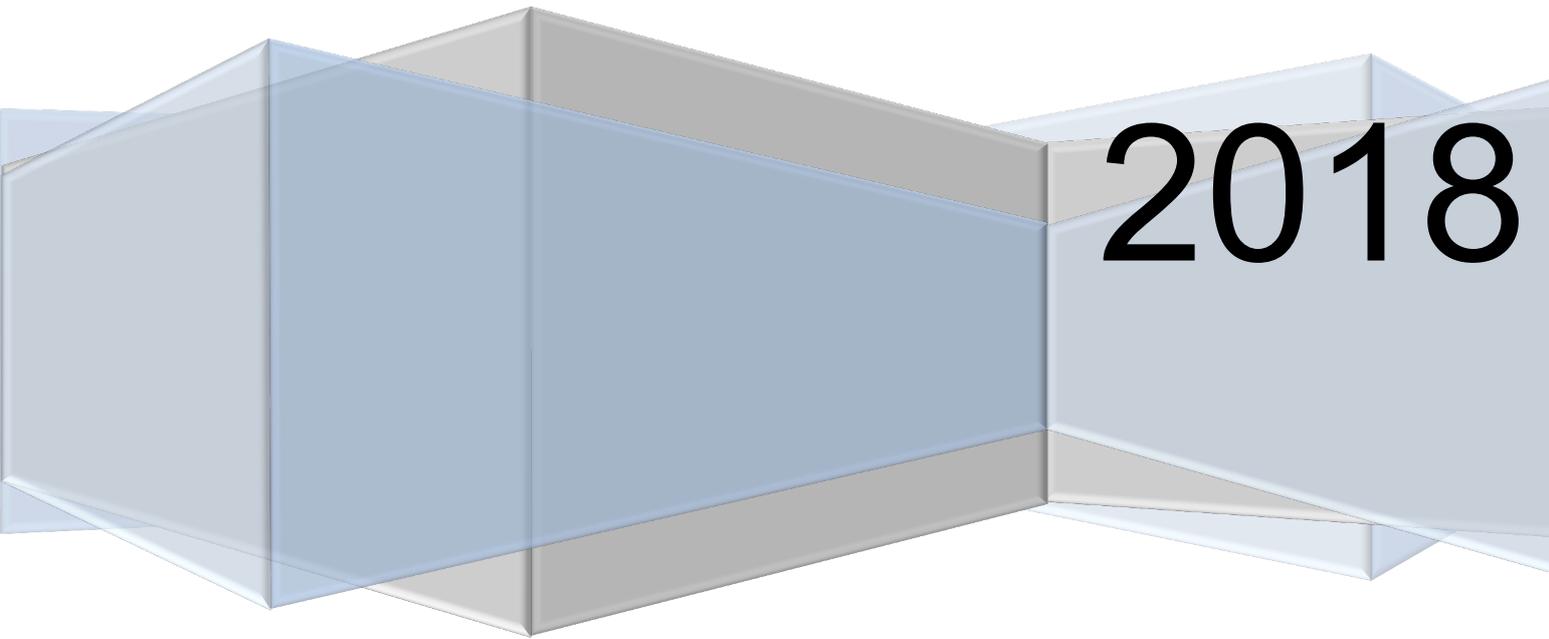


Southampton Pharmaceutical Needs Assessment



2018

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2 Executive Summary

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

In Southampton there are 43 community pharmacies and one dispensing appliance contractor.

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

In particular, this is based on:

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

3 Introduction

3.1 Definition and purpose of the PNA

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

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

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

3.2 Historical and Legal Background

The Health Act 2009¹ sets out the minimum standards for PNAs and the use of PNAs as the basis for determining market entry to NHS pharmaceutical services provision. The Regulations came into force in May 2010 and required Primary Care Trusts (PCTs) to develop and publish their first PNA under these Regulations by 1 February 2011.

The Health and Social Care Act 2012² brought about major reforms to the NHS. From April 2013, PCTs were abolished and their duties transferred to other organisations. Responsibility for developing, updating and publishing a local PNA was transferred to Health and Wellbeing Boards. In addition this Act also transferred the responsibility of using the PNA as the basis for determining market entry to a pharmaceutical list and dispensing doctor list from the PCT to NHS England.

The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013³ set out the legislative basis for developing and updating PNAs. The National Health Service (Pharmaceutical and Local Pharmaceutical Services) (Amendment

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

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

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

and Transitional Provision) Regulations 2014⁴ have been published to amend these regulations following a report published by the Joint Committee on statutory instruments. More recently, The NHS (Pharmaceutical and Local Pharmaceutical Services) (Amendment) Regulations 2016 were published.

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

4 Process for producing the Pharmaceutical Needs Assessment

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

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

Stage 1: Formation of a steering group

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

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

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

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

Stage 2: Collation of information and data

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

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

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

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

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

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

Stage 3: Analysis

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

Stage 4: Draft PNA

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

Stage 5: Consultation

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

Stage 6: Review of consultation responses

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

Stage 7: Publication

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

5 Introduction

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

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

5.1 The Southampton Locality

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

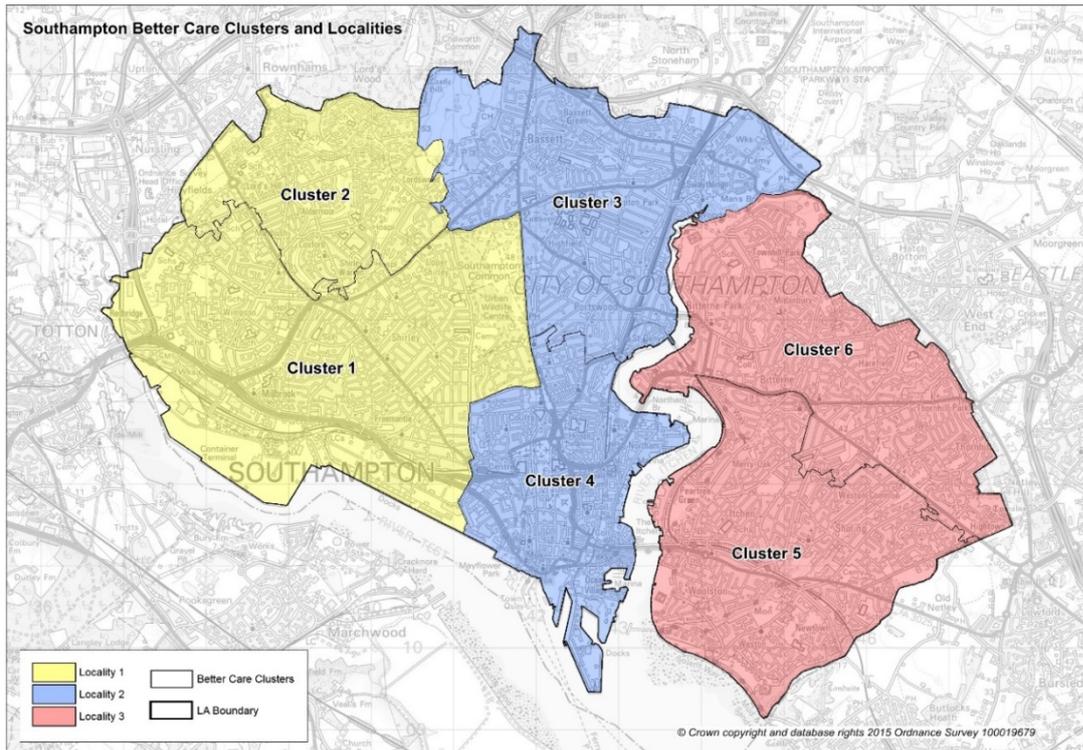


Figure 1. Southampton Better Care Clusters and localities

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

There are four hospital sites in Southampton:

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

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

NHS Southampton CCG had 30 member GP practices at August 2017⁵. The GP out of hours service is provided by UHS Pharmaceutical Service. There are 36 NHS dental practices providing NHS dental services and 15 opticians in the Southampton City Health and Wellbeing Board area⁶. A behaviour change service (“Southampton Healthy Living”) commissioned by Southampton City Council supports individuals with smoking, alcohol and weight management issues.

⁵ NHS Choices; NHS Southampton CCG; accessed via <http://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=89740>

⁶ NHS England Area Team; personal communication on 2nd October 2017

6. Current Pharmaceutical Services

NHS Act 2006⁷ sets out the definition for pharmaceutical services.

6.1 Community Pharmacy

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

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

6.2 Distance Selling Pharmacies

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

6.3 Dispensing Doctor

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

6.4 Local Pharmaceutical Services Scheme

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

6.5 Dispensing Appliance Contractor

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

⁷ <http://www.legislation.gov.uk/ukpga/2006/41/contents>

6.6 Pharmacies close to Southampton boundaries

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

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

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

6.7 Pharmaceutical Needs assessment map

The PNA requires a map that shows all current pharmaceutical service providers. Figure 2 is the designated map as required by paragraph 7 of Schedule 1 of the 2013 Regulations.

This map will be updated, during the lifetime of this PNA, when pharmacy premises open, close or relocate. This map shows the locations of the 43 community pharmacies and one dispensing appliance contractor.

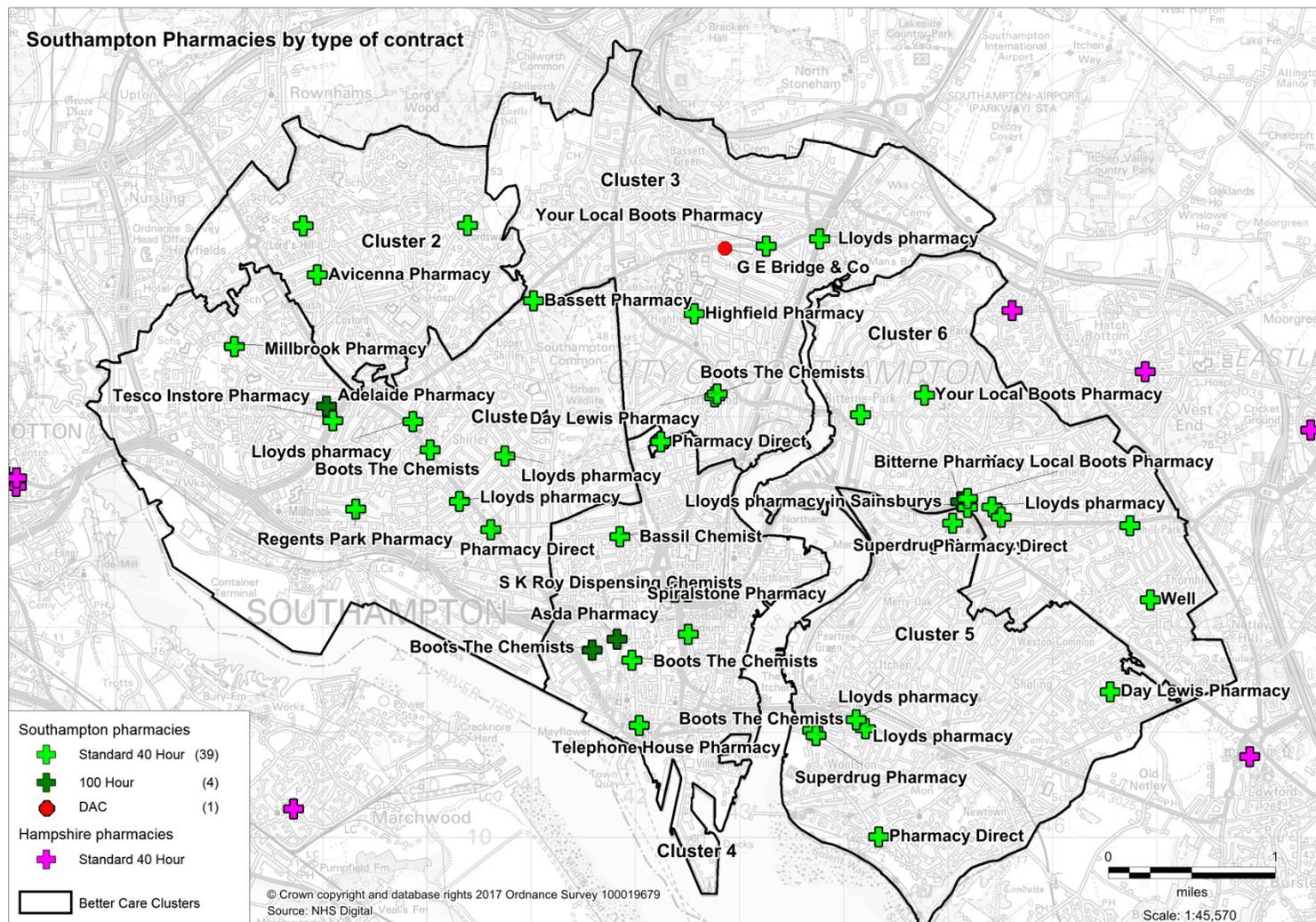


Figure 2. The map detailing the location of Pharmaceutical Service providers in Southampton; and the nearest providers outside the city (Sept 2017)

7. NHS Pharmaceutical Services

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

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

7.1 Access to Pharmaceutical Services⁸

7.1.1 Opening hours

The opening hours used in this section are based on the total opening hours (both 'core' and 'supplementary' hours) as held by NHS England for July 2017. This is based on the 43 community pharmacies in the city at 1st October 2017. The removal of one contractor from the pharmaceutical list did not change these opening hours. Details of individual pharmacy opening times can be found on the NHS Choices website⁹.

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

7.1.2 100 hour core hour of service pharmacies

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

⁸ Public Health data held following PNA questionnaire/ data collection from Portsmouth pharmacies June 2014

⁹ NHS Choices website - available at <http://www.nhs.uk/Pages/HomePage.aspx>

7.1.3 Opening hours Morning

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

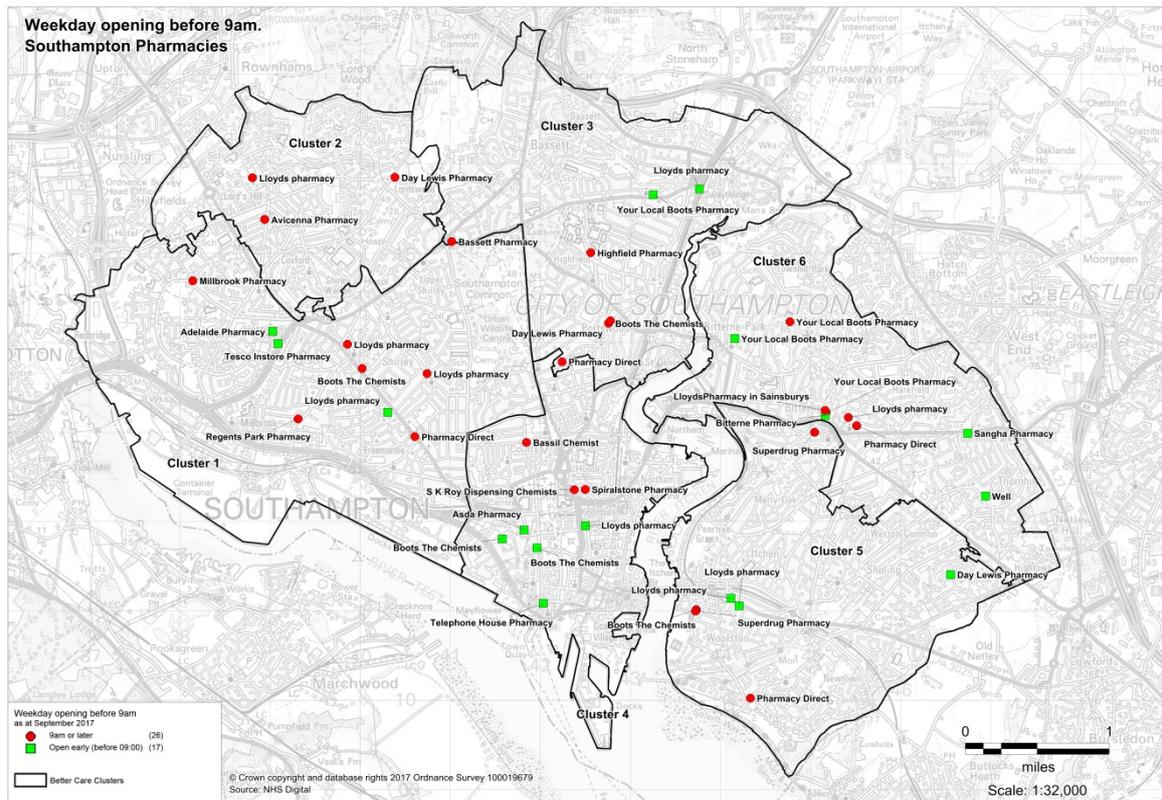


Figure 3. Map of weekday morning opening times for community pharmacies in Southampton, as at September 2017

7.1.4 Opening Hours Lunchtime

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

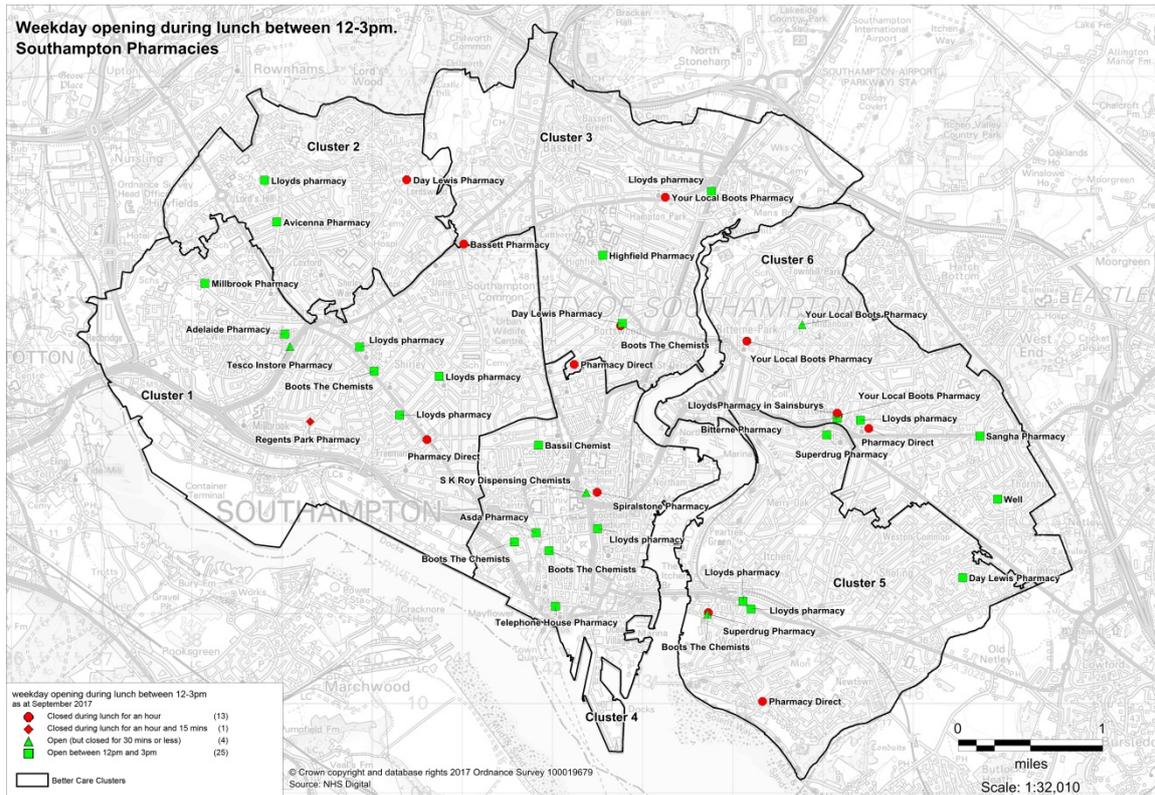


Figure 4. Map of weekday lunchtime opening times for community pharmacies in Southampton, as at September 2017

7.1.5 Opening Hours Evening

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

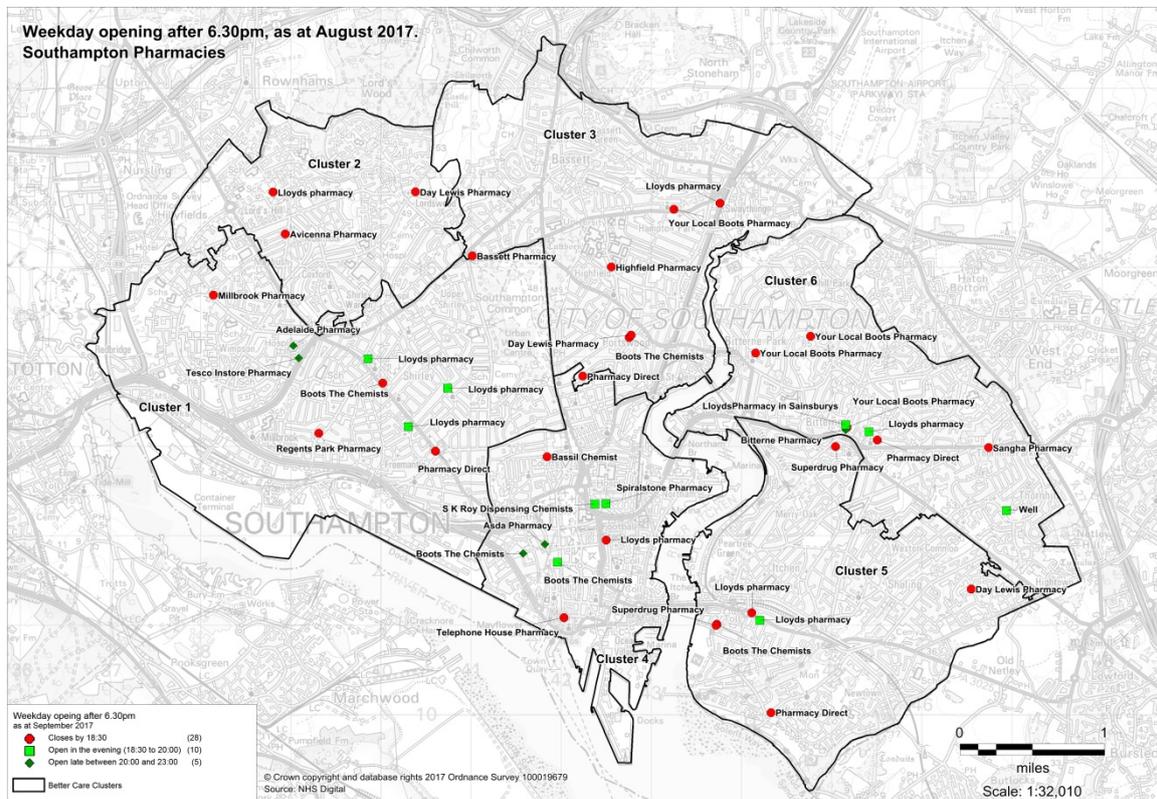


Figure 5. Map of weekday evening opening times for community pharmacies in Southampton, as at September 2017

7.1.6 Saturday opening

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

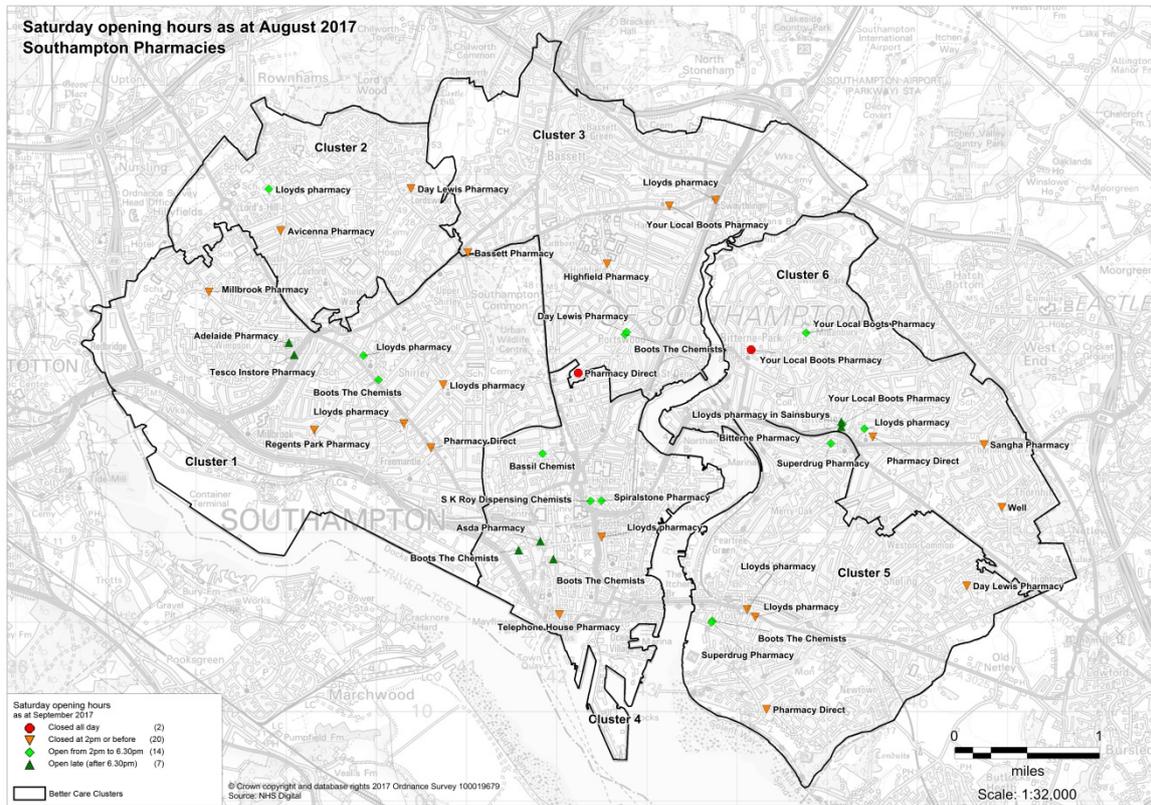


Figure 6. Map of Saturday opening times for community pharmacies in Southampton, as at September 2017

7.1.7 Sunday opening

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

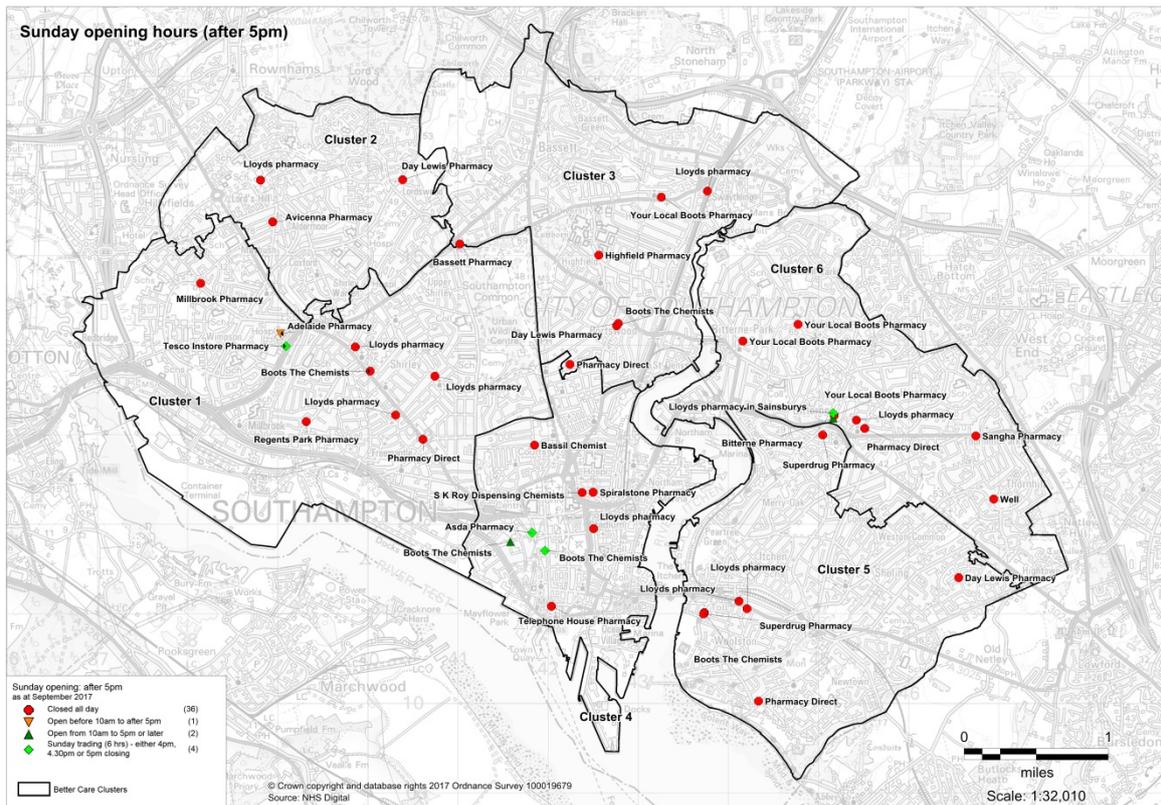


Figure 7. Map of Sunday opening times for community pharmacies in Southampton, as at September 2017

7.1.8 Bank Holiday

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

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

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

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

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

7.1.9 Access Distance

7.1.9.1 Pharmacies with buffer zone of 1.6km

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

7.1.9.2 Driving

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

7.1.9.3 Cycling

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

7.1.9.4 Public Transport (Rail in particular)

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

7.1.9.5 Walking

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

7.1.9.6 Proximity to GP Practices

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

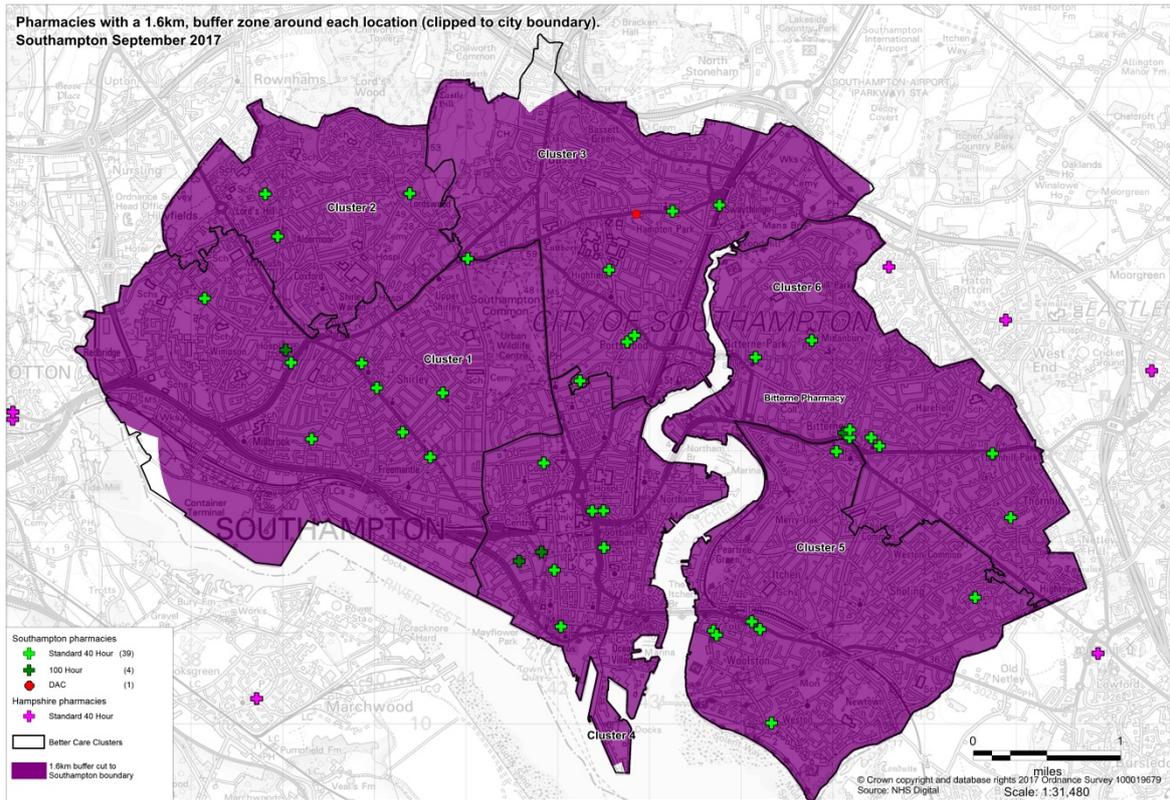


Figure 8. Map of pharmacies with a 1.6km straight line buffer zone (purple), Southampton.

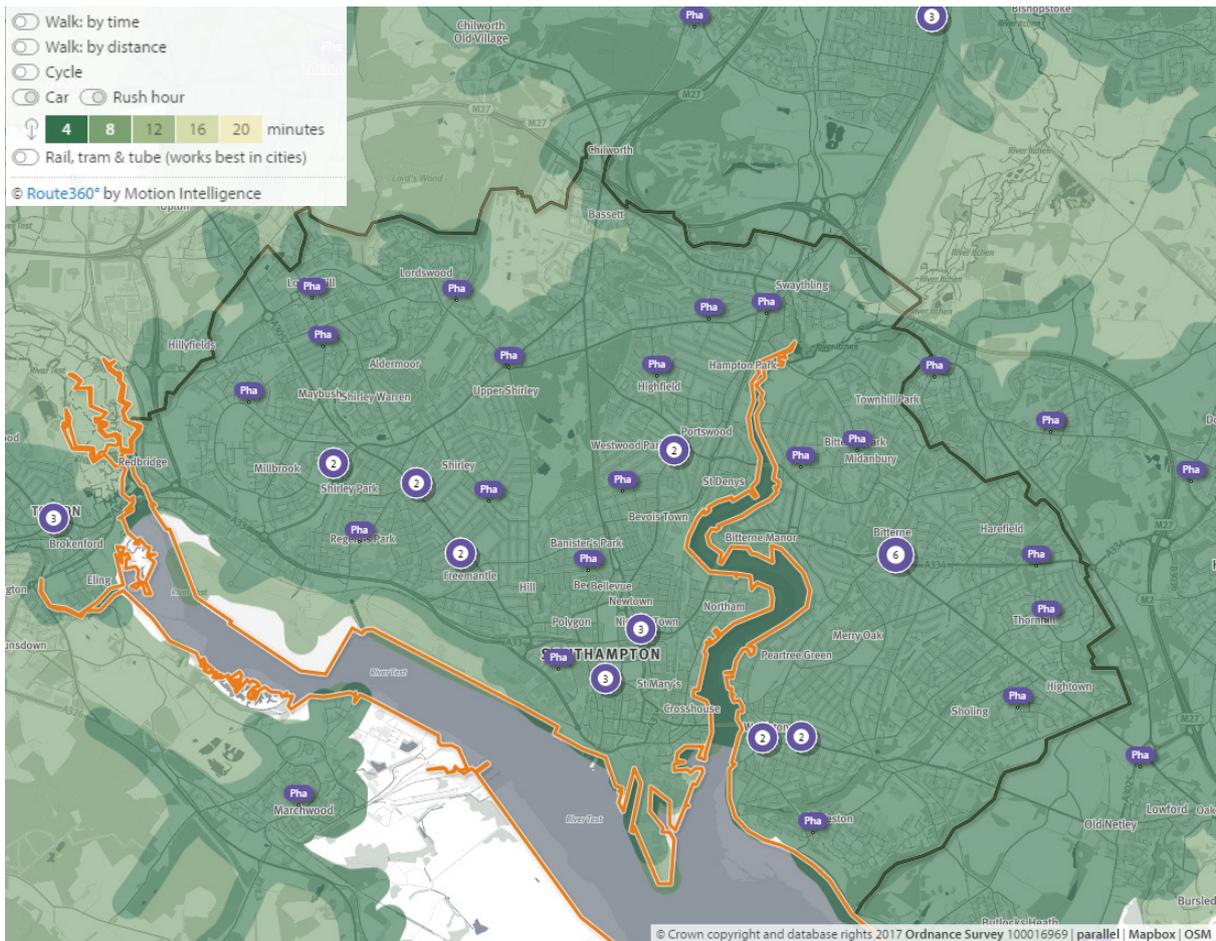


Figure 9. Map of drive times in rush hour from pharmacies (excluding distance selling) in Southampton and outside of the local authority boundary. Source: SHAPE place, Public Health England.

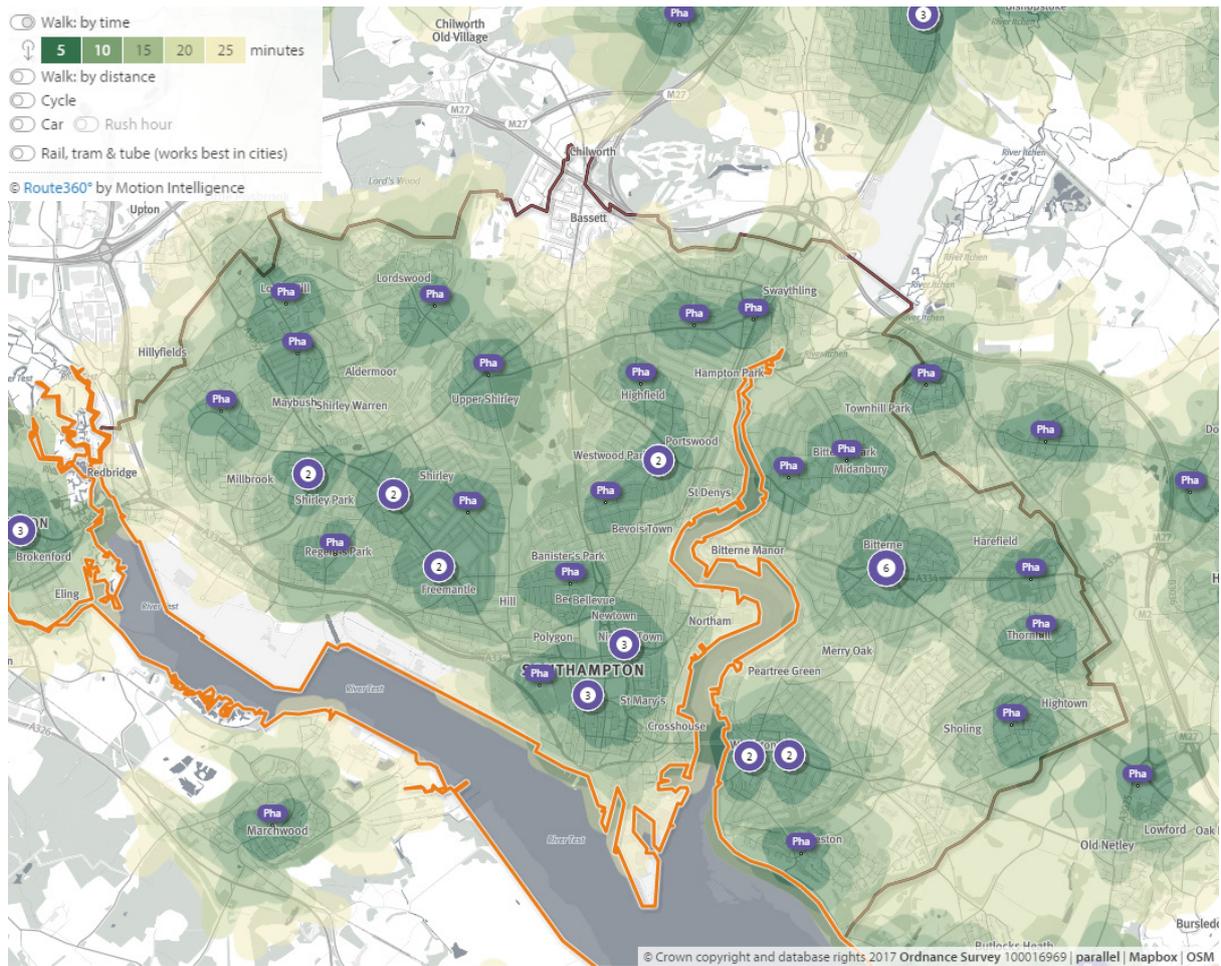


Figure 10. Map of walking times (5-25 minutes) from pharmacies in Southampton (excluding distance selling) and outside of the local authority boundary. Source: SHAPE place, Public Health England.

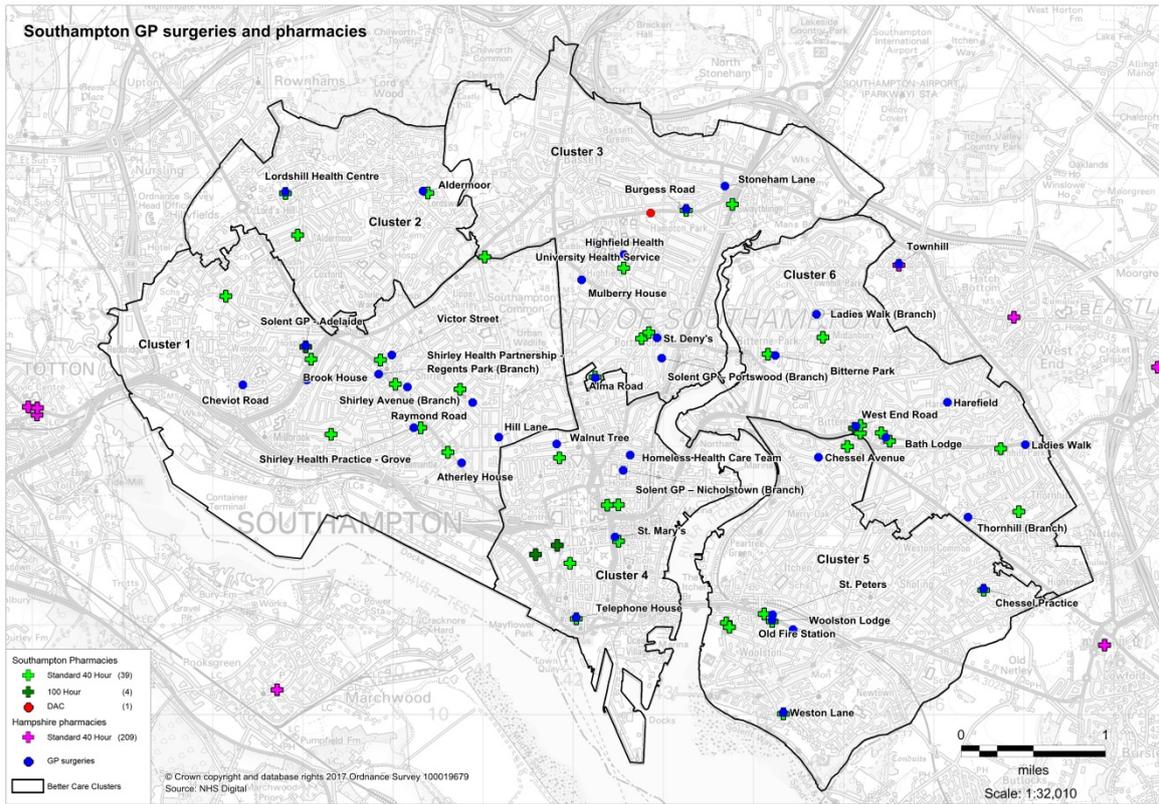


Figure 11. Map of GP surgeries proximity to pharmacies in Southampton (September 2017).

7.1.10 Access for residents with additional needs

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

Housebound

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

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

Equality Act

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

Access Languages

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

These were the languages identified from individual pharmacies:

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

7.2 Essential Services

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

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

7.2.1 Dispensing NHS prescriptions

A range of nationally¹⁰ and locally available statistics¹¹ has been researched to determine whether there is sufficient capacity within Southampton pharmacies to dispense prescriptions generated within the city.

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

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

Density of pharmacies

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

¹⁰ NHS Business services

¹¹ E pact data held by NHS Southampton CCG for April 2016-March 2017

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

Table 1. Community pharmacies on a pharmaceutical list at 31 March 2017 (prior to consolidation application which took effect from 1st September 2017), prescription items dispensed per month and population by NHS England Region 2015-16¹³

7.2.2 Repeat Prescribing and Electronic Prescription Service

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

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

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

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

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

7.3 Advanced Services

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

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

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

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

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

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

7.3.1 Medicine Use Reviews

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

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

7.3.2 New Medicine Service

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

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

7.3.3 Appliance Use Reviews

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

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

7.3.4 Stoma Customisation Services

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

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

7.3.5 Flu Vaccination Service

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

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

7.3.6 NHS Urgent Medicine Supply Advanced Service

The NHS Urgent Medicine Supply Advanced Service (NUMSAS) is running in some areas of the country as a pilot service until end September 2018. It began operating in Southampton in January 2018. It is a service that manages a referral from NHS 111 to a community pharmacy because they need urgent access to a medicine or appliance that they have been previously prescribed on an NHS prescription, enabling access to medicines or appliances out of hours.

7.4 Enhanced and other locally commissioned services

Enhanced services are listed in the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013¹⁴ and the provision in Southampton is summarised below.

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

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

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

7.4.1 Pharmacy Urgent Repeat Medicine Service

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

7.4.2 Minor ailment service

Minor ailments are defined as common or self-limiting or uncomplicated conditions which can be managed without medical intervention. The management of patients with minor self-limiting conditions, impacts significantly upon GP workload. The situation is most acute

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

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

7.4.3 Palliative Care Service

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

7.4.4 Needle and Syringe Exchange Service

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

7.4.5 Emergency Hormonal Contraception

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

7.4.6 NHS Health Checks

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

7.4.7 Supervised consumption

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

7.4.8 TCAM (Transfer of Care around Medicines)

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

Hospital pharmacists will use PharmOutcomes (a secure software system) to refer patients nearing discharge to the patients chosen local community pharmacy. A member of the community pharmacy team will then contact the patient ideally within three days to arrange for them to come in for a consultation. This visit may then result in the completion of a Medicines Use Review, New Medicine Service and/or other suitable services; such as repeat dispensing, home delivery, stop smoking, flu vaccination. Evidence has shown real benefits to patients receiving such interventions through reduced readmission rates back into hospital and improved health outcomes¹⁵.

7.5 Healthy Living Pharmacies

The Healthy Living Pharmacy (HLP) framework is a tiered commissioning framework aimed at achieving consistent delivery of a broad range of high quality services through community pharmacies to meet local need, improving the health and wellbeing of the local population and helping to reduce health inequalities¹⁶.

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

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

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

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

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

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

8. Public engagement

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

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

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

Table 4. Age profile of respondents to the public survey

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

Other respondent information included:

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

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

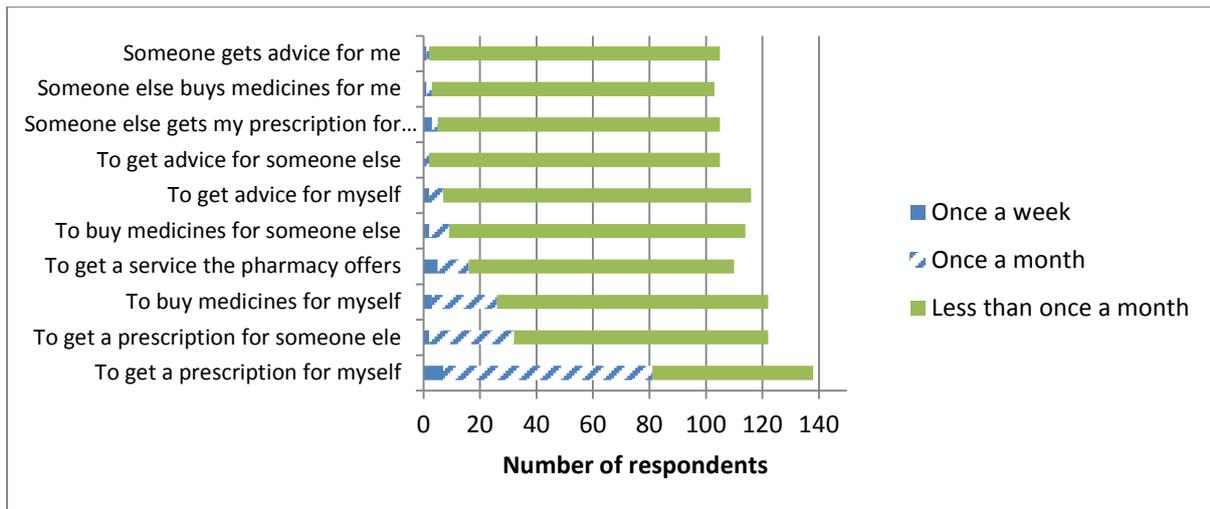


Figure 12. Reason and frequency given by survey respondents for using a community pharmacy

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

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

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

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

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

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

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

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

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

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

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

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

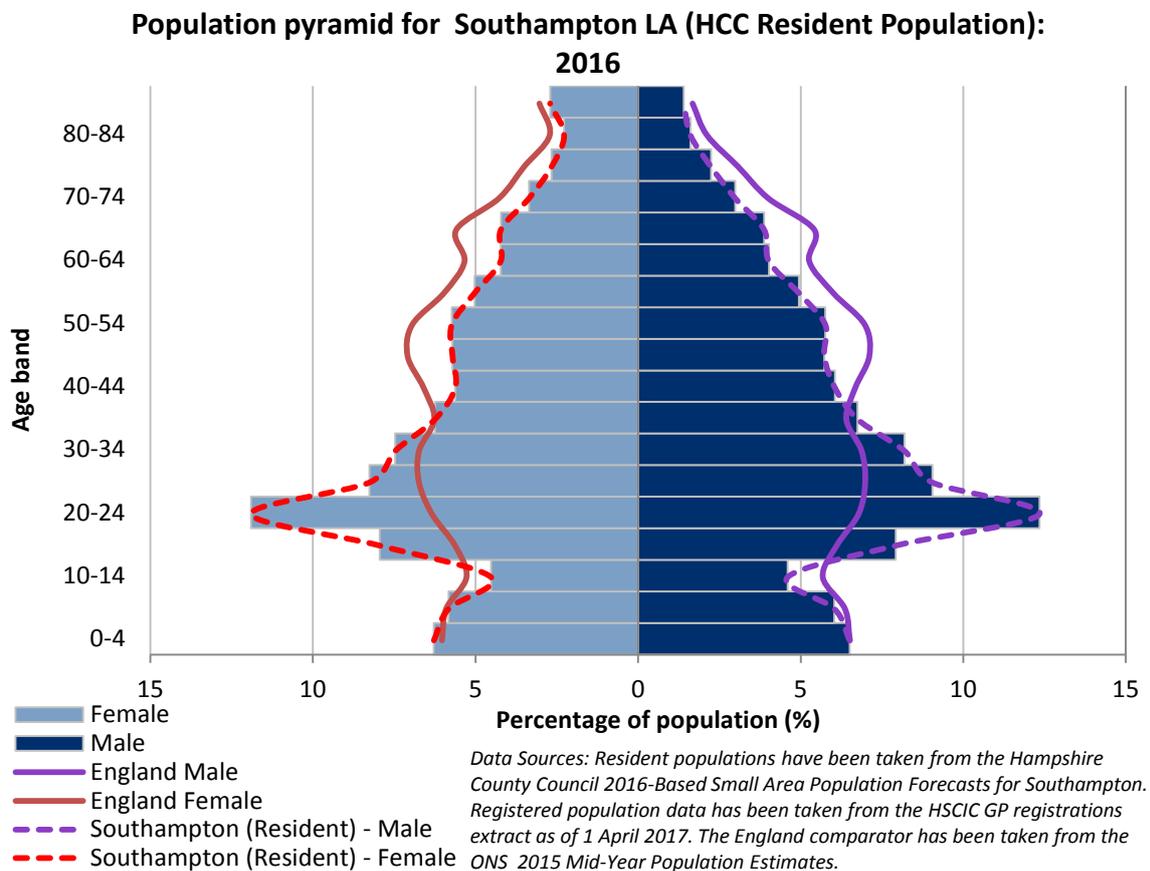
Table 7. Information on healthy living being offered by community pharmacies and Healthy Living Pharmacy status as reported by survey respondents

9. Population and demography

9.1 Population

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

Figure 13.



¹⁷ Southampton JSNA. August 2017

9.2 Population forecasts

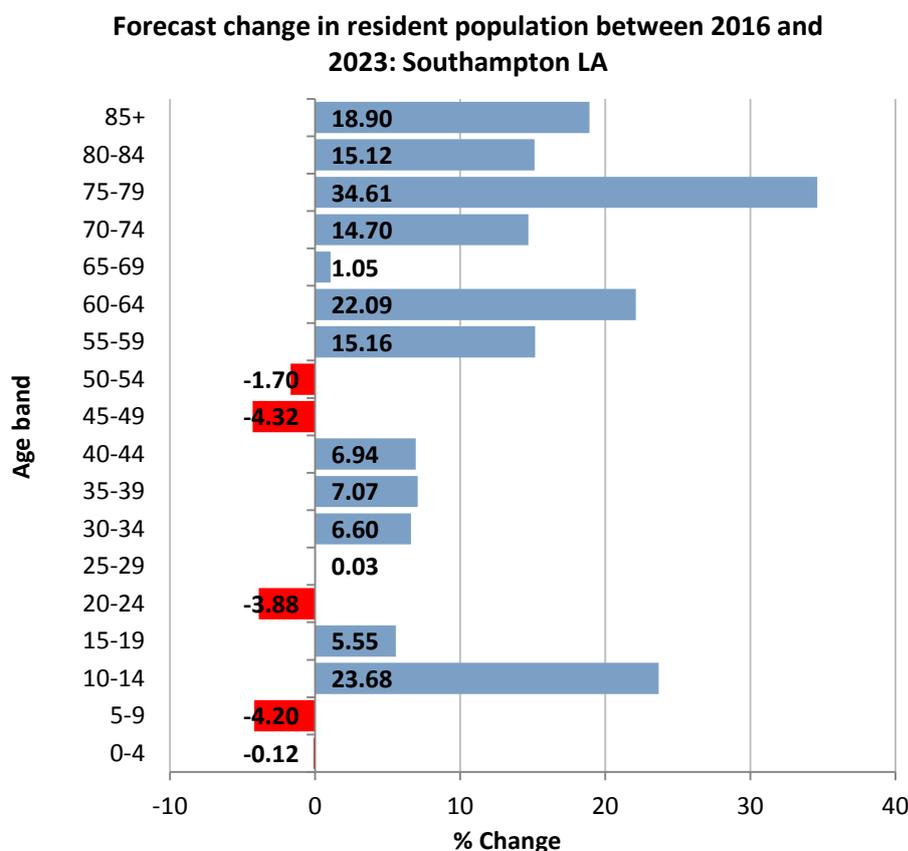
There are many uncertainties around current and future population numbers. The Southampton JSNA currently uses data produced by Hampshire county council (HCC) which incorporates the results of the 2011 Census. Hampshire County Council's small area population forecasts (SAPF) are based on the planned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

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

The older population is projected to grow proportionally more than any other group in Southampton over the next few years (Figure 14.). The over 65 population is set to increase by nearly 5% between 2016 and 2023, with the over 85 population set to increase by nearly 19%. Importantly the proportion of the population of working age is set to increase by only 5% potentially influencing productivity and the skill pool of the resident workforce. It may also have an impact on the informal and community care available to the changing population structure. The chart below shows how the age of population is expected to change up to 2023.¹⁸

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

Figure 14.



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

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

Longer term projections, based on past trends, predict a 38% increase in over 65s in Southampton between 2010 and 2035 with the number of residents in the city aged over 85 reaching 8,500 by 2035.²⁰

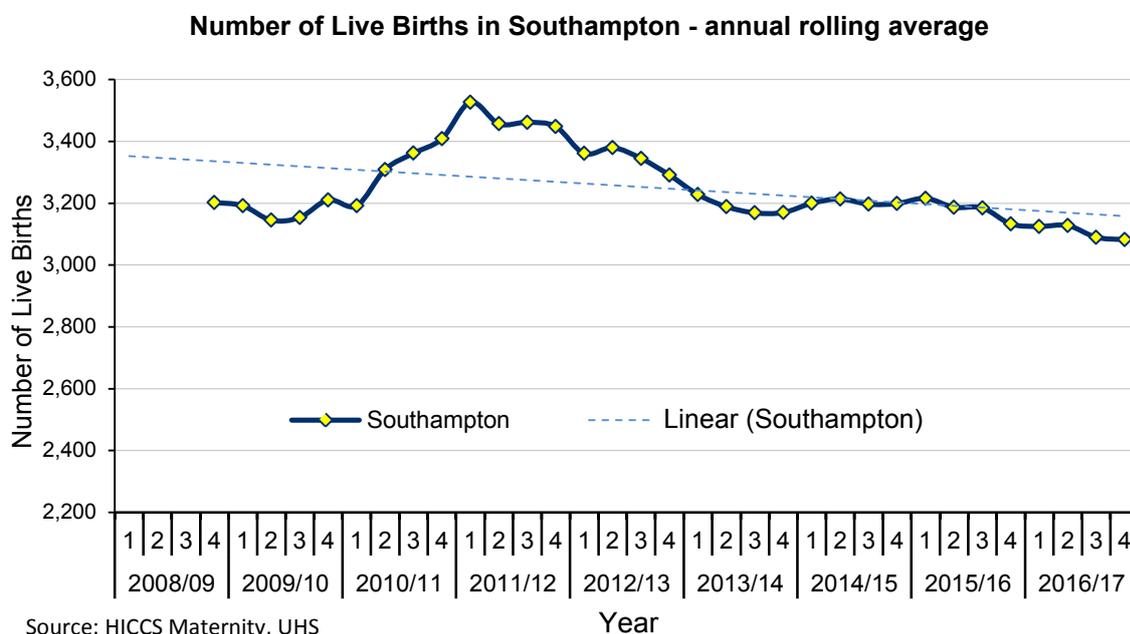
According to the HCC forecasts, the number of 0-4 year olds will decrease by 0.1% between 2016 and 2023. Local monitoring of births at Southampton University Trust (SUHT) reveals that births have fallen by -3.7% between 2008/09 and 2016/17, although recent data

¹⁹ Hampshire County Environment Department's 2016-based Southampton Small Area Population Forecasts

²⁰ Office for National Statistics (ONS) subnational population projections. Published 23 May 2016

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

Figure 15



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

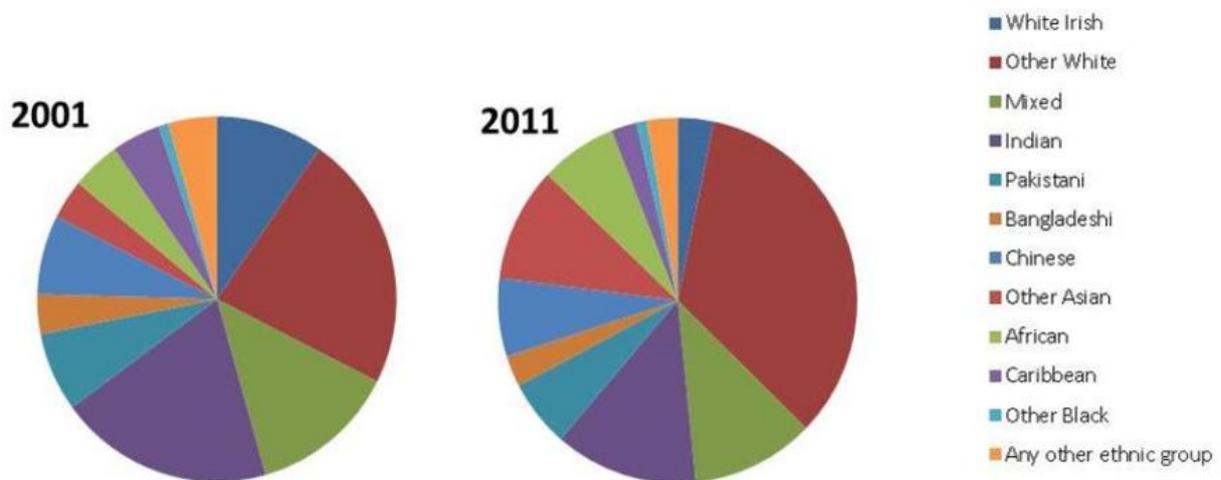
In 2015, the general fertility rate for Southampton by electoral ward ranged from 92.9 births per 1000 females aged 15 to 44 years in Redbridge to 32.9 births per 1000 females aged 15 to 44 years in Swaythling.

9.3 Ethnicity, migration, language and religion

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

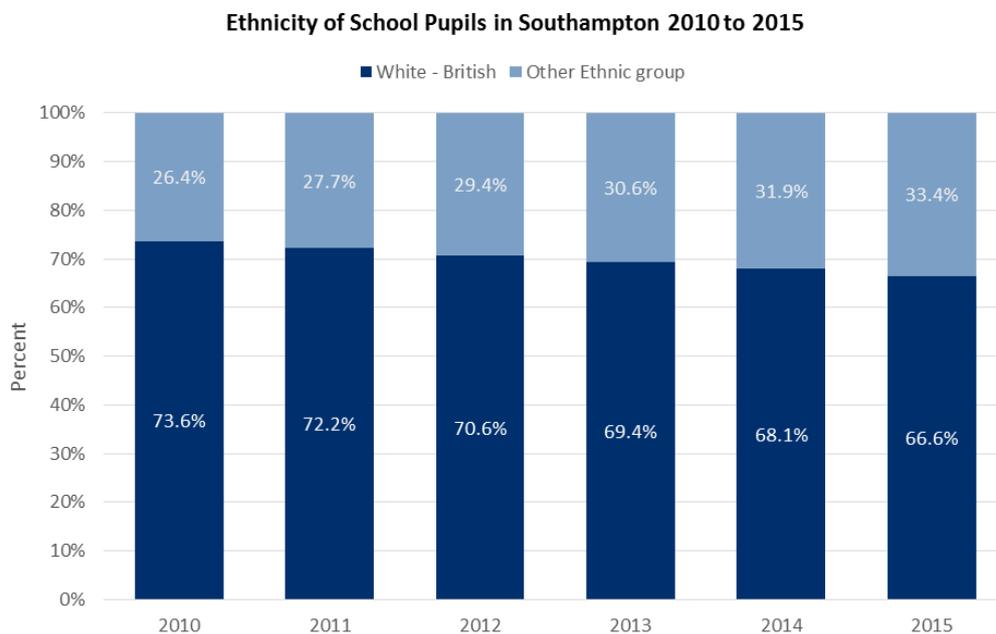
Based on results from the 2011 Census, Southampton now has residents from over 55 different countries who between them speak 153 different languages. In the 2011 Census 77.7% of residents recorded their ethnicity as white-British, which is a decrease of 11% from 2001. The pie charts in Figure 16 show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

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



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

Figure 17.



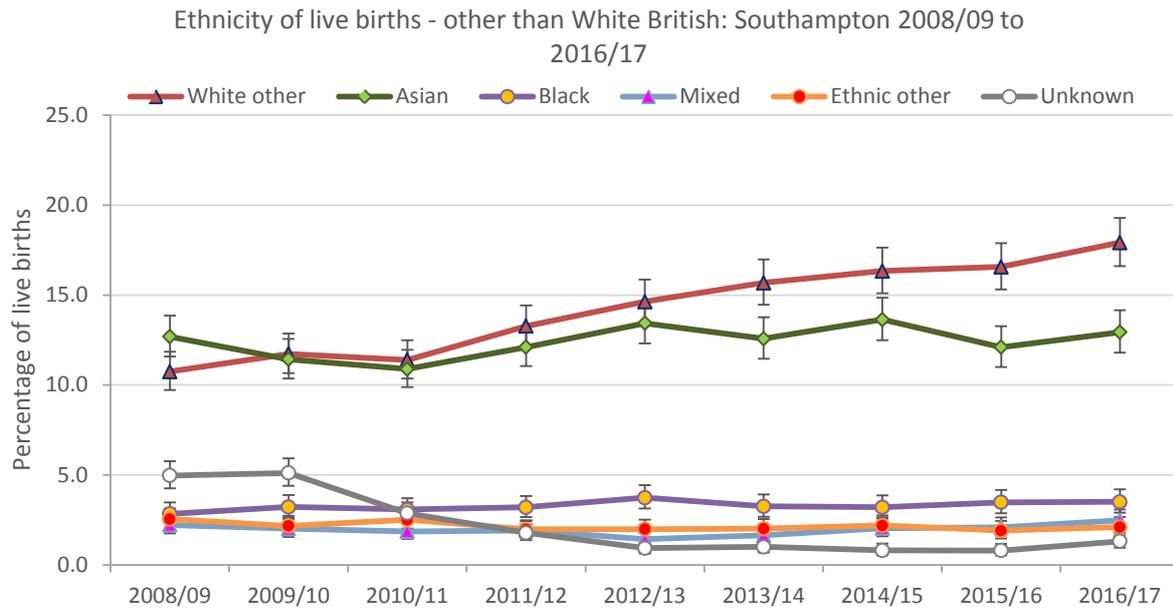
Source: Annual School Census, Southampton City Council
 Notes: Does not include Oasis Academies for 2010 & 2011

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

first language other than English; a rise from 8.4% in 2007. In 2007 there were 427 pupils whose first language was Polish but by 2012 this had risen to 1,282²¹.

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

Figure 18



Source: UHS Midwifery database, Southampton CCG

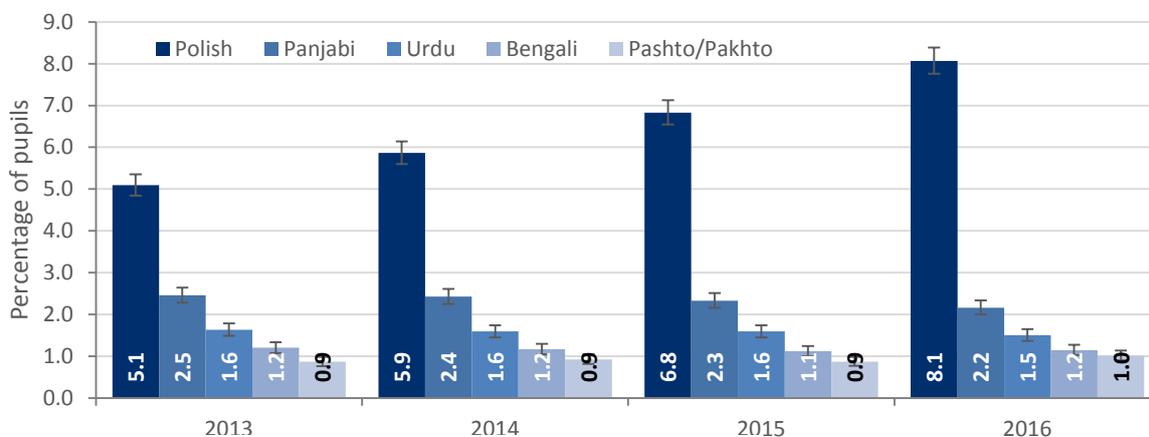
Just under 71% of Southampton residents hold a UK passport, 17.4% hold no passport and 6.5% hold an EU passport. Of the 41,651 people not born in the UK, over 58% have lived here for more than 5 years. Just over 31% of those people born outside the UK are aged 25 to 34 (2011 Census).

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

²¹ Southampton JSNA. September 2014

Figure 19

Five most spoken languages in Southampton schools, excluding English:
2013 to 2016



Sources: Southampton City Council Children's Data Team

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

Table 8. Self reported religion of Southampton residents

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

9.4 Socio-economic factors and measures of deprivation

9.4.1 Southampton's local economy

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

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

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

²² ONS Migration ending June 2015

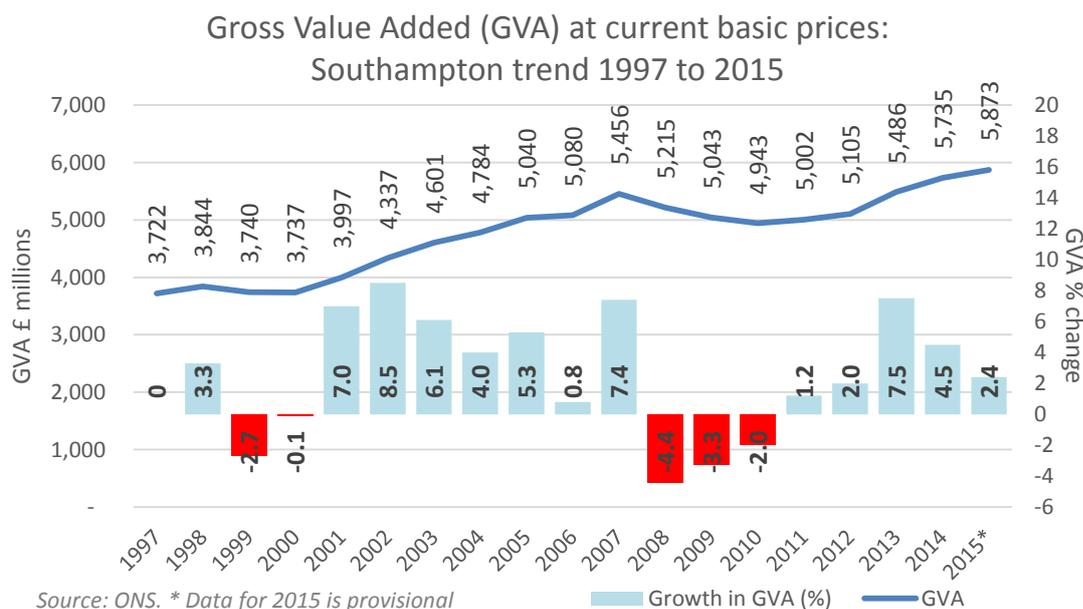
²³ Southampton City Council (2015) Children's Data Team

²⁴ ONS 2011 Census

²⁵ Associated British Ports Website (2017) http://www.abports.co.uk/Our_Locations/Southampton/

²⁶ ONS (2016) Regional Gross Value Added (Income Approach) 1997 to 2015: December 2016

Figure 20



9.4.2 Major regeneration projects

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

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

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

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

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

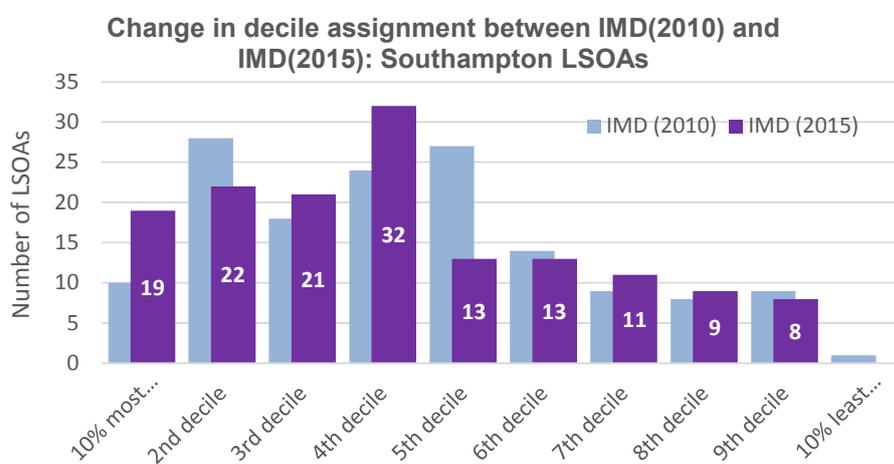
- Lidl Regional Distribution Centre with an investment of around £50M
- 1,620 new residential units at Centenary Quay and 350 at Meridian Waterside.
- 525 student residential units in Portswood (former B&Q site) and 350 at City Gateway.
- Higher educational facilities at the Southampton Marine and Maritime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

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

9.4.3 Overall Deprivation

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

Figure 21

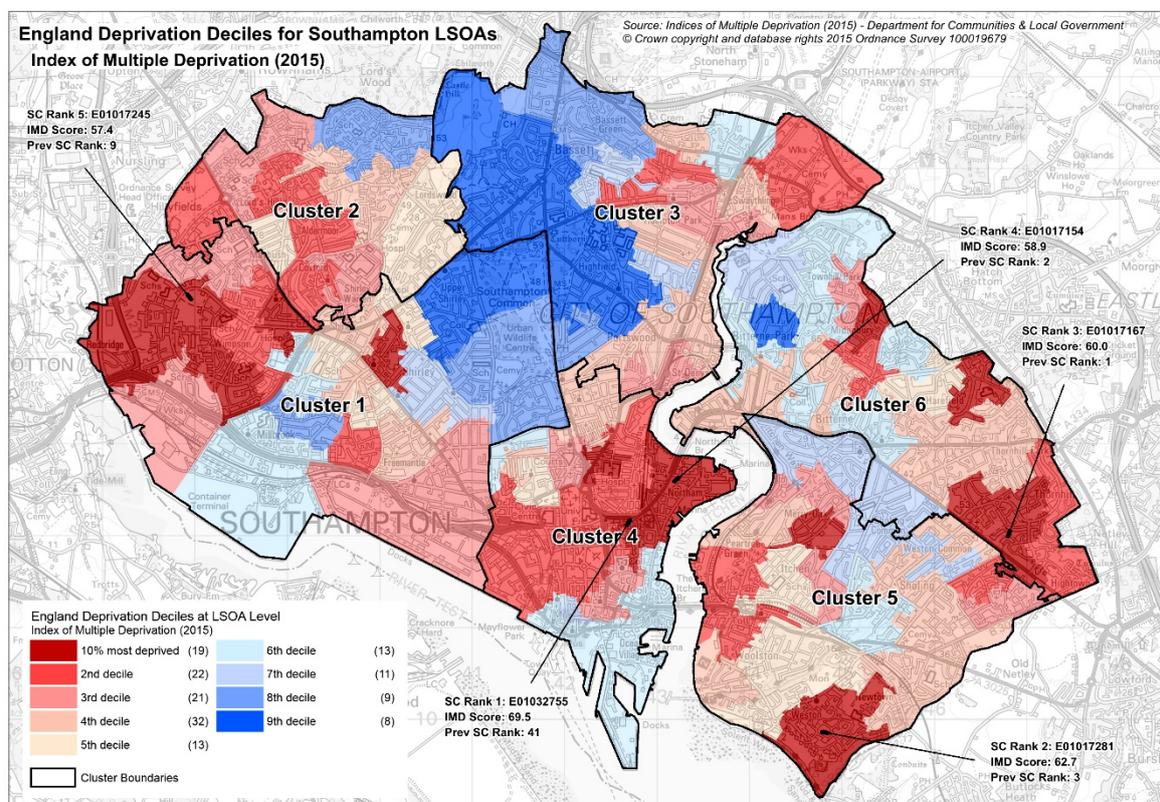


Source: DCLG. Note: IMD (2010) data is based on PHE rebased figures for 2011 LSOAs

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

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

Figure 22.



9.4.4 Income Deprivation

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

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

9.4.5 Children affected by deprivation

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

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

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

9.4.6 Older people affected by deprivation

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

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

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

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

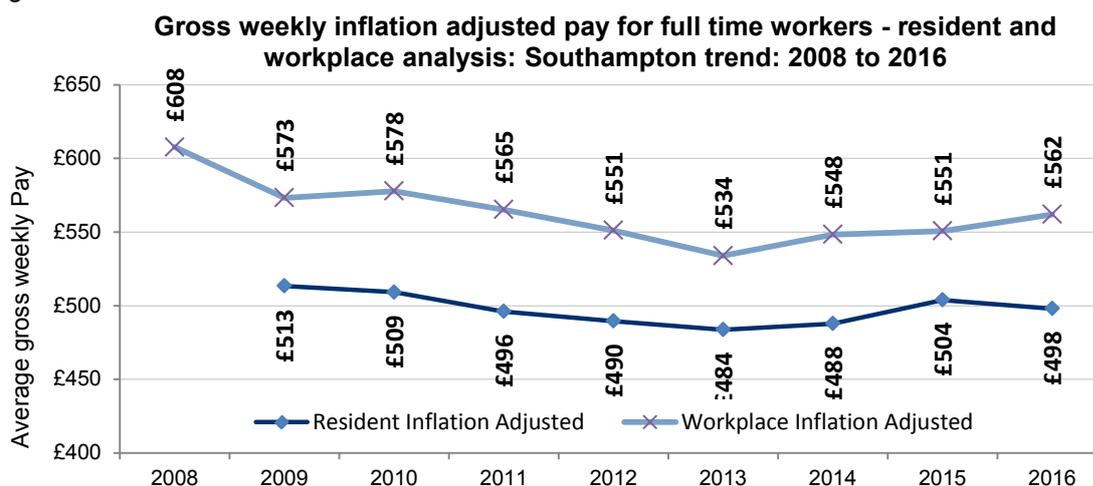
of 16.2%, and broken down into electoral ward level ranges from 11.1% in Bassett ward to 38.0% in Bevois ward.²⁹

9.4.7 Unemployment, employment, education and training

Unemployment among adults of working age in Southampton has fallen over the last few years in line with national trends, with the number of people claiming Job Seeker's Allowance and Universal Credit in Southampton remaining fairly stable over the last 12 months at around 1.6% (June 2017),³⁰ whilst those claiming out of work benefits have fallen from 9% in November 2014 to 8.2% in November 2016.³¹

As illustrated in Figure 23, after adjusting for inflation, weekly pay for Southampton residents and workers has increased in 'real' terms since 2013 following a period of steady decline from 2008.³² This is due to a combination of growth in average earnings and the continued relatively low level of inflation. However, adjusted for inflation, earnings are not yet back to their peak in 2008, and weekly earnings for residents fell slightly in 2016 by -1.2% in 'real' terms (workplace earnings increased by 2.1%).

Figure 23



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

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

²⁹ Income deprivation Affecting Older People Index 2015 via Local Health Profiles, Public Health England www.localhealth.org.uk

³⁰ Nomis (experimental) - counts the number of people claiming JSA and Universal Credit who are out of work

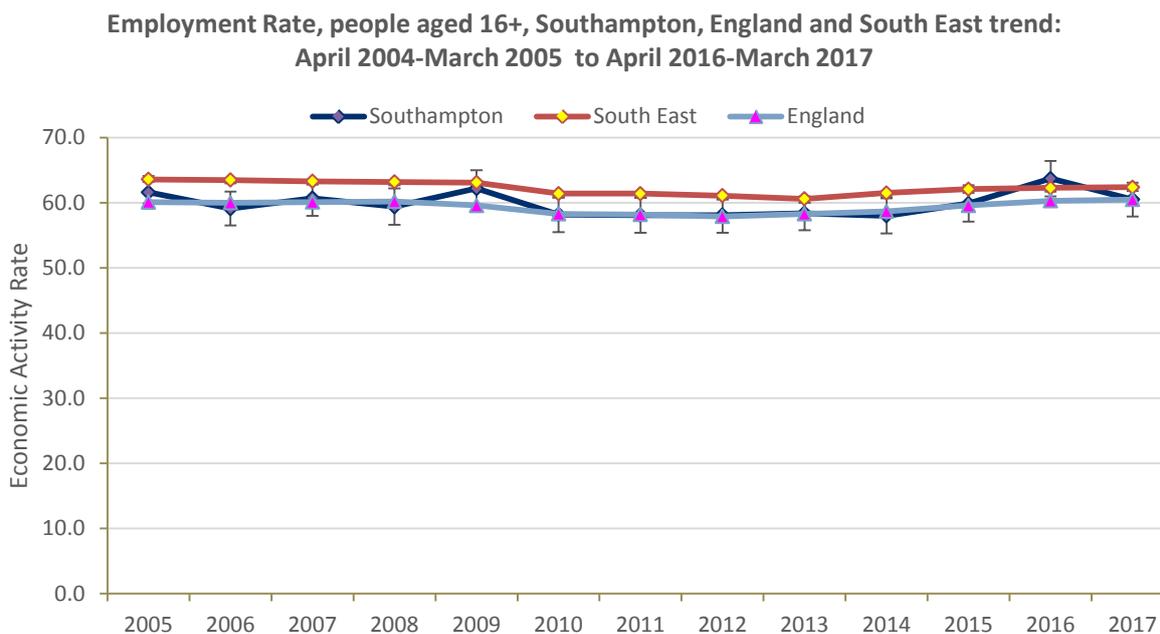
³¹ Benefit Claimants Working Age Group ONS 2016

³² ONS(2016) Annual Survey of Hours and Earnings (ASHE) adjusted using the Consumer Prices Index of Inflation

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

The chart below (Figure 24) shows that in the financial years from April 2004 to March 2017 (except 2015/16 when Southampton's employment rate was significantly higher), the employment rate in Southampton fluctuates but remains statistically similar to the England average³³.

Figure 24



Source: Annual Population Survey, Office for National Statistics

In July 2017, there were people claiming 3,110 jobseekers allowance in the city. This translates to 1.8% unemployed people in Southampton³⁴. This is slightly lower but not significantly than the national percentage (1.9%).

Education and training for young people improve employment opportunities. In 2015/16, 53.0% of Southampton pupils achieve 5 or more GCSE grades A*-C (including English and Mathematics), this was significantly lower than the national percentage (57.8%).

In 2015, the percentage of Southampton's young people aged 16-18 years not in education, employment or training (NEET) was 4.7%, and this was higher but not significantly than the rate for England (4.2%). The rates for Southampton and England has decreased annually since 2011.

³³ Annual Population Survey, Office for National Statistics

³⁴ Nomis –Job Seekers Allowance claimants and notified job vacancies as at July 2017 Southampton.

9.5 Housing

9.5.1 Household composition

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

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

Table 9. Marital status for Southampton residents, 2011

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

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

9.5.2 Housing stock

In 2016, there are an estimated 104,660 homes in Southampton³⁵, the details of which are shown in Table 10.

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

Table 10. Profile of housing stock in Southampton, 2016

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

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

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

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

9.6 Crime and Disorder

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

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

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

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

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

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

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

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

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

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

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

9.7 General health needs of Southampton

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

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

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

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

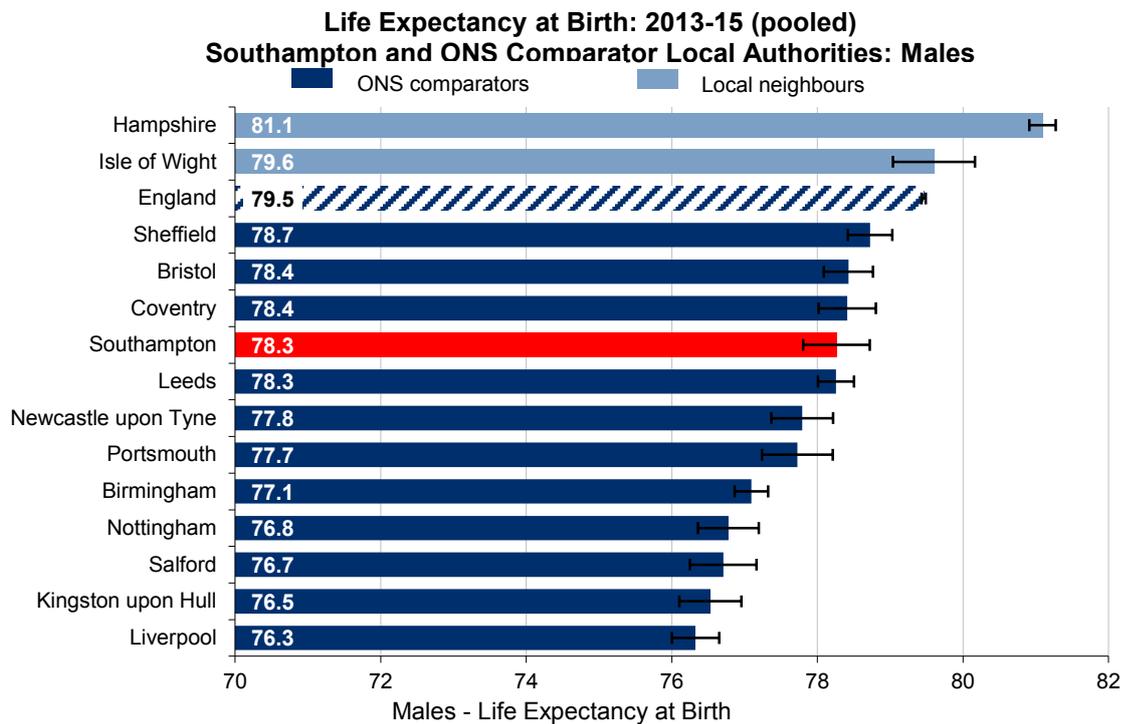
³⁷ February 2010 <http://www.marmotreview.org/>

9.8 Life Expectancy and Mortality

9.8.1 Life expectancy

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

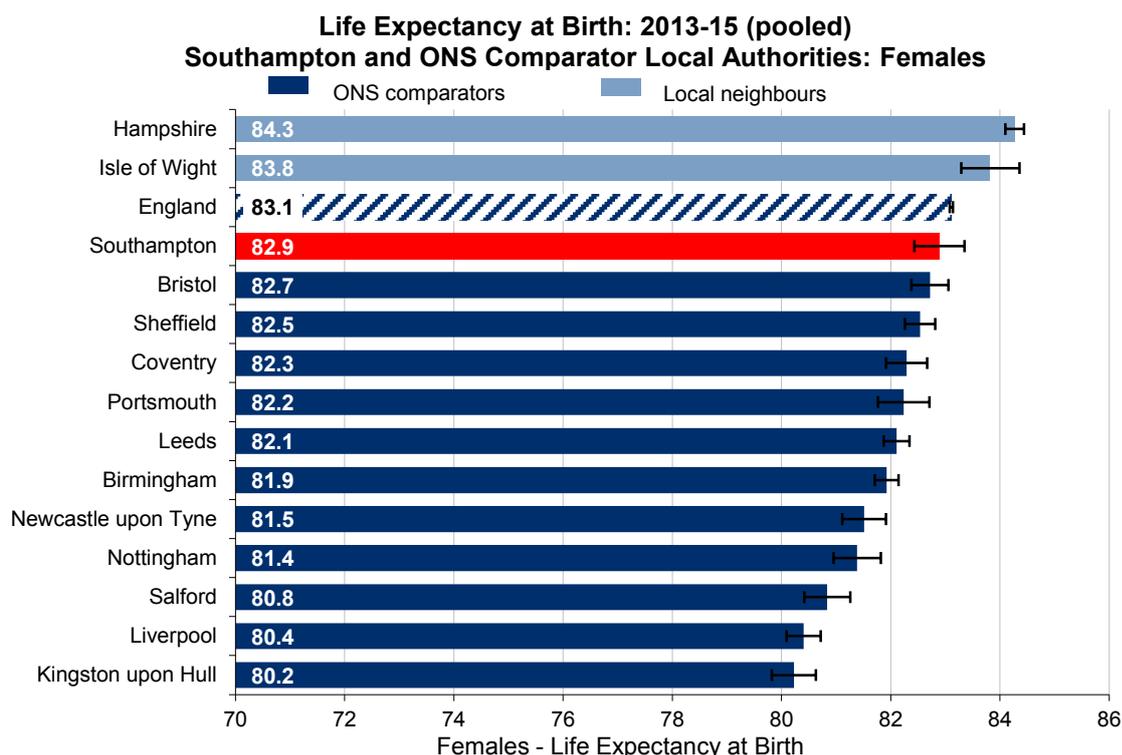
Figure 25



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

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

Figure 26



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

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

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

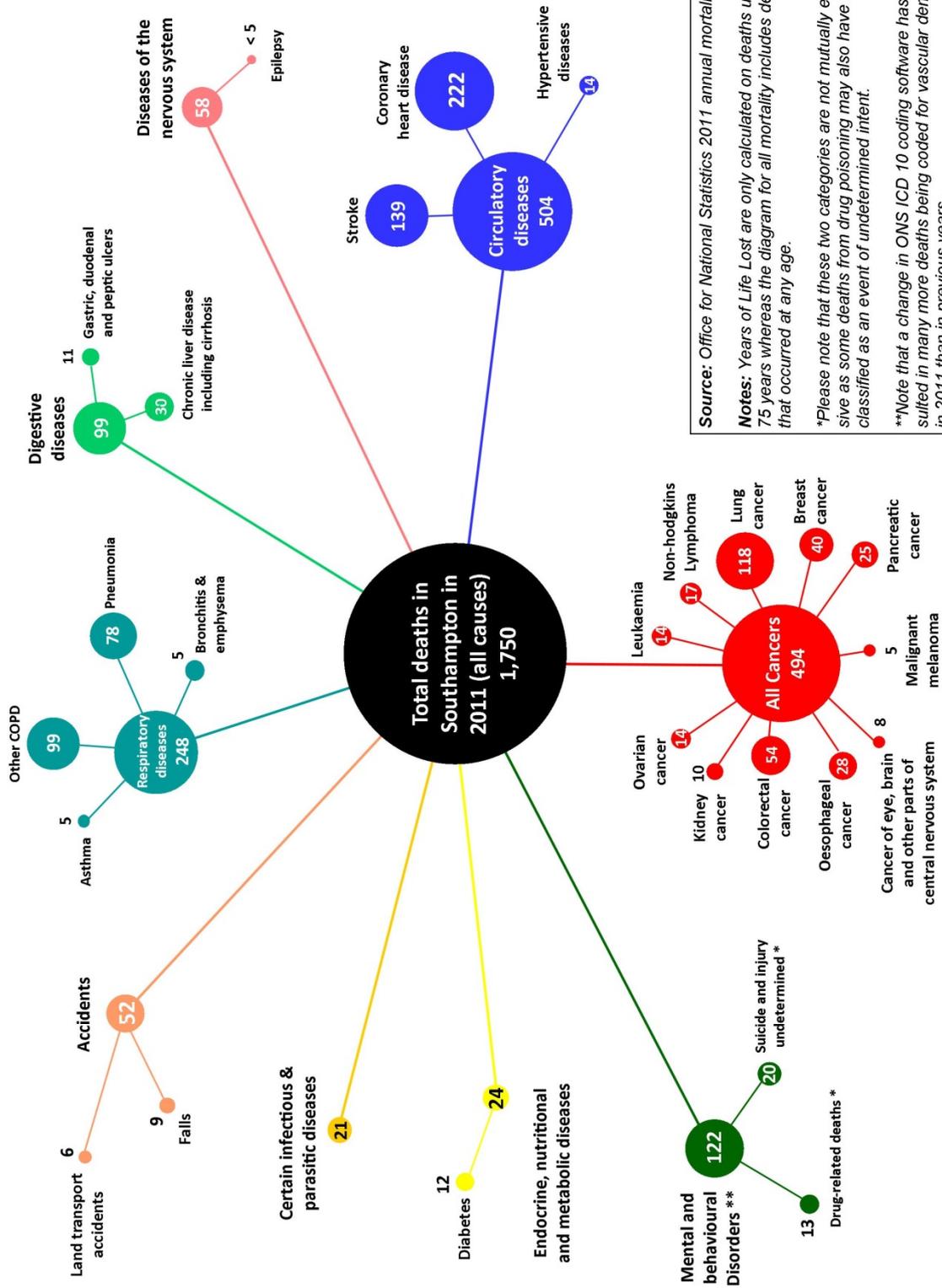
Disability free life expectancy highlights inequality in the average number of years a person could expect to live free of an illness or health problem that limits their daily activities. The number of years of disability-free life expectancy at birth for both males and females are lower, but not significantly in Southampton (61.4 years and 62.9 years respectively) compared to England (63.2 years and 63.3 years respectively).

Many long term health conditions increase markedly with age; consequently the effect of the aging population on the prevalence of these diseases in Southampton is significant.

9.8.2 Mortality

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

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



Source: Office for National Statistics 2011 annual mortality file

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

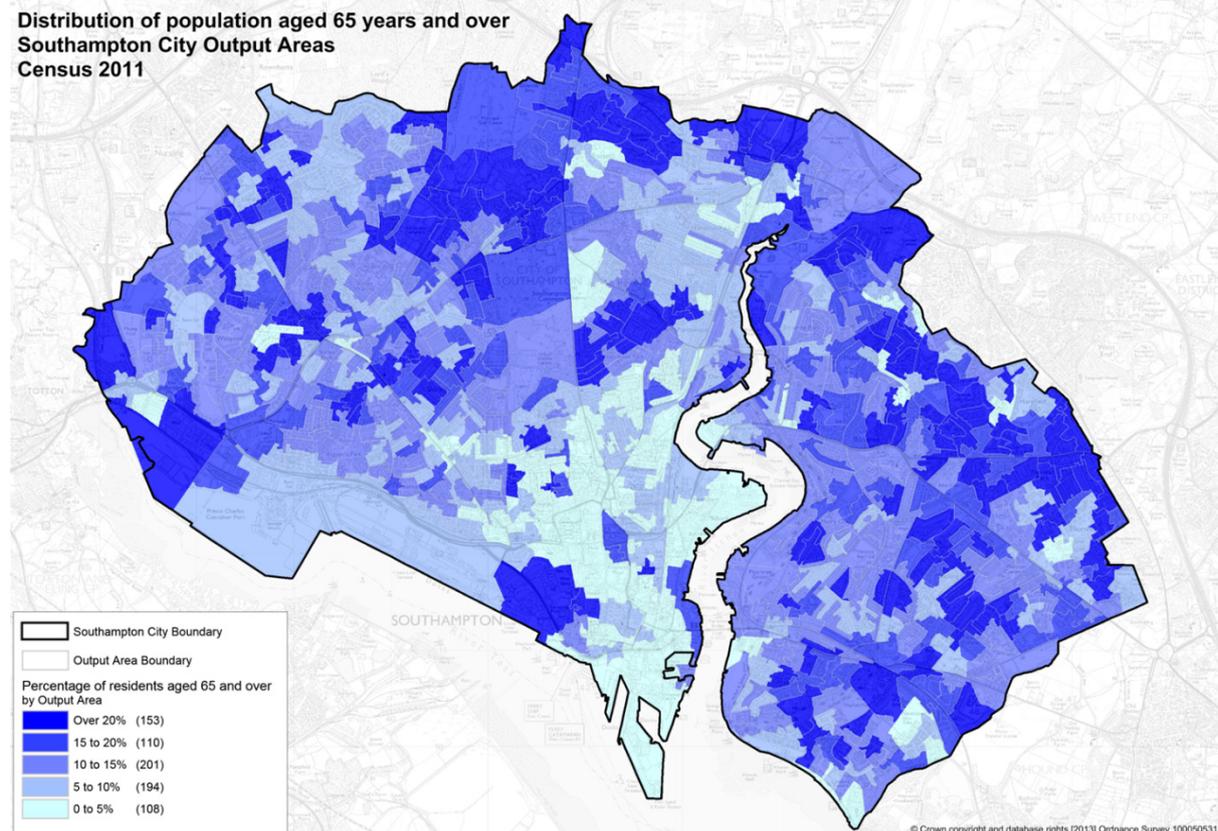
*Please note that these two categories are not mutually exclusive as some deaths from drug poisoning may also have been classified as an event of undetermined intent.

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

9.8.3 Ageing population and chronic conditions

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

Figure 27



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

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

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

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

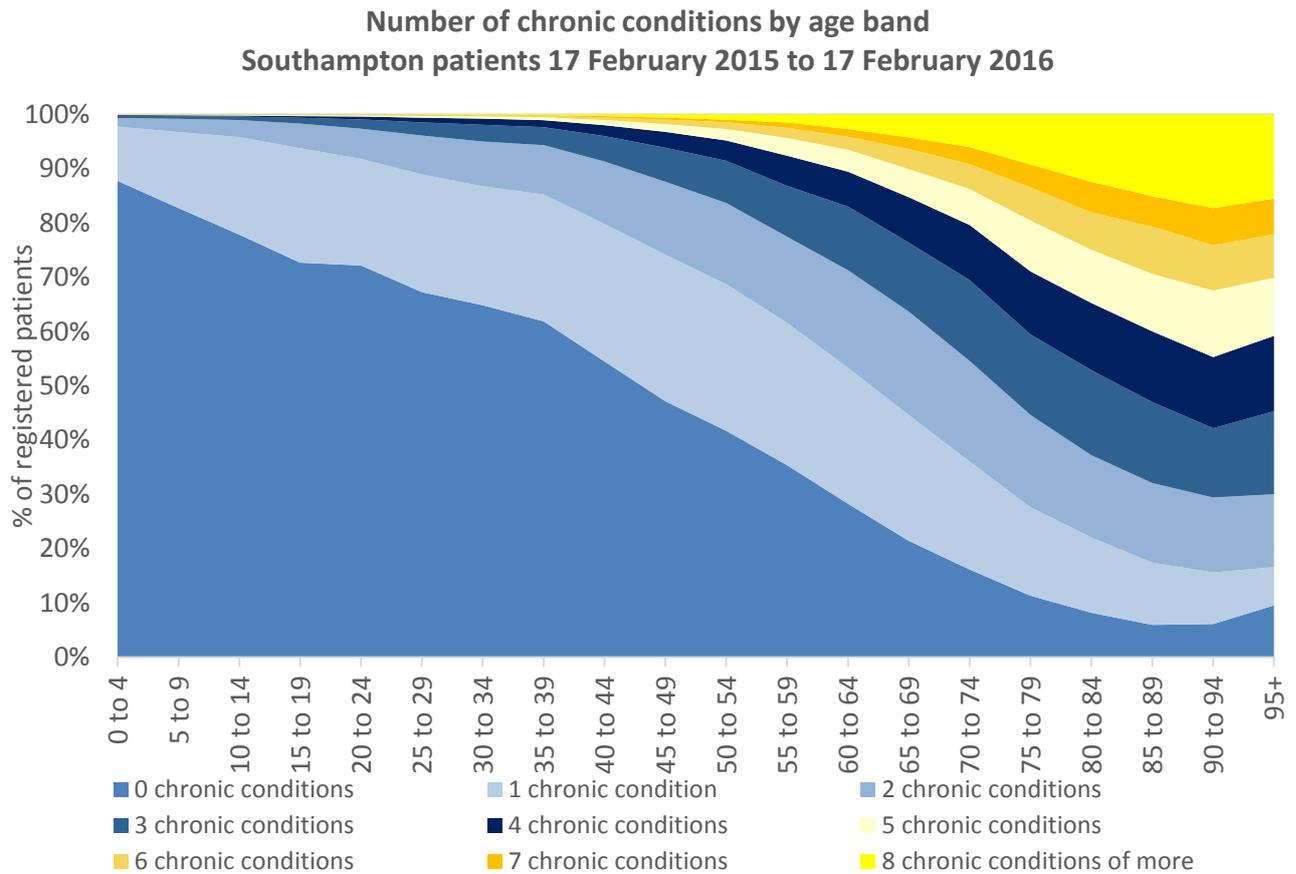
- rate of deaths from Cancer among people aged 65 years and over;
- rate of deaths from Respiratory disease among people aged 65 years and over;
- population vaccination coverage - Flu (aged 65+);
- preventable sight loss - age related macular degeneration (AMD);
- and hip fractures in people aged 65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

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

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

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

Figure 29



Source: Adjusted Clinical Groups (ACG) March 2016

9.8.4 Long Term Conditions and Ill Health

9.8.4.1 Cancer

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9.8.4.2 Coronary heart disease (CHD)

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

⁴⁰ NHS Choices: Bowel Screening <http://www.nhs.uk/Conditions/bowel-cancer-screening/Pages/Introduction.aspx>

⁴¹ NHS Choices: Cervical Screening <http://www.nhs.uk/conditions/Cancer-of-the-cervix/Pages/Introduction.aspx>

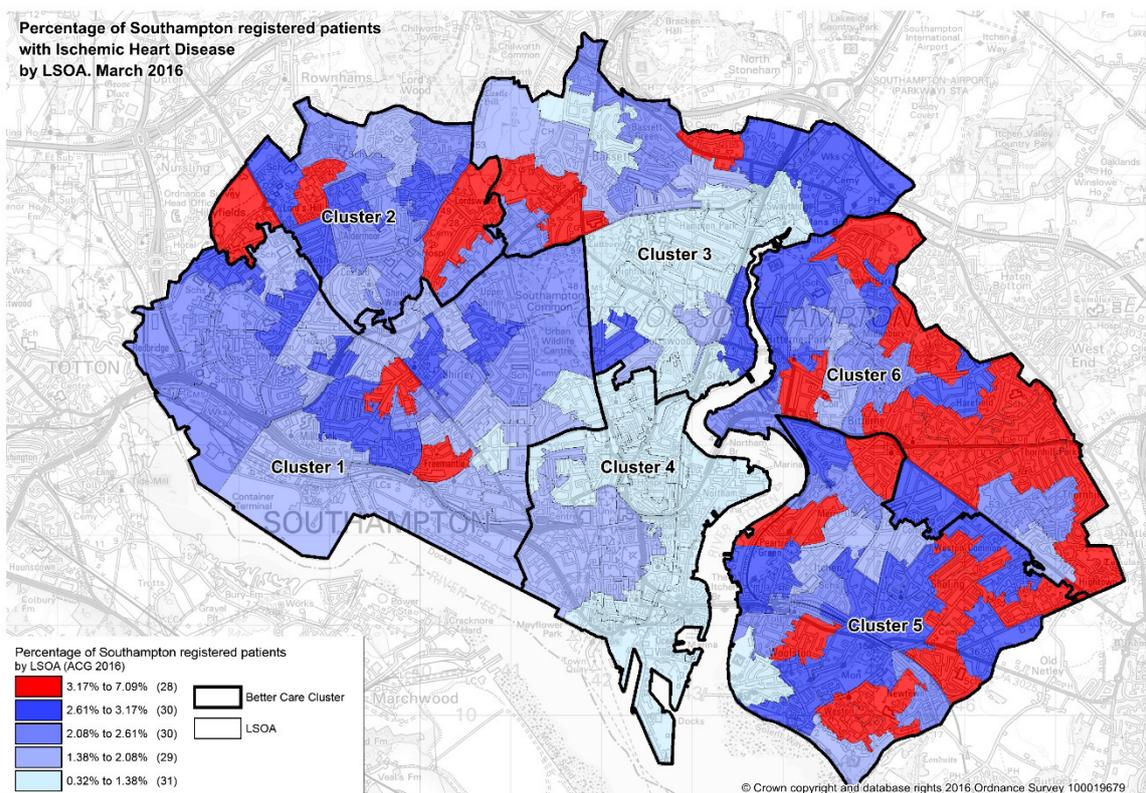
More recent modelled estimates focus on the age group 55 to 79 year old. In 2015 the estimated prevalence for this age group in Southampton was 8.1% equating to 3,740 55 to 79 year old with CHD.⁴²

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

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

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

Figure 30



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

9.8.4.3 Stroke

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

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

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

9.8.4.4 Hypertension

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

In March 2016 there were 29,613 people on hypertension registers in Southampton, giving a raw prevalence of 10.7%. However, the most current modelled estimate⁴⁴ of hypertension predicts an estimated prevalence across the city of diagnosed hypertension of 16.2% (around 33,580 adults aged 16+) and undiagnosed hypertension of 10.7% (around 22,072 adults aged 16+). Please note, these models assume Southampton's population structure and related characteristics (age, gender, ethnicity, and deprivation) remain similar to that of the model.

9.8.4.5 Atrial fibrillation (AF)

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

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

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

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

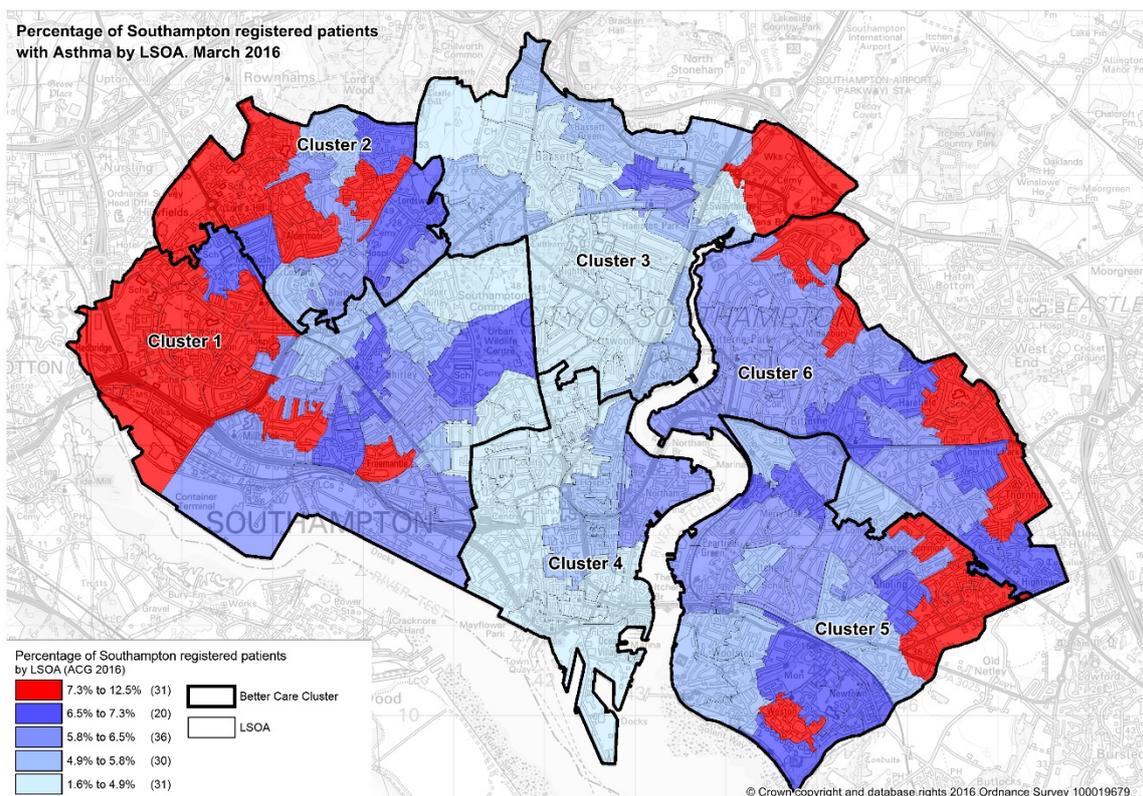
Public Health England investigated this to be underestimate and have modelled for Southampton 2015/16 expected prevalence of AF to be 1.9% of registered patients, however this estimate is based on assuming Southampton's population structure and related attributes remain similar to that used in the model.

9.8.4.6 Asthma

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

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

Figure 31

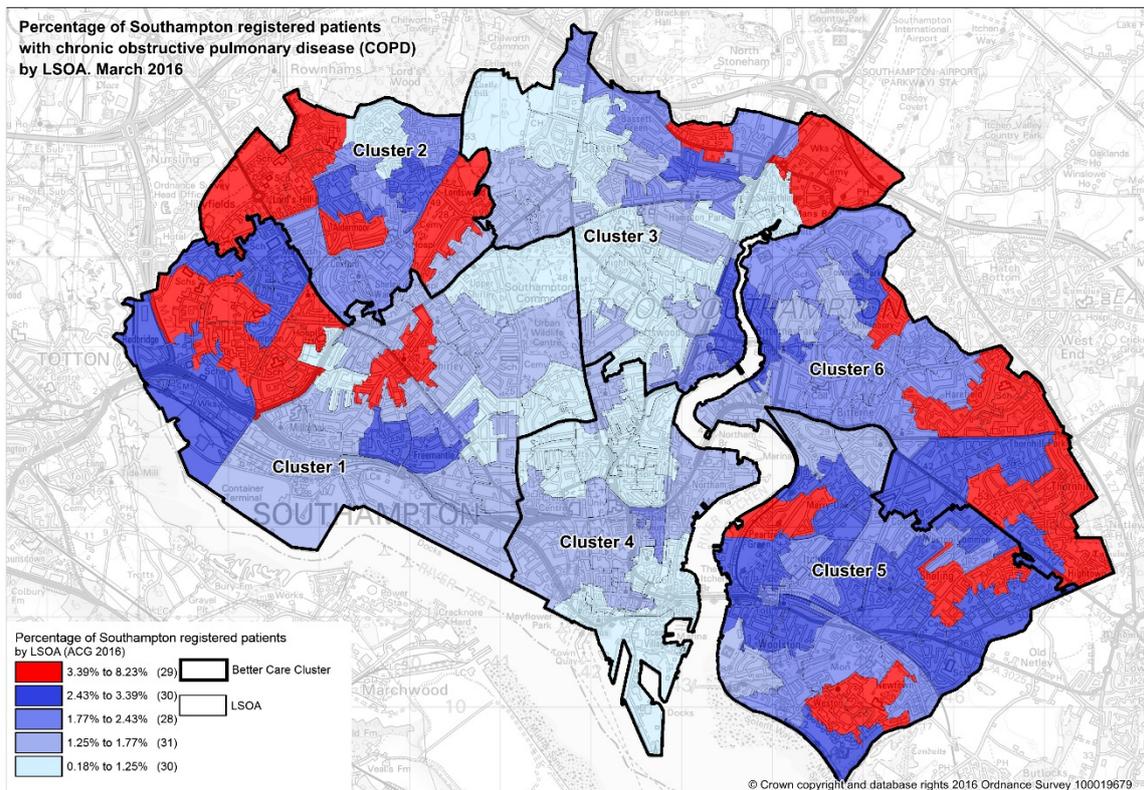


9.8.4.7 Chronic obstructive pulmonary disease (COPD)

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

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

Figure 32



However, there is a disparity between disease prevalence estimates from large surveys, in particular the Health Survey for England, and the number of patients diagnosed and registered in QOF. The most current modelled estimate⁴⁵ of COPD predicts an estimated prevalence across the city of 2.5% equating to 6,170 Southampton residents.

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

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

9.8.4.8 Kidney disease

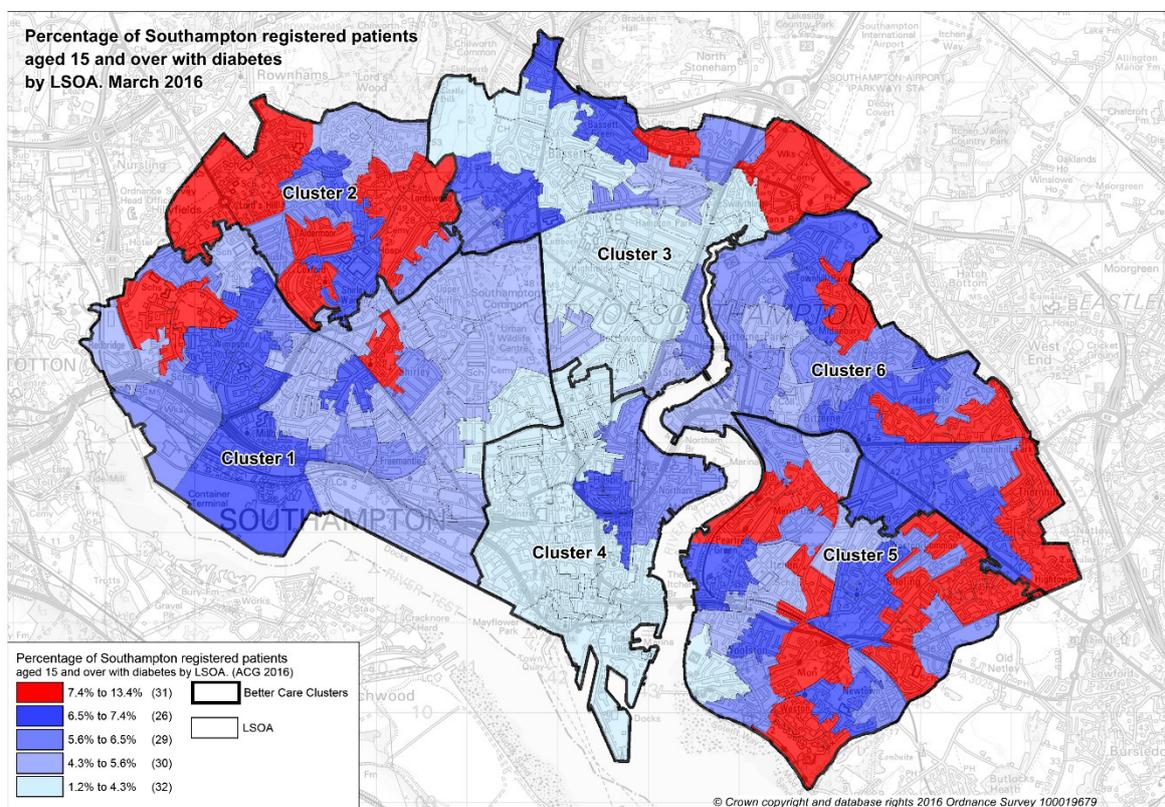
In March 2016 GP QOF data showed 6,777 people on GP disease registers with chronic kidney disease (CKD). The prevalence of diagnosed CKD amongst people aged 18 years and over in Southampton is 3.0% (compared to 4.0% in the CCG Cluster comparator group) although this varies from 0.2% to 5.5% by Southampton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

9.8.4.9 Diabetes

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

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

Figure 33



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

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

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

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

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

9.8.4.10 Sight loss

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

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

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

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

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

9.8.4.11 Hearing loss and deafness

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

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

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

Modelling from PANSI/POPPI predict there are 5,053 Southampton residents aged 18-64 and 14,601 residents aged 65 years and over predicted to have a moderate or severe, or profound hearing impairment, by age, and this is projected to increase to 5,398 and 21,455 by 2035.⁴⁹

9.8.4.12 Levels of disability among children and young people

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

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

⁴⁶ DLA Entitlement (Count) Department for Work and Pensions

⁴⁷ Disease and risk factor prevalence, PHE Fingertips

⁴⁸ DLA Entitlement (Count) Department for Work and Pensions

⁴⁹ Projecting Older People Population Information System (POPPI) and Projecting Adult Needs and Service Information (PANSI), Oxford Brookes University

⁵⁰ DLA Entitlement (Count) Department for Work and Pensions

9.8.4.13 Levels of disability among adults

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

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

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

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

Modelling by POPPI estimates in 2017, there are 6,291 people aged 65 and over unable to manage at least one mobility activity on their own, (This estimate is adjusted for the underlying age and gender distribution). Activities include: going out of doors and walking down the road; getting up and down stairs; getting around the house on the level; getting to the toilet; getting in and out of bed. This is predicted to increase to 9,122 Southampton residents aged 65 and over by 2035.⁵⁵

9.8.4.14 Human immunodeficiency virus (HIV)

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

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

⁵¹ RAP P1 via PHE Fingertips

⁵² DLA Entitlement (Count) Department for Work and Pensions

⁵³ Projecting Adult Needs and Service Information (PANSI), Oxford Brookes University

⁵⁴ DLA Entitlement (Count) Department for Work and Pensions

⁵⁵ Projecting Older People Population Information System (POPPI), Oxford Brookes University

9.8.4.15 Mental health and neurological conditions

There is no good health without good mental health and this is important across the life-course. Early intervention is at the heart of the Government's approach to improving outcomes for children and families. This is set out clearly in the public health White Paper Healthy Lives, Healthy People,⁵⁶ and the mental health strategy No Health without Mental Health⁵⁷ as well as the recommendations of Graham Allen's review of early intervention⁵⁸. No Health without Mental Health, the Government mental health strategy was published in 2011. It states that mental health is everyone's business – individuals, families, employers, educators and communities all need to play their part.

9.8.4.16.1 Children and Young People

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

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

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

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

⁵⁶ Department of Health. Healthy Lives, Healthy People: our strategy for public health in England 2010 <https://www.gov.uk/government/publications/healthy-lives-healthy-people-our-strategy-for-public-health-in-england>

⁵⁷ Department of Health The mental health strategy for England 2011 <https://www.gov.uk/government/publications/the-mental-health-strategy-for-england>

⁵⁸ Cabinet Office and Department for Work and Pensions, Early intervention: the next steps 2011 <https://www.gov.uk/government/publications/early-intervention-the-next-steps--2>

⁵⁹ Campion J and Fitch C. (2013) Guidance for commissioning public mental health services, p. 33. <http://www.icpmh.info/wp-content/uploads/icpmh-publicmentalhealth-guide.pdf>

⁶⁰ Kurtz Z. (1996) Treating Children Well: a guide to using the evidence base in commissioning and managing services for the mental health of children and young people

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

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

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

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

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

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

⁶¹ Public Health England, Children and Young People's Mental Health and Wellbeing <https://fingertips.phe.org.uk/profile-group/child-health/profile/cypmh>

⁶² Self-harm in over 8s: long-term management <https://www.nice.org.uk/guidance/cg133>

⁶³ NHS Digital. NatCen Social research Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 <http://content.digital.nhs.uk/catalogue/PUB21748> applied to the Hampshire County Council 2016-based Small Area Population Forecast

9.8.4.16.2 Adults

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

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

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

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

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

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

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

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

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

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

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

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

The APMS 2014 survey found a fifth of adults (20.6%) reported that they had thought of taking their own life at some point. Applying this prevalence to the Southampton adult population (aged 16 years and over), in 2017 an estimated 43,065 adults had had suicidal thoughts within their lifetime; this number is projected to increase to 44,950 adults in 2023.⁶⁵

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

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

9.8.5.16.3 Older people

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

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

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

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

9.9 Taking responsibility for health

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

9.9.1 Smoking

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

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

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

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

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

9.9.2 Excess weight and physical activity

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

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

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

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

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

9.9.3 Sexually transmitted infections (STIs)

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

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

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

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

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

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

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

9.9.4 Alcohol and drug misuse

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

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

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

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

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

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

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

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

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

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

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

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

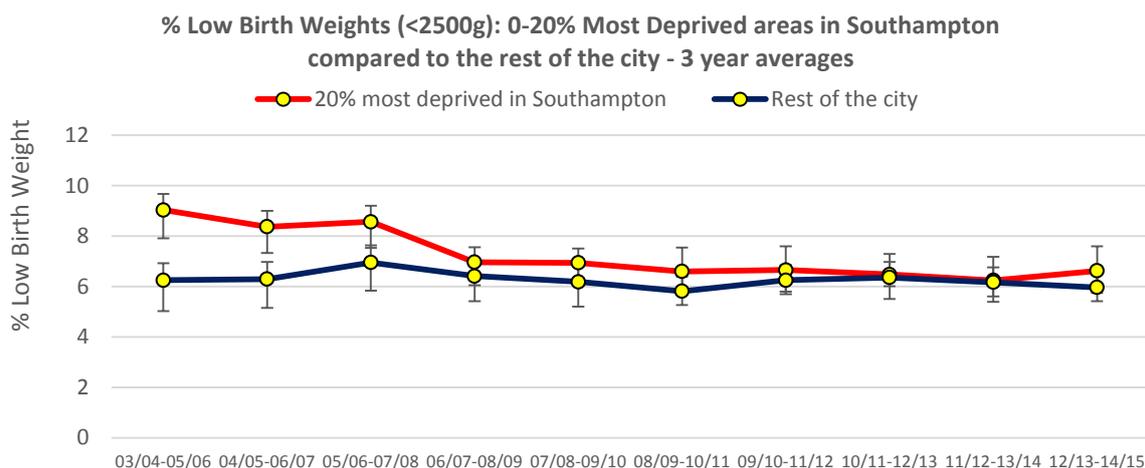
9.10 Parenting, childhood and adolescence

9.10.1 Low birth weight

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

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

Figure 34



9.10.2 Levels of caesarean versus normal births

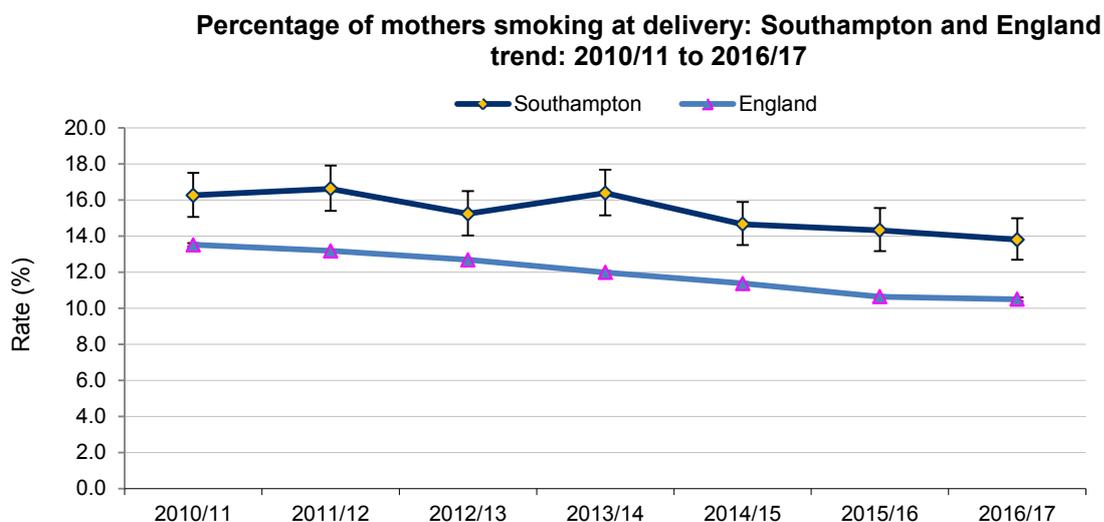
Variations in the level of caesarean births relate more to the effective use of resources than need. The proportion of total births that were normal deliveries in 2014/15 was 59.4%. The proportion that were caesarean section was 23.4%, the same as the previous year (SUHT) births and bookings data). To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

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

9.10.3 Smoking during pregnancy

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

Figure 35

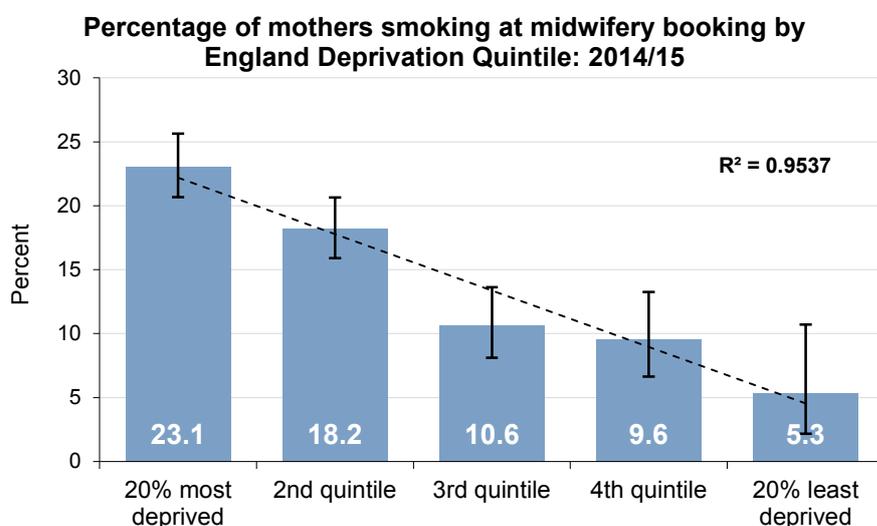


Sources: Copyright © 2017. Health and Social Care Information Centre, Lifestyles Statistics.

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

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

Figure 36



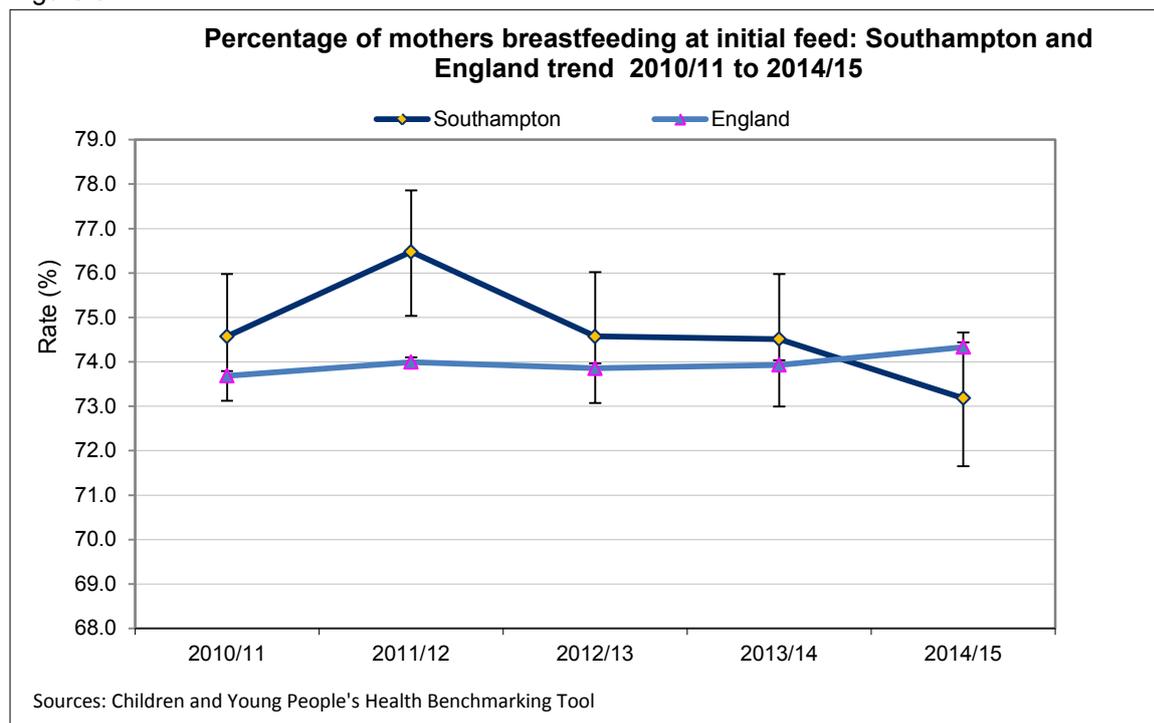
Sources: UHS Midwifery database: Southampton CCG

9.10.4 Breastfeeding initiation and maintenance

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

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

Figure 37



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

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

9.10.5 Child dental/oral health

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

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

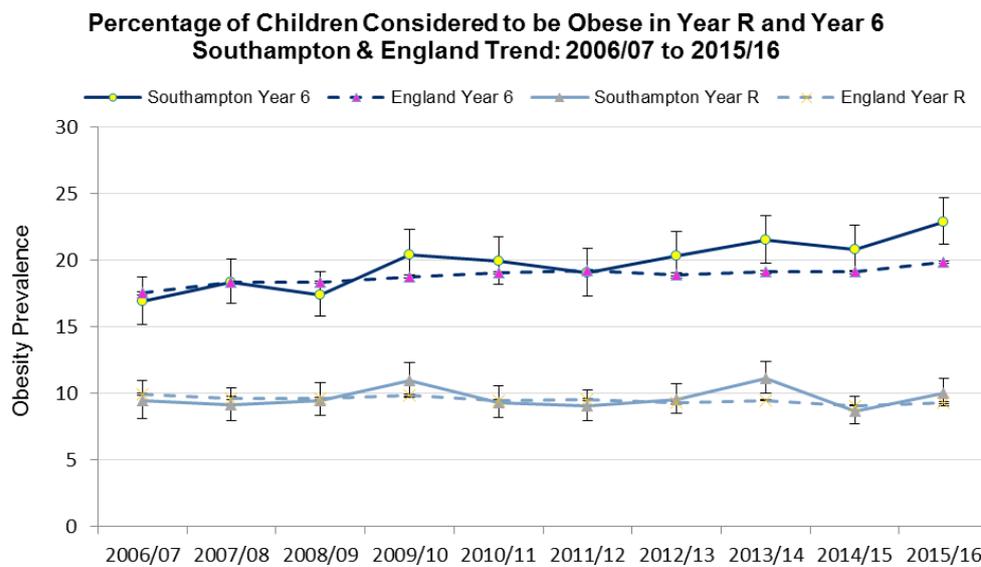
Dental extractions are also more common amongst children from the more deprived areas of Southampton. There is a large gap in the rate of children with teeth extracted under general anaesthetic between the highest and lowest deprivation quintiles over both years. Each GA extraction for school-aged children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

9.10.6 Childhood obesity

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

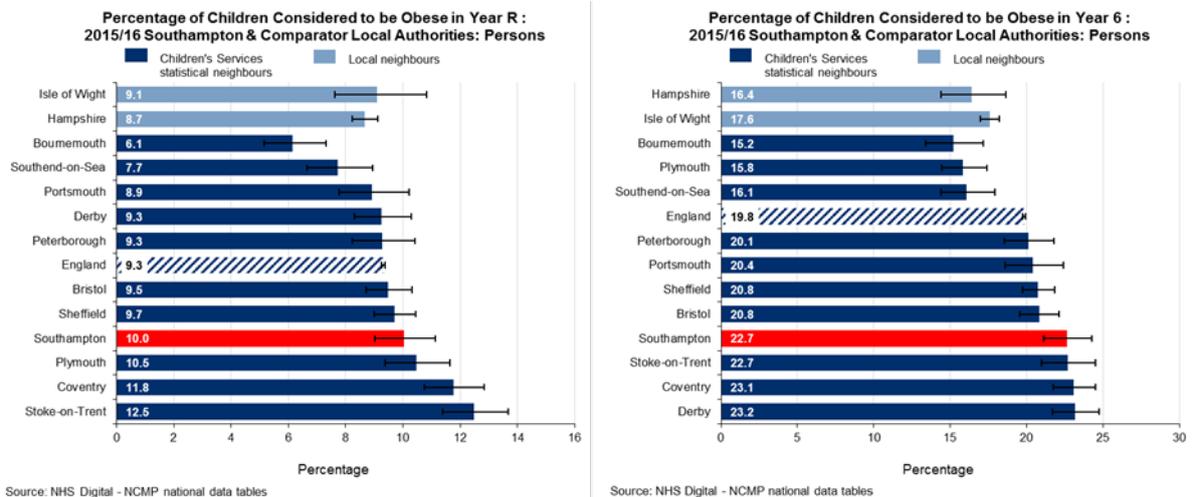
Similar to the national picture, overweight and obesity prevalence is significantly higher in Year 6 compared to Year R. In Southampton, the prevalence of obesity for Year 6 children has increased from 20.8% in 2014/15 to 22.9% in 2015/16, but because of the relatively wide confidence intervals associated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

Figure 38



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

Figure 39

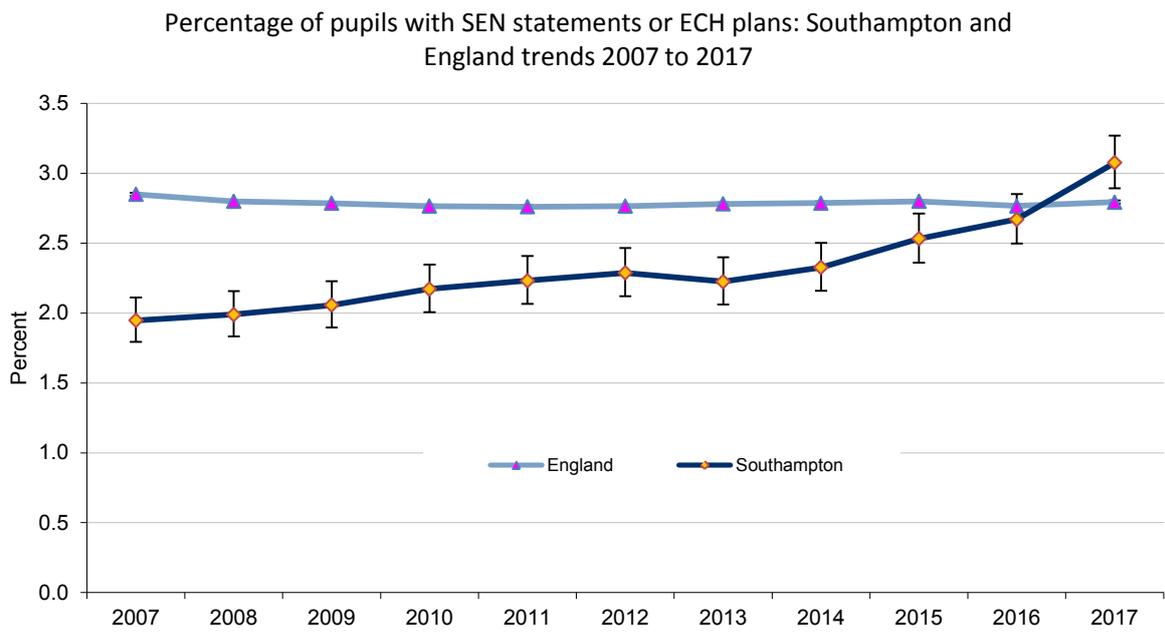


A longitudinal analysis of the ten years of data available locally shows that over 70% of children classified as overweight in Year 6 were previously of a healthy weight at 4-5 years of age. This proportion increased significantly (at the 95% confidence level) from 66.5% in 2012/13 to 77.4% in 2014/15,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

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

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

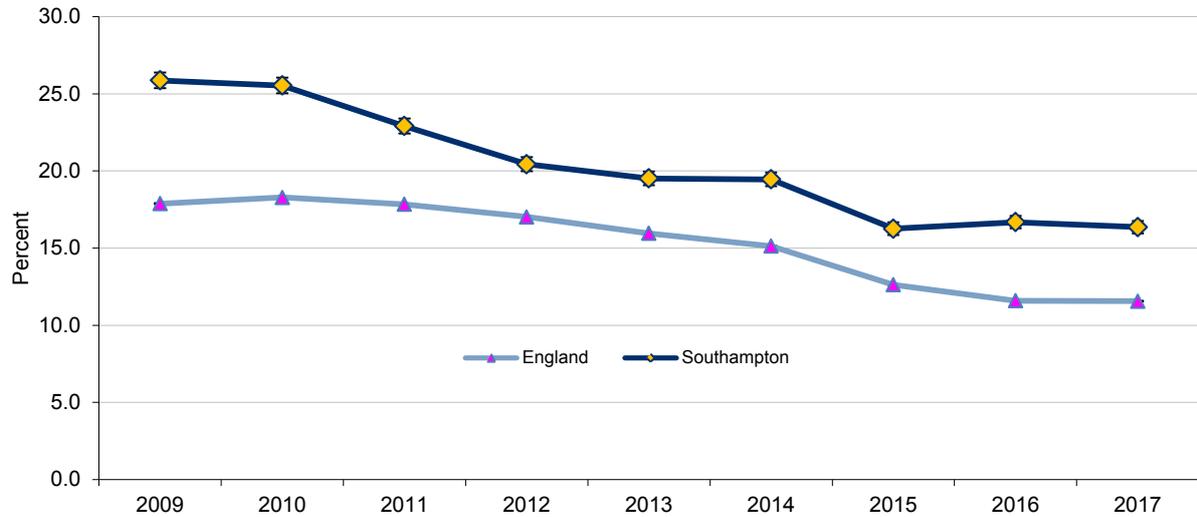
Figure 40



Source: Department for Education

Figure 41

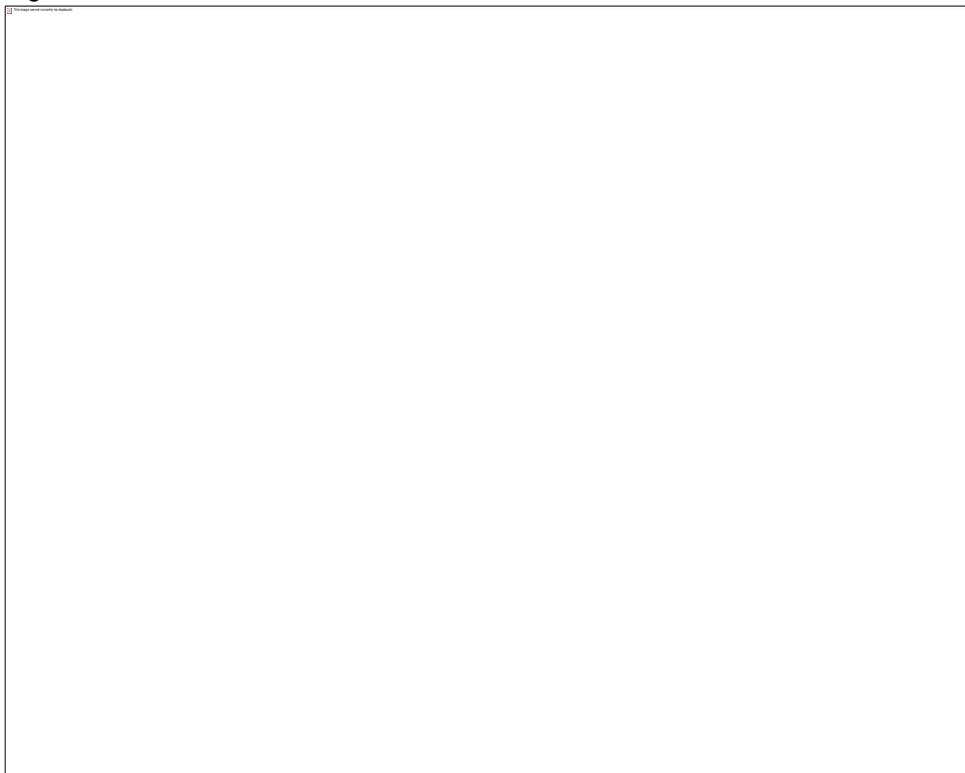
Percentage of pupils with SEN support: Southampton and England trends 2009 to 2016



Source: Department for Education

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

Figure 42



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

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

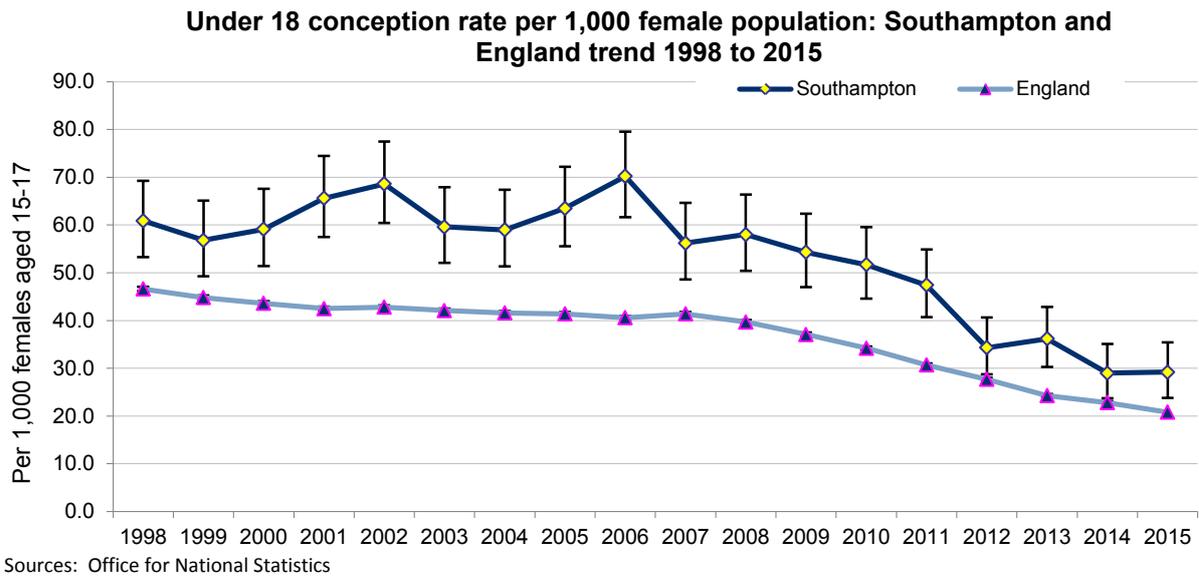
Setting	Area	Total Pupils	Statements or EHC plans		SEN support		Total pupils with SEN	
			Number	%	Number	%	Number	%
Primary	Southampton	20,331	339	1.7	3,621	16.1	3,621	17.8
	South East	724,988	10,584	1.5	81,699	11.3	92,283	12.7
	England	4,689,658	62,390	1.3	570,714	12.2	633,104	13.5
Secondary	Southampton	10,149	130	1.3	1,734	17.1	1,864	18.4
	South East	504,728	8,147	1.6	52,096	10.3	60,243	11.9
	England	3,223,089	55,867	1.7	345,139	10.7	399,006	12.4

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

9.10.8 Teenage pregnancy

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

Figure 43



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

Figure 44

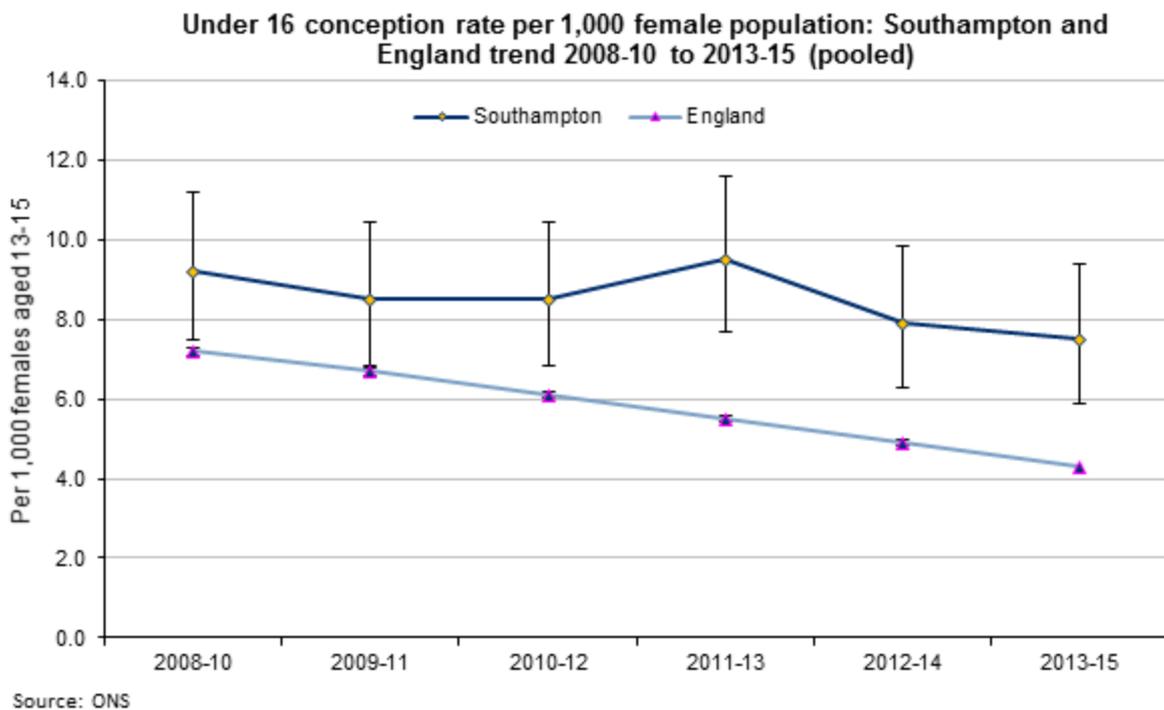
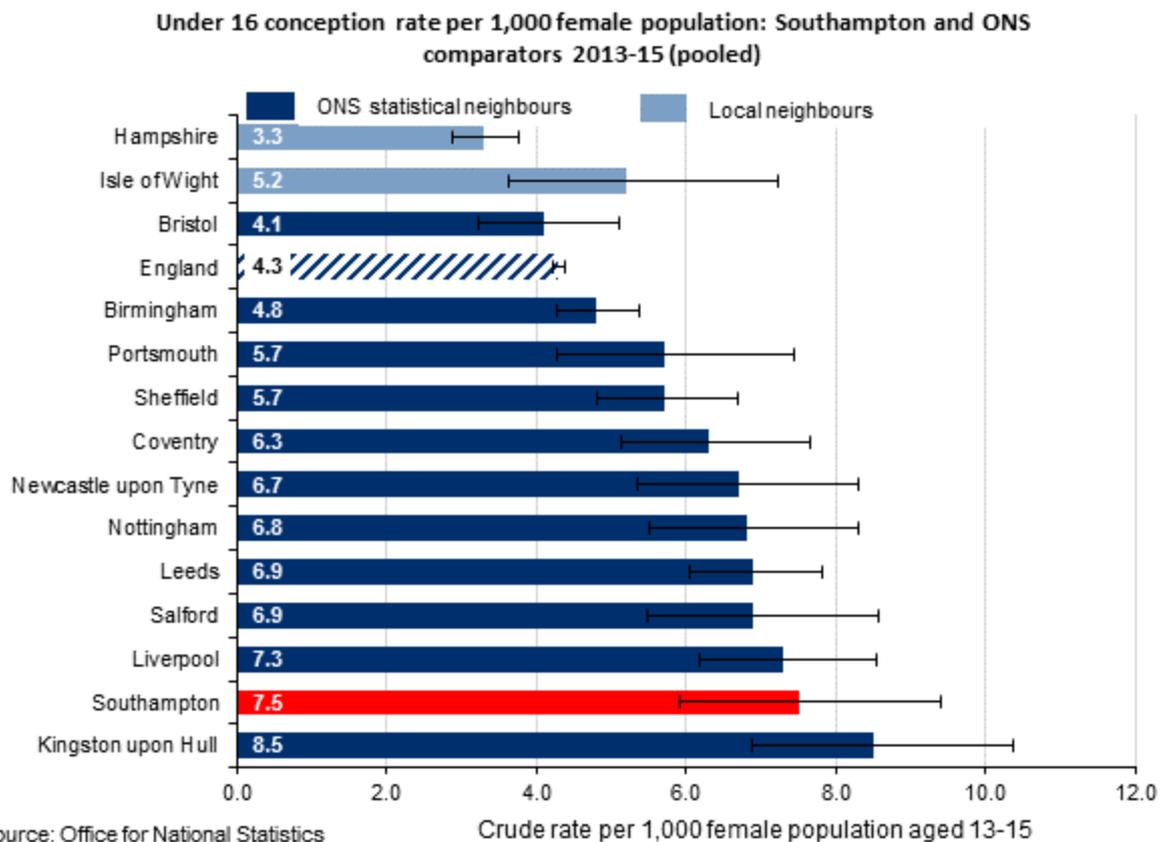


Figure 45



9.10.9 Termination of pregnancy

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

9.10.10 Misuse of alcohol and other substances by young people

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

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

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

9.11 Protecting the Population

9.11.1 Environmental exposures

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

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

Poor air quality is a significant public health issue. Particulate matter (PM_{2.5}) has a significant contributory role in human all-cause mortality and in particular in cardiopulmonary mortality. Southampton's level of PM_{2.5} is 9.2 µg/m³ which is higher than the England average of 8.3 µg/m³. Southampton level has decreased annually between 2011 and 2015 but has remained higher than the England average. In 2015, the estimated fraction of all-cause adult mortality attributable to anthropogenic particulate air pollution (measured as fine particulate matter, PM_{2.5}) for Southampton was 5.2% higher than the percentage for England (4.7%). The fraction of mortality attributable to particulate air pollution has fallen over time in line with the particulate levels.

9.11.2 Safeguarding for children and vulnerable adults

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

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

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

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

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

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

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

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

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

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

9.11.3 Health protection from communicable diseases

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

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

9.11.3.1 Tuberculosis (TB)

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

9.11.3.2 Hepatitis C

Public Health England has produced a tool for estimating the prevalence of Hepatitis C in a local population based on national rates⁶⁸. Using this tool, there are an estimated 606 people living in Southampton with Hepatitis C virus. The Health protection team received between 45-66 new reports of Hepatitis C infections amongst Southampton city residents per year over the last five years.

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

9.11.3.3 Healthcare associated infections (HCAI)

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

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

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

9.11.3.4 Vaccine preventable disease

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

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

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

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

9.11.3.5 Pandemic flu

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

⁶⁹ Public Health England. MRSA bacteraemia: annual data <https://www.gov.uk/government/statistics/mrsa-bacteraemia-annual-data>

⁷⁰ Public Health England. Clostridium difficile infection: annual data <https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data>

⁷¹ Communicable Disease Control, Public Health England (Wessex)

9.11.3.6 Port health

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

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

9.12 Inequalities and specific needs for key population groups

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

9.12.1 University Students

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

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

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

9.12.2 Carers

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

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

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

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

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

9.12.3 Disability

9.12.3.1 People with learning disabilities

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

As a consequence the treatment regimens of people with a learning disability can be complex, involving several different prescribers with medicines frequently used outside their product license.⁷²

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

9.12.3.2 Adults with autistic spectrum conditions

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

9.12.4 Lesbian, gay, bisexual and transgender community

9.12.4.1 Sexual orientation

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

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

9.12.4.2 Transgender

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

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

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

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

assigned as boys at birth (now trans women) and 20% as girls (now trans men). Gender variant people present for treatment at any age. The median age is 42.⁷⁵

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

9.12.5 Age

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

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

9.12.6 Ethnicity, migration, language and religion

Cultural difference can affect health and wellbeing:

- Ethnic differences in health are most marked in the areas of mental wellbeing, cancer, heart disease, HIV, TB and diabetes.
- An increase in the number of older BME people is likely to lead to a greater need for provision of culturally sensitive social care and palliative care.
- BME populations and religious groups may face discrimination and harassment and may be possible targets for hate crime
- Migrants may have limited health literacy to spoken and written information that is not in their first language
- Possible link with 'honour based violence' which is a type of domestic violence motivated by the notion of honour and occurs in those communities where the honour concept is linked to the expected behaviours of families and individuals.
- Female genital mutilation is related to cultural, religious and social factors within families

⁷⁵GIRES. The Number of Gender Variant People in the UK - Update 2011. GIRES; 2011

9.12.7 Gender

- Male healthy life expectancy in Southampton is 60.9 years which is significantly lower than the national average of 63.4 years.
- Inequalities in health are also greater for men in the city; there is a difference in life expectancy of 7.7 years for men from the most deprived 20% compared to those from the least deprived (the gap for women is 3.7 years).
- Domestic violence (mainly against women) is an issue in Southampton. In the last two years 450 referrals have been made to Multi Agency Risk Assessment Conferences because victims are at high risk of serious injury or death.

9.12.8 Port workers and visitors

Southampton is a port city where the threat of communicable diseases posed by the large scale movements of goods and people through the port needs to be monitored. 1.2 million TEU (Twenty Equivalent Unit) container movements of cargo, over 79,000 shipping movements and 170 cruise ship arrivals annually require a range of diverse environmental health control functions from Southampton Port Health Services.

9.12.9 Veterans

In common with other areas of the country, routinely collected local data for veterans in Southampton are extremely limited. Consequently for the Southampton veterans' health needs assessment⁷⁶ national data was used. The following data are taken from the veterans' health needs assessment dated September 2012.

Applying estimates of the national veteran population obtained from survey data from the Annual Population Survey 2014⁷⁷ to the HCC SAPF gives an estimated 18,782 veterans living in the city. Most veterans are estimated to be in the older age groups, with 32% aged 55-74 years old, and 22% aged 75-84 years.

The RBL found the ex-Service population is elderly and declining in size. Unsurprisingly, given the age profile of the ex-Service community, many of the most common difficulties experienced are those faced by many elderly people more generally: problems getting around, and feeling exhausted and socially isolated.

The RBL report suggests that between 2014 and 2030, the UK veteran population will reduce from 10% of the UK population to 6%. Although the overall number of veterans is projected to decline, the proportion of veterans aged 85 years and over is projected to increase. This is likely to be a reflection of the last veterans of the National Service cohort moving through the age profile, as well as increasing longer life expectancy within the UK population as a whole. However, there are increased proportions in age groups 16-24 years and 25-34 years due to the majority of personnel leaving the Armed Forces each year being in the younger age groups. There is also an unquantified impact of reductions in overall Service numbers which may lead to personnel leaving sooner than expected. The health

⁷⁶ <http://www.publichealth.southampton.gov.uk/Images/Veterans'%20Needs%20Assessment%20May'12.pdf>

⁷⁷ The UK ex-Service community: A Household Survey 2014, Royal British Legion

<http://www.britishlegion.org.uk/get-involved/campaign/public-policy-and-research/the-uk-ex-service-community-a-household-survey/> applied to Hampshire County Environment Department's 2016-based Southampton Small Area Population Forecasts

needs of younger veterans are likely to differ significantly from those in older age groups for example within the ex-Service community 16-34 year olds, particularly veterans and those who live alone, report a number of issues around debt, employment and transition, and a significant proportion have caring responsibilities..

⁷⁸In March 2017, 767 people were in receipt of an occupational pension under the Armed Forces Pension Scheme. The largest proportions of these veterans live in SO16 and SO19 which are the postcode districts covering the West and East/South localities in Southampton. These localities include some of the city's most deprived areas. These two postcode districts also contained the majority of the 390 people in receipt of a war disablement pension (68 and 66 respectively).

A recent review of health and social factors affecting veterans suggest that overall the health of the veteran population is comparable to that of the UK's general population⁷⁹. A study by the RBL in 2014⁸⁰ includes self-reported health information from veterans and the wider ex-service community (including dependents) found the top ten difficulties to be for the following conditions:

- Getting around outside the home
- Feeling depressed
- Exhaustion/pain
- Getting around inside the home
- Loneliness
- Bereavement
- Poor bladder control
- House/garden maintenance
- Not enough money for day-to-day living
- Not enough money to buy/replace items need

Veterans aged 16-64 are more likely than the general population of the same age to report a long-term illness that limits their activities (24% vs 13%).

This includes:

- Depression – 10% vs 6%
- Back problems – 14% vs 7%
- Problems with legs and feet – 15% vs 7%
- Problems with arms – 9% vs 5%
- Heart problems – 12% vs 7%
- Diabetes – 6% vs 3%
- Difficulty hearing – 6% vs 2%, and
- Difficulty seeing – 5% vs 1%

One in ten of the ex-Service community reports feeling depressed and this peaks at 14% of those aged 35-64 also one in six reports some relationship or isolation difficult,. The most reported physical self-care difficulty is exhaustion and pain, reported by almost one in ten, followed by poor bladder control, reported by slightly fewer. Both problems are,

⁷⁸ Location of armed forces pension and compensation recipients: 2017 Ministry of Defence
<https://www.gov.uk/government/statistics/location-of-armed-forces-pension-and-compensation-recipients-2017>

⁷⁹ Fear N, Wood D, Wessely S for the Department of Health. *Health and social outcomes and health services experiences of UK military veterans - a summary of the evidence*. London: November 2009. Available at:
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113749.pdf

⁸⁰ The UK ex-Service community: A Household Survey 2014, Royal British Legion
<http://www.britishlegion.org.uk/get-involved/campaign/public-policy-and-research/the-uk-ex-service-community-a-household-survey/>

unsurprisingly, slightly more prevalent among those with a long-term illness or disability. Poor bladder control is more likely to be reported by those aged 75-94 (one in ten), but reports of exhaustion and pain peak at age 45-54 (13%). Compared with the adult population of England and Wales, the ex-Service community is more likely to have some caring responsibility. The difference is greatest for those aged 16-34, so this difference is not explained by the older age profile of the ex-Service community. In total, 23% of those aged 16-64 have a caring responsibility, compared with 12% nationally.

9.12.10 Homelessness

In Southampton city, the statutory homelessness rate was 1.47 per 1,000 households (2015/16), a decrease from 1.85 per 1,000 households the previous year. This compares to a rate of 2.52 per 1,000 households in England in 2015/16 (with the previous year's rate of 2.40 per 1,000). Southampton's statutory homeless rate is lower than 10 ONS peers and higher than two ONS peers.⁸¹

The average life expectancy for homeless women is 43 years old and for homeless men is 47 years old. Drug and alcohol abuse are particularly common causes of death among the homeless population, accounting for just over a third of all deaths, and homeless people is nine times more likely to commit suicide than the general population.⁸²

Southampton's homelessness prevention strategy 2013/18 highlights that the impact of the recession on homelessness has not yet been fully realised in Southampton, partly due to the relatively low local house values and low interest rates. It notes a significant decline in homelessness applications and acceptances from 2003-2009 as a result of increased homelessness prevention and improved housing options for people at risk. It also describes the impact of homelessness rise since 2009 on households with dependent children. There has been a 68% increase in the number of households with dependent children accepted as homeless since that time. The figures for other priority need groups have either remained static or continued to fall since 2009.

⁸¹ Public Health Outcomes Framework, www.phoutcomes.org

⁸² NHS Choices. Behind the Headlines (2011) <https://www.nhs.uk/news/lifestyle-and-exercise/homeless-die-30-years-younger-than-average/>

9 Potential future need

9.2 Housing developments

The Strategic Housing Land Availability Assessment (SHLAA)⁸³ for Southampton indicates where housing developments are likely to occur. This indicates that during 2018-22 (which spans the lifetime of this PNA), 3,900 new dwellings are anticipated in the city. This is taken into account by the Hampshire County Council population forecasts used in section 9.1.

Also, as described in section 9.4.2, urban in-fill is anticipated to be a substantial source of housing supply. There is also major growth anticipated concentrated in the city centre across various sites, ongoing major development at centenary quay in Woolston and a range of council estate regeneration schemes.

The potential increase in pharmaceutical services is expected to be met within existing provision.

9.3 GP extended opening

Southampton is part of the second wave of sites selected in March 2015 to help improve access to general practice and stimulate innovative ways of providing primary care services. This pilot is providing extended opening of GP practices from 6:30pm to 9pm on weekdays, from 8am to 4pm on a Saturday and from 8am to 2pm on a Sunday. The service is provided from six hubs across the city, with only three open at any one time. The hubs have GPs, Advanced Nurse Practitioners and Healthcare Assistants providing same day and routine appointments. Many GP consultations result in a prescription being issued. Community pharmacies within Southampton offer good access through supplementary hours and four 100 hour pharmacies which have, to date, met any increased demand from pharmaceutical services that GP extended opening may have had.

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

10 Gaps in provision

10.1 Necessary services

The Health and Wellbeing Board consider the location, number, distribution and choice of pharmaceutical services serving Southampton residents to meet the needs of the population.

In particular, this is based on:

- Almost all of the Southampton population is within a 1.6km straight line distance of a community pharmacy.
- A good geographical spread of community pharmacies across the city and within communities experiencing greatest deprivation.
- There being 18 community pharmacies per 100,000 Southampton population, which is very similar to the average for Wessex and is broadly in line with the national average.
- Over 99% of the Southampton population are within a 20 minute walk of a community pharmacy.
- Just over nine in every 10 (92.3%) respondents to a public survey said it took 15 minutes or less to get to a community pharmacy.
- Consideration of opening hours from early morning, through lunchtimes and late into the evening as well as weekend opening.
- All pharmacies provide the full range of essential pharmaceutical services
- There is good provision of advanced services across the city.
- A large proportion of community pharmacies providing a delivery service to residents, including housebound patients.
- There will not be substantial changes in population areas, nor major development, which can be anticipated during the three-year lifespan of this PNA, which would warrant the need for additional pharmaceutical services. Smaller changes would be managed by existing providers.

10.2 Improvements and better access

The Health and Wellbeing Board consider that there is currently no identified need for improvements and better access to pharmaceutical services in Southampton.

In particular, this is based on:

- Four 100 hour pharmacies, supplementary hours in other Southampton community pharmacies as well as provision in a neighbouring Health and Wellbeing Board area provide improvements and better access which meets the needs of Southampton residents.
- This current provision is expected to continue to meet any increase in need as a result of further increase in extended hours of opening by GP practices or known planned developments.
- There is good provision of advanced services across the city.
- There are a range of enhanced and locally commissioned services delivered in the city.

11 Conclusion

The Health and Wellbeing Board consider has considered the provision of pharmaceutical provision in Southampton and concludes:

- The current need for pharmaceutical services is met by the existing providers on the pharmaceutical list.
- There will not be substantial changes in population areas, nor major development, during the three-year lifespan of this PNA, which would warrant the need for additional pharmaceutical services. Smaller changes would be managed by existing providers.
- Southampton residents can use pharmaceutical services offered by distance selling pharmacies which provide improved access and greater choice.
- There is good coverage across the city of Advanced, Enhanced and locally commissioned services in place.
- The Health and Wellbeing Board has not identified any specific improvements or better access that could be met by an additional pharmaceutical services provider at this time.
- Future improvements or better access will be met by the current pharmaceutical service providers.

12 Appendix A: Terms of Reference

Pharmaceutical Needs Assessment Steering Group

Terms of Reference

The Pharmaceutical Needs Assessment (PNA) is a legal duty of the Health and Wellbeing Board (HWB). The HWB is required to publish the revised PNA for its area by 1st April 2018. The PNA is used by NHS England to make decisions on which NHS funded pharmaceutical services need to be provided in the local area. Failure to publish a robust PNA, which has been produced in line with requirements of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 could lead to legal challenges, particularly as the local PNA is central to making decisions about new pharmacy openings. The steering group is preparing this document on behalf of the Director of Public Health for presentation to the HWB.

Purpose:

The steering group will:-

- Oversee the development and publication of a separate PNA for Southampton City Council (PCC) and Southampton City Council (SCC)
- Agree a project plan and timetable for the development of the PNAs and ensure representation of the full range of stakeholders
- Agree the format and content of the PNAs
- Ensure that the PNAs reflects any future needs for, or improvement or better access to, pharmaceutical services as will be required by the local population
- Ensure the PNAs meets the requirements of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013
- Ensure the PNAs fulfils its statutory duties for consultation for the PNA
- Ensure publication of the PNAs within the required timescale
- Ensure the PNAs comply with requirements of each local authority to ensure authorisation by the respective HWB.

Membership

The membership of the steering group is as follows:-

Southampton City Council

Claire Currie (Chair)
James Hawkins
Janet Byng

Public Health Consultant (on behalf of PCC and SCC)
Specialist Public Health Intelligence Analyst
Public Health Team Administrator

Southampton City Council

Dan King

Service Lead – Intelligence and Strategic Analysis

NHS Southampton Clinical Commissioning Group

Janet Bowhill

Pharmaceutical Adviser

NHS Southampton City Clinical Commissioning Group

Sue Lawton

Locality Lead Pharmacist for West / Community
Pharmacy Development Manager

Hampshire and Isle of White Local Pharmaceutical Committee

Paul Bennett (until June 2017)

Chief Officer

Debby Crockford (from July 2017)

NHS England Wessex Local Area team

Leslie Riggs

Interim Contracts Manager (Pharmacy and Optometry),
NHS England (Wessex)

Healthwatch representatives

Siobhain McCurrach (Southampton) Project Manager, Learning Links

Rob Kurn (Southampton) Healthwatch Southampton Manager

An agreed deputy may be used where the named member of the group is unable to attend.

Other staff members/stakeholders may be invited to attend meetings for the purpose of providing advice and/or clarification to the group.

Where there are discussions in the steering group specific to one City Council, only those members representing the City in question may take part.

Declarations of interest

Members must declare any pecuniary or personal interest in any business on the agenda for it to be formally recorded in the minutes of the meeting.

Meetings

All meetings will have an agenda and minutes. The frequency of the meetings will be determined by the chair of the group in line with the development of the PNA.

Accountability and reporting

The PNA steering group will be accountable to the Southampton Health and Wellbeing Board and separately to the Southampton Health and Wellbeing Board for the PNA being developed for the respective areas. The PNA steering group will report on progress on a three monthly frequency or as required by the Health and Wellbeing Board.

The pre-consultation drafts and the final draft PNAs will be presented to their respective Health and Wellbeing Board for approval.

13 Appendix B: Policy context

Pharmacies have a major role to play in helping improve the public's health, with 1.6 million people visiting a pharmacy each day⁸⁴. There were approximately 12,000 community pharmacies in England (2065) and 79% of people have visited a pharmacy at least once in the last 12 months.

Pharmacists are experts in the use of medicines to treat disease and are an appropriate first point of contact for dealing with an array of health concerns. Pharmacists work within a code of ethics that requires them to continuously develop their professional knowledge and competence relevant to their field of practice. Pharmacists are responsible for the supply of most medicines available to the public. They advise the public and other professionals on the safe and effective selection and use of medicines and other health-related matters. Pharmacies provide a range of services in the heart of neighbourhood communities where they are within reach of the people who need them most – poorer people, older people and people with a disability or chronic condition.

The role of community pharmacy is evolving. Distance selling pharmacies are providing greater choice and accessibility for the public to pharmaceutical services. They are also changing the community pharmacy provision from the traditional high street provision.

Published in April 2016, the General Practice Forward View set out a vision to improve patient care and access, and invest in new ways of providing primary care. The General Practice Forward View committed to over £100m of investment to support an extra 1,500 pharmacists to work in general practice by 2020/21. This is in addition to over 490 pharmacists already working across approximately 650 GP practices as part of a pilot, launched in July 2015.

Pharmacists working as part of the general practice team aim to resolve day-to-day medicine issues and consult with and treat patients directly. This includes providing extra help to manage long-term conditions, provide advice for those on multiple medications, improving the quality of care and ensuring patient safety.

In August 2016 the Community Pharmacy Forward View was published by PSNC and Pharmacy Voice, with the support of the RPS English Pharmacy Board which set out the ambition for the sector. It focused on three key roles:

- As the facilitator of personalised care for people with long-term conditions;
- As the trusted, convenient first port of call for episodic healthcare advice and treatment; and
- As the neighbourhood health and wellbeing hub.

For 2017/18, The Department of Health (DH) introduced a Quality Payments Scheme as part of the Community Pharmacy Contractual Framework. This scheme involves payments being made to community pharmacy contractors meeting certain gateway and quality criteria. Achieving Healthy Living Pharmacy status is included in these criteria.

⁸⁴ Local Government Association; The community pharmacy offer for improving the public's health <https://www.local.gov.uk/sites/default/files/documents/community-pharmacy-offer--9b3.pdf>

14 Appendix C: Consultation report

Consultation Requirements

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

Publication of draft PNA

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

Consultation period

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

Consultation Activities

Consultation questions

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

Consultation with professional stakeholders

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

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

Consultation with the public

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

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

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

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

Response

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

Summary

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

Responses

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

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

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

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

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

Table 1. Summary of responses to consultation question one

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

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

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

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

Table 2. Summary of responses to consultation question two

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

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

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

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

Table 3. Summary of responses to consultation question three

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

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

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

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

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

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

Table 4. Summary of responses to consultation question four

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

*For both surveys these were strongly agree or agree responses

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

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

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

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

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

Access

- Acknowledgement that for those that do not have a car access may be more difficult (2 comments)
 - Access in mornings and evenings to accommodate those who work during working day (1 comment)
 - Pharmacies are located in the wrong places (1 comment)
- See question 6 response to comments regarding 'access'.

Capacity

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

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

Quality of service

- Pharmacies do not always have medications in stock (1 comment)
 - Concern that a number of pharmacies do not provide service efficiently (1 comment)
 - General concern re quality of service at a particular pharmacy (1 comment)
- See question 6 response to comments regarding 'quality of service'.

- No reason given (1 response)

Table 5. Summary of responses to consultation question five

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

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

Four comments were from professional stakeholders.

Comment

We believe that participation in the NHS Urgent Medicine Supply Advanced Service would improve patient access to medicines during the out of hours period, and would improve convenience for patients, with fewer referrals from 111 to the Out of Hours Service providers.

Response

NHS Urgent Medicine Supply Advanced Service (NUMSAS) has now started in Southampton, from 8th January 2018 and accepts referrals from NHS 111. This was not stated in the consultation draft and has since been updated. NUMSAS is being run as a

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

Comment

We could not identify from the needs assessment whether there are plans to widen the availability of naloxone for overdoses caused by heroin and other opiates

Response

Naloxone is available through the drug treatment service in Southampton within an inclusive approach to individuals not engaged in drug treatment. The provision of naloxone through other settings, including pharmacies, will be kept under review.

Comment

We do not agree that there will be an increase in demand for internet services that would necessitate the establishment of a Distance Selling Pharmacy (DSP). DSPs must cover the whole country, and several already exist. Community Pharmacies are already providing delivery services that sufficiently cater for the housebound. Although a delivery service is not a pharmaceutical service, and would therefore not usually be referred to in this assessment, we feel it is an important point to note.

Response

In the 2013 Regulations, DSPs are the only exemption category from the current market entry regulations. Therefore, the use of the PNA for market entry does not apply to distance selling pharmacies. Consideration to DSPs have been included in the PNA as they contribute to the overall pharmaceutical provision of an area (although, as has recognised in the comment made, activity is not solely located to the area in which a DSP is based).

Comment

The PNA needs to acknowledge that Hampshire residents may use services in Southampton in particular Out of Hours

Response

Text will be amended to acknowledge more explicitly that Hampshire residents can choose to use pharmacies located in Southampton.

There were sixteen written comments from members of the public to this question.

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

Access

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

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

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

Quality of service

There were eleven comments relating to quality of service.

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

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

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

15 Appendix D: Equality and Safety Impact Assessment



Equality and Safety Impact Assessment

The **Public Sector Equality Duty** (Section 149 of the Equality Act) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people carrying out their activities.

The Equality Duty supports good decision making – it encourages public bodies to be more efficient and effective by understanding how different people will be affected by their activities, so that their policies and services are appropriate and accessible to all and meet different people’s needs. The Council’s Equality and Safety Impact Assessment (ESIA) includes an assessment of the community safety impact assessment to comply with section 17 of the Crime and Disorder Act and will enable the Council to better understand the potential impact of the budget proposals and consider mitigating action.

Name or Brief Description of Proposal	Southampton Pharmaceutical Needs Assessment 2018
Brief Service Profile (including number of customers)	
<p>A Pharmaceutical Needs Assessment (PNA) is a statement of current pharmaceutical services provided in the local area. It also assesses whether or not the pharmaceutical services provision is satisfactory for the local population and identifies and perceived gaps in the provision.</p> <p>The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for developing an updating PNAs. It is a statutory requirement for the Health and Wellbeing Board to publish a revised assessment within three years of its previous PNA. The refreshed Southampton PNA must be published on 1st April 2018.</p>	
Summary of Impact and Issues	
<p>The PNA reflects the current and future needs for pharmaceutical services. This affects the residents of Southampton, people who work and study in the city and partner NHS organisations including NHS Southampton City Clinical Commissioning Group, Southampton University Hospitals NHS Foundation Trust, GP practices and the existing community pharmacy network. This PNA refreshes the previous assessment published on 1st April 2015.</p> <p>Access to high quality pharmaceutical services is particularly relevant for those taking medicines, typically people suffering from long term conditions and disproportionately affect those in ill-health and older adults.</p> <p>There is no specific impact on any one group. Everyone may need access to pharmaceutical services in the city. The PNA has made specific reference to a range of groups.</p>	

Potential Positive Impacts	
The PNA describes provision of pharmaceutical services including locally commissioned services and their role in promoting health and wellbeing of the people of Southampton.	
The PNA has been developed to ensure a good range of pharmaceutical services may be accessed by the local population of Southampton. Many services have been identified and their beneficial impact on health and wellbeing described.	
Responsible Service Manager	Claire Currie Consultant in Public Health, Portsmouth City Council
Date	February 2018
Approved by Senior Manager	Jason Horsley Joint Director of Public Health
Date	February 2018

Potential Impact

Impact Assessment	Details of Impact	Possible Solutions
Age	<p>This PNA identified good provision of services for all ages. Medicines use increases with age. The majority of older adults will be taking at least one regular prescription medicine.</p> <p>All pharmacy contractors were asked about their services that would support older adults. These services include prescription collection and home delivery of medicines. Distance selling pharmacies also provide additional choice and increases accessibility to older adults some of whom may have limited mobility. Adjustments to the dispensing process include easy open containers and large print labels.</p> <p>Distance Selling Pharmacies registered outside of Southampton provide additional choice and increases accessibility to older adults who may have limited mobility.</p>	N/A
Disability	<p>This PNA identified good provision of people with disabilities.</p> <p>Pharmacy contractors were asked to describe adjustments they make in their service for this group. This included wheelchair access into premises and consulting rooms. During the data collection process it was confirmed that the majority of pharmacies in the city offer a prescription collection service and free home delivery service providing a service to housebound patients and others. Distance selling pharmacies also provide additional choice and</p>	N/A

Impact Assessment	Details of Impact	Possible Solutions
	increases accessibility to individuals with disabilities who may have limited mobility.	
Gender Reassignment	No specific impact has been identified from this PNA.	N/A
Marriage and Civil Partnership	No specific impact has been identified from this PNA.	N/A
Pregnancy and Maternity	<p>No specific impact has been identified from this PNA.</p> <p>Community pharmacies can provide an important source of advice for minor ailments for conditions such as constipation which can commonly occur in pregnancy. For women planning pregnancy, access to a community pharmacy for advice can also be important.</p>	N/A
Race	<p>No specific impact on a particular group has been identified from this PNA.</p> <p>Higher prevalence of some health conditions is associated with particular ethnic groups. Questions were asked about languages spoken by pharmacy staff which have been summarised in the PNA.</p>	N/A
Religion or Belief	<p>No specific impact has been identified from this PNA.</p> <p>The General Pharmaceutical Council has published guidance to clarify that while a pharmacist may be unwilling to provide a particular service due to religious reasons or personal values and beliefs, they should take steps to make sure the person asking for care is at the centre of their decision-making, so that they are able to access the service they need in a timely manner.</p>	N/A
Gender	<p>No specific impact for either men or women has been identified from this PNA.</p> <p>Life expectancy of men is lower than that for women in Southampton and nationally.</p>	N/A
Sexual Orientation	No specific impact has been identified from this PNA.	N/A
Community Safety	No specific impact has been identified from this PNA.	N/A
Poverty	<p>No specific impact has been identified from this PNA.</p> <p>Areas of deprivation have been described and considered in light of pharmaceutical provision.</p>	N/A
Other Significant Impacts	No additional impacts identified. Reference to services beneficial to carers have been made within the document.	N/A
