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Health and Wellbeing Board

Wednesday, 13th March, 2024
at 5.30 pm

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Finn (Chair)

Councillor Fielker

Councillor Kenny

Councillor P Baillie

Councillor Houghton

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 (DCS)

Claire Edgar – Executive Director Wellbeing and Housing (DASS)

Rob Kurn – Healthwatch

Dr Sarah Young - NHS Southampton Clinical Commissioning Group, (Vice Chair)

Vacancy – Mental Health Clinician

Dr Michael Roe – Local Paediatrician

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

Contacts
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Democratic Support Officer
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BACKGROUND AND RELEVANT INFORMATION

Purpose of the Board

The purpose of the Southampton Health and Wellbeing Board is:

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

Southampton: Corporate Plan 2022-2030 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

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.

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 2023/2024

13 September 2023
13 December 2023
13 March 2024

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 Panel made in accordance with Council Procedure Rule 4.3.

2 STATEMENT FROM THE CHAIR

3 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

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

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

4 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 13 December 2023 and to deal with any matters arising, attached.

5 HEALTH IN ALL POLICIES

Report of the Cabinet Member for Adults & Health outlining progress in delivering Health in all Policies

6 MENTAL HEALTH & WELLBEING STRATEGY

Report of the Cabinet Member for Adults & Health outlining the new Mental Health & Wellbeing Strategy for Southampton.

7 ROUTINE CHILDHOOD IMMUNISATIONS - STRENGTHS AND NEEDS ANALYSIS

Report of the Cabinet Member for Adults & Health outlining childhood immunisation uptake rates and feedback from providers and parents in order to improve uptake.

8 TOBACCO, ALCOHOL AND DRUG STRATEGY UPDATE

Report of the Cabinet Member for Adults and Heath outlining delivery of the Tobacco, Alcohol and Drug Strategy

Tuesday, 5 March 2024 Director – Legal and Governance

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 13 DECEMBER 2023

Present: Councillors Fielker (Chair), Finn and Houghton
Debbie Chase, Robert Henderson, James House, Dr Michael Roe and Suki Sitaram

Apologies: Councillors Kenny, P Baillie, also Claire Edgar, Rob Kurn, Paul Grundy Young, Grundy, Edgar, Kenny and Johnson

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

The apologies of Councillor P Baillie, Councillor Kenny, Councillor Winning, Natalie Johnson, Rob Kurn, Dr Sarah Young, Clare Edgar, Robin Poole and Paul Grundy were noted.

The Board noted that Rob Kurn had arranged for Suki Sitaram, Chair of Healthwatch; and that Paul Grundy had arranged for Dr Trevor Smith to attend the meeting as their representatives for the purposes of this meeting.

The Board also noted that Dr Hannah Burgess was no longer in post and therefore there was a vacancy for a mental health services representative on the Board.

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

RESOLVED: that the minutes for the Panel meeting on 13 September 2023 be approved and signed as a correct record.

8. **DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2023-24**

The Board considered the Annual Director of Public Health Report 2022-23 which detailed the importance of good work and fair employment for individual and population health.

The Board noted that the reports focus on workplace health and wellbeing and good work aligned with the Southampton Joint Health and Wellbeing Strategy (2017-2025) and the Health In All Polices approach as approved by Council and set out in the Southampton City Council Corporate Plan 2022-30

The Board noted that the health foundation had set out targets that could be utilised to help measure progress on the recommendations from the report.

The Board noted that the number of young people in Southampton who were Not in Education, Employment or Training (NEET) were higher than average and the factors that affected this would be the number of children who were in care or had Special Educational Needs and Disability or involved in youth offending behaviour.

The Board noted that positive action had been achieved across the recommendations made in the Annual Director of Public Health Report from 2022.

RESOLVED: that Board members would consider how the report's recommendations can be implemented in their respective organisation as Anchor Institutions and key employers in the city.

9. **HEALTH PROTECTION ANNUAL REPORT**

The Board received and noted the Health Protection Annual Report which provided assurance on behalf of the Director of Public Health and the Health and Wellbeing Board in respect of deliver of the local health protection function in Southampton

The Board noted that the Health Protection Board was a key mechanism for facilitating partnership working. The Health Protection Board had captured learning from the COVID response and found that partnership working in Southampton was particularly strong and the quality of communications regarding rapid changes in national or regional strategy was one of the biggest challenges for the delivery of the local response to the pandemic. Southampton City Council's Health Protection Team had supported numerous incidents, situations and enquiries over the last twelve months including the COVID enquiry. The Board noted that the Southampton Health Protection Dashboard was very useful.

10. **UPDATE ON JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) AND OUTCOMES OF THE HEALTH & WELLBEING STRATEGY 2017-2025**

The Board considered the report of the Cabinet Member Adults, Health and Housing which provided an update on the Southampton Health and Wellbeing Strategy (HWBS) indicators and the most recent year's work programme of the Joint Strategic Needs Assessment (JSNA).

Vicky Toomey, Senior Strategic Intelligence Analyst. Intelligence, Innovation & Change, Southampton City Council; was present and with the consent of the Chair addressed the Board.

The Board noted that the 2021 Census data was published this year which has helped to provide up-to-date information on the city population, although it was noted that the Covid pandemic may have skewed the data on home carers and there was less data on the student population as the Census was taken when students had returned home for the Easter break.

The Board also noted that outcomes achieved to date included the development of the Tobacco, Alcohol and Drug Strategy; the smoke free and vaping strategy and a mental health strategy is planned to be published in 2024.

The Board noted that monitoring and analysis of the HWBS and the JSNA would be utilised to identify new priorities for the next strategy when the current strategy term ends in 2025. It was also noted that oral health was a priority issue for Healthwatch however, dentistry had not been included in the strategy due to the challenges of obtaining data on this issue.

RESOLVED: that consideration would be given to the availability of data on dentistry and oral health in the city and the inclusion of this topic in the JSNA and consideration for inclusion in the next HWBS strategy

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DECISION-MAKER:	Health and Wellbeing Board
SUBJECT:	Health in All Policies: the next phase approach and framework to reduce health inequalities in Southampton
DATE OF DECISION:	13 March 2024
REPORT OF:	**COUNCILLOR MARIE FINN** **CABINET MEMBER FOR ADULTS & HEALTH**

CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY
N/a

BRIEF SUMMARY

In March 2023, the Health and Wellbeing Board agreed to further develop a Health In all Policies (HiAP) approach at Southampton City Council (SCC). This being subsequent to the SCC commitment for HiAP, as part of the Health and Wellbeing Strategy 2017-25 at the council meeting of 15 March 2017. This paper:

1. Recaps the definition, approach and framework agreed by the Board,
2. Summarises the progress made during Phase One of the project and
3. Presents options for the focus of Phase Two for discussion and agreement by the Board.

RECOMMENDATIONS:

	(i)	Notes the **progress** made to date in framing, developing toolkits and resources, collecting case studies and supporting progress in defined priority areas across the three pillars of the agreed framework for HiAP: • ***Processes:*** development of tools and resources, advice for improvements in equality and safety impact assessment in SCC and engagement and advice in processes to maximise social value and net health gain from procurement or development activities • ***Programmes:*** the food environment, planning for health, inclusion of employee health and wellbeing in wider business support and active travel • ***Strategic joint action:*** including a HiAP approach within the tobacco alcohol and drug strategy, ongoing evidence and needs informed decision making within strategy development. This also includes Hampshire and Isle of

		Wight level leadership to improve the impact of Health Anchors on health and wellbeing, particularly as employers.
	(ii)	Commits to **embedding** a HiAP approach more widely within SCC and partner organisations to deliver continued focus on the 'building blocks for good health' (see 1.2). This includes ongoing monitoring and evaluation of the impact of Phase One activities
	(iii)	Follows a **moderate approach** for Phase Two of the programme (see report for details)**,** with Board members providing supportive leadership to champion HiAP within their organisations and teams. Supports and guides **enablers for Phase Two**, including wider visibility and leadership to enact HiAP (processes, programmes and strategic joint action) across activities in the city, increased focus on evaluation and evidence of impact and supporting cross-team working to identify and realise wider opportunities in decision making. This includes overcoming barriers to embedding HiAP within Board members' teams and networks.
	(iv)	Supports and guides **enablers for Phase Two**, including wider visibility and leadership to enact HiAP (processes, programmes and strategic joint action) across activities in the city, increased focus on evaluation and evidence of impact and supporting cross-team working to identify and realise wider opportunities in decision making. This includes overcoming barriers to embedding HiAP within Board members' teams and networks.
	(v)	Supports opportunities arising from the alignment between HiAP and: • The Health Determinants Research Collaborative (HDRC) Southampton ambition to support and enable better evidence informed decision making and evaluation of impact of decisions including health considerations in Phase One and Two. • Action to embed sustainability in all policies, as reducing health inequalities requires action to create healthy and sustainable places and communities, with common policy actions supporting both (e.g. active travel, green spaces, the food environment, transport and energy efficient housing).
REASONS FOR REPORT RECOMMENDATIONS		
	The specific proposals have been developed with increasingly limited capacity in mind, following last year's agreement to review the scale of activity at the end of the first phase of work.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
	Alternative approaches considered and rejected include: • No longer considering health within processes, strategy and programme activities (missing the opportunity to harness additional positive impact for Southampton residents from scheduled work and failing to deliver Health and Wellbeing Strategy principles and commitments). • Taking a more intensive approach towards implementing HiAP in the City, such as becoming a Marmot or WHO Healthy City, at this stage (presenting significant resource implications).	

DETAIL (Including consultation carried out)	
1.	**Background**
1.1	As agreed by the Board in March 2023, the SCC Public Health team has been leading the first phase of a programme of work to develop and implement a Health in All Policies (HiAP) approach, with focussed delivery in Phase One. A HiAP approach aims to ***"systematically take into account the health implications of decisions, seek synergies and avoid harmful health impacts in order to improve population health and health equity"***[1]. The approach is a key principle for implementation of the Health and Wellbeing Strategy and has also been echoed in commitments of the SCC Corporate Plan and Southampton's Health and Care Strategy.
1.2	There can be a tendency to think of people's health as only individual (for example caused only by their genes or their 'innate healthiness', what they eat, how much they exercise, how easy it is to access the healthcare they need) but a large part of what makes us healthy is related to the options presented by our circumstances such as our jobs, homes, education and surroundings. These are the building blocks of health[2] and the drive behind our HiAP work. When some of the building blocks are not in place or are in bad shape, for example through poor housing, social isolation or financial worry, it puts a strain on our bodies. This can result in increased stress, high blood pressure, and a weaker immune system for example[3]. This framing has been used to engage with SCC teams and colleagues on the importance of considering health in their policies, programmes and strategic joint action.
1.3	Local authorities make a significant impact on health and wellbeing, health inequalities, and ill-health prevention, just by virtue of the type of work that they do (Figure 1). They have the power to design, deliver and invest in the things that keep people healthy – the building blocks of health. A HiAP approach focuses and amplifies this impact by making collaboration and consideration of health the default way of working.

[1] World Health Organisation 'Health in all policies: training manual' June 2015 https://www.who.int/publications/i/item/9789241507981

[2] https://www.health.org.uk/publications/how-to-talk-about-the-building-blocks-of-health

[3] E.g. Guidi et al (2021), 'Allostatic load and its impact on health: a systematic review', Psychotherapy and Psychosomatics. 2021; 90(1), https://karger.com/pps/article/90/1/11/294736/Allostatic-Load-and-Its-Impact-on-Health-A

or The Health Foundation (2019), 'Allostatic load: how stress in childhood affects life-course health outcomes', https://www.health.org.uk/publications/allostatic-load

	 **Figure 1: How local government impacts health and wellbeing, Local Government Association, 2020[4]**
1.4	As set out in the March 2023 paper to the Health and Wellbeing Board[5], good health and health equity support realisation of aspirations for economic prosperity and opportunity for all. In a virtuous circle, this economic growth and opportunity in turn can improve population health and reduce inequality, hence the importance that is placed on considering health within wider policies across the City.
2.	**Progress towards Health in All Policies**
2.1	Activity to implement HiAP launched in April 2023. This included project planning, stakeholder mapping, engagement with teams working on the priorities agreed by the Health and Wellbeing Board (paragraphs 20-24 of the March 2023 HWBB paper) and development of a Logic Model to show how the project's resources and activities would translate into deliverables and outcomes (see Appendix 1).
2.2	As proposed in March 2023, the overall **framework** for embedding a HiAP approach at SCC comprised of focussed action in three areas: • ***Processes***: developing new mechanisms to improve collaborative working towards better health; • ***Programmes***: developing a particular service or programme by focusing on collaborative working to address health impacts; • ***Strategic joint action***: influencing over-arching strategic factors or initiatives that also impact on health.
2.3	**Case studies** have been collected and form part of the wider resources to illustrate what HiAP looks like and support wider action. Partners across SCC were engaged to understand the extent to which they already considered and

[4] Social determinants of health and the role of local government

[5] https://www.southampton.gov.uk/modernGov/documents/s60500/Health%20in%20All%20Policies%20the%20next%20phase%20approach%20and%20framework%20to%20reduce%20health%20inequalities%20in%20South.pdf

	acted on the effect of projects or policies on health in the three framework areas. This highlighted areas of good practice and case studies, for example many aspects of transport policy and its programmes were already well-informed by the mutual benefits of good travel systems for health and vice versa. Other case studies include collaboration towards health inclusion in the Local Plan, planning applications, the biodiversity and climate change strategies, the whole systems approach to childhood obesity and the Tobacco Alcohol and Drug Strategy.
2.4	During 2022-23, the SCC Sustainability team made good progress in influencing staff across the council to think about the impact of their work and policies on the environment, climate change and sustainability. Aiming to learn from their approach, collaborate and make efficiencies, workstreams were combined where appropriate.
2.5	**Progress has been made in developing PROCESSES that support HiAP including:** • Development of a suite of resources for SCC staff (a Sharepoint hub) with next steps to include external web resources to - Explain HiAP, including narrative on the importance of the 'building blocks of health' and aims of HiAP. - Provide a practical guide to implementing a HiAP approach within teams and/or projects. - Inspire through case studies describing where HiAP has already been implemented at SCC. - Guide on how to collect and use data/evidence to inform decision-making. • Provide further detail, tools and resources for staff with an interest and/or opportunity to embed health in their work.A review of best practice and advice to strengthen how health and wellbeing are considered as part of the SCC Equality and Safety Impact Assessment (ESIA) including - Review of other local authorities' impact assessment processes and consideration of best practice. - Review of SCC ESIA and proposal of associated health impact guidance. • Provision of support advice in work to maximise social value and net health gain from procurement or development activities, including preparation for Health Impact Assessments following the new Local Plan and SCC processes to maximise social value.
2.6	**Progress has been made through PROGRAMMES that support HiAP including:** • Enhancing the consideration of health in planning and development, in particular incorporation of health considerations into the draft Local Plan. This work has been led by the jointly appointed Spatial Planning for Health Specialist. • Progressing a programme of work to improve the food environment to - Launch a programme of work to create a healthier, sustainable food environment with the aim of reducing the prevalence of overweight or obesity (in collaboration with colleagues across the council, the University of Southampton and the wider city system).

	- Assess the availability and affordability of healthy food by sampling food retail stores in district and local centres across the city to better understand our local food environment. - Complete whole system research and progress in strategic engagement towards adopting a Whole Systems Approach to address the drivers of childhood obesity. - Launch a Food Insecurity Task and Finish group to support partners working with communities at risk of food insecurity (aligned to the Council's wider Cost of Living work). • Activities to improve health through work and employment with - The Director of Public Health Annual Report for 2022-23 focusing on workplace health and wellbeing and the importance of good work for health. Drawing on economic development evidence, it included challenges to local employers and was disseminated widely through promotional communications across the city. - Delivery of health and inclusion activities within SCC, including input of health intelligence and evidence-based resources to support scaled impact for SCC employees. - Development of new resources and support for employers in the city with the SCC business support team, including the creation of workplace health content for the new Solent Business and Skills Solution training platform. • Identification of good practice and input to social value opportunities with transport teams.
2.7	**Progress has been made through STRATEGIC JOINT ACTION that supports HiAP including:** • Continued application of a HiAP approach in implementation of the tobacco, alcohol and drugs strategy, with engagement across all Directorates of the council. • Wider engagement across SCC Directorates and partner agencies to increase understanding of the building blocks for good health, opportunities to influence these through core business and therefore the strengths of considering health within their work. • Ongoing evidence and needs informed decision making within strategy development to benefit health and health inequalities in Southampton, including the Homelessness and Rough Sleeping Strategy 2024-29, Mental Health and Wellbeing Strategy, Domestic Abuse and Violence Against Women and Girls Strategy 2023-28, Climate Change Strategy and Biodiversity Strategy. • Hampshire and Isle of Wight Integrated Care Board (ICB) leadership to improve the impact of Health Anchors on health and wellbeing, particularly as employers. At present, this is exploring opportunities for a local Health Anchors Network and mobilising work to focus on Anchors as employers, with the ICB strategy team coordinating action across the NHS to widen participation in health and care apprenticeships, alongside development of a work and health partnership.
3.	**Where could Health in All Polices go next?**

3.1	Phase One has made progress in discrete areas of work and in development of tools and resources to support wider HiAP activities. Progress in Phase One suggests that scaling and embedding this in Southampton requires **wider visibility and leadership** to enact HiAP (processes, programmes and strategic joint action) and high-level support to guide **further cross-team working** in order to identify and realise wider opportunities in decision making. The importance of an increased focus on **evaluation and evidence of the impact** of decisions has also been identified, with clear link into Southampton's Health Determinants Research Collaboration (HDRC) focus on evidence informed decision making.
3.2	Now that HiAP is entering its second year, it is useful to take stock and review collective ambition and scope. As an approach that aims to "*systematically take into account the health implications of decisions, seek synergies and avoid harmful health impacts in order to improve population health and health equity*", better, more evidence-informed decision making is the ultimate aim of the programme but the scale of ambition for this can vary considerably when working alongside multiple completing priorities. This paper outlines three potential scenarios for the next phase of work, with detail informed by known models in operation in other Local Authorities, applicability to the Southampton context and capacity for delivery: A Light-touch B Moderate C Fully engaged
3.3	**Option A: Light-touch** In this scenario, the instances where a HiAP approach can be implemented are opportunistic. Using the resources and promotional material delivered in Phase One, individuals, teams and directorates are aware of the HiAP rationale, the corporate commitment and the support that is available. There are few structural components or mechanisms to require consideration of health (limited to equality and safety impact assessment and other standard tools). Opportunities to highlight and address health and sustainability impacts are identified and supported ad hoc. ***Benefits and opportunities:*** • Ready for immediate implementation (tools and resources in place). • Offers potential to impact on health and health inequalities through existing projects and strategic joint action. • Limited capacity required from wider teams and project support. • Can be kept under review informally or through a regular update on progress to the Board. ***Limitations and risks:*** • With focus on opportunistic instances and less emphasis on co-ordination of agendas and collaborative working across teams, may have limited impact on many of the building blocks for good health. ***Requirements:***

	• Ongoing support from public health to keep tools and resources up to date. • Alignment with HDRC to evidence impact of decisions considering health.
3.6	**Option B: Moderate approach** A moderate approach to HiAP builds on Option A but within directorates and organisations there is leadership and strategic alignment to secure commitment to HiAP principles. Agreed processes and/or management tools across teams scale consideration of health in decision making (be it processes, programmes or strategic joint action), including collaboration across teams. Decision making includes explicit consideration of health impacts when developing new policies or services. Outside SCC, partners are actively engaged in strategic joint action to improve health and reduce inequalities and adapt their own ways of working (as anchor institutions) in the key five areas in order to: 1. Widen access to good work 2. Work closely with partners across a place 3. Purchase locally and for social benefit 4. Use buildings and spaces to support communities 5. Reduce environmental impact ***Benefits and opportunities:*** • Leadership, commitment and processes across Directorates reduces the need for project work and central coordination. • Can be implemented in the short to medium-term. • More effective and evidenced collaboration and consideration of health impacts, supporting elected members and other decision makers to identify where HiAP has been considered to inform decision making. ***Limitations and risks:*** • Requires leadership across directorates and organisations. ***Requirements:*** • Ongoing support from public health to keep tools and resources up to date. • Leadership across directorates and partner organisations. • Clear processes to support rapid and efficient collaboration. • Alignment with HDRC Southampton to evidence impact of decisions considering health.
3.7	**Option C: Fully engaged** With a fully engaged scenario, Southampton embarks on a systematic programme of work aligned to a national or international programme. It is a high-profile and profound collaborative movement with population health and sustainability goals as the focal point of all council action. Depending on the Board's preference it may invoke adoption of national or international

	programmes of work such as 'Marmot city'[6] or WHO European Healthy Cities[7], or model other regions' or countries' approaches towards improving health equity and better decision-making (e.g. Wales' independent Commissioner for Future Generations[8], or Lancashire and Cumbria Health Equity Commission[9]). ***Benefits and opportunities:*** • Significant opportunity to drive improvement in health and wellbeing outcomes and reduce health inequalities through high profile collaboration. • Moves beyond HiAP to an externally supported framework of action. ***Limitations and risks:*** • Lack of sustainable capacity to deliver change on this scale at the present time undermines longer term progress in delivering wider health outcomes and reducing inequalities. • May have a longer lead-in time to deliver change and embed new ways of working if opportunistic work ceases. ***Requirements:*** • Potential investment in adoption of national or international programmes. • Leadership across directorates and partner organisations.
4.	**Recommendations and decisions**
(i)	That the Board notes the **progress** made to date in framing, developing toolkits and resources, collecting case studies and supporting progress in defined priority areas across the three pillars of the agreed framework for HiAP: • ***Processes:*** development of tools and resources, advise for improvements in equality and safety impact assessment in SCC and engagement and advice in processes to maximise social value and net health gain from procurement or development activities. • ***Programmes:***the food environment, planning for health, inclusion of employee health and wellbeing in wider business support and active travel. • ***Strategic joint action:*** including a HiAP approach within the tobacco alcohol and drug strategy, ongoing evidence and needs informed decision making within strategy development. This also includes Hampshire and Isle of Wight level leadership to improve the impact of Health Anchors on health and wellbeing, particularly as employers.
(ii)	That the Board commits to **embedding** a HiAP approach more widely within SCC and partner organisations to deliver continued focus on the 'building blocks for good health' (see 1.2). This includes ongoing monitoring and evaluation of the impact of Phase One activities.

[6] E.g Coventry Marmot City Evaluation 2020 - IHE (instituteofhealthequity.org)
[7] Become a member (who.int)
[8] https://www.futuregenerations.wales/work/health-and-well-being/
[9] Lancashire and South Cumbria Health Equity Commission (HEC) - IHE (instituteofhealthequity.org)

(iii)	That the Board follows a **moderate approach** for Phase Two of the programme**,** with Board members providing supportive leadership to champion HiAP within their organisations and teams.
(iv)	Supports and guides **enablers for Phase Two**, including wider visibility and leadership to enact HiAP (processes, programmes and strategic joint action) across activities in the city, increased focus on evaluation and evidence of impact and supporting cross-team working to identify and realise wider opportunities in decision making. This includes overcoming barriers to embedding HiAP within Board members' teams and networks.
(v)	That the Board supports opportunities arising from the alignment between HiAP and: • The HDRC Southampton ambition to support and enable better evidence informed decision making and evaluation of impact of decisions including health considerations in Phase One and Two. • Action to embed sustainability in all policies, as reducing health inequalities requires action to create healthy and sustainable places and communities, with common policy actions supporting both (e.g. active travel, green spaces, the food environment, transport and energy efficient housing).
RESOURCE IMPLICATIONS	
Capital/Revenue	
	None – recommendations would be delivered within existing resource and aligned to existing public health team portfolios.
Property/Other	
	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
	Health and Social Care Act 2012 (Health and Wellbeing Boards: functions, para 195 Duty to encourage integrated working).
Other Legal Implications:	
	None
RISK MANAGEMENT IMPLICATIONS	
	None
POLICY FRAMEWORK IMPLICATIONS	
	None, proposal aligns with Health and Wellbeing Strategy.

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	All
SUPPORTING DOCUMENTATION	
Appendices	

1.	Implementing Health in All Policies at Southampton City Council: Logic Model (updated February 2023)

Documents In Members' Rooms

1.	None

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

Other Background Documents
Other Background documents available for inspection at:

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

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Implementing Health in All Policies at Southampton City Council: Logic Model - Updated February 2023

Purpose	Implement a Health in All Policies approach to scale local progress towards improving population health and reducing health inequalities			
Stakeholders	Council teams and departments, Integrated Care Partnership, wider Wessex health partners, Universities			
Resources/Inputs	**Activities**	**Outputs**	**Outcomes**	**Impact**
What resources do we have available to us? **Financial** • Within existing budget **Resources** • Impetus of inclusion of HiAP in Corporate Plan • National guidance, toolkits, case studies • Resources and contacts from other local authorities • LGA HiAP Network • Existing health inequalities tools e.g. HIA, HEAT • Stakeholder capacity • Existing decision-making processes and SCC governance (including review/improvement) **People** • Task group • DPH, Exec Director, Cabinet Member & CEO as promoters • Stakeholder staff across all SCC Directorates (interested representatives) • Wider Anchor Institution teams and leaders	**What are we doing with the resources we have?** ***Project management*** • Fortnightly task group meetings • Communications planning and delivery • Delivery, oversight and monitoring ***Processes*** • Wider strategic visibility and leadership for HiAP • Evolving existing processes within policy and decision-making to embed consideration of health , including supporting effective cross-team working and transparency to inform decision making • Strengthening of health considerations in social value procurement • Creating a suite of supporting resources to support officers and teams to consider health needs and evidence • Building the evidence base and collecting examples of good practice to inspire ***Programmes*** • Use of tools, resources and cross-team expertise to inform programmes of work that have the potential to impact on health and health inequalities ***Strategic joint action*** • Use of tools, resources and cross-team expertise to inform programmes of work that have the potential to impact on health and health inequalities • Stakeholder mapping and programme of engagement events • Creating engagement materials • Identifying wider strategic areas that require greater depth of PH engagement • Fostering leadership to encourage and enable staff	**What products or services are achieved from the activities?** ***Project management*** • Monitoring outputs o Quarterly Health and Care Strategy oversight o Collection of good practice/success o 12m report to DMT, CMB and HWBB • Scoping future phases of work and planning decision-making ***Processes*** • Revised SCC policy and decision-making process • Revised SCC ESIA and supporting resources • New SCC HIA process and supporting resources • Strengthened SCC and partner social value procurement process • Health in All Policies internal and external hubs with explainers, toolkits, case studies and supporting resources • Evaluation of the impact of decisions, including follow up of decision making assumptions (linked to HDRC) ***Programmes – phase 1*** • Strengthened health consideration in planning and development, and in particular the new draft Local Plan • Workplan to create an improved food environment • Strengthened health input into workplace wellbeing and good work including o New resources and support for local businesses o Annual Director of Public Health report 2022-23 on good work o SCC workplace wellbeing and inclusion • Identification of health aspects of transport policy and procurement • Further programmes as identified e.g. housing ***Strategic joint action*** • Distributed strategic leadership to include health and health inequalities consideration in wider strategic activities and transformation in Southampton • New Tobacco Alcohol and Drugs Strategy that engages all directorates • HIOW ICB leadership to strength Health Anchors activity	**How will things change as a result of the outputs? Short Term** • Stakeholders understand the importance of health. They know where their own programmes and goals impact health and where health impacts their programmes and goals. • Stakeholders consider the health and health inequality impacts of their work, follow the process and use the tools and resources in programmes of work and strategic joint action • Shared goals are identified and cross-team working identifies additional opportunities and risks for health and health inequalities related to decisions, programmes of work or strategic joint action • Staff access and use the toolkits and supporting resources • New policies and programmes consider health • Strategic decisions are made with transparent visibility of opportunities or risks to health and wellbeing and any cross-team input that has informed these • Improved governance and decision-making that is documentable and more evidence-led • Successes are evidenced, celebrated and shared	**If benefits to participants are achieved, what happens? Long Term** • More effective decision making and governance • Health outcomes indicators improve and health inequalities reduce • Measures of the wider determinants of health improve • Stakeholders' long-term targets are more likely to be achieved • Improved partnership and cross-team working supports staff and teams to deliver their roles and functions • Staff have a better shared understanding of other teams' work and this informs more effective action for Southampton residents • The knowledge and evidence base is grown, informing ongoing improvement

ASSUMPTIONS
There is sustained political and strategic commitment to embed health across all council workstreams, leading across teams and supporting change
The case and definitions used in the programme are understood and shared across teams and organisations.
Staff can understand, access and use the supporting resources to enable them to consider health in their work
The processes and tools to consider heath and health inequalities are part of good governance. The impact on staff capacity in delivery of core functions is minimal or l and re-couped at a later stage when HiAP benefits are achieved or decision-making more efficient
Consideration of health results in changes to policies and programmes that would otherwise not have happened

EXTERNAL FACTORS
Health and Care Partnership Board governance is required to oversee delivery of the Health and Care Strategy, including bringing about HiAP changes
Impact of multiple competing priorities could impact on strategic bandwidth or capacity reduction across teams
Staff turnover or change could impact on sustained leadership and championing across different teams or organisations.

DECISION-MAKER:	Health & Wellbeing Board
SUBJECT:	Southampton Mental Health and Wellbeing Strategy
DATE OF DECISION:	13 March 2024
REPORT OF:	**COUNCILLOR MARIE FINN** **CABINET MEMBER FOR ADULTS & HEALTH**

CONTACT DETAILS				
Executive Director	**Title**	Dr Debbie Chase, Director of Public Health		
	Name:	Debbie Chase	Tel:	
	E-mail:	debbie.chase@southampton.gov.uk		
Author:	**Title**	Consultant in Public Health		
	Name:	Dr Emily Walmsley	Tel:	
	E-mail:	Emily.walmsley@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY
N/a
BRIEF SUMMARY
This report seeks Board approval of the new Southampton Mental Health and Wellbeing Strategy and accompanying documents, prior to being submitted to Cabinet for approval. The Health & Wellbeing Board was briefed on the rational, scope, approach and timeline during the engagement phase in September 2023 (verbal), and the strategy has now been finalised following public consultation and refinement from feedback.
RECOMMENDATIONS:

	(i)	To recommend that Cabinet approves the new Southampton Mental Health and Wellbeing Strategy as attached in appendix 1 and supporting documents (appendix 2-4).
	(ii)	To continue to develop the detailed action plan and establish the multi-agency Southampton Mental Health and Wellbeing Partnership to deliver the strategy.
REASONS FOR REPORT RECOMMENDATIONS		
1.	The Southampton Mental Health and Wellbeing strategy has now been finalised, following the completion of the full strategy development cycle including engagement, drafting, public consultation, and refinement from feedback.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
	Not having a city-wide Mental Health and Wellbeing Strategy for the city risks worsening the health of Southampton residents, increasing inequalities, and creating a wider impact on services downstream. There would also be impacts on the existing local suicide prevention work programme as the new	

	strategy aimed to replace the local Suicide Prevention Plan 2020-2023 through inclusion as 1 of the 6 priorities.
	Having only a strategy and detailed action plan for suicide prevention in Southampton (i.e. adopting only priority outcome 6: 'Working together to prevent suicide and self-harm and support those who are impacted' from the Mental Health and Wellbeing Strategy). The three-year Southampton Suicide Prevention Plan ended in 2023. To incorporate and refresh this plan, priority 6 of the new strategy is focussed on suicide prevention.
DETAIL (Including consultation carried out)	
1.	In September 2022 the Health and Wellbeing Board approved the adoption of the Office for Health Improvement and Disparities (OHID) Prevention Concordat for Better Mental Health for Southampton. This is a nationally recognised commitment that aims to take a prevention-based approach to improving public mental health. A requirement of the Concordat is that there is a local public mental health plan in place and that a multi-agency partnership for mental health and wellbeing is established. In September 2023 the Health and Wellbeing Board received a verbal update on the development of the Southampton mental health and wellbeing strategy and were invited to contribute to the development.
2.	The city-wide Southampton Mental Health and Wellbeing Strategy is a five year strategy that sets out our shared vision that people in Southampton have good mental health and wellbeing, whatever their background or the circumstances in which they live. It describes our approach and underlying principles to achieving this vision. The strategy outlines six priority areas in which collaborative work across the city will be focused and includes accompanying aims and actions of each. The current landscape of mental health and wellbeing for Southampton, the wider determinants of health, and inequalities for mental health and wellbeing are detailed in the strategy and have formed the basis of the approach.
3.	The strategy has been developed by the Public Health and Policy teams of Southampton City Council. A successful engagement phase for the strategy ran from July to October 2023, including involvement of a wide range of stakeholders from providers, community and voluntary organisations, people with lived experience, and key service leads and Boards at Southampton City Council. Input gained from this phase informed the priorities and strategy content.
4.	Southampton City Council undertook a public consultation on a draft Mental Health and Wellbeing Strategy over an 8-week period between 24th November 2023 and 18th January 2024. The consultation was publicised by press releases, e-bulletins, social media, stakeholder forums and the SCC website. Printed copies of the consultation were available from Southampton libraries. People were able to respond via the online questionnaire, by letter or email. Overall, the consultation received 191 responses. Active consultation was also carried out to increase participation in target groups. These included receiving verbal feedback from mental health participation groups, peer support groups, community groups, and conversations with individuals who did not have access to the internet.
5.	Feedback from the consultation showed most respondents agreed with the proposed vision and six priority areas in the draft strategy overall (86%) and

	found it clear and easy to understand (77%). Most respondents also agreed with each priority (89-90%) and rated them as effective (57-70%). In comments, feedback covered themes including inclusivity, the need for clarity around terms used and raised the need for additional focus on specific groups. A full breakdown of the results can be found the full consultation report (Appendix 3). Feedback from the consultation has now been reflected in the strategy and is detailed in the table of post-consultation strategy amendments (Appendix 4).
6.	A new multi-agency partnership will be established to oversee the delivery of the Southampton Mental Health and Wellbeing Strategy for the city. This partnership will include membership across relevant Southampton City Council services, NHS services, voluntary and community organisations, and people with lived experience. This Partnership will sit alongside the existing Southampton Suicide Prevention Partnership and report to the Health and Wellbeing Board. Links to other relevant partnerships and strategies will be maintained through membership on this group. The partnership will continue to develop the detailed action plan to deliver the strategy. The new multi-agency Southampton Mental Health and Wellbeing Partnership will report progress annually to stakeholders and to the Health and Wellbeing Board.
RESOURCE IMPLICATIONS	
Capital/Revenue	
	There is no statutory requirement to have a mental health and wellbeing strategy and there are no additional financial commitments arising from approving this strategy, to Southampton City Council or partner organisations. The commitments made will be delivered through utilising and targeting the existing resources available in the system through partnership working. Local authorities do, however, have responsibility for local suicide prevention action plans through Health and Wellbeing Boards.
Property/Other	
	None.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
	There is no statutory requirement to have a mental health and wellbeing strategy. Local authorities do, however, have responsibility for local suicide prevention action plans through Health and Wellbeing Boards. This strategy is within the remit of the Health and Wellbeing Board to approve, prior to review and approval by Cabinet.
Other Legal Implications:	
	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	
	Although it is not a statutory requirement to have a mental health and wellbeing strategy, there is a risk that without one the mental health and

	wellbeing of residents in Southampton will be worse and inequalities will increase. Considerable engagement with this strategy has already taken place from partner organisations, community and voluntary organisations, and members of the public. If this strategy does not reach completion there is the risk of reputational damage for the Council as the organisation leading the development.
POLICY FRAMEWORK IMPLICATIONS	
	Prior to strategy development all relevant Southampton strategies relating to mental health and wellbeing were reviewed to ensure alignment and integration of the current strategy.

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices	
1.	Southampton Mental Health and Wellbeing Strategy
2.	Southampton Mental Health and Wellbeing Strategy ESIA
3.	Consultation on a draft Southampton mental health and wellbeing strategy - full report
4.	Table of post-consultation strategy amendments

Documents In Members' Rooms

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

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Title of Background Paper(s)	**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.	
2.	

SOUTHAMPTON MENTAL HEALTH AND WELLBEING STRATEGY

Foreword.

Mental health and wellbeing affects us all. Research from The Mental Health Foundation suggests that nearly 2 in 3 of us will experience a mental health problem during our lives, and 1 in 6 is managing fluctuating levels of distress each week. It could be a family member, a neighbour, a colleague, you, or me. This is why it's important we all recognise that mental health and wellbeing is everybody's business.

In recent years we have travelled a long way as a society in acknowledging mental health. Much ground has been covered in challenging the taboo and stigma in which it was once surrounded, and we have made steps towards tackling discrimination. Likewise, the importance of wellbeing has become a widely discussed topic, and significantly more is understood about how we can all live healthier, happier, and more balanced lives. Despite this, life remains tough for many people in our city. The pressures of the pandemic, rapidly followed by a cost-of-living crisis, means chronic stress remains an everyday factor for far too many, and there is much to still be done to address this.

Unifying our work on mental health is a welcomed development, as it demonstrates clear purpose in the city's ambition to help improve the mental health and wellbeing of the whole population, and the steps needed to get there. This strategy provides a focus for local leadership to take collaborative and concerted action to tackle poor mental health, and the conditions that drive it. Our collective challenge is improving the wellbeing, and lives, of the people of Southampton, so we can all truly thrive.

Rob Kurn, CEO, Southampton Voluntary Services

Improving the mental health and wellbeing of Southampton's residents is a goal Solent Mind is passionately committed to. We know its success will take many different people working together, from across all parts of the City, and at times, in new ways, to make a long term difference. We are determined to play our role in rising to this task, and work alongside others to deliver both this strategy and our own purpose "**Supporting everyone to develop positive mental wellbeing, live well and thrive".** We look forward to working with you.

Sally Arscott, CEO, Solent Mind.

As Solent Mind's Peer Support Service in Southampton, and as people with lived experience, we are grateful that our opinions have been valued, enabling us to be part of the development of this strategy. The engagement and participation of people with lived experience is vital to understanding, and addressing, the mental health inequalities within our city. We believe all Southampton residents have the right to good mental health and well-being, and that the subject of mental health should be on everyone's agenda. As people with lived experience, we want to be consulted and included in meaningful change.

Our Peer Support Service works across the whole of Southampton, and as such, is well placed to see the everyday struggles that people are facing. Every day, we bear witness to the social, economic, and the intergenerational trauma, that is adversely affecting health and wellbeing within our city. As Peer Workers, human connection is at the heart of our approach – ***'we listen, connect and inspire hope authentically, through our lived experience'***. As with everybody who has inputted into this strategy, we feel it is vital that we all work collaboratively, holistically, and proactively in order to fulfil this strategy's shared vision. We all need to support those in need, when they need it, and to challenge the stigma around mental health, self-harm and suicide that still prevails.

Southampton Peer Support Service welcomes this mental health strategy. We pledge to support this vital work in any way we can, and are committed to working with our partners across Southampton – to make Southampton a great place to live in line with Solent Mind's own values:

' Compassionate, Listening, Inclusive, Effective, Together '

Solent Mind Peer Support Service

Overview

This is a strategy for the whole city. It was developed with our partners across the city, including people with lived experience of poor mental health and those who support them. It reflects our shared priorities and the aspirations of services that support mental health and wellbeing in Southampton.

Our shared vision is that people in Southampton have good mental health and wellbeing, whatever their background or the circumstances in which they live. This strategy describes our approach to achieving this vision. It outlines the actions that we will take together to address the needs of our residents and communities.

This strategy does not contain all the details about how we will achieve our ambitions. These will be in an accompanying action plan. To facilitate a city-wide approach to this strategy we are setting up a multi-agency, Southampton Mental Health and Wellbeing Partnership. This will complement our existing Southampton Suicide Prevention Partnership.

Our actions align to six priority areas:

1. There is a positive culture that promotes mental health and wellbeing in Southampton.
2. We have greater focus on the areas of people's lives that impact their mental health and wellbeing.
3. People in Southampton get support for their mental health and wellbeing when they need it.
4. Everyone has the opportunity to have positive mental health and wellbeing and is able to benefit from support that is right for them.
5. Children and young people get the best start in life for their mental health and wellbeing and families are supported.
6. Working together to prevent suicide and self-harm, and support those who are impacted.

What is mental health and wellbeing and who is this strategy for?

Mental health and wellbeing are not just about the absence of mental illness. It is about our feelings and emotions, our social connections, connections with the world around us, and our ability to live the lives we want to live. Mental health and wellbeing are fundamental to everything we do. In Southampton we are taking a positive approach to mental health. We are focusing on the importance of mental wellbeing for people to live a fulfilling and productive life within their families and communities. This strategy is for everyone.

Everyone has ups and downs in their lives at different times. Emotions and challenges form a part of the human experience. Life is particularly hard at the moment for a lot of people. The pandemic, the cost of living and other national and global challenges have impacted our mental health and wellbeing. As well as creating environments that promote wellbeing, it is essential that support is provided when people are struggling with their mental health. Mental health services are crucially important for people with mental illness or crisis, but this strategy is not only about these services. It focuses on preventing poor mental health and promoting wellbeing, looking at all the different things that are important for mental health and wellbeing.

There are many things that affect mental health and wellbeing, both negatively (risk factors) and positively (protective factors). Through the prevention of risk factors and promotion of protective factors we hope to improve mental health and wellbeing in Southampton.

Although this strategy is not about specific mental health disorders or conditions, it is relevant to people who have mental health illnesses like depression, anxiety, schizophrenia or bipolar, a condition like dementia, a learning disability, who have a drug or alcohol issues or who are neurodiverse. It is important that this strategy considers everyone's mental health and wellbeing. We know that everyone, including those who are living with other diagnoses, disabilities or difficulties, can benefit.

We are in challenging financial times, and we know that services are under pressure. However, there is amazing work going on across Southampton that we need to celebrate and build on. Community groups, libraries, mosques, gurdwaras, synagogues, churches, temples, coffee mornings, sports teams (and so much more) are all supporting mental health and wellbeing of people in Southampton.

This is an ambitious strategy that reflects the importance of mental health and wellbeing across nearly every area of our lives. It outlines how partners across Southampton will work together to promote mental health and wellbeing and reduce inequalities. This strategy reflects the ambitions around mental health and wellbeing of the whole city. The responsibility for making these ambitions happen is a shared one.

Our shared vision is that:

People in Southampton will have good mental health and wellbeing, whatever their background or the circumstances in which they live.

Our approach to achieving this.

- We will ensure "**parity of esteem"** where mental health is **valued the same as physical health** and gets the same recognition and support that physical health does.
- We will work together in **partnership** to promote good mental health and wellbeing.
- We will recognise that different challenges and life events, at **different stages of life**, impact mental health and wellbeing.
- We will recognise the value of our **voluntary, community and social enterprise** organisations as equal partners in preventing mental health problems and promoting wellbeing.
- We will focus on **prevention and early intervention** of mental health illness, escalation and crisis and celebrate **lived experience and recovery** to help others.
- We will recognise the impact of **trauma** on mental health and wellbeing and take a Trauma Informed Practice approach to all our work and services.
- We will use the **evidence base** to inform our decisions.

Our underlying principles

There are some principles that underpin this strategy and the work that we will do together to improve the mental health and wellbeing of people in Southampton:

- Everyone should be understood, respected and supported and everyone's mental health will be valued (to create a Mental Health Friendly City).
- We will 'be human' and show kindness and compassion to those around us and those we are supporting.
- Language will be used that demonstrates the respect, value and kindness that every resident of Southampton deserves. We acknowledge that the language we use matters and is ever-changing, and we will be kind and patient when people don't always get it "right".
- People with lived experience will be involved and included in all our decisions on mental health and suicide prevention.
- Inequalities will be reduced by providing intervention and support according to need.
- Mental, physical and social health are interwoven and need to be valued equally and considered together.
- Stigma around mental health and suicide will be challenged.
- Suicide prevention is everyone's business.

Our commitments that include mental health and wellbeing in Southampton.

Trauma Informed Practice

In Southampton we are committed to the delivery of Trauma Informed Practice. This means that we recognise that trauma can affect individuals, groups and communities and that exposure to trauma can impact an individual's neurological, biological, psychological and social development. Our approach works to increase awareness within services of how trauma can impact on individuals, groups and communities. This can include their ability to feel safe and develop trusting relationships with health, care and education services. We hope that taking this approach will make it easier for people who have experienced trauma to get the help they need.

Prevention Concordat

We have shown our commitment to cross-sector action to improve the mental health and wellbeing of residents by our intention to sign the Prevention Concordat for Better Mental Health (OHID). This reflects our chosen focus on:

- The wider determinants for mental health and wellbeing, including protective and risk factors and reducing health inequalities.
- A prevention-focused approach to improving the public's mental health.
- Evidence-based planning and commissioning to increase the impact on reducing health inequalities.

Setting the Scene.

Mental health and wellbeing in Southampton

Poor mental health affects a lot of people. Data taken from Southampton Data Observatory show that nearly a fifth (18.7%) of people over 16 years old in Southampton have a common mental health problem and 1.13% of registered patients have a diagnosis of severe mental illness. Both figures are higher than the average in England. "Common mental health problems" means conditions like anxiety and depression. "Severe" or "serious" mental illness means conditions like bipolar disorder, or schizophrenia. Anxiety and depression can still significantly impact some people. When asked about their mental health, nearly a quarter of adults in Southampton report high anxiety and 10% report low happiness. When children and young people in Southampton were surveyed, only 51% said they are happy with their mental health.

Wider determinants of mental health and wellbeing

There are many areas of people's lives that affect their mental health and wellbeing. These include social, economic, and physical environments in which they live at different times. Southampton has a high prevalence of risk factors for poor mental health and wellbeing:

- **Deprivation**: Southampton is ranked 55th most deprived out of 317 local authorities in England, where 1 is the most deprived.
- **Low income and financial insecurity**: In 2019, 13.5% of Southampton residents lived in an area experiencing deprivation relating to low income, this is higher than the English average of 12.9%.
- **Child poverty:** In 2021/22, 25% of children in Southampton aged under 16 were living in relative low-income families, significantly higher than the national average (23.8%).
- **Housing**: 6.2% of houses in Southampton are overcrowded, significantly higher than national average (4.8%).
- **Educational attainment**: Average attainment 8 scores (at GCSE) in Southampton are worse than England overall and significantly worse for children in care and children eligible for free school meals.
- **Preparation for employment**: 6% of Southampton's 16-17yr olds are either not in education, employment or training or their activity is not known. This is significantly worse than the national average (4.7%).
- **Adverse Childhood Experiences**: 363 per 10,000 children in Southampton are supported by Children's Services due to abuse or neglect, significantly worse than England average.
- **Physical health conditions**: 16% of Southampton's population have a long-term health problem or disability.
- **Social isolation and loneliness**: 36.7% of Southampton's over 65yr olds live alone, this is higher than the national average. Although living alone does not necessarily mean someone is lonely, a 2016 residents survey found 30,000 residents said they feel lonely in their daily lives.

Southampton residents also benefits from some protective factors for mental health and wellbeing:

- **Employment**: Rates of employment in Southampton are similar to the England average (74.3% in Southampton and 75.4% in England).
- **Access to green space and the Natural Environment**: 95% of the city have access to green space of at least 2 hectares (just under the size of five football pitches), within 5 minutes walking time. However, access to green space is not experienced equally across the city, some areas have far less.

Inequalities in mental health and wellbeing

There is inequality in the conditions in which people in Southampton live. This results in inequalities in mental health and wellbeing. People with poor mental health are more likely to experience other health inequalities. For example, people with severe mental illnesses in England on average die 15-20 years earlier than the general population.

There are some people and communities in Southampton that we know are at higher risk of poor mental health and wellbeing:

- **Ethnic minorities**: People from ethnic minority groups have higher rates of diagnosis of mental illness, delays in support until crisis situations, hospital admissions due to mental illness, poor treatment outcomes and disengagement from mental health services.
- **Children in care and care leavers**: Nationally, half of children in care meet the criteria for a mental health disorder.
- **People who identify as LGBTIQ+:** Nationally, half of LGBTIQ+ people experience depression, three in five experience anxiety, one in eight LGBTIQ+ people (aged 18 to 24) had attempted to end their life and almost half of trans people had thought about taking their life.
- **Carers**: Carers are twice as likely to have a long term physical or mental health condition. Furthermore, only 30% of adult carers in Southampton get as much social contact as they would like.
- **Young carers**: Nationally, 60% young carers feel their caring role has affected their emotional wellbeing. Their caring role can be associated with stress, anxiety, low self-esteem, missing school, not participating in activities, and a lack of social connections.
- **Neurodiversity**: 1 in 7 people in the UK are neurodivergent and neurodivergent people have a higher risk of poorer mental health and suicide. An estimated 70% of people who are on the autistic spectrum have a co-occurring mental health condition.
- **Co-occurring conditions:** Nearly two thirds of people entering drug and alcohol treatment programmes have mental health needs.
- **Social care users**: Half of all adult social care users in Southampton have depression or anxiety.
- **Homeless households and rough sleepers**: In Southampton 10.4 per 1,000 households are assessed as being homeless. 45% of people experiencing homelessness have been diagnosed with a mental health issue. This rises to 8 out of 10 people who are sleeping rough.
- **Domestic abuse victims/survivors:** Nationally, people who are survivors of domestic abuse are three times more likely to develop a serious mental illness, and twice as likely to have already experienced some form of mental illness.
- **Gypsy, Roma and Travellers**: People who are Gypsy, Roma and Travellers have higher rates of depression and anxiety and are at higher risk of suicide.

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Suicide and self-harm

The rate of suicide in Southampton has decreased over recent years and is now similar to the England average (9.5 per 100,000 in Southampton). There are approximately 21 deaths by suicide each year in Southampton. Every death is an avoidable tragedy and the impact of each death is huge, with estimates of 60 to 135 people affected by each one. Three quarters of deaths by suicide are in males and one quarter in females.

Self-harm is a concern in its own right, as well as being a risk factor for suicide. Local hospital admissions for self-harm in 10-24 year olds are significantly higher in Southampton than the national average (689 vs 550 per 100,000).

Priority outcome 1: There is a positive culture that promotes mental health and wellbeing in Southampton.

Our mental health and wellbeing is impacted by our surroundings and our social connections. Therefore, it's important that our city promotes and protects the mental health and wellbeing of everyone.

We know that stigma, discrimination and racism have harmful effects on mental and physical health through the trauma they cause. We also know that stigma and discrimination against people with mental health problems can have a big impact and create further inequalities through bodily stress responses, poor access to mental and physical healthcare, dying earlier, exclusion from education and employment, increased risk of contact with the criminal justice system, victimisation, poverty and homelessness.

A city that promotes mental health and wellbeing needs to recognise and overcome stigma, discrimination, racism and promote inclusivity for everyone. It needs to celebrate the city and communities within it and the mental health of people who live and work here.

While developing this strategy, we heard from people with lived experience that the societal pressures and the traumas that they experience have the greatest impact on their mental health. We heard about people's experiences of visiting services where they felt like there was "something wrong with them" for not fitting into societal norms or that they "needed to be fixed". Individuals feel isolated and we recognise that the city needs to take a more holistic approach.

There is a positive culture and environment that promotes mental health and wellbeing in Southampton.	
What do we want to achieve?	**How will we achieve this?**
Southampton is a place where everyone can benefit from our city-wide commitment to mental health and wellbeing.	Make Southampton a *Mental Health Friendly City* where everyone's mental health is encouraged and valued. Work in collaboration to strengthen the delivery and promotion of cultural and community focused activities that bring people together and support physical and mental health. This will build on community assets and celebrate Southampton as a place to live. Embed a Trauma Informed Practice approach in all our settings and services using the Southampton Trauma Informed Practice Concordat Delivery Framework. This includes supporting both children and adults who have experienced trauma in childhood (Adverse Childhood Experiences) . Create positive, safe places to live- supporting housing, food security, sleep and protection from "public nuisances" of excess noise, light or smells.
People with lived experience are at the heart of our work and decision making around mental health and wellbeing.	People with lived experience will have membership on the Southampton Suicide Prevention Partnership and Southampton Mental Health and Wellbeing Partnership. Feedback updates on progress on delivery of this strategy to people with lived experience.
We all share agreed language about mental health and wellbeing that includes, values and respects people.	Agree shared language around mental health and suicide to be used by partners in collaboration with people with lived experience.
We will increase awareness and inclusivity and reduce stigma and discrimination.	Collective action on understanding and addressing systemic racism and community trauma, and the impacts on mental health and wellbeing. An understanding of the impacts of trauma caused through discrimination and stigma to be promoted widely through services via training, equalities champions and increased diversity of workforce where possible.

	Strengthening work with faith communities around awareness and reducing stigma, empowering people within communities to speak about mental health.
We are promoting positive messaging about mental health and wellbeing.	Promote messaging about mental health and wellbeing via regular comms and campaigns, using agreed public mental health and wellbeing messaging across partners and organisations. Promote messaging that celebrates mental health and encourages people in Southampton to make connections with others, recognising the importance of social connectedness and the power of saying “hello”.
Workplaces in Southampton are committed to improving the mental health and wellbeing of their staff.	Map the range of mental health and wellbeing support that is available to people working across Southampton to enable policy and workforce development programmes to be embedded in all organisations. Workplaces, including Anchor institutions, will be encouraged and supported to improve mental health and wellbeing through frameworks and tools that are right for them, including Workplace Wellbeing Charter and Wellbeing at work Commitment.
There will be strong leadership in mental health and wellbeing.	Establish Southampton’s Mental Health and Wellbeing Partnership. Demonstrate our commitment to prevent poor mental health and promote good mental wellbeing through adoption of the Prevention Concordat for Better Mental Health and embedding mental health in all policies.

Priority outcome 2. We have greater focus on the areas of people’s lives that impact their mental health and wellbeing.

Everyone should have the right to live healthy lives and have positive mental health. However, inequalities in some of the basic building blocks of life such as education, good employment, housing, and health mean this is not the case. It’s these same building blocks that are impacted by poverty. A focus on these factors means doing things like improving people’s opportunity to stay in education, find opportunities for work, and have adequate housing. These are things that we know are important for mental health and wellbeing.

We also need to focus on protective factors like physical activity and social connections. Building social networks is incredibly important for daily wellbeing and for protecting against the impacts of challenges when they arise.

We heard from people with lived experience that there needs to be a focus on loneliness and isolation and that, for lots of people, loneliness and isolation are the biggest trigger in why their wellbeing declines. We heard that a positive social circle of supportive, trustworthy and honest people that recognise you as who you are is a protective factor that improves mental health and wellbeing.

While developing this strategy we also heard that people with poor mental health do not always know where to get financial support and sometimes have additional needs to get into employment.

We have greater focus on the areas of people's lives that impact their mental health and wellbeing.	
What do we want to achieve?	**How will we achieve this?**
Conditions in which people live and the opportunities for education and employment in Southampton are improved, and this will reduce inequality.	Improve the quality of homes, help people live in the home that's right for them and reduce homelessness and rough sleeping. Keep people in their homes by strengthening partnerships and integration between housing services and other services that support vulnerable people or people in crisis (e.g. substance use and mental health) so people at risk of losing their homes are identified and supported early. Support people to be in employment and reduce the numbers of those not in education, employment or training by offering independent life skills workshops and apprenticeship schemes, including support for employers. Help children and young people to stay in their own schools through anti-bullying work and support during transitions (e.g. from year 6 to 7).
Everyone in Southampton can enjoy and benefit from things that improve mental health and wellbeing.	Clean air and increased access to, and perception of safety of green spaces in Southampton. Access to physical activity is increased through the delivery of the We Can Be Active Strategy and the development and promotion of activities that support people's physical and mental wellbeing, provided by members of the Physical Activity Alliance, Energise Me and others. Health and care partners support people to move more. For example, through social prescribing and other services such as talking therapies.
People are supported to build social connections.	Work collectively to provide and promote opportunities for creating and maintaining social connections through activities run by peer-led, community and faith groups, and other activities such as volunteering and befriending.

	Implement the Hampshire and Isle of Wight Integrated Care Partnership social connectedness framework in Southampton. Work with Young Southampton to support the provision of positive activities for young people across the city to participate in.
People can access advice about managing the cost of living and the mental health impacts of financial anxiety, and food insecurity.	Provide debt and mental health training for frontline workforces. Enhance advice and signposting for mental health in financial support services and ways to provide financial support and advice when people are struggling.

Priority outcomes 3: People in Southampton get support for their mental health and wellbeing when they need it.

This strategy strives to promote mental wellbeing and to prevent poor mental health in everyone. However, there will be times when support is needed, and people should be able to access appropriate levels of support at the right time. This should include support in the community as well as specialist support if needed. We need to continue to support the creation of connections between people and the organisations that support mental health and wellbeing.

While developing this strategy we heard from people with lived experience about the importance of peer support and community groups/projects and how they have positively impacted the mental health and wellbeing of people with lived experience. We also heard how difficult it is to find appropriate support and that there is a lack of understanding of when the "right time" is to seek support. There needs to more accessible information about mental health support across the city.

People in Southampton get support for their mental health and wellbeing when they need it.	
What do we want to achieve?	**How will we achieve this?**
Communities support the mental health and wellbeing of their residents.	Voluntary, community and social enterprise organisations that provide support for mental health and wellbeing will be connected via the Southampton Mental Health Network and other community networks. Directories of mental health, wellbeing and social support will be provided.

	Develop and promote recognised mental health and wellbeing and suicide prevention training for the workforce and volunteers, accompanied by appropriate support structures to retain competence and capability in using these skills. Develop a city-wide communications plan around what's available to support mental health and wellbeing.
A broad range of support for mental health and wellbeing is available to people before they need specialist services.	Promote mental health and wellbeing support and services so people know what is available and how to access it, ensuring that the information can be understood by the people who need it. Health partners, such as primary care, facilitate navigation into support and activities in the community. Peer models of support in the community are strengthened, and sharing of stories about experience and recovery are encouraged and celebrated.
If people need help, they are able to access mental health services or crisis support.	Promote accurately what mental health services and crisis support is available, along with an understanding of when it is needed and how it should be accessed.

Priority outcome 4: Everyone has the opportunity to have positive mental health and wellbeing and is able to benefit from support that is right for them.

There are inequalities in mental health and wellbeing and many of these are linked to other challenges a person might be facing, whether that's physical health problems, neurodiversity, disability, addiction or discrimination. Not everyone is able to get the help they need, and we must work towards overcoming barriers they face. We need to think about the whole person and all their needs. We need to recognise that people are complex and diverse and that a "one-size fits all" approach won't work.

We know that people who experience long term physical conditions are more likely to have poor mental health and wellbeing. We also know that people experiencing poor mental health are more likely to have poor physical health leading to worse outcomes. It is therefore important that the physical health of people with mental health problems is properly supported.

This strategy does not include preventing dementia as a disease because this is included in cardiovascular disease prevention. However, dementia can be associated with poor mental health, and people with dementia may benefit from the same mental health and wellbeing support as others.

While developing this strategy we heard from people with lived experience that some ethnicities and cultures have felt left behind or missed from previous plans or strategies. We were told that people with learning difficulties and neurodiversity require appropriate support. We also heard from some people that their mental health is not taken seriously because of their addictions so a stronger understanding of mental health with addiction is needed.

Everyone has the opportunity to have positive mental health and wellbeing and is able to benefit from support that is right for them.	
What do we want to achieve?	**How will we achieve this?**
Inequalities in mental health and wellbeing are reduced.	Ensure mental health support is accessible and appropriately tailored for everyone who needs it. For example, for people with learning disability or neurodiversity. A person-centred approach is taken for people with co-occurring needs such as mental health, social care, and addiction (alcohol, drugs, gambling), and joined up working between services that support them is strengthened. Mental health and wellbeing support is tailored for people most vulnerable to poor mental health, such as care leavers, LGBTIQ+ people, refugees and asylum seekers and those who've experienced trauma.

	Carers are supported to look after their mental health and wellbeing and maintain social connections, including through flexible respite options that are right for them and the cared for person. The mental health and wellbeing needs of older people are addressed through strengthening social connectedness and improving access to appropriate services and support for them. This will include talking therapies, preparation for older age, bereavement, and alcohol use support.
The mental health and wellbeing needs of people from different ethnic and cultural backgrounds are met and they are supported in the way that is right for them.	Work with communities to better understand the mental health and wellbeing needs of people from different ethnic and cultural backgrounds in Southampton. Communities could be formed of people from geographical locations or be made up of people from particular ethnic backgrounds or faiths, or Gypsy, Roma and Traveller communities. Promote an understanding of the barriers and needs of ethnic minorities among the mental health work force, education settings and other partner organisations in Southampton. Use data from services to inform provision, accessibility and the promotion of services to those who are not being reached.
The needs of people with mental health problems are holistically met, reducing the inequality in health and wellbeing.	People with severe mental health problems are supported to improve their physical health. For example, treating tobacco dependency, reducing alcohol-related harm and reducing the risk of cardio-vascular disease. Making Every Contact Count (MECC) is adopted and used in mental health services to support healthy conversations about improving physical health. Training for professionals around co-occurring conditions including the causes of substance use and how we talk about it.

Priority outcomes 5: Children and young people get the best start in life for their mental health and wellbeing, and families are supported.

Putting in the ingredients for positive mental health and wellbeing needs to start in the early years. We know that half of mental health problems are established by age 14 and three quarters by age 24. We also know that the mental health of parents and carers has a significant impact on children and young people's current and future mental health and life chances. Supporting the mental health and wellbeing of children and young people through their families, communities and education settings is essential.

While developing this strategy we heard from people with lived experience that there needs to be better connection with schools about awareness of mental health and wellbeing support. We were told that tools and resources, such as peer support groups in schools, are needed to help support young people to look after each other's wellbeing. We also heard that support is needed for the parents or carers of young people who have poor mental health.

Children and young people get the best start in life for their mental health and wellbeing and families are supported.	
What do we want to achieve?	**How will we achieve this?**
Positive perinatal mental health and wellbeing for all the family.	Make perinatal mental health and wellbeing support available to pregnant people and new parents. Other professionals who come into contact with new families are trained and supported to identify mental health concerns.
Parents, carers and families can access a wide range of support in their communities.	Groups and parenting programmes will be provided by Family Hubs and other community organisations, including support for dads. Clinical Leads offer mental health support within Children and Families First (previously Early Help). Implement the Family Safeguarding Model, including mental health support workers who support families most at risk. Promote accurately what mental health services and crisis support is available for children and young people, along with an understanding of when it is needed and how it should be accessed.

A positive concept of emotional and mental health will be promoted and children and young people are able to have healthy conversations about emotions.	Promoting confidence in talking about emotions, the language to use, the risks of labelling, and encouraging body positivity and inclusivity. This will be achieved via delivery of education sessions to staff in schools, and training in children and young people's emotional wellbeing to wider workforces. Helping families have confidence in having conversations with young people, particularly if they have additional needs via training.
Education settings are healthy environments that promote good mental health and wellbeing of children, young people and staff, as well as teaching them about maintaining emotional wellbeing.	Delivery of the Healthy Early Years Award and Healthy High 5 to education settings across the city. Schools in Southampton have access to Mental Health Support Teams and a 'whole school approach' to promotion of student and staff wellbeing is adopted, ensuring that the school community works together to maintain good mental health and wellbeing for all. BeeWell survey (a national and independently evaluated wellbeing survey) is conducted in schools and intervention based on the findings are delivered.
Children, young people and families are supported through transitions, both in their development and between services.	New families are supported into parenthood via antenatal support and Family Hubs. Early help is provided at critical reachable moments e.g. school transition, during puberty, students arriving in the city for university etc. Young people leaving care or transitioning from child to adult social care or mental health care, or out from tier 4 (in-patient) mental health placements are appropriately supported.
Parents, carers and families who provide support for a child or young person are given the tools and support they need.	Increase identification of young carers and their access to support, and increase the number of people in the city who can offer that support. Parents and carers of children and young people with additional needs are supported to look after their mental health and wellbeing through understanding of the support that's available to them and their families, access to activities, and flexible respite options that are right for them and the child or young person they care for. Foster carers will be supported with training around mental health, therapeutic support during placements, and provision of support at placement endings.

Priority outcome 6: Working together to prevent suicide and self-harm and support those who are impacted.

Deaths from suicide are tragic and have a devastating effect on families, friends, and communities. Suicide prevention refers to the collective efforts needed to reduce these deaths, recognising that each death is often the endpoint in a complex history of events and risk factors. Much of the prevention for suicide at a population level will be the same as prevention for poor mental health, such as reducing isolation, unemployment and the impact of trauma, taking a holistic approach. However, preventing deaths by suicide also requires more specific action based on who we know is at risk and what we know works. From national and local data, we know that risk factors for suicide include:

- Men, particularly middle-aged men (and also younger males).
- People experiencing mental health problems.
- People experiencing relationship difficulties, unemployment, financial difficulties, physical health problems, housing difficulties and/or social isolation.
- Bereavement, especially bereavement by suicide.
- People with previous attempts of suicide.
- People with adverse childhood experiences including sexual abuse
- People with co-occurring drug and/or alcohol use and mental health problems.
- People formerly convicted of a crime.
- People who have experienced abuse (either as victims or witnesses).
- People experiencing isolation from others.
- People who have been diagnosed with a terminal or chronic illness.
- People experiencing bullying.
- People who are neurodivergent.
- People who identify as LGBTIQIA+.

While developing this strategy we heard from people with lived experience that stigma and the language used about suicide needs to be addressed. We also heard that support services for those experiencing suicidal thoughts need to more accessible and that support for those bereaved by suicide should be widely available. People with lived experience shared concerns about young people and the harms of social media, calling for further interventions for online safety. We also heard that we need to talk more with parents and schools about suicide and self-harm, and the support that is available to them.

Working together to prevent suicide and self-harm and support those who are impacted.	
What do we want to achieve?	**How will we achieve this?**
Partners across the city will work together to make suicide prevention everyone's business and maximise collective impact to prevent suicide and self-harm	Continue Southampton's multi-agency suicide prevention partnership, including people with lived experience in the membership. Clear messaging using the correct language and terminology about suicide prevention that is shared by all partners and organisations in their comms and promotion. Promotion and encouragement across the city of basic training in suicide prevention and how to talk about suicide.
Improved data and evidence so that effective, evidence-informed and timely interventions continue to be adapted.	Real time surveillance (RTS) of data via the Hampshire Isle Of Wight (HIOW) RTS group informs prevention and postvention action. Southampton Suicide Audits completed regularly, complemented with findings from drug-related audits where helpful. Strengthen links to academic research about suicide prevention for the purposes of both informing and learning.
Provision of tailored support to priority groups, including those at higher risk.	Appropriate support is provided and promoted for people at greater risk of suicide including middle aged males, neurodivergent people, people in contact with the criminal justice system, LGBTQIA+ people, and other priority groups. Public awareness mental health campaigns aiming to reduce stigma are targeted at these groups. Develop and provide a comprehensive training offer to ensure the provision of mental health, self-harm and suicide prevention training to frontline staff who come into contact with those at risk of suicide. Workplace wellbeing and suicide prevention and postvention support targeted at workplaces with employees of higher risk of suicide, including the development of suicide prevention tools and policies.
Common risk factors linked to suicide are addressed by providing early intervention and tailored support.	Review self-harm pathway to improve early identification and early intervention. Alcohol, drugs and gambling recovery services are skilled in identifying and supporting suicide risk and working collaboratively with mental health services.

	Domestic abuse is recognised as a risk factor for suicide and early support is provided for both victims and perpetrators.
Promotion of online safety and responsible media content to reduce harms and improve signposting to helpful information about suicide and self-harm prevention.	Develop shared messaging around online harms and social media, to be delivered by all partners. Education about social media harms and safe use of social media for CYP, families and professionals who work with them. Promotion of the R;pple browser extension across all educational establishments (schools, colleges and universities) which signposts to relevant support services instead of harmful searches. Work with media to ensure Samaritan's best practice guidance is adhered to, including signposting to local crisis support when appropriate.
Enabling access to effective crisis support for people who need it	Promote accurately what crisis support is available and how to access it. Support for families and carers of people who are at risk of, or have tried to, take their own life (support those who are supporting).
Reducing access to means and methods of suicide to prevent deaths.	Timely surveillance and appropriate response to methods via the HIOW RTS group. Review of high-frequency locations in Southampton and appropriate action to reduce deaths by suicide, including inclusion of suicide risk assessment and mitigation included in planning. Collaborative working with British Transport Police and Network Rail. Promotion of safe prescribing, supply and storage of medicines.
Continue to provide effective bereavement support to those affected by suicide.	Continue providing and improving access to bereavement support and services locally, for all age groups.
Focus on preventing suicide in children and young people.	Develop suicide prevention and response plans including a prevention/postvention protocol for education settings and a HIOW RTS plan for responding to deaths by suicide in children and young people. Review self-harm pathways and support for young people and provide support in local Emergency Departments for young people who attend for self-harm. Work with Universities in Southampton to support universities to embed the Suicide-safer universities guidance, which covers both prevention of suicide and compassionate responses to suicide in universities.

Delivering our strategy.

Next steps

Further details about how we will achieve the ambitions within this strategy will be described in an action plan. A multi-agency Mental Health and Wellbeing Partnership will be established to coordinate and oversee the delivery of this action plan and strategy, complementing our existing Suicide Prevention Partnership. In addition to regular oversight by these partnerships, progress will be reviewed and reported annually to the Health and Wellbeing Board. We will also share our learning and experience with stakeholders and nationally whenever possible.

Monitoring for this strategy

To demonstrate progress towards the delivery of this strategy and to monitor outcomes to inform future direction of work, a mental health and wellbeing outcome framework will be developed. We know that while outcome measures can provide a broad view of how well we are doing across the city on delivering this strategy, they rarely paint a complete picture. We will therefore also include feedback in the form of stories, case studies or feedback from people with lived/living experience, service users, and service providers where appropriate. The outcome measures will include:

Diagnosed mental health and suicide.

Rates of mental illness provided by these measures do not necessarily indicate the true number of people with poor mental health, they reflect the number who have attended services (GP, A&E or hospital) needing help and have received a diagnosis that has been recorded on an NHS system. They may therefore only reflect a proportion of those with problems. It may be that, by working on reducing the stigma associated with mental health, more people come forward for help and these numbers increase.

- Percentage of adults diagnosed with depression.
- Percentage of adults diagnosed with severe mental illness.
- Rates of death by suicide.
- Hospital admissions as a result of self-harm (10-24 years).

Self-reported mental health and wellbeing.

- Percentage of people (16+) with low happiness score.
- Percentage of people (16+) with high anxiety score.

- Young people wellbeing score on school survey (BeeWell).

Measures of impact on risk/protective factors.

- Percentage of adult carers (18+) who have as much social contact as they would like.
- Percentage of adult carers (65+) who have as much social contact as they would like.
- Percentage of adult social care users who have as much social contact as they would like (18+ years).
- Percentage of adult social care users who have as much social contact as they would like (65+ years).
- Percentage of physically active adults (age 19+).
- Percentage of physically active young people (age 5-16).
- Number of people in alcohol and drug treatment.
- Percentage of school pupils (with SEN) with social emotional and mental health needs.
- Percentage of looked after children whose emotional wellbeing is a cause of concern.

Measures of impact on wider determinants.

- Percentage of persistently absent pupils primary.
- Percentage of persistently absent pupils secondary.
- Average Attainment 8 score (GCSE).
- Percentage of 16 to 17 year olds not in education, employment or training (NEET) or whose activity is not known.
- Percentage of people aged 16 - 64 years in employment.

Engagement work and consultation.

This strategy was developed collaboratively with our partners across the city, including people with lived experience of poor mental health and/or suicide and those who have supported them. Southampton's Mental Health and Wellbeing Strategy reflects the priorities of residents with lived experiences and the aspirations of our partners and services across the city who support the mental health and wellbeing of Southampton.

Engagement with partner organisations across the city.

We have talked to partner organisations across the city via a number of engagement workshops in the early stages of strategy development to determine the shared priorities of the city. During these sessions we spoke with service providers, the voluntary community sector, charities and the Southampton Mental Health Network. We worked with attendees to identify their shared priorities and commitments and began to map assets across the city to identify what is working well and what more may be required.

Engagement with key stakeholders within the Council.

To emphasise a focus on the risk and protective factors of mental health we have talked to key individuals and services across the Council who can influence on the wider determinants of resident's health. We have also spoken with key Boards and groups to develop priorities and ensure the voices of the residents they work to represent are heard.

Engagement with people with experience of mental health and suicide.

In order to truly reflect the priorities of residents across the city, we have talked to people across the city who have lived experience of poor mental health and suicide. People with lived experience have shared their experiences to inform the development of the strategic priorities. This has been through engagement forums such as the initial workshops, peer support groups, young peoples' participation groups and engagement sessions within care settings such as Natalie House. People with lived experience have also supported the development of the strategic vision, our approach and the principles identified in this strategy.

Links with existing plans and strategies.

- Health and Wellbeing Strategy (2017-2025)
- Southampton City Council Corporate Plan (2022-2030)
- Children and Young People's Strategy (2022-2027)
- Southampton City Children and Young People's Emotional and Mental Health Wellbeing Plan – 2022 refresh
- Prevention and Early Intervention priorities (2022-27)

- Early Years priorities (2022-27)
- Children in our care: Our Corporate Parenting Plan (2022-2027)
- Tobacco, Alcohol and Drugs Strategy 2023-2028
- Physical Activity and Sports ('We Can Be Active') Strategy (2022)
- Adult Carers Strategy 2021-26
- Young Carers Strategy 2021-26
- Domestic Abuse and Violence Against Women and Girls Strategy 2023-2028
- Homelessness Prevention Strategy (2018-2023)
- Cultural Strategy (2021-2031)
- CVD prevention local delivery action plan (awaited)
- Southampton Trauma Informed Practice Concordat Delivery Framework (awaited)

Glossary of terms used in this strategy

People with lived experience: Also called people with living experience or people with experience. These are people who either are or have been affected in some way by poor mental health or suicide in themselves or someone they are close to.

Wider determinants: These are the social, economic and environmental factors which impact on people's physical and mental health. They are like the building blocks of health. To create a healthy society that supports mental health and wellbeing we need the right building blocks in place like quality housing, good education and stable jobs. These will allow people to withstand the shocks and challenges of life.

Inequalities: Not everybody has the same amounts of money, power or resources in their lives because these are not fairly distributed across society. This means that some people face more challenges than others which impacts their physical, social and mental health.

Deprivation: In health and social care, deprivation usually refers to lacking income, employment, education, health, housing, or could relate to higher local crime levels, barriers to services, or quality of outside space. When the term poverty is used, it usually refers to low income.

LGBTQIA+: People who are lesbian, gay, bisexual, transgender, queer or questioning, intersex, or asexual (LGBTQIA+)

Trauma: Often defined as an experience that happens in a person's life resulting in physical, mental, or emotional harm. This can be a single event or series of events like being a victim of sexual or other abuse or can be due to a persons' circumstances such as experiencing ongoing trauma from racism or discrimination or trauma from the stigma of having a mental health illness. All these causes of trauma can have negative impacts on physical, social and mental health.

Adverse Childhood Experiences (ACEs): Highly stressful and potentially traumatic events or situations that occur in childhood and/or adolescence. These can include neglect as well as physical, sexual and emotional abuse.

Trauma Informed Practice: This is an approach that thinks about all the ways a person can have experienced trauma in their lives and how this can affect them physically, socially and mentally. If people in services are trained in this approach, they can help people recover from this trauma.

Systemic racism: Sometimes called Institutional racism. Policies and practices that exist throughout societies or organisations that result in and support a continued unfair advantage to some people, and a harmful and unfair treatment of others, based on race.

Community trauma: Also called collective trauma. It relates to a shared experience that affects a whole community rather than an individual. Examples are racism, slavery, forcible removal from a family or community, genocide or war.

Holistic: This is taking into account the whole person, both physically and mentally, and providing care and support for all their needs.

Early intervention: This means identifying and providing early support to people who may be at risk of poorer mental health and wellbeing. It can also mean providing support at an earlier age to mitigate the factors that could contribute to poor mental health and wellbeing later in life.

Real Time Surveillances (RTS): This is a system for monitoring suspected deaths by suicide captured from police data in real time. This up-to-date information about suicide in our area helps to identify and implement support to prevent suicide in a timely manner.

Postvention: This refers to interventions provided for people who have been impacted by suicide. This aims to reduce risk of further deaths by suicide and also to help bereavement and healing. Postvention can be aimed at anyone who has been impacted by the death, including family, friends, work colleagues, communities, first responders etc.

Anchor Institutions: Anchor Institutions are large organisations that are unlikely to relocate and have a significant stake in local communities, effectively anchored in their surrounding areas. They usually employ a lot of people and have sizeable assets that can be used to support local community health and wellbeing, including tackling inequalities.

R;pple browser extension: This is a software tool that provides mental health resources to people who are searching for harmful online content relating to suicide and self-harm.

Data included in this strategy can be found on the Southampton City Council Data Observatory Homepage (southampton.gov.uk)

If you need help with your mental health a list of local, national and online mental health support services and resources on our website: https://www.southampton.gov.uk/mental-health

If you, or someone you know, are experiencing an emotional crisis, phone Samaritans for free from any phone on 116 123.

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SOUTHAMPTON CITY COUNCIL

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	Mental Health and Wellbeing Strategy 2023-2028

Brief Service Profile (including number of customers)

This is a city-wide strategy for all who live and work in Southampton. While mental health services are crucially important for people with mental illness, this strategy is not directly about these services. It focuses on prevention of mental health problems and promotion of wellbeing, taking a wider determinants approach to supporting people to have better mental health and wellbeing.

There are many factors that affect mental health and wellbeing, both negatively (risk factors) and positively (protective factors). This strategy aims to address these through action to prevent or support the experience of risk factors for those who need it, and to promote the enjoyment of protective factors for everyone. Although this strategy is not about specific mental health disorders or conditions, it is relevant to people who do have a disorder (e.g. common mental health illness like depression or anxiety, a serious mental health illness like schizophrenia or bipolar, or a condition like dementia) as there will still be things that can improve their mental health and wellbeing in addition to specialist support.

This is an ambitious strategy that covers a broad range of factors for mental health and wellbeing, which reflects the importance of mental health and wellbeing across nearly every area of our lives. It outlines how partners across Southampton will work together to promote mental health and wellbeing and reduce the inequalities that some people experience.

Summary of Impact and Issues
This Mental Health and Wellbeing Strategy focuses on prevention of mental health problems and promotion of wellbeing, taking a wider determinants approach to supporting people to have better mental health and wellbeing. There is a risk of greater ongoing mental health and wellbeing inequalities if we do **not** pursue this strategy. **We have not identified any risks of delivering this strategy, that would have a negative impact on the protected characteristics identified in this ESIA.** Data provided below are taken from the Southampton Data Observatory Homepage (southampton.gov.uk)
Potential Positive Impacts
This strategy aims to deliver positive impacts though 6 priority areas: 1. There is a positive culture that promotes mental health and wellbeing in Southampton. 2. We have greater focus on the areas of people's lives that impact their mental health and wellbeing. 3. People in Southampton get support for their mental health and wellbeing when they need it. 4. Everyone has the opportunity to have positive mental health and wellbeing and is able to benefit from support that is right for them 5. Children and young people get the best start in life for their mental health and wellbeing and families are supported. 6. Working together to prevent suicide and self-harm, and support those who are impacted.

Responsible Service Manager	
Date	
Approved by Senior Manager	
Date	

Potential Impact

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Age	**No negative impacts of the draft strategy identified**. There could be potential impacts across all age groups if we did not pursue this strategy.	We will continue to consider the voices of, and impacts to people of all ages, when developing and implementing this strategy.

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
	Nearly a fifth (18.7%) of people >16 years old in Southampton have a common mental health problem and 1.13% of registered patients over 16 have a diagnosis of severe mental illness, both of which are higher than the England average. Nearly a quarter of adults in Southampton report high anxiety and 10% report low happiness. When children and young people in Southampton were surveyed, only 51% said they are happy with their mental health. Older people are at higher risk of loneliness and isolation which we know is a risk factor which had led to poor mental health.	This strategy takes an across the life course approach with a dedicated priority focusing on children and young people being given the best start in life for their mental health and wellbeing and helping families to support each other.The mental health and wellbeing need of older people are addressed through strengthening social connectedness and improving access to appropriate services and support for them, including preparation for older age, bereavement and alcohol use.
Disability	**No negative impacts of the draft strategy identified**. There could be potential impacts associated in people with disabilities if we did not pursue this strategy. 16% of Southampton's population have a long-term health problem or disability. This strategy recognises disability as a risk factor of mental health.	We will continue to consider the voices of, and impacts to people with disabilities, when developing and implementing this strategy. This strategy will support and create equal opportunities to have positive mental health and wellbeing, and equal opportunity to benefit from support when it is needed, including those with disabilities. It focuses on the protective factors that support to

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
		improve mental health and wellbeing.
Gender Reassignment	**No negative impacts of the draft strategy identified**. There could be potential impacts associated with those undergoing/completed gender reassignment if we did not pursue this strategy. Nationally, half of LGBTQIA+ people experience depression, three in five experience anxiety, one in eight LGBTQIA+ people aged 18 to 24 had attempted to end their life and almost half of trans people had thought about taking their life.	We will continue to consider the voices of, and impacts to people of all sexes and genders, when developing and implementing this strategy. This strategy aims to reduce inequalities in mental health and wellbeing, through the available tailored mental health and wellbeing support for people most vulnerable to poor mental health such as those going through or completed gender reassignment.
Care Experienced	**No negative impacts of the draft strategy identified**. There could be potential impacts associated with those who have experienced being in care if we did not pursue this strategy. Southampton has 560 children in care, half of children in care meet criteria for a mental health disorder.	We will continue to consider the voices of, and impacts to people who have experienced being in care, when developing and implementing this strategy. This strategy aims to appropriately support Young people leaving care or transitioning from children's to adult social care or mental health care, or out from tier 4 mental health placements. Foster carers will be supported with training around mental health, therapeutic support during placements, and provision of support at placement endings.
Marriage and Civil Partnership	**No negative impacts of the draft strategy identified**.	
Pregnancy and Maternity	**No negative impacts of the draft strategy identified**. There could be	We will continue to consider the voices of, and impacts to

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
	potential impacts associated within pregnancy and maternity residents if we did not pursue this strategy. This strategy takes an across the life course approach and recognises this protected characteristic as a risk factor of mental health and reflects the protective factors to support residents.	people who are pregnant or parents, when developing and implementing this strategy. This strategy aims to achieve positive perinatal mental health and wellbeing for all the family, with other professionals who come into contact with new families being trained and supported to identify mental health concerns.
Race	**No negative impacts of the draft strategy identified**. There could be potential impacts for residents of all races if we did not pursue this strategy. People from ethnic minority groups have higher rates of diagnosis of mental illness, delays in support until crisis situations, hospital admissions due to mental illness, poor treatment outcomes and disengagement from mental health services.	We will continue to consider the voices of, and impacts to people of all ethnicities, when developing and implementing this strategy. This strategy has a priority for people to have equal opportunity to have positive mental health and wellbeing, and equal opportunity to benefit from support when it is needed, including the mental health and wellbeing needs of people from different ethnic and cultural backgrounds being met, and they are supported in the way that is right for them. The strategy will achieve this by working with communities to better understand the mental health and wellbeing needs of people from different ethnic and cultural backgrounds in Southampton It will promote understanding of the barriers and needs of ethnic minorities among the mental health work force,

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
		education settings and other partner organisations.
Religion or Belief	**No negative impacts of the draft strategy identified**. There could be potential impacts for residents of all religions and faiths if we did not pursue this strategy. This strategy will increase awareness and inclusivity and reduce stigma and discrimination, strengthening work with faith communities around awareness and reducing stigma, and empower people within communities to speak about MH.	We will continue to consider the voices of, and impacts to people of all religions and beliefs, when developing and implementing this strategy. This strategy will encourage and support residents to build social connections by promoting opportunities for creating and maintaining social connections through activities run by peer-led, community and faith groups.
Sex	**No negative impacts of the draft strategy identified**. There could be potential impacts for residents of all genders if we did not pursue this strategy.	We will continue to consider the voices of, and impacts to people of all genders, when developing and implementing this strategy.
Sexual Orientation	**No negative impacts of the draft strategy identified**. There could be potential impacts associated with LGBTQIA+ residents if we did not pursue this strategy. Nationally, half of LGBTQIA+ people experience depression, three in five experience anxiety, one in eight LGBTQIA+ people aged 18 to 24 had attempted to end their life and almost half of trans people had thought about taking their life.	We will continue to consider the voices of, and impacts to people of all sexual orientation, when developing and implementing this strategy. This strategy aims to reduce inequalities in mental health and wellbeing, through the available tailored mental health and wellbeing support for people most vulnerable to poor mental health such as those who identify as LGBTQIA+.

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Community Safety	**No negative impacts of the draft strategy identified**. This strategy aims to allow everyone to enjoy and benefit from protective factors for mental health and wellbeing, including increased access to, and perception of safety of green spaces in Southampton.	We will continue to consider the impact on community safety, when developing and implementing this strategy.
Poverty	**No negative impacts of the draft strategy identified**. There could be potential impacts associated with residents experiencing poverty if we did not pursue this strategy. Southampton is ranked 55th most deprived out of 317 local authorities in England, where 1 is the most deprived. In 2019, 13.5% of Southampton residents lived in an area experiencing deprivation relating to low income, this is significantly higher than the English average of 12.9%. We identify the impact of poverty, low income, financial insecurity and poor housing as a risk factor for poor mental health in the strategy.	We will continue to consider the voices of, and impacts to people of experiencing poverty, when developing and implementing this strategy. This strategy has a priority to have greater focus on the areas of people's lives that impact their mental health and wellbeing. Specifically, people are supported with cost of living, including the mental health impacts of financial anxiety and food insecurity.
Health & Wellbeing	**No negative impacts of the draft strategy identified**. There could be potential impacts associated with Mental Health and Wellbeing of residents if we did not pursue this strategy.	We will continue to consider the voices of, and impacts to people's health and wellbeing, when developing and implementing this strategy.
Other Significant Impacts	**No negative impacts of the draft strategy identified**.	We will continue to consider other significant impacts,

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
		when developing and implementing this strategy.

Draft Mental Health & Wellbeing Strategy

consultation report

southampton dataobservatory

Data, Intelligence & Insight Team | *February 2024*

Contents

Introduction

Southampton City Council undertook a public consultation on a draft Mental Health & Wellbeing Strategy.

This consultation took place between **24/11/2023 – 18/01/2024** and received **191** responses.

The aim of this consultation was to:

- Communicate clearly to residents and stakeholders the proposals for the Mental Health & Wellbeing Strategy;
- Ensure any resident, business or stakeholder in Southampton that 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 of the strategy in a different way.

The primary method of gathering feedback for this consultation was via online questionnaire, distributed by public health networks, stakeholder groups, and on social media. Physical paper versions of the questionnaire were also made available, and respondents could also email yourcity.yoursay@southampton.gov.uk with their feedback, as well as respond by post.

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

It is important to be mindful that a consultation is not a vote, it is an opportunity for stakeholders to express their views, concerns and alternatives to a proposal. 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.

Consultation principles

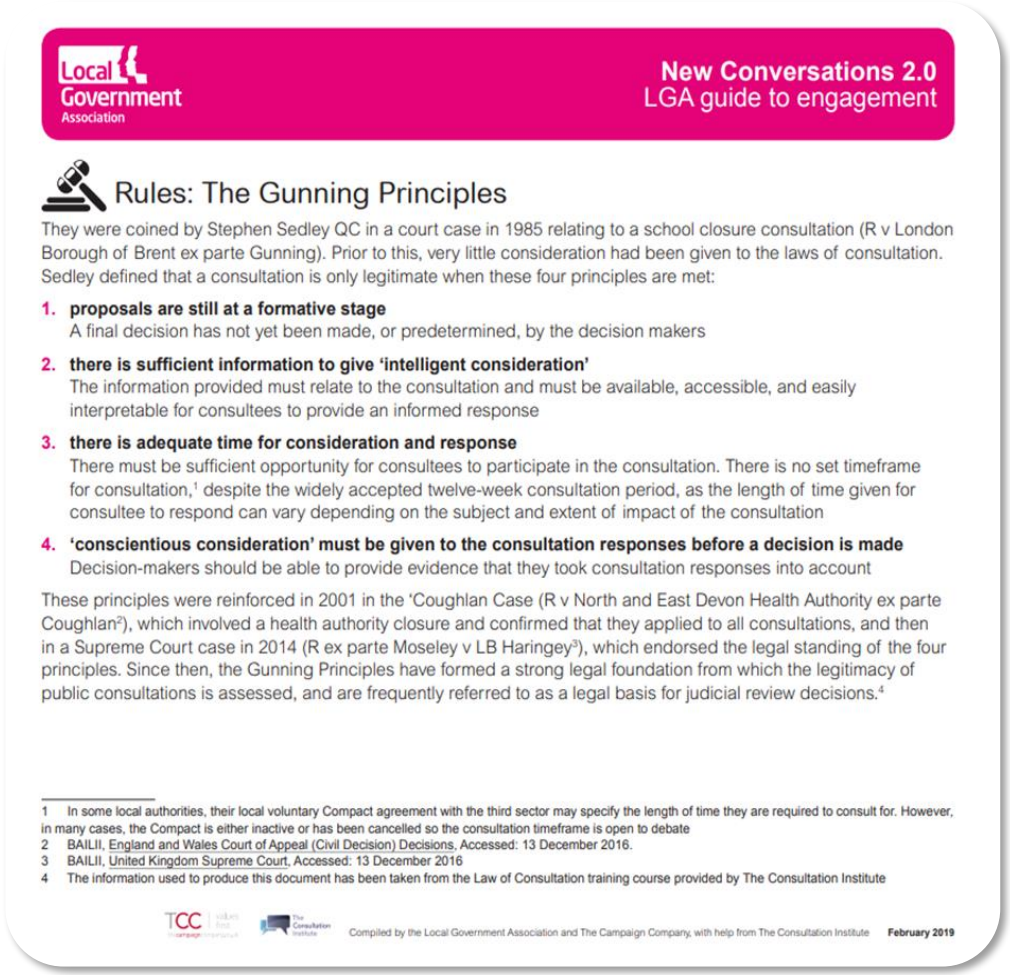
Southampton City Council is committed to consultations of the highest standard and which are meaningful and comply with the *Gunning Principles,* considered to be the legal standard for consultations*:*

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, and;

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**

Methodology & promotion

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 way, 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:

- Press release;
- Council e-bulletins;
- Social media channels;
- Stakeholder forums;
- Southampton City Council website.

All questionnaire results have been analysed and presented in graphs within this report. Respondents were also given opportunities throughout the questionnaire to provide written feedback on the proposals. All written responses and questionnaire comments have been read and then assigned to categories based upon sentiment or theme.

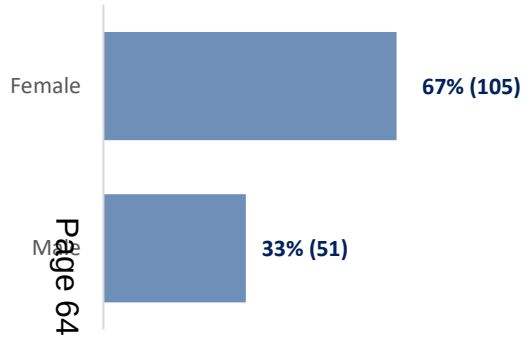
Who are the respondents?

Total responses

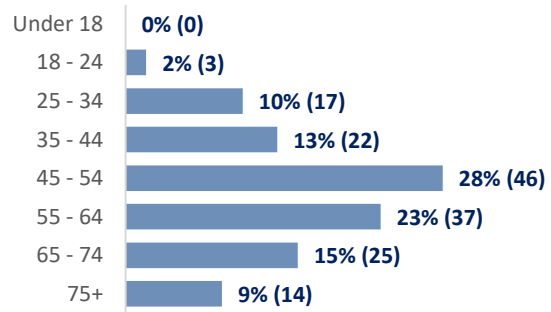
184 survey responses
7 email/letter responses
191 total

Graphs on this page are labelled as percentage (count).

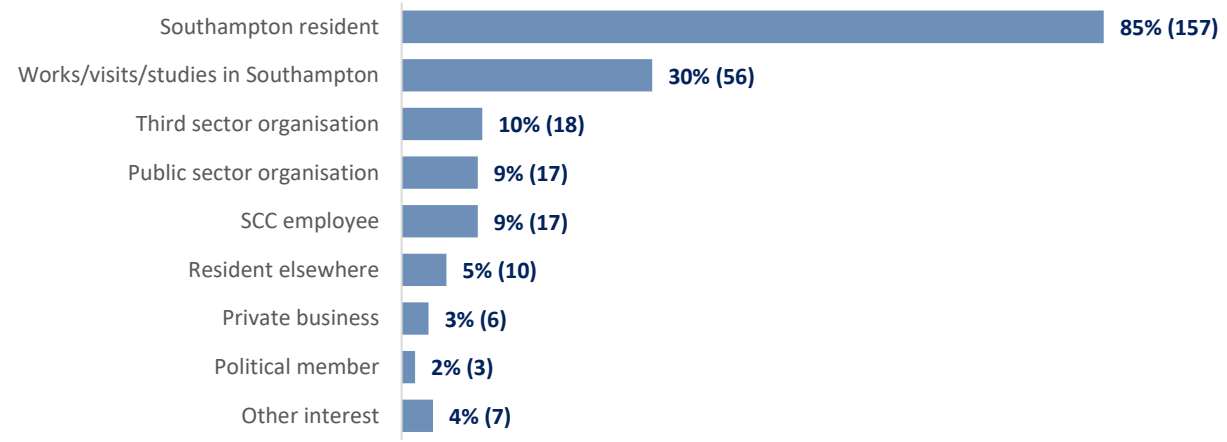
Sex



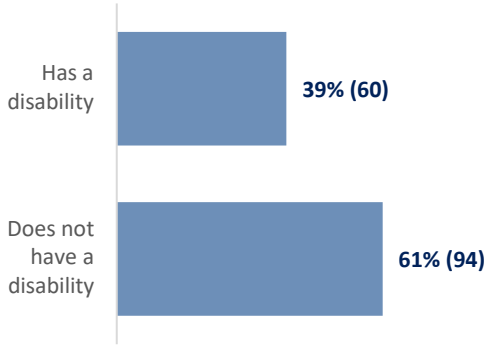
Age



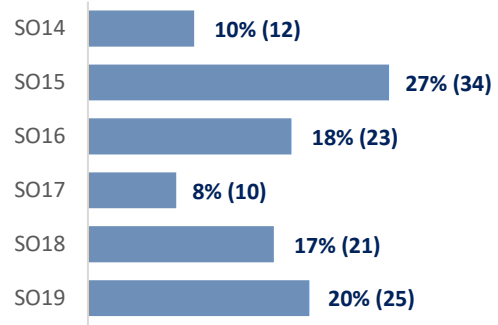
Interest in the consultation



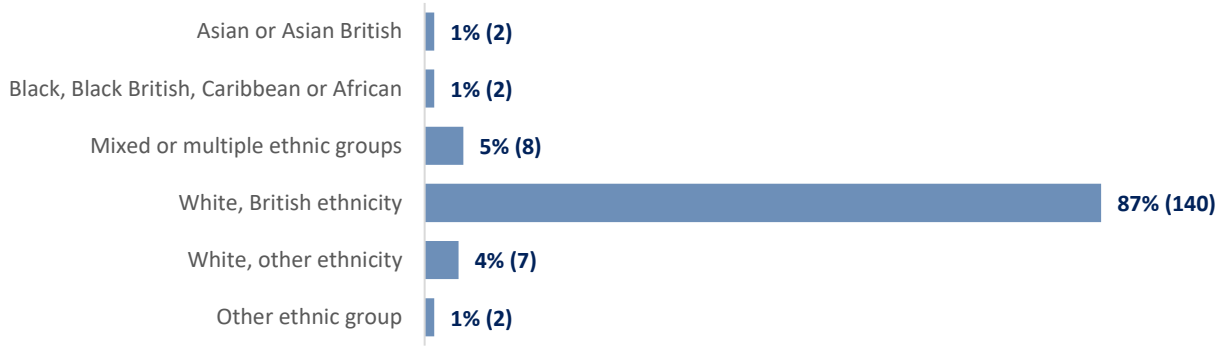
Disability



Postcode



Ethnicity



Source: Draft Mental Health & Wellbeing Strategy consultation, *November 2023 – January 2024*

Consultation feedback

Vision statement & overall priorities

Vision & broad priorities

This is a draft strategy for the whole city. It was developed with our partners across the city, including people with lived experience of poor mental health and those who support them. It reflects our shared priorities and the aspirations of services that support mental health and wellbeing in Southampton.

Our vision for the draft strategy is:

"People in Southampton will have good mental health and wellbeing, whatever their background or the circumstances in which they live."

This strategy describes our approach to achieving this vision. It outlines the actions that we will take together to address the needs of our residents and communities.

There are many things that affect mental health and wellbeing, both negatively (risk factors) and positively (protective factors). Through the prevention of risk factors and promotion of protective factors we hope to improve mental health and wellbeing in Southampton.

Mental health services are crucially important for people with mental illness or crisis, but this strategy is not only about these services. It focuses on preventing poor mental health and promoting wellbeing, looking at all the different things that are important for mental health and wellbeing.

Although this strategy is not about specific mental health disorders or conditions, it is relevant to people who have mental health illnesses like depression, anxiety, schizophrenia or bipolar, a condition like dementia, a learning disability, who have a drug or alcohol issues or who are neurodiverse. It is important that this strategy considers everyone's mental health and wellbeing. We know that everyone, including those who are living with other diagnoses, disabilities or difficulties, can benefit.

This is an ambitious strategy that reflects the importance of mental health and wellbeing across nearly every area of our lives. It outlines how partners across Southampton will work together to promote mental health and wellbeing and reduce inequalities.

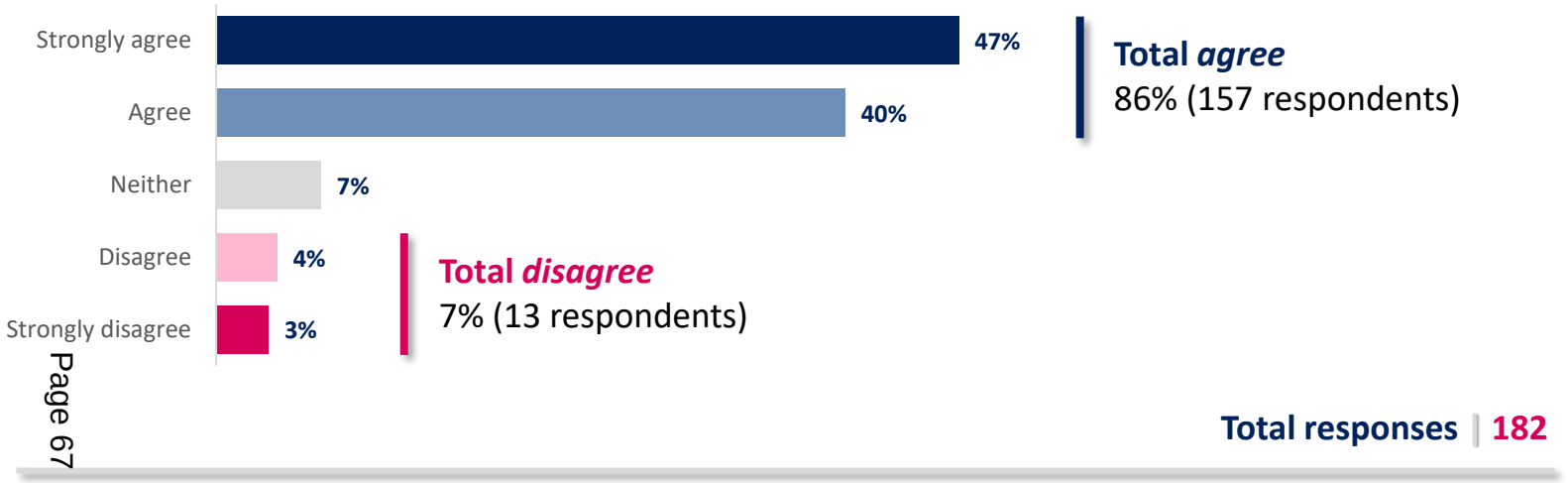
Our actions align to six priority areas:

1. There is a positive culture that promotes mental health and wellbeing in Southampton.
2. We have greater focus on the areas of people's lives that impact their mental health and wellbeing.
3. People in Southampton get support for their mental health and wellbeing when they need it.
4. People have equal opportunity to have positive mental health and wellbeing and equal opportunity to benefit from support when it is needed.
5. Children and young people get the best start in life for their mental health and wellbeing and families are supported.
6. Working together to prevent suicide and self-harm, and support those who are impacted.

Source: Draft Mental Health & Wellbeing Strategy consultation, *November 2023 – January 2024*

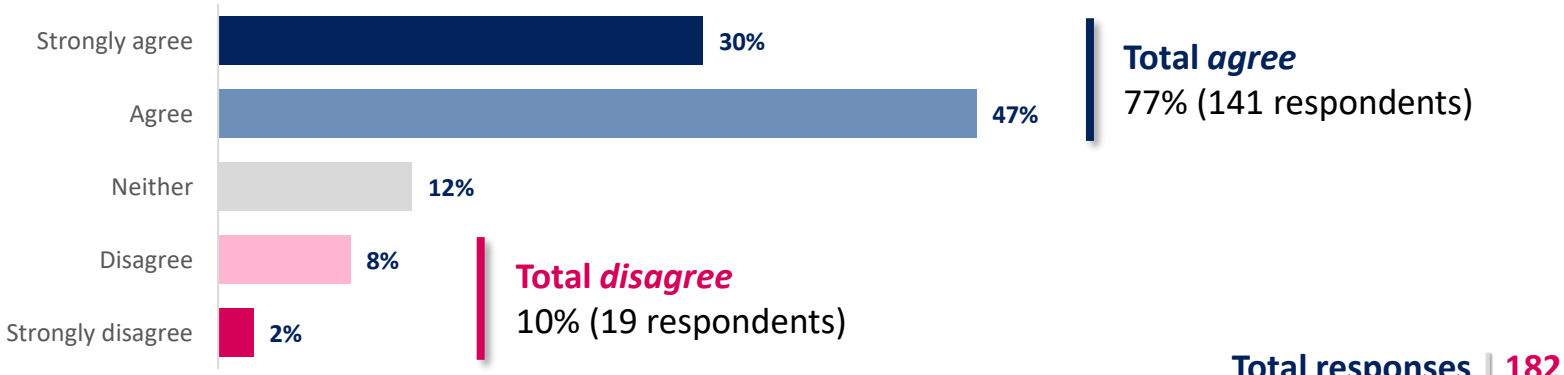
Feedback on the overall vision

Question 1 | To what extent do you agree or disagree with the focus of the proposed vision and six priority areas overall?



Total responses | **182**

Question 2 | To what extent do you agree or disagree that the proposed vision and six priority areas are clear and easy to understand?



Total responses | **182**

Key findings

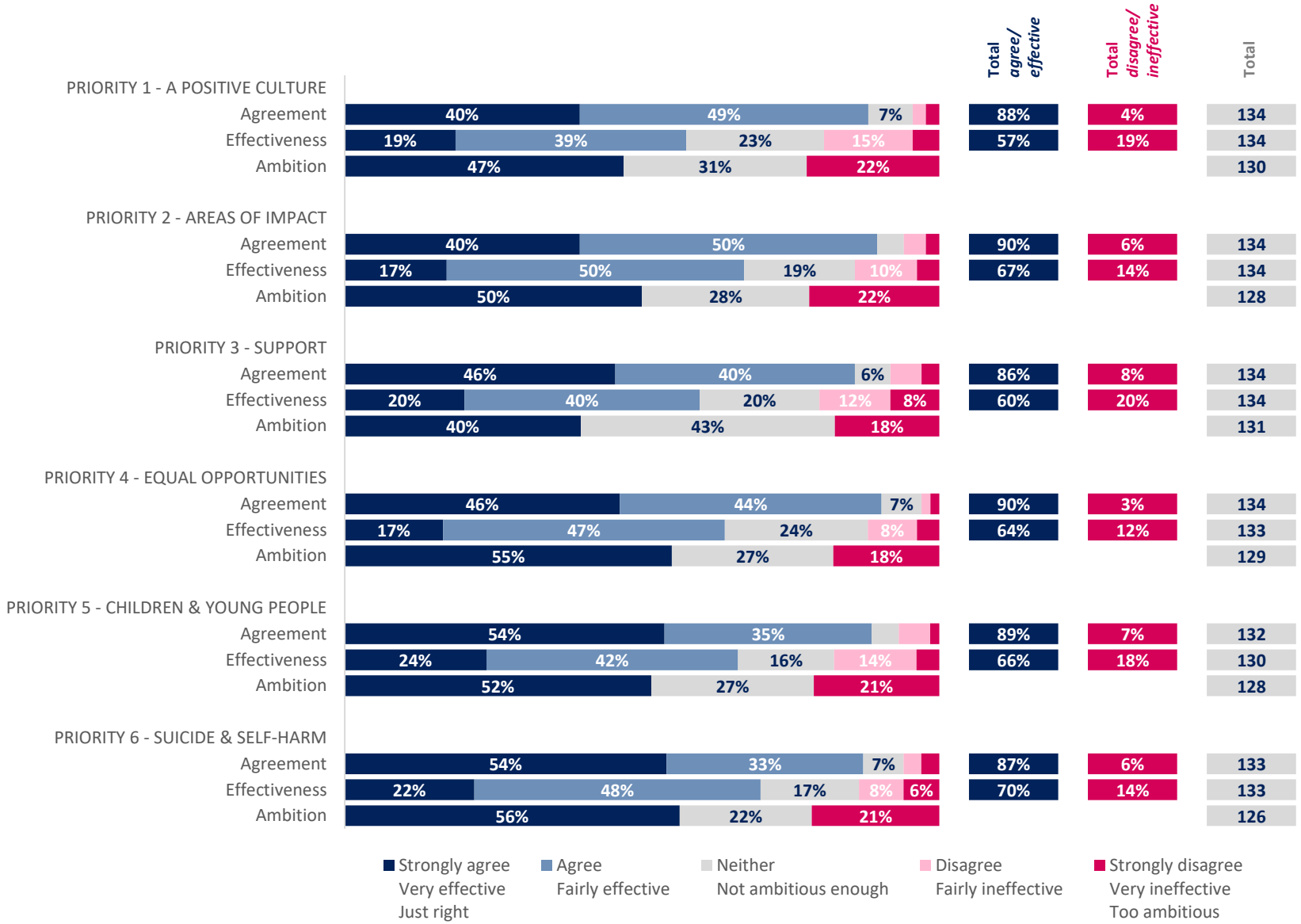
- 86% of respondents said they agreed with the draft vision and the priorities overall, including 47% that said they strongly agreed
- All breakdowns responded similarly, between 80% and 93% *agree*
- 77% of respondents agreed that the draft strategy was clear and easy to understand

Source: Draft Mental Health & Wellbeing Strategy consultation, *November 2023 – January 2024*

Summary of feedback on the priorities

If you need someone to talk to, you can contact Southampton Samaritans (116 123) or Solent Mind (text 'lighthouse' to 07451 276 010)

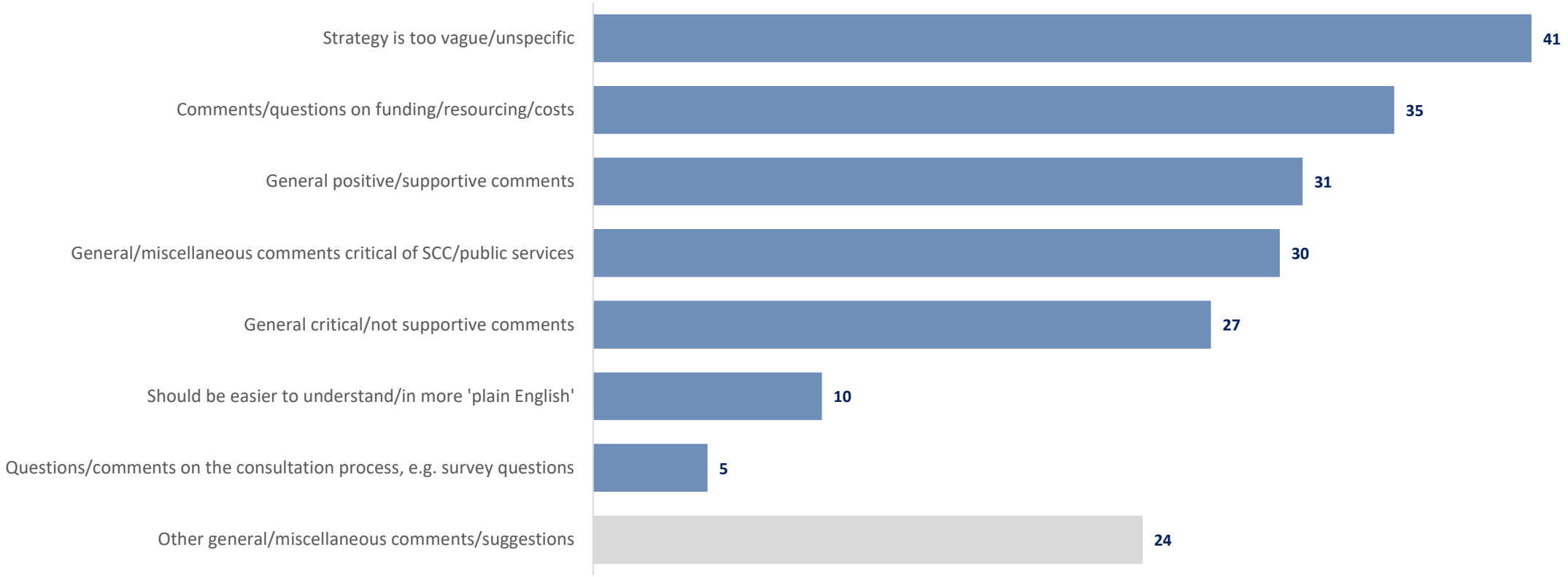
southampton dataobservatory



Source: Draft Mental Health & Wellbeing Strategy consultation, *November 2023 – January 2024*

Free-text comments on the draft strategy overall*

**Number of comments per comment theme.*



Source: Draft Mental Health & Wellbeing Strategy consultation, *November 2023 – January 2024*

Consultation feedback

Priorities

Priority 1 – A Positive Culture

Our mental health and wellbeing is impacted by our surroundings and our social connections. Therefore, it's important that our city promotes and protects the mental health and wellbeing of everyone.

We know that stigma, discrimination and racism have harmful effects on mental and physical health through the trauma they cause. We also know that stigma and discrimination against people with mental health problems can have a big impact and create further inequalities through bodily stress responses, poor access to mental and physical healthcare, dying earlier, exclusion from education and employment, increased risk of contact with the criminal justice system, victimisation, poverty and homelessness.

A city that promotes mental health and wellbeing needs to recognise and overcome stigma, discrimination, racism and promote inclusivity for everyone. It needs to celebrate the city and communities within it and the mental health of people who live and work here.

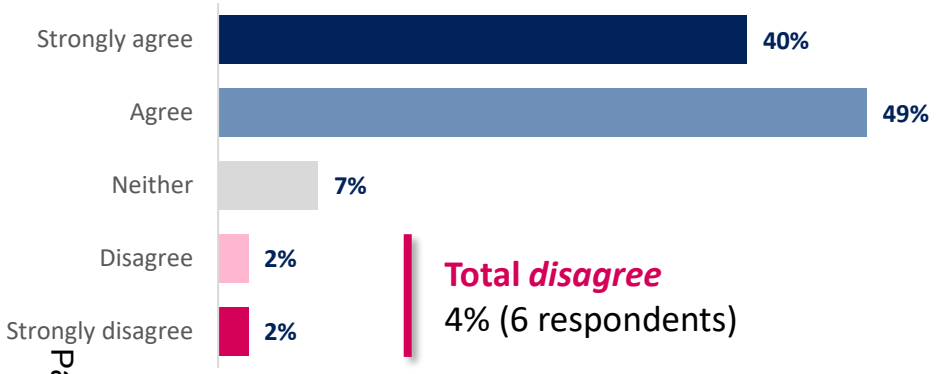
What do we want to achieve?

- Southampton is a place where everyone can benefit from our city-wide commitment to mental health and wellbeing
- People with lived experience are at the heart of our work and decision making around mental health and wellbeing
- We all share agreed language about mental health and wellbeing that includes, values and respects people
- We will increase awareness and inclusivity and reduce stigma and discrimination
- We are promoting positive messaging about mental health and wellbeing
- Workplaces in Southampton are committed to improving the mental health and wellbeing of their staff
- There will be strong leadership in mental health and wellbeing

Source: Draft Mental Health & Wellbeing Strategy consultation, *November 2023 – January 2024*

Priority 1 – A Positive Culture

Question 5 | To what extent do you agree or disagree with the proposals for this priority?

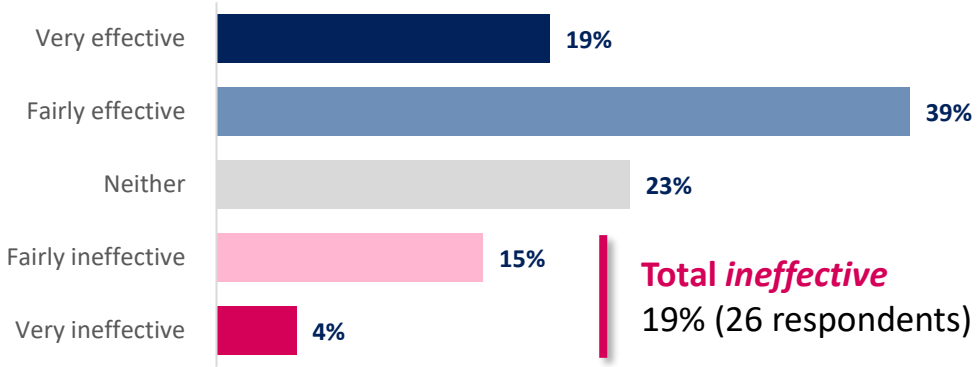


Total *agree*
88% (118 respondents)

Total *disagree*
4% (6 respondents)

Total responses | **134**

Question 6 | How effective do you feel these proposals would be towards achieving this priority?

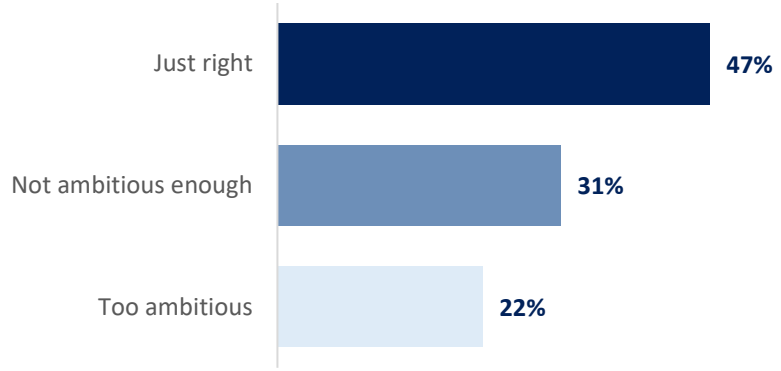


Total *effective*
57% (77 respondents)

Total *ineffective*
19% (26 respondents)

Total responses | **134**

Question 7 | How ambitious do you feel our plans are?



Total responses | **130**

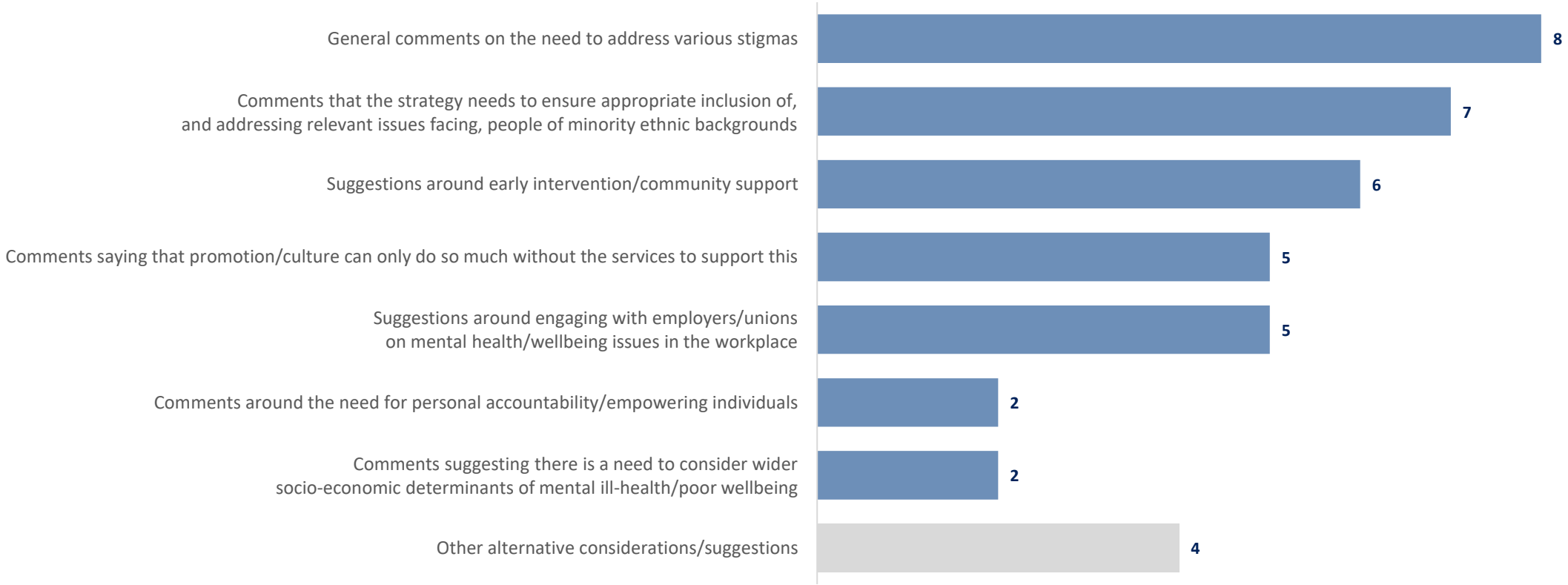
Key findings

- 88% of respondents said that they agreed with the proposals regarding this priority, including 40% that said they strongly agreed
- 57% of respondents said this part of the draft strategy would be effective if implemented, less than the 88% that said they agreed with this element overall
- More responded neither (23%) than responded *ineffective* (19%)
- 47% said that this priority had the right amount of ambition

Source: Draft Mental Health & Wellbeing Strategy consultation, *November 2023 – January 2024*

Priority 1 – A Positive Culture *free-text comments**

**Number of comments per comment theme.*



Source: Draft Mental Health & Wellbeing Strategy consultation, *November 2023 – January 2024*

Priority 2 – Areas of Impact

Everyone should have the right to live healthy lives and have positive mental health. However, inequalities in some of the basic building blocks of life means this is not the case. A focus on these building blocks means improving people's opportunities for things like education, employment, and housing. These are things that we know are important for mental health and wellbeing.

We also need to focus on protective factors like physical activity and social connections. Building social networks is incredibly important for daily wellbeing and for protecting against the impacts of challenges when they arise.

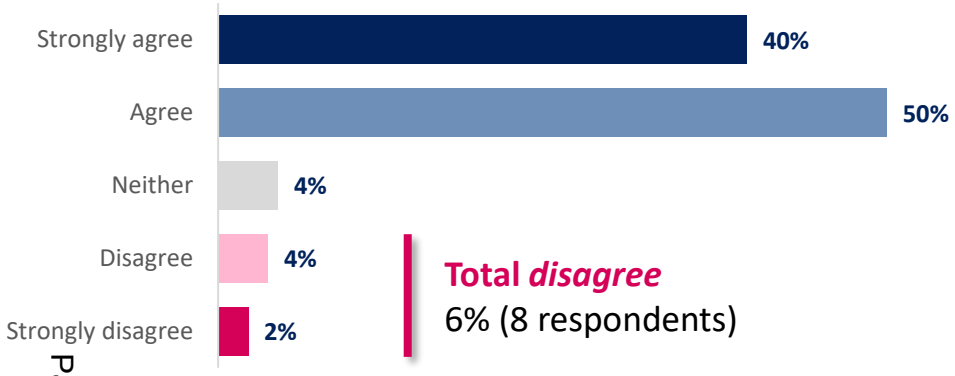
What do we want to achieve?

- Conditions in which people live and the opportunities for education and employment in Southampton are improved, and this will reduce inequality
- Everyone in Southampton can enjoy and benefit from things that improve mental health and wellbeing
- People are supported to build social connections
- People can access advice about managing the cost of living and the mental health impacts of financial anxiety and food insecurity

Source: Draft Mental Health & Wellbeing Strategy consultation, *November 2023 – January 2024*

Priority 2 – Areas of Impact

Question 9 | To what extent do you agree or disagree with the proposals for this priority?

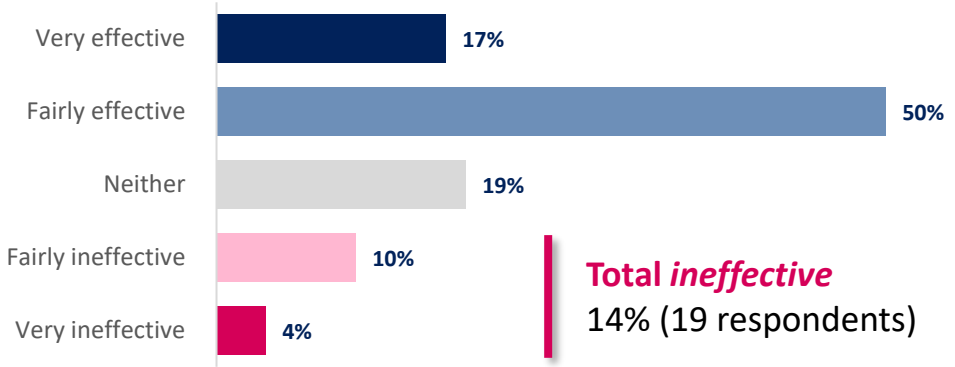


Total *agree*
90% (120 respondents)

Total *disagree*
6% (8 respondents)

Total responses | 134

Question 10 | How effective do you feel these proposals would be towards achieving this priority?

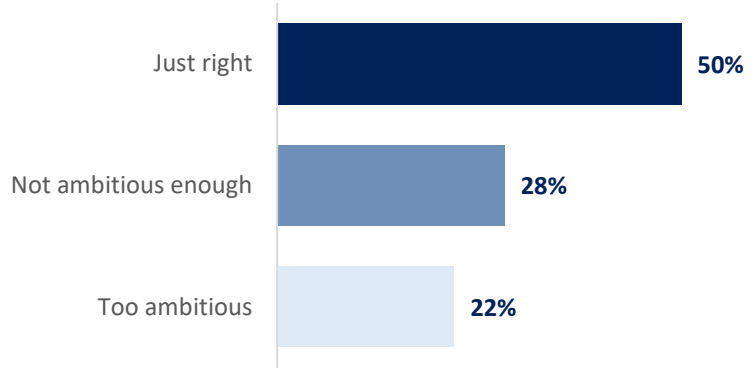


Total *effective*
67% (90 respondents)

Total *ineffective*
14% (19 respondents)

Total responses | 134

Question 11 | How ambitious do you feel our plans are?



Total responses | 128

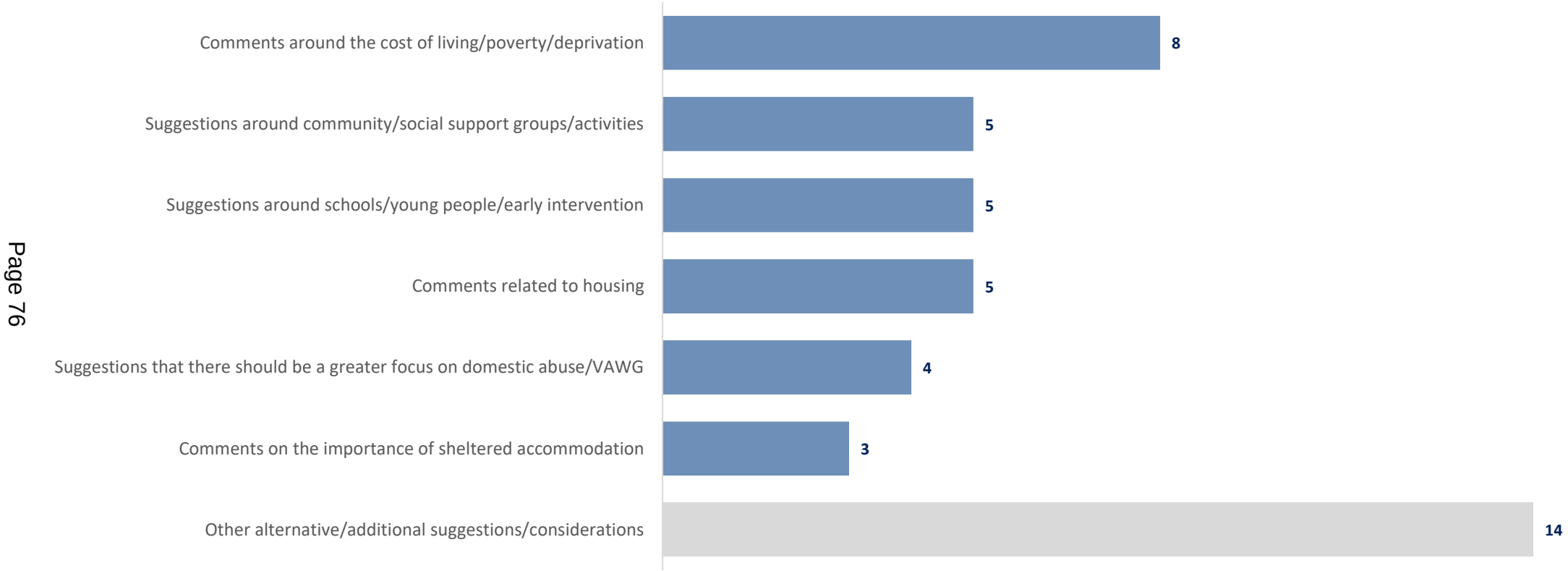
Key findings

- 90% of respondents said that they agreed with the proposals for this priority
- 67% said that the proposals on this priority would be *effective*, again, less than the 90% that said they agreed with the proposals generally
- Again, all breakdowns responded similarly, responding *effective* between 59% and 71%
- 50% said that the proposals for this priority had the right levels of ambition

Source: Draft Mental Health & Wellbeing Strategy consultation, *November 2023 – January 2024*

Priority 2 – Areas of Impact *free-text comments**

**Number of comments per comment theme.*



Source: Draft Mental Health & Wellbeing Strategy consultation, *November 2023 – January 2024*

Priority 3 – Support

This strategy strives to promote mental wellbeing and to prevent poor mental health in everyone. However, there will be times when support is needed, and people should be able to access appropriate levels of support at the right time. This should include support in the community as well as specialist support if needed. We need to continue to support the creation of connections between people and the organisations that support mental health and wellbeing.

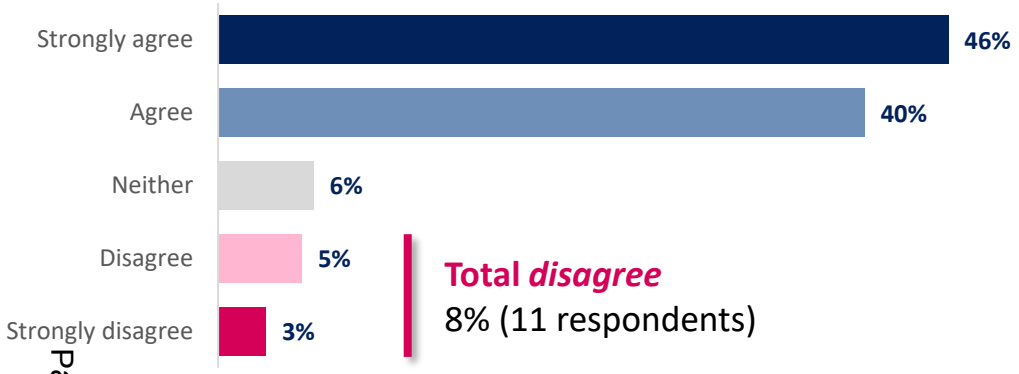
What do we want to achieve?

- Communities support the mental health and wellbeing of their residents
- A broad range of support for mental health and wellbeing is available to people before they need specialist services
- If people need help, they are able to access mental health services or crisis support.

Source: Draft Mental Health & Wellbeing Strategy consultation, *November 2023 – January 2024*

Priority 3 – Support

Question 13 | To what extent do you agree or disagree with the proposals for this priority?

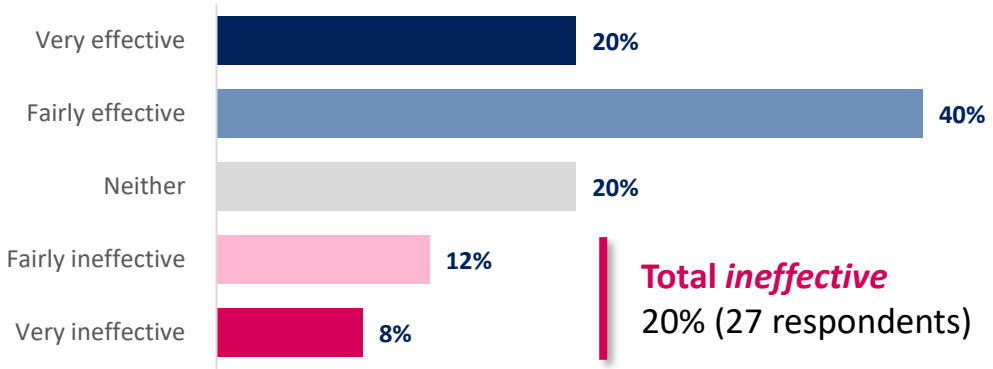


Total *agree*
86% (115 respondents)

Total *disagree*
8% (11 respondents)

Total responses | **134**

Question 14 | How effective do you feel these proposals would be towards achieving this priority?

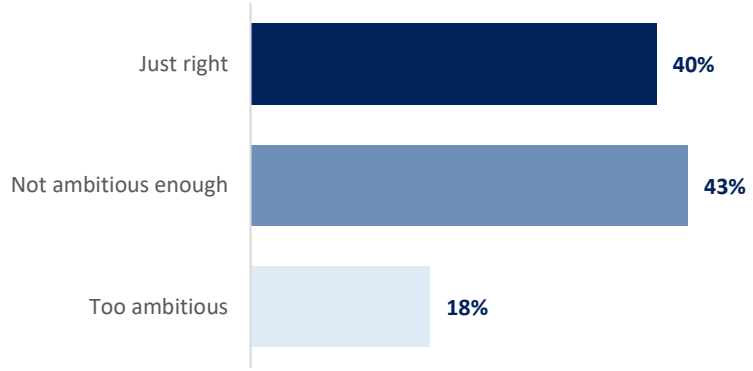


Total *effective*
60% (80 respondents)

Total *ineffective*
20% (27 respondents)

Total responses | **134**

Question 15 | How ambitious do you feel our plans are?



Total responses | **131**

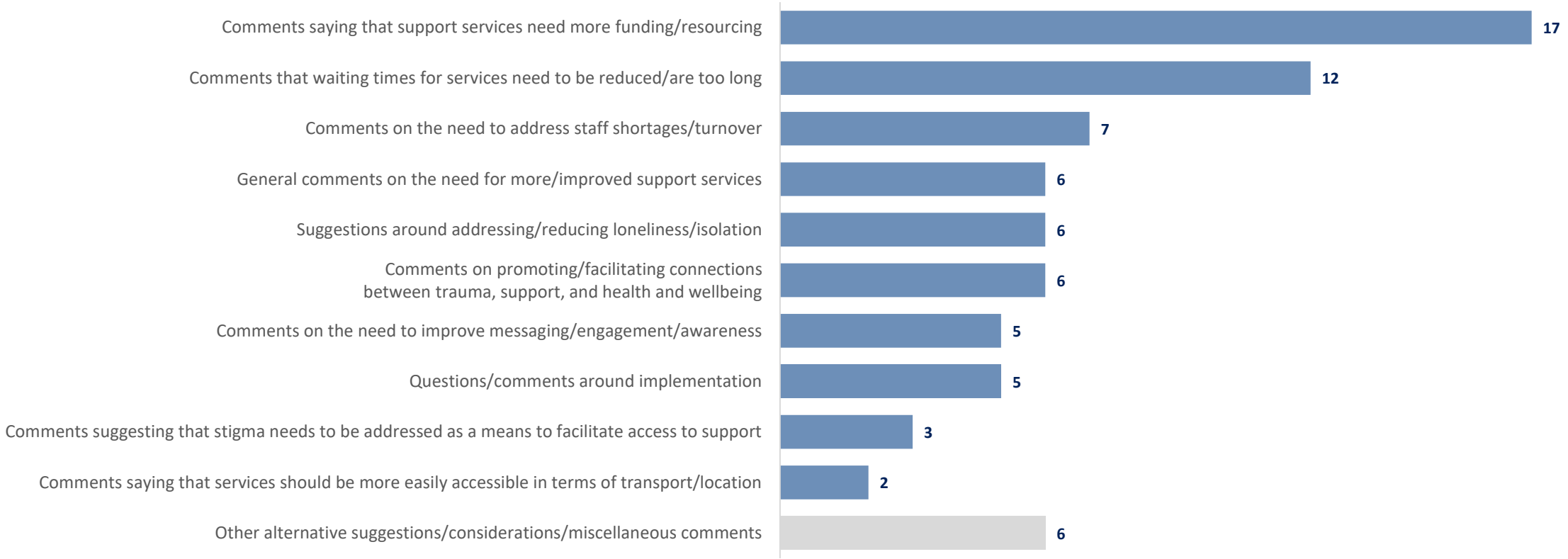
Key findings

- 86% agreed with the proposals for this priority, including 46% that said they strongly agreed
- 60% said the proposals for this priority would be effective, again, less than the 86% that said they agreed with the proposals generally
- Responses overall were split between just right (40%) and not ambitious enough (43%)

Source: Draft Mental Health & Wellbeing Strategy consultation, *November 2023 – January 2024*

Priority 3 – Support *free-text comments**

**Number of comments per comment theme.*



Source: Draft Mental Health & Wellbeing Strategy consultation, *November 2023 – January 2024*

Priority 4 – Equal opportunities

There are inequalities in mental health and wellbeing and many of these are linked to other challenges a person might be facing, whether that's physical health problems, neurodiversity, disability, addiction or discrimination. Not everyone is able to get the help they need and we must work towards overcoming barriers they face. We need to think about the whole person and all their needs. We need to recognise that people are complex and diverse and that a "one-size fits all" approach won't work.

We know that people who experience long term physical conditions are more likely to have poor mental health and wellbeing. We also know that people experiencing poor mental health are more likely to have poor physical health leading to worse outcomes. It is therefore important that the physical health of people with mental health problems is properly supported.

This strategy does not include preventing dementia as a disease because this is included in cardiovascular disease prevention. However, dementia can be associated with poor mental health, and people with dementia may benefit from the same mental health and wellbeing support as others.

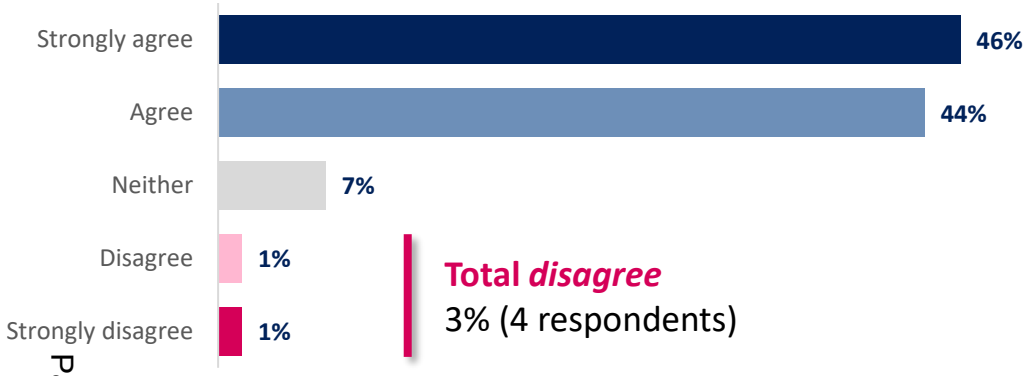
What do we want to achieve?

- Inequalities in mental health and wellbeing are reduced
- The mental health and wellbeing needs of people from different ethnic and cultural backgrounds are met and they are supported in the way that is right for them
- The needs of people with mental health problems are holistically met, reducing the inequality in health and wellbeing

Source: Draft Mental Health & Wellbeing Strategy consultation, *November 2023 – January 2024*

Priority 4 – Equal opportunities

Question 17 | To what extent do you agree or disagree with the proposals for this priority?

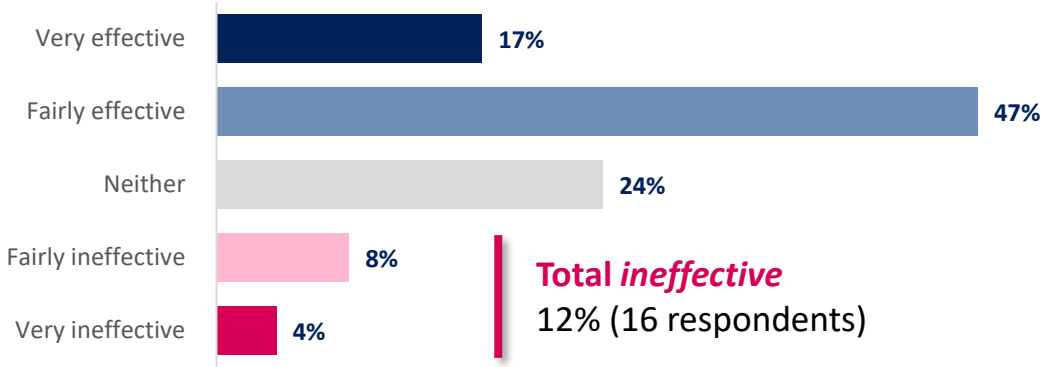


Total *agree*
90% (121 respondents)

Total *disagree*
3% (4 respondents)

Total responses | 134

Question 18 | How effective do you feel these proposals would be towards achieving this priority?

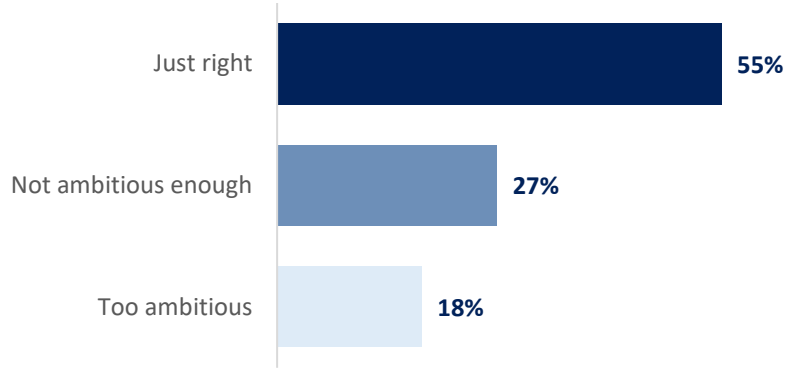


Total *effective*
64% (85 respondents)

Total *ineffective*
12% (16 respondents)

Total responses | 133

Question 19 | How ambitious do you feel our plans are?



Total responses | 129

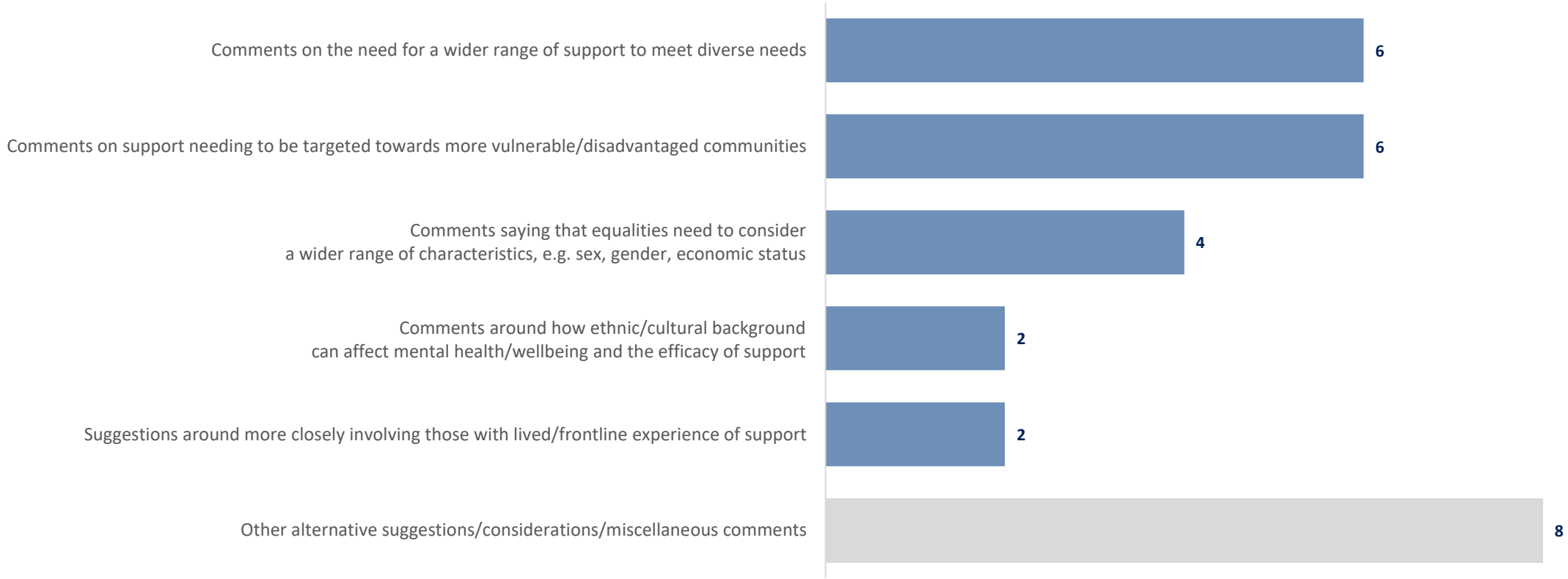
Key findings

- 90% of respondents agreed with this priority, including 46% that said they strongly agreed
- 64% said these proposals would be *effective* if implemented, with a quarter (24%) saying they would be neither *effective* or *ineffective*
- As with the other priorities, less said these proposals would be effective than the 90% that agreed with them overall
- Overall responses were 55% just right, with all breakdowns responding similarly

Source: Draft Mental Health & Wellbeing Strategy consultation, *November 2023 – January 2024*

Priority 4 – Equal opportunities *free-text comments**

**Number of comments per comment theme.*



Source: Draft Mental Health & Wellbeing Strategy consultation, *November 2023 – January 2024*

Priority 5 – Children & Young People

Putting in the ingredients for positive mental health and wellbeing needs to start in the early years. We know that half of mental health problems are established by age 14 and three quarters by age 24. We also know that the mental health of parents and carers has a significant impact on children and young people's current and future mental health and life chances. Supporting the mental health and wellbeing of children and young people through their families, communities and education settings is essential.

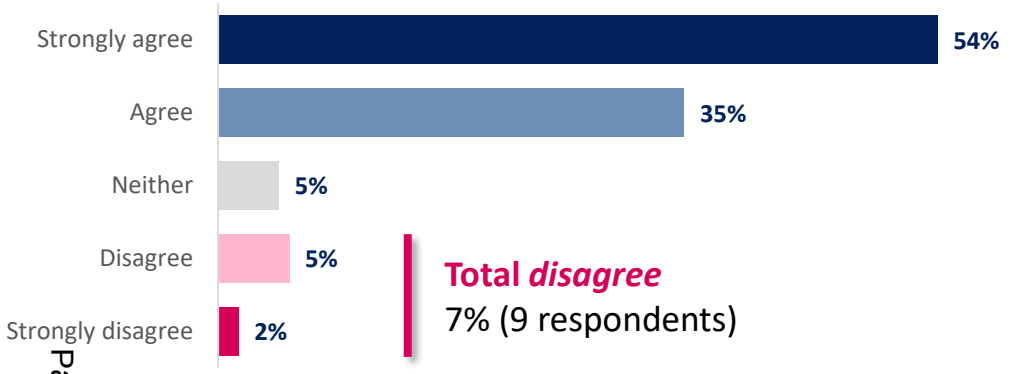
What do we want to achieve?

- Positive perinatal mental health and wellbeing for all the family
- Parents, carers and families can access a wide range of support in their communities
- A positive concept of emotional and mental health will be promoted and children and young people are able to have healthy conversations about emotions
- Education settings are healthy environments that promote good mental health and wellbeing of children, young people and staff, as well as teaching them about maintaining emotional wellbeing
- Children, young people and families are supported through transitions, both in their development and between services
- Parents, carers and families who provide support for a child or young person are given the tools and support they need

Source: Draft Mental Health & Wellbeing Strategy consultation, *November 2023 – January 2024*

Priority 5 – Children & Young People

Question 21 | To what extent do you agree or disagree with the proposals for this priority?

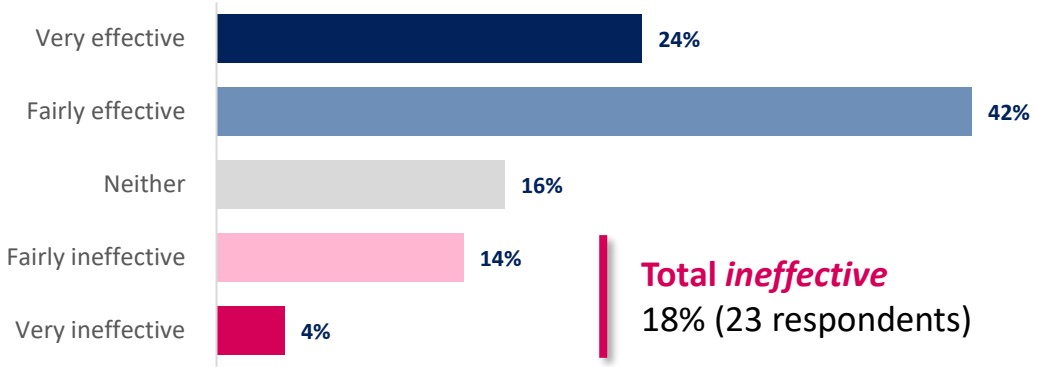


Total *agree*
89% (117 respondents)

Total *disagree*
7% (9 respondents)

Total responses | **132**

Question 22 | How effective do you feel these proposals would be towards achieving this priority?

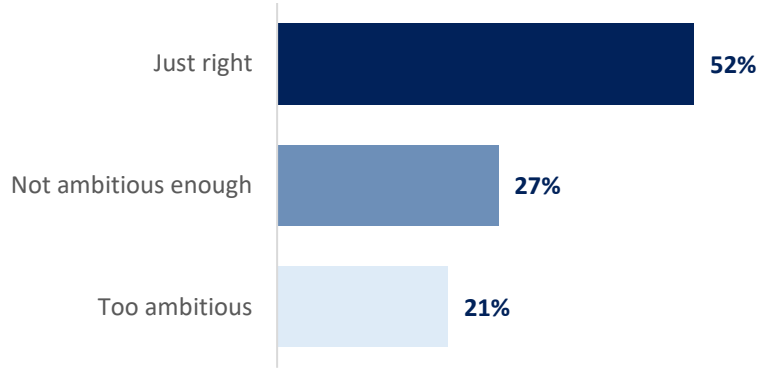


Total *effective*
66% (86 respondents)

Total *ineffective*
18% (23 respondents)

Total responses | **130**

Question 23 | How ambitious do you feel our plans are?



Total responses | **128**

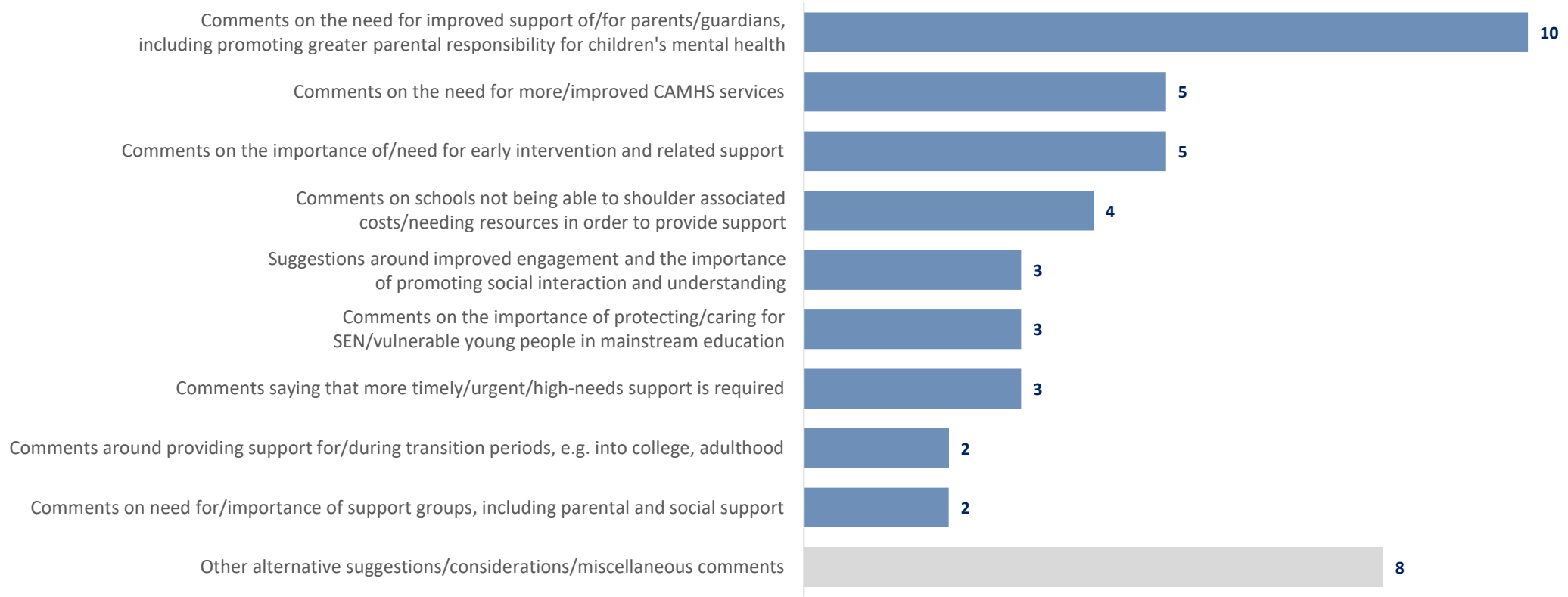
Key findings

- 89% said that they agreed with this priority, including 54% that said they strongly agreed
- 66% of respondents said that the proposals for this priority would be *effective* if implemented, again, less than the 89% that said they agreed with the priority
- 52% said the level of ambition was just right

Source: Draft Mental Health & Wellbeing Strategy consultation, *November 2023 – January 2024*

Priority 5 – Children & Young People *free-text comments**

**Number of comments per comment theme.*



Source: Draft Mental Health & Wellbeing Strategy consultation, *November 2023 – January 2024*

Priority 6 – Suicide & self-harm

If you need someone to talk to, you can contact Southampton Samaritans (116 123) or Solent Mind (text 'lighthouse' to 07451 276 010)

southampton dataobservatory

Deaths from suicide are tragic and have a devastating effect on families, friends, and communities. Suicide prevention refers to the collective efforts needed to reduce these deaths, recognising that each death is often the endpoint in a complex history of events and risk factors. Much of the prevention for suicide at a population level will be the same as prevention for poor mental health, such as reducing isolation, unemployment and the impact of trauma. However, preventing deaths by suicide also requires more specific action based on who we know is at risk and what we know works. From national and local data, we know that risk factors for suicide include:

- Men, particularly middle-aged men (and also younger males)
- People experiencing mental health problems
- People experiencing relationship difficulties, unemployment, financial difficulties, physical health problems, housing difficulties and/or social isolation
- Bereavement, especially bereavement by suicide
- People with previous attempts of suicide
- People with co-occurring drug and/or alcohol use and mental health problems
- People formerly convicted of a crime
- People who have experienced abuse (either as victims or witnesses)
- People experiencing isolation from others
- People who have been diagnosed with a terminal or chronic illness
- People experiencing bullying
- People who are neurodivergent
- People who identify as LGBTIQ+

What do we want to achieve?

- Partners across the city will work together to make suicide prevention everyone's business and maximise collective impact to prevent suicide and self-harm
- Improved data and evidence so that effective, evidence-informed and timely interventions continue to be adapted
- Provision of tailored support to priority groups, including those at higher risk
- Common risk factors linked to suicide are addressed by providing early intervention and tailored support
- Promotion of online safety and responsible media content to reduce harms and improve signposting to helpful information about suicide and self-harm prevention
- Enabling access to effective crisis support for people who need it
- Reducing access to means and methods of suicide to prevent deaths
- Continue to provide effective bereavement support to those affected by suicide
- Focus on preventing suicide in children and young people

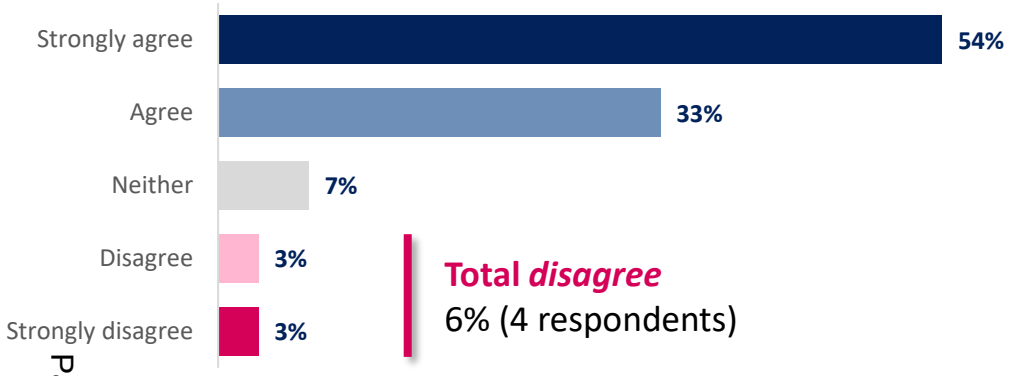
Source: Draft Mental Health & Wellbeing Strategy consultation, *November 2023 – January 2024*

Priority 6 – Suicide & self-harm

If you need someone to talk to, you can contact Southampton Samaritans (116 123) or Solent Mind (text 'lighthouse' to 07451 276 010)

southampton dataobservatory

Question 25 | To what extent do you agree or disagree with the proposals for this priority?

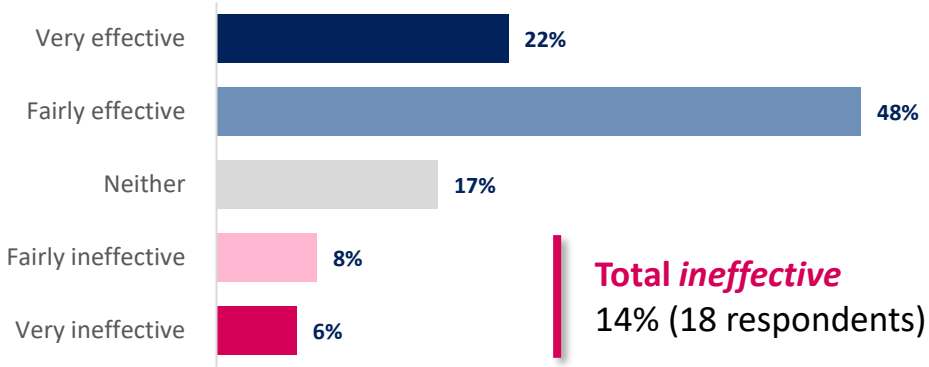


Total *agree*
87% (116 respondents)

Total *disagree*
6% (4 respondents)

Total responses | 133

Question 26 | How effective do you feel these proposals would be towards achieving this priority?

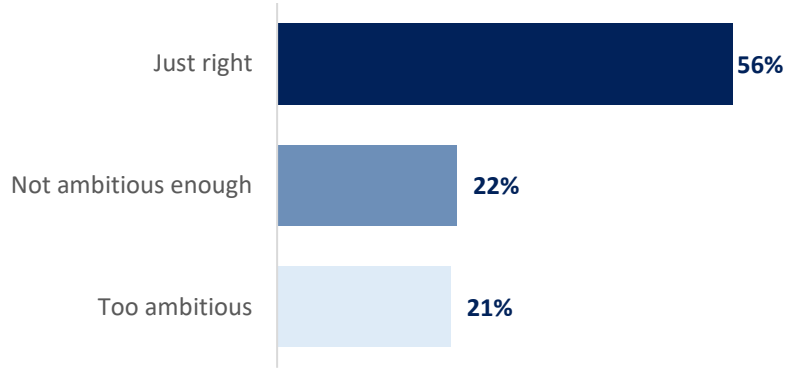


Total *effective*
70% (93 respondents)

Total *ineffective*
14% (18 respondents)

Total responses | 133

Question 27 | How ambitious do you feel our plans are?



Total responses | 126

Key findings

- 87% said that they agreed with this priority, including 54% that said they strongly agreed
- 70% of respondents said that the proposals for this priority would be *effective* if implemented, again, less than the 87% that said they agreed with the priority
- Over half (56%) said the level of ambition was just right

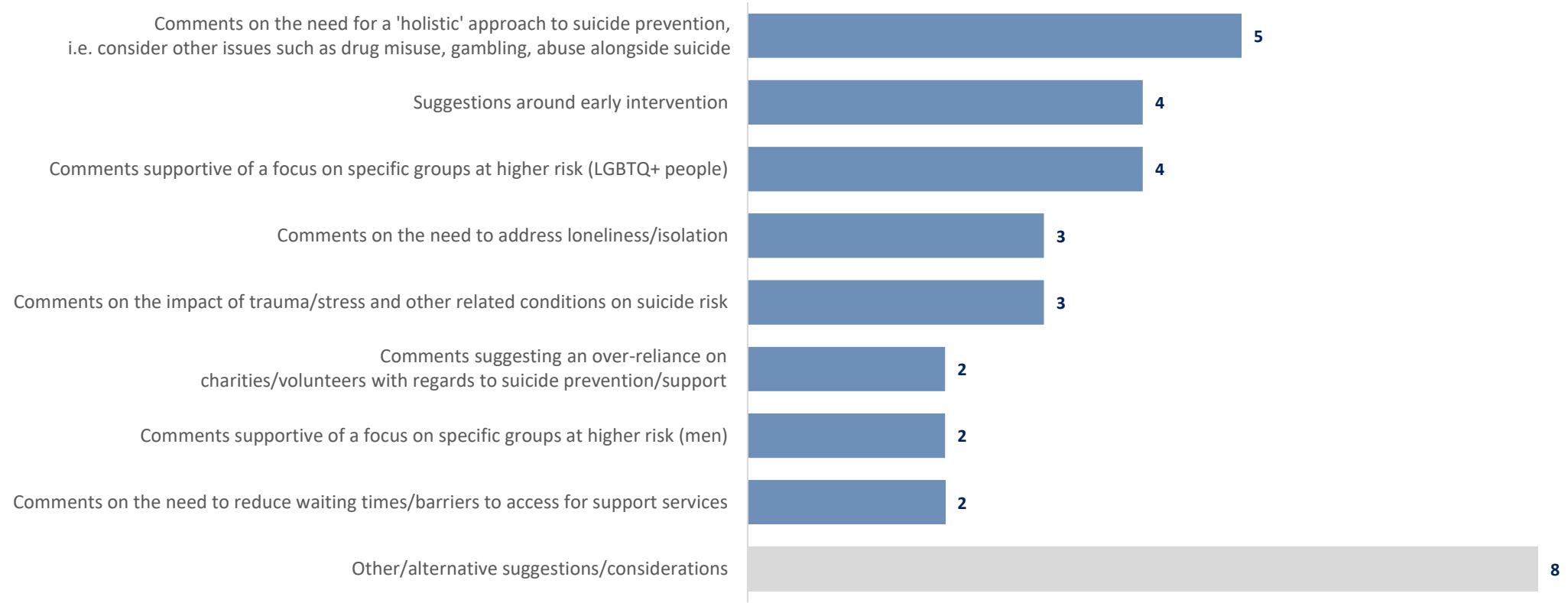
Source: Draft Mental Health & Wellbeing Strategy consultation, *November 2023 – January 2024*

Priority 6 – Suicide & self-harm *free-text comments**

If you need someone to talk to, you can contact Southampton Samaritans (116 123) or Solent Mind (text 'lighthouse' to 07451 276 010)

southampton dataobservatory

**Number of comments per comment theme.*



Source: Draft Mental Health & Wellbeing Strategy consultation, *November 2023 – January 2024*

Consultation feedback

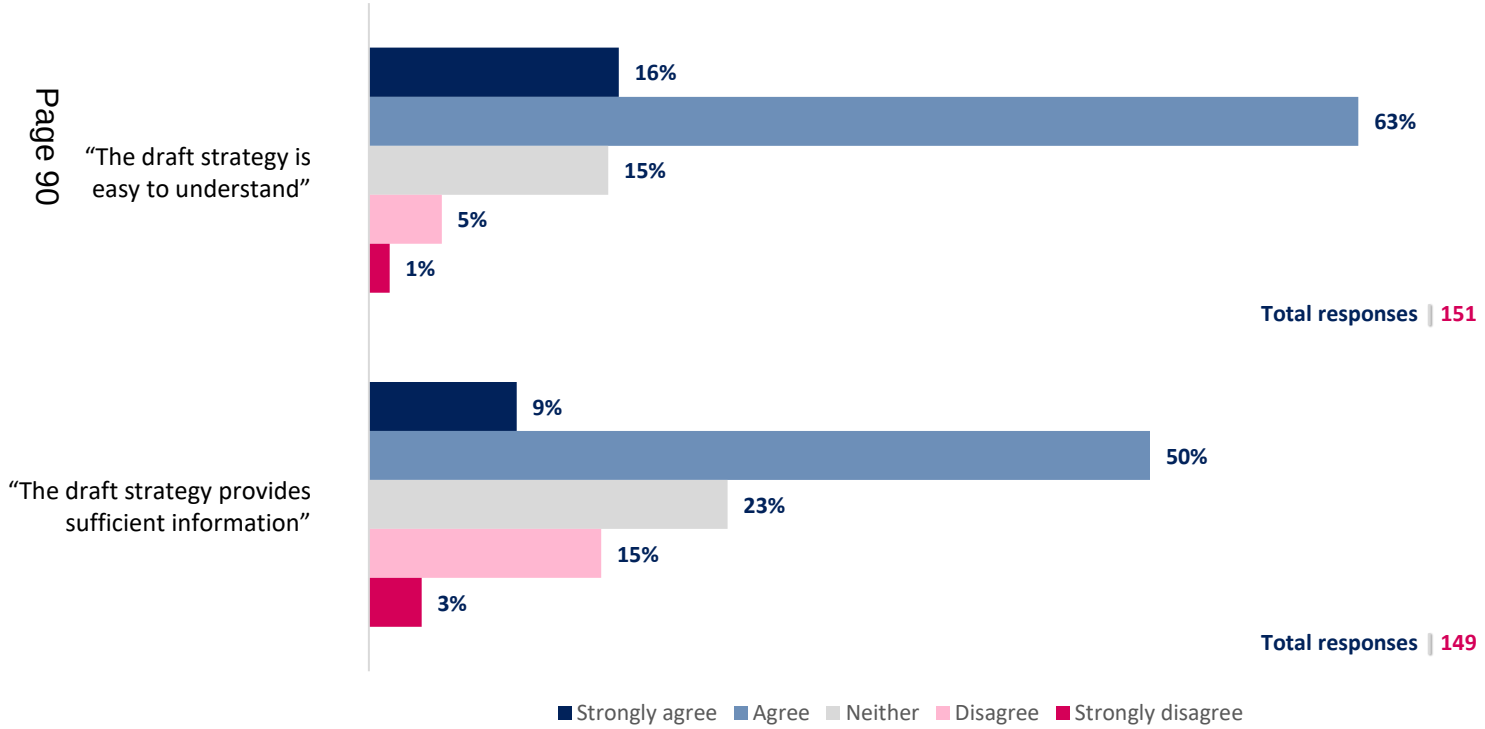
Reading the draft strategy

Reading & understanding the draft strategy

Question 29 | Have you read the proposed draft strategy?

Question 30 | If you have read the proposed draft strategy, to what extent do you agree or disagree with the following statements?

Asked if "Yes, all of it" or "Yes, some of it" response to question 29.



Key findings

- Of the 87% of respondents that said they'd read at least *some* of the draft strategy, 79% said that it was easy to understand, and 59% said that it contained an appropriate amount of information
- For both questions, *neither* was a more popular response than overall *disagree* responses – 15% versus 6% and 23% versus 18% respectively

Source: Draft Mental Health & Wellbeing Strategy consultation, *November 2023 – January 2024*

Considerations of the consultation feedback –

Mental Health & Wellbeing Strategy 2024

Consultation feedback		Officer response	Actions proposed
Broad themes	**Comment themes**		
Quantitative feedback	86% of respondents said they agreed with the draft vision and the priorities overall, including 47% that said they strongly agreed.		None
	77% of respondents agreed that the draft strategy was clear and easy to understand.	While it is positive that a large majority of respondents found the strategy clear and easy to understand we are committed to making the strategy as accessible as possible.	We will create a one page strategy that is more accessible. Some of the more complex terms have been added to the glossary at the bottom.
	Respondents agreed with each individual priority between 86% and 90%.		None
	Respondents said that each individual priority would be effective between 57% and 70%.		None
	Respondents said each individual priority had the right levels of ambition by 50% or more apart from priority one (positive culture – 47% *just right*, 31% *not ambitious enough*) and priority three (support – 40% *just right*, 43% *not ambitious enough*)		None
	87% of respondents said that they'd read at least part of the draft strategy: of these, 79% said that it was easy to understand, and 59% said that it contained an appropriate amount of information	We are really pleased that such a high proportion of respondents have read the strategy and gave positive feedback about the accessibility and relevance.	None
General/overall comments	Strategy is too vague/unspecific (*41 comments*)	We have chosen to keep the strategy high level and then create an action plan that will set out how we will deliver against the priority areas and how we will measure success.	We will create an action plan that we will use to deliver the strategy.
	Comments/questions on funding/resourcing/costs (*35 comments*)	The strategy does not have additional budget attached to it – it is intended to set out the principles we will use to work in partnership with services across the city.	None
	General/miscellaneous comments critical of SCC/public services (*30 comments*)		None
	General positive/supportive comments (*31 comments*)	We welcome the supportive comments on the draft strategy.	None
	General critical/not supportive comments (*27 comments*)		None
	Should be easier to understand/in more 'plain English' (*10 comments*)	While it is positive that a large majority of respondents found the strategy clear and easy to understand we are committed to making the strategy as accessible as possible.	We will create a one page strategy that is more accessible.
	Questions/comments on the consultation process, e.g. survey questions (*5 comments*)	One comment references that readers of the strategy might be upsetting for some readers.	We have added in signposting to mental health support.
Priority 1 – A positive culture	Comments that the strategy needs to ensure appropriate inclusion of, and addressing relevant issues facing, people of minority ethnic backgrounds (*7 comments*)	There were suggestions around supporting ethnic minority residents to lead conversations about mental health and take on roles within services as this would improve accessibility of services and improve service delivery.	We have covered our ambition to further diversify our workforce and work with community leaders in priority four.
	Comments saying that promotion/culture can only do so much without the services to support this (*5 comments*)	We understand this but would like to improve the way we work alongside other partners and promote what is available to residents. This is not in place of service delivery.	None
	General comments on the need to address various stigmas (*8 comments*)	Addressing the stigma that accessing mental health services can bring is central to the strategy. We understand the impact of stigma and trauma on mental health and have added our commitment to increasing awareness of this in priority one.	We will broaden

Consultation feedback		Officer response	Actions proposed
Broad themes	**Comment themes**		
	Suggestions around engaging with employers/unions on mental health/wellbeing issues in the workplace (*5 comments*)	We acknowledge that working with unions and work places as well as sources of employment support is really important and will include this in the action plan.	We will reference the importance of employment to good mental health in the strategy.
	Suggestions around early intervention/community support (*6 comments*)	We have acknowledged the importance of early intervention and community support throughout the strategy.	None
	Comments around the need for personal accountability/empowering individuals (*2 comments*)	We acknowledge the power of empowering people to look after their mental health in our communications and campaigns.	None
	Comments suggesting there is a need to consider wider socio-economic determinants of mental ill-health/poor wellbeing (*2 comments*)	This strategy takes a wider determinants approach.	None
Priority 2 - Areas of impact	Suggestions around community/social support groups/activities (5 *comments*)	We recognise that isolation and loneliness contribute to poor mental health – community and social support activities are set out under priority two. This includes activities for children and young people.	None
	Suggestions around schools/young people/early intervention (*5 comments*)	This strategy establishes early intervention as a key principle and the importance of mental health awareness and support at school as well as a safe stable home. This is set out under priority five.	None
	Comments around the cost of living/poverty/deprivation (*8 comments*)	Poverty and deprivation are a contributing factor to poor mental health.	We have added poverty as a risk factor in the introduction to the strategy and in priority two.
	Comments related to housing (*5 comments*)	There were a number of comments suggesting that links between mental health and housing could be stronger. We want to recognise the impact of poor quality housing on mental health as well as the impact of insecure housing.	None.
	Comments on the importance of sheltered accommodation (3 *comments*)		None
	Suggestions that there should be a greater focus on domestic abuse/VAWG (*4 comments*)	The Councils Domestic Abuse Strategy sets out how victims and survivors of domestic abuse can access mental health support. There are representatives from mental health services that sit on the Domestic Abuse Partnership Board.	The Southampton Mental Health and Wellbeing Partnership will also have links to the Domestic Abuse Partnership Board.
Priority 3 - Support	Comments that waiting times for services need to be reduced/are too long (*12 comments*)	This strategy aims to set out principles and ways of working rather than address issues with service provision.	None
	Comments saying that support services need more funding/resourcing (*17 comments*)	While this strategy shows our commitment to improving mental health in Southampton. The strategy will help us make best use of existing resources through partnership working but there is no additional funding attached to the strategy.	None
	General comments on the need for more/improved support services (*6 comments*)		None
	Comments on the need to improve messaging/engagement/awareness (*5 comments*)	We have committed to creating a city wide communications plan to share information about services available to support mental health and wellbeing in priority one of the strategy. We will consider using channels that will help us reach all residents.	None
	Comments suggesting that stigma needs to be addressed as a means to facilitate access to support (*3 comments*)	This is a really important point and we address how we reduce stigma under priority one. We will work with faith groups and other community groups to address the stigma attached to accessing support, this is set out in priority 4.	None
	Questions/comments around implementation (*5 comments*)	We will work on an action plan which will detail how we will deliver the various elements of this strategy. A mental health and wellbeing partnership will also be established that will oversee delivery of the strategy.	None
	Comments on the need to address staff shortages/turnover (*7 comments*)	These specific points commenting on service delivery are beyond the scope of this strategy.	None
	Suggestions around addressing/reducing loneliness/isolation (*6 comments*)	We recognise that isolation and loneliness are key contributors to poor mental health and reference this in the strategy.	None
	Comments saying that services should be more easily accessible in terms of transport/location (*2 comments*)	Services need to be accessible to users and we will promote services available locally. Transport planning is beyond the scope of this strategy.	None
	Comments on promoting/facilitating connections between trauma, support, and health and wellbeing (*6 comments*)	A couple of respondents ask for a definition of trauma and trauma informed practice they ask that the trauma informed board is referenced in the strategy. The Mental	None

Consultation feedback		Officer response	Actions proposed
Broad themes	**Comment themes**		
		Health and Wellbeing Partnership will also have representation from the Trauma Informed Board. Some respondents references links between trauma, mental health and substance use and this is referenced in the strategy.	
Priority 4, Equal opportunities	Comments on the need for a wider range of support to meet diverse needs (*6 comments*)	Support needs to meet diverse needs of residents across the city and this is set out in the strategy.	We have made a number of amendments to wording in the strategy to specifically reference particular communities and address comments.
	Comments on support needing to be targeted towards more vulnerable/disadvantaged communities (*6 comments*)	Mental health services should reflect the cities diversity. One comment states that mental health services for Gypsy, Roma and Traveller communities is not mentioned in the strategy – especially given a recent EHRC report about poor mental health within this community.	One comment referencing mental health in the Gypsy Roma Traveller Community has been addressed and this group is identified in the strategy.
	Comments saying that equalities need to consider a wider range of characteristics, e.g. sex, gender, economic status (*4 comments*)	Some feedback suggested our definition of characteristics was too narrow. We have amended this in line with those used by the Charity Mind. This strategy also links to the Violence Against Women and Girls strategy which addresses some specific support for victims of FGM. One comment references language as a barrier to accessing mental health support – the strategy sets out that services will be ''accessible and appropriately tailored'' and this would include meeting language needs.	We have amended the acronym used from LGBTIQ+ to LGBTQIA+ as suggested by a respondent.
	Comments around how ethnic/cultural background can affect mental health/wellbeing and the efficacy of support (*2 comments*)	We have addressed this important point in the strategy and are committed to working with communities to better understand mental heath and wellbeing needs.	None
	Suggestions around more closely involving those with lived/frontline experience of support (2 *comments*)	Working with people with lived experience of poor mental health and of barriers to accessing support is central to the strategy and we will continue to do this as we deliver the strategy.	None
Priority 5, Children & young people	Comments on the need for improved support of/for parents/guardians, including promoting greater parental responsibility for children's mental health (*10 comments*)	The strategy includes multiple commitments to supporting families throughout childhood.	None
	Comments on schools not being able to shoulder associated costs/needing resources in order to provide support (*4 comments*)	The strategy acknowledges that services and budgets are stretched but that we need to consider how to deliver the best services we can for young people within existing budgets. The mental health support teams are currently funded by central government to support young people in schools.	None
	Comments on the need for more/improved CAMHS services (5 *comments*)	The availability of (CAMHS) Child and Adolescent Mental Health Services is beyond the remit of this strategy. The strategy does cover promotion of what services are available rather than access criteria for specific services.	We have added a section on the promotion of CAHMS and how to access it.
	Comments on the importance of/need for early intervention and related support (*5 comments*)	We agree that early intervention is key to supporting good mental health in children and young people. The Healthy Early Years award is an accreditation that offers support for early years settings to support good mental health and wellbeing to under fives this includes a mental health and wellbeing strand.	None
	Suggestions around improved engagement and the importance of promoting social interaction and understanding (*3 comments*)	We cover this under priority 3 the strategy states ''A positive concept of emotional and mental health will be promoted and children and young people are able to have healthy conversations about emotions.''	We have added a refence to inclusivity.
	Comments around providing support for/during transition periods, e.g. into college, adulthood (*2 comments*)	We cover the importance of transitions for young people in priority three.	None
	Comments on need for/importance of support groups, including parental and social support (*2 comments*)	The strategy covers groups and parenting programmes provided by Family Hubs.	None
	Comments on the importance of protecting/caring for SEN/vulnerable young people in mainstream education (*3 comments*)	The provision of SEND support and education reform is out of scope of this strategy.	None

Consultation feedback		Officer response	Actions proposed
Broad themes	**Comment themes**		
	Comments saying that more timely/urgent/high-needs support is required (*3 comments*)	The availability of (CAMHS) Child and Adolescent Mental Health Services is beyond the remit of this strategy. The strategy does cover promotion of what services are available rather than access criteria for specific services.	None
Priority 6 - Suicide and self-harm	Comments on the need for a 'holistic' approach to suicide prevention, i.e. consider other issues such as drug misuse, gambling, abuse alongside suicide (*5 comments*)	We detail how we will take a holistic approach to suicide prevention in both the introduction to priority 6 but have clarified this.	We have reiterated our commitment to taking a holistic approach in the introduction to priority 6.
	Suggestions around early intervention (*4 comments*)		None
	Comments supportive of a focus on specific groups at higher risk (LGBTQ+ people) (*4 comments*)	We are grateful for comments that alerted us to the need to add in some further detail here.	We have added in a commitment to focus on suicide prevention for those who identify as LGBTQIA+ in table six.
	Comments on the need to address loneliness/isolation (*3 comments*)	We have reference the importance of reducing loneliness and social isolation in the introduction to this section and in priority two.	None
	Comments suggesting an over-reliance on charities/volunteers with regards to suicide prevention/support (*2 comments*)	Charities and community organisations are key to delivery of suicide prevention. The strategy outlines the charity and voluntary sector as equal partners.	None
	Comments supportive of a focus on specific groups at higher risk (men) (*2 comments*)		None
	Comments on the need to reduce waiting times/barriers to access for support services (*2 comments*)	The strategy establishes priorities and principles for partnership working rather than service delivery or commissioning.	None
	Comments on the impact of trauma/stress and other related conditions on suicide risk (*3 comments*)	We recognise that we need to be clear on the impact of childhood and other trauma on poor mental health and suicide risk. We have made some amendments to affirm our commitment here.	We have added sexual abuse as a risk factor in the strategy and the strategy commits to taking a trauma informed approach to preventing suicide.

DECISION-MAKER:	Health & Wellbeing Board
SUBJECT:	Routine Childhood Immunisations – Strengths and Needs Analysis
DATE OF DECISION:	14 March 2024
REPORT OF:	**COUNCILLOR MARIE FINN** **CABINET MEMBER FOR ADULTS & HEALTH**

CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY
N/a

BRIEF SUMMARY
Southampton City Council has a legal duty to protect the health of residents. The childhood immunisation programme is arguably the most important public health measure to protect health second to clean water.
This needs assessment provides data, evidence and insight on current childhood immunisation uptake rates, feedback from service providers and parents and opportunities to further improve future uptake. This assessment is particularly important and timely given the current UK measles outbreak.

RECOMMENDATIONS:		
	(i)	To accept the recommendations from the childhood immunisation strengths and needs assessment 'CHISANA' on engagement, inequalities and inclusion, service improvement and partnership working.
	(ii)	To note and comment on the engagement strategy.

REASONS FOR REPORT RECOMMENDATIONS	
1.	To provide the Health & Wellbeing Board with an update as to the current status regarding routine childhood immunisations in Southampton, highlight the needs that have been identified and plans to engage on key recommendations to improve uptake locally.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
	N/a

DETAIL (Including consultation carried out)

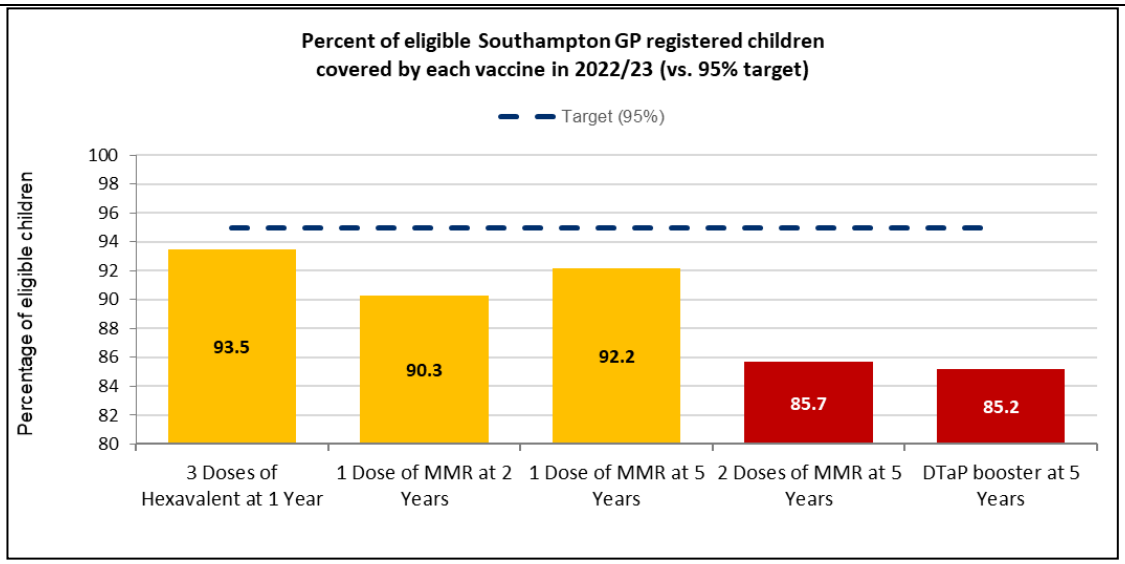
SUMMARY:	
1.0	A comprehensive Childhood Immunisation Strengths and Needs Assessment (CHISANA) with a focus on immunisations in children aged 0-5 years living in Southampton was conducted. It has sought to understand why uptake rates of childhood immunisation are declining and, consider what practical and immediate action can be taken to address the issues that may be contributing to this. This paper summarises the key findings, including highlighting some of the work that is already undertaken to commission and deliver immunisations in Southampton as well as key recommendations and opportunities to positively influence uptake. Completion of this report comes at a time of recent and ongoing outbreaks of measles in London and the West Midlands where most cases are in children who have not received one or both doses of the MMR vaccination (see Appendix 2, Measles Briefing).
2.0	**BACKGROUND and BRIEFING DETAILS**
2.1	According to the World Health Organisation (WHO), around 4-5 million deaths are prevented globally each year through immunisation programmes making it one of the most straightforward, successful and cost-effective public health interventions. Children that are immunised are protected from a number of infectious diseases that can cause serious illness or disability and, in some cases, can be fatal. Maintaining high coverage rates is extremely important to help avoid outbreaks of vaccine-preventable diseases, avoid increasing numbers of patients requiring health services and to considerably reduce morbidity and mortality. Vaccines also protect our economy and our public services from the disruption and economic loss of an outbreak or pandemic, as well as the personal discomfort and distress borne by young people and families affected by an illness. Vaccinations will also help reduce use of antibiotics and the growing issue of antimicrobial resistance.
2.2	Globally childhood vaccination programmes have been a huge success. However, high immunisation uptake is required to protect as many of the eligible population as possible. For highly infectious diseases such as measles, The World Health Organisation (WHO) recommends an uptake of 95% or greater for herd or population level immunity ensuring those that can't be vaccinated (for example children under 1) are protected by those around them. It is concerning that uptake in childhood immunisations in Southampton and England has been steadily decreasing. This decline started prior to the COVID-19 pandemic. Whilst higher than the national average, Southampton rates for 2022/23 were 90% for MMR at one year and 86% for two doses of MMR at 5 years. Whilst these rates fall short of the WHO 95% target, they are notably higher than rates in Birmingham and Coventry where many of the cases in the current West Midlands outbreak have occurred. Whilst this is encouraging, the findings of CHISANA will help support current national catch-up campaigns for MMR as well as improve uptake within the routine childhood immunisation schedule.
2.3	The Childhood Immunisation Strengths and Needs Assessment (CHISANA) seeks to understand why pre-school immunisation uptake is declining and consider what practical and immediate action can be taken to address the issues that may be contributing to this. It highlights the work that is already being undertaken to commission and deliver immunisations in Southampton. It also recognises that it is not possible to reliably link the decline in uptake to any one single issue or address it with any one intervention. Many of the themes and recommendations put forward in this assessment have been previously identified in various studies and reports locally and nationally over the last 10-15 years.
2.4	There are multiple opportunities to help positively influence uptake of childhood immunisations from before a child is born right up to when they begin school. From midwives to early years settings, health colleagues and community leaders – we all play our part in protecting children and preventing outbreaks.

2.5	**Roles and Responsibilities for Delivery of Childhood Immunisations** • The DHSC sets performance targets, and the UK Health Security Agency undertakes surveillance of vaccine-preventable diseases. • NHS England is responsible for the commissioning of immunisations and vaccinations through the public health functions agreement (S7A). This responsibility will move to the ICB in April 2024. • Routine childhood immunisations in children aged 0-5 and adult vaccinations are usually delivered by GP surgeries. School-age services are coordinated by seven regional NHS England teams and delivered through School-Aged Immunisation Service (SAIS). • In Southampton, NHS Solent manage the school aged immunisation (SAI) programme including offering school age catch up clinics. • Health visitors and midwives have a crucial role to play advocating for childhood immunisations and supporting parents to make the decision to get their children immunised. Delivery of this forms part of the statutory responsibilities of local authority public health teams. • Local authority Directors of Public Health have a scrutiny and assurance role in relation to vaccinations, including providing appropriate challenge to the arrangements for screening and immunisation programmes. Also advocating for reducing health inequalities and improving access for under-served groups. • Public health teams are also in a unique position to understand the health needs of their local population and have a role to play in supporting vaccination services. This may be through helping immunisation teams' work with frontline services such as health visitors or children's centres or supporting pop-up vaccination clinics. They can also support health promotion through their communication channels and networks.
3.0	**Scope and Approach**
3.1	CHISANA has focused on routine immunisations 0-5 years age group. The overall aim of the UK's current routine childhood immunisation schedule[1] is to provide protection against the following 14 vaccine preventable infections via 7 different vaccines:
3.2	• Haemophilus influenzae type b (Hib) • Hepatitis B • Human Papillomavirus • Influenza • Measles • Meningococcal disease • Mumps • Pertussis (whooping cough) • Pneumococcal disease • Polio • Rotavirus • Rubella (German measles) • Shingles • Tetanus
3.3	All vaccinations offered on the schedule are free of charge. None of them are compulsory.

[1] **The UK's current routine childhood immunisation schedule, Complete routine immunisation schedule from 1 September 2023 - GOV.UK (www.gov.uk) [accessed 30/01/24)**

3.4	Many different stakeholders have a role to play in delivery of the childhood immunisation programme. Our approach to undertaking this needs assessment has reflected this. The needs assessment has been undertaken via a multi-disciplinary working group which has drawn together colleagues from NHS England Screening and Immunisation Team (SIT), The Integrated Commissioning Board (ICB), Public Health and Data and Intelligence. We have spoken to/interviewed a range of key stakeholders involved in vaccination delivery including: 1) NHS England (NHSE) SIT Team 2) Child Health Information System (CHIS) Team 3) NHS Solent School Aged Immunisation Service (SAIS) 4) Health Visitor Lead 5) Healthier Together 6) GP Maternity Lead 7) Solent Looked After Children (LAC) Team 8) We have undertaken a parent survey (834 respondents) and workforce survey (23 out of 25 GP Practices from across Southampton responded) to gain insights, experiences and attitudes. 9) We have reviewed documents relating to governance and accountability. 10) We have analysed *COVER[2] data on vaccination uptake across the city to gain a more detailed picture as to what the numbers can tell us about what is happening locally, and we have considered how this can be linked to other issues such as deprivation and ethnicity. 11) Key policy and guidance has been reviewed and the findings and recommendation drawn together to build on and support the recommendations in this report. 12) We have also carried out a desk-based audit of all the key digital information sources, including GP Practice websites, available to parents. 13) Recent learning from the COVID-19 vaccination programme has also been draw together to consider where and how this can be applied to childhood immunisations. 14) We have also considered how the pandemic might have contributed to falling uptake of childhood immunisations (pandemic factors).
4.0	**Data Analysis**
4.1	<u>Indicators</u> 5 key childhood vaccination uptake indicators have been analysed. • 3 doses of Hexavalent at 1 year of age. • 1 dose of MMR at 2 years of age • 1 dose of MMR at 5 years of age • DTaP booster at 5 years of age • 2 doses of MMR at 5 years of age
4.2	Although Southampton uptake has been consistently higher than the National Average, in 2021/22 and 2022/23 Southampton missed the 95% target for all 5 indicators. Uptake for 2 indicators was below 90% and rated red (2 doses MMR at 5 years and DTaP booster at 5 years).This data indicates that uptake gets worse as children get older and that the declining trend is continuing.

[2] **Cover of Vaccination Evaluated Rapidly (COVER) programme: annual data on coverage achieved by the childhood immunisation programme {accessed 30/01/24)**

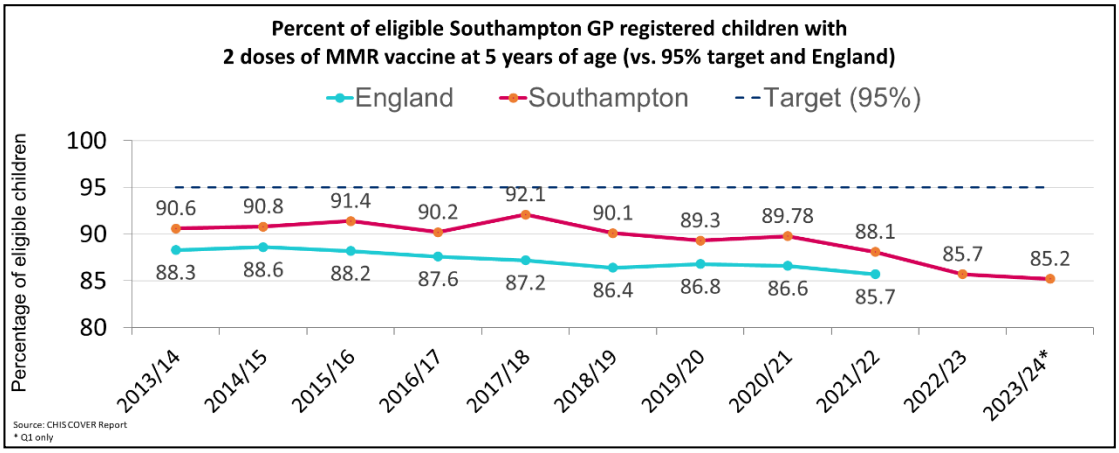


4.3 Analysis has been carried out across 5 indicators. A summary of the findings is provided in the table below. A summary of the findings is provided in the table below which provides percentage uptake by anonymised GP practice in the city.

Anonymised GP Practice	% Uptake (2022/23)				
	3 Doses of Hexavalent at 1 Year	1 Dose of MMR at 2 Years	1 Dose of MMR at 5 Years	DTaP booster at 5 Years	2 Doses of MMR at 5 Years
GP-1	88.8	88.1	89	79	79.7
GP-2	93.8	94.5	86.8	76.7	79.9
GP-3	90.6	91.9	93.5	83.5	82.5
GP-4	93.6	96.3	93.6	91.3	91.3
GP-5	88.4	88	90.3	74.8	77.7
GP-6	93.9	94.4	95.9	88.9	88.5
GP-7	91.9	90.7	86.4	79.5	81.8
GP-8	93.1	93.8	92.4	83.5	83.5
GP-9	87.1	90.1	86.1	83.5	83.5
GP-10	96.6	95.8	87.5	73.6	75
GP-11	95.5	96.1	93.5	84.9	85.5
GP-12	88.5	91.2	89.7	82.1	82.8
GP-13	81.3	86.7	91.2	85.3	85.3
GP-14	97.6	96.5	96.6	90.7	92.2
GP-15	96.2	92.6	98.1	92.5	90.6
GP-16	95.7	97.6	91.5	89.4	89.4
GP-17	93.1	100	86.5	76.9	78.8
GP-18	98.6	98.6	92.4	81.8	80.3
GP-19	100	91.1	88.9	77.8	84.4
GP-20	97.2	98.4	93.1	86.1	84.7
GP-21	97.4	100	100	97.3	94.6
GP-22	99.2	95.6	97.4	91	89.7
GP-23	97.3	97.4	94.4	93.3	93.3
GP-24	97.5	98.1	96.1	91.4	91.4
GP-25	96.8	94.7	94.7	94.7	94.7

Context:

- The size of the eligible cohort at each GP Practice varies year on year. The average eligible cohort for 2022/23 was 360 children per practice (ranging between 88 and 1,312).
- There was no clear trend between the size of the cohort/number of children eligible and vaccination uptake.
- There is some evidence to suggest a link between the overall GP registered population deprivation score and practice level vaccine uptake, but this is not consistent across the city and without individualised uptake data is not possible to draw firm conclusions.

	• Further analysis carried out identified that the average gap to 95% for 2022/23 for 2 doses of MMR at age 5 was the equivalent to an average of 12 additional children at each GP practice having the vaccine per year (ranging from 0-43).
4.4	A rise in measles cases globally and in the UK, has resulted in recent outbreaks in London and the West Midlands. In Southampton we have looked closely at uptake for MMR. The graph below shows uptake for 2 doses of MMR vaccine at 5 years of age. 
5.0	**Key Findings**
5.1	1) The Childhood immunisation programme is a huge success. Trust in Southampton remains high and 90% of parents we spoke to were happy with the service they have received. Whilst rates are declining, we did not find evidence of any significant anti-vaccine sentiment and Southampton uptake is consistently higher than the national average. 2) It has not been possible to secure meaningful ethnicity-based data or establish trends as to who isn't getting vaccinated. This makes it difficult to tailor services to need and to address any health inequalities in uptake that might exist. 3) There are opportunities to strengthen promotion of vaccination across the system by training and empowering a wide range of professionals and people from within the community (community centred approaches) to have conversations about the importance of vaccination with parents, and confidently address concerns and myths. 4) Practical issues, such as ease of booking and availability of appointments, remain a significant barrier for parents. There is a need for a greater range of appointment times and a more personalised approach to following up missed appointments. 5) Ensuring services are tailored to meet needs does not mean treating all people the same. Providing more bespoke support for parents and families that need it, such as parents of children with disabilities, families with chaotic lives, or for whom English is not a first language, should be prioritised. 6) It not possible to point to one single cause or solution to improve immunisation uptake. It will require action and sustained effort across a number of different elements, and multiple stakeholders have a role to play.
6.0	**Recommendations**
6.1	Recommendations have been developed to address the issues identified as a result of undertaking the needs assessment. These have been grouped into four themes. Each of the themes is further underpinned by 5 recommendations. To help with implementation, these have been prioritised according to feasibility and impact using a prioritisation matrix. A summary is provided below:

	1) **Theme one: Engagement –** these recommendations focus on strengthening communications and engagement in relation to the promotion of vaccination by training and equipping professionals across the system to as well as utilising a range of trusted stakeholders including community leaders and trusted people of influence. 2) **Theme two: Inequalities and inclusion** – these recommendations seek to improve issues identified that relate to information availability and the accessibility of advice and appointments, in particular the need to offer more highly tailored services for individuals needing additional support. 3) **Theme three: Service improvement** – these recommendations focus on further improving services through the provision of enhanced staff training (with a particular focus on inequalities, appointment availability, improving data recording, cleansing and extraction processes, providing a more personalised process for appointment follow up and improving the ethnicity based data recording policy. 4) **Theme four: Partnership working** – these recommendations focus on working together across the system to ensure a sustained focus and coordination action on vaccination uptake.
7.0	**Next Steps**
7.1	<u>Assigning, Implementing and Monitoring Recommendations</u> The report and findings will be shared with the Screening Immunisation Oversight Group (SIOG), which brings together key stakeholders from NHSE, ICB and Public Health, to discuss how to maximise benefit at a system and local level.
7.2	<u>Engagement</u> We will be using the needs assessment to share findings and engage with and support stakeholders across the system. The aim of this will be to generate the sustained and coordinated effort that will be required to increase uptake over the forthcoming months and the years ahead. An engagement plan has been developed that identifies key stakeholder and range of different mechanisms to ensure that the profile of childhood immunisations is raised that everyone understands the shared responsibility we have for promoting them. This engagement work will be led by public health and developed collaboratively with the working group. The engagement plan has been developed and will be rolled out over the coming weeks. A summary is provided below. *Engagement with GP Practices* This will include offering GP Practices the opportunity for a one-on-one meeting to go through the findings from CHISANA including practice specific data which has been anonymised within the report. *Engagement with Primary Care Colleagues – TARGET Event* We will be presenting alongside ICB colleagues at the Primary Care TARGET on 7th March 2024. These events are well subscribed by a range of primary care colleagues working in frontline roles including GPs and Practice Nurses. The event will provide an ideal platform to share the findings from CHISANA and engage with key stakeholders. *Engagement with external stakeholders also supporting vaccination*

	We will engage with other key individuals and services and stakeholders across the system that have a direct interest in childhood immunisation, including the School Aged Immunisation Service (SAIS), Midwifery Services, Health Visitors, CHIS, Healthier Together, Participation Officers, Named Nurse- Looked After Children (LAC) *Engagement with key stakeholders within the Council* We will engage key individuals and services across the Council that have a role to play in promoting vaccination to families but may not be aware of how they can positively influence impact. This will include social workers, family hub staff, education settings (schools and early years), family support workers, community engagement colleagues. We will also engage with and attend key Boards, groups and meetings to present themes and gather feedback including CMB, the Health & Wellbeing Board and Health Protection Board (HPB). *Engagement with Community Groups and Faith Leaders* We will identify opportunities to engage with community groups, including Faith Leaders, the community engagement leads network (health and wellbeing champions), Future communities group and other voluntary sector groups. *Engagement with Public Health colleagues* We recognised the importance of sharing the work that we have undertaken with counterparts working in other parts of the country and will therefore publish CHISANA and the parent survey report on the data observatory so that it can be accessed and where beneficial used by others to support their own work. We will be attending the South-East Public Health Conference and hope to have secured a slot to share our findings and invite feedback at this event. We will also share the findings with health protection leads in regional meetings.
7.3	**Wider Workforce Capacity Building** We have been successful in securing a small grant to work in partnership with NHS Solent Educational team to deliver a series of routine immunisation training sessions for wider workforce (not directly involved in delivery of immunisations) but who play an important role, as trusted individuals, in promoting childhood immunisations. This will include: • Family hub staff. • Social workers (supporting LAC) • Health Visitors. • Midwives. • Social prescribers. • Early years staff. • School nurses. • Other staff deemed eligible. The sessions will aim to highlight the important role participants can play in promoting childhood immunisation through their conversations and interactions with parents. It will equip them with the knowledge and confidence to tackle difficult questions, explore myths and misinformation and impart key messages about the vital role vaccinations play in protecting children from infectious diseases. It will also highlight additional information and practical support available for parents where this is needed.
7.4	**Routine Childhood Immunisation – Translated Storytelling Film** We have also secured a small grant to work in partnership with a third party to develop translated media content/assets in a format that will be available to be shared and utilised by a wide range of organisations, groups and businesses across the city via multiple channels. This may include:

	• Sharing content via social media platforms, organisational websites and local radio. • Sharing content in waiting rooms and venues that utilise screens to share information with customers. • Utilising content within training sessions to help convey key messages. This educational project aims to tackle falling rates of childhood immunisation and address issues of inequality in relation to information availability so that parents can make informed and confident decisions about their children's health. The project will help build the capability and capacity of the future and existing public health and wider health and care workforce, by providing much needed translated assets and engaging content in relation to routine childhood immunisations.
RESOURCE IMPLICATIONS	
Capital/Revenue	
	There are currently no additional financial commitments associated with delivery of CHISANA over and above the sustained Health Protection Officer Time that is being applied to this by from within the Public Health, Health Protection.
	This in depth needs assessment has been undertaken to provide an improved and robust understanding of the issues related to routine childhood immunisation locally. It is hoped that the collaborative approach taken to the work will help to secure the necessary buy in and support for delivery of the recommendations by key stakeholder. The completion of this report comes at a time when nationally there is an increased spotlight on the issues of childhood immunisations and the plans that are in place to share and engage the work will help to further amplify these messages.
	Governance and alignment with other strategies and corporate priorities Improving childhood Immunisation uptake is a key target within Southampton strategies including the Health and Wellbeing Strategy, Health and Care Strategy, Children and Young People's Strategy, Local priorities and action for improving MMR uptake are also described in an improving MMR HIOW uptake strategy.
Property/Other	
	N/a
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
	Local authority Directors of Public Health have a scrutiny and assurance role in relation to vaccinations, including providing appropriate challenge to the arrangements for screening and immunisation programmes. Also advocating for reducing health inequalities and improving access for under-served groups.
Other Legal Implications:	
	N/a
RISK MANAGEMENT IMPLICATIONS	
	Undertaking this needs assessment provides the DPH with assurance that sufficient scrutiny and focus is being applied to the issue of falling rates of childhood immunisation. It will be important to continue to review progress against the recommendations once these have been published.

	Challenges implementing the recommendations outlined in the needs assessment and a failure to reverse the decline in uptake, will result in an increasing risk of outbreaks of serious vaccine preventable diseases. These pose a significant harm to children in the city. Will provide an update on childhood vaccination rates and progress of a local action plan to the HWB in March 2025. Additional assurance and improvement can be gained through participation in sector wide improvement programmes and wider action that is being led by the ICB at a local level.
POLICY FRAMEWORK IMPLICATIONS	
	N/a

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices	
1.	CHISANA full report
2.	Measles briefing

Documents In Members' Rooms

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

Title of Background Paper(s)		**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.	N/a	

Childhood Immunisation Strengths and Needs Assessment (CHISANA)

January 2024

In partnership with Southampton Place ICB

Contents

CHISANA prepared by:
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Glossary of terms

Term/Acronym	Definition
The Child Health Information Service (CHIS)	The primary objective of CHIS is to ensure standardised and accurate data and information to support the commissioning and delivery of child health services.
"COVER" Cover of Vaccination Evaluated Rapidly Data	Cover of Vaccination Evaluated Rapidly : (COVER) programme
Department for Health and Social Care (DHSC)	Government department responsible for government policy on health and social care matters in England. It oversees the National Health Service NHS and led by the Secretary of State for Health and Social Care.
Did Not Attend (DNA)	When a patient misses their appointment, it is referred to as a 'Did Not Attend' (DNA)
Herd or Population Immunity	Herd immunity occurs when the majority of a population develops immunity against a contagious disease either through vaccination or due to a previous infection. This significantly reduces the likeliness of disease transmission from one person to another
Joint Committee on Vaccination and Immunisation (JCVI)	Provides independent vaccination policy advice to DHSC.
HIOW	Hampshire and Isle of Wight.
Immunity	Immunity is the ability of the human body to protect itself from infectious disease
Improving Immunisation Uptake Team Initiative (IIUT)	A specialist team that works closely with and is part of, SCW's Child Health Information Services (CHIS). The IIUT are focused on reducing variation in immunisations and increasing uptake rates in children aged 0 – 5 years.
Integrated Care Board (ICB)	Statutory bodies that are responsible for planning and funding most NHS services in the area
National Health Service England (NHSE)	NHS England is an independent non-departmental public body, responsible for providing national leadership and direction for NHS organisations in England.
National Audit Office (NAO)	The National Audit Office is an independent Parliamentary body in the United Kingdom which is responsible for auditing central government departments, government agencies and non-departmental public bodies.
National Institute for Health and Care Excellence (NICE)	The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care.

Glossary of terms

Term/Acronym	Definition
Quality and Outcomes Framework (QOF)	Sets out how GP's are contracted & remunerated for providing good quality care to their patients.
Screening and Immunisation Team (SIT)	Embedded within regional NHS teams and provide specialist support and advice.
Strategic Immunisations Oversight Group (SIOG)	Provides oversight and governance for delivery of vaccination delivery. Chaired by NHSE.
The Green Book	The Green Book has the latest information on vaccines and vaccination procedures, for vaccine preventable infectious diseases in the UK.
Vaccine	Vaccines teach your immune system how to create antibodies that protect you from diseases.
Was Not Brought (WNB)	"Was Not Brought" (WNB) replaces the phrase "Did Not Attend" for children, in order to protect babies and young people who are not brought to appointments when an adult does not take them resulting in possible medical neglect
World Health Organisation (WHO)	The World Health Organization (WHO) is a specialized agency of the United Nations responsible for international public health.
United Kingdom Health Security Agency (UKHSA)	A government agency in the United Kingdom, responsible since April 2021 for England-wide public health protection and infectious disease capability and replacing Public Health England. It is an executive agency of the Department of Health and Social Care (DHSC).
Uptake	Vaccine uptake or vaccination rate: the number of people vaccinated with a certain dose of the vaccine in a certain time period.

DPH foreword

Debbie Chase
Director of Public Health

Why are childhood immunisations important?

Around 4-5 million deaths are prevented globally each year through immunisation programmes making it one of the most **straightforward, successful** and **cost-effective** public health interventions.

Children that are immunised are protected from infectious diseases which can cause serious illness or disability and, in some cases, be fatal. **Maintaining high coverage rates is extremely important** to help avoid outbreaks of vaccine-preventable diseases, avoid increasing numbers of patients requiring health services and to reduce mortality and morbidity. Vaccines also protect our economy and our public services from the disruption and economic loss of an outbreak or pandemic, as well as the discomfort and distress borne by young people and families affected by an illness. Furthermore, vaccinations will also help reduce use of antibiotics and the growing issue of antimicrobial resistance. So, **it is in everyone's interest to ensure that vaccine preventable diseases are kept at bay**.

Globally childhood vaccination programmes have been a huge success. However, high immunisation uptake is required to protect as many of the eligible population as possible. **For highly infectious diseases such as measles, The World Health Organisation recommends an uptake of 95% or greater for herd or population level immunity** ensuring those that can't be vaccinated (for example children under 1) are protected by those around them. It is concerning that uptake in childhood immunisations in Southampton and England has been steadily decreasing for *some time.* This decline started prior to the COVID-19 pandemic. Whilst higher than the national average Southampton rates for 2022/23 were 90% for MMR at one year and 86% for two doses of MMR at 5 years.

This comprehensive Childhood Immunisation Strengths and Needs Assessment (CHISANA) seeks to understand **why pre-school immunisation uptake is declining and importantly, consider what practical and immediate action can be taken to address the issues that may be contributing to this**. It highlights the excellent work that is already being undertaken to commission and deliver immunisations in Southampton. It also highlights **that it is not possible to reliably link the decline in uptake to any one single issue or address it with any one intervention**. Many of the themes and recommendations put forward in this assessment have been previously identified in studies and reports locally and nationally over the last 10-15 years. **We know what we need to do**. Achieving them will only be possible by building further on the excellent work across the entire system, and a renewed commitment to take even greater steps to address inequalities.

There are multiple opportunities to help positively influence uptake of childhood immunisations from before a child is born right up to when they begin school. From midwives to early years settings, health colleagues and community leaders – we must all play our part to protect children and prevent outbreaks. Together we can make this happen and give our children the best chances for a healthy future.

Context and Introduction

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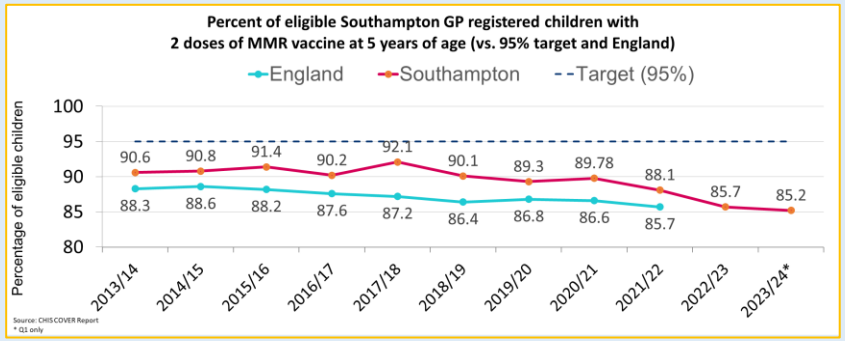
Infection and Immunisation over time – measles and MMR as an example

1988

Introduction of measles, mumps and **rubella (MMR) vaccine Oct 1988. Uptake** levels **in excess of 90%, measles transmission substantially reduced.** Notifications of measles fell progressively to extremely low levels. Children in the UK no longer exposed to measles infection. If they had **not** been immunised, they **remained susceptible to an older age.**



2016/17

The UK achieved the WHO 95% target (first dose in 5-year-olds) for the first time and **measles was considered eliminated in the UK,** meaning transmission had stopped, **but by 2018 it was spreading once more**, and the UK lost its measles elimination status.

Vaccination Uptake Improves

1998 Wakefield Report

2020 COVID- 19 Pandemic

2023 Outbreaks of measles in UK

1980's | 1990's | 2000's | 2010's | 2020's

Vaccination Uptake Declines

1993/94

Measles epidemic led to **138 teenagers** being **admitted to one hospital. A vaccination campaign** was **implemented** in **November 1994** and over **8 million children aged between 5 and 16 years were immunised with Measles & Rubella (MR) vaccine**. A two-dose measles schedule was introduced in October 1996.

1998

A now **discredited report** linking MMR to autism resulted in national **vaccine coverage dropping below 80%** for one dose of MMR due to widespread concerns.

2012/13

The number of reported measles cases once again increased despite high levels being achieved in two-year-olds in England. This was thought to be due to the high numbers of under immunisation in the 10-16 years olds that missed out in the late 1990's early 2000's.

2018/19

Rates start to decline. UK **loses measles elimination status.**

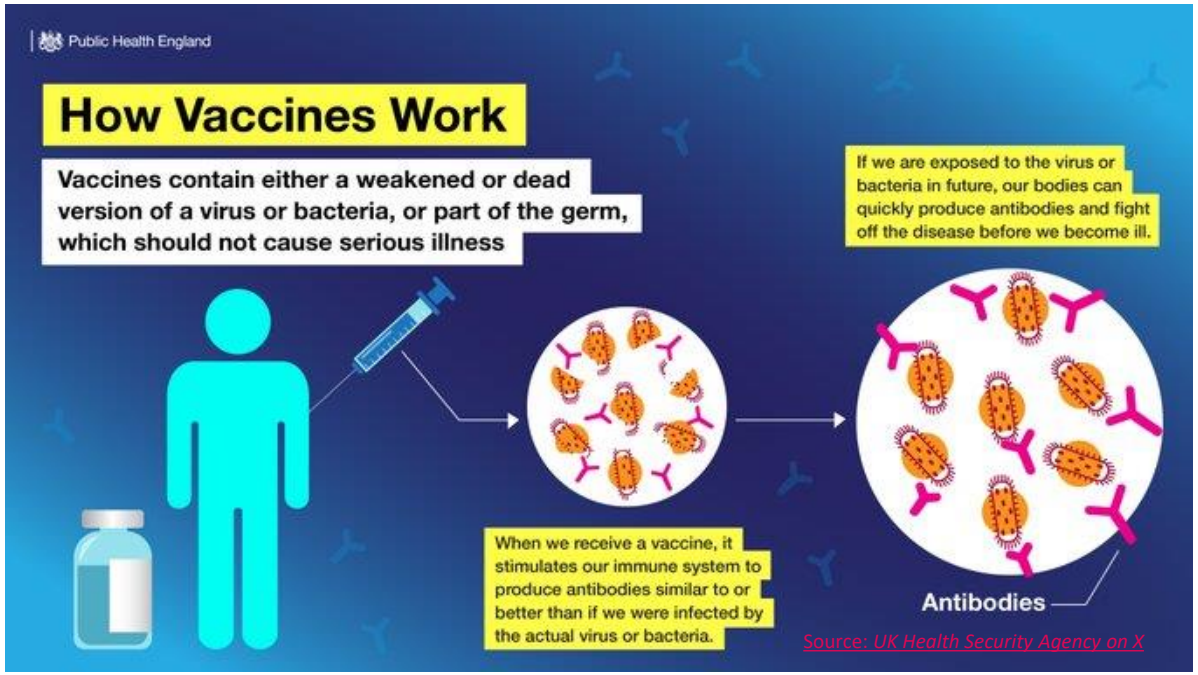
2023

Post pandemic, vaccine uptake rates for **routine childhood programmes have continued to fall globally**. Coverage for the measles, mumps and rubella (MMR) vaccination programme in the UK has also fallen to the lowest level in a decade.

Measles is a highly contagious disease caused by a virus which usually results in a high fever and rash and can lead to serious disability, infections or death. Accelerated immunisation activities have had a major impact on reducing measles deaths, but **we have recently seen outbreaks in the UK** due to the falling level of population immunity. Uptake for the first dose of the MMR vaccine in children aged 2 years in England is 85.6% , and uptake of 2 MMR doses at age 5 years is 85.5%. This is **below the 95% target set by the World Health Organization (WHO)** as necessary to achieve and maintain elimination. *"Measles activity is picking up globally with outbreaks affecting many parts of Africa and some of South East Asia; WHO has warned that a resurgence of measles is now an imminent threat, particularly due to the fall in vaccination rates during the COVID-19 pandemic" (UKHSA February 2022).*

Laboratory confirmed cases of measles, rubella and mumps in England: January to March 2023 - GOV.UK (www.gov.uk)

Immunity and how vaccines work



Source: UK Health Security Agency on X

Immunity

- **Immunity** is the ability of the human body to protect itself against infectious disease which includes innate mechanisms and acquired systems.
- **Innate immunity** is **present from birth** and includes physical barriers, such as skin, as well as chemical barriers e.g. digestive enzymes.
- **Acquired immunity** is generally specific to a single organism, or to a group of closely related organisms. There are two basic mechanisms for acquiring immunity – active and passive. **Active immunity** is protection that is produced by an individual's own immune system and is long-lasting. **Passive immunity** is transfer of antibodies from immune individual, most commonly across the placenta and is temporary.

How vaccines work

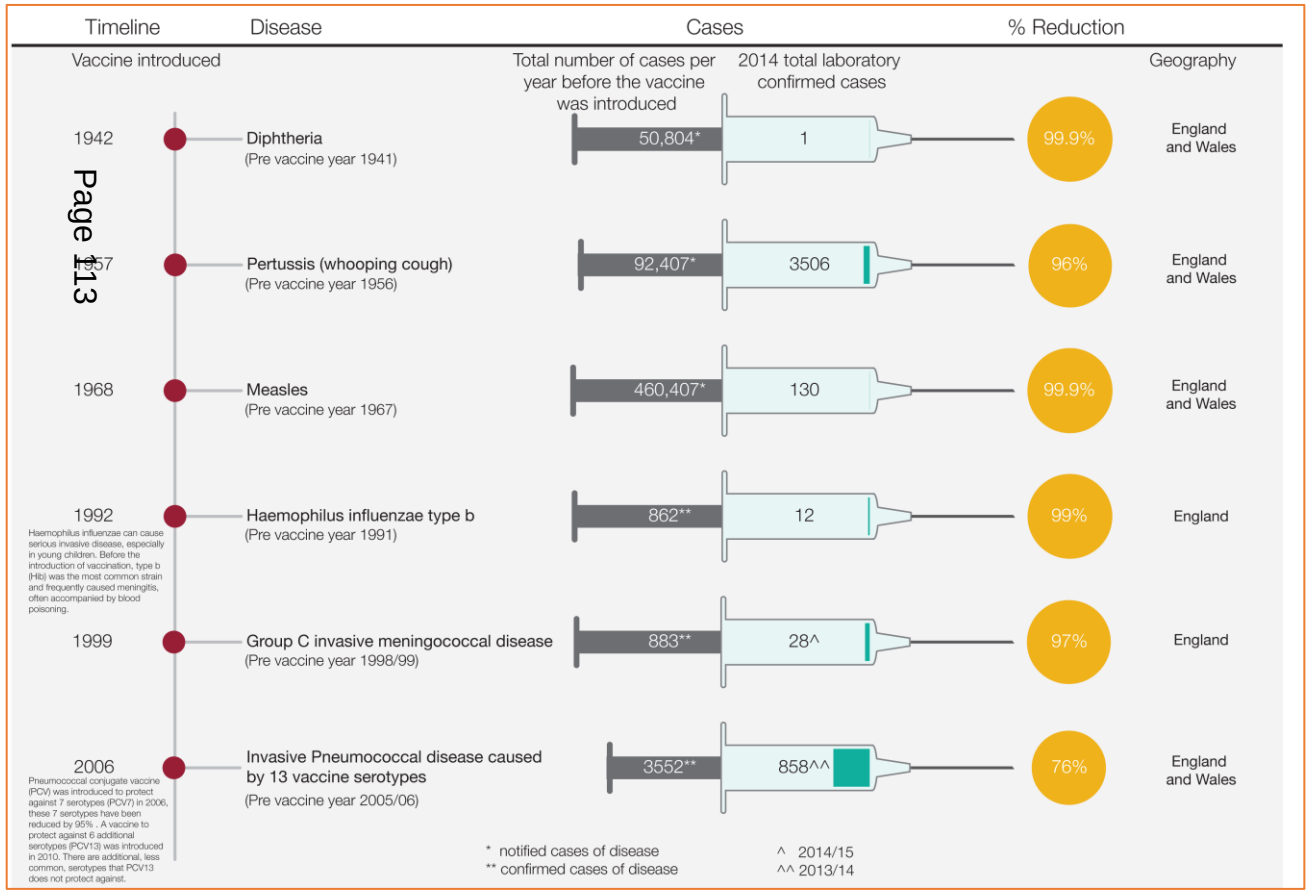
- Vaccines are a type of prescription-only medicine that are designed to **stimulate a person's immune system to produce antibodies** that will fight a specific disease. Vaccines contain a small part of the bacterium or virus that causes a disease, or tiny amounts of the chemicals the bacterium produces. If a vaccinated individual comes into contact with an infection, the antibodies will recognise it and be ready to protect them.
- Vaccines produce their protective effect by **inducing active immunity** and providing **'immunological memory'.**
- Vaccinations are essential services **for ensuring that children are protected against vaccine preventable diseases**.
- The UK's **current routine immunisation schedule uses seven types of vaccines** which provides **protection against 14 infections**, including measles, meningococcal disease, and polio.
- **No vaccine offers 100% protection** and a proportion of individuals get infected despite vaccination. Primary failure occurs when an individual fails to make an initial immunological response to the vaccine. **This risk is reduced by offering a second dose of vaccine**. Secondary failure occurs when an individual responds initially but then protection wants over time. A booster dose is given to improve protection.
- **Vaccines protect the individual** who receives the vaccine. **Vaccinated individuals are also less likely** to be a **source of infection** to others.
- **When vaccine coverage is high enough** to induce high levels of population immunity, **infections may even be eliminated from the country or region** e.g. smallpox.

Source: Greenbook chapter 1 immunity and how vaccines work (publishing.service.gov.uk) (accessed 28/8/23

Immunity and how vaccines work

Thanks to vaccination we have seen 99.9% reductions in infection like diphtheria (a highly contagious potentially fatal bacterial infection) and Haemophilus influenza type b (a serious infection especially for infants and young children).

Vaccines save lives. They prevent around 3-4 million deaths worldwide every year and the World Health Organization states that **after clean water, vaccination has the greatest impact on health globally**



Source: Immunisation in numbers – 5 fascinating facts - UK Health Security Agency (blog.gov.uk)

Benefits of vaccination:

- Saves millions of lives.
- Prevents disease, disability and suffering.
- Safe and effective.
- Protects you, your child and other people in your community by stopping disease spreading.
- Can reduce inequalities and poverty.
- Reduces time away from childcare/school and work helping save time and money.
- Reduces the burden on the health system and helps reduce use of antibiotics.

Aim of our Childhood Immunisations Strengths and Needs Assessment

Aim

To **understand** and **assess** the **strengths** and **needs in relation to routine childhood immunisation uptake (0-5 age group) in Southampton** and **what is being done to address them,** identify **priorities** and gaps and make **recommendations** for further action.

Working with colleagues across the system, SCC HPT have undertaken a Childhood Immunisations Strengths and Needs Assessment (CHISANA) to better understand the issues surrounding uptake of routine childhood immunisation across the city. This has informed the development of the themes and recommendations set out in this report.

"Statistics released by NHS digital in 2022 illustrated that vaccination coverage had **decreased in 13 out of the 14 routine childhood vaccination measures in 2021-22**, with **no vaccinations meeting the 95% target** set by the WHO."

Statistics published for all routine childhood vaccinations in England in 2021-22: statistical press release - NDRS (digital.nhs.uk)

Objectives of CHISANA

This needs assessment seeks to understand:

- **Who** are the children that aren't having vaccines?
- **Why** aren't they having vaccines?
- **How** can we support higher uptake?

The needs assessment will allow commissioners and providers of childhood immunisation services to use a systematic approach to understanding the needs of the population in relation to childhood immunisation, and allow for the planning and delivery of effective and equitable services.

Some of the key themes that we are looking to explore the 4 P's - Practice, Population, Personal, Pandemic. Including:

- Accessibility (appointments and advice)
- Insights (voice of workforce and parents)
- Impact of and learning from the pandemic (particularly regarding inequalities)
- Data - what's missing and could be improved?

Objectives:

1. Provide an **analysis of existing data:** national/ local data and **summarise the status of current vaccine uptake locally, with key benchmarking against other comparator populations** (highlight any data limitations).

2. Describe the existing **childhood immunisation legislation, policy** and **guidance at the national and local levels.**

3. Describe the **existing childhood immunisation service provision** across the city and highlight where **any inequalities** exist within this service provision.

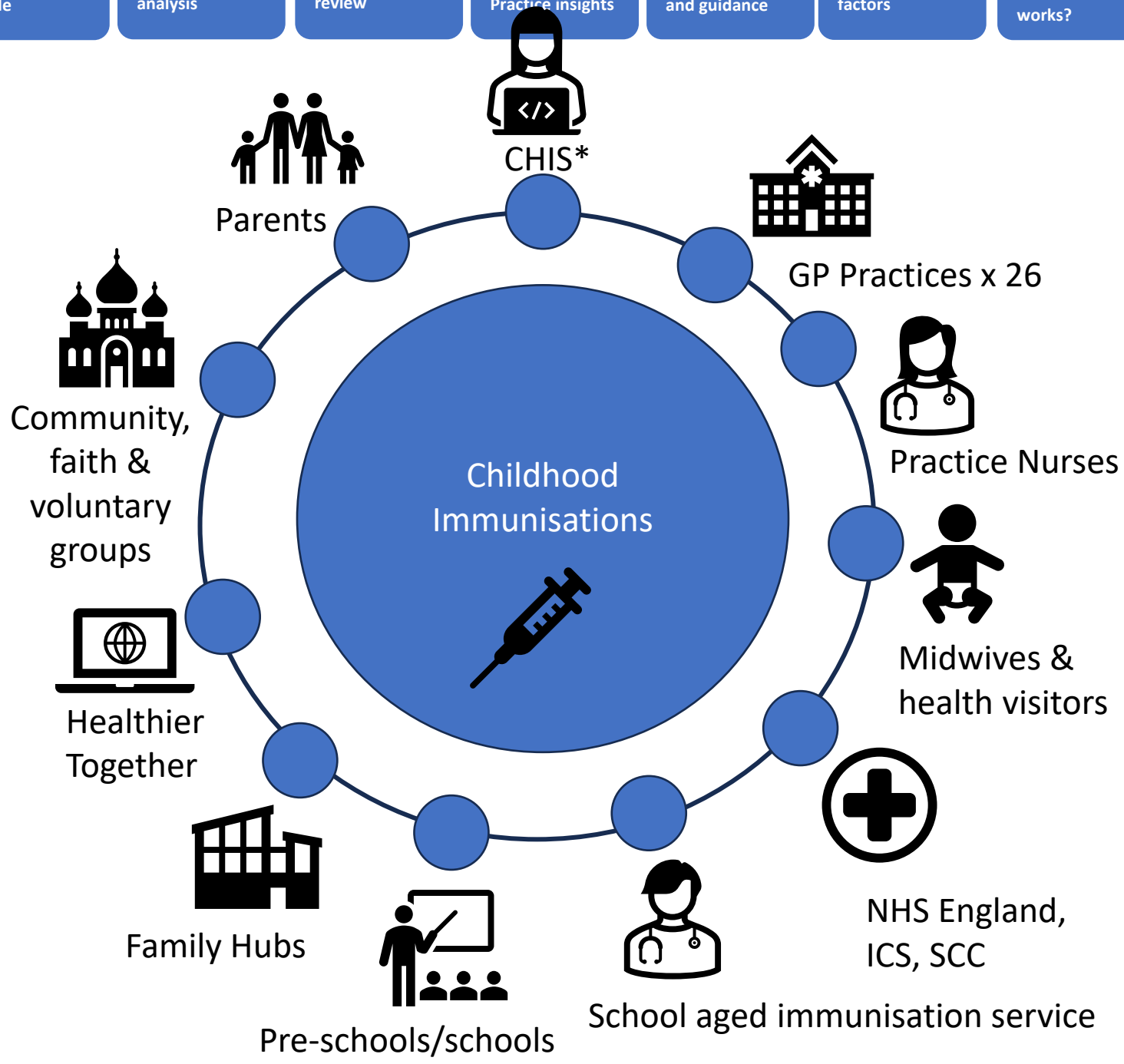
4. **Present stakeholder views as to what is working well and where improvements are needed**, as well as identify **any another factors (enablers and barriers)** that may be positively and negatively affecting vaccine uptake across the city.

5. **Identify the most important needs** in relation to routine childhood immunisations: in the short, medium and long term highlighting areas of higher need according to (but not limited to) geography, gender, ethnicity and socioeconomic status.

6. **Identify key recommendations based on this local intelligence and learning** from other areas (including COVID Vaccination programme) that can inform an ongoing programme of work.

Working together

- Many different stakeholders have a role to play in delivery of the childhood immunisation programme.
- **Our approach** to undertaking this needs assessment has reflected this.
- The project has been undertaken via a **multi-disciplinary working group** and we have reached out and sought input and views from a wide range of stakeholders.
- This includes **engaging with parents** and **workforce**.
- Improving and maintaining uptake **will require coordinated and sustained action from all parties taking every opportunity to promote and support immunisation at every stage of a child's journey from 0-5 years of age.**



***The Child Health Information Service (CHIS).** The primary objective of CHIS is to ensure standardised and accurate data and information to support the commissioning and delivery of child health services. This means providing a service that delivers a comprehensive local record of a child's public health (screening, immunisation and other health protection or health improvement interventions) and of their community-based healthcare.

Scope of CHISANA

The overall aim of the UK's current routine childhood immunisation schedule is to provide protection against the following **14 vaccine preventable infections via 7 different vaccines**:

- Haemophilus influenzae type b (Hib)
- Hepatitis B
- Human Papillomavirus
- Influenza
- Measles
- Meningococcal disease
- Mumps
- Pertussis (whooping cough)
- Pneumococcal disease
- Polio
- Rotavirus
- Rubella (German measles)
- Shingles
- Tetanus

This project has focused on **routine immunisations 0-5 years age group.**

The routine childhood immunisation schedule also aims to protect against cancers related to HPV. These vaccinations are offered to boys and girls aged twelve to thirteen years old.

The whole UK schedule would also include adult immunisations and selective childhood immunisations.

All vaccinations offered on the schedule are free of charge. None of them are compulsory.

Source: schedule (publishing.service.gov.uk)

Routine childhood immunisations — From September 2023

Age due	Diseases protected against	Vaccine given and trade name		Usual site[1]
Eight weeks old	Diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenzae type b (Hib) and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa or Vaxelis	Thigh
	Meningococcal group B (MenB)	MenB	Bexsero	Left thigh
	Rotavirus gastroenteritis	Rotavirus	Rotarix[2]	By mouth
Twelve weeks old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa or Vaxelis	Thigh
	Pneumococcal (13 serotypes)	PCV	Prevenar 13	Thigh
	Rotavirus	Rotavirus	Rotarix[2]	By mouth
Sixteen weeks old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa or Vaxelis	Thigh
	MenB	MenB	Bexsero	Left thigh
One year old (on or after the child's first birthday)	Hib and MenC	Hib/MenC	Menitorix	Upper arm/thigh
	Pneumococcal	PCV booster	Prevenar 13	Upper arm/thigh
	Measles, mumps and rubella (German measles)	MMR	MMRvaxPro[3] or Priorix	Upper arm/thigh
	MenB	MenB booster	Bexsero	Left thigh
Eligible paediatric age group[4]	Influenza (each year from September)	Live attenuated influenza vaccine LAIV	Fluenz Tetra[3,5]	Both nostrils
Three years four months old or soon after	Diphtheria, tetanus, pertussis and polio	dTaP/IPV	Boostrix-IPV	Upper arm
	Measles, mumps and rubella	MMR (check first dose given)	MMRvaxPro[3] or Priorix	Upper arm
Boys and girls aged twelve to thirteen years	Cancers and genital warts caused by specific human papillomavirus (HPV) types	HPV[6]	Gardasil 9	Upper arm
Fourteen years old (school Year 9)	Tetanus, diphtheria and polio	Td/IPV (check MMR status)	Revaxis	Upper arm
	Meningococcal groups A, C, W and Y	MenACWY	Nimenrix	Upper arm

Source: Routine childhood immunisations schedule from September 2023 (publishing.service.gov.uk)

Childhood Immunisations Strength and Needs Assessment (CHISANA) Project Overview

- Executive Summary
  - Summary of approach.
    Key findings, headlines and priorities.
- Background and Context
  - Aim, objectives scope
  - Introduction to vaccination & why important
  - City Profile
    (Demographics, deprivation, languages, other features)
  - Southampton Vaccination delivery
    (How & who)
- Data Review
  - Vaccine uptake data review
    (summary of trends)
  - Uptake by GP practice
    (anonymised)
  - Comparator review
    (HIOW and National)
  - Narrative – what is the data telling us?
  - Data limitations
    What is missing that would be helpful?
- Insights (experiences & voices)
  - Information Available (desk-based review)
  - GP Practice Questionnaire and site visits
  - Parent Experiences and Attitudes
    (focus groups and/or surveys) – consider specific groups
  - Workforce Experiences (midwives, health visitors, early years, schools)
- Learning
  - Learning from COVID vaccination
    (target groups & approaches that worked)
  - Case Studies
    (Positive/negative deviation)
  - ICB Immnisation self-assessment
  - National Studies and Recommendations
  - Impact of COVID
- 4 P's – Findings (strengths & needs)
  - Practice
  - Population
  - Person
  - Pandemic
- Recommendations and Next Steps
  - Short
  - Medium
  - Long term

The childhood immunisation strengths and needs assessment (CHISANA) has several strands to it. These aim to bring together Southampton specific data, insights and experiences from across all aspects of the childhood immunisation patient journey, to identify themes and recommendations.

Method

To understand and examine the issues relating to the delivery of pre-school immunisations in Southampton, we have drawn on a variety of evidence sources.

1. We have **spoken to/interviewed a range of key stakeholders** involved in vaccination delivery including:
   - NHS England (NHSE) SIT Team
   - Child Health Information System (CHIS) Team
   - NHS Solent School Aged Immunisation Service (SAIS)
   - Health Visitor Lead
   - Healthier Together
   - GP Maternity Lead
   - Solent Looked After Children (LAC) Team

5 key childhood vaccination uptake indicators have been analysed.
- 3 doses of **Hexavalent** at 1 year of age.
- 1 dose of **MMR** at **2 years** of age
- 1 dose of **MMR** at **5 years** of age
- **DTaP** booster at **5 years** of age
- 2 doses of **MMR** at **5 years** of age

2. We have **undertaken a parent survey (834 respondents)** and **workforce survey (23 out of 25 GP Practices from across Southampton responded)** to gain insights, experiences and attitudes.
3. We have **reviewed** documents relating to **governance and accountability.**
4. We have **analysed *COVER data** on vaccination uptake across the city to gain a more detailed picture as to what the numbers can tell us about what is happening locally, and we have considered how this can be linked to other issues such as deprivation and ethnicity.
5. Key **policy and guidance has also been reviewed** and the **findings and recommendation drawn together** to build on and support the recommendations in this report.
6. We have also **carried out a desk-based audit of all the key digital information sources,** including GP Practice websites, available to parents.
7. Recent **learning from the COVID-19 vaccination programme** has also been draw together to consider where and how this can be applied to childhood immunisations.
8. We have also **considered how the pandemic might have contributed to falling uptake** of childhood immunisations (pandemic factors).

*Cover of Vaccination Evaluated Rapidly : (COVER) programme annual data on coverage achieved by the childhood immunisation programme

Building on strong foundations

Many of the recommendations in this report build on the findings and recommendations highlighted in previous reports, guidance and frameworks relating to the delivery of childhood vaccinations. These include*: (where publicly available links have been provided).*

Association Directors of Public Health (ADPH), Sector Lead Improvement Vaccination Report	Not publicly available	2023
European Vaccine Action Plan	WHO-EURO-2014-2227-41982-57703-eng.pdf	2015-2020
European Vaccine Action Plan	WHO-EURO-2014-2227-41982-57703-eng.pdf	2015-2020
NHS South, Central West (SCW) Improving Immunisation Uptake Team (IIU) Initiative and Paper	Not publicly available	2018
Briefing Paper, Improving uptake of cervical screen and childhood immunisations in the Eastern European population in Southampton City.	Not publicly available	2019
Improving uptake of services by Eastern European population in Southampton City	Improving health and uptake of services by the Eastern European population in Southampton City	2019
Moving the Needle	https://www.rcn.org.uk/-/media/Royal-College-Of-Nursing/Documents/Publications/2022/February/010-074.pdf	2019
National Audit Office (NAO), Investigation into pre-school vaccination	National Audit Office (NAO) investigation into pre-school vaccination	2019
Southampton City Council (SCC), MMR Workshop (held March 2020)	MMR workshop DC_TH_030220.pptx	2019
Tailoring immunisation programmes	https://www.who.int/europe/publications/i/item/9789289054492	2019
UK Measles and Rubella Elimination Strategy	UK Measles and Rubella elimination strategy 2019 (publishing.service.gov.uk)	2019
Public Health England (PHE) National Immunisation Programme: health equity audit	National Immunisation Programme: health equity audit (publishing.service.gov.uk)	2021
Local Government Association (LGA), Increasing uptake for vaccinations: maximising the role of councils	'Increasing uptake for vaccinations: Maximising the role of councils'	2020
Equity and Best Practice immunisation, Factsheets, WHO	Equity and Best Practice immunisation - Factsheets - Immunisation Advisory Centre (immune.org.nz)	2022
Hampshire and Isle of Wite (HIOW) ICB DPH Imms self-assessment score sheet	Not publicly available	2022
Royal College of Nursing (RCN), Immunisation Knowledge and Skills Competence Assessment Tool, Third Edition	https://www.rcn.org.uk/-/media/Royal-College-Of-Nursing/Documents/Publications/2022/February/010-074.pdf	2022
Vaccine uptake in the general population, NICE guideline	Vaccine uptake in the general population (nice.org.uk)	2022
National Voices, 'Accessible and inclusive communication within primary care: What matters to people with diverse communication needs'	Accessible_and_inclusive_communication_within_primary_care.pdf (mcusercontent.com)	2023
NHS Vaccination Strategy (December 2023)	NHS England » NHS vaccination strategy	2023

Findings and Recommendations

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Six things we learned!

1. The **Childhood immunisation programme** is a **huge success**. **Trust remains high** and **90% of parents** we spoke to were happy with the service they have received. Whilst rates are declining, we **did not find** evidence of any significant **anti-vaccine sentiment** and Southampton uptake is consistently higher than the national average. These are **strong foundations on which to build**.

2. It has **not been possible to get any meaningful ethnicity-based data** or establish trends as to who isn't getting vaccinated. This makes it **difficult to tailor services** to need and to address any health inequalities in uptake that might exist.

3. There are opportunities to **strengthen promotion of vaccination across the system** by training and empowering a wide range of professionals and people from within the community (community centred approaches) to have conversations about the importance of vaccination with parents, and confidently address concerns and myths.

4. **Practical issues**, such as **ease of booking and availability of appointments**, **remain a significant barrier** for parents. There **needs** to be a **greater range of appointment times** and a more **personalised approach** to following up missed appointments.

5. Ensuring **services are tailored** to meet needs **does not mean treating all people the same.** Providing more **bespoke support** for parents and families that need it, such as parents of children with disabilities, families with chaotic lives, or for whom English is not a first language, should be prioritised.

6. It **not possible to point to one single cause or solution** to improve immunisation uptake**.** It will require **action and sustained effort across a number of different elements**, and **multiple stakeholders have a role to play**.

CHISANA Key Findings - SWOT

Strengths

92% and **93% of parents** told us **vaccinations** are **important for children under 12 months** and **18mths- 5 years** respectively. **Trust remains high** despite the COVID-19 pandemic with **1 in 5 parents** we spoke to indicating their feelings are **MORE positive.**

Stakeholders across the system **are committed** to improving vaccination rates and there are **already many excellent working practices in place.**

Whilst rates in Southampton are declining **the city has consistently achieved better than England average**. The **average gap to 95%** for 2021/22 was the equivalent to **7 additional children** at each GP practice having each vaccine.

There has been **significant learning** in relation to the delivery of vaccinations and inequalities during the COVID-19 pandemic **that can be applied to childhood immunisations.**

Limited evidence of any major impact on vaccination from **anti-vax messages.**

90% of parents who responded to our survey and who have had their children vaccinated said that they were **satisfied with the vaccine visit.**

COVER data for Southampton indicates that for **7 out of 25 GP Practices are achieving 90% or over for all 5 indicators** that were included within this study.

Parents we spoke **to understand the importance** of getting vaccinated and have generally had **good experiences**, but **making it easy and accessible**, including **offering a variety of appointments** to accommodate working parents **remains vital.**

52% of practices say the **wait for an appointment** is **less than a week.**

Weaknesses

Childhood vaccination (0-5 years age group) **uptake in Southampton has been excellent**, but **rates are decreasing** for all 5 indicators.

Only **61% of GP Practice** websites have **information on all recommended vaccines.** There is a gap in information about **specific diseases.**

COVER data for Southampton indicates that for **25 out of 25 GP Practices** are **NOT meeting the target (95%) in any of the 5 indicators** that were included within this study.

Data indicates that **MMR uptake rates at 5 years** and **DTaP at 5 years are most concerning**.

Only **35% of GP practices had translated information** on childhood immunisations available on their website. There are **disparities across the City in terms of the accessibility of practice websites** and the **information available** including translated materials and **signposting** to other sources of information.

17% of GP practices are **not offering catch up clinics** despite the data indicating that immunisation tales off as children get older.

There is **no shared communications plan at system level**. Comms planning **tends to be opportunistic**/off the back of national campaigns. Need for consistent and targeted messages that avoids parents feeling bombarded.

It has **not been possible to get meaningful ethnicity related data** relating to childhood immunisation uptake from GP Practices across Southampton. **This is a significant barrier to establishing any trends** linked to ethnicity and in turn informing targeted approaches such as WHO TIP approach.

S W O T

CHISANA Key Findings – Summary (SWOT)

Opportunities

Utilising community leaders, groups and other providers to help promote vaccinations is a cost-effective and proven approach that could be better harnessed.

Ease of access, including; being sent **reminders, flexibility of appointments** and **support with booking** ~~an~~ remains important, and there is scope for improvement on this.

There may be opportunities to **utilise secondary care teams** working in the communities.

Educating workforce with the **provision of enhanced training**, as well as **refreshing knowledge** is vital and there are opportunities for this to be strengthened pre and postnatally.

Opportunities to **strengthen closer working between GP practices, health visitors and midwives.**

Where ethnicity/language is recorded there may be an opportunity to **harness technology and send information/text in preferred language**.

The National Parent Attitudes survey highlights that **having a conversation with a health professional** can be key to giving parents confidence. Scope for this to be offered more routinely.

Utilise **heightened awareness** resulting from spikes in cases such as measles.

78 LAC children (0-4) in SCC care (November 2023). Opportunities to work with **Social Workers** to help **secure parental consent** for childhood immunisations.

Consider **utilising alternative venues** to deliver routine childhood immunisations e.g. Family Hubs.

Scope to more proactively provide support and **advice for any specific needs.**

Existing initiatives e.g. pre-vaccine 'meet the nurse' visit and utilising **vaccine supporters at the front desk** to welcome and support patients **could be replicated** elsewhere.

With **majority of clinics held on weekdays** there is scope to improve flexibility and range e.g. wider range of dates and times including **holding clinics at weekends**.

Explore ways to **link parents to children** so that when a parent contacts the surgery opportunities to flag immunisations can be taken.

Threats

Some parents may **not** be **aware of the serious harms infectious diseases can cause a child** and **the vital and incredibly effective role immunisations play in preventing this**. The earlier this conversation & education starts in pregnancy the better.

The **number of trained immunisers in the city** could present problems for **workforce continuity** and **knowledge retention** in the future.

Some **parents remain concerned about the safety of MMR** and there is also evidence to suggest that **parents may benefit from being reminded about the benefits of vaccinations, risks of not being vaccinated** and **reassurance about side effects**.

There is a **correlation between deprivation** and **low immunisation uptake,** but this complex issue is not fully understood.

In Southampton the **percentage of mothers born outside of the UK** is **increasing (41%).** Any barriers linked to ethnicity are therefore likely to get worse.

Too much weight may be being given to the view that **parents aren't immunising** their child because they '**don't believe in vaccination'.** This is potentially a **barrier to understanding and addressing other factors**, such as getting time off work, needing more support or access to information in their own language.

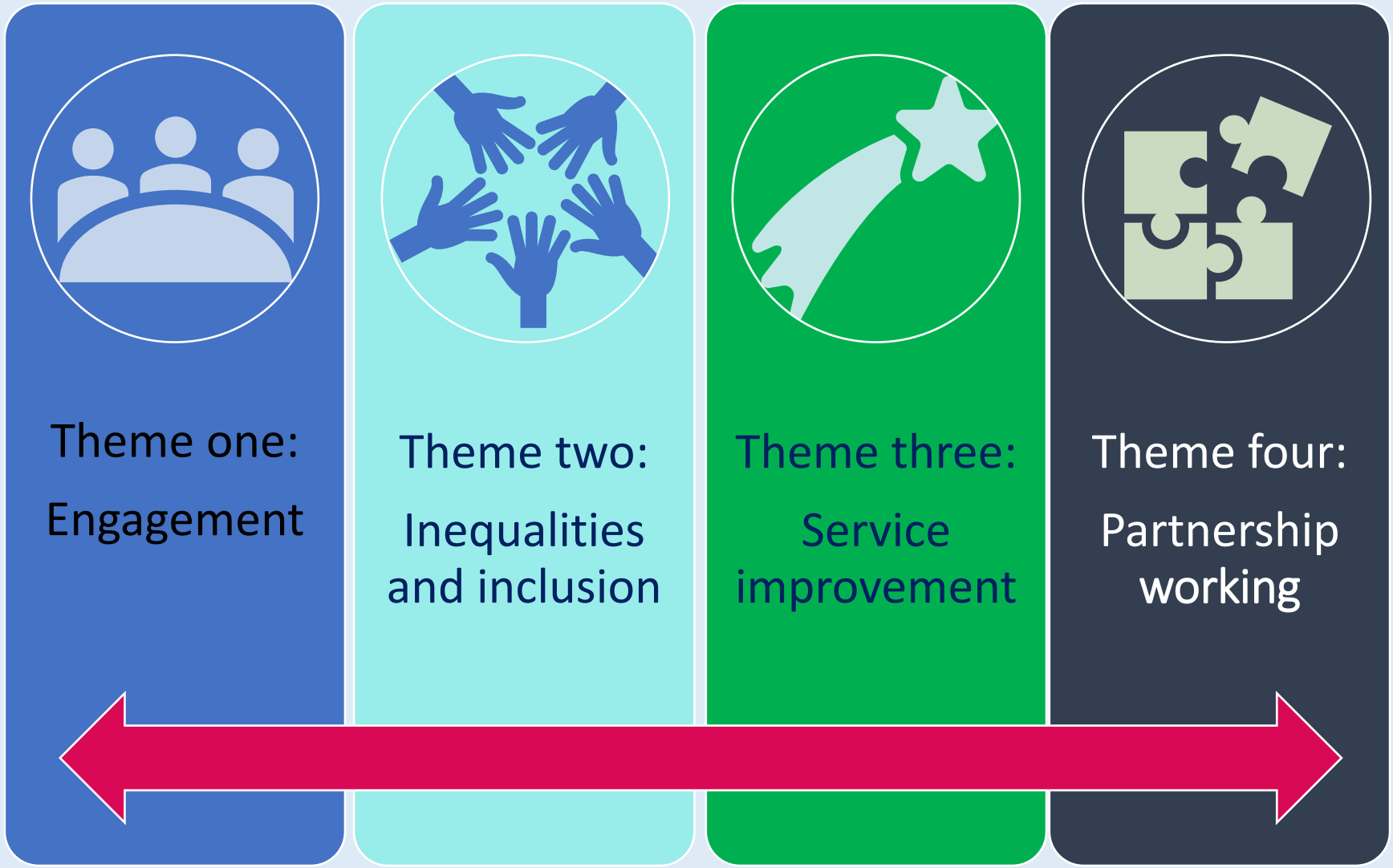
It has **not been possible to identify any trends** as to **who is not taking up childhood immunisations**.

Where respondents indicated their **feelings** about childhood immunisations are **less positive** since the COVID-19 pandemic, **concerns about side effects was the reason most given**.

Our survey would indicate that we **have not heard from parents who are not engaging with services** or taking up vaccination

CHISANA Recommendations

4 Themes



Recommendations: Theme one - Engagement

1. Strengthen promotion at every stage of a child's journey.

Offer awareness (refresher) sessions for professionals across the system to ensure all (health visitors, midwives, practice nurses, admin leads, front line staff, pharmacies, schools/early years, family hub staff etc) understand their role in promoting immunisation *(from antenatal to adulthood).*

See RCN 8's: https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2018/october/pdf-007201.pdf

2. Tailored comms. & engagement campaign.

Design & deliver a targeted & sustained grass roots comms & engagement campaign utilising multiple channels & simple messaging. Address myths, promote benefits & invite questions using different mechanisms & forums.

e.g. Q&A community awareness sessions at family hubs, translated videos.

3. Collate and distribute Childhood Imms comms assets.

Collate and coordinate distribution of assets to a variety of stakeholders across the city (GP Practices, Family Hubs, Schools, Early Years providers, Healthier together, Community venues) via a central point to facilitate & support sharing of assets locally.

4. Utilise faith & community leaders & groups.

Utilise community leaders & trusted people of influence e.g. faith leaders, groups, champions, social prescribers, baby banks, to promote importance of childhood immunisations, provide reassurance & tackle myths.

**see vaccine champion's model.*

5. Targeted promotion of MMR.

Design a targeted public campaign to directly address prevailing concerns about perceived risks of MMR and continue to promote uptake across the city, particularly focusing on areas of highest deprivation.

**build on existing HIOW MMR uptake strategy and work e.g. webinars held for community children's nurse teams.*

Recommendations: Theme two - Inequalities and inclusion

6. Information availability

Appointment letters, reminders & information should be sent/available in a range of formats & languages (including easy read). Information to be proactively shared with parents prior to vaccination appointment & translation function available via Practice website.

7. Proactively provide reassurance

Time should be built into appointments to reassure parents about vaccine safety as well as potential 'normal' reactions e.g. raised temperature after Men B, to help reduce parental anxiety such as concerns about vaccine overload.

8. Trial alternative delivery model and venues.

Trial alternative venues for delivery of vaccinations in low uptake areas. Consider family hubs, fire stations* & other community venues, and ensure all practices are offering catch up clinics as well as a home immunisation service**.

**fire stations were used very successfully during the COVID-19 vaccination campaign.*
**Unsure if this is currently being offered by any Southampton GP Practices.*

9. Support for Additional needs.

Specialist support to be proactively offered by all practices to parents that need additional help and support immunising children with additional needs such as autism or disabilities or multiple children e.g. longer appointment slots.

10. Named frontline community immunisation champion.

Directly follow up with families that have repeatedly not taken up appointments and provide a supportive, culturally sensitive service, and the necessary awareness of and ability to address any concerns or issues that parents may have.

**This could be city wide, PCN or Practice based or sit within Health Visiting team if they are sent the list by CHIS*
***this approach was highlighted by SCW Thames Valley 'Improving Immunisation uptake Team Initiative (IIU) .*

Recommendations: Theme three - Service improvement

11. Enhanced Staff Training.

All key staff to undertake enhanced training (tailored to Southampton) to ensure consistency of service & message dissemination, and that they have confidence to address concerns about side effects. Inequalities & what's needed to address them to be included.

12. Greater appointment availability.

Greater range and availability of appointments required, including different /varied days and times of the week and weekends, to ensure working parents can fit in an appointment around other commitments.

13. Review data recording, cleansing, coding & extraction processes.

Ensure that frequent data cleansing is undertaken & that coding & data recording *(including immunisation history)* processes are tightened up to ensure that incomplete or out of date data is not negatively impacting uptake rates. Improve mechanisms to extract, utilise and share ethnicity-based data to enable accurate & timely understanding of the local situation.

14. Personalised (telephone) DNA/WNB Processes.

DNA* and WNB** processes to be reviewed to ensure it is working for their population. Consider personalising & captured at practice level. Ensure individuals that miss appointments are followed up in person by someone trained to discuss any concerns or issues and provide reassurance. *(Practice Nurse working with 'named' immunisation admin support)*

**DNA = Did Not Attend*
*** WNB= Was Not Brought*

15. Ethnicity based data recording Policy.

Explore potential for a city-wide ethnicity-based data recording policy, to ensure a consistent and robust approach to capturing data. This will enable culturally sensitive services to be tailored & developed that meet the varying needs of different groups, as well as identification of any ethnicity related barriers that may be impacting uptake.

Recommendations: Theme four - Partnership Working

16. Establish local childhood imms Action Plan and group.

Establish a system led over-arching Immunisation Action Plan and group to coordinate effort, monitor progress/impact, and sustain focus across the entire system, to ensure delivery of recommendations and sharing of good practice, local initiatives and resources.

17. Increase uptake of Health Visitor 1 & 2 yearly reviews.

Healthy Child Programme 1 and 2 yearly reviews are not received by every family (53% and 60% respectively). This may impact on immunisation uptake with Health Visiting team missing opportunities to review and promote childhood immunisations.
(participation officer is already looking at understanding and addressing this)

**This is often delivered by practitioners so they should be included in any training.*

18. 'Share' resources within PCN's & across Southampton.

Consider and identify where services or capacity could be enhanced by 'sharing' resources across PCN's and/or Southampton e.g. clinic times, staff to cover sickness or expand offer and/or range of venues.

e.g. could trial extended hours.

19. Define responsibilities for local delivery.

Identify and agree leadership and accountability for different aspects of immunisation and vaccination programme. Named leads for key areas of delivery e.g. names lead for primary care and agreed lead for immunisation within each GP practice to who messages are communicated. Agree leadership for different elements.

**highlighted in Sector Lead Improvement (SLI) Imms report*

20. Integrated GP MDT meetings.

Immunisations to be routinely discussed at integrated team meetings at PCN level to review uptake & initiatives.

FIRST? - Prioritisation Matrix

FIRST – Prioritisation Matrix

What to do FIRST?

A matrix to assist with prioritising recommendations and action plans. It will help identify where to focus activity so that resources can be directing to the areas that will have the greatest impact in the short, medium and long term. It can help with undertaking phased approach by identifying which things need to be done immediately and which may need to wait until a later date.

Criteria	Description	Rating	Score
F: Feasible	How viable is implementing this going to be from an economic perspective and in terms of political will and acceptability?.	H/M/L	3/2/1
I: Impact or inequalities	What potential impact will this have on addressing inequalities?		
R: Reach	What is the population reach?		
S: Success	How confident are you this will succeed. Has this been piloted elsewhere? What is the evidence?		
T: Time	How long is this likely to take to see results and how urgently is it needed? (Fast = High) Urgent (High)		

Recommendation Number	Score	FIRST –Priority Ranking
4. Utilise faith & community leaders & groups.	17	1
9. Support for additional needs.	16	2
10. Named frontline community immunisation champion.	16	2
12. Greater appointment availability.	15	3
6. Information availability.	15	3
2. Tailored comms and engagement campaign	14	4
3. Collate & distribute Childhood Imms comms assets.	14	4
13. Review data recording, cleansing, coding & extraction processes.	14	4
14. Personalised DNA/WNB Processes	14	4
15. Ethnicity based data recording policy.	14	4
7. Proactively provide reassurance.	13	5
11. Enhanced staff training	13	5
16. Establish local childhood imms action plan and group	13	5
1. Strengthen Promotion at every stage of a child's journey	13	6
20. Integrated GP MDT meetings.	12	7
8.Trial alternative delivery model and venues.	11	8
18. Share resources within PCNs & across Southampton.	11	8
19. Define responsibilities for local delivery.	10	9
5. Targeted promotion of MMR.	9	10
17. Increase uptake of Health Visitor 1 & 2 year reviews.	9	10

Opportunities to strengthen and promote vaccination

Midwives
Start conversation early in pregnancy, including what comes next when the child is born, and what comes beyond (teenage years booster and HPV).

The routine childhood immunisation programme is also supported by health visitors who at mandated baby visits at the ages of 10 to 14 days, 6 to 8 weeks and 1 year promote and discuss immunisations with parents.

Antenatal groups could play a role in promoting vaccination & educating parents.

GP Practice
Support parents to get appointment booked in. Check imms are up to date. Send reminders e.g. birthday/celebration cards. Cleanse data & put in place robust administration ensuring the right codes are used.

Health Visitor
To discuss importance, encourage and remind.

Midwives
To check and remind.

Family Hubs
Educate & promote childhood immunisation.

9-12 month development check
Check imms status and ensure booking is made.

Nurseries and Pre-schools
To remind, encourage and support parents to check and get children vaccinated. Include within Policy.

2-year development check
Check imms status and have next stage vaccination discussion. Discuss any concerns.

Schools
School readiness – opportunity to promote via briefings & materials that go out to parents.

Secondary Care
Take any opportunities in secondary care units such as paediatric assessments, community nursing and Children's Outreach and Assessment Support Team (COAST) to promote childhood vaccinations.

Key recommendations:

- **Train and prepare all professionals to discuss and promote immunisation early in pregnancy** and then at key touch points **at every stage of a child's journey.**
- Training should include **likely conversations including; addressing concerns, dispelling myths and how to access support with any additional needs.**

Strengthening this will help to ensure every opportunity is taken to support parents to get children vaccinated.

Moving the Needle RSPH

Factors affecting uptake of childhood vaccination (potential enablers and barriers)

Practice Factors

What we considered:

- Data recording & cleansing processes.
- DNA/WNB processes.
- Accessibility and range of appointments.
- Facilities and support available.
- Initiatives in place.
- Website and information accessibility.

What we found:

- Practices across Southampton are already doing many of the things required to enable childhood vaccination.
- Building on existing approach and tailoring services even further to the needs of the population is required to further improve the service and maximise efforts to increase uptake. This requires good quality ethnicity-based data.

Person Factors

What we considered:

- **Confidence** levels amongst parents & whether past experiences have impacted this.
- **Complacency** as to the benefits of childhood immunisations & awareness of the risks of choosing not to.
- **Convenience** & accessibility & the role this might play for parents.
- **Compassion** & reassurance shown by health care providers for any specific needs & concerns e.g. needle phobia, safety & side effects.

What we found:

- Parents trust in childhood immunisations remains high, but they may benefit from being reminded as to the risks & benefits.
- Convenience, ease of access, support and practical issues is key.
- Being able to have a conversation with a health care provider or other trusted individuals can also play an important role.
- Some parents remain concerned about side-effects and expressed concerns about MMR.

Population Factors

What we considered:

- Culture and beliefs that may be influencing attitudes.
- Ethnicity and country of birth.
- Languages spoken.
- Age of child.
- Deprivation & other socio-economic factors that may be impacting on ability to take up immunisations such as cost of living crisis.

What we found:

- There is a correlation between high deprivation and uptake of childhood immunisations.
- Information availability in an accessible format e.g. translated assets, is important of parents who may have literacy issues or do not have English as a first language.
- Appointment availability outside of working hours is important for working parents.
- Extracting ethnicity data was not sufficient to identify trends.

Pandemic Factors

What we considered

- Poor access during the early stages of the pandemic.
- Additional strain on and reprioritisation of health services and lasting capacity issues.
- Whether the COVID vaccination programme has negatively impacted parental attitudes to routine childhood immunisations.
- How any changes in service provision have impacted on parents' experiences of accessing childhood immunisations.
- Learning from the pandemic.

What we found:

- Trust in childhood immunisation remains high, even where parents felt less positive about the COVID vaccine.
- There is scope to use trusted stakeholders across the system to engage with parents and promote childhood immunisations.

Poole's 4 x Ps

Practice Attributes/Enablers (checklist)

✓ **Dedicated Immunisation Lead/Champion** Dedicated and trained immunisation lead who can answer questions, provide reassurance and sign-post additional help and support. Will be aware of the specific needs of the local community and understand issues related to inequality.	✓ **Personalised DNA &WNB Processes** Did Not Attend (DNA) and Was Not Bought (WNB) processes are personalised. Practice attempts to make contact via telephone using staff members trained in immunisations, to understand any needs, answer questions and provide support. If appropriate, will link up with other professionals such as health visitors and social/family support workers.	✓ **Accessible Website** Practice website includes and/or signposts parents to key information about childhood immunisations in a readily accessible format appropriate to the needs of the local community. Translation facility is available and working and contact number for further advice and support advertised	✓ **Multiple Trained Immunisers** Sufficient numbers of trained immunisers to ensure workforce continuity, knowledge retention and offer the level of support and flexibility required. Staff will have undertaken enhanced training, so that they are able to answer questions and understand the potential barriers and facilitators.
✓ **Vaccinate Opportunistically** Take every opportunity to check immunisation status of children and where eligible offer to vaccinate/arrange appointment to vaccinate/discuss vaccination.	✓ **Catch up Clinics Offered** Catch up clinics/programe of work offered where there are more children needing to be vaccinated than there are appointments available. Practices have flexibility and know how many children require vaccinating and are proactive in this approach.	✓ **Family Friendly Environment** Family friendly facilities and environment that welcomes families and makes them feel safe and supported e.g. space for buggies, changing area, play space and support for multiple children e.g. 'Well Child Clinic' so parents can avoid general illness	✓ **Data Cleansing** Practice undertakes regular (monthly) data cleansing to ensure that records are up to date and ensure prompt action is taken.
✓ **Ethnicity Data Recorded** Robust recording of ethnicity-based data to help inform any targeted initiatives that may be needed.	✓ **Will Vaccinate Without Red Book** Will vaccinate even if parent has forgotten to bring child's personal health record (red book).	✓ **Meet the Nurse** Option to meet the nurse prior to immunisation appointment so that they can ask any questions and discuss any specific needs or concerns.	✓ **Hours of Operation** Offer a range of appointments including a mixture of mornings and afternoon, before 8am, at weekends and opportunistically.
✓ **Promotion & Education** Every opportunity it taken to promote and educate parents and staff as to the importance of childhood immunisation ensuring that information and knowledge remains up to date, and the health literacy of patients/caregivers is strengthened.	✓ **Translated Materials** Materials are proactively offered in a range of languages prior to immunisation appointments and additional information and resources signposted.	✓ **Bespoke Support** Positive and supportive environment. Flexible to unforeseen circumstances which occur. Actively listens to the needs of parents, with a particular focus on underrepresented groups. Longer appointment slots available to accommodate additional needs.	✓ **Multi-Disciplinary Approach** Stakeholders across the system are linked in and understand their role in promoting childhood immunisations thorough their interactions and relationship with parents.

Tailoring Immunisation Values and Principles

In Southampton, the findings from the parent survey carried out as part of this needs assessment support and align with previous studies relating to parent attitudes and childhood immunisations, including The Royal Society for Public Health**, 'Moving the Needle, promoting vaccination uptake across the life course' (2019),** and **The UKHSA National Childhood vaccines: parental attitude's survey (2022).**

These studies indicate that **parent attitudes to routine childhood immunisations remains positive**. **Common threads** relating to accessibility, concerns over side effects, awareness of the risks and benefits, language and cultural issues repeatedly come up. These underline that **to achieve equity**, **services need to be tailored to the specific needs of the local population** with **bespoke services and support** for parents and families that need it and recognition that the **social determinant of health, may create barriers**. **It does not mean treating all people the same.**

The World Health Organisation (WHO) Regional Office for Europe has developed the **Tailoring Immunisation Programme (TIP) approach**. It **provides stakeholders** working in the field of immunisation **with proven tools** to identify suboptimally vaccinated populations, determine barriers and drivers and design interventions. The approach is **underpinned by six values (see diagram)** opposite which can be applied when designing a targeted intervention.

Source: TIP: tailoring immunization programmes (who.int) (accessed 21/11/23)

Accountability and Governance

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Governance of pre-school vaccinations in England

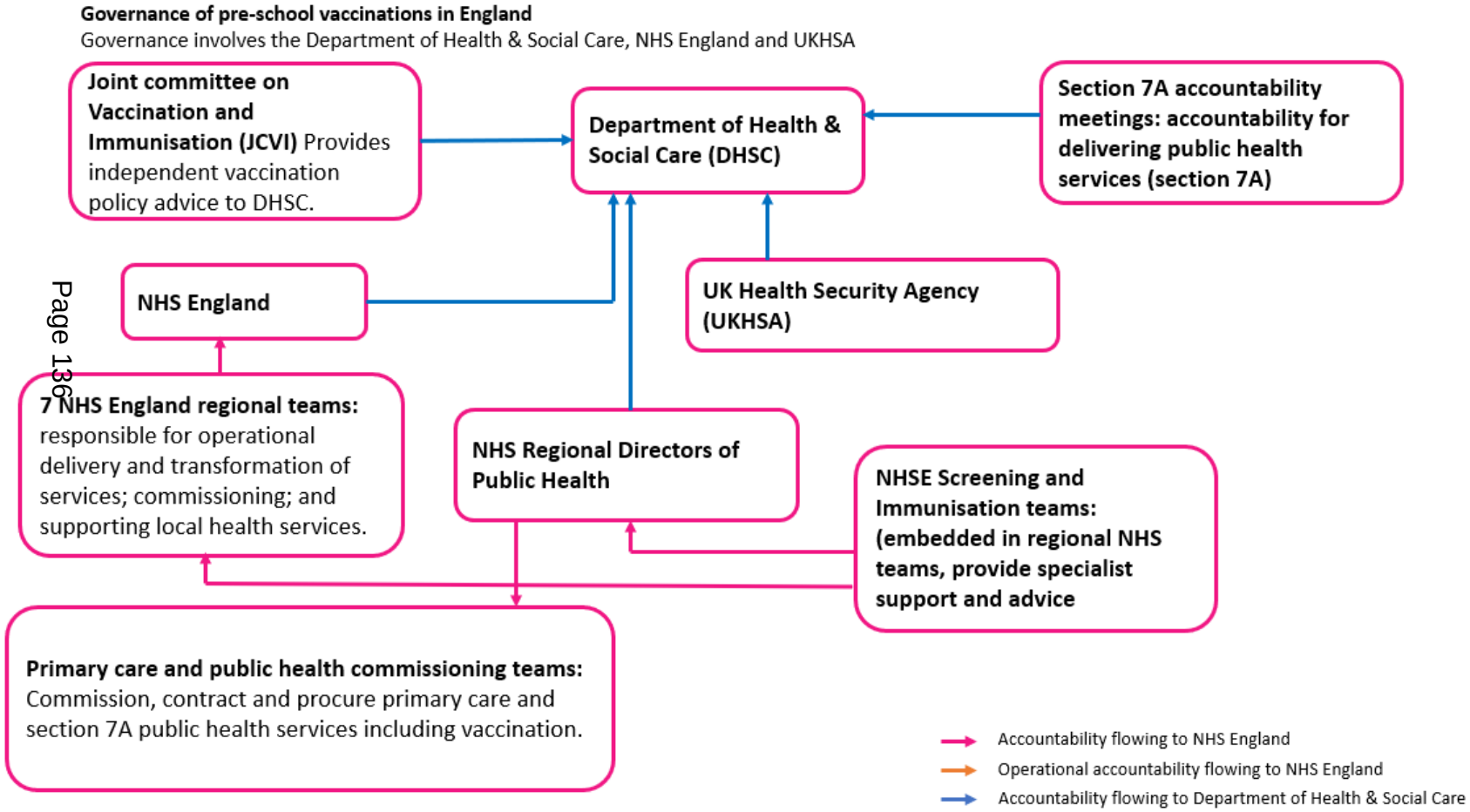


Diagram adapted and updated from: Investigation into pre-school vaccinations (nao.org.uk) (2019)

- **The Department for Health and Social Care (DHSC) chairs the Section 7A accountability meetings which is a public health oversight meeting** where the performance of vaccination programmes and other public health services are discussed every three months. These are attended by DHSC, NHS England (NHSE) and United Kingdom Health Security Agency (UKHSA) (formerly PHE).
- The DHSC is advised by the **Joint Committee on Vaccination and Immunisation (JCVI),** an independent expert advisory committee.
- **UKHSA and NHSE attend the Public Health Oversight Group which provides informal insights** to the Section 7A accountability meetings as part of its wider role in monitoring performance of services delivered through Section 7A.
- **NHSE Regional teams** are responsible for quality and the financial and operational performance of all NHS organisations in their region. The regional teams **commission vaccination and Child Health Information Services (CHIS) within the regions.**

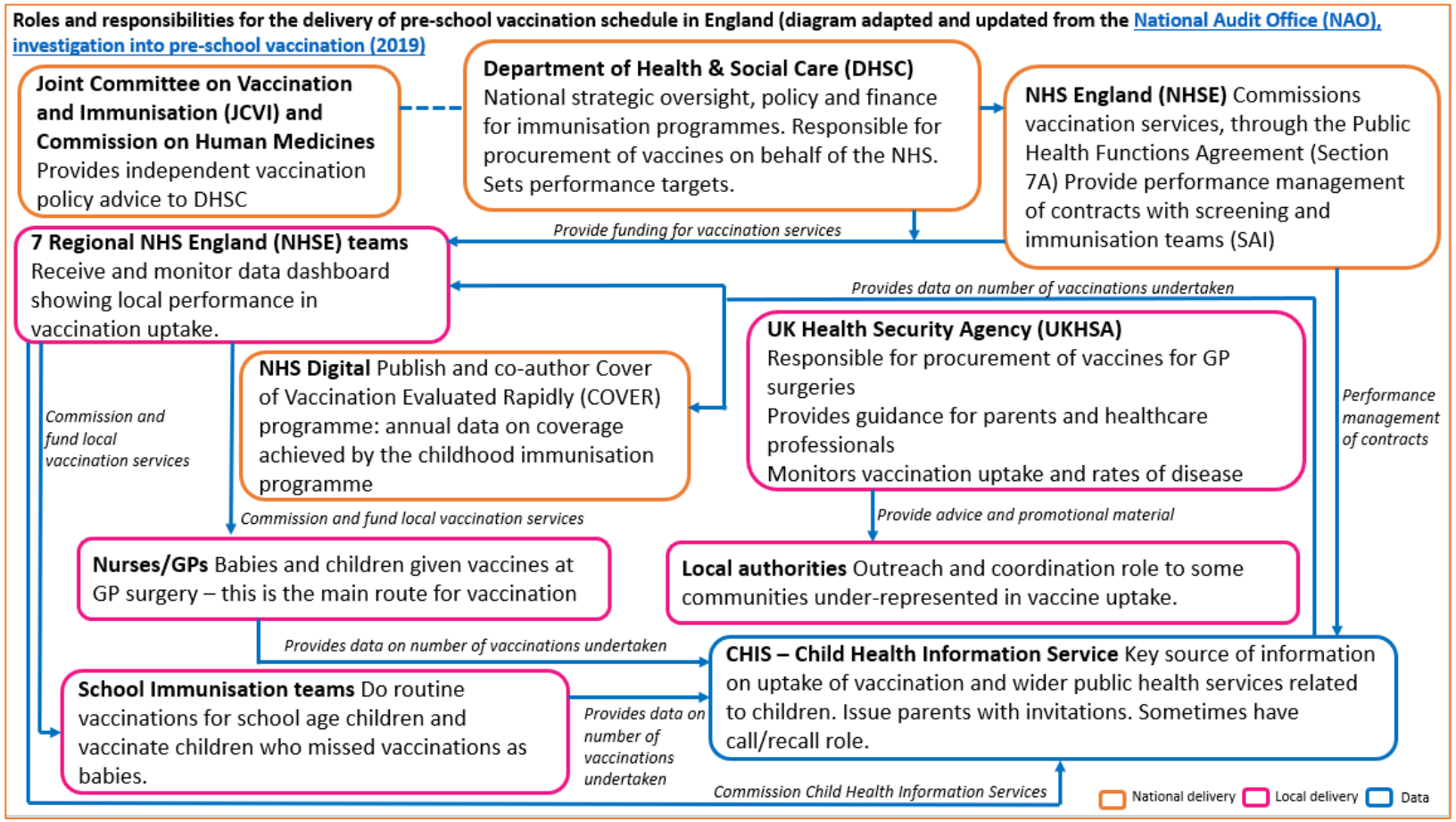
Roles and responsibilities for delivery of the pre-school vaccination schedule in England

- The **DHSC sets performance targets,** and the UK Health Security Agency undertakes surveillance of vaccine-preventable diseases.
- **NHS England** is **responsible** for the **commissioning** of immunisations and vaccinations through the public health functions agreement (S7A). This responsibility will move to the ICB in April 2024.

- **Pre-school** and **adult vaccinations** are usually **delivered by GP surgeries.** School-age services are co-ordinated by seven regional NHS England teams and delivered through School Immunisation Teams.

- **In Southampton, NHS Solent** manage the **school aged immunisation (SAI) programme** including offering school age catch up clinics.

- **Health visitors** and **midwives** have a crucial role to play **advocating for childhood immunisations** and **supporting parents** to make the decision to get their children immunised. Delivery of this forms part of the **statutory responsibilities** of local authority **public health teams** and are commissioned through the annual Public Health Grant from DHSC.

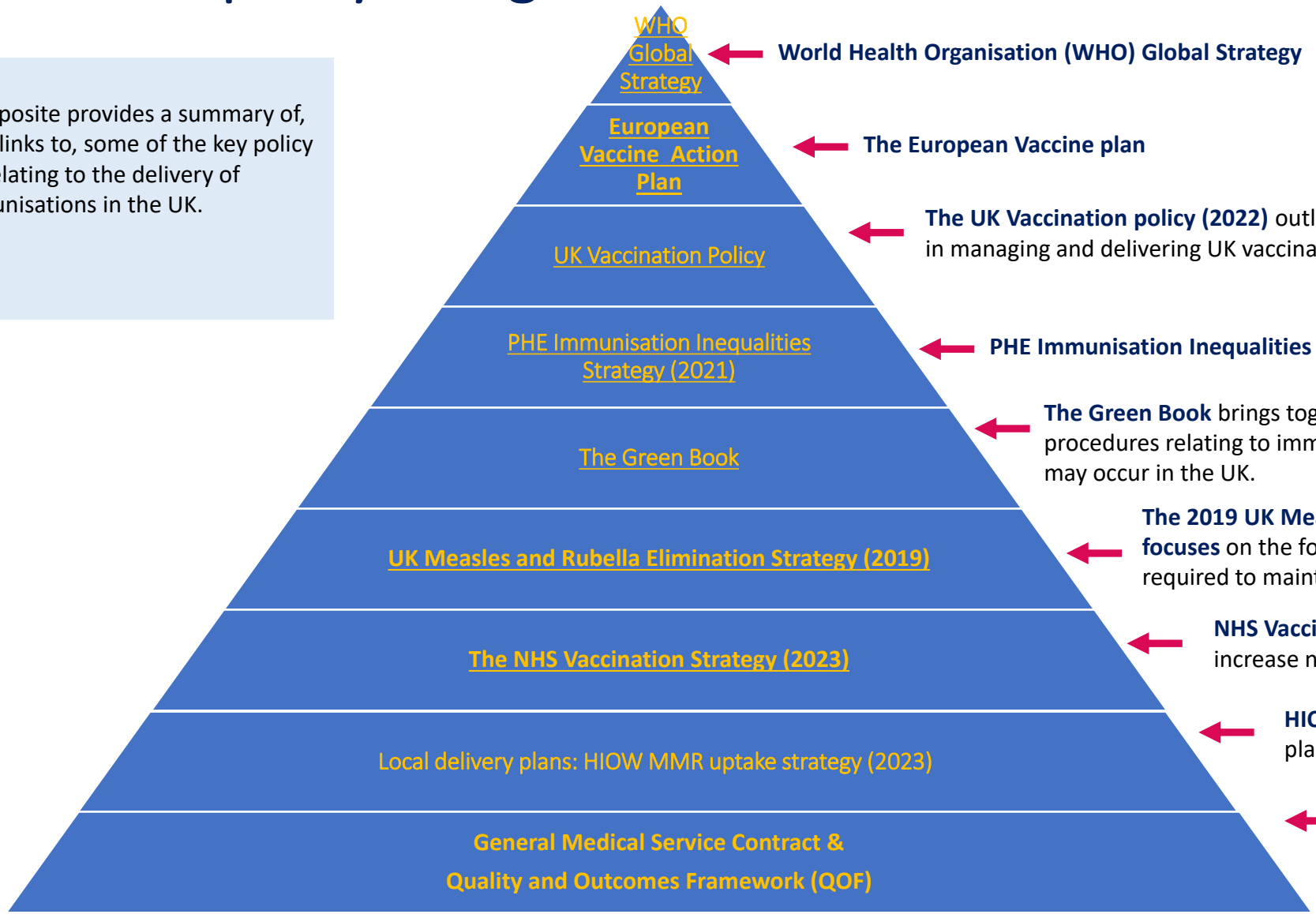


- Local authority Directors of Public Health have a **scrutiny and assurance role** in relation to vaccinations, including providing appropriate challenge to the arrangements for screening and immunisation programmes. Also advocating for reducing health inequalities and improving access for under-served groups.

- **Public health teams** are also **in a unique position to understand the health needs of their local population** and have a role to play in supporting vaccination services. This may be through helping immunisation teams' work with frontline services such as health visitors or children's centres or supporting pop-up vaccination clinics. They can also support health promotion through their communication channels and networks.

Key vaccination policy and guidance

The diagram opposite provides a summary of, where possible links to, some of the key policy and guidance relating to the delivery of childhood immunisations in the UK.



World Health Organisation (WHO) Global Strategy

The European Vaccine plan

The UK Vaccination policy (2022) outlines the roles of various organisations in managing and delivering UK vaccination programmes.

PHE Immunisation Inequalities Strategy (2021)

The Green Book brings together all documents, information and procedures relating to immunisation against infectious diseases that may occur in the UK.

The 2019 UK Measles and Rubella Elimination Strategy focuses on the four core components that were set out as required to maintain elimination.

NHS Vaccine Strategy (2023) sets out plans to increase national vaccine uptake.

HIOW MMR Uptake strategy (2023) sets out plans to increase uptake locally.

The GMS Contract and The Quality and Outcomes Framework (QOF) sets out how GP's are contracted & remunerated for providing good quality care to their patients.

Local mechanisms, meetings and key points of contact for delivery

Hampshire and Isle of Wight (HIOW) Strategic Immunisations Oversight Group (SIOG)

- Provides oversight and governance for delivery of vaccination delivery.
- Chaired by: NHSE
- Frequency: Quarterly
- Membership: ICB, Local Authority, NHS E

Southampton Health Protection Board (HPB)

- Chaired by: SCC Consultant Lead, Health Protection
- Frequency: Quarterly
- Attended by: LA Health Protection Public Health, LA Communications lead, ICB Infection Prevention and Control (IP&C), Solent University, University of Southampton (UOS), University Hospital Southampton (UHS), Southampton Voluntary Services (SVS), UKHSA, Port Health, Public Health Screening and Immunisations Team (SIT) Lead Consultant.
- Reports to: Health and Wellbeing Board

Other key points of contact:

- Deputy Chief Medical Officer Children and Young People (CYP)
- ICB Southampton Place Director
- Deputy Director-Primary Care
- Primary Care Quality Lead, HIOW ICB

Southampton Profile

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Background

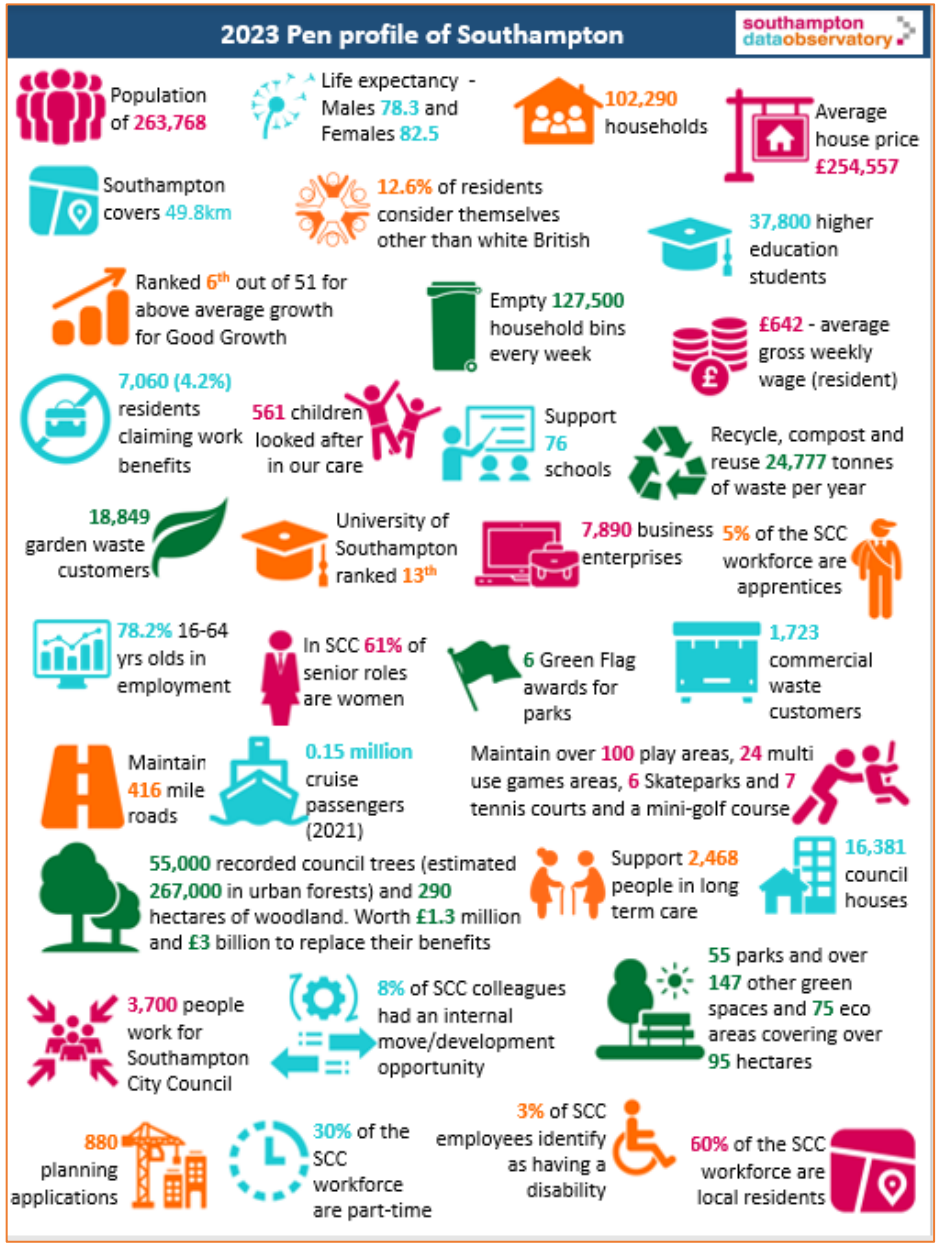
Many health outcomes in Southampton remain below regional and national average. We know that inequalities in the conditions in which we are born, grow, live, work and age lead to further unfair and avoidable different experiences of health and wellbeing. Therefore, reviewing data and information about the city's demographics is important to help us better understand and explain uptake of childhood immunisations in the city, consider what the strengths and needs might be, as well as inform service design and delivery.

Key findings:

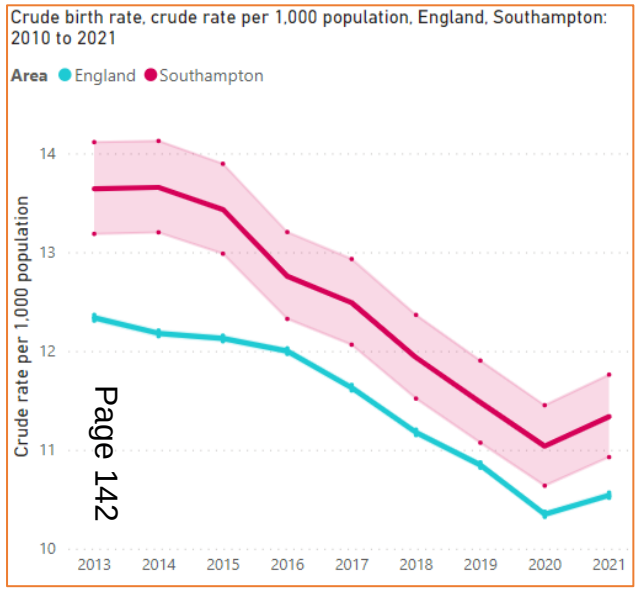
- Despite a **predicted increase** in Southampton's population, **Southampton has seen a decrease in both fertility rates and the number of births.**
- **41% of live births in Southampton were born to mothers who were born outside the UK (2022).**
- There is **some evidence** to suggest a **link between the overall GP registered population deprivation score and practice level vaccine uptake**, but this is not consistent across the city and without individualised uptake data is not possible to draw firm conclusions.

What does this mean for Southampton?

- Whilst the falling birth rate might indicate the numbers requiring vaccination will reduce, the diverse make up of the city, wide range of languages spoken and significant deprivation means **the need for a culturally tailored and supportive immunisation service is likely to increase.**
- Service design should aim to ensure that any **issues, such as language barriers** and **cultural and religious beliefs** that might be barriers to uptake, are given sufficient **priority.**



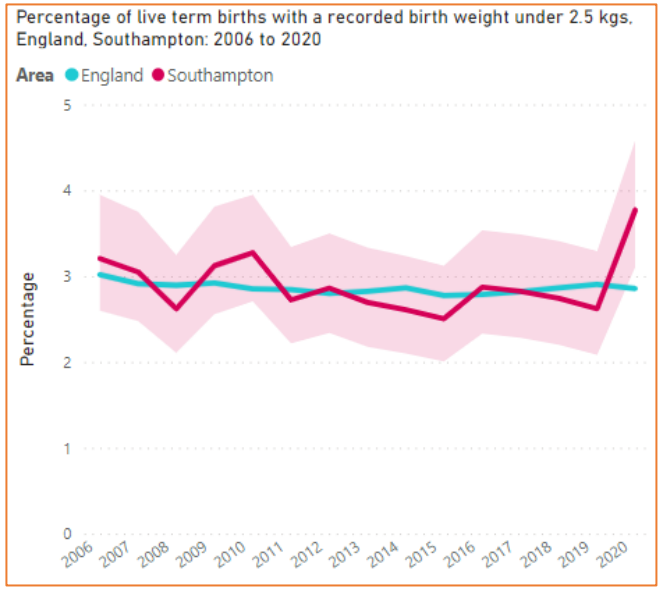
Births



The **birth rate** in Southampton remains **significantly higher** than England, although both are **falling** over time

Local rates are **falling faster** than nationally

In the **20% most deprived** areas, birth rates (12.4 per 1k) are **1.6x higher** than in the 20% least deprived (7.6 per 1k)



A **public health concern** is babies being born of **low birth weight** (under 2.5kg).

In **2020, 3.8%** of births were of **low birth weight; significantly higher** than **England.**

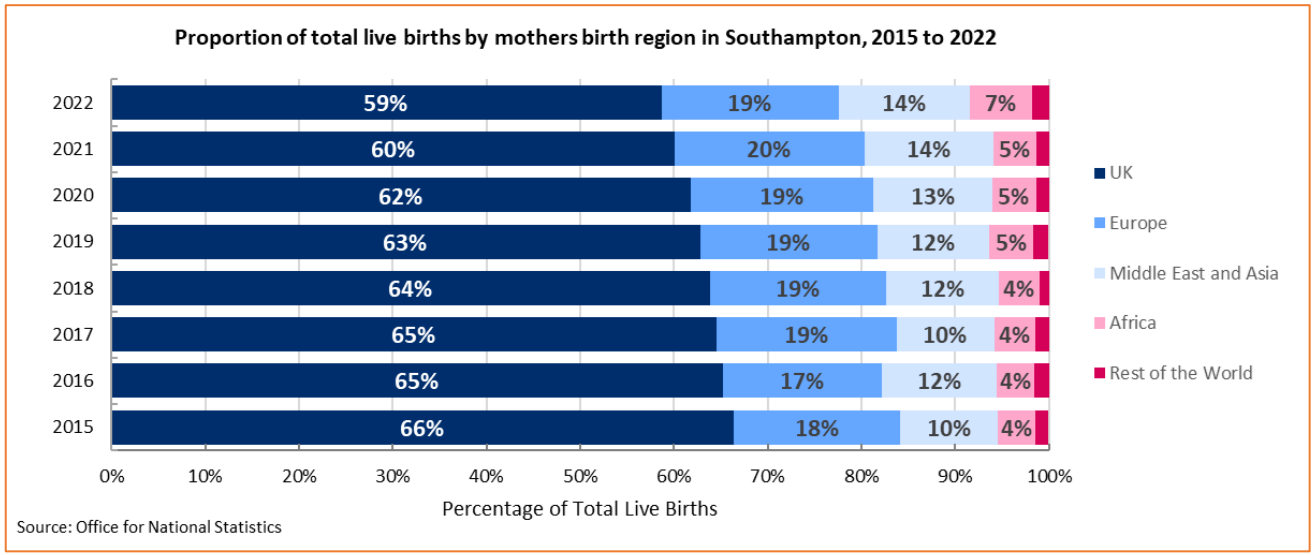
Bevois Ward was found to have the **highest percentage** of **low birthweight** babies. Local analysis shows **Bevois** has a **higher concentration** of **Asian mothers** who are **more likely** to have **lower birth weight** babies compared to the **UK average**. This reflects published literature where analysis confirms **lower birth weight** in second generation **South Asian babies.**

In **2018-20**, the percentage of low weight births in the **20% most deprived** areas (3.5%) was **3.2x higher** than in the **20% least deprived** (1.1%)

Source: *Microsoft Power BI*

Births data details the **mothers birth region,** understanding this, along with births rates and changes in migration helps with **maternity service** and **school pupil place planning.**

In Southampton, the percentage of **mothers born outside the UK is increasing**.

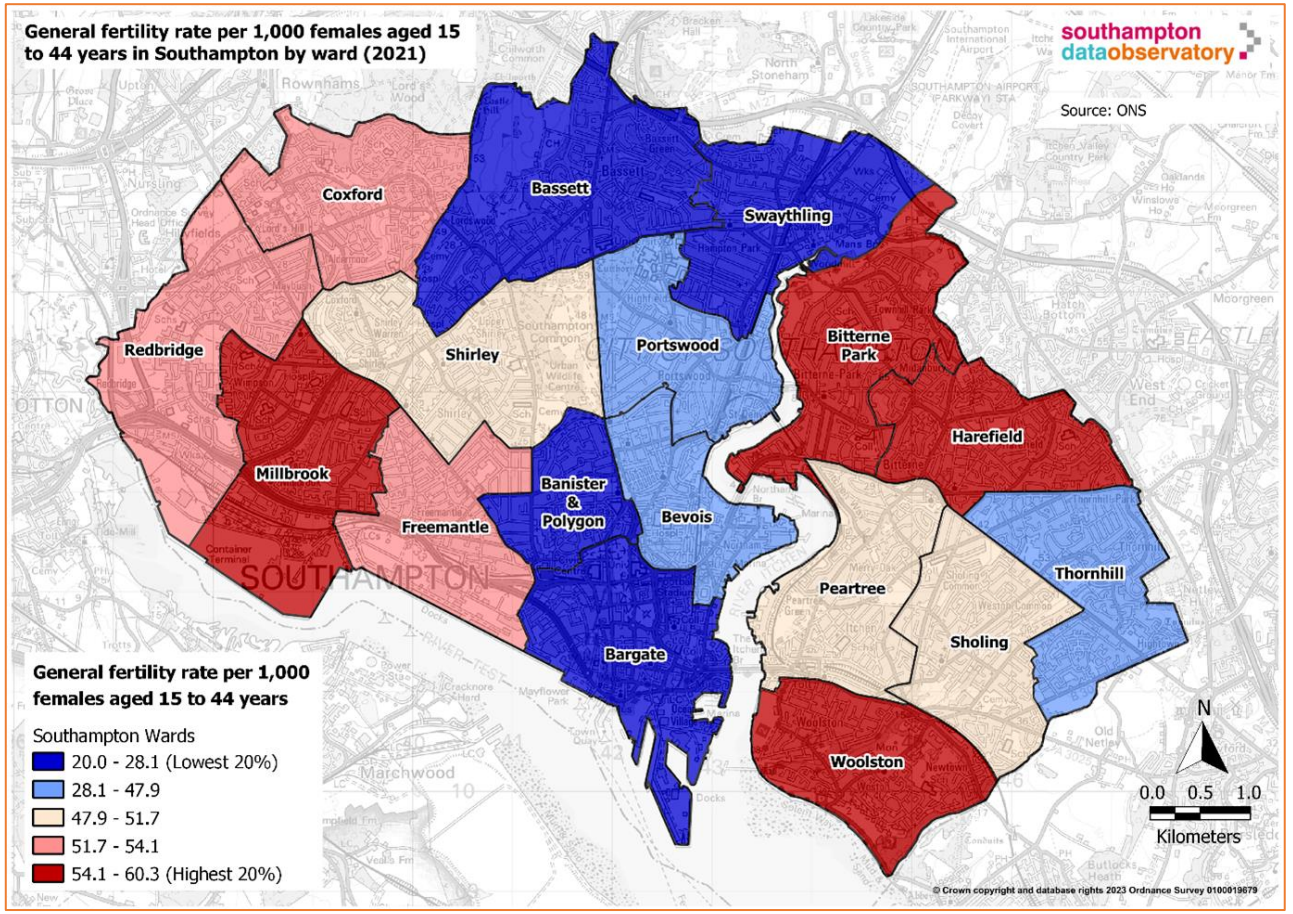


Source: *https://data.southampton.gov.uk/population/births/*

Population and demographics

- In 2022, the resident population of **Southampton was estimated to be 263,769,** of which **129,191 (49.0%)** were **female** and **134,578 (51.0%)** were male.
- **Children between the ages 0 to 5 make up 6.5% (17,032)** of the population, which is similar to the England average of 6.9% (MYE 2020)
- **18.5% (48,818) of Southampton's resident population is aged between 16 and 24 years compared to just 10.5% in England.** This is largely due to Southampton being a university city and home to approximately 37,800 students
- Despite a **predicted increase** in Southampton's population **to approximately 270,000 by 2040** from the current population of approximately 260,000, **Southampton has seen a decrease in both fertility rates and the number of births.**
- Whilst the **number of births remains higher than the national average** (11.0 per 1,000 population in Southampton compared to 10.3 nationally), both the **general fertility rate** at **48.3 per 1,000 females aged 15 to 44 years,** and **total fertility rate,** at **1.4 children per woman,** remain **below** the **national average of 55.3** and **1.6** respectively.

Source: Southampton Data Observatory



What does this mean for Southampton?

- In Southampton the **percentage of mothers born outside of the UK** is **increasing.**
- In **2022, 41% of live births were born to mothers who were born outside the UK.** Of the live births in Southampton, **19% were to mothers born in Europe, 14% to those born in the Middle East and Asia, 7% to mothers born in Africa and 2% were born in the rest of the world.**
- Understanding a mothers' background can allow for **tailoring of service provision to ensure a healthier antenatal, delivery and postnatal period** for both mother and child.

Inequality and deprivation

- Health inequalities are avoidable differences in health outcomes between groups of people due to social, geographical, biological or other factors.
- A health equity audit carried out by PHE in 2021 highlighted that **avoidable inequalities in vaccination still exist within some population groups**.
- NHS England has a legal duty to offer immunisation to ' under represented groups'. These groups may require special arrangements. Consequently, a reduction in health inequalities is a key objective for the delivery of the immunisation programme.
- At the regional level, **London** and the **South East tend to have the lowest coverage for most childhood vaccines**, and the North East the highest. **Performance varies with vaccine type** and **worsens for booster doses**. These figures highlight geographical inequalities in terms of vaccine timeliness as well as uptake.
- The graph opposite taken from PHE's Health Equity Audit shows a **correlation between deprivation lower immunisation uptake**. Whilst **falls in immunisation** uptake have been seen nationally across most programmes, they have been **larger in the most deprived deciles** compared to the nation average.

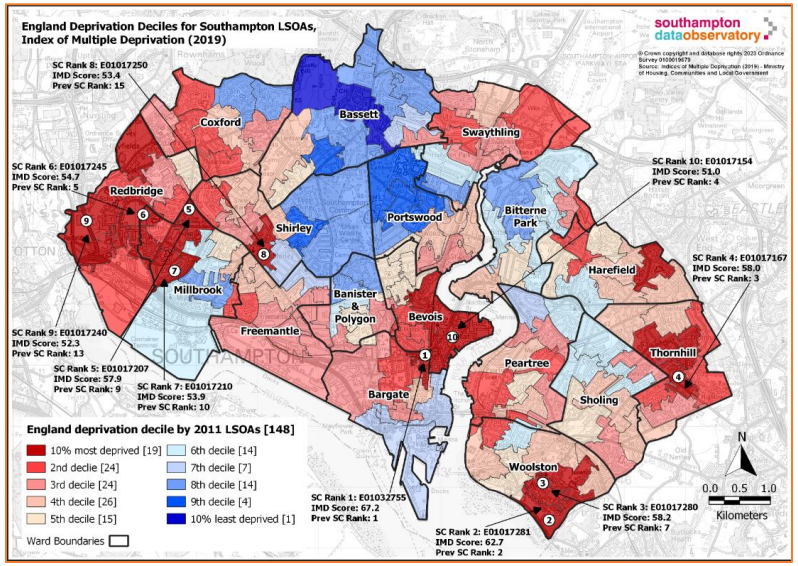
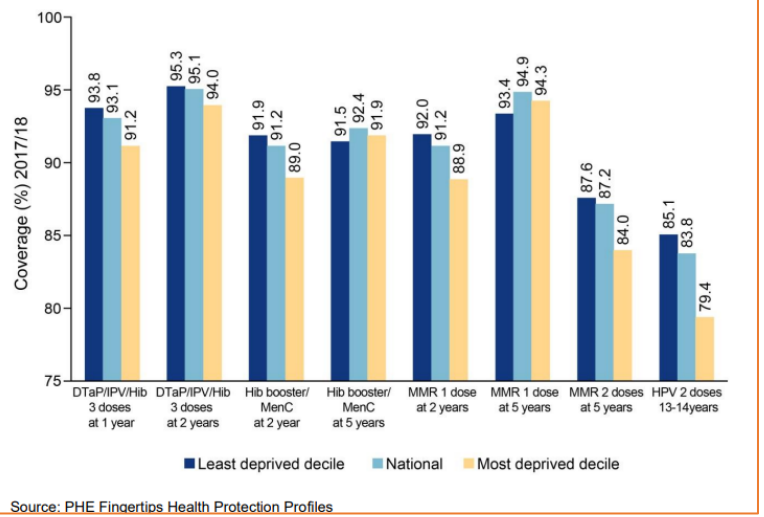


Chart 1. Immunisation coverage nationally, and in the least- and most- deprived population decile for routine childhood and HPV immunisation programmes with data available, England 2017 to 2018



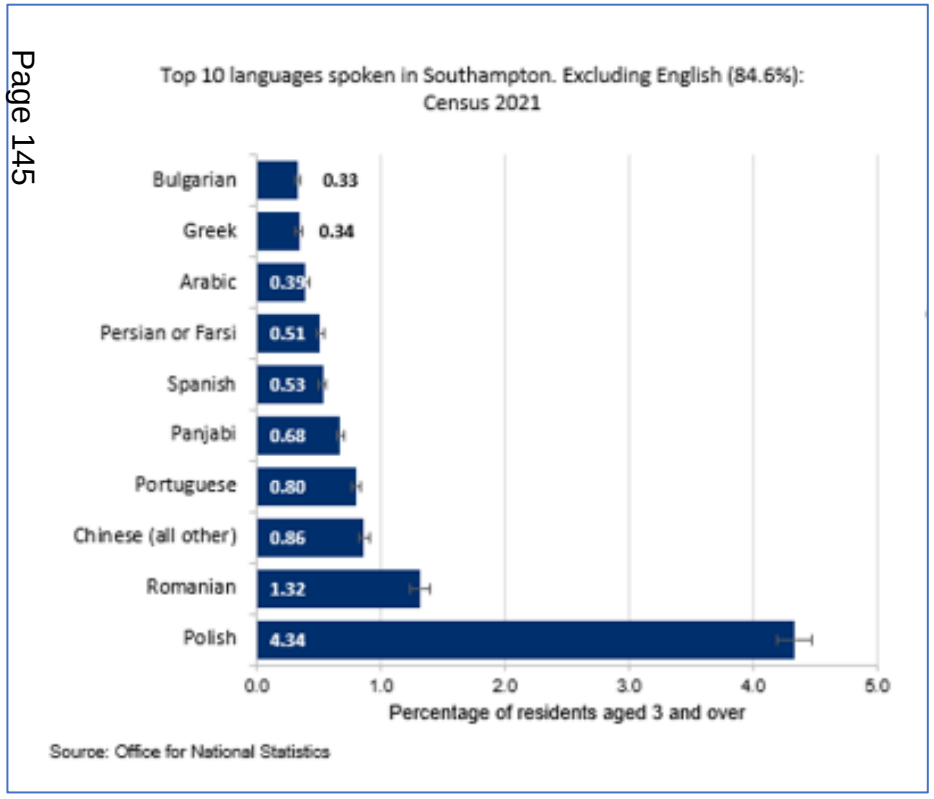
Source: PHE Fingertips Health Protection Profiles

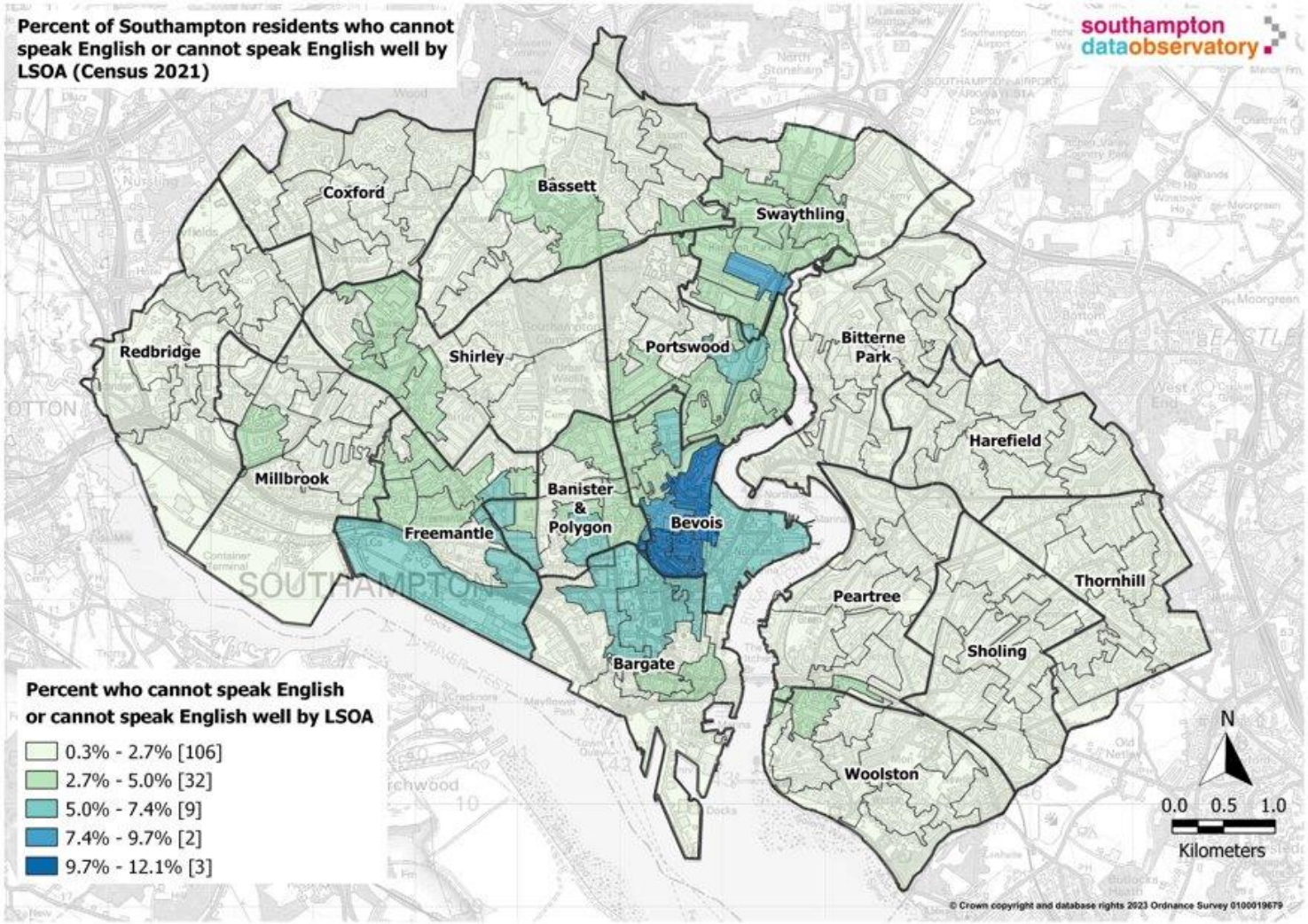
What does this mean for Southampton?

- The Index of Multiple Deprivation (IMD 2019) illustrates how **Southampton continues to be a relatively deprived city**. Based on average deprivation rank of its neighbourhoods (LSOAs), **Southampton** is now **ranked 55th** (where 1 is the most deprived) **out of 317 local authorities**: more deprived than the comparator cities of Bristol (82nd), Leeds (92nd) and Sheffield (93rd).
- When we look at the Index of multiple deprivation map (2019) we can see there are **pockets of high-levels of deprivation** across the city including the wards of **Redbridge, Beovis, Bargate, Woolston, Shirley, Thornhill** and **Harefield.**

Ethnicity, language and religion

- Diversity is increasing in Southampton with residents from over **55 different countries, speaking 165 different languages.**
- 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.
- In Bevois there is a very high percentage of different languages spoken and this may be even higher for literacy. Both language and literacy may be barriers to vaccination.





Ethnicity, language and religion

- The NAO Health Equity report states that for the routine childhood vaccinations there was **no simple relationship between ethnicity and coverage**. However, coverage did appear to be **more consistently lower than White-British children in certain ethnic groups**, for example **Black Caribbean, Somali, White Irish and White Polish populations.**

- It is notable that some ethnic groups **including South Asian ethnicities, tended to enjoy similar or higher** vaccination coverage than White children.
- This relationship is less clear **for MMR**, with **coverage of children of White ethnicity** being **similar to or lower than other non-White groups.** This may be linked to the false but prevailing concerns about MMR.
- The report also found that where both deprivation and ethnic origin were adjusted for, **deprivation** was typically **less of a determinant of vaccination** uptake **than ethnic group**.
- There is **less evidence relating to the link between inequalities** in vaccination coverage **and religious affiliation** and this is mainly in **Orthodox Jewish** communities.
- The NAO report also found that **children with learning disabilities were much less likely to be vaccinated** than their peers.

Other under vaccinated groups

- There have also been well documented outbreaks in Europe and the UK in both **traveller communities** and **Steiner communities**.
- Outbreaks in **migrant communities** also suggest that this is another group that may be under vaccinated for whom the vaccination status may be unknown
- There is limited evidence around vaccine coverage amongst **looked after children (LAC)** but what is available suggests they are **less likely to be vaccinated (estimated this could be equivalent to 31 children in Southampton)**.
- **Having a large family** reduces likelihood of vaccination against MMR of primary course.
- Parental age, specifically **mothers aged 20 or under** at birth, is significantly associated with being under immunised.

Source: National Health Equity Audit (2021).

Percent of Southampton residents who cannot speak English or cannot speak English well by ward (Census 2021)

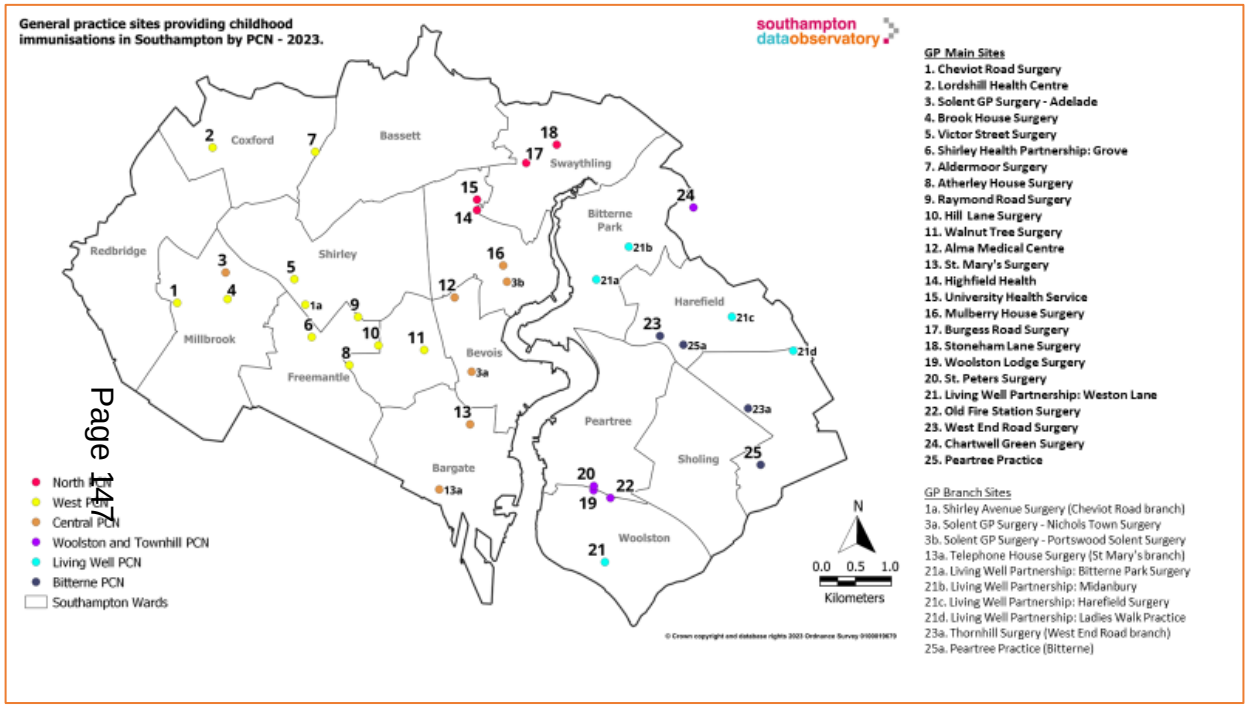
	Total number of residents	Cannot speak English		Cannot speak English well		Cannot speak English or cannot speak English well	
Bevois	15,817	162	1.0%	1,053	6.7%	1,215	7.7%
Bargate	15,112	73	0.5%	567	3.8%	640	4.2%
Banister & Polygon	16,396	56	0.3%	504	3.1%	560	3.4%
Swaythling	15,084	72	0.5%	444	2.9%	516	3.4%
Portswood	12,623	43	0.3%	389	3.1%	432	3.4%
Freemantle	11,433	35	0.3%	348	3.0%	383	3.3%
Shirley	14,550	56	0.4%	296	2.0%	352	2.4%
Millbrook	13,930	36	0.3%	263	1.9%	299	2.1%
Bassett	14,208	32	0.2%	246	1.7%	278	2.0%
Woolston	15,118	34	0.2%	225	1.5%	259	1.7%
Bitterne Park	14,794	26	0.2%	186	1.3%	212	1.4%
Redbridge	13,985	28	0.2%	184	1.3%	212	1.5%
Coxford	13,579	23	0.2%	166	1.2%	189	1.4%
Peartree	13,816	24	0.2%	158	1.1%	182	1.3%
Harefield	12,754	17	0.1%	149	1.2%	166	1.3%
Thornhill	13,856	25	0.2%	113	0.8%	138	1.0%
Sholing	13,572	14	0.1%	99	0.7%	113	0.8%
	240,627	756	0.3%	5,390	2.2%	6,146	2.6%

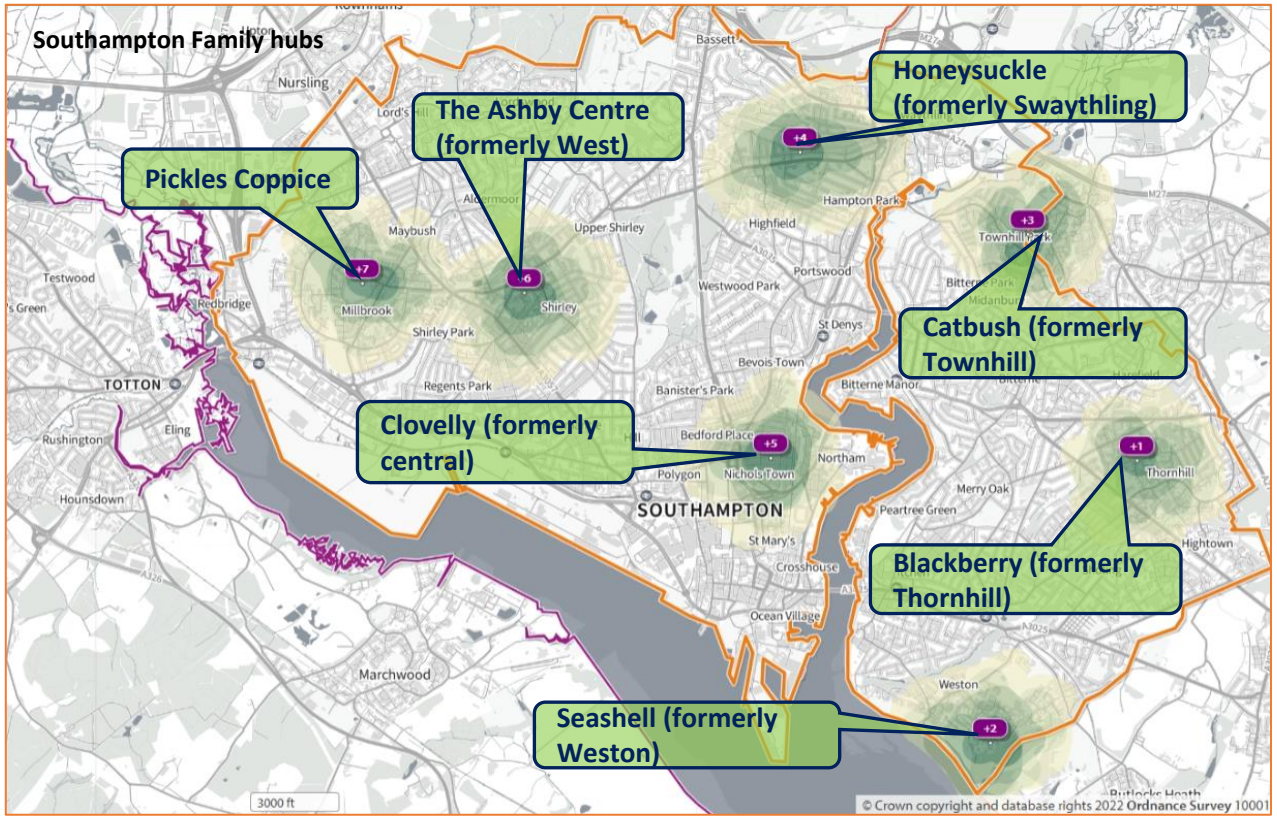
Source: Census 2021

What does this mean for Southampton?

- Establishing a clear link, or trends, concerning ethnicity and vaccination uptake in Southampton is difficult due to a **lack of sufficient ethnicity-based data**.
- When considering the demographic and ethnic profile of Southampton it is likely that **issues such as language and culture may be affecting immunisation uptake negatively**.
- This **underlines the importance of tailoring services to the needs of the local community,** particularly in wards where there are high numbers of non-English speakers and/or multiple languages spoken. Also **ensuring that translated information is provided proactively** and **support available** to those that need it as well as working with community/faith leaders.

GP Practices and family hubs





- Southampton has 6 Primary Care Networks (PCN's) which are comprised of 26 GP practices. 25 of these offer childhood immunisations (see map above).
- There are also 7 Family Hubs.

What does this mean for Southampton?

- Southampton Family Hubs were launched in 2023. **These venues have the potential to support promotion and delivery of routine childhood immunisations** in the city. Staff working at these facilities have contact with parents across the city and engage with them on a range of topics. Some of the venues also have the space and facilities to accommodate clinics.
- Utilising alternative venues to deliver vaccinations was highly successful during COVID and is also identified as a recommendation within Nice Guidance, 'Vaccine uptake in the general population' (2022).

Local Data Analysis

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Data analysis

SCC data and intelligence team have analysed available COVER data (Cover Of Vaccination Evaluated Rapidly) to get a more detailed understanding of where the opportunities and challenges may be to improve uptake of childhood immunisations and reverse the declining trend.

Approach

- **5 key childhood vaccination** uptake indicators have been analysed.
  - 3 doses of **Hexavalent** at 1 year of age.
  - 1 dose of **MMR** at **2 years** of age
  - 1 dose of **MMR** at **5 years** of age
  - **DTaP** booster at **5 years** of age
  - 2 doses of **MMR** at **5 years** of age
- The **COVER report (Q1-4 22/23 and Q1 2023/34)** data is provided by **CHIS** (Child Health Information Services), based on the information they receive from GP practices.
- **25/26 Southampton GPs included in the analysis (Homeless Healthcare is not included in the COVER report data).**
- Southampton **GP practice names** have been **anonymised**.
- The WHO target level of uptake for these vaccines is 95%.
  Where a RAG rating has been used in this document:
  - **Red** uptake is less that 90%
  - **Amber** uptake is between 90% and 94.9%
  - **Green** uptake is at or above the target of 95%
- The 'gap to 95%' has been calculated to show **how many additional vaccinations** would be needed for each GP practice to **reach 95%.**

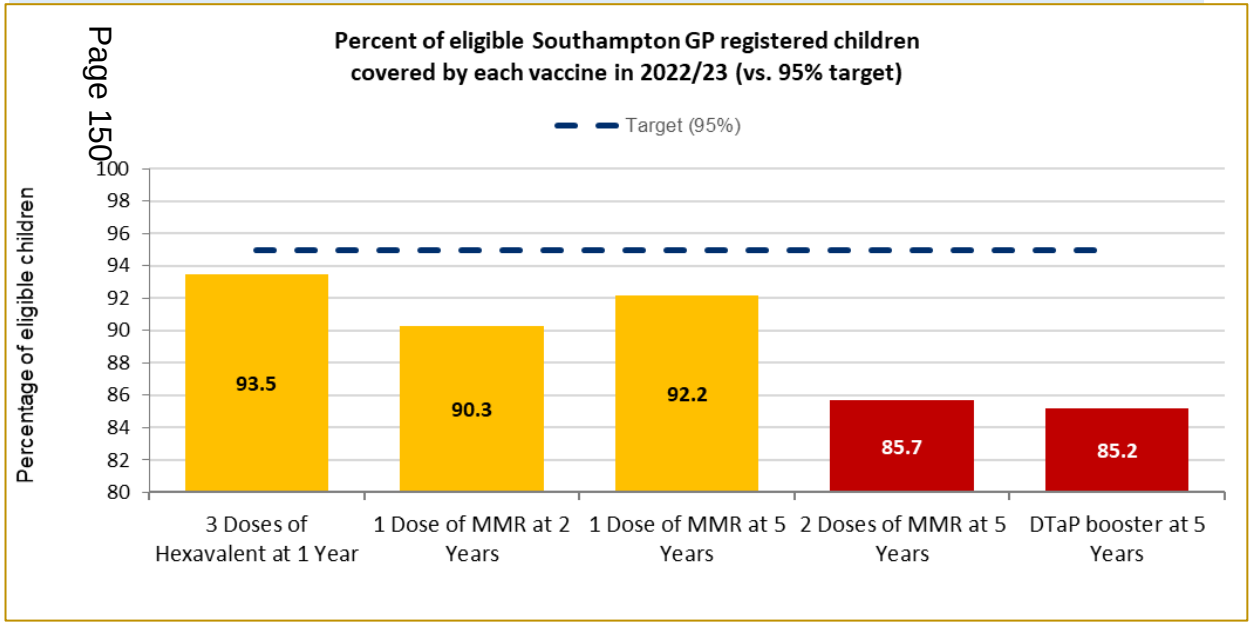
Key findings:

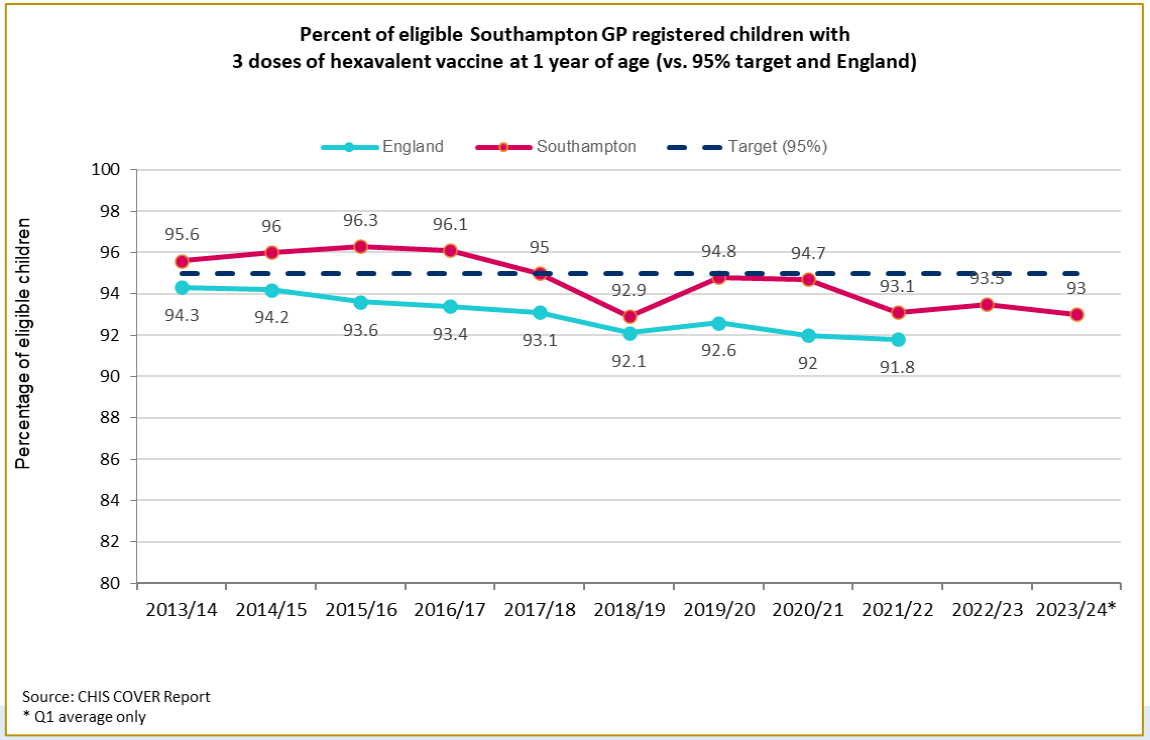
- **In 2021/22 and 2022/23** Southampton **missed** the target (95%) **for all 5 indicators.**
- Uptake in Southampton and England has been **decreasing** for **all 5 indicators**.
- **9/25** Southampton GP practices were **amber** or **red** for all 5 indicators in 2022/23.
- **0/25** Southampton GP practices were **green** for all 5 indicators in 2022/23.
- There was **no clear trend between** the **size of the cohort**/number of children eligible and **vaccination uptake**
- The **average gap to 95%** for 2022/23 was the equivalent to **7 additional children** at each GP practice having each vaccine.
- **Data is lacking on local uptake amongst people from different ethnicities**, including Eastern Europeans.
- **Absolute numbers** required to meet 95% target by individual GP practice is **relatively small**.

Vaccine uptake

All 5 indicators

- **In 2021/22 and 2022/23** Southampton **missed** the 95% target for **all 5 indicators**.
- Uptake for **2 indicators** was below 90% and rated **red (2 doses MMR at 5 years** and **DTaP booster at 5 years).**
- This data indicates that **uptake gets worse as children get older and that the declining trend is continuing.**





Source: CHIS COVER Report
* Q1 average only

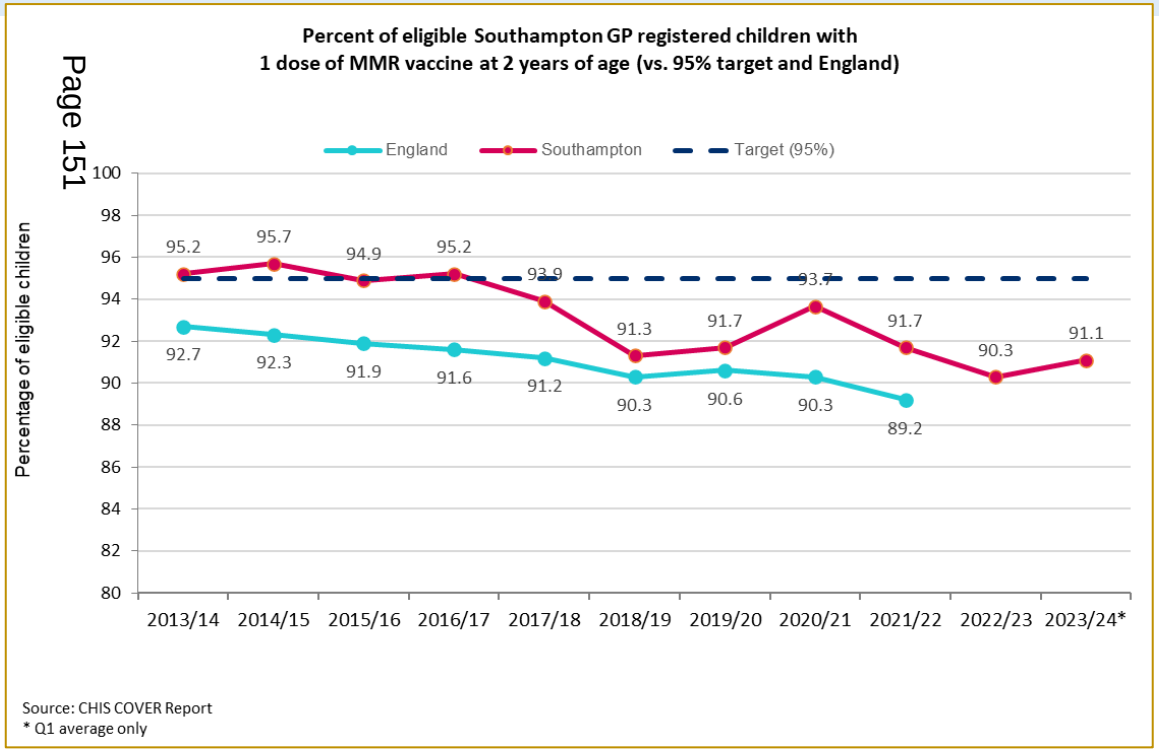
Hexavalent (3 doses at 1 year of age)

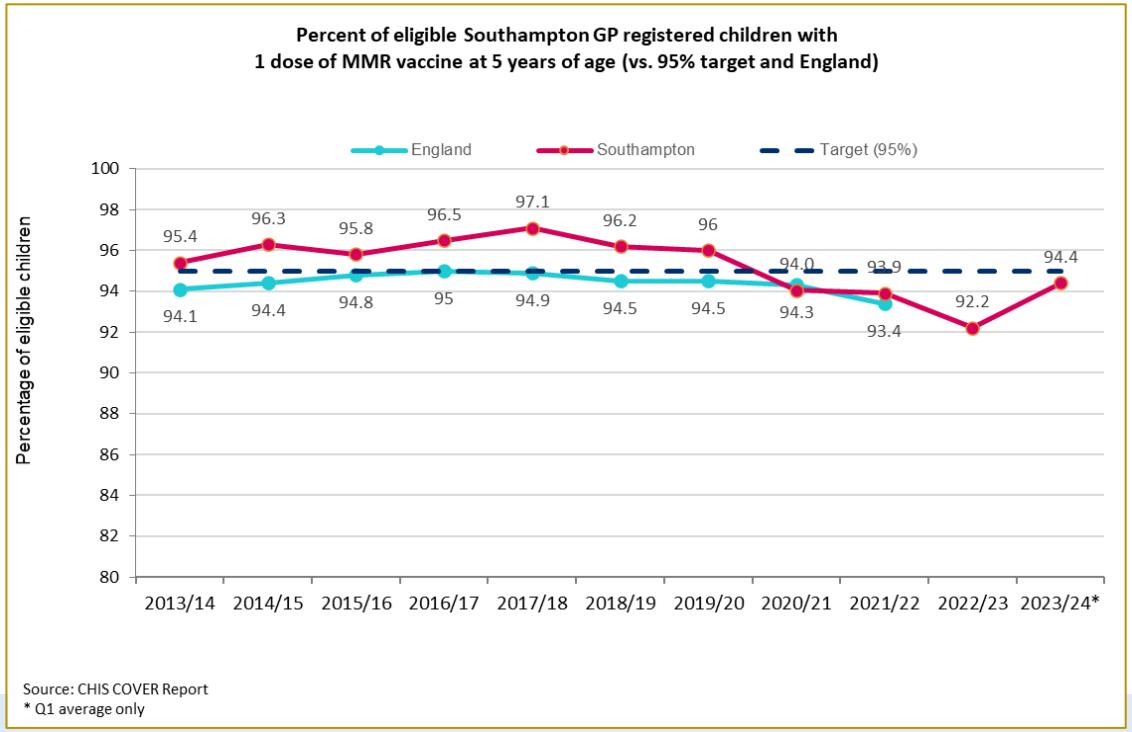
- **3 doses of hexavalent at 1 year of age** has been below the target of 95% in Southampton for the **last 5 years.**
- The **highest uptake** in **Southampton** over the last 5 years was during the peak of the COVID-19 pandemic (2019/20 and 2020/21), uptake was **within 0.3%** of target during these years. Uptake has decreased since.
- **Uptake in Southampton and England** has been **decreasing.**

Vaccine uptake

MMR (1 does at 2 years of age)

- **1 dose of MMR at 2 years of age** has been **below the target** of 95% in Southampton for the **last 6 years** but has **increased slightly in Q1 of 2023/24.**
- The **highest uptake** in **Southampton** over the last 4 years **was in 2020/21 during the peak of the COVID-19 pandemic.** Uptake has decreased since.
- Overall the trend in uptake for Southampton and England has been **decreasing and getting worse** and **remains below 95%.**





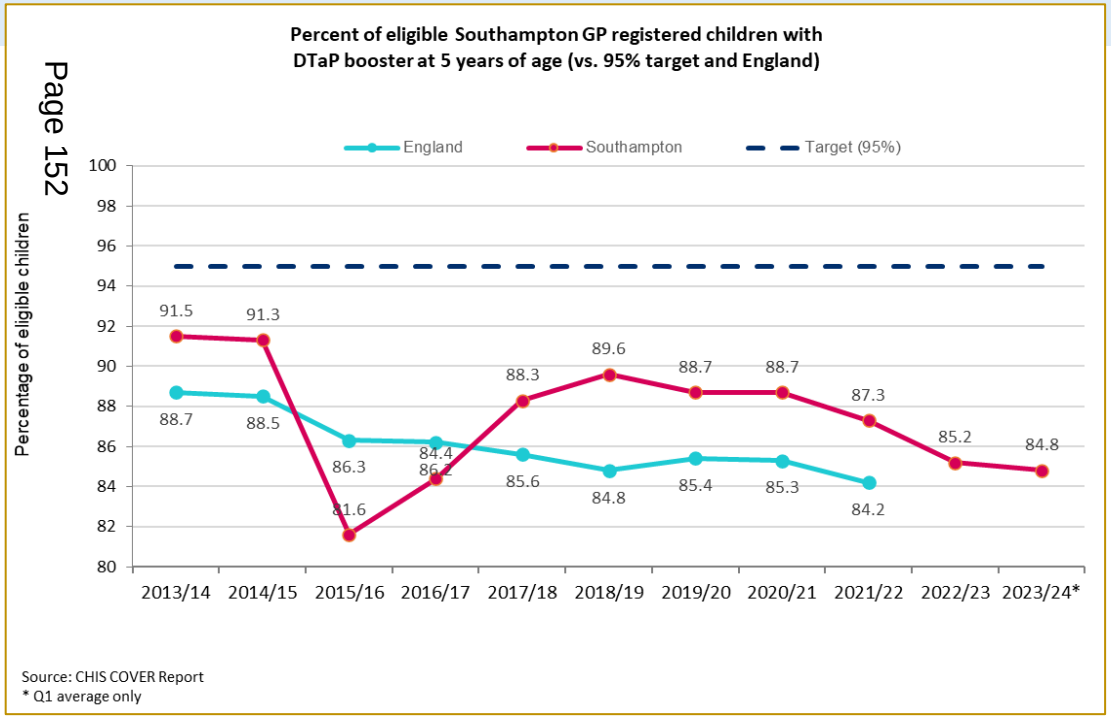
MMR (1 dose at 5 years of age)

- **1 dose of MMR at 5 years of age** has been **below the target** of 95% in Southampton for the **last 2 years** and is **on track to miss again in 2022/23.**
- **Uptake was increasing** in Southampton **until 2017/18. Uptake has reduced every year since.**
- Uptake has **increased to 94.4% in Q1 of 2023/24**
- **Prior to this, uptake in Southampton and England** had been **decreasing and getting worse** year on year since 2017/18.

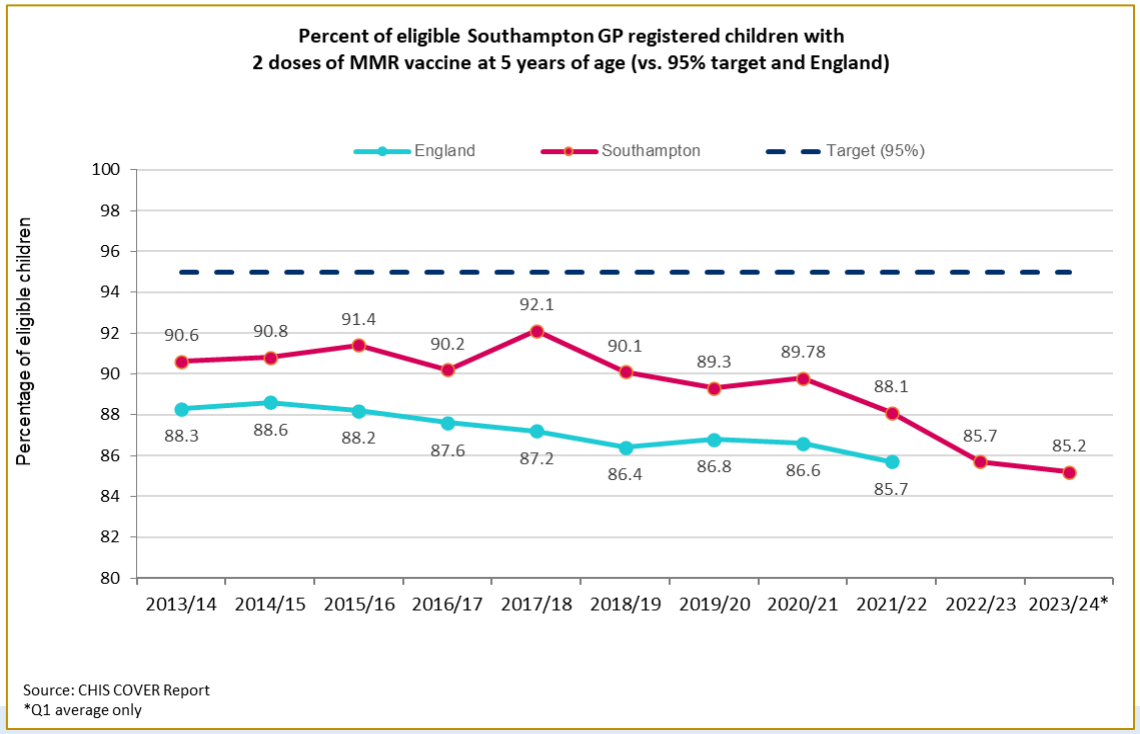
Key vaccine uptake

DtAP booster at 5 years of age

- **DTaP booster at 5 years of age** has been **below the target** of 95% in Southampton **since records began in 2013/14** and is **on track to miss again in 2023/24.**
- **Uptake in Southampton and England** has been **decreasing and getting worse.**



Source: CHIS COVER Report
* Q1 average only



Source: CHIS COVER Report
*Q1 average only

MMR (2 dose at 5 years of age)

- **2 doses of MMR at 5 years of age** has been **below the target** of 95% in Southampton **since records began in 2013/14** and is **on track to miss again in 2023/24.**
- **Uptake in Southampton and England** has been **decreasing.**

Vaccine uptake

Uptake by anonymised Southampton GP practice

- **9/25 Southampton GP practices** were **amber** or **red** for all 5 indicators in 2022/23.
- **0 Southampton GP practices** were **green for all 5 indicators.**
- **1 Southampton GP practice** was **red for all 5 indicators**.

Anonymised GP Practice	% Uptake (2022/23)				
	3 Doses of Hexavalent at 1 Year	1 Dose of MMR at 2 Years	1 Dose of MMR at 5 Years	DTaP booster at 5 Years	2 Doses of MMR at 5 Years
GP-1	88.8	88.1	89	79	79.7
GP-2	93.8	94.5	86.8	76.7	79.9
GP-3	90.6	91.9	93.5	83.5	82.5
GP-4	93.6	96.3	93.6	91.3	91.3
GP-5	88.4	88	90.3	74.8	77.7
GP-6	93.9	94.4	95.9	88.9	88.5
GP-7	91.9	90.7	86.4	79.5	81.8
GP-8	93.1	93.8	92.4	83.5	83.5
GP-9	87.1	90.1	86.1	83.5	83.5
GP-10	96.6	95.8	87.5	73.6	75
GP-11	95.5	96.1	93.5	84.9	85.5
GP-12	88.5	91.2	89.7	82.1	82.8
GP-13	81.3	86.7	91.2	85.3	85.3
GP-14	97.6	96.5	96.6	90.7	92.2
GP-15	96.2	92.6	98.1	92.5	90.6
GP-16	95.7	97.6	91.5	89.4	89.4
GP-17	93.1	100	86.5	76.9	78.8
GP-18	98.6	98.6	92.4	81.8	80.3
GP-19	100	91.1	88.9	77.8	84.4
GP-20	97.2	98.4	93.1	86.1	84.7
GP-21	97.4	100	100	97.3	94.6
GP-22	99.2	95.6	97.4	91	89.7
GP-23	97.3	97.4	94.4	93.3	93.3
GP-24	97.5	98.1	96.1	91.4	91.4
GP-25	96.8	94.7	94.7	94.7	94.7

NB:

- *The size of the eligible cohort at each GP Practice varies year on year.*
- *The average eligible cohort for 2022/23 was 360 children per practice (ranging between 88 and 1,312).*
- *There was no clear trend between the size of the cohort/number of children eligible for vaccination and uptake.*

Hexavalent (3 doses at 1 year of age)

- **5 Southampton GP practices** had **less than 90% uptake** for **3 doses of hexavalent vaccine at 1 year of age** in 2022/23.
- **13 Southampton GP practices** had **more than 95% uptake** in 2022/23.

MMR (1 dose at 2 years of age)

- **3 Southampton GP practices** had **less than 90% uptake** for 1 dose of MMR vaccine at 2 years of age in 2022/23.
- **12 Southampton GP practices** had **more than 95% uptake** in 2022/23.

MMR (1 dose at 5 years of age)

- **8 Southampton GP practices** had **less than 90% uptake** for **1 dose of MMR vaccine at 5 years of age** in 2022/23.
- **6 Southampton GP practices** had **more than 95% uptake** in 2022/23.

MMR (2 doses at 5 years of age)

- **18 Southampton GP practices** had **less than 90% uptake** for **2 Doses of MMR at 5 Years of age** in 2022/23.
- **0 Southampton GP practices** had **more than 95% uptake** in 2022/23.

DTaP booster (at 5 years of age)

- **17 Southampton GP practices** had **less than 90% uptake** for the **DTaP booster at 5 Years of age in 2022/23.**
- **1 Southampton GP practices** had **more than 95% uptake** in 2022/23.

Gap to 95%

Hexavalent (3 doses at 1 year of age)

- **74 more children** would have needed vaccinating for all GP practices in Southampton **to reach 95%.**

MMR (1 dose at 2 years of age)

- **65 more children** would have needed vaccinating for all GP practices in Southampton **to reach 95%.**

MMR (1 dose at 5 years of age)

- **109 more children** would have needed vaccinating for all GP practices in Southampton **to reach 95%**

MMR (2 doses at 5 years of age)

- **306 more children** would have needed vaccinating for all GP practices in Southampton **to reach 95%.**

DTaP booster (at 5 years of age)

- **300 more children** would have needed vaccinating **for all GP practices** in Southampton **to reach 95%**

Gap to 95%* (2022/23)

Anonymised GP Practice	3 Doses of Hexavalent at 1 Year	1 Dose of MMR at 2 Years	1 Dose of MMR at 5 Years	DTaP booster at 5 Years	2 Doses of MMR at 5 Years
GP-1	17	22	17	45	43
GP-2	3	1	16	35	29
GP-3	10	7	3	23	25
GP-4	6	0	7	18	18
GP-5	7	7	5	21	18
GP-6	2	2	0	14	15
GP-7	4	5	12	21	18
GP-8	2	2	3	10	10
GP-9	8	5	11	14	14
GP-10	0	0	6	16	15
GP-11	0	0	3	19	18
GP-12	8	6	8	19	18
GP-13	5	3	2	4	4
GP-14	0	0	0	9	6
GP-15	0	2	0	3	5
GP-16	0	0	2	3	3
GP-17	2	0	5	10	9
GP-18	0	0	2	9	10
GP-19	0	2	3	8	5
GP-20	0	0	2	7	8
GP-21	0	0	0	0	1
GP-22	0	0	0	4	5
GP-23	0	0	1	2	2
GP-24	0	0	0	6	6
GP-25	0	1	1	1	1

* Number of extra children taking up the vaccine for the practice to reach 95% coverage (rounded up to the nearest whole number)

Desk-Based Review

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Desk-based information review

Method:

- **35 websites (26 of which were GPs,** including homeless health) were included **in a desk-based review method.**

All were reviewed by 1 person who looked at;

- availability of information on childhood immunisations
  - language and accessibility
  - use of signposting
  - pathway to book a childhood immunisation appointment
- website was inaccessible (at time of review)
- findings were put into quantitative data
- Other information sources included within the review:
  - Healthier together website
  - NHS vaccinations page
  - Family Assist
  - National Childbirth Trust
  - UHS Maternity Services
  - Southampton City Council
  - Hampshire Healthy Families
  - Gov.uk

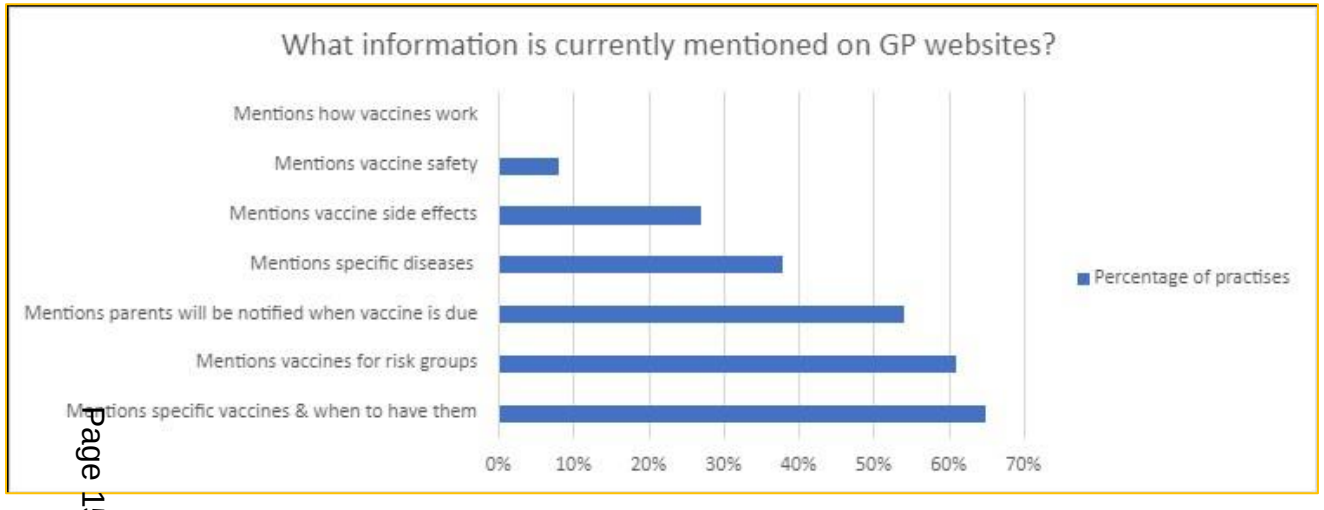
Key findings:

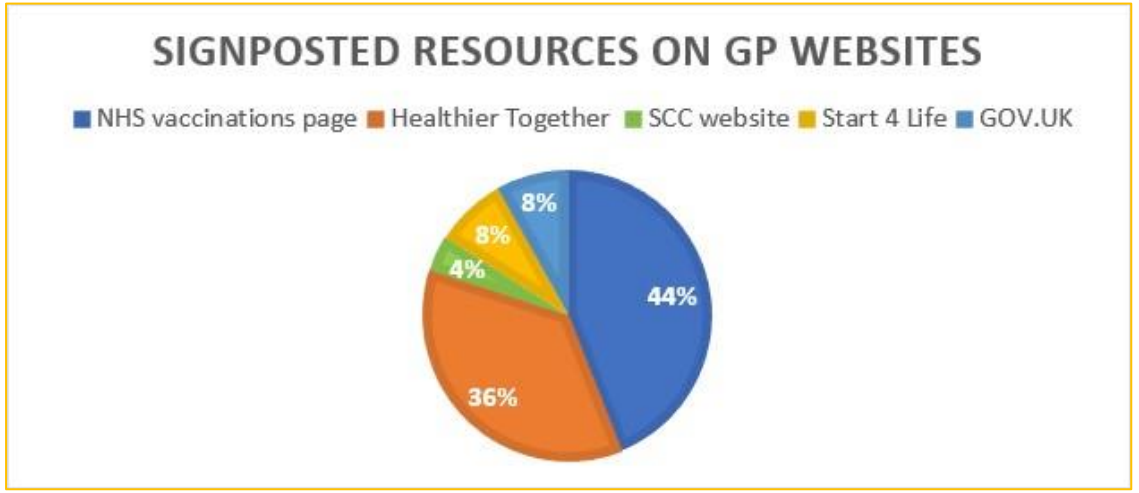
- There is **significant variation** in the **quality, scope and accessibility of information** available via practice websites relating to childhood immunisations.
- Whilst our review **did NOT find a correlation** between the **quality of practice websites and uptake**, the **inconsistency between practices across the city may be adding to inequities** in accessibility.
- Some GP practices located within **wards with high numbers of residents for who English is not a first language did not** have a **translation function available.**
- There is **scope for all Practice websites to improve** the quality and **accessibility of information available** in relation to childhood immunisations.

Key recommendations:

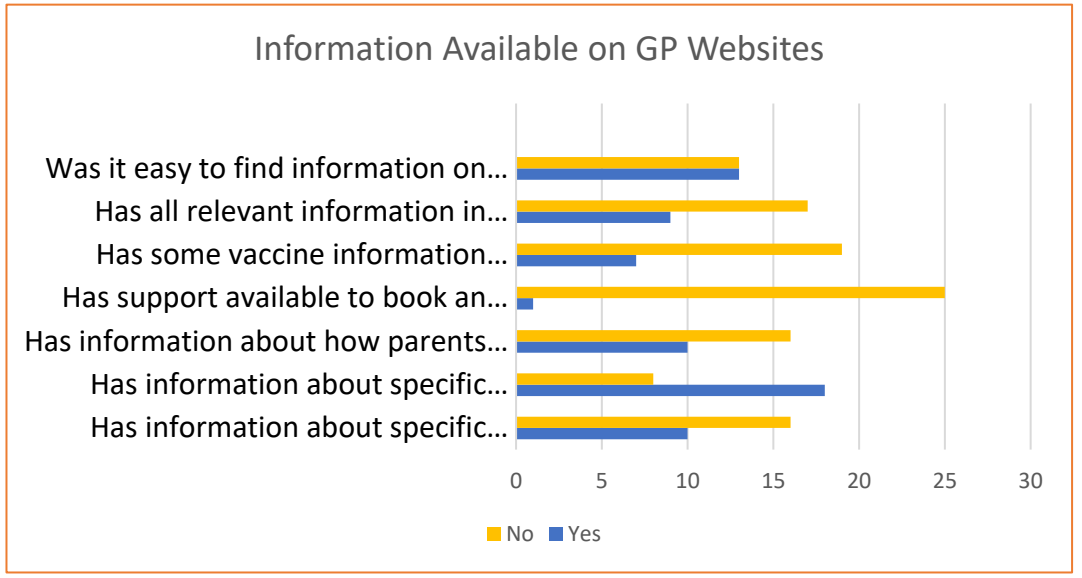
- All GP websites to have the **translation option available** on the **whole page.**
- All to have **childhood immunisations section, that is easily accessible** from the home menu.
- **Direct route to book/rearrange an appointment** from the childhood immunisations page.
- **Support for booking** an appointment or **accessing additional help and information** advertised.
- More **information on diseases** the vaccines protect against.
- **Signposting** to **key websites** including NHS and Healthier Together.
- More **information on vaccine safety and importance** ~~**and successes of vaccinations.**~~
- Support for parents in **confirming child immunisation status**
- **Consider statements from faith leaders** as to importance of childhood vaccination.

Findings





What Information is available	Mentions specific vaccines & when to have them	Mentions vaccines for risk groups	Mentions parents will be notified when it's due	Mentions specific diseases	Mentions Vaccine side effects	Mentions vaccine safety	Mentions how vaccines work
No. of practises	17	16	14	10	7	2	0
Percentage of practises	65%	61%	54%	38%	27%	8%	0%



Key Findings

- We know that **language and literacy may be a barrier**, particularly in parts of the city where there are high numbers of individuals for whom English is not a first language
- **Only 35% of GP practices had translatable information** on childhood immunisations available on their website.
- **5 practices indicated that there was the option but the function is not working** (those powered by 'Mysurgery' system)
- The majority of GPs **(61%) have information on all recommended routine vaccines** but there's a gap in information about specific infectious diseases.
- Childhood immunisation **information** was **hard to find on 50% GP websites** (subjective to 1 researcher's experience).
- **NHS vaccination page is included on most** GP pages (Positive).
- **Most** practices **do not offer support with booking** an appointment, **only 1 GP mentioned support.**
- **Other parent-guardian resources** for immunisations are **under signposted .**

Examples of good practise

✓**Information available** as to recommended routine vaccinations and when to have them

✓**Signposting other resources**: NHS vaccinations page, healthier together website, start for life

✓Option **to translate the page**, with options of over 100 languages.

✓**Speaker translation option** for the whole page (Healthier together website)

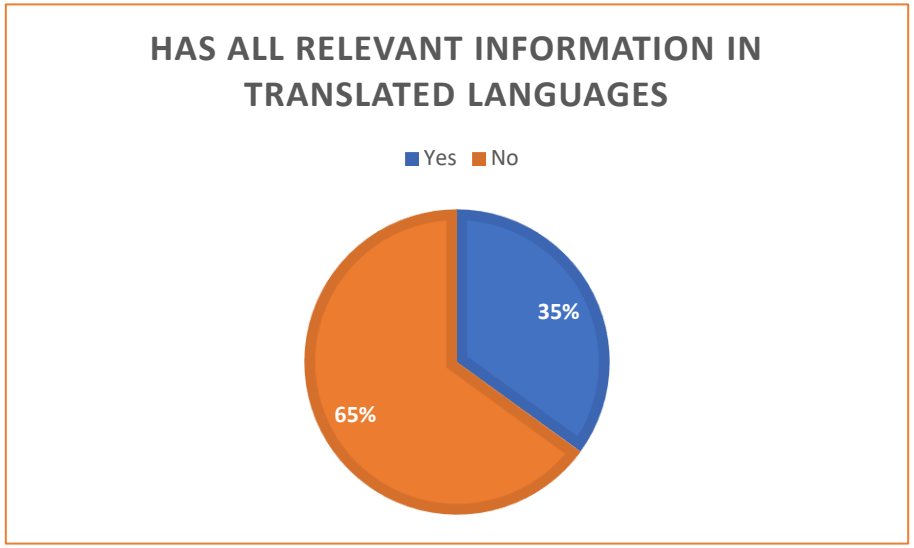
✓An **accessibility menu** to change the page (e.g. dyslexia friendly)

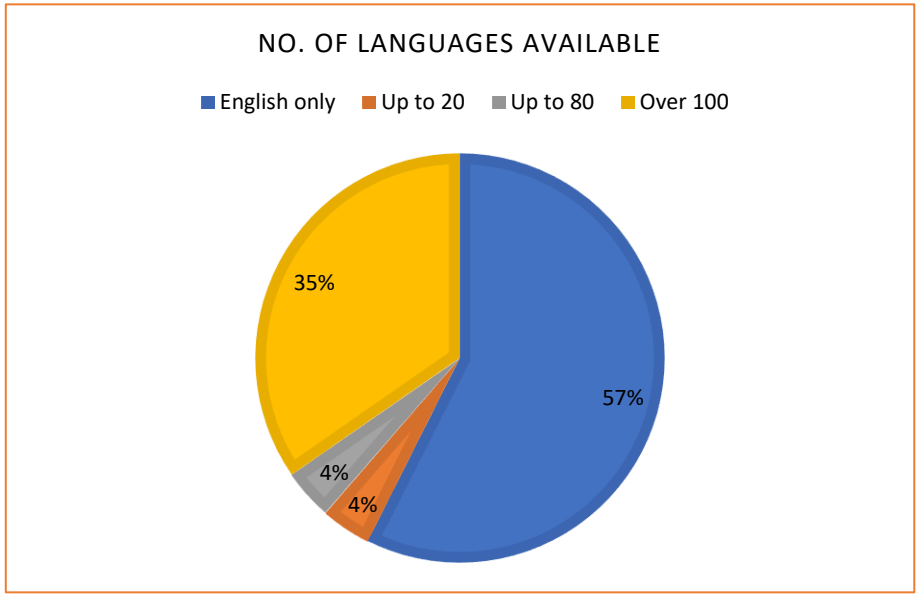
✓1 practice included the **statement from the Muslim Council of Britain** on the importance of vaccinations

✓**Myths about immunisation** section (National Childbirth Trust)

✓**Information on the importance** of vaccinations and that it's **safe**

✓Availability of an **electronic consent** form (Hampshire healthy families)





Parent Insights

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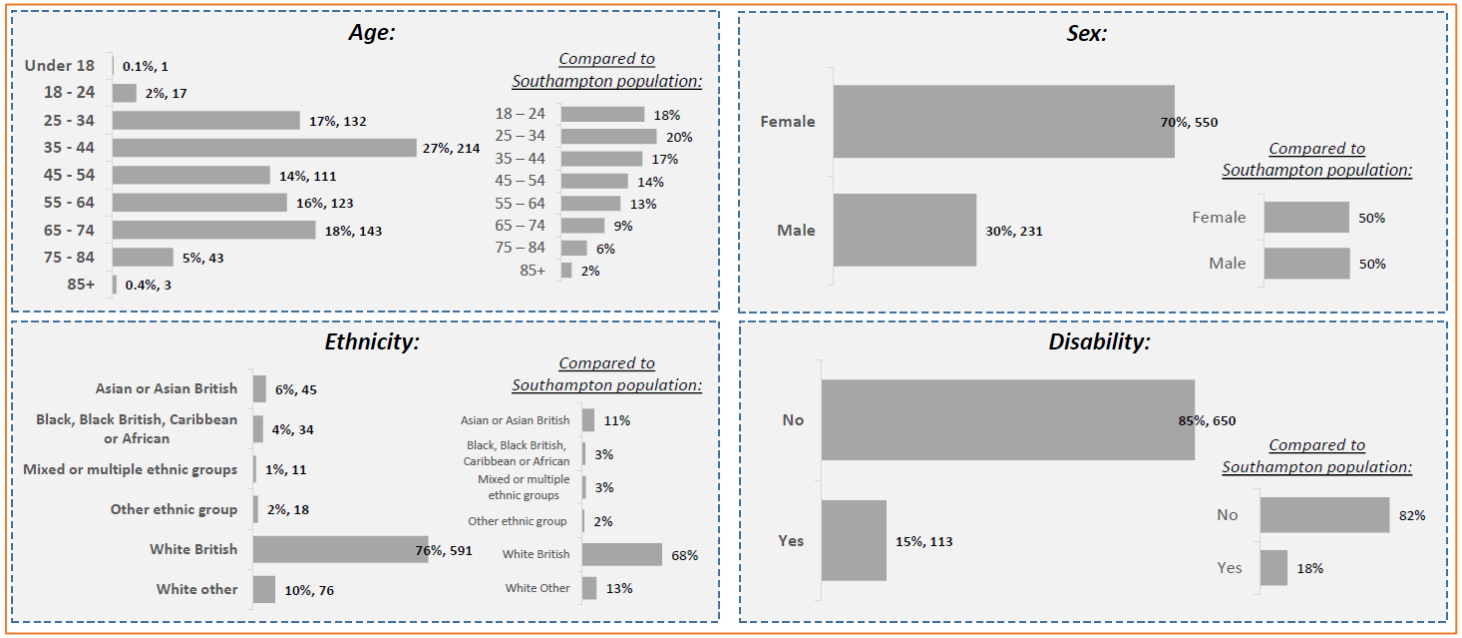
CHISANA Parent Survey

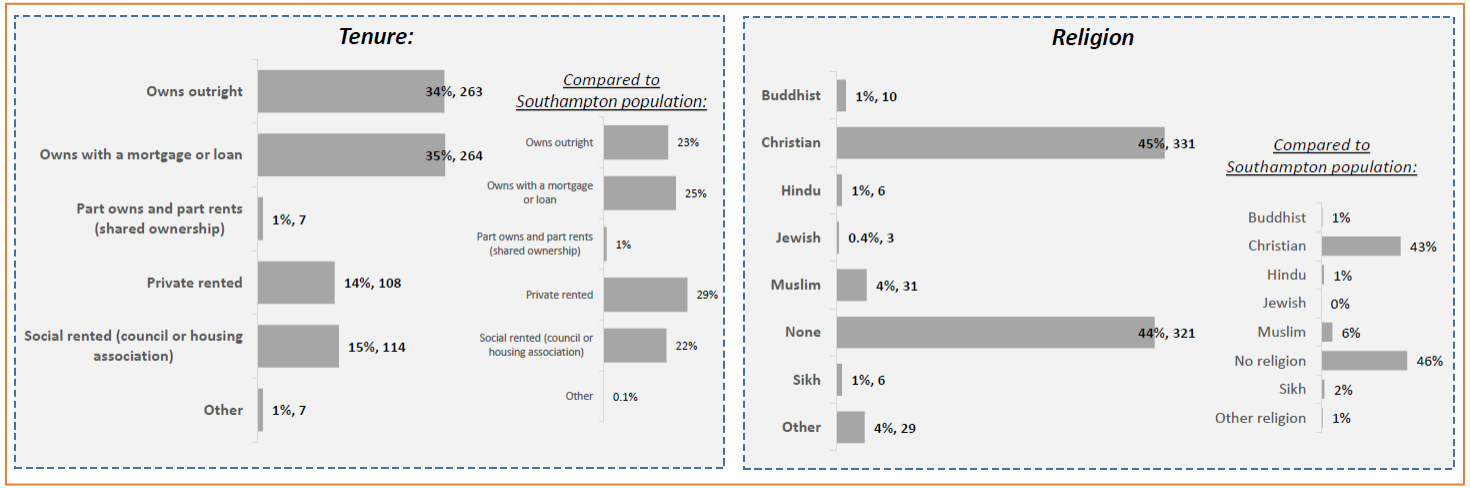
SCC designed and carried out a survey to explore the views and experiences residents have regarding routine childhood vaccinations offered to children under five years of age. Fieldwork took place between 13th June – 2nd July 2023.

- Total of **823 responses** through promotion across;
  - E-alerts, People's Panel, SCC website, Social media
  - Libraries, Family hubs, Tenant participation, Gateway
  - In-person events e.g. toddler groups
  - Shared with businesses and organisations
  - At local community groups and venues including food banks, community centres and parks

About the respondents

- **401 of the 823** respondents were a parent, guardian or carer of a child/children under the aged of 10, expecting a child/children or planning to have a child/children.
- **70%** of people who took part in the survey **were Female.**
- **76%** of respondents were **White British**. Responses collected from across other ethnic groups was **close to being representative of the general Southampton Population**.
- **15%** of responses were also collected from **parents with a disability.**
- **15% (114)** of respondents indicated they **reside in social rented housing** (council or housing association), **14% (108) in private rented** and **1% (7) Part own and part rents (shared ownership)**.
- **34% (263) own their housing outright** and **35% (264) own with a mortgage or loan**.





N.B: The survey was only available in English which may have been a barrier to some ethnic groups participating. Support was available in person with many of the surveys undertaken verbally and in some cases with the help of a translator.

Parent Survey - Key findings

Importance of vaccination

- The **importance of vaccination was high regardless of the age of the child.**
- **Feelings** around childhood immunisation are **generally high.**
- **92% said vaccinations are important** for children **under 12 months**
- **93% said vaccinations are important** for children aged **between 12-18 months and 18**

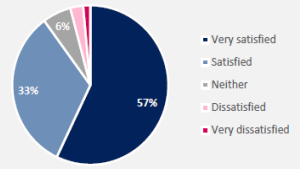
Important of child vaccines by age

Question: How important do you think routine childhood immunisations are for the following age groups?

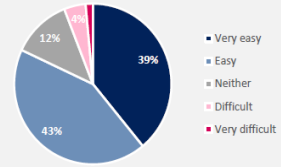
Overall:

3. Respondents have had good experiences when receiving vaccinations.

90% of respondents who had their children vaccinated said that they were **satisfied with their vaccine visits**.



82% of respondents found it **easy to book vaccinations** for their children.



Nationally, 84% of parents found it easy to get a convenient appointment.
Source: Childhood Vaccines Parental Attitudes Survey

Uptake

- **90% of our survey respondents** who have children under 10 said their children were **fully vaccinated.**
- **88%** of those who are planning or expecting a child said that they **plan to get them vaccinated**. This is similar to the average vaccination uptake across Southampton, which was 91% in 2021/22 *(source: CHIS COVER report)*

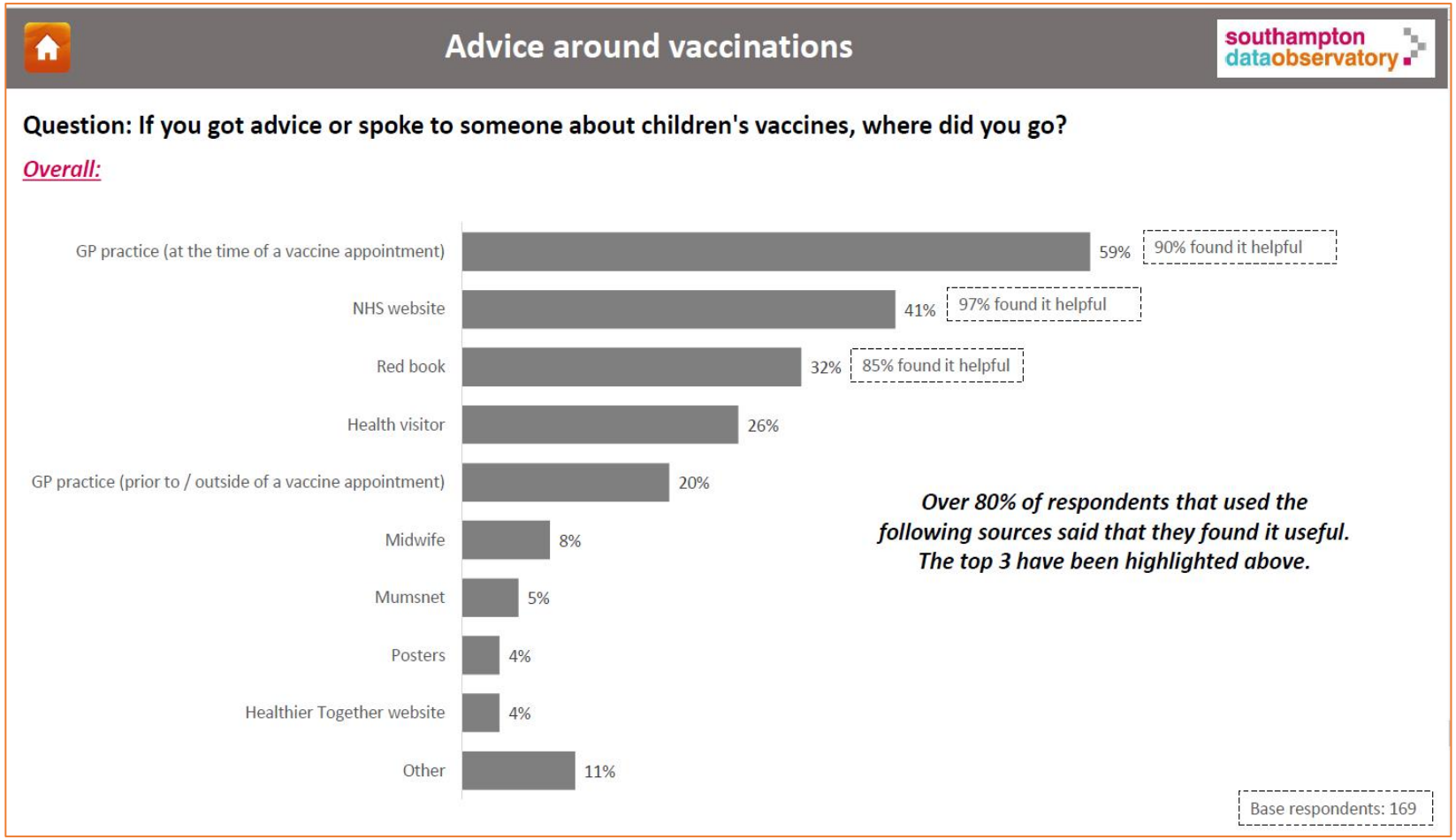
Parent Survey - Key findings

Advice

- Around half of respondents, **49%, got advice** about their children's vaccines.
- The most common place respondents went for advice was at **a GP practice and the NHS website**. The majority of people **found these sources helpful.** The most common reason for those who didn't get any advice was because they didn't feel they needed more information.

Experience of receiving vaccination

- **90% of respondents** who had their children vaccinated said that they were **satisfied with the vaccine visit.**



Parent Survey - Key findings

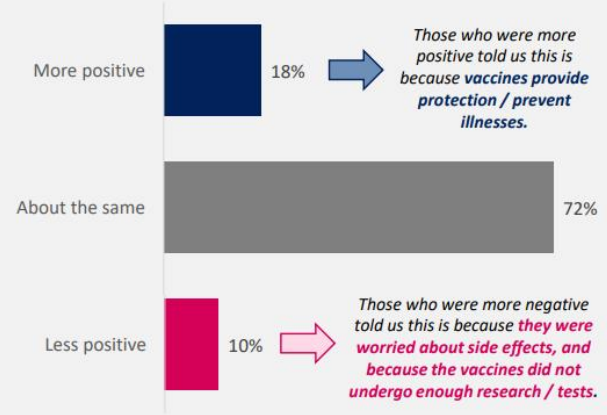
Enablers and barriers

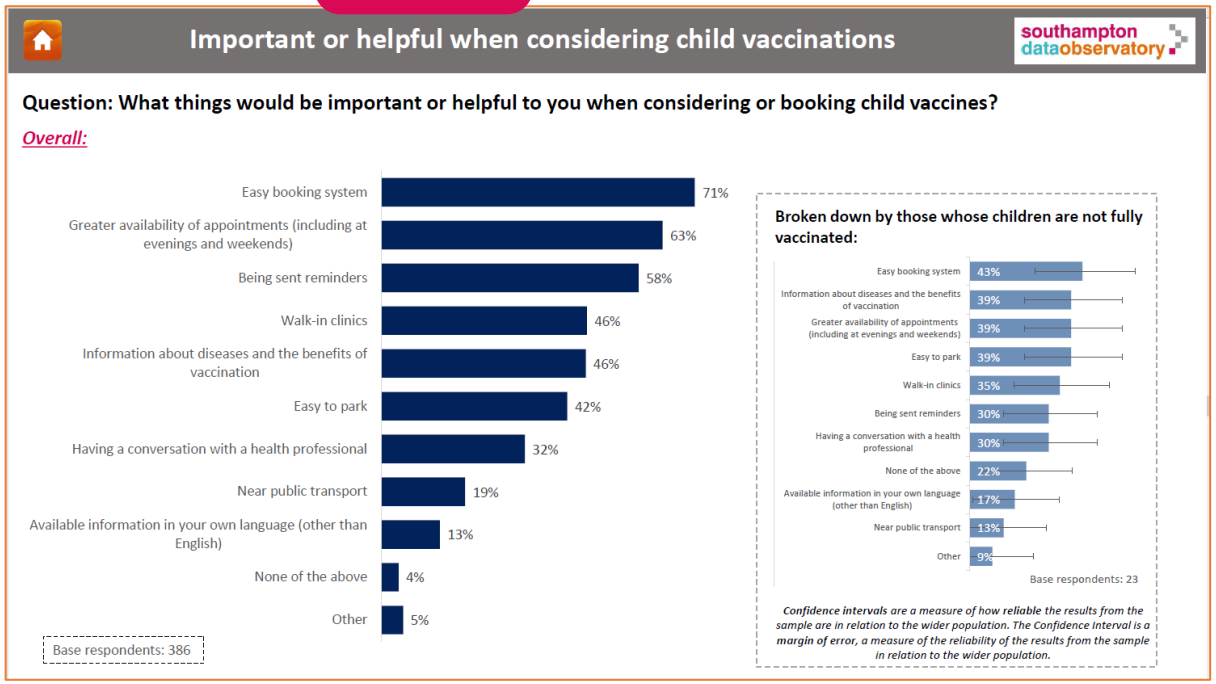
- The **single most important or helpful thing** people would look for when booking a vaccine in an **easy booking system, greater availability of appointments** and **being sent reminders**.
- The most common barrier that respondents had was **a bad experience in a GP surgery or vaccination centre (10%)**.

Feelings since the COVID pandemic

- Whilst the majority feel the same about childhood vaccinations following the COVID-19 pandemic, around **1 in 5 respondents** told us that their feelings are now **more positive**.
- Where respondents indicated their feelings about childhood immunisations are less positive since the COVID-19 pandemic, **concerns about side effects was the reason most given**.

Whilst the majority feel the same about childhood vaccinations following the COVID-19 pandemic, around **1 in 5** respondents told us that their feelings are now more positive.





Key recommendations:

- **Greater availability of appointments** required (evenings/weekends).
- All GP practices to consider **automatically sending an appointment with a date and** time and have dedicated email or telephone option for any queries or needs (including rescheduling).
- Ensure that parents are sent **information in their chosen language.**
- Offer **support for parents with children with additional needs** e.g. assistance keeping children calm at the time of appointment and/or longer appointment slots.
- Proactively provide greater **education and reassurance** regarding **side effects.**
- Directly **address myths** and **concerns.**
- **Promote** the **benefits.**

Parent Survey - Anecdotes

When carrying out surveys face to face, parents would sometimes continue the conversation and share further views in relation to childhood immunisations. It wasn't always possible to capture these comments within the survey template. Some of the comments that came up most frequently have been captured and summarised in quotes below. These provide further insights about parent's feelings and experiences of getting children immunised in Southampton.

Some parents told us about…

Vaccine hesitancy
Parents I know are anti-immunisation because of conspiracy theories or because they favour alternative medicine and 'organic' food.

Additional needs
It is stressful attending an appointment with an autistic child and having to restrain them. I need to know there will be support with this.

Ease of booking
It is so much easier when the GP just sends the appointment, but it can be very difficult to rearrange

Walk in clinics
I don't like walk in clinics because I am unsure how long I'll have to wait and whether my child will have a tantrum.

Walk in clinics are great.

Side effects
My child felt unwell after their vaccine, so they haven't had their boosters.

Language
My wife is unable to read letters and information that arrive in English

Appointment availability
Limited appointment options. I need weekends and/or evenings or walk in. Appointment time clashed with work, so I had to move to a different surgery.

Benefits
I was reluctant to vaccinate my children because I was worried about the side effects. A relative explained the benefits in my own language and I am now less anxious.

Specialist advice
I had a premature baby and the nurses seemed unsure as to what was best for a low weight (for age) baby, including dosing with Calpol.

COVID Vaccine
The COVID vaccine was developed far too rapidly, but this has not impacted how I feel about childhood immunisations. If anything, I feel it is more important.

MMR
I believe that this may have been a 'cover up'.

My child reacted after the first one, so I won't have the second.

Support
I worry about seeing my child distressed so I have asked Grandma to take them to the appointment.

Practice Insights

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CHISANA Workforce Survey

- SCC designed and carried out a GP practice survey to explore the views, experiences and approaches regarding the delivery of routine childhood vaccinations to under five years of age in Southampton. The survey took place between 13th June – 2nd July 2023. It was live for 3 weeks and was sent to all 25 GP Practices in Southampton offering childhood immunisations.

About the respondents

- Total of 23 responses from **25 GP Practices**.
- **56%** of respondents were **practice nurse or immunisation lead nurse**. **26% practice managers**. **9% GP** and **9% other.**

Key Findings - Strengths

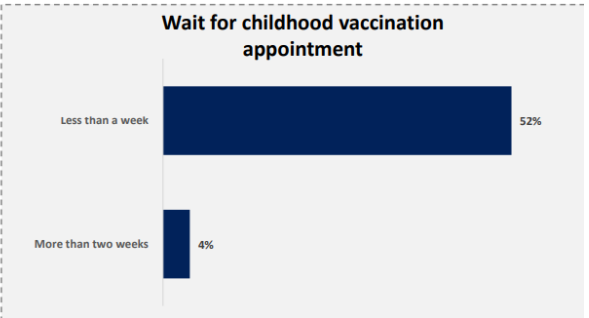
- **95%** of practices have a **dedicated immunisation lead**.
- **83%** are **using translation resources**.
- **91%** of GP Practices said their process is to **book appointments themselves**.
- **52%** say the **wait** for an appointment is **less than a week**.
- **83%** say they hold ***catch up clinics**
- **100%** say they **will vaccinate without red book.**
- **100%** say they have **completed accredited training**.

92% of GP practices said their process for parents / carers / guardians to book a child vaccine appointment was to contact them themselves. However, waiting for parents / carers / guardians to contact the practice scored just under at **83%**.

Contacting parents through **text messaging reminders** is the most popular DNA process **(96%).** This was also shown across the breakdowns.

Just over **half (52%)** state the wait for an appointment is **less than a week.**

Lower uptake (aged 1) **(80%)** and Medium uptake (aged 5) **(78%)** were the highest scoring for having to wait less than a week. However, they also scored the lowest for GP practice's contacting parents regarding appointments **(78%) & (89%).**

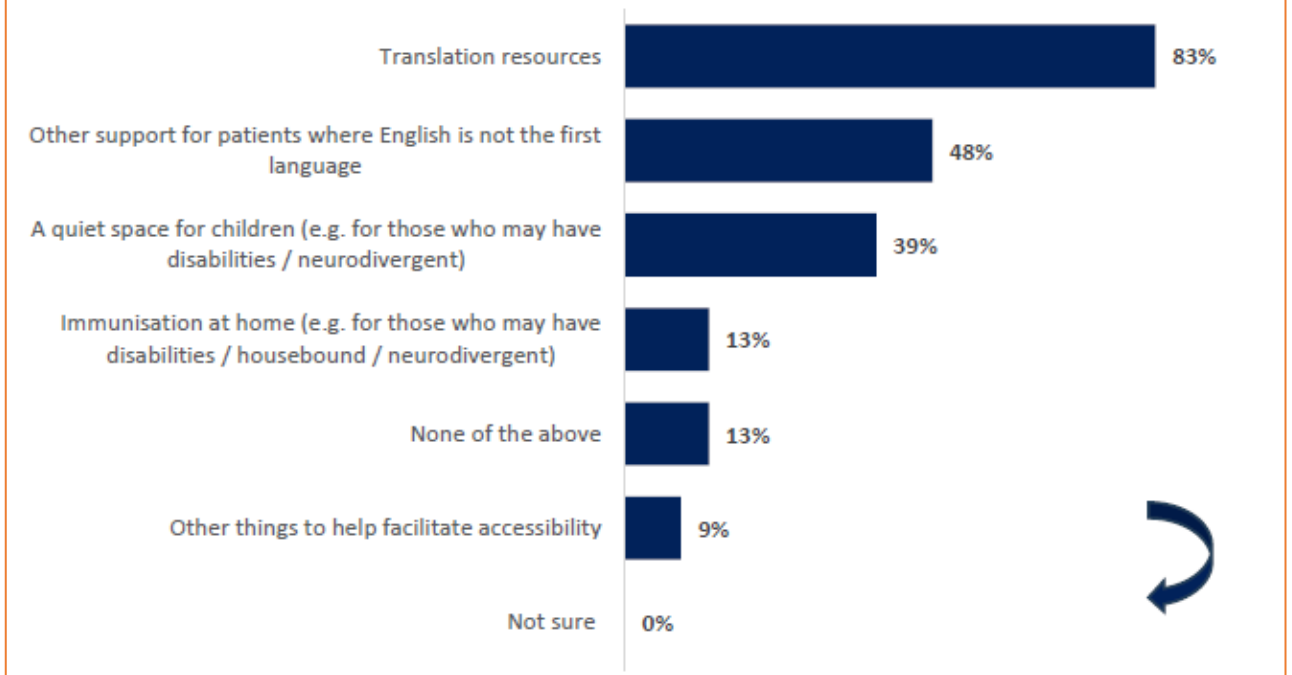


**the term 'catch up clinics' may be referred to differently in different practices/settings but usually refers to either a) a 'catch up' programe of work designed to 'catch-up' anyone who has missed doses of vaccinations, or b) where there are more children needing to be vaccinated that there are appointments available. Practices should offer flexibility, know how many children require vaccinating and be proactive in this approach.*

CHISANA Workforce Survey

Question: Does your practice provide any of the following facilities/support to improve accessibility for childhood immunisations?(please tick all that apply) *Multiple choice*

Overall:



- *"Language line if necessary"*
- *"One set clinic a week- Monday afternoons. Otherwise, children can be booked in anytime Mon-Fri between 8-6. I have had contact with parents of neurodivergent children and booked them in at the end of clinics and welcomed them straight into the clinic rooms, so they don't have to wait in loud waiting areas"*
- *"We can offer a pre-vaccination visit to 'meet the nurse' for anyone who might benefit from that. And a longer appointment slot for any children with disabilities."*

Key findings

- **83%** of responses said that have **translation resources** that provide support to improve accessibility.

Base respondents: 23

CHISANA Workforce Survey

Key Findings – Opportunities for Improvement

It is difficult to draw out any significant theme or pattern from the survey that explains the data but the surveys do highlight opportunities for improvement

Trained Immunisers

- **5 GP Practices (22%) who responded to our survey** have indicated they have **only 1 x trained immuniser.** Workforce continuity is a risk (business continuity, knowledge, capacity). 4 of these practices also indicated that their clinics are 'always full'.

Discussing vaccinations

- Only **43% have multi-disciplinary team (MDT) meeting** where vaccinations are discussed. Opportunity to strength this and working more closely with health visitors and midwives.

Working with health visitors/midwives

- Only **36% say** that they work with them on an **ad hoc basis**. **27% say** they work with them **monthly**.
- **5% said** they **do not work with them** at all.

Data Cleansing

- Accurate data and records and routine data cleansing could have significant improvements on practice data. **35% of practices** indicated they were **not sure how often they cleanse practice population register.**

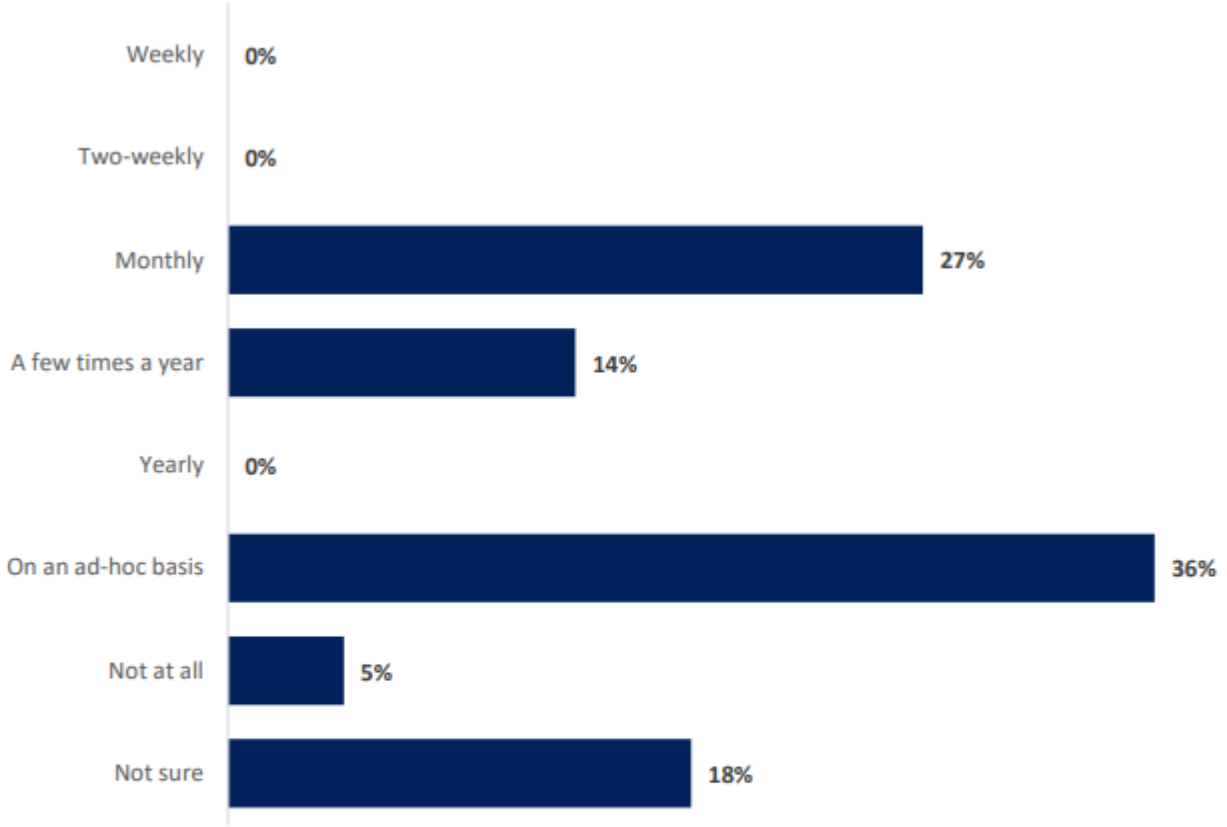
Initiatives

- **50%** of practices who responded say they **were not sure if they undertake any initiatives** for child immunisations.

CHISANA Workforce Survey

Question: How often do you/your practice do the following? Work with health visitors/midwives *Single choice*

Overall:



Key findings

- **36%** said that on an **ad-hoc basis** the practice works with a health visitor/midwife.
- **5%** of the practices said they **do not work at all** with health visitors/ midwives.

Base respondents: 23

CHISANA Workforce Survey

Key Findings – Opportunities for Improvement (continued)

Barriers and Enablers

Translation resources

- **83%** are **using translation resources**. This is encouraging but it is not clear from the survey how these are used. Further work required to understand at what stage these are provided and how actively they are promoted.

Barriers

- **'Don't believe in vaccination', 'Forgotten/not got around to it, 'Obtained/obtaining a vaccine outside of UK** and **'English not first language'** were the barriers most frequently selected by Practices in response to 'select any elements you or your colleagues have experienced as barriers to getting their children vaccinated'. This contrast with the parent survey which highlighted appointment availability, having a conversation with a health care provider and being sent reminders.

Initiatives

- **52% were not sure** if their practices are offering any initiatives.
- **30% said no** they aren't running any initiatives and **17% indicated 'yes'** they are running initiatives. This would indicate scope for more initiatives at practice level.

Bad experience

- There were very few examples provided in relation to 'bad experience'.

CHISANA Workforce Survey

Question: What hours are child immunisation clinics held or offered at your practice? (please tick all that apply) *Multiple choice*

Clinics are being held/offered mainly during **weekdays between 8am – 6:30pm (87%).** While no clinics are being held during **evenings (after 6:30pm)** on both weekdays and weekends.

While **11%** of Lower uptake (aged 1) and **11%** Medium uptake (aged 5) had clinics **rarely full.**

CHISANA Workforce Survey

Booking process

DNA Process

- **96% send text messages**. Evidence suggests that having a conversation with a health care provider can be vital where parents are hesitant or have concerns. **Exploring a more personalised approach** e.g. phone call, may help address this.

Operational hours

Appointment availability/operational hours

- GP practices are split on the time spent holding child immunisation clinics per week, with **both 2-4 hours** and **more than 8 hours** receiving **35%.**
- **8 x GP practices** indicated that they are **not offering more than 4 hours** of childhood immunisation clinics a week.
- **13 x GP Practices** are **not offering** childhood immunisations **opportunistically.**

Appointment time

- The survey indicates that on average **10 minutes is available per immunisations** carried out. Longer appointment slots should be available to allow time to discuss benefits and answer any questions, particularly where there may be language barriers.
- Longer slots should also be made available for larger families so multiple vaccinations can be given at one appointment.

Catch up Clinics

- 17% are not offering catch up clinics despite the data indicating that immunisation tales off at children get older and may benefit from opportunities to get up to date.

Key recommendations:

- Longer appointments for parents with children with additional needs.
- Was not Brough (WNB) and Did Not Attend (DNA) DNA Processes and ensure this is personalised.
- Ensure translation resources are being use prior to appointment
- Catch up clinics to be offered as standard by all GP Practices.
- Longer appointment slots should be available to allow time to discuss benefits and answer any questions.
- Strengthen work with health visitors/midwives to ensure routine collaboration.
- PCN wide collaboration – only 13% are looking to share staff within the PCN. Explore scope for greater collaboration within PCNs.
- New initiatives above and beyond standard practice should be routinely offered.

Previous Studies and Guidance

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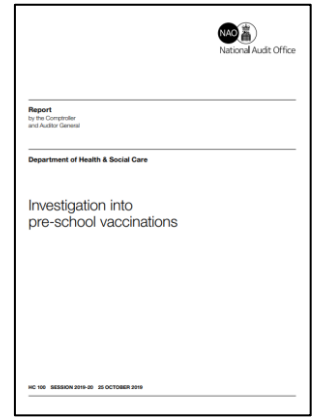
Investigation into pre-school vaccines NAO (2019)


National Audit Office

Report
by the Comptroller and Auditor General

Department of Health & Social Care

Investigation into pre-school vaccinations

HC 100 SESSION 2019–20 25 OCTOBER 2019

Key findings/themes:

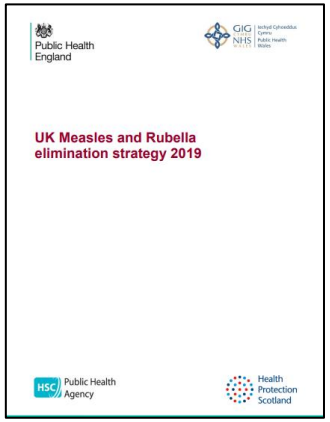
- **No single issue** but a range of **factors that operate together** are causing a decline.
- **Inconsistencies** in how healthcare **professional remind (call/recall) parents** to vaccinate their children.
- Parents can find it difficult to access vaccination services citing **timing and childcare as barriers**. Some under-served communities do not access healthcare in expected ways e.g. traveller communities or religious groups.
- **Limited evidence of any major impact** on vaccination uptake **from anti-vaccination messages**. *This is backed up by our own survey and the National UKHSA parent attitudes survey.*
- A **small minority of parents** are reluctant because of **concerns about vaccination** (complacency, inconvenience or lack of confidence).
- NHS England and PHE (UKHSA) do not know the relative impact of the possible causes on the declining uptake of vaccination. **Unable to indicate the extent to which each factor impacts on uptake nationally**.
- NHS England and PHE monitor regional variations at a high level.
- NHSE and PHE **do not use a consistent approach to engage with under-served groups**.
- PHE, NHSE and the Department of Health and Social Care are **developing a joint communications strategy to promote positive messages** and **overcome vaccine hesitancy**.

Source: Investigation into pre-school vaccinations (nao.org.uk)

> *NHSE considers that there is a **link between deprivation and uptake of MMR**. Whilst higher deprivation can be associated with lower vaccination uptake, **there is also in its view, some evidence of wider dissemination of anti-vaccination messages and vaccine hesitancy amongst higher income groups.** However, the data, when analysed by areas of deprivation indicate the **uptake of MMR is lower in the most deprived local authorities.***
> (p28)

> *In 2018, a small-scale review of GP practices in England by PHE and the London School of Hygiene and Tropical Medicine showed **no GP practices** (out of nine) **had services to increase uptake in groups who had low vaccination uptake or to identify vulnerable or 'under-served' populations.** In its action plan, NHS England requested that regional teams share examples of local responses to measles outbreaks in under-served communities.*
> *(p35).*

UK measles and rubella elimination strategy (2019)



Key findings/themes:

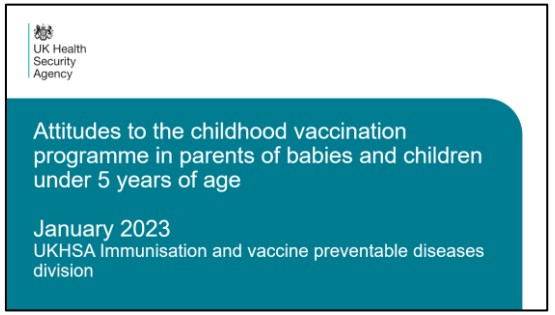
- UK achieved elimination status in 2016 but lost status in 2018.
- **Young people born between 1998/99 and 2003/04** (aged 15 to 20 years in 2018) are **most susceptible**. ('Wakefield Cohort' now aged 19-25.
- **London remains the most vulnerable region** with immunity targets not achieved for many birth cohorts - including younger children of primary and secondary school age.
- There are **inequalities in vaccine uptake** by ethnicity, deprivation and geography and the burden of measles and rubella falls disproportionately on certain communities.
- **Measles and rubella remain endemic in many other countries** and, with current large measles outbreaks across Europe**, imported infections pose a very real threat** to the UK's recent achievements.
- **Prior** to **Measles vaccine there were 100 deaths** from acute measles in the **UK each year.**
- **Rubella infection in pregnancy** caused a **significant burden** in terms of **terminations and babies born with Congenital Rubella Syndrome**

Source: UK Measles and Rubella elimination strategy 2019 (publishing.service.gov.uk)

Four key components to strategy:

1. Achieve and sustain **≥ 95% coverage with two doses of MMR vaccine** in the routine childhood programme (**<5 years old**).
2. Achieve **≥ 95% coverage with two doses of MMR vaccine in older age cohorts** through **opportunistic and targeted catch-up** (>5 years old).
3. **Strengthen measles and rubella surveillance** through rigorous case investigation and testing **≥80% of all suspected cases with an Oral Fluid Test (OFT)**
4. Ensure **easy access to high-quality, evidence-based information** for health professionals and the public.

National vaccine attitude parents (under 5s), 2022



An email was sent on 2nd September 2022 to parents registered with Bounty (a commercial parental marketing organisation) of behalf of UKHSA.

- 328,542 email addresses.
- A total of 1485 surveys were completed.
- People living in London were under-represented and the Southeast were over-represented.
- Older mothers were over-represented and younger mothers were under-represented
- White British parents were over-represented and non-white parents were under-represented (based on ethnicity of live births, 2007 to 2019)

Key Findings:

- **95%** of parents **think vaccines work**, **91%** of parents **think vaccines are safe** and **90% trust vaccines.**
- **71%** of parents remember **recently coming across information** about vaccines for babies or young children.
- **74% o**f parents came across information that **made them feel vaccination was important** for their baby or child.
- Only **15%** of parents read, heard or saw **something that made them concerned or worried** about their baby or child having their vaccines. **This most often came from friends or family, social media, the internet (Netmums or Mumsnet), TV or magazines or radio.** This was most often about 1) Coronavirus vaccine 2) MMR vaccine 3) DTaP-IPV-Hib-HepB vaccine.
- **Meningitis and septicaemia** were considered very serious by **95%** of parents.
- Parents reported that the **most common sources** of vaccine information came from the **red book/Personal Child Health Record (52%), health visitor of midwife (49%), other healthcare professional (40%) the NHS website (31%), NHS leaflet (25%).**
- **90%** of parents **thought that measles, rubella, mumps, polio, pneumonia and hepatitis could be serious** or very serious.
- COVID-19, flu and rotavirus were least likely to be considered serious.
- **92%** of parents were **happy with vaccine safety.**
- **95%** of parents felt that their baby **would have all vaccines offered before any discussion** with a health professional.
- **36%** of parents **felt more confident** about vaccinating their baby **after receiving information from a health professional**.
- **42%** of parents who **were undecided** about whether to get their baby vaccinated **felt more confident after speaking to a health professional.**
- **90%** of parents agreed they **like to have their child vaccinated at their GP practice.**
- **98%** of parents agreed that they **like to be reminded about upcoming appointments.**

Source: Childhood vaccines: parental attitudes survey 2022 findings - GOV.UK (www.gov.uk)

Moving The Needle: Promoting vaccination uptake across the life course (2019)

Royal Society for Public Health (RSPH)

In 2018, RSPH carried out an investigation into attitudes to and awareness of vaccinations with regards to childhood, adolescent, working age adulthood and older age. This included a literature review or relevant articles, and three public surveys (adults, parents and workforce).

Key findings/themes:

Access:

- **Timing, availability** and **location identified as barriers** although the vast majority who chose not to vaccinate did not cite inconvenience as a key factor.
- **Improving access** to vaccination remains **crucial** especially when tackling inequalities.

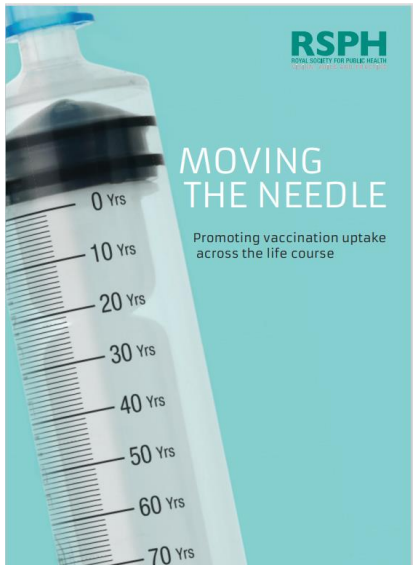
Attitudes:

- Attitudes are largely positive. **91% agreed vaccines are important for their children's health.**
- **Fear of side effects** of vaccines was consistently found to be the primary reason for choosing not to vaccinate (except for the childhood flu vaccine, for which it was the second most common reason).
- **Lack of confidence in the effectiveness** was the number one reason for choosing not vaccinate against flu.
- **Fairly low understanding of herd protection** and the **myth of vaccine overload remains persistent** with just over a quarter (28%) of people believing you can have too many vaccinations'

Influences:

- **Trust** in healthcare professionals **remains very high.**
- **Social media** was identified as **propagating negative messages** around vaccination.
- **Traditional media** continues to be **influential** particularly seen in the ongoing ramifications of the Wakefield scandal.

Source: RSPH | Moving the Needle: Promoting vaccination uptake across the life course



Calls to action

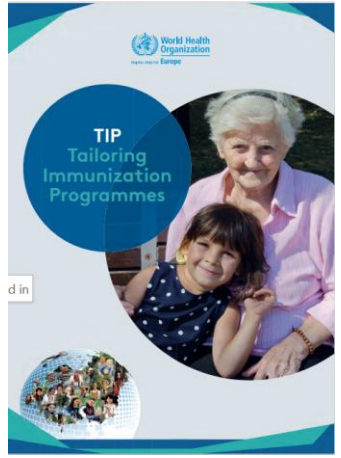
- **Tackling negative misconceptions of vaccines**
  - Efforts to limit health misinformation online and via social media should be increased, especially by social media platforms themselves.
  - Responsibility of the press to share factual information about vaccines should be enforced by considering health impact when the IPSO Editor's Code is broken.
  - Education on vaccines in schools should be increased and improved, especially in the PSHE curriculum.
- **Improving access to vaccinations**
  - Vaccinations should be offered in a more diverse range of locations, including high street pop-ups, utilising the wider public health workforce.
  - Health professionals to use the Making Every Contact Count (MECC) approach to ensure vaccine advice is delivered across the health system.
  - Reminder services to be improved by using innovative methods such as social media pop-ups.

'Tailoring Immunisation Programmes' (TIP) approach, 2019

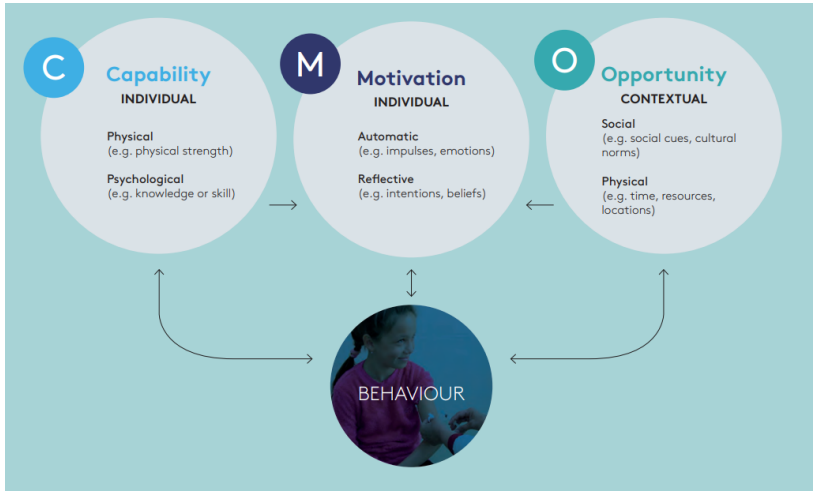
The WHO Regional Office for Europe developed the Guide to tailoring immunisation programmes (TIP), offering countries a process through which to diagnose barriers and motivators to vaccination in susceptible low vaccination coverage and design tailored interventions. The approach aims to integrate people centred research and behavioural insights.

Key findings/themes:

- A TIP approach aims for **high quality** and **equitable vaccination uptake**. This means achieving the same level of vaccination uptake across population groups, regardless of factors such as income, education, geography, ethnicity or integration in society.
- Equitable vaccination uptake can be achieving through **considering** and **addressing differences** and inequalities by ensuring **vaccination services are tailored to meet the needs of patients**. **It does not mean treating all people the same.**
- Assuming that knowledge alone will lead to behaviour change to make the 'right' decision ignores other **important influences on behaviour**.
- Psychological science has shown that **facilitating the vaccination behaviours directly** e.g. changing the encounter with the health worker, can have a great impact than trying to change how people think and feel about vaccination.
- **System factors** such as policies, health service provision, cost and logistics are important for vaccination behaviour.
- **Other context factors** such as **cultural, community, social support, norms** and **identity, including religious, education** or **philosophical one's** shape vaccination attitudes and behaviours.
- TIP processes also contribute to strengthening **health literacy. People need to be supported to access services** as well as with **clear, appropriate, accessible information.**
- **The TIP approach suggests a phased approach** and **provides a framework** and **exercises to design an intervention** to address research findings using a logical approach. *Source: 9789289054492-eng.pdf (who.int)*



> "Social and behavioral insights studies and engagement of stakeholders can help in first understanding the problems and then designing immunization programme solutions tailored to the local barriers to vaccination." P6



The COM-B model was originally developed for any behaviour in any setting and TIP adapt it for vaccination behaviours. Barriers and enablers are linked to associated COM-B factors and mapped to appropriate intervention types for target groups.

HIOW MMR data and knowledge, (2020)

Workshop and study carried out in HIOW in 2020 but interrupted by COVID pandemic. Particular focus on Eastern European community.

Key findings/themes:

- **Importance of data quality** and **accuracy** including:
  - *Accurate coding and recording*
  - *Patient movement and deregistration/cleansing*
  - *Practice mergers affecting process alignment and activity.*
  - *Issues with MMR1 being given too early due to recall system.*
- Practice processes for **call/recall** of those under-immunised
- **Language/knowledge/understanding of parents**, **Health Care Providers** and **community.**
- **Health Care Providers** are the **most trusted source** therefore contact with services is important.
- Main languages spoken in schools: **Polish, Panjabi, Urdu, Pashto/Pashto, Bengali, Romania**

What Works?

- **Actively engaging** and working alongside the target audience.
- Access to services and **practical help** to book and attend appointments.
- **Information tailored** at different communities
- **Personal reminders** and GP endorsement.
- **Use of pharmacies, retail outlets** and **local community venues.**

Southampton

Language	Number of pupils	Percent
English*	23,392	72.2
Polish	2,677	8.3
Panjabi	645	2.0
Urdu	494	1.5
Pashto/Pakhto	383	1.2
Bengali	351	1.1
Romanian	321	1.0
Dari Persian	270	0.8
Farsi/Persian (Any Other)	258	0.8
Arabic	254	0.8
Portuguese	223	0.7
Malayalam	213	0.7
Russian	195	0.6
Somali	149	0.5
Spanish	139	0.4
Chinese	107	0.3
Persian/Farsi	107	0.3
Italian	101	0.3
Kurdish	99	0.3
Lithuanian	95	0.3
Bulgarian	88	0.3
French	87	0.3
Hindi	87	0.3
Latvian	80	0.2
Hungarian	79	0.2
Filipino	71	0.2

Languages spoken in schools 2020

Specific barriers for EE women

NHS

- Low healthcare self-efficacy and lack of trust
  - Understanding of entitlements to healthcare
  - Language barriers / health literacy

"The GP I have here is good but… I don't really trust, I don't know… There's something in me, I just know that in Poland they will do all the tests.. Maybe because its in Polish, but I speak English fluently"

- Low perception of risk of disease
- Practical barriers: childcare, time off work
- Roma travellers: mobility, literacy, trust

What does the EE population look like in Southampton?

NHS

- Polish:
  - 6% (15,000 people)
  - Second most common nationality (6%) after British (82%)
- Romanian: 1%; 3,000 people
- Slovakian: 0.4%; 1000 people

HIOW MMR data and knowledge, (2020)

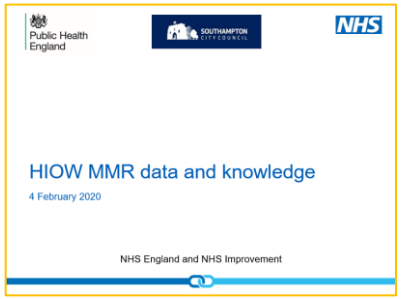
Lessons from good practice in England

- **Combination of interventions** work best.
- **Tailor services to specific needs** of target group.
- **Provide outreach** support to engage, support and inform.
- **Support primary care** to engage under-represented populations.
- Use **community specific communication channels.**

Tailoring Immunisation Programmes
Charedi community, north London
Implementation of the WHO's Tailoring Immunisation Programmes (TIP)

Summary:

- No HIOW area achieving 95% uptake
- Some variation between GP practices – absolute numbers by practice small
- Potential for different health beliefs, cultural difference and language barriers.
- Broad ethnicity high % white other, high %not recorded.
- Lower uptake in most deprived areas of city.
- Families supported by both universal and intensive health visiting provision.
- Need for local system approach to improve MMR uptake.



Who isn't attending for MMR1 and MMR2 - snapshot

NHS

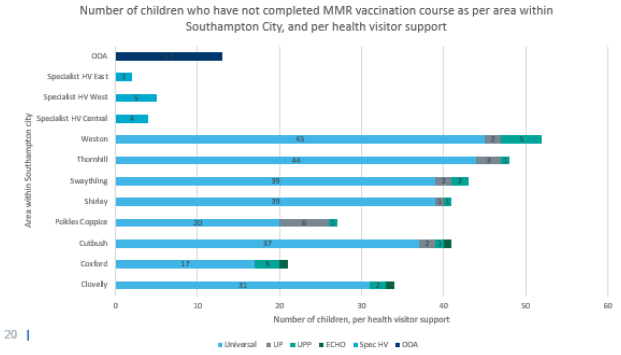
- Birth cohort born in a 6 month consecutive period in 2015/16 registered at GP practices in Southampton, due to start school Sept 20
- 331 children in cohort, 52% male. 23 – parents refused vaccination

Ethnicity
- White British 36% (120/331), White other 29%
- Asian 8%
- Black 4%
- Other 3%
- Not recorded 21%

19

Who isn't attending for MMR by locality and health visiting provision

NHS



20

Sector Lead Improvement (SLI) (ADPH) 2022

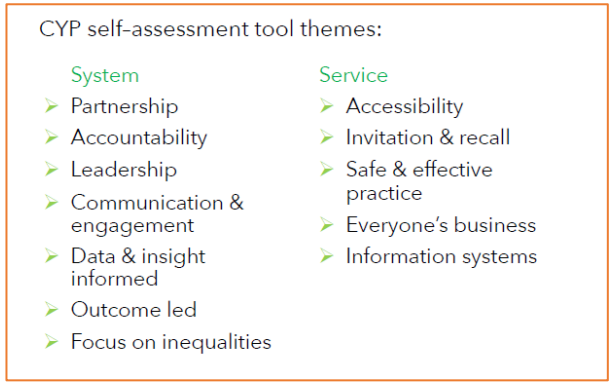
In August 2022 as part of the Southeast Sector Lead Improvement (SLI) programme, a sector led immunisations and vaccination project was funded by the NHSE Covid Vaccination Programme (Demand Team) for the Association of Directors of Public Health Southeast (ADPH SE). ADPH SE commissioned Population Health Ltd to work with the SE DPH and their teams, **bringing all the Covid vaccine inequalities work together in a learning event and good practice report to support the Covid vaccine uptake rate as part of Sector Led Improvement**.
This piece of work was time limited and undertook a baseline assessment of immunisations & vaccination systems & services across the ADPH SE area in November 2022. The scope of this project was initially focused on COVID but was widened to encompass routine immunisations (child and adult) and season immunisations (influenza and Covid). A summary of the findings from the learning event held November 2022 are provided below.

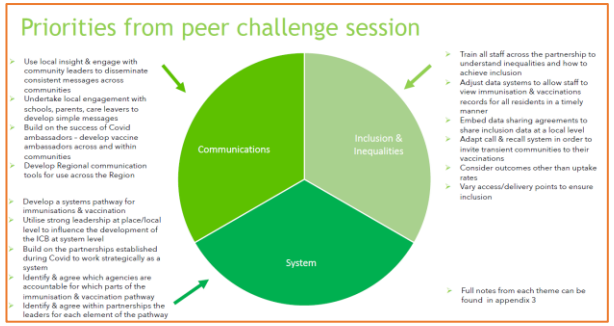
Key findings/themes:

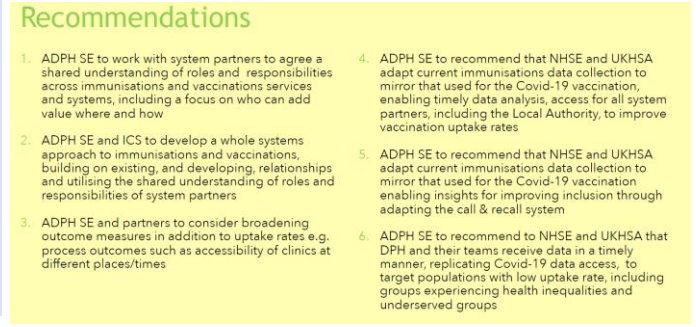
- The key messages taken away from the event were the **need to collaborate with colleagues** and work in partnership at ICB level and to have **Regional collaboration for proactive communications**.
- **Three priority areas were identified during the challenge session. These related to**
  1) **Communication**
  2) **Inclusion and inequalities**
  3) **System**

Conclusions: The project highlighted excellent partnership work being undertaken to commission and delivery immunisation

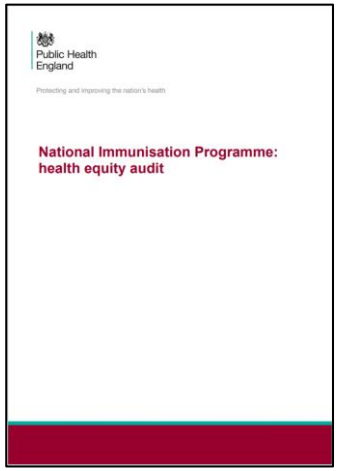
- **Delivery of immunisations is complex** requiring an **understanding** of **roles and responsibilities** of all partners and an **ongoing commitment.**
- Insights must be utilised to **understand and address vaccine hesitancy** for routine vaccinations.
- **Timely** and appropriate **data is urgent.**
- Learning from Covid – 19 should be harnessed, in particular the **'can-do' attitude** to vaccinate at speed through accessible services with the **support of community leaders.**
- **Findings** from report to be used as baseline and **as a resource for DPH** and their teams to **inform strategic approach.**







National immunisation programme: health equity audit (2021)



The audit aimed to describe how the national immunisation programme identifies and addresses inequalities; describe the areas and extent of inequalities in vaccine coverage; identify evidence gaps for areas where inequalities have not yet been adequately estimated; identify how inequalities in vaccination uptake may arise, to inform a framework for action.

Key findings/themes:

- Equality in immunisation is an important way to address health inequalities. Ensuring coverage is not only high overall, but also within underserved communities is also **essential for disease control and elimination strategies.**
- "The Immunisation Programme has achieved high coverage overall in the population. However, we have demonstrated that **avoidable inequalities in vaccination still exist** within some population groups.
- **Inequalities** in immunisation for a given population group can be **complex** to describe and **may vary** between areas.
- **Community, institutional**, and **policy factors**, as well as the **health beliefs** and **knowledge** of individuals and within families **may lead to inequalities** in vaccination.
- There are **limitations in terms of available data** and **evidence to describe and monitor the situation,** and to **explain why inequalities** may have occurred.

Recommendations (in brief):

1. Develop **a national vaccinations inequality strategy**, and **provide a template local action plan to enable best practice**;
2. **Share new practice** and **evaluation findings between stakeholders** to develop the evidence base;
3. Develop **locally relevant data** and **intelligence** resources to support needs assessment;
4. Use existing data sources to develop a routine report to **monitor inequalities** in routine vaccination coverage for key indicators, at national and regional level;
5. Continue **national level leadership** and support **to address inequalities."**

Source: National Immunisation Programme: health equity audit (publishing.service.gov.uk)

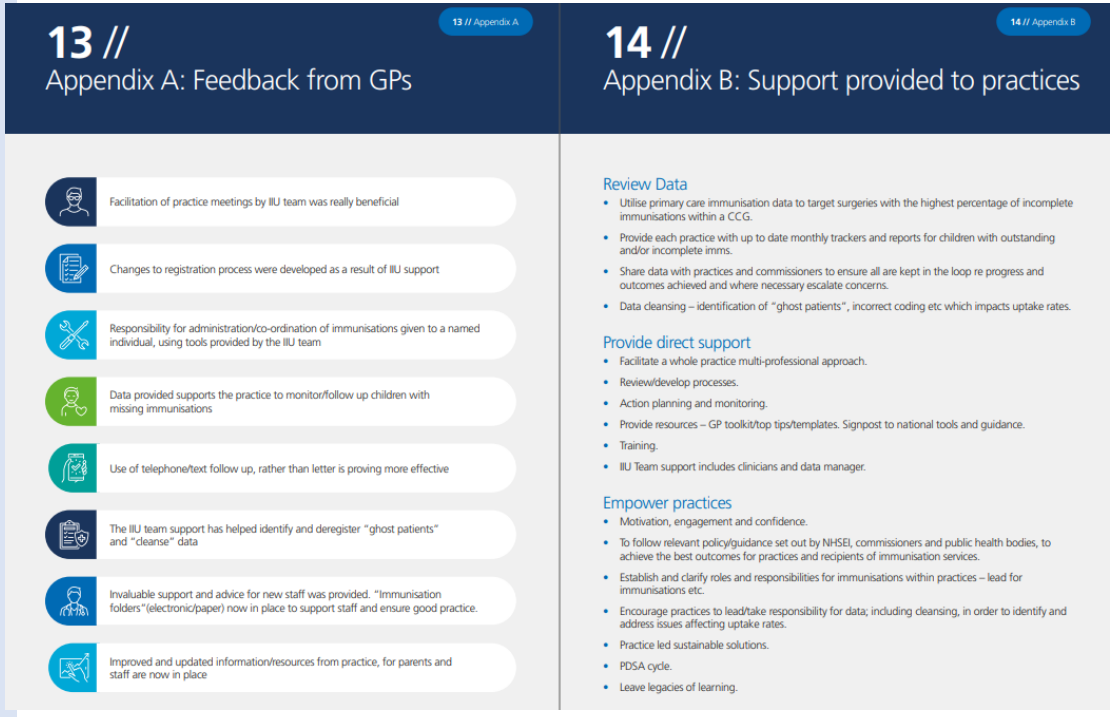
> *In the least deprived decile coverage decreased for 3/9 indicators and increased in 5/9, whereas in the most deprived decile coverage decreased for 8/9 indicators and falls were greater than the national average. Thus, **though falls in coverage were seen nationally across most programmes, they were larger in the most deprived compared to the average**, whilst coverage was more likely to have increased in the least deprived (except for HPV), widening inequalities compared to 2016 to 2017. Further analysis is required to place these findings in the context of longer-term trends in coverage for more and less deprived populations.* (p20)

Improving immunisation uptake (IIU)

The IIU initiative was developed as a result of a health inequalities pilot project that took place in 2017. The initial project clearly demonstrated that **health inequalities could be reduced** with the **nurse leading the project worked closely with the Child Health Information Service (CHIS).** A further one-year pilot was commissioned by NHSEI and the Improving Immunisation Uptake (IIU) Team was established with the objectives of reducing variation in immunisation uptake across the Thames Valley, through the utilisation of CHIS data and direct collaboration with colleagues in primary care, predominantly General Practice. The model chosen provided the opportunity for **dedicated clinical input**, **cleansed CHIS data** and **"hands on" direct practical support** to be deployed by the team **to GP's**. This approach ensure **targeted support was provided**, which not only improved immunisation uptake rates in the short term but also empowered GP's to develop their own whole practice approach to achieve long term and sustainable high vaccination uptake rates.

Key findings/themes:

- Ongoing **facilitation of change crucial**.
- Immunisation **processes weren't reviewed regularly** or in place.
- Many practices has **no clinic or admin lead**. Where immunisation leads were in place **roles/responsibilities** were often **undefined** and/or agreed.
- A **whole practice approach** often **wasn't in place** with **little collaborative** working **between clinical and admin** staff (often first point of contact for queries) and **no clear escalation plan** for common issues.
- **Availability** and **flexibility of immunisation appointments** was a common challenge identified by both staff and parents. This affected timeliness of immunisation and also contributed to Did Not Attends (DNA's).
- Many practice Nurses (and some Practice Managers) were **unaware of their immunisation uptake rates** and how robust processes (such as new registrations), could help improve these.
- Many **practices did not understand the role of CHIS** and their processes/data requests.
- **Data quality was a major ongoing issue** for practices with "ghost patients" common place on missing immunisation reports with **no process to identify these** and **deregister where appropriate**.
- **Sharing good practice** across GP's helped individual surgeries recognise where they could make improvements and the benefits that could be realised as a result.



Reducing difference in the uptake of immunisations (NICE Guidance)

The NICE guidelines set out recommendations for local commissioners and providers of healthcare that should be taken into account alongside individual needs, preferences and values of their patients or the people using their services.

Key findings/themes:

Recommendations are set out in relation to the following areas;

- Named vaccination leads.
- Designing and raising awareness of payment schemes.
- Making vaccination services accessible and tailoring to local needs.
- Audit and feedback.
- Training and education for health and social care practitioners.
- Appointments and consultations.
- Using compatible systems and processes.
- Keeping records up to date.
- Identifying people eligible for vaccination and opportunistic vaccination.
- Recording vaccination offers and administration.
- System organisation and accessibility issues.
- Initial invitations.
- Reminders and escalation of contact.
- People who are not registered with a GP practice.
- Vaccinations for school-aged children and young people.

Box 1 Some key barriers to routine vaccine uptake

- Inflexible and inconvenient clinic times and locations
- Perceived lack of balanced information (including misinformation)
- Language and literacy problems
- Insufficient time in consultations to discuss concerns about vaccinations
- Lack of staff training in how to discuss vaccinations effectively
- Uncertainty about vaccine safety and effectiveness
- Uncertainty about whether vaccines are needed (including how severe the diseases are or how likely it is that someone will be exposed to the disease)
- Previous negative experiences of vaccination
- Lack of trust in the government, drug companies and the healthcare system
- Religious or cultural views that are against vaccination (this may relate to specific vaccinations, for example HPV [human papillomavirus])
- Individual barriers such as needle phobia or sensory impairment.

Box 2 Some population groups that are known to have low vaccine uptake or be at risk of low uptake

- People from some minority ethnic family backgrounds
- People from Gypsy, Roma and Traveller communities
- People with physical or learning disabilities
- People from some religious communities (for example, Orthodox Jewish)
- New migrants and asylum seekers
- Looked-after children and young people
- Children of young or lone parents
- Children from large families
- People who live in an area of high deprivation
- Babies or children who are hospitalised or have a chronic illness, and their siblings
- People not registered with a GP*
- People from non-English-speaking families*
- People who are homeless*

Communities with low uptake other than those listed above may also be identified specifically in your local area.

Sources: UK Health Security Agency (previously Public Health England) Health Equity Audit of the National Immunisation Programme, apart from those marked with an asterisk, which were raised by the committee.

Source: Vaccine uptake in the general population (nice.org.uk) Replaces 'Immunisations: reducing differences in uptake in under 19s, 2009'.

Pandemic Factors

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Literature review

A literature review was carried out to understand the impact of the pandemic on routine childhood vaccination uptake.

Context

- Globally, the COVID-19 pandemic has had a significant impact on childhood immunisation uptake worldwide. With **increased strain on healthcare systems**, **lockdowns**, and the **suspension of routine vaccination services**, **many children missed out on timely vaccinations**.
- According to the World Health Organization (WHO), **around 80 million children under the age of one** are **at risk of diseases** like diphtheria, measles, and polio because routine immunisation services have been disrupted due to COVID-19.
- The pandemic has also affected vaccine supply chains and caused delays in vaccine shipments, leading to shortages in some cases. Additionally, **caregivers may have been hesitant to take their children to healthcare facilities due to fear of exposure to COVID-19**, leading to a decrease in immunisation uptake.
- Global decline in childhood immunisation uptake during the COVID pandemic. This combined with increased migration increases the risk of outbreaks in the UK.

Approach

- 26 studies were included within the review.
- 21 of 26 eligible studies sighted decreased vaccination rates in children during the COVID-19 pandemic.
- 3 x studies sighted increased uptake or no significant changes, only in influenza vaccination.
- 2 x remaining studies (Brazil and Sweden) showed no significant change in vaccination rates during the pandemic.

Key findings: Summary of 'Pandemic Factors'

1) Parental hesitation
- Reduction in 'well child' visits reported in almost all studies reporting decreased immunisations.
- Fears of COVID infection outweighing importance of routine immunisations in the UK.
- Fear of overburdening the NHS during and post pandemic.

2) Social distancing policies and lockdown
- Disruption to usual services
- Disruption to transportation and accessibility
- Health services closed or reduced.

3) Severe shortages of healthcare providers
- Disruptions in supply chain due to border closures and travel restrictions contributed to disruption to immunisation program in many countries
- Redistribution of health work and budget diverted to COVID-19
- Staff shortages due to COVID isolation policies

4) Absence of clear guidelines and recommendations for non-COVID-19 issues
- Ineffective communication between healthcare staff and policy makers (reported in Pakistan, Bangladesh and Nigeria)
- Shortages of PPE for health workers made staff reluctant to engage with patients in primary care.

5) Reprioritisation and changes to how services are delivered
- Move from in person visits and consultation to virtual visits.

Vaccination **did however increase in demand** in some countries
- Switzerland post pandemic survey parents expressed enthusiasm for influenza vaccination for children (more than double previous year).
- Similar behaviour observed in China (80% declared willingness for influenza vaccine)
- The global issue of COVID-19 seems to change public behaviour towards influenza vaccination overwhelmed by COVID-19 the most.

Literature Review - Key recommendations:

Delivery of a strong childhood immunisation programme requires a multi-faceted approach that involves several steps, including:

1. Education and awareness:

Education should be provided to parents, caregivers, and healthcare professionals on the importance of childhood immunisations. This could be in the form of educational campaigns, brochures, social media campaigns, and community outreach programs.

2. Vaccine availability and accessibility:

Vaccines should be readily available and accessible to all children, regardless of their socioeconomic status or geographic location. This can be achieved through school-based vaccination programmes, community clinics, and mobile vaccination clinics.

3. Monitoring of immunisation rates:

Routine monitoring of immunisation rates will ensure that all children receive scheduled vaccines. Medical professionals and government organisations should implement programmes that track vaccination rates and identify areas that require improvement.

4. Promotion of vaccine safety and efficacy:

The safety and efficacy of vaccines should be well-documented and communicated to parents and caregivers. Providing this information can help address vaccine hesitancy and concerns.

5. Partnership and collaboration:

The successful delivery of childhood immunisation programmes requires a collaborative and multi-disciplinary approach involving local and national governments, medical professionals, and advocacy groups.

6. Reminder systems:

A system should be in place to remind parents and caregivers about upcoming immunisations. Reminder systems can help ensure that children receive all vaccines according to their schedule.

7. Continuous improvement:

Evaluation and monitoring of the programme to identify areas for improvement is essential. The programme should be continuously evaluated, with a focus on identifying areas that require improvement and addressing those areas through targeted interventions.

Learning from COVID What Works?

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Learning from COVID

A review of the approach taken to successfully deliver COVID-19 vaccinations across the city was undertaken. The review aimed to identified key strengths and considered any learning that could be applied to routine childhood immunisation uptake.

Approach

Key learning and success factors to the approach taken were considered in relation to;

- Communications and engagement - the approach to developing a communications and engagement strategy.
- Partnership working - The approach taken to partnership working and how this supported delivery.
- Accessibility - the arrangements that were put in place to make vaccination easy and accessible for residents.
- Digital tools – the use of digital tools in support of the vaccination programme.

What does this mean for Southampton?

- Approaches used during the pandemic, in particular engaging with stakeholders and communities to have conversations about vaccination, could be replicated for routine childhood immunisations. There is considerable scope to build on this success and utilise existing resources, workforce and relationships across the system and community.
- Communications in relation to Childhood Immunisation are predominantly lead Nationally with local level cascading assets opportunistically across the system. There is scope for development of a targeted and localized shared communications plan at a system level to help ensure consistent, effective and targeted messaging when needed.
- Learning from COVID underlines the importance of convenience and providing **practical help to book appointments**.
- There is scope to consider utilising pharmacies, retail outlets and local community venues in support of the childhood immunisation programme.

Key findings: What Worked?

- ✓ **Utilising trusted people of influence** within communities (faith and community workers, schools, parents, businesses and champions) to promote and have conversations about vaccination, was key to securing engagement and build trust.
- ✓ Messages were at times **better received** when they **aren't seen to be coming from the Council or the Government**.
- ✓ Taking a **'hyper-local' approach**, including using a range of local communication channels (local radio stations, social media groups, faith leaders etc) to disseminate key messages tailored to local needs, including **translated assets.** This was **enabled by good quality ethnicity-based data** made available during the pandemic.
- ✓ Providing **practical help** to book appointments to make getting vaccinated as convenient as easy as possible.
- ✓ Using **pharmacies, retail outlets** and **local community venues** (as we learned in COVID).
- ✓ **Need for local system approach** to improve MMR uptake.

Communication

- Communication is key when it comes to vaccine uptake. The UK COVID vaccine delivery programme developed extensive communication strategies to promote vaccine uptake, including social media campaigns, public figures getting vaccinated, and mass vaccination sites.
- Similar communication efforts could be developed to promote childhood immunisations, including targeted social media campaigns, school-based vaccine programs, and messaging that addresses common concerns and misconceptions.

Local Efforts:

- One Southampton campaign– **targeted comms** using uptake data by LSOA.
- **Translated comms** for low uptake communities and ethnicities.
- **Traditional flyers** and posters delivered in low uptake postcodes.
- **Social media campaigns** through community groups on apps like NextDoor – a neighbourhood based social media platform.
- **OOH digital billboards** – In high traffic areas and areas of low uptake.
- **Local Radio and TV/social media adverts** using Unity 101 and Awaz FM.

Engagement and Trust

- Engaging local communities, community leaders, and influencers helped in **building trust at the grass roots level.**
- Engaging with communities through **transparent and consistent communication** helped **address concerns, dispel myths**, and provide **accurate information** about vaccines. This educational approach helped build trust by empowering individuals with knowledge to make **informed decisions** about vaccination.

This involvement facilitated **open discussions**, **allowed concerns to be addressed**, and ensured that **communities felt heard** and understood.

- Recognising and **respecting cultural and religious factors** helped to build trust amongst different communities.
- By **actively engaging**, informing and building trust with families, confidence in childhood immunisations could increase.

Local Efforts:

- Focus groups in areas of low uptake
- Vaccine Champions – trusted community groups or organisations
- Covid-19 champions – shared information
- Resident surveys

Partnership working

- Successful delivery of the COVID-19 vaccination programmes required **community collaboration, partnerships,** and **targeted outreach efforts.**
- If contractual and practical issues can be overcome, this same approach could be applied to achieve a **more holistic approach to childhood immunisations** that engages multiple community stakeholders and healthcare providers to increase vaccine uptake.

Local Partners:

- Southampton and Solent University
- Solent NHS
- HIOW ICS
- University Hospital Southampton
- Southampton City Council
- Southampton Voluntary Services
- Faith Groups
- Local Businesses
- Refugee Charities
- Community groups
- Domestic Violence Charities

Accessibility

- Access to vaccines plays a significant role in vaccine uptake.
- The UK COVID vaccine delivery programme used large-scale vaccination sites and mobile vaccination teams to increase access to vaccines.
- Likewise, childhood immunisation programmes could **consider alternative delivery models to increase accessibility and uptake.**

Local Efforts:

- Places of worship
- Leisure centres
- Community centres
- Family spaces (swimming pools, health centres, Hubs)
- Local fire stations (Health Hubs)

Digital tools

- The UK COVID vaccine delivery programme developed a digital tool, the NHS COVID Pass, which allows people to prove their vaccination status.
- Such **digital tools could be developed to support delivery and monitoring of childhood immunisations**, which could help to identify and address areas with low uptake.
- It could also serve as a **convenient** way **for parents** to keep track of their child's vaccine schedule.

Appendices

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Appendix One - What do to FIRST? Prioritisation Matrix

Recommendation	F: Feasible		I: Impact on inequalities		R: Reach		S Success		T: Time		Score
1. Strengthen Promotion at every stage of a child's journey	Medium	2	Medium	2	Medium	2	Medium	2	Low High	2 3	13
2. Tailored comms and engagement campaign	Medium	2	Medium	2	Medium	2	High	3	Medium High	2 3	14
3.Collate & distribute Childhood Imms comms assets	High	3	High	3	Medium	2	Medium	2	Medium Medium	2 2	14
4.Utilise faith & community leaders & groups	High	3	High	3	Medium	2	High	3	High High	3 3	17
5.Targeted promotion of MMR.	Low	1	Low	1	Low	1	Medium	2	Low High	1 3	9
6. Information availability.	High	3	High	3	Medium	2	Medium	2	Medium High	2 3	15
7. Proactively provide reassurance.	Medium	2	Medium	2	Medium	2	High	3	Medium Medium	2 2	13
8.Trial alternative delivery model and venues.	Low	1	Medium	2	Low	1	High	3	Medium Medium	2 2	11
9.Support for additional needs	High	3	High	3	Medium	2	High	3	Medium High	2 3	16
10.Named frontline community immunisation champion.	High	3	High	3	Medium	2	High	3	Medium High	2 3	16

Appendix One - What do to FIRST? Prioritisation Matrix

Recommendation	F: Feasible		I: Impact on inequalities		R: Reach		S Success		T: Time		Score
11. Enhanced staff training	Medium	2	Medium	2	Medium	2	High	3	Medium Medium	2 2	13
12. Greater appointment availability.	Medium	2	Medium	2	Medium	2	High	3	High High	3 3	15
13. Review data recording, cleansing, coding & extraction processes.	Low	1	High	3	High	3	High	3	Low High	1 3	14
14. Personalised DNA/WNB Processes	Medium	2	Medium	2	Medium	2	High	3	Medium High	2 3	14
15. Ethnicity based data recording policy.	Low	1	High	3	Medium	2	High	3	Medium High	2 3	14
16. Establish local childhood imms action plan and group	High	3	Medium	2	Medium	2	Medium	2	Medium Medium	2 2	13
17. Increase uptake of Health Visitor 1 & 2 year reviews.	Medium	2	Low	1	Low	1	Medium	2	Low Medium	1 2	9
18. Share resources within PCNs & across Southampton.	Medium	2	Medium	2	Low	1	Medium	2	Medium Medium	2 2	11
19. Define responsibilities for local delivery.	High	3	Low	1	Low	1	Medium	2	Low Medium	1 2	10
20. Integrated GP MDT meetings.	High	3	Medium	2	Medium	2	Medium	2	Low Medium	1 2	12

Appendix 2 - Findings from each strand and how they link to recommendations

Ref	Key Issues Identified		Recommendations	
1. Local Data Analysis	• In **2021/22** Southampton **did not reach the target (95%) for all 5 indicators** • **Uptake** has been **decreasing ~~and getting worse~~** for all 5 indicators. • **Absolute numbers required to meet 95%** by individual GP practice is **relatively small.** • **Data indicates** that there is a **link between deprivation and low uptake.**	• It was **not possible to obtain meaningful ethnicity-based data** for GP Practices. • **Rates for MMR (1 dose and 1 year and 5 years) have increased in 2023 Q1**. This could be attributed to recent comms & engagement in response to increase in measles cases Nationally.	11) 13) 15)	Enhanced staff training including reinforcing MECC approach at all levels. Review data recording, cleansing, coding & extraction processes. Include process to check imms stats of new patient registrations and share with CHIS. Also regularly inform CHIS of children moving out of area. Develop a city-wide ethnicity-based data recording policy.
2. Pandemic Factors	• **Parental hesitation** - fears of COVID infection outweighed importance of routine immunisations in the UK which may have impacted uptake. • **Social distancing policies and lockdown** - Health services being reduces of closed during the pandemic and disruption to usual services including transportation acting as a barrier to getting children vaccinated. • **Severe shortage of healthcare providers** – staff shortages and diversion of resources to COVID-19. • **Reprioritisation and changes to how services are delivered** – move from in person visits to virtual consultations may have had an impact	• **The COVID-19 pandemic has had a significant impact on childhood immunisation uptake worldwide**. With increased strain on healthcare systems, lockdowns, and the suspension of routine vaccination services, many children have missed out on timely vaccinations. • **Some countries have reported increased enthusiasm post-pandemic** for influenza vaccination (more than double the previous year)	1) 2) 8) 13) 16) 17) 18) 19)	Strengthen promotion at every stage of a child's journey Local comms& engagement plan. Trial alternative delivery model and venues. Review data recording, cleansing, coding & extraction processes. Establish local childhood imms uptake group and action plan. Increase uptake of health visitor 1 & 2 year reviews. Share resources within PCNs and across Southampton. Integrated GP MDT meetings.
3. Desk Based Review	• Only **35% of GP practices had translated information** on childhood immunisations available on their website. • **5 practices** indicated that there was the option to translate but the **function wasn't working** • **61% have information on all recommended vaccines** but there is a **gap in information about specific diseases**.	• Most practices **do not offer support with booking** an appointment. • Parent/guardian **resources are under signposted**.	3) 5) 6) 9) 10)	Collate and distribute childhood immunisation comms assets. Target promotion of MMR. Information availability and accessibility (including translated information in different formats). Support for additional needs. Named front line community immunisation champion

Appendix 2 - Findings from each strand and how they link to recommendations

Ref	Key Findings/Issues Identified		Recommendations	
4. Parent and Practice Insights	**Parent insights** • **92% said vaccinations** are **important** for children **under 12 mths**. • **93% said vaccinations** are **important** for children **aged between 12-18 months and 18 months – 5 years** • Whilst the **majority feel the same** about childhood vaccinations **following the COVID-19 pandemic**, around **1 in 5 respondents** told us that their feelings are now **more positive**.	• **90% of our survey respondents** who has **children under 10 said their children were fully vaccinated.** • **88%** of those who are planning or expecting a child said that they **plan to get them vaccinated.** • The **single most important or helpful thing** people would look for when booking a vaccine in an **easy booking system, greater availability of appointments** and **being sent reminders**. • The most common barrier that respondents had was **a bad experience in a GP surgery or vaccination centre (16%)**.	6) 7) 8) 9) 10) 11) 12) 14)	Information availability. Proactively provide reassurance. Trial alternative delivery model and venues. Support for additional needs. Named frontline community immunisation champion. Enhanced staff training. Greater appointment availability. Personalised (telephone) DNA processes.
	Practice insights • **Discussing vaccinations** – only **43% have multi-disciplinary team (MDT) meeting** where vaccinations are discussed. • Only **36% say** that they work with Health Visitors on an **ad hoc basis**. **27% say** they work with them **monthly**. **5% said** they **do not work with them** at all. • **Data Cleansing** – accurate data and records and routine data cleansing could impact on figures. • **DNA Process** – **96% send text messages**. Evidence suggests that having a conversation with a health care provider can be vital where parents are hesitant or have concerns.	• **Appointment availability/operational hours** – GP practices are split on the time spent holding child immunisation clinics per week, with **both 2-4 hours** and **more than 8 hours** receiving **35%.** • **Appointment time** - Survey indicates that on average **10 minutes is available per immunisations** carried out. **Longer appointment slots** should be available where additional support is required, to allow time to discuss benefits and answer any questions. • **Catch up Clinics** – 17% are not offering catch up clinics despite the data indicating that immunisation tales off at children get older.	13) 12) 14) 16) 18) 20)	Review data recording, cleansing, coding, extraction processes. Greater appointment availability. Personalised DNA processes. Establish local childhood imms uptake group and action plan. Share resources within PCN's & across Southampton. Integrated GP MDT meetings.
5. Previous Studies & Guidance	• **Inconsistencies in** how healthcare professionals **remind/recall** parents to vaccinate. • **Limited evidence** of any major impact on vaccination from **anti-vax messages.** • **Improving access** to vaccination remains crucial. • **Fear of side effectives**, **lack of confidence** in effectiveness, **low understanding** of herd immunity and myths remain persistent. • **Combination of interventions** works best. • Need to **collaborate with colleagues** and work in partnership. • **Small minority** of parents **concerns over vaccination.**	• Link between **deprivation and uptake of MMR**. • There are **inequalities in vaccine uptake** by ethnicity, deprivation and geography. • **42% of parents** who were undecided about whether to get their baby vaccinated **felt more confident after speaking to health professional**. • Ensuring **services are tailored** to meet needs **does not mean treating all people the same.** • **Health literacy** – people need to be supported to access services. • **Learning from COVID-19** should be **harnessed.** • **Delivery** of immunisations **is complex** and requires understanding of roles and responsibilities of all partners and ongoing commitment.	2) 4) 5) 7) 10) 11) 12) 14) 15) 16) 19)	Local comms & engagement campaign. Utilise faith & community leaders & groups. Targeted promotion of MMR. Proactively provide reassurance. Named frontline community immunisation champion. Enhanced staff training. Greater appointment availability. Personalised DNA and WNB processes. Ethnicity based data recording policy. Establish local childhood imms uptake group and action plan. Define responsibilities at a local level.

Appendix 2 - Findings from each strand and how they link to recommendations

Ref	Key Findings/Issues Identified		Recommendations	
6. Learning from COVID	• **Utilising people of influence** within communities was used effectively during the pandemic response and roll out of the Covid-19 vaccination programme.. This could be replicated for other initiatives. • Taking a **hyper-local approach**, including using local radio, social media, faith leaders etc to disseminate key messages.	• Providing **practical help to book appointments**. • Using pharmacies, retail outlets and local community venues to promote vaccination. • **Need for local system approach to improve MMR** and across all vaccinations e.g. Strategic Vaccination Uptake Group (SVUG)	2) 3) 4) 5) 8) 9) 16) 18) 20)	Local comms& engagement plan. Collate and distribute childhood imms comms assets. Utilise faith & community leaders & groups Targeted promotion of MMR Trial alternative delivery model and venues. Named frontline community immunisation champion. Establish local childhood imms uptake group and action plan. Share resources within PCN@s and across Southampton. Integrated GP MDT meetings.

Appendix 3- Literature Review

- Bellizzi, Saverio; Pichierri, Giuseppe; Kheirallah, Khalid and Panu Napodano, Catello M, 2022, **Global health priorities: repositioning routine immunization for infants,** *Journal of infection in Developing Countries 16(10)*, pp. 1648-1649

- Falkenstein Hgander, Kathy; Aronsson, Bernice; Danielsson, Madelene; Lepp, Tiia;Kulane, Asli and Schollin Ask, Line, 2021, **National Swedish survey showed that child health services and routine immunisation programmes were resilient during the early COVID-19 pandemic**, *Acta Paediatrica 110(9),* pp.2559-2566

- Jarchow-MacDonald, Anna;Burns, Ruth;Miller, Jessica;Kerr, Linda and Willocks, Lorna J. 2021, **Keeping childhood immunisation rates stable during the COVID-19 pandemic,** *The Lancet.Infectious Diseases* 21(4), pp. 459-460

- Kostandova; Natalya; Loisate, Stacie; Winter, Amy;Moss, William J; Giles, John R; Metcalf, C.J.E; Mutembo, Simon and Wesolowski, Amy, 2022, **Impact of disruptions to routine vaccination programs, quantifying burden of measles, and mapping targeted supplementary immunization activities**, Epidemics 41, pp 100647

Lassi, Zohra S.;Naseem, Rabia;Salam, Rehana A.;Siddiqui, Faareha and Das, Jai , 2021, **The Impact of the COVID-19 Pandemic on Immunization Campaigns and Programs: A Systematic Review.** *International Journal of Environmental Research and Public Health* 18(3)

- Maltezou, Helena C.;Medic, Snezana;Cassimos, Dimitrios C.;Effraimidou, Evgnosia and Poland, Gregory A. 2022, **Decreasing routine vaccination rates in children in the COVID-19 era**, *Vaccine 40(18),* pp. 2525-2527

- McNally, Veronica Valentine and Bernstein, Henry H. 2020, **The Effect of the COVID-19 Pandemic on Childhood Immunizations: Ways to Strengthen Routine Vaccination,** *Pediatric Annals* 49(12), pp. e516-e522

- McQuaid, Fiona;Mulholland, Rachel;Sangpang Rai, Yuma;Agrawal, Utkarsh;Bedford, Helen;Cameron, J. C.;Gibbons, Cheryl;Roy, Partho;Sheikh, Aziz;Shi, Ting;Simpson, Colin R.;Tait, Judith;Tessier, Elise;Turner, Steve;Villacampa Ortega, Jaime;White, Joanne and Wood, Rachael, 2022, **Uptake of infant and preschool immunisations in Scotland and England during the COVID-19 pandemic: An observational study of routinely collected data**, *PLoS Medicine 19(2),* pp. e1003916

- Rachlin, Audrey;Danovaro-Holliday, M.;Murphy, Padraic;Sodha, Samir V. and Wallace, Aaron S. , 2022, **Routine Vaccination Coverage - Worldwide, 2021,** *MMWR.Morbidity and Mortality Weekly Report 71(44*), pp. 1396-1400

- Saxena, Sonia;Skirrow, Helen and Bedford, Helen, 2020, **Routine vaccination during covid-19 pandemic response,** BMJ (Clinical Research Ed.) 369, pp. m2392

- Wong, Yen Jun and Lee, Shaun Wen Huey, 2021, **'COVID-19: A call for awareness or mandatory vaccination even in pandemics?,** Journal of Global 11, pp. 03005

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Appendix 2 - Measles - Briefing

Measles is a the most infectious of all diseases transmitted through the respiratory tract. It is a notifiable and vaccine-preventable disease. Global cases of measles are high due to poor vaccination coverage made worse by the Covid-19 pandemic. Imported cases are therefore likely. In England there has been an increase in cases over the last year following low numbers during the pandemic years – most were in London where there is lower vaccine coverage compared to other areas. In late 2023 case numbers began to rise in the West Midlands where there are now established outbreaks with community transmission in those without vaccination. In this outbreak there have been 203 laboratory confirmed cases and 113 probable cases (linked directly to confirmed cases) and of these 80% have been in Birmingham and 8% in Coventry but there have also been cases in most local authority areas in the West Midlands region. In children measles is an unpleasant childhood illness but most make a full recovery. Complications are rare but some people are more at risk, including babies and people with weakened immune systems. These complications include pneumonia, encephalitis, blindness and seizures. It is also more severe in pregnancy, and increases the risk of miscarriage, stillbirth, or preterm delivery.

In the UK, measles vaccine is offered as part of the routine childhood vaccination schedule within the MMR vaccine that protects against measles, mumps and rubella. Dose 1 is offered at 12 months of age, and dose 2 at 3 years and 4 months of age both provided in primary care. Measles vaccine is highly effective, with one dose offering 95% protection and the second dose boosting protection even further.

Rates of MMR vaccination have dropped in Southampton and England over the last 10 years. Three indicators are used to monitor uptake including one dose by 2 years, one dose by 5 years, and two doses (complete course) by 5 years. For uptake of vaccine in 2022/23, Southampton has higher uptake compared to Birmingham and Coventry (see table 1). However most local authority areas in England fall short of the WHO target of 95% population coverage target required to eliminate the infection. We are therefore likely to see individual cases of measles in unvaccinated children living in Southampton (either linked to international travel or with direct links to cases in other areas where community transmission is happening such as the West Midlands) with a risk of transmission to other un or under-vaccinated children and those with weakened immune systems. Any cases that occur will be rapidly assessed and managed by UK Health Security Agency.

Table 1: MMR coverage 2022/23 by Local Authority Area and England average

Uptake Data 2022/23	MMR 1 dose at 2 years	MMR 1 dose at 5 years	MMR 2 doses at 5 years
England	89%	93%	85%
Birmingham	82%	88%	75%
Coventry	87%	91%	82%
Southampton	90%	92%	86%

They key public health control measure is to continue to work towards high level of MMR coverage as part of the routine childhood immunisation schedule, catch-up campaigns for those who missed their early childhood doses for any reason, and new migrants. Two age cohorts are particularly at risk. First those aged 18-23 years (born 1998-99 and 2003-4) affected by misinformation in the late 1990's, and those born in 2015 and 2019 where MMR doses were due during the pandemic. Healthcare providers have been updated regularly and are alerted to considering measles diagnosis in children presenting with a compatible rash as well as ensuring clinical staff are fully vaccinated. There is also an NHS national catch-up campaign currently requiring practices to undertake local call and recall for eligible individuals aged 12 months to and including 5 years, as well as supporting requests for vaccination of those aged 6-25 years identified through a phased national call and recall. MMR vaccine can be given at any age.

DECISION-MAKER:	Health and Wellbeing Board
SUBJECT:	Update on the Southampton City Council Tobacco, Alcohol and Drugs Strategy 2023-2028
DATE OF DECISION:	13 March 2024
REPORT OF:	COUNCILLOR MARIE FINN CABINET MEMBER FOR ADULTS & HEALTH

CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY
N/a

BRIEF SUMMARY
This paper updates the Health and Wellbeing Board on the progress of the Southampton City Council Tobacco Alcohol and Drug (TAD) Strategy 2023-2028 in 2023 and plans for 2024. The paper is for information and agreement.

RECOMMENDATIONS:		
	(i)	The Board continues to note the significant harm that tobacco, alcohol and drugs cause in Southampton and notes the progress made in implementing the Southampton Tobacco Alcohol and Drug Strategy, 2023-28.
	(ii)	The Board continues to actively champion the implementation of the strategy, including: • All organisations use their impact as Anchor Institutions[1], to prevent and reduce harm from tobacco, alcohol and drugs, including vaping when used other than by adults as a tool to stop smoking. This includes visible leadership, such as a Smokefree commitment, and a "Health in all policies" approach. • the non-judgemental language: of drug and alcohol use or harm, rather than "misuse"; and of tobacco dependency and treatment, particularly in a health care context.

[1] "Anchor Institutions" are organisations that have an important, large impact on a place, with impact through all or most of employment and skills, buying and commissioning, capital and estates, environmental sustainability, and as a partner with others in a place.

		• evidence-informed policy
	(iii)	Board members contact Public Health if they would like further advice or support for their strategic or operational work on tobacco, alcohol, drugs and/or vaping.
REASONS FOR REPORT RECOMMENDATIONS		
	To implement the SCC Tobacco, Alcohol and Drugs strategy and thereby prevent and reduce harm, improve outcomes and achieve value for money.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
	None.	
DETAIL (Including consultation carried out)		
	Summary The Tobacco, Alcohol and Drug (TAD) Strategy was enacted on the 1st of January 2023. Executive Director portfolios changed in early 2023, and the commitments were re-aligned to directorates accordingly. This is the first annual update to Health and Wellbeing Board. Summary of 2023 Progress: • Baseline Key Performance Indicators show mixed performance compared to England and substantial local need. • Implementation of the strategy is broadly on track, with the pace and scale affected by organisational capacity and funding. • We have an increased cross-council focus on youth vaping and responded to the national consultation. • We secured significant additional ring-fenced grants via the Office for Health Improvement and Disparities (OHID): £1.07M ring-fenced Supplemental Grant for Drug Treatment and £0.72M grant for Drug Treatment for Rough Sleepers, 23/24. We were also successful in bidding to secure 250 vape starter kits, free from OHID, to offer as part of treatment to priority groups in late 23/24 and into 24/25. • SCC continues to be a signatory of the Local Government Declaration on Tobacco Control and chairs a successful local, multiagency Reducing Drug Harm Partnership. • Significant increase in the numbers of people in tobacco, alcohol and drug treatment and support services • Many care pathways have been strengthened e.g. improved Continuity of Care from prisons to community drug and alcohol services. • Our local tobacco, alcohol and drugs work has been highlighted as good practice regionally and nationally. Looking forward to 2024, we note: • The announcement of proposed new national legislation for tobacco and vaping, increasing the age of sales, banning single-use vapes and restricting vape flavours, packaging &/or visibility of vapes in shops. A	

	consultation about vape sales restrictions and a free vote for MPs is due within this Parliament. • Continuing changes to the illicit drug market internationally, which may put local people who use drugs at increased risk of overdose. • Three ring-fenced grants are expected, subject to OHID approval and the maintenance of Public Health grant spend: Supplemental Grant for Drug Treatment, Drug Treatment for Rough Sleepers and a new grant to commission Local Stop Smoking Services. • Financial uncertainty, with the Public Health Grant, Supplemental Grant and Rough Sleepers' Grants only confirmed to March 2025. The Individual Placement Support grant to support people recovering from drug and alcohol issues into work is also only confirmed to March 2025. The new smoking grant will be awarded annually, up to 2028/9 and may fluctuate. • Importance of embedding the TAD strategy within organisational change programmes, strategies, policies and plans, including the SCC Corporate Plan and the next Health & Wellbeing Strategy. • Continued importance of embedding identification, brief interventions and support across pathways, as per the strategy. • Ongoing cost pressures across the health and care system, with some of our commissioned services offering fixed term posts and vulnerable to high staff-turn over. • Local elections including the Office of Police & Crime Commissioner, and preparations for a national election. • Limits of internal capacity. It's within the terms of the drug treatment and smoking grants to increase internal public health and commissioning capacity to manage the grants, but this has not gone ahead during the recruitment freeze. Similarly, the Trading Standards team are limited by their capacity in responding to the growth in illegal vape sales. • We are due to hear whether a bid for further free vape starter kits from OHID has been successful. • We are preparing to commission a needs assessment of alcohol and drugs services for adults, which will include a focus on interdependencies across the Council. • Importance of Partners continuing to work alongside Southampton City Council to reduce the harm from tobacco, alcohol and drugs, and also from vaping when used other than by adults to stop smoking.
	The cross-Council strategy describes how we will reduce the harm from tobacco, alcohol and drugs (TAD). Our vision is that we are a city of "Help, Harm reduction, Hope, Health promotion & prevention, and Health equality" (5 Hs). The strategy outlines key principles and needs. It focusses on strategic programmes, one for each directorate. All commitments are either proven good practice or innovative and based on public health principles.

	The list of directorate commitments was updated since Cabinet approval to reflect revised Executive Director portfolios, with suggested TAD priorities for 2023. The updated programmes are: ○ **Programme 1**: Wellbeing: Children & Learning ○ **Programme 2:** Wellbeing and Housing ○ **Programme 3:** Place ○ **Programme 4:** Corporate Services
	Governance The strategy sits under the Health and Wellbeing Strategy and Board. While it is cross-council, the Wellbeing and Housing directorate maintains oversight. Four new forums inform and support the strategy: 1. The Southampton Reducing Drug Harm Partnership oversees implementation of the national drugs strategy locally[2]. The Partnership is chaired by Dr Debbie Chase, Director of Public Health. It is multiagency, with elected members, police, health, and other services, as well as links to the Safe City Partnership and Health & Wellbeing Board. It is a condition of the national strategy and Supplemental Grant for Drug Treatment that we have a local partnership. 2. A *Drug and Alcohol Treatment Partnership* is co-chaired by the Integrated Commissioning Unit and Public Health. It reports to the Reducing Drug Harm Partnership. It focusses on multi-agency clinical and operational issues, to ensure pathways are safe and effective. 3. A *cross-council vaping group*, with a focus on young people, chaired by Public Health. It collaborates on operational issues and responded to a national consultation. 4. A *Tobacco Dependency Treatment Provider Network* is run by our SCC-commissioned service, Southampton Smokefree Solutions, on behalf of SCC. The network provides ongoing training, cohesion and quality assurance of all tobacco dependency advisors in Southampton. It has more than 140 members.
	Key Performance Indicators A public KPI dashboard for the strategy is updated annually. Directorates may use additional monitoring internally, e.g. contract monitoring and restricted, provisional data from national sources which cannot be made public. Each directorate also provides an annual report, via this Health and Wellbeing Board update. Further data, beyond the KPIs, is at Southampton data observatory- tobacco, alcohol, drugs.
	The current KPI dashboard includes the most recent, publicly available data. This paper uses that data as of 15 February 2024. This is mostly calendar year 2021 or financial year 2021/22. It pre-dates the start of the TAD strategy and provides a baseline to measure future progress. There is comparative data for areas with similar populations (15 Local Authorities in the 4th most deprived decile, including Southampton) and for England.

[2] From harm to hope: A 10-year drugs plan to cut crime and save lives - GOV.UK (www.gov.uk)

	In general, tobacco, alcohol and drug harms are related to deprivation. Southampton is in the 4th most deprived decile nationally, with 14 other Local Authorities. Southampton has significant need. Latest estimates are that, locally, 26,541 adults (18+) smoke tobacco; 5,355 people are alcohol dependent; 1,734 people use opiates and/or crack cocaine; and 1,706 children live with an adult who is alcohol dependent. The KPIs show a mixed baseline and that our commissioned services are already reaching many populations: • The number of people setting a quit date and stopping smoking through services is higher than the national average and compares well against comparator local authorities[3]. • Our alcohol data is complex. We have a higher (worse) rate of alcohol-related admissions to hospital than England and rank poorly against comparators. We are also in the worst 3 authorities in the 4th decile of deprivation for unmet need[4], although in line with England. These metrics in part reflect good practice at University Hospital Southampton, where they assess all inpatients for alcohol issues so they can provide good care. This means we are likely to be better locally at identifying and recording alcohol issues than is usual nationally. • Our unmet need for treatment for opiate and/or crack use is similar to England and we are in the best 3 authorities among our comparators. Our indicator data is otherwise similar to England and our comparators, or better compared to England or comparators but not both. A RAG-rated[5] summary of our KPIs is in **Appendix 1**.
	2023 Progress, including directorate programmes Progress reports by each Directorate bring this data to life, **Appendix 2**. Of note: a) Vaping has been a major focus in 2023, detailed in **Appendix 3**. b) A needs assessment is underway to update our understanding of how tobacco, alcohol, drugs and vaping affect children and young people in Southampton. c) We've provided significant support to the NHS to be smokefree: • Southampton Health & Care Strategy Commitment • Supporting implementation of NHS Long Term Plan across Hampshire and the Isle of Wight, on behalf of the ICB, and in Southampton

[3] The KPI dashboard is designed to use the national Public Health Outcomes Framework data where possible. This currently shows smoking service data from 2019/20. Reliable operational data from NHS Digital for 2022/23 shows we're now performing much better than England, with a much higher rate of people setting a quit data and stopping smoking – more than 100% and 50% above England respectively.

[4] Unmet need compares the estimated total number of people with a condition in the population (including people not yet diagnosed) minus the total number of people in treatment.

[5] RAG-rated means using a traffic-light system to categorise indicators as red, amber or green.

	• NHS Smokefree Pledge signed by: 2 PCNs, NHS Solent, Southern Health NHS Trust. • UHS is working to be smokefree from April 2024 • Southampton Smokefree Solutions commissioned to 2026 to support NHS (and others) d) We secured significant additional ring-fenced grants via the Office for Health Improvement and Disparities (OHID): £1.07M ring-fenced Supplemental Grant for Drug Treatment and £0.72M grant for Drug Treatment for Rough Sleepers, 23/24. We were also successful in bidding to secure 250 vape starter kits, free from OHID, to offer as part of treatment in late 23/24 and into 24/25 to people who are using our homeless hostels, with scope to also use them through our alcohol, drug and mental health services. We are due to hear whether a bid for further free vape starter kits from OHID has been successful. e) SCC continues to chair a successful local, multiagency Reducing Drug Harm Partnership. f) There is a significant increase in the numbers of people in tobacco, alcohol and drug services. g) Many care pathways have been strengthened e.g. improved Continuity of Care from prisons to community drug and alcohol services.
	Our work has been highlighted as good practice regionally and nationally, including: a) Our cross-council strategy • Presentation to the Association of Directors of Public Health • Article by the Chair of the Health & Wellbeing Board Tobacco, Alcohol and Drugs: A combined harm reduction approach - ChamberUK b) Smokefree Primary Care Networks, 2023 South East Public Health Conference c) Alcohol telephone line, 2023 South East Public Health Conference. d) Our tobacco dependency treatment model and quit rate Southampton: Embedding stop smoking expertise across services | Local Government Association.
	Plans for 2024 Directorates have outlined how they will implement their commitments in 2024 in **Appendix 2**. We are also preparing to commission a needs assessment of alcohol and drugs services for adults, including interdependencies with council services, such as adult social care, children's and housing. This will inform future plans. As context, work on tobacco, alcohol, drugs and vaping across the Council will be shaped by: a) The announcement of proposed new national legislation for tobacco and vaping, increasing the age of sales, banning single-use vapes and restricting vape flavours, packaging &/or visibility of vapes in shops. A

	consultation about vape sales restrictions and a free-vote for MPs is due within this Parliament. b) Continuing changes to the illicit drug market internationally, which may put local people who use drugs at increased risk of overdose. c) Three ring-fenced grants, subject to OHID approval and the maintenance of Public Health grant spend: Supplemental Grant for Drug Treatment, Drug Treatment for Rough Sleepers and a new grant to commission Local Stop Smoking Services. d) Financial uncertainty, with the Public Health Grant, Supplemental Grant and Rough Sleepers' Grants only confirmed to March 2025. The Individual Placement Support grant to support people recovering from drug and alcohol issues into work is also only confirmed to March 2025. The new smoking grant will be awarded annually, up to 2028/9 and may fluctuate. e) Importance of embedding the TAD strategy within organisational change programmes, strategies, policies and plans, including the Corporate Plan and the next Health & Wellbeing Strategy. f) Continued importance of embedding identification, brief interventions and support across pathways, as per the strategy. g) Ongoing cost pressures across the health and care system, with some of our commissioned services offering fixed term posts and vulnerable to high staff-turn over. h) Local elections including the Office of Police & Crime Commissioner, and preparations for a national election. i) Limits of internal capacity. It is within the terms of the drug treatment and smoking grants to increase internal public health and commissioning capacity to manage the grants, but this has not gone ahead during the recruitment freeze. Similarly, the Trading Standards team are limited by their capacity in responding to the growth in illegal vape sales.
RESOURCE IMPLICATIONS	
Capital/Revenue	
	There is no direct risk to the General Fund from this strategy, which specifies that the pace and scale of implementation is dependent on resources. Three ring-fenced grants were used to deliver some projects in line with the strategy, subject to grant spending requirements and restrictions: • The Public Health Grant • The Supplemental Grant for Drug Treatment • The Drug Treatment for Rough Sleepers' Grant. These are all confirmed only to March 2025. We are also due to receive up to £314k in a new ring-fenced grant for tobacco dependency treatment services in 2024/5. The Supplemental, Rough Sleepers and forthcoming Tobacco Dependency grants require that we increase numbers of people in treatment, increase numbers of people being

	TAD-free, and that we maintain levels of funding from the public health grant for these services - 2020/21 for alcohol & drugs, 2022/23 for tobacco. In total, £6.6M grant funding was allocated to tobacco, alcohol and drugs treatment in 2023/4: Public Health Grant (Drugs and Alcohol) £3.97M including housing-related support and residential rehabilitation. Public Health Grant (Tobacco) £855k SSMTRG £1.07m (previously £655k 22/23, due to be £2.07M 24/25) RSDATG £717k
Property/Other	
	None.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
	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'. The Council signed up to the Local Government Declaration on Tobacco Control in 2014 and thereby committed to having a Tobacco Control Plan.
Other Legal Implications:	
	None
RISK MANAGEMENT IMPLICATIONS	
	None.
POLICY FRAMEWORK IMPLICATIONS	
	This work contributes to the following goals and priorities of a wide range of Council Plans and Strategies, including: • Southampton City Council Corporate Plan 2022/30 • Southampton City Strategy 2015-25 • Health and Wellbeing Strategy 2017-2025 Children and Young People's Strategy 2022/27 • Southampton Domestic Abuse and Violence Against Women and Girls Strategy 2023 – 2028 • Southampton Safe City Strategy 2022 – 2027

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	All
SUPPORTING DOCUMENTATION	
Appendices	

1.	Table of Key Performance Indicators
2.	Directorate 2023 Report and 2024 Plans
3.	2023 work on vaping

Documents In Members' Rooms

1.	None

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

Other Background Documents
Other Background documents available for inspection at:

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

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Appendix 1

Table of Key Performance Indicators

This table summarises how local performance compares to England and how we rank within the group of 15 Local Authorities in the 4th most deprived decile nationally.

The data was taken from the KPI dashboard, accessed 15 February 2024, using the most recent, public data available, with different time periods for different indicators. All pre-date the implementation of the TAD strategy and provide a baseline to measure future progress. Importantly:

- The comparison to England shows statistical significance.
- The ranking within the comparator group does not show statistical significance or that we are very different to the other Local Authorities. Being in the top or bottom 3 does not mean the difference is statistically significant. Mid-ranking means ranking 4th – 12th / the 15 authorities.

Indicators	Compared to England	Comparator group rank / 15	See note:
Tobacco Indicators			
1. Smoking prevalence in adults (18+)	Similar	Mid-rank	1.
2. Smokers setting a quit date	Worse	Worst 3	2.
3. Smokers that have successfully quit at 4 weeks	Worse	Worst 3	
4. Smoking rates at time of delivery	Similar	Mid-rank	
Alcohol Indicators			
5. % adults drinking over 14 units per week,	Similar	Mid-rank	
6. Estimated prevalence of adults with alcohol dependency	Similar	Worst 3	3.
7. Number of people in structured treatment	No comparison	No comparison	
8. Successful completion of alcohol treatment	Similar	Mid-rank	
9. Under-75 mortality rate from alcohol liver disease.	Similar	Worst 3	3.
10. Admission episodes for alcohol-related conditions (Narrow)	Worse	Worst 3	3.
11. Estimated unmet need – Alcohol	Similar	Worst 3	3.
12. Alcohol-specific mortality	Similar	Mid-rank	3.
13. Alcohol-related mortality	Worse	Mid-rank	3.
Drugs Indicators			
14. Estimated prevalence of Crack use	Similar	Mid-rank	
15. Estimated prevalence of opiate use	Similar	Best 3 (lower)	
16. Estimated prevalence of opiate &/or crack use	Similar	Mid-rank	
17. Hospital admissions due to drug poisoning	Worse	Mid-rank	
18. Hospital admissions due to substance (mis)use (15 to 24 years)	Worse	Mid-rank	
19. Estimated unmet need – Opiates &/or crack cocaine	Similar	Best 3 (lower)	5.
20. Percentage of people in drug treatment who have received a hepatitis C test	Similar	Mid-rank	
21. Successful completion of drug treatment: opiates	Similar	Best 3 (higher)	
22. Successful completion of drug treatment: non opiates	Worse	Mid-rank	
23. Drug use deaths	Similar	Mid-rank	

Notes to accompany the table:

1. OHID estimate smoking prevalence annually. For Southampton it is 13.2% for 2022/23, higher than 12.5% estimated by OHID for 2021/22. OHID noted uncertainty about 21/22 data due to the

pandemic and data collection methods being less robust. The confidence intervals are high so this figure should be used with caution. A more accurate measure is the 5-year trend, which in Southampton is on a steady downward trajectory, from 17.4% in 2017.

2. These are 2019/20 smoking figures from the Public Health Outcomes Framework. More recent 2022/3 NHS Digital data, provided by local authorities, shows our rate of people setting a quit date was twice the national average (better) and our quit rate was more than 50% better than the national average

3. Our alcohol data partly reflects good practice at University Hospital Southampton, where all inpatients are assessed for alcohol use so they can receive the right care. This is not yet widespread in other hospitals. Hospital coding is used to inform estimates of the prevalence of alcohol dependence, admissions specific or related to alcohol, and mortality specific or related to alcohol.

4. This is estimated as:
    - Estimated no. people using crack cocaine &/or opiates
    - Minus the no. people in treatment
    - Divided by the estimated no. people using crack cocaine &/or opiates.

Appendix 2

Tobacco Alcohol and Drug (TAD) Strategy 2023-2028

Directorate Reports: 2023 Action and 2024 Plans

This is a narrative report to complement the dashboard of Key Performance Indicators. It is part of annual reporting to the public Health & Wellbeing Board. It takes each directorate programme in turn, listing the commitments, 2023 actions (Year 1 of the strategy) and 2024 plans (Year 2 of the strategy). It is intentionally high level and focusses on the actions within the gift of Southampton City Council.

Programme 1: Wellbeing: Children & Learning

1) 2023 Headlines

- This programme has 10 commitments, of which 5 were prioritised for particular focus in 2023.
- Children and Young People Tobacco, Alcohol, Drugs and Vaping Needs Assessment underway
- Drug and alcohol support workers now embedded in Family Hubs

a) **Strengths**

- Additional funding (Supplementary Substance Misuse Treatment and Recovery Grant – SSMTRG) has supported an improved 'joined up' approach between Children's Social Care and Young Peoples Drug and Alcohol treatment and support services
- Reducing Drug Harm Partnership (RDHP) providing senior leadership, challenge and oversight.

b) Risks and issues

- Public health and SSMTRG grants only confirmed to March 2025.

2) 2023 Implementation Report on each commitment

Commitment: 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. ***2023 Priority***

Progress to date (Jan – Dec 2023)

Maternity Service:

- Public Health Midwives, Tobacco Dependency Advisor (TDA) and administrative staff recruited and trained by Southampton Smokefree Solutions to facilitate National Institute of Health and Care Excellence (NICE) and National Centre for Smoking Cessation Training (NCSCT) evidence-based intervention. All midwives have received smoking cessation training, ongoing CPD available and pathways are live with a focus on Needing Extra Support Teams (NEST) where there is the greatest inequality.
- All women identifying as smokers, when booking in with maternity services, will be allocated a Smokefree Midwife.
- Nationally, the challenges with data recording and reporting, have improved. This includes the sharing of local Saving Babies Lives V3 smoking cessation data with public health and other partners to understand activity.
- This commitment is supported by Integrated Commissioning Board (ICB) and University of Southampton (UHS)Hospital Trust to implement NHS Long Term Plan pathway.
- Smoking at time of delivery (SATOD) Provisional data as of November 2023 = 8.9% which is a downward trajectory, with data quality to be confirmed.

Other Services: Family Nurse Partnership: Training and support provided to staff to ensure high quality evidence-based interventions are delivered along with direct supply nicotine replacement (NRT)

Future Work Planned (Provisional or agreed)

- A continued drive towards more accurate reporting and increased engagement for 2024.
- Strengthen links with Health Visitors.

- Identify opportunities to strengthen Tobacco Dependency Advisor support to pregnant people and their families across a variety of settings.
- National incentive scheme to be launched in 2024, to be delivered by maternity services. (Links with commitment 2 below)
- Scope submitting Expression of Interest to national "Swap2 Stop" scheme Feb 2024, for vape starter kits in 24/25 as part of tobacco dependence treatment (links with commitment 2 below)

Commitment 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).

Progress to date (Jan – Dec 2023)

- Scoping of a local e-cigarette/vape pilot began but was paused following the national Swap2Stop vape scheme announcement.
- Incentives pilot planning paused following announcement of national incentive scheme due in 2024.

Future Work Planned (Provisional or agreed)

- National incentive scheme is to be launched in 2024, to be delivered directly by maternity services. (Links with commitment 1 above)
- Scope submitting an Expression of Interest to national "Swap2 Stop" scheme, for vape starter kits in 24/25 as part of tobacco dependence treatment (links with commitment 1 above)
- Expanded national Smokefree Generation campaigns due in 2024 (all age). We will check NHS and others run the campaigns locally.

Commitment: 3**.** Identify and support more **children and young people living with alcohol and drug dependent adults *2023 Priority***

Progress to date (Jan – Dec 2023)

- Children and Young People Tobacco, Alcohol, Drugs and Vaping Needs Assessment underway, due for completion in Spring 2024, will include a review of the needs of children and young people living with drug or alcohol dependent adults.
- Co-located specialist drug and alcohol youth workers within the Youth Hub, working jointly with Childrens Social Care.
- Detached youth workers provide outreach to "hot spots" within the city where young people gather and work to form trusting relationships.
- Education Support workers work with teaching staff and young people experiencing drug and alcohol issues to provide early intervention and prevention and support for those living with adults experiencing drug and/or alcohol issues.

Future Work Planned (Provisional or agreed)

- Agree and implement joint action plan in light of needs assessment to improve identification, pathways and interventions with Children's and Adult Social Care, Drug and Alcohol Support Services and others.
- Commencement of the Family Safeguarding Model, which will include three specialist substance use workers within the multi-agency team that supports families.

Commitment: 4. Support young people and families **most at risk** of substance use or criminal exploitation with early, targeted support ***2023 Priority***

Progress to date (Jan – Dec 2023)

- Co-located specialist drug and alcohol youth workers within the Youth Hub, working jointly with Childrens Social Care.
- Family Nurse Partnership continue to play a key role in identifying harmful use of drugs and alcohol in the people they support, as well as supporting people to reduce harm and engage in treatment.

- Increased CYP Drug and Alcohol Support Services outreach provision in place.
- Piloted Risk outside the Home (ROTH) conferences, as an alternative to Child Protection Conferences for young people, as part of a pilot with Durham University.
- Youth Justice Service, Young People's Service and the Inclusion and Prevention Service providing help, support, diversion and protection approximately 200 young people at any one time where is a significant risk of substance use or criminal exploitation.
- Holiday Activities Fund (HAFF) activity targeted to provide diversionary activities during school holidays which are times where risks of substance use and exploitation can increase.

Future Work Planned (Provisional or agreed)

- Agree and implement joint action plan in light of needs assessment to improve identification, pathways and interventions with Children's and Adult Social Care, Drug and Alcohol Support Services and others.
- ICU to consider development of a plan with Young Peoples Drug and Alcohol Support Service to increase numbers in treatment and support.
- From December 2023 a Health, Education and Learning Pathway (HELP) has been developed to provide a clinical framework around help, support and rehabilitation available for young people in the criminal justice system. This approach will improve the quality of intervention to this cohort of young people with a high risk of exploitation or substance use.

Commitment: 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 ***2023 Priority***

Progress to date (Jan – Dec 2023)

Vaping prioritised for 2023:

- All Southampton schools invited to join the local Personal, Social & Health Education (PSHE) Networks, guided by public health priorities and supported by the PSHE Association. This includes membership to the PSHE Association for all schools, providing quality assured resources, ongoing training and expert advice to all schools.
- Teachers received regular updates, guidance and a range of new resources on vaping.
- New cross-council vaping group focussing on youth vaping established by public health, meeting regularly and responded to the government's call for evidence and the consultation on youth vaping and tobacco legislation, and sharing national public health announcements.

Other progress:

- Agreed new offer by Drug and Alcohol Support Services to educational settings, working closely with schools, offering 1-1 support for young people who are experiencing difficulties with drugs and alcohol and advice for teachers on how to work effectively with young people who are using substances with a view to referring them into services.
- Tobacco, Alcohol & Drugs lesson plans available for all schools (primary, secondary, SEND, FE Colleges) via PSHE Assoc membership. All school PSHE leads offered CPD through termly network meetings.
- Children and Young People Tobacco, Alcohol, Drugs and Vaping Needs Assessment underway, due for completion spring 2024.

Future Work Planned (Provisional or agreed)

- Ongoing PSHE support for schools through the PSHE networks and membership to the PSHE Association.
- National Relationships, Sex and Health Education (RHSE) curriculum under review by the government, any changes to be communicated and supported locally, as appropriate.
- Use tobacco, alcohol, drugs & vaping needs assessment and Beewell Survey to inform future work.

Commitment 6. Work with others to support a wide range of **leisure activities** in the city for children and young people, as prevention and diversion.

Progress to date (Jan – Dec 2023)

- The HAFF programme has a specific delivery programme targeted at young people from the youth justice and other significantly vulnerable adolescent groups to provide a programme of exciting, high adrenalin activates during school holidays as a diversion from substance use and exploitation. In 2023 80 young people accessed these activities.
- The Saints foundation are commissioned and access funding from a variety local and national sources to provide an extensive programme of social inclusion and positive activities for the most vulnerable young people in the city.
- Outreach Youth Work is being Co-ordinated across the city targeting the Redbridge, Thornhill and St Mary's areas and is being delivered by the council, No limits and Youth Options.

Future Work Planned (Provisional or agreed)

- The council and police are developing a public health approach to serious youth violence and exploitation, which has been evaluated as effective in Glasgow and the West Midlands. The Focused Deterrent model is scheduled to be operational from April 2024.
- Three organisations Youth Options, Testlands and No Limits have accessed funding from the Youth Investment Fund to transform buildings to increase the capacity and quality of Youth Provision across the city. The Youth Settings benefitting from this central government funding are Mansell Park Pavilion in Redbridge, Coxford Community Centre in Lordshill and the No Limits setting in the Avenue.

Commitment: 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

Progress to date (Jan – Dec 2023)

- Regular input to PSHE coordinators network meetings of reputable sources of information, including presentations from local and national agencies offering support.
- No Limits website updated with additional drug and alcohol information and SCC Webpage content under review.
- Agreed new offer by Drug and Alcohol Support Services to educational settings which will include training to teaching staff to improve drug education within schools and develop a whole school approach.

Future Work Planned (Provisional or agreed)

- Continued input to PSHE coordinators network meetings of reputable sources of information, including presentations from local and national agencies offering support.
- Maintain Communications Plan to support national campaigns, with NHS leading where appropriate (eg. Dry January Alcohol Awareness Week, No Smoking Day, Stoptober)
- Explore options for strengthening Family Hubs support around Smokefree Families and helping people to stop smoking.
- Ongoing review of TAD content on key websites such as, Southampton City Council, Wessex Healthier Together, No Limits, Change Grow Live to ensure the TAD information is accurate.

Commitment 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.

Progress to date (Jan – Dec 2023)

- Co-located specialist drug and alcohol youth workers within the Youth Hub, working jointly with Childrens Social Care.

- Children and Young People Tobacco, Alcohol, Drugs and Vaping Needs Assessment underway to update understanding of unmet need and opportunities to improve early intervention and support.

Future Work Planned (Provisional or agreed)

- Agree and implement joint action plan in light of needs assessment to improve identification, pathways and interventions with Children's and Adult Social Care, Drug and Alcohol Support Services and others.

Commitment: 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. ***2023 Priority***

Progress to date (Jan – Dec 2023)

- Reviewing of current pathways and support via health reviews for children in care underway, with a view to improving opportunities for reducing risk and harm.
- Phoenix service was ceased in 2023 after supporting two communities of women with their complex needs around having children taken into care. Therapeutic support and substance use support is still available to these women.

Future Work Planned (Provisional or agreed)

- Review data collection for children in care to better understand health needs and harms around smoking, alcohol, drugs and vaping.
- Agree and implement joint action plan in light of needs assessment to improve identification, pathways and interventions for children in care and care leavers.

Commitment 10. Link with wider prevention and resilience work as part of the **Children and Young People's Strategy**

Progress to date (Jan – Dec 2023)

- TAD priorities for 2023 agreed by the Children and Young People's Strategic Partnership Board.
- Commitments to prevent and reduce harm from tobacco, alcohol and drugs are included in the Children and young people's Strategy and the Prevention and Early Intervention Plan.

Future Work Planned (Provisional or agreed)

- Ongoing commitment to achieving Child Friendly Southampton, overseen by the new Child Friendly Board (previously the Children and Young People's Strategic Partnership Board), will include *Healthy* as a priority in our local Child Friendly Plan.

Programme 2. Wellbeing and Housing

Part A. Health and Adult Social Care

1) 2023 Headlines

This programme has 20 commitments and 11 were prioritised for particular focus in 2023.

a) Strengths

- 14% increase in numbers of adults (18+) engaging in Drug and Alcohol Treatment and Support from March 2022
- Additional funding (Supplementary Substance Misuse Treatment and Recovery Grant (£1.07m 23/24) – SSMTRG and Rough Sleeper Drug and Alcohol Treatment Grant (£717k 23/24) - RSDATG) has supported improved reach, delivery and outcomes of Drug and Alcohol treatment and support services
- Nearly 3 times more people who smoke set a quit date through services over last 3 years (469 19/20; 1,582 22/23) and successfully quit at 4 weeks (134 19/20; 654 in 22/23).

b) Risks and issues

- Public Health, Supplemental and Rough Sleepers Treatment Grants only confirmed to 31 March 2025. These grants fund the tobacco, alcohol and drug treatment services commissioned by SCC.
- Increased circulation nationally of synthetic opioids, with increased risk of drug-related deaths

A breakdown for each commitment follows. **Part B** covers Housing and Communities, which were originally in a different directorate when the Strategy was written.

2023 Implementation Report

Commitment: 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. ***2023 Priority***
Progress to date (Jan – Dec 2023) Pathways and services mostly now in place, with the rest in active development. For example: • 69 new practitioners trained, 61 current practitioners attended CPD training, 109 practitioners attended Very Brief Advice (VBA) training - many working in these treatment pathways. • Primary Care Network (PCN) Mental Health Practitioners trained in Very Brief Advice and PCN internal pathways to their stop smoking services strengthened. Ongoing support from Southampton Smokefree Solutions (SSS). • Change Grow Live (CGL) supported to now deliver stop smoking treatment as part of drug and/or alcohol treatment. • SSS providing tobacco dependency treatment to people in hostels and hostel workforce. SCC secured free vape starter kits from OHID as a treatment option to March 2025 for people who are homeless. • 16 pharmacies (increased from 9) now offer the Locally Commissioned Service, including to people who are pregnant or have serious mental illness (SMI). • Data observatory and other sources have information split for some groups.
Future Work Planned Continue to improve and further develop support for underserved groups including: • As a key principle of allocating new 24/25 ring-fenced grant for Local Authorities for Local Stop Smoking Services only, balanced with the grant aim of increasing volume. • Exploring further wave for OHID vape starter kit scheme, as part of the full treatment pathway • Identify opportunities to strengthen tobacco dependency support in community services for mental health, learning disability and neurodiversity.

- Continue to promote sign up to the NHS Smokefree pledge to remaining PCNs. (Rest of NHS signed up).

Commitment: 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. ***2023 Priority***

Progress to date (Jan – Dec 2023)

- Personalised care is core to all service delivery with a range of opportunities for people to stop smoking**.**
- All our services are "vape friendly", i.e. can offer advice to people who prefer to stop smoking using vapes.
- Stop smoking support, including a vape offer funded through the supplemental drug grant, for CGL staff and clients
- Successful in securing free vape starter kits to supplement the treatment options for our complex needs pathways, particularly for people who are in homeless hostels.

Future Work Planned

- The new ring-fenced grant for local stop smoking services will be allocated in line with the full guidance (due end of January) and aligned with the TAD strategy, focussing on populations experiencing the highest harms from tobacco.
- Scope submissions of further bids to the national vape starter kit scheme.

Commitment: 3. Support the NHS to implement the NHS Long Term Plan commitment to offer tobacco dependency treatment for inpatients. ***2023 Priority***

Progress to date (Jan – Dec 2023)

- Regular contribution to NHS Long Term Plan (LTP) steering groups, with pathways in place for the LTP commitments for acute, maternity and mental health inpatients.
- University Hospital Southampton (UHS) Discharge pilot funded by Public Health (PH) commenced. This offers continuity of care into the community, for people who have a smokefree admission and might not cope with being signposted to separate community services.
- Discharge pathways from UHS secondary care to primary care community services have been set up for all other patients.
- Ongoing training, CPD & quality assurance provided by SSS to ensure evidence based high quality provision and reporting.
- HIOW/ICB completion of the nationally recommended "CleaR" self-assessment tool to share expertise & identify gaps.
- SCC Public Health Consultant leadership of the whole HIoW ICB Long Term Plan implementation, chairing ICB Steering Group of Trusts, Local Authorities and ICB, pending establishment of ICB posts.

Future Work Planned

- Continue to ensure effective pathways from inpatients to community support to enable a 4-week quit.
- Continue to support NHS with training, CPD and guidance on the evidence base for effective interventions to improve quality and increase quit attempts, directly and via commissioned specialist service, SSS.
- NB this area is led by NHS. Maintain strategic focus on underserved groups, whole-system approach at Place, and links to non-health settings and SCC-commissioned services.

Commitment: 4. Run campaigns to encourage people to stop smoking, including the role of e-cigarettes ***2023 Priority***

Progress to date (Jan – Dec 2023)

- January 2023 smoking cessation messages delivered as part of new year campaign.
- No Smoking Day (March 2023)
- Stoptober 2023 - month long campaign, amplifying the national assets.

- World No Tobacco Day (May 23)
- SSS supported all providers to deliver campaigns and attended local community events across the city.
- SCC website: vaping use and safe disposal advice added and promoted to all practitioners. Updated regularly with new information.

Future Work Planned (Provisional or agreed)

- Ongoing annual campaigns, amplifying national campaigns and those led by NHS as appropriate. National campaigns receiving additional national funding from 2024/25.

Commitment: 5. Review alcohol 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.

Progress to date (Jan – Dec 2023)

- Mapping of alcohol use disorder pathways from Primary Care into specialist treatment completed
- New Alcohol and non-opiate Team Leader post created and operational in Adult Drug and Alcohol Service.

Future Work Planned (Provisional or agreed)

- Adult (18+) Drug and Alcohol Health Needs Assessment planned, for completion Autumn 2024
- Drug and Alcohol Treatment Partnership (DATP) to consider and implement learning from alcohol pathway mapping to improve identification, signposting and referral routes
- Alcohol Awareness, Identification and Brief Advice training planned (Spring 2024) for frontline SCC teams and partner organisations, e.g. mental health services, DWP and others. Outcomes: improved knowledge and understanding of risks, brief advice skills and referrals into treatment.

Commitment: 6. Understand high rate of alcohol attendances/ admissions to University Hospital Southampton (UHS) ***2023 Priority***

Progress to date (Jan – Dec 2023)

- Initial work completed. High rates influenced by innovative approaches at UHS resulting in better identification, recognised nationally as good practice.

Future Work Planned (Provisional or agreed)

- Ongoing monitoring and collaboration by ICU and Public Health with UHS to maintain understanding of model and impact.
- To be part of adult needs assessment.

Commitment: 7. Run a campaign to improve awareness of alcohol harm and promote non-drinking and lower-risk drinking ***2023 Priority***

Progress to date (Jan – Dec 2023)

- Dry January campaign, Jan 2023
- Alcohol awareness week, 3-9 July 2023

Future Work Planned (Provisional or agreed)

- Dry January 2024.
- 2024/5 campaign plan to be developed with NHS and provider services. (NB Impact in this area will be through multiple actions, including the training action above).

Commitment: 8. Review how Health and Care system can increase the **identification** of Alcohol Use Disorders ***2023 Priority***

Progress to date (Jan – Dec 2023)

- Mapped pathways from Primary Care into Drug and Alcohol Treatment and Support Services for people with Alcohol use Disorders.

Future Work Planned (Provisional or agreed)

- Implement learning from pathway mapping to improve joint working between Primary Care and Drug and Alcohol Treatment and Support Services
- Strengthen pathway between South Central Ambulance Service and Drug and Alcohol Services for people attended by paramedics
- Commission Alcohol Identification and Brief Intervention training for frontline services, planned for Spring 2024, from Supplemental Grant.
- Adults needs assessment, to report by Autumn 2024, to include pathways with SCC frontline services, so impact on SCC service need and demand is understood and people get the alcohol support they need.

Commitment: 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.

Progress to date (Jan – Dec 2023)

- Background review completed previously.

Future Work Planned (Provisional or agreed)

- No further action at this stage, prioritised for later in the strategy's period of implementation and/or if new funding opportunities arise.

Commitment: 10. Develop business case and, if advantageous, secure funding for **drug care team** at University Hospital Southampton (UHS) ***2023 Priority***

Progress to date (Jan – Dec 2023)

- UHS internal business case for Drug Team completed by UHS, with input by Public Health Team and ICU.

Future Work Planned (Provisional or agreed)

- Consider SCC role in pathways involving acute trust in Adults Drug and Alcohol Health Needs Assessment

Commitment: 11. Review **harm reduction services** to increase the number of people who use them. This may include incentives, in line with national guidance

Progress to date (Jan – Dec 2023)

- Audit of Non-Fatal Overdose (NFOD) "Near Miss" Reports Southampton, 2022/23 completed
- Updated Drug-Related Death (DRD) Prevention plan drafted

Future Work Planned (Provisional or agreed)

- Adult (18+) Drug and Alcohol Health Needs Assessment planned for completion Autumn 2024
- Establish DRD Prevention Plan working group, as a sub-group of the Drug and Alcohol Treatment Partnership (DATP) to oversee and drive implementation

Commitment: 12. Review population-level needs of people who use **prescription drugs** illicitly and/or non-opiate drugs.

Progress to date (Jan – Dec 2023)

- New alcohol and non-opiate team leader post created and operational in adult drug and alcohol services.

Future Work Planned (Provisional or agreed)

- Will be part of Adult (18+) Drug and Alcohol Health Needs Assessment planned for completion Autumn 2024.

Commitment: 13. Continue response system with Hampshire and Isle of Wight to assess and respond to intelligence of increased risk from illicit supply ***2023 Priority***

Progress to date (Jan – Dec 2023)

- Continued active involvement in Hampshire Drug Information System (HDIS), run in office hours. Investigated and responded to intelligence of possible incidents in Southampton and, also, across HIoW for possible local impact.
- HDIS process annual review completed

Future Work Planned (Provisional or agreed)

- Develop 24/7 cover and Emergency Response. Current system otherwise during service office hours.
- Work across HIOW and Southeast Region to support an increase in toxicology testing of illicit substances. This will improve intelligence so we know what residents may be at risk from, particularly at a time of increasing national prevalence of synthetic opioids in the illicit drug market

Commitment: 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 ***2023 Priority***

Progress to date (Jan – Dec 2023)

- 14% increase in the number of adults accessing structured drug and alcohol treatment from 2021/22
- Alcohol Brief Intervention Telephone Line proving an effective pathway into structured treatment for people with Alcohol Use Disorders (AUD)
- Recent, evidenced improvement in continuity of care (CoC) from prison into community Drug and Alcohol Treatment and Support Services
- SCC Presentation to Office of Police & Crime Commissioner-led event on Continuity of Care from prison into community services.

Future Work Planned (Provisional or agreed)

- Meet new national targets of numbers of people in treatment
- PH and ICU continue to work regionally, and in the city to continue to improve Continuity of Care from secure estate into community drug and alcohol services.

Commitment: 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.

Progress to date (Jan – Dec 2023)

- Service outline shared with SCC Connect Team lead.
- Criminal Justice Intervention Team (CJIT) established within Drug and Alcohol Treatment and Support Services
- Draft Southampton Mental Health & Wellbeing Strategy considered by Southampton Reducing Drug Harm Partnership, chaired by SCC.
- Substance Use Social Work Team. Snapshot June-Sept 2023: contributed to 10 Multi Agency Risk Management Processes and 10 Safeguarding planning meeting processes, including domestic abuse (8), self-neglect (8), physical/sexual assault (4).

Future Work Planned (Provisional or agreed)

- Consideration begun at Adult Social Care Senior Management Team, January 2024.
- Maintain CJIT team through Supplementary Substance Misuse Treatment and Recovery Grant (SSMTRG) funding
- To be considered as part of Adults needs assessment

Commitment: 16. Ensure there is **accessible information** about tobacco, alcohol and drug use and support, supplementing national information as applicable and including easy read materials.

Progress to date (Jan – Dec 2023)

- Websites of SCC and treatment services maintained

Future Work Planned (Provisional or agreed)

- Review SCC website including Directory

Commitment: 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.

Progress to date (Jan – Dec 2023)

- Independent Peer Support Service tender process begun
- Public Involvement Leads on Southampton Reducing Drug Harm Partnership. Partnership chaired by SCC, one Public Involvement Lead is from SCC. Commissioning Standards framework identified for local use.

Future Work Planned (Provisional or agreed)

- Independent Peer Support Service to be procured in 2024
- Adult alcohol & drugs needs assessment to include qualitative insights
- Public Involvement aspects of Commissioning Standards to be incorporated into Reducing Drug Harm Partnership workplan.

Commitment: 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. ***2023 Priority***

Progress to date (Jan – Dec 2023)

- SCC continued to adhere to the Local Government Declaration on Tobacco Control, signed 2014.
- Continued to use all opportunities to encourage workforce health and wellbeing in relation to tobacco, alcohol and drugs. SSS offer training to all staff at a variety of levels, as appropriate, to promote a smokefree workforce. Occupational Health at UHS offer support for staff, from trained practitioners.
- Shared the SCC guidance on safe disposal of vapes and recycling options for staff and practitioners.
- SCC drug and alcohol staff policy developed.

Future Work Planned (Provisional or agreed)

- Continue to promote the NHS Smokefree Pledge to all NHS organisations not yet signed.
- Encourage Occupational Health leads to offer a clear pathway for staff to receive support for tobacco, alcohol and/or drugs.
- Scoping a fixed-term additional workplace-based tobacco dependency treatment pathway for SCC staff, with a focus on staff groups with higher rates of smoking and/or who support client groups with higher rates of smoking.

Commitment: 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.

Progress to date (Jan – Dec 2023)

- Completed audit of Non-Fatal Overdose (NFOD) “Near Miss” Reports Southampton, 2022/23.
- Maintained data observatory and contract monitoring.

- Needs assessment of children and young people underway, including vaping.

Future Work Planned (Provisional or agreed)

- Childrens' and young peoples' needs assessment to be finished
- Adult (18+) Drug and Alcohol Health Needs Assessment planned for completion Autumn 2024

Commitment: 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

Progress to date (Jan – Dec 2023)

- SCC Public Health represented on Faculty of Public Health Drugs Special Interest Group (SIG)
- SCC Public Health participation in UK Anti-Stigma Network
- SCC presentations and information presented to Association of Directors of Public Health, South East Public Health Conference, Chamber UK and LGA.

Future Work Planned (Provisional or agreed)

- Opportunistic, depending on capacity.

Part B. Housing and Communities

1) **2023 Headlines**

This programme has 7 commitments; 3 were prioritised for particular focus in 2023.

Strengths

- Drug Testing on Arrest interventions piloted and now embedded, increasing identification of harmful use of drugs and supporting engagement with Drug and Alcohol Treatment and Support.
- Co-ordinated response between SCC teams (Community Safety, Public Health, ICU) and Drug and Alcohol Treatment and Support Services to address drug related anti-social behaviours.
- Collaboration with Police and Office of Police and Crime Commissioner.

Risks and issues

- Perceived, and evidenced, increase in alcohol and drug-related anti-social behaviour and other harm.

2) **2023 Implementation Report on each commitment**

Commitment 1. Work with the Fire Service on **fire prevention**

Progress to date (Jan – Dec 2023)

- Fire service contact identified; meeting being arranged to cover smoking, alcohol and drugs.

Future Work Planned (Provisional or agreed)

- Exploratory work to understand opportunities, strengthen prevention and referral pathways and align strategic approaches.

Commitment 2 (alcohol) & 3 (drugs) Review opportunities for diversion from criminal justice into treatment ***2023 Priority***

Progress to date (Jan – Dec 2023)

- Drug testing on arrest provision and pathway in place, including new lead worker in police custody and evidence of positive outcomes.
- Increased number and trend of people subject to Drug Rehabilitation Requirement (DRR) and Alcohol Treatment Requirement (ATR) community sentences.

- Senior police leadership on Reducing Drug Harm Partnership (RDHP), including as Deputy Chair and theme lead.
- Office of Police and Crime Commissioner representation on Reducing Drug Harm Partnership (RDHP)

Future Work Planned (Provisional or agreed)

- Planned review of Conditional Cautioning data and provision
- To be part of Adults drug & alcohol needs assessment, planned to report Autumn 2024

Commitment: 4. Link prevention and treatment pathways with police and criminal justice system enforcement

Progress to date (Jan – Dec 2023)

- Criminal Justice Intervention Team (CJIT) established and working closely with National Probation Service, local prisons and police.
- Drug Testing on Arrest (DToA) piloted. New DToA worker recruited, provision established, referrals increasing.
- Improvements made to continuity of care from prisons to community drug and alcohol treatment
- Further work embedded in Reducing Drug Harm Partnership (RDHP) plan

Future Work Planned (Provisional or agreed)

- Will be part of Adults needs assessment
- Deliver SCC-parts of Reducing Drug Harm Partnership delivery plan

Commitment: 5. 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. ***2023 Priority***

Progress to date (Jan – Dec 2023)

- Ongoing joint working
- Improved reporting and auditing mechanisms for Drug Related Litter
- Coordinated work on anti-social behaviour in city centre, for example, a multi-agency response to drug-taking related challenges in St Mary's

Future Work Planned (Provisional or agreed)

- Maintain collaboration

Commitment: 6. Support **community champions** to be able to share information and influence tobacco, alcohol and drug-related harm

Progress to date (Jan – Dec 2023)

- Public health leads for tobacco, alcohol and drugs attended Community Champions Meetings to hear and respond to their views on TAD and related issues

Future Work Planned (Provisional or agreed)

- To be scoped

Commitment: 7. 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. ***2023 Priority***

Progress to date (Jan – Dec 2023)

- Homeless Prevention Strategy under development
- Exploratory discussions to identify staff training needs and pathways for tobacco dependency support.
- Included in RDHP Delivery Plan

Future Work Planned (Provisional or agreed)

- Alcohol Awareness, Identification and Brief Intervention training for frontline services, including 'Housing' and 'Homelessness' planned for Spring 2024
- To be included in Adults Drug and Alcohol Health Needs Assessment

Programme 3. Place

1) 2023 Headlines

This programme has 12 commitments, of which 4 were prioritised for particular focus in 2023Good progress made in Planning and in aligning SCC Festival and Events Strategy with TAD objectives. Licensing and Trading Standards investigations and enforcement continue too, with a significant growth in illegal vapes and underage vape sales. The pace and scale of our work is limited by resources.

2) 2023 Implementation Report on each commitment:

Commitment: 1. Encourage **smoke-free public places** frequented by children, young people and families including parks, school gates and other places.
Progress to date (Jan – Dec 2023)
Future Work • Support Family Hubs to be smoke-free including embedding tobacco dependency treatment

Commitment: 2. Support the public sector and wider employers to be s**mokefree** sites and organisations.
Progress to date (Jan – Dec 2023) • Encouraged and supported NHS organisations to sign the NHS Smokefree Pledge, including Central Primary Care Network, Woolston & Townhill Primary Care Network and University Hospital NHS Trust (in preparation). The PCNs were the first PCNs to sign nationally. Support also provided to NHS Solent and Southern Health NHS Trust to maintain their existing NHS Smokefree Pledge.
Future Work • Maintain SCC sites as smokefree, continue to support NHS to be smokefree and use smokefree sites as an example in wider "Anchor Institutions" / Health in all policies work

Commitment: 3. Use Trading Standards powers and approaches to identify and reduce illicit tobacco, underage sales and non-compliant e-cigarettes, as applicable ***2023 Priority***
Progress to date (Jan – Dec 2023) • Routine underage tobacco, alcohol & vape sales test purchasing continues, with several successful raids on underage sales and over 2,600 unlawful vapes seized April 23 – Jan 24. • Trading Standards active in cross-council vaping work, e.g. vaping group, response to the government's "call for evidence" on youth vaping and consultation on "Smokefree Generation" policy proposals.
Future Work • Maintain investigations, within limits of capacity • Understand any local impact of forthcoming national illicit tobacco funding, mostly going to HMRC.

Commitment: 4. Use and enforce the licensing policy ***2023 Priority***
Progress to date (Jan – Dec 2023) • Statement of Licensing Policy runs 2012-2026 • Director of Public Health represented and consulted on licensing applications and activity
Future Work • Continue to use and enforce the licensing policy • Continue to ensure Director of Public Health involvement

Commitment: 5. Review opportunities for **alcohol-free public places** including places frequented by children.
Progress to date (Jan – Dec 2023)
Future Work

Commitment: 6. 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 ***2023 Priority***
Progress to date (Jan – Dec 2023) • DASH (No Limits) scoping out-reach to night-time economy • SCC Festival and Events Strategy developed in alignment with TAD strategy
Future Work • Festival and Events Strategy working group will consider TAD in future event planning

Commitment: 7. Identify ways to welcome new business to the **late-night economy** that do not serve alcohol and are attractive to a range of ages
Progress to date
Future Work

Commitment: 8. Keep the need and feasibility of **sharps bins** under intermittent review.
Progress to date (Jan – Dec 2023) • A cross-council group considers drug-related litter, including whether sharps bins are warranted.
Future Work • Continue to keep under review

Commitment: 9. Use the **Local Plan** and associated policies to design-out spaces that enable anti-social behaviour or crime.
Progress to date (Jan – Dec 2023) • Planning applications continue to be assessed against policies of the adopted Development Plan including *Policy CS13 – Fundamentals of Design*, particularly criterion 10 which states developments should "Place 'people first', designing out the risk of crime and promoting development at a human scale". Where planning applications do not meet the requirements of this policy, Planning Officers can use this to leverage improvements to the application through negotiations with the applicant. If the application does not deliver the necessary improvements then this could be used as justification for refusing the proposals. • Consultation on the Draft Plan with Options version of the new Local Plan, known as the Southampton City Vision, concluded on 3rd January 2023. • The Draft Plan includes the new *Policy DE1 – Placemaking and Quality of Development* which will replace the current Policy CS13. The new policy requires development to comply with various criteria, including criterion 17 which states "Create safe, secure, welcoming and attractive spaces, streets, landscaping, access and buildings which encourage positive social interaction and natural surveillance through layout, the positioning of building entrances and windows of habitable rooms, appropriate lighting, and other

measures to design out crime, including the location of car and cycle parking; and avoid opportunities for concealment and unobserved means of escape."
- Planning Policy Officers have been reviewing and analysing the responses to the consultation and published a summary of this analysis on 15th January 2024.

Future Work
- Planning Policy Officers will now use the results of the consultation and relevant evidence documents to select options for policies and make any necessary changes to the wording of policy text. These will then be collated into a final Pre-Submission version of the City Vision that will be subject to a further round of public consultation.
- The Government intends to introduce National Development Management Policies (NDMPs), most likely in 2024. It is not yet clear what the NDMPs would cover. They could include matters such as designing-out crime. Planning Policy Officers will review the NDMPs once published to understand any implications for the Local Plan. The Local Plan is not allowed to substantially repeat or vary from an NDMP.

Commitment: 10. Support the work of the Employment Support Team, and others, who support people with long term unemployment into work (alcohol & drugs) ***2023 Priority***

Progress to date (Jan – Dec 2023)
- Employment support team working collaboratively with drug and alcohol treatment services to deliver Individual Placement Service (IPS). 24 job starts reported in 2022/23, 33 in 2023/24 up to end Q3.

Future Work
- Will continue into 2024/25 (Until March 2025 when the funding concludes)
- Contribution to plan to be integrated within the Inclusive Growth Action Plan (currently in draft) and Social Value Action Plan (Draft)
- Employment is also a key commitment in the multiagency Southampton Reducing Drug Harm Partnership delivery plan.

Commitment: 11. Scope strategic approach to licensed **events** including harm minimisation

Progress to date (Jan – Dec 2023)
- SCC Festival and Events Strategy developed in alignment with TAD strategy

Future Work
- PH represented on working group to inform future events

Commitment: 12. 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

Progress to date (Jan – Dec 2023)
- SCC Festival and Events Strategy developed in alignment with TAD strategy

Future Work
- Explore the potential to strengthen smokefree and alcohol-free policies within future leisure contracts
- Identify if there are any opportunities to strengthen pathways between leisure services and tobacco, drug and alcohol treatment and recovery services

Programme 4. Corporate Services, Strategy and Performance

1) 2023 Headlines

This programme has 12 commitments, of which 4 were prioritised for particular focus in 2023. The SCC Drug and Alcohol Workforce Strategy (DAWP) was written and approved, aligned with the TAD strategy. However, limited resources available, including officer capacity, to develop and deliver training to support implementation

2) 2023 Detailed Implementation Report

Commitment: *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* ****2023 Priority****

Progress to date (Jan – Dec 2023)

- Public Health briefing to newly elected members updated and delivered by Director of Public Health October 2023.
- Local Government Pension Scheme, as run by Hampshire Pension Service, already now includes advice to pension managers to recognise the risk of investing in tobacco.

Future Work Planned (Provisional or agreed)

- Maintain annual briefing for newly elected members and prepare communications plan for all elected members and staff, with a focus on reporting any contact from the tobacco industry.

Commitment: *2. Support NHS commitment to be Smokefree* ****2023 Priority****

Progress to date (Jan – Dec 2023)

- Southampton Health & Care Strategy Commitment
- Supported implementation of NHS Long Term Plan in Southampton, with active membership on Trust and ICB steering groups.
- Encouraged and supported local NHS organisations to sign the NHS Smokefree Pledge, e.g. Central PCN, Woolston & Townhill PCN, UHS pending. Also supported NHS Solent and Southern Health NHS Trust to maintain their Pledge. Joint presentation of work with Central PCN to regional Public Health Conference.
- Commissioned Southampton Smokefree Solutions to support frontline health and care services with training, continuing professional development and quality assurance, so we have sound provision and reporting.
- Developed stop smoking pathways from secondary to primary care, for inpatients being discharged.
- Ongoing monitoring of public health-funded NHS tobacco dependency services, with sharing of good practice.
- No Smoking Day and Stoptober campaigns supported and delivered.

Future Work Planned

- Explore opportunities for closer collaboration with Hampshire County Council for cross-border issues affecting local NHS organisations.

Commitment 3. Support **wider stakeholders** to be smokefree and influence pension investments by leading by example if possible.

Progress to date (Jan – Dec 2023)

- Promoted and celebrated the signing of NHS Smokefree Pledge and Local Government Declaration on Tobacco Control
- Highlighted the benefits of being a smokefree organisation and supporting these initiatives with local organisations.
- Local Government Pension Scheme, as run by Hampshire Pension Service, already now includes advice to pension managers to recognise the risk of investing in tobacco.

Future Work

- Maintain our Local Government Declaration on Tobacco Control and support wider stakeholders on an opportunistic basis.

Commitment: *4. Maintain advertising guidance on Alcohol* ****2023 Priority****

Progress to date (Jan – Dec 2023)

- Maintained - Adverts which *promote the sale or consumption of alcohol or tobacco, or other products deemed significantly harmful to health and/or communities* are not allowed Advertising guidance (southampton.gov.uk)

Future Work

- Maintain current advertising policy

Commitment: 5. Promote a **positive cultural norm** of healthier ways of connecting, socialising and relaxing, including in internal communications and the workplace.

Progress to date (Jan – Dec 2023)

- Incorporated within health and being work with staff.
- SCC Drug and Alcohol Workforce Strategy (DAWP) designed and approved, development and content informed by and aligned with TAD approach.

Future Work

- To be considered in future strategic and workforce well-being planning

Commitment: 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.

Progress to date (Jan – Dec 2023)

- Planned to start next year.

Future Work

- Incorporate into wider review of Equality Impact Assessments, as part of Health in all Policies approach**.**

Commitment: 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.

Progress to date (Jan – Dec 2023)

- Planned to start next year

Future Work

- Incorporate into wider review of Social Value Act, as part of Health in all Policies approach**.**

Commitment: 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.

Progress to date (Jan – Dec 2023)

- SCC Drug and Alcohol Workforce Policy (DAWP) designed and approved
- Services promoted to staff through internal communications channels including wellbeing bulletins.

Future Work

- Training for workforce and managers to prepare for, and support, DAWP implementation in development. The Policy is due to be implemented 1.4.24
- Alcohol Awareness and Identification and Brief Advice training planned for Spring 2024, primarily for frontline services and is also open to managers.
- Scope feasibility of a specific tobacco dependency campaign and treatment offer to staff

Commitment: *9. Supporting Elected Members in their health-promoting role* ****2023 Priority****

Progress to date (Jan – Dec 2023)

- New member induction
- Briefings, updates, and responses to queries provided for elected members relating to vaping and young people, safe disposal of vapes, national consultations, drugs, and alcohol.
- SCC responded to the government's "call for evidence" and the Smokefree Generation consultation.
- Elected member membership on Reducing Drug Harm Partnership (RDHP)

Future Work

- Maintain support to Elected Members

Commitment: 10. Support wider stakeholders to be **health-promoting settings**.

Progress to date (Jan – Dec 2023)

- Strategic opportunities for Health in all policies and "Anchor institutions" work highlighted to partners
- Commission Southampton Smokefree Solutions to run an Alliance for Tobacco Dependence Advisors
- NHS supported to be Smokefree

Future Work

- Alcohol Awareness, Identification & Brief Intervention training for frontline services planned for Spring 2024
- In general, to be led through wider work on Health in all policies and Anchor Institutions.

Commitment: 11. **Apply learning** from the "Health in all policies" approach of this strategy to other issues.

Progress to date (Jan – Dec 2023)

- The first phase of work towards embedding a Health in all policies (HiAP) approach in Southampton began in April 2023
- The overall framework for embedding a HiAP approach in Southampton comprises action in three areas: process, programmes, and strategic joint action.
- The TAD Strategy is an example of strategic joint action to embed HiAP and is a key case study enabling other SCC teams' awareness of what HiAP can look like in practice.

Future Work

- Continue to collate learning from this example of strategic joint action and share through the wider HiAP programme to apply to other drivers of health and health inequality in Southampton.

Commitment: 12. Support the public sector and wider employers with example **Human Resources policies.**

Progress to date (Jan – Dec 2023)

- Future priority

Future Work

- Anticipated in later years of this strategy.

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Appendix 3

Annual report on work on vaping in 2023

Southampton City Council is committed to reducing tobacco-related harm, as outlined in the Tobacco, Alcohol and Drugs strategy. Part of this response is the use of nicotine e-cigarettes/vapes as an evidence based tool for stopping smoking, recommended by NICE Recommendations on treating tobacco dependence | Tobacco: preventing uptake, promoting quitting and treating dependence | Guidance | NICE

For people who smoke, switching to vaping can be an effective tool and less harmful than tobacco. During 2020 to 2021 vaping was nationally associated with the highest rates of successful quits. Nicotine vaping in England: 2022 evidence update main findings - GOV.UK (www.gov.uk)

A recent Cochrane review (January 2024) reported that nicotine e-cigarettes can help people to stop smoking for at least six months. Evidence showed they worked better than nicotine replacement therapy, and probably better than e-cigarettes without nicotine. Electronic cigarettes for smoking cessation - Lindson, N - 2024 | Cochrane Library

Public Health advice remains clear that for adults who smoke, switching to vaping can be an effective tool and less harmful than tobacco, however, if you do not smoke, do not vape – whatever your age. It is not completely harmless, and the long-term effects are unknown.

Safe disposal of single use vapes. Working in collaboration with the council Waste Management and Communications teams, clear messaging has been shared regarding the safe disposal of all vapes. This encourages people to dispose of vapes safely by returning them to a vape retailer or taking them to a dedicated collection point at your local Household Waste Recycling Centre Household Waste Recycling Centre.. More and more big retailers now also have collection points. The importance of never throwing vapes in household waste or recycling bins, as they can cause serious fires, hurt crews and slow down bin collections has been highlighted.
https://www.recycleyourelectricals.org.uk/

Trading Standards have carried out several raids to seize illicit vapes and where products have been sold underage.

Southampton city council activity during 2023 included:

- Monitoring research, data, government debates & committees, position statements, media announcements, responding to queries.
- Tobacco, alcohol, drugs and vaping in young people needs assessment carried out.
- Establishing a cross council vaping group with the purpose of:
    - To better understand the rapidly developing agenda
    - To identify and prioritise the key issues (young people)
    - To share intelligence and respond to ongoing queries
- Coordinating a council response to government consultation on “Creating a smokefree generation and tackling youth vaping” Creating a smokefree generation and tackling youth vaping consultation: government response - GOV.UK (www.gov.uk)

- Continuing Professonal Development to the PSHE Network and training for teachers, Education Oversight group updates, presentations to Headteacher forums.
- Commissioning training for Health and Care Practitioners, delivered by Southampton Smokefree Solutions.
- Co-production of resources on the safe disposal of vapes for practitioners and organisations across the city.
- Contribution to national, regional & local resources and guidance, including information for schools.
- Sharing regular updates on sources of support, guidance & resources for local schools
- Successful bid for national Swap2Stop scheme providing free vape kits to groups with higher smoking prevalence and unmet need.