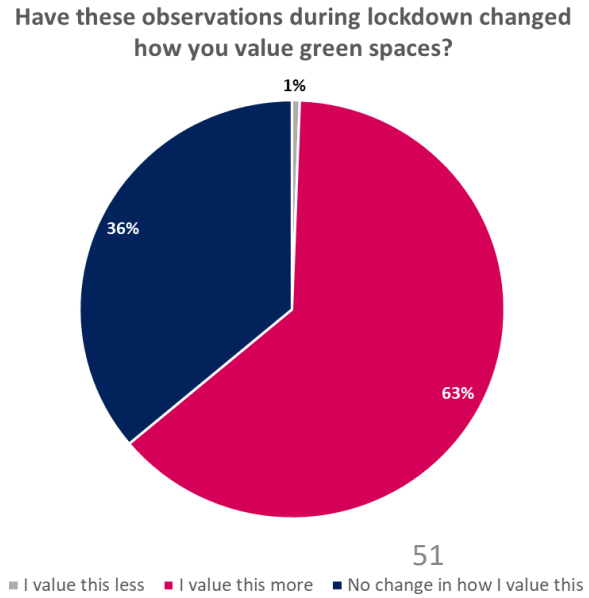



Use of green spaces was initially reduced during the first lockdown, but as government measures increasingly recognised the public health importance of physical activity and allowed more time to be spent outside the home, use of green spaces increased. Southampton residents subsequently placed more value on green spaces

We asked residents about green spaces in the third resident's survey (July 2020):

Residents observed increased use of greenspace throughout lockdown, as well as better air quality and quieter streets

63% of respondents reported valuing green space more



# Conclusions: looking to the future and recovery

As more data becomes available, we will be able to better understand the impacts of the COVID-19 pandemic in Southampton. Already we can see a disproportionate affect in those living in the most deprived neighbourhoods both in the direct and indirect health impacts. Where we have relied on national data for England/UK, it is important to remember that Southampton has higher deprivation on average than England, so the effects of COVID-19 may be even greater. Impacts may be further amplified when we are able to better understand variation in impacts across ethnicity when the 2021 Census data becomes available.

In almost every area, inequalities in the effects of COVID-19 are evident, with groups who were already disadvantaged suffering more. In general, the least deprived were protected from the worst effects of the pandemic.

The ability for people to lead healthy lives and enhance their wellbeing was also affected.

**Who were most affected?**

- People living with deprivation and illness, those of older age and those from ethnic minority groups and other vulnerable populations – people who in many cases had no choices about how they could respond to the pandemic
- Children and young people's lives including educational disruption with long-term effects not yet quantifiable

# Conclusions: looking to the future and recovery

**Challenges for the road ahead – how will we prioritise need?**

- Deprivation
  - Close association between deprivation and vulnerability to COVID-19 and its wider affects; lower uptake of vaccine
- Older people
  - More affected, shielded more, support reduced, isolation increased, iatrogenic
  - Care homes: essential to maintain high standards of infection, prevention and control
- Minority ethnic groups
  - Disproportionately affected, occupational effects, lower uptake of vaccine
- Children and young people
  - Mental health
  - Education and prospects
  - Resilience
- Those with existing illness and new illness
  - Exacerbated effects
  - Long Covid
  - Carers
- Mental health
- Healthy behaviours and underlying factors

**Opportunities**

- Capitalise on the renewed attention on health inequalities, public health and the importance of physical and mental wellbeing for society
- The pandemic has shown how closely health can be related to the economy which supports our Health in All Policies approach
- To build upon community engagement using new and refreshed partnerships and new ways of working to build capacity
- Use key learning from the pandemic response and strong partnerships that have developed to prepare for any future pandemic
- Use these insights to help inform the Health & Wellbeing Strategy going forward
- Capitalise on the finding that people value air quality and green spaces more by promoting the Green City agenda and encourage more outdoor activity

# Conclusions: Approach for future focus and recovery

**On the basis of our local data and evidence of impact, the recommendation is to continue to focus on reducing health inequalities to improve overall health and wellbeing. The following 'build back fairer' approach is already incorporated in Southampton's health and wellbeing strategy as underlying principles for delivery. For recovery we must amplify actions, with emphasis on the early years:**

Build Back Fairer Priorities:

1. REDUCING INEQUALITIES IN EARLY YEARS
2. REDUCING INEQUALITIES IN EDUCATION
3. BUILD BACK FAIRER FOR CHILDREN AND YOUNG PEOPLE
4. CREATING FAIR EMPLOYMENT AND GOOD WORK FOR ALL
5. ENSURING A HEALTHY STANDARD OF LIVING FOR ALL
6. CREATING AND DEVELOPING HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES
7. STRENGTHENING THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

Build Back Fairer: The COVID-19 Marmot Review - The Health Foundation

| | |
|---|---|
| **DECISION-MAKER:** | **Health and Wellbeing Board** |
| **SUBJECT:** | **Health and Wellbeing Board Membership** |
| **DATE OF DECISION:** | **15 December 2021** |
| **REPORT OF:** | **Cabinet Member for Health and Adult Social Care** |

| **CONTACT DETAILS** | | | | |
|---|---|---|---|---|
| **Executive Director** | **Title** | **Executive Director, Wellbeing (Health & Adults)** | | |
| | **Name:** | **Guy Van Dichele** | Tel: | |
| | **E-mail** | **Guy.VanDichele@southampton.gov.uk** | | |
| **Author**: | **Title** | **Director of Public Health** | | |
| | **Name:** | **Debbie Chase** | Tel: | |
| | **E-mail** | **Debbie.Chase@southampton.gov.uk** | | |

| **STATEMENT OF CONFIDENTIALITY** | | |
|---|---|---|
| Not applicable | | |
| **BRIEF SUMMARY** | | |
| The Southampton Health and Wellbeing Board reviewed progress with Southampton's health and wellbeing strategy at their meeting in October 2021. They welcomed progress to date and recommended a more focused approach on key strategic priorities in the future to ensure delivery. In achieving this, the Board recommended review of membership to ensure that the Board it is 'fit for purpose' for future delivery. This briefing provides recommendations on future membership and board approach to achieve this aim. | | |
| **RECOMMENDATIONS:** | | |
| | (i) | To consider membership changes in light of future strategic intent and changes in health and care system governance and agree quorum requirement |
| | (ii) | To consider board working practices going forwards |
| **REASONS FOR REPORT RECOMMENDATIONS** | | |
| 1. | At request of the HWB, this paper provides intentions for future membership and approach to strengthen the work of the Board going forwards. Recommendations from HWB on future membership will be submitted to Council for agreement of changes to the Constitution. | |
| **ALTERNATIVE OPTIONS CONSIDERED AND REJECTED** | | |
| 2. | Alterative option is to make no changes to membership or approach. The Board agreed that this is not an option as it needs to be 'fit for purpose' going forwards. | |
| **DETAIL (Including consultation carried out)** | | |
| 3. | Health and wellbeing boards (HWBs) were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local | |

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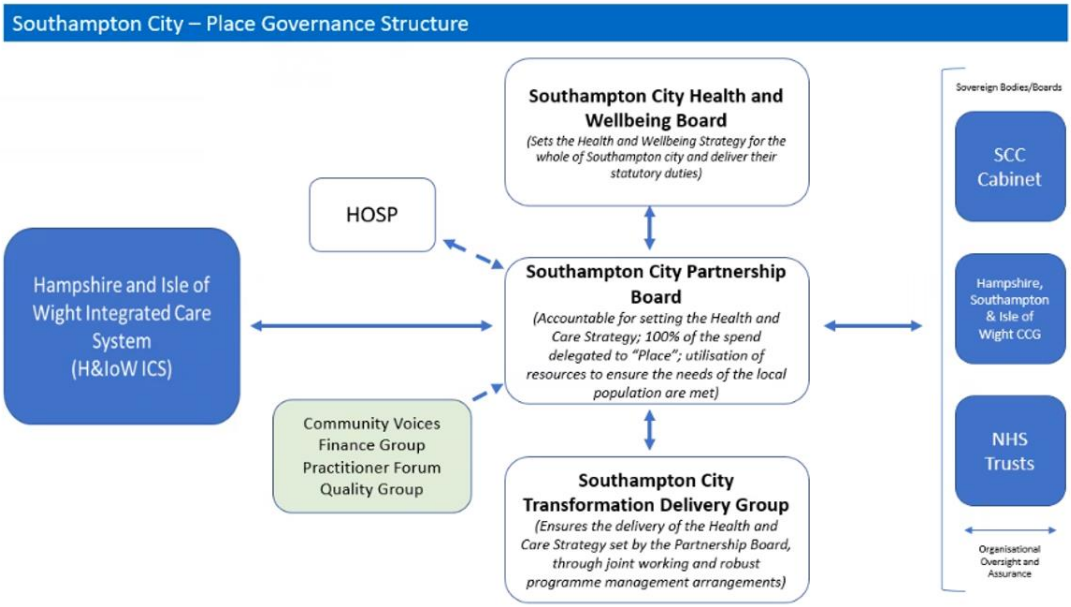
| | health and care system could work together to improve the health and wellbeing of their local population. HWB have limited formal powers; these being to deliver a joint strategic needs assessment and a health and wellbeing strategy. They are constituted as a partnership forum rather than an executive decision-making body. Southampton's HWB is accountable to Cabinet. |
| 4. | HWBs have evolved in their approach since becoming operational in April 2013. Initially, focus was on supporting the development of integrated health and care services, through the Better Care Fund. In Southampton, this responsibility now sits with the Joint Commissioning Board. In the Summer 2021, Southampton HWB took on a new responsibility, incorporating the COVID-19 Local Outbreak Engagement Board within its remit in recognition that we are now 'living with covid'. |
| 5. | From April 2022, HWBs will form part of the governance structure of the Integrated Care System, helping to strengthen the links between the wider health and care system and local population health and wellbeing. |
| 6. | The Hampshire and Isle of Wight Integrated Care System (ICS) becomes a legal entity from April 2022. The establishment of the ICS aims to bring about place-based planning and delivery of health and care services to meet local population needs whilst benefiting from the economies of scale of agencies in working in partnership across Hampshire and Isle of Wight to provide services.   |
| 7. | The role of the HWB within this new ICS governance structure is beginning to take shape, it will be the forum for ensuring that the health and wellbeing needs of Southampton's population inform service delivery and community support offers to improve health and wellbeing and reduce health inequalities; through delivery of our health and wellbeing strategy. The Joint Commissioning Board will become Southampton Partnership Board and ensure that the health and care strategy for Southampton is delivered. |
| | **HWB membership** |
| 8. | HWB membership is defined within the Health and Social Care Act 2012 Section 194 (2) (a) and requires that the minimum membership shall be: |

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| | • At least one elected Member of Southampton City Council (to be appointed by the Leader of the Council having had due regard to the recommendations of the Health & Well Being Board)<br>• The Director of Public Health (DPH)<br>• The Director of Adult Social Services (DASS)<br>• The Director of Children's Services(DCS)<br>• A representative of Healthwatch<br>• A representative from NHS Commissioning Board's Wessex Area team<br>• A representative from NHS Southampton Clinical Commissioning Group<br>• Such other persons as the Council considers appropriate.<br><br>The Council constitution states that membership and composition of the Board will be determined by Council and reviewed on an annual basis. |
| 9. | The Board's Terms of Reference, purpose and responsibilities can be found in Appendix I (incorporating the Southampton COVID-19 Local Outbreak Engagement Board Terms of Reference). Current voting membership is:<br>- Elected member lead for health and social care (Chair)<br>- Clinical Director for Southampton (representative of Hampshire, Southampton and Isle of Wight Clinical Commissioning Group)<br>- Opposition member lead for health and social care<br>- Three additional Councillors appointed by Council under the rule of proportionality<br>- Executive Director Wellbeing (Children and learning)<br>- Executive Director Wellbeing (Adults and health)<br>- Director of Public Health<br>- Healthwatch representative<br><br>The Board previously also included a voting representative from NHS England, but this membership responsibility has recently been discharged to CCGs.<br><br>In addition, the Chief Medical Officer at University Hospital Southampton and the SCC Clinical Director for Quality and Integration regularly join as invited guests. |
| 10. | Beyond the requirements of the Health and Social Care Act 2012, HWB membership has been constituted to best serve the local population's health and wellbeing so there is variation in membership between local areas. Appendix II shows the membership of the HWBs of Hampshire County Council and Portsmouth City Council for comparison. |
| | **Proposals for future membership** |
| 11. | As can be seen from Appendix III, membership of Southampton's board meets the minimum requirement and provides additional councillor support. There is more breadth of agency representation in Hampshire's and Portsmouth's HWBs. |
| 12. | The recommendation from Southampton's HWB is that additional members should be considered to add value, vision, skills and representation of key organisation. The Chair also recommends that the number of members is limited to prevent reduced traction and focus on intent. |

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| 13. | In consideration of representation from neighbouring HWBs and initial discussions with the Chair of the board and a small number of members, representation from the following groups and organisations should be considered:<br>• Primary care provider representative(s) from local PCNs<br>• Secondary care provider representative(s)<br>• Community care provider representative(s)<br>• Social care provider representative(s)<br>• Voluntary Community & Social Enterprise (VCSE) representative(s)<br>• Member of Youth Parliament<br>• Additional Healthwatch members<br>• Mental health representative from provider organisation(s)<br>• University/academic membership<br>• Police and Crime representative<br>• Fire and Rescue representative<br>• Education representative<br>• Housing/tenants representative |
| 14. | As part of the process of agreeing future membership, quorum required for HWB meetings should be considered. For meetings to be quorate, currently at least one Councillor, one member of Healthwatch and one representative from Health must be present. |
| 15. | Consideration could also be given towards consistency with other local HWBs' changing memberships. |
| | **Working practices** |
| 16. | Future discussions on evolving working practices could include consideration of:<br>• A combination of formal and informal (workshops) meetings<br>• Focusing each meeting on specific commitments in the HWBS strategy and ensuring action focused approach<br>• Each member taking responsibility for specific commitments in the HWBS<br>It is important that the HWB drives action through local system leadership and does not take on the role of scrutiny, this is already achieved through the local Health and Overview Scrutiny Panel. |
| | **Next steps** |
| 17. | • The Board is asked to make suggestions for additional members and/or structure and/or working practices<br>• Work to continue with other local authorities towards aligning membership structure with other local HWBs (which may also be changing)<br>• A paper proposing a revised HWB membership to be brought to the next HWB meeting in March 2022, with recommendations for changing working practices and membership for consideration of Council. |
| **RESOURCE IMPLICATIONS** | |
| **<u>Capital/Revenue</u>** | |
| 18. | Expenses and training costs associated with new members. |

| | |
|---|---|
| **Property/Other** | |
| 19. | None. |
| **LEGAL IMPLICATIONS** | |
| **Statutory power to undertake proposals in the report:** | |
| 20. | Health and Social Care Act 2012 |
| **Other Legal Implications:** | |
| 21. | None |
| **RISK MANAGEMENT IMPLICATIONS** | |
| 22. | None |
| **POLICY FRAMEWORK IMPLICATIONS** | |
| 23. | The proposals are in accordance with the Policy Framework |

| | |
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| **KEY DECISION?** | **No** |
| **WARDS/COMMUNITIES AFFECTED:** | All |
| SUPPORTING DOCUMENTATION | |
| **Appendices** | |
| 1. | Terms of Reference, Purpose and Responsibilities of the Board |
| 2. | Membership of other local Health and Wellbeing Boards |
| 3. | Health and Social Care Act 2012 – relevant excerpts |

**Documents In Members' Rooms**

| | |
|---|---|
| 1. | None |
| **Equality Impact Assessment** | |
| **Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.** | **No** |
| **Data Protection Impact Assessment** | |
| **Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out.** | **No** |
| **Other Background Documents**<br>**Other Background documents available for inspection at:** None | |

| | | |
|---|---|---|
| **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. | N/A | |

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**Appendix I: Terms of Reference, Purpose and Responsibilities of the Board**

**GENERAL TERMS OF REFERENCE FOR HEALTH AND WELLBEING BOARD**

a) The Health and Wellbeing Board is a committee of the Council under S102 (1) of the Local Government Act 1972.

b) The Council has arranged under S101 of that Act for the discharge by the Board of such functions as are set out in the terms of reference set out below.

c) Certain functions under S196 (2) of the Health and Social Care Act 2012 may be delegated by the Board to officers. Full details may be found in the Officer's Scheme of Delegation which may be obtained from the Democratic Services Manager. Other matters falling within these Terms of Reference may be delegated to a Sub Committee of the Board.

d) Where a function or matter within the Board's competence has been delegated to an officer or a sub-committee, the Board may exercise that function/matter concurrently with the officer to whom it has been delegated.

e) The exercise of any function or matter within the Council's competencies always subject to any relevant requirement of the Council's Constitution including any Special Procedure and Protocol drawn up and approved by the Senior Manager: Legal, HR and Democratic Services in pursuance of Council Procedure Rule 26.2. A Special Procedure giving effect to The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 has been approved in accordance with Council Procedure Rule 26.2. The Special Procedure disapplies the provisions of the Local Government and Housing Act 1989 relating to the political proportionality on committees and sub-committees and providing that a person who is a member of the Board shall not be treated as a non-voting member unless the full Council directs otherwise, together with other voting and ancillary matters has been approved in accordance with Council Procedure Rule 26.2.

**TERMS OF REFERENCE**

1. Section 194 (2) (a) of the Health and Social Care Act 2012 requires that the minimum membership of the Health and Wellbeing Board shall be:

- At least one elected Member of Southampton City Council (to be appointed by the Leader of the Council having had due regard to the recommendations of the Health & Well Being Board)
- The Director of Public Health (DPH)
- The Director of Adult Social Services (DASS)
- The Director of Children's Services(DCS)
- A representative of Healthwatch
- A representative from NHS Commissioning Board's Wessex Area team
- A representative from NHS Southampton Clinical Commissioning Group
- Such other persons as the Council considers appropriate.

The actual membership and composition of the Board will be determined by Council and reviewed on an annual basis.

The Board shall:

2. Appoint such sub-committees, working groups or time limited groups as it considers appropriate to fulfil the Health and Wellbeing functions on behalf of the Council

3. For the purpose of advancing the health and wellbeing of the people in its area; encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner.

4. Provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging the making of arrangements under S75 of the National Health Service Act 2006 in connection with the provision of such services.

5. Encourage persons who arrange for the provision of any health related services in its areas to work closely with the Health and Wellbeing Board.

6. Encourage persons who arrange for the provision of any health or social care services in its areas and persons who arrange for the provision of any health related services in its area to work closely together.

7. Exercise the functions of a Local Authority and its partner clinical commissioning groups under sections 116 and 116A of the Local Government and Public Involvement in Health Act 2007.

8. Exercise any functions that are exercisable by the Authority to promote or advance health and wellbeing not otherwise reserved to Council or the Executive.

9. Provide opinion on whether the Local Authority is discharging its duty under section 116B of the 2007 Act.

10. The functions referred to at 8 above do not apply to the functions of the Authority by virtue of Section 244 of the National Health Service Act 2006.

**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; and Ensuring safety in improving health and wellbeing outcomes

## SOUTHAMPTON COVID-19 LOCAL OUTBREAK ENGAGEMENT BOARD (NOW PART OF HEALTH & WELLBEING BOARD)

### Terms of Reference

### Purpose

The Southampton Covid-19 Local Outbreak Engagement Board is responsible for strategic oversight of health protection regarding Covid-19 in Southampton, including prevention, surveillance, planning and response to ensure they meet the needs of the population.

The Board will support the local delivery of the primary objectives of the Government's strategy to control the Covid-19 reproduction number (R), reduce the spread of infection and save lives, in doing so help to return life to as normal as possible, for as many people as possible, in a way that is safe, protects our health and care systems and releases our economy.

The response will be delivered at various levels and by various partner organisations, but these will need to be brought together at local authority level through the Executive Director of Wellbeing (Health & Adults), supported by the Director of Public Health as lead officer, to ensure a community focus and appropriately tailored response. In addition to the place-based approach overseen by the Board the levels will include:

- National - a National Outbreak Control Plans Advisory Board will be established to draw on expertise from across local government and ensure the NHS Test and Trace programme builds on local capability, and to share best practice and inform future programme development;
- Regional - Co-ordination required on a regional level will be provided through the HIOW Local Resilience Forum and Integrated Care System arrangements;
- Local – Southampton COVID-19 Health Protection Board, working through Local Engagement Boards to define measures to contain outbreaks and protect health.

### Membership

- Chair: Leader of the Council
- Deputy Chair: Cllr White (Chair of HWB, Cabinet Member for Health & Adult Social Care)
- Cllr P Baillie, Cabinet Member for Children's Social Care Learning

Board supported by:

- Director of Public Health, SCC

- Director – Adult Social Care, SCC
- Director – Children's Social Care, SCC
- CCG Governing Body Chair
- Healthwatch & SVS Deputy Chief Executive
- Medical Director, University Hospitals Southampton
- Director of Meachers Transport – representative of Southampton Chamber of Commerce
- Southampton City Council Communications Lead Officer

The Board will invite representation from other organisations or roles specific to the agenda items under consideration.

**Objectives**

The Southampton Covid-19 Local Outbreak Engagement Board will:

- Be the public face of Southampton City Council's response in the event of an outbreak of COVID-19
- Provide political oversight of ongoing development and delivery of the Southampton City Local Covid-19 Outbreak Control Plan, including:
- Approving recommendations from the Health Protection Board for allocation of resources to support the effective delivery of the Plan
- Lead engagement with local communities, advising on community engagement, including with vulnerable and/or higher risk communities of interest
- Approve the communications strategy for the Local Outbreak Control Plan
- Approve implementation measures (or make recommendations to other bodies where appropriate) that will prevent virus transmission.
- Monitor the response to local outbreaks and ensure learning informs future practice
- Make recommendations for the wider policy agenda including the recovery workstreams, NHS Recovery and Restoration programme and the Health and Wellbeing Strategy

**Accountability**

The group will be accountable to Cabinet in its Statutory role, bringing together key partners in the local health and care system.

It will also have reporting relationships to

- HIOW level governance process for functions delivered at this level
- Southampton's Health and Wellbeing Board

**Frequency of Meetings**

The Board will meet as and when considered necessary by the Chairman of the Board. Meetings are open to the public.

An agenda and papers will be published at least 5 working days before the meeting. Conflicts of interest must be declared by any member of the group.

**Quoracy**

A quorum for meetings will be a minimum of 2 people, one of whom will be the Chair or nominated Co-Chair.

**Review**

Terms of Reference will be reviewed on a bi-monthly basis

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**Appendix II: Membership of other local Health and Wellbeing Boards**

**Hampshire County Council**

1. Councillor Liz Fairhurst (Chairman) Executive Lead Member for Adult Services and Public Health
2. Dr Barbara Rushton (Vice-Chairman) South East Hampshire Clinical Commissioning Group
3. Councillor Roz Chadd Executive Lead Member for Children's Services
4. Graham Allen Director of Adults' Health and Care
5. Simon Bryant Director of Public Health
6. Steve Crocker Director of Children's Services
7. Dr David Chilvers Fareham & Gosport Clinical Commissioning Group
8. Dr Nicola Decker North Hampshire Clinical Commissioning Group
9. Cllr Anne Crampton District/Borough Council Member Representative
10. Cllr Philip Raffaelli District/Borough Council Member Representative
11. Tricia Hughes District/Borough Council Chief Executives Representative
12. Julie Amies Voluntary and Community Sector Representative
13. Ron Shields Provider Representative: Community and Mental Health NHS Trusts
14. Alex Whitfield Provider Representative: Acute Health Trusts
15. David Radbourne NHS England (Wessex)
16. Ann Smith Healthwatch Hampshire
17. Donna Jones Police and Crime Commissioner
18. *Councillor Fran Carpenter (Deputy)*
19. *Councillor Pal Hayre (Deputy)*
20. *Paul Archer (Deputy) Deputy to Director of Adult's Care and Health*
21. *Suzanne Smith (Deputy) Deputy to Director of Children's Services*
22. *Johanna Jefferies (Deputy) Deputy to Director of Public Health*
23. *Dr Rory Honney (Co-opted Deputy) West Hampshire Clinical Commissioning Group*
24. *Dr Steven Clarke (Co-opted Deputy) North East Hampshire and Farnham Clinical Commissioning*
25. *Dr Robin Harlow (Co-opted Deputy) Fareham & Gosport Clinical Commissioning Group*
26. *Dr Matt Nisbet (Co-opted Deputy) North Hampshire Clinical Commissioning Group*
27. *Maggie MacIsaac (Co-opted Deputy) South Eastern Hampshire Clinical Commissioning Group*
28. *Cllr Tony Capon (Co-opted Deputy) District/Borough Councillor Substitute*
29. *Nick Tustian (Co-opted Deputy) District/Borough Council Chief Executives Representative*
30. *Paula Anderson (Co-opted Deputy) Provider Representative for Community and Mental Health Trusts*
31. *Mary O'Brien (Co-opted Deputy) Wessex Local Area Team of NHS England*
32. *Carol Harrowell (Co-opted Deputy) Voluntary and Community Sector Representative*

**Portsmouth City Council**

1. Councillor Jason Fazackarley (Joint Chair)
2. Councillor Gerald Vernon-Jackson CBE Portsmouth City Council - Leader
3. Councillor Suzy Horton
4. Councillor Lewis Gosling
5. Councillor Kirsty Mellor
6. Councillor Jeanette Smith
7. Councillor Luke Stubbs (Standing Deputy) Portsmouth City Council - Opposition spokesperson
8. Dr Linda Collie (Joint Chair) PCCG
9. Dr Nick Moore Portsmouth CCG
10. Jo York Health & Care Portsmouth
11. Penny Emerit Portsmouth Hospitals University NHS Trust
12. Maggie MacIsaac Integrated Care System and CCG
13. Andy Silvester CCG Lay Member
14. Jackie Powell CCG Lay Member
15. Helen Atkinson Director of Public Health
16. Roger Batterbury Healthwatch Portsmouth
17. Sarah Beattie National Probation Service
18. Andy Biddle Adult Social Care
19. Professor Gordon Blunn University of Portsmouth
20. Sue Harriman Solent NHS Trust
21. Clare Jenkins Hampshire Constabulary
22. Frances Mullen Portsmouth Education Partnership
23. Paul Riddell Hampshire Fire & Rescue Service
24. Dianne Sherlock Voluntary and Community Sector representative chosen by PVCN

## Appendix III: Health and Social Care Act 2012 (legislation.gov.uk) – relevant excerpts

**194 Establishment of Health and Wellbeing Boards**

(1)A local authority must establish a Health and Wellbeing Board for its area.

(2)The Health and Wellbeing Board is to consist of—

(a)subject to subsection (4), at least one councillor of the local authority, nominated in accordance with subsection (3),

(b)the director of adult social services for the local authority,

(c)the director of children's services for the local authority,

(d)the director of public health for the local authority,

(e)a representative of the Local Healthwatch organisation for the area of the local authority,

(f)a representative of each relevant clinical commissioning group, and

(g)such other persons, or representatives of such other persons, as the local authority thinks appropriate.

(3)A nomination for the purposes of subsection (2)(a) must be made—

(a)in the case of a local authority operating executive arrangements, by the elected mayor or the executive leader of the local authority;

(b)in any other case, by the local authority.

(4)In the case of a local authority operating executive arrangements, the elected mayor or the executive leader of the local authority may, instead of or in addition to making a nomination under subsection (2)(a), be a member of the Board.

(5)The Local Healthwatch organisation for the area of the local authority must appoint one person to represent it on the Health and Wellbeing Board.

(6)A relevant clinical commissioning group must appoint a person to represent it on the Health and Wellbeing Board.

(7)A person may, with the agreement of the Health and Wellbeing Board, represent more than one clinical commissioning group on the Board.

(8)The Health and Wellbeing Board may appoint such additional persons to be members of the Board as it thinks appropriate.

(9)At any time after a Health and Wellbeing Board is established, a local authority must, before appointing another person to be a member of the Board under subsection (2)(g), consult the Health and Wellbeing Board.

(10)A relevant clinical commissioning group must co-operate with the Health and Wellbeing Board in the exercise of the functions of the Board.

(11)A Health and Wellbeing Board is a committee of the local authority which established it and, for the purposes of any enactment, is to be treated as if it were a committee appointed by that authority under section 102 of the Local Government Act 1972.

(12)But regulations may provide that any enactment relating to a committee appointed under section 102 of that Act of 1972—

(a)does not apply in relation to a Health and Wellbeing Board, or

(b)applies in relation to it with such modifications as may be prescribed in the regulations.

(13)In this section—

(a)"enactment" includes an enactment contained in subordinate legislation (within the meaning of the Interpretation Act 1978);

(b)"elected mayor", "executive arrangements" and "executive leader", in relation to a local authority, have the same meaning as in Part 1A of the Local Government Act 2000;

(c)"relevant clinical commissioning group", in relation to a local authority, means any clinical commissioning group whose area coincides with or falls wholly or partly within the area of the local authority.

(14)In this section and in sections 195 to 199, “local authority” means—

(a)a county council in England;

(b)a district council in England, other than a council for a district in a county for which there is a county council;

(c)a London borough council;

(d)the Council of the Isles of Scilly;

(e)the Common Council of the City of London in its capacity as a local authority.

**195 Duty to encourage integrated working**

(1)A Health and Wellbeing Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner.

(2)A Health and Wellbeing Board must, in particular, provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services.

(3)A Health and Wellbeing Board may encourage persons who arrange for the provision of any health-related services in its area to work closely with the Health and Wellbeing Board.

(4)A Health and Wellbeing Board may encourage persons who arrange for the provision of any health or social care services in its area and persons who arrange for the provision of any health-related services in its area to work closely together.

(5)Any reference in this section to the area of a Health and Wellbeing Board is a reference to the area of the local authority that established it.

(6)In this section—

- “the health service” has the same meaning as in the National Health Service Act 2006;
- “health services” means services that are provided as part of the health service in England;
- “health-related services” means services that may have an effect on the health of individuals but are not health services or social care services;
- “social care services” means services that are provided in pursuance of the social services functions of local authorities (within the meaning of the Local Authority Social Services Act 1970).

**196 Other functions of Health and Wellbeing Boards**

(1)The functions of a local authority and its partner clinical commissioning groups under sections 116 and 116A of the Local Government and Public Involvement in Health Act 2007 (“the 2007 Act”) are to be exercised by the Health and Wellbeing Board established by the local authority.

(2)A local authority may arrange for a Health and Wellbeing Board established by it to exercise any functions that are exercisable by the authority.

(3)A Health and Wellbeing Board may give the local authority that established it its opinion on whether the authority is discharging its duty under section 116B of the 2007 Act.

(4)The power conferred by subsection (2) does not apply to the functions of the authority by virtue of section 244 of the National Health Service Act 2006

**197 Participation of NHS Commissioning Board**

(1)Subsection (2) applies where a Health and Wellbeing Board is (by virtue of section 196(1)) preparing—

(a)an assessment of relevant needs under section 116 of the Local Government and Public Involvement in Health Act 2007, or

(b)a strategy under section 116A of that Act.

(2)The National Health Service Commissioning Board must appoint a representative to join the Health and Wellbeing Board for the purpose of participating in its preparation of the assessment or (as the case may be) the strategy.

(3)Subsection (4) applies where a Health and Wellbeing Board is considering a matter that relates to the exercise or proposed exercise of the commissioning functions of the National Health Service Commissioning Board in relation to the area of the authority that established the Health and Wellbeing Board.

(4)If the Health and Wellbeing Board so requests, the National Health Service Commissioning Board must appoint a representative to join the Health and Wellbeing Board for the purpose of participating in its consideration of the matter.

(5)The person appointed under subsection (2) or (4) may, with the agreement of the Health and Wellbeing Board, be a person who is not a member or employee of the National Health Service Commissioning Board.

(6)In this section—

- "commissioning functions", in relation to the National Health Service Commissioning Board, means the functions of the Board in arranging for the provision of services as part of the health service in England;
- "the health service" has the same meaning as in the National Health Service Act 2006.

**198 Discharge of functions of Health and Wellbeing Boards**

Two or more Health and Wellbeing Boards may make arrangements for—

(a)any of their functions to be exercisable jointly;

(b)any of their functions to be exercisable by a joint sub-committee of the Boards;

(c)a joint sub-committee of the Boards to advise them on any matter related to the exercise of their functions.

**199 Supply of information to Health and Wellbeing Boards**

(1)A Health and Wellbeing Board may, for the purpose of enabling or assisting it to perform its functions, request any of the following persons to supply it with such information as may be specified in the request—

(a)the local authority that established the Health and Wellbeing Board;

(b)any person who is represented on the Health and Wellbeing Board by virtue of section 194(2)(e) to (g) or (8);

(c)any person who is a member of a Health and Wellbeing Board by virtue of section 194(2)(g) or (8) but is not acting as a representative.

(2)A person who is requested to supply information under subsection (1) must comply with the request.

(3)Information supplied to a Health and Wellbeing Board under this section may be used by the Board only for the purpose of enabling or assisting it to perform its functions.

(4)Information requested under subsection (1) must be information that relates to—

(a)a function of the person to whom the request is made, or

(b)a person in respect of whom a function is exercisable by that person.

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| **DECISION-MAKER:** | Health and Wellbeing Board |
| **SUBJECT:** | Briefing on UK City of Culture Bid and formal backing |
| **DATE OF DECISION:** | 15 December 2021 |
| **REPORT OF:** | **Cabinet Member for Health and Adult Social Care** |

| **CONTACT DETAILS** | | | | |
|---|---|---|---|---|
| **Executive Director** | **Title** | Executive Director for Community, Culture and Homes | | |
| | **Name:** | Mary D'Arcy | Tel: | 023 8083 4611 |
| | **E-mail:** | Mary.D'arcy@southampton.gov.uk | | |
| **Author**: | **Title** | Programme Manager | | |
| | **Name:** | Tom Tyler | Tel: | 023 8083 2695 |
| | **E-mail:** | Tom.Tyler@southampton.gov.uk | | |

| **STATEMENT OF CONFIDENTIALITY** |
|---|
| Not applicable. |
| **BRIEF SUMMARY** |
| The UK City of Culture competition is a title given to a location in the UK every 4 years. The aim of the competition is to use culture as a means of growth, recovery and change, such as recovery from Covid19, positive social and economic outcomes and to build and strengthen communities. |
| Southampton is bidding to become UK City of Culture in 2025. The bid is being managed by Southampton 2025 Trust on behalf of the city and is overseen by Trustees from Southampton City Council, GO! Southampton, Solent University Southampton and Southampton University. The bid team are working in collaboration with partners from across the city and are informed by an extensive consultation process. |
| Following the successful submission of our Expression of Interest in July 2021 we have been longlisted to the final 8 locations and have been asked to submit a full bid application. Due to the competitive nature of the bid process, this report and appendices will cover publicly available information on the process and our bid. |
| The City of Culture Bid Team would like to brief the Health and Wellbeing Board on the UK City of Culture process and by referencing previous city's, highlight some of the potential benefits that Southampton could receive should we win. We would like to secure the support of the Health and Wellbeing board for Southampton's bid to become UK City of Culture 2025. |
| **RECOMMENDATIONS:** |

| | | |
|---|---|---|
| | (i) | For the Health and Wellbeing board to formally support Southampton's bid to become UK City of Culture. |
| **REASONS FOR REPORT RECOMMENDATIONS** | | |
| 1. | UK City of Culture is an opportunity to secure long term benefits such as helping to address the social needs of our city; opportunities for young | |

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| | people; economic benefits, regional, national and international profile raising for the City as well as using culture as a catalyst to bring the City together and drive change. |
| 2. | During Hull's year of being the UK City of Culture in 2017, 9 out of 10 residents engaged with at least one cultural event and over 56,000 school children took part in activities, with 34% reporting improvements in their self-esteem. Throughout 2017, the value of tourism to the city of Hull, as a result of being awarded UK City of Culture status was £300M, with over 6 million visits to the city. One in four businesses within the city employed new staff and more than 800 new jobs were created in the cultural and visitor economy sector leading up to the year itself. Demonstrating the real value that being UK City of Culture can bring. |
| **ALTERNATIVE OPTIONS CONSIDERED AND REJECTED** | |
| 3. | N/A |
| **DETAIL (Including consultation carried out)** | |
| 4. | At the Southampton City Council (the Council) Annual General Meeting in May 2019, a joint motion was carried to support and progress a UK City of Culture 2025 bid ('the bid') for Southampton. It was agreed that Southampton should bid for UK City of Culture in a meaningful way, due to the economic benefits it can bring; opportunities for young people; putting Southampton on the map and its ability to help address the social needs of our city. The UK City of Culture process will also be an important element of the city's post Covid recovery. |
| 5. | To date the bid team have undertaken significant consultation activity and received a large number of survey responses from the city and wider region. This has included stakeholder engagement sessions with: Artists, Cultural and Creative Sectors, Businesses, Residents, Councillors, statutory partners and key institutions in the city. Most importantly, the consultation focused reaching residents from across the City, encouraging participation from underrepresented groups to ensure that many city-wide voices are heard and contribute towards shaping Southampton's bid. The most recent City Survey showed that 82% of respondents supported Southampton's bid to become UK City of Culture. |
| 6. | **Social impact for previous winners**<br>During the 2013 Derry-Londonderry UK City of Culture, 83% of the most deprived parts of the city attended a UK City of Culture event.<br><br>During 2017 Hull built on the experiences of Liverpool (European City of Culture) and Derry-Londonderry. During Hull's year of culture 9/10 residents engaged with at least one cultural activity. 100+ schools engaged in the "No Limits" learning programme which taught teachers how to use culture and creativity within their lessons to inspire, engage and innovate how students engaged with their studies. Throughout Hull's year of culture 56,000 young people took part in activities with 34% reporting improvements in self-esteem. |
| 7. | **Economic impact for previous winners** |

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| | Derry-Londonderry with over 535,000 people visiting the city during its year of culture, with 40 new businesses opening in the city during this period.<br><br>Hull reported a total of £300M+ value of tourism during 2017 with over 6M visits to the city. Since being awarded the 2017 title for UK City of Culture in 2013, over 800 new jobs were created in the cultural and visitor economy sector. Hotel occupancy in the city increased by +10.5% and 1 in 4 businesses employed new staff in 2017. |
| 8. | **Legacy potential**<br>While benefits during the year of culture itself are important, so are the long-term changes that come from winning the competition. Previous winners such as Hull and Derry-Londonderry have not managed to leverage the competition to deliver the longer term change possible. The legacy element of the competition is a vital part of any bid. |
| **RESOURCE IMPLICATIONS** | |
| **Capital/Revenue** | |
| 9. | N/A |
| **Property/Other** | |
| 10. | N/A |
| **LEGAL IMPLICATIONS** | |
| **Statutory power to undertake proposals in the report:** | |
| 11. | N/A |
| **Other Legal Implications:** | |
| 12. | None |
| **RISK MANAGEMENT IMPLICATIONS** | |
| 13. | Risks are managed as part of our bid process and all key risks to the delivery of a winning bid are detailed in our submissions to DCMS. |
| **POLICY FRAMEWORK IMPLICATIONS** | |
| 14. | A successful City of Culture Bid will deliver positive impacts for the city in line with the Policy Framework, as set out at Article 4.01 of the Council's Constitution.<br><br>The Bid will support the delivery of the Health and Wellbeing Strategy outcomes:<br>• Inequalities in health outcomes are reduced – helping reduce inequalities through access to culture<br>• Southampton is a healthy place to live and work with strong, active communities – the Bid will bring communities together as part of the citywide activity<br><br>It will support the achievement of the following aspects of the Transport Vision in the Local Transport Strategy 2040 'Connected Southampton': |

| | |
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| | • Improving the attractiveness of public spaces and streets to support growth, improve health and wellbeing and enable sustainable growth;<br><br>Tackling inequalities through improving accessibility and by designing transport improvements so that they meet the needs of everyone in society and that everyone can get around more safely and easily; |
| 15. | A successful Bid will also support the delivery of the Council Corporate Plan 2020 – 2025, and its commitment to delivering a greener, fairer and healthier city. The Bid will support the focus on communities, culture and homes, including the commitment to developing a cultural city. |

| | |
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| **KEY DECISION?** | **~~Yes~~/No** |
| **WARDS/COMMUNITIES AFFECTED:** | |
| SUPPORTING DOCUMENTATION | |
| **Appendices** | |
| 1. | Presentation to be given at board. |

**Documents In Members' Rooms**

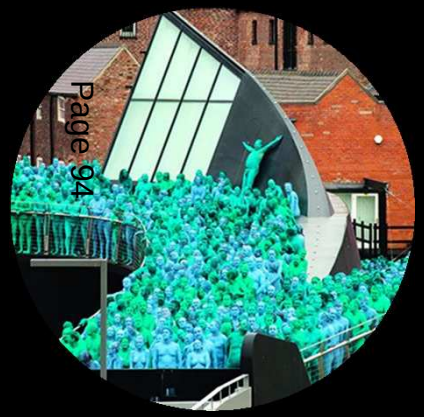
| | |
|---|---|
| 1. | None |
| **Equality Impact Assessment** | |
| **Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.** | **~~Yes~~/No** |
| **Data Protection Impact Assessment** | |
| **Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out.** | **~~Yes~~/No** |
| **Other Background Documents**<br>**Other Background documents available for inspection at:** | |

| | | |
|---|---|---|
| **Title of Background Paper(s)** | | **Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)** |
| 1. | None | |

SOUTHAMPTON
UK CITY OF CULTURE
BID 2025

UK CITY OF CULTURE
BIDDING CITY

www.Southampton2025.co.uk | @Southampton2025 | #SO25





# WHAT IS UK CITY OF CULTURE

- UK City of Culture is a designation given to an area in the United Kingdom for a period of one year, every four years.
- The competition is administered by the Department for Digital, Culture, Media and Sport and has a panel of independent judges.
- The designation of UK City of Culture brings tangible economic, social and cultural benefits leading up to, during and beyond the year that the city holds the status.
- Coventry is the holder for 2021.
- The aim of the competition is to use culture as a means of growth, recovery and change, such as recovery from Covid19, positive social and economic outcomes and to bui and strengthen communities.
- Our bid is lead by Southampton 2025 Trust.
- We are bidding to become UK City of Culture 202

# IMPACT ON PREVIOUS WINNERS

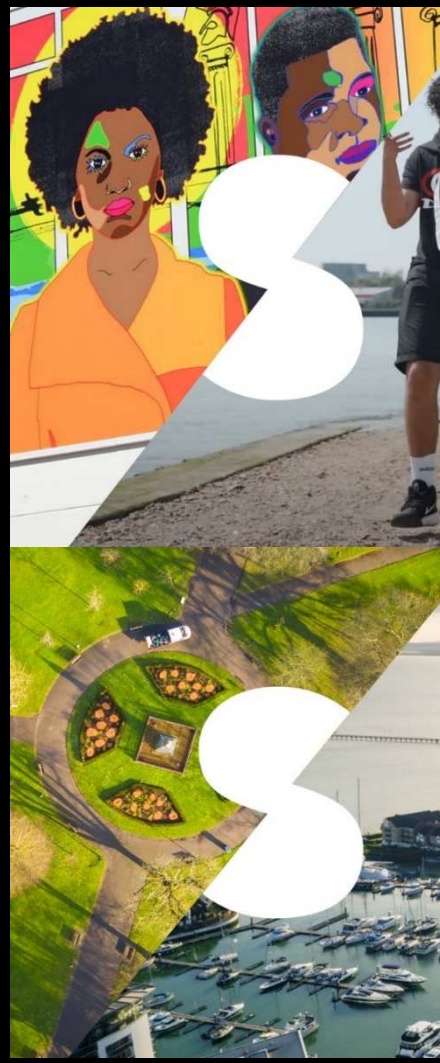
**ocial**

During the 2013 Derry-Londonderry UK City of Culture, 83% of the most deprived parts of the city attended a UK City of Culture event.

During 2017 Hull built on the experiences of Liverpool (European City of Culture) and Derry-Londonderry. During Hull's year of culture 9/10 residents engaged with at least one cultural activity.

100+ schools engaged in the "No Limits" learning programme which taught teachers how to use culture and creativity within their lessons to inspire, engage and innovate how students engaged with their studies.

Throughout Hull's year of culture 56,000 young people took part in activities with 34% reporting improvements in self-esteem.



# IMPACT ON PREVIOUS WINNERS

**conomic**

Derry-Londonderry reported over 500,000 people visiting the city during its year of culture, with 40 new businesses opening in the city during this period.

Hull reported a total of £300M+ value of tourism during 2017 with over 6M visits to the city. Since being awarded the 2017 title for UK City of Culture in 2013, over 800 new jobs were created in the cultural and visitor economy sector. Hotel occupancy in the city increased by +10.5% and 1 in 4 businesses employed new staff in 2017.

**egacy potential**

While benefits during the year of culture itself are important, so are the long-term changes that come from winning the competition. The legacy element of the competition is a vital part of any bid.

# COMPETITION

| ity/town | Pop. | Notes |
|---|---|---|
| rmagh Banbridge nd Craigavon | 214,090 | Northern Irish bid. Was a location that came forward at EOI stage, hadn't been publicly announced prior. |
| radford | 532,279 | One of the early competitors. |
| ornwall | 565,968 | Led by LEP, launched off the back of the G7 summit. |
| ounty Durham | 527,000 | Previous bid in 2014, wasn't shortlisted. |
| erby | 252,500 | Local authority and partnership-led. |
| irling | 94,300 | Scottish Bid. |
| rexham County orough | 136,000 | Welsh Bid. Wrexham is bidding for city status in 2022. |

# JUDGES PANEL

Sir Phil Redmond (Chair)

Claire McColgan (Deputy Chair)

Lynne Best (representative for Northern Ireland)

Nick Capaldi (representative for Wales)

Roberta Doyle (representative for Scotland)

Martyn Henderson (representative for England)

Andrew Barnett (leads the Calouste Gulbenkian Foundation in the UK)

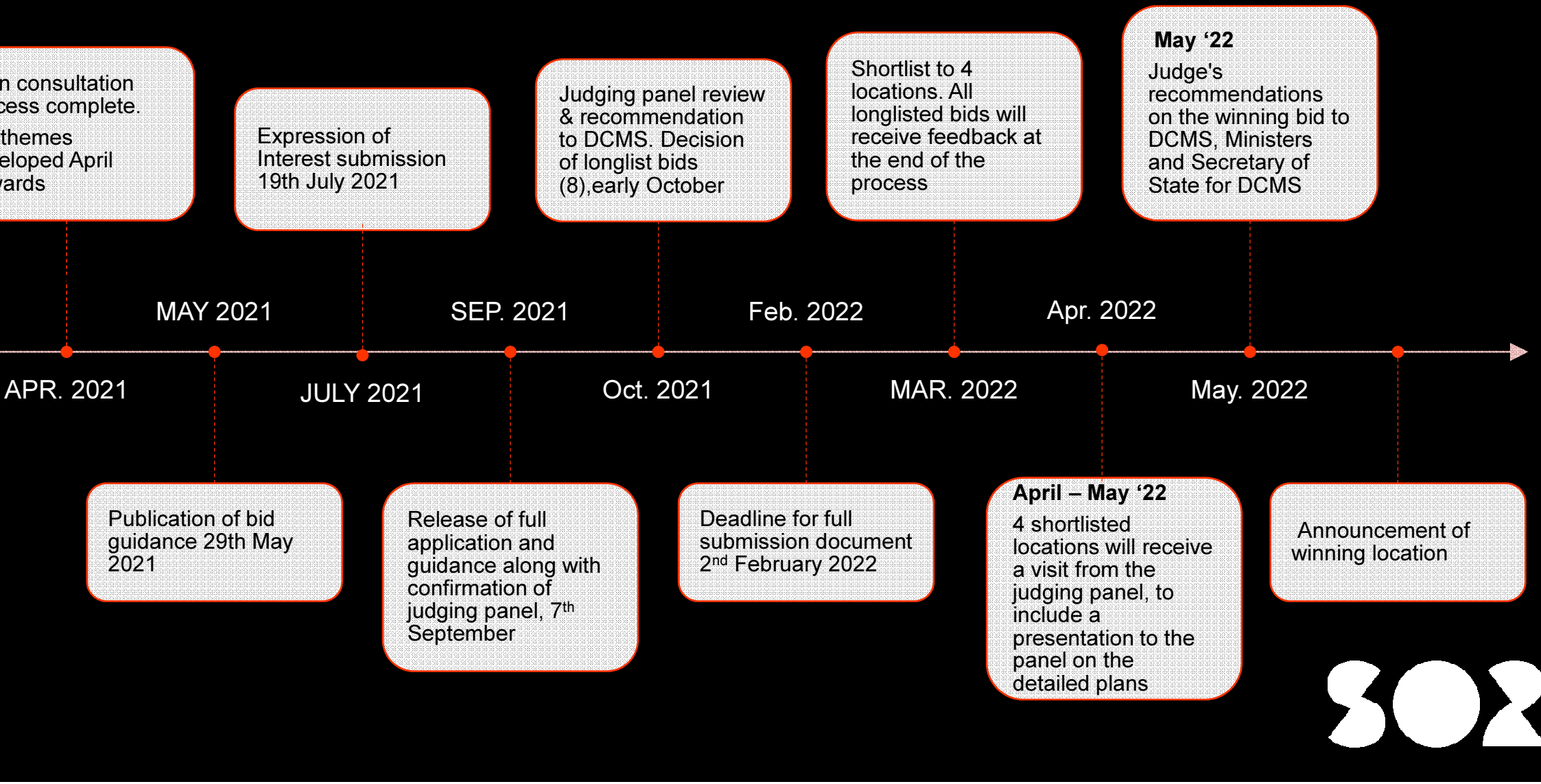
Rebecca Matthews (Managing Director of Glasmuseet Ebeltoft, Denmark's museum of contemporary international glass art)

Aideen McGinley (DCMS advisory panel in previous two UK CoC competitions and CEO of Ilex urban regeneration company)

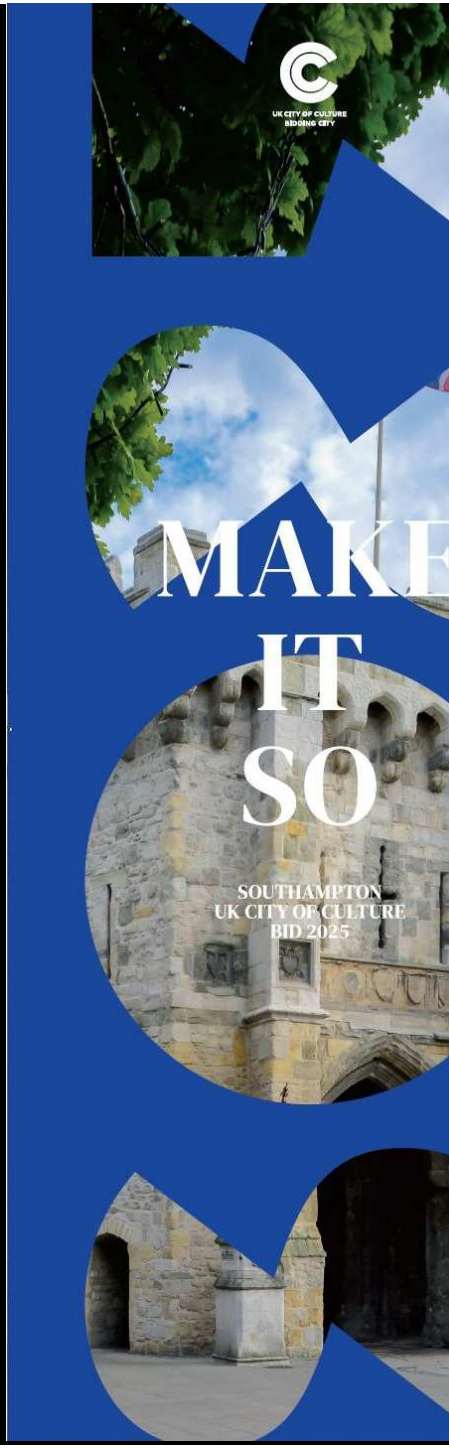
Tateo Nakajima (Arup Fellow and internationally recognized leader in design and planning of cultural venues and developments)

Jamie Njoku-Goodwin (Chief Executive of UK Music, the collective voice of the UK music industry)

# TIMELINE


n consultation
cess complete.
themes
eloped April
vards
APR. 2021
Publication of bid guidance 29th May 2021
MAY 2021
Expression of Interest submission 19th July 2021
JULY 2021
Release of full application and guidance along with confirmation of judging panel, 7th September
SEP. 2021
Judging panel review & recommendation to DCMS. Decision of longlist bids (8),early October
Oct. 2021
Deadline for full submission document 2nd February 2022
Feb. 2022
Shortlist to 4 locations. All longlisted bids will receive feedback at the end of the process
MAR. 2022
April – May ‘22
4 shortlisted locations will receive a visit from the judging panel, to include a presentation to the panel on the detailed plans
Apr. 2022
May ‘22
Judge's recommendations on the winning bid to DCMS, Ministers and Secretary of State for DCMS
May. 2022
Announcement of winning location


# THANK YOU
# &
# ANY QUESTIONS?



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| **DECISION-MAKER:** | **Health and Wellbeing Board** |
| **SUBJECT:** | **PROPOSAL TO CREATE A NEW COMBINED TOBACCO, ALCOHOL & DRUG STRATEGY (FOR APPROVAL/ ADOPTION AT NOVEMBER 2022 CABINET)** |
| **DATE OF DECISION:** | **15 December 2021** |
| **REPORT OF:** | **COUNCILLOR White**<br>**CABINET MEMBER FOR Health and Adult Social Care** |



| **CONTACT DETAILS** | | | | |
|---|---|---|---|---|
| **Executive Director** | **Title** | Executive Director Wellbeing (Health and Adults) | | |
| | **Name:** | Guy Van Dichele | Tel: | 07703 498223 |
| | **E-mail** | Guy.VanDichele@Southampton.gov.uk | | |
| **Author**: | **Title** | Public Health Consultant | | |
| | **Name:** | Charlotte Matthews | Tel: | 07765 666764 |
| | **E-mail** | Charlotte.Matthews@southampton.gov.uk | | |



| **STATEMENT OF CONFIDENTIALITY** | | |
|---|---|---|
| None | | |
| **BRIEF SUMMARY** | | |
| This briefing paper seeks approval to proceed with the development of a new 5-year Tobacco, Alcohol and Drugs strategy under the Health and Wellbeing Strategy and Board. | | |
| **RECOMMENDATIONS:** | | |
| | (i) | The development of a combined Tobacco, Alcohol & Drugs Strategy to run for 5 years, with a cross-council approach. |
| | (ii) | The new strategy sits under the Health and Wellbeing Strategy and Board. |
| | (iii) | The schedule for the new strategy is:<br>• a final draft by April 2022;<br>• statutory 12-week public consultation from June 2022, after the pre-election period and May elections have concluded;<br>• formal adoption through Cabinet by the end of November 2022. |
| **REASONS FOR REPORT RECOMMENDATIONS** | | |
| 1. | It is a statutory requirement for Local Authorities to have 'a strategy for combatting the misuse of drugs, alcohol and other substances in the area', under the Crime and Disorder Act 1998 (as amended by the Police and Justice Act 2006). Southampton City Council's (SCC) separate Drugs and Alcohol Strategies expired in 2020. Operational work on drugs and alcohol has continued since then. Developing new strategies was deprioritised as not critical during the immediate pandemic response. New national strategies are due this month. There is high local need. | |

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| 2. | The Council signed up to the Local Government Declaration on Tobacco Control in 2014, committing the Council to have a local Tobacco Control plan. There was a plan until 2017. Work has continued since then, although it has not been captured in one, single plan. A new national strategy is due this year. Local smoking rates are high. |
| 3. | At present, the Drug Strategy sits under the Safe City Strategy and Partnership; the Alcohol Strategy sits under the Health and Wellbeing Strategy and Board. This disconnects the two issues which are addressed through similar stakeholders and agencies. Having a third, separate Tobacco strategy would exacerbate this. Tobacco, alcohol and drug use often cluster in the population and all are risk factors for higher Covid-19 harms. All feature in the 5-year Health and Care Strategy for Southampton. |
| 4. | The existing drug and alcohol strategies are both 3-year strategies. A 5-year strategy will bring the strategy period in line with the Health & Wellbeing Strategy and the Southampton City Strategy. |
| **ALTERNATIVE OPTIONS CONSIDERED AND REJECTED** | |
| 5. | Single strategies have been rejected as it would miss the opportunity for a joined-up approach particularly with regards to approaches focussed on families, the city as a place, safer communities and health in all policies. Also duplicates work and does not make the best use of stakeholder time. |
| **DETAIL (Including consultation carried out)** | |
| 6. | Tobacco, alcohol and drugs are leading causes of premature death, inequalities and wider harm locally, nationally and internationally. **Appendix 1** describes this harm as context. |
| 7. | Positioning a new, combined strategy under the Health and Wellbeing Strategy will strengthen our focus on prevention, harm minimisation, treatment and relapse prevention. It will join up workstreams and stakeholders. |
| 8. | The Safe City Partnership and the Executive Directors and Cabinet Members currently responsible for the Drugs and the Alcohol strategies have agreed in principle to a new combined strategy under the Health and Wellbeing Strategy and Board. The strategy will be developed, implemented and reviewed with Safe City and other partners to aligns with wider priorities and outcomes. |
| 9. | The new strategy is an opportunity for a step-change in the scale and scope of our work and ambition. Most local work to date has focused on treating individuals who seek treatment or criminal justice. The most effective approaches do not focus on individuals, treatment or legal enforcement alone. An early, draft framework for the strategy has 5 key themes, based on evidence of what works and current national strategy. It reflects the whole-council approach required, broadly aligned with Executive Directors, as shown in Figure 1: |

**Figure 1. Draft strategy themes – for development with stakeholders**

**Children & Young People**

- Prevent children and young people from starting
- Protect children and young people from adult use including young carers

**Health & Care - Treatment systems**

- Identifying people with problematic use
- Reducing the harm from use
- Supporting people to stop using tobacco, alcohol and drugs

| | | |
|---|---|---|
| | • Supporting people to stay tobacco, alcohol and drug free<br>• Carers<br>• Workforce development | |
| | **Place**<br>• Public places – free of use for civic pride, social norms, safety, litter<br>• Workplaces, skills and employment<br>• Housing – for people with drug and alcohol issues, consideration of smokefree housing<br>• Planning and urban design | |
| | **Safer Communities**<br>• Reducing illicit or illegal supply<br>• Reducing the associated impact to communities<br>• Reducing the fear of crime | |
| | **Health in all Policies**<br>• Health in all contracts and commissioning<br>• Workforce wellbeing – support and HR policies<br>• Relationship to industry including advertising policy<br>• Pension investments | |
| 10. | We envisage a short, high-level strategy. Outcomes will be reviewed at least annually. We will have more detailed action plans when useful. Process measures and Key Performance Indicators in contracts will inform our monitoring. This will include people's lived experiences as well as data. | |
| **RESOURCE IMPLICATIONS** | | |
| **Capital/Revenue** | | |
| 11. | There are no resource implications inherent in having a combined strategy for 5 years under the Health and Wellbeing Strategy and Board. | |
| 12. | The strategy will be written within current funding levels and areas for development or additional funding will be flagged. | |
| **Property/Other** | | |
| 13. | There are no property or other implications inherent in having a combined strategy for 5 years under the Health and Wellbeing Strategy and Board. | |
| **LEGAL IMPLICATIONS** | | |
| **Statutory power to undertake proposals in the report:** | | |
| 14. | This paper is within the remit of the Health and Wellbeing Board to approve. | |
| **Other Legal Implications:** | | |
| 15. | Early advice from Legal Services has confirmed there is no requirement to extend the current drug or alcohol strategy any further as there is no direct impact to service provision or access, given:<br>1) neither strategy contains date-specific provision of any services that end once the strategy expires<br>2) the Health and Wellbeing Strategy is still in date and the Safe City Strategy is due for approval at March 2022 Cabinet<br>3) the new combined Tobacco, Alcohol and Drugs strategy can now be developed. | |
| 16. | Legal services and the Policy team also recommend: | |

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| | 1) the appropriate governance route to proceed with the proposal in this paper is by seeking the approval of the Health and Wellbeing Board in December 2021.<br>2) The strategy development process includes a full 12-week public consultation on the draft outside of the pre-election period in 2022 before proceeding to Cabinet approval. |
| **RISK MANAGEMENT IMPLICATIONS** | |
| 17. | We will not meet our statutory obligation if we do not have a drug and alcohol policy. We will not meet our commitment to have a tobacco control plan if we do not have a tobacco control strategy. |
| **POLICY FRAMEWORK IMPLICATIONS** | |
| 18. | The proposals contained in the report are in accordance with the Council's Policy Framework Plans. |

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

SUPPORTING DOCUMENTATION

| | |
|---|---|
| **Appendices** | |
| 1. | Summary of tobacco, alcohol and drug harm |

**Documents In Members' Rooms**

| | |
|---|---|
| 1. | None |
| **Equality Impact Assessment** | |
| **Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.** | **No** |
| **Data Protection Impact Assessment** | |
| **Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out.** | **No** |

**Other Background Documents**
**Other Background documents available for inspection at: N/A**

| **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 City Council Drugs Strategy, 2017-2020, available from **Key strategies, plans and policies (southampton.gov.uk)** | Not exempt or confidential |
| 2. | Southampton City Council Alcohol Strategy, 2017-2020, available from **Key strategies, plans and policies (southampton.gov.uk)** | Not exempt or confidential |

**Appendix 1**

## Summary of Tobacco, Alcohol & Drug-related Harm

1. Tobacco, alcohol and drugs are leading causes of premature death, inequalities and wider harm locally, nationally and internationally. Taken together, the three risk factors have a significant impact on residents of all ages, on our health and care system, and the nature of Southampton as a place to work and live. All disproportionately affect people who live with trauma and/or chronic stress including poverty. Each substance compounds the effects of the others and make anxiety, depression and other mental health conditions worse.

   Examples of the scale of the local impact

2. **Smoking** - Public Health England is clear that "*Smoking is the most important cause of preventable ill health and premature mortality in the UK*". Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. It is also a risk factor for many other cancers, e.g. of the lip, mouth, throat, bladder, kidney, stomach, liver and cervix. Half of smokers die prematurely from smoking, typically 10 years earlier than non-smokers. Tobacco also drives need and/or demand in relation to social care, fire safety, litter and workforce productivity. An estimated 35,000 people in Southampton smoke.

3. **Alcohol** is the biggest risk factor for death, ill-health and disability among 15-49 year olds in the UK, and the fifth biggest risk factor across all ages. Alcohol is a causal factor in more than 60 medical conditions, including cancers, high blood pressure, cirrhosis of the liver, and depression. It also contributes to obesity and wider social harm. Locally, an estimated:
   i. 3,459 people are alcohol-dependent
   ii. 36,000 people drink at higher risk levels of more than 14 units a week.
   iii. 1,261 local children live with an alcohol-dependent adult.

   There are over 1,500 alcohol-related admissions to hospital a year in Southampton. There were 2,615 alcohol affected crimes in Southampton in 2019/20 and 70% were violent crimes.

4. **Drugs** - An estimated 1,200 local people use crack cocaine and/or illicit opiates, with half estimated to inject their drugs. An estimated 593 local children live with an opiate-dependent adult. There were 989 recorded drug offences (any drug) in Southampton in 2019/20, a 37.4% increase compared to the previous year, reflecting a considerable focus on drug crime in Southampton. The drug offence rate is over six times higher in our most deprived neighbourhoods compared to our least deprived neighbourhoods. 38 people died directly from drug use between 2018-2020, and this figure would have been substantially higher if not for the prevention measures already in place. There is also harm from the illicit use of prescription medications.

5. Each of the risk factors is a risk factor for increased harm from COVID-19. People who smoke are more likely to be seriously ill. Alcohol and illicit drugs impair our ability to make safer decisions. Most drug-related deaths involve compromised respiratory health.

6. More information about local need is available from Southampton Data Observatory and Public Health Outcomes Framework - PHE.

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| **DECISION-MAKER:** | Health and Wellbeing Board |
| **SUBJECT:** | Better Care Fund Narrative Plan and Template 2021/2022 |
| **DATE OF DECISION:** | 15/12/2021 |
| **REPORT OF:** | **COUNCILLOR I. White**<br>**CABINET MEMBER FOR Health and Adult Social Care** |

| **CONTACT DETAILS** | | | | |
|---|---|---|---|---|
| **Executive Director** | **Title** | Executive Director, Wellbeing (Health and Adults) | | |
| | **Name:** | **Guy Van Dichele** | Tel: | 07703 498 223 |
| | **E-mail** | **Guy.VanDichele@southampton.gov.uk** | | |
| **Author**: | **Title** | **Associate Deputy Director, Integrated Commissioning Unit** | | |
| | **Name:** | **Moraig Forrest-Charde** | Tel: | 07769640375 |
| | **E-mail** | moraig.forrest-charde@nhs.net | | |

| **STATEMENT OF CONFIDENTIALITY** |
|---|
| Not Applicable |
| **BRIEF SUMMARY** |
| The papers for consideration, and sign off, are written in response to the Better Care Fund Policy Framework and Planning Guidance, the latter being published on the 30th of September 2021. These papers were submitted to the regional Better Care Fund (BCF) team for assurance on the 16th of November as required in the Planning Guidance. |
| There are two papers - planning narrative and template which both of which were required in response to the Planning Guidance. The narrative was structured with a set of questions set by the national BCF team, the responses to these questions are informed by the 5 Year Health and Care Strategy, which builds on the work in response to the pandemic and new national policy i.e. hospital discharge policy. These priorities were identified in the Joint Commissioning Board (JCB) briefing April 2021 and are reflected in the narrative response. The template required detail of income and planned expenditure, setting of targets against the nationally set metrics and assurance that the planning requirements have been met. |
| The content of these two papers is not repeated in this document rather a summary of the requirements, with the papers included as an addendum. |
| **RECOMMENDATIONS:** |

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| | (i) | Health and Wellbeing Board note the delegated approval of the Better Care Fund Policy Framework and Planning Guidance by the Health and Wellbeing Board Chair, following agreement of the CEO of the Local Authority and Accountable Officer of the Clinical Commissioning Group (CCG). |

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| | (ii) | Health and Wellbeing Board note that response from the regional BCF team regarding assurance is expected on the 9th of January 2022. |
| **REASONS FOR REPORT RECOMMENDATIONS** | | |
| 1. | The BCF requires clinical commissioning groups and local authorities to agree a joint plan, owned by the Health and Wellbeing Board. These are joint plans for using pooled budgets to support integration, governed by an agreement under section 75 of the NHS Act (2006). | |
| **ALTERNATIVE OPTIONS CONSIDERED AND REJECTED** | | |
| 2 | No other options considered, sign off by the Health and Wellbeing Board is a requirement set out in the BCF Policy Framework and Planning Guidance. | |
| **DETAIL (Including consultation carried out)** | | |
| 3 | **Policy Framework and Planning Guidance**<br>The Department of Health and Social Care published the BCF Policy Framework for 2021/2022 on the 19th of August 2021 and the Planning Guidance, which supports the framework, on the 30th of September 2021. A summary of the requirements within the framework are provided below.<br>• BCF remains the government's vehicle for driving health and social care integration, through the following –<br>  ○ Health and Wellbeing Board agreement of a joint plan – CCGs and LAs<br>  ○ Building on progress made during the pandemic<br>  ▪ Strengthening integration of commissioning and delivery<br>  ▪ Delivering person-centred care[1] (strength based approach)<br>  ▪ Continuing to support system recovery from the pandemic<br>• NHS contributions, pooled fund arrangements -<br>  ○ Can be in excess of the minimum requirements (as previously)<br>  ○ Include funding that supports delivery of the Care Act requirements<br>  ○ Includes support to Reablement and provision of carers breaks<br>  ○ Meets the requirement of a 5.3% rise in the minimum NHS contribution to the fund.<br>• Disability Facilities Grant – as previously, no changes noted.<br>• iBCF – as previously, no changes noted.<br>• Conditions and Metrics outlined in the plan –<br>  ○ Jointly agreed plan – signed off by Health and Wellbeing Board<br>  ▪ Includes agreed approach for embedding the current discharge policy.<br>  ○ NHS contribution in line with the required uplift i.e. 5.3%<br>  ○ Invests in NHS out of hospital services | |

[1] NHS England » Comprehensive model of personalised care

- Plan for improving outcomes for people being discharged from hospital, including
  - Continued implementation of the High Impact Change Model for Managing Transfers of Care[2], focusing on
    - Reducing LOS, in particular % of hospital inpatient who have been in hospital for longer than 14 and 21 days
    - Improving the proportion of people discharge home using data on discharge to their usual place of residence.
- Further metrics to be included as part of plan and reporting are –
  - Avoidable admissions to hospital through rate of emergency admission for ambulatory care sensitive conditions[3]
  - Long term admissions to residential care homes – reported previously
  - Effectiveness of Reablement – reported previously.

A narrative and template were required in response to the Policy Framework and Planning Guidance, the former is based upon our 5 Year Health and Care Strategy and priorities identified in the JCB briefing April 2021. The narrative plan and template were submitted to the BCF team regionally for assurance and sign off on 16th of November 2021.

The narrative plan and template must reflect how commissioners will work together in 2021-22 to:

• continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally

• overarching approach to support people to remain independent at home

• a narrative on the approach in the area to jointly improving outcomes for people being discharged from hospital, and for reducing the percentage of hospital inpatients who have been in hospital for more than 14 and 21 days (National condition 4)

Local sign off requirements are - Health and Wellbeing Board, CEO of the local authority and Accountable Officer of the CCG. Following submission, if sign off is by the delegated authority for the Health and Wellbeing Board, presentation to said Health and Wellbeing Board is requirement before the 16th of December 2021. Prior to submission the necessary sign off arrangements were followed, including delegation to Health and Wellbeing Board BOARD chair ahead of this meeting.

For avoidance of doubt all of the conditions were met at the time assurance is being sought for the Southampton plan.

[2] **Managing transfers of care – A High Impact Change Model: Changes 1-9 | Local Government Association**

[3] **Ambulatory Care Sensitive Conditions (ACSC) - NHS Digital**

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| 4 | **Narrative Plan Priorities**<br>The plan includes the following priorities for 2021/2022 -<br>• **Priority 1**: Delivering on Avoidable Admissions - Strong focus on admission avoidance through our urgent Response Service and Enhanced Health in Care Homes (EHCH) arrangements.<br>• **Priority 2**: Focus on embedding the new approach to discharge, including Discharge to Assess and home first as a feature within the BCF plan.<br>o Including the Community Discharge Hub/Single Point of Access (SPoA)<br>o A flexible and broad offer of discharge to assess provision (D2A), promoting a home first approach<br>• **Priority 3**: Focus on reducing long term admissions to residential care, including elements of the High Impact Change Model (Reducing preventable admissions to hospital and long-term care)<br>• **Priority 4**: Increase the number of people who see benefit from Reablement, meaning a continued focus on reducing dependency on longer term care provision.<br>• **Priority 5**: Implement new models of care which better support the delivery of integrated care and support in our communities and work towards anticipatory care as standard.<br>• **Priority 6:** Effective utilisation of the Disability Facilities Grant – promoting independence and personalised care/strength based approaches.<br>**Changes to our previous BCF** plan are based upon the above priorities and recovery of services post pandemic across all schemes. In summary these are:<br>Priority 1 and 4<br>• Expansion and redesign of our Urgent Response Service/Urgent Community Response and Reablement Service through a number of funding sources.<br>• Expansion of our EHCH service arrangements through commissioned contracts with our GP federation and partnership work with Primary Care Networks.<br>• Expanding our mental health crisis offer through the 'Lighthouse', a city based community facility that supports individuals in a recovery-focused way to manage their mental health crisis.<br>• Development of Children's Hospital at Home service, building on the learning from Covid Virtual Wards in adults.<br>Priority 2<br>• Embedding the new discharge pathways in particular through making the Single Point of Access a sustainable element of delivery model.<br>• Working with our provider market to promote a flexible offer of Discharge to Assess (D2A) arrangements to care homes and patients own homes (Home First)<br>Priority 3 and 5<br>• Roll out of integrated care teams with a broader scope across the city, building on the test and learn work of the last 2 – 3 years. SCC developing a |

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| | locality model in Adult social care, Children's social care and Communities aligns with this roll out.<br>• Further developments in our prevention and early intervention offer and LD integrated commissioning approach that promote people staying well and independent for longer, 'active lives'.<br>• Development of the locality model for supporting children and families with SEND as part of the next phase of service redesign (the Children's Destination 22 programme)<br>• Expansion of Crisis and Therapeutic offer within the integrated health and social care provision for children with complex behavioural & emotional needs.<br>• Enhanced Primary Care Mental Health Team through a dedicated Southampton City Mental Health Partnership Board, with collaboration between CCG, PCNs, SHFT, DHUFT (IAPT) and VSCE delivery of the Community Mental Health Transformation continues.<br>Priority 6<br>• Implementation of recommendations following a comprehensive review of DFG undertaken during 2020/2021.<br>o Substantial system change in relation to ensure effective provision of adaptations through the DFG that promotes independence for the residents of Southampton.<br><br>**The Narrative Plan and Template are included as appendices to this document for further detail.** |
| 5 | **BCF local reporting and oversight.**<br>BCF quarterly updates continue to be presented to the Joint Commissioning Board with Q1 update on 19/08/2021 and Q2 on 21/10/2021. In addition the BCF Finance and Performance Group meet six times in the year with the purpose of<br>'the Better Care Finance and Performance Monitoring Group (F&PMG ) is have oversight of the Better Care Fund S75 agreements and to provide assurance to Joint Commissioning Board that the funding and performance are being appropriately and effectively managed' |
| **RESOURCE IMPLICATIONS** | |
| **Capital/Revenue** | |
| 6 | Financial and resource implications are described in the pooled fund details within the narrative plan and template. These pooled fund arrangements have been in place since agreement between the CCG and Local Authority at the outset of this year.<br>The ICU in Southampton manages (on behalf of the Health and Wellbeing Board) one of the largest Better Care pooled funds in the country. Mandated level for 2021/2022 of £32.469m and a total pooled fund of £135.420m, £86.013m from the CCG and £49.407m from SCC. These BCF plan distributes these funds across ten schemes, noted within the narrative and detailed in the expenditure tab of the BCF 2021/2022 planning template.<br>A detailed breakdown of income and expenditure by scheme can be found within the template which is included as an appendix to this document. |

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| **Property/Other** | |
| 7 | Not Applicable |
| **LEGAL IMPLICATIONS** | |
| **Statutory power to undertake proposals in the report:** | |
| 8 | The legal framework for the Better Care Pooled Fund derives from the amended NHS Act 2006, which requires that in each Local Authority area the Fund is transferred into one or more pooled budgets, established under Section 75, and that plans are approved by NHS England in consultation with DH and DCLG. The Act also gives NHS England powers to attach additional conditions to the payment of the Better Care Fund to ensure that the policy framework is delivered through local plans. In 2021-2022, NHS England set the following conditions:<br>• A Jointly Agreed plan between local health and social care commissioners, signed off by the Health and Wellbeing Board<br>• NHS contribution to adult social care to be maintained in line with the uplift to the CCG minimum contribution<br>• Invest in NHS-commissioned out-of-hospital services<br>• A plan for improving outcomes for people being discharged from hospital<br>Southampton is compliant with all four of these conditions. |
| **Other Legal Implications:** | |
| 9 | Not applicable |
| **RISK MANAGEMENT IMPLICATIONS** | |
| 10 | The risks are as follows –<br>• There is a risk of overspend against a small number of schemes within the pooled fund, in particular Learning Disability Commissioning and Aids to independent. The former related to the complexity of care and support required for the client group and the latter to the risk in equipment needs again with rising levels of complexity and frailty within the city. Each of these schemes are under close scrutiny and where possible the overspend is mitigated.<br>• The successful delivery of the stretch targets set as part of this planning process are subject to multiple system forces e.g. availability of workforce in adult social care providers will have a direct impact on delivery of hospital discharge metrics and reablement metric. At this point in time focus on recruitment and retaining of this workforce is a priority for the local authority and its commissioned providers.<br>• University Hospitals Southampton Foundation Trust (UHS) is identified as a 'trust of focus' by NHS England, as a result of discharge performance, and as such there will be a greater level of scrutiny of the submission for Southampton. Therefore there is a risk that the regional BCF team, working with NHS England and local government representatives, will not be sufficiently assured by the content of Southampton's narrative plan and template and request additional detail ahead of giving full assurance. This risk however remains low as a result of all of the conditions having been met. |
| **POLICY FRAMEWORK IMPLICATIONS** | |
| 11 | Southampton's Better Care Programme supports the delivery of outcomes in the Council Strategy (particularly the priority outcomes that "People in Southampton live |

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| | safe, healthy and independent lives" and "Children get a good start in life") and CCG Operating Plan 2017-19, which in turn complement the delivery of the local HIOW Sustainability and Transformation Partnership, NHS 5 Year Forward View, Care Act 2014 and Local System Plan. |
| 12 | Southampton's Better Care Plan also supports the delivery of Southampton's Health and Wellbeing Strategy 2017 - 2025 which sets out the following 4 priorities:<br>• People in Southampton live active, safe and independent lives and manage their own health and wellbeing<br>• Inequalities in health outcomes and access to health and care services are reduced.<br>• Southampton is a healthy place to live and work with strong, active communities<br>• People in Southampton have improved health experiences as a result of high quality, integrated services |

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| **KEY DECISION?** | **Yes** |
| **WARDS/COMMUNITIES AFFECTED:** | |
| SUPPORTING DOCUMENTATION | |
| **Appendices** | |
| 1. | Southampton BCF Narrative Plan 20212022 |
| 2. | Southampton BCF Planning Template 20212022 |

**Documents In Members' Rooms**

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| 1. | |
| 2. | |
| **Equality Impact Assessment** | |
| **Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.** | **No** |
| **Data Protection Impact Assessment** | |
| **Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out.** | **No** |
| **Other Background Documents**<br>**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. | | |
| 2. | | |

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# Better Care Fund Narrative Plan

# Southampton

# Health & Wellbeing Board – Southampton City

# 2021/2022

1. ***Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils. How have you gone about involving these stakeholders?***

The Better Care Plan (BCF) for Southampton has its basis in our 5 year Health and Care Strategy (2020 – 2025). This strategy was formed through a partnership of health, care and community and voluntary sector representation and based on the Joint Strategic Needs Assessment (JSNA). The slide below provides an overall summary of the strategy –


This year's BCF plan has been informed by a range of groups within the governance structure. The Better Care Steering Board being the driving force behind the plan, both in its formation and oversight. This board is formed of our leaders in health care, adult and children's social care, public health ,CCG and Primary Care Networks (clinical leads), Community and Voluntary Sector and officers within the CCG and Local Authority (including representation from Housing). In addition, linked with the priorities in the slide above there are a range of other groups which have contributed to form the BCF plan for this year, these include –

- Ageing Well Group
- End of Life Steering Group
- Children's Multiagency Partnership Board
- Learning Disability Partnership Board
- Onward Care Group (Complex discharge and Integrated Discharge Bureau)
- Mental health forum/No wrong door group

- Operational Delivery Group – Southampton and South West Hampshire
- Carers Partnership Board - Southampton

These groups are formed of a wider range of partners from across the system of health, care and wider wellbeing: Local Authority, including Public Health, Adult Social Care, Children and Families, Communities, and Housing; CCG; health care providers including acute care, community care and mental health; Community and Voluntary sector; Primary Care and Primary Care Networks; Carers and people who use our services. Together these groups help to inform the next steps in delivering our 5 year Health and Care Plan and, with it, the next stages for the BCF Plan in 2021-2022.

## *2. Executive Summary*

**Priorities for 2021/2022**

- **Priority 1: Delivering on Avoidable Admissions -** Strong focus on admission avoidance through our urgent Response Service and Enhanced Health in Care Homes (EHCH) arrangements.
- **Priority 2: Focus on embedding the new approach to discharge,** including Discharge to Assess and home first as a feature within the BCF plan.
    - Including the Community Discharge Hub/Single Point of Access (SPoA)
    - A flexible and broad offer of discharge to assess provision (D2A), promoting a home first approach
- **Priority 3: Focus on reducing long term admissions to residential care,** including elements of the High Impact Change Model (Reducing preventable admissions to hospital and long-term care)
- **Priority 4: Increase the number of people who see benefit from Reablement,** meaning a continued focus on reducing dependency on longer term care provision.
- **Priority 5: Implement new models of care (within Adults and Children's)** which better support the delivery of integrated care and support in our communities and work towards anticipatory care as standard.
- **Priority 6: Effective utilisation of the Disability Facilities Grant –** promoting independence and personalised care/strength based approaches.

**Changes to our previous BCF plan** are based upon the above priorities and recovery of services post pandemic across all schemes. The details of schemes within our BCF plan can be found in Appendix 1, in summary these are:

Priority 1 and 4

- Expansion and redesign of our Urgent Response Service/Urgent Community Response and Reablement Service through a number of funding sources.
- Expansion of our EHCH service arrangements through commissioned contracts with our GP federation and partnership work with Primary Care Networks.
- Expanding our mental health crisis offer through the 'Lighthouse', a city based community facility that supports individuals in a recovery-focused way to manage their mental health crisis.

- Development of Children's Hospital at Home service, building on the learning from Covid Virtual Wards in adults.

Priority 2

- Embedding the new discharge pathways in particular through making the Single Point of Access a sustainable element of delivery model.
- Working with our provider market to promote a flexible offer of Discharge to Assess (D2A) arrangements to care homes and patients own homes (Home First)

Priority 3 and 5

- Roll out of integrated care teams with a broader scope across the city, building on the test and learn work of the last 2 – 3 years. SCC developing a locality model in Adult social care, Children's social care and Communities aligns with this roll out.
    - Including linking of further services with Early Help and Young People's locality teams.
- Further developments in our prevention and early intervention offer and LD integrated commissioning approach that promote people staying well and independent for longer, 'active lives'.
- Development of the locality model for supporting children and families with SEND as part of the next phase of service redesign (the Children's Destination 22 programme)
- Expansion of Crisis and Therapeutic offer within the integrated health and social care provision for children with complex behavioural & emotional needs.
- Enhanced Primary Care Mental Health Team through a dedicated Southampton City Mental Health Partnership Board, with collaboration between CCG, PCNs, SHFT, DHUFT (IAPT) and VSCE delivery of the Community Mental Health Transformation continues.

Priority 6

- Implementation of recommendations following a comprehensive review of DFG undertaken during 2020/2021.
    - Substantial system change in relation to ensure effective provision of adaptations through the DFG that promotes independence for the residents of Southampton.

***3. Governance***
***Please briefly outline the governance for the BCF plan and its implementation in your area.***

The Governance Structure for the BCF plan in place at the outset of 2021/2022 will be reviewed during that year to reflect the changes which will be required with the next stage of Integrated Care System Development. These arrangements, and those in the future, link with Southampton and South West local delivery system through our Operational Delivery Group, providing cross system oversight for the acute trust footprint.

The details below describe the existing arrangements, noting that the new governance arrangements for April 2022/2023 are at the design stage. These new governance

arrangements include a Programme Management approach to all areas of the BCF plan and wider 5 year Health and Care Strategy. Strengthening the oversight and challenge within the Southampton system.

**Health and Wellbeing Board**

The Health and Wellbeing Board (HWBB) acts as a formal committee of Southampton City Council, charged with promoting greater integration and partnership between the NHS, public health and local government. It has ongoing oversight of the Southampton City Health and Care Strategy and the BCF plan. The HWBB provides oversight and strategic direction for the Joint Commissioning Board and Better Care Southampton Board

**Joint Commissioning Board**

The Board monitors the performance of the Integrated Commissioning unit and ensure that it delivers the statutory and regulatory obligation of the partners of the Better Care Fund and relevant Section 75 agreements. Acting as the single health and care commissioning body for the city of Southampton and a single point for decision making. The JCB membership includes the main commissioners of health and care services in the city; Southampton local team representatives from Hampshire, Southampton and IoW Clinical Commissioning Group and Southampton City Council. The JCB ensures effective collaboration, assurance, oversight and good governance arrangements to ensure achievement of the city's health and care strategic objectives. The JCB enable continued engagement and momentum of the strategy and assist with resolving any delivery issues which cannot be resolved by the Better Care Southampton Board.

**Better Care Southampton Board**

The Better Care Southampton Board membership includes senior representatives from key health and care organisations across the city, including the voluntary sector. The purpose of the Board is to set strategic direction and oversee the successful delivery of the strategy. The Board will hold the delivery groups to account for delivering the agreed plans and outcomes, and will help to remove barriers to progress. Progress will be regularly reviewed to ensure that actions not only remain on track and anticipated key outcomes can be fully realised, but that the delivery plan is updated with new actions and measures as appropriate. A range of health and care outcome indicators will be monitored to inform whether the interventions in the strategy are having an impact.

**Finance and Performance Monitoring Group**

The purpose of the Better Care Finance and Performance Monitoring Group (F&PMG) is to have oversight of the Better Care Fund S75 agreements and to provide assurance to Joint Commissioning Board that the funding and performance are being appropriately and effectively managed. It is formed from CCG and Local Authority officers, including finance leads, with appropriate authority, including those that lead individual schemes. The schemes are :–

1. Supporting Carers
2. Integrated Locality Working
3. Integrated Rehabilitation and Reablement and Hospital Discharge
4. Aids to Independence
5. Prevention and Early Intervention

6. Learning Disability Integration
7. Promoting uptake of Direct Payments
8. Transforming Long Term Care
9. Integrated provision for children with special educational needs and disability (SEND)
10. Integrated health and social care provision for children with complex behavioural & emotional needs

**Delivery Groups**

There are a number of delivery groups in the city which are responsible for delivery of individual elements of the BCF plan and 5 Year Health and Care Strategy. They broadly represent the main programmes of work and include –

- Ageing Well Group
- End of Life Steering Group
- Workforce Group - multiagency
- Childrens Multiagency Partnership Board
- Rehab and Reablement Partnership Board
- Mental Health Partnership Board
- Carers Partnership Board
- Learning Disability – Co-production Group

All of these groups are formed of the relevant partners, with a strong focus on inclusivity enabling a coproduction approach as standard. In addition the Ageing Well Group and LD Coproduction group include representation from Adult Social Care Partners and housing leads within the Local Authority. Coproduction in some settings is driven by groups which have this as their specific purpose, e.g. Carers and Learning Disability. These groups form part of the overall infrastructure and therefore promote design changes to services in medium and long term.

***4. Overall approach to integration***
***Brief outline of approach to embedding integrated, person centred health, social care and housing services including***

The **joint priorities** for 2021-22 are as follows -

Priority 1: Delivering on Avoidable Admissions - Strong focus on admission avoidance through our Urgent Response Service and Enhance Health into Care Homes (EHCH) arrangements.

Priority 2: Focus on embedding the new approach to discharge, including discharge to assess and home first as a feature within the BCF plan.

- Including the Community Discharge Hub/Single Point of Access (SPoA)
- A flexible and broad offer of discharge to assess provision (D2A), promoting a home first approach

Priority 3: Focus on reducing long term admissions to residential care, including elements of the High Impact Change Model (Reducing preventable admissions to hospital and long-term care)

Priority 4: Increase the number of people who see benefit from Reablement, meaning a continued focus on reducing dependency on longer term care provision.

Priority 5: Implement new models of care which better support the delivery of integrated care and support in our communities and work towards anticipatory care as standard.

Priority 6: Effective utilisation of the Disability Facilities Grant – promoting independence and personalised care/strength based approaches.

**Approaches to joint/collaborative commissioning**

Southampton has an Integrated Commissioning Unit (ICU) which commissions health, care, and support services for the people of Southampton on behalf of Southampton City Council and Hampshire, Southampton, and Isle of Wight (HSI) NHS Clinical Commissioning Group. The purpose of the ICU is to enable both organisations to work together to make best use of our resources to commission sustainable, high quality services which meet the needs of local people now, and in the future.

Our key service objective is redesigning and commissioning across the full life course to manage increasing demand for health and social care, improve outcomes, improve quality, increase effective use of resources, avoid costs and release savings. Based on understanding the current and future health and care needs of the local community:

- Health and Care system redesign and transformational change, working together across health and social care to deliver integrated, person centred, joined up care for people in Southampton and to strengthen prevention and early intervention to support people to maintain their independence and wellbeing
- Development of integrated rehabilitation and reablement services; improvements to mental health crisis care; leadership of the design and implementation of integrated Children's services; establishment of Community Solutions; refocus Housing Related Support; leadership of Southampton Five Year Health and Care Strategy
- Improve and sustain quality of services across the health and care market, including effective contract management and monitoring, to ensure that people are provided with a safe, high quality, positive experience of care in all health and care providers ranging from individual social care providers and voluntary sector organisations to large health providers such as University Hospital of Southampton NHS Trust
- Support commissioning activities that facilitate, manage and develop a strong provider market that is able to respond to an increasingly diverse and complex customer group
- The scope of services commissioned includes all children and young people, adult health and social care, public health and housing for vulnerable people in the Council. For the CCG the services include all community health services (children and adults), services for those with mental health problems, disabilities or long-term conditions plus acute care for children and maternity services.
- The ICU also manages (on behalf of the Joint Commissioning Board/ HWBB) one of the largest Better Care pooled funds in the country. Mandated level for 2021/2022 of £32,469,932 and a total pooled fund of £140.358m, £86.080m from the CCG and £54.278m from SCC.
- The ICU aligns aspects of the Council and Southampton City Clinical Commissioning group (CCG) commissioning functions under a single management structure, with

staffing from each organisation committed to the ICU in exercise of powers under section 113 of the 1972 Act, to work towards the delivery of a shared strategy.

The work of the ICU continues, working closely with transformation colleagues within partner organisations and with commissioning colleagues across the ICS. There is active work “leaning in “ to support Primary care with their commissioning functions, The planning for future governance as the Integrated Care System evolves will further strengthen collaborative commissioning approaches.

Collaborative work is being undertaken to refresh the Children’s strategy for the city and review and refresh the commissioning and provision of services.

Throughout last year and this the ICU has supported the system of health and care to consider the impact of the pandemic on BCF and wider plans. The evidence of this is seen in the refresh of the 5 Year Health and Care strategy which now reflects adjusted timelines for many of the schemes in BCF. Some examples are –

- Extra Care – new site in the city having an adjusted timeline to reflect the impact of the pandemic on social care market and therefore the ability to have robust onsite care provision for this important and complex client group.
- Home First principle - in implementing our hospital discharge and admission avoidance schemes, the ICU has supported the system to work with the social care provider market, acknowledging the significant pandemic impact on capacity and workforce in this setting which has been a limiting factor for the implementation of this principle. This is evidenced through a workforce plan set up with the system, including social care providers, that begins to address these challenges.
- End of life care – this year, in response to the rising levels of frailty in the population and rising demand for end of life support, we have promoted earlier implementation of a 24/7 end of life support service with our charitable partner in the city. This has been a significant success, supported by joint working between said partner, our community health provider and Acute Visiting Service Provider in the city.

**Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.**

Overall the demand for services promoting independence has significantly increased over the last 18 months. Evidence within our Rehab and Reablement service would suggest that this is related to the change in hospital discharge process and an increasing level of frailty in our younger and older old population. The Joint Equipment Service supports this with a rise in the mean pieces of equipment per person rather than in the numbers of people requiring equipment, with the costs of this service rising by approximately 33%.

In addition to that noted earlier, there are a range of schemes in place which aim to support people to remain independent at home. The first of which being Integrated Rehab and Reablement, a service that has been in place for several years. The service has an integrated leadership team, and provider section 75, in place that promotes an integrated approach to delivery. Based upon the success of this service additional resource has been

provided to expand it to achieve more hours of care and Reablement delivered, during this year, from the CCG allocation in addition to Ageing Well funding for Urgent Community Response.

A key element of the above service is Reablement, which has been part of the integrated service promoting independence for a number of years. Again, building upon the success of the service and the rise in demand related to increasing frailty, there has been investment in this service to make available greater capacity to respond to said demand. The impact on the metric (proportion of older people who were still at home 91 days after discharge from hospital into Reablement/rehabilitation services) is expected to be one of status quo, see 8.5 in the metrics element of the planning template.

In conjunction with the above service the development of community integrated teams continues through our 'One Team' programme. This, as noted in previous plans, includes integration of core community services for adults to promote proactive and reactive health and care for people with complex needs. The work progressed significantly during the pandemic, in particular focusing upon the clinically extremely vulnerable patient group, which provides a strong foundation on which to build this year. This year, and next, will see a formalisation of these arrangements across the city, including elements such as colocation.

All of the above is included as part of our Ageing Well plan, a subset of the 5 year Health and Care Strategy. This plan, and the BCF, includes a carers (unpaid) work stream. Carers have long been a focus of the BCF in Southampton with this year seeing the conclusion of a scrutiny enquiry, writing of two strategies (young carers and adult carers) and initial implementation of the recommendations. Elements of this new carers work is supported by the iBCF grant and seeks to support a strength based approach for our unpaid carers in the city.

Also as part of the 5 year Health and Care strategy we have a Die Well plan which describes the next stages for the development for end of life services and services that support the preparation or planning stage. This year includes the move towards earlier identification of end of life cases, potentially as early as 3 years before death, enabling better preparation and anticipatory care planning. Also, building upon the pandemic response closer working between our end of life services, primary care acute visiting service and community health services is embedding.

The above work is a key element of the personalised care approach being implemented in the city, along with this we are reviewing progress made on the personalised care model in the city this year. Prior to the pandemic we had made significant inroads into implementing the model, however we expect there to have been some impact as a result of the pandemic response. The key areas of focus are: Personalised Care and Support Planning across specialist and core services; Section 117 after care Personal Budget roll out; growing community capacity; social prescribing; and finally service self-assessment of personalised care approaches. These elements together promote a personalised care approach to care that seeks to support individuals to remain independent and in their own home.

Live Well is another subset of the 5 year Health and Care Strategy which includes many of the areas noted within section 7 of this document. This programme of work includes many of the elements encompassed within the BCF plan, e.g.: mental health transformation; prevention and early intervention/healthy lifestyles; and substance use disorder services. In this year there have been developments in our community crisis support ('the Lighthouse') for individuals living with a mental illness, as well as an enhancement to the primary care mental health support.

'The Lighthouse' is a city based community facility that supports individuals in a recovery-focused way to manage their mental health crisis. Local residents using The Lighthouse receive interventions in a therapeutic environment offered by mental health nurses, as well as peer supporters who bring their lived experience to the service. Review of patient outcomes and experience of the virtual model offered during the pandemic has been undertaken to build a more sustainable model which will be expanded to other areas of the city.

Enhanced Primary Care Mental Health Team. Through a dedicated Southampton City Mental Health Partnership Board, with collaboration between CCG, PCNs, Southern Health Foundation Trust, Dorset Healthcare Foundation Trust (Improving Access to Psychological Therapies) and VSCE, delivery of the Community Mental Health Transformation continues. This includes the Enhanced Primary Care Mental Health Team to meet the identified PCN demographic and population health needs. People with unmet significant health needs in Primary Care include; people with serious mental illness (SMI), frequent attenders, people with traits of personality disorder, people stepping down from adult mental health services, physical health checks of patients with SMI. The success of this is through the Additional Roles Reimbursement Scheme (PCNs) and our local transformation plan.

Start Well is another subset of the 5 Year Health and Care Strategy. This programme of work includes many of the same principles found across our Better Care plan, in particular its focus on strengthening early intervention and family centred approaches and integrated locality teams. This year's Better Care plan is supporting work specifically in relation to implementing new models of care (priority 5) which include strengthening the integrated crisis, therapeutic and outreach/consultation offers in our Building Resilience and Strengths Service (a joint funded children's health and social care team for children with the most complex behavioural needs) and redesigning the integrated Jigsaw Service (a jointly funded children's health and social care team for children with learning disabilities) to provide advice and support as part of the early help work in localities. In addition work is in progress to support priority 1 (admission avoidance) including the establishment of a new Children's Hospital at Home Team to support families manage minor child illnesses in the community and the development of a Children's Acute Psychiatric Liaison service to support the Emergency Dept, incorporating youth workers provided by a voluntary sector partner (No Limits) who provide valuable advice, support and signposting for young people.

5. ***Supporting Discharge (national condition four)***
   ***What is the approach in your area to improving outcomes for people being discharged from hospital?***
   ***How is BCF funded activity supporting safe, timely and effective discharge?***

Improving outcomes for people discharged from hospital has always been a central element of Southampton's BCF Plan. Over the past 18 months, the CCG and the Council, working in partnership with health and care providers, the voluntary and community sector and Health-watch have transformed the model to meet the national requirements, first published in March 2020, reinforced in August 2021. In August 2021, we took stock of the implementation of this model (including reference to the High Impact Change Model for Managing Transfers of Care[1])

[1] https://local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/refreshin

and developed a forward plan for the remainder of 2021/22 and beyond, taking account of the need to improve patient outcomes, most importantly strengthening our approach to home first.

The key aims of our discharge model moving forward are to:

- Promote and support people to retain as much independence as possible and maximise their potential for remaining in their own homes – data from April 2019 to Jul 21 is showing that on average 94.8% of patients return to their usual place of residence varying from 93% - 95% each month. Our comparator average is 93.7%. Local analysis suggests that patients over 80 are the least likely to return to their usual place of resident and so our focus will particularly be on supporting the older client group to regain their independence. Noting that local data and BCF data sets are not comparable and the latter is not available with an age profile breakdown, **ambition will be improvement in this metric with the older persons group whilst sustaining performance of 94.8% against the BCF data set**.
- Seek to reduce onward care costs by reducing dependence on bed based and more intensive care wherever possible
- Extend the re-ablement offer to all patients leaving hospital on pathway 1
- Strengthen flexibility in the use of bed based interim care for those who need it to ensure that these resources are utilised more effectively.
- Reduce hospital length of stay, thereby preventing wherever possible people from deconditioning in a hospital bed – data from April 2019 – July 21 shows that 10.4% of patients in Southampton had a 14+ LOS and 5.4% a 21+ LOS (compared to a comparator average of 10.9% and 5.8% respectively). Further analysis shows that this increases with age – highest in over 65yrs and white British ethnicity. Thus the ambition this year will be to see a reduction in the 14+ and 21+ LOS figure of 0.4% respectively.
- Continue to develop the multiagency team approach through further extension of our community based multiagency discharge hub to speed up discharge and manage all step up and step down activity
- Our ambition this year is to sustain the performance of 94.8%, BCF metric, of people being discharged to their usual place of residence and to reduce long lengths of stay by 0.4%. The new model will achieve this through:
- A stronger focus on earlier discharge planning, at the point of admission and within the first 12 hours
- Strengthened Community Discharge Hub with additional Social Work and CHC capacity.
- Development of a flexible core community bed offer. In the new model we are disinvesting in interim D2A beds but need to make sure that those beds that remain are more flexible according to the current needs in the system.
- Strengthened health and care services in the community with the agility to respond quickly and flexibly to greater levels of complexity and acuity in people's own homes at any time of the day 24/7.

In order to deliver this model, we have agreed to prioritise as a system greater investment in the following areas (further detail of which can be found in the embedded document):

- Home care – workforce development as well as additional hours for bridging, night-time care and long term care
- Reablement care
- Community therapy (OT and Physio)
- Community Urgent Response to provide clinical support into care packages and placements as well as our virtual ward model

- Additional Voluntary Sector capacity – including ongoing investment in our existing Welcome Home Scheme
- Additional health and social worker capacity in the Community Discharge Hub to support increased numbers of discharges home and increase in-reach into the hospital
- Additional capacity in community equipment
- Working with L.A. housing services, including Homelessness services, to promote hospital discharge for those that are either Homeless or at risk of Homelessness.

These plans are still subject to confirmation of finances but over the next 12 months, as the home care provision is enhanced, we would envisage decommissioning some of our D2A beds, thereby releasing funding that can be reinvested in the services above.

The BCF is key to supporting this work. Historically we have used the BCF to pool funding, with additional contributions from both the CCG and the Council, to provide us with the flexibility required to deliver our discharge plans. In 2021/22 this part of our BCF pooled fund comes to £17.6M including iBCF investment and covers our integrated Rehab and Reablement Service, Hospital Discharge Team, and additional investment into our Urgent Response Service and D2A schemes – which include both a D2A model for Pathway 1 (supporting people in their own homes) and a D2A model for pathway 2 (for people unable to return straight home). We have also used the BCF to invest additional health funding in home care which has also included training in clinical skills and community equipment and have used some of the iBCF funding for joint work with the Hampshire Care Association to support the market around Covid-19 response and recovery, workforce development, understanding cost pressures and completing a 'cost of care' exercise. The Rehab and Reablement elements noted here are key to meeting the ambition set for metric 8.5 – Proportion of older people who were still at home 91 days after discharge from hospital into Reablement/rehabilitation services.

We note that the BCF funded elements do not form the totality of the hospital discharge arrangements, particularly given the winter surge plans being developed at this point in time. However, in Southampton the scale of the BCF pooled fund arrangement are such that a significant proportion of this work is in scope. Extra care is one such service, with some elements funded from within BCF (e.g. care provision) and others within the wider L.A. scope. This service is one of the key enablers for hospital discharge, supporting timely discharge for often our older population who are resident in those settings.

We will be looking to build on this approach going forward, subject to 22/23 finances, to deliver the plans above.

University Hospitals Southampton Foundation Trust (UHS) is one of the organisations in the SE that is described as a 'trust of concern'. The data made available as part of the BCF planning process highlights the following –

- Southampton city sum of Emergency Admissions to UHS – 43.59%, noting that being the area in which the trust is based it is the acute trust which serves the majority of our residents/patients.
- Southampton city sum of Emergency Admission to UHS that have a 21+ LOS – 36.05% and a similar position with 14+ LOS.

Whilst this detail suggests that longer stays are an even greater concern for people living outside of Southampton, the city's commissioners and providers of health and care are working hard with UHS towards improving this position. In addition to the discharge developments noted above (in section 5 of the narrative) Southampton and South West

System has a comprehensive ‘winter surge plan’ which is regularly reviewed in response to the changing circumstances.

6. ***Disabled Facilities Grant (DFG) and wider services***
   ***What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?***

**DFG**

A substantial cross agency review was led by Foundations, national experts on the use of the DFG, between August 2019 and January 2020, focussing on: local processes and practices associated with the assessment and delivery of home adaptations; national good practice; and opportunities afforded through the flexible use of the DFG to improve support and access for disabled and older people. The implementation of the review was held up during the pandemic response until April 2021 when 2 work streams were developed to meet the reviews recommendations.

The work streams focus on

- Refining the DFG assessment and adaptation process to promote a more efficient service which will have an impact on more people as a result. A cross agency project group has been established to undertake this work stream involving social care, health and housing, this group is still in the early stages of its development. The first outcomes of this work will be seen before the end of this financial year.
- Promoting the utilisation of the DFG through short and medium term projects which can be implemented with immediate effect and seek to work with a range of services and sectors across health, care and housing to do so. This has been made possible through utilisation of an underspend existing from previous years DFG. These include –
    - Setting aside a proportion of the grant to allow for the Joint Equipment Store to undertake low cost adaptation activity (e.g. ceiling hoists).
    - Extending the warm homes scheme to incorporate a “safe homes” element.
    - Supporting the Sensory Service Team, part of our integrated rehab and Reablement services, to train other professional to recognise sensory loss early which then allows them to intervene early to work with individuals to maintain their independence including the use of equipment and self-management techniques.
    - Increase in OT support in both children’s and adult services to manage DFG assessments.
    - Extension of a Handy person’s scheme that undertakes small work at a very low cost (e.g. hand rails, banisters etc).

By working with a broader scope of partners to implement the short and medium term schemes, a positive impact is expected during the second half of 2021/2022. Further expectation being, for these schemes, that some of these initiatives will be established as permanent elements of our offer as part of the revised ongoing DFG process.

**Housing Related Support**

Housing Related Support (HRS), a scheme fully under the BCF plan, is a key part of the wider prevention and early intervention work which is undertaken in the city. During this year significant effort is being made in reviewing all of our Housing Related Support services, including those for young people, adults and older persons. This review work is undertaken, not only to ensure that contracting requirements are met, but also to enable provision which strives to build the foundation for people to live independent and fulfilling lives. The primary aim of these services being to reduce inequalities, confront deprivation and work with people to build resilience communities in which they live independently.

The review of the service offer for young people and adults is informed by a broad range of stakeholders and service users, including: local authority housing and homeless services; alcohol and substance use disorder services; homeless healthcare; adult and children's social care. A range of improvements will be included in the services, procurement to be completed during the last half or 2021/2022, which enable the following –

- Development of independent living skills and with it support to move on to settled accommodation.
- Improvements in reported physical wellbeing, emotional wellbeing and mental health.
- Improvement in individuals and families link with their communities to promote an outcome of settled accommodation.

These improvements will be made possible through a strong relationship between the commissioned services and their partners in health care, including substance use disorder services and mental health. These relationships are not part of an integrated offer rather a formal approach to partnership which meets the needs of the population.

The older persons HRS (55yrs+) will also be reviewed this year, in scope will be floating support provision and that which is provided within a specific setting e.g. our extra care schemes. The primary aim for these services remains to live independent and fulfilling lives, where possible enabling them to remain in their home with support rather than moving to a 24 hour care setting. This year saw the addition of a new extra care facility for the city, taking the total to 6, an expansion which places greater importance on this review and the support service itself.

The HRS service is critical to the success of these facilities acting as a bridge with other key support services for the residents, e.g. home care, adult social care, housing services, community and voluntary sector and health care. Again, whilst not formal integration, the strong partnerships between these services enable successful support for this client group. As such the review will include engagement with all of these partners and make recommendations for continue improvements in partnership approaches that promote the independence of residents and their ability to remain within that setting.

### *7. Equality and health inequalities.*

Southampton is an ethnically diverse city:

- **22.3%** of Southampton's residents are from an ethnic group other than White British, compared to 20.2%nationally (2011 Census).
- Southampton has residents from over 55 different countries who between them speak 153 different languages (2011 Census).
- Disability-free life expectancy at birth for males in Southampton is **59.6years**, compared to 62.9 nationally (2016-18). Disability-free life expectancy at birth for females in Southampton is **58.2 years**, compared to 61.9 nationally (2016-18).

- Around **123,000** people in Southampton have a long-term health condition (such as diabetes, heart disease, epilepsy, breathing problems etc.). Over half of these people have two or more conditions for which they need ongoing support.
- 610 adults with a learning disability in Southampton receive long-term support from the local authority (2018/19)
- 3.9% of supported working age adults with a learning disability in paid employment, compared to 5.9% nationally (2018/19).
- **13.5%** of people aged 16 years and over in Southampton have a long-term mental health problem, compared to 9.9%nationally (2018/19).

A more general indicator which shows inequality across the population is **life expectancy**. In Southampton, people living in the most deprived areas of the city die earlier than those living in the least deprived areas. Males living in the most deprived areas of the city are likely to die 6.7 years earlier than males living in the less deprived areas of the city. Females living in the most deprived areas of the city are likely to die 3.1 years earlier than females in the less deprived areas of the city. The actions we have identified focus on impacting on these areas, with a focus on the four priority areas identified below. The greatest challenge, including consideration of the cultural diversity of Southampton, is this gap between those living in the most and least deprived areas of the city. The Health and Wellbeing Strategy, whilst inclusive of the BCF plan, has multiple other schemes and strategies to promote improvements in this overall picture, including: Be Well Strategy; Suicide Prevention Plan; Tobacco Control Plan; Drugs Strategy; and Children and Young people Strategy.

Multiple areas within BCF plan include aspect which support vulnerable people, from ethnic groups other than white British, to access services. Including prevention and early intervention services, e.g. Community Wellbeing Team, Smoking cessation and Housing Related Support, having a targeted approach for those groups and areas of the city. This is further enhanced by BCF schemes working in collaboration with other service areas delivered or commissioned by the Local Authority or CCG, e.g. housing services for Council Tenants, Employment Support Teams and Healthy Homes/fuel poverty.

In addition the city's homeless or at risk of homelessness population includes people from a range of vulnerable groups/protected characteristics. The services provided for our homeless population largely sit outside of the BCF plan, however there is clear evidence that this group are greatly disadvantaged should they experience a health crisis and hospital admission. A review of this area has been undertaken in year and proposals developed from that which will be implemented either in Q4 of this year or early in the BCF plan for next year.

In this context and that of the vision of the Southampton Health and Wellbeing Strategy of 'a culture and environment that promotes and supports health and wellbeing for all', a number of priority areas within the BCF plan have been identified. These are –

1. People living with a learning disability – We have also been able to forecast increases in people with a learning disability. Between 2018 and 2023, the number of people with a learning disability is estimated to increase by 4.2%.
2. Older people – Southampton will see a rise in population overall of 5% by 2023 (based on 2018 population data) the age group with the biggest percentage increase will be the older old i.e. 80+ yrs (14.5%), adding more pressure onto the city's health and care services.
    a. Of note, though not exclusively older persons, prior to the impact of COVID we expected to see 9.7% increase in Frailty, 11.6% increase in Dementia and 10.3% increase in people living with 5 or more long term conditions all by 2023.

3. People living with a disability – whilst a proxy measure, we expect the number of people needing home care support with five or more activities of daily living (such as bathing, using the stairs, getting dressed) to increase by 11.8% between 2018 and 2023. Evidence to date supports this with a rise of the mean home care hours per person from 10 hours per week to 14 hours per week in the last year.
4. People living with mental illness - Social distancing and the impacts of lockdown will (for many) exacerbate existing conditions such anxiety and depression, and create "new" mental health needs. There is a high risk that social distancing may turn into 'social isolation' for those without a strong network of family and friends and a way to connect to others outside the home (known higher risk groups are men, older people and those that live alone).

**Changes from previous BCF plan, including inequality of outcomes related to the national metrics.**

Changes to the BCF plan which relate to hospital discharge will not be repeated here, see section 5 for detail. Similarly those changes which relate to DFG and Housing can be found in section 6.

**Learning Disability** commissioning and integration has long been a part of Southampton's BCF, Active Lives is one of the draft key priorities within the Southampton Learning Disabilities Transformation Strategy. The vision states that 'People with learning disabilities will be able to reach their goals and ambitions, through the delivery of good local joint planning, where the voice of the person and their carers are heard, and current inequalities are addressed, by the creation of opportunities, in every part of their lives'.

Whilst focussed on adults with learning disabilities, the Active Lives model also provides an enabling function for the wider system to those with autism and/or mental health illness, as it seeks to lay the foundations for a broader range of community supports, through breaking new ground in the city on key issues such as employment and inclusivity. Active Lives will deliver an outcome-focused model which enables individuals to increase their independence skills based on a robust, person-centred assessment and review process and more meaningful, community-based activities, including employment.

As well as offering a wider more inclusive community offer, Active Lives will transform the current model of day support by providing a much more strengths based, person centred and flexible offer which is based around individual outcomes and integrated within local communities. It will include a person centred, strengths-based assessment function, tied closely to outcomes which are regularly monitored, and integrated with a life skills approach and a bespoke employment function.

Further work through partnership between primary care and one of our prevention and early intervention services (Community Wellbeing Team) aims to improve the levels of physical health checks in this client group and at the same time promote Covid and Flu vaccination up take. Whilst this area is not identified through the national metrics it is a key priority for the city and will contribute to admission avoidance to acute care and residential settings.

**Older people**, as noted in section 5 of this document this group has been a strong focus in much of the hospital discharge work, as we build upon the lessons learnt in 2020/2021. Local intelligence suggests that the oldest old, i.e. 80+yr olds, have the lowest rate of being discharged to their usual place of residence. Whilst this level of detail is not available in the BCF data packs, it is clearly a priority area for the city.

Section five clearly describes some of the work aimed at achieving the above ambition. There is other work underway focusing on prevention and early intervention for this population group, in particular though our work with the community and voluntary sector. Building on the lessons learnt in 2020/2021 our commissioned community development and community navigation service (social prescribing resource in addition to PCN roles) is focusing on how we support older people, and other vulnerable groups, to resume or return to services where safe and appropriate to do so. Where it is not safe to do so they are working with local communities to promote digital engagement and with it access to wellbeing support. These approaches are aimed at supporting wellbeing and by so doing supporting people to remain independent for longer. This, along with the investment (in year) into Reablement noted in section 5, is key to supporting the delivery of metric 8.4 – Long-term support needs of older people met by admission to residential and nursing care homes.

Our Ageing Well group has also considered the High Impact Change Model – Reducing preventable admissions to hospital and long-term care[2]. In Q2 and Q3 will be undertaking a self-assessment against this model to identify other areas for consideration, building on the prevention and early intervention work and by so doing promote admissions avoidance to hospital and long term care.

Linked to this is the Ageing Well allocation (in year and included within the rehab and Reablement scheme) for 2 hour Urgent Community Response will be largely targeting this population, aiming to promote admission avoidance that meets the standards set out in the Ageing Well requirements. Clearly linked with admissions avoidance and supporting people to remain in their own homes for as long as possible. This is a key are for Southampton noting that of the NHS metrics this is the only one where performance is worse than our comparator local authorities and the England average (unplanned Hospitalisations for Chronic Ambulatory Care Sensitive Conditions).

**People living with a disability and/or multiple long term conditions** will benefit from the community work noted above. In addition there is a strong focus on supporting life planning and anticipatory care planning in our Community Wellbeing Team and also our End of Life Services. The latter promoting life and anticipatory care planning as early as possible, potentially up to 3 years before the end of life. These two services are working to ensure that people seek out the support or make the changes, they may need or wish to, in order to stay well and independent for as long as possible.

In addition work is ongoing in the city to support people who are living with multiple long term conditions, including those conditions which are most prevalent e.g. Diabetes, Heart Failure and Chronic Obstructive Pulmonary Disease. There is a broad support offer, including person centre approaches, supporting self-management and specialist care and advice where this is required. This work contributes to our admission avoidance work overall and supports metric 8.1, Unplanned hospitalisation for Chronic Ambulatory Care Conditions.

**People living with mental illness** are benefiting from a mental health investment across the ICS in this year, not formally part of the BCF plan. Elements which are included within the BCF plan include an expansion of the support for primary care to provide health checks for people who are living with a SMI through our Community Wellbeing Team. This offer will, as with LD, promote access to flu and Covid vaccination, along with the offer of health and wellbeing planning support.

[2] Reducing preventable admissions to hospital and long-term care – A High Impact Change Model | Local Government Association

Our Improving Access to Psychological Service has undergone a recommissioning process this year, building upon national requirements, best practice and local developments in support of post Covid demand. Impact from this will be seen next year with the new contracts starting on the 1st of April.

The city have also commissioned a mental health network, formed of interested organisations from across the community and voluntary sector. This will enable the sharing of good practice locally, enable partnership opportunities and bidding collaboratives. All of which aims to benefit the local population who are living with a mental illness. In addition the city has commissioned an extension of the JSNA that focuses upon mental health needs, which will be utilised to inform further mental health developments in the coming year.

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# Better Care Fund 2021-22 Template

**2. Cover**

**Version 1.0**

HM Government

NHS

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|---|---|
| **Health and Wellbeing Board:** | Southampton |
| **Completed by:** | Moraig Forrest-Charde |
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| **Contact number:** | 7769640375 |

**Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):**

| | |
|---|---|
| **Job Title:** | Chair of HWB and Cabinet Member for Health and Adult Social Ca |
| **Name:** | Cllr Ivan White |

| | |
|---|---|
| **Has this plan been signed off by the HWB at the time of submission?** | Delegated authority pending full HWB meeting |
| **If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:** | Wed 15/12/2021 |

<< Please enter using the format, DD/MM/YYYY
Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

| | Role: | Professional Title (where applicable) | First-name: | Surname: | E-mail: |
|---|---|---|---|---|---|
| ***Area Assurance Contact Details:** | Health and Wellbeing Board Chair | Cllr | Ivan | White | councillor.i.white@southampton.gov.uk; |
| | Clinical Commissioning Group Accountable Officer (Lead) | | Maggie | MacIsaac | maggie.macisaac@nhs.net; |
| | Additional Clinical Commissioning Group(s) Accountable Officers | | Maggie | MacIsaac | maggie.macisaac@nhs.net; |
| | Local Authority Chief Executive | | Sandy | Hopkins | Sandy.hopkins@southampton.gov.uk; |
| | Local Authority Director of Adult Social Services (or equivalent) | | Guy | Van Dichele | Guy.VanDichele@southampton.gov.uk |
| | Better Care Fund Lead Official | | Moraig | Forrest-Charde | moraig.forrest-charde@nhs.net |
| | LA Section 151 Officer | | John | Harrison | John.Harrison@southampton.gov.uk |
| *Please add further area contacts that you would wish to be included in official correspondence --> | | | | | |
| | | | | | |
| | | | | | |

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

**Template Completed**

| | Complete: |
|---|---|
| 2. Cover | Yes |
| 4. Income | Yes |
| 5a. Expenditure | Yes |
| 6. Metrics | Yes |
| 7. Planning Requirements | Yes |

<< Link to the Guidance sheet

^^ Link back to top