Public Document Pack

Health and Wellbeing Board

Wednesday, 11th December, 2024
at 5.30 pm

Conference Room 3 and 4 - Civic Centre

This meeting is open to the public

Members

Councillor Finn (Chair)

Councillor Houghton

Councillor Laurent

Councillor McManus

Councillor Winning

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)

Suki Sitaram– Healthwatch

Dr Sarah Young – Clinical Director, Southampton Place Hampshire and Isle of Wight Integrated care Board, (Vice Chair)

Vacancy – Mental Health Clinician

Dr Michael Roe – Local Paediatrician

Dr Trevor Smith – Deputy Chief Medical Officer at University Hospital Southampton NHS Foundation Trust;

Contacts
Emily Goodwin
Democratic Support Officer
Tel: 023 8083 2302
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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 2024/2025

24 July 2024
4 September 2024
11 December 2024
5 March 2025

CONDUCT OF MEETING

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

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

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

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

DISCLOSURE OF INTERESTS

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

DISCLOSABLE PECUNIARY INTERESTS

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

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

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

Other Interests

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

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

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

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

Principles of Decision Making

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

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

In exercising discretion, the decision maker must:

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

AGENDA

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

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

2 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 4 September 2024 and to deal with any matters arising, attached.

5 PHARMACEUTICAL NEEDS ASSESSMENT

Report of the Director of Public Health outlining the statement of the needs for pharmaceutical services in Southampton.

6 HEALTH PROTECTION ANNUAL REPORT

Report of the Director of Public Health outlining the Health Protection Annual Report which provides assurance of delivery of the local health protection function in Southampton.

7 DIRECTOR OF PUBLIC HEALTH - ANNUAL REPORT

Report of the Director of Public Health outlining the contents of the DPH Annual Report.

Tuesday, 3 December 2024 Director – Legal and Governance

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HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 4 SEPTEMBER 2024

Present: Councillors Finn (Chair), Houghton, Laurent, McManus and Winning
Suki Sitaram, Debbie Chase, Robert Henderson, Dr Sarah Young (Vice-Chair), Dr Michael Roe, Claire Edgar and Dr Tevor Smith

Apologies: James House

Also in attendance: Rob Kurn, Kate Concannon

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

RESOLVED : that the Minutes of meetings held on 13 March 2024 and 24 July 2024 be signed as a correct record of the neetings

7. **UPDATE FROM SOUTHAMPTON CARERS PARTNERSHIP BOARD**

The Board received a briefing from the Carers Partnership Board.

Andy Scorer and Claire May-Molinero were present and with the consent of the Chair addressed the meeting.

The Board discussed an number of issues including:

- The activities of the Carers Partnership Board;
- The priorities of the Carers Action Plan;
- The importance of collaboration with and inclusion of Carers when designing services to help design services in coproduction with those that require the services and not impose a service on them;
- The need for hospitals and doctors surgeries to be more aware of the difficulties that changing or cancelling appointment may have on carers;
- Support for young carers between 18-25 years of age. It was acknowledged that more work on aiding young people to transition from young carers to adult cares was required;
- The significant economic costs to both the City and to the indivdual in ensuring that people can best fulfil their caring rules and take an active part in the community;
- The amount of change within the local system with the development of the Integrated Neighbourhoods Team and the need to ensure that support for carers.

Board Members what actions they would take back to their organisation following the presentation members listed a number of actions including:

- Wendy Rees, Southern Health, committed to look at how Southern Health can take the impact on carers into account when appointments are moved.

- Dr Sarah Young, Integrated Care Board (ICB), committed to refresh good practice guidance for GP surgeries and encourage them to share good practice

in the City as a means of driving improvement. Dr Young will also ensure co-production of the new Integrated Neighbourhood Teams work.

- Councillor Winning felt that as a large employer, the City Council must be carer-friendly. As such Cllr Winning would like to ensure that the Local Authority has embedded support for unpaid carers in the City Council workforce, which would result in a happier and healthier workforce.

- Trevor Smith, University Hospitals Southampton, committed to look at the process for short term cancellation of operations in hospital and the impact this has on carers and in doing so will also link with the University Hospitals Southampton Carers' forum.

- Debbie Hendry, Unpaid Carers Support Southampton, would like to return and update the Board on the work being done by their service.

- Kate Concannon, Principal Social Worker for Adult Services committed to work on a 'menu' of carers breaks (supported by Accelerated Reform Funding), look at how to better support carers at the hospital via the Accelerated Reform Funding, identify young carers who care for people known to Adult Social Care, update the Adult Social Care 'Who's Who' and share widely, increase the uptake of carers training for Adult Social Care Staff, look at the role of Carers' Champion in new Adult Social Care teams. It was noted that although not a board member but had attended for the purposes of this item.

- Dr Debbie Chase, Director of Public Health, committed to work with Dr Sarah Young to contribute to the work around the Integrated Neighbourhoods Team.

- Jamie Schofield, Integrated Commissioning Unit, committed to encourage the ICB to have a lead for carers. He will also encourage the ICB to revisit strategically where the Carers' Forum fits into the wider system, as a co-produced piece of work. (Jamie is not a board member but attended for this item).

- Rob Kurn, Southampton Voluntary Services, committed to raise awareness of unpaid carers, continue to take referrals in through SO:Linked and share information on the 'Next Steps' transitions service for young people moving into adulthood. He also explained that the SVS programme 'Coproduction Corner' helps organisations in the City by showing how they can facilitate coproduction of services in the City.

- Rob Henderson, Executive Director of Children's Services & Learning (DCS) agreed with the commitments made by Kate Concannon and Jamie Schofield, and emphasised the importance of coproduction and work around transition.

- Claire Edgar, Executive Director for Wellbeing (DASS) emphasised the importance of promoting the work around carers in the city, and making sure that young carers are known to adult social care.

- Mike Roe raised that young carers often do not go to university because they are caring. Debbie Hendry confirmed that Unpaid Carers Support Southampton are addressing this and supporting young carers in this area specifically.

RESOLVED:

1. Noted the presentation and update from the Carers Partnership Board; and
2. Agreed the support that members of the Health and Wellbeing Board to progress the priorities of the Carers Partnership Board.

8. **OUTCOME OF LOCAL AREA SPECIAL EDUCATIONAL NEEDS AND DISABILITIES (SEND) AREA INSPECTION**

Board Members considered the report of the Cabinet Member for Children and Learning detailing the outcome of the recent investigation into the provision of Special Educational Needs in the City.

The Board were briefed by the Executive Director for Children and Learning who acknowledged that the report was fair and its findings fell in lie with known areas of required improvement within the service. It was noted that there is a strain on provision of these services nationally and that overall the local services were performing better than a number of authorities. However the report had highlighted that there was work to be done. The Executive Director and the Cabinet Member accepted this and set the out what steps that needed to be addressed. It was noted that the authority needed to commit to the actions and cultural requirements set out in section 5 of the report.

It was explained that regionally authorities were coming together in a workshop to attempt to find solutions that would be exchanging examples of best practice and develop ways to deliver improvements regionally.

Resolved:

1. That the inspection feedback is noted
2. That the action plans in development are noted
3. That Health and Wellbeing Board partners as strategic leaders for the system commit to the actions and cultural change required to deliver the areas of improvement

9. **PARTNERSHIP APPROACH TO HEALTHY, SUSTAINABLE FOOD**

The Board considered the report of the Cabinet Member for Adults and Health detailing the recommendations to support the development of a City-wide food partnership, provide system leadership and oversight.

The Board received a presentation detailing a number of issues including:

- The health, economic, environmental and social imperatives to the City and globally of the current food system. Officers detailed the complexity of the current system and stressed that changing it would only be possible with a group actions;

- What were the potential of a food partnership approach could give the City and how its scope could achieve a betterment to the residents economically, socially and environmentally;
- The ability to reduce duplications overlap and waste within the system;
- How the partnership approach would amongst other benefits enable access to funding, greater economies of scale, increase community aware and resilience; and
- Organisations already involved in the Partnership.

RESOLVED:

1. Health and Wellbeing Board members support the development and growth of the city-wide food partnership, including a bid to become a Sustainable Food Place member.
2. Health and Wellbeing Board members provide system leadership by promoting food partnership efforts in their own respective organisations and encouraging active contribution to the food partnership.
3. The Health and Wellbeing Board provides a degree of governance and oversight by reviewing the progress of the City-wide food partnership in 12 months' time.

DECISION-MAKER:	Health & Wellbeing Board
SUBJECT:	Pharmaceutical Needs Assessment
DATE OF DECISION:	11th December 2024
REPORT OF:	COUNCILLOR MARIE FINN CABINET MEMBER FOR ADULTS AND HEALTH

CONTACT DETAILS				
Executive Director	**Title**	Interim Executive Director of Community Wellbeing, Children and Learning (DASS and DCS)		
	Name:	Rob Henderson	Tel:	
	E-mail:	robert.henderson@southampton.gov.uk		
Author:	**Title**	Director of Public Health		
	Name:	Dr Debbie Chase	Tel:	023 80
	E-mail:	debbie.chase@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY
N/a

BRIEF SUMMARY

The Health and Wellbeing Board has a statutory responsibility to publish a statement of the needs for pharmaceutical services of the population in its area, referred to as a Pharmaceutical Needs Assessment (PNA). This briefing defines what is needed to do this and the steps we are taking to ensure this is in place.

This briefing summarises the draft PNA report that will form the basis of a 60-day statutory consultation.

The main finding in the PNA draft report is that, in Southampton, the number, distribution and choice of pharmaceutical services meet the current and future needs of the population Therefore, there is no identified need for improvements or better access to pharmaceutical services in the city.

The HWB is asked to approve the PNA draft report for consultation. The consultation will identify if endorsed by the majority of the consultation responses.

RECOMMENDATIONS:		
	(i)	To approve the draft PNA for consultation.

REASONS FOR REPORT RECOMMENDATIONS	
	The PNA draft report has been prepared using national guidelines, following a process agreed by the HWB and with guidance from the PNA steering Group. Conducting the PNA has involved a thorough assessment of current pharmaceutical services and the need for these services, both now and in the

	future. This has lead to the conclusion that there is no identified need for improvements or better access to pharmaceutical services in the city. As due process has been followed in order to draft the PNA and reach this conclusion, it is recommended that the HWB now approves the draft report for consultation.
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
	N/a
DETAIL (Including consultation carried out)	
	Summary of PNA report The PNA draft report is split into two parts – Part A is the main report and Part B contains the Appendices. The main report defines the different types of pharmacies and pharmaceutical services alongside the current provision of these in Southampton, which has 38 community pharmacies. It then comprehensively considers temporal access to pharmaceutical services by looking at opening hours and geographical access by looking at the distribution of pharmacies and their catchments areas via various means of transport. Assessment of the needs for pharmaceutical services in Southampton is underpinned by a wealth of demographic, economic and health data which is contained as a supporting Appendix in Part 2 as well as being summarised in the main report. All the information collated for the PNA informs a 'gap analysis' which covers the current situation and the future, based on anticipated levels of development and associated population growth. The initial consultation with pharmacy contractors surveyed service provision. Despite only 13 responses of the 38 pharmacies, the responses illustrate no identified need for improvements or better access. We will be considering reopening the survey with the aid of the local pharmacy committee to improve response rates for a more complete data set of responses, however the initial responses have given us enough data to determine if there are any gaps The conclusion of the PNA is that, in Southampton, the number, distribution and choice of pharmaceutical services meet both the current needs of the population and future needs within the lifetime of this PNA. Therefore, there is no identified need for improvements or better access to pharmaceutical services in the city. This conclusion is based on the following observations: • There is a good geographical spread of community pharmacies across the city. • Almost all of Southampton's population is within a 1.6km straight line distance of a community pharmacy. There are two exceptions to this but, more detailed analysis has led to the conclusion that neither indicates a gap in pharmaceutical provision

	• There are 14.8 community pharmacies per 100,000 population in Southampton, which is very similar to the average for neighbouring areas and is broadly in line with the national average • Over 98% of the Southampton population are within a 20-minute walk of a community pharmacy • With three 100-hour pharmacies in Southampton, supplementary hours in other pharmacies and provision in neighbouring HWB areas, there are sufficient access times to meet the needs of the city's residents • All pharmacies provide the full range of essential pharmaceutical services • There is good provision of advanced services across the city Next steps • Once the PNA draft report has been approved by the HWB, the next step is a statutory 60-day consultation with a specified range of organisations. The consultation is planned for 60 days between January to April 2025. In order to gain views of all stakeholders and users of pharmaceutical services in the city, this will be a public consultation. • Following this, consultation responses will be considered, a consultation report will be written (and included as an appendix to the PNA) and the PNA main report will be amended if appropriate. • It should be noted that if, as a result of the consultation, a need for improvements or better access to pharmaceutical services is identified, then there will need to be a second period of consultation, although this does not have to be for 60 days. • The final version of the PNA will then be taken to the HWB after the consultation has end and before October to gain approval to publish in advance of the statutory deadline of 1st October 2025.
RESOURCE IMPLICATIONS	
Capital/Revenue	
	None
Property/Other	
	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
	There is a legal duty to undertake this work as part of the NHS (Pharmaceutical & LPS) Regulations 2013, which result from the amended Health Act 2009.
Other Legal Implications:	
	None
RISK MANAGEMENT IMPLICATIONS	
	If the draft PNA report is not adopted by the HWB at its December meeting, then the timetable for production of the final PNA is at risk. Failure to publish

	the final PNA by 1st October 2025 (in a form that complies with the minimum requirements set out in the 2013 regulations) presents a risk of judicial review. It should be noted that the five-year national Community Pharmacy Contractual Framework arrangement which was agreed in the summer of 2019 ended on the 1st April 2024. Negotiations on the arrangements for the current financial year – 2024/25 – are still in progress between Community Pharmacy England, the Department of Health and Social Care (DHSC) and NHS England. Until these negotiations have concluded, existing service arrangements will continue as previously announced.
POLICY FRAMEWORK IMPLICATIONS	
	None

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices	
1.	Draft Pharmaceutical Needs Assessment parts 1 and 2

Documents In Members' Rooms

1.	
2.	
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.		
2.		

Southampton Pharmaceutical Needs Assessment (PNA) Part 1: Main report

Last updated November 2024

Contents

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Part 2 is a separate document containing:

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

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1. Executive summary

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

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

The PNA defines the different types of pharmacies and pharmaceutical services alongside the current provision of these in Southampton, which has 38 community pharmacies as of September 2024.

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

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

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

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

This conclusion is based on the following observations:

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

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

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

- There are 14.8 community pharmacies per 100,000 population in Southampton, which is very similar to the average for neighbouring areas and is broadly in line with the national average (Section 7.7)
- Over 99% of the Southampton population are within a 20-minute walk of a community pharmacy (Section 7.5)
- With three 100-hour pharmacies in Southampton, supplementary hours in other pharmacies and provision in neighbouring Health and Wellbeing Board areas, there are sufficient access times to meet the needs of the city's residents (Section 6)
- All pharmacies provide the full range of essential pharmaceutical services (Section 5.6)
- There is good provision of advanced services across the city (Section 5.7)
- There are a range of enhanced and locally commissioned services delivered in the city (Sections 5.8 and 5.9)
- A large proportion of community pharmacies provide a delivery service to residents, including housebound patients (Section 5.9.7)
- Since the COVID-19 pandemic there has been a marked increase in the use of distance selling pharmacies (Section 5.2)
- In Southampton, fewer items are dispensed per pharmacy than in neighbouring areas or nationally suggesting that demand is being met (Section 7.7)

It should be noted that the five-year national Community Pharmacy Contractual Framework arrangement which was agreed in the summer of 2019 ended on the 1st April 2024. Negotiations on the arrangements for the current financial year – 2024/25 – are still in progress between Community Pharmacy England, the Department of

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Health and Social Care (DHSC) and NHS England. Until these negotiations have concluded, existing service arrangements will continue as previously announced.

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2. Introduction

2.1 Definition and purpose of the PNA

Production of a Pharmaceutical Needs Assessment (PNA) is a statutory requirement for each local Health and Wellbeing Board (HWB) every three years or more frequently.[1]

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

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

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

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

2.2 Historical and Legal Background

The Health Act 2009 [2] sets out the minimum standards for PNAs and the use of PNAs as the basis for determining market entry to NHS pharmaceutical services provision.

[1] Department of Health, Pharmaceutical Needs Assessment, Information pack for local Health Authority Health and Wellbeing Boards, May 2013. Pharmaceutical Needs Assessment Information Pack (publishing.service.gov.uk) (accessed 10/10/2024)

[2] National Health Service Act 2009 available at http://www.legislation.gov.uk/ukpga/2009/21/contents (accessed 10/10/2024)

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The Regulations came into force in May 2010 and required Primary Care Trusts (PCTs) to develop and publish their first PNA under these Regulations by 1 February 2011.

The Health and Social Care Act 2012[3] brought about major reforms to the NHS. From April 2013, PCTs were abolished, and their duties transferred to other organisations. Responsibility for developing, updating and publishing a local PNA was transferred to HWBs. In addition, this Act also transferred the responsibility of using the PNA as the basis for determining market entry to a pharmaceutical list and dispensing doctor list from the PCT to NHS England.

The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013[4] set out the legislative basis for developing and updating PNAs. The National Health Service (Pharmaceutical and Local Pharmaceutical Services (Amendment and Transitional Provision) Regulations 2014[5] have been published to amend these regulations following a report published by the Joint Committee on statutory instruments. More recently, The NHS (Pharmaceutical and Local Pharmaceutical Services) (Amendment) Regulations 2016 were published.

The first PNA to be produced by the Southampton HWB was published on 1 April 2015 to comply with these regulations. An updated report was published by the HWB on 19 July 2022.[6]

[3] Health and Social Care Act 2012 available at http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted (accessed 10/10/2024)

[4] The NHS (Pharmaceutical Services and Local Pharmaceutical Regulations) 2013 available at http://www.legislation.gov.uk/uksi/2013/349/contents/made (accessed 10/10/2024)

[5] The National Health Service (Pharmaceutical and Local Pharmaceutical Services) (Amendment and Transitional Provision) Regulations available at http://www.legislation.gov.uk/uksi/2014/417/contents/made (accessed 10/10/2024)

[6] Southampton PNAs are available at https://data.southampton.gov.uk/health/pharmaceutical-needs-assessment/ (accessed 02/10/2024)

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2.3 Structure of the PNA

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

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

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

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

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3. Process for producing the Pharmaceutical Needs Assessment

The PNA has been undertaken in line with the requirements the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for developing and updating PNAs. The National Health Service (Pharmaceutical and Local Pharmaceutical Services (Amendment and Transitional Provision) Regulations 2014 have been published to amend these regulations following a report published by the Joint Committee on statutory instruments. More recently, The NHS (Pharmaceutical and Local Pharmaceutical Services) (Amendment) Regulations 2016 were published. [7] And under the direction of the PNA steering group.

The Southampton PNA 2025 has been in development since September 2024. The document has been written with assistance from partners in neighbouring Local Authorities which is gratefully acknowledged. The process has had many steps; the key stages are outlined below.

Stage 1: Formation of a steering group

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

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

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

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Stage 2: Collation of information and data

The Joint Strategic Needs Assessment for Southampton has been extensively used to give an overview of major health and wellbeing needs of the local population. This information is included as Appendix A in Part 2 of the PNA.

Every existing community pharmacy in Southampton (n=38) were invited to complete a detailed questionnaire about their services to inform the development of the PNA. This survey was open from 2 October 2024 to 30 October 2024. There were thirteen responses from pharmacies in Southampton for the survey giving a 34.2% response rate.

Data held by NHS England and NHS Business Services Authority was used to inform the Southampton picture of local pharmaceutical provision, including data on delivery of advanced services. National and locally held statistics have been examined to determine levels of activity in delivering current services.

Expertise and advice have also been sought, and is gratefully acknowledged, from NHS Hampshire and Isle of Wight ICB (integrated Care Board), NHS England, Community Pharmacy South Central and from Southampton City Council's Public Health, Planning, Economic Development, Data, Intelligence and Insight, Housing and Communications departments.

Stage 3: Analysis

The information collated was used to carry out a gap analysis to identify any current or future gaps of pharmaceutical provision within the city. The Steering Group agreed that living within 1.6 km (straight-line distance) from a pharmacy would be the key criterion for the gap analysis; this distance is used in the NHS Pharmaceutical Services Regulations 2013 when applications are determined under the "market entry" process. [8] Other factors, such as opening hours and services provided, also informed the gap analysis.

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

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

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Stage 4: Draft PNA

The draft PNA (Part 1 Main Reports and Part 2 Appendices) is due to be examined by the Southampton Health and Wellbeing Board (HWB) in December 2024.

Stage 5: Consultation

A consultation with members of the public on the document, in line with the statutory requirements will be held later.

Stage 6: Review of consultation responses

The steering group will consider the consultation responses. A report will be prepared on the information gathered in the consultation and the steering group's considerations; this will be included as Appendix C in Part 2 of the PNA. The consultation with pharmacies is due to end on 30 October 2024 and a further consultation will take place in the spring (2025) with member of the public.

Stage 7: Publication

The draft document will be presented to the HWB in December 2024 for approval, the final draft will then go to public consultation between February and April before the planned publication of the PNA in July 2025.

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4. Southampton Context

Southampton is on the south coast of England and is the largest city in Hampshire. It is a diverse city with a population of 264,957 people comprising 108,885 households, 64,668 children and young people (aged 0-19 years), 79,400 residents who are none white British and approximately 40,000 students.

Between 2025 and 2028, the lifetime of this PNA, the population of Southampton is predicted to rise by 2.2%, with the over 65s projected to increase by approximately 7.3% and the and under 15s populations is predicted to fall by 1.9%.

This ageing of the population will have an increasing impact on the demand for health and social care services in Southampton. Health risks, alcohol, unhealthy eating and lack of physical activity have a substantial impact on the health of the city's population. In Southampton childhood obesity (in Year 6) and alcohol-related hospital admissions are significantly higher than the national average. This is all influenced and compounded by the wider determinants, or building blocks, of health such as the circumstances that we live including neighbourhood, housing, education, and employment/income. Inequalities in health and wellbeing outcomes are evident in the city and that this inequality gap is not narrowing.

Much of the data used to inform the PNA is from the Joint Strategic Needs Assessment of the Southampton Data Observatory[9] and is included as Appendix A in Part 2. Some of the data in this PNA is presented at a sub-city geography of electoral wards and the following ward map (Figure 1) is included to set this into context. However, the PNA has largely been conducted at a city-wide level because wards and localities are not a relevant geography when considering pharmaceutical services in a compact urban area such as Southampton.

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

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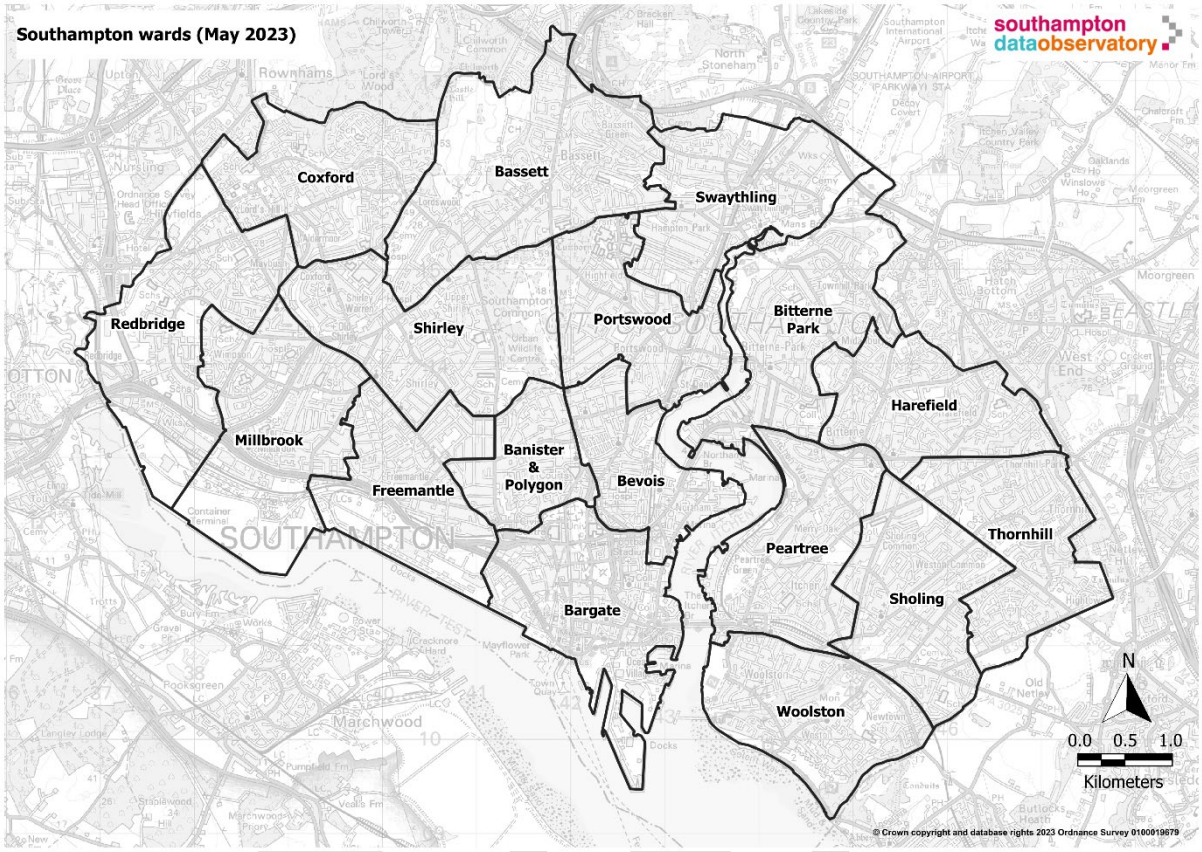
Figure 1: Southampton ward boundaries



4.1 NHS services

Other NHS services can affect the need for pharmaceutical services, including hospital and community services as follows. There are four hospital sites in Southampton:

Southampton General Hospital (SGH) - part of University Hospital Southampton NHS Foundation Trust, provides a range of services including emergency and critical care is provided in the hospital's special intensive care units, operating theatres, acute medicine unit and emergency department (A&E), as well as the dedicated eye casualty.[10]

Princess Anne Hospital (PAH) - part of University Hospital Southampton NHS Foundation Trust, provides services including maternity care, for about 5,000 women each year from around Southampton. It is also a regional centre for foetal and maternal medicine, providing specialist care for women with medical problems during

[10] University Hospital Southampton, NHS Foundation Trust https://www.uhs.nhs.uk/for-visitors/southampton-general-hospital (accessed 10/10/2024)

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pregnancy, and for those whose babies need extra care before or around birth. Other services include genetics and breast screening.[11]

Southampton Children's Hospital (SCH) - part of University Hospital Southampton NHS Foundation Trust, is a major centre for specialist paediatric services in the south of England.[12]

The Royal South Hants Hospital (RSH) - provides a wide range of outpatient, day and inpatient surgical operations, diagnostic procedures, and sexual health services. Some services are provided by Solent NHS Trust, Practice Plus Group and others by University Hospital Southampton NHS Foundation Trust.[13] The Southampton urgent treatment centre is also based at Royal South Hants and is run by Practice Plus Group.[14] This is a minor injuries unit (MIU) which offers treatment, advice and information on a range of minor injuries and illness.

Patients attending these, on either an inpatient or outpatient basis, may require prescriptions to be dispensed. There are three hospital pharmacies providing services; an inpatient pharmacy serving patients at SGH, PAH and SCH, a pharmacy for outpatients located at SGH and the third pharmacy is located at RSH. These pharmacies are operated by UHS Pharmacy Ltd.[15]

In the NHS Hampshire and Isle of Wight ICB 26 member GP practices within the Southampton boundary as of September 2024. The GP out of hours service is provided by UHS Pharmaceutical Service. There are 27 NHS dental practices providing NHS dental services and 26 opticians in the Southampton HWB area.[16]

[11] University Hospital Southampton, NHS Foundation Trust https://www.uhs.nhs.uk/for-visitors/princess-anne-hospital (accessed 10/10/2024)
[12] University Hospital Southampton, NHS Foundation Trust https://www.uhs.nhs.uk/for-visitors/southampton-childrens-hospital (accessed 10/10/2024)
[13] University Hospital Southampton, NHS Foundation Trust https://www.uhs.nhs.uk/for-visitors/royal-south-hants (accessed 10/10/2024)
[14] Practice Plus Group Urgent Treatment Centre (UTC) https://www.southamptonutc.nhs.uk/ (accessed 10/10/2024)
[15] University Hospital Southampton, NHS Foundation Trust https://www.uhs.nhs.uk/departments/medicines-and-therapies/pharmacy (accessed 10/10/2024)
[16] Pharmacy, Optometry and Dental Improvement, Hampshire and Isle of Wight ICB September 2024

5. Current Pharmaceutical Services

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

The start of April 2024 marked the end of the five-year Community Pharmacy Contractual Framework arrangement which was agreed in the summer of 2019. Negotiations on the arrangements for the current financial year – 2024/25 – are still in progress between Community Pharmacy England, the Department of Health and Social Care (DHSC) and NHS England. Until these negotiations have concluded, existing service arrangements will continue as previously announced.

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

5.1 Community pharmacies

Southampton has 38 community pharmacies providing NHS services; since the previous PNA, the following community pharmacies have closed:

- Lloyds Pharmacy Asda central Southampton (closed August 2024)
- Boots the Chemist 9 Victoria Road Woolston Southampton (ceased to provide pharmaceutical services from 27 January 2024)

Pharmacies can be divided into those providing a minimum of 40 hours of NHS pharmaceutical services each week and those providing 100 hours per week. In Southampton, there are 35 pharmacies providing '40 core hours' of service and 3 pharmacies providing '100 core hours' of service. Three of the 40-hour pharmacies choose to open for longer and these additional hours are referred to as 'supplementary hours'. More information on changes to pharmacies are available on the PNA web page on Southampton Data Observatory.[17]

[17] PNA on Southampton Data Observatory - https://data.southampton.gov.uk/health/pharmaceutical-needs-assessment/ (accessed 02/10/2024)

5.2 Distance selling pharmacies

Distance selling pharmacies provide services solely to customers who do not attend the premises, for example internet services only. Southampton has no distance-selling pharmacies. However, Southampton residents may choose to have their prescriptions dispensed from any pharmacy across the country including distance selling pharmacies. This trend increased, in line with other internet shopping trends, during the COVID-19 pandemic. The Pharmaceutical Journal estimates that in England the number of items dispensed by Distance Selling Pharmacies increased by 45% between 2019 and 2020. In Southampton there has been an increase in prescriptions dispensed by Distance Selling Pharmacies from 2.4% in 2019/20 to 7.4% in 2022/23.

5.3 Dispensing doctor

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

5.4 Local Pharmaceutical Services Scheme

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

5.5 Dispensing Appliance Contractor

A Dispensing Appliance Contractor (DAC) specialises in dispensing appliances (e.g., stoma care products) rather than medicines. Southampton does not have a DAC. The two closest DAC are in Bishops Waltham and Southsea.

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5.6 Essential Services

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

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5.6.1 Dispensing Medicines and Repeat Dispensing

In 2022/23 there were 4,451,438 items prescribed by Southampton GPs dispensed across the country (3,237 sites).

Looking in more detail at these prescribed items in more detail:

- 75.7% of prescribed items are dispensed within Southampton community pharmacies
- 1.7% of items are dispensed by GPs in Southampton
- 8.3% are dispensed in the Hampshire
- 16.0% are dispensed outside of Southampton or Hampshire
- 7.4% dispensed by distance selling pharmacies
- The top distance selling pharmacy is Pharmacy2U ltd (FLM49) prescribing 36.9% of all distant selling items

Although not an essential service, the Electronic Prescription Service (EPS) allows prescribers to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. All GP practices and pharmacies in Southampton are enabled to dispense in accordance with the EPS and all actively participate in the programme. Between January and June 2024 95.1% of prescriptions were dispensed via EPS.

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

Of the thirteen responses from Southampton pharmacies, all thirteen pharmacies dispense appliances, two of the thirteen pharmacies exclude stoma appliances and one dispenses just dressings. Two pharmacies offer stoma appliance customisation.

5.6.2 Disposal of Unwanted Medicines:

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

5.6.3 Public Health Promotion of Healthy Lifestyles:

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

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5.6.4 Signposting Customers to Appropriate Services:

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

5.6.5 Support for Self-care:

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

5.6.6 Clinical Governance:

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

5.6.7 Discharge Medicines Service (DMS):

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

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

5.6.8 Pharmacy First Service (PFS)

The Pharmacy First Service was launched by the NHS and central government on 31 January 2024. This new service includes the service previously known as the NHS Community Pharmacist Consultation Service (CPCS). The CPCS included patient referrals for urgent repeat medication or to assess acuity of minor illness symptoms and provide advice to support next steps. Referrals to community pharmacies were made by telephony services for NHS 111 or Integrated Urgent Care Clinical Assessment Services (IUC CAS) for patients who could be seen by a community pharmacist closer to their home. The service was later extended to cover referrals

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for low acuity minor illness from general practice settings and referrals from 999 services and 111Online for minor illness and urgent repeat medication.

The Pharmacy First advanced service incorporates the previous CPCS service (both urgent medicines supply and minor illness elements) and builds on this to enable community pharmacy to complete episodes of care for seven common conditions following specific clinical pathways. The seven common conditions are:

- Sinusitis
- Sore throat
- Earache
- Infected insect bite
- Impetigo (a bacterial skin infection)
- Shingles
- Uncomplicated urinary tract infections in women

Pharmacy First is offered by all pharmacies in Southampton and between February and April 2024 there have been over 4,085 consultations.

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5.6.9 Healthy Living Pharmacy (HLP) Level 1 status:

Most pharmacies in England previously met the HLP requirements following local initiatives with commissioners or the Pharmacy Quality Scheme. However, the laying of new NHS regulations in October 2020, made HLP requirements a new Terms of Service requirement for all pharmacies from 1 January 2021.

5.7 Advanced services

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

5.7.1 New Medicine Service (NMS)

The NMS provides support for people with long-term conditions and who have newly been prescribed a medicine. The aim of the services is to help improve medicines adherence; it initially focused on a small number of conditions; this list was increased in September 2021.

Through the New Medicine Service, community pharmacists provide support to patients and carers, helping them manage newly prescribed medicines for a long-term condition, and supporting patients to make shared decisions about their care. This service also provides an opportunity to promote lifestyle changes or other non-pharmacological interventions to enhance well-being in people with long term conditions.

The conditions eligible for the service are:

- asthma and COPD
- diabetes (Type 2)
- hypertension
- hypercholesterolaemia
- osteoporosis
- gout
- glaucoma
- epilepsy
- Parkinson's disease
- urinary incontinence/retention
- heart failure
- acute coronary syndromes

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- atrial fibrillation
- long term risks of venous thromboembolism/embolism
- stroke/transient ischemic attack
- coronary heart disease

5.7.2 NHS Flu Vaccination Service

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

For the period September 2022 to March 2023, NHS England data show 34 of the 38 (89.5%) pharmacies in Southampton were accredited to deliver flu vaccinations. A total of 15,763 vaccinations were given during this period.

5.7.3 COVID-19 services

NHS England has confirmed that pharmacies will be able to give COVID-19 vaccinations and the timings for the autumn/winter programme. The groups being offered in the autumn/winter 2024/25 season are:

- residents in a care home for older adults;
- all adults aged 65 years and over;
- persons aged 6 months to 64 years in a clinical risk group, as defined in tables 3 and 4 of the COVID-19 chapter of the UK Health Security Agency Green Book on immunisation against infectious disease; and
- frontline health and social care workers and staff working in care homes for older adults. Including: community pharmacy staff

The COVID-19 vaccinations will be available from 3 October 2024 to 31 January 2025. With flu vaccinations continuing until 31 March 2025.

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5.7.4 Number of Lateral Flow Device (LFD) Test Supply Service

Since the COVID-19 pandemic the NHS offers COVID-19 treatment to people with COVID-19 who are at risk of becoming seriously ill. The list of eligible patients includes the following, for a full list of eligible patients please see the Nice Guidelines [18]:

- People with Down's syndrome and other genetic disorders
- People with various type of solid cancer
- People with Immune-mediated inflammatory disorders
- People with Immune deficiencies
- People aged 85 years and over
- People with end-stage heart failure who have a long-term ventricular assistance device
- People on the organ transplant waiting list
- People resident in a care home who are aged 70 years and over
- People resident in a care home who have a BMI of 35 kg/m2 or more
- People resident in a care home who have diabetes
- People resident in a care home who have heart failure
- People currently in a hospital who are aged 70 years and over
- People currently in a hospital who have a BMI of 35 kg/m2 or more
- People currently in a hospital who have diabetes
- People currently in a hospital who have heart failure

It is currently estimated that around 3.9 million patients nationally are potentially eligible for free lateral flow device (LFD) tests. Although access to LFD tests may be supplemented by other pathways, (for example, through anticipatory or specialist care), community pharmacy is well placed within the local community to provide local and rapid access for patients.[19]

Access to COVID-19 community-based treatment will continue to be based on a confirmed COVID-19 infection, achieved with a diagnostic LFD test, in line with some of the recommended treatment's product licences. Given the short efficacy window for treatment and practical implications of point of care testing, tests need to be available for eligible patients to access in advance of developing symptoms.

[18] NICE 29 March 2023 - Nirmatrelvir plus ritonavir, sotrovimab and tocilizumab for treating COVID-19 https://www.nice.org.uk/guidance/ta878/chapter/5-Supporting-information-on-risk-factors-for-progression-to-severe-COVID19

[19] NHS England - NHS lateral flow device tests supply service for patients potentially eligible for COVID-19 treatment: service specification https://www.england.nhs.uk/publication/nhs-lateral-flow-device-tests-supply-service-for-patients-potentially-eligible-for-covid-19-treatment-service-specification/ (accessed 11/10/2024)

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This service is to offer at risk patients eligible for COVID-19 treatments, access to LFD tests to enable testing at home for COVID-19, if they develop symptoms of infection. A positive LFD test result will be used to inform a clinical assessment to determine whether the patient is suitable for and will benefit from NICE recommended COVID-19 treatments.

In Southampton, between January and March 2024, 16 pharmacies offered this service.

5.7.5 Hepatitis C Antibody Testing Service

The Community Pharmacy Hepatitis C Antibody Testing Service was decommissioned in April 2023.

5.7.6 Stoma Appliance Customisation

Stoma customisation services aim to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste. This service is usually provided by DACs. In June 2024, NHS Business Service Authority data shows that there were no pharmacies offering Stoma Appliance Customisation in Southampton. In the pharmacy contractors survey open from 2 October 2024 to 30 October 2024, two pharmacies of the thirteen responses offered stoma appliance customisation.

5.7.7 Appliance Use Reviews

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

5.7.8 Hypertension Case-Finding Service

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

In June 2024, 29 pharmacies (76.3%) of 38 pharmacies offered this service. Between January and June 2024, 4,676 checks for blood pressure.

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5.7.9 Smoking Cessation Advanced Service

In early 2022, the Smoking Cessation Advanced Service was introduced for patients who started their stop-smoking journey in hospital. This service allows NHS trusts to refer patients to a pharmacy of their choice so they can continue receiving treatment, advice and support with their attempt to quit smoking when they are discharged. University Hospital Southampton offers this service. With free NHS stop smoking support being available before the hospital stay, during the period in hospital and after discharge.

Nicotine replacement products are available to support patients during their stay in hospital as an inpatient and patients can be referred to one of the smoking cessation advisors who give advice around medication, effective behaviour change and support.

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5.8 Enhanced Services

5.8.1 Bank Holiday Opening

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

5.8.2 Pharmacy Urgent Repeat Medicines Service

There is one enhanced service which is locally commissioned in Hampshire - the Wessex Pharmacy Urgent Repeat Medicines (PURM) Service, this service has been decommissioned and become part of the Pharmacy First service, for more information see section 5.6.8.

5.9 Locally Commissioned and other non-NHS Services

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

5.9.1 Minor Ailment Service

Minor ailments are defined as common, self-limiting, or uncomplicated conditions which can be managed without medical intervention. The management of patients with minor self-limiting conditions impacts significantly upon GP workload. The situation is most acute where patients do not pay prescription charges and may not have the resources to seek alternatives to a prescription from their GP. The minor ailment service is now supplied under the Pharmacy First service, for more information see section 5.6.8.

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5.9.2 Palliative Care Drugs Service

Drugs used for palliative care reasons can be required at short notice and are not items which are routinely stocked at all community pharmacies. The Palliative Care Drugs Service is commissioned by Hampshire, Southampton and Isle of Wight CCG and aids accessibility to these drugs for individuals who are being cared for in community settings. Six of the thirteen respondents to the pharmacy contractors survey offer on-demand availability of drugs for palliative care.

5.9.3 Pharmacy Needle and Syringe Programme

The needle and syringe programme for people who inject drugs is a crucial component in providing a comprehensive harm reduction programme. The aim of this service is to:

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

Two of the thirteen respondents to the pharmacy contractors survey offer a needle and syringe programme.

5.9.4 Emergency Hormonal Contraception (EHC) Service

The Southampton City Council Public Health Team commissions the EHC services which aims to reduce unwanted pregnancies and terminations by providing EHC, to support women aged under 25 who have had unprotected sex and help contribute to a reduction in the number of unplanned pregnancies.

This is through a Patient Group Direction (PGD) which provides a legal framework to allow pharmacists to supply specified medicines to a pre-defined group of patients, without them having to see a prescriber. Clients excluded from the PGD criteria should be referred to another local service provider that will be able to assist them as soon as possible.

Ten of the thirteen respondents to the pharmacy contractors survey offer emergency hormonal contraception.

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5.9.5 Supervised Consumption

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

Seven of the thirteen respondents to the pharmacy contractors survey offer supervised consumption, also known as supervised administration.

5.9.6 Stop Smoking Service

A smoking cessation service for clients who need support to give up smoking using one-to- one interventions is offered. In March 2024, 19 pharmacies in Southampton offered this service. The service includes an initial assessment to ascertain how ready the client is to make a change and how they would be best supported.

NHS Digital data shows that between April 2022 and March 2023, there were 298 people who set a smoking quit date through pharmacies and, of these, 123 (41.3%) had successfully quit at 4 weeks (self-reported). The same percentage when compared with all setting in Southampton 1,583 people setting a quit rate and 653 (41.3%) were successful quitters.

5.9.7 Delivery Services

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

Of the thirteen respondents to the pharmacy contractor survey, eleven deliver dispensed medicines, free-of-charge upon request, five deliver dispensed medicines with a charge and three of the pharmacies that offer a free service also offer a paid service.

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5.9.8 Access Languages

The pharmacy workforce in Southampton embraces a range of nationalities and cultural backgrounds. The contractor survey showed that, at that time, there were 20 different languages spoken amongst Southampton pharmacy staff. It is not unusual for residents who are from other countries and cultures to seek out services from a pharmacy that speaks their native language.

In the pharmacy contractor's survey respondents were asked about languages spoken by members of staff. Along with English, the following languages were reported by the thirteen respondents, along with the number of pharmacies in brackets:

- Hindi (8 pharmacies)
- Punjabi (7 pharmacies)
- Urdu – (5 pharmacies)
- Telugu – (3 pharmacies
- Romanian – (3 pharmacies)
- Gujarati – (3 pharmacies)
- Farsi – (3 pharmacies)
- Nigerian – (2 pharmacies)

Other additional languages include, Arabic, Bengali, Cantonese, Filipino, Italian, Mandarin, Pashto, Polish, Swahili and Turkish.

5.9.9 Accessibility

The pharmacy contractor's survey also asked about accessibility to the pharmacy, of the thirteen respondents all thirteen have step free access and twelve of the thirteen have wheelchair access. Also four of the thirteen respondents said their pharmacy had access to an induction loop.

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6. Temporal Access to Pharmaceutical Services

6.1 Opening Hours

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

The opening hours used in this section are based on the total opening hours (both 'core' and 'supplementary' hours) for the 38 community pharmacies in the city, as held by NHS England on 2 September 2024. The removal of two contractors from the pharmaceutical list now means that there is one less 100 hour contact pharmacy (Lloyds Pharmacy in Asda) in Southampton. Details of individual pharmacy opening times can be found on the NHS website.[20]

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

6.2 100-hour Core Hour of Service Pharmacies

There are three '100-hour pharmacies' in the city which opened using the 'necessary or expedient' test under the 2005 exemptions to the market entry system. These pharmacies provide 100 core hours per week of pharmaceutical services. They give Southampton residents greater access to pharmaceutical services by extending opening hours both in the morning and late into the evening plus extended weekend coverage.

These pharmacies meet an identified need for pharmaceutical services for both 'out of hours' dispensing services and for the general population who wish to seek professional help for health and lifestyle advice, treating minor ailments and conditions that may be managed by self-care.

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

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

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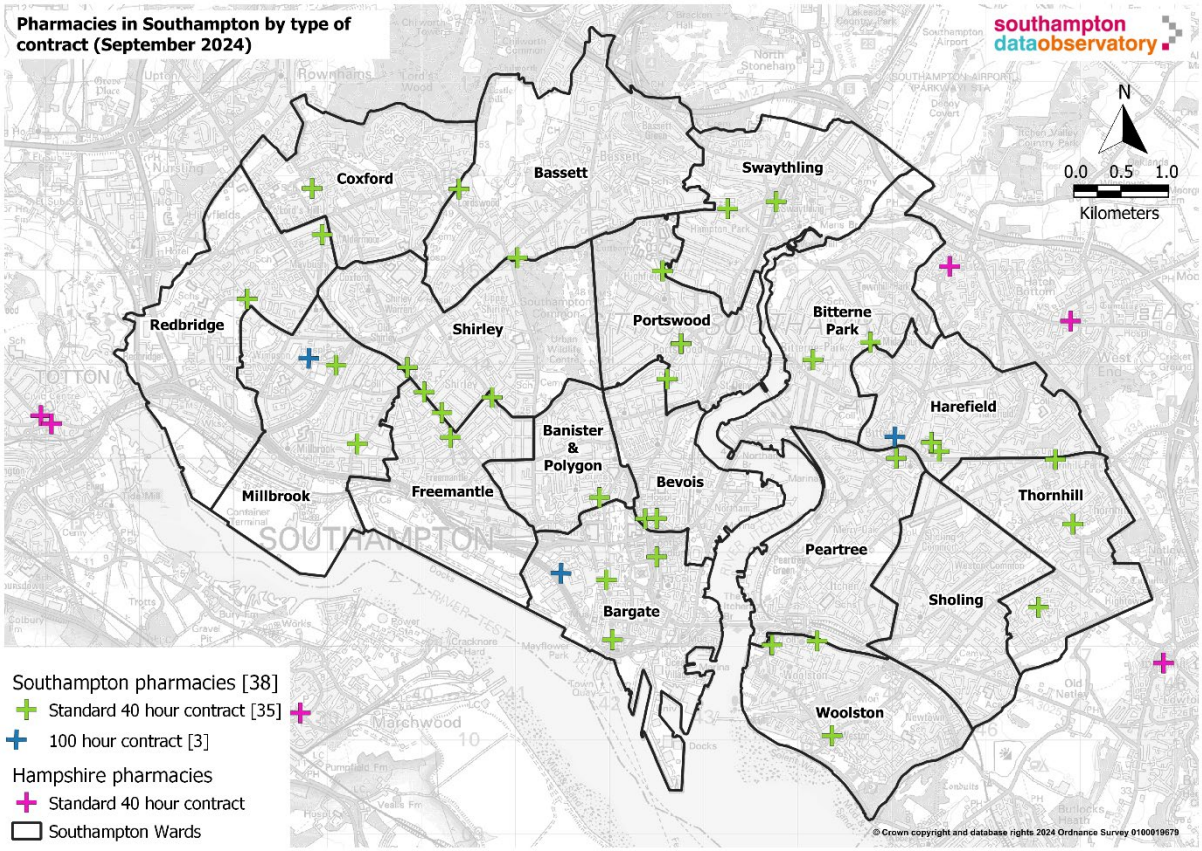
Figure 2: Pharmacies in Southampton by type of contract as of September 2024



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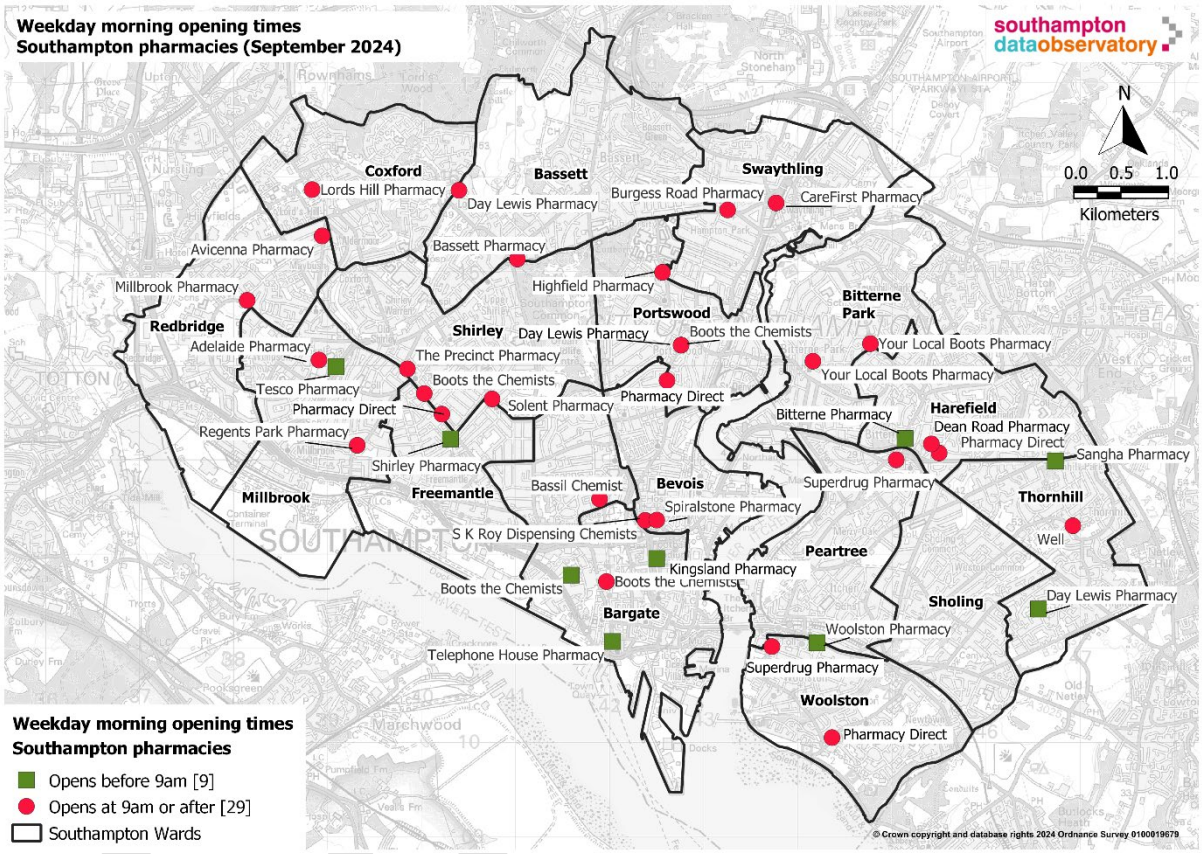
6.3 Opening Hours Mornings

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

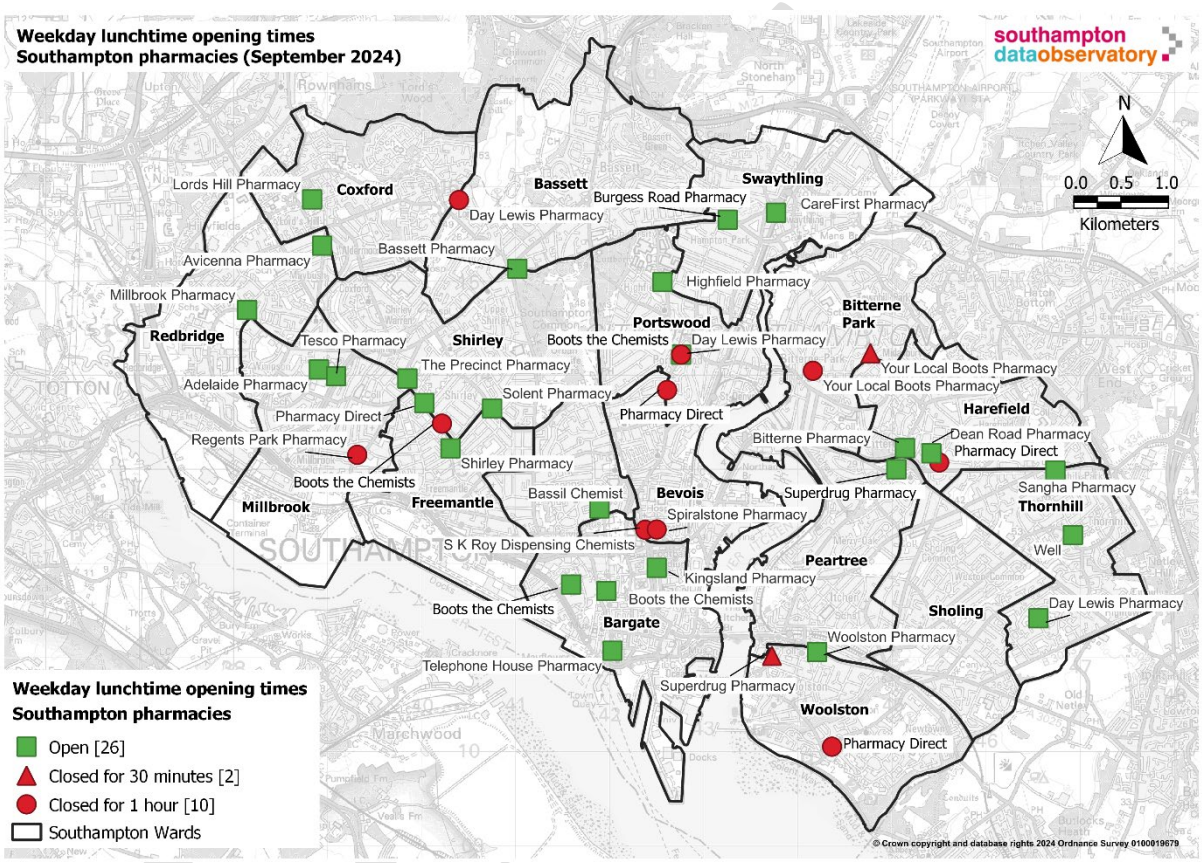
Figure 3: Map of weekday morning opening times for community pharmacies in Southampton as of September 2024



6.4 Opening Hours Lunchtime

There is access to NHS pharmaceutical services throughout the lunch period (1pm and 2pm) in 26 pharmacies. Ten pharmacies are closed for one hour 1pm and 2pm. One is closed for 30 minutes, from 1pm to 1.30pm and one is closed between 1pm and 3pm.

Figure 4: Map of weekday lunchtime opening times for community pharmacies in Southampton as of September 2024



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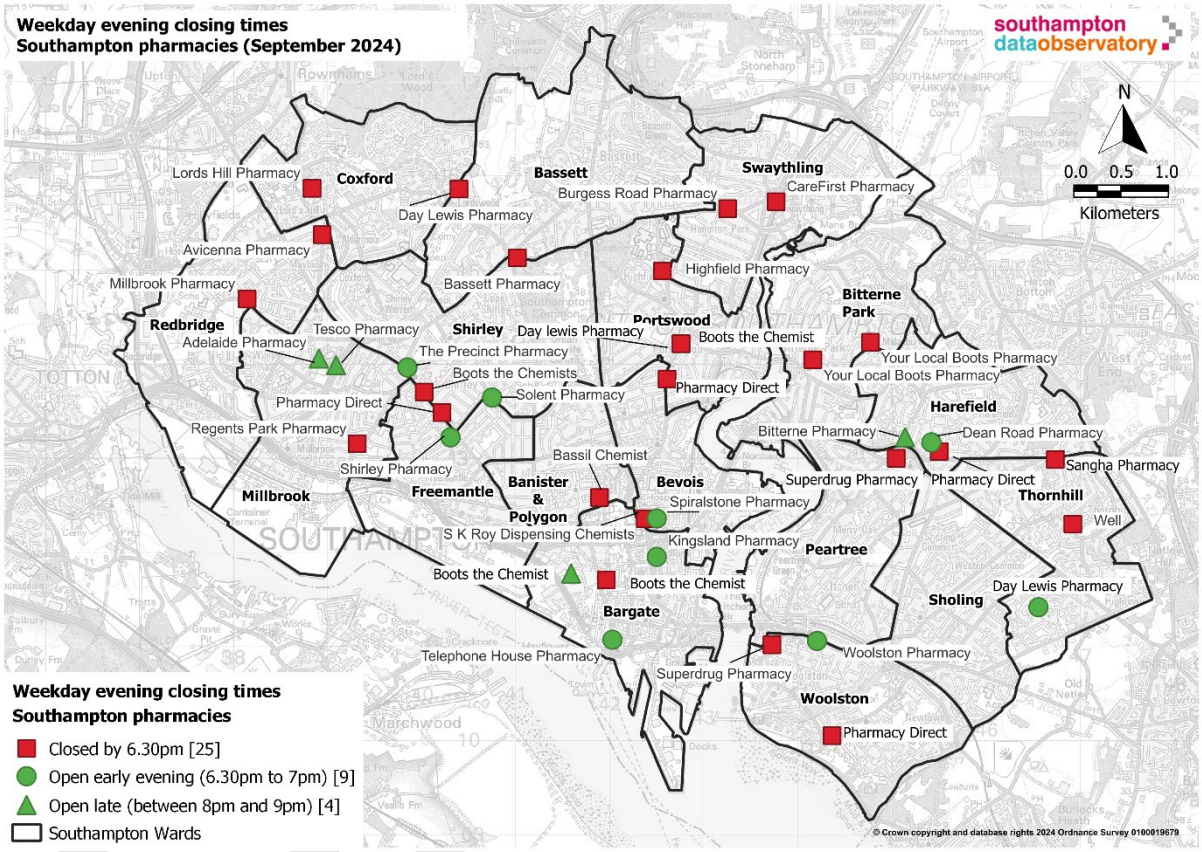
6.5 Opening Hours Evenings

Four pharmacies are open later in the evening between 8pm and 9pm. Nine are open between 6.30pm and 7pm. The remaining twenty-five close by 6.30pm.

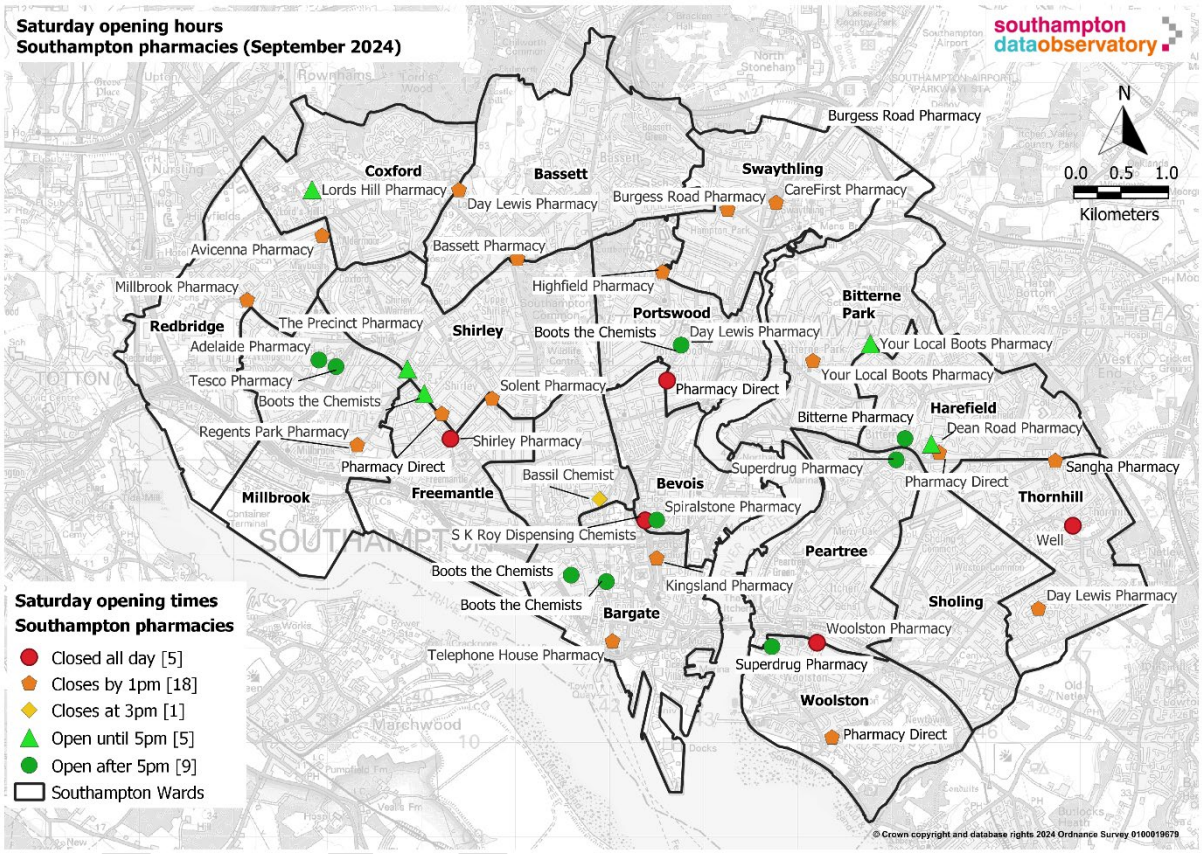
Figure 5: Map of weekday evening opening times for community pharmacies in Southampton as of September 2024



6.6 Saturday Opening

Thirty-three community pharmacies are open for at least a part of the day on a Saturday and the remaining five are closed all day. Eighteen pharmacies close by 1pm, one closes at 3pm, five are open until 5pm and nine are open after 5pm.

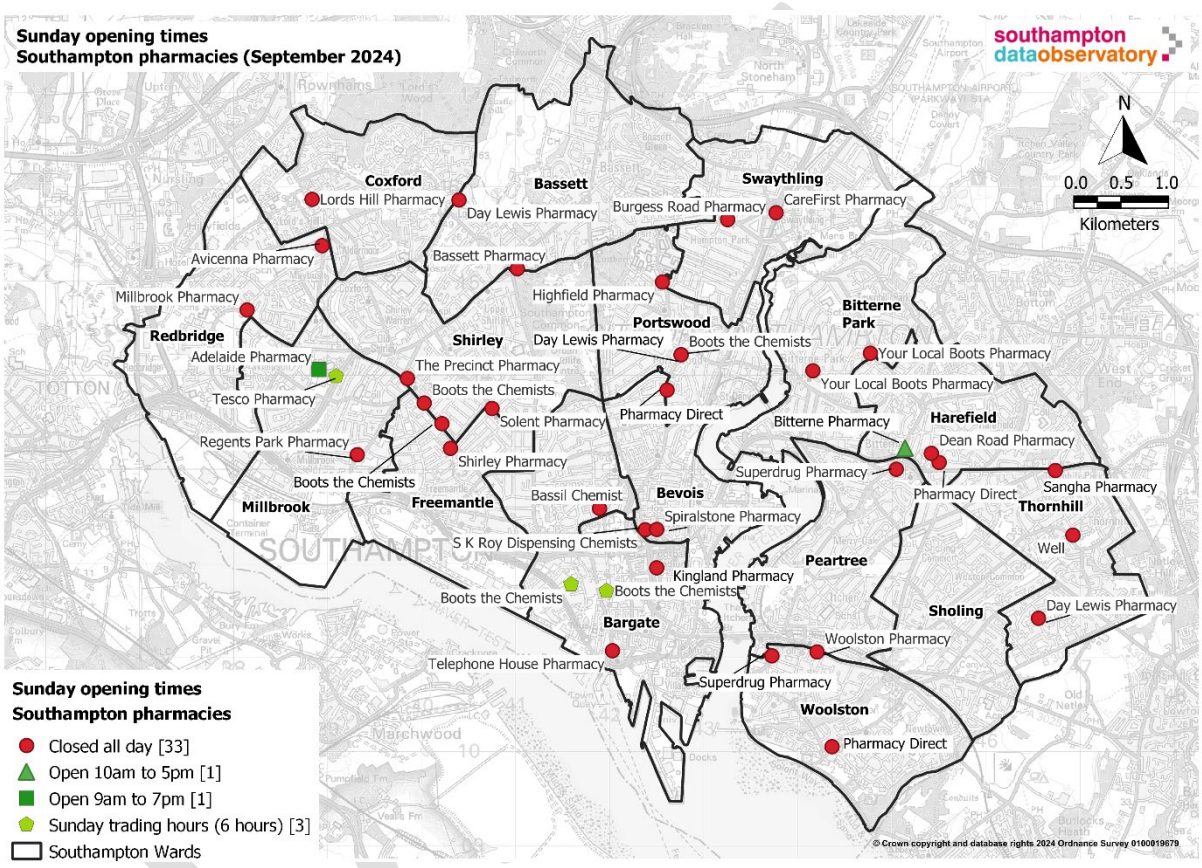
Figure 6: Map of Saturday opening times for community pharmacies in Southampton as of September 2024



6.7 Sunday Opening

Five pharmacies are open regularly on a Sunday. For three of these pharmacies the Sunday trading laws limit opening times to six hours only with typical closing times between 4pm and 5pm. One pharmacy is open for 7 hours (10am to 5pm) and another pharmacy is open for 10 hours between 9am and 7pm.

Figure 7: Map of Sunday opening times for community pharmacies in Southampton, as of September 2024



6.8 Bank Holiday

Community pharmacies are not required to open on bank holidays. For major bank holidays, such as Christmas Day and Easter Sunday, voluntary opening by a small number of pharmacies has ensured sufficient pharmaceutical services for the city to enable urgent prescriptions to be dispensed and self-care remedies to be purchased. Bank Holiday opening is arranged through commissioning of an Enhanced Service that the pharmacies were invited to apply for.

Details of opening times for these holidays are published on the NHS UK website [21] and are usually available on the NHS England website.[22]

Additionally, there is a GP out of hours service provided at the Royal South Hants hospital by the Practice Plus Group Urgent Treatment Centre, which is open Monday to Friday 7:30am to 10pm and on weekends and bank holidays from 8am to 10pm.[23]

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

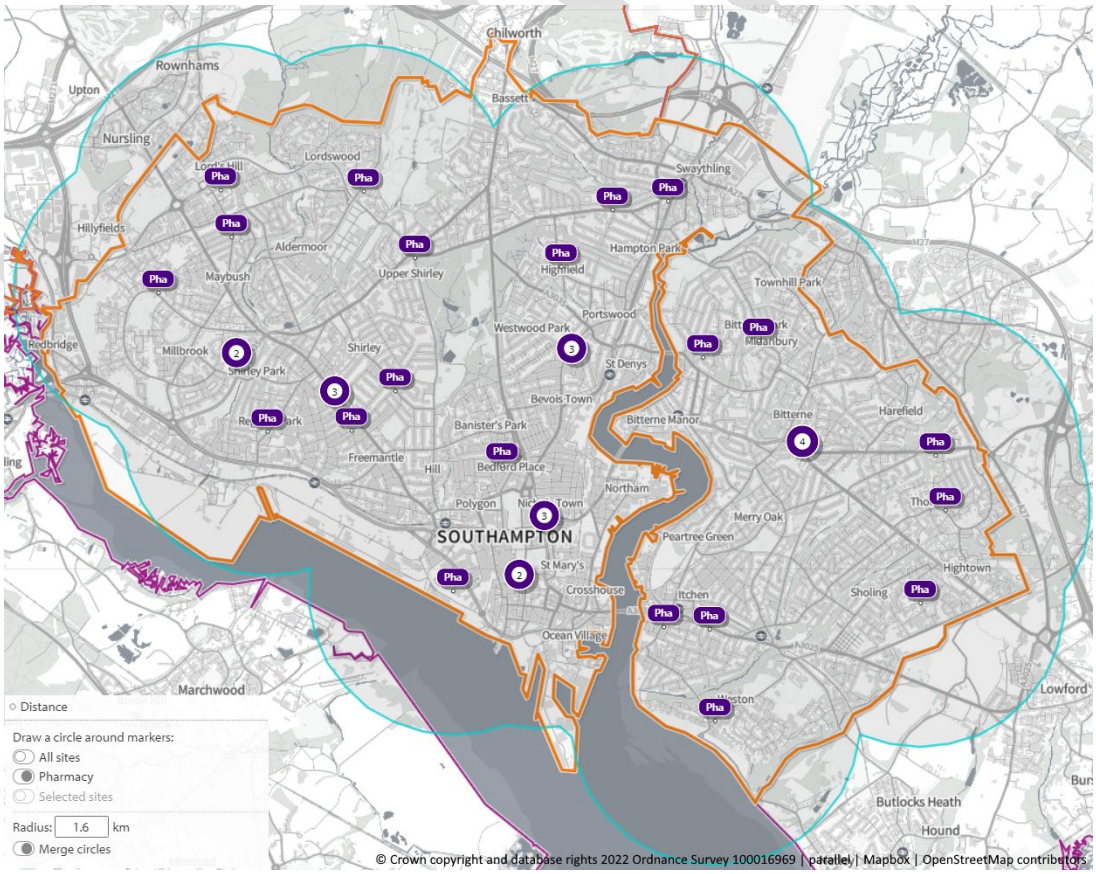
7. Geographical Access to Pharmaceutical Services

7.1 Pharmacies with Buffer Zone of 1.6km

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

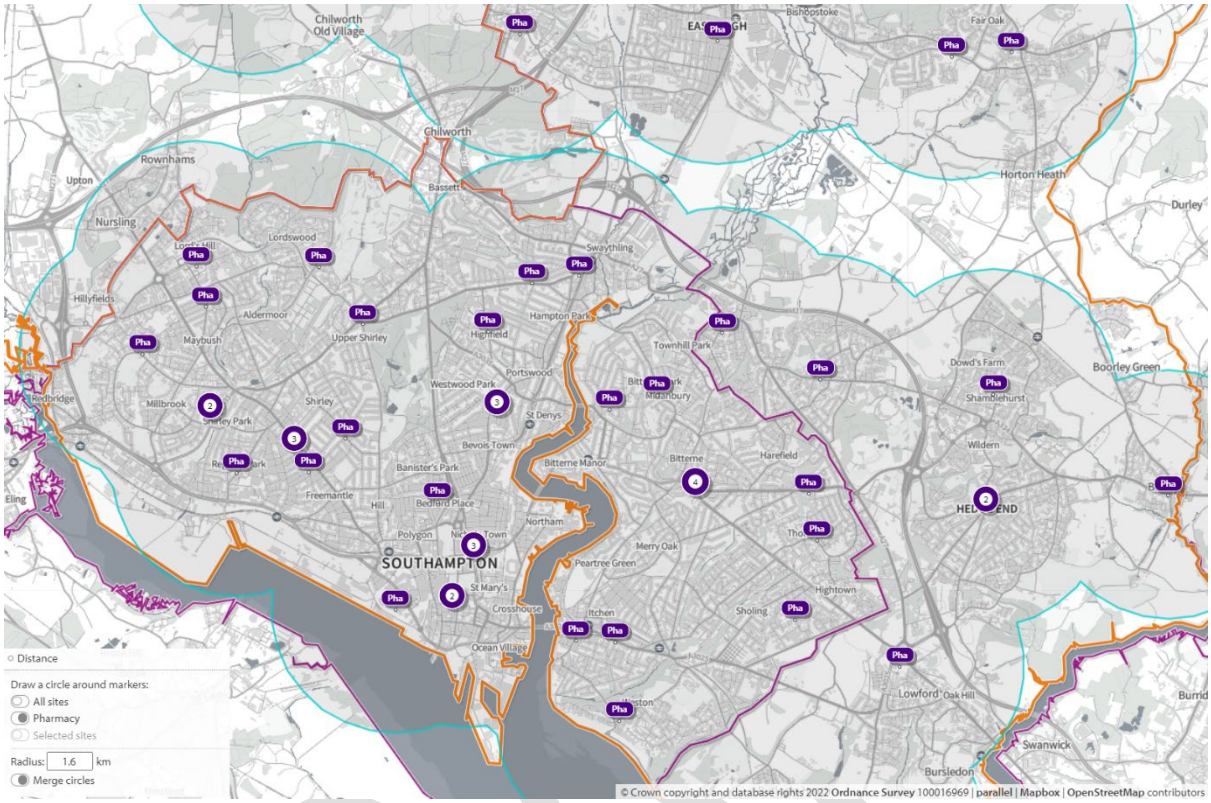
Another area outside the 1.6km buffer zone is on the northern edge of the city (part of Bassett, south of Chilworth). This is also slightly further than 1.6km from the nearest pharmacy in Hampshire (ASDA in Chandler's Ford) as shown in Figure 9. This is a very small area in one of the least deprived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

Figure 8: Map showing distance zone of 1.6km from a pharmacy inside Southampton (September 2024)



Source: SHAPE place, Public Health England

Figure 9: Distance 1.6km from a pharmacy including those in Hampshire that are close to the Southampton boundary (September 2024)



Source: SHAPE place, Public Health England

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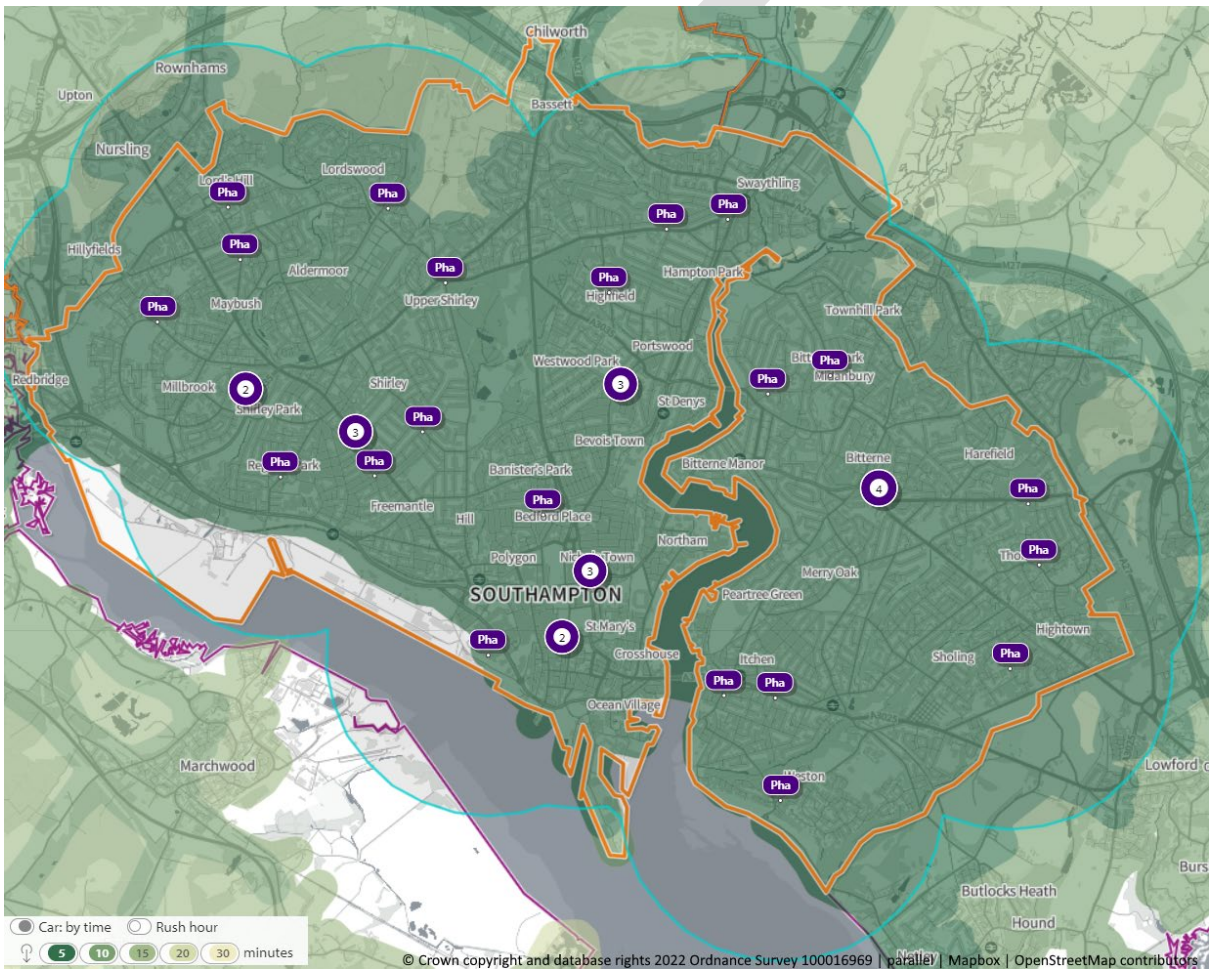
7.2 Driving

During 'rush hour' (normal speed limits but taking into account junctions, crossings and traffic lights with the additional congestion data and road density analysis), a pharmacy in Southampton should still be accessible within a five-minute drive (in dark green) for most parts of the city, with only a few small areas with low residential density being an eight-minute drive or more from a pharmacy (figure 10).

Figure 10: Map of drive times in rush hour from pharmacies (excluding distance selling) in Southampton and outside of the local authority boundary (September 2024)

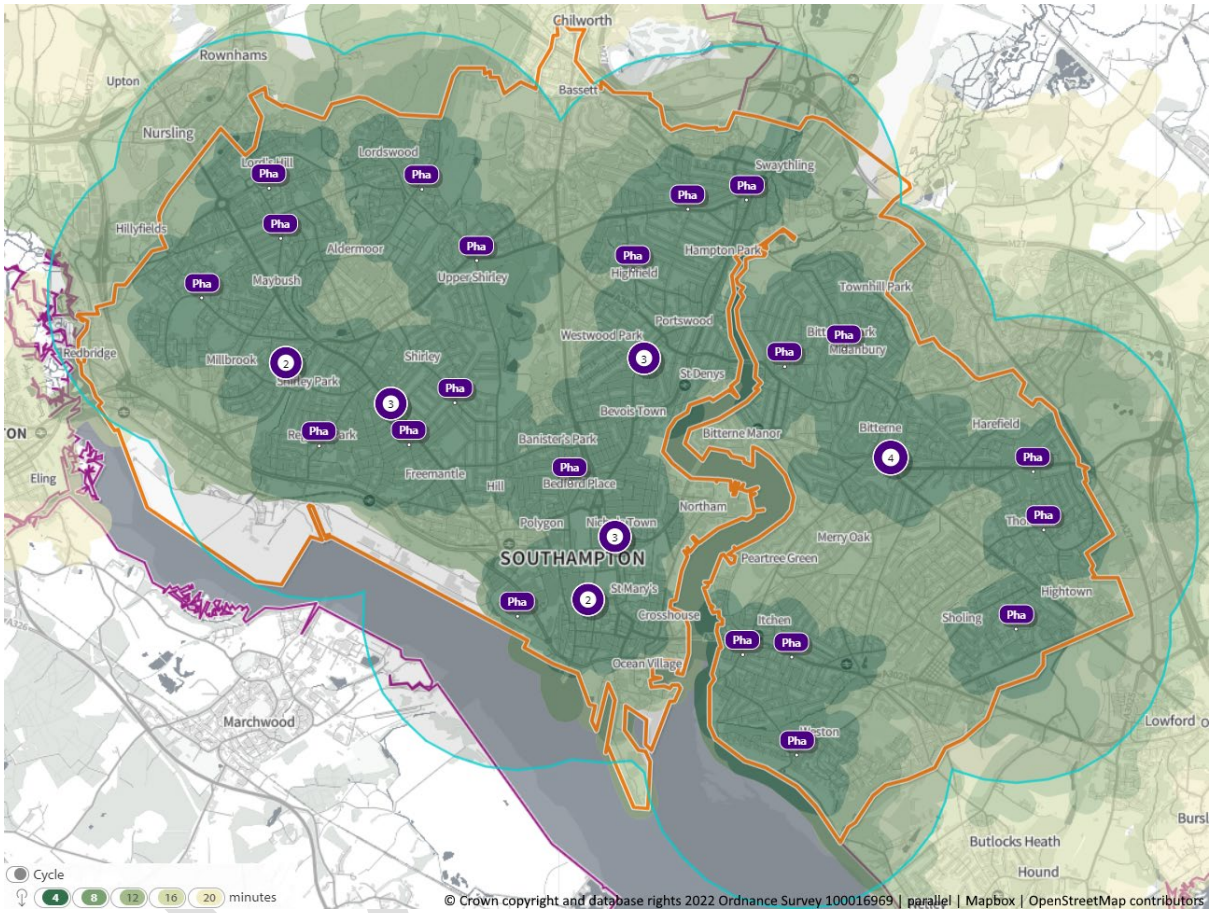


Source: SHAPE place, Public Health England

7.3 Cycling

Seventy-eight percent of the Southampton population are within a four-minute cycle ride (in dark green) of a pharmacy; and 100% of the population are within an eight-minute cycle ride, this assumes a cycle speed of 15km per hour (kph) or 9.3 miles per hour (mph).

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



Source: SHAPE place, Public Health England

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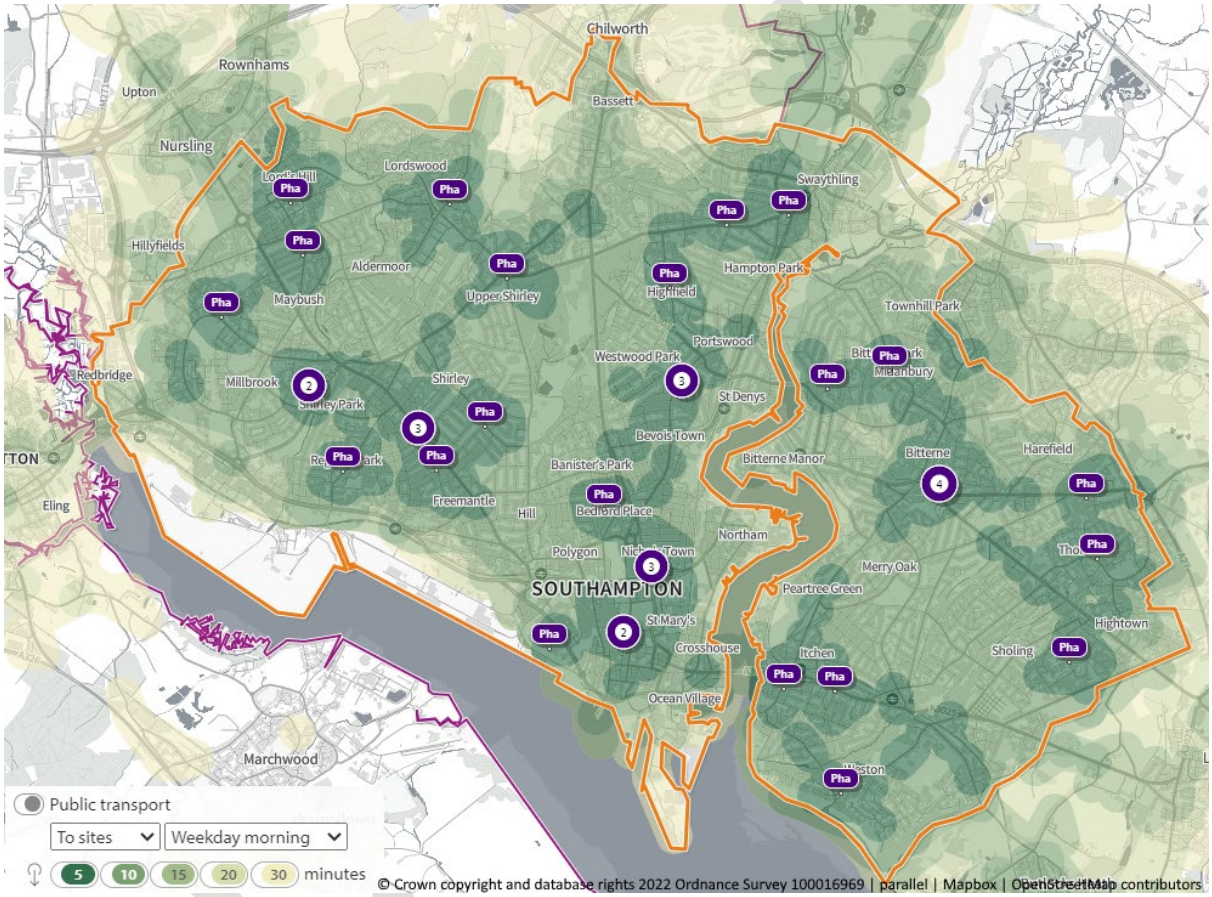
7.4 Public Transport

Residential areas of Southampton are well covered by bus stops and bus routes, therefore, access to pharmacies in Southampton are well served by public transport. Figure 12 below shows the number of pharmacies in Southampton and travel times to those sites. Approximately 51% of the population (based on MYE 2022) is within 5 minutes of a pharmacy.

Figure 12: Using public transport to visit sites including pharmacies



Source: SHAPE place, Public Health England

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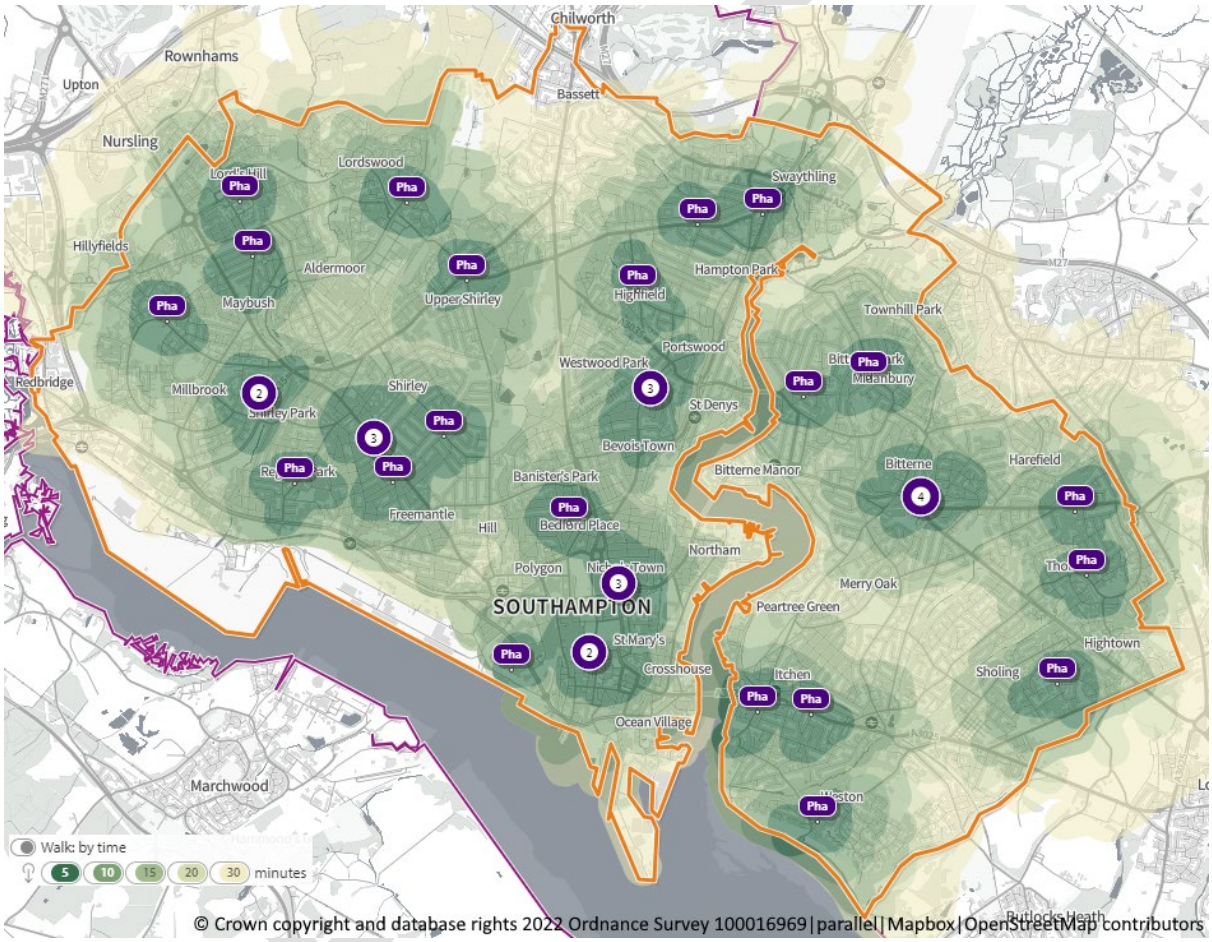
7.5 Walking

Over 98% of the population can reach a pharmacy in Southampton within a 20-minute walk (assuming the average walking speed is 3.1 mph). Just over 41% of the Southampton population is within a five-minute walk of a pharmacy. The entire Southampton population is within a 30-minute walk of a pharmacy (Figure 13).

Figure 13: Map of walking times (5-30 minutes) from pharmacies in Southampton (excluding distance selling) and outside of the local authority boundary (September 2024)

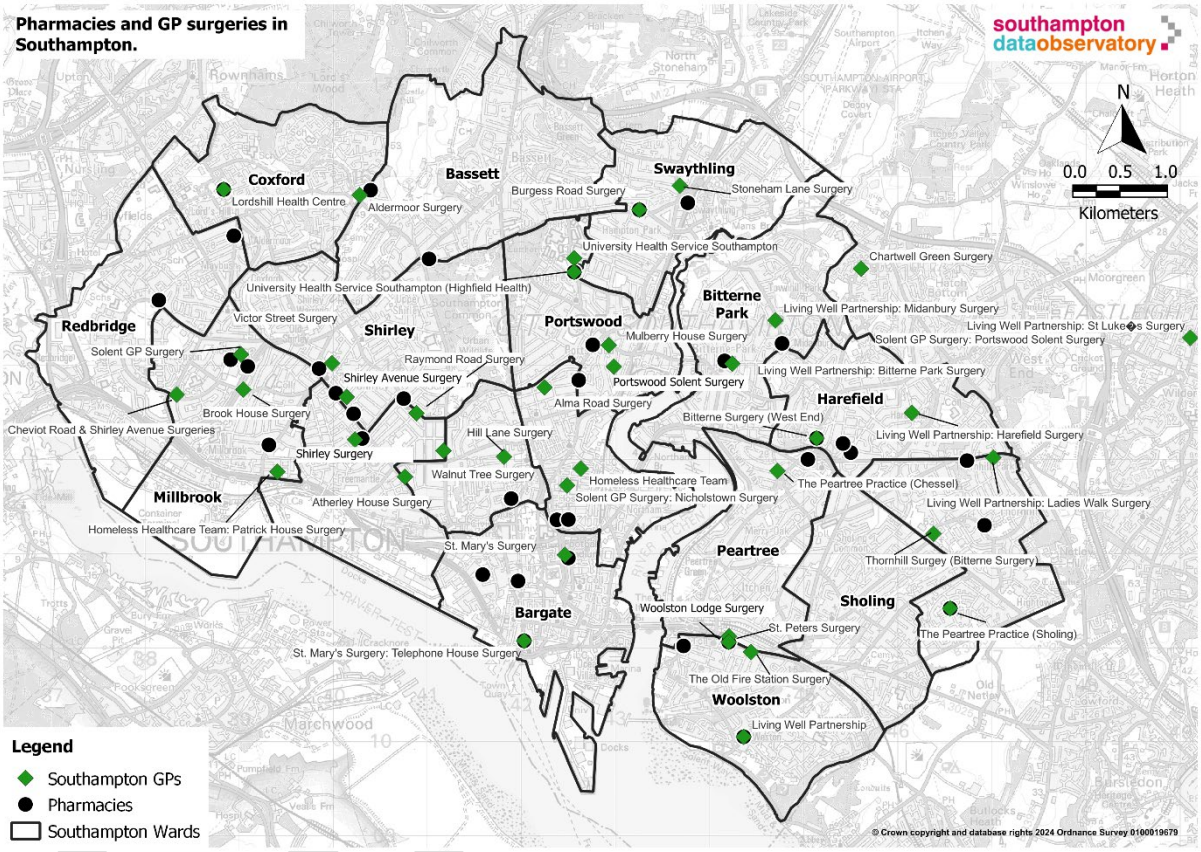


Source: SHAPE place, Public Health England

7.6 Proximity to GP Practices

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

Figure 14: Map of GP surgeries proximity to pharmacies in Southampton (October 2024)



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7.7 Density of Pharmacies

Based on the number of community pharmacies on the pharmaceutical list as of 2 September 2024, Figure 15 shows that Southampton had 14.8 pharmacies per 100,000 population which is higher than the Hampshire and Isle of Wight ICB rate of 13.6 per 100,000 and lower than the England average (20.3 per 100,000 population).

The average number of prescription item dispensed each financial year per pharmacy was lower than the Hampshire and Isle of Wight ICB area but higher than the England average.

Figure 15: Pharmacy density – items dispensed April 2022 to March 2023

April 2022 to March 2023	Number of community pharmacies	Prescription items dispensed	Population mid-year estimate 2023	Pharmacies per 100,000 population	Average number of dispensed items	
					per pharmacy	per pharmacy per month
England	11,687	1,177,346,927	57,690,323	20.3	100,740	8,395
Hampshire and Isle of Wight ICB	283	33,704,373	2,035,872*	13.9	119,097	9,925
Southampton	38	4,212,393	256,110	14.8	110,852	9,238

Source: NHSBSA and population from ONS mid-year population estimate 2023

* Population used for Hampshire and Isle of Wight ICB is Hampshire, Portsmouth, Southampton and Isle of Wight

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8. Population and health

To assess the need for pharmaceutical services in Southampton, it is necessary to understand the city's population and their socio-economic characteristics and health needs. Appendix A, in Part 2 of the PNA, uses data from the Joint Strategic Needs Assessment (JSNA) on the Southampton Data Observatory[24] to provide a very comprehensive picture of Southampton's population which is briefly summarised below.

8.1 Demography and socio-economic factors

8.1.1 Population

In 2023, the resident population of Southampton is estimated to be to be 264,957 [25] with 331,827 people registered with GP practices in September.[26] Southampton has a much younger profile than the England average, largely because of the number of students in the city. However, the older population is projected to grow proportionally more than any other group over the next few years; for instance, the over 65 population is set to increase by 7.3% between 2025 and 2028, and over 85 by 7.7%.

8.1.2 Future dwellings and population changes

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

The Strategic Housing Land Availability Assessment (SHLAA)[27] for Southampton indicates likely housing developments. The housing requirement for the city is 16,300 dwellings in the period 2006 – 2026. More information on housing developments in the city is available in section 11.1.3 in part 2.

These housing requirements are taken into account by the Hampshire County Council population forecasts which predict an increase in dwellings of 2,954 (2.7%)

[24] Southampton Data Observatory https://data.southampton.gov.uk/
[25] Small Area Population Forecasts statistics from Hampshire County Council https://data.southampton.gov.uk/population/population-size-and-structure/ (accessed 20/09/2024)
[26] NHS Digital https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice (accessed 20/09/2024) The Living Well Partnership includes two surgeries outside the Southampton boundary
[27] Strategic Housing Land Availability Assessment, Southampton City Council, accessed via http://www.southampton.gov.uk/planning/planning-policy/research-evidence-base/shlaa.aspx

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between 2023 and 2028. The increase in dwellings across Southampton translates to a population increase of 5,903 (2.2%).

The largest growth in dwellings over the 2023-28 period is predicted to be in Bargate (1,684 dwellings; 19.2%) – over seven times the city average, followed by Bitterne park (220 dwellings; 3.2%) and Banister & Polygon (216 dwellings; 2.9%). Therefore, it follows that the largest growth in population is predicted to be in Bargate (3,257 people; 15.7%) followed by Banister & Polygon (596 people; 3.2%). Redbridge is predicted to see a small fall in population (-26 people: -0.2%) over the same period.

8.1.3 Ethnicity

Based on results from the 2021 Census, Southampton has residents from over 70 different countries who between them speak over 160 different languages.[28] In the 2021 Census, in Southampton, 68.1% of usual residents are white British, a decrease of -7.9% since Census 2011. Compared with a decrease of -1.7% in England. Meaning that the population of Southampton is getting more ethnically diverse. In Southampton, 31.9% of residents consider themselves other than white British, compared with 22.3% in 2011. An increase of 50.2% or just over 26,500 people. The school census in Southampton in 2023 revealed that 43.4% of pupils were from an ethnic group other than white British.

8.1.4 Deprivation

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

8.2 General health needs of the city

Life expectancy in Southampton is 77.8 years for males and 82.4 years for females compared to the England averages of 78.9 and 82.8 respectively (2020-22). Of the 1,948 deaths of Southampton residents in 2022, cancer was the most common (508 deaths; 26.1%), followed by circulatory diseases (462 deaths; 23.7%) and respiratory diseases (259 deaths; 13.3%). People with circulatory and respiratory disease will more likely be prescribed medication by GPs to help manage their conditions.

[28] Schools, pupils and their characteristics, Department for Education 2023. https://data.southampton.gov.uk/population/ethnicity-language-and-identity/ Accessed 29/07/2024

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In Southampton, in 2022/23, 3,551 or 1.12% of patients with schizophrenia, bipolar affective disorder and other psychoses as recorded on practice disease registers, which is significantly higher to that of the England average of 1.00%. In October 2024 1.1% (2,912) of patients are recorded on GP registers as having a severe mental illness (SMI).

Health behaviours are also relevant to needs for pharmaceutical services. Appendix A includes information on smoking, excess weight, sexually transmitted infections and alcohol and drug use. For instance, In 2022 around 1 in 8 people (13.2%) in Southampton smoke, equivalent to 28,000 people. Compared with 12.7% in England and 10.5% in Hampshire. Southampton is the 6th highest in our ONS comparator group. This is an increase from 2021 and is now higher than England, but not significantly.

Pharmaceutical services are needed for long term conditions as well as acute injuries, ailments and infections.

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8.3 Specific Needs for Key Population Groups

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

8.3.1 University Students

The most common health issues associated with students are:

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

8.3.2 Carers

In the 2021 census, 18,136 people (7.7%) 1 in 13 people, said they provide some level of unpaid care in Southampton. This was significantly lower than the England average (8.8%) and was the third lowest rate among Southampton's ONS comparator group. Significantly more people in Southampton said they were in good health compared to the England average in the 2021 census. This, along with the city's relatively young population, may explain why there is slightly less unpaid care provided in Southampton.

8.3.3 Disability - People with a Learning Disability

There are an estimated 1,583 residents aged 15+ with a learning disability in the city.[29] People with learning disabilities have differing and often complex health care needs leading to increased prescribing and risk of polypharmacy. People with learning disabilities have a higher prevalence of:

- Depression
- Asthma
- Diabetes
- Epilepsy

[29] Learning disabilities – Southampton Data Observatory https://data.southampton.gov.uk/health/disabilities/learning-disabilities/ accessed 20/09/2024

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8.3.4 Disability - Adults with Autistic Spectrum Conditions

A local estimate of the prevalence of autistic spectrum conditions in adults aged 16 years and over in Southampton was produced using national prevalence estimates derived from the 2014 Adult Psychiatric Morbidity Survey. In 2023, it is estimated that there are 1,153 males (1.1% of male population) and 212 females (0.2% of the female population) aged 16 years and over in Southampton who would screen positive for autism spectrum conditions.[30]

8.3.5 Lesbian, Gay, Bisexual, and Transgender Community

For the first time Census 2021 included a question on sexual orientation. Although voluntary, people aged 16 and over were asked to complete.

In Southampton, there are 4,071 (2.0%) people who are gay or lesbian 5th highest amongst our ONS comparators and significantly higher when compared with 1.5% for England as a whole. There are also 4,830 people (2.4%) who are bisexual the 3rd highest amongst our ONS comparator group with Bristol as the highest (3.1%) and higher when compared to 1.3% in England. In Southampton, there are also 1,181 people (0.6%) who are other sexual orientations, including pansexual, asexual and queer. Third highest amongst ONS comparators and higher compared to 0.3% in England. In Southampton 8.3% of the people who filled in the Census didn't answer this question, higher than England (7.5%).

In the 2021 Census there was a question on gender identity, which asked people aged over 16 what their gender identity was. In Southampton, 92.3% of the over 16 population identified as the same sex as registered at birth, the 2nd lowest amongst our ONS comparators and significantly lower when compared to 93.5% for England. Coventry is the lowest at 91.6% and Plymouth is the highest at 94.2%.[31]

In Southampton, 1,633 people (0.80%) aged 16 and over identified themselves as a different sex from that registered at birth. This is significantly higher when compared

[30] NHS Digital. NatCen Social research Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014 (accessed 16/08/2024) applied to the Hampshire County Council 2023-based Small Area Population Forecast

[31] In the 2021 Census this question was voluntary, in Southampton, 6.9% of people aged 16 and over did not answer the question higher than England (6.0%). More details on https://data.southampton.gov.uk/population/census-2021/ (Accessed 14/10/2024)

to 0.55% for England. Southampton is ranked 3rd highest amongst our ONS Comparators, the largest being Newcastle upon Tyne (0.87%).[32]

8.3.6 Age

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

- Health issues tend to be greater amongst the very young and the very old
- In Southampton's 0 to 4 year olds, 99.6% are without chronic conditions. By age 60 to 64 over half (55.3%) have at least one LTC, by the age of 80 to 84 43.1% have at least 3 LTC and people aged 90 and over 8.4% have at least 6 long term conditions.
- In 2022/23, a higher rate of older people (aged 65 year and over) in Southampton access long term support through adult social services than is the case nationally (5,965 per 100,000 compared with 5,185 per 100,000).[33]

8.3.7 Ethnicity, Migration, Language and Religion

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

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

8.3.8 Gender

In 2018-20, in Southampton, healthy life expectancy for males was 61.4 years, which is lower than the national average of 63.1 years. For females, healthy life expectancy in Southampton is 63.1 years, which again is lower than the national average of 63.9 years. This suggests that in Southampton there is a wider healthy life expectancy gap (1.7 years) between males and females than that seen nationally (0.8 years).

[32] In the 2021 Census - In Southampton 8.3% of the people who filled in the Census didn't answer this question, higher than England (7.5%). Moe information on https://data.southampton.gov.uk/population/census-2021/ (accessed 14/10/2024)

[33] Personal Social Services Adult Social Care Survey, England, 2022-23 Adult Social Care Activity and Finance Report - NHS England Digital table 36 (Accessed 20/09/2024)

8.3.9 Port Workers and Visitors

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

8.3.10 Veterans

The 2021 Census recorded 6,361 (3.1%) Southampton residents (aged 16 and over) who had previously served UK armed forces or reserves (veterans). Southampton's percentage of veterans is lower when compared to England (3.8%) and the 5th lowest percentage amongst our ONS comparators which range from 8.4% in Plymouth to 2.4% in Bristol.

In Southampton, 86.8% of people who previously served in the UK armed forces or in the reserves were male and 13.2% were females. This is similar to England where 86.5% of veterans were male and 13.5% were female. (More information is provided in Appendix A section 11.7.11):

8.3.11 Travellers

In September 2021, there were twenty-six pitches across Southampton and nine Travelling show people yards, making a total of 35 plots across Southampton. In the 2021 Census 918 people recorded themselves as Roma (578) or Gypsy or Irish Traveller (340) just 0.4% of the population. Key barriers to health in these communities include lower health literacy and cultural distrust of systems.

8.3.12 Homelessness

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

The average life expectancy for women experiencing homelessness is 43 years and for men is 47 years. Deaths related to drug and alcohol use are prevalent amongst this population, accounting for just over a third of all deaths, and people experiencing

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homelessness are nine time more likely to commit suicide than the general population.[34]

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

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9. Gap Analysis

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

9.1 Do existing pharmaceutical services meet current needs?

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

- There is a good geographical spread of community pharmacies across the city (Section 7)
- Almost all of Southampton's population is within a 1.6km straight line distance of a community pharmacy (Section 7.1). There are two exceptions to this but, for the following reasons, neither is considered to indicate a gap in pharmaceutical provision:
    - The first is a small area in the west which is part of the industrial dock area and has no residential development; people who work in this area are considered to be sufficiently covered by pharmaceutical provision in Totton
- The second is four residential streets have been identified with no pharmacy provision within a 1.6km radius. These are all gathered in an area of the Bassett Ward at the north of the city, which abuts the M27 and the A27 and is centred on the SO16 7HT postcode. Although there are no pharmacies within a 1.6km radius of these four streets, the area is well served by main roads for those with access to a car, and by several bus routes for those that use public transport.[36] These bus routes connect Bassett to the city centre and Portswood, with one route additionally providing access to the large ASDA, Bournemouth Road in Chandler's Ford, Eastleigh which has its own pharmacy. Additionally, there are four pharmacies just over a 1.6km distance away from this area. There are 14.8 community pharmacies per 100,000 population in Southampton, which is very similar to the average for neighbouring areas and is broadly in line with the national average (Section 7.7)

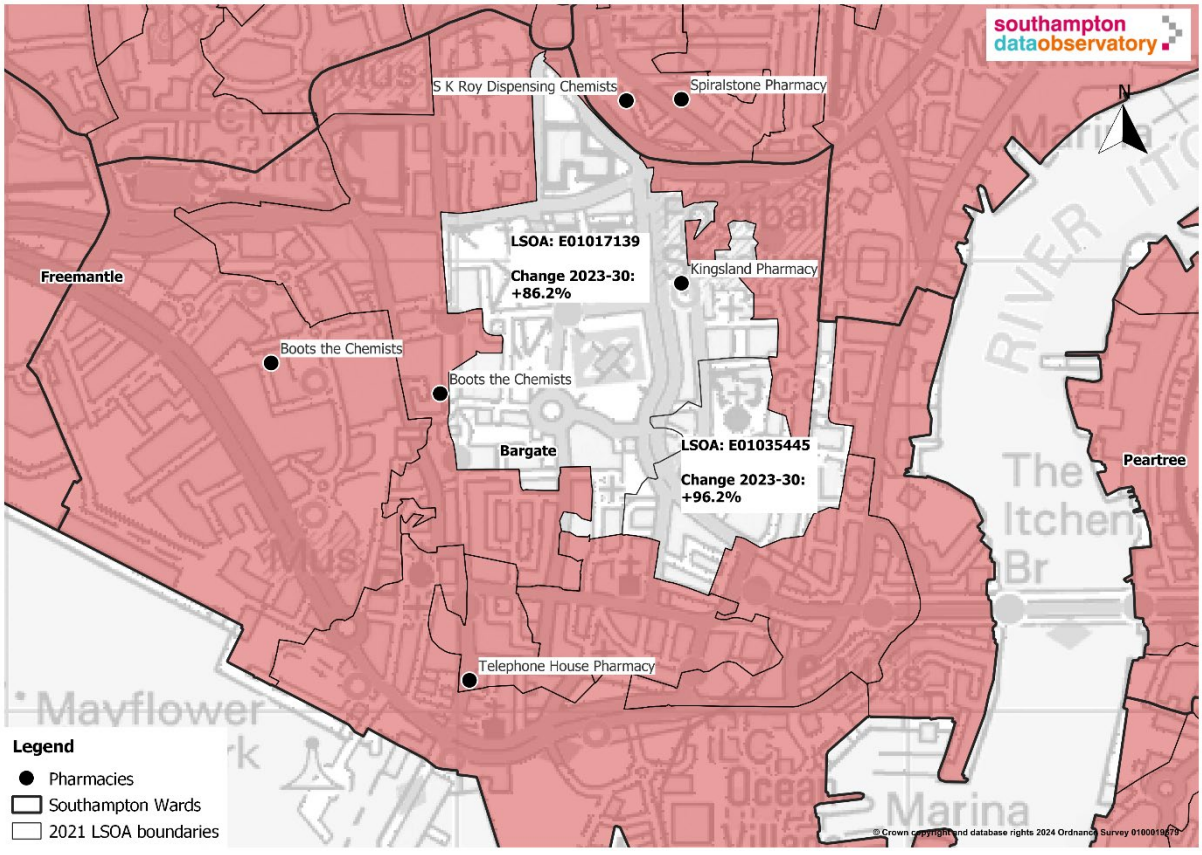
[35] The NHS (Pharmaceutical Services and Local Pharmaceutical Regulations) 2013 available at http://www.legislation.gov.uk/uksi/2013/349/contents/made (accessed 15/10/2024)
[36] Bus service https://myjourneysouthampton.com/bus/ (accessed 15/10/2024)

- Over 98% of the Southampton population are within a 20 minute walk of a community pharmacy (Section 7.5)
- With three 100-hour pharmacies in Southampton, supplementary hours in other pharmacies and provision in neighbouring HWB areas, there are sufficient access times to meet the needs of the city's residents (Section 6)

9.2 Do existing pharmaceutical services meet future needs?

An assessment of forecasted population growth in the city identified Bargate ward as the area with significant new development within the lifetime of the PNA. In particular, there are 2 Lower Super Output Areas (LSOAs) in Bargate ward which are forecast to have a large increase in population between 2023-2030; these are shown in Figure 16. LSOA E01017139 is predicted to increase by 86.2% and E01035445 is predicted to increase by 96.2%. There are five pharmacies within easy reach of those two areas, suggesting that pharmaceutical cover is sufficient to cope with population growth. Overall predicted increase for Southampton is 7.5% between 2023 and 2030.

Figure 166: LSOA (2021) in central Southampton population change 2023 to 2030



Source: Hampshire County Council Small Area population forecasts 2023-base

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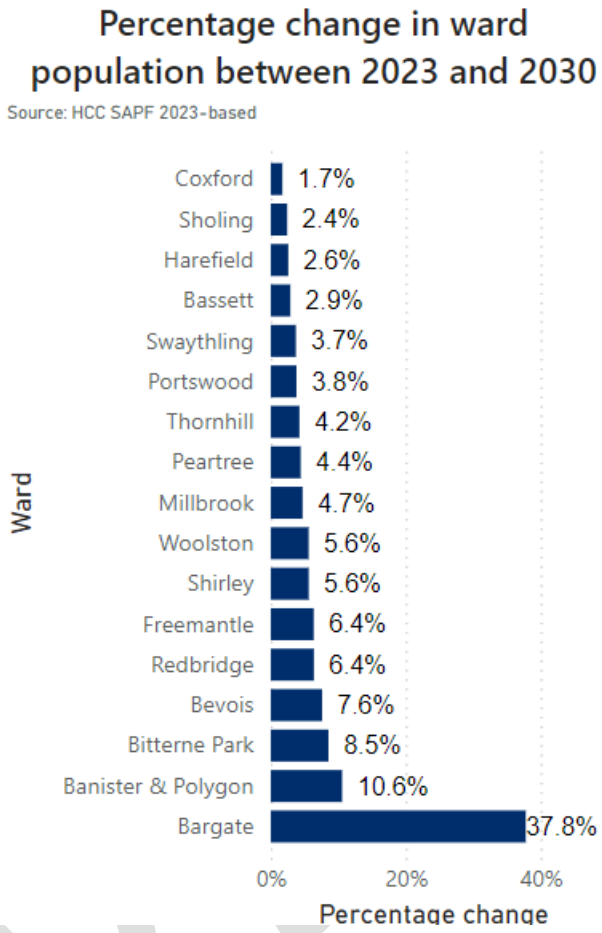
Figure 17: Forecast population change for Southampton wards 2023-2030



Source: Hampshire County Council's 2023-based Small Area Population Forecasts

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

10. Conclusion

The conclusion of this PNA is that the number, distribution and choice of pharmaceutical services meet the needs of the population and will meet future needs within the lifetime of this PNA. Therefore, there is no identified need for improvements or better access to pharmaceutical services in the city. The conclusion will be updated when the public survey have been completed and the document has been to HWB.

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Southampton Pharmaceutical Needs Assessment (PNA) Part 2: Appendices

Last updated November 2024

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

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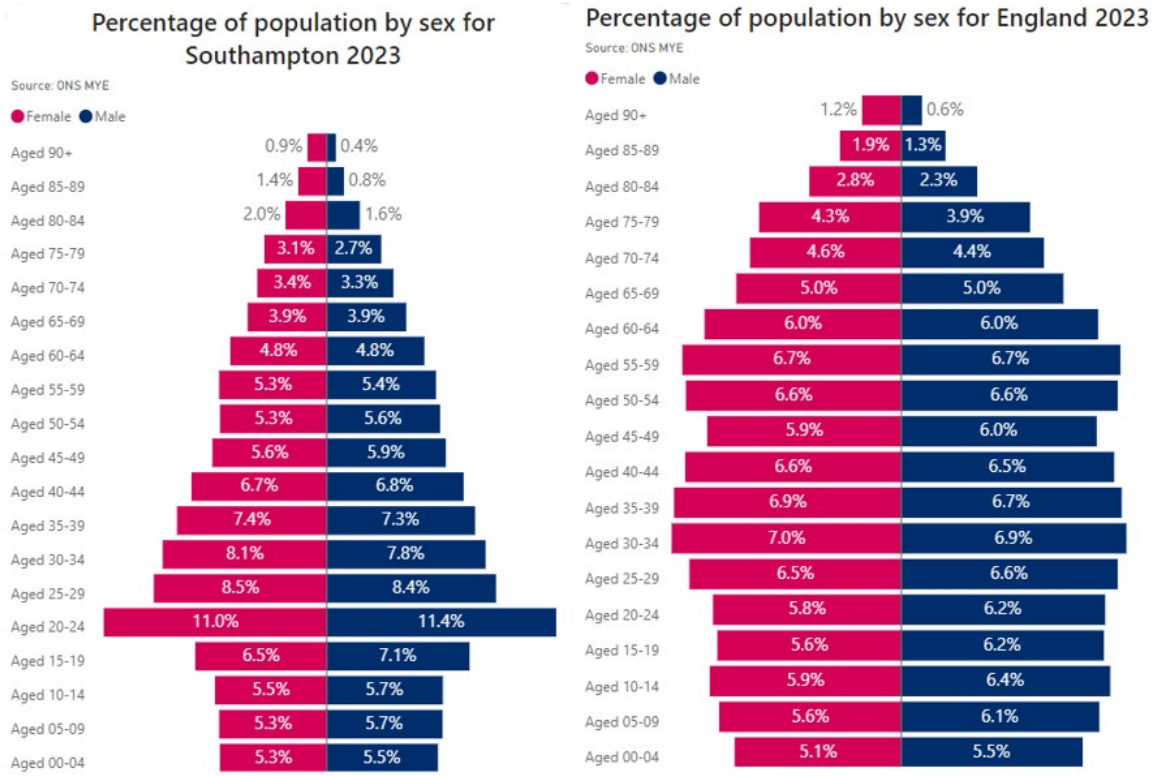
11. Appendix A: Supporting Information

11.1 Population

In 2023, the resident population of Southampton is estimated to be to be 264,957[40] with 332,245 people registered with GP practices in July 2024.[41] The population pyramids in Figure 18, for 2023, show how the profile of Southampton's population differs from the national average. This is because of the large number of students in the city; 18.0% of Southampton's population is aged between 15 and 24 years, compared to just 11.9% in England.[42]

Figure 18: Population by age and sex for England and Southampton 2023



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

[40] Hampshire County Environment Department's 2023-based Southampton Small Area Population Forecasts https://www.hants.gov.uk/landplanningandenvironment/facts-figures/population/estimates-forecasts

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

[42] Southampton population dashboard. July 2024 https://app.powerbi.com/view?r=eyJrIjoiNzgxZjAzNTQtZDg5Ni00NTczLWE0Y2EtY2FjNTNiNjhlMzk4IiwidCI6IjNhM2IwNzlhLTY0YzAtNDcxYy05MmU1LTRlOTE5ZTMwN2NhOCIsImMiOjh9

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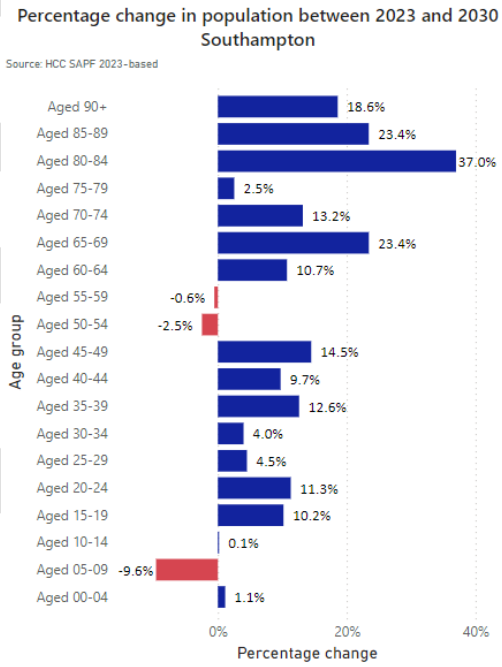
There are many uncertainties around current and future population numbers. The Southampton JSNA currently uses data produced by Hampshire County Council (HCC)[43] which incorporates the results of the 2021 Census. HCC's small area population forecasts (SAPF) are based on the planned completions of residential dwellings in Southampton, which predict an increase in dwellings of 6,718 (6.2%) between 2023 and 2030. The largest growth in dwellings is predicted to be in Bargate (3,465 dwellings; 43.4%) – seven times the city average, followed by Banister and Polygon (557 extra dwellings; 7.8%) and Bitterne Park (473 extra dwellings; 7.0%). The increase in dwellings across Southampton translates to a population increase of 19,967 (7.5%) between 2023 and 2030. Due to the planned residential development, the largest population growth is predicted to be in Bargate (7,269 people or 37.8%) followed by Banister & Polygon (1,886; 10.6%). The smallest increase can be found in Coxford (253; 1.7%) over the same period.

The older population is projected to grow proportionally more than any other group in Southampton over the next few years (Figure 19). The over 65s population is projected to increase between 2022 and 2030, from 38,472 in 2023 to 45,493 in 2030, an increase of 7,021 or 18.2%. The over 85s population is forecast to grow from 5,840 in 2023 to 7,094 in 2030, an increase of 21.5% between the 2023 and 2030.

Figure 19: Population change by age, in Southampton, between 2023 and 2030



Source: Hampshire County Council 2023-Based Southampton Small Area Population Forecasts

[43] Hampshire County Environment Department's 2023-based Southampton Small Area Population Forecasts https://www.hants.gov.uk/landplanningandenvironment/facts-figures/population/estimates-forecasts

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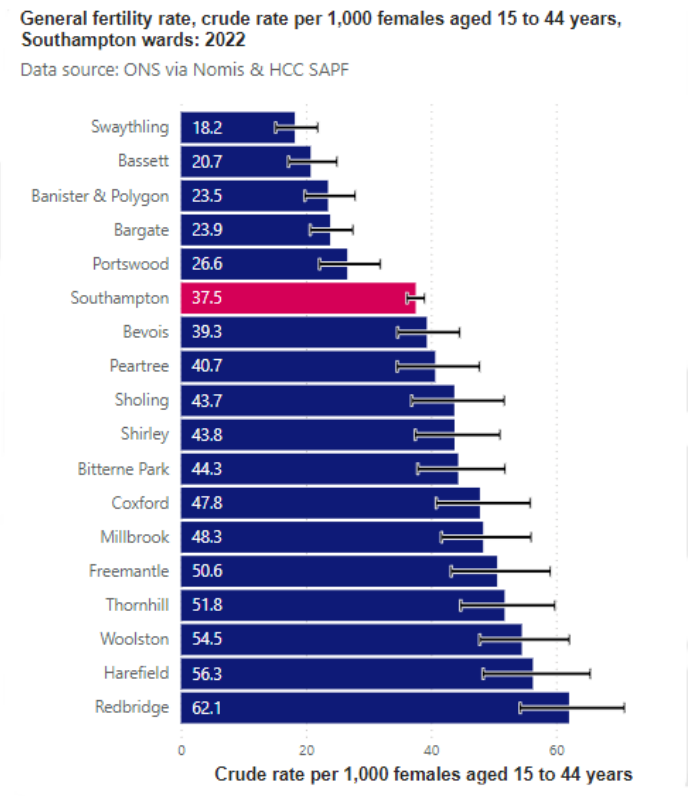
Life expectancy in Southampton is 77.8 years for males and 82.4 years for females compared to the England averages of 78.9 and 82.8 respectively (2020-22 pooled). In addition, although people are living longer, it is often with multiple long-term conditions and an extended period of poor health and/or disability.

According to the Hampshire County Council forecasts, the number of 0 to 4-year-olds will increase by 1.1% between 2023 and 2030

Between 2013 and 2021 general fertility rates in the city have decreased from 58.3 to 48.6 per 1,000 females aged 15-44 years. The 2021 figures compare with 54.8 per 1,000 females aged 15 to 44 years across the South East and 54.3 per 1,000 in England.

In 2022, the general fertility rate for Southampton by electoral ward ranged from 62.1 births crude rate per 1,000 females aged 15 to 44 years in Redbridge to 18.2 in Swaythling (Figure 20).

Figure 200: General fertility rate in Southampton wards 2022



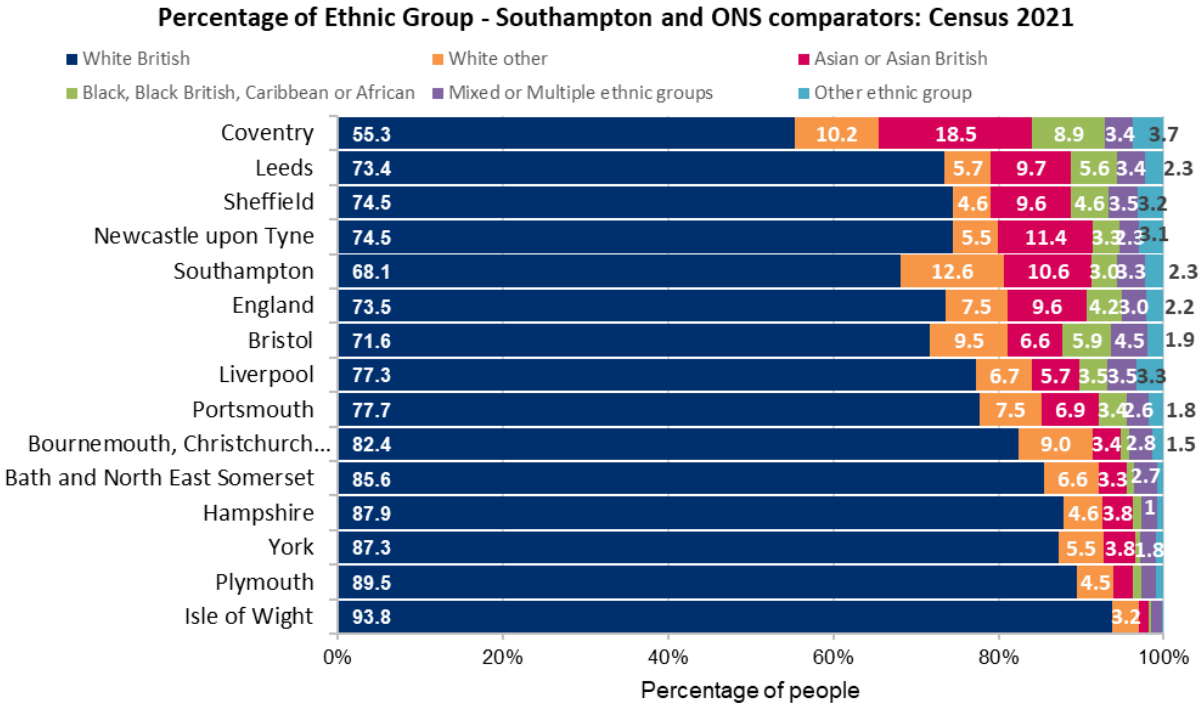
Source: Office for National Statistics

11.1.1 Ethnicity, Migration, Language and Religion

Data on long-term international migration up to the end of June 2023 shows that Southampton has more international incomers than leavers (10,438 compared to 4,807). There is also a high level of internal migration, with 17,776 people arriving and 20,067 leaving over the same period.

Based on results from the 2021 Census, Southampton has residents from over 70 different countries who between them speak over 160 different languages.[44] In the 2021 Census, in Southampton, 68.1% of usual residents are white British, a decrease of -7.9% since Census 2011. Compared with a decrease of -1.7% in England. Meaning that the population of Southampton is getting more culturally diverse. In Southampton, 31.9% of residents consider themselves other than white British, compared with 22.3% in 2011. An increase of 50.2% or just over 26,500 people.

Figure 21: Ethnicity of resident population 2021 census



Source: Office for National Statistics

[44] Schools, pupils and their characteristics, Department for Education 2023. https://data.southampton.gov.uk/population/ethnicity-language-and-identity/ Accessed 29/07/2024

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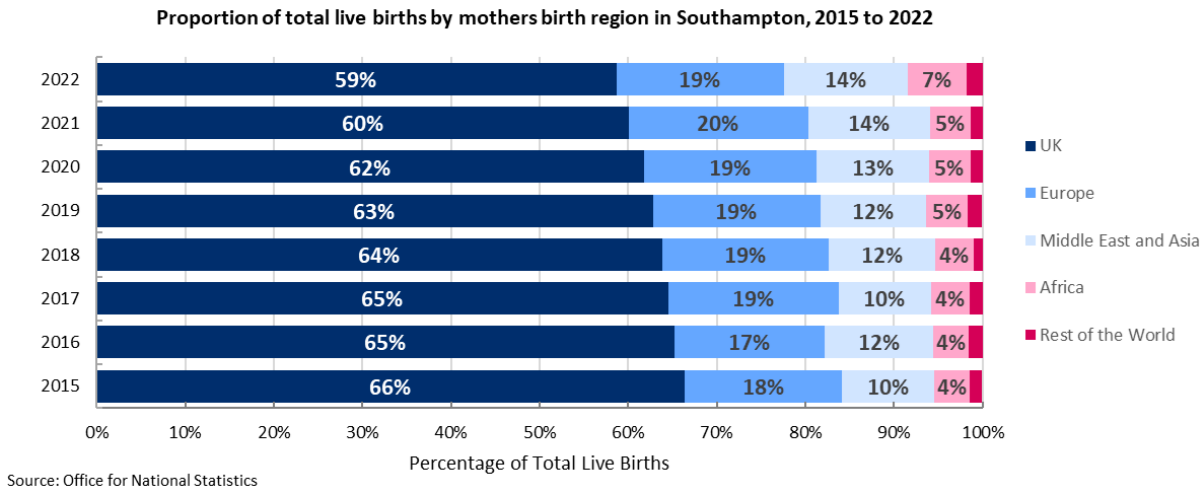
Within Southampton, there is a wide variation in ethnic diversity. In Bevois ward, the largest ethnic group is white British at 36.1% followed by Asian or British Asian (29.1%) and 18.2% of the population are white other (than white British). In Freemantle, the largest ethnic group is white British (56.1%) followed by white other (than white British) (21.5%). Sholing has the largest white British ethnic group (87.3%).

Looking in more detail at the changes in ethnicity across Southampton wards, there has been a fall in the white British population across all wards except Woolston (an increase of 1.4%), ranging from a fall of -0.9% in Redbridge to a fall of -16.0% in Portswood.

In Southampton wards, the largest changes in the number of people by ethnic groups, between Census 2011 and Census 2021, show an increase in Bargate of 2,154 white (other than white British), 1,491 Asian or British Asian (including 582 Chinese) and 621 Black, Black British, Caribbean or African people. The wards with higher percentages of ethnic groups above the city average remain the same as were recorded for the 2011 Census (Bevois, Bargate, Freemantle, Swaythling, Portswood, Bassett and Shirley).

In Southampton 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. Southampton has a higher proportion of live births born to non-UK-born mothers than its local neighbours, 32% in Portsmouth, 19% in Hampshire and 9% on the Isle of Wight, reflecting the diversity of Southampton's community, see Figure 23. In the 2021 Census 26.2% of Southampton residents were born outside UK, compared to 19.7% for England.

Figure 22: Mothers country of birth - Southampton 2015 to 2022



Source: Office for National Statistics

In Southampton, there is an increase of 17.7% from 4,587, in 2011 to 5,398 in 2021, who cannot speak English well. There was also an increase of 6.1% (44 people) in the number of people who cannot speak English. Nationally 17.1% cannot speak English well and 3.1% cannot speak English at all.

The top 10 first languages spoken in Southampton, according to the 2021 Census, excluding English (84.6%) are Polish, Romanian, Chinese, Portuguese, Spanish, Persian or Farsi, Arabic, Greek and Bulgarian. Polish speakers make up 4.34% of the population an increase of 26.3% between the 2011 and 2021 Census. Although Romanian speakers make up only 1.32%, they have increased by 924.5% between the two Census.

In Southampton schools in 2023, 31.1% of school pupils had a first language other than English, higher than the England average of 20.2%. Data from the spring 2023 school census shows that English is ranked 1 in all wards. The ward with the highest percentage for English is Thornhill at 87.4% of pupils, followed by Sholing (87.0%), the lowest ward is Bevios has only 28.0% of pupils with English as a first language.[45]

In the January 2023 school census, the top five languages spoken in Southampton schools (excluding English) are show in Figure 24 below.

Figure 23: Top 5 languages spoken in Southampton schools 2023 (excluding English)

Top 5 languages	Number of pupils	% of total
Polish	2,626	8.1%
Romanian	609	1.9%
Panjabi	551	1.7%
Urdu	516	1.6%
Pashto/Pakhto	482	1.5%

Source: 2023 School Census. Children's Data Team Southampton City Council.

[45] Schools, pupils and their characteristics, Department for Education 2023/24. https://explore-education-statistics.service.gov.uk/find-statistics/school-pupils-and-their-characteristics Accessed 30/07/2024

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The following statistics in Figure 25 for self-reported religion of Southampton residents are taken from the 2021 Census.

Figure 24: Religion from 2021 Census, for Southampton

Religion	Number	Percentage
No religion	108,000	43.4
Christian	99,910	40.1
Not answered	16,412	6.6
Muslim	13,893	5.6
Sikh	4,192	1.7
Hindu	3,265	1.3
Other religion	1,663	0.7
Buddhist	1,333	0.5
Jewish	254	0.1

Source: Office for National Statistics 2021 Census

11.1.2 Southampton's Local Economy

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

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

Major employers include ABP, IKEA, Ocean Infinity, Southampton City Council, the NHS, the University of Southampton and Solent University, Quilter, Carnival, Maritime & Coastguard Agency, DP World (container port) and Southampton based rail and bus companies. The city has five million visitors a year for retail and leisure

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

[47] Associated British Ports Website https://www.abports.co.uk/locations/southampton/ (Accessed 30/07/2024)

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activities and its night-time economy has grown in recent years. Although this has been affected by the COVID-19 pandemic in 2020 and 2021. The ABP Port forms a key asset to the city and the Solent area. The port is also considered as the capital of England's cruise industry, and Europe's leading turnaround cruise port. In 2023, there were 2.73m cruise passengers and similar forecast for 2024.

Productivity and growth can be measured using Gross Value Added (GVA), which is a key economic indicator. It measures the performance of each individual producer or industry and their input to the economy. The most recent data (2022) estimates the Southampton economy to be worth £10 billion. This equates to a net increase of +13.2% (+£1.2 billion) since 2019 (pre-pandemic baseline). The national and regional GVA(B), which includes estimates of GVA balanced against the effects of inflation,[48] also increased during this period (+13.0% and +13.2% respectively), albeit at a slightly lesser rate than Southampton. Overall, this highlights positive economic recovery and subsequent growth since the COVID-19 pandemic in Southampton.

Additionally, GVA(B) per head of population has also increased in Southampton, experiencing a +11.7% increase from £35,503 in 2019 to £39,665 in 2022. The latest revisions have impacted the long-term trend of GVA(B) per head, with Southampton now showing to have had a value greater than England and South East averages consistently since 2010, see Figure 26, below, for details.[49]

[48] ONS – GVA(B) - Regional gross value added (balanced) QMI - Office for National Statistics (ons.gov.uk) (accessed 15/10/2024)
[49] Southampton economic assessment https://data.southampton.gov.uk/economy/economic-assessment/ (Accessed 30/07/2024)

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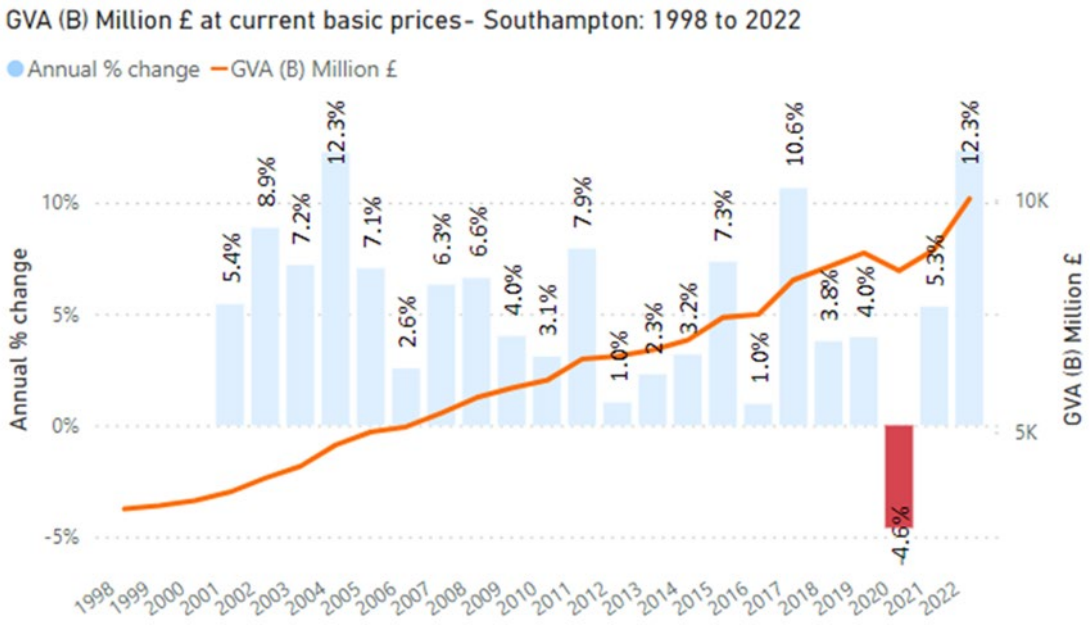
Figure 25: GVA (B) million £ at current basic prices - Southampton 1998-2022



11.1.3 Major Regeneration Projects

Southampton has many regeneration projects recently completed or underway, to meet the housing needs of the city's population growth, there are a number of major developments taking place that will help regenerate key areas and facilitate good growth and future prosperity. Significant levels of development are expected to be an ongoing feature of the city as part of the Southampton Renaissance and as set out in the Southampton City Vision, which is the city's new Local Plan.

In the city centre, construction work is ongoing to deliver the mixed-use redevelopment of the Bargate Shopping Centre. The development will include 519 new apartments and the developer has stated they expect the first residents will move in at the start of 2026.

The redevelopment of Chapel Riverside has delivered 204 new dwellings to date with planning permission having been granted for the remaining phases to provide 316 new apartments. Unfortunately, the developer Inland Homes entered administration at the end of 2023, but work is ongoing to identify a new developer to take forward those final phases.

The former Debenhams at the Queens Buildings on Queensway now has planning permission for 607 new dwellings (598 apartments and 9 houses) and the former Toys R Us on Western Esplanade has planning permission to be redeveloped for a mixed-use development including 603 apartments. The former Olleco plant on Royal Crescent Road now has planning permission for 397 apartments which will be

operated as co-living accommodation. All three of these developments are expected to come forward over the next few years.

Other major development completions in the city centre include:

- The conversion and extension of 43-49 London Road – 20 apartments
- The redevelopment of 5A-6A Bedford Place – 10 apartments
- The conversion and extension of 19-21 High Street – 23 apartments
- The conversion and upward extension of 64 London Road – 34 apartments

Major development with planning permission and are expected to be completed in the next few years include:

- The conversion of Queensway House at 11 Queensway – 33 apartments
- The conversion of Thomas House at 28-30 Bernard Street – 15 apartments
- The redevelopment of 127-131 Albert Road South – 20 apartments
- The redevelopment of 6-12 Royal Crescent Road – 36 apartments
- The redevelopment of 119-122 High Street and 55-59 Castle Way – 98 apartments
- The development of land to the rear of 104-106 East Street – 16 apartments
- The conversion of Dukes Keep on Marsh Lane – 118 apartments
- The development of land to the rear of 56 High Street – 29 apartments
- The conversion and upward extension of 124-126 Above Bar Street – 17 apartments
- The conversion of Friary House on Briton Street – 46 apartments
- The conversion of 49-50 High Street and the rear of 48 High Street – 12 apartments
- The conversion of 12-14 Carlton Place – 16 apartments
- The conversion of 8-9 College Place – 21 apartments

Elsewhere in the city, construction work has continued at the Centenary Quay development with a further 161 apartments now having been completed. This means the total number of new dwellings delivered at Centenary Quay has reached 1,115. The final phase of Centenary Quay now has planning permission for 164 dwellings (32 houses and 132 apartments) and will be delivered in the next few years.

Work is also taking place to progress the regeneration of the Townhill Park Estate, which involves the demolition of 416 existing dwellings to be replaced by 665 new high-quality, more sustainable dwellings. The first 56 dwellings have been completed and further phases are now being promoted through the Council's Affordable Housing Framework.

Developments that are progressing well and should be completed soon include the conversion of Compass House on Romsey Road to deliver 241 apartments, the

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redevelopment of the former East Point Centre on Burgoyne Road for 128 dwellings (21 houses and 107 apartments) and the redevelopment of the former car showroom at 75 The Avenue for 66 assisted living apartments and an 80-bed care home.

Other major developments outside of the city centre that have now been completed include:

- The redevelopment of 57A Rockstone Lane – 13 apartments
- The redevelopment of the former Oakland School on Fairisle Road - 103 dwellings (62 houses and 41 apartments)
- The redevelopment of Herbert Collings House at 5 Northleigh Corner on Walnut Avenue – 14 apartments
- The upward extension of Elmfield North and West Blocks on Millbrook Road East – 16 apartments
- The redevelopment of the former snooker hall on Church End – 12 dwellings (3 houses and 9 apartments)

Other major developments outside of the city centre, that have planning permission and are expected to be completed in the next few years include:

- The redevelopment of 22-28 Onslow Road – 16 apartments
- The redevelopment of Southern House on Shirley Road – 14 dwellings (3 houses and 11 apartments)
- The conversion of the commercial units at 67-71 Millbrook Road East – 22 apartments
- The redevelopment of 411-419 Millbrook Road West – 10 flats
- The redevelopment of 2 Victor Street – 45 flats
- The redevelopment of Bitterne Parish Church Office – 15 houses
- The conversion and upward extension of 75-79 Shirley Road – 12 flats
- The redevelopment of Horseshoe Park at Horseshoe Bridge – 47 flats

11.1.4 Overall Deprivation

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

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

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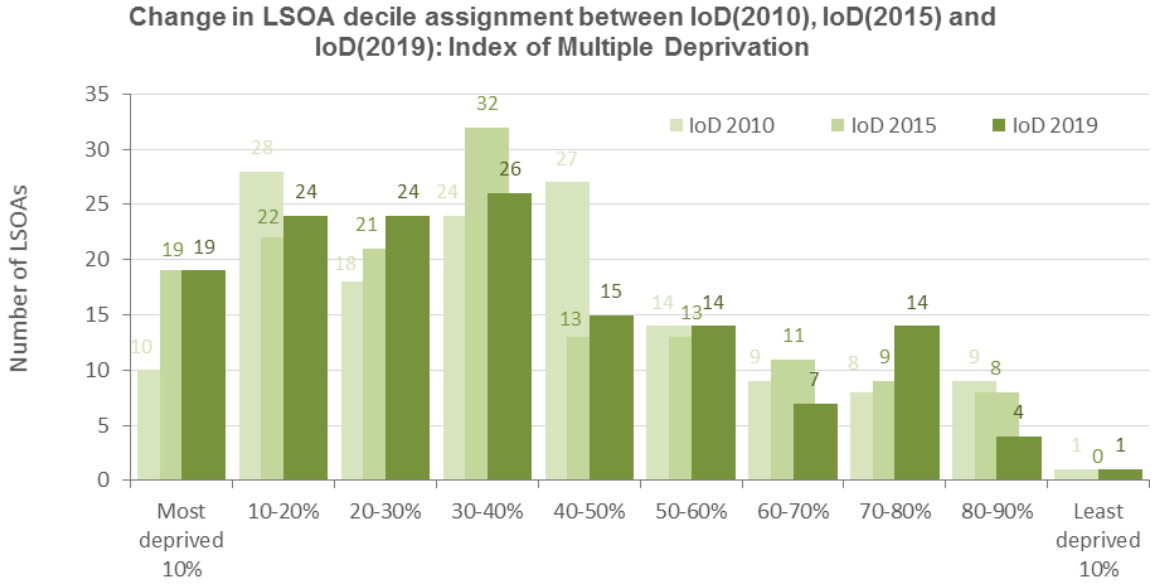
Figure 26: Change in LSOA decile assignment between Index of Deprivation (IoD) 2010, 2015 and 2019 Index of Multiple Deprivation



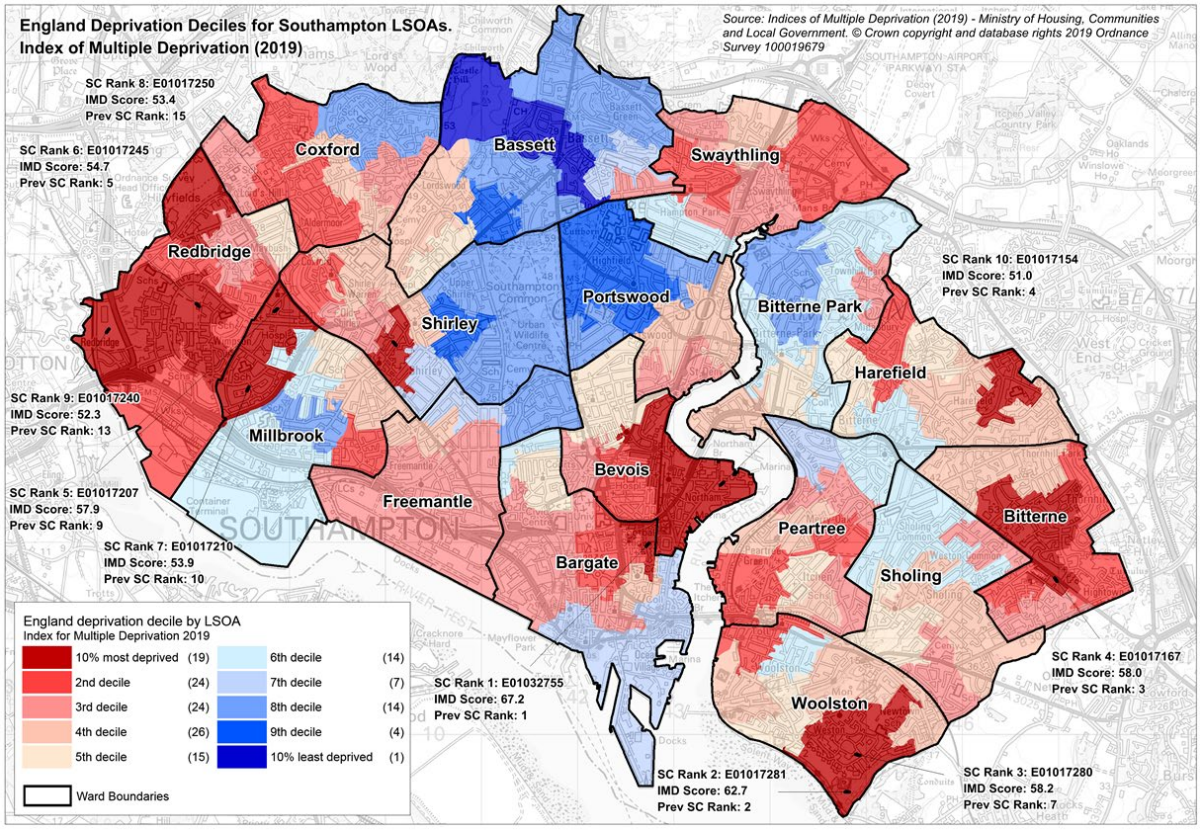
Source: DCLG. Note: IMD (2019) data is based on PHE rebased figures for 2011 LSOAs

The IMD 2019 is based on the concept that deprivation consists of more than just poverty. Poverty is not having enough money to get by on whereas deprivation refers to a general lack of resources and opportunities. The IMD brings together a range of indicators, which cover specific aspects of deprivation. These indicators are aggregated into seven domains, which are then weighted and combined to create the overall IMD. The majority of data underpinning the IMD 2019 is from 2015/16, although some is more recent.

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

As noted at the beginning of this section, deprivation is a significant issue in Southampton and is a wider determinant of health outcomes. The following map (Figure 28) shows how the LSOAs in Southampton score on the IMD scale. Better health outcomes are expected in those areas shaded in blue (the darker the blue, the better the outcomes), and poorer health outcomes are expected in those areas shaded in red, with the worst outcomes expected in those areas shaded in the darkest red.

Figure 27: Overall deprivation by England deciles for Southampton 2019



11.1.5 Income Deprivation

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

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11.1.6 Children Affected by Deprivation

The Marmot Review (2010)[50] suggests there is evidence to show that childhood poverty leads to premature mortality and poor health outcomes for adults. There is also a wide variety of evidence to show, that children who live in poverty are exposed to a range of risks that can have a serious impact on their mental health. Reducing the numbers of children who experience poverty should improve these adult health outcomes and increase healthy life expectancy.

In 2020/21, figures on households with below average income, from the Department for Work and Pensions, suggest that there are 3.3 million (23%) children under 16 in the UK living in absolute poverty (after housing costs). Applying this percentage to Southampton, it is estimated that there could be 10,000 children living in absolute low income in the city.

Figures on children living in low-income families are also produced by the Department for Work and Pensions. In 2021/22, 25% of children in Southampton aged under 16 are living in relative low income families, significantly higher than the national average (23.8%).

11.1.7 Older People Affected by Deprivation

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

11.1.8 Unemployment, Employment, Education, and Training

In 2022/23, 80.1% (139,300) of the working age population in Southampton were economically active, increasing by +2.1 percentage points (+3,700 people) from the previous period, and remains similar to both the national (78.6%) and South East (80.7%) averages.

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

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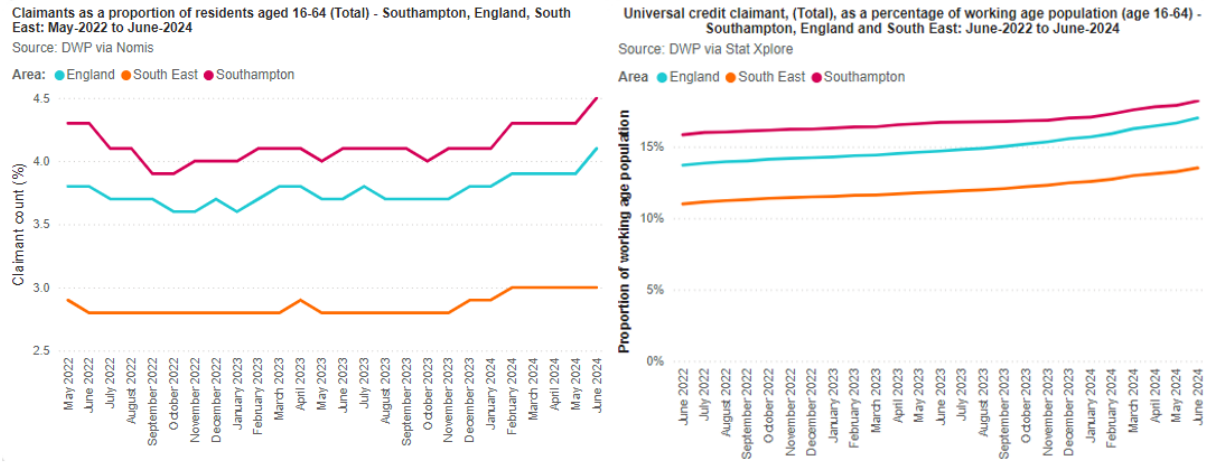
In addition, unemployment in Southampton has experienced an overall decline since 2010. In 2022/23, 4.3% (6,000) of working age adults in Southampton were unemployed, a decrease from the previous financial year (4.8%). Although, it is important to emphasise that the changes observed in Southampton in recent years are not statistically significant. Unemployment data is from the Labour Force Survey (LFS), which is considered the most reliable source of unemployment data, following changes to the benefits system and the introduction of Universal Credit.

Claimant count data is published monthly and allows for the proportion of adults claiming out of work benefits to be monitored in detail. Locally and nationally the number of adults claiming out of work benefits has stagnated over the last year. As of April 2024, 4.4% (7,395) of the working age population were claiming out of work benefits in Southampton; an increase of +470 claimants (+6.8%) since April 2023 (4.1%). Whilst progress has been made in recovering from the COVID-19 pandemic, Southampton is yet to return to the pre-pandemic baseline (less than 3.5% in January to March 2020). This could possibly be linked to recent financial pressures and economic uncertainty. More information can be found in the benefits dashboard on Southampton Data Observatory.[51]

Figure 28: Job-seekers Allowance (JSA) claimants and Universal Credit claimants for Southampton from May 2022 to June 2024



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

As can be seen from Figure 30 below, there continues to be an inequality gap in terms of pay between those working in the city and those resident in the city. In 2023, the median gross weekly pay for full-time workers was £704, compared to £652 for residents; a difference of £52, the third largest gap amongst comparators. Workplace

[51] Southampton Data Observatory Economic assessment resources section.https://data.southampton.gov.uk/economy/economic-assessment/ (Accessed 10/09/2024)

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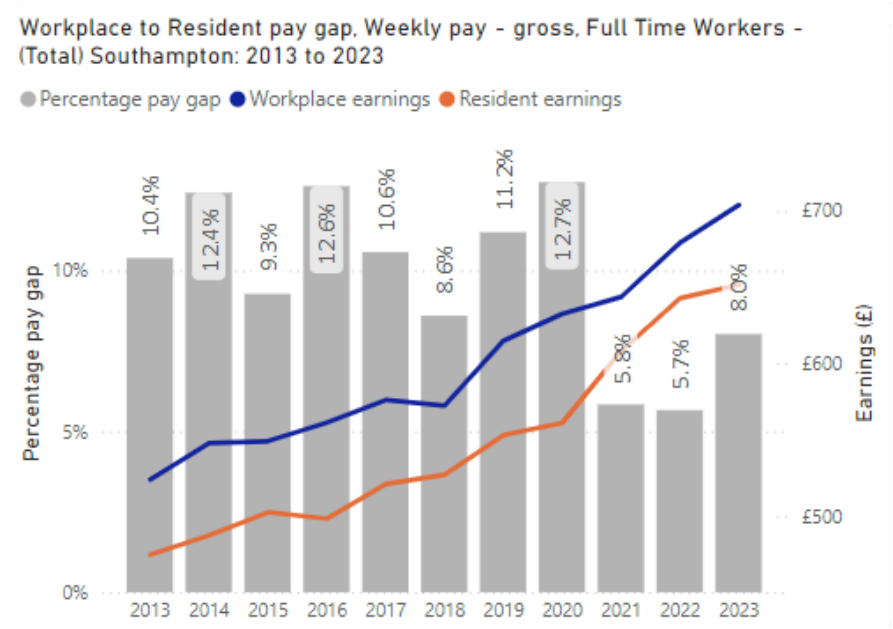
pay is higher but not significantly than the national average (£684), whilst resident pay is lower but not significantly than the average (£683).

Figure 29: Workplace and residents pay gap, for Southampton 2013 to 2023



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

Levels of pay for jobs located in Southampton are now higher than the England average and the highest on offer amongst the city's statistical neighbours. Southampton is home to large businesses requiring higher skilled workers, as well as hosting university workers and graduates. However, the relatively high levels of income available to workers in the city is not directly reflected in the economic wellbeing of Southampton residents. The average house price in Southampton (£240,777 in May 2024) is 7.3 times the average annual salary for residents (£33,101).

Since 2020 all GCSEs had been converted to a scale of 9-1 with no unreformed GCSEs graded A*-G remaining. Attainment 8 measures a pupil's average grade across eight subjects including English and Maths. 2023 is the second consecutive year since 2019 that Key Stage 4 grades are being based on exams and assessments after two years (2020 and 2021) of alternative arrangements in response to Coronavirus. Unlike 2022, students have not been given advanced information about topics they are likely to be tested on in 2023. Grades are expected to fall back in line with results in 2019. However, some of the adjusted measures from 2022 remain in place. Exams were spaced out more than they were prior to the pandemic, allowing for rest and revision. In addition, some subjects provided

formulae and equations, and students will not be expected to confront unfamiliar words in language exams.

In 2023, Southampton had an Attainment 8 points score of 42.9, which is lower than the national average of 46.3. In view of achieving Grade 5 or above in English and Mathematics GCSEs, Southampton had 38.1% of pupils achieve, which is also lower than the national average of 45.3%.

In 2023, 30.0% of Southampton pupils entered the English Baccalaureate (EBacc). The 2023 National average for pupils entering the EBacc was 39.3%. Southampton pupils achieved an EBacc points score of 3.67, which is lower than the National average of 4.05.

In 2022, the percentage of Southampton's young people aged 16-17 years not in education, employment, or training (NEET) was 4.1%, and this was higher than the rate for England (2.8%).[52]

[52] DfE – NEET and participation: Local authority figures. https://www.gov.uk/government/publications/neet-and-participation-local-authority-figures (Accessed 30/07/2024)

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11.1.9 Housing Composition

The number of households in Southampton with at least one resident increased from 98,254 in 2011 to 102,291 in Census 2021, an increase of 4.1%. This is lower than the overall England increase of 6.2% and is the 6th lowest change amongst our ONS comparators.

The number of one person households in Southampton has increased from 33,241 in 2011 to 33,711 in Census 2021 an increase of 1.4%. Older person single households increased by 1.5% between 2011 and 2021 (it should be noted that in 2011 census older people were classified as aged 65 and over. In the 2021 Census they are classified as 66 and over).

One family households increased from 53,070 in 2011 to 58,597 households in 2021 an increase of 10.4%. Lone parent families increased from 10,048 in 2011 to 11,270 in 2021 an increase of 12.2%.

The number of other household types including full time students fell from 11,943 in 2011 to 9,983 households in 2021 a decrease of -16.4%. This may be due to fewer student households in Southampton due to the COVID-19 pandemic restrictions.

In the 2021 Census Southampton, had 4,635 (1.9%) widowed residents and 28,186 (11.3%) who were separated or divorced. There were 74,518 (29.9%) people who were married or in a registered civil partnership and over 97,000 (39.0%) people who were never married and never registered a civil partnership.

Figure 30: Marital status of Southampton Residents – 2021 Census

Marital status for Southampton residents (2021 Census)	Number	Percentage
Never married and never registered a civil partnership	97,029	39.0
Married or in a registered civil partnership	74,518	29.9
Separated, but still legally married or still legally in a civil partnership	18,630	7.5
Divorced or civil partnership dissolved	9,556	3.8
Widowed or surviving civil partnership partner	4,635	1.9
Never married and never registered a civil partnership	97,029	39.0

Source: Office for National Statistics 2021 Census

The 2021 Census data also showed Southampton has a similar proportion of families that are large (3+ children) as the national average.

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11.1.10 Housing Stock

In 2023, there were an estimated 108,885 homes in Southampton,[53] the details of which are shown in Figure 32. The proportion of housing stock in Southampton that was local authority owned, was over twice the national average.

Figure 31: Housing stock in Southampton

Tenure	Number	Percentage of total	
		Southampton	National
Local Authority (incl. owned by other LAs)	16,304	15.0%	6.2%
Private Registered Provider providers of social housing (includes Housing Associations)	7,979	7.3%	10.5%
Private sector	84,602	77.7%	83.3%
Total (all housing)	108,885		

Between 2020/21 and 2023/24 there have been 1,120 dwelling completions in Southampton. For more information on the latest developments is available in section 11.1.3 above.

More people have been helped to stay in their homes for longer with over 5,600 adaptions to homes since 2011. Licensing has been introduced for Houses in Multiple Occupancy (HMOs) to raise standards and mitigate the impacts of HMOs on the city. In 2024 there are 2,060 properties registered.[54]

11.1.11 Crime and Disorder

In 2022/23, Southampton had an overall crime rate of 144 crimes per 1k population, which is significantly higher than the national average and remains the highest amongst comparator Community Safety Partnerships (CSPs). Southampton accounted for 20% of total recorded crime across Hampshire and Isle of Wight

[53] Department for Communities and Local Government Live tables on dwelling stock (including vacant). https://www.gov.uk/government/statistical-data-sets/live-tables-on-dwelling-stock-including-vacants (Accessed 30/07/2024)

[54] Southampton City Council Housing Strategy 2016-2025. https://www.southampton.gov.uk/housing/housing-policies/ (Accessed 17/09/2024)

Constabulary in 2022/23 and has the 9th highest total recorded crime rate among English and Welsh CSPs with a valid crime rate (296 total).[55]

There were 35,485 police recorded crimes in Southampton during 2022/23, which is an increase of +3.8% (+1,296 crimes) compared to the previous year (2021/22). This increase is in line with local and national trends, with Hampshire and Isle of Wight Constabulary experiencing a +2.8% increase and England (excluding Devon and Cornwall Police) a +4.6% increase over the same period. However, it is important to note that changes in the volume of crimes vary across different crime groups. Additionally, police recorded crime only includes crimes that have been reported to and recorded by the police, with 'hidden' crimes such as domestic abuse far more likely to be underreported than other offences such as theft.

The Crime Survey for England and Wales (CSEW) notes that police recorded crime is not the most reliable measure of crime trends. This is because police recorded crime trends can be impacted by changes to recording practices, policing activity and public reporting of crime.

The CSEW estimates that total crime decreased by -15% in the year ending March 2023 compared to the pre-pandemic baseline (year ending March 2020). However, the change in total police recorded crime nationally and in Southampton between 2019/20 (pre-pandemic baseline) and 2022/23 represents a statistically significant increase. Differences between CSEW findings and police recorded crime are likely in part due to different methodologies. Additionally, trends in police recorded crime data are influenced by factors including increased awareness and reporting of crime.

Between 2021/22 and 2022/23, there has been a decline in the number of offences for 16 of the 32 offence types. There have been notable declines in:

- Violent crime (-1.9%),
- Residential burglary (-1.1%)
- Hate crime (-7.1%)
- Alcohol affected crime (-10.8%)
- Stalking and harassment (-0.4%),
- Anti-social behaviour (-30.4%)

Notable increases include:

- Vehicle offences (+27.9%)

[55] Safe City Strategic Assessment 2022-2023. https://data.southampton.gov.uk/media/m20a2aoj/safe-city-strategic-assessment-report-2022-23.pdf (Accessed 30/07/2024)

- Possession of weapon offences (+17.1%)
- Possession of bladed implement (+22.4%)
- Serious knife crime (+17.9%)
- Drug offences (+19.0%)
- Drug affected crime (+7.6%)

There continues to be a decline in anti-social behaviour offences in Southampton, with a -30.4% decline in the last year (-49.9% since 2019/20). Similar declines have been observed across Hampshire and Isle of Wight Constabulary (-23.5%) and all other districts (-28.7% in Portsmouth) in the last year. However, it is important to note that this does not necessarily reflect a true decline, due to perceived barriers to reporting crime and ASB, with over 70% of respondents witnessing or experiencing antisocial behaviour in the 2023 Southampton community safety survey not reporting the incident.

As of the May 2023 local elections, the Southampton electoral ward boundaries were reviewed by the Local Government Boundary Commission. As a result of this review, Banister and Polygon was introduced as a new ward in the city centre, Bitterne ward was renamed Thornhill and many wards underwent boundary changes. There were 2,827 crimes recorded in Banister and Polygon in 2022/23. Compared to the old ward boundaries, 39.7% would have previously been counted in Bevois ward, 38.2% in Bargate and 22.0% in Freemantle. Therefore, it is not advisable to compare the distribution of crime by wards to that published in previous assessments.

Bargate (295 crimes per 1k population) ward had the highest overall crime rate among Southampton wards in 2022/23. Bargate ward covers the city centre, which is where a large proportion of the day and night-time economy is in Southampton, which are associated with certain crime types, such as alcohol affected crime. However, it is important to note that the high crime rates in the city centre will be influenced by the resident population being used as the denominator. Therefore, the 'transient' population; those that travel into the city centre, are not captured in the denominator. Bevois, Banister & Polygon, Freemantle and Thornhill wards also show significantly higher total crime rates than the Southampton average in 2022/23.

Overall crime continues to be strongly patterned with deprivation. In 2022/23, the overall crime rate in the 20% most deprived neighbourhoods was 2.6 times higher than in the 20% least deprived neighbourhoods in Southampton. Although crime rates remain significantly higher in the 20% most deprived Southampton neighbourhoods compared to the 20% least deprived neighbourhoods, this gap appears to be narrowing; having been 3.7 times higher in 2019/20, 3 times higher in 2020/21 and also 2.6 times higher in 2021/22. However, this change appears to be driven by higher crime rates in the 20% least deprived neighbourhoods (+33.8%

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increase in the crime rate from 2019/20), rather than lower crime rates in the 20% most deprived neighbourhoods (-3.8% decline in the crime rate from 2019/20).

From 2021/22 to 2022/23, total crime increased in 10 out of 17 wards (Figure 2.10). The largest percentage increase in total crime between 2021/22 and 2022/23 was in Harefield ward (+22.3%), followed by Thornhill (+17.9%) and Bargate (+10.3%) wards. Notably, declines in total crime were seen in Millbrook (-11.1%), Shirley (-10.2%) and Swaythling (-8.0%) wards. Although, geographical analysis may be influenced by key police sites located in Freemantle and Shirley wards.

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

[56] Southampton Data Observatory. https://data.southampton.gov.uk/community-safety/safe-city-strategic-assessment/ (accessed 13/09/2024)

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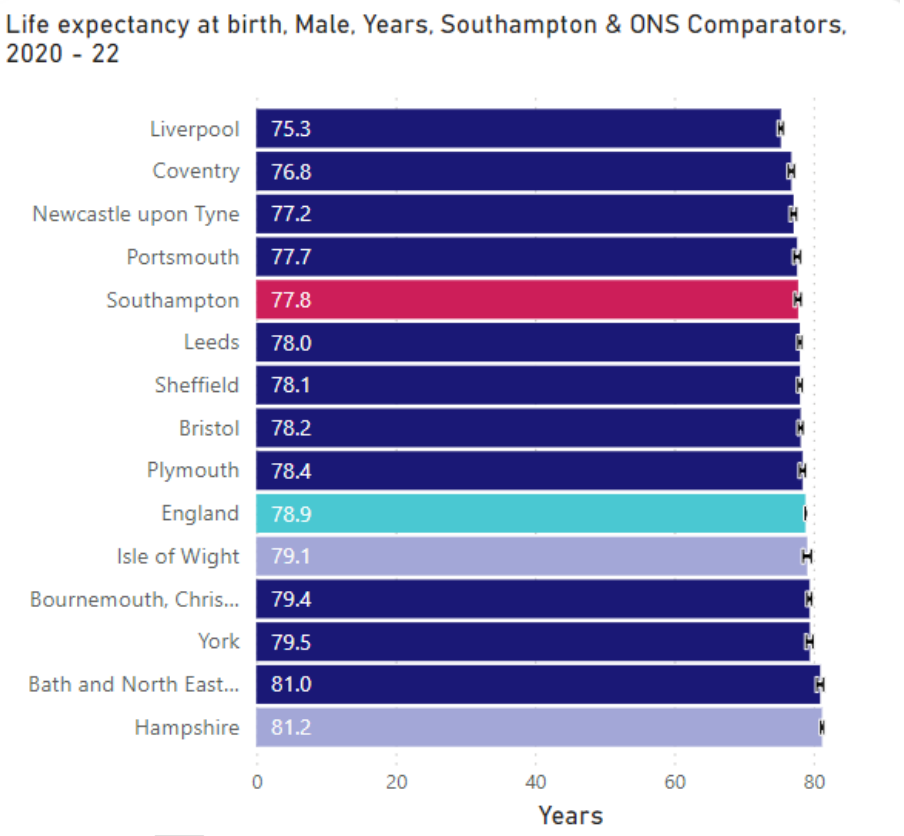
11.2 General Health Needs of Southampton

11.2.1 Life Expectancy

Life expectancy at birth for males living in Southampton is currently estimated to be 77.8 years for the 2020-22 (pooled) period, significantly lower than the England average male life expectancy of 78.9 years and ranked 5th lowest among our ONS comparators. Male life expectancy had been decreasing in Southampton since the highest, recorded in 2017-19 (pooled) period, in line with the England trend. Between 2010-12 and 2016-18 (pooled) male life expectancy has plateaued around the 78-year mark, failing to keep in line with overall England increases.

Figure 32: Life expectancy at birth (Male) 2020-2022



Source: Office for National Statistics (ONS)

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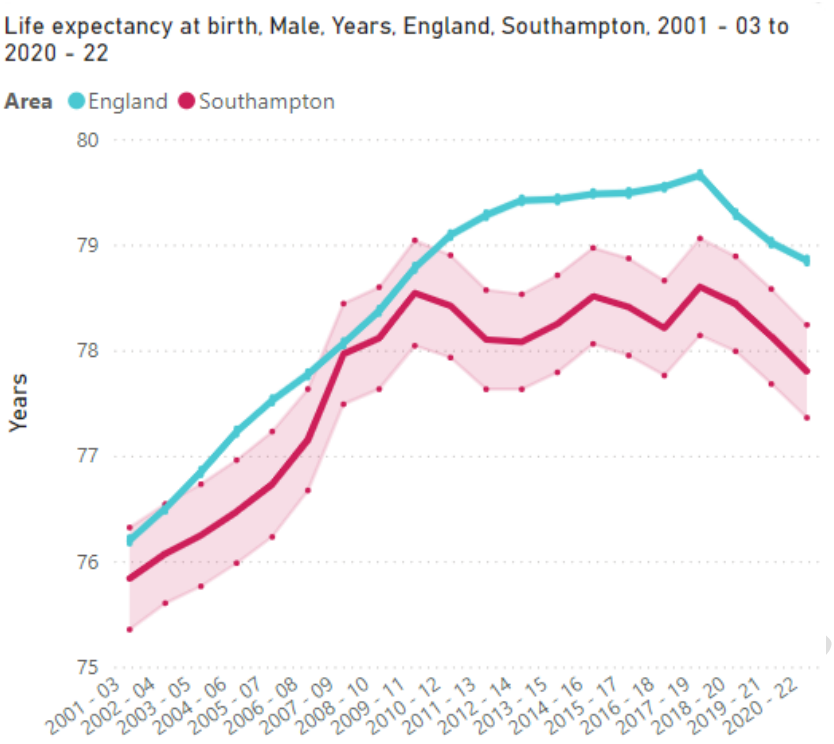
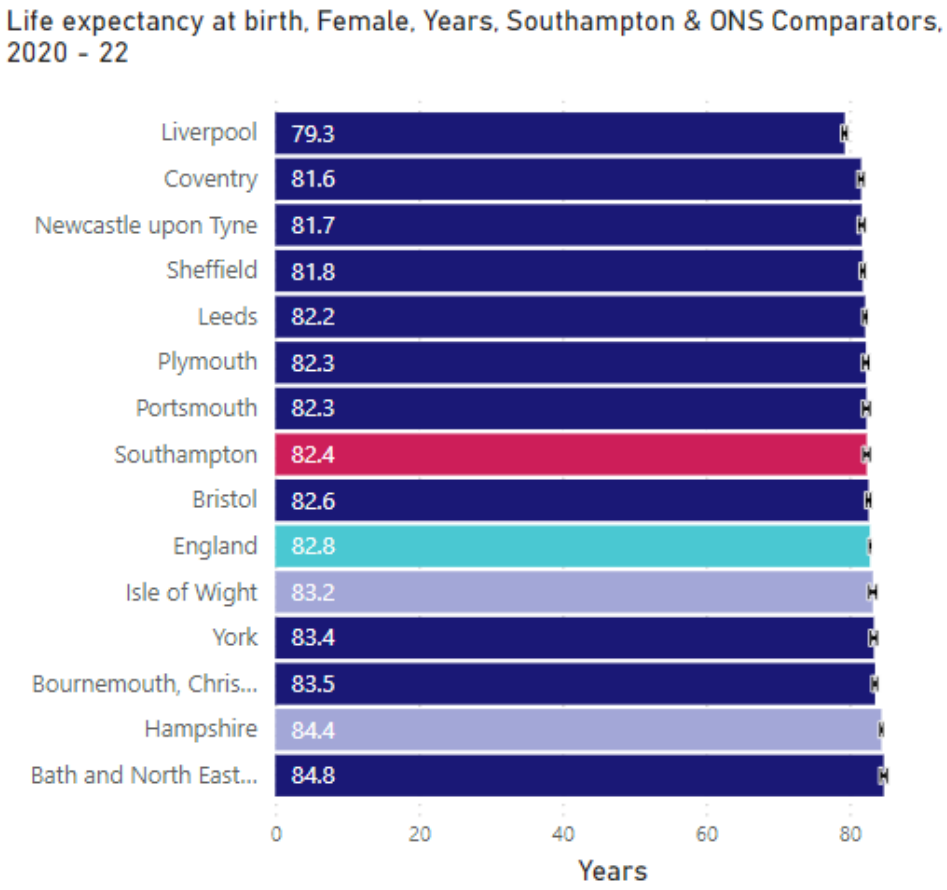
Figure 33: Life expectancy at birth (Male) Southampton and England trend: 2001-03 to 2020-22



Source: Office for National Statistics (ONS)

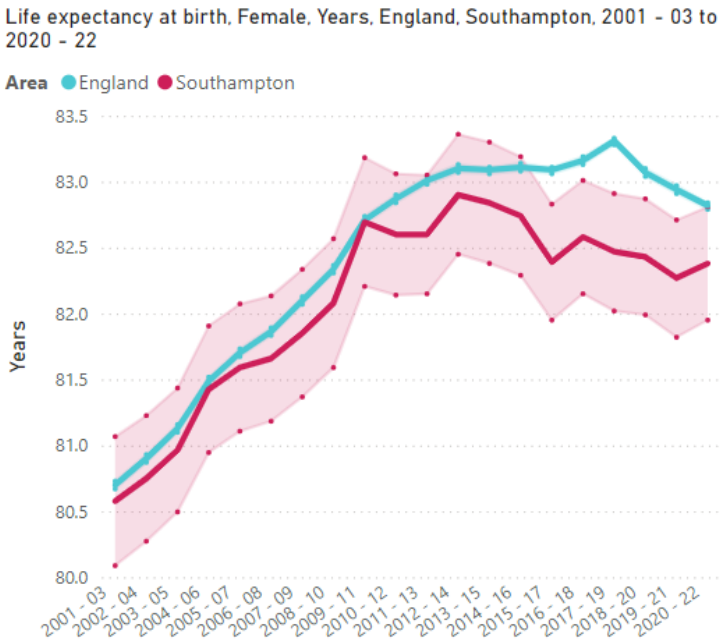
Female life expectancy at birth is 82.4 years (2020-22 pooled), which is lower than the England average of 82.8 years. Since 2015-17 Southampton female life expectancy has been significantly lower than the England average. The gap between Southampton and England life expectancies was at its widest of 10 months for females in 2017-19 and 16 months for males in 2016-18 and since those periods the gap has been narrowing overall. For males and females, in Southampton and England life expectancy for 2018-20, 2019-21 and 2020-22 encompassing COVID-19 pandemic mortality, dipped compared to life expectancy for 2017-19. The chart shows the trend in life expectancy between 2001-03 and 2020-22 for males and females. (Figure 35).

Figure 34: Life expectancy at birth (Female) Southampton and ONS comparators 2020-22



Source: Office for National Statistics (ONS)

Figure 35: Life expectancy at birth (Female) Southampton and England trend: 2002-03 to 2020-22



Source: Office for Health Improvement and Disparities (OHID) - Public Health Outcomes Framework (PHOF)[57]

At a ward level, the latest data for the 2020-22 period shows that Banister & Polygon ward has the lowest life expectancy for females at 80.8 years, whilst Bevois had the highest with 88.5 years (Bargate has been excluded due to small numbers for certain age bands affecting the reliability of the calculations). Thornhill has the lowest life expectancy for males at 76.0 years, whilst Bitterne Park has the highest at 81.6 years (again excluding Bargate).

When looking at the England deprivation quintiles for the 2020-22 period, males living in the 20% most deprived areas of the city live on average 5.3 years less than those living in the 20% least deprived areas. Females in the 20% most deprived areas live 3.9 years less than those in the 20% least deprived areas.

In 2018-20, in Southampton, healthy life expectancy for males was 61.4 years, which is lower than the national average of 63.1 years. For females, health life expectancy in Southampton is 63.1 years, which again is lower than the national average of 63.9 years. This suggests that in Southampton there is a wider healthy life expectancy gap (1.7 years) between males and females than that seen nationally (0.8 years).

[57] Office for Health Improvement and Disparities (OHID) - Public Health Outcomes Framework (PHOF) Public Health Outcomes Framework - OHID (phe.org.uk) (assessed 01/08/2024)

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Website: https://data.southampton.gov.uk

Whilst healthy life expectancy nationally has remained relatively stable over the last decade, there has been more variation in Southampton, particularly for females. In 2018-20 (pooled) period, female healthy life expectancy increased to 63.1 years after dramatically falling to 59.8 years in 2016-2018.

Disability-free life expectancy (DFLE) is an estimate of the number of years lived without a long-term physical or mental health condition that limits daily activities. In 2018-20, males in Southampton could expect to live 61.1 years disability-free, which is lower than the England average of 62.4 years, although not statistically significantly so. Despite females living longer than males, in Southampton and nationally, women live fewer years disability-free. In Southampton females have a disability-free life expectancy of 59.1 years, which is slightly lower than the England average of 60.9 years, although not statistically significantly so. Since 2014-2016, disability-free life expectancy of both males and females has decreased in Southampton at a quicker rate than nationally.

11.2.2 Mortality

In 2022, there were 1,948 deaths registered in Southampton and, of these deaths, the underlying causes responsible were.

The three main causes were:

- Cancer - 508 deaths (26.1%)
- Circulatory diseases – 462 deaths (23.7%)
- Respiratory diseases - 259 deaths (13.3%)

- Lung cancer accounted for 1 in 20 of all deaths and 1 in 5 cancer deaths (100 deaths)
- 46.3% of circulatory disease deaths were caused by Ischaemic heart diseases, also known as coronary heart disease (214 deaths)
- 49.4% of all respiratory disease deaths were attributed to other COPD (128 deaths)
- COVID-19 was responsible for 3.4% deaths in 2022, a 72.2%, decrease from 2021 deaths (237 COVID deaths)

Around 40.6% of deaths occurred in a hospital setting, 18.8% in a care home and 31.9% in the individuals own home.

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

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Figure 36: Deaths by cause in Southampton 2022

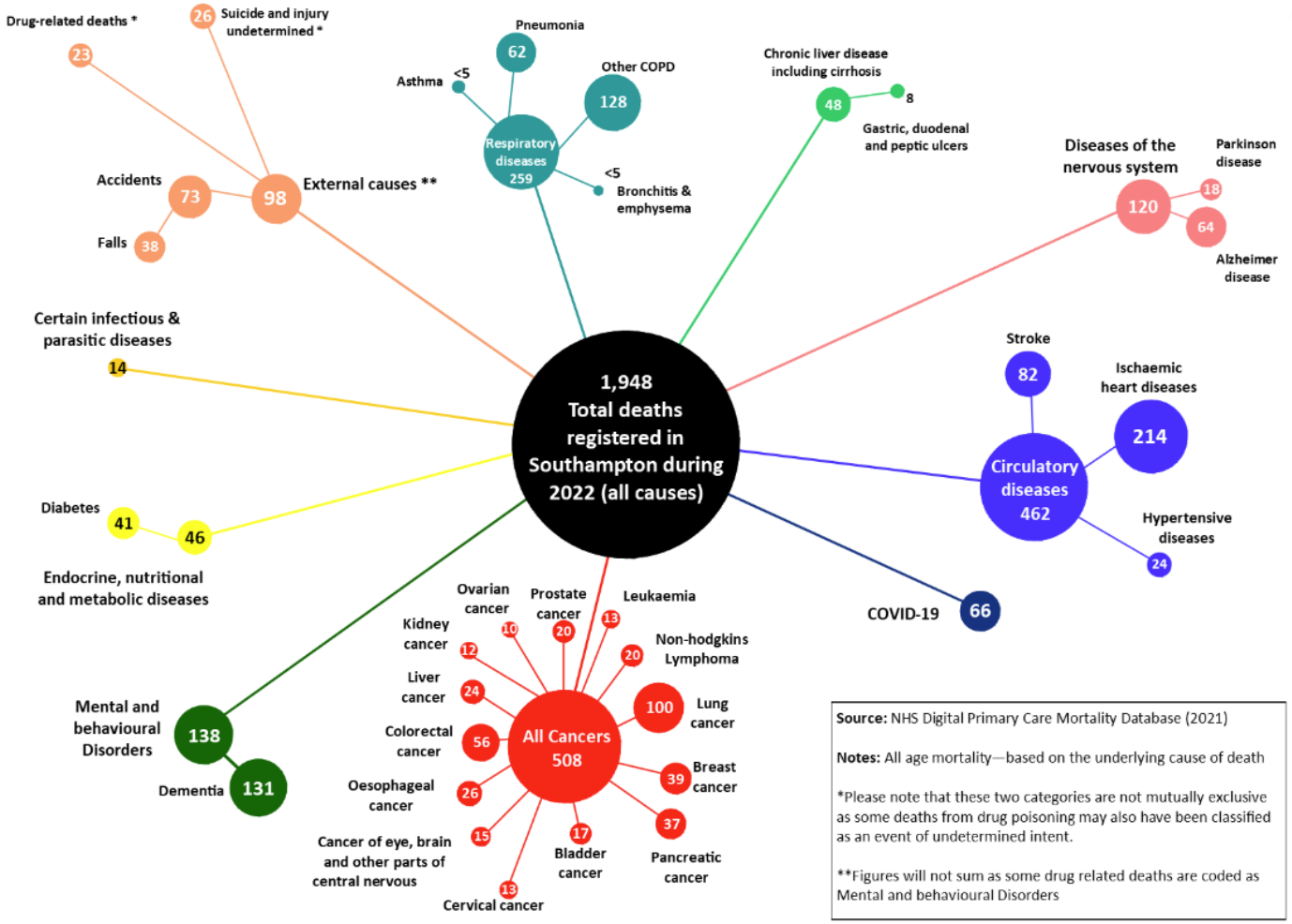

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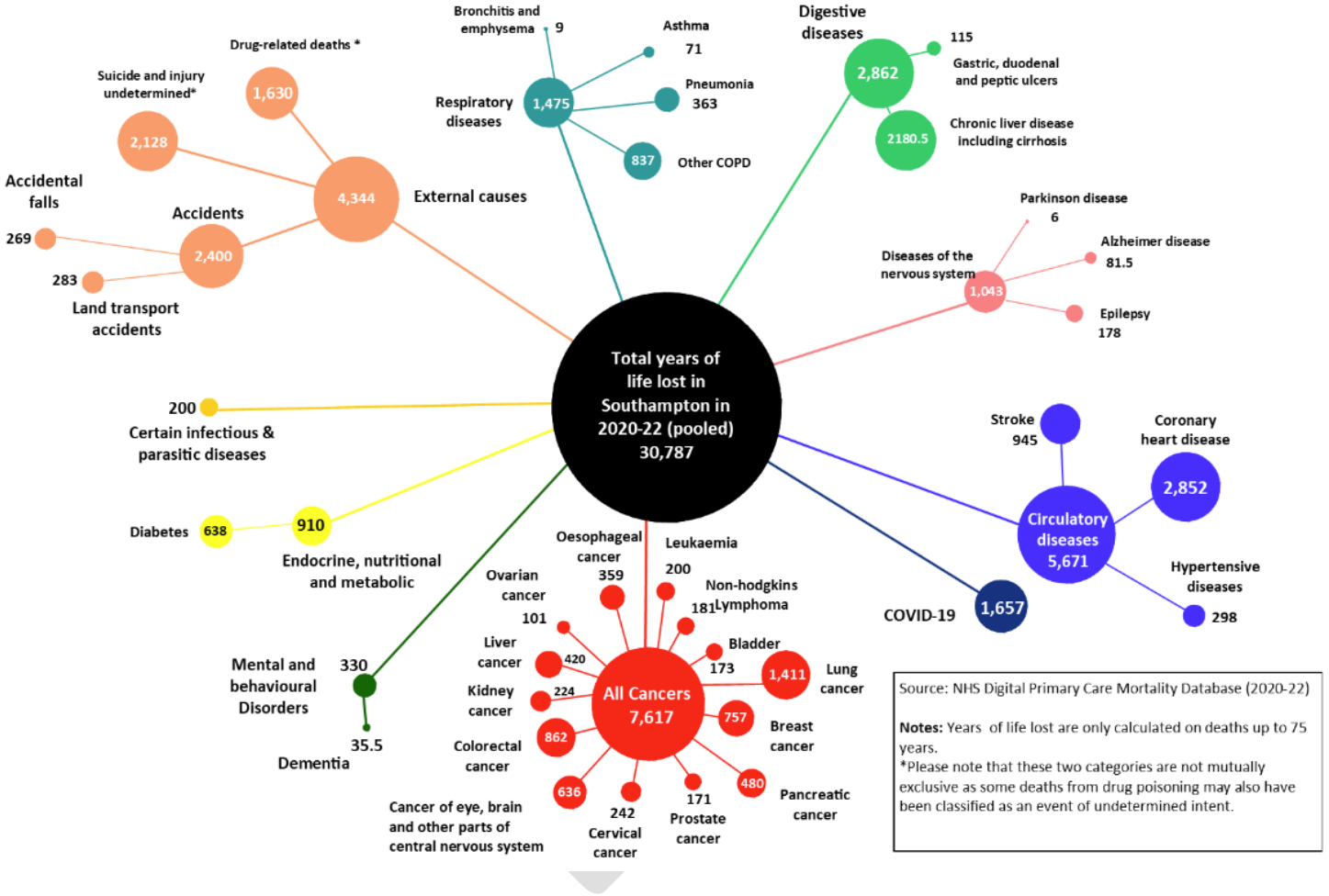
Figure 37: Years of life lost in Southampton (YLL) – 2020-22



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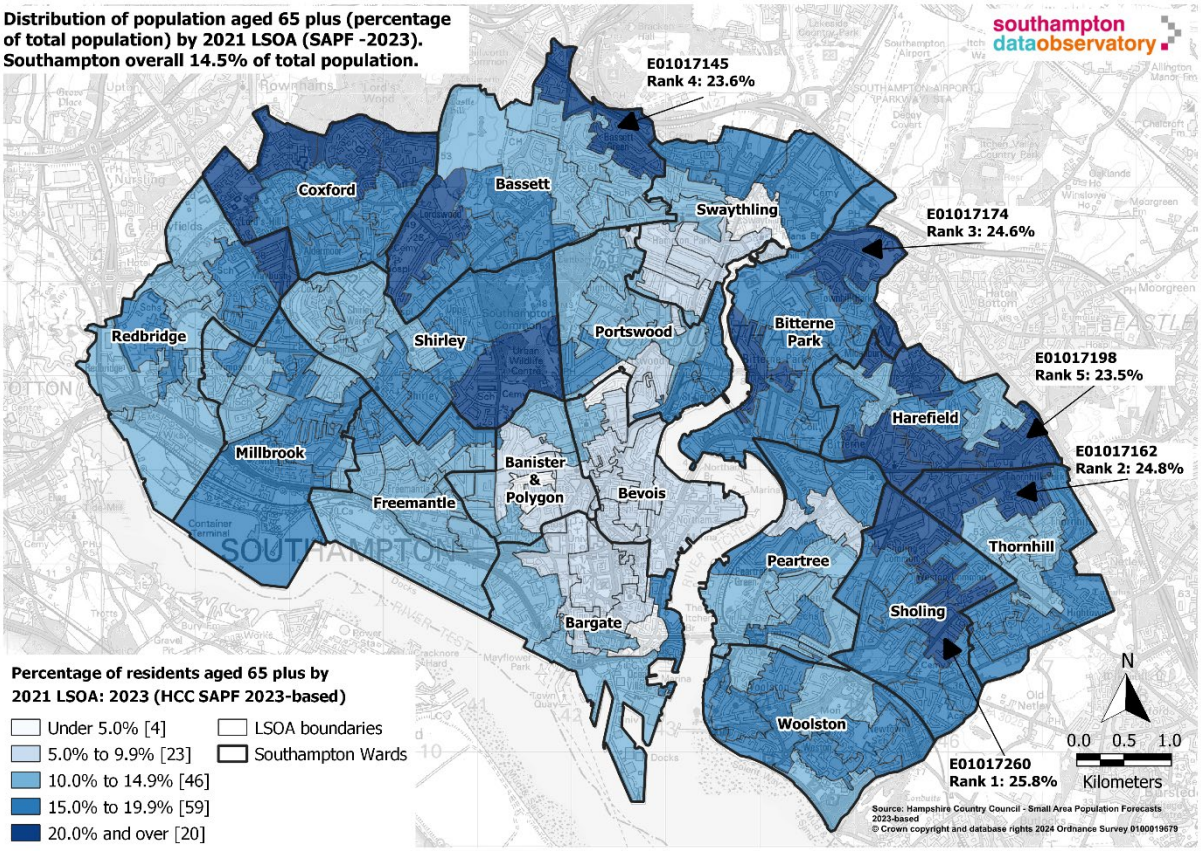
11.2.3 Ageing Population and Chronic Conditions

According to Hampshire County Council (HCC) Small Area Population Forecast (SAPF) estimates, that in 2023, there are 38,4782 residents aged 65 years and over in Southampton. The map below (Figure 39) shows the distribution of these older people across the city. The proportions are lower in the central areas of the city where there is a large student population.

Figure 38: Distribution of population aged 65 plus in Southampton (2023)



The Productive Healthy Ageing Profile and the Palliative and End of Life Care Profile produced by the Office for Health Improvement & Disparities[52] provides a useful snapshot of indicators at local authority level. It shows that older people in Southampton have significantly worse than the England average outcomes for several key indicators:

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

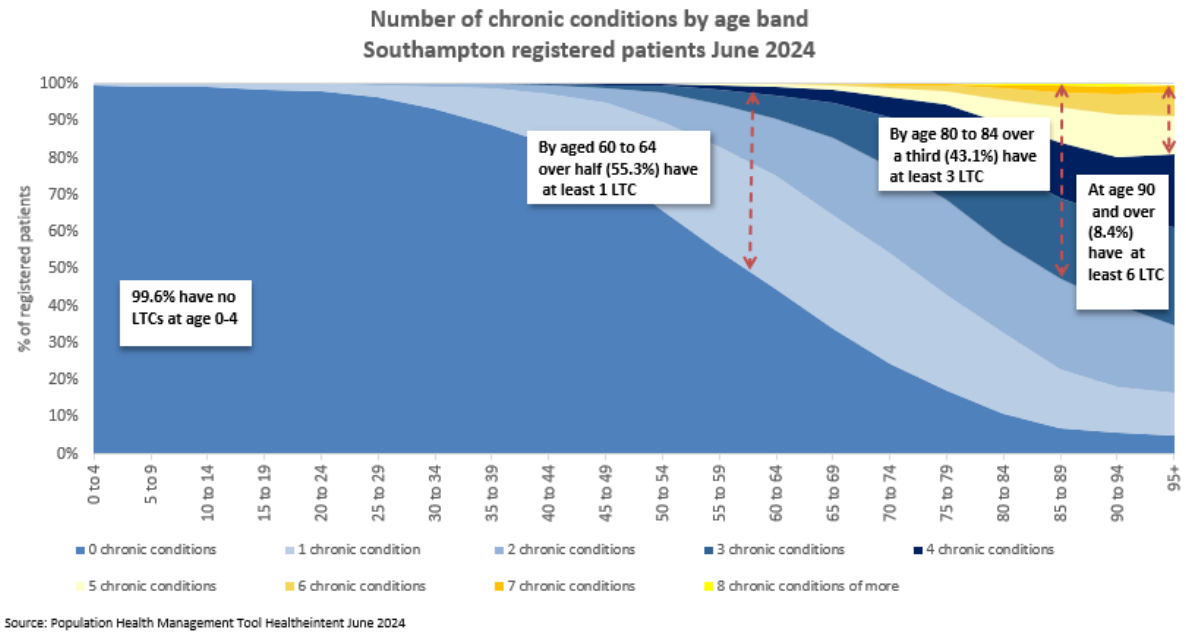
[52] Office for Health Improvement & Disparities Fingertips Public health profiles - OHID (phe.org.uk)

- permanent admissions to residential and nursing care homes per 100,000 aged 65 years and over
- rate of deaths from cancer among people aged 65 years and over
- rate of deaths from respiratory disease among people aged 65 years and over
- rate of admission episodes for alcohol-related conditions (Narrow) – 65+ years
- rate of emergency admissions for dementia (aged 65+)
- and emergency hospital admissions due to falls aged 65 and over

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

Figure 40 illustrates the growing importance of effectively managing long-term conditions (LTCs) as the population grows older. The number of LTCs change with age, possibly making care more complex and costly. The data from the Population Health Management Tool does not include low back pain so will look differently from previous versions.

Figure 39: Number of chronic conditions by age band. June 2024



Source: Population Health Management Tool Healtheintent June 2024

In Southampton's 0 to 4 year olds, 99.6% are without chronic conditions. By age 60 to 64 over half (55.3%) have at least one LTC, by the age of 80 to 84 43.1% have at least 3 LTC and people aged 90 and over 8.4% have at least 6 long term conditions.

11.2.4 Cancer

In 2023, nearly 1 in every 4 deaths in Southampton was from cancer (24.1%). Lung cancer alone caused 1 in every 20 deaths (112 people). Southampton has worse cancer mortality than England for almost all mortality measures. Despite cancer mortality decreasing and getting better for England and Southampton since 2001 – 2003, Southampton's mortality has always been slightly higher than the England average. The reduction in cancer mortality has been slower in Southampton than the rest of England, causing the gap between England and Southampton to grow. For the period 2020 – 2022, cancer mortality in Southampton (278.5 DSR per 100,000) was significantly higher than the England average (251.7 DSR per 100,000).

For the period 2020 – 2022, Southampton had the 5th highest rate in England for colorectal cancer mortality (32.2 DSR per 100,000), significantly higher than the England average of 25.7. Southampton's cancer mortality is also worse than the England average for lung, bladder, oesophageal, alcohol related cancer, 'preventable' cancer and under 75 cancer mortality.

Years of life lost (YLL) is a measure of the average time a person would have lived had they not died before the age of 75 years. This data helps measure the social and economic loss from dying younger and highlights the specific causes of death affecting younger people. In 2023, nearly 11,000 years of life were lost for Southampton residents aged under 75 years. During this period cancer was by far the biggest cause of life lost, responsible for 25.5% of YLL (the equivalent of 2,767 years). Lung, breast and colorectal cancer caused the most YLL of all the cancers. Colorectal cancer caused only 1.8% of all cancer deaths but accounted for 7.9% of YLL, reflecting the younger average age of people who died from colorectal cancer in Southampton. Conversely, prostate cancer caused 1.4% of all cancer deaths but only accounted for 0.7% of YLL.

Successful treatment is much more likely if cancer is diagnosed at an earlier stage. Screening can catch cancer in its earliest stages or (in some cases) before it has even formed. Widespread screening and quick referrals can significantly improve cancer outcomes within a population. In England there are 3 major cancer screening programmes:

- Cervical screening (offered to all women aged 25 to 64 to check the health of cells in the cervix. It is offered every 3 years for those aged 25 to 49, and every 5 years from the ages of 50 to 64)

- Breast screening (offered to women aged 50 to 70 to detect early signs of breast cancer. Women over 70 can self-refer)

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- Bowel cancer screening (everyone aged 60 to 74 is offered a bowel cancer screening home test kit every 2 years)

Despite the proven efficacy of early cancer diagnosis, cervical and breast cancer screening coverage has been steadily falling in England and Southampton since 2010. In Southampton, 62.3% of eligible women (registered with a GP) have been screened for breast cancer within the last 36 months (2023). This is significantly worse than the England average of 66.2% and is nearly 10 percentage points lower than Southampton's coverage in 2010 (72.0%). While Southampton and England's coverage had been steadily decreasing in the years prior to 2020, the COVID-19 pandemic severely disrupted breast cancer screening. England's coverage has increased year on year since 2021, however Southampton's recovery has been slower (2023 was worse than the year prior).

Cervical screening coverage (among people aged 50 to 64 years) in Southampton (68.3% in 2023) is also significantly lower than the England average (74.4%). Southampton would have needed to screen 1,158 extra people to match England's coverage in 2023. Southampton's coverage was more than 10 percentage points better in 2012 (77.7%). This decline increased during the COVID-19 pandemic, however cervical screening coverage was not as badly impacted as breast screening.

While bowel cancer screening coverage is significantly lower in Southampton (68.6%) than the England average (72.0%), it is the cancer screening programme with the best coverage. It was historically the screening programme with the worst coverage for England and Southampton, however coverage has been steadily improving since 2015. This may be, in part, due to the introduction of less intrusive home testing kits.

Early cancer detection statistics are monitored closely by central government, local government and the NHS as they are such influential public health measures. The NHS has set an ambitious target of diagnosing 75% of all cancers at stage 1 or 2 by 2028. England currently diagnoses 54.4% of all cancers at stage 1 or 2 (in 2021). England's rate has remained similar since 2013. Southampton was significantly better than England in 2021, achieving 58.8% (and has been improving over time). This is also the best rate compared to all of Southampton's CIPFA comparator cities. Despite this, Southampton would have needed to diagnose 178 more cancer cases at stage 1 or 2 to achieve the NHS 2028 target of 75%. While this may seem like an unrealistic target, significant technological advances in early detection (particularly in testing and artificial intelligence) are likely to improve early detection rates over the coming years.

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11.2.5 Coronary Heart Disease (CHD)

In 2022/23, there were 6,963 people on CHD registers in Southampton giving a crude prevalence rate of 2.2%, compared with 3.0% in England. Prevalence across GP populations in 2022/23 vary between 0.2% (University Health Service) and 3.2% (The Peartree Practice).

The data shows a lower incidence rate for CHD for Southampton, however in terms of deaths, Southampton is significantly worse than the England average. Between 2020-22, the DSR for Southampton was 48.2 per 100,000 population aged under 75. Significantly worse than the England average of 40.6 per 100,000 population aged under 75.

The data shows a lower incidence rate for CHD in Southampton, however in terms of deaths, Southampton is significantly worse than the England average in 2020-2022 (48.2 and 40.6 per 100,000 population under 75 respectively).

Coronary heart disease was the main cause of death for 12.5% of Southampton deaths in 2023.

11.2.6 Stroke

In 2022/23, QOF data showed 4,861 people in Southampton (1.5%) were recorded on practice disease registers with stroke or transient ischaemic attacks, compared to 1.8% across England.

In 2023, 4.4% of deaths in Southampton were due to strokes. Stroke is a leading cause of adult disability in the UK. Two-thirds of people who survive a stroke find themselves living with a disability. Many strokes are preventable and with some lifestyle changes the risk can be reduced. This includes stopping smoking, being more active, drinking less alcohol, eating a healthy diet and staying a healthy weight.[53]

In 2022/23, hospital admissions due to stroke (all ages) were significantly higher in Southampton (194.1 DSR per 100,000 population) compared to the England average (168.4 DSR per 100,000 population).

[53] Stroke Management – Stroke Association https://www.stroke.org.uk/stroke/manage-risk (Accessed 21/08/2024)

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11.2.7 Hypertension

Hypertension or high blood pressure contributes to cardiovascular disease (CVD), strokes, renal disease, vascular disease including aortic aneurysms and shows few, if any, symptoms until the disease is advanced. In 2022/23, there were 36,092 people on hypertension registers in Southampton, a prevalence of 11.4%, lower than the England average of 14.4%.

11.2.8 Atrial Fibrillation (AF)

Atrial fibrillation is the most common heart rhythm disturbance, affecting around 1.4 million people in the UK. People with atrial fibrillation are more at risk of having a stroke. It can affect adults of any age, but it is more common in older people. Atrial fibrillation is more likely to occur in people with other conditions, such as high blood pressure (hypertension), atherosclerosis or a heart valve problem.

Early detection of AF with treatment reduces the likelihood and severity of stroke. In Southampton, in 2022/23, QOF data showed that 5,166 people were registered with AF which is a prevalence rate of 1.6% compared to 2.1% in England.

11.2.9 Persistent Asthma

In 2022/23, there were 18,258 people on GP asthma registers in Southampton giving a crude prevalence rate of 6.1% which is significantly lower than the England average of 6.5%. Prevalence varies at sub city level in 2021 between 3.7% in Bargate ward and 9.0% Redbridge ward.

11.2.10 Chronic Obstructive Pulmonary Disease (COPD)

In 2022/23, there were 6,484 registered patients on COPD registers in Southampton- a crude prevalence rate of 2.0%, statistically similar to the England rate of 1.8%. In 2021, prevalence varies between 1.1% in Bargate ward and 3.8% in Redbridge ward.

11.2.11 Kidney Disease

Chronic kidney disease (CKD) is a long-term condition where the kidneys do not work as well as they should. It is a common condition often associated with getting older. It can affect anyone, but it's more common in people who are black or of south Asian

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origin. CKD can get worse over time and eventually the kidneys may stop working altogether, but this is uncommon. [54]

In 2022/23, there were 5,559 patients in Southampton (2.2%) aged 18 years and over with CKD compared with 4.2% in England. In the same period among Southampton GPs this varies between 4.1% at the Raymond Road surgery and 0.1% at the University Health Service.

11.2.12 Diabetes

In 2022/23, 16,437 (6.3%) patients aged 17 or over in Southampton were recorded on practice disease registers as having type 2 diabetes mellitus. This is lower when compared to 7.5% in England. In the same period among Southampton GPs, the prevalence ranges from 0.7% at the University Health Centre to 9.0% at Lordshill Health Centre.

Modelled estimates predict the prevalence of diabetes is set to increase. By 2040, Southampton's diabetic population is estimated to be 10,146 people aged 18 and over, an increase of 12.4% from 2023 (9,024), assuming no change in the underlying population of age, sex and ethnicity, levels of excess weight and physical inactivity.[55] Poor diabetic foot care can result in lower limb amputations in diabetic patients.

Among GPs in Southampton in 2022/23, people with type 2 diabetes aged 12 and over who have received an annual foot check range from 50.8% at the Mulberry House Surgery to 92.5% in Chartwell Green Surgery.

However as described previously, there are potentially several thousand people in the city unaware of the importance of foot care with their undiagnosed diabetes, increasing their risk of ulceration, reduced sensation/circulation and potential lower limb amputation.

11.2.13 Sight Loss

Diabetic retinopathy is a complication of diabetes, caused by high blood sugar levels damaging the back of the eye (retina). It can cause blindness if left undiagnosed and untreated. Early detection through screening can reduce the risk of blindness.[56]

[54] NHS England CKD https://www.nhs.uk/conditions/kidney-disease/ (Accessed 21/08/2024)
[55] Protecting older people information system (POPPI) https://www.poppi.org.uk/index.php?pageNo=416&areaID=8332&loc=8332 (Accessed 21/08/2024)
[56] NHS England https://www.nhs.uk/conditions/diabetic-retinopathy/ (Accessed 21/08/2024)

In 2022/23, Southampton's rate of preventable sight loss due to diabetic eye disease in those aged 12 years and over was 6.4 per 100,000 population. This is significantly higher than England's rate of 2.9 per 100,000.

Age related macular degeneration (AMD) and glaucoma are the two other types of eye disease which can result in blindness or partial sight if not diagnosed and treated in time. In 2022/23, Southampton's rate of AMD was 144.3 per 100,000 population aged 65 and over, significantly higher than England's rate of 105.6 per 100,000 aged 65 plus. In 2022/23, Southampton's rate of preventable sight loss due to glaucoma is lower but not significantly to the rate for England (10.4 per 1000,000 aged 40 plus compared to 13.5 per 100,000 aged 40 plus respectively).

In 2022/23, there were 125 people aged 65 to 74, registered blind or partially sighted people in Southampton, a rate of 681 per 100,000 population, significantly higher than the England average of 533 per 100,000 population. When compared to those people aged 75 and over in the same period (2022/23), the rate in Southampton is 2,273 per 100,000 population, which is significantly lower to the England value of 3,031 per 100,000 population.

In February 2024, 106 Southampton residents (1.6% of all people claiming DLA) were registered for Disability Living Allowance (DLA) with the main disabling condition recorded as 'Visual Disorders and Diseases' (higher than the England average of 1.5%). Of these residents registered with 'Visual Disorders and Diseases' as their main disabling condition, 29 (0.7%) people were aged under 16 years, 33 (3.2%) people were aged 16 to 64 years old, and 48 (3.4%) people were aged 65 year and over. [57]

Modelling predicts in 2023 there are 109 Southampton residents aged 18-64 and 3,163 residents aged 65 years and over predicted to have a moderate or serious visual impairment. This is predicted to increase to 112 people aged 18-64 and 4,082 for people aged over 65 years of age by 2040.[58]

[57] DWP - Disability Living Allowance (Cases in Payment) https://stat-xplore.dwp.gov.uk/webapi/jsf/login.xhtml (Accessed 23/08/2024)
[58] Projecting Older People Population Information System (POPPI) and Projecting Adult Needs and Service Information (PANSI), Oxford Brookes University https://www.poppi.org.uk/index.php?pageNo=341&areaID=8332&loc=8332 (Accessed 23/08/2024)

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11.2.14 Hearing Loss and Deafness

Infants have their hearing checked within hours of birth through the newborn infant screening programme. In 2022/23, 99.4% of infants in Southampton were correctly screened within 5 weeks of birth. Which is significantly better than the England average of 98.5%.

It is estimated that there are 34,548 people aged 18 and over in Southampton with some hearing loss in 2023 and is estimated to increase by 18.1% to 40,794 people in 2040. For people aged 18 and over with severe hearing loss, its estimated to increase 29.0% from 3,551 people in 2023 to 4,580 people in 2040.[59]

The 2024 GP patient survey estimates that's for the Hampshire and Isle of Wight Integrated Care System, 6.2% of the GP registered population reported that they had deafness or severe hearing loss, which is just over 1000 people.

In February 2024, 96 (1.5% of people claiming DLA) Southampton residents were registered for Disability Living Allowance (DLA) with the main disabling condition recorded as 'hearing disorders'. Of these residents registered with 'hearing disorders' as the main disabling condition, 47 people were aged under 16 years, 35 people were aged 16 to 64 years old, and 5 people were aged 65 years and over.[60]

[59] Projecting Older People Population Information System (POPPI) and Projecting Adult Needs and Service Information (PANSI), Oxford Brookes University https://www.poppi.org.uk/index.php?pageNo=419&areaID=8332&loc=8332 (Accessed 23/08/2024)
[60] DWP - Disability Living Allowance (Cases in Payment) https://stat-xplore.dwp.gov.uk/webapi/jsf/login.xhtml (Accessed 23/08/2024)

11.2.15 Levels of Disability

In February 2024, data on Disability Living Allowance (DLA) claimants amongst the under 16 years old shows that 3,963 children in Southampton, receive DLA. Of those children claiming DLA, 2,247 children (56.7%) had a main disabling condition classed as learning difficulties. The second most common main disabling condition was Behavioural Disorder with 817 children (22.0%). Hyperkinetic Syndrome, also known as ADHD, was the third most common diagnosed main disabling condition with 255 children (6.4%).[61]

In February 2024, there were 1,044 Southampton residents aged 16 to 64 years receiving DLA. The most common disabling condition was learning difficulties (n=300, 28.7%). The second most common main disabling condition was psychosis with 102 adults (9.8%) aged 16 to 64.[62]

In the same period (February 2024), 1,431 adults aged 65 years and over were receiving DLA. The most common main disabling condition was arthritis, accounting for 32.0% of those aged 65 years and over in receipt of DLA (n=460). Back pain was the second main disabling condition (7.5%, n=107) and disease of the Muscles, Bones or Joints (7.1%, n=102) was the third the main disabling. This shows physically disabling conditions are more prolific in older adults compared to working age adults receiving DLA.[63]

In Southampton, between April 2014 and August 2024, there are 2,621 residents with support from Adult Social Care, with the current primary support reason of:[64]

- Sensory support (visual or hearing impairment) - 38
- Physical support (access and mobility support or personal care support) – 1,437
- Social support (substance use support or social isolation support) – 20
- Learning Disability support - 563
- Mental Health support - 346
- Support with Memory and Cognition - 205

[61] DLA Entitlement (Cases in payment) Department for Work and Pensions https://stat-xplore.dwp.gov.uk/
[62] DLA Entitlement (Cases in payment) Department for Work and Pensions https://stat-xplore.dwp.gov.uk/
[63] DLA Entitlement (Cases in payment) Department for Work and Pensions https://stat-xplore.dwp.gov.uk/webapi/jsf/tableView/tableView.xhtml
[64] Adult Social Care – Southampton City Council

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Modelled estimates suggest that in 2023 there are 10,278 people aged 65 and over in Southampton who need help with at least one domestic task. These domestic tasks include:

- Doing routine housework or laundry
- Shopping for food
- Getting out of the house
- Doing paperwork or paying bills

This is predicted to increase to 13,291 Southampton residents aged 65 and over by 2040, an increase of 3,013 or 29.3%.[65]

11.2.16 Human Immunodeficiency Virus (HIV)

In 2022, 436 Southampton residents (2.74 per 1,000 population aged 15 to 59) were seen at HIV services - an increase of 56.8% (158 more residents) since 2011 diagnosed with a HIV infection and accessing HIV care.[66]

Late diagnosis of HIV is the most important predictor of morbidity and mortality among those with HIV infection. Among those diagnosed in England, those diagnosed late in 2019 had more than a 7-fold increased risk of death within a year of diagnosis compared to those diagnosed promptly, and this indicator is essential to evaluate the success of expanded HIV testing. In 2020-22, 22 people (42.3%) had a late diagnosis, lower, but not significantly, than the England average of 43.3%.

[65] Projecting Older People Population Information System (POPPI), Oxford Brookes University https://www.poppi.org.uk/index.php?pageNo=329&sc=1&loc=8332&np=1 (Accessed 23/08/2024)
[66] OHID Fingertips - https://fingertips.phe.org.uk/search/90790#page/4/gid/1/pat/15/par/E92000001/ati/502/are/E06000045/iid/90790/age/238/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0 (Accessed 23/08/2024)

11.3 Mental Health and Neurological Conditions

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

11.3.1 Children and Young People

One in ten children aged 5 to 16 years has a clinically diagnosable mental health problem and, of adults with long-term mental health problems, half will have experienced their first symptoms before the age of 14. Self-harming and substance use are known to be much more common in children and young people with mental health disorders – with ten per cent of 15 to 16 year olds having self-harmed. Failure to treat mental health disorders in children can have a devastating impact on their future, resulting in reduced job and life expectations. In 2022/23, Southampton had a crude rate of 130.4 per 100,000 for hospital admissions due to mental health conditions in ages under 18, significantly higher than the England average of 80.8 per 100,000.

In 2022/23, there were 360 young people admitted to hospital for self-harm aged between 10 and 24 years, a DSR of 632.8 per 100,000 population which is significantly worse than the England average of 319.0 DSR per 100,000.

Looked after children in care and care leavers: Nationally, half of looked after children meet the criteria for a mental health disorder. On 31 March 2023, Southampton had 538 children looked after. In 2021/22, 36.0% of children looked after were identified whose emotional wellbeing was cause for concern.

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. The 2021 Census recorded in Southampton 314 unpaid carers are under 16, of which, 103 (a third) provide more than 20 hours of care a week. This is likely to be an underestimate.

Self-harm and suicide among young people are extremely important issues. Many psychiatric problems, including borderline personality disorder, depression, bipolar disorder, schizophrenia, and drug and alcohol use disorders, are associated with self-harm. Self-harm increases the likelihood of a person eventually dying by suicide by between 50 and 100 times that of the rest of the population in a 12-month period.[67]

[67] Self-harm in over 8s: long-term management https://www.nice.org.uk/guidance/cg133 (accessed 11/09/2024)

The 2014 Adult Psychiatric Morbidity Survey (APMS 2014)[68] found one in four, 16 to 24 year old women (25.7%) reported having self-harmed at some point; more than twice the rate for men in this age group (9.7%). Using small area population projections for 2023, this equates to 6,087 women and 2,453 men aged 16 to 24 years having self-harmed at some point.[69]

11.3.2 Adults

Mental illness, also called mental health conditions, refer to a wide range of mental health conditions, these disorders can alter mood, thinking and behaviour. The most frequently occurring include common mental disorders, depression, severe mental illnesses, including Schizophrenia and bipolar disorder and self-reported wellbeing, more details are available below.

It was estimated, in 2017, that 18.7% of the Southampton population were likely to have a common mental health disorder. This is significantly higher than the estimate for England (16.9%) and this estimate is likely to be an under estimation of the whole population as it does not take into consideration those people living in institutional settings or those people experiencing homelessness. In the same period, it is estimated that in Southampton 11.5% of people aged 65 and over have a common mental disorder, higher but not significantly from the England average of 10.2%.

In Southampton, in 2022/23, 3,551 or 1.12% of patients with schizophrenia, bipolar affective disorder and other psychoses as recorded on practice disease registers, which is significantly higher to that of the England average of 1.00%. In October 2024 1.1% (2,912) of patients are recorded on GP registers as having a severe mental illness (SMI).

In 2022/23, 32,971 patients or 12.8% of registered patients in Southampton, aged 18 and over, have depression this is lower than the England average of 13.2%. In Southampton, in 2021/22 4,032 or 1.6% of registered patients aged 18, were newly diagnosed as having depression. Higher but not significantly than the England average of 1.5%.

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

[68] NHS England Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014 (accessed 11/09/2024)
[69] HCC SAPF 2023 base in Population Power Bi available from https://data.southampton.gov.uk/population/population-size-and-structure/ (accessed 11/09/2024) and Self-harm in over 8s: long-term management https://www.nice.org.uk/guidance/cg133 (accessed 11/09/2024)

Respondents to the 2024 GP patient survey (carried out between January and March 2024) were asked the question "Which of the following long-term conditions or illnesses do you have?" Looking at the results for percentage who have a mental health condition, by Primary Care Network (PCN):

- Living Well Partnership PCN – 18.8%
- Southampton North PCN – 18.7%
- Southampton West PCN – 16.4%
- Woolston & Townhill PCN – 16.2%
- Bitterne PCN – 16.1%
- Southampton Central PCN – 13.8%

The Mental Health and Wellbeing JSNA profile shows Southampton has higher rates compared to England for related risk factors; including smoking at time of delivery, child poverty for those aged under 16 years old, excess weight for Year 6 children, children looked after, children in need due to abuse, neglect or family dysfunction, pupils with behavioural, emotional and social support needs, violent crime (including sexual violence), crime, deprivation and current smoking in adults. These topics are covered in other sections of this document.

Evidence shows work has a generally positive effect on both physical and mental health and wellbeing across society. In 2020/21, the gap in the employment rate for those who are in contact with secondary mental health services (aged 18 to 69) and on the Care Plan Approach, and the overall employment rate in Southampton was 76.0 percentage points, this is significantly worse than the England gap of 66.1 percentage points.

In 2022/23, the gap in the employment rate for those with a physical or mental long-term health condition (aged 16 to 64) and the overall employment rate in Southampton was 10.2 percentage points, lower, but not significantly, than England (10.4 percentage points). In the same period for Southampton, the gap in the employment rate for those who are in receipt of long-term support for a learning disability (aged 18 to 64) and the overall employment rate was 72.6 percentage points, higher, but not significantly, than the gap for England (70.9 percentage points).

In 2022/23, Southampton had a significantly higher rate of emergency hospital admissions for intentional self-harm (all ages) than England (285.3 DSR per 100,000 population compared to 126.3 DSR per 100,000 population).

The Adult Psychiatric Morbidity Survey (APMS) 2014 survey found a fifth of adults (20.6%) reported that they had thought of taking their own life at some point. Applying this prevalence to the Southampton adult population (aged 16 years and over), in 2023 an estimated 45,318 adults had had suicidal thoughts within their lifetime; this number is projected to increase to 49,644 adults in 2030.[70]

In 2021-23, the age-standardised mortality rate from suicide and injury of undetermined intent (aged 10 and over) per 100,000 is 11.6 in Southampton, higher, but not significantly, than the England average of 10.7. The rate of suicide and mortality from injury undetermined for males is significantly higher than the rate for females, locally and nationally.

In 2020-22, Southampton's DSR of years of life lost due to mortality from suicide and injury undetermined (aged 15 and 74) is 34.7 per 10,000 population, higher, but not significantly, than England (34.1 per 10,000 population).

11.3.3 Older People

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

Dementia is a life-limiting condition, it is the 6th biggest cause of death in England (GBD 2019). Alzheimer's is the most common form of dementia and accounts for more than half of England's dementia cases. It is estimated that more than 800,000 people are currently living with dementia in England. Dementia is significantly more prevalent amongst older people, around 98% of people with dementia in England are aged 65 or over. Due to England's ageing population, where the 65 and over age group is growing year-on-year, dementia cases are projected to reach one million in England by 2035.

In 2020, Southampton's crude prevalence of dementia among under 65 year olds (2.2 per 10,000 population) was significantly lower than the England average (3.1 per 10,000) and was the second lowest rate among its CIPFA comparators. Southampton also has one of the lowest crude dementia rates of its CIPFA comparators for people aged 65 or over (4.0% in 2020).

[70] NHS Digital. NatCen Social research Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014. http://content.digital.nhs.uk/catalogue/PUB21748 applied to HCC 2023-based Small Area Population Forecast

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To understand the true scale of dementia in a population, it is more useful to use modelled estimates rather than diagnosed cases as many people have dementia without a formal diagnosis. Dementia prevalence is surveyed in a sample population by age and sex, these prevalence rates are then applied to the population structure of a given area. In 2023 there were 1,726 people aged 65 or over in Southampton diagnosed with dementia, however the number of people living with dementia in the city was estimated to be significantly higher (2,663). This is expected to reach 4,480 by 2040

For age standardised emergency admissions among people aged 65 and over Southampton has the 7th highest rate in England (5,507 per 100,000 people in 2019/20), this is 57% higher than the England average (3,517). Short stay emergency admissions are also significantly higher than the England average. While these rates are noteworthy, hospital admission statistics are easily skewed by different coding practices. An admission in Southampton may have a dementia code added to it where it wouldn't in other parts of the country. We know from alcohol and obesity related admission statistics that Southampton hospitals use secondary coding to improve care pathways, however this makes comparisons less robust as Southampton looks exceptionally high.

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11.4 Health Behaviours

The 'Health Behaviours' theme of Southampton's JSNA (embedded in the Southampton Data Observatory [71] is split into four distinct topics: 'smoking', 'healthy weight', 'sexual health' and 'alcohol & drugs'.

11.4.1 Smoking

Smoking is the leading cause of preventable death and disease in the UK and the leading factor for disability-adjusted life years. Every year around 78,000 people in the UK, die from smoking, with many more living with debilitating smoking-related illnesses. Smoking increases the risk of developing more than 50 serious health conditions including cancer, heart disease, other vascular diseases and Chronic Obstructive Pulmonary Disease (COPD). Ischemic Heart Disease, COPD, cancer and a stroke are 4 of the top 6 conditions causing the greatest disease burden with smoking as an upstream factor. In addition, 1 in 9 pregnant women still smoke nationally with the associated risks of miscarriage, premature birth, still birth, low birth weight and neonatal complications. Tobacco is the largest contribution to years of life lost for both males and females.

In 2022 around 1 in 8 people (13.2%) in Southampton smoke, equivalent to 28,000 people. Compared with 12.7% in England and 10.5% in Hampshire. Southampton is the 6th highest in our ONS comparator group. This is an increase from 2021 and is now higher than England, but not significantly.

In 2021, more males smoke than females and they are more likely to smoke between the ages of 30 and 39 years. Smoking amongst men peaks between the ages of 35 and 39 years (3,530 registered patients). Whereas for females smoking peaks between the ages of 30 and 34 years (2,579 registered patients).

11.4.2 Excess Weight and Physical Activity

In Southampton, 29.5% of adults aged 18 and over are classified as obese (BMI greater than or equal to 30kg/m²) in 2022/23, higher, but not significantly, than the England average of 26.2%. During the same time period for Southampton, the percentage of physical activity of at least 150 minutes per week amongst adults (aged 19 and over) is 66.9% which is lower, but not significantly, than the England percentage of 67.1%.

[71] Southampton Data observatory https://data.southampton.gov.uk/

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Active transport has benefits for health in terms of reducing the risk of chronic disease such as coronary heart disease or stroke and improving mental health and well-being In 2019/20, during the pandemic, the Department for Transport reported that 1.9% of Southampton residents cycled three times per week compared to 2.3% England.

11.4.3 Sexually Transmitted Infections (STIs)

In 2023, a total of 1,891 STIs were newly diagnosed in Southampton residents, with a rate of 748 per 100,000 significantly higher than the England average of 704 per 100,000. The rate has decreased from 2012, with an increase in 2022. This may have been caused by the lack of diagnosis during the pandemic. The most commonly diagnosed STI was chlamydia, followed by gonorrhoea then genital warts.

11.4.4 Alcohol Use

The 2014 What about YOUth survey estimates that 63.3% of 15-year-olds in Southampton have ever had an alcoholic drink and 5% of this age group report being regular drinkers. These figures are not significantly higher than the national average.

It is thought that in Southampton, 41,807 individuals (20.6% of people over 18) drink over 14 units of alcohol a week (a level considered as high risk), lower but statistically similar to the England average (22.8%). It is estimated that 2.7% of adults locally are dependent drinkers, nearly double the England rate of 1.4%.

Much of the night-time economy is surrounding the consumption of alcohol and yet in Southampton 14.9% of the adult population are thought to abstain from alcohol. Conversely, there is a similar proportion (14.5% of adults) who reported to have binge-drunk on their heaviest day (drinking more than 6 units by women or 8 units by men).

Profiles for England show men are more likely to drink alcohol at increasing or higher risk levels (with those aged 40 to 64 years being heaviest drinking age group amongst both men and women). Also, those in the most deprived areas had the highest proportion of non-drinkers at 28.9%. Alcohol consumption at an increased or higher risk level is more prevalent in more deprived areas.
Alcohol-related hospital admissions can be used as a measure to indicate the burden of excessive alcohol consumption on the health of a population. Three hospital admissions measures can be used: alcohol-specific, alcohol-related (narrow) and alcohol-related (broad):

- **Alcohol-specific** hospital admissions are where the primary or any of the secondary diagnoses are wholly attributable to alcohol
- **Alcohol-related** admissions are those which can partly be attributed to alcohol

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- *The broad definition* encompasses admissions where the primary or secondary diagnoses is an alcohol-related condition
- *The narrow definition* only includes admissions where the primary diagnosis is alcohol-related

The broad measure can be more sensitive to changes in coding practices over time, the narrow definition can understate the role of alcohol in the admission.

Southampton is shown to have a higher rate of alcohol-specific and alcohol-related (broad) hospital admissions than England. Alcohol affects many illnesses and treatments. University Hospital of Southampton (UHS) asks all Southampton inpatients about alcohol so they can provide the right care. This is good practice which is not common in other hospitals yet. It means our numbers are higher because UHS is thorough in identifying and recording alcohol use. In other areas of the country, alcohol is likely to contribute to as many hospital admissions but may be less likely to be consistently identified and/or recorded so their reported numbers are lower.

Men are twice as likely as women in Southampton to be admitted to hospital for alcohol-specific health issues, increasing to 3 times more likely for broadly categorised alcohol-related issues.

Despite increasing alcohol-specific hospital admissions across all ages, when looking specifically at those aged under 18, Southampton admissions have fallen over the last 10 years, reducing the rate from 102.5 to 61.7 admissions per 100,000 people aged under 18, in 2018/19 to 2020/21. This remains statistically worse than the England average of 29.3 per 100,000 people.

In England, alcohol related hospital admissions increase with age, peaking at 40 to 64 years for narrow admissions. In Southampton under the age of forty, the gap between male and female hospital admissions for alcohol-related conditions (narrow) is similar, 273.2 (males) vs 223.0 (females) in 2021/22. This difference increases with age, men aged 65+ are just under 3 times more likely than their female counterparts to be admitted to hospital for alcohol-related conditions (narrow).

11.4.5 Drug use

In Southampton, all individuals in contact with services were seen within three weeks to commence their first drug treatment. It is estimated that almost half (44.7%) of opiate and/or crack cocaine users aged 18 and over were not in contact with drug treatment services in 2020/21, showing a high level of unmet need. The number of adults in treatment at specialist drug use services in Southampton equated to 5 in every 1,000 adults, higher when compared to the England average of 4 in 1,000

(2020/21). In 2021, of those non-opioid users accessing treatment, 41.5% successfully completed the program and did not re-present within 6 months. This is a steep increase from 28.9% in 2020 and now statistically significantly higher than England (34.3%). For opioid users, 5.6% successfully completed the program higher than England (5.0%).

Demographic profiling for England shows in 2021/22, 7 out of 10 people in treatment for drug use were male. The age of those entering treatment has been increasing, with the median age of those in treatment for problems with non-opiates currently at 31 years old, increasing to 43 for those in treatment for problems involving opiates.

For Southampton, substance use hospital admission rates are only available for young people aged 15 to 24. Hospital admission rates for this age group had been steadily rising at a similar rate both across England and Southampton over the last 10 years. From the period 2013/14 to 2015/16, Southampton's rate has risen from 96.6 per 100,000 persons to 109.5 per 100,000 persons in 2015/16 to 2016/17 and has then decreased to 101.8 per 100,000 in 2018/19 to 2020/21 statistically significantly higher than the England value of 81.2 per 100,000 persons.

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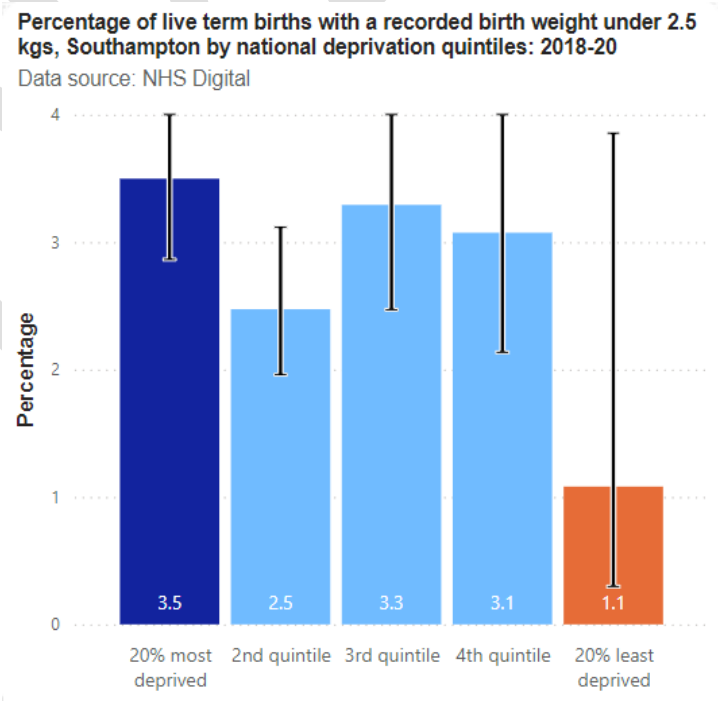
11.5 Maternal, Child and Young People's Health

11.5.1 Low Birthweight

Low birthweight is defined as a recorded birth weight under 2.5kgs. Low birthweight among infants is strongly associated with infant mortality, as well as disability and disease throughout child and adulthood, which can have wider impacts such as reduced educational achievement. Southampton has a statistically similar percentage of live term births with a low birthweight to the England average, 3.4% compared to 2.8%.

For the period of 2018 to 2022, the percentage of low birthweight babies across the city ranges from 1.7% in Bassett and 6.1% in Bevois. However, Bevois appears to be an outlier, with the second highest percentage at 3.9% in Woolston. It is unknown exactly why Bevois has such a high rate, it is likely the result of a combination of factors. Low birthweight is closely associated with deprivation, with babies born into the most deprived quintile are 2.2x more likely to be underweight than their counterparts born into the least deprived quintile in 2020-2022 by local IMD. Local analysis also shows Bevois has a higher concentration of Asian mothers who are more likely to have lower birth weight babies compared to the UK average.

Figure 40: Percentage of live term births with a recorded birthweight under 2.5kgs Southampton, by England deprivation quintiles.



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11.5.2 Smoking During Pregnancy

Smoking during pregnancy causes premature births, miscarriage and perinatal deaths. It also increases the risk of stillbirth, complications in pregnancy, low birthweight, and of the child developing other conditions in later life. Between 2018/19 to 2020/21 (pooled) 13.7% of women were smoking at the time of booking and appointment with midwife.

In 2022/23, 8.9% of women in Southampton were smoking at the time of delivery, statistically similar to the England rate of 8.8%. Locally, this is the first time Southampton has been statistically similar to England, following a decreasing trend since 2010/11.

In 2010 showed nationally pregnant women from routine and manual occupations are much more likely to smoke and to have done so during pregnancy than those from professional and managerial occupations (20% compared to 4%).[72]

Figure 46 demonstrates the wide disparity across the city with significantly higher rates of smoking at midwifery booking in the most deprived areas of the city compared to the least deprived.

[72] McAndrew F, Thompson J, Fellows L et al (2012) Infant Feeding Survey 2010. A survey conducted on behalf of the Information Centre for Health and Social Care. Leeds: The Information Centre for Health and Social Care. https://digital.nhs.uk/data-and-information/publications/statistical/infant-feeding-survey/infant-feeding-survey-uk-2010

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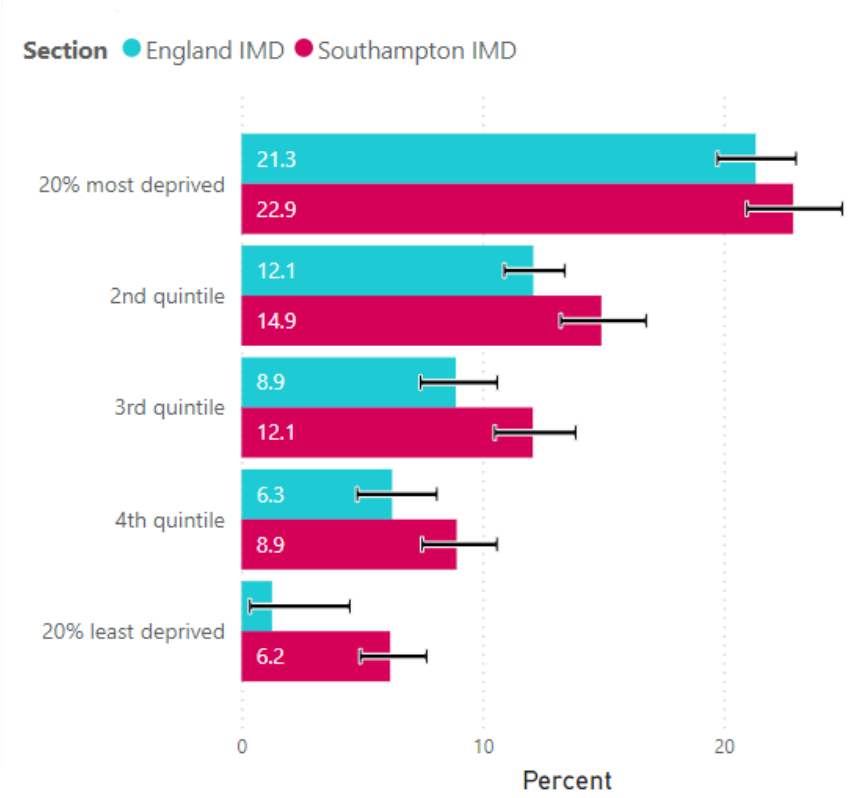
Figure 41: Percentage of mothers smoking at midwifery booking England and local deprivation quintiles 2018/19 to 2020/21 (pooled)



Source: Maternity services dataset (MSDS)

11.5.3 Breastfeeding Initiation and Maintenance

In 2020/21, data was collected on baby's first breastmilk feed for both Southampton and England. Data showed that 71.8% of local mothers were giving breastmilk as a baby's first feed, higher, but not significantly, than England's rate of 71.7%.

Another indicator looks at breastfeeding after the neonatal period where women continue to breastfeed at 6 to 8 weeks and beyond. In Southampton, a local target has been set to reach 50% of new mother's breastfeeding at 6 to 8 weeks. This target was met in 2018/19 and continues to improve. In 2022/23, 54.6% of women still breastfed at 6 to 8 weeks, significantly higher than the England average of 49.2% over the financial year.

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11.5.4 Childhood Obesity

Obesity in childhood is closely linked to obesity in adulthood and with a wide range of poor long term physical and mental health outcomes related to poor diet and low levels of physical activity. According to the most recent published results from the National Child Measurement Programme (NCMP) from 2022/23, 9.5% of children in reception are obese (including severe obesity), higher but not significantly than the England average of 9.2%. The prevalence of obesity has decreased slightly from the previous year (11.0% compared to 9.5%), but the long-term trend to 2019/20 was relatively stable.

In Southampton, the prevalence of obesity (including severe obesity) for Year 6 children is 26.2%, significantly higher than the England average of 22.7%. The figures for Southampton have been increasing since 2006/07 (18.2%). No data was collected in 2020/21 due to schools being shut in the pandemic.

Linked analysis from 2022/23 shows that when looking at the changes in weight status from Year R to Year 6, of the children who were overweight in Year 6 (14.3%), 71.1% were a healthy weight in Year R, 20.7% were overweight and a further 7.6% were obese.

Figure 42: Prevalence of overweight children in Year 6 by their year R weight grouping

Of the 25.4% of children who were obese in Year 6, 44.4% were healthy weight in Year R, 23.9% were overweight and 31.8% were obese.

Figure 43: Prevalence of Obese children in Year 6 by their year R weight grouping

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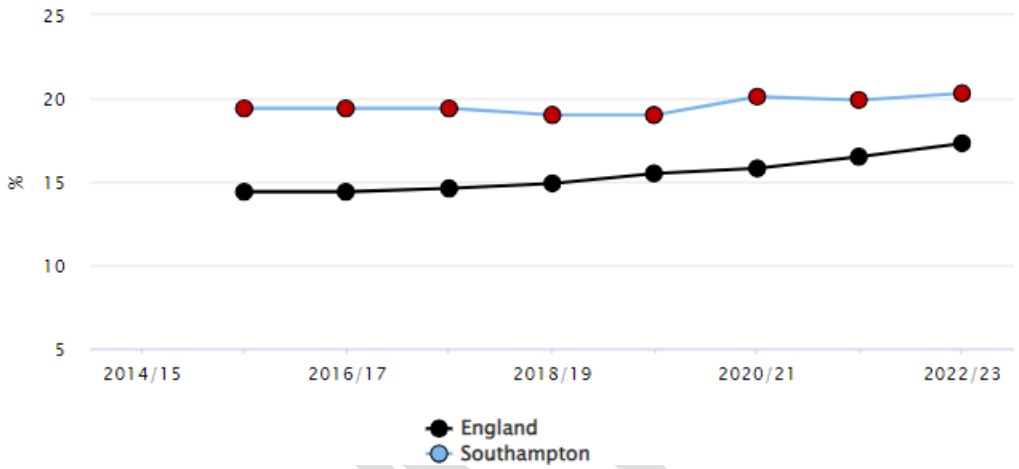
11.5.5 Children & Young People with Special Education Needs (SEN)

In 2022/23 there were 7,210 pupils (20.3%) in Southampton schools with a special educational needs, significantly higher than the England average of 17.3%.

Figure 44: Percentage of pupils with Special Educational Needs Support 2014/15 to 2022/23: Southampton and England trend



Source: Fingertips[73]

In 2022/23, 3.1% of primary school pupils in Southampton have social, emotional and mental health needs, significantly higher when compared to 2.8% in England. In Southampton during the same period, 4.7% of secondary school age pupils have social, emotional and mental health needs, significantly higher when compared with 3.5% in England.

[73] OHID Fingertips ID 90898 - https://fingertips.phe.org.uk/search/SEN#page/4/gid/1/pat/15/par/E92000001/ati/502/are/E06000045/iid/90898/age/217/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0

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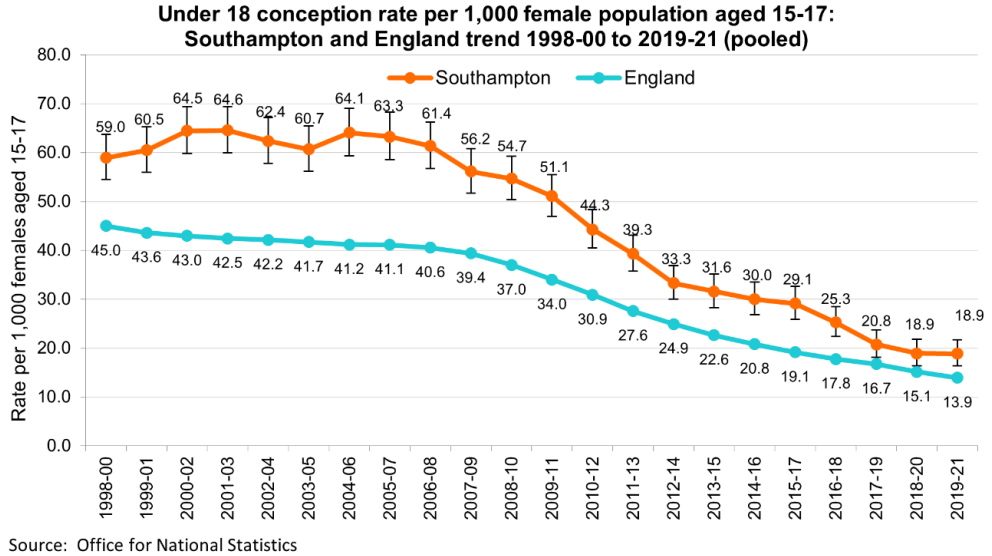
11.5.6 Teenage Pregnancy

A large proportion of teenage pregnancies are unplanned and around half end in abortions. Teenage pregnancies are an avoidable experience for most young women. Although, for some young women having a child can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the parent and the child. Around 1 in 5 young women aged 16 to 18 who are not in education, training or employment are teenage mothers; young fathers are also more likely to have poor education and have a greater risk of being unemployed in adult life.

Teenage conceptions in Southampton among females aged under 16 (aged 13-15) in 2021 is 2.9 per 1,000 (11 conceptions). If Southampton had 3 fewer conceptions, it would have the same rate as England of 2.1 per 1,000.

For females aged under 18, Southampton's rate continues to fall faster than the England average. The conception rate is 17.3 per 1,000, the lowest rate for Southampton since 2001. However, Southampton is the 5th highest amongst its ONS comparators and significantly higher than England's rate of 13.1 per 1,000.

Figure 45: Conceptions in females aged under 18 years, crude rate per 1,000 females aged 15 to 17 years. Southampton and England trend 1998-00 to 2019-21 (pooled)



Source: Office for National Statistics

11.5.7 Termination of Pregnancy

In Southampton 725 abortions were carried out in 2021, this is a crude rate of 20.4 per 1,000 females. This is significantly higher than the England average (17.9 per 1,000). It is important that females requesting an abortion have early access to services and support, as the earlier in the pregnancy the abortion is performed, the lower the risk of complications there are. Data from the most recent period (2021) shows that within Southampton 89.0% of abortions were performed within 10 weeks gestation, which is similar to the England average of 88.6%.

11.5.8 Use of Alcohol and Other Substances by Young People

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

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

In the 2021 Smoking, drinking and drug use among Young People in England (SDD) survey of secondary school pupils (aged 11 to 15 year olds) across England, 13% of 11 year olds had consumed alcohol and this had increased to five times higher, 65% by the age of 15. The survey asked about the previous 4 weeks and 17% of 15 year olds had drank alcohol (but not been drunk) and 21% had been drunk.

Despite increasing alcohol-specific hospital admissions across all ages, when looking specifically at those aged under 18, Southampton admissions have fallen over the last 10 years, reducing the rate from 102.5 to 61.7 admissions per 100,000 people aged under 18, in 2018/19 to 2020/21. This remains statistically worse than the England average of 29.3 per 100,000 people.

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11.6 Protecting the Population

11.6.1 Environmental Exposures

Prior to the mid-1980s asbestos was widely used in the ship-building industry. Exposure to asbestos is the leading cause of a cancer called mesothelioma which can affect the tissues covering the lungs or the abdomen. The city's ship-building heritage means that, although mesothelioma is a relatively rare cancer, Southampton is included within ten geographical areas of Great Britain with the highest male mesothelioma death rates for the period 1981-2022 (425 deaths for Southampton male residents). These areas include other prime ship-building locations of the last 40 years, as shown in Figure 53. There were 58 female deaths from mesothelioma in the same period, and Southampton is ranked 26th.[74]

Figure 46: Mesothelioma mortality in Great Britain: number of deaths and Standardised Mortality Ratios for males by area, 1981-2022

Rank within GB	Area	Male deaths	Standardised Mortality Ratios (SMRs)	95% Confidence Interval	
				Lower	Upper
1	Barrow-in-Furness	305	399.3	355.7	446.7
2	West Dunbartonshire	302	350.8	312.4	392.7
3	North Tyneside	579	276.3	254.2	299.7
4	South Tyneside	445	273.0	248.2	299.6
5	Plymouth	648	261.1	241.4	282.0
6	Portsmouth	464	260.0	236.9	284.8
7	Medway	504	232.3	212.5	253.5
8	Hartlepool	201	221.4	191.8	254.2
9	Gosport	170	215.6	184.4	250.6
10	Southampton	425	215.1	195.1	236.5

Source: HSE http://www.hse.gov.uk/statistics/assets/docs/mesoarea.xlsx

Poor air quality is a significant public health issue. Particulate matter (PM2.5) has a significant contributory role in human all-cause mortality, particularly cardiopulmonary mortality. In 2022, Southampton's level of PM2.5 was 8.2 µg/m3 which is statistically similar to the England average of 7.8 µg/m3, using the new method of concentration of PM2.5.

In 2022, the estimated fraction of all cause adult mortality attributable to anthropogenic particulate air pollution (new method) as measured as fine particulate

[74] Health and Safety Executive, Mesothelioma Mortality in Great Britain by Geographical area, 1981–2022 https://www.hse.gov.uk/statistics/assets/docs/mesoarea.pdf page 4 (accessed 04/09/2024)

matter, PM2.5 for Southampton was 6.1% statistically similar to the percentage for England (5.8%). The fraction of mortality attributable to particulate air pollution has fluctuated but decreased overall from 2018 to 2022 but since particulate matter can be affected by weather patterns, trends overtime should be interpreted cautiously.

11.6.2 Safeguarding for Children and Vulnerable Adults

Southampton has a relatively young age profile, with the population aged 10 to 24 years predicted to grow by +7% by 2029. There is evidence to suggest that young people can be at a higher risk of becoming involved in crime, either as a victim or an offender. The likelihood of a young person becoming involved in crime increases with negative risk factors such as, but not limited to experiencing adverse childhood experiences, family conflict, poor attendance and exclusion from school. The above factors highlight the importance of early intervention to prevent young people from becoming involved in crime in the first place.

13.5% of victims and 14.6% of suspects or offenders identified in Southampton in 2022/23 were aged under 18 years. The risk of young people becoming involved in crime also varies across crime groups, with certain crimes skewed towards younger age profiles, for example violent crime.

In 2022/23 there were 538 children in care, in Southampton, a rate of 108 per 10,000 population aged under 18 years, significantly worse than the England rate of 71 per 10,000.

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

Injuries are a source of harm for children and a leading cause of hospitalisation and represent a major cause of premature mortality for children and young people.

In 2022/23, the rate of children aged 0 to 4 years old with hospital admissions caused by unintentional and deliberate injuries in Southampton was 105.6 per 10,000 population, statistically similar to England's rate of 92.0 per 10,000. The trend in Southampton has been decreasing and getting better from a rate of 211.4 per 10,000 in 2011/12. This trend should continue to be monitored to see if the decline experienced over the last year is sustained.

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However, Southampton remains significantly worse than the England average for hospital admissions due to unintentional and deliberate injuries among the 15 to 24 years age group in 2022/23.

Vulnerable adults include adults in contact with secondary mental health services and adults with a learning disability. Living in settled accommodation improves their safety and reducing their risk of social exclusion. Maintaining settled accommodation and providing social care in this environment promotes personalisation and quality of life, prevents the need to readmit people into hospital or more costly residential care and ensures a positive experience of social care. More information is available in section 11.7.3 below.

In 2020/21, the percentage of adults in contact with secondary mental health services who live in stable and appropriate accommodation in Southampton was 26.0%, this is significantly lower than the England average of 58.0%. In 2019/20, the percentage of adults with a learning disability who live in stable and appropriate accommodation in Southampton was 82.4%, this is significantly better than the England average of 77.3%.

11.6.3 Health Protection from Communicable Diseases

- **Tuberculosis (TB):** Cases of TB in Southampton have seen an overall decrease since the peak in 2011-13 (18.3 per 100,000 population). In 2020-22, the rate per 100,000 population of new TB notifications in Southampton was 8.8, statistically similar to the England average of 7.6 per 100,000 population. This is lowest rate since pre 2001-03. In 2021, 85.7% of drug sensitive TB cases had completed a full course of treatment by 12 months, also similar to the England percentage (84.2%). The highest percentage of drug completion locally was in 2013 with a coverage of 96.9%.

- **Hepatitis C:** In 2021, Hepatitis C had a detection rate of 46.1 per 100,00 population. This was significantly higher than the England crude rate of 27.8 per 100,000 population. Hepatitis C has a higher prevalence among those people who inject drugs. In 2017/18, 85.0% of those people in drug use treatment in Southampton received a Hepatitis C test, similar to the England average of 84.2%.

- **Healthcare Associated Infections (HCAI):** Healthcare-associated infections (HCAIs) can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. The term HCAI covers a wide range of infections. The most well-known HCAI include those caused by methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C. difficile). In the University Hospital

Southampton, there were 6 cases of overnight bed days of MRSA bacteraemia[75], 157 cases of Clostridium difficile (C. diff) infection[76] and 412 cases of E.coli bacteraemia in 2022/23 (a rate of 1.52, 39.9 and 104.6 respectively).

- **Vaccine Preventable Disease:**

Routine childhood immunisation ensures children are best protected against a range of vaccine preventable diseases. Vaccination is safe and effective. In 2024, the UK has seen increases in cases of measles and pertussis. Vaccination rates have been falling nationally and locally over the last 10 years and dropped further during the COVID-19 pandemic.

Measles is a highly infectious acute viral illness. It is a notifiable disease and vaccine-preventable. Global cases of measles are high due to poor vaccination coverage made worse by the COVID-19 pandemic. Imported cases are therefore likely.

Vaccine has been available in the UK since 1968 but low coverage of population until MMR vaccine in 1988 and due to subsequent lower transmission, unvaccinated children remain highly susceptible to measles infection, and this continues to the present day. The target for uptake is 95% of the population to protect everyone. In 2021/22 in Southampton in 92% of children had their 1st MMR by age 2 years but this drops to 88% of children having their second dose by 5 years. Both are higher than the England average

Since 1 January 2024, there have been 2,012 laboratory confirmed measles cases reported in England (46% in London, 28% in the West Midlands, and 9% in East Midlands. 129 upper tier local authorities (UTLA) have reported at least one confirmed case with symptom onset since 1st January. The majority of the cases, (62%), have been in children under 10 and young people and adults aged 15-34 (31%). In the same period there have been 13 confirmed measles cases (correct at 30th September 2024) in Southampton. Most of these were travel related with no sustained community transmission.

[75] Public Health England. MRSA bacteraemia: annual data https://www.gov.uk/government/statistics/mrsa-bacteraemia-annual-data (accessed 16/09/2024)

[76] Public Health England. Clostridium difficile infection: annual data Clostridioides difficile (C. difficile) infection: annual data - GOV.UK (www.gov.uk) (Accessed 16/09/2024)

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Whooping cough, also known as pertussis, is a highly contagious bacterial infection that mainly affects the lungs and airways. Whooping cough is sometimes known as the 100-day cough because of how long it takes to recover from it. It spreads very easily and can be serious. It's important for babies, children and anyone who's pregnant to get vaccinated against it.

Whooping cough can affect people of all ages and while it can be a very unpleasant illness for older vaccinated adolescents and adults, young babies who are too young to be fully protected through vaccination are at increased risk of serious complications or, rarely, death.

Since 1 Jan 2024, there have been 5337 suspected cases in South East: 2005 confirmed, compared with 858 cases for the whole of last year (2023).
Of the 4992 cases with age information available, 61 (1.2%) were under 3 months old, 48 (0.9%) were 3-5 months old and 57 (1.1%) were 6-11 months old

- **Seasonal Flu:**

The seasonal flu vaccine is recommended for the very young, older people, pregnant women and those who are immunosuppressed with certain underlying conditions. In the 2023/24 'flu season', 41.3% of people at risk had a vaccination administered between 1st September and the end of February. Under the national goal of 55%, but statistically similar to the England average of 41.4%.Eligibility has been extended to children aged 2 years and older over the last few years.

Port Health: In 2023, Southampton port handled 30.62 million tonnes of cargo by volume, and 1.50 million units[77] and 2.73 million cruise passengers coming to 5 cruise terminals annually require a range of diverse environmental health control functions from Southampton Port Health Services. Food and people now travel over far greater distances than ever before, creating the conditions necessary for widespread and rapidly occurring outbreaks of disease. Infectious diseases such as cholera persist and return, and recent decades have shown an unprecedented rate of emergence of new zoonoses within the UK. It is anticipated that container volumes and shipping movements will continue to grow but accurate projections are somewhat difficult in the current economic climate. It is also anticipated that the number and details of intervention will also increase in line with the effects of climate change, food fraud and adulteration which have clear implications for food

[77] Department for Transport – Maritime Statistics https://maps.dft.gov.uk/maritime-statistics/index.html (accessed 16/08/2024)

production, food security and food safety. Southampton City Council continually assesses resource threats and requirements and delivery outcomes.

11.7 Specific Needs for Key Population Groups

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

11.7.1 University Students

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

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

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

11.7.2 Carers

Carers are a critical, and often under-recognised and under-valued resource in caring for vulnerable people. In the 2021 census, 18,136 people (7.7%) 1 in 13 people, said they provide some level of unpaid care in Southampton. This was significantly lower than the England average (8.8%) and was the third lowest rate among Southampton's ONS comparator group. Significantly more people in Southampton said they were in good health compared to the England average in the 2021 census. This, along with the city's relatively young population, may explain why there is slightly less unpaid care provided in Southampton.

Southampton has lower percentages of unpaid carers across all age and economic activity groups compared to England. Southampton's 2021 percentage of unpaid carers was also lower than the 2011 census (8.6%), however 'unpaid care' was more tightly defined in the 2021 census question so a robust comparison cannot be made.

Differences in percentages of unpaid carers by ethnicity group may be due to cultural differences or a combination of factors mentioned in this analysis. The white British

ethnicity group provide the highest amount of unpaid care from 9.0% of residents in this ethnicity group. This is also group with the highest percentage reporting in “not good health”.

A higher (80.5%) percentage of residents who are white British, are providing some level of unpaid care compared to the percentage of this ethnicity within the Southampton (68.5%) population. Looking specially at those providing 50+ hours of unpaid care a week across the city, 82.1% of those providing this are white British.

Breaking down hours provided by ethnic group (including the more common sub groups) show whilst 9.0% of white British provide the most unpaid care; Asian Bangladeshi (8.9%) and Black Caribbean (8.8%) also give more than the Southampton average (7.7%). During the pandemic, changes in caring patterns where normally from several individuals in multiple households changed to single individuals from one household in line with government guidelines to reduce infection spread, this may be a factor on the data.

The highest groups by ethnicity providing 20+ hours of care a week, recorded in the 2021 Census were 5.4% of Asian Bangladeshi (aged 5+), 4.7% of white British (aged 5+) and 4.4% of Black Caribbean (aged 5+). The highest percentage by ethnic group providing 50+ hours is Asian Bangladeshi (3.3%).

A deeper dive looking at differences by sex and ethnicity, showed 53.7% of Asian unpaid carers are females, rising to 60.5% among Asian Pakistani residents. Black unpaid carers are 56.6% females and 58.9% of white British unpaid carers are females.

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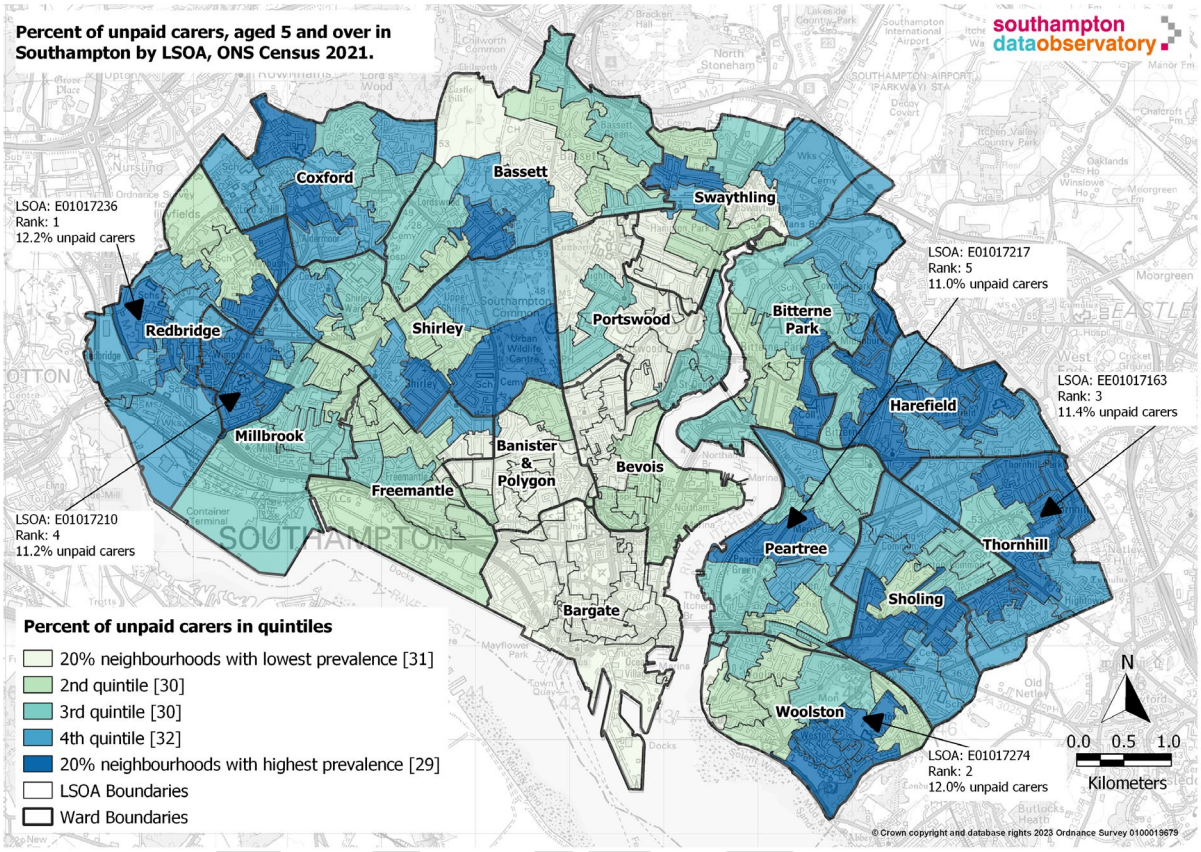
Figure 47: Percent of unpaid carers, aged 5 and over in Southampton by LSOA 2021 Census



The rate of unpaid carers is lower in Southampton's north and central locality. Most of these areas have a younger average age and a larger student population or have the affluence to provide paid care.

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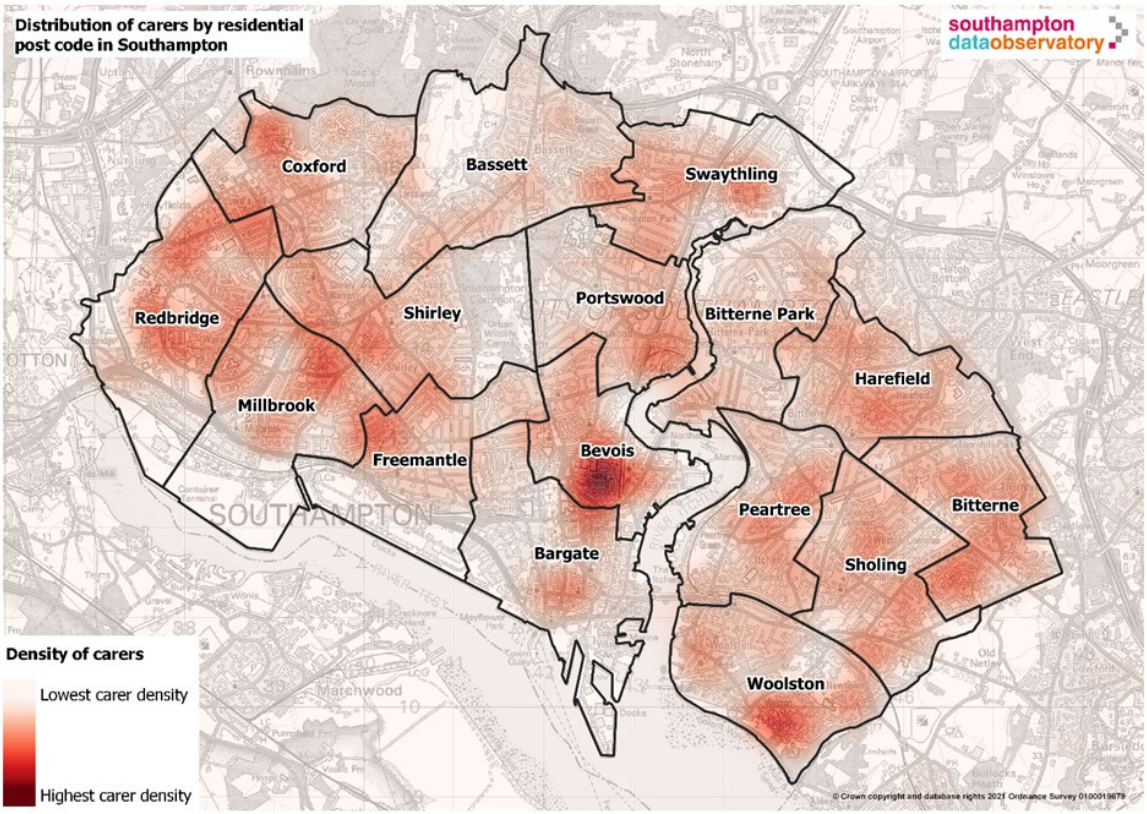
Figure 56: Distribution of carers by residential postcode in Southampton August 2021



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

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11.7.3 Disability - People with a Learning Disability

There is a gap between the number of people who are estimated to have a learning disability and those who are registered with a GP.

Across Southampton PCNs, 1,583 GP registered patients were registered as having a learning disability, a prevalence of 0.49% for 2022/23. The prevalence ranged by practice from 0.02% of patients at University Health Service to 0.94% at Lordshill Health Centre. The next highest prevalence was at Stoneham Lane Surgery and Shirley Health Partnership, both with a prevalence of 0.71%.

In Southampton the key characteristics of people with learning disabilities are:

- More males, than females have a learning disability
- A higher percentage of residents who have a learning disability live in Coxford, Redbridge and Thornhill
- Prevalence in the most deprived areas of Southampton is four times higher than in the least deprived areas (6.72 per 1,000 population in the 20% most deprived areas compared to 2.61 per 1,000 population in the least deprived areas).

People with a learning disability often have a significantly higher prevalence of other health conditions compared to people without learning disabilities. These conditions can include the following, please note that percentages are for the period 2021-22 and are for the Hampshire and Isle of Wight Sub-ICB, (this is not an exclusive list of conditions):

- Asthma - 9.0% of patients with Learning disabilities have an active diagnosis of asthma, higher when compared to 6.4% of patients without LD
- Autism – 31.2% of patients with LD have a diagnosis of autism significantly higher than patients without LD (1.0%)
- Dementia – 1.5% of patients with LD have a diagnosis of dementia higher when compared to 0.8% of patients without LD
- Depression - 15.2% of patients with LD have and active diagnosis of depression, slightly lower when compared to patients without LD (15.9%)
- Diabetes – 6.9% of patients with LD have an active diagnosis of diabetes mellitus and a record of IFCC-HbA1C in 2021/22 , higher when compared to 4.2% of patients without LD
- Epilepsy - 18.1% of patients with LD have Epilepsy, significantly higher than those patients without LD (0.6%)
- Hyperthyroidism – 7.2% of patients with LD have a diagnosis of hyperthyroidism higher than those patients without LD (3.6%)

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- Severe mental illness – 6.5% of patients with LD have a diagnosis of severe mental illness significantly higher than those patients without LD (0.8%)[78]

The type of conditions with higher diagnosed prevalence among people with a learning disability tend to be those that involve self-management. Higher prevalence often occurs at an earlier age in a person's lifetime for people with a learning disability compared to those without.

For instance, the percentage of people with a learning disability are likely to have a higher BMI than the general population. In 2021-22, in the Hampshire and Isle of Wight sub-ICB, 24.5% of people with learning disabilities had a BMI assessment classification (or downs syndrome BMI centile classification) of obese (BMI equal or over 300). Significantly higher when compared to 8.3% for the general population.

lack of physical activity. They may also be prescribed medicines that increase the risk of diabetes, e.g., antipsychotics. As a consequence, the treatment regimens of people with a learning disability can be complex, involving several different prescribers with medicines frequently used outside their product license.[79]

[78] Learning disabilities – Southampton Data Observatory https://data.southampton.gov.uk/health/disabilities/learning-disabilities/ accessed 16/08/2024

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

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11.7.4 Disability - Adults with Autistic Spectrum Conditions

A local estimate of the prevalence of autistic spectrum conditions in adults aged 16 years and over in Southampton was produced using national prevalence estimates derived from the 2014 Adult Psychiatric Morbidity Survey. In 2023, it is estimated that there are 1,153 males (1.1% of male population) and 212 females (0.2% of the female population) aged 16 years and over in Southampton who would screen positive for autism spectrum conditions.[80]

11.7.5 Lesbian, Gay, Bisexual and Transgender Community

For the first time Census 2021 included a question on sexual orientation. Although voluntary, people aged 16 and over were asked to complete.

In Southampton, there are 4,071 (2.0%) people who are gay or lesbian 5th highest amongst our ONS comparators and significantly higher when compared with 1.5% for England as a whole. There are also 4,830 people (2.4%) who are bisexual the 3rd highest amongst our ONS comparator group with Bristol as the highest (3.1%) and higher when compared to 1.3% in England. In Southampton, there are also 1,181 people (0.6%) who are other sexual orientations, including pansexual, asexual and queer. Third highest amongst ONS comparators and higher compared to 0.3% in England. In Southampton 8.3% of the people who filled in the Census didn't answer this question, higher than England (7.5%).

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

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

In the 2021 Census there was a question on gender identity, which asked people aged over 16 what their gender identity was. In Southampton, 92.3% of the over 16

[80] NHS Digital. NatCen Social research Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014 (accessed 16/08/2024) applied to the Hampshire County Council 2023-based Small Area Population Forecast

population identified as the same sex as registered at birth, the 2nd lowest amongst our ONS comparators and significantly lower when compared to 93.5% for England. Coventry is the lowest at 91.6% and Plymouth is the highest at 94.2%.

In Southampton, 1,633 people (0.80%) aged 16 and over identified themselves as a different sex from that registered at birth. This is significantly higher when compared to 0.55% for England. Southampton is ranked 3rd highest amongst our ONS Comparators, the largest being Newcastle upon Tyne (0.87%).

In Southampton, 0.15% of people were trans women, the highest ranking amongst our ONS comparators and higher when compared to 0.10% England. The same percentage (0.15%) were trans men and is ranking 1st amongst ONS comparators. There were 390 people (0.19%) with other gender identities in Southampton.

11.7.6 Age

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

- Health issues tend to be greater amongst the very young and the very old
- In Southampton's 0 to 4 year olds, 99.6% are without chronic conditions. By age 60 to 64 over half (55.3%) have at least one LTC, by the age of 80 to 84 43.1% have at least 3 LTC and people aged 90 and over 8.4% have at least 6 long term conditions. In 2022/23, a higher rate of older people (aged 65 year and over) in Southampton access long term support through adult social services than is the case nationally (5,965 per 100,000 compared with 5,185 per 100,000). [81]

11.7.7 Older Adults mental health

The older we get, the risk factors that may lead to social isolation and loneliness increase. In the latest analysis report from Age UK, older people aged 50+ in England are:

- 5.2 times more likely to be often lonely if they are facing bereavement
- 1.6 times more likely to be often lonely if they are living alone
- 3.7 times more likely to be often lonely if they are living with limiting disabilities or illnesses
- 2.6 times more likely to be often lonely if they are caring for a partner

[81] Personal Social Services Adult Social Care Survey, England, 2022-23 Adult Social Care Activity and Finance Report - NHS England Digital table 36 (Accessed 20/09/2024)

- Physical and mental health difficulties, making it harder to participate in activities and maintain relationships
- 2.3 times more likely to be often lonely if they have low fixed incomes, such as pensions, making activities unaffordable
- 3.0 times more likely to be often lonely if they don't feel they belong to their neighbourhood e.g., Digital exclusion
- Reduced mobility and loss of access to affordable, reliable, and/or suitable modes of transport

Gender identity may have an impact on social isolation and loneliness; however, evidence doesn't suggest that one gender is lonelier than the other. LGBTQ+ people are at a greater risk of loneliness as social rejection, exclusion, and discrimination can lead LGBTQ people to feel lonelier. Older LGBTQ+ people more vulnerable to social isolation as they are more likely to be single, living alone and less contact with relatives. A person's long-term health, disability or mental health impacts the risk of loneliness and social isolation. Family circumstances can contribute to loneliness, such as: adult children leaving home, bereavement, becoming single, weak familial relationships, and being at home with young children. People from a lower socio-economic status or a socio-economically disadvantaged area are at a higher risk. This could be due to inequality in resources and limited finances.

11.7.8 Ethnicity, Migration, Language and Religion

In the 2021 Census in Southampton, 31.9% of residents consider themselves other than white British, compared with 22.3% in 2011. An increase of 50.2% or just over 26,537 people. Within Southampton, there is a wide variation in ethnic diversity. In Bevois ward, the 36.1% of residents are white British, followed by 29.1% of residents who are Asian or British Asian and 18.2% of the population are white other (than white British). In Freemantle, 56.1% are white British, followed by white other (than white British) (21.5%). Sholing has the largest white British population at 87.3%.

Cultural difference can affect health and wellbeing:

- Ethnic differences in health are most marked in the areas of mental wellbeing, cancer, heart disease, HIV, TB and diabetes
- An increase in the number of older people from ethnic minorities is likely to lead to a greater need for provision of culturally sensitive social care and palliative care.
- Ethnic minority populations and religious groups may face discrimination and harassment and may be possible targets for hate crime[82]

[82] Hate Crime on Southampton Data Observatory https://data.southampton.gov.uk/community-safety/hate-crime/ (Accessed 16/08/2024)

- Migrants may have limited health literacy to spoken and written information that is not in their first language[83]
- Possible link with 'honour-based violence' which is a type of domestic violence motivated by the notion of honour and occurs in those communities where the honour concept is linked to the expected behaviours of families and individuals
- Female genital mutilation[84] is related to cultural, religious, and social factors within families.

11.7.9 Gender

- In 2018-20, in Southampton, healthy life expectancy for males was 61.4 years, which is lower than the national average of 63.1 years. For females, health life expectancy in Southampton is 63.1 years, which again is lower than the national average of 63.9 years. This suggests that in Southampton there is a wider healthy life expectancy gap (1.7 years) between males and females than that seen nationally (0.8 years).[85]
- In 2020-22, in Southampton, looking at the England deprivation quintiles, males living in the 20% most deprived areas of the city live on average 5.3 years less than those living in the 20% least deprived areas. Females in the 20% most deprived areas live 3.9 years less than those in the 20% least deprived areas.[86]
- The most recent community safety survey also highlighted that over half of respondents that witnessed or were a victim of crime did not report the incident. This is particularly concerning for high harm and priority offences, such as hate crime (80%), sexual assault (74%), Violence against women and girls (68%), domestic abuse (58%) and serious violent crime (53%).[87]

11.7.10 Port Workers and Visitors

Southampton is a port city with the potential for communicable diseases to be spread by the large-scale movements of goods and people through the port.

[83] Ethnicity, language and identity on Southampton Data Observatory https://data.southampton.gov.uk/population/ethnicity-language-and-identity/ (Accessed 16/08/2024)
[84] NHS Overview of FGM https://www.nhs.uk/conditions/female-genital-mutilation-fgm/ (Accessed 16/08/2024)
[85] Life Expectancy on Southampton Data Observatory https://data.southampton.gov.uk/health/life-expectancy-and-mortality/life-expectancy/ (accessed 16/08/2024).
[86] Life Expectancy on Southampton Data Observatory https://data.southampton.gov.uk/health/life-expectancy-and-mortality/life-expectancy/ (accessed 16/08/2024).
[87] Southampton City Council Safe City Assessment. https://data.southampton.gov.uk/media/m20a2aoj/2022-23-safe-city-strategic-assessment-report.pdf page 73 (accessed 16/08/2024).

In 2023, Southampton port handled 30.62 million tonnes of cargo by volume, and 1.50 million units[88] and 2.73 million cruise passengers coming to 5 cruise terminals annually require a range of diverse environmental health control functions from Southampton Port Health Services. As ferry port, Southampton serves around 3 million passengers to and from the Isle of Wight.

11.7.11 Veterans

The 2021 Census recorded 6,361 (3.1%) Southampton residents (aged 16 and over) who had previously served UK armed forces or reserves (veterans). Southampton's percentage of veterans is lower when compared to England (3.8%) and the 5th lowest percentage amongst our ONS comparators which range from 8.4% in Plymouth to 2.4% in Bristol.

In Southampton, 86.8% of people who previously served in the UK armed forces or in the reserves were male and 13.2% were females. This is similar to England where 86.5% of veterans were male and 13.5% were female.

Veterans are more likely to be older people; 51.7% of veterans locally and 53.2% of veterans nationally are aged 65 and over. The range across the city shows 62.7% of veterans in Bassett who were aged 65 and over, higher compared to 36.2% in Bevois. Differences by sex reflects National Service legislation (1939 to 1960), showing in Southampton, 42.7% of female veterans and 53.1% of male veterans were aged 65 years. In England, this percentage is 40.5% of female veterans and 55.2% are males are aged 65 and over.

In Southampton, 35.9% of veterans, reported themselves to be in bad health higher when compared to 35.5% of veterans in England, but also far higher than the 20.1% of the overall city population (aged 16 and over) reporting to be in bad health. This may be due to service sustained injuries. Variation among Southampton wards range from 43.3% of veterans in both Coxford and Bitterne are not in good health to Bargate (30.7%).

Three out of ten veterans (31.4%) are disabled under the Equality Act and of those 48.4% of people who served had their day-to-day activities limited a lot and 51.6% reported having their day-to-day activities limited a little. This compares to two out of ten (19.8%) for Southampton's general population who are disabled under the Equality Act - with 39.8% of all Southampton residents aged 16 and over had their day-to-day activities limited a lot and 60.2% limited a little.

[88] Department for Transport – Maritime Statistics https://maps.dft.gov.uk/maritime-statistics/index.html (accessed 16/08/2024)

Information from PTSD UK suggests that the estimated rate of PTSD among UK veterans of all conflicts is 7.4%. The rate for PTSD among the public is 4%. Using this rate (7.4% of 6,361 veterans), would suggest that there are 470 veterans have PTSD in Southampton.[89]

The University Hospital Southampton NHS Foundation Trust is one of 104 NHS providers that are accredited to have the best care for veterans, to help care for people that serve or have served in the UK armed forces and families. These Veteran Aware trusts are helping to provide and improve veterans' care, as part of the Veterans Covenant Healthcare Alliance (VCHA).

11.7.12 Travellers

In September 2021, there were twenty-six pitches across Southampton and nine travelling show people yards, making a total of 35 plots across Southampton. In the 2021 Census, 918 people recorded themselves as Roma (578) or Gypsy or Irish Traveller (340), just 0.4% of the population. Key barriers to health in these communities include lower health literacy and cultural distrust of systems.

11.7.13 Homelessness

Southampton had an overall rate of 5.3 households threatened by homelessness per 1,000 households in 2021/22, which was similar to the national average (5.6 per 1,000 households) and 6th lowest among comparators. Notably, Southampton had a significantly lower rate of households threatened by homelessness compared to Portsmouth (7.7 per 1k households).

Based on Autumn count data, the number of people rough sleeping on a single night in Southampton was three times higher in 2022 (27 people) compared to 2021 (9 people). Looking at trends over time, the average count between 2010 and 2022 was 20 people a year, with the 2022 count (27 people) above this average.

In addition, there are believed to be high numbers of 'hidden homeless' people who are housed by family and friends in shifting circumstances, but not always captured as part of the official figures. Underpinning these upward trends are the various causes of homelessness, of which, the most important remains the supply and affordability of decent housing.

[89] PTSD UK https://www.ptsduk.org/?gad_source=1&gclid=CjwKCAjw8fu1BhBsEiwAwDrsjN9atkbOe0lsOCV6RSU5H_-GAFmO42MEzTYWbkRVlHzkG2YQg9KACxoC3RQQAvD_BwE (accessed 16/08/2024)

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The average life expectancy for women experiencing homelessness is 43 years old and for men it is 47 years old. Drug and alcohol use are particularly common causes of death among the homeless population, accounting for just over a third of all deaths, and people experiencing homelessness are nine times more likely to commit suicide than the general population.[90]

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

The 619 known rough sleepers provided 1,048 reasons for their rough sleeping, with Mental Health (26.7%) and Drug Addiction (23.9%) being the most represented reasons. Other reasons given were Prison (16.5%), Physical Disability (13.8%), Alcohol issues (13.5%), Domestic Violence (3.1%) and Learning Difficulties (2.6%).

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

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

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

The Pharmaceutical Needs Assessment (PNA) is a legal duty for Health and Wellbeing Boards (HWBs). Hampshire, Portsmouth, Southampton and Isle of Wight (HIOW) HWBs are each required to publish a revised PNA for their area by 1st October 2022. The PNAs are used by NHS England to make decisions on which NHS funded pharmaceutical services need to be provided in each local area. Failure to publish a robust PNA, which has been produced in line with requirements of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 could lead to legal challenges, particularly as the local PNA is central to making decisions about new pharmacy openings.

The HIOW PNA Steering Group exists to guide the preparation of the PNA documents on behalf of the HIOW Directors of Public Health for presentation to the HWBs.

12.1 Purpose

The Steering Group will: -

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

Data, Intelligence & Insight Team
Strategy & Performance,
Southampton City Council, Southampton, SO14 7LT

E-mail: data.observatory@southampton.gov.uk
Website: https://data.southampton.gov.uk

12.2 Membership

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

Southampton City Council
Robin Poole - Public Health Consultant
Vicky Toomey – Principal Analyst (Public Health)
Vanella Mead – Strategic Data Analyst

Portsmouth City Council
Matt Gummerson – Head of Strategic Intelligence and Research

Hampshire County Council
Catherine Walsh – Senior Public Health Intelligence Analyst
Thomas Ruxton – Senior Public Health Intelligence Analyst

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

Community Pharmacy HIOW
Artur Pysz – Joint Chief Officer
Alison Freemantle – Joint Chief Officer

South East Pharmacy Optometry and Dentistry Commissioning Hub – Working on behalf of all ICBs across the South East
Amanda Borland – Senior Commissioning Manager – Pharmacy and Optometry

Health and Care Portsmouth / Hampshire and Isle of Wight ICB
Simon Cooper – Director of Pharmacy, Optometry and Dentistry (HIOW ICB) and Medicines Optimisation (Portsmouth)
An agreed deputy may be used where the named member of the group is unable to attend.
Other staff members/stakeholders may be invited to attend meetings for the purpose of providing advice and/or clarification to the group.

NHS Frimley – Frimley Health and Care Integrated Care System
Yinka Kuye – Community Pharmacy Clinical Lead

An agreed deputy may be used where the named member of the group is unable to attend. Other staff members/stakeholders may be invited to attend meetings for the purpose of providing advice and/or clarification to the group.

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

12.3 Declarations of interest

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

12.4 Meetings

All meetings will have an agenda and action notes. There will be scheduled meetings of the steering group although this schedule may be adjusted, if necessary, by agreement of the group.

12.5 Accountability and reporting

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

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13. Appendix C – Consultation report

13.1 Details of the consultation

Southampton City Council will conduct a public consultation on a draft Pharmaceutical Needs Assessment ("PNA").

The aim of this consultation will be to:

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

13.2 Results of the consultation

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

13.3 Consideration of the consultation results

The steering group will look at the consultation results at a future meeting.

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14. Appendix D - Equality and Safety Impact Assessment

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

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

Figure 48: The Equality Duty

Name or Brief Description of Proposal	**Southampton Pharmaceutical Needs Assessment 2025**
Brief Service Profile (including number of customers)	
A Pharmaceutical Needs Assessment (PNA) is a statement of current pharmaceutical services provided in the local area. It also assesses whether the pharmaceutical services provision is satisfactory for the local population and identifies any perceived gaps in provision. The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for developing and updating PNAs. It is a statutory requirement for the Health and Wellbeing Board to publish a revised assessment within three years of its previous PNA. This PNA is due to be published in 1 October 2025.	
Summary of Impact and Issues	
The PNA reflects the current and future needs for pharmaceutical services. This affects the residents of Southampton, people who work and study in the city and partner NHS organisations including NHS Hampshire and Isle of Wight ICB, Southampton University Hospitals NHS Foundation Trust, GP practices and the existing community pharmacy network. This PNA refreshes the previous assessment published on 1 October 2022. Access to high quality pharmaceutical services is particularly relevant for those in ill health who are taking medicines, typically people suffering from long term conditions and older adults. But there is no specific population group	

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that is impacted as everyone may need access to pharmaceutical services in the city. The PNA, therefore, makes reference to a range of groups.	
Potential Positive Impacts	
The PNA has been developed to ensure a good range of pharmaceutical services may be accessed by the local population of Southampton. Many services have been identified, including locally commissioned services, and their role in promoting health and wellbeing of the people of Southampton is described.	
Responsible Service Manager	Robin Poole Public Health Consultant
Date	08/11/2024
Approved by Senior Manager	Debbie Chase Director of Public Health
Date	08/11/2024

Potential Impact:

Figure 49: Potential impact DRAFT – not currently up to date

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Age	This PNA identified good provision of services for all ages. Medicine use increases with age. The majority of older adults will be taking at least one regular prescription medicine. The PNA has considered services that would support older adults such as prescription collection and home delivery of medicines. Distance selling pharmacies, including those registered outside of Southampton, also provide additional choice, and increase accessibility to older adults, some of whom may have limited mobility. Age-Adjustments to the dispensing process which may support older people include easy open containers and large print labels.	N/A
Disability	The PNA has considered services that would support people with a disability such as home delivery of medicines. Distance selling pharmacies provide additional choice and increase	N/A

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Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
	accessibility to individuals with disabilities who may have limited mobility.	
Gender Reassignment	No specific impact has been identified from this PNA.	N/A
Marriage and Civil Partnership	No specific impact has been identified from this PNA.	N/A
Pregnancy and Maternity	No specific impact has been identified from this PNA. Community pharmacies can provide an important source of advice for minor ailments, such as constipation, which can commonly occur in pregnancy. For women planning pregnancy, access to a community pharmacy for advice can also be important.	N/A
Race	No specific impact on a particular group has been identified from this PNA. Information has been collected and summarised in the PNA on languages spoken by pharmacy staff.	N/A
Religion or Belief	No specific impact has been identified from this PNA. The General Pharmaceutical Council has published guidance[91] to clarify that while a pharmacist may be unwilling to provide a particular service due to religious reasons or personal values and beliefs, they should take steps to make sure the person asking for care is at the centre of their decision-making, so that they are able to access the service they need in a timely manner.	N/A

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

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Sex	No specific impact for either men or women has been identified from this PNA.	N/A
Sexual Orientation	No specific impact has been identified from this PNA.	N/A
Community Safety	No specific impact has been identified from this PNA.	N/A
Poverty	Areas of deprivation have been described and considered in this PNA but no specific impact has been identified.	N/A
Health & Wellbeing	The PNA has looked at the health and wellbeing of Southampton's population and at how the needs of different groups may vary. In relation to this, the PNA has assessed access to, and availability of, pharmaceutical services in the city.	
Other Significant Impacts	Community pharmacists tend to be the most accessible health care professionals for the general public. Pharmacies can be particularly effective in providing services to more underserved groups as they offer a walk-in service and do not require an appointment. Some specific population groups (such as people experiencing homelessness and vulnerable migrants) have become even more reliant on pharmacies for their health and care needs as a result of the effects of the pandemic. Public Health England has published guidance[92] on the unique role that pharmacy teams, located in the heart of communities, can play in helping to address health inequalities.	

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

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
	There is also further guidance[93] available how pharmacies can be inclusive and on the role that pharmacies can plan in ensuring equitable access[94] to vaccinations.	

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

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

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DECISION-MAKER:	Health and Wellbeing Board
SUBJECT:	Health Protection Annual Report 2024
DATE OF DECISION:	11 December 2024
REPORT OF:	COUNCILLOR MARIE FINN CABINET MEMBER FOR ADULTS & HEALTH

CONTACT DETAILS				
Executive Director	**Title**	Interim Executive Director of Community Wellbeing, Children and Learning (DASS and DCS)		
	Name:	Rob Henderson	Tel:	
	E-mail:	robert.henderson@southampton.gov.uk		
Author:	**Title**	Public Health Consultant		
	Name:	Dr Robin Poole	Tel:	
	E-mail:	robin.poole@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY
N/a

BRIEF SUMMARY
This paper summarises the Health Protection (HP) Annual Report (see Appendix 1) which provides assurance on the behalf of the Director of Public Health and Health and Wellbeing Board in respect of delivery of the local health protection function in Southampton.

RECOMMENDATIONS:		
	(i)	To note the contents of this paper and the Health Protection Annual Report (Appendix 1).

REASONS FOR REPORT RECOMMENDATIONS	
1.	The HP report is a formal record of: • Activity and developments nationally and locally relating to health protection • Health Protection Board (HPB) activity • Situations and issues relating to health protection over the last year • Work to develop and maintain preparedness, and capacity to respond to future incidents • Priorities for the next year • Highlights of key issues and risks

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
	N/a

DETAIL (Including consultation carried out)	
	Background

	1.	The Director of Public Health has a responsibility under the National Health Service Act 2006 and the Health and Social Care Act 2012 to provide assurance to the Local Authority on the adequacy of prevention, surveillance, planning and response to reduce the harm from health protection issues that affect Southampton residents.
	2.	Health Protection is a term used to encompass a wide range of activities within public health aimed at protecting the population from both infectious diseases, and non-infectious threats to health, such as chemicals or extreme weather. Under the Civil Contingencies Act (2004) Southampton City Council (SCC) is a Category One responder which places a legal duty on the organisation to respond to major incidents and emergencies.
	3.	Directors of Public Health have a wider health protection role in supporting the UK Health Security Agency (UKHSA), which is the lead agency responsible for delivery of the specialist health protection function, with the management of incidents and outbreaks within their local authority area. This requires close collaboration and communication both regarding emerging health protection issues and in response to any individual situation.
	4.	The Health Protection Function is delivered by a range of organisations in Southampton. Local authorities (LAs) and Directors of Public Health (DsPH) have a statutory role to maintain an oversight function, ensuring plans are in place to mitigate health protection risks for their population, and to support the health protection response work of the UK Health Security Agency (UKHSA) as the lead agency actively planning for and leading the local response to health protection incidents and emergencies.
	5.	Category one responders are also responsible for warning and informing and advising the public. The Emergency Preparedness Resilience and Response (EPRR) team lead on emergency planning and business continuity both internally and externally and coordinate multi-agency planning and response via the Local Resilience Forum (LRF). EPRR hold multiple plans and link with the Local Health Resilience Partnership (LHRP) as well as colleagues in Port Health and Environmental Health. The Integrated Commissioning Board (ICB) also has responsibility for elements of health, and as a Category 1 responder, work closely with relevant partners to exercise and prepare for infections, environmental, radiological and chemical emergencies. The ICB also employs an Infection Prevention and Control Team (IPC) with capacity in Southampton part-funded by the public health grant. NHS England is responsible for commissioning and quality assuring population screening and immunisation programmes. SCC public health also work closely with NHS colleagues, educational providers and the voluntary sector.
	6.	During the COVID-19 pandemic, like many Local Authorities, SCC Public Health Team rapidly expanded the Health Protection capacity, with fixed term posts and reprioritisation of existing team responsibilities, to undertake the significant volume of work generated in response to the pandemic. Since then, national Covid-19 funding for Local authorities has come to an end. The council health protection

team has reduced in size and shifted their focus from reactive response to broader health protection issues. Alongside this the team has sought to embed learning from the pandemic and vital health protection, infection prevention and control (IPC) and emergency planning capacity and skills across the team to maintain resilience and ensure readiness for any future pandemic response. They continue to contribute to the ongoing national covid inquiry and draw on and fresh insights, and this year SCC internal audit will focus on corporate resilience.

The Health Protection Annual Report

7. The Health Protection Annual Report aims to concisely draw together work undertaken by the public health - health protection team. It has been structured around the three priority areas 'Prepare, Response, Build', which are set out in the UKHSA three-year Strategic plan, published August 2023.

8. **Prepare**: Preparedness involves ensuring that we, as an organisation, and our partners are prepared for future health threats that we might face, such as emerging infectious disease, or increasing threats from climate change and extreme weather. As well as attending multi-agency scenario-based exercises, including a Hampshire County Council lead measles exercise, several emergency plans have been updated and developed in partnership with colleagues in Emergency Planning. This includes an in-depth review (ongoing) of the organisations pandemic flu plan to replace it with a pandemic framework in order to capture learning from the COVID response. The adverse weather plan has also been updated and the Public Health Team have developed an internal Incident Response Plan (IRP) to support them with any significant future response.

Partnership Working: A key mechanism for facilitating partnership working in the Health Protection Board (HPB). This multi-agency forum meets quarterly to consider local health protection issues. The HPB is chaired and facilitated by the SCC Public Health Consultant lead for Health Protection. Meetings follow a standard agenda with a focused item each time. In the last year these have included: Bed bug awareness (not usually considered a health protection issue, findings from the Childhood Immunisations Strengths and Needs Assessment (CHISANA), Sexually Transmitted Infections (STI's) and a literature review of Recreational Water-related infectious disease.

Communications Campaigns: The HP team together with communications colleagues also support and input to comms campaigns, to get public health messages out to residents and raise awareness of specific issue. These have included; winter wellness, summer safety and supporting the National catch up campaign for Measles Mumps and Rubella (MMR) and launch of the new Respiratory Syncytial Vaccination (RSV) vaccination programme.

Education and early years webinars: Southampton City Council hosted a series of Education Settings Winter Illness webinars for Educational Leads and Early Years providers. These were focused on gastrointestinal outbreaks, scarlet fever, and respiratory illnesses. The

aim of the webinars was to provide educational settings with guidance and support in relation to managing outbreaks of infectious disease to minimise any potential impacts and disruption.

9. **Respond**: A significant element of health protection involves responding to situations and incidents when they happen. Whist UKHSA regional Health Protection Teams (HPTs) lead on the response to outbreaks, SCC HPT provide addition support including local intelligence and insights. Over the last 12 months we have supported numerous incidents, situations and enquiries.

10. **Build:** improving routine childhood immunisation uptake in Southampton has been, and continues to be, a significant focus for the team over the last 12-18 months. An in-depth Childhood Immunisation Strengths And Needs Assessment (CHISANA) identified a series of recommendations to improve uptake and initiatives have been undertaken as result of this including commissioning wider workforce training and developing a language free film resource which normalises childhood immunisation as 'one more way to keep them safe' alongside other everyday things such as using stairgates, car seats and handwashing.

11. **Links with the Southampton Health and Wellbeing Strategy.** Objectives relevant to health protection within the current Health and Wellbeing Strategy include the promotion of immunisation, focus on clean air, and through reducing avoidable deaths linked to fuel poverty (excess winter deaths). These outcomes can be measured through population vaccination coverage (such as MMR at one and five years), fraction of mortality attributable to particulate air pollution, and excess winter deaths index.

12. Priority areas in 2024/25 as agreed by the Health Protection Board are:

1.	**Assurance of specialist areas: continue to monitor the performance of specialist areas (see assurance measures on slides 6 and 7), identify risks, ensure mitigation is in place and escalate, as necessary.**
2.	**Communicable disease control: actively participate in the prevention, preparedness and management of outbreaks and incidents with partner agencies to slow down and prevent the spread of communicable disease and manage environmental hazards.**
3.	**Warn and inform: Continue to ensure that the public and partner organisations are informed about emerging threats to health.**
4.	**Immunisation uptake: help improve immunisation uptake and reduce inequalities in uptake through the following: inputting to the HIOW MMR Oversight Group and Screening and Immunisation Oversight Group (SIOG), contributing to the development of local vaccination delivery plans, implementing the findings and recommendations from CHISANA, joint working with commissioners, providers, and communities to take collaborative action to expedite improvements and amplify local communications.**

	5.	**TB Pathways: improve pathways and governance for tuberculosis cases, particularly for residents with no recourse to public funds.**
	6.	**Pandemic readiness: retain capacity to respond to threat of a future pandemic by finalising a local pandemic framework and undertaking a pandemic Exercise.**
	7.	**Collaborative working: maintain collaborative system working with key partners across the system.**
	8.	**Antimicrobial resistance (AMR): contribute and support ongoing system wide efforts to counter the growing threat of AMR.**
	9.	**Climate change: undertake a Climate Change health Impact Assessment *(Scoping in autumn 2024 and planned to commence spring 2025).***

RESOURCE IMPLICATIONS	
Capital/Revenue	
	There are no financial implications for Southampton City Council in relation to maintenance of this function over and above the Public Health Grant funded officer costs.
Property/Other	
	N/a
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
	National Health Service Act 2006
	Health and Social Care Act 2012
Other Legal Implications:	
	N/a
RISK MANAGEMENT IMPLICATIONS	
	N/a
POLICY FRAMEWORK IMPLICATIONS	
	N/a

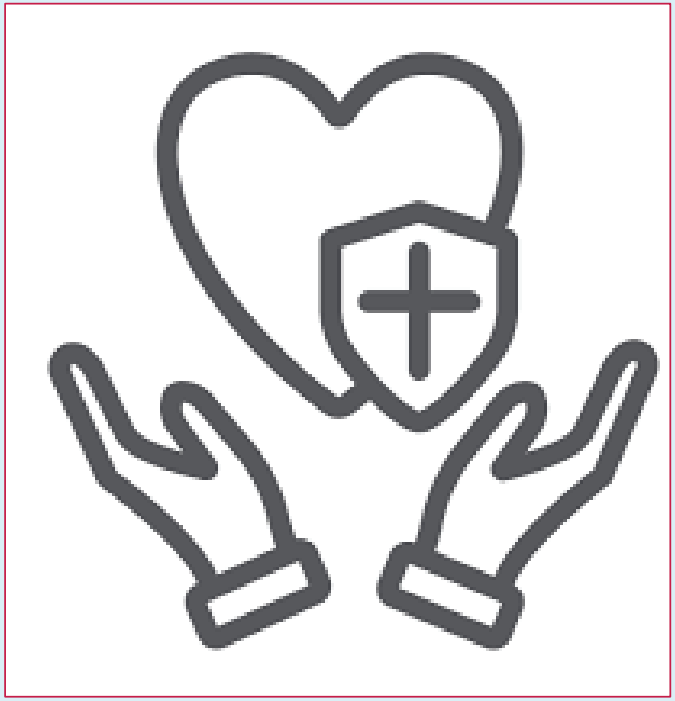
KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	All
SUPPORTING DOCUMENTATION	
Appendices	
1.	Health Protection Annual Report 2024

Documents In Members' Rooms

1.		
2.		
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.		
2.		

Health Protection Annual Report 2024, Public Health

September 2023 – September 2024



Document approval

Prepared for:	**Southampton Health and Wellbeing Board (HWBB)**
Author:	Rebecca Norton, Senior Practitioner Health Protection
Reviewed by:	Dr Robin Poole, Consultant Health Protection
Approved by:	Dr Debbie Chase, Director of Public Health
Date:	24th October 2024

SOUTHAMPTON CITY COUNCIL

Contents

SOUTHAMPTON CITY COUNCIL

Introduction and Background

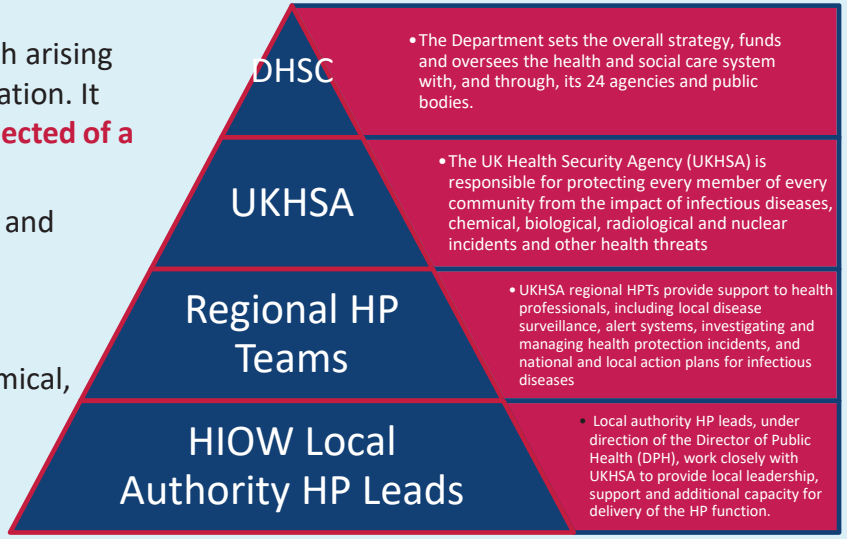
The Director of Public Health has a responsibility under the National Health Service (NHS) Act 2006 and the Health and Social Care Act 2012 to provide assurance to the Local Authority on the adequacy of prevention, surveillance, planning and response to reduce the harm from health protection issues that affect Southampton residents. Local Authorities have a critical role in protecting the health of their local population, both in terms of helping prevent threats arising and in ensuring appropriate responses to incidents that present a threat to the public's health.

Health Protection is a term used to encompass a wide range of activities within public health aimed at protecting the population from both infectious diseases, and non-infectious threats to health, such as chemicals or extreme weather conditions. Under the Civil Contingencies Act (2004) SCC is a Category One responder which places a legal duty on the organisation to respond to major incidents and emergencies. Directors of Public Health have a wider health protection role in supporting the UK Health Security Agency (UKHSA), which is the lead agency responsible for delivery of the specialist health protection function, with the management of incidents and outbreaks within their local authority area. This requires close collaboration and communication both regarding emerging health protection issues and in response to any individual situation.

Scope of Health Protection

Health protection practice aims to prevent, assess and mitigate risks and threats to human health arising from communicable diseases and exposure to environmental hazards such as chemicals and radiation. It covers an extensive range of exposures, risks and diseases. **Core health protection functions expected of a local health system include:**

- Emergency Preparedness, Resilience and Response (EPRR)
- Communicable disease control
- Risk assessment and risk management
- Risk communication
- Incident and outbreak investigation and management
- Monitoring and surveillance of communicable diseases
- Infection Prevention and Control (IPC) in health and social care and other settings e.g. schools etc
- Delivery and monitoring of immunisation and vaccination programmes
- Environmental public health and control of chemical, biological and radiological hazards
- Responding to European Centre for Diseases Prevention and Control and the World Health Organisation (WHO)



Report Structure

The **Structure of this 2023-24 report**

This report documents the progress made by the Health Protection Board during September 2023-24. It is structured around the three strategic aims**, 'Prepare, Respond and Build',** set out by UKHSA [UKHSA 3-year strategic plan] published August 2023. The report aims to concisely draw together some of the key work undertaken in relation to the health protection function across the city, in order to provide assurance, highlight risks, challenges and priorities, as well as inform planning for the future. Where possible links to supporting documents are provided to avoid reproducing information that is available in more detailed studies and reports elsewhere.

Aim of report

The purpose of this report is to **provide the Director of Public Health DPH, Health Protection Board** and **Health and Wellbeing Board (HWBB)** with an update on **health protection assurance arrangements** and **activities in Southampton** over the last year.

Objectives

The objectives of the report are to:

- Report on **activity** and **key developments nationally** and **locally** relating to health protection.
- **Capture** Health Protection Board **(HPB) activity**.
- **Reflect on situations** and issues that have arisen over the last year.
- **Summarise work undertaken** to develop and **maintain preparedness** and **reactive capacity**
- **Inform** and **shape priorities** for the coming year.
- **Highlight** key **issues and risks**.

UKHSA Strategic Priorities 2023/26

Heath Protection Remit of SCC Public Health Team

Delivery of the Health Protection Function

The Health Protection Function is delivered by a range of organisations in Southampton. Local authorities (LAs) and Directors of Public Health (DsPH) have a statutory role to maintain an oversight function, ensuring plans are in place to mitigate health protection risks for their population, and to support the health protection response work of the UK Health Security Agency (UKHSA) actively planning for and leading the local response to health protection incidents and emergencies. Category one responders are also responsible for warning and informing and advising the public, The Emergency Preparedness Resilience and Response (EPRR) lead on emergency planning and business continuity both internally and externally and coordinate multi-agency planning and response via the Local Resilience Forum (LRF). EPRR hold multiple plans and link with the Local Health Resilience Partnership (LHRP) as well as colleagues in Port Health and Environmental Health (EH). The Integrated Care Board (ICB) also has responsibility for elements of health protection, and as a Category 1 responder, work closely with relevant partners to exercise and prepare for infections, environmental, radiological and chemical emergencies. The ICB also employs an Infection Prevention and Control Team (IPC) with capacity in Southampton part-funded by the public health grant. NHS England is responsible for commissioning and quality assuring population screening and immunisation programmes.

During the COVID-19 pandemic, like many Local Authorities, SCC Public Health Team rapidly expanded the Health Protection capacity, with fixed term posts and reprioritisation of existing team responsibilities, to undertake the significant volume of work generated in response to the pandemic. Since then, national Covid-19 funding for Local authorities has come to an end. The health protection team has reduced in size and shifted their focus from reactive response to broader health protection issues. Alongside this the team has sought to embed learning from the pandemic and vital health protection, infection prevention and control (IPC) and emergency planning capacity and skills across the team to maintain resilience and ensure readiness for any future pandemic response. They continue to contribute

In summary, the health protection remit of the Southampton City Council (SCC) public health team is:

1. **EPRR –** HP Incident response, planning, training and exercising, stakeholder relationships and capacity building.
2. **Advice/Scrutiny/Challenge –** Commissioning, programme performance.
3. **Comms –** Cascading information, warn and inform, providing specialist advice and support to senior officers, elected members, colleagues, residents and high-risk settings *e.g. Infection Prevention & Control (IPC).*
4. **Maintaining a watching brief –** Surveillance, attending briefings, engagement.
5. **Supporting outbreak control** – attending IMT's, providing local intelligence.
6. **Infection prevention and control -** Supporting health and social care sector and other settings e.g. schools etc as well as cascading of information and providing education webinars and forums.

Local Health Protection Assurance and Quality Standards

The DPH is a statutory chief officer of their authority, accountable for the delivery of public health responsibilities, and the principal adviser on all health matters to elected members and officers, with a front-line leadership role spanning all 3 domains of public health – health improvement, health protection and healthcare public health.

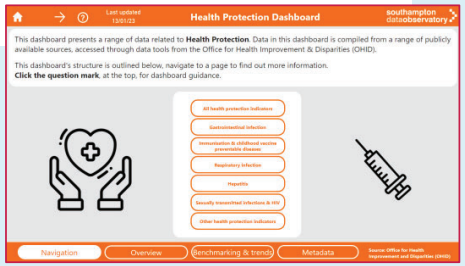
The DPH also has a vital system leadership role, working closely with place-based organisations in efforts to secure better public health. The DPH will raise health protection risks with relevant, responsible agencies and is responsible for briefing the Health & Wellbeing Board, a strategic partnership between the council and the NHS, who aim to improve the health and wellbeing of residents. They key mechanism for the DPH to gain assurance for health protection is via the Southampton City Council Health Protection Board (HPB), alongside specialist boards within the wider HIOW ICB and NHS England footprint, such as the Screening and Immunisation Oversight Group (SIOG).

Local health protection systems should ensure that organisational and system-level governance arrangements are in place to assure and improve the quality of services provided to protect health.

The following specialist health protection areas and quality standards have been identified to meet local priorities and aspirations:

1. Immunisation
2. Infection Prevention and Control (IPC)
3. Environmental Hazards and public health (and control of chemical, biological and radiological hazards)
4. Emergency Planning Resilience and Response (EPRR)
5. Communicable Disease Control
6. Risk Communication

SCC data and intelligence team have developed a Health Protection Dashboard which compiles a range of publicly available health protection data into an easy to navigate platform accessible to professionals, businesses, the voluntary sector, citizens and communities.



The HPB agenda is planned to ensure that all specialist health protection areas are reviewed and discussed in HPB meetings throughout the year, which then enables members to seek assurance on their status and the progress made in managing issues and risks. Assurance is achieved through a combination of in-depth discussion on specific agenda items and through the performance monitoring section of the meeting.

SOUTHAMPTON CITY COUNCIL

Local Health Protection Assurance and Quality Standards (specialist areas)

No	Key Outcomes/Aims for SCC Health Protection Function	Key Indicator(s)	Assurance Mechanism/Lead
Specialist Area 1: Immunisation			
1. A	Children are protected against key vaccine preventable diseases by immunisation	Pertussis vaccine uptake amongst pregnant women. (RSV vaccine from Sep 2024)	HIOW SIOG
		Call and recall arrangements implemented.	HIOW SIOG
		Achieving target immunisation coverage for all childhood vaccine preventable diseases. COVER	HIOW SIOG
		Seasonal influenza vaccine uptake in children of primary school age.	HIOW SIOG
1. B	Transmission of Hepatitis B and Hepatitis C is minimised	Achieve high rates of HBV vaccination coverage in all high-risk groups, (NICE QS65).	HIOW SIOG
1. C	Reduce transmission of TB, including drug resistant TB	BCG newborn vaccination programme	HIOW SIOG
1. D	Older adults are protected against key infectious diseases through vaccination (focus on prevention in aspects of HP)	Uptake of Covid-19, influenza, pneumococcal and shingles vaccines *RSV vaccine from Sep 2024	HIOW SIOG
1. E	Reduced inequalities in vaccine coverage across communities	Achieve high vaccination and immunisation coverage in all clinical risk groups (including flu vaccination as per NICE NG103 [15]); in communities with known low uptake; and, in under-served populations including, for example, migrants, people experiencing homelessness, and traveller communities.	HIOW SIOG
Specialist Area 2: Infection Prevention and Control (IPC)			
2. A	Spread of common infections amongst children is reduced through hand and respiratory hygiene	Local audit of promotional activities. Delivery of training on educational sector outbreak packs. Monitoring outbreaks via UKHSA dashboard	ICB IPC and SCC PH
2. B	Reduce transmission of TB, including drug resistant TB	Participation in quality initiatives including TB cohort review in high-incidence areas.	ICB TB leads / SE TB Control Board / HIOW Cohort review
		Arrangements in place to support TB patients with social risk factors during diagnosis and treatment including those who are homeless and those with no recourse to public funds.	ICB TB leads / SCC PH / HIOW Cohort review
2. C	Minimise harm by preventable health and social care associated infections	Rate of health care associated Gram Negative Blood Stream Infections - MRSA, C. *difficile* and E.coli bacteraemia; PHE Fingertips.,	ICB IPC team
2. D	Reduce harms and long-term risks from antimicrobial resistance	12-mth rolling totals of numbers of prescribed antibiotic items, as per STAR-PU, by ICB in England. Progress against AMR strategy	HIOW ICB Medicines optimisation team & ICB IPC team
2. E	Assurance of Infection Prevention and Control expertise and support to health and social care settings.	Number of care home outbreaks supported by local IPC teams	ICB IPC team

Local Health Protection Assurance and Quality Standards

No	Key Outcomes/Aims for SCC Health Protection	Key Indicator(s)	Assurance Mechanisms/Lead
Specialist Area 3: Environmental Hazards and public health (and control of chemical, biological and radiological hazards)			
3. A	People live and work in areas with good air quality	Health is included as a key consideration in local plans to reduce exposure to air pollution in line with NICE QS181 and NG70 [18,19].	SCC AQAP, Annual Status Report
3. B	Health is included as a key consideration in local plans to reduce exposure to air pollution in line with NICE QS181 and NG70 [18,19].	Fraction of mortality attributable to particulate air pollution - PHE Fingertips	TBC
3. C	Foodborne and Waterborne illness	Environmental health team response to local situations and delivery of Food Hygiene Inspection Programme.	Environmental Health lead
3. D	Control of infectious disease on board incoming vessels and preventing the introduction into the country of dangerous epidemic, contagious and infectious diseases and ensuring wholesomeness of imported food.	Port Health monitoring and responding to Maritime Declarations of Health	Port Health lead
Specialist Area 4: Emergency Planning Resilience and Response (EPRR)			
4. A	Meet the requirements set out in the Civil Contingencies Act 2024 to ensure sufficient oversight of risks and preparedness.	EPRR are active members of the LRF, inputting to core work streams and forums , including training and exercising, risk and planning, the LHRP and HPB. PH are given opportunity to participate in system wide preparedness work. Public Health are kept sighted on any health risks and notified (and supported) of incidents (in and out of hours).	EPRR lead
Specialist Area 5: Communicable Disease Control			
5. A	Minimise the harm caused by outbreaks and incidents	The local LHRP, with its health protection assurance function, sits within the local governance and assurance framework, has clarity of responsibility and a written protocol / plan is in place for the management and governance of local outbreaks and incidents.	LHRP
		There is a documented agreement that funding disagreements will not lead to delays in delivering interventions.	LHRP
Specialist Area 6: Risk Communication			
5. A	The public and partner organisations are informed about emerging threats to health.	Local review of the planned and reactive comms campaigns that are undertaken.	Communication Lead / SCC PH

Guidance documents that have helped inform the development of our approach and health protection priorities locally include:

1. What Good Looks Like for High Quality Local Health Protection Systems
2. Directors of Public Health in Local Government: Roles, Responsibilities, and Context
3. Functions and Standards of a Public Health System
4. Policy Position: What we say about… Health Protection

Related Areas

There are several public health services and programmes that are closely related to and may overlap with the Health Protection portfolio, but do not fall within the Governance and assurance of the Southampton Health Protection Board (HPB). These include:

- Sexual Health including Sexually Transmitted Infections (STI's)
- Substance use, including associated risks of blood borne viruses (BBV's)

The SCC Health Protection Team link up with relevant leads overseeing these areas to exchange information and identify any shared opportunities to promote and improve services, as well as ensuring that we are alerted to any emergency problems.

Progress on priorities from previous HPAR – 2023

Key: RAG Rating (self-assessment)
- Red – limited/no progress on priority
- Amber – moderate/some progress on priority
- Green – significant/full progress on priority

In the last Health Protection Board report (2023) the Health Protection Board committed to improving all work streams and identified six priorities to be addressed in order for the Director of Public Health (DPH), on behalf of the local authority, to be further assured that suitable arrangements are in place in Southampton to protect the health of the population.

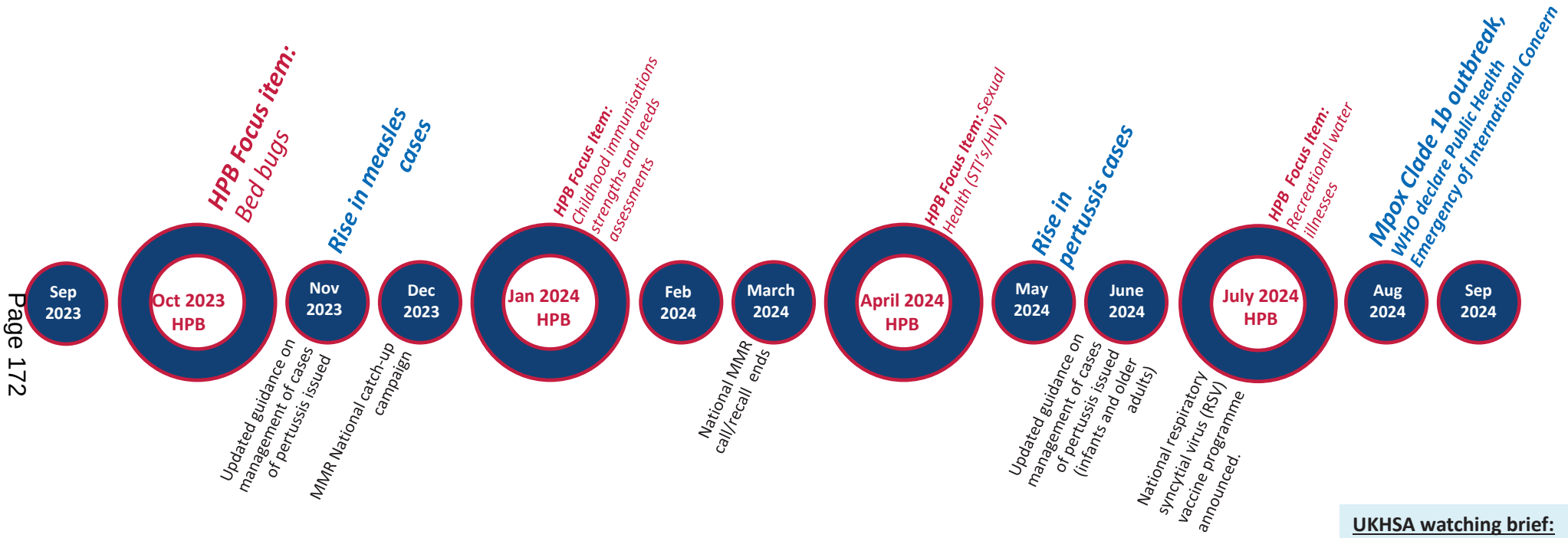
No	Priority	RAG Rating	Status update
1.	**Pandemic Flu/outbreak response plans:** The health protection team will work with emergency planning colleagues to undertake a review of, and update, existing pandemic flu and outbreak response plans to ensure that arrangements are streamlined and align with national and regional arrangements.		*Plan review is underway. Existing Pandemic Flu plan to be reworked and replaced by a single pandemic framework, also incorporating learning from COVID. Pandemic exercise to be timetabled for autumn 2024.*
2.	**The Reactor Emergency Plan (REPPIR:** The Reactor Emergency Plan (REPPIR) is also due to be updated in 2023. Updated public information for the detailed emergency planning zone (DEPZ) for residents and businesses which will be reissued in Summer 2024 as per the three-year cycle. The outline planning zone (OPZ) public information is due to be reissued in October 2023.		*The Reactor Emergency Plan is currently under review, due to be consulted on this Autumn. Three yearly exercise scheduled for 2nd October 2025 (Portsmouth focused this time). This will likely be an SCG level exercise with a STAC and Media Cell. The Public Information leaflet for those in the 5km Outline Planning Zone was reissued in November 2023. The Public Information leaflet for residents and businesses within the 1.5km Detailed Emergency Planning Zone is currently being reviewed and due to be issued shortly. This leaflet is printed and posted to all residents and businesses within the zone.*
3.	**Air quality:** The health protection team will be working with lead SCC air quality officers in supporting an air quality healthcare professional engagement project.		*Clean Air Clinical Champions project commissioned by SCC and delivered by Global Action Plan and the Environment Centre progressing well. Currently over 50 champions recruited to the network.*
4.	**Climate change:** A climate change health impact assessment will be scoped out to bring focus to the significant health threats presented by climate change and consider what this means for Southampton. The team will also be undertaking a rapid literature review into open water swimming and infectious disease risks.		*Open water swimming rapid evidence review completed and published on Southampton Data Observatory (Recreational Use of Open Water)* *Climate Change health Impact Assessment planned to commence Autumn 2024.*
5.	**Childhood Immunisations Strengths and Needs Assessment (CHISANA)** Findings and recommendations from the CHISANA will be shared with the health and wellbeing board (HWB) in March 2024.		*CHISANA was shared and signed off by the HWBB in March 2024. See summary report. The findings and recommendations identified are being used to inform and drive forward action across the system to improve uptake of routine childhood immunisations for Southampton.*
6.	**Reactive capacity** Continuing to react to and provide additional capacity to health protection situations and incidents will remain a priority, including working with agencies to share latest information and good practice.		*The DPH is informed of outbreaks, incidents and exceedances via email alerts and represented at all local outbreak control meetings. SCC Public Health colleagues continue to attend key EPRR forums as well as participating in training and exercises and inputting to the development of plans and procedures that will support a response. Key communicable diseases this year have included measles and pertussis.*

Priorities – 2024/25

The Health Protection Board remains committed to improving all work streams within available resources. The following nine priorities have been agreed for 2024-2025 by the Health Protection Board as priority issues to be addressed.

No	Priority
1.	**Assurance of specialist areas: c**ontinue to monitor the performance of specialist areas (see assurance measures on slides 6 and 7), identify risks, ensure mitigation is in place and escalate, as necessary.
2.	**Communicable disease control:** actively participate in the prevention, preparedness and management of outbreaks and incidents with partner agencies to slow down and prevent the spread of communicable disease and manage environmental hazards.
3.	**Warn and inform:** Continue to ensure that the public and partner organisations are informed about emerging threats to health.
4.	**Immunisation uptake:** help improve immunisation uptake and reduce inequalities in uptake through the following: inputting to the HIOW MMR Oversight Group and Screening and Immunisation Oversight Group (SIOG), contributing to the development of local vaccination delivery plans, implementing the findings and recommendations from CHISANA, joint working with commissioners, providers, and communities to take collaborative action to expedite improvements and amplify local communications.
5.	**TB Pathways:** improve pathways and governance for tuberculosis cases, particularly for residents with no recourse to public funds.
6.	**Pandemic readiness:** retain capacity to respond to threat of a future pandemic by finalising a local pandemic framework and undertaking a pandemic Exercise.
7.	**Collaborative working:** maintain collaborative system working with key partners across the system.
8.	**Antimicrobial resistance (AMR):** contribute and support ongoing system wide efforts to counter the growing threat of AMR.
9.	**Climate change:** undertake a Climate Change health Impact Assessment *(Scoping in autumn 2024 and planned to commence spring 2025).*

High level timeline



Key:

- *Health Protection Board meetings and focus items*
- *Notable rise in cases*
- *Health protection campaigns and/or policy updates*

UKHSA watching brief:

- Avian Influenza
- Measles
- Mpox
- Covid-19
- Seasonal Flu

Prepare

Preparedness

Preparedness involves ensuring that we, as an organisation, and our partners are **prepared for future health threats** that we might face, be that new emerging infectious diseases or increasing threats from climate change and extreme weather.

We do this in multiple ways including:

- Working closely with key partners on initiatives, such as **routine vaccination programmes**.
- **Maintaining readiness to respond** by undertaking training and attending exercises to explore key scenarios including
- Inputting to the **development and delivery of response plans** locally.
- **Participating in** and inputting to the work of the **Local Resilience Forum (LRF)** including attending LHRP meetings and relevant Working on Tuesdays (WOT) sessions.
- Receiving, assimilating and disseminating **stakeholder cascades** from UKHSA.
- **Monitoring latest data and surveillance reports** including the weekly Notification of Infectious Diseases (NOIDS) report, COVID-19 dashboard and COVID-19, influenza and other seasonal respiratory illnesses surveillance report.
- **Anticipating future threats** and hazards.

Plans, policies and Standard Operating Procedures (SOPs)

The following policies and plans were developed and updated in 2023-24 period.

- **Southampton City Council Pandemic Plan - Updated July 2024:** The existing Southampton City Council Pandemic Flu plan has been replaced by a pandemic response framework. This aims to provide the council with a generic and flexible response to any type of human pandemic.
- **Cold weather and heatwave plans - Updated June 2024:** A new national Adverse Weather and Health Plan (AWHP) was published by UKHSA in April 2023 and updated June 2024. The SCC heatwave plan and cold weather plan have been reviewed and combined into a Joint Adverse Weather and Health Plan.
- **Public Health Incident Management Plan (IMP) –September 2024: A** PH Incident Management Plan (IMP) has been developed. This plan sets out the overarching generic framework and structure required to support the PH team to respond to any type of public health related incident at a local, national or international level.

https://documents.hants.gov.uk/emergencyplanning/CommunityRiskRegisterbooklet.pdf

Partnership Working

Many different stakeholders have a role to play in the delivery of Health Protection. The pandemic highlighted how crucial trusted relationships are at times of crises, and how much can be achieved when individuals and organisations come together to work towards a shared objective. Fostering and maintaining these relationships is an important aspect of the local authority health protection function. Our approach to the delivery of health protection reflects this. As a team we work to maintain relationships with key partners across many different areas.

Key mechanisms for achieving this are **The Health Protection Board (HPB),** which brings together stakeholders from across the city to consider local health protection issues, and **the Local Resilience Forum (LRF)** which includes emergency services, councils, businesses and voluntary organisations from across Hampshire and Isle of Wight (HIOW).

We also engage with a range of stakeholders via other forums and groups including:

- The University Oversight Group (UOG)
- The Local Health Resilience Partnership (LHRP)
- Health Protection Leads Screening and Immunisation (SIT) meeting
- HIOW MMR uptake oversight group
- UKHSA HP West of Region/Southeast Forum
- DsPH Regional meeting (via DPH as required)
- HIOW Flu operational delivery group
- GP reference group (as required)
- HIOW ICB Migrant working group – (Asylum seekers and refugees)
- Environmental health meetings
- UKHSA TB Meetings, Cohort review, SE TB board, Southampton TB Commissioning meetings.
- Education Oversight Group (EOG)
- HIOW ICB IPC network meetings
- SCC Adult health and Social Care Quality and Safeguarding meetings

Attending these forums helps to ensure that:

- We **retain** and continue to **develop relationships** with key partners.
- Share and keep abreast of good practice
- Have oversight of developing issues and intelligence.
- Work collaboratively towards shared goals.

https://www.hants.gov.uk/community/localresilienceforum

The Health Protection Board (HPB)

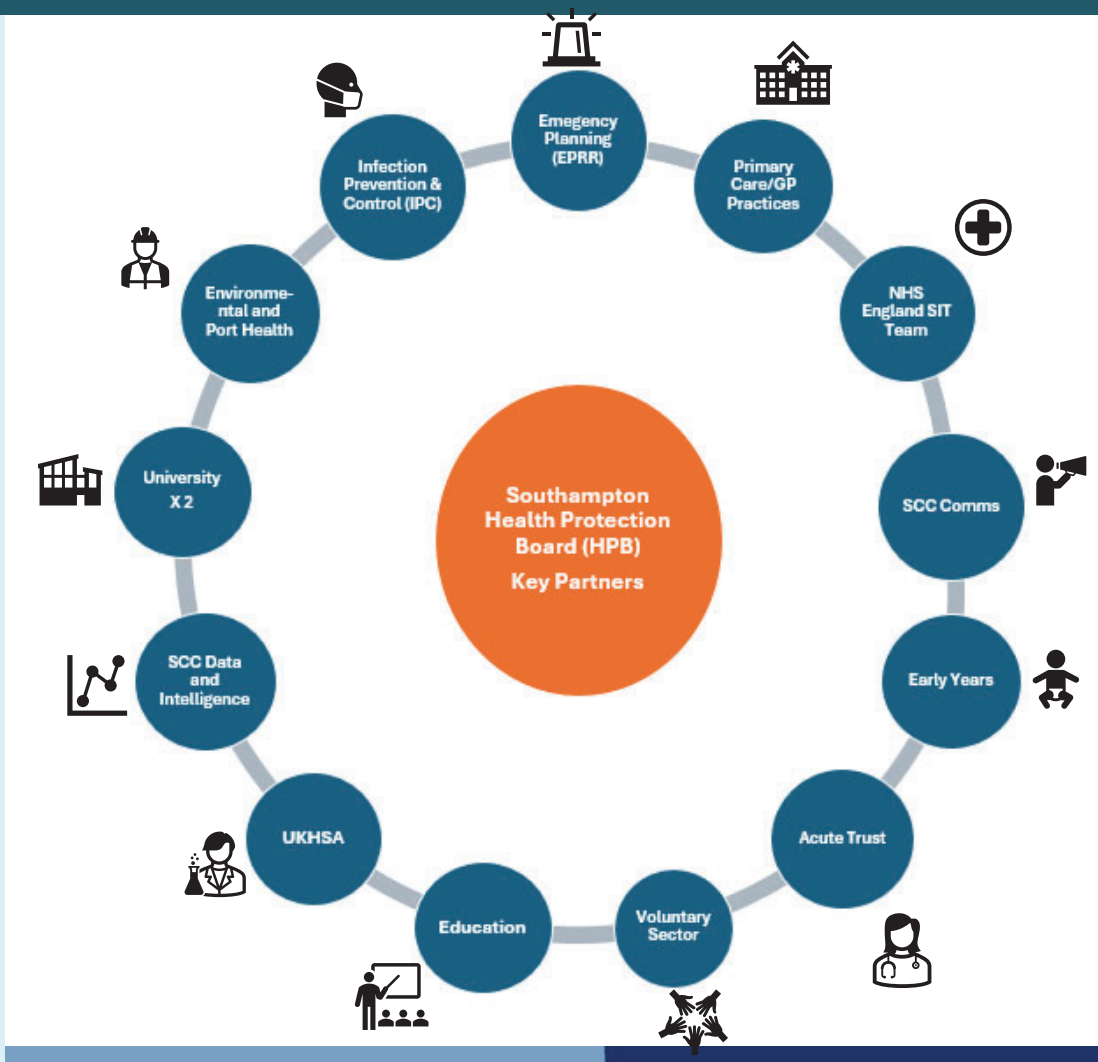
The **Southampton Health Protection Board (HPB)** is a collaborative forum that brings together key partners from across the city. It retains **oversight of health protection related indicators**, **reviews specific issues** of concern related to health protection for local people with a view to **investigate or escalate as required**. The HPB enables strong relationships between all agencies to be maintained and developed to provide a robust health protection function in Southampton. Throughout 2023-2024 the HPB continued to provide a forum for professional discussion of health protection plans, performance, risks and opportunities for joint action.

Southampton City Council (SCC) and the Director of Public Health (DPH) have a critical role in protecting the health of its population. To carry out this role the DPH works in partnership with key system partners via the Health Protection Board (HPB). **The HPB is chaired by the Public Health Consultant lead for health protection on behalf of the DPH**. The **HPB is accountable on matters of Health Protection** to the Southampton City Council Health and Well Being Board (HWBB) . Where appropriate (where matters involve wider partners), the board will liaise closely with the Local Health Resilience Partnership (LHRP).

The HPB provides a forum for discussing strategic and operational health protection issues; reviewing outbreaks and incidents; and learning lessons identified. It also provides a forum where cross-organisational issues can be discussed and solutions identified; as well as providing a forum to share national guidance, local intelligence and maintain oversight of key risks.

The HPB meeting four times a year. It is **attended by a core group of members from UKHSA, SCC, the two Southampton universities, Southampton Voluntary Services (SVS), Emergency Planning, ICB infection prevention and control, and University Hospital Southampton (UHS)**. Other 'wider members' are invited to attended as required. The format of the meeting follows a standard agenda with a focus item each quarter. The HPB seeks assurance on six key strands of activity including:

1. Immunisation programmes
2. Infection Prevention and Control (IP&C)
3. Environmental Hazards and public health
4. Emergency Preparedness and response to incidents and emergencies
5. Outbreaks and communicable diseases
6. Risk communication



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HPB Focus Items – Sep'23- Sep'24

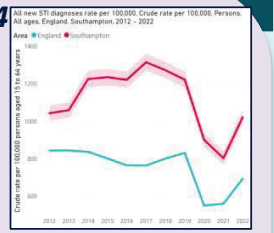
Bed bugs update – *HPB December 2023*

- Bedbugs are small insects that often live on furniture or bedding. Their bites can be itchy, but do not usually cause other health problems.
- Bed bugs can affect hotels and cruise ships, as well as residents' home, particularly social housing and tower blocks. Bedbugs can live in the cleanest of homes and can survive without warmth and food sources for some time. They can be carried on clothing, luggage and furniture. Exterminating them can be difficult requiring fumigation by a professional which can be very costly. Southampton public health and comms team supported the development of a bedbug campaign with environmental health to raise awareness of the signs, symptoms and treatment of bedbugs following a period of increased bedbug outbreaks. This was an opportunity to raise awareness amongst HPB partners.

Childhood immunisations Strengths and Needs Assessment (CHISANA) – *HPB January 2024*

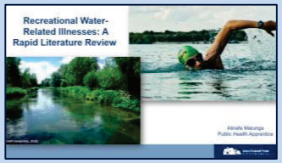
- A comprehensive Childhood Immunisation Strengths and Needs Assessment (CHISANA) with a focus on immunisations in children aged 0-5 years living in Southampton has sought to understand why uptake rates of childhood immunisation are declining and, consider what practical and immediate action can be taken to address the issues that may be contributing to this.
- 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 were shared with HPB partners. Completion of the report came at a time of recent and ongoing outbreaks of measles in London and the West Midlands. The needs assessment is being used to drive work to increase uptake across the system.
- Childhood immunisations (southampton.gov.uk) and CHISANA Summary Report

Sexually Health - Transmitted Infections (STI's/ HIV) – *HPB April 2024*



- STI testing and diagnoses fell during the pandemic.
- There has been a national focus on testing and service recovery; testing rates have increased but STI diagnosis rates have not yet recovered to pre-pandemic levels.
- Young people experience the highest diagnosis rates of the most common STIs, potentially due to higher rates of partner change.
- Diagnosis rates were higher in people of black ethnicity, with particularly high rates amongst those of black Caribbean ethnicity – previous research suggests this is due to underlying socio-economic factors rather than unique clinical or behavioural factors.
- Diagnosis rates were higher and increasing in GBMSM for specific infections (including gonorrhoea and less frequently reported STIs).
- Reviewing data at the HPB with partners provided an opportunity to consider training opportunities as well as promotion of key sexual health prevention messages and services within the student and wider population. www.letstalkaboutit.nhs.uk

Recreational Water Illnesses– *HPB July 2024*



- Open-water swimming, where individuals swim in recreational waters such as lakes, rivers, and seas, is becoming increasingly popular in the United Kingdom (UK) (Outdoor Swimmer, 2021). There is developing evidence regarding the benefits of engaging with natural aquatic environments, often called 'blue spaces', on people's health and wellbeing, with associations of enhanced mental well-being and increased opportunities for social interactions and physical activity (Oliver et al., 2023
- However, the absence of disinfectant properties in open water poses a risk to human health, individuals can be exposed to waterborne pathogens that may be naturally present in the aquatic environment or introduced through contamination from various sources of pollution: humans, sewage overflows, industrial activities, animals or wildlife; consequently, recreational water users may have a greater susceptibility to infectious disease transmission.
- The review, which was shared with HPB partners, evaluated results from epidemiological studies between 2000 and 2023 that explored evidence of illness and risk of illness. It also brought together evidence-based guidance. HPB partners were asked to support within signposting appropriate information to the public to mitigate risks.

Communications Campaigns

Communications, engagement and **promotion** is a key aspect of Heath Protection. This involves a combination of both council-led campaigns, where we produce organic content and artwork to reflect the identity and need of the local population, and national-led campaigns, where we publicise campaigns produced by The Department of Health and Social Care (DHSC), UKHSA and the NHS, cascading to key partners.

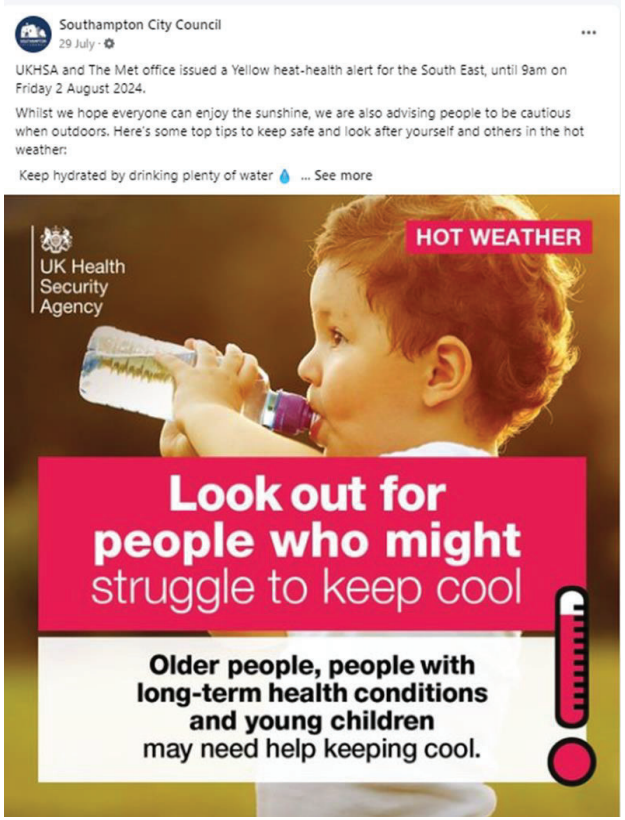
Communications colleagues work with Public Health, the Data Team and partner agencies across the city to ensure **campaign materials are tailored to the areas of need, ensuring that where possible, materials are accessible** and made **available in multiple languages.**

Crisis communications is also an important element of health protection communications. This requires a council-wide approach to developing key messages, drafting media statements and issuing press releases in response to a health protection risk, outbreak or emergency alert.

Multi-agency working plays a key part in health protection campaigns and our communication colleagues work closely with counterparts in HIOW ICB, NHS trusts, hospitals, Primary Care Networks (PCNs), neighbouring local authorities and third sector community organisations to help share important health messages across Hampshire and the Isle of Wight.

Over the last year we have supported and delivered a number of health protection campaigns including:

- Winter wellness – including winter vaccination programme (flu & covid), staying warm and Group A Strep
- Summer safety – including hot weather and heat wave alerts, sun safety, tick safety and travel vaccinations
- National catch up campaign for Measles Mumps and Rubella (MMR) and launch of the new Respiratory Syncytial Vaccination (RSV) vaccination programme.



Education and early years webinars

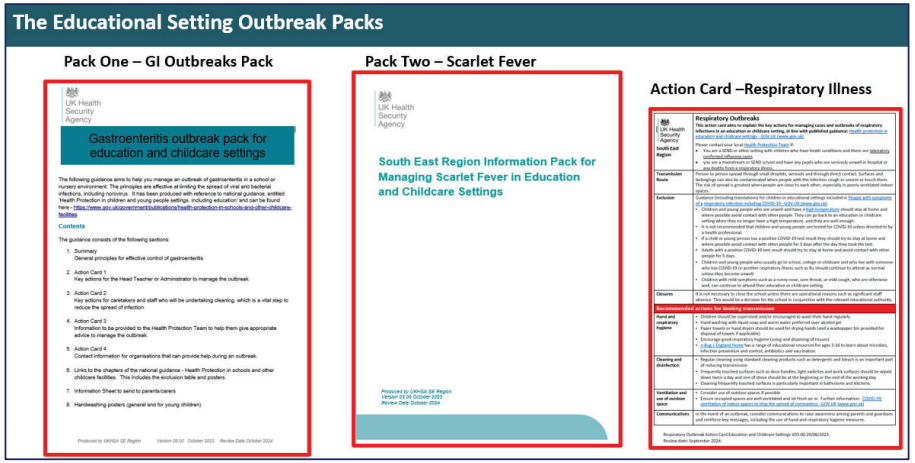
Southampton City Council hosted a series of Education Settings Winter Illness webinars for Educational Leads and Early Years providers. These were focused on gastrointestinal outbreaks, scarlet fever, and respiratory illnesses.

The aim of the webinars was to: Provide educational settings with **guidance and support** in relation to **managing outbreaks of infectious disease** to **minimise any potential impacts** and **disruption.**

Objectives:

- **Highlight** and **explain** some of the **key advice, guidance** and **processes** contained with the UKHSA Education settings information packs. **Minimise any delays** to settings getting the appropriate advice and **taking necessary actions**.
- Ensure education settings **experiencing more serious outbreaks** are **appropriately supported**.
- **Standardise** outbreak **response processes.**
- Consider **key preventative measures**.
- **Signpost** useful information.
- Opportunity to **ask questions**.

Going forward SCC will continue to make a similar offer to Education Settings on a annual basis and by exception for specific diseases.



SOUTHAMPTON CITY COUNCIL

Respond

Situations and Incidents

An element of health protection involves **responding to situations and incidents** when they happen. Whilst **UKHSA regional Health Protection Teams (HPTs) lead on the response** to outbreaks, **SCC Health Protection team provide additional support** including local intelligence and insights. This might include:

- **Retaining oversight** of situation reports and surveillance and attending briefings to ensure intelligence is cascaded to key partners across the city.
- Providing a **rapid response** to incidents.
- **Cascading information** and guidance to key stakeholders.
- **Supporting communications** and engagement.
- **Briefing** senior officers and Councillors as required.
- Providing **Public Health advice** to colleagues and residents.
- Providing UKHSA with **local intelligence** and Insights to support and shape communications and response plans.
- **Responding to queries** from residents, colleagues and councillors.

SCC Health Protection team activity

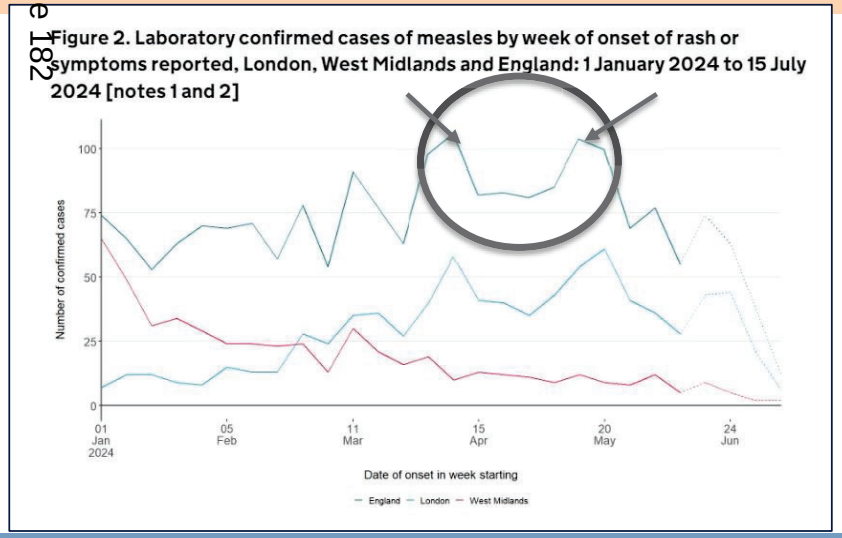
- Throughout the last year the Local Authority has worked closely with colleagues at UKHSA, in their lead role, to address a number and range of infections. The team have **responded to queries** and **provided advice** to a number of infectious diseases and/or concerns from the public.
- Examples include: **Scabies, TB, water quality, chickenpox, measles, norovirus and COVID-19.**

Specialist IPC advice

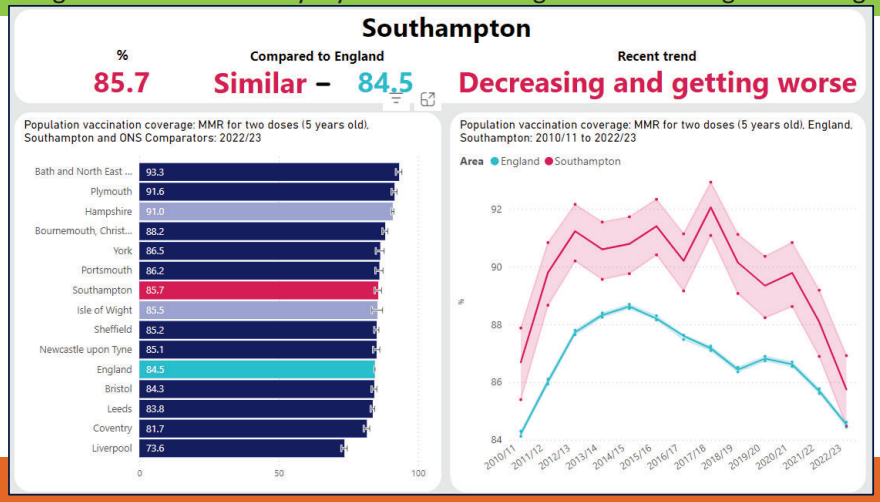
- IPC advice has also been provided, to many external agencies by our **Senior Health Protection and Infection Prevention and Control Nurse Specialists,** including educational settings, businesses, Port Health, hotels, hostels and care homes.
- The team also **cascade UKHSA** and **NHS England national guidance on IPC** and many Infectious diseases especially to the Adult Social Care sector and other relevant settings.
- **IPC Advice and support** is also given on a day-to-day basis in response to outbreaks as well as many queries and concerns.

Measles – vaccine preventable

- **Measles** is a **highly infectious** acute **viral illness**. It is a **notifiable disease** and **vaccine-preventable**.
- Global cases of measles are high due to poor vaccination coverage made worse by the Covid-19 pandemic. **Imported cases are therefore likely.**
- Vaccine has been available in the UK since 1968 but low coverage of population until MMR vaccine in 1988 and due to subsequent lower transmission, **unvaccinated children remain highly susceptible to measles infection**, and this continues to the present day
- Since 1 January 2024, there have been **2,012 laboratory confirmed measles cases reported in England (46% in London, 28% in the West Midlands, and 9% in East Midlands.** 129 upper tier local authorities (UTLA) have reported at least one confirmed case with symptom onset since 1st January. **The majority of the cases, (62%), have been in children under 10 and young people and adults aged 15-34 (31%).**
- Since January 1st 2024, there have been 13 confirmed measles cases (as of September 2024) in Southampton. These have been travel-related with no sustained community transmission**.**
- **Measles cases peaked at the end of March 2024 and again at the end of April 2024.**



Vaccination with the MMR is key to **keeping the Southampton population safe**. MMR is part of the routine childhood immunisation schedule. Two doses are given – 1st at 12 months and 2nd at 3 years & 4 months of age. MMR can be given at any age to those who have missed it – **a catch up campaign continues**. The target for uptake is 95% of the population to protect everyone. In 2022/23 in Southampton in 90% of children had their 1st MMR by age 2 years but this drops to 86% of children having their second dose by 5 years. Both are higher than the England average



Actions taken:

- SCC has conducted a **Childhood Immunisation Strengths and Needs Assessment** to understand factors that could help increase uptake of childhood immunisations, including MMR. Findings and recommendations are being used to inform action across the system. There is no single cause or solution and increasing uptake will require sustained action from multiple partners.
- The MMR oversight group is overseeing implementation of the HIOW MMR improving uptake plan.
- Training is being offered to the wider workforce to support promotion of vaccination an SCC is engaging with primary care on the issue.

Priorities going forwards:

- Help improve immunisation uptake and reduce inequalities in uptake through the following: inputting to the HIOW MMR Uptake Group, contributing to the development of local vaccination delivery plans, including in the HIOW ICB response to the National Vaccine Strategy. Implementing the findings and recommendations from CHISANA, joint working with commissioners, providers, and communities to take collaborative action to expedite improvements and amplify local communications.

Confirmed cases of measles in England by month, age, region and upper tier local authority: 2024 - GOV.UK (www.gov.uk)

Confirmed cases of measles in England by month, age, region and upper tier local authority: 2024 - GOV.UK (www.gov.uk)

Health Protection Dashboard: Microsoft Power BI

Pertussis – vaccine preventable

- Whooping cough, also known as pertussis, is a **highly contagious bacterial infection** that mainly affects the lungs and airways. Whooping cough is sometimes known as the 100-day cough because of how long it takes to recover from it.
- It spreads very easily and can be serious. **It's important for babies, children and anyone who's pregnant to get vaccinated against it.**
- Whooping cough can affect people of all ages and while it can be a very unpleasant illness for older vaccinated adolescents and adults, young babies who are too young to be fully protected through vaccination are at increased risk of serious complications or, rarely, death.
- Since 1 Jan 2024, there have been **5337 suspected cases in the South East**: **2005 confirmed (to September 2024),** compared with 858 cases for the whole of last year (2023).
- Of the 4992 cases with age information available, 61 (1.2%) were under 3 months old, 48 (0.9%) were 3-5 months old and 57 (1.1%) were 6-11 months old

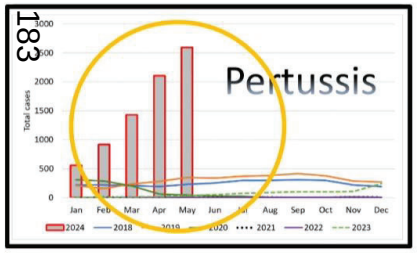
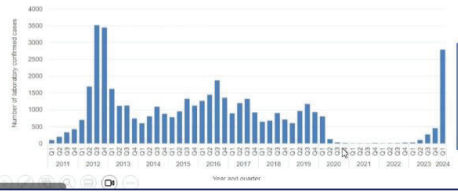


Figure 3. Laboratory confirmed cases of pertussis by quarter in England: 2011 to 2024 (note 1)



Age group	2018	2019	2020	2021	2022	2023	2024, cumulative to end May
Under 3 months	49	83	30	1	2	48	262
3 to 5 months	26	32	15	1	3	23	138
6 to 11 months	17	21	5	0	0	25	122
1 to 4 years	87	147	49	3	10	53	395
5 to 9 years	139	222	52	2	3	79	875
10 to 14 years	288	467	150	3	3	177	1,750
15 years and over	2,342	2,706	693	39	47	453	4,057
Total	2,948	3,680	994	49	68	858	7,599

UKHSA data reports 7,599 laboratory confirmed cases January to May 2024 (compared to 83 in 2023)

In the 12 years prior to the introduction of maternal pertussis vaccination in October 2012, 63 deaths occurred in babies aged under one year with confirmed pertussis. Since the introduction of pertussis vaccination in pregnancy, from 2013 to the end of May 2024, there have been 29 deaths in babies with confirmed pertussis who were all too young to be fully protected by infant vaccination. Sadly, this includes 8 deaths in infants who had contracted pertussis between January and May 2024. Of the 29 infants that died, 23 had mothers who were not vaccinated in pregnancy.

Confirmed cases of pertussis in England by month - GOV.UK (www.gov.uk)

- The pre-natal vaccination programme is the main route to protecting children from Pertussis.

In 2023/24, pertussis vaccine was offered in 100% of pregnancies at UHS and 83% accepted the vaccine. This compares very favourably with the England average of 59%.

Actions taken:

- SCC has supported UKHSA with cascading information to primary care. The Director of Public Health has also sent letters GP Practices and Midwives thanking them for their continued efforts in promoting and supporting vaccinations at every opportunity as well as sign-posting information and resources.
- IPC team have cascaded information to primary care and also to Adult health and social care sector as part of Occupational health requirements.

Priorities going forwards:

- Continue to help support increased immunisation uptake working with colleagues across the system.

Common Respiratory Infections - Covid-19,Flu, RSV

- **Covid-19** is a respiratory infection caused by SARS-CoV-2 virus. We continue to live safely with it alongside other respiratory infections, including **Influenza (flu)** and **Respiratory Syncytial Virus (RSV).** This is reflected in current guidance people with symptoms of a respiratory infection including Covid-19 and living safely with respiratory infections, including Covid-19. The likelihood of being admitted to hospital directly due to coronavirus (COVID-19) is greatly reduced in the general population.
- Testing for Covid in healthcare settings is now mainly targeted at informing clinical care. Surveillance (testing) continues within acute hospital settings, and for people at higher risk of severe infection who may be eligible for anti-viral treatment. Genomic sequencing of hospitalised positive cases continues to help provide insight into emerging variants.
- The continued threat from new variants of Covid-19 and Flu are helpful reminders of the importance of aligning to our SCC living with Covid strategic objectives of retaining our agility and capability to respond within the SCC health protection, emergency planning, and wider council teams.
- RSV is a common respiratory virus that causes serious lung infections. Whilst it can occur at any age, the risk and severity of RSV and its complications are increased in older adults and in neonate and small babies and it has considerable impact on individuals and NHS services during the winter months.

There are steps we can all take to reduce the spread of infection, such as practicing good hygiene. Alongside this, **vaccination is the best line of defence for protecting the most vulnerable. The Covid-19 and Influenza vaccination** continues to be offered to those at most risk of severe infection as part of seasonal campaigns.

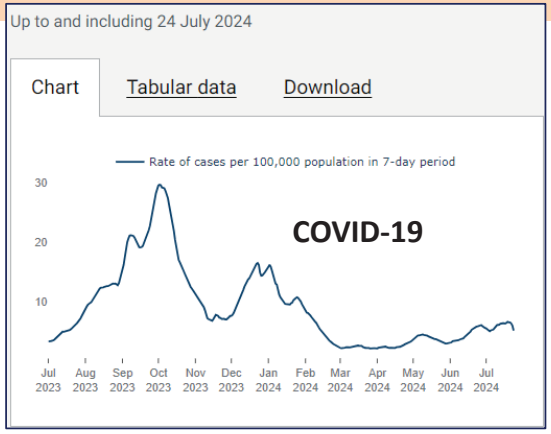
Following guidance from the Joint committee on Vaccination and Immunisation (JCVI), **2 new respiratory syncytial virus (RSV) vaccination programmes will be rolled out from 1st September 2024**, for older adults and during pregnancy for infant protection.

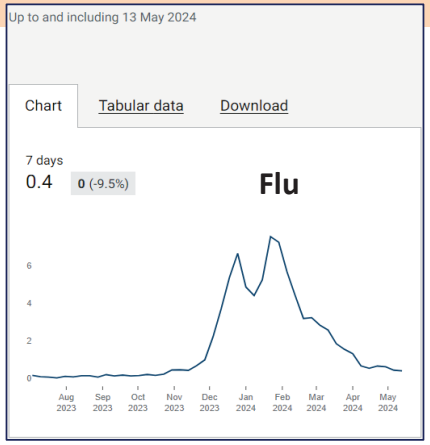
Actions taken:

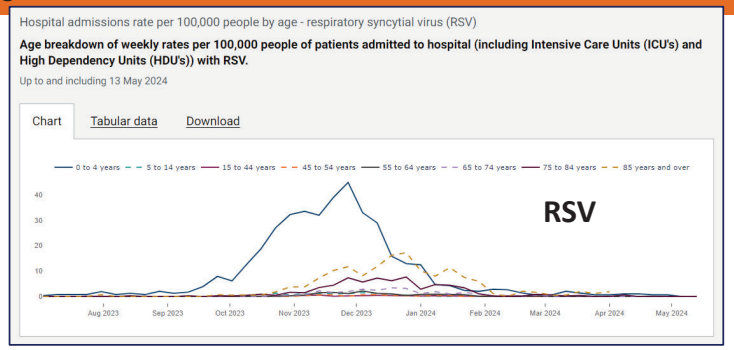
- SCC has supported comms campaigns to help promote vaccination to eligible groups and remind the population about the steps we can all take to minimise the spread of infection.

Priorities going forwards:

- Continuing to support communications campaigns and inputting to system wide work to increase uptake across all vaccination programmes.







- *In care homes LFD testing is still used to test the first five symptomatic residents in suspected outbreaks; testing is still used in symptomatic healthcare professionals caring for patients with severely weakened immune systems
- The UKHSA data dashboard shows public health data across England. It builds on the success and is an iteration of the COVID-19 UK dashboard. It presents a range of data on respiratory viruses.

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Mpox

Mpox is caused by the Monkeypox virus (MPXV) a virus from the same family as smallpox. Patients present with a rash illness which may be mild and localised, or severe and disseminated. There are two distinct clades:

- **Clade 2** is responsible for the global outbreak that began in 2022, and which has resulted in a number of cases in the UK.
- **Clade 1** is considered more severe than clade 2, leading to it being currently classified by the world health organisation as a high consequence infectious disease (HCID). Historically clade 1 MPXV has been reported only in 5 central African countries. However, recent cases in additional countries within Central and East Africa mark the first known expansion of it's geographical range, heightening the risk of spread beyond the region. Evidence of sexual transmission of Clade I MPXV has emerged in the DRC.
- The World Health Organisation (WHO) has determined that the upsurge of mpox in the Democratic Republic of the Congo (DRC) and a growing number of countries in Africa constitutes a public health emergency of international concern (PHEIC) under the International Health Regulations (2005) (IHR). The WHO declaration which will release funding to accelerate vaccine access for lower-income countries and support surveillance, preparedness and response activities.

About mpox

- Mpox is a rare disease that is caused by infection with monkeypox virus (MPXV). The virus is related to but distinct from the ones that cause smallpox and cowpox.
- Symptoms of mpox begin 5 to 21 days (average 6 to 16 days) after exposure with initial clinical presentation of fever, malaise, lymphadenopathy (swelling of lymph nodes/glands) and headache. Within 1 to 5 days after the appearance of a fever, a rash develops, often beginning on the face or genital area and it may then spread to other parts of the body. The rash is sometimes confused with chickenpox. It starts as raised spots, which turn into small blisters filled with fluid. These blisters eventually form scabs which later fall off. Most individuals experience a mild illness, with spontaneous and complete recovery within 3 weeks.
- Treatment for mpox is mainly supportive. However, severe illness can occur and sometimes results in death. The risk of severe disease is higher in children, pregnant women and immunosuppressed individuals i.e. it is centred around managing symptoms.

Vaccination

- There is currently no vaccine licensed in the UK or Europe for immunisation against mpox. However, as mpox is related to the virus which causes smallpox, vaccines developed for smallpox are considered to provide cross-protection against mpox.
- Vaccination does not give full immunity but gives some protection against the most serious outcomes for all variants of mpox.

Steps we can take to prepared and reduce risks:

- There are no cases of Clade I MPXV confirmed in the UK and the UK Health Security Agency (UKHSA) has assessed the current risk to the UK population as being low. However, planning is underway to prepare for any cases that we might see in the UK. This includes ensuring that clinicians are aware and able to recognise cases promptly, that rapid testing is available, and that protocols are developed for the safe clinical care of people who have the infection and the prevention of onward transmission.
- The Council Public Health team will monitor this situation as it evolves. We are working with our partners, including UKHSA, Hampshire and Isle of Wight and Frimley Integrated Care Boards (ICBs), NHS England, acute Trusts, community pharmacy, and our commissioned sexual health services to ensure systems and processes are in place to respond to any local cases.

Actions taken:

- SCC has supported UKHSA with cascading briefing notes, guidance, action cards to primary care.

Priorities going forwards:

- Continuing to remain briefed and support the international response at a local level.

Infection Prevention and Control (IPC) and Health Protection

SCC has the support of **two Senior Health Protection and IPC Specialist Nurses**, who are also part of the wider NHS HIOW ICB, IPC team as well as being an integral part of the Health protection team at SCC. They work collaboratively on many initiatives, **providing expert advice** and **guidance to a broad range of health and social care settings**, **protecting vulnerable people from infection**, **reducing the risk of outbreaks**, and **reducing the impact** when they do.

The IPC team :

- ✓ **Collaborate** with the SCC public health team, as required, to **communicate infection prevention** and **control and health protection advice** to a broad range of settings and stakeholders including **schools and early years** as well as ensuring the Director of Public Health and Health Protection team are kept up to date with **outbreaks, healthcare acquired infection rates** and **other concerns and issues** identified across Southampton.
- ✓ **Provide additional infection prevention and control or health protection advice** across other portfolio areas where relevant such as **to sexual health** or **substance use services**, **Environmental Health, Port Health, Adult and Children's services**.
- ✓ Attend Southampton **asylum seeker contingency hotel** and other relevant meetings to provide infection prevention and control, and health protection advice as required **to reduce the risk of infection and outbreaks**.
- ✓ **Support** and work closely with SCC adult **quality and safeguarding team** by **undertaking visits to care homes** where concerns are raised as well as attending Quality and Safeguarding meetings with providers to **advise and support** both parties.
- ✓ **Undertake visits** to **Health and Social care sector homes** and premises **advising and supporting managers** to ensure they are complying with the health and Social Care Act IPC requirements.
- ✓ Undertake **education sessions to all sectors as required**, this can be face to face, via webinars, care home forums, or to individual Schools, care homes etc where specific concerns are raised and identified. These topics cover many areas such as the importance of hand hygiene, respiratory hygiene, use of Personal Protective Equipment (PPE), cleaning standards, outbreak management etc
- ✓ **Cascade up to date relevant national guidance to all Health and Social care settings** via weekly forums, newsletters etc
- ✓ Attending and participating in **TB cohort review** and **networking meetings** as required as well as working collaboratively with SCC public health (health protection) team and NHS commissioners to review the delivery of TB services in the city.
- ✓ IPC support and **participate in Incident Management Team meetings** as required including those convened by the UK Health Security Agency including but not limited to health, social care, and educational settings.
- ✓ Regularly support and **advise Care Homes** in the **management of outbreaks of infections** such as **Norovirus, Acute Respiratory infections, Scabies** and other **causative agents** and they ensure these topics are covered in education sessions.

Build

Capacity building

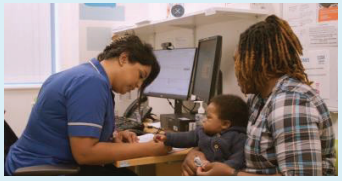
The Childhood Immunisation Strengths and Needs Assessment (CHISANA) identified a series of recommendations to improve uptake including recommendation no 1) Strengthening promotion at every stage of a child's journey and recommendation no 6) Information availability (information being available in a range of formats and languages).

Wider workforce training – 'Jab Chat'

- SCC secured NHS England 'wider workforce development' grant funding to commission the development and delivery of vaccination training. This educational project aims to tackle falling rates of routine childhood immunisations by developing the knowledge and confidence of the wider workforce to have short conversations with parents about the importance of childhood immunisations.
- The training is aimed at professionals who are not directly responsible for delivering vaccinations, but who have been identified as having a key role, as trusted individuals, in promoting childhood immunisations.
- Using healthy conversation principles, the training aims to equip attendees with the knowledge and confidence to initiate short, reassuring, and supportive conversations with parents about routine childhood immunisations.
- Target workforce includes: Family hub staff, social workers, health visiting practitioners, early years providers, engagement workers and staff supporting administration of vaccinations

Language Free Resource

- To tackle a decline in routine childhood immunisation uptake, and inequalities in relation to information availability, SCC secured grant funding to commission the development of a language free resource (short film) to provide engaging and fresh content. The film normalises childhood immunisations as 'one more way to keep them safe' alongside other everyday actions like using stairgates, car seats and washing hands. The film is hosted on the Healthier Together website.
- To develop and test the creative concept, several focus group sessions were undertaken. This enabled us to gauge views and invite discussion in relation to what parents felt they would and wouldn't like to see. We were also able to recruit Southampton residents to feature in the film.
- Target audience includes: All parents, in particular under-represented groups, for whom English may not be a first language.



SOUTHAMPTON CITY COUNCIL

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DECISION-MAKER:	Health & Wellbeing Board
SUBJECT:	Director of Public Health Annual Report 2023-24
DATE OF DECISION:	11 December 2024
REPORT OF:	COUNCILLOR MARIE FINN CABINET MEMBER FOR ADULTS AND HEALTH

CONTACT DETAILS				
Executive Director	**Title**	Interim Executive Director of Community Wellbeing, Children and Learning (DASS and DCS)		
	Name:	Rob Henderson	Tel:	
	E-mail:	robert.henderson@soutampton.gov.uk		
Author:	**Title**	Director of Public Health		
	Name:	Dr Debbie Chase	Tel:	
	E-mail:	debbie.chase@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY
N/a

BRIEF SUMMARY

Under the Health and Social Care Act 2012 and the NHS Act 2006, the Director of Public Health has a statutory duty to prepare an independent report on the health of the local population, and the Local Authority has a duty to publish it.

The subject of this year's annual report is community-centred approaches to health and wellbeing. These are methods that mobilise assets within communities, promote equity and social connectedness, and increase people's control over their lives.

Short statements from Cllr Finn and Cllr Houghton, and the Chief Exec at Southampton Voluntary Services, in support of the report have been included as part of the Foreword.

RECOMMENDATIONS:

	(i)	To note the contents of the annual report, particularly the 4 recommendations to: • Identify strengths and enable communities to take control • Build support around families, communities and neighbourhoods, not professions and focus on prevention and early intervention • Prioritise communities with poorer health outcomes to reduce health inequalities and assess the impact of a community-centred approach • Shift mindsets to embed a different relationship between communities and organisations.

REASONS FOR REPORT RECOMMENDATIONS	
	N/a
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
	N/a
DETAIL (Including consultation carried out)	
	The report's focus on community-centred approaches to health and wellbeing aligns with the Southampton Joint Health and Wellbeing Strategy (2017-2025) and the aims of the SCC Community Prevention Transformation Programme 2024. The report will be formatted by the SCC Design Team and is due to be published online in mid-January, first having been presented at the Health and Wellbeing Board meeting on 11 December 2024. An accompanying video will be published as part of a wider communications plan to promote the annual report.
RESOURCE IMPLICATIONS	
Capital/Revenue	
	N**/a**
Property/Other	
	N**/a**
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
	The requirements for the Director of Public Health to prepare an Annual Report, and for the Local Authority to publish it, are set out in the Health and Social Care Act 2012 and the NHS Act 2006.
Other Legal Implications:	
	N**/a**
RISK MANAGEMENT IMPLICATIONS	
	N**/a**
POLICY FRAMEWORK IMPLICATIONS	
	N**/a**

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	All
SUPPORTING DOCUMENTATION	
Appendices	
1.	Director of Public Health Annual Report 2023/24 – Community-centred Approaches to Health and Wellbeing

Documents In Members' Rooms

1.		
2.		
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.		
2.		

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Director of Public Health Annual Report 2023/24

SOUTHAMPTON CITY COUNCIL

Contents

FOREWORD FROM

Dr Debbie Chase

This represents my fourth annual public health report, and having focused on COVID-19, health inequalities and the workplace in previous years, it's timely I now focus on the 'heart' of our city; our communities, and how taking a community-centred approach can protect and improve health and wellbeing. In fact, all my previous annual reports recognise the ability of communities in achieving this as a building block for health, but this report gives communities centre stage and offers recommendations to enhance the power of this approach in Southampton.

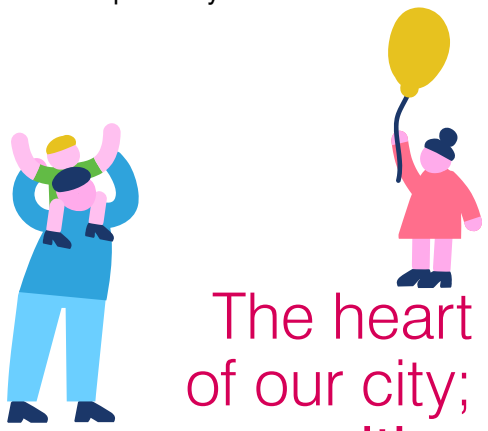
Communities are a coming together of people, perhaps with shared values and/or purpose, of experience and/or place. They have a shared identity and can be strong influencers of health and wellbeing. This can be through achieving social connectedness, through different activities such as physical activity and most importantly through building confidence and self-esteem. This in turn can build capability and independence.

What this report describes are the ways in which community-centred approaches can be achieved, alongside case studies of approaches already underway or being developed in our city. We have some wonderful community assets, be they community groups, voluntary sector organisations, parks, cultural opportunities and buildings and there are examples of harnessing these and the vibrancy and opportunity that has come with them. What I am seeking to achieve with this report is identifying more of these assets and further developing those community strengths.

This report includes learning from other areas in the country. Places where a long-term strategic commitment has been made to ensure a community-centred approach and evidence to date shows the benefits of this, not only in improving life chances for residents but also in more efficient use of finite public sector funds. This is what I am seeking for Southampton through the 'Community Prevention Transformation Programme'.

It is timely that we focus on a community-centred approach, given the challenges for our health and care system and what we know about increasing health inequalities and their impact in Southampton. Our city is fortunate to have many great assets, it also now has a Health Determinants Research Collaboration (HDRC) to provide an infrastructure for evidence informed decision-making and working with communities to reduce health inequality. I look forward to working with you all, and most importantly our communities, in helping achieve health equity for our city.

Dr Debbie Chase
Director of Public Health,
Southampton City Council



The heart of our city; our communities

FOREWORD FROM Rob Kurn

When we think of health, our minds naturally fall to services that treat and care for us when we are ill, like our wonderful NHS. However, overall, we spend little time with our health care services, and whilst they offer vaccines, health checks and other preventative measures, their impact on "health creation" is limited.

Our "health" is created through the quality of the "building blocks" of health that we experience – through our homes, our communities, our work, the food we eat, the recreation we take, our education, and environment. Therefore, it is commendable that this report focuses on the role of communities in creating health, as these are where we spend much of our time.

Unfortunately, all is not equal within Southampton's communities. Our experiences of the building blocks of health differ greatly across our neighbourhoods, with men and women in our least affluent neighbourhoods living on average 8 and 3 years less, respectively, than those in the most affluent areas. Similar discrepancies can be seen within the city's global majority population, driven by the chronic stress of discrimination, both seen and unseen.

Despite these disparities, quite rightly, this report is optimistically framed. Because it focuses on the community assets we have that can make a difference. The organisations, the informal groups and clubs, the volunteers, the buildings, the knowledge and skills, the sense of place and local pride, creativity and leadership that is evident across Southampton. These are assets we must harness, and build on, to create greater health. Across the city we see examples of communities doing things for themselves; whether driven by faith, or personal belief in equity, diversity and inclusion, and a sense of social justice - they are all examples of civil society in action.

An important aspect of the community-centred approach outlined in this report is enabling communities to be a driving force in local decision making. We have groundbreaking local examples of how communities are shaping decisions through peer research programmes, coproduction projects, and citizen panels.

The city is now afforded the opportunity to build on this work, through the five-year Health Determinants Research Collaboration, outlined in these pages, which will ensure that local people are at the heart of priority setting. As a person born and bred of the city, this is an exciting time to be working for change, and improved health, in Southampton.

Rob Kurn
Chief Executive,
Southampton Voluntary Services

FOREWORD FROM

Councillor Marie Finn

In Southampton we have many exciting and diverse communities. I am delighted that we will be focussing on different ways that services can work with local people as equal partners so that we can recognise our communities as assets and support them to grow and thrive.

It is important to us that our communities are strong, and that people get a real voice in local decision making and that we build trust between us all. We know that our social connections can make all the different to how we feel and how healthy we are. Community collaboration makes us all stronger. This report shows many examples where services and communities are working together, building strong relationships and trust to improve lives and support good health and wellbeing. This enthusiasm and creativity is inspirational in showing what is possible when a council works with local people as equal partners.

Thank you to everyone across the city who has shared their fantastic work, and I look forward to seeing the recommendations carried forward for all our benefit.

Councillor Marie Finn
Cabinet Member for Adults and Health

FOREWORD FROM

Councillor Houghton

By recognising the impact of where we live, as well as our experiences, the Director of Public Health makes a compelling case for community solutions to improve health outcomes. The examples cited in the report are a valuable insight into Southampton communities who have already improved the health of their communities, by working hard to support each other. To make the most impact, we need to bring individuals and communities with us, ensuring local understanding and ownership of solutions, while also supporting these communities by giving them the building blocks of support and investment.

Councillor Houghton
Shadow Cabinet Member for Adults and Health

Background

WHAT CREATES GOOD HEALTH?

For a community to thrive, the right building blocks of health need to be in place. Jobs, access to education, homes, public transport, social networks - it is these building blocks that enable the conditions for good health[1]. When any of these blocks are missing, people are put at a disadvantage. They are less likely to achieve good health and lives can be cut short.

While access to good healthcare (e.g. GP care or hospital services) is an important block in supporting health, this is just one part of the picture. Much of what impacts health in Southampton and beyond is influenced by the communities in which we live.

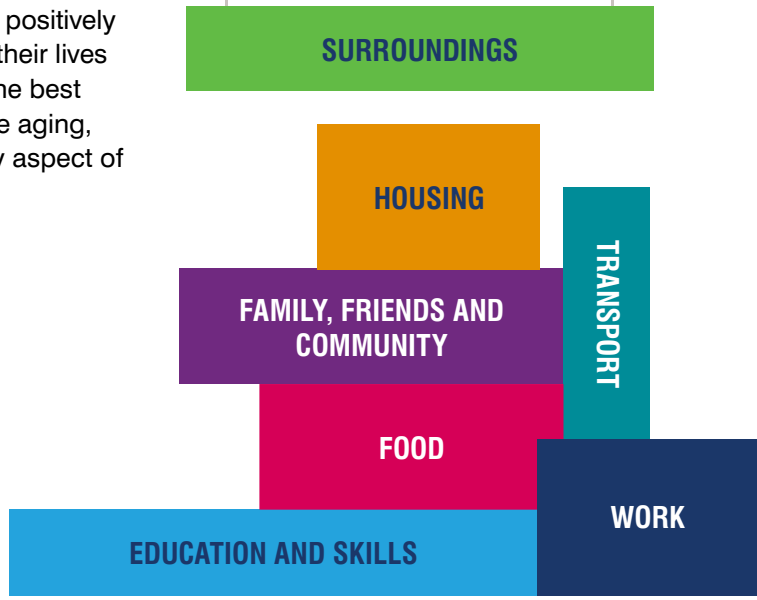
Social connections with friends, family and communities are one vital component. Evidence shows that when people have strong supportive networks, they are more able to meet challenges in life and less likely to rely on other coping mechanisms, or experience poor outcomes. In other words, people who are part of strong communities are more resilient.

Being disconnected from friends, family and their communities, can create the conditions for loneliness and social isolation which may have a damaging impact on health. Recent studies have found poor social relationships were associated with an increased risk of heart disease and stroke (30%)[2], in addition to an increased risk of mental health disorders[3], and dementia (50%)[4]. Studies have also shown people who are lonely overall die earlier[5] and this could have the same impact as smoking up to 15 cigarettes a day[6].

Having strong social networks and connected communities can positively influence individuals across their lives from helping children have the best start in life, into healthy active aging, and can impact almost every aspect of their lives.

What is a community?

A community can be defined by geography (e.g. the city of Southampton), a culture, faith, or language, a set of shared values or experiences, or another characteristic. A community's identity is not fixed - how a community defines itself may change over time, and people can be part of many different communities.



ENGAGEMENT AND EMPOWERMENT

Enabling communities to have a voice in decision-making and in how resources are used can empower people to have more control over their lives[7]. This can happen through development of individual self-efficacy and self-esteem, and through mobilising resources, building confidence and energy as a community.

Involving communities in this way can ensure the best use of resources. Better intelligence can be gathered to paint a fuller picture of what's happening on the ground and systems can be designed around groups of people. While increased feelings of ownership can improve use or uptake, and long-term sustainability can be supported. Finally, additional holistic approaches i.e. those in the voluntary and community sector, can be identified.

For example, better understanding why a community is not physically active may result in finding out why local parks or green spaces aren't being used. This insight could then help identify solutions that not only improve physical activity levels but also increase community cohesion, feelings of safety, social connectedness, and reduce crime and vandalism.

Although all members of a community can benefit from increased involvement in decision-making, those from typically excluded groups and those at greatest risk of poor health can particularly benefit. What matters most to these groups can be prioritised and what is needed to create change in these seldom heard groups is better understood. In addition, potentially overlooked or unrealised assets in a community can be fully developed and supported to benefit community members.

WHAT ARE COMMUNITY ASSETS?

Southampton has many different communities and all of them have strengths or assets that support people's health and wellbeing.

Some assets in our city are well known, such as physical buildings, while others can be harder to recognise, such as skills, knowledge, and networks or social connections.

Types of community assets

- **The skills, knowledge, and commitment of individual community members**
- **Friendships, good neighbours, local groups, community and voluntary association**
- **Physical, environmental and economic resources that enhance wellbeing**
- **The resources and facilities within the public, private and third sector**

WHAT IS A COMMUNITY-CENTRED APPROACH?

Taking a community-centred approach can also be described as taking an asset-based or strength-based approach.

It means identifying and developing our communities' strengths rather than focusing on weaknesses (what's strong, not what's wrong), working together in partnership with individuals and communities (do with, not to and less of an us and them mindset), and looking for the opportunities, not what is missing. It also means aiming to build capability and independence in ways that benefit health and wellbeing and are sustainable (instead of relying on external services and programmes to intervene), and empowering people and communities to have more control over their lives.

Importantly, this approach values and prioritises building strong social networks, relationships, and community life, and the impact these can have on health outcomes.

Working with communities can focus on changing the conditions that can create good health (the building blocks) in local places, rather than treatment of a condition or issue in professional silos.

This is an approach that promotes working upstream to change the environment and conditions in which people live in our city before a crisis point has occurred, to prevent it from happening, or at least lessen its impact.

An asset-based approach

- ✓ Starts with assets in the community
- × not deficits

- ✓ Identifies opportunities and strengths
- × not problems

- ✓ Sees people as the answer
- × not an external service or programme to intervene

- ✓ Focuses on communities and neighbourhood
- × not individuals

- ✓ Sees people as having knowledge and skills to offer and contribute
- × not as receivers or users of a service

- ✓ Helps people take control
- × rather than passive and done-to

TACKLING INEQUALITIES

"To improve health inequalities, social connections need to be strengthened and resources within communities mobilised across the social gradient"

Fair Society, Healthy Lives
The Marmot Review, 2010[8].

This was one of the recommendations from the Marmot Review, a pivotal report on inequalities in England that is often referred in work aiming to improve equity in health and wellbeing.

In the context of the Marmot Review, this recommendation means that communities at greater risk of poor health outcomes need to be prioritised in terms of support, over other groups who are already achieving better health. Such as starting with these communities first to identify and build their assets.

Creating and developing healthy and sustainable places and communities is one of the eight principles that an area must adopt to become a 'Marmot Place' - a movement to reduce health inequalities that was created following the Marmot Review[9].

In chapters 3-5 of this report, the different ways people, groups and organisations can help strengthen social connections and mobilise assets to create healthy communities is discussed, through using a community-centred approach.

HDRC SOUTHAMPTON:
BETTER EVIDENCE, BETTER DECISIONS

Southampton City Council is one of thirty local authorities across the UK to be awarded funding from the **National Institute for Health and Care Research (NIHR)** to establish a Health Determinants Research Collaboration (HDRC).

The purpose of this funding is to help use and generate evidence to make better decisions relating to the building blocks of health.

Over the next few years, HDRC Southampton will be co-producing research priorities with communities and jointly applying for funding. If successful, communities can get involved in the research (with appropriate skills development) and work with partners to implement the findings to improve outcomes and reduce inequalities.

NIHR | Health Determinants Research Collaboration Southampton

Better evidence, better decisions.

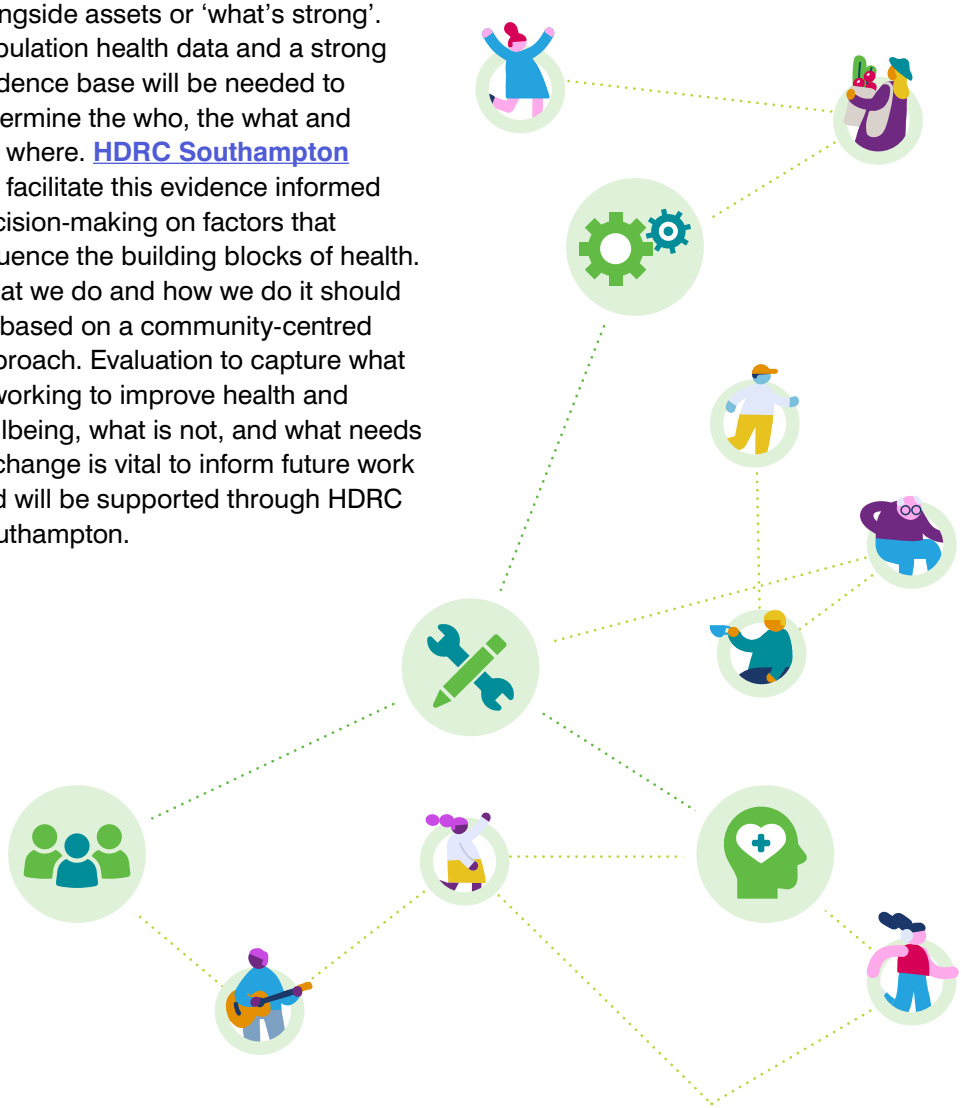
data.southampton.gov.uk/research/hdrc-southampton/

WHY ARE COMMUNITY-CENTRED APPROACHES SO IMPORTANT?

There is an ongoing need to shift towards creating and building health in communities rather than only aiming to prevent and treat disease. Taking a community-centred approach has the potential to benefit individuals, communities and organisations.

Individuals and communities can benefit from improved health outcomes through increased social networks, internal capability and control, as well as having environments, external services and programmes better designed to meet their needs. While different people, groups and organisations do and can benefit by making the best use of their resources to achieve those better health outcomes - through prioritising most at risk groups, designing more effective and sustainable solutions to meet real need, and through intervening early to prevent downstream crisis.

This approach still considers need or 'what's wrong' but does so with communities in partnership, and alongside assets or 'what's strong'. Population health data and a strong evidence base will be needed to determine the who, the what and the where. HDRC Southampton will facilitate this evidence informed decision-making on factors that influence the building blocks of health. What we do and how we do it should be based on a community-centred approach. Evaluation to capture what is working to improve health and wellbeing, what is not, and what needs to change is vital to inform future work and will be supported through HDRC Southampton.



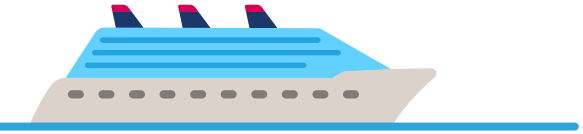
Health & wellbeing of Southampton

Southampton is a vibrant, hard-working city located on the south coast as a bustling global seaport. It has a rich cultural heritage, reflected in its medieval buildings, museums, theatres, and galleries.

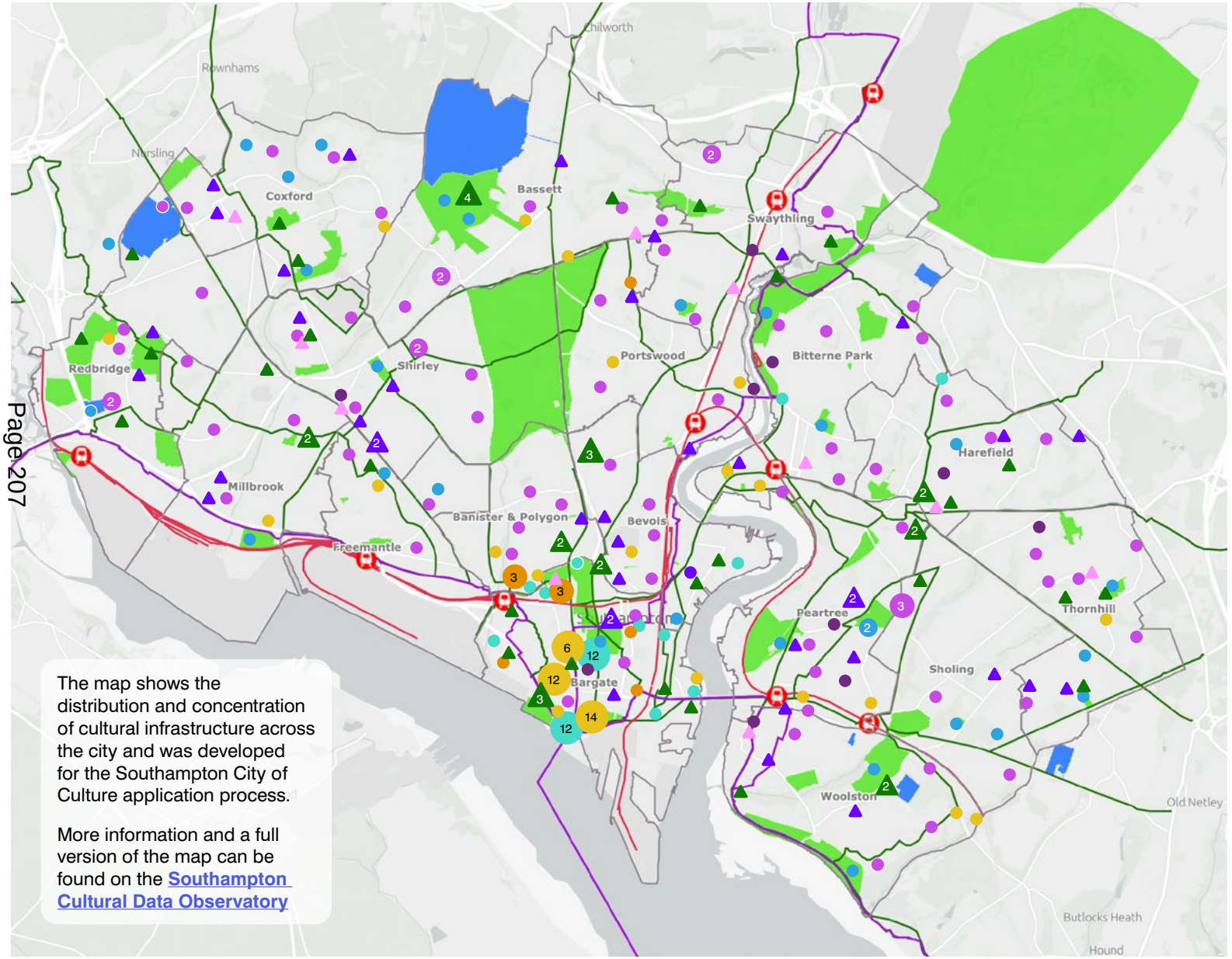
Our city is home to international businesses, including those based around the port, two high ranking universities, Southampton and Solent, a leading research and teaching hospital trust, and a Premier League football team, the Saints.

Southampton Common, our city's largest green space, measures 168 football pitches in size. It is just one of the 200 green spaces in the city, including parks, gardens, recreation grounds and ecology areas. Of Southampton's 55 parks, 11 have achieved national **Green Flag Award status.**

The rivers Test and Itchen run alongside and cut through our city respectively, providing access to Southampton's blue space, as do our city's many marinas, such as Ocean Village.



CULTURAL INFRASTRUCTURE IN SOUTHAMPTON



The map shows the distribution and concentration of cultural infrastructure across the city and was developed for the Southampton City of Culture application process.

More information and a full version of the map can be found on the Southampton Cultural Data Observatory

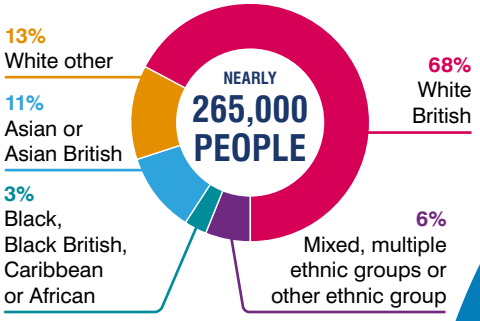
- Gymnasiums, Sports Halls and Leisure Centres
- Halls and Community Centres
- Libraries
- Museums and Public Galleries
- Scheduled Monument
- Schools
- Social Clubs
- Sports Grounds, Stadia and Pitches
- Theatres and Concert Halls
- Youth Organisations
- Railway Stations

- Railway Lines
- National Cycle Network
- Cycle Routes
- Public Parks
- Public Sports Areas

A SNAPSHOT OF SOUTHAMPTON

3 LOCALITIES
West, North & Central, and East

17
Electoral Wards



Hello · Salut · Olá · مرحبا · Cześć · 你好 · Hola

NEARLY 160 LANGUAGES ARE SPOKEN
English is the main language spoken by over 8 in 10 residents
followed by Polish, Romanian, Chinese, Portuguese

Of people who are economically active
4 IN 10 HAVE A DEGREE level qualification or higher

1 IN 4 HAVE AT LEAST A-LEVEL
or equivalent qualifications or higher.
Higher than both the South East and England averages (20.7% and 20.3%)

People who live and work in our city are
PAID £2,624 LESS
per year than people who travel into our city for work and live outside it
£33,101 vs £35,745 average wage[11]

THE MEDIAN HOUSE PRICE
is the most affordable in the South East

More affordable than the England average
7.61x vs. 8.18x annual median income

This picture is similar when looking at rental prices vs monthly earnings, compared with the England average.

JUST OVER 1 IN 5 DWELLINGS
have been retained as **council owned** or housing association owned dwellings
Compared to 1 in 7 in England

Skills and employment
Southampton is similar to the South East and the England averages

NEARLY 8 IN 10
working age population (aged 16-64) **economically active**

1 IN 25 are unemployed[11]

Nearly everyone has access to
A LOCAL PARK OR GREEN SPACE
in our city within a 10-minute walk

98%

Nearly half are less than a 5-minute walk.

However, according to national guidance **there isn't enough green space available per person for our city**[12]

Not everyone feels safe in these spaces. **Only 65% and 56%** of men and women feel safe in parks during the day.

25% & 8% AT NIGHT
for men and women[13]

SOUTHAMPTON'S YOUNG DEMOGRAPHIC

NEARLY 1 IN 5 PEOPLE
are aged between 16-24 years
COMPARED TO **JUST 1 IN 10 IN ENGLAND**
This is largely due to Southampton's student population

NEARLY 1 IN 7 PEOPLE
are aged over 65 years
COMPARED TO **NEARLY 1 IN 5 IN ENGLAND**[11]

Source: Southampton Data Observatory (11, 12, 13)

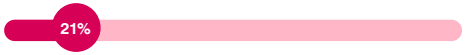
A SPOTLIGHT ON SOCIAL CONNECTEDNESS

Southampton is made up of many strong, connected communities, who overall feel belonging, trust and safety within their local area[13,14].

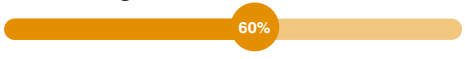
Within Southampton, local surveys have shown nearly **8 in 10 (77%)** felt strongly that they belonged to their local area.

People who were Black, Asian, or within an ethnic minority felt most strongly they belonged to their local area **(93%)**, as did those living in the electoral wards of Portswood **(97%)**, Shirley **(91%)** and Bargate **(90%)**.

However, around **1 in 5 (21%)** did not feel strongly that they belonged to their local area[13].



The majority of people **(60%)** agreed that their local area is a place where people from different backgrounds get on well together



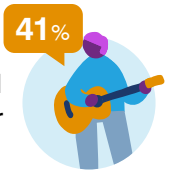
This was felt most strongly by people who were from ethnic minorities.

Around 1 in 7 (15%) disagree that their local area is a place where people from different backgrounds get on well together[14].

Most people (83%) felt that they could ask relatives, friends or neighbours for help, which has increased year on year. Women and people over 75 years were most likely to feel they could ask for help.

Around 1 in 16 (6%) felt that they did not have relatives, friends of neighbours that they could ask for help[13].

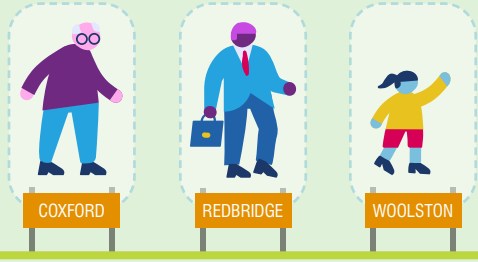
The majority of people felt safe during the day in their local area and in our city centre **(77% and 65% respectively)**. People were more likely to feel unsafe at night in their local area **(48% and 58% respectively)**. People living in Basset, Portswood, and Swaythling felt safest after dark compared with Thornhill and Coxford[14].



Around 4 in 10 people in Southampton (41%) had volunteered or given unpaid help to any groups, clubs or organisations in the last 12 months and **more than 1 in 4 (28%)** had volunteered in the last month. People aged 35-44, and those living in Woolston were the most likely to have volunteered. While **around 6 in 10 (59%)** people had not volunteered or given unpaid help to any groups, clubs or organisations in the last 12 months[13].

Nearly 7 in 10 (67%) people reported that they did not feel lonely or isolated in their daily lives. With men, those aged 25-34, and ethnic minorities being the least likely to report feeling lonely or isolated. **Around 1 in 6 (16%)** people reported they feel lonely and isolated in daily life[13].

Using a variety of different information sources combined, the social isolation risk score was created for all the different areas in our city[15].



The results showed that **Coxford, Shirely, Millbrook, Woolston and Redbridge** residents rank as being at the highest risk of social isolation in our city. People over 65 years were most at risk of social isolation if they lived in Coxford, while people under 15 were most at risk if they lived in Redbridge. Working aged people (16-64) were most at risk if they lived in Woolston.

HEALTH INEQUALITIES IN SOUTHAMPTON

While Southampton is a great place to live for many, all is not equal.

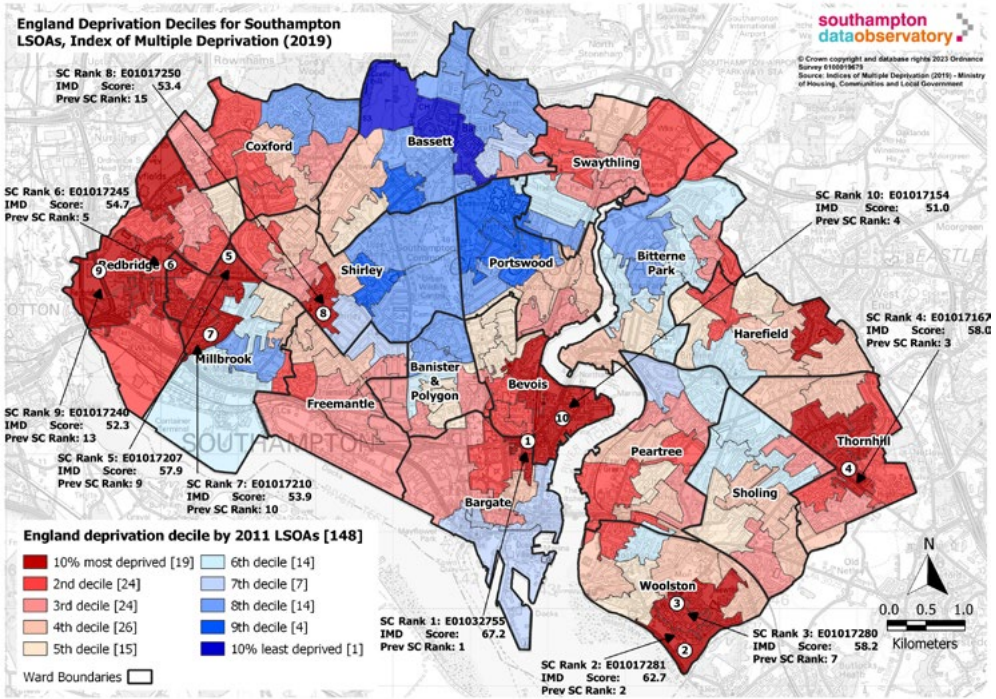
There are significant differences in the health and wellbeing experienced between groups of people in our city including different ethnic groups, genders, ages, and neighbourhoods.

One method of measuring health inequalities is by looking at health outcomes by an area's deprivation score. This score combines multiple pieces of information about an area, such as people's income, education, employment, health, as well as data about housing, services, and crime.[10]

People living in the most deprived places in Southampton are expected to live a quarter **(24%)** of their life in poor health, compared with just a seventh **(15%)** for people living in the least deprived, who are also expected to live longer.

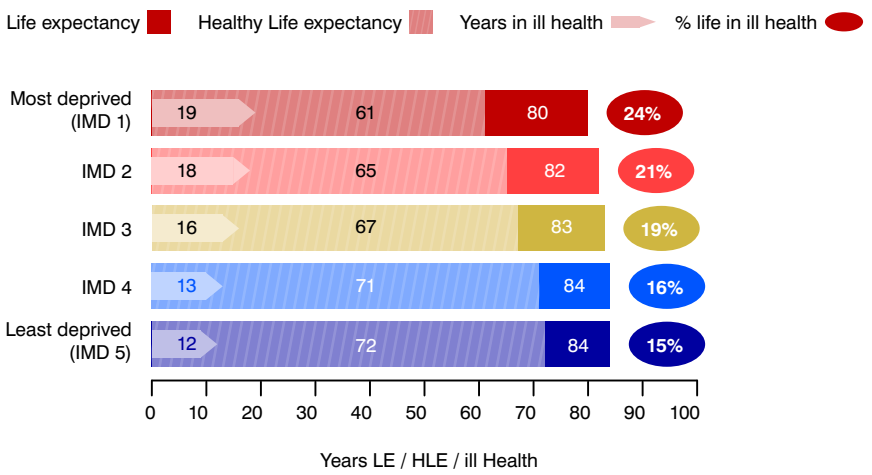
For example, women living in Basset are expected to have nearly 11 extra years living in good health compared with women in Bevois **(70.4 vs 61.2).** Men living in Basset are expected to have 8 extra years living in good health compared with men in Thornhill **(68.6 vs 60.1 years)**.

The trend is similar for average overall life expectancy. Women living in the most deprived areas of our city are expected to live **3.4 years less** than women living in the least deprived areas. Men living in the most deprived areas of Southampton are expected to live **7.8 years less** than men living in the least deprived. There has been no evidence of this inequality gap in life expectancy narrowing over time.

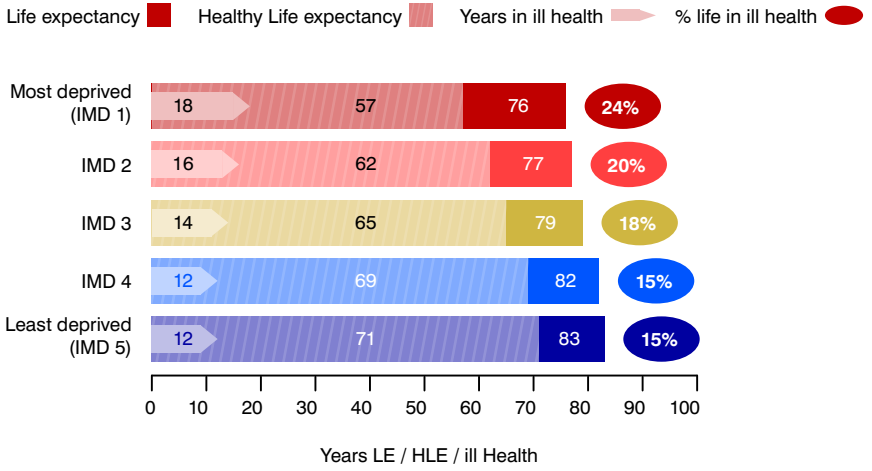


HEALTH INEQUALITIES IN SOUTHAMPTON

Life expectancy compared with healthy life expectancy for FEMALES in Southampton by England deprivation quintiles 2019 - 21*



Life expectancy compared with healthy life expectancy for MALES in Southampton by England deprivation quintiles 2019 - 21*



Source: NHS England and ONS using ONS Silcocks method for Life Expectancy and ONS Sullivan method for Healthy Life Expectancy
*Provisional data

HEALTH INEQUALITIES IN SOUTHAMPTON

Inequalities for children & young people

There are also stark differences in children and young people's health and wellbeing depending on where they live in our city.

Giving children the best start in life is the biggest influence on their health and wellbeing as an adult. This includes time before birth, their education, how physically healthy they are, and their emotional wellbeing.

Below is a comparison between children living in the most and least deprived neighbourhoods in Southampton[10].

Smoking in pregnancy (at time of delivery) rates

9.5X HIGHER

(April 2022 to March 2024)

Overweight or Obese weight at year 6

1.9X HIGHER

(2020/21 to 2022/23 pooled)

Overweight or Obese weight at year R

1.3X HIGHER

(2020/21 to 2022/23 pooled)

Achieving 'attainment 8' at key stage 4 (a measure for 8 GCSE subjects including English and Maths)

1.6X LOWER

(2020/21 to 2022/23)

Child protection plans

5.7X HIGHER

(2020/21 to 2022/23)

Children in need

3.8X HIGHER

(2020/21 to 2022/23)

Children looked after

4.5X HIGHER

(2020/21 to 2022/23)

Absence from school

1.8X HIGHER

(2020/21 to 2022/23)

A SPOTLIGHT ON ST MARY'S COMMUNITY

> St Mary's is a unique area in Southampton, the sense of community and family is very apparent.
>
> There is a tremendous feeling of belonging amongst the community and the respect between the different communities. Most people living in St Mary's generally stay in St Mary's for a long time.
>
> **Community Engagement Manager,** Stronger Communities Team, Southampton City Council

In order to understand our communities, it often useful to look at data and information at a hyper-local level.

St Mary's sits within the Bevois ward of Southampton. It is home to St Mary's church, (where it takes its name), St Mary's Leisure Centre, a Fire Station, two Mosques, Gurdwara, and it sits adjacent to St Mary's Football Stadium, home of the Saints football team.

Overall, the community has a very diverse population compared to the Southampton average. In the neighbourhood where St Mary's Leisure Centre is located, 7 in 10 (71.7%) people are from ethnic minorities, compared to 3 in 10 (31.9%) across Southampton as a whole[16].

In the same neighbourhood, the deprivation score for the area is high, and ranks as one of the 20% most deprived neighbourhoods in our city.

In a local survey for St Mary's[16], nearly everyone asked **(88%) felt good/ positive** about their area with around only 1 in 20 **(6%) feeling negative/bad.**

Below is a comparison between the neighbourhood where St Mary's is located and the Southampton average.

Unemployment
St Mary's 5%
Southampton 4%

No qualifications
St Mary's 25.2%
Southampton 12.3%

School sessions missed
St Mary's 8.5%
Southampton 8.1%

Persistent absentees
(more than 10% sessions)
St Mary's 29.3%
Southampton 22.6%

Total crime (per 1000 people)
St Mary's 163
Southampton 123

Violent crime (per 1000 people)
St Mary's 64
Southampton 48

The top 3 things identified as assets they love in their area were:

People | Religious buildings | Access to the shops

When asked what people would like to see more of in their area the top responses were:

Youth activities | Employment Opportunities | Sports and leisure

Community spaces & social groups

Community-centred approaches

Using a community-centred approach isn't a new idea. There are many different examples in Southampton where these approaches are being used to create positive change for people's health and wellbeing.

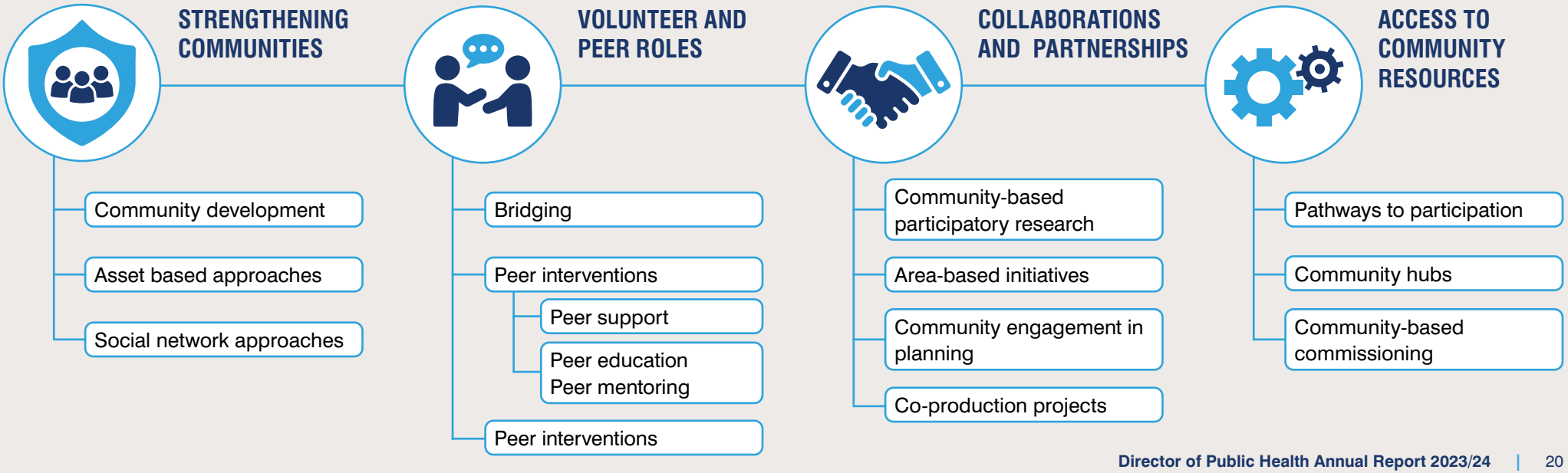
There is no single method for taking a community-centred approach. In 2015, Public Health England (later replaced by the Office for Health Improvement and Disparities) described a 'menu of options' or variety of project types that can be embedded in wider work and activities[1].

Broadly these project types cover 4 strands: those that strengthen communities, those that involve volunteer and peer roles, those that involve collaborations and partnerships, and those that provide access to community resources. The project type chosen will ultimately depend on the aim and resources available in each individual situation, and many projects will overlap multiple of these types.

While there is more work to be done to adopt and embed this approach across Southampton, this chapter highlights and showcases examples of good practice across our city.

Outside of Southampton, many other areas of areas of the UK have been using a community-centred approach to improve people's health and wellbeing. At the end of the next chapter, ten areas of best practice have also been identified and described.

THE FAMILY OF COMMUNITY-CENTRED APPROACHES



STRENGTHENING COMMUNITIES

These are projects that involve strengthening and empowering communities by building their capacity to be able to take action on health.

This would mean that communities at a local level are able to voice and identify their priority health issues and together help create and implement solutions, with the aim of creating supportive and healthy environments in which to live. They typically involve a combination of building community capacity, strong social networks for mutual aid, and community-led activities.

Outcomes

More confident active communities, increased social engagement, social support and extensive social networks.

Community Development Groups

SO:Links

Southampton Voluntary Services (SVS) facilitate communities working together through 'SO:Links' – their local community-led groups across our city. This approach brings local residents, volunteers, community activists, community groups, faith-based organisations, local health and council representatives, community navigators and social prescribers and a host of other people together based on postcode geography.

They are connections designed to share resources and information, both local and city-wide opportunities and help local people have a say in what they want to see in their area. Everyone has an opportunity to suggest themes or contribute to each meeting. They also enable communities to work together on new projects and initiatives, with support from others in the community and from 'SO:Linked' community development workers.

Facilitated by SVS, each community network is led in a different way as appropriate for the individual community.

The SO18 group for example, organise quarterly themed community breakfast meetings to allow agencies and community members to come together to share information and identify gaps in services. At the meetings, attendees get served a free breakfast and get a chance to listen to speakers, pick up leaflets, ask questions and make suggestions. Themes so far have included physical activities, support for unpaid carers, low-cost activities for young people, energy support and support with housing, debts and benefits.

Feedback from attendees has consistently been that these meetings are informative and promote joined-up working.

> "It is a great opportunity to network and meet other individuals and organisations who operate within a similar geographical area and who are also aiming to make a difference in the local community."
>
> "Has given me valuable contact information for representatives that I have met at these meetings and insight into what they do."
>
> "Avoid working in a silo, helps shape our vision to support those in our area without duplicating or competing with what already exists."

Asset Based Community Development

Energise Me Millbrook

Energise Me has been working with the Millbrook community in Southampton on what matters most to them. While improving how active residents were, was important for Energise Me, they recognised that this may be a long way down some people's priority lists, and instead started with the priorities of the community.

An asset-based community development (ABCD) approach was adopted, putting communities in the driving seat. From the start, Energise Me spent time understanding what goes on in Millbrook, identifying the assets of individuals, associations and institutions that form the community and stories from people they met.

Their first event – a party celebrating Millbrook at the Saints Pub– brought together people in the community who were already trying to make Millbrook even better. People at the event were given the space to voice things that mattered to them and that they wanted to improve, like having more things for young people to do and reducing anti-social behaviour in their green spaces. Following this event, the community assets were mapped – and it was found that while there were many assets that could facilitate people being active, they were not being used.

Multiple existing groups already in place, such as the Youth Activities and Health and Wellbeing groups, have been used to form a joint approach between organisations already working in the area and the community to share resources, working towards a joint purpose, and focusing on driving positive change.

Positive impacts arising from these collaborations have been:

- Community development training for local organisations including members of Millbrook Matters, who were inspired to take up an opportunity to visit Manchester and see another area's ABCD work first-hand
- Coordinated diversionary activity in response to high levels of anti-social behaviour, particularly at Halloween, reduced incidents from 48 in 2021 to 3 in 2023
- A dedicated housing association community engagement officer became entrusted and embedded, making positive impact within the community, although no longer in post
- Coordinated resident health and wellbeing survey distributed via door knocking with 50-60 responses, which found missing services and access points, and established the preferred methods of communication (a mix of online and offline)

Social Network Approaches

Men's Sheds

The Shirley Men's Shed aims to provide a safe space for (mostly) men to get together to create, converse and connect, thereby combatting loneliness and isolation, and in so doing help maintain and improve their mental health.

Men's Sheds are similar to garden sheds – a place to enjoy making and mending, however rather than working in solitude, Men's Sheds are about social connections, friendship building, sharing skills and knowledge, and laughter. Sheds bring health benefits by encouraging physical and mental activity, and improved wellbeing by providing a way to stay socially integrated in the local community.

The idea for a Men's Shed in Shirley was first discussed in 2018 by a group of like-minded people at St James Road Methodist Church. A committee was formed to take the idea forward, followed by an agreement between the Church Council to give permission to use a spare plot of their land for the building of the Men's Shed. Funding was raised through various fundraising events and grant applications including funding from the National Lottery.

Despite some delays and set-backs including those caused by the COVID-19 pandemic, the foundations for the Men's Shed were eventually laid in spring 2021, and the shed officially opened by the Lord Mayor in July 2022.

Since this time, the Men's Shed has gone from strength to strength. It has now grown to include around 40 members and has even needed to build an additional work shed and a storage shed to cater for new equipment and products made for sale at events and for requests.

The Men's Shed has been involved with projects from local schools and Southampton City Council to make items for environmental projects such as hedgehog boxes, planters, plastic bottle greenhouse etc. Several members have been involved in installing Spitfire plaques in various locations throughout Shirley. They have also supported members socially with trips to Solent Aviation Museum, Christmas meals, sales events and visits from local voluntary groups.

> "I have a long history of mental health issues and struggle to interact with people but find the camaraderie with the members at the shed help we with these struggles"
>
> "As I can no longer drive it enables me to meet new people, make friends and chat"

The Shirley Men's Shed is a registered charity and a member of the UK Men's Shed Association.

VOLUNTEER AND PEER ROLES

These are projects that focus on enhancing a person's capability to work in a paid or voluntary role within their own community to create change.

They would use their own lived experience, cultural knowledge, and social connections to provide advice, information and support. Or they may also organise activities around health and wellbeing. These roles would focus on reaching people who are most in need of support e.g. disadvantaged communities, those that are socially isolated, or with a health condition.

Outcomes

Volunteers may gain skills and self-confidence; communities may benefit from behaviour change, increased social support, or better management of health conditions.

Bridging Roles

COVID-19 Vaccine Champions

Two types of COVID-19 related champions were developed by Southampton Public Health Team as part of efforts to respond to COVID-19 pandemic.

The COVID-19 Community Champions initiative began in September 2020 and involved volunteers signing up to receive the latest information and advice about preventing the spread of infection and to feedback to the council about issues our community were facing, so the council could better respond to local need. This was achieved through weekly live briefings, drop-in sessions, email bulletins and social media posts. Anyone who wanted to volunteer was able to, without targeting specific groups or communities. In January 2022, there were 451 COVID-19 Community Champions.

The Vaccine Champions programme ran between February 2022 and March 2023, with funding from the Department of Levelling Up, Health and Communities. The purpose was to increase COVID-19 vaccination rates, particularly amongst communities and groups where vaccination uptake had been lower. The approach was proactive in engaging organisations linked to communities with large numbers of unvaccinated people through either grant funded work or information sharing. Engaging communities in delivery of specific elements of the outbreak response supported targeted work, and information sharing approaches have strengthened relations and provided valuable community insights.

A realist evaluation[17] found that the programmes (including Community Participatory Action Research, a case study included below) all drew from six underlying concepts to deliver meaningful engagement with communities:

- Building trust through community connections
- Fostering relationships and collaboration
- Provision of training and resources
- Local community knowledge and expertise
- Community representation and leadership
- Appropriate communication and information sharing

Peer-based interventions

Mind Peer Groups

Solent Mind run a total of 15 different peer support groups and workshops throughout our city to support people with their mental health and wellbeing. These include a combination of general community-based groups where anyone experiencing mental ill health is invited to join, and diagnosis-specific peer groups such as ADHD, PTSD, and Bipolar, which accept referrals from primary care and community mental health teams.

Each group is led by a peer – either employed by or volunteering for Solent Mind who has lived experience of mental health conditions. The groups ranging from 3-10 people are informal and are a safe space for members. Each group, has either discussion topics or activities around its theme, including a check-in, and chats with tea with biscuits.

Through these peer groups, members are able to share their experiences with others and gain support from people experiencing similar emotions and identification without judgement, as well as build longer term friendships and connections.

Solent Mind Peer Support run closed groups for people with severe and enduing mental health needs, who have often been isolated in their homes and not previously attended support in a group setting. In these groups members have made friends and grown a support network which continues outside of Solent Mind.

Each month Solent Mind's Peer Support Team run approx. 60 groups in Southampton which support on average per month around 162 people in their mental health and wellbeing journey.

Members of the groups collaborated to hold an art exhibition last October (2023) in Central Library for Mental Health Week.

> "Peer support has helped me learn more about myself and others. I have met the most wonderful people and true friends. Peer support workers and peers can understand each other on a similar level, as we can all relate to each other and share similar difficulties yet show strength in our ability to keep going after many setbacks and challenges faced."
>
> "Peer support has given me more confidence in myself and the hope and faith that things can get better. This is something I find so comforting"

Volunteer Health Roles

Communicare

Communicare offers a wide range of services that enrich the quality of life and reduce loneliness and isolation for people in Southampton. For example, their befriending service offers positive social relationships and peer support through regular voluntary contacts.

In 2023, Communicare's 300+ volunteers gave almost 20,000 hours of time and touched the lives of 821 individuals or families following 2,838 requests for their services.

Communicare offers personalised onboarding and regular information sessions for their volunteers, as well as a yearly conference for volunteers and board members to connect. They also facilitate "patch groups" for volunteers who live in the same locality to provide peer support and social connections.

Their work relieves loneliness and enriches people's quality of life.

> Me and Beth have been visiting Derek for a few months now and it has become a midweek staple to our routine. It has the comfort of feeling like we are visiting a friend, which in fact we are. We chat about lots of different things from what we've been up to in the week and how Derek's allotment is coming along to putting the world to rights and sharing stories of times gone by and our families…
>
> We'd recommend befriending to anyone who thinks they may enjoy it, as you will!

COLLABORATIONS AND PARTNERSHIPS

These projects involve working in partnership with communities in planning and shared decision-making.

Communities may be involved in any stage from identifying needs and agreeing priorities, to design and implementation or evaluation. Power sharing is an important part of these projects i.e. how much are professionals facilitating and empowering communities in decision-making?

Outcomes

Services and programmes better suited to real needs and better insight and intelligence; community members may gain skills, knowledge, and leadership opportunities.

Community-based Participatory Research

In 2021, Southampton started some Community Participatory Action Research (CPAR) to understand the impact of COVID-19 on our city's more vulnerable communities. Partners including Southampton Voluntary Services, The Young Foundation and local community groups worked together to enable local communities to identify what is important for them and what action is needed.

Altogether, 14 peer researchers were recruited into 5 projects. Community members then co-produced an action-plan based on their four main themes (1) communication and trust (2) green spaces (3) communities and institutions and (4) housing and transport.

Trust was built with our community organisations as the CPAR approach paid community researchers fairly for their time and gave communities valuable experience and skills (including free qualifications on offer from The Young Foundation).

An evaluation by the National Institute for Health and Care Research (NIHR) Public Health Intervention Responsive Studies Teams (PHIRST) said "representation and involvement of community members, establishing and building on trust, adequate training and resources, and clear communication from trusted community members and organisations are catalysts for meaningful engagement with communities".

Two of the five research organisations (Awaaz FM and We Make Southampton) have received additional funding, and their work continues to improve connections between professionals and communities.

Community-centred research

Building on from the early success of CPAR in our city, HDRC Southampton aims to give all residents the opportunity to influence what research is undertaken and to get involved in that research.

A vital principle of HDRC is to work with members of the public and local communities to ensure that we understand and address the issues that are their priority, and that the work is shaped with and by them.

There will be opportunities for local residents and community organisations to be involved in all stages of HDRC Southampton, including:

- Management
- Setting research priorities
- Co-producing research
- Disseminating findings
- Taking action, based on research findings, to achieve better outcomes for the city.

Area-based Initiatives

St Mary's Pilot

St Mary's is one of the most diverse and deprived neighbourhoods in Southampton, as described in 'a spotlight on St Mary's community' section of this report, and at the same time there is a strong sense of community and belonging in this locality. These are some of the key reasons why this area was chosen as a pilot for Southampton City Council's 'Community Prevention Transformation Programme'. The programme is described in Chapter 5.

The local community places strong value in preserving and better utilising St Mary's leisure centre for community needs. Using data, intelligence and insight from our community on needs and local assets, this pilot involves working with the community to better use this valued space to meet health and wellbeing, skills development and job opportunity needs.

The pilot is currently being scoped and linked to plans for an Integrated Neighbourhood Team within the same area. It will involve local partnership working between the council, NHS, voluntary sector and most importantly help shape a new way of working with our community within a locality. The aim of the pilot is to firstly enable our community to be empowered to control what is offered and how this helps them make changes to improve life chances and secondly ensure that assets are recognised and utilised to achieve this.

Community Engagement in Planning

Saints Foundation SO14 Active

Saints Foundation's SO14 Active (Active Through Football) programme encourages people within the SO14 postcode community to get moving with sports-based exercise sessions. This community is amongst the most deprived and ethnically diverse areas in our city with some of the lowest levels of physical activity.

The SO14 Active model worked with partners including Southampton City Council, Energise Me, Southampton Voluntary Services, Solent NHS Trust, and Hampshire Football Association to ensure the whole community has a voice in the development of the programme. Together they worked to understand the community's priorities and the contributions people were already making and would like to make in the future.

Several different engagement events were held, including one-to-one conversations, virtual world cafés and a programme of social listening. They also created an asset map that identified the businesses and physical resources, local associations, and institutions and, most importantly, the people who are great assets within our place.

SO14 Active now delivers a varied programme of sessions focusing on utilising local green and open spaces and is driven by community engagement.

An evaluation survey for the programme revealed that 53% of participants increased their weekly physical activity levels, 50% had improved their mental wellbeing and 25% increased their confidence they can achieve their goals.

> "I was given the opportunity to meet new people, have fun, being active and learn new skills"
>
> "Makes me happy and enjoy the exercise. Makes my body stronger. To know more friends."

Coproduction

SVS Teenage Girls in Parks

Southampton's Physical Activity Alliance is a collaboration of partners working together to implement the We Can Be Active Strategy[18].

The alliance has identified that teenage girls need more support to be active and that our city's excellent parks and open spaces do not always offer girls what they need. In response to this, members of the alliance worked with Southampton Voluntary Services (SVS) and academics from the University of Southampton (with support from The New Things Fund), to conduct a research project on coproduction with a focus on teenage girls using parks.

Recognising that coproduction means involving our community in the design and delivery of services, this project invited teenage girls to a workshop to give their views on the design of parks in their locality, how safe they feel in parks and what could be done to encourage use of parks. The workshop was led by representatives from two welcoming community groups (Monty's Community Hub and Veracity Life), known and trusted by many local people, who were able to create an environment for talking openly about the issues.

The girls had lots of ideas about new infrastructure, such as play equipment and picnic benches, and they were able to share these ideas through drawing and collage.

A second workshop was held with key stakeholders with experience in projects associated with parks and open spaces, community safety and health. This workshop was to get ideas for policy and service changes to better meet the needs of teenage girls.

The next steps are to develop an action plan, identify who has the capacity to be involved, and how additional resources are secured to create capacity.

Additionally, the findings from this work are being incorporated into a wider SVS project, 'coproduction corner', in partnership with HDRC Southampton, to develop co-production in our city. The first phase of this wider work has recommended planning welcoming and safe spaces to ensure meaningful interactions, training in coproduction skills, building in a strong ethics process and focusing on the 'so what'.

This work has also highlighted that co-production takes time in order to build trust, and that it is not a 'free' activity so resources need to be allocated appropriately.

ACCESS TO COMMUNITY RESOURCES

These projects focus on connecting people to community resources within the large and diverse voluntary and community sector

i.e. non-traditional providers, to meet a health need or improve wellbeing. This could be connecting to information, services, or groups through an established referral route.

Outcomes

Communities gain access to non-clinical solutions such as social support and increased awareness of voluntary and community sector resources.

Pathways to Participation

Community Roots

The Community Roots allotment project offers supported volunteering opportunities to adults living within Southampton who are recovering from mental health conditions, such as depression, anxiety or alcohol/ substance use issues.

People come to Community Roots through several channels. For example, there are regular contacts through partnership organisations such as Change Grow Live, the Society of St James and the probation service. As a social prescribing initiative people can also be referred to the project by social prescribers, health professionals and SO:Linked community navigators, as well as direct self-referrals.

The allotment is a calm, peaceful place to escape the distractions of everyday life.

It offers an opportunity to get some fresh air and exercise while regaining independence, building self-esteem and learning new skills.

Through the project, participants with non-clinical needs experience social connection through meeting new people and working as a team to grow, cook, and eat fresh produce.

Community Roots is one of four projects in Southampton involved in the Green Social Prescription Project, which means people are referred to the project from healthcare services.

Since October 2023, volunteers have given 600+ hours of time through Community Roots and have meaningfully impacted the lives of over 38 people in our city through projects that have connected people and supported residents and the local authority in making the most out of the allotment space available in our city.

“I love learning new things about plants, it really helps my well-being and is therapeutic”

“Healthy, open space and great for meeting new friendly people”

“Helps me get back into a routine, feeling more confident and gives me a positive feeling”

Community Hubs

Southampton Family Hubs

All families need support from time to time to help their babies and children thrive, whether that's from friends, family, volunteers, or practitioners. The ambition of Family Hubs is for every family to receive the support they need, when they need it. And that all families have access to the information and tools they need to care for and interact positively with their babies and children, and to look after their own wellbeing.

The Clovelly Family Hub is one of the seven family hubs in Southampton, and is situated in an area of need, supporting children living in Bevois, Bargate and Swaythling. It offers various universal and targeted groups, parenting programmes and one-to-one support. Through a collective effort they create a "one stop shop" for families, ensuring that all a family's needs are met, joining multiple agencies together from health, midwifery, speech and language, portage, and community organisations.

Staff are trained in numerous support needs, including infant feeding, parenting, SEND, perinatal mental health, and school readiness.

As well as providing support from the hubs, the team also goes out into our community to reach families who would most benefit, makes partnerships with community organisations, and has created satellite hubs within health settings. An example of this is the partnership created with health colleagues in the Nichols Town Surgery, which has enabled the team to raise awareness of the importance of childhood vaccination within culturally diverse communities in our city.

Evaluation data collected by the Family Hubs have shown through this approach they have been able to support more families living in the most deprived areas compared to those living in the least.

"I am so grateful for the help and support that we have received from the hub."

"The parent programme has improved my parenting and helped me to safeguard my children. I have a better understanding of my children's emotions and how to respond to them and meet their needs. I have learnt ways to speak with my children and adults."

"This support has been a life saver for me and my daughter. My daughter wouldn't be as social as she is now. Because of the group and the staff, I feel more confident and social"

"Having Satellite Family Hubs in the GP surgery has helped remove some of the barriers to access that some of our patients may have faced.

Our practice nurses have in the past felt stretched in baby clinic to complete immunisations and give the relevant advice in the time pressured environment. As partners with Family hub the nurses have been able to refer babies for support with education around breast feeding, weening community groups and advice with a trusted team.

This multiagency working has meant that both parties are able to support families better giving a timely service in a one shop stop and we feel privileged to have worked with the to provide this service to our patients"

Naomi Caldwell
Lead Advanced Clinical Practitioner, Solent GP Surgery

Community-based commissioning

Community Falls Prevention

Around one in three adults over the age of 65 will have at least one fall a year, with rates being highest in areas of deprivation in our city.

The Saints Foundation are the charitable arm of Southampton Football Club and provide mobility, strength and balance programmes delivered by level 4 postural stability experts, to those who have had a fall and/or who are at risk of having a fall. The service was designed with communities and there has been ongoing feedback from service users to shape priorities. Building on the commissioned service, the Saints Foundation have been able to secure funding from other sources to supplement the classes in place, including developing links and support for inpatients.

Community-based commissioning remains an aspiration in Southampton.

Within the **Community Prevention Transformation Programme,** a new more collaborative approach to procuring services has been proposed, that would work more closely with the local sector. This approach would aim to support the changing needs of communities, delivering more flexible outcomes-based services, that could adapt to residents' priorities.

BEST PRACTICE FROM OTHER AREAS IN UK

Many areas in the UK have already adopted and embedded working in a community-centred way to improve people's health and wellbeing.

We have identified and briefly described 10 areas of best practice from across the UK to learn more about what could be applied in Southampton, how existing community-centred approaches might be scaled up, and the impact this may have.

1. Wigan –

public services in Wigan went through a major transformation, based on the idea of building a different relationship with local people. This involved wide ranging changes from training all social workers in ethnography to start conversations with a 'blank mind' and focus on understanding, to creating a Communities Investment Fund to support community building, and new multi-agency 'huddles' across services to break down silos. The new approach to delivering services has become known as the 'Wigan Deal'. Wigan has seen an increase in healthy life expectancy, outpacing similar councils since the transformation and achieved greater financial stability, most notably in Adult Social Care.

2. Greater Manchester –

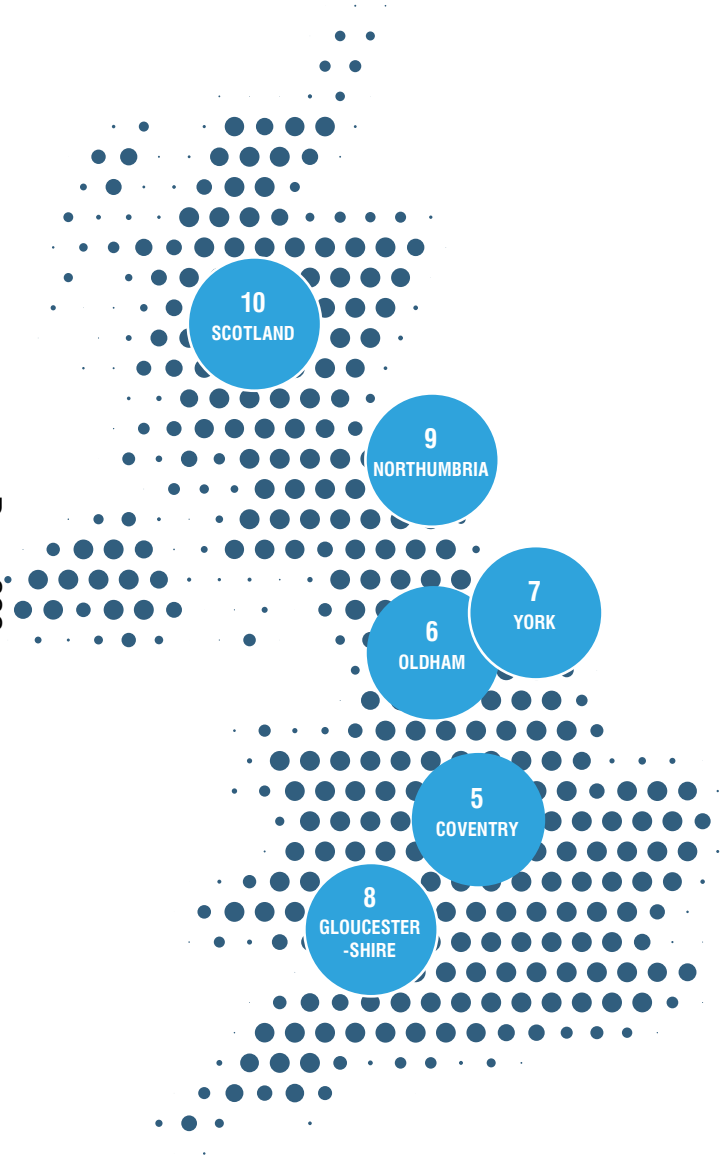
transformed their public services to work around individual neighbourhoods, breaking down traditional structures, and adopting an asset-based approach. Seven core principles were adopted across Greater Manchester, including shared decision-making and coproduction.

3. Barking and Dagenham –

created a new operating model for public services. Structures were redesigned around individuals rather than professions. A new culture was embedded to value different capabilities - empathy, trust, warmth, a deep understanding of services and networks, and to signpost and advice appropriately. New technology platforms were adopted to better collect and then use insight and to allow voluntary and community sector organisations to come in and support.

4. Leeds –

starting in the Adults and Health Department in the Council, ABCD was adopted then expanded across the whole city. The shared vision was that everyone should have the opportunity to contribute, be valued and involved, and for communities to recognise their assets, forge connections and make the changes they want to see. As a result, it was estimated that for every £1 invested in ABCD in Leeds, there was a £27.20 return on investment. Externals evaluators of Leeds ABCD work found three main outcomes – individuals and communities are better connected, communities could identify and work to bring about the changes they want to see, and people had good friends.



5. Coventry –
committed to taking an asset-based approach as a council as well as becoming a Marmot Place in 2013, adopting the 5 Marmot principles (covered in last year's Annual Public Health Report[19]). As a result of this work, Coventry has improved its ranking from 59th of all English LAs in 2015 for deprivation to 81st in 2019, whereas most other West Midlands LAs rankings worsened. The city also saw a 20% reduction in the number of neighbourhoods falling into the 'most deprived' IMD category and rises in average life expectancy of males and females over the same time-period.

6. Oldham –
worked with the shared framework for Greater Manchester to adopt asset-based working as their everyday approach. This includes creating a centralised Social Prescribing programme for the whole area. As a result, Oldham saw a reduction in A&E visits and GP appointments following implementation of the programme.

7. York –
has taken on ABCD to build wellbeing in the city. A key element of this approach has been local area coordination which involves a team of coordinators to support local people to build their own agency and capability and focus on assets in the community. This approach has been adopted in multiple delivery areas including Adult Social Care and Housing.

8. Gloucestershire –
began their journey to ABCD in 2010 starting with a core team and one charity, before scaling to the whole council and external partners. A community builder was employed, the Your Gloucester Community Fund created, ABCD was embedded into every council job description and the council plan, and contracts handed over to community groups.

9. Northumbia –
reformed services based on what matters to an individual, not specialisms. The aim was for public services to create conditions that enabled people to thrive, building individual capability.

10. Scotland –
shifted to an asset-based working through a range of projects, focusing on co-developing, community-led action to local priorities. A community-led action research programme supports real-time learning, at least 1% of council budgets are committed to participatory budgeting, and creation of citizen juries for shared decision-making.

For more information, please see the HDRC Evidence Review on Asset-Based Working in Local Authorities[19].

Conclusions

Much of what impacts health is influenced by the communities in which we live. Social networks and relationships within communities are important building blocks to good health.

Every community, and individual, has strengths and assets. Taking a community-centred approach is a different way of working to improve health and reduce inequalities, that builds from our communities' strengths and looks for the opportunities rather than focusing on need and what is missing. It aims to empower people and communities to have more independence and control in their lives and move upstream to generate health and prevent crisis points.

Southampton is a great place to live for many, however all is not equal.

Organisations that have a role in health and wellbeing have an important part to play in mobilising our communities' assets. This is through strengthening communities, building collaborations and partnerships, growing volunteering and peer roles, and improving access to community resources.

Many organisations in Southampton have been leading the way in terms of using this community-centred approach. From engaging with the SO14 community, to running peer-to-peer mental health support groups, to delivering community allotments for people with substance use issues. These projects demonstrate pockets of good practice in our city for others to learn from, and from which to scale.

Elsewhere in the UK, a community-centred approach has been used for some time to various extents. From being employed in stand-alone projects in Oldham, to integration into a whole council's way of working in Leeds, to full public service redesign and transformation in Wigan.

These areas of best practice can be used for valuable lessons of what works, what can be achieved, and how this way of working can be scaled up in Southampton for the benefit of communities.

Recommendations

Working in a different way with communities has the potential to deliver better health and wellbeing outcomes – for individuals, communities, and organisations in our city.

While Southampton has pockets of good practice in using community-centred approaches, there is much progress that can be made to scale up this work across our city.

Areas of best practice in the UK can be looked to for valuable lessons on how to grow and build on this approach to fully embed in Southampton, as well as national guidance on taking a whole system approach originally from Public Health England.

The recommendations set a framework for all of us working or living in Southampton to take forward to help embed a community-centred approach.

1

Identify strengths and enable communities to take control

Recognise everyone and every community as having something to offer, with strengths and assets to be revealed, and take steps to empower people and communities in decision-making to build independence and resilience.

This will involve moving away from viewing people as service users with problems to be solved to people and communities being co-creators of their own health.

HDRC Southampton offers a platform to help achieve this. It will involve our community in setting priorities for the research needed to inform decision-making. This programme also provides an opportunity to upskill local people in research methods, therefore, investing in our local residents and providing a pool of community researchers for future evidence building.

For example, through undertaking peer research to enable voices of those with lived experience to be incorporated into the evidence used in decision-making.

2

Build support around families, communities and neighbourhoods, not professions and focus on prevention and early intervention

Move to place-based working with communities at the heart, rather than working via professional specialisms/silos.

- Mobilise around communities and a joint goal.
- Create strong and trusted local partnerships that cross organisational boundaries – statutory, voluntary and community sector and communities themselves.
- Aim to break down silo working within departments and organisations and improve multi-disciplinary working.
- Co-commission at a community or neighbourhood level.
- Redesign systems to create the conditions for good health and to prevent crisis or intervene early.
- Prioritise factors that protect against poor health, improve wellbeing, and create health, rather than treating disease.

Recommendations

3

Prioritise communities with poorer health outcomes to reduce health inequalities and assess the impact of a community-centred approach

Through HDRC Southampton, make greater use of evidence, insight, data and technology to inform who is at greater risk of poor health.

- Use population health data to identify the issues creating health inequalities.
- Work with communities to identify their assets, to determine how to best support, and how to build and develop these assets.

In collaboration with partners, HDRC Southampton can support new and innovative approaches to evaluation such as combining quantitative measures with qualitative storytelling.

- Change what we measure to capture health and social outcomes that matter to people.
- Measure improving protective factors that help people avoid poor health outcomes, rather than only the poor outcomes.
- Include stories and a citizen voice, particularly from people from marginalised communities.

4

Shift mindsets to embed a different relationship between communities and organisations

Create organisational culture change to work in a different way - changing mindsets and beliefs.

- Train and upskill workforces to help develop behaviours, knowledge and skill set to have a different conversation with communities
- Bold leadership and commitment at every level to promote and give permission to change the way we work
- A strong narrative to explain and tell the story of why change is needed both internally and externally.

SOUTHAMPTON'S COMMUNITY PREVENTION TRANSFORMATION PROGRAMME

Our communities and links with services such as those delivered through the council can affect our health, wellbeing and ability to have control over our lives.

The Southampton City Council's Transformations Programme[20] for Community Prevention seeks to keep communities healthy and independent to prevent, reduce, and delay the demand for services or more complex interventions. It aims to give communities greater ability to improve health and wellbeing and have a say in what and how it is provided. There will be a stronger alignment of resource use with the assets within localities, including community assets and Integrated Neighbourhood Teams as these develop in Primary Care.

The programme will align a strong prevention approach with our community assets and priorities to improve life chances and reduce health inequalities across all age groups. This includes links to reducing crime, the impact of health threats and support for the growth and prosperity agenda. The focus is on laying the foundation for the future of public service provisions, in Southampton within a wider partnership approach to community prevention including local communities and organisations who work with them.

FINAL THOUGHTS

Taking a community-centred approach to health and wellbeing and reducing inequalities takes a leap of faith.

It requires a focus on changing the relationship services have with communities so that communities have more say and control over what makes a difference in their lives. In this way we can ensure best use of public sector money and improve outcomes at the same time.

This doesn't mean that we are not needs led and evidence informed in what we provide. Evidence on need, value for money and what works is crucial to make change happen. Saying that, without our community having a say in how we use this evidence and how we meet these needs together we will never achieve the benefits we are all looking for.

It also means valuing and enhancing the great assets communities bring and considering these as solutions to prevent ill health alongside other factors.

This 'culture change' is not easy, it'll take years to embed. This is why the **Community Prevention Transformation Programme** has a 10-year timeframe, starting with pilots to test opportunities to expand community-centred approaches in more deprived communities and higher risk groups of people. We need to ensure our long-term commitment is incorporated into our city's strategic aspirations with recognition that we achieve this with as well as for our local communities.

Progress on past Recommendations

Dr Debbie Chase
Director of Public Health,
Southampton City Council

My last two Annual Public Health reports[21,22] considered the policy areas for action to reduce health inequalities in Southampton,

firstly with a focus on the breadth of policy actions and last year with an in depth look at good work and fair employment. Actions from both reports are long term ambitions that I and many others hold for our city. Progress will be required over many years to achieve the reductions in deprivation and inequalities that places such as Coventry have demonstrated to be possible.

Last year, I described that we had secured a number of the foundational leadership commitments required for us to take meaningful action to reduce health inequalities, including the commitment to embedding health in all policies. I explained that evidencing progress against the core indicators identified to measure progress in reducing health inequalities would take time and sustained effort in the face of changing need. This included sustained progress in establishing a different relationship with communities. There is a risk that improvements in our relationship with communities will stall after the fantastic work developed during COVID-19, hence the focus of this year's report.

I have seen progress against recommendations from last year's report on Good Work and Fair Employment. This has included the focus on work and health in our large city employers and advice for small to medium sized enterprises. There are examples of good practice in our anchor institutions, but more benefit could be achieved for our local population through their role as purchasers, employers, building owners and partners. For longer term gain, good work and fair employment will form a key element of the city's growth and prosperity planning.

The progress against the previous two year's recommendations is clear, and I have made further recommendations this year so that our communities form a strong building block for good health. With time and sustained focus, we can expect to see measurable impact against the key measures of inequality.

Glossary

Anchor Institutions
Large organisations rooted in the city that can have a significant impact on the community as purchasers, employers, building owners and civic partners. E.g. Universities, hospitals, councils and large private sector firms.

Asset-based approach
Methods that identify and mobilise the assets of individuals, communities and organisations to enhance capabilities and address health inequalities.

Asset-Based Community Development (ABCD)
A specific methodology, developed in the US, that focuses on creating social change by identifying and building assets within a community. It places emphasis on strengthening relationships within communities and on community-initiated activities.

Children in need
Defined by the Children Act 1989, relating to a child being unable to achieve or maintain a reasonable standard of health or development without provision of services from a local authority or is disabled.

Community
A group of people who have common characteristics or interests, defined by geographical location, race, ethnicity, age, occupation, a shared interest or affinity, or other common bonds.

Community asset
These include community associations, local services, informal groups and networks, physical and economic resources, and the skills, knowledge and commitment of residents.

Community-centred approach
Methods that mobilise assets within communities, promote equity, social connectedness and increase people's control over their health and lives.

Deprivation
In health and social care, deprivation usually refers to lacking income, employment, education, or health, having barriers to housing or services, or could relate to higher local crime levels, or quality of outside space.

Economically active
People over 16 years old in employment or unemployed but looking for work and could start within two weeks or waiting to start a job that had been offered and accepted.

Equity
All groups in society achieving health outcomes that are as good as those for the most socially advantaged group. Some groups may need additional help due to their circumstances to achieve those same health outcomes.

Green Flag Award
The benchmark international standard for publicly accessible parks and green spaces in the United Kingdom and around the world.

Indices of Multiple Deprivation (IMD)
The official measure of relative deprivation covering seven different domains (see Deprivation) for small areas in England

Inequality
Avoidable differences in health outcomes between groups or populations such as differences in how long we live, or the age at which we get preventable diseases or health conditions.

Glossary

Integrated Neighbourhood Teams (INT)
Bring together multi-disciplinary professionals from different organisations across health and care services.

Public Health England (PHE) / Office for Health Improvement and Disparities (OHID)
An office within the Department for Health and Social Care responsible for health improvement, prevention of poor health, and health inequalities. PHE ceased operations in 2021 and OHID was established.

Marmot Place
A place that recognises health and health inequalities are mostly shaped by the social determinants of health: the conditions in which people are born, grow, live, work and age, and takes action to improve health and reduce health inequalities.

Neighbourhoods
Neighbourhood-level analysis refers to Lower Layer Super Output Areas (LSOAs), which is a census geography area. There are 152 LSOAs in Southampton and there is an average population of 1,500 people per LSOA.

Quintile
A value that represents one fifth (20%) of a given population. The first quintile represents the lowest fifth of the data. The last quintile represents the highest fifth of the data.

Ward
An area within a local authority used for electoral purposes. There are 17 electoral wards in Southampton.

Voluntary, Community, and Social Enterprise Sector (VCSE)
An umbrella term for a range of different organisations working with a social purpose. Also commonly known as the third sector or the charity sector.

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