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Health and Wellbeing Board

Wednesday, 27th November, 2013
at 5.30 pm

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Shields (Chair)
Councillor Bogle
Councillor Baillie
Councillor Lewzey
Councillor McEwing

Rob Kurn – Health Watch
Alison Elliott – Director of People
Dr A Mortimore – Director of Public Health
Dr S Townsend – Clinical Commissioning Group (Vice Chair)
Dr S Ward – NHS England Wessex Local Area Team

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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 City Council's Priorities:

- **Economic**: Promoting Southampton and attracting investment; raising ambitions and improving outcomes for children and young people.
- **Social**: Improving health and keeping people safe; helping individuals and communities to work together and help themselves.
- **Environmental**: Encouraging new house building and improving existing homes; making the city more attractive and sustainable.
- **One Council:** Developing an engaged, skilled and motivated workforce; implementing better ways of working to manage reduced budgets and increased demand.

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
    - Ensuring safety in improving health and wellbeing outcomes

Smoking policy – The Council operates a no-smoking policy in all civic buildings.
Mobile Telephones – Please turn off your mobile telephone 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.
Proposed Municipal Year Dates

2013	2014
23 October	29 January
27 November	26 March

CONDUCT OF MEETING

BUSINESS TO BE DISCUSSED

Only those items listed on the attached agenda may be considered at this meeting.

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 "personal" or "prejudicial" interests they may have in relation to matters for consideration on this Agenda.

DISCLOSURE OF INTEREST

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

DISCLOSABLE PERSONAL 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 fo 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 a, '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

Agendas and papers are now available via the Council's Website

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 DISCLOSURE OF PERSONAL AND PREJUDICIAL 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.

3 STATEMENT FROM THE CHAIR

4 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 23rd October 2013 and to deal with any matters arising, attached.

5 INTEGRATED TRANSFORMATION FUND UPDATE

To note the joint report of the Chief Executive, Southampton Clinical Commissioning Group and Director of People, Southampton City Council providing an update on the progress towards developing a local plan for integrated working and the development of a pooled budget, attached.

6 SOUTHAMPTON SAFEGUARDING ADULTS BOARD ANNUAL REPORT

To consider the Independent Chair's Annual report for Southampton Safeguarding Adults Board, attached.

7 SAFE CITY AND YOUTH JUSTICE STRATEGY

To consider the report of the Director of Public Health, for the Board to identify any relevant implications arising from the 2013/14 Safe City Plan and Youth Justice Strategic Plan, attached.

8 PUBLIC HEALTH SOUTHAMPTON : PROGRESS OF ARRANGEMENTS FOR HEALTH EMERGENCY PLANNING AND HEALTH PROTECTION

To note the report of the Director of Public Health, detailing progress on the arrangements for health emergency planning and health protection, attached.

9 UPDATE FROM THE CHAIR, HEALTH AND WELLBEING BOARD

To consider the report of the Chair of the Health and Wellbeing Board providing an update to the Board, attached.

Tuesday, 19 November 2013

HEAD OF LEGAL AND DEMOCRATIC SERVICES

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 23 OCTOBER 2013

Present: Councillors Baillie, Bogle, Lewzey, McEwing and Shields
Andrew Mortimore, Dr Steve Townsend, Dr Stuart Ward and Rob Kurn

Apologies: Alison Elliott

13. **DISCLOSURE OF PERSONAL AND PREJUDICIAL INTERESTS**

Councillor Shields declared a personal interest in that he was a member of Healthwatch England and a Council appointed representative of Solent NHS Trust and remained in the meeting and took part in the consideration and determination of the items on the agenda.

Councillor Bogle declared that she was a Council appointed representative of University Hospital Southampton NHS Foundation Trust and remained in the meeting and took part in the consideration and determination of the items on the agenda.

Councillor Lewzey declared that he was a Council appointed representative of Southern Health NHS Foundation Trust and remained in the meeting and took part in the consideration and determination of the items on the agenda.

14. **STATEMENT FROM THE CHAIR**

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

RESOLVED that the Minutes of the meeting held on 14th August 2013 be approved and signed as a correct record.

16. **THE NHS COMMISSIONING LANDSCAPE**

The Board received and noted the report of the Medical Director, NHS England, Wessex Local Area Team outlining the major elements in the NHS commissioning landscape following the Health and Social Care Act 2012 which resulted in a major re-organisation of the NHS.

The Board also received a presentation from Dr Stuart Ward, Medical Director, NHS England providing an overview of the organisation in both its national and local role.

Mr D Smith and Ms J Freelander representing “Southampton Keep our NHS Public” were in attendance and with the consent of the Chair addressed the meeting.

The Board particularly noted the following points:-

- That public accountability to NHS England would be via the national Board however from a local perspective in relation to the area teams there was an expectation that Healthwatch would be utilised to represent the public voice.
- Commissioning Support Units (CSU’s) were hosted at “arms length” by NHS England.
- NHS Property Services Ltd owned the Royal South Hants (RSH) Hospital site; NHS Property Services Ltd was the landlord and took instruction from the

Clinical Commissioning Group as commissioners. The transfer of the RSH site had taken place within a legacy document from Primary Care Trusts to Clinical Commissioning Groups. The Clinical Commissioning Group made clear that the RSH was a key strategic site and would continue to be supported and developed. NHS Property Services as landlords had a responsibility to maximise and utilise estates; the RSH was utilised and as such the Clinical Commissioning Group were supportive of the transfer to NHS Property Services and as commissioners were comfortable as to the future of the RSH was not under threat as they could helpfully control access to facilities.

- Plans for vascular services in the area were being finalised by the Clinical Senate and would be published within the next week.

17. **SEASONAL PLAN 2013/14**

The Board received and noted the report of the Director of System Delivery, Southampton City Clinical Commissioning Board detailing key aspects of the 2013/14 Seasonal Plan. It was noted that organisations were required to develop seasonal plans, particularly for winter to ensure business continuity and contingencies were in place for times of exceptionally high demand for local services.

Jane Hayward, Chief Executive of University Hospital Southampton NHS Foundation Trust was in attendance and with the consent of the Chair addressed the meeting.

The Board particularly noted the following points:-

- This year's readiness for a seasonal surge and clinical risk was more evenly spread throughout the Health system.
- Robust plans were in place for surge, escalation and preparedness.
- A non recurrent local fund of £3¼ million had been put in place this year, most of which had been allocated. All parties had created a change and resilience programme to facilitate the fund and changes that would want to be embedded for the future. A full evaluation would be needed of the impact of the change and resilience programme through the winter. Whilst a challenging winter was still to be faced this year it was considered that organisations were better prepared and there was better partnership working.
- Joint working with Health and Social Care was taking place to improve social care packages and domiciliary care which were longer term projects anticipated to be in place April 2014 onwards.
- £10k had also been put in place this year to facilitate patients leaving hospital and returning home.
- Capacity issues in nursing homes was an issue in discharging patients from hospital, this was currently being reviewed by Systems Chief's to see whether places that had been suspended could be opened up together with resolving longer term capacity issues by such things as re- enablement packages which would take investment and would need to be identified within existing budgets.

18. **UPDATE ON USE OF FUNDING TRANSFER FROM NHS TO SOCIAL CARE IN 2013/14**

The Board received and noted the report of the Chief Executive, Southampton City Clinical Commissioning Group and Director of People, Southampton City Council providing an update on the use of funding transfer from NHS to Social Care in 2014. It was noted that the March meeting of the H&WBB had agreed proposed priorities for the

use of the funding transfer and which were based on the priorities within the Joint Strategic Needs Assessment and existing commissioning plans for both health and social care which had been used to inform the allocation of funding.

The Board noted that within the priority outcomes key areas for development were peer support to develop focus on self management and reduce incidence of relapse, development of extra care services for those with dementia and complex health needs and substance misuse prevention and early treatment.

19. **UPDATE ON INTEGRATION TRANSFORMATION FUND IMPLEMENTATION**

The Board received and noted the report of the Chief Executive, Southampton City Clinical Commissioning Group and Director of People, Southampton City Council providing an update on the integration transformation fund implementation and providing details of timetables and procedures for developing pooled budgets. It was noted that the Local Government Association had issued new information as of 17th October 2013 in relation to the fund key aspects which were:-

- Performance Related Funding
  £1 billion (locally approximately £4.6m) of the integrated transformation fund in 2015/16 would be dependent of performance and local areas would need to set and monitor achievement of these outcomes during 2014/15. NHS England would be working with central Government on the details of the scheme but it was anticipated it would consist of a combination of national and locally chosen measures. 50% of the pay for performance element would be paid at the beginning of 2015/16, contingent on the H&WBB adopting a plan that met the national conditions by April 2014, and on the basis of 2014/15 performance. The remaining 50% would be paid in the second half of the year and could be based on in-year performance.
- Finances
  Expectations were that £2bn nationally would come from savings in existing spending on acute care. Requirements of the fund were likely to significantly exceed existing pooled budget arrangements, councils and CCG's would therefore need to redirect funds from activities to shared programmes that delivered better outcomes for individuals. Local areas may choose to add to the fund to achieve larger whole scale change.
- Stakeholder Engagement
  There was a need to engage from the outset with all providers, both NHS and Social Care, likely to be affected by the use of the fund in order to achieve the best outcomes for local people. A shared view of the future shape of services would need to be developed, there would also need to be an assessment of future capacity requirements across the system.

The Board particularly noted the following points:-

- The integrated transformation fund was not new money, it was money transferred from health to local authorities under a S75 agreement.
- Plans would need to be signed off by H&WBB's.
- Finalised financial figures would not be available until December 2013; currently everything was based on estimates.
- This fund would provide opportunity to review services and provide differently.
- A 5 year overarching plan would be required however it would be a 2year plan that would need to be submitted for the remainder of the 2015/16 funding

- There would be focus groups to ensure stakeholder engagement which would be separate to any budget consultation processes.
- The scale of the challenge of the integrated transformation funding was huge and would be a cultural change; colleagues would need to be supported through the processes.
- The time period for delivery of this was very short particularly given the scale of change and the pace that was needed.

20. **PROPOSAL TO JOIN THE SMOKEFREE ACTION COALITION**

The Board considered the report of the Director of Public Health detailing a proposal to submit an application on behalf of the Council to join the Smokefree Action Coalition (SFAC), the national campaign network for tobacco control. The SFAC had over 100 member organisations across the country representing health, social care, trading standards, environmental health and many other parts of civil society. Membership was free to local authorities, provided many benefits, and sent a strong message of the Council's commitment to tackling tobacco control. Smoking remained the main cause of preventable deaths in England, and was a major cause of health inequalities.

RESOLVED that the Health and Wellbeing Board submit an application on behalf of the Council for membership of the Smokefree Action Coalition.

21. **UPDATE FROM THE CHAIR, HEALTH AND WELLBEING BOARD**

The Board received and noted the report of the Chair of the Health and Wellbeing Board detailing actions taken and correspondence to the Chair since the August meeting of the H&WBB.

DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		UPDATE ON INTEGRATION TRANSFORMATION FUND IMPLEMENTATION		
DATE OF DECISION:		28TH NOVEMBER 2013		
REPORT OF:		CHIEF EXECUTIVE SOUTHAMPTON CCG AND DIRECTOR OF PEOPLE		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Stephanie Ramsey**	**Tel:**	**023 80296941**
	E-mail:	**Stephanie.ramsey@southamptoncityccg.nhs.uk**		
Director	**Name:**	**Alison Elliott,** **Director of People SCC** **John Richards,** **Chief Executive SCCCG**	**Tel:**	**023 80832602** **02 380296923**
	E-mail:	**Alison.elliott@southampton.gov.uk** **John.richards@southamptoncityccg.nhs.uk**		
STATEMENT OF CONFIDENTIALITY				
None.				

BRIEF SUMMARY

The aim of the Integration Transformation Fund (ITF) is to provide an opportunity to transform care so that people are provided with better integrated care and support, the main focus being on development of high quality, co-ordinated care for frail older people and those with long term conditions.

To access the ITF there is a requirement to develop a local plan by March 2014, which will need to set out how the pooled funding will be used and the ways in which the national and local targets attached to the performance-related elements will be met. This paper outlines the progress in developing the plan.

RECOMMENDATIONS:

(i) That the progress towards developing the local plan for integrated working and the development of a pooled budget be noted

REASONS FOR REPORT RECOMMENDATIONS

1. Plans for the use of the pooled monies will need to be developed jointly by the Clinical Commissioning Group and local authority and signed off by each of these parties and the local Health and Well Being Board by March 2014.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. Options for use of the ITF will be developed as part of the planning process. The options will identify how the funding streams already coming into the

CCG and SCC, that are badged under the ITF, can be redesigned to achieve integration priorities

DETAIL (Including consultation carried out)

3. Progress in plan development

A project plan was shared with the Board as part of the Project Brief Document in October. This paper outlines progress in achievement of the plan. The first stakeholder workshop is being held on 21 November 2013 and so an update from this event will be reported verbally at the meeting.

4. Priorities to be delivered through the ITF have been identified by the working group as:

- Greater service/organisational integration
- Implementation of shared care planning and system/s at scale
- A much stronger focus on prevention and identifying need earlier (risk stratification)
- A significant shift towards more person centred care across the whole system
- A significant shift in resources and activity to an out of hospital model

5. Benchmarking and horizon scanning

Work is underway to review local and national practice in relation to integration and to build this into local planning. Elements of this will be shared at the stakeholder workshop on 21st November. Torbay has been highlighted as a national exemplar of successful integration. A lead from Torbay will be presenting at Southampton's second stakeholder event on 12 December and also acting as a critical friend in the development of Southampton's local plan.

6. Definition of Strategic Intent

The ITF is identified as a way to achieve integration as defined in 'Integrated care and support: our shared commitment' (2013). This is described from the perspective of the individual – as being able to "plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me".

7. The evolving vision to transform current provision over the next 5 years is to create an integrated health and social care system that:

- Ensures that people are encouraged by those services they have contact with to maintain their health and wellbeing and use the opportunities and resources available to help them to be as independent as possible and reach their full potential.

- Supports people to recognise that they or others need help by providing information that helps them to assess what they need and decide what to do next.
- Provides easily accessible information for parents and carers to help them to proactively support, and where necessary advocate for the person they are caring for.
- Undertakes integrated needs assessment and risk profiling using professional judgement and data which enables the early identification of need and proactively seeks to meet this need in a preventative way.
- Develops effective and efficient cross agency ways of working that deliver timely and coordinated support by the right people in the right place that help people to achieve their full potential and be as independent as possible.
- Ensures that on-going help, if required, places the person at the heart of the planning process, is of a high quality and encourages choice, self-reliance, and anticipates future need.
- Ensures carers are supported to maintain the effective role they play in supporting individuals.

These key outcomes will be further refined and developed throughout the plan development.

8. Scope

Work has been progressed to undertake a high level scoping exercise of the potential provision that may be included in the ITF and how these resources might relate to the wider system. Services partially or wholly funded through Social Care Transfer, Reablement and Carers Break funding will automatically form part of this early scoping activity as these funding streams will form part of the developing ITF. However the opportunity to pool other health and local authority resources to support the delivery of the ITF agenda is also being considered.

9. Initial scoping work has identified a number of key “high level” functions that are important for effective integrated working. These findings will stimulate some of the discussions at the stakeholder event :

- Interagency identification of individuals with complex needs who would benefit from a more targeted approach – this will involve developing integrated systems that identify early the group of adults the agenda is looking to target.
- Locality based multi-agency planning and case management – this includes the concept of a lead professional or care coordinator/navigator
- Integrated Crisis response – bringing together crisis response services from across the system
- Integrating reablement and rehab services that can have both a “step up and step down” function to prevent hospital admission or support earlier discharge
- Proactive and integrated discharge processes – Co-ordination that starts

as soon as person enters hospital

- Remodelling of community support/stronger role for voluntary & community sector; embedding of personalisation approaches
- Information points and how these relate to "front door" services.

  7-day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

10. The workshop will also begin to define a set of shared values between agencies and stakeholders in order to take this work forward.

11. Financial modelling

Early modelling on current activity and spend, with a focus on reducing length of acute stay, has been undertaken to assess the possibility of shifting resources to a community based model. Some opportunities have been identified but further modelling is to be undertaken.

Financial models being considered include Year of Care tariff that has been piloted by West Hampshire CCG to try to determine an "average" cost for a patient with long term conditions and also a Reablement Tariff. These models are currently being reviewed .

12. Consultation and stakeholder engagement

A stakeholder engagement plan has been updated and is attached in Appendix 1. Two main stakeholder workshops have been set up for 21 November and 12 December.

RESOURCE IMPLICATIONS

Capital/Revenue

23.

£1.9 billion existing funding continued from 14/15 this money will already have been allocated across the NHS and social care to support integration	
£130 million Carers' Breaks funding	£350 million capital grant funding (including £220m of Disabled Facilities Grant).
£300 million CCG reablement funding.	£1.1 billion existing transfer from health to social care.
Additional £1.9 billion from NHS allocations Includes funding to cover demographic pressures in adult social care and some of the costs associated with the Care Bill. Includes £1 billion that will be performance related, with half paid on 1 April 2015 (which we anticipate will be based on performance in the previous year) and half paid in the second half of 2015/16 (which could be based on in year performance).	

The Integration Transfer Fund (ITF) does not come into full effect until 2015/16 but it is expected that Clinical Commissioning groups (CCGs) and Local Authorities build momentum in 2014/15, using the additional £200m due to be transferred to LAs to support transformation. This is assumed to be transferring from CCG baselines but this is still to be confirmed. In effect there will need to be two-year plans for 2014/15 and 2015/16, which must be in place by March 2014.

2014/15 will be a lead in and planning year. 2015/16 full level of funding will be released.

Property/Other

24. To be determined as part of the planning work

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

25. NHS England Publications Gateway Ref 00314 outlines the initial details of the Integration Transformation Fund.

Detailed guidance will be included in the NHS Planning Framework once issued. NHS England and the LGA and ADASS will work with DH, DCLG, CCGs and local authorities over the next few months on the following issues:

- Allocation of Funds
- Conditions, including definitions, metrics and application
- Risk-sharing arrangements
- Assurance arrangements for plans
- Analytical support e.g. shared financial planning tools and benchmarking data packs.

Other Legal Implications:

26. None

POLICY FRAMEWORK IMPLICATIONS

27. This will impact on SCC and CCG Commissioning intentions

KEY DECISION? Yes

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Stakeholder Engagement Plan

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	Yes – will be developed as part of the planning process

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

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

Integration Transformation Fund
Stakeholder Engagement Plan

Stakeholder	Aim	Means of Communication	When	Who	Notes
Primary Care	To ensure that primary care are engaged and at the heart of developing the local plan	GP Forum	28th November 6.30pm	Sue Robinson	
		General Assembly	10th December 1.30pm	Sue Robinson/Mike Ruse	
		TARGET	13th November	Mike Ruse	As part of a general session on IPCC
		West Locality Meeting	6th November	SRob/Steve(JS/DC/AL)	
		East Locality Meeting	21st November	MikeR/ (JS/DC/AL)	
		Central Locality Meeting	7th November	DJP/ (JS/DC/AL) James Rimmer	
Public and Patients	To ensure public and patients understand the strategic intent and are able to contribute their thoughts and experiences to the development of the model. To explore co-production approaches.	Equality Reference Group	12th November 6pm		
		Patients Forum	3rd December 12:00		
		Comms and engagement group	17th December 15:00		
		Carers Group and other groups from DB – DC forwarding	16th December 2.30 pm		

Local Authority Staff	To ensure LA staffs are engaged and are able to contribute their thoughts and experiences to the development of the model. Need for LA buy in	Leadership group	26th November	SR	Standard presentation and questions
		CMT	12th November	SR/DC	
		DMT	13th November	DC	
Councillors/members in the Local Authority	To ensure high level buy in	Cabinet Member briefing Dave Shields/Cllr Jeffrey	15th November	Cllr Shields/Steve/DC/AL/JS	
Solent NHS Trust Staff	To ensure Solent staff are engaged and are able to contribute their thoughts and experiences to the development of the model Need for community provider buy in	Management & Staff meetings (via VP Board rep)	26th November	DC/AW meeting	Standard presentation and questions
		Executive review meeting	5th November	SR	
Southern Staff	To ensure Southern staff are engaged and are able to contribute their thoughts and experiences to the development of the model	Individual Management & Staff meetings (via VP Board rep)	5 November	Chris ash/SR meeting	Standard presentation and questions
		Executive review / strategic exchange meeting	5th December	Carole Binns	Meeting held with Sue Harriman and SR 31/10/13

	Need for community provider buy in				
UHS Staff	To ensure hospital staff are engaged and are able to contribute their thoughts and experiences to the development of the model Need for acute hospital provider buy in	Individual Management & Staff meetings (via VP Board rep)	TBA	TFG member (DC/AL/JS)	Standard presentation and questions
		Executive review/strategic exchange meeting	8th November	SR	
MPs	To ensure MPs engaged and supportive of proposals	Individual meetings	13th January	JR/ST/AL/JS/DC	Standard presentation and questions
All Stakeholder workshops	To ensure wide scale engagement, contribution and buy in to the model	Workshop in **November** to confirm vision and explore scope/opportunities	21st November 9:00-13:00 Holiday Inn	DC/SRob	Standard presentation and questions
		Workshop in **December** to consult/challenge draft model	12th December 13:00 to 15:00 Holiday Inn	DC/SRob	Standard presentation and questions
Voluntary and Community Sector	To ensure VCS engaged and are able to contribute their thoughts and experiences.	JSNA and other meetings from DB	13th November	DB	Standard presentation and questions

	To support VCS market development and co-production				
Health Watch	To enlist support in engagement of wider audience and co-production.	Attendance at Healthwatch meeting	TBA	DB	Standard presentation and questions
HOSC	To ensure HOSC supportive of proposals.	Presentation to Panel	21st November	SRam/SRob	
Integrated Commissioning Board (Chief Officers)	To ensure high level buy in and commitment.	Discussion at ICB meetings	13th December	SRam	
LMC	To ensure LMC support	Discussion at LMC meeting	2nd December meeting with LMC in Steve's diary 9:00-10:30	Steve T/Jamie Schofield	Standard Presentation of questions

DECISION-MAKER:		HEALTH AND WELL BEING BOARD		
SUBJECT:		SOUTHAMPTON SAFEGUARDING ADULTS BOARD ANNUAL REPORT		
DATE OF DECISION:		27 NOVEMBER 2013		
REPORT OF:		INDEPENDENT CHAIR – SOUTHAMPTON SAFEGUARDING ADULTS BOARD		
CONTACT DETAILS				
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BRIEF SUMMARY

This report outlines the work being undertaken by Southampton Safeguarding Adults Board (SSAB) to coordinate strategic and operational multi agency working to ensure the safety of adults at risk in Southampton.

RECOMMENDATIONS:

(i) the committee notes the report

(ii) the committee requests yearly reports on the work of the SSAB

REASONS FOR REPORT RECOMMENDATIONS

1. SSAB interface with the Health and Well Being Board will support cross agency engagement and collaborative working in safeguarding

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3 To fail to report on the work of the SSAB would reduce opportunity for effective strategic engagement around the adult safeguarding agenda with a key partner.

DETAIL

4. SSAB is a multi agency committee of senior representatives from adult social care, health commissioners and providers, police, housing, community safety, criminal justice, voluntary organisations and service user group representatives. Its remit is to prioritise and coordinate the strategic development of adult safeguarding across Southampton and to provide governance and assurance on the safety of vulnerable residents locally. It does this through 3 main areas of activity

- Coordinating what is done by each agency to ensure the safety and well being of adults at risk

- Providing governance on the effectiveness and outcomes of the work being done across agencies
- Ensuring awareness of adult safeguarding across the community to support both prevention and early identification of safeguarding issues

The 2012/2013 annual report of the SSAB is attached in Appendix 1. Key activity and outcomes of the Board and details the priorities for action for the coming year are highlighted below.

5. Since the publication of the last annual report the operational arrangements of the Board has changed in response to the proposals in the Care Bill. The first Independent Chair was appointed in September 2012, Terms of Reference have been rewritten and membership reviewed. A multi agency budget has been identified for the first time. A “real life” agenda item has been introduced to ensure Board members are in touch with the realities of day to day practice issues. The cross Hampshire safeguarding policy and procedure has been reviewed as has the procedure for serious case reviews which will in future use a systems learning approach.

6. A key focus for the Board has been the development of an integrated performance management report. Whilst this report will require further work in the coming year it gives the Board the tools to scrutinise the quality and impact of adult safeguarding practice deployed by all agencies.

7. Adult safeguarding has been subject to significant level of national scrutiny in the last year with the exposure of the abuse at Winterbourne View Hospital and the Francis report on the excessive deaths at Mid Staffordshire Hospital. The SSAB has scrutinised the local response to these issues and will continue to do so. The action plan developed in response to a serious case review commissioned in 2011 and a domestic homicide review have also been subject to Board scrutiny throughout the year.

8. Prevention and awareness raising has continued with activities such as the development of appropriate safeguards in the vetting of providers to be part of the “Support with Confidence” website, work by Trading Standards to develop no cold calling zones and the development of a public education leaflet. A risk panel has been set up to support choice, control and appropriate risk taking in care arrangements. Keeping safe guides have been developed for service users.

9. Joint working arrangements at operational level locally are good and there has been work throughout the year to continue to improve these, particularly with community safety casework services, with the fire service around fire safety needs of vulnerable adults, who are more likely to be victims of fire death, and with trading standards for a number of individuals targeted as repeat victims of financial abuse.

10. Staff development continues to be a focus and programmes have been developed for staff in response to specific needs such as a safeguarding awareness training pack designed to be cascaded to a wider audience and a Health Providers forum.

11. The safety of contracted services is an important focus of work for the Board. A best practice in care audit checklist has been launched and training for

voluntary and independent providers has included a Managing Safely course which has been well attended.

12. Service user feedback tool has been developed to audit the experience of individuals subject to safeguarding processes in Adult Social Care. This will be rolled out to other key agencies next year.

13 Over the next year the SSAB key priorities for work includes

- Continuing to develop strategic links with partners such as GPs, Health Watch, the Crown Prosecution Service and the Police and Crime Commissioner.
- Strengthening the voice of adults at risk in determining the work of the Board and hearing of their experiences of safeguarding
- Developing the performance and governance information available to the Board, undertaking audits of specific areas such as the use of CA12 police alerts on individuals who are considered vulnerable and audit the NHS decision making in raising concerns and in safeguarding action
- Work to embed and develop safeguarding operational practice such as ensuring fire safety action plans are in place in all appropriate cases, developing the use of the police "safety net" system to highlight addresses of adults at risk and introduce the well being trigger tool
- Continue to focus on staff development working across Hampshire to develop a training and development strategy and integrating provision of training

RESOURCE IMPLICATIONS

Capital/Revenue

All of the work described will be undertaken within the identified SSAB budget provided by Police, Clinical Commissioning Group and Adult Social Care on pro rata basis

Property/Other

There are no other implications

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

As described in "No Secrets" guidance 2003 the local authority is required to take the lead agency role in ensuring effective arrangements are in place to secure the safety of vulnerable adults in Southampton.

Other Legal Implications:

N/A

POLICY FRAMEWORK IMPLICATIONS

N/A

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Southampton Safeguarding Adults Board Annual Report

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

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

Southampton Safeguarding Adults Board

Annual Report 2012 – 2013

Agenda Item 6

Appendix 1

Foreword by the Independent Chair

I am delighted to provide this foreword to Southampton's Safeguarding Adults Board (SSAB) Annual Report for 2012/13. I was appointed as the Independent Chair of SSAB in September 2012 and chaired my first SSAB in November 2012. My role is: to provide informed support and challenge to the work of all agencies working with adults at risk in Southampton; to ensure that the SSAB operates effectively (setting clear, evidence informed, priorities for multiagency working and driving progress towards meeting those priorities and targets); to commission Serious Case Reviews where needed (and to ensure that any recommendations are enacted by SSAB members); and to ensure that the SSAB contributes effectively to broader work and other partnerships devoted to the wider safety and wellbeing of adults at risk. As an independent chair, my role is to add value to the quality and impact of safeguarding adults partnerships and practice locally, focussing clearly on the best interests of adults at risk. It is with this independence in mind that I write this foreword.

Throughout 2012/13, the SSAB has operated within a context of significant systems change and funding pressures. These have affected all agencies working with adults at risk in Southampton. Of particular note, the level of structural and systems change that has taken place across the NHS over 2012/13 has been enormous. The city's Primary Care Trust and the Strategic Health Authority covering Southampton have been abolished and replaced by a GP led Clinical Commission Group and new commissioning support arrangements. Southampton City Council assumed new responsibilities for public health in this period and created a People Directorate from its previously separate children and adults departments. Hampshire Constabulary has appointed its first Police and Crime Commissioner. New partnership working arrangements have accompanied these changes. Of most particular note, Southampton's Health and Wellbeing Board has a duty to produce a health and wellbeing strategy for the city (that will improve people's health and wellbeing and reduce health inequalities), ensure that the Clinical Commissioning Group retains and meets local public health priorities and, most recently announced, review and approve the local plans for the new integrated health and social care fund that will be available for 2014/15 and 2015/16. Throughout 2012/13, therefore, many of the agencies in Southampton responsible for safeguarding adults have been subject to wholesale change and transition. This has inevitably been accompanied by changes in personnel (including membership of the SSAB) and governance systems.

The SSAB has also been acutely aware of the significant financial stress that all member agencies have experienced throughout 2012/13. It is factually accurate to say that, nationally, local authorities have been cut earlier and harder than the rest of the public sector – and this is true also of Southampton. But the NHS, the police and the fire and rescue service in Southampton have also experienced unprecedented levels of financial pressures – with significant budget reductions in the Hampshire Constabulary and the Hampshire Fire and Rescue Service as well as very challenging efficiency targets for all local NHS organisations. Equally, the voluntary and independent sector organisations who work with adults at risk in Southampton (whether as campaigning organisations or as service providers) have seen grants reduced (or even removed altogether) and fee levels held at previous year's rates, regardless of inflation. For the SSAB, therefore, these budget cuts and pressures have meant that agencies have had to interrogate every aspect of their investment in safeguarding adults work, ensuring that maximum value and impact is derived from every pound and penny spent. It is testament to the priority given to safeguarding adults at risk by all SSAB members that we have already identified and agreed our multiagency budget for 2014/15.

Of course, also throughout 2012/13, safeguarding adults has been subject to significant public scrutiny and policy change nationally. The horrific abuse of adults at risk, perpetrated by staff at Winterbourne View Hospital, and exposed by the Panorama programme in May 2011, created a national outcry of outrage and derision. In responding to the Winterbourne View Hospital Serious Case Review and its own internal inquiries, the Department of Health issued revised statutory guidance to the NHS and local authorities. Amongst other things, this guidance marks a radical change in commissioning practice across health and social care and the SSAB has been scrutinising local plans developed in response to the Department of Health requirements. The Francis Report into the poor care and excessive deaths of patients using Mid Staffordshire NHS Foundation Trust services has also resulted in key new policies, procedures and practices designed to safeguard adults at risk including a "duty of candour" across all health professionals. As a consequence, the SSAB has undertaken a key piece of work this year to develop and implement a comprehensive integrated performance management system. This will be completed in 2013/14, but the SSAB is already better able to scrutinise the quality and impact of safeguarding practice deployed by different agencies, not just adult social care as previously.

All told, 2012/13 has been an exceptionally busy year for the SSAB and I am very grateful for the support I have been given in my role as independent Chair, especially by Sue Lee, Eleanor Wilson and Carol Valentine. This 2012/13 Annual Report is grounded in the key questions issued by the Association of Directors of Adult Social Services and the Local Government Group in late 2011:

1) How do you demonstrate that people's lives are improved as a result of safeguarding? Are they and do they feel safer and are their circumstances improved?

2) Has safeguarding (and dignity) been subject to some form of independent scrutiny or checking? What has changed as a result?

3) What can you tell your local population about the quality and safety of local services – Personal Assistants, care at home, care homes and hospitals etc?

4) What can you tell your local population about police and criminal justice sectors' responses to safeguarding?

5) How is your SAB demonstrating its effectiveness?

(Local Accounts: Safeguarding - Advice Note for Directors).

These are the key questions which, in our duties and responsibilities as the SSAB, we must deliver transparency and critique. I commend this Annual Report to you.

Dr Carol Tozer
Independent Chair
SSAB

9 August 2013

1. What is driving change in the safeguarding agenda in Southampton?

1.1 Since the publication of the last annual report, there have been many and significant changes in the adult safeguarding arena. For example, the Care Bill proposes to place Safeguarding Adults Boards on a statutory footing and contains a number of clauses relating to the protection of adults who are subject to abuse and are unable to protect themselves. The Care Bill not only formalises the local authority's duty to lead adult safeguarding but it also recognises the pivotal role played by Safeguarding Adults Boards by putting them on a statutory footing:

- Local authorities will be responsible for establishing and running Safeguarding Adults Boards.
- Boards must co-ordinate and ensure the effectiveness of what each of its members does.
- The local authority, Clinical Commissioning Group and chief officer of police must be core members (Boards have the power to determine other appropriate members).
- The Board must publish a strategic plan each financial year setting out how it will protect people at risk of harm and what each member is to do to implement the strategy.
- At the end of the financial year the Board must publish an annual report on its achievements, members' activity and findings from any Safeguarding Reviews during that period.
- It must consult its area's Health Watch and involve the community in preparing the strategy.

1.2 In March 2013. the Association of Directors of Adult Social Services published advice and guidance which outlines a clear framework for the on-going development of and improvement in safeguarding services including the role of local safeguarding adults boards. The following priorities are highlighted:

- personalised safeguarding by focusing on people and the outcomes they want;

- Collaborative leadership as the key to cross agency engagement and effectiveness in the safeguarding agenda;

- Effective interfaces with Health and Wellbeing Boards, Community Safety Partnerships, Safeguarding Children Boards, etc.;

- Access to responsive specialist services so that there are a range of responses and options to support people with difficult decision making;

- Proportionate safeguarding so that our systems are not swamped and we do not miss the really serious concerns;

- Fully integrating commissioning, contracts management, care management review and safeguarding intelligence;

- Availability of good quality local services which prevent abuse and afford people dignity and respect;

- Access to criminal and/or restorative justice so that some people get extra support to challenge and change harmful or abusive situations, and arrange services and supports that meet the outcomes they want and

- Effective preventative work and early intervention to address risks before they reach crisis point.

1.3 There have also been a number of high profile scandals such as Winterbourne View and Mid Staffordshire highlighting critical failings in care and the safeguarding systems designed to protect vulnerable service users. The reports into both of these make far reaching recommendations for adult safeguarding which emphasise the need for joined up risk management and intelligent commissioning.

1.4 In 2012/13, the Hampshire 4LSAB local Multi Agency Safeguarding Adults Policy and Procedures were reviewed and updated with the new version being published in July 2013. The updated Hampshire 4LSAB local Multi Agency Safeguarding Adults Policy and Procedures are informed by national best practice and local learning. They provide a clear focus on the need for safeguarding responses to be led by the person affected e.g. "*no decision about me without me"*. It also highlights the range of community safety contexts where abuse may be happening such as 'mate crime', so called honour based violence, human trafficking, exploitation by extremist radicalisers, etc. The Policy focuses on promoting a culture of positive risk taking where individualised support can be offered and choice and control is maintained by the individual. It provides tools to ensure proportionate response to risk and enhanced practice guidance such as managing self neglect. The Policy is based on the principles of:

- *Empowerment and a presumption of person led decision making*
- *Protection by providing support for those in greatest need*
- *Prevention by taking action before harm occurs*
- *Proportionality by making the least intrusive response to risk*
- *Partnership by services working with their communities*
- *Accountability through accountable and transparent service delivery*

2. How do we operate as Safeguarding Adults Board in Southampton?

2.1 SSAB leads a commitment to improve outcomes for people at risk of harm and is a standing committee of senior/lead officers within adult social care, health, housing, community safety, criminal justice, voluntary organisations and service user representative groups. Its remit is to agree objectives, set priorities and co-ordinate the strategic development of adult safeguarding across Southampton. The SSAB safeguards and promotes the welfare of adults' significant risk through three main areas of activity:

- Co-ordinating what is done by each agency represented on the Board for the purposes of safeguarding and promoting the wellbeing of adults at risk in the area of the authority;

- Ensuring the effectiveness of what is done by each such person or body for that purpose and

- Increasing community involvement and awareness of Safeguarding Adults to ensure the principle that 'Safeguarding is Everybody's business' is promoted.

2.2 In September 2012, an Independent Chair was appointed to lead the SSAB. Since this appointment, a number of steps have been taken to improve the effectiveness of the Board including a review of membership to ensure representatives have sufficient seniority and authority to make commitments and decisions on behalf of their organisation; introduction of the 'Real Life' case study as the first agenda item at Board meetings to provide immediate focus on effective partnership working to secure positive outcomes for service users; use of impact analysis reports to evaluate the difference made as a result of partner agencies' implementation of recommendations arising from Serious Case Reviews and finally, the introduction of Board Development Days. SSAB members are now asked to complete an evaluation following each meeting and the information gained is used to improve the management of the meetings.

3. Who are adults at risk in Southampton?

3.1 Our safeguarding adults' arrangements emphasise the importance of keeping the safeguarding effort focused on working with the person being harmed and to support improvement in their safety and wellbeing. Our local safeguarding arrangements are designed to support an adult who:

1) has needs for care and support (whether of not the local authority is meeting any of those needs),

2) is experiencing, or is at risk of abuse or neglect, ***and***

3) *as result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.*

3.2 In 2012/13 285 number of people in Southampton were identified as at risk and requiring support under local safeguarding adults' procedures. Of these only 12 were repeat referrals during the year. Compared to last year, this represents a decrease of 17 (5.0 %) in the number of people referred. We have analysed referrals received locally and can see that compared to other similar local authorities our referral rates for 2011/12 are lower than average by nearly 40 per cent. The most common form of abuse reported in 2012/13 was Financial followed by Physical which is not consistent with other similar local authorities.

3.3 In terms of safeguarding referrals related to care and support services, there has been a small increase compared to the number received last year. In 2012/13, a total of 280 safeguarding alerts were received from a broad range of sources including adult social care and NHS professionals, care providers, Care Quality Commission, relatives, etc. Unsurprisingly, the main type of concern reported was neglect/acts of omission (221 cases) but there was also an increased number of physical abuse referrals (35) where I the main a staff member was alleged to be responsible. The 280 safeguarding alerts related to 83 separate providers (including Acute, Community and Adult Mental Health NHS services). A number of important trends have emerged from the analysis of the provider safeguarding interventions and these include poor standards of nursing competencies, poor management and leadership, poor governance, difficulties in recruiting good calibre staff and poor organisational culture. The number of providers referred together with the repeating pattern of concerns is concerning given the relatively small geographic area covered by Southampton. This clearly indicates the need for continued quality assurance and service improvement work within commissioning and contracts teams across agencies.

3.4 In order to better protect local people at risk, SSAB has recognised the importance of effective risk management and of engaging people in their own risk management in order to prevent risks escalating to the point of crisis. SSAB has asked local agencies to focus on timely preventive support and early intervention. For example, Adult Social Care holds regular multi disciplinary Risk Panels to which local professionals can make referrals if they are concerned about a person at risk in order to develop a risk management plan.

3.5 SSAB has recognised that the number of safeguarding referrals received provides only a narrow window to understand the nature and prevalence of risk/harm experienced by local vulnerable people and for this reason, it has recently introduced an Integrated 'Adults at Risk' Monitoring Tool. The information provided will enable a more realistic picture to emerge

and will, over time enable SSAB to monitor the effectiveness of a wide range of processes aimed at safeguarding local people and to target preventive work in key areas based on the intelligence provided.

3.6 SSAB recognises that learning from experience is the key to improving the safety of adults at risk locally. To that end, the Board commissioned a report on the circumstances surrounding the tragic death of Mr A. It developed a robust action plan to improve practice locally and has evaluated how actions have improved safety of vulnerable adults locally. Adult safeguarding was represented on the Domestic Homicide Review Panel regarding Miss Y. The Board also recently reviewed the report and recommendations arising from the report and will be ensuring that action is taken over the next year to improve safety for those at risk of domestic abuse. During 2012/13, there been four serious case review referrals relating to Southampton residents. None of these resulted in a serious case review being commissioned by the Board as the chronologies provided highlighted that the cases referred did not meet the criteria. However, where chronologies highlighted potential learning, further actions were taken for example, by SSAB commissioning an overarching review of cases in one local NHS trust to identify trends and root causes regarding a number of suicides and another NHS Trust undertaking a trend Serious Incident Requiring Review (SIRI) into a number of serious safeguarding concerns raised regarding one of its services.

4. What difference does our safeguarding services making to the lives of local people?

4.1 The following section provides a number of case studies to illustrate the positive impact good safeguarding can have on the lives of people at risk or in vulnerable situations. They show that effective outcomes are achieved by offering personalised safeguarding which focus on the individual and the outcomes they want. An underlying theme in a number of the case studies is the importance of effective prevention and early intervention work to avoid risks escalating to the point of crisis. However, where a safeguarding intervention is necessary, the case studies illustrate the importance of effective information sharing and partnership working in order to make proportionate responses at the lowest level of intervention possible to manage the presenting risks. The case studies also show that often safeguarding is often a gateway for people to get the extra support and services they need to manage their own risks and to achieve the outcomes they want.

Making a Difference: safeguarding against financial exploitation

Information was reported to police of regular, high value cash withdrawals being debited from a 76 year old vulnerable customer's account. The account holder was elderly and being cared for by two family carers and there were also concerns about the person's welfare. Initial safeguarding actions were taken. The accounts were frozen by the bank and the Police led a planned arrest operation working in conjunction with adult social services which provided an emergency placement in a local care home for the elderly person. The carers involved were arrested. During the investigation it became clear that one of the carers had been abusing the trust and confidence of his elderly relative and had withdrawn £4400 in a month to spend on personal items having recently lost their job. As part of the safeguarding process, an allocated social worker assisted the elderly client to attend the bank and gain access and control again over his banking. In May 2013 the offender received 4 months imprisonment suspended for 2 years, 60 hours unpaid work and was ordered to pay back £4400 in compensation.

Making a Difference: early intervention and supporting people to manage their own risks

Steven is 71 years old and was living in his own 3 bed house which was subject to possession proceedings for mortgage arrears. He also had multiple debts. Concerns were raised about a number of people who had befriended Steven staying at his property and to whom he gave money. Items were reportedly stolen from the house which had no electricity and was in a state of disrepair. Steven was described as having a chaotic lifestyle having little money to live on because when his pension was paid into the bank it was swallowed up by his overdraft. A safeguarding referral was made and through this process, housing support staff helped Steven find suitable supported accommodation. Eventually, Steven secured a 60plus flat which included an emergency alarm cord. On-going 60plus support was provided until the remaining issues were resolved. Steven felt much more positive about the future as moving to the flat was a fresh start.

Making a difference: safeguarding against 'mate crime'

James is 40 year old and lives in supported housing. He has a diagnosis of paranoid schizophrenia and has a long history of solvent abuse. James is in regular contact with the community mental health and substance misuse teams. Support staff became concerned about James' drug use after used needles were found in his room as he was not known to inject substances. On questioning he said his friends were visiting him and that he would buy some drugs which they would use. Also, his 'friends' would inject him with some substance in return for him buying all the drugs. James didn't know what he was being injected with. Staff made a safeguarding alert and James was actively involved in the subsequent safeguarding process. His drug screen was positive for heroin and benzodiazepines and whilst James was assessed as having the capacity to make decisions about his use of illicit substances and allowing other people to inject him, staff were able to talk to him about the risks and consequences posed. As a result, James decided to reduce and then stop his drug use and to limit the amount of money he was prepared to spend on himself and others. There was a marked improvement in James' engagement with services which helped him obtain clean needles and syringes for injecting and a sharps box for safe disposal of his drug equipment. Improved security at his accommodation discouraged his 'friends' and drug dealers from visiting him and he noticed an improvement in his financial situation as a result. James has now stopped using heroin or injecting substances, and although he still occasionally uses solvents or legal highs, the level of his drug use has decreased. James decided not to pursue drug rehabilitation services at this time and has chosen to remain at his accommodation. He has begun to attend the cinema regularly but is no longer in regular contact with his drug dealers or 'friends'.

Making a difference: keeping people safe in care settings

A safeguarding alert was received into the Safeguarding Adults Team regarding a local nursing home highlighting a wide range of serious issues and practices which if true, were placing residents at significant risk. These included:- medication being used without prescription; inadequate/inappropriate wound care for pressure ulcers; unsafe moving and handling practice; insufficient staffing levels for the dependency levels of the residents; nursing competencies not being assessed; care not reflecting dignity for residents. In view of the seriousness and number of concerns raised, placements into the service were suspended whilst the Safeguarding Adults Team worked with the service to ensure the safety of the residents. More safeguarding concerns were uncovered during the investigations which led to daily monitoring visits being carried out by the Safeguarding Adults Team. Multi agency assessments and reviews were carried out on all residents which identified that a small number of residents were at significant risk because the service was consistently failing to meet their needs. The Safeguarding Team led a multi-disciplinary review process (involving social workers, specialist nurses, consultants and GP's) to decide if a move to alternative accommodation was in the best interests of each of the residents concerned. The resident themselves and their families were involved in the decision making. Six people moved to an alternative care home. This approach gave the nursing home more capacity to meet the needs of the remaining residents. It worked with the Safeguarding Adults Team throughout the process and significant progress was made to improve practice and the residents' wellbeing. The safeguarding process was completed once the nursing home could evidence that the improvements it had made had been sustained. As a result of this intervention, the nursing home is now considered to provide good quality and safe care for residents.

5. Review of the SSAB Business Plan 2012/13

5.1 2011, SSAB produced a Business Plan detailing key priorities and objectives for 2011/14. During the year, SSAB has received regular updates on progress. The mechanism for delivering Business Plan objectives is through the work of Sub Groups or Task and Finish Groups which will focus on tackling specific aspects or tasks within the Business Plan. Whilst these groups are co-ordinated by the SSAB Board Manager, there is an expectation that Board Members and/or their representatives will either lead and/or actively participate in these work streams. Last year a wide range of such groups were set up covering topics such as Fire Safety, Integrated Dashboard, Safety Net, Multi Agency Thresholds Audit, User Feedback, Community Safety etc.

5.2 In order to achieve consistency across Hampshire in safeguarding policies, procedures and practice guidance the four Hampshire local safeguarding boards meet on a regular basis and undertake joint work. For example, in 2012/13 we jointly reviewed and updated the local Multi Agency Safeguarding Policy which was published in June 2013. The Policy now contains pan Hampshire practice guidance covering a range of topics such as Managing Self Neglect, NHS Safeguarding Investigations, Safeguarding in Provider Services, etc. This collaborative approach between the 4LSAB's is important not only from a consistency point of view but also for agencies either with a county wide remit or where they work with more than one of the Hampshire local authorities.

5.3 Progress against the current SSAB Business Plan is highlighted below:

What we said we would do	What we did
Effective governance to deliver better outcomes for adults at risk.	
Review of SSAB Terms of Reference and Board membership.	SSAB Terms of Reference were revised. A Constitution and Member Handbook was produced outlining role requirements for members. Board membership was revised to ensure senior representation from key agencies.
Review of chairing arrangements and improvements to management of meetings.	A jointly funded Independent Chair has been appointed. A standardised meeting agenda and report template have been introduced. A 'Real Life' case study is the first agenda item placing immediate focus on effective partnership working to secure positive outcomes. Meetings follow a standardised agenda and are evaluated.
SSAB Peer Audit and Self Audit	A LGA Peer Review was planned for 2013 but has been deferred until 2014. However, a collaborative audit was undertaken in 2012 by SSAB to assess how the board was functioning in the light of the ADASS/LGA Standards and Performance Framework. An organisational self audit tool was introduced to assist partner agencies develop their safeguarding.
Scrutiny arrangements and links with key strategic partners	Regular reports have been made to the SCC Overview and Scrutiny Panel. Links have also been established with the Health and Wellbeing Board and Health Watch. SSAB is represented on the LSCB and has established links with the Safe City Partnership which now includes a section on safeguarding adults.

What we said we would do	What we did
***Prevention and awareness*:**	
Links with Support with Confidence.	Work has been undertaken with the Support with Confidence scheme to ensure appropriate safeguards have been built into the operation of the scheme.
On line information about adult safeguarding.	A new on line abuse reporting process has been set up and the SCC Safeguarding Adults website has been updated.
Publication of publicity and information raising awareness of safeguarding awareness and how to report concerns.	Co-production of a safeguarding public leaflet which has been distributed across the County. A Wellbeing Tool has been drafted and will be published in the autumn 2013.
Tacking financial Abuse	Trading Standards have delivered 34 presentations to target groups. 30+ active No Cold Calling Zones have been established. 270 reports of consumer complaints relating to mass marketing fraud (lottery, prize draws, directory entry etc) were responded to together with 118 reports of consumer complaints relating to doorstep crime cold called doorstep sales).
Wellbeing Trigger Tool	The content, contact details and referral processes have been identified. However it has not been possible to translate this into a useable tool without the allocation of resources. It has been identified that this task was also being pursued by a third sector organisation and additionally had been commissioned from Capita. It will be necessary therefore, to link the work of these strands. This will be included in the SSAB Priorities for 2013/14.

What we said we would do	What we did
Prevention and Awareness	
Southampton Voluntary Services	SVS has continued to highlight safeguarding adults to the voluntary sector as part of its support and advice role. It has briefed the sector on the new Disclosure and Barring Service & has hosted a well attended 2 days regional training for counter signatories with Disclosure and Barring Service. specialists. In 2012/13 SVS had the umbrella CRB checking role which ended in July 2013. Now SVS, in partnership with a private sector provider, facilitates online checks for local groups wishing to use the Disclosure and Barring Service.
Effective joint working:	
Clear information about the range of community safety casework services and clear links and referral routes between community safety casework services and adult safeguarding.	A Community Safety Resource Pack has been published explaining all community safety casework services and referral routes. A Community Safety training module has been developed and delivered to Adult Social Care. Training on safeguarding adults has been provided to Community Safety staff.
Adult safeguarding in the Safe City Plan.	Adult safeguarding issues are included in the current Safe City Plan.
Clear protocols between Adult Social care and Police Central Referral Unit (CRU).	The CRU now screens all CA12's prior to sending these to SCC. This has led to a decrease in the overall number of CA12s being raised and the quality and relevance of the reports has improved. A SSAB priority for the coming is to implement a joint triage process. An Audit will take place in the autumn 2013 to review what is referred by agencies to ensure that process is picking up cases appropriately.

Effective joint working:	
Fire Safety	HFRS and ASC have developed a process for responding to the fire safety needs of people at risk or in vulnerable situations. Fire safety has been built into the initial assessments undertaken by domiciliary agencies' when they set up a care package. HFRS has introduced an on line referral form. Training has been provided by HFRS to carers.
Community Safety	In 2012-13, there were 219 Anti Social Behaviour (ASB) incidents involving vulnerable victims of which 102 were identified as at being 'high risk'. There 109 ASB Multi Agency Risk Assessment Conferences (MARAC) held. 483 people were referred for a Domestic Violence MARAC, of which 94 were repeat cases. 140 hate crime incidents were reported to SCC (130 of these were reports of graffiti.) No Hate Crime MARAC's were held. No PREVENT referrals have been received.
Tackling financial abuse	Trading Standards has identified thresholds, drafted referral criteria and are signed up to receive CA15 reports direct from Hampshire Police. Access to PARIS is required in order to create a problem profile to ensure that Trading Standard's response is accurately targeted to maximise positive outcomes. Trading Standards has undertaken safeguarding interventions for 5 people identified as repeat victims of financial abuse. Trading Standards has established a Memorandum of Understanding with Hampshire Constabulary to receive CA15 reports re financial abuse.
Safety Net pilot – using address to flag safeguarding concerns.	The preparatory work has been undertaken for a pilot study which will be included SSAB Priorities 2013/14.

What we said we would do	What we did
Effective Joint Working	
Risk Panel	ASC has established a Risk Panel to respond to the needs people at risk or in vulnerable situations but who may not meet the threshold for interventions under safeguarding procedures. Operating to agreed terns of reference and referral criteria the Risk Panel has reviewed 40 cases high risk cases (falling sort of safeguarding thresholds) and agreed a risk management plan for each during 2012/13. The Risk Panel is a collaborative process and involves partner agencies.
Human Trafficking	ASC provided a rest centre during Operation Helm in which the police removed a number of people believed to be at significant risk, from a local traveller site. This work led to a member of ASC staff receiving an award from the Chief Constable. Links have been made with the Salvation Army, who is the Home Office approved local provider.
PREVENT	Southampton has established a multi agency 'Channel Panel' to respond to people at risk of radicalisation. Hosted by Community Safety, Adult safeguarding is represented on this panel. No PREVENT referrals were received in 2012/13.
Domestic Violence Homicide Reviews (DHR) integrated into safeguarding process	The Community Safety Partnership has implemented a clear process for conducting DHR's. SSAB was included on a recent DHR and the resulting report was presented to SSAB in 2013.

What we said we would do	What we did
Clear legal, policy and professional framework for staff:	
Review and update the 4LSAB local multi agency Safeguarding Policy and Procedures.	The Hampshire 4LSAB Safeguarding Policy and Procedures was reviewed and an updated version was launched in June 2013. The Safeguarding Policy reflects best practice and national/local developments. The Policy and related practice guidance is available on the intranet and internet. This policy now contains a section on practice guidance that has been adopted Hampshire wide and in a number of cases, reflects guidance developed in Southampton.
Revise training programmes and materials in light of revised 4LSAB Safeguarding Policy.	Revision of training programmes and materials has not yet been completed but will be included in the SSAB Priorities 2013/14.
Develop a 4LSAB wide Information Sharing Protocol	A joint information sharing protocol is included in the 4LSAB Safeguarding Policy and Procedures.
Develop and launch a local Self Neglect policy and practice guidance.	SCC has published a Managing Self Neglect Policy and related practice guidance. A staff training module has also been developed and included in the Modular Safeguarding Training Programme. This policy has now been adopted by the other Hampshire local authorities. Solent has produced internal guidance on Supporting Clients who Self Neglect which has been ratified by the NHSLA group. This is accessible to all staff via the internet.

What we said we would do	What we did
Provider organisations safeguarding policies	
Southampton Voluntary Services	SVS is updating its safeguarding adults' policy in line with the latest Hampshire 4LSAB guidance and once approved, will be disseminate across the sector as a model for other groups to use.
NHS providers	The Hampshire NHS Consortium has developed a decision making thresholds tool to guide NHS staff on making safeguarding referrals to the local authority. This mirrors other NHS thresholds developed in other regions. The draft went out for consultation in October 2012 and is now ready to be piloted by Solent, Southern Health and Southampton University Hospital trust. Solent will be piloting the tool in the Portsmouth area to evaluate the effectiveness of the tool. In 2013/14, SSAB will be commissioning an audit from the NHS Trusts of concerns raised and the decision making regarding referrals to local authority safeguarding teams.
Skilled, competent staff:	
Programme of safeguarding workshops for managers.	In 2012/13, a series of multi agency safeguarding workshops for managers was held and delivered by nationally recognised subject experts. Topics included Managing Self neglect and Safeguarding and the Law. There was good cross sector representation on all the seminars. A programme for the coming year has been agreed for the coming year.
Increase uptake from partner agencies on the multi-agency Safeguarding Modular Training.	Attendance from partner agencies on the SCC Safeguarding Modular Training has remained very low. This is possibly because agencies deliver their own in house training (NHS providers) or they buy into course run by HCC.

What we said we would do	What we did
Skilled, competent staff:	
Support the safeguarding awareness training of front line staff and provide partner organisations	A cascade safeguarding awareness training pack has been developed and is available to partner agencies to assist with their in house training. Various cohorts of SCC frontline staff have attended safeguarding adults training such as financial assessment officers and community safety staff.
Undertake a review of the Training Strategy in 2012.	The review of the Safeguarding Training Strategy has not been completed but will be included in the SSAB Priorities 2013/14.
Offer professionals forums to discuss safeguarding practice	A Health Providers Forum has been set up to allow cross sector learning and development of cross sector polices and processes. However, a professionals' forum in ASC has not been set up.
Safeguarding in Social Work Education	In 2012/13, SCC delivered the Safeguarding Unit on the Post Qualifying Social Work course at Solent University and provided input on the Social Work degree course.
Pilot National Competency Framework for Safeguarding.	This has not been completed but will be included in the SSAB Priorities 2013/14.

What we said we would do	What we did
Prevention and safeguarding at the centre of personalised services	
Outcome statements	SSAB has agreed a set of statements against which to measure outcomes in safeguarding. Work is in progress to have these adopted by the Hampshire 4LSAB's to provide consistency and synergy for partner agencies with a county wide remit.
Risk Panel to support staff.	The Risk Panel has met regularly and of the 40 cases referred, a significant number relate to direct payment holders.
Develop "Keeping Safe" and "How to Guides" for direct payment holders and keeping safe" template for personalised support plans	These have been produced via Spectrum CIL. 'Keeping Safe' included in Support Plan template in Adult Social Care.
Establish process for Direct Payment users to access DBS checks for personal carers.	Not completed but will be included in SSAB Priorities 2013/14.
Develop mechanisms for privately employed carers to access training and development.	Funded training and development opportunities are available e.g. via Skills For Care. This information is promoted nationally and is locally targeted to individual employers through the Direct Payment Support Service Contract that SCC has with Spectrum CIL.

What we said we would do	What we did
Facilitate informal networks for Direct Payment holders *Provide workshops for Direct Payment users to support them in their role as employer.* *Develop Financial Abuse Guidelines (to reflect ACPO guidance).*	3 x Peer Support Group sessions have been facilitated by Spectrum CIL and will form part of a rolling programme. 3 x training sessions for individual employers have been held during the year, facilitated and delivered by Spectrum CIL Not completed but will be included in the SSAB Priorities 2013/14.
Ensuring the availability of good quality local care services: *Further quality develop in contract monitoring in services contracted by CCG and SCC and implement a quality audit programme in commissioned services.* *Protocol for Managing Safeguarding in Provider Services (SIPS).*	Capacity within the Integrated Commissioning and Contract Monitoring Team has been increased. Over the past year, the new Quality Assurance Team has developed the tools to work with care homes, domiciliary care providers, day centres and other care providers. Quality audits have been undertaken in 44 care homes. Day centre reviews have commenced. In domiciliary care, 10% of service users have been asked their views on care provision and feedback given to the care agencies as part of the quality assurance process. The SIPS process has been updated to reflect the key findings arising from the West Sussex Judicial Review. The safeguarding clause in the contract Terms of Inclusion have been updated and rewritten. Both processes have been adopted by 4LSAB.

What we said we would do	What we did
Ensuring the availability of good quality local care services:	
Launch the Best Practice in Care Checklist (BPICC) audit tool and use in future contract monitoring.	The BPICC is routinely used in provider audits, contract monitoring and Support with Confidence registration.
Improving standards in nursing care.	The SCC safeguarding team hosts a regular clinical forum for nurses to improve clinical competencies. A Panel has been set up to review all grade 3 and 4 pressure ulcers to determine root causes.
Developing practice and promoting training and support of staff in contracted services	A training programme for voluntary and independent providers (VIP) has been implemented. This includes the Managing Safely course (based on the BPICC and linked to CQC Outcome Standards). In 2012/13, a total of 42 local managers attended this training (4 courses in total).
Robust performance monitoring	
Audits of practice across all agencies	A process is in place in Solent, Southern Health and Adult Social Care to audit individual workers practice. A multi agency Thresholds audit has been planned to take place autumn 2013.
Integrated 'Adults at Risk' Monitoring Tool	An integrated *'Adults at Risk' Monitoring Tool* providing dashboard performance information has been developed and is now being reported to SSAB. The other Hampshire LSAB's who are considering whether to adopt this.

What we said we would do	What we did
Service user feedback	A *User Feedback Tool* and process have been developed. This is designed to foster the involvement of people in their own safeguarding as a means of meeting the SSAB goal of local services providing P*ersonalised Safeguarding*. However, the survey has not yet been implemented but will be included in the SSAB Priorities 2013/14. This approach has been adopted by some of the other Hampshire LSAB's.
Professionals views on "what works".	Regular *Real Life* case study on SSAB agenda allows practitioners to highlight cases where good partnership working has led to positive outcomes and to feedback on practice issues.
Publication of regular key performance indicators and safeguarding activity reports.	Regular reports are presented to SSAB together with trend and comparator information to inform the Board of the effectiveness of local safeguarding and any gaps to target key areas for service planning and development.
Mechanisms to promote learning from experience and evidence based practice:	
Learning from Serious Case Reviews and national inquiries.	The Safeguarding Manager reviews national SCR and highlights learning to SSAB via briefings and an on line learning log was set in up Adult Social Care.

What we said we would do	What we did
Mechanisms to promote learning from experience and evidence based practice:	
Mr A Serious Case Review	Learning from the Mr A Serious Case Review has been a key focus of SSAB. A multi agency action in response to the recommendations made was produced by SSAB and partners required to report progress at each Board meeting. In 2013, as a means of assessing the difference SCR action plan made in practice and to outcomes, SSAB introduced an impact analysis tool.
Winterbourne View	The *Winterbourne View SCR* has been a key focus of SSAB. The response of local agencies has been closely monitored. SSAB developed a multi agency action plan and a local implementation group was set up. This group has been making regulars to the SSAB on the progress against the recommendations in the action plan.
Mid Staffordshire Inquiry	SSAB has also closely monitored local agencies' response to the *Francis Report* and the *Patients First and Foremost* government response and asks for regular progress reports.
Review of Serious Case Review Process	SSAB and HSAB jointly commissioned a review of the current policy which has yet to be finalised. This will be in the SSAB Priorities 2013/14.
Systems Learning Approach	SSAB jointly commissioned SCIE led System Learning Training course. A pilot will be set up to test System Learning for Partnership Reviews.

What we said we would do	What we did
Services shaped by users and carers:	
Revise contents of training to reflect carer perspective.	Not yet undertaken but will be included in the SSAB Priorities 2013/14.
Seek feedback from carers on their experience of safeguarding.	Not yet undertaken. This will be included in the SSAB Priorities 2013/14.
Recognise carers as expert partners in safeguarding.	Integrated Commissioning Team are developing "Experts by Experience" to support quality assurance. This will be included in the SSAB Priorities 2013/14.

6. How do we know local professionals have the right knowledge and skills to provide good safeguarding?

6.1 Learning and development is the key to ensuing safeguarding concerns are responded to effectively and to fostering an ethos where safeguarding is seen as *"everybody's business"*. Learning and development is promoted through a wide range of approaches. Providers of adult social care such as care homes and domiciliary agencies can access training via a Council funded Voluntary and Independent Providers Training Programme which has this year been built around learning from quality assurance reviews of services and trend analysis of safeguarding activity in provider services. Statutory agencies offer safeguarding training as part of their mandatory programmes. As the information below shows, awareness training is offered to staff working in a very wide range of roles. The following table provides a summary of partner agency training and development on safeguarding during 2012/13.

6.2 Multi-Agency Safeguarding Learning and Development Summary 2012/13

Agency	What's available?
SCC	SCC provides a wide range of safeguarding adults' related training both for its own staff as well as those working in the independent sector. A total of 144 staff attended courses related to MCA/DOLS (75 SCC and 69 VIP staff). A total of 177 provider staff attended Safeguarding Awareness Training (112 SCC and 65 VIP) and a further 81 provider staff attended safeguarding refresher training (65 SCC and 16 VIP). SCC also provides modular based safeguarding training for staff involved in safeguarding investigations reflecting the various aspects of the safeguarding process. A total of 303 staff attended these training courses. However, only 4 of the places were taken by colleagues from partner agencies. Over a third of the total number of places on the modular training (108) was for Community Safety related subject areas which underlines the success of the Community Safety Resource Pack and Training launched in 2012.
Police	In 2013, Hampshire constabulary organised seminars for officers covering a number of themes in mental health including Restraint, Patient Violence within a Health Setting; Transport, Section 135 Mental Health Assessments, Mental Capacity Act, Autism Awareness, Care Plans, Section 136 MHA . These have been opened up to colleagues from other agencies.
University Hospital Trust Southampton	UHTS care groups are required to undertake multi professional DOLS and MCA training as part of statutory and mandatory training days. Face to face training on MCA is delivered on the half rolling days on a monthly basis for senior nurses and medical staff. Publicity and awareness material has been produced for medical staff in the form of a business card and poster campaign which is provided on their induction training (x 2 cohorts per user). MCA, DOLS and safeguarding training x 2 sessions has been delivered to overseas nurses and foundation degree students. MCA, DOLS and safeguarding is included in the induction training for overseas nurses. The Trust provides online training for MCA/DOLS and safeguarding. The DOLS component will be updated over the coming year. The Trust's DOLS process has been updated and publicised on the intranet and DOLS training is available to individuals when they apply for a DOLS in their area.

Agency	What's available?
Solent	Solent's corporate induction course covers Safeguarding Adults MCA/ DOLS and are also addressed in the Essential Training updates all staff are required to undertake every two years. The Trust also makes available to clinical staff half day courses on Disclosures and Raising Alerts and Safeguarding and the Law which covers information sharing, MCA and Best Interests. A full day Mental Health Act course is also available for relevant staff groups. Bespoke training is also provided to small clinical groups on safeguarding adults. PREVENT Health WRAP has been provided for approx 1560 staff across the Trust.
Southern Health Foundation Trust	In SHFT mandatory training is delivered at two levels and is supported by a structured programme of professional development: Level 1: Non-clinical staff attend an Integrated children and adults session (day 2 of corporate Induction); e-learning refresher and bespoke face to face sessions as required. Level 2: Clinical staff attend a Children and Adults session (day 4 of corporate Induction which includes MCA & DOLS); Children and Adults session (as an Essential Training Day which includes MCA & DOLS). Level 3: Advanced Safeguarding Adults (a one day optional session); Advanced Safeguarding Children; Mental Capacity Act & DOLS; Domestic Violence & Abuse (incorporates MARAC & CAADA-DASH approved training). Level 4: SCC Modular training and HCC 6 day assessment and investigation training. Additional courses are available: PREVENT Short Health WRAP; Safeguarding Adults Road Show (adapted for delivery in adult mental health, learning disability and community health services).

Agency	What's available?
South Central Ambulance Service	SCAS have developed a Trust wide face to face training programme on mental capacity which includes DOLS with in an emergency setting. This is being delivered to all front line staff and will be completed by the end of December 2013.
Housing	A total of 479 members of front line and support staff completed Safeguarding Children and Adults Awareness Training in 2011-12 run by Solent University. Office based staff were sent the presentation and asked to fill in a checklist at the end to confirm completion. Frontline staff included all trade staff; supported housing staff; Neighbourhood Warden; Community alarm Service; Tower block Wardens; Housing Managers and support staff. All office and business support staff also attended this training.

7. SSAB Actions and Priorities 2013/14

7.1 As the Business Plan Review shows, there has been a significant amount of progress and success in achieving the goals set by SSAB in its Business Plan. This has been achieved through strong and collaborative leadership by the Board and the on-going commitment of partner agencies to work together to achieve these goals. It is clear however, that the work must continue and for the coming year SSAB will be focusing on the following priorities:

Board management:

- Produce a Safeguarding Strategic Plan each financial year setting out how it will protect people at risk of harm and what each member organisation will be doing to implement the strategy. The Strategy will be developed in consultation with Health Watch and the local community.

- Review Board membership to ensure service user and family carer representation, Lead GP, Health Watch, Crown Prosecution Service and the Police and Crime Commissioner.

- Member organisations to conduct the Safeguarding Organisational Self Assessment and collated results reported to SSAB.

- SSAB to participate in the LGA Peer Review.

- At the end of the financial year, publish an annual report in May 2014 on its achievements, members' activity and findings from any Serious Case Reviews.

- Update the SSAB Media and Communications Protocol.

- Produce a SSAB Dispute Resolution Protocol.

- Review Task and Finish Groups to reflect 2013/14 Priorities.

Governance:

- Implement clear reporting arrangements and assurance that safeguarding is embedded in the strategies and plans of the Council and its partners.

- Maintain clear links with the Overview and Scrutiny Committee, Cabinet and portfolio holders.

- Regularly review governance arrangements to anticipate and quickly respond to outside organisational changes.

- Finalise and implement the Serious Case Review (Safeguarding Reviews) process and reporting arrangements.

- Implement a process for keeping track of action plans and implementation of recommendations

- Actively monitor the implementation and impact of local action plans regarding Winterbourne View and the Francis Report.

- Implement a Pilot the 'Learning Together' (Systems Learning Approach) for cases with bad outcomes but falling short of SCR criteria.

Robust performance monitoring and quality assurance mechanisms:

- Implementation of the Integrated Dashboard

- Implementation of User Feedback Tool

- Implementation of a multi agency + single agency safeguarding audit programme.

- Development of pan Hampshire approach and shared I statements

Operational Developments

- Development and implementation of a joint triage process between Adult Social Care, Police and Adult Mental Health
- Implementation of the Fire Safety Action Plan and Fire Deaths Review process
- Implementation of the Safety Net pilot
- Implementation of the user feedback process
- Implementation of the Well Being Trigger Tool.
- Undertake an audit from the NHS Trusts of concerns raised and the decision making regarding safeguarding referrals.

Partnership working

- Maintain corporate links with the Local Safeguarding Children's Board, Safe City Partnership and Learning Disability Partnership Board to ensure the work of the SSAB and each of these boards is mutually compatible, both strategically and operationally.
- Links and regular meetings with Hampshire 4LSAB's via the Inter Authority Management Committee.
- Regular meetings of the Hampshire 4LSAB chairs and board managers to develop a joint work programme.
- Links with Regional and National Safeguarding Leads Networks.

Workforce Development:

- Review the multi agency safeguarding training strategy.
- Increase partner agencies uptake of Southampton Modular Training.
- Develop a Hampshire 4LASB training strategy and provision
- Pilot Safeguarding Competency Framework
- Provide multi agency safeguarding workshops for managers to ensure ethical and legal literacy around safeguarding.
- Set up a multi agency professional safeguarding practice development forum.
- Revise training programmes and materials re updated 4LSAB Safeguarding Policy.
- Publish multi agency practice guidance on responding to financial abuse.

8. Recommendations

8.1 SSAB to endorse and ratify the Annual Report.

8.2 Once the Annual Report is ratified, SSAB to establish a small Task and Finish to develop the action plan to enable the priorities highlighted above to be realised, to agree a work programme for the coming year and to assign lead roles amongst member organisations. Implementation of the action plan should be and contributions from member organisations secured as appropriate.

8.3 The Annual Report to be presented at a range of senior management and strategic forums as follows:

- SSAB Independent Chair to present to People Director, Overview and Scrutiny Committee, Council Management Team and Health and Wellbeing Board.

- SSAB member organisations to present to chief officers and relevant strategic forums within their own organisations.

8.4 SSAB to agree (in accordance with the SSAB media protocol) a media release to promote the positive work on safeguarding at a local level highlighted in the report.

8.5 A SSAB development day to be held in January 2014 to review progress and to ensure appropriate arrangements are in place for April 2014 when the Board is placed on a statutory footing.

DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		SAFER CITY AND YOUTH JUSTICE STRATEGY		
DATE OF DECISION:		27TH NOVEMBER 2013		
REPORT OF:		DIRECTOR OF PUBLIC HEALTH		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Andrew Mortimore**	**Tel:**	**023 80**
	E-mail:	**Andrew.mortimore@southampton.gov.uk**		
Director	**Name:**	**Andrew Mortimore**	**Tel:**	**023 80**
	E-mail:	**Andrew.mortimore@southampton.gov.uk**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

The Council has adopted a Safe City Plan 2013/14 and a Youth Justice Strategic Plan 2013/14. The Health and Wellbeing Board has an opportunity to assess any implications in these plans for the Health and Wellbeing Board.

RECOMMENDATIONS:

(i) That the Board identifies any relevant implications arising from the 2013/14 Safe City Plan and Youth Justice Strategic Plan.

REASONS FOR REPORT RECOMMENDATIONS

1. To enable the Health and Wellbeing Board to identify relevant issues on the 2013/14 Safe City and Youth Justice Strategic Plan.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

3. At its meeting on 18th September 2013, the Council adopted the 2013/14 Safe City Plan and the Youth Justice Strategic Plan. Both plans form part of the Council's policy framework, and as such need to be adopted by the full council meeting, rather than just by the Cabinet. The Safe City Plan is developed through the Southampton Safe City Partnership. Both the plans require significant inter-agency co-operation and input.

4. Whilst neither strategy had formal input from the Health and Wellbeing Board during the course of their development, some members of the Board have made contributions through their inputs into other bodies and organisations.

5. Chief Superintendent Fulton, the Chair of the Southampton Safe City Partnership and Cllr Kaur, Cabinet Member for Communities will be in attendance, and the Board will have the opportunity to explore the health-related issues that arise from these strategies.

RESOURCE IMPLICATIONS

Capital/Revenue

6. None.

Property/Other

7. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

8. The powers of the Health and Wellbeing Board are set out in the Health and Social Care Act 2012.

Other Legal Implications:

9. None.

POLICY FRAMEWORK IMPLICATIONS

10. Both the Safe City Plan and the Youth Justice Strategic Plan form part of the council's policy framework.

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	A''

SUPPORTING DOCUMENTATION

Appendices

1.	Safe City and Youth Justice Strategy – Report and appendices to Cabinet (17th September) and Council (18th September 2013)

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

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

DECISION-MAKER:		CABINET COUNCIL		
SUBJECT:		SAFER CITY AND YOUTH JUSTICE STRATEGY		
DATE OF DECISION:		17 SEPTEMBER 2013 18 SEPTEMBER 2013		
REPORT OF:		CABINET MEMBER FOR COMMUNITIES		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Suki Sitaram**	**Tel:**	**023 80832060**
	E-mail:	**suki.sitaram@southampton.gov.uk**		
Director	**Name:**	**John Tunney**	**Tel:**	2 **832602**
	E-mail:	**john.tunney@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

Southampton Safe City Partnership is responsible for reducing crime and disorder and has a statutory duty under the Police and Justice Act 2006 to meet established national minimum standards which includes producing an annual Strategic Assessment to inform the Safe City Plan. This Plan is included in the council's Policy Framework and hence requires Full Council approval.

The Safe City Plan will be a working document shared within the Partnership. The actions in this Plan will have read-across with the Council Plan, including joint projects and actions with other relevant work in the City. The council is a key member of the Safe City Partnership and has a pivotal role in working with partners to make Southampton a safer city.

The Council is also now responsible for the Youth Offending Service, which makes a significant contribution to the priorities and work of the Safe City Partnership and therefore, this report recommends that the 2 plans should be considered as a combined Safer City and Youth Justice Strategy. The 2 plans have been produced in an easy to understand, accessible format on a single page. This report seeks support for the Council's contribution towards the implementation of the Safe City Partnership Plan and the Youth Justice Strategic Plan within existing budgets.

RECOMMENDATIONS:

Cabinet

(i) To delegate authority to the Head of Communities, Change and Partnerships to agree any final amendments to the Safe City Plan 2013/14 (Appendix 2) and the Youth Justice Strategic Plan 2013/14 (Appendix 3 and 4) following consultation with the Cabinet Member for Communities and the Council's Management team.

(ii) Subject to (i) above, to recommend the Safe City Plan 2013/14 (Appendix 2) and the Youth Justice Strategic Plan 2013/14 (Appendix 3 and 4) to Council for approval.

Council

(i) To approve the Safe City Plan 2013/14 (Appendix 2) and the Youth Justice Strategic Plan 2013/14 (Appendix 3 and 4).

REASONS FOR REPORT RECOMMENDATIONS

1. The Police and Justice Act 2006 places a duty on Crime and Disorder Reduction Partnerships to meet established national minimum standards. This includes producing an Annual Strategic Assessment to inform the Safe City Plan. This Plan is included in the Council's Policy Framework and has to be approved before publication.

2. The Youth Offending Service is required to publish a Youth Justice Strategic Plan in line with the Crime and Disorder Act, 1998, Part iii, Section. 40. The Youth Justice Strategic Plan is also included in the Council's Policy Framework and has to be approved before publication.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. As it is the Council's statutory duty to approve these plans, no other options were considered.

DETAIL (Including consultation carried out)

4. The priorities for community safety are informed by an annual strategic assessment of crime and disorder issues in the City (Appendix 1). The Safe City Plan 2013/14 attached at Appendix 2 takes into account this strategic assessment.

5. Southampton has experienced a sustained positive downward trend in many crimes and this is mainly due to productive partnership working, both between agencies and with local communities. Successes include:
    - Reduction of 16% in total crime in the City
    - 1,418 fewer violent crime offences, a 19% reduction including decreases of:
        - 31% in alcohol related violence
        - 16% in domestic violence offences
        - 28% in serious sexual offences
    - Reduction of 20% in burglary
    - Reduction of 22% in theft of a vehicle
    - Reduction of 15% in recorded theft from a vehicle
    - Reduction of 21% in theft from a person
    - Reduction of 11% for total ASB incidents
    - Reduction of 37% in arson

6. The City's comparator position in relation to crime rates for other cities in our most similar group has also improved for:
    - All crime
    - Sexual offences
    - Other sexual offences
    - Rape
    - Burglary
    - Burglary (Dwelling)
    - Burglary (non dwelling)
    - Vehicle Offences
    - Arson
    - Violence with Injury
    - Violence without injury
    - Public Order
7. However, even though crime rates have come down in Southampton, this has been in line with the national trend and therefore, in some critical areas, the City's comparative position needs significant improvement. This is particularly so for:
    - Criminal Damage
    - Criminal Damage /Arson
    - Violence with Injury
    - Violence without injury
    - Theft from Person
    - Burglary (non dwelling)
    - All crime
    - Possession of drugs
8. The priorities and actions therefore reflect the need to focus on improving our comparative position in relation to the above in addition to improvements in reducing reoffending (particularly domestic violence and youth), ASB in some areas of the City and drug related crimes.
9. The Youth Justice Strategic Plan identifies the following priorities in addition to implementing an action plan to deliver improvements within the service:
    - Reducing custody;
    - Reducing the number of first time entrants into the criminal justice system;
    - Reducing reoffending; and
    - Reducing youth crime.

10. It is recognised that the Council and its partners would benefit from building on the synergy between community safety and youth offending functions. Therefore, the Council is being requested to consider the 2 plans together in order to start the development of a single safer city and youth justice strategy. The Council is in dialogue with the Local Government Association about benefiting from a Peer Review for the wider community safety function early next year.

11. The Cabinet Member has also requested that officers explore the following:
    - Closer alignment across the Council of community safety, emergency planning and enforcement functions
    - Consider options with the Safe City Partnership and the Youth Offending Board for improving the governance arrangements for these areas as the key partners are on both partnerships.

RESOURCE IMPLICATIONS

Capital/Revenue

12. There are no additional resource requirements as Council led actions to deliver targets detailed in these plans will be met within existing budgets.

Property/Other

13. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

14. The Crime and Disorder Act 1998 (amended by the Police and Justice Act 2006) places a statutory duty on Crime and Disorder Reduction Partnerships to produce a strategic assessment and a Partnership Plan outlining its priorities to tackle crime and disorder.

15. All Youth Offending Services are required to submit a Youth Justice Strategic Plan to the Youth Justice Board and Ministry of Justice, and the Plan needs to be endorsed by full Council (Crime and Disorder Act, 1998, Part iii, Section 40).

Other Legal Implications:

16. None

POLICY FRAMEWORK IMPLICATIONS

17. The Safe City Plan is included in the Council's Policy Framework. These plans link with a range of other strategies and plans including the Health and Wellbeing Strategy and the Integrated Offender Management Plan.

KEY DECISION?	Yes
WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Draft Crime and Disorder Strategic Assessment
2.	Draft Southampton Safe City Partnership Plan 2013/14
3.	Southampton Youth Justice Strategic Plan 2013/14 – plan on a page
4.	Southampton Youth Justice Strategic Plan 2013/14 – detailed plan

Documents In Members' Rooms

	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	Yes

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

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

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Draft Crime and Disorder Strategic Assessment 2012/13

Safe City Partnership
making Southampton safer

CONTENTS

METHODOLOGY

This assessment is based primarily on data sources from partner agencies, particularly Police performance data from 1st April 2012 to 31st March 2013. These include:

- Hampshire Constabulary Record Management System crime and incident data
- Hampshire Constabulary Business Objects crime data
- I-Quanta data set
- Southampton City Council data from:
    - Drug Action Team (DAT)
    - Youth Offending Service
    - Enforcement work
    - Public Perception Survey
- Hampshire Probation Trust
- Safety Net

EXECUTIVE SUMMARY

Southampton Safe City Partnership is responsible for reducing crime and disorder and has a statutory duty under the Police and Justice Act 2006 to meet established national minimum standards, including completion of an annual Strategic Assessment to inform the Safe City Plan.

Crime and anti-social behaviour has fallen significantly in the City during the reporting period of 2012/13, with the exception of increases in:

- Drug related violence
- Number of first time entrants into the criminal justice system
- Youth reoffending rates
- Vehicle related nuisances

There were also slight increases in crimes with small volumes of offences, i.e. car key burglaries and distraction burglaries.

The City's comparative position in the Most Similar Group (MSG) of Community Safety Partnerships has improved in 12 of the 17 comparisons. The priority however remains the need to improve our comparative position for:

- Criminal damage
- Criminal damage/ arson
- Violence with injury
- Violence without injury
- Theft from person
- Burglary (non dwelling)
- All crime
- Possession of drugs

Therefore the Safe City Partnership Priorities (2012 – 2015) remain relevant:

- Reducing crime, anti-social behaviour, fires and road collisions in strategic localities across the city
- Reducing the harms caused by drugs and alcohol
- Reducing repeat victimisation with a focus on vulnerable victims and targeted communities.

In addition, the 2012/13 Strategic Assessment highlights the need to broaden the focus to include two new priorities:

- Reduce Reoffending
  The data suggests that Southampton's performance has deteriorated, particularly in relation to offenders who are on Licence. The data shows a poor comparative position when compared to our most similar group. In addition a focus on reoffending across all partnership from Night Time Economy to Domestic Violence, including more preventative work is an imperative for continuing to sustain crime reductions.

- Reducing Youth Crime
  Southampton's performance in relation to reducing first time entrants to the criminal justice system has bucked the regional downward trend and youth re-offending levels have increased and are higher than national and regional averages. Our comparative position in this area has not improved.

OVERVIEW

1. This strategic assessment is an analysis providing an overview of crime and disorder issues for the City including performance against the Safe City Partnership's three priorities as set out in the 2012-2015 Plan. This includes an analysis of performance against spotlight issues from the 2012-13 Annual Plan including:
   - Delivering the Families Matters Agenda
   - Progressing the reducing reoffending project
   - Delivering the Alcohol Treatment Programme
   - Delivering Operation Fortress
   - Reducing seasonal peaks in crime
   - Implementing recommendations from case reviews, including Domestic Homicide Reviews

2. The strategic assessment provides the 'evidence base' for Southampton Safe City Partnership to identify priorities, objectives and targets for crime, anti-social behaviour, substance and alcohol misuse and offending behaviour to inform the Safe City Partnership Plan for 2013-14.

3. An overview and analysis of the following issues are included in this document:
   - Levels and patterns of crime and disorder and substance misuse
   - Why changes have occurred
   - Main issues identified from community engagement activity
   - Performance against the 2012-15 Partnership priorities
   - Progress on the spotlight issues

Introduction of Police Crime Commissioners (PCC)

4. Police and Crime Commissioners were elected by the public on 15 November 2012 and Simon Hayes was appointed as the PCC for Hampshire and the Isle of Wight. All funding previously provided by the Home Office for Community Safety Partnerships are now allocated to the PCC. In the bidding process Southampton was successful in securing funding for the following five projects:

Application title	**Funding awarded**
Research, analysis and customer feedback	£23,750
Domestic homicide reviews	£11,250
Community messaging	£13,500
Physical security measures	£15,000
Night time economy	£32,000
Total funding	**£95,500**

5. The PCC has identified four key Priorities:
   - Improve frontline policing to deter criminals and keep communities safe
   - Place victims and witnesses at the heart of policing and the wider criminal justice system
   - Work together to reduce crime and anti-social behaviour in your community
   - Reduce re-offending

6. The PCC awarded the funding on the basis of a 25% reduction on the previous year's funding from the Home Office. Each bid had to show how the project addressed at least one of his key priorities.

7. Although the PCC replaced the Police Authority, he is not a 'responsible authority' in terms of the Safe City Partnership and can only be invited as an observer. The PCC has

announced that he will be appointing a Commissioning Manager for the next round of funding, the arrangements for which have yet to be announced.

8. All crime in the City came down over the last year from 26,165 to 21,929 (16%). This reduction continues the trend seen in the last few years and is in line with national trends for crime rates. It is also reflected in reduction in many types of specific crimes which have a significant impact on local communities, businesses and services. They have the greatest impact both directly in terms of numbers of victims but also indirectly in respect of public perceptions of safety. The percentage change in the last year is positive in all of these high volume categories.

High Volume Crime/Incident Type	% Change (from 2011 –2012)	Reduction in number of offences
Anti-Social Behaviour	-10.65%	1,642
Violent Crime	-19.29%	1,418
Criminal Damage	-15.84%	681
Serious Acquisitive Crime	-19.49%	699
Non Dwelling Burglary	-27.35%	474
Shoplifting	-15.96%	395

9. In January 2012 the Community Safety Team conducted a 'Perception of Crime Survey, asking 'How safe do you feel in Southampton?'. 85% of the 872 respondents (partners and residents) felt very safe or fairly safe during the day while only 39% felt fairly safe at nights. Of the respondents 73% were residents of Southampton and 74% worked in Southampton.

10. In 2013 Southampton City Council commissioned a school survey with 2,114 Southampton children (1,063 boys, 1,051 girls). This showed that over 30% of Year 4 and Year 6 pupils had been bullied last year compared to 18.6% of Year 11 pupils. Approximately 25% of pupils I Years 4, 6, 9 and 11 felt unsafe near home after dark. The percentage of children who had taken more than a sip of alcohol rose steadily as they grew older from Year 6 (22.5%) to Year 11 (76.8%).

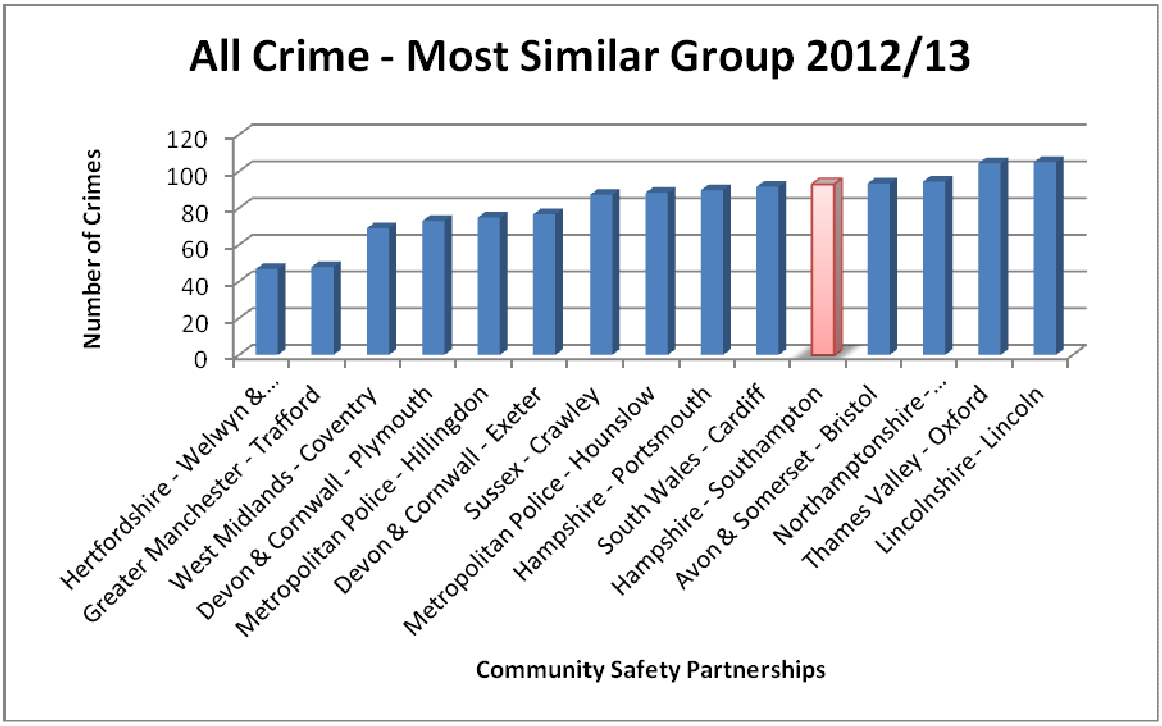
Southampton Crime Overview and Performance 2013

11. The table below reflects the quantitative change in crime/incidents levels recorded for the period 1st April to 29th February in 2012 and 2013 from Hampshire Constabulary Records Management System (RMS) data.

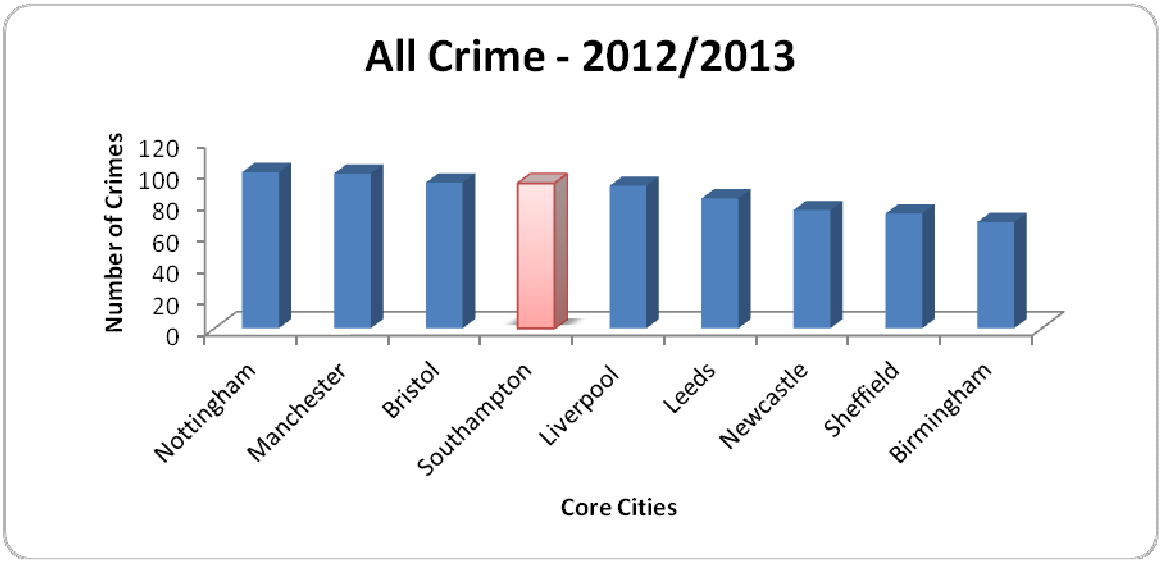
Crime Type	2011/12 Total	2012/13 Total	% change
All crime	26,165	21,929	-16.2
ASB Incidents including:	17,946	16,034	-10.7
Vehicle Related Nuisance	945	1,338	41.6
Criminal Damage	4,299	3,618	-15.8
Violent Crime including:	7,349	5,931	-19.3
Violence with Injury	3,000	2,341	-22
Knife Crime	343	278	-19
Gun Crime	37	26	-29.7
Youth on Youth Violence	224	238	6.3
Alcohol and Public Place Violence	1,005	686	-31.7
Homicide	12	4	-66.7
Threat to life	113	61	-46
Drug Related Violence	42	49	16.6
Serious Sexual Offences	271	196	-27.7
Protecting the Vulnerable including:			
Domestic Violence	1,433	1,208	-15.7
Missing Persons	1,392	1,177	-15.4
Hate Crime	364	323	-11.3
Child Abuse	33	29	-12.1
Honour Based Violence	9	4	-55.6
Other crimes including			
Theft	5,357	4,508	-15.8
Shoplifting	2,474	2,079	-16
Burglary Non-Dwelling	1,733	1,259	-27.4
Serious Acquisitive Crime including:	3,585	2,886	-19.5
Burglary Dwellings	1,253	985	-21.4
Distraction Burglary	7	11	57.1
Car Key Burglary	17	40	135.3
Robbery	393	313	-20.4
Thefts from Motor Vehicle	1,350	1,140	-15.6
Thefts of Motor Vehicle	523	404	-22.8

HOW WE COMPARE WITH OTHER CITIES

12. The City's performance is measured against a 'Most Similar Group' (MSG) of Community Safety Partnerships. Southampton's ranking improved 2 places in 2012/13 for all crime (total recorded crime) improved to 11 out of 15 (1=best) compared to 13 out of 15 in 2011/12.



13. In 2012/13, Southampton improved its relative position to the 8 Core Cities for All Crime (total recorded crime) to 6th out of 9 compared to last in 2011/12.



14. However, in 2012/13 Southampton's figure for All Crime was higher (93 per 1,000 population), compared to the Core Cities average of 86 per 1,000 population.

LEVELS AND PATTERNS OF CRIME AND DISORDER AND SUBSTANCE MISUSE

15. The highest volume crimes/incidents, with the highest number of offences, remain the same as last year:
    - Violent Crime
    - Anti-Social Behaviour
    - Theft
    - Criminal Damage
    - Shoplifting

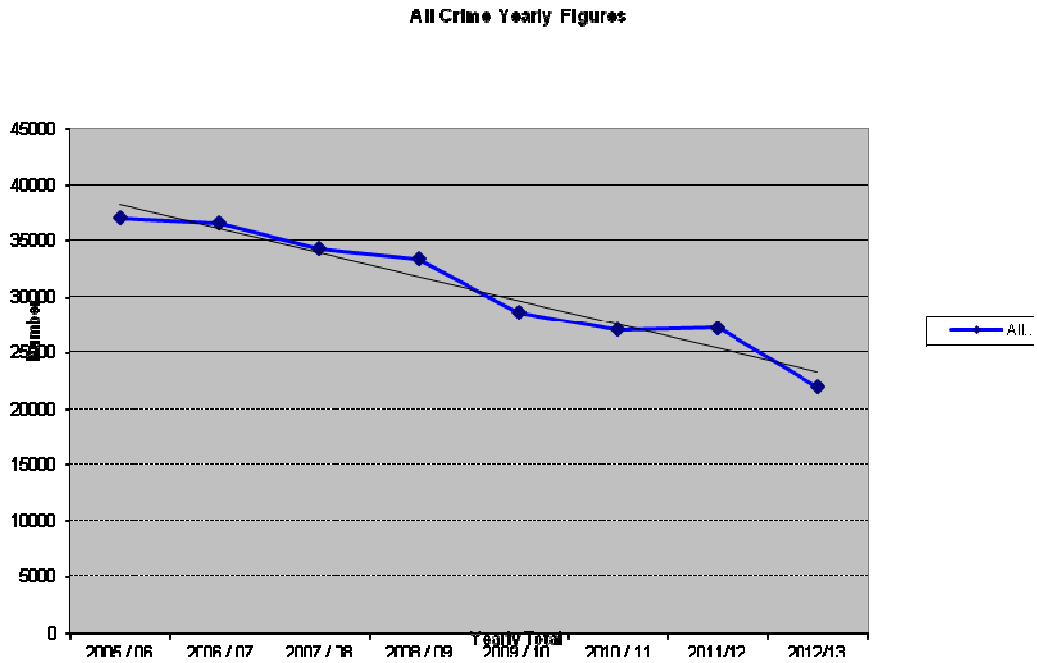
16. Although all crime categories have fallen significantly, there are sub sets of certain crime types which have shown an increase. Of these increases, only one type of crime (vehicle related nuisance) is a high volume sub set of anti-social behaviour. Anti-social use of motor vehicles is a sub category of anti-social behaviour and relates to complaints by members of the public about anti-social use of motor cycles or cars. There are certain areas of the City where this type of ASB is more prevalent, including Sholing Valley, Lordshill, Millbrook, Daisy Dip and Thornhill. The Police conduct regular operations targeting this type of behaviour and when offenders are stopped, they are given warnings under section 59, Police Reform Act 2002. If the same vehicle is seen again being used in an anti-social manner it can be seized.

17. In addition, an issue of concern is the small percentage increase in youth on youth violence, when considered alongside the increase in first time entrants to the Criminal Justice System. This small rise is also against the downward national trend. As a result of this rating, partners had already implemented action to address the most prolific youth offenders who make up a significant proportion of reoffending.

18. Other very low volume crimes that have gone up are:
    'Car key' burglaries: Where the purpose of the burglary is to remove the car keys and then steal high value motor vehicles. These offences make up just 4% of the total number of dwelling burglaries. Although there has been a significant increase numbers still remain low and where they are committed the Police have known who the offender is and targeted them accordingly.
    'Distraction burglaries': Where offenders distract residents and then enter other parts of the property to steal. These are very low numbers compared to overall numbers of dwelling burglaries. These are very rare offences in Southampton.

All Crime (total level of crime recorded in the City)

19. In 2012/13 the positive downward trend for most crime types continued, including reductions in repeat incidents of domestic violence and night time economy violent crime. The year-on-year reductions in All Crime seemed to have levelled off in 2011 with an increase of just 0.5%. However, over the last twelve months the figures have taken a significant downward trend, reducing by a further 16.19% against a target of 5%. This downward local trend in crime over the last few years reflects the national position.



20. The Police crime statistics identify the top ten streets for all crime. With the exception of 'West Quay Shopping Centre', the remaining streets are all locations included in the Night Time Economy. Bevois Valley Road replaces Shirley High Street this year with the order changed slightly but not significantly.

Street Name	Number of Offences
Above Bar	666
London Road	359
Portswood Road	333
West Quay Road	311
Portland Terrace	258
Shirley Road	230
Bedford Place	228
West Quay Shopping Centre	228
High Street	217
Bevois Valley Road	215

21. This downward trend in all crime is mirrored in a 20% reduction in the number of incidents dealt with as a result of CCTV operations and a 12% reduction in the number of arrests associated with these. In 2012/13 the CCTV operators dealt with 6,559 incidents, of which 1,238 resulted in an arrest by the Police. They also responded to 1,080 calls from Southampton Businesses Against Crime (SOBAC) and 1,529 from the Night Time Economy. They initiated 740 incidents through proactive monitoring of cameras. The data collection for SOBAC, Night Time Economy and CCTV Operator initiated incidents were only available for the period from July 2011 to March 2012. When comparing the similar period from this year's data there have also been reductions in these activities. SOBAC calls reduced by 42%, NTE calls reduced by 15% and operator initiated incidents fell by 12%.

22. The figure for the number of Help Point Calls in car parks was only collected from September 2011. During the period Sep 2011 to March 2012 the CCTV operators dealt with 9,533 calls for help. During this reporting period that figure fell to 7,910, a reduction of 17%. The service has, during 2012/13, answered 92.8% of calls against a set a target of answering 75% of 'help point' calls within 8 seconds.

KEY CRIME TYPES CONTRIBUTING TO 'ALL CRIME'

Anti-Social Behaviour (ASB)

23. In April 2011 the Home Office required Police Forces to change the way in which anti-social behaviour was recorded. Previously there had been 14 different categories of anti-social behaviour. Since April 2011 the following three main headings are used:
    - Personal – where the caller or call taker perceive that the anti-social behaviour is targeted at an individual or group.
    - Nuisance – where the anti-social behaviour causes nuisance, offence etc to the community in general
    - Environmental – where the anti-social behaviour has an effect on the natural, built and social environments.

24. According to Police statistics for the period March 2011 to February 2012 there were a total of 17,946 incidents of anti-social behaviour. This figure has fallen to 16,034 in the current financial year (Mar 2012 to Feb 2013), a reduction of 10.7%, achieving the target set.

Use of ABCs and ASBOs

25. This reduction can in part be attributed to the work by partners both with vulnerable victims and alleged perpetrators. Multi agency actions to identify and protect vulnerable victims of ASB focuses on supporting victims, carrying out target hardening and taking robust action against perpetrators. This includes the use of ASB powers such as Acceptable Behaviour Contracts, Anti-Social Behaviour Orders and Injunctions and action against tenancy where the perpetrator lives in social housing. Alongside enforcement action, partners regularly discuss opportunities to offer support and diversion to more positive activities.

26. In 2012/13 the number of young people asked to sign Acceptable Behaviour Contracts, doubled from 24 to 49. In this reporting period the city council successfully applied for 12 Anti-Social Behaviour Orders, up from the four applied for in the previous year. During the year there has been some success in securing anti-social behaviour orders against groups of young people including non association clauses. This tactic worked well to stop significant harm caused by small groups acting together.

Section 30 Dispersal Orders

27. There were three Section 30 Dispersal Orders implemented in 2012/13, an increase in one from the previous year. The CTCG coordinates the response to 'hot spots' of anti-social behaviour and worked with the Police to implement four Section 30 Dispersal Orders, two in Windrush Road, one in Montague Avenue and one in the City Centre Car Parks. The profile of offenders causing ASB varies according to the location. In the city centre and night time economy, the offenders tend to be adults with behaviours involving street drinking, begging, incidents associated with rough sleeping and drink related incidents as well as public urination.

28. However, outside the city centre the vast majority of offenders are under the age of 18 years, with some as young as 10. Males continue to be the main offenders but most recently there has been an emergence of more young females engaged in significant and serious ASB. Youth related ASB and criminal damage tends to take place during after-school hours and through the night with vulnerable areas identified as school routes, parades of shops and park areas on the outer city estates with green areas also attracting motorcycle nuisance.

Young people

29. It must always be recognised that only a very small minority of young people are engaged in anti-social behaviour; it is estimated that less than 1% of the city youth population come

to the attention of partner agencies. However, for the very small minority of young people involved in ASB the local and national evidence suggests ASB can be a precursor to more serious offending behaviour including violent crime and arson as well as criminal damage and vehicle crimes. ASB also has links to under-age drinking. Southampton Police analysis identifies offender profiles that suggest youths (white, aged 14-19 years) known for ASB often escalate to committing violence and are known to agencies. While younger youths aged approximately 10-13 years are linked to reports of low level ASB, such as stone throwing and damage can escalate to underage drinking and cannabis use, particularly if older peers are doing this. ASB and violence have a generational link with some families producing offenders across generations. This profile supports the new Families Matter agenda that focuses partnership effort and resources on families with multiple needs and also reinforces the importance of early interventions with young people at risk of offending behaviour that could escalate.

30. Youth related ASB and damage takes place during after-school hours and through the night with vulnerable areas identified as school routes, parades of shops and park areas on the outer city estates with green areas also attracting motorcycle nuisance.

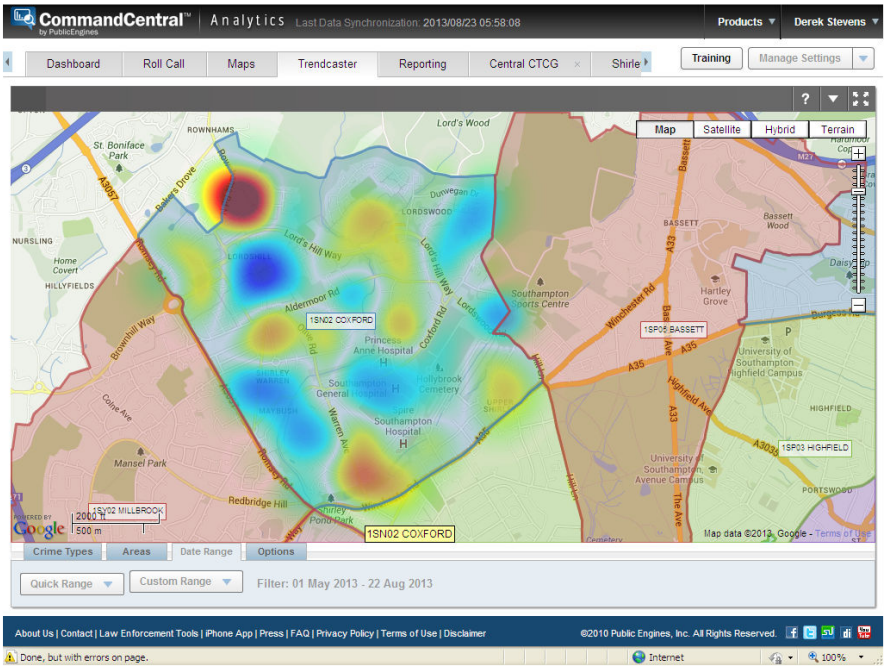
Top streets for Anti-Social Behaviour

	Street Name 2011/12		**Street Name 2012**	**Trend**
1	London Road (231)	1	High Street (204)	⇧
2	Above Bar Street (203)	2	Above Bar Street (203)	⇔
3	Shirley Road (186)	3	London Road (197)	⇩
4	High Street (131)	4	Shirley Road (175)	⇩
5	Bedford Place (128)	5	Montague Avenue (145)	⇧
6	Portswood Road (128)	6	Wimpson Lane (135)	NEW
7	Golden Grove (113)	7	International Way (119)	NEW
8	Weston Lane (108)	8	Portswood Road (118)	⇩
9	Portsmouth Road (93)	9	Windrush Road (114)	NEW
10	Montague Avenue (89)	10	Hinkler Road (108)	NEW

31. Four new street names now appear in this top ten list. They are all outside of the city centre and in mainly residential locations with the exception of Portswood Road. Anti-social behaviour in the suburbs continues to centre around small shopping parades, e.g. Windrush Road, Montague Avenue. Larger shopping areas continue to attract underage drinking and associated anti-social behaviour, e.g. Bitterne Precinct and Lordshill Precinct.

32. The top streets for anti-social behaviour are regularly discussed at the Community Tasking and Coordinating Groups and result in increased partnership activity. This has included the use of Section 30 (Windrush Road), Street CRED events (Windrush Road and Portswood Road) and deployment of Decoy Bus (Wimpson Lane). They also result in a greater targeting of those involved in causing the anti-social behaviour which results in use of multiple Acceptable Behaviour Contracts or referrals to Families Matter. This work is reflected in the streets that have come off this list in 2012/13.

33. The Community Safety Team continues to coordinate partnership responses to anti-social behaviour at the monthly Community Tasking and Coordinating Groups. There are four of these, based on the four police sectors of Portswood, Central, Shirley and Bitterne. They meet monthly to discuss where anti-social behaviour is taking place and who is responsible for causing it. In the last year more use has been made of Crime Reports to inform the meetings about volumes, locations and trends.



Supporting victims

34. Partners identified more vulnerable victims, the figure rising from 148 to 219, a 48% increase. Of these 109 were identified as being High Risk and resulted in an ASB Multi-Agency Risk Assessment Conference. This was a 22% increase on the number of ASB MARACs held in the previous year. The Community Tasking and Coordinating Group (CTCG), managed and chaired by the Community Safety Team, monitors all vulnerable victims and ensure that the risk is either mitigated or eliminated. At the same time the partners have continued to identify those responsible for causing anti-social behaviour and instigated early interventions. The main tool for early intervention is the Acceptable Behaviour Contracts (ABC).

Housing

35. Southampton City Council owns and manages 18,760 premises. This includes premises leased to residents. There was a 20.3% decrease in the number of ASB cases dealt with by Housing, falling from 1,836 in 2011/12 to just 1,663 in 2012/13. Other enforcement action taken by Housing includes the serving of a notice seeking possession that can ultimately lead to eviction of tenants. In 2012/13 a total of 43 notices were served, compared to 42 in 2011/12.

36. Where anti-social behaviour is reported to Housing Officers that involves disputes with neighbours, a referral is automatically made to New Forest Mediation Services. The number of cases referred in 2012/13 rose to 473 from 430 in 2011/12 with only 9 resulting in all parties attending mediation, compared to 12 in the previous year.

Fly-tipping

37. Included in the Home Office definition of anti-social behaviour is the offence of fly-tipping. This is the depositing of any rubbish or litter in the open air that equates to the equivalent of one or more black bin bags of rubbish.

38. In 2012/13 the council's Open Spaces team recorded and dealt with 7,819 incidents of fly-tipping, compared to 7,355 the previous year, a rise of 6.3%. City Patrol officers regularly investigate offences of fly-tipping and during the year have used Regulation of Investigatory Powers Act 2000 applications to conduct directed surveillance of hot spot areas. The main areas of concern include areas where there are high volumes of houses of multiple occupation, e.g. Newtown, Polygon and Portswood. The installation of a secure gate has virtually eliminated the problem at one hot spot, Coxford Road.

Graffiti

39. The Open Spaces team also monitor and respond to incidents of graffiti. They regularly remove graffiti on council owned property but will also remove offensive graffiti regardless of property ownership. In line with figures for other crime types, there have been significant decreases in the number of incidents of graffiti being reported to the Local Authority and the resultant volumes of graffiti removed.

INCIDENTS	2011/12	2012/13	Change
Total incidents	580	397	-31.6%
Central	295	225	-23.7%
East	198	92	-53.5%
West	87	80	-8.0%

Square metres removed	2011/12	2012/13	Change
Total	1,943.5	1354.5	-30.3%
Standard	1,551.5	1026.5	-33.8%
Urgent (Offensive)	392	328	-16.3%

Criminal Damage

40. Despite the continued reduction in incidents, Southampton still ranks 15/15 when compared to its 'most similar group' of Community Safety Partnerships for Criminal Damage. Across Southampton during 2012/13 there were 3,618 Criminal Damage offences recorded. This is a reduction of 15.8% on 2011/12 (681 less offences), continuing the downward trend over the past 6 years.

Criminal Damage - Year on Year reductions from 2006/7		
2012/13	3,618	⇩ 16%
2011/12	4,299	⇩ 11%
2010/11	4,824	⇩14%
2009/10	5,623	⇩22%
2008/09	7,199	⇩13%
2007/08	8,302	⇩10%
2006/07	9,246	⇧2.5%
2005/06	9,017	-

41. A significant proportion of Criminal Damage offences coincide with areas where there is also youth related ASB and juvenile nuisance. 4 of these (marked in red) are in the top 10 location streets for Anti-Social Behaviour for the past six months:

Street	No. of offences
Above Bar Street	34
London Road	34
Windemere Avenue	29
Wimpson Lane	27
Spring Road	25
Southern Road	23
Green Lane	22
Meggeson Avenue	22
St Deny's Road	22
Millbrook Road West	21

Shirley Road	21

Partnership Activity

42. Hotspots for ASB, Criminal Damage and Arson continue to be managed through CTCGs in order to direct partnership interventions including patrols, Street CREDs, Dispersal Orders, street briefings and special operations. Seasonal peaks for criminal damage and anti-social behaviour have been addressed through 'Seasonal Campaigns' set up through the Safe City Partnership. The autumn campaign coordinates partnership activities to address increased figures during Halloween and Bonfire.

43. The council has introduced Street CRED (Crime Reduction and Environment Days). These are days of action in specific community locations identified as having high levels of anti-social behaviour. Since they were set up in October 2012, there have been 21 events involving various Local Authority teams, the Police, Fire and Health services. This has resulted in tonnes of rubbish being removed, vegetation cut back and new plants and trees planted. Community Payback have provided approximately 50 hours of free labour.

Arson

44. Arson figures have continued to mirror the decrease in crime figures in 2012/13. There are some very significant reductions in a number of areas as can be seen in the tables below.

Year	Primary Fires	% Difference Year on year	Secondary fires	% Difference Year on year	Total	% Difference Year on year
2012 - 2013	423	-17%	319	-54%	742	-39%
2011 - 2012	508	-4%	700	-9%	1,208	-5%
2010 - 2011	531		769		1,300	

Year	Chimney Fires	% Difference Year on year	Deliberate Primary Fires	% Difference Year on year	Deliberate Secondary Fires	% Difference Year on year
2012 - 2013	9	-57%	88	-42%	218	-56%
2011 - 2012	21	17%	153	-3%	491	-12%
2010 - 2011	18		158		560	

45. The only increase recorded was the attendance of Hampshire Fire and Rescue at Road Traffic Collisions. This includes extracting people trapped, making the scene or vehicle safe, washing down and offering advice to other emergency services. A breakdown of 'false alarms' show that all categories of call have seen reductions during this reporting period compared with increases for the similar period last year.

Year	All False Alarm	% Difference Year on year	RTC	% Difference Year on year
2012 - 2013	1256	-7%	174	22%
2011 - 2012	1351	6.40%	143	-7%
2010 - 2011	1270		153	

Year	False – Good intent	% Change Year on year	Auto Fire Alarm	% Change Year on year	False and Malicious	% Change Year on year	Total	% Change Year on year
2012 - 2013	419	-4.60%	773	-6.40%	64	-25.60%	1,256	-7%
2011-2012	439	0.60%	826	11.60%	86	-9.50%	1,351	6.40%
2010-2011	436		739		95		1,270	

46. Other calls for the assistance of Hampshire Fire and Rescue Service have remained fairly constant over the last three years, but show the variety of the work undertaken.

Incident Type	2012-2013	2011-2012	2010-2011
Other transport incidents	1	2	0
Flooding	34	36	45
Rescue or evacuation from water	2	0	0
Other rescue/release of persons	23	32	21
Animal assistance incidents	19	38	18
Hazardous materials incident	9	9	8
Spill and leaks (not RTC)	24	24	28
Lift Release	89	82	118
Making safe (Not RTC)	10	10	5
Effecting entry/exit	97	85	86
Removal of objects from people	48	37	23
Suicide/attempts	5	3	2
Evacuation (no fire)	3	0	1
Water provision	0	0	0
Assist other agencies	24	37	28
Advice only	10	14	8
Stand by	2	3	1
No action (not false alarm)	23	25	23
Total	**423**	**437**	**415**

47. Data in relation to the existence and functionality of smoke alarms show that there is still a lot of work to do in terms of encouraging the public to fit and maintain smoke alarms in their premises.

Year	Percentage of dwelling fires where a smoke alarm was not fitted	Percentage of dwelling fires with smoke alarms fitted where smoke alarm was not working	Percentage dwelling fires where a smoke alarm operated and raised the alarm	Percentage dwelling fires where a smoke alarm operated but did not raise the alarm
2012-2013	30%	33%	51%	16%
2011-2012	27%	25%	57%	18%
2010-2011	38%	28%	56%	16%

48. Finally the Fire Service record the numbers of casualties present at any category of incident they attend. There has been a significant reduction in the number of casualties at fires, but an increase in those at the scene of Road Traffic Collisions.

Local Authority Enforcement
The Local Authority has a wide range of powers and the table below shows the wide variety and volume of actions taken. In the table, Environmental Health (EH) includes Noise, Nuisance, Contaminated Land, Private Housing and City Patrol and Parking (CP&P) includes parking fraud.

Formal Action	EH	Trading Stds	Port Health	CP & P	Total
Boarding Up of Empty Premises Notices	2	0	0	0	**2**
Cautions for Misuse of Parking Documents	0	0	0	27	**27**
CLE26 (notification to DVLA of untaxed vehicles)	0	0	0	313	**313**
Consumer Safety Suspension/Withdrawal Notices	0	29	0	0	**29**
Filthy and Verminous Notices	1	0	0	0	**1**
Fixed Penalty Notices	0	0	0	109	**109**
Food Safety Emergency Prohibition Notices	9	0	0	0	**9**
Food Safety Improvement Notices	29	0	0	0	**29**
Health & Safety Improvement Notices	4	0	0	0	**4**
Health & Safety Prohibition Notices	2	0	0	0	**2**
Imported Food/Feed Detention/Destruction Notices	0	0	#	0	**32**
Improvement Notice	4	0	0	0	**4**
Licence Reviews (Resulting in revocation, suspension or conditions)	0	5	0	0	**5**
Litter Clearance Notices	0	0	0	97	**97**
Noise Abatement Notices	412	0	0	0	**412**
Other Abatement Notices (+ Notice of Temporary Closure under Food Hygiene (England) Regulations 2006)	19	0	0	0	**19**
Prevention of Damage by Pest Act Notices	10	0	0	0	**10**
Prosecutions Authorised	54	3	0	4	**61**
Prosecutions Completed	40	2	0	13	**55**
Requirement to Produce Authority to Transport Controlled Waste Notices	0	0	0	18	**18**
Seizures of stereo equipment	5	0	0	0	**5**
Shellfish Temporary Closure Notices	0	0	3	0	**3**
Ship Sanitation Exemption Certificates	0	0	#	0	**128**
Simple Cautions Issued	6	52	0	0	**58**
Voluntary closure of food premises	2	0	0	0	**2**
Voluntary surrender of food	2	0	0	0	**2**
Voluntary Surrender of Unsafe Goods	0	52	0	0	**52**
	601	**143**	**163**	**581**	**1488**

Road Safety

49. Balfour Beatty Living Places have produced the Annual Road Safety Report for Southampton. This is based upon the figures for the year ending December 2012. The summary of the report shows the following:
    - Reported casualties were up on 2011 by 0.5%, but Killed or Seriously Injured (KSI) casualties went down by 40%.
    - Vulnerable road user (pedestrian, cycle and motorcycle) casualties formed 45% of all casualties and 88% of all KSI casualties.
    - There was a 30% decrease in the number of reported KSI casualties in 2012. This follows a 52% increase in the number of KSI casualties from 2009 to 2011.
    - In Southampton the average cost of an accident in 2012 was £58,682.87, and the average cost of a casualty was £41,299.41.
    - The total cost to the local economy of Personal Injury Accidents (PIA) during 2012 was £37 million.
    - Taking into account non-reported injury accidents and 'Damage Only' accidents the total cost to Southampton's economy of road accidents is estimated at £78 million for 2012.
    - The number of accidents involving young car drivers (U25) fell by 30% in 2012. The number of KSI accidents involving young car drivers rose dramatically in 2012 to 20 from just 5 in 2011 and 3 in 2010.

50. The report also shows the short term trend for accidents and casualties. This shows reductions in figures for all categories with the exception of 'slight injuries, which saw a small increase.

Year	Accidents	Casualties	Slight	Serious	Fatalities
2003	816	996	892	98	6
2004	826	1032	925	105	2
2005	731	867	767	96	4
2006	701	829	739	86	4
2007	704	847	762	80	5
2008	622	755	659	91	5
2009	628	756	657	99	0
2010	650	784	662	119	3
2011	671	817	663	152	2
2012	632	777	667	109	1

Hate Crime

51. In 2012/13 Police in Southampton recorded 308 Hate Crimes. Of these 137 were detected, a detection rate of 45%. During the year the Police launched their Hate Crime booklet and associated smart phone App. Both encourage reporting of incidents and provide details of the Southampton City Council Hate Crime Reporting Line. However there were only 18 reports to the SCC Hate Crime line. In addition to this the Parks and Street Cleansing Teams identified 121 incidents of 'hate crime' graffiti.

Category of Crime	Number	Highest volume of offences in	Number
Disability	13	Shirley North	45
Faith Religion	8	Shirley South	46
Honour Based Violence	5	Newtown	25
Race	224	Polygon	31
Sexual Orientation	58	City Centre	29
Total	308		

Serious Acquisitive Crime

Robberies

52. Southampton has one of the highest rates of Robbery in the Hampshire Police force. During 2012/13 there were 738 recorded robberies in Hampshire and Isle of Wight, of these 313 occurred in Southampton (42%). There have been several spikes in offences during the year, but these have been quickly resolved when offenders have been arrested.

53. Robbery has reduced by 20.35% (80 offences) and the majority of robbery offences are youth on youth, ranging from 11yr olds to 16yr old victims (offenders are often the same age). Local youths are thought to be responsible and see fellow youths as easy targets. Personal electronic items such as iPods and smart phones are targeted. Knives have on occasion been threatened but not used in 6% (18) of offences. However, there is the potential for violence to escalate due to many of the known offenders having increasing cannabis habits.

54. Youth on youth violence has slightly increased (14 offences) in this reporting period due to an increase in youth on youth robberies being recorded in Bitterne and Central Southampton. It is thought that this has increased due to ownership of portable electronic items being increasingly more common amongst youths. A report conducted by the Carphone Warehouse stated that 2.8 million children nationally now have a smartphone, including almost one million 8-12 year olds (25%). This makes them more of a vulnerable target.

55. Many of the suspects involved have cannabis habits and when socialising in groups they often take advantage the 'gang' style status it gives them and can use this threat for personal gain. There is a potential for an escalation in violence used. Youth groups are linked to ASB and Criminal Damage and can appear as quite an intimidating threat to the wider local community.

Reoffending

56. Recent data suggests that the reoffending rate in Southampton has deteriorated. The group of particular concern involves those released on licence. It indicates that Offenders on Community Orders re-offend less than elsewhere in Hampshire but that Offenders subject to licence re-offend significantly more. Southampton cases represent 22% of all Hampshire Probation Trust (HPT) cases. 26% of all HPT licences are held in Southampton.

Offending Profile

57. The age group most likely to be involved in offending is 18-24 years and this demographic group has increased in Southampton at twice the national average. Although this in part reflects a high student population, longer term projections suggest a decline in this age group. However, in the short term (the next 5 years) young people are more likely to be offenders or victims.

ALL PROBATION CLIENTS		
	Clients	**Re-offending Rate per 100 offenders**
Birmingham	18,918	12.04
Liverpool	9,395	14.39

Manchester	11,451	16.78
Sheffield	6,410	16.83
Leeds	11,809	18.53
Nottingham	6,602	18.55
Southampton	3,754	19.07
Birmingham	13,312	19.09
Bristol	7,724	20.05
Liverpool	5,686	20.69
Newcastle	4,765	34.10

Clients on Community Orders

	Clients	Re-offending Rate per 100 offenders
Southampton	2,964	18.15
Manchester	8,062	18.26
Sheffield	4,617	19.32
Leeds	8,356	19.70
Nottingham	4,585	20.76
Bristol	5,566	22.10
Portsmouth	1,910	25.29
Newcastle	3,809	37.20

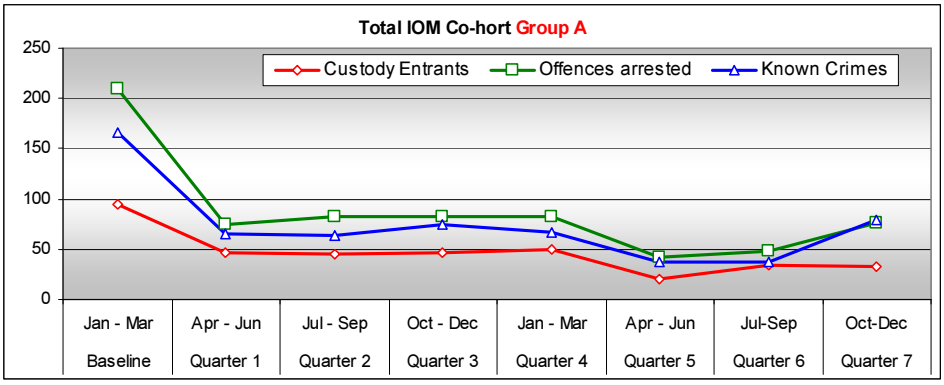
Reoffending Rate for Probation Clients

Clients on Licence		
	Clients	**Re-offending Rate per 100 offenders**
Sheffield	1,793	10.43
Liverpool	3,709	10.87
Birmingham	5,606	11.92
Manchester	3,389	13.28
Nottingham	2,017	13.53
Bristol	2,158	14.78
Leeds	3,453	15.70
Portsmouth	595	19.50
Newcastle	956	21.76
Southampton	790	22.53

Integrated Offender Management (IOM)

The western area IOM team are currently working with 120 offenders across the 4 district areas of Southampton. Group A consisted of 67 IOM Offenders who were tracked over a period of 21 months from their entry in to IOM. This has shown:

- 64.9% reduction in the number of Police custody entrants.
- 63.6% reduction in the number of offences they were arrested for



IOM House

58. The analysis of stay and offending behaviour of the 39 residents of the IOM House shows that:

- During a period of 6 months at liberty before arriving in the house this group of residents committed 256 offences.
- During their time in the IOM House they committed only 37 offences (85% reduction)
- In the 6 months at liberty after they left the IOM house they committed only 70 offences (72% reduction).

Remand Applications Court Sentencing

59. The IOM team are providing bespoke Court and Remand information to support the 'Officer in the Case' in achieving the strongest possible sentence and remand in custody. All Red IOM Remand hearings are attended by the IOM Team and information is discussed in person with the CPS Lawyer. Information relating to their failure to take the opportunities offered to them through the IOM pathways and their risk of reoffending is highlighted to the courts. This action has seen a significant success in the number of successful remand applications and increased court sentences.

IOM Pathways

60. Successful intervention by the IOM Partners (Hampshire Probation Trust and the Society of St James) has resulted in significant improvements in the needs of individual offenders. Offenders are scored on their individual needs against the 7 pathways on arrival with the IOM team and then again at the point at which they are exited and deregistered. In the last quarter there was an 87.5 % improvement in the drugs status for those deregistered with an overall improvement of 28.4 % across all pathways.

Co located IOM Teams

61. Hampshire Probation Trust and the Society of St James are co-located at Southampton Central Police Station. The real time sharing of information is allowing the teams to assess and manage the risk of offending by IOM offenders. Having these teams working together is also really ensuring swift justice; Warrants, recalls to prison and breach of Probation orders are being immediately highlighted and the IOM team driving any activity needed to bring the offender to justice.

62. The IOM Police are having a real input in to the licence conditions of IOM offenders when they are released on licence. As a result, with the assistance of the district teams, stricter enforcement of Probation Licences is being ensured which is preventing offending or returning offenders to custody swiftly.

Identifying the right Offenders

63. The IOM Team are striving to include the offenders that cause the most harm in the communities through their offending. The IOM team are working with Western Intelligence, District TCG's, & Operation Fortress to identify these offenders and open them to the IOM Scheme wherever possible.

Youth Offending

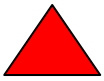
64. The Safe City Partnership monitors three main indicators in relation to young people:
- **Re-offending -** In comparison with other areas Southampton figures are still higher than the national and regional average. There has been an increase in the proportion of young people who re-offend from 38.8% to 46.8%.
- **Reducing Custody -** Whilst the performance has seen an improvement for this period in the rate per 1000 10-17 population from 2.39 to 1.70 Southampton is still higher than both national and regional averages.
- **First Time Entrants into the criminal justice system** - This has also seen an increase for the October to September reporting period. In the previous year the rate per 100,000 10-17 population was 911, which has now risen to 1,028.

65. The reasons for Southampton's adverse position are still being explored. However, it is known that a small number of young people are responsible for a significant proportion of offences being committed by young people. These young people have been identified and work has commenced to discuss action plans with each of them at a regular Priority Young People multi-agency meeting involving the Police, Youth Offending Service and Community Safety. A reduction in the reoffending of this small group will have a huge impact on overall performance. The Community Tasking and Coordinating Group also monitor young people who are coming to light for anti-social behaviour and their offending behaviour. These young people are regularly discussed to agree multi agency action to address their behaviour. This involves decisions to take enforcement action as well as divert to projects such as Families Matter.

66. As a result of the upward trend in this area the Safe City Partnership has identified this as a priority for 2013/14.

Re-offending

67. A 12 month rolling cohort starting every quarter measures the number of offenders that re-offend and the number of re-offences that they commit, over the following 12 month period. It is an identical methodology to that used for adult offenders – and covers all young people in a cohort who have received a substantive pre-court or court disposal.

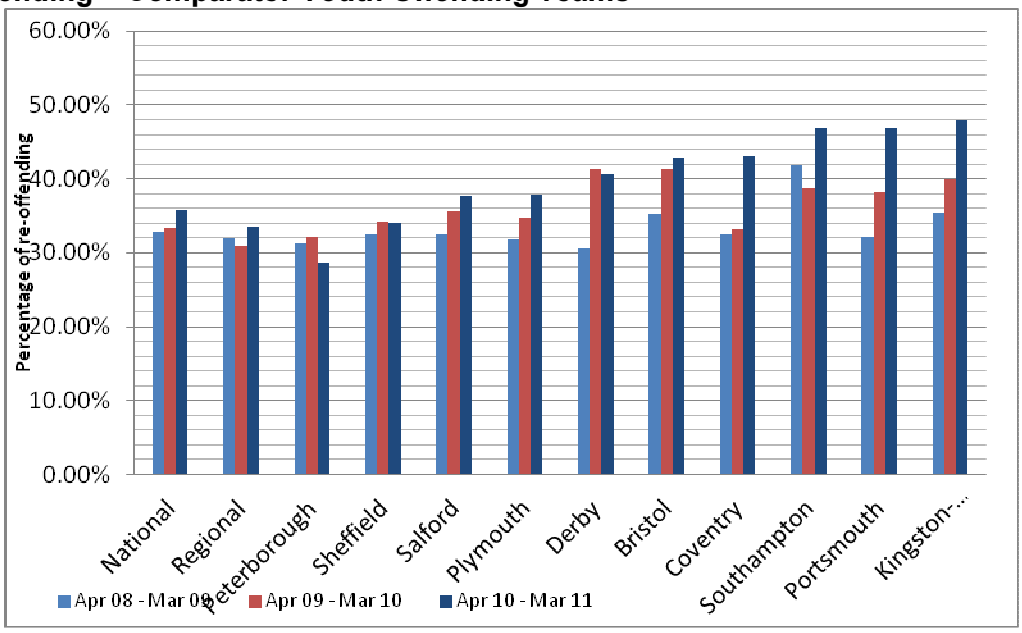
Year	Cohort Size	Re-Offenders within 12 months	Re-Offences within 12 months	Proportion of YPs who Re-Offend
Apr 09 – Mar 10	676	262	876	38.8%
Apr 10 – Mar 11	**434**	**203**	**701**	**46.8%**
Target Green <35% Amber <45% Red >45%				
Measure This indicator measures re-offending using data drawn from the Police National				

68. Southampton's re-offending rate is still higher than the national and regional averages (see overleaf) and is amongst the highest of its comparator YOTs. Performance is variable in most, with only Peterborough demonstrating a consistently downward trend, so it is difficult to identify any patterns/trends. Overall although the cohort size has reduced the proportion of offences per offender has increased from 1.3 to 1.62.

69. The Priority Young People (PYP) scheme has now been developed to respond to the re-offending level in Southampton. This partnership approach involves YOS, police and community safety co-ordinating responses in respect of the most high risk young people in the City, as identified through YOS and police data.

70. It is proposed that the 2013/14 YOS target for reducing re-offending should be a reduction of 5%. Quarterly re-offending rates within the initial PYP cohort will be monitored and reported to both the board and the Safer City Partnership.

Re-Offending – Comparator Youth Offending Teams



Reducing Custody

71. There has been an improvement in the level of custodial sentencing for the latest rolling 12 month period. The custody rate for the period January 2012 to December 2012 expressed per 1000 10 to 17 population reduced from 2.39 in 2011 to 1.70.

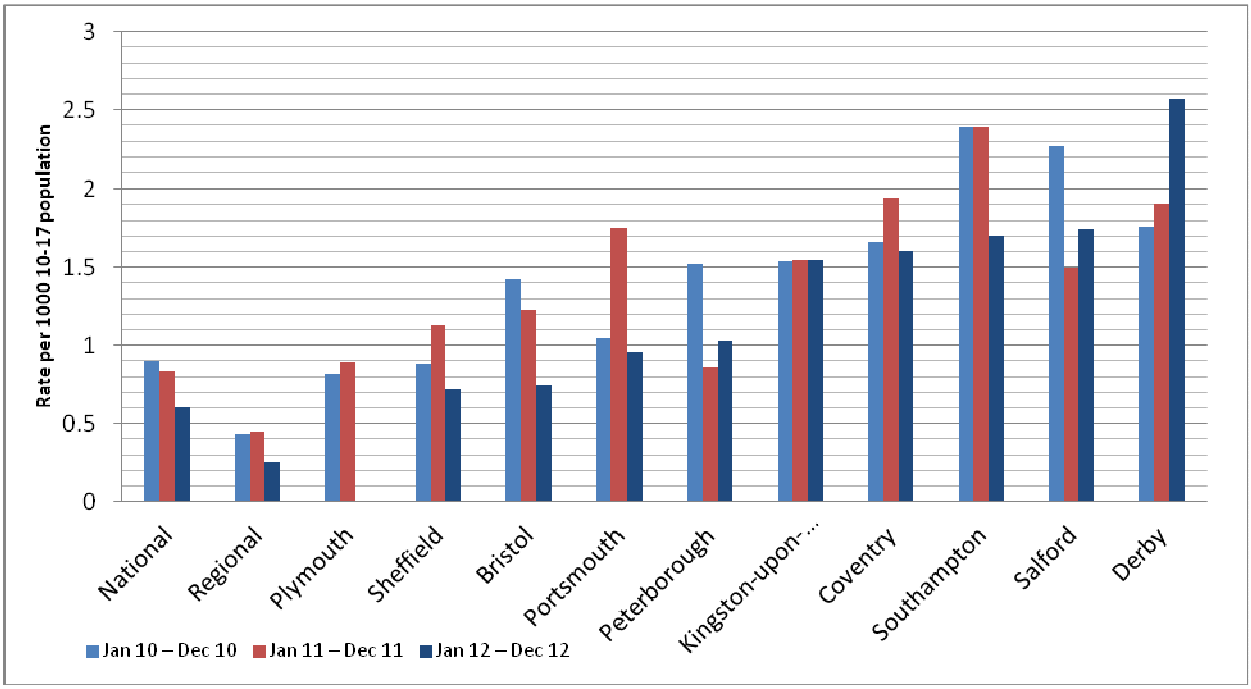
72. Southampton's custody rate is still higher than both the national and regional averages and the latest data is again higher than all but two of the comparator YOTs listed overleaf. It is again difficult to identify any particular patterns amongst the comparators, although the predominant trend is downwards.

73. In order to support further service improvement, the Youth Justice Board Local Partnership Delivery Advisor has analysed a selection of Southampton pre-sentence reports and her findings are available for discussion today. The report has been discussed with the senior practitioners as part of a quality assurance workshop in order to support more consistent gate keeping practices. Further work will be undertaken, on the back of the recommendations, to drive the custody rate down further. It is proposed that the YOS 2013 / 14 target for reducing custody should be <1.00 per 1000 young people, 10 – 17 population.

Year	Number of Custodial sentences	Rate per 1000 10 to 17 Population
Jan 11 – Dec 11	49	2.39
Jan 12 – Dec 12	**27**	**1.70**

Target Green < 1.50 Amber < 2.50 Red > 2.50 (per 1000)	
Measure This indicator measures the number of custodial sentences given to young people per 1,000 young people (10 to 17 years) in the locality. It is drawn from YOIS and uses population data taken from the Office of National Statistics mid-year estimates. Latest data is in **bold**.	

Custody – Comparator Youth Offending Teams



First Time Entrants

74. There was a rise in First Time Entrants (FTEs) compared to the period in the previous equivalent year from 911 per 100,000 for the 10-17 year olds (between October 2010 and September 2011) to 1,028 per 100,000 for the 10-17 year olds (between Oct 2011 and Sep 2012). Southampton's rate is higher than both the national and regional average and indeed higher than any of its comparator YOTs. There is a consistently downward trend in most areas, in contrast to these local figures.

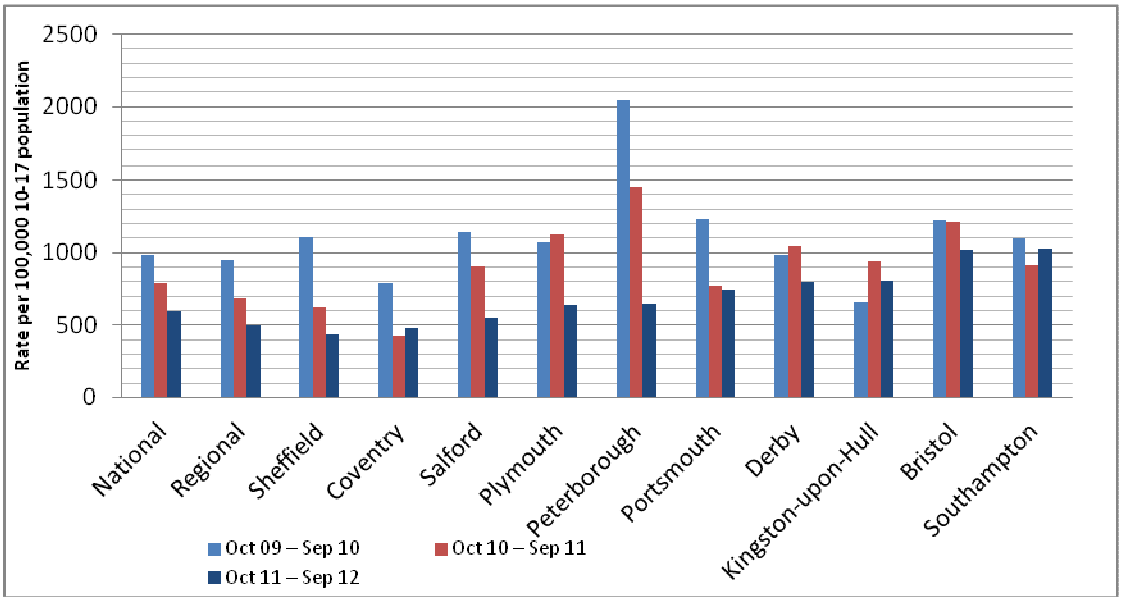
75. The Youth Offending Service in partnership with Community Safety and the Police has reviewed the use of community resolutions for young people who offend as an alternative to a caution or court action. As a result training for police inspectors around the use of community resolution has been completed. The YOS police officer and case workers tasked with early intervention work are increasing their visibility at Southampton Police Station in order to support diversion disposals with police colleagues. A 'telephone triage' arrangement is also being discussed.

76. It is proposed that the YOS 2013/14 target for reducing First Time Entrants should be a reduction of 10%. The number of young people successfully completing Youth Restorative Disposals will be reported to the Safe City Partnership, in addition to the YOS Management Board. A Youth Restorative Disposal is an alternative to formal action such as a caution or court appearance. It can take the form of an apology to the victim, clearing up damage caused, or work within a community to make up for the offence committed.

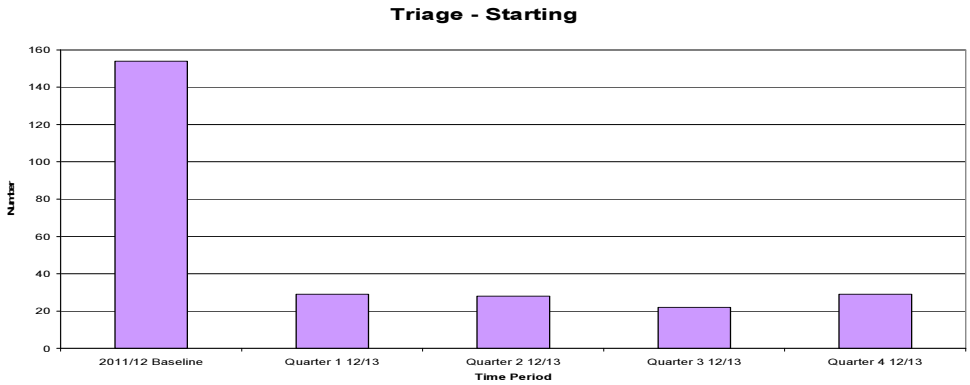
Year	Number of FTEs	Rate per 100,000 10 to 17 Population
Oct 10 – Sep 11		911
Oct 11 – Sep 12	**193**	**1028**

Target Green < 950 Amber <1000 Red >1000 (per 100k)	
Measure This indicator measures First Time Entrants (FTE) using data drawn from the Police National Computer – the graph displays the number of FTEs as a rate per 100,000 young people (10 to 17 years) locally. It uses population data taken from the Office of National Statistics mid-year estimates. The cohort represents young people who have received a first 'substantive outcome' in the period i.e. Reprimand, Final Warning or court outcome. Latest data is in **bold.**	

First Time Entrants – Comparator Youth Offending Teams



Triage / Youth Restorative Disposal



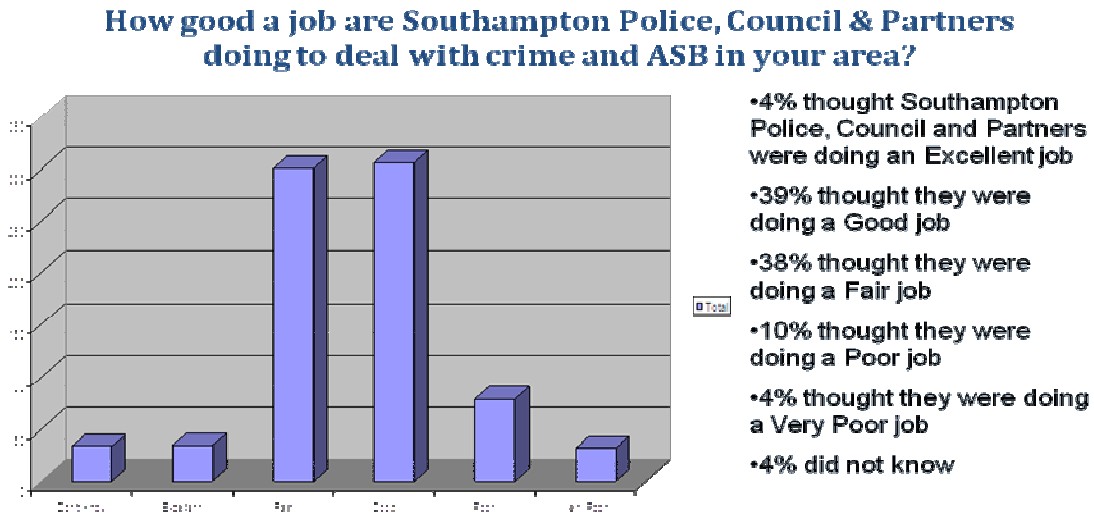
	2011/12 Baseline	Qtr 1 2012/13	Qtr 2 2012/13	Qtr 3 2012/13	**Qtr 4 2012/13**
TRIAGE / YRD	154	29	28	22	**29**

Measure: This indicator measures the number of Triage interventions that the YOT has commenced during the quarter.

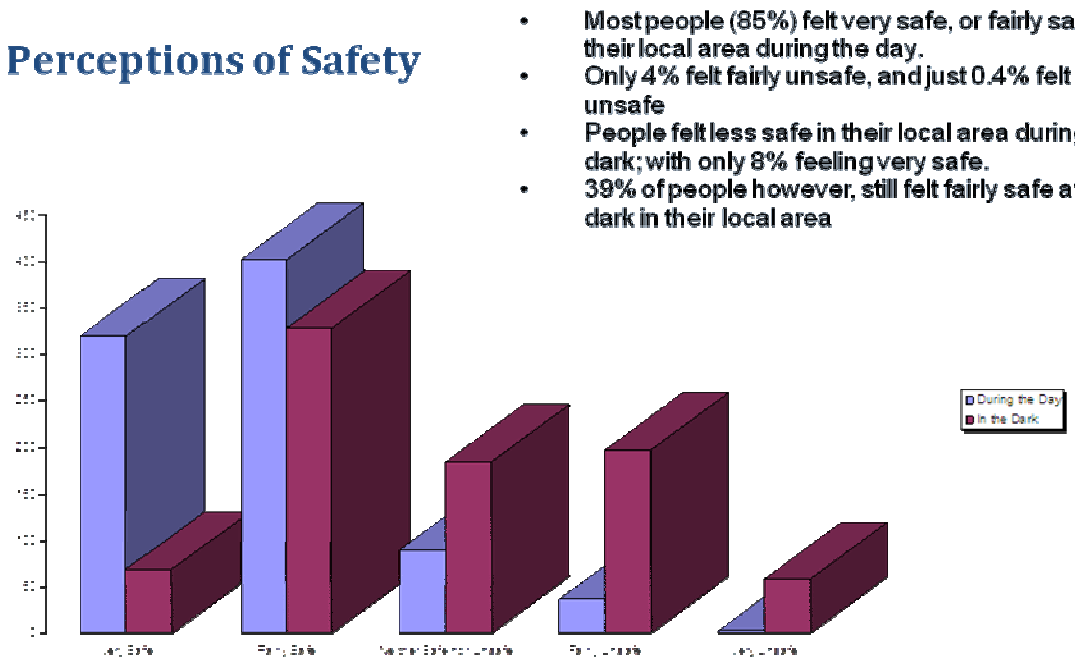
PUBLIC PERCEPTION AND INVOLVEMENT

77. In the 2010 City Survey (of a representative sample of residents) 91% said they felt safe in their local area during the day (up 6% from 2008); 57% said they felt safe in their local area after dark (up 19%). 50% of residents felt the Council and Police successfully tackle crime and anti-social behaviour (up 27% from 2008). However, when asked if crime was increasing or decreasing, 72% said it remained unchanged, 20% thought crime had gone up and only 8% said crime had decreased.

78. In January 2012 the Community Safety Team conducted a 'Perception of Crime Survey, asking 'How safe do you feel in Southampton. This was sent to officers in all of the partner agencies that work together on the Safe City Partnership as well as Neighbourhood Watch Coordinators. Both target audiences were asked to cascade the survey and as a result 872 partners and residents responded. Of the respondents 73% were residents of Southampton and 74% worked in Southampton. It is intended to complete a further City Survey in the autumn of 2013



79. Perceptions of safety showed that more people felt unsafe during the hours of darkness compared to during the day.



80. A comparison between the PLACE Survey (2008), the City Safety Survey (2010) and the Perception Survey (2012) showed that there had been a significant decrease in public perceptions across the city both during the day and after dark; with a 7% decrease and 17% decrease respectively. However, these figures should be viewed with caution due to the different sample size and methodology of each survey.

81. When asked what the most important issues were for the City the responses adduced the following responses:
    - Anti-social Behaviour was the most important problem in Southampton that respondents felt the Safe City Partnership should focus on with 42% of respondents feeling that this was a very big problem in Southampton.
    - The next highest category was alcohol-related crime with 31% of respondents stating this was a very big problem in Southampton.
    - 30% of people thought drugs was a very big problem in Southampton
    - 21% of people thought that physical assault was a very big problem
    - 20% of people felt criminal damage was the most important problem
    - 19 % thought sexual assaults and verbal abuse in the street were a very big problem respectively
    - Domestic Violence came in at 17%, and burglary at 16%
    - Lower categories of priorities were vehicle vandalism / theft; robbery and racial and homophobic abuse and attacks.

82. Of particular concern is that, of the 30% of respondents who had been a victim of crime or anti-social behaviour, 39% did not report the incident. Reasons given were a perception that the Police would not investigate, or that they felt that the incident was too trivial.

83. In 2013 Southampton City Council commissioned a school survey with 2,114 Southampton children (1063 boys, 1051 girls). The survey produced the following results:

Bullying

Reported bullying falls Y4-Y11
Fear of bullying falls Y4-Y11
Dissatisfaction with bullying rises between Y4 and Y11

Bullying in Southampton 2012-13	Year 4	Year 6	Year 9	Year 11
Bullied in the last year	32.9%	31.5%	23.7%	18.2%
Bullying sometimes makes me afraid	26.3%	28.7%	26.9%	12.2%
Bullying often makes me afraid	9.1%	5.9%	5%	3.6%
I am not happy about how my school deals with Bullying	13.5%	14.8%	28.7%	27.1%

Feeling Safe

Children feel safest at home

The lower fear of bullying at secondary doesn't translate into feeling safer at school

The least safe feeling place is near their home after dark and using public transport

Where our children feel unsafe	Year 4	Year 6	Year 9	Year 11
I feel unsafe at home	3.6%	1.5%	0.8%	2.5%
I feel unsafe near home after dark	26.3%	28.7%	26.9%	24.4%
I feel unsafe near home during the day	5.3%	3.1%	4.2%	2.5%
I feel unsafe at school	3.8%	4.4%	9.7%	6.9%
I feel unsafe travelling to and from school	6.9%	7.9%	9.1%	5.7%
I feel unsafe using public transport	19.2%	18.2%	20.5%	12.7%

Alcohol, tobacco and drugs

Age brings increased exposure to risks around choices on the above

Alcohol, smoking and drugs	Year 4	Year 6	Year 9	Year 11
Have drunk more than a sip of alcohol	N/A	22.5%	52.8%	76.8%
Have drunk alcohol without my parents knowing	N/A	6.4%	15.5%	20.0%
One or more parents smoke in my home	45.1%	49.1%	48.8%	42.5%
Have been offered illegal drugs	N/A	N/A	17.9%	34.3%

PERFORMANCE AGAINST THE 2012-15 PARTNERSHIP PRIORITIES

Priority 1 – Reduce Crime, ASB, Fires and road collisions in strategic localities across the city

Population

84. The 2011 Census population of Southampton is 236,900. The population pyramid for Southampton shows we have a large number of people aged 20 to 24 (20,900) this is partly due to the large student population recorded in the 2011 Census. Just under 17% of Southampton's population is aged between 18 and 24 years compared to 9.4% nationally. The number of people aged 65 years and over is set to rise by 10% between 2011 and 2017. (17% between 2011 and 2021) (*Source SNPP 2011 base*).

Population	**236,900**
• Residents with ethnic origin other than White British	52,900
• Students	20,900
• Residents living in top 5 priority neighbourhoods (LSOA)	14,600
• Children under 16	41,348
• Working age population 16 – 64 (69.6% of total population)	180,201
• People over 65	30,776
• People over 70	22,129

Source: 2011 Census ONS Crown Copyright Reserved

85. In the 2011 Census there were 101,272 residential dwellings in the City and this is forecast to increase to 109,200 by 2019 - a growth of 7.3%.

86. The Index of Multiple Deprivation identified five areas in Southampton as areas of high deprivation, namely Weston, Northam, Millbrook, Redbridge and Thornhill. As crime and disorder issues in these areas were greater priority in other areas, the focus has been in Bitterne, Sholing and Harefield where crime rates were much higher than the identified area of deprivation in the east of the City. When prioritising resources the Police and partners agreed to direct them to these high crime areas.

87. This priority was addressed through the Community Tasking and Coordinating Groups that meet once a month in the four police station areas. These meetings make extensive use of the Crime Reports system to identify 'hot spots' and rising trends in crime and disorder.

88. The partners who make up the Community Tasking and Coordinating Group review hot spot locations for crime and anti-social behaviour as well as those coming to notice for their anti-social or offending behaviour. As a result coordinated actions by relevant partners are agreed. Decisions are taken about the application for Section 30 Dispersal Orders, the use of Street CRED, additional police activities and special operations to address identified issues. These include operations to address underage drinking, damage to buses and anti-social use of motor cycles.

89. At each Community Tasking and Coordinating Group the Community Priorities identified at Police and Communities Together (PACT) meetings are discussed for all 22 Safer Neighbourhood areas. Any issues identified are dealt with appropriately.

90. **Developing a multi-agency approach**
We developed a multi agency approach to identifying and supporting victims of ASB which has improved identification of victims who are vulnerable. In additions partners worked together to develop action plans to tackle 'spikes' in various crimes at certain

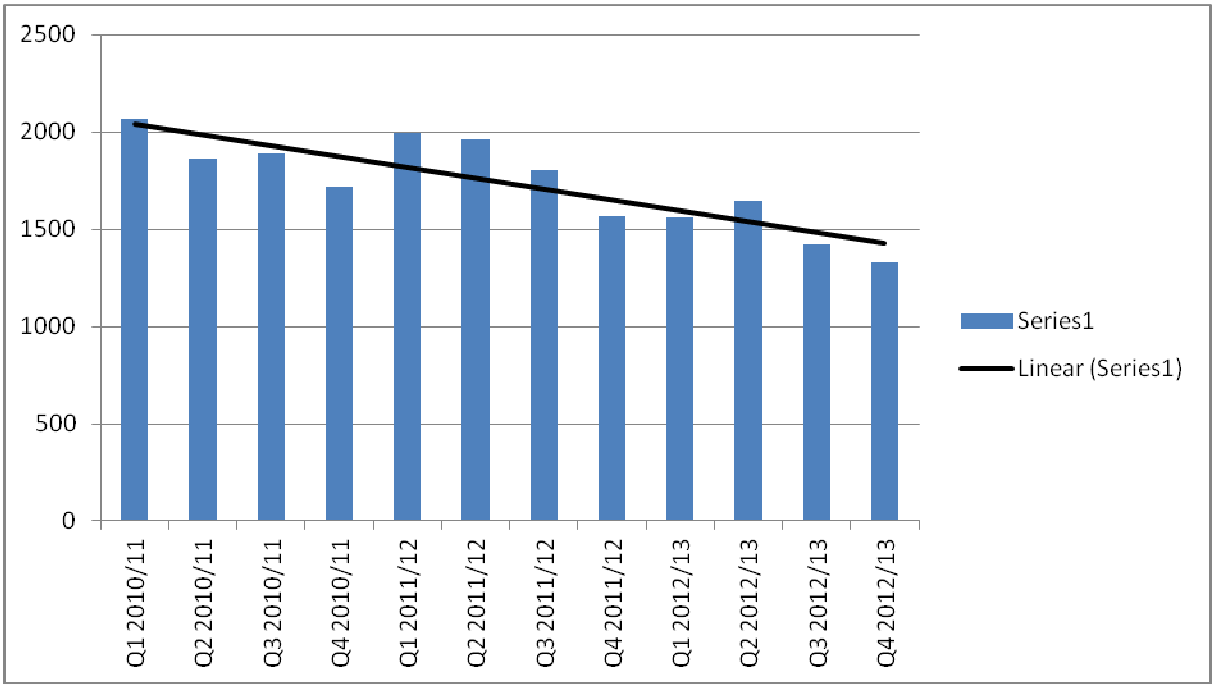
times of the year and tackle various hot spots through patrols, Street CREDs, dispersal orders, street briefings and special operations.
These actions resulted in a reduction in 'student' burglaries, and reductions in ASB and arson during the Halloween and Bonfire period. In addition the number of younger people who have signed an Acceptable Behaviour Contract has increased by 104% from 24 in 2011/12 to 49 in 2012/13.

91. **Enforcement and neighbourhood safety**
Residents in 11 parts of the city, including Bevois Valley, Portswood, Polygon, Irving Road, Violet Road, Riverside Park, Rockstone Lane, and Vanguard Road benefited from a Street CRED in 2012/2013 led by the council. The Street CREDs join up services to make immediate environmental improvements to an area and provide safety advice. The activity resulted in tonnes of rubbish being removed, vegetation cut back and new plants and trees planted. Community Payback have provided approximately 50 hours of free labour along with council teams from Open Spaces, Waste and Recycling, Environmental Health, City Patrol, Community Safety, volunteer organisations and local community have all contributing to the Street CRED days.

Priority 2 – Reduce the Harm Caused by Alcohol and Drugs

Violent Crime

92. 'Violent crime' is a generic term covering a range of offences from common assault to harassment although according to the British Crime Survey almost half of all recorded violence involves no physical contact. At the other extreme Most Serious Violence are police recorded offences where the injury inflicted or intended is life threatening and both nationally & locally this makes up between 2 – 3% of all violent crime. Violent crime represents on average just under a quarter of all crime.

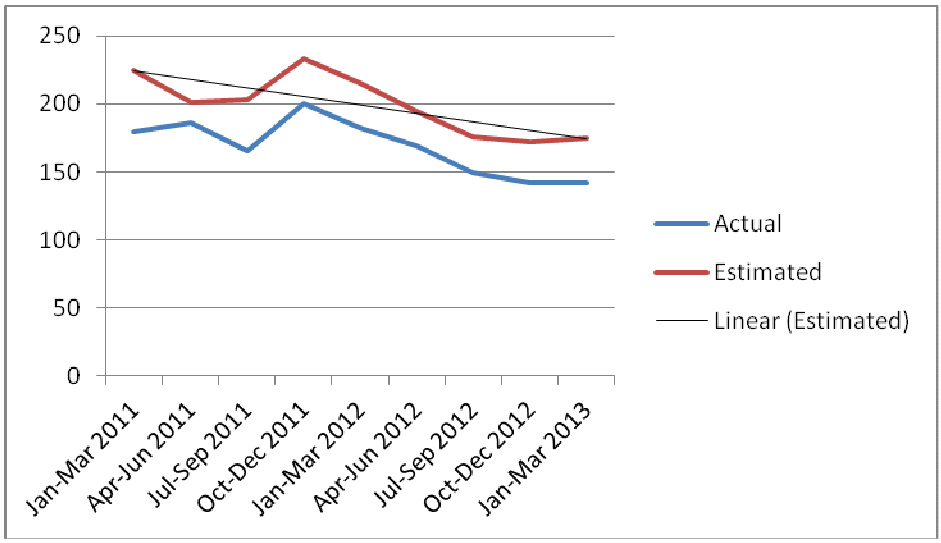


93. In the Strategic Assessment period (2012/13) violent crime reduced by 19.29% (1,418 less violent crimes compared to the same period in 2011/12) and this continues a year on year decline as shown in the chart above. Within this category Violence with Injury reduced by 21.96%. The key components of violent crime are:
- Night time economy alcohol-related violence (makes up about 11.5% of violent crime)
- Domestic violence (makes up 20.36% of violent crime)

- Serious sexual violence
- Drug related violence (key contributor to most serious violence)

Night Time Economy (NTE)

94. Alcohol-related violence in the city centre at night is prevalent in all urban areas and a significant cause for concern at a local and national level. Violence in the night time economy has reduced for the successive year, with a 31.7% drop in 2012/13. This fall in recorded violent crime coincides with Emergency Department data which shows the number of presentations to the hospital emergency department late at night as a result of assaults – this data shows an 18% reduction in 2012/13. Southampton is a leading city in collecting Emergency Department data on assaults which reflect peak night time economy periods and thus are linked to predominantly alcohol-related incidents. This data is a valuable indicator as it captures unreported (to the Police) incidents and thus together with police data provides a more accurate picture of the prevalence of alcohol-related violence in the city, as well as contributing to a measure of the impact and associated costs on the NHS. Emergency Department assault data shows a fall of 862 presentations of assault between the hours of 18:00 and 09:00 in 2011 to 758 in 2012, a 12% reduction.



95. Victims of assaults are more likely to be males, making up 77% of all victims. Males aged between 18 and 24 are also more likely to be victims of assault, making up 31% of all victims. The gender of offenders is known in 73% of all presentations to the Emergency Department. Males were involved as offenders in 89% of these assaults. Offences occur in the area of the city dominated by bars and clubs (SO14) and peak times are Friday & Saturday nights between 22:00 and 03:00 – although there is also a small peak on Tuesday nights.

96. It is difficult to attribute the reduction in violent crime in the night time economy as there are so many factors that can have an effect. However, the Safe City Partnership has over the last three years ensured that there are a suite of initiatives to tackle this issue. High visibility and targeted police patrols taking early and robust action to deal with crime and disorder obviously play a big part in reducing violent crime alongside other key measures including the regular deployment of Taxi Marshalls, Street Pastors and the ICE Bus. In addition the Licensing Trade, supported by the Local Authority and the Police has introduced the Red Card scheme. This results in offenders being banned from licensed premises for varying periods of time. The newly formed Licensing Action Group coordinates enforcement action across a range of agencies and together monitor adherence to licensing law and conditions as well as considering new applications for licenses or event notices.

97. There has been a 28.7% decrease in Alcohol and Public Place Violence. The economic climate has led to a reported 20% reduction in footfall in the NTE area, which has in turn led to a reduction in officers employed to police the night time economy at the weekend. Night time economy related Personal Robbery and Sexual Offences have also seen a reduction in offences – In this period there have been 7 indecencies (+1), 1 rape (-1) and 9 robberies (-3) which link directly to the night time economy

98. Alcohol is thought to be the main driver however it is thought that there are individuals who use drugs as well as drinking alcohol which can also be a catalyst for violence. Pre-loading is an ongoing issue, particularly in the current economic climate where many pubs now are not able to promote 'cheap' alcohol due to licensing restrictions.

99. Night time economy violence is still a risk for the city due to the high volume of pubs/clubs/bars etc in the city centre area, coupled with the high density of student population. The main risk is for any minor altercation to potentially escalate and result in serious injury or death. The other significant risk is intoxication through excessive alcohol consumption to the extent that it causes serious physical harm or death (see Alcohol section).

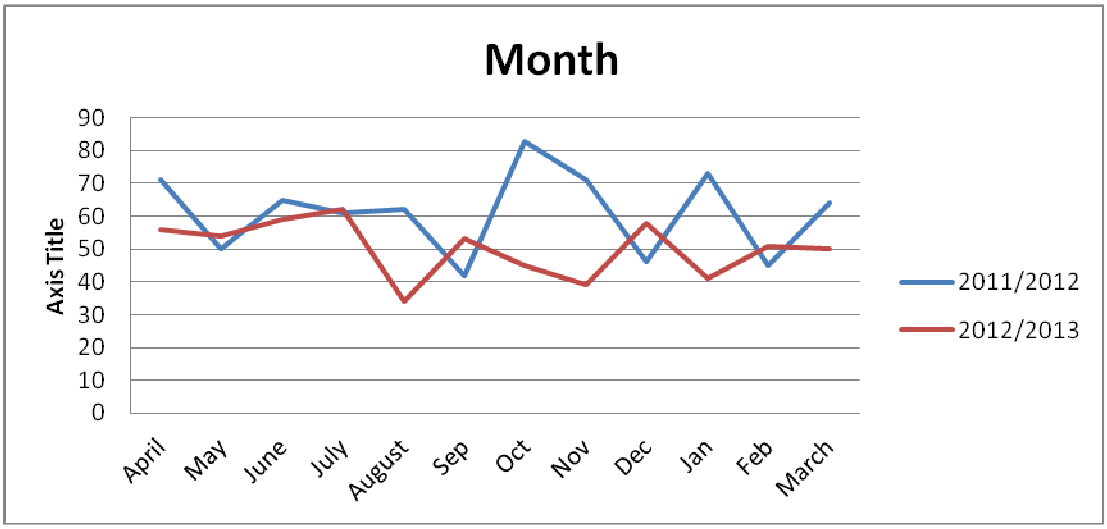
Red Card

100. The Red Card Scheme was launched in July 2012 and is a zero tolerance banning scheme designed to keep trouble makers and criminals away from licensed premises and the wider Night Time Economy. The licensed premises under the banner of Southampton Licensing Link will administer the scheme and will work closely with the Police, Local Authority and City Watch (CCTV). Those people involved in alcohol related crime and disorder will be considered for a Red Card and banned from participating premises for a set time. There have been 163 Red Cards issued up to 31st March 2013.

101. From 1st May 2013 a NHS funded drink aware course run by Druglink will be linked to the Red Card Scheme. Those who choose to go on these courses will have their ban reduced or have no ban at all.

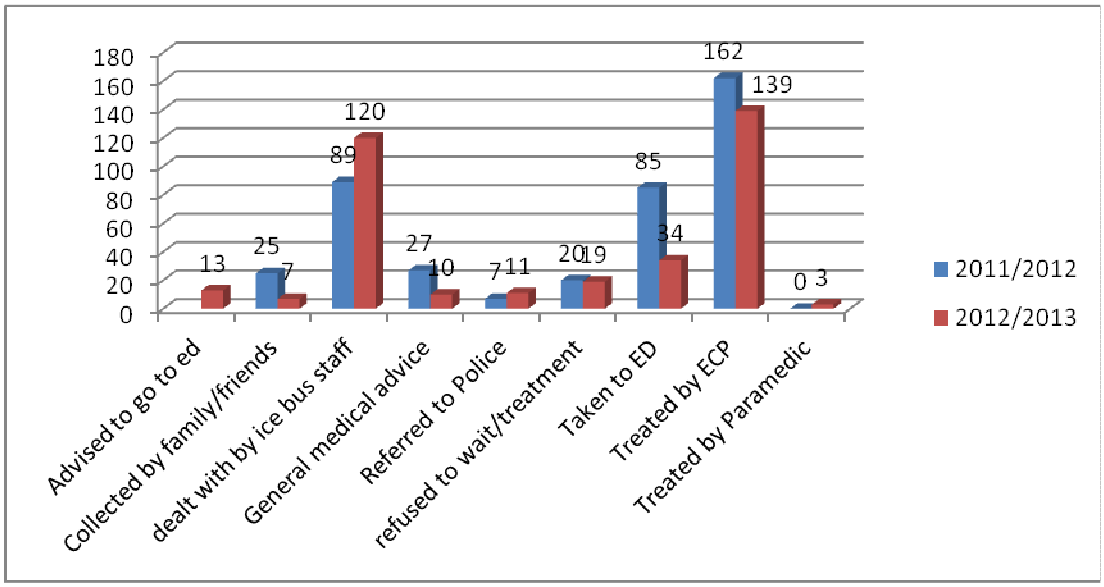
Emergency Department Data

102. Since 2006 Emergency Department (ED) data has been analysed by the Community Safety Team and Police. The data alongside Police, ICE bus and other partners is used by the Police in order for them and their partners to deploy resources more effectively. Community Safety are responsible for a completing a full analysis report which would be used at strategic level to develop policies and strategies. From April 2012 to March 2013 assault admissions to the emergency room reduced by 18% from 733 assaults in 2011/2012 to 602 in 2012/2013. However, assault presentations did increase during the months of May, September and December.



I.C.E (In Case of Emergency) Bus

103. The ICE Bus has been in operation since December 2009 and has dealt with over 1,300 clients. In 2012/13 the staff dealt with 357 clients which is a reduction of 14% which could be caused by the reduction in violent crime, reduction in those visiting the city centre at night and the withdrawal of the ambulance response paramedic. Of those dealt with, 20% were injured as a result of an assault, 19% were injured and in drink, 15% were intoxicated and 15% were in need of welfare support. The ICE bus also assisted during a 'Carnage' event which was partially funded by the 'Carnage' organisers. In 2013 the ICE bus will also be out extra nights helping those in need during the Fresher's Fortnight.



Safe in Sound Project

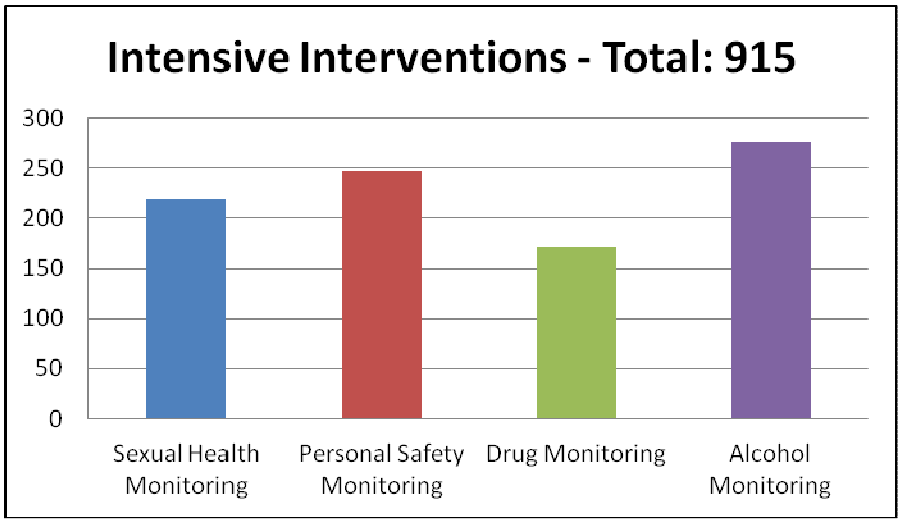
104. Safe in Sound is a volunteer peer led project primarily based in the City Centre and looks at raising awareness of health related issues and potential risk taking behaviours in the night time economy. Their work focuses on substance and alcohol use, sexual health and the personal safety of those people who are using venues in town.

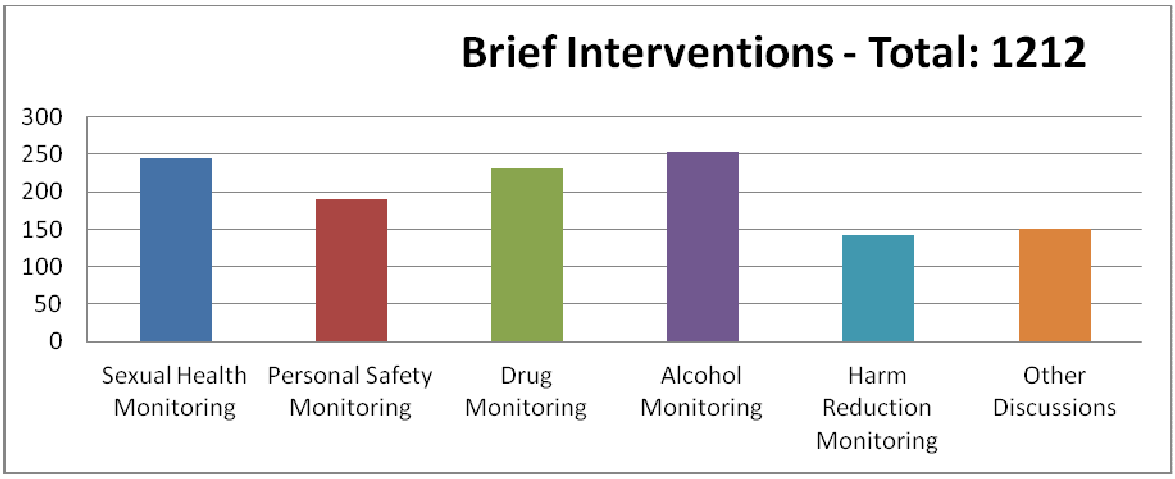
105. Current work shows there is a rise in the popularity of 'legal highs', due to websites openly marketing and adapting the products to young people by claiming that effects mimic that of Class A and B drugs. With these substances being produced at the alarming rate, it has been a focus of the project to deliver general harm reduction information to the people who are most at risk to use these. There has also been an increase in individuals taking MDMA, which is a pure form of Ecstasy.

106. Along with the persistent prevalence of alcohol use within the city, seeing new products like 'Crunk Juice' and alcohol related sexual crime at a significant high, the need for the project to offer information and support is as great as ever. There has been an increase with pre drinking before going out and views on marijuana are very liberal, this all aids in individuals being intoxicated before going out. Due to financial climate many individuals are feeling the pinch and opt for house-parties or staying in with friends, this unfortunately cannot be monitored.

Health Outreach

107. Safe in Sound delivered 31 outreach sessions in key hot spots in the night time economy, where volunteers visit night clubs and streets with high levels of activity to offer support and advice. During these sessions there were:





Safe in Sound statistics

108. General Night Time Economy Trends (of 241 people)
- 47% of young people claim to go out to the NTE over 2 nights a week
- 74% of young people walked home by themselves on a night out in the last year

109. Alcohol (267 people)
- 35% of young people are at a higher risk of alcohol related illnesses
- 42% of young people drink more than 10+ units on a night out
- 55% of young people had forgotten what happened on a night out in the last year

110. Drugs (out of 241 people)
- 16% of Young people admit to taking MDMA/Ecstasy on a night out in the last week
- 12% cocaine
- 26% marijuana
- 11% legal highs

111. Drugs (out of 156)
- 55% claimed to have taken illegal drugs in the last year
- 45% claimed to have taken legal highs in the last year
- 12% claimed they cannot get through the week without drugs
- 33% do regrettable things due to drug use

112. Sexual Health
- 26% of sexually active young people claimed to never use contraception (of 213 people)
- 45% of young people claimed regretting a sexual experience in the last year
- 35% of young people claimed to have had sex in a public place in the last year (212 people)
- 29% of young people claimed to never have had a sexual health check (211 people)
- 24% of young women had used emergency contraception in the last year (208 people)
- Given out over 3000 condoms

Street Pastors

113. Over the last year Street Pastors have increased the number of volunteers who are now patrolling as Street Pastors. They continue to patrol the Night Time Economy every Friday and Saturday between 2200 and 0400, as well as one Tuesday a month. They have also expanded the remit of their patrols into Hoglands Park, Guildhall Square and some patrols in Shirley. During 2012/13 they recorded the following statistics:

Activity	Numbers
Number of drunk people who needed some form of assistance	306
Number of aggressive situations where street pastors intervened to calm things down	69
Number of vulnerable people assisted to locate their friends or assisted to get home	122
Number of injured or unwell people given assistance	98
Number of times called for ambulance or paramedic	31
Bottles or glasses picked up from the street - Does not include broken glass swept up	4473
Number of times broken glass was swept up	185
Number of people referred to ICE bus or referred by ICE bus	45
Number of times called to assist by CCTV, Door Staff, paramedic or Police	141

Serious Sexual Offences

114. There were 196 sexual offences reported to police in the Strategic Assessment period and this represents a 27.7% fall on the previous year. This also continues a reducing trend over the last two years. Detection rates for this crime in Southampton have increased. However, it is known that rape and other serious sexual offences are under-reported. Rape Crisis helpline offers advice to people affected by issues of rape and sexual abuse and they report a substantial increase in clients accessing support in 2012 – 1,928 calls compared to 1,768 in the previous year. Of those 957 were female and 81 male (this does not necessarily reflect current or recent offending behaviour).

115. With an improving position in local data year-on-year Southampton is improving in its comparative rankings in this area. For example in comparison to our most similar group

of 15 cities Southampton is in 8th position out of 15 for sexual offences (1 = best). This is an improvement of 6 places on the previous year.

116. Victims of serious sexual offences are in the majority female between 16 and 30 years old.

117. Although the number of recorded crimes in this area is relatively low and the potential risk of 'stranger' attacks exceptionally low this crime-type has a high impact on victims and a high public profile with media coverage often fuelling fear of crime especially amongst young people.

118. Alcohol consumption is a critical factor in serious sexual offences especially those linked to the NTE. Alcohol is the biggest vulnerability for both victim and offender.

Drug related Violence

119. Transient Class A suppliers continue to infiltrate the city, primarily from London, bringing a risk of violence. Areas most vulnerable are Newtown, St. Marys and Millbrook. Knives and bladed articles remain the most common weapons. Reported incidents include murder (April 2012), attempted murder (April 2012) and a serious assault of a Shirley-based drug dealer (February 2013). There was a lack of intelligence reporting and increased tensions prior to these, indicating intelligence gaps around drug related violence events including the acquisition of weapons and contact with enforcers. Serious violent offences are mainly transient offenders on local dealers however, there have been a number of local on local offences too. Robberies (of mainly drugs/money) mainly involve local drug dealers, particularly those trying to increase their status or reclaim back drug debt.

120. Operation Fortress began in May 2012. Increased intelligence sharing has developed significantly between Operation Fortress and Metropolitan Police Service (MPS), improving the intelligence picture and enhancing disruption activity. There are currently 24 overt Fortress-led investigations and 10 networks believed to be at increased risk of committing drug-related violence within the city.

121. Intelligence indicates that Operation Fortress has impacted on dealers (changing their methods due to Operation Fortress tactics), and is restricting supply and reducing demand. An increase in actionable drugs intelligence may be linked to the fact that Operation Fortress is able to respond to drug intelligence, which has led to some good results being obtained.

122. An increase in tensions between drug-related nominals linked to court cases has been identified. Intelligence reported threats and intimidation in relation to a related court trial and concerns have been raised in relation to other operations.

123. Difficulties have also been encountered in relation to a lack of cooperation with the Police, particularly where nominals and witnesses are themselves involved in drugs and violence.

124. A strong media campaign has ensured that officers from partner agencies are fully engaged, with increased reporting suggesting an increased awareness of the issue of drug related violence. Significant community engagement and partnership working is seeking to restrict supply, reduce demand, and rebuild communities. The first ‘Crack House’ closure in Southampton in 6 years was led by Operation Fortress, a positive result for the local community.

Key Driver

125. The Class A Drugs market fuels this issue. The most common cause of violence in this period is a perceived financial loss to a drug dealer, either through police seizures or theft by associated/rival runners.

Risk

126. Ultimately the risk is loss of life and/or serious injury. This has implications in terms of cost of investigation, often hampered by a lack of co-operation by those involved; the impact on local communities, and the Force reputation. This remains an unpredictable offence, despite increased knowledge of involved networks.

127. During the 2012/13 period Operation Fortress officers have:
    - Detained 212 persons
    - Seized approximately £149,865 street value of controlled drugs
    - Seized approximately £106,090 in cash.

Drug Action Team

128. The performance of the Drug Action Team is measured against other Drug Action Teams within the South East region, or against Drug Action Teams that are considered to be of similar size and demographics.

129. In November 2011 the National Treatment Agency (NTA) published the new "Diagnostic and Outcome Measure Executive Summary" report, which is a quarterly report that contains key treatment outcome and diagnostic data at a partnership level to assist local areas to monitor performance and compare that to national trends. The report has been designed to give an 'at a glance' view of performance against outcomes for different levels of stakeholders in the partnership.

130. All items on the report are for adults and key outcome indicators are broken down by opiate only and non opiate users and graphical trend data is also presented alongside most indicators, either as a trend graph or pie chart. All items on the report are based on the adult treatment population.

131. Partnership clusters based on characteristics affecting outcomes of opiate users in treatment have been created to allow for benchmarking against similar partnerships.

132. The most significant targets being monitored by the National Treatment Agency Regional Manager's team are those of successful completions and the number of service users within a 6 month period who go on to represent to treatment services within 6 months of discharge.

133. The DOMES report is a high level report that we need to rely on in order to understand what the data is telling us about our current treatment system. The National Treatment Agency will now use DOMES to demonstrate to Public Health England and to government that the treatment system works appropriately and is able to deliver the best returns for the money invested.

134. The first graph illustrated shows progress against the 2010/11 baseline and shows us the trend in performance. The number of service users who have completed treatment successfully as compared with the number who completed successfully in the previous quarter had risen by 1. The treatment system needs to increase the number of successful completions by 15 in order to be on a par with those DAT's in the top quartile.

DIAGNOSTIC OUTCOMES MONITORING EXECUTIVE SUMMARY

Southampton

Report period	Quarter 4	Opiate cluster	Cluster D	Non opiate cluster	Cluster B

1 INVESTMENT

£2,080,826

PTB	DH DIP	HO DIP	Mainstream	Prison	Other
£ 1,795,697	£ 186,055	£ 99,075	£ -	£ -	£ -

2 SUCCESSFUL COMPLETIONS

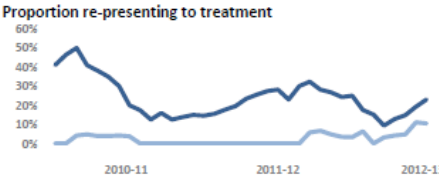
Successful completions as a proportion of all in treatment (rolling 12 months)		2011-12 Local	Latest Local	Top quartile range for cluster and no. range to achieve this
Opiate	(%)	7.4%	10.0%	9.3% to 14.1%
Completions / Total number in treatment	(n)	56/755	77/773	73 - 109/773
Non opiate	(%)	41.5%	32.9%	46.8% to 69.8%
Completions / Total number in treatment	(n)	44/106	47/143	67 - 100/143

Opiate clients

Non opiate clients

Proportion who successfully completed treatment in the first 6 months of the latest 12 month period and re-presented within 6 months		Latest Local	Top quartile range for cluster and no. range to achieve this
Opiate	(%)	23.1%	15% to 10.9%
Clients re-presenting / Total completions	(n)	9/39	5 - 4/39
Non opiate	(%)	10.5%	2.7% to 0%
Clients re-presenting / Total completions	(n)	2/19	0 - 0/19

Proportion re-presenting to treatment



Growth in successful completions since 2011-12		2011-12 Local	Cluster average
Opiate	(%)	37.5%	-10.0%
Non opiate	(%)	6.8%	7.3%

Growth from 2011-12

Criminal Justice clients	Latest Local
Successful completions as a percentage of total Criminal Justice clients in treatment	17.6% 52/296

Proportion who successfully completed treatment in the first 6 months of the latest 12 month period and re-presented within 6 months	Latest Local
	21.9% 7/32

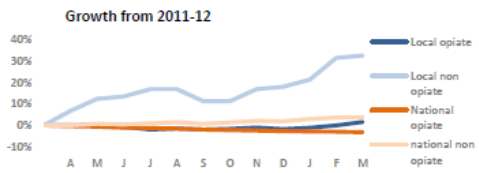
3 PUBLIC HEALTH OUTCOME FRAMEWORK: INDICATOR 2.15

Proportion of all in treatment, who successfully completed treatment and did not re-present within 6 months		Latest Local	Latest National
Opiate	(%)	7.6%	8.3%
Completed and did not re-present	(n)	58/764	13099/157113
Non opiate	(%)	40.3%	40.40%
Completed and did not re-present	(n)	48/119	15370/38079

4 EFFECTIVE TREATMENT

Growth in clients in effective treatment since 2011-12

		Latest Local	National average and number required to achieve this
Opiate	(%)	1.6%	-3.2%
In effective treatment	(n)	713	680
Non opiate	(%)	32.6%	3.8%
In effective treatment	(n)	118	93



5 TIME IN TREATMENT

Proportion of clients still in treatment between 4-6 years and longer than 6 years	Years	Local	National average
	Between 4-6	12.6%	14.2%
	More than 6	14.9%	23.8%

Average length of time in treatment (years): 3.0

Criminal Justice clients

Proportion of the treatment population: 25%

Average length of time in treatment (years): 1.4

Successful completions Opiate users

135. Successful completions for opiate users have continued to grow steadily and have now reached 10%. This places Southampton within the top quartile for high performing DAT's. This is even more pleasing as the number of opiate using service users has risen, against the national trend. National average percentage rates remained constant at 8.5%.

Successful completions – non opiate users

136. For non opiate users, the story is unfortunately less positive. Since November 2012 the percentage of non-opiate users successfully completing has fallen. However, this is largely due to the large increase in the number of non-opiate users who are now being recorded on the national data system NDTMS (National Drug Treatment Monitoring System). The numbers of service users in treatment has risen from approximately 100 in September 2012 to 143 in March 2013. The DAT officers were aware that the uploading of non-opiate users onto the national data system would result in a temporary apparent fall in performance and it is anticipated that this will stabilise during the first quarter of 2013/14. We expect performance to show improvement in the quarter 2 DOMES report.

137. In the meantime, it must be noted that in terms of actual numbers, successful completions have risen slightly.

138. **Successful Completions Criminal Justice –** Criminal Justice service users continue to complete successfully at a higher rate of 17.5%. However, re-presentations are also high at 21.9%

Re-presentations to treatment

139. Unfortunately, the previous progress that we had made with re-presentations to treatment has not been maintained in the second half of the last financial year. Re-presentations to treatment (i.e. the percentage of service users who have re-presented to treatment services within 6 months of having successfully completed.) have risen for both opiate and non-opiate users:

Opiate users: **23.1%** (from 12.9% in December 2012)
Non opiate users: **10.5%** (from 4.2% in December 2012)

140. The DAT officers have met with treatment providers regarding the fall in performance for both non-opiate users and re-presentations. Performance Improvement Plans have been refreshed and providers are working co-operatively together and with DAT officers to ensure that performance improves in this area.

Numbers in Effective Treatment

141. Total numbers of opiate users in effective treatment (i.e. in treatment for 12 weeks or more, measured over a rolling 12 month period) has increased by 1.6% which is against the national trend, where the number of opiate users has fallen by 3.2%.

142. The very substantial increase in the number of non-opiate users in treatment is as a result of the upload of all opiate users and will stabilise to a figure more in line with the national average in the next quarter.

Treatment Outcome Profile

143. As you will note from the DOMES report, TOPs information is missing once more from the report. This is due to some difficulties experienced by the treatment providers with the identification of which care co-ordinator/key worker is responsible for upload. Following a meeting with the Models of Care co-ordinator, this problem has now been resolved. We are confident that TOPs compliance will be fully restored in quarter 2 of the new financial year.

Young Peoples Substance Misuse service - DASH:

144. DASH is a service that is delivered in partnership by the voluntary organisation No Limits and Solent NHS Trust to provide help and support for young people who have a problem with drugs, alcohol or solvents.

145. DASH helps young people aged 11 – 17 years take their first step to ask for help and support in confidence. They are offered a regular meeting with a DASH worker at a place where they are likely to be most at ease.

146. The DASH service can give information, advice, support and counselling and can offer a variety of treatments, including harm reduction and needle exchange. Young people are able to learn more about the substances they are using, their effects and risks and learn how to keep safe if using drugs or alcohol.

147. Overall performance by the Young Peoples substance misuse service is generally above national and comparator areas this financial year:
    - All Young People have a wait of less than 3 weeks to start first intervention
    - 94% offered Hep B vaccination - compared to 87% Child wellbeing index quintile 4 and 83% nationally
    - 84% of interventions are multiple modalities - compared to 63% Child wellbeing index quintile 4 and 51% nationally
    - 83% have a planned exit from treatment (i.e. successful completion) - compared to 82% Child wellbeing index quintile 4 and 79% nationally
    - 6% of planned exits re-presented within 6 months - compared to 7% Child wellbeing index quintile 4 and nationally

Local Performance Indicators - 12/13

148. The service is meeting the majority of the local key performance indicators however the number of referrals to the new service as at qtr 4 is 133 compared to a target of 150. The service has had 14,519 contacts with young people who have been through outreach and 1,486 have received a brief alcohol and/or drug intervention. Of those referred to the treatment service:

149. All young people in treatment:
    - received a comprehensive assessment and a care plan
    - are joint worked with other services and have a key worker allocated
    - have received structured psychosocial interventions.

Alcohol

150. Alcohol continues to cause harm at population level, creating significant problems nationally and among communities in Southampton. Lifestyle and health service data show local people continue to use alcohol at harmful levels and in ways that put both their health and the health of others at risk. Most local outcome measures are worse than the national benchmarks, but recent trends, both locally and nationally, show a small but significant change for the better. With limited progress on the national responsibility deal, and no sign of national action on minimum pricing, tackling alcohol marketing, or low cost sales, the onus remains on local partnerships and communities to tackle the considerable harm caused by alcohol.

Table: Alcohol Profile for Southampton (outcomes and estimates from 2008-2012)

Alcohol Issue	Southampton	National Average
Alcohol-attributable mortality amongst males[1]	38.1 *	35.5 *
Alcohol-specific hospital admissions for under 18s[2]	97.2 **	55.8 *
Alcohol-specific hospital admissions for males[3]	515.7 *	450.9 *
Alcohol-related recorded crimes[4]	12.4 **	7.0 **per 1,000
Alcohol-related violent crimes[5]	10.1 **	5.0 ** per 1,000
Alcohol-related sexual offences[6]	0.20**	0.13 ** per 1,000
Synthetic estimates of binge drinking[7]	24.3%	20.1%

Source: LAPE http://www.lape.org.uk/index.html

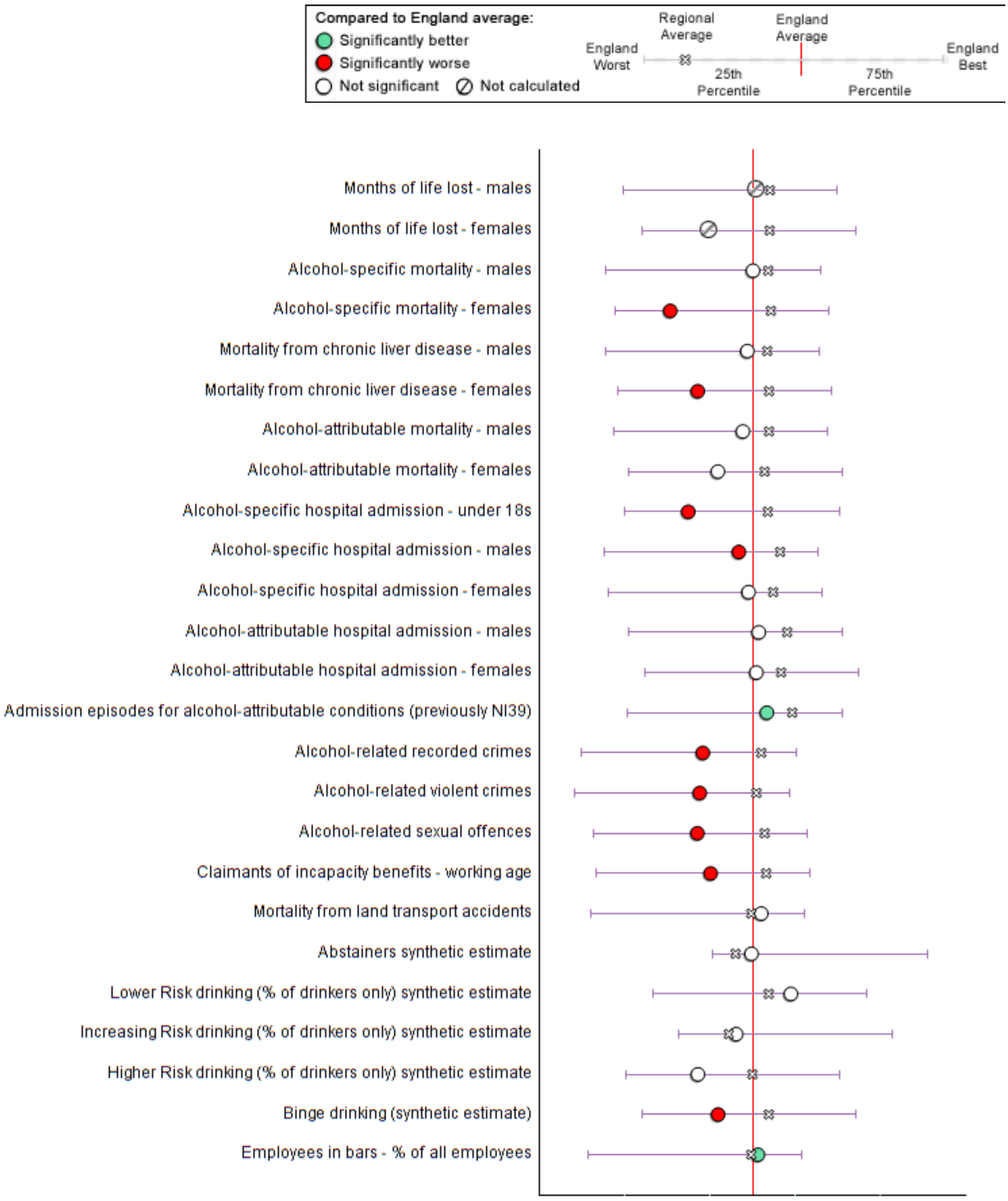
1. Alcohol-attributable mortality - males/females - Deaths from alcohol-attributable conditions (all ages, male/female), directly standardised rate per 100,000 population Mortality 2010, mid-year population estimate 2010).
2. Alcohol-specific hospital admission - under 18s - Persons admitted to hospital due to alcohol specific conditions crude rate per 100,000 population. 2008/09-2010/11
3. Alcohol-specific hospital admission - males/females - Persons admitted to hospital due to alcohol-specific conditions (all ages, male/female), directly standardised rate per 100,000 population. Activity 2010/11 Does not include attendance at A&E.

4,5,6. Alcohol-attributable crimes rate per 1,000 population. Home Office recorded crime statistics 2011/12). Attributable fractions for alcohol for each crime category were applied.

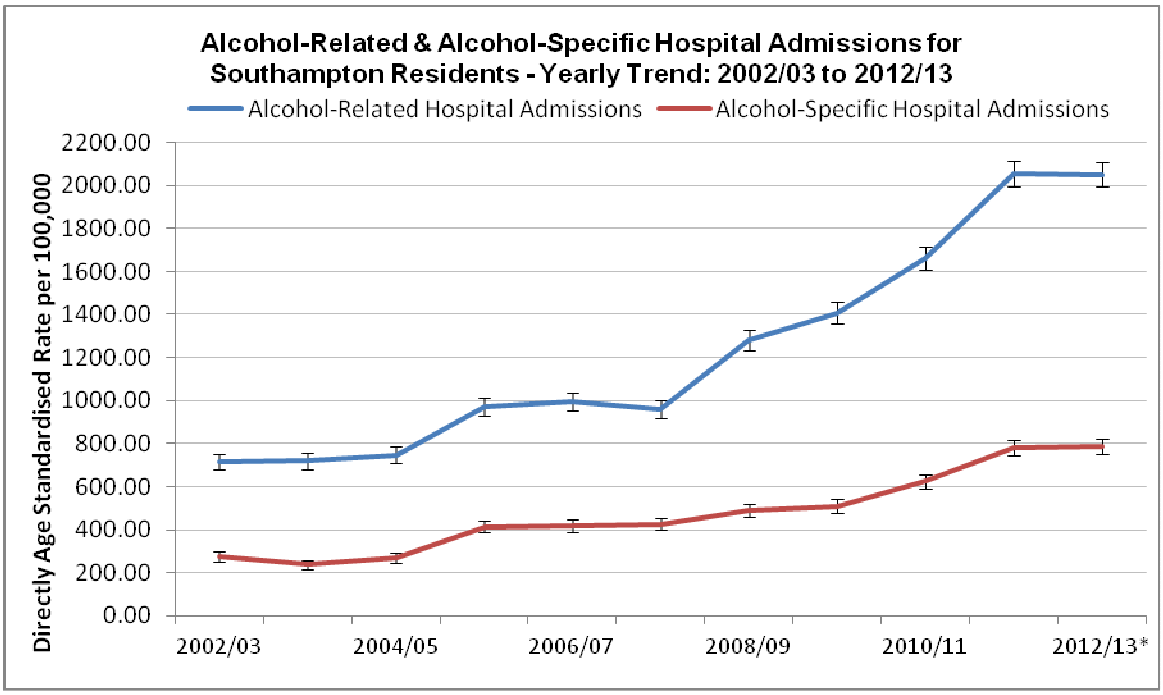
7. Binge drinking Synthetic estimate of the proportion (%) of adults who consume at least twice the daily recommended amount of alcohol (8 or more units for men and 6 or more units for women) (2007-2008). Dataset published March 2011 and updated April 2012).

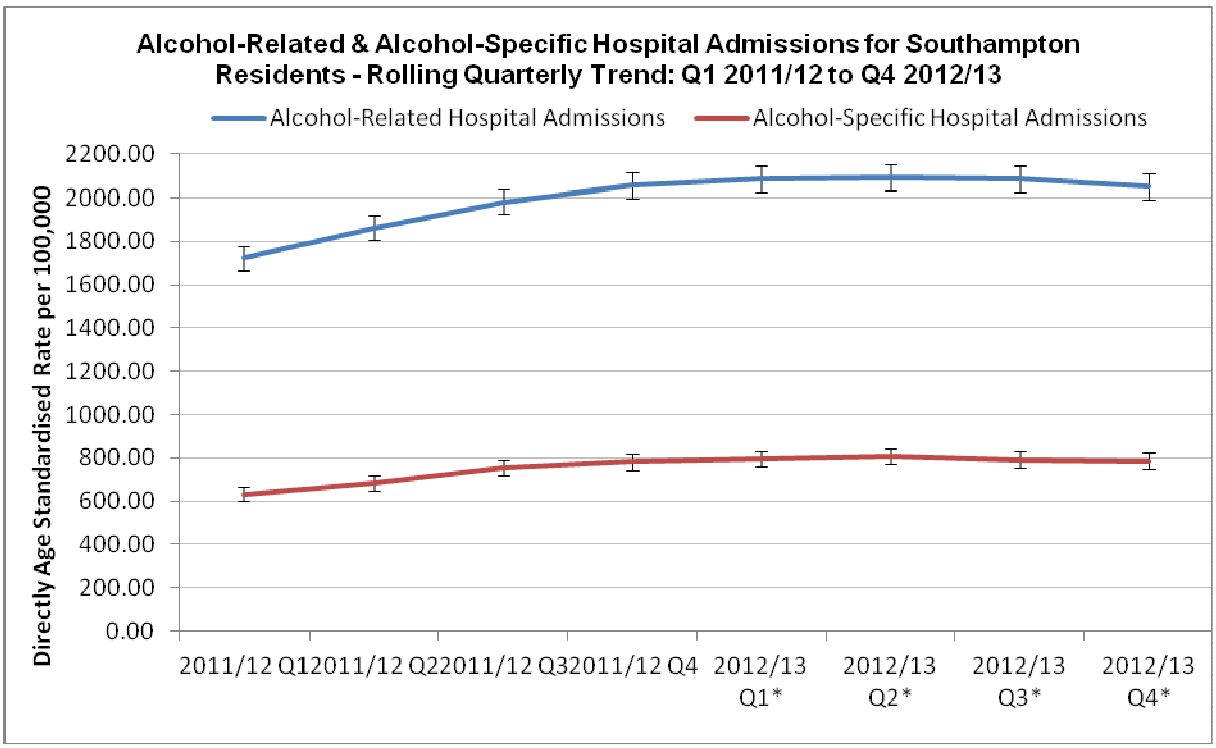
151. Estimates suggest Southampton has between 11,000 and 12,000 dependent drinkers. Current policy and local service developments are driving up the number accessing treatment, delivering more behavioural interventions and issuing more prescriptions for treating addiction. Despite increased investment in services, the majority of dependent drinkers still do not engage with treatment. Hospital admissions for those under 18 and among adult drinkers have fallen, but still remain higher than the national rate, and still give cause for concern. School based campaigns continue to target secondary school children in an effort to reduce underage drinking, but retailers, communities and families must take responsibility for this problem to be effectively managed, and to minimise the harm that results. Work with universities continues, with a special emphasis on new students this autumn and promoting a range of community safety initiatives that aim to reduce the risks of alcohol related crime and injury. The challenges caused by alcohol remain, and future generations remain at risk in the city. More treatment options have to be explored, especially for dependent drinkers while the wider population needs to be encouraged to drink more safely and responsibly to avoid significant health and social problems in the future. Local alcohol partnerships have a significant and ongoing challenge.

152. The North West Public Health Observatory produce the Local Alcohol Profile for England that shows comparative position of Local Authorities against a range of measures compared to the national average. As can be seen Southampton scores significantly worse in a number of areas.


Compared to England average:
Significantly better
Significantly worse
Not significant
Not calculated
England Worst
Regional Average
England Average
England Best
25th Percentile
75th Percentile
Months of life lost - males
Months of life lost - females
Alcohol-specific mortality - males
Alcohol-specific mortality - females
Mortality from chronic liver disease - males
Mortality from chronic liver disease - females
Alcohol-attributable mortality - males
Alcohol-attributable mortality - females
Alcohol-specific hospital admission - under 18s
Alcohol-specific hospital admission - males
Alcohol-specific hospital admission - females
Alcohol-attributable hospital admission - males
Alcohol-attributable hospital admission - females
Admission episodes for alcohol-attributable conditions (previously NI39)
Alcohol-related recorded crimes
Alcohol-related violent crimes
Alcohol-related sexual offences
Claimants of incapacity benefits - working age
Mortality from land transport accidents
Abstainers synthetic estimate
Lower Risk drinking (% of drinkers only) synthetic estimate
Increasing Risk drinking (% of drinkers only) synthetic estimate
Higher Risk drinking (% of drinkers only) synthetic estimate
Binge drinking (synthetic estimate)
Employees in bars - % of all employees

The following tables show although in the last decade there has been an upward trend in alcohol attributable hospital admission rates this has plateaued during 2012/13.





Priority 3 Reduce Repeat victimisation with a focus on vulnerable victims

Domestic Violence and Abuse (DVA)

153. DVA accounts for approximately a quarter of all recorded violence across the Police Western area.

154. Data backed by local experience suggests Southampton has exceptionally high levels of reporting of domestic violence and domestic abuse. CAADA is a national charity that leads on domestic violence risk and reduction activity. It estimates that nationally 40 cases per 10,000 (of adult females) will be referred to the MARAC. In Southampton, we have approx 48 cases per 10,000 being referred.

155. SCC Community Safety is leading on the development of an integrated approach to domestic and sexual violence in the city. Bringing together a number of domestic violence / sexual violence specialist services within the city – this alliance, now known as 'PIPPA' are collectively working to improve the responses to victims of sexual / domestic violence across the city. Within this model, a single point of contact (SPOC) for professionals has been operational, since July 2012 (this is solely staffed by the IDVA team, 5 days a week). The SPOC works with other agencies in the city, to support identification and routinely assessing risk, to offer initial crisis and safety planning advice and proactively make onward referrals to other specialist services as appropriate.

156. This service has been received well and there has been a marked rise in numbers of calls over the last quarter (almost double); particularly by health professionals, where calls to PIPPA are 55% of total calls (n=207). 84 referrals have been made for onward support to the specialist domestic violence /sexual violence services in the city; as you would expect, 67% of these have come from health services.

157. Workforce development is also a key feature of PIPPA, both for the specialist workers and an awareness raising / risk assessment training programme for partners. During 2012/13, 19 training sessions have been delivered by PIPPA to a total of 248 individuals from a variety of agencies and there is a further 9 training sessions confirmed for 2013/14.

158. A significant majority of victims of DVA are female but it is a crime with male victims too – 4% of referrals at highest risk level in Southampton are male – national data suggest up to 1 in 6 men experience DVA in their lifetime. Nearly 70 % of the highest risk victims are under 35 years of age. (The average age range of victims is 21 – 30 years). With the introduction of a new domestic violence and abuse definition (March 2013), locally we are expecting to see an increase in identification and referrals for those aged under 18.

159. In Southampton 19% of highest risk DVA cases are from black and ethnic minority communities (compared to an 18.3% profile) and 3% of the victims at highest risk have a registered disability, however data from the IDVA service suggests that this figure is 19%. National and local experience identifies the connectivity between what is called the 'toxic trio' of alcohol and drugs, mental health and DVA. DVA has a profound impact on children and young people too; 50% of child protection referrals in Southampton have DVA as an identified factor.

160. In August 2012 Southampton launched its IRIS project (Identification and Referral to Improve Safety). This is funded by Health and operated by Aurora New Dawn who provide training for GP's and all surgery staff to enable them to identify and refer victims of domestic violence. More than 66 victims of Domestic Abuse have been supported as a result of this new project and 20 out of 38 GP Surgeries in the city have signed up to the project.

INFLUENCING FACTORS

Welfare Reforms

161. The Welfare Reform Act (2012) represents the biggest change to the welfare benefit system in 60 years. The Welfare Reforms are being implemented nationally with the aim of creating a simpler and fairer system and creating the right incentives to assist more people into work. The reforms cover a whole spectrum of welfare and housing benefit changes and will pave the way for the introduction of Universal Credit, which will replace means-tested benefits for people of working age by 2017.

Local Impact:

162. Working age people are most affected, with many living in the most deprived areas of the city and already experiencing poverty due to increased living costs within a difficult economic climate. This reduced income is likely to increase financial hardship for many and may not only lead to increased debt for some but also affect other aspects of their lives.

163. Financial pressures may also lead to further community safety issues for individuals, households and whole communities including:
    - Increased stress, mental health, and suicide risk.
    - Family tension and breakdown of relationships or family units.
    - Inability to afford the basic household bills or small extras – days out, holidays, pets.
    - Increased child poverty / fuel poverty
    - Independence at risk for some and increased risk of homelessness
    - Build-up of community tensions

Families Matter

164. Families Matter is a new programme in Southampton (delivering the national Troubled Families agenda). Families Matter works intensively with local families who have multiple and complex needs. The multi-agency programme focuses on families where there is poor school attendance, worklessness and/or youth offending or anti-social behaviour.

165. The Police, Probation, Community Safety, Youth Offending and Domestic Violence services in Southampton are all an integral part of the Families Matter (Troubled Families) Programme. Each of the Police and Crime Partners has seconded Families Matter (FM) Lead Practitioners as part of a core multi-disciplinary team. This model enables close joint working between “crime partners” and a wide breadth of other services such as Education Welfare, Family & Parenting, Voluntary Sector and Employment specialists.

166. National evidence clearly links family experience to the risk of offending; 63% of boys with convicted fathers, go on to be convicted; children in a “troubled family” are 36 times more likely to be excluded from school and 6 times more likely to get into trouble with the police. There are also well established links between parental domestic abuse, mental health and substance misuse increasing the risk of harm to children and young people.

167. Traditionally, most of the key services tackling offending, focus on reducing re-offending and consequently the responses are often reactive, with interventions late and at the most costly stage. Families Matter seeks to tackle re-offending and crime prevention as part of whole-family and co-ordinated agency work. The programme represents a significant shift in approach by Police and crime partners to take earlier interventions to reduce crime.

KEY FINDINGS AND CONCLUSIONS

Overall Crime and Disorder in the City has reduced significantly in this reporting period, with all crime falling by 16%. This was despite a small increase (0.5%) in 2011/12 which had ended a five year period of consecutive reductions.

The reductions in crime cover the full range of crime types, with 24 out of 28 categories showing an improvement on the previous year. The most significant reductions included:

- Violent Crime
- Serious Acquisitive Crime

The highest crime types by volume are

- Violent Crime
- Anti-Social Behaviour
- Theft
- Criminal Damage
- Shoplifting

All of these showed significant reductions of between 10 and 20%.

The most significant adverse percentage changes in the last 12 months were for:

- Youth on Youth Violence
- Vehicle Related Nuisance

When comparing performance with our most similar group, Southampton has improved in relation to the 'All Crime' classification by three positions. Overall Southampton has improved its relative position in 12 out of 17 categories monitored by the Home Office. There are two categories, Theft and Robbery, where we maintained the same position. In only three categories, Criminal Damage, Criminal Damage/Arson and Possession of Drugs did we show an adverse change in comparison with our most similar group. Even where our performance has shifted adversely, the change has only been by one place.

The three current Safe City Partnership Priorities (2012 – 2015) remain relevant for the following reasons:

Reduce Crime and ASB in key locations
The Strategic Assessment shows 'hot spot' locations for ASB that are both recurring (in the City Centre) but with new emerging locations in the neighbourhood areas. This reinforces the need for a constant geographical focus on crime reduction, but with ability to shift resources as and when new 'hot spot' locations are identified.

In the few areas where we have seen an increase in commission rates e.g. Vehicle Related Nuisance, these have only impacted certain areas of the city.

Reduce the harm caused by drugs and alcohol
Despite reductions, the Night Time Economy remains a 'hot spot' for crime and anti-social behaviour. The Strategic Assessment identifies new issues in relation to alcohol harm, including intoxication leading to serious health concerns, and a rise in health indicators in relation to harm caused by alcohol, particularly to females. The intensive focus by Operation Fortress on Class A Drug Supply and Serious Drug Related Violence reinforces the need to continue to continue the partnership approach to restrict supply, reduce demand and rebuild communities.

Repeat Victimisation
The focus under this priority is Domestic Violence as a result of it having the highest recidivist rate of all crimes. Despite performance related to reducing repeat incidents of domestic violence being well above national average, the city still has high reporting rates and demands on services including safeguarding and DV specialist services remain high.

Despite a decrease in the incidents of anti-social behaviour, we have seen an increase in the number of individuals identified as being vulnerable as a result of their experiences. This has placed additional demand for specialist interventions and support. It highlights the continuing need to prioritise the partnership support to vulnerable adults.

In addition to the existing priorities, the Strategic Assessment highlights the need to broaden the focus to include two new priorities:

Reducing Youth Crime
Southampton's performance in relation to reducing first time entrants to the criminal justice system has bucked the regional downward trend and youth re-offending levels have increased and are higher than national and regional averages. Our comparative position in this area has not improved.

Reduce Reoffending
The data suggests that Southampton's performance has deteriorated, particularly in relation to offenders who are on Licence. The data shows a poor comparative position when compared to our most similar group. In addition a focus on reoffending across all partnership from Night Time Economy to Domestic Violence, including more preventative work is an imperative for continuing to sustain crime reductions.

Additional areas for attention
In addition the Strategic Assessment highlights a few areas that warrant increased attention, focus and further exploration by the Partnership. These include:

- Children and Young People's perceptions of safety, particularly on public transport
- Road Safety – young car drivers in the Killed, Serious Injury showed a significant increase despite small numbers.
- Continuing focus on addressing the concerns raised by the increased use of legal highs
- Monitoring the impact of welfare reforms on crime and safety
- Vehicle related nuisance
- The support that crime and safety partners can contribute to improving school attendance
- Work with schools to raise awareness on anti bullying and youth on youth violence
- Explore links between cannabis and youth crime

Safe City Partnership
making Southampton safer

SOUTHAMPTON SAFE CITY PLAN 2013 - 14

OUR PRIORITIES

- Reduce crime and anti-social behaviour in key locations
- Reduce the harm caused by drugs and alcohol
- Reduce repeat victimisation
- Reduce reoffending
- Reduce youth crime

WHAT HAPPENED TO CRIME IN SOUTHAMPTON IN 2012/13?

Comparison figures are in relation to the 15 most similar cities as defined by ONS where 1 is the best

Our comparative position improved for	Relative position 2011/12	Relative position 2012/13
All crime	14	11
Sexual offences	14	8
Other sexual offences	12	7
Rape	14	10
Burglary	11	8
Burglary (dwelling)	8	7
Burglary (non dwelling)	14	12
Vehicle Offences	9	7
Arson	8	7
Violence with Injury	15	14
Violence without injury	14	13
Public order	13	9

We need to improve our comparative position for	Relative position 2011/12	Relative position 2012/13
Criminal damage*	14	15
Criminal damage /Arson *	14	15
Violence with injury *	15	14
Violence without injury*	14	13
Theft from person *	12	12
Burglary (non dwelling)*	14	12
All crime*	14	11
Possession of drugs	8	9

**Despite comparator positions requiring improvement the number of crimes recorded in 2012/13 reduced in all of these areas*

Our most similar cities include:

- Bristol
- Cardiff
- Coventry
- Crawley
- Exeter
- Hillingdon
- Hounslow
- Lincoln
- Northampton
- Plymouth
- Portsmouth
- Oxford
- Sussex
- Trafford
- Welwyn and Hatfield

All Crime

- In total crime in the City reduced by 16% from 2011/12 to 2012/13
- The total number of crimes reduced from 26,165 in 2011/12 to 21,929 in 2012/13
- Southampton has 93 crimes per 1,000 persons; the average for the group is 82 per 1,000
- The total reoffending rate was 9.7%. The national average is 9.35%
- 308 hate crime cases were recorded of which 73% were race related

Violent Crime

- 1,418 fewer violent crime offences in 2012/13 compared to 2011/12, a 19% reduction, inlcuding decreases of:
  - 31% in alcohol related violence
  - 16% in domestic violence offences
  - 28% in serious sexual offences
- Drug related violence rose by 17% in 2012/13
- There were 94 repeat domestic violence cases at multi agency risk assessment conferences (MARACs) in 2012/13

Theft & Burglary

- There were reductions in the followings crimes from 2011/12 to 2012/13:
  - 20% in burglary
  - 22% in theft of a vehicle
  - 15% in theft from a vehicle
  - 21% in theft from a person
- 56 crimes of metal theft were recorded in 2012/13

Anti Social Behaviour (ASB)

- 11% decrease in ASB incidents in 2012/13 compared to 2011/12
- 37% decrease in arson in 2012/13 compared to 2011/12
- There were 2,169 alcohol related hospital admissions compared to 2,153 last year
- The 4 Community Tasking and Coordinating Groups across the city addressed hot spots of anti-social behaviour and took action to deal with alleged perpetrators
- Vehicle related nuisance incidents increased from 945 in 2011/12 to 1,338 in 2012/13

Youth Crime

- 22 fewer young people aged between 10 and 17 received a custodial sentence in 2012/13 compared with 2011/12 (from 49 to 27)
- First time entrants to the youth justice system increased by 13%, rising from 911 (Oct 2010 to Sep 2011) to 1,028 per 100,000 10-17 year olds (Oct 2011 and Sep 2012)
- The youth reoffending rate was 47%. This is an increase of 8% and around 10% higher than the national average.

OUR KEY CHALLENGES

- **Performance**
  - Improving comparative performance with similar cities for all crime
  - Reducing reoffending – particularly in relation to young people and domestic violence
  - Building on the 'whole family' approach to reduce youth offending and ASB

- **Working smarter**
  - Managing reducing resources
  - Working together to respond to the significant organisational and legislative changes while targeting resources to achieve the greatest impact
  - Ensuring all plans, developments and services consider the impact on crime and disorder in the city
  - Responding to issues caused by welfare reforms and changing demographics

SOUTHAMPTON SAFE CITY PLAN 2013 - 14

Safe City Partnership
making Southampton safer

OUR SUCCESSES IN 2012/13

Priority	Actions	Results
Reduce crime and anti-social behaviour in key locations	**Tackling ASB** • We developed a multi agency approach to identifying and supporting victims of ASB which has improved identification of victims who are vulnerable. • Partners worked together to develop action plans to tackle 'spikes' in various crimes at certain times of the year and tackle various hot spots through patrols, Street CREDs, dispersal orders, street briefings and special operations.	Increase from 148 to 219 the number of vulnerable victims of ASB identified. Reduction in 'student' burglaries, and reductions in ASB and arson during the Halloween and Bonfire period. Number of younger people who have signed an Acceptable Behaviour Contract has increased by 104% from 24 in 2011/12 to 49 in 2012/13.
	Enforcement and neighbourhood safety • Organised new Street CRED events, led by the council, that join up services to make immediate environmental improvements to an area and provide safety advice. • Street CREDs were carried out in Bevois Valley, Portswood, Polygon (3), Irving Road, Violet Road, Riverside Park, Rockstone Lane (2) and Vanguard Road.	Residents across the city benefited from a Street CRED in 2012/2013. Tonnes of rubbish have been removed, vegetation cut back and new plants and trees planted. Community Payback have provided approximately 50 hours of free labour along with council teams from Open Spaces, Waste and Recycling, Environmental Health, City Patrol, Community Safety, volunteer organisations and local communities have all contributing to the Street CRED days.
Reduce the harm caused by drugs and alcohol	• Operation Fortress was set up to tackle Class A drug supply and associated violence. The project supports vulnerable victims, refers drug users into treatment and offers community reassurance. • Alcohol awareness campaigns in schools and specific treatment for alcohol addiction has received additional focus.	During 2012/13 Operation Fortress Officers have: Detained 212 people, seized drugs with a street value of £149,865 and £106,090 in cash. 10 % (47/173) successful treatment completions for opiate users and 33% (47/143) for non opiate users. Alcohol related hospital admissions have stabilised in 2012/13.
Reduce repeat victimisation	**Support to victims of domestic violence**: • Set up a new health funded project called IRIS to support victims of domestic abuse • A review into a domestic homicide in the City resulted in a range of recommendations. • A dedicated point of contact for professionals was established through PIPPA (Prevention, Intervention & Public Protection Alliance) which is an alliance of domestic and sexual violence services in the City.	More than 66 victims of domestic abuse have been supported and 20 out 38 of the city's GP practices have signed up. All recommendations from the Domestic Homicide Review (DHR) have now been implemented resulting in DV training to 248 professionals. PIPPA have taken 450 calls from frontline workers.
Reduce reoffending	**Safety in the night time economy:** • Street Pastors recruited additional volunteers, night patrols in the City Centre, parks, some schools and outlying districts as well as in the University of Southampton. • Launched the Red Card in July 2012. • ICE bus support to people included those with issues such as accidental issues, victims of assault, those needed general help, those needing help getting home and a place of safety provided for those in need.	32% reduction in NTE violence. 18% reduction in assault presentations at the Emergency Department. 163 individuals received Red Cards for bad behaviour banning them from all licensed premises. 357 people were supported by the ICE Bus. 595 people were supported by the Street Pastors.
Reduce youth crime	• Southampton Youth Offending Service was inspected in February 2013 by Her Majesty's Inspectorate of Probation	Southampton YOS scored higher than average in all 4 inspected areas and the Southampton Offending Behaviour Programme was identified as 'an area of emerging practice' by the Youth Justice Board for England and Wales.
Partnership working	• Set up the Families Matter Programme to work with 685 families with multiple and complex needs. Reducing youth crime and anti-social behaviour is a core focus of this new programme that takes a 'whole family' challenge approach to tackle offending behaviours.	A team of 36 professionals from a range of partner agencies, including Police, Probation, YOS and Community Safety are currently supporting 353 families under the Families Matter programme.
	• The Police and Crime Commissioner has been appointed and we successfully bid for £95,500 to support strategic priorities.	Funding has been allocated to support Taxi Marshalls, future DHR, Ambulance Support for the ICE BUS, victim support and support for Safe City Partnership seasonal campaigns.

WHAT WE ARE GOING TO DO TO IMPROVE?

Priorities	Key actions	Lead Agency	How we will measure success
Reduce crime and anti-social behaviour in key locations	Develop a 'place' focused ASB plan to tackle entrenched hot spot areas and emerging hot spot streets or neighbourhoods.	Police	• Achieve a further 5% reduction in ASB to below 15,230 incidents in 2013/14 • Reduce incidents of ASB in hot spot areas by coordinating partnership responses • Improve the comparable position for criminal damage by 2 places to 13th in relation to the 15 most similar cities
	Undertake a peer review of the Partnership to ensure priorities reflect City needs, is operating effectively, improve links with the youth offending service and learn from best practice	Council	
Reduce the harm caused by drugs and alcohol	Improve commissioning for treatment pathways and preventative activities to reduce the harms caused by alcohol and drug misuse and introduce an alcohol awareness course running alongside the Red Card scheme.	CCG / Council	• Reduce alcohol related hospital admissions by 5% to below 2,060 in 2013/14 • Increase successful completion as a percentage of the total number in drug treatment • Reduce drug related violence by 10% to below 45 recorded incidents in 2013/14
	Maintain multi agency Operation Fortress to restrict the supply and demand for class A drugs and rebuild affected communities	Police	
Reduce repeat victimisation and focusing on vulnerable victims	Review the provision and commissioning of Domestic Violence services	Council	• Repeat attendance at Domestic Violence MARACs reduced by 20% in 2013/14 to below 76
	Continue to develop multi-agency responses to protect vulnerable victims of ASB and crime.	All	• Increase identification and risk assessment of vulnerable adults • Decrease in repeat victimisation relating to ASB
Reduce reoffending	Development and implementation of a Serious Youth Crime Prevention Action Plan.	YOS	• Reduce the youth reoffending rate by 5% from 47% to 42% • Reduce total reoffending rate by 3% to 9.4%
	Identify and implement partnership actions targeting licensed offenders.	Probation	
Reduce youth crime	Identification of, and joint agency interventions work with, young people whose offending behaviour has become entrenched. This will include delivering Families Matter and tackling youth crime within a whole family approach.	YOS	• Reduce first time entrants into the youth justice system by 10% from 1,028 per 100,000 10-17 year olds to 925 per 100,000 10-17 year olds (1,028 per 100,000 10-17 year olds equates to 193 first time entrants) • Reduce the number of crimes committed by young people by 200
	Implement the new priority young offenders scheme where partners join together to identify and take actions to reduce repeat offending.	All	

Southampton Youth Justice Strategic Plan 2013-14

Our priorities

Reduce the number of first time entrants to the criminal justice system

Reduce re-offending

Reduce custody

Reduce youth crime

Our successes in 2012/13

Priorities	Actions	Results
Reduce the number of first time entrants to the criminal justice system	Worked to improve the quality of accommodation recording so that data can be more effectively analysed where accommodation isn't suitable. The YOS manager reviewed each case where accommodation was assessed as unsuitable and reported to the YOS Management Board.	3.78% increase of young people who were assessed as residing in suitable accommodation from 90.37% in 2011/12 to 94.15% in 2012/13.
Reduce re-offending	Taken steps to improve completion of risk and vulnerability management plans.	Achieved steady progress ensuring that 100% of plans were completed on time by the 3rd quarter.
	Developed the Offending Behaviour programme.	90 young people attended a total of 742 sessions over 2012/13 and the programme has been identified as 'an area of emerging practice' by the Youth Justice Board for England and Wales.
Reduce custody	Worked successfully to reduce the number of custodial sentences imposed.	Number of custodial sentences imposed reduced from 49 in 2011/12 to 28 in 2012/13.
	Out of court disposals.	Exceeded the local target of 25% of Final Warnings finishing with an intervention.
	Restorative disposals.	Exceeded the Safer City Partnership target of 50% of Youth Restorative Disposals receiving Restorative Justice disposals.
	Improvements in enforcement measures to be sufficiently robust and improving confidence in our service. The YOS Parenting Officer now attends Court to advise magistrates on a weekly basis.	Supervised 19 Parenting Orders and 51 voluntary parenting disposals. Prosecuted two parents for breaching their Parenting Orders. Parenting Officer delivered 40 group work sessions over the year.
	Steps to increase the Referral Order Panel Member base and the number of volunteers to support the delivery of restorative justice interventions.	Increased our Referral Order Panel Member base to 21 and recruited a further 10 volunteers to support the delivery of restorative justice interventions.
Reduce youth crime	Effective use of the Asset tool in offending behaviour assessments for young people who score 2 or more for substance and alcohol use and making referrals to the Youth Offending Service Substance Misuse Worker for further assessment and intervention.	Achieved our Safer City Partnership target of 100% for such assessments. Offered 65 tier three substance misuse interventions.
	Southampton Youth Offending Service was inspected in February 2013 by Her Majesty's Inspectorate of Probation.	Southampton YOS scored higher than average in all 4 inspected areas and the Southampton Offending Behaviour Programme was identified as 'an area of emerging practice' by the Youth Justice Board for England and Wales.

SOUTHAMPTON CITY COUNCIL

Our challenges

Custody rate remains higher than the national average, despite improvement in 2012/13.

Re-offending rate remains 10% higher than the national average.

First time entrants into the criminal justice system have increased since last year and are higher than all our comparator cities.

The age group most likely to be involved in offending is 18-24 years

What we are going to improve

Priorities	Key actions	How we will measure success
Reducing rate of first time entrants into the criminal justice system	• Greater direct engagement with police to support diversionary work and more robust analysis of local data. • Participate in Out of Court Disposal training when it is rolled out later in the year.	• Reduce first time entrants into the youth justice system by 10% from 1,028 to 925 per 100,000 10-17 year olds (1,028 per 100,000 10-17 year old equates to 193 first time entrants). • Increase in the number of young people successfully completing diversion programmes.
Reduce re-offending	• Development and implementation of a Serious Youth Crime Prevention Action Plan. • Establish a multi-agency Priority Young People Panel which will action plan on a monthly basis for a cohort of young people identified as 'high risk' offenders. Young people will be referred into the Families Matter initiative, as appropriate. • Work with Hampshire Constabulary to raise awareness and understanding of frontline police of the opportunities afforded by community resolution as a result of the Legal Aid, Sentencing and Punishment of Offenders Act, 2012. • YOS participation in the Youth Justice Board reducing re-offending project.	• Reduce the re-offending rate from 47% to 42%.
Reducing custody	• Analyse custodial sentences to identify trends and areas for improvement. • Further work to develop the YOS offending behaviour programme; specifically there will be a review of the YOS quality assurance process in respect of gate keeping pre-sentence reports. • Work with magistrates to build confidence in YOS proposals to the Court will continue.	• Achieve 'promising status, as assessed by the Youth Justice Board. • Reduce the custody level to below 1.0 per 1,000 10-17 year olds (28 custodial sentences in 12/13 = 1.7 per 1,000. To achieve the level of 1.0 per 1,000 there would need to have been less than 20 custodial sentences in 12/13).
Reducing youth crime	• Identification of, and joint agency interventions work with, young people whose offending behaviour has become entrenched. • Implement the new Priority Young Offenders Scheme where partners join together to identify and take actions to reduce repeat offending.	• Reduce the number of crimes committed by young people by 200.

SOUTHAMPTON CITY COUNCIL

Youth Justice Strategic Plan 2013 – 14

Contents

Forward

This year's Youth Justice Strategic Plan is significant for Southampton Youth Offending Service, marking the end of the first year as a standalone entity within the City, after disaggregation from Wessex Youth Offending Team.

The past year has been one of challenges, some unexpected, but also of opportunities and service progression. In June 2012 Sue Morse, the YOS manager became seriously unwell. Instrumental to the disaggregation of the service, Sue has now retired and our thoughts and best wishes are with her.

Despite this sad and unexpected development, the team has worked hard to successfully integrate with colleagues across the city. Co-location with the city's leaving care services has supported meaningful joint work in preparation for Legal Aid, Sentencing and Punishment of Offenders Act. Further work is planned in 2013 – 14 to better improve the offending outcomes for children in care.

Service performance in respect of reducing custodial sentences has been strong in the past year and local achievements are notable. The service enters its second year acknowledging the requirement to reducing re-offending and first time entrant rates in Southampton. Strong partnership arrangements are being developed to meet these needs.

Elsewhere, there is clear evidence of innovation and developing practice. The YOS offending behaviour programme has been identified as an area of 'emerging practice' by the Youth Justice Board. A strong partnership is also developing with Southampton Solent University. This involves social work student volunteers supporting restorative justice work in the city and the university acting as a 'critical friend' as part of the development of the YOS Service User Involvement strategy.

The local Troubled Families initiative, 'Families Matter' is a further example of developing practice and three lead practitioners have been based at YOS. These placements afford significant opportunities in respect of effective intervention with families where youth offending is persistent and the YOS is well placed to develop strong partnership responses over the coming year.

Southampton Youth Offending Service was subject to a Short Quality Screening inspection by HMI Probation in February 2013 and it was noted that the level of service maintained over this formative period was 'commendable'. The inspection feedback, whilst noting areas for improvement, also highlights firm foundations for the aspirations of the service within the city.

On behalf of the Management Board we are pleased to endorse the Southampton Youth Justice Strategic Plan for 2013 – 14 and look forward to another exciting and successful year.

Graham Talbot
Head of Education

Councillor Kaur
Cabinet Member for Communities

Section 1: Our Vision, Purpose and Principles:

Vision:

Southampton Youth Offending Service is committed to contributing to a fair and effective Criminal Justice System which will provide justice for victims and local communities, rehabilitation, punishment and positive opportunities for young people and value for money.

Purpose

Our purpose is to prevent young people offending and once in the Criminal Justice System to accurately assess and offer high quality interventions to young people to reduce crime and to protect victims, in order to increase public safety in Southampton.

We will do this by:

- preventing offending
- reducing re-offending
- improving outcomes for young people
- protecting the public from the harm that young people can cause to individuals, communities and the public and
- working to ensure custody is limited only for those young people whose risk cannot be managed in the community

Principles:

The principles underpinning our service are:

- Regard for the safety of the public as a priority
- Provision of a fair and equitable service to young people, staff, victims and the wider public
- Respect for young offenders as young people
- Respect for diversity in terms of race, gender, disability, age and sexual orientation
- Promotion of the rights of victims and the rights and responsibilities of children, young people and their families
- Valuing staff as our most important resource
- Actively promoting appropriate interventions and sentencing
- Provision of a quality service which is effective, efficient and gives value for money

Section 2: Service Priorities 2013 – 14

1. Improvement in key performance areas

Southampton Youth Offending Service will strive to reduce custody, re-offending and first time entrants' rates and improve Education, Training and Employment outcomes by:

- Developing a robust partnership approach with police and other agencies to effectively intervene with the small group of young people that commit the highest number of offences in Southampton.
- Working with the police to review and revitalise the effective use of Community Resolutions with young people in the city.
- Using the YOS education planning forum to effectively respond to the needs of NEET children in partnership with colleagues from inclusion services.

2. Delivery of high quality work

Southampton Youth Offending Service will ensure that all its work is of a high quality by:

- Ensuring a continued commitment to the Youth Justice Board Effective Practice Forum and local best practice meetings
- Enabling staff and managers through training, appraisal and professional development as per the service training needs analysis and plan
- Ensuring that interventions with young people who commit sexual offences involve robust risk management and safeguarding work, delivered through effective partnership arrangements and that offending behaviour work with individuals is undertaken using an evidence-based practice model
- Embedding rigorous quality assurance processes into the service, linked to team and individual performance and development
- Embedding reflective supervision practices into individual and group supervision
- Work with the Youth Justice Board in respect of the service, adopting the revised assessment framework, Asset Plus

3. Restorative Justice

Southampton Youth Offending Service will further embed restorative justice into the heart of its work by:

- Developing a formal restorative justice strategy that will confirm best practice and process for all staff and volunteers working for the service

- Building upon existing arrangements with Southampton Solent University to increase the capacity and quality of the YOS with regard to restorative justice work across the service

- Ensuring that every young person who receives a custodial sentence is offered the opportunity to engage in a restorative justice intervention

- Working with statutory partners within the People Directorate of Southampton City Council to develop restorative justice and mediation opportunities. These will support young people's understanding of the impact of their behaviour and promote positive change, thereby benefitting the local community

4. Service User Involvement

Southampton Youth Offending Service will ensure that young people, families and victims are at the centre of its work by:

- Implementing its Service User Involvement Strategy with support and critical input from partners at Southampton Solent University

- Developing the understanding that the 'voice of the child' is a critical component of effective work with children. In our assessments and interventions we will robustly identify children's own views and perspectives so that we can more effectively reduce offending, safeguard children and protect the public.

- Creating a young persons' forum which will contribute to future service development

5. Resourcing

Southampton Youth Offending Service will protect future service delivery by working with partners in respect of youth justice funding provision; ensuring that the service is effective in delivering its core objectives and represents 'value for money' by:

- Engaging with the office of the Hampshire Police and Crime Commissioner to discuss local youth justice provision and needs.

- Ensuring that the partnership arrangements that support the service are enshrined within a formal service level agreement.

- Undertaking to complete and review the post inspection improvement plan

6. Priority Groups

Whilst all young people in Southampton should expect high quality interventions, Southampton Youth Offending Service has identified three groups that we feel should receive priority support. These are young people leaving custody, children looked after and families within the Families Matter[1] cohort. Southampton Youth Offending Service will improve outcomes for these children and families by:

- Developing a forum in Southampton that will support a coordinated approach to the resettlement of young people leaving custody. This will align with the city's supported accommodation strategy and involve statutory partners, alongside voluntary accommodation, training and resettlement providers

- Providing a robust service in and out of Court so that magistrates have full confidence in local alternatives to remand into Youth detention Accommodation

- Working in partnership with the leaving care service to explore responses to offending by young people in care and participating in the SE7 regional forum

- Ensuring that Families Matter Lead Practitioners are fully integrated into the team and that YOS officers and staff have a good understanding of the aims and objectives of Families Matter

- Fully utilise the opportunity to refer relevant young people from the YOS re-offending and education forums into Families Matter for additional support

(1) In Southampton, the local Troubled Families initiative is called 'Families Matter'.

Section 3: Performance and Practice

Our Successes:

During 2012 – 13, Southampton YOS has:

- Worked successfully to reduce the number of custodial sentences imposed from 49 in 2011 – 12 to 28 in 2012 – 13 (figures taken from YOIS data).

- Worked to improve the quality of accommodation recording so that data can be more effectively analysed in respect of those cases where accommodation isn't suitable. In 2012 – 13, 94.15% of young people were assessed as residing in suitable accommodation; this was a 3.78% increase from the 2011 / 12 baseline of 90.37%. The YOS manager reviewed each case where accommodation was assessed as unsuitable and reported to the YOS management board.

- Achieved steady progress against the completion of risk and vulnerability management plans; ensuring that 100% of plans were completed on time by quarter three.

- Exceeded the local target of 25% of Final Warnings finishing with an intervention.

- Exceeded our Safer City Partnership target of 50% of Youth Restorative Disposals receiving RJ disposals.

- Achieved our Safer City Partnership target of ensuring that 100% of young people who score 2 or more for substance and alcohol use; in offending behaviour assessments undertaken using the Asset tool; are referred to the Youth Offending Service Substance misuse worker for further assessment and intervention.

- Offered 65 tier three substance misuse interventions.

- Participated in the Hampshire Constabulary Scrutiny Panel; as noted in the *Swift and Sure Justice* white paper published in July 2012.

- Supervised 19 Parenting Orders and 51 voluntary parenting disposals. The YOS parenting officer now attends Court to advise magistrates on a weekly basis and we have prosecuted two parents for breaching their Parenting Orders; ensuring that our enforcement measures are sufficiently robust and improving confidence in our service. Our Parenting Officer delivered 40 group work sessions over the year.

- Developed our offending behaviour programme so that 90 young people attended a total of 742 sessions over 2012 – 13.

- Increased our Referral Order Panel Member base to 21 and recruited a further 10 volunteers to support the delivery of restorative justice interventions.

Performance Summary:

Whilst the custody rate in Southampton remains above the national average; performance in the past year has been positive, with the number of custodial sentences reducing significantly against that of the previous year. Local indicators around accommodation and risk and vulnerability management are also encouraging.

Conversely, the re-offending rate in Southampton has stayed stubbornly around 10% higher than the national average and first time entrants levels have increased in comparison to the previous year (although the most recent FTE level still remains lower than for the equivalent period in 2009 / 10). There are clear plans in place to address these issues; alongside the local education, training and employment engagement; in the coming year.

'Examples of Good Practice' are included throughout the section to give an overview of service development and practice throughout the year.

Example of Good Practice: Offending Behaviour Programme

The Southampton Youth Offending Service Offending Behaviour Programme is designed to maximise the impact of Youth Offending Service supervision of young people, with five key themes:

- **Reducing re-offending**
- **Responding to risk of harm / safeguarding**
- **Developing victim awareness and empathy**
- **Diverting young people from crime**
- **Facilitating community integration**

Young people are referred onto different components of the programme, depending upon their needs / areas of risk. Each component of the programme is linked to ASSET risk areas and the five Every Child Matters Outcomes.

Young people subject to an Intensive Supervision and Surveillance (ISS) requirement of either a Youth Rehabilitation Order or a Bail Supervision Programme can be referred onto the programme by their supervising officers. However, a group management plan has been put in place, which ensures that young people can access all elements of the programme.

The programme also offers a clear opportunity for partnership working. Some examples of this are:

- **Hampshire Fire and Rescue Service delivering their Teenage Road Accident Prevention Training (TRAPT) course**
- **Barnadoes and Star Sexual Health Project staff delivering safeguarding sessions**
- **A community reparation project, co-facilitated with Catch 22**
- **Football and gym sessions coached by Hampshire Football Association and Golden Ring Boxing Club, Southampton**

The Offending Behaviour Programme was identified by the Youth Justice Board as an area of emerging practice in January 2013.

Performance against National Indicators:

Reducing Custody

Example of Good Practice: Pre-sentence report forum.

On a fortnightly basis Youth Offending Service staff meet to discuss current pre-sentence reports as a group. Cases are reviewed and sentencing proposals is considered. This arrangement offers different perspectives on cases and encourages the sharing of best practice. The service assesses that the forum has contributed to the reduction of custodial sentences during the last year.

When the service was subject to SQS inspection in February 2013, the inspectors noted the pre-sentence report forum as an area of good practice.

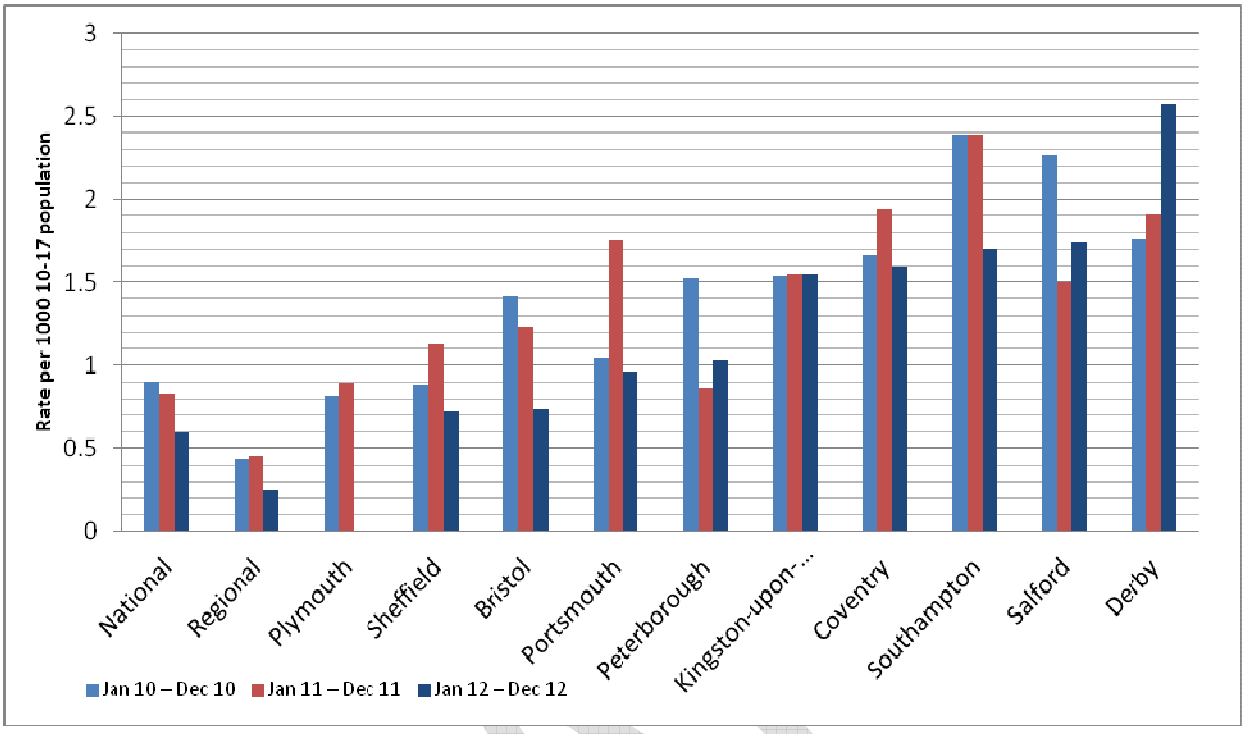
Commentary

In respect of this national indicator, the most recent information has been used. This was discussed by the YOS management board in April 2013. The custody rate for the period January 12 to December 12 expressed per 1000 10 to 17 population was 1.70 (2.39 and 2.39 in the equivalent periods in 2010 and 2011, respectively). There is therefore a very pleasing and quite significant improvement in the level of custodial sentencing for the latest rolling 12 month period. YOIS data indicates 28 custodial periods for 2012 / 13 compared to 49 during the preceding reporting year.

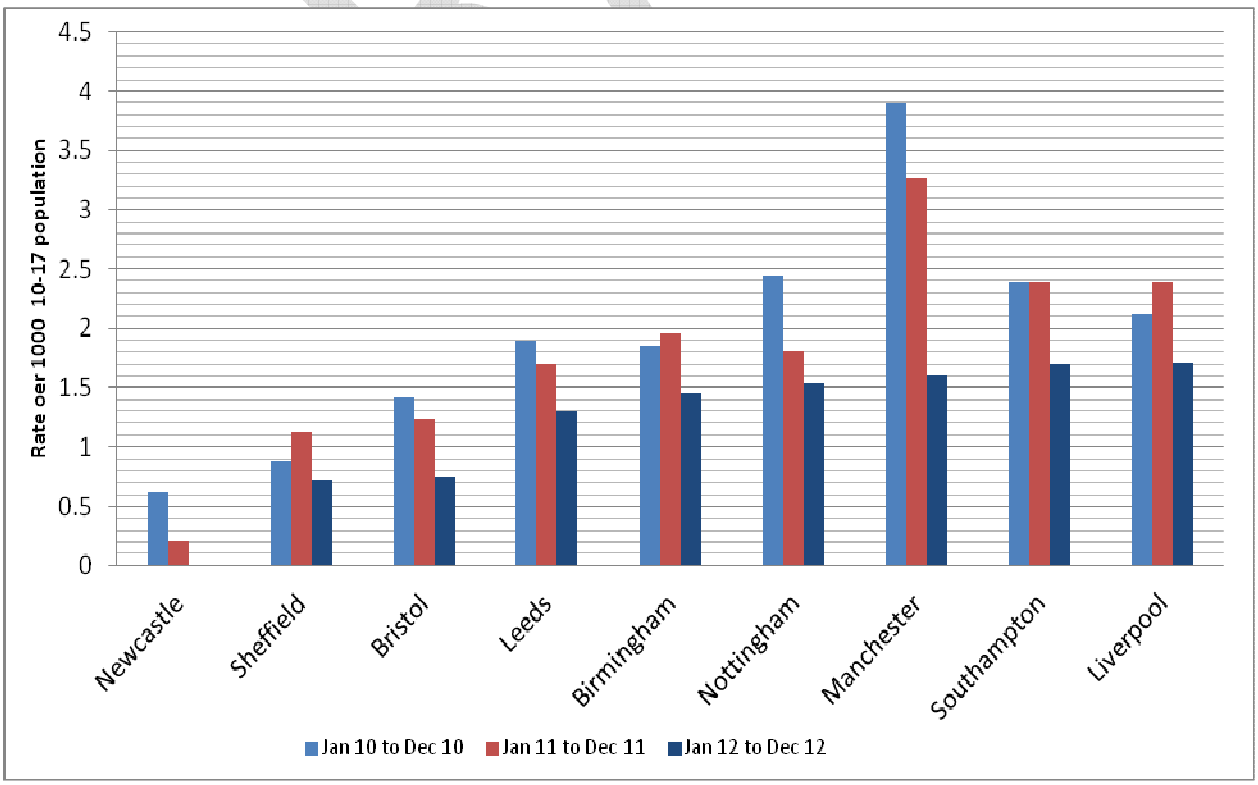
In 2013 / 14 Southampton Youth Offending Service will reduce the custody level to <1.0 per 1000 10 to 17 population:

- Working with the Youth Justice Board, the YOS will analyse custodial sentences for the 2011 – 12 period in order to identify trends and areas for improvement.
- There will be further work to develop the YOS offending behaviour programme; specifically to achieve 'promising status, as assessed by the Youth Justice Board.
- There will be a review of the YOS quality assurance process in respect of gate keeping pre-sentence reports.
- Work with magistrates to build confidence in YOS proposals to the Court will continue.

Custody: Southampton and Comparator YOTs



Custody: Southampton and Core Cities



Reducing Re-offending

Example of Good Practice: Andrew

Andrew was charged with a public order offence after he threw a chair over a balcony at a busy shopping centre. He received a 12 month intensive Referral Order and was banned from the centre. Andrew told his YOS officer that he regretted what he had done and did not think of the consequences.

The YOS Restorative Justice Officer liaised with the managers of the shopping Centre and was put in contact with SOBAC (Southampton Businesses Against Crime). Through discussion, a direct mediation session was agreed by Andrew, SOBAC and the shopping centre manager.

The mediation session was very positive in helping Andrew realise the full impact of what he had done. He apologised directly to the manager. Andrew took much time and effort writing letters of apology to the manager and to the two security staff members who were nearly hit by the chair. One of the security staff had also shared that they were a strong supporter of a cancer charity. Andrew completed a session promoting a Twilight Walk which was organised by the charity.

Andrew was discharged from his order for completing all that was needed and complying well throughout the duration.

Commentary:

In respect of this national indicator, the most recent information has been used. This was discussed by the YOS management board in April 2013. For the period April 2010 – March 2011, Southampton's re-offending rate is higher than the national and regional averages and on a par with Kingston upon Hull and Portsmouth. All other comparator YOTs have lower rates, however. There is an upward trend in most, with only Peterborough demonstrating a consistently downward trend. One of the reasons for the increase is the smaller cohort size resulting from the success of preventative work, as a higher proportion of those being tracked are at greater risk of re-offending.

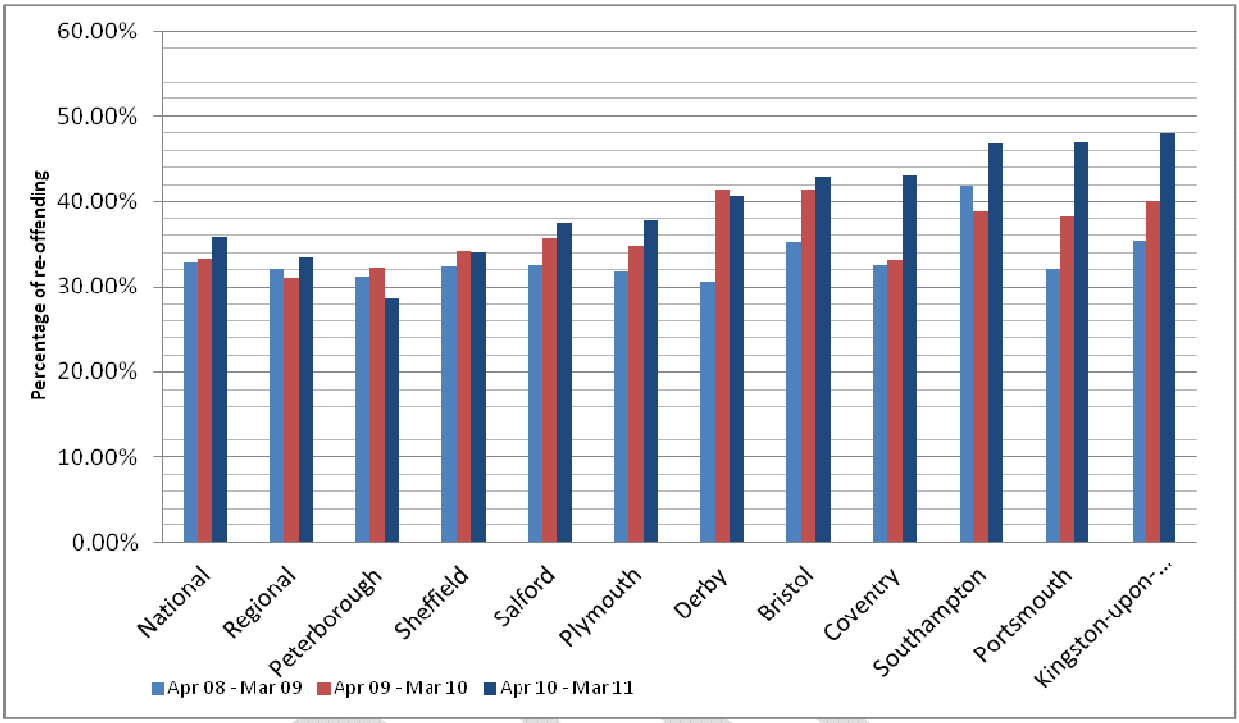
In 2013 / 14, Southampton Youth Offending Service will reduce the re-offending rate by 5%:

- Working with the Youth Justice Board, The YOS has identified a cohort of young people has been identified as 'high risk' offenders. Arrangements are developing with police and community safety to create a multi-agency *Priority Young People* panel which will action plan in respect of these young people on a monthly basis. Young people will be referred into the Families Matter initiative, as appropriate. Re-offending rates within the cohort will reported to the YOS management board on a quarterly basis.

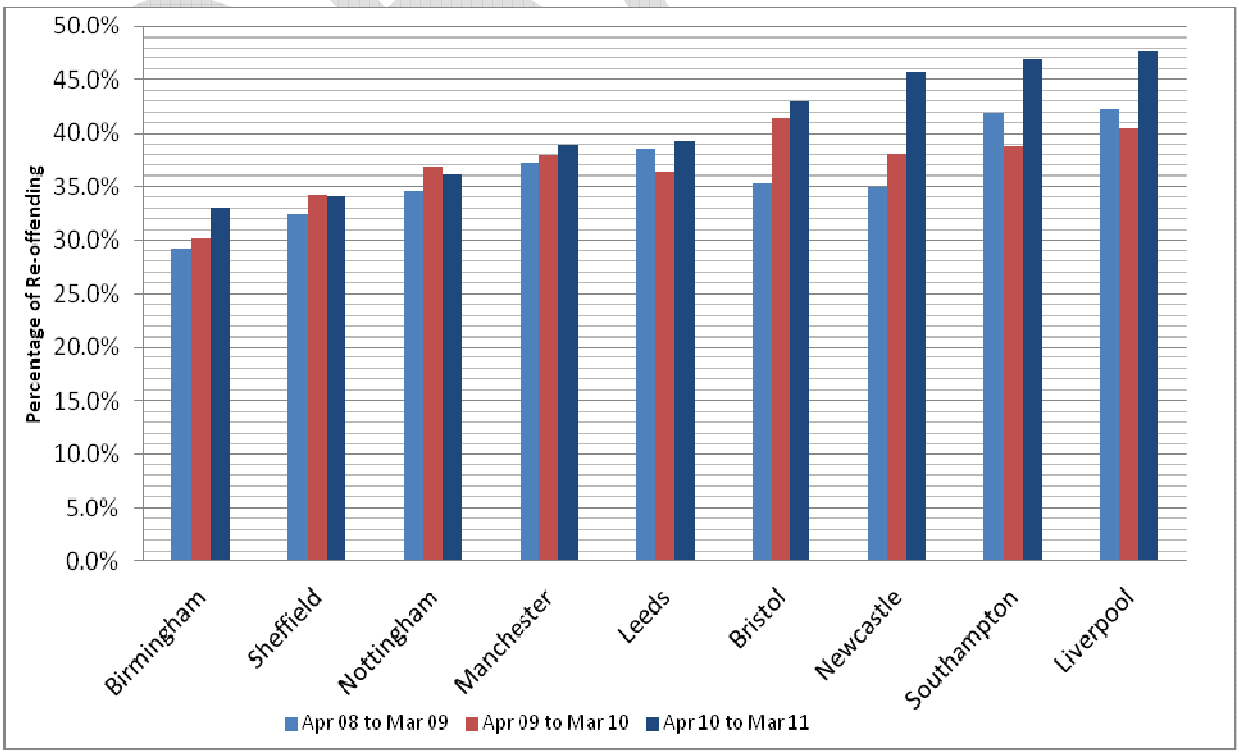
- Separately, the YOS manager is working with colleagues from Hampshire Constabulary in respect of raising frontline police understanding of the opportunities afforded by community resolution as a result of the Legal Aid, Sentencing and Punishment of Offenders Act, 2012. The aim will be to divert less entrenched young

offenders from committing further crime. Strategically, this will be supported by local senior police representation on the YOS Management Board.

Re-offending: Southampton and Comparator YOTs



Re-offending: Southampton and Core Cities



First Time Entrants

Example of Good Practice: The 'Take a Risk?' programme.

'Take a Risk?' has been developed by one of our seconded social workers, alongside our health worker and substance misuse workers. The aims of the programme are to:

- **Encourage young people to consider the consequences of violent and / or risk taking behaviour; alongside substance and alcohol misuse.**
- **Develop a greater sense of victim empathy in young people.**

The programme involves:

- **A group work session covering the impact of risk taking behaviour**
- **A victim empathy session**
- **A meeting with medical staff at Southampton Accident and Emergency Ward**
- **A session with service users from Headway, an acquired brain injury charity.**

The programme has run three times in the past year and 34 young people have completed component sessions. Of these, 14 (41%) have re-offended since attending the sessions (of the 14 three via breach of order). Twenty young people (59%) have not re-offended.

Commentary:

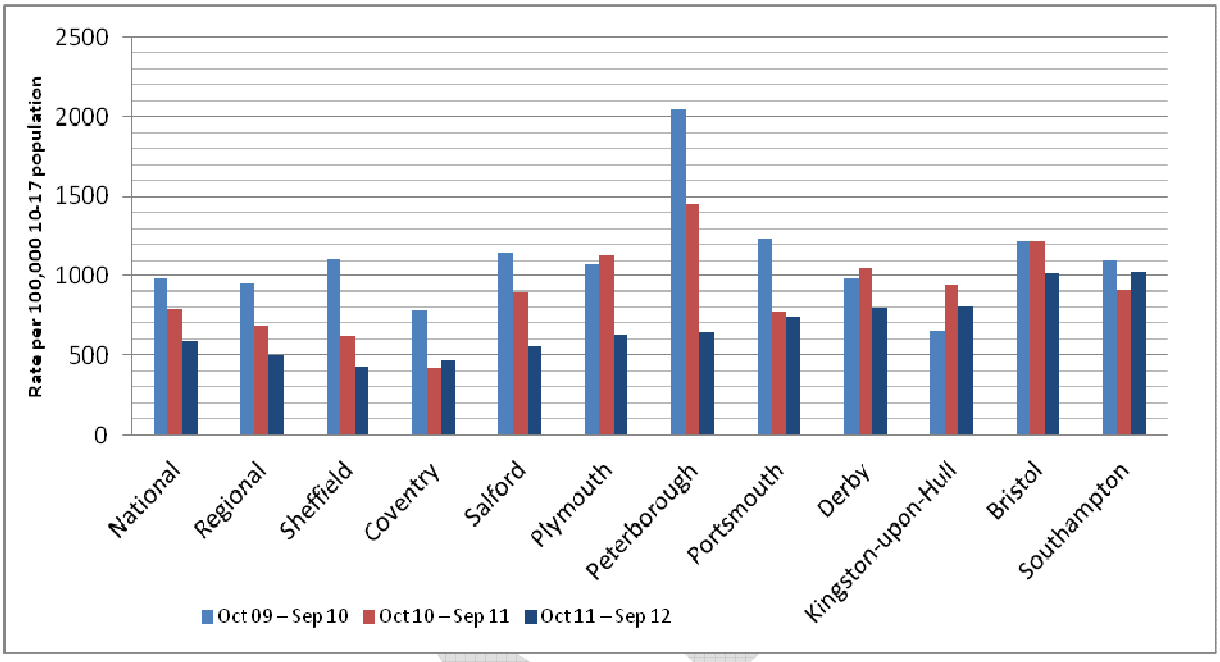
In respect of this national indicator, the most recent information has been used. This was discussed by the YOS management board in April 2013. For the period October 2011 to September 2012, the data is consistent with the picture over previous quarters and indicates that; although the FTE figures remain lower than in 2009 to 2010; there has been an increase in comparison with the 2010 to 2011 data. Local analysis indicates that a drop in the use of Youth Restorative Disposals may have created a 'reversing trend' in respect of FTE figures; as reprimands have been given in some cases where community resolution may have been possible.

In 2013 / 14 Southampton Youth Offending Service will reduce the First Time Entrants rate by 10%

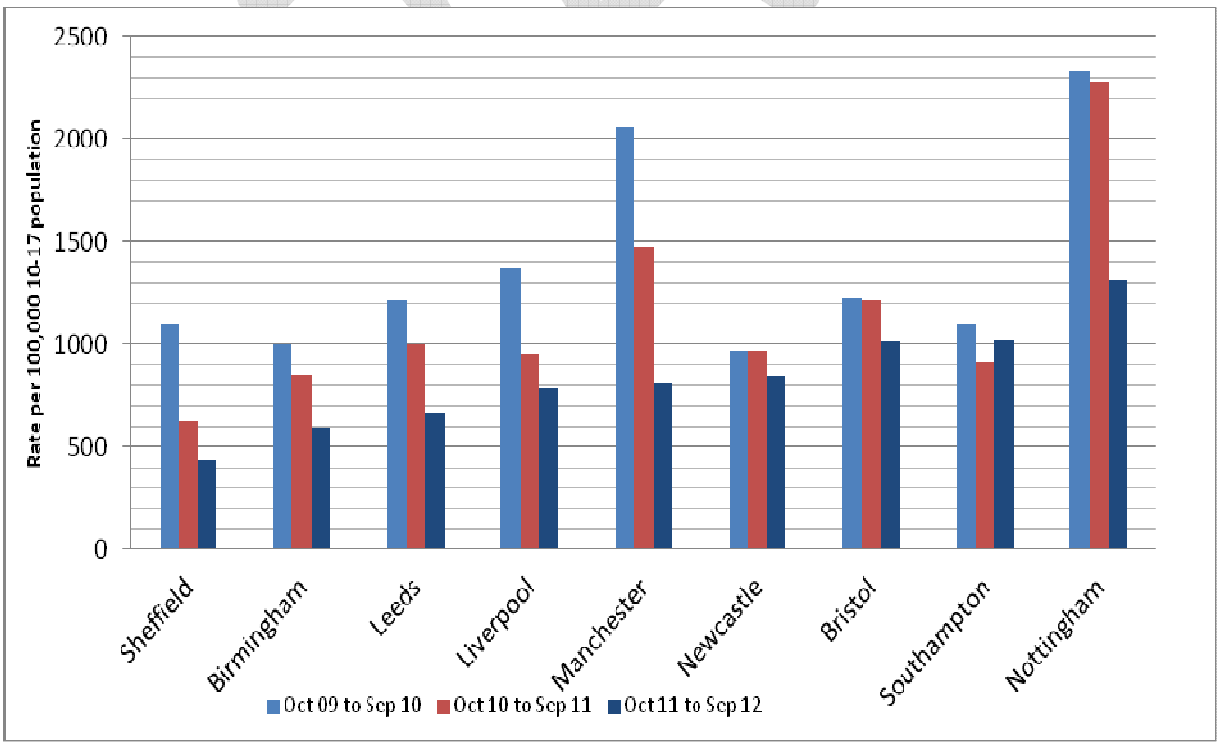
- Over the next year the YOS early intervention officer and police officer will more directly engage with police in Southampton to support our diversion work. This will be supported by effective engagement with senior police officers in the city and through more robust analysis of local FTE data with Hampshire Constabulary colleagues. The number of young people successfully completing diversion programmes will be reported to the YOS management board on a quarterly basis.

- The YOS early intervention officer and police officer have attended Hampshire Constabulary custody sergeants training will also participate in Out of Court Disposal training for police officers when it is rolled out later in the year.

First Time Entrants: Southampton and Comparator YOTs



First Time Entrants: Southampton and Core Cities



Local Indicators

Example of Good Practice: Kri-8 Arts Award

The project is funded by the Winchester School of Art Research Centre for Global Futures in Art, Design and Media and run through the John Hansard Gallery at Southampton University. It has the main aim of delivering a high quality, long-term, Arts Award embedded programme for young people who have offended. This partnership was timed perfectly with the recent re-structuring of the Southampton Youth Offending Service (SYOS.)

The Arts Award is run by Trinity Guildhall College. The YOS students are currently studying at Bronze (GSCSE C grade) level. The main reason that the arts award is perfect for SYOS is that it offers so much more freedom than regular education. There are no wrong or right ways of doing things by the young people. It's completely about encouraging them to express themselves.

The project started in October 2013. Seven young people have attended to date; only one of whom has re-offended. Five of the young people are accessing training / college provision. One remains Not in Education, Training or Employment (NEET).One young person is in custody. Whilst the group is small, its profile is significant: young people had convictions for or were awaiting trial for robbery; one young person was involved in a high degree of offending / anti-social behaviour.

Commentary:

To maximise the opportunities for children and young people in Southampton, performance indicators of accommodation suitability and access to education provision have been retained locally and performance is reported to the Management Board. The local targets are that 95% of young offenders are in suitable accommodation and 75% of young offenders are in full time education, training or employment. For the local indicators, data for April 2012 to March 2013 is available.

Progress has been achieved in the past year around accommodation suitability, principally because of the improved accuracy of YOS recording. This has enabled management review of all cases assessed as unsuitable. Accommodation was assessed as suitable in 94.15% of cases in 2012 – 13, compared to 90.37% in the previous reporting year. The YOS is confident that its target of 95% will be met in the coming year.

Education, Training and Employment engagement within the YOS cohort has unfortunately reduced in 2012 – 13 to from a baseline of 55.46% to 50.19%. The YOS Education Pathway has been reviewed robustly to meet the performance issues in this area.

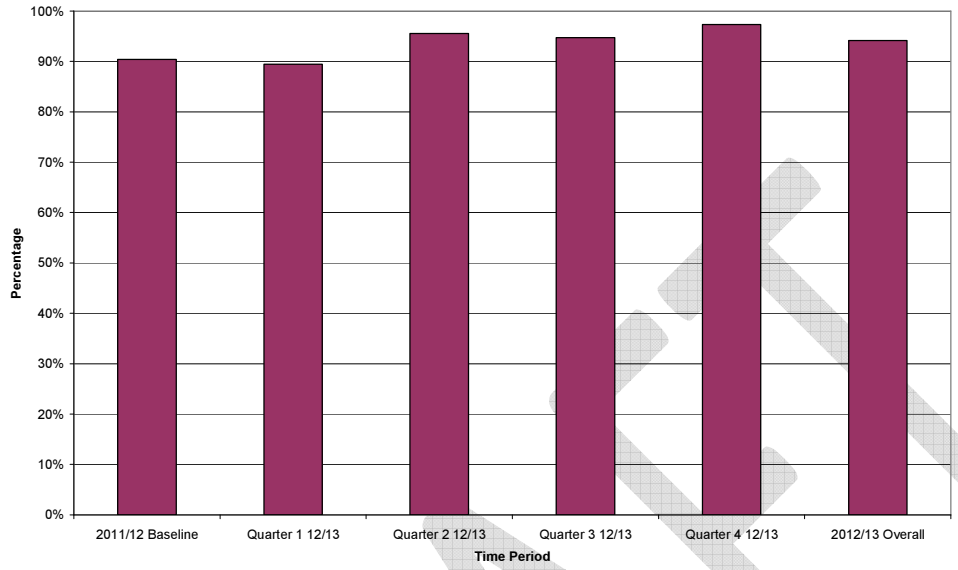
In 2013 / 14 Southampton Youth Offending Service will ensure that 95% of young offenders are in suitable accommodation and 75% of young offenders are in full time education, training or employment:

- The YOS education pathway has now been reviewed. A monthly education planning meeting has been developed that will run on a monthly basis for the 2013 – 14 period. Inclusion service management have committed to attend this meeting.

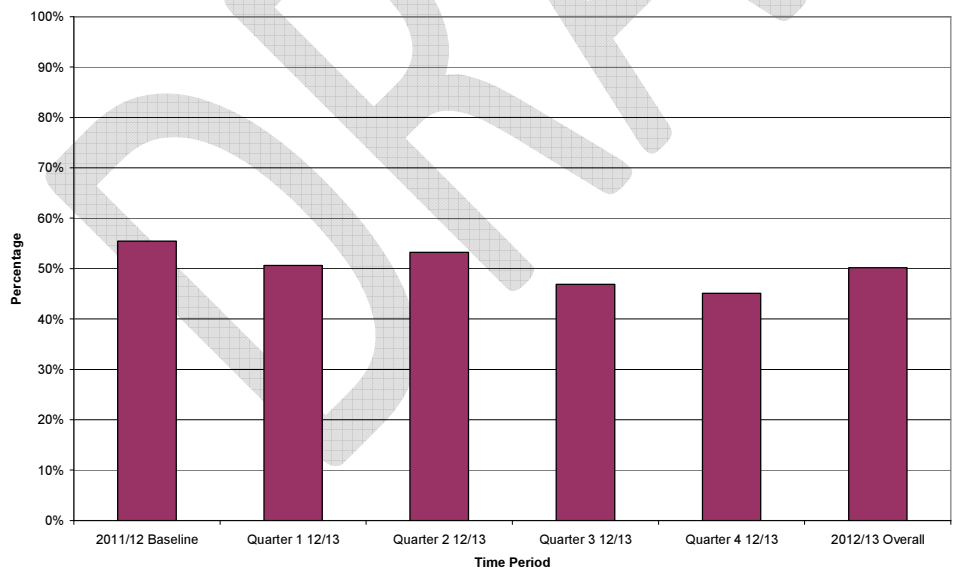
- Action plans will be created for individual cases. These will be reviewed as part of the planning process. The management board will be updated regarding engagement and attendance progress for cases.

- The development of a local resettlement forum, aligned with local supported accommodation strategy, will strengthen service responses in respect of the accommodation and ETE needs of young people leaving custody.

Accommodation



Education, Training and Employment



Remand Management: Local Response to Legal Aid, Sentencing and Punishment of Offenders Act

Example of Good Practice: Engagement with local courts

In February 2013, two lead youth magistrates from West Hampshire Youth Court attended an afternoon workshop at Church View. They met with frontline YOS staff, specialist workers and young people. There was also a strategic component to the event, with senior local authority managers appraising of work in respect of young offenders and care leavers. The magistrates left with a better understanding of local partnerships which will be built upon at further training events.

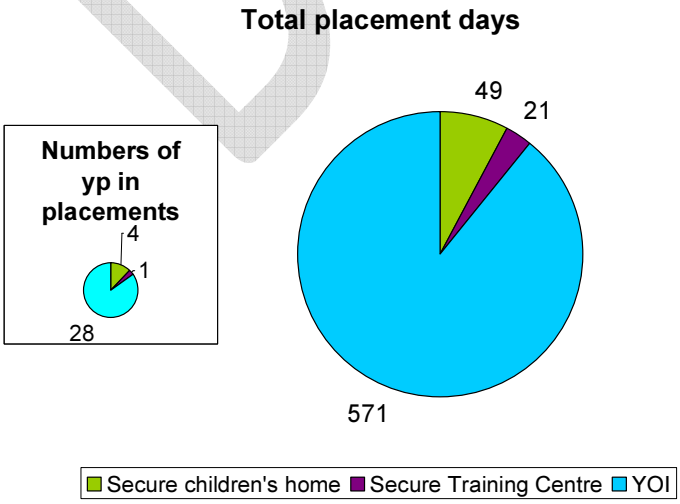
Commentary:

An impact of the Legal Aid, Sentencing and Punishment of Offenders Act is the devolution of remand accommodation funding from the YJB to local authorities from April 2013. This development could have significant financial implications and consequently the management board took the decision to start reviewing remand bed usage as part of the quarterly performance review.

The data covers the first three quarters of 2012 – 2013. Subsequent data will be produced on a quarterly basis. Initial assessment of the financial impact of the LASPO; taking into account the amount of funding likely to be awarded; is cautiously favourable. However, the areas of development will respond to the potential risks.

Areas for development:

- Implementation of the revised Safeguarding Strategy which will support a co-ordinated response between YOS and children's services in respect of children remanded and / or at risk of remand.
- Development of robust alternatives to secure remand: to include the YOS offending behaviour programme and enhance bail supervision.
- Ongoing work to improve the confidence of magistrates and judges in respect of the YOS and the wider local authority.



Section 4: Inspection and Improvement Plan

Southampton YOS was subject of a HMI Probation Short Quality Screening Inspection between 4th and 6th February 2013. The inspectors stated:

> *Overall, we found that the majority of assessments and plans were done to a sufficient standard. There were areas for improvement, particularly around quality assurance processes to ensure that a greater proportion of the work was of a good standard, that staff appropriately included new information in assessments and that the quality of work to ensure the sentence is served is improved.*

Southampton YOS was last inspected in May 2011 whilst part of Wessex Youth Offending Team. This was a full inspection and Wessex was rated as requiring 'significant' improvement in relation to addressing safeguarding issues and managing risk of harm and 'moderate' improvement in relation to addressing risk of re-offending.

Short Quality Screening inspections are indicative only, given the comparatively small number of cases. The scores for key areas are shared with the YOS manager and the average percentage scores for cases where the inspection criteria were met; based on the data provided for each area; are confirmed thus:

Southampton YOS: Average percentage score – key areas, SQS.

Reducing re-offending	**82.1%**
Protecting the young person	**81.2%**
Protecting the public	**77.8%**
Ensuring that sentence is served	**88.57%**

Whilst these scores are encouraging, there is clear evidence within the 'protecting the public' component that the service needs to do better in respect of our risk assessment and case management. Related to this, management oversight is a clear area for improvement.

The inspection recommendations are acknowledged and an improvement plan has been completed to embed consistent good practice and quality assurance processes within the service.

Inspection Improvement Plan:

Reducing the risk of re-offending:

Area for Improvement	Method	How improvement will be evidenced	By When	Lead
1. Assessment quality	a. All case holders to undertake Youth Justice Board assessment training in March 2013	Course completion will be confirmed with YJB	Completed	Senior Practitioners
	b. All appraisals for YOS Officers will include a target in respect of assessment quality; linked to the local effective practice proforma.	Monthly management quality assurance exercises will confirm that staff are working to effective practice guidance	Completed and ongoing	Senior Practitioners
2. Restorative Justice	a. Development and implementation of service Restorative Justice policy	Completion of policy with action plan and timelines. Deferred to June 2013	May 2013	YOS Manager
	b. Development of the reparation volunteer role to increase the service capacity for effective restorative justice work intervention	Restorative justice staff are currently working with 13 new volunteers Restorative justice performance is monitored on a quarterly basis	Ongoing	Restorative Justice Workers YOS manager
	c. Ensure Restorative Justice referrals for all custody cases	Referrals will be checked through monthly management quality assurance	Completed and ongoing	Senior Practitioners
3. Report writing quality	a. Continue to implement report quality assurance process	Quarterly pre-sentence report reviews	Ongoing – next date 20/03/13	YOS manager
	b. Ensure all staff have access to relevant policies and procedures	Paper and electronic copies available to staff	Completed	YOS manager
	c. Continue to implement fortnightly team discussions in respect of new pre-sentence reports	Dates arranged for 2013 / 14 period	Completed	YOS manager
4. Planning and Review	See above 1b	Monthly management quality assurance exercises will confirm if staff are working to effective practice guidance	Completed and ongoing	Senior Practitioners

Operational management:

Area for Improvement	Method	How improvement will be evidenced	By When	Lead
1. Training and Development	a. Completion of training needs analysis for 2013 / 14.	Development of training timetable for staff	March 2013	YOS manager

Protecting the public:

Area for Improvement	Method	How improvement will be evidenced	By When	Lead
1. Risk assessment	a. All case holders to undertake HCC Risk assessment and MAPPA training	Course completion will be confirmed with HCC	Completed	Senior Practitioners
	b. Ensure all staff have access to relevant policies and procedures	Paper and electronic copies available to staff	Completed	YOS Manager
2.Management Oversight	a. Appraisal targets for senior practitioners will include a target in respect of staff oversight / quality	Monthly management quality assurance exercises will confirm that senior practitioners are working to effective practice guidance	Completed	YOS manager

Protecting the child or young person:

Area for Improvement	Method	How improvement will be evidenced	By When	Lead
1. Management Oversight	a. Appraisal targets for senior practitioners will include a target in respect of staff oversight / quality	Monthly management quality assurance exercises will confirm that senior practitioners are working to effective practice guidance	Completed and ongoing	YOS manager

Ensuring that sentence is served:

Area for Improvement	Method	How improvement will be evidenced	By When	Lead
1. Enforcement and compliance	a. Revise Enabling Compliance Policy in line with inspection recommendations	Revise policy to be shared with staff	Completed	YOS manager
	b. All appraisals for YOS Officers will include a target in respect of enforcement and promoting compliance	Monthly management quality assurance exercises will confirm that staff are working to effective practice guidance	Completed	Senior Practitioners

Section 5: Resourcing and Value for Money

Table 1: Funding Contributions 2013 - 14:

Partner	Funding Contribution (£)	
	2012 / 13	2013 / 14
Southampton City Council	**619,400**	**591,500**
Health	**57,000**	**57,000**
Police Authority	**16,200**	**-**
Police and Crime Commissioner	**-**	**28,600**
Police	**68,800**	**68,800**
Probation	**76,300**	**74,000**
Youth Justice Board	**295,300**	**249,200**
Total	**1,133,000**	**1,069,100**

Table 2: Southampton Youth Offending Service Disposals 2012 – 13

Type	No.		% of Total		Young People	
	11/12	12/13	11/12	12/13	11/12	12/13
Prevention (Youth Restorative Disposals)	147	106	24	23	144	106
Final Warning Interventions	68	93	10	19	67	93
1st Tier sentences *(Referral and Reparation Orders)*	143	104	22	21	135	97
Community Sentences *(All other Community Sentences)*	228	157	36	32	132	105
Custodial sentences	49	28	8	5	39	23
Total	635	488	100	100	517	424

Commentary

This year, a lower award in total funding by the Youth Justice Board and the Police and Crime Commissioner has resulted in YOS partner contributions reducing by 5.6%. Southampton City Council and, to a lesser degree, Hampshire Probation Trust have also reduced their contributions. However, the local authority remains the principle statutory contributor to the YOS and has robustly supported the service in the face of this year's budget reduction. Savings have been made through a restructure which is summarised in 'Risks to Further Delivery'.

In 2012 / 13, the number of young people working with the Youth Offending Service reduced from 517 to 424. This represents a reduction of 18% in comparison with the previous year. The total number of disposals reduced by 23% from 635 to 488. Numbers have decreased across the scope of YOS interventions, with only Final Warnings increasing. However the service still met its intervention target in this area. The reduction in custodial sentences is clearly positive and indicative of the valuable work that the service is undertaking in respect of this national indicator by offering more robust community-based interventions as sentencing proposals to the Court.

The reduction in Youth Restorative Disposals (YRDs) is assessed to have impacted upon First Time Entrants figures which have increased in Southampton. Local analysis indicates that YRDs could be considered more rigorously by police in the city. Therefore, it is expected that numbers in this cohort will increase in 2013 / 14 as the YOS works with police colleagues to revitalise diversion work in Southampton.

Analysis of the cohort receiving community sentences is particularly relevant because it is within this group that young people are more likely to receive more than one order; through revocation and re-sentence. Within the smaller cohort, there has been a reduction in the average number of sentences per offender from 1.72 sentences per offender in 2011 / 12 to 1.49 sentences per offender in 2012 / 13. This reduction is interesting in the context of the recent SQS inspection result in which the YOS scored highest in ensuring sentence was served.

The reduction in young people accessing the service should be seen in the context Southampton Youth Offending Service reviewing and fully integrating its offending behaviour programme (which was previously managed by a separate team) into its core business; creating additional responsibilities for YOS staff and providing added value for money. The programme is now included in the YJB effective practice library and 90 young people attended sessions in 2012 – 13.

It has been possible to identify the level of contact for the first three months of YOS supervision in respect of 86 Referral Orders and 126 Youth Rehabilitation Orders. This data has been compared with the sample selected for the previous Youth Justice Strategic Plan.

Table 3: Levels of Contact for Referral Orders and Youth Rehabilitation Orders

Order	**Standard 2x contacts per month**		**Enhanced 4x contacts per month**		**Intensive 12x contacts per month**		**Total**	
	11/12	12/13	11/12	12/13	11/12	12/13	11/12	12/13
Referral Order	49	44	46	42	0	0	95	86
Youth Rehabilitation Order	*10*	*12*	*107*	*97*	*17*	*17*	*144*	*126*

Again, the level of standard and enhanced supervision for Referral Orders is comparable, indicating the degree of intervention that some first tier cases can require. The requirement for enhanced contact clearly increases within the YRO cohort. Interestingly, despite the reduction in numbers of YROs in 2012 / 13, the level of intensive supervision has remained the same, possibly because of the use of more robust community sentences as opposed to the imposition of custody.

Finally, the service response to the Legal Aid, Sentencing and Punishment of Offenders Act is relevant to note. In 2012 / 13, the YOS was heavily involved in preparing for the impact of the act: by working with the Youth Justice Board to finalise the statistical data on which the funding award will be based; revising local processes with safeguarding colleagues in the local authority and starting an important dialogue with local magistrates around the availability of robust community bail provision. In 2013 / 14, the work of the Youth Offending Service will be key, in the court context, to ensure that remand into Youth Detention Accommodation is kept to a minimum and used only when absolutely necessary. Effective court, remand and bail management by the Youth Offending Service should therefore provide clear value for money by reducing the cost of unnecessary remands.

Section 6: Risks to Future Delivery

The principal risk to future delivery remains financial pressures on the pooled YOS budget. The reduction in funding available to the service this year has been addressed through restructuring; a senior manager and an unqualified member of staff have left the service and will not be replaced. One of the YOS education posts has also been deleted.

Despite these responses, financial support must be considered pro-actively by partners to ensure that the service develops to meet local need with integrity. In 2012 – 13 the YOS management board will work to agree a partnership agreement that will support future service delivery.

The consideration following on from the restructure is clearly around the quality of service. Management oversight was noted as an area for improvement in the recent short quality screening inspection. Consequently, a revised quality assurance process has been developed to ensure that quality of provision is improved and then maintained.

The YOS response to the restructure has also involved the review of the YOS education pathway to ensure more effective partnership responses to children not in education training or employment. The requirement that the YOS personal advisor completes Education, Health and Social plans in respect of vulnerable children should add to the effectiveness of the service. Similarly, the placement of three Families Matter workers in the team offers the opportunity of more targeted work with high risk families.

A related risk is that the funding allocated by partners does not adequately reflect or address local need. Liaison with the office of the Police and Crime Commissioner will be necessary in 2013 – 14 to discuss service provision in Southampton with future Community Safety funding in mind.

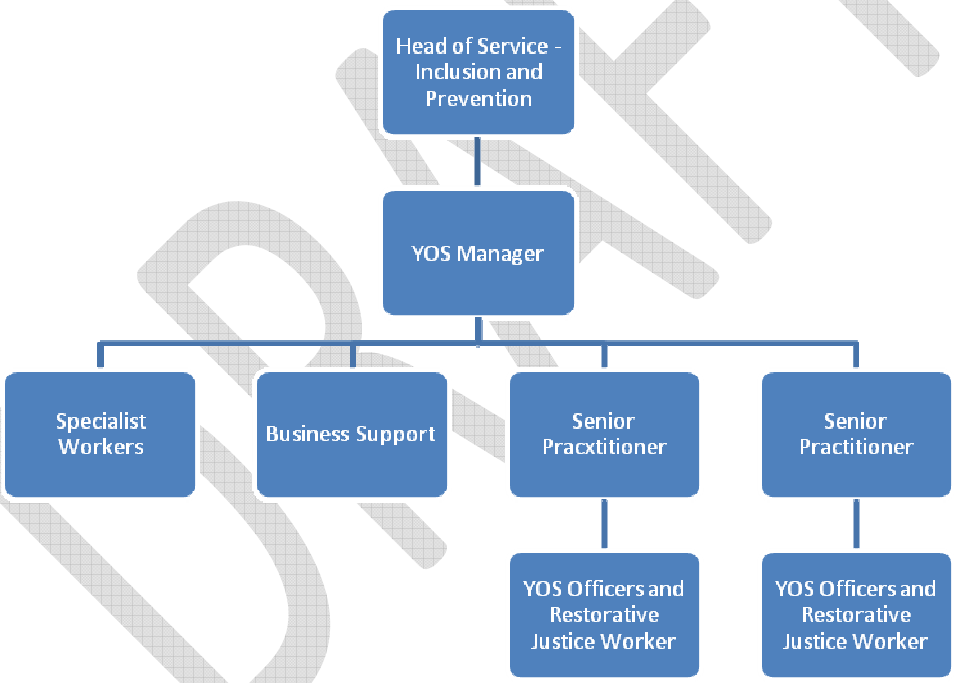
The devolved secure remand budget, as a result of the Legal Aid, Sentencing and Punishment of Offenders Act, also presents a potentially significant risk to Southampton City council as the principle financial contributor to the YOS. The local response has been sufficiently robust and liaison with the courts continues.

Hampshire Probation Trust faces significant changes in respect of *Transforming Rehabilitation* agenda which aims to reform the delivery of adult probation services. Clarification will need to be sought in relation to any impact around staff and funding provision for the Youth Offending Service.

Finally, the requirements around Youth Justice Board funding have changed this year with Effective Practice grants being administered. It will be important that the YOS service delivery progresses with the grant requirements in mind. Positively, a recent visit by the YJB audit team did not raise any significant issues.

Section 7: Structure and Governance

The Youth Offending Service is a statutory service, positioned within the People's Directorate of Southampton City Council. The team is multi-disciplinary with each statutory partner contributing staff. There are 20 full time and five part time members of staff within the team. Youth Offending Service Officers are seconded from Southampton City Council and Hampshire Probation Trust. Specialist workers include a seconded police officer, a personal advisor, and health and substance misuse workers. Three Families Matter Lead Practitioners have recently started working in the team.



Southampton Youth Offending Service management board is chaired by the Senior Officer for Prevention and Inclusion. Statutory Partners are represented by senior officers of Southampton City Council People's Directorate, Southampton Primary Care Trust, Hampshire Constabulary and Hampshire Probation Trust.

In addition, the management board includes representation from Housing, Community Safety and the Courts on an ad-hoc or permanent basis as mutually agreed. The management board is linked to the relevant local authorities including Children's Trust arrangements, Local Safeguarding Children's Board, Local Criminal Justice Board and Safe City Partnership.

The board provides strategic direction and support to the YOS manager; ensuring that planning is undertaken to reduce re-offending safeguard children and young people. Meetings are convened on a quarterly basis. Further sub-groups of the management board may be set up from time to time.

The Management Board oversees and contributes towards the Youth Offending Service's statutory aim of reducing re-offending. It fulfils the requirements of the Crime and Disorder Act 1998 and YJB guidance by ensuring that Southampton Youth Offending Service has sufficient resources and infrastructure to deliver youth justice services in its area in line with the requirements of the National Standards for Youth Justice Services.

The management board also ensures that relevant staff are seconded to the Youth Offending Service in line with the requirements of the Crime and Disorder Act 1998 and that the Youth Offending Service has sufficient access to mainstream services provided by partners and other key agencies.

In exceptional circumstances, where consideration is being given to derogating from a particular National Standard; the board will inform the relevant YJB Head of Business Area of the decision, rationale and the action plan and timelines to reinstate compliance. The board would monitor the action plan on a regular basis and progress reported to the YJB Head of Region or Head of YJB for Wales and YJB Head of Performance on a regular basis.

The board agrees the funding arrangement and ensure that arrangements are in place for a pooled budget. It ensures that information is exchanged between partner agencies in line with relevant legislation and in particular the Crime and Disorder Act 1998.

Finally, the board receives quarterly performance reports and works with the Youth Offending Service Manager to improve and sustain performance and quality standards. It also considers reviews of serious incidents (as defined by the YJB).

Section 8: Contribution to Partner's Strategies

Families Matter

Nationally, the 'Troubled Families' initiative has the aim of reaching 120,000 families. These families are characterised by there being no adult in the family working, children not being in school and family members being involved in crime and anti-social behaviour.

These families almost always have other often long-standing problems which can lead to their children repeating the cycle of disadvantage. One estimate shows that in over a third of troubled families, there are child protection problems. Another estimate suggests that over half of all children who are permanently excluded from school in England come from these families, as do one-in-five young offenders.

Other problems such as domestic violence, relationship breakdown, mental and physical health problems and isolation make it incredibly hard for families to start unravelling their problems.

In Southampton, the local 'Trouble Families' programme is called 'Families Matter'. Lead Practitioners have been placed with services across the city to work with families who are experiencing difficulties with one or more of these issues:

• Crime and Anti-social behaviour
• Parenting challenges
• Poor school attendance
• Serious financial issues.

Southampton Youth Offending Service contributes by:

- Hosting three Families Matter Lead Practitioners in the team. These staff will work in partnership with YOS colleagues and wider professional networks to intervene with at least 54 families in 2013 – 14. In July 2013, the service had worked with 39 families.

- Referring families into the Families Matter programme to ensure additional and co-ordinated support for those families assessed to be most at risk.

- Ensuring alignment between YOS and wider local authority strategy through the manager responsible for Families Matter attending the YOS management board.

Health and Wellbeing strategy

The purpose of the Joint Strategic Needs Assessment (JSNA) is to help professionals, services and communities to improve the health and wellbeing of Southampton's population through clearly identifying local needs. "Gaining Healthier Lives in a Healthier City" is Southampton's second Joint Strategic Needs Assessment (JSNA) and covers 2011 - 14.

Particular priorities have been identified in respect of:

- Tackling teenage pregnancies.

- Reducing sexually transmitted disease.

- Increasing numbers accessing substance misuse treatment.

Southampton Youth Offending Service contributes by:

- Working with health colleagues to inform and update the Joint Strategic Needs Assessment.

- Identifying and raising awareness of health problems/risk behaviours within its service group.

- Promoting positive health choices through its sexual health and relationships, emotional first aid and smoking cessation work.

- Delivering brief interventions for lower level needs and delivering substance and alcohol misuse, intervention at tier two and three level.

- Referring to services where specialist assessment and treatment is required.

Operation Fortress

Operation Fortress is a multi-agency operation which involves enforcement of the law by the police against drug trafficking and abuse, and support for victims of drug abuse, giving them the chance of a dignified exit from drugs and an opportunity to build a new way of life.

The three aims of the operation are:

- To restrict the supply of Class A drugs
- To reduce the demand for Class A drugs
- To re-build affected communities

The work police undertake to restrict the supply of drugs is just one part of Operation Fortress. The police have been overwhelmed by the level of support and interest received from partners and community groups who have been keen to get involved in the operation.

Partner support means that Operation Fortress can have a lasting impact in Southampton and make a long-term positive difference to reducing the demand for drugs and re-building the lives of people affected by drug-related crime.

Southampton Youth Offending Service contributes by:

- Developing the Serious Youth Crime Prevention Strategy in partnership with colleagues from Hampshire Constabulary and Community Safety

Integrated Offender Management

Integrated Offender Management (IOM) is an initiative to reduce crime and reduce re-offending by a more intensive case management approach to certain individuals. It will also provide support for those with drug and alcohol dependency linked to their offending behaviour. It aims to provide the right interventions to the right individuals at the right time through breaking the cycle of their offending behaviour. The services to address individual need include health, education, employment opportunities, housing, drug, alcohol and parenting skills programmes.

IOM involves close working between Hampshire Probation Trust, Hampshire Constabulary, Hampshire County Council, the unitary authorities of Portsmouth, Southampton and Isle of Wight local health authorities, Community Safety Partnerships, Prison Service, Youth Offending Teams (YOT) and providers who manage outreach, engagement and specialist substance misuse advice and support.

Information sharing and communication is key to the success of IOM, with partnership working being the driving force behind the schemes across Hampshire and the Isle of Wight. Co-ordination pan-Hampshire has been led by the Local Criminal Justice Board.

IOM will focus on those repeat offenders who meet a specific criteria or pattern of behaviour and will also include designated drug and alcohol related offending. Within IOM, individuals will be offered the opportunity to receive advice and assistance to help them change their lives; the aim is to stop their offending behaviour, thereby reducing crime in order to benefit the individual and our communities.

With the introduction of IOM in Hampshire and the Isle of Wight, the following offenders will be brought into the scheme: those who are arrested on four or more occasions in a three-month period; those who are assessed as at risk of not complying with a Court Order; and identified Persistent and priority Offenders (PPOs).

It will also give priority to those offenders receiving a prison sentence of less than a year, who are not already under Probation supervision, with a focus particularly on high risk groups such as women, and males from a black or ethnic minority background. It will also work with the Youth Offending Teams to continue interventions for some young people whose high level of offending requires their consideration within the IOM initiative.

Southampton Youth Offending Service contributes by:

- Working with Hampshire Probation Service to ensure effective transitions for young people moving from youth to adult supervision at 18 years of age

- Working with Hampshire Constabulary regarding the development of the seconded police officer role in order to maximise the opportunities afforded in respect of a partnership approach to integrated offender management around monitoring, intelligence gathering and enforcement

- Working in partnership with police and community safety to develop a forum in which to action-plan multi-agency responses in respect of high risk offenders

Prevention and Inclusion Services

As part of Prevention and Inclusion Services The Youth Offending Service works alongside other teams to ensure: the entitlement of all children and young people to good quality, universal services; facilitating access to statutory provision; early intervention; transition across services.

There are three key delivery principles: an Integrated Assessment of Need; collective ownership; workforce development.

Southampton Youth Offending Service contributes by:

- Ensuring that effective preventative work is undertaken by monitoring and reviewing levels of engagement and exit strategy planning in respect of young people subject to Youth Restorative Disposals

- Ensuring that Youth Offending Service prevention staff participate in local 'Team Around the Child' arrangements for relevant cases

- Ensuring that the service contributes to further developing the Southampton Integrated Assessment of Need model

Contribution to Safeguard young people in Southampton

The Youth Offending Service, alongside its wider statutory partners, have a mutual duty to make effective local arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children known to the youth justice

system. YOS participation in respect of local Safeguarding Children's Board arrangements and the review of the Youth Offending – Safeguarding Protocol in 2012 ensure that the service is strategically and operationally aligned with the city's wider safeguarding priorities.

Southampton Youth Offending Service contributes by:

- Ensuring that there is Youth offending Service participation in key areas so that the youth justice perspective in the development of local safeguarding strategy is maintained

- Monitoring and reviewing its work in line with the Southampton Youth offending Service – Safeguarding Protocol to ensure that vulnerable children are kept safe, with particular emphasis on children looked after, care leavers and children in custody

Safe City Partnership Plan

The primary aim and core business of the Safe City Partnership is to prevent and reduce crime, anti-social behaviour, fires and road collisions across Southampton. The partnership also aims to help tackle the root causes of crime.

The Draft Safe City Partnership priorities for 2013 – 14 are:

- Reducing crime and anti-social behaviour in key locations

- Reducing the harm caused by drugs and alcohol

- Reducing repeat victimisation with a focus on vulnerable victims and targeted communities

- Reduce re-offending

- Reduce youth crime

In addition to the work that Southampton Youth Offending Service undertakes to reduce reoffending by young people and youth crime, Southampton Youth Offending Service also contributes to achieving Safe City Partnership priorities by:

- Ensuring that 100% of young people who score 2 or more for substance and alcohol use in offending behaviour assessments undertaken using the Asset tool are referred to the Youth Offending Service Substance Misuse Worker for further assessment and intervention

- Aiming to ensure 50% of young people subject to Youth Restorative Disposals who have been referred for intervention by the police undertake meaningful reparation, taking into account victim wishes

- Participating in multi-agency Community Tasking and Coordination meetings to address anti-social behaviour in communities

- Ensuring that individual and group offending behaviour interventions reflect local priorities

DECISION-MAKER:		HEALTH & WELLBEING BOARD		
SUBJECT:		PUBLIC HEALTH: ARRANGEMENTS FOR HEALTH EMERGENCY PLANNING AND HEALTH PROTECTION		
DATE OF DECISION:		27 NOVEMBER 2013		
REPORT OF:		ANDREW MORTIMORE, DIRECTOR OF PUBLIC HEALTH, SCC		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Debbie Chase**	**Tel:**	**023 80833738**
	E-mail:	**Debbie.chase@southampton.gov.uk**		
Director	**Name:**	**Andrew Mortimore**	**Tel:**	**023 8083 3204**
	E-mail:	**Andrew.mortimore@southampton.gov.uk**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

This report describes the arrangements for health emergency planning and health protection that became local authority responsibilities from 1st April 2013.

RECOMMENDATIONS:

(i) That the Board recognise the critical role of the SCJHPF in providing assurance to the DPH and feeding into the Local Health Resilience Partnership (LHRP) thus fulfilling statutory requirements;

(ii) That the Board recognise the link between the impact of successful health protection mechanisms, for example vaccinations /immunisation programmes, and ill health associated with higher levels of deprivation;

(iii) That the Board adopts the World Health Organisation (WH0) 95% uptake target for vaccination which at that level will provide herd immunity to the remaining population.

REASONS FOR REPORT RECOMMENDATIONS

1. To provide the members of the Health & Wellbeing Board with an understanding of the health protection responsibilities for the city of Southampton

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2,. None. It is considered important for the members of the Health & Wellbeing Board to be regularly updated on the progress of arrangements for health emergency planning and health protection.

DETAIL (Including consultation carried out)

3. Health protection involves protecting the public from infectious disease and other threats from health, which may include chemicals and poisons, radiation and environmental hazards. It includes measures of prevention such as immunisations and vaccinations (including childhood, flu, travel) and responding to outbreaks to prevent spread of disease within communities (including meningitis, tuberculosis, hepatitis and other blood borne viruses). It also involves reacting in a timely fashion to incidents which may include major incidents and ensuring that the Emergency Preparedness Resilience and Response of Health is maintained and where needed strengthened. Appendix 1 is a briefing to Cllr Kaur on Emergency Planning & Business Continuity.

4. Local leadership from the Director of Public Health (DPH) is crucial to delivery of the health protection function and partnership working both internally and externally to the local authority with NHS England, Public Health England, the Clinical Commissioning Group and local providers of services. National leadership is provided by Public Health England. The Wessex Centre for Public Health England is based at Whitely, near Southampton.

5. Under health protection legislation (Department of Health 2010), local authorities have powers to require, request or take action for the purposes of preventing, protecting against, controlling or providing a public health response to the incidence or spread of infection or contamination which this presents, or could present, significant harm to human health. This might in rare situations include enforcing the requirement for a child to remain off school if their attendance could present a significant harm to others and powers of entry to inspect premises.

6. The DPH should ensure that effective arrangements are in place to reduce the risk of outbreaks of infectious disease, to manage those outbreaks effectively and to learn from them when they occur. The Health & Social Care Act 2012 stipulates that the DPH has responsibility to:

- Ensure plans are in place to protect the health of the geographical population from threats ranging from relatively minor outbreaks and health protection incidents to full scale emergencies;
- Respond to local outbreaks and incidents;
- Maintain Public Health surveillance of all aspects of the occurrence and spread of disease pertinent to effective control in order to inform and direct public health action.

Appendix 2 describes the health protection duty of local authorities.

The following paragraphs describe the mechanisms in place to discharge these responsibilities.

7. A Southampton local multi-agency forum, Southampton City Joint Health Protection Forum, (SCJHPF*)* links to the core health protection and emergency preparedness responsibilities of the Hampshire and Isle of Wight Local Health Resilience Partnership (LHRP) and the Southampton Health and Wellbeing Board. Whilst the group is there to provide assurance to the DPH that appropriate health protection planning mechanisms are in place for Southampton city residents and visitors, the forum will also act as an information exchange between public, voluntary services and private providers including Solent and Southampton University. The terms of reference for the Southampton City Joint Health Protection Forum are set out in Appendix 3.

8. Since the move of specialist public health from the NHS into the City Council a training needs assessment has been carried out within the Public Health team. This analysis has identified that required skills and knowledge in health protection and emergency planning require updating. The public health protection emergency planning manager is in discussion with Public Health England on what training programmes will be made available to staff within the next 12 months. Where appropriate, any training opportunities that would assist the generalist emergency planners will be made available to them.

9. Public Health England Wessex provides the DPH with monthly surveillance data on the occurrence and spread of disease within the local population. This information is cascaded and action taken as required, protecting public health. Appendix 4 is the memorandum of understanding with Public Health England.

10. Tackling of infectious disease threats will be an integral part of Health and Wellbeing Board's work in reducing health inequalities and improving the health of the population. This must include ensuring that immunisation programmes are effectively commissioned, cover a high proportion of the target population, are delivered safely and effectively and are having a measurable impact on the prevalence of these diseases

11. NHS England commissions screening and immunisation programmes. A draft Screening and Immunisation Governance and Assurance Framework has recently been issued by NHS England (Wessex). Local Authorities, through the DPH, will seek assurance from NHS England that programmes are commissioned and delivered safely, effectively and equitably for the

Wessex population. It has been proposed that the DPH will be a member of the partnership group, Chaired by the Head of Public Health Commissioning, NHS England (Wessex). The role of this group will be to identify and prioritise screening and immunisation need and link this into local Joint Strategic Needs Assessments.

RESOURCE IMPLICATIONS

Capital/Revenue

12. The cost of delivering these functions relates to officer time and is contained within the public health staff budget.

Property/Other

13. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

14. The responsibilities for emergency planning and health protection are set out in the Health & Social Care Act 2012 and the Civil Contingencies Act 2004.

Other Legal Implications:

15. None.

POLICY FRAMEWORK IMPLICATIONS

16. None.

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Emergency Planning & Business Continuity Update - Briefing Paper to Cllr Kaur [EP Unit Southampton City Council: August 2013]
2.	Protecting the health of local population: the new health protection duty of local authorities under the Local Authorities (Public Health Functions & Entry to Premises by Local Healthwatch Representatives) Regulations 2013 [DH,PHE,LGA:May 2013]
3.	Terms of Reference of the Southampton City Joint Health Protection Forum v9a [Public Health Southampton City Council: Oct 2013]
4.	Memorandum of Understanding: Public Health England Hants, Isle of Wight, Dorset Centre & Public Health Southampton City Council [PHE: August 2013]

Documents In Members' Rooms

1.	None.

Equality Impact Assessment

Do the implications/subject of the report require an	No

Equality Impact Assessment (EIA) to be carried out.	

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

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

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BRIEFING PAPER

SUBJECT: Emergency Planning and Business Continuity Update

DATE: 20th August 2013

RECIPIENT: Cllr Kaur – Cabinet Member for Communities

THIS IS NOT A DECISION PAPER

SUMMARY:

This report provides an update on the duties, obligations and capabilities Southampton City Council (SCC) has in relation to Contingencies Act 2004. These duties comprise assessment of risks, the compilation, exercising and review of emergency response and business continuity plans, warning and informing the public, responding to emergencies and collaboration with other agencies including the emergency services.

BACKGROUND and BRIEFING DETAILS:

Emergency Response Team

The pre-identified SCC Emergency Response Team (ERT) comprising some 52 key executive, professional lead and support officers from the authority who continue to engage in training, familiarisation, exercising and response as necessary. Tests of this capability both in and out of hours suggest an ongoing availability of approximately 70% which is excellent for a voluntary scheme. Four monthly general update bulletins and weekly 'on call' contact rotas are published.

Following recent organisational restructure and the departure of key experienced personnel the ERT arrangements have been reviewed. Duty Directors, Balfour Beatty and Capita have an important role within the structure and are supported by the Emergency Planning Manager (EPM) and the staff in the Emergency Planning Unit (EPU) in times of heightened alert.

The local NHS Public Health team has now been structurally integrated within the council effective from April 2013. The arrival brings with it new accountabilities for the council, such as the protection of the health of the population of Southampton. The Director of Public Health (DPH) is supported by a Consultant and Emergency Planning Officer. The DPH is focussed on fulfilling his statutory duties by working with multi-agency health partners, including local NHS providers, to ensure responses to health related incidents are tested, well co-ordinated and effective.

Divisional Business Continuity Plans (BCP)

A recent organisational restructure has triggered a review of BCP's co-ordinated through Directors and their Management teams. This review will also inform a number of SCC risk specific emergency plans developed in accordance with guidance issued by the Civil Contingencies Secretariat.

The ongoing support of CMT in ensuring corporate ownership, consistent application and broader awareness is essential. The benefits of doing so have been demonstrated within the SCC response to a number of recent disruptive challenges including power, IT and civic building 'outages' and severe weather. EPU staff continue to assist and facilitate the process.

BRIEFING PAPER

Hampshire & Isle of Wight Local Resilience Forum (LRF)

The Chief Executive and EPM participate within the inter agency LRF Executive forum chaired by the Chief Constable. The EPM attends the subordinate interagency Delivery Group. In addition, each officer within the EPU supports the work of two subgroups of the LRF. In close liaison with service management the EPM continues to represent the interest of the SCC Port Health Team, which is separately designated under the Act as a Category 1 Responder.

Major Incident Plan/Emergency Control Centre

The City Council Major Incident Plan was reviewed and republished in January 2012. Issues subsequently refined since publication include: key roles and responsibilities, command and control structure and recovery obligations falling to the authority. The EPU and Emergency Control Centre (ECC) transferred to the City Depot complex in November 2011 now supporting closer working relations with Port Health and other key staff including the Facilities Manager and City Depot.

The facility also serves as a temporary back up ECC for Esso Fawley complex following the demolition of Fawley Power Station. This was recently tested and worked well.

Health Protection

Public Health has re-established the Southampton City Joint Health Protection Forum, which will link to the core health protection and emergency preparedness responsibilities of the Local Health Resilience Partnership (LHRP) and the Southampton Health and Wellbeing Board.

Whilst the group is there to provide assurance to the DPH that appropriate health protection planning mechanisms are in place for Southampton city residents and visitors the forum will also act as an information exchange between public, voluntary services and private providers including Solent and Southampton University.

Exercising and Training

SCC staff continue to actively participate in joint emergency services and local authority exercises and seminars, the most recent being “Ex Carmeron” (June 2013) with Portsmouth City Council.

Refresher ECC training for incident controllers, specialist leads and support staff was undertaken in November 2012. This again was well received and productive. It is also proposed to provide a broader awareness opportunity for CMT and Heads of Service with responsibility within the SCC ERT Rota.

The Public Health team will be working with partners across the city to ensure access to NHS and Public Health training is made available to the appropriate staff. The importance of maintaining competencies in health protection planning will be key to an effective emergency response.

Southampton has been identified by the Home Office as one of eighteen major UK economic and travel hubs. SCC has now delivered the required Plan and follow up exercise in liaison with the emergency services, the port and airport. National Counter Terrorism Office feedback has informed the development and recent publication of Version 2 of the plan.

BRIEFING PAPER

Nuclear Submarine Berth

The 3 year Radiation (Emergency Preparedness and Public Information) Regulations (REPPIR) legal compliance cycle was recommenced in December 2012 with the publication of the 'SotonSafe' Plan Version 6. The interagency SotonSafe Emergency Planning Group now led by SCC Head of Regulatory Services and monitored by the Office of Nuclear Regulation (ONR), part of the Health and Safety Executive (HSE), continues to meet twice annually.

This submarine berth within the Port continues to present its challenges, however a recent national audit of the site plan proved favourable. The way the Council has discharged its regulatory obligations has been cited as best practice.

Given the limited attendance, other obligations and pressures there are no current plans to repeat public meetings. However, an offer has been made by the EPM to meet with the lobbying group Solent Coalition Against Nuclear Submarines (SCANS) on a periodic basis.

Whilst submarine visits to the Port are infrequent it is important the momentum is maintained and complacency does not arise. Related costs are recovered from the Navy.

Following the tragic events of the 8th April 2011 during a submarine visit to the Port by HMS Astute statutory proceedings have now concluded. Plans have been implemented as a result of the incident and have been ratified by the ONR.

Incidents of Note

Recent incidents of note involving the EPU and its support colleagues have included oil and chemical pollution, major fires, evacuation, severe weather and large scale power failures.

A number of events involving torrential rain, high tides and surface water resulting in flash flooding in August and September continue to highlight the increasing challenges across the City and in particular the Itchen Basin and arterial road network in and adjacent to Port. The EPU contribute to the work of the SCC Flood Risk Board in terms of planning and sustainability, development and emergency response. New legislation places additional duties upon the authority including that of post event investigation. Whilst still in its infancy, such a cross directorate and partnership initiated by SCC is being cited as best practice within both the H&IOW LRF and elsewhere.

Proceedings arising from the Shirley Towers Fire on 6th April 2010 have now concluded. The Rule 43 Coroner's Inquest outcome and recommendations have now been published. The implementation of these continue to be lead by the Head of Housing Services supported by the EPM.

Future Developments and the EPM

The EPM has further developed collaborative working arrangements with New Forest and Eastleigh Borough Councils to mutual benefit resulting in an annual income of £15k.

Following an organisational review and report to CMT in May 2013 the EPU recently transferred to the Head of Regulatory Services Division. An action plan is in place to ensure timely and effective succession planning for a number of retiring officers within the EPU. A recruitment process is underway aimed to ensure an adequate handover between the former EPM retiring in October 2013 and their replacement. Proposed closer on call working and training with Environmental Health management will forge greater lead emergency officer resilience. A cross directorate EP & BC Management Board to oversee

service delivery and corporate compliance will be chaired by the Director of Public Health. Terms of reference will be agreed at its forthcoming inaugural meeting.

RESOURCE/POLICY/FINANCIAL/LEGAL IMPLICATIONS:

There are no legal implications other than the statutory duty and guidance which directs the council's preparedness and there is the potential for reputational damage, litigation and costs should the council fail to meet these statutory obligations.

World events and Government impetus, not least in relation to the critical threats of pandemic influenza, industrial unrest, weather extremes and terrorism will ensure that emergency planning, business continuity and the capability of responders remain a priority for the Council.

OPTIONS and TIMESCALES: N/A

Appendices/Supporting Information: N/A

Further Information Available From:

Name: Graham Wyeth – Emergency Planning and Business Continuity Manager

Tel: 023 8083 2089

E-mail: graham.wyeth@southampton.gov.uk

Meeting **Southampton Joint Health Protection Forum**

Document **Terms of Reference**

Purpose	To provide a forum to discuss emerging threats to the public, encompassing current planning for the prevention and response to health protection incidents and outbreaks. This forum will focus on the Local Authorities new duty to protect the health of Southampton City. This forum will be a local voice for Southampton, linking to the core health protection and emergency preparedness responsibilities of the Local Health Resilience Partnership [LHRP] and the Southampton Health and Well Being Board. Health protection includes (but is not defined to) infectious disease, environmental health hazards/contamination and extreme weather conditions	
Membership	Chair – Public Health Consultant Lead for Emergency Planning Southampton City Council [SCC]	
	Wessex Local Area Team (NHS England)	Public Health SCC
	Public Health England	Southampton University
	Care UK	University Hospital Southampton FT
	Southampton City Clinical Commissioning Group	Southern Health FT
	Spire	Solent NHS FT
	Southampton Voluntary Service	Solent University
	*other organisations by appointment	Regulatory Services, SCC

Objectives

- To provide a local forum within which all health partners are able to discharge their statutory duties under health protection *[as per Section 6C of the NHS Act 2006 and Civil Contingencies Act 2004-revised 2012];*

- To provide assurance to the Director of Public Health for Southampton that appropriate health protection planning and Emergency Preparedness Resilience & Response (EPRR) mechanisms are in place for Southampton City residents and visitors.

- To ensure that plans of local organisations (both public and independent) support the need of the local community, taking into consideration relevant aspects of the Health & Well Being agenda;

- To act as an information exchange for Southampton partners following Local Health Resilience Partnership meetings:

- To ensure the local implementation of national and regional guidance requirements in relation to health protection;

- To identify key issues within the Local Health Resilience Partnership, with specific relevance to Southampton City, in order that these may be raised at a suitable multi-agency level;

- To agree locally clear escalation routes in the event of a **health protection incident**, including any service level agreements between provider organisations;

- To provide a planning forum for multi-agency training and exercise programmes in relation to local health protection.

Frequency of Meetings

Following the inaugural meeting to agree Terms and Conditions members have agreed to a frequency of 3 times per calendar year. The group may also be convened, if deemed valuable, due to extraordinary events for example viral outbreaks or environmental hazards.

A quorum for meetings will be a minimum of 5 people.

Example of types of issues this sub-committee will deal with will be:

- Infectious disease
  - Tuberculosis (TB)
  - Pandemic Flu
- Health Care Acquired Infections (HCAI)
- Environmental health hazards
- Adverse Weather
- Air Quality
- Surge Capacity (as a consequence to health incidents)

July 2013

MEMORANDUM OF UNDERSTANDING

MOU between

(1) Public Health England (Hants, Isle of Wight, Dorset) Centre and

(2)Southampton City Council

1. INTRODUCTION

1.1. This Memorandum of Understanding (MOU) establishes a framework for working arrangements between Public Health England (PHE) Hants, Isle of Wight, Dorset Centre and the LAs. Under the MOU, relevant joint plans describing the working arrangement, will be developed and agreed.

1.2 The MOU is not legally binding. All the parties to this agreement accept and agree that this does not hold them into any legally binding arrangement and that there are no intentions to create legal relations.

1.3 The organisations agree to endorse the objectives and principles of the MOU and to work in accordance with the practice set out in the MOU and future agreed joint plans.

1.4 The MOU and agreed joint plans should be reviewed every 2 years or earlier if requested by any of the organisations involved. This is to enable:

- monitoring of their effectiveness
- taking account of developing best practice
- allowing for changing circumstances, including opting out of the MOU.

2. THE ROLES AND RESPONSIBILITIES OF PHE AND THE LAs

2.1 The Hants, Isle of Wight, Dorset Centre is the local office for the national Public Health England (PHE), which draws together the expertise of a wide range of health, scientific and related staff into one organisation when responding to new and existing threats to health. The Hants, Isle of Wight, Dorset Centre's role includes local disease surveillance, the investigation and management of health protection incidents and outbreaks and the delivery and monitoring of national action plans for infectious diseases at local level. Within this role the PHE team provides assistance to the LAs and other organisations with responsibilities for protection of public health as well as acting as a gateway to the PHEs centres of specialist expertise such as the Centre for Radiation, Chemical and Environmental Hazards.

2.2 The PHE centre maintains and develops surveillance systems for communicable diseases and infection in accordance with the Health Protection (Notification) Regulations 2010.

2.3 The LAs have statutory responsibilities and powers to provide regulatory services on a diverse range of topics that impact on public health including food safety, health and safety at work, communicable disease, pollution control, housing, and licensing. Local Authorities also have duty to develop a community strategy, in consultation with partners, which sets out how they will promote the economic, social and environmental well-being within their local community. These responsibilities may be carried out through a variety of activities including advisory, enforcement,

education, licensing, health promotion and working with partner organisations; with the aim of ensuring compliance with the law and protection of public health.

2.4 As of 1st April 2013, the Public Health Directorate of the Primary Care Trust will transfer from the NHS to the Dorset County Council. The Local Authority, and the Director of Public Health acting on its behalf, have a pivotal place in protecting the health of its population. They will be required to ensure plans are in place to protect the health of their geographical population from threats ranging from relatively minor outbreaks to full scale emergencies.

2.5 Upper tier local authorities will be given a duty to ensure plans to protect the health of their populations are in place. Where the Director of Public Health identifies issues it will be his or her role to highlight them, and escalate as necessary, providing advice, challenge and advocacy to protect the local population, working with Public Health England which will provide specialist health protection services.

3. OBJECTIVES

The organisations signed up to the MOU endorse the following objectives to:

3.1. Work together to protect the community (and all parts of the community) against infection and contamination.

3.2. Establish effective working arrangements based on co-operation, partnership and mutual assistance between the PHE centre and the LAs based on local arrangements.

3.3. Ensure effective decision-making and investigation processes whilst maintaining the independence of each of the organisations.

3.4. Ensure that the roles and responsibilities are clearly understood by all the organisations signed up to the MOU and their partner organisations.

4. PRINCIPLES

The organisations signed up to the MOU endorse the following principles:

4.1. The health protection of the public is paramount.

4.2. Openness and partnership working with the public and with all our partnership organisations with the aim of improving protection of public health.

4.3 Any organisation may act immediately and independently where urgent action is required to protect public health.

4.4 All relevant evidence and factual information should be shared and disclosed between the PHE Centre and the LAs, except where prevented by specific legislation. Proper control should be exercised over the confidentiality of patient or business information.

4.5 There should be a commitment by the organisations to communicate and consult with each other at an early stage on all issues that may affect their roles and responsibilities.

4.6 There should be a commitment by the organisations to work towards achieving a common position on health protection issues and when communicating health protection messages. Wherever possible, each organisation's communications and media teams should work closely together when dealing with the media.

4.7 During specific incidents there should be an agreement on the communication strategy being used and the key messages for any public statements. This must include the sharing of media releases and briefings in advance of publication to allow time for discussion and understanding of the issues. Each organisation must consider the impact of the release of information which could be seen as commercially sensitive/damaging or confidential.

4.8 Where there is a dispute between organisations, attempts should be made to resolve the dispute at the appropriate management level as quickly as possible, this may include gaining further legal advice on the roles, responsibilities , duties or powers of either party . Where disputes cannot be resolved quickly they should be escalated to higher levels of management within the organisations. The reasons for any differing views as well as any decisions should be recorded.

5. PRACTICE FOR WORKING ARRANGEMENTS

The organisations signed up to the MOU endorse the following practice for working arrangements:

5.1. Each organisation should nominate named officers to coordinate their activities in implementing the MOU.

5.2 Meetings to develop, discuss, agree, and *I* or review the MOU and *I* or joint plans should be through the established liaison groups such as the Dorset Health Protection Committee or the Heads of Regulatory Service meeting . It is recommended that they should be held at least twice a year. Special liaison meetings may be called if required.

5.3 Roles and responsibilities should be clearly identified in local plans and appropriate arrangements should be agreed to cover the public health investigation and management of individual cases of infection or contamination that have implications for the local population.

5.4 Roles and responsibilities should be clearly identified in local plans and appropriate arrangements should be agreed for the investigation and management of suspected communicable disease control incidents affecting the community, including outbreaks of infection. Investigation and management should be led by either the PHE Centre or one or more of the LAs depending on the nature of the incident or outbreak.

5.5 Each organisation should ensure that there are adequate arrangements to provide a continuous responsive service (24 hours) to deal with urgently arising problems.

5.6 All relevant staff within the respective organisations should be informed of the contents of the MOU and any agreed joint plans.

5.7 Each organisation should ensure that staff engaged on health protection duties are suitably qualified and competent and are properly authorised where this is required.

5.8 Each organisation should ensure that there are robust emergency planning, resilience and response arrangements in place, which may involve arrangements for mutual aid between LAs and access to surge capacity across PHE centres. This may be part of the organisation's wider emergency planning services.

5.9 Arrangements should be in place for regular liaison between the organisations for routine purposes as well as during investigations of infection and contamination cases.

5.10 Opportunities to provide joint training and awareness-raising programmes for staff should be established.

5.11 Appropriate exercises should be designed and undertaken to test whether the local arrangements are working.

5.12 Local plans (as appropriate) should be developed, agreed and implemented, establishing practical working arrangements that support continual co- operation to achieve the objectives and principles of the MOU.

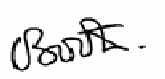
5.13. The joint plans should include the following elements:

- Clarification of roles and responsibilities
- Enforcement activity and authority
- Surveillance, incident recognition and alerting
- Liaison arrangements, for regular routine purposes as well as during incidents and outbreaks
- Operational arrangements, including the handover arrangements within each organisation
- Outbreak investigation and management
- Agreement on sharing of information
- Protocol for the agreement of any media releases
- Maintenance of up to date staff and operational contacts.

6. SIGNATURES

The signatures of the proper officers of the PHE Hants, Isle of Wight, Dorset Centre and the LAs who are parties to the MOU have been added below. These signatures demonstrate our willingness to work together in accordance with the objectives, principles and practices set out in the MOU but without an intention to create any legally binding relationship by so signing.

Authority/Organisation	Name	Date
PHE Wessex Centre	Dr Linda Booth	August 2013



Department of Health | Public Health England | Local Government Association

Protecting the health of the local population: the new health protection duty of local authorities under the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013[1]

Purpose of this document

This document explains the new health protection duty of local authorities under regulation 8 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, made under section 6C of the National Health Service Act 2006 ("NHS Act 2006") (as inserted by section 18 of the Health and Social Care Act 2012[2]), which came into force on the 1st of April 2013 ("6C Regulations")[3].

The 6C Regulations and this document focus principally on arrangements for preventing and planning response to health protection incidents and communicable disease outbreaks that do not require mobilisation of a multi-agency response under the Civil Contingencies Act 2004 ("CCA")[4]. It complements the Department's publications on emergency preparedness[5], resilience and response (EPRR) arrangements[6].

The Secretary of State has the overarching duty to protect the health of the population, a duty which will generally be discharged for him by Public Health England (PHE). The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 delegate to local authorities the critical role of providing information and advice to relevant organisations (including PHE) so as to ensure all parties discharge their roles effectively for the protection of the local population.

If the Secretary of State considers that (for any reason, and in any location) the local arrangements are inadequate, or that they are failing in practice, then he must take the action that he believes is appropriate to protect the health of the people in that area.

Background

The arrangements for health protection from April 2013 build on the strengths of the existing system. The activity previously carried out by the Health Protection Agency (HPA) under the

Health Protection Agency Act 2004[7] is now the responsibility of the Secretary of State, under new statutory health protection functions (in particular section 2B of the NHS Act 2006). In practice that activity will be carried out by PHE) an executive agency of the Department of Health. Primary Care Trusts and Strategic Health Authorities were abolished on 1 April 2013[8].

The 6C Regulations provide for each local authority to "provide information and advice to every responsible person and relevant body within, or which exercises functions in relation to, the authority's area, with a view to promoting the preparation of appropriate local health protection arrangements ("health protection arrangements"), or the participation in such arrangements, by that person or body". More detail on the legislative framework is available at Annex A.

The director of public health (DPH) is responsible for the local authority's contribution to health protection matters, including the local authority's roles in planning for, and responding to, incidents that present a threat to the public's health. PHE has a responsibility to deliver the specialist health protection response, including the response to incidents and outbreaks, through the PHE Centres which take on the functions of the former Health Protection Units. These roles are complementary and both are needed to ensure an effective response. In practice this means that there must be early and ongoing communication between the PHE Centre and DPH regarding emerging health protection issues to discuss and agree the nature of response required and who does what in any individual situation.

The local health protection system therefore involves the delivery of specialist health protection functions by PHE, and local authorities providing local leadership for health. In practice, local authorities and PHE will work closely together as a single public health system. This joint working with clarity of responsibilities between them is crucial for safe delivery of health protection, and practical guidance for these arrangements is at Annex B.

The aim of the new arrangements is for an integrated, streamlined health protection system that delivers effective protection for the population from health threats, based on:

- a clear line of sight from the top of government to the frontline;
- clear accountabilities;
- collaboration and coordination at every level of the system; and
- robust, locally sensitive arrangements for planning and response[5].

Unitary and lower tier local authorities have existing health protection functions and statutory powers under the Public Health (Control of Disease) Act 1984[9], as amended by the Health and Social Care Act 2008, and regulations made under it[10] as well as other legislation, such as the Health and Safety at Work Act etc 1974[11] and

the Food Safety Act 1990[12] and associated regulations, which enables them to make the necessary interventions to protect health.

The key elements of health protection

Health protection seeks to prevent or reduce the harm caused by communicable diseases and minimise the health impact from environmental hazards such as chemicals and radiation.

As well as major programmes such as the national immunisation programmes and the provision of health services to diagnose and treat infectious diseases, health protection involves planning, surveillance and response to incidents and outbreaks.

Local authorities (and directors of public health (DsPH) who would usually act on their behalf) have a critical role in protecting the health of their population, both in terms of planning to prevent threats arising, and in ensuring appropriate responses when things do go wrong.

The scope and scale of work by local government to prevent threats to health emerging, or reducing their impact, will be driven by the health risks in a given area.

Understanding and responding to those health risks needs to be informed by Joint Strategic Needs Assessments (JSNAs)[13], Joint Health and Wellbeing Strategies (JHWS), and the health and social care commissioning plans based upon them.

Local government will work with local partners to ensure that threats to health are understood and properly addressed.

PHE, with its expertise and local health protection teams, has a critical role to play in responding directly to incidents and outbreaks, and in supporting local authorities in their responsibilities to understand and respond to potential threats.

The NHS will also continue to be a key partner in planning and securing the health services needed to protect health and in mobilising NHS resources in response to incidents and outbreaks.

Prevention

Local authorities already have existing duties and powers to tackle environmental hazards (see earlier "Background" section). The move of local public health functions from the NHS into local government opens up new opportunities for joint work with environmental health colleagues to tackle areas where there are potential threats, including infectious diseases, and environmental hazards.

The local leadership of DPH, on behalf of local authorities, is critical to ensuring that the local authority and local partners are implementing preventative strategies to tackle key threats to the health of local people.

In taking forward this preventative role, local authorities, usually led by their DPH, will work closely with local PHE centres, which will provide a range of health protection services, including collection, analysis, interpretation of surveillance data, expert epidemiological and public health advice on hazards and effective interventions, and support to develop and implement local prevention strategies. Local teams will also wish to develop relationships with NHS England Local Area Teams, for example in relation to the commissioning of screening and immunisation programmes.

Planning and preparedness

Effective planning is essential to limit the impact on health when hazards cannot be prevented. The legal duty under the NHS Act 2006 to protect the population rests with the Secretary of State and is discharged through PHE, which provides the specialist health protection expertise to support local agencies in developing their plans to respond to public health emergencies and incidents.

Upper tier and unitary local authorities also have a new health protection duty, which involves the local authority discharging aspects of the Secretary of State's duty to take steps to protect public health. The duty takes the form of a statutory requirement (under the section 6C Regulations referred to above) to provide information and advice to certain persons and bodies, with a view to promoting the preparation of appropriate health protection arrangements. Such arrangements should cover threats ranging from relatively minor communicable disease outbreaks and health protection incidents to full-scale emergencies.

In practice, this means that the DPH will provide information, advice, challenge and advocacy on behalf of their local authority, to promote preparation of health protection arrangements by relevant organisations, operating in their local authority area[14]. The DPH, on behalf of their local authority, should be absolutely assured that the arrangements to protect the health of the communities that they serve are robust and are implemented appropriately to local health needs. They also need the opportunity to escalate concerns as necessary, when they believe local needs are not being fully met. They should expect a highly responsive service from PHE and other partners in this respect.

This local authority role in health protection planning is not a managerial, but a local leadership function. It rests on the personal capability and skills of the local authority DPH and their team, on behalf of the local authority, to identify any issues and advise appropriately. But it is underpinned by legal duties of cooperation, contractual arrangements, and clear escalation routes.

Responsibility for responding appropriately to the local authority's

information and advice (and accountability for any adverse impact if that advice is not heeded) rests with other organisations[15].

The 6C Regulations serve as a key lever for local authorities to improve the quality of health protection arrangements in their local areas through the effective escalation of issues. They may raise issues locally, with the partner concerned, the Health and Wellbeing Board (HWB), or directly with commissioners if there are concerns about commissioning of services.

To help ensure that public health advice is appropriately taken account of, there is a range of legal duties and escalation routes, which are discussed further below.

Relationships and accountabilities

Successful health protection requires strong working relationships at the local level. To underpin and support good working relationships, there are a number of legal and other levers to ensure that the relevant organisations do what is required of them to protect the public and take public health advice.

The Secretary of State expects PHE, as an executive agency of the Department of Health, to cooperate with the NHS (NHS England, CCGs, commissioning support units and providers) and local authorities, and to support them in exercising their functions.

PHE is able to provide a wealth of health protection expertise to local authorities to help them in their health protection function as well as delivering directly to the public. To assist this process, PHE should agree with local authorities the specialist health protection support, advice and services that they will provide; this agreement should build on existing arrangements between the NHS, local authorities and the PHE centres.

The NHS England Standard Contract outlines what NHS organisations are expected to deliver in terms of health protection generally, as well as emergency planning (including significant incident and emergency) management and any cooperation requirements necessary to achieve those objectives.[16]

NHS England and CCGs have a duty to cooperate with local authorities on health and well-being under the NHS Act 2006[17].

This includes cooperating around health protection, including the sharing of plans.

The Health and Social Care Act 2012 makes clear that both NHS England and CCGs are under a duty to obtain appropriate advice, including from persons with a broad range of professional expertise in "the protection or improvement of public health"[18]. This includes the advice of local authorities, usually delivered

through their director of public health. The leadership of the director of public health in this context is highlighted by local health resilience partnerships being co-chaired by a director of public health, ensuring their ability to scrutinise and be assured of the plans to respond to emergencies for the communities they serve.

Putting the new mandatory function into practice

Over and above their existing responsibilities as Category 1 responders under the CCA, under the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 upper tier and unitary local authorities are required to take certain steps to protect the health of their local population. In particular, as explained above, they are required to provide information and advice with a view to promote the preparation of health protection arrangements by key health and care partners within the local area[19], recognising that PHE provides the specialist health protection functions of the Secretary of State.

The Department of Health does not expect local authorities to produce a single all-encompassing "health protection plan" for an area, but rather to promote preparation of effective health protection arrangements by local organisations, operating in their areas. This includes commissioning plans aimed at prevention of infectious diseases, as well as joint approaches for responding to incidents and outbreaks agreed locally with partners, including PHE and the NHS.

Local co-operation agreements, memorandums of understanding and protocols between key partners on response to outbreaks are already in place and work well in some areas. These need to be revised and updated for the new system, given the new statutory responsibilities of Public Health England and Local Authorities described in this factsheet. The content of these agreements is for local determination, and local partners may wish to review or update their existing documents, taking into account the core elements to local arrangements which experience suggests should be in place in every area (many of which are set out in regulation 8(7) of the section 6C Regulations) including:

- clearly defined roles and responsibilities for the key partners (comprising at least the local authority, PHE, NHS England, CCGs and primary and secondary care NHS providers), including operational arrangements for releasing clinical resources (e.g. surge capacity from NHS-funded providers) with contact details for a key responsible officer and a deputy for each organisation
- local agreement on arrangements for a 24/7 on-call rota of qualified personnel to discharge the functions of each organisation

- clear responsibilities in an outbreak or emergency response, including the handover arrangements
- information-sharing arrangements to ensure that PHE, the director of public health and the NHS emergency lead are informed of all incidents and outbreaks
- arrangements for managing cross-border incidents and outbreaks
- arrangements for exercising and testing, and peer review
- arrangements for stockpiling of essential medicines and supplies, as appropriate
- escalation protocols and arrangements for setting up incident/outbreak control teams
- arrangements for review (the Department of Health recommends this should take place at least annually).

Local authorities may wish to establish a local forum for health protection issues, chaired by DPH, to review plans and issues that need escalation. This forum could be linked to the HWB, if that makes sense locally.

Ensuring that data can flow to the right people in the new system in a timely manner will be key to making the new arrangements work.

The Public Health Outcomes Framework[20], published on 23 January 2012, contains a health protection domain. Within this domain there is a placeholder indicator, "Comprehensive, agreed inter-agency plans for responding to public health incidents". The Department of Health is taking forward work to ensure that it can effectively measure progress against this indicator.

Next steps and further work

The Department of Health and PHE will publish further guidance on the wider health protection system in due course, building on discussion with the NHS, local government and public health stakeholders. This will include guidance on escalation routes where agreement on any aspect of preparation or response cannot be reached locally.

Annex A: Legislative framework

Under section 2A of the NHS 2006 Act (as inserted by section 11 of the Health and Social Care Act 2012), the Secretary of State for Health has a duty to "take such steps as the Secretary of State considers appropriate for the purpose of protecting the public in England from disease or other dangers to health".

In practice, PHE will carry out much of this health protection duty on behalf of the Secretary of State.

Under the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 unitary and upper tier local authorities have a new statutory duty to carry out certain aspects of the Secretary of State's duty take steps to protect the health of the people from England from all hazards[21], ranging from relatively minor outbreaks and contaminations[22] , to full-scale emergencies, and to prevent as far as possible those threats arising in the first place[23]. In particular, regulation 8 requires that they provide information and advice with a view to promoting the preparation of health protection arrangements by "relevant bodies" and "responsible persons", as defined in the regulations. In addition, regulation 7 requires local authorities to provide a public health advice service to clinical commissioning groups (CCGs), which includes advice on health protection.

They will continue to use existing legislation to respond to health protection incidents and outbreaks (see above).

Directors of public health (DsPH) are employed by local authorities and are responsible for the exercise of the new public health functions. Directors will also have a responsibility for "the exercise by the authority of any of its functions that relate to planning for, and responding to, emergencies involving a risk to public health"[24].

Under new section 252A of the NHS Act 2006[25], NHS England will be responsible for (a) ensuring that clinical commissioning groups and providers of NHS services are prepared for emergencies, (b) monitoring their compliance with their duties in relation to emergency preparedness and (c) facilitating coordinated responses to such emergencies by clinical commissioning groups and providers.

The Health and Social Care Act 2012 also amends section 253 of the NHS Act 2006 (see section 47 of the 2012 Act), so as to extend the Secretary of State's powers of direction in the event of an emergency to cover an NHS body other than a local health board (this will include NHS Commissioning Board and clinical commissioning groups); the National Institute for Health and Care Excellence; the Health and Social Care Information Centre;

any body or person, and any provider of NHS or public health services under the Act.

Under the consequential amendments made by the Health and Social Care Act 2012, the NHS England and Public Health England (as part of the Department of Health exercising the Secretary of State's responsibilities in relation to responding to public health emergencies) will be Category 1 responders under the CCA, requiring them to cooperate and work together in the planning of responses to civil contingencies.

CCGs will be Category 2 responders under the Act giving them a duty to provide information and cooperate with civil contingency planning as needed. Local authorities[26] will remain Category 1 responders under the CCA.

Annex B

Local authorities and Public Health England relationship in respect of health protection

This annex is intended to provide clarity around the respective roles of local authorities and Public Health England (PHE) in relation to health protection to support a safe transition of this function into the new system after 1 April 2013, and has been agreed by PHE, the Association of Directors of Public Health and the Faculty of Public Health. It summarises the statutory responsibilities and collaborative working relationships necessary between local authorities and PHE to deliver effective arrangements to protect the public's health.

1. The statutory responsibilities of local authorities government and of PHE

Health protection includes (but is not confined to) infectious disease, environmental hazards and contamination, and extreme weather events.

The statutory responsibility to protect the health of the population transferred from the Health Protection Agency (HPA) to the Secretary of State for Health on 1 April 2013. Secretary of State's responsibility will mainly be discharged through PHE. However, there are also some specific powers delegated to local authorities under the 6C Regulations. These are to give information and advice on appropriate health protection arrangements within their local area to every responsible person and relevant body, and to provide health protection advice to clinical commissioning groups.

PHE will be responsible for providing the specialist health protection functions previously carried out by the HPA including the specialist response to incidents.

As part of the local authority's responsibilities the director of public health (DPH), on behalf of the local authority, has a duty to prepare for and lead the local authority's response to incidents that present a threat to the public's health.

District and unitary authorities also have defined responsibilities in respect of environmental health, which may be discharged in a variety of different ways in different geographical areas. For example, some districts may wish to combine their environmental health capacity across a wider area with DPH leadership from the county; some unitary authorities may wish to have environmental health within the DPH's

leadership responsibilities, whilst in others they may be entirely separate.

The DPH is a statutory member of the Health and Wellbeing Board (HWB). HWBs is to ensure leaders from health and care systems and the public work together to improve the health and wellbeing of their local population and reduce health inequalities. Board also ensure public engagement and input to joint strategic needs assessments and to health and wellbeing strategies. Boards will also ensure that commissioners work collaboratively to meet the health and wellbeing needs of the community.

2. Practical implications of statutory changes, underlying principles and collaborative support arrangements

To deliver effective planning and response arrangements at local level there needs to be constructive and collaborative working relationships between PHE and the local DPH. Whilst there will be variations in different localities, it is possible to identify a set of principles and support arrangements to enable the delivery of effective local authority and PHE health protection functions. These include:

DPH and PHE relationship

The DPH has a duty to prepare for and lead the local authority's response to incidents that present a threat to the public's health. PHE has a duty to deliver the specialist health protection response. These roles are complementary and both are needed to ensure an effective response.

PHE delivery

PHE continues to deliver the specialist health protection functions described in the HPA's previous work on the "model health protection unit".

These are:

- Responding to and managing outbreaks and incidents
- Responding to cases, enquiries and providing advice
- Surveillance and epidemiology study
- Health protection leadership/ stakeholder relationship management
- Contributing to and influencing PHE Programme Board activities and other internal work streams
- Research and development
- Underpinning activities (management, governance arrangements, continuous professional development etc.)

  This includes the provision of PHE support for DsPH addressing issues of environmental health planning applications (e.g. for waste incinerators)

Health and Wellbeing Boards

Local authorities, with their Health and Wellbeing Boards (HWBs), and through their DsPH will wish to assure that acute and longer term health protection responses and strategies delivered by PHE are delivered in a manner that properly meets the health needs of the local population. PHE Centres and DsPH will agree the reporting of health protection arrangements to HWBs to include local agreement of health protection priorities on an annual cycle and any ad hoc reporting for serious incidents or areas of concern.

We would not expect PHE to be represented on the HWB but to attend for specific health protection related discussions. Attendance would be primarily in support of the DPH who is the local leader for health in the local authority.

Mobilising resources for incidents

DsPH, with their local health leadership role, will work with colleagues from PHE to establish arrangements for mobilising resources to respond to incidents and outbreaks. This will include advice to CCGs, discussions with the Local Area Teams of NHS England, and particularly through the joint chairmanship arrangements of the Local Health Resilience Forum. We would expect the work to establish these arrangements to take place as soon as possible so that PHE staff can access support directly from providers when needed. We would also expect that DsPH would wish to be assured that these plans will work effectively when required.

Communications, information and concerns

The PHE Centre and the DPH will develop a shared understanding around communications about health protection concerns. The PHE Centre will keep the DPH informed about health protection issues and of the action being taken to resolve them.

PHE will provide to Local authorities, via their DsPH, the information, evidence and examples of best practice to support the Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWS). There needs to be a clear programme of engagement at national and local level to determine what form this information can most helpfully be provided in.

PHE will support transparency and accountability across the public health system including the provision of information and discussions with local authorities in relation to achievement of public health outcomes.

PHE will also highlight issues of concern to local authorities, for example if there is no system for Environmental Health Officer support to respond to outbreaks of infection.

Workforce and training

PHE will work with DsPH and, where appropriate, other council officers, in providing development, education and other support to the activities of HWBs on issues of relevance to the health of the local population.

PHE will support local authorities to develop a trained and knowledgeable public health workforce, including in the area of health protection.

Further guidance is to be provided separately on a number of other issues including out of hours and Science and Technical Advice Cells (STAC) arrangements.

References

[1] S.I. 2013/351; available at http://www.legislation.gov.uk/uksi/2013/351/contents/made

[2] The Health and Social Care Act 2012 is available at: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

[3] These Regulations are made under section 6C of the National Health Service Act 2006 ("NHS Act 2006") (as inserted by section 18 of the Health and Social Care Act 2012)

[4] Available at: http://www.legislation.gov.uk/ukpga/2004/36/contents

[5] "Emergency" is defined by the Civil Contingencies Act 2004, section 1 to mean: (a) an event or situation which threatens serious damage to human welfare in a place in the UK, (b) an event or situation which threatens serious damage to the environment of a place in the UK, or (c) war, or terrorism, which threatens serious damage to the security of the UK. Civil Contingencies Act 2004. Available at: http://www.legislation.gov.uk/ukpga/2004/36/section/1

[6] Arrangements for emergency preparedness, resilience and response in the new system from April 2013 are available at: http://www.dh.gov.uk/health/2012/04/eprr

[7] See The Health Protection Agency Act 2004. Available at: http://www.legislation.gov.uk/ukpga/2004/17/contents

[8] Factsheets on the role of public health in local government and the Public Health England operating model are available at: http://healthandcare.dh.gov.uk/public-health-system

[9] The Public Health (Control of Disease) Act 1984 is available at: http://www.legislation.gov.uk/ukpga/1984/22

[10] See Health protection legislation guidance 2010 at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114510

[11] The Health and Safety at Work etc Act 1974 is available at: http://www.legislation.gov.uk/ukpga/1974/37

[12] The Food Safety Act 1990 is available at: http://www.legislation.gov.uk/ukpga/1990/16

[13] Joint Strategic Needs Assessment statutory guidance can be found at: http://healthandcare.dh.gov.uk/jsnas-jhwss-guidance-published/

[14] Regulations 8, S.I. 2013/351; available at http://www.legislation.gov.uk/uksi/2013/351/contents/made

[15] Regulations 8, S.I. 2013/351; available at http://www.legislation.gov.uk/uksi/2013/351/contents/made

[16] NHS Standard Contract 2012/2013 can be found at: https://www.gov.uk/government/publications/leave-for-will-pls-nhs-standard-contracts-for-2012-13

[17] The NHS Act 2006, section 72. Available at: http://www.legislation.gov.uk/ukpga/2006/41/section/72

[18] For NHS Commissioning Board: Health and Social Care Act 2012, part 1, section 23, inserting section 13J into the NHS Act 2006; for CCGs: HSC 2013, part 1, section 26, inserting section 14W into the NHS Act 2006. Available at: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

[19] S.I. 2013/351; available at http://www.legislation.gov.uk/uksi/2013/351/contents/made

[20] *Improving outcomes and supporting transparency: a public health outcomes framework for England 2013-1016.* Available at: www.dh.gov.uk/health/2012/01/public-health-outcomes

[21] Building on the principle of the "all hazards" approach as outlined in health protection legislation and accompanying guidance. Available at:http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_114589.pdf

[22] All kinds of contamination, including chemical or radiation, as per section 45A of the Public Health (Control of Disease) Act 1984 as amended by the Health and Social Care Act 2008

[23] This is very similar to the principles set out in Health Services Guidance (93)56 on public health responsibilities of the NHS and the roles of others, which highlights the leadership role of the director of public health in a health authority and notes that he or she should "ensure that appropriate arrangements are in place for the control of communicable disease and of non-communicable environmental hazards and that the responsibilities of those involved are clearly defined in each case."

[24] See new section 73A(1)(d) of the NHS Act 2006, as inserted by section 30 of the Health and Social Care Act 2012

[25] Section 252A has been inserted by section 46 of the Health and Social Care Act 2012

[26] "Local authority" holds the definition as under section 2B of the National Health Service Act 2006 (as inserted by section 12 of the Health and Social Care Act 2012) means a county council in England; a district council in England, other than a council for a district in a county for which there is a county council; a London borough council; the Council of the Isles of Scilly; the Common Council of the City of London.

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DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		CHAIR'S REPORT		
DATE OF DECISION:		27TH NOVEMBER 2013		
REPORT OF:		CHAIR, HEALTH AND WELLBEING BOARD		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Councillor Dave Shields**	**Tel:**	**023 8083 4960**
	E-mail:	**councillor.d.shields@southampton.gov.uk**		
STATEMENT OF CONFIDENTIALITY				
None.				

BRIEF SUMMARY

To note the actions taken by the chair of the Health & Wellbeing Board since the October 2013 meeting and any items of important correspondence.

RECOMMENDATIONS:

(i) To note those actions taken by the chair of the Health & Wellbeing Board since the 23rd October 2013 meeting

(ii) To note any items of key correspondence received by the chair of the Health & Wellbeing Board since the 23rd October 2013 meeting

REASONS FOR REPORT RECOMMENDATIONS

1. This report provides a brief snapshot of the activity undertaken by the chair of the Health & Wellbeing Board in between formal meetings

2. This report also details any important correspondence entered into by the chair of the Health & Wellbeing Board in between formal meetings

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. None

DETAIL (Including consultation carried out)

4. Since the October meeting of the Health & Wellbeing Board the chair has been involved in the following activities:

- Work with the LGA's Director for the Health & Wellbeing Board System Improvement Programme (Caroline Tapster) in the organisation and facilitation of and participation in an informal board meeting (6th November) looking at developmental issues for members in light of some of the forthcoming challenges – especially in respect of the Integrated Transformation Fund.
- Attendance at the LGA Leadership Academy for adult social care and health (13-14th November) involving twenty other local authority chairs/ members of Health & Wellbeing Boards from across the country (including those representing Poole and the Isle of Wight).

4. Since the October meeting of the Health & Wellbeing Board the chair has received the following items of correspondence:

An invitation from Business South on 24th October to sponsor a regional conference in the new year aimed at local businesses and key providers of health and social care services from public, independent and voluntary sectors (see summary in the appendix)

RESOURCE IMPLICATIONS

Capital/Revenue

5. None

Property/Other

6. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

7. None

Other Legal Implications:

8. None

POLICY FRAMEWORK IMPLICATIONS

9. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	ALL

SUPPORTING DOCUMENTATION

Appendices

1.	Outline Proposal from Business South for a Regional Conference on Health - Summary

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper(s) Relevant Paragraph of the Access to

		Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None.	

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APPENDIX 1

OUTLINE PROPOSAL FROM BUSINESS SOUTH FOR A REGIONAL CONFERENCE ON HEALTH – SUMMARY

Health is a major issue for everyone in the south. Following discussions with major health providers from the public, private and voluntary sectors across its region (i.e. Dorset, Poole, Bournemouth, Hampshire, Isle of Wight, Southampton and Portsmouth), *Business South* has identified a communication gap that it would like to help to bridge.

Business South sees a need to provide a forum where providers from all sectors can meet, exchange ideas and progress projects together with the aim of developing and strengthening the health voice in the region and playing a full and active part in the Government's integration agenda.

To that end, *Business South* proposes a major Health Conference in the spring of 2014 and, with the support of Chief Executives from University Hospital Southampton NHS Foundation Trust, Solent NHS Trust and Southern Health NHS Foundation Trust, it has invited the Secretary of State for Health to address the conference along with some other key national and regional speakers.

The aim is to give the audience of business leaders a better understanding of the health of the region, the issues people are facing, the excellence that exists here and a better idea of what more can be achieved by working closer together.

Anticipated outcomes from the conference include businesses signing up to a **Get Healthy Together** initiative and the launch of a **Health Action Group** made up of private, public and voluntary sector health providers alongside key businesses.

It is felt that the event would benefit considerably from the involvement of Health & Wellbeing Boards in the Wessex area along with senior Council representatives with their various responsibilities for economic development, public health, adult social care and community leadership.

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