JSNA Executive Summary

Background and context

The purpose of this document is to help professionals, services and communities themselves to improve the health and wellbeing of Southampton's population through clearly identifying local needs. " Gaining Healthier Lives in a Healthier City" is Southampton's second Joint Strategic Needs Assessment (JSNA) and will cover needs for 2011-14. The JSNA sets out to identify the 'big picture' for health and wellbeing. The JSNA defines a needs assessment as '*a systematic method for reviewing the health and wellbeing needs of a population, leading to agreed commissioning priorities that will improve health and wellbeing outcomes and reduce inequalities.* Department of Health JSNA Guidance p.7 (2007). The picture of health and wellbeing in the city set out in this JSNA has been informed by a wide range of data sets (available through the JSNA data compendium web site: www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/public-health-data/jsna/data/ and through stakeholder and public engagement.

This document summarises the key themes and issues that have emerged from a five month consultation and engagement process with the public, voluntary sector, health and social care stakeholders and elected representatives. www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/public-health-data/jsna/consultform/ and the Health Maters magazine http://www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/public-health-data/jsna/health-matters-2010/ published in July 2010. Feed back has been received on what are seen as the main priorities for attention and investment which have been matched against the data to inform conclusions from this analysis.

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. This assessment also integrates the six key recommendations from Sir Michael Marmot's report Fair Society (2010), www.marmotreview.org/ probably the most important evidence based commentary on health for a generation.

This version of the JSNA will inform developments during a time of substantial change for the NHS and the city council. The Primary Care Trust will cease to exist after March 2013, and the new GP Commissioning Consortium will then take over responsibility for commissioning most of the health services required for local people. The public health function will transfer to the local authority at the same time that Public Health England is established. This JSNA will help to inform commissioning decisions during the tightest public spending environment in a generation.

This summary illustrates that improving health and wellbeing in a city such as Southampton will not simply be about delivering more health and social care services. It recognises that enabling people to live healthier lives is as much about helping people maximise their own individual potential and, helping them to create a safe and pleasant environment to live in, as it is about improving the quality and accessibility of services. Ultimately each individual has a personal responsibility to make mature and sensible decisions for their own health and to help their children to make good decisions about diet, exercise, drugs, alcohol and sexual health.

Many people are shocked by the scale of health inequalities that exist in Southampton in 2011. We have a highly valued NHS and the overall health of the population in the city has improved greatly over the past 50 years. Yet in the wealthiest part of Southampton, in Bassett, a man can expect to live to 80.6 and women 84.0 years, while a few kilometres away in Bitterne, one of the cities poorer wards, male life expectancy is 75.3 and female 79.9 years. These differences in life expectancy of 5.3 and 4.1 years respectively for men and women are significant enough not to be a coincidence. Dramatic health inequalities are still a dominant feature of health in Southampton (adapted from Marmot 2010).

Health inequalities are not inevitable and can be significantly reduced. They stem from avoidable inequalities in society: of income, education, employment and neighbourhood circumstances. Often inequalities present before birth set the scene for poorer health and other outcomes accumulating through the course of our residents lives.

Within this JSNA an initial attempt has been made to describe some of the health assets which include factors or resources which enhance the ability of individuals, communities and populations to maintain and sustain health and well-being. These assets can operate as protective and promoting factors to buffer against life's stresses. Indeed, asset based community development (ABCD) presents an evidence-based framework to help practitioners recognise that as well as having needs and problems, communities also have social, cultural and material assets. These are what help them overcome the challenges they face. The asset approach does not replace investment in improving services or tackling the structural causes of health inequality. While it may help reduce demands on services in the long term and bring about more effective services, it is not a no-cost or a money-saving option.

Other major developments in train that affect future services are the recommendations from the Munro Review of Child Protection (2011) and the changes in autonomy of schools and their funding.

The government has indicated that the JSNA is to remain a key tool for informing commissioning decisions. The Health and Social Care Bill proposes placing a duty on the City Council and GP consortium to work jointly to produce future versions of the JSNA. This would then inform the production of a Joint Health and Wellbeing Strategy. This will be the overarching framework from which the commissioning plans for the NHS, social care, public health and other services would be developed.

A GP commissioning consortia is being established for the city which will shape services and drive improvements locally, within a national framework and with support and guidance from the NHS Commissioning Board. This will create an integrated system between consortia and the Board, which supports the delivery of national accountabilities as well as local priorities. Local consortia will also work closely with the Health and Wellbeing Board to ensure commissioning is joined up between the NHS, public health and social care.

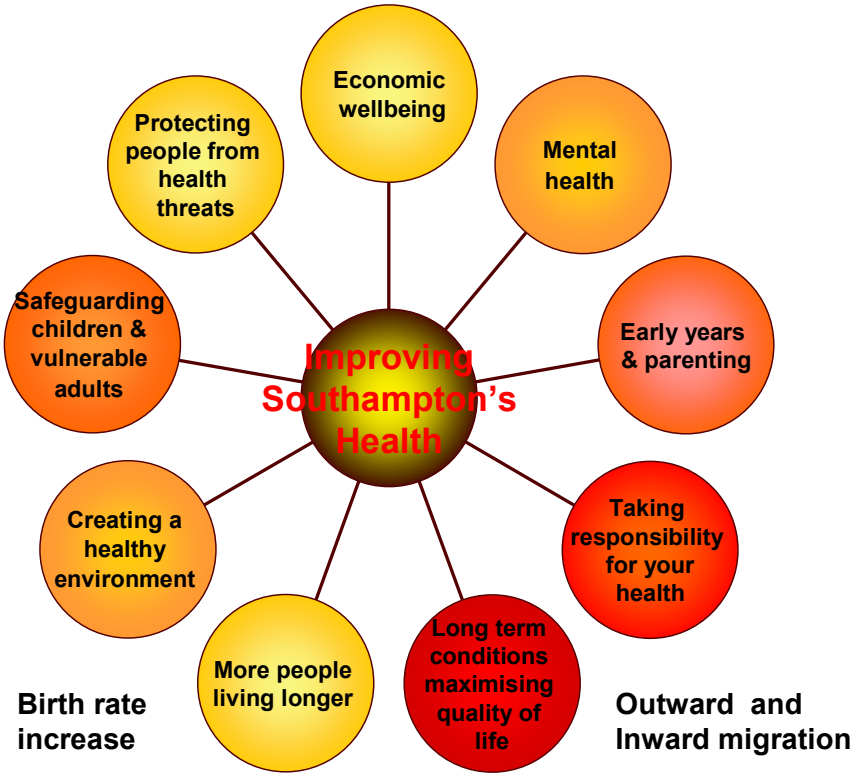
A key challenge from central government will be to ensure a developing focus on prevention at a time when public sector budgets are being cut back and statutory service provision is under pressure. Some of the needs identified through the JSNA process provide the basis for identifying where some of the most cost-effective preventative actions might be taken.

Our commissioning framework aims to:

1. Put people at the centre of commissioning
2. Understand the needs of populations and individuals
3. Share and use information more effectively
4. Assure high quality providers for all services
5. Recognise the interdependence of work, health and well-being
6. Develop incentives for commissioning for health and well-being
7. Make it happen through capable leadership and local accountability

Following extensive public and stakeholder consultation nine key themes for a healthier population have been identified. These are underpinned by a good understanding of Southampton's changing population – each theme also dovetails to the Marmot 2010 main policy recommendations in a 'Fair Society, Healthy Lives' to ensure consistency with national requirements of local services.

Figure 1 JSNA 9 Key themes



Main policy recommendations from *Fair Society, Health Lives*: (Marmot 2010)

A. Giving every child the best start in life (highest priority recommendation) – what happens during early years (starting in the womb) has lifelong effects on many aspects of health and well-being from obesity, heart disease and mental health, to educational achievement and economic status. Later interventions, although important, are considerably less effective where good early foundations are lacking. That is why this review proposes a rebalancing of public spending towards the early years, more parenting support programmes, a well-trained early years work force and high quality early years care.
B. Enabling all children, young people and adults to maximize their capabilities and have control over their lives – educational achievement brings with it a whole range of achievements including better employment, income and physical and mental health. Evidence suggests it is families rather than schools that have the most influence on educational attainment therefore building closer links between schools, the family, and the local community are important to reducing educational inequalities.
C. Creating fair employment and good work for all – being in employment is protective of health; conversely unemployment contributes to poor health. Jobs need to offer a decent living wage, opportunities for in-work development, good management practices, the flexibility to enable people to balance work and family life, and protection from adverse working conditions that can damage health.
D. Ensuring a healthy standard of living for all – having insufficient money to lead a healthy life is a highly significant cause of health inequalities. Standards for a minimum income for healthy living (MIHL) need to be developed and implemented – the calculation includes the level of income needed for adequate nutrition, physical activity, housing, individual and community interactions, transport, medical care and hygiene.
E. Creating and developing sustainable places and communities – many policies which would help mitigate climate change would also help reduce health inequalities – for instance more walking, cycling and green spaces. The Marmot review proposes common policies to reduce the scale and impact of climate change and health inequalities. Good quality neighbourhoods can make a significant difference to quality of life and health – this relates both to the physical environment and to the social environment. Social support, within and between communities is critical to physical and mental well-being.
F. Strengthening the role and impact of ill-health prevention - many of the key health behaviours important for the development of chronic disease follow the social gradient: smoking, obesity, lack of physical activity, unhealthy nutrition and drug misuse. The review argues for more funding to prevent ill health (currently it is only four percent of the NHS budget) and action to treat drug misuse as a medical problem. The NHS alone cannot tackle the social causes of ill health; action must come from families, schools, employers and government.

Theme 1 – Improve Economic Wellbeing

"Whilst many parts of the city are enjoying economic success, for a number of families, vulnerable adults and older people on fixed incomes, making ends meet is a daily struggle". (Consultation response)
Wages in Southampton are falling behind England and the South East average

Marmot recommendations C - *Create fair employment and good work for all* and D - *Ensure healthy standard of living for all* (Marmot 2010)

The benefits of reducing health inequalities are economic as well as social. The cost of health inequalities can be measured in human terms, years of life lost and years of active life lost; and in economic terms, by the cost to the economy of additional illness. (Sir Michael Marmot 2010)

Low average wages and high average house prices are key drivers behind the need to improve economic wellbeing as a means of reducing health inequalities and contributing to improved health. The first city priority, "to achieve sustained economic growth", and the economic development challenges, provide a focus to deliver higher levels of economic wellbeing.

People on lower incomes living in the most deprived areas in the city have shorter lives than those in the more affluent areas, with premature deaths (under age 75) 62.5% higher and increasing, the life expectancy of men being lower by 3.5 years and widening, and for women by 1.4 years and narrowing.

Deprivation is a significant issue in Southampton with the City being ranked as the 4th most deprived local authority in the South East and 81st out of the 326 local authorities in England according to the Index of Multiple Deprivation (IMD) 2010 In April 2010 12.6% of the working age population were claiming 'out-of-work' benefits compared to 9.5% across the South East region. In 2009 the estimated average weekly earnings for a full-time employee in Southampton were £441.60 or £95 a week less compared with a South East average of £536.60. Nearly 28% of Southampton's children are classified as living in poverty.

The landmark Marmot review "Fair Society, Healthy Lives" published in 2010, provided evidence showing the clear link between economic wellbeing and health, with inequality in illness accounting nationally for productivity losses of £31-33 billion per year, lost taxes and higher welfare payments in the region of £20-32 billion per year and additional NHS healthcare costs in excess of £5.5 billion per year.

The city has been successful in attracting major businesses into the city over the past 10 years. Having established businesses and new key players in the city economy is important for maintaining a reputation which will continue to attract other companies to supply a continuing flow of new employment opportunities. The data suggests that local people are losing out to people living outside the city when it comes to getting the better paid jobs. Traditionally the city has relied heavily on the public sector, with the local authority, NHS and universities providing employment for approximately 36,400 people (ONS 2009). The 2010 public spending review is yet to impact fully upon the city.

For Southampton to remain competitive it is essential to focus on improving the skills and educational attainments of city residents, and reduce the gap between those

achieved in the city and in neighbouring areas, as unemployment rates are highest amongst those with no or few qualifications. Special attention needs to be paid to ensure that people with disabilities and mental ill-health, young people, and other vulnerable and excluded groups are not trapped in a cycle of low-paid, poor quality work and unemployment.

Addressing these needs contributes to the following city challenges:

- Encourage higher levels of employment and economic activity
- Tackling deprivation in specific areas of the city
- Health at work

Theme 2 Improve mental health

"Mental health affects everything we do, our drive, our motivation, our self-esteem and this rubs off on those around us".(Consultation response)
There are high levels of both severe and common mental health problems in Southampton

Marmot recommendations C - *Create fair employment and good work for all,* E - *Create and develop healthy sustainable places and communities* and F - *Strengthen the role and impact of ill health prevention* (Marmot 2010)

Mental health is everyone's business, yet when we are well we rarely think about it. Good mental health and resilience are fundamental to our physical health, our relationships, our education, our training and our work to achieve individual and collective potential. Good mental health is the foundation for wellbeing and effective functioning both for individuals and their communities. Mental wellbeing is about our ability to cope with life's problems and make the most of life's opportunities; it is about feeling good and functioning well, as individuals and collectively.

Mental ill health takes the largest portion of NHS funding in the city. Poor mental health is a big issue in terms of funding for the local NHS and social care and in terms of the misery it causes individuals, families and communities.

We know that at least one in four people will experience a mental health problem at some point in their life and one in six adults have a mental health problem at any one time. Self harming in young people is not uncommon (10-13% in the UK) of 15-16 year olds have self harmed. Almost half of all adults will experience at least one episode of depression during their lifetime and one in ten new mothers experience postnatal depression. About one in 100 people has a severe mental health problem, with around 60% of adults living in hostels having a personality disorder.

In 2009/10 there were 2,561 people in Southampton recorded on GP Registers as suffering from severe mental illness. City GPs also recorded 1,257 patients on dementia registers and 23,388 on depression registers. The number of 18-64 year olds in the city with a common mental health disorder is projected to rise to 30,223 in 2030. Depression is the most common mental health problem of later life. At any given time 10-15% of over 65s will be depressed (NSF for Older People, 2001). There is considerable unmet need. One in 4 older living in the community have symptoms that are severe enough to warrant intervention, but only one third of older

people with depression ever discuss this with their GP. Only half are diagnosed and treated with anti-depressants.

In the period 2007/08 to 2009/10 the number of people in Southampton on dementia registers increased by over 17% but this change reflects improved recording, changing demographics as well as increased prevalence.

Over the period 2007 to 2009 there were 78 deaths from suicide (or undetermined injury) involving Southampton residents. In comparison with similar cities Southampton has a relatively low suicide rate of approximately 8.2 per 100,000 population. However, this is higher than England and each case represents a tragic and potentially avoidable death.

A review of recent evidence suggests that building the following actions into day to day lives is important for wellbeing, for example:

- connecting with the people around us, with family, colleagues and neighbours. Building these connections will support and enrich our lives
- becoming or remaining active - exercising makes people feel good. Most importantly, discover a physical activity to enjoy and that suits individual level of mobility and fitness.
- taking notice – be curious and be aware of the world how it feels. Reflecting on experiences will help appreciate what matters in life
- learning new things help us feel more confident as well as being enjoyable
- give time – seeing ourselves linked to the wider community can be incredibly rewarding and creates connections with the people around.

(New Economics Foundation 5 Ways to Wellbeing [2008]).

The new Mental Health Strategy *No Health Without Mental Health* (2011) is a cross government strategy for people of all ages, with the ambitious aim to mainstream mental health in England. Locally a multi-agency approach will be addressing the key objectives identified in the Strategy

There are some positive developments in the city – e.g. Steps to Wellbeing Service which is improving access to psychological therapies (IAPT) addressing mild to moderate depression and anxiety continues to develop.

Addressing these needs requires

- choice of psychological therapies available for those who need them
- reduce stigma and discrimination which can result in people with mental health problems not seeking help and unable to engage in ordinary life
- provision of better support for women's mental health during pregnancy and the post-partum period
- societal effort to reduce social isolation thereby reducing risk of depression particularly in older people
- better integration of physical and mental health

Theme 3 Improve early years experience/ better parenting and family support

"Adults should practice what they preach and eat a balanced diet and more fruit so they stay healthy!" … "*Giving children love, affection and time is key."* (Consultation responses)
High levels of inequality prevent many children and young people gaining the best start in life

Marmot recommendations A - *Give every child the best start in life* and F - *Strengthen the role and impact of ill health prevention* (Marmot 2010)

The collective ambition of local agencies working with children, young people and families for the long term wellbeing of every child and young person in the City is set out in the 2009-12 CYPP. Underpinning these priorities is a commitment to address the following needs based priorities;

Raising attainment and transforming the way we organise schools; creating buildings which support the aspirations of children, young people and the wider community.

Historically, the results of children attending Southampton schools have been lower than the results achieved nationally at every stage of measured education. Results for Southampton school children have started to close significantly at the end of Foundation Stage (age 5) and are at or above the national average at Key Stage 1 (age 7). Whilst the gap is closing at Key Stage 2 (age 11) and Key Stage 4 / GCSE (Age 16) there is still some way to go before the results of children attending Southampton schools reach national averages in these latter stages.

Reducing the numbers of young people who are not in education, employment and training (NEET) and improve the numbers of young people who have the right qualifications and skills for a successful adult life. Since levels of 16-18 year NEET started to be measured and became a local authority responsibility, levels in Southampton have been above both national levels and those in comparator authorities. As is the case for GCSE performance, there remain gaps in the performance of children and young people on both Level 2 and Level 3 qualifications at age 19. The City does perform relatively strongly in relation to closing the gap in the percentage of young people from low income households progressing to Higher Education.

Reducing the gaps in outcomes for children and young people from priority neighbourhoods and from socially excluded backgrounds when compared to city averages. There has been significant progress in closing the gap in attainment between young people from priority neighbourhood areas and the City Average in the last three years. The City also performs generally well in relation to the relative educational performance of children and young people with Special Educational Needs, and for children and young people from minority ethnic communities.

Increasing the numbers of young people who take part in positive activities rather than getting involved with crime or anti-social behaviour. There have been significant developments in the scope for children and young people to get more involved in positive activities as a consequence of extended school provision, though results from the Tellus4 survey in 2009 did not indicate strong performance. There have been significant gains in relation to virtually all areas of Youth Offending, and levels of first time entrants to the Criminal Justice System have fallen particularly sharply.

Reducing teenage pregnancy has long been seen as a proxy measure of low aspirations among young people. Southampton has historically been a relatively poor performer in relation to teenage pregnancy rates. In recent years, targeted action with young people in schools and the community does seem to have resulted in a sustained reduction in teenage pregnancy rates for the City. 2009 figures published in February 2011 show a rate of 49.2 per 1,000, and 3rd out of 11 similar

cities, compared to 65.6 per 1,000 in 2001, when Southampton was 10th out of 11 similar cities.

Improving the oral health among children and young people.
By the age of 12 years Southampton children experience significantly higher rates of dental decay (37%) compared to South Central (28.9%) and England (33.4%). This not only reflects data from when children are young (dental health age 5 has historically indicated problems in Southampton), but is significant as this is our first assessment of the population in relation to the oral health adult teeth

Each of the priorities in the CYPP is based upon ongoing needs assessment, set out in the JSNA data compendium.

Theme 4 Taking responsibility for health

"There's not enough P.E in school. Some schools also have embarrassing P.E uniforms so girls start to get into the habit of hating P.E at an early age 'cos of the way they feel when they're in the uniform." (Consultation response)
Lifestyle choices such as smoking, alcohol, diet and low levels of physical activity are responsible for much ill health in Southampton

Marmot recommendations B - *Enable all children, young people and adults to maximise their capabilities and have control over their lives* and E - *Create and develop healthy sustainable places and communities* (Marmot 2010)

Taking responsibility for health and lifestyle are important from cradle to grave; even pre-pregnancy diet, alcohol, smoking and drug consumption and levels of physical activity can have an impact on a child yet to be conceived. Much of the modifiable disease prevalence within Southampton reflects the poor lifestyle choices that many in the City population make.

In Southampton 23.4% of children in reception classes are overweight and a further 10.7% obese; this increases to almost 33.4% overweight by year 6 with 20.2% obese. The standard for obesity in 1990 was 5%. Only 41% of children in the city participate in more than 3 hours of sport a week. Unless parents, our schools and wider society supports these children to have a healthy weight, this will further impact on diseases such as diabetes, cancers and coronary heart disease in later life. Diabetes is increasing by 6% per annum in the city and much of type II diabetes is preventable or the onset can be delayed, but is affecting more children. At any time there are now between 20 and 40 patients in the general Hospital weighing over 30stones. Balancing dietary intake of food against the physical expenditure of energy requires rebalancing to improve health potential of all those who are overweight.

Excessive alcohol consumption is impacting negatively on the city population; there are 41.4 alcohol-attributable deaths per 100,000 amongst males in Southampton compared to a national average of 36.1. In addition to this there are 129.4 alcohol-specific hospital admissions for under 18s per 100,000 in Southampton compared to a national average of 72.3. This misuse costs Southampton around £12 million per annum and puts strain on emergency department resources as well as the abuse and violence suffered by staff. Younger adults are being diagnosed with alcohol induced liver damage increasing hospital demand, some requiring organ transplants.

Southampton is estimated to have smoking prevalence of 22.57% in adults aged 18 years and over, which is significantly higher than the national average of 20.99% (2009-10). However, data from GP records of adults aged 16 years and over shows a rate of 21.35%. Smoking costs the NHS locally £49.8 million and reduces disability free years due to sickness and disease. Each day there is a death due to a smoking related disease, whilst many more young people start the habit.

In common with the rest of the region, drug misuse prevalence is apparently highest among the 25-35 year age group. However, the use of so-called "recreational" drugs is reported to be growing within the under 18 year old age range and also the 18-25 age range, with an increasing number of individuals presenting at the open access services for assistance with stimulant and "legal high" usage.

There are some really positive developments happening in Southampton and continued investment will be required to maintain these improvements. For example, breast feeding initiation has increased to 75% (from 69% in 2008/9). Cardiovascular disease checks are now carried out by all GP practices for 40 – 75 year olds offering support for lifestyle changes.

Addressing these needs requires:

- increasing physical inactivity across the lifespan, particularly in childhood to create a healthy active blueprint for life
- reduce alcohol consumption – the most robust evidence is to increase taxation on each unit of alcohol
- stopping the inflow of young people recruited as smokers
- assisting every smoker to stop their dependence on tobacco and protecting families and communities from tobacco related harm
- re-focus drug treatment services on the need to plan for recovery and re-integration, thus improving the rate of planned exits from treatment

The NHS and City Council cannot maintain a health and social care safety net without Southampton's people playing their part in making sustainable lifestyle changes and reducing the burden of need.

Theme 5 Living with long-term conditions -maximising the quality of life

"Preventing and reducing the burden of long term conditions, particularly those that drastically reduce the quality of an individual's life, have to be a priority, together with better support for carers." (Consultation response)
More people are living with long term conditions in Southampton whose quality of life could be improved

Marmot recommendations B - ***Enable all children, young people and adults to maximise their capabilities and have control over their lives*** **and D -** ***Ensure healthy standard of living for all*** **(Marmot 2010)**

Preventing the onset of disease and disability through adopting healthy lifestyles was a need expressed throughout our consultation. One positive consequence of wider improvements in health and well-being achieved over recent decades has been that more people are living longer. Living longer poses challenges for health and

wellbeing services. In Southampton disability free life expectancy is lower than the national average at 60.9 years for men and 63.4 years for women compared with 61.7 years and 64.2 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.

According to the Department of Health (2010) long term conditions represent 69% of health and care spend, 77% of inpatient bed days, 55% of GP appointments and 68% of outpatient and emergency department appointments. This care transcends organisational boundaries of social care, primary, community and hospital care. Increasing numbers of people have more than one long term condition yet face an increasingly fragmented specialised response.

Around 86,000 people in Southampton are estimated to be living with long term health conditions, such as asthma, diabetes, heart disease, hypertension, dementia, epilepsy and severe mental illness; these conditions are not curable, but treatable and require on-going treatment and monitoring. A further 2,395 people require regular case management to co-ordinate their complex treatment and care needs. Approximately half of those with a long term condition (LTC) report that this condition limits their daily activities or work and many of those who responded to our public consultation stated that long-term stress was an issue detrimental to their wellbeing.

There are an estimated 1,900 children and young people (4.3%) living in Southampton with moderate or severe disabilities. Males make up two-thirds of this group and females a third. The majority of these children live in priority neighbourhoods, with deprivation an additional burden to these children and their family. Their disabilities are generally chronic, limiting and include learning disabilities, physical disability, autistic and sensory disorders.

Proactive disease or case management of long-term conditions can make a real difference to people with a single condition or a range of problems that threaten their health and wellbeing. Some of these patients will be case managed by their GP practice whilst others are case managed by the Complex Care Teams (Joint Health and Social Care teams including Community Matrons). Those who had self-care plans reported that they felt more in control.

End of life care is about enabling people to live their life to the end with dignity and having their choices recognised. Not all people will be able to plan for their death, but for a number of people, particularly with a long-term condition, planned care will enable them to experience a peaceful and dignified death.

In summary these needs were to:

- stay independent, socially engaged and physically active
- be in control and manage my illness
- have better support for carers
- be offered improved care at the end of life and treated with dignity
- ensure that palliative care is extended to people with other diseases besides cancer to ensure equity of access depending on need(e.g. heart failure, COPD)
- have timely bereavement counselling available in all GP practices
- improved integration between health and social care could provide better co-ordination.

Theme 6 More people living longer

"Older people can do fun things too… to stay healthy – if they can't afford 'wi fit' at home, they could come to our youth club – maybe?" (Consultation response)
The ageing profile of Southampton is likely to increase the number of people living with disabilities, as people tend to pick up disabilities through injury or degenerative conditions as they get older

Marmot recommendations D- *Ensure healthy standard of living for all* and E - *Create and develop healthy sustainable places and communities* (Marmot 2010)

Average life expectancy across the city is below the average for England. In 2007/2009 the average life of men was 78.4 years against the England average of 78.25, and for women it was 82.4 years against an England average of 82.31 years.

The fastest growing sector of the population is that aged 65 years and over, with the over 65's set to increase by 14% between 2010 and 2017 whilst the number of people over 85 years is forecast to grow from 5,183 to 6,034.

The ageing population is placing an increasing demand on both health and social care services. For example with joint replacements due to disease and or injury, the number of hip replacements performed increased by 31.9% over 5 years from 2004/05 to 2008/09, while in the same period the number of knee replacements performed increased by 16.3%. Many of those having suffered a fall and fractured hip never get fully back the independence that they previously enjoyed. The chances of having cancers generally increase with age. Within hospital care medical and surgical cancer therapies increase between 4-5% with new patients each year.

Between 2003/04 and 2007/08 the number of people aged 65 and over receiving social care services rose from 181.8 per 1,000 to 194.7 per 1,000, an increase of 7.1% over 5 years. This contrasts with the England average, which fell from 159.1 per 1,000 in 2003/04 to 149.6 per 1,000 in 2007/08, and meant the number of older people receiving social care services was 30% above the average for England by 2007/08. These figures correlate with the lower number of years of disability-free life experienced by people in the economically most deprived neighbourhoods. The number of older people with dementia receiving services grew by 14% between 2004/05 to 2008/09. Whilst new drugs are being developed, the demands for dementia support and care are expected to increase in line with the growth on the population aged over 85.

Long term conditions in later life tend to become more complex and may become multiple, requiring more reactive and proactive and health and social care and carer input as discussed earlier. Within these tight economic constraints, primary, acute and social care services will be under pressure to meet expressed demand, but meeting needs effectively will require smart commissioning to ensure the most vulnerable, including the frail elderly, have a voice.

Age-related macular degeneration (AMD) is the leading cause of sight loss in the western world but only half of adults have heard of it. This was borne out by a poll of more than 4,000 people on behalf of the College of Optometrists. Results indicated a lack of awareness of the condition, with people also unaware that diet and smoking is linked to eye disease.

The key need to be addressed for the current adult population is to

- encourage people to achieve the healthiest possible lives so they can enjoy the highest possible quality of life in old age. Consequently they would then create a lower demand for services when they are older.
- enable those who have reached older age and who require assistance to have choice to access to the appropriate type of good quality accommodation, so they can live independent lives in a community setting for as long as possible.
- use the personalisation of social services to provide an opportunity for those in need and eligible for services to select the style of support that suits their life and expectations, and this will have a significant impact on the existing provision of care, particularly that supplied by the local authority.
- increase the opportunities offered by telemedicine and telecare to maintain older peoples independence at home
- provide access to good quality information and advice for those people in need of support who are not eligible for local authority funded services
- to further integrated discharge and re-ablement teams across health and social care to support those older people who have undergone treatment in hospital
- expand the 24/7 palliative care provision for those who wish to remain at home.

In summary there needs to remain good public health population wide intelligence and analytical function to enable the future health and wellbeing board to perform its oversight of health and social care commissioning.

Theme 7 – Creating a healthier environment

"Lack of green, safe areas and access to low cost sport….overcrowding and poor housing conditions, (Consultation response)
Ensure the physical environment in local areas helps to promote walking, cycling and safe local recreation and play.

Marmot recommendations E - *Create and develop healthy sustainable places and communities* (Marmot 2010)

The environment in which people live has a major influence on health outcomes. Southampton is the 21st most densely populated area in England and Wales, with 47.4 people per hectare (2009), there are strong links between density of population and deprivation. A good home environment provides security, affordable warmth and adequate ventilation. A good work environment minimises risk of the development of long-term illnesses and injuries. A healthy external environment contributes to reduction of crime and improved public safety, lower levels of pollution, access to public transport, access to places for safe play, exercise and recreation. Over time, the development of a more sustainable environment at home, work and externally should contribute to better physical and mental health in the city.

Southampton's position as a major port for the import of goods into the country means a continuing need for a high quality Port Health service. This provides protection not only to residents of the city, but the UK as a whole and Europe.

Southampton City Council has a leading role to play in addressing the issues set out above. The decent homes programme has brought about substantial improvements

to the 18,000 council homes in the city. However, there are major health issues created by poor housing conditions in the privately owned, and private rented sectors. Fuel poverty created by poor insulation and rising energy prices is a major health and wellbeing issue for many residents in the city.

Effective transport planning provides opportunities for access to public transport and provides safe spaces for walking and cycling. The forthcoming review of the Local Transport Plan needs to maximise their potential to improve exercise and activity levels and improve air quality. It also needs to secure adequate public transport at the right times to reduce social isolation, which will then contribute to improved mental health.

Future development plans need to incorporate guidance produced by the National Institute for Health and Clinical Excellence on promoting and creating built environments that encourages and supports physical activity, and planners will need to work with developers to ensure that new developments minimise the opportunity for, and fear of, crime and anti-social behaviour. The maintenance and improvement of existing parks and open spaces and maximising the opportunity for the development of new areas will provide opportunities for people to exercise and socialise.

The council has responsibility for 6,000 places of work and 1,800 food premises in the city. Ensuring compliance with health and safety and pollution legislation reduces the risk of injury and illness and levels of sickness, worklessness and long-term absence from work.

Once the Public Health service is transferred to local government in 2013 it will provide further opportunities for the council to improve its focus on health issues and outcomes.

Theme 8 - Improving safeguarding for children and vulnerable adults

"Good parenting and a stable safe home life…with support from family and an engaged community". "Reducing Social isolation" (Consultation responses)
High numbers of vulnerable families living under pressure means that more children and adults are at risk of harm, and safeguarding needs are high in the city

Marmot recommendations A - *Give every child the best start in life* and B - *Enable all children, young people and adults to maximise their capabilities and have control over their lives* (Marmot 2010)

The 2004 Children Act was created to improve arrangements for effective joint working between public bodies and other service providers in regulating official intervention in family life to meet the interests of vulnerable children. The Act also made changes to laws that pertain to children who are particularly dependent on the actions of public bodies for their wellbeing, notably in relation to children in care, children subject to child protection plans and the handling of crimes against children. It was a central part of the national response the Victoria Climbie Inquiry. A range of outcomes related to vulnerable children are set out in the Every Child Matters framework. These are covered in the JSNA data compendium, but they identify

vulnerability relating to factors such as child poverty, child protection, neglect, abuse or exposure to crime, drugs or alcohol.

The Association of Directors of Adult Social Services published its national framework for safeguarding standards in 2005 and these have been developed and implemented in Southampton. A safeguarding adults policy has been published jointly by Southampton City Council, Portsmouth City Council and Hampshire County Council, and a summary has been made available in leaflet form and as a web document.
www.southampton.gov.uk/living/adult-care/safeguarding-adults-from-abuse/

The Council and its statutory partners have put in place and delivered a major programme of safeguarding awareness training relating to people working with children, young people and vulnerable adults. Safeguarding training is now integrated into induction for the workforce. All relevant employees and volunteers working closely with children, young people and vulnerable adults should be subject to Criminal Records Bureau (CRB) checks. They should also know how to act upon and respond to concerns relating to a child's wellbeing.

In relation to children and young people a number of statutory services exist to ensure that those most vulnerable to abuse, neglect or harm are protected, that those in the care of local authorities and their partners are well provided for, and are supported in entering adult life in their turn well placed to achieve economic wellbeing and to become effective parents. For vulnerable adults the key policy drivers are to;

- ensure that safeguarding practices are fully aligned to the coalition government's Vision for Social Care,
- take actions to increase awareness of safeguarding issues with people who fund their own care and
- increase the number of staff within the independent sector who have accessed training on safeguarding awareness.
- ensure there are adequate resources to investigate safeguarding referrals from people with learning disabilities.
- ensure that teenage and young adults are properly supported when they transfer from children to adult care.

In 10 out of 15 performance measures for children in care, outcomes are improving in 2010-11. Performance in relation to the timeliness of reviews in Child Protection cases also remains strong. Despite this, the number of children and young people needing specialist social care support has risen sharply since September 2008. For example;

- The number of children subject to Child Protection Plans has more than doubled from 106 (a rate of 24.9/10,000) to 252 (58.1/10,000) in December 2010.
- The number of children in local authority care has risen from 283 (a rate of 65.2 per10,000) to 382 (88.0 per10,000) in December 2010.

Theme 9 Protecting people from threats to health

"Preventing diseases is important, vaccinations, school health – make sure sexual health is included" (Consultation response)
Vaccination coverage continues to miss some vulnerable children; sexually transmitted disease including HIV continues to increase in the city year on year

Marmot recommendations A - *Give every child the best start in life* and F - *Strengthen the role and impact of ill health prevention* (Marmot 2010)

Throughout a lifespan there may be many threats to health; this high level assessment will focus on some of the key threats and their mitigation. After clean safe water, immunisation is the most effective public health intervention in the world for saving lives and promoting good health. Immunisations protect the individual, family and the community from the effect of illness, morbidity and mortality, being very cost effective and safe.

The UK national childhood immunisation programme is delivered mainly through primary health care services. The uptake of vaccines in Southampton is relatively high when compared with national data, just below 95% coverage, although there is considerable variation across the city. This reflects a national picture where differences in uptake are associated with a range of social, economic, maternal and infant related factors.

Sexually transmitted infections (STI's) continue to increase in the city with the 16 to 24 age group having over half the burden of disease. Sexual Health Services are treating 50% more people with ano-genital herpes now than in 2005 and 64% increase in chlamydia treatment over the same period. Uptake rates for chlamydia screening remain low in the city so the true burden of disease may be even higher. Ano-genital herpes is the most common ulcerative STI in the UK. It is incurable but can be managed with antiretroviral drugs to prevent further outbreaks and transmission to others. Genital herpes can cause severe systemic disease in the immuno-supressed and is associated with a greater risk of acquiring HIV. It may also cause severe problems in neonates if transmitted from mother to child during birth.

Blood borne viruses - Human Immunodeficiency Virus (HIV) continues to be one of the most important communicable diseases in the UK. It is an infection associated with serious morbidity, high cost of treatment and care, significant mortality and high number of potential life years lost. HIV can lead to the development of AIDS but if detected early can be managed with antiretroviral therapies reducing the incidence of AIDS and preventing early death. From 2004 to 2009 the city has seen an increase of 60% in people diagnosed with HIV and accessing services, 1.57 per 1,000, higher than the South Central Strategic Health Authority average of 1.13 per 1,000 (Office of National Statistics mid 2008 estimates). This does not take into account undiagnosed prevalence, thus the actual rate may be higher. This is very worrying as currently there remains no cure for HIV and drug costs alone to mediate the symptoms cost the city around £1.9million a year.

Hepatitis B and C remain serious public health issues with potentially grave complications, shortening life expectancy. Much of the burden of this disease is undiagnosed. Hepatitis B and C are potentially preventable, as is much of the associated morbidity with timely identification and treatment.

Health Care Acquired Infections (HCAIs) remain a continuous threat and emphasis needs to be placed on the health economy wide efforts to tackle HCAI's. These are infections that are acquired (by patients or staff) following admission to hospital or as a result of healthcare interventions in other healthcare facilities.

Tuberculosis is a growing problem nationally and an issue locally predominantly, but not exclusively, through migration. The typical TB sufferer in the city becomes unwell within the first ten years of arrival. This latent TB requires vigilance to ensure the public know how to access treatment and screening services and requires vigilance on the part of GP practices and occupational health services to be TB aware.

Protection from environmental hazards can be exemplified by that of U/V radiation (sunlight) whereby excessive exposure may give rise to skin cancers. Since 2003 there has been an increase of 100% in malignant melanomas, thankfully the number of people involved is small but prevention is better than cure.

A changing population underpins the above key themes needs

"Southampton as a rich vibrant city has to continue to respond to the changing population and their needs, including the impact on birth rate and migration" (Consultation response)
The city enjoys a diversity of people which enriches our population, but the pace of population change challenges service delivery

Marmot recommendation D- *Ensure healthy standard of living for all* (Marmot 2010)

In 2010 the total population of Southampton is estimated to be 237,470[1] with 264,573 people registered with GP practices. The profile of the City's population differs from the national average because of large number of students; over 17% of Southampton's population is aged between 18 and 24 years compared to just 9.5% nationally.

Southampton is a diverse City; in 2007 it was estimated[2] that 17.3% of residents were of an ethnic group other than White British compared to 16.4% nationally. This is a higher proportion than in most of the Cities considered 'most similar'[3] to Southampton. The annual school census in the City in 2010 revealed that 26.4% of pupils were from an ethnic group other than White British. In 2009/10 32% of live births in Southampton (where ethnicity was known) were non-White British or Irish. Looking at trends in ethnicity of live births, it is the other White background which has risen most significantly in recent years; rising from 8% on 2006/07 to 12% in 2009/10.

Those children under 5 years proportionately use the NHS more than other children. Growth in this group has particularly impacted on maternity and paediatric care and health visitor services. A quarter of all paediatric non-elective admissions are for those children under 4 years of age. Typically a GP sees each pre-school child six times a year and school aged children two or three times.

The number of pupils whose first language is not English has risen from 8.4% in 2007 to 12.7% in 2010 with 54 languages other than English spoken in city schools. In 2007 there were 427 pupils whose first language was Polish by 2010 this had risen to 902.

[1] Hampshire County Council 2010-based Small Area Population Forecasts (Alternative version) – provisional as at February 2011.
[2] ONS experimental statistics
[3] ONS 2001 Classification of Areas

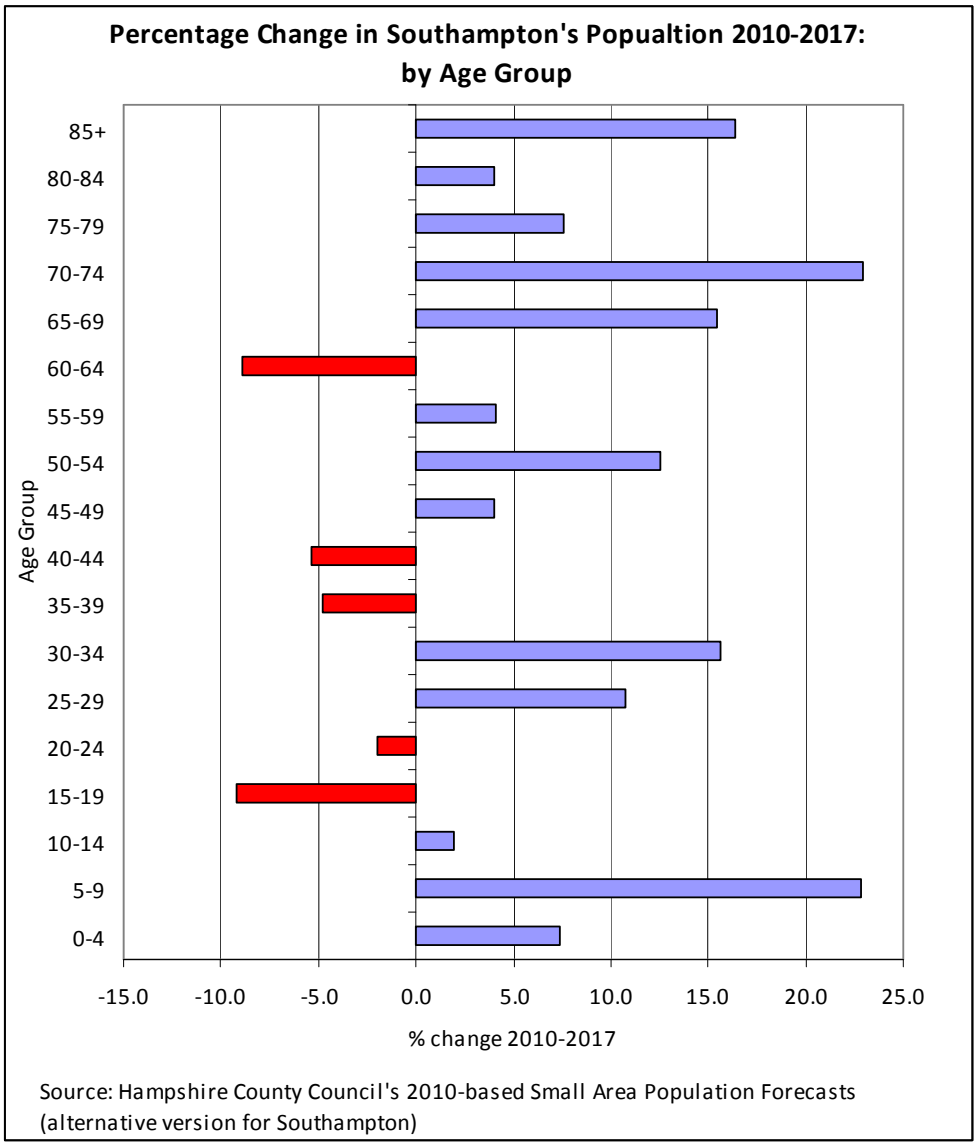
There are many uncertainties around current and future population numbers. There will be a national Census this year (2011) which, if good coverage is achieved, will provide some clarity. However, the results are unlikely to be available until 2012/13 at the earliest. In the meantime, the latest data produced by Hampshire County Council (HCC)[1] provides the best available forecast of the population. These forecasts are based on the planned completions of residential dwellings in the City; they predict an increase in dwellings of 6.4% between 2010 and 2017. Bargate, Woolston and Bevois are the wards set to see the biggest increases in dwellings.

The increase in dwellings across the City translates to a population increase of 11,176 (4.7%) over the same period. It is the older population that will grow proportionally more over the next few years as discussed earlier. Importantly the proportion of the population of working age is steadily declining and this may impact on the informal and community care available to the changing population structure.

According to the HCC forecasts the number of births will increase by 8.5% over the forecast period. However, local monitoring of births at SUHT reveals that since 2004 there has been an average year-on-year increase of about 5% suggesting that despite improvements in the HCC methodology and the use of local fertility assumptions they may still be underestimating the very significant increases in fertility in the City. Between 2003 and 2010 general fertility rates in the City have increased from 48.4 to 56.3 per 1000 females aged 15-44. In 2010 Bitterne ward had the highest fertility rates in at 91.0 per 1000.

A population forecast for the Southampton showing age group changes until 2017 is below. People in age groups 5 to 9 years and 70 to 74 years show the largest increase over 20%, whilst 15 to 19 year and 60 to 64 years show the largest decrease around 8%.

Southampton population changes by age group 2010 to 2017

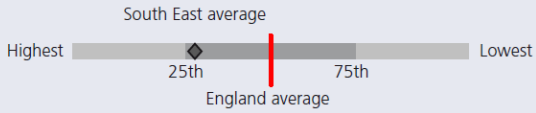


The disease prevention profile that follows is illustrative of the way data can be presented in the JSNA

Health Summary for Southampton

The chart below shows how performance on prevention in this PCT compares to the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which is shown as a bar. The average result for England is shown by a red line, which is always at the centre of the chart. A red circle indicates that this area is significantly worse than England for that indicator. A green circle shows a significantly better performance, but it may still indicate scope for improvement.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated



Domain	Indicator	Local Number	Local Value	England* Median	England* Worst	England Range	England* Best
Pregnancy	A1 Antenatal booking before 12 weeks	2843	72.0	82.3	45.8		100.0
	A2 Smoking in pregnancy	553	n/a	14.9	31.4		4.4
	A3 Screening for infectious disease - Hep B	6186	91.7	*96.5*	*68.7*	No England values available	*100.0*
Infants	B1 Newborn bloodspot screening - PKU	3243	100.0	*99.9*	*97.4*	No England values available	*100.0*
	B2 Breastfeeding initiation	2512	n/a	72.0	39.9		93.0
	B3 Breastfeeding at 6-8 weeks	1233	37.1	41.6	14.7		80.6
	B4 Newborn hearing screening	3054	89.4	94.7	64.2		98.3
Children	C1 Immunisation - MMR	2923	91.0	89.2	73.0		96.7
	C2 Immunisation - PCV	2878	89.6	89.3	63.9		97.4
	C3 Child obesity aged 4-5 years	200	9.3	9.5	14.7		5.9
	C4 Childhood injury	715	166.6	119.9	215.3		68.5
Young people	D1 Immunisation - HPV	924	81.0	78.6	0.3		97.9
	D2 Chlamydia screening	7468	15.6	23.0	8.3		40.8
	D3 48-hour access to GUM clinic	8425	89.4	89.3	69.1		99.6
	D4 Alcohol-specific hospital stays	157	122.5	62.4	168.6		19.8
Adults	E1 Breast cancer screening	10374	71.9	77.5	50.9		84.8
	E2 Cervical cancer screening	44780	75.6	79.3	66.4		85.4
	E3 Bowel cancer screening					Data not available until 2011	
	E4 Diabetic retinopathy screening	8441	91.9	91.4	70.8		98.5
	E5 Successful smoking quitters	1814	923.6	899.6	405.7		1933.9
	E6 Smoking quit rate	1814	50.9	49.1	31.1		69.8
	E7 Smoking status recorded	45919	93.8	95.3	93.3		97.4
	E8 Hepatitis B immunisation in prisoners	n/a	n/a	*36.8*	*3.3*	No England values available	*54.1*
	E9 Hypertension	n/a	11.4	10.7	13.8		8.3
Older people	F1 Warm Front Grants	926	3.9	4.9	0.4		15.6
	F2 Hip fractures	198	466.1	482.2	660.9		327.8
	F3 Immunisation - Flu	22816	73.6	72.4	64.9		78.2

* Where England values are unavailable South East data ranges are presented in purple italics

Notes (numbers in BOLD refer to the above indicators)

A1 % of women who have seen a midwife, or a maternity healthcare professional, by 12 weeks and 6 days of pregnancy 2009/10 **A2** % of mothers smoking at time of delivery 2009/10 **A3** % of pregnant women receiving a hepatitis B test 2008/09 **B1** % screening coverage for phenylketonuria (PKU) in newborns 2008/09 **B2** % of mothers initiating breastfeeding 2009/10 **B3** % of mothers breastfeeding at 6–8 weeks 2009/10 **B4** % hearing screen complete by 4/5 weeks after birth 2009/10 **C1** % of children immunised against measles, mumps and rubella (MMR) by their 2nd birthday 2009/10 **C2** % of children immunised with the pneumococcal conjugate vaccine (PCV) by their 2nd birthday 2009/10 **C3** Prevalence (%) of obesity among children in Reception (aged 4–5 years) 2008/09 **C4** Emergency hospital admissions caused by unintentional or deliberate injuries to under 18s per 10,000 population 2009/10 **D1** % children (school Year 8 girls) receiving human papillomavirus (HPV) vaccinations 2008/09 **D2** % 15–24 year old population tested for chlamydia 2009/10 **D3** % first GUM attendances seen within 2 working days 2009/10 **D4** Persons aged under 18 years admitted to hospital with alcohol-specific conditions, crude rate per 100,000 2006/07 to 2008/09 **E1** % women aged 53–64 years screened for breast cancer in last 3 years 2008/09 **E2** % women aged 25–64 years with less than 5 years since last adequate cervical smear test 2009/10 **E3** No data available until 2011 **E4** % of patients with diabetes who have a record of retinal screening in the previous 15 months 2009/10 **E5** Successful quitters at 4 week follow up as % of those setting a quit date 2009/10 **E6** Successful smoking quitters per 100,000 population aged 16 years and over 2009/10 **E7** % patients with any or any combination of the following conditions: coronary heart disease, stroke or transient ischaemic attack, hypertension, diabetes, chronic obstructive pulmonary disease, chronic kidney disease, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the previous 15 months 2009/10 **E8** % uptake of hepatitis B vaccinations in prisons, within 31 days of reception 2009/10 **E9** Percentage point difference between modelled estimates of the prevalence of hypertension and reported prevalence by GPs 2009/10 **F1** Warm Front Grant qualifying referrals rate per 1000 population 2009/10 **F2** Emergency hospital admissions for hip fracture, directly age-standardised rate per 100,000 persons aged 65 years and over 2009/10 **F3** % persons aged 65 and over immunised against influenza 2009/10.

A guidance document is available alongside this profile to provide additional information for each indicator

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