Public Document Pack

Health and Wellbeing Board

Wednesday, 14th December, 2022
at 5.30 pm

Committee Room 1 - 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
Claire Heather
Senior Democratic Support Officer
Tel: 023 8083 2412
Email: claire.heather@southampton.gov.uk

BACKGROUND AND RELEVANT INFORMATION

Purpose of the Board

The purpose of the Southampton Health and Wellbeing Board is:

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

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

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

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

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

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

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

Responsibilities

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

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

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

Dates of Meetings: Municipal Year 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 confirm the recommended appointment of Dr Sarah Young as Vice-Chair of the Board for the Municipal Year 2022-2023 following the previous meeting not being quorate.

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 meeting held on 6th October 2021, 2nd March and 21st September 2022 and to deal with any matters arising, attached.

6 ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2022

Report of the Director of Public Health outlining the state of health of the Southampton population in 2022

7 INTEGRATED CARE PARTNERSHIP INTERIM INTEGRATED CARE STRATEGY

Report of the Cabinet Member for Health, Adults and Leisure outlining the key priorities in the draft Interim Integrated Care Strategy of the Integrated Care Partnership

8 JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) ANNUAL SUMMARY AND HEALTH AND WELLBEING STRATEGY UPDATE

Report of the Cabinet Member for Health, Adults and Leisure providing a summary JSNA and an update on the progress of the Health and Wellbeing Strategy 2017-25

9 PROPOSAL TO ADOPT THE PREVENTION CONCORDAT FOR BETTER MENTAL HEALTH

Report of the Cabinet Member for Health, Adults and Leisure proposing the adoption of the Prevention Concordat for Better Mental Health

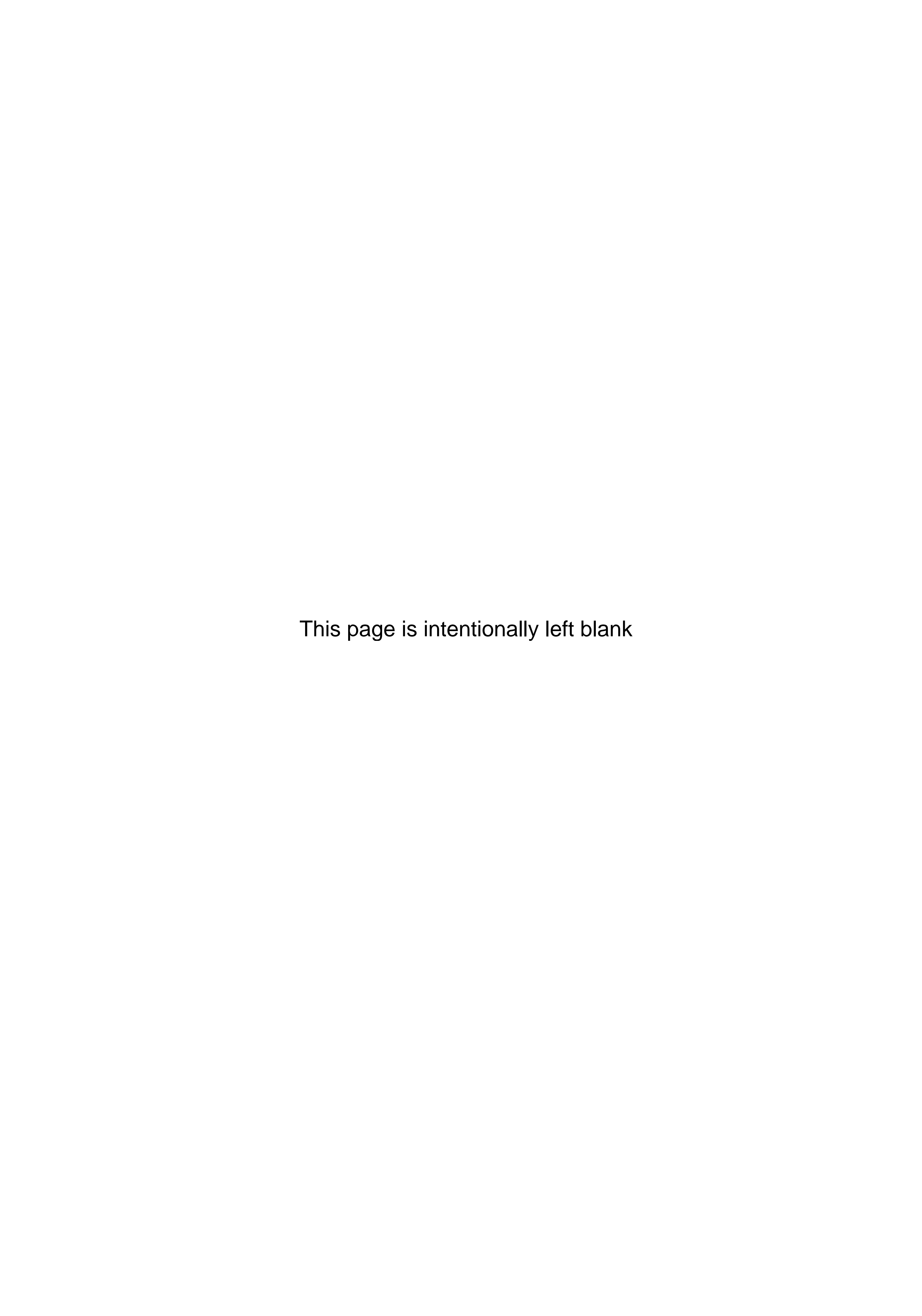
10 SEXUAL HEALTH NEEDS ASSESSMENT

Report of the Cabinet Member for Health, Adults and Leisure summarising the work to understand and improve sexual and reproductive health outcomes in Southampton

11 TOBACCO, ALCOHOL AND DRUGS STRATEGY 2023-2028

Report of the Cabinet Member for Health, Adults and Leisure proposing the approval of the new Tobacco, Alcohol and Drugs Strategy 2023-2028

Tuesday, 6 December 2022 Executive Director – Legal and Business Services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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

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.

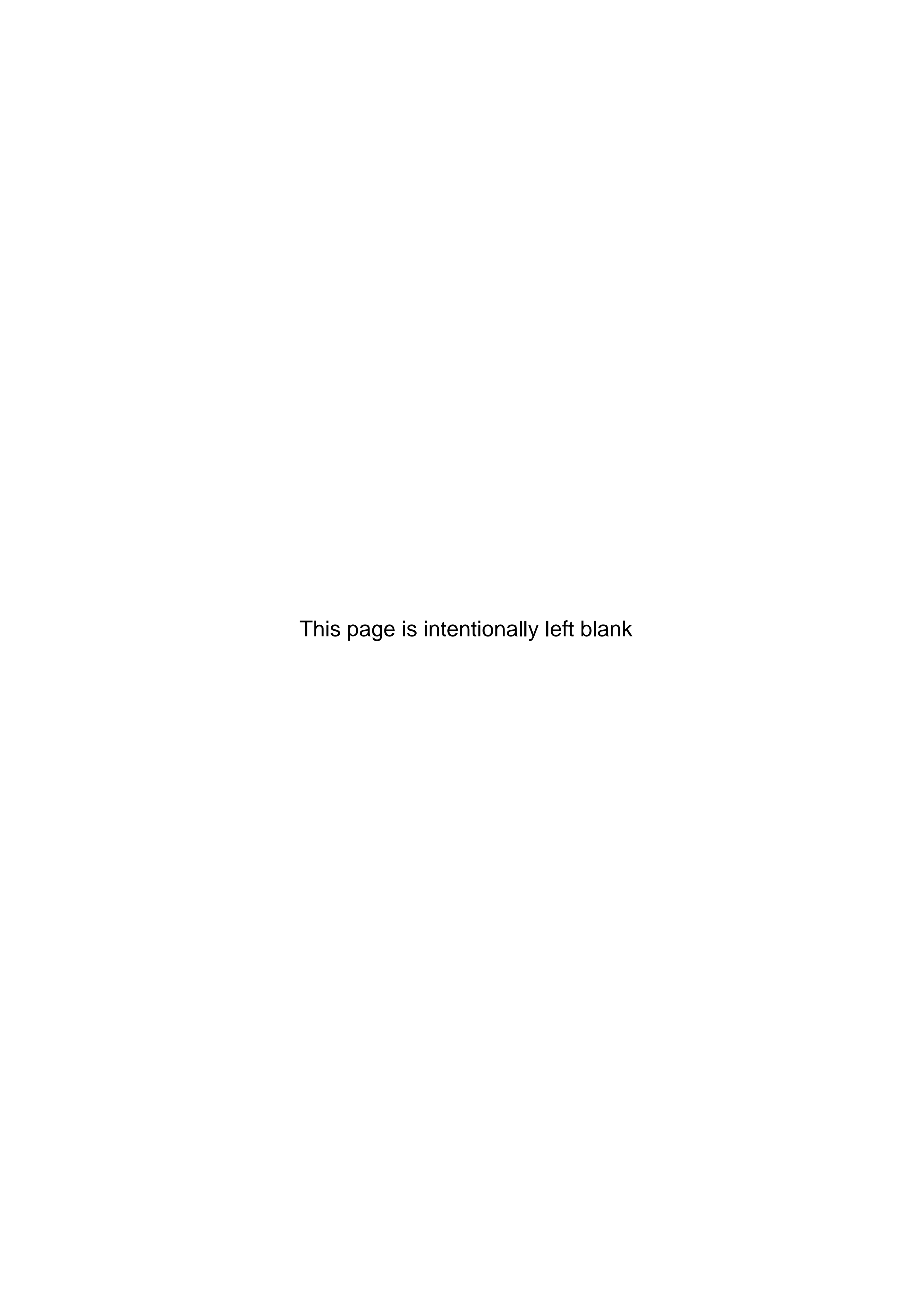
The Board wished to use the H&WBB to achieve transformation and to build on the existing strong base line.

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, Robert Henderson, Guy Van-Dichele and Dr Sarah Young

Apologies: Councillors Streets

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

The apologies of Councillor Streets were noted.

10. **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 Dichelle, Executive Director of Wellbeing for Adults and Health; and Robert Henderson, Executive Director of Wellbeing for Children and Learning had joined the meeting via Microsoft Teams and with the consent of the chair contributed to the meeting.

11. **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.

12. **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.

13. **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 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

14. **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 celebrate what needed to be improved

RESOLVED:

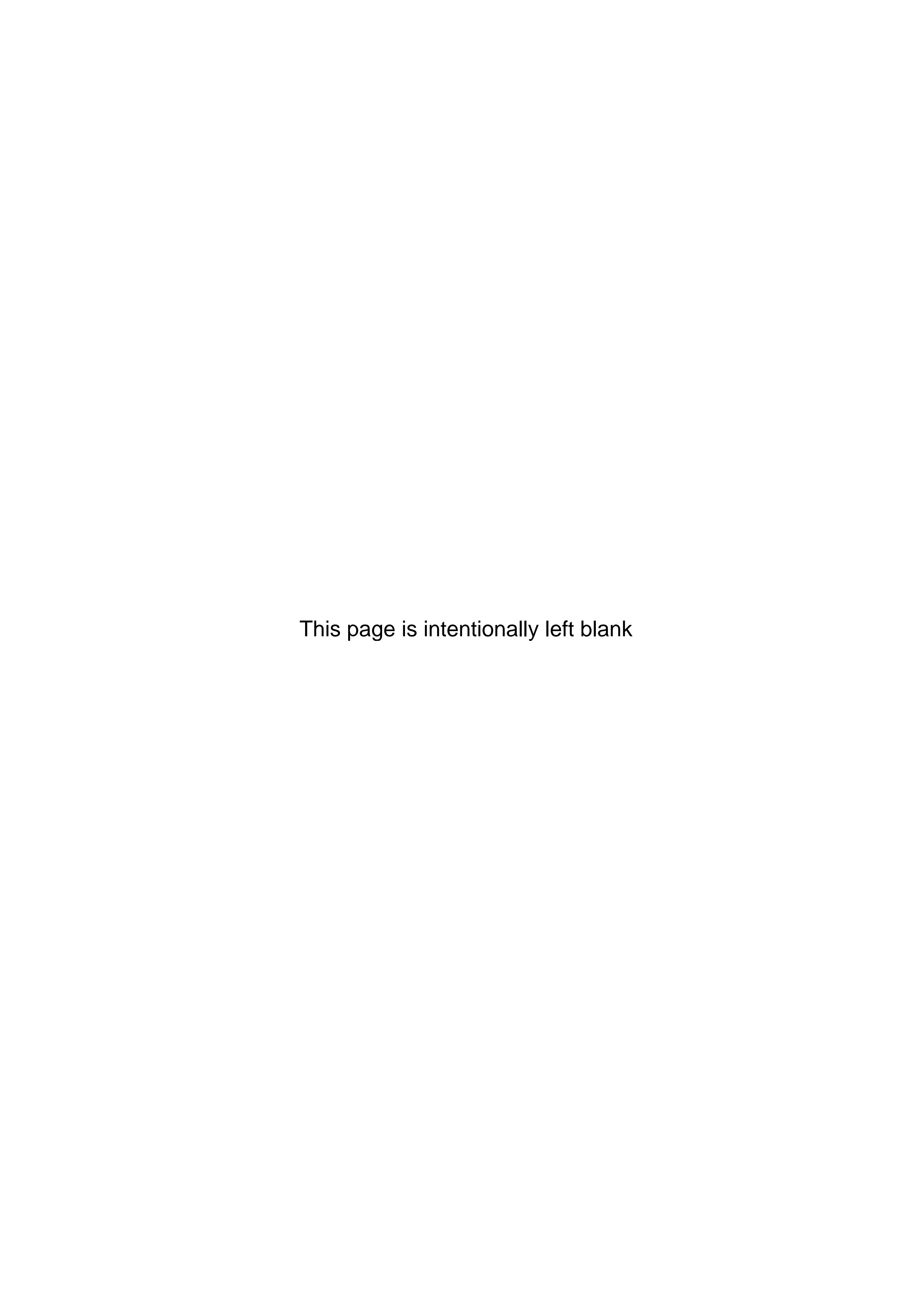
(i) That the SCC Healthy Weight Declaration action plan be approved.
(ii) That the Board recommended that the Council signed the Local Authority Declaration on Healthy Weight and embedded the Healthy Weight Declaration as a key strategic priority across the whole council.

15. **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, Director of Integrated Commissioning, 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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HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 21 SEPTEMBER 2022

Present: Councillors Fielker - (Chair), Dr Paffey (Minutes 7-9) , Professor Margetts and 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 and Care
Dr Sarah Young – NHS Southampton Clinical Commissioning Group
Dr Hana Burgess – Mental Health Clinician
Dr Michael Roe – Local Paediatrician

NOTE: THIS MEETING WAS NOT QUORATE THEREFORE NO DECISIONS WOULD BE ABLE TO BE TAKEN AT THE MEETING ONLY RECOMMENDATIONS TO THE NEXT MEETING FOR RATIFICATION. ANY URGENT DECISIONS WOULD BE TAKEN IN ACCORDANCE WITH THE CHIEF OFFICERS GENERAL POWERS IN THE OFFICER SCHEME OF DELEGATION

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

2. **ELECTION OF VICE-CHAIR**

The Board noted that Dr Sarah Young had been proposed and seconded as Vice-Chair for the 2022/2023 Municipal Year which would be agreed at the December meeting due to this meeting not being quorate.

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

The minutes of the meetings held on 6th October 2021 and 2 March 2022 were noted and would be formally approved at the December meeting due to this meeting not being quorate.

4. **UPDATE ON MENTAL HEALTH IN SOUTHAMPTON**

The Board received and noted the 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.

The report was seeking approval to proceed with the adoption of the Office for Health improvement and Disparities (OHID) Prevention Concordat for Better Mental Health for Southampton and submission of application to join the Prevention Concordat.

The Board noted that the work of the Concordat would be reported to and monitored by the Mental Health and Wellbeing Partnership which sits under the Health and Wellbeing Board.

The Board recommended approval to proceed with the adoption of the Concordat which would require formal ratification at the December meeting due to this meeting not being quorate.

5. **TOBACCO, ALCOHOL AND DRUG STRATEGY: UPDATE ON PROGRESS**

The Board received and noted a presentation from Lisa Erlandsen, Policy and Strategy Officer detailing progress on the Tobacco, Alcohol and Drug Strategy.

The Board noted the consultation had concluded on 4th September 2022 and work was now taking place to replace the existing strategy with the 2023 – 2028 new strategy. There would be five themes within the new strategy around Help, Harm Reduction, Hope, Health Promotion and Health Equality. It was noted that this was the first strategy to cover tobacco specifically.

Formal sign off of the strategy would come to the December meeting of the Board prior to Cabinet decision on 20th December.

6. **PHARMACEUTICAL NEEDS ASSESSMENT**

The Board received and noted the report of the Cabinet Member for Health, Adults and Leisure detailing the final Pharmaceutical Needs Assessment (PNA) which the Health and Wellbeing Board had a statutory responsibility to publish by the end of October 2022.

The report was seeking approval of the final PNA and the process for dealing with changes to the need for, or the availability of, pharmaceutical services during the lifetime of the PNA.

It was noted that due to the meeting not being quorate and the need to meet statutory requirements for the publication of the PNA which could not be deferred to the next meeting of H&WBB in December, the Board recommended the decision be taken in accordance with the Chief Officers General Powers in the Officer Scheme of Delegation and Dr Debbie Chase, Director of Public Health takes the decision in order to meet statutory requirements.

7. **IMPROVING THE LOCAL FOOD ENVIRONMENT**

The Board received and noted the report of the Cabinet Member for Health, Adults and Leisure detailing way to improve the local food environment and the implications of new legislation on hight fat, salt and sugar foods.

The Board noted the national context and the publication of the Government Food Strategy in June 2022 which covered a range of factors including food supply, sustainability as well as health and the local programmes taking place to improving the local food environment.

8. **BETTER CARE FUND YEAR END REPORT 2021/2022 AND 2022/23 NARRATIVE PLAN AND TEMPLATES**

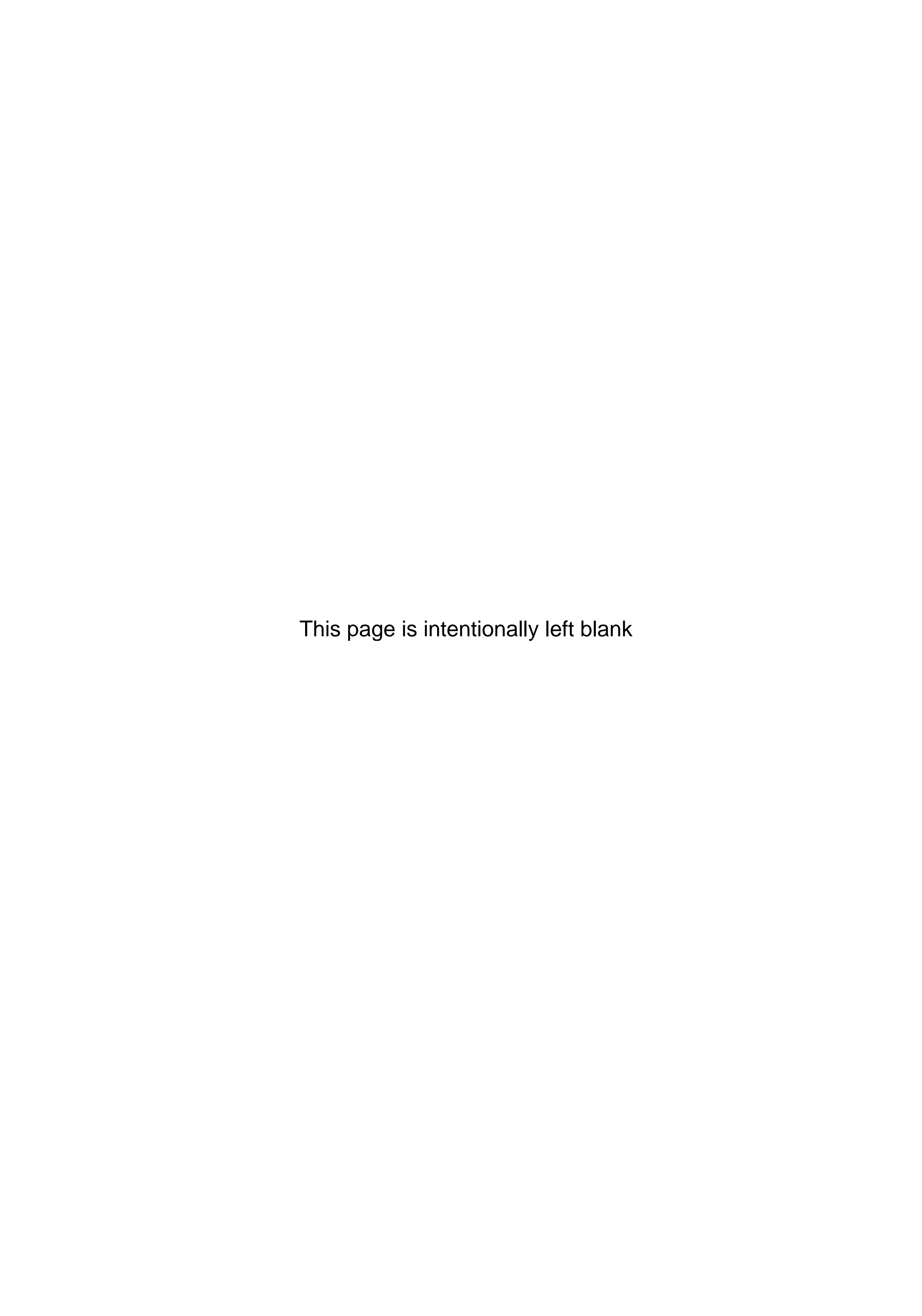
The Board received and noted the report of the Cabinet Member for Health, Adults and Leisure detailing the Better Care Fund Year End Report 2021/2022 and 2022/2023 Narrative Plan and Templates.

The report was seeking approval of the year end return 2021/2022 as detailed in appendix 1 of the report and the response to Better Care Fund Policy Framework and Planning Guidance which was required to be submitted by Monday 26th September 2022.

It was noted due to the meeting not being quorate and the need to meet statutory requirements for the submission of the Better Care Fund Year End return which could not be deferred to the next meeting of H&WBB in December, the Board recommended the decision be taken in accordance with the Chief Officers General Powers in the Officer Scheme of Delegation and Dr Debbie Chase, Director of Public Health takes the decision in order to meet statutory requirements for submission.

9. **CHILD FRIENDLY SOUTHAMPTON UPDATE**

The Board received and noted the report of the Cabinet Member for Health, Adults and Leisure outlining progress to date towards Child Friendly City status in Southampton following the adoption of the Council's Corporate Plan in July 21 which set out the objective to "Achieve our ambition to become a UNICEF Child Friendly City by 2024/25.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DECISION-MAKER:	Health and Wellbeing Board
SUBJECT:	Director of Public Health Annual Report 2022
DATE OF DECISION:	14 December 2022
REPORT OF:	**CABINET MEMBER FOR HEALTH, ADULTS AND LEISURE**

CONTACT DETAILS				
Executive Director	**Title**	Director of Public Health		
	Name:	Debbie Chase	Tel:	023 80
	E-mail	Debbie.chase@southampton.gov.uk		
Author:	**Title**	Director of Public Health		
	Name:	Debbie Chase	Tel:	023 80
	E-mail	Debbie.chase@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY

N/A

BRIEF SUMMARY

The Director of Public Health has a statutory duty to write an independent annual report to demonstrate the state of health within their communities. This year's report focusses on working with our local communities to reduce health inequalities by improving the wider determinants of health. The report highlights the need for action across the core drivers of health inequality with a renewed focus on:

- Giving every child the best start in life
- Enabling all children, young people and adults to maximise their capabilities and have control over their lives
- Creating fair employment and good work for all
- Ensuring a healthy standard of living for all
- Creating and developing healthy and sustainable places and communities
- Strengthening the role and impact of ill-health prevention

Actions proposed by the report include:

1. **Amplifying leadership for health inequalities**, specifically by: supporting the workforce to develop a shared understanding of the causes of health inequalities and benefit of delivery effective interventions at scale; and advocacy on behalf of our residents.
2. **Maximising the impact of our core business on the 'causes of the causes'**, specifically by: growing momentum for work to increase the impact of locally anchored organisations on employment and growth; and applying a health in all policies approach.

3. **Continuing to do what we know works**, specifically through: evidence and research informed practice, evaluation; and a focus on health inequalities in redesign and improvement work.
4. **Working with and alongside our communities**, specifically by: scaling ways of working developed during COVID; nurturing assets and engaging with the strength and power of our communities; and giving children and young people capacity to influence as a UNICEF child friendly city.
5. **Harnessing the benefit of system working**, specifically by: putting health equity at the centre of collective action supported by monitoring of key indicators; acting collectively around tobacco and organisational influences on health and wellbeing; and focussing on improvements in equity of access, outcome and experience across our services.

These actions link closely to the ambitions within the Joint Health and Wellbeing Strategy and will be shared and built into strategic programmes of work in the City and wider Hampshire and Isle of Wight programmes that impact on the health of Southampton residents. A review of progress against implementation will form part of next year's Annual Public Health Report.

RECOMMENDATIONS:		
	(i)	The Health and Wellbeing Board is asked to consider the recommendations proposed by the Director of Public Health.
	(ii)	In recognition of the significant impact that local organisations have on the local population's health and wellbeing, Health and Wellbeing Board partners are asked to support joint work as Anchor Institutions. Specifically, this will involve considering their organisation's role in collective action to increase the impact of local employment, procurement and estate on health and wellbeing as well as consideration of environmental impact.

REASONS FOR REPORT RECOMMENDATIONS	
1.	N/A
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
2.	N/A
DETAIL (Including consultation carried out)	
3.	Independent report on the state of the health of the Southampton population.
RESOURCE IMPLICATIONS	
Capital/Revenue	
	The report does not have direct resource implications
Property/Other	
	N/A
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
	Health and Social Care Act 2012

Other Legal Implications:	
	N/A
RISK MANAGEMENT IMPLICATIONS	
	N/A
POLICY FRAMEWORK IMPLICATIONS	
	The focus on health inequalities aligns with the Southampton Joint Health and Wellbeing Strategy (2017-2025)

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

SUPPORTING DOCUMENTATION

Appendices	
1.	The Director of Public Health Annual Report will be available at **Southampton Public Health Annual Reports**

Documents In Members' Rooms

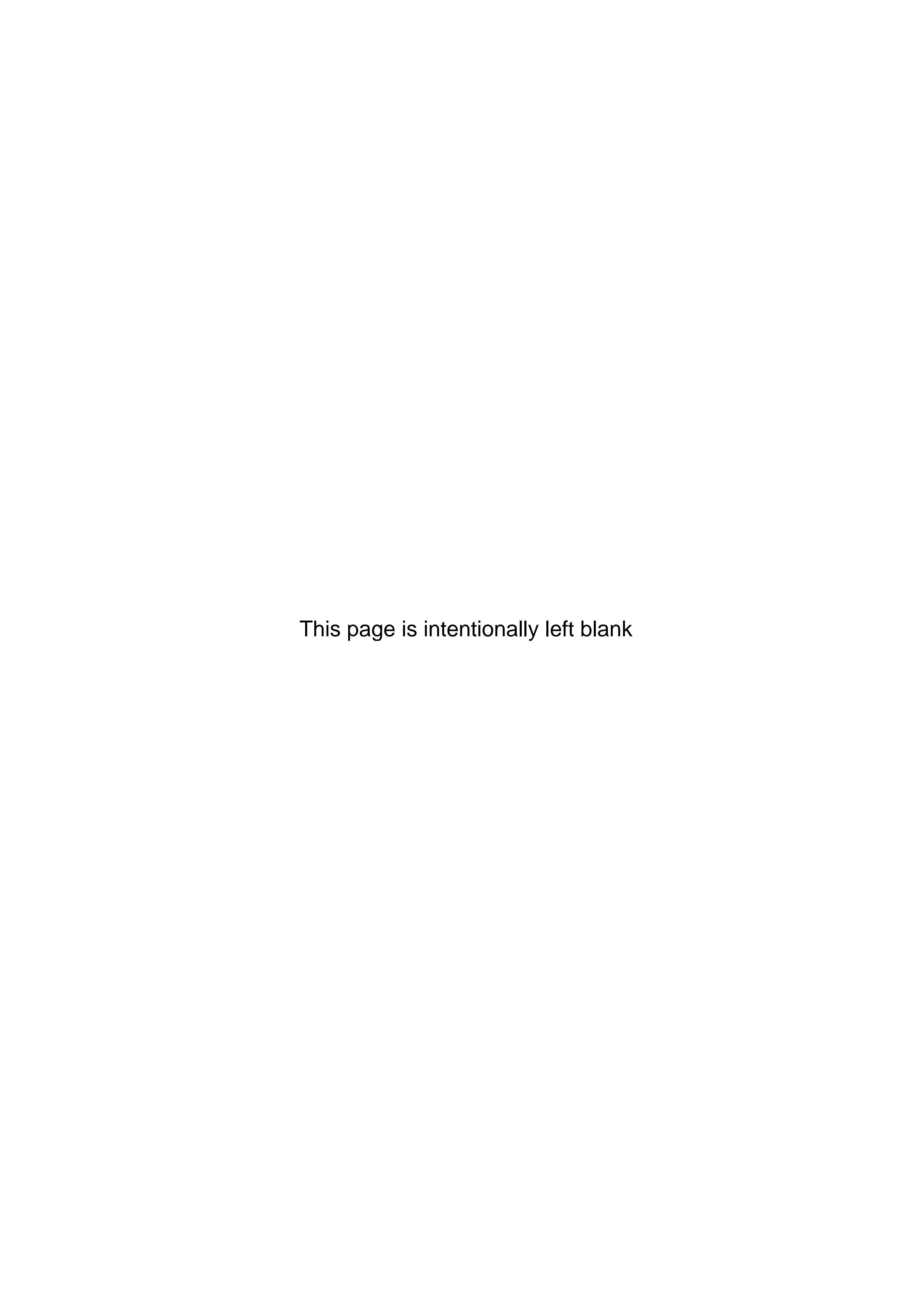
	None

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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DECISION-MAKER:	Health and Wellbeing Board
SUBJECT:	Hampshire and Isle of Wight Integrated Care Partnership Interim Integrated Care Strategy
DATE OF DECISION:	14 December 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**	Director of Partnerships/Strategic Partnership Lead		
	Name:	Ros Hartley/ Fran White	Tel:	
	E-mail	Ros.hartley1@nhs.net **/** f.white1@nhs.net		

STATEMENT OF CONFIDENTIALITY
N/A

BRIEF SUMMARY

This report sets out the key priorities as outlined in the draft Interim Integrated Care Strategy.

Background

- Southampton City Council is part of the Hampshire and Isle of Wight Integrated Care System, which was set up in July 2022 as part of the new Health and Social Care Act 2022. The Integrated Care system sees the formation of two new statutory health and care components; the Integrated Care Board and the Integrated Care Partnership.
- Integrated Care Partnerships are formed of upper tier local authorities and member(s) of the newly formed Integrated Care Board. The partnerships can choose to co-opt other members. Their primary purpose is to develop the Integrated Care Strategy for the Integrated Care System and to oversee and ensure the delivery of this strategy.
- Whilst the Integrated Care Partnership is still in formation, there is a national requirement that Integrated Care Partnerships write an Interim integrated care strategy by December 2022. Work has been ongoing over the last year, alongside partners in Local Authorities and other partners (e.g. Fire and Rescue, Police, Voluntary and Community Sector, Healthwatch, Local residents etc.) to build a case for change based on local evidence and insight in order to develop the strategic priorities for health and care in the Hampshire and Isle of Wight System.
- The purpose of the Integrated Care Strategy is to describe our ambitions and priorities across the Hampshire and Isle of Wight system where we can achieve tangible benefits by working together as a new, wider partnership across the system. It should build on the work of the Local Health and

Wellbeing Boards, but should not duplicate, but set priorities where joint working, beyond place, is most helpful. • The strategy which will be submitted in December 2022 will be Interim and there will be further work to do in 2023 as a partnership to develop this strategy and ensure it delivers the ambitions it sets out. • The Integrated Care Partnership is establishing the governance support required to ensure the partnership is successful and the delivery of the strategy. • The attached paper sets out the proposed strategic priorities for the Hampshire and Isle of Wight System.		
RECOMMENDATIONS:		
	(i)	To note and support the direction of travel as outlined in the draft strategy
	(ii)	To seek views from the board on how we ensure that the Southampton City Health and Wellbeing Board are part of the continuing development and delivery of the priorities within the draft strategy.
REASONS FOR REPORT RECOMMENDATIONS		
1.	The draft strategy has been developed in partnership with local authorities; the Joint Strategic Needs Assessment and Health and Wellbeing Strategy for Southampton City alongside those of our other local authorities have been used to inform the case for change and priorities. The strategy has been developed in close partnership working with the Directors of Public Health from the local authorities to ensure that it builds on and supports the work ongoing at a place level. To ensure the effective delivery of the strategy, it is recognised that partnership working with our Health and Wellbeing Boards will be vital.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	N/A	
DETAIL (Including consultation carried out)		
3.	Please see attached slide deck for the detail of the strategy and how we have engaged across the Southampton system with partners to inform the development of five strategic priorities. Slide 6 details the different groups we have engaged with across Southampton. Slide 11 details our strategic priorities.	
RESOURCE IMPLICATIONS		
<u>Capital/Revenue</u>		
4.	There are no resource implications inherent in supporting the Interim Integrated Care strategy.	
<u>Property/Other</u>		
5.	There are no property or other implications	
LEGAL IMPLICATIONS		

Statutory power to undertake proposals in the report:	
6.	N/A
Other Legal Implications:	
7.	None
RISK MANAGEMENT IMPLICATIONS	
8.	None
POLICY FRAMEWORK IMPLICATIONS	
9.	None

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

SUPPORTING DOCUMENTATION

Appendices	
1.	Draft Hampshire and Isle of Wight Interim Integrated Care Strategy

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 - ESIAs are carried out at an individual project level**
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)**
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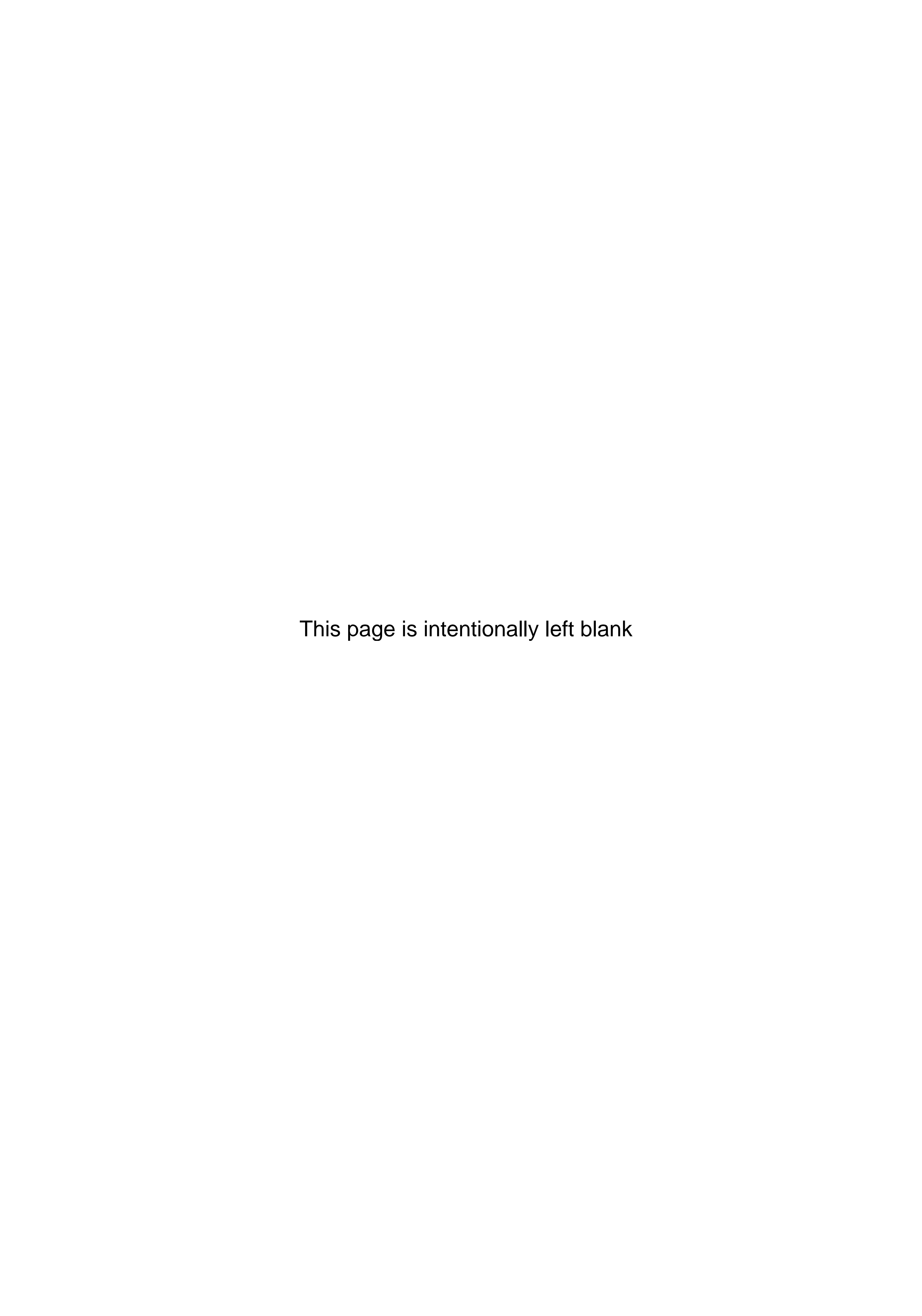

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DRAFT
All sections of this document are draft and under frequent revision and edit

Hampshire and Isle of Wight Interim Integrated Care Strategy DRAFT

As at 24 November 2022 (for publication December 2022)

This interim strategy has been jointly developed by partners and stakeholders from the Hampshire and Isle of Wight System

Integrated care partnerships bring together a broad range of organisations from the NHS, local authorities, the fire and rescue service, police, Healthwatch and the voluntary sector. These organisations already work together to look at where we can work together in even better ways to join up care, reduce health inequalities, and support communities and local people to be healthier, happier and wealthier. The integrated care partnership is responsible for setting the strategy for health and care in Hampshire and Isle of Wight to meet local healthcare, social care and public health needs. This interim strategy has been jointly developed by partners and stakeholders. We will continue to work with new and existing partners to further develop and deliver our strategy.

Mid Hampshire Healthcare
FirstCity Care Group
Wessex Local Medical Committees
Havant Borough Council
Gosport Borough Council
Disabled People's Voice Hampshire
Energise Me
NHS South, Central and West Commissioning Support Unit
Mind Solent
Hart District Council
Action Hampshire
Southampton Voluntary Services
Isle of Wight Age UK
Hampshire Constabulary
Keep Well Collaborative
Hampshire County Council
Southampton City Council
Gosport Voluntary Action
NHS Hampshire and Isle of Wight
NHS GP Health Service
help & care
NHS University Hospital Southampton NHS Foundation Trust
NHS Dorset HealthCare University NHS Foundation Trust
Eastleigh Borough Council
Wessex Academic Health Science Network
Hampshire & Isle of Wight Fire & Rescue Service
Hampshire Local Optical Committee
NHS Hampshire Hospitals NHS Foundation Trust
Portsmouth City Council
University of Portsmouth
Fareham Borough Council
East Hampshire District Council
Practice Plus Group Hospital, Southampton
NHS Health Education Wessex
HIVCA Hampshire & Isle of Wight VCSE Health and Care Alliance
Portsmouth Age UK
Rushmoor Borough Council
Healthwatch Isle of Wight
Wessex Voices
Healthwatch Southampton
NHS Solent NHS Trust
NHS Portsmouth Hospitals University NHS Trust
Basingstoke and Deane
Isle of Wight Council
New Forest District Council
Healthwatch Portsmouth
Healthwatch Hampshire
Police & Crime Commissioner Hampshire & Isle of Wight
The Princess Royal Trust for Carers in Hampshire
Leonard Cheshire
NHS Isle of Wight NHS Trust
Hampshire and Isle of Wight Local Dental Committee
NHS Southern Health NHS Foundation Trust
Mountbatten
Rowans Hospice
Hive Portsmouth
Winchester City Council
Isle of Wight Care Partnership
Southampton Solent University
Contemplation
Wessex Pharmacy
Test Valley Borough Council
Barnardos
Hampshire Care Association

Intention is to have this or just organisation names if that's preferred) on inside cover of the document

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Foreword

Building a better future together

The Hampshire and Isle of Wight Integrated Care Partnership brings together a broad alliance of partners whose key focus is centred on improving the health, happiness, wealth and wellbeing of the population. Building on our strong track record of working together as partners and with local people, we look to the future with great optimism. We are united in our ambition to work with communities to create a society in which every individual can truly thrive throughout the course of their life, from childhood through to old age. Our mission is to deal with the pressures and challenges of today, seize opportunities and together build a better future.

Through working closely with local communities, with regard to health and care, we know that people want:

- More choice and control over their own health and wellbeing
- Clear, timely and accessible information and communication to support them to better manage their own lives, including their health and care, and
- To be able to access a greater range of services and resources from their homes and communities, making the best use of technology where appropriate.

Providing better joined up services in Hampshire and Isle of Wight

We share a vision of being one of the best health and care systems in England, drawing on national and international innovation and research to support our work. Our strategy requires a commitment from all partner organisations across all sectors to work together in new and different ways to address our challenges and transform our health and care system. We aim to address the challenges people experience in accessing services and to ensure that services feel joined up and seamless to the people using them.

This interim strategy, our first as a new integrated care partnership, is ambitious. It is set against a challenging backdrop. Local people are experiencing widening inequalities, varied access to services and in some cases, poor experiences of health and care support. The Covid-19 pandemic and significant increases to the cost of living have placed additional pressure on households and individuals, as well as on voluntary, community and public sector resources including education, housing, fire, police, social care and health services. Demand for health services is increasing more quickly than its funding and more quickly than we can recruit and train staff. Funding levels in social care have been repeatedly cut for over a decade, whilst care demands have continued to rise. The November 2022 Autumn Statement is positive for health and care finances but challenges remain. Rising inflation, increasing energy prices and government fiscal policy, impact households and businesses across the country, and place additional pressure on already overstretched public and voluntary services.

We know too, that staff across our various organisations continue to work incredibly hard under continued strain and that the impact of the pandemic is far from over. Recruiting, developing, supporting and retaining outstanding staff across all partner organisations is a core strategic priority for us as a partnership, to enable us to deliver excellent outcomes and services for local people, as well as developing new roles. We want all colleagues in employed and voluntary roles within Hampshire and Isle of Wight to feel they can make a fulfilling contribution and build a rewarding career.

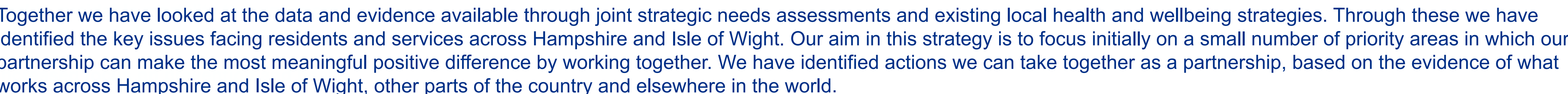
It is vital that we work on our priorities together to provide a health and care service fit for all for the future

Across our system, we have lots of plans, strategies and insight. Through the integrated care partnership, we are embracing the opportunity to better coordinate our efforts and strengthen the golden thread which connects us, our services and our support for local people. We are committed to working together to explore new options to make best use of the collective resources available. This interim strategy is a strong first step and will continue to evolve and build momentum as we develop how we work together. We would like to thank the huge number of colleagues and members of our local communities for their input in shaping this interim strategy and their ongoing commitment, insight and support.

We are ready for the opportunities ahead and we are committed to working together to provide the best possible care and support, and ultimately, to improve the health, happiness, wealth and wellbeing of local people.

Developing our interim strategy

Our interim strategy has been created through our Integrated Care Partnership, rooted in the needs of local people and communities.


Together we have looked at the data and evidence available through joint strategic needs assessments and existing local health and wellbeing strategies. Through these we have identified the key issues facing residents and services across Hampshire and Isle of Wight. Our aim in this strategy is to focus initially on a small number of priority areas in which our partnership can make the most meaningful positive difference by working together. We have identified actions we can take together as a partnership, based on the evidence of what works across Hampshire and Isle of Wight, other parts of the country and elsewhere in the world.

This interim integrated care partnership strategy provides a strategic direction and key commitments at a headline level. It is not a detailed operational plan. Our local authorities and the NHS are required to give full attention to the partnership strategy in considering how we plan, commission and deliver services. The integrated care board and NHS partners take into account this partnership strategy when developing more detailed delivery plans to support the national requirement for a five-year NHS 'joint forward plan' by April 2023.

Information and people involved in shaping this strategy

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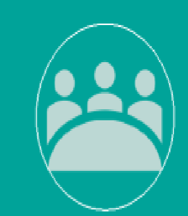
The views of local people and other stakeholder insights

Healthwatch, Hampshire Together and Isle of Wight public engagement, workforce and digital strategy coproduction, community engagement events, staff engagement, co-design workshops, focus groups, surveys

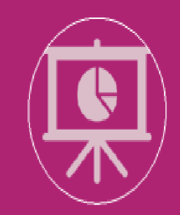
Joint strategic needs assessment and Health and Wellbeing Board strategies

Portsmouth, Southampton, Isle of Wight and Hampshire joint strategic needs assessments and strategies, plus the combined system wide needs assessment and covid impact needs assessment



Partner perspective, priorities and strategies

Councillors; governors; public health; voluntary sector; strategy, workforce, finance, nursing, medical and other health & care professionals; fire; police; education; adult & childrens services; housing; clinical cabinet; prevention & inequalities, digital, quality & transformation boards; system chiefs; Health & Wellbeing Boards



Other data, evidence and information

Marmot Review, Care Quality Commission, NHS Staff Survey, Hospital Episode Statistics, financial & workforce returns, NHS payments to General Practice, Skills for Care workforce estimates, reference costs, Office for Health Improvement and Disparities; Office for National Statistics

1. **We reviewed the available data and evidence** (Hampshire and Isle of Wight Joint Strategic Need Assessments, Health and Wellbeing strategies, system diagnostics)

2. **We worked with our local communities and across partner organisations to understand their perspectives and priorities** – we had multiple conversations with the integrated care partnership and in other focus groups and meetings with colleagues to inform and our themes for initial focus as a partnership.

3. **We identified five priority areas for initial focus:** children and young people; mental wellbeing; prevention of ill health and promotion of healthy lifestyles; workforce; digital and data. We continued working with all partners to identify data, insights and evidence around each of these themes.

4. We held a workshop on 28 September 2022 in which members of the public and colleagues **reviewed the evidence** under each theme and **created a longlist** of ideas for our joint work as a partnership on our five priority areas. Following the workshop we continued to work with all partners to flesh out these ideas.

5. We agreed the **priority areas** for our interim strategy. These are the areas around which we will focus our early work together as a new partnership. We have each committed to working together to seize opportunities to enhance our existing work in these areas. It is important to note that this strategy does not set out all the work happening across Hampshire and Isle of Wight. Furthermore, we will review our strategy regularly as a partnership to ensure our priority areas of focus are relevant and that we make continuous progress against them. This will include working with health and wellbeing boards to further develop, implement and refresh our partnership strategy.

This strategy:

- ✓ builds on **work already completed** (including the joint strategic needs assessments and health and wellbeing strategies)
- ✓ focuses on **better integration of health, social care, wider public sector and voluntary sector services**
- ✓ sets priorities for joint working where **collective working (beyond place) is most helpful**
- ✓ Is **co-developed** with a wide range of partners
- ✓ will **be updated regularly** to reflect the changing needs of local people and opportunities to work even more effectively together

Our strategy on a page

Stand by to update with final version

Our shared aims

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development.

Our challenges

Our population is growing and ageing. Improvement in life expectancy has stalled and begun to fall. Vulnerable people are dying younger and suffering poorer health than the general population. Inequalities are getting worse and drive worse outcomes. Challenges in workforce supply, funding, demand for services outstripping supply, impact of Covid-19 and cost of living. Without check inequalities will grow, years lived in poor health will increase and services will not cope.

A radically different approach

Working together across all partners to take a community-centred approach to wellbeing. Seizing the opportunities offered by working together as a system and partnership with a mandate to use collective resources in new and different ways to build a better future - health, happiness, wealth and wellbeing.

Priority areas: Themes that emerged from evidence and conversations in Hampshire and Isle of Wight

- **Children and young people** We want all children to get the best possible start in life, regardless of where in Hampshire and Isle of Wight they are born.
- **Mental wellbeing** We want mental wellbeing to be at the forefront of all that we do and to ensure as much importance is given to mental wellbeing as physical health.
- **Promoting good health and providing proactive care** We want to enable every individual to live more of their life in a state of good health and be able to access resources and services in their communities.

Initial areas of focus for the partnership

- **Work to ensure the "best start in life" for every child** by focussing on the care and support that families receive in the first 1000 days of a child's life
- **Providing proactive, integrated care for people with complex** needs to provide care closer to home and shift focus from cure to prevention
- **Improving social connectedness (reducing social isolation)** to enhance people's physical and mental health and wellbeing
- **Supporting people with the cost of living** to reduce the impact of financial pressures on people's lives
- **Better supporting people affected by childhood trauma** by adopting a trauma informed approach
- **Providing healthy lifestyles and mental wellbeing support in community settings** for examples schools and youth groups, community centres

We will focus on these areas to enable delivery of our priorities

- **Our workforce:** We want to ensure we can attract, recruit and retain people with the right skills and values to enable provision of high quality health and care services for the population of Hampshire and Isle of Wight. .
  - **Build workforce capacity to meet demand**
  - **Ensure the availability of the right skills and capabilities**
  - **Ensure people who provide services are well supported and feel valued**
- **Digital solutions, data and insights:** We want to harness the benefits that digital solutions can offer and ensure they are available to everybody, regardless of age and household income
  - **Empower people to use digital solutions**
  - **Support our workforce**
  - **Improve information sharing between IT systems**
  - **Improve our digital solutions**

Developing the "Hampshire and Isle of Wight way"

As we work together to deliver our priorities, we will continue to learn together, and build our culture, capabilities and collaboration as a new integrated care partnership: working with communities; adopting a continuous learning approach; developing a shared understanding of our opportunities and challenges, and shared vision; focusing on outcomes; building a high trust and high support culture; drawing on insights from all partners; listening to each other; focussing on priorities that resonate with all partners; making the best use of collective resource and capacity, strengthening our population health approach and developing our approach to collective assurance and accountability.

Contents

01	02	03	04	05	06
Introduction and context	Insights	Our priorities	Delivering the strategy	Sign off and review	X
	Pages X		Pages X	Pages X	Pages X
• DESCRIPTIO	• DESCRIPTION	• DESCRIPTION	• DESCRIPTION	• DESCRIPTIO N	• DESCRIPTIO N

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Introduction and context

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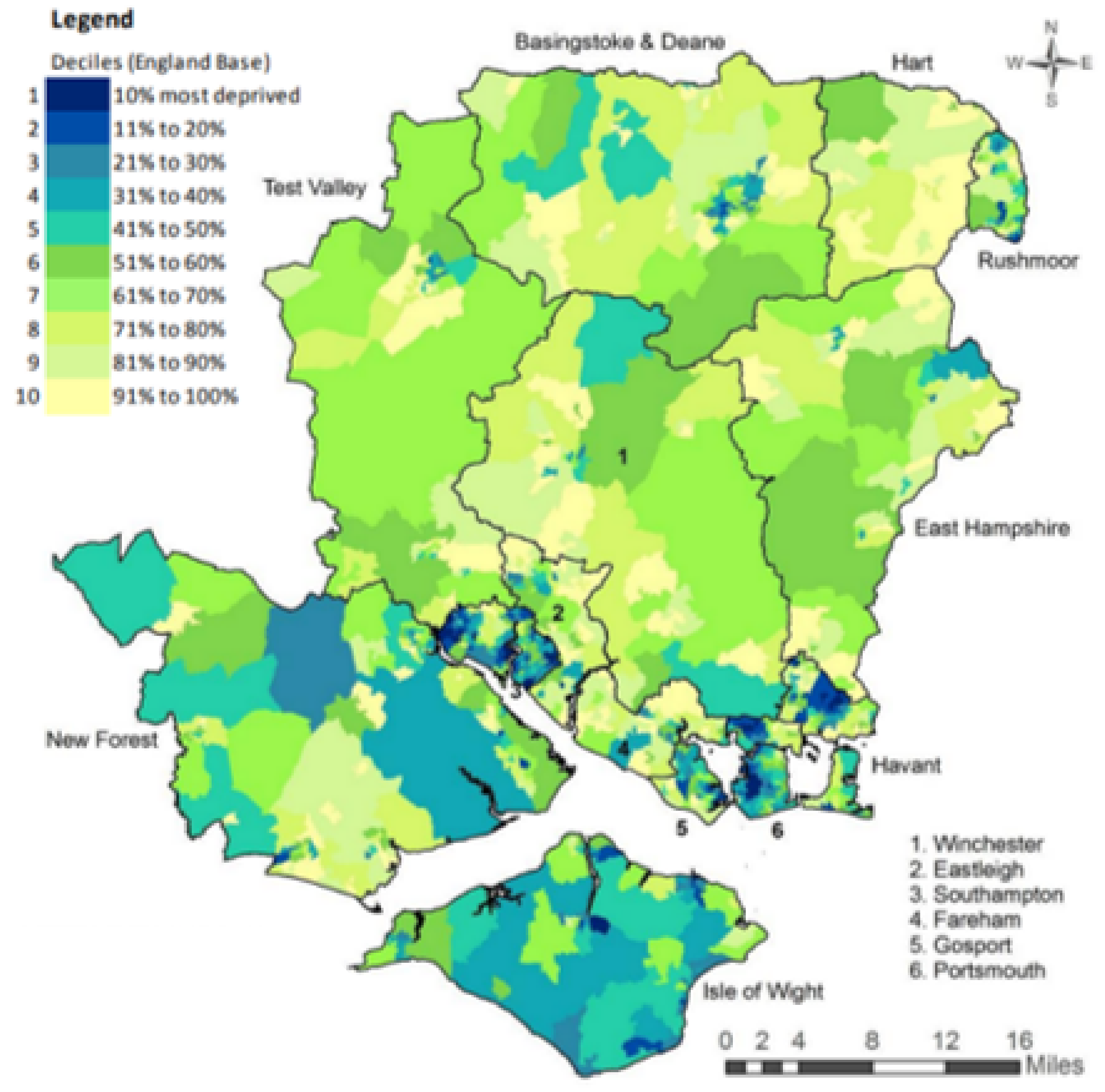


The population we serve

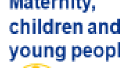
The Hampshire and Isle of Wight integrated care system serves a population of 1.9 million people and is the 10th largest of the 42 systems across England. Our four places – Hampshire, Portsmouth, Southampton and Isle of Wight - are the foundation of our system.

Overall, our population is ageing and living with increasing frailty and multiple health needs, especially in rural areas, particularly west Hampshire and the Isle of Wight. In urban areas such as Southampton and Portsmouth, the population is younger (particularly owing to university students) and more ethnically diverse here and in north-east Hampshire compared to the rest of the area (overall 93.8% white). There are also higher levels of deprivation and mental health vulnerability in these areas. The age of people living on the Isle of Wight is similar to other places popular with retirees, but more people live alone. We also have coastal communities; 92.7% of the Island's population are resident in areas defined as coastal. These areas have lower life expectancy and higher rates of many diseases in comparison to non-coastal areas.

Steeped in iconic history, areas of outstanding natural beauty, and hundreds of miles of coastline, this is a beautiful part of one of the most prosperous countries in the world – but we know that not all members of our community are in a position to experience it as such. In Hampshire and Isle of Wight, healthy life expectancy has decreased in most areas, meaning people are living more of their lives in poor health.

This is particularly the case for people living in the most deprived areas. Smoking, poor diet, physical inactivity, obesity and harmful alcohol use remain leading health risks, resulting in preventable ill health.

We know that baseline levels of health, as well as people's experience of public services, are not the same for everybody and can vary depending on where somebody was born and lives as an adult, their level of income and education and factors such as ethnicity, gender, age and sexuality. This is known as experiencing **health inequalities**; addressing these inequalities in Hampshire and Isle of Wight is a priority that runs throughout this strategy.

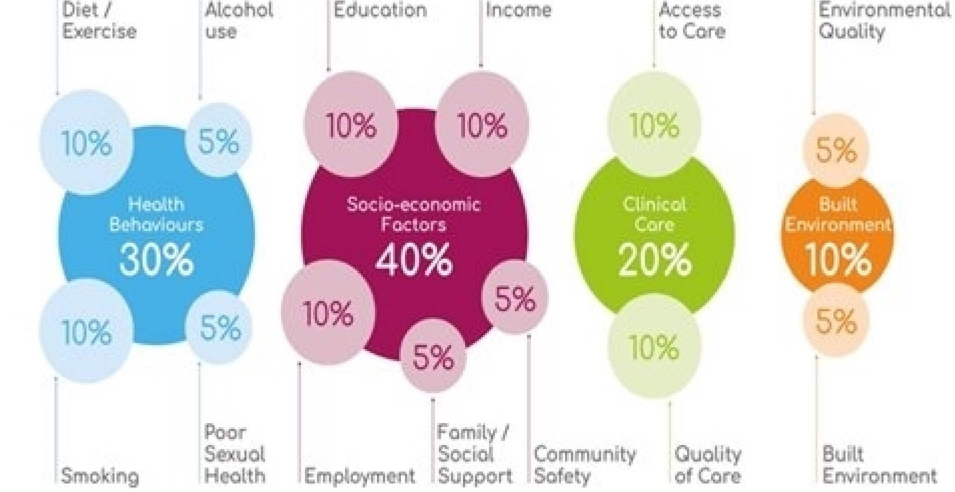
Demographics	In the next 5 years, the 75+ age group is expected to grow by 18% with likely increases in complex multimorbidity, a big driver of health service need, particularly in west Hampshire and Isle of Wight. But younger populations in Southampton and Portsmouth drive different needs. Cancer and circulatory disease accounted for just over half of the deaths (51%) across Hampshire and Isle of Wight in 2020. Ethnic diversity varies across the patch and is increasing overall.
Deprivation	Life expectancy and healthy life expectancy at birth are lowest for people living in more deprived areas of the patch. On average, people in the more deprived areas live a shorter life than those in the least deprived areas (3 years less for men and 2.8 years for women). They are also more likely to spend more of their life in poor health.
Maternity, children and young people 	There were 18,945 births in 2020, continuing the decrease in birth rate observed in recent years. Smoking rates among pregnant women (9.1%) are above the national ambition of 6% by end of 2022. Many babies and mothers would have missed out on the best start in life during the Covid-19 pandemic, which also led to increasing childhood obesity, mental health disorders and missed vaccinations.
Behaviours	Smoking (at 92.7% recording is lower than England), poor diet, physical inactivity, obesity and harmful alcohol use are leading health risks, driving preventable ill health. Tobacco, high body mass index and high blood sugars drive the most death and disability across the system.
Inequalities	Several population groups across Hampshire and the Isle of Wight experience more health risks and outcomes compared to England. People in disadvantaged areas are at greater risk of having multiple conditions and that too, 10 to 15 years earlier than people in affluent areas. Trends for both Southampton and Isle of Wight show increases in male life expectancy inequality. Additionally, Covid-19 has exposed, exacerbated, and created new health and social care inequalities.
Ill health and multimorbidity	Southampton and Portsmouth have higher preventable, premature death rates due to cancer, cardiovascular, liver and respiratory disease compared to England, again highlighting the focus on prevention. Deaths from these key causes are also major contributors to the gap in life expectancy between the most and least deprived quintiles across the system. Cardiovascular disease is the single biggest condition where lives can be saved. These issues need to be tackled through effective public health measures and primary prevention.

Produced by the Hampshire & Isle of Wight, Southampton and Portsmouth Public Health Intelligence Teams

The issues that affect our health and wellbeing

Hampshire and Isle of Wight

As is the case elsewhere in the United Kingdom, people are dying earlier than they should due to preventable and avoidable ill health and there are wide inequalities in life expectancy. Almost every aspect of our lives – our jobs, homes, access to education, public transport and whether we experience poverty, racism or wider discrimination – impacts our health and, ultimately, how long we will live. These factors are often referred to as **the wider determinants of health**.



SOURCE Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute in US to rank countries by health status

Long term conditions: Around 30 per cent of all people with a long-term physical health condition also have a mental health problem with a higher proportion reporting high levels of anxiety

Housing: Those in rented accommodation are more likely to feel lonely often, especially in 16–24-year-old population groups

Health behaviours: Adults with depression are twice as likely to smoke as adults without depression. People with schizophrenia are three times more likely to smoke than other people and tend to smoke more heavily.

Social connectiveness: Those with an underlying health condition more likely to feel lonely often – especially in the younger 16–24-year-old population groups

The impact of deprivation

Life expectancy and healthy life expectancy at birth are lowest for people living in more deprived areas. On average, people in the more deprived areas of Hampshire and Isle of Wight live a shorter life than those in the least deprived areas (**3 years less for men and 2.8 years for women**). They are also more likely to spend more of their life in poor health. Portsmouth and Southampton see greater levels of deprivation, ranking 57 and 55 out of 317 local authorities in England (where a ranking of 1 = the local authority with the highest level of deprivation).

Hampshire is among the least deprived authorities although there are areas that fall within the most deprived areas in the country.
10% of children in Hampshire aged 0 to 15 years are living in income deprived families, and9% of residents aged 60 or over experience income deprivation

Isle of Wight is the 80th most deprived authority in England. 92.7% of the Island's population are resident in areas defined as coastal and these coastal areas have lower life expectancy and higher rates of many diseases in comparison to non-coastal areas.Just over half the population of the Island lives in area which are in the three deciles of highest deprivation.

Portsmouth is ranked 57th most deprived authority in England. 13% of Portsmouth's population live in the 10% most deprived areas nationally, and over 60% are in the most deprived two quintiles.
25% of households in Portsmouth are in relative poverty. In 2019/20 17% of children were in absolute low-income families (before housing costs). This varies from 29% of children in the most deprived ward to 7% of children in the least deprived ward.

Southampton is ranked 55th most deprived authority in England. 28% of Southampton's population live in neighbourhoods within the 20% most deprived areas nationally.

The challenging environment in which services are operating

Health Inequalities

Some communities experience significantly poorer **access, outcomes and life expectancy** than the rest of our population. In Hampshire and Isle of Wight we see:

- Higher levels of emergency care compared to the rest of England, especially in more deprived areas, where access to primary care, outpatient care and planned care are lower.
- Deaths from cancer, circulatory and respiratory diseases are the greatest causes of the differences in life expectancy between the most and least deprived. More deprived areas see higher levels of heart disease, diabetes, chronic obstructive pulmonary disease and mental health issues. People living in these areas are also more likely to experience not just one, but multiple ongoing health conditions.
- A boy born in our most deprived areas will live on average between 6.1 years to 9.1 years less compared to a boy born in our least deprived area, and for a girl, between 2.3 years to 5.5 years less.
- Covid-19 has created additional health and social care needs and disproportionately impacted people living in more deprived areas, people with learning disabilities, older people, men, some ethnic minority groups, people living in densely populated areas, people working in certain occupations and people with existing conditions.
- Premature mortality in people with severe mental illness is higher than the national average on the Isle of Wight, Southampton and Portsmouth.

Across Hampshire and Isle of Wight, these are some of the differences between the most deprived 20% of residents and the least deprived 20%:

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Our strategy is set in the context of an increasingly difficult environment for all partner organisations.

Although NHS funding has not decreased in real terms, demand for services increases faster than the funding. The NHS is responding to ever more complex and long-lasting care needs without an accompanying increase in resource. In local authorities, budgets for the full range of services, including housing, education, public health and social care, have drastically reduced for over a decade, whilst demand and complexity of need has continued to grow, as have challenges sustaining the independent sector care market.

Recruiting and retaining health and care staff remains a challenge. Local employment levels are relatively high but low skilled. National staff shortages have been further exacerbated by the Covid-19 pandemic and the current cost of living. Meeting these challenges requires looking in new ways at the workforce we have, including new staffing models and the ability for staff to create meaningful career paths across health and social care. For our staff to provide excellent care to local people, they need to feel well looked after and supported and have access to opportunities to grow their skills and talents.

Cost of living pressures affect residents and services alike. Rising inflation and increased costs of energy and food have a negative impact on people's health, which drives up demand for healthcare services. Modelling carried out by Bristol University recently found that the impact of cost of living pressures over the winter could cause between 5 and 13% additional demand for urgent care and mental health services[1].

Demand for all health and care services is continually increasing. The number of people waiting for an operation has increased, but fundamental problems with flow through hospitals and workforce availability limit the rate with which services can treat people. Urgent care is currently experiencing unprecedented pressure. For both physical and mental healthcare, many people are being admitted to hospital who would be better looked after in the community. People are staying in hospital longer than is beneficial - waiting to be discharged, and then sometimes being readmitted. If emergency activity continues to rise at historic rates, there will be 15-20% more non-elective admissions by 2025. This will put increased pressure on our ability to treat people waiting for planned care procedures.

There are several drivers for these pressures including people's underlying health, difficulties recruiting staff, higher levels of absence due to Covid-19 and the amount of funding available. In winter 2021 there were around 55,000 people in Hampshire and Isle of Wight at particularly high risk of needing emergency care, of whom just over half had at least one of the following, largely preventable conditions: heart disease, chronic obstructive pulmonary disease, and diabetes.

Addressing the issues that affect people's health and wellbeing in such a challenging environment requires us to think differently. This strategy is not about simply doing more, it is about taking a radically different approach.

1 Revealed: how cost of living pressures will exacerbate emergency care demand | Comment | Health Service Journal (hsj.co.uk)

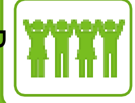
We are working with local communities to understand what is most important to them

In developing this strategy, we have reflected on insight from our local communities, which partners across the partnership have sought in a number of ways.

What we did

Surveys on a range of topics, online and face to face, in clinical and community settings, with many directly targeted to different local communities

Co-design groups, workshops and events on topics such as our community involvement approach, digital transformation and the development of the new integrated care partnership

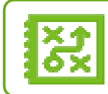


Attended local community events, both in person and virtually

Discussed issues at regular Integrated Care Board and other groups with representatives from across communities

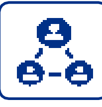
Focus groups on a range of topics

Funding partners such as Healthwatch and community groups to undertake targeted research



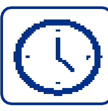
Engagement programmes to support procurement and transformation plans

What we heard

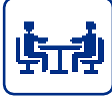


People want more join up between different services, from GPs to hospitals to social care; education and housing too

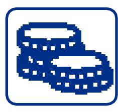
People want to be more involved in how their care is delivered, to have better communication with health and care services, and be clearer about what is available to them



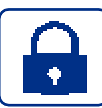
Access is an issue, with people identifying the need for more specialist access and shorter waiting times, and more consistent support services across our geography



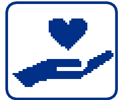
Whilst people say digital technology has its benefits, it is important to ensure that no-one is left behind. Face to face appointments are still highly valued



Cost of living is a concern across the system. Also people see opportunities to improve and expand the health and care workforce including use of volunteers



Other issues weigh on people too. In rural areas, equipment and plant theft are big concerns. In urban areas people are concerned with protecting their homes and property



Carers and young carers support, and greater collaboration with schools, primary care and other health services is vital

Our response to the needs of our population is primarily through our work in local places

This strategy has been developed in collaboration with local authorities to ensure this strategy builds on the work of our four health and wellbeing boards and their strategies and plans in our four local places - Hampshire Southampton, Portsmouth and the Isle of Wight.

Our strategy identifies a small number of priority areas where there is an opportunity to add value across our four places, recognising that most of the work undertaken to tackle health inequalities, improve health outcomes and service delivery, and contribute to social and economic development is delivered in local places.

These are the themes that are common to all four local health and wellbeing strategies:

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Theme	Priorities
Children and Young people	Reduce Inequalities Work with parents, families, schools and early years settings Improve physical wellbeing and improve lifestyles Improve emotional wellbeing and mental health
Living Well and Improving Lifestyles	Encourage healthier lifestyle choices and healthy approaches in schools and organisations Promote mental wellbeing and reduce mental ill health Promote active travel, create a greener, cleaner environment
Connected Communities	Joined up approaches across providers Building community networks Building on social capital
Housing	Ensure residents are able to live in healthy and safe homes Ensure home environments enable people to stay well Recognise and ensure that communities and families are not adversely impacted through poverty

Place	Priorities
Hampshire	Enable planning for older age living Ensure Palliative Care Collaboration is in place Support those at end of life to be in preferred setting Encourage improvement in skills and capacity to have early conversations on end of life Improve bereavement support and service locally
Isle of Wight	Invest in prevention and early intervention to help health and wellbeing Improve housing standards and reduce fuel poverty, social isolation and loneliness Include health inequalities in policy development and commissioning Reduce health inequalities gap in the city
Portsmouth	Provide immediate support to people in financial hardship Helping people access the right support at the right time Repair relationships to support our most vulnerable Develop stronger models of support for landlords and tenants for longer, successful tenancies Develop models of housing that suit individual needs Implement Homelessness and Rough Sleeping Strategy to provide support for the most vulnerable
Southampton	Support people to live active, safe and independent lives and management their own wellbeing Reduce inequalities in health outcomes, make Southampton a healthy place to live and work with strong and active communities Ensure people in Southampton have improved health experiences as a result of high-quality integrated service

The work we do together as a whole integrated care system complements and supports the work that we do together in our four places

What is an integrated care system?

NHS England defines an integrated care system as "partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area." (NHS England » What are integrated care systems?)

The purpose of integrated care systems is to bring partner organisations together to:

Improve outcomes in population health and healthcare

Tackle inequalities in outcomes, experience and access

Help support broader social and economic development

Enhance productivity and value for money

Integrated Care Systems

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Collaborating as an integrated care system is expected to help health and care organisations to tackle complex challenges, including:

Every part of our integrated care system has a role to play in delivering the priorities set out in this strategy.

Our **four local places** analyse the health and care needs of their residents and set local strategies for meeting these needs in their area. Their work feeds into and informs this partnership interim strategy document. The four places take local action to deliver for the needs of their local communities alongside the priorities agreed in this document.

The Integrated Care Partnership develops the strategy to address root causes of health and wellness, tackle health inequalities and bring partners together to work together in new ways. The Integrated Care Partnership sets strategic priorities based on sound evidence and that are within our gift to tackle as a partnership.

Our **Integrated Care Board** is responsible for planning NHS services across Hampshire and Isle of Wight and allocating resources across all health services. The integrated care board will ensure that the planning, quality monitoring, improvement and transformation of health services aligns and contributes to the priorities described in this partnership strategy.

Each organisation in our integrated care system sets strategies that address the challenges and opportunities facing their specific organisation. As partners that have worked together to agree partnership strategic priorities, these organisations will ensure that their organisational strategies contribute to the delivery of the priorities set out in this document.

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Our strategic priorities

SECTION IN DRAFT

Core to our strategy: a new way of working together in partnership

To enable the best possible outcomes for the people of Hampshire and Isle of Wight, we are thinking and acting beyond the core services we deliver (and the way we currently deliver these services) to focus on improving the overall wellbeing of our population. We know that health and care is impacted by multiple factors including education, housing, employment and environment. We also know that the links between our services and the way people access them, and 'flow' through them – can make a big difference to experiences, outcomes and the efficiency of these services. We can only address these factors through partnership working between all public services, the voluntary, community, faith and social enterprise sector, our local businesses and employers and, most importantly, communities themselves. To do this we need to move towards:

- a radically different and more ambitious partnership approach to supporting people to build health, happiness, wealth and wellbeing, recognising the importance of the wider determinants of health and focus on reducing health inequalities.
- high-quality **care and support for our population** built on collaboration between all partners removing any artificial divides and using our collective resources to best affect, making decisions based on data, intelligence and insight
- A model **of community empowerment** which listens to and works alongside communities and enables and supports people to live healthy, independent lives, reducing the need for services and ensuring that, when people do need services, we deliver consistently **high quality, efficient, effective services** wherever people go in Hampshire and the Isle of Wight.

Hampshire and Isle of Wight partners have worked together over the last year to design the integrated care partnership; including what our priorities should be and how we will deliver them as a system. Whilst the partnership is still in its formation there are a number of features which will support in the development of the integrated care partnership:

- ✓ Our partnership will develop and change over time as we work together and learn more
- ✓ We will build from what is already working well in the system
- ✓ Our places are the foundation of the partnership
- ✓ We have opportunities through coming together at scale and will focus on what we can add to support people across our system

On 28th September 2022 we held an event with a wide range of stakeholders, who will be involved in the integrated care partnership moving forward, to help us to determine our strategic priorities. Together, we developed a set of principles based on feedback for how we should work as a partnership:

1. use the voice of the public, communities, patients and our staff to shape our work
2. use evidence on which to base our decisions, looking critically at the wider determinants of health inequalities, innovative and evaluative in our approach
3. focus on where we can make improvements and the experience people have of all our services, making changes centred around local people and populations
4. keep engaging across the system so that:
   - our priorities are co-produced and all partners have an opportunity to shape them;
   - we understand the priorities driving each of our partner organisations;
   - all partners can recognise the importance and relevance of whole system strategic priorities.
5. not seek to detract from organisations' existing strategies or health and wellbeing board plans. Our work should supplement and support existing plans and strategies.
6. use clear language to describe our work.

Five priority areas emerged from our initial assessment of data and understanding insights from communities and colleagues. Working together in our new partnership, we will initially focus on these five priority areas:

Mental wellbeing

Good health and proactive care

Children and young people

Our people (workforce)

Digital and data

Selecting our priorities as a partnership

Our priorities seek to address the challenges, described on page xxx within the context of the current environment, described on page xxx, focusing on an initial, small number of priority areas for us to work together on as a new partnership over the next few years.

When deciding on our priorities, we considered the extent to which each priority was a significant problem or opportunity in Hampshire and Isle of Wight, and the potential the partnership has to make progress in terms of better meeting the needs of local people, and supporting them to lead healthier, happier, wealthier lives with an increased sense of wellbeing.

This is an interim strategy, produced during the formative months of the partnership, at the end of 2022. The partnership is committed to working together to further explore the proposed areas of focus under each of our strategic priorities, develop detailed delivery plans, and continually improve and refine the strategy to ensure our priorities remain relevant and that we make continuous progress against them.

We codeveloped the following strategy design principles to support us as a partnership, in decided which priorities we should include in our strategy. These principles are as follows:

- ✓ People and communities have told us are important to them
- ✓ Address the root causes of what affects people's health and quality of life
- ✓ Address health inequalities
- ✓ Address at least one of the following points:
  - Making care and services more joined up for people
  - Making it easier for people to access the services they need
  - Giving people more choice and control over the way their care is planned and delivered
- ✓ Affects more than one geographical area (i.e. place) and warrants a system-wide focus. (If the priority area only affects one place then it is better sitting in a local health and wellbeing strategy)
- ✓ Are supported by a strong, evidence-based case for change – for example there are currently poor outcomes in this area
- ✓ Need all system partners to work together to tackle them and make best use of our combined capacity and capabilities
- ✓ Are recognisable and relevant to all system partners and support existing strategies
- ✓ Are within our gift as a partnership to impact.

The intended impact of our strategy

Ultimately, we intend for our work together as a partnership to improve the health, happiness, wealth and wellbeing of the local population.

In doing so, over the medium to longer term, this will:

- Reduce the demand for health and care services
- Enable us to further improve the quality of service we provide
- Relieve pressure on the people who work in our organisations
- Enable us to live within our financial means

In the meantime, partners in local places; partnerships working with people with very specific needs, for example around housing; and organisations with common features, such as our primary care colleagues, acute hospital trusts and the voluntary and community sector, will continue to work together to do all they can to meet the health and care needs of local people in increasingly effective ways.

In combination, through our immediate and longer-term work together, across the whole system and more locally, we deliver on the intended benefits of integrated care, as previously described:

Our strategic priorities

Stand by to update with final version

Our shared aims	Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experience and access	Enhance productivity and value for money	Help the NHS support broader social and economic development.
Our challenges	Our population is growing and ageing. Improvement in life expectancy has stalled and begun to fall. Vulnerable people are dying younger and suffering poorer health than the general population. Inequalities are getting worse and drive worse outcomes. Challenges in workforce supply, funding, demand for services outstripping supply, impact of Covid-19 and cost of living. Without check inequalities will grow, years lived in poor health will increase and services will not cope.			
A radically different approach	Working together across all partners to take a community-centred approach to wellbeing. Seizing the opportunities offered by working together as a system and partnership with a mandate to use collective resources in new and different ways to build a better future - health, happiness, wealth and wellbeing.			
Priority areas: Themes that emerged from evidence and conversations in Hampshire and Isle of Wight	**Children and young people** We want all children to get the best possible start in life, regardless of where in Hampshire and Isle of Wight they are born.	**Mental wellbeing** We want mental wellbeing to be at the forefront of all that we do and to ensure as much importance is given to mental wellbeing as physical health.	**Promoting good health and providing proactive care** We want to enable every individual to live more of their life in a state of good health and be able to access resources and services in their communities.	
Initial areas of focus for the partnership	**Work to ensure the "best start in life" for every child** by focussing on the care and support that families receive in the first 1000 days of a child's life			
	Providing proactive, integrated care for people with complex needs to provide care closer to home and shift focus from cure to prevention			
	Improving social connectedness (reducing social isolation) to enhance people's physical and mental health and wellbeing			
	Supporting people with the cost of living to reduce the impact of financial pressures on people's lives			
	Better supporting people affected by childhood trauma by adopting a trauma informed approach			
	Providing healthy lifestyles and mental wellbeing support in community settings for examples schools and youth groups, community centres			
We will focus on these areas to enable delivery of our priorities	**Our workforce:** We want to ensure we can attract, recruit and retain people with the right skills and values to enable provision of high quality health and care services for the population of Hampshire and Isle of Wight. .	**Build workforce capacity to meet demand**	**Ensure the availability of the right skills and capabilities**	**Ensure people who provide services are well supported and feel valued**
	Digital solutions, data and insights: We want to harness the benefits that digital solutions can offer and ensure they are available to everybody, regardless of age and household income	**Empower people to use digital solutions** / **Support our workforce**	**Improve information sharing between IT systems**	**Improve our digital solutions**
Developing the "Hampshire and Isle of Wight way"	**As we work together to deliver our priorities, we will continue to learn together, and build our culture, capabilities and collaboration as a new integrated care partnership:** working with communities; adopting a continuous learning approach; developing a shared understanding of our opportunities and challenges, and shared vision; focusing on outcomes; building a high trust and high support culture; drawing on insights from all partners; listening to each other; focussing on priorities that resonate with all partners; making the best use of collective resource and capacity, strengthening our population health approach and developing our approach to collective assurance and accountability.			

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Initial areas of focus for the partnership

- **Work to ensure the "best start in life" for every child** by focussing on the care and support that families receive in the first 1000 days of a child's life
- **Providing proactive, integrated care for people with complex** needs to provide care closer to home and shift focus from cure to prevention
- **Improving social connectedness (reducing social isolation)** to enhance people's physical and mental health and wellbeing
- **Supporting people with the cost of living** to reduce the impact of financial pressures on people's lives
- **Better supporting people affected by childhood trauma** by adopting a trauma informed approach
- **Providing healthy lifestyles and mental wellbeing support in community settings** for examples schools and youth groups, community centres

We will focus on these areas to enable delivery of our priorities

Our workforce: We want to ensure we can attract, recruit and retain people with the right skills and values to enable provision of high quality health and care services for the population of Hampshire and Isle of Wight. .	**Build workforce capacity to meet demand**	**Ensure the availability of the right skills and capabilities**	**Ensure people who provide services are well supported and feel valued**	
Digital solutions, data and insights: We want to harness the benefits that digital solutions can offer and ensure they are available to everybody, regardless of age and household income	**Empower people to use digital solutions**	**Support our workforce**	**Improve information sharing between IT systems**	**Improve our digital solutions**

Developing the "Hampshire and Isle of Wight way"

As we work together to deliver our priorities, we will continue to learn together, and build our culture, capabilities and collaboration as a new integrated care partnership: working with communities; adopting a continuous learning approach; developing a shared understanding of our opportunities and challenges, and shared vision; focusing on outcomes; building a high trust and high support culture; drawing on insights from all partners; listening to each other; focussing on priorities that resonate with all partners; making the best use of collective resource and capacity, strengthening our population health approach and developing our approach to collective assurance and accountability.

Children and Young People

Hampshire and Isle of Wight

What have we heard from our communities and partners?

"Children and young people should be our first priority; they are the future of Hampshire and the Isle of Wight"

- "We know if you get it right in the first 1,000 days, then the chances of positive outcomes are massively increased, even if they then experience adversity after first three years"
- "If a child enters school with a health inequality, this gap is likely to never close"
- "Adverse childhood experiences and trauma can lead to cardio-vascular disease, poor mental health, obesity, not educated, repeat victim and perpetrator – if we can work together on it will really benefit us"
- Young carers are cut off and potentially suffering from social isolation

The outcome we want to achieve: We want all children to have the best possible start in life, regardless of where in Hampshire and Isle of Wight they are born, and have positive physical, emotional and mental wellbeing.

Where we are today?

- **Best start in life:** Many babies and mothers have missed out on the best start in life during the Covid-19 pandemic, which exacerbated existing health inequalities and led to increasing childhood obesity, mental health disorders and missed vaccinations.
- **Obesity**: the England average is 9.9% in reception year - children on the Island and Portsmouth are above this, and Southampton is 9.9%. The British Medical Journal reports hospitalisation, illness and avoidable long term conditions could be reduced by 18% if all children were as healthy as the most socially advantaged.
- **Mental health:** Children whose parents have a mental health disorder, those in a family with unhealthy family functioning, and/or in lower income households are more at risk of developing a mental health disorder. 16,485 children and young people accessed NHS funded mental health services in 2021/22 (37% more children than in 2019/20). When compared to their peers, children under the care of mental health services are almost 20 times more likely to enter the judicial system. There has been a 295% increase in referrals to children and young people inpatient services since the start of the pandemic (over 50% of this for specialised eating disorder services)
- Increases in **Education Health and Care Plans** for children with Special Educational Needs and Disabilities.

What do we know works?

- If children and families **get the best start in a child's first 1,000 days** of life, then the likelihood of that child going on to achieve more through education, maximise their potential and lead healthy independent lives increases.
- **Intervening early**, redirecting resources towards prevention and working restoratively with families and individuals supports them to build on their own strengths and resilience to improve their lives. Family hubs provide additional resource in three geographies to extend and deepen family support programmes and support parents early on in their parenting journey
- **Strong integrated pathways of support** eg: there is strong evidence in Portsmouth that children want school based support on healthy lifestyles and mental health support. Early support for child emotional wellbeing including schools based programme - e.g. My Happy Mind.
- **Peer support** groups for pregnant women and their families
- Focused, family-based multi-professional support for **neurodiverse children**.

Our areas of focus as a new partnership

Building on what we know works, and further research and innovation, we will work together to explore what more or different we can do in:

- Focusing on the **"best start in life" for every child** by ensuring families receive good care and support (including for their mental wellbeing) in the first 1,000 days of a child's life
- **Improving access and mental health outcomes** for children and adolescent mental health services
- **Working with schools on prevention and early intervention** to reduce the risk and increase protective buffers at an individual, relationship, community and societal level. Meeting the health needs of vulnerable groups including 'looked after children' and care experience young people
- Continuing our **trauma-informed approach** led by Public Health, Police and Crime Commissioner and Hampshire Constabulary
- **Co-locating services** to enable a family-based approach to accessing services, co-designed with parents and carers to ensure a common language and understanding across services
- Further developing a **joint children's digital strategy**

What are the benefits for:

Local people: reduced health inequalities, improved mental health and wellbeing (reduced anxiety, reduced suicides, reduced eating disorders) and physical health, improved educational attainment, better inclusion and engagement in schools, societal benefits e.g. reduction in crime
Our staff: increased fulfilment knowing they can deliver the above, plus reduced pressure, increased satisfaction
Partners: positive impact on society and the economy, reduced demand for services in the future.

Mental wellbeing

Working through comments from mental health team – awaiting wording and data updates

Hampshire and Isle of Wight

What have we heard from our communities and partners?

"The non-clinical route into mental health and wellbeing support is just as important as the clinical route"

- Prioritising and promoting mental health and wellbeing is a priority across all partners, for all population age groups
- "Focus on illness is too strong and should be more of a focus on wellness"
- "Secondary care in mental health is just the tip of the iceberg - there needs to be many rafts of supporting scaffolds in place"
- "We need to challenge ourselves that access is the same and equitable", and continue to improve parity of physical and mental health
- We need to state tangible solutions with ambitious targets and do a few things well

The outcome we want to achieve: improve the population's mental health, emotional wellbeing and physical health, by focussing on prevention and working more closely with communities in the provision of excellent, equitable, joined-up services, care and support.

Where we are today?

- **Prevalence of mental health conditions varies across our geography**, e.g. the Island has the highest prevalence of severe mental illness, followed by Southampton and Portsmouth
- **Mental health problems have greater and wider impact in some groups than others**, e.g. the largest proportion of the population claiming Employment Support Allowance due to mental health problems is those aged 18-24yrs; impacts are inequitable in deprived and ethnic minority communities
- **We are below the national average and peer top quartile for some services**, e.g waiting times for children and young people, people living with a serious mental illness who have not had their regular 'physical health check' in primary care, and below national targets for improving access to psychological therapies and dementia diagnosis
- **There is a mismatch between the needs of population and the capacity of services**, and this varies across our system, so some people more impacted than others
- **Far reaching mental health impact of Covid19 still to be fully realised**; but has exacerbated inequalities for marginalised people/groups, especially those struggling with their mental health and wellbeing before the pandemic.

What do we know works?

- **Collaboration and determined focus on prevention and early intervention** e.g. Isle of Wight's Mental Health Alliance, partnering between Shout mental health text service & 111 Mental Health Triage Team, social prescribing.
- **Single points of access and 'no wrong door' approaches** - through join up between local authorities, primary care and voluntary care / social enterprises, improve the quality and availability of urgent care
- **Lessening the stigma around mental health and wellbeing** – coordinated communication campaigns between services / organisations e.g. 'Its OK not to be OK'
- **Digitally enabled support and care**, e.g.: psychological therapies and advice and information
- **Adopting 'outreach' approaches** through other healthcare interactions e.g. dentists, opticians to identify individuals who may be at risk
- **Expanding access to support in local communities** via innovation between partners e.g. co-location of services, mobile/pop up support in 'trusted' places where people live or gather e.g. Hampshire Homeless Health Teams, Joint work with Faith Leaders (Covid 19 Vaccination)

Our areas of focus as a new partnership

Building on what we know works, and further research and innovation, we will work together to explore what more or different we can do in:

- **Emotional wellbeing** and prevention of psychological harm - including excess morbidity and excess mortality associated with severe mental illness.
- **Improving mental health and emotional resilience** for children and young people, especially as they move into adulthood, and for families, parents and carers of children
- **Better connecting people** to avoid loneliness and social isolation
- Focused work to **prevent suicide**
- **Improving access to bereavement support** and services locally, for all age groups
- **Addressing inequalities in access and outcomes and enabling people to navigate through services**
- **Supporting the mental health and wellbeing of our staff** through policy and workforce development eg: Mental Health First Aiders

What are the benefits for:

Local people: reduced health inequalities, improved mental health and wellbeing (reduced anxiety, reduced suicides, reduced eating disorders) and physical health, greater independence, and for children and young people - improved educational attainment

Our staff: increased fulfilment knowing they can deliver the above, plus reduced pressure, increased satisfaction

Partners: increased effectiveness, improved productivity and workforce supply (resulting from improved mental health and physical health and/or reduced caring responsibilities for others with mental health support needs), positive impact on the economy, unmet need recognised and addressed.

Promoting good health and providing proactive care

What have we heard from our communities and partners?

"We need to be tackling the 'causes of the causes' of people's ill health"

- If trends continue, preventable ill-health and deaths will grow, as will health inequalities and our services will become increasingly unsustainable. There is a great deal we can and are doing, but there is more we could do together
- Deprivation is often hidden in rural communities – we need to prioritise areas of greatest need/ inequality – recognising we can't do all of this at once
- There is a role for all partners in improving health of our population, not just in terms of managing the conditions that people have already been diagnosed with, but addressing some of the wider determinants of health

The outcome we want to achieve: We want to enable every individual to live more of their life in a state of good health and be able to access resources and services in their communities and to narrow the gap between the richest and poorest.

Where we are today?

- **Outcomes vary widely**, eg: some of the lowest avoidable and preventable mortality rates in some areas, other areas significantly above national median
- **Some people suffer poorer health and die younger**, eg: people with learning disabilities (life expectancy 14 years less for males, 18 years less for females), people who are homeless, gamblers, refugees carers, people with mental health needs (eg: a person with schizophrenia dies up to 20 years earlier, the last 7 years in poor health)
- **The greatest contribution in life expectancy gap** between the most and least deprived is linked to circulatory diseases, cancer and respiratory diseases
- **Stagnating lfe expectancy improvements** particularly in the more deprived areas, (especially females). Time spent in good health has decreased
- **These outcomes can be changed,** eg: smoking remains the biggest preventable killer and major contributor to health inequalities; alcohol admissions are increasing, particularly in Southampton and west Hampshire; top issues noted in patient records: 1. hypertension, 2. depression, 3. obesity
- **Feeling isolated** is linked to early death, poor health and wellbeing - social isolation is associated with a greater risk of inactivity, smoking, risk-taking behaviour, coronary heart disease, stroke, depression and low self-esteem.

What do we know works?

- **Taking a life course approach** recognising there are a wide range of protective and risk factors that influence health and wellbeing over the life span and that people's outcomes can be improved throughout life
- **Reducing health inequalities** through the life course requires a whole-of-society approach dealing comprehensively with all health determinants. We know that clinical care only contributes to 20% of an individual's health outcomes and therefore to improve our population health and wellbeing we need to focus on the other contributing factors, eg: health behaviours (smoking, diet, alcohol), socioeconomic factors (family/social support), the environment people live in (housing)
- **Promoting healthy behaviours** eg: healthy diet, healthy weight, smoking cessation - helps with major conditions i.e. cancer, depression, dementia, diabetes and cardiovascular disease
- **Better connecting people** (tackling social isolation) improves health outcomes and reduces the need for health services and residential care, supports employment and increases workplace productivity. Services which build on the community model of empowerment, like social prescribing in healthcare settings, voluntary and community befriender services and local government community connector services all have positive impacts. These services can deliver up to a 68% reduction in using services; up to 88% of people who access these services have a better understanding of their community support and a 10% increase wellbeing measures eg: connectedness to others.
- **Providing proactive, integrated care for people**, especially those with complex needs, providing care closer to home, shifting focus to prevention, and reducing reliance on support services including urgent or emergency care.
- **Core 20+5 approach** to health inequalities: focusing on the most deprived 20% of the population plus other local population groups experiencing inequalities in five clinical areas: maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension.

Our areas of focus as a new partnership

Building on what we know works, and further research and innovation, we will work together to explore what more or different we can do in:

- **Improving social connectedness and support in communities -** leveraging existing community assets and empowering citizens
- **Providing support for healthy behaviours and mental wellbeing in community settings**; targeted approaches on evidence-based issues eg: lung health checks, vaping prevention in children, visual impairment for those with learning disabilities
- **Ensuring equal importance is given to mental wellbeing and physical health** and tackling the stigma of mental health
- Supporting people to minimise the potential health and wellbeing impacts of **cost of living pressures**
- **Providing proactive, integrated care** for people with complex needs
- A **healthy ageing** approach, supporting people to benefit from smoking cessation, alcohol dependency and weight management services; building prevention into pathways regards modifiable risk factors (smoking, obesity, 5-a day, physical activity, alcohol/drugs)
- **Combining resources** on housing, mental health, refugees, homeless, rough sleepers and 'Core20+5'

What are the benefits for:

For local people: no matter what a person's circumstances are, they can be assured of dignity and security as they age; improvedhealth, happiness, wealth and wellbeing; longer lives and increased overall years of good health
For staff: more able to meet needs of local people, fulfilling work, less pressure, with a focus on prevention and early intervention
For partners: people living longer, healthier, happier, wealthier lives which reduces demand and unmet need, delivers efficiencies, improved effectiveness

Our people, digital technology and data are key to enabling us to deliver our priorities

Our people: the people that work across all our services are vital to the delivery of this strategy. We have a highly skilled, dedicated and committed workforce across Hampshire and Isle of Wight, including a huge contribution from volunteers and informal carers.

External factors lead to increased demands on services and the people that deliver them. People are living and working longer, necessitating radical changes in how we structure work, eg: flexibility, mid-career shifts, re-skilling, and delayed retirement. The health and wealth of the workforce affects the health and wealth of local people. In the NHS, 1 in 4 staff members are 'lower paid' (defined as earning up to £12.73 per hour in 2021/22, just below average UK hourly earnings). By comparison, around 4 in 5 social care employees are 'lower paid' by the same measure. Our workforce has faced unprecedented challenges over the Covid-19 pandemic and demonstrated exceptional resilience, including adopting new practices to sustain services for the benefit of local people.

Our workforce is stretched, both in Hampshire and Isle of Wight and across the country. Workforce wellbeing remains a key priority across all sectors. In June 2022 alone the NHS lost 476,900 days (nationally) to sickness and absence due to anxiety, stress and depression. As of September 2021, nearly 100,000 NHS vacant posts, and 105,000 in social care were being advertised nationally. An estimated extra 475,000 jobs are needed in health and 490,000 in social care across the country by the next decade. We recognise the imperative to re-examine the way we work and innovative delivery pathways supported by digital technology.

Workforce challenges in Hampshire and Isle of Wight

- Domiciliary care workforce shortages, particularly in Isle of Wight, south-west and south-east Hampshire
- NHS workforce supply pipelines unable to keep pace with current demand, particularly for nursing, midwifery, medical and allied health roles
- Our workforce is not representative of the communities we serve, which might then impact on the inclusivity of services we provide
- Staff morale and engagement scores are generally declining across the NHS.

Digital solutions, data and insights: harnessing the power and innovation of technology and information technology will help us to deliver better quality, more efficient care, closer to people's homes and communities, in a way that fits people's individual needs and lifestyles. Joining up data, technology and information systems will also support us to join up our care and improve services and support our workforce to be more efficient. Data held by the NHS, and generated by smart devices worn by individuals, presents opportunities to support everyone with access to their health information and personalise many more health interventions.

However, the complexity, cost and time it takes to introduce some new digital solutions, join up data and create insight we can act on continues to present a challenge. Additionally, most local people understand the benefit of digital solutions and shared data, but we must continue to be respectful of the views and preferences of those who still have reservations or are unclear. For example:

- **Sharing patient information** – a Wessex Care Records survey highlighted:
  - 86% understood their information was shared for their care and treatment, but less were aware it was shared for planning services (46%)
  - Respondents were positive about potential future uses such as sharing for planning and improving services (77%)
  - There was less support for sharing with other organisations, ie: the charities/universities carrying out research (58%), other organisations, such as councils, providing care and support (53%) and companies developing new treatments (38%)
- **Face-to-face still highly valued** – Hampshire Fire Service asked what people thought the challenges were to accessing services. Respondents said access to technology was the main barrier (46% said face to face communication was best)
- **Remote monitoring needs to be effective** – Healthwatch England asked people about their experience of remote monitoring. People said there are many benefits to blood pressure monitoring at home, including peace of mind, feeling in control and convenience, but there are serious questions about whether the benefits of better health are being realised and gaps in GP processes need to be addressed to avoid demotivating people and missing opportunities to address blood pressure problems.

Our people (workforce)

What have we heard from our communities and partners?

"Without the workforce, none of our ambitions will be achieved"

- "We can't do anything without our people. They need to be supported, inspired and have good access to continuous development.
- "[We need] a workforce that is engaged, empowered and always learning and striving to improve."
- "There is the opportunity join up our training and retention offer, including creating employment opportunities for our local population to improve their health outcomes"
- Reductions in workforce puts pressure on loyal staff and shortages are getting worse across all roles
- The rising cost of living is creating downward pressure on the real wages of our workforce and making it even harder to recruit
- Our workforce doesn't match need with some areas very well served and others (often more deprived) areas underserved
- There is some duplication in roles, especially between "first contact" staff

The outcome we want to achieve: We want to ensure we can attract, recruit and retain people with the right skills and values to enable provision of high quality health and care services for the population of Hampshire and Isle of Wight.

Where we are today?

- Untapped resources in voluntary and community sector
- Increasing sickness absence rates, eg: NHS increased to 5.2% in June 2022; 23.2% of sickness due to anxiety, stress, depression and other mental health
- Annualised growth for the health workforce is 4% per year over the past five years, but there is still shortfall, NHS vacancies at 10% in south east region April –June 2022. 2021/22 NHS staff retention rate at 14%
- At the time of the 2011 census, there were 39,437 unpaid carers across our system providing for family members or friends. The total number is now likely to be much higher. However, during Covid-19, we have seen a breakdown in unpaid carer arrangements and voluntary and community sector care support is also compromised. Many of the people being supported in this way are living with long term, often life long, care and support needs. Without the amazing commitment and dedication of unpaid carers the health and care system would quickly come to a standstill.

What do we know works?

- Concerted focus to improve diversity, inclusivity and belonging and the development of a universal workforce
- Collaboration in recruitment and retention, including international recruitment
- Making every contact count
- Health and wellbeing at work, including support for menopause and staff fast track referrals into support services
- Joining up pathways into education around healthy lifestyles into care, health and voluntary sector roles
- Levelling up through employment - securing good work is a key indicator to improve individual, and collective, health and economic wellbeing outcomes
- Organisational development networks across partner organisations to work together on development and share best practice
- 'Education to employment' projects working with schools and colleges
- Joint leadership and transformation programmes eg: Hampshire 2020 programme

Our areas of focus as a new partnership

Building on what we know works, and further research and innovation, we will work together to explore what more or different we can do in:

- Building workforce capacity to meet demand: Grow the workforce for the future by extending recruitment and working closely with education providers, building our ability to share system resources and move between organisations, harness the untapped support of volunteers and implement effective, collaborative workforce planning which accounts for labour market flows across health and care sectors and their interaction with the wider economy, designing innovative new roles with career pathways to suit tailored needs.
- Ensuring the availability of the right skills and capabilities to deliver, safe high-quality care.
- Ensuring people who provide services are well supported and feel valued, taking a system-wide approach to organisational development and support offers for our staff, including access to mental health first aid support and trauma counselling, and supporting people with unpaid caring roles, as well as improving diversity and inclusivity.

What are the benefits for:

Local people: better availability of staff with the right capabilities means better access to high quality services. There is a direct link between staff feeling supported and valued and being able to deliver high quality, compassionate care.

Our staff: increased fulfilment, increased job and career satisfaction, lower levels of stress, avoid duplication of recruitment and training requirements, feel able to deliver care of the quality to which they aspire, improved personal health and wellbeing.

Partners: improved workforce supply and pipeline; creation of new roles to support delivery of key priorities at place (e.g. case management). If staff shortages in one part of the system are addressed, this has a positive impact on workforce capacity across all sectors. Positive impact on the economy and wider determinants of health for local people employed locally.

Digital solutions, data and insights

Hampshire and Isle of Wight

What have we heard from our communities and partners?

"There is a known need for digital systems to be integrated and compatible: without this there is a decline in efficiency and collaboration"

- "A shared single picture of vulnerability is essential so that we can target activity to the sections of the population that need it most"
- "It's about the enablers. That's where we can get traction as a system"
- Systems are not connecting with each other: too many systems creates duplication. We are wasting time by not have the right access to the right equipment or networks to do work in real time.
- Increased awareness and concern about digital exclusion. This is not just about access to computers and the internet, but includes issues such as privacy, disability and access for carers.

The outcome we want to achieve: We want to harness the benefits that digital solutions can offer to our local people, carers and staff, ensuring they are available to everybody, regardless of age, disability or household income.

Where we are today?

- People are now using **digital tools for online consultations**, accessing their GP record, and to seek advice and guidance.
- **Digital exclusion** is having an increasing impact on the most vulnerable in our society. People that are digitally excluded often pay more for household bills, earn less, have lower levels of educational attainment and can suffer more from social isolation, which impacts on both mental and physical health.
- We have a **range of different IT systems** that do not all "talk" to each other.
- Our **data sets** are not yet as sophisticated or joined up as they need to be to enable excellent decision making including individual care and service planning.
- Health and care can be **slower to adopt** digital innovation.

What do we know works?

- **Giving local people more control of their care** for example by sharing your Covid-19 status or ordering repeat prescriptions through the NHS App or viewing your latest test results and communicating with your healthcare professional via MyMedicalRecord
- **Providing users with simple secure access to the information they need**, for example by providing care homes with access to the system-wide shared care record to see any new patients history such as medications and allergies.
- **Bringing information from multiple sources together in one place** and reducing the number clicks and logins, for example with single sign on to the shared care record or through electronic patient record portals.
- **Reducing unnecessary travel time** for patients and local people by providing robust secure mobile access to systems and giving patients the choice of virtual consultations.

Our areas of focus as a new integrated care partnership:

Building on what we know works, and further research and innovation, we will work together to explore what more or different we can do in the following areas:

- We will **empower local people** to use digital solutions through promoting and engagement in digital services. We will provide resources and support for local people to engage in digital to ensure equity of access to all health and care services
- We will **support our workforce** to be confident and competent in using digital solutions to provide high quality care
- We will **improve how we share information** between different IT systems and remove the organisational, digital, data and technology boundaries created by legacy systems to better support care provision and the creation of integrated datasets to support planning
- We will **continue to improve our digital solutions**, focusing initially on investment in shared electronic health and care records. We will explore digital innovations in improving health and modernising care and experience, including the use of apps and wearable devices

What are the benefits for:

Local people: can receive care at home, where appropriate and only need to say things once. People feel they are always involved and have control of their own care, can access care and information in a way that meets their individual needs and helps them to make choices about their own health and wellbeing. Our local people do not feel digitally excluded and can access to a range of services.

Our staff: can access equipment that is modern, reliable and fast, and helps productivity, releasing more time for providing care. Staff can review and update patient records when and where they need to, using joined up systems that talk to each other. Staff can easily communicate with colleagues across different organisations involved in the care of local people.

Partners: Reduced efficiencies by saving staff time and avoiding duplication; facilitates joined up care and services; enables real-time, consistent capturing of information which improves our understanding of people's needs and helps decision making; enables joined up data sets to support better planning, including our population health approach.

How we will deliver our partnership strategy

SECTION IN DRAFT

Our 'strengths based' approach

Our strategy focuses on a small number of initial priority areas to make the best use of our combined resources, including the strengths of our local communities and our ***strategic assets*** across Hampshire and the Isle of Wight. As we work together to deliver our priorities, we will also develop the way that we work together as a partnership, continuing to learn together and draw on our collective insights and talented people.

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The strength of our communities

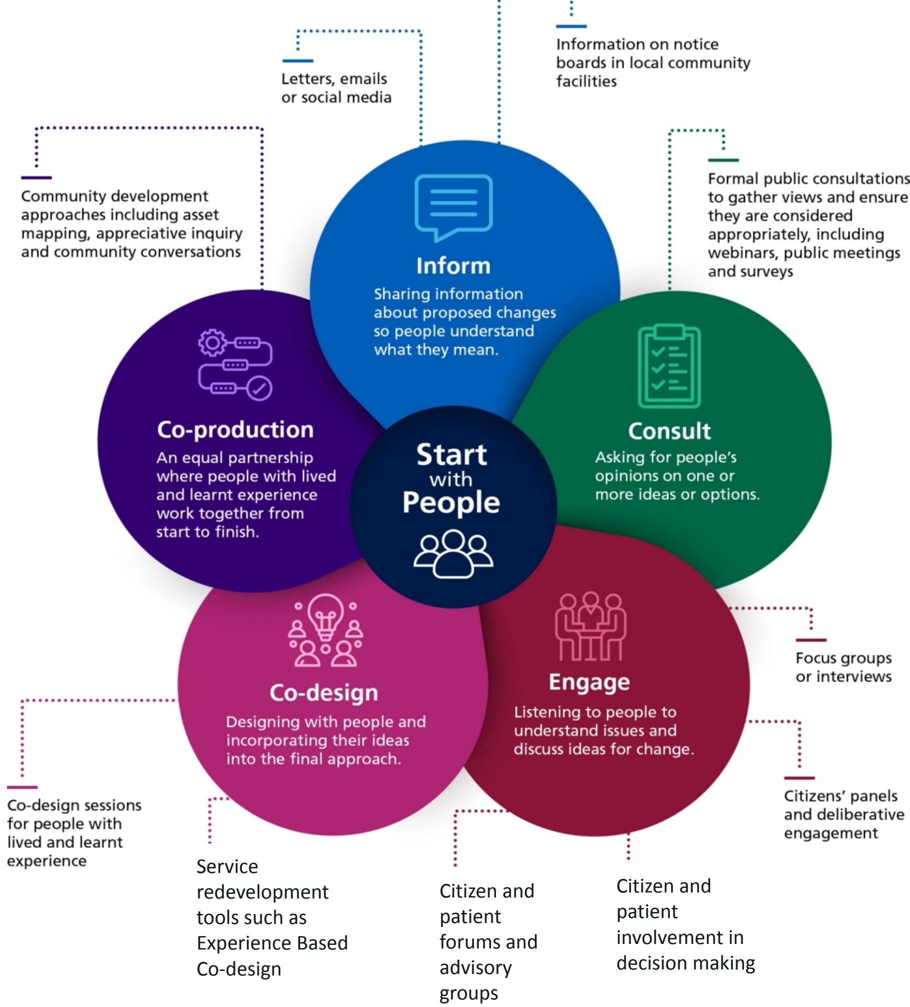
Our ambition is it to harness the resources, skills, knowledge and experience of the communities we serve. We have strong communities, within which many people give their time and skills as volunteers, and thousands of people providing unpaid care to their loved ones. Our voluntary, community and social enterprise sector is a significant asset and makes a huge contribution to our communities.

Thousands of students attend higher education here and we are home to outstanding centres of research and innovation in our local universities and academic health science network. We have a thriving cultural scene and industries providing employment and infrastructure.

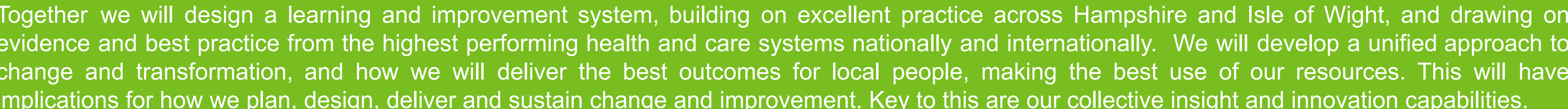
Using community assets we will address health inequalities, improve and innovate the way we deliver services and support local communities to improve their health, happiness, wealth and wellbeing.

As described earlier in this document, we have drawn upon insights from local people to inform this interim strategy. Our community involvement approach, incorporates many ways of working with local people (see right), and builds on existing best practice carried out by partners and communities here and in other places, strengthening the valuable relationships we have, and meeting the needs of our diverse communities.

As part of this, we are launching a project aimed at supporting under-served communities to participate in research to improve access, resources and support for these communities. The project brings together voluntary; community; social enterprise; local government; health and adult social care partners, the University of Winchester and people with lived experiences. This will be instrumental in the delivery of this strategy and our ongoing work as a partnership with our local communities.



Developing our learning system


Together we will design a learning and improvement system, building on excellent practice across Hampshire and Isle of Wight, and drawing on evidence and best practice from the highest performing health and care systems nationally and internationally. We will develop a unified approach to change and transformation, and how we will deliver the best outcomes for local people, making the best use of our resources. This will have implications for how we plan, design, deliver and sustain change and improvement. Key to this are our collective insight and innovation capabilities.

Our population health approach: building capability across the "four Is"

Building these capabilities will enable us to deliver a population health management approach to support us in delivering our strategic priorities.

Infrastructure

Organisational and human factors such as dedicated systems leadership and decision making on population health and PHM

Digitised health & care providers and **common integrated health and care record**

Linked health and care data architecture and a single version of the truth

Information Governance – whole system data sharing and processing arrangements that ensure data is shared safely securely and legally

Intelligence

Advanced analytical tools and software and system wide multi-disciplinary analytical teams, supplemented by specialist skills

Analyses and actionable insight – to understand health and wellbeing needs of the population, opportunities to improve care, manage risks and reduce inequalities

Alignment of multi-disciplinary analytical and improvement teams to work with and advise providers and clinical teams

Development of a cross system ICS intelligence function providing support to all levels of system

Interventions

Care model design and delivery through' proactive and anticipatory care models with a focus on prevention and early intervention and reducing health inequalities

Community well-being – asset based approach, social prescribing and social value projects

Citizen co-production in designing and implementing new proactive integrated care models

Monitoring and evaluation of patient outcomes and impact of intervention to feed into continuous improvement cycle

Incentives

Incentives alignment – value and population health based contracting and blended payment models

Workforce development and modelling – upskilling teams, realigning and creating new roles

Enabling governance to empower more agile decision making within integrated teams

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Research and innovation

There are vast opportunities for research and innovation to help address challenges around:

- workforce
- mental health and wellbeing, particularly for children and young people
- new approaches to care for people living with long term conditions and for older people
- making the best use of digital solutions
- accessing routine care following the Covid-19 pandemic.

Some of these innovations help us to deliver the right things at the right times in the right place, making the most efficient use of workforce and empowering people in their own care. Other innovations drive technical efficiencies in established pathways of care. As in other global health systems, the adoption of innovations in health and care is patchy, driven by the way innovation is prioritised and funded. In the United Kingdom, we invest heavily in invention, but our ability to make use of inventions does not always keep pace.

Working as an integrated care partnership allows us to better align all the organisations in our system to make better use of innovations. Other factors that support this include the merging and therefore better alignment of central bodies, and our collective experiences of working through the Covid-19 pandemic, which changed our understanding of what is possible and how to enable rapid invention, adaptation and use of innovations. In Hampshire and Isle of Wight we will seek out research and innovation that directly supports our five strategic priorities, work out how these can be adopted across our partners and services, and develop our capacity and capability to sustain and spread innovations as part of our learning system approach. In doing so we will make best use of:

- Relationships with academic networks and institutions
- Commercial support and relationships with industry
- Design support and implementation science
- Real world evidence about what works well
- National networking, sharing, learning and supporting.

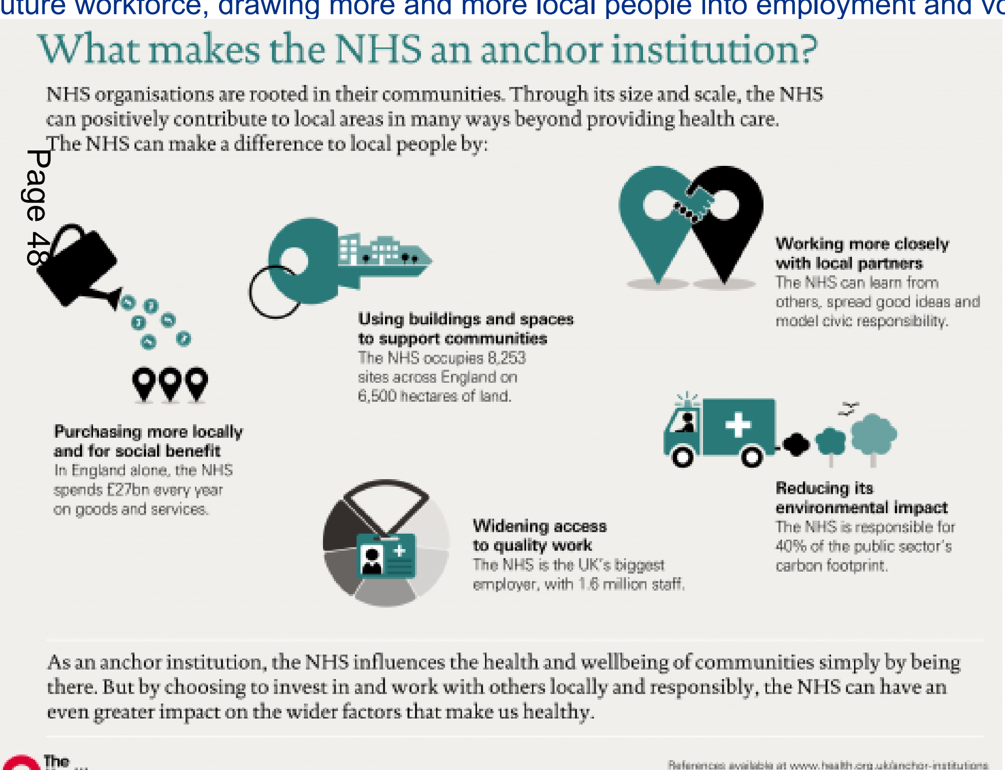
Ensuring our organisations benefit broader society and support environmental sustainability

Our organisations as "anchor institutions"

Large businesses, local authorities, NHS and other public sector organisations, are rooted in their local communities and can make a big contribution to local areas in many ways, far beyond our core purpose as organisations. The term ***anchor institutions*** refers to large organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. Anchors get their name because they are unlikely to relocate, given their connection to the local population, and have a significant influence on local health and wellbeing.

The Health Foundation developed the graphic (bottom left) to show how NHS organisations act as anchor institutions in their local communities. Although the graphic refers to the NHS, the same principles apply to partners, including local authorities, universities and large employers.

We are increasingly conscious of our potential to make an even greater contribution to broader society and the environment and are working to better understand and realise this potential. In our workforce priority, we describe our ambition to work together to improve the health, happiness, wealth and wellbeing of local people working in our organisations, and our future workforce, drawing more and more local people into employment and volunteering.



Opportunities to work together for a cleaner, greener environment for us all

Another area of focus for us as anchor institutions, is our work to address the climate crisis, as described below.

- **Reducing carbon emissions** through energy and water efficiencies and clean technology installations will contribute to cleaner air across Hampshire and Isle of Wight, and offer the potential to reduce the pressure on our system by lowering rates of chronic disease such as cardiovascular disease in our local population
- **Supporting local biodiversity** through creating or enhancing green spaces on our estate (land) to promote residents, staff and wider community health and wellbeing now and in the future
- **Empowering and supporting our workforce** to make greener decisions through creating an innovative environment, where our people feel able to embrace sustainability practices in their day-today actions and has a positive effect on their wellbeing at work
- **Reducing indirect environmental impacts** and maximising social value by choosing local and conscientious suppliers where possible e.g. maximising efficiencies in transporting of goods
- **Reducing operational waste** including choosing low carbon alternatives such as reusable equipment and reutilising where possible

Our partnership is committed to maximising our positive contribution to our local area wherever possible.

System funding and finance

All system partners are operating within an increasingly difficult national economic environment. Local authorities continue to work creatively with partners and populations to deliver statutory services within revenue and capital resources. At the time of writing, the impact of the recent 2022 Autumn Statement is still being worked through by councils. However, it is assumed that the overarching position remains relatively unchanged. Challenges coping within normal inflationary pressures, over a decade of reductions in core budgets, in addition to the significant unfunded growth in demand and costs, particularly in adults' and children's social care, and the crisis in special education needs, means that some local authorities are now pressing for fundamental change either in the way these services are funded, or in our statutory obligations.

This further demonstrates the need to focus on the priority areas set out in this interim strategy to improve the health and wellbeing of local people. Partners are also keen to better understand the totality of our funding envelope and explore opportunities to work together to make best use of the funding available.

Money the NHS in Hampshire and Isle of Wight receives

The NHS in Hampshire and Isle of Wight receives £3.7bn for the health and care of its population, equating to approximately £1,756 per head of population. This is a high level of funding per head of population but it is overfunded using a national formula and we expect to receive the lower levels of funding growth than other parts of the country in future years, with potentially reduced additional central support for individual NHS organisations' inherent financial challenges.

Of Hampshire and Isle of Wight's £3.7 billion NHS funding:

- £2.1 billion is spent on NHS providers within Hampshire and Isle of Wight, of which £0.3bn is spent on mental health services (a small proportion of which is with providers outside of Hampshire and Isle of Wight).
- £0.3 billion is spent on GP services with a further £0.3bn on wider primary care
- £0.2 billion is spent on continuing care services for people with very complex health and care needs
- £0.1 billion is spent with local councils, including through joint funding arrangements.

Broadly speaking, we receive the same level of income from activities such as training and research and development as other systems of a similar size and scale. However, some systems do receive much more funding for research and development - this is an area we will look to grow in Hampshire and Isle of Wight.

Nationally and in our system, local authorities are facing financial pressures in adult and children's social care, public health and the broader services that impact health and wellbeing outcomes. At the same time the health and care system faces further activity, workforce and financial challenges going forward across the NHS, local authorities and the voluntary sector.

Making best use of our resources

As a partnership, we are working together to explore what we can do to make better use of our resources, including:

- How to deliver efficiencies so that more funding can be made available to deliver our five strategic priorities
- Developing an equity model to ensure investment decisions are driven by population need and support reductions in the health inequalities described in this interim strategy
- Collectively driving funding to the right places to ensure best value, care and support for local people
- Making more use of pooled funds through the use of Section 75 agreements between local authority and NHS partners, and similar, where appropriate
- Exploring how we could operate an 'open book' financial culture
- Developing our shared approach to taking difficult financial decisions
- Exploring how all partner organisations can support local economic development.

Section 75 agreements

Section 75 of the NHS Act 2006 allows partners (NHS bodies and councils) to contribute to a common fund which can be used to commission health or social care related services. This power allows a local authority to commission health services and NHS commissioners to commission social care. It enables joint commissioning and commissioning of integrated services.

Established section 75 arrangements are already in place between our integrated care board and our four upper tier local authority areas. This mechanism has resulted in a major increase in pooled budgets over the years in some parts of our system, where partners have agreed to share risks and rewards and accountability for outcomes.

Further integration of care, while complex to deliver, is recognised as a much needed response to the challenges of rising demand and budgetary constraints. Our ambition is to utilise the section 75 agreements as the vehicle to further drive integration of services at a local level and also deliver on the strategic objectives of this strategy.

Implementation and delivery plans, measuring progress and learning as we go

During the early part of 2023, we will:

- publish easy read and summary versions of our interim strategy, and invite further reflections and feedback from local people and partners to further inform our next work together to translate this strategy into delivery, as well as future refreshes of this strategy
- work together and with local people, especially those with lived experience, to
  - develop our delivery framework for each of our priority areas
  - create a clear dashboard to measure and report progress in our delivery of our strategy on a quarterly and annual basis. This will be publicly available to ensure transparency and promote accountability
  - establish effective ways of reflecting on, and learning from our work together as a 'learning system'
- use this interim strategy to inform the development of the NHS five-year joint forward plan, and inform future versions of individual health and wellbeing strategies, NHS organisations' plans and other strategies and plans

If you would like to be involved in these activites, please contact [insert contact email address, refer to ICS website?]

An ongoing, iterative process of strategy development across our partnership

Our interim strategy sets out the initial priorities we will address together as a partnership. We will regularly review our five priorities to ensure that they remain relevant to our context and environment and that we are delivering improvements in these areas for our local community.

The integrated care partnership strategy is informed by other local strategies and plan, and in turn informs the refresh of those strategies and plans over time. This is an iterative process, and joining up the priority areas across our various strategies and plans forms part of our new ways of working together.

The integrated care partnership strategy ***informs*** the development of other local plans and strategies

For example:
- Local health and wellbeing strategies
- Integrated Care Board Joint Forward Plan
- Annual operating plans for organisations
- Our community involvement approach
- Digital strategy
- NHS Transformation programmes
- Core 20+5 programme
- Workforce strategies and people plans
- Children and Young People strategy
- Mental health strategy

Hampshire and Isle of Wight Integrated Care Partnership Strategy

For example:
- Local health and wellbeing strategies
- Integrated Care Board Joint Forward Plan
- Annual operating plans for organisations
- Our community involvement approach
- Digital strategy
- NHS Transformation programmes
- Core 20+5 programme
- Workforce strategies and people plans
- Children and Young People strategy
- Mental health strategy

A wealth of local plans and strategies ***inform*** the development of the integrated care partnership strategy

DECISION-MAKER:	Health and Wellbeing Board
SUBJECT:	Joint Strategic Needs Assessment (JSNA) Annual Summary and Health and Wellbeing Strategy Update
DATE OF DECISION:	14 December 2022
REPORT OF:	Cabinet Member for Health, Adults and Leisure

CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY

Not applicable

BRIEF SUMMARY

The Southampton Health and Wellbeing Strategy 2017-2025 was developed by the Health and Wellbeing Board, and adopted by Council in March 2017, in agreement with the then Southampton Clinical Commissioning Group (CCG) Governing Body.

The strategy sets out the strategic vision for improving the health of residents and workers, and reducing health inequalities in the city. It includes the outcomes the city wants to achieve by 2025 and is based on evidence from the Joint Strategic Needs Assessment (JSNA), stakeholder engagement and public consultation. This paper provides an update on the progress of the strategy over the last year and reports on the strategy's associated indicators. It also provides a summary of the JSNA: the full JSNA is housed within the Southampton Data Observatory.

RECOMMENDATIONS:

	(i)	The Board notes the findings of the JSNA summary
	(ii)	The Board notes the progress against the Health and Wellbeing Strategy to date
	(iii)	The Board re-commits to the promotion and implementation of the strategy
	(iv)	The Board continues to lead a multi-faceted approach to reducing health inequalities and improving health. It agrees that priorities for the next year should be COVID-19 recovery, protecting a good start in life, all age mental health, reducing smoking prevalence and embedding a Health in All Policies approach locally, as well as a focus on building and improving

		effective system leadership and partnerships within the new health infrastructure.

REASONS FOR REPORT RECOMMENDATIONS	
1.	Local Authorities and Integrated Care Boards (ICBs) have equal and joint statutory duties to deliver a Health and Wellbeing Strategy that sets out how they plan to work together with local partners to meet health and care needs identified in the JSNA
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
2.	N/A
DETAIL (Including consultation carried out)	
Background	
3.	The Health and Wellbeing Strategy 2017-2025 (Appendix 1) sets out our vision that Southampton promotes and supports health and wellbeing for all. It commits to significantly improve health and wellbeing and reduce health inequalities in Southampton by 2025. The strategy lists four key strategic outcomes with high-level activities which will contribute to achieving them. The strategy includes measures from the Office of Health Improvement and Disparities' (formerly Public Health England) Public Health Outcomes Framework so we can monitor population need and our impact.
4.	This paper provides an update on the work that has been undertaken in connection with the Strategy (Appendix 2), and changes in the key health indicators (included in Appendix 3), since the last update in September 2021.
Southampton's Joint Strategic Needs Assessment	
5.	Health and Wellbeing Boards are responsible for producing a JSNA under the Health & Social Care Act 2012. The JSNA is an assessment of the current and future health and social care needs of the community. Its purpose is to improve health and wellbeing and reduce inequalities. As a statutory requirement, it should also inform health and wellbeing commissioning plans. The process to produce the JSNA can be locally determined. There is no mandated format, core dataset or update schedule. The Southampton JSNA is brought together with other data, intelligence, specialist reports, needs assessments, summary analysis and headline statistics covering the city's population, health, community safety, economy and public services within the Southampton Data Observatory. Health and Wellbeing Boards should develop a Health and Wellbeing Strategy paying due regard to the evidence set out in the JSNA. The Southampton Health and Wellbeing Strategy is monitored using a key set of performance indicators (KPIs). These can be accessed via a regularly refreshed Power BI dashboard and are set out in Appendix 3. Appendix 3 also provides a summary of the JSNA, illustrating the context for the city and the JSNA purpose. It highlights key intelligence deliverables over the time since the last update in September 2021 and takes a deeper dive into some of the indicators within the Strategy. Appendix 3 additionally showcases summaries of bespoke topic analyses that support the JSNA: 2021 Census releases, Covid Impact Assessment refresh, long-term/chronic conditions data pack including neighbourhood prevalence and forecasted prevalence by age group, childhood obesity and the food environment.

Summary of progress against the Strategy's priorities

6. The priority for action during much of 2021-22, particularly the first half, has been responding to the pandemic, which has meant that in some cases, work towards the goals of the Strategy has not proceeded as previously planned. Data collection and publication has also been affected by the pandemic in some cases, and the impact of the pandemic itself on health is still being understood.

Overarching indicators

Life expectancy is one of the Strategy's overarching indicators. In Southampton for 2018-20, men live 13 months less and women live 8 months less compared to England averages.

Life expectancy (at birth)	Southampton	England
Males	78.3 yrs	79.4 yrs
Females	82.5 yrs	83.1 yrs

Life expectancy has reduced for males in Southampton since 2017-19, when it was 78.5 yrs, but stayed the same for females. In England over the same period, life expectancy has also reduced from 79.8yrs for males and 83.4yrs for females.

In 2018-20, Southampton women live for a longer period in poorer health (19.4 years) than Southampton men (17.0 years).

Comparing the most deprived 20% of Southampton to the least deprived 20%, the life expectancy at birth gap is 8.1 years for men and 3.4 years for women (2019-21).

7. A commentary on the Strategy's other key indicators can be found in Appendix 3 slides 4 to 7. Of particular note for Southampton:

- Excess weight in 4/5 year olds is significantly higher and 10/11 year olds higher than England and with a steeper overall increase
- Number of children in relative low income families is consistently significantly higher than England and the gap is getting worse
- Smoking prevalence in adults is decreasing overall, 2019 data (16.8%) significantly higher than England (13.9%), although there are caveats around the accuracy of the data
- Local depression prevalence (12.4%) has increased similarly along with national rates (12.3%) for 2020/21
- Under 75 mortality from preventable liver disease: data for 2016-18 & 2017-19 is the highest since 2001-03, significantly higher than England
- Injuries due to falls in those aged 65+ is increasing overall whilst England average remained stable
- Data for people in employment to end of March 2021 saw Southampton significantly higher than England, however the impact of COVID-19 has since seen significant increases and also sub-city variation

Progress on commitments in the Strategy

8. A summary of progress towards the twenty-six commitments in the Strategy can be found in Appendix 2.

9. **Priority 1: People in Southampton live active, safe and independent lives and manage their own health and wellbeing**

Activity to promote and encourage healthier lives continues to be a focus, and a number of new initiatives, services and alliances have been developed. Much work

	to encourage more physical activity in the city has been underway, and the forthcoming Tobacco, Alcohol and Drugs Strategy has been developed in consultation during 2022. Children and young people have continued to be a focus with the development of Family Hubs for example, and the Phoenix@Pause programme that supports vulnerable women who have had multiple children taken into care is seeing good outcomes. Mental health and suicide prevention has also been a priority. More community-based schemes to help people remain independent and safe in their own homes have been established and the work of social prescribers and community navigators has been crucial. Strategies to engage communities with the aim of increasing uptake of COVID-19 vaccination have shown success.
10.	**Priority 2: Inequalities in health outcomes are reduced** Reducing health inequalities is a strong thread running through all work, which is needs-led. Support is targeted at those groups and individuals who need it most. The development of a Health in All Policies framework to be held by the Health and Wellbeing Board will be an important step towards embedding this approach further across the council and partners and help address inequalities in the city, which have been exacerbated by the pandemic.
11.	**Priority 3: Southampton is a healthy place to live and work with strong, active communities** Enabling and supporting communities is a vital part of work to improve health outcomes, and connections within our communities can be a strong enabler for health and wellbeing. The work undertaken by the Stronger Communities team and the local area team to support community networks and assets has continued to grow and achieve great results during 2021-22, and more use of community-centred approaches is also a priority for the Public Health team going forward. The cost of living crisis has meant that work towards addressing housing standards and fuel poverty, which has been scaled-up, is even more important. Significant developments towards healthy planning policy have been the appointment of a Spatial Planning for Health Specialist and the revised Local Plan consultation.
12.	**Priority 4: People in Southampton have improved health experiences as a result of high quality, integrated services** Integration and joint working is a key priority for the Health and Care Strategy 2020-25 as well as the Health and Wellbeing Strategy, and is monitored by the Better Care Steering Board. Case management, early intervention and locality working are proving to be important approaches for delivery. System leadership towards these goals through the Health and Wellbeing Board and the newly established HIOW Integrated Care System will be crucial in rising to the growing health challenges in the City.
13.	**Conclusions** In teams, departments and partnerships across the city, improving health outcomes and reducing health inequalities remains the highest priority. The scale of the challenge is significant across the board. Action continues to need to be multi-faceted, taking account of all health needs, but emerging priorities for 2023 are likely to be: - Ensuring children have the best start in life - Improving mental health across the lifecourse - A continued focus on reducing smoking prevalence - Embedding a Health in All Policies approach

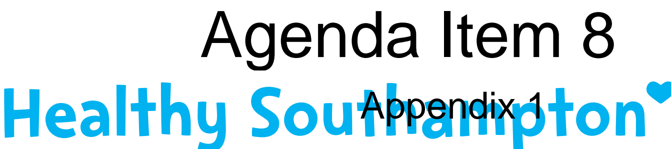
	- Building and improving effective system leadership and partnerships within the new health infrastructure
RESOURCE IMPLICATIONS	
Capital/Revenue	
	None
Property/Other	
	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
	Health and Social Care Act 2012
Other Legal Implications:	
	None
RISK MANAGEMENT IMPLICATIONS	
	N/A
POLICY FRAMEWORK IMPLICATIONS	
	N/A

KEY DECISION?	**No**
WARDS/COMMUNITIES AFFECTED:	All
SUPPORTING DOCUMENTATION	
Appendices	
1.	Southampton Health and Wellbeing Strategy 2017-2025
2.	Summary of progress on the HWBS
3.	JSNA Summary and HWBS indicators

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	



Health and Wellbeing Strategy 2017-2025

Our vision is that Southampton has a culture and environment that promotes and supports health and wellbeing for all. Our ambition is to significantly improve health and wellbeing outcomes and reduce citywide health inequalities in Southampton by 2025.

This Strategy sets out the outcomes that Southampton Health and Wellbeing Board wants to achieve over the next eight years. These outcomes will be achieved by working with partners across the city, and with Southampton's residents and diverse communities.

Southampton's Health and Wellbeing Board is a statutory partnership and a committee of the Council which brings together the city's health and social care commissioners, including Southampton City Clinical Commissioning Group, Southampton City Council and NHS England. The Board has oversight of health and wellbeing in the city. Its role is to develop joint priorities for local commissioning to ensure delivery of the right outcomes, and to provide advice, assistance or other support to improve the health and wellbeing of the city's diverse communities.

The Health and Wellbeing Board is committed to working together with the people of Southampton to improve the health and wellbeing of residents, with an equal focus on physical and mental health. At a time of increasing demand on services and pressures on funding, it is even more important to make sure the city is a healthy place by supporting people to take responsibility for their health, and that services are delivered as efficiently as possible, targeting them towards those people who need the most help.

Key facts about Southampton

247,569 people live in Southampton, and this is expected to grow by nearly 5% by 2022, to 259,615. The GP registered population of Southampton is 282,393

98,000 There are around 98,000 households in the city – with 51% owner occupiers and 25% living in privately rented homes

34,557 people aged 65+ live in the city, and this is expected to increase by 12% by 2022, By 65, about a third of people have at least 3 chronic conditions

53,928 children and young people (aged 0-17) live in the city, and this is expected to increase by 5.9% by 2022

40,000 There are 2 universities and around 40,000 students living in the city

22.4% of Southampton residents are non-white British, of which 14% are Black or Minority Ethnic

30,250 residents live in the 10% most deprived areas of the city

83.1 **78.2** Life expectancy in the city is and 83.1 years for women 78.2 years for men, with variances across different parts of the city

55% Around 55% of Southampton residents exercise regularly, doing at least 150 minutes of physical activity per week

£450 million Health and Wellbeing Board partners spend around £450 million per year on health and care services in the city

What do we want to achieve and why is this important?

People in Southampton live active, safe and independent lives and manage their own health and wellbeing

We want to support more people to choose active and healthy lifestyles, to improve their physical and mental health. When people take responsibility for their own health and the health of their children through positive lifestyle changes, this improves their wellbeing, prevents ill health and helps them to stay independent in their own homes and communities for longer.

Inequalities in health outcomes are reduced

Health and wellbeing outcomes are very different for men, women and different communities in Southampton, and there are significant health inequalities in our city. We want to improve the health and wellbeing of all residents and reduce inequalities so that everyone, and especially vulnerable children and adults, has increased opportunities and a better quality of life.

Southampton is a healthy place to live and work with strong, active communities

Being healthy and well for a lifetime involves much more than good health and social care services. Many different things impact on health and wellbeing, like housing, jobs, leisure, sport and access to open spaces, education, health services and transport. We want Southampton to be a healthy place, with healthy workplaces and communities which are strong and resourceful, making best use of their community assets.

People in Southampton have improved health experiences as a result of high quality, integrated services

We want to make sure people get high quality support when and where they need it. This means making sure services are designed around the needs of people, and that residents are involved in the design and delivery of services to improve their experiences of integrated services. We want to focus on prevention and early help, and deliver services that are accessible and coordinated so that people receive joined up, seamless care. Integrating services across health and social care also means that all health and wellbeing partners can work more effectively and efficiently together, so that resources and assets are used where they are needed most.

Our challenges

- Health inequalities are a big challenge in the city. Men in the least deprived areas live 8 years longer than in the most deprived; for women the difference is 4.7 years.
- 6,050 people are claiming health related employment benefits (ESA and Incapacity Benefit) – 3.5% of the working population.22.7% of children under 16 in Southampton live in poverty – higher than the England average of 18.6% – and this is linked to poor health outcomes.
- Southampton children and young people are more likely to be admitted to hospital for mental health conditions than the national average.
- Children in the city have high levels of obesity, poor dental health and admission to hospital for injuries.
- The city has high numbers of Looked After Children in comparison to many other cities.
- Although life expectancy is increasing, as people are living longer more of them are living with complex needs.
- 20.4% of people in Southampton smoke (16.9% in England). The rate is significantly higher in the most deprived areas.
- Almost two thirds (62.6%) of adults in Southampton are classified overweight or obese.
- The rate of deaths relating to drug poisoning is 5.1 per 100,000 population (2013-2015), higher than the England average of 3.9 per 100,0000.
- Alcohol specific hospital admissions have increased significantly since 2010 and in 2014/15 there were 1,060 admissions.
- There is growing evidence of the impact of social isolation and loneliness on health.
- Although Southampton has significantly reduced the rates of teenage conceptions from 47.4 per 1,000 teenagers (aged 15-17) in 2011 to 29.0 in 2014, it remains above the England average.
- Nearly 10,000 households are estimated to experience fuel poverty in Southampton.
- Air pollution is a significant health issue for Southampton, with 6.2% of deaths attributable to air pollution in 2010. Long term exposure to air pollution increases the risk of deaths from cardiovascular and respiratory conditions.

What do residents say?

- The majority of residents (70%) self-assessed their health as being good or very good.
- Mobility problems, cancer, mood/contentment and money are their greatest health and wellbeing concerns for the future.
- Residents are already doing things to be healthier such as not smoking, eating healthily and limiting alcohol consumption.
- Fewer residents told us that they make use of helplines and websites, talk to friends and family about their concerns or attend health checks / screenings.
- Some of the things residents said they could do to be more healthy include:
  - Having a better work life balance and going to more social venues
  - Doing more volunteering
  - De-stressing regularly and getting better sleep
  - Being able to exercise more

(Research undertaken 2016, 900 respondents)

Outcome | What are we going to do?

People in Southampton live active, safe and independent lives and manage their own health and wellbeing

- Encourage and promote healthier lifestyle choices and behaviour, with a focus on smoking, alcohol / substance misuse, healthy weigh, and physical activity including walking and cycling more.
- Encourage and promote healthy relationships and wellbeing of individuals of all ages, carers and families, particularly for those at risk of harm and the most vulnerable groups through increasing early help and support.
- Support people to be more independent in their own home and through access to their local community, making best use of digital tools including Telecare.
- Ensure that information and advice is coordinated and accessible.
- Prioritise and promote mental health and wellbeing as being equally important as physical health.
- Increase access to appropriate mental health services as early as possible and when they are needed.
- Make every contact count by ensuring all agencies are able to identify individual needs and respond /refer to services as appropriate.
- Promote access to immunisation and population screening programmes.

Inequalities in health outcomes are reduced

- Reduce the health inequalities gap between the most deprived and least deprived neighbourhoods in the city using the evidence of what works in the Marmot review of Health Inequalities.
- Take action to improve men's health to reduce the difference between male and female life expectancy through community based initiatives to deliver behaviour change.
- Reduce inequalities in early childhood development by ensuring good provision of maternity services, childcare, parenting and early years support.
- Work with schools to improve healthy lifestyle choices and mental wellbeing and reduce the harm caused by adolescent risk taking.
- Target access to advice and navigation to services to those who are most at risk and in need, to improve their health outcomes.
- Ensure that health inequalities are taken into account in policy development, commissioning and service delivery.
- Provide support to help people access and sustain quality jobs, targeting those who are long term unemployed or with families.

Southampton is a healthy place to live and work with strong, active communities

- Support development of community networks, making best use of digital technology, community assets and open spaces.
- Improve housing standards and reduce illness and avoidable deaths related to fuel poverty.
- Develop an understanding of, and response to, social isolation and loneliness in the city.
- Work with city planners to ensure health is reflected in policy making and delivery.
- Deliver a cleaner environment through a clean air zone with vehicle access restrictions to the city.
- Work with employers and employees to improve workplace wellbeing through healthier work places.

People in Southampton have improved health experiences as a result of high quality, integrated services

- Improve health outcomes for residents, at a lower cost, through integration and joint working across all health and council services.
- Prioritise investment in and embed a prevention and early intervention approach to health and wellbeing across the city.
- Deliver a common approach to planning care tailored to the needs of the individual or family.
- Deliver the right care, at the right time, in the right place by working as locally as possible and shifting the balance of care out of hospital to community providers.
- Maximise opportunities for prevention and early intervention through making every contact with services count.

How will we measure success?

The Public Health Outcomes Framework is a comprehensive list of desired outcomes and indicators that help measure how well public health and wellbeing is being improved and protected in an area. The Health and Wellbeing Board will focus on a selection of these indicators that a) require the most improvement and b) will best indicate progress towards the outcomes in this strategy.

Priority area	Measure		
Overarching	Life expectancy at birth	Life expectancy at 65 years	Healthy Life Expectancy at birth
	Under 75 years mortality rate from cardiovascular disease	Under 75 years mortality rate from respiratory disease	Mortality rate from causes considered preventable
Children & Young People/ Early years	Smoking status at time of delivery	Breastfeeding prevalence at 6-8 weeks after birth	Child excess weight in 4-5 and 10-11 year olds
	Population vaccination coverage – MMR for one dose (2 years old)	Looked after children rate	School readiness
	Children in low income families (under 16s)	Hospital admissions caused by unintentional and deliberate injuries (0-14 years)	Under 18 years conception rate
Adults	Smoking prevalence in adults	Suicide rate	Depression recorded prevalence
	Injuries due to falls in people aged 65 years and over	HIV late diagnosis	Under 75 years mortality rate for liver disease considered preventable
	TB incidence (3 year average)		
Healthy settings	Fraction of mortality attributable to particulate air pollution	Percentage of people aged 16-64 years in employment	Excess winter deaths index

The full Public Health Outcomes Framework can be found at **www.phoutcomes.info**

Our principles

1 Promote prevention and early help

2 Consider health in all policies

3 Work with residents and communities to:
- Jointly plan, design and deliver services
- Develop resilience
- Make it easier for people to make healthy choices.

4 Deliver services that:
- Are designed with residents
- Are proportionate to the level of need
- Are accessible to vulnerable groups
- Are personalised, safe, effective and value for money
- Give equal priority to physical and mental health.

The Health and Wellbeing Strategy is supported by a number of city wide strategies and action plans

Health and Wellbeing Strategy (southampton.gov.uk), 2017-2025. Progress update October 2022

	Priority Commitments	Lead agencies, departments & services	Latest achievements and activities
	People in Southampton live active, safe and independent lives and manage their own health and wellbeing		
1.1	Encourage and promote healthier lifestyle choices and behaviour, with a focus on smoking, alcohol / drug use, physical activity, and a healthy weight, including walking and cycling more.	SCC Public Health	Smoking - New training and quality improvement service commenced, Southampton Smokefree Solutions, supporting local health & care providers to enable people to be smokefree - Smoking cessation embedded in maternity service and NHS Lung Health Checks service at University Hospital Southampton - Primary Care Networks providing stop smoking support, in addition to open-access services in commissioned Pharmacies - Developing plans to support mental health, drug and alcohol and homelessness services to be smokefree - "Quit for Covid" campaign Physical activity - The Southampton Health and Wellbeing Board adopted the We Can Be Active (WCBA) Strategy in March 2022 - A new Physical Activity Alliance (PAA), made up of internal and external partners, held a workshop in April 2022 to develop the Action Plan for the WCBA Strategy - The WCBA Strategy and Action Plan supports the Leisure vision for the city - The PAA meets quarterly to review progress on the Action Plan and to work collaboratively to inspire and support active lifestyles so that all residents can be active in a way that suits them - In January 2022 voluntary and community groups were invited to apply for 'Active Communities' grants of up to £5k towards projects that would support our target groups to become more active. Funding was distributed in Feb/March 2022 to 7 projects which included an over 50's Lunch club with seated exercises classes, wheelchair accessible planters and swimming lessons for African men - A Physical Activity Community Navigator has been employed as part of a pilot project to support people who are inactive to move more - Implementation of the WCBA Action Plan is possible because of the active engagement of PAA members who represent a vast range of organisations and disciplines, including Sustainable Travel, physical activity providers, voluntary sector, town planning and the CYP/early years sector Healthy weight - National "Better Health" campaign and NHS online tools promoted locally - Childhood obesity Cabinet Action Plan includes intergenerational prevention and the food environment Alcohol/drug use - New telephone support line for alcohol - Successful bid for extra PHE funding for drugs services - Young People's service provides educational sessions about risk in secondary schools - New Tobacco, Alcohol and Drugs strategy developed during 2022, for Cabinet approval in December 2022.
1.2	Encourage and promote healthy relationships and wellbeing of individuals of all ages, carers and families, particularly for those at risk of harm and the most vulnerable groups through increasing early help and support.	SCC Public Health	Sexual health - Current services continue to provide targeted support to vulnerable groups (i.e. teenagers, homeless population, sex workers, men who have sex with men) - Sexual Health Improvement plan 2020-24 is in place, although delayed by COVID-19. Current priorities include identifying and reducing inequalities in sexual health, equitable provision of Emergency Hormone Contraceptive, and quality and access to Long Acting Reversible Contraceptive - Needs assessment completed to inform new sexual health improvement programme and support sexual health service commissioning to improve outcomes in the city Children and young people - The Children and Young People's Strategy 2022-27 has been completed, along with eight strategic plans for delivery, including the prevention and early intervention plan. The Children and Young People's Strategic Partnership and a number of subgroups have been established to provide oversight of these strategies. - Southampton City Council has been awarded funding for the Family Hubs and Start for Life Programme which includes work across six priority areas including the development of Family Hubs in the city.

	Priority Commitments	Lead agencies, departments & services	Latest achievements and activities
			Vulnerable groups - Phoenix@Pause Southampton service has been supporting vulnerable women who have had multiple children taken into care to meet their complex needs (e.g. mental health, domestic violence, substance use, housing), and is demonstrating good outcomes. The first cohort of women supported by the service have now completed the programme and work with the second cohort is underway. The service recently introduced a bespoke therapeutic pathway which is supporting the women psychologically. - Holistic outreach service commissioned to support women who sell sex on the street - Domestic Abuse Cabinet Action Plan in place Carers - Strong programme of reaching out to carers (paid and unpaid) to promote the Covid Vaccination programme
1.3	Support people to be more independent in their own home and through access to their local community making best use of digital tools including Telecare.	Southampton's Local Area Team (previously ICU)	- ICB funded Communicare : Hello Southampton offering daily phone call health and wellbeing check-ins by volunteers, Home Welcome - a good neighbour visiting people after illness or hospital discharge - SO:Linked So:Connect digital inclusion project - Piloting of Domestic Navigation scheme providing an alternative to home care provision, with good neighbours, digital support for shopping, development and access to food pantries across the City, Welfare rights support to maximise incomes to provide income to afford non-registered home help support. Initial funded home help to bridge support. - A continued flexible and creative approach to reaching those in need and promoting their independence and wellbeing has been at the centre of what SO:Linked has done in recent months - A network of Social Prescribers and Community Navigators has been developed to promote sharing of good practice and continue to innovate and promote access to community assets - Working with CVSE organisations to promote 'digital enabling' aiming to reach more people through this approach, building on the successes during the pandemic response - ICB funded Warm Spaces for Elderly Frail and patients with respiratory needs in fuel poverty, coordinated by SO:Linked. Development of a Warm Spaces map, Single referral route through Community Navigation service, Small grants to community and luncheon clubs, Mobile Information POD for remote access to Advice Southampton Support, emergency equipment/supplies for urgent needs. Additional Warm Spaces capacity provided by Saints Foundation, Age UK Southampton and Spectrum. Additional volunteers for above supported by Communicare.
1.4	Ensure that information and advice is coordinated and accessible	Southampton's Local Area Team (previously ICU)	- Advice Southampton consortium of providers of advice information and guidance services. Development of information pods allowing access to AIG (Advice, Information and Guidance) services remotely (avoiding need for bus journey). Continued development of information pods has been a feature this year working in collaboration with the city's libraries. - AIG has continued to adapt to the changing need more recently to the rising demand for advice and support with cost of living challenges. - Promoting debt advice through nationally funded Money and Pensions Service, sustaining the service during a time of uncertainty regarding longer term funding and position.
1.5	Prioritise and promote mental health and wellbeing as being equally important as physical health.	SCC Public Health	- Connect 5 mental health training has been available for frontline workers across the city who are in contact with residents, particularly those who are vulnerable to mental ill health and suicide. Over 120 people have been trained in Southampton so far. - Continued support for mental health campaigns including Time to Talk, World Mental Health Day and Suicide Prevention Day. - Other public health campaigns highlight mental health benefits of physical activity, reducing drinking and stopping smoking. Suicide prevention - HIOW ICS Suicide prevention programme ended this year - 3-year programme of work across HIOW. The programme has launched a HIOW suicide specific bereavement support service, grants have been awarded to voluntary, community and social enterprise organisations to deliver innovative local projects to reduce suicide, a training package for primary care has been developed and launched, a post working across mental health and substance use teams has been funded, training for frontline workers has been commissioned, a Real Time Surveillance (RTS) system is being developed, and a self-harm support service tender has been awarded and due to launch in the winter. - Work is ongoing to increase the representation and involvement of people with living experience (PLE) in suicide prevention work in Southampton

	Priority Commitments	**Lead agencies, departments & services**	**Latest achievements and activities**

			- Southampton Suicide Audit 2019-20 has been completed and will inform the Southampton Suicide Prevention Plan and work of the Suicide Prevention Partnership
			  - An ICS mental health needs assessment has been completed
			  - Planning is underway to sign up to the Prevention Concordat for Better Mental Health (once full approval from HWBB received)

1.6	Increase access to appropriate mental health services as early as possible and when they are needed.	Southampton's Local Area Team (previously ICU)	Community Transformation "No Wrong Door" Programme - Achievement of 'exemplary' quality mark for Southampton Mental Health Individual Placement and Support Service and achieved target to provide access to 210 people with severe and enduring mental health issues. - Establishment of local delivery group for 16 – 25 year olds mental health pathways, involving local statutory, voluntary and service user organisations with co-production to develop pathways. - Development of Hub and Spoke model for Adult Eating Disorders and establishment of SHFT Eating Disorders Hub and development of physical Health Check in Adult Eating Disorders Local Incentive Scheme. - Dedicated Southampton City Mental Health Partnership Board, with collaboration between ICB, PCNs, SHFT, DHUFT (IAPT) and VSCE. - Community Mental Health Transformation with collaborative development of new PCN based Enhanced Primary Care Mental Health roles, and leadership in place delivering evidence based individual and group intervention in Primary Care settings. - Embedding integrated working between Primary Care, IAPT and secondary care services with work towards no referrals progressing - Serious Mental Illness physical health check facilitator providing training and support to Primary Care and outreach support, alongside provision of point of care testing technology in every GP Practice and piloting one stop clinics to increase uptake. - Complete Mental Health Housing Needs Assessment and published Market Position Statement - Launch Southampton grant giving scheme to strengthen VCSE growth and building community assets, development of Saints by you Side programme for men, and Mayfield Nurseries horticultural therapy programme. - Development of Southampton Mental Health Network and Southampton Mental Illness Lived Experience (SMILE) Network to make Southampton a "Mental Health Friendly City". - Additional Mental Health support for Rough Sleepers with mental health and psychology staff co-located and integrated alongside rough sleeping drug and alcohol team - Achieved target of 60% of people experiencing first episode psychosis being treated with a NICE recommended package of care within two weeks of referral - Introduction of Early Intervention in Psychosis cannabis prevention peer-led group providing support and psychoeducation - Gambling Harm Clinic launch in Southampton with expansion plans across ICS - Increased expansion of the ICS Wide Mental Health Rapid Response vehicle with demonstrated reduced conveyance to the Emergency Department with an increase in See and Treat. - ICS Wide funding for dedicated Mental Health crisis care liaison lead in South Central Ambulance supporting the bi-lateral management and strategic transformation and SCAS in regard to Mental Health Response and on-scene support. - ICS achievement of NHS England Assurance Quarterly targets for Mental Health Crisis Care 'all age'. - ICS led extension of the Secure Care UK Mental Health Transport Services to secure transport provision and capacity. - ICS led co-ordination of the Mental Health Resilience and Winter Operating Plan supporting Urgent and Emergency Care colleagues. - Supporting the expansion of crisis alternatives in Southampton with the development of a second Lighthouse in Bitterne and contribution towards the Academic Health Science Network evaluation of the Crisis Alternative services. - Roll out of the Collaborative Assessments and Management of Suicidality training across Southern Health in partnership with Public Health and a Health Education England. - Contract award of the Suicide and Bereavement Support Service (Amparo) as part of Suicide Prevention Wave funding to meet ICS plans and targeted approach from NHSE. - ICS Wide Mental Health Digital development of SHOUT to increase digital access to people in mental health crisis, text 'HANTS' to 85258, linked back to the 111 Mental Health Triage Service. - Southern Health Abbey Ward mobilisation of estate completed to provide an additional 10 female psychiatric intensive care beds for the ICS population. - Investment to meet CORE 24 standards for psychiatric liaison services at UHS with agreed phased workforce plans in place over two years Improved access to evidence-based psychological therapies

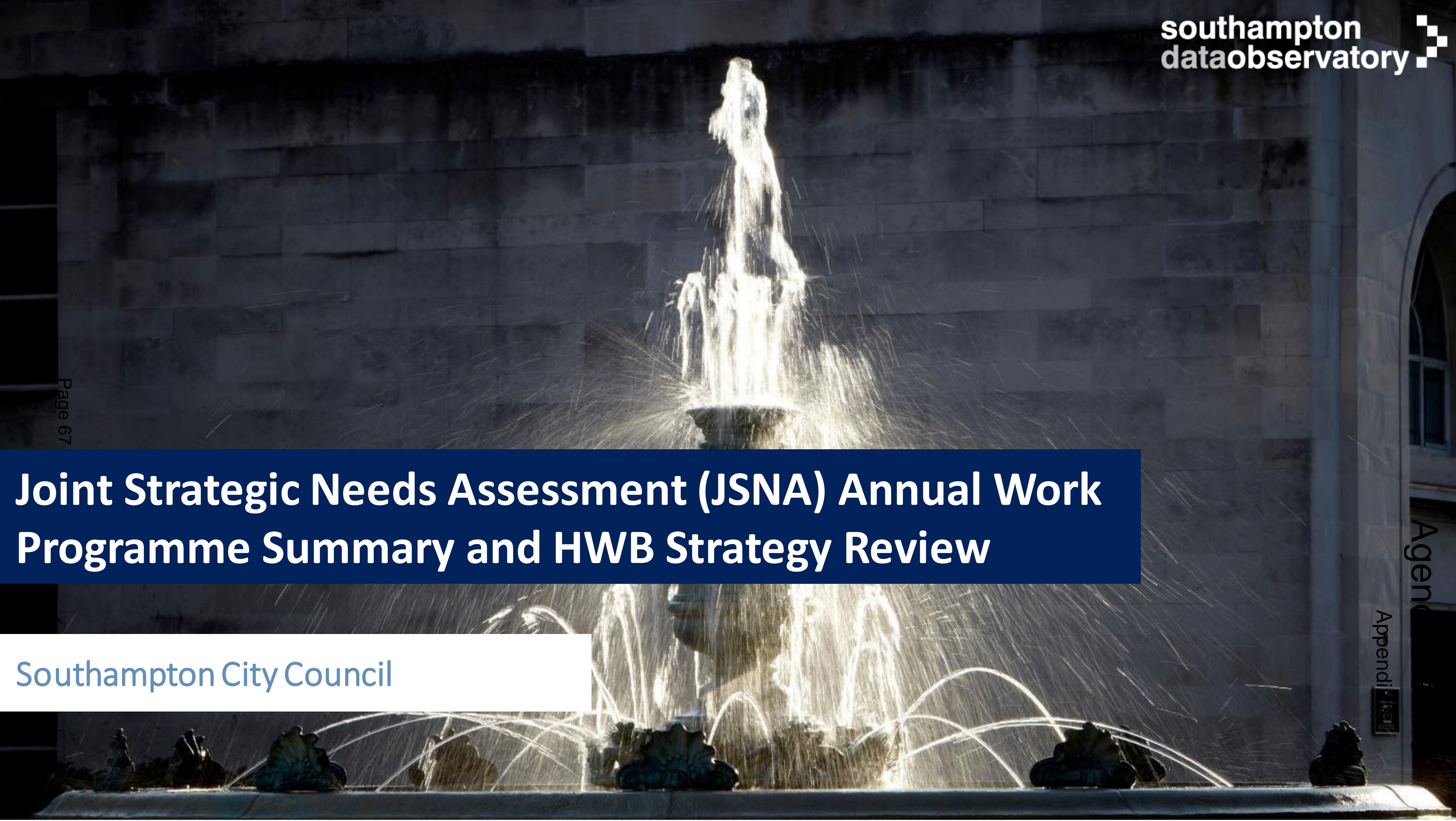
	Priority Commitments	Lead agencies, departments & services	Latest achievements and activities
			- Mobilisation of new contract and re-design of service provision to localities aligning with Enhanced Community Transformation - Development of Community Development role to work alongside less represented groups to increase access and advance equalities - Integrated working with Enhanced Primary Care Mental Health Teams - Development of digital direct bookable slots in GP Practices - Delivery of general access Cost of Living webinar across all GP Practices - Joint Working Protocol in place with Change, Grow, Live and No Limits, Southampton's Substance Use Disorder Service providers for people with a co-occurring mental health and substance disorder conditions Dementia - Southampton Dementia Festival showcasing information about city-wide services and support opportunities for those people living with dementia, their family and carers - Re-commissioning of Dementia Friendly Southampton bringing together community groups, charities, businesses, local government and local residents - Increase in provision of Memory Cafes in the city and delivery of Dementia Navigation
1.7	Make every contact count by ensuring all agencies are able to identify individual needs and respond /refer to services as appropriate.	SCC Public Health and Southampton's Local Area Team (previously ICU)	- Making Every Contact Count (MECC) training paused by Health Education England (HEE) during Covid19, programme now restarting. - MECC training offered to Primary Care Networks, Citizen's Advice and available to all NHS organisations. - Links made with health protection and stronger communities team to train COVID/community engagement officers in MECC - Supporting the HEE project to offer MECC training focussed on alcohol to GP practices - Investigating links to SCC customer service programme - Specified in key health and care contracts
1.8	Promote access to immunisation and population screening programmes.	NHS England, HIOW ICS, SCC Public Health	Covid-19 vaccination - Integrated support for programme across NHS and Local Authority partners - Vaccine champions programme recruited paid and unpaid champions across communities to deliver activities and support local residents to access vaccination - Evergreen offer of vaccination and continued approaches to provide 'drop in' offers in community venues and at events e.g.jobs and wellbeing fair and community venues across the city and there has been a decrease in the number of unvaccinated individuals (for both first or second doses) across all age groups. The booster programme continues with the support of vaccination champions to engage communities less likely to access vaccinations. Immunisation and screening programmes - NHSE review of covid impact on uptake, local programme in place to increase uptake in recovery with key target dates for delivery - Preparations for Hampshire and Isle of Wight Integrated Care Board responsibilities on immunisation and screening - Delivery of NHS Health Checks by General Practice continues, with an increase in offers of health checks and take up of that offer by residents in the last quarter. A catch up of people who weren't invited as a result of the Covid-19 pandemic is not planned at present, as activity has increased naturally in line with capacity, this will continue to be monitored.
	Inequalities in health outcomes are reduced.		
2.1	Reduce the health inequality gap between the most deprived and least deprived neighbourhoods in the city through a community based approach that is proportionate to level of need.	Southampton's Local Area Team (previously ICU), SCC Public Health	- Green network is now in place and working with partners to develop opportunities to grow, cook and eat together across the generations. - Digital inclusion through SO:Connect, is now a standard part of the community development and navigation work of the city. - SCC led COVID champions scheme working with community representatives to share COVIC information and bridge between the council and communities to improve wider health needs - COVID vaccination champions scheme funding and engaging with communities to support access to COVID vaccination with a focus on groups with lowest uptake, including areas of deprivation - Continuing the work of the local solutions groups, within individual communities, to promote services available and identify gaps in provision.
2.2	Take action to improve men's health to reduce the difference between male and	SCC Public Health	- All public health activities and communications are needs-led, where access and uptake is low for males, provision is increased and more targeted – proportionate to this increased need

	Priority Commitments	Lead agencies, departments & services	Latest achievements and activities
	female life expectancy through community based initiative to deliver behaviour change.		- Southampton's Covid-19 vaccination campaigns, COVID vaccination champions and pop up opportunities targeting priority groups, geographical areas and occupations where uptake low, males having lower uptake than females in many of these groups - Suicide prevention programme includes a second year of innovation fund projects that focus on suicide prevention through innovative models of delivery in the community - Men are identified as a high-risk group in the Southampton Suicide Prevention Plan 2020-23 - Community services for smoking, alcohol, drugs and cardiovascular disease risk screening through NHS Health Checks. Rates all typically higher among men.
2.3	Reduce inequalities in early child development by ensuring good provision of maternity services, childcare, parenting and early years support.	SCC Public Health and Southampton's Local Area Team (previously ICU)	- Maternity services offering stop smoking support to pregnant women who are smokers with behavioural support and direct supply NRT. - Maternity service supporting covid-19 vaccination of pregnant women and encouraging young women considering pregnancy to get vaccinated - Continued delivery of healthy child programme with a focus on the 5 mandated contacts and targeted support for those who need it - Continued delivery of Family Nurse Partnership (FNP) to support young parents to ensure best start in life - Continued delivery, and extension to further venues, of Healthy Early Years Award (HEYA) - Awarding of start for Life funding and ongoing Development of Family Hubs
2.4	Work with schools to improve healthy life style choice and mental wellbeing and reduce adolescent risk taking	SCC Public Health	- Work with Lifelab to support children's understanding of covid-19 in primary and secondary schools and rollout of the covid-19 testing programme - Work to increase engagement with Healthy High 5 award in primary and secondary schools across the city - Health protection team support to schools in the event of outbreaks and to provide preventative advice and support with risk assessments - Schools continue to have access to expert advice, guidance and resources from the PSHE Association in response to the statutory RSHE curriculum - Four mental health support teams (MHST) fully mobilised in Southampton covering ~90% of school and college pupils. - Delivery of Anna Freud and SCC workshops with schools and other partners. - Educational sessions on drugs offered to all secondary schools - COVID vaccination champions programme recruited primary schools as champions to disseminate "l*et's talk about COVID-19 jabs*" and "*living with COVID*" information, face masks and hand sanitisers to approximately 10,000 children across 26 primary schools and run an artwork competition (with prizes awarded by the Mayor) to promote safe behaviours.
2.5	Target access to advice and navigation to services for those who are most at risk and in need to improve their health outcomes.	Southampton's Local Area Team (previously ICU)	See 1.4
2.6	Ensure that health inequalities are taken into account in policy development, commissioning and service delivery.	SCC Public Health	- This priority is built into aligned strategies and plans to ensure delivery - Development of a health in all policies framework held by the Health and Wellbeing Board to track progress
2.7	Provide support to help people access and sustain quality jobs, targeting those who are long term unemployed or with families.	Employment services SCC	- Service provides high quality and timely advice to residents from ages 16 and above; particularly those who are measurably disadvantaged in the labour market, including people with neuro-diversity, Secondary mental health conditions, people with a learning disability, new mothers returning to work, young adults, tenants of the Council, people with Musculo skeletal conditions, and people recovering from substance or alcohol abuse - The Service is funded entirely through grants/commissions secured with DWP, NHS, ICU, Southern Health, DLUHC, Adult Services and the EU, to provide ongoing unemployment support to disadvantaged people - The Service has secured a number of awards during 2022 including; Exemplary status (IPS), Matrix accreditation, and BASE Team of the Year - The service is also active in helping us plan for and understand the different risks that communities across the city will endure from the impact of growing unemployment, below entry level skills and dealing with debt and poor mobility – linking into Levelling Up agenda to guide our anti-poverty response, promote prosperity and work together through the auspices of Southampton Connect and the Economic and Green Growth Strategy. The team led on the development of the 3 year Implementation Plan for the UK Shared Prosperity Fund, and is the lead partner for the Multiply (Improving basic numeracy skills for adults) programme - The Adult and Community Learning programme continues to provide entry level and employment skills to disadvantaged adults in our City, and learner numbers are noticeably improving following the supressed numbers

	Priority Commitments	Lead agencies, departments & services	Latest achievements and activities
			during the Pandemic. Priority Groups include people with a declared learning difficulty or health condition, Learners from Black, Asian or Minority Ethnic communities, Unemployed people, and residents who do not have a full level 2 qualification
	Southampton is a healthy place to live and work with strong, active communities		
3.1	Support development of community networks, making best use of digital technology, community assets and open spaces.	SCC Stronger Communities team with Southampton's Local Area Team (previously ICU)	- SO:Linked developed a Social Prescribing network for the city, funded by NHS England and Improvement to share resources, training and develop a health & social care system service improvement plan for the function of Social Prescribing. - Stronger Communities team is growing and strengthening community engagement networks, attracting significant media interest in its activities and increased demand for the team's input to a range of issues (flytipping, health inequalities, ASB, youth participation) - A new engagement leads network has been convened and has met six times, proving to be an effective and growing forum for engagement leads to compare and share activity city wide. - The Community Engagement and Cohesion Team have taken significant strides in raising SCC's profile by being available and present, gathering community insights and coordinating engagement activities. Successes include: - Piloting of Love Where You Live events in Harefield and Newtown preceded by thousands of door knocks pre-event, delivering a Community Day with a range of themed zones for agencies, community programmes and residents to interact and respond to a locally derived issue; the model has led to a commitment to deliver a minimum of six events in 2023 in left behind neighbourhoods applying the mantra 'build up', 'turn up' and 'follow up' - The teams have been heavily invested in organising street level engagements to survey residents impacted by anti-social behaviour - The COVID Champions network evolved into the Vaccine Champions programme, supporting a broad span of grant funded initiatives to tackle vaccine hesitancy and support take up; the approach has grown to most recently delivering a Job and Wellbeing fair attended by 300 job seeking residents, which itself has grown from a range of Health Hubs delivered via the programme.. - The SO:Let's Connect forum is exploring the voluntary sector's capacity to utilise and benefit from digital technology - The Stronger Communities team has also been active in supporting a range of sports-based initiatives, such as the Positive Through Football meeting, Energise Me, legacy work for the Euros 2022 and the Saints Foundations Active Through Football Community programme. The team is leading the cities response to the Playzone Initiative, Football Foundation funded capital investment to improve multi-use games areas in areas with lowest physical activity - Stronger Communities is working with a national charity, the Young People's Foundation Trust to create a Local Youth Partnership of youth sector organisations. - Southampton has been accepted onto the UNICEF UK Accredited Child Friendly Cities programme and is the first city on the South Coast to do so. Our ambitions for a Child Friendly City have involved engagements with 2000 plus children to understand their priorities for the delivery phase. - SO:Linked local solutions groups continue to develop. Mapping of available resources. This has enablement the development of the SOLID (SO:Linked Community Directory) which works in collaboration with the Southampton Information Directory. - Developing responses to need (e.g. Men in Sheds/Youth Clubs) - Supporting communities to get involved with the City of Culture Bid - SO:Linked in the process of working with local solution groups to define the current community asset offer for various target groups (e.g. Children and families/adults with mental health needs/older people/Carers) - SO:Linked delivering infrastructure that supports network development, along with CVSE organisations.
3.2	Improve housing standards and reduce illness and avoidable deaths related to fuel poverty.	SCC Public Health	- Through Advice Southampton Environment TEC have offered support to residents in fuel poverty - Southampton Warmth for All Partnership continues and is chaired by the Director of Public Health - Increased City-wide action in Winter 2022 to raise awareness of benefits and interventions to reduce illness through 'cost of living' work
3.3	Develop an understanding of, and response to, social isolation and loneliness in the city.	Southampton's Local Area Team (previously ICU)	- So:Linked mapped community assets and available on website - SOLID - Continue to access GENIE tool to reduce loneliness - Carers in Southampton - Increased City-wide action in Winter 2022 to improve social connections and opportunities for communities coming together in warm spaces as part of 'cost of living' work - ICS mental health needs assessment completed

	Priority Commitments	Lead agencies, departments & services	Latest achievements and activities
			Communicare schemes (see above) - See 1.3
3.4	Work with city planners to ensure health is reflected in policy making and delivery.	SCC Public Health	- Spatial Planning for Health Specialist (SPHS) recruited and in post for two years from July 2022 - SPHS has already formed a link between Public Health and Planning teams, redrafted the Public Health and Planning protocol, supported Public Health responses to large scale planning applications and provided guidance on planning matters - A draft 'Local Plan with options' has been written and will go to public consultation in Nov/Dec 2022. The SPHS was instrumental in developing The Food and Drink policy within the Draft Plan which includes measures to restrict the proliferation of hot food takeaways. The SPHS has also supported the development of other policies which support the creation of health promoting environments, including active travel, protection of existing open spaces and support for the creation of new spaces, and a requirement for Health Impact Assessment for applications meeting certain criteria. - In the future, the SPHS will support the Public Health team to develop skills and expertise in healthy place making, as well as working on other projects such as the food environment and the Green Grid. The approach taken in this area of work will also inform the developing Health in All Policies workstream (see 2.6) - Our approach to healthy place making, through the employment of a SPHS, is subject to an independent evaluation by an academic team from Lancaster and Liverpool Universities (funded by the National Institute for Health Research)
3.5	Deliver a cleaner environment through a clean air zone with vehicle access restrictions to the city.	SCC Transport	The air programme sits within the wider Green City programme incorporating other sustainability agendas. Progress on air quality projects and opportunities for linkages are discussed in regular Green City board meetings. Local NO2 Plan/ Non-charging CAZ Through a detailed business case exercise including thorough modelling and consultation exercises, Southampton City Council was able to demonstrate that a charging Clean Air Zone was not necessary in securing compliance with relevant air quality objectives within the shortest possible time. Instead, a series of non-charging measures (Referred to as The Local NO2 Plan) were presented and approved by central government to help ensure compliance would be achieved and maintained. Measures included a low emission taxi incentive scheme, a bus retrofit programme, a targeted active travel engagement campaign, an enhanced sustainable distribution centre, new taxi only rapid charge points and more. These measures share the same aim as a charging zone, largely in making public transport cleaner and encouraging modal shift without the unintended consequences charging can bring. The Plan was launched in 2019 and concluded in 2021 with all measures being implemented according to the expectations of central government despite some changes needed as a result of the pandemic. Key successes in the plan include: • 53% of the taxi and private hire in the fleet now consisting of hybrid or electric vehicles – up from less than 10% 5 years ago • 100% of Southampton operating buses meeting Euro VI Euro VI equivalence The Council continue to work with central government to monitor and evaluate the effectiveness of the plan and understand whether any further measures may be required. Air Quality Action Plan The Council is scheduled (cabinet in December) to adopt an update to its Air Quality Action Plan which will set out projects to be delivered over the next 5 years to further reduce the impacts of air quality on the city's residents. Updating the plan and implementing measures within it is a statutory duty under The Environment Act which includes new responsibilities and powers under the 2021 update. It's also being developed to maintain the momentum of the Local NO2 Plan and provide a policy umbrella where all air quality projects outside of The NO2 Plan can be delivered under. These include: • Air Quality Engagement Programme – wood burning engagement campaign, schools engagement project (currently recruiting a post to deliver this) and healthcare engagement project (bid pending result) • E-taxi and van trial scheme – ERDF funded project providing 50% off lease of a taxi or van, and the introduction of 5-8 new rapid chargers • Network of new low-cost monitors In total the plan consists of 60 new measures which can reduce the impact of air quality across 5 priority areas, on top of an existing 40 measures the Council has implemented or is implementing regardless across all service areas. The Council has been able to monitor a steady improvement in air quality in the city since 2013.

	Priority Commitments	Lead agencies, departments & services	Latest achievements and activities
3.6	Work with employers to improve workplace wellbeing through healthier work places.	SCC Public Health and employment services	- Public Health is supporting a cross-council Wellbeing Strategic Group reviewing and revising the support available to improve staff health and wellbeing - In partnership with colleagues in Economic Development and Sustainable Travel, Public Health is working to engage employers and organisations anchored in our city, to improve their health impact as an employer including workplace wellbeing - One Southampton jobs and wellbeing fair held at the Guildhall to bring together employers looking for staff, residents looking for work and health check and vaccination offers to improve health and wellbeing
	People in Southampton have improved health experiences as a result of high quality, integrated services		
4.1	Improve health outcomes for residents, at a lower cost, through integration and joint working across all health and Council services.	Southampton's Local Area Team (previously ICU)	- The city's services continue to work towards the delivery of integration and joint working as part of the implementation of the Health and Care Strategy 2020-25. This is evidenced in services for all age groups, including SEND services, 0 – 19 services, Rehab and Reablement services and finally core community services (One Team) for adults and older people. Delivery of this programme is monitored through the Better Care Steering Board, Integrated Commissioning Unit. - Testing of 'One Team' approach has expanded to the East and West of the city. Promoting integration between core community health and care services - Proactive case management approaches have been in place as part of One Team and Locality working for some time, further work is underway to promote a more standardised approach ahead of this winter (2022/2023). This provides part of the foundation for a Population Health Management approach.
4.2	Prioritise investment in and embed a prevention and early intervention approach to health and wellbeing across the city.	Southampton's Local Area Team (previously ICU)	- Monitoring delivery of the Health and Care Strategy for Southampton which has a prevention and early intervention approach at its core - Ensuring decision making on council financial savings takes account of impact of reducing preventative activity. Public Health Grant underspend being used to support - Promotion of community solutions and other prevention and early intervention work with our community and voluntary section remains a priority for the city – including SO:Linked, AIG and our Mental Health Network. - The proactive case management approach being developed targets secondary prevention. - Continued investment in eat well approaches and weight management underpins prevention initiatives in the city.
4.3	Deliver a common approach to planning care tailored to the needs of the individual or family.	Southampton's Local Area Team (previously ICU)	- The Community Wellbeing Service promotes proactive care planning and provision for some of our most vulnerable residents e.g. those living with a Severe Mental Illness, Learning Disability and/or Frailty. This service works as an integral part of One Team which supports a multidisciplinary approach to care and health delivery for those whose needs are more complex. - Anticipatory Care Planning is a key part of ensuring that people's needs are not only tailored to their specific circumstances but also enable a look to the future through 'just in case' planning.
4.4	Deliver the right care, at the right time, in the right place by working as locally as possible and shifting the balance of care out of hospital to community providers.	Southampton's Local Area Team (previously ICU)	- Single Point of Access development for the city, initially to support hospital discharge embedded.
4.5	Maximising opportunities for prevention and early intervention through making every contact with services count.	SCC Public Health	See 1.7 above - Working through the health and care strategy 'prevention and health inequalities' board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The JSNA (Joint Strategic Needs Assessment)

- Health & Wellbeing Boards are responsible for producing a JSNA (Health & Social Care Act 2012)
- The JSNA is an assessment of the current and future health and social care needs of the community
- Purpose is to improve health & wellbeing and reduce inequalities
- Statutory requirement to produce AND inform health and wellbeing commissioning plans
- Locally determined process - No mandated format, core dataset or update schedule. Southampton JSNA is brought together with other data, intelligence, specialist reports, needs assessments, summary analysis and headline statistics covering the city's population, health, community safety, economy and public services within the Southampton Data Observatory
- Health and Wellbeing Boards should develop a Health and Wellbeing Strategy paying due regard to the evidence set out in the JSNA.
- The Southampton Health and Wellbeing Strategy is monitored using a key set of performance indicators (KPIs). These can be accessed via a regularly refreshed Power BI dashboard. They are also available to view (along with commentary) within this slide pack here.

HWBB Priorities and Indicators

southampton dataobservatory

Outcome / What are we going to do?

People in Southampton live active, safe and independent lives and manage their own health and wellbeing

- Encourage and promote healthier lifestyle choices and behaviour, with a focus on smoking, alcohol / substance misuse, healthy weigh, and physical activity including walking and cycling more.
- Encourage and promote healthy relationships and wellbeing of individuals of all ages, carers and families, particularly for those at risk of harm and the most vulnerable groups through increasing early help and support.
- Support people to be more independent in their own home and through access to their local community, making best use of digital tools including Telecare.
- Ensure that information and advice is coordinated and accessible.
- Prioritise and promote mental health and wellbeing as being equally important as physical health.
- Increase access to appropriate mental health services as early as possible and when they are needed.
- Make every contact count by ensuring all agencies are able to identify individual needs and respond /refer to services as appropriate.
- Promote access to immunisation and population screening programmes.

Inequalities in health outcomes are reduced

- Reduce the health inequalities gap between the most deprived and least deprived neighbourhoods in the city using the evidence of what works in the Marmot review of Health Inequalities.
- Take action to improve men's health to reduce the difference between male and female life expectancy through community based initiatives to deliver behaviour change.
- Reduce inequalities in early childhood development by ensuring good provision of maternity services, childcare, parenting and early years support.
- Work with schools to improve healthy lifestyle choices and mental wellbeing and reduce the harm caused by adolescent risk taking.
- Target access to advice and navigation to services to those who are most at risk and in need, to improve their health outcomes.
- Ensure that health inequalities are taken into account in policy development, commissioning and service delivery.
- Provide support to help people access and sustain quality jobs, targeting those who are long term unemployed or with families.

Southampton is a healthy place to live and work with strong, active communities

- Support development of community networks, making best use of digital technology, community assets and open spaces.
- Improve housing standards and reduce illness and avoidable deaths related to fuel poverty.
- Develop an understanding of, and response to, social isolation and loneliness in the city.
- Work with city planners to ensure health is reflected in policy making and delivery.
- Deliver a cleaner environment through a clean air zone with vehicle access restrictions to the city.
- Work with employers and employees to improve workplace wellbeing through healthier work places.

People in Southampton have improved health experiences as a result of high quality, integrated services

- Improve health outcomes for residents, at a lower cost, through integration and joint working across all health and council services.
- Prioritise investment in and embed a prevention and early intervention approach to health and wellbeing across the city.
- Deliver a common approach to planning care tailored to the needs of the individual or family.
- Deliver the right care, at the right time, in the right place by working as locally as possible and shifting the balance of care out of hospital to community providers.
- Maximise opportunities for prevention and early intervention through making every contact with services count.

How will we measure success?

The Public Health Outcomes Framework is a comprehensive list of desired outcomes and indicators that help measure how well public health and wellbeing is being improved and protected in an area. The Health and Wellbeing Board will focus on a selection of these indicators that a) require the most improvement and b) will best indicate progress towards the outcomes in this strategy.

Priority area	Measure		
Overarching	Life expectancy at birth	Life expectancy at 65 years	Healthy Life Expectancy at birth
	Under 75 years mortality rate from cardiovascular disease	Under 75 years mortality rate from respiratory disease	Mortality rate from causes considered preventable
Children & Young People/ Early years	Smoking status at time of delivery	Breastfeeding prevalence at 6-8 weeks after birth	Child excess weight in 4-5 and 10-11 year olds
	Population vaccination coverage – MMR for one dose (2 years old)	Looked after children rate	School readiness
	Children in low income families (under 16s)	Hospital admissions caused by unintentional and deliberate injuries (0-14 years)	Under 18 years conception rate
Adults	Smoking prevalence in adults	Suicide rate	Depression recorded prevalence
	Injuries due to falls in people aged 65 years and over	HIV late diagnosis	Under 75 years mortality rate for liver disease considered preventable
	TB incidence (3 year average)		
Healthy settings	Fraction of mortality attributable to particulate air pollution	Percentage of people aged 16-64 years in employment	Excess winter deaths index

The full Public Health Outcomes Framework can be found at **www.phoutcomes.info**

We have been monitoring Southampton against the measures set out in the Health and Wellbeing Strategy. These indicators are also available on constantly refreshed PowerBI dashboard

Key points – Overarching indicators: Life expectancy and mortality

- In Southampton, **men** live **13 months less** and **women** live **8 months less** compared to the England average
- Southampton **women** live for a **longer period** in **poorer health** (19.4 years) than Southampton men (17.0 years) [Poorer health years = Life Expectancy – Healthy Life Expectancy]
- The **mortality rate** from causes considered preventable and the under-75 mortality rates from cardiovascular disease and respiratory diseases **remains higher than England**. In recent pooled periods, **Southampton rates** for **men** have **declined** but have **increased** for **women** for these three indicators. (Nationally, the rates for causes considered preventable and cardiovascular for women are decreasing – respiratory rates for women are increasing)
- Comparing the **most deprived 20%** of Southampton to the **least deprived 20%,** life expectancy at birth gap **8.1 years** for **men** and **3.4 years** for **women** (2019-21)

Priority area	Measure	Unit	Latest period	Southampton Sparkline	Southampton value	England value	ONS Comparator Ranking (1 out of 12 is worse, worst third in pink)	Significance compared to England value
Overarching	Life expectancy at birth (Male)	Years	2018 - 20		78.3	79.4	5	Significantly lower
	Life expectancy at birth (Female)	Years	2018 - 20		82.5	83.1	7	Significantly lower
	Life expectancy at 65 years (Male)	Years	2018 - 20		17.9	18.7	5	Significantly lower
	Life expectancy at 65 years (Female)	Years	2018 - 20		20.7	21.1	8	Significantly lower
	Healthy Life Expectancy at birth (Male)	Years	2018 - 20		61.4	63.1	5	Lower
	Healthy Life Expectancy at birth (Female)	Years	2018 - 20		63.1	63.9	6	Lower
	Under 75 mortality rate from cardiovascular diseases considered preventable (2019 definition) Male	per 100,000	2017 - 19		45.7	40.8	6	Higher
	Under 75 mortality rate from cardiovascular diseases considered preventable (2019 definition) Female	per 100,000	2017 - 19		19.9	15.9	5	Higher
	Under 75 mortality rate from respiratory disease considered preventable (2019 definition) Male	per 100,000	2017 - 19		36.1	22.5	3	Significantly higher
	Under 75 mortality rate from respiratory disease considered preventable (2019 definition) Female	per 100,000	2017 - 19		31.5	18.1	2	Significantly higher
	Under 75 mortality rate from causes considered preventable Male	per 100,000	2017 - 19		240.8	188.6	4	Significantly higher
	Under 75 mortality rate from causes considered preventable Female	per 100,000	2017 - 19		137.5	97.9	4	Significantly higher

Key points – Children and Young people

- **Smoking at time of delivery** (11%) **higher** but not **significantly** than England (10%). Previous years significantly higher. Recent years show **Southampton** percentage **decreasing faster** rate **than nationally**.
- **Breastfeeding** prevalence at 6-8 weeks after birth **increasing** and **higher** than **national** average (53% vs. 45%)
- **Excess weight** in 4/5 years old significantly higher and 10/11 years old higher than England and with a steeper overall increase, (see slide 27) 2020/21 uses local data as published data for all local authorities unavailable due to insufficient pandemic-related coverage
- **Children Looked After rate** similar 2019 to 2021, **higher than England** but **gap reducing**. **School readiness** following national **increases** and **MMR vaccination** (age 2) recent years **significantly higher** and **increasing** overall trend vs. **national decline**
- Teenage conception **decreased overall** at a **faster** rate than **nationally** over **last 15 years**, despite significantly higher than England in 2020 (2018 and 2019 was statistically similar)
- **Children** in relative **low income** families, **consistently significantly higher** than England and **gap getting worse**
- Hospital admissions caused by **unintentional and deliberate injuries** in **children** under 15 years **lowest rate** in last 10 years

Priority area	Measure	Unit	Time period	Southampton Sparkline	Southampton value	England value	ONS (n=12) Comparator Ranking (1 is worse, worst third in pink)	Significance compared to England value
Children & Young People/Early years	Smoking status at time of delivery (Female)	%	2020/21		10.7	9.6	5	Higher
	Breastfeeding prevalence at 6-8 weeks after birth - current method	%	2020/21		53.4	47.6	2 of 5	Significantly higher
	Child excess weight in 4-5 year olds	%	2020/21		32.7	27.7	Insufficient data	Significantly higher
	Child excess weight in 10-11 year olds	%	2020/21		41.0	40.9	Insufficient data	Higher
	Population vaccination coverage - MMR for one dose (2 years old)	%	2020/21		93.7	90.3	8	Higher
	Children looked after	per 10,000	2021		96.0	67.0	3	Significantly higher
	School readiness: Good level of development at the end of reception	%	2018/19		71.1	71.8	9	Lower
	School readiness: Year 1 pupils achieving the expected level in the phonics screening check	%	2018/19		82.1	81.8	10	Higher
	Children in relative low income families (under 16s)	%	2020/21		22.2	18.5	6	Significantly higher
	Hospital admissions caused by unintentional &deliberate injuries in children (aged 0-14 yrs)	per 10,000	2020/21		65.0	75.7	9	Significantly Lower
	Under 18s conception rate / 1,000 (Female)	per 1,000	2020		20.7	13.0	2	Significantly higher

Key points – Adults

- **Smoking prevalence** in adults **decreasing** overall, 2019 data (16.8%) significantly higher than England (13.9%), 2020 has cautionary flag around data collection, true value is expected to lie between 2019 and 2020 values
- **Suicide rate** (2019-21 9.5 per 100k) **similar** to **England** and lowest rate in last 12 three-year pooled periods, however **coroner** hearings and **registered** dates may have been **delayed** due to **COVID-19**.
- Local **depression prevalence** (12.4%) has **increased** similarly **along** with **national** rates (12.3%) for 2020/21
- Under 75 mortality from **preventable liver disease**, data 2016-18 & 2017-19 **highest since 2001-03**, **significantly higher** than **England**
- **HIV late diagnosis** in people first diagnosed with HIV in the UK, now 37% continues with a 4th consecutive 3 year pooled period **lower** than **national average** (43%)
- **TB incidence locally** (9.8 per 100k) **significantly higher** than England (8.6 per 100k) and **lowest** since 2001-03
- **Injuries due to falls** in those aged 65+ **increasing overall** whilst **England average** remained **stable**, pandemic period saw falls locally and nationally decline in line with stay-at-home/social distancing compliance

Priority area	Measure	Unit	Time period	Southampton Sparkline	Southampton value	England value	ONS (n=12) Comparator Ranking (1 is worse, worst third in pink)	Significance compared to England value
Adults	Smoking Prevalence in adults (18+) - current smokers (APS)	%	2020		11.8	12.1	8	Lower
			2019		16.8	13.9	3	Significantly higher
	Suicide rate (age 10+ years)	per 100,000	2019 - 21		9.5	10.4	11	Lower
	Depression: Recorded prevalence (aged 18+)	%	2020/21		12.4	12.3	4	Higher
	Injuries due to falls in people aged 65+ (Persons)	per 100,000	2020/21		2918.6	2023.0	2	Significantly higher
	Injuries due to falls in people aged 65+ years (Male)	per 100,000	2020/21		2659.4	1667.3	2	Significantly higher
	Injuries due to falls in people aged 65+ years (Female)	per 100,000	2020/21		3092.8	2284.8	3	Significantly higher
	Under 75 mortality rate from liver disease considered preventable (2019 defn)	per 100,000	2017 - 19		23.2	16.7	3	Significantly higher
	HIV late diagnosis in people first diagnosed with HIV in the UK	%	2019 - 21		37.3	43.4	10	Lower
	TB incidence (3 year average)	per 100,000	2018 - 20		9.8	8.0	3	Higher

Key points – Healthy settings

- 2020 saw fraction of mortality attributable to particulate air pollution higher than England average (6.3 versus 5.6%) and places Southampton 2nd highest among comparators. All areas
- **Excess winter deaths not significantly different** to **England average** and follows national warm/cold winter trends. The data has not be revised at local authority level for Winter 2020 to 2021 which nationally showed a growth of excess winter deaths driven by the large number of coronavirus (COVID-19) deaths in the non-winter months of 2020 (April to July) and the winter months of 2021 (December to March).
- Data for **people in employment** to end of March 2021 saw Southampton significantly higher than England, however the impact of COVID-19 has since seen significant increases and also sub-city variation (see slides on benefits in Covid Impact Assessment section)

Priority area	Measure		Time period	Southampton Sparkline	Southampton value	England value	ONS (n=12) Comparator Ranking (1 is worse, worst third in pink)	Significance compared to England value
Healthy settings	Fraction of mortality attributable to particulate air pollution (new method)	%	2020		6.3	5.6	2	Not comparable
	Percentage of people aged 16-64 in employment	%	2020/21		80.0	75.1	11	Significantly Higher
	Excess winter deaths index (Persons)	Ratio	Aug 2019 - Jul 2021		7.4	17.4	11	Lower
	Excess winter deaths index (Male)	Ratio	Aug 2019 - Jul 2021		11.0	17.5	11	Lower
	Excess winter deaths index (Female)	Ratio	Aug 2019 - Jul 2021		3.6	17.3	11	Lower

2022/23 JSNA work programme

- JSNA analysis produced this year on bespoke topic areas, showcased in this slide set, are;
  - 2021 Census
  - Long-term/chronic conditions, childhood obesity and food environments
  - Covid Impact assessment
- The JSNA work programme will be defined by the JSNA steering group with new updates published on the Southampton Data Observatory. The work programme aligns with stakeholder priorities for needs assessments and strategies, such as Sexual Health Needs Assessment, Physical Activity Strategy, Tobacco, Alcohol & Drugs Strategy, Childhood Obesity Task and Finish Group recommended analysis
- Refreshed and new JSNA pages/products on the data observatory this year are;

Demography
- Population change
- 2021 Census*
- Births
- Population

Healthy People
- Disability overview*
- Diabetes
- Life expectancy and mortality
- Chronic conditions*
- Covid impact assessment*

Healthy Lives
- Healthy weight
- Alcohol
- Sexual health
- Drugs

Healthy Places
- Food environment
- Economic assessment
- Benefit maps
- Pharmaceutical Needs Assessment*

*Most products include interactive dashboards. The asterisked products have intelligence compiled in written reports and/or slide sets instead.

Census 2021 Population

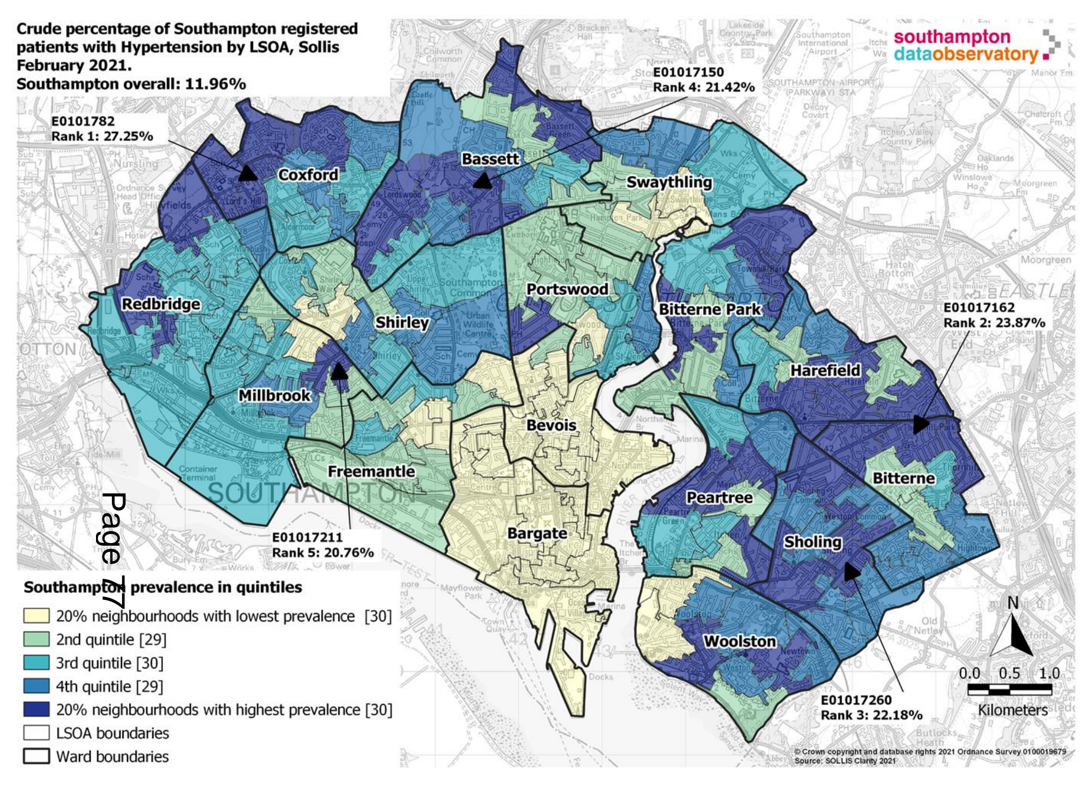
- The Office of National Statistics has started to release data collected about our residents from the 2021 Census
- In Southampton, the **population size** has **increased** by **+5.1%**, from around 236,900 in 2011 to 249,000 in 2021. The total population in the city in **2021** was **estimated** to be **261,716** (similar to the estimates on the previous slide). This is **lower** than the overall **increase** for **England** of **+6.6%**.
- Southampton ranked 70th for total population size out of 309 local authority areas in 2021. This is the same position it held a decade ago in 2011.
- Although the overall **population** has **increased**, there are **variations by age** group within the city
  - There was a **decrease** of **-10.4%** in the **under 5 years** population between 2011 (15,400) and 2021 (13,800) which is reflective of **decreasing birth rates** locally and nationally (see previous slide)
  - The population aged **5 to 14** has increased by **+20.5%** to 28,200
  - The population aged **15 to 24** has **decreased** by **-9.1%** which reflects the **reduced student residency** in the city during the pandemic (when the census was conducted)
  - The number of older people aged **65 to 84** has **increased** by **+13.4%** reflecting the **ageing population**.
- The number of **households** in Southampton **increased** from 98,300 in 2011 to 102,300 in Census 2021, an increase of **+4.1%**.
- The city's residents are **more densely populated**, with an **increase** from 47.5 people per hectare in the 2011 to 49.9 per hectare in 2021

Census 2021 – Upcoming releases

- **Further data** on different Census topics and themes is due for release over the next few months
- Analysis illustrating the **changes** since the **2011 Census** and **benchmarking** against our ONS comparators helps to build a **detailed snapshot** of **local society**. It will also help Southampton City Council and partners **plan and fund** local services.
- Analysis of **upcoming releases** will be available on the Southampton Data Observatory, hopefully within a few days after release, which will help **further understanding** of **Southampton communities**
- Data for on communities including **ethnicity, national identity, religion and language** within the city, is only available via the 10 yearly Census. It will give us an **up-to-date profile** of the population to support and inform health and wellbeing commissioning plans that improve health & wellbeing and reduce inequalities
- Upcoming releases include:
  - Demography and migration — 02 November 2022
  - UK armed forces veterans — 10 November 2022
  - Ethnic group, national identity, language, and religion — 29 November 2022
  - Labour market and travel to work — 08 December 2022
  - Housing — 05 January 2023
  - Sexual orientation and gender identity — 06 January 2023
  - Education — 10 January 2023
  - Health, disability, and unpaid care — 19 January 2023

Analysis will be available on the Census 2021 Southampton Data Observatory Page

Chronic/Long-term conditions (LTCs)

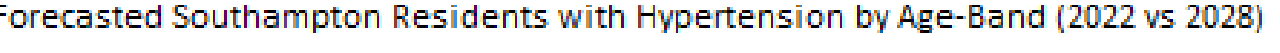


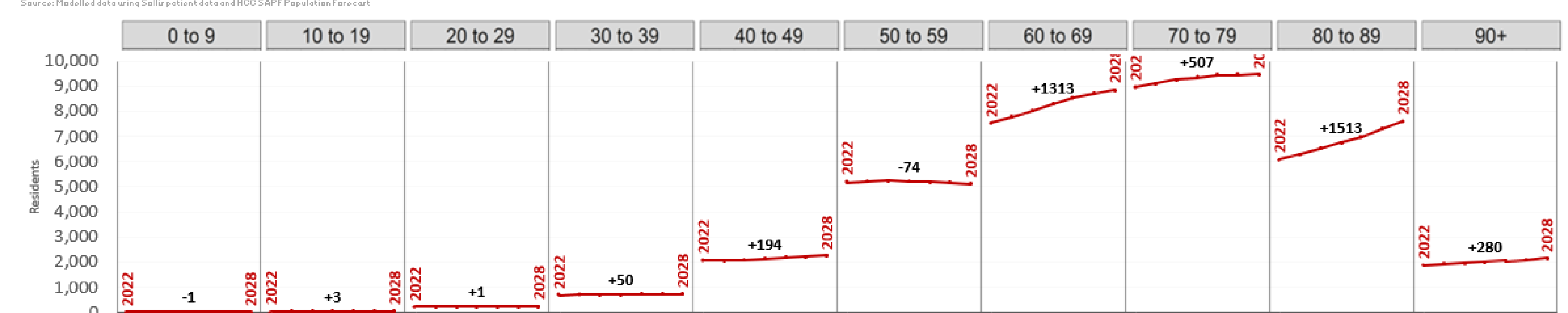
A [data pack] mapping the GP **diagnosed prevalence** of **18 common chronic/long-term conditions,** and 3-5+ **multiple conditions** across the city is available. This also includes **modelled forecasts of disease prevalence** by **age** and **locality** for these **conditions** in the **future.**

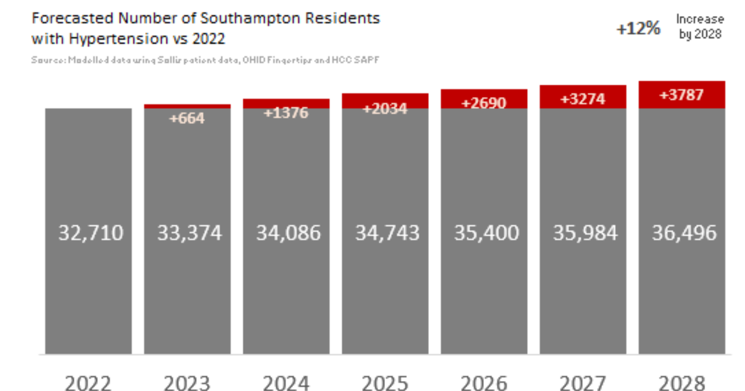
The top **FOUR** diagnosed conditions of Southampton registered patients are **hypertension, frailty, asthma** and **diabetes.**

Additional logistic modelling using the **GP data** and **Health Survey for England data** estimated **5,600** residents need for **help** with 5 or more **activities of daily living** in 2022, which is expected to increase by **+14%** to 6,400 **by 2028**

Note: The graphics shown are for hypertension







Why is tackling Childhood obesity in Southampton important?

- The **leading cause** of **disability** is a **high body mass index.**

- Obesity in children is a risk factor for obesity in adulthood, which is a leading cause in a vast range of conditions*.
(*Conditions such as asthma and other respiratory problems, eating disorders, mental health disorders and psychosocial risks, cardiovascular diseases, Type 2 diabetes, musculoskeletal problems, sleep apnoea etc.)

- Before the pandemic, a **Scrutiny enquiry recommendation** on childhood obesity was that **analysis** was conducted on **childhood obesity** and the **food environment**. Analysis on childhood obesity and the food environment was provided for a Task & Finish Group, available on the JSNA in the resources section of the Healthy weight JSNA topic page .

- In Southampton the level of obesity among **year R** children has **remained stable** and **similar** to the **national** average, whereas rates in **year 6** children have **increased** overtime and have become **worse** than **England**.

- During the **COVID-19** pandemic, data was collected from a **representative sample (2020/21)**. Reception Year data for this period showed a **significantly higher increase** for obesity (17.1%) and excess weight (32.7%) prevalence locally and nationally compared to the previous four years.

- The Year 6 2020/21 sample for Southampton was **too small** to make **robust** statistical comparisons. However, the prevalence for **Year 6 obesity** (26%) and **excess weight** (41%) **mirrored** the **national** figures and **increasing prevalence** in the trend data follows the **national direction** of travel.

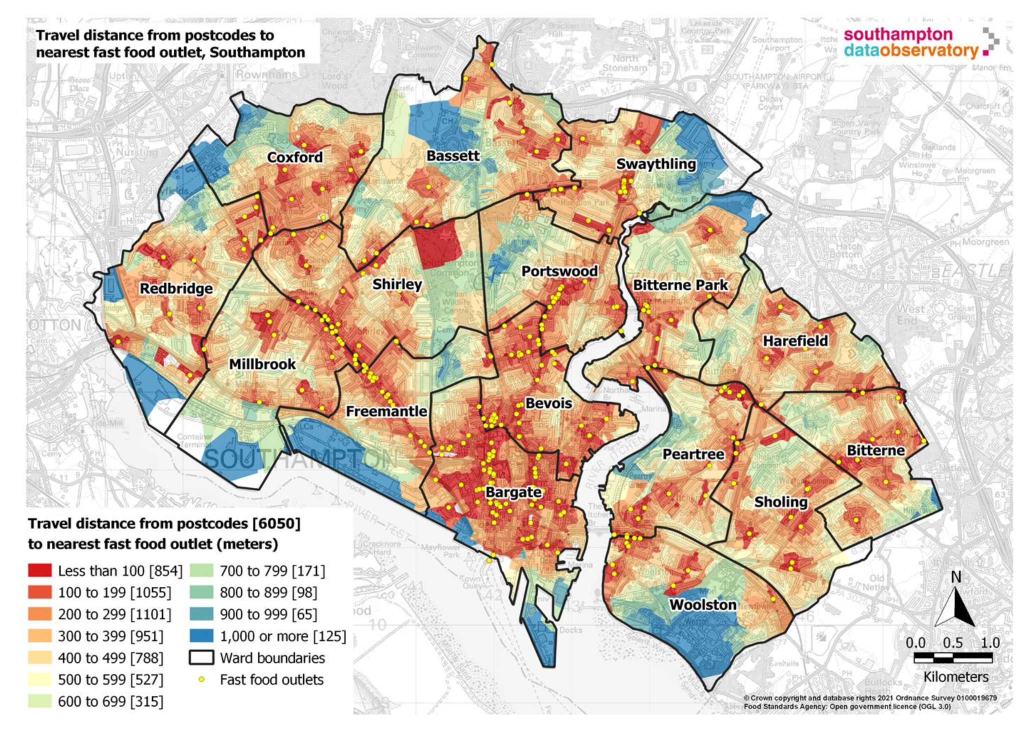
- The data also showed the **gap** in **obesity prevalence** between children in the **most and least deprived parts** of Southampton has **widened**. Linked analysis showed **7 out of 10 overweight** Year 6 children and **4 out of 10 obese** Year 6 children were of a **healthy weight previously** in Reception year.

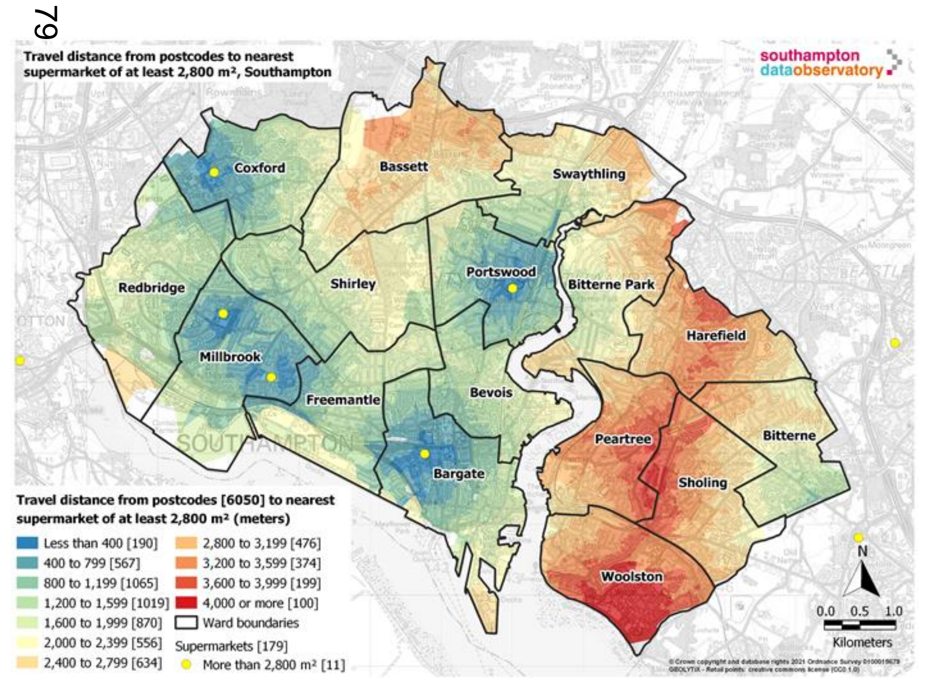
The Food Environment

Food environment impacts on childhood obesity

Fast food outlet data highlighted the **majority of residents** live with a **5-10 minute** drive or a **1km walk** of a **fast food** outlet

Almost all residents are **within a mile** of a fast food outlet, **7 out of 10 schools** are **within 400m** of a **fast food** outlet, with closer proximities in the city centre and deprived areas.





Access to **supermarkets** with **larger floor spaces** (2,800+ m^2) holding **more range** and more likely to include **budget brands** is **further** away from people in the **East** of the city and **Bassett** and **Swaythling**.

People in **deprived** areas are **less likely** to order groceries **online**

The full food environment analysis is on the Data Observatory

- **Most aspects of health and wellbeing covered by the JSNA were impacted by the pandemic including those monitored against the Health and Wellbeing Strategy**
- Further analysis of the direct and indirect impacts of the pandemic are included in the Covid-19 Impact Assessment, set out in three sections; Healthy People, Healthy Living and Healthy Places
- Many impacts are yet to be fully realised and the Covid-19 Impact Assessment is refreshed regularly as more data is made available and further understanding reached. Future impacts suggest this winter would have an impact on health and wellbeing inequalities in the community given the challenges of heating costs and the impact of the cost-of-living increase.

- The assessment showed **significant impact** of the **Covid-19 pandemic** on the **health of Southampton residents.** Analysis including looking at **inequalities**, showing there were **significant differences** in **cases** (in the first three waves) and **hospital admissions** when comparing those living in the 20% most deprived neighbourhoods with those living in the 20% least deprived - with **higher rates in the most deprived**
- There have been some **negative impacts** such as an **increase in mental health issues** but also some **positive impacts** such as **reduction in smoking, increased value of air quality** and **clean air**, and an increase in **physical activity**.
- Analysis incorporates national and local data including Southampton resident survey data

Covid-19 Impact Assessment

DECISION-MAKER:	Health and Wellbeing Board
SUBJECT:	Proposal to adopt the Prevention Concordat for Better Mental Health for Southampton
DATE OF DECISION:	14 December 2022
REPORT OF:	Cabinet Members for Health, Adults and Leisure

CONTACT DETAILS				
Executive Director	Title	Director of Commissioning, Integrated Health and Care		
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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 (18.7%). This is significantly worse than the England and South East average,	

[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

	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 J
uly 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

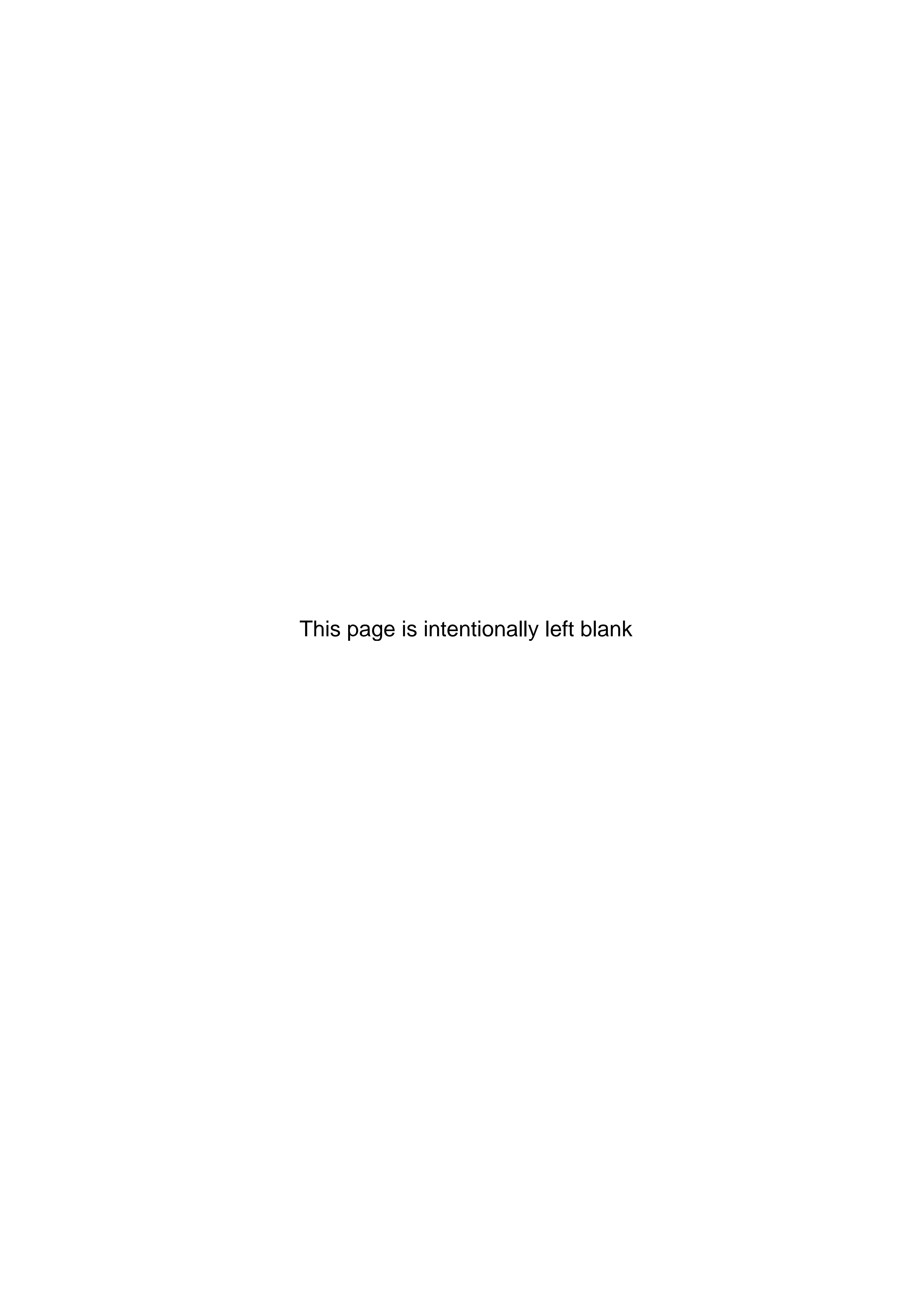
[6] Southampton Suicide Prevention Plan 2020-23: [illegible] for Southampton Suicide Prevention Plan.pdf

	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		
	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.		**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:	Sexual Health and Reproductive Health Needs Assessment
DATE OF DECISION:	14th December 2022
REPORT OF:	CABINET MEMBER FOR HEALTH, ADULTS AND LEISURE

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STATEMENT OF CONFIDENTIALITY
N/A

BRIEF SUMMARY

This report provides the Health and Wellbeing Board with a summary of work to understand and improve sexual and reproductive health outcomes and reduce sexual and reproductive health inequalities in Southampton, including arrangements for implementation of actions.

Sexual health in Southampton is influenced by a wide range of universal preventative services and almost every part of our healthcare system. The Southampton sexual health needs assessment used a systematic approach with a combination of quantitative data, service user and staff surveys, qualitative research and stakeholder engagement to understand the sexual and reproductive health needs of the population, together with the assets available to support these needs. The full report is provided in Appendix 1 and published online here.

The needs assessment identified good quality and effective sexual healthcare once people are seen within services. The findings from the needs assessment were grouped into three key themes: prevention, equity, and relationships and system working; these have informed the recommendations. Opportunities were identified to address the high rates of sexually transmitted infections and termination of pregnancy, low uptake of the most effective methods of contraception, and inequalities in sexual health outcomes found for some of our communities. The report recommendations focus on strengthening joint governance and leadership to improve the population impact of services across the city, better collaboration between different parts of the health and care system and with our communities, a stronger focus on equity, improved awareness of and access to services and normalising conversations around sex and reducing stigma as routes to improving sexual health outcomes.

Delivery of improvement activities will be coordinated by a renewed sexual health network. Discussions, including NHSE as HIV service commissioners, are underway to scope the most effective commissioning and governance approaches for integrated sexual health services. The intention is for these to be delivered at Southampton level and, when there is good reason to do so, with partners across Hampshire and Isle of Wight.		
RECOMMENDATIONS:		
	(i)	To consider the findings of the health needs assessment, specifically that implementation of recommendations and clinical joint-working is taken forward through a renewed sexual health network at place level (Southampton).
	(ii)	It is recommended that sexual health and wellbeing is promoted across the city's communities and the health and care system via strong relationships and partnerships; reducing stigma through conversations in the community and at health and care touch points, and improving awareness and access to services when residents need them, will contribute to improving sexual health outcomes.
REASONS FOR REPORT RECOMMENDATIONS		
1.	Sexual health in Southampton is influenced by a wide range of universal preventative services and almost every part of our healthcare system; alignment of service provision and clinical pathways through a network will be key for effective delivery.	
2.	The health needs assessment has identified opportunities to improve health and wellbeing of the local population and reduce inequalities.	
3.	Prevention and early intervention are essential to improve sexual and reproductive health outcomes in Southampton; this includes creating an open sexual health culture.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
4.	N/A	
DETAIL (Including consultation carried out)		
5.	Sexual health services (SHS) are commissioned at a local level to meet the needs of the population on a range of issues such as sexually transmitted infections (STIs), contraception, relationships, and unplanned pregnancy. Local authorities must make provision for comprehensive open access sexual health services (including STI testing and treatment, notification of sexual partners of infected persons and free provision of contraception). Services are provided across general practice, community services, hospitals, pharmacies, and the voluntary sector. Tailored provision is available for young people, and other groups requiring enhanced support to access services such as people with learning disabilities and women who sell sex. Within the needs assessment, the national and local context has been presented, quantitative and qualitative data collated from several sources to include demographics, service data, public and workforce surveys and interviews with individuals representing people with learning disabilities and	

	their carers and people from ethnic minority communities. Further stakeholder engagement included the discussion of findings and recommendations at a workshop as well as those stakeholders commenting on the final draft of the needs assessment. The existing level 3 specialist sexual health service contract ends in March 2024. Collaborative commissioning discussions, including NHSE as HIV service commissioners, are underway to scope the most effective collaborative commissioning approaches for the integrated sexual health service, across Hampshire, IOW, Portsmouth and Southampton.
RESOURCE IMPLICATIONS	
Capital/Revenue	
6.	No additional funding implications
Property/Other	
7.	N/A
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
8.	Local authorities have a statutory duty (Health and Social Care Act 2012) to provide or make arrangements to secure the provision of open access sexual health services in their area. HIV treatment and care, abortion, gynaecology, vasectomy and sterilisation services continue to be commissioned by the NHS.
Other Legal Implications:	
9.	N/A
RISK MANAGEMENT IMPLICATIONS	
10.	N/A
POLICY FRAMEWORK IMPLICATIONS	
11.	**Southampton City Health and Care Strategy 2020-2025**: reducing inequalities, early help and care, improving joined-up and whole-person care and improving mental and emotional wellbeing are aligned with the HNA recommendations. **Southampton Children and Young People's Strategy 2022-2027:** alignment with addressing inequalities in teenage conception rates and provide timely access to welcoming and effective sexual health services for all young people **Southampton Joint Health and Wellbeing Strategy (2017-2025)**: supports key strategy elements including encouraging and promoting healthy relationships and wellbeing, reducing the health inequalities gap, improved health experiences as a result of high quality, integrated services and the specific success measure of HIV late diagnosis.

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

<table>
<tr><td colspan="3"><u>SUPPORTING DOCUMENTATION</u></td></tr>
<tr><td colspan="3">Appendices</td></tr>
<tr><td>1.</td><td colspan="2">Southampton Sexual and Reproductive Health Assessment</td></tr>
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<tr><td colspan="3">Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out.</td><td>Yes approved</td></tr>
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Southampton
Strategic Assessment
(JSNA)

Sexual Health and Reproductive Health Needs Assessment

Last Updated November 2022

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1. Executive Summary

Sexual health is a state of physical, emotional, mental and social wellbeing in relation to sex and sexuality. Good sexual health requires positive and respectful approaches to sexuality and sexual relationships, pleasurable and safe sexual experiences that are free from coercion, discrimination and violence, and sexual rights to be upheld for all[1]. Sexual health outcomes are important for public health in Southampton because:

- Sexually transmitted infections (STIs) are rising overall which impacts people's mental health and wellbeing, physical health and relationships, as well as their use of services.
- Contraception and provisions for termination of pregnancy allow choice and control over reproductive health, it is vital that these services are accessible and visible.
- Significant and persisting inequalities in sexual health are experienced by some communities nationally and locally, exacerbated by barriers to accessing care and preventative services, and reinforced by stigma associated with sexual activity, sexual health and sexual health services.
- Southampton's young, increasingly diverse and growing population makes sexual health an especially pertinent issue for the city, with particular implications for the demand for and design of services.

The timing of this health needs assessment is significant as recent years have seen temporary changes to the delivery of health services in the city alongside changes in social interaction as a result of the pandemic. There remain many unknowns regarding the impact of these changes on people's sexual health, including whether some people have been disproportionally affected. Some of the service changes, such as increasing use of online services and development of the termination of pregnancy at home pathway, pave the way for new approaches, but also need monitoring for unintended consequences.

This health needs assessment (HNA) uses a systematic approach with a combination of quantitative data, service user and staff surveys, qualitative research and stakeholder engagement to understand the needs of the population in terms of their sexual and reproductive health, together with the assets available in the city to support these needs. Within this, the HNA attempts to understand the additional needs and support available for certain groups, who may need a different approach to improve and maintain their sexual health and wellbeing.

[1] Office for Health Improvement and Disparities. *Sexual and reproductive health and HIV: applying All Our Health.* 2022

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1.1 Findings

Prevention

Southampton has seen a steady decline in under 18-year-old conceptions since 2007 and is below the England average for terminations of pregnancy in the same age group. However, Southampton has high and increasing rates of STIs, low testing rates in important pathways such as termination of pregnancy, a high percentage of late diagnosis of HIV, increasing rates of terminations of pregnancy (ToP) and low uptake of long-acting reversible contraception, with stakeholders describing access to sexual health services as difficult. Once people are in contact with the services they are seen quickly and receive results and treatment in a timely manner. Almost twice as much long-acting reversible contraception is provided in primary care rather than within specialist services, and this is important as primary care has been found to be the preferred place for women to access contraception.

Relationships and Sex Education is delivered across the city to young people. There is a gap in provision for all people who may benefit from it, i.e., Special Educational Needs schools and people with a Learning Disability regardless of age. Training to enable the health and care workforce to have sexual health conversations as part of their everyday working routines is not being accessed.

Equity

There are significant gaps in local knowledge regarding some population groups, their sexual health, and the challenges they face which may impact their wellbeing. Where we do have the necessary information, it demonstrates that young people, men who have sex with men (MSM), people from black and mixed ethnicities and people living in the more deprived areas of the city are disproportionately burdened with sexual ill-health.

Use of services by different population groups is widening, including the use of online services but some people still find it harder to access services than others. Stakeholders have emphasised that stigma, perceptions, and taboos all play a part in perpetuating inequalities.

Relationships and system working

Professionals and services across Southampton are not always joining up to meet the sexual health needs of residents, particularly for people with additional needs. There is variable awareness of what sexual health services are being provided across the city. Examples of stigma persist and improved trust can be built with communities.

Consistent and clear messaging, sexual health promotion and education for all those who may benefit from it, across the population, workforce and throughout the life course are not always being delivered.

1.2 Recommendations

Relationships and system working

Many partners are involved in sexual health pathways. It is recommended that governance and leadership at place and system is developed, directed by a new Southampton sexual health network with an agreed vision, objectives and action plan, and maximising synergies at system level for tackling health inequalities.

The network will aim to build capacity across Southampton to meet the sexual health needs of all residents, fostering relationships and facilitating work with communities to co-design solutions for improving sexual health in the city, as well as overseeing quality and the long-term legacy of the Covid-19 pandemic.

Prevention

Prevention is not an add on, but an integral part of action to improve sexual health outcomes in the city, including within clinical services. This includes striving to create a positive sexual health culture in Southampton.

It is recommended that primary prevention focuses on sexual health promotion, with an annual plan for Relationships and Sex Education (RSE) provision, training, campaigns and supporting events such as Pride and World Aids Day. This will support communication about sexual health becoming regular and universal, developed with and tailored for the people we know are experiencing sexual health inequalities and ensure that RSE and training is planned for certain communities, age groups and formal and informal roles to specifically address the inequalities identified in this needs assessment.

The annual plan would also include a focus on promotion of interventions such as pre-exposure prophylaxis for HIV and HPV vaccination to those who are eligible.

Secondary prevention should be addressed through access to services and specifically testing. It is recommended that existing health and care touch points be utilised for sexual health conversations, when people access any service or attend for check-ups, in particular for related services such as termination of pregnancy and maternity.

It is important for residents and the health and care workforce to be aware of the sexual health services available in the city and for the workforce to know how to help people access them via signposting or referral. Sexual health services need to be available where and how people want to access them, as well as being responsive to need. The new network should also commit to improving workforce diversity and representativeness for our different communities to improve accessibility.

Increasing awareness of and access to the full range of contraceptive choices, including dispelling any myths that may be preventing use of the most effective method, will contribute to an improvement in reproductive health.

A better understanding of the recent patterns in testing, such as the reduction in full STI tests, and in particular the promotion of opportunities for HIV testing with residents and professionals in the city, will address the current trend for increasing rates of STIs by reducing onward transmission.

Equity, normalising conversations about sex and reducing stigma are golden threads running through all the recommendations.

1.3 Next Steps

The learning and priorities highlighted by this needs assessment will be taken forward within Southampton and alongside similar work in Hampshire, Isle of Wight, and Portsmouth. This will include informing a service review for the re-commissioning of the specialist sexual health service.

2. Overview

2.1 Why carry out a SHNA?

A health needs assessment (HNA) is a systematic method of identifying unmet health and healthcare needs in a population and the changes required to address those needs. ‘Need’ is commonly referred to as the capacity to benefit from healthcare and can be normative (based on professional judgement), felt (an individual’s perception of their need), expressed (a vocalisation of need or how people use services, i.e., demand) or comparative (relative needs of different groups).

This sexual health needs assessment will allow commissioners and providers of health services to use a systematic approach to understand the needs of the population in relation

to their sexual health and the local assets available to support them. As part of a commissioning process, this will allow the planning and delivery of effective and equitable services and support.

2.2 Why is sexual health important?

Sexual health is a state of physical, emotional, mental, and social wellbeing in relation to sex and sexuality. Good sexual health requires positive and respectful approaches to sexuality and sexual relationships, pleasurable and safe sexual experiences that are free from coercion, discrimination and violence and sexual rights to be upheld for all.[2]

468,342 new sexually transmitted infections (STIs) were diagnosed at sexual health services in England in 2019, a 5% increase on the previous year.[3] STIs left untreated can lead to long term physical health consequences for the individual, such as infertility or AIDS. STIs can also have wider impacts on mental health, and relationships. England has seen increases in the incidence of several common STIs, in particular chlamydia, gonorrhoea, syphilis, and herpes (to note however that COVID-19 has had an impact on STI diagnoses which is discussed further in this HNA).[4,5] Rarer infectious agents such as mycoplasma genitalium, shigella and trichomoniasis are also becoming an increasing issue. Antimicrobial resistance is arising, which poses new treatment challenges.[6]

STIs, such as HIV and chlamydia, are often asymptomatic. Untreated infection provides opportunities for further spread in the population. In contrast, treatment of STIs, or HIV that reduces the viral load to undetectable levels, makes them untransmissible to others. Inequalities are also important with young people, people living with HIV, certain ethnic minority communities, people living in deprived areas and MSM disproportionately affected by STIs.[7]

---

[2] Public Health England, *Sexually transmitted infections and screening for chlamydia in England*, (London, Crown, 2019) < Sexually transmitted infections and screening for chlamydia in England: 2021 report - GOV.UK (www.gov.uk)> (accessed 31 October 2022)

[3] Public Health England. *Health matters: preventing STIs, GOV.UK* < Health matters: preventing STIs - GOV.UK (www.gov.uk)> (accessed 31 October 2022).

[4] Public Health England, *Addressing the increase in syphilis in England: PHE action plan.* (London, UK: Crown, 2019) < Addressing the increase in syphilis in England: PHE action plan (publishing.service.gov.uk)> (accessed 31 October 2022)

[5] Terrence Higgins Trust and BASHH, *The State of The Nation. Sexually transmitted infections in England,* (London, UK: Terrence Higgins Trust, 2020) < State of the nation report v2.pdf (tht.org.uk)> (accessed 31 October 2022)

[6]Terrence Higgins Trust and BASHH, *The State of The Nation. Sexually transmitted infections in England,* (London, UK: Terrence Higgins Trust, 2020) < State of the nation report v2.pdf (tht.org.uk)> (accessed 31 October 2022)

[7]ibid

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2.3 Why are sexual health services important?

Sexual health services (SHS) are commissioned at a local level to meet the needs of the local population, including provision of information, advice, and support on a range of issues, such as sexually transmitted infections (STIs), contraception, relationships and unplanned pregnancy. Local authorities commission comprehensive open access sexual health services (including free STI testing and treatment, notification of sexual partners of infected persons and free provision of contraception). Some specialised services are directly commissioned by Integrated Care Boards (ICBs – previously Clinical Commissioning Groups), such and abortion and vasectomy services, and at the national level by NHS England e,g. HIV treatment and care services.[8] Services are provided across general practice, community services, hospitals, pharmacies, and the voluntary sector. Tailored provision is available for young people, and other groups requiring enhanced support to access services such as people with learning difficulties and women who sell sex. A range of effective methods of contraception, prophylaxis in the form of medication and vaccines, simple diagnostic tests and effective treatments are available. High quality accessible and equitable SHS are needed to successfully deliver these interventions on a background of challenges, such as asymptomatic disease, misinformation, stigma, and emerging new infections and antimicrobial resistance to existing ones.

The economic costs of STIs are vast, but effective services can save money. Excluding HIV, STI treatment costs were estimated at £620 million for the UK in 2011; the burden of disease and therefore the cost will have increased since. On the other hand, for every £1 spent on contraception £11 is saved elsewhere on healthcare, and HIV detected and treated early costs £12,600 per year, compared to £23,442 when diagnosed at a late stage.[9]

The other major role for SHS is in providing information, advice and support on contraception, relationships, and unplanned pregnancy. Preventing unplanned pregnancy is one the greatest reproductive health concerns for women; it is important for women to have control over their reproductive health including choices around contraceptive use.[10] 45% of pregnancies are unplanned or associated with ambivalence (mixed feelings about the pregnancy).[11] For mothers, unplanned pregnancy is associated with obstetric

[8] Public Health England, *Commissioning local HIV sexual and reproductive health services* (London, UK: Crown, 2013) < Commissioning local HIV sexual and reproductive health services - GOV.UK (www.gov.uk)> (accessed 31 October 2022)
[9] Department for Health and Social Care. *A Framework for Sexual Health Improvement in England* (London, UK: Crown, 2013) <A Framework for Sexual Health Improvement in England - GOV.UK (www.gov.uk)> (accessed 31 October 2022)
[10] Public Health England. *What do women say? Reproductive health is a public health issue* (London, UK: Crown, 2018). < What do women say? Reproductive health is a public health issue (publishing.service.gov.uk)> (accessed 31 October 2022)
[11]Wellings, Kaye *et al.* 'The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)' *Lancet,* vol. 382,9907 (2013): 1807-16

complications, later presentation for antenatal care and antenatal and postnatal depression. There can also be impacts on children in terms of low birthweight, physical and mental health, and lower performance on cognitive tests. Nationally and locally, there has been significant progress in reducing teenage conception. However, rates are still high in comparison to the rest of Western Europe. Inequalities between areas persist with deprived areas disproportionally affected.[12]

3. National and local legislation, policy, strategy, and guidance

3.1 National

The Framework for Sexual Health Improvement in England sets out the need for a sustained focus on sexual health across the life course, with 4 priority areas[13] (figure 1):

1. Sexually transmitted infections (STIs)
2. HIV
3. Contraception and unwanted pregnancy
4. Preventing teenage pregnancy

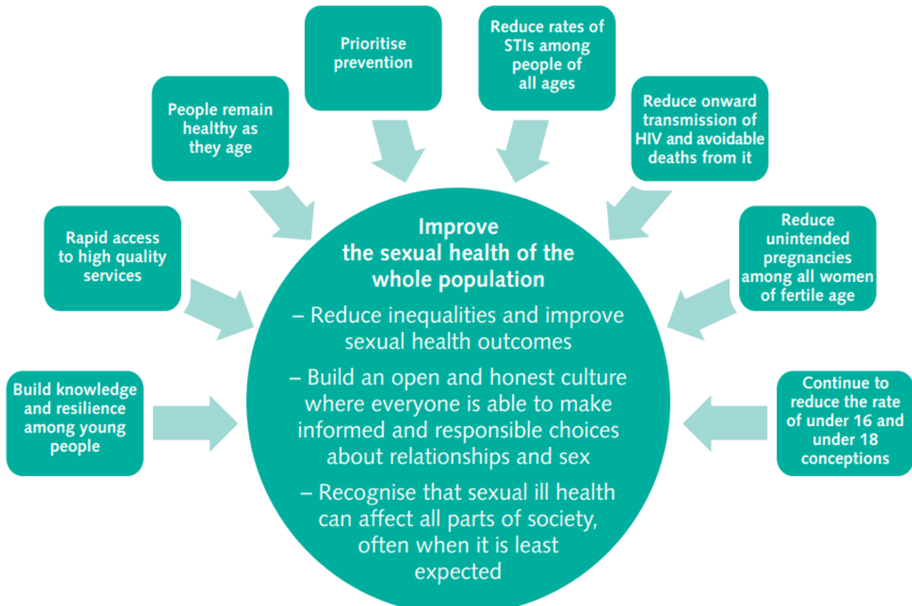

Figure 1: Key objectives Department of Health Framework for Sexual Health Improvement in England

[12] Public Health England, *Teenage Pregnancy Prevention Framework* (London, UK: Crown, 2018) <Teenage pregnancy prevention framework - GOV.UK (www.gov.uk)> (accessed 31 October 2022)
[13] Department for Health and Social Care. *A Framework for Sexual Health Improvement in England.*

The national **Public Health Outcomes Framework (PHOF)** includes seven indicators related to sexual health:[14]

1. Under 18 conceptions rate per 1000 women aged 15-17
2. HIV late diagnosis in people first diagnosed with HIV in the UK (%)
3. Chlamydia detection rate in 15 – 24-year-olds per 100,000 (males and females)
4. Under 16s conception rate per 1000 women aged 13-15
5. Violent crime – sexual offenses per 1000 population
6. New STI diagnoses (excluding chlamydia aged under 25) per 100,000
7. Population HPV vaccination coverage % (males and females)

National Chlamydia Screening Programme (NCSP)[15]

In June 2021, changes were made to the NCSP to focus on opportunistic screening of young women to reduce the reproductive harm of untreated infection. This means that in community settings, screening is now only proactively offered to young women. This should be combined with reducing time for results and treatment, more effective partner notification and re-testing following treatment. Men are still offered testing where there is a specific indication such as symptoms or a partner with chlamydia. These changes are to allow the programme to maximise health benefits by focusing on the population where there is most harm from untreated infection.

NICE Guidance

New NICE guidance 'Reducing sexually transmitted infections' was published in June 2022. The guideline includes recommendations on[16]:

- Reducing the risk of people getting and transmitting STIs
- Improving uptake and increasing the frequency of STI testing
- Partner notification
- HPV and hepatitis A and B vaccination in gay, bisexual, and other men who have sex with men.
- Pre-exposure prophylaxis for HIV

Further guidelines give specific advice for particular interventions or population groups:

- NICE guidance on Long-acting reversible contraception provides best-practice advice on the provision of information and care for women considering or using LARC. [17]

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[14] Office for Health Inequalities and Disparities. *Public Health Outcomes Framework* (2022), *Crown* <fingertips.phe.org.uk> (accessed 31 October 2022).
[15] Public Health England, *Changes to the National Chlamydia Screening Programme (NCSP) (2021), GOV.UK* < Changes to the National Chlamydia Screening Programme (NCSP) - GOV.UK (www.gov.uk)> (accessed 31 October 2022).
[16] National Institute for Health and Care Excellence, *Reducing sexually transmitted infections* (2022), NICE < Overview | Reducing sexually transmitted infections | Guidance | NICE> (accessed 31 October 2022)
[17] National Institute for Health and Care Excellence, *Long-acting reversible contraception* (2019), NICE < Overview | Long-acting reversible contraception | Guidance | NICE> (accessed 31 October 2022)

- Guidance on condom distribution schemes specifically details best-practice to deliver these schemes, including targeting services to meet the needs of local populations.[18]
- The contraceptive services in under-25s guideline makes recommendations based on evidence of interventions and programmes proven to be effective in this age group.[19] It emphasises the need for inclusive and universal services, along with additional tailored support for those who are socially disadvantaged or find it challenging to use contraceptive services.
- The Abortion care guideline aims to improve the organisation of services and make abortions easier to access.[20] There are detailed recommendations on care at different gestational stages and recommendations for same day access to contraception.
- HIV testing guideline detailing how to tailor services to local prevalence, increase awareness of testing, reduce barriers to testing and increase opportunities for testing across primary, secondary, specialist sexual health and community care.[21]

HIV

The Department of Health and Social care has made a commitment to zero new transmissions of HIV by 2030, detailed in a national HIV action plan. To reach this aim there are three progress markers, to be achieved by 2025[22]:

- To reduce the number of people first diagnosed in England from 2,860 in 2019, to under 600 in 2025
- To reduce the number of people diagnosed with AIDS within 3 months of HIV diagnosis from 219 to under 110
- To reduce deaths from HIV/AIDS in England from 230 in 2019 to under 115

Women's health strategy 2022-2032[23]

This 10-year strategy includes ambitions that are particularly relevant for this sexual health HNA:

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[18] National Institute for Health and Care Excellence, *Sexually transmitted infections: condom distribution schemes* (2017), NICE < Overview | Sexually transmitted infections: condom distribution schemes | Guidance | NICE< (accessed 31 October 2022)

[19] National Institute for Health and Care Excellence, *Contraceptive services for under 25s* (2014), NICE <Overview | Contraceptive services for under 25s | Guidance | NICE> (accessed 31 October 2022)

[20] National Institute for Health and Care Excellence, *Abortion care* (2019), NICE <Overview | Abortion care | Guidance | NICE> (accessed 31 October 2022)

[21] National Institute for Health and Care Excellence, *HIV testing: increasing uptake among people who may have undiagnosed HIV* (2016), NICE < Overview | HIV testing: increasing uptake among people who may have undiagnosed HIV | Guidance | NICE> (accessed 31 October 2022)

[22] Department of Health and Social Care, *Towards Zero - An action plan towards ending HIV transmission, AIDS and HIV-related deaths in England - 2022 to 2025* (London, UK: Crown, 2021) < Towards Zero - An action plan towards ending HIV transmission, AIDS and HIV-related deaths in England - 2022 to 2025 - GOV.UK (www.gov.uk)> (accessed 31 October 2022)

[23] Department of Health and Social Care, *Women's Health Strategy* (London, UK: Crown, 2022) <Women's Health Strategy for England - GOV.UK (www.gov.uk)> (accessed 31 October 2022).

- Girls and boys receive high-quality, evidence-based education from an early age on fertility, contraception and pregnancy planning, maternity care, and pregnancy loss.
- Women are supported through high-quality information and education to make informed decisions about their reproductive health, including if and when to have a child.
- All women who want contraception can access their preferred type of contraception in a convenient way.

Plans for sexual and reproductive health, a priority area, will be set out in 2022, and will include a focus on increasing access and choice around contraception, including LARC, and for improving women's experiences around using contraception, for example the fitting and removal of LARC.

The Hatfield Vision[24]

The Faculty of Reproductive and Sexual Health's vision, endorsed by 28 organisations, has an ambition that by 2030: "reproductive health inequalities will have significantly improved for all women and girls, enabling them to live well and pursue their ambitions in every aspect of their lives". To reduce these disparities, the vision is underpinned by 16 goals, these include goals centred around all women having the ability to make choices about if and when to have children, access and standards of contraceptive care and abortion care, and access to information.

Early medical abortion at home

During the COVID-19 pandemic the UK government put in place a temporary approval in England, for early medical abortion (EMA) pills to be taken at home for pregnancies of up to 10 weeks following a remote consultation with a clinician. This was to reduce the risk of transmission of COVID-19 and ensure continued access to abortion services. Following a public consultation, the temporary measure is now permanent.[25]

Teenage pregnancy prevention[26]

The Teenage Pregnancy Prevention Framework provides an evidence-based approach for collaborative system-wide action to prevent unplanned teenage pregnancy and encourage the development of healthy relationships.

[24] Faculty of reproductive and sexual health, *The Hatfield Vision*, The Faculty of Sexual and Reproductive Healthcare < FSRH Hatfield Vision July 2022 - Faculty of Sexual and Reproductive Healthcare> (accessed 31 October 2022)
[25] Rough, E, *Early medical abortion at home during and after the pandemic* (2022), UK Parliament <Early medical abortion at home during and after the pandemic - House of Commons Library (parliament.uk)> (accessed 31 October 2022)
[26] Public Health England, *Teenage Pregnancy Framework (2018)*.

Figure 2: Ten key factors for effective local strategies. Teenage pregnancy prevention framework. Public Health England/ Local Government Association

Relationship and sex education

In 2019, Relationships Education was made compulsory for all primary schools and Sex Education (RSE) was made compulsory for all secondary schools in the UK[27], though pupils can still opt out.

3.2 Local Context

Southampton City Health and Care Strategy 2020-2025[28]

This strategy highlights the vision shared in Southampton to enable everyone to live long, healthy and happy lives, with the greatest possible independence. This will be achieved by:

1. Reducing inequalities and confronting deprivation

[27] Department for Education, *Relationships Education, Relationships and Sex Education (RSE) and Health Education.* (London, UK: Crown, 2019) < Relationships and sex education (RSE) and health education - GOV.UK (www.gov.uk)> (accessed 31 October 2022).

[28] Southampton City Council. *Southampton City Health and Care Strategy 2020-2025, Southampton.gov.uk* <PowerPoint Presentation (southampton.gov.uk)> (accessed 31 October 2022)

2. Tackling the city's biggest killers
3. Improving mental and emotional wellbeing
4. Working with people to build resilient communities and live independently
5. Improving earlier help, care, and support
6. Improving joined-up, whole-person care

Whilst this Health and Care Strategy does not explicitly mention sexual health, reducing inequalities, early help and care and improving joined-up and whole-person care are all highly relevant to sexual health and sexual health services. Good sexual health also contributes to mental and emotional wellbeing.

Southampton Children and Young People's Strategy 2022-2027[29]
Vision: We want all children and young people in Southampton to get a good start in life, live safely, be healthy and happy and go on to have successful opportunities in adulthood.

Southampton city council plans to work together with parents, families, carers, and communities to improve outcomes for children in the city, focusing on prevention and early help and on providing the right help, at the right time. The strategy sets out that, as part of its priority for children to be happy and healthy, Southampton City Council will work with partners to address inequalities in teenage conception rates and provide timely access to welcoming and effective sexual health services for all young people.

Southampton sexual health improvement plan (2020-2024) priorities:
The current Southampton Sexual and Reproductive Health Improvement Plan built upon a previous strategic improvement plan for sexual health and teenage pregnancy in Southampton (2014-17). Developed with local stakeholders, it outlined priorities for the next five years to inform commissioning and transformation plans. The governance of the plan was to be via a local implementation group and the Health and Wellbeing Board, however changes to personnel and the Covid-19 pandemic have hindered its implementation. Priorities are to:

1. Promote a culture supporting good sexual and reproductive health for all which prioritises prevention and reduces stigma, prejudice, and discrimination.

[29] Southampton City Council. *Southampton Children and Young People's Strategy 2022-2027, Southampton.gov.uk.* <MRD 1 - Children and Young Peoples Strategy 2022-2027.pdf (southampton.gov.uk)> (accessed 31 October 2022).

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2. Ensure access to services that improve sexual health outcomes for everyone, with no groups left behind. Services should offer early detection, effective support/treatment, and reduction in onward transmission of sexually transmitted infections, including HIV.
3. Support women and men in avoiding unplanned pregnancies, including unplanned teenage pregnancies through good access to family planning advice and a full range of contraceptive options.
4. Take action to reduce teenage pregnancy
5. Safeguard and promote the welfare of those most at risk of poor outcomes including vulnerable adults, children, and young people, protecting them from exploitation and abuse through fostering effective partnership between all relevant services and agencies.
6. Offer SHS that are proportionate to level of need, providing 'right care in the right place' and focusing on prevention.

3.3. What has changed since the 2014 SHNA and what new challenges does Southampton face now?

Southampton faces several new key challenges in relation to sexual health. Demand had been rising for SHS before the Covid-19 pandemic. From March 2020 there was severe disruption to services, caused by the pandemic, which led to a decrease in testing and diagnosis of STIs and access to contraceptives. However, the pandemic also brought about changes to service provision with an increase in STI home testing and the introduction of Early Medical Abortion at home. We do not yet know the full impacts of the pandemic on the sexual health of people in Southampton, but they are likely to be felt for a number of years.

So far in 2022, 3 new cases of antibiotic-resistant Neisseria gonorrhoeae have been identified in England.[30] Although most common in the Asia-Pacific region, it is unclear at this stage whether this is likely to be a longer-term trend and if it will emerge as a specific Antimicrobial Resistance challenge for Southampton in the coming years.

On the background of a healthcare system under high pressure, SHS are now at the centre of the response to the monkeypox outbreak. Monkeypox can affect anyone, but particularly if you have had close contact, including sexual contact, with someone with symptoms. Most cases in the current outbreak have been in men who have sex with men, or who identify as

[30] UK Health Security Agency, *More cases of antibiotic resistant gonorrhoea identified in England, GOV.UK* <More cases of antibiotic resistant gonorrhoea identified in England - GOV.UK (www.gov.uk)> (accessed 6 June 2022)

gay or bi-sexual.[31] Whilst cases continue to rise, there is concern in terms of the additional service demand from diagnosis, after care and pre-exposure vaccination for SHS, along with the potential impact on staffing.

Prevention and sexual health promotion continue to be imperative. The introduction of compulsory relationship and sexual health education in 2019 is hoped to contribute to improving the outcomes for future generations.

3.4 Aims and Objectives of the Health Needs Assessment

Aim: To assess the current and estimate the future sexual health needs of Southampton city residents, how they are currently being addressed and whether they are being met or not.

Objectives:

1. Describe the sexual health needs of Southampton City Council residents epidemiologically, highlighting areas of higher need according to (but not exclusively) geography, age, gender (identity), sexual orientation, ethnicity, and socioeconomic status.
2. Describe the existing sexual health legislation, policy, and guidance at national and local levels
3. Describe the existing sexual health service provision across the city
4. Highlight where sexual health inequalities exist within these descriptions (epidemiological evidence, focussed policies and specific service provision)
5. Present the range of stakeholder views on need, as well as current and the potential for future service provision; providing a picture of what is working well and, where improvements are needed, what they might be
6. Make recommendations based on this local intelligence as well as evidence-based interventions identified in the literature
7. Link the recommendations to the development of a sexual health strategic vision and objectives for Southampton (to replace the improvement plan) and the service review for the future re-procurement of the level 3 specialist sexual health service.

3.5 Scope

- Residents of Southampton and users of SHS within the city.
- STIs including HIV, contraception and termination of pregnancy and teenage pregnancy.
- Covering the period from the last Sexual Health Needs Assessment in 2014.

[31] UK Health Security Agency, *Monkeypox cases confirmed in England – latest updates, GOV.UK* <Monkeypox cases confirmed in England – latest updates - GOV.UK (www.gov.uk)> (accessed 31 October 2022)

- Sexual assault referral centres and sexual violence, antenatal blood borne virus screening and HIV care and treatment are not in scope of this needs assessment but will be important to review elsewhere.[32]

References to 'women', 'female' and 'women's health' throughout this document are used for brevity. We recognise that the health needs and services discussed in relation to 'females' and 'women' are relevant for cisgender women, transgender men and non-binary (assigned female at birth) people who have not had hysterectomy or bilateral oophorectomy.

References to 'men' and 'males' are also used for brevity and we recognise that the health needs and services discussed in relation to males and men are relevant for cisgendered men, transgender women and non-binary (assigned male at birth) people.

3.6 Methods

This HNA combines three common approaches (Stevens and Raffety)

1. Epidemiological: considering the epidemiology of STIs in the Southampton population, current service provision, and the quality of those services and interventions.
2. Comparative: comparing service provision between different populations.
3. Corporate: based on the views of stakeholders including staff, the public and service users. This HNA has a particular focus on the views of people with learning disabilities and their carers, and people from ethnic minority communities.

Quantitative data has been collated from the Southampton Data Observatory, GUMCAD (the mandatory surveillance system for sexually transmitted infections, it collects data on STI tests, diagnoses, and services from all commissioned sexual health services in England), commissioned services and public and staff surveys. Where data is available, comparisons are made to national data and ONS comparator areas. Population Health Ltd undertook interviews with people with learning disabilities and their carers and people from ethnic minority communities for the qualitative aspect of this HNA.

Service data has been grouped according to four of Maxwell's dimensions of quality[33]: access to services, equity, efficiency, and effectiveness, with the survey and qualitative data addressing the further two dimensions of social acceptability and relevance to need.

[32] More information on sexual violence can be found: Safe City Strategic Assessment 2020/21 (southampton.gov.uk) and Violence against women and girls profile (southampton.gov.uk)

[33] Maxwell R J, 'Quality Assessment in Health' Br Med J (Clin Res Ed). 288,6428 (1984): 1470–1472.

Initial findings and recommendations were discussed at a stakeholder workshop, leading to further refinement of those recommendations.

3.7 Notes on data sources and limitations

- An HNA offers a snapshot in time for a particular health topic; relevant new data is regularly made available.
- Sexual health data is available from a variety of sources, including GUMCAD, OHID fingertips, direct from services and NHS digital. This HNA has focused on routine data from GUMCAD, OHID fingertips and directly from services, these sources are routinely accessed locally and data quality, strengths and limitations of these sources are understood.
- Office for Health Inequalities and Disaparities (Fingertips) data was released for 2021 in October 2022. As the HNA was undertaken prior to this, the October release data is not included.
- The Southampton Data Observatory Sexual Health Dashboard is updated regularly and is a source of up to date data from Fingertips for Southampton[34].
- Users of SHS in Southampton will not fully align with our resident population; people are free to access SHS wherever they choose and may not do so in the area that they live.
- Data from the integrated sexual health service will not cover all contacts, testing and treatment for sexual health in the city; some activity will take place in primary or secondary care for example.
- The latest data available at the time of writing was used for this HNA, but will differ in terms of the exact year due to different collection and validation methods.
- Census data, used particularly for demographic information, is from 2011 and therefore very out of date; 2021 census information should soon be available.
- Particularly in relation to asymptomatic disease, not all those who would benefit from sexual and reproductive services access them. The quantitative data used in this HNA only includes individuals who have accessed services (expressed need) and so is an incomplete picture of the population need. We have therefore had to make inferences regarding the underlying population need from this data
- The ONS comparator areas referred to are: York, Isle of Wight, Newcastle upon Tyne, Portsmouth, Bristol, Plymouth, Sheffield, Bournemouth, Bath and North East Somerset, Coventry, Liverpool and Leeds. Up to date comparator graphs can be found on the Southampton Data Observatory Sexual Health Dashboard.

[34] Southampton Data Observatory is available from: [Southampton Data Observatory]

- Wider factors that also contribute to sexual health outcomes e.g., income, living conditions, employment, education, or community assets that promote good sexual health have not been addressed fully.

4. Background

4.1 Population size and demographics

In 2020, the resident population of Southampton is estimated to be 260,111 people. The population pyramids in figure 3, for 2020, show how the profile of Southampton's population differs from the national average. There are a large number of young people in the city; 19.5% of Southampton's population is aged between 15 and 24 years, compared to just 11.7% nationally.[35] This is driven in part by the city's two universities. There is a projected increase in the population aged 15-19, but also in the population groups age 30 to 54 years.[36] In general, young people experience the highest diagnosis rates of the most common STIs likely due to higher rates of partner change among 16- to 24-year-olds.[37] Nationally there has been an increase in new STI diagnoses in the over 25 age group, this is mostly driven by large increases for MSM.[38] Locally we also have evidence of increases in termination of pregnancy in over 25s. Population increases in young adult age groups are therefore an important factor when planning to meet the future demand for sexual health services in Southampton.

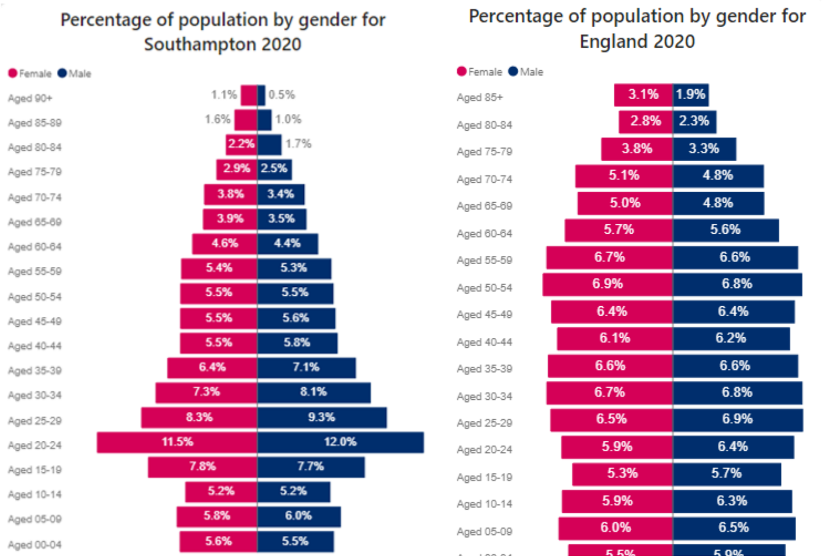

Figure 3: Population by age and gender for England and Southampton 2020. Source: Small Area Population Forecast, Hampshire County Council and mid-year population forecast, ONS

[35] Southampton Data Observatory, *Population dashboard, Southampton Data Observatory,* <Population Power Bi> (accessed 7 June 2022)
[36] Hampshire County Environment Department's 2020-based Southampton Small Area Population Forecasts
[37] Mercer CH, Tanton C, Prah P *et al.* 'Changes in sexual attitudes and lifestyles in Britain through the life course and over time: Findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal)'. *Lancet* 382(2013);1781-1794
[38] UK Health Security Agency. *Sexually transmitted infections (STIs): annual data tables, GOV.UK* <Sexually transmitted infections (STIs): annual data tables - GOV.UK (www.gov.uk)> (accessed 31 October 2022).

4.2 Birth rates and reproductive health

Birth rates are important to consider in this sexual health needs assessment as a large proportion of pregnancies (45%) are unplanned or associated with ambivalence, with the potential to be influenced by RSE and access, effective use, and acceptability of contraception.[39]

Local monitoring of births at University Hospital Southampton (UHS) indicates that births have fallen by -15.6% between 2008/09 and 2020/21 (figure 4). Between 2011 and 2019 general fertility rates (per 1,000 females aged 15 to 44) in the city decreased from 63.4 to 50.0. The 2019 figure compares with 56.9 across the South-east and 57.7 in England. However, there is a wide variation across the city. 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 5). Higher fertility rates tend to be associated with more deprived areas of the city.

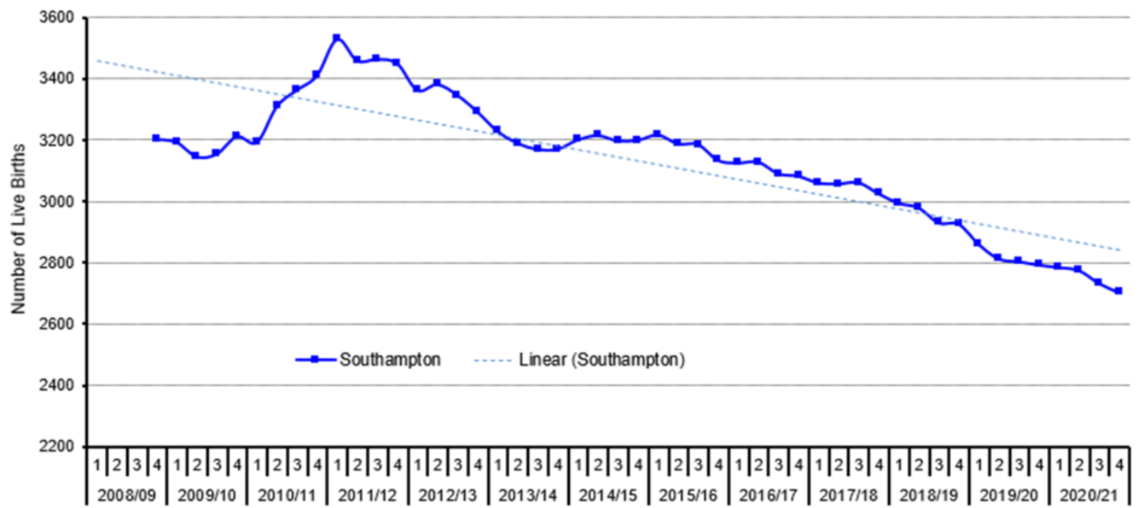

Figure 4: Number of live births in Southampton, annual rolling average 2008/09 to 2020/21. Source: HICCS Maternity, UHS

[39] Wellings, Kaye *et al.* The prevalence of unplanned pregnancy and associated factors in Britain (2013).

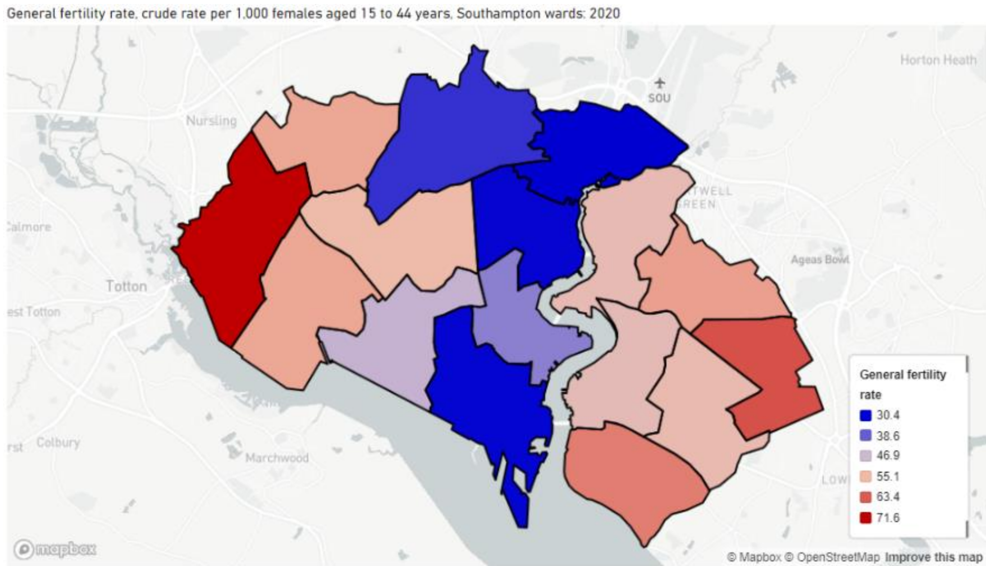

Figure 5: General fertility rate crude rate per 100,000 females aged 15 to 44 years. Southampton wards 2020.

4.3 Ethnicity, Migration, Language and Religion

Diversity is increasing in Southampton with residents from over 55 different countries, speaking 153 different languages.[40] Understanding the ethnic and cultural make-up of the city is important for ensuring services are tailored for differing cultures and their current and future sexual and reproductive health needs taken into consideration. Nationally women born outside the UK have total fertility rates of 2.0 compared to 1.5 for UK-born mothers. There are inequalities in terms of sexual health related to ethnicity which will be explored later in this HNA.

In 2011, 77.7% of residents recorded their ethnicity as White-British, a decrease of 11% from 2001 and 17.6% of residents were born outside UK, compared to 13.8% for England[41]. 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. In 2020/21, 39.4% of pupils were from an ethnic group other than white British, an increase from 24.8% in 2015/16. This suggests higher diversity in the population of childbearing age than the population overall.[42] In 2021, 40% of live births were born to Southampton mothers who were themselves born outside of the UK and 42.9% of live births (where ethnicity was known) were to mothers of ethnic groups other than white British or Irish (figures 6 and 7).

[40]Office of National Statistics, *2011 Census, ons.gov.uk* < 2011 Census - Office for National Statistics (ons.gov.uk)> (accessed 31 October 2022)
[41]Department for Education, *Schools, pupils and their characteristics 2020/21,* GOV.UK <https://explore-education-statistics.service.gov.uk/find-statistics/school-pupils-and-their-characteristics> (accessed 22 November 2021)
[42] School census 2020/21

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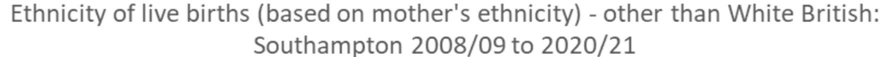
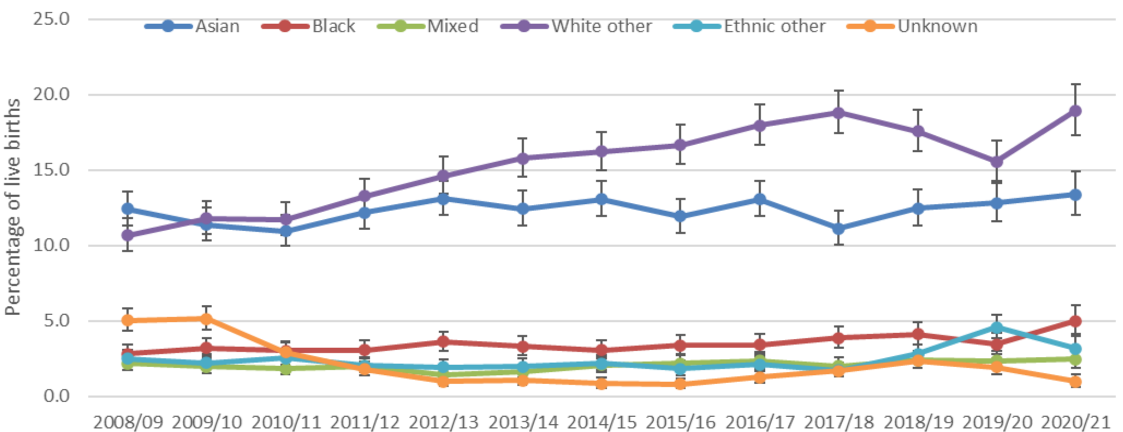
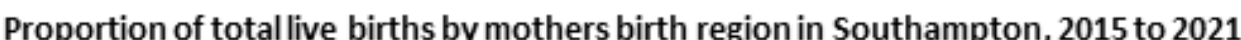




Source: UHS Midwifery database, Southampton CCG

Figure 6: Ethnicity of live births (based on mother's ethnicity) - other than White British: Southampton 2008/09 to 2020/21



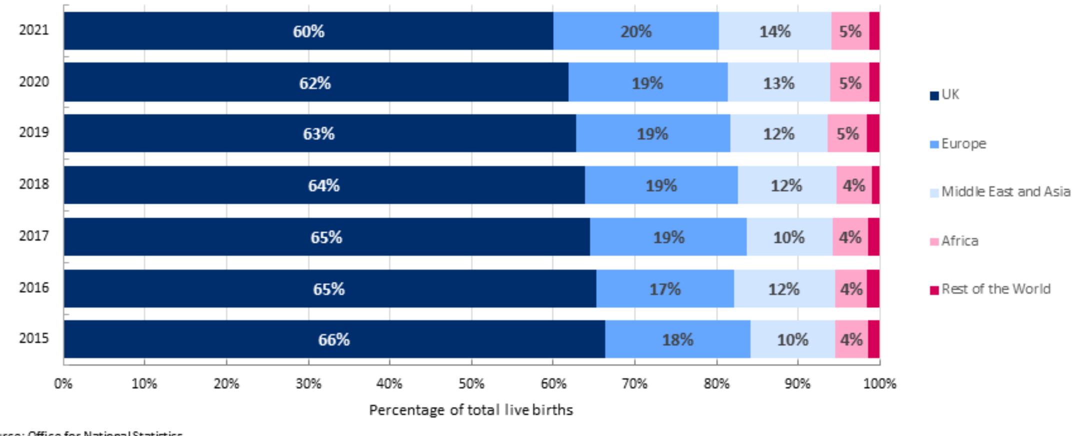


Figure 7: Proportion of total live births by mother's birth region in Southampton, 2015-2021

4.4 Impact of the COVID-19 pandemic on sexual health

In 2020/21, in light of Covid-19 restrictions, SHS had substantially reduced capacity to deliver face-to-face consultations and underwent rapid reconfiguration to increase access to STI testing via telephone or internet consultations. Between March and May 2020 there was an overall reduction in consultations, testing and diagnoses (figure 8).[43] From single point of

[43] Public Health England, *The impact of the COVID-19 pandemic on prevention, testing, diagnosis and care for sexually transmitted infections, HIV and viral hepatitis in England* (London, UK: Crown, 2020) <COVID-19: impact on STIs, HIV and viral hepatitis, 2020 report (publishing.service.gov.uk)> (accessed 6 June 2022)

access (SPA) data for the SHS, we know that demand decreased during the same period. We do not know whether the decreases seen in diagnoses were due to reduced sexual activity, changes in access or a perceived lack of availability of services during lockdowns, or a combination of these factors. In the South-east, STI testing fell markedly between 2019 and 2020 (by 27%), similar to the decrease seen in England (26%).[44] There was a slight increase in the STI positivity, from 5.6% in 2019 to 5.7% in 2020.[45] The large number of diagnoses in 2020 could be evidence of sustained STI transmission during this period, though pre-existing undiagnosed STIs will also have been identified. Community surveys suggest that, although fewer people reported meeting new sex partners during 2020 compared to previous years, a substantial proportion still had an ongoing risk for STIs (for example, unprotected sex with new partners)[46]. Though the decrease in diagnoses was seen across all infections, larger decreases were seen in diagnoses for STIs usually diagnosed on clinical examination, such as genital warts or genital herpes, when compared to those that could be readily diagnosed using remote self-sampling kits, such as chlamydia and gonorrhoea.

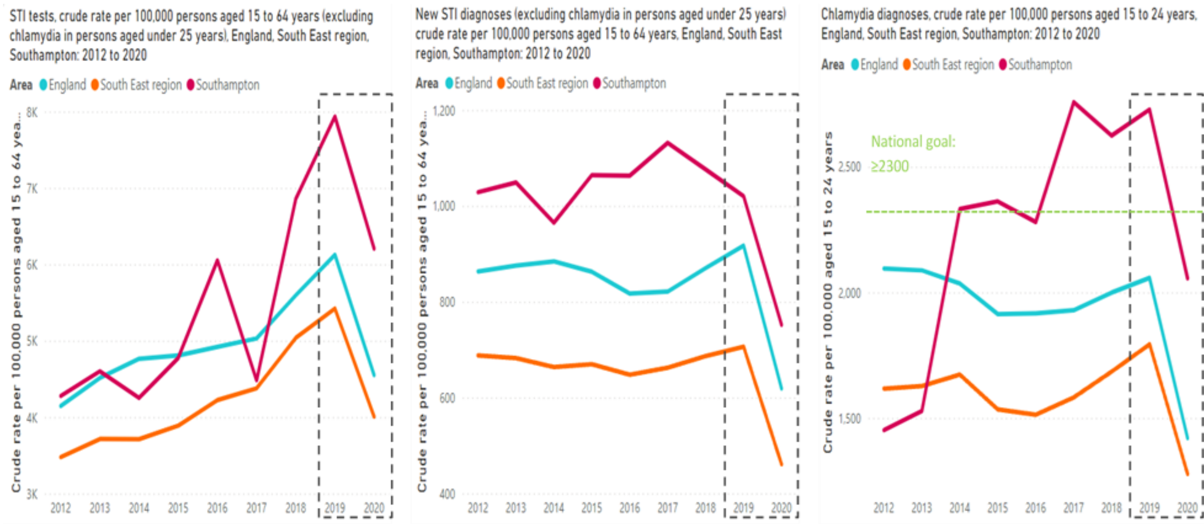


Figure 8: STI tests, new diagnosis, and chlamydia diagnosis 2012 to 2020. The dashed boxes highlight changes from the year prior to the Covid-19 pandemic, to the first year of the pandemic.

As yet, we do not know what the full impact of the Covid-19 pandemic will be on STIs in Southampton:

- Restrictions may have temporarily reduced sexual contact, therefore reducing STIs.

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[44] Data excludes chlamydia in under 25-year-olds
[45] UK Health Security Agency, *Spotlight on sexually transmitted infections in the South East* 2020 (London, UK: Crown, 2020) <Spotlight on sexually transmitted infections South East 2020 (publishing.service.gov.uk)> (Accessed 21 September 2022)
[46] ibid

- More restricted access to contraceptives and testing may mean higher risk sexual activity.
- Evidence of an increase in online testing in certain groups, for example MSM and over 30s; easy access to this form of testing may have encouraged people to test who would not have attended a face-to-face consultation.
- Risk behaviours may have changed following the lifting of restrictions.

This makes assessment of current need, analysis of trend data and projecting future need challenging. We do know however that in 2020 STIs continued to disproportionately impact gay, bisexual, and other MSM, young people aged 15 to 24 years, and people of Black Caribbean ethnicity, therefore addressing these health inequalities remains imperative.[47]

5. Incidence and prevalence of Sexually Transmitted Infections (STIs)

Key findings for Southampton:

- Despite falls in 2020, STI testing rates remain higher than the England average and second highest amongst ONS comparators.
- The proportion of positive tests is increasing and is similar to England overall.
- New diagnoses per 100,000 population are double the national rate, despite decreasing since 2017.
- Over half of new diagnoses are in 15–24-year-olds, but in older age groups there was a bigger difference between Southampton and England figures, suggesting there is more testing in older age groups than nationally or a greater burden of disease.
- Almost 1/3 of newly diagnosed men were MSM
- People of Black ethnicity were 4.2 times and Mixed ethnicity 2.8 times more likely to be newly diagnosed with an STI than people of White ethnicity.
- Women aged between 15 and 19 are at particular risk of re-infection, though both men and women in this age group had higher reinfection rates than nationally.

[47] UK Health Security Agency, *Summary profile of local authority sexual health Southampton, fingertips.phe.org.uk* <SPLASH Southampton 2022-01-27 (phe.org.uk)> (accessed 12 May 2022)

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5.1 STI testing

STI testing rates (excluding Chlamydia screening in persons aged under 25 years) for individuals aged 15 to 64 years have fluctuated year on year in Southampton since 2012 (figure 9). But as a general trend have been increasing and at a faster rate than observed nationally. The 2020 Southampton rate was a 22% decrease from 2019 and likely because of the COVID-19 pandemic, as similar decreases were observed both nationally and in comparative areas. Testing rates remained significantly higher than England, 6,206 vs. 4,549 per 100,000 persons aged 15 to 64. In 2020, Southampton was second to Portsmouth for the highest rate of STI tests amongst the ONS comparator group.

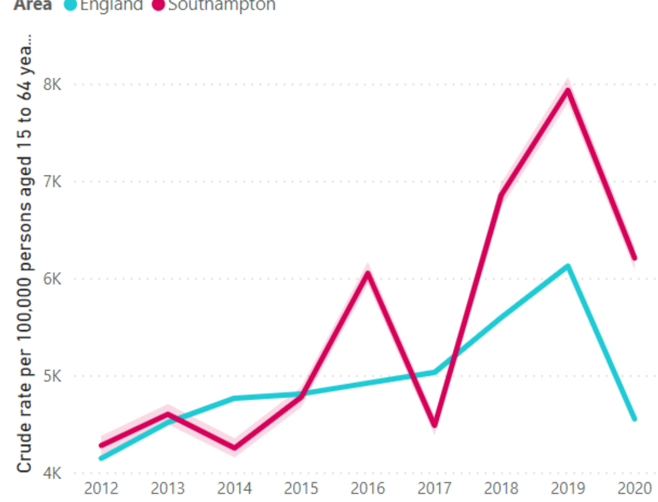

Figure 9: STI tests, crude rate per 100,000 persons aged 15-64 years (excluding chlamydia in persons aged under 25 years) in Southampton 2012 to 2020

5.2 Testing positivity

Of those STI tests (excluding chlamydia screening in persons aged under 25 years) undertaken in Southampton in persons aged 15 to 64 years (figure 10). 7.2% had a positive result, lower but not significantly when compared nationally (7.3%) and 3rd highest amongst ONS comparators. The proportion of positive tests has been increasing since 2012, despite the COVID-19 pandemic.

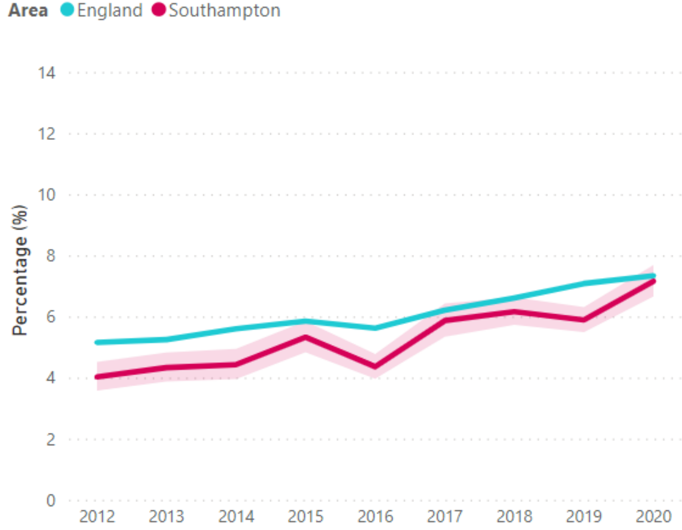

Figure 10: Percentage of positive STI tests in persons aged 15-64 years, excluding chlamydia in persons aged under 25.

5.3 New diagnoses

In 2020, Southampton, 1,310 per 100,000 population STIs (aged 15 to 64 excluding chlamydia in persons under

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25) were newly diagnosed compared with a rate of 629 per 100,000 nationally.[48] New diagnoses have been falling in Southampton since 2017, though more sharply in 2020. Despite this, they remain significantly higher than England and 2nd highest amongst ONS comparators.

Of those diagnosed with a new STI in Southampton in 2019 (the latest available demographic information):

- 50.3% were female compared to 49.7% male
- 56.3% were aged between 15 and 24 years old
- 32.5% of newly diagnosed men were gay, bisexual or MSM

The rate of diagnoses varied by age group. When compared to national rates the difference between Southampton and England increased with age group for those aged 20 and over. For 20- to 34-year-olds, Southampton was only 1.1 times higher than the national average, increasing to 2.6 times for those over 65 years. This difference in those aged 65+ years appears to be driven by males within this age group who have 3.2 times as many new diagnoses than the national average. Locally females had higher rates than nationally in all other age groups, peaking at 1.9 times higher in 45- to 64-year-olds.[49]

In 2019 the largest proportion of new STI diagnoses in Southampton were in those of White ethnicity (56.3%) followed by Black (5.9%) and Mixed ethnicity (4.4%), although 28.5% of cases had no specified ethnic group. However, when looking at the rate per 100,000 population those of Black ethnicity were 4.2 times and Mixed ethnicity 2.8 times more likely to be newly diagnosed with an STI than those of White ethnicity. This pattern is observed nationally as well as locally. In 2019, 22% of new STI diagnoses were in people born overseas.[50]

5.4 Reinfections

Continuous reinfections with an STI can negatively impact the short and long-term health of individuals as well as increasing the likelihood of further onward transmission; this is a burden on services across the health system. Between 2015 and 2019, 7.6% of women and 8.6% of men who presented at a Southampton SHS with a new STI became re-infected within 12 months compared to 7.1% of women and 9.9% of men nationally. Amongst 15- to

[48] Office for Health Improvement and Disparities, *Sexual and Reproductive Health Profiles, Fingertips.phe.org.uk* <Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)> (accessed 06 June 2022)
[49] Difference in incidence between local and national figures.
[50] Public Health England, *SPLASH supplement Southampton* (London, UK: Crown, 2021)

19-year-olds, the reinfection rates of women (12.7% in Southampton and 11.4% nationally) were higher than those for men (11.1% in Southampton and 10.4% nationally).[51]

6. STI Diagnoses by type

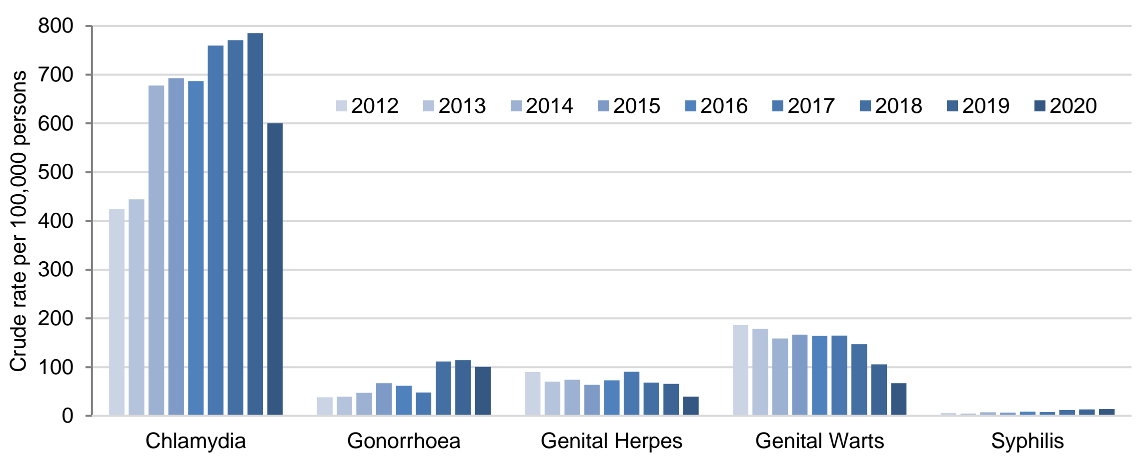
Key findings for Southampton:

- Prior to the pandemic, chlamydia, gonorrhoea, and syphilis diagnoses were increasing whilst genital warts and genital herpes were decreasing.
- New chlamydia diagnoses are high, with just under half of diagnoses in 20–24-year-olds but increasing faster in over 25s. It is more commonly diagnosed in women.
- Chlamydia screening is lower than for most ONS comparators. The detection rate for ages 15- 24 years was below the national goal for 2020 and is much lower in males than females.
- Pelvic inflammatory disease rates are high suggesting a high burden of untreated STIs, particularly chlamydia, in the population
- Gonorrhoea diagnoses are increasing: 2/3 are in men and just under half in men who identify as gay and bisexual.
- The HPV vaccine appears to be contributing to falling rates of genital warts, but progress may be hampered by the impact of education disruption on vaccinations in 2020/21.
- Genital herpes diagnosis appears to have been particularly affected by the Covid-19 pandemic. 2 in every 3 diagnoses are in women.
- Syphilis is following the national trend of increasing diagnoses. Most diagnoses are in men (9/10) and 3 in every 4 in men who identified as gay or bisexual.

6.1 Diagnosis by infection type

The following chart (figure 11) illustrates the crude rate of STI diagnoses by type in Southampton between 2012 and 2020. All STI diagnoses remained similar or dropped in 2020, it is likely the pandemic contributed to this. For chlamydia, gonorrhoea and syphilis, the diagnosis rate has increased overall. Conversely, genital herpes and genital warts have decreased.

[51] Public Health England, *SPLASH supplement Southampton (2021)*



Source: Office for Health Inequalties and Disparities

Figure 11: The crude rate of STI diagnoses by type in Southampton between 2012 and 2020

6.2 Chlamydia

Chlamydia is the most frequently diagnosed STI in England and in Southampton, with rates of infection substantially higher in young people aged 15 to 24. Just under half of all diagnoses were made in 20- to 24-year-olds. Overall chlamydia diagnosis rates are 600 per 100,000, second highest amongst ONS comparators, and 2.1 times higher than the England average (figure 12).

Chlamydia diagnoses, crude rate per 100,000 persons all ages, England, Southampton: 2012 to 2020

Area England Southampton

Figure 12: Chlamydia crude diagnosis rate per 100,000 persons all ages

Most chlamydia infections are asymptomatic. These cases are identified through screening, STI testing based on risk, and testing of individuals presenting with other symptomatic infections. In 2020, 14.4% of young people (aged 15-24) in Southampton were screened for chlamydia, statistically similar to England (14.3%), but the fourth lowest among its ONS comparator group.

Data up until 2022 is benchmarked against a detection rate of at least

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2,300 cases per 100,000 for 15–24-year-olds; diagnosis at this rate was considered likely to result in continued reduction in the prevalence of chlamydia. In 2020, Southampton had a detection rate of 2,056 cases per 100,000 young people - 244 detections below this goal. Prior to 2020, Southampton had reached this ambition every year since 2014 (except for 2016), suggesting this reduction was due to the Covid-19 pandemic – either via the disruption to services or changes in sexual activity. Despite not reaching the goal, in 2020 the detection rate for Southampton was significantly higher than England and 9 of its ONS comparators. The detection rate is far higher for females (2,312 per 100,000) than males (1,361 per 100,000). However, between 2019 and 2020, detection rates decreased by 34.4% for females, a steeper decline than for males (20.1%). The UK Health Security Agency now recommends that local authorities work towards a female only detection rate of 3,250 per 100,000 aged 15 to 24 (Female), however data will only be benchmarked against this from 2022. See also page 11 regarding changes to the National Chlamydia Screening Programme, to focus on reducing reproductive harm through targeting only women aged 15-24.

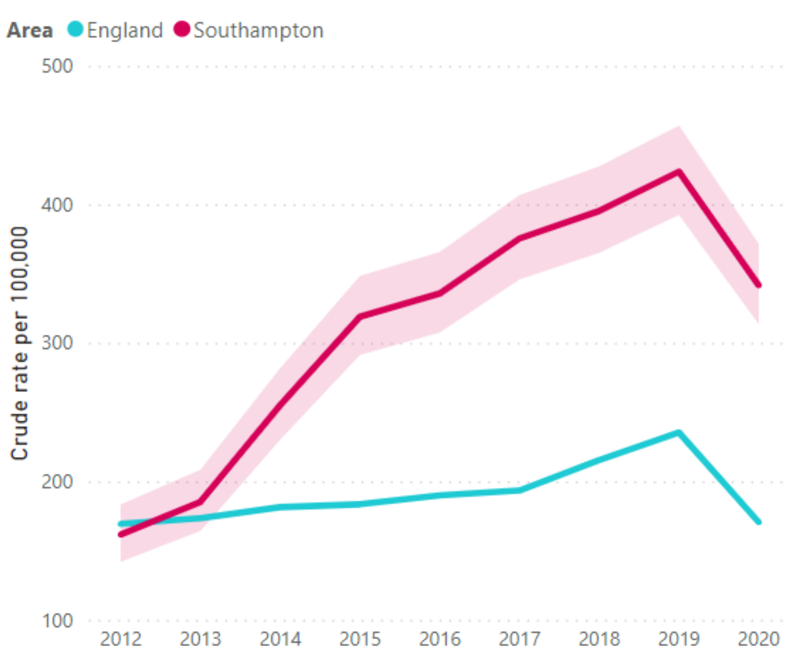

Figure 13: Chlamydia diagnoses, crude rate per 100,000 persons aged over 25 years, Southampton 2012-2020

Although chlamydia diagnoses are higher in younger people, over 25s have seen faster increases (figure 13). In 2012, over 25s had a diagnosis rate statistically similar to that seen nationally, but in 2019, they were almost double (785.3 per 100,000 persons in Southampton vs. 407.2 nationally) and 2.6 times higher than in 2012. In 2020, the first pandemic year, diagnosis rates reduced from a high of 423.7 per 100,000 people in 2019 to 341.7. This is a smaller percentage decrease to that observed across England (235.4 per 100,000 people in 2019 to 170.6 per 100,000 people in 2020).

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6.3 Gonorrhoea

Gonorrhoea is an STI caused by a bacteria called Neisseria gonorrhoeae or gonococcus and can usually be treated with a course of antibiotics. In 2020, gonorrhoea was the second most diagnosed STI in Southampton with a diagnosis rate of 100.1 cases per 100,000 population, statistically similar to the England average of 100.9 cases. Despite a 12.5% drop in diagnoses from 2019 to 2020, the prevalence of gonorrhoea has continued to increase since 2012 and is currently 2.6 times as high as the 2012 rate. Two thirds of gonorrhoea diagnoses are in men and just under half of all diagnoses are in men who identify as gay and bisexual.

6.4 Pelvic Inflammatory Disease (PID)

Pelvic inflammatory disease (PID) is an infection of the female reproductive system. It often can be asymptomatic or cause non-specific symptoms, but sometimes leads to severe symptoms that need hospital treatment. Untreated chlamydia and gonorrhoea are major causes of PID. Even when mild or asymptomatic, PID is an important disease of the reproductive system as it can lead to infertility if not treated or treatment is delayed. PID admissions amongst 15- to 44-year-old women had been increasing at a faster rate than seen nationally or amongst comparable areas prior to the Covid-19 pandemic (figure 14). The current rate for 2020/21 in Southampton is 286 per 1,000 women, significantly higher than England's rate of 186 per 1,000 women. Southampton's rate has been significantly higher than England since 2015/16 and is the highest amongst its ONS comparators and local neighbours.[52] This suggests a higher burden of untreated chlamydia and gonorrhoea in the population.

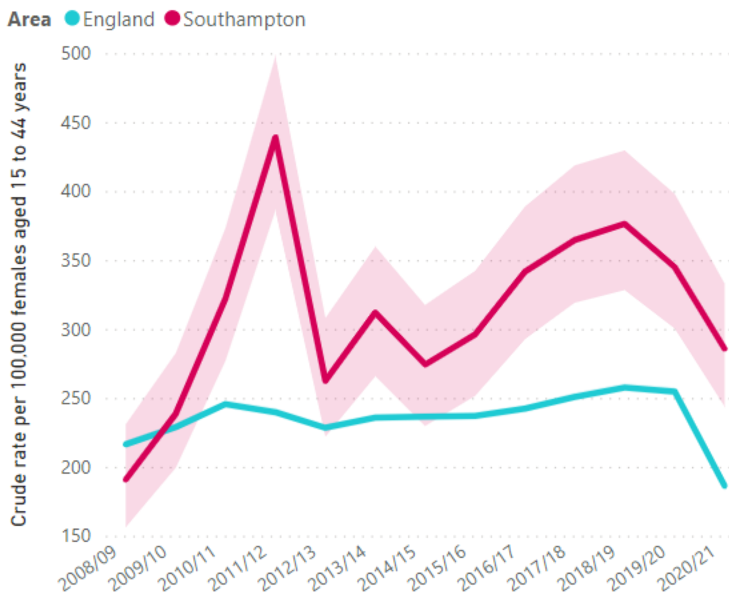

Figure 14: PID admissions crude rate per 100,000 females aged 15 to 44 years

[52] Hospital Episode Statistics, NHS Digital 2020/21

6.5 Syphilis

Syphilis is a bacterial infection that can usually be cured with a short course of antibiotics but like chlamydia and gonorrhoea can be caught more than once. In Southampton, 13.8 syphilis diagnoses were made per 100,000 people (35 cases), higher but statistically similar to the national average of 12.2 per 100,000. This is over double the rate observed in 2012 (5.9 per 100,000) and follows the trends seen nationally. Of the STIs discussed in this section, syphilis is the only STI to see an increase in diagnosis rate between 2019 and 2020 (from 13.1 to 13.8) despite decreasing nationally. These increases may appear larger due to small numbers of cases. Just under 9 out of 10 syphilis diagnoses were in men with the majority in the 25 to 34 age group. Approximately three quarters of all diagnoses were in men who identified as gay or bisexual.

6.6 Human Papilloma Virus (HPV)

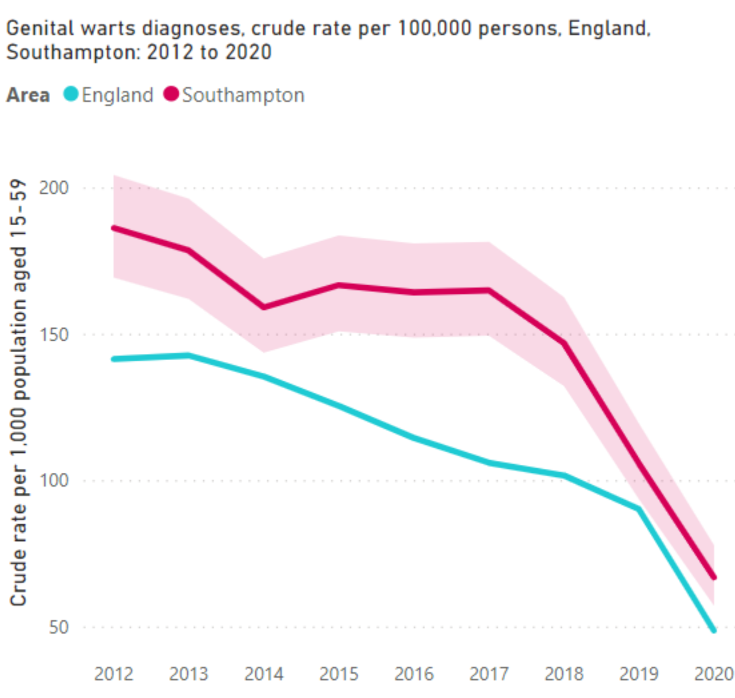

Figure 15: Genital warts diagnoses crude rate per 100,000 persons

Most people will have HPV in their lifetime, 40% of women are infected within two years of becoming sexually active.[53] Most infections do not require intervention, but the infection can persist, and symptoms potentially recur. High-risk subtypes, transmitted via sexual activity, are linked to the development of cancers, such as cervical cancer (high risk HPV subtypes found in more than 99%), anal cancer, genital cancers, and cancers of the head and neck. Prevention is therefore critical, through barrier contraception and vaccination.

Genital Warts are caused by infection with specific subtypes of Human Papillomavirus. There is no cure, but symptoms are treatable. In Southampton diagnoses of genital warts have reduced 64.1% from a rate of 186.1 per 100,000 in 2012 to 66.8 cases per 100,000

[53]National Institute for Health and Care Excellence, *Cervical cancer and HPV* (2022), NICE < Cervical cancer and HPV | Health topics A to Z | CKS | NICE> (accessed 31 October 2022)

population in 2020 (figure 15). Southampton's rate has been significantly higher than the England average throughout. The chart shows when comparing the most recent local rate to the national average of 48.6 cases per 100,000 population, this gap has been shrinking since 2017.[54] A likely explanation for the reduction is the introduction of the HPV vaccine for girls aged 12 and 13 years, which from 2012 also protected against the HPV subtypes that cause genital warts and from 2019 was extended to boys. Due to Southampton's young population, the primary recipients of the HPV vaccination intervention, the steeper rate decrease and narrowing of the gap against the national rates is expected. In 2019/20, 88.4% of girls and 81.3% of boys received their first HPV vaccination dose, below the national goal of over 90%. Coverage for 12–13-year-old girls fell further in 2020/21 to 80%; this is higher than the England average (77%), but lower than south-east (84%).[55] In previous years, Southampton had reached this target for girls, so this is likely because of school and healthcare disruption during the pandemic (HPV vaccinations are routinely provided in school). This fall in vaccinations could negatively influence genital warts (as well as cervical cancer) rates in the coming years. Catch up opportunities are offered up to the point children leave school at the end of year 11, which may improve uptake in the cohorts which faced the most disruption.

MSM up to and including 45 years of age, trans women (if their risk of getting HPV is similar to the risk of MSM) and trans men who have sex with men (up to and including 45 years of age) are also all eligible for HPV vaccination on the NHS at sexual health services and HIV clinics. We do not have local data on coverage.

To note that the Joint Committee on Vaccination and Immunisation made a statement in August 2022 that after considering mounting evidence of protection from one dose of the vaccine and following stakeholder consultation, it advises the following revised dosing schedule:

- a one-dose schedule for the routine adolescent programme and MSM programme before the 25th birthday
- a 2-dose schedule from the age of 25 in the MSM programme
- a 3-dose schedule for individuals who are immunosuppressed and those known to be HIV-positive

[54] Office for Health Improvement and Disparities, *Sexual and Reproductive Health Profiles, Fingertips.phe.org.uk* <Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)> (accessed 06 June 2022)
[55] Office for Health Improvement and Disparities, *Sexual and Reproductive Health Profiles, Fingertips.phe.org.uk* <Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)> (accessed 06 June 2022)

A policy decision by UKHSA, NHS England and the Department of Health and Social Care will need to be made regarding this advice. If the policy decision agrees with the JCVI advice, the earliest date of implementation would be the academic year 2023 to 2024.[56]

6.7 Genital Herpes

A larger proportion of Herpes infections are due to herpes simplex virus (HSV) type 2, although type 1 infection is also seen. Similar to genital warts, those diagnosed with herpes can experience recurrent episodes that require treatment. In 2020, Southampton had a first episode genital herpes diagnosis rate of 39.2 cases per 100,000 population (99 cases), similar to the national average of 36.3 cases per 100,000 population.

Of the STIs discussed in this section, genital herpes saw the largest relative drop between 2019 and 2020 (40.3%) and is the STI where Southampton has the lowest rank when compared to its ONS comparators (7th highest). Two thirds of diagnosed cases were in women with the most common age group being 20- to 24-year-olds. The most common age group for men was slightly older, 25- to 34-year-olds.

6.8 Hepatitis B

Hepatitis B is a viral infection spread through sexual activity, shared needles or needlestick injuries, tattoos or piercing with unsterilised equipment or blood transfusions in countries where the blood is not screened for hepatitis B. The infection affects the liver and can cause acute and/or chronic problems, including increasing the risk of liver damage and liver cancer. The incidence rate in Southampton in 2018 was 1.19, however small numbers of cases make comparison with other areas unreliable.

[56] Joint Committee on Vaccination and Immunisation, *JCVI statement on a one-dose schedule for the routine HPV immunisation programme, GOV.UK* <JCVI statement on a one-dose schedule for the routine HPV immunisation programme - GOV.UK (www.gov.uk)> (accessed 28 October 2022)

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7. HIV

Key findings for Southampton:

- Prevalence has increased over the last 10 years, with a rate similar to that of England.
- New diagnoses are higher than nationally and 3rd highest amongst ONS comparators, despite comparatively low testing.
- Late diagnoses are higher than nationally and higher than the national goal (less than 25% of diagnoses), particularly for heterosexual men and women.
- There was a sharp decrease in HIV testing of eligible persons nationally and locally between 2019 and 2020; this is on a background of a decreasing trend in testing in the city since 2012.

7.1 Overview

HIV (human immunodeficiency virus) is a virus that damages the immune system and weakens the ability to fight everyday infections and diseases. In England, an estimated 96,200 people were living with HIV in 2019, including an estimated 5,900 with an undiagnosed HIV infection, equivalent to 6% of the total. An estimated 2,800 gay and bisexual men were living with undiagnosed HIV and 2,900 heterosexual people. If untreated, the time from HIV infection to AIDS and death is a decade on average.[57]

Whilst there is currently no cure for HIV, there are very effective drug treatments, antiretroviral therapy (ART), that enable most people living with HIV to live a long and healthy life. If the viral load is suppressed through treatment for 6 months or more, HIV is not transmissible through sex (known as undetectable = untransmissible or U=U). Late diagnosis, classed as a person diagnosed with a CD4 count under 350 within 3 months, is the most important predictor of morbidity and increases the risk of dying by eight times. [58,59]

7.2 HIV prevalence

In 2020, 2.5 in every 1,000 people aged 15 to 59 years had a diagnosis of HIV in Southampton and were accessing HIV services (405 people) – higher but not significantly than the England rate (2.3 per 1,000 people) but significantly higher than Hampshire and the

[57] Department of Health and Social Care, *Towards Zero - An action plan towards ending HIV transmission, AIDS and HIV-related deaths in England - 2022 to 2025* (London, UK: Crown, 2021) < Towards Zero - An action plan towards ending HIV transmission, AIDS and HIV-related deaths in England - 2022 to 2025 - GOV.UK (www.gov.uk)> (accessed 31 October 2022)
[58] A type of immune system cell, the count of which is used to monitor the functioning of the immune system in HIV and disease progression.
[59] Department of Health and Social Care, *Towards Zero - An action plan towards ending HIV transmission, AIDS and HIV-related deaths in England - 2022 to 2025* (London, UK: Crown, 2021)

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Isle of Wight (1.17 and 0.63 per 1000 respectively). Both nationally and locally the prevalence of HIV has been increasing over the last ten years – up from 1.8 in Southampton in 2011. Despite this, 2020 saw a decrease of 0.1 compared to 2019 but this may reflect a reduction in testing during the COVID-19 pandemic.[60]

7.3 HIV Testing coverage

In 2020, 42.7% of eligible persons attending a specialist sexual health service in Southampton were tested for HIV.[61] This is lower than England, the Southeast and most ONS comparators. Although testing was already decreasing from a high of 79.4% in 2012, a sudden fall of 23.2 percentage points is observed from 2019 to 2020.[62] A similar decrease was seen nationally and across many comparator areas.[63] South east data suggests that this may be due to a rise in the proportion of eligible persons not being offered an HIV test (17.2% in 2019 vs. 35.1% in 2020), rather than changes in the proportion of those declining a test when offered, which remained more stable (15.2% in 2019 vs. 18.3% in 2020).[64,65] This is likely to be related to changes in the operation of testing services during the COVID-19 pandemic.

7.4 New diagnoses

Testing in Southampton identified 9.6 new HIV diagnoses per 100,000 people aged 15 and over in 2020. Despite decreasing from 18.8 in 2011, Southampton continues to be statistically worse than the national average of 5.7. It has the third highest rate of its ONS comparators, is three times higher than Hampshire and six times higher than the Isle of Wight. This is despite comparatively low testing rates.

7.5 Late diagnoses

During 2018-20, 44.0% of adults diagnosed with HIV in Southampton were classed as receiving a late diagnosis; higher than the England average of 42.4% and missing the

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[60] Office for Health Improvement and Disparities, *Sexual and Reproductive Health Profiles, Fingertips.phe.org.uk* <Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)> (accessed 06 June 2022)

[61] Note that these figures differ from the HIV testing data in 10.9, this is due to a combination of factors including the use of financial year vs. calendar year, new patients vs. all eligible patients as the denominator and data being presented by area of residence vs. by service.

[62] Office for Health Improvement and Disparities, *Sexual and Reproductive Health Profiles, Fingertips.phe.org.uk* <Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)> (accessed 06 June 2022)

[63] Office for Health Improvement and Disparities, *Sexual and Reproductive Health Profiles, Fingertips.phe.org.uk* <Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)> (accessed 06 June 2022)

[64] UK Health Security Agency. *HIV testing, PrEP, new HIV diagnoses, and care outcomes for people accessing HIV services: 2022 report* (London: Crown, 2022) < HIV testing, PrEP, new HIV diagnoses, and care outcomes for people accessing HIV services: 2022 report - GOV.UK (www.gov.uk)> (accessed 14th November 2022)

[65] UK Health Security Agency, *HIV: annual data tables, GOV.UK* < HIV: annual data tables - GOV.UK (www.gov.uk)> (accessed 14th November 2022)

national goal of less than 25%. The proportion of late diagnoses was lowest for men having sex with other men (40.0%) and highest for heterosexual men (55.6%), but both heterosexual men and women (50.0%) were also above the national goal. In a pilot of a late diagnosis review protocol across the Southeast of England, people who were diagnosed late were more likely to be male, older, heterosexual, of Black African heritage and living in a deprived area. There were also differences within groups, for example between genders within ethnicities, and between people who had lived in England for a long time versus those who had recently migrated, within people born outside of the UK. Three out of four (75%) of the cases reviewed had a least one missed opportunity to test, just under half (49%) of these were within General Practice.

8. Teenage conceptions

Key findings for Southampton:

- Teenage conceptions are falling but remain significantly higher than national levels.
- Rates vary across the city; there is known to be a strong correlation with deprivation.

Teenage conceptions in Southampton among females aged under 16 and 18 years have declined in recent years. In 2020, the under 16 conception rate was 5.4 per 1,000 women aged 13 to 15 years, significantly higher than the national average (2.0 per 1,000 women aged 13 to 15 years). Conceptions under 18 years (aged 15-17) declined by 68% between 2009 (54.3 per 1,000) and 2018 (17.4 per 1,000), a faster decline than nationally during the same period (37.1 to 17 per 1,000 or 55%). However, the current under 18 years rate 20.7 per 1,000 remains significantly higher than the national rate (13.0 per 1,000 females aged 15-17). Southampton is in the 20 highest local authorities in England for under 18 conceptions. The proportion of conceptions leading to ToP has been steadily rising in under 18-year-olds, both nationally and locally, but in Southampton is lower than the national average. Currently 44% of conceptions in under 18s in Southampton end in ToP, below the national average of 53%. In under 16-year-olds these figures are 55% locally and 65% nationally.

Ward analysis shows that Bitterne, Redbridge and Swaythling wards have the highest percentages of teenage mothers aged under 20 years (aged 13-19 at midwifery booking). There is a very strong correlation between deprivation and teenage pregnancies, with the percentage of teenage pregnancies 5.3 times higher for females living in the most deprived England deprivation quintile compared to the least deprived.

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9. Sexual health services

9.1 Organisation of services

SHS are provided across 3 levels: Universal services, Targeted services, and Specialist Integrated Sexual & Reproductive Health Services. The provision at each level and main providers are summarised in table 1.

Table 1: The three levels of sexual health services in Southampton

	Services provided	Current provider(s) include
Level 1: Universal Services	Primary care and community pharmacy, school nursing, health visiting, health promotion services, youth and community services, voluntary sector provision, walk-in centres, school, and college settings. Level 1 service content- sexual health campaigns; brief interventions; foundation level contraception in community settings e.g., condom distribution and c-card scheme; chlamydia screening; prescribing of basic contraception in primary care.	General Practice Community pharmacy School nursing Health visiting Solent NHS within hubs and spokes Schools and colleges Voluntary and community sector Range of frontline services working with at risk groups
Level 2: Targeted Services	Primary care, specialist sexual health nurse team, health promotion outreach, targeted clinical delivery in outreach, trained youth, and community workers, commissioned voluntary sector provision to reach target communities / groups. Level 2 service content- level 1 offer to targeted groups e.g. vulnerable young people, homeless, BME, learning disabilities, single gender work, commercial sex workers; targeted sex & relationships education (above what is delivered by schools themselves) ; provision of full-range of contraception and sexual health service in school and college settings; pregnancy testing in trained services; emergency hormonal contraception in community pharmacy;	General practice Southampton Primary Care Limited (SPCL) Community pharmacies Solent NHS Trust within hub and spokes No Limits – subcontracted by Solent NHS Trust Terrence Higgins Trust -

	sexual health nurse-led sessions working under Patient Group Directions (dual sexual health service provision) in locality spokes, LARC provision and HIV testing in general practice and remote HIV testing	subcontracted by Solent NHS Trust SH:24 Targeted healthcare services (e.g. homeless, children in care)
Level 3: Specialist Integrated Sexual & Reproductive Health Services **Hub and Spoke model**	Contraception & Sexual Health and GUM community hub, including specialist services for young people, sex workers, people with a learning disability and high-risk MSM, and some specific provision delivered in spokes; unplanned pregnancy assessment and early medical abortion; psycho-sexual services; complex contraception and specialist infection screening, treatment, and management; development of PGDs. Highly specialist delivery through the hub e.g., surgical terminations, removal of deep implants, specialist HIV services.	Solent NHS Trust British Pregnancy Advisory Service (BPAS) through hub – subcontracted by Solent NHS Trust

9.2 Outreach for groups most at risk from harm

The community Sexual Health Team (CSHT) from Solent NHS Trust works in partnership with No Limits Consortium and Terrace Higgins Trust (through a memorandum of understanding) to increase access for groups most at risk, maximise digital solutions (for example social marketing to link in with the LGBT community*)* and work with established VCS organisations.

No Limits is also commissioned to provide:

1. Health & wellbeing school and college drop-ins (open access) – including, but not limited to sexual health.
2. Sexual health provision at centrally located drop-in (open access)
3. Lesbian. Gay, Bisexual and Transgender (LGBT) health education and support sessions, information, and advice – a weekly programme of health education and support including reproductive and sexual health, particularly HIV/STIs, and sexual exploitation.

9.3 Geographical locations:

Services are located centrally (Royal South Hants Hospital and No Limits advice centre) or to the east of the city (Bitterne Health Centre with limited hours). These locations may mean reaching the services is challenging for some residents living in other areas of the city, particularly for those with limited income for transport, and also discourage attendance due to the time required to attend.

10. Service data

Key findings for Southampton:

Accessibility

- Numbers of contacts and individuals using integrated SHS are lower than prior to the Covid-19 pandemic.
- Most people who are seen within the service are receiving prompt care and diagnosis

Equity

- The proportion of service users who are aged over 25, male, of an ethnicity other than 'white British' and lesbian, gay or bisexual is increasing, but service use is still not always in line with level of need (including for those who are most deprived and males).

Effectiveness

- STI testing is recovering from a large drop in 2020/21, but the proportion of full STI screens has decreased leaving a potential for an increase in undiagnosed syphilis and HIV.
- Fewer interventions are being undertaken; there is some suggestion that testing is not reaching populations with the highest need.
- There is a low detection rate in the National Chlamydia Screening Programme and delays in treatment could lead to increased transmission.

Efficiency

- Increasing numbers are opting to use online services.

10.1 Overview

All data is for 2021/22 and from Solent NHS Trust unless otherwise specified and refers to Southampton city residents. [66] Solent NHS Trust is the provider for the Integrated Sexual Health service across Southampton, Hampshire, Portsmouth, and Isle of Wight.

The integrated service is commissioned to provide services via three different routes:

- Local Authority Commissioned: Integrated GUM and contraception services, chlamydia screening, sexual health promotion/outreach, HIV pre-exposure prophylaxis (PrEP), digital front door and remote testing, psychosexual counselling, system leadership & network management
- CCG Commissioned: Termination of pregnancy and vasectomies
- NHS England: HIV treatment and care, HPV vaccination and Sexual Assault Referral Centres.

89% of consultations for Southampton residents took place within the city or online in 2019, with the remainder mostly elsewhere in Hampshire.[67]

10.2 How quickly are people getting care?

99% of residents contacting the service, were seen or assessed within 2 working days of first recorded contact. Note however findings from the survey regarding making contact with the service. 99% of test results are received within 7 working days of the specimen being taken.

10.3 Who is accessing services?

The absolute number of contacts and the number of individuals using the integrated SHS (excluding ToP, HIV, vasectomy and psychosexual) are both lower in 2021/22 compared with 2019/20 (figure 16 and 17). Prior to this, both number of contacts and individuals had been showing an increasing trend.

[66] Solent NHS Trust - Service Activity & Performance: Integrated Sexual Health Service
[67] Public Health England. *SPLASH supplementary report* (2021)

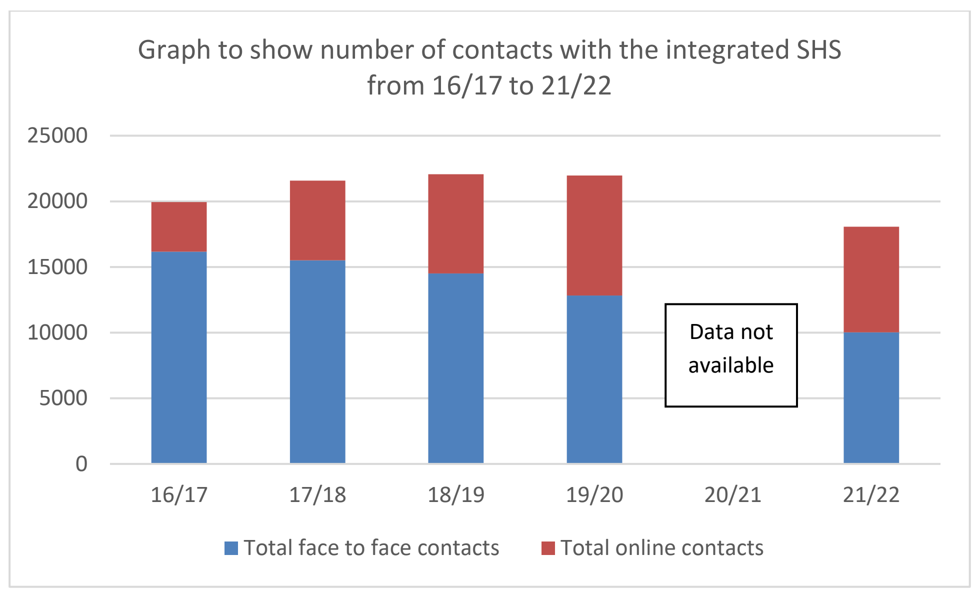

Figure 16: Graph showing the number of contacts with the integrated SHS from 2016/17 to 2021/22 face to face and online (excluding ToP, HIV, vasectomy and psychosexual). Source: Solent NHS

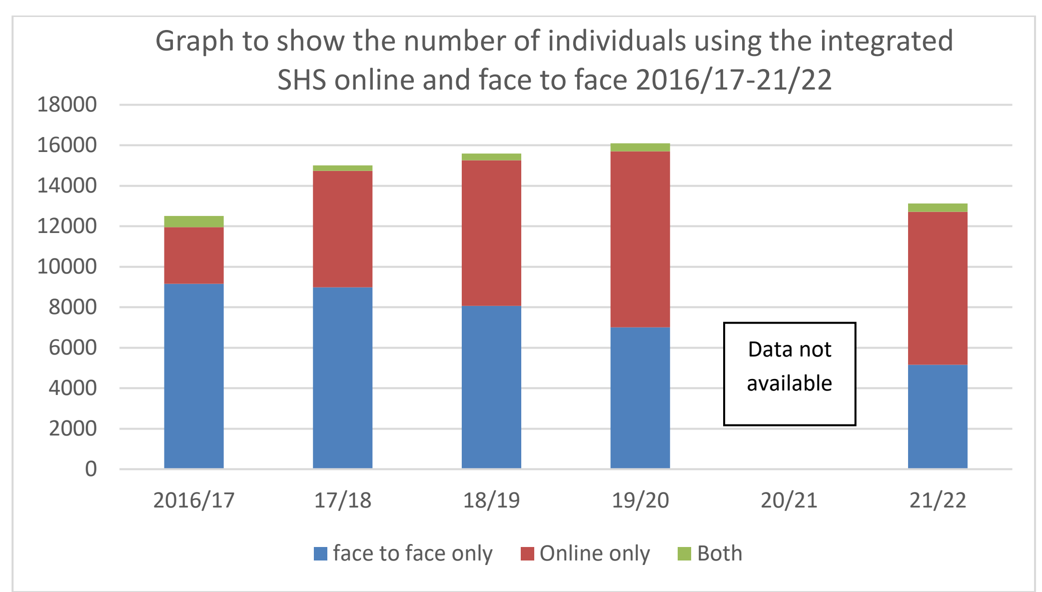

Figure 17: Number of individuals using the Integrated SHS from 2016/17 to 2021/22 (excluding ToP, HIV, vasectomy and psychosexual). Source: NHS Solent

The longer-term impact of the Covid-19 pandemic is currently unknown, including whether numbers of contacts and individuals accessing the service will increase to pre-pandemic levels, and how they will choose to have that contact; face to face or online. Data from the end of this current year 2022/23, may begin to shed light on this.

Service users aged 20-24 (27.2%) and 25-29 (20.5%) make up almost half of those accessing SHS. This is expected as they account for 41% of the population in Southampton, and young

people are known to have a higher level of sexual health need. The proportion of under 20s contacts has decreased year-on-year (8.9% in 21/22 compared to 13.2% in 16/17), as have those for 20-24 years (26.4% in 21/22 compared to 31.3% in 16/17). Access is similar across the three most deprived quintiles but lower than in the least deprived. We know that more deprived groups are disproportionately affected by STIs so equitable service provision would see higher access in the most deprived quintiles.

The proportion of males accessing is increasing – 34.3% in 21/22 compared to 29.3% in 16/17, this has shown small increases year-on-year. The proportion of contacts with the service by people from ethnicities other than 'white British' is increasing – 35.4% in 21/22 compared to 29.7% in 16/17. There is an increase in the proportion of individuals using the SHS who identify as bisexual (98% increase between 2019/20 and 2021/22), gay (16% increase) and lesbian (48% increase). Overall, 16% of individuals using SHS in 2021/22 were LGB; based on the additional need in MSM it is appropriate to see higher use for the LGB community than in the population overall.

In terms of access via the outreach service, there is a clear trend for level of deprivation, with access significantly higher in the most deprived quintile – although numbers accessing are low. 90% of contacts via the outreach service are female, 74% under 20s, 95% heterosexual and 86% White British.

10.4 How are people accessing services?

Two in three tests were completed online, although this decreased from three in four during the peak of the COVID-19 pandemic in 2020/21, the rate of online completion has gradually been increasing over the last 5 years (figure 18).[68] The proportion of male contacts online has increased – 39.3% in 21/22, the previous peak was 33.7% in 18/19; this is a greater increase than seen in overall service, suggesting that males may find online services more appealing. The proportion of under 25 contacts has decreased, perhaps due to increased awareness of online services to over 25s due to the pandemic. Again, as per access generally, the proportion of online contacts with the service by people from ethnicities other than 'White British' has increased – 35.3% in 21/22, it was 16.7% in 16/17 – although this could be due to improved recording. There is also an increase in the proportion of bisexual and gay users of the online services. Online activity is lower in the most deprived quintile. Provision of online services may have helped access for those facing stigma and discrimination.

[68] Solent NHS Trust - *Service Activity & Performance: Integrated Sexual Health Service*

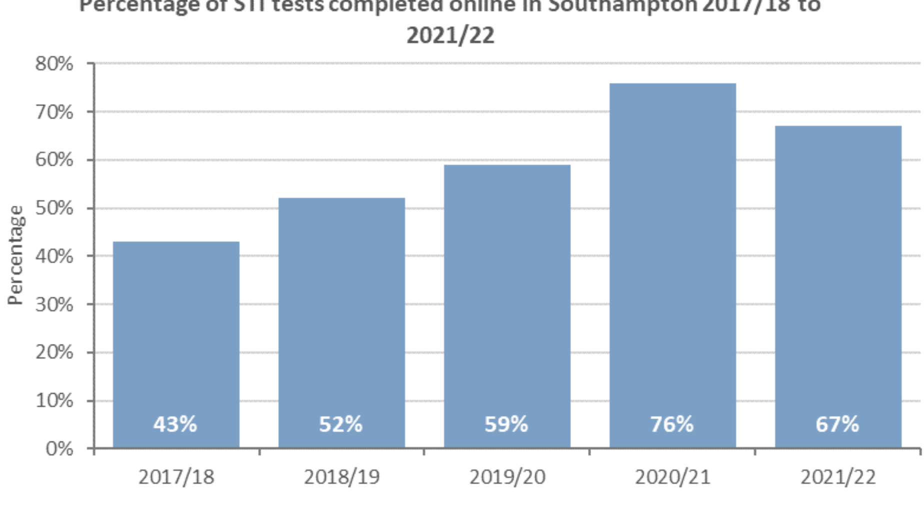

Figure 18: Percentage of tests completed online 2017/18 to 2021/22

10.5 How frequently are people being re-infected?

This gives an indication of the effectiveness of SHS in the prevention of secondary infection. Services at all 3 levels will have an impact on this. 9% of diagnoses are for people who have previously been diagnosed in the last 12 months. STI reinfection rate increased by 4 percentage points (an increase of 44%) between 2019/20 and 2020/21, this could in part be due to the challenges in accessing services during the COVID pandemic. As discussed in section 5, reinfection rates are particularly high for those aged under 19.

10.6 What STIs are being tested for?

The British Association for Sexual Health and HIV (2015) recommend that asymptomatic patients should be offered screening for HIV, syphilis, gonorrhoea and chlamydia, with additional hepatitis A, B and C testing for higher risk groups.[69] The HIV Action Plan supports the introduction of 90% of new sexual health service attendees testing for HIV, as standard and NICE guidelines advise to offer and recommend an HIV test to everyone who attends for testing or treatment.[70,71] The overall STI Testing activity has increased year-on-year up to

[69] British Association for Sexual Health and HIV. *Clinical Effectiveness Group guidance on tests for Sexually Transmitted Infection* (Staffordshire, UK: BASHH, 2015) < Microsoft Word - STI testing tables 2015 Dec update-4.docx (bashhguidelines.org)> (accessed 1 November 2022)
[70] National Institute for Health and Care Excellence, *HIV testing: increasing uptake among people who may have undiagnosed HIV* (2016), NICE < Overview | HIV testing: increasing uptake among people who may have undiagnosed HIV | Guidance | NICE> (accessed 31 October 2022)
[71] NICE. *HIV testing: increasing uptake among people who may have undiagnosed HIV*. (2016)

2019/20. During 2020/21 there was a significant decrease in the number of tests carried out, but in 2021/22 this has returned to pre-pandemic levels.[72]

Most of the testing taking place is for a full STI test (chlamydia, gonorrhoea, syphilis, and HIV - 51.4%)[73]. Three site testing[74](12.1%), chlamydia and gonorrhoea only testing (12%) and hepatitis A, B and C testing (12%) account for most of the other tests. Figure 19 shows how this has changed over time. Almost all saw some recovery from the significant drops in 2020/21. Notably, full STI tests now make up a smaller proportion of the total (60% in 2019/20 vs. 51% in 2021/22), which may be particularly significant for HIV and syphilis, which are not frequently tested for outside of a full STI test. We don't know whether there is a correlation between the increase in online testing and the drop in the proportion of full STI testing (i.e., the blood test element of remote testing is not being taken up).

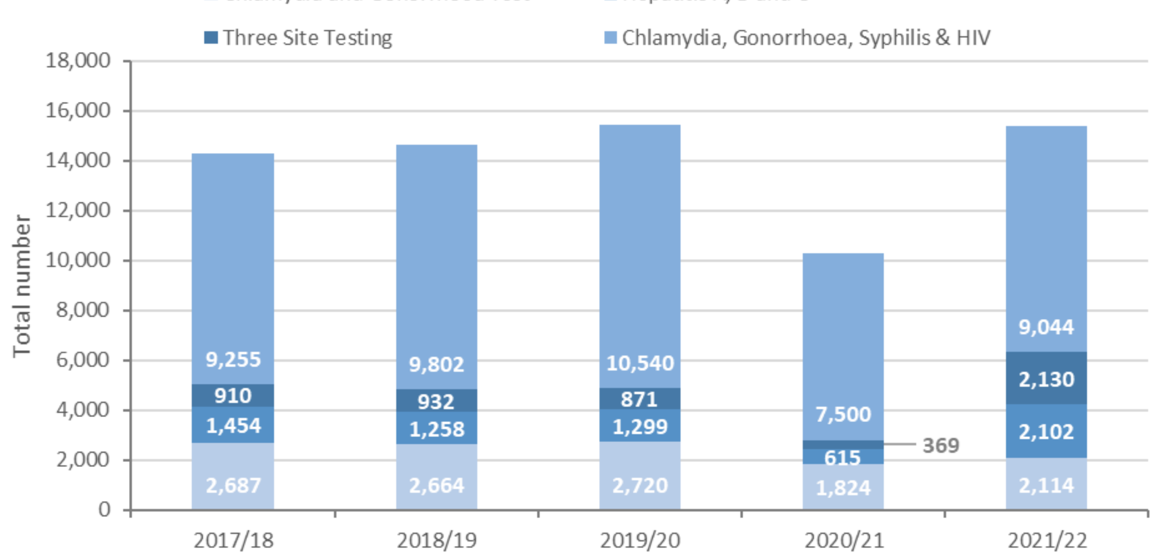

Figure 19: Total number of STI tests in Southampton 2017/18 to 2021/22

10.7 STI treatment

STI Intervention activity has decreased in each of the last two years (figure 20).
The ratio of STI Testing to STI intervention has decreased from1:0.69 to 1:0.35. This could be for one of several reasons including:

[72] Service Activity & Performance: Integrated Sexual Health Service report (2022)
[73] Service Activity & Performance: Integrated Sexual Health Service report (2022)
[74] Testing for chlamydia and gonorrhoea that includes screening of the throat, rectum and a urine test or vaginal swab

- Lower risk/more asymptomatic individuals using online services during Covid-19 disruptions i.e. the service not reaching those most likely to have an STI
- Data artefacts e.g., changes in coding.
- A disconnect in the pathway between testing and treatment.
- True lower prevalence of disease

The timing of the drop in interventions following a rise up until 2019/20, suggests a relationship with the Covid-19 pandemic. Testing, but not intervention, rates had returned to pre-pandemic levels in 2021/22.

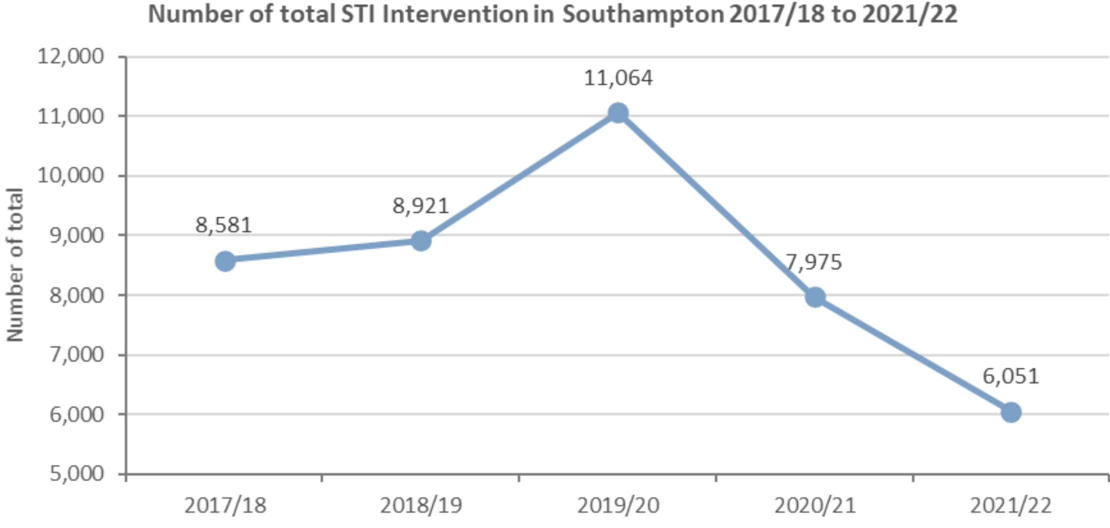

Figure 20: Number of total STI interventions in Southampton 2017/18 to 2021/22

10.8 The National Chlamydia Screening Programme

The aim of the National Chlamydia Screening Programme (NCSP) is to reduce the harm caused by untreated chlamydia infection. The programme proactively offers women under 25 chlamydia screening in the sexual health service and online.

There is a low detection rate for chlamydia with a significant drop from 2020/21. The percentage of positive tests was increasing, with more than 1 in 5 tests being positive in 2020/21 but dropped to just 1 in 13 in 2021/22. It should be noted that this data from OHID Fingertips differs considerably from data directly from Solent NHS Trust, the reasons for which are unclear and warrant further investigation.

99% of **positive results** notified within 2 days of receiving the result from the lab

Positive patients receiving treatment within:

72% Within 14 days of test

82% within 30 days of test

82% within 6 weeks of test

99% of **negative results** notified within 5 days of receiving the result from the lab

Partners of index patient contacted and receiving treatment within:

84% Within 14 days of index patient's treatment

100% Within 30 days of index patient's treatment

Figure 21: The National Chlamydia Screening Programme

In general, treatment waiting times and results notification have improved year-on-year up to 2020/21 however there has been a notable decrease in positive patients who receive their results within 14 days, 30 days, and 6 weeks in 2021/22 (with treatment falling below the national auditable outcome standard of 85% within 3 weeks).[75] 100% of partners are contacted and treated within 30 days of treatment starting for the index patient (figure 21). Delays in treatment provide more opportunity for transmission.

10.9 HIV testing

Overall HIV testing rates have been discussed in section 7.3. The proportion of new STI patients who accept a HIV test as part of an STI screen within service is high for all, MSM and Black and Afro-Caribbean patients, at 86%, 97% and 91% respectively.[76] This uptake has remained stable during COVID.[77]

Southampton City Council makes the National HIV self-sampling service available to its residents. The latest national data suggests the service is successfully engaging most at-risk groups and those who have never tested before or test infrequently.[78]

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[75] UK Health Security Agency, *Standards English National Chlamydia Screening Programme* (London, UK: Crown, 2022) <English National Chlamydia Screening Programme (publishing.service.gov.uk)> (accessed 1 November 2022)

[76] Note that these figures differ from the HIV testing data in 7.3, this is due to a combination of factors including the use of financial year vs. calendar year, new patients vs. all eligible patients as the denominator and data being presented by area of residence vs. by service.

[77] Solent NHS Trust. Service Activity & Performance: Integrated Sexual Health Service - 2022

[78] Public Health England, *National HIV self-sampling service November 2018 to October 2019* (London, UK: Crown, 2020) <National HIV self-sampling service: November 2018 to October 2019 (publishing.service.gov.uk)> (accessed 1 November 2022)

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A proportion of testing also takes place for women as antenatal screening by maternity services. The latest figures show that in Q3 20/21 at University Hospitals Southampton, 99.9% of eligible women had a HIV screening result.[79] We do not have local data regarding diagnosis rate from antenatal screening, however nationally only 11.9 per 100,000 eligible pregnant women (0.12%) screened positive, though the majority would have already been diagnosed before pregnancy.[80]

10.10 HIV prevention

Individuals can take precautionary medication to reduce the risk of contracting HIV. Pre-exposure prophylaxis (PrEP) can be taken before possible exposure whilst post-exposure prophylaxis (PEP) can be taken after. The latter is not intended for regular use by people who may be exposed to HIV frequently.[81] In Southampton PrEP and PEP can be obtained from Sexual Health Clinics (depending on eligibility for PrEP and PEP). PrEP data is difficult to interpret (due to how it is collated nationally) and is an aspect of service reporting and monitoring that requires further focus to understand the need, sufficiency and equity of offer (this is being actively worked on by the service).

10.11 Hepatitis A and B Vaccination

Hepatitis B vaccination has been part of the routine childhood vaccination schedule since 2017, but it is also offered to previously unvaccinated adults at risk of infection or severe complications. In context of sexual risk factors, this includes people who change their sexual partners frequently, men who have sex with men, sexual partners of someone with hepatitis B and male and female sex workers. There has been a marked improvement in high-risk patients being offered and having the Hepatitis B vaccination (figure 22), though the latter remains lower than the desired threshold for the service (80%).

The NICE guideline on reducing sexually transmitted infections contains guidance on hepatitis A vaccination, including that it should also be opportunistically promoted to MSM.[82] The number of MSM receiving a first and subsequent Hepatitis A vaccination doses (of Southampton registered population) in 2019 was 160 and 91, 70 and 51 in 2020 and 99

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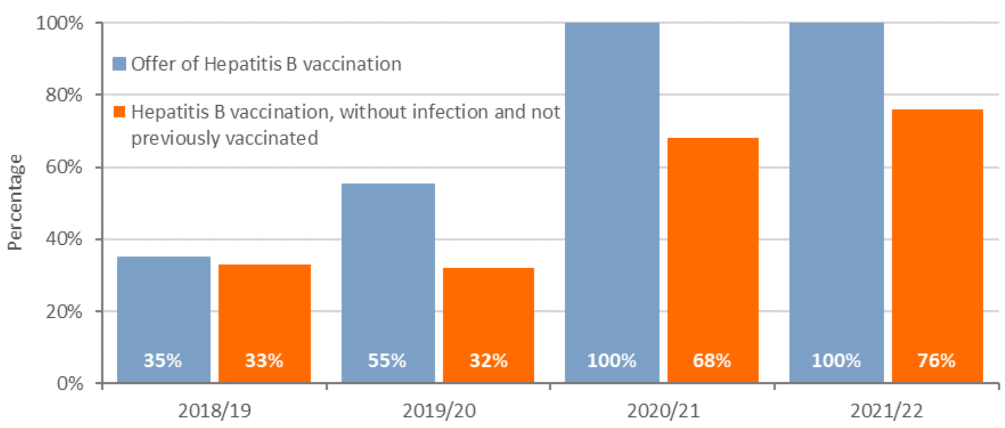
[79] NHS England, *NHS screening programmes: KPI reports 2021 to 2022* (2022), *GOV.UK* < NHS screening programmes: KPI reports 2021 to 2022 - GOV.UK (www.gov.uk)> (accessed 1 November 2022)

[80] UK Health Security Agency, *HIV testing, new HIV diagnoses, outcomes and quality of care for people accessing HIV services: 2021 report* (London, UK: Crown, 2022) <HIV testing, PrEP, new HIV diagnoses, and care outcomes for people accessing HIV services: 2022 report - GOV.UK (www.gov.uk)> (accessed 1 November 2022)

[81] Terrence Higgins Trust, *PEP (post-exposure prophylaxis for HIV)*, *Terrence Higgins Trust* <https://www.tht.org.uk/hiv-and-sexual-health/pep-post-exposure-prophylaxis-hiv> (accessed 6 June 2022).

[82] National Institute for Health and Care Excellence (2022). *Reducing sexually transmitted infections.* NICE

and 39 in 2021.



Source: NHS Solent Sexual Health Services

Figure 22: Percentage of high-risk people offered the Hepatitis B vaccination and patients who were vaccinated in Southampton 2018/19 to 2021/22

10.12 Reproductive Health

Key findings for Southampton:

Accessibility

- Episodes of contraceptive care from SHS are now similar to pre-pandemic.
- Access to free emergency hormonal contraception from community pharmacies is being increased to over 25s.
- The overall rate of termination of pregnancy (ToP) in Southampton is similar to national rates.
- The number of terminations of pregnancy (ToP) have remained relatively stable, as have the proportion completed within 9 weeks gestation (93%) despite significant changes to provision with the Emergency Medical Abortion (EMA) at home pathway.
- STI testing and LARC after termination of pregnancy has fallen sharply.

Equity

- ToP is significantly higher in the most deprived quintile than in the two least deprived quintiles. The proportion of ToPs for people of Black, Asian, and mixed ethnicities has increased between 2019/20 and 2021/22.

Effectiveness

- LARC uptake in the overall population has decreased and is below the national level.
- Repeat terminations in Southampton are the third highest amongst ONS comparators. 1 in 3 under 25 years olds having a termination of pregnancy in 2020 had previously had one; this is higher than previous figures.

10.13 Contraception

Data on contraception is provided in terms of episodes of care, therefore it is not possible to determine the number of individuals receiving contraception from Solent NHS Trust. There have been changes in coding that make trends difficult to interpret with any certainty, but there appears to have been a decreasing trend prior to and during the pandemic, with a large decrease from 7,439 in 2019/20 to 6,348 in 2020/21 and a recovery in 2021/22 to pre-pandemic levels (figure 23).

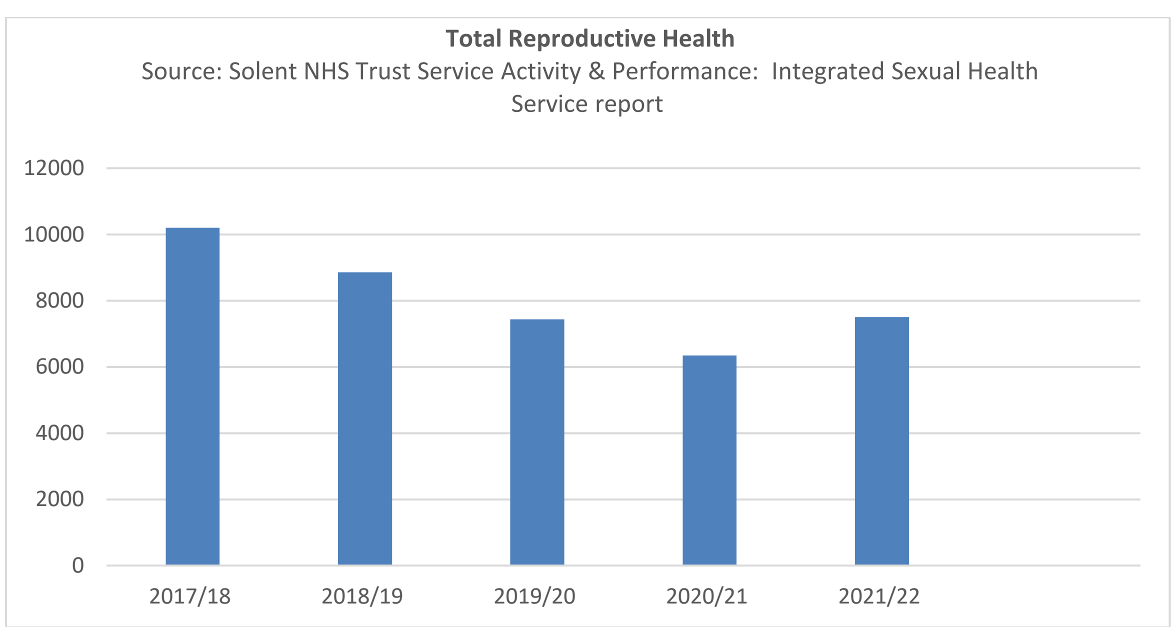


Figure 23: Total episodes of care for reproductive health 2017/18 to 2021/22

10.14 Emergency hormonal contraception (EHC)

EHC provision is commissioned from community pharmacies. In 2021/22, in response to a service review, access has been widened so over 25s can now receive free EHC. Most EHC is provided through pharmacies (figure 24).[83]

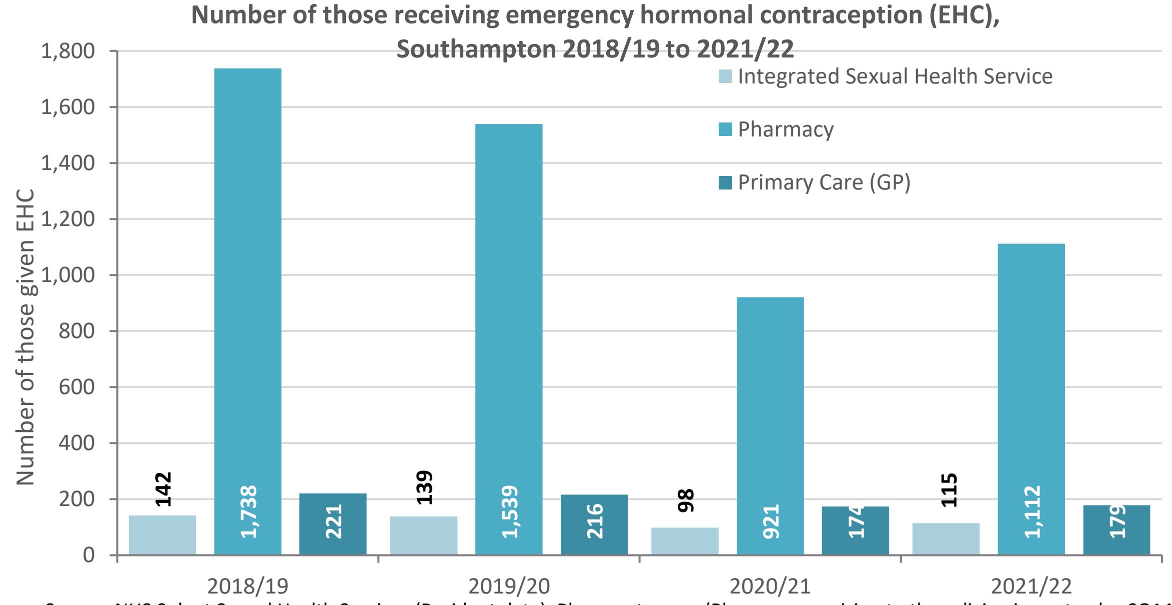


Figure 24: Number of those receiving EHC in Southampton from 2018/19 to 2021/22

[83] Solent NHS Trust Integrated Sexual Health Service

A recent service evaluation undertaken by the University of Southampton, Solent NHS Trust, Local Authorities and Pharmacies across Hampshire, IOW, Portsmouth and Southampton demonstrated that 25% of requests for EHC could not be met that day largely due to the pharmacists being busy or not being accredited to provide the service. Pharmacists were also unlikely to discuss LARC, STI testing or provide/signpost to free condoms.

10.15 Long-acting Reversable Contraception (LARC)

LARC is one of the most effective methods in reducing unwanted pregnancy, as they do not rely on a daily routine like other forms of contraceptive such as the pill. LARC includes contraceptive injections, implants, the intrauterine system (IUS) or the intrauterine device (IUD). However, the contraceptive injection is not included within LARC indicators as this method has a higher failure rate.

LARC (along with HIV testing with a focus on those most at risk of infection) is currently commissioned from Southampton Primary Care Limited (SPCL) and delivered by them and the GP Practices who they have contracts with, giving coverage across the city. LARC is also provided by Solent NHS Trust within the SHS. Excluding injections, 30.1 LARC were prescribed per 1,000 females aged 15 to 44 in 2020 down from 50.1 in 2018. Prior to the COVID-19 pandemic Southampton had a higher rate of LARC prescriptions than England overall, but Southampton has seen a larger decline than seen nationally and is now below the national average. The 2020 rate is also 4th lowest out of ONS comparators. Of 30.1 per 1000 prescriptions in 2020, 19.3 were prescribed by GPs and 10.8 were prescribed by sexual and reproductive health services. Whilst the rate prescribed by sexual and reproductive health services saw the biggest decline even before the impact of the pandemic (2018 to 2019), GP prescriptions went up between 2018 and 2019 before seeing a decrease in 2020.[84]

LARC uptake for women within the sexual health service (as a % of women given contraception) was consistently above 40% apart from in 2019/20 when it fell to 33%. Service disruption will have impacted on uptake due to the lockdown and staffing challenges. 2021/22 saw an improvement to 40%. LARC is more likely to be chosen by older women using SHS for contraception (62% in over 25s vs. 47% in under 25s in 2020) and the proportion of women overall choosing LARC at SHS is higher than the southeast and England.[85]

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[84] Office for Health Improvement and Disparities, *Public health profiles (2022), fingertips.phe.org* <https://fingertips.phe.org.uk> (accessed 6 June 2022)
[85] Ibid

LARC and contraceptive injections are also provided by general practice (figure 25 and 26). More LARC and most contraceptive injections are provided in general practice.

The Phoenix Team are Southampton's Pause Practice for women who have had children removed from their care and are at risk of this cycle repeating. They are supported to take a 'pause in pregnancy' using long-acting reversible contraception. The aim is to give the women space to use the help of an intensive programme of support to address their unmet needs and difficulties. A national evaluation suggests that after the first 21 months of Pause, there is an average reduction of 11 children not going into the care system.[86]

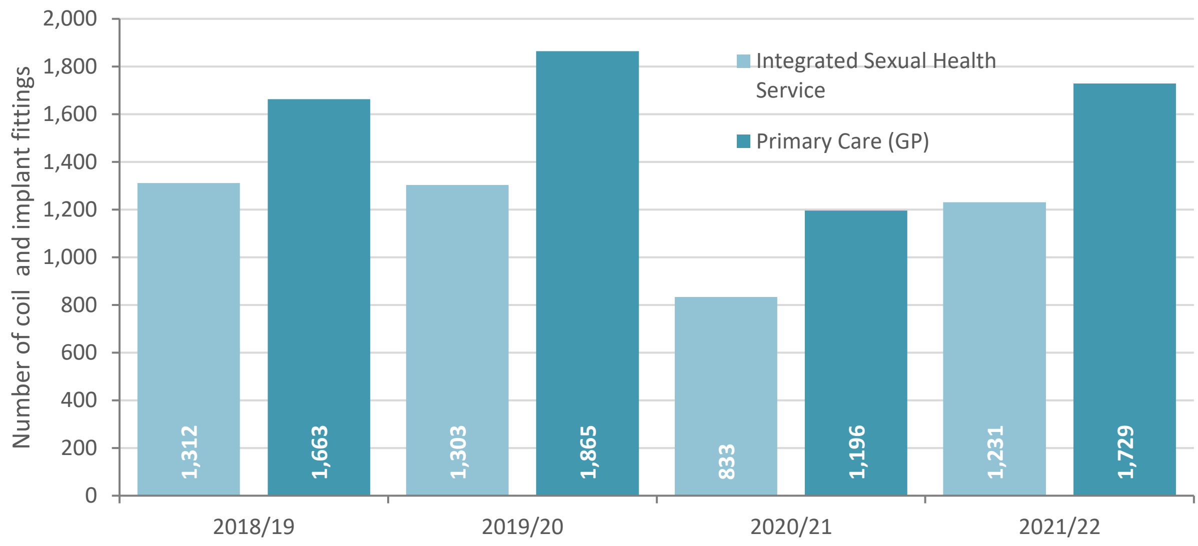
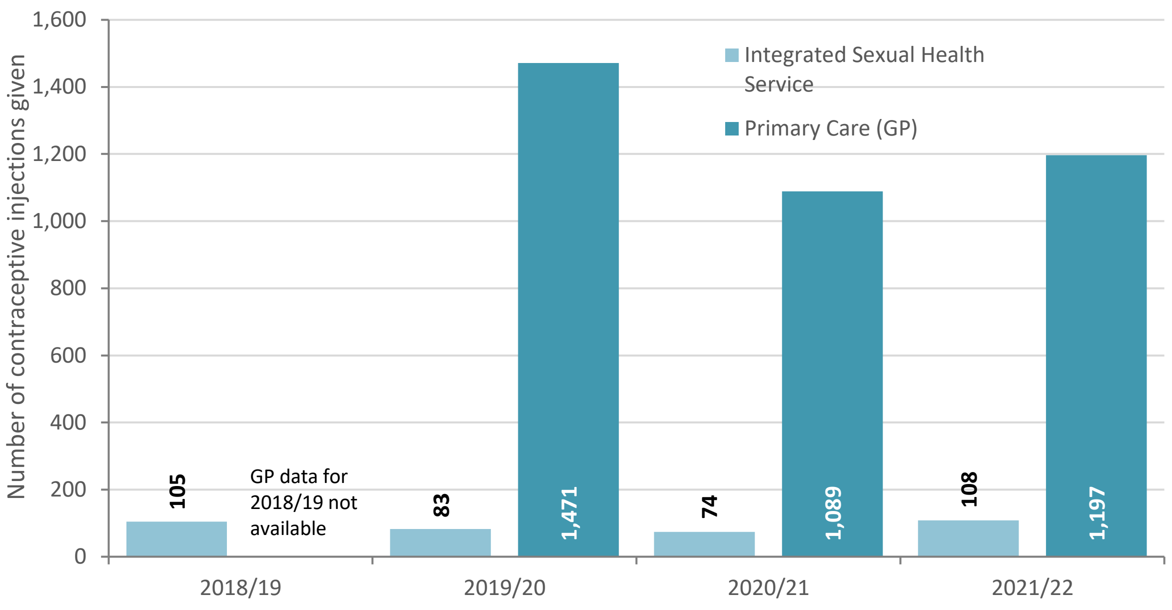


Figure 25: Number of coil and implant fittings within the integrated sexual health service and primary care 2018/19 to 2021/22

[86] Southampton City Council, *Phoenix @ Pause Southampton: Business case for a sustained service*, <Decision - Phoenix @ Pause Southampton: Business case for a sustained service | Southampton City Council> (accessed 27 October 2022)



Source: NHS Solent Sexual Health Services (Resident data) and NHS Hampshire & IOW ICB Primary Care (Registered patient data)

Figure 26: Number of contraceptive injections given in Southampton Integrated Sexual Health Service and Primary Care 2018/19 to 2021/22

10.16 Terminations of pregnancy

In Southampton in 2020, 18.5 terminations of pregnancy occurred for every 1,000 females aged 15 to 44 years (1,066 terminations), similar to the national average of 18.9. The most common age group for terminations to occur were those aged 20 to 29 years old.[87]

Under 25s

In Southampton a third of ToPs were for those aged under 25. There was a decrease in the rate of under 25 ToPs between 2016-18 compared to 2019-21 (figure 27).

[87] Southampton data observatory, *Sexual health dashboard* <Microsoft Power BI> (accessed 21 September 22)

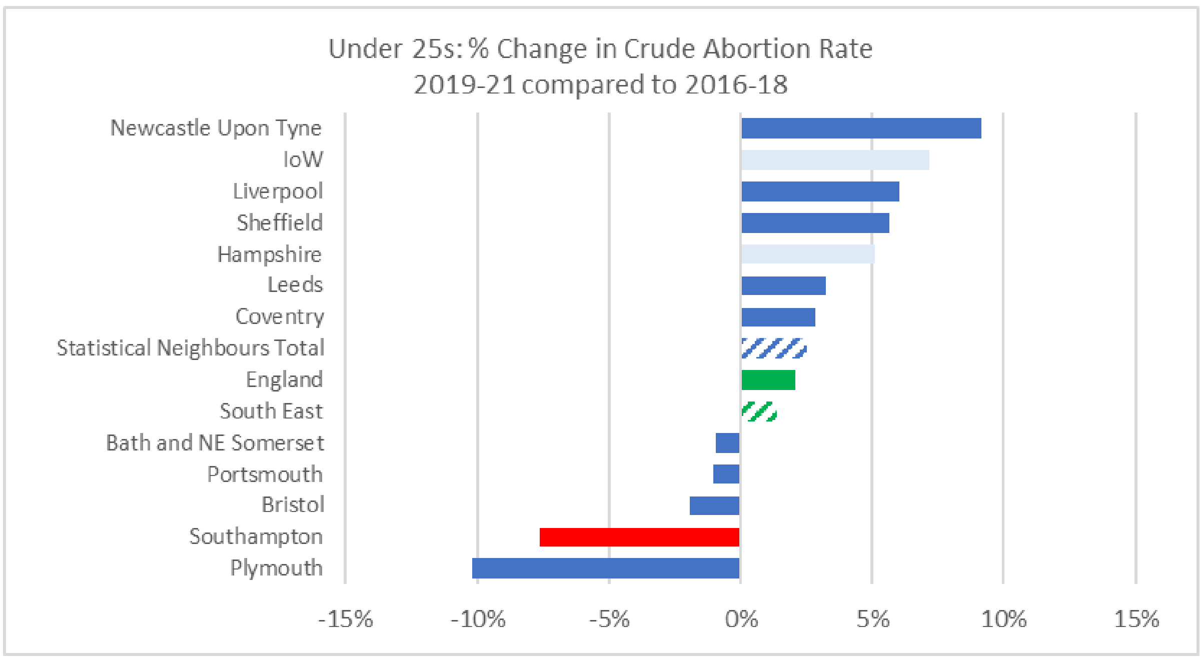


Figure 27: Percentage change in crude abortion rate for under 25s 2019-21 compared to 2016-18

In 2020, there were 117 (31.0%) under 25 repeat ToPs, compared with 29.2% nationally. This is the third highest amongst Southampton's ONS comparators.[88] Of the women aged under 25 who had a ToP in 2012, around 1 in 6 women had previously had a ToP. In 2020 this had increased to just under 1 in 3 women.[89]

25 and over

ToP in females aged 25 and over is increasing and accounts for two thirds of those in Southampton. Over the last five years Southampton has had a higher rate of ToP compared to the national average in this age group. In 2020 this stood at 19.4 terminations per 1,000 females aged 25 to 44 in Southampton and 17.6 nationally. In 2019-21, Southampton ranked 4th highest amongst its ONS comparators for its increase in ToPs over 25s (figure 28). This does not appear to be related to access to EHC being restricted to people under 25 (from 2019-21) as the increase is similar to England and lower than both Hampshire and the Isle of Wight who continued to provide free EHC to all ages during this time.

[88] Southampton data observatory, *Sexual health dashboard* <Microsoft Power BI> (accessed 21 September 22)
[89] Ibid

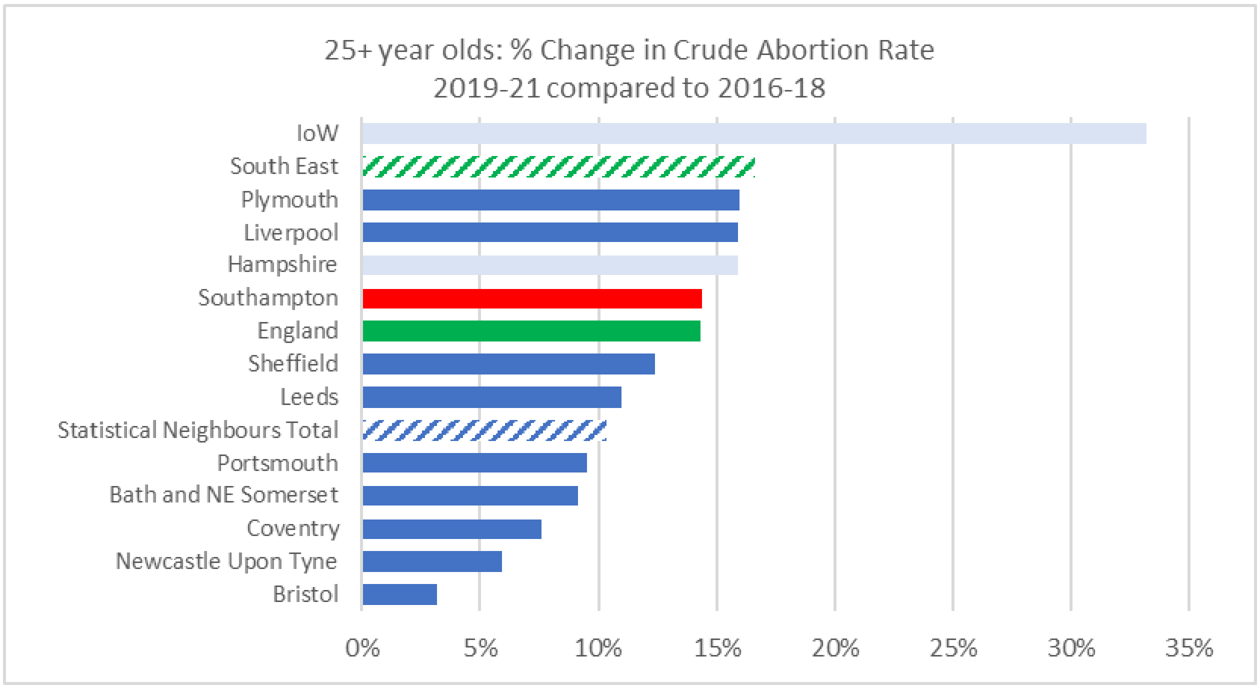


Figure 28: % change in crude abortion rate for over 25s 2019-21 compared to 2016-18

The number of terminations of pregnancy by SHS have remained relatively stable, as have the proportion completed within 9 weeks gestation (93%) despite significant changes to provision during the pandemic with the introduction of the Emergency Medical Abortion (EMA) at home pathway. ToP is significantly higher in the most deprived quintile than in the two least deprived quintiles. The proportion of ToPs which are accessed by people of Black, Asian, and mixed ethnicities increased between 2019/20 and 2021/22.

There is an increasing number (and %) of procedures that are an Early Medical Abortion (EMA). In 2017/18, there were 374 EMA procedures (40% of total procedures) compared to 978 (85%) in 2021/22 – a 161% increase in numbers (figure 29).[90] According to service data, following a rise in the proportion of (self-reported) repeat terminations during 2020/21 (up 6 percentage points to 46% of all terminations), there followed a fall in 2021/22 to a lower than pre-pandemic levels (20%). A fall has been seen over 5 years in early surgical ToP, with little change in surgical ToP 15+ weeks.

[90] Solent NHS Trust. *Service Activity & Performance: Integrated Sexual Health Service report*

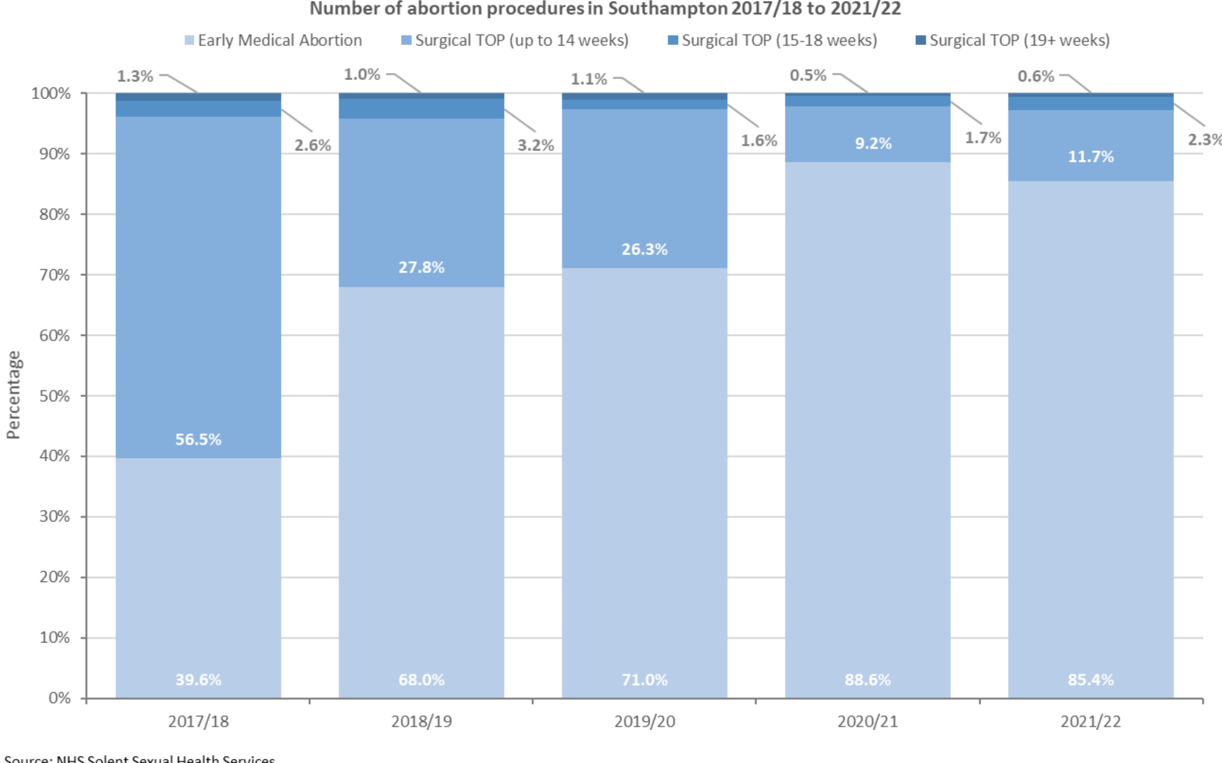


Figure 29: Number of abortion procedures in Southampton 2017/18 to 2021/22

Uptake of chlamydia screening by young people aged 15 to 24 accessing ToP services has fallen significantly during COVID with <10% uptake in 2021/22 compared to >60% before the pandemic. STI testing overall fell dramatically from 80% in 2019/20 to just 1% in 2021/22. Despite the relatively high rates of LARC prescription within the main sexual health service, the uptake has been consistently low for women who have a ToP, with only 1 in 17 women having a LARC in 2021/22.[91] The introduction of the EMA at home pathway, which prevented disruption of terminations due to Covid-19, is likely contributing to these changes.[92]

The earlier ToPs are performed the lower the risk of complications. Of those terminations that were NHS-funded 87.6% were under 10 weeks compared to 88.1% nationally. Proportionally this has been slowly increasing since 2012.[93] In 2021/22, 99% of women received a surgical procedure within 5 working days of the woman's decision to proceed. For the previous two years it had been 100%.[94]

[91] Solent NHS Trust Integrated Sexual Health Service
[92] Solent NHS Trust - *Service Activity & Performance: Integrated Sexual Health Service report*
[93] Southampton data observatory, *Sexual health dashboard* <Microsoft Power BI> (accessed 21 September 22)
[94] Solent NHS Trust - *Service Activity & Performance: Integrated Sexual Health Service report*

10.17 Vasectomy

A vasectomy is a surgical procedure that is 99% effective at preventing pregnancy. Other advantages include that long-term health effects are rare, it is safer than female sterilisation and it doesn't affect hormone levels, sex drive or interfere with sex. Whilst it is considered permanent and therefore removes the need for contraception for the purposes of birth control, it does not offer protection against STIs.

The number of vasectomy procedures increased year-on-year from 2017/18 to 2019/20, however a decrease of almost 50% was observed during 20/21 due to the impact of COVID-19. Since the introduction of the community vasectomy service, a significant shift in procedures being performed within the community compared to acute services from 48% in 2017/18 to 95% in 2021/22. In 2021/22, 94% of vasectomies took place within 18 weeks. No complications or infections have been recorded from vasectomy procedures for Southampton men. [95]

10.18 Psychosexual

Many individuals face difficulties relating to sex at some point in their life which can cause distress and unhappiness. Some people can manage this themselves but for those that cannot, psychosexual services seek to help individuals to address these issues. Psychosexual counselling is not available in all areas of the UK and is dependent on local commissioning. In Southampton, approximately 100 referrals for psychosexual counselling are accepted by the service per year. However, there have been challenges with waiting times and there is limited capacity within this small but important service. Referrals are made only via primary care. In 2021/22, 7% of individuals were offered an initial assessment within 35 working days of the referral receipt. Of those who are recommended therapy, less than one quarter commence therapy within 30 working days from initial assessment. Just over half of assessments were completed within 18 weeks from date of referral. Further information on effectiveness, equity, relevance, and acceptability of this service is not available.

11. Sexual health promotion, outreach, and community work

11.1 No Limits service

From January to March 2022, there was a return of full delivery of health and wellbeing drop-in sessions in schools and colleges, within 12 schools and 3 further education colleges.

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[95] Solent NHS Trust Service Activity & Performance: Integrated Sexual Health Service report

511 young people were supported in 1,236 interactions, with relationships being the most discussed theme. Sexual health was also amongst topics most frequently discussed. 55 referrals were made to sexual health services from school and FE college drop-ins and the advice centre/advice line.[96]

Between January and April 2022, Breakout Youth, LGBT support from No Limits, made contact with 27 young people through group meetings (a mixture of virtual and face to face) covering a range of topics and 17 through one-to-one sessions. A specific group session was held on health, including some input from a sexual health worker.[97]

11.2 Relationship and Sex Education (RSE)

All schools are supported to follow the statutory guidance for teaching RSE Relationships.[98] Personal, social, health and economic education (PSHE) leads are offered CPD and training through termly network meetings, and access to quality assured teaching resources, through membership to the PSHE Association.

The Solent Sexual Health Promotion (SHP) Team deliver education to priority schools as identified by the Teenage Pregnancy Partnership, based on TP rates. This is 6 sessions, 5 delivered by No Limits and 1 by SHP. The schools identify the 12 young people from Yr9 who attend. The SHP team do also work in alternative education settings, including Pupil Referral Units. Any school can refer a young person to the SHP team for 1:1 support if they have a specific need or concern.

They have a range of training available including RSE 1&2, GIO (Get it on condom provision), pregnancy testing, as well as train the trainer and recorded webinars.

11.3 Overall outreach and health promotion summary

For 2021/22:

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[96] No Limits – *Southampton Schools and Colleges Health and Wellbeing Drop-ins. Performance monitoring report* January to March 2022.
[97] Breakout Youth LGBT provision January to April 2022
[98]Department for Education, *Relationships Education, Relationships and Sex Education (RSE) and Health Education.* (London, UK: Crown, 2019) < Relationships and sex education (RSE) and health education - GOV.UK (www.gov.uk)> (accessed 26 October 2022).

Relationship and Sex education:

194 pupils receiving RSE programmes

120 professionals received RSE training

Behaviour change interventions:
Behaviour change interventions:

15 intensive behaviour sessions for MSM (up to 6 per individual)

1,374 one-to-one brief and **32** intensive (up to 6 per individual) sessions for young people

70% of those receiving Intensive Behaviour Change interventions report improvement in confidence and ability to manage and improve sexual health

Sexual health promotion and HIV prevention sessions:

7 group sessions reaching **524** young people (under 25) at risk of poor sexual health outcomes

14 group sessions reaching **190** LGBT young people (16-24 or 19+ with additional vulnerabilities); **2** sessions for LGBT young people (20+ years

Black and ethnic minorities:

2 Barber/Weave shops supported with sexual health training and signposting and **3** providing condoms

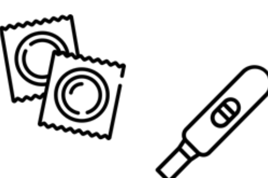
4 BAME, faith and community leaders engaged to share information to help destigmatise HIV, increase uptake of testing and PrEP and contraception.

Advertising and social media:

112 social media posts aimed at MSM

5 targeted sexual health adverts on apps

79 contacts on Adultswork aimed at sex workers (MSM/trans)



7,848 condoms and **220** Pregnancy tests requested by "Get it on" sites (free condoms and pregnancy tests for young people)

Figure 30: Summary of outreach and sexual health promotion 2021/22

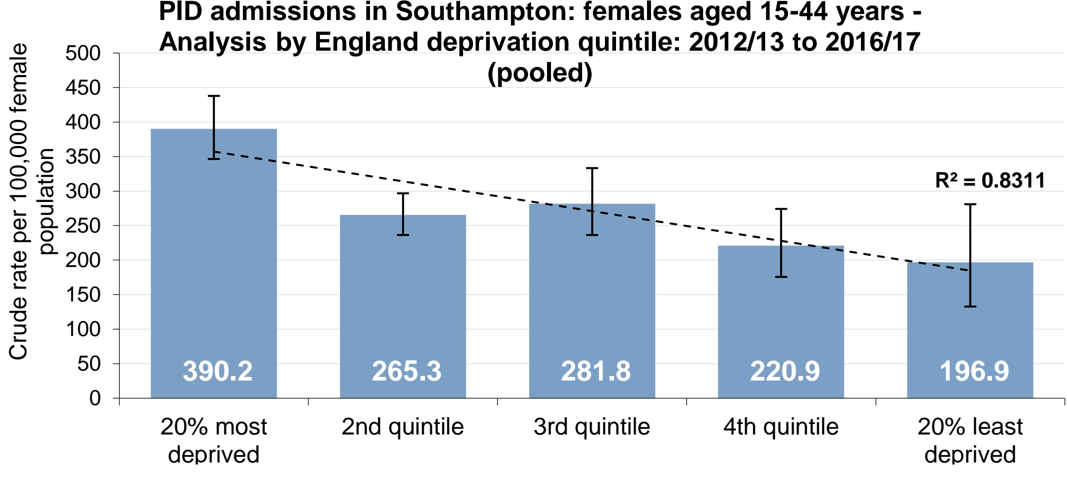
12. Health inequalities

Key findings for Southampton:

- We know that certain communities experience health inequalities in relation to sexual health, often due to stigma, difficulties in accessing services, lack of information, complex personal and medical histories.
- Whilst we have some local information on ethnicity, age, gender, sexuality, women who sell sex on street and people with learning disabilities, there are significant gaps in our understanding.
- We have no local information on the sexual health needs and outcomes for the transgender community, looked after children, people with physical disabilities and complex needs, people with mental health needs and the homeless. National data and research tell us that these are particularly vulnerable groups.

12.1 Deprivation

The correlation between teenage conceptions and ToP and deprivation has already been demonstrated. There is no recent data for STI incidence and prevalence by deprivation; the latest data (2013-2017) showed an association between greater deprivation and higher PID admissions and HIV diagnoses (figure 31 and 32). Nationally, in 2021 rates of new STI diagnoses were lower than the national average in the four least deprived deciles and highest in the fourth most deprived decile at 601 per 100,000 population.[99]



Source: Hospital Episode Statistics

Figure 31: PID admissions in Southampton by deprivation quintile 2012/13 to 2016/17

[99] Office for Health Improvement and Disparities, *Sexual and Reproductive Health Profiles, Fingertips.phe.org* <Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)> (accessed 26 October 2022).

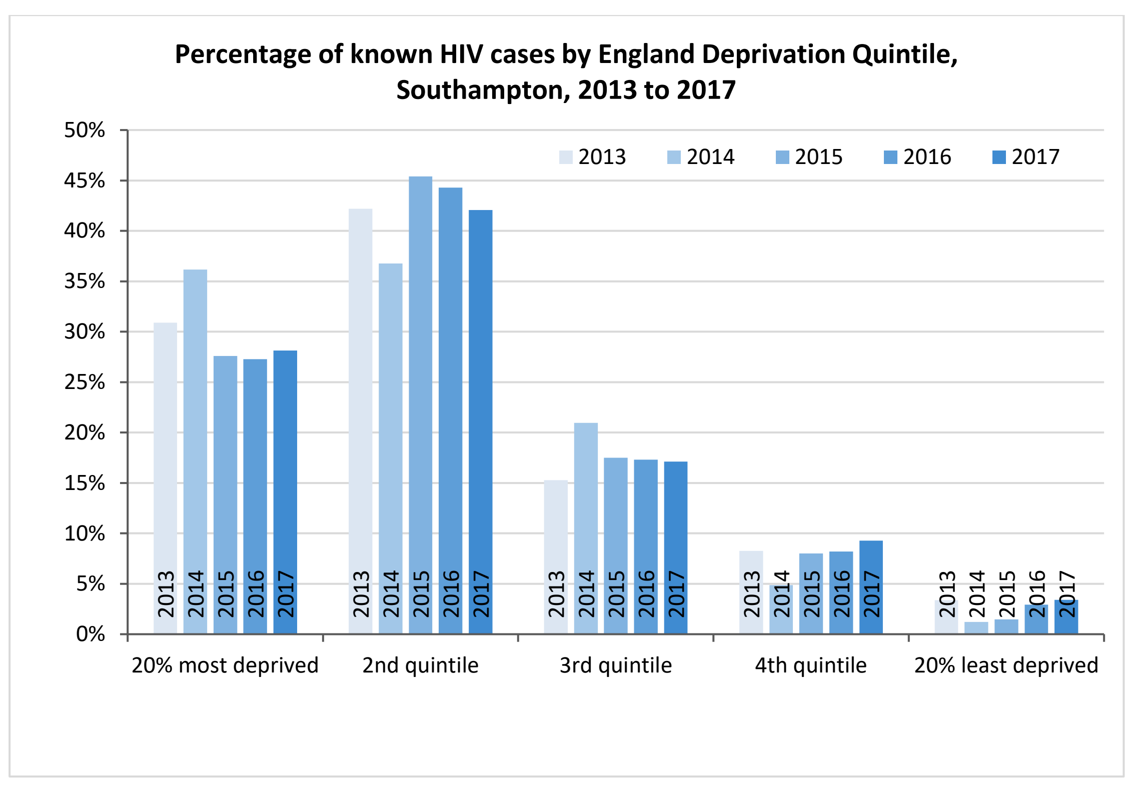


Figure 32: Percentage of known HIV cases in Southampton by deprivation quintile 2013-2017

12.2 Lesbian, Gay, Bisexual, and Transgender Community

The proportion of men in the UK identifying as gay or bisexual increased from 1.9% to 3.4% between 2014 and 2020 (between 2,075 and 3,713 people in Southampton).[100] Men who have sex with men (MSM) are disproportionally affected by STIs. In 2018, MSM accounted for 47% of gonorrhoea and 75% of syphilis diagnoses, and since 2009 rates have risen by 643% and 236% respectively, compared to 249% and 165% respectively in the population overall[101]. This is thought to be due to a combination of factors, including increased frequency of testing and greater sexual risk taking.[102]

[100] Office for National Statistics, *Sexual Identity, ONS* <available from: Sexual identity - Office for National Statistics (ons.gov.uk)> (accessed 26 October 2022)
[101] Public Health England, Health matters: preventing STIs, GOV.UK < Health matters: preventing STIs - GOV.UK (www.gov.uk)> (accessed 31 October 2022).
[102] MacGregor L, Speare N, Nicholls J*, et al*. 'Evidence of changing sexual behaviours and clinical attendance patterns, alongside increasing diagnoses of STIs in MSM and TPSM' *Sexually Transmitted Infections* 97 (2021):507-513.

In 2020, the proportion of women in the UK identifying as lesbian or bisexual was 2.8%, a rise from 1.4% in 2014.[103] There is less information available on the sexual health of lesbian and bisexual women. It is thought that most women who have sex with women (WSW) also have sexual activity with men or have had at some point.[104] This is important to note as, though transmission of STIs occurs between women, it is less common than between men and women. There is some evidence to suggest that barriers to good sexual health for WSW include: lack of awareness of risk, a significant number not taking precautions, such as barrier contraception or cleaning sex toys, and low testing rates.[105] People who identify as lesbian made up 0.5% of individuals using the service in 2020/21, but due to the data available, it is difficult to interpret whether this is appropriate service use for this group.

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. There is no reliable information regarding the size of the trans population in Southampton. 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. The limited available evidence suggests higher rates of HIV and that trans people in England are twice as likely to have a late-stage diagnosis.[106] Societal stigma can impact on access and use of services. Trans people are less likely to attend a sexual health clinic compared to cis-gendered people (26% vs. 36%) and more likely to report having a negative experience when doing so.[107,108,109]

12.3 Women selling sex 'on street' (SSOS).

People who sell sex are among the most vulnerable in society. Women who sell sex 'on street' experience disproportionate health and social inequalities when compared to other populations. They also have higher rates of mental illness and often lower literacy levels; these factors affect sexual health risks and service access. Around 50 women sell sex on street in Southampton over any 3-month period. We do not know how many local people

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[103] Office for National Statistics, *Sexual Identity, ONS* < Sexual identity - Office for National Statistics (ons.gov.uk)> (accessed 26 October 2022)
[104] Mercer C, Bailey J, Copas A. 'Women who report having sex with women: British national probability data on prevalence, sexual behaviours, and health outcomes' *American Journal of Public Health* 98,6 (2017)
[105] Moores, S. *A hidden population: What are the sexual health needs of women who have sex with women?* (London, UK: The Faculty of Sexual and Reproductive Healthcare, 2017)
[106] Hibbert MP, Wolton A, Weeks H, *et al*. 'Psychosocial and sexual factors associated with recent sexual health clinic attendance and HIV testing among trans people in the UK' *BMJ Sexual & Reproductive Health* 46 (2020):116-125.
[107] A person whose sense of personal identity and gender corresponds with their birth sex.
[108] Hibbert MP, Wolton A, Weeks H, *et al*. 'Psychosocial and sexual factors associated with recent sexual health clinic attendance and HIV testing among trans people in the UK' *BMJ Sexual & Reproductive Health* 2020;**46:**116-125.
[109] Government Equalities Office, *National LGBT Survey* (London, UK: Crown, 2018) < National LGBT Survey: Research report - GOV.UK (www.gov.uk)> (accessed 1 November 2022)

use sex workers and also have sexual contact with others. The sexual health of women SSOS is important both for the women themselves and to reduce onward transmission to their own sexual contacts or those of their clients.

A rapid health needs assessment for women SSOS was undertaken in 2020.[110] In relation to sexual health and access to mainstream services it found:

- Significant risk of acquiring STIs and blood borne viruses and passing these on to others. 'Safer sex' is not always practised.
- Complex medical and personal histories, patterns of work and sleep and stigma, lead to mainstream services not meeting their needs.
- The women recognise the risks they face and would like to engage with support but struggle to do so.
- A perceived lack of specialist knowledge and training in this area.
- The importance of trust building as a principle aim for services.
- Increased vulnerability due to the Covid-19 pandemic through diminished access to services and contraception and increased risk-taking due to fewer income opportunities.

Since completion of the rapid health needs assessment, an evening (6-11pm) outreach service Kaleidoscope has been piloted and following its success extended. Its aim is to 'reduce the impact of risks, experienced by women SSOS' and one of its outcomes is to support clients to engage with other specialist services to reduce incidences of STIs. The service uses 'Blue Light' principles of helping reduce risk and managing harm, together with Trauma Informed Approaches to engage with women SSOS. The need for further work regarding men who sell sex and women who sell sex off street was also highlighted.

The weekly TULIP clinic is also available as a walk-in service for sex workers and escorts.

12.4 Homelessness

People who are homeless have higher rates of STIs and unplanned pregnancies.[111] This is for several reasons that impact on sexual health risk and service access including[112]:

1. Barriers to service access: stigma, strict access times, fear
2. Low-self-esteem, history of abuse (domestic abuse, violence, and rape, forced street sex work), neglect of health, high rates of mental health conditions.

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[110] Matthews C, Sophie Robin S, McAllister C. *A rapid joint strategic needs assessment of Women Selling Sex 'On Street'* (2020), Southampton City Council and Southampton City Clinical Commissioning Group.

[111] Department for Health and Social Care. *A Framework for Sexual Health Improvement in England* (London, UK: Crown, 2013) <A Framework for Sexual Health Improvement in England - GOV.UK (www.gov.uk)> (accessed 31 October 2022)

[112] McGregor F *et al* (2018) 'Nurse-led sexual health clinics in hostels for homeless people' *Nursing Times* 114,5 (2018); 42-46.

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3. Drug use and its impact on a chaotic lifestyle.
4. Pressure to exchange sex for food, shelter, money, and drugs
5. Lack of knowledge of STIs and contraception
6. Lower literacy levels.

12.1 per 1000 households in Southampton are owed a prevention or relief duty under the Homelessness Reduction Act, which means they are homeless or at risk of homelessness.[113]

The multidisciplinary Homeless HealthCare Team (HHCT) is a specific service for people who are homeless, including those in temporary accommodation and asylum seekers and migrants without support. As of April 2022, the service had 456 registered patients, but the team also provide services to temporary residents. The HHCT provide certain services in relation to sexual health including blood borne virus screening discussion and prescribing of contraceptive options (excluding the fitting and implanting of intrauterine devices and implants) and EHC, initial SH promotion, STI advice and referral to SHS, advice and referral in cases of unplanned or unwanted pregnancy. The new patient check includes blood borne virus screening and vaccination for Hep B if appropriate. The HHCT is based in a Day Centre for homeless people where the Two Saints charity also provides food, clothing, washing facilities, accommodation, and benefits support.

12.5 Ethnic Minority Groups

People of black ethnicity in the UK account for a disproportionate number of STI diagnoses, including HIV. However, the population rates vary considerably among Black ethnic groups. People of Black Caribbean and Black non-Caribbean/non-African ethnicity have the highest diagnosis rates of many STIs, whilst Black Africans have relatively lower rates.[114] Black ethnicities (particularly Black African) have a high proportion of late HIV diagnoses compared to other ethnicities.[115] There is also evidence of poorer HIV outcomes for some minority ethnic groups.[116] Where local data is available, it has been included throughout this Health Needs Assessment, but also summarised here:

[113] Office for Health Improvement and Disparities, *Public health profiles (2022)*
[114] Public Health England, *Sexually transmitted infections: Promoting the sexual health and wellbeing of people from a Black Caribbean background* (London, UK: Crown, 2021) <STIs: promoting the sexual health and wellbeing of people from a Black Caribbean background (publishing.service.gov.uk)> (accessed 1 November 2022)
[115] UK Health Security Agency, *HIV testing, new HIV diagnoses, outcomes and quality of care for people accessing HIV services: 2021 report*

[116] Dhairyawan, R., Okhai, H., Hill, T., Sabin, C. 'A.b,c; for the UK Collaborative HIV Cohort (UK CHIC) Study Differences in HIV clinical outcomes amongst heterosexuals in the United Kingdom by ethnicity', *AIDS* 35,11 (2021):1813-1821

- In 2019, people of Black ethnicity were 4.2 times and Mixed ethnicity 2.8 times more likely to be newly diagnosed with an STI than people of White ethnicity.
- The proportion of ToPs for people of Black, Asian, and mixed ethnicities increased between 2019/20 and 2021/22.
- In a pilot of a late diagnosis review protocol across the Southeast of England, Black African heritage was associated with late diagnosis.
- The proportion of contacts with the service by people from ethnicities other than 'white British' has increased (both online and face to face), but this could be due to improved recording.
- 91% of Black and Afro-Caribbean residents take an HIV test when attending the sexual health service; this is higher than for all residents (86%).

12.6 Children who are Looked After (CLA)

There are around 497 children in care in Southampton and the rate of children who are looked after aged 10-15, is significantly higher than England overall (137 per 10,000 vs. 62).[117,118] CLA are vulnerable to early and unprotected sexual experiences. A quarter of care leavers are pregnant or young parents within a year. They are disproportionally affected by risk factors for teenage pregnancy such as experience of abuse, poor mental health, low educational attainment, school absence, contact with the police and poverty. Additional negative experiences such as bereavement and experience of sexual violence affect unaccompanied asylum-seeking children. Children who are looked after need additional support to develop safe and respectful relationships, and to use contraception effectively. Statutory guidance states that if they should become pregnant, children who are looked after should receive information and support to make choices around pregnancy and dedicated antenatal and postnatal support.[119] Children in Care Health Team (Solent NHS Trust) carry out a full health assessment on all children entering the care system which includes identifying any unmet sexual health needs.[120] The initial referral is made by Children's Services on entry to the care system, but once in care, referrals can be made by the young person, their carers, or other professionals.

[117] Office for Health Improvement and Disparities, *Public health profiles (2022), fingertips.phe.org*
[118] Ibid
[119] Department for Health and Department for Children, Schools and Families, *Statutory Guidance on Promoting the Health and Well-being of Looked After Children* (London, UK: Crown, 2022) <Promoting the health and wellbeing of looked-after children - GOV.UK (www.gov.uk)> (accessed 1 November 2022)
[120] Solent NHS Trust, *Children in Care Health Team*, Solent NHS Trust <Children in Care Health Team | Solent> (accessed 21 September 2022)

The R.O.S.E clinic provides a sexual health service for individuals who are at risk of sexual exploitation, regardless of age at the Royal South Hants Hospital. Access is via professional referral (appendix 1).

12.7 People with Learning Disabilities

People with learning disabilities (PLD) are a vulnerable group in relation to sexual health for several reasons, including increased risk of sexual exploitation and a lack of systematic provision of relationship and sex (RSE) education.[121,122] Specialist sexual health clinics called SHIELD (Sexual Health Information Education Learning Disability) have been set up in Hampshire, Portsmouth and Southampton providing reasonable adjustments (appendix 1).

A LD Sexual Health Needs Assessment was carried out in 2016-2017 by Solent NHS trust. This focused primarily on RSE. It identified the need for training for professionals, parents, carers, and volunteers in how to provide RSE and continued provision of the SHIELD clinics with more training for clinical staff on how to support people with LD.

See also the qualitative research in the stakeholder experiences section.

12.8 Physical Disabilities & Complex Needs

People with physical disabilities and complex needs are a heterogeneous group; they will have diverse needs in relation to sexual health and how they access services will vary considerably. This makes having a local understanding of health inequalities challenging. However, we know that barriers to sexual healthcare can include attitudinal barriers (e.g., assumptions regarding sexual activity or ability to care for children), physical challenges to accessing services and health information not being provided in an accessible format.

12.9 People with Mental Health needs

People with mental illness are more likely to have blood borne viruses (and STIs), unintended pregnancies and experience domestic and sexual violence than the general population. There is an additional risk where there is also substance use. Increased risk of

[121] Franklin, A., Raws, P. and Smeaton, E. *Unprotected, overprotected: Meeting the needs of young people with learning disabilities who experience, or are at risk of, sexual exploitation* (Barkingside, UK: Barnardo's, 2015) <Unprotected Overprotected: meeting the needs of young people with learning disabilities who experience or are at risk of sexual exploitation | Barnardo's (barnardos.org.uk)> (accessed 1 November 2022)

[122] Garbutt, R., Boycott-Garnett, R., Tattersall, J. and Dunn, J. *Final Report: Talking about sex and relationships: The views of young people with learning disabilities* (Leeds, UK: CHANGE, 2010).

mental illness is also associated with extensive experience of physical and sexual violence.[123] People with severe mental illness can experience poor sexual health for several reasons, including due to stigma, symptoms that affect their sexual behaviour (e.g. increasing risk taking, inability to discuss their sexual health needs), side effects of psychotropic medication, previous experiences of sexual abuse and challenges with some social skills (e.g., assertiveness).[124,125]

We do not have any local data on the sexual health needs of people with severe mental illness in Southampton or any specific services that address the sexual health needs of this group. People who are registered with a GP as having a severe mental illness should be offered an annual physical health check; sexual health questions are not currently included within this.

12.10 Substance use

Substance use can impact sexual health in a number of ways. These include:

1. Increased sexual risk taking associated with alcohol use and poor sexual health outcomes such as unplanned pregnancies and STIs.
2. Earlier alcohol use is associated with early onset of sexual activity and is a marker of later sexual risk-taking.
3. Sexual assault is strongly correlated with alcohol use by victim and perpetrator[126].
4. Increased risk of blood borne infections through injection of drugs which can then be passed on through sexual activity.
5. Where drug use takes place associated with sexual activity, the risk of transmission of STIs increases.
6. Chemsex can increase the risk of infection from blood borne viruses and other STIs.[127]

The majority of those impacted by the effects of alcohol and drugs on sexual health will not be in contact with drug and alcohol services.

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[123] NHS England, Department of Health, Public Health England*, Improving the physical health of people with mental health problems: Actions for mental health nurses* (London, UK: Crown, 2016) <JRA_Physical_Health_revised.pdf (publishing.service.gov.uk)> (1 November 2022).
[124] Hughes, L. *Sex and Mental Health: Why we don't talk about it, and why we should*, (London, UK: Royal College of Psychiatrists, 2019) <Sex and Mental Health: Why we don't talk about it, and why we should (rcpsych.ac.uk)> (accessed 1 November 2022)
[125] Ramluggun,P., Tibbatts T., and Luby R. 'Promoting the sexual health of people living with severe mental illness'. *Mental Health Practice* 2020
[126]The Royal College of Physicians, *Alcohol and sex: a cocktail for poor sexual health.* A report of the Alcohol and Sexual Health Working Party (London, UK: Royal College Physicians, 2011)
[127] Public Health England, *Substance misuse services for men who have sex with men involved in chemsex* (London, UK: Crown, 2015) < Main heading (publishing.service.gov.uk)> (accessed 1 November 2022)

Approximately 850-900 adults are in structured treatment with drug and alcohol services (provided by Change Grow Live) in Southampton at any time. The current service specification does not include sexual health promotion, however the initial assessment includes some questions related to risk behaviours. In addition, blood borne viruses are discussed and testing provided, hepatitis B vaccinations offered, condoms available if requested and service users are signposted to sexual health services for STI testing.

No Limits provide a youth drug and alcohol service, with approximately 150 young people engaged, mostly 18-24 years old. The initial assessment for new service users includes asking about previous use of sexual health services and screening and contraception is offered through the weekly sexual health clinic at No Limits or service users are supported to use the online service.

12.11 Students

University undergraduate students are at higher risk than the general population of STIs and unplanned pregnancies. There are around 40,000 students in Southampton, some of whom will be users of sexual health services in the city. They are an important population due to movement between term time and non-term time addresses meaning that the prevalence of STIs in different areas of the UK and internationally, and AMR overseas, are also relevant. We have no specific information on the sexual health needs of the university population.

12.12 New communities

Southampton's 2008 Sexual Health HNA made specific reference to new communities in the city: large numbers of economic migrants from Eastern Europe, but also other new communities such as Kurdish, Iranian, Afghan and Somalian with a large proportion of single young men. We await the 2021 Census data for more information on new communities in the city, however we do know that Southampton has recently become home to more people from Afghanistan and Ukraine. There is currently uncertainty over their specific sexual health needs, sexual and reproductive health services are known to be vitally important to all migrants, refugees and displaced persons. As general principles sexual health services and sexual health promotion will need to be accessible and understanding.

13.Stakeholder experiences

13.1 Overview

Qualitative research into the sexual health needs and experiences of people with learning disabilities (PLD) and people from ethnic minority communities was commissioned for the

purposed of this health needs assessment. The findings contribute to our understanding of the relevance to need and acceptability of services (Maxwell's domains of quality).

13.2 Summary of findings for PLD

Culture and stigma

- Perceptions of PLD, sex and sexual health was a strong theme with reports that some parts of society including some people who work with PLD hold views such as PLD should not or do not have sex, and contraception should start with sterilisation or implants.
- Parents and carers want to protect those they care for and are concerned that if they talk about sex this might encourage sexual activity.
- Amongst PLD there are variable views regarding sex and sexual health depending on abilities, capacity, and level of independence
- Differing sexualities also need to be recognised within the PLD community

Education and training

- Mainstream sex and relationships education is inadequate for PLD with a significant lack of understanding regarding STIs, contraception, condom use, skills, and self-esteem
- RSE taught in educational settings might not reflect PLD levels of cognitive ability, emotional or physical maturity, or utilise language they are familiar with. There is some bespoke RSE or healthy relationship conversations, but these can be limited in content and not universally available
- There is no systematic way of promoting sexual health and positive relationships for PLD across all the services working with PLD.

Sexual health services

- Accessing sexual health services was a significant issue – general lack of awareness, staff attitudes and perceptions, travel barriers, limited information, digital services are challenging for PLD. The Shield clinic is underused and not well known.
- Community PLD nurses were viewed as first 'port of call' for sexual health advice,
- Access to services is reactive rather than proactive.
- Sexual health is included in the NHS LD annual health check template, however it might not be covered due to time required to enable and ensure individuals' understanding and nearly one third of those entitled to their LD annual health check are not receiving them.

Carers and support services

- People closest to PLD played a vital role in supporting an individual with relationships, sex, and sexual health needs. Their attitude and skillset in relation to this is variable but could be addressed through training and signposting.

- There is an appetite for PLD services to play a bigger part in delivering some of this bespoke work for PLD, and for parents and carers.
- The roles of knowledgeable advocates could help to bridge gap between individuals and services, helping PLD to articulate their needs.
- There are differing needs and issues in relation to sexual health and forming relationships.

Vulnerabilities and risks

- Those with mild learning disabilities don't always tell services; this can hinder the professional adapting their approach.
- Some of those who do not have the skills to develop healthy sexual relationship are at risk of offending.
- A significant proportion of PLD have been exploited sexually.
- Risky sexual behaviour occurs with underlying themes of equating sex with being loved, wanting the experience of a relationship, or wanting a child.
- Those supporting PLD focus on seeking contraception from sexual health services, rather than reducing STIs or promoting healthy relationships

13.3 Summary of findings for people from ethnic minority communities

Culture and stigma

- Stigma was a strong theme with sex and sexual health being a taboo in some communities. This influenced feelings and experiences of sex, as well as access to services
- Participants felt that working within communities would facilitate change and break down taboos and barriers.
- Relationship and sex education in schools and other educational settings is seen as having a positive effect for future generations and influencing older generations through conversations.

Diversity

- There are many differences between groups: between men and women, people from different religions, different country of origin, different generations.
- Stigma regarding sexual health is higher in some communities than others.
- Communities are more likely to be aware of and access contraceptive services compared to services for STIs.
- In many communities managing conception is thought to be a female responsibility and for men there is a lack knowledge and understanding of sexual health.
- There is a lack of prevention of STIs, particularly in older generations.

Sexual health services

- A lack of awareness of sexual health services especially online services.

- A significant barrier is the fear of being seen at the sexual health clinic, though the services themselves are perceived to be confidential, efficient and provide a good service
- Participants suggested that sexual health services should be integrated into other services, to reduce the stigma of accessing them.

Barriers to service access

- Men are less likely to access services than women because of stigma.
- Difficulty in booking appointments leads to people giving up; walk in was suggested.
- There are mixed reports in relation to digital services with some feeling they would not use online ordering due to concerns about family finding out when they are delivered.

Contraception

- Black African communities prefer natural methods of preventing pregnancies
- Women are more open to contraception but prefer to avoid hormone related products.

Vulnerable groups

- Illegal immigrants and asylum seekers, sex workers, people who are homeless, those with addictions, mental health service users, young people living within strict families, those not in employment, education, or training, those living in deprived area and people identifying as LGBTQ+, especially those from orthodox religious communities, were all thought to be less likely to access services.

Education and awareness

- 'Teachable moments' were also suggested as times to target sexual health information. These include religious festivals and during pregnancy.
- Participants felt that there should be more use of online sexual health promotion materials as well as hard copies and it should be translated into community languages.
- Further work to raise awareness with young people in education and the club scene was suggested.

Community engagement

- Much more community engagement needed and awareness raising at a range of touchpoints including shops, foodbanks, community groups and religious buildings.
- Participants have suggested a range of methods for increasing community engagement including attendance at community events for a range of NHS services, campaigns using local media and use of community languages.
- Time needed for sexual health services to build up networks, relationships, and trust with communities.
- Sharing the findings of this work would be a helpful way of building bridges with communities.

Click on the image below for the full findings and recommendations.

13.4 Resident survey

As well as the interviews with representatives from the Learning Disabilities and ethnic minority communities, a residents and staff survey (linked through image below and in 13.5) was undertaken which provides insights into the experience of using and delivering services. Responses from residents were subjected to statistical analysis and despite the small sample size there were some significant findings.

Key findings from resident survey (87 respondents):

- The internet and GP/Nurse are most common source of information on Sexual Health Services.
- Less than half were aware of the availability of HIV prevention, Hep B/HPV prevention, vasectomy advice, the partner notification contacting service and counselling for psychosexual problems.
- Significantly more men than women were aware of pre-exposure HIV prevention medication.
- People of white ethnicity were more aware of the availability of HIV testing in comparison to people from ethnic minority backgrounds (73% vs. 55.6%).
- People describing themselves as LGBTQ+ were significantly more aware of HIV prevention services and Hep B and HPV vaccination.
- Both in person (79%) and online services (68%) are preferred to telephone appointments (44%).
- Significantly more white people considered online services to be important in comparison to people from ethnic minority communities.
- Most believed SHS in person, online and GP should provide care, rather than emergency departments, colleges and universities or pharmacies.
- Most important for using the service was location (private, nearby) and accessibility (parking, transport). Followed by access outside of 9-5 hours and walk in services
- Just over a third of respondents reporting that they had previously not used a SHS when they may have benefited; the most common reason was not being able to get an appointment, followed by lack of awareness of services and not being able to get through on the phone.
- The service most used was STI testing.
- Experiences were overall very positive, but most people did not find the length of time for an appointment reasonable and only a third agreed that it was easy to get through on the phone.

13.5 Workforce survey

Key findings from the workforce survey (26 respondents):

- Most of the workforce surveyed found staff during the referral process were helpful and that it was easy to find information on sexual health services in Southampton.
- When making a referral, most did not find it easy to get through on the phone and did not think the length of time to get an appointment was reasonable.
- Most referrals made by respondents are for contraceptives and STI testing.
- Most would like to be kept up to date with services via a website or email.
- 68% feel they have training needs, with a range of needs identified, particularly around services available and STI training. Most would prefer webinars or other online training.

14.Conclusions, Recommendations, Next Steps

14.1 Conclusions

Within this needs assessment, the sexual health needs of Southampton residents have been described using both quantitative data and views expressed qualitatively, highlighting where some people have additional needs, what services already exist to meet them and where there remain gaps in provision. We have presented this in the context of national and local policies and strategic direction. The findings, grouped into three key themes: prevention, equity and relationships and system working, will now be summarised and have informed the development of recommendations for sexual health in the city.

Prevention:

Southampton has seen a steady decline in under 18-year-old conceptions since 2007 and is below the England average for terminations of pregnancy in the same age group. Almost

twice as much long-acting reversible contraception is provided in primary care rather than within specialist services, and this is important for equity of access across the city, provision of care that is most appropriate for the level of complexity and for patient choice: primary care has been found to be the preferred place for women to access contraception.[128]

However, there is evidence that efforts to prevent poor sexual health and improve outcomes for Southampton residents are not currently as effective as they could be. This is demonstrated by:

- High and increasing rates of the most common STIs, including re-infections
- Testing rates that are high overall, but in some instances, have decreased dramatically, for example following an Early Medical Abortion, and not everyone is being tested for the full range of STIs
- High late diagnoses of HIV, with low testing levels and high overall diagnosis rates
- High rates of onward consequences such as PID
- Increasing rates of ToP and repeat ToP
- Low and decreasing rates of LARC access and demand
- A fall in vaccination coverage for HPV during the pandemic

Stakeholders have described access to sexual health services as difficult. This is not confined to the integrated sexual health service; reports of not being able to access EHC via pharmacies are not uncommon. Once people are in contact with the services they are seen quickly and receive results and treatment, overall, in a timely manner.

RSE is delivered across the city to young people. There is a gap in provision for all people who may benefit from it, i.e., SEN schools and people with a Learning Disability regardless of age.

Training to enable the health and care workforce to have sexual health conversations as part of their everyday working routines is not being accessed, and therefore opportunities to support people with their sexual health are being missed.

Equity

There are significant gaps in local knowledge regarding some population groups, their sexual health, and the challenges they face which may impact their wellbeing. We know however that:

[128] Public Health England. *What do women say? Reproductive health is a public health issue* (London, UK: Crown, 2018)

- Young people carry a greater burden of STIs in general, but particularly chlamydia and re-infections, as well as repeat terminations
- MSM experience higher rates of syphilis and gonorrhoea
- There are higher rates of new diagnosis of STIs in people of black and mixed ethnicities, compared with white people
- People who live in the more deprived areas of the city are more likely to experience teenage conception and need a ToP

Use of services by different population groups is widening, including the use of online services, however this differs across communities and within them. Some people find it harder to access services than others; people from ethnic minority communities, people living in deprived areas of the city, people who sell sex, people with a learning disability. With online services becoming more popular, we don't know whether this helps people who don't want to access in this to be seen face to face, or whether it is further excluding them.

People experiencing sexual health inequalities are likely to be facing the same challenges in other aspects of their lives, and some contend with multiple inequalities. Stakeholders have emphasised that stigma, perceptions and taboos all play a part in perpetuating these inequalities with reference to people's sexual practices and improving and maintaining their sexual and reproductive health.

We have gaps in our knowledge regarding the sexual health inequality experienced by some people, in part due to reduced access to data but mostly because we don't understand the 'why' well enough. Nor do we really understand why the interventions we have tried have not fully worked. There is learning that can be taken, for example from the success of reducing teenage pregnancy over the last two decades.

Relationships and system working

Professionals and services across Southampton are not joining up to meet the sexual health needs of residents. There is also variable awareness of what sexual health services are being provided across the city. This means that:

- The resident and the health and care workforce have an incomplete awareness of who is providing what, where, when and how, and how they can signpost to, refer to and access those services.
- When people have needs that require additional support, expertise is not being coordinated to meet those needs, for example bringing people with expertise in learning disabilities together with sexual health practitioners.

Some communities need a different approach to improve and maintain their sexual health, including:

- Addressing stigma and perceptions that may be acting as barriers
- Building trust over time with professionals and services

Consistent and clear messaging, sexual health promotion and education for all those who may benefit from it, across the population, workforce and throughout the life course are not being delivered.

14.2 Recommendations:

Recommendations are presented in line with two of the themes identified throughout the needs assessment; relationships and system working and prevention, with the third theme of equity woven into all recommendations. It is hoped that a further important finding from this needs assessment, the necessity to normalise conversations about sex, sexual identity and sexual health within our communities and services to address stigma and encourage a positive sexual health culture, will be addressed by all the recommendations.

Relationships and system working

In order to strengthen governance and leadership for sexual health in Southampton, it is recommended that:

- The governance of sexual health outcomes in Southampton is agreed at both the place level and across the wider system.
- The needs assessment is presented to Southampton's Health and Wellbeing Board
- A sexual health network is developed in Southampton with representation from commissioners, public health, providers, primary care, pharmacy, professionals working with groups experiencing inequalities, education and the voluntary and community sector. This network will provide informal networking opportunities, as well as governance and action on sexual health in Southampton.
- Opportunities to bring sexual health into conversations at the system level are maximised, for example with regards health inequalities, the focus on people from ethnic minority communities, people with Learning Disabilities, as well as openings for joint working such as vaccination campaigns.

Networking and Engagement

In terms of networking and engagement, it is recommended that:

- The new Southampton Sexual Health Network agrees a vision and objectives for sexual health in Southampton and develop and monitor an action plan to address the recommendations in the HNA.

- The network supports development of primary care level capacity for sexual health, for example with training, and facilitate conversations to meet need across all services.
- The sexual health network monitors the currently unknown longer-term impacts of pandemic disruptions and the newer ways of delivering the service, with a shorter interval before sexual health needs are reassessed (e.g., through a rapid HNA).
- Using lessons learned from the Covid-19 vaccination campaign, sexual health champions and peer mentors will be developed with communities
- Solutions are co-designed and tested with communities to address specific aspects of the sexual health outcomes we and they would like to improve across the city.

Prevention

Primary prevention

Sexual Health Promotion

It is recommended that primary prevention focuses on sexual health promotion including:

- Developing a shared and collaborative annual sexual health promotion (SHP) plan for Southampton that includes RSE provision, training for the health and care workforce, campaigns and support for events such as Pride, World Aids Day (WAD), HIV Testing Week, Sexual Health Week, and Freshers Week at the universities
- An annual SHP plan using regular opportunities for universal communication with residents, as well as tailored communication (both in content and delivery) for the people we know are experiencing sexual health inequalities which is developed with them. In particular, young people (including the student population), men who have sex with men, the LGBTQ+ community, ethnic minority communities, people experiencing deprivation, people with learning disabilities, and potentially our new communities.
- The Sexual Health Network fostering relationships that allow communication between partners when sexual health promotion is required for emerging issues and improvement
- Refining local data to have a better understanding of who is being offered, accepts and continues to use PrEP. Using this knowledge, alongside the NICE guidance to increase awareness of PrEP availability amongst residents and the workforce.
- Supporting the school nursing service by promoting opportunities to have HPV vaccination in Years 9, 10 and 11 if missed in Year 8, as well as raising awareness of the availability of vaccination at GP surgeries for those over school age and up to 25 years.
- Integrating opportunities for wider health promotion within sexual health services, particularly where other activities increase sexual health risk (for example alcohol risk assessments and substance use).
- Harnessing the benefit of sexual health promotion within clinical services and not as a separate offer.

Relationships and Sex Education

To build on the current RSE provision in Southampton, it is recommended that:

- Existing forums for RSE and Personal, Social, Health and Economic Education (PSHE) are used to have a shared understanding of what is being delivered in which schools, what further input is required and where, including for our new communities.
- Additional focused RSE continues to be delivered to schools in areas with higher teenage pregnancy rates, acknowledging the link with deprivation, and explore via existing forums what other support those schools might need.
- Training is developed for anyone who works with and cares for people of any age with learning disabilities, to reduce the stigma associated with sex and sexuality and increase their confidence to talk about sexual health, better meeting their needs and reducing risk.

Secondary prevention

Access to services

For services to be accessible to residents and equitable, it is recommended that:

- Through the SHP plan, it is ensured that residents and the health and care workforce, as well as education and voluntary organisations, are aware what sexual health services are available in the city, where to go for that information and how to signpost and/or refer.
- Health and care touch points that provide opportunities to discuss sexual health and signpost to services are mapped, available levers are used to maximise these, working together to make sexual health a priority in those moments. This will include but not be limited to annual checks for people with learning disabilities, severe mental illness, children who are looked after, people accessing drug and alcohol services.
- When there are opportunities to review the venues services are delivered from, that they fit with what we know about how people move about the city, particularly people experiencing inequality, and where they would be comfortable accessing a sexual health service.
- The sexual health network monitors and assures sexual health services are responsive, including that:
    - Specialist sexual health service to continue with work already started to improve the patient experience at the front door
    - There is work with the other Local Authorities in HIOW, the ICB and Community Pharmacy South Central to identify solutions that promote consistency within the EHC service.

- The diversity of the sexual health workforce and patient forums is reviewed as this will have an impact on accessibility for different communities, with a commitment to improving representativeness for our communities.
- Online resources and services are scaled and adapted with consideration of equity – discuss with communities what they are comfortable accessing online and explore other options for remote contraception and STI testing.
- The equity audit of the clinical outreach service is used to assess whether it is reaching all groups highlighted as experiencing inequalities, and whether there is scope to broaden this type of delivery to other groups of people who find it difficult to access clinic settings.
- Women's awareness of and access to the full range of contraceptive choices is increased and women are supported to make the right choice for them. For example, by dispelling any myths that may be preventing them from choosing the most effective method.
- The Sexual Health Network oversees the restoration of opportunities for women to consider a LARC within the new EMA at home pathway.
- The offer of LARC in maternity services pilot is evaluated.

Testing

In order to optimise STI testing in Southampton it is recommended:

- To undertake an audit to investigate why full STI testing is not being taken up as readily, understand any patterns in who is and is not having a full screen, and explore ways to promote it, including to those more at risk from HIV and syphilis.
- To map the current opportunities for HIV testing in the city, their promotion and delivery.
- To ensure the approach to HIV testing is in line with NICE guidelines including HIV testing in GP practices and hospitals and explore the potential for point of care testing in the city.
- To support health professionals to recognise when to test for HIV, for example when it is clinically indicated or someone is registering for the first time, through existing and bespoke training.
- For the Sexual Health Network to oversee the restoration of opportunities for women to access STI testing within the new EMA at home pathway.

14.3 Next steps

The recommendations from this HNA will inform the development of a sexual health strategic vision, objectives and action plan for Southampton. These will replace the current sexual health improvement plan. The findings and recommendations will also inform a service review for the re-procurement of the level 3 specialist sexual health service, with the

current contract ending in March 2024. The evidence from this HNA will be used to generate local conversations at place and strategic discussions at system level. Through similar work being undertaken in our neighbouring Local Authorities, shared challenges and opportunities for coordinated and joint action can be identified.

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Appendix 1: Level 3 sexual health clinics

Name of clinic	Location	Eligibility	Opening hours	Drop in or booked appointment	Service details
Royal South Hants Hospital	SO14 0YG	All	Monday and Thursday 8:30am – 7pm Tuesday and Wednesday 8:30am -5pm Friday 8:30 – 3pm	Booked (same day available) Under 18 drop in 3-6pm Mondays Self-referral	Contraception, HIV and GUM Psychosexual counselling available via referral from GP
Bitterne Health Centre	SO18 6BT	All	Wednesday 1:30 – 6pm	Booked Self-referral	
TULIP clinic	SO14 0YG	Anyone involved in commercial sex work.	Wednesdays: 12:30pm to 2:00pm and 5:00pm to 6:30pm	Walk-in	Contraception, HIV and GUM services
Clinic Xtra – Royal South Hants Hospital	SO14 0YG	Tailored services for men who have sex with men, regardless of HIV status	Thursday 5-7pm	Booked Self-referral	rapid HIV testing post exposure prophylaxis for HIV (PEPSE) advice and support for pre exposure prophylaxis for HIV (PrEP) hepatitis testing and vaccination

					STI testing and treating referrals for 1:1 support referrals for support around chemsex and substance misuse condoms and lube sexual health advice
The R.O.S.E clinic	SO14 0YG	Individuals who are at risk of sexual exploitation, all ages		Referral only	
No limits Southampton	SO14 2DF	Aged 13 to 25 and living in Southampton	Thursday 1:30 – 4:30pm	Booked Self-referral	Sexual health advice Contraception, including injections, implants and condoms STI screening and treatments Pregnancy testing Drop-ins in schools and colleges (condoms, STI testing and pregnancy testing) “let’s talk” RSE in schools and colleges across Hampshire with Solent NHS trust.
Taunton College Young People Service	SO15 5RL	Students only	Term-time Mondays 1-3pm		
Sexual Health Information Education Learning Disability (SHIELD) clinic – Royal South Hants Hospital	SO14 0YG	People with LD		Booked Self-referral or referred by professional	Contraception, HIV and GUM services. Reasonable adjustments: Designated appointment time Minimised waiting room time Named nurses with a special interest in LD A named sexual health practitioner. Easy read information.

Online services by Solent NHS Trust	www.letstalkaboutit.nhs.uk				Appointment booking STI self-sampling test (over 18s only) chlamydia self-sampling test (16 to 24 years only) Condoms by post Signposting to other providers (e.g. the National HIV self-sampling initiative) Information on sexual health and contraception.
National HIV self-sampling service	Freetesting HIV | Free HIV Kits for Self-testing at Home	All	NA	NA	Self-sampling for HIV at home

DECISION-MAKER:	HEALTH AND WELLBEING BOARD
SUBJECT:	TOBACCO, ALCOHOL AND DRUGS STRATEGY 2023-2028
DATE OF DECISION:	14TH DECEMBER 2022
REPORT OF:	COUNCILLOR LORNA FIELKER CABINET MEMBER FOR HEALTH, ADULTS AND LEISURE

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STATEMENT OF CONFIDENTIALITY		
None		
BRIEF SUMMARY		
This briefing paper outlines the final documents for the new 5-year Tobacco, Alcohol and Drugs Strategy. Subject to Health and Wellbeing Board and Cabinet approval, this new Tobacco, Alcohol and Drugs Strategy will be formally adopted by Southampton City Council and in force from 1st January 2023.		
RECOMMENDATIONS:		
	(i)	That the Health and Wellbeing Board approve the new Tobacco, Alcohol and Drugs Strategy for the city (as attached at appendix 1)
	(ii)	That the Board recommend that Cabinet approve the Strategy for adoption at their 20th December 2022 Cabinet meeting
REASONS FOR REPORT RECOMMENDATIONS		
1.	Given the significant nature of the strategy, which affects the whole city and all residents, and that the Health and Wellbeing Board will be monitoring the strategy delivery, both Board and Cabinet approval of the strategy is essential for the strategy to be adopted.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	Not having a city-wide strategy to tackle tobacco, alcohol and drugs in Southampton risks the safety and wellbeing of those affected in the city, as well as the wider impacts of these issues on the city and its workers and residents. Not having a strategy would also mean we would not meet our statutory requirement to have strategies in place for both drugs and alcohol, or meet our commitment as signatories to the Local Government Declaration on Tobacco Control to have a tobacco control strategy.	

3.	When considering the timespan for this new combined strategy, given that tobacco, alcohol and drugs are complex challenges, a 5-year strategy has been chosen so that we have time to build on what we are already doing well, carry out further research, establish new ways of working and make a difference. This is longer than the previous drug and alcohol strategies, which were both 3-year strategies, and will bring the strategy refresh frequency in line with those such as the Health & Wellbeing Strategy and the Southampton City Strategy. The new Tobacco, Alcohol & Drug Strategy is therefore a 5-year strategy (2023 – 2028), with outcomes reviewed at least annually.
DETAIL (Including consultation carried out)	
4.	The combined Tobacco, Alcohol and Drugs Strategy articulates how we, as a Council, will reduce the harm to people who use tobacco, alcohol and drugs, as well as harms to people around them, and harms across the City of Southampton as a whole.
5.	This strategy describes how we will achieve this by working across the council to deliver 5 strategic programmes of work, one for each council directorate, which are evidence-based or innovative. This whole-council approach is necessary to ensure we have as much impact as possible and will ensure we can work efficiently. Approximate current tobacco, alcohol and drug estimates for Southampton, as well as considered impacts of this strategy, are detailed in the strategy itself (Appendix 1) as well as the accompanying Equality and Safety Impact Assessment (ESIA) (Appendix 2).
6.	Where there are any directorate portfolio changes or restructures within Southampton City Council (SCC) during the lifetime of the strategy, work programmes will be moved to the appropriate new directorates to ensure continuing ownership and responsibility.
7.	The new strategy will be monitored by the Health and Wellbeing Board, with coordination under the council's Adults' directorate. However, there will also be clear links to other relevant directorates, as well as to other council strategies and partnerships including the Safe City Partnership.
8.	This draft Tobacco, Alcohol and Drugs Strategy summarises its vision with 5 Hs: Help, Harm reduction, Hope, Health promotion, and Health equality.
9.	This strategy has been developed by the Public Health and Policy teams of Southampton City Council. We have engaged colleagues across the council and with stakeholders across the city. This included a full 12-week public consultation which ran from 13th June to 4th September 2022. This was publicised internally to colleagues, externally through partners in the city, as well publicly through the following channels: • Website (both the consultation page and a news post) • Social media • E-bulletins (City News, Communities bulletin and Your City, Your Say) • Press release • Digital posters.
10.	There were a total of 263 responses to the public consultation. 259 of the responses were made via the consultation questionnaire, whilst the other 4 responses were received via email. A full breakdown of the results can be found in Appendix 3.

11.	The strategy has been refined in response to the feedback received from the public consultation, as well as through engagement forums (including a session with over 60 Adult Social Care workers) and through feedback received from the Overview and Scrutiny Management Committee on 13th October 2022.
12.	The strategy now has additional information about current work on mental ill health and on other underlying factors relating to reducing the harms of tobacco, alcohol and drugs, as well as further clarification on how the strategy will be operationalised. There is also additional mention and clarification of the scope of the strategy relating to prescription drugs and vaping. More information on the changes made in response to feedback can be found in Appendix 4. Once adopted, the strategy will undergo a final design process, and the fully designed version will be available in early 2023.
RESOURCE IMPLICATIONS	
Capital/Revenue	
13.	Public Health grant money and other grant money will be used to deliver some projects in line with the strategy, subject to grant spending requirements and restrictions. The Council is in receipt of a Supplemental Grant to support the implementation of the National Drugs Strategy, of £655k for 2022/23. The grant must be spent on increasing drug treatment capacity and quality. It is a condition of the grant that we also maintain 2020/21 levels of funding from the public health grant on drug and alcohol services and set up a new Reducing Drug-Harm Partnership to oversee local drug treatment outcomes, as well as delivery of the rest of the national drugs strategy. The grant is due to continue in 2023/24 and 2024/25, although it is subject to agreement by the treasury and only indicative at this stage. There is no direct risk to the General Fund from this strategy.
Property/Other	
14.	There are no additional resource requirements arising from approving the strategy. The commitments are framed so that they are either within existing resources or highlight that a business case will be explored. Any cost pressures will be considered for feasibility within normal yearly budgeting activity or as other funding opportunities arise. The strategy will have more impact with more funding.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
15.	It is a statutory requirement under the Crime and Disorder Act 1998 (as amended by the Police and Justice Act 2006) for Local Authorities to have 'a strategy for combatting the misuse of drugs, alcohol and other substances in the area'. SCC previously had both a Drug Strategy and an Alcohol Strategy in place which have now expired (there is currently no statutory requirement for local authorities to have a strategy covering tobacco, although the Council signed up to the Local Government Declaration on Tobacco Control in 2014).
Other Legal Implications:	
16.	The consultation and design of the proposed strategy has been undertaken having regard to the requirement of the Equality Act 2010, in particular s.149 of the Public Sector Equality Duty ("PSED"). All actions delivered under the

	strategy and associated Action Plans will be implemented having regard to this duty. Further detail is provided in the ESIA attached at appendix 2.
RISK MANAGEMENT IMPLICATIONS	
17.	It is a statutory requirement to have a substance use strategy. As a Council, we have commitment to have a tobacco control strategy, under the Local Government Declaration on Tobacco Control. This new strategy therefore mitigates the risks of not having strategies in place.
POLICY FRAMEWORK IMPLICATIONS	
18.	This strategy will support relevant Policy Framework items (embedded in the council's Constitution: Part 2, Article 4.01) including the Crime and Disorder Reduction Strategy (the council's 'Safe City' Strategy 2022-2027) and the Health and Wellbeing Strategy (2020-2025).

KEY DECISION?	**Yes**
WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Draft Tobacco, Alcohol and Drugs (TAD) Strategy 2023-2028
2.	TAD Strategy ESIA
3.	Consultation on a draft Tobacco, Alcohol & Drugs Strategy 2023 - 2028 - full report
4.	Table of post-consultation strategy amendments

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**
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	

FINAL DRAFT

Southampton City Council

Tobacco, Alcohol and Drugs Strategy, 2023-2028

Providing help, hope and harm reduction; promoting health and health equality

All information is correct at the time of writing this strategy. Please check the Council website for the latest information.

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Foreword from Dr Debbie Chase

Director of Public Health

"The harm associated with smoking, alcohol and drugs to individuals and the knock-on impact to families and communities is well known. Within our City, approximately 34,000 adults smoke, 1,200 children are living with an adult who is dependent on alcohol and 600 children are living with an adult who is dependent on opiates or crack.

There is a strong foundation of work within the City, with a focus on making a difference at the earliest stage. We have much to celebrate. We also want to be bold with our vision and strive to achieve even more together so that Southampton really can become a city where everyone has the best opportunities possible for health and wellbeing.

If there is anything positive we can take from living through the Covid pandemic, it is that we have shown what we can achieve when we work together and the importance of health to our families, communities, workplaces and more. Now is our opportunity to apply all of this to our tobacco, alcohol and drugs work to take it to the next level. I look forward to the next 5 years."

Foreword from Cllr Lorna Fielker

Cabinet Member for Health, Adults and Leisure

"Good health and wellbeing transforms our lives. Sadly, many people still have preventable illnesses and die before time. Harm from tobacco, alcohol and drug use is common. Most people start smoking, drinking or using drugs before they are an adult.

It is challenging but not impossible to change this. This strategy sets out a new way of working by being pioneers and joining these areas of work together. We have also adopted a new health in all policies approach, so that working together across the council we can make sure we have the biggest impact possible.

We have considerable experience to build on and will continue to use the evidence of what works. We will offer help and hope; promote health and reducing health inequalities in all that we do."

Thank you to everyone who has contributed to the development of this strategy, *particularly everyone who shared their own challenges with smoking, alcohol and/or drugs with us.*

Free, confidential help for anyone worried about smoking, alcohol or drug use is available from *Better health (southampton.gov.uk)* ***or by speaking to a health professional.***

Our Strategic Approach

This strategy describes our vision for how we, as a Council, will reduce the harm to people who use tobacco, alcohol and drugs, as well as harm to people around them, and harm across the City of Southampton as a whole. It covers everyone who lives, works in, or visits the city; it covers every person, every community and every place in the city – even the Council itself.

This strategy then describes how we will achieve this by working across the council to deliver 5 strategic programmes of work, one for each council directorate (department). This whole-council approach is necessary to ensure we have as much impact as possible and work efficiently. We also outline how we will monitor the impact of the strategy.

Working together

It makes sense to bring our work on tobacco, alcohol and drugs together. All are important. They are often used at the same time or by the same people. Similar approaches and agencies are involved with working on them too, like drug and alcohol services, health services including mental health services, schools, the police and the wider criminal justice system.

Tobacco, alcohol and drugs are complex challenges. This strategy covers 5-years so that we have time to build on what we are already doing well, establish new ways of working and make a difference. We will not "solve" tobacco, alcohol and drug use in 5 years, but we will be able to make real progress. We are confident that this strategy will stay relevant and that it addresses the core areas of work.

This strategy is a Council strategy. This strategy describes what we will do and re-states our commitment to ongoing partnership and collaboration with stakeholders. We will make the most progress by working together as a whole system. We look forward to continuing to work with organisations and communities across the city.

This strategy is non-judgemental and compassionate, because:

- Use of tobacco, alcohol and/or drugs often starts in childhood or as young adults, before we can fully understand or judge the immediate and long-term risks, and when we may be more influenced by the significant people in our lives and marketing. For example, one of the main risk factors for young people smoking is that they live with an adult who smokes.
- Tobacco, alcohol and drugs can seem like they make us feel better which can be very compelling, particularly when we're stressed, tired, shy or lonely. But biologically, they can make us feel worse through cravings, low mood and/or anxiety. Withdrawal symptoms, including the way they affect our brain, can make it difficult to reduce or stop using them.
- For many people with tobacco, alcohol and drug dependence and higher-risk use, their use is not simply a choice. It is a symptom of other problems, such as mental ill health, abuse, grief, loss and other trauma. These same difficulties can also make it

very difficult to limit, reduce or stop using, without help, and sometimes even with help.

- Many people who smoke or who have alcohol or drug-related issues are ashamed of their use or the associated problems. It can take courage to seek help and any judgement would further put people off. Even if we don't directly work with people with tobacco, alcohol and drug issues, we will be living and working among people with those issues or may have them ourselves. Compassion and self-compassion are effective in improving engagement in services and outcomes.

Nevertheless, this strategy is hopeful. Smoking prevalence, in Southampton, has reduced from 21% in 2012 to 16.8% in 2019,[1] and nationally 70% of smokers want to quit. More than 1,100 people a year already use our alcohol and drug services, with between 350 and 450 successfully completing treatment and many more accessing help and advice to get control and reduce harm. 57% of people who used our Alcohol Brief Intervention Telephone Support Line achieved their goal of abstinence or more controlled drinking in 2021/22.

This strategy unites colleagues across the council and shows them what they can do. It will also show residents, visitors and other stakeholders in the city what we're striving to achieve and the role they can play to help each other to be happy, hopeful and healthy.

Developing and writing this strategy

This strategy describes our direction and the breadth of the work we will do as a Council. It is short, so that it is easy to read. It focuses on the key headlines of what we are aiming for and the main areas of work we will do to achieve it.

This strategy is innovative for bringing together tobacco, alcohol and drugs and taking a whole-council approach. This will help us take every opportunity to reduce harm and improve health, wellbeing and the city as a whole.

This strategy has been developed by the Public Health and Policy teams of Southampton City Council. We have engaged colleagues across the council and stakeholders across the city. Many contributors to this strategy have shared their personal experience of tobacco, alcohol and drugs too.

Our strategy is based on the evidence of what works, from research or local experience. It is all legal. We believe this strategy will help us build on all the hard work to date across the council to make an even bigger difference. Southampton City Council has committed to having a tobacco strategy, under the Local Government Declaration on Tobacco Control. Local councils also have a legal duty to have an alcohol and drugs strategy.

This strategy does not reflect everything that is happening in the city related to tobacco, alcohol and drug-related harm. The Safe City Partnership, for example, leads on community safety including reducing violent crime related to Tobacco, Alcohol and Drugs. The new Reducing Drug Harm Partnership, set up to oversee the implementation of the 2021 National Drug Strategy, brings together key leaders including Police, Probation, Public Health, Primary

[1] 2020 data was collected in a different way and so is not recommended for comparison with previous years.

Care, University Hospital Southampton, Mental Health Services and Southampton City Council. The Children and Young People's Strategy and the Southampton City Council Corporate Plan 2022-2030 both focus on ensuring all children have the best start in life. Safeguarding Boards review and protect the needs of children, young people and adults from serious neglect or abuse. The new Domestic Abuse and Violence Against Women and Girls Strategy highlights how alcohol and drugs affect domestic abuse. Schools teach children and young people knowledge and skills to help them resist any pressure to experiment with substances. This work -and much more- complements the work of the Health and Wellbeing Board and this strategy.

The pace and scale of the implementation of this strategy will depend on resources available. For example, Southampton has been awarded additional funding to improve the capacity and quality of drug treatment services as part of the new national Drug Strategy, published December 2021. The funding is for 3 years, from 2022/23 to 2024/25, subject to annual approval by HM Treasury.

Setting the Scene

We have a strong foundation and consensus to build on, including previous alcohol and drugs strategies, a drug-related litter scrutiny inquiry and cabinet action plan, and the Director of Public Health annual report of 2018 which focussed on drug-related harm. The Safe City Strategy and Violence Reduction Unit have a focus on reducing alcohol and drug-related harm too.

We already support, commission and fund an extensive range of free and confidential prevention, support and treatment services across the city and run seasonal public campaigns. As well as mainstream provision, examples of local innovation to date include:

- Maternity services help pregnant women to stop smoking as part of routine care, and this has now been extended to the Family Nurse Partnership who provide extra support for pregnant women aged 24 years and under
- Primary Care Networks (of GP practices) develop and deliver specialist stop smoking support in local communities
- A telephone helpline providing support for people concerned about their drinking
- A specialist team that reaches, supports and treats people who use alcohol and/or drugs and are homeless, live in hostels or have similar complex needs.
- University Hospital Southampton NHS Trust has a dedicated Alcohol Care Team. Additionally, medicines management technicians discuss alcohol consumption with all patients when they are admitted to hospital, to ensure they receive safe care and further help if required.
- Testing for Hepatitis C in pharmacies, as part of Southampton University-led research to eliminate Hepatitis C in the city by 2025. People who inject drugs are at greater risk of getting hepatitis C, a virus that can be fatal.
- An outreach service to identify and support women selling sex on street, to help to keep them safer including drug and alcohol support.

This work will be continued under this strategy, as resources allow and assuming ongoing review continues to show it is effective.

Nevertheless, there is still high unmet need in the city and too many children, young people and adults are harmed by tobacco, alcohol and drugs. This harm includes illness, violence, abuse and exploitation, trauma and more.

Approximate estimates for Southampton:

- Approximately 34,000 local people smoke. Nationally, 1/2 of people who smoke die from smoking-related illnesses, on average 10 years earlier than non-smokers but increasing to 15-20 years for people with severe mental illness
- 299 pregnant women a year have not been able to stop smoking by the time of delivery, despite usually wanting to
- Pregnant women living in the most deprived areas of Southampton are 4 times more likely to smoke than pregnant women living in the most affluent areas

- Approximately 41,807 local people (20.6% of residents over 18) drink at increasing risk levels, consuming over 14 units of alcohol a week, a level considered as high risk. Conversely, 14.9% of adults in Southampton never drink alcohol. Alcohol is a leading cause of liver disease, cancer, obesity and mental ill health
- One of the highest rates of alcohol-related hospital admissions in the country
- An estimated 5355 people who live in Southampton are alcohol dependent
- 1,200 children live with an alcohol-dependent adult
- 1,200 local people use illicit opiates (heroin) or crack cocaine
- 2,268 alcohol-related crimes a year, 71% violent.
- 1,242 drug-related crimes a year
- 600 children live with an adult dependent on illicit opiates
- 66,000 adults are affected by the drug or alcohol use of someone they know
- For children and young people under 18, alcohol use is 5 times higher for those living in the most deprived areas of Southampton compared to the most affluent areas of Southampton. Drug use is 8 times higher.

More data and information, including the annual Safe City Assessment on crime and safety are available from Southampton Data Observatory

Tobacco, alcohol and drugs can affect nearly every aspect of council work – from litter to community safety, from licensing to our parks. Tobacco, alcohol and drugs are common, preventable reasons why people need health and social care services. These are all potentially preventable financial costs for the council and wider system, or at least opportunities to use the same funding for better outcomes.

The negative effects of tobacco, alcohol and drugs affect everyone, but the people most affected by the harm tend to be people living in poverty or who are otherwise marginalised. Nationally, half of the difference in life expectancy between wealthier and poorer communities is attributable to smoking.

Tobacco, Alcohol and Drugs – A Vision for 2028

The **five Hs** of our vision frame what we want to achieve in Southampton by 2028, ensuring that **Southampton is a city of:**

Help for people concerned for themselves or others, with information and services that are easy to access, timely, safe and effective. All health and care and wider services will discuss tobacco, alcohol and drugs as part of routine care and provide help and support. Services will have a "no wrong door" approach and help people to get the support they need. Services will work well together. They will provide support and treatments based on evidence and innovation.

Harm reduction. Help will be available to people whether they want to be safer while using tobacco, alcohol and drugs; reduce their use; stop using or stay free from use. Harm reduction includes making sure that people who inject drugs have sterile, safe equipment.

Hope, with visible communities of people celebrating their progress through treatment and recovery and living healthier, happier lives. This will reduce stigma and isolation and inspire others. It is also part of changing our broader culture to be more sensitive to tobacco, alcohol and drug-related harm.

Health promotion and prevention. Prevention is better than cure. We will help our residents understand the risks of tobacco, alcohol and drugs. We aim to give every child the best start in life, including supporting families with tobacco, alcohol and drug use in the family and protecting people from harm caused by others. We will take every opportunity to make sure the places where we live, learn, work and relax keep us safe and well. This means promoting ways of life that are free from smoking, higher-risk levels of alcohol, or drugs.

Health equality. Everyone needs the opportunity to be free from the harms of tobacco, drugs and alcohol. We will focus most on supporting people who are more likely to use tobacco, alcohol or drugs or who face barriers to reducing harm to themselves or others. Our services will be sensitive to and celebrate the rich diversity of our communities and meet any additional needs that people have, such as sensory or mobility needs. Our work will be informed by people with lived experience of tobacco, alcohol and drug-related harm.

This is based on the evidence of what works to reduce harm and reflects local consensus. Behavioural science shows us that people need to have the capability, opportunity and motivation to change, and that services and interventions need to be easy, attractive, socially acceptable and timely. Working as a whole system and collaborating with local people is key.

We want to be at the leading edge of local authority work on tobacco, alcohol and drugs. Our work will continue to be based on evidence and, where there is a gap in the research evidence, we will innovate and evaluate our work. We will use national guidance, statistics, people's experiences and research to inform our work. As a minimum, we will compare

ourselves to Local Authorities with similar city populations, such as Bristol, Plymouth and Portsmouth[2].

[2] More information is in the Indicator section.

Our strategy to achieve this vision

We will make the biggest difference in reducing the harm from tobacco, alcohol and drugs, if we continue to recognise them as complex issues, making sure our work has breadth and depth and is embedded in all we do. This means our work will be across:

- All ages, sensitive to different life stages
- All places, settings and communities
- The whole Council, with leadership by each directorate
- All types of tobacco, alcohol and illicit drugs, including shisha, cannabis, illicit use of prescription drugs and more
- Topics, as they link to tobacco, alcohol and drugs, including education, community safety, social care, housing and much more
- Services and pathways, organisations and professions.

This strategy uses 'proportionate universalism'. This means that everyone benefits, according to their need. There is a strong focus on people with the greatest needs who require the most support, as well as a secondary focus on the large numbers of people with less intensive needs so that we reduce health inequalities and improve health at scale.

Groups experiencing the greatest harm from tobacco, alcohol and drugs include people living in poverty, people in marginalised groups, people with severe mental illness and people who are homeless or living in other difficult situations. People in these circumstances are also more likely to be coping with past or current trauma and face barriers to changing their substance use or less personal support to do so.

Tobacco and drug use by people who might think they are not harming others, still harms people with less power or resources and drives crime. The World Health Organisation highlights the global impacts of tobacco. There are 1.2m deaths across the world from second-hand smoke a year. Children are sold tobacco and used to produce it, and tobacco farming and production brings its own health risks. Illicit tobacco can involve serious organised crime and tobacco companies. Counterfeit tobacco is unsafe for the people producing and using it. Tobacco that is sold without paying tax reduces money available for public services. Drug-related harm affecting others includes people-trafficking, “county lines” where drug dealers coerce children, young people and vulnerable adults to transport drugs around the country, “cuckooing” where drug dealers deal drugs from the homes of vulnerable adults and exploit them, and violence, trauma, danger and dependence throughout the production and trade of drugs.

The diversity of our population and workforce is key. Our work will be person-centred and promote dignity. Everyone has their own relationship with tobacco, alcohol and drugs, their own values and circumstances, so a personalised approach is vital.

Strategic programmes: 5 for 5.

We will deliver our Vision through 5 strategic programmes, each running for the 5 years of this strategy. There is one strategic programme for each relevant council directorate and

another corporate programme for internal, cross-cutting work, such as human resources. The programmes are:

1. Wellbeing (Children and Learning)
2. Wellbeing (Health and Adult Social Care)
3. Place
4. Communities, Culture and Homes
5. Corporate

The programmes follow, showing key priorities subject to resources. Together they will deliver the 5 "Hs" of our vision: help, harm reduction, hope, health promotion and health equality. Each directorate will drive their programme, link it with their broader work and collaborate with partners and stakeholders. The programmes will develop over time and may include any other work that will deliver our vision as new needs, opportunities or research evidence arises.

Example areas of focus

The programmes are comprehensive and will result in a step-change in local experience and outcomes. Some elements are particularly important if we are to make a real difference because we have high unmet need, either compared to other areas, compared to the evidence or as highlighted by local stakeholders. They are:

- ***Children and families*** – supporting families affected now and preventing the next generation from developing harmful use and making sure children's views shape our work. This will also support our ambition to be a Child Friendly City and uphold the principles of the UN Charter of the Rights of Children.
- ***Accessible services*** – ensuring people get help quickly and easily
- ***Visible recovery communities*** – this means people celebrating either being tobacco, alcohol and drug-free or being more in control of their use. This boosts self-esteem and enables people to support each other. It will inspire others to get help and reduce the stigma many people feel and prevents them from seeking help. We do not yet have the peer support in Southampton that some cities have.
- ***Mental health conditions and services*** – people with mental ill health tend to have much higher use of tobacco, alcohol and drugs and vice versa. People with both conditions can find it hard to get mental health treatment, may struggle to engage with treatment and support for use of drugs and alcohol, and are also vulnerable to exploitation and at higher risk of suicide.
- ***Our workforces*** – providing training and supporting their wellbeing.
- ***Full range of substances*** - ensuring our work focusses on tobacco, alcohol and drugs like cannabis, amphetamines and ketamine, as well as on crack and opiates.
- ***Housing and employment*** – joining up our work and ensuring people have the circumstances to survive and thrive.
- ***Collaboration, evidence and innovation*** – we will collaborate with our networks to implement what has been shown to work and, where the evidence is less clear, to innovate, evaluate and share our work.

Programme 1 - Wellbeing: Children & Learning

We are ambitious in our programme to support children and young people, to promote good health and wellbeing, and to protect them from the harms of tobacco, alcohol and drugs (whether from their own use, or from significant others around them). We have an aspiration beyond this strategy to become a UNICEF Accredited Child Friendly City.

Many young people underestimate the addictiveness of tobacco and the immediate risks of alcohol and cannabis intoxication including being vulnerable to danger from others such as sexual assault, or from falls and road traffic injuries, as well as long-term harm to development and mental health from continued use.

- Children and young people living with adults/siblings who smoke are 3x more likely to become smokers than those in non-smoking households. Most smokers first start smoking before they are 18.
- It is estimated that around 8,500 young people aged 16-24 took an illicit drug last year and, of those, just under 100 young people used opiates and/or crack cocaine.

Parents and carers with drug or alcohol dependence may struggle to recognise and meet their children's needs.

- 1,200 children, in Southampton, live with an alcohol-dependent adult
- 600 children, in Southampton, live with an adult dependent on illicit opiates

Our key focus in this area over the next 5 years is to:

- Prevent children and young people from starting using tobacco and e-cigarettes, alcohol under-age or at higher risk levels or drugs. This includes:
    - Increasing the proportion of children who grow up in families where no-one smokes, drinks alcohol above the guidance for lower risk, or uses drugs. This is delivered through this programme and through the other programmes in this strategy.
    - Preventing childhood adverse experiences, like poverty, untreated mental ill health, domestic abuse in the family, and ensuring all children have a good relationship with a trusted adult.
    - Enabling children and young people to feel confident in themselves, to be emotionally literate and to support them with skills and knowledge so they can be safe.
    - Promoting a positive child and youth culture of being tobacco (and e-cigarette), alcohol and drug-free, without alienating those who find that difficult
- Help children and young people who use tobacco (and e-cigarettes), alcohol and/or drugs to stop and stay substance free, or to be as safe as possible.
- Protect children and young people from adult, sibling or peer use.
- Protect children from exploitation related to tobacco, alcohol and drugs
- Contribute to ensuring Southampton is a Child-Friendly City.

This tobacco, alcohol and drugs work overlaps with the broader Children and Young People's Strategy, which is underpinned by strategic plans for:

- Prevention and Early Intervention
- Youth Justice
- Corporate Parenting
- Education
- Emotional Wellbeing and Mental Health
- Participation

<table>
<tr><th colspan="3">Our Key Projects and Priorities</th></tr>
<tr><th>Tobacco</th><th>Alcohol</th><th>Drugs</th></tr>
<tr><td>1. Continue to incorporate support to stop smoking in maternity services and other health and care services for pregnancy and early years, including health visitors.
2. A possible, pilot e-cigarette scheme and consider incentives pilot for pregnant women and a campaign for people who provide childcare (grandparents/significant others).</td><td colspan="2">3. Improve family pathways, interventions and support where children, young people or adults who have children have substance use issues or disorders. This includes improving identification of children, adults and families in need; exploring specialist alcohol and drugs workers in Children's teams; and ensuring smooth transition to adult services.
4. Link with wider work to provide prevention and early intervention to children, families and young people, particularly those at higher risk of developing alcohol and/or drug issues.</td></tr>
<tr><td colspan="3">5. Review and strengthen prevention and early intervention work in 0-25 education settings, such as early years, schools, colleges and universities. This includes delivering prevention as educators, employers, and as important local organisations.
6. Work with others to support a wide range of leisure activities in the city for children and young people, as prevention and diversion.
7. Promote accessible, reputable information for children, young people, families and the workforces supporting them, about tobacco, alcohol and drugs and where to get help.
8. Increase the number of young people receiving early intervention support and treatment, sensitive to different needs related to gender, sex, sexuality, disability including learning disabilities, neurodiversity, race, culture and ethnicity and more.
9. Review and strengthen support for children who are looked after, their carers, care leavers to at least 25 years old and people in the Phoenix service, which helps people at risk of having children taken into care.
10. Link with wider prevention and resilience work as part of the Children and Young People's Strategy</td></tr>
</table>

Programme 2 - Wellbeing: Health and Adult Social Care

We are committed to supporting all adults to access services to help them contain, reduce, or stop their substance use. Critical to this is ensuring that support is provided quickly, and that we operate a 'No Wrong Door' approach, so that no matter which service somebody approaches, they get the help they need. We will also have strong, supportive messages to promote health and prevent illness. In Southampton:

- Each year 10,200 (30%) of smokers make a serious attempt to quit, with approximately 1,700 (5%) quitting successfully.
- Approximately 41807 adults drink at increasing risk levels
- More than 5,000 people are estimated to have alcohol dependence
- 675 adults with alcohol dependence live with children
- 1,200 people use illicit heroin or crack cocaine

Many people use more than one substance or have more than one need. For example, approximately 44% of adults starting treatment for alcohol use disorders also smoke. Nationally, more than half of people who have a substance use disorder will also experience a co-occurring mental health disorder, like anxiety, depression, bipolar disorder and schizophrenia. People with co-occurring substance use and mental ill health conditions are at higher risk of dying early, including by suicide.

An estimated one in three people in the UK are negatively affected by the use of drugs and alcohol by someone they know, and have an increased risk of mental ill health, relationship difficulties, financial strain, isolation, stigma and domestic abuse.

Our key focus in this area over the next 5 years is to:

- Identify more people with higher-risk use
- Strengthen services which help people with tobacco, alcohol and/or drug use, to stop or reduce their use or at least be safer while using. Support healthcare services to embed identification, very brief advice and brief interventions in routine care. Increase the number of people in specialist alcohol and drug services.
- Support people who achieve recovery to stay tobacco, alcohol and/or drug free, and to be visible if they wish to inspire others and reduce stigma
- Ensure help is in place to support those affected by someone else's use of drugs or alcohol
- Work with mental health and substance use disorder services to improve access to treatment and support for people with co-occurring conditions
- Support council-wide work to address underlying issues related to the use of tobacco, alcohol and drugs, including work to improve population mental health and wellbeing.

<table>
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<tr><th>Tobacco</th><th>Alcohol</th><th>Drugs</th></tr>
<tr>
<td rowspan="2">1. Support provision for underserved groups who experience high rates of smoking harm, including pregnant women, people with severe mental illness, people who are homeless, and people who have alcohol, drug or mental health conditions.
2. Promote personalised care (“tailored quit”) and the use of e-cigarettes as a way of stopping smoking, in line with regional and national guidance.
3. Support the NHS to implement the NHS Long Term Plan commitment to offer tobacco dependency treatment for inpatients.
4. Run campaigns to encourage people to stop smoking, including the role of e-cigarettes.</td>
<td>5. Review support for underserved groups, including people who are older, people from Black and Ethnic Minorities, and people with long term conditions or disabilities including mental health needs, learning disabilities and neurodiversity.
6. Understand high rate of attendances/ admissions to UHS
7. Run a campaign to improve awareness of alcohol harm and promote non-drinking and lower-risk drinking
8. Review how the health and care system can increase the identification of people at risk of alcohol-related harm.</td>
<td>9. Consider business case for 5-year local pilot of diamorphine treatment for people with treatment-resistant heroin use, in line with current national guidance.
10. Develop business case and, if advantageous, secure funding for drug care team at UHS
11. Review harm reduction services to increase the number of people who use them. This may include incentives, in line with national guidance.
12. Review population-level needs of people who use prescription drugs illicitly and/or non-opiate drugs.
13. Continue response system with Hampshire and Isle of Wight to assess and respond to intelligence of increased risk from illicit supply</td>
</tr>
<tr><td colspan="2">14. Use the National Drugs Strategy funding (2022-2025) to increase the number of people in treatment, including people with both drug and alcohol use disorders, and to implement this strategy where possible within the conditions of the funding.</td></tr>
<tr><td colspan="3">15. Strengthen pathways with the criminal justice system, mental health system, adult social care, domestic abuse, the system for care leavers and support for veterans. Link with the Suicide Prevention Strategy.
16. Ensure there is accessible information about tobacco, alcohol and drug use and support, supplementing national information as applicable and including easy read materials.
17. Strengthen the work and influence of people with lived experience, including service user, carer and recovery communities, engagement and co-production. This will be important for people with alcohol and drug-dependence. It is also important for people who have complex needs and have stopped smoking, e.g. people with severe mental illness.
18. Review the needs of the local health and care workforce, both their own health, wellbeing and safety in relation to tobacco, alcohol and drugs; and also workforce planning and training so that we have the workforce needed to deliver support and treatment.</td></tr>
</table>

<table>
<tr><th colspan="3">Our Key Projects and Priorities</th></tr>
<tr><th>Tobacco</th><th>Alcohol</th><th>Drugs</th></tr>
<tr><td colspan="3">19. Maintain a programme of needs assessments and reviews to ensure our work remains rooted in local evidence, including audits of drug-related deaths and non-fatal overdoses, and scoping any gaps in knowledge about the needs of local people which are related to gender, sex, sexuality, disability, neurodiversity, race, culture and ethnicity or other personal characteristics.
20. Advocate for evidence-based tobacco, alcohol and drugs practice and policy regionally and nationally, for example there is strong international evidence for overdose prevention facilities.</td></tr>
</table>

Programme 3 - Place

The places where we live our lives play a key role in any successful tobacco, alcohol and drug strategy. This programme of work will address that, with evidence-based ways to make Southampton as smoke and drug- free as possible and so that alcohol-related harm is minimised. We will work to ensure our city is a safe and rewarding place to be for everyone. For example, it is estimated that 14.2% of local adults do not ever drink, so ensuring our leisure and night-time economy reflects this is important. There are links to being a Child-Friendly City (Programme 1 of this strategy) too.

Our key focus in this area over the next 5 years is to:

- Have more public places that are free from tobacco, alcohol or drug use, particularly those that children and young people are exposed to
- Support employers to promote health and reduce harm from tobacco, alcohol and drugs
- Increase employment and skills for people with alcohol and/or drug-use disorders
- Use planning and urban design to design health-promoting public and domestic spaces that also design out crime and fear of crime
- Reduce tobacco, alcohol and drug litter through reduced use and safer disposal.

<table>
<tr><th colspan="3">Our Key Projects and Priorities</th></tr>
<tr><th>Tobacco</th><th>Alcohol</th><th>Drugs</th></tr>
<tr><td rowspan="2">1. Encourage smoke-free public places frequented by children, young people and families including parks, school gates and other places
2. Support the public sector and wider employers to be smokefree sites and organisations</td><td>3. Review opportunities for alcohol-free public places including places frequented by children.
4. Identify ways to welcome new business to the late-night economy that do not serve alcohol and are attractive to a range of ages</td><td>5. Keep the need and feasibility of sharps bins under intermittent review</td></tr>
<tr><td colspan="2">6. Use the Local Plan and associated policies to design-out spaces that enable anti-social behaviour or crime.
7. Support the work of the Employment Support Team, and others, who support people with long term unemployment into work</td></tr>
<tr><td colspan="3">8. Work with local retail, leisure sector and others to make it easy for people to enjoy themselves in places free of tobacco, alcohol and drugs.
9. Support the public sector and wider employers with example Human Resources policies</td></tr>
</table>

Programme 4 – Communities, Culture and Homes

The communities we live in make a big difference to our health and wellbeing. Some communities have more tobacco, alcohol and drug-related harm than others. People who are homeless are particularly vulnerable to harm from tobacco, alcohol and drugs, including harm from other people using substances or exploitation.

- Southampton residents living in the most deprived areas are 3.4 times more likely to be admitted to hospital because of alcohol.
- Drug and alcohol-related crime is clustered in the city centre and deprived areas
- Tobacco, alcohol and drugs exacerbate poverty, diverting household income from other priorities.

Our key focus in this area over the next five years is to work with local partners such as the Safe City Partnership, Hampshire Constabulary and the Voluntary Sector to:

- Reduce illicit or illegal supply of tobacco, alcohol and drugs
- Keep people safe from harm (Safe City Strategy Priority 1)
- Make the most of opportunities to strengthen communities and housing in a health-promoting way

This will involve elements of:

- Community relations, autonomy and reporting
- Regulation and enforcement – licensing and trading standards, including protecting children and young people from underage sales
- Engagement with businesses, the voluntary sector and others
- Diversion from criminal justice into treatment &/or rehabilitation

Our Key Projects and Priorities		
Tobacco	**Alcohol**	**Drugs**
1. Work with the Fire Service on **fire prevention** 2. Use **Trading Standards powers and approaches** to identify and reduce illicit tobacco, underage sales and non-compliant e-cigarettes, as applicable.	3. Encourage a **night-time economy** that has a wide range of offers, including alcohol-free beverages in licensed premises and alcohol-free places more widely. 4. Use and enforce the **licensing policy.** 5. Review opportunities for **diversion** from criminal justice into treatment	**6.** Review opportunities for **diversion** from criminal justice into treatment **7.** Link prevention and treatment pathways with police and criminal justice system **enforcement**

Our Key Projects and Priorities		
Tobacco	**Alcohol**	**Drugs**
8. Support the **Violence Reduction Unit** (VRU) and the **Safe City Partnership**'s work to improve community safety, informed by their "Problem Profile", the Safe City Assessment and resident surveys. 9. Support **community champions** to be able to share information and influence tobacco, alcohol and drug-related harm 10. Support housing staff with **training** and optimise **housing policies** to support residents to live in smokefree accommodation, engage in alcohol and/or drug treatment and sustain recovery. 11. Scope strategic approach to licensed **events** including harm minimisation		

Programme 5 – Corporate

Ensuring a 'Health in all Policies' approach not just for our Council workforce, but for the workforces of those we contract and commission to provide services in the city, is another key strand of this strategy. We are committed to demonstrating and modelling a responsible approach to tobacco, alcohol and drugs, and will be proactive in working with other organisations to encourage similar 'Health in all Policies' approaches across the city too.

Our key focus in this area over the next 5 years will revolve around the following core areas:

- Health in all contracts and commissioning
- Workforce wellbeing – support and HR policies
- Advertising guidance
- Relationship to industry including staff pensions

<table>
<tr><th colspan="3">Our Key Projects and Priorities</th></tr>
<tr><th>Tobacco</th><th>Alcohol</th><th>Drugs</th></tr>
<tr><td rowspan="2">1. Continue to abide by and promote the Local Government Declaration on Tobacco Control, including embedding in all contracts and influencing pension investment if possible
2. Support NHS commitment to be Smokefree
3. Support wider stakeholders to be smokefree and influence pension investments by leading by example if possible.</td><td>4. Maintain advertising guidance to not advertise alcohol
5. Promote a positive cultural norm of healthier ways of connecting, socialising and relaxing, including in internal communications and the workplace.</td><td></td></tr>
<tr><td colspan="2">6. Review guidance for officers completing Equality Impact Assessments so that the needs of people with alcohol and/or drug dependency are included as appropriate.</td></tr>
<tr><td colspan="3">7. Use a "health in all contracts" approach - optimise use of the Social Value Act in relation to tobacco, alcohol and drugs, during procurement and incorporate it into standard contracts
8. Strengthen workforce wellbeing within the Council, including policies, training for managers, promoting services to staff and role of commissioned services, e.g. occupational health
9. Support Elected Members to be health-promoting in their roles
10. Support wider stakeholders to be health-promoting settings.
11. Apply learning from the "Health in all policies" approach of this strategy to other issues</td></tr>
</table>

Implementing and monitoring the strategy

Next steps

Officers will embed the Vision, approach and principles of this strategy in the Council's work. We will incorporate it into existing work and structures wherever possible. Progress will be reviewed annually and reported to the Health and Wellbeing Board. We will also share our learning and experience with stakeholders and nationally whenever possible.

Each directorate and team across the council will develop the work that applies to them in more detail, supported by Public Health if required. They will join it up with other work they are doing, for maximum efficiency and impact, and scale and pace it in line with the funding and other resources available. With 5 programmes and more than 50 priority projects and developments, it is not practical to detail all the objectives and plans here. The details of the work will change over time, as new research evidence is published, if the law changes or if more funding is available. If directorate structures change during the lifespan of this strategy, the strategy will still stand and the plans and reporting underneath this strategy will simply be updated to reflect Director portfolios. This strategy will provide an overview throughout, providing a common goal that we will all work towards.

Governance and monitoring for this strategy

This strategy sits under the Council's "Health and Wellbeing Strategy" and will be overseen by the Health and Wellbeing Board. It overlaps with many other council and national strategies and boards too, such as the Safe City Strategy and Partnership, which leads on community safety and crime.

A new Tobacco, Alcohol and Drugs overview group will monitor the overall impact of this strategy, primarily through the Key Performance Indicators and narrative reports from directorates. They will also consider headline data indicators from the Office of Health Improvement and Disparities, the National Drug Treatment Monitoring System and other reliable sources of intelligence.

The overview group will report to the Health and Wellbeing Board at least annually, in collaboration with directorates. Directorates will monitor the progress of their programmes. Commissioners and service managers will manage the performance of services. The Safe City Partnership will continue to monitor and lead related work on community safety. This currently includes an annual survey which asks residents about their experiences and views on drug and alcohol-related crime.

The overview group will be a small programme management group, rather than duplicate the large partnership forums which already exist in many forms. The group will work through these forums. As a Council we will work with local people to shape and deliver our work through:

- Elected members

- Community engagement forums, as part of the work of each directorate
- Services user and carers engagement and the co-production of interventions and services, by commissioned services in particular
- Collaboration with wider stakeholders, run by or representing local people
- Staff with lived experience
- The publication of council papers and other public communications.

We will:

- Focus on monitoring outcomes with some activity and output measures too.
- Compare our progress over time and against other comparable local authorities.
- Be careful that we do not allow what we monitor to have unintended consequences, for example, in working to reduce emergency hospital attendances we do not want to dissuade people from seeking or receiving help. We instead want to make sure that people receive care in a planned way, for their benefit, wherever possible.
- Consider repeating an Equality Impact Assessment half-way through the strategy, or sooner if indicated.

We are aiming for improvement on all measures and to be at least as good as local authorities who have city populations like ours. The National Drugs Strategy was published in 2021 and further guidance is due on how the performance of local authorities will be measured. We will incorporate the requirements into this local strategy.

Our Key Performance Indicators for this strategy follows:

Key Performance Indicators

Measures	**Indicators** Indicators marked *are also indicators of the Health and Wellbeing Strategy.		
	Tobacco	**Alcohol**	**Drugs**
Process measures (in addition to progress reports from Directorates)	1. Maintain or increase people making a quit attempt through commissioned services	2. Increase people in treatment 3. Reduce alcohol-related hospital admissions	4. Increase people in treatment 5. Reduce drug-related hospital admissions
Output measures	6. Increase quits through commissioned services	7. Increase successful treatment completion 8. Reduce unmet need as reported by NDTMS	9. Increase successful treatment completion (opiate/non-opiate) 10. Reduce unmet need as reported by NDTMS

Outcome measures	11. Reduce % pregnant women who are smokers at time of delivery* 12. Reduce smoking prevalence in adults*	13. Reduce mortality rate for people aged under 75 years old from liver disease considered preventable* 14. Reduce alcohol deaths (specific and related) 15. Reduce prevalence of higher risk drinking (14 units or more pw) 16. Prevalence of alcohol use disorders 17. Alcohol-related crime	18. Contain drug-related deaths and reduce if possible 19. Increase reporting of non-fatal overdoses and reduce incidents (locally generated) 20. Maintain low blood-borne virus rates 21. Reduce prevalence of drug use disorders. 22. Reduce drug-related crime

A “dashboard” report of these indicators will be produced annually, including at the start of the strategy going live. There is sporadic national data on smoking prevalence for 15 year olds, last available for 2014/15 by local authority and for 2018 for England. We will add this in as a KPI if official reporting resumes.

Commissioners and service managers have detailed targets in contracts for individual services. Each directorate is welcome to set their own targets too, if helpful. We are not setting overarching targets in this broader strategy. It would be clumsy to set numbers now to aim for. We are instead aiming for as much progress as we can make and to ensure we perform as well or better than similar authorities.

Health and Wellbeing Strategy indicators

This work of this strategy will contribute to a wider range of Health and Wellbeing Strategy indicators too:

Tobacco	Alcohol	Drugs
Contributes to: • Under 75 years mortality rate from cardiovascular disease • Under 75 years mortality rate from respiratory disease	Contributes to: • Injuries due to falls in people aged 65 years and over • Percentage of people aged 16-64 years in employment • Depression recorded prevalence • Suicide rate	Contributes to: • Looked after children rate • Percentage of people aged 16-64 years in employment • HIV late diagnosis • Depression recorded prevalence • Suicide rate

Tobacco	Alcohol	Drugs
All contribute to:		
• Life expectancy at birth • Life expectancy at 65 years • Healthy Life Expectancy at birth • Mortality rate from causes considered preventable • Excess winter deaths index		

Comparator areas

Southampton is in the 4th most deprived decile of Local Authorities nationally. The other areas are Brent, Bristol, Calderdale, County Durham, Coventry, Darlington, Derby, Enfield, Lewisham, Luton, Plymouth, Southwark, Stockton-on-Tees and Wigan.

This grouping is based on the Indices of Multiple Deprivation, which groups areas with similar levels of poverty or wealth. The most recent groupings were done in 2019. All the Local Authorities across the country were ranked by deprivation. This list was then split into 10 equal-sized categories, known as "deciles". The top group are the 10% of Local Authorities with the most affluent populations in the country. This includes Hampshire. The population of Portsmouth are in the 3rd most deprived decile, slightly more deprived than Southampton. The population of the Isle of Wight are in the 5th most deprived decile, slightly more affluent than Southampton.

Crime data uses comparisons which are slightly different. Bristol, Derby, Luton and Plymouth are also comparators, but the others are then not in the IMD group: Cardiff, Eastbourne, Gloucester, Hounslow, Leeds, Newcastle upon Tyne, Portsmouth, Plymouth, Reading and Slough.

Engagement and consultation work

Engagement with key stakeholders within the Council: During the co-production stage for this strategy, we worked with selected internal stakeholders to produce the outline strategy. We worked with all directorate areas, but particularly with adults' and children's social care and education colleagues, and housing and homelessness services, who often work closely with people with Substance Use Disorders (SUDs). In addition to this, during the public consultation process we conducted a focus group with over 60 frontline Adult Social Care and safeguarding workers to discuss elements of the strategy and to gain further input and feedback from key frontline staff. We also had individual meetings with all Health and Wellbeing Board members, who will be responsible for monitoring and overseeing implementation of the strategy, and with political representatives.

Engagement with service users (current and former) and those with lived experience: In the formation of this strategy, we actively worked with people with lived experience of these issues to ensure that their views, and those of past and present service users, were listened to and reflected within the strategy as much as possible. We worked closely with service providers including CGL and No Limits, and attended a recovery artwork exhibition event from one of our city service providers to meet staff and service users. Some of the artwork displayed at the event will be intentionally featured within the final strategy design to reflect the people our services help within the city, and in particular to reflect the 'Hope' strand of our '5 H's', a reminder that positive change is possible.

Engagement with other groups and partner organisations: We also engaged widely with community organisations working in Southampton, as well as family support groups such as Parent Support Link. Health and commissioning colleagues within and outside Southampton City Council were also actively consulted and engaged with (including GPs and primary care, and University Hospital Southampton), as well as specialist experts at Southampton University. We also circulated our public consultation widely across health and safeguarding networks, as well as the voluntary and community sector.

Public Consultation: As part of this strategy process, we conducted a 12-week full public consultation, which ran from 13th June to 4th September 2022. In total, we received 263 responses during this consultation process (259 to the online consultation questions, and a further 4 responses via either email or letter). We have carefully compiled and examined all feedback, which has been used to inform revisions and updates to the final strategy version. The biggest priorities highlighted by respondents were mental health and early education/interventions, and this has been used to inform further development in our strategic priorities going forward.

Our strategy data: The local data used to inform, develop and produce this final strategy has mostly been sourced from the Southampton City Council Data Observatory, which uses reputable national and local sources, as well as from other teams working within and alongside SCC. This includes (but is not limited to) service providers, the voluntary sector, safeguarding partners, as well as from needs assessments and other reviews undertaken as part of the strategy development process. National and regional figures, as well as local breakdowns compiled by national and regional organisations have been obtained from sources including the Department for Health and Social Care (DHSC), the Office for Health Inequalities and Disparities (OHID), the National Drug Treatment Monitoring System (NDTMS) and Hampshire and Isle of Wight Integrated Care Board (ICB).

Thank you to everybody who participated both at co-production stage and during the consultation process. All input and feedback was gratefully received and carefully considered in the development of the final version of this new Tobacco, Alcohol and Drugs Strategy 2023-2028.

Further information

If you would like any further information on this strategy and our work to reduce the harms of tobacco, alcohol and drugs within the city, please email publichealth@southampton.gov.uk

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.

Name or Brief Description of Proposal	SCC Tobacco, Alcohol and Drug (TAD) Strategy 2023 - 2028
Brief Service Profile (including number of customers)	
An estimated 34,000 Southampton residents smoke; 41,807 Southampton residents drink more than 14 units a week (the threshold for lower risk consumption); and 1,200 adults use heroin or crack cocaine. Many others are affected by harm from this use and the dependent and non-dependant use of other drugs. This ESIA considers the impacts of the publication and implementation of our Council, combined, Tobacco, Alcohol and Drug (TAD) Strategy. Our 5 year (2023 – 2028) TAD strategy, due to be published and enacted on the 1st of January 2023, covers everyone who lives, works in, or visits the city; it covers every person, every community and every place in the city and articulates how we will work as a council, and collaboratively with partners, to reduce harm to people who use tobacco, alcohol and drugs, to people around them, and across the City of Southampton as a whole. This Tobacco, Alcohol and Drugs (TAD) strategy describes how we will achieve this by working across the council to deliver 5 strategic programmes of work, one for each council directorate, which are evidence-based or innovative. This whole-council approach is necessary to ensure we have as much impact as possible and	

work efficiently. It reflects the "health in all policies" commitment in the Health and Wellbeing Strategy.

Where there are any directorate portfolio changes or restructures within Southampton City Council (SCC) during the lifetime of the strategy, work programmes will be moved to the appropriate new directorates to ensure continuing ownership and responsibility.

Tobacco, alcohol, and drugs present complex challenges. This strategy covers 5-years so that we have time to build on what we are already doing well, establish new ways of working and make a difference. We cannot "solve" tobacco, alcohol, and drug-related harm in 5 years, but we can build on strong work to date to make meaningful progress and we will monitor a range of indicators and outcomes.

The strategy is comprehensive and intended to complement, rather than duplicate, related work that already exists, for example the Children and Young People's Strategy, the Safe City Partnership, the Violence Reduction Unit and more.

It is a statutory requirement for the council to have alcohol and drug strategies. As signatories to the Local Government Declaration on Tobacco Control, the Council has also committed to having a Tobacco Control Plan.

Summary of Impact and Issues

The TAD strategy is focussed on reducing inequalities and on strengthening equality, diversity and inclusion.

There is a risk of greater ongoing health inequalities if we do **not** pursue this strategy.

No other risks have been identified.

More information about the Impact and Issues follows as background:

Impact of tobacco, alcohol and drugs in Southampton

There is high tobacco, alcohol and drug-related harm in Southampton. Estimates for Southampton are included in the draft strategy, including:

- Approximately 34,000 local people smoke. Nationally, 1/2 of people who smoke die from smoking-related illness, on average 10 years earlier than non-smokers but increasing to 15-20 years for people with severe mental illness.
- 299 pregnant women a year have not been able to stop smoking by the time of delivery, despite usually wanting to
- Pregnant women living in the most deprived areas of Southampton are 4 times more likely to smoke than pregnant women living in the most affluent areas.

- Approximately 41,807 local people drink at increasing risk levels, over 14 units per week. Conversely, 14.9% of adults in Southampton never drink alcohol. Alcohol is a leading cause of liver disease, cancer, obesity and mental ill health.
- One of the highest rates of alcohol-related hospital admissions in the country
- 1,200 children live with an alcohol-dependent adult
- 1,200 local people use illicit opiates (heroin) or crack cocaine
- 2,268 alcohol-related crimes a year, 71% violent.
- 1,242 drug-related crimes a year
- 600 children live with an adult dependent on illicit opiates
- 66,000 adults are affected by the drug or alcohol use of someone they know
- For children and young people under 18, alcohol use is 5 times higher for those living in the most deprived areas of Southampton compared to the most affluent areas of Southampton. Drug use is 8 times higher.

Further data is available from Southampton Data Observatory

The negative effects of tobacco, alcohol and drugs affect everyone, but the people most affected by the harm tend to be people living in poverty or who are otherwise marginalised. For example, nationally, half of the difference in life expectancy between wealthier and poorer communities is attributable to smoking.

The Strategy content

The proposed Council vision for the strategyfocusses on 5 "Hs":

- Help
- Harm reduction.
- Hope
- Health promotion.
- Health equality – summarised as "equality" and meaning both equality and equity of outcomes.

This vision will be delivered through 5 programmes:

- Wellbeing (Children and Learning)
- Wellbeing (Health and Adult Social Care)
- Place
- Communities, Culture and Homes
- Corporate

Programmes include commitments to understand and meet the unmet needs of underserved groups. We will consider completing an Equity Impact Assessment half-way through the life-span of the strategy.

In this way equality, diversity and inclusion is woven through each level of the strategy.

The Strategy development process

The strategy builds on strong foundations of strategic and commissioning work to date. SCC have already consulted, engaged with and is committed to working collaboratively with partner agencies, and commissioned services, to reduce the harms associated with the use of tobacco, drugs and alcohol to individuals, their families, communities and, to the city more broadly.

This strategy has been developed by the Public Health and Policy teams of Southampton City Council. We have engaged colleagues across the council and with stakeholders across the city. Some contributors to this strategy have shared their personal experience of tobacco, alcohol and drugs too.

This engagement process included a full 12-week public consultation which ran from 13th June to 4th September 2022. This was publicised internally to colleagues, externally through partners in the city, as well publicly through the following channels:

Website (both the consultation page and a news post)
Social media
E-bulletins (City News, Communities bulletin and Your City, Your Say)
Press release
Digital posters.

Potential Positive Impacts

The strategy engages and empowers SCC to work across directorates, and with strategic partners to work collaboratively to reduce tobacco, alcohol and drug related harm.

This strategy intends to ensure that people of all ages, genders and ethnicities live healthier, happier lives, whatever challenges, or vulnerabilities they may have. It is focussed on reducing inequalities and promoting equality, diversity, and inclusion.

This strategy uses 'proportionate universalism', seeking to improve the health and wellbeing of everyone. Whilst there is naturally a strong focus on people with the greatest needs who require the most support, it also means that everyone benefits proportionate to their needs.

Groups experiencing the greatest harm from tobacco, alcohol and drugs include people living in poverty, people in marginalised groups, people with severe mental illness and people who are homeless or living in other difficult situations. People in these circumstances are also more likely to be coping with past or current trauma

and face barriers to changing their substance use or less personal support to do so. The diversity of our population and workforce is key. Our work will be person-centred and promote dignity. Everyone has their own relationship with tobacco, alcohol and drugs, their own values and circumstances, so a personalised approach is vital. As part of this strategy, we will seek to further increase our understanding of the impact of tobacco, alcohol and drugs on different people – including by protected characteristic; enhance and inform our current work; expand the range of evidence-based interventions and develop innovative approaches.	
Responsible Service Manager	Helen Dougan and Colin McAllister, Senior Public Health Practitioners
Date	03.11.22
Approved by Senior Manager	Charlotte Matthews, Public Health Consultant
Date	03.11.22

Potential Impact

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Age	**No negative impacts of the draft strategy identified**. There would be risks if we did not pursue this strategy. This has been confirmed during the consultation period which included responses from people from across the life course, and included services and organisations that represent or reach young people and families. **Strategy content** There is no risk from the content of the strategy. The draft strategy will strengthen equity of outcomes for people of all ages. It has a dedicated programme for children and young people, as well as for adults, and there are links between the two programmes for family work.	We will continue to consider, throughout our work to implement this strategy and through the governance processes, the voices of, and impacts to, people of all ages.

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
	The Wellbeing (Children and Learning) programme will be led by the corresponding directorate, who will embed it in their wider work for maximum reach and effectiveness. There are commitments to ensure we understand and meet the needs of people transitioning between children's and adult services and of older people too. Background information The stigma associated with the use of drugs and alcohol may result in a reluctance to engage in treatment and support. People with protected characteristics may be more impacted by this. Older people can experience a greater impact from the use of tobacco alcohol and drugs. Younger people may be less aware of the potential, long-term harm. Children who live with adults or siblings who smoke are 3 times more likely to become smokers than those in non-smoking households. The strategy looks across all age groups. It will be supported by work with all stakeholders, internal and external to the council, to ensure the needs of different age cohorts are engaged, informed, and supported using evidence-based, age-orientated interventions. It includes the impact of adult behaviour on children and has a strong focus on prevention. The strategy also prioritises supporting recovery communities, reflecting the needs of our diverse population, which is intended to mean by age too. This will reduce the stigma associated with seeking help or overcoming tobacco, alcohol and drug-related harm. Each programme will be led by a directorate, who can join it to other work they are doing to improve outcomes for people of all ages.	

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Disability	**No negative impacts of the draft strategy identified**. There would be risks if we did not pursue this strategy. **Strategy content** There are no negative impacts of the strategy. The draft strategy will strengthen equity of outcomes for people with disabilities or additional needs of any kind. There are priorities to ensure we have data and other information about needs, that our services are accessible and that we join up pathways. The strategy has a strong focus on people with co-occurring mental health conditions, which would include disabilities. The strategy also prioritises supporting recovery communities, reflecting the needs of our diverse population, to help celebrate and reduce the stigma associated with seeking help or overcoming tobacco, alcohol and drug-related harm. Each programme will be led by a directorate, who can join it to other work they are doing to improve outcomes for people with disabilities. There would be a risk if we did not pursue this strategy. <u>Background information</u> Some people with disabilities are at greater risk of tobacco, alcohol or drug-related harm. This can be through the use of TAD to relieve symptoms or isolation; underlying health vulnerabilities, and/or because other people's use may affect them more – including exploitation. The stigma associated with the use of tobacco, drugs and alcohol may result in a reluctance to engage in treatment and support. People with	We will continue to consider, throughout our work to implement this strategy and through the governance processes, the voices of, and impacts to, people with disabilities.

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
	protected characteristics may be more impacted by this, including people with disabilities. People with certain disabilities, reduced cognition, comprehension, or literacy may require additional support to understand and engage with this strategy. Ensure all services consider the needs of all people and are empowered and resourced to make 'reasonable adjustments' to provision	
Gender Reassignment	**No negative impacts of the draft strategy identified**. There would be risks if we did not pursue this strategy. **Strategy content** This strategy is for 'all people' whatever gender they identify as and/or any type of gender transition. The strategy includes a focus on monitoring and improving equity. The aim to strengthen recovery communities may be particularly helpful to champion. <u>Background information</u> The evidence base is developing. People who identify as transgender, non-binary, gender-fluid or as any other gender other than that they were assigned at birth are more likely, nationally, to experience tobacco, alcohol and/or drug related harm. This includes higher use by some people and barriers to accessing and staying in treatment. The stigma associated with the use of tobacco, drugs and alcohol may result in a reluctance to engage in treatment and support. People with protected characteristics may be more impacted by this.	We will continue to consider, throughout our work to implement this strategy and through the governance processes, the voices of, and impacts to, people of all sexes and genders.

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
	The Strategy's focus on inequalities and equality will provide a useful mechanism to ensure all services and agencies have inclusive policies in place, including for the needs of people who are transgender, non-binary or gender fluid.	
Marriage and Civil Partnership	**No negative impacts of the draft strategy identified**. There would be risks if we did not pursue this strategy. The use of tobacco, drugs and alcohol can negatively impact relationships and can be a driver or facilitator of domestic and sexual abuse. This strategy therefore includes links to strategic work on domestic and sexual abuse. The commitment to equity and to the needs of underserved groups will help to ensure that no-one is disadvantaged because they are married or in a civil partnership, or not.	We will continue to consider, throughout our work to implement this strategy and through the governance processes, the voices of, and impacts to, people of all martial or relationship status.
Pregnancy and Maternity	**No negative impacts of the draft strategy identified**. There would be risks if we did not pursue this strategy. **Strategy content** The strategy includes a focus on strengthening support for pregnant women and their significant others, as part of Programme 1. Wellbeing (Children and Learning). This includes continuing to embed support in routine care with specialist support as required and exploring the provision of e-cigarettes and/or other incentives to pregnant women. This is based on national clinical guidance of what works. Incentives can be important to help people override the automatic draw to substances, particularly if they are living in complex circumstances and have a lot of different stresses	We will continue to consider, throughout our work to implement this strategy and through the governance processes, the voices of, and impacts to, people during pregnancy.

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
	to manage. The number of women smoking at the time of delivery is also a proposed indicator. <u>Background information</u> Tobacco, alcohol and/or drug use during pregnancy is often harmful to both mother and baby in the short and long term and can adversely affect others in the home. Reducing harm and use is key to reduce stillbirths and similar serious harm. Additionally, pregnant women are vulnerable to harm from those smoking, drinking or taking drugs around them. Pregnant women are at greater risk of domestic abuse, which can be affected by alcohol and drugs.	
Race	**No negative impacts of the draft strategy identified**. There would be risks if we did not pursue this strategy. **Strategy content** Tobacco, alcohol and drug use disorders do not discriminate. But people from local minority/global majority backgrounds are under-represented in our treatment and support services. This strategy will review support for underserved groups, including people who are older, people from Black and Ethnic Minorities, and people with long-term conditions or disabilities including mental health needs. This strategy will also promote diversity through the work on workforce planning, recovery communities and campaigns.	We will continue to consider, throughout our work to implement this strategy and through the governance processes, the voices of, and impacts to, people of all races and ethnicities.
Religion or Belief	**No negative impacts of the draft strategy identified**. There would be a risk if we did not pursue this strategy. **Strategy content** This strategy promotes equitable access and encourages embedded support as part of a	We will continue to consider, throughout our work to implement this strategy and through the governance processes, the voices of, and impacts to, people of all faiths and of none.

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
	patient care pathway, enabling individuals to access support through existing services. All services will offer confidential support. <u>Background information</u> Some faiths forbid or discourage the use of tobacco, alcohol and drugs. This can mean some people try to hide their substance use and delay seeking support. For others, faith is a protective factor against harmful use, to cope with harm from others or inspiring them to support people with tobacco, alcohol and drug issues.	
Sex	**No negative impacts of the draft strategy identified**. There would be a risk if we did not pursue this strategy. **Strategy content** This strategy is for all people, whether assigned male, female or intersex at birth, and for all expressions of sex (or gender) identity through life. The strategy focusses on equality and equity. Needs assessments will continue to reflect any differences by gender. Commissioners will continue to include information about the gender of service users as part of monitoring. Care will continue to be provided based on individual needs and risk. The Pregnancy section above is an important part of ensuring that women or people with other gender identities aren't disadvantaged by being pregnant or during pregnancy.	We will continue to consider, throughout our work to implement this strategy and through the governance processes, the voices of, and impacts to, people of all sexes and genders.
Sexual Orientation	**No negative impacts of the draft strategy identified**. There would be a risk if we did not pursue this strategy. **Strategy content** This strategy is for all people. We have specified work in Programme 1 (Wellbeing - Children and Learning) and Programme 2 (Wellbeing – Health	We will continue to consider, throughout our work to implement this strategy and through the governance processes, the voices of, and impacts to, people of all sexualities.

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
	and Adult Social Care) to ensure the needs of people who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual or in another way (LGBTQIA+) are understood and met. Our focus on supporting inclusive recovery communities and workforce planning will also support inclusion. Background information Nationally, people who identify as LGBTQIA+ tend to have higher rates of tobacco, alcohol and drug use, due to a complex interplay of factors. People who identify as LGBTQIA+ can feel or be alienated by services that do not represent or meet their needs.	
Community Safety	**No negative impacts of the draft strategy identified**. There would be a risk if we did not pursue this strategy. **Strategy content** Programme 4 (Communities, Culture and Homes) includes work to support and complement the Violence Reduction Unit, the Safe City Strategy and the Safe City Partnership in particular. Background information Tobacco, alcohol and drug related harm includes substantial risks to community safety, as detailed in the Safe City Assessment Safe City Strategic Assessment (southampton.gov.uk). For example, in 2020/21, there were 2,268 alcohol-related recorded crimes and 1,242 drug-related recorded crimes in Southampton.	We will continue to consider community safety throughout the strategy implementation.
Poverty	**No negative impacts of the draft strategy identified**. There would be a risk if we did not pursue this strategy. **Strategy content**	We will continue to consider poverty throughout the implementation of this strategy.

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
	Tobacco, alcohol and drug-related harm most heavily affects people living in poverty. This strategy will mitigate, reduce and where possible, prevent this harm. This will enable people living in poverty to experience less health inequality compared to people who do not. This strategy will not be able to get rid of all health inequalities related to tobacco, alcohol, drugs and poverty. Mitigating, reducing and preventing poverty (and adverse childhood experiences) will be important wider work, beyond the scope of this strategy, to reduce tobacco, alcohol and drug use rates and harm in the long term. <u>Background information</u> Groups experiencing the greatest harm from tobacco, alcohol and drugs include people living in poverty. For example, smoking accounts for half of the difference in life expectancy between the least and most deprived in society. Behavioural science focusses on capability, opportunity and motivation. This strategy supports the capability and opportunity for people living in poverty to reduce tobacco, alcohol and related harm. It builds motivation too, but that is not necessarily lacking. People living in more deprived areas or from marginalised groups, are often just as motivated but may be using at higher levels, live in less supportive environments and have more competing priorities. Supporting adult smokers to quit empowers them to break from tobacco addiction and improve financial security for the family. The same applies for people reducing or stopping their alcohol or drug use. There are direct financial benefits from not spending on substances. Additionally, being tobacco and drug-free, and drinking at lower risk levels or not at all, brings health benefits that mean people	

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
	are less likely to be ill and more able to secure and maintain employment. The alcohol harm paradox describes how disadvantaged populations who drink the same or lower levels of alcohol, experience greater alcohol-related harm than more affluent populations.	
Health & Wellbeing	**No negative impacts of the draft strategy identified**. There would be a significant risk if we did not pursue this strategy. The strategy focusses on improving health and wellbeing and reducing other types of harm from tobacco, alcohol and drugs. The strategy sits under the Health and Wellbeing Strategy and the Health and Wellbeing Board. Background information Harm to health and wellbeing includes illness, premature death, as well as poor quality of life. For example, nationally, half of smokers die from smoking, with people with severe mental health conditions having a life expectancy 15-20 years less than other people mainly due to smoking. Alcohol is a leading cause of premature death for adult men. An estimated 1,200 children live with an adult who is alcohol dependent, and an estimated 600 children live with an adult who is dependent on illicit opiates (heroin) &/or crack cocaine – some children may appear in both estimates.	
Other Significant Impacts	No other negative impacts identified for Equality and Safety.	

Consultation on a draft Tobacco, Alcohol & Drugs Strategy 2023 – 2028
Full results summary
southampton dataobservatory
Data, Intelligence & Insight, September 2022

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Introduction & methodology

Introduction & methodology

Southampton City Council undertook public consultation on a draft Tobacco, Alcohol & Drugs Strategy 2023 – 2028.

The consultation took place between **Monday, 13 June** and **Sunday, 04 September 2022.**

The aim of this consultation was to:

- Communicate clearly to residents the proposals of the draft strategy;
- 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 objectives in a different way.

This report summarises the aims, principles, methodology and results of the consultation. It provides a summary of the 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/or 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.

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

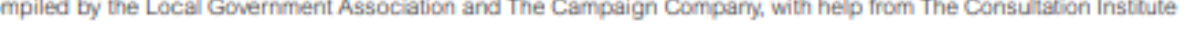
Rules: The Gunning Principles

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:

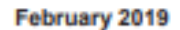
1. **proposals are still at a formative stage**
   A final decision has not yet been made, or predetermined, by the decision makers
2. **there is sufficient information to give 'intelligent consideration'**
   The information provided must relate to the consultation and must be available, accessible, 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

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:

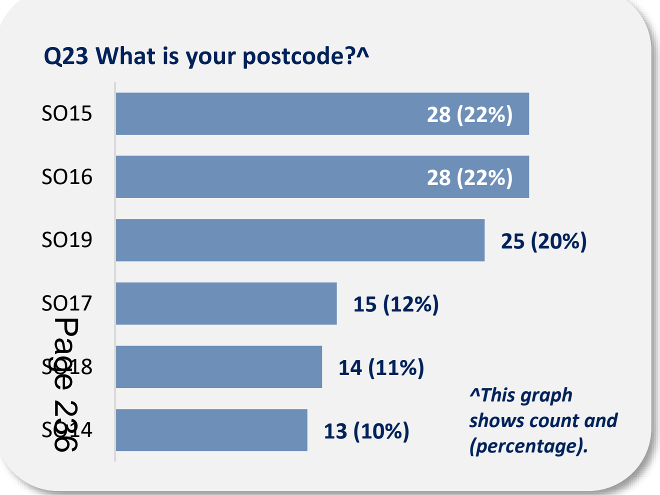
- Via the Southampton City Council website;
- On social media;
- Via the e-bulletins City News, Communities, and Your City, Your Say;
- Press releases;
- An email from the SCC Director of Public Health to partners and stakeholders, and;
- Digital posters.

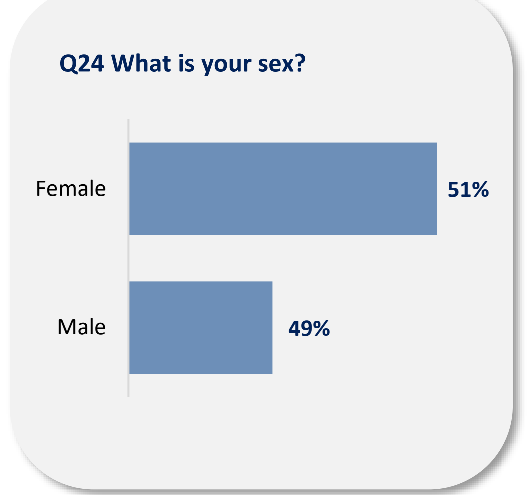
All questionnaire results have been analysed and presented in graphs within this report. Respondents were given opportunities throughout the questionnaire to provide written feedback on the proposals. In addition anyone could provide feedback in letters and emails. We have provide quotes all the free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

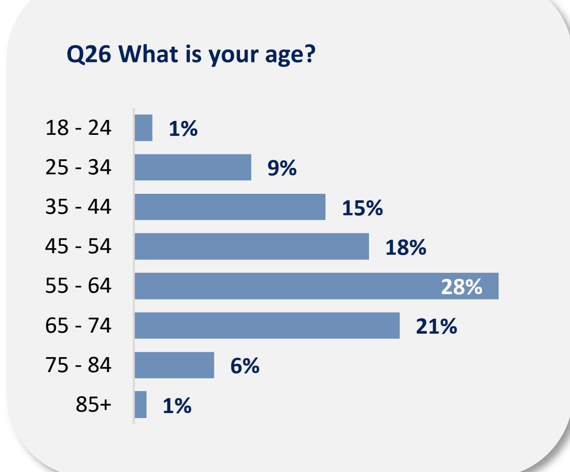
Who are the respondents?

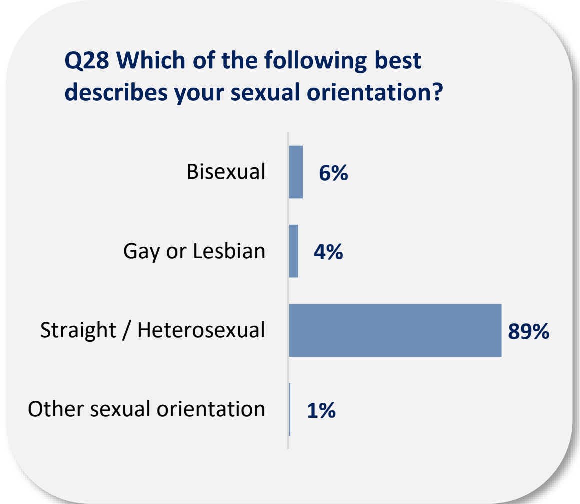
Who are the respondents?

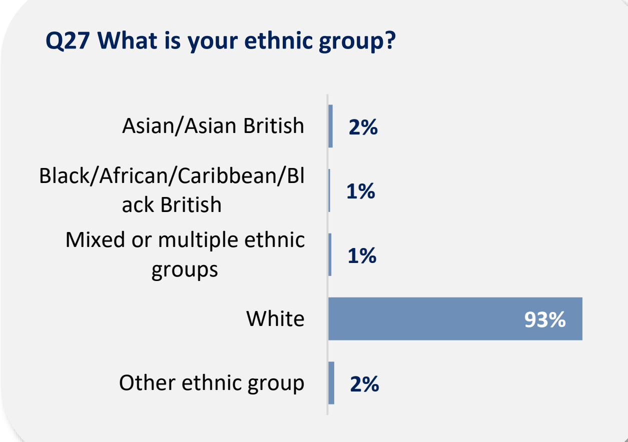
Overall, there were **263** separate responses to the consultation. Of these, **259** were **online questionnaire** responses, and **4** were responses received by either **email or letter**. The following graphs break down these responses by count.

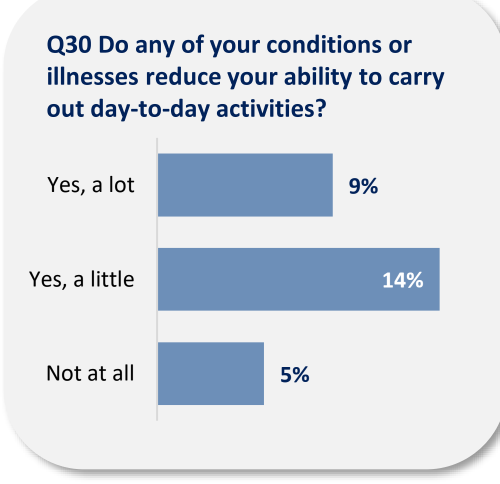


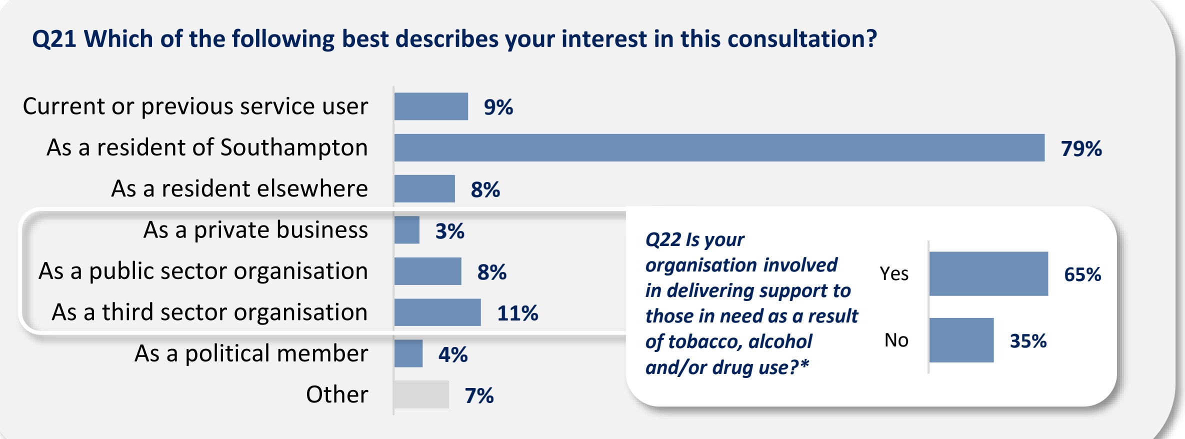






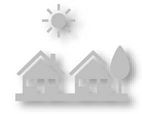






*Question 22 was asked of those who answered either private business, public sector organisation and/or third sector organisation to question 21. Percentages are of those that answered question 22, and not of total respondents.

Question 1 | The Five Hs & Vision for 2028



A vision for 2028

The first area covered by the consultation were the **Five H’s** that together make up the vision in the strategy. The following slides in this section detail the feedback provided on the below:

The **Five H's** of our vision outline what we want to achieve in Southampton by 2028, ensuring that **Southampton is a city of**:

Help for people concerned for themselves or others, with information and services that are easy to access, timely, safe, and effective. All health, care and wider services will discuss tobacco, alcohol and drugs as part of routine care and provide help and support. Services will have a "no wrong door" approach and help people get the support they need. Services will work together, and provide support and treatment based on evidence and innovation.

Harm reduction. Help will be available to people whether they want to be safer while using tobacco, alcohol and/or drugs, reduce their use, stop using, or stay free from use. Harm reduction also includes making sure that people who inject drugs have sterile, safe equipment.

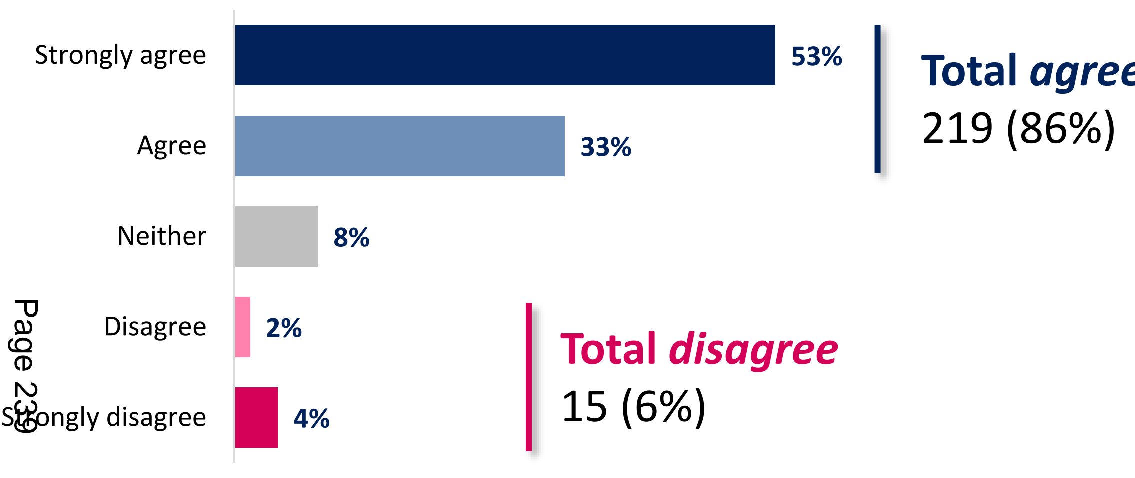
Hope, with visible communities of people celebrating their progress through treatment and recovery and living healthier, happier lives. This will reduce stigma and inspire others, and is also part of the changing of our broader culture to be more sensitive to alcohol, tobacco, and drug-related harm.

Health promotion and prevention. Prevention is better than cure. We will help our residents understand the risks of tobacco, alcohol and drugs. We aim to give every child the best start in life, including supporting families with tobacco, alcohol, and drug use in the family and protecting people from harm caused by others. We will take every opportunity to make sure the places where we live, learn, work and relax all keep us safe and well. This means promoting ways of life that are free from smoking, higher-risk levels of alcohol, and drugs.

Health equality. Everyone needs the opportunity to be free from the harms of tobacco, drugs and alcohol. We will focus most on supporting people who are more likely to use tobacco, alcohol or drugs or who face barriers to reducing harm to themselves or others. Our services will be sensitive to, and celebrate, the rich diversity of our communities, and meet any additional needs that they may have, such as sensory or mobility needs. Our work will be informed by people with lived experience of tobacco, alcohol, and drug-related harm.

Q1a To what extent do you agree or disagree with the Five Hs of our vision for 2028? *Help*

Total respondents | **255**



Total *agree*
219 (86%)

Total *disagree*
15 (6%)

Key findings

- A majority (86%) of respondents agree with the *help* element of the vision, including a majority (53%) who *strongly agree.*
- Those responding on behalf of a business or organisation responded *agree* by 12% points more than total respondents overall (98% and 86% respectively), including 64% that responded *strongly agree* (11% points more than total respondents overall, at 53%).

Breakdowns

	Strongly agree	Agree	Neither	Disagree	Strongly disagree	Total agree (%)	Total disagree (%)	Total (count)
I currently receive, or have previously received, support from tobacco, alcohol, and/or drug services**	74%	13%				87%	9%	23
As a resident of Southampton	48%	37%	9%			85%	6%	198
Businesses & organisations*	64%	34%				98%	0%	51
Female	52%	37%	9%			88%	3%	104
Male*	54%	29%	10%			83%	7%	99
Ages 18 - 34**	41%	36%	9%	9%		77%	14%	22
Ages 35 - 64	56%	32%	8%			87%	5%	126
Ages 65+*	49%	35%	12%			84%	4%	57
Disabled*	57%	29%	7%			86%	7%	58

■ Strongly agree ■ Agree ■ Neither ■ Disagree ■ Strongly disagree

**Less than 100 respondents. **Less than 50 respondents.*
Breakdowns with less than 20 respondents not shown.

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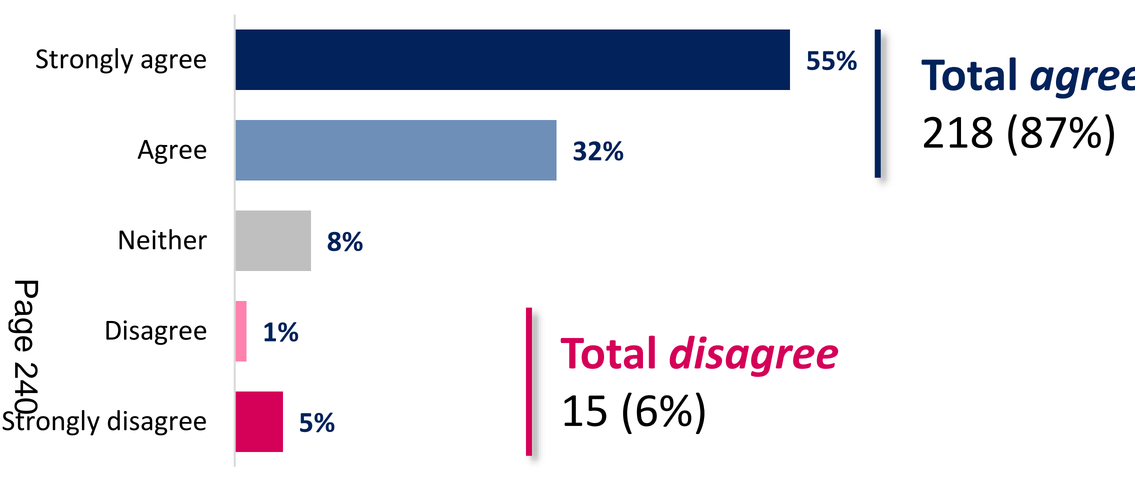
Q1b To what extent do you agree or disagree with the Five Hs of our vision for 2028? *Harm reduction*



Page 240

Key findings

- A majority (87%) of respondents agree with the *harm reduction* element of the vision, including a majority (55%) that *strongly agree.*
- Those responding on behalf of a business or organisation responded *agree* by 9% points more than total respondents overall (96% and 87% respectively), including 64% that responded *strongly agree* (9% points more than total respondents overall, at 55%).

Breakdowns

	Strongly agree	Agree	Neither	Disagree	Strongly disagree	Total agree (%)	Total disagree (%)	Total (count)
I currently receive, or have previously received, support from tobacco, alcohol, and/or drug services**	65%	26%				91%	4%	23
As a resident of Southampton	51%	35%	8%			86%	7%	196
Businesses & organisations*	64%	32%				96%	0%	51
Female	56%	35%	7%			91%	2%	103
Male*	50%	32%	9%		7%	82%	9%	98
Ages 18 - 34**	45%	41%		9%		86%	14%	22
Ages 35 - 64	52%	36%	7%			87%	6%	126
Ages 65+*	58%	25%	13%			84%	4%	55
Disabled*	63%	25%	7%			88%	5%	57

■ Strongly agree ■ Agree ■ Neither ■ Disagree ■ Strongly disagree

*Less than 100 respondents. **Less than 50 respondents.*
Breakdowns with less than 20 respondents not shown.

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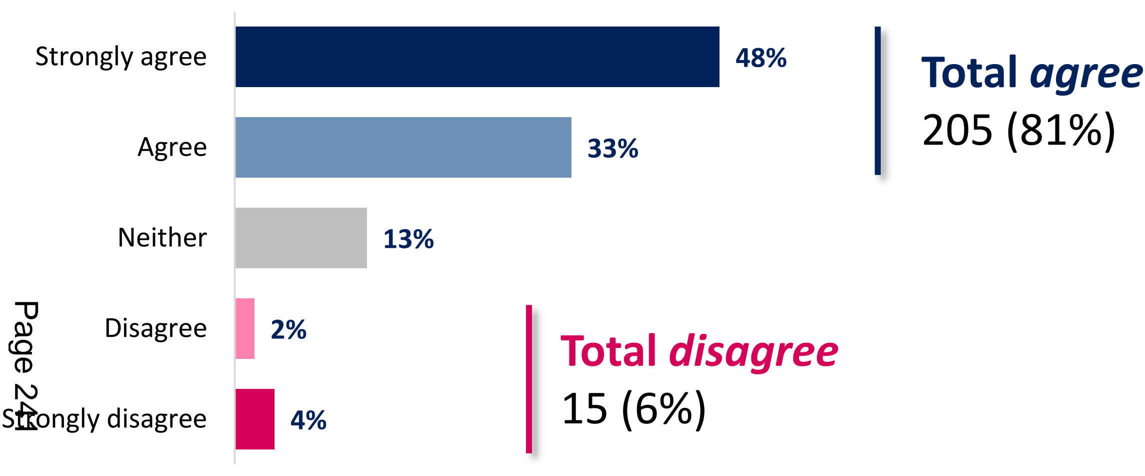
Q1c To what extent do you agree or disagree with the Five Hs of our vision for 2028? *Hope*

Total respondents | 253



Key findings

- A majority (81%) of respondents agree with the *hope* element of the vision, including almost half (48%) that *strongly agree.*
- Again, those responding on behalf of a business or organisation responded *agree* by 13% points more than total respondents overall (94% and 81% respectively), including 53% that responded *strongly agree* (5% points more than total respondents overall, at 48%).

Breakdowns

	Strongly agree	Agree	Neither	Disagree	Strongly disagree	Total agree (%)	Total disagree (%)	Total (count)
I currently receive, or have previously received, support from tobacco, alcohol, and/or drug services**	61%	30%				91%	4%	23
As a resident of Southampton	43%	36%	15%			79%	6%	197
Businesses & organisations*	53%	42%				94%	0%	51
Female	45%	40%	11%			85%	4%	105
Male*	47%	28%	18%			75%	7%	97
Ages 18 - 34**	41%	41%		9%		82%	14%	22
Ages 35 - 64	45%	36%	13%			81%	6%	126
Ages 65+*	48%	29%	20%			77%	4%	56
Disabled*	54%	31%	8%			85%	7%	59

■ Strongly agree ■ Agree ■ Neither ■ Disagree ■ Strongly disagree

**Less than 100 respondents. **Less than 50 respondents.*
Breakdowns with less than 20 respondents not shown.

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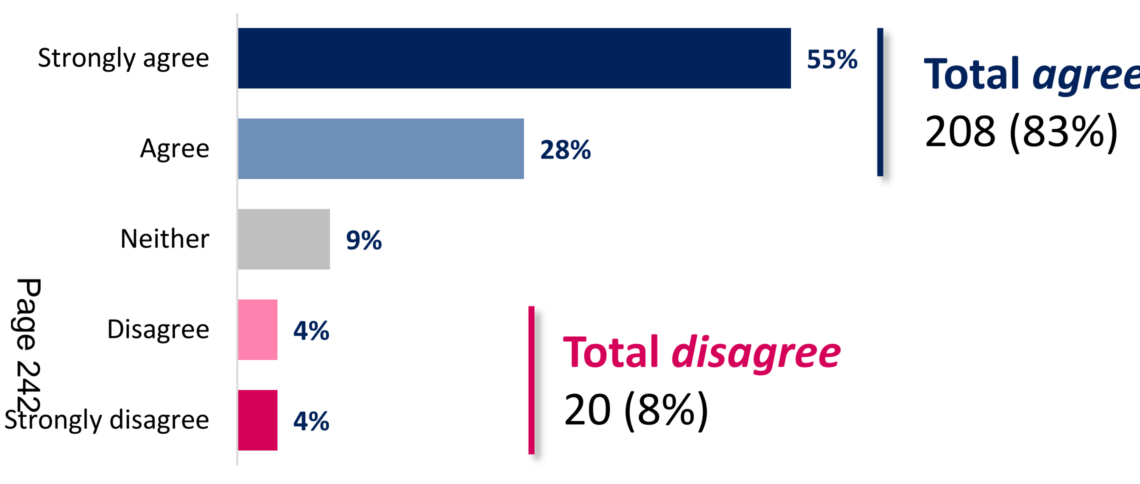
Q1d To what extent do you agree or disagree with the Five Hs of our vision for 2028?

Total respondents | 251



Key findings

- A majority (83%) of respondents agree with the *health promotion and prevention* element of the vision, including a majority (55%) that *strongly agree.*
- Those responding on behalf of a business or organisation responded *agree* by 13% points more than total respondents overall (96% and 83% respectively), including 64% that responded *strongly agree* (9% points more than total respondents overall, at 55%).

Breakdowns

	Strongly agree	Agree	Neither	Disagree	Strongly disagree	Total agree (%)	Total disagree (%)	Total (count)
I currently receive, or have previously received, support from tobacco, alcohol, and/or drug services**	48%	26%	13%	9%		74%	13%	23
As a resident of Southampton	52%	31%	9%			83%	8%	195
Businesses & organisations*	64%	32%				96%	2%	51
Female	56%	29%	9%			85%	7%	104
Male*	52%	30%	10%			81%	8%	97
Ages 18 - 34**	43%	38%		14%		81%	14%	21
Ages 35 - 64	52%	33%	10%			84%	6%	126
Ages 65+*	60%	20%	13%			80%	7%	55
Disabled*	57%	26%		9%		83%	12%	58

■ Strongly agree ■ Agree ■ Neither ■ Disagree ■ Strongly disagree

**Less than 100 respondents. **Less than 50 respondents.*
Breakdowns with less than 20 respondents not shown.

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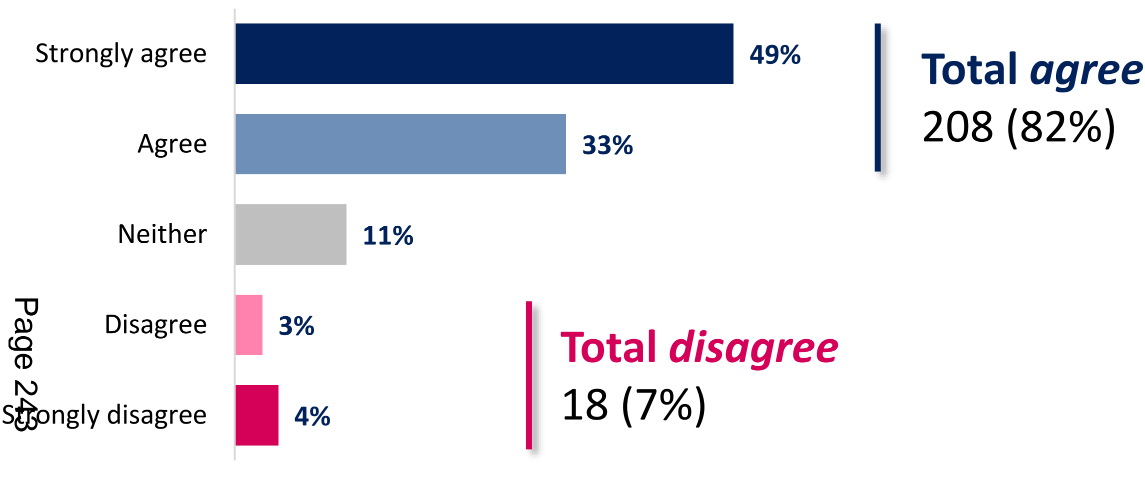
Q1e To what extent do you agree or disagree with the Five Hs of our vision for 2028?



Breakdowns

	Strongly agree	Agree	Neither	Disagree	Strongly disagree	Total agree (%)	Total disagree (%)	Total (count)
I currently receive, or have previously received, support from tobacco, alcohol, and/or drug services**	65%	17%	9%		9%	83%	9%	23
As a resident of Southampton	45%	35%	13%			80%	7%	198
Businesses & organisations*	63%	35%				98%	0%	52
Female	52%	38%	7%			90%	4%	106
Male*	43%	30%	18%			73%	9%	97
Ages 18 - 34**	41%	41%		9%		82%	14%	22
Ages 35 - 64	48%	34%	13%			82%	6%	127
Ages 65+*	48%	34%	11%			82%	7%	56
Disabled*	54%	31%	7%			85%	8%	59

■ Strongly agree ■ Agree ■ Neither ■ Disagree ■ Strongly disagree

*Less than 100 respondents. **Less than 50 respondents.*
Breakdowns with less than 20 respondents not shown.

Key findings

- A majority (82%) of respondents agree with the *hope* element of the vision, including almost half (49%) that *strongly agree.*
- Those responding on behalf of a business or organisation responded *agree* by 16% points more than total respondents overall (98% and 82% respectively), including 63% that responded *strongly agree* (14% points more than total respondents overall, at 49%).

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Q1 To what extent do you agree or disagree with the Five Hs of our vision for 2028? *Summary*

	Strongly agree	Agree	Neither	Disagree	Strongly disagree	Total agree (%)	Total disagree (%)	Total (count)
Harm reduction	55%	32%	8%		5%	87%	6%	252
Help	53%	33%	8%		4%	86%	6%	255
Health promotion and prevention	55%	28%	9%	4%	4%	83%	8%	251
Health equality	49%	33%	11%		4%	82%	7%	254
Hope	48%	33%	13%		4%	81%	6%	253

Key findings

- All of the Five Hs of the vision had a majority total *agree* responses of between 81% and 87%
- Of these, only *hope* and *health equality* did not also have a majority that responded *strongly agree* (48% and 49% respectively) – these had a slightly higher number of *neither* responses (13% and 11% - *help*, *harm reduction*, and *health promotion and prevention* had between 8% and 9% *neither* responses each)
- No element of the vision had more than 19% total *neither* and *disagree*

Question 3 | Proposed focus

The next area covered by the consultation was the **focus** of the draft strategy. The following slides in this section detail the feedback provided on the below:

We must make sure our work has breadth and depth, and is embedded in all we do. This means that everyone benefits according to their need. We propose a strong focus on people with the greatest needs who require the most help, as well as support for the large numbers of people needing less, so we reduce health inequalities and improve health for everyone.

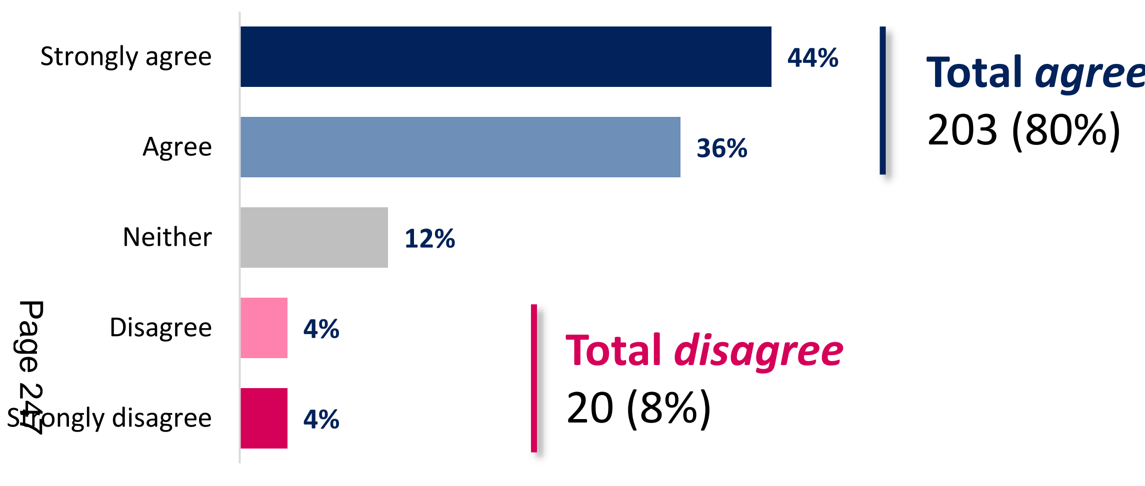
Groups experiencing the greatest harm from tobacco, alcohol and drugs include people living in poverty, people in marginalised groups, people with severe mental illness, and people who are homeless or living in other difficult situations. People in these circumstances are also more likely to be coping with past or current trauma and face barriers to changing their substance use or less personal support to do so.

To what extent do you agree or disagree with our proposed focus?

"A stronger focus on people with the greatest needs who require the most help."

Q3 To what extent do you agree or disagree with our proposed focus?

Total respondents | **254**



Key findings

- A majority of respondents *agreed* with the focus (80%) including 44% who *strongly agreed*
- Men responded *strongly disagree* to a greater extent than women, at 7% to 0% respectively. This is reflected in 10% of male respondents responding *disagree* overall compared to 5% of female respondents
- Again, those responding on behalf of a business or organisation responded *agree* to the greatest extent (87%), including 52% that *strongly agree* (though these numbers are lower than for the vision)

Breakdowns

	Strongly agree	Agree	Neither	Disagree	Strongly disagree	Total agree (%)	Total disagree (%)	Total (count)
I currently receive, or have previously received, support from tobacco, alcohol, and/or drug services**	43%	39%				83%	13%	23
As a resident of Southampton	43%	37%	12%			80%	8%	198
Businesses & organisations*	52%	35%	9%			87%	4%	52
Female	45%	40%	10%			85%	5%	105
Male*	44%	34%	12%		7%	78%	10%	98
Ages 18 - 34**	50%	36%				86%	9%	22
Ages 35 - 64	41%	38%	13%			79%	8%	125
Ages 65+*	47%	33%	14%			79%	7%	58
Disabled*	51%	32%	12%			83%	5%	59

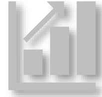
■ Strongly agree ■ Agree ■ Neither ■ Disagree ■ Strongly disagree

**Less than 100 respondents. **Less than 50 respondents.*
Breakdowns with less than 20 respondents not shown.

Q2 What more would you like to tell us about our vision for 2028?
Q4 What more would you like to tell us about what you think of our focus? *(free-text questions)*

Response	Count
General positive comments on the strategy/vision	27
Make sure services are appropriately resourced/staffed	25
Ensure a connected approach and co-ordination between services, e.g. the police, social care, the NHS	19
Resource should be prioritised to where it will be most effective - desire/willingness/ability to change should be prioritised over need	9
The means of targeting support should be improved	2
Other - further suggestions/changes	5

Questions 6 – 14 | Impact of the programmes



Our strategy to achieve this vision – how will we deliver our vision?

The next area covered by the consultation were the **five strategic programmes** that will help deliver the aims of the draft strategy. The following slides in this section detail the feedback provided on the below:

We will deliver our vision through five strategic programmes, each running for the five years of the strategy (2023 - 2028). There is one programme for each of the four broad main parts of the council, called directorates. There is also another corporate programme for internal, cross-cutting work, such as human resources.

The five strategic programmes are:

1. *Wellbeing - Children & Learning*
2. *Wellbeing - Health & Adult Social Care*
3. *Place*
4. *Communities, Culture & Homes*
5. *Corporate*

Together, these programmes will deliver the **Five Hs** of our vision: help, harm reduction, hope, health promotion, and health equality. Each directorate will run their own programme, its key projects, and its main priorities. They will also link it with their broader work and collaborate with partners and stakeholders. The programmes will develop over time as new needs, opportunities, or research arises.

Our strategy to achieve this vision – how will we deliver our vision?

Programme One – Children & Learning

This programme focuses on the health and wellbeing of children and young people. We want to protect them from the harms of tobacco, alcohol and drugs, whether from their own use or from the use of significant people in their lives.

We aim to:

- Prevent children and young people from starting using tobacco, alcohol (either under-age or at higher risk levels) or drugs
- Help children and young people who use tobacco, alcohol and/or drugs to stop and stay substance-free, or to be as safe as possible
- Protect children and young people from adult, sibling, or peer use
- Contribute to ensuring Southampton is a Child-Friendly City

Programme Two – Health & Adult Social Care

This programme focuses on adults. We want to protect them from the harms of tobacco, alcohol, and drugs. We want to ensure support is in place and that people who need help can find it and engage with it. We also want to make sure people know and understand the risks caused by tobacco, alcohol and drugs.

We aim to:

- Identify more people with higher-risk use
- Strengthen services which help people with tobacco, alcohol and/or drug use, to stop or reduce their use or at least be safer while using
- Support healthcare services to embed identification, very brief advice and brief interventions in routine care
- Increase the number of people in specialist alcohol and drug services
- Support people who achieve recovery to stay tobacco, alcohol, and drug-free, and to be visible if they wish to inspire others and reduce stigma
- Ensure help is in place to support those affected by someone else's use of drugs or alcohol
- Work with mental health services to improve treatment and support for people with co-occurring conditions

Our strategy to achieve this vision – how will we deliver our vision?

Programme Three - Place

This section focuses on our city and how we propose to work to ensure Southampton is a safe and rewarding place to be for everyone.

We aim to:

- Have more public places that are free from tobacco, alcohol and drug use, particularly those that children and young people are exposed to
- Support employers to promote health and reduce harm from tobacco, alcohol and drugs
- Increase employment and skills for people with alcohol and/or drug-use disorders
- Use planning and urban design to design health-promoting public and domestic spaces that also design out crime and fear of crime
- Reduce tobacco, alcohol, and drug-related litter through reduced use and safer disposal

Programme Four – Communities, Culture & Homes

This programme looks at how we live in our city and how this strategy can be safer, healthier and happier.

By working with our partners, we aim to:

- Reduce the illicit or illegal supply of tobacco, alcohol and drugs
- Keep people safe from harm
- Make the most of opportunities to strengthen communities and housing in a health-promoting way

Programme Five – Corporate

This last programme is all about the council itself, and how we can ensure all the people who work for and with the council can be healthier and happier.

Our key focus areas are:

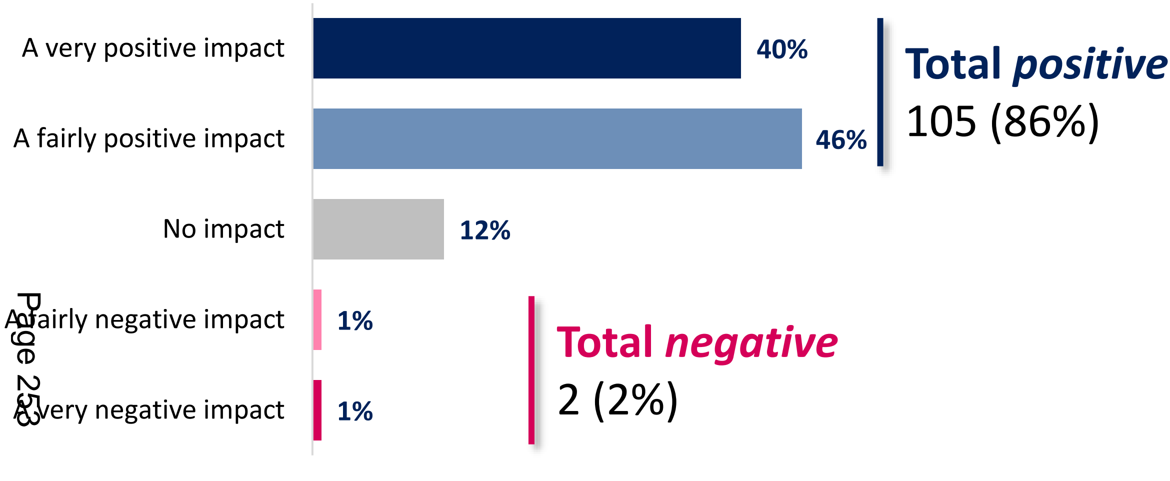
- Health in all contracts and commissioning
- Workforce wellbeing via support and HR policies
- Advertising guidance
- Relationships with industry, including staff pensions

Q6 Children & Learning Programme

What impact do you feel this will have on you, your family, your business, and/or the wider community?

Total respondents* | **122**

**This question was only asked of those who selected the Children & Learning programme as an option for question five.*



Key findings

- Majority of respondents responded *positive* (86%)
- Though all three breakdowns have low base numbers, it is notable that among male respondents, respondents aged 65 or over, and those responding on behalf of a business or organisation, there were no *negative* responses, either *fairly* or *very negative*

Breakdowns

	A very positive impact	A fairly positive impact	No impact	Total positive (%)	Total negative (%)	Total (count)
As a resident of Southampton*	39%	46%	14%	85%	1%	93
Businesses & organisations**	42%	48%	10%	90%	0%	30
Female*	41%	44%	11%	86%	3%	63
Male**	40%	45%	15%	85%	0%	40
Ages 35 - 64*	43%	48%	8%	90%	2%	61
Ages 65+**	39%	35%	26%	74%	0%	31
Disabled**	38%	38%	22%	75%	3%	32

■ A very positive impact ■ A fairly positive impact ■ No impact ■ A fairly negative impact ■ A very negative impact

**Less than 100 respondents. **Less than 50 respondents. Breakdowns with less than 20 respondents not shown.*

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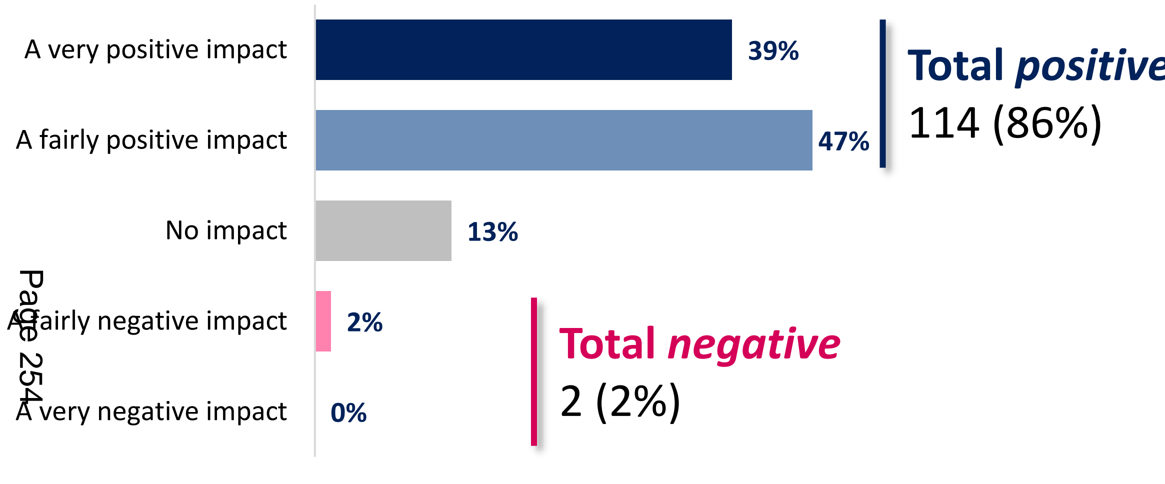
Q8 Adult Social Care Programme

What impact do you feel this will have on you, your family, your business, and/or the wider community?

Total respondents* | **133**

**This question was only asked of those who selected the Adult Social Care programme as an option for question five.*



Breakdowns

	A very positive impact	A fairly positive impact	No impact	A fairly negative impact	A very negative impact	Total positive (%)	Total negative (%)	Total (count)
As a resident of Southampton	31%	50%	17%			81%	2%	102
Businesses & organisations**	56%	41%				97%	0%	31
Female*	40%	47%	14%			86%	0%	58
Male*	34%	50%	13%			84%	4%	56
Ages 35 - 64*	40%	49%	11%			89%	0%	70
Ages 65+**	41%	34%	19%	6%		75%	6%	32
Disabled**	37%	39%	20%			76%	5%	41

**Less than 100 respondents. **Less than 50 respondents.*
Breakdowns with less than 20 respondents not shown.

Key findings

- Majority of respondents (86%) responded *positively*
- No respondents that were either female or aged between 35 and 64 responded with a *negative* sentiment
- No respondents responded with a *very negative impact* sentiment

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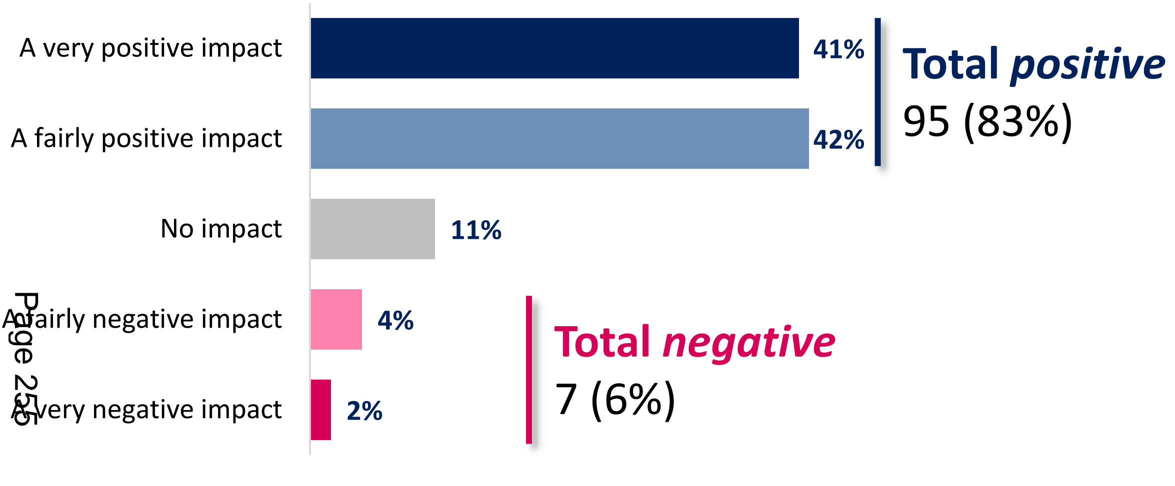
Q10 Place Programme

What impact do you feel this will have on you, your family, your business, and/or the wider community?

Total respondents* | 114

This question was only asked of those who selected the Place programme as an option for question five.



Key findings

- Majority of respondents (83%) responded *positively*
- Female respondents responded *very positively* (47%) to a greater extent than male (38%) by 9% points

Breakdowns

	A very positive impact	A fairly positive impact	No impact	A fairly negative impact	A very negative impact	Total positive (%)	Total negative (%)	Total (count)
As a resident of Southampton*	41%	42%	12%			83%	5%	93
Businesses & organisations**	41%	41%	13%	6%		81%	6%	31
Female*	47%	38%	11%			85%	4%	53
Male*	38%	44%	10%			82%	8%	50
Ages 35 - 64*	44%	35%	15%			79%	6%	62
Ages 65+**	47%	44%				91%	6%	32
Disabled*	29%	48%	13%	6%		77%	10%	31

*Less than 100 respondents. **Less than 50 respondents.
Breakdowns with less than 20 respondents not shown.

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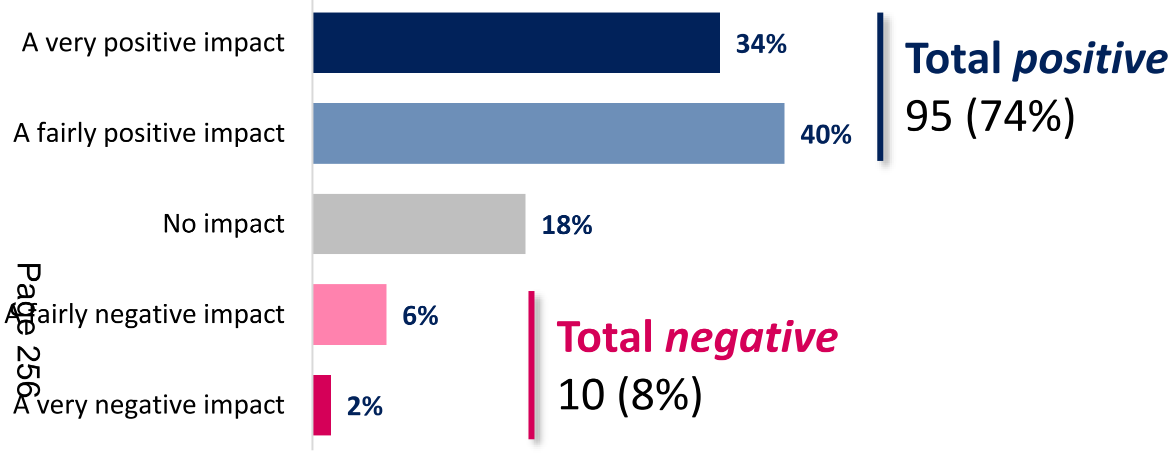
What impact do you feel this will have on you, your family, your business, and/or the wider community?

Total respondents* | 128

**This question was only asked of those who selected the Communities, Culture & Homes programme as an option for question five.*



Breakdowns

	A very positive impact	A fairly positive impact	No impact	A fairly negative impact	A very negative impact	Total positive (%)	Total negative (%)	Total (count)
As a resident of Southampton	34%	39%	22%			72%	6%	101
Businesses & organisations**	33%	47%	11%	8%		81%	8%	35
Female*	36%	37%	24%			73%	3%	59
Male*	37%	38%	15%	8%		75%	10%	52
Ages 35 - 64*	36%	39%	16%	7%		75%	9%	69
Ages 65+**	40%	33%	23%			73%	3%	30
Disabled**	29%	43%	20%	9%		71%	9%	35

**Less than 100 respondents. **Less than 50 respondents.*
Breakdowns with less than 20 respondents not shown.

Key findings

- Majority of respondents responded *positively* (74%)
- Female respondents responded *no impact* to a greater extent (24%) than male respondents (15%) and respondents aged between 35 and 64 (16%)

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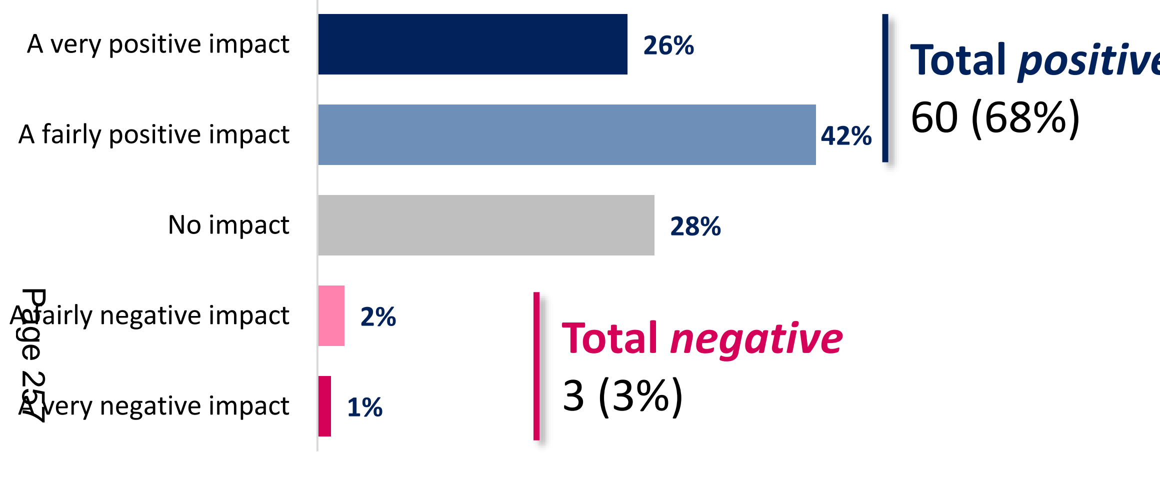
Q14 Corporate Programme

What impact do you feel this will have on you, your family, your business, and/or the wider community?

Total respondents* | 88

This question was only asked of those who selected the Corporate programme as an option for question five.



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Key findings

- Majority responded *positively* (68%), however this is six percentage points less than the next programme, Communities, Culture & Homes (74%) and also received the least total responses (88) out of the five programme questions (responses ranging from 133 to 114)

Breakdowns

	A very positive impact	A fairly positive impact	No impact	Total positive (%)	Total negative (%)	Total (count)
As a resident of Southampton*	23%	42%	31%	65%	4%	71
Businesses & organisations**	27%	50%	23%	77%	0%	25
Female**	22%	47%	28%	69%	3%	36
Male**	30%	38%	30%	68%	3%	40
Ages 35 - 64**	29%	39%	29%	67%	4%	49
Ages 65+**	29%	43%	29%	71%	0%	21
Disabled**	20%	48%	32%	68%	0%	25

■ A very positive impact ■ A fairly positive impact ■ No impact ■ A fairly negative impact ■ A very negative impact

**Less than 100 respondents. **Less than 50 respondents. Breakdowns with less than 20 respondents not shown.*

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Questions 6 – 14 What impact do you feel this will have on you, your family, your business, and/or the wider community? *Summaries*

Programme	Very positive impact	Fairly positive impact	No impact	Fairly negative impact	Very negative impact	Total positive (%)	Total negative (%)	Total (count)
Children & Learning	40%	46%	12%			86%	2%	122
Adult Social Care	39%	47%	13%			86%	2%	133
Place	41%	42%	11%	4%		83%	6%	114
Communities, Culture & Homes	34%	40%	18%	6%		74%	8%	128
Corporate*	26%	42%	28%			68%	3%	88

*Less than 100 respondents.

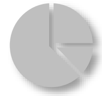
Key findings

- All five of the programmes had a majority *positive* responses (between 68% and 86% each)
- The *Corporate* programme had the lowest total *agree* and *neither* responses (68% and 28% respectively), also receiving the lowest total number of responses for the programme questions overall (88)
- Of the programmes with over 100 responses, *Communities, Culture & Homes* received the lowest total *positive* (74%) and the largest number of respondents that said the programme would have *no impact* (18%)
- *Children & Learning*, *Adult Social Care* and *Place* all received between 83% and 86% total *positive* responses each

Q2 What more would you like to tell us about your thoughts on the […] programme? *(free-text questions)*

Area	Response	Count
Adult Social Care	Address underlying issues related to use of TAD (e.g. mental health and wellbeing)	22
	Ensure support for parents/families with TAD use problems	12
	Make sure safe accommodation and/or residential support is available	6
	Other - further suggestions/changes	4
Children & Learning	Focus on/measures to turn young people away from TAD/help them avoid TAD	24
	Address the use of vaping in young people	4
	More should be done to address child exploitation related to TAD	2
Communities, Culture & Homes	Address underlying issues related to use of TAD (e.g. deprivation, homelessness)	20
	Ensure services promote equality and accommodate and represent communities	14
	More targeted policing/enforcement of TAD-related crimes and policies	12
	General concerns about safety in Southampton	4
	Recommendations of a 'homes first' policy to address the underlying causes of TAD-related issues	2
	Address TAD and related crime issues associated with prostitution around Empress Road	2
	Other - further suggestions/changes	5
Place	Ban/reduce TAD use in public spaces	13
	Ensure employers are supportive and/or not discriminatory	4
	Make sure there are still designated areas for smokers	3
	General concerns about place in Southampton	2
	Other - further suggestions/changes	6
	Other - positive	1
Corporate	Other - positive	1
	Other - further suggestions/changes	1

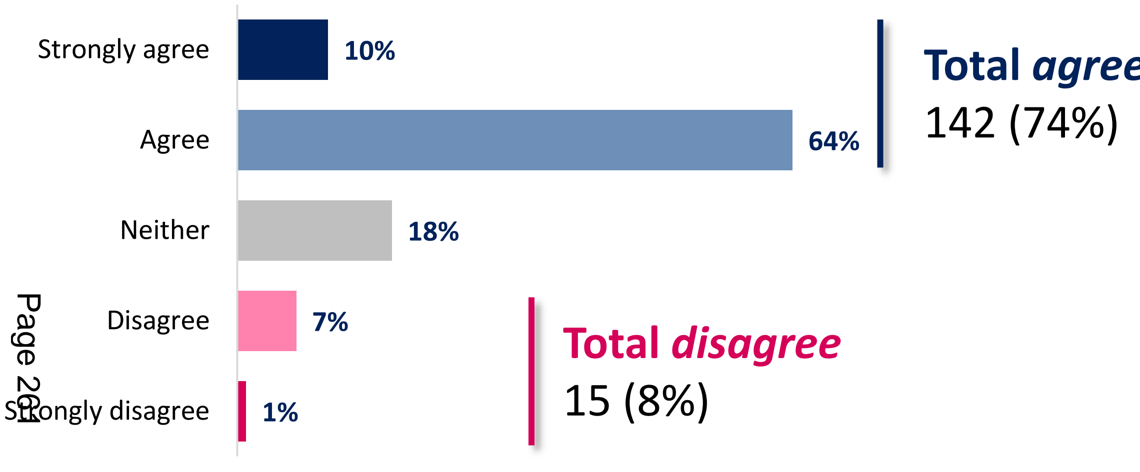
Question 17| Contents of the draft strategy



Q17a To what extent do you agree or disagree with the following statement? *"The draft strategy is easy to understand"*

Total respondents* | **191**

**This question was only asked of those who confirmed they had read the draft strategy in response to question 16 (194 of 256 respondents confirmed they had read at least some of the draft strategy).*



Breakdowns

	Strongly agree	Agree	Neither	Disagree	Strongly disagree	Total agree (%)	Total disagree (%)	Total (count)
As a resident of Southampton	9%	63%	19%	8%		71%	9%	150
Businesses & organisations**	17%	67%	10%	7%		83%	7%	41
Female*	16%	63%	18%			79%	4%	80
Male*		67%	18%	11%		70%	12%	73
Ages 35 - 64*	10%	65%	18%	7%		75%	7%	92
Ages 65+**	8%	65%	18%	6%		73%	8%	49
Disabled**		71%	18%	9%		73%	9%	45

**Less than 100 respondents. **Less than 50 respondents.*
Breakdowns with less than 20 respondents not shown.

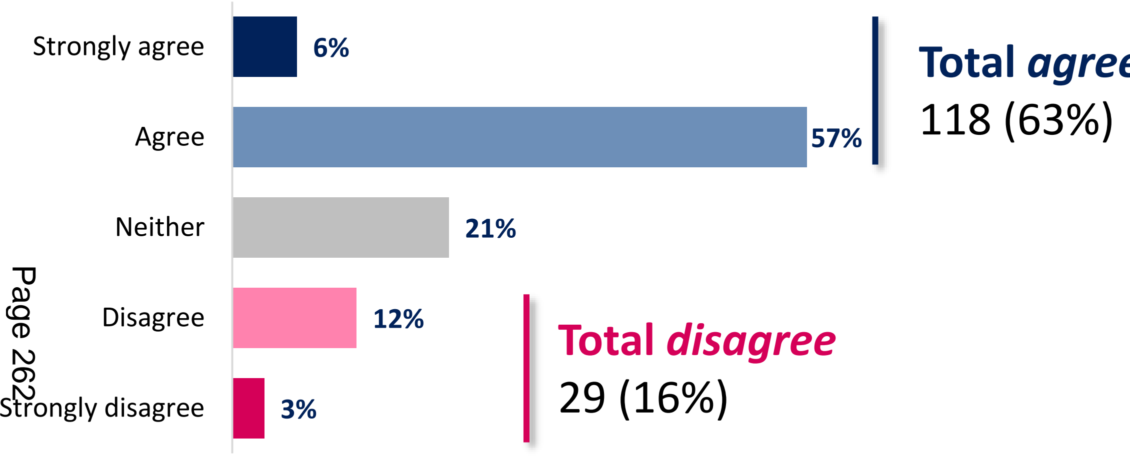
Key findings

- Majority of total respondents (74%) *agreed* (total sentiment) with the statement, including 10% total who *strongly agreed* and 64% total that *agreed*
- Female respondents responded total *agree* to the greatest extent (79%) and male respondents to the least extent (70%)
- Of breakdowns of 50 respondents or more, males responded total *disagree* to the greatest extent at 12% (8% points more than female at 4% total disagree)

Q17b To what extent do you agree or disagree with the following statement? *"The draft strategy provides sufficient information"*

Total respondents* | **187**

**This question was only asked of those who confirmed they had read the draft strategy in response to question 16 (194 of 256 respondents confirmed they had read at least some of the draft strategy).*



Total *agree*
118 (63%)

Total *disagree*
29 (16%)

Key findings

- Majority of respondents responded *agree* (63% total agree sentiment), and 57% total respondents also responded *agree* (as per scale option)
- More respondents responded *neither* (21%) than responded *disagree* (16%)
- Male respondents responded *disagree* (25%) to a greater extent than female (10%), while female respondents said *neither* (23%) in greater numbers than male (15%)

Breakdowns

	Strongly agree	Agree	Neither	Disagree	Strongly disagree	Total agree (%)	Total disagree (%)	Total (count)
As a resident of Southampton	5%	55%	22%	14%		61%	17%	146
Businesses & organisations**	10%	54%	20%	10%	7%	63%	17%	41
Female*	9%	57%	23%	9%		66%	10%	77
Male*		58%	15%	19%	6%	60%	25%	72
Ages 35 - 64*	4%	60%	16%	18%		65%	19%	91
Ages 65+**	6%	51%	26%	9%	9%	57%	17%	47
Disabled**		59%	25%	14%		59%	16%	44

**Less than 100 respondents. **Less than 50 respondents.*
Breakdowns with less than 20 respondents not shown.

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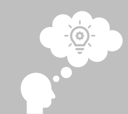
Q18 If there were parts of the strategy that you did not understand or you feel needed more information, please provide further details below *(free-text questions)*

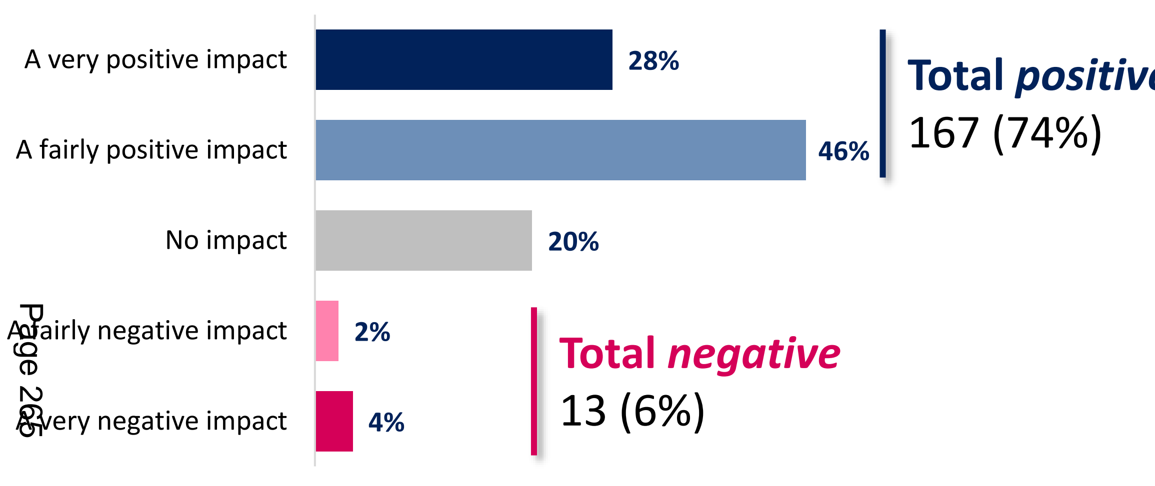


Response	Count
The strategy is too vague and needs more specifics around how aims will be achieved	36
Other - positive	4
Other - further suggestions/changes	1

Question 19| Potential impact of the draft strategy

Q19 If the draft strategy were to be implemented, what impact do you feel this may have on you, your family, your business, and/or the wider community?

Total respondents | 226



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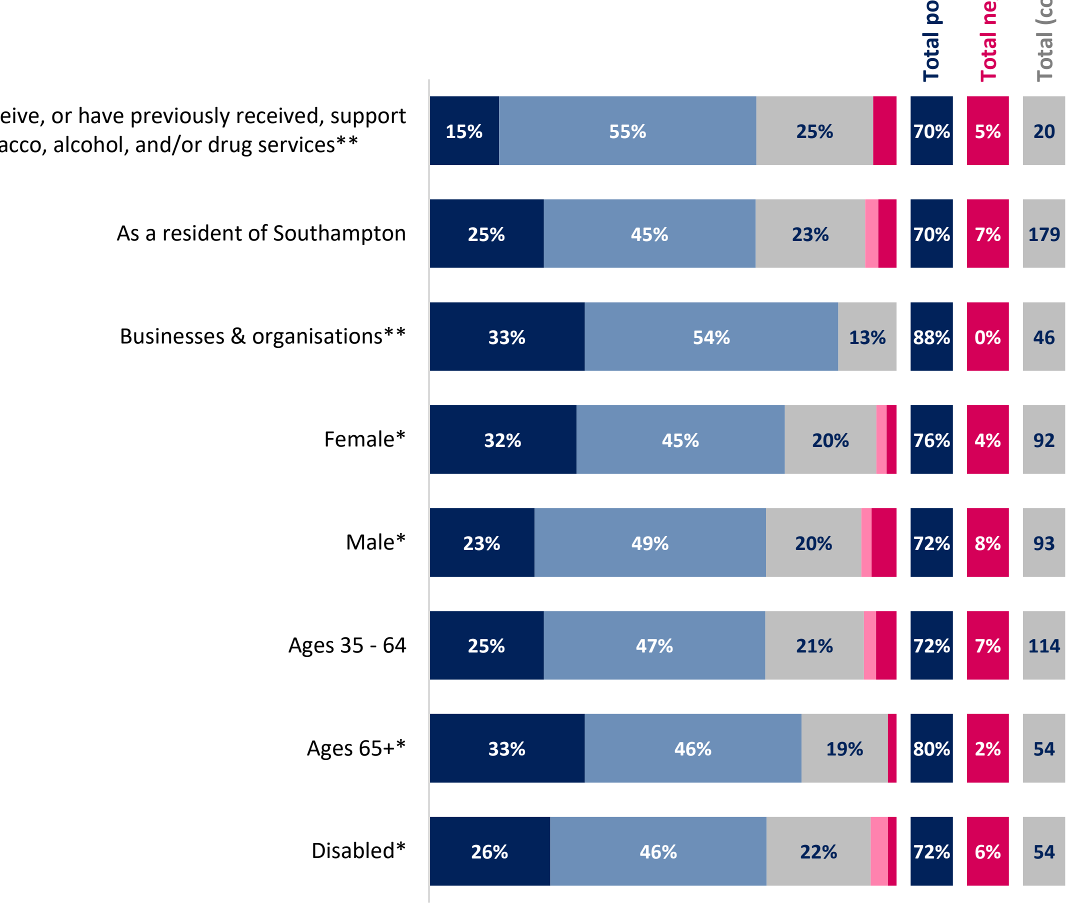
Key findings

- Majority of respondents responded *positively* (74%), with 46% responding *fairly positively*
- More respondents responded *no impact* than responded *negative* (20% and 6% respectively)
- Female respondents responded *very positively* to a greater extent than male by 9% points (32% and 23% respectively)
- Respondents aged between 35 and 64 responded *positive/negative* to a similar extent to males (72%/7% and 72%/8% respectively) and respondents that said that they were disabled (72%/6%)
- Respondents aged 65 or more responded *positively* to the greatest extent (80%)

Breakdowns



*Less than 100 respondents. **Less than 50 respondents.
Breakdowns with less than 20 respondents not shown.*

Q20 Please use the space below to tell us more about the potential impacts of the draft strategy, and if there is anything else we should consider or that you feel is missing from the proposals *(free-text questions)*

Response	Count
Reduce the supply/demand of/for TAD in the city	20
Improve/increase messaging/education to reduce TAD use	18
Comments that the strategy may not be effective i.e. due to experiences with previous policies/strategies	15
Comments critical of current TAD services generally	10
Marijuana should be legalised (inc. for medicinal purposes)	8
Focus on early intervention/prevention generally	7
Don't lose sight of those who may not recognise their need for support and/or otherwise may fall 'under the radar'	7
Ensure services are accessible, e.g. readily available and not prohibitively costly or online-only	6
There is a risk of TAD policies having a detrimental impact on civil liberties	6
Include plans for safe injection sites/drug consumption rooms	6
Support people with recovery outside of care with opportunities and development	6
It should be down to the individual to take responsibility for their own TAD use	6
Give support rather than punishment where appropriate	5
Address the use of vaping generally	4
Make the strategy document shorter and easier to read	3
Comments critical of the consultation process	3
Comments critical of current TAD services waiting times	2
There is a lack of focus on treatment for gambling addiction	2
Other - further suggestions/changes	9
Other - positive	3

Theme	Detail	Officer response	Actions proposed/taken
Quantitative feedback			
Vision & the Five Hs	All of the Five Hs of the vision had a majority total *agree* responses of between 81% and 87%. Of these, only *hope* and *health equality* did not also have a majority that responded *strongly agree* (48% and 49% respectively) – these had a slightly higher number of *neither* responses (13% and 11% - *help, harm reduction*, and *health promotion and prevention* had between 8% and 9% *neither* responses each). No element of the vision had more than 19% total *neither* and *disagree.*	No officer response required (positive consultation feedback where majority agreed with the statement).	None required
Focus	A majority of respondents *agreed* with the focus (80%) including 44% who *strongly agreed.* Men responded *strongly disagree* to a greater extent than women, at 7% to 0% respectively. This is reflected in 10% of male respondents responding	No officer response required (positive consultation feedback where majority agreed with the statement).	None required

Theme	Detail	Officer response	Actions proposed/taken
	disagree overall compared to 5% of female respondents. Again, those responding on behalf of a business or organisation responded *agree* to the greatest extent (87%), including 52% that *strongly agree* (though these numbers are lower than for the vision).		
Children & Learning Programme	Majority of respondents responded *positive* (86%). Though all three breakdowns have low base numbers, it is notable that among male respondents, respondents aged 65 or over, and those responding on behalf of a business or organisation, there were no *negative* responses, either *fairly* or *very negative.*	No officer response required (positive consultation feedback where majority agreed with the statement).	None required
Health & Adult Social Care Programme	Majority of respondents (86%) responded *positively.* No respondents that were either female or aged between 35 and 64 responded with a *negative* sentiment. No respondents responded with a *very negative impact* sentiment.	No officer response required (positive consultation feedback where majority agreed with the statement).	None required
Place Programme	Majority of respondents (83%) responded *positively.*	No officer response required (positive consultation feedback where majority agreed with the statement).	None required

Theme	Detail	Officer response	Actions proposed/taken
	Female respondents responded *very positively* (47%) to a greater extent than male (38%) by 9% points.		
Communities, Culture & Homes Programme	Majority of respondents responded *positively* (74%). Female respondents responded *no impact* to a greater extent (24%) than male respondents (15%) and respondents aged between 35 and 64 (16%).	No officer response required (positive consultation feedback where majority agreed with the statement).	None required
Corporate Programme	Majority responded *positively* (68%), however this is six percentage points less than the next programme, Communities, Culture & Homes (74%) and also received the least total responses (88) out of the five programme questions (responses ranging from 133 to 114).	Extra clarification has been sought, also incorporating feedback from Scrutiny Committee, regarding how Corporate contracts are monitored, to ensure compliance from our providers in this area where a commitment (around tobacco, alcohol and drugs) has been made. This will not be added into the strategy document itself but will be fed into later discussions on this programme of work with service leads.	None required
Understanding the strategy & additional information	Majority of total respondents (74%) *agreed* (total sentiment) with the statement ("the draft strategy is easy to understand"), including 10% total who *strongly agreed* and 64% total that *agreed.* Majority of respondents responded *agree* ("the draft strategy provides	No officer response required (positive consultation feedback where majority agreed with the statement).	None required

Theme	Detail	Officer response	Actions proposed/taken
	sufficient information") (63% total agree sentiment), and 57% total respondents also responded *agree* (as per scale option).		
Impact(s) of the strategy	Majority of respondents responded *positively* (74%), with 46% responding *fairly positively.* More respondents responded *no impact* than responded *negative* (20% and 6% respectively). Female respondents responded *very positively* to a greater extent than male by 9% points (32% and 23% respectively). Respondents aged between 35 and 64 responded *positive/negative* to a similar extent to males (72%/7% and 72%/8% respectively) and respondents that said that they were disabled (72%/6%). Respondents aged 65 or more responded *positively* to the greatest extent (80%).	No officer response required (positive consultation feedback where majority agreed with the statement).	None required

Qualitative feedback

Theme	Detail	Officer response	Actions proposed/taken
Adult Social Care Programme	Address underlying issues related to use of TAD (e.g. mental health and wellbeing) (22 comments)	We are aware of the – often complex – underlying causes leading to more significant (and problematic) tobacco, alcohol and drug use. This has already been well articulated in the strategy and in the Adult Social Care (ASC) programme of work (Programme 2). We consulted with ASC workers and Mental Health commissioners during the engagement phase, and early discussions are also underway, coordinated by our Public Health team, around future mental health and wellbeing plans and strategies for the city.	In order to better articulate some of this work, in response to this consultation feedback we have now added new wording into the 'key focus' section (in the Adult Social Care: Programme 2 section) section to reflect this, which reads: "Support council-wide work to address underlying issues related to the use of tobacco, alcohol and drugs, including work to improve population mental health and well-being."
	Ensure support for parents/families with TAD use problems (12 comments)	There are already a number of projects underway in this area to identify and address these issues, which include: • The Phoenix Project, a trauma-informed intensive support service aimed at women aged 18-44 who have had their children permanently removed from their care and remain at risk of repeat pregnancies and removals of subsequent children	These are articulated in the key priorities section of Programme 1: Children and Learning, so no changes required.

Theme	Detail	Officer response	Actions proposed/taken
		• The placement of young people's drug and alcohol workers in family hubs (currently being rolled out).	
	Make sure safe accommodation and/or residential support is available (6 comments)	As part of RSI (Rough Sleeper Initiative) work, the Housing First scheme is now being rolled out in the city. There are also Housing Support contracts via commissioning services that support people with their tenancies (more information on page 7 of this document).	Enhanced the existing text on commitments within housing to be clearer.
Children & Learning Programme	Focus on/measures to turn young people away from TAD/help them avoid TAD (24 comments)	The actions and priorities in this area that are within the scope of this strategy are well-articulated in the key priorities section in CYP section. However, our Children and Young People's Strategy 2022-2027 (and the eight action plans sat underneath it), as well as other relevant strategies such as the 'We Can Be Active' strategy on physical activity in the city, will cover other projects they are also undertaking in this area.	None required
	Address the use of vaping in young people (4 comments)	Work is already underway on this, but this feedback indicates that we need to articulate is more clearly within the strategy document itself.	We have added 'and e-cigarettes' into several Programme sections to emphasise that work to tackle tobacco use will also cover e-cigarettes/vapes too.
	More should be done to address child exploitation related to TAD (2 comments)	Work is already underway on this, but this feedback indicates that we need to articulate is more clearly within the strategy document itself.	We have added the line "Protect children from exploitation related to tobacco, alcohol and

Theme	Detail	Officer response	Actions proposed/taken
		Some other projects/related actions are also covered separately in the Safe City Partnership Strategy.	drugs" to the key focus section in Programme 1.
Communities, Culture & Homes Programme	Address underlying issues related to use of TAD (e.g. deprivation, homelessness) (20 comments)	As part of RSI (Rough Sleeper Initiative) work, the Housing First scheme is now being rolled out in the city. This has been commissioned on a five-year contract. There are also long-standing Housing Support contracts via commissioning services that support people with their tenancies, one of which is specifically an alcohol accommodation support service for those with SUD's. In addition, some RSI funding is allocated to fund a mental health worker that will sit within the Housing team, and we have a Homeless Healthcare service that works on underlying health issues for homeless service users. Within that service there is dedicated mental health support to the homeless population.	Enhanced the existing text on commitments within housing to be clearer, to now read: "Support housing staff with training and optimise housing policies to support residents to live in smokefree accommodation, engage in alcohol and/or drug treatment and sustain recovery."
	Ensure services promote equality and accommodate and represent communities (14 comments)	This is already a running theme throughout the document and is also mentioned explicitly within the Adults section. In addition, the Equality and Safety Impact Assessment (ESIA) document compiled to accompany the draft strategy, specifically examines any anticipated negative impacts (and potential mitigations) of the strategy on those with protected characteristics under equality laws.	None required.

Theme	Detail	Officer response	Actions proposed/taken
	More targeted policing/enforcement of TAD-related crimes and policies (12 comments)	This issue falls under the Safe City Strategy and Partnership which works more on enforcement related issues. This strategy is a more public health-focused document. However, this could be articulated slightly more in the document.	We have added a line in the strategy document to better articulate the collaborative approach with (and specific work of) the Safe City Strategy and Partnership on this topic.
	General concerns about safety in Southampton (3 comments)	See above comment.	See above comment.
	Address TAD and related crime issues associated with prostitution around Empress Road (2 comments)	See above comment.	See above comment.
	Recommendations of a 'homes first' policy to address the underlying causes of TAD-related issues (2 comments)	As mentioned earlier in this document, as part of RSI (Rough Sleeper Initiative) work, the Housing First scheme is being rolled out in the city.	None required
Place Programme	Ban/reduce TAD use in public spaces (13 comments)	This has already been covered in the Programme: Place section.	None required
	Ensure employers are supportive and/or not discriminatory (4 comments)	The strategy already articulates clearly what we will aim to do both as an employer and organisation ourselves, but also through those we contract out to provide services too. We would hope that other employers follow the same model but recognise that we have no direct ability to influence this.	None required
	Make sure there are still designated areas for smokers (3 comments)	Current smoke-free legislation is designed to keep enclosed spaces smoke-free, but do not apply to outside spaces where people can still choose to	None required

Theme	Detail	Officer response	Actions proposed/taken
		smoke. We therefore do not feel there is any adjustment needed to the strategy relating to these comments.	
	General concerns about place in Southampton (2 comments)	No officer response required (general comments about the city centre, not within the scope of this strategy).	None required
Vision & focus	General positive comments on the strategy/vision (27 comments)	No officer response required (positive agreements/comments).	None required
	Make sure services are appropriately resourced/staffed (25 comments)	Additional information added in to clarify both the resources available and the limitations on what can be committed to at this time.	Additional information added: "The pace and scale of the implementation of this strategy will depend on resources available. For example, Southampton has been awarded additional funding to improve the capacity and quality of drug treatment services as part of the new national Drug Strategy, published December 2021. The funding is for 3 years, from 2022/23 to 2024/25, subject to annual approval by HM Treasury."

Theme	Detail	Officer response	Actions proposed/taken
	Ensure a connected approach and co-ordination between services, e.g. the police, social care, the NHS (19 comments)	This is something that the new Reducing Drug Harm Partnership (RDHP) will be key in facilitating. We have added some information on this into the strategy.	Additional information added to the 'Developing and writing this strategy' section as follows: "…newly convened Reducing Drug Harm Partnership, set up to oversee the implementation of the National Drug Strategy, brings together key leaders including Police, Probation, Public Health, Primary Care, University Hospital Southampton, Mental Health Services and Southampton City Council".
	Resource should be prioritised to where it will be most effective - desire/willingness/ability to change should be prioritised over need (9 comments)	This is something that is articulated early-on in the strategy (in the 'Our strategy to achieve this vision' section) with the reference to 'proportionate universalism', directing resource to where it is needed the most. This is also emphasised within our '5 H's' of the strategy, particularly 'Hope' (emphasising that change is possible), and 'Harm reduction' (recognising that not everybody will want to stop and taking a non-judgmental and individualised approach which also	None required

Theme	Detail	Officer response	Actions proposed/taken
		recognises the value of harm reduction support to individuals).	
	The means of targeting support should be improved (2 comments)	We are regularly working with frontline teams and other internal and external stakeholders to find new and improved ways of targeting support to those who need it.	None required
Additional information & understanding	The strategy is too vague and needs more specifics around how aims will be achieved (36 comments)	Specific targets and actions will be agreed within individual directorates, and set out in their own action plans for the strategy sections relevant to their portfolio. Directorates will begin discussions around action plans once the final strategy has been agreed and is in place.	To be considered when action plans are discussed within each programme of work.
Impact(s) & additional suggestions	Reduce the supply/demand of/for TAD in the city (20 comments)	This is something that is articulated already within the Safe City Strategy which was finalised and approved in March 2022, and as such does not fall within the scope of this strategy.	None required
	Improve/increase messaging/education to reduce TAD use (18 comments)	Vape messaging is currently being reviewed, and there is already a commitment in the Programme section for Children & Learning to "Review and strengthen prevention and early intervention work in 0-25 education settings". We would need this review to be complete and to understand what changes were needed before doing this.	Reviews already either underway or in the pipeline.
	Comments that the strategy may not be effective i.e. due to experiences with previous policies/strategies (15 comments)	Specific targets and actions will be agreed within individual directorates, and set out in their own action plans for the strategy sections relevant to their portfolio. Directorates will begin discussions around action plans once the final strategy has been agreed and is in place. The strategy will also be overseen and monitored by the Health and Wellbeing Board, and	To be discussed when KPIs and action plans are formalised within each directorate's programme of work.

Theme	Detail	Officer response	Actions proposed/taken
		annual updates given against key KPI's to track progress.	
	Comments critical of current TAD services generally (10 comments)	A number of comments highlighted that mention of and awareness of neurodiversity in service provision needed to be improved in the strategy document. This has been done. Any individual comments that raise concerns about an individual experience of frontline services will be looked at within the teams directly.	Neurodiversity has now been added into sections of the strategy where relevant.
	Marijuana should be legalised (inc. for medicinal purposes) (8 comments)	The council must design policies and projects whilst being mindful of any restrictions that exist within current UK laws. This proposal would be in contravention of the Misuse of Drugs Act.	None required
	Focus on early intervention/prevention generally (7 comments)	This is already covered extensively in the strategy both through our 4th 'H' ("Health promotion and prevention), as well as in the Children and Learning Programme of work where early intervention and prevention is a key element.	None required
	Don't lose sight of those who may not recognise their need for support and/or otherwise may fall 'under the radar' (7 comments)	See above comment – this falls under the early intervention and prevention section which is well articulated within the strategy.	None required
	Ensure services are accessible, e.g. readily available and not prohibitively costly or online-only (6 comments)	In relation to drug and alcohol service provision, current Substance use Disorder Services (SUDS) are free, confidential and open access, this means that anyone can be referred or refer themselves. Every person presenting to SUDS will receive a triage/ assessment and be offered appropriate advice, treatment and support, according to risk and need.	None required

Theme	Detail	Officer response	Actions proposed/taken
		Support is delivered face-to-face, in the main, although on-line and telephone support is available. In relation to tobacco services, there is a universal stop smoking offer at some pharmacies with free behavioural support & NRT, and we are seeking to increase this offer across the city.	
	There is a risk of TAD policies having a detrimental impact on civil liberties (6 comments)	We recognise the importance of personal choice in public health approaches. These of course need to be balanced with ensuring people are informed of the risks on which to make those choices, and the educational elements of the strategy focus on addressing this need for further education and awareness.	None required
	Include plans for safe injection sites/drug consumption rooms (6 comments)	We recognise that there is strong international evidence for overdose prevention facilities, sometimes known as drug consumption rooms or safer injecting facilities. SCC must act within the constraints of the Misuse of Drugs Act, which, currently prohibits the development of these interventions. Our strategy commits us, however, to *"**Advocate** for evidence-based tobacco, alcohol and drugs practice and policy regionally and nationally, for example there is strong international evidence for overdose prevention facilities".*	None required
	Support people with recovery outside of care with opportunities and development (6 comments)	Supporting visible recovery communities is a key focus of our new strategy, we will be working with our commissioned drug and alcohol treatment providers to ensure this ambition is met.	None required

Theme	Detail	Officer response	Actions proposed/taken
		Please see the section "**Visible recovery communities** – this means people celebrating either being tobacco, alcohol and drug free or being more in control of their use. This boosts self-esteem and enables people to support each other. It will inspire others to get help and reduce the stigma many people feel and prevents them from seeking help. We do not yet have the peer support in Southampton that some cities have but aspire to grow this and create a vibrant recovery community for the city.	
	It should be down to the individual to take responsibility for their own TAD use (6 comments)	This has already been articulated well in the strategy as follows: *"For many people with tobacco, alcohol and drug dependence and higher-risk use, their use is not simply a choice. It is a symptom of other problems, such as mental ill health, abuse, grief, loss and other trauma. These same difficulties can also make it very difficult to limit, reduce or stop using, without help, and sometimes even with help."* Our TAD strategy seeks to help people make informed choices to lead healthier and happier lives, free from the harms caused by TAD, and to support people, with TAD dependence to achieve recovery.	None required
	Give support rather than punishment where appropriate (5 comments)	This strategy, and our work with commissioned Substance Use Disorder Services, seeks to divert people from drug and Alcohol driven criminality into treatment and support.	None required

Theme	Detail	Officer response	Actions proposed/taken
		Laws around substances and general sentencing guidelines are a national policy decision. We need to operate within the law.	
	Address the use of vaping generally (4 comments)	We had added in additional references to e-cigarettes/vapes in the strategy document to reflect this feedback. A review of the communications around vaping is already underway.	Amended in strategy and vape review underway
	Make the strategy document shorter and easier to read (3 comments)	As this is a combined strategy, there's a limit to how short we can make it without compromising on the detail needed to understand three complex and interlinked areas.	None required
	Comments critical of the consultation process (3 comments)	A number of comments felt that the consultation process was an unnecessary use of local government resource. As a local government authority, we have a duty to consult residents and stakeholders in the city on certain decisions and strategy/policy documents, and we must operate within these requirements.	None required
	Comments critical of current TAD services waiting times (2 comments)	Our Substance Use Disorder Services consistently meet all waiting time targets. The National Target is "people engaging in treatment with SUDS for opiate and non-opiate use should wait less than 3 weeks from assessment to access their 1st intervention". In 2020 –21 this target was met 100% in Southampton. Our local targets: 1. People who use drugs and/or alcohol are offered a triage/initial assessment within 2 working days of referral a. 100% Q1 & Q2 2022/23	None required

Theme	Detail	Officer response	Actions proposed/taken
		2. First clinical interventions are in place within 5 working days following the comprehensive assessment a. 100% Q1 & Q2 2022/23 In relation to stop smoking waiting times, because there are lots of providers for stop smoking support the waiting times can be more complicated to compile. However, we are continually seeking to reduce waiting times to a minimum.	
	There should be more mention of harmful use of prescription drugs (1 comment)	Whilst there is a notable focus on illicit drugs in the strategy, we do know that people can also experience harms from prescribed drugs too and this is something we, and frontline services, are continuing work on. Substance Use Disorder Services (SUDS) do have ongoing work with the pain team at the hospital and collaborative approaches are in place between those services to support clinicians in Primary and Secondary Care. There is already a reference to illicit use of prescribed drugs in the adult priorities section. However, we have added another reference in for clarity on the remit of this strategy.	We have added a reference to illicit prescription drugs in the 'Our strategy to achieve this vision' section. It now reads that our work will be across 'All types of tobacco, alcohol and illicit drugs, including shisha, cannabis, illicit use of prescription drugs and more'.
	There is a lack of focus on treatment for gambling addiction (2 comments)	A number of comments have already expressed concerns that the strategy document is too long, in part because it was important to ensure this strategy gave ample consideration for each of tobacco, alcohol and drugs. It was therefore felt that adding another area of work into the document would have further lengthened the document.	None required

Theme	Detail	Officer response	Actions proposed/taken
		The links between gambling and tobacco, alcohol and drug addictions are also currently not as strong/established as the links within/between tobacco, alcohol and drugs themselves. Effective parameters for the strategy had to be set and it was felt that it was not the right time to include gambling within the scope of this strategy. In terms of licensing and premises guidance, the SCC Gambling Statement of Principles was renewed earlier this year and remains in place until 2025.	

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