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Health and Wellbeing Board

Wednesday, 21st September, 2022 at 5.30 pm

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Fielker (Chair)

Councillor Dr D Paffey

Councillor Margetts

Councillor P Baillie

Councillor White

Debbie Chase – Director of Public Health

James House - Managing Director, Southampton Place, Hampshire and Isle of Wight Integrated Care Board

Robert Henderson – Executive Director Wellbeing (Children and Learning)

Terry Clark - Director of Commissioning – Integrated Health & Care (DASS)

Rob Kurn – Healthwatch

Dr Sarah Young - NHS Southampton Clinical Commissioning Group,

Dr Hana Burgess – Mental Health Clinician

Dr Michael Roe – Local Paediatrician

Paul Grundy - Chief Medical Officer at University Hospital Southampton NHS Foundation Trust;

Contacts
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Senior Democratic Support Officer
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BACKGROUND AND RELEVANT INFORMATION

Purpose of the Board

The purpose of the Southampton Health and Wellbeing Board is:

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

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

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

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

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

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

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

Responsibilities

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

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

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

Dates of Meetings: Municipal Year 2022/2023

21 September 2022
14 December 2022
8 March 2023

CONDUCT OF MEETING

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

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

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

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

DISCLOSURE OF INTERESTS

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

DISCLOSABLE PECUNIARY INTERESTS

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

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

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

Other Interests

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

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

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

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

Principles of Decision Making

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

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

In exercising discretion, the decision maker must:

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

AGENDA

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

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

2 ELECTION OF VICE-CHAIR

To elect a Vice Chair for the Municipal Year 2022/23.

3 STATEMENT FROM THE CHAIR

4 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

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

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

5 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meetings held on 6 October 2021 and 2 March 2022 and to deal with any matters arising, attached.

6 UPDATE ON MENTAL HEALTH IN SOUTHAMPTON

Report of the Cabinet Member for Health, Adults and Leisure detailing activity to support and improve mental health in Southampton and seeking support for future priorities

7 TOBACCO, ALCOHOL AND DRUG STRATEGY: UPDATE ON PROGRESS

To receive a presentation from Charlotte Mathews, Public Health Consultant detailing progress with developing the new strategy

8 PHARMACEUTICAL NEEDS ASSESSMENT

Report of the Cabinet Member for Health, Adults and Leisure providing a briefing on the final PNA report following consultation and the amendment process to be followed during the lifetime of the PNA.

9 IMPROVING THE LOCAL FOOD ENVIRONMENT

Report of the Cabinet Member for Health, Adults and Leisure outlining ways to improve the local food environment and detailing the implications of new legislation on high fat, salt and sugar foods.

10 BETTER CARE FUND YEAR END REPORT 2021/2022 AND 2022/23 NARRATIVE PLAN AND TEMPLATES

Report of the Cabinet Member for Health, Adults and Leisure detailing the Better Care Fund Year End Report 2021/2022 and 2022/23 Narrative Plan and Templates

11 CHILD FRIENDLY SOUTHAMPTON UPDATE

Report of the Cabinet Member for Health, Adults and Leisure outlining progress towards Child Friendly City status in Southampton

Monday, 12 September 2022 Director Legal and Governance

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HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 6 OCTOBER 2021

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

Apologies: Councillors

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

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

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

RESOLVED

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

3. **STATEMENT FROM THE CHAIR**

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

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

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

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

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

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

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

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

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

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

6. **HEALTH AND WELLBEING STRATEGY UPDATE**

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

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

RESOLVED

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

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

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

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

RESOLVED

(i) That progress against the development of the Hampshire and Isle of Wight Integrated Care System be noted; and

(ii) That progress on the proposed Place based governance be noted and that comments raised at the meeting contribute to the model development.

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

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

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HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 2 MARCH 2022

Present: Councillor White, Rob Kurn, Debbie Chase, and Dr Sarah Young

Apologies: Councillors Streets

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

The apologies of Councillor Streets were noted.

19. **STATEMENT FROM THE CHAIR**

The Chair noted that in light of the current Covid Omicron variant surge the meeting would be held as a hybrid meeting. To be lawfully constituted it would still be held in the Civic Centre and open to the public but only core members of the Board along with key supporting officers would be in the room in order to keep everyone as safe as possible. Other officers, elected members and the public had been encouraged to join the meeting via Microsoft Teams and contribute that way.

The Board noted that the Board members: Councillor P Baillie; Councillor Fielker; Guy Van Dichele, Executive Director for Wellbeing for Adults and Health; and Robert Henderson, Executive Director for Wellbeing for Children and Learning had joined the meeting via Microsoft Teams and with the consent of the chair contributed to the meeting.

20. **HEALTH AND WELLBEING BOARD MEMBERSHIP AND WORKING PRINCIPLES**

The Board considered the report of the Cabinet Member for Health and Adult Social Care proposing updates to membership and new working principles for the Health and Wellbeing Board.

Mirembe Woodrow, Public Health Senior Practitioner, was present and with the consent of the chair addressed the meeting.

The Board noted that increased involvement of the voluntary, community and social enterprise groups would be valuable and that as partnership forum representatives of these groups should be invited to contribute to the Board through a process that would also be relevant to their service delivery and resources.

RESOLVED:

(i) That recommendations would be submitted to Council which proposed that the terms of reference and membership of the board be amended as outlined in paragraphs 9 and 10

(ii) That the working practices set out in the report would be adopted by the Board to enhance effectiveness, efficiency and influence across the local health and wellbeing landscape.

(iii) That representatives of relevant voluntary, community and social enterprise groups would be invited to participate in thematic discussions at Board meetings
(iv) That the membership of the board would be reviewed after 12 months.

21. **PHARMACEUTICAL NEEDS ASSESSMENT DRAFT REPORT**

The Board considered the report of the Cabinet Member for Health and Adult Social Care which requested that the Board approved the Pharmaceutical Needs Assessment (PNA) Draft Report to be distributed for consultation.

Becky Wilkinson, Public Health Consultant was present and with the consent of the Chair addressed the meeting.

The Board noted that in addition to the needs highlighted by the assessment, there were some areas of the city where residents had reported difficulties accessing pharmaceutical services by public transport or outside of normal hours and that digital pharmacies had also impacted on how residents access pharmaceutical services.

RESOLVED:

(i) that the PNA Draft Report for consultation be approved
(ii) that representation would be made to NHS England which highlighted that Southampton had identified that public transport access and the impact of digital pharmacies should also be taken into consideration in the PNA.

22. **PROPOSAL TO ADOPT A NEW PHYSICAL ACTIVITY STRATEGY FOR SOUTHAMPTON**

The Board considered the report of the Cabinet Member for Health and Adult Social Care which outlined a proposal to adopt the HIOW 'We Can Be Active' Strategy as the new Physical Activity Strategy for Southampton.

Becky Wilkinson, Public Health Consultant was present and with the consent of the Chair addressed the meeting.

The Board noted that:

- The new strategy would provide strong links with other key strategy's such as the Green City and Child Friendly City strategies.
- The new strategy should take into account those provisions in the previous strategy that had been effective.
- The new strategy should provide a clear understanding of what is considered 'activity' and should make sure that provision would be accessible by residents in their locality.

RESOLVED:

(i) That the 'We Can Be Active' strategy would be adopted as the new physical activity strategy for Southampton.
(ii) That a local Southampton Action Plan would be co-produced by the internal Southampton City Council Physical Steering Group and the external Southampton Physical Activity Alliance

(iii) That analysis would be carried out on the effectiveness of the previous Physical Activity Strategy

23. **THE LOCAL AUTHORITY DECLARATION ON HEALTHY WEIGHT**

The Board considered the report of the Cabinet Member for Health and Adult Social Care which detailed the actions taken for Southampton City Council (SCC) to sign-up to the Local Authority Declaration on Healthy Weight.

Ravita Taheem, Senior Public Health Practitioner, was present and with the consent of the Chair, addressed the meeting.

The Board noted that the declaration provided the opportunity to celebrate what had already been achieved and to focus on what needed to be improved

RESOLVED:

(i) That the SCC Healthy Weight Declaration action plan be approved.
(ii) That the Board recommended that the Council signed the Local Authority Declaration on Healthy Weight and embedded the Healthy Weight Declaration as a key strategic priority across the whole council.

24. **CHILDREN AND YOUNG PEOPLE STRATEGY**

The Board received and noted the report of the Executive Director for Children and Learning which outlined the key developments undertaken over the last two years to improve outcomes for Children and Young People in Southampton and priorities for improving outcomes moving forward.

Donna Chapman, Associate Director, Integrated Commissioning Unit, was present and with the consent of the Chair addressed the meeting.

The Board noted that the strategy would be launched in April and included four key areas where a collaborative approach was required for key outcomes to be achieved.

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DECISION-MAKER:	HEALTH AND WELLBEING BOARD
SUBJECT:	PROPOSAL TO ADOPT THE PREVENTION CONCORDAT FOR BETTER MENTAL HEALTH FOR SOUTHAMPTON
DATE OF DECISION:	21 SEPTEMBER 2022
REPORT OF:	CABINET MEMBER FOR HEALTH, ADULTS AND LEISURE

CONTACT DETAILS				
Executive Director	**Title**	Director of Commissioning, Integrated Health and Care		
	Name:	Terry Clark	Tel:	
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Author:	**Title**	Consultant in Public Health		
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STATEMENT OF CONFIDENTIALITY
None
BRIEF SUMMARY
This report seeks approval to proceed with the adoption of the Office for Health Improvement and Disparities (OHID) Prevention Concordat for Better Mental Health for Southampton, which aims to improve mental health through a prevention-based approach. Improving mental health and wellbeing of residents is identified within the Southampton Health & Wellbeing Strategy and Health and Care Strategy, however there is not currently a city-wide mental health and wellbeing plan for adults. Adopting the concordat would involve committing to the development of a Southampton mental health and wellbeing plan for adults and creating a multi-agency city partnership as part of OHID's 5-domain framework. We propose the plan would sit under Southampton's Health and Wellbeing Strategy and Board, alongside Southampton's Suicide Prevention Plan.
RECOMMENDATIONS:

	(i)	To proceed with the preferred option to adopt the OHID Prevention Concordat for Better Mental Health for Southampton, including the following steps: • Submit an application to OHID to join the Prevention Concordat • Establish a multi-agency partnership for adult mental health & wellbeing, with links to relevant groups and networks • Identify a leader for adoption of the Concordat in Southampton who ideally sits on the Health & Wellbeing Board

		• Review the Hampshire and Isle of Wight (HIOW) Mental Health Needs Assessment alongside data and intelligence around need for Southampton • Conduct a Community Asset Mapping exercise • Co-develop a plan for mental health and wellbeing based on local priorities
	(ii)	To continue with a separate multi-agency Southampton Suicide Prevention Partnership for the city, to support the delivery of the Southampton Suicide Prevention Plan 2020-23.
REASONS FOR REPORT RECOMMENDATIONS		
1.	Mental wellbeing is more than the absence of mental illness, it is linked with an individual's emotional, physical and social wellbeing and the wider social, economic, cultural and environmental conditions in which they live. A recent ICS-level HIOW Mental Health Needs Assessment identified, and reviewed the distribution, of risk factors and protective factors for mental health across HIOW, including vulnerabilities relating to children and young people, poverty and financial insecurity, education, employment, and housing. Certain groups were identified as being at greater risk of poor mental health including people who are homeless or unemployed, on low incomes or financially insecure, using substances or alcohol, who have had a number of Adverse Childhood Experiences, those living in areas of high crime or who have experienced violence and those in contact with the criminal justice system. Carers, those with long term conditions or disability, including autism and ADHD, those who identify as LGBTQ+, people from Black African and Caribbean backgrounds, Pakistani and Bangladeshi men, older people, those who have been bereaved, care leavers and those transitioning from child and adolescent mental health services (CAMHS) services may also all be at increased risk of poor mental health.
2.	The mental health needs assessment highlighted that Southampton has a consistently higher prevalence of risk factors for mental health (such as alcohol misuse and poor housing), in addition to a lower prevalence of protective factors (such as educational attainment and financial security) compared with England average and is often higher than HIOW neighbours[1]. Risk factors relating to children and young people (CYP) were particularly highlighted for Southampton including significantly worse rates for children in care due to abuse or neglect, looked after children, young people in employment, education, or training, and income deprivation affecting children, compared to the England average[1]. The prevalence of these risk factors in CYP will contribute to poor mental health that may be experienced later on in adulthood. Within the city, these risk and protective factors are not equal amongst the population, with worse outcomes strongly and consistently associated with residents living in the most deprived areas of the city[2].
3.	In Southampton, the estimated prevalence of common mental health disorders (aged 16+ years) such as depression and anxiety, is around 1 in 5

[1] HIOW Mental Health Needs Assessment: 1. Facts; 2. Voices, 3. Act, 2022

[2] Southampton Data Observatory: Neighbourhood Needs Analysis 2021 [Accessed July 2022] https://data.southampton.gov.uk/images/neighbourhood-need-analysis-may 2021_tcm71-454135.pdf

	(18.7%). This is significantly worse than the England and South East average, and the highest prevalence amongst HIOW neighbours[3,]. The projected prevalence of common mental health disorders is also increasing over time[4]. This pattern of poor mental health in the City is also reflected in self-reported wellbeing with Southampton having the highest proportion of individuals reporting a low happiness score in 2020/21 across HIOW. Just over 1% of people in Southampton have a diagnosis of severe mental illness (SMI), which is a little higher than England, South East, and most parts of HIOW. People with SMI are at a greater risk of poor physical health and have a higher premature mortality than the general population. In England they die an average 15 to 20 years earlier than the general population and have 3.7 times higher death rate for ages under 75 than the general population.[1] Self-reported wellbeing and prevalence of common mental disorders do not mirror the expected distribution of mental health as predicted by risk and protective factors and at-risk groups. It is likely that there is more undiagnosed and unrecognised poor mental health in Southampton.
4.	COVID-19 is recognised as a public mental health emergency that has exacerbated existing mental health inequalities. The HIOW Mental Health Needs Assessment found through a series of stakeholder interviews, that mental health needs and demand had changed over the course of the pandemic[1]. This included an overall increased in lower-level mental health issues and an exacerbation of existing mental health issues due to isolation and loneliness. Due to the social and economic consequences of the pandemic, OHID states that tackling mental health at a population level has never been more important, and promotion of better mental health and prevention should be included in restoration and recovery plans.
5.	The improvement of residents' mental health and wellbeing is a core priority that runs across multiple Southampton strategies including the Health and Wellbeing Strategy, Health and Care Strategy, Children and Young People's Strategy, and the Suicide Prevention Plan among others. There is also a strong focus on improving mental health service delivery under the HIOW adult community mental health transformation programme (No Wrong Door), of which Southampton City Council is a partner organisation.
6.	The Council will have signed up to the Mental Health Challenge, coordinated by the Centre for Mental Health[5]. This is a network of local authorities started in 2012 who are recognised for their commitment for introducing effective interventions and speaking up for mental health. There are now more than 130 councils in England with Member Champions for mental health. This Challenge sets out a commitment to the belief that as a local authority we have a crucial role to play in improving the mental health of everyone in our community and tackling some of the widest and most entrenched inequalities in health. Southampton City Council will align our local mental health work to that of the network, supported by our SCC mental health champion.

[3] OHID, Fingertips: Mental Health & Wellbeing JSNA Profile [Accessed July 2022] Mental Health and Wellbeing JSNA - OHID (phe.org.uk);

[4] Southampton Data Observatory: Mental Health JSNA 2019 – Data Compendium Resource, Tab: MHProject18to64 [accessed July 2022]. Mental health and wellbeing (southampton.gov.uk)

[5] Mental Health Challenge, Centre for Mental Health [Accessed August 2022] Mental Health Challenge | Centre for Mental Health

7.	Work is already taking place across the city to prevent poor mental health and promote wellbeing such as that carried out by the Southampton Suicide Prevention Partnership, CYP Emotional Mental Health Steering Group, and partner organisations. In addition to multiple teams in Southampton City Council (SCC) and organisations in the city working to improve the wider determinants of health. However, currently there is no specific mental health and wellbeing plan or partnership group within Southampton that brings together the wide range of SCC teams and partner organisations across the City to prevent poor mental health and promote wellbeing for adults. This gap means that while action is being taken across the city, this is not being informed by a collective vision, is often conducted in isolation, and is at risk of duplication. There is also a missed opportunity for collaborative working at scale and sharing of capacity and resources.
8.	The Prevention Concordat for Better Health is a nationally recognised commitment created by OHID that aims to take a prevention-based approach to public mental health. Its purpose is to improve the mental health and wellbeing of residents by improving the wider determinants for mental health including both protective and risk factors and reducing health inequalities. It has been adopted by more than 50 local authorities in England (including Hampshire County Council) as well as a wide range of national statutory organisations, professional bodies, and voluntary, community and social enterprise (VCSE) organisations.
9.	The commitment involves the use of an established 5-domain framework for effective local action on better mental health, including: 1. Needs and asset assessment 2. Partnership and alignment (multi-agency group) 3. Translating into deliverable commitments (local plan) 4. Defining success outcomes and evaluation 5. Leadership and accountability Through adopting the Concordat and taking coordinated local action, the aim is for Southampton to better enable the prevention of poor mental health and promote wellbeing for its residents.
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
10.	To produce a local mental health and wellbeing plan independently and not adopt the Concordat. This is not recommended due lost opportunity for support from OHID via an established and nationally supported framework, community of practice, and suite of guidance and resources. In addition to lacking a joined-up approach within HIOW Integrated Care System (ICS).
11.	To not adopt the concordat or produce a local mental health and wellbeing plan, continuing only with the Suicide Prevention Plan. This is not recommended due to the lost opportunity to improve Southampton residents' mental health and wellbeing, as informed by the HIOW Mental Health and Wellbeing Needs Assessment.
DETAIL (Including consultation carried out)	
12.	Southampton City Council previously developed a Public Mental Health Strategy 'Be Well' (2012-2015) in partnership with Southern NHS Trust which

	focused on prevention and addressing mental health stigma, however this is no longer active.
13.	The first HIOW Mental Health Needs Assessment for adults has been commissioned at an ICS level (released in June 2022). This has involved analysis of relevant public health data indicators, qualitative interviews conducted with stakeholders, and development of six high-level recommendations. Adoption of the OHID Prevention Concordat is based on recommendation 3: Embed prevention throughout all care and support with earlier intervention.
14.	The proposed multi-agency partnership group (framework domain 2) would include teams and organisations which can impact on mental health and wellbeing in Southampton, including risk and protective factors for mental health. Related groups and networks within Southampton such as the Suicide Prevention Partnership will be linked in via member representatives.
15.	The Southampton Suicide Prevention Plan[6] aims to reduce the number of suicides in Southampton and ensure provision of support to those who are bereaved by suicide, focusing on but not limited to groups at high risk of taking their own life. It sits under the Southampton Health and Wellbeing Board with direct oversight by the Southampton Suicide Prevention Partnership (led by Public Health). Actions within the plan are delivered by members across the partnership. The 2018-20 Southampton suicide audit is currently being carried out by the Public Health team and due for completion in September 2022 and will inform additional or updated priorities of the plan.
16.	The Hampshire and Isle of Wight ICS Suicide Prevention Programme received £1.2m funding from NHS England over three years ending March 2022. The programme was led by public health across HIOW, including Southampton City Council. There were three areas of focus for the programme, based on evidence provided by National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) about the highest levels of need and included men (particularly those aged 35-54), people who use mental health services and people who have self-harmed. All HIOW workstreams were chosen on this basis and underpinned by local needs. The programme has included suicide specific bereavement support, real time surveillance (RTS), workforce training, self-harm support, workplace postvention and support, primary care awareness and support, co-occurring mental health and substance use, grants awarded to voluntary, community and social enterprise organisations, and development of a People with Lived Experience (PLE) Bureau.
17.	Southampton City Council delivers Mental health awareness campaigns to promote better mental health and wellbeing for residents. Recent campaigns have been delivered jointly between Public Health and SCC Communications teams and cascaded to partners, including World Wellbeing Week (June 27th – July 3rd) reaching an audience of >11,000 people through social media and >2,500 views of promotional videos, Mental Health Awareness Week (May 9th – 15th) reaching an audience of >10,000 people on social media, and Loneliness Awareness Week (June 13th – 19th) reaching >2,000 people on social media. Plans are currently underway for Suicide Prevention Day in

[6] Southampton Suicide Prevention Plan 2020-23 Action for Southampton Suicide Prevention Plan.pdf

	September, with a joint HIOW approach. Delivery of these annual campaigns would be incorporated into the new local mental health and wellbeing plan.
18.	SCC has previously adopted the Time to Change Employer Pledge for workplace mental health and promoted this to Southampton employers. This was complemented by the SCC 'Wellbeing@Work' programme involving advice and events for employers. Both initiatives were led by HR and supported by Public Health, however, Time to Change Employer Pledge has since been decommissioned nationally and the Wellbeing@Work Programme is no longer active. SCC also employs Mental Health First Aid Champions and Wellbeing Champions who are supported by HR. Workplace mental health and wellbeing initiatives would be incorporated into the new mental health and wellbeing plan to improve the mental health of SCC staff and support employers in Southampton.
RESOURCE IMPLICATIONS	
Capital/Revenue	
19.	There are no resource implications inherent in adopting the concordat. Signing up to the concordat has no cost as it is funded centrally via OHID as part of the Department for Health and Social Care. Any new local plan can be developed within current funding levels and areas for development or additional funding will be flagged.
Property/Other	
20.	There are no property or other implications.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
21.	This paper is within the remit of the Health and Wellbeing Board to approve.
Other Legal Implications:	
22.	The creation of any new local plan for mental health and wellbeing would follow SCC Policy guidance on public consultation.
RISK MANAGEMENT IMPLICATIONS	
23.	Although it is not a statutory requirement to adopt the concordat, Southampton's population has a high level of risk factors for poor mental health and low levels of protective factors[1], in addition a higher prevalence of mental health disease which justifies coordinated action across the city, led by SCC.
24.	In 2018, Hampshire County Council adopted the concordat and for IOW Council the process is now underway. By Southampton also joining this would create parity with our neighbours and an opportunity for a joined-up approach within the ICS, (and nationally), reducing duplication and encourage collaborative working and pooling of resources locally.
POLICY FRAMEWORK IMPLICATIONS	
25.	The Policy team will review all relevant Southampton strategies relating to mental health and wellbeing to ensure alignment and integration of any new local plan – this has been scheduled to begin in September 2022.

KEY DECISION?	**No**
WARDS/COMMUNITIES AFFECTED:	
SUPPORTING DOCUMENTATION	
Appendices	
1.	None

Documents In Members' Rooms

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

Title of Background Paper(s)		**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.	OHID Prevention Concordat for Better Mental Health Framework: Prevention Planning Resource for Local Areas	Not exempt or confidential

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DECISION-MAKER:	**Health and Wellbeing Board**
SUBJECT:	**Pharmaceutical Needs Assessment Final Report and Process for dealing with changes**
DATE OF DECISION:	**21st September 2022**
REPORT OF:	**COUNCILLOR FIELKER** **CABINET MEMBER FOR HEALTH, ADULTS AND LEISURE**

CONTACT DETAILS				
Executive Director	**Title**	Director of Commissioning, Integrated Health and Care		
	Name:	Terry Clark	Tel:	023 80
	E-mail	Terry.Clark@nhs.net		
Author:	**Title**	Public Health Consultant		
	Name:	Becky Wilkinson	Tel:	07774 336072
	E-mail	Becky.Wilkinson@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY
NOT APPLICABLE
BRIEF SUMMARY
The Health and Wellbeing Board (HWB) has a statutory responsibility to publish a statement of the needs for pharmaceutical services of the population in its area, referred to as a Pharmaceutical Needs Assessment (PNA). The draft PNA was approved by the HWB in March 2022 and was then subject to a 60-day statutory consultation. The main finding of the PNA draft report was that, in Southampton, the number, distribution and choice of pharmaceutical services meet the current and future needs of the population. Therefore, there was no identified need for improvements or better access to pharmaceutical services in the city. This finding was endorsed by the majority of the consultation responses. This briefing reports on the consultation responses to the draft PNA and proposes that no change is made to the PNA report as a result. This briefing also describes the on-going responsibilities of the HWB in respect to changes to the need for, or the availability of, pharmaceutical services during the lifetime of the PNA and proposes a process for dealing with these changes. The HWB is asked to approve both the PNA final report and the process for dealing with changes.
RECOMMENDATIONS:

	(i)	To approve the PNA final report

	(ii)	To approve the process for dealing with changes to the need for, or the availability of, pharmaceutical services during the lifetime of the PNA
REASONS FOR REPORT RECOMMENDATIONS		
1.	The PNA report has been prepared using national guidelines, following a process agreed by the HWB and with guidance from the PNA Steering Group. The consultation on the draft PNA also followed due process and the responses were analysed by the SCC Research and Insights team then given thorough consideration by the PNA Steering Group. The proposed process for dealing with changes during the lifetime of the PNA is based on national guidance and has been developed through discussion with the PNA Steering Group.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
	NOT APPLICABLE	
DETAIL (Including consultation carried out)		
	Final PNA Report following the Consultation A consultation on the draft PNA Report was held, in line with the statutory requirements, during April and May 2022. The PNA steering group considered the consultation responses and, as the majority of respondents supported the conclusions of the PNA, the group agreed that no changes to the document should be made. Appendix 1 of this briefing is a report of the consultation which will also be made available on the PNA pages of the SCC Data Observatory website; a summary of this report, and of the steering group's considerations, is included as Appendix C in Part 2 of the PNA Report (see Appendix 3 of this briefing). The two parts of the final PNA report, following the consultation, are included as Appendix 2 and 3. Note the only changes from the draft PNA report (which was approved by the HWB in March 2022) are to report on the consultation and the fact that no change to the PNA conclusions is required as a result. Process for dealing with changes to pharmaceutical services Appendix 4 sets out a process for dealing with changes to the need for, or the availability of, pharmaceutical services during the lifetime of the PNA. This sets out the legal responsibilities for HWBs in relation to the requirements for producing a new PNA or publishing a 'supplementary statement' (which is statement of fact describing significant changes to the availability of pharmaceutical services). The main stages of the process are as follows: Any significant changes in the need for pharmaceutical services will be identified via a standing item at the Southampton Joint Strategic Needs Assessment (JSNA) Steering Group. The changes will then be reported to the	

	named Public Health Consultant leading on the PNA who will be responsible for briefing the HWB, or delegated sub-committee, of the change. The HWB (or sub-committee) will decide whether producing a new PNA would be a disproportionate response to the changes identified. NHS England (NHSE) provide quarterly updates on changes in the availability of pharmaceutical services to interested parties. Going forward, NHSE have been asked to include the generic email address strategic.analysis@southampton.gov.uk in the distribution list for these updates. This email address is checked at least once a week by the Data, Intelligence and Insight Team. The Data, Intelligence and Insight Team will make the first check of the notified change to see if any further action is required. This will include updating a map, if necessary, which will be held on the PNA pages of the Data Observatory website to show the locations of pharmaceutical services in the city. If further action is required, or if there is any uncertainty, the change will be escalated to the named Public Health Consultant leading on the PNA who will be responsible for briefing the HWB of the change. The HWB, or delegated sub-committee, will use the decision-making flowchart from national guidance to decide if a new PNA or supplementary statement is needed. If a supplementary statement is needed, the HWB will use the templates available in the national guidance and publish the statement on the PNA pages of the SCC Data Observatory website.
RESOURCE IMPLICATIONS	
Capital/Revenue	
	None
Property/Other	
	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
	There is a legal duty to undertake this work as part of the NHS (Pharmaceutical & LPS) Regulations 2013, which result from the amended Health Act 2009.
Other Legal Implications:	
	None
RISK MANAGEMENT IMPLICATIONS	
	If the final PNA report is not adopted by the HWB at its September meeting, then there is a risk of not meeting the deadline for publication of 1st October

	2022 (in a form that complies with the minimum requirements set out in the 2013 regulations) which presents a theoretical risk of judicial review.
POLICY FRAMEWORK IMPLICATIONS	
	None

KEY DECISION?	**N/A**
WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices	
1.	Report of the PNA consultation
2.	PNA Report Part 1 Main: Report
3.	PNA Report Part 2: Appendices
4.	Process for dealing with changes in the need for, or the availability of, pharmaceutical services

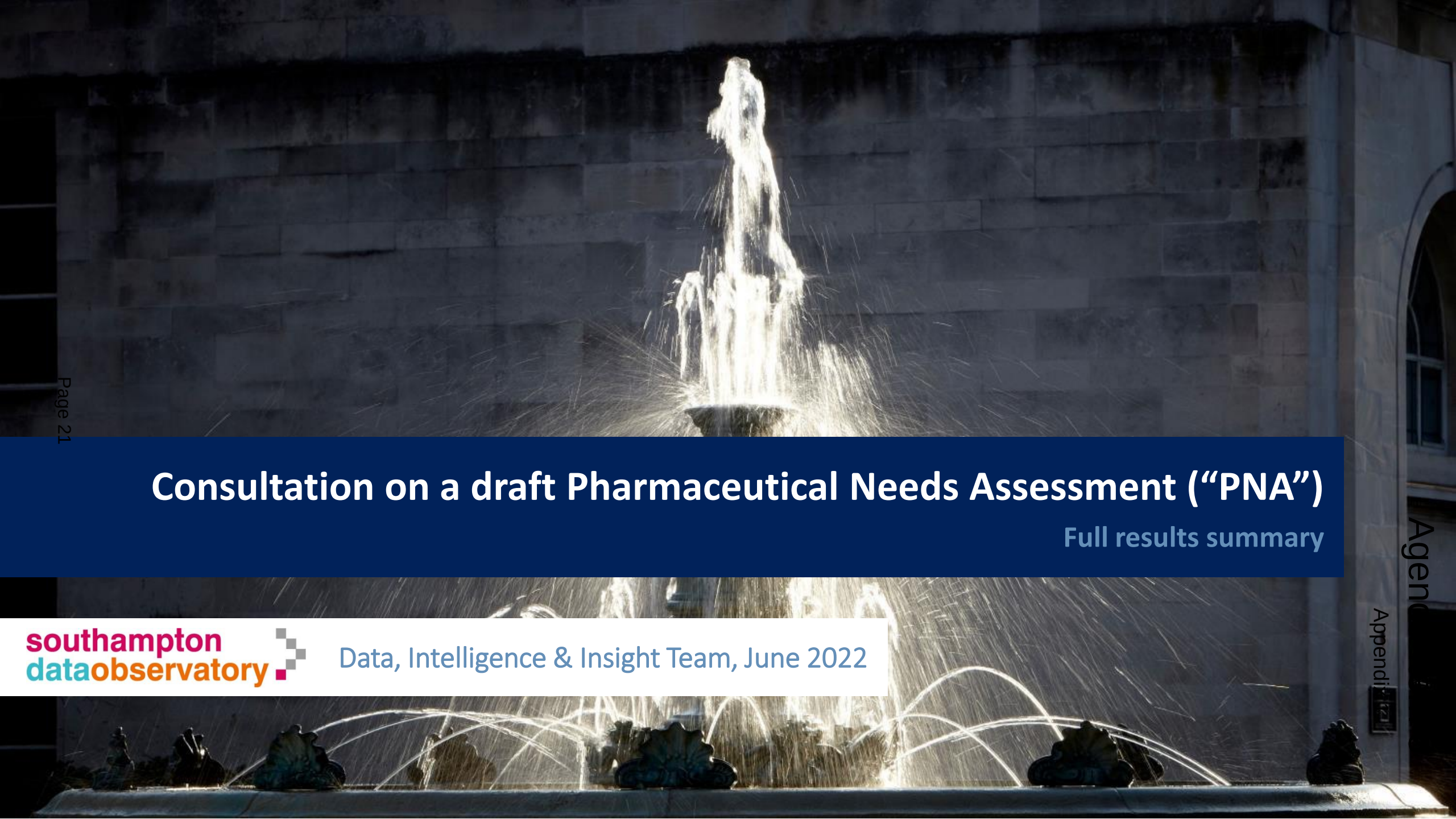
Documents In Members' Rooms

	None
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.	**Yes (included in Part 2 of the Final PNA report – see Appendix 3)**
Data Protection Impact Assessment	
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out.	**No**

Other Background Documents

Other Background documents available for inspection at:

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



Consultation on a draft Pharmaceutical Needs Assessment (“PNA”)

Full results summary

southampton dataobservatory

Data, Intelligence & Insight Team, June 2022

Contents

Introduction & methodology

Southampton City Council undertook public consultation on a draft Pharmaceutical Needs Assessment ("PNA") for Southampton, Portsmouth, Hampshire, and the Isle of Wight.

The consultation took place between **Friday 01 April** and **Sunday 31 May 2022**.

The aim of this consultation was to:

- Communicate clearly to residents and stakeholders the proposed content of the Pharmaceutical Needs Assessment;
- Ensure any resident, business or stakeholder who wished to comment on the proposals had the opportunity to do so, enabling them to raise any impacts the proposals may have, and;
- Allow participants to propose alternative suggestions for consideration which they feel could achieve the objective in a different way.

This report summarises the aims, principles, methodology and results of the public consultation. It provides a summary of the consultation responses both for the consideration of decision makers and any interested individuals and stakeholders.

It is important to be mindful that a consultation is not a vote, it is an opportunity for stakeholders to express their views, concerns and alternatives to a proposal. Equally, responses from the consultation should be considered in full before any final decisions are made. This report outlines in detail the representations made during the consultation period so that decision makers can consider what has been said alongside other information.

Introduction & methodology

Southampton City Council is committed to consultations of the highest standard, which are meaningful and comply with the **Gunning Principles** (considered to be the legal standard for consultations):

1. ***Proposals are still at a formative stage (a final decision has not yet been made)***
2. ***There is sufficient information put forward in the proposals to allow 'intelligent consideration'***
3. ***There is adequate time for consideration and response***
4. ***Conscientious consideration must be given to the consultation responses before a decision is made***

Local Government Association

New Conversations 2.0
LGA guide to engagement

Rules: The Gunning Principles

They were coined by Stephen Sedley QC in a court case in 1985 relating to a school closure consultation (R v London Borough of Brent ex parte Gunning). Prior to this, very little consideration had been given to the laws of consultation. Sedley defined that a consultation is only legitimate when these four principles are met:

1. **proposals are still at a formative stage**
   A final decision has not yet been made, or predetermined, by the decision makers
2. **there is sufficient information to give 'intelligent consideration'**
   The information provided must relate to the consultation and must be available, accessible, and easily interpretable for consultees to provide an informed response
3. **there is adequate time for consideration and response**
   There must be sufficient opportunity for consultees to participate in the consultation. There is no set timeframe for consultation,[1] despite the widely accepted twelve-week consultation period, as the length of time given for consultee to respond can vary depending on the subject and extent of impact of the consultation
4. **'conscientious consideration' must be given to the consultation responses before a decision is made**
   Decision-makers should be able to provide evidence that they took consultation responses into account

These principles were reinforced in 2001 in the 'Coughlan Case (R v North and East Devon Health Authority ex parte Coughlan[2]), which involved a health authority closure and confirmed that they applied to all consultations, and then in a Supreme Court case in 2014 (R ex parte Moseley v LB Haringey[3]), which endorsed the legal standing of the four principles. Since then, the Gunning Principles have formed a strong legal foundation from which the legitimacy of public consultations is assessed, and are frequently referred to as a legal basis for judicial review decisions.[4]

1 In some local authorities, their local voluntary Compact agreement with the third sector may specify the length of time they are required to consult for. However, in many cases, the Compact is either inactive or has been cancelled so the consultation timeframe is open to debate
2 BAILII, England and Wales Court of Appeal (Civil Decision) Decisions, Accessed: 13 December 2016.
3 BAILII, United Kingdom Supreme Court, Accessed: 13 December 2016
4 The information used to produce this document has been taken from the Law of Consultation training course provided by The Consultation Institute

Compiled by the Local Government Association and The Campaign Company, with help from The Consultation Institute **February 2019**

southampton dataobservatory

Introduction & methodology

The agreed approach for this consultation was to use an online questionnaire as the main route for feedback. Questionnaires enable an appropriate amount of explanatory and supporting information to be included in a structured questionnaire, helping to ensure respondents are aware of the background and detail of the proposals.

Respondents could also write letters or emails to provide feedback on the proposals. Emails or letters from stakeholders that contained consultation feedback were collated and analysed as a part of the overall consultation.

The consultation was promoted in the following ways:

- Posts on social media channels Facebook and Twitter;
- Links via the Southampton City Council website, and;
- Emails sent to specified organisations.

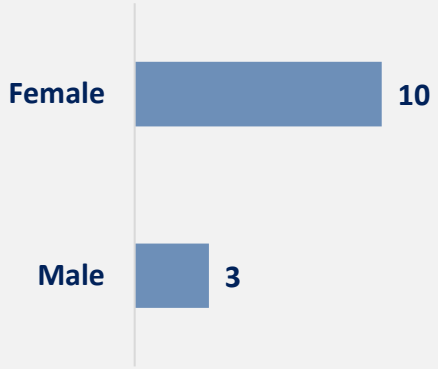
All questionnaire results have been analysed and presented in graphs within this report. Respondents were given opportunities throughout the questionnaire to provide written feedback on the proposals. In addition anyone could provide feedback in letters and emails. We have provide quotes all the free text feedback provided.

Who were the respondents?

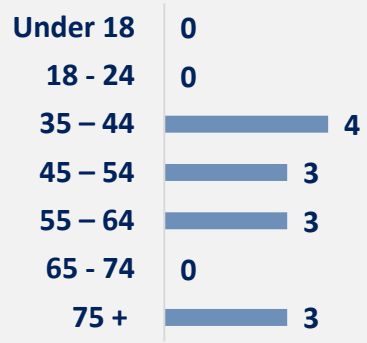
Overall, there were **21** separate responses to the consultation. The following page includes demographic breakdowns of the respondents by *count*.

	Count
Questionnaire	19
Emails, letters	2
Total	21

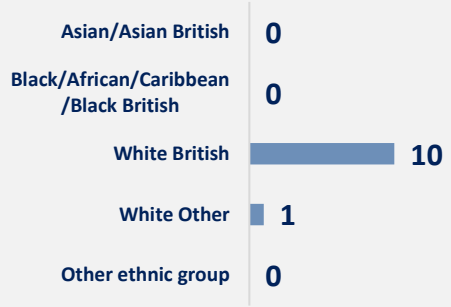
Q13 What is your sex?



Q15 What is your age?

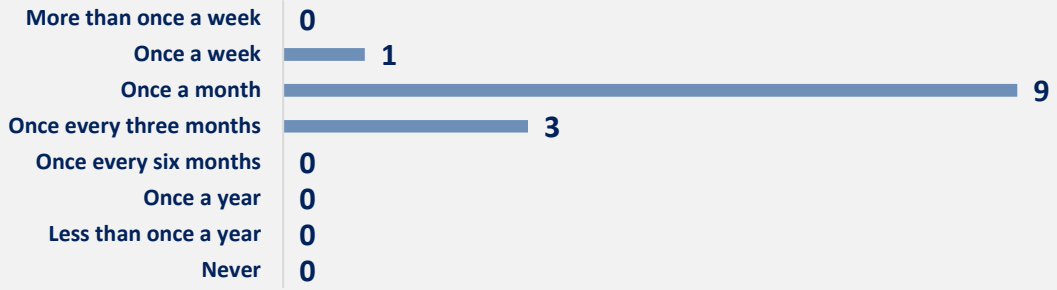


Q16 How would you describe your ethnic group?



Q1 Which of the following best describes your interest in this consultation?

Q12 On average, how regularly do you use pharmaceutical services?



Additional questions in the detailed consultation

Consultation respondents were asked if they would like to respond to either a short or detailed version of the consultation questionnaire, with the detailed version having more questions covering different parts of the draft PNA. The additional questions for the detailed version of the survey were questions **3** through **7**.

2 out of **19** respondents to the online questionnaire answered the detailed version of the consultation questionnaire. A table summarising their responses to the additional questions in the detailed consultation can be found below.

Question	Strongly agree	Agree	Neither	Disagree	Strongly disagree	Don't know
To what extent do you agree or disagree that the purpose of the Draft Pharmaceutical Needs Assessment is explained in the document?	1	1				
"The Draft Pharmaceutical Needs Assessment reflects the current provision of pharmaceutical services within your area"	1			1		
"The Draft Pharmaceutical Needs Assessment highlights all the pharmaceutical services that could be provided in the community pharmacy setting"	1					1
"The Draft Pharmaceutical Needs Assessment reflects the needs of your area's population"	1		1			
"The Draft Pharmaceutical Needs Assessment identifies all gaps in service provision"	1					1
Market entry e.g. decisions on applications for new pharmacies	1					
How pharmaceutical services may be commissioned in the future	1					
Future pharmaceutical services provision and plans for pharmacies	1					

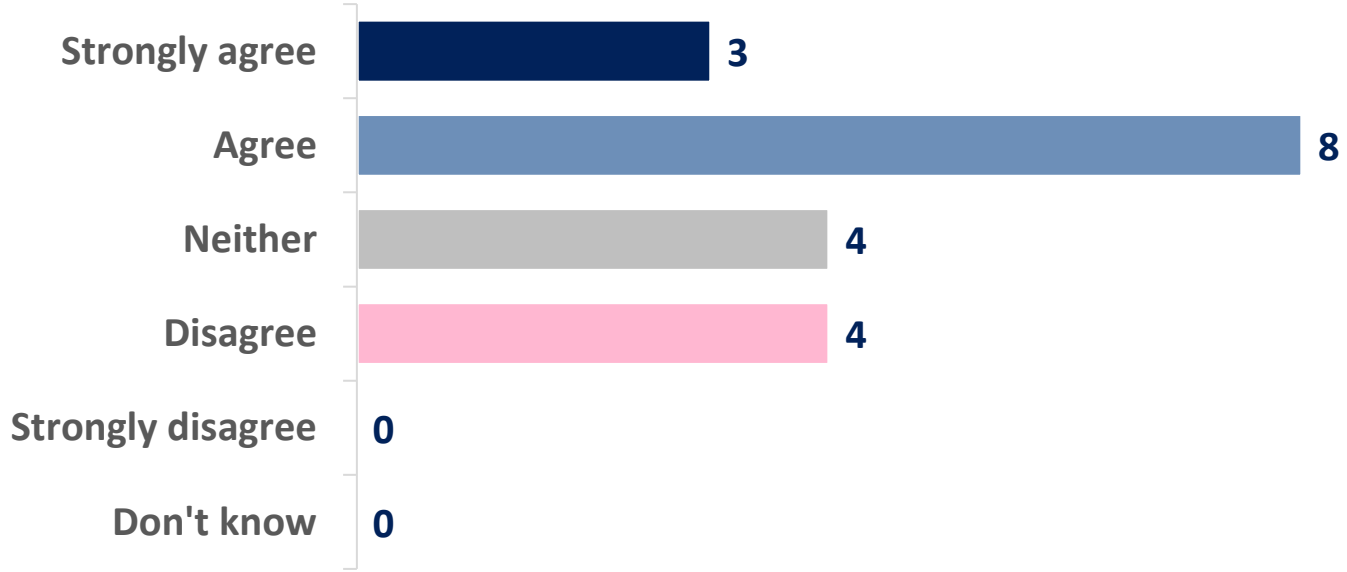
Feedback on draft PNA conclusions

Conclusions of the draft PNA

“A Pharmaceutical Needs Assessment (PNA) is a statement of current pharmaceutical services provided in the local area, which is used by NHS England when responding to applications for opening of additional pharmacies, relocation of premises and amendments to opening hours for pharmaceutical services. A PNA is not, therefore, a typical health needs assessment.

The Southampton PNA concludes that the number, distribution, and choice of pharmaceutical services meet the needs of the population and will meet future needs within the next three years. Therefore, there is no identified need for improvements or better access to pharmaceutical services in the city.”

To what extent do you agree or disagree with the conclusions of the Draft Pharmaceutical Needs Assessment?



Total *agree*
11
58%

Total *disagree*
4
21%

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Free text comments

Detailed consultation questionnaire*

Q6 If you disagree with anything in the sections outlined, or have any comments, impacts, suggestions or alternatives you feel we should consider, please provide details

- *"Some of the data is out of date and incorrect. Some pharmacies have closed , take longer than 30 min lunch and are closed before 5.30 pm This does not meet the need of people working and it takes longer than 4 mins to reach a pharmacy from sholing No mention of automatically sending prescriptions to pharmacies so they are not collected as stated in the document"*

Short consultation questionnaire

Q10 If you disagree, or have any comments, impacts, suggestions or alternatives you feel we should consider within the Draft Pharmaceutical Needs Assessment, please provide details

- *"A pharmacy existing in an area does not therefore mean that the pharmacy actually fulfills the needs of the area. Our local pharmacy is shut for large portions of the day, will sometimes only accept cash, and often doesn't have what I need anyway. So although I have a pharmacy within walking distance I cannot actually use it, I must take an hour out of my day to drive to the nearest precinct and use the pharmacy there. This is a big hassle for me but will be considerably more of an issue for those who do not drive and are not mobile enough to walk the distance (i.e., the elderly or disabled customers who will rely much more on having a local pharmacy). The actual level of service provided by pharmacies must be considered here."*
- *"Pharmacies are not open towards the east of the city after 5.30pm and open at 9 am as well as close for lunch which does not meet the need for people working when prescriptions are automatically sent to a nominated pharmacy There should be a rota of late night pharmacies in each locale which needs to be communicated so the prescription can be sent to the correct one."*
- *"My local pharmacy is archaic. Their system is often confusing to them which causes greater waiting times. They shut at lunch which does not suit everyone (for example it would be easier for me to pop in during my lunch. They have several members of staff, lunch could be staggered)."*
- *"My only concern is finding a pharmacy that is open out of hours. If there are only 4 open in the whole city this isn't enough."*
- *"I live in Bitterne and there are a number of pharmacies in my local area"*

Comments received via email response

- *"Thank you for inviting [REDACTED] to comment on the Southampton Pharmaceutical Needs Assessment as a statutory partner. We have considered the document and agreed with the conclusion. Our only other comment is to highlight and welcome the opportunity for General Practice and Community Pharmacies to work in an even closer way when commissioning of Community Pharmacy is delegated to Integrated Care Systems from NHS England (either 1st April 2022 or 2023 depending on region)."*
- *"The draft PNA clearly sets out the population needs and current provision. We agree that the number, distribution, and choice of pharmaceutical services meets the needs of your population and will meet future needs within the next three years."*

*No comments were received for questions 4 or 8 in the detailed version of the consultation questionnaire.

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Southampton Pharmaceutical Needs Assessment (PNA)

Part 1: Main report

Last Updated July 2022

Data, Intelligence & Insight Team
Intelligence, Innovation and Change,
Southampton City Council, Southampton, SO14 7LT

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Part 2 is a separate document containing:

Appendix A: Supporting Information
Appendix B: Steering Group Terms of Reference
Appendix C: Consultation Report
Appendix D: Equality and Safety Impact Assessment

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1. Executive summary

The statutory Pharmaceutical Needs Assessment (PNA) is a statement of current pharmaceutical services provided in the local area. The PNA is used to assess whether the pharmaceutical services provision is satisfactory for the local population and to identify any gaps in the provision. The PNA is, therefore, a market entry document and not a typical health needs assessment.

This document describes the process undertaken to produce the PNA and details the specific Southampton context which should be borne in mind when considering the provision of pharmaceutical services.

The PNA defines the different types of pharmacies and pharmaceutical services alongside the current provision of these in Southampton, which has 40 community pharmacies.

The PNA then comprehensively considers temporal access to pharmaceutical services by looking at opening hours and geographical accessibility by looking at the distribution of pharmacies and their catchments areas via various means of transport.

Assessment of the needs for pharmaceutical services in Southampton is underpinned by a wealth of demographic, economic and health data which is contained as a supporting Appendix in Part 2 but summarised in this main document. The supporting information also includes a detailed consideration of inequalities and specific population groups.

All the information collated in the PNA informs a 'gap analysis' which covers the current situation and the future, based on anticipated levels of development and associated population growth.

The conclusion of this assessment is that, in Southampton, the number, distribution, and choice of pharmaceutical services meet the needs of the population and future needs within the lifetime of this PNA. Therefore, there is no identified need for improvements or better access to pharmaceutical services in the city.

This conclusion is based on the following observations:

- There is a good geographical spread of community pharmacies across the city (Section 7)
- Almost all of Southampton's population is within a 1.6 km straight line distance of a community pharmacy (Section 7.1). There are two exceptions to this but, for

the following reasons, neither is considered to indicate a gap in pharmaceutical provision (Section 9.1):

  - The first is a small area in the West which is part of the industrial dock area and has no residential development; people who work in this area are considered to be sufficiently covered by pharmaceutical provision in Totton
  - The second is four residential streets in the Bassett area which are not within 1.6 km of a pharmacy. Further analysis of this area shows that it is well served by main roads for those with access to a car, and by two bus routes for those that use public transport. Additionally, there are four pharmacies just over a 1.6 km distance away from this area. Consequently, this area is not considered to have a gap in pharmaceutical provision

- There are 16 community pharmacies per 100,000 population in Southampton, which is very similar to the average for neighbouring areas and is broadly in line with the national average (Section 7.7)
- Over 99% of the Southampton population are within a 20-minute walk of a community pharmacy (Section 7.5)
- With four 100-hour pharmacies in Southampton, supplementary hours in other pharmacies and provision in neighbouring Health and Wellbeing Board areas, there are sufficient access times to meet the needs of the city's residents (Section 6)
- All pharmacies provide the full range of essential pharmaceutical services (Section 5.6)
- There is good provision of advanced services across the city (Section 5.7)
- There are a range of enhanced and locally commissioned services delivered in the city (Sections 5.8 and 5.9)
- A large proportion of community pharmacies provide a delivery service to residents, including housebound patients (Section 5.9.7)
- Housing development during the lifetime of this PNA are focused within Bargate ward in the city centre. Further analysis (Section 9.2) shows that there is already a high concentration of pharmacies in the area where most new development is planned and two of these pharmacies have 100-hour contracts. Therefore, there is no evidence of need for additional pharmacies. Smaller residential development planned for other areas of the city can also be managed by existing providers.
- Since the COVID-19 pandemic there has been a marked increase in the use of distance selling pharmacies (Section 5.2)

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- In Southampton, fewer items are dispensed per pharmacy than in neighbouring areas or nationally suggesting that demand is being met (Section 7.7)

A consultation in line with the statutory requirements was held during April and May 2022. The steering group considered the considered the consultation responses and, as the majority of respondents supported the conclusions of the PNA, the group agreed that no changes to the document should be made.

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2. Introduction

2.1 Definition and purpose of the PNA

Production of a Pharmaceutical Needs Assessment (PNA) is a statutory requirement for each local Health and Wellbeing Board (HWB) every three years or more frequently.[1] Although the 2013 regulations require the next pharmaceutical needs assessment to be published by 1 April 2022, this will be amended to 1st October 2022 as a result of the ongoing response to the Covid-19 pandemic[2].

The PNA is how the pharmaceutical services in a HWB area are assessed to determine whether they are adequately meeting the needs of the population or whether there are any gaps in provision. If gaps are found, or are likely to occur in the future, then the PNA should recommend how they can be filled.

NHS England is responsible for using PNAs as the basis for determining 'market-entry' to the local pharmaceutical list; hence this document will be used when applications are received to enter or amend the pharmaceutical list within the Southampton HWB area.

PNAs are also a key tool to inform the commissioning of essential, enhanced and advanced pharmaceutical services from community pharmacies by NHS England and of complementary local services commissioned by the Public Health department of the local authority and by other local commissioners such as the Clinical Commissioning Group (CCG).

The content of a PNA is determined by the guidance and PNAs do not, therefore, include all the elements found in a typical 'health needs assessment'. Instead, a PNA would usually be supported by the data and information on health needs in the Joint Strategic Needs Assessment (JSNA). In Southampton updates to the JSNA have been delayed due to diversion of resources to COVID-19 work. Consequently, a great deal of supporting information needed to be pulled together for this PNA; this is presented as Part 2 of the report and will subsequently be used to update the JSNA.

[1] Department of Health, Pharmaceutical Needs Assessment, Information pack for local Health Authority Health and Wellbeing Boards, May 2013. Pharmaceutical Needs Assessment Information Pack (publishing.service.gov.uk)

[2] Department of Health and Social Care Pharmaceutical Needs Assessment, Information pack for local Health Authority Health and Wellbeing Boards, October 2021 Pharmaceutical needs assessments: Information pack for local authority health and (publishing.service.gov.uk)

2.2 Historical and Legal Background

The Health Act 2009[3] sets out the minimum standards for PNAs and the use of PNAs as the basis for determining market entry to NHS pharmaceutical services provision. The Regulations came into force in May 2010 and required Primary Care Trusts (PCTs) to develop and publish their first PNA under these Regulations by 1 February 2011.

The Health and Social Care Act 2012[4] 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 HWBs. In addition, this Act also transferred the responsibility of using the PNA as the basis for determining market entry to a pharmaceutical list and dispensing doctor list from the PCT to NHS England.

The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013[5] set out the legislative basis for developing and updating PNAs. The National Health Service (Pharmaceutical and Local Pharmaceutical Services (Amendment and Transitional Provision) Regulations 2014[6] 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 HWB was published on 1 April 2015 to comply with these regulations. An updated report was published by the HWB on 1 April 2018.[7]

2.3 Structure of the PNA

This PNA document firstly describes the process undertaken and details the specific Southampton context which should be borne in mind when considering the provision of pharmaceutical services.

[3] National Health Service Act 2009 available at http://www.legislation.gov.uk/ukpga/2009/21/contents
[4] Health and Social Care Act 2012 available at http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
[5] The NHS (Pharmaceutical Services and Local Pharmaceutical Regulations) 2013 available at http://www.legislation.gov.uk/uksi/2013/349/contents/made
[6] 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
[7] Southampton PNAs are available at Pharmaceutical Needs Assessment (southampton.gov.uk)

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The PNA then defines the different types of pharmacies and pharmaceutical services alongside the current provision of these in Southampton. There is then a comprehensive consideration of access to pharmaceutical services both in terms of temporal access (i.e., opening hours) and geographical access (including drive-times, walk-times, cycle times and public transport).

Assessment of the needs for pharmaceutical services in Southampton is underpinned by a wealth of demographic, economic and health data which is contained in a supporting Appendix in a separate document (Part 2) but summarised in this main document. The supporting information also includes a detailed consideration of inequalities and specific population groups.

All the information collated in the PNA informs a 'gap analysis' which covers the current situation and the future based on anticipated levels of development and associated population growth. This is used to draw a conclusion on whether the number, distribution and choice of pharmaceutical services In Southampton meet the current and future needs of the population.

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3. 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 following the latest guidance[8] and under the direction of the PNA steering group.

The Southampton PNA 2022 has been in development since September 2021. The document has been written with assistance from partners in neighbouring Local Authorities which is gratefully acknowledged. The process has had many steps; the key stages are outlined below.

Stage 1: Formation of a steering group

A steering group was formed to oversee the development of the Southampton PNA (see Appendix B in Part 2 for the Steering Group Terms of Reference). The group had representation from key stakeholders, including Community Pharmacy South Central and NHS England.

The group oversaw the development of the PNA and ensured that the PNA conformed to the relevant regulation and statutory requirements on behalf of the HWB.

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. This information is included as Appendix A in Part 2 of the PNA.

Every existing community pharmacy in Southampton (n=40) was invited to complete a detailed questionnaire about their services to inform the development of the PNA. This survey was open from 13 December 2021 until 17 January 2022. Response was initially low because the timing of the survey coincided with pressures on pharmacies due to the accelerated COVID-19 booster roll-out, lateral flow test distribution and seasonal winter pressures. In acknowledgement of this, the deadline for the survey was extended. The survey resulted in 24 responses (a response rate of 60%).

[8] Department of Health and Social Care Pharmaceutical Needs Assessment, Information pack for local Health Authority Health and Wellbeing Boards, October 2021 Pharmaceutical needs assessments: Information pack for local authority health and (publishing.service.gov.uk)

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Data held by NHS England 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.

Expertise and advice have also been sought, and is gratefully acknowledged, from NHS Hampshire, Southampton and Isle of Wight CCG, NHS England, Community Pharmacy South Central and from Southampton City Council's Public Health, Planning, Economic Development, Research & Insight, Housing and Communications departments.

Stage 3: Analysis

The information collated was used to carry out a gap analysis to identify any current or future gaps of pharmaceutical provision within the city. The Steering Group agreed that living within 1.6 km (straight-line distance) from a pharmacy would be the key criterion for the gap analysis; this distance is used in the NHS Pharmaceutical Services Regulations 2013 when applications are determined under the "market entry" process [9]. Other factors, such as opening hours and services provided, also informed the gap analysis.

Following the analysis, a draft consultation document was completed in line with national guidance and approved by the steering group and Director of Public Health.

Stage 4: Draft PNA

The draft PNA (Part 1 Main Reports and Part 2 Appendices) was approved for consultation by the Southampton Health and Wellbeing Board (HWB) in March 2022.

Stage 5: Consultation

A consultation in line with the statutory requirements was held during April and May 2022.

Stage 6: Review of consultation responses

The steering group considered the considered the consultation responses and, as the majority of respondents supported the conclusions of the PNA, the group agreed that no changes to the document should be made. A report has been prepared on the information

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

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gathered in the consultation; a summary of this report and the steering group's considerations is included as Appendix C in Part 2 of the PNA.

Stage 7: Publication

The final document will be presented to the HWB in September 2022 for approval before the planned publication of the PNA by 1 October 2022.

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4. Southampton Context

Southampton is on the south coast of England and is the largest city in Hampshire. It is a diverse city with a population of 264,658 people comprising 107,695 households, 64,232 children and young people (0-19 years), 53,000 residents who are not White British and approximately 40,000 students. Between 2022 and 2025, the lifetime of this PNA, the population of Southampton is predicted to rise by 3.1%, with the over 65s and under 15s populations projected to increase by approximately 6.9% and 0.1% respectively.

This ageing of the population will have an increasing impact on the demand for health and social care services in Southampton. Lifestyle factors also have a substantial impact on the health of the city's population, 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 wider determinants of health such as poor living circumstances and 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.

Much of the data used to inform the PNA is from the Joint Strategic Needs Assessment of the Southampton Data Observatory[10] and is included as Appendix A in Part 2. Some of the data in this PNA is presented at a sub-city geography of electoral wards and the following ward map (Figure 1) is included to set this into context. However, the PNA has largely been conducted at a city-wide level because wards and localities are not a relevant geography when considering pharmaceutical services in a compact urban area such as Southampton.

[10] Southampton Data Observatory https://data.southampton.gov.uk/

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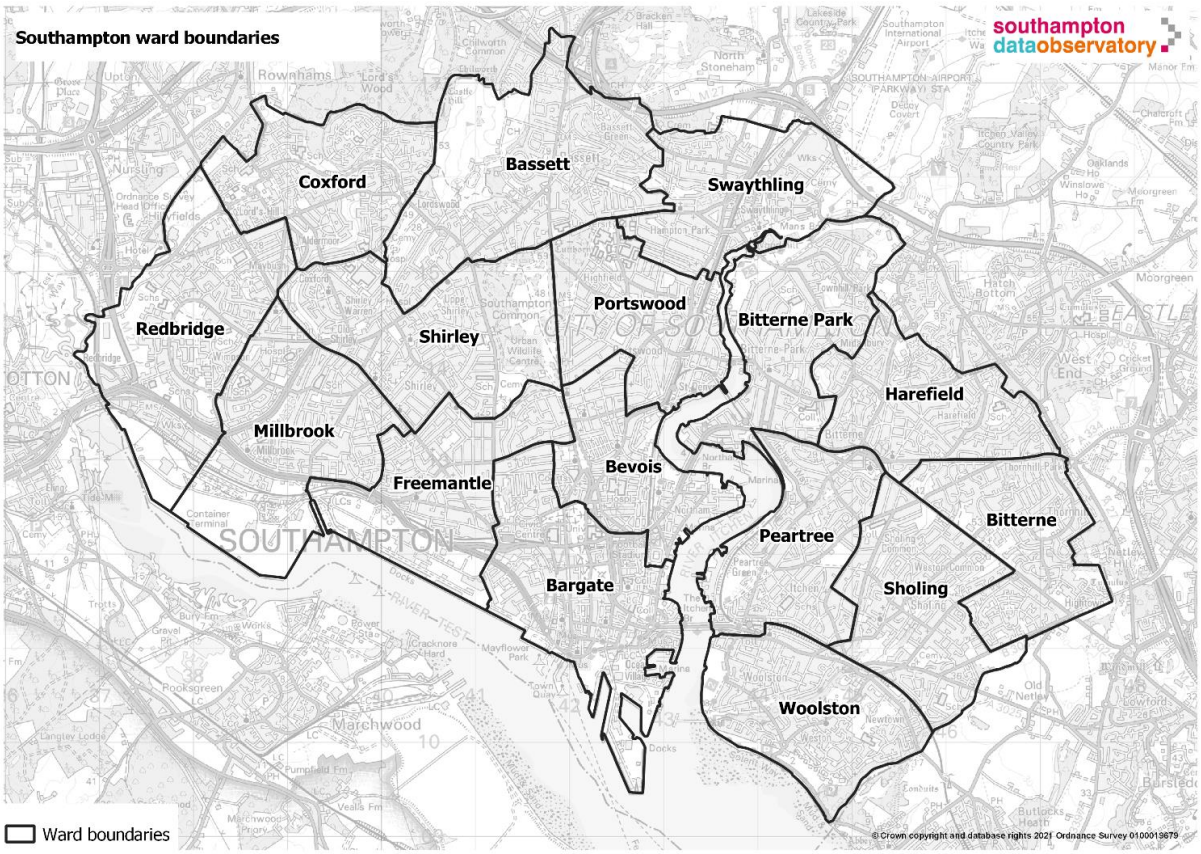
Figure 1: Southampton ward boundaries



Other NHS services can affect the need for pharmaceutical services, including 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 emergency and critical care is provided in the hospital's special intensive care units, operating theatres, acute medicine unit and emergency department (A&E), as well as the dedicated eye casualty.[11]

Princess Anne Hospital (PAH) - part of University Hospital Southampton NHS Foundation Trust, provides services including maternity care, for about 5,000 women each year from around Southampton. It is also a regional centre for foetal and maternal medicine, providing specialist care for women with medical problems during pregnancy, and for those whose babies need extra care before or around birth. Other services include genetics and breast screening.[12]

[11] University Hospital Southampton, NHS Foundation Trust https://www.uhs.nhs.uk/for-visitors/southampton-general-hospital

[12] University Hospital Southampton, NHS Foundation Trust https://www.uhs.nhs.uk/for-visitors/princess-anne-hospital

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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.[13]

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 Solent NHS Trust, Practice Plus Group and others by University Hospital Southampton NHS Foundation Trust.[14] The Southampton urgent treatment centre is also based at Royal South Hants and is run by Practice Plus Group.[15] A minor injuries unit (MIU) which offers treatment, advice and information on a range of minor injuries.

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 Pharmacy Ltd.[16]

NHS Hampshire, Southampton and Isle of Wight CCG had 40 member GP practices within the Southampton City boundary as of October 2021. The GP out of hours service is provided by UHS Pharmaceutical Service. There are 31 NHS dental practices providing NHS dental services and 15 opticians in the Southampton HWB area.[17]

[13] University Hospital Southampton, NHS Foundation Trust https://www.uhs.nhs.uk/for-visitors/southampton-childrens-hospital
[14] University Hospital Southampton, NHS Foundation Trust https://www.uhs.nhs.uk/for-visitors/royal-south-hants
[15] Practice Plus Group https://www.southamptonutc.nhs.uk/
[16] University Hospital Southampton, NHS Foundation Trust https://www.uhs.nhs.uk/departments/medicines-and-therapies/pharmacy
[17] NHS England South East Region Team; personal communication on 2 October 2017

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5. Current Pharmaceutical Services

The Community Pharmacy Contractual Framework (CPCF) for 2019/20 to 2023/24 (published in July 2019) is NHS England's latest statement of what is expected of pharmacists providing NHS services. Pharmacy contractors can provide three main types of service that fall within the definition of NHS pharmaceutical services, namely essential, advanced and enhanced services, and these can be complemented by services commissioned locally by CCGs and Public Health Teams.

Defined below are the different types of pharmacies and pharmaceutical services and details of the current provision of these in Southampton.

5.1 Community pharmacies

Southampton has 40 community pharmacies providing NHS services; since the previous PNA, the following three community pharmacies have closed:

- Lloyds Pharmacy Bitterne (closed 24 November 2018)
- Boots Pharmacy West End Road Bitterne (closed 4 May 2019)
- Lloyds Pharmacy Portsmouth Road (closed 12 November 2020)

Note: on 14/02/2022 NHS England granted an application by Arun Sharma Chemists Limited for a 'No Significant Change Relocation' from 93 Gordon Avenue, Portswood, Southampton, SO14 6WB to 108 Portswood Road, Portswood, Southampton, SO17 2FW. For the purposes of this draft PNA report, this pharmacy is considered at its original address.

Pharmacies can be divided into those providing a minimum of 40 hours of NHS pharmaceutical services each week and those providing 100 hours per week. In Southampton, there are 36 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'.

5.2 Distance selling pharmacies

Distance selling pharmacies provide services solely to customers who do not attend the premises, for example internet services only. Southampton has no distance-selling pharmacies. However, Southampton residents may choose to have their prescriptions dispensed from any pharmacy across the country including distance selling pharmacies. This trend increased, in line with other internet shopping trends, during the COVID-19 pandemic.

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The Pharmaceutical Journal estimates that in England the number of items dispensed by Distance Selling Pharmacies increased by 45% between 2019 and 2020. In Southampton we have seen an increase in prescriptions dispensed by Distance Selling Pharmacies from 0.65% in 2016/17 to 4.88% in 2020/21.

5.3 Dispensing doctor

Dispensing doctors are General Practitioners (GPs) who mainly provide services to patients in rural areas, where there are not any community pharmacies or where access to pharmaceutical services is difficult for reasons of distance. Southampton is a totally urban area and therefore none of the GP practices in Southampton are on the dispensing doctor list.

5.4 Local Pharmaceutical Services Scheme

Local Pharmaceutical Services pharmacies (LPS) provide a service tailored to specific local requirements. A typical example would be for very rural areas where a pharmacy would not be financially viable without this type of arrangement. Southampton, being an urban area, has no LPS.

5.5 Dispensing Appliance Contractor

A Dispensing Appliance Contractor (DAC) specialises in dispensing appliances (e.g., stoma care products) rather than medicines. Southampton does not have a DAC. The previous PNA identified one DAC (GE Bridge and Co at 226 Burgess Road) which has since changed ownership to Charles S Bullen Stoma Care Ltd and relocated to Unit 4, Clayland's Road, Bishop Waltham, which is outside the Southampton area.

5.6 Essential Services

Essential services are those which each community pharmacy must provide. All community and distance selling (internet) pharmacies with NHS contracts provide the full range of essential services which are as follows:

5.6.1 Dispensing Medicines and Repeat Dispensing

In 2020/21 there were 3,798,144 items prescribed by Southampton GPs dispensed across the country (3,301 sites). 98.4% of these prescription items are dispensed through 100 sites. Further analysis of these 100 sites shows that:

- 88.6% of these prescriptions are dispensed within Southampton community pharmacies;
- 4.0% are dispensed in the surrounding area of Hampshire such as Totton, Hedge End, Hamble, West End and Bursledon;
- 1.6% are personally administered items, which are bought in and used by the GP practice e.g. vaccinations;
- 0.7% dispensed by specialist appliance suppliers;
- 4.9% dispensed by distance selling pharmacies

At least two thirds of all prescriptions generated in primary care are for patients needing repeat supplies of regular medicines, and since 2005 repeat dispensing has been an Essential Service within the CPCF.

Although not an essential service, the Electronic Prescription Service (EPS) allows prescribers to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. All GP practices and pharmacies in Southampton are enabled to dispense in accordance with the EPS and all actively participate in the programme.

Between May and October 2021, 98.9% of all prescribed items in Southampton were electronically prescribed (compared with 90.8% nationally and 92.9% for NHS Hampshire, Southampton and Isle of Wight CCG). Over the same period, 8.9% of these electronically prescribed items were repeat dispensing in Southampton (compared with 14.9% nationally and 14.3% for NHS Hampshire, Southampton and Isle of Wight CCG).

Pharmacies dispense appliances as well as medicines. Results from the contractor questionnaire showed:

- 70.8% (17 out of 24) community pharmacies dispensed stoma appliances
- 79.2% (19 out of 24) community pharmacies dispensed incontinence appliances
- 100% (24 out of 24) community pharmacies dispensed dressings

Eleven out of 24 community pharmacies who responded dispensed ‘other’, 5 of these pharmacies detailed ‘trusses’, these are most commonly used to support people with hernias.

5.6.2 Disposal of Unwanted Medicines:

All pharmacies are obliged to accept back unwanted medicines from patients.

5.6.3 Public Health Promotion of Healthy Lifestyles:

Each financial year, pharmacies are required to participate in up to six health campaigns at the request of NHS England. This generally involves the display and distribution of leaflets provided by NHS England.

5.6.4 Signposting Customers to Appropriate Services:

Pharmacies are expected to support people who ask for assistance by directing them to the most appropriate source of help.

5.6.5 Support for Self-care:

Pharmacies are expected to provide advice and support to enable people to derive maximum benefit from caring for themselves or their families.

5.6.6 Clinical Governance:

Clinical governance is a framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care. Pharmacies are responsible for applying clinical governance principles to the delivery of services e.g., use of standard operating procedures; recording, reporting and learning from adverse incidents; participation in continuing professional development and clinical audit.

5.6.7 Discharge Medicines Service (DMS):

The DMS became a new Essential service within the CPCF on 15th February 2021. NHS Trusts are able to refer patients to the DMS at their community pharmacy if the patient would benefit from extra guidance around new prescribed medicines. The service has been identified by NHS England's Medicines Safety Improvement Programme to be a significant contributor to the safety of patients at transitions of care, by reducing readmissions to hospital.

Note that in Southampton the DMS has superseded the Transfer of Care around Medicines service that was previously provided by pharmacies.

5.6.8 Healthy Living Pharmacy (HLP) Level 1 status:

Most pharmacies in England previously met the HLP requirements following local initiatives with commissioners or the Pharmacy Quality Scheme. However, the laying of new NHS

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regulations in October 2020, made HLP requirements a new Terms of Service requirement for all pharmacies from 1 January 2021.

5.7 Advanced services

Pharmacies may choose whether they wish to provide these additional, advanced services as long as they meet the requirements set out in the Secretary of State Directions. The pharmacies receive remuneration from the NHS for providing advanced services.

5.7.1 New Medicine Service (NMS)

The NMS 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 initially focused on a small number of conditions, but this list was increased in September 2021.

5.7.2 NHS Flu Vaccination Service

Every year, from September to March, the NHS runs a seasonal influenza vaccination programme to protect those who are most at risk of serious illness or death should they develop influenza. Community pharmacies have been providing flu vaccinations under a nationally commissioned service since September 2015 to support the national vaccination programme.

For the period September 2020 to March 2021, NHS England data show 34 of the 40 (84%) pharmacies in Southampton were accredited to deliver flu vaccinations. A total of 8,616 vaccinations were given during this time period.

5.7.3 Community Pharmacist Consultation Service (CPCS)

This service was launched across England in October 2019. The CPCS manages a referral from NHS 111 to a community pharmacy where a patient has contacted NHS 111 for low acuity conditions/minor illness or for urgent medicine supply. The service enables appropriate access to medicines or appliances out-of-hours via community pharmacy, relieving pressure on urgent and emergency care services by shifting demand from GP out-of-hours providers to community pharmacy.

Between April 2020 to March 2021, 38 of the 40 pharmacies in Southampton carried out these consultations, resulting in 1,556 consultations.

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5.7.4 Hepatitis C Antibody Testing Service

The Community Pharmacy Hepatitis C Antibody Testing Service was added to the CPCF in 2020, commencing on 1 September. It is focused on provision of point of care testing for Hepatitis C antibodies for people who inject drugs.

As of January 2022, one Southampton pharmacy was providing this service as a pilot funded through the University of Southampton. This pilot is ending prior to the implementation of the national service commissioned by NHS England.

5.7.5 Stoma Appliance Customisation

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 usually provided by DACs. For April 2020 to March 2021, NHS England data show seven pharmacies were accredited to provide this service in the city.

5.7.6 Appliance Use Reviews

Appliance Use Reviews can be carried out by a pharmacist or a specialist nurse in the pharmacy or at the patient's home, however, this service is generally provided through DACs.

5.7.7 Hypertension Case-Finding Service

The Hypertension Case-Finding Service was commissioned as an Advanced service from 1 October 2021. The service has two stages – the first is identifying people at risk of hypertension and offering them blood pressure measurement. The second stage is offering 24-hour ambulatory blood pressure monitoring, where clinically indicated. The blood pressure test results will then be shared with the patient's GP to inform a potential diagnosis of hypertension.

The service received a soft launch and uptake has been relatively slow due to pressures related to the COVID-19 pandemic. It is anticipated that more local pharmacies will sign up to provide this advanced service over the lifetime of this PNA.

5.7.8 Smoking Cessation Advanced Service

In early 2022, the Smoking Cessation Advanced Service will be introduced for patients who started their stop-smoking journey in hospital. This service will allow NHS trusts to refer

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patients to a pharmacy of their choice so they can continue receiving treatment, advice and support with their attempt to quit smoking when they are discharged. Work is still underway to finalise the service specification and other details. It is expected that this service will continue to develop over the lifetime of this PNA.

5.8 Enhanced Services

5.8.1 Bank Holiday Opening

A Bank Holiday service is provided for Christmas Day, Boxing Day, New Year's Day and Easter Sunday, which is coordinated by NHS England.

5.8.2 Pharmacy Urgent Repeat Medicines Service

There is one enhanced service which is locally commissioned in Hampshire - the Wessex Pharmacy Urgent Repeat Medicines (PURM) Service. This service 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. This service is currently under review as it has been largely superseded by the CPCS, with some exceptions, such as walk-in provision. The number of pharmacies offering this service continues to decrease as a result.

In 2021/22, 11 community pharmacies were accredited to provide the PURM Service in Southampton.

5.9 Locally Commissioned and other non-NHS Services

Locally commissioned services can be contracted via a number of different routes and by different commissioners, including local authorities and CCGs. Some other relevant non-NHS services are also described below as, although they are not defined as pharmaceutical services, they do add context to the overall provision in Southampton.

5.9.1 Minor Ailment Service

Minor ailments are defined as common, 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

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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 reducing the time spent managing these conditions would enable GPs to focus on more complex cases. The aim of the Minor Ailment Service, which is commissioned by Hampshire, Southampton and Isle of Wight CCG, is to improve access and choice for people with minor ailments.

The service is available in all areas of Southampton and now covers 26 conditions. The number of pharmacies offering the service varies from month to month due to changes within the pharmacy teams.

5.9.2 Palliative Care Drugs 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. The Palliative Care Drugs Service is commissioned by Hampshire, Southampton and Isle of Wight CCG and aids accessibility to these drugs for individuals who are being cared for in community settings. In 2021/22, seven community pharmacies in Southampton were accredited to provide this service.

5.9.3 Pharmacy Needle and Syringe Programme

Needle Exchange services for injecting drug users are a crucial component in providing a comprehensive harm reduction programme. The aims of this service is to:

- reduce the spread of blood borne pathogens (HIV, Hepatitis B & C)
- provide information and advice to reduce the harms associated with injecting drug use
- encourage use of other drug services and facilitate referrals to other agencies where appropriate

In 2021/22 six pharmacies, geographically spread across the city, were contracted by Southampton City Council Public Health Team to provide sterile injecting equipment to people who inject drugs to reduce harm. This service is currently undergoing a review to inform new contracts due to commence in April 2022.

5.9.4 Emergency Hormonal Contraception (EHC) Service

The Southampton City Council Public Health Team commissions the EHC services which aims to reduce unwanted pregnancies and terminations by providing EHC, to support women

aged under 25 who have had unprotected sex and help contribute to a reduction in the number of unplanned pregnancies.

This is through a Patient Group Direction (PGD) which provides a legal framework to allow pharmacists to supply specified medicines to a pre-defined group of patients, without them having to see a prescriber. Clients excluded from the PGD criteria should be referred to another local service provider that will be able to assist them as soon as possible. In 2021/22 there were 31 pharmacies in Southampton contracted to provide free EHC to women aged under 25.

5.9.5 Supervised Consumption

Opiate Substitute Therapy (OST) medication (methadone and buprenorphine oral formulations) is used for maintenance therapy in the management of opioid dependence, as part of a programme of treatment and support. To reduce risk and support compliance, administration of these medications can be supervised in community pharmacies, which also provides routine and structure for the individual, and encourages engagement with other healthcare provision delivered by the pharmacies.

Southampton City Council's Public Health Team currently contracts 13 pharmacies, geographically spread across the city, to provide interventions to supervise the consumption of OST medication for a proportion of people being prescribed OST as part of their engagement in community-based Substance Use Disorder Services. The supervised consumption service is currently undergoing a review to inform new contracts due to commence in April 2022.

5.9.6 Stop Smoking Service

A smoking cessation service for clients who need support to give up smoking using one-to-one interventions is offered by 11 pharmacies In Southampton (although as at January 2022 services at three of these are currently paused). The service includes an initial assessment to ascertain how ready the client is to make a change and how they would be best supported.

NHS Digital data shows that in 2020/21 there were 277 people who set a smoking quit date through pharmacies and, of these, 92 (33%) had successfully quit at 4 weeks (self-reported). This compared with 724 across all settings of which in Southampton 283 (39%) were successful quitters.

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5.9.7 Delivery Services

Many pharmacies provide a delivery service; sometimes this is provided free and sometimes they make a charge for it. As these are private services, there is no NHS data available to ascertain the level of provision in Southampton. However, results from the contractor questionnaire showed:

- (70.8%) 17 out of 24 community pharmacies who responded collected prescriptions from GP practices
- (62.5%) 15 out of 24 community pharmacies who responded deliver dispensed medicines - free of charge
- (39.1%) 9 out of 23 community pharmacies who responded deliver dispensed medicines – for a charge
- (34.8%) 8 out of 23 community pharmacies who responded deliver dispensed medicines to selected patient groups (for example those receiving end of life care, in a care home, housebound)
- (30.4%) 7 out of 23 community pharmacies who responded deliver dispensed medicines to selected geographical areas (for example within a five-mile radius or within postcode sector)

5.9.8 Access Languages

The pharmacy workforce in Southampton embraces a range of nationalities and cultural backgrounds. The contractor survey showed that, at that time, there were 20 different languages spoken amongst Southampton pharmacy 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 across the 24 pharmacies that responded to the contractor survey:

Arabic	Gujarati	Mandarin	Russian
Bengali	Hindi	Nigerian	Spanish
English	Hungarian	Polish	Swahili
Farsi	Lithuanian	Panjabi	Telugu
Filipino	Malay	Romanian	Urdu

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5.10 COVID-19 services

Since the onset of the COVID-19 pandemic, pharmacies have taken a leading role in providing COVID-19 related services to the public. These services are described separately because of the uncertainty in how long into the lifetime of the PNA they will be relevant for.

5.10.1 COVID-19 Vaccination Service

One pharmacy in Southampton has provided the COVID-19 vaccination service. Between April 2020 and March 2021, NHS England data shows 9,949 vaccinations were administered.

5.10.2 COVID-19 Lateral Flow Device Distribution Service

At the end of March 2021, a new Advanced service – the NHS community pharmacy COVID-19 Lateral Flow Device (LFD) distribution service (or 'Pharmacy Collect' as it is described in communications to the public) – was added to the CPCF.

This service, which pharmacy contractors can choose to provide as long as they meet the necessary requirements, aims to improve access to COVID-19 testing by making LFD test kits readily available at community pharmacies for asymptomatic people.

Between 29th March 2021 and 18th October 2021 47,166 LFD packs were given out across 38 pharmacies in the city.

5.10.3 COVID-19 Supervised Testing

This locally commissioned service offers supervised testing for COVID-19 of eligible, asymptomatic patients, using an LFT device. It is offered in 8 pharmacies in Southampton and between 22nd March to 27th Sept 2021 850 tests conducted were conducted with 6 people testing positive for COVID-19.

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6. Temporal Access to Pharmaceutical Services

6.1 Opening Hours

A PNA should identify the necessary services that are required at specified times and the following consideration of opening hours helps set the context for this assessment.

The opening hours used in this section are based on the total opening hours (both 'core' and 'supplementary' hours) for the 40 community pharmacies in the city, as held by NHS England on 15th October 2021. The removal of three contractors from the pharmaceutical list since the previous PNA did not change these opening hours as the number of 100-hour pharmacies remined the same. Details of individual pharmacy opening times can be found on the NHS website.[18]

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.

6.2 100-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 give 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.

Through the following consideration of opening hours, no need for improvements or better temporal access to pharmaceutical services in the city has been identified.

[18] NHS website - available at http://www.nhs.uk/Pages/HomePage.aspx

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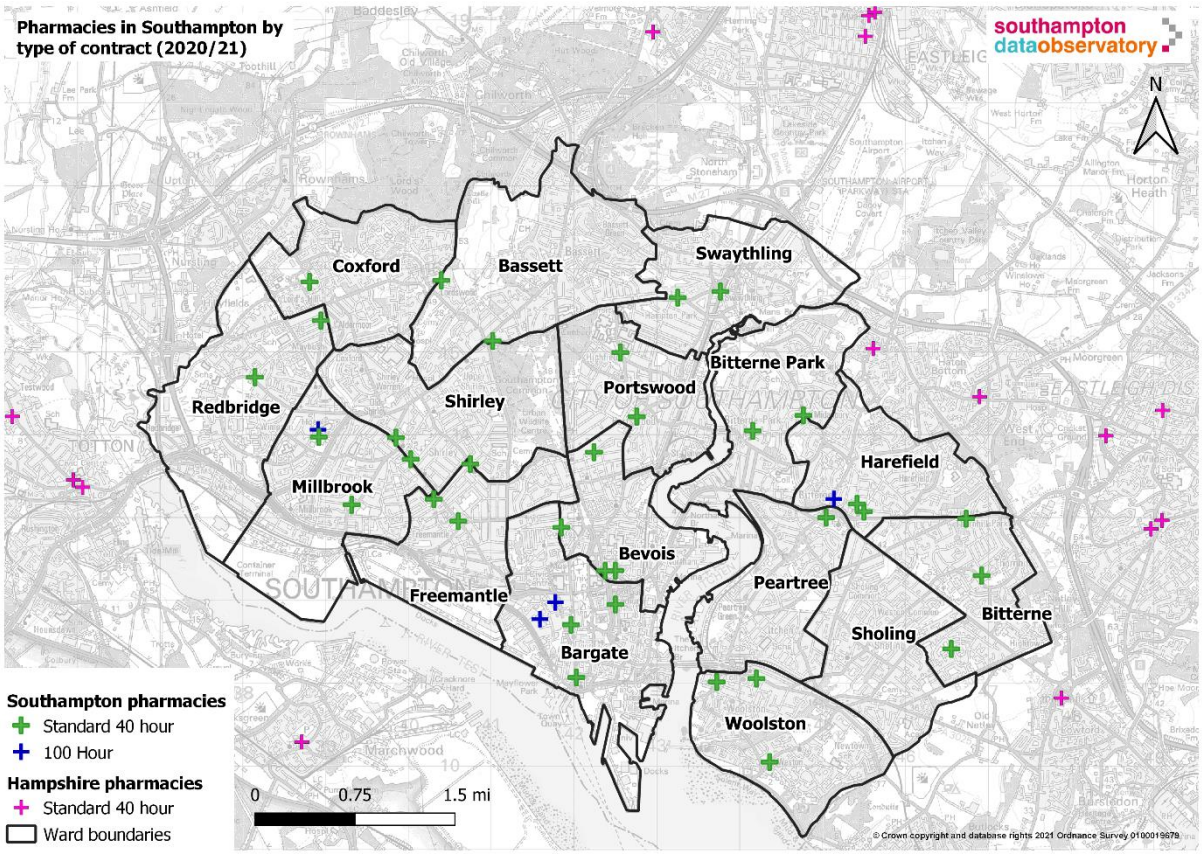
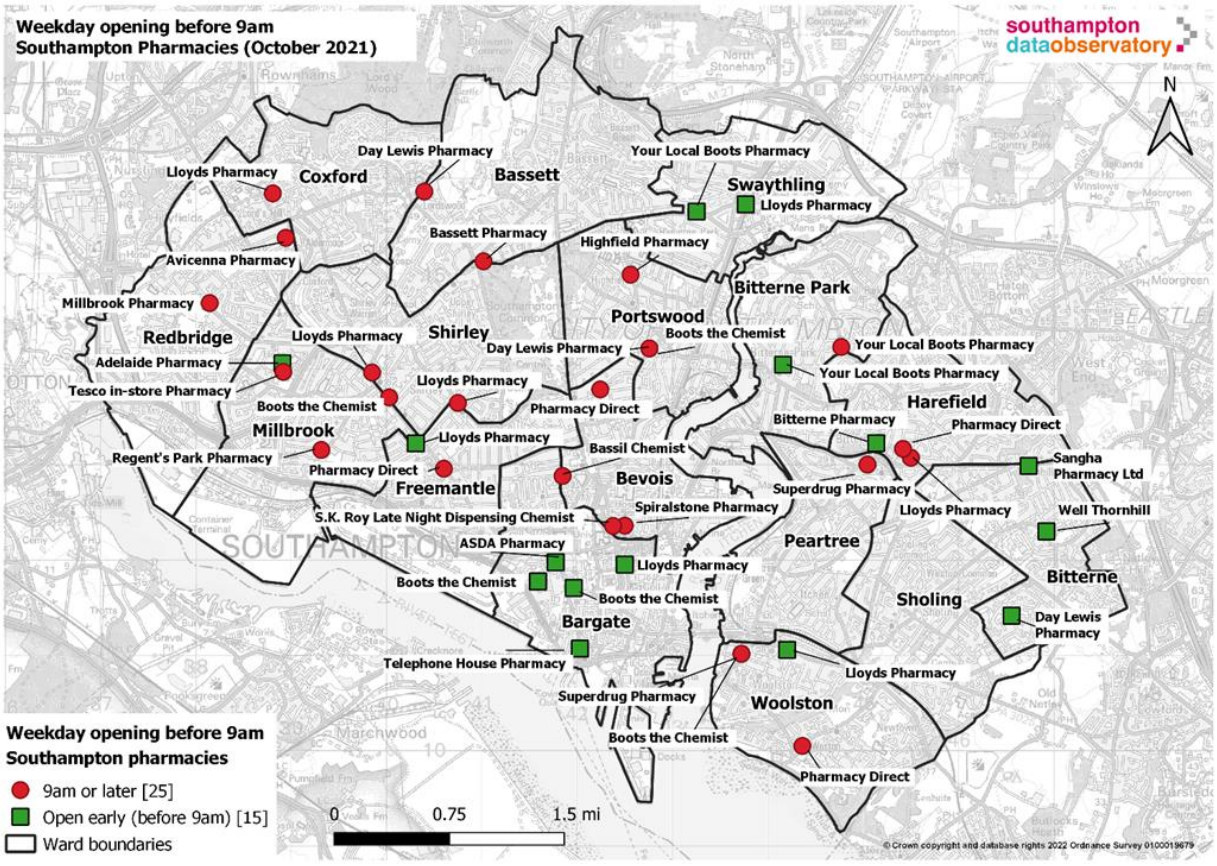
Figure 2: Pharmacies in Southampton by type of contract as of October 2021



6.3 Opening Hours Mornings

For early morning access 16 pharmacies open before 9am on weekdays. There is fair geographical spread across the city of pharmacies with early opening, although pharmacies in the northwest of the city tend to open after 9am.

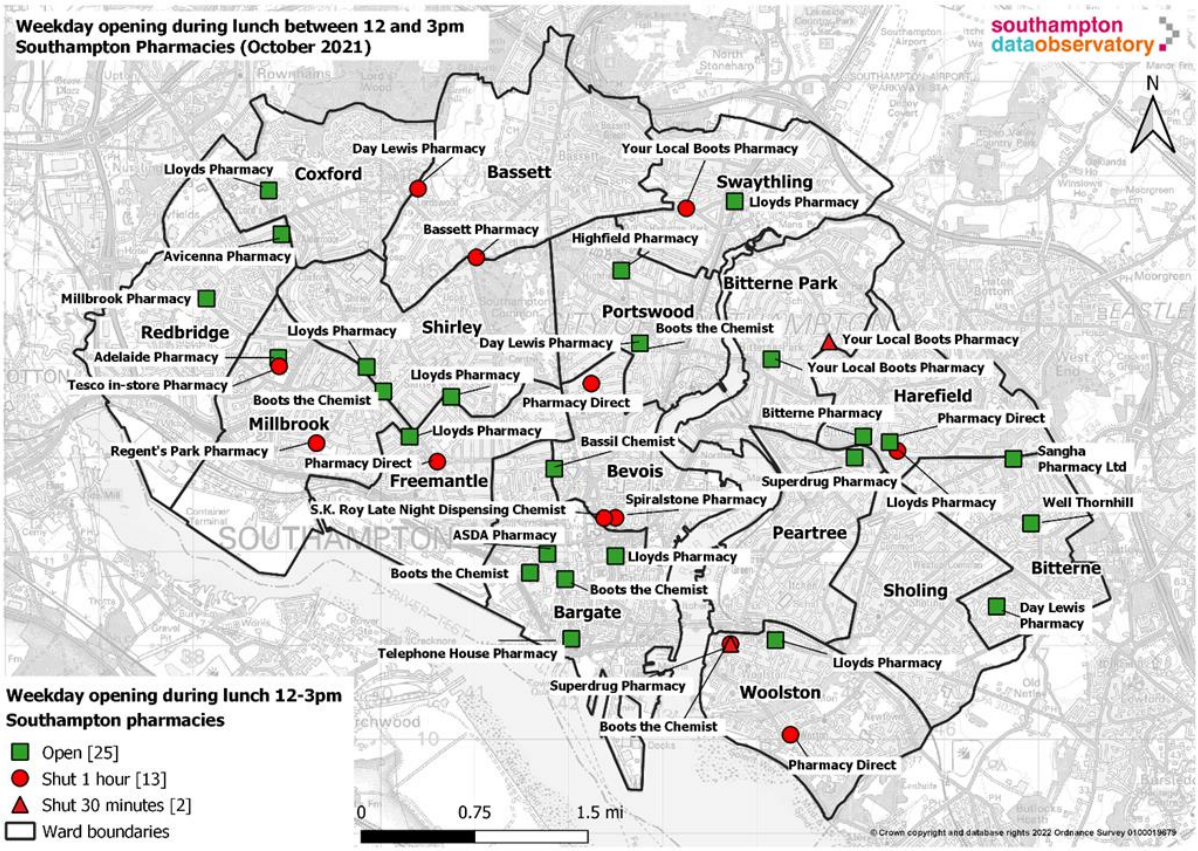
Figure 3: Map of weekday morning opening times for community pharmacies in Southampton as of October 2021



6.4 Opening Hours Lunchtime

There is access to NHS pharmaceutical services throughout the lunch period (12pm to 3pm) in twenty-five local pharmacies. Eleven pharmacies are closed for one hour during lunch. The remaining four pharmacies are closed for 30 minutes.

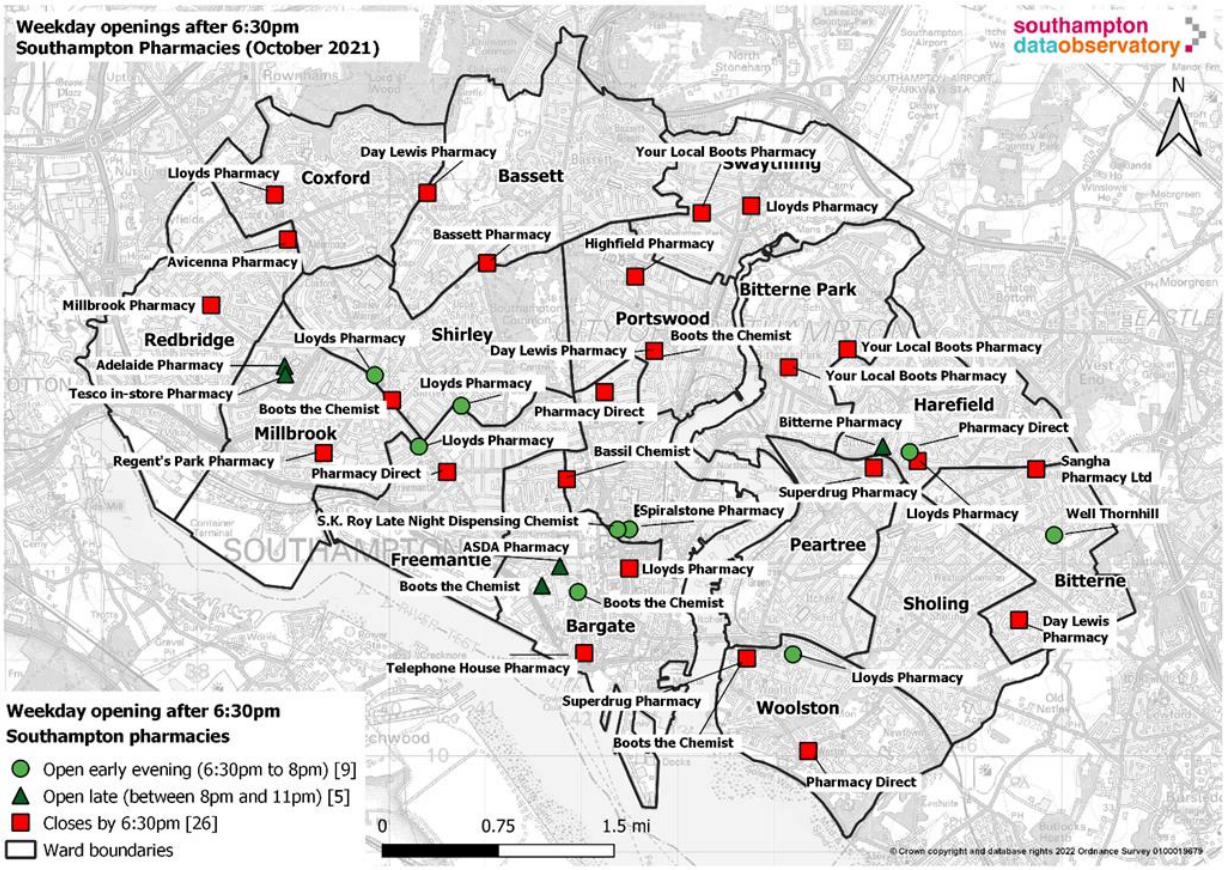
Figure 4: Map of weekday lunchtime opening times for community pharmacies in Southampton as of October 2021



6.5 Opening Hours Evenings

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

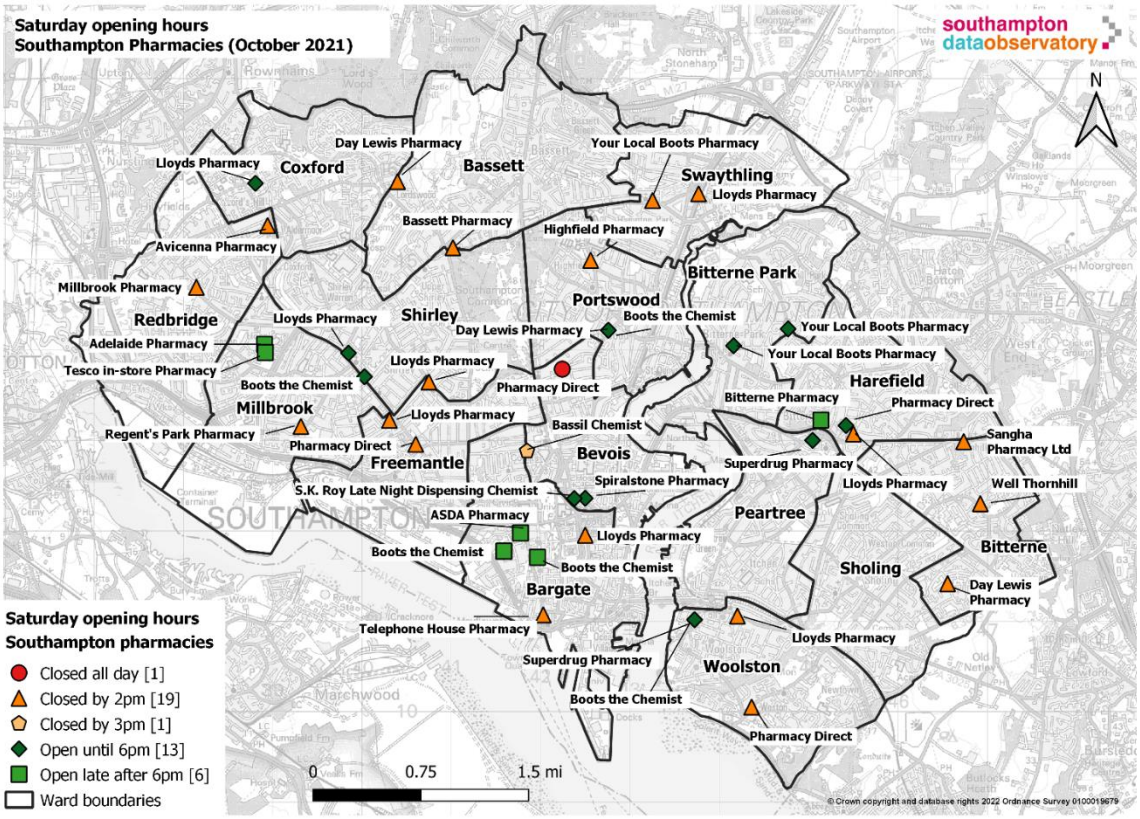
Figure 5: Map of weekday evening opening times for community pharmacies in Southampton as of October 2021



6.6 Saturday Opening

Thirty-nine community pharmacies are open for at least a part of the day on a Saturday with only one pharmacy closed all day. Nineteen pharmacies close at 2pm or before, one closes at 3pm, thirteen are open until 6.30pm and six are open after 6.30pm.

Figure 6: Map of Saturday opening times for community pharmacies in Southampton as of October 2021



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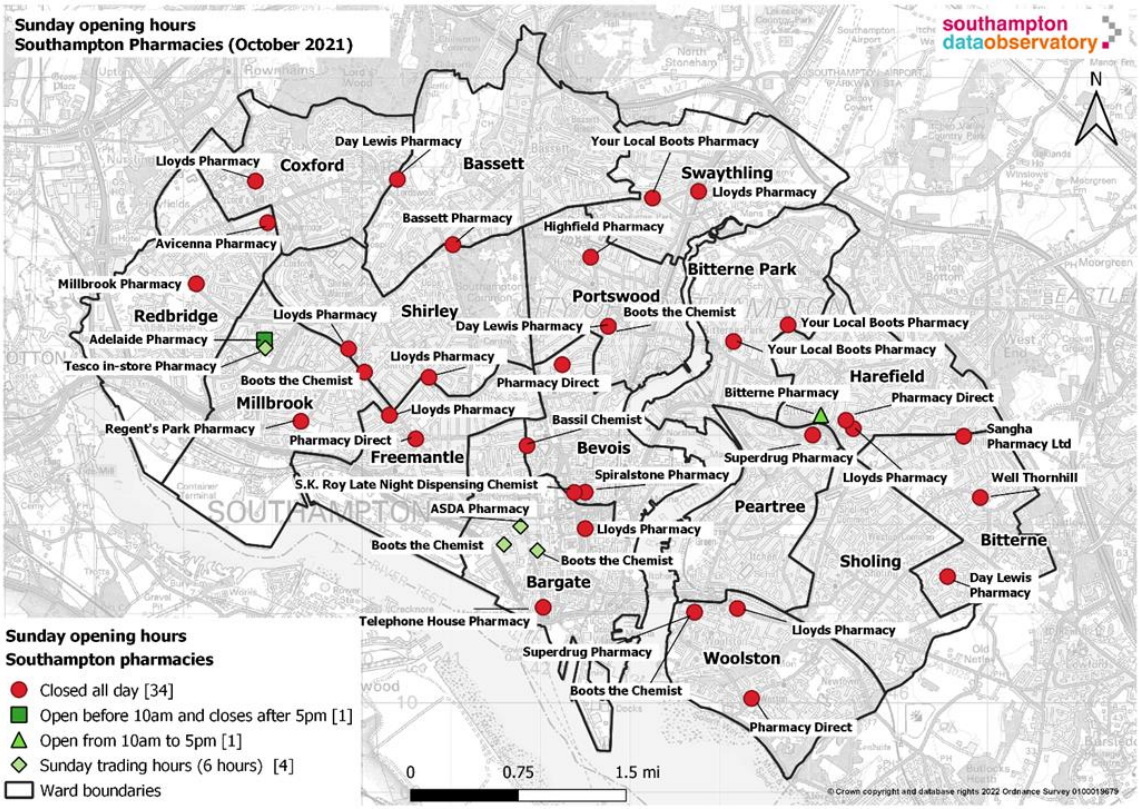
6.7 Sunday Opening

Six 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. One pharmacy is open for 7 hours (10am to 5pm) and another pharmacy is open for 10 hours between 9am and 7pm.

Figure 7: Map of Sunday opening times for community pharmacies in Southampton, as of October 2021



6.8 Bank Holiday

Community pharmacies are not required to open on bank holidays. For major bank holidays, 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. Bank Holiday opening is arranged through commissioning of an Enhanced Service that the pharmacies were invited to apply for.

Details of opening times for these holidays are published on the NHS UK website[19] and are usually available on the NHS England website.[20] There is also a GP out of hours service provided by UHS Pharmaceutical service.

Additionally, there is a GP out of hours service provided at the Royal South Hants hospital by the Practice Plus Group Urgent Treatment Centre, which is open Monday to Friday 7:30am to 10pm and on weekends and bank holidays from 8am to 10pm.[21]

[19]NHS Find a pharmacy https://www.nhs.uk/service-search/find-a-pharmacy/results/Southampton?latitude=50.9048925726334&longitude=-1.4043126425974952
[20] NHS England Pharmacy opening times https://www.england.nhs.uk/south-east/info-professional/pharm-info/pharmacy-opening-hours/
[21] Practice Group Urgent Treatment centre https://www.southamptonutc.nhs.uk/

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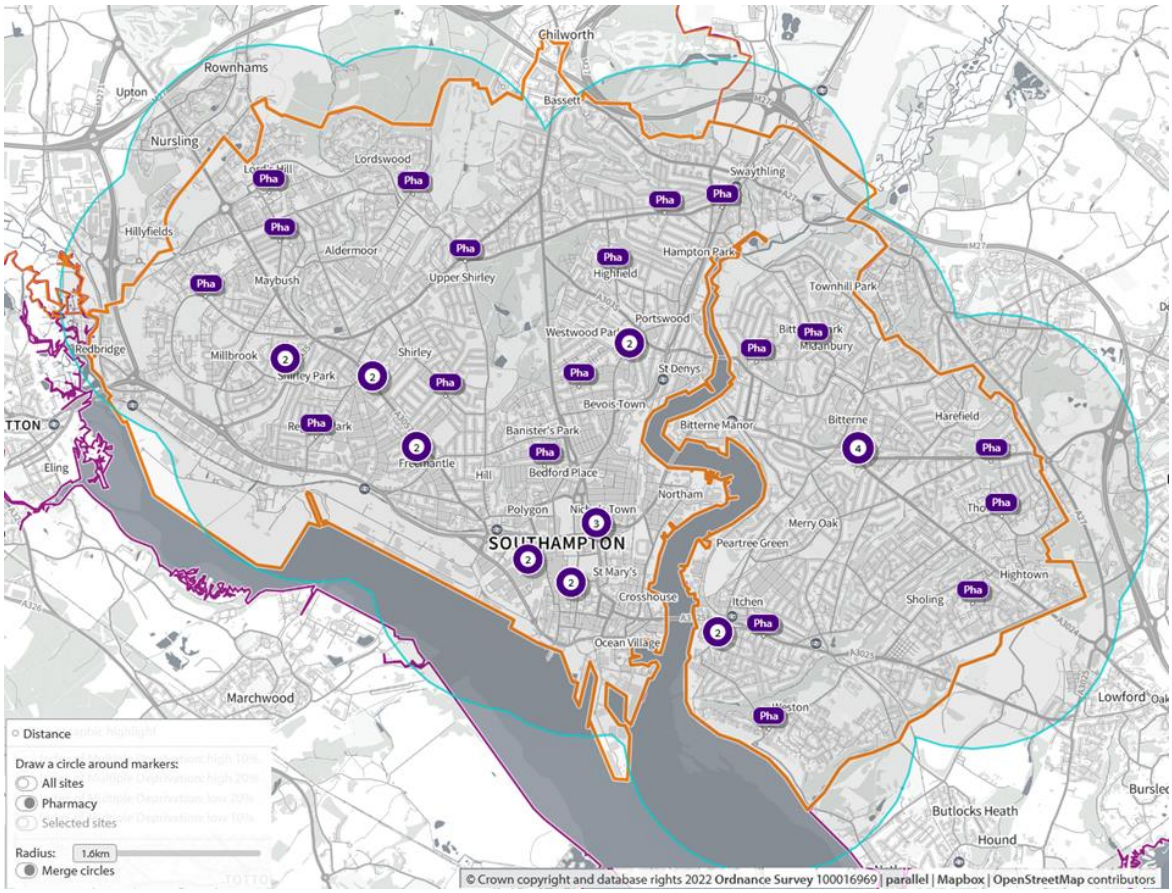
7. Geographical Access to Pharmaceutical Services

7.1 Pharmacies with Buffer Zone of 1.6km

Figure 8 shows all pharmacy locations in Southampton with a buffer zone of 1.6km (approximately 1 mile) Euclidean distance (straight line). This demonstrates that the majority of Southampton's population are within 1.6km of a pharmacy. There is a small area in the west, which is part of the industrial dock area and has no residential development, that is outside the merged buffer zone. However, people who work in this area are sufficiently covered by pharmaceutical provision in Totton.

Another area outside the 1.6km buffer zone is on the northern edge of the city (part of Bassett, south of Chilworth). This is also slightly further than 1.6km from the nearest pharmacy in Hampshire (ASDA in Chandler's Ford) as shown in Figure 9. This is a very small area in one of the least deprived areas of the city which has good access to pharmacies by car; this area is given special consideration in the gap analysis in Section 9.

Figure 8: Map showing distance zone of 1.6km from a pharmacy inside Southampton



Source: SHAPE place, Public Health England

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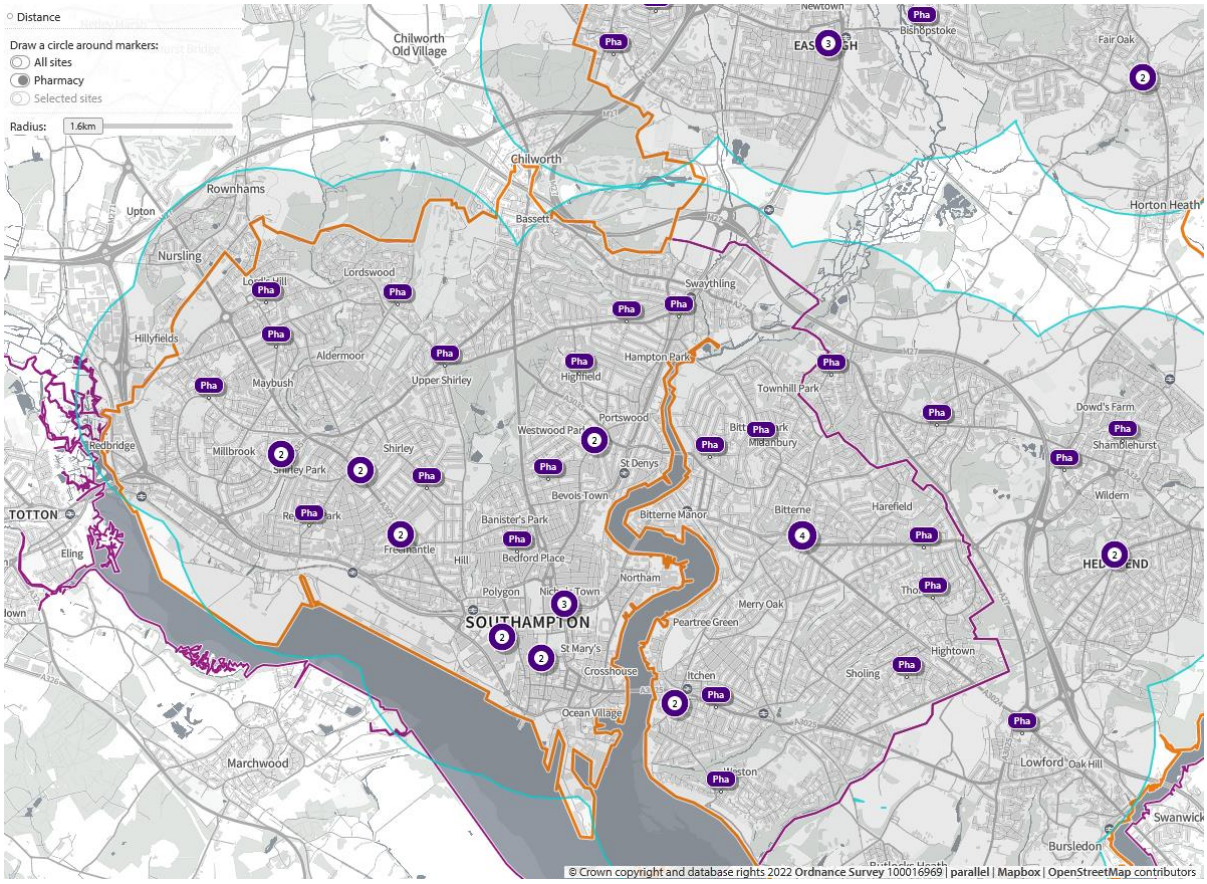
Figure 9: Distance 1.6km from a pharmacy including those in Hampshire that are close to the Southampton boundary



Source: SHAPE place, Public Health England

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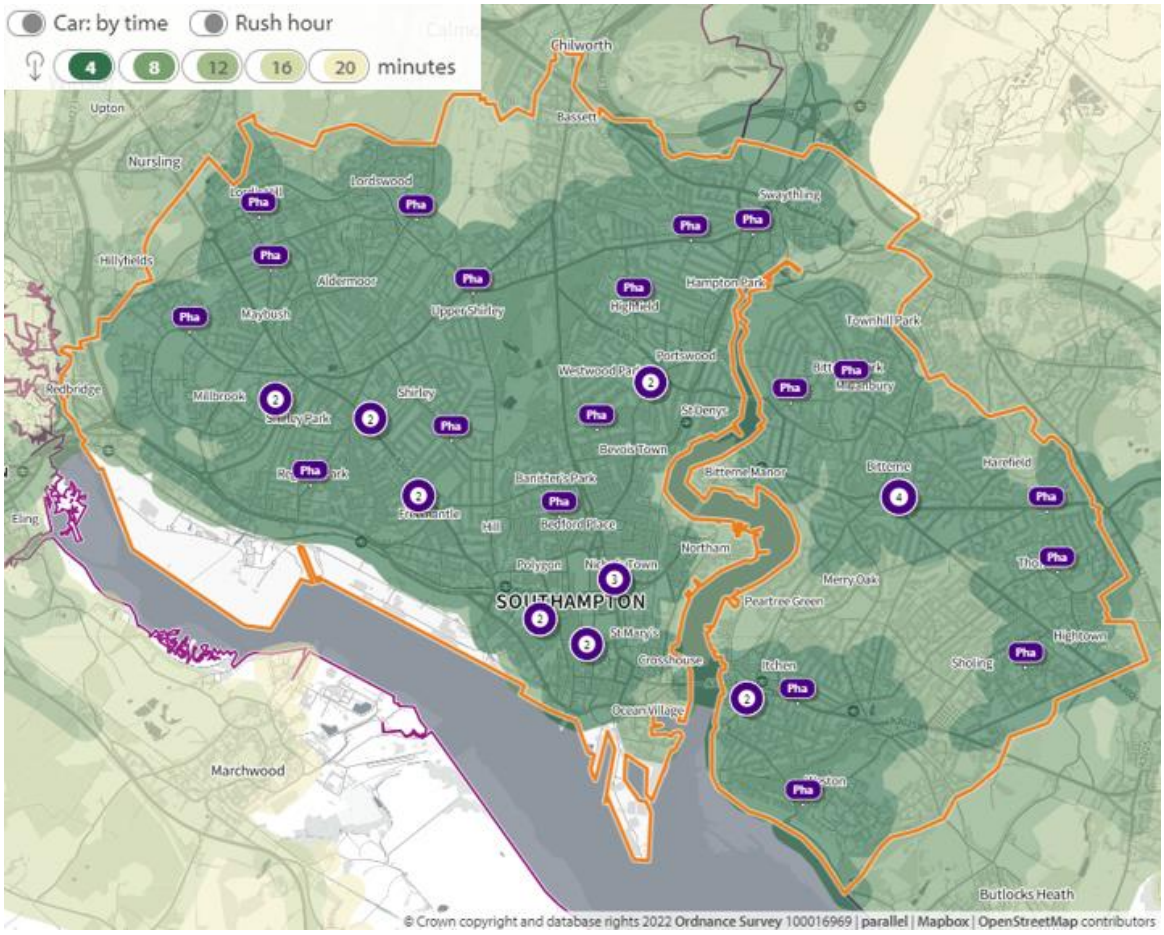
7.2 Driving

During 'rush hour' (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 10).

Figure 10: 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

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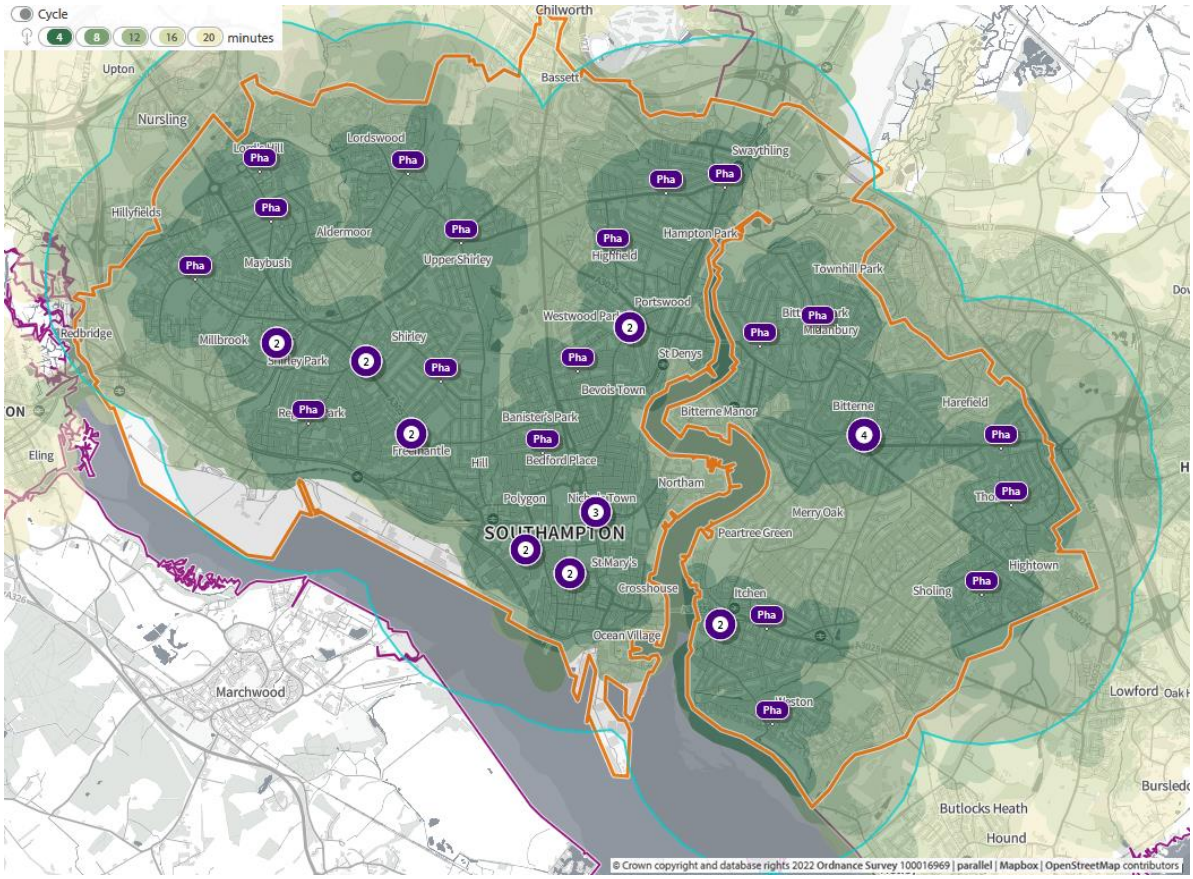
7.3 Cycling

Seventy-nine percent of the Southampton population are within a four-minute cycle ride of a pharmacy; and 100% 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).

Figure 11: Cycling time to pharmacies (4 to 20 minutes)



Source: SHAPE place, Public Health England

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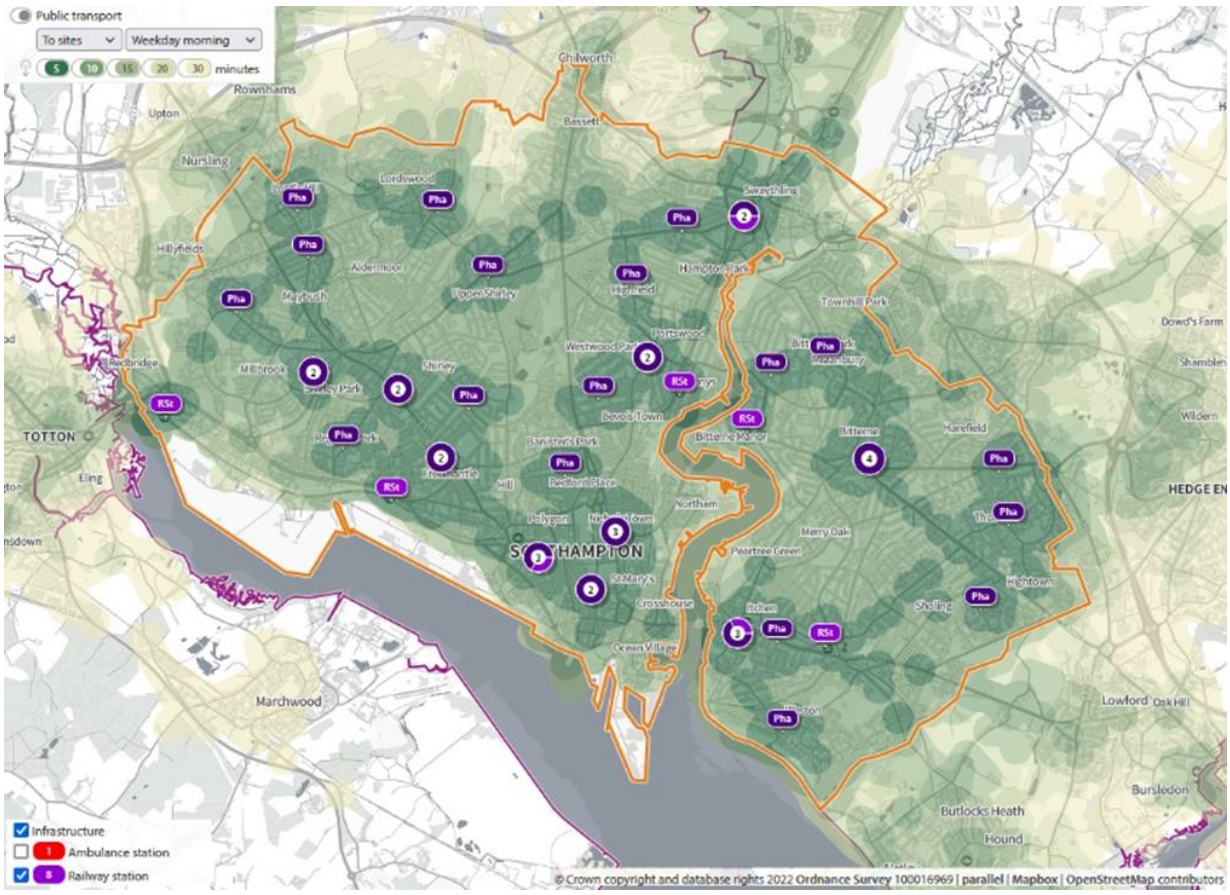
7.4 Public Transport

Residential areas of Southampton are well covered by bus stops and bus routes, therefore, access to pharmacies in Southampton are well served by public transport. Figure 12 below shows the number of pharmacies and train stations in Southampton and travel times to those sites.

Figure 12: Using public transport to visit sites including pharmacies and train stations

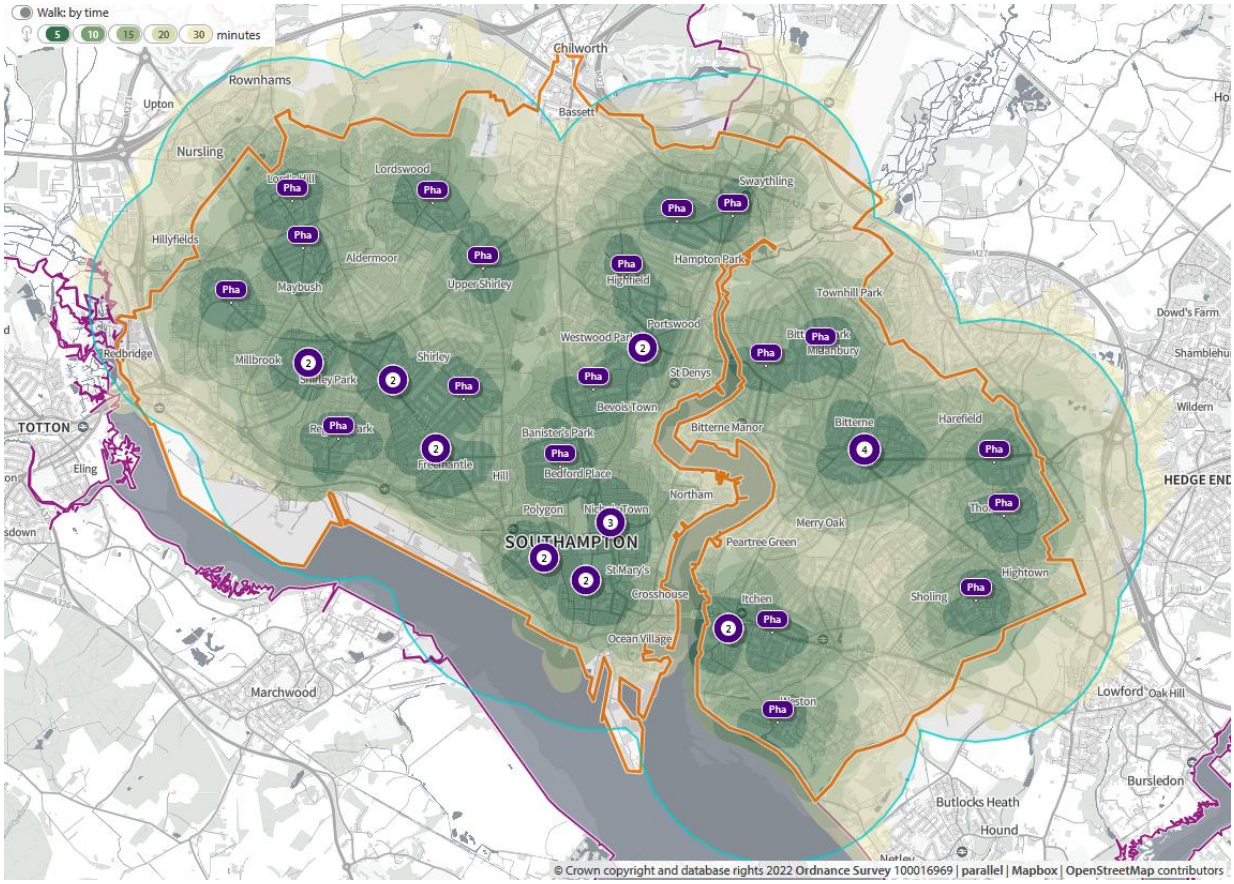


Source: SHAPE place, Public Health England

7.5 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). Nearly 50% of the Southampton population is within a five-minute walk of a pharmacy. The entire Southampton population is within a 30-minute walk of a pharmacy (Figure 13).

Figure 13: Map of walking times (5-30 minutes) from pharmacies in Southampton (excluding distance selling) and outside of the local authority boundary



Source: SHAPE place, Public Health England

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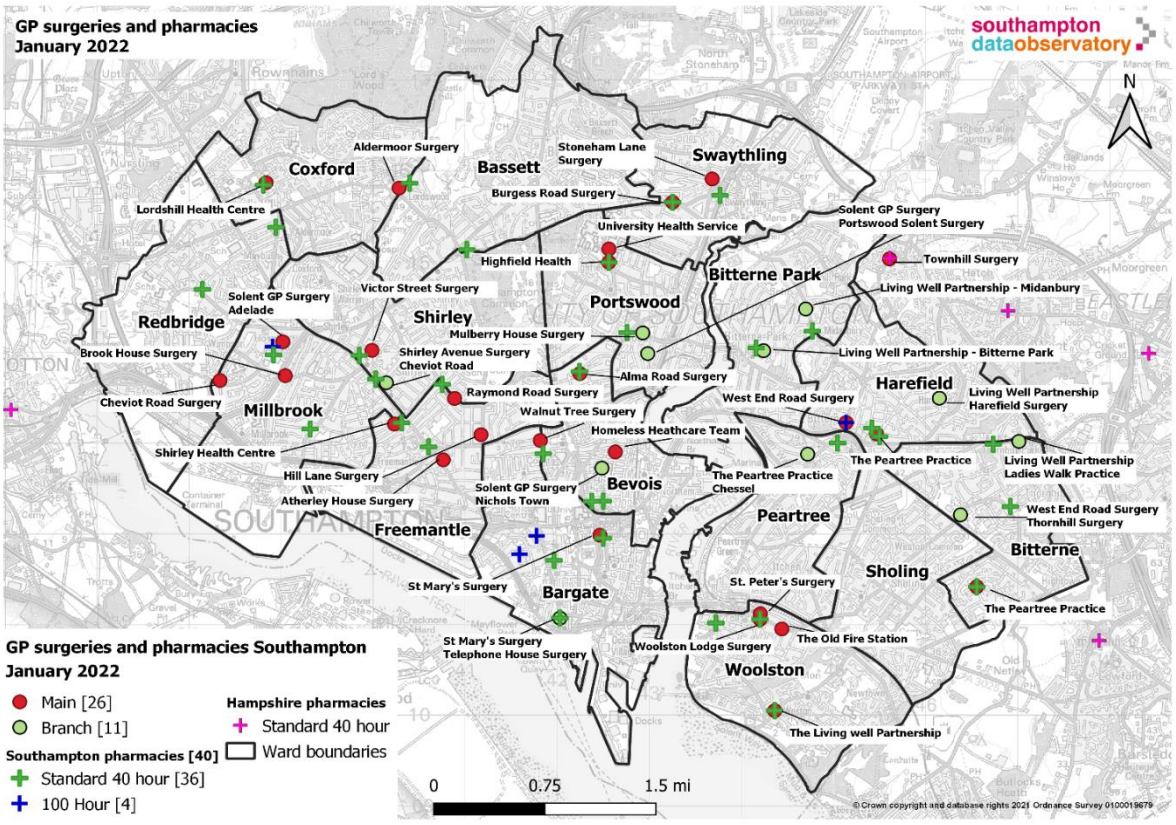
7.6 Proximity to GP Practices

Figure 14 shows that Southampton's all GP surgeries are in relatively close proximity to a pharmacy.

Figure 14: Map of GP surgeries proximity to pharmacies in Southampton (October 2021)



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7.7 Density of Pharmacies

Based on the number of community pharmacies on the pharmaceutical list as at 31st March 2021, Figure 15 shows that Southampton had 15.8 pharmacies per 100,000 population which is similar to 16.6 per 100,000 for the Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) region and lower than the England average (18.9 per 100,000 population).

The average number of prescription item dispensed each year per pharmacy was slightly lower than the HIPS and England averages. The data illustrate that there are less pharmacies in the city per population compared to the HIPS area and nationally. However, less items are dispensed per month locally per pharmacy, despite the availability of less pharmacies per 100,000 population.

Figure 15: Pharmacy density

2020-21	Number of community pharmacies	Prescription items dispensed	Population mid-year estimate 2020	Pharmacies per 100,000 population	Average number of dispensed items	
					per pharmacy	per pharmacy per month
England	10,715	945,569,340	56,550,138	18.9	88,247	7,354
Hampshire, Portsmouth, Isle of Wight, and Southampton	332	29,689,245	1,999,066	16.6	89,425	7,452
Southampton	40	3,487,020	252,872	15.8	87,176	7,265

Source: PNA- pharmacy dispensary data (2020-21) and ONS mid-year population estimate 2020

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8. Population and health

To assess the need for pharmaceutical services in Southampton, it is necessary to understand the city's population and their socio-economic characteristics and health needs. Appendix A, in Part 2 of the PNA, uses data from the Joint Strategic Needs Assessment (JSNA) on the Southampton Data Observatory[22] to provide a very comprehensive picture of Southampton's population which is briefly summarised below.

8.1 Demography and socio-economic factors

8.1.1 Population

In 2022, the resident population of Southampton is estimated to be to be 264,658 [23] with 307,119 people registered with GP practices in January 2022.[24] Southampton has a much younger profile than the national average, largely because of the number of students in the city. However, the older population is projected to grow proportionally more than any other group over the next few years; for instance, the over 65 population is set to increase by 6.9% between 2022 and 2025, and over 85 by 6.5%.

8.1.2 Future dwellings and population changes

In order to assess whether the location, number, and choice of pharmaceutical services meet current and future needs in Southampton we need to first consider the anticipated growth in dwellings and population in the city within the lifetime of this PNA.

The Strategic Housing Land Availability Assessment (SHLAA)[25] for Southampton indicates likely housing developments. The housing requirement for the city is 16,300 dwellings in the period 2006 – 2026. A total of 5,179 dwellings were constructed up to March/April 2012. The outstanding number of dwellings required 2012 - 2026 is therefore 11,121 dwellings, an average of 795 dwellings per year covering the lifetime of the PNA.

These housing requirements are taken into account by the Hampshire County Council population forecasts which predict an increase in dwellings of 3,594 (3.3%) between 2022

[22] Southampton Data Observatory https://data.southampton.gov.uk/
[23] Hampshire County Council https://www.hants.gov.uk/landplanningandenvironment/facts-figures/population/estimates-forecasts
[24] NHS Digital https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice
[25] Strategic Housing Land Availability Assessment, Southampton City Council, accessed via http://www.southampton.gov.uk/planning/planning-policy/research-evidence-base/shlaa.aspx

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and 2025. The increase in dwellings across Southampton translates to a population increase of 8,198 (3.1%).

The largest growth in dwellings over the 2022-25 period is predicted to be in Bargate (1,588 dwellings; 14.3%) – over four times the city average, followed by Woolston (466 dwellings; 6.2%) and Redbridge (248 dwellings; 3.4%). Therefore, it follows that the largest growth in population is predicted to be in Bargate (3,301 people; 12.5%) followed by Woolston (1,158; 6.7%). Bitterne is predicted to see a small fall in population (-27 people;-0.2%) over the same period.

8.1.3 Ethnicity

In the 2011 Census 22.3% of residents recorded their ethnicity as a group other than White British and there is wide variation in diversity within the city; in Bevois ward, over half of residents (55.4%) are from a non-White British ethnic group compared to 7.6% in Sholing. The school census in Southampton in 2020/2021 revealed that 39.4% of pupils were from an ethnic group other than White British.

8.1.4 Deprivation

Southampton is relatively deprived, ranking 55th (where 1 is the most deprived) out of 317 local authorities, and significant inequalities exist within the city. There is a strong association between deprivation and poor outcomes, such a health and crime; for instance, the overall crime rate is 3.1 times higher in most deprived neighbourhoods of the city, compared to the least deprived.

8.2 General health needs of the city

Life expectancy in Southampton is 78.3 years for males and 82.5 years for females compared to the England averages of 80.6 and 84.1 respectively (2018-20). Of the 2,000 deaths of Southampton residents in 2020, cancer was the most common (518 deaths), followed by circulatory diseases (453 deaths) and respiratory diseases (235 deaths). People with circulatory and respiratory disease will more likely be prescribed medication by GPs to help manage their conditions.

Mental health is also an important issue in relation to needs for pharmaceutical services. In 2021, the GP patient survey estimated Southampton had a prevalence of long-term mental health problems among the GP population of 12.2%, this was significantly higher than the national prevalence (11.0%).

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Health behaviours are also relevant to needs for pharmaceutical services. Appendix A includes information on smoking, excess weight, sexually transmitted infections and alcohol and drug use. For instance, in 2017-19, more people died from smoking attributable deaths in Southampton than the national average (260.6 per 100,000 population, compared to 202.2 per 100,000 in England) and more people are admitted to hospitals with smoking related illnesses.

Pharmaceutical services are needed for long term conditions as well as acute injuries, ailments and infections. This has been particularly evident during the COVID-19 pandemic. For more information on COVID-19 please see section 11.6.3 in Appendix A and the COVID-19 Impact Assessment on the Southampton Data Observatory.[26]

8.3 Specific Needs for Key Population Groups

The following groups have been identified as living in the city and their specific needs are summarised below and described in full in Appendix A.

8.3.1 University Students

The most common health issues associated with students are:

- Mumps
- Chlamydia testing
- Meningitis
- Contraception, including EHC provision
- Mental health and wellbeing

8.3.2 Carers

The 2011 Census revealed that, in Southampton, 8.6% (or 1 in 12) of the population provided 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.

Local data from Carers in Southampton (n=2,539) on the distribution of carers known to them revealed hotspots of carers in the city.

[26] COVID-19 updates - https://data.southampton.gov.uk/health/disease-disability/covid-19/covid-19-updates/ resources section. COVID-19 Impact Assessment

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8.3.3 Disability - People with a Learning Disability

There are an estimated 5,100 residents aged 15+ with a learning disability in the city.[27] People with learning disabilities have differing and often complex health care needs leading to increased prescribing and risk of polypharmacy. People with learning disabilities have a higher prevalence of [28]:

- Depression
- Asthma
- Diabetes
- Epilepsy

8.3.4 Disability - Adults with Autistic Spectrum Conditions

In 2020, it is estimated that in Southampton there are 1,200 males (1.1% of male population) and 210 females (0.2% of the female population) aged 16 years and over who would screen positive for autism spectrum conditions.[29]

8.3.5 Lesbian, Gay, Bisexual, and Transgender Community

In 2017, research carried out by Public Health England estimated 2.5% of adults surveyed identified themselves as gay, lesbian bisexual or 'other'; in Southampton this would equate to 5,260 adults. The research found a larger proportion of men stating they were gay compared to women. The largest percentage among any age group is in the 25 to 34 age.[30]

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.

[27] Southampton Data Observatory https://data.southampton.gov.uk/health/disease-disability/learning-disabilites/

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

[29] 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

[30] Producing modelled estimates of the size of the LGB population of England https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585349/PHE_Final_report_FINAL_DRAFT_14.12.2016NB230117v2.pdf

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Specific issues for this population group include being targets for hate crime and mental illness, such as depression and anxiety. The prevalence of smoking, alcohol and drug use is also higher in the LGBT community.

8.3.6 Age

Mental health needs by age are explored in Appendix A Section 11.3 and the health needs of Southampton's children are highlighted in Section 11.5.

- Health issues tend to be greater amongst the very young and the very old
- The number of chronic conditions increases with age: data from GP practices in 2021 in Southampton was analysed showing that by age 40-44 over half have at least 1 long term condition (LTC), by age 60-64 over a third (38%) have at least 3 LTCs and by age 80-84 over a third (34%) have at least 6 LTCs
- A higher rate of older people in Southampton access long-term support through adult social services than is the case nationally[31]

8.3.7 Ethnicity, Migration, Language and Religion

Cultural difference can affect health and wellbeing in many ways including:

- Ethnic differences in health are most marked in the areas of mental wellbeing, cancer, heart disease, HIV, TB and diabetes.
- Migrants may have limited health literacy to spoken and written information that is not in their first language

8.3.8 Gender

Male healthy life expectancy in Southampton is 60.7 years which is significantly lower than the national average of 63.2 years. Inequalities in health are also greater for men in the city: life expectancy at birth is 8.7 years lower for men in the most deprived 20% of the city compared to the least deprived 20% (the equivalent difference is 4.1 years for women, 2018-20).

[31] NHS Digital Adult Social Care Analytical Hub https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-adult-social-care-survey/england-2019-20

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8.3.9 Port Workers and Visitors

Southampton is a port city and, therefore, there is potential for communicable diseases related to the large-scale movements of goods and people through the port.

8.3.10 Veterans

There are an estimated 10,750 veterans living in the city. Most veterans are estimated to be in the older age groups, with 29% aged 55-74 years old, and 31% aged 75-84 years. [32,33] The common health and wellbeing difficulties experienced by veterans include (More information is provided in Appendix A section 11.7.11):

- Socially isolation
- Depression
- Problems with legs and feet
- Heart problems
- Diabetes
- Difficulty hearing
- Difficulty seeing

8.3.11 Travellers

In July 2021, there were 21 traveller caravans in Southampton's authorised site (Kanes Hill). The site has seen a decreasing trend since January 2018 where 36 caravans were recorded. Key barriers to health in these communities include lower health literacy and cultural distrust of systems.

8.3.12 Homelessness

In 2019/20, Southampton's rate of households in temporary accommodation (1.8 per 1,000 households) was significantly lower than the national average (3.8 per 1,000 households). The city's rate of households owed a duty under the Homelessness Reduction Act (10.9 per 1,000 households) was also significantly lower than the national average (12.3 per 1,000

[32] Annual population survey: UK armed forces veterans residing in Great Britain 2017 - GOV.UK (www.gov.uk)

[33] 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

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households), however the rate of households with dependent children owed a duty under the Homelessness Reduction Act (19.8 per 1,000 households) was significantly higher than the national average of (14.9 per 1,000 households).

The average life expectancy for women experiencing homelessness is 43 years and for men is 47 years. Deaths relative to drug and alcohol use are prevalent amongst this population, accounting for just over a third of all deaths, and people experiencing homelessness are nine time more likely to commit suicide than the general population.[34]

[34] '*Homelessness Kills*' report by Crisis available here: crisis_homelessness_kills_es2012.pdf

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9. Gap Analysis

The information collected and analysed for this PNA has been used to carry out a 'gap analysis' to establish whether the pharmaceutical services in Southampton meet current and future needs. The Steering Group agreed that living within 1.6km (straight-line distance) from a pharmacy would be the key criterion for the gap analysis; this distance is used in the NHS Pharmaceutical Services Regulations 2013 when applications are determined under the "market entry" process [35]. Other factors, such as opening hours and services provided, also informed the gap analysis.

9.1 Do existing pharmaceutical services meet current needs?

In terms of current needs, the PNA has ascertained the following:

- There is a good geographical spread of community pharmacies across the city (Section 7)
- Almost all of Southampton's population is within a 1.6km straight line distance of a community pharmacy (Section 7.1). There are two exceptions to this but, for the following reasons, neither is considered to indicate a gap in pharmaceutical provision:
    - The first is a small area in the west which is part of the industrial dock area and has no residential development; people who work in this area are considered to be sufficiently covered by pharmaceutical provision in Totton
    - The second is four residential streets have been identified with no pharmacy provision within a 1.6km radius. These are all gathered in an area of the Bassett Ward at the north of the city, which abuts the M27 and the A27 and is centred on the SO16 7HT postcode. Although there are no pharmacies within a 1.6km radius of these four streets, the area is well served by main roads for those with access to a car, and by two bus routes for those that use public transport.[36] These bus routes connect Bassett to the city centre and Portswood, with one route additionally providing access to the large ASDA, Bournemouth Road in Chandler's Ford, Eastleigh which has its own pharmacy. Additionally, there are four pharmacies just over a 1.6km distance away from this area, at least two of which note on their websites that they

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

[36] Bus map: Southampton Public Transport Map (myjourneysouthampton.com)

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provide delivery options to the Bassett area.[37,38] There are two pharmacies further away (one in Portswood, one in Bitterne Village) that offer deliveries within a 5-mile radius,[39] an area which includes the streets in question

- There are 16 community pharmacies per 100,000 population in Southampton, which is very similar to the average for neighbouring areas and is broadly in line with the national average (Section 7.7)
- Over 99% of the Southampton population are within a 20 minute walk of a community pharmacy (Section 7.5)
- With four 100-hour pharmacies in Southampton, supplementary hours in other pharmacies and provision in neighbouring HWB areas, there are sufficient access times to meet the needs of the city's residents (Section 6)
- All pharmacies provide the full range of essential pharmaceutical services (Section 5.6)
- There is good provision of advanced services across the city (Section 5.7)
- There are a range of enhanced and locally commissioned services delivered in the city (Sections 5.8 and 5.9)
- A large proportion of community pharmacies provide a delivery service to residents, including housebound patients (Section 5.9.7)
- Since the COVID pandemic there has been a marked increase in the use of distance selling pharmacies (Section 5.2)
- In Southampton, fewer items are dispensed per pharmacy than in neighbouring areas or nationally suggesting that demand is being met (Section 7.7)

Therefore, it is considered that the number, distribution and choice of pharmaceutical services meet the current needs of the population.

9.2 Do existing pharmaceutical services meet future needs?

Assessment forecast population growth in the city identified Bargate ward as the area with significant new development within the lifetime of the PNA. In particular, there are 4 Lower Super Output Areas (LSOAs) in Bargate ward which are forecast to have a 17.2% increase in population between 2022-25; these are shown in Figure 16.

[37] Boot's delivery service https://www.boots.com/prescription-support/prescription-delivery-service
[38] LloydsDirect https://www.lloydsdirect.co.uk/delivery-and-collection
[39] Sangha Pharmacy (Thornhill Park Road), and Day Lewis (Portswood Road)

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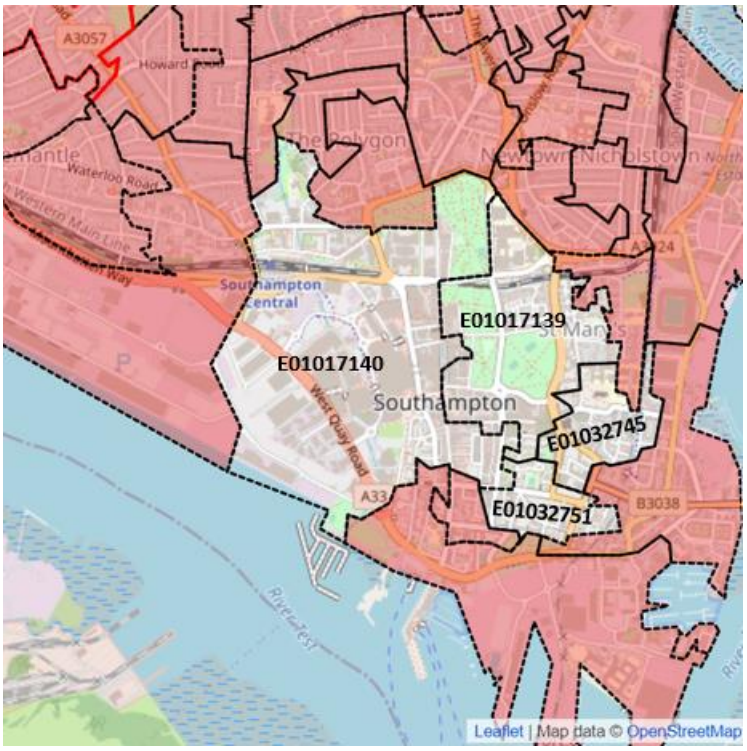
Figure 166: LSOA in central Southampton



Source: OpenStreetMap

This area of Bargate ward is served by four pharmacies; three are located within LSOA E010140 (two of which are part of the 100 hour service; ASDA Pharmacy and Boots the Chemist in West Quay shopping centre and the third is Boots the Chemist Above Bar). A fourth pharmacy is Lloyd's Pharmacy in St Mary's Street, which is in LSOA E01017139.

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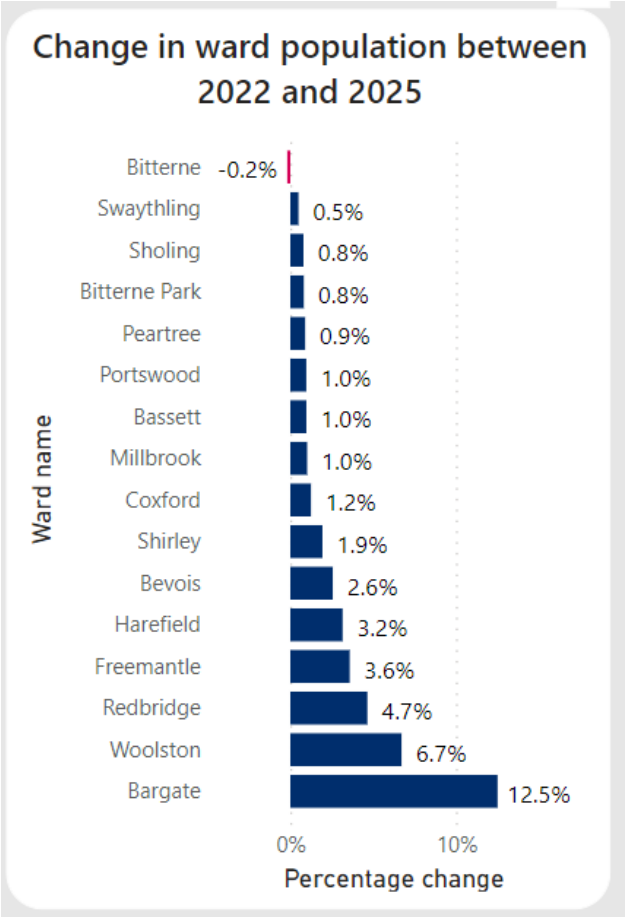
Figure 17: Forecast population change for Southampton wards 2022-25



Source: Hampshire County Council's 2020-based Small Area Population Forecasts

Population growth across the rest of the city is not forecast to be significant within the lifetime of the PNA, as the chart in Figure 17 shows. Therefore, it is anticipated that the future demand for pharmaceutical services from residential development in Southampton can be met by existing providers.

10. Conclusion

The conclusion of this PNA is that the number, distribution and choice of pharmaceutical services meet the needs of the population and will meet future needs within the lifetime of this PNA. Therefore, there is no identified need for improvements or better access to pharmaceutical services in the city.

This conclusion was supported by the majority of respondents to the statutory consultation.

Southampton Pharmaceutical Needs Assessment (PNA) - DRAFT Part 2: Appendices

Last Updated July 2022

Note: **Part 1** is the main PNA report and is in a separate document.

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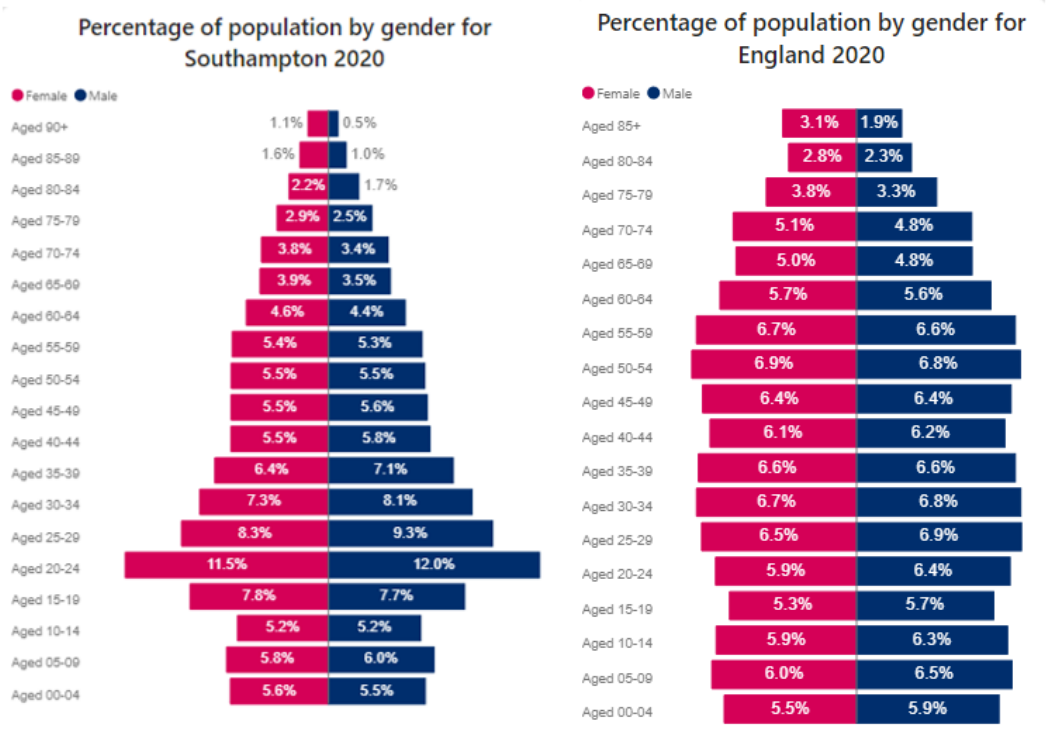
11. Appendix A: Supporting Information

11.1 Population

In 2022, the resident population of Southampton is estimated to be to be 264,658[40] with 307,119 people registered with GP practices in January 2022.[41] The population pyramids in Figure 18, for 2020, show how the profile of Southampton's population differs from the national average. This is because of the large number of students in the city; 19.5% of Southampton's population is aged between 15 and 24 years, compared to just 11.7% nationally.[42]

Figure 18: Population by age and gender for England and Southampton 2020



Source: Small Area Population Forecast, Hampshire Country Council and Mid-Year Population Forecast, Office for National Statistics

[40] Hampshire County Environment Department's 2020-based Southampton Small Area Population Forecasts https://www.hants.gov.uk/landplanningandenvironment/facts-figures/population/estimates-forecasts

[41] NHS Digital https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice

[42] Southampton population dashboard. January 2022 https://app.powerbi.com/view?r=eyJrIjoiNzgxZjAzNTQtZDg5Ni00NTczLWE0Y2EtY2FjNTNiNjhlMzk4IiwidCI6IjNhM2IwNzlhLTY0YzAtNDcxYy05MmU1LTRlOTE5ZTMwN2NhOCIsImMiOjh9

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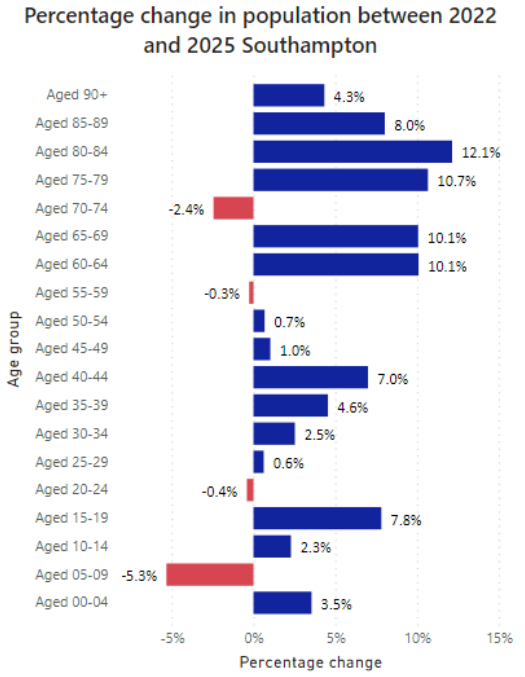
There are many uncertainties around current and future population numbers. The Southampton JSNA currently uses data produced by Hampshire County Council (HCC)[43] which incorporates the results of the 2011 Census. HCC's small area population forecasts (SAPF) are based on the planned completions of residential dwellings in Southampton, which predict an increase in dwellings of 3,594 (3.3%) between 2022 and 2025 – the lifetime of this PNA. The largest growth in dwellings is predicted to be in Bargate (1,588 dwellings; 14.3%) – over four times the city average, followed by Woolston (466 dwellings; 6.2%) and Redbridge (248 dwellings; 3.4%). The increase in dwellings across Southampton translates to a population increase of 8,198 (3.1%) between 2022 and 2025. Due to the planned residential development, the largest population growth is predicted to be in Bargate (3,301 people; 12.5%) followed by Woolston (1,158; 6.7%). Bitterne's population is predicted to fall by approximately -27 (-0.2%) 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 19). The over 65s population is projected to increase between 2022 and 2025, from 38,025 in 2022 to 40,650 in 2025, an increase of 6.9%. The over 85s population is forecast to grow from 5,744 to 6,119, an increase of 6.5%.

Figure 19: Population change by age, in Southampton, between 2022 and 2025



Source: Hampshire County Council 2020-Based Southampton Small Area Population Forecasts

[43] Hampshire County Environment Department's 2020-based Southampton Small Area Population Forecasts https://www.hants.gov.uk/landplanningandenvironment/facts-figures/population/estimates-forecasts

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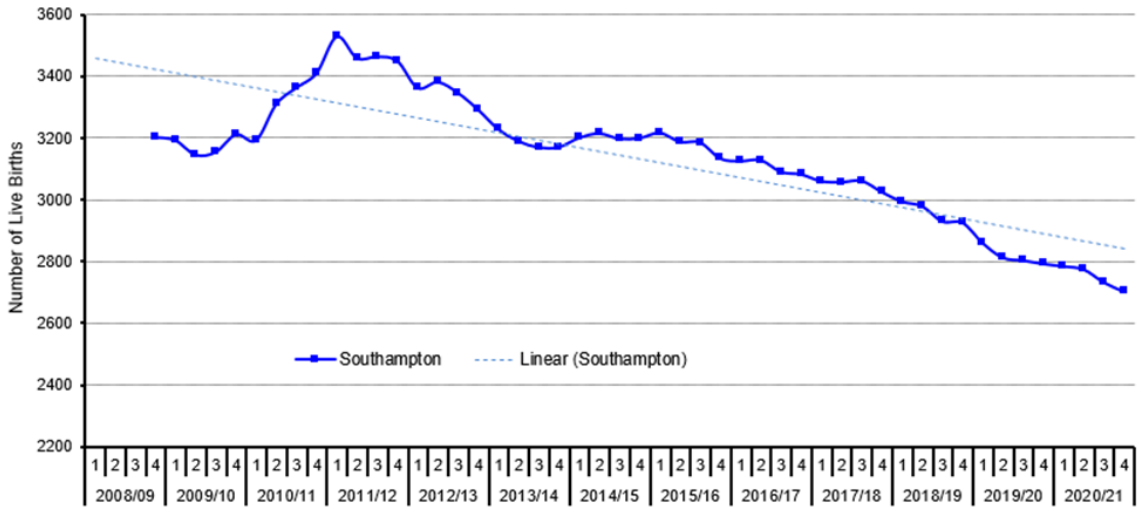
Life expectancy in Southampton is 78.3 years for males and 82.5 years for females compared to the England averages of 80.6 and 84.1 respectively (2018-20). In addition, although people are living longer, it is often with multiple long-term conditions and an extended period of poor health and/or disability.

According to the HCC forecasts, the number of 0- to 4-year-olds will increase by 3.5% between 2022 and 2025, however, local monitoring of births at University Hospital Southampton (UHS) reveals that births have fallen by -15.6% between 2008/09 and 2020/21 (Figure 20).

Figure 20: Number of live births in Southampton, annual rolling average 2008/09 to 2020/21



Source: HICCS Maternity, UHS

Between 2011 and 2019 general fertility rates in the city have decreased from 63.4 to 50.0 per 1,000 females aged 15-44 years. The 2019 figures compare with 56.9 per 1,000 females aged 15 to 44 years across the South East and 57.7 per 1,000 in England.

In 2020, the general fertility rate for Southampton by electoral ward ranged from 71.6 births per 1,000 females aged 15 to 44 years in Redbridge to 30.4 in Swaythling (Figure 21).

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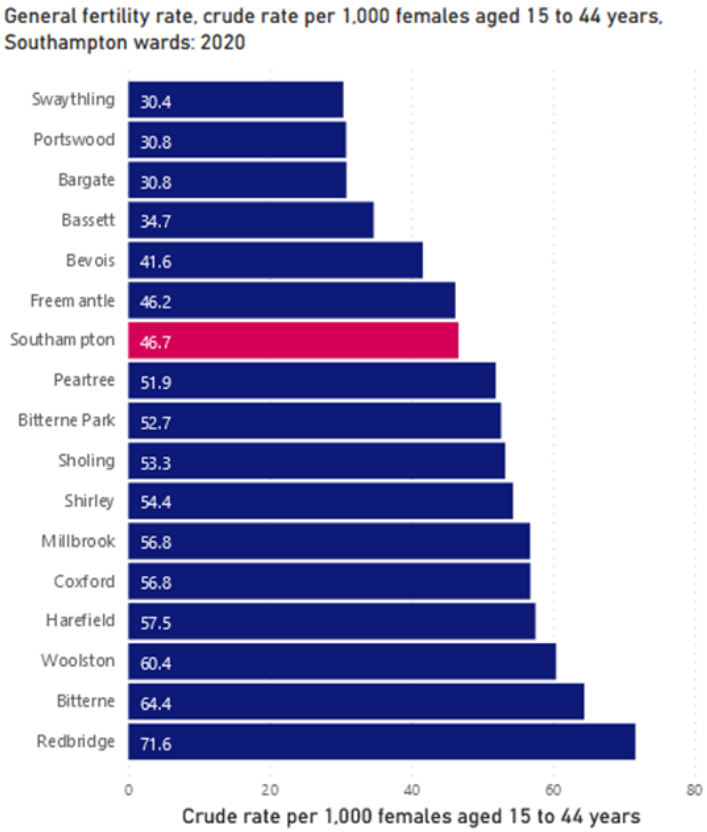
Figure 21: General fertility rate in Southampton wards 2020



Source: Office for National Statistics

11.1.1 Ethnicity, Migration, Language and Religion

Data on long-term international migration up to the end of June 2020 shows that Southampton has more international incomers than leavers (6,790 compared to 3,869). There is also a high level of internal migration, with 15,531 people arriving and 19,067 leaving over the same period. More recently these movements have been impacted by the restrictions resulting from the COVID-19 pandemic. The latest figures include a mix of data from pre-COVID-19 time (up to March 2020) and from during the pandemic (April to December 2020).

Based on results from the 2011 Census, Southampton has residents from over 55 different countries who between them speak 153 different languages.[44] 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 22, show that the biggest change has been in the 'Other White'

[44] Schools, pupils and their characteristics, Department for Education 2020/21. https://explore-education-statistics.service.gov.uk/find-statistics/school-pupils-and-their-characteristics Accessed 22/11/2021

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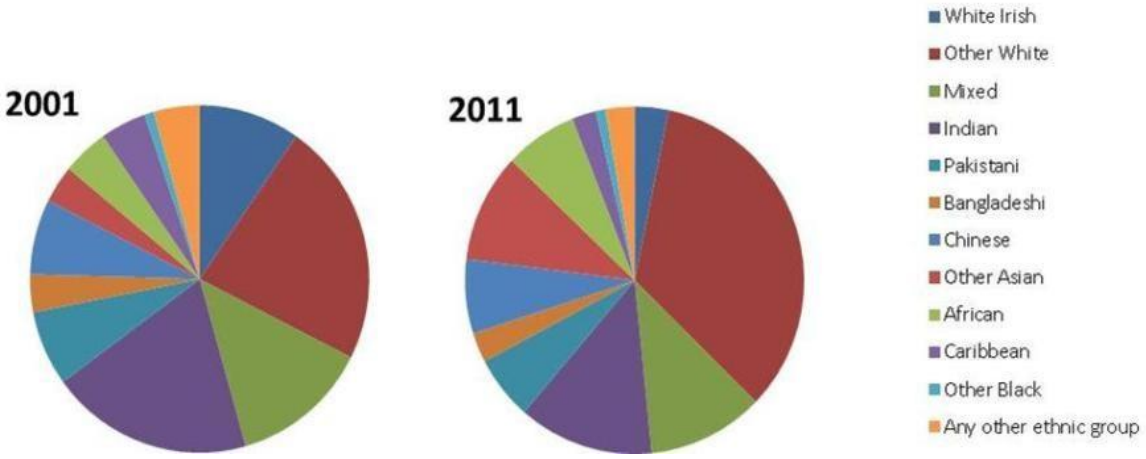
population (which includes migrants from Europe) as this increased over the 10 year period by more than 200% (from 5,519 to 17,461).

Figure 22: Ethnicity of resident population reported in the 2001 and 2011 census



Source: Office for National Statistics 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 school census in Southampton in 2020/2021 revealed that 39.4% of pupils were from an ethnic group other than White British. This has increased from 24.8% in 2015/16.

In 2020/21, just over 42.9% 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 18.9% (2020/21), see Figure 23. In 2011 17.6% of Southampton residents were born outside UK, compared to 13.8% for England.

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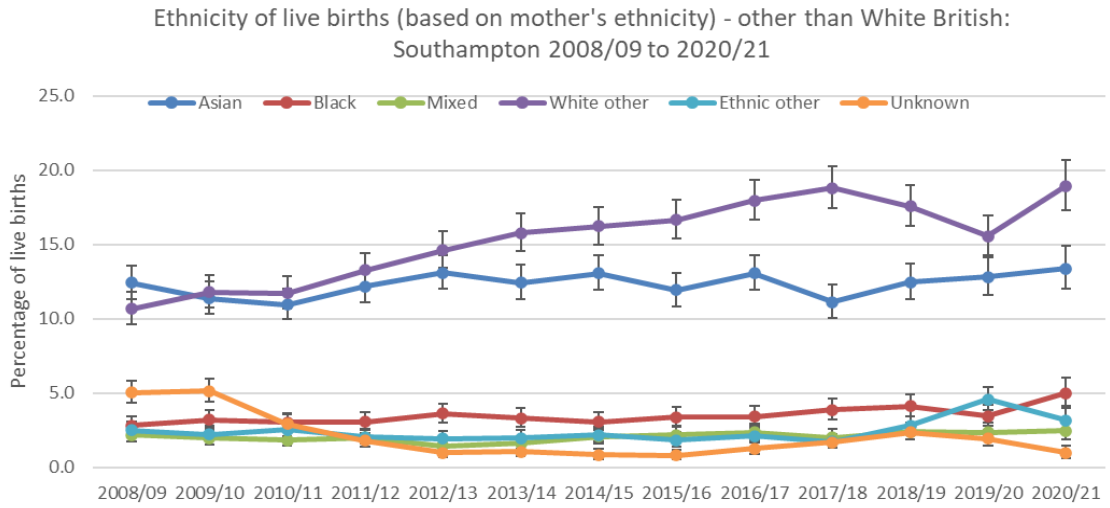
Figure 23: Ethnicity of live births (based on mother's ethnicity) - other than White British: Southampton 2008/09 to 2020/21



Source: UHS Midwifery database, Southampton CCG

Southampton has a higher proportion than nationally 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 2020/21 found that 28% of school pupils had a first language other than English; a rise of 3.2% percentage points from 2015/16.[45] In the January 2021 school census, the top five languages spoken in Southampton schools (excluding English) are show in Figure 24 below.

Figure 24: Top 5 languages spoken in Southampton schools 2021 (excluding English)

Top 5 languages	Number of pupils	% of total
Polish	2,677	8.4
Panjabi/Punjabi	578	1.8
Urdu	487	1.5
Romanian	445	1.4
Pashto/Pakhto	406	1.3

Source: 2021 School Census. Children's Data Team Southampton City Council.

[45] Schools, pupils and their characteristics, Department for Education 2020/21. https://explore-education-statistics.service.gov.uk/find-statistics/school-pupils-and-their-characteristics Accessed 22/11/2021

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The following statistics in Figure 25 for self-reported religion of Southampton residents are taken from the 2011 Census.

Figure 25: Religion from 2011 Census, for Southampton

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
Buddhist	1,331	0.6
Other religions	1,329	0.6
Jewish	254	0.1

Source: Office for National Statistics 2011 Census

11.1.2 Southampton's Local Economy

Southampton is the UK's number one vehicle handling port, handling 900,000 vehicles per year. It is also Europe's leading turnaround cruise port, welcoming around two million passengers annually and is home to the UK's largest cruise line operators. It is also home to the second largest container terminal in the UK and in 2018 handled more than 1.9 million twenty-foot equivalent units (TEUs).[46]

The Port of Southampton supports 45,600 jobs and contributes £2.5 billion to the nation's economy every year. As the UK's number one export port, Southampton handles exports worth £40 billion annually, including £36 billion destined for markets outside the EU.[47]

Major employers include Southampton City Council, the NHS, the University of Southampton and Southampton Solent University, Carnival, Old Mutual Wealth, DP World (container port) and Southampton based rail and bus companies. The city has five million

[46] The twenty-foot equivalent unit (TEU) is an inexact unit of cargo capacity, often used for container ships and container ports. It is based on the volume of a 20-foot-long (6.1 m) intermodal container, a standard-sized metal box which can be easily transferred between different modes of transportation, such as ships, trains, and trucks.

[47] Associated British Ports Website (2018) https://www.abports.co.uk/locations/southampton/ (Accessed 02/12/2021)

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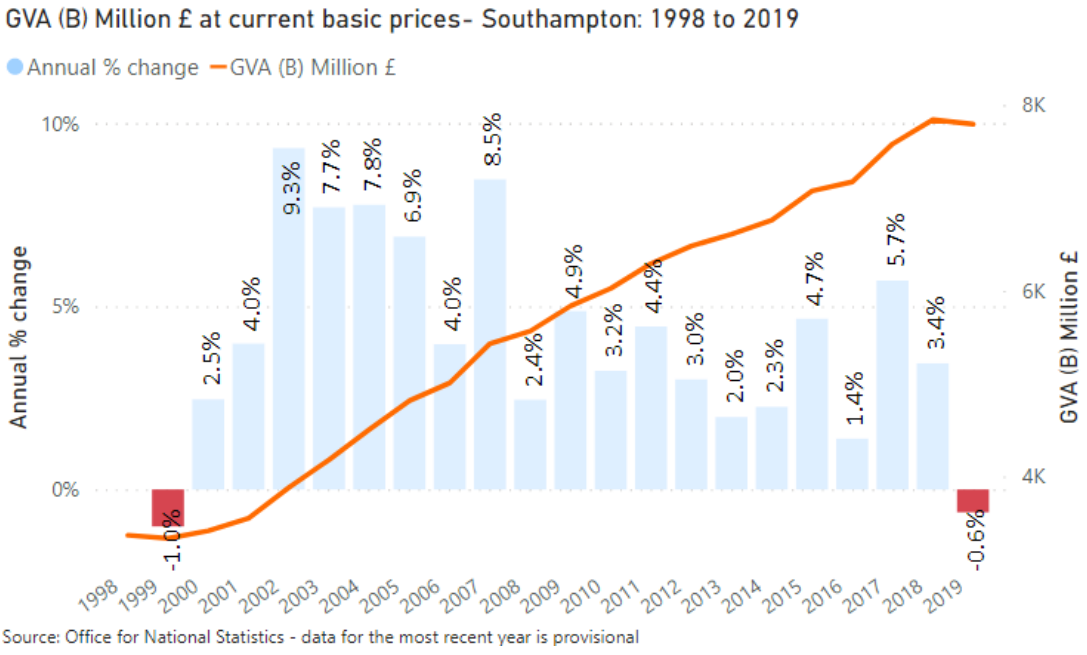
visitors a year for retail and leisure activities and its night-time economy has grown in recent years. Although this has been affected by the COVID-19 pandemic in 2020 and 2021.

Productivity and growth can be measured using Gross Value Added (GVA), which is a key economic indicator. It measures the performance of each individual producer or industry and their input to the economy. The most recent data (2019), estimates the Southampton economy to be worth 7.8 billion, which is a decline of -0.6% compared to the previous year. Despite this decline, economic growth up to this point was relatively healthy. Additionally, GVA (B) per head of population in Southampton (£30,865) was higher than the national average (£30,239) in 2019. GVA (B) per head is a useful way of comparing regions of different sizes and is an important indicator for benchmarking economic growth, see Figure 26, below, for details.[48]

Figure 26: GVA (B) million £ at current basic prices - Southampton 1998-2019



Source: Office for National Statistics - data for the most recent year is provisional

11.1.3 Major Regeneration Projects

Southampton has many regeneration projects recently completed or underway. Notable schemes delivering new homes in the city centre have been the Chapel Riverside with 205 new riverside dwellings, the old Fruit and Vegetable Market site at Queensway and Bernard Street with a further 279 apartments plus another 94 apartments which were delivered alongside the 85 room Harbour Hotel. Just outside of the city centre boundary there are 159

[48] Southampton economic assessment https://data.southampton.gov.uk/economy/economic-assessment/ (Accessed 02/12/2021)

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new homes at the former Meridian TV Studios site, directly adjacent to the River Itchen and Northam Bridge, in addition to 106 new homes at Townhill Park and 103 at Centenary Quay in Woolston.

Between 2018 and 2021 there have been a number of large-scale developments granted planning permission with more continuing to emerge into 2022. Most recently, for the former Toys R Us site located in the city centre between Southampton Central Station and West Quay, the 'Maritime Gateway' proposal has been submitted. The scheme proposes 600 new homes plus office and retail space. Another notable scheme, approved in 2021, is the Bargate Quarter redevelopment which comprises 519 new residential units and flexible commercial floorspace plus drinking establishments/bar uses (Sui-Generis) and associated public realm improvements in the heart of the city centre.

Other large-scale outstanding permissions also include:

- 2 Victor Street – 45 flats
- 69-73 Dairy Crest Road – 49 retirement flats
- Compass House, Romsey Rd – 19 flats (one permission), conversion from office use to 241 flats (separate permission)
- Dukes Keep, Marsh Lane – conversion from office use to 147 flats
- Frobisher House, Blechynden Terrace - conversion from office use to 63 flats
- Land to the rear of the Dolphin Hotel, High Street – 72 flats
- Norwich House, Southbrook Road - conversion from office use to 74 flats
- Former Oaklands School, Fairisle Road – 193 dwellings (41 flats and 62 houses)
- Woodside Lodge, Wimpson Lane – 98 flats

11.1.4 Overall Deprivation

Whilst Southampton has achieved significant economic growth in the last few years, the city characteristics relating to poverty and deprivation present challenges more in common with urban areas outside of the South East.

The Index of Multiple Deprivation (IMD 2019) illustrates how Southampton continues to be a relatively deprived city (Figure 27). Based on average deprivation rank of its neighbourhoods (Lower Super Output Areas - LSOAs), Southampton is now ranked 55th (where 1 is the most deprived) out of 317 local authorities: more deprived than comparator cities of Bristol (82nd), Leeds (92nd) and Sheffield (93rd). Southampton has 19 LSOAs within the 10% most deprived in England and one in the 10% least deprived.

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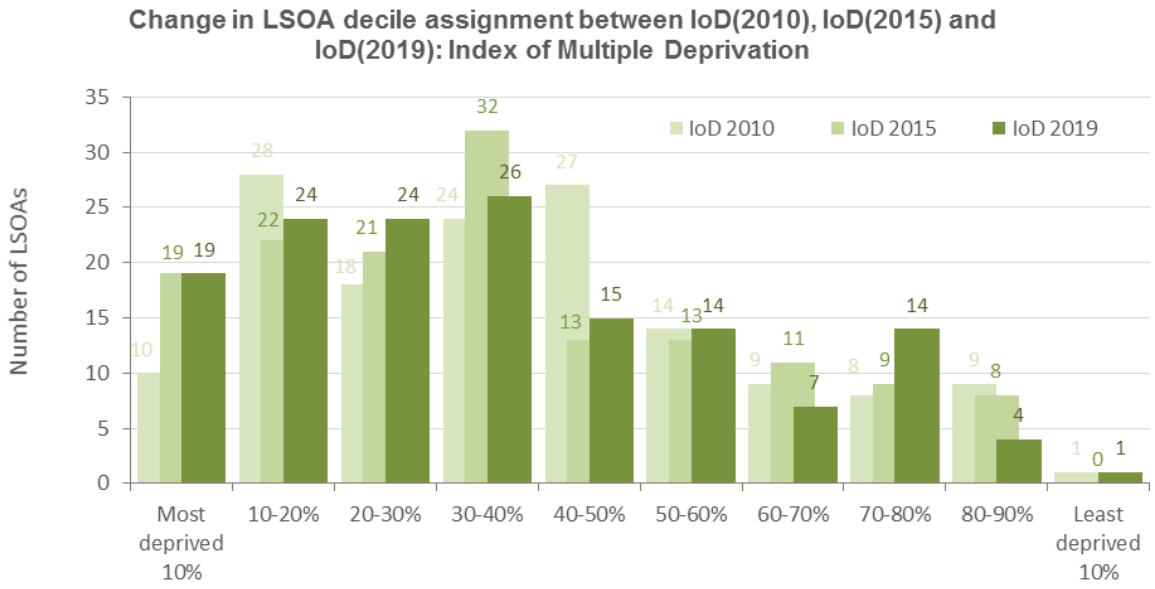
Figure 27: Change in LSOA decile assignment between Index of Deprivation (IoD) 2010, 2015 and 2019 Index of Multiple Deprivation



Source: DCLG. Note: IMD (2019) data is based on PHE rebased figures for 2011 LSOAs

The IMD 2019 is based on the concept that deprivation consists of more than just poverty. Poverty is not having enough money to get by on whereas 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 data underpinning the IMD 2019 is from 2015/16, although some is more recent.

The seven domains are income, employment, education, skills and training, health, crime, barriers to housing and services and finally living environment. In addition, the IMD also has two supplementary indices: Income Deprivation Affecting Children (IDACI) and Income Deprivation Affecting Older People Index (IDAOPI).

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 28) shows how the LSOAs in Southampton score on the 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.

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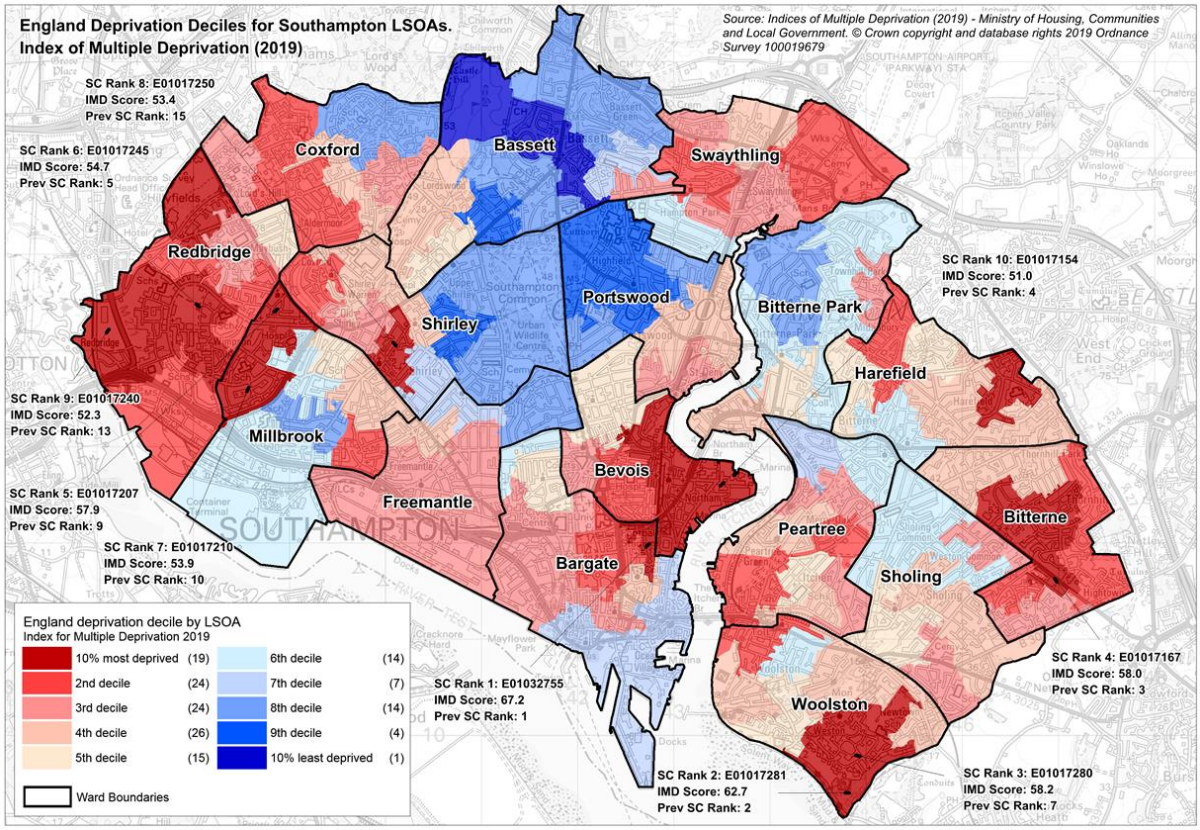
Figure 28: Overall deprivation by England deciles for Southampton 2019



11.1.5 Income Deprivation

At city level, Income Deprivation worsened by two places between 2015 and 2019 and, of the 148 LSOAs in Southampton, 27 moved into a more deprived decile, 100 have remained in the same decile and 21 have moved into a less deprived decile. Southampton has 13 LSOAs within the 10% most income deprived in England (16 in 2015) and 6 LSOAs in the 10% least deprived (7 in 2015). This suggests that the number of neighbourhoods experiencing the most extreme income deprivation has reduced since 2015. However, in 2019, 51 LSOAs were in the most deprived 30% nationally, compared to 47 in 2015, suggesting a more uniform shift in relative income deprivation in Southampton.

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11.1.6 Children Affected by Deprivation

The Marmot Review (2010)[49] 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 2019/20, nearly 22.0% of children in Southampton were living in child poverty. This is defined as children, aged under 16, living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income. This is significantly worse than the England average of 19.1%.

11.1.7 Older People Affected by Deprivation

Older people are one of the most vulnerable groups in society. At city level, Income Deprivation Affecting Older People Index (IDAOPI) worsened by four places between 2015 and 2019. However, there have been variations at neighbourhood level in the city. Southampton has 13 LSOAs within the 10% most deprived in England (11 in 2015) and four LSOAs in the 10% least deprived (four in 2015). This suggests that the number of neighbourhoods experiencing the most extreme income deprivation has increased since 2015. There was also an increase in the number of LSOAs in the most deprived 30% nationally (66 LSOAs in 2019 compared to 54 in 2015).

11.1.8 Unemployment, Employment, Education, and Training

The impact of COVID-19 on jobs in the city and across the country has already become apparent (Figure 29). As a pre-pandemic benchmark, 3.2% (5,555) of adults aged 16-64 in Southampton were estimated to be claiming out of work benefits as of February 2020, with this figure more than doubling between March 2020 and March 2021 throughout a series of lockdowns, both locally and nationally. A reduction has been observed since April 2021 with a gradual decrease in claimant count. As of December 2021, 4.9% of the working age population in Southampton were claiming out of work benefits.

Universal credit data is available as a total for everyone claiming or by those in work or out of work, a similar picture to the claimant count figure can be seen with those claiming universal credit. The total figure also includes those not looking for work. The number of

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

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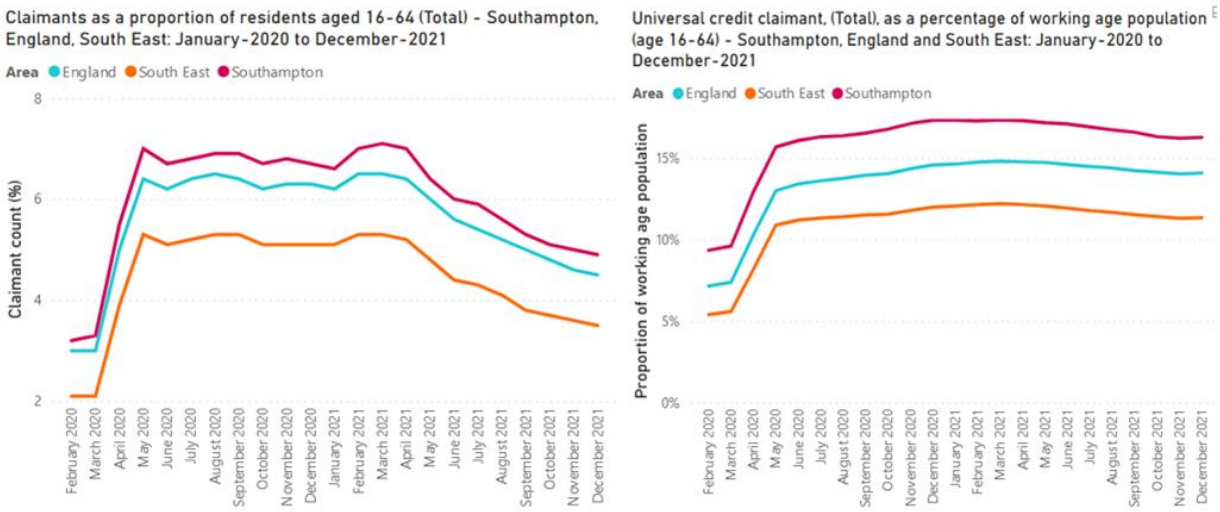
people claiming in January 2020 was 9.1% of the working age population. In March 2021 this increased to 17.3% and has remained fairly steady. In December 2021, 16.3% were claiming universal credit. More information can be found in the benefits dashboard on Southampton Data Observatory.[50]

Figure 29: Job-seekers Allowance (JSA) claimants and Universal Credit claimants for Southampton from February 2020 to December 2021



Source: Department of Work and Pensions via Nomis and Stat-Xplore

As can be seen from Figure 30 below, there is a gap in the amount of pay between those workers who are residents of Southampton and those whose workplace is the city. The average weekly earnings for residents was £563 in 2020 whereas the average weekly workplace earnings were £635, a difference of £72 or 12.7%.

[50] Southampton Data Observatory Economic assessment resources section.https://data.southampton.gov.uk/economy/economic-assessment/ (Accessed 03/12/2021)

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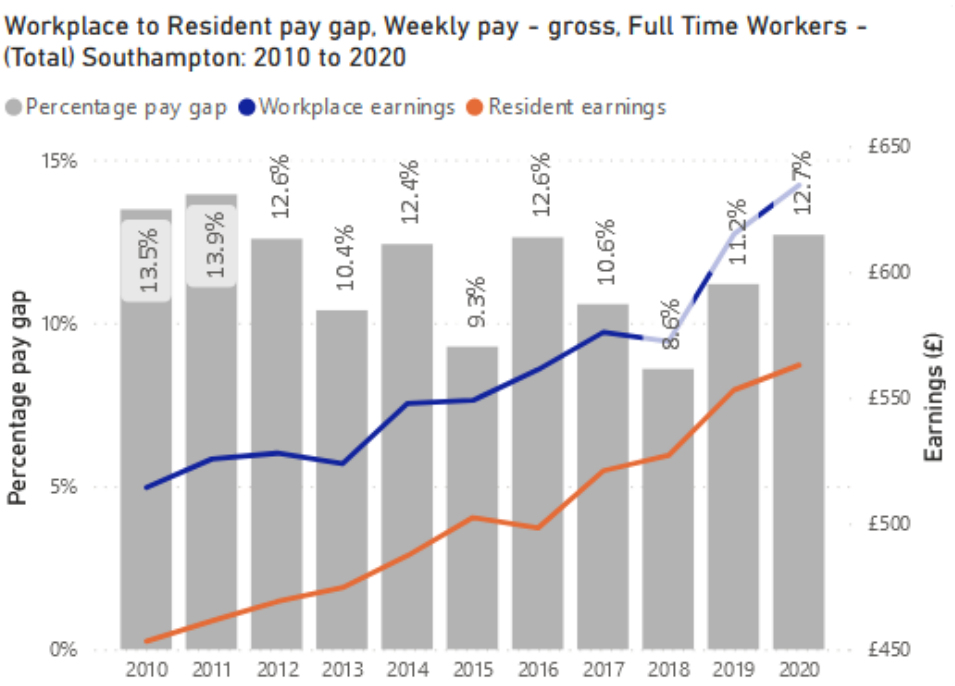
Figure 30: Workplace and residents pay gap, for Southampton 2010 to 2020



Source: Office for National Statistics – Annual Survey of Hours and Earnings (ASHE)

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. However, the relatively high levels of income available to workers in the city is not directly reflected in the economic wellbeing of Southampton residents. The average house price in Southampton (£229,777 in September 2021) is 7.1 times the average annual salary for residents (£32,445).

The way in which school pupils were examined changed in 2016 with the introduction of attainment 8 and progress 8. In 2017, new, reformed English and Maths GCSEs were first examined and a new grading of 9-1 was introduced, with 9 being the highest grade. In 2018, reformed English Baccalaureate GCSEs and several other key subjects were first examined using the 9-1 grading. In 2019 further reformed GCSE qualifications were introduced on the 9-1 grade scale. For the first time in 2020 all GCSEs had been converted to a scale of 9-1 with no unreformed GCSEs graded A*-G remaining. Consequently, any trend comparisons made between 2016 and 2020 results for the key headline performance measures must be treated with caution.

Attainment 8 measures a pupil's average grade across eight subjects including English and Maths. Due to the coronavirus pandemic, the summer exam series was cancelled in 2020. Pupils scheduled to sit GCSE and A/AS level exams in 2020 were awarded either a centre assessment grade or their calculated grade using a model developed by Ofqual (whichever

was the higher of the two). Due to the way in which grades were awarded in 2020, data on attainment is not comparable to previous years; however, we are still able to benchmark against statistical neighbours. Southampton has an attainment eight score of 46.2 (2020/21)[51], which is lower than the national average of 50.9. In view of achieving Grade 5 or above in English and Mathematics GCSEs, Southampton has 41.8% pupil achieved, which is also lower than the national average of 51.9%.

In 2020, 30.7% of Southampton pupils entered the English Baccalaureate (EBacc) which was a decrease of 3.1% from the proportion of Southampton pupils entering the EBacc in 2019 (34.8%). The 2020 National average for pupils entering the EBacc was 39.8%.

Overall 15.3% of Southampton pupils achieved the EBacc at grade 5 or above in 2020, which was 2.2% above 2019 performance of 13.1%. In 2020, 21.3% of National pupils achieved the EBacc at grades 5 or above, a gap of 6.0% to the 2020 Southampton average (15.3%).

In 2020, the percentage of Southampton's young people aged 16-17 years not in education, employment, or training (NEET) was 4.4%, and this was higher than the rate for England (2.8%). The rates for Southampton and England have increased since 2016. [52]

11.1.9 Housing Composition

The 2011 Census revealed lots about the way people live in Southampton, including information on household composition (Figure 30). As expected from having a large student population, Southampton had a higher proportion of single (never married) residents than nationally (33.3% compared with 25.8%). Southampton had 10,249 widowed residents and 17,184 who were single through separation or divorce. There were 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%).

[51] Department for Education - Key stage 4 performance 2021.https://www.gov.uk/government/statistics/key-stage-4-performance-2021 (Accessed 24/01/2022)
[52] DfE – NEET and participation: Local authority figures. https://www.gov.uk/government/publications/neet-and-participation-local-authority-figures (Accessed 03/12/2021)

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Figure 31: Marital status of Southampton Residents

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
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

Source: Office for National Statistics 2011 Census

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

11.1.10 Housing Stock

In 2020, there were an estimated 108,556 homes in Southampton,[53] the details of which are shown in Figure 32. The proportion of housing stock in Southampton that was local authority owned, was over twice the national average.

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

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Figure 32: Housing stock in Southampton

Tenure	Number	Percentage of total	
		Southampton	National
Local Authority (incl. owned by other LAs)	16,110	14.80%	6.40%
Private Registered Provider providers of social housing (includes Housing Associations)	7,947	7.30%	10.50%
Other public sector	0	0.00%	0.10%
Private sector	84,499	77.80%	83.00%
Total (all housing)	108,556	100.00%	100.00%

Between 2018 and 2021 there have been over 2,400 new homes built across the city. In recent years, estate regeneration projects have been undertaken in Hinkler Road, Laxton Close, Exford Avenue and Cumbrian Way. Additionally, there have been energy efficiency improvements using 'Eco' funding at International Way and 73 wheelchair liveable properties.

More people have been helped to stay in their homes for longer with over 5,600 adaptions to homes since 2011 and over the last 20 years Southampton City Council have brought back more than 2,000 empty homes into use. Licensing has been introduced for Houses in Multiple Occupancy (HMOs) to raise standards and mitigate the impacts of HMOs on the city.[54]

11.1.11 Crime and Disorder

Data from the 2021 Strategic Assessment covering the period of April 2020–March 2021 is impacted by the COVID-19 pandemic. Changes in police recorded crime over the last year should be interpreted in light of coronavirus restrictions and limited social contact. Important to emphasise that coronavirus has not only altered the volume of crime, but patterns too. Changes in recorded crime figures vary by crime type, with some crime types experiencing an increase during 2020/21.

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

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In 2020/21, Southampton had an overall crime rate of 112 crimes per 1,000 population. Southampton accounted for 20.1% of total recorded crime across Hampshire Constabulary in 2020/21. Southampton has the highest total reported crime rate and highest crime severity amongst iQuanta comparators. Caution should be taken when making comparisons because of variations in reporting and recording between forces.[55]

Between 2019/20 and 2020/21 there was an 11.4% decline in total police recorded crime in Southampton. England (-14.4%) and Hampshire Constabulary (-12.9%) also experienced a decline in total police recorded crime during the same period.

Southampton experienced a -10.1% decline in the crime severity score of all crimes between 2019/20 and 2020/21, with Hampshire Constabulary (-9.5%) and England (-13.8%) also experiencing a decline. Despite the decline in the volume and severity of total recorded crime over the last year, Southampton is highest among statistical comparators and higher than the national average when considering the volume (rate) and severity of total recorded crime.

Between 2019/20 and 2020/21, there has been a decline in the number of offences for 19 of the 31 offence types. There have been notable declines in:

- Violent crime (-5.1%),
- Sexual offences (-13.5%); including rape (-12.9%),
- Residential burglary (-15.6%),
- Crimes involving a bladed implement (-8.0%),
- Alcohol affected crime (-13.3%)
- Anti-social behaviour (-10.7%)

Notable increases include:

- Domestic flagged crime (2.6%),
- Domestic violent crime (3.3%),
- Stalking and harassment (22.3%) (including malicious communications),
- Drug offences (33.0%),
- Drug affected crime (17.0%)
- Hate crime (19.4%)

[55] Safe City Strategic Assessment 2020-2021. https://data.southampton.gov.uk/images/safe-city-strategic-assessment-summary-slideset-2020-21_tcm71-450629.pdf

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There is local evidence to suggest that the decline in anti-social behaviour and increase in stalking and harassment offences may be due to changes in the way crimes are being classified based on victim perception.

The role of COVID-19 also needs to be acknowledged, in terms of the impact it has had on the volume of offences, and in changing crime patterns.

At ward level, total crime continues to be significantly higher in Bevois and Bargate wards. The link between crime and deprivation remains strong. The overall crime rate is 3.1 times higher in most deprived neighbourhoods in the city, compared to the least deprived.

Bargate, Freemantle, Shirley, Bevois, Bitterne and Redbridge wards had a significantly higher total crime rate than the city average, with some of the most deprived neighbourhoods in the city located in Bevois, Bitterne and Redbridge wards. Bevois ward is significantly worse than the city average for all crime types.

Sholing and Bassett are better than the city average for all crime types, with these wards where some of the least deprived neighbourhoods in the city are located.

Overall crime decreased in 11/16 wards, the largest decrease of overall crime seen in Bargate (-37.7%); this illustrates the impact of COVD-19 restrictions, particularly suppression of the night time economy.

For more information on crime in Southampton please see the Safe City Strategic Assessment: 2020/21 available on Southampton Data Observatory.[56]

11.2 General Health Needs of Southampton

11.2.1 Life Expectancy

Life expectancy is the number of years a baby born today would expect to live where he or she to experience a particular area's age-specific mortality rates for that time period throughout his or her life. In 2018-20, male life expectancy was 78.3 years; significantly lower than England (79.4 years), and 5th lowest out of 12 in Southampton's Office for National Statistics (ONS) comparator group.

[56] Southampton Data Observatory. https://data.southampton.gov.uk/community-safety/safe-city-assessment/

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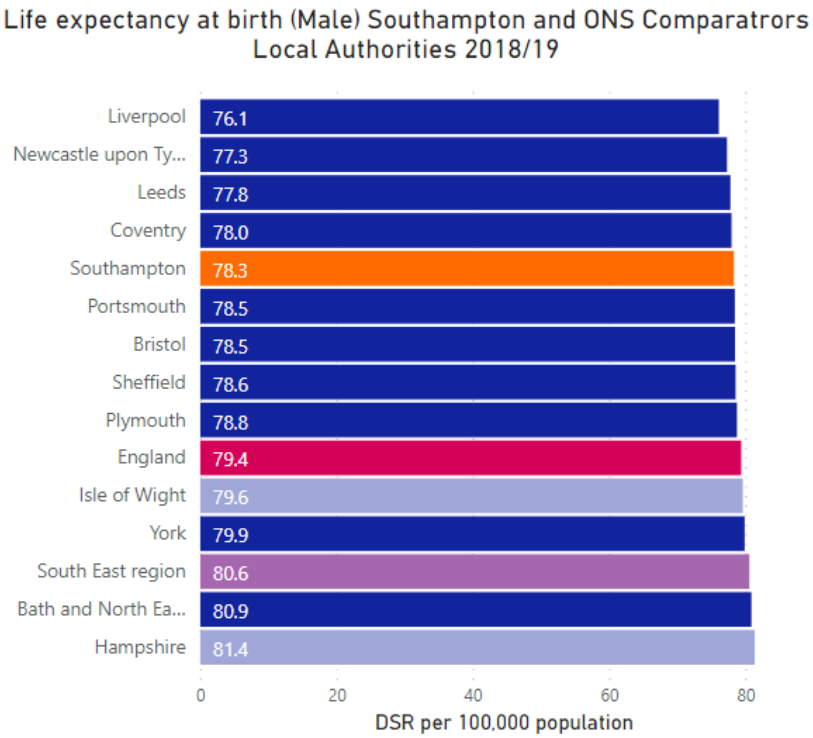
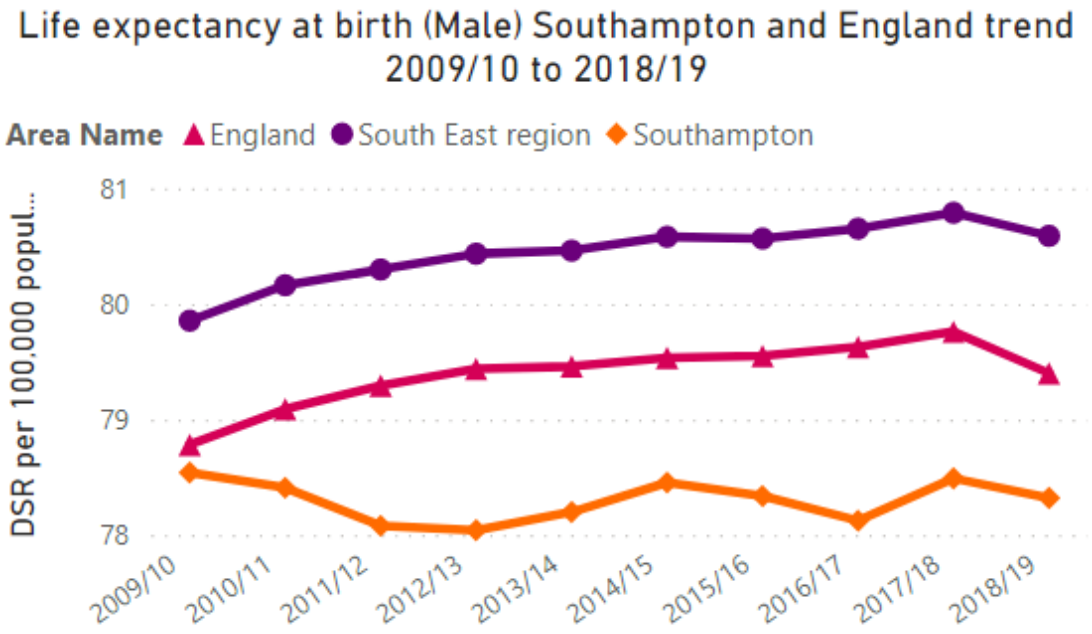
Figure 33: Life expectancy at birth (Male)



Source: Office for National Statistics (ONS)

Figure 34: Life expectancy at birth (Male) Southampton and England trend: 2009/10 to 2018/19



Source: Office for National Statistics (ONS)

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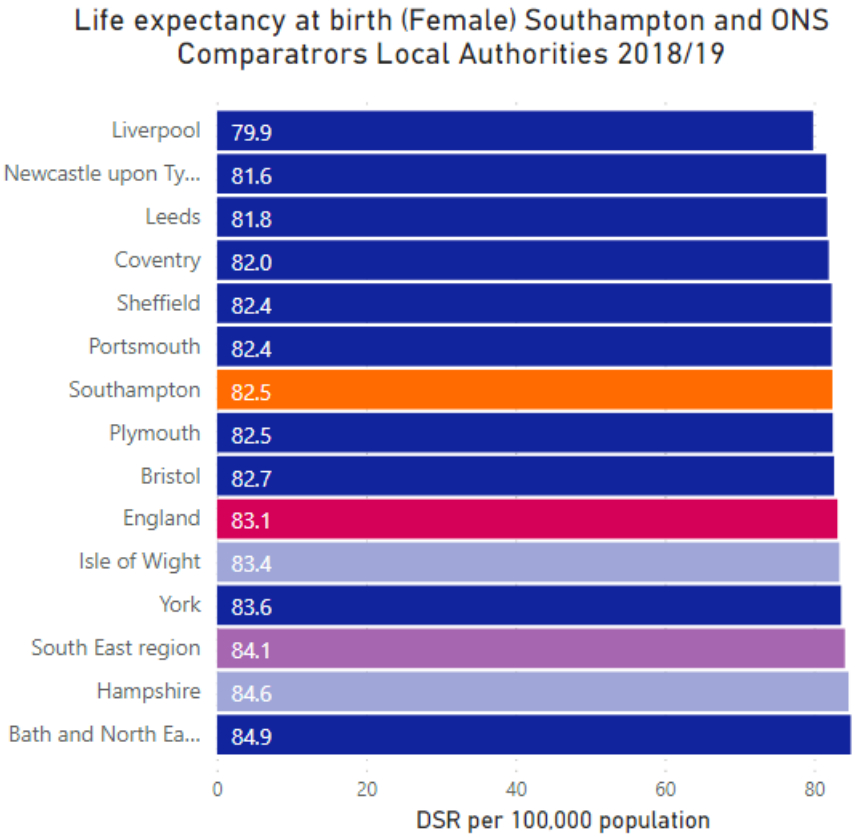
In 2018-20, female life expectancy at birth was improving (82.5 years); significantly lower than England (83.1 years) and the 7th lowest amongst Southampton's 12 ONS comparators group (Figure 35).

Figure 35: Life expectancy at birth (Female)



Source: Public Health England - Public Health Outcomes Framework (PHOF)[57]

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

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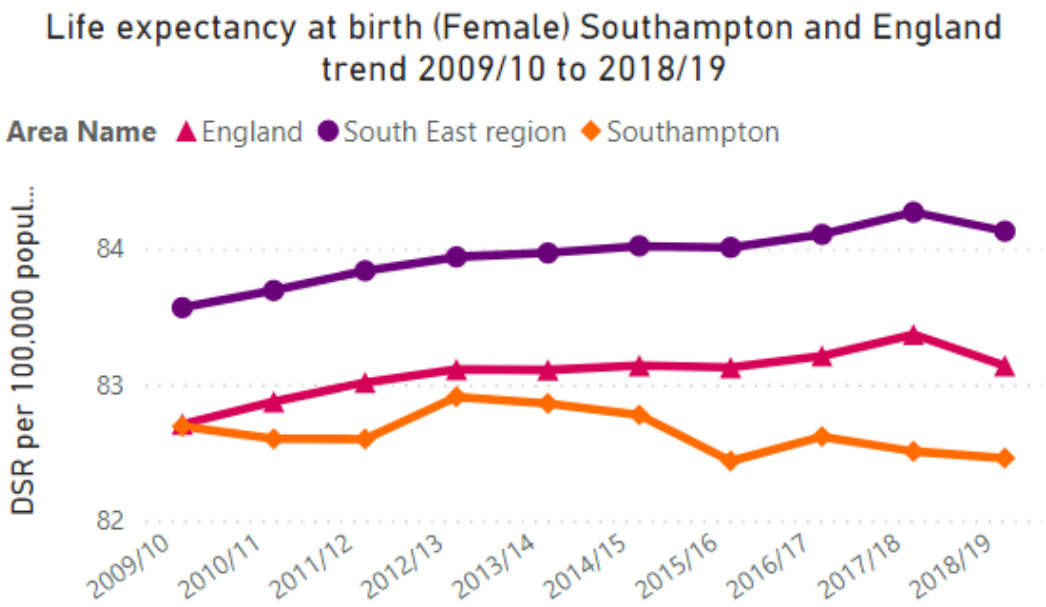
Figure 36: Life expectancy at birth (Female) Southampton and England trend: 2009/10 to 2018/19



Source: Public Health England - Public Health Outcomes Framework (PHOF)[58]

Nationally, life expectancy at birth increased steadily for both males and females through the 2000s. In the last 10 years life expectancy for males in Southampton has remained significantly worse than the England average. Female life expectancy in the city has increased alongside the England average until 2015-17 and since then life expectancy for females has consistently been significantly worse.[59]

The life expectancy at birth gap between the most deprived 20% of Southampton to the least deprived 20%, is 8.7 years for men and 4.1 years for women (2018-20).

In 2017-19, the number of years of healthy life expectancy for males are significantly lower and for females are lower but not significantly in Southampton (60.7 years and 62.6 years respectively) compared to England (63.2 years and 63.5 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 in 2017-19 are lower, but not significantly in Southampton (61.4 years and 59.6 years respectively) compared to England (62.7 years and 61.2 years respectively). Many long-term

[58] Public Health England - Public Health Outcomes Framework (PHOF) http://www.phoutcomes.info/
[59] Office for Health Improvement & Disparities Fingertips Public health profiles - OHID (phe.org.uk)

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

11.2.2 Mortality

In 2020 there were 2,000 deaths registered in Southampton's resident population and, of these deaths, the underlying causes responsible were cancer 25.8%, coronary heart disease 9.7%, stroke 4.8% and other circulatory diseases 8.1%. Just under 12% were respiratory deaths and 8.7% of deaths had an underlying cause of COVID-19. Around 38.3% of deaths occurred in a hospital setting, 22.6% in a nursing/care home and 29.9% in the individuals own home.

Figures 37 and 38 illustrate the causes of mortality and year of life lost in Southampton.

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Figure 37: Deaths by cause in Southampton 2020

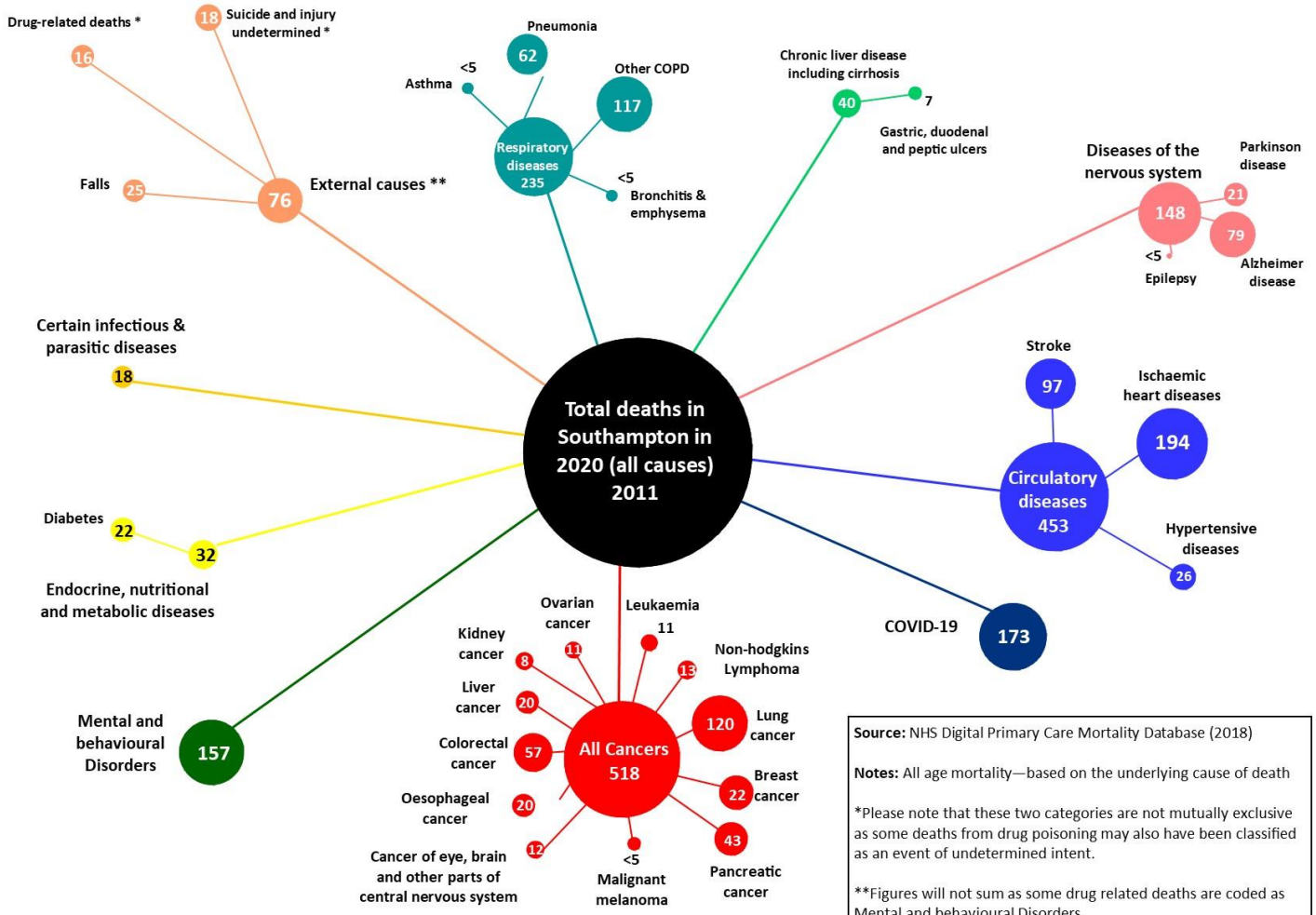

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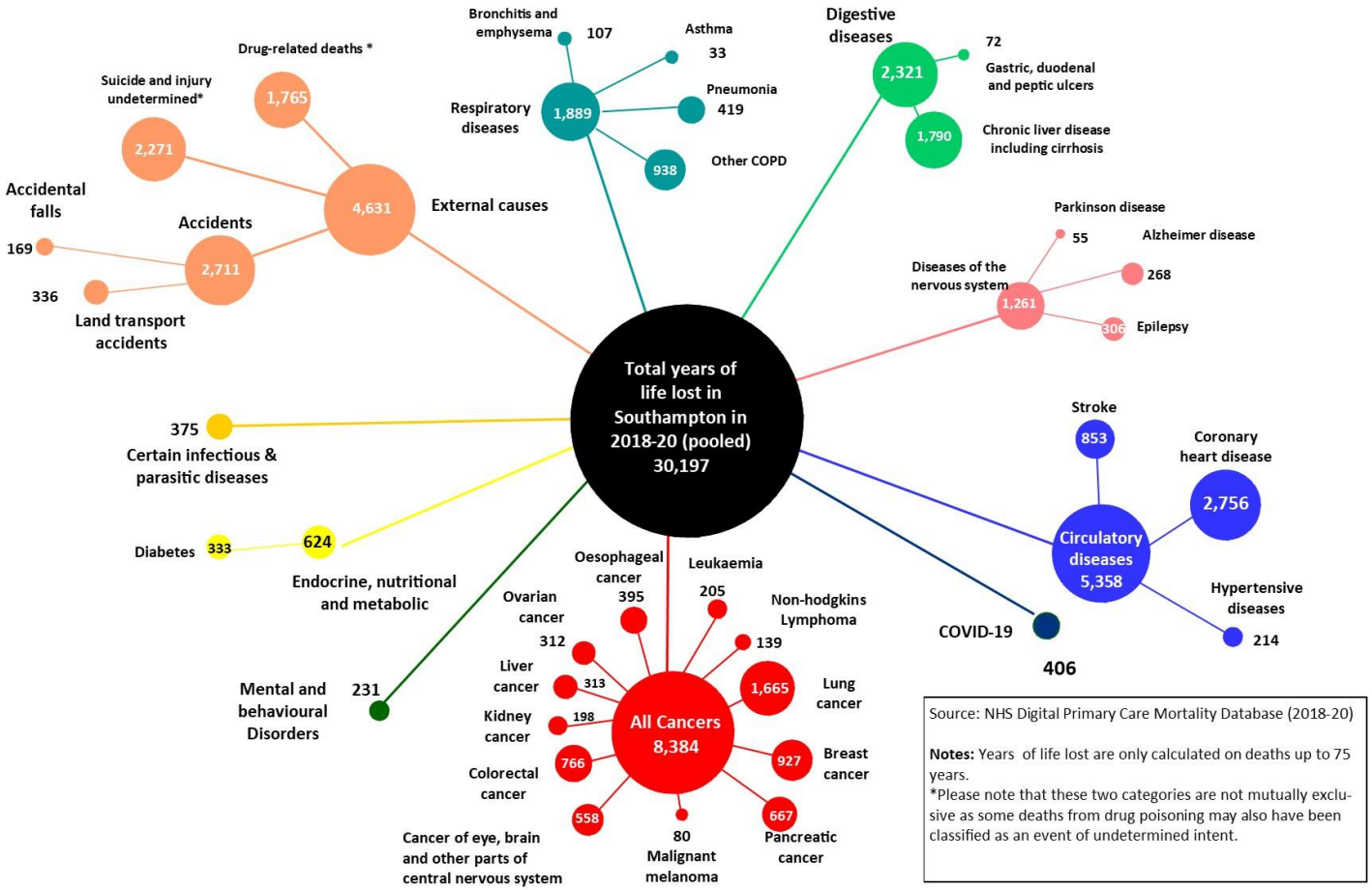
Figure 38: Years of life lost in Southampton (YLL)



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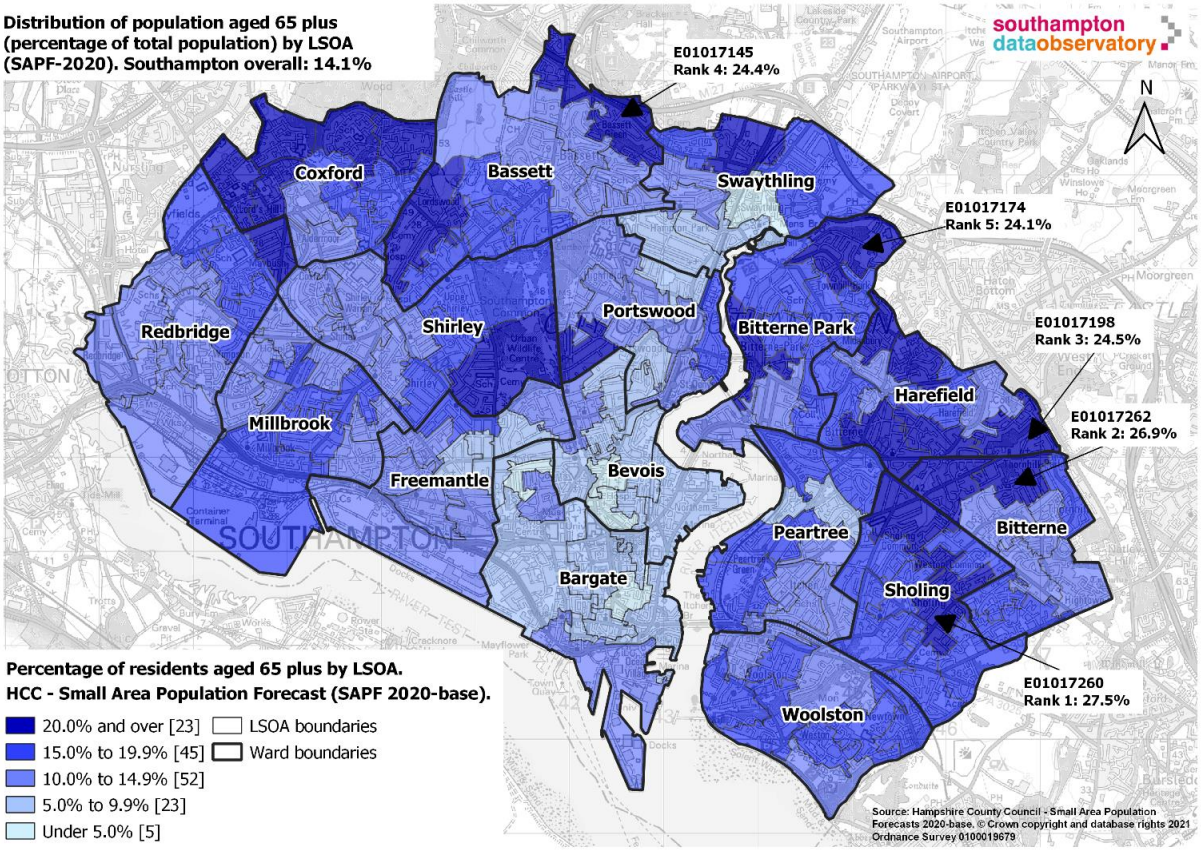
11.2.3 Ageing Population and Chronic Conditions

According to HCC SAPF estimates, there are 36,562 residents aged 65 years and over in Southampton. The map below (Figure 39) 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 39: Distribution of population aged 65 plus in Southampton (2020)



The Productive Healthy Ageing Profile and the Palliative and End of Life Care Profile produced by Public Health England[54] provides a useful snapshot of indicators at local authority level. It shows that older people in Southampton have significantly worse than the England average outcomes for several key indicators:

- male and female life expectancy at aged 65 years
- percentage of deaths in usual place of residence among people aged 65 years and over

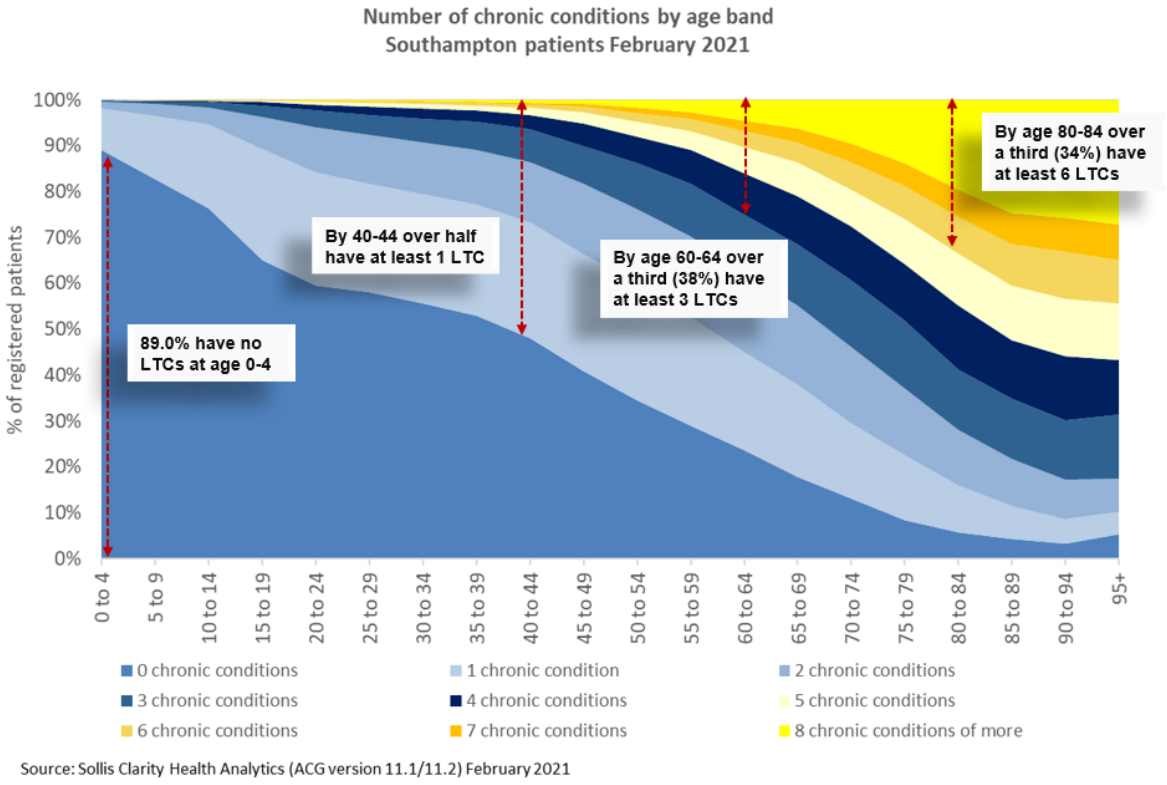
[54] Office for Health Improvement & Disparities Fingertips Public health profiles - OHID (phe.org.uk)

- permanent admissions to residential and nursing care homes per 100,000 aged 65 years and over
- 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
- rate of admission episodes for alcohol-related conditions (Narrow) – 65+ years
- rate of emergency admissions for dementia (aged 65+)
- and emergency hospital admissions due to falls 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 40 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 40: Number of Chronic Conditions by age band 2021



Source: Sollis Clarity Health Analytics (ACG version 11.1/11.2) February 2021

In Southampton's 0- to 4-year-olds, 89% are without 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, half of Southampton's residents will have at

least one LTC and when aged around 60-64 years, over a third (38%) have at least three LTCs. As the population increases so does the multi-morbidities and at age 84-89 years approximately a third (34%) have at least six LTCs.

11.2.4 Cancer

In 2020, there were 2,000 deaths in Southampton and 25.8% of these were caused by cancer. This is statistically similar to the percentage of cancer deaths nationally (24.2%). In March 2021 there were 6,886 people diagnosed with cancer and on GP disease registers, 2.4% are living with cancer in Southampton compared to 3.2% nationally.

The crude cancer incidence rate in the NHS Southampton CCG was 441 new cases per 100,000 population in 2019/20, significantly lower than the national rate of 531 new cases. However, from 2014 to 2018 (pooled), Southampton had an indirectly standardised cancer incidence ratio of 108.6, significantly higher than England (100) and all ONS comparators.

Up-to-date cancer incidence data for Southampton is limited since the merging of Southampton CCG with Hampshire and Isle of Wight CCGs in April 2021. The latest incidence data for Southampton covers 2014 to 2018. The data shows when compared with England (100.0), Southampton's standardised incidence ratio are:

- Significantly higher for all cancers (108.6)
- Lower but not significantly for breast cancer (98.7)
- Similar for colorectal cancer, also known as, bowel cancer (100.0)
- Significantly higher for lung cancers (132.8)
- Significantly higher for prostate cancers (108.3)

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

In 2017-19, the premature mortality rate from cancer for Southampton was 158 deaths per 100,000 population under 75 years – this was significantly higher than the rate for England (129 per 100,000 population under 75 years old).

In 2017-19, premature mortality for all cancer (excluding non-malignant melanoma) for persons, males and females, premature mortality from breast cancer and all age mortality from lung cancer are significantly higher than the England average.

Lung cancer is the second most common cancer (after skin cancer) in England and Wales, with an estimated 47,000 new cases being diagnosed every year. It is the most common

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cause of cancer-related death in both men and women.[55] Lung cancer continues to be one of the most common cancers in Southampton.

In Southampton, in 2016-18, there were 106 lung cancer registrations per 100,000 population, significantly higher than the rate for England (78 registrations per 100,000 population). In 2015-19 there were 2,617 deaths from cancer amongst city residents and of these 358 were caused by lung cancer.

In 2017-19, Southampton had a significantly higher rate (260.6 per 100,000) of smoking-attributable deaths in persons aged 35+ years compared to England (202.2 per 100,000).

Bowel cancer is the most common cause of cancer death following lung cancer and breast cancer, around 1 in 20 people develop bowel cancer. More than 9 out of 10 cases of bowel cancer in the UK are diagnosed in people over the age of 50. 1 in 15 men and 1 in 18 women will be diagnosed with bowel cancer during their lifetime. In 2020 there were 57 deaths in the city from colorectal cancer.

Bowel Cancer Screening Programme is offered to people aged 60 to 74 every two years. This has been extended to include 56 to 59 year olds and people aged over 75 can request a screening.[56]

In Southampton, 22,253 GP registered patients (around 64.6%) had taken up bowel screening in 2020/21 and this varies between 52.0% and 76.1% 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 2020/21, 51.1% of females aged 50 to 70 years registered within the Southampton CCG eligible for breast cancer screening had been screened within the previous 3 years; this varies between 8.6% and 74.1% across GP practice populations. The coverage in Southampton was significantly lower than the national uptake percentage (61.3%).

Every year, 3,200 women are diagnosed with cervical cancer in the UK and just under 1,000 die. It is a disease that mainly affects sexually active women aged between 30 and 45 years old. 99.8% of cervical cancers are due to persistent HPV infection. The introduction in 2008

[55] NHS Choices. www.nhs.uk/conditions/cancer-of-the-lung/pages/introduction.aspx?url=pages/what-is-it.aspx
[56] NHS Choices: Bowel Screening https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/962386/Population_screening_timeline_national_updated_2021.pdf

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of a vaccine against human papilloma virus (HPV) for teenage girls promises to markedly reduce the incidence of this disease in the future.[57]

The uptake of this vaccine in the city has been good. In 2019/20, 88.4% of Year 8 girls received the first vaccination and 89.3% their second vaccination - completing this programme. The uptake across England has fallen dramatically due to the COVID-19 pandemic; 59.2% for first vaccination and 64.7% for second vaccination. This decrease in coverage was not as drastic locally in Southampton. The national benchmark for the first dose and both doses is 90% uptake.

11.2.5 Coronary Heart Disease (CHD)

In 2020/21, there were 6,218 people on CHD registers in Southampton giving a crude prevalence rate of 2.2%, compared with 3.0% nationally. Prevalence varies between 0.2% and 3.2% across GP practice populations. The 2011 modelled estimate of CHD is higher at 9,822 giving a crude rate of 3.9%. More recent modelled estimates focus on the age group 55 to 79 year olds. In 2015 the estimated prevalence for this age group in Southampton was 8.1% equating to 4,175 adults aged 55 to 79 years with CHD in 2020.[58]

The data shows a significantly lower incidence rate for CHD for Southampton, however in terms of deaths, Southampton is significantly higher than the national average. In 2020/21, NHS Southampton CCG had a directly standardised rate of 336.0 per 100,000 population of all ages for CHD, statistically lower than the national average (367.6 per 100,000), it has also been statistically lower since 2003/04, however the premature mortality rate from coronary heart disease in 2017-19 for Southampton residents was significantly higher than the rate for England (47 deaths per 100,000 compared to 37 deaths per 100,000 respectively). Coronary heart disease was the main cause of death for 9.7% of Southampton deaths in 2020.

The following map (Figure 41) was produced using data from Sollis Clarity Health Analytics showing the highest and lowest recorded prevalence for Ischemic Heart Disease.

[57] NHS Choices: Cervical Screening http://www.nhs.uk/conditions/Cancer-of-the-cervix/Pages/Introduction.aspx

[58] Estimates modelled from the Whitehall II study (PHE Fingertips) applied to Hampshire 2020-based Small Area Population Forecasts

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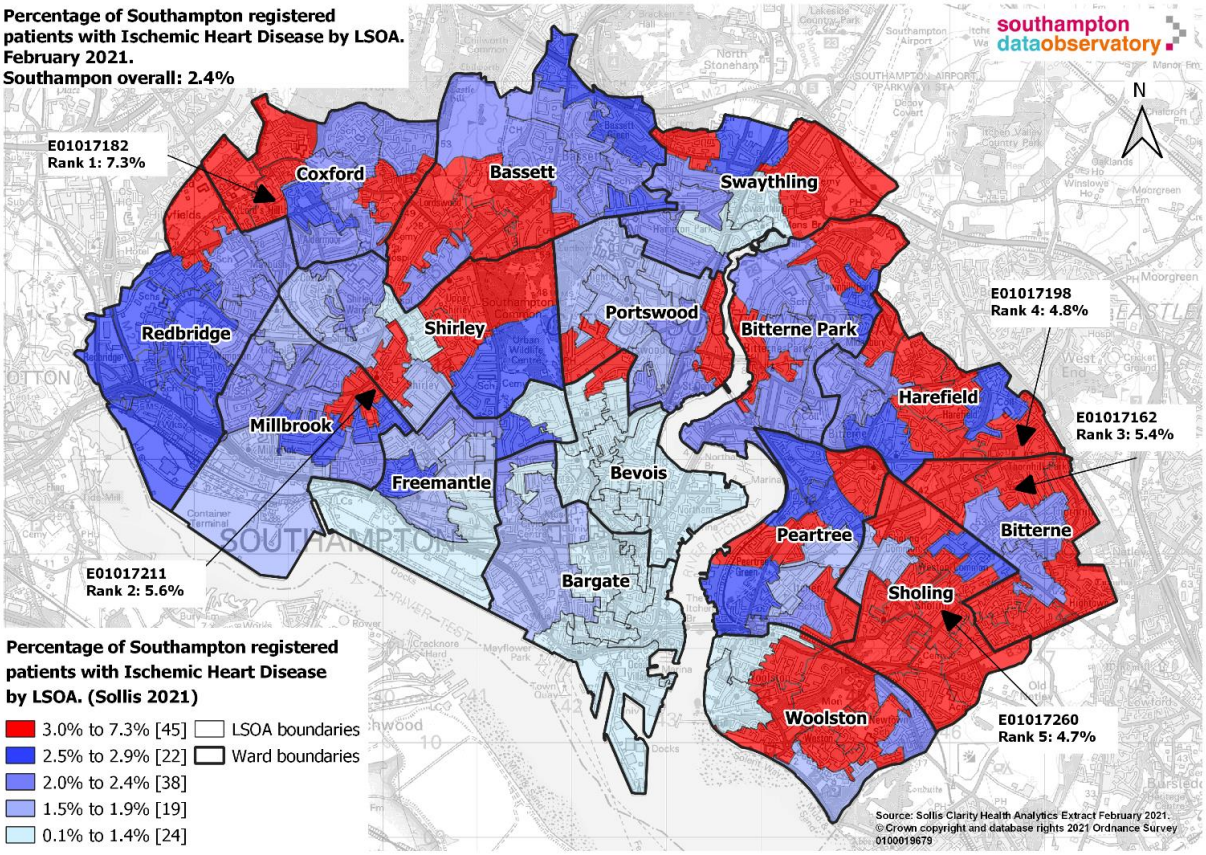
Figure 41: Percentage of Southampton registered patients with Ischemic Heart Disease by LSOA, February 2021



11.2.6 Stroke

In 2020, stroke was the main cause for 4.8% of Southampton deaths. 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 2020/21, all aged stroke admissions were significantly higher for NHS Southampton CCG compared to England (217.1 admissions per 100,000 population compared to 161.8 admissions per 100,000 respectively).

In 2020/21 GP Quality and Outcomes Framework (QOF) data showed 4,259 (1.5%) people being cared for with stroke or transient ischaemic attacks, compared with England 1.8%. Prevalence varies between 0.2% and 2.8% across GP practice populations. The most recent

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modelled estimated for 55 to 79 year olds, 3.8% will have suffered a stroke equivalent to around 1,960 people in 2020.[59]

11.2.7 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 2021, there were 31,530 people on hypertension registers in Southampton, giving a raw prevalence of 10.9%, lower than the national average of 13.9%. Prevalence varies between 1.4% and 14.5% across GP practice populations.

11.2.8 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. In March 2021, GP QOF data showed 4,609 people registered with AF which equates to a raw prevalence rate of 1.6% against a national raw prevalence rate of 2.0%. Prevalence varies between 0.1% and 2.4% across GP practice populations.

Public Health England analysis suggests that the prevalence of AF has been underestimated and in 2019 modelled the expected prevalence of AF in the NHS Southampton CCG to be 1.9% of registered patients. However, this estimate assumes Southampton's population structure and related attributes remain similar to that used in the model.

11.2.9 Persistent Asthma

In March 2021, there were 16,440 people on GP asthma registers in Southampton giving a crude prevalence rate of 6.1% which is significantly lower than the national average of 6.5%. Prevalence varies between 2.4% and 10.0% across GP practice populations.

Figure 42 uses data from the Sollis Clarity Health Analytics showing the highest and lowest recorded prevalence of asthma among Southampton's GP registered patients, including the top 5 LSOAs. This data is recorded by GPs to the same definition as the QOF but allows sub-city analysis at LSOA level.

[59] Estimates modelled from the Whitehall II study (PHE Fingertips) applied to Hampshire 2020-based Small Area Population Forecasts

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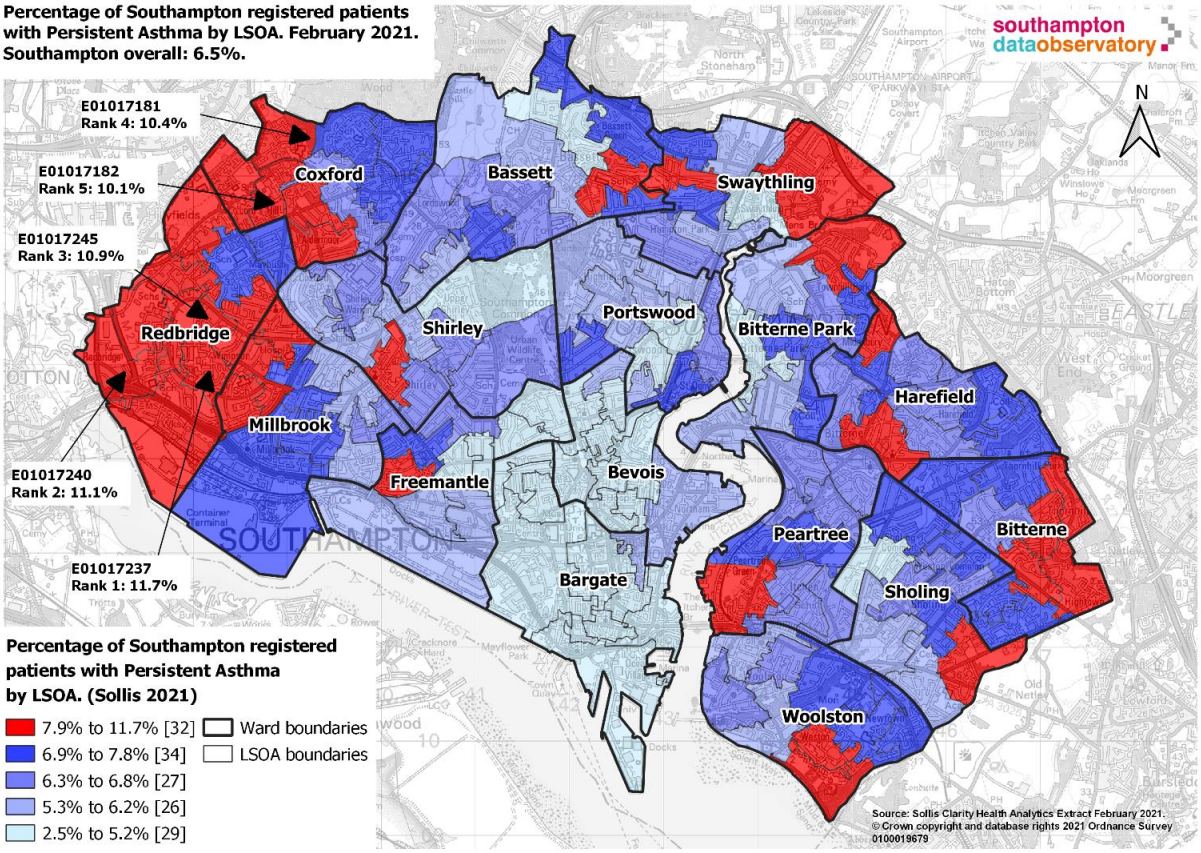
Figure 42: Percentage of Southampton registered patients with Persistent Asthma by LSOA, February 2021



11.2.10 Chronic Obstructive Pulmonary Disease (COPD)

In March 2021, there were 6,146 registered patients recorded by GPs for the QOF on COPD registers in Southampton. This data allows comparisons with England and shows a crude prevalence rate of 2.1% which is significantly higher than the England rate (1.9%). Prevalence varies between 0.1% and 3.4% across GP practice populations.

The range of the recorded prevalence of COPD for Southampton GP registered patients can be seen in Figure 43, which was produced using data from the Sollis Clarity Health Analytics from February 2021 using the same definitions as QOF but allowing sub-city analysis.

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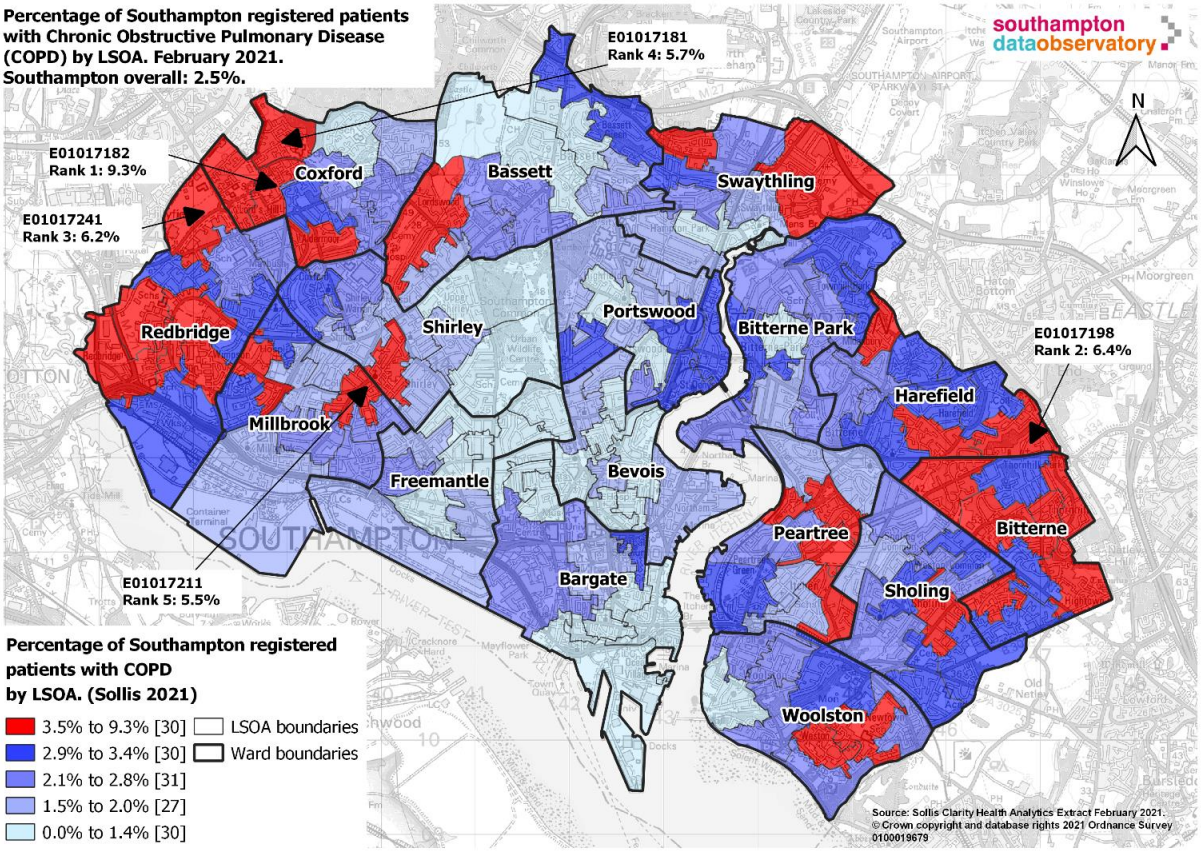
Figure 43: Percentage of Southampton registered patients with COPD by LSOA, February 2021



11.2.11 Kidney Disease

In March 2021, GP QOF data showed 5,499 people aged 18 years and over on GP disease registers with chronic kidney disease (CKD). Therefore, the prevalence of diagnosed CKD amongst people aged 18 years and over in Southampton is 2.3% (compared to 4.0% nationally). Although, this varies from 0.2% to 4.1% across 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 being cardiovascular disease, hypertension, and diabetes. These often coexist with other risk factors such as obesity, coming from a lower socioeconomic group and from a minority ethnic group, particularly Black and Asian.

11.2.12 Diabetes

In March 2021, there were 14,489 people (aged 17 plus) on GP diabetes registers in Southampton which gives a crude prevalence rate of 6.1%, significantly lower than the England rate of 7.1%. Prevalence varies between 0.8% and 8.5% across GP practice populations. Much diabetes is undiagnosed and modelled estimates of the true underlying

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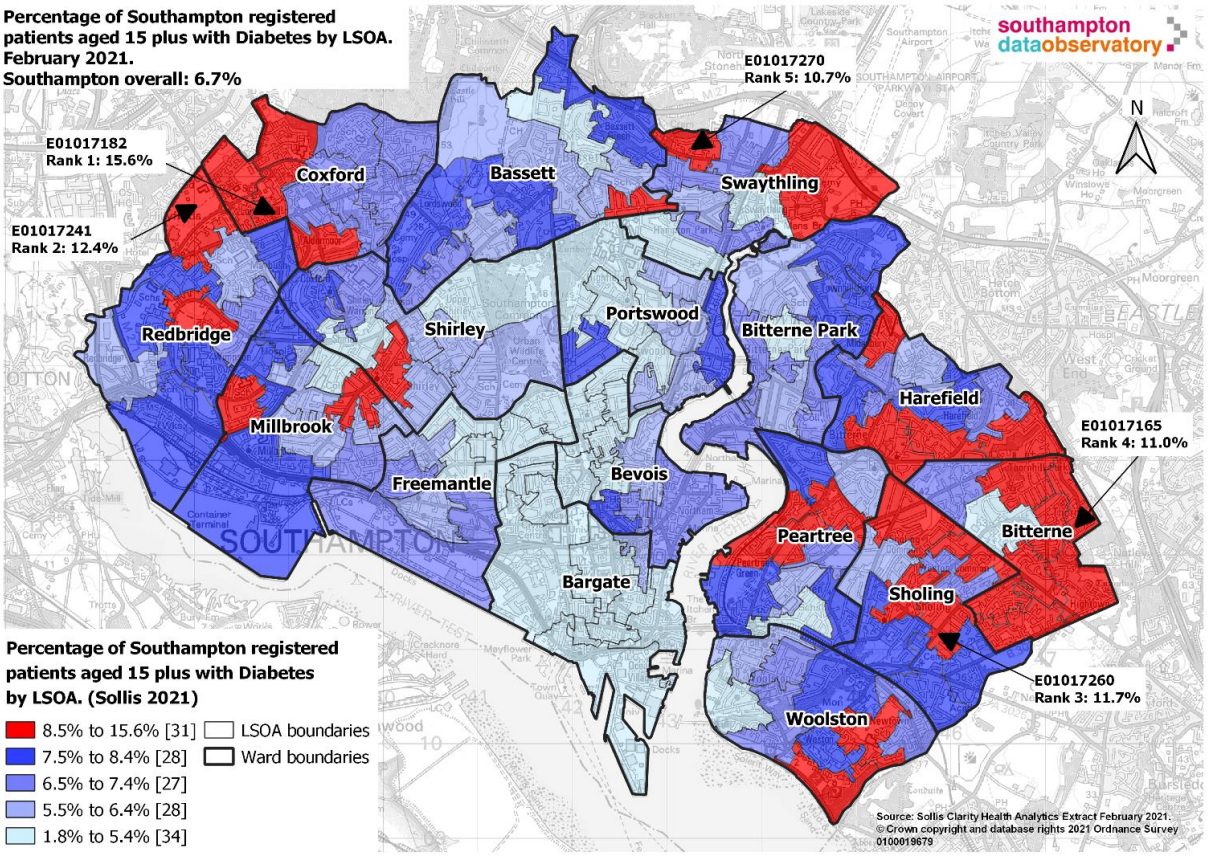
prevalence put the total burden in the city at nearly 16,625 people (a crude rate of 7.3%) for 2017. Modelled estimates predict the prevalence of diabetes is set to increase. By 2035, Southampton's diabetic population is estimated to be 18,166 an increase of 19.2% from 2020 (15,242), assuming no change in the underlying population of age, sex and ethnicity, levels of excess weight and physical inactivity.

Figure 44: Percentage of Southampton registered patients with Diabetes by LSOA, February 2021



Poor diabetic foot care can result in lower limb amputations in diabetic patients. In 2019/20 of the 14,445 Southampton diabetic GP registered patients aged 12 years and over, almost 1 in 5 (18.3% or 2,650) did not attend an annual foot check. This varies between GP populations ranging from 2.5% to 28.4%. However as described previously, there are potentially several thousand people in the city unaware of the importance of foot care with their undiagnosed diabetes, increasing their risk of ulceration, reduced sensation/circulation and potential lower limb amputation.

In terms of other long-term conditions for diabetic patients, the 2021 extract from the Sollis tool profiled diabetic patients' most common co-morbidities, showing a proportion of Southampton diabetic patients are also at risk of developing depression (20%),

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hyperlipidemia (21%), asthma (13%), chronic renal failure (13%), Ischemic Heart Disease (14%) and COPD (10%).

11.2.13 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 2019/20, Southampton's rate of preventable sight loss due to diabetic eye disease in those aged 12 years and over was 5.1 per 100,000 population. This is higher but not significantly than the rate for England (2.9 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. In 2019/20, Southampton's rate of AMD is also higher but not significantly compared to England (112.2 per 100,000 aged 65+ compared to 105.4 per 100,000 aged 65+ respectively). Southampton's rate of preventable sight loss due to glaucoma is higher but not significantly to the rate for England (18.1 per 1000,000 aged 40+ compared to 12.9 per 100,000 aged 40+ respectively).

Sight impaired and severe sight impairment replace the terms partially sighted and blind for registration purposes. In 2019/20, there were 575 registered blind or partially sighted people in Southampton (over half, n=425, were aged over and 75 years and over).

In May 2021, 133 Southampton residents (0.05%) were registered for Disability Living Allowance with the main disabling condition recorded as 'blindness' (higher than the national average of 0.04%). Of these residents registered with 'blindness' as their main disabling condition, 26 people were aged under 16 years, 44 people were aged 16 to 64 years old, and 63 people were aged 65 year and over. [60]

Modelling predicts there are 110 Southampton (in 2020) residents aged 18-64 and 1,018 residents aged 65 years and over predicted to have a serious visual impairment, by age, and this is projected to increase to 113 and 1,491 respectively by 2040.[61]

[60] DLA Entitlement (Count) Department for Work and Pensions

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

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11.2.14 Hearing Loss and Deafness

Infants have their hearing checked within hours of birth through the newborn infant screening programme. In 2019/20, 98.3% of infants in Southampton were correctly screened within 5 weeks of birth.

Since 2010, the number of people registered deaf or hard of hearing has not been published. NHS England have produced a tool to estimate hearing loss by local authority and CCG.[62] The tool estimates in 2020, the number of adults with hearing loss of 25 dBHL (Decibels Hearing Level) was 34,440 (17,240, aged 18 to 70 and 17,200 aged over 70 years) are expected to increase to 42,900 by 2035. The 2020/21 GP patient survey estimates 4.7% of the GP registered population reporting deafness or severe hearing loss, which is around 5,500 people.[63]

In May 2021, 87 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, 41 people were aged under 16 years, 27 people were aged 16 to 64 years old, and 16 people were aged 65 years and over.[64]

11.2.15 Levels of Disability among Children and Young People

In May 2021, data on Disability Living Allowance (DLA) claimants amongst the under 16 years old shows that 2,739 Southampton children receive DLA. Fifty-four per cent (1,487 children) of those receiving DLA had their main disabling condition classed as 'learning difficulties'. Four hundred and sixty-four (16.9%) shared the second most common main disabling condition; Behavioural Disorder. Hyperkinetic Syndrome, also known as ADHD, was the third most common diagnosed main disabling condition for 251 children (9.2% of DLA recipients aged under 16).[65]

Living in the city, 3,234 residents are known to Adult Social Care as visually/hearing impaired and/or with a physical disability:[66]

[62] NHS England » Hearing Loss Data Tool
[63] Disease and risk factor prevalence, PHE Fingertips
[64] DLA Entitlement (Count) Department for Work and Pensions
[65] DLA Entitlement (Count) Department for Work and Pensions
[66] Most are aged 18+ and a few are under 18. 209 individuals are known to adult social care for two or all of the three groups listed. Living outside the city, 148 individuals known to SCC Adult Social Care as visually/hearing impaired and/or with a physical disability, live outside the city boundary in SCC funded permanent residential/nursing homes.

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- 947 registered visually impaired
- 1,111 registered hearing impaired
- 1,385 people with general classes of physical disability

In May 2021, there were 1,277 Southampton residents aged 16 to 64 years receiving DLA. The most common disabling condition was learning difficulties (n=285, 22.3%). Around 150 adults (12.1%) aged 16 to 64 were classified as receiving DLA for the main disabling condition of psychosis, which was the second most common.[67]

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 data suggest that in 2020 there were 5,293 adults aged 18-64 with a moderate physical disability and a further 1,253 with a serious physical disability living in Southampton. By 2040 there are projected to be over 6,500 adults of working age with a moderate or serious physical disability in Southampton.[68]

In May 2021, 1,729 adults aged 65 years and over were receiving DLA. The most common main disabling condition was arthritis, accounting for 31.7% of those aged 65 years and over in receipt of DLA (n=548). Back pain was the second main disabling condition (7.5%, n=129) and disease of the Muscles, Bones or Joints (6.6%, n=114) was the third the main disabling. This shows physically disabling conditions are more prolific in older adults compared to working age adults receiving DLA. [69]

Modelling estimates that in 2020, there were 6,310 Southampton residents aged 65 years and over unable to manage at least one mobility activity on their own (estimates were adjusted for age and gender). These mobility 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 8,631 Southampton residents aged 65 and over by 2040.[70]

[67] DLA Entitlement (Count) Department for Work and Pensions https://stat-xplore.dwp.gov.uk/
[68] Projecting Adult Needs and Service Information (PANSI), Oxford Brookes University https://www.pansi.org.uk/index.php?pageNo=396&areaID=8640&loc=8640
[69] DLA Entitlement (Count) Department for Work and Pensions https://stat-xplore.dwp.gov.uk/webapi/jsf/tableView/tableView.xhtml
[70] Projecting Older People Population Information System (POPPI), Oxford Brookes University https://www.poppi.org.uk/index.php?pageNo=342&areaID=8640&loc=8640

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11.2.16 Human Immunodeficiency Virus (HIV)

In 2020, 405 Southampton residents (2.5 per 1,000 population aged 15 to 59) were accessing HIV care at NHS services - an increase of 45% (126 more residents) since 2011 accessing HIV care.

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 2018-20, of those Southampton residents diagnosed with HIV, 44% had a late diagnosis, this is above the national goal of less than 25%.

11.3 Mental Health and Neurological Conditions

There is no good health without good mental health, and this is important across the life course.

11.3.1 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 (The National Statistics Socio-economic classification (NS-SEC) of household reference person). The 2020based local population estimates for the estimated prevalence for children and young people aged 5-16 years in Southampton of mental health disorders, was 3,266 (9.8%); for emotional disorders, 1,233 (3.7%); conduct disorders 2,000 (6.0%) and hyperkinetic disorders 533 (1.6%).

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.[71]

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; more than 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.[72]

[71] Self-harm in over 8s: long-term management https://www.nice.org.uk/guidance/cg133
[72] Self-harm in over 8s: long-term management https://www.nice.org.uk/guidance/cg133

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In 2019/20, 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 (684 per 100,000 population aged 10 to 24 years, compared to 439 per 100,000 population aged 10 to 24 years respectively).

11.3.2 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, anxiety and obsessive-compulsive disorder. The APMS 2014 categorises mixed anxiety and depressive disorder; generalised anxiety disorder; depressive episode; all phobias; obsessive compulsive disorder; and panic disorder as CMDs. The AMPS 2014 found one in five (20.7%) women are affected by common mental disorders and one in eight men (13.2%).

In 2020/21, in Southampton, the prevalence of people recorded with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses is 3,174 people 1.21% of people of all ages, and the same in England.

In 2020/21, 28,455 people registered with their GP as having depression (with a diagnosis since 2006). This gives a crude prevalence rate of 12.4% which slightly higher than the figure for England (12.3%).

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 2021, the GP patient survey estimated Southampton had a prevalence of long-term mental health problems among the GP population of 12.2%, this was significantly higher than the national prevalence (11.0%).

The Mental Health and Wellbeing JSNA profile shows 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, children looked after, children in need due to abuse, neglect or family dysfunction, pupils with behavioural, emotional and social support needs, violent crime (including sexual violence), crime, deprivation and current smoking in adults. These topics are covered in other sections of this document.

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Evidence shows work was generally good for both physical and mental health and wellbeing across society. In 2019/20, the gap in the employment rate for those in contact with secondary mental health services and the overall employment rate in Southampton was 72.0 percentage points, this is significantly worse than the gap nationally (67.2 percentage points). In 2019/20 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 (14.4 percentage points compared to 10.6 percentage points). For Southampton's residents with a learning disability the point gap in their employment rate and the overall employment was 71.9 points, lower than the national gap (70.6 percentage points).

In 2019/20, Southampton had a significantly higher rate of emergency hospital admissions for self-harm (all ages) than England (409.3 per 100,000 population compared to 192.6 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 2020 an estimated 44,220 adults had had suicidal thoughts within their lifetime; this number is projected to increase to 47,400 adults in 2027.[73]

In 2018-20, Southampton's suicide and mortality from injury undetermined directly age standardised rate (DSR) aged 15 and over (9.8 per 100,000 population) lower but not significantly than England (10.4 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.

11.3.3 Older People

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, better infection control, increased longevity and improved diagnostic techniques.

[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 HCC 2020-based Small Area Population Forecast

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Dementia is one of the main causes of disability in later life ahead of cancer, CVD and stroke. In 2020, the recorded prevalence in dementia for Southampton GP registered patients aged 65 years and over was 3.99% (n=1,485), this was higher but not significantly than the national average of 3.97%. Although the actual number of people living with dementia is likely to be higher.

The prevalence of dementia is closely associated with age and gender. With the ageing population, modelling estimates the number of people aged 65 years and over predicted to have dementia in Southampton to be 2,449 in 2020 and set to increase to around 2,864 in 2030 and 3,480 in 2040[74].

In 2019/20, the rate of emergency inpatient hospital admissions of people (aged 65+ years) with a mention of dementia was 5,507 per 100,000 population aged 65+. This was significantly higher than the rate for England (3,517 per 100,000 population aged 65+ years).

11.4 Health Behaviours

The 'Health Behaviours' theme of Southampton's JSNA (embedded in the Southampton Data Observatory[75] is split into four distinct topics: 'smoking', 'healthy weight', 'sexual health' and 'alcohol & drugs'.

11.4.1 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. In 2020, the prevalence of smoking (available through Annual Population Survey estimates) in the city was 11.8%, lower but not significantly compared to the national average of 12.1%. However, the ONS[76] have warned that pandemic-related changes to survey methodology in 2020 (from face-to-face interview to telephone), have resulted in lower prevalence estimates and wider levels of uncertainty. The previous prevalence recorded for Southampton in 2019 was 16.8%, significantly higher than the national average of 13.9%. In 2020, smoking rates were higher (but not significantly) among the city's routine and manual workers with rates of 22.2% in Southampton compared to 21.4% nationally. In 2020/21,

[74] Projecting Older People Population Information System (POPPI), Oxford Brookes University https://www.poppi.org.uk/index.php?pageNo=342&areaID=8640&loc=8640
[75] Southampton Data observatory https://data.southampton.gov.uk/
[76] Office for National Statistics. Local tobacco control profiles for England: short statistical commentary, December 2021 - GOV.UK (www.gov.uk)

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10.7% of pregnant women in the city were recorded as smoking at the time of delivery. This is higher, but not significantly than the national average of 9.6%.[77]

Men living in Southampton have significantly lower healthy life expectancy than the national average (60.7 years compared with 63.2 years), and smoking is one of the main causes for this. In 2017 to 2019, more people died from smoking attributable deaths in Southampton than the national average (260.6 per 100,000 population, compared to 202.2 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 high healthcare need and demand, impacting on primary care (GP Practices, pharmacies and more) and also increasing the number of hospital admissions, especially in the winter months. In 2019/20, 1,901 per 100,000 admissions to hospital were directly attributable to smoking. The cost per capita of smoking attributable hospital admissions for Southampton in 2020 was estimated to be £3.31.[78]

11.4.2 Excess Weight and Physical Activity

In 2019/20, 59.3% of Southampton's adults are estimated to be overweight or obese which is lower but not significantly from the national average of 62.8%. In 2019/20 physical activity amongst adults in Southampton were 62.4% which is lower, but not significantly, than the national levels (66.4%) and lower than most of the city's ONS peers.

In 2020/21, the Active Lives Survey found that 59.5% of Southampton residents do at least 150 minutes of activity per week (lower than the national percentage of 60.9%).

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 2019, the Department for Transport reported that 2.9% of Southampton residents cycled five times per week and 17.3% cycled at least once per month compared to 3.0% and 16.1% respectively in England.

[77] Fingertips Local Tobacco Control Profiles. https://fingertips.phe.org.uk/profile/tobacco-control/data#page/3/gid/1938132886/pat/6/par/E12000008/ati/402/are/E06000045/iid/93798/age/168/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

[78] ASH Ready Reckoner 2022. https://ash.org.uk/ash-ready-reckoner/

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11.4.3 Sexually Transmitted Infections (STIs)

In 2020, a total of 2,291 STIs were diagnosed in Southampton residents, with the distribution varying considerably across the city (906 per 100,000 population, significantly higher compared to the England average 562 per 100,000 population). The COVID-19 pandemic appears to have decreased the number of STI diagnoses locally and nationally, with a significantly higher rate observed in 2019 (Southampton - 1,225 per 100,000 population and England 830 per 100,000 population). The most commonly diagnosed STI was chlamydia, followed by gonorrhoea then genital warts.

11.4.4 Alcohol and Drug Use

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.

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 under the influence of drink or intoxicated and 64% were aged 18 to 24 years.

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 2019/20 rate of hospital admissions for all ages and those aged under 18 years (2017/18-2019/20) 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 that was attributable to alcohol, and the narrow is 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 2018/19, 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.

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In 2018/19, using the narrow measure the rate of admission episodes for alcohol-related conditions (all ages) was significantly higher than the rates for England.

In 2018/19 Southampton also had higher rates than the national average for:

- Admission episodes for alcohol-related unintentional injuries conditions (Narrow), persons (higher but not significant)
- Admission episodes for mental and behavioural disorders due to use of alcohol condition (Narrow), persons (significantly higher)
- Admission episodes for intentional self-poisoning by and exposure to alcohol condition (Narrow), persons (significantly higher)
- Admission episodes for mental and behavioural disorders due to use of alcohol condition (Broad) persons (significantly higher)
- Admission episodes for alcoholic liver disease condition (Broad), persons (significantly higher)[79]

Data around alcohol and drugs can have a number of caveats that need understanding, some caution might be needed in reporting statistics. Some hospitals might be better than others at coding hospital admissions linked with alcohol, this needs to be considered when comparing with other areas (benchmarking). Over time, some hospitals' coding systems and coding quality may change which might affect year-on-year trends.

More men in Southampton are dying because of alcohol than the national average; between 2017-19 there were 99 deaths specifically due to alcohol in Southampton; 70 in males and 29 in females.

In October 2021, Southampton had a significantly higher rate (44.4 per 100,000 working age population) of Personal Independence Payments (PIP) with alcohol misuse as the main disabling condition compared to the national average (28.3 per 100,000 working age population).

In 2019/20, there were 1,175 Southampton residents in treatment at specialist drug misuse services. In 2019, 36 clients who used opiates had successfully completed drug treatment (4.7%). This proportion percentage was lower but not significantly than England (5.6%). Whereas 33.5% (129) of clients using non-opiates successfully completed drug treatment, also not significantly lower than the national average (34.2%).

[79] https://fingertips.phe.org.uk/static-reports/local-alcohol-profiles/at-a-glance/E06000045.html?area-name=Southampton

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In 2020/21, 22.2% of Southampton adults with a need for substance use treatment successfully engaged in community-based structured treatment following release from prison. This was significantly lower than the proportion for England (38.1%).

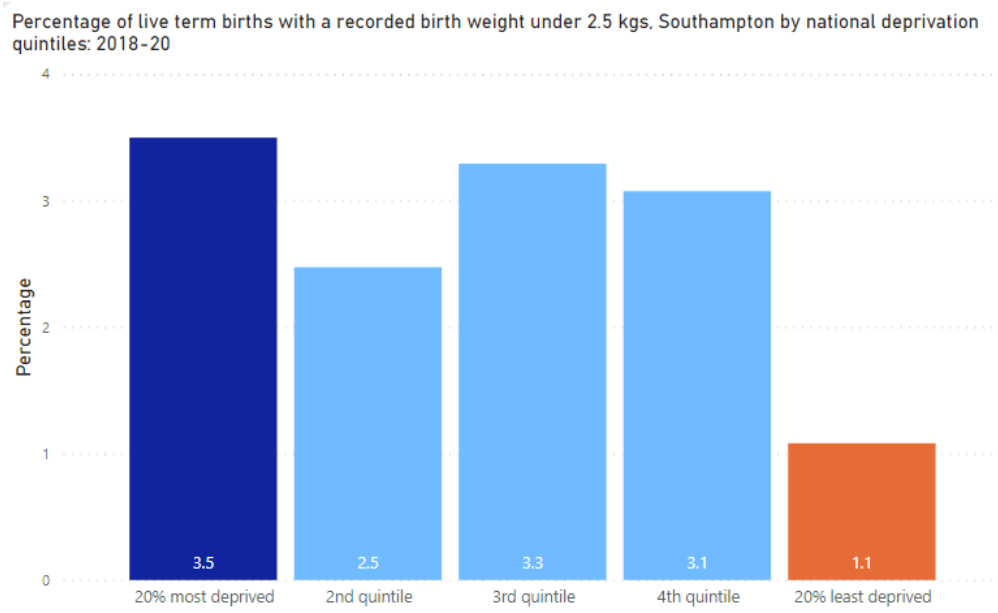
11.5 Maternal, Child and Young People's Health

11.5.1 Low Birthweight

Low birthweight 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 diabetes, stroke and heart disease risk in adults. In 2019, the rate of low birthweight babies born at term (babies with a recorded birthweight of less than 2,500 grams and a gestational age of at least 37 complete weeks) in Southampton was 2.6% of all term births; similar to the England average of 2.9%. This has fluctuated but decreased overall since 2010.[80]

The decline in low birthweight has been more rapid in those parts of the city with the highest levels of economic deprivation. The highest percentage of low birthweight babies by deprivation quintile is seen in the most deprived quintile in the city.

Figure 45: Percentage of live term births with a recorded birthweight under 2.5kgs Southampton



[80] OHID Fingertips. https://fingertips.phe.org.uk/search/low%20birth%20weight#page/4/gid/1/pat/6/par/E12000008/ati/202/are/E06000045/iid/20101/age/235/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

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11.5.2 Smoking During Pregnancy

Smoking during pregnancy is strongly associated with numerous health problems for newborn babies. There is evidence to suggest that the number of mothers smoking at midwifery booking has reduced significantly from 20.2% in the 2008/09 period to 14.6% in the 2020/21 period. There are differences between ethnic communities, with 'White British' mothers having smoking rates significantly higher than the city average.

Data shows that in the 2020/21 period, 7.6% of mothers who smoked at the time of midwifery booking had a premature baby. In addition, 12.4% of women who smoked at the time of midwifery booking had a low birthweight baby. Low birthweight often results in more intensive medical care, higher morbidity and delayed development in childhood. In 2020/21, 10.7% of women in Southampton were still smoking at the time of delivery, statistically similar to the national rate of 9.6%. Locally, this is the first time Southampton has been statistically similar to England, following a decreasing trend since 2010/11.

Research in 2010 showed 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%).[81]

Figure 46 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.

[81] 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. https://digital.nhs.uk/data-and-information/publications/statistical/infant-feeding-survey/infant-feeding-survey-uk-2010

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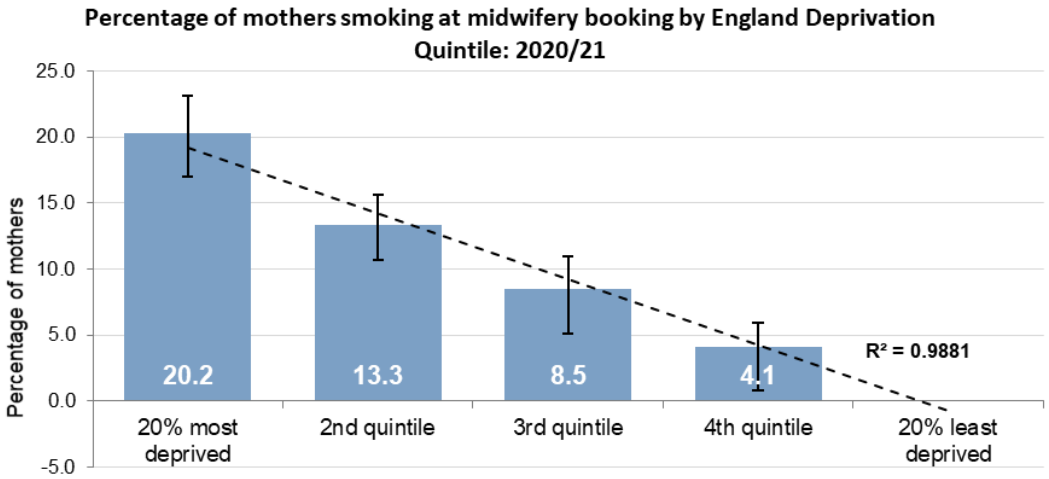
Figure 46: Percentage of mothers smoking at midwifery booking England deprivation quintiles 2020/21



Source: Ministry of Housing, Communities & Local Government, UHS Midwifery database: Southampton CCG

11.5.3 Breastfeeding Initiation and Maintenance

There have been changes in monitoring this area through the new maternity services dataset. In 2018/19 data was collected on baby's first breastmilk feed for both Southampton and England and data showed that 72.2% of local mothers were giving breastmilk as a baby's first feed, significantly higher than 67.4% nationally. Data collection in other recent years had not occurred.

Another indicator looks at breastfeeding after the neonatal period where women continue to breastfeed at 6-8 weeks and beyond. In Southampton a local target has been set to reach 50% of new mother's breastfeeding at 6-8 weeks, this target was met in 2018/19 and continues to improve. In 2020/21, 53.4% of women still breastfed at 6-8 weeks, significantly higher than the England average of 47.6% over the financial year.

11.5.4 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 published results from the National Child Measurement Programme (NCMP) from 2019/20, 14.2% of children in reception classes are overweight and 9.9% obese (including severe obesity). The prevalence of obesity has

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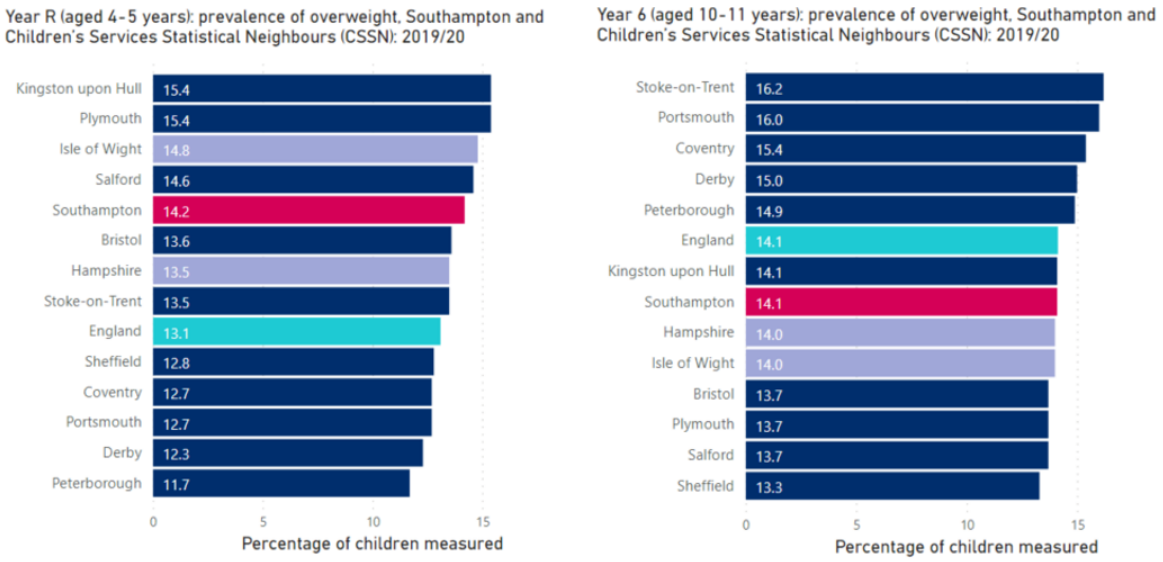
decreased slightly from the previous year (10.3% compared to 9.9%), but the long-term trend to 2019/20 was relatively stable.[82]

In Southampton, the prevalence of obesity (including severe obesity) for Year 6 children has increased from 22.5% in 2015/16 to 23.8% in 2019/20. Results from the 2019/20 NCMP show that 14.2% of Southampton children in Year 6 classes are overweight (including severe obesity). Figure 47 show the trend and benchmark the prevalence of obesity respectively for Year R and Year 6 children.

Figure 47: Year R and Year 6 prevalence of overweight



Recent local unpublished data shows between 2016/17 and 2019/20 levels of childhood obesity and excess weight for reception year children locally and nationally have remained at statistically similar levels. However, the latest data for 2020/21 shows a significantly higher increase for obesity and excess weight prevalence in reception year locally and nationally compared to the previous four years. In addition, looking at the data for 2020/21, the prevalence of obesity and excess weight for Southampton reception year children is significantly higher than national levels whereas for the previous two years it was similar.

[82] Please note:
The 2019/20 NCMP data collection stopped in March 2020 when schools were closed due to the COVID-19 pandemic. In a usual NCMP collection year, national participation rates are around 95% (over a million) of all eligible children, however in 2019/20 the number of children measured was around 75% of previous years. Despite the lower than usual number of measurements, analysis by NHS Digital indicates that figures at national and regional level are directly comparable to previous years, for all breakdowns.

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Linked analysis looking at the changes in weight status from Year R to Year 6 of the same 6,000 Southampton children found of those children who were overweight in Year 6, the majority had been healthy weight in reception, whilst over a fifth had remained overweight and a further 8% had been obese.

Figure 48: Prevalence of overweight children in Year 6

Additionally, over two-thirds (67%) of obese children had not been obese in reception, in fact the biggest proportion was for those who had been healthy weight (41%).

Figure 49: Prevalence of Obese children in Year 6

11.5.5 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 Special Educational Needs (SEN). In 2021, 18.4% of primary and 18.0% of secondary school pupils in Southampton have SEN; highest among comparators and significantly higher than the national average of 14.6% and 13.5% respectively. SEN among primary school pupils has experienced a decline and levelled of, whereas SEN among secondary school pupils has increased over last two years; from the decline experienced since 2016.

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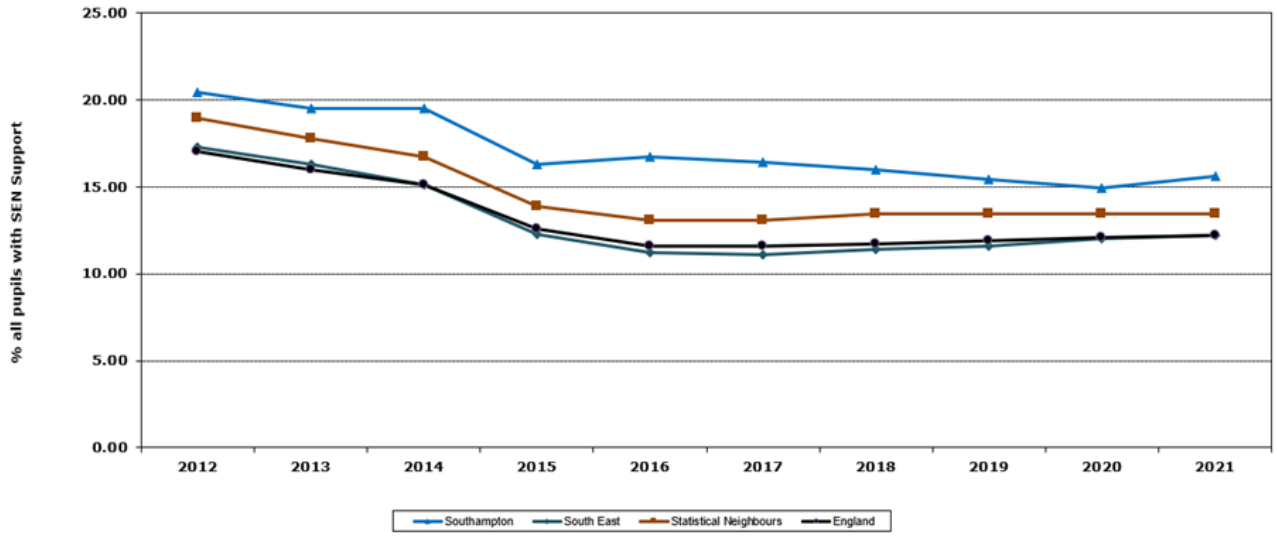
Figure 50: Percentage of pupils with Special Educational Needs Support 2012 to 2021: Southampton, England, and statistical neighbours



Source: LAIT tool Department for Education[83]

Schools census data from January 2021 illustrates the extent of SEN across primary and secondary cohorts (Figure 51). 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.

Figure 51: Education Health and Care (EHC) Plans / SEN in Primary and Secondary School cohorts – January 2021

Settings (State-funded schools)	Area	Total Pupils	Statements or EHC plans		SEN support	
			Number	%	Number	%
Primary	Southampton	20,129	489	2.4	3,221	16.0
	South East	729,242	16,318	2.2	88,793	12.2
	England	4,660,264	95,601	2.1	586,926	12.6
Secondary	Southampton	11,929	257	2.2	1,885	15.8
	South East	552,577	10,964	2.0	62,003	11.2
	England	3,493,507	68,370	2.0	401,563	11.5
Total state-funded schools	Southampton	34,485	1,512	4.4	5,149	14.9
	South East	1,458,218	51,384	3.5	152,423	10.5
	England	8,911,887	303,668	3.4	1,002,442	11.2

Source: Department for Education

In Southampton, 3.7% of primary and 4.0% of secondary school pupils have social, emotional or mental health needs (2020), both percentages significantly higher than the national average. Similar to SEN, the percentage of primary school pupils with social, emotional or

[83] Local Authority Interactive Tool Department for Education
https://www.gov.uk/government/publications/local-authority-interactive-tool-lait

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mental health needs has experienced a decline over the last year, with an increase seen for secondary school pupils.

Estimated forecasts for the percentage of pupils requiring SEN Support are not available at this time for inclusion in this assessment.

11.5.6 Teenage Pregnancy

In 2019, Southampton's under 18 conception rate was 18.5 per 1,000 females aged 15-17 years old. Figure 52 below shows that the Southampton rate has been consistently higher than the national rate since the 1998. However, having fallen by approximately 70%, the rate in Southampton has been statistically similar to the national average since 2018.

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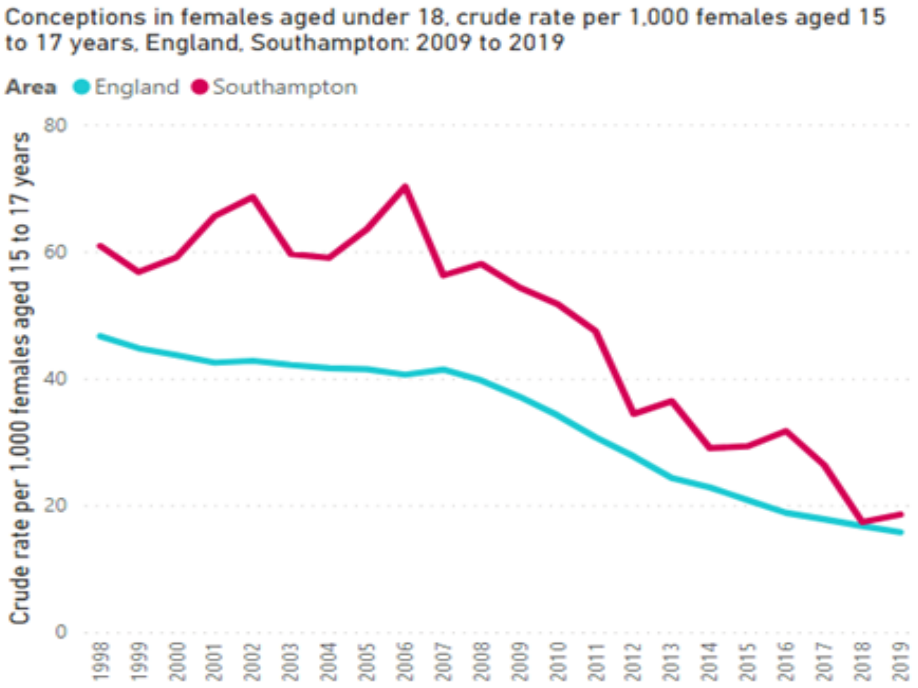
Figure 52: Conceptions in females aged under 18 years, crude rate per 1,000 females aged 15 to 17 years. Southampton and England 2009 to 2019



In the 2017-19 period there were 25 conceptions amongst girls aged under 16 years, giving a rate of 2.5 per 1,000 compared with 2.6 for England over a three-year period from 2017 to 2019.

11.5.7 Termination of Pregnancy

In Southampton 1,066 abortions were carried out in 2020, this is a crude rate of 18.5 per 1,000 females. This rate is not significantly lower than the England average (18.9 per 1,000). In the city, 87.6% of NHS abortions are performed under 10 weeks gestation; this is also similar to the national average of 88.1%. Southampton also has a statistically similar rate of repeat abortions compared to England for all ages (31.0 % compared to the national average of 29.2%).

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11.5.8 Use 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).

11.6 Protecting the Population

11.6.1 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. The city's ship-building heritage means that, although 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 1981-2019 (402 deaths for Southampton male residents). These areas include other prime ship-building locations of the last 40 years, as shown in Figure 53. There were 55 female deaths from mesothelioma in the same period, and Southampton is rank 20.[84]

[84] Health and Safety Executive, Mesothelioma Mortality in Great Britain by Geographical area, 1981–2019 https://www.hse.gov.uk/statistics/causdis/mesothelioma/mesoarea.pdf

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Figure 53: Mesothelioma mortality in Great Britain: number of deaths and Standardised Mortality Ratios for males by area, 1981-2019

Rank within GB	Area	Male deaths	Standardised Mortality Ratios (SMRs)	95% Confidence Interval	
				Lower	Upper
1	Barrow-in-Furness	289	414.9	368.5	465.6
2	West Dunbartonshire	289	367.3	326.2	412.2
3	North Tyneside	547	288.3	264.7	313.5
4	South Tyneside	414	278.1	252.0	306.2
5	Portsmouth	443	271.4	246.7	297.8
6	Plymouth	592	262.7	242.0	284.7
7	Medway	466	238.6	217.4	261.3
8	Hartlepool	185	224.2	193.0	258.9
9	Southampton	402	223.0	201.7	245.9
10	Gosport	154	217.7	184.6	254.9

Source: HSE www.hse.gov.uk/statistics/tables/mesoarea.xlsx

ONS Mortality data shows over the period 2013-2020 there were an average of 12 deaths per year to Southampton residents from mesothelioma.

Poor air quality is a significant public health issue. Particulate matter (PM2.5) has a significant contributory role in human all-cause mortality, particularly cardiopulmonary mortality. In 2019, Southampton's level of PM2.5 was 8.8 µg/m3 which was similar to the England average of 9.0 µg/m3. Although, evidence suggests that levels may have been lower during the COIVD-19 pandemic.

In 2019, the estimated fraction of all cause adult mortality attributable to anthropogenic particulate air pollution (measured as fine particulate matter, PM2.5) for Southampton was 5.0% similar to the percentage for England (5.1%). The fraction of mortality attributable to particulate air pollution has fluctuated but decreased overall from 2010 to 2019.

11.6.2 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.

Children's early experiences have a significant impact on their development, educational attainment, and future life chances. Children in contact with social services are more likely

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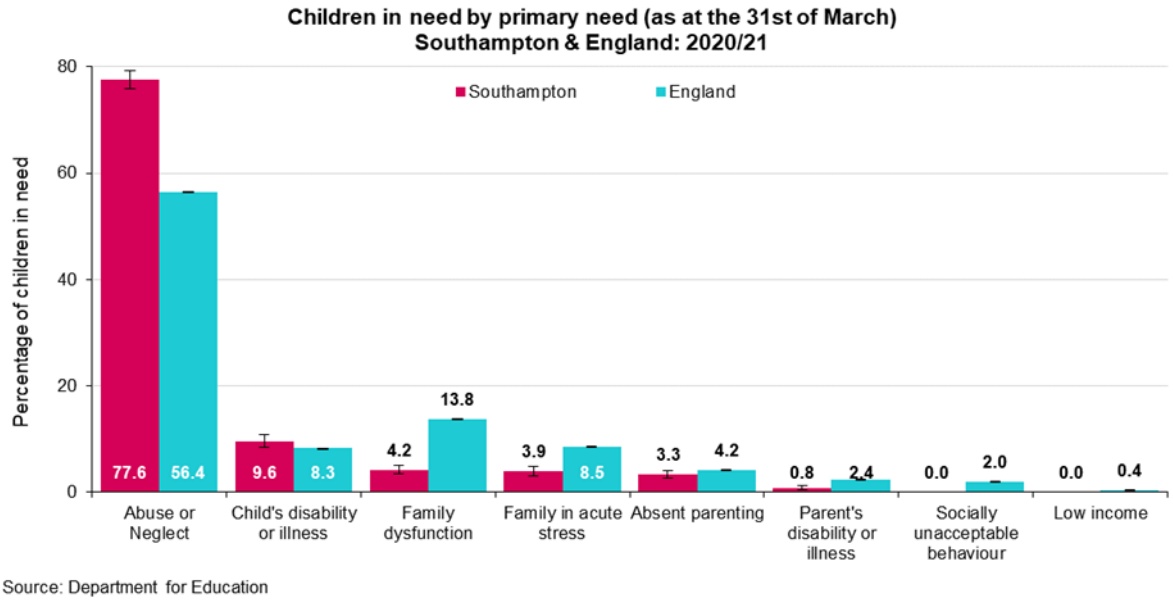
to experience poorer health and educational outcomes than their peers, as well as being more likely to offend,[85] with children looked after five times more likely to offend than all children.[86,87]

Southampton has 96 children looked after per 10,000 aged under 18 years (2021), which is 3rd highest among community safety partnerships statistical comparators and significantly higher than the national average of 67. The Southampton children looked after rate has seen an overall decline since 2016, although the rate has remained significantly higher than the national average since 2011.

As of March 2021, Southampton had 427 children in need (CIN) per 10,000 aged under 18 years, which is 3rd highest among statistical comparators and significantly higher than the national average. The chart below shows that 77.6% of Southampton's 2,210 CIN have a primary need of abuse or neglect, which is significantly higher than the national average of 56.4% for this category.

Figure 54: Children in need by primary need



Source: Department for Education

[85] Young Minds – Childhood adversity, substance misuse and young people's mental health (2016).https://youngminds.org.uk/media/1547/ym-addaction-briefing.pdf

[86] Criminal Justice System Statistics Quarterly (2018) https://www.gov.uk/government/statistics/criminal-justice-system-statistics-quarterly-december-2017

[87] Education Policy Institute – vulnerable children and social care in England: a review of the evidence (2018).https://epi.org.uk/wp-content/uploads/2018/04/Vulnerable-children-and-social-care-in-England_EPI.pdf

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Bullying has a strong effect on the mental health of those bullied and can often damage their outcomes in other areas of life and 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.

Southampton has a similar rate to the national average for hospital admissions due to unintentional and deliberate injuries among the 0 to 14 age group, with the Southampton trend declining from a rate of 495 admissions per 10,000 population aged 0 to 14 in 2018/19 to 410 admissions per 10,000 population in 2019/20. This trend should continue to be monitored to see if the decline experienced over the last year is sustained. However, Southampton remains significantly worse than the national average for hospital admissions due to unintentional and deliberate injuries among the 15 to 24 years age group in 2019/20.

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 2019/20, the percentage of adults in contact with secondary mental health services who live in stable and appropriate accommodation in Southampton was 17.0%, this is significantly lower than the England average of 58.0%. In 2019/20, the percentage of adults with a learning disability who live in stable and appropriate accommodation in Southampton was 82.0%, this is significantly better than the England average of 77.3%.

11.6.3 Health Protection from Communicable Diseases

- **Tuberculosis (TB):** Cases of TB in Southampton seen an overall decrease since the peak in 2011-13 (18.3 per 100,000 population). In 2018-20, the rate per 100,000 population of new TB notifications in Southampton was 9.8 statistically similar to the national average 8.0 per 100,000 population. This is lowest rate since pre 2001-03. In 2019, 85% of drug sensitive TB cases had completed a full course of treatment by 12 months, also similar to national percentage (82.0%). The highest percentage of

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drug completion locally was in 2017 with a coverage of 93.3%. Since 2004, the number of cases completing treatment has ranged annually of between 12 and 41.[88]

- **Hepatitis C:** In 2017, Hepatitis C was detected in 35 residents with a rate of 14.7 per 100,00 population. This was lower but not significantly than the national rate of 18.4 per 100,000 population. Hepatitis C has a higher prevalence among those people wo inject drugs. Eighty-five percent those people in drug use treatment in Southampton in 2017/18 received a Hepatitis C test, similar to the national average of 84.2%.

- **Healthcare Associated Infections (HCAI):** Between April 2018 and March 2021 there were 8 of Methicillin-resistant Staphylococcus aureus (MRSA) amongst the population registered with GPs in Southampton.[89] During April 2018 to March 2021 there were, 131 cases of Clostridium difficile (C. diff) infection amongst people registered with Southampton GPs.[90] Throughout 2010/11 to 2020/21 the local rate of cases has been lower than the national average. E.coli bacteraemia cases between 2012/13 and 2020/21 have ranged between 124 and 151 cases per year with an annual rate consistently lower than nationally.[91]

- **Vaccine Preventable Disease:** The routine surveillance and epidemiology of measles, mumps and rubella in the UK has been impacted in a number of ways during the COVID-19 pandemic, as follows:[92]

    - The reduction in international travel will have reduced the number of measles and rubella importations, providing fewer opportunities for new chains of transmission
    - Social distancing and lockdown measures are likely to have had a limited impact on measles transmission which is many times more infectious than SARS-CoV-2, However, there has been a significant impact on health-seeking behaviour, making it more likely that people with mild symptoms do not present to healthcare services.

[88] OHID Public Health Profile https://fingertips.phe.org.uk/
[89] Public Health England. MRSA bacteraemia: annual data MRSA bacteraemia: annual data - GOV.UK (www.gov.uk)
[90] Public Health England. Clostridium difficile infection: annual data Clostridioides difficile (C. difficile) infection: annual data - GOV.UK (www.gov.uk)
[91] Public Health England. Escherichia coli (E. coli): annual data https://www.gov.uk/government/statistics/escherichia-coli-e-coli-bacteraemia-annual-data
[92] UK Health Security Agency Laboratory confirmed cases of measles, rubella and mumps, England: July to September 2021 (publishing.service.gov.uk)

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Usually, mumps is most commonly seen amongst university students and adolescents. This is not unusual as transmission is usually fuelled 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.

In recent data available at national level in England, there were no laboratory confirmed mumps infections between July and September 2021 compared with 2 in the previous quarter of 2021 and in the period between July and September 2021 there were no laboratory confirmed measles cases reported. The total number of laboratory confirmed measles cases in 2021 remains 2.

There has been no new laboratory confirmed cases of rubella reported in the UK since 2019. With such low numbers reported nationally, there will be an even smaller number locally. Between 2012 and 2018 there were 3 cases of measles reported in the city. Data shows the two cases in 2016 were known to occur amongst unvaccinated individuals. Mumps has been more prevalent, following a peak of 63 cases in the city in 2013, cases have seen an overall annual decline to 3 cases in 2018.

Pertussis (also known as whooping cough) cases in the city showed 24 cases recorded in 2015, falling to 7 cases in 2016 and 2 cases in 2017. There was a peak of 46 cases recorded in 2012 which started to decline with the introduction of pertussis vaccine for pregnant women, and the associated awareness increasing.

- **Pandemic Flu:** Each year the NHS prepares for the unpredictability of flu, which could 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 2020 population would mean an estimated 130,060 people could become symptomatic and 6,500 people could die.
  The flu vaccine is recommended for the very young, older people, pregnant women and those who are immunosuppressed with certain underlying conditions. During the 2021/22 'flu season', at the peak of the Omicron COVID-19 variant, the flu vaccine was also recommended for the main carer of an older or disabled person, close contacts of immunocompromised individuals and all children aged 2 to 15 years.[93]

- **COVID-19 pandemic:** A COVID-19 Impact Assessment was carried out in Autumn 2021 to ensure that we are doing as much as we can with the resources available to protect

[93] Annual Flu Programme Annual flu programme - GOV.UK (www.gov.uk)

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and improve the health and wellbeing of the residents of Southampton in COVID-19 recovery over the months and years to come. Community pharmacies are key in the distribution of lateral flow tests through the QR coded ordering and collection service allowing stock distribution control. Additionally, pharmacies have been supporting individuals in supervising how to carry out lateral flow tests in a clean environment on the premises. (see section 5.10 COVID-19 Services).

- **Port Health:** The port hosts the largest cruise passenger operation in the UK and is Europe's leading turnaround cruise port (1.72 million passengers in 2016-18). It is also the UK's number one vehicle handling port (900,000 vehicles in 2021)[94] and the UK's most productive container port. In quarter 1 of 2020 Southampton turned around 8.2 million tonnes of cargo.[95] 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.

11.7 Specific Needs for Key Population Groups

The following patient groups, who may have particular needs, have been identified as living within the HWB's area:

11.7.1 University Students

As mentioned earlier, approximately 40,000 students live in the city with over 7,600 international students each year. These students represent more than 135 countries studying at the University of Southampton and Solent University. The health issues most commonly associated with students are:

- Mumps
- Chlamydia testing
- Meningitis

[94] ABP ports Southampton 2021 https://www.abports.co.uk/locations/southampton/
[95] Department for Transport 2020 https://www.gov.uk/government/statistics/port-freight-annual-statistics-2020

- Contraception, including EHC provision
- Mental health problems

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.

11.7.2 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 provided 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.

Of those who provide care in Southampton in 2011, 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% in 2011. This is equivalent to 4,802 people.

The 2021 Census data is not yet available, however local data from Carers in Southampton (n=2,539) on the distribution of carers known to them revealed hotspots of carers living centrally in Bevois, in Bitterne and Woolston in the east, and in a stretch from Freemantle to Redbridge across the western localities. These happen to be in some of the more deprived parts of Southampton. There are predominantly more females than males acting as carers, and they are most commonly aged between 45 and 65 years.

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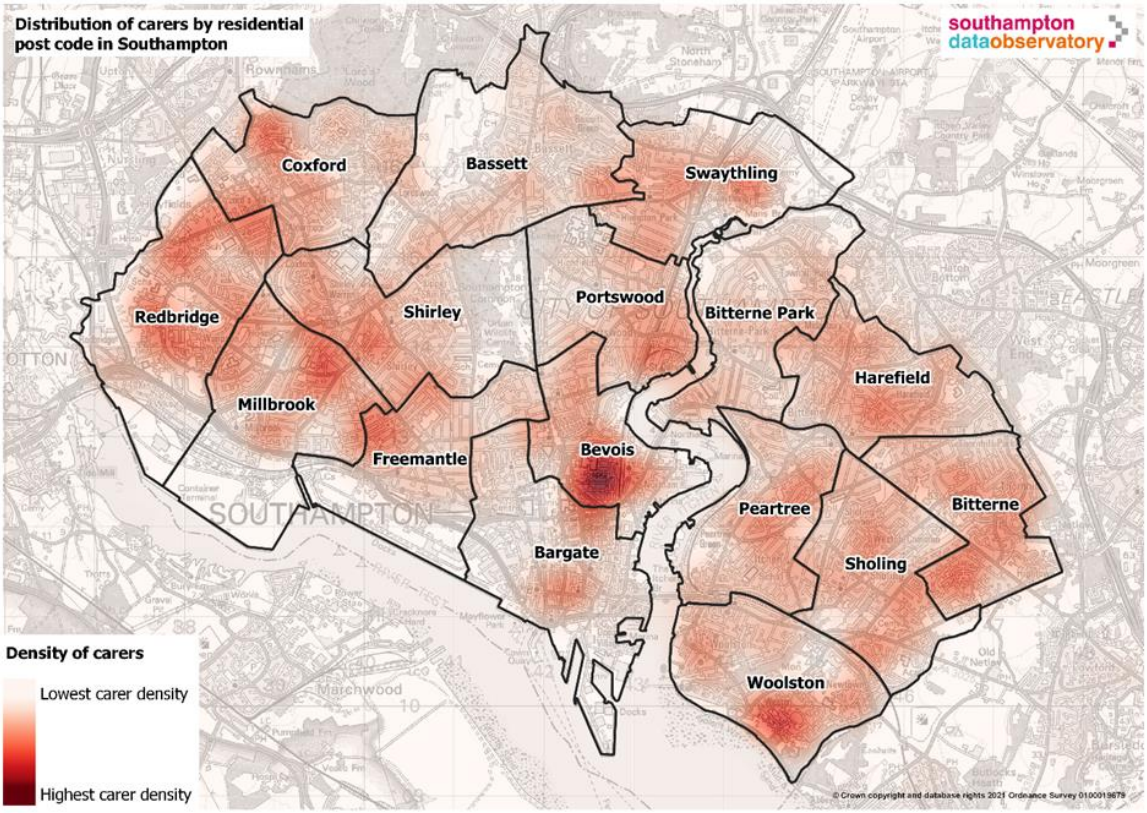
Figure 55: Distribution of carers by residential postcode in Southampton August 2021



In 2018/19, Southampton's carers had lower levels of satisfaction with social services than the national average (37.1% compared to 38.6%). In 2018/19 22.2% of social care users and carers felt they had as much social contact as they would like, this is significantly worse than the national average (32.5%). Nearly 66% of carers in Southampton reported that caring had caused them feelings of stress compared to 60.6% nationally.

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.

11.7.3 Disability - People with a Learning Disability

In 2019/20, there were 1,402 Southampton registered patients aged 18 years and over on the learning disabilities register (0.5% of registered patients – the same prevalence as England). However, there are an estimated 5,100 residents aged 15 years and over diagnosed and undiagnosed with a learning disability in the city.[96]

[96] Southampton Data Observatory https://data.southampton.gov.uk/health/disease-disability/learning-disabilites/

People with learning disabilities have differing and often complex health care needs leading to increased prescribing and risk of polypharmacy. A health needs assessment of people with learning disabilities found they had higher prevalence of depression, asthma, diabetes, and epilepsy. 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.[97]

11.7.4 Disability - Adults with Autistic Spectrum Conditions

A local estimate of the prevalence of autistic spectrum conditions in adults aged 16 years and over in Southampton was produced using national prevalence estimates derived from the 2014 Adult Psychiatric Morbidity Survey. In 2020, it is estimated that there are 1,200 males (1.1% of male population) and 210 females (0.2% of the female population) aged 16 years and over in Southampton who would screen positive for autism spectrum conditions.[98]

11.7.5 Lesbian, Gay, Bisexual, and Transgender Community

In 2017, research carried out by Public Health England estimated 2.5% of adults surveyed identified themselves as gay, lesbian bisexual or 'other'; in Southampton this would equate to 5,260 adults. The research found a larger proportion of men stating they were gay compared to women. The largest percentage among any age group is in the 25 to 34 years.[99]

Specific issues for this population group include being targets for hate crime, mental illness such as depression and anxiety, smoking and substance use.

Trans is an umbrella term to describe people whose gender is not the same as, or does not sit comfortably with, the sex they were assigned at birth. Being trans does not imply any specific sexual orientation. Some people consider being trans a very private matter and can

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

[98] 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

[99] Producing modelled estimates of the size of the LGB population of England https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585349/PHE_Final_report_FINAL_DRAFT_14.12.2016NB230117v2.pdf

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be subjected 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 Gender Identity Research & Education Society (GIRES), 60% of those presenting with gender dysphoria underwent transition; of these 80% were 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 years.[100]

GIRES estimate a prevalence of gender variance of 600 per 100,000 which would equate to 1,560 people in Southampton.

11.7.6 Age

Mental health needs by age are explored in Section 11.3 and the health needs of Southampton's children are highlighted in Section 11.5.

- Health issues tend to be greater amongst the very young and the very old
- The number of chronic conditions increases with age: data from GP practices in 2021 in Southampton was analysed showing that by age 40-44 over half have at least 1 long term condition (LTC), by age 60-64 over a third (38%) have at least 3 LTCs and by age 80-84 over a third (34%) have at least 6 LTCs (Figure 40).
- In 2020/21, a higher rate of older people (aged 65 year and over) in Southampton access long term support through adult social services than is the case nationally (6,935 per 100,000 compared with 5,280 per 100,000).[101]

11.7.7 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

[100] GIRES. The Number of Gender Variant People in the UK - Update 2011. GIRES; 2011 https://www.gires.org.uk/
[101] NHS Digital Adult Social Care Analytical Hub. https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-adult-social-care-survey/england-2019-20

- An increase in the number of older people from ethnic minorities is likely to lead to a greater need for provision of culturally sensitive social care and palliative care.
- Ethnic minority 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.

11.7.8 Gender

- Male healthy life expectancy in Southampton is 60.7 years which is significantly lower than the national average of 63.2 years
- Inequalities in health are also greater for men in the city; comparing the most deprived 20% of Southampton to the least deprived 20%, life expectancy at birth gap 8.7 years for men and 4.1 years for women (2018-20)
- In 2020/21, 51.3% of violent victims were female and 48.7% male and females continue to be more likely to be repeat victims of violent crimes than males[102]
- The most recent community safety survey also highlighted that over half of respondents that witnessed or were a victim of crime did not report the incident. This is particularly concerning for high harm and priority offence groups such as sexual assaults, serious violent crime, domestic abuse and Violence Against Women and Girls.

11.7.9 Port Workers and Visitors

Southampton is a port city with the potential for communicable diseases to be spread by the large-scale movements of goods and people through the port. 1.9 million TEU (Twenty Equivalent Unit) container movements of cargo, over 79,000 shipping movements and 2 million cruise passengers coming to 5 cruise terminals annually require a range of diverse environmental health control functions from Southampton Port Health Services. As ferry port, Southampton serves around 3 million passengers to and from the Isle of Wight.

[102]Southampton City Council Safe City Assessment. https://data.southampton.gov.uk/community-safety/safe-city-assessment/

11.7.10 Veterans

In common with other areas of the country, routinely collected local data for veterans in Southampton are extremely limited.

Applying estimates of the national veteran population (4.7%) obtained from survey data from the Annual Population Survey 2017[103] to the HCC SAPF gives an estimated 10,750 veterans living in the city. Hampshire as a wider ceremonial county area including Portsmouth and Southampton is estimated to have 7.1% veterans within the 16 years and older population, if this prevalence was applied to Southampton it would equate to 15,220 veterans. Most veterans are estimated to be in the older age groups, with 29% aged 55 to 74 years old, and 31% aged 75 to 84 years. [104,105]

The Royal British Legion (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 reflect 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 to 24 years and 25 to 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 needs of younger veterans are likely to differ significantly from those in older age groups for example within the ex-Service

[103] 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-ahousehold-survey/ applied to Hampshire County Environment Department's 2016-based Southampton Small Area Population Forecasts

[104] Annual population survey: UK armed forces veterans residing in Great Britain 2017 - GOV.UK (www.gov.uk)

[105] 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

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community 16 to 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.[106]

In March 2021, there were 777 people in receipt of an occupational pension under the Armed Forces Pension Scheme. The largest proportions of these veterans live in postcodes 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 (54 and 62 respectively).

A study by the RBL in 2014.[107] 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 years 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%

[106] Location of armed forces pension and compensation recipients: 2021 Ministry of Defence Location of armed forces pension and compensation recipients: 2021 - GOV.UK (www.gov.uk)
[107] 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-ahousehold-survey/

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- 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 years, and one in six reports some relationship or isolation difficulties. 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 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 years (one in ten) but reports of exhaustion and pain peak at age 45 to 54 years (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 years, so this difference is not explained by the older age profile of the ex-Service community. In total, 23% of those aged 16-64 years have a caring responsibility, compared with 12% nationally.

11.7.11 Travellers

In July 2021, there were 21 traveller caravans in Southampton's authorised site, Kanes Hill, a decline in numbers since January 2018 when 36 caravans were recorded. Key barriers to health in these communities include lower health literacy and cultural distrust of systems.

11.7.12 Homelessness

In 2019/20, Southampton's rate of households in temporary accommodation (1.8 per 1,000 households) was significantly lower than the national average (3.8 per 1,000 households). The city's rate of households owed a duty under the Homelessness Reduction Act (10.9 per 1,000 households) was also significantly lower than the national average (12.3 per 1,000 households), however the rate of households with dependent children owed a duty under the Homelessness Reduction Act (19.8 per 1,000 households) was significantly higher than the national average of (14.9 per 1,000 households).

The average life expectancy for women experiencing homelessness is 43 years old and for men it 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 people

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experiencing homelessness are nine times more likely to commit suicide than the general population.[108]

A study of homelessness service users between 2017/18 and 2019/20 was undertaken by Southampton City Council in March 2021. The study identified 619 rough sleepers, but it is recognised that the rough sleeping population is fluid in its composition, and there are a number of services assisting them out of rough sleeping.

The 619 known rough sleepers provided 1048 reasons for their rough sleeping, with Mental Health (26.7%) and Drug Addiction (23.9%) being the most represented reasons. Other reasons given were Prison (16.5%), Physical Disability (13.8%), Alcohol issues (13.5%), Domestic Violence (3.1%) and Learning Difficulties (2.6%).

The majority of known rough sleepers gave their nationality as 'British' (76%) with Polish being the second highest (12%) reported nationality. Over the course of the study, there was a decreasing trend for Polish rough sleepers (13% down to 8%) with an increasing trend in British homeless (77% increasing to 82%).

[108] '*Homelessness Kills*' report by Crisis available here: crisis_homelessness_kills_es2012.pdf

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12. Appendix B – HIOW Pharmaceutical Needs Assessment Steering Group Terms of reference

The Pharmaceutical Needs Assessment (PNA) is a legal duty for Health and Wellbeing Boards (HWBs). Hampshire, Portsmouth, Southampton and Isle of Wight (HIOW) HWBs are each required to publish a revised PNA for their area by 1st October 2022. The PNAs are used by NHS England to make decisions on which NHS funded pharmaceutical services need to be provided in each 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 HIOW PNA Steering Group exists to guide the preparation of the PNA documents on behalf of the HIOW Directors of Public Health for presentation to the HWBs.

12.1 Purpose

The Steering Group will: -

- Oversee the development and publication of a separate PNA for Hampshire County Council (HCC), Isle of Wight Council (IOWC), Portsmouth City Council (PCC) and Southampton City Council (SCC)
- Agree a timetable for the development of the PNAs
- Guide the PNAs to meet the requirements of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and by the required timescale
- Advise on the statutory duties for consultation for the PNAs

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12.2 Membership

The membership of the HIOW PNA steering group is as follows:-

- Hampshire County Council
  Catherine Walsh, Senior Public Health Intelligence Analyst

- Isle of Wight Council
  Simon Squibb, Public Health Practitioner (Analyst)

- Portsmouth City Council
  Matt Gummerson, Strategic Lead for Intelligence
  James Hawkins Specialist Public Health Intelligence Analyst

- Southampton City Council
  Becky Wilkinson, Consultant in Public Health (Chair)
  Vicky Toomey, Senior Strategic Intelligence Analyst
  Philip Gilbert, Public Health Practitioner

- Community Pharmacy South Central
  Debby Crockford, Chief Officer

- NHS England (South East Region)
  Marian Basra, Senior Commissioning Manager (Pharmacy and Optometry)

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 Local Authority, only those members representing the Local Authority in question may take part.

12.3 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.

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12.4 Meetings

All meetings will have an agenda and action notes. There will be three scheduled meetings of the steering group (November 2021, February 2022 and July 2022) although this schedule may be adjusted if necessary, by agreement of the group.

12.5 Accountability and reporting

The PNA steering group will be accountable to the Directors of Public Health across HIOW.

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13. Appendix C – Consultation report

13.1 Details of the consultation

Southampton City Council undertook public consultation on a draft Pharmaceutical Needs Assessment ("PNA") for Southampton between Friday 01 April and Sunday 31 May 2022.

The aim of this consultation was to:

- Communicate clearly to residents and stakeholders the proposed content of the Pharmaceutical Needs Assessment
- Ensure any resident, business or stakeholder who wished to comment on the proposals had the opportunity to do so, enabling them to raise any impacts the proposals may have
- Allow participants to propose alternative suggestions for consideration which they feel could achieve the objective in a different way.

The approach to the consultation, as agreed by the Steering Group, was to use an online questionnaire as the main route for feedback. Respondents could also write letters or emails to provide feedback on the proposals. Emails or letters from stakeholders that contained consultation feedback were collated and analysed as a part of the overall consultation.

The consultation was promoted in the following ways:

- Posts on social media channels Facebook and Twitter
- Links via the Southampton City Council website
- Emails sent to specified organisations.

13.2 Results of the consultation

Overall, there were 21 responses to the consultation, 19 via the questionnaire and 2 via email. The majority of the respondents (58%) agreed with the conclusions of the PNA, 21% disagreed and 21% neither agreed nor disagreed.

There were some free-text comments made by respondents which were shared with the steering group for consideration. These mainly related to opening times and locations of specific pharmacies.

A detailed report of the consultation and the results is available on the Southampton Data Observatory (PNA).

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13.3 Consideration of the consultation results

The steering group discussed the consultation results at its meeting on 8th July 2022 and would like to thank all those who took the time to respond. Having considered the results, the steering group agreed:

1. There should be no change to the conclusions of the PNA based on the responses (as the vast majority agreed with the conclusions)
2. That many of the comments raise concerns and issues that are out of the remit of the PNA
3. That some of the comments relate to business operations for the individual pharmacies
4. That particular issues raised will be passed on to members of the steering group who are more appropriately placed to address them through non-PNA channels, including those concerns and issues outside the remit of the PNA and relating to individual pharmacy business operations.

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14. Appendix D - 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 proposals and consider mitigating action.

Figure 56: The Equality Duty

Name or Brief Description of Proposal	**Southampton Pharmaceutical Needs Assessment 2022**
Brief Service Profile (including number of customers)	
A Pharmaceutical Needs Assessment (PNA) is a statement of current pharmaceutical services provided in the local area. It also assesses whether the pharmaceutical services provision is satisfactory for the local population and identifies any perceived gaps in provision. The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for developing and 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. An exception to the deadline has been made because of the COVID-19 pandemic so the refreshed Southampton PNA must be published by 1st October 2022.	
Summary of Impact and Issues	
The PNA reflects the current and future needs for pharmaceutical services. This affects the residents of Southampton, people who work and study in the city and partner NHS organisations including NHS Hampshire, Southampton and Isle of Wight 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 2018. Access to high quality pharmaceutical services is particularly relevant for those in ill health who are taking medicines, typically people suffering from long term conditions and older adults. But there is no specific population group that is	

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impacted as everyone may need access to pharmaceutical services in the city. The PNA, therefore, makes reference to a range of groups. The impacts of the COVID-19 pandemic may have changed the way people use pharmaceutical services and this is considered in the PNA. For instance, we know that inequalities have increased as a result of the pandemic and that some specific population groups (e.g., people experiencing homelessness and vulnerable migrants) may have increased reliance on pharmacies for their health and care needs. Additionally, pharmacies (like other health and care providers) are increasingly offering remote consultations. These can give many benefits to patients but also come with a quality risk.	
Potential Positive Impacts	
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, including locally commissioned services, and their role in promoting health and wellbeing of the people of Southampton is described.	
Responsible Service Manager	Becky Wilkinson Consultant in Public Health
Date	February 2022
Approved by Senior Manager	Debbie Chase Director of Public Health
Date	February 2022

Potential Impact:

Figure 57: Potential impact

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Age	This PNA identified good provision of services for all ages. Medicine use increases with age. The majority of older adults will be taking at least one regular prescription medicine. The PNA has considered services that would support older adults such as prescription collection and home delivery of medicines. Distance selling pharmacies, including those registered outside of Southampton, also provide additional choice, and increase accessibility to older	N/A

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Southampton City Council, Southampton, SO14 7LT

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Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
	adults, some of whom may have limited mobility. Age-Adjustments to the dispensing process which may support older people include easy open containers and large print labels.	
Disability	The PNA has considered services that would support people with a disability such as home delivery of medicines. Distance selling pharmacies provide additional choice and increase accessibility to individuals with disabilities who may have limited mobility.	N/A
Gender Reassignment	No specific impact has been identified from this PNA.	N/A
Marriage and Civil Partnership	No specific impact has been identified from this PNA.	N/A
Pregnancy and Maternity	No specific impact has been identified from this PNA. Community pharmacies can provide an important source of advice for minor ailments, such as constipation, which can commonly occur in pregnancy. For women planning pregnancy, access to a community pharmacy for advice can also be important.	N/A
Race	No specific impact on a particular group has been identified from this PNA. Information has been collected and summarised in the PNA on languages spoken by pharmacy staff.	N/A
Religion or Belief	No specific impact has been identified from this PNA. The General Pharmaceutical	N/A

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Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
	Council has published guidance[109] 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.	
Sex	No specific impact for either men or women has been identified from this PNA.	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	Areas of deprivation have been described and considered in this PNA but no specific impact has been identified.	N/A
Health & Wellbeing	The PNA has looked at the health and wellbeing of Southampton's population and at how the needs of different groups may vary. In relation to this, the PNA has assessed access to, and availability of, pharmaceutical services in the city.	
Other Significant Impacts	Community pharmacists tend to be the most accessible health care professionals for the general public. Pharmacies can be particularly effective in providing services to more underserved groups as they offer a walk-in service and do not require an appointment. COVID-19 has had a disproportionate impact on many who already face disadvantage, discrimination and unequal health outcomes. Some specific population groups (such as people experiencing homelessness and vulnerable migrants) have become even more reliant on	

[109] https://www.pharmacyregulation.org/sites/default/files/in_practice-_guidance_on_religion_personal_values_and_beliefs.pdf

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Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
	pharmacies for their health and care needs as a result of the pandemic. Public Health England has published guidance[110] on the unique role that pharmacy teams, located in the heart of communities, can play in helping to address health inequalities. There is also further guidance[111] available how pharmacies can be inclusive and on the role that pharmacies can plan in ensuring equitable access[112] to vaccinations.	

[110] Pharmacy teams – seizing opportunities for addressing health inequalities. https://psnc.org.uk/wp-content/uploads/2021/09/Pharmacy-teams-seizing-opportunities-for-addresssing-health-inequalities.pdf

[111] Joint National Plan for Inclusive Pharmacy Practice in England.https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Inclusive%20Pharmacy%202021/Joint%20National%20Plan%20for%20Inclusive%20Pharmacy%20Practice%20-%2010%20March.pdf

[112] Delivering an open access vaccination clinic. https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/12/C1463-community-pharmacy-toolkit-delivering-an-open-access-vaccination-clinic.pdf

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Southampton Pharmaceutical Needs Assessment (PNA):

Process for dealing with changes in the need for, or the availability of, pharmaceutical services

Last Updated July 2022

Contents

Data, Intelligence & Insight Team
Intelligence, Innovation and Change,
Southampton City Council, Southampton, SO14 7LT

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1. Purpose of this document

This document describes the legal responsibilities for Southampton's Health and Wellbeing Board (HWB) when there is a change to the need for, or the availability of, pharmaceutical services during the lifetime of the Pharmaceutical Needs Assessment (PNA).

The document then details the process that will be followed in Southampton to allow the HWB to fulfil these on-going PNA regulatory requirements.

2. The legal context

Section 128A of the National Health Service Act 2006 (NHS Act 2006) requires every HWB to assess the need for pharmaceutical services in its area and to publish a statement of its assessment (a PNA). HWBs will then be required to publish their next PNA within three years. However, significant changes to the need for, or availability of, pharmaceutical services in the area may result in occasions where a HWB board will need to publish its next PNA sooner or publish a 'supplementary statement' (a statement of fact describing significant changes to the availability of pharmaceutical services). The circumstances for this are set out in the 2013 regulations which can be found on the legislation.gov.uk website.

The 2013 regulations state that a HWB must produce a new PNA if it identifies changes to the need for pharmaceutical services, which are of a significant extent. This could be due to changes in:

- the number of people in the area who require pharmaceutical services
- the demography of the area
- risks to the health or wellbeing of people in the area (both residents and visitors)

The only exception to this requirement is where the HWB is satisfied that producing a new PNA would be a disproportionate response to the changes.

A supplementary statement is published to explain significant changes to the availability of pharmaceutical services where:

- the changes are relevant to the granting of a future application(s) for inclusion in the pharmaceutical list for the HWB area
- the HWB is satisfied that producing a new PNA would be a disproportionate response to those changes (or it is already producing its next PNA but is satisfied that it needs to immediately modify the existing document in order to prevent significant detriment to the provision of pharmaceutical services).

Supplementary statements are statements of fact only; they do not make any assessment of the impact the change may have on the need for pharmaceutical services. Effectively, they are an update of what the PNA says about the availability of pharmaceutical services. They are not a vehicle for updating what the PNA says about the need for pharmaceutical services.

Since 5 December 2016 pharmacies have been able to apply to NHS England (NHSE) to consolidate the provision of pharmaceutical services at two pharmacies onto one site. NHSE is directed to refuse a consolidation application if it satisfied that to grant it would create a gap in pharmaceutical services provision that could be met by an application offering to:

- meet a current or future need for pharmaceutical services, or
- secure improvements or better access to pharmaceutical services

HWBs will be notified of consolidation applications and must make representations in writing which indicate whether or not granting the application would create such a gap. They will have 45 days to submit such representations and will receive a number of reminders of this statutory duty if they do not respond within the 45 days.

If one of the pharmacies closes and the HWB is of the opinion that the closing does not create a gap then it must issue a supplementary statement. This statement remains in place and provides regulatory protection for the continuing pharmacy against an application offering to meet a need for, or secure improvements or better access to, pharmaceutical services for the remaining lifetime of the PNA.

If a consolidation application is refused, the owner of the site that was to be closed can still give notice to NHSE that they intend to close the pharmacy. The HWB would then need to consider whether it will need to provide a supplementary statement following this closure. If the refusal was because NHSE was satisfied that to grant the consolidation would create a gap in pharmaceutical services provision, then a supplementary statement would be required following the closure of the premises.

A PNA must include a map that identifies the premises at which pharmaceutical services are provided within the area of the HWB. This map must be kept up-to-date but this does not necessarily mean there is a need to republish the whole PNA or even a supplementary statement.

The services that pharmacies provide are subject to national negotiation, and it is therefore possible that during the lifetime of the PNA new essential or advanced services will be rolled out. It is not possible for the HWB to foresee what new advanced services may be launched (any new essential services would have to be provided by all pharmacies), so this would be something to consider as part of the ongoing duties regarding producing new PNA and/or publishing supplementary statements.

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3. Process for dealing with changes

Changes in the need for pharmaceutical services will be identified via Southampton Joint Strategic Needs Assessment (JSNA). At each JSNA Steering Group meeting there will be a standing item on the agenda for members to raise any significant changes in the following:

- the number of people in the area who require pharmaceutical services
- the demography of the area
- risks to the health or wellbeing of people in the area (both residents and visitors)

The changes will then be reported to the named Public Health Consultant leading on the PNA who will be responsible for briefing the HWB, or delegated sub-committee, of the change. The HWB (or sub-committee) will decide whether producing a new PNA would be a disproportionate response to the changes identified.

Primary Care Support England (PCSE) are responsible for notifying all interested parties, including the HWB, when:

- a pharmacy or dispensing appliance contractor opens new premises or relocates to new premises
- a change of ownership application takes place
- Consolidations of two pharmacies

NHSE is responsible for notifying all interested parties, including the HWB when:

- core and/or supplementary opening hours change
- pharmacy or dispensing appliance contractor premises close permanently
- when a dispensing practice ceases to dispense either to a particular area or completely

NHSE provides a quarterly update to all interested parties, including the HWB, on all of these points (including those under the remit of the PCSE).

To ensure this information is acted upon, NHSE have been advised to include the following generic email address in their quarterly notifications of changes to pharmaceutical services in the city (even though other named individuals are also automatically notified – including the Director of Public Health):

strategic.analysis@southampton.gov.uk

This generic email address is checked regularly (at least weekly) by the Data, Intelligence and Insight Team.

The Data, Intelligence and Insight Team will make the first check of the notified change to see if any further action is required. The legislation states that an up-to-date map showing the location of pharmaceutical services within the HWB area must be maintained. Therefore, the Data, Intelligence and Insight Team will publish a map on the PNA pages of the Data Observatory website and update it, as appropriate, when changes are received from NHSE.

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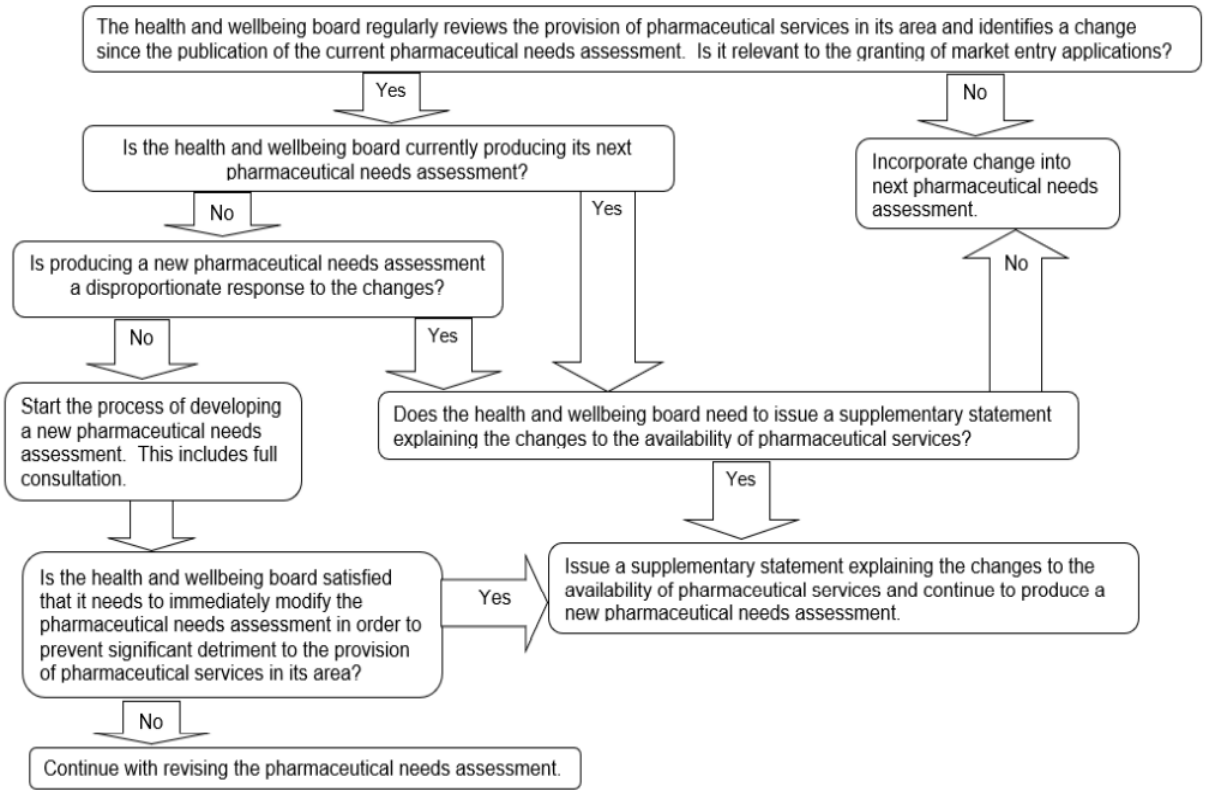
If further action is required, or if there is any uncertainty, the change will be escalated to the named Public Health Consultant leading on the PNA who will be responsible for briefing the HWB of the change.

The HWB, or delegated sub-committee, will then make the decision on whether a new PNA of supplementary statement is needed.

A decision-making flowchart from national guidance is shown in Figure 1; this will be used by the Southampton HWB, or delegated sub-committee, to decide if a new PNA or supplementary statement is needed. [1]

Figure 1: Decision-making flowchart



Source: Pharmaceutical needs assessments: Information pack for local authority health and (publishing.service.gov.uk)

If a supplementary statement is needed, the HWB will use the templates published in the national guidance (Appendix 1).

[1] Pharmaceutical needs assessments: Information pack for local authority health and (publishing.service.gov.uk) accessed 07/06/2022

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Appendix 1: Templates for supplementary statements

Template for opening of a new pharmacy

Health and wellbeing board logo and address

Supplementary statement to the [insert name] pharmaceutical needs assessment

Date pharmaceutical needs assessment published –

Date supplementary statement issued –

The pharmaceutical needs assessment for the area of [insert name] Health and Wellbeing Board identified in section/chapter [X] a need for the following:

- [insert details of need(s) identified and the service(s) required to meet that need for the particular locality]

[NHS England and NHS Improvement/NHS Resolution] granted an application by [insert name of contractor] to open a pharmacy at [insert address] to provide the following pharmaceutical services:

- [insert all pharmaceutical services that the applicant is to provide]

These services will be provided at the following times:

- [insert core and supplementary hours as detailed in the application]

The pharmacy opened on [insert date of opening].

Supplementary statement issued by: *(This should be the name of the person or panel/committee who has been authorised to issue supplementary statements).*

Post:

Date:

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Template for closing of a pharmacy

Health and wellbeing board logo and address

Supplementary statement to the [insert name] pharmaceutical needs assessment

Date pharmaceutical needs assessment published –

Date supplementary statement issued –

The following pharmacy has closed:

- [insert name and address of pharmacy]

The pharmacy provided the following pharmaceutical services:

- [insert all pharmaceutical services that the pharmacy provided]

These services were provided at the following times:

- [insert core and supplementary hours]

The pharmacy closed on [insert date of opening].

Supplementary statement issued by: *(This should be the name of the person or panel/committee who has been authorised to issue supplementary statements)*

Post:

Date:

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Template for consolidation of two pharmacies

Health and wellbeing board logo and address

Supplementary statement to the [insert name] pharmaceutical needs assessment

Date pharmaceutical needs assessment published –

Date supplementary statement issued –

This should be the name of the person or panel/committee who has been authorised to issue supplementary statements.

The following pharmacy has closed as a result of a successful consolidation application:

- [insert name and address of pharmacy]

The pharmacy provided the following pharmaceutical services:

- [insert all pharmaceutical services that the pharmacy provided]

These services were provided at the following times:

- [insert core and supplementary hours]

The pharmacy closed on [insert date of opening].

It is the opinion of [insert name] Health and Wellbeing board that the removal of this pharmacy from the pharmaceutical list does not create a gap in pharmaceutical services provision that could be met by a routine application:

- to meet a current or future need for pharmaceutical services, or
- to secure improvements, or better access, to pharmaceutical services

Supplementary statement issued by: *(This should be the name of the person or panel/committee who has been authorised to issue supplementary statements).*

Post:

Date:

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DECISION-MAKER:	**Health and Wellbeing Board**
SUBJECT:	**Improving the local food environment**
DATE OF DECISION:	**21 September 2022**
REPORT OF:	**CABINET MEMBER FOR HEALTH, ADULTS AND LEISURE**

CONTACT DETAILS				
Executive Director	**Title**	Director of Commissioning, Integrated Health and Care		
	Name:	Terry Clark	Tel:	
	E-mail	Terry.Clark@nhs.net		
Author:	**Title**	Senior Public Health Practitioner		
	Name:	Ravita Taheem	Tel:	07825 609377
	E-mail	Ravita.Taheem@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY
None
BRIEF SUMMARY
Local authorities are well placed to shape the local food environment for residents. In Southampton, priorities in recent years have focussed on food poverty and holiday hunger, however the Scrutiny Inquiry into childhood obesity in 2020 highlighted the broader issue of the local food environment and approaches being pioneered by other UK cities to enable residents to make healthy food choices easier. The food environment also came into national focus recently with the publication of the Government Food Strategy which prioritised health, sustainability, and a secure food supply. This briefing provides a short summary of the national context and local work, a detailed paper will be presented to the Health and Wellbeing Board in the Autumn. The aims of this summary paper are: • To raise awareness of the projects currently being undertaken to influence the local food environment • To initiate discussions and inform local priorities and highlight where cross-department working could strengthen programmes to support a healthier food environment
RECOMMENDATIONS:

	(i)	To consider the range of projects currently being undertaken to improve the local food environment and identify opportunities for joint working across the Council to support a healthier food environment
	(ii)	To consider participation in a whole systems approach workshop for leaders to identify strategic opportunities for intervention on obesity prevention
	(iii)	Consider how cross council buy-in could be achieved for a policy to limit advertising of HFSS

	(iv)	To consider the benefit of a Local Food partnership (via the Sustainable Food Places award) to underpin local work to improve the food environment
REASONS FOR REPORT RECOMMENDATIONS		
1.	To raise awareness of work to improve the local food environment and initiate discussions to inform future priorities, in support of achieving the recommendations of the Scrutiny Inquiry into tackling childhood obesity.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	N/A	
DETAIL (Including consultation carried out)		
3.	**National context** **Government Food Strategy** Attention to the food environment came to the fore recently with the publication of the Government Food Strategy in June 2022. The strategy covered a range of factors including food supply, sustainability, as well as health. Most notably, the strategy included plans to consult on an ambition for 50% of public sector spend to go on locally produced food or food certified to higher standards; a requirement for school leaders and governors to publish a "school food vision"; and plans to gather insights from areas that have a Local Food Partnership (a number of UK cities have these as part of the Sustainable Food Places award). Many of the recommendations were deferred to consultation or to the forthcoming Health Disparities White Paper. **The Food (Promotion and Placement) Regulations 2021** New legislation the Food (Promotion and Placement) Regulations 2021 are due to come into force on 1st October 2022 in England and Wales. This regulation will impact retailers, including franchises, with more than 50 employees and relevant floor space of more than 185.8m^2 (although the delayed promotion element of the regulations is not reliant on premises size) and aim to restrict the promotion and placement of food and drink identified as high in fat, sugar, and salt (HFSS). This is part of national policy to promote healthy weight and improve population health, and it will enable supermarkets and other retailers to alter retail environments so that healthy choices are the easy choices for consumers. As highlighted in a previous briefing (taken to both Cllr Fielker's and Cllr Renyard's CMB), at present due to financial pressures on the Council, proactive local enforcement of this legislation will not be possible. The Council will be responding reactively to complaints/concerns reported and will take steps to advise and enforce where required. Preliminary checks when visiting premises for other purposes are also being considered.	
4.	**Local programmes** **Sign-up to the Local Authority Declaration on Healthy Weight** The Local Authority Declaration on Healthy Weight sets out a series of ambitions for the Council to create a healthy weight environment. The Council signed up to this declaration with cross-party support in March 2022.	

Whole systems approach

The local application of the recommended whole systems approach to obesity and childhood obesity is underway. Ten workshops have been undertaken with a range of officers, external teams and members of the community. An initial analysis revealed that societal changes such as an increase in working families is restricting time to prepare healthy meals and the concurrent rise in convenience food has resulted in the replacement of nutritious consumption with that of a processed, less nutritious, diet. At the same time healthy food is less affordable and requires skill and equipment to prepare, whereas less healthy food tends to last longer and is easier to prepare.

Additional themes included the knowledge, skills, and motivation to cook and consume healthy food; access and prevalence of fresh vs convenience food retail outlets; and communication and promotion of healthy food choices particularly directly to younger audiences. However, it was recognised that, albeit well-intentioned, interventions solely targeting individuals to increase knowledge and skills would not have the necessary system-wide influence required to alter trends in childhood obesity.

Data revealed that a focus should be placed upon actions that will influence the entire city and initiate commitments or ownership across sectors to drive forward a change in the food environment. For example, a city-level approach to a food strategy or committing to nationally recognised programme such as the Sustainable Food Places Award could define high-level goals for council leaders, corporate partners, social enterprises, and community networks to strive towards.

Furthermore, a strategy which can identify gaps in the data such as the distance from an individuals' residence to a fresh food retail environment could be valuable for how local authority environmental planning can support areas and positively influence the behaviours of local residents.

Plans for a WSA workshop with Council leaders are supported by Cllr Fielker, in order to explore the strategic opportunities for intervention.

Local programmes and interventions

In addition to the nationally funded HAF (Holiday Activities Fund) programme for pupils eligible for free school meals, funding has been provided to:

- Increase the number local cook and eat programmes for young families.
- Engage more settings with the local Healthy Early Years Award and Healthy High-5 programme for schools.
- Run a local network (leadership provided by City Catering and Abri) to develop skills and capacity among local providers of cook and eat programmes.
- Roll out the Early LifeLab programme to all primary schools in the city. This programme makes the science behind the need for healthy diet, physical activity and sleep accessible to children, helping them to

	discover why this matters for themselves, and supports children and their families in making healthy choices. **Strengthening guidance on advertising of HFSS** The Communications team at the Council will be building on the Council's existing advertising policy to strengthen guidance to reduce the advertising of HFSS food and drink. An initial discussion has taken place with Sustain, an organisation working to improve the food system and who have supported several councils to implement these policies. Sustain indicated that where policy implementation has been successful, securing cross-council agreement was crucial at the start to avoid unnecessary delays. **Local mapping** A rapid mapping exercise was undertaken by the Council's Intelligence team using existing data to inform priorities for the local food agenda. This looked at hot food takeaways in the city within a 400m of schools. Across the whole city 72.4% of schools are within 400 metres of a fast-food outlet. Schools around the city centre and more deprived wards are generally in closer proximity to fast-food outlets. However, most fast-food outlets in close proximity to secondary schools are closed around 3/4pm, except for around St. Anne's (Bevois/centre) and coffee shops/outlets within larger retailers across the whole city. The mapping also looked at accessibility to supermarkets across the city and showed that there are longer travel distances to the largest supermarkets (2800m^2) in East of the city. This may be problematic as larger supermarkets are likely to have a greater selection of affordable, healthy food. **Healthy Start Scheme** The University of Southampton were recently awarded funding by the National Institute of Health and Care Research to evaluate the Healthy Start (HS) scheme. Healthy Start is a national scheme for pregnant women and families who are in receipt of certain benefits, it provides free maternal and child vitamins and vouchers for money off fruit, vegetables, milk, and infant formula. The Public Health team is collaborating with the University on this project. The research aims to understand: • why some families who can claim for HS vouchers use them and others don't, and how this decision affects the foods they buy and eat • what impact changes to the HS system have had on families (like raising the voucher amount from £3.10/week to £4.25 and registering online) • what impact vouchers can have on children's development • how health and social care professionals, community workers, charities, and food stores support families to use HS vouchers and eat healthily • what people think can be done to make the voucher system better
5.	**Future direction** The Sustainable Food Places award provides a helpful structure which has been used by many UK cities to create a local food network and a local food strategy. The award has the following six domains and may be an option for

	the Council to take a holistic approach to improving the local food environment: 1. Taking a strategic and collaborative approach to good food governance 2. Building public awareness, active food citizenship and a local good food movement 3. Tackling food poverty and diet related ill-health and increasing access to affordable healthy food 4. Creating a vibrant, prosperous, and diverse sustainable food economy 5. Transforming catering and procurement and revitalizing sustainable food supply chains 6. Tackling the climate emergency through sustainable food & farming and an end to food waste
6.	**Recommendations** • To consider the range of projects currently being undertaken to improve the local food environment and identify opportunities for joint working across the Council to support a healthier food environment • To consider participation in a whole systems approach workshop for leaders to identify strategic opportunities for intervention on childhood obesity • Consider how cross council buy-in could be achieved for a Council policy to limit advertising of HFSS • To consider the benefit of a Local Food partnership/network (via the Sustainable Food Places award) to underpin local work to improve the food environment
RESOURCE IMPLICATIONS	
Capital/Revenue	
7.	No additional funding is being requested.
Property/Other	
8.	N/A
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
9.	S111 Local Government Act 1972 and S1 Localism Act 2011
Other Legal Implications:	
10.	N/A
RISK MANAGEMENT IMPLICATIONS	
11.	N/A
POLICY FRAMEWORK IMPLICATIONS	
12.	The proposals contained within this report support the delivery of the Southampton City Council corporate plan 2021-2025 to improving health and learning for our children and adults across the city and reducing childhood obesity.

KEY DECISION?	**No**

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices	
	None

Documents In Members' Rooms

	None

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

Other Background Documents
Other Background documents available for inspection at:

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

DECISION-MAKER:	Health and Wellbeing Board
SUBJECT:	Better Care Fund Year End Report 2021/2022 and 2022/2023 Narrative Plan and Templates
DATE OF DECISION:	21/09/2022
REPORT OF:	Cllr L Fielker Cabinet member for Health, Adults and Leisure

CONTACT DETAILS				
Executive Director	**Title**	**Director of Commissioning – Integrated Health & Care**		
	Name:	**Terry Clark**	Tel:	07789679659
	E-mail	**Terry.Clark@nhs.net**		
Author:	**Title**	**Deputy Director, Integrated Commissioning Unit**		
	Name:	**Moraig Forrest-Charde**	Tel:	07769640375
	E-mail	**moraig.forrest-charde@nhs.net**		

STATEMENT OF CONFIDENTIALITY
Not applicable
BRIEF SUMMARY
Partners across Southampton have set out ambitious plans for residents to Start well, Live Will, Age Well and Die Well in the Southampton Health & Care Strategy. These papers set out the performance of our Better Care Fund (BCF) for 22/23 and the plans we have in place to further integrate our service provision and deliver improved outcomes for residents and patients. The BCF is the vehicle for pooled funding and planning to achieve these plans.
In 2021/22 against a backdrop of Covid, locally as a system we performed well and have much to be proud of. Part of the BCF Framework requires a Year End Return for 2021/2022 to be returned to NHS England, setting out how we delivered our plans. This return was submitted under delegated authority due to timescales, however formal sign off it required by the Health and Wellbeing Board (HWB).
In late July, the 2022/23 Policy and Planning return for BCF was published. The local area is responsible for submitting plans to the regional Better Care Fund (BCF) team for assurance by the 26th of September.
The content of these papers are not repeated in this document rather a summary of the requirements, with all papers included as an addendum. Noting that all planning requirements were met in 2021/2022 and will be met in 2022/2023.
RECOMMENDATIONS:

	(i)	Health and Wellbeing Board approve the year end return 2021/2022 as set out in appendix 1.
	(ii)	Health and Wellbeing Board approve the draft response to Better Care Fund Policy Framework and Planning Guidance, following agreement of the CEO of the Local Authority and Accountable

		Officer of the Integrated Care Board (ICB), and delegate authority to the Chair of the board to sign off the final submission.
REASONS FOR REPORT RECOMMENDATIONS		
1.	The BCF requires Integrated Care Boards and local authorities to agree a joint plan, owned by the Health and Wellbeing Board. These are joint plans for using pooled budgets to support integration, governed by an agreement under section 75 of the NHS Act (2006).	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	No other options considered, sign off by the Health and Wellbeing Board is a requirement set out in the BCF Policy Framework and Planning Guidance.	
DETAIL (Including consultation carried out)		
3.	**BCF Year-end return 2021/2022** - The Department of Health and Social Care published the BCF Policy Framework for 2021/2022 on the 19th of August 2021 and the Planning Guidance, which supports the framework, on the 30th of September 2021. In response to this a narrative plan and template were submitted to the BCF team regionally for assurance and sign off on 16th of November 2021. The national team requested a year-end return be submitted on or before the 27th of May 2022. Ahead of submission of the year-end return to the national team officers holding the following roles were briefed for their agreement and where appropriate delegated sign off was obtained, subject to HWB approving at this meeting – • Executive Director Health and Adult Social Care (SCC); • Direct of Commissioning – Integrated Health & Care (SCC & HIOW ICB); • Managing Director – Southampton Place Based Team (HIOW ICB); • Chair of Health and Wellbeing Board (SCC) The submission confirmed that all conditions set in the policy and planning guidance for 2021/2022 were met and that performance against the metrics was excellent given the challenges faced by residents and services in that year. Five metrics were set nationally, for one of theses there was no access to national data in order assess the position for the city, i.e. unplanned hospitalisation for chronic ambulatory care sensitive conditions. The remaining four were either on target to meet the plan for that year or very close to meeting plan: • proportion of inpatients resident for 14 days or more and 21 days or more; whilst not quite on plan Southampton performed well against our comparators and the mean figure for England. • Percentage of People who are discharged from acute hospital to their normal place of residence – on track to meet target, an excellent achievement given the rising levels of demand and frailty in our population. • Rate of permanent admission to residential care per 100k population (65+ yrs of age) – missed plan by a small margin. An excellent achievement, plus it should be noted that the trajectory for the last	

	three years has been a downward trend which is a very positive achievement. • Proportion of older people who were still at home 91 days after discharge from hospital into reablement/rehabilitation services – on plan and again good performance.
4.	**Policy and planning guidance 2022/2023, including BCF Plan Priorities** The Department of Health and Social Care published the BCF Policy Framework and planning guidance for 2022/2023 on the 21st of August 2022. As in previous years there are four national conditions set out in the policy and planning guidance which aim to drive health and social care integration. Setting and agreeing a joint plan, which is agreed by the Health and Wellbeing board, is the first of these, along with setting the NHS minimum contribution, commitment to invest in NHS commissioned out-of-hospital services and focusing on the following BCF policy objectives. o Enable people to stay well, safe and independent at home for longer o Provide the right care in the right place at the right time (focusing on hospital discharge) The first of these is an additional objective for this year, how the system addresses it, along with the other conditions, is set out in the narrative which can be found in appendix 2. The narrative plan and related templates therefore reflect how commissioners will work together in 2022-23 to: • continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • Including a high level description of the governance process in place to enable such an approach. • overarching approach to support people to remain independent at home • a narrative on the approach in the area to jointly improving outcomes for people being discharged from hospital, and therefore increasing the proportion of people who return home to their usual place of residence **Additional requirements for 2022/2023** This year the BCF planning guidance requires the following to be completed – • Self-assessment by the place-based system/HWB area against the High Impact Change Model (HICM) – Managing Transfers of Care[1] which was refreshed by the Local Government Association in July 2020. Reference to this will be made in the narrative. • Completion of a capacity and demand model for intermediate care services locally, this tool is under development and as such will not undergo assurance and therefore the content does not require sign off. The outputs from the HICM will contribute to local planning and development of the support commissioned, and delivered, to enable effective transfers of care. However, whilst a requirement of the planning process, assurance will only be required that the self-assessment has been completed.

[1] **Managing transfers of care – A High Impact Change Model | Local Government Association**

	Similarly the capacity and demand model for intermediate care will be based on local planning for 2022/2023 and as such the output will contribute to ongoing work through the year. The capacity and demand model does require submission as part of the policy and planning guidance response however the content will not be subject to the assurance process. The planning template which provides a full financial and metrics breakdown of the plan for this year, this can be found in Appendix 3. The metrics for this year no longer include the inpatients resident for 14 and 21 days and an adjustment has been made to the first metric to support readily available data and with it self-assessment of the system. The metric is now 'Indirectly standardised rate (ISR) of admissions per 100,000 population'. The priorities in this years plan have been adjusted slightly to reflect the new requirements and our local health and care strategy and health and wellbeing plan. They are - • **Priority 1: Delivering on Avoidable Admissions/enable people to stay well, safe and independent at home for longer -** Strong focus on prevention, admission avoidance through our urgent Response Service, proactive care at home (reducing preventable admission to long term care) and Enhanced Health in Care Homes (EHCH) arrangements. • **Priority 2: Further developing the discharge model to promote right care in the right place at the right time:** including Recovery and Assessment and Home First as a feature of the BCF plan. o Hospital Discharge process and out of hospital capacity o A flexible and broad offer of recovery and assessment, promoting a home first approach o Particular focus on discharge capacity for those with the most complex needs • **Priority 3: Increase the number of people who see benefit from Rehabilitation and Reablement,** meaning a continued focus on reducing dependency on longer term care provision. • **Priority 4: Implement new models of care (within Adults and Children's)** which better support the delivery of integrated proactive care and support in our communities. • **Priority 5: Effective utilisation of the Disability Facilities Grant –** promoting independence and personalised care/strength-based approaches. The narrative plan provides further detail on the developments and services which contribute to these priorities.
5.	**BCF sign off and local reporting and oversight 2022/2023.** Local sign off requirements are - Health and Wellbeing Board, CEO of the local authority and Accountable Officer of the ICB. Unlike previous years this process is expected to be complete ahead of the submission date of the 26th of September, however the request for delegated authority to the HWB chair is requested should there be small changes required ahead of the final submission.

	BCF updates continue to be presented to the Joint Commissioning Board with the 2021/2022 update and outline of planning for 2022/2023 planned for September 2022. In addition the BCF Finance and Performance Group meet six times in the year with the purpose of 'the Better Care Finance and Performance Monitoring Group (F&PMG) is have oversight of the Better Care Fund S75 agreements and to provide assurance to Joint Commissioning Board that the funding and performance are being appropriately and effectively managed'
RESOURCE IMPLICATIONS	
Capital/Revenue	
6.	Southampton HWBB area has one of the largest Better Care pooled funds in the country. Financial and resource implications are described in the pooled fund details within the year-end return 2021/2022 and narrative plan and template 2022/2023. 2021/2022 - The mandated level for 2021/2022 was £32,469,932 and at the beginning of the year there was a total pooled fund of £135,420,940, £86,013,511 from the ICB and £49,407,429 from SCC. During the year additional investments were made by both organisations meaning that the actual pooled fund income was £138,954.039. Adjustments to income when compared with plan relate to in part the 6-month budgeting cycle within the ICB during 2021/2022. 2022/2023 - Mandated level for 2022/2023 of £33.892m and a total pooled fund of £143.562m, £91.259m from the ICB and £52.303m from SCC. The BCF plan distributes these funds across ten schemes, noted within the narrative and detailed in the expenditure tab of the BCF 2022/2023 planning template.
Property/Other	
7.	Not applicable
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
8.	The legal framework for the Better Care Pooled Fund derives from the amended NHS Act 2006, which requires that in each Local Authority area the Fund is transferred into one or more pooled budgets, established under Section 75, and that plans are approved by NHS England in consultation with DH and DCLG. The Act also gives NHS England powers to attach additional conditions to the payment of the Better Care Fund to ensure that the policy framework is delivered through local plans. Southampton is compliant with all conditions in 2021/2022 and 2022/2023.
Other Legal Implications:	
9.	Not applicable
RISK MANAGEMENT IMPLICATIONS	
10.	There remain risks of greater expenditure than that set at the beginning of each year, the management of this risk is set out in the S75 agreement making clear how such expenditure will be managed by the two organisations.

	These areas are subject to scrutiny and where appropriate subject to review in order to identify ways to ensure appropriate budget allocation going forward. In 2022/2023 • There is a risk of overspend against a small number of schemes within the pooled fund, in particular Learning Disability Commissioning and Aids to independence. The former related to the complexity of care and support required for the client group and the latter to the risk in equipment needs again with rising levels of complexity and frailty within the city. Each of these schemes are under scrutiny and where possible the overspend is mitigated. • The successful delivery of the stretch targets set as part of this planning process are subject to multiple system forces e.g. availability of workforce in adult social care providers will have a direct impact on delivery of hospital discharge metrics and reablement metric. At this point in time focus on recruitment and retaining of this workforce is a priority for the local authority and its commissioned providers.
POLICY FRAMEWORK IMPLICATIONS	
11.	Southampton's Better Care Programme supports the delivery of outcomes in the Council Strategy (particularly the priority outcomes that "People in Southampton live safe, healthy and independent lives" and "Children get a good start in life") and ICB Operating Plan 2017-19, which in turn complement the delivery of the local ICB plan, NHS 5 Year Forward View, Care Act 2014 and Local System Plan.
12.	Southampton's Better Care Plan also supports the delivery of Southampton's Health and Wellbeing Strategy 2017 - 2025 which sets out the following 4 priorities: • People in Southampton live active, safe and independent lives and manage their own health and wellbeing • Inequalities in health outcomes and access to health and care services are reduced. • Southampton is a healthy place to live and work with strong, active communities • People in Southampton have improved health experiences as a result of high quality, integrated services

KEY DECISION?	**Yes**
WARDS/COMMUNITIES AFFECTED:	All
SUPPORTING DOCUMENTATION	
Appendices	
1.	2021/2022 BCF year-end return
2.	Southampton BCF Narrative Plan 20222023
3.	Southampton BCF Planning Template 20222023

Documents In Members' Rooms

	None

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

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Better Care Fund 2021-22 Year-end Template

7. ASC fee rates

Selected Health and Wellbeing Board: Southampton

The iBCF fee rate collection gives us better and more timely insight into the fee rates paid to exte
Given the introduction of the Market Sustainability and Fair Cost of Care Fund in 2022-23, we are
with previous years.

These questions cover average fees paid by your local authority (gross of client contrib
need to be calculated from records of payments paid to social care providers and the nu

We are interested ONLY in the average fees actually received by external care provider
your local authority is able to afford.

In 2020-21, areas were asked to provide actual average rates (excluding whole market support s
of the COVID-19 pandemic), as well as a 'counterfactual' rate that would have been paid had the
care to inform policymaking. In 2021-22, areas are only asked to provide the actual rate paid to p

Specifically the averages SHOULD therefore:
- EXCLUDE/BE NET OF any amounts that you usually include in reported fee rates but are n
- EXCLUDE/BE NET OF any amounts that are paid from sources other than eligible local aut
Nursing Care and full cost paying clients.
- EXCLUDE/BE NET OF whole-market COVID-19 support such as Infection Control Fund payments
- INCLUDE/BE GROSS OF client contributions /user charges.
- INCLUDE fees paid under spot and block contracts, fees paid under a dynamic purchasi
commissioned by your local authority and fees commissioned by your local authority as p
- EXCLUDE care packages which are part funded by Continuing Health Care funding.

If you only have average fees at a more detailed breakdown level than the three service
of 65+ residential without dementia, 65+ residential with dementia) **please calculate for**
category: 1. Take the number of clients receiving the service for each detailed category.
2. Divide the number of clients receiving the service for each detailed category (e.g. age
relevant service (e.g. age 65+ residential).
3. Multiply the resultant proportions from Step 2 by the corresponding fee paid for each
4. For each service type, sum the resultant detailed category figures from Step 3.

Please leave any missing data cells as blank e.g. do not attempt to enter '0' or 'N/A'.

	For information - your 2020-21 fee as reported in 2020-21 end of year reporting *
1. Please provide the average amount that you paid to external providers for home care, calculated on a consistent basis. (£ per contact hour, following the exclusions as in the instructions above)	£18.32
2. Please provide the average amount that you paid for external provider care homes without nursing for clients aged 65+, calculated on a consistent basis. (£ per client per week, following the exclusions as in the instructions above)	£710.16
3. Please provide the average amount that you paid for external provider care homes with nursing for clients aged 65+, calculated on a consistent basis. (£ per client per week, following the exclusions in the instructions above)	£833.82
4. Please provide additional commentary if your 2020-21 fee is different from that reported in your 2020-21 end of year report. Please do not use more than 250 characters.	

Footnotes:

* ".." in the column C lookup means that no 2020-21 fee was reported by your council in the 20

** For column F, please calculate your fee rate as the expenditure during the year divided by th pick up any support that you have provided in terms of occupancy guarantees.
(Occupancy guarantees should result in a higher rate per actual user.)

*** Both North Northamptonshire & West Northamptonshire will pull the same last yea County Council.

rnal care providers, which is a key part of social care reform.

exploring where best to collect this data in future, but have chosen to collect 2021-22 data th

utions/user charges) to external care providers for your local authority's eligible clie
mber of client weeks they relate to, unless you already have suitable management inf

rs for your local authority's eligible supported clients (gross of client contributions/us

such as the Infection Control Fund but otherwise, including additional funding to cover cost pre
pandemic not occurred. This counterfactual calculation was intended to provide data on the l
providers (not the counterfactual), subject to than the exclusions set out below.

not paid to care providers e.g. your local authority's own staff costs in managing the co
thority funding and client contributions/user charges, i.e. you should EXCLUDE third pa

.

ng system, payments for travel time in home care, any allowances for external provide
part of a Managed Personal Budget.

types of home care, 65+ residential and 65+ nursing requested below (e.g. you have th
each of the three service types an average weighted by the proportion of clients tha

65+ residential without dementia, age 65+ residential with dementia) by the total num

detailed category.

Average 2020/21 fee. If you have newer/better data than End of year 2020/21, enter it below and explain why it differs in the comments. Otherwise enter the end of year 2020-21 value	What was your actual average fee rate per actual user for 2021/22?	Implied Uplift: Actual 2021/22 rates compared to 2020/21 rates
£18.32	£19.04	3.9%
£710.16	£796.14	12.1%
£833.82	£951.17	14.1%

20-21 EoY report

ıe number of actual client weeks during the year. This will

ar figures as reported by the former Northamptonshire

nrough the iBCF for consistency

nts. The averages will likely
ormation.

ser charges), reflecting what

essures related to management
long term costs of providing

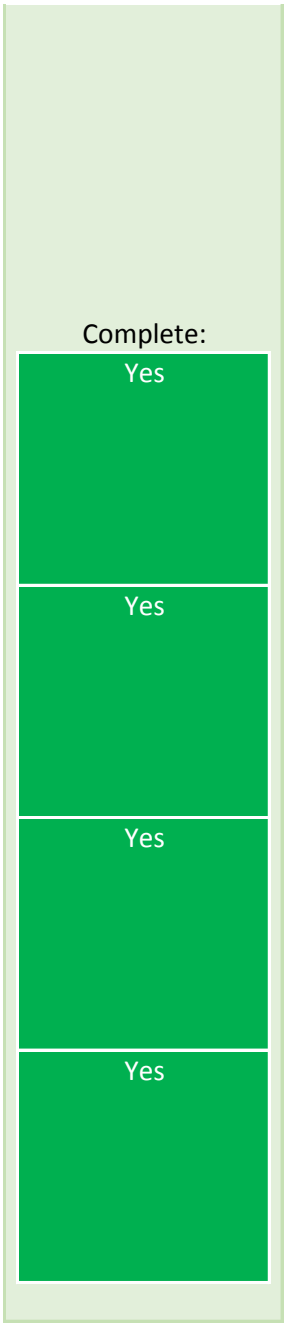
mmissioning of places.
arty top-ups, NHS Funded

r staff training, fees directly

ne more detailed categories
at receive each detailed

nber of clients receiving the

Checklist


Complete:
Yes
Yes
Yes
Yes

Department of Health & Social Care | Department for Levelling Up, Housing & Communities | Local Government Association | NHS England

BCF narrative plan template

Health and Wellbeing Board(s)

Southampton City

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

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

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

are a range of other groups which have contributed to form the BCF plan for this year, these include –

- Ageing Well Group - Southampton
- End of Life Steering Group – Southampton and South West Hampshire
- Children's Multiagency Partnership Board - Southampton
- Learning Disability Partnership Board - Southampton
- Onward Care Group (Complex discharge and Integrated Discharge Bureau) – Southampton and South West Hampshire
- Mental health forum/No wrong door group – two levels, Southampton and ICB
- Local Delivery System Group – Southampton and South West Hampshire
- Carers Partnership Board – Southampton
- Better Care Finance and Performance Group – Southampton
- Discharge and Community Capacity Cell – Hampshire and IoW

These groups are formed of a wider range of partners from across the system of health, care and wider wellbeing: Local Authority, including Public Health, Adult Social Care, Children and Families, Communities, and Housing; ICB; health care providers including acute care, community care and mental health; Community and Voluntary sector; Primary Care and Primary Care Networks; Carers and people who use our services. Together these groups help to inform the next steps in delivering our 5 year Health and Care Plan and, with it, the next stages for the BCF Plan in 2022-2023.

As part of the wider context the Integrated Commissioning Unit works with partners across the care system to develop market position statements which reflect local need and seek to stimulate the market. Further to this social care providers have engagement through a number of forums and processes which guides their work in partnership with the ICB and LA and thus contributing to the overall picture.

Public health colleagues have worked with commissioners, services and service users to identify the impact of the Covid 19 pandemic on our population and services. This has helped to inform the planning for this financial year and will continue to do so going forward. Evidence of this is seen in the work with the social care market in particular and core community services who are responding to a rise in the levels of complexity of both people living with physical illness, mental illness and related frailty. Reference to a change in the provision can also be found in the section related to hospital discharge or 'Provide the right care in the right place at the right time'.

2. Executive summary

This should include:

- Priorities for 2022-23
- Key changes since previous BCF plan

Priorities for 2022-2023

The Southampton 5 year health and care strategy (2020 – 2025) provides strategic direction for all system partners with the priorities listed below generated by all system partners. These priorities are distributed across the four programme areas of Start Well, Live Well,

Age Well and Die Well. The BCF priorities, as a subset of the overall health and care strategy delivery, are informed by this priority setting process.

Start Well

1. Reducing childhood obesity
2. Improving children and young people's emotional and mental wellbeing
3. Improving outcomes in the Early years - personal, social and emotional development; communication and language; and physical development

Live Well

4. Improving Mental Health & tackling loneliness
5. Improving lives for the most vulnerable, e.g. people with LD, MH problems, people living in most deprived areas
6. Tackling smoking, drugs and alcohol misuse

Age Well

7. Proactive Care approach

Die Well

8. Early identification of people at End of Life
9. Promote accessibility of End of Life care for all
10. Out of Hospital End of Life Care Coordination

Detailed below are the BCF priorities in relation to the 5 year health and care strategy and BCF policy and planning requirements -

- **Priority 1: Delivering on Avoidable Admissions/enable people to stay well, safe and independent at home for longer -** Strong focus on prevention, admission avoidance through our urgent Response Service, proactive care at home (reducing preventable admission to long term care), carers services and Enhanced Health in Care Homes (EHCH) arrangements.
- **Priority 2: Further developing the discharge model to promote right care in the right place at the right time:** including Recovery and Assessment and Home First as a feature of the BCF plan.
    - Hospital Discharge process and out of hospital capacity
    - A flexible and broad offer of recovery and assessment, promoting a home first approach
    - Particular focus on discharge capacity for those with the most complex needs
- **Priority 3: Increase the number of people who see benefit from Rehabilitation and Reablement,** meaning a continued focus on reducing dependency on longer term care provision.
- **Priority 4: Implement new models of care (within Adults and Children's)** which better support the delivery of integrated proactive care and support in our communities.
- **Priority 5: Effective utilisation of the Disability Facilities Grant –** promoting independence and personalised care/strength-based approaches.

Key Changes to our previous BCF plan build upon the excellent foundation of previous years and are based upon the above priorities, in summary these are:

Priority 1

- Expansion and redesign of our Urgent Response Service/Urgent Community Response and Reablement Service through a number of funding sources.
    - Virtual Ward developments in year, supported by existing and service development funding, will become central to this integrated approach to admission avoidance.
- Refresh of our wrap around approach with care homes including our core community services and EHCH service arrangements.
- Embedding the enhanced Primary Care Mental Health Team which is delivered through a dedicated Southampton City Mental Health Partnership Board, with collaboration between ICB, PCNs, SHFT, DHUFT (IAPT) and VSCE delivery of the Community Mental Health Transformation continues.
- Promoting further work to implement the adults and young people's carers strategies which have already benefited from a range of good practice developments in 2021/2022.
- Review and refresh of VCSE prevention and early intervention offer, including advice, information and guidance and community development.
- Further developments in our prevention and early intervention offer and LD integrated commissioning approach that promote people staying well and independent for longer, 'active lives'.

Priority 2

- Refresh of the discharge operational processes, building upon the extensive work undertaken in 2021/2022 to embed the new discharge guidance.
- Clear plan for rehab/reablement and recovery and assessment provision, beds and community, in scope -
    - Priority areas include addressing the demand for those with the most complex needs
    - General and specialist rehabilitation
    - Wrap around services for recovery and assessment provision

Priority 3

- Embedding of the rehab and reablement offer available to the city's residents, building on the development work undertaken in 2021/2022.
- Aligning current rehab and reablement offer with the Virtual Ward (VW) developments to ensure effective onward support for VW patients.

Priority 4

- Continued roll out of integrated care teams/One Team with a broader scope across the city, building on the test and learn work of the last 2 – 3 years. Aligned with this

SCC are developing a locality model in adult social care, Children's social care and Communities.

    - Including linking of further services with Early Help and Young People's locality teams.

- Development of the locality model for supporting children and families with SEND as part of the next phase of service redesign (the Children's Destination 22 programme)
- Improving care for the most vulnerable children and reducing health inequalities – through a broadening of the therapeutic approach as part of the Integrated Health and Social Care provision for children with complex behavioural & emotional needs.

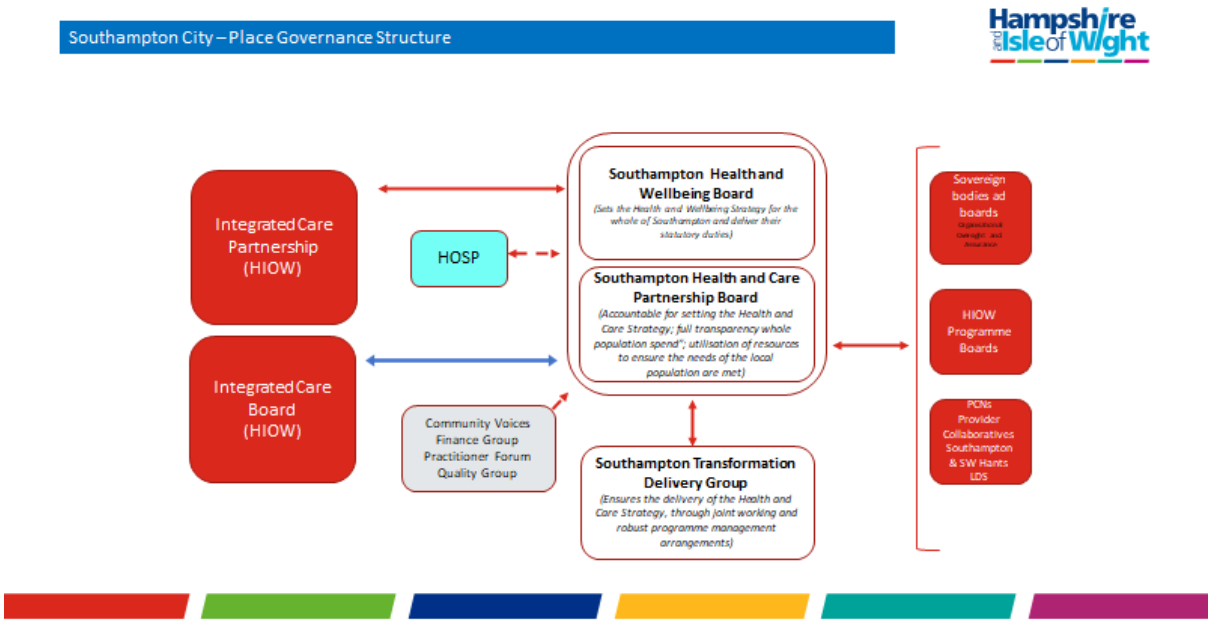
Priority 5

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

3. **Governance**

The Governance Structure for the BCF plan in place at the outset of 2022/2023 has been reviewed to reflect the changes which will be required with the next stage of Integrated Care System Development. These arrangementslink with Southampton and South West local delivery system through our Local System Delivery Group, providing cross system oversight for the acute trust footprint.

The details below describe the new governance arrangements being implemented in the second quarter of this financial year. These new governance arrangements include a Programme Management approach to all areas of the BCF plan and wider 5 year Health and Care Strategy. Strengthening the oversight and challenge within the Southampton system. The slide below represents the proposed governance structure for implementation following the instigation of the ICB on the 1st of July 2022.



Health and Wellbeing Board

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

Southampton Health and Care Partnership Board

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

Southampton Transformation Delivery Group

The Southampton Transformation Delivery Group, which will be implemented later this year, includes membership from senior representatives of key health and care organisations across the city, including the voluntary sector. The purpose of the Board is to ensure the delivery of the Health and Care Strategy (of which the BCF plan is a subset), through joint working and robust programme management arrangements. The group will hold the programmes groups to account for delivering the agreed plans and outcomes and will help to

remove barriers to progress. Progress will be regularly reviewed to ensure that actions not only remain on track and anticipated key outcomes can be fully realised, but that the delivery plan is updated with new actions and measures as appropriate. A range of health and care outcome indicators will be monitored to inform whether the interventions in the strategy are having an impact.

Until the new delivery group is formally in place the pre-existing arrangement with the Better Care Steering Board will be sustained. Details of the function for this board are available in the previous return for 2021/2022.

Finance and Performance Monitoring Group

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

1. Supporting Carers
2. Integrated Locality Working/One Team
3. Integrated Rehabilitation and Reablement and Hospital Discharge
4. Aids to Independence
5. Prevention and Early Intervention
6. Learning Disability Integration
7. Promoting uptake of Direct Payments
8. Transforming Long Term Care/iBCF
9. Integrated provision for children with special educational needs and disability (SEND)
10. Integrated health and social care provision for children with complex behavioural & emotional needs

Delivery Groups

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

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

All of these groups are formed of the relevant partners, with a strong focus on inclusivity enabling a coproduction approach as standard.

4. Overall BCF plan and approach to integration

The **joint priorities** for 2022/2023 are those stated in the priorities section on page 3 of this document. The narrative below outlines specific areas of work that are embedding integrated, person-centre health, social care and housing services.

Approaches to joint/collaborative commissioning

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

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

- Health and Care system redesign and transformational change, working together across health and social care to deliver integrated, person centred, joined up care for people in Southampton and to strengthen prevention and early intervention to support people to maintain their independence and wellbeing
- Sustaining and further developing integrated rehabilitation and reablement services; improvements to mental health crisis care; leadership of the design and implementation of integrated Children's services; gorwing Community Solutions; refocus Housing Related Support; leadership of Southampton Five Year Health and Care Strategy
- Improve and sustain quality of services across the health and care market, including effective contract management and monitoring, to ensure that people are provided with a safe, high quality, positive experience of care in all health and care providers ranging from individual social care providers and voluntary sector organisations to large health providers such as University Hospital of Southampton NHS Trust
- Support commissioning activities that facilitate, manage and develop a strong provider market that is able to respond to an increasingly diverse and complex customer group
- The scope of services commissioned includes all children and young people, adult health and social care, public health and housing for vulnerable people in the city. For the ICB the services include all community health services (children and adults), services for those with mental health problems, disabilities or long-term conditions plus acute care for children and maternity services.
- The ICU also manages (on behalf of the Joint Commissioning Board/ HWBB) one of the largest Better Care pooled funds in the country. Mandated level for 2022/2023 of £22.892m and a total pooled fund of £143.562m, £91.259m from the ICB and £52.303m from SCC.
  The ICU aligns aspects of the Council and Southampton City Integrated Care Board (ICB) commissioning functions under a single management structure, with staffing from each organisation committed to the ICU in exercise of powers under section 113 of the 1972 Act, to work towards the delivery of a shared strategy.

How BCF funded services are supporting your approach to integration

Intermediate care – In addition to that noted earlier, there are a range of schemes in place which support people to remain independent at home. The first of which being Integrated Rehab and Reablement, a successful service that has been in place for several years. The service has an integrated leadership team and provider section 75 in place that promotes an integrated approach to delivery.

During the last year we have continued to see a rise in the demand and complexity of need for intermediate care, supported in part by the expansion to our Urgent Community Response/Urgent Response Service (URS). URS form part of our integrated rehab and reablement service in the city, and as such the embedding of the 2 hour response expansion from 2021/2022 is a key priority for this year's BCF plan. The Virtual Ward expansion, supported by SDF funding this year, will also form part of the integrated rehab and reablement service and therefore the BCF plan will include oversight of this exciting opportunity for that service. Delivery of metric 8.1 (rate of unplanned hospitalisation) is predicated on the success of embedding these functions into our integrated offer.

Southampton also makes a significant investment in reablement provision which along with clinical elements of the integrated service seeks to promote independence and of course promote the achievement of metrics 8.4 & 8.5. Comprehensive capacity and demand planning work has been undertaken to ascertain what level of recovery and assessment provision (previously known as D2A) is required for the city – further detail can be found in the element of this narrative which responds to national condition 4, 'right care in the right place at the right time'.

Joint Equipment Service - Overall the demand for services which promote independence has continued to increase in this phase of the pandemic. Evidence within our Rehab and Reablement service would suggest that this is related to the change in hospital discharge process and an increasing level of frailty in our younger old and older old population. The Joint Equipment Service supports this position with the plan continuing to promote innovation in this key area of integration.

Ageing well - All of the above is included as part of our Ageing Well plan, a subset of the 5 year Health and Care Strategy. This plan, and the BCF, includes a carers (unpaid) work stream. Carers have long been a focus of the BCF in Southampton with this year seeing further implementation of the two strategies (adults and young carers) following the conclusion of a scrutiny enquiry in 2021/2022. This carers work is made possible under the BCF pooled fund arrangements and supported as a key programme area for the ICB and SCC.

The Ageing Well plan also includes the development of community integrated teams or our 'One Team' programme. This, as noted in previous plans, includes integration of core community services for adults to promote proactive and reactive health and care for people with complex needs. The work here continues driving forward the proactive care approach with our Primary Care Networks, inclusive of our approach to care home support and Enhanced Health into Care Homes (EHCH).

Die well - Also as part of the 5 year Health and Care strategy we have a Die Well plan. This describes the next stages for the development for end-of-life services and services that

support the preparation or planning stage. This year includes continued work across the system of care on earlier identification of end-of-life cases (though the One Team work), potentially as early as 3 years before death, enabling better preparation and anticipatory care planning.

Live Well - is another subset of the 5 year Health and Care Strategy which includes areas noted in the inequalities section of this narrative. This programme of work includes many of the elements encompassed within the BCF plan, e.g.: mental health transformation; prevention and early intervention/healthy lifestyles; and substance use disorder services. In this year there have been developments in our community crisis support through the 'no wrong door programme' for individuals living with a mental illness, this includes the embedding of the primary care mental health support which is delivered in partnership with our mental health provider.

Start Well - is another subset of the 5 Year Health and Care Strategy. This programme of work includes many of the same principles found across our Better Care plan, in particular its focus on strengthening early intervention and family centred approaches and integrated locality teams. This year's Better Care plan is supporting work specifically in relation to implementing new models of care (priority 4) which include strengthening the integrated crisis, therapeutic and outreach/consultation offers in our Building Resilience and Strengths Service (a joint funded children's health and social care team for children with the most complex behavioural needs) and implementation of the redesign recommendations for the integrated Jigsaw Service (a jointly funded children's health and social care team for children with learning disabilities) to provide advice and support as part of the early help work in localities.

Further work is in progress to support priority 1 (admission avoidance) including embedding of the new Children's Hospital at Home Team to support families manage minor child illnesses in the community and the development of a Children's Acute Psychiatric Liaison service to support the Emergency Dept, incorporating youth workers provided by a voluntary sector partner (No Limits) who provide valuable advice, support and signposting for young people.

5. Implementing the BCF Policy Objectives (national condition four)

Enable people to stay well, safe and independent at home for longer

The Southampton approach to supporting people to stay well, safe and independent at home is multifaceted, together the approaches described below contribute to the achievement of our BCF plan and with it this objective and metrics 8.1, 8.4 & 8.5 -

- The integration of our rehab and reablement services enables a seamless approach from crisis/urgent response into recovery, rehab and reablement services. Completion of the capacity and demand template, as a requirement of this return, will continue to inform the planning for future service developments.
- Further development of an integrated community/One team approach, providing multidisciplinary working at a neighbourhood/locality level, which includes a proactive care element for targeted client groups.

- Continued commitment to delivering our community wellbeing service which works through our One Team (health and social care), PCNs and social prescribing to promote independence and supported self-management.
    - The scope of this service being physical illness, mental illness and those living with a learning disability – therefore providing access to support and anticipatory care planning for a broad range of the population. See inequalities section for further details.
- Strong commitment to prevention and early intervention which includes a range of initiatives that promote access, and support to access, assets within our community.
    - One of these services, SO:Linked, provides a community development function that supports community and voluntary sector organisations to form and/or grow along with community navigation which enhances the work undertaken by our PCN employed social prescribers.
    - An SCC promoted community led support service which will accelerate further development of local asset-based delivery this year and the two years following.
- Commissioning a wide range of housing related support provision, including a older persons focused service that has a strong focus on people living in our extra care facilities in the city.
    - The service works in collaboration with the designated home care provision for these facilities thus promoting the ability for residents to remain safe and at home.
    - This service also provides the care line/response line for the city which delivers a specific falls response function in partnership with our NHS falls services in the city.
- Commissioning End of Life services which promote early planning for people entering perhaps the last three years of life, made possible through partnerships with core community services in the city.

This list is not exhaustive, however in all cases made possible under the BCF approach in the city. The asset based working and proactive care made possible through these commissioning arrangements provide a sound basis for Southampton in preparing for further Anticipatory Care approaches going forward. This in work in turn will promote local implementation of the NHS England improvement programme for health inqualities, Core20PLUS5[1].

Provide the right care in the right place at the right time – Our approach to integrating care to deliver better outcomes

Integration is at the heart of Southampton's approach to hospital discharge and ensuring that the right care is provided in the right place at the right time. The city operates as part of a wider Southampton & South West Hampshire Local Delivery System (SSWH LDS) with health and care partners across both Southampton City Council, Hampshire County Council and the Integrated Care System to coordinate discharge arrangements around the geographical footprint covered by Southampton University Hospital Trust. The Southampton system confirms a refresh of the self-

[1] NHS England » Core20PLUS5 – An approach to reducing health inequalities

assessment against the High Impact Change Model for managing transfers of care[2] has been undertaken. Our discharge arrangements are based around 3 over-riding principles:

- People will not remain in hospital when they no longer need to be there – every effort will be made to ensure that discharge happens on the day they no longer meet the criteria to reside which requires early planning
- Every effort should be made to discharge a person back to their own home – "Home First" principle
- All discharges will be safe, person centred and take account of the needs, wishes and best outcomes for the person and their family

These principles in turn are underpinned by the following key metrics that we are using to measure effectiveness:

- Reduction in patients still in hospital who do not meet the criteria to reside (CTR)) and thereby a reduction in bed days lost
- Increase in people able to be discharged to their own homes
- Reduction in permanent residential care admissions (aged 65 and over)

At an operational level, local discharge pathways in Southampton are coordinated via a community based Single Point of Access (SPOA) which brings together local teams under a single SPOA lead to streamline and integrate care for people coming out of hospital on pathways 1 (home with support), 2 (short stay bed) and 3 (permanent 24 hour care bed). The SPOA brings together our integrated Rehab and Reablement service, Adult Social Care Discharge team and Continuing Health Care team to plan and support hospital discharges. Whilst not currently co-located with the hospital, SPOA staff have office space within the hospital and they are increasingly in-reaching into the wards.

We will be reviewing the functioning of our SPOA during 22/23 against the Transfer of Care Hub national guidance with a view to further integrating processes and the various teams, further exploring co-location with the hospital, strengthening case management for people on the D2A pathways and bringing in additional services, in particular housing and VCSE representation. We will also be looking to extend the role of the SPOA to coordinate step up care for people in crisis as well as step down from hospital.

How we are using collaborative commissioning and the BCF pooled fund to support delivery of our aims for hospital discharge

The BCF provides the vehicle for both setting out our jointly agreed strategy as well as implementing our intentions for hospital discharge and providing the right care in the right place at the right time, which for most should be their own home . We are using our BCF pooled fund to jointly commission and fund a range of integrated services. This includes:

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

- Our joint funded integrated rehab and reablement services, identified in the above section, functions within a single team and as such enables a more seamless offer to be delivered, focussed around the needs of the person and facilitating the ability to manage people who also have health/clinical needs at home as part of their reablement episode.
- Short term service capacity which includes home care as well as recovery and assessment beds, jointly funded by the ICB and the Council
- Joint funding of the SPOA functions, mentioned earlier in this section, including assessment and case management

Use of the S75 powers have enabled us to flex health and Local Authority resources within the integrated services to where they best meet need and deliver on our jointly agreed priorities. For example we are investing additional health funding this year through the BCF in:

- Additional home care capacity – short term bridging hours, including enhanced support for people with more complex needs – recognising the impact this also has on improving health outcomes and reducing demand for acute health services by keeping people well and independent for longer
- Enhanced therapy to support more people on pathways 1 and 2 to achieve their optimum potential and return or remain at home
- Case management and additional assessment functions to ensure timely assessment for people being discharged to assess and ensure that every effort is being made to maximise their independence
- VCSE activity providing practical support for people returning home, e.g. the welcome home service
- Trusted assessor to support more timely discharge

The collaborative commissioning arrangements we already have in place through the ICU (as described earlier in this narrative submission) enable a joined up view of the market, joined up planning cycles, and integrated contracting. For example we have joint commissioning frameworks for home care, including short term bridging services which support hospital discharge, and residential placements, operating on behalf of both the ICB and Council; as well as a single brokerage team for both Adult Social Care and Continuing Health Care.

How primary, community and social care services are being delivered to support people to remain at home

As already highlighted, our joint commissioning arrangements enable a more joined up approach to service delivery; we are able to target both health and care resources to work together to support more people at home. The integrated Rehab and Reablement Service has already been shown to be an example of this and is currently keeping 75.2% of people at home 91 days post discharge. We are looking to increase this to 76.8% in 2022/23 and are exploring how we can further streamline pathways so that no patient comes out of hospital on Pathway 1 without being considered for reablement; this will also involve exploring the potential to skill up some of our home care providers in reablement and the extension of our therapy offer, as noted above.

In addition, we will be exploring how community health services could better "lean in" to home care packages to support providers through a mix of training and direct intervention in meeting the needs of people requiring clinical interventions, e.g. enteral feeding, collar care, insulin injections. This forms part of our "Home First" workstream (see below) and work is underway to scope the level of need for clinical interventions, working with providers, and consider the best model to support this need in a home environment moving forward.

We are also working with the VCSE to make best use of their resource and expertise in providing practical and emotional support to people in their own homes and ensure that this is considered for all people on pathways 0 and 1 and as part of the long term care plans for people on pathway 2. Southampton already has a range of provision delivered by the VCSE, including a Welcome Home scheme for people returning home from hospital, Advice Southampton offering advice, information and support, a Community transport scheme focussed on getting people back home from hospital, Carers in Southampton service, a network of community navigators and the Living Well Service which supports older people in their local communities, facilitating a range of social activities and support. These services are already promoted through the Patient Hub which is located in the hospital for people on pathway 0. We shall be looking at how we better utilise this offer for people leaving hospital on pathways 1 and 2 during 2022/23 through further development of our SPOA and links with the VCSE.

Further development and enhancement of our SPOA to include coordination of step up as well as step down support across primary, community and social care will also support the delivery of joined up health and care to support people in their own homes.

Our "One team" development (also described in this narrative submission), implementation of proactive case management at scale and roll out of Population Health Management tools from this Autumn also supports the delivery of integrated care to enable people to remain at home.

Our plans for further improving discharge and ensuring that people get the right care in the right place

As a SSWH LDS we have developed a 4-point plan with partners from across health and social care for improving hospital discharge. These four workstreams have been influenced by our re-assessment of discharge arrangements against the Hospital Discharge High Impact Change Model and the 10 interventions identified in the 100 Day Challenge. The 4 key workstreams are outlined below:

- **Improving Operational processes** – To ensure that operational processes are purposeful and functional and deliver a discharge pathway that aspires to home first. Key areas of focus are:
    - Embedding the use of Criteria to Reside on all wards
    - Optimising early discharge planning from the point of admission (aiming for EDD to be set within 48 hours, and ideally within 24 hours)

    - Ensuring the SPOAs have sufficient and accurate information, right first time, to support discharge planning, ensuring that patients are attributed to the correct discharge pathway from the start
    - Clear accountability of roles, responsibilities, and decision-making
    - Clear escalation process across all levels
    - Review and update of choice policy
- **Home First** – the BCF data identifies that Southampton is already achieving 94.83%. We are looking to improve on this and achieve 95.24% and reduce the rate of permanent admissions to care homes through this workstream which is focussing on increasing the number of people who can return home by expanding and enhancing the suite of options available including; urgent crisis response, domiciliary support, live in care, reablement and intermediate care as well as access to other community based services including those provided by the voluntary sector. Key areas of focus are:
    - Developing the home care market and support required to enable more people with higher levels of acuity and complexity to return home
    - Enhancing therapy offer to support more people at home
    - Greater us of care technology
    - VCSE
- **Making the best and most appropriate use of short term beds** – To ensure that the right people are admitted to short term beds and proactively supported to maximise their independence potential and return home. Key areas of focus are:
    - Improving assessment and case management processes to ensure that people's long term care needs are assessed in a timely way and there are clear person centred plans and outcomes in place from the earliest opportunity which are closely monitored to
    - Enhancing the therapy offer into short term beds
    - Redefining and recommissioning our short term recovery and assessment beds against a revised specification and key performance indicators with a much stronger reablement ethos
    - Re-commissioning short term beds for people with more complex needs
    - Whole system review of Community Rehab beds to ensure that we are maximising effectiveness and capacity across the whole LDS
- **Improving support to care homes and managing greater levels of acuity and complexity** – To improve flow into care homes and support with managing people when they become more unwell or if they have more complex needs. Key areas of focus are:
    - Development and promotion of the use of Telecare and Telemedicine services to provide advice and support (roll out of Restore 2 across all care homes, vital signs measurement)
    - Training and development of care home staff
    - Anticipatory care planning
    - Improving communication between care homes and health services and the quality of hospital discharge, including roll out of the trusted assessor role

6. Supporting unpaid carers.

The local authority, having completed a scrutiny enquiry focused on informal carers in the last year, have completed the process of drafting strategies for both 'Adults' and 'Children and Young People'. These strategies have informed a range of developments to improve carer identification, carer voice and carer support over the next three years. Some examples of these developments are included below.

New investment in a local charity to support the provision of short carers breaks, Communicare, funded through a development grant (under the BCF pooled fund arrangement). The delivery is through a 'good neighbours' network which aims to support carers to have a break for a short time, the functions include -

- Good neighbours support carers whose cared for have lower levels needs, not including personal care
- Carry out a survey of carers of people living with dementia to identify what the carers needs are and how best to support them
- Piloting and testing new approaches for the provision of carers breaks
- Develop a route to allow good neighbours to become more skilled and able to offer personal care for an individual they may have built up a rapport with whose needs have progressed. This route will be via the Shared Lives scheme and is being explored in year.

The council is also reviewing the residential carers breaks/respite provision to ensure that it continues to meet the requirements of the local population. This is a key part of the implementation of the carers strategies for 'Adults' and 'Children and Young People' and the far reaching development plan to improve carer identification, carer voice and carer support.

The carers support services, which have been in place for a number of years, are being reviewed in year with new services to be commissioned for a start date of April 2023. The breadth and depth of the new service will represent the direction stated by the strategies. Aligned with this work, we are exploring using libraries to develop easy to access carers information sites, three libraries have been identified to do this initially. The service is likely to comprise trained library staff, carers volunteers, carer services staff working together. Carers will be able to access information pods which enable video links and document sharing with a range of services which include Advice Southampton, Adult Social Care Connect, Housing etc.

7. Disabled Facilities Grant (DFG) and wider services

DFG

In 2020 Southampton City Council commissioned a comprehensive review into the delivery of its Disabled Facilities Grant Programme and the effectiveness of its Housing Assistance Policy to help deliver meaningful improvements for older and disabled residents of Southampton. Building on this, following the relaxation of covid restrictions, SCC committed to a wholescale internal review of these services to help ensure:

- Significant efficiencies made for Adult Social Care and Children's Social Care provision.
- Help meet BCF aims and objectives to assist older and disabled people to remain in their homes for longer, avoid hospital admissions, establish a new approach to discharge, reduce admissions into residential care, promote independence through personalised care, deliver a strength-based initiative to provide speedier better-quality adaptations, and better value for money across all disability services.

- Clarity between adaptation delivery and the ambitions of SCC's BCF key priorities to develop an integrated approach to housing and adaptations, as well as helping to achieve significant reductions in the waiting times for adaptations for older and disabled residents.

This review is now in its delivery stage, and will positively impact on SCC's overall adaptation delivery for older and disabled residents as well as the over-arching aims and objectives of the BCF:

In 2022-23, as part of SCC's action plan to develop a new strength based integrated housing adaptations service, we will:

- Introduce an in-house home improvement agency, the Home Adaptation Service (HAS) to improve strategic and practical delivery of adaptations in Southampton in the private housing sector, and create a new integrated service of Housing Occupational Therapists (ASC) and Housing Technical Surveyors
- Appoint a Disabled Facilities Grant/ HAS Manager to take responsibility for strategic direction, reporting and performance across all private and council adaptation services reporting directly to the BCB and senior management at SCC
- Make immediate changes to the current Housing Assistance Policy and introduce a Fast-Track Grant up to £10k and a further grant assistance of £1k to the Joint Equipment Store (JES) on top of the £1k currently available for older and disabled applicants for disability equipment. This will assist in reducing demand from a Mandatory DFG, speed up the delivery of straight forward adaptations and help reduce waiting times
- Introduce a new Discretionary Housing Assistance Policy to broaden the assistance available for older and disabled applicants and help reduce reduce waiting times for DFG's
- Recruit additional caseworker support to assist older and disabled residents through their adaptation pathway and help reduce DFG / Assistance waiting times

- Introduce a new IT Platform to improve joint reporting and business analysis
- Introduce new business processes in grant pathways to speed up overall delivery of adaptations for older and disabled residents, reduce paperwork, hand-offs and reduce the underspend of the DFG budget
- Broaden the joint working and support for initiatives such as the Hoarder Scheme, the Wheelchair Service and improved technology options for older and disabled residents, amongst others

The improvements planned this year will create a more effective and accessible provision of the DFG, doing so through internal and external partnership approaches.

Health, social care and Housing services

Housing Related Support (HRS), a scheme fully under the BCF plan, is a key part of the wider prevention and early intervention work which is undertaken in the city. During last year these services were recommissioned to reflect the changing needs identified by a comprehensive review which was undertaken in the previous year. A range of improvements will be included in the services which enable the following –

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

These improvements will be made possible through a strong relationship between the commissioned services and their partners in health care, including substance use disorder

services and mental health. Early implementation against these improvements underway with the HRS service critical to their success through acting as a bridge with other key support services for the residents.

The older persons HRS (55yrs+) has also been reviewed in light of the strong focus on developing extra care facilities in the city. Indeed, last year saw the opening of an additional state of the art extra care facility for the city, which in turn benefits from the support of this service in partnership with adult social care and private sector dedicated home care provision. This year work will continue, through this service, SCC Housing, Commissioning and Adult Social care to further develop the extra care model for the city. Commissioning will add to this by procuring a framework for housing with care to promote a similar type of support, which together with housing providers, will enable people to stay in the community/their own home for longer.

Equality and health inequalities

Southampton is an ethnically diverse city:

- **22.3%** of Southampton's residents are from an ethnic group other than White British, compared to 20.2%nationally (2011 Census).
- Southampton has residents from over 55 different countries who between them speak 153 different languages (2011 Census).
- Disability-free life expectancy at birth for males in Southampton is **59.6years**, compared to 62.9 nationally (2016-18). Disability-free life expectancy at birth for females in Southampton is **58.2 years**, compared to 61.9 nationally (2016-18).
- Around **123,000** people in Southampton have a long-term health condition (such as diabetes, heart disease, epilepsy, breathing problems etc.). Over half of these people have two or more conditions for which they need ongoing support.
- 610 adults with a learning disability in Southampton receive long-term support from the local authority (2018/19)
- 3.9% of supported working age adults with a learning disability in paid employment, compared to 5.9% nationally (2018/19).
- **13.5%** of people aged 16 years and over in Southampton have a long-term mental health problem, compared to 9.9%nationally (2018/19).

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

Multiple areas within BCF plan include aspects which support vulnerable people, from ethnic groups other than white British, to access services. Including prevention and early intervention services, e.g. Community Wellbeing Team, Smoking cessation and Housing Related Support, having a targeted approach for those groups and areas of the city. This is further enhanced by BCF schemes working in collaboration with other service areas

delivered or commissioned by the Local Authority or ICB, e.g. housing services for Council Tenants, Employment Support Teams and Healthy Homes/fuel poverty.

In this context, and that of the vision of the Southampton Health and Wellbeing Strategy of 'a culture and environment that promotes and supports health and wellbeing for all', a number of priority areas within the BCF plan have been identified. Each of these will be considered in turn.

People living with a learning disability – We have also been able to forecast increases in people with a learning disability. Between 2018 and 2023, the number of people with a learning disability is estimated to increase by 4.2%. Learning Disability commissioning and integration has long been a part of Southampton's BCF, Active Lives is one of the key priorities within the Southampton Learning Disabilities Transformation Strategy. The vision states that 'People with learning disabilities will be able to reach their goals and ambitions, through the delivery of good local joint planning, where the voice of the person and their carers are heard, and current inequalities are addressed, by the creation of opportunities, in every part of their lives'. This is a long term piece of work which got underway in 2021/2022 and will continue through 2022/2023.

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

Older people – Southampton will see a rise in population overall of 5% by 2023 (based on 2018 population data) the age group with the biggest percentage increase will be the older old i.e. 80+ yrs (14.5%), adding more pressure onto the city's health and care services. As noted in discharge section this group has been a strong focus in much of the hospital discharge work. Local intelligence suggests that the oldest old, i.e. 80+yr olds, have the lowest rate of being discharged to their usual place of residence. Whilst this level of detail is not available in the BCF data packs, it is clearly a priority area for the city.

The hospital discharge narrative clearly describes some of the work aimed at achieving the above ambition. There is other work underway focusing on prevention and early intervention for this population group, in particular through our work with the community and voluntary sector. The commissioning and development of Social Prescribing functions (above that stated as a requirement within the Primary Care Network Additional Roles scheme) through our SO:Linked service and wider Housing Related Support service are enabling targeted prevention and early intervention work with our older population. In 2022/2023 this will continue to develop to include digital skills and engagement, use of green spaces and general access to community assets. In addition the commissioning team will undertake a full review of this provision to inform the future planning for prevention and early intervention more generally for the city. By supporting people to remain independent for longer this, along with our rehab and reablement service are key to supporting the delivery of metric 8.4 – Long-term support needs of older people met by admission to residential and nursing care homes.

Linked with this our key aging well priority for 2022/2023 is a proactive care approach delivered through ongoing development of integrated care/One Team approach, working in partnership with the community and voluntary sector, all with the foundation of implementing a Population Health Management approach. This priority seeks to work with our most vulnerable population, in particular older people, to ensure that proactive or anticipatory care planning is part of a standard offer in the city.

People living with a disability – whilst a proxy measure, we expect the number of people needing home care support with five or more activities of daily living (such as bathing, using the stairs, getting dressed) to increase by 11.8% between 2018 and 2023. Evidence to date supports this with a rise of the mean home care hours per person from 10 hours per week to 14 hours per week in the last two years.

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

People living with mental illness – there is clear evidence to suggest that the pandemic has had an exacerbating effect on existing conditions such anxiety and depression and create “new” mental health needs.

As such people living with mental illness are benefiting from a mental health investment across the ICB in this year, including the ‘no wrong door’ programme. Elements which are included within the BCF plan include an expansion of the support for primary care to provide health checks for people who are living with a SMI through our Community Wellbeing Team. This offer will, as with LD, promote access to flu and Covid vaccination, along with the offer of health and wellbeing planning support. Significant improvements are being seen in the levels of vaccination and health checks for these populations.

The city has significant investment in recovery approaches and rehabilitation for this client group. This year a full review of the rehabilitation offer is underway at an ICS level as well as locally. The latter will include consideration of the housing provision which can more fully enable recovery for this client group. This approach is clear evidence of how working in a within an integrated commissioning setting better meets the needs our most vulnerable clients groups.

People with health and care needs from population groups other than white British – specific engagement with and approaches targeted at non-white British population are in place for a wide range of services. It is particularly evident in many of our prevention and early intervention services, for example our community solutions service (community development and navigation) which works with representative groups, including faith groups, to increase accessibility and promote appropriate service provision. Our Community Wellbeing Team, the service which promotes proactive care in the city, have a similar approach. This service works with referrers to actively seek patients who are non-white British and require a proactive care approach. This service also promotes proactive work with three of the five

focus areas included as part of the core20plus5[3] improvement approach: Severe mental Illness (promoting access to annual health checks and vaccination); Chronic Respiratory Disease (driving the update of all vaccinations in the frailest and most vulnerable members of our population); and Hypertension case finding (through health screening for all patients referred to the service for a proactive approach). As we proceed into the second half of this year the ICS will identify the population group experiencing poorer health outcomes, in keeping with the 'PLUS' element of the improvement approach, the Community Wellbeing Team, along with other services, will be engaged to wrapping care planning and proactive provision around the patients identified.

[3] NHS England » Core20PLUS5 – An approach to reducing health inequalities

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Better Care Fund 2022-23 Template

2. Cover

Version 1.0.0

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- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2022-23.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.
- Where BCF plans are signed off under a delegated authority it must be reflected in the HWB's governance arrangements.

Health and Wellbeing Board:	Southampton
Completed by:	Moraig Forrest-Charde
E-mail:	moraig.forrest-charde@nhs.net
Contact number:	7769640375
Has this plan been signed off by the HWB (or delegated authority) at the time of submission?	Yes
If no please indicate when the HWB is expected to sign off the plan:	
If using a delegated authority, please state who is signing off the BCF plan:	

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

Job Title:	HWB Chair and Cabinet Member for Health, Adults and Lesiure
Name:	Cllr Lorna Fielker

	Role:	**Professional Title (e.g. Dr, Cllr, Prof)**	**First-name:**	**Surname:**	**E-mail:**
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Lorna	Fielker	Fielker, Lorna (Cllr) <Councillor.L.Fielker@sout
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Maggie	MacIsaac	maggie.macisaac@nhs.net
	Additional ICB(s) contacts if relevant		Maggie	MacIsaac	maggie.macisaac@nhs.net
	Local Authority Chief Executive	Mr	Mike	Harris	Mike.Harris@southampton.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Mr	Vernon	Nosal	Vernon.Nosal@southampton.gov.uk
	Better Care Fund Lead Official	Mrs	Moraig	Forrest-Charde	moraig.forrest-charde@nhs.net
	LA Section 151 Officer	Mr	John	Harrison	John.Harrison@southampton.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->					

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

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	No
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

DECISION-MAKER:	Health and Wellbeing Board
SUBJECT:	Child Friendly Southampton Briefing for Discussion
DATE OF DECISION:	21 September 2022
REPORT OF:	**CABINET MEMBER FOR HEALTH, ADULTS AND LEISURE**

CONTACT DETAILS				
Executive Director	**Title**	Executive Director Children and Learning		
	Name:	Robert Henderson	Tel:	023 8083 4899
	E-mail	Robert.Henderson@southampton.gov.uk		
Executive Director	**Title**	Executive Director Communities, Culture & Homes		
	Name:	Mary D'Arcy	Tel:	023 8083 4611
	E-mail	Mary.D'arcy@southampton.gov.uk		
Author:	**Title**	Child Friendly Project Officer		
	Name:	Sallie White	Tel:	n/a
	E-mail	Sallie.White@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY
None
BRIEF SUMMARY
Southampton City Council has been exploring the potential to become a Child Friendly City since 2017 following the launch of its Restorative Charter in November 2017. The initiative has had the support of both the current and previous administration which has incorporated the initiative into the new Corporate Plan for 2021 to 2025. In February 2022 Southampton City Council 'onboarded' with UNICEF UK as an official candidate city and this continues to be among the main priorities of the new administration and UNICEF have welcomed the consensus there is within Southampton for the initiative.
Responsibility for pursuing a Child Friendly City is led by the Children and Young People's Participation Team within Stronger Communities, working collaboratively with the Children's and Learning Service, with Rob Henderson as the programme sponsor. The rationale for locating the initiative within Stronger Communities is to ensure that the rights of children can be promoted across the organisation as well as city wide. A range of Ambassador organisations have now been appointed. Rights based practice for children is already starting to influence programme designs and local strategies, reflected for example in the current DA/VAWG Strategy (in draft), the Prevention and Early Help Strategy, the Safe City Strategy and the Tobacco, Alcohol and Drugs Strategy (in draft).
On 21st July 2021 the Corporate Plan for 2021 to 2025 was approved at full council which set the objective to 'Achieve our ambition to become a UNICEF Child Friendly City by 2024/25'. The plan set the following milestones:

- Acceptance onto accreditation programme by Autumn 2021 (achieved)
- Install first children's mayor by May 2022 (achieved)
- New programmes of support and engagement involving children and young people by March 2022 (ongoing)
- Rights of children enshrined in local policy making and scrutiny processes by 2024.

The new Corporate Plan (in draft) has embedded Child Friendly. Rights based practice for children is being incorporated the other initiatives such as the Accessibility Inquiry Report Action Plan, transport initiatives, Child Centred Policing and the Southampton Cultural Education Partnerships, Connecting Cultures Programme.

RECOMMENDATIONS:		
	(i)	That the Health and Wellbeing Board considers and notes this report.
REASONS FOR REPORT RECOMMENDATIONS		
1.	The Chair requested that the Health and Wellbeing Board Panel receives an update on Child Friendly Southampton.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
	N/A	
DETAIL (Including consultation carried out)		
2.	Southampton City Council officially joined UNICEF UK as a candidate city joining the programme on 21st February 2022. The Success in joining the programme means Southampton is the first South Coast City in the UK to join the programme along with Aberdeen, Cardiff, Derry and Strabane, Liverpool, Nottingham, Wokingham and the London Boroughs of Lambeth and Redbridge.	
3.	Several local partners have stepped forward to support Southampton's Journey as Ambassadors. Ambassadors' main role is to support the implementation of the programme and to support Children and Young People to be engaged. Ambassadors so far are: • Saints Foundation, • No Limits, • Solent NHS Trust, • GO! Southampton Business Improvement District, • John Hansard Gallery • The Mayflower Theatre Trust. • Artswork, • City Catering, • Sound Pop Academy, • Yellow Door, • Southampton Cultural Services. • West Quay A bi-monthly ambassadors network meeting takes place to keep ambassadors informed and engaged. Ambassadors also oversee the	

	programme as a governance structure with links to the Executive Steering Group.
4.	An internal Executive Steering Group has been established, chaired by the Executive Director for Children and Learning, inclusive of representation from the following teams, who as internal stakeholders have been invested in supporting our ambition to become a Child Friendly City: • Public Health • Cultural Services (and Southampton's Cultural Education Partnership) • Transport • Urban Design and Planning • Children and Learning • Green City • Strategic Skills • Democratic Services A Child Friendly Youth Board involving young people themselves is being developed.
5.	The Programme is overseen by a dedicated Project Officer who links with UNICEF UK coordinators to ensure the programme is on track and each milestone is being achieved. Investment in a project officer was a pre-requisite for acceptance on to the programme. The Project Officer links with internal and external partners to involve each of them in the many aspects of the programme. Whilst the Project Officer holds the work plan for the programme the achievement of accreditation is a Southampton wide responsibility with the governance structure being key to the movement. Without the support of the Steering Group, Ambassadors, and other key partners the programme would not be possible.
6.	Joining the programme supports us in achieving our vision for children and provides a clear framework to deliver improved outcomes for all children who live or visit the city. Southampton has a strong foundation upon which to build success with Southampton Connect, (representing key partners including business), demonstrating a commitment to support the child friendly ambition – this is articulated in the five-year Health and Wellbeing Strategy and Children and Young People's Strategy.
7.	Our key priorities are: • To hear the voices of children, families, and communities on an individual basis but also on all key decisions within the city. • To develop strong pathways for education, training and employment and post 16 education and learning pathways leading to skilled and meaningful work in our growing economy. • To keep children safe, tackling domestic abuse, youth crime and all forms of exploitation. • To support young people with emotional and mental health issues and ensuring we provide environments where young people can talk and get the support they need. • To ensure that as a city of culture, children are at its core, and we continue to develop and build on our initiatives for children to engage in a range of cultural activities.

8.	The UNICEF programme will support Southampton City Council and its partners through a three-stage process of Discovery, Development, and Implementation. Our key priorities will be established towards the end of Discovery in October 2022 following extensive engagement. The main aim of Discovery is to talk to Children and Young People about their thoughts and feelings. Throughout June, July and August a Children and Young People's survey has been undertaken capturing this information. This will be presented at a Discovery Day in October where the city will vote on their top three badges (areas) from a list provided by UNICEF UK: • Safe and Secure • Flourishing • Education and Learning • Participating • Child Friendly Services • Place • Family and Belonging • Healthy • Equal and Included • Innovation This sits alongside three mandatory badges Communication, Culture and Co-operation and Leadership.
9.	A badge rationale report will be submitted to UNICEF UK based on the evidence from the Discovery Phase which will be written by the steering group. This will lead into the Development Phase where Southampton will write 6 actions plans based on each badge which will be the focus of the journey for the following 3-5 years (Delivery Phase).
10.	To date we have had 955 qualitative interactions with Children and Young People under the age of 18. This has been via: • Mainstream online/ paper survey • Easy read online / paper survey • 5 online / paper activity sheets • Focus group with Looked After Children • Roadshow visiting youth settings through June • Attendance at events such as Mela, SPCA Play Day and more • Engagement via Ambassadors, Steering Group and Schools Most interactions have been in person at a range of community events and have been supported by Stronger Communities Team staff who have interviewed or interacted with children.
11.	Other points to note: • Whilst all Child Friendly activity is encouraged, UNICEF UK expect applicant cities to first focus on activity that will be recognised under the badge scheme. Early business engagement work has started, but this is a longer-term ambition to ensure accreditation is prioritised. • There are currently no cities in the UK that have yet been given recognition but four are expected to be, by 2023.

	• We are exploring the potential to partner with other cities in the international network of accredited cities, including cities in Poland, Japan and Canada. • Contact has already been made with Cardiff and Barnet to support peer learning, with close connections maintained with other Child Friendly Cities: as part of a bi- monthly coordinators meeting
12.	Other key milestones that support our ambition include: • The launch of Southampton's first Children's Mayor who was appointed at this years' 800th Mayor Making Ceremony • The Child Friendly Youth Board aims to launch in September 2022. The group will work alongside existing governance structures to oversee the implementation of the programme. • Discovery Day on 25 October 2022 when badges will be agreed. • International Children's Day on 20 November 2022 when the Child Friendly flag will be raised at the Civic Offices.
RESOURCE IMPLICATIONS	
Capital/Revenue	
13.	Accreditation to the programme is on a pro-rata basis determined by City size and is £35,000 per annum which is within the allocated budget for the programme, confirmed with finance. A full time Child Friendly Project Officer has been appointed to steer the programme. There are however no other resources currently budgeted for and contributions or in-kind support from programme partners will in time be necessary to ensure meaningful engagement with children can take place.
Property/Other	
14.	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
15.	S.111 Local Government Act 1972
Other Legal Implications:	
16.	The inclusion of, or reference to children's rights into Southampton City Council legal processes will be better understood once the city embarks on the 'Delivery Phase' of the programme.
RISK MANAGEMENT IMPLICATIONS	
17.	The proposals are included with the current Corporate Plan for 2021-2025 and the new draft Corporate Plan (yet to be published).
POLICY FRAMEWORK IMPLICATIONS	
18.	The process of ensuring that children's rights are embedded in local processes will require some further work to understand the implications within our constitutional and legal frameworks.

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

SUPPORTING DOCUMENTATION	
Appendices	
1.	UNICEF UK CFC Participation Criteria

Documents In Members' Rooms

	None

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

Other Background Documents
Other Background documents available for inspection at:

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

CHILD FRIENDLY CITIES & COMMUNITIES

A global Unicef initiative

PARTICIPATION CRITERIA

The Child Friendly Cities & Communities programme welcomes expressions of interest from councils who are ambitious in their local vision for children and young people and ready to pioneer a high-profile initiative over a minimum three-year partnership with Unicef UK. In order to join the programme, councils must be able to demonstrate political and strategic commitment to embedding children's rights across the city/community, and be willing to work collaboratively and creatively with Unicef UK, local partners and children and young people to achieve this. Unicef UK will work with councils to develop a realistic action plan and sustain momentum throughout the journey.

If you're interested in working with us, we invite you to submit a formal expression of interest outlining your reasons for wanting to join the programme and evidencing how you meet the participation criteria. Full participation criteria are below, and a formal expression of interest form accompanies this document. We will be in touch shortly after your submission to arrange a discussion before making a decision.

Formal expressions of interests are currently to be submitted by invitation only following earlier discussion with the Child Friendly Cities & Communities team at Unicef UK.

CRITERIA

Before joining the programme it's important that both Unicef UK and the council are confident that the city or community is ready to implement an ambitious child rights programme of change. We therefore ask interested councils to confirm the following:

1. MOTIVATION AND READINESS

Is this the right time for your council and the wider city/community to join the programme?

Enthusiasm to join the programme should be backed up by a readiness to implement an ambitious local programme of work. Councils will be required to benchmark local child rights outcomes, identify strengths and gaps and develop and implement new child-centred approaches and/or build on and scale existing ones. All of this will be done in collaboration with local partners, children and young people and with training and support from Unicef UK. It will require leadership, governance, imagination, sustained effort and a pioneering spirit from across the city/community. Reflecting on the full participation criteria should help councils decide whether the city/community is 'implementation ready'.

2. VISION

Do you have a clear vision of what you hope to achieve for children and young people through participation in the programme?

Child Friendly Cities & Communities seeks to realise the UN Convention on the Rights of the Child – a comprehensive human rights treaty which sets out a vision of childhood underpinned by dignity, equality, safety and participation – at the local level. Embedding children's rights in the planning, design and delivery of local services requires a long term commitment to change, and a readiness to involve children as partners and key stakeholders.

3. COMMITMENT TO CHILD-CENTRED PRACTICE

Can you build on a pre-existing commitment to child rights and child-centred practice?

Our programme is strengths-based. This means highlighting and building on existing good practice, as well as identifying gaps and developing new ways of working. There are many existing programmes, initiatives and embedded ways of working – from small-scale local projects to national schemes and models – that chime with a child rights-based approach. Some examples are 'asset-based approaches', 'restorative practice' and 'co-production'. We want to ensure local authorities' participation in the programme helps them break new ground, while maximising the impact of existing or planned initiatives.

4. A MEANINGFUL COMMITMENT TO CHILDREN AND YOUNG PEOPLE'S PARTICIPATION

Are you committed to enabling children's ongoing, meaningful participation and forging new ways of supporting children and young people's involvement in local decision-making?

Central to adopting a child rights-based approach is a requirement that children be seen as capable, resourceful and competent individuals and that they are supported – through enabling structures and processes – to play an active role in shaping local services. We see this as an iterative and collaborative process; working in partnership to build on existing good practice, while identifying and tackling barriers that may prevent children and young people from participating in the life of their community. Special attention should be paid to supporting children who find it harder to have a say in matters that affect them.

5. COMMITMENT TO LEARNING AND REFLECTION

Are you prepared to take part in a learning programme which requires reflection, experimentation and ongoing data collection and monitoring?

One of the goals of the programme is to grow the evidence base in support of child rights in practice. We are committed to continuous learning and reflective practice. Throughout the delivery of the programme we'll be working with in-house and external evaluation partners to capture data, collect evidence and measure the impact the

programme is having on local outcomes for children. We'll enthusiastically welcome the involvement of local research partners such as universities or consultancies.

6. COMMITMENT AT ALL LEVELS AND CROSS-COUNCIL BUY-IN

Is there political commitment to the programme as well as commitment from across the wider council?

Successful participation in the programme requires sustained commitment at all levels: from elected members through directors and heads of key services, to team leaders and frontline staff. As well as confirming that there is cabinet level support for the work, councils are asked to designate at least six "champions" whose role it will be to raise the profile of the programme and promote the work that takes place over its lifetime. Two champions must be political, while the remaining champions should represent an influential cross-cutting profile of the council. Champions should come together on a regular basis to ensure effective coordination of the programme.

7. GOVERNANCE AND COORDINATION

Will there be a robust, transparent and accountable local governance and coordination structure in place to implement the programme?

In order to effectively manage, monitor and reflect on progress, it's vital to coordinate and regularly review programme activities. We'll need to know that this has been given serious and sensible thought ahead of commencing programme activities so we'll ask for a named coordinator(s) and evidence that this person(s) will be supported by robust coordination and governance structures. This could be an existing multi-agency group, partnership board or scrutiny committee. Or it could be a brand new group bringing together programme champions who then report to an established committee.

8. PLACE-BASED APPROACH

Will you take an inclusive, collaborative, community-wide approach in your delivery of the programme?

In order to flourish, children and young people rely on a wide range of services – statutory, voluntary and private – which is why we ask councils to take a whole community approach and reach out to key local partners, organisations and agencies to successfully implement the programme. This might include Clinical Commissioning Groups, Councils for Voluntary Services, the police, the local media etc. We'll need to know that local partners will play a substantial role in the ideation, development and delivery of the programme. You may also consider the role of the local partners in the governance of the work (see criteria 6 and 7).

9. COSTS AND AVAILABLE RESOURCES

Can you commit to paying the direct programme fees and ensure there are adequate resources available locally to implement the programme over three years?

Programme fees: Unicef UK charges an annual fee (subject to review in 2019). Unicef UK is a registered charity operating on a not-for-profit basis. All income raised contributes to the administration of the programme and the delivery of services.

Indirect costs: In addition to the programme fee, councils may incur indirect costs resulting from local coordination of the programme. Indirect costs are not prescribed but could include, for example, the creation of a dedicated post or a part-time secondment, provision of training venues, releasing staff for training and planning activities, producing awareness-raising materials and outreach events etc.

10. STANDARDS

Can you explain how joining the programme will contribute to improving local standards and outcomes?

While participation in the programme comes with the opportunity to obtain international recognition as a "Child Friendly City" or "Child Friendly Community", Unicef is not an inspectorate like Ofsted or the Care and Social Services Inspectorate. We welcome interest from and will work with councils regardless of their current inspection outcome if they are able to make a very strong case that they are ready, but we will never recognise a council with a poor or inadequate inspection outcome as 'Child Friendly'. It's therefore important that applying councils are confident that this is the right time to join the programme (see criteria 1) and are able to explain how joining the programme will contribute to and complement existing improvement plans. We'll also expect the council to engage in honest dialogue with Unicef UK about this from the outset. Councils joining the programme with a poor or inadequate outcome may take longer to gain 'Child Friendly' status, but it is our strong belief that the full adoption of a child rights-based approach will lead to improved services for children and young people.

11. YOUR EXPECTATIONS

Can you identify what support you might need from Unicef UK to ensure success in the programme?

The Child Friendly Cities & Communities programme is collaborative by design. The success of the programme is dependent on ongoing dialogue and co-operation between Unicef UK and councils, including local delivery partners (see criteria 8) and children and young people (see criteria 4). We'd like to have a good understanding of your particular local needs and how you would best like us to support you throughout your programme journey.