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Health and Wellbeing Board

Wednesday, 26th March, 2014 at 6.00 pm

Council Chamber - Civic Centre

This meeting is open to the public

Members

Councillor Shields (Chair)
Councillor Jeffery
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

Contacts
Sharon Pearson
Democratic Support Officer
Tel: 023 8083 4597
Email: sharon.pearson@southampton.gov.uk

BACKGROUND AND RELEVANT INFORMATION

Purpose of the Board
The purpose of the Southampton Health and Wellbeing Board is:

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

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 INTERESTS

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

DISCLOSABLE PECUNIARY INTERESTS

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

(i) Any employment, office, trade, profession or vocation carried on for profit or gain.

(ii) Sponsorship:

Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.

(iv) Any beneficial interest in land which is within the area of Southampton.

(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.

(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.

(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

a) the total nominal value 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 an, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

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

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

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

Principles of Decision Making

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

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

In exercising discretion, the decision maker must:

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

AGENDA

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 29th January 2014 and to deal with any matters arising, attached.

STRATEGIC DEVELOPMENTS

5 LSCB ANNUAL REPORT

Report of the Independent Chair, Local Safeguarding Children's Board (LSCB), attaching the 2012-13 Annual Report, setting out the activities delivered by and performance of Southampton Local Safeguarding Children Board, attached.

6 PUBLIC HEALTH ANNUAL REPORT

Report of the Director of Public Health, attaching the Public Health Annual Report for the Health and Wellbeing Board to consider and note future implications to the Board, attached.

7 NHS SOUTHAMPTON CITY CLINICAL COMMISSIONING STRATEGY 2014-2019 "A HEALTHY AND SUSTAINABLE FUTURE"

Report of the Chief Executive, Southampton City CCG, requesting that the Board support the strategic direction outlined and to comment on the priorities and outcomes identified, attached.

BOARD APPROVALS

8 SOUTHAMPTON'S RESPONSE TO GOVERNMENT PLEDGE FOR BETTER CHILDREN AND YOUNG PEOPLE'S OUTCOMES

Report of the Director of Public Health, recommending that the Health and Wellbeing Board signs up to the National Pledge for better health outcomes for Children and Young People, attached.

9 TACKLING TEENAGE PREGNANCY

Report of the Director of Public health requesting that the Health and Wellbeing Board supports the development of a new sexual health plan for Southampton, incorporating teenage pregnancy as a priority, attached.

10 TOBACCO CONTROL PLAN

Report of the Director of Public Health, for the Board to agree the Tobacco Control Plan and a working group to deliver the actions outlined in the plan, attached.

BOARD UPDATES

11 BETTER CARE SOUTHAMPTON UPDATE

Report of the Director of Quality and Integration, providing an update on the progress towards implementation of Better Care in Southampton, attached.

Tuesday, 18 March 2014 HEAD OF LEGAL AND DEMOCRATIC SERVICES

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 29 JANUARY 2014

Present: Councillors Shields (Chair), Baillie and Lewzey, Andrew Mortimore, Dr Steve Townsend and Rob Kurn

In attendance: Mr S Hayes – Police and Crime Commissioner for Hampshire
Ms R Cassy – Southampton Keep our NHS Public (SKONP)
Councillor M Stevens – Chair – OSMC
Councillor Parnell – OSMC Member

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

The Board noted the apologies of Dr Ward, Councillors Jeffery and McEwing and Alison Elliott and that Stephanie Ramsey was in attendance and representing Alison Elliott for the purpose of this meeting.

The Board also noted that Councillor Jeffery had replaced Councillor Bogle as a Board Member in accordance with Procedure Rule 4.3.

32. **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 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.

33. **STATEMENT FROM THE CHAIR**

LSCB 2012/13 Annual Report – to be distributed electronically to all Board members for their perusal prior to the 26th March Board Meeting.

Draft – First Issue of Health and Wellbeing Board Newsletter – to be distributed electronically to all Board Members for their comments on the suggested text and design.

Healthwatch – Rob Kurn provided a brief update on new members of the strategy group.

Keep our NHS Public were concerned about the privatisation of the NHS and wished to be kept up to date on any contracts. This update would be provided to the Health Overview and Scrutiny Panel who would inform the Health and Wellbeing Board of the outcome.

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

RESOLVED that the Minutes of the Meeting held on 27th November 2013 be approved and signed as a correct record.

35. **BETTER CARE FUND - SOUTHAMPTON SUBMISSION**

The Board considered the report of the Director of People, Southampton City Council and Chief Executive, Southampton City Clinical Commissioning Group, providing details of the Better Care Fund proposals for Southampton for sign off and approval by the Cabinet and the CCG Governing Body.

The Board also received a presentation from the Director of Quality and Integration, providing further information on the delivery of "Better Care" in Southampton.

The Board particularly noted the following points:-

- the Better Care Fund had previously been known as the Integration Transformation Fund;
- that the first cut of the Better Care Plan template had to be submitted by 14th February and the final revised submission, as an integral part of the CCG's Strategic and Operational Plan by 4th April 2014;
- that 25% of the pooled fund was performance related with 50% to be paid on 1 April 2015 based on national conditions and 2014/15 performance against targets and 50% paid on 1 October 2015 based on national conditions and 2014/15 performance against targets; if targets were not achieved, monies would not be withheld but a recovery plan would be required which would be strictly monitored;
- the local target was to reduce injuries due to falls in people aged 65 and over as it was felt that this data was quantifiable and would impact on other targets;
- Southampton's case for change was an increasing older population, more people living with two or more long term conditions, loneliness, changing expectations, legislation and reduced resources with our aims being personalisation of care, prevention and early intervention, broadening community capacity and helping people retain and regain their independence;
- this was a 2 year plan with a 5 year strategy and involved integrated locality teams made up of professionals;
- implementation of the plan would be defining the plan during the 2014 2015 shadow year, establishment of a pooled fund and single point of access for integrated care during 2015-2016 and 2016 onwards rolling out to other client groups, establishing management structures and continue to embed and develop the model;

Mr S Hayes, Police and Crime Commissioner for Hampshire was present and with the consent of the Chair addressed the meeting. The Board noted his comments and request that the Health and Wellbeing Board engage with the Police in the implementation of the plan as the new model of the policing plan involved more emphasis on neighbourhood policing to prevent crime and offending and protection of vulnerable people and they had commissioning funding to meet these requirements.

RESOLVED:

(i) that the Better Care Fund proposals for Southampton be signed off for approval by the Cabinet and the CCG governing body;
(ii) that Cabinet and the CCG governing body approve the arrangements for the bid under Section 75 of the NHS Act 2006; and
(iii) that authority be delegated to the Director of People and the CCG Chief Executive, in consultation with the Chair and Vice-Chair of the Health and Wellbeing Board, to make any drafting or other changes required prior to final submission of the Southampton Better Care Fund application.

36. **INTEGRATED PERSON-CENTRED CARE PROGRAMME - "MAKING IT REAL"**

The Board considered the report of the Director of Quality and Integration Integrated Commissioning Southampton City CCG/Southampton City Council providing details and requesting commitment to the Making it Real initiative.

The Board noted that Making it Real was an initiative from Think Local Act Personal (TLAP), a national, cross sector leadership partnership focused on driving forward work with personalisation, community-based social and more recently healthcare.

RESOLVED:

(i) that the Health and Wellbeing Board declared their commitment to the Making it Real initiative; and
(ii) that stakeholder mapping be undertaken against the Progress Markers for both Making it Real and NHS England at the same time for the roll out of personal health budgets.

37. **LEARNING DISABILITIES 2013/14 JOINT HEALTH AND SOCIAL CARE SELF ASSESSMENT FRAMEWORK**

The Board received the report of the Director of Quality and Integration , Southampton City CCG/Head of Integrated Strategic Commissioning Southampton City Council, providing information on the introduction of the Learning Disability Joint Health and Social Care Self Assessment Framework (JHSCSAF) and to note that a further progress report would be brought back to the Board.

The Board also received a presentation from the Director of Quality and Integration, providing further information on the Learning Disability Joint Health and Social Care Self Assessment Framework.

The Board noted the following points:-

- that this was the first time that the assessment had been completed in a joined up manner and that the framework would ensure a targeted approach to improving health inequalities and achieving equal and fulfilling citizenship helping commissioners and local people assess how well people with a learning disability were supported ;

- that people with learning disabilities were 58 times more likely to die before the age of 50 than the general population as they were at greater risk to social determinants of poorer health, health problems associated with specific genetic and biological causes, communication difficulties, personal health risks and behaviours and deficiencies relating to access to healthcare provision;
- the Staying Healthy, Being Safe and Living Well Priorities detailed in the action plan were monitored on an ongoing basis; and
- LD health group and the Vulnerable People and Learning Disability Partnership Boards would provide oversight on the progress made.

RESOLVED:

(i) that the progress achieved to date on a number of key targets be welcomed and to note that there were still areas that required improvement; and

(ii) that a further report on progress of the actions set out in the self assessment be brought back to the Health and Wellbeing Board in 12 months.

38. **JOINT COMMISSIONING POLICY STATEMENT FOR WORKING WITH CHILDREN AND ADULTS WITH LEARNING DISABILITIES WHOSE CARERS/SERVICES ARE CHALLENGED BY THEIR BEHAVIOUR**

The Board considered the report of the Director of Quality and Integration Commissioning Southampton City CCG/Southampton City Council, requesting support for consultation on the draft policy statement and the implementation of the initial plan.

The Board noted the following issues:-

- young people with learning difficulties up to the age of 16 years were well provided for but when they reached 18 years this support appeared to fall away;
- the implementation of the Children and Young People Development Service (0-25 years) would ensure that individuals and families had access to specialist knowledge and skills to assess and manage challenging behaviour;
- there was not always a consistent point of contact for people with learning disabilities in care plans and this needed to be focussed on;
- many people with learning disabilities resided in residential accommodation and moved around which created problems with the point of contact and this needed to be worked into the system with people being supported into appropriate accommodation; and
- safeguarding systems were reactive and should be more proactive.

RESOLVED:

(i) that the Southampton Health and Wellbeing Board supported consultation on the draft policy statement; and

(ii) that the Southampton Health and Wellbeing Board supported implementation of the initial action plan, recognising that this might change following consultation and to note that the submission to Improving Health and Lives would be reflected in the Autism Self Assessment Framework and key areas of progress made.

39. **SOUTHAMPTON HEADSTART PROGRAMME**

The Board considered the report of the Director of Public Health, providing an overview and requesting support of an application by Southampton City Council in respect of a National Big Lottery Fund programme called HeadStart.

The following was noted:-

- that Southampton was one of 12 areas selected by the Big Lottery Fund to manage a local HeadStart programme, which aimed to help young people between the ages of 10 and 14 years within an identified area, particularly those most at risk of poor mental health outcomes with a view to increasing their long term resilience in relation to mental and emotional health;
- that Cabinet approval would be required to submit an application for the Year one programme in advance of the 17 April 2014 deadline;
- that if the Year one application was successful, Southampton would be invited to submit a further application for consideration for a further five years funding, in an expanded programme worth up to £10m total investment from Big Lottery;
- mental health required more attention and it was important that there was earlier intervention and support for young people with problems; and
- it was important that the programme was sustainable.

RESOLVED

(i) that the Health and Wellbeing Board welcomed the HeadStart Programme and requested that officers ensure that the programme was sustainable; and

(ii) that Cabinet approval to submit an application for the Year one programme was required prior to the 17 April deadline.

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DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		LOCAL SAFEGUARDING CHILDREN BOARD ANNUAL REPORT		
DATE OF DECISION:		26 MARCH 2014		
REPORT OF:		KEITH MAKIN INDEPENDENT CHAIR OF LSCB		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Sarah Lawrence**	**Tel:**	**023 8083 2468**
	E-mail:	**Sarah.lawrence@southampton.gov.uk**		
Director	**Name:**	**Alison Elliott**	**Tel:**	**023 80**
	E-mail:	**Alison.elliott@southampton.gov.uk**		
STATEMENT OF CONFIDENTIALITY				
NOT APPLICABLE				

BRIEF SUMMARY

1.1 The attached Annual Report sets out the activities delivered by and performance of Southampton Local Safeguarding Children Board (LSCB) during 2012-13.

1.2 Statutory guidance "Working Together to Safeguard Children" (Dfe, 2013) states that the Chair of the LSCB must publish an annual report and that this report be submitted to the Chair of the Health and Wellbeing Board. This report is submitted according to this guidance, and to seek the views of the Board on future links between HWBB and LSCB.

1.3 Section 13 of the Children Act 2004 requires each Local Authority to establish an LSCB for their area and specifies the organisations and individuals that should be represented. The LSCB has a range of roles and functions including developing local safeguarding policy and procedures and scrutinising local arrangements. Working Together and the Children Act set out the objectives and functions of LSCB's as to:

- Coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
- Ensure the effectiveness of what is done by each such person or body for those purposes.

1.4 This annual report is for 2012-13, the report for the current year will be produced and published in a timely manner to be submitted to relevant bodies earlier in the forthcoming financial year.

RECOMMENDATIONS:

(i) That the report is received by the Health and Wellbeing Board, with

priorities noted for the LSCB Business Plan 2013-14.

(ii) That future links and joint working between HWBB and LSCB are considered and agreed.

REASONS FOR REPORT RECOMMENDATIONS

1. Statutory guidance "Working Together to Safeguard Children" (Dfe, 2013) states that the Chair of the LSCB must publish an annual report and that this report be submitted to the Chair of the Health and Wellbeing Board

2. Children and young people in the city can only be safeguarded if the key agencies work together, this applies to the strategic boards operating in the city. The presentation of this report is a key step in ensuring that the HWWBB and LSCB not only meet statutory requirements, but that we work together to establish a collective approach to achieve joint outcomes for our children.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

Not Applicable

DETAIL (Including consultation carried out)

See attached report.

RESOURCE IMPLICATIONS

Capital/Revenue

Not Applicable

Property/Other

Not Applicable

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

Not Applicable

Other Legal Implications:

Not Applicable

POLICY FRAMEWORK IMPLICATIONS

Not Applicable

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Appendices

1.	Local Safeguarding Children Board Annual Report 2012-13
2.	LSCB Flyer

Documents In Members' Rooms

1.	N/A

Equality Impact Assessment

Do the implications/subject of the report require an 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(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
	N/A	

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Southampton
Local Safeguarding Children Board

Annual Report 2012-13

Contents

Chair's foreword

As the chair of the Local Safeguarding Children Board for Southampton, I am pleased to present this annual report covering the period from April 2012 to March 2013. I came into post during the autumn 2013 and so while I was not in the chairing role during the time period covered by this report I have reviewed the information contained within and am reflecting on this from that position.

The Board is established in law with the purpose of satisfying itself as to the effectiveness of member agencies in keeping Southampton's children as safe as possible. It is expected to challenge the work of members and providers of services to assess performance and highlight areas of strengths and weaknesses. It is also expected to coordinate work in Southampton to safeguard and promote the welfare of children and young people in Southampton.

To enable the Board to meet these objectives it has an annual business plan. The priorities from the 2012-13 business plan are listed in the appendix and an appraisal and commentary of achievements against these is given in this report.

The Board's statutory duties and functions are detailed in Working Together[1]. The guidance identifies that there needs to be systematic and regular scrutiny of local provision, and resulting action following challenge of where change is needed. A review of the work during the year 2012-13 shows some evidence of this challenge and influence. For example the way in which the Board influenced Local Authority budget setting. During this year the Board held an extraordinary meeting to consider the impact of the proposals on children and young people and their families. This meeting challenged proposals and proposed changes to the budget. The work resulted in amendments being adopted to the Council budget plans.

I feel there is still much to do to ensure that the Board is robustly and systematically delivering its unique role to scrutinise local services to ensure they are safeguarding children and young people, and this is reflected in our Business Plan for 2013/14. Adoption of the South East Quality Assurance Framework in Southampton will aid the Board in doing this and will help us to become in effect, a local inspection unit for the City in regards to safeguarding children and young people.

The Board continues to face challenges in how we ensure that the voices of children, young people and their families are meaningfully reflected in our work. This needs to be a key focus of our activities and this is recognised in the LSCB business plan for 2013/14 and will be one of my key priorities to action. I plan to lead a real focus on engaging with Southampton's diverse communities and families on safeguarding issues building on some good practice demonstrated during this year.

When a child dies or is seriously injured and the case meets the criteria for 'serious case review' as defined in Working Together, the Board has a statutory duty to deliver and publish a report which clearly states lessons to be learned for services to prevent similar tragedies occurring. In 2012-13 the Board received the report of the case of Child F, a child harmed by ingestion of methadone and also Child G, who tragically died. Both reports contained significant learning. During 2012-13 the Board received updates on progress of actions coming from Child F; the board also delivered learning workshops to professionals from local agencies. The findings from the review of Child F influenced some significant changes in practice locally during 2012-13 particularly in relation to safeguarding children and young people through adult focussed services such as substance misuse. As a Board we will work on our processes to ensure they are systematic and robust to enable lessons to be learned and changes implemented as part of our learning and improvement framework.

The Board is in a unique position to coordinate safeguarding activities. During 2012-13 the Board showed promise of strategic development, including the focus on Early Intervention reflected in our Business Plan and current work, particularly looking at how we coordinate and evaluate multi agency safeguarding training and have oversight of developments in the city that will have an impact on safeguarding issues such as the Multi Agency Safeguarding Hub (MASH).

I am pleased to report that Board membership is wide ranging which is positive and highlights the dedication locally to ensuring partnership working to safeguard our children and young people. It is a challenge to chair large meetings as size inhibits discussion and scrutiny which is one of our key functions. Throughout the work in 2013-14 I will work towards finding a way of ensuring the structure of the Board and its governance allows for the Board to deliver its core role.

I welcome this opportunity to lead the Board at this challenging and changing time and the work to ensure the safeguarding and welfare of our children and young people, and look forward to reporting progress and analysis of this in the annual report for this current year.

Keith Makin

[1] The 2013 version of this guidance came into effect outside the timeframe of this report.

1 Introduction

1.1 This report sets out the activities delivered by and performance of Southampton Local Safeguarding Children Board (LSCB) during 2012-13. This information provides a baseline and a focus for the business plan and activities for 2013-14. The information contained within has been gathered from a review of minutes of board and sub committee meetings along with the knowledge of board and sub committee members.

1.2 Section 13 of the Children Act 2004 requires each Local Authority to establish an LSCB for their area, and specifies the organisations and individuals that should be represented. The LSCB has a range of roles and functions including developing local safeguarding policy and procedures and scrutinising local arrangements. Working Together and the Children Act set out the objectives and functions of LSCB's as to:

- coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
- ensure the effectiveness of what is done by each such person or body for those purposes.

2 Governance and Accountability

2.1 The LSCB has a constitution which sets out the membership, objectives and functions of the board in accordance with the Childrens Act 2004.

2.2 The LSCB employed Donald McPhail as its Independent Chair during 2012-13, responsible for:

- Chairing the Board's bi-monthly meetings
- Chairing of the Executive Group
- Providing direction on emerging issues from serious case reviews
- Attending and challenging the Children and Young People's Trust Board
- Supporting sub committees chairs to progress the business plan
- Supporting Southampton City Council scrutiny function in relation to safeguarding
- Chairing the Serious Case Review sub committee

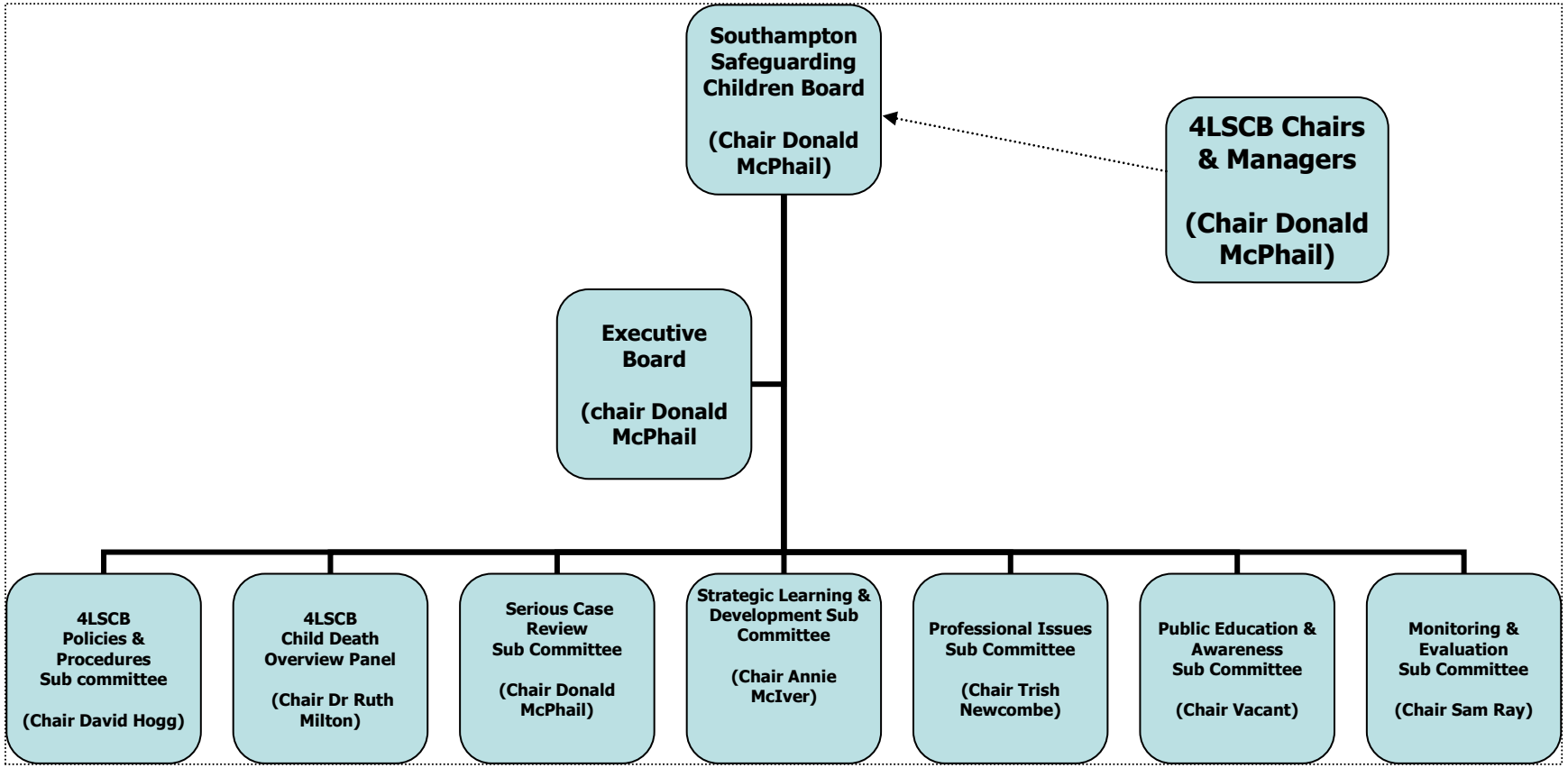
2.3 Business function

The LSCB has a business office function that includes the roles of full time Board Manager and Business Co-ordinator. The business office experienced a period of change during this year as the permanent post of Board Manager was temporarily filled from April to August 2012, with a permanent Board Manager in post from August 2012 - March 2013, this Board manager then left the post at the end of March 2013[2]. The Business Co-ordinator post was occupied during 2012-13[3] providing some continuity. Southampton City Council Democratic Services provides clerical support to the LSCB Main Board and Executive.

[2] A new Board Manager also came into post in June 2013.
[3] A new Business Coordinator came into post in September 2013.

2.4 Structure

The Board structure during 2012-13 was as follows:



Southampton LSCB linked also to the following local partnerships:

- Southampton Children and Young People's Trust Board
- Southampton Safeguarding Adults Board
- Southampton Safe City Partnership
- Southampton Health and Wellbeing Board

2.5 4LSCB's

Southampton LSCB participated during 2012-13 to the '4LSCB' arrangement whereby the Hampshire, Portsmouth, Southampton and the Isle of Wight boards join

to share policies and practice across the county. The mechanism for this to be delivered is the Chairs and Managers Group which was chaired during 2012-13 by Donald McPhail, Southampton LSCB Chair. The work of the 4LSCB's also links through its policy and procedure work to ensure consistency across the county, shared guidance for professionals as well as policies and procedures can be accessed via www.4lscb.org.uk. The 4LSCB's also pool resources to provide the Child Death Overview Panel function in one pan Hampshire service.

2.6 Frequency of Meetings

The Full Board met bi-monthly with membership reflecting statutory guidance contained within Working Together. See Appendix 1 for a full list. The Executive of the LSCB met bi-monthly between full board meetings to plan agenda's and support the main Board with business performance, highlighting areas for development. Membership of the Executive during 2012-13 is listed in Appendix 1.

The LSCB sub committees, as detailed in the structure chart above, met according to their terms of reference and at least quarterly throughout the year. Chairs of the committees reported to the LSCB main board via headline reports, they also met regularly as a group with the Independent Chair.

2.7 Financial Contributions

Contributions to the 2012/2013 budget were received as follows. This is in accordance with contributions previously agreed and documented within a Pooled Budget Agreement:

Source	**£**
Southampton Clinical Commissioning Group	31,426
Police	12,533
Hampshire Probation	2,504
CAFCASS	550
Southampton City Council	73,756
Area Based grant (for CDOP)	6,300
Total contributions	127,069
Balance brought forward from 11/12	38,359
Total	165,428

3 Progress and Achievements

3.5 Quality Assurance

In 2012-13 Southampton LSCB ensured scrutiny of local work to safeguard and promote the welfare of children in the following ways:

- Reports to Board in the format of; Standing Items, Reports to the board – as annual reports or those requested by the Independent Chair and board members.
- Extraordinary meetings
- The work of the sub committees – reported at each main Board meeting

The narrative below gives a description of activities undertaken by the LSCB to deliver its quality assurance role.

3.6 Reports to Board:

The Board requested updates and reviewed progress on the following standing items issues at each meeting:

- Leadership reports from: Social Care, Police, Schools, Health to include issues around budgets and retention of key staff.
- Issues and challenges to the Children and Young People's Trust.
- Child Death Overview Panel – Quarterly Report.
- MAPPA – Multi Agency Public Protection Arrangements.
  MARAC – Multi Agency Risk Assessment Conferences.
- CAFCASS – Children and Family Court Advisory and Support Services.
- Issues from Inspections.
- Issues from other agencies and partnerships including any capacity issues / organisational changes.

3.7 Reports requested and submitted to the LSCB during 2012-13 were as follows:

1. **Midwifery Audit of Safeguarding Processes and Information sharing with GP's**
   An audit of safeguarding processes and information sharing with GP's as a result of a Serious Case review in Southampton. Board members scrutinised the report and advised further recommendations which were followed up by the services involved.
2. **Grading Policy for Hampshire Constabulary**
   The board received and endorsed a report detailing revised grading policy for responses by police to child abuse cases. This policy was bought about from a Partnership Review of a case in Southampton.
3. **Children First Contact Audit**
   A report detailing key findings and recommendations from an audit of the contact service in Children's Social Care, this was commissioned by the LSCB to look into cases that did not reach the threshold criteria outlined in the published guidelines for referrals to social care. Findings highlighted concerns to the Board, and recommendations resulting from this audit were passed to the Children & Young People's trust for action.

4. **Domestic violence and abuse in Southampton**
   Details of a new initiative to coordinate responses to domestic abuse and improve outcomes for families experiencing abuse were presented to the Board. The Board endorsed the proposals and requested progress reports on this issue.
5. **Honour Based Violence and Forced Marriage**
   Details of work in Southampton to respond to these issues was presented, the Board suggested an annual report should be submitted.
6. **Southampton Joint Health and Wellbeing Strategy**
   Consultation draft received of this document, Board members challenged the content due to; lack of focus on safeguarding children and young people, caution about expectations of doing more for less in terms of resources, and a need for more emphasis on disabled children.
7. **Health CQC inspection**
   The Board received feedback and updates on progress regarding the actions identified by the CQC inspection, particularly regarding the availability of examination facilities for children and young people that had been victims of sexual assault. This action was completed and the board received feedback on this.
8. **Progress of OFSTED Action Plan**
   A plan as a result of the OFSTED inspection in 2012 (see p15 for more detail) was presented to the LSCB, with explanation of actions to be taken.
9. **Looked After Children living away from home**
   The Board received a report detailing the number of LAC who were placed away from Southampton, missing from placements and those in bed and breakfast accommodation. The Board requested 6 monthly updates from the Local Authority on this matter.
10. **Welfare Reforms**
    The Board received a report detailing the reforms implemented nationally and the impact predicted on children and families in the City.
11. **Escalation Policy and Notification of Incidents**
    The Board sought assurance that local agencies were aware of escalation policy and correct procedure around notifications of incidents to senior managers where safeguarding children and young people was an issue. This was as a result of a recent Serious Case Review.
12. **Child Sexual Exploitation**
    A report was considered giving detail of CSE and the LSCB's role in tackling this issue in Southampton. Links to national work were considered and the Board agreed to establish a group to drive this agenda on behalf of the Board.
13. **Young People and Prostitution**
    The Board requested a report following an issue raised by members, and received information from local services on the scale of the issue in the City.
14. **Multi Agency Supervision**
    The Board heard from local services regarding multi agency supervision and a workshop to develop this area. The Board recommended this was implemented as soon as possible.
15. **Independent Schools**
    The Board sought clarification of allegations and investigations into abuse incidents within an independent school in the County which had children from Southampton attending. The Board then sought assurance of the standards for safeguarding that were in place from commissioners of independent schools including academies and free schools as well as independent providers of other services.
16. **Local Authority Designated Officer (LADO)**
    The annual report of the Local Authority Designated Officer for 2010/11 and 2011/12 was received by the board. It was noted that a plateau appeared to have been reached in terms of the volume of referrals. There had been some positive developments, specifically with regard to physical intervention in

schools and risk by association assessments. It was noted that the role of the LADO was being reviewed within the Local Authority specifically to involve Human Resources. Reference was made to an alleged incident at an Independent School outside the Local Authority area. The Board noted it was important any learning from the review of this should be shared with the independent schools in the city.

17. **Fostering Services**

The Board received a report detailing safeguarding in Foster Care Services. It was noted that in December 2011 the Fostering Service was inspected by Oftsed and received an Overall quality rating of 'Outstanding' and the section entitled "Protecting children from harm or neglect and helping them stay safe" was judged as Outstanding. The Board noted the Safeguarding allegations that had been made in the last year in relation to Local Authority Foster Carers. There had been 8 allegations in total, 4 at level 1, 1 at level 2 and 3 at level 3. The Board noted that examples of a level 2 allegation was over chastisement and level 3 was child protection issues such as physical abuse/injury. The following outcomes were noted:-

- All of the level 1 were No Further Action
- The Level 2 allegation was unfounded. Further matching work took place with the carer regarding the placement of children in the 0-3 age range.
- Of the 3 level 3 allegations, the first was no further action, training and support was offered to the carer. The second was substantiated and at panel agreement was made to change their approval (boys only), and for the carers to attend a range of training prior to another child being placed. The third level 3 was currently ongoing. This allegation was historical but due to the young woman disclosing further details the police had chosen to reinvestigate. The service was currently awaiting the outcome of the investigation.

3.8 Extraordinary Meetings & Workshops

Local Authority Budget Proposals

Proposals for the Local Authority Budget in future years were bought to the board in a detailed presentation focusing on the impact these may have on safeguarding and promoting the welfare of children and young people. An extraordinary meeting was held to receive feedback from Board members on the proposals, and Board members scrutinised the impact of the proposals within their own agencies feeding into this meeting. As a result the Board Chair challenged the proposals with the Local Authority.

Early Intervention Workshop

A workshop to look at the role of the Board in delivering and evaluating Early Intervention work took place and actions to follow up were agreed.

3.9 The work of Sub Committees

Serious Case Review Sub Committee

- Case reviews delivered and action plans that were monitored by the group over this period included:
- Serious Case Review of Child F (published October 2012)
- Serious Case Review of Child G (completed November 2012)
- Partnership Reviews for 3 cases.

Actions that were monitored and subsequently signed off as a result of SCRs include:

- A clear pathway for domestic violence referrals produced – through Pippa (local alliance of domestic and sexual violence services) and IRIS (GP focussed domestic abuse work) and enhanced training.
- Drug Action Team conducted a case note audit which was partly focused on safeguarding as a result of the SCR recommendation.

- Police offer guidance on checks that need to be taken, when analysing the risk of repeated abuse in a household.
- All officers and staff in the Police Public Protection Central Referral Unit and Public Protection Unit Investigation Teams, provided with the latest single and multi-agency guidance on identifying and responding to allegations of complex child abuse.
- The Child Abuse Investigation Grading Policy was amended to explicitly include complex child abuse investigations as Grade A referrals for allocation to Child Abuse Investigation Teams.
- Development of forms and assessment tools to identify safeguarding concerns across the health disciplines to ensure professionals are:

  - clear regarding their purpose and threshold criteria,
  - capturing relevant information, including that of the father/significant male, and
  - clear whether the completion of forms or assessment tools are mandatory or discretionary.

- Report to the Board on the capacity within teams who have been 'Achieving Best Evidence' (ABE) trained in both children services and police
- Ensure current training includes appropriate response when there is an allegation made.

Professional Issues Sub Committee

Policies reviewed and scrutinised by the group:

- Southampton University Hospital Trust Safeguarding Policy and Restraint Policy.
- Southampton Football Club Safeguarding Policy.
- Hampshire Probation Trust Safeguarding Policy.
- Jigsaw (Multi Agency Team – disabled children) Safeguarding policy.
- Society of St James (Homeless charity) Safeguarding Policy.
- Medaille Trust (Human Trafficking victims support charity) Safeguarding Policy.
- Crime Reduction Initiative (health and social care charity) Safeguarding Policy.
- Rape Crisis safeguarding policy.
- Parent Support Link safeguarding policy.
- Started to review Adult Services' policies (continued post April 13).

The group delivered the following actions in response to Child F Serious Case Review:

- Multi agency policy on supervision orders created and agreed.
- Addition made to policy framework to include neglect as a specific issue.
- Domestic violence pathway guidance reviewed.
- Briefing paper produced for Adults and Children's Services on the respective roles and responsibilities of MARAC and Child Protection Conferences.

- Substance Misuse services commissioner requested to report to the board on the extent to which safeguarding standards are being complied with and an action plan.

Monitoring and Evaluation Sub Committee

The group experienced a change of chairing arrangements mid- year. The framework for reporting data and service updates was revised and the group were presented with detail of:

- Safeguarding data – the group reviewed progress against a previously agreed data, highlighting trends and concerns which were escalated to the main board. The group also suggested a revised data set to be developed and agreed.
- Ethnicity data – a review of the previous year's data with highlighted issues taken forward to the main board.
- Children Missing Education – following this report issues around recording and high numbers were reported to the board, and it was agreed that regular reports would be made to this group.
- Children Looked After (CLA) education measures.
- Children's Social Care single agency report - highlighting progress and barriers against an improvement plan following the Ofsted inspection
- Youth Offending Service single agency report.
- LADO report (also reported to the main board).

Audits were undertaken relating to:

MARAC (Multi Agency Risk Assessment Conferences for Domestic Violence), key findings:

- Requirement to be more precise in identifying risks and attaching an action to those risks – this action was fed back to the MARAC Chairs
- LSCB to monitor outcomes and effectiveness of MARACs – action to undertake a small audit tracking the information flow and outcomes of a sample of cases.

MAPPA (Multi Agency Public Protection Arrangements), key findings:

- Good multiagency working.
- Concerns about attendance – particularly with regard to Children's Services and GPs. Actions were proposed.

Attendance at Child Protection Conferences, key findings:

- Issues with GP attendance.
- Housing always send written reports if not in attendance.
- Core group date is not always set.

Issues raised by this group to the main Board included:

- The group reviewed multi agency data which showed that abuse and neglect referrals had risen significantly.

- Impact of the recruitment and retention issues within Children's Social Care such as number of vacancies, agency staff and newly qualified social workers on the performance data and progress of an improvement plan.
- Ethnicity data highlights that all BME (Black and Minority Ethnic) groups are underrepresented in Children Looked After and Children in Need populations. Asian children were particularly under represented (comprising 4% of Children in Need, compared with 11% of children in schools).
- The group looked at the children missing education data. A joint protocol with Health was suggested to agree a position and course of action regarding the high numbers of children missing education that were recorded. Further action was agreed to ensure that track the children.

Public Education and Awareness sub committee

- Developed and published a quarterly newsletter for the LSCB.
- Revised and published the Southampton Neglect Tool.
- Promoted a Barnardos Child Sexual Exploitation information leaflet.
- Linked to Muslim Council of Southampton.
- The LSCB Website was created ensuring publicly available links to procedures and to national campaigns and local services.
- Website included a section particularly targeting parents from EU accession states / new communities in the city.
- Review of a local school pupil survey that was reported to the group.

Strategic Learning & Development Group

- The following child safeguarding training was reviewed by the group against a set of agreed good practice criteria:
- Adult Services training in parenting capability.
- Hidden Harm (Alcohol, substance misuse, mental health & domestic violence).
- Core Groups training.
- Honour Based Violence training.
- Housing Safeguarding Children training.
- The group also sought assurance and reviewed current multi-agency training arrangements, the key findings of this were:
- Voluntary sector take up of training courses was low and the group agreed to monitor this.
- NHS staff rarely attend current multi agency training as they have their own provided in house which it was felt misses the multiagency benefits.
- 1600 attendees at multi agency training over the last financial year, with the largest sector represented being Early Years/Childcare providers.

Child Death Overview Panel (CDOP)

The Child Death Overview Panel function for Southampton is delivered by a pan Hampshire service. The Annual Report for CDOP is published on the following link: CDOP Website

3.10 Business Plan

The LSCB worked to an agreed Business Plan for 2012-13. This plan was developed based on "the Joint Strategic Needs Assessment, local priorities and delivery of local performance indicators to improve safeguarding outcomes for children and young people" (taken from the Business Plan). The priorities within this plan are listed below, along with a summary of action taken by the LSCB and its partners during 2012-13 to deliver these:

Developing policies and procedures in line with Working Together to include implementation plans by each agency

Southampton LSCB works within a framework of 4LSCB's in Hampshire and the Isle of Wight to ensure policies and procedures are current and easily available to professionals working in the City and across the County. The Professional Issues Sub Committee (PISC) works with the 4LSCB Procedures Group to implement these and a summary of their work during this year is given above under a section entitled The Work of Sub Committees. Working Together was updated at the end of this financial year, and work to update procedures was carried over to the 2013/14. Southampton LSCB website was updated this year and contains clear links to the 4LSCB policies.

Establishing the programme of audits to include single agency and multi-agency audits

A calendar of audits was delivered during 2012-13 as detailed in the Monitoring and Evaluation Sub Committee feedback above. In addition the Board requested feedback from services about the impact budget changes had or were having on retention of staff. This was a regular item on the Board agenda and was fed back within headline reports to Board from statutory partners.

Implementing standards in safeguarding for commissioners and the community and voluntary sector

The Board contributed to a Local Authority Quality Assurance Steering Group during 2012-13 via the Board Manager. The Southampton (Health) Clinical Commissioning Group developed safeguarding commissioning standards for independent providers.

Voluntary sector colleagues worked with National DBS service to brief on changes to the system for voluntary sector organisations and although the CRB/ DBS umbrella service offered by the local Voluntary Sector umbrella organisation (Southampton Voluntary Service) has closed due to lack of funding, a partnership with private sector providers was negotiated and now offers a reduced processing route and ongoing guidance on safeguarding policies and procedures.

Listening to the voices of children and young people to better meet their safeguarding needs

The Board intended to capture the voices of children and young people in existing forums, and to monitor how voices of children and young people were recorded within the audit process, the LSCB audit pro forma included a section to ask about the 'impact on the child'. In addition a pupil survey for children attending schools in Southampton was planned by the Local Authority during 2012-13 to which the board had links.

Implementing the learning the themes from Serious Case Reviews and Child Death Reviews both national and local

Learning seminars were delivered highlighting the learning from national and local reviews. Over 100 professionals attended learning workshops following the publication of Child F. Board members were well briefed to disseminate learning from both Child F and G cases at main Board and sub committee meetings. Serious Case Review sub committee monitored and evaluated the progress of services in implementing the specific and multi agency lessons learned from Child F and Child G.

Working with adult services to improve outcomes for children and young people

The Board reviewed policies to safeguarding children where focus is on adults in the family in services such as substance misuse and domestic violence. Following the investigation into the Child F Serious Case Review, the Drug Action Team together with Senior Commissioners for SCC took the decision to bring commissioners and providers for the substance misuse services together in order to ensure that actions coming from this were carried out, and that further gaps that were identified in Safeguarding processes in these services were dealt with effectively. The Drug Action Team manager now sits on the LSCB to ensure effective links.

Southampton City Council Adult services delivered a refresher training programme for Adult Social Care staff, due to significant numbers of new staff in service and focussed on improving links between LSCB and the Safeguarding Adults Board. This included the senior manager for Safeguarding Adults attending the LSCB.

Southern Health Foundation Trust amended its safeguarding training to ensure integrated children's and adults safeguarding training to level 2 for all its divisions. The overall compliance of children's safeguarding training in adults divisions is rising and general feedback about its content is positive and encouraging.

Using local data to have a clear understanding about safeguarding needs in Southampton

The Board received and agreed a multi agency data set in quarter 4 of the year to be reported to the Board on a quarterly basis from that point forward. See Appendix 2 for the full list of data.

Maintaining the effective governance arrangements in the Board and Sub committees

Membership of the board was reviewed as required during 2012/13. Additional membership included Drug Action Team Manager and Safeguarding Adults Leads. In addition in Health membership of the LSCB transferred from the SHIP PCT cluster to the Executive Nurse of the CCG. The Designated Doctor and Nurse are advisers to the Board, and are members of the Serious Case Review, Monitoring and Evaluation, Learning and Development and Professional Issues sub committees. The Designated Nurse is also a member of the 4 LSCB pan Hampshire procedures committee.

4 Inspections

4.1 In April 2012 Care Quality Commission and Ofsted carried out an inspection of safeguarding children and looked after children services in Southampton. The Southampton Local Safeguarding Children Board contributed this and a full report of findings can be found on the following link: http://www.ofsted.gov.uk/local-authorities/southampton. The overall effectiveness of the council and its partners in safeguarding children and young people was deemed as adequate.

4.2 Ofsted highlighted that significant challenges had been faced by the council and its partners to reorganise safeguarding services both strategically and operationally over the past two years. They noted that actions taken had resulted in improved performance and practice in some safeguarding areas, for example in the contact and referral services. However, many initiatives are flagged as very recent or are being further developed, and most had yet to be sustained. They noted an insufficient track record of sustained improvement across most safeguarding outcome areas, for example in the timeliness of assessments.

4.3 The main findings were as follows:

Safeguarding services	
Overall effectiveness	adequate
Capacity for improvement	adequate
Safeguarding outcomes for children and young people	
Children and young people are safe and feel safe	adequate
Quality of provision	inadequate
The contribution of health agencies to keeping children and young people safe	adequate
Ambition and prioritisation	adequate
Leadership and management	adequate
Performance management and quality assurance	adequate
Partnership working	adequate
Equality and diversity	adequate
Services for looked after children	
Overall effectiveness	adequate
Capacity for improvement	adequate

How good are outcomes for looked after children and care leavers?	
Being healthy	good
Staying safe	adequate
Enjoying and achieving	adequate
Making a positive contribution, including user engagement	adequate
Economic well-being	inadequate
Quality of provision	inadequate
Ambition and prioritisation	adequate
Leadership and management	adequate
Performance management and quality assurance	adequate
Equality and diversity	adequate

4.4 The Board received regular updates from the Head of Safeguarding Children at Southampton City Council and Director for Children's Services on improvements made as a result of the inspection through a standing item on the agenda.

4.5 The LSCB was highlighted in the Ofsted report as below and specific action to improve performance in areas highlighted were also as follows:

A well coordinated response to children who go missing is guided by a clear SSCB protocol that involves all relevant agencies. Effective risk assessment of each incident takes account of historical factors to ensure that cases are prioritised appropriately.

Health providers have taken appropriate action to address significant deficits in the arrangements for safeguarding children and young people that were identified in recent serious case reviews in the area. This is being closely monitored through governance arrangements, commissioning and reporting through the SSCB.

The Independent Chair of the SSCB has provided strong challenge, for example in relation to the potential threats to safeguarding service delivery posed by recent industrial action in the council. Local priorities have been identified and acted on, for example in relation to neglect following the findings of a serious case review. There is elected member representation on the SSCB, however the Chair has no formal contact with the council's Chief Executive or Leader and this may limit the Board's influence. Furthermore, some service deficits, such as the lack of community paediatric health and forensic sexual assault provision at weekends, had not been formally identified and considered by the Board.

The SSCB and its constituent partners have undertaken work with local mosques and madrassahs to raise awareness and ensure compliance with safeguarding standards.

Through reports and its own audit activity, the SSCB maintains a close view of safeguarding performance across the partnership, and has been instrumental in raising concerns about the performance of safeguarding services within the council.

The SSCB has also collated and reviewed audits by partner agencies. However, it has not conducted thematic audits or systematic, in-depth audits of practice. This is recognised and plans are being developed to begin this work.

However, parents and records indicate that attendance at core group meetings by some professionals such as health visitors and school staff is not sufficiently regular or consistent. The SSCB has recognised this, but has yet to take effective action. Difficulties in weekend access to paediatric child abuse medical examinations and sexual abuse forensic services have been examined at strategic level by health commissioners but have not been identified as a concern by the SSCB.

The SSCB enables partners to work well together overall to deliver and develop safeguarding services. The Board provides some challenge to partners, where services are not performing to a sufficient standard. However, more work is required to ensure that child protection core groups are effective.

4.6 In terms of Health, the contribution of agencies to keeping children and young people was judged to be adequate in this inspection and for Looked After Children, the 'being healthy' outcome was judged to be good. A recommendation was made by inspectors in relation to facilities for medical

examination of children under 13years following abuse, including sexual assault to be available at weekends. This recommendation was taken to the Board of Clinical Commissioners (SHIP) and following their support, the service has been commissioned on a Hampshire wide basis and became operational in January 2013. This is a considerable achievement as few areas in England, outside London and the larger cities are able to deliver this service.

4.7 Several recommendations were also made by inspectors regarding the Looked After Children Health Team (Solent NHS Trust) team to ensure the health needs of care leavers are adequately addressed. A comprehensive review of capacity within the Solent Looked After Health Team was undertaken by the Designated Nurse and additional resource has been allocated. Accountability frameworks for Looked After Children within Solent NHS Trust continue to be addressed.

5 Priorities for the coming year

5.1 The narrative in previous sections provided an opportunity for analysis of the LSCB's success in delivering its core functions and objectives during 2012/13. It is clear from this that the board received much information regarding local services provision and activities and debated and scrutinised some key areas through its main Board meetings and sub committee activities.

5.2 There is clear evidence that more needs to be done to continue to develop the boards activities following areas:

1. Governance arrangements – revising constitution, membership and group terms of reference to reflect Working Together 2013.
2. Ensuring the voices of children and young people are integral to the work of the LSCB.
3. Regular and systematic assessment, scrutiny and monitoring of local services and practice to ensure that children and young people are safe.
4. Ensuring that local multi agency training is available and effective at improving safeguarding practice.
5. Development of local Serious Case Review processes to ensure reviews take place and learning is implemented in a timely manner.
6. Be clear about thresholds for services, including early help services and publish a document explaining this.
7. Ensure local awareness of safeguarding issues, and how to identify and respond.
8. Improve practice by reviewing and implementing safeguarding policies and procedures.
9. Coordinate local work to respond to child sexual exploitation, missing young people and human trafficking.

The LSCB have agreed that these 9 areas will form the basis of the Business Plan for 2013-14. Detail of implementation of these is given in the LSCB's Business Plan for 2013-14, which is available on the Southampton LSCB website. The revised priorities have been identified following consideration of the information contained within this Annual Report alongside:

- Working Together 2013, Children Act 2004 and the Local Safeguarding Children Boards Regulations 2006.
- The South East LSCB Quality Assurance Framework.
- Priorities and themes identified by LSCB members at the 2013 Business Planning Day.
- Ofsted and Care Quality Commission 2012 inspection.
- Consideration of the proposed characteristics of LSCBs to be reviewed in future Ofsted inspections.

Appendix 1 Membership of the Southampton Local Safeguarding Children Board 2012-13

Member agency/organisation
Independent Chair
Vice Chair (Head of Safeguarding, Children's Services and Learning)
Director of Children's Services and Learning
LSCB Board Manager
Chair of Strategic Learning and Development Group
Chair of Monitoring & Evaluation sub committee
Chair of Professional Issues sub committee
Chair of Public Education & Awareness sub committee
Community & Voluntary sector
CAFCASS – Child and Family Court Advisory Support Service
Hampshire Constabulary
Youth Offending Team
National Probation Service – Hampshire Branch
Designated Doctor, NHS Southampton
Designated Nurse, NHS Southampton
NHS Southampton
Southampton University Hospital Trust
Southern Health
Solent Health
GP Safeguarding Lead
South Central Ambulance Service
Primary Head teacher
Further Education College
Southampton City Council Housing
Southampton Safeguarding Adults Board
Executive Member, Children's Services and Learning
Lay Member
Membership of Executive:
LSCB Independent Chair LSCB Manager Head of Safeguarding, Southampton City Council Children's Services Prevention & Inclusion Services, Southampton City Council Head of Public Protection, Hampshire Constabulary Director, University Hospital Trust SHIP Primary Care Trust (Health) Cluster

Appendix 2 Data Set for Southampton Local Safeguarding Children Board 2012-13

Description	2010-11	2011-12	2012-13
Number of contacts	11246	14652	12218
Number of new referrals	3172	3672	3882
Rate of referrals	733	794	822
% of Referrals that are re-referrals (within 1 year)	30%	29%	31%
% of referrals where decision made within 24 hours	N/A	79%	56%
% of Initial Assessments completed in 10 days	87%	60%	68%
% of Core Assessments completed in 35 days	63%	43%	38%
Number of strategy discussions started	1718	1710	1322
Number of Section 47s Started	N/A	1390	1328
Number of Initial Child Protection Conferences held (including Transfer-Ins)	437	438	426
Rate (per 10,000) of Initial Child Protection Conferences held (including Transfer-Ins)	101	95	92
% of Initial Child Protection Conferences held within 15 working days (including Transfer-Ins)	80%	72%	73%
% of Initial Child Protection Conferences resulting in a Child Protection Plan	77%	82%	84%
Number of Children with a Child Protection Plan	279	269	233
Rate (per 10,000) of Children with a Child Protection Plan	64	58	50
% of Review Child Protection Conferences held on time	98%	89%	99%
Number of children in need at end of period	1881	2046	2092
Rate (per 10,000) of Children in Need at end of period	434	443	445
% of CiN baseline audits Good/Outstanding	n/a	n/a	17%
% of CiN baseline audits Adequate	n/a	n/a	53%
% of CiN baseline audits inadequate	n/a	n/a	31%
Number of Children Looked After at end of period	386	429	482
Rate (per 10,000) of Children Looked After at end of period	89	93	103
Number of Children newly Looked After during period (count of episodes, not children)	173	193	219

Appendix 2 Data Set for Southampton Local Safeguarding Children Board 2012-13

Description	2010-11	2011-12	2012-13
Number of Children ceasing to be Looked After during period (count of episodes, not children)	165	153	173
CLA reviews on time (former NI 66)	85%	82%	82%
% of CLA placed 20 miles from their home (distance between current home and placement addresses, not the home address from which they came into care)	9%	10%	11%
Number of CLA placed with IFA foster carers	58	62	86
% of children with three or more placements in 12 months	9%	10%	10%
% of children looked after for 2.5 years or more and aged under 16 who have been in the same placement for two years, or are placed for adoption and their adoptive placement plus their previous placement totals 2 years	68%	77%	73%
% CLA with up to date Health Assessment (first HA within 28 days, then six monthly for children under 5 and yearly for children aged 5 and over)	new measure - n/a	new measure - n/a	new measure - n/a
% children looked after for a year continuously who have had a dental check in the year	90%	87%	88%
% of children looked after for a year continuously persistently absent from school	n/a	11%	5%
% of children looked after continuously for a year offending	14%	14%	12%
% of care leavers in contact	n/a	n/a	81%
% of care leavers in contact and in suitable accommodation	73% (old definition)	61% (old definition)	67% (old definition)
% of care leavers in contact and in Education, Employment or Training	53% (old definition)	44% (old definition)	41% (old definition)
Number of children in Private Fostering arrangements	5	6	10
Number of PF contacts	n/a	n/a	21
Number of new of new notifications	n/a	n/a	15
Number of new PF arrangements	n/a	n/a	12
Current PF arrangements	n/a	n/a	6
Average SW Caseload - IAT, Protection and Court	22.6 (old definition including staff on maternity leave)	23.4 (old definition including staff on maternity leave)	20.7 (old definition including staff on maternity leave)

Appendix 2 Data Set for Southampton Local Safeguarding Children Board 2012-13

Description	2010-11	2011-12	2012-13
Average SW Caseload - Pathways	22.5 (old definition including staff on maternity leave)	19.1 (old definition including staff on maternity leave)	18.8 (old definition including staff on maternity leave)
Number of children using an advocate	1	1	1
Total number of complaints made	138	182	179
Number of Common Assessment Framework (PreCAF) assessments completed: (pre-birth 5).	N/A	498	479
Number of Common Assessment Framework (CAF) assessments completed	N/A	169	237
Total CAFs/ PreCAFs	N/A	667	716
Social Care workforce – Establishment	N/A		89.4
Social Care workforce – numbers in post	N/A		91.4
Social Care workforce – permanent staff	N/A		71.9
Social Care workforce – temporary staff	N/A		19.5
Vacancy rate of key parts of the Children's Workforce (annual average): Social Care.	N/A		19.6%
Infant Mortality rate	N/A	5.5	3.9
Child Death Reviews undertaken on behalf of LSCB	N/A		1.0
Emergency hospital admissions caused by accidental and deliberate injuries to children	N/A	164.8	156.8
% Total Absence in Schools	N/A	5.8	5.4
% Secondary Fixed Term Exclusions	N/A	23.3	16.1
Number of children killed or seriously injured in Road Traffic Accidents	N/A	13	19
Services for Privately Fostered Children (OfSTED)	N/A	Good	Good
Services to support Fostering (OfSTED)	N/A	Outstanding	Outstanding
Adoption Services (OfSTED)	N/A	Good	Good
Rate of 1st time entrants to the Criminal Justice System per 100,000	N/A	841	1011
Proportion of children living in Poverty	N/A	26.8	n/a
CLA / Safeguarding Announced Inspection (OfSTED)	N/A	Adequate	Adequate

What is the LSCB?

Children in Southampton can only be properly kept safe if the key agencies work together.

Local Safeguarding Children Board (LSCB)s were established by the Children Act 2004 to help make sure that this happens. LSCBs are the key system in every local authority area of the country for organisations to come together to agree on how they will cooperate with one another and ensure their work to safeguard and promote the welfare of children is effective. The purpose of this partnership working is to hold each other to account and to ensure safeguarding children remains high on the agenda in the City.

Who are the members of the LSCB?

The LSCB is led by an Independent Chair supported by a Board Manager and a Business Coordinator.

The Board is made up of members from local agencies such as Police, Children Services, Adult Services, Probation, Health, Voluntary Sector, Schools and Housing.

Southampton LSCB has a number of sub groups working on key issues which involve a wide range of services. The LSCB aims to include the voices of children, young people and their families as well as frontline professionals in its work.

What does the LSCB do?

The LSCB has core functions set out in the Children Act 2004 and in *Working Together to Safeguard Children – A guide to inter-agency working to safeguard and promote the welfare of children 2013* including:

- Monitoring and evaluating the effectiveness of what is done in the city to safeguard children and promote their welfare
- Developing policies and procedures for safeguarding and promoting the welfare of children
- Raising awareness of the need to safeguard children and young people
- Participating in the planning of services for children
- Undertaking serious case reviews and reviews of child deaths, advising on lessons to be learned.

For more information on Southampton LSCB, please visit www.southamptonlscb.co.uk.

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DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		PUBLIC HEALTH ANNUAL REPORT 2013		
DATE OF DECISION:		26 MARCH 2014		
REPORT OF:		DIRECTOR OF HEALTH		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Rebecca Wilkinson**	**Tel:**	**023 80 833871**
	E-mail:	**rebecca.wilkinson@southampton.gov.uk**		
Director	**Name:**	**Dr Andrew Mortimore**	**Tel:**	**023 80 833738**
	E-mail:	**ndrew.mortimore@southampton.gov.uk**		
STATEMENT OF CONFIDENTIALITY				

BRIEF SUMMARY

The Director of Public Health has a duty under the NHS Act 2006 to write an annual report on the health of the local population and the local authority has a duty to publish it. The content and structure of the report is to be decided locally.

RECOMMENDATIONS:

(i) The Health and Wellbeing Board are welcomes the Public Health Annual Report and considers the implications for the future work of the Board.

REASONS FOR REPORT RECOMMENDATIONS

1. The purpose of the Director of Public Health's Annual Report is to make an assessment of the health of the local population and make recommendations on key actions that would lead to an improvement in the populations health

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None

DETAIL (Including consultation carried out)

3. This is the first report since Public Health leadership and responsibilities transferred from the NHS back to Councils on 1st April 2013. It reports on the state of Southampton's health, underlying trends and future challenges, and make recommendation for how health can be improved.

4. Many health indicators in Southampton are moving in the right direction – life expectancy is improving, deaths from heath disease and stroke are falling and cancer survival rates are improving. However there has been limited progress in narrowing the health gap between the wealthy and those who are on low incomes, and many challenges remain or have increased in significance. The economic problems faced by the UK over the last five years have increased the likelihood that the least well off will continue to have poorer health.

5. Improving the public's health and tackling these challenges require "the organised efforts of society". Public health in the Council will work in partnership for a healthier city, a place which is safe and healthy and where people thrive. The report aims to make clear what these challenges are and point the way to how we can make further progress.

6. For the purpose of the annual report, we are presenting a highlight report which sets out the key health issues the City faces, whether the situation is improving or worsening and the key factors that need to be addressed to improve health.

7. There are four sets of outcomes that we need to focus on to make progress in improving health. As with last year's report, we devote a chapter to each of these, and feature some examples of work that is going on to improve these outcomes

8. Shelter and security are basic needs and health suffers when these are not met. Chapter Two looks at how housing can affect health through overcrowding, insecure tenancies, poor insulation, lack of affordable or effective heating, damp and homelessness. There are many challenges to making more and better housing available in the city, but the opportunities that do exist need to be grasped.

9. Being safe and feeling safe in our homes and neighbourhoods is an essential part of wellbeing. Every year crime and disorder in the city is assessed and plans and actions agreed by a range of agencies to make the city a safer place to live in, work in or visit. Community safety has direct impacts on health and this is explored in the report.

10. Our health is affected by our behaviours and the way we choose to live our lives. Although fewer people are smoking, it is still the single biggest cause of early deaths. Further action to reduce the burden of disease it causes is discussed in Chapter 3. There has been much recent discussion about what causes happiness and enables people to be content. The links between wellbeing and mental health are explored and approaches that would improve mental wellbeing are outlined.

11. Chapter 4 focuses on threats to health that are related to infection. Much can be done to reduce risks linked to common infectious diseases. Sexual health is more than just the avoidance of infections, and this is also discussed in the chapter.

12. The final chapter focuses on two chronic illnesses that affect both the quality and length of life – diabetes and kidney disease. Much can be done to prevent these problems and to limit their impact if they are detected early and managed well.

RESOURCE IMPLICATIONS

Capital/Revenue

13. None

Property/Other

14. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

15. Section 73B(5) & (6) of the NHS Act 2006, inserted by section 31 of the Health and Social Care Act 2012.

Other Legal Implications:

16. None

POLICY FRAMEWORK IMPLICATIONS

17. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Appendices

1.	Public Health Annual Report

Documents In Members' Rooms

1.	N/A

Equality Impact Assessment

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

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Agenda Item 6

Appendix 1

Health in Southampton 2013

Report from the Public Health Director for Southampton

Southampton City Public Health Annual Report 2013:

Health in Southampton

Contents

Finding out more about the health of Southampton

As well as publishing an Annual Report and a Joint Strategic Needs Assessment (JSNA), we also produce a number of other resources that help build up a more detailed picture of health in Southampton. The back catalogue of annual reports is available on our website; these give an in-depth analysis of a range of topics that remain current in our City. We also publish briefing notes which are a comprehensive look at topics such as child growth, inequalities and sexual health. We produce profiles of the sixteen electoral wards in the city; these are available as an interactive mapping tool on our website.

Please visit our website to access any of these resources:

www.publichealth.southampton.gov.uk

Acknowledgements

Many thanks to Rebecca Wilkinson for editing this report and to the following members of the public health team for their contributions: Debbie Chase, Bob Coates, Ginny Cranshaw, Helen Cruickshank, Sally Denley, Dan King and Sarah McCann.

Special thanks also to guest contributors Simon Fraser, Lisa Raison-Trehy, Paul Roderick and Derek Stevens.

Preface

This is my first report since Public Health leadership and responsibilities transferred from the NHS back to Councils on 1st April 2013. In it I report on the state of Southampton's health, underlying trends and future challenges, and make recommendations for how health can be improved.

Southampton is a great city, whether you live here, work here or are a visitor. Many health indicators are moving in the right direction – life expectancy is improving, deaths from heart disease and stroke are falling and cancer survival rates are improving. However there has been limited progress in narrowing the health gap between the wealthy and those who are on low incomes, and many challenges remain or have increased in significance. The economic problems faced by the UK over the last five years have increased the likelihood that the least well off will continue to have poorer health.

Improving the public's health and tackling these challenges require "the organised efforts of society". Public health in the Council will work in partnership for a healthier city, a place which is safe and healthy and where people thrive. I hope this report will make clear what these challenges are and point the way to how we can make further progress.

Dr Andrew Mortimore
Director of Public Health
Southampton City Council
March 2014

Introduction

There is now a wealth of information that helps us understand the health of people in Southampton. For five years the Council has worked with the local NHS on a Joint Strategic Needs Assessment (JSNA). This resource is regularly updated and paints a picture of what life is like in Southampton and what the health challenges are. The full JSNA is a web-based resource and can be found at www.publichealth.southampton.gov.uk/jsna

As well as data and analysis, there are mapping tools and summaries which enable a detailed picture to be built up on a wide range of topics.

For the purpose of the annual report, we are presenting a highlight report which sets out the key health issues the City faces, whether the situation is improving or worsening and the key factors that need to be addressed to improve health.

There are four sets of outcomes that we need to focus on to make progress in improving health. As with last year's report, we devote a chapter to each of these, and feature some examples of work that is going on to improve these outcomes.

Shelter and security are basic needs and health suffers when these are not met. Chapter Two looks at how housing can affect health through overcrowding, insecure tenancies, poor insulation, lack of affordable or effective heating, damp and homelessness. There are many challenges to making more and better housing available in the city, but the opportunities that do exist need to be grasped.

Being safe and feeling safe in our homes and neighbourhoods is an essential part of wellbeing. Every year crime and disorder in the city is assessed and plans and actions agreed by a range of agencies to make the city a safer place to live in, work in or visit. Community safety has direct impacts on health and this is explored in the report.

Our health is affected by our behaviours and the way we choose to live our lives. Although fewer people are smoking, it is still the single biggest cause of early deaths. Further action to reduce the burden of disease it causes is discussed in Chapter 3. There has been much recent discussion about what causes happiness and enables people to be content. The links between wellbeing and mental health are explored and approaches that would improve mental wellbeing are outlined.

Chapter 4 focuses on threats to health that are related to infection. Much can be done to reduce risks linked to common infectious diseases. Sexual health is more than just the avoidance of infections, and this is also discussed in the chapter.

The final chapter focuses on two chronic illnesses that affect both the quality and length of life – diabetes and kidney disease. Much can be done to prevent these problems and to limit their impact if they are detected early and managed well.

Technical Note

This report uses the four themes of the Public Health Outcomes Framework (PHOF) as its structure. At the start of each theme a 'spine chart' of the relevant indicators for Southampton is presented. The diagram below shows how to interpret the spine charts and further information is available at www.phoutcomes.info

Data has now been published for the over-arching PHOF indicators of life expectancy and healthy life expectancy. Southampton has significantly lower healthy life expectancy than the national average for men (61.1 years compared with 63.2 years).

Data has also been published for the 'slope index of inequality' - this is the difference (in years) in life expectancy between the most and least deprived 10% of the population. For men in Southampton this is 9.4 years and for females it is 5.8 years. The confidence intervals are wide around these figures so it is difficult to draw conclusions about changes over time or differences between areas. This data relates to 2009-11. Previous data for this indicator was for the 5 year period 2006-10 and for males was 8.0 years but the confidence intervals are too wide to conclude that inequality amongst men is definitely increasing. Indeed, local analysis[1] shows very little change in the gap for male life expectancy over the past few years.

	Overarching indicators	Period	Local value	Eng. value	Eng. lowest	Range	Eng. highest
0.1i	Healthy life expectancy at birth - Male	2009 - 11	61.1	63.2	55.0		70.3
0.1i	Healthy life expectancy at birth - Female	2009 - 11	64.6	64.2	54.1		72.1
0.1ii	Life Expectancy at birth - Male	2010 - 12	78.5	79.2	74.0		82.1
0.1ii	Life Expectancy at birth - Female	2010 - 12	82.7	83.0	79.5		85.9
0.2i	Slope index of inequality in life expectancy at birth based on national deprivation deciles within England (provisional) - Male	2009 - 11	-	9.65	-		-
0.2i	Slope index of inequality in life expectancy at birth based on national deprivation deciles within England (provisional) - Female	2009 - 11	-	7.18	-		-
0.2iii	Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (provisional) - Male	2009 - 11	9.4	-	-		-
0.2iii	Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (provisional) - Female	2009 - 11	5.8	-	-		-
0.2iv	Gap in life expectancy at birth between each local authority and England as a whole - Male	2010 - 12	-0.71	0.00	-5.21		2.89
0.2iv	Gap in life expectancy at birth between each local authority and England as a whole - Female	2010 - 12	-0.31	0.00	-3.51		2.89

Appendix 1 includes an alternative representation of the PHOF indicators; this time shown as a 'tartan rug' that compares Southampton with the local authorities considered 'most similar'2.
Appendix 2 provides profiles of the sixteen electoral wards in Southampton. Appendix 3 is a summary of statistics for the city which can be cut-out and folded into a credit card sized 'pocket profile'.

Summary of health and wellbeing needs in Southampton

The Secretary of State for Health has placed a duty on local government and clinical commissioning groups to conduct an assessment of the current and future health needs of the population – called a 'Joint Strategic Needs Assessment' (JSNA). Southampton's JSNA is available at www.publichealth.southampton.gov.uk/jsna

Through consultation with stakeholders, nine key themes were developed as the structure of the Southampton JSNA. This section summarises the key findings within each of the themes.

Economic Wellbeing

With 26% of children living in poverty in Southampton, the JSNA has identified a key need to maximise family incomes. Recent analysis[1] of health status in the most deprived communities in the city compared to the least deprived shows evidence of a narrowing of the gap for some indicators such as breastfeeding and premature mortality from circulatory disease. However, for key measures, such as early deaths from cancer and life expectancy amongst women, the inequalities gap appears to be widening. The basic human need for shelter is examined in the JSNA and highlighted in Section 1.1 on Housing.

Mental Health

In Southampton there are 2,758 people registered with their GP as having a severe and enduring mental illness (schizophrenia, bipolar disorder and other psychoses) and 13,800 people have been diagnosed with depression since 2006. Not all mental illness has been diagnosed by a GP so the true population prevalence is likely to be higher. Indeed it is estimated that one in four people will have a mental illness at some time in their lives. Over the 2010-12 period there were an average of 28 suicides per year among Southampton residents. Mental wellbeing is about more than just new possessions and expensive holidays; for instance, Section 2.2 of this report talks about happiness and 'five steps to wellbeing'.

Early Years

The past few years have seen some positive changes in children's outcomes in the city; for instance, smoking in pregnancy has reduced from 25.1% in 2003/04 to 19.4% in 2011/12 whilst breastfeeding has increased over the same period from 69.4% to 76.5%. The inequalities gap for these indicators has also reduced. There have been recent improvements in GCSE and Key Stage 2 results for Southampton's children but educational attainment remains a concern with school absence and exclusions being particular issues for the city[3].

Although there has been a decline in teenage pregnancy since 1998-00, this remains a very significant issue for Southampton with 170 under 18 year old girls becoming pregnant in 2011 giving a higher rate than amongst the city's statistical peers (see Section 3.1 Sexual Health). The JSNA identifies a need to support young parents to reduce the cyclical nature of teenage pregnancy.

Taking Responsibility for Health

Smoking was at its peak in the late 1940's when 82% of men and 41% of women smoked. Rates fell steadily between the mid-1970's and early 1980's. The rate of decline then slowed and since 2000 prevalence has been declining at a rate of about 0.4% a year. Smoking prevalence in Southampton tends to be higher than the national average, largely because of the demographic and socio-economic make up of the city. In 2003/05 Southampton's smoking prevalence was estimated to be 27% compared to around 24% nationally. By 2011/12 prevalence in the city had fallen to 23% whereas the national rate was 20%. Despite this decline, smoking remains the biggest cause of premature mortality; accounting for around 340 deaths per year in the city and an estimated 2,100 hospital admissions. The JSNA identified a need for a Tobacco Control Plan in the city; read more about this in Section 2.1 on Smoking.

Other lifestyle factors are also of huge importance to health and wellbeing. The JSNA covers obesity, sexual health and substance misuse. Alcohol harm needs to be tacked at individual, family, community and city levels. Over the period 2009-11 there were 100 deaths to Southampton residents from liver disease that were considered preventable. Overall alcohol is estimated to cost the health service in Southampton about £12 million each year[4].

Long Term Conditions

Around 86,000 people in Southampton (32% of the population) are estimated to be living with a long term condition such as asthma, diabetes or heart disease. Over time there have been significant improvements in mortality from some of these conditions; for instance, between 1998-00 and 2008-10 mortality rates from CHD have reduced by about 49% which is equivalent to 200 fewer deaths per year.

The recorded prevalence of certain conditions continues to rise for instance there were 7,563 people on GP's diabetes registers in 2004/05 but this had grown to 11,545 in 2012/13 (although this is partly as a result of increased recording rates).

Nevertheless, the true underlying prevalence is much higher (about 14,000 people in Southampton). Diabetes is further examined in Section 4.1 of this report.

With much co-morbidity the JSNA identified person centred care as a priority for the city and the local CCG now have a program in place to work towards a better model of integrated care[5].

In 2012/13 there were 946 people with learning disabilities (LD) on primary care registers yet population prevalence in Southampton (including mild LD) is estimated to be over 4,900. The JSNA identified this group and their carers as needing better co-ordination of care.

Nationally there is a 'dementia gap' between the numbers diagnosed and the true prevalence; in Southampton there were 1,376 people recorded on GP dementia registers in 2012/13 but the true numbers are estimated to be nearer to 2,400. The JSNA highlights a key need for early dementia diagnosis and better services.

More Years, Better Lives

The population is ageing which presents a reason to celebrate but also many challenges; by 2030 there will be 51% more people age 65+ in England compared to 2010 and currently 10.7 million people in Great Britain can expect inadequate retirement incomes[6]. In Southampton the number of people aged over 85 is expected to increase from 5,300 to 6,000 between 2011 and 2018 and then to over 10,000 by 2035. The JSNA emphasises that longer lives should be better lives and not spent in ill health.

End of life care is about enabling people to live their life to the end with dignity and having their choices respected. The proportion of people dying at home has increased very slightly over the past few years in the city but the JSNA recommends more be done to raise public awareness around death and support people to express their preferences for end of life care and place of death.

Creating a Healthier Environment

The environment theme covers a wide range of factors so has been subdivided into Community Safety, Transport and Place.

Violent crime rates are high in Southampton; this may be partly an affect of local recording practices but nonetheless crime, and fear of crime, represents a very real issue for the city with impacts reaching beyond the victims to the whole of society (see Section 1.2 on Violent Crime).

Active travel offers huge potential health benefits such as reducing the risk of coronary heart disease or stroke and improving mental well-being. In 2011 61% of employed residents in Southampton were travelling to work in a car or van – little change from in 2001. However, the proportion walking to work had increased from 13.3% to 16.5%. The layout of our city can influence opportunities to be physically active so planning policy has a key role to play. Studies have found that income-

related inequality in health is affected by exposure to green space – people with close access to green space live longer, even after adjusting for social class, employment and smoking.

Improving Safeguarding

The JSNA identifies key needs around the protection of vulnerable children and adults. There has been an on-going increase in the referrals of children and young people at risk of abuse or neglect over the past few years. Over the period 2009 to 2013 the rate of children in care increased by 58% in Southampton compared to an 11% increase nationally[7]. In the year ending March 2013 Southampton City Council carried out 285.7 Section 47 Child Protection investigations for every 10,000 children (compared with 111.5 per 10,000 nationally) and the city had 91.6 per 10,000 children subject to an initial child protection conference compared with 52.7 per 10,000 nationally[8]. These high rates in Southampton reflect both the level of need in the City and children's service provision. To ensure that children's needs are met at the earliest stage, a children's services transformation programme was initiated in September 2013. Historically economic hardship has been linked to pressure on families and increased demand for safeguarding services so there is a very real risk of a worsening situation as the global economic recession and national welfare reforms start to impact.

Protecting People

Health protection includes communicable diseases – such as the common infections covered in Section 3.2 of this report – and other risks to health such as environmental health hazards, extreme weather and trading standards. Being a port city means Southampton has particular needs in terms of the risks to health that the movement of people and cargo can present. Fortunately the widespread implementation of immunisation programmes has led to huge improvements in health. There is, however, still work to be done in promoting the uptake of vaccinations. For instance, MMR uptake in the city, whilst higher than the national average, is still below the 95% target that would offer 'herd immunity'. Additionally, coverage of seasonal flu vaccine amongst health and care workers must be improved to ensure patients are protected.

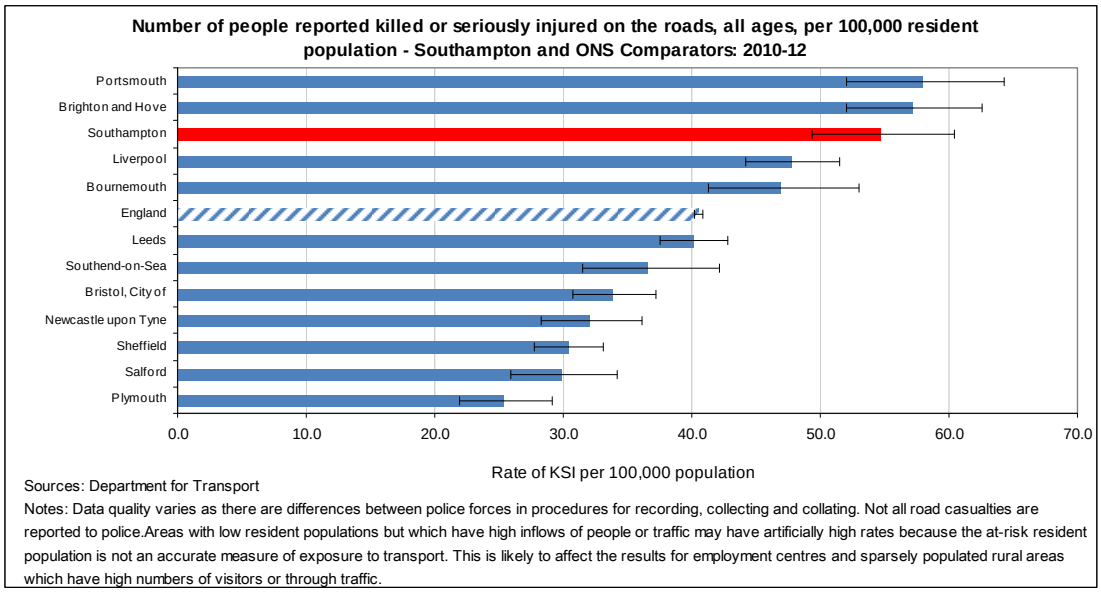
Theme 1: Wider impacts on health and wellbeing

The first theme of this report is based on the wider determinants of health which include the environment, the economy and society. The World Health Organisation (WHO) describes social determinants of health as the conditions in which people are 'born, grow, live, work and age'[9]. Lack of income, inappropriate housing, unsafe workplaces and poor access to healthcare are just some of the influences on the health of individuals and communities. Improving educational attainment, clever use of planning policy and enabling communities to work together can all have a positive impact on health and reduce inequalities. These issues are dealt with in more detail in the Southampton JSNA www.publichealth.southampton/jsna

Wider determinants of health	Period	Local value	Eng. value	Eng. lowest	Range	Eng. highest
1.01i Children in poverty (all dependent children under 20)	2011	25.3	20.1	46.1		6.6
1.01ii Children in poverty (under 16s)	2011	25.9	20.6	43.6		6.9
1.02i School Readiness: The percentage of children achieving a good level of development at the end of reception	2012/13	50.8	51.7	27.7		69.0
1.02i School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception	2012/13	37.9	36.2	17.8		60.0
1.02ii School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check	2012/13	70.5	69.1	58.8		79.0
1.02ii School Readiness: The percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check	2012/13	62.0	55.8	37.2		70.9
1.03 Pupil absence	2011/12	5.87	5.11	6.66		4.30
1.04 First time entrants to the youth justice system	2012	968	537	1,427		151
1.05 16-18 year olds not in education employment or training	2012	6.3	5.8	10.5		2.0
1.06i Adults with a learning disability who live in stable and appropriate accommodation	2011/12	80.4	70.0	30.9		93.8
1.06ii % of adults in contact with secondary mental health services who live in stable and appropriate accommodation	2012/13	27.4	58.5	5.5		94.1
1.08i Gap in the employment rate between those with a long-term health condition and the overall employment rate	2012	5.1	7.1	-5.3		21.7
1.08ii Gap in the employment rate between those with a learning disability and the overall employment rate	2011/12	62.7	63.2	40.2		73.1
1.08iii Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	2012/13	65.7	62.3	53.1		75.1
1.09i Sickness absence - The percentage of employees who had at least one day off in the previous week	2009 - 11	2.3	2.2	3.5		0.6
1.09ii Sickness absence - The percent of working days lost due to sickness absence	2009 - 11	1.5	1.5	2.7		0.3
1.10 Killed and seriously injured casualties on England's roads	2010 - 12	54.7	40.5	81.8		16.9
1.11 Domestic Abuse	2011/12	16.2	18.2	5.2		34.4
1.12i Violent crime (including sexual violence) - hospital admissions for violence	2010/11 - 12/13	88.9	57.6	167.8		9.3
1.12ii Violent crime (including sexual violence) - violence offences per 1,000 population	2012/13	19.0	10.6	4.1		27.1
1.12iii 1.12iii- Violent crime (including sexual violence) - Rate of sexual offences per 1,000 population	2012/13	1.08	0.83	0.34		2.01
1.13i Re-offending levels - percentage of offenders who re-offend	2011	30.2	26.9	14.4		36.3
1.13ii Re-offending levels - average number of re-offences per offender	2011	0.97	0.78	0.31		1.27
1.14i The percentage of the population affected by noise - Number of complaints about noise	2011/12	10.5	7.5	58.4		2.5
1.14ii The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime	2006/07	7.7	5.4	0.3		29.8
1.14iii The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time	2006/07	24.3	12.8	0.8		57.5
1.15i Statutory homelessness - homelessness acceptances	2011/12	1.9	2.3	0.2		9.7
1.15ii Statutory homelessness - households in temporary accommodation	2011/12	1.5	2.3	32.4		0.0
1.16 Utilisation of outdoor space for exercise/health reasons	Mar 2012 - Feb 2013	16.0 $	15.3	0.5		41.2
1.17 Fuel Poverty	2011	9.8	10.9	18.0		3.8
1.18i Social isolation: % of adult social care users who have as much social contact as they would like	2012/13	40.8	43.2	31.9		53.5
1.18ii Loneliness and isolation in adult carers	2012/13	47.4	41.3	23.9		58.5

The first domain of the PHOF covers these wider impacts on health and wellbeing. Southampton has poorer outcomes than nationally in terms on children in poverty, pupil absence, youth offending, road traffic accidents, violent crime and complaints about noise (see spine chart below).

As rates of injury and death from road traffic accidents are significantly higher in Southampton than in many of its similar authorities (see chart below) further work has been done on this by the Public Health Information Team. This shows that although the number of accidents has fallen over the past decade, the proportion that are serious accidents has increased – see the full report for further details http://www.publichealth.southampton.gov.uk/healthintelligence/briefings.aspx.



Sources: Department for Transport

Notes: Data quality varies as there are differences between police forces in procedures for recording, collecting and collating. Not all road casualties are reported to police.Areas with low resident populations but which have high inflows of people or traffic may have artificially high rates because the at-risk resident population is not an accurate measure of exposure to transport. This is likely to affect the results for employment centres and sparsely populated rural areas which have high numbers of visitors or through traffic.

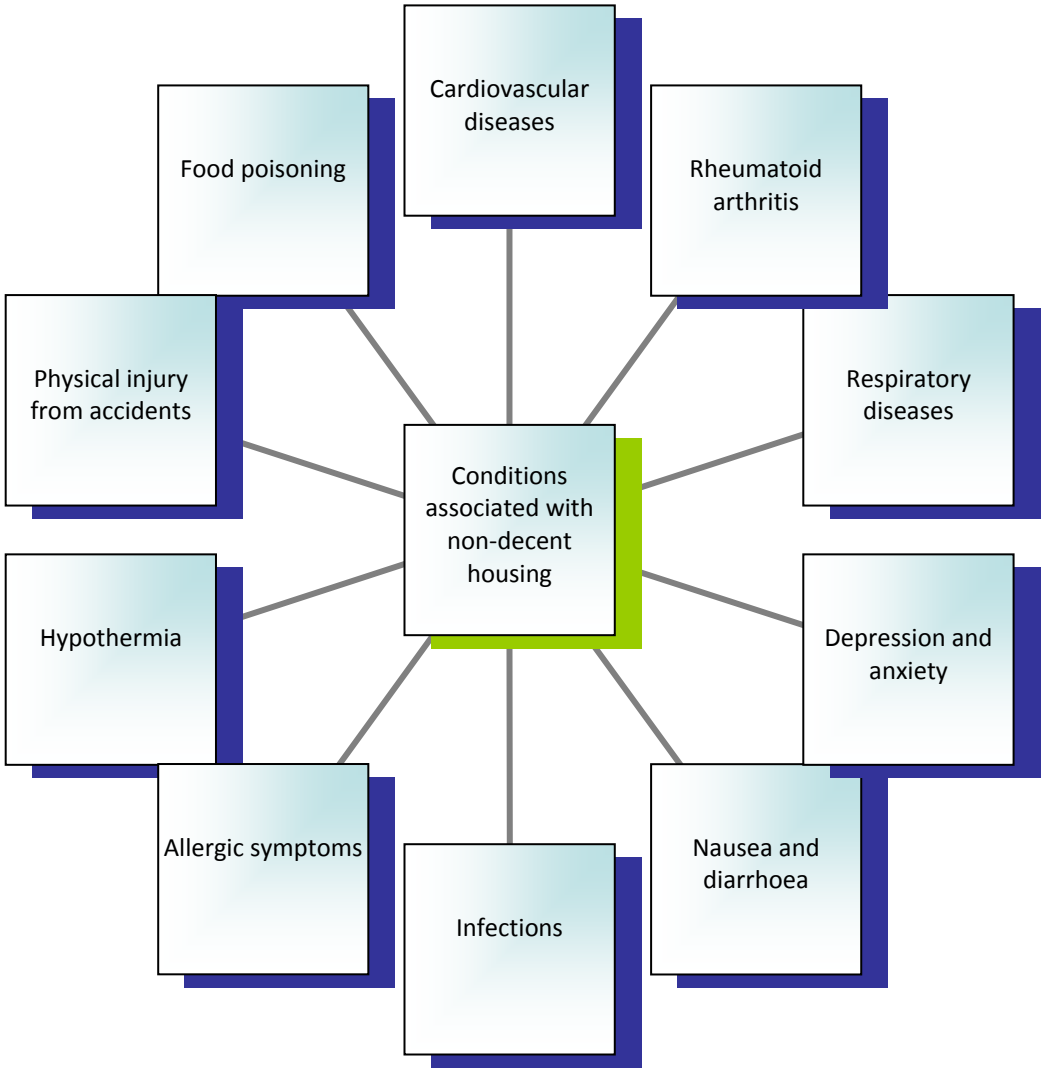
This year's report focuses in on two very important wider impacts on health – housing and violent crime.

1. 1. Housing

Why is this issue important?
Shelter is a primary need. Decent and accessible housing is a fundamental starting point for people to enjoy better health; it allows them to connect with employment and social activities which themselves mitigate against social isolation and mental and physical ill health.

The relationship between housing and health is multi-layered: for example, poor quality building materials can affect a resident's health; poor design can lead to hazards; and overcrowding can lead to spread of disease and poor mental health. However, poor housing conditions often coexist with other forms of deprivation (unemployment, poor education, ill health, social isolation etc), making it difficult to isolate, modify and assess the overall health impact of housing conditions.

The effects of housing on health[10]



Poor housing conditions are estimated to cost the NHS at least £600 million per year[11]. The conditions associated with poor housing are summarised above but the strongest links are with accidents (of which 45% occur in the home) and cold (as covered in the 2011 Public Health Annual Report http://www.publichealth.southampton.gov.uk/healthintelligence/phar.aspx)

There are broader aspects of housing that affect health such as overcrowding, sleep deprivation, community safety and features of the local infrastructure including proximity to parks and shops selling affordable, healthy food[12]. Housing can have a huge impact on mental wellbeing; Bonnefoy[13] explains "poor quality housing, providing insufficient protection from the outside, from noise, from scrutiny, and intrusion can be the source of major suffering".

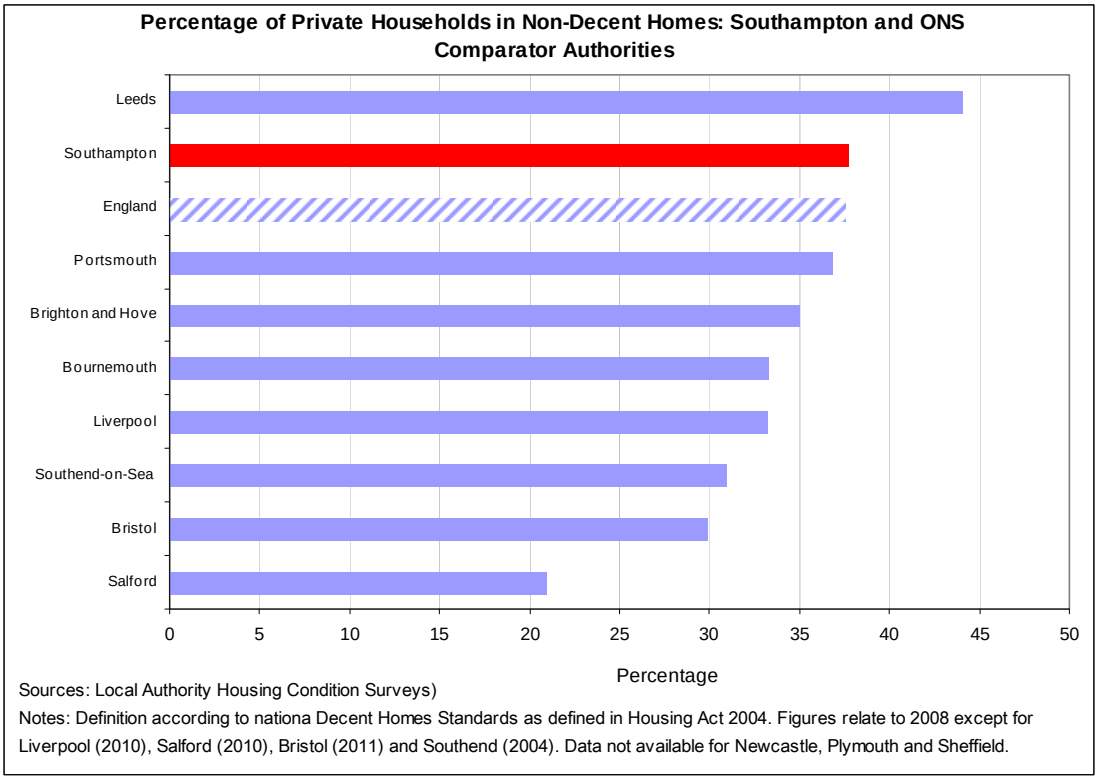
Houses in Multiple Occupation (HMOs) are defined as dwellings containing more than one household and residents of HMOs have been found to be four times more likely to suffer injury and twice as likely to die in a fire than people living in single dwellings[12].

The Southampton context

In Southampton 25% of all households live in privately rented accommodation, the national average is just 17%. Of the privately rented homes in the city, over 7,000 are HMOs.

In 2011, 13.6% of households in the city were defined as over-crowded according to the definition used in the Census. This is higher than the national average of 8.7% and also higher than many of the city's most similar authorities. In the city centre wards of Bargate and Bevois more than a quarter of households are defined as over-crowded and in some neighbourhoods in these wards the proportion rises to over 40%.

Over 28,000 (38%) of privately owned and rented homes in the city do not meet the Decent Homes Standard, of which 8,500 are occupied by vulnerable people. Older properties (pre-1919) are generally in the worst condition. The chart below shows that Southampton has a relatively high percentage of non-decent private housing stock compared to its most similar authorities. The total cost to make decent the private dwellings in the city that have health and safety hazards, or significant repair issues, poor amenities or are lacking in adequate energy efficiency measures is estimated at £111 million[14].



There is an estimated need for 3,900 adaptations for disabled people which is anticipated to cost around £21 million.

Nearly a quarter (23%) of all homes in the City are in the Social Housing sector of which over 17,000 are in the ownership and management of Southampton City Council (SCC). Whilst 96% of SCC properties meet the Decent Homes standard, there will still be an investment of over £200 million needed to maintain and improve homes in the next four years.

SCC has over 14,000 households on its housing waiting list; even though 1,600 properties are let each year there are, on average, 400 new applications each month. The average wait for 1 bed property is 7 years and the average wait for 3 bed house is 6 to 7 years. Therefore the City has about 2,000 overcrowded households within social housing. In 2011/12 over 1500 homeless households were assessed with the majority being supported to maintain their accommodation. However, 250 single homeless people are seen each month by the Street Homeless Prevention Team and on average 10 to 12 rough sleepers are found on outreach each week.

SCC also has over 3,300 properties specifically designated for older people. The population is ageing and longer term population projections predict a 42% increase in over 65s in Southampton between 2010 and 2035, with numbers aged over 85 reaching 10,000 by 2035.

What can be done?

There is already much work going on to improve housing for the residents of Southampton. For instance, in 2011, SCC was awarded £6.2m in grant funding from the Community Energy Saving Programme (CESP) via British Gas. This funding was to make considerable energy saving improvements and reduce tenants' heating and hot water bills in the four tower blocks in International Way (Oslo Towers, Havre Towers, Hampton Towers and Copenhagen Towers). Rotterdam was initially excluded from the CESP works and was later funded separately from the Energy Company Obligation (ECO) part of Ofgem for an identical programme of work.

An additional £3m was added to this budget by SCC to enable a 'whole building' approach to both improving residents' homes and reducing the carbon footprint of the 520 homes (including Rotterdam).

Additionally SCC now has an additional licensing scheme for smaller Houses in Multiple Occupation in four wards of the city - Bargate, Bevois, Swaythling and Portswood which aims to ensure well managed and safe properties. This will protect the welfare of the residents and reduce impacts on the neighbourhood.

In the 2015/16 Spending Review the government allocated £3.8bn budget for health and social care services, shared between NHS and local authorise to provide more integrated services. Social housing is well placed to be a partner in developing local integrated services as the close relationship with tenants mean staff can be involved in prevention work.

Other housing initiatives that could improve health and wellbeing include tackling the hardest to heat properties and giving tenants training on energy saving strategies plus more control over their own heating.

Key recommendations

- Mitigating the impact of overcrowding and poor housing on efforts of parents to help their children succeed
- Designing out crime through town planning and estate regeneration

- Social housing providers should be fully engaged in local plans to develop more integrated health and social care services
- Social housing staff should be trained and help to promote health campaigns in order to support tenants and enhance their wellbeing
- The government's move towards integrated services should be used as an opportunity for social housing to become a service provider for wider health commissions as it is for sheltered housing supported care
- Designing and prioritising specialist homes for older people, along with services that help people adapt their homes and increase use of assistive technology to reside at home for longer
- Adopt an affordable warmth policy which prioritises energy efficiency measures in council accommodation along with access to information and training about how to reduce energy costs and keep the home warm, damp and draught free
- Expand the programme of retrofit measures for SCC properties to improve heating and insulation systems.

1. 2. Violent Crime

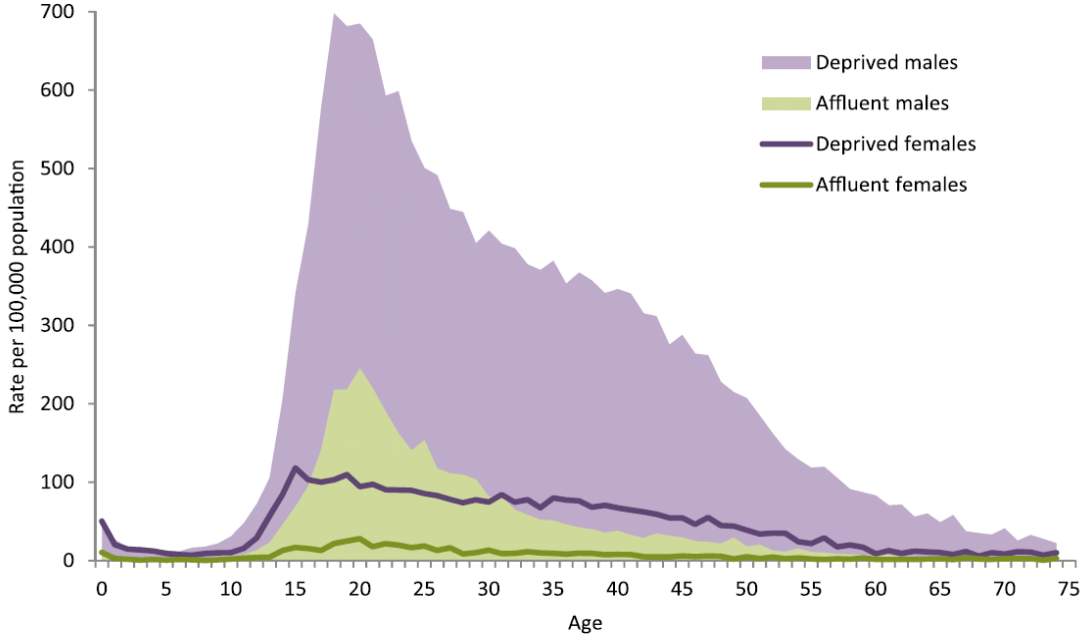
Why is this issue important?

Violence is estimated to cost the NHS £2.9 billion every year. This figure underestimates the total impact of violence on health as, for instance, exposure to violence as a child can increase risks of substance abuse, obesity and illnesses such as cancer and heart disease in later life. The total costs of violence to society are estimated at £29.9 billion per year.[15]

Violence has immediate impacts; firstly the obvious physical and emotional injury but also wider effects on education, employment and housing. In the short term it can also lead to disrupted eating or sleeping patterns and use of alcohol or drugs as a coping mechanism. Fear of violence in the community can limit the use of parks and open spaces for recreation and physical exercise. Longer term impacts of childhood violence include poor educational attainment, reduced economic prospects, behavioural problems, substance misuse and poor physical and mental health. Also, violence is contagious; exposure to violence, especially as a child, makes individuals more likely to be involved in violence in later life.

Violence frequently has a disproportionate impact on older people. Despite the absolute number affected by violence being lower than amongst younger adults and teenagers, the fear of crime and violence for older people can be especially disabling and give rise to significant emotional distress, anxiety and social isolation.

Annual rates of emergency hospital admissions for violence across England, by age, sex and deprivation[16]



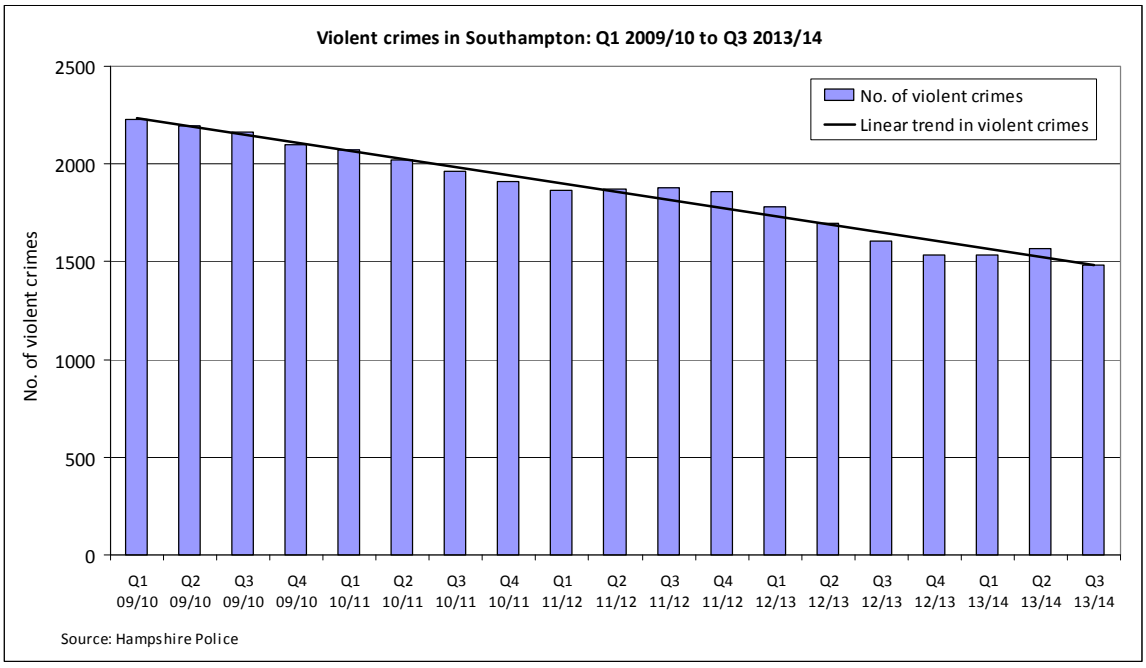
Violence shows one of the strongest inequalities gradients; emergency hospital admission rates for violence are around five times higher in the most deprived communities than in the most affluent (see chart above).

Violence prevention is a critical element in tackling other public health issues. Violence impacts on mental wellbeing and quality of life, prevents people using outdoor space and public transport and inhibits the development of community cohesion

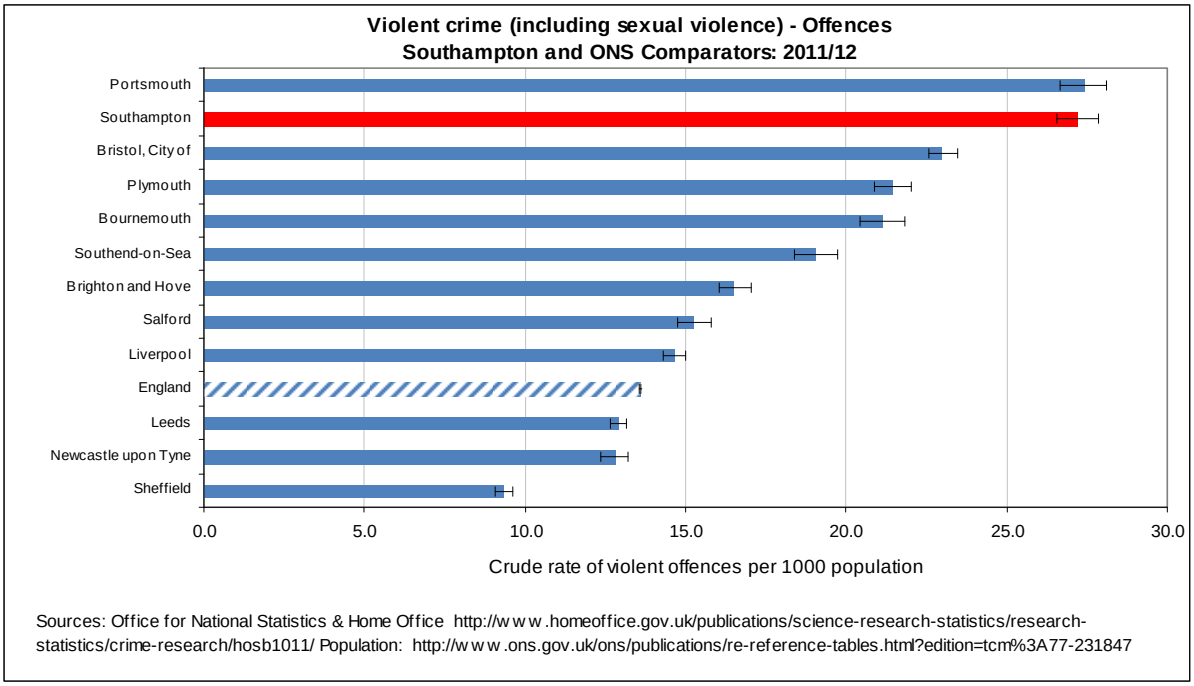
For every hospital admission for violence, a further ten assault victims require treatment at emergency departments (EDs). Violent crime represents, on average, just under a quarter of all crime.

The Southampton Context

The chart below shows that violent crime in Southampton has been declining over the past few years.



However, police recording of violent crime shows rates in Southampton are still very high compared to the national average and other similar authorities (see chart below). Clearly this indicator is subject to variation according to the recording practices of each police force. It is also important to consider that a large proportion of violent crimes are not reported to the police.



Sources: Office for National Statistics & Home Office http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/hosb1011/ Population: http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-231847

In order to better understand the scale of the violent crime problem in Southampton we can also look at other sources such as hospital statistics. During 2009/10-2011/12 the rate of admissions due to violence was higher in Southampton (directly age standardised rate of 92.1 per 100,000) than the national average (67.7 per 100,000). The city rates were also significantly above some of its most similar authorities (e.g. Sheffield, Brighton and Portsmouth) but lower than Leeds, Salford and Liverpool. Hospital admissions generally represent the more serious forms of violence.

The Southampton Community Safety Strategic Assessment[17] identifies the key components of violent crime as:

- Night time economy alcohol-related violence which makes up about 11.5% of all violent crime
- Domestic violence which accounts for 20% of all violent crime
- Serious sexual violence
- Drug related violence

Southampton is a leading city in collecting Emergency Department (ED) data on assaults during peak night time economy periods which are thus linked to predominantly alcohol-related incidents. This data is a valuable indicator as it captures unreported incidents and, therefore, together with police data provides a more accurate picture of the prevalence of alcohol-related violence in the city. ED assault data (between the hours of 6pm and 9am) show a fall from 862 presentations in 2011 to 758 in 2012, a 12% reduction.

There were 196 sexual offences reported to police in the Southampton 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. Although the number of recorded crimes of this type 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.

With respect to drug crime, 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. There are currently 24 overt investigations and 10 networks believed to be at increased risk of committing drug-related violence within the city.

Victims of violence are more likely to become perpetrators of violence so it is worrying that in a recent survey of Southampton school pupils over 30% of those respondents from years 4 and 6 had been bullied.

What can be done?
Much is already being done in the city to reduce violent crime and its impacts:-

- 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 (In Case of Emergency) Bus. In addition the Licensing Trade, supported by SCC and the Police has introduced the Red Card scheme.
- The ICE Bus has been in operation since December 2009 and has dealt with over 1,300 clients.

- 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.

- Over the last year the number of volunteers who are now patrolling as Street Pastors has increased. They continue to patrol the Night Time Economy every Friday and Saturday between 22:00 and 04:00, as well as one Tuesday a month.
- In May 2012 Hampshire Constabulary launched Operation Fortress, a two-year programme to reduce the harm of organised and violent crime linked to drugs in Southampton. The programme worked closely with partner agencies, and has successfully targeted dealers and the drug supply chain, specifically those that engaged in violent and exploitative behaviours. Numerous arrests and prosecutions have resulted, a local crack house has been closed and a significant amount of drugs and money has been recovered in this period.

There are other prevention approaches to violence which could be adopted in Southampton. For instance, interventions that develop parenting skills, support families and strengthen relationships between parents, carers and children can have long lasting violence prevention benefits. Such interventions are cost-effective; they can prevent child abuse and improve child behaviour, reducing children's risks of involvement in violence in later life.[15]

Delinquent behaviour, criminal activity and gang membership in youth are key risk factors for involvement in violence. Interventions that work with high risk youth to change their behaviour can be important in preventing future violence.

The consumption of alcohol is strongly associated with violence. Measures to limit access to alcohol and reduce alcohol consumption among hazardous and harmful drinkers can have important violence prevention impacts. The criminal justice system does direct offenders into addiction treatment (both alcohol and drugs) on discharge from court or prison, but the widespread availability of low cost alcohol, and a culture that supports binge drinking and excess alcohol use perpetuates the problem and makes prevention difficult.

Pricing of alcohol affects consumption; based on a review of the evidence, the former Chief Medical Officer for England recommended a minimum price of 50p per unit in his 2008 Annual Report[18].

Community interventions are important including neighbourhood infrastructure and access to green space. It is also crucial to offer care and support to the victims of violence to break the cycle.

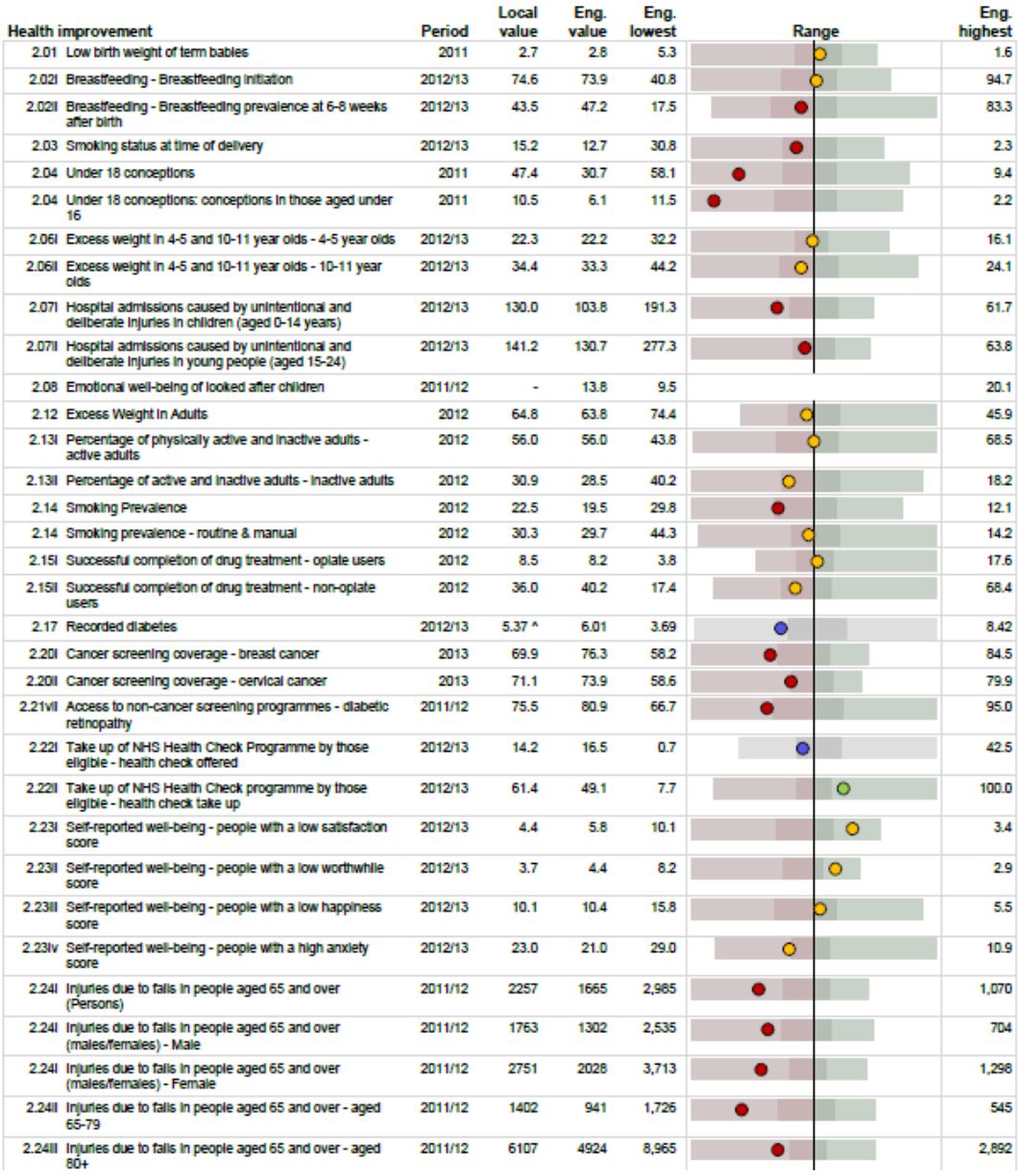
Through the Health and Social Care Act, Directors of Public Health in local authorities are responsible for the public health aspects of the promotion of community safety, violence prevention, responses to violence, and local initiatives to tackle social exclusion.

Key Recommendations

- Increase violence prevention measures such as family support and community action
- Explore the potential of the late night levy (a way licensing authorities can raise a contribution from late-opening alcohol suppliers towards policing the night-time economy (Police Reform and Social Responsibility Act 2011)
- Work with schools to raise awareness on anti bullying and 'youth on youth' violence
- Promote safe drinking awareness with teenagers and young adults in areas where high rates of violence occur
- Increase access to alcohol treatment for those that drink harmful levels of alcohol, and target individuals who cause alcohol offenses
- Continue advocacy and lobbying on minimum pricing for alcohol

Theme 2: Health lifestyles

This section examines the health improvement domain of the PHOF which covers 30 outcome areas relating to healthy lifestyle choices and mental wellbeing across the life course.



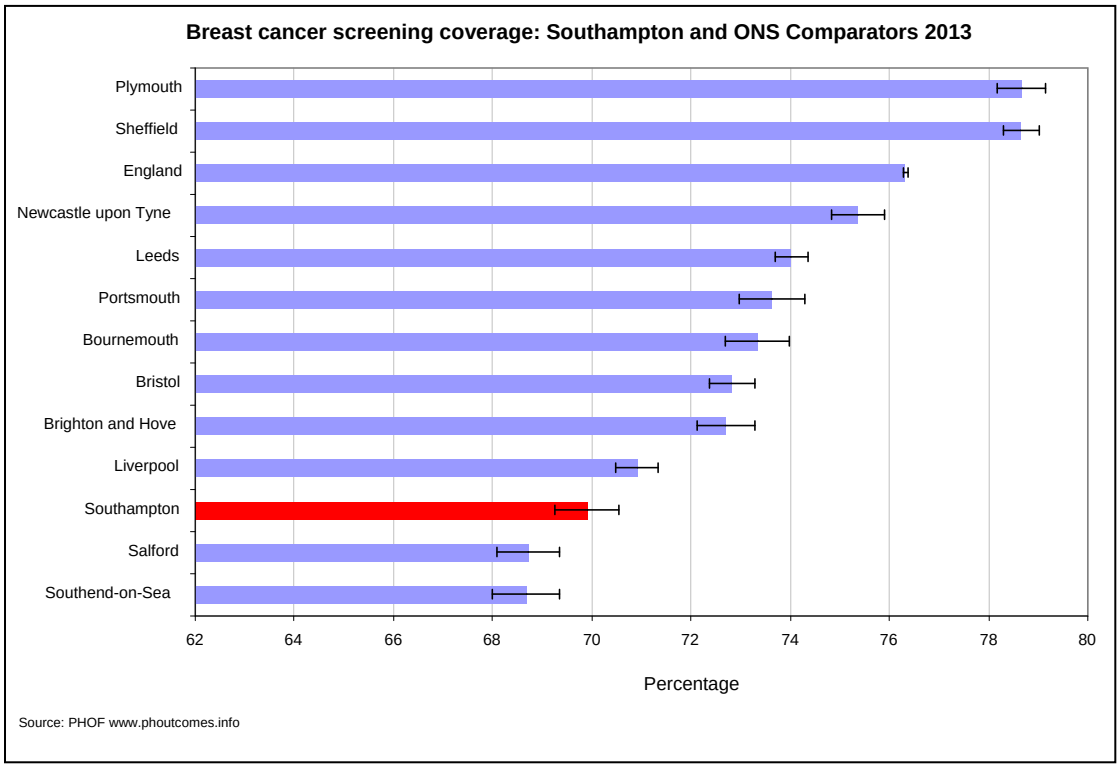
Health improvement	Period	Local value	Eng. value	Eng. lowest	Range	Eng. highest
2.01 Low birth weight of term babies	2011	2.7	2.8	5.3		1.6
2.02i Breastfeeding - Breastfeeding initiation	2012/13	74.6	73.9	40.8		94.7
2.02ii Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth	2012/13	43.5	47.2	17.5		83.3
2.03 Smoking status at time of delivery	2012/13	15.2	12.7	30.8		2.3
2.04 Under 18 conceptions	2011	47.4	30.7	58.1		9.4
2.04 Under 18 conceptions: conceptions in those aged under 16	2011	10.5	6.1	11.5		2.2
2.06i Excess weight in 4-5 and 10-11 year olds - 4-5 year olds	2012/13	22.3	22.2	32.2		16.1
2.06ii Excess weight in 4-5 and 10-11 year olds - 10-11 year olds	2012/13	34.4	33.3	44.2		24.1
2.07i Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2012/13	130.0	103.8	191.3		61.7
2.07ii Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)	2012/13	141.2	130.7	277.3		63.8
2.08 Emotional well-being of looked after children	2011/12	-	13.8	9.5		20.1
2.12 Excess Weight in Adults	2012	64.8	63.8	74.4		45.9
2.13i Percentage of physically active and inactive adults - active adults	2012	56.0	56.0	43.8		68.5
2.13ii Percentage of active and inactive adults - inactive adults	2012	30.9	28.5	40.2		18.2
2.14 Smoking Prevalence	2012	22.5	19.5	29.8		12.1
2.14 Smoking prevalence - routine & manual	2012	30.3	29.7	44.3		14.2
2.15i Successful completion of drug treatment - opiate users	2012	8.5	8.2	3.8		17.6
2.15ii Successful completion of drug treatment - non-opiate users	2012	36.0	40.2	17.4		68.4
2.17 Recorded diabetes	2012/13	5.37 ^	6.01	3.69		8.42
2.20i Cancer screening coverage - breast cancer	2013	69.9	76.3	58.2		84.5
2.20ii Cancer screening coverage - cervical cancer	2013	71.1	73.9	58.6		79.9
2.21vii Access to non-cancer screening programmes - diabetic retinopathy	2011/12	75.5	80.9	66.7		95.0
2.22i Take up of NHS Health Check Programme by those eligible - health check offered	2012/13	14.2	16.5	0.7		42.5
2.22ii Take up of NHS Health Check programme by those eligible - health check take up	2012/13	61.4	49.1	7.7		100.0
2.23i Self-reported well-being - people with a low satisfaction score	2012/13	4.4	5.8	10.1		3.4
2.23ii Self-reported well-being - people with a low worthwhile score	2012/13	3.7	4.4	8.2		2.9
2.23iii Self-reported well-being - people with a low happiness score	2012/13	10.1	10.4	15.8		5.5
2.23iv Self-reported well-being - people with a high anxiety score	2012/13	23.0	21.0	29.0		10.9
2.24i Injuries due to falls in people aged 65 and over (Persons)	2011/12	2257	1665	2,985		1,070
2.24i Injuries due to falls in people aged 65 and over (males/females) - Male	2011/12	1763	1302	2,535		704
2.24i Injuries due to falls in people aged 65 and over (males/females) - Female	2011/12	2751	2028	3,713		1,298
2.24ii Injuries due to falls in people aged 65 and over - aged 65-79	2011/12	1402	941	1,726		545
2.24iii Injuries due to falls in people aged 65 and over - aged 80+	2011/12	6107	4924	8,965		2,892

The foundations for virtually every aspect of human development – physical, intellectual and emotional are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and wellbeing[19].

In Southampton many outcomes for children and young people are poor. For instance, injuries to children are an issue and teenage conceptions are very high in the city (a matter which is covered in more detail in Section 3.2 on Sexual Health).

Adult smoking prevalence and smoking in pregnancy are higher than the national average and in a recent, local school survey over 46% of children surveyed said that one or both of their parents smoke[20]. Section 2.1 of this report explores the issues around smoking and what can be done.

Amongst adults PHOF monitors uptake of the NHS Health Check programme which was described in last year's report[21] as well as screening programmes. Southampton has poorer uptake of breast cancer, cervical cancer and diabetic retinopathy screening rates than nationally (see chart below).



2. 1. Smoking

Why is this issue important?

Smoking remains the main cause of preventable death in England, and is a major cause of health inequalities. There is a high cost from smoking both to individuals and local economies, causing nearly 80,000 deaths in England during 2011[22]. Smoking harms nearly every organ of the body and dramatically reduces both quality of life and life expectancy. Smoking impacts on the families of smokers; every year in the UK second hand smoke results in over 20,000 cases of lower respiratory tract infection, 120,000 cases of middle ear disease and around 9,500 admissions to hospital[23].

The Southampton Context

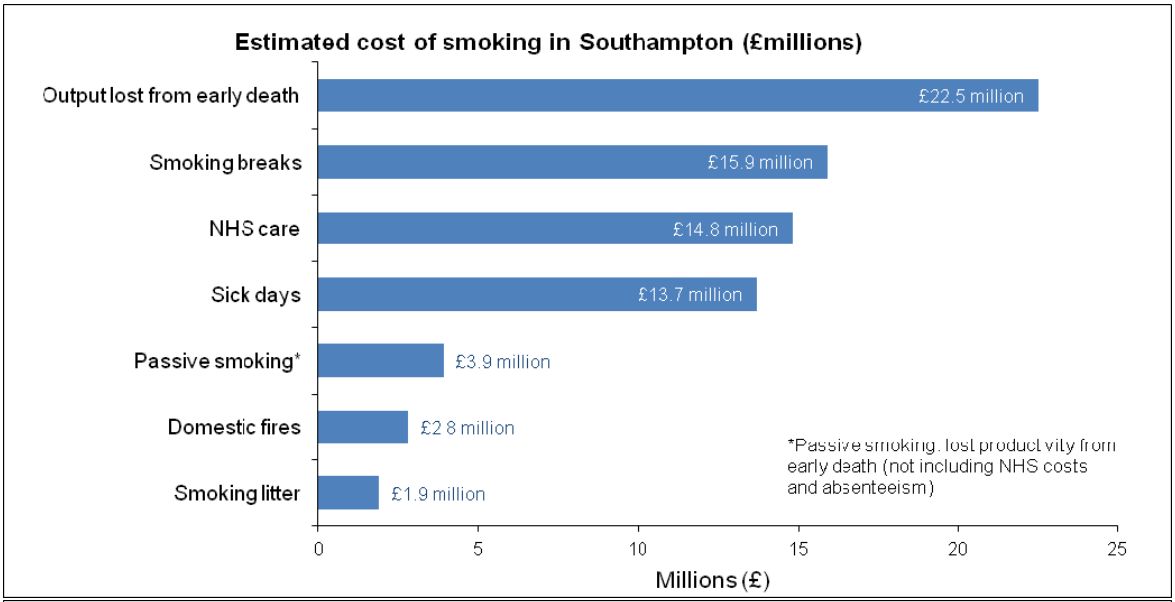
Nearly one quarter of people still smoke in Southampton. Compared to the national picture where smoking prevalence has decreased to 20%, prevalence in Southampton is 22.6%. More people die in Southampton as a result of smoking than the national average (age standardised rate of 234 per 100 000, compared to 201 in England), and deaths from lung cancer and chronic obstructive pulmonary disease are also higher than the national average.

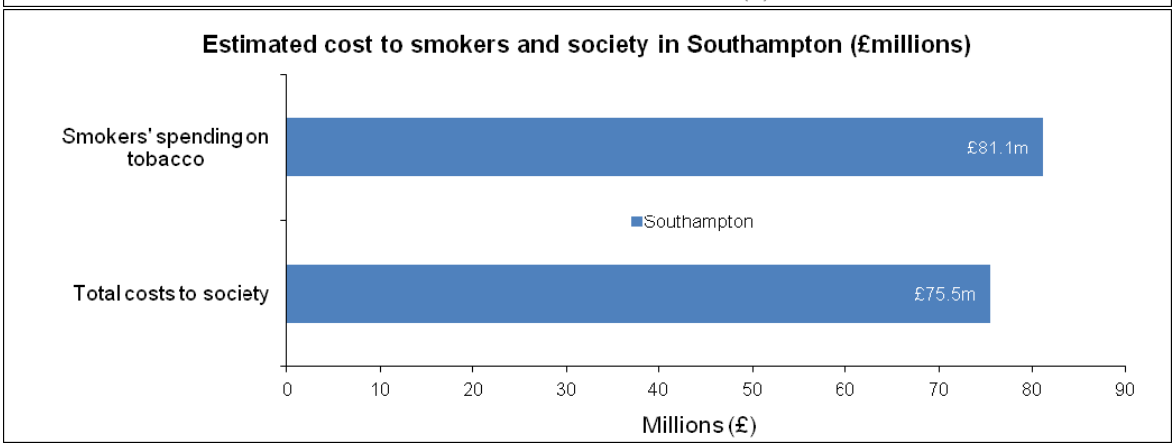
Southampton's Health and Wellbeing Strategy[24] has identified smoking as one of the key challenges in the city to be addressed. For this reason there continues to be investment in helping smokers to quit, educating young people about the dangers of smoking and prevention of long term conditions by reducing the harmful effects of tobacco. An estimated 870 children start smoking each year in the city[25].

We know that smoking is a major cause of health inequalities and that prevalence rates vary across the city, with the highest rates estimated to be in Redbridge, Weston and Thornhill. Hospital admissions due to smoking are higher than the national average, and the highest rates are in Bitterne and Redbridge wards (2426 per 100,000 and 2369 per 100,000 respectively for 2009/10 - 2011/12) compared to the city average of 1747 per 100,000. Smoking rates are higher amongst the city's routine and manual classes at 36.8% compared to the national average of 30.3%[26]. Smoking in pregnancy rates are also higher than average at 16.6%, compared to the national average of 13.2%.

Smoking in Southampton is estimated to cost our population £70.9m annually[27]. Someone smoking 20 cigarettes a day spends £2555 a year on tobacco (based on the average cost of £7 a pack). Local employers and businesses lose from increased sickness, and an estimated £81.1m annually is lost to Southampton's local economy by spending on cigarettes and tobacco. Around £1.9m is spent by SCC each year on picking up litter from tobacco products.

The cost of smoking in Southampton (Action on Smoking and Health, 2013)[27]





What can be done?

There are some positive actions that can be taken and smoking is now one of the key priorities of the Health and Wellbeing Strategy. SCC has shown its commitment to reducing the harm done by tobacco by joining the Smoke Free Action Coalition in October 2013. We do need to do better in this area and the Council is currently developing its first Tobacco Control Plan to support this work, outlining key priorities for 2014-2016 to reduce the harmful effects of tobacco in the city.

The key work streams of the Tobacco Control Plan are:

1. Stopping the promotion of tobacco

Supporting the work of Trading Standards and Environmental Health, in partnership with the local business community, to ensure compliance with legislation in local businesses.

2. Effective regulation of tobacco products

Partnership working with Trading standards, Police and HMRC to improve local intelligence on illicit tobacco to control smuggled and counterfeit tobacco. Local

authority support for the Local Government Declaration on Tobacco Control, and the campaign for plain standardised tobacco packaging through the Smoke Free Action Coalition.

3. Helping tobacco users to quit

Commissioning specialist services to support all smokers wanting to quit ensuring open access, and in particular:

- Pregnant women who smoke
  Ensuring that local Maternity services actively work alongside other partners to reduce smoking rates among pregnant women
- Young people
  Building on existing work to deliver targeted evidence-based interventions to ensure all schools in the city comply with legislation and have smoke free policies in place, and in addition the delivery of educational and quitting programmes in schools and colleges.

4. Reducing exposure to second hand smoke, especially children

Promotion of smoke free environments and raising awareness of the harm caused by tobacco through smoke free homes campaign work with Sure Start Children Centres and Early Years settings.

5. Effective communications for tobacco

Ensuring a robust approach to working with the media, communications and public education about smoking by harnessing local authority communications and delivering local support for key national campaigns, such as Stop Smoking Day in March, Stoptober and Smokefree homes.

Quote from a Stoptober participant…

"My family had nagged me to give up for a long time and my daughter had me on a 'reduction' programme earlier this year, so the next step for me was definitely Stoptober. I had support from a Public Health Practitioner and went to Quitters for advice and nicotine replacement therapy before the big day. Throughout October I also attended weekly Quitters sessions. I made it through Stoptober and have now gone for nearly 2 months without a cigarette . I highly recommend it!! It's not been easy but I now have more money and can run further, I've stopped coughing and generally feel fitter. I still can't believe I've quit - it feels great. Thanks to Stoptober and everyone else who supported me."

Key Recommendations

- Adoption and implementation of the SCC Tobacco control plan
- Continued investment to tackle smoking with young people
- Investment to support work with families on smoke free homes and cars
- Support for the implementation of NICE recommendation for routine carbon monoxide screening for all pregnant women in maternity settings (http://guidance.nice.org.uk/PH26)

2. 2. Happiness

Why is this issue important?

In recent years there have been substantial advances in the science of wellbeing with increasing evidence as to the factors that affect happiness and new ways of measuring happiness more accurately. We now have the opportunity to use this evidence to increase wellbeing in our personal lives, workplaces, schools and communities.

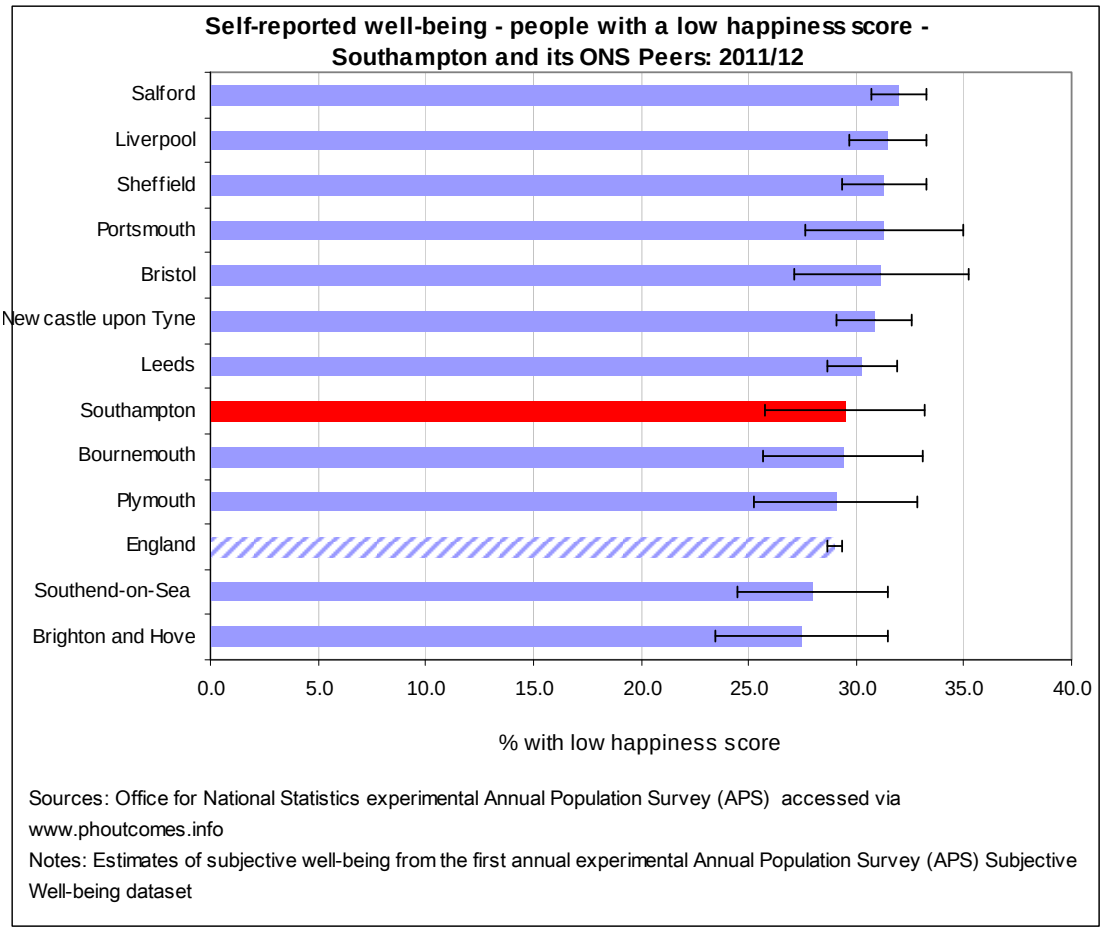
Added to this is an emerging body of proof showing a link between positive emotions, happiness and our state of health right across the life course. In childhood issues such as neglect, violence or living in poor accommodation can affect the developing brain and other organ systems, which can lead to a faster heart rate, higher blood pressure and a rise in stress hormones. Anxiety or depression increases the risk of dying in people with heart disease. Loneliness and social isolation can have a major impact on older people's health.

Financial difficulties have a profound impact on happiness and wellbeing. Mental health is affected by the psychological effects of low income and unemployment as well as by the material consequences of financial pressures. The global economic downturn plus the impact of benefit reforms in this country are likely to have a significant impact on the population's wellbeing.

The Southampton context and challenges

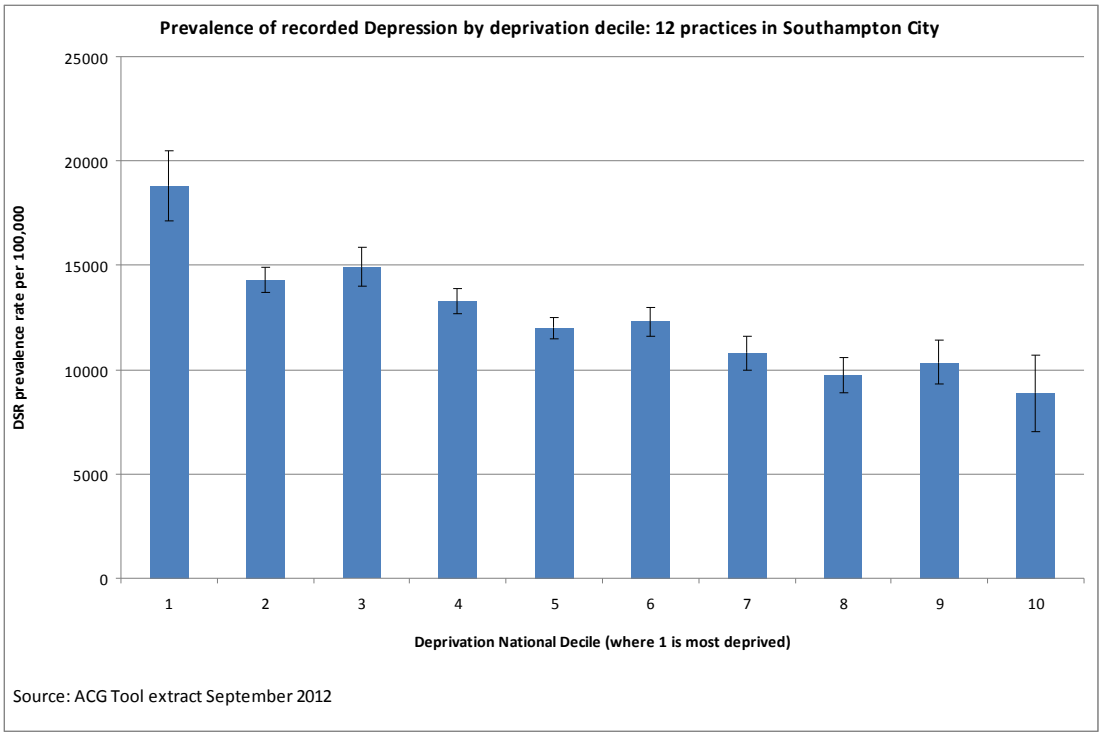
The Office of National Statistics (ONS) started to measure 'how society is doing' in 2010[28] when there was recognition that measures such as Gross Domestic Product were inadequate as indicators of the state of the nation. The new national measures were designed to assist the government in developing positive policies to improve wellbeing. According to the UK's statisticians the factors most associated with personal wellbeing are health, employment and relationship status.

The graph below shows how Southampton compares to its statistical neighbours in terms of self reported wellbeing – people with a low happiness score. The city value is close to the national average.



This overall measure masks persistent health inequalities in the City and the number of people living with a severe mental illness is higher than the rate for England; these issues clearly have an impact on the physical health and wellbeing of those affected and their families.

Data from 12 GP practices in Southampton has been analysed to show how more deprived areas have higher rates of recorded depression even after age has been accounted for (see chart below).



A recent survey of school children in Southampton used a 'happiness scale' developed by Ofsted[29] in consultation with children and young people. The survey found that 12.7% of children surveyed in Year 4 had a score of 'unhappy' rising to 17.6% amongst children surveyed from Years 9 and 11.

According to a study carried out for the Office for National Statistics in 2004/05[30] one in ten children aged 5 to 16 has a clinically significant mental health problem. Research has identified two main dimensions termed resilience and risk factors that influence whether a child is likely to develop mental health problems.

- Resilience refers to protective factors enabling some children to cope
- Risk factors increase the probability of a child developing a mental health problem.

There is a growing evidence base around building on the protective factors which enable children to become more resilient in order to promote mental health[31].

In Southampton welfare reforms are estimated to result in an overall financial impact of £53 million in 2015/16 which equates to 34,157 households having an average loss of £1,551 per year[32]. The impacts of these changes on mental wellbeing are likely to be significant.

What can be done?

The return of public health to local authorities brings with it greater opportunities to improve wellbeing by tackling health inequalities and supporting innovative partnerships and plans to improve peoples health and wellbeing.

The 'Be Well' Public Mental Health and Wellbeing Strategy for Southampton[33] identified ten key areas, based on local need, that seek to improve people's wellbeing over the next three years. At the heart of this strategy are the Five Ways to Wellbeing[34].

Five Ways to Wellbeing:

1 Be Connected – try and find ways to connect with the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your community. Building these connections will support and enrich you every day.

2 Be Active – go for a walk or run. Step outside. Cycle, play a game, garden, dance. Exercising makes you feel good. Discover an activity you enjoy that suits your level of fitness.

3 Be Curious – Explore what is going on around you, notice the changing seasons. Reflecting on your experiences will help you appreciate what matters to you.

4 Be Keen to learn new things: – Sign up for that course, learn to cook your favourite food or play a musical instrument. Learning new things will make you feel more confident as well as having fun.

5 Be Helpful – do something nice for someone. Thank someone. Volunteer your time, join a community group. Seeing yourself and your happiness links to the wider community, can be rewarding and creates connections with people around you.

There are also a number of local initiatives in the City that aim to reduce negative factors, build resilience and improve people's wellbeing across the life course. These can relate directly to mental health such as the Emotional First Aid courses being delivered in all Southampton Secondary Schools and the "Talking Therapies" service for people with anxiety and depression; through to partnership approaches that seek to address the negative impacts of the economic downturn, job losses and benefit changes.

The Supported Housing Volunteers scheme provides activities for more than 600 people in the city which enrich the lives of the recipients and the volunteers alike. The activities include lunch clubs, music sessions, technology workshops and day trips. Marge (pictured) is an 81 year old volunteer whose involvement in the scheme has had a really positive impact on her mental and physical wellbeing. Marge says that if it were not for the volunteering she does and the inclusion with local community she would be far less happy.

Recommendations

- Adopt a public health approach in the development of strategies which promote wellbeing for the whole population including activities which build social capital and community resilience
- Develop and deliver an anti-stigma work stream that reduces the discrimination experienced by people with mental health issues
- Continue to publicise and promote the five ways to wellbeing across the City
- Expand and develop the successful local emotional first aid programme so that more young people, families and school communities benefit from this approach to mental health resilience.

Theme 3: Protection from health threats

The third theme of this report, and of the PHOF, is concerned with protecting the population's health from major infectious diseases and environmental threats to health. The reduction of the infectious disease burden, through improved hygiene, vaccination and antibiotics, has been one of the success stories of the 20th century. Yet, infectious disease is still a major problem, accounting for 10% of the NHS budget[35].

The recent update of the 'protecting people' theme in the Southampton JSNA covered all aspects of infectious diseases including Port Health and immunisation information. The JSNA also now includes more detail about environmental health and trading standards in the city plus emergency planning for major incidents and extreme weather.

In the PHOF, Southampton's performance in this theme is generally similar to the national average although Chlamydia diagnosis rates are significantly lower and this is discussed further in Section 3.1 on Sexual Health.

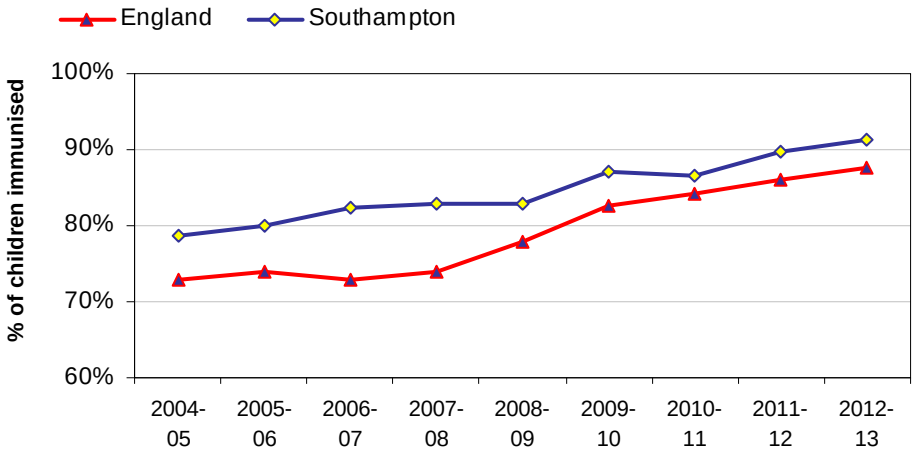
	Health protection	Period	Local value	Eng. value	Eng. lowest	Range	Eng. highest
3.01	Fraction of mortality attributable to particulate air pollution	2011	6.3	5.4	3.0		8.3
3.02i	Chlamydia diagnoses (15-24 year olds) - Old NCSP data	2011	2098	2125	783		5,995
3.02ii	Chlamydia diagnoses (15-24 year olds) - CTAD - Female	2012	1880	2568	987		7,314
3.02ii	Chlamydia diagnoses (15-24 year olds) - CTAD	2012	1500	1979	703		6,132
3.02ii	Chlamydia diagnoses (15-24 year olds) - CTAD - Male	2012	1137	1368	383		4,364
3.03i	Population vaccination coverage - Hepatitis B (1 year old)	2012/13	100 ^	-	-		-
3.03i	Population vaccination coverage - Hepatitis B (2 years old)	2012/13	81.8 ^	-	-		-
3.03iii	Population vaccination coverage - Dtap / IPV / Hib (1 year old)	2012/13	95.3 ^	94.7	79.0		99.0
3.03iii	Population vaccination coverage - Dtap / IPV / Hib (2 years old)	2012/13	97.0 ^	96.3	81.9		99.4
3.03iv	Population vaccination coverage - MenC	2012/13	94.3 ^	93.9	75.9		98.8
3.03v	Population vaccination coverage - PCV	2012/13	94.9 ^	94.4	78.7		99.0
3.03vi	Population vaccination coverage - Hib / MenC booster (2 years old)	2012/13	93.1 ^	92.7	77.0		98.3
3.03vi	Population vaccination coverage - Hib / Men C booster (5 years)	2012/13	90.5 ^	91.5	75.7		98.1
3.03vii	Population vaccination coverage - PCV booster	2012/13	94.6 ^	92.5	75.1		97.5
3.03viii	Population vaccination coverage - MMR for one dose (2 years old)	2012/13	94.1 ^	92.3	77.4		98.4
3.03ix	Population vaccination coverage - MMR for one dose (5 years old)	2012/13	95.3 ^	93.9	82.1		98.3
3.03x	Population vaccination coverage - MMR for two doses (5 years old)	2012/13	91.2 ^	87.7	68.9		97.0
3.03xii	Population vaccination coverage - HPV	2012/13	89.1 ^	86.1	62.1		96.2
3.03xiii	Population vaccination coverage - PPV	2012/13	70.5 ^	69.1	55.3		77.0
3.03xiv	Population vaccination coverage - Flu (aged 65+)	2012/13	75.5 ^	73.4	65.5		80.8
3.03xv	Population vaccination coverage - Flu (at risk individuals)	2012/13	53.2 ^	51.3	44.2		68.8
3.04	People presenting with HIV at a late stage of infection	2010 - 12	48.9	48.3	0.0		80.0
3.05i	Treatment completion for TB	2012	88.2	82.8	22.6		100.0
3.05ii	Incidence of TB	2010 - 12	16.5	15.1	0.0		112.3
3.06	Public sector organisations with a board approved sustainable development management plan	2011/12	75.0	84.1	20		100

Vaccination is a way of protecting the whole population. If enough people in a community are vaccinated it becomes harder for the disease to pass between those

who have not been vaccinated. This is called 'herd immunity'. The proportion of people who have to be vaccinated to achieve herd immunity varies depending on the characteristics of the disease and the effectiveness of the vaccine.

Before immunisation programmes began, measles claimed approximately 1000 lives in the UK each year[35]. For measles the UK recommendation is that at least 95% of children should have the MMR vaccine before age two and a booster before age five to achieve herd immunity and prevent outbreaks. The chart shows that vaccination rates have increased over the past few years and the Southampton rate is higher than the national average but remains below the 95% threshold.

MMR: Coverage at Age 5 2004/05-2012/13



Data Source: NHS Immunisation Statistics

There have been no confirmed measles cases in Southampton since March 2010 but a drop in coverage rates nationally in the late 1990's and early 2000's (when concern around the discredited link between autism and the vaccine was widespread) means the potential for cases and outbreaks is at its highest. This has led to a national programme to 'catch-up' children in the age range 11-16 years.

This year has seen the introduction of several new vaccination schedules including a new shingles vaccine for people aged 70 to 79 and a new oral vaccine for babies to protect against rotavirus, a common cause of diarrhoea and sickness, there is more about this in Section 3.2 on Common Infections.

3. 1. Sexual health

Why is this issue important to health?

Most adults in England are sexually active but despite this, sexual health remains a sensitive subject which many find difficult to talk about. This can affect how people access good quality information about sexual health and how they access services. This is particularly important for some groups who experience disproportionately worse sexual health. For example, we know that men who have sex with men and some black and ethnic minority groups are at considerably higher risk of poor sexual health.

Reducing sexually transmitted infections (STIs) and avoiding unwanted pregnancies are two key goals within the wider context of promoting a sexually healthy population. STIs affect health in different ways, from the minor inconvenience of taking antibiotics to long term chronic illness or infertility. Unplanned pregnancies can have significant health and emotional impacts on the individual, particularly young people, but are also an important societal issue when costs of terminations and supporting vulnerable parents are taken into account.

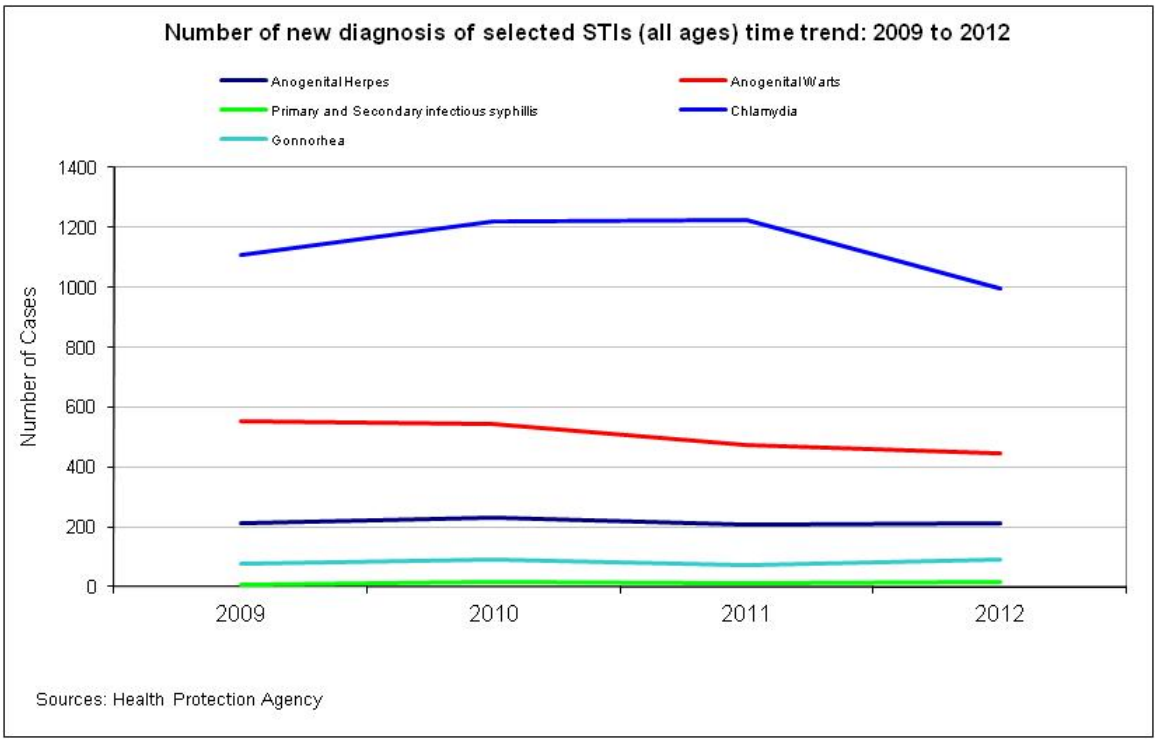
The PHOF contains three indicators specific to sexual health, highlighting the need to continue and sustain efforts in these areas:

1. Chlamydia diagnoses
2. People presenting with HIV at a late stage of infection
3. Under 18 conceptions

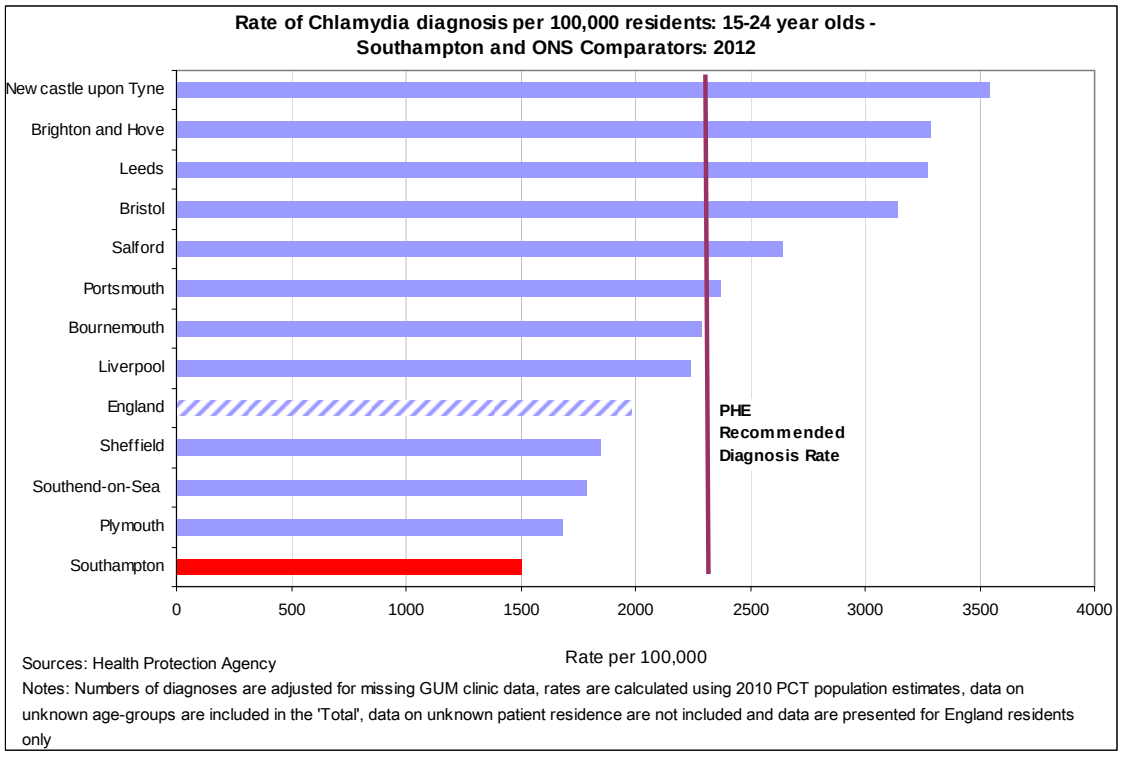
Southampton context and challenges

<u>STIs</u>

Southampton is ranked 43 out of 326 local authorities in England for rates of acute STIs, (where 1 has the highest rates). The most commonly diagnosed STI is chlamydia, followed by anogenital warts and herpes (see chart below). Although the incidence of syphilis and gonorrhoea is lower than the other STIs, they are important infections because we know that a relatively high proportion of men who have sex with men are affected.



In 2012, the rate of chlamydia diagnoses per 100,000 young people aged 15-24 in Southampton was 1,500. We have a considerable challenge to achieve the diagnosis rate of 2,300 recommended by Public Health England and a delivery plan is in place locally to increase the rate of positive tests. This plan aims to embed chlamydia screening in sexual health services, general practice, pharmacies and antenatal services, as well as target those who might be at particular risk of sexually transmitted infections through outreach testing.



HIV

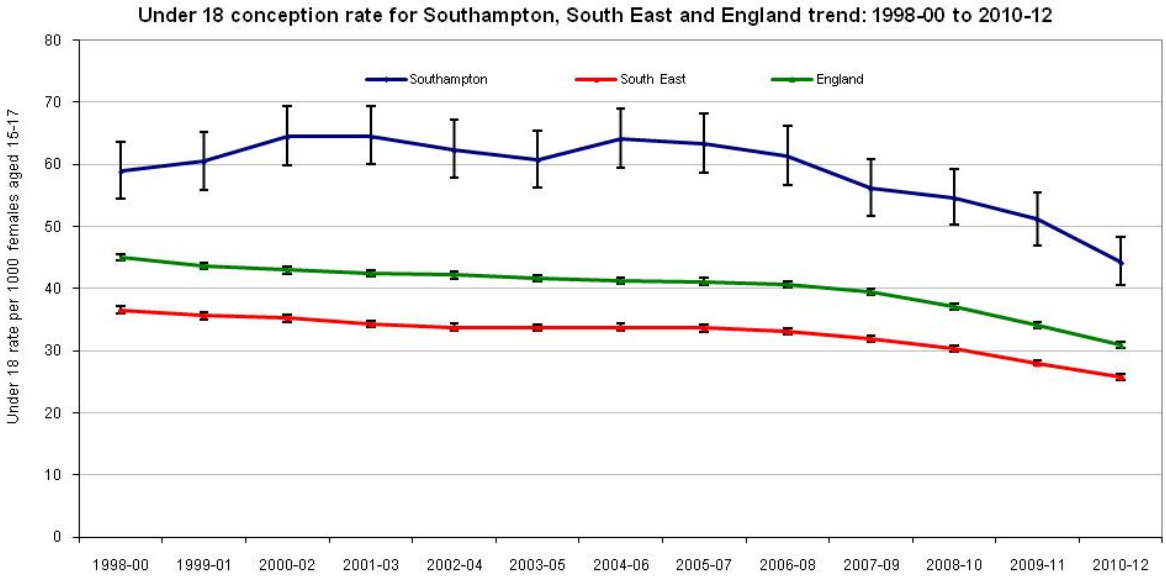
Delayed identification and treatment for HIV is associated with higher morbidity and short-term mortality. For this reason, we monitor the proportion of HIV diagnoses that are made at a late stage of infection (where the CD4 count is less than 350 cells/mm^3). In Southampton, around half of all HIV diagnoses are made at a late stage, which is very similar to the national average.

In 2012, the HIV prevalence in Southampton was 1.95 per 1,000 population compared to 2.05 per 1,000 in England. If the prevalence rises above 2.0 per 1,000, national recommendations state that routine HIV testing should be implemented for all general medical admissions and for all new registrants in primary care.

Teenage conceptions

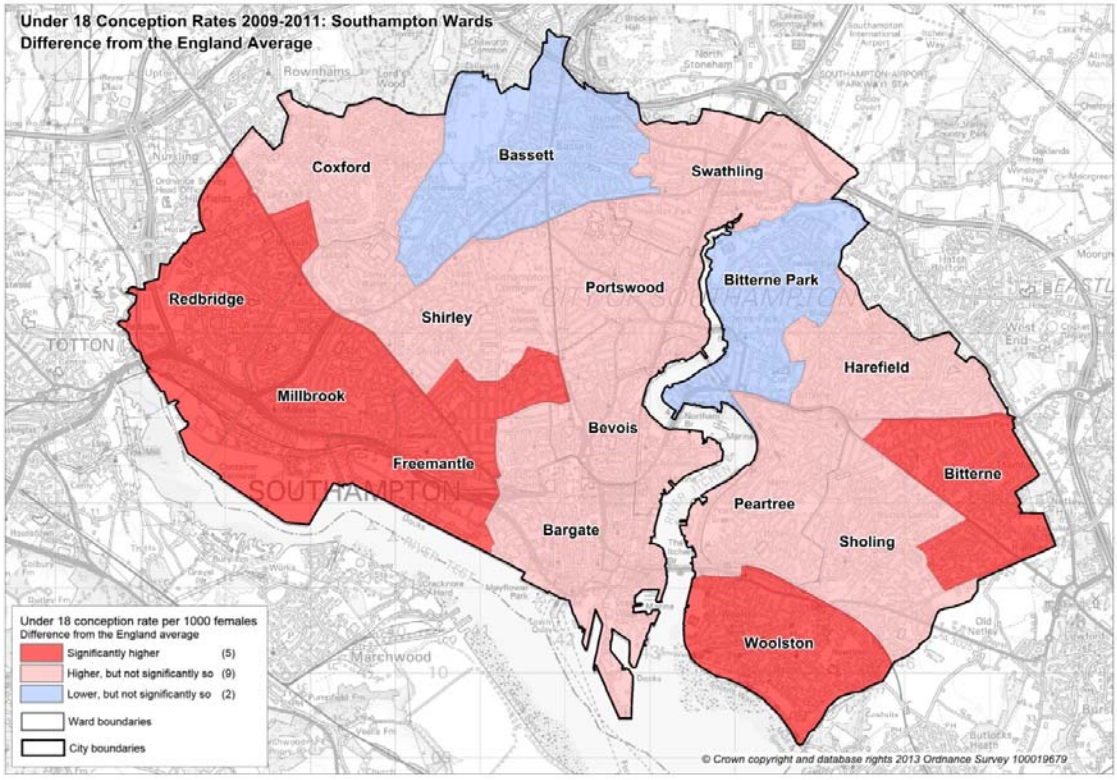
For most young women who become pregnant under the age of 18, this is an unintentional consequence of sexual relationships. National data suggests that around three quarters of teenage pregnancies are unplanned and half end in abortion. Unfortunately, teenage parents experience poor outcomes in education and employment and are at risk of economic difficulties and mental health problems. In addition, the children of teenage parents are also vulnerable to health and social problems; they are at a higher risk of infant mortality, poor health, low educational attainment and growing up in poverty.

Although under 18 conceptions have decreased in Southampton over the last decade, they remain significantly higher than rates for both England and the South East (see chart below). The rate of decline had been slower in Southampton than in England, the South East, and most of its statistical neighbours but this has improved in recent years.



Source: Office for National Statistics and Teenage Pregnancy Unit, Crown Copyright.
Notes: Rates are per 1000 female population aged 15-17.

At ward level, Redbridge, Millbrook, Freemantle, Woolston and Bitterne have under 18 conception rates that are significantly higher than the England average.



The under 16 conception rate in Southampton is of particular concern. In 2011, Southampton had an under 16 conception rate of 10.5 per 1,000 females aged 13-15, ranking the city in the seventh worst position in England. In 2012, the under 16 conception rate decreased but remains significantly higher than the South East and England. While the under 16 conception rate is based on small numbers and therefore subject to annual variation, the relatively high rate in Southampton alerts us to the critical importance of focussing efforts and resources on reducing unplanned pregnancies, particularly in this younger age group.

What can be done about it

Since April 2013, the commissioning arrangements for sexual health services have changed significantly. SCC is now responsible for many aspects of sexual health services but the Southampton Clinical Commissioning Group and NHS England also have a role. These changes have given us a timely opportunity to review sexual health in Southampton and identify how we can work together to improve outcomes for our population.

The reasons behind sexual risk taking which could lead to unplanned pregnancy or the acquisition of sexually transmitted infections are complex, and influenced by a combination of behavioural, familial and social factors. Despite this, we know that two key approaches can help reduce the risk:

1. The provision of high quality sex and relationship education for all young people, including targeted work with vulnerable groups, with clear links to contraceptive and sexual health services
2. Good access to all methods of contraception, including long acting reversible contraception and condoms, for all ages.

In 2014, we will be launching a new sexual health strategy for Southampton which will set out how we will work together to improve sexual health in the city. We want this strategy to underpin accessible, effective and integrated sexual health education, advice and services which help us to:

- reduce STIs
- avoid unwanted pregnancies
- reduce inequalities in sexual health
- promote healthy sexual relationships

Recommendations

- Continue commitment to invest in sexual health services across the city
- Promote STI and HIV testing in a variety of settings
- Strategic coordination of school-based sex and relationship education
- Multi disciplinary engagement in the new sexual health strategy

3. 2. Common infectious diseases

Why is this issue important?

All infectious diseases are potentially preventable. Better living conditions, improvements in sanitation and hygiene, mass vaccination and improvements in medical treatments have resulted in decreases in infectious disease in England for several decades.

However, infectious disease is still a significant issue; for instance, around 50% of children's GP consultations are for infectious diseases[35]. People who have underlying health problems, compromised immune systems and the youngest and eldest in our community are the most vulnerable to the complications of infectious disease. Infectious disease is a marker for social and economic disadvantage. Those people who are worse off economically experience higher rates of disease and poor outcomes.

Two of the most common infectious diseases are respiratory and gastrointestinal infections. Respiratory infections, particularly pneumonia and exacerbations of chronic bronchitis, are the leading cause of infectious disease mortality and morbidity, particularly among the elderly and those with underlying chronic disease. Influenza or 'flu' is a respiratory illness associated with infection by influenza virus. Symptoms frequently include headache, fever, cough, sore throat, aching muscles and joints. There is a wide spectrum of severity of illness ranging from minor symptoms through to pneumonia and death.

Gastrointestinal infections are a major cause of potentially preventable illness, and cause outbreaks in both community and healthcare settings. Every year in the UK there are an estimated 17 million cases, affecting around 25% of the population, leading to about a million GP consultations and nearly 19 million days lost from school or work[36].

Gastrointestinal infection due to verocytotoxin producing E. coli (VTEC) can be fatal, particularly in young children or the elderly, and is the commonest cause of acute kidney failure in children, complicating approximately 10% of reported infections each year. Every year, particularly in the winter months, outbreaks of norovirus infection result in closures of hospital wards, with a significant impact on the healthcare system.

The economic burden from infectious diseases in England, including costs to the health service, to the labour market and to individuals themselves, is estimated at £30 billion each year, with a large proportion of these costs incurred because of respiratory or gastrointestinal infections.

The Southampton Context

Surveillance of infectious diseases is undertaken by Public Health England. Notification of infectious disease will underestimate the true number of cases. It has been estimated that for each reported case of gastrointestinal infection, there are 147 unreported cases.

Influenza is seasonal and more common in the winter months. The number of cases usually increases markedly from October until December/January. In the Winter of 2012/13, the 'flu' season started later and was more prolonged than previous years. There were approximately 20 cases per 100,000 population across the South East region during this time.

There are a number of gastro-intestinal infectious diseases. By far the most common is infection with Camplylobacter; 285 cases were reported in Southampton City in 2012/13. Collectively, other forms of gastro-intestinal disease contributed to 91 reported cases during this time.

Norovirus infection outbreaks accounted for 64% of all outbreaks notified to Public Health England in Southampton. Thirty nine outbreaks of Norovirus were reported between April 2012 and March 2013.

Norovirus Outbreaks in Southampton City between April 2012 and March 2013

Principal Context	Count of Principal Context
Care Home	16
Hospital	14
*Cruise Ships**	*5*
Nursery/School	4
Grand Total	**39**

Data source: PHE Centre Wessex HPZone Database

**Home Port of Southampton.*

What can be done?

Vaccination

Vaccination has had a major impact on the reduction in infectious diseases and resulting reductions in health inequalities over time. However, differences in vaccine uptake persist. The NHS Influenza vaccination programme[37] aims to protect those who are at most risk of serious illness or death from Influenza and reduce transmission of the infection. Over 75% of people aged 65 years and over received the vaccination in 2012/13. Yet only 53% of people 'at risk' and 40% of pregnant women were vaccinated.

This year, for the first time, children aged 2 to 3 years have been offered the vaccine. This childhood flu vaccination programme will be extended to children and young people up to the age of 16 years in the near future. It is an employer's responsibility to ensure staff are vaccinated.

Rotavirus is a highly infectious gastrointestinal disease. Vaccination for rotavirus has very recently been incorporated into the childhood immunisation programme. It is offered to babies aged two and three months alongside their other routine vaccinations.

Hygiene standards

There are simple measures that can be undertaken to reduce the risk of infection. These include adequate hand washing, disinfecting of surfaces and covering the mouth and nose when coughing or sneezing. National and local campaigns continue to raise awareness of these measures.

Through following robust infection control standards in healthcare settings, residential care settings, schools, children's centres and other establishments whether vulnerable people gather infection risk can be reduced

School nurses and health visitors are well placed to provide advice to teachers, parents and children about prevention of infectious disease. There are educational programmes such as 'e-bug' that provide a useful learning tool for school children. Further work is required within settings to encourage a more robust preventative approach to infectious disease management.

Outbreak management

Public Health England co-ordinates response and provides guidance to schools and residential care homes on actions required in the event of an infectious disease outbreak. Surveillance mechanisms are in place to ensure that outbreaks are identified at the earliest opportunity.

Other preventative measures

Breastfeeding has a large impact on the risk of gastrointestinal disease in the young. National research[38] shows that if 45% of women exclusively breastfed for four months, and if 75% of babies in neonatal units were breastfed at discharge, every year there could be an estimated 3,285 fewer gastrointestinal infection-related hospital admissions and 10,637 fewer GP consultations. This would result in over £3.6 million saved in treatment costs annually.

Key Recommendations

- Address inequalities due to infectious diseases in the local Health and Wellbeing strategy
- Work with PHE Wessex to raise local awareness of infectious disease control and to support local action

- Work with employers to encourage influenza vaccination of staff and raise local public awareness of vaccination
- Appoint an Infection Control Nurse to co-ordinate education and training of Health and Social Care staff on infection prevention
- Work with local Children's Centres, Schools and Care homes to raise awareness of common infectious diseases and benefits of prevention including immunisation

Theme 4: Living long, living well

This final theme is concerned with reducing preventable ill health and premature mortality. The chart below shows the main causes of disability and ill health in the UK; it is clear to see the importance of lifestyle and early intervention in preventing premature morbidity and mortality.

Burden of disease attributable to 20 leading risk factors for both sexes in 2010, expressed as a percentage of UK disability-adjusted life years[39]

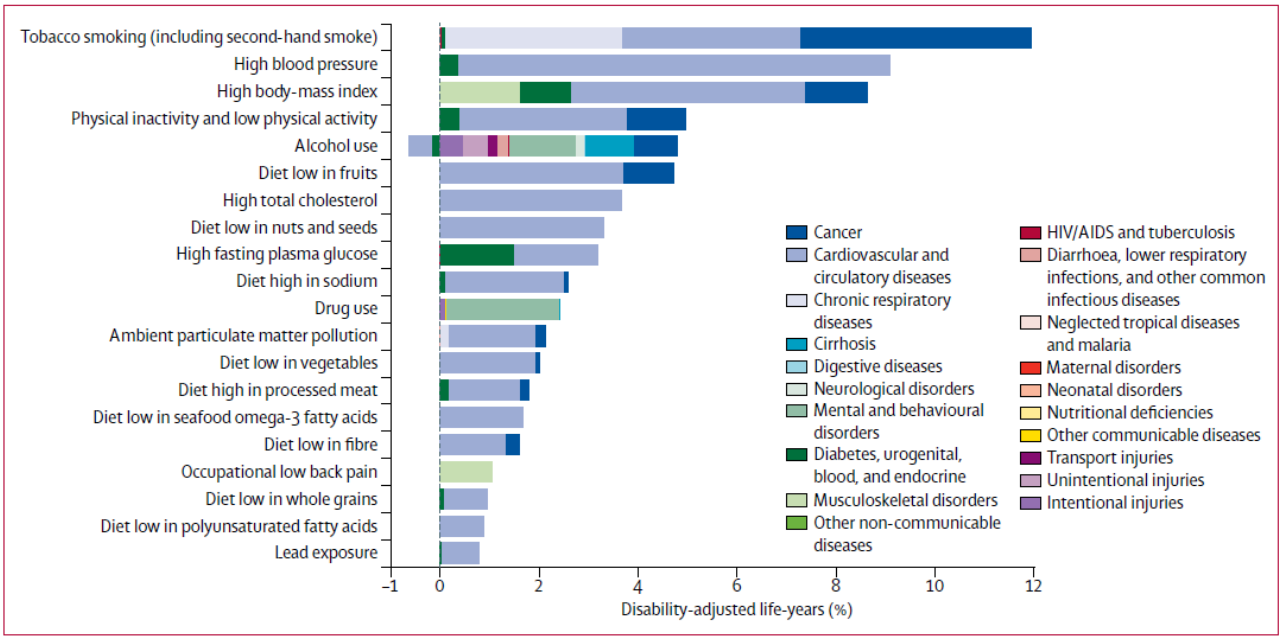


Figure 7: **Burden of disease attributable to 20 leading risk factors for both sexes in 2010, expressed as a percentage of UK disability-adjusted life-years**
The negative percentage for alcohol is the protective effect of mild alcohol use on ischaemic heart disease and diabetes.

Note: The negative percentage for alcohol is the protective effect of mild alcohol use on ischaemic heart disease and diabetes

The PHOF measures for this final theme show that Southampton has poorer outcomes than average in terms of children's tooth decay, mortality from preventable causes and premature mortality from cancer and respiratory disease. Rates of preventable sight loss are also higher in the city than nationally; one of the major causes of sight loss is diabetic eye disease and Section 4.1 looks in more detail at diabetes in the city.

Over the 2009-11 period there were nearly 100 deaths from preventable kidney disease to Southampton residents aged under 65. This issue is looked at more closely in Section 4.2

Healthcare and premature mortality		Period	Local value	Eng. value	Eng. lowest	Range	Eng. highest
4.01	Infant mortality	2009 - 11	4.30	4.29	8.02		2.28
4.02	Tooth decay in children aged 5	2011/12	1.14	0.94	2.10		0.35
4.03	Mortality rate from causes considered preventable	2010 - 12	222.6	187.8	340.5		136.2
4.03	Mortality rate from causes considered preventable - Male	2010 - 12	276.2	238.4	430.9		164.9
4.03	Mortality rate from causes considered preventable - Female	2010 - 12	170.4	140.6	253.9		94.7
4.04i	Under 75 mortality rate from all cardiovascular diseases	2010 - 12	93.8	81.1	144.7		55.7
4.04i	Under 75 mortality rate from all cardiovascular diseases - Male	2010 - 12	131.6	114.0	204.4		79.3
4.04i	Under 75 mortality rate from all cardiovascular diseases - Female	2010 - 12	57.7	50.1	88.4		28.6
4.04ii	Under 75 mortality rate from cardiovascular diseases considered preventable	2010 - 12	60.1	53.5	95.2		29.3
4.04ii	Under 75 mortality rate from cardiovascular diseases considered preventable - Male	2010 - 12	89.9	80.8	142.5		44.5
4.04ii	Under 75 mortality rate from cardiovascular diseases considered preventable - Female	2010 - 12	31.7	27.6	54.4		15.0
4.05i	Under 75 mortality rate from cancer	2010 - 12	161.6	146.5	207.3		113.5
4.05i	Under 75 mortality rate from cancer - Male	2010 - 12	182.1	163.6	238.9		122.8
4.05i	Under 75 mortality rate from cancer - Female	2010 - 12	143.0	130.8	181.3		105.3
4.05ii	Under 75 mortality rate from cancer considered preventable	2010 - 12	98.1	84.9	134.9		53.8
4.05ii	Under 75 mortality rate from cancer considered preventable - Male	2010 - 12	106.6	92.7	154.4		53.1
4.05ii	Under 75 mortality rate from cancer considered preventable - Female	2010 - 12	90.4	77.9	121.4		54.6
4.06i	Under 75 mortality rate from liver disease	2010 - 12	20.5	18.0	41.6		10.3
4.06i	Under 75 mortality rate from liver disease - Male	2010 - 12	29.0	23.7	58.4		13.0
4.06i	Under 75 mortality rate from liver disease - Female	2010 - 12	12.0	12.6	25.0		6.9
4.06ii	Under 75 mortality rate from liver disease considered preventable	2010 - 12	18.3	15.8	38.2		9.0
4.06ii	Under 75 mortality rate from liver disease considered preventable - Male	2010 - 12	27.1	21.1	54.9		10.8
4.06ii	Under 75 mortality rate from liver disease considered preventable - Female	2010 - 12	- x	10.6	21.4		6.3
4.07i	Under 75 mortality rate from respiratory disease	2010 - 12	42.6	33.5	81.6		20.5
4.07i	Under 75 mortality rate from respiratory disease - Male	2010 - 12	53.5	39.6	92.1		24.6
4.07i	Under 75 mortality rate from respiratory disease - Female	2010 - 12	32.2	27.9	71.5		12.6
4.07ii	Under 75 mortality rate from respiratory disease considered preventable	2010 - 12	26.1	17.6	45.0		7.9
4.07ii	Under 75 mortality rate from respiratory disease considered preventable - Male	2010 - 12	29.4	20.1	50.4		10.6
4.07ii	Under 75 mortality rate from respiratory disease considered preventable - Female	2010 - 12	23.0	15.2	40.2		7.3
4.08	Mortality from communicable diseases	2010 - 12	54.6	64.8	97.9		47.0
4.08	Mortality from communicable diseases - Male	2010 - 12	65.9	75.1	118.9		55.2
4.08	Mortality from communicable diseases - Female	2010 - 12	45.6	58.7	89.8		37.3
4.10	Suicide rate	2010 - 12	12.5	8.5	14.5		4.8
4.10	Suicide rate - Male	2010 - 12	17.1	13.3	22.6		7.5
4.10	Suicide rate - Female	2010 - 12	7.9	4.0	8		2
4.11	Emergency readmissions within 30 days of discharge from hospital	2010/11	12.2	11.8	13.8		8.1
4.11	Emergency readmissions within 30 days of discharge from hospital - Male	2010/11	12.4	12.1	14.8		8.6
4.11	Emergency readmissions within 30 days of discharge from hospital - Female	2010/11	11.9	11.4	13.2		7.2
4.12i	Preventable sight loss - age related macular degeneration (AMD)	2011/12	197.1	110.5	12.8		225.2
4.12ii	Preventable sight loss - glaucoma	2011/12	11.6	12.8	3.0		34.5
4.12iii	Preventable sight loss - diabetic eye disease	2011/12	8.3	3.8	0.9		15.8
4.12iv	Preventable sight loss - sight loss certifications	2011/12	69.1	44.5	5.1		82.5
4.14i	Hip fractures in people aged 65 and over	2011/12	450.5	457.2	599.5		337.9
4.14ii	Hip fractures in people aged 65 and over - aged 65-79	2011/12	228.5	222.2	346.7		135.7
4.14iii	Hip fractures in people aged 65 and over - aged 80+	2011/12	1449	1515	2,021		993
4.15i	Excess Winter Deaths Index (Single year, all ages)	Aug 2011 - Jul 2012	21.9	16.1	30.7		2.1
4.15ii	Excess Winter Deaths Index (single year, ages 85+)	Aug 2011 - Jul 2012	21.3	22.9	53.1		-7.6
4.15iii	Excess Winter Deaths Index (3 years, all ages)	Aug 2009 - Jul 2012	21.8	16.5	27.4		6.4
4.15iv	Excess Winter Deaths Index (3 years, ages 85+)	Aug 2009 - Jul 2012	29.8	22.6	38.5		11.3

4. 1. Diabetes

Why is this issue important?

Diabetes mellitus is a common condition in the general population, affecting about 1 in every 20 people. It is becoming more common, partly as a result of better diagnosis and partly due to changes in population structure and risk factor prevalence. A small proportion of people may be able to stop the onset of diabetes by making changes in lifestyle, and with the help of certain drugs, but for most people, once established, they will have to live with diabetes for the rest of their lives. If it is well controlled, life expectancy may be unaffected, but a large proportion of people living with diabetes will develop complications and this may shorten lives and reduce the quality of life. Diabetes when present for many years can increase the risk of a number of other conditions, such as stroke, peripheral vascular disease and heart disease; diabetes also contributes to multi morbidity. For those under 65 years, it is also the commonest cause of blindness and partial sight and kidney failure.

The onset of diabetes may be insidious for those who develop the condition later in life (predominantly "type 2" Diabetes) and it is estimated nationally that 800,000 people have diabetes without knowing it. Symptoms may be non-specific, or unrecognized at this stage. Sometimes recurring infections may raise suspicion (e.g. troublesome skin infection) or excessive thirst and frequent passage of urine may be a warning of raised blood sugars and high levels of glucose in the urine. Roughly 90% of people with diabetes have a form called Type 2, characterised by raised blood sugars, high levels of insulin and other changes such as raised fats in the blood.

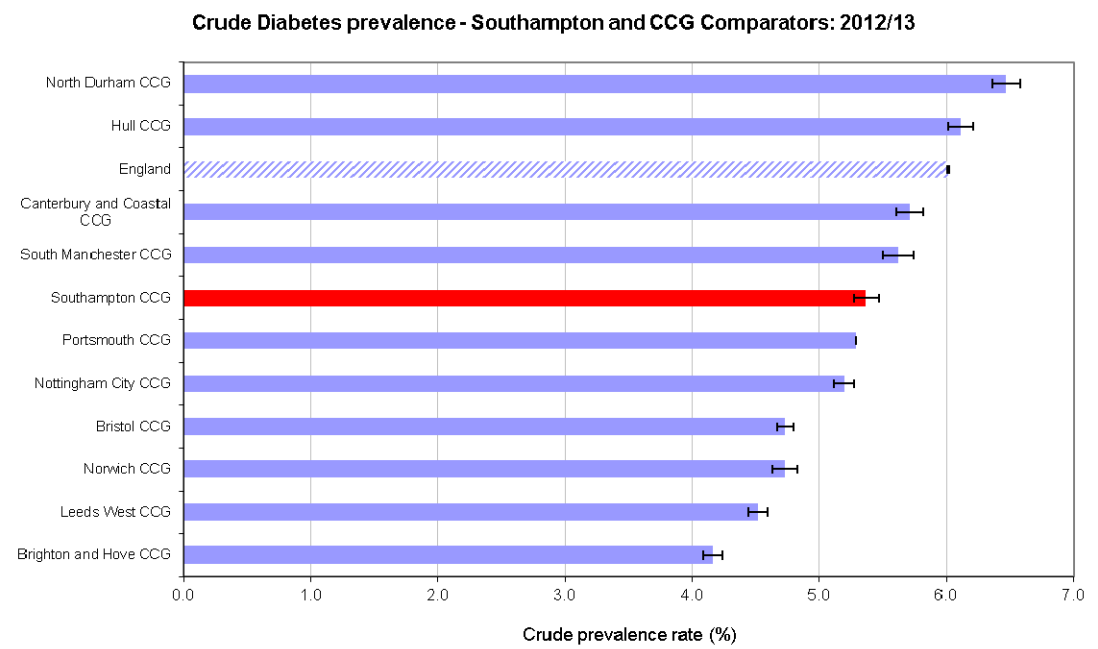
Type 1 diabetes occurs in a smaller number of people (roughly 10% of all the people affected by diabetes) and it usually occurs in childhood or early adult years. Symptoms are more obvious, the onset is rapid, caused by a sudden rise in blood sugar, with a build- up of acids called ketones in the blood. Insulin levels are usually very low, blood sugar very high, and the blood and urine becomes more acid. This can make a person very ill, progressing if untreated to a diabetic coma, collapse and death. People may present as an emergency, with diabetic keto-acidotic coma and this has to be treated as an emergency by a specialist team. Type I diabetes is usually diagnosed rapidly and insulin treatment started immediately. This will need to continue for the rest of that person's life in most cases.

A more recent type of diabetes called MODY – maturity onset diabetes of the young - has been found in children who are obese. This variant of diabetes was first described in the USA, but cases in the UK have been diagnosed over the last five years as childhood obesity increases.

The Southampton Context

Higher levels of diabetes occur in different communities, but the main risk factor is advancing age (Type 2 cases increase steadily in late adult and retirement years)

followed by ethnicity (diabetes is linked to ethnicity – with an especially high prevalence amongst people of South Asian, African and African-Caribbean origin). Populations that gain weight easily, and especially those that become obese, are at increased risk of diabetes. As both overweight and obesity increase in the general population (including younger children) then we can expect more diabetes to occur in the future, including the MODY condition described above. Southampton is a population that includes significant numbers of Asians and Africans; between 2001 and 2011 the percentage of Asian residents in the city rose from 4.5% to 8.4%. Southampton has levels of obesity equivalent to the UK average and our population is ageing. As the risk factors for diabetes are becoming more prevalent in the local population, it is likely to increase as a problem in future.



Sources:Quality and Outcomes Framework as at end of July 2013 accessed via NHS Information Centre Copyright ©2013, The Health and Social Care Information Centre, Prescribing Support Unit. All rights reserved.
Notes: These are crude rates and therefore do not take account of the underlying age structure of the population.

GP practices in Southampton collect data on people aged over 17 years with diabetes. This is used to measure standards of care in the Quality and Outcomes Framework (QOF). Using this data, we can estimate and compare the prevalence of diabetes in the city with other similar urban populations in England. The chart above shows Southampton has a mid-position when crude prevalence is compared to other areas, and at 5.4% is significantly below the average for England.

These figures should be interpreted with caution as the QOF data provides only a crude rate for adults only (i.e. the age structure of the adult population has not been taken into account). Additionally the accuracy and completeness of the QOF registers is unknown. We have seen year on year increases in the numbers on the QOF register, so it is probably a more accurate measure of true prevalence now than several years ago, but it is likely to still underrepresent the true prevalence.

Public Health England has produced Diabetes Community Health Profiles for every CCG[40]. The Southampton profile uses data from the National Diabetes Audit which shows that people in the city with diabetes have a 57% greater chance of dying in a one year period than the general population (this compares with an increased risk nationally of 40%).

What can be done?

The onset of diabetes can be delayed or prevented in some, but once established, the best outcomes can only be achieved by good control of blood sugar through diet, oral hypoglycaemic tablets, or insulin and careful control of blood pressure and vascular risk factors. Control of vascular risk is especially important because people affected by diabetes have an increased risk of cardiovascular problems, and research shows the importance of keeping blood sugars within an acceptable range, whilst also controlling blood pressure and blood lipids optimally. A key component of good quality diabetes care is education for the patient and their carers or partners. There are carefully structured education programmes designed specifically for people with diabetes, and it is important that these are accessed by anyone newly diagnosed. Research shows this affects outcomes for the better when delivered in a structured way.

Despite the ease with which a blood or urine sugar can be measured, we do not have an effective population screening programme to reliably detect the onset of diabetes. The national screening committee is keeping this under review, but has no plans to introduce population screens[41]. Current policy encourages opportunistic testing in people at increased risk, for example those from ethnic minorities or those with a family history. The diabetes charity Diabetes UK[42] has established a partnership with Tesco to encourage opportunistic testing, and they have made available a free diabetes self-assessment online and at local pharmacies. During 2013 Diabetes UK carried out 212 risk assessments at road shows in Southampton. These provide the public with advice on managing risk factors and what to do in case risk is high and they need a GP assessment. GPs test patients for diabetes if they have symptoms that might suggest the condition, and in addition the health check programme promotes vascular risk assessment and glucose testing in adults whose risk is elevated. Southampton is actively promoting this approach http://www.publichealth.southampton.gov.uk/healthimprovement/healthchecks/

One subgroup of patients with very severe obesity complicated by diabetes may benefit from bariatric surgery. This reliably reduces weight, and in selected patients can reverse the diabetes completely. This additional benefit of obesity surgery is recognized in the bariatric surgery policy in our area, which includes diabetes in the eligibility for surgery.

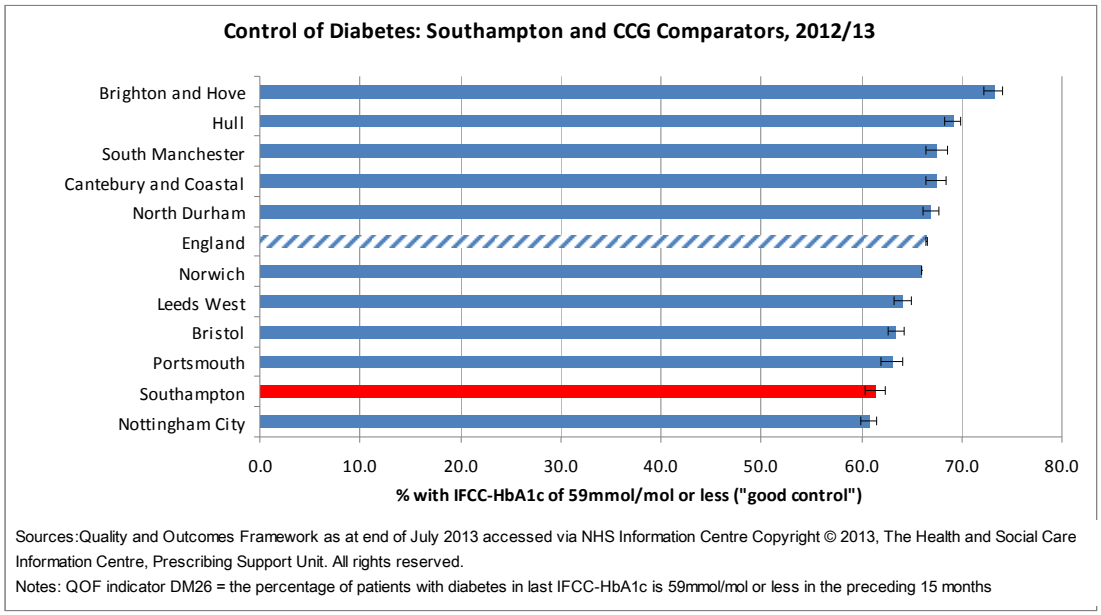
A more recent approach to diabetes prevention is focusing on people who have “pre diabetes”. In this group blood sugar is not yet raised, but there are signs of insulin resistance and a raised blood insulin level that may be linked to raised fats in the blood also. Researchers have been studying the effects of intensive physical activity

and use of medication (for example metformin) to see if the onset of diabetes can be delayed or prevented in this high risk group. The benefits appear promising in a number of initial research studies.

From a more public health perspective we encourage increasing physical activity (most of us are too sedentary for optimal health), and maintaining an optimal body weight and healthy diet to reduce the risk of vascular disease and cancers in all people. This more generic approach should reduce the prevalence of diabetes, but requires a concerted effort on the part of the population, and especially those struggling with overweight and sedentary lifestyles.

Stopping smoking plays an especially important role in diabetes management, because smoking increases complications such as vascular disease and blindness several fold.

Southampton CCG has made diabetes management a priority this year, and is working hard on improving the quality of care provided in primary and secondary care. A local clinical network has been established to engage clinicians and patients in this programme of quality improvement.



Sources:Quality and Outcomes Framework as at end of July 2013 accessed via NHS Information Centre Copyright © 2013, The Health and Social Care Information Centre, Prescribing Support Unit. All rights reserved.
Notes: QOF indicator DM26 = the percentage of patients with diabetes in last IFCC-HbA1c is 59mmol/mol or less in the preceding 15 months

The chart above shows that control of blood sugar amongst diabetic patients is lower in Southampton than amongst other similar CCGs.

The roles of primary care specialist nurses, podiatrists, GPs, vascular and diabetes specialists in hospitals are included in the work of the network.

The challenge of improving quality and achieving better population outcomes is a significant one, which depends equally on effective testing, earlier diagnosis, and delivering high quality care. To achieve this, clinicians need to work in partnership with people affected by diabetes, and those at higher risk, to ensure earlier diagnosis and high quality effective long term care.

Recommendations

- Increase uptake of Health Checks and subsequent opportunistic testing for diabetes amongst those found to be at higher risk

- Encourage use of the free self-assessment and testing service on offer from the Diabetes UK and Tesco partnership to reduce the number of undiagnosed cases in the city

- The CCG should continue to promote the clinical network, focusing on population outcomes that will benefit the most from quality improvement initiatives

- Public health approaches to encourage healthy eating, and reduce sedentary behaviour are essential to avoid increasing obesity, overweight and continuing rises in the prevalence of diabetes in the local population

- Proactive management of people with pre diabetes needs to be optimized to reduce risk in those at highest risk. Smoking cessation in this group should remain an especially high priority alongside exercise promotion.

4. 1. Kidney disease

Why is this issue important?

Chronic kidney disease (CKD) is a common long term condition. It is strongly associated with other chronic conditions like cardiovascular disease and diabetes, and is more common in ageing populations and some BME groups.

Blood pressure is a common risk factor in all three conditions. Diabetes is now the commonest cause of kidney failure in the UK. Internationally, the burden of disease from high blood pressure is being recognised as one of the most important factors contributing to poor health and premature mortality.

A proportion of people with CKD may progress to end stage renal disease (ESRD) when dialysis or kidney transplantation is required. The majority live with sufficient reserve kidney function to manage without dialysis, but the different kidney conditions can cause a wide range of symptoms with varied complications. This makes CKD hard to diagnose from clinical symptoms alone, and this means the condition may be under diagnosed and treated in the general population.

Kidneys play a complex role in regulating fluid and electrolytes in our body, controlling blood pressure, bone mineral content, and production of red blood cells. Nitrogen waste products are removed in urine, while the kidneys can also secrete hormones and excrete drugs from the body. We are unaware of our kidneys when they are working normally.

Kidney diseases are diverse and may present few outward symptoms, despite complex metabolic changes that may accompany kidney damage. Therefore, kidney disease is hard to diagnose. Kidney stones are an exception, causing acute loin pain.

Microscope examination of the urine can also pick up abnormal cells, blood cells and crystals, and has been used to test and diagnose kidney diseases for hundreds of years. Ultrasound imaging, more sophisticated blood and urine laboratory tests, and tests on the immune system enable more sophisticated diagnosis and management. These tests are available to GPs.

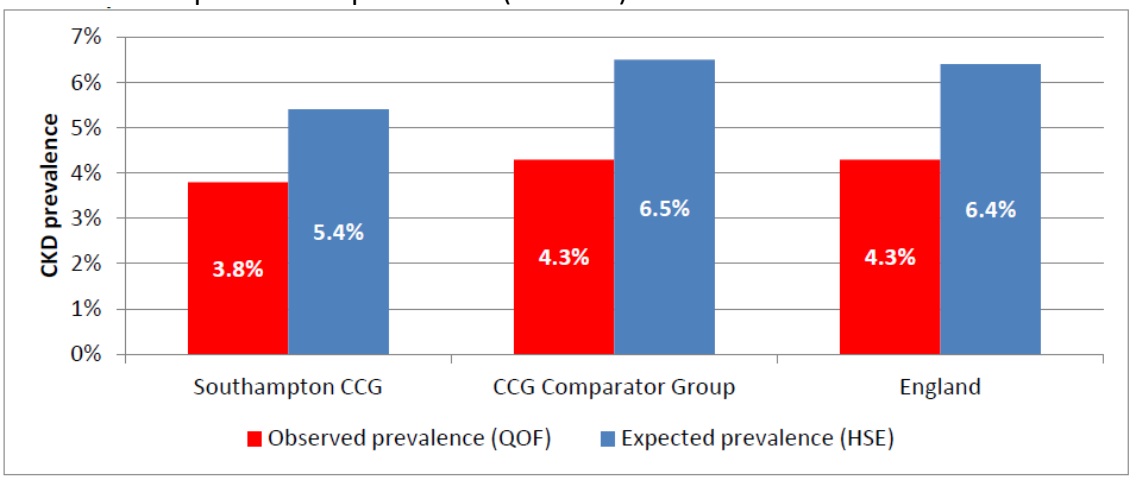
The Quality and Outcomes Framework (QOF)[43] encourages GPs to test patients to see if they have renal diseases, and sets targets for certain aspects of treatment. QOF registers enable a crude estimate of the prevalence of CKD in the population, and comparison between different populations.

The Southampton Context

A recent publication[44] provided a comparison between the QOF registers in different CCGs in England. Southampton has a significantly lower number of recorded CKD cases than would be expected, as is the case both nationally and amongst the city's

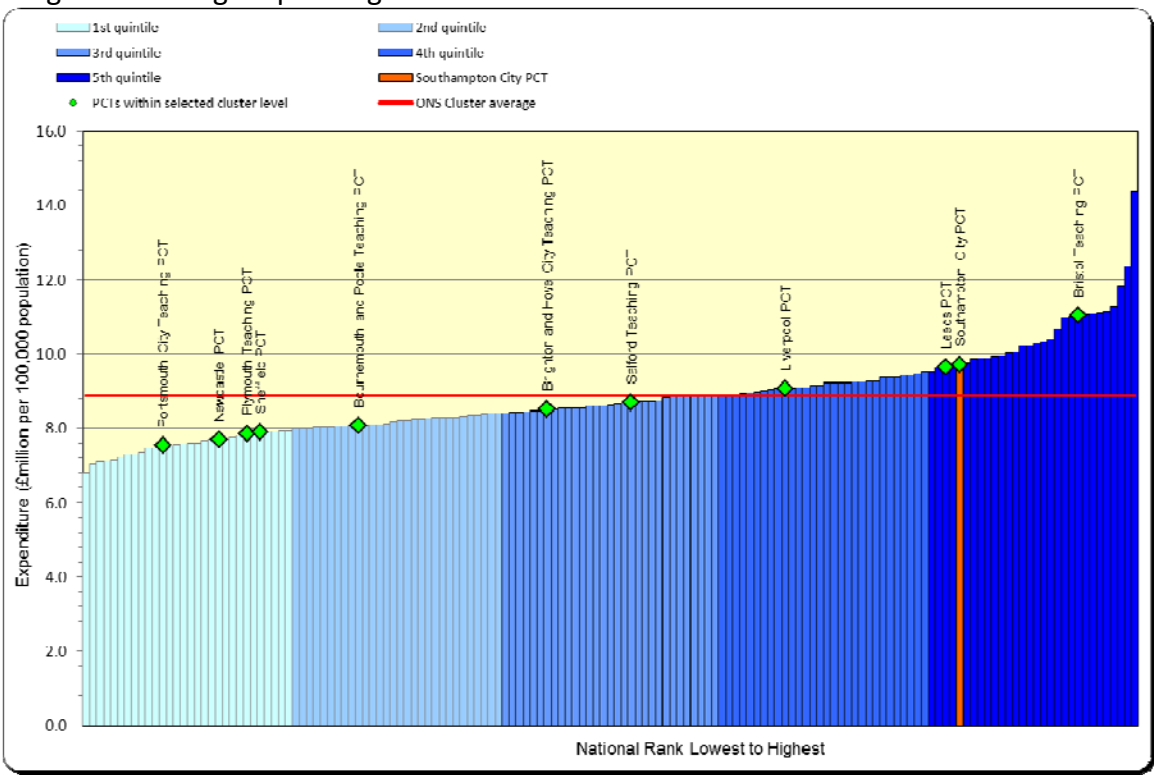
comparator group. This raises concern over the potential for under-diagnosis across the city population, and under reporting in the QOF registers.

Observed and expected CKD prevalence (2011-12)[44]



Southampton spends a significant amount on care of renal disease in the community, but a lot more on expensive hospital care, including dialysis and transplantation. Renal disease is included in the broader classification of genitourinary diseases and is included in programme budget analysis by the Right Care programme[45]. This provides information on expenditure in different programme areas. The analysis ranks our population against other similar areas. In this case it uses the former PCT areas for comparison. Southampton is in the fifth quintile for spending.

Programme Budget Spending



The challenge from these analyses appears two-fold: the first is under-diagnosis, and the attendant loss of opportunities to treat the renal condition and prevent deterioration. The second points to a higher expenditure in hospital, suggesting renal conditions have presented at a more severe stage and require more expensive care in hospital or the specialised renal unit.

A research study has been under way for two years at the University of Southampton into this issue across Hampshire. Use of the Hampshire Health Record has enabled people with signs of renal disease to be identified from an electronic record, and this used to compare with the GP register of cases. The preliminary findings show that many people with CKD have been diagnosed and investigated appropriately, but that there are also significant numbers of people whose CKD may not have been recognised and have therefore not been included on the practice QOF registers. Important aspects of their care, such as urine testing for protein and control of blood pressure, may therefore not have been ideal.

What can be done?

Earlier identification of people with CKD and more complete registration will help focus efforts on improving care for cases of CKD, and this in turn should reduce the number of people requiring hospital care.

In general CKD is not reversible, but the rate at which it deteriorates can be modified if diagnosed at a sufficiently early point in the natural history of the disease. In this context blood pressure (BP) is especially important, with strong evidence that optimal control of raised BP can reduce the rate of deterioration of kidney function.

An important aspect for future research is to identify ways to detect and prevent acute kidney injury (AKI) – a common cause of hospital admission for people with CKD.

Recommendations

- The CCG is encouraged to take note of the national and local analyses that suggest under-registration of renal conditions on QOF registers.

- Local research will soon be available to help practices identify a greater number of cases with CKD. Use of the Hampshire Health Record, still widely available to clinicians and researchers, is an important opportunity to target treatment more effectively, and its use should be encouraged.

- The findings of research locally must be fed back proactively to local GPs and others who diagnose renal conditions locally.

More structured care, and especially improved control of high blood pressure can reduce progression of kidney disease and is cost effective, especially in people with diabetes who are at increased risk of kidney failure.

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Key

Local authorities in ONS Regional Centres Group ranked in descending order of deprivation

- Fourth highest or worst values
- Fifth to eighth highest worst values values
- Lowest four values

* Value suppressed

(Where not all the data has been provided by comprators, tri-colouring split by thirds of number of values given for indicator)

Southampton compared to England

- Significantly worse than England
- No statistically significant difference
- Significantly better than England
- Significance could not be calculated
- \- Value not recorded

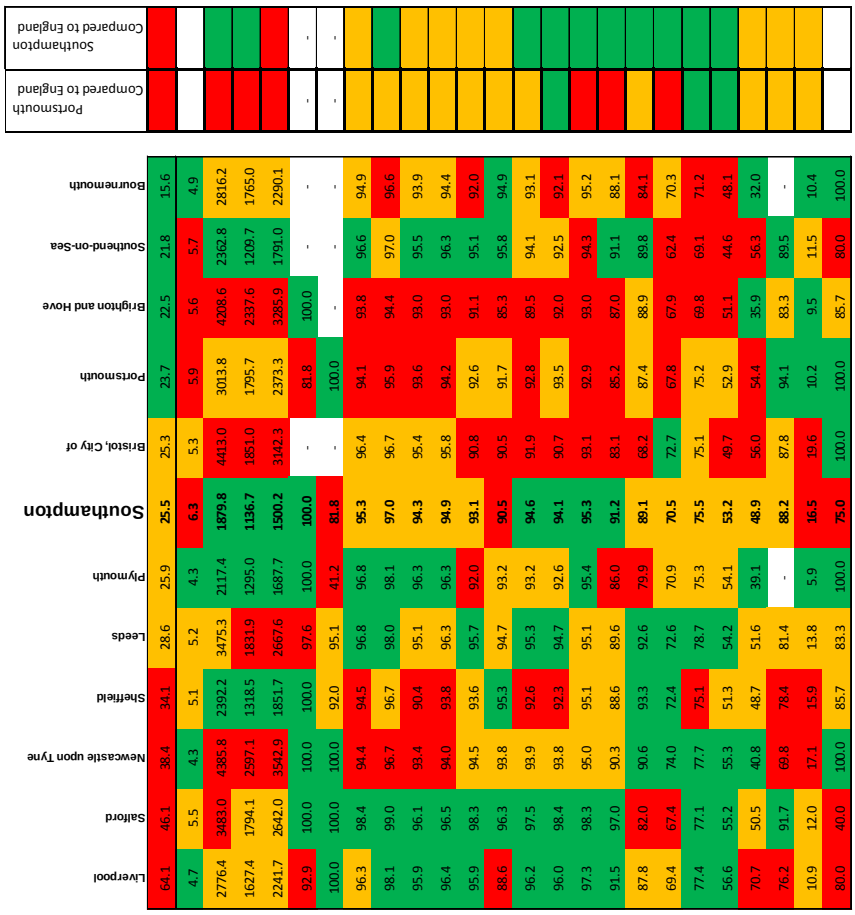
Source: http://www.phoutcomes.info/ Copyright © 2014, Public Health England. Delivered in partnership with the Department of Health accessed 10/03/2014

Over-arching indicators

Indicator	Liverpool	Salford	Newcastle upon Tyne	Sheffield	Leeds	Plymouth	**Southampton**	Bristol, City of	Portsmouth	Brighton and Hove	Southend-on-Sea	Bournemouth	Portsmouth Compared to England	Southampton Compared to England
Ranked order of deprivation (Index of Multiple Deprivation, 2010)	64.1	46.1	38.4	34.1	28.6	25.9	**25.5**	25.3	23.7	22.5	21.8	15.6		
0.1i - Healthy life expectancy at birth	58.2	56.7	60.7	59.3	60.8	60.9	**61.1**	63.1	62.2	63.0	63.0	63.0		
0.1i - Healthy life expectancy at birth	58.3	57.8	60.4	61.2	62.1	60.7	**64.6**	63.2	62.0	64.0	64.6	63.9		
0.1ii - Life Expectancy at birth	76.1	76.1	77.5	78.7	78.0	78.3	**78.5**	78.3	78.2	78.7	79.7	78.6		
0.1ii - Life Expectancy at birth	80.2	80.5	81.4	82.4	82.1	82.1	**82.7**	83.0	82.6	83.0	82.6	83.1		
0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (provisional)	9.8	11.3	13.8	9.9	11.8	7.6	**9.4**	8.4	9.7	10.1	9.4	8.7	-	-
0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (provisional)	9.3	7.9	11.0	7.8	8.3	6.0	**5.8**	4.9	6.2	6.6	8.1	4.0	-	-

Indicator	Liverpool	Salford	Newcastle upon Tyne	Sheffield	Leeds	Plymouth	Southampton	Bristol, City of	Portsmouth	Brighton and Hove	Southend-on-Sea	Bournemouth	Portsmouth Compared to England	Southampton Compared to England
1.01i - Children in poverty (all dependent children under 20)	32.5	27.6	28.4	23.9	21.8	21.6	25.3	24.9	24.4	19.6	22.8	19.4		
1.01ii - Children in poverty (under 16s)	33.0	28.3	29.0	24.4	22.5	22.4	25.9	25.3	25.2	19.7	23.5	19.7		
1.02i - School Readiness: The percentage of children achieving a good level of development at the end of reception	50.5	52.8	43.6	51.0	51.3	57.3	50.8	49.5	54.7	44.8	44.9	57.5		
1.02i - School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception	36.6	41.4	28.4	36.8	33.6	42.4	37.9	33.7	45.8	26.5	26.0	42.2		
1.02ii - School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check	58.8	69.1	68.6	64.8	70.3	70.5	70.5	69.7	66.8	63.8	63.6	70.0		
1.02ii - School Readiness: The percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check	48.5	59.2	55.5	51.4	56.0	60.3	62.0	58.5	56.1	46.8	48.1	57.9		
1.03 - Pupil absence	5.9	5.1	5.7	5.5	5.2	5.5	5.9	5.7	5.7	5.4	5.3	5.5		
1.04 - First time entrants to the youth justice system	727.8	521.3	815.8	369.5	645.8	669.8	968.2	935.8	598.7	405.0	453.0	370.7		
1.05 - 16-18 year olds not in education employment or training	9.3	6.2	9.8	7.7	6.2	7.8	6.3	7.9	7.8	6.7	5.4	5.4		
1.06i - Adults with a learning disability who live in stable and appropriate accommodation	86.3	91.7	87.9	68.0	83.7	67.6	80.4	53.6	68.4	72.0	87.9	58.0		
1.06ii - % of adults in contact with secondary mental health services who live in stable and appropriate accommodation	49.2	78.2	42.4	70.9	52.5	53.0	27.4	59.2	60.9	58.4	70.2	19.9		
1.08i - Gap in the employment rate between those with a long-term health condition and the overall employment rate	12.5	13.6	9.0	8.9	9.5	8.7	5.1	8.0	3.1	9.5	4.9	5.8		
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate	50.6	59.8	57.0	59.0	60.5	65.6	62.7	63.5	64.0	58.2	61.2	65.4		
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	57.3	59.5	53.8	62.9	56.9	63.0	65.7	60.4	68.1	63.9	63.6	68.5		
1.09i - Sickness absence - The percentage of employees who had at least one day off in the previous week	3.1	2.3	1.5	2.5	3.2	3.3	2.3	1.6	2.4	2.2	2.4	3.3		
1.09ii - Sickness absence - The percent of working days lost due to sickness absence	2.1	1.7	1.2	1.8	2.0	2.7	1.5	1.3	1.6	1.4	1.5	2.5		
1.10 - Killed and seriously injured casualties on England's roads	47.7	29.9	32.0	30.4	40.1	25.3	54.7	33.9	57.9	57.2	36.5	46.9		
1.11 - Domestic Abuse	29.7	23.0	24.2	22.9	21.4	19.0	16.2	12.1	16.2	13.1	20.0	12.4		
1.12i - Violent crime (including sexual violence) - hospital admissions for violence	167.8	103.7	82.3	65.5	98.1	69.2	88.9	77.5	56.8	53.4	48.9	46.3		
1.12ii - Violent crime (including sexual violence) - violence offences per 1,000 population	10.6	10.4	9.6	7.0	10.3	17.9	19.0	15.1	20.3	12.8	13.8	13.3		
1.12iii- Violent crime (including sexual violence) - Rate of sexual offences per 1,000 population	0.8	0.7	0.8	0.5	1.1	1.4	1.1	1.2	1.0	1.3	1.1	1.0		
1.13i - Re-offending levels - percentage of offenders who re-offend	31.3	27.1	36.3	28.2	27.8	27.5	30.2	32.0	29.6	27.2	26.0	28.2		
1.13ii - Re-offending levels - average number of re-offences per offender	1.0	0.8	1.3	0.8	0.8	0.7	1.0	1.0	1.0	0.9	0.8	0.9		
1.14i - The percentage of the population affected by noise - Number of complaints about noise	5.7	3.9	5.9	3.6	10.0	5.7	10.5	10.2	6.6	12.1	15.1	7.4		
1.14ii - The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime	5.8	12.7	5.1	3.6	4.6	4.1	7.7	4.9	11.3	8.7	5.6	5.5		
1.14iii - The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time	14.0	42.8	7.6	6.8	8.8	7.0	24.3	10.5	42.0	26.5	8.1	8.3		
1.15i - Statutory homelessness - homelessness acceptances	1.4	2.9	1.7	6.0	2.1	2.0	1.9	1.6	6.0	4.3	1.2	1.7		
1.15ii - Statutory homelessness - households in temporary accommodation	0.2	0.6	0.2	0.7	0.4	0.9	1.5	0.9	0.9	6.5	0.5	0.3		
1.16 - Utilisation of outdoor space for exercise/health reasons	18.8	9.3	15.8	15.2	17.9	17.1	16.0	15.0	14.6	19.4	-	19.9		
1.17 - Fuel Poverty	14.1	11.1	12.1	11.0	11.0	10.2	9.8	11.3	10.7	11.3	12.8	11.2		
1.18i - Social Isolation: % of adult social care users who have as much social contact as they would like	48.8	37.5	45.5	44.9	47.5	48.7	40.8	42.5	48.6	46.9	46.3	40.2		
1.18ii - Loneliness and Isolation in adult carers	27.4	40.0	51.9	43.0	42.1	36.5	47.4	46.2	57.3	34.1	40.5	35.3		

Indicator	Liverpool	Salford	Newcastle upon Tyne	Sheffield	Leeds	Plymouth	**Southampton**	Bristol, City of	Portsmouth	Brighton and Hove	Southend-on-Sea	Bournemouth	Portsmouth Compared to England	Southampton Compared to England
Ranked order of deprivation (Index of Multiple Deprivation, 2010)	64.1	46.1	38.4	34.1	28.6	25.9	**25.5**	25.3	23.7	22.5	21.8	15.6		
2.01 - Low birth weight of term babies	3.2	3.1	3.2	2.9	3.1	2.9	**2.7**	2.3	2.5	2.7	2.1	2.6		
2.02i - Breastfeeding - Breastfeeding initiation	50.9	58.3	67.4	77.7	68.2	69.1	**74.6**	80.7	75.4	86.7	73.0	76.9		
2.02ii - Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth	29.1	36.4	44.9	50.9	47.3	34.2	**43.5**	-	46.5	70.5	36.7	52.3		
2.03 - Smoking status at time of delivery	18.3	16.2	17.1	14.0	13.0	16.7	**15.2**	12.3	17.3	6.7	11.5	13.2		
2.04 - Under 18 conceptions	39.6	41.9	42.9	35.2	38.1	43.6	**47.4**	33.2	33.3	29.4	34.8	31.7		
2.04 - Under 18 conceptions: conceptions in those aged under 16	9.7	8.5	11.0	6.7	8.5	7.7	**10.5**	5.4	6.1	6.8	9.4	5.1		
2.06i - Excess weight in 4-5 and 10-11 year olds - 4-5 year olds	28.6	23.0	26.3	19.6	22.8	24.8	**22.3**	21.9	24.2	21.3	22.9	21.4		
2.06ii - Excess weight in 4-5 and 10-11 year olds - 10-11 year olds	39.1	36.0	37.9	33.7	33.8	32.1	**34.4**	33.9	35.6	26.6	32.0	31.5		
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	107.0	163.9	131.8	83.9	114.0	153.3	**130.0**	104.2	104.8	110.8	84.0	116.6		
2.07ii - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)	145.0	161.9	125.6	97.4	141.5	127.1	**141.2**	137.3	121.8	116.2	132.2	169.8		
2.08 - Emotional well-being of looked after children	12.4	13.1	10.5	-	15.3	17.3	**-**	14.8	13.7	14.8	14.3	13.8		
2.12 - Excess Weight in Adults	67.2	63.3	60.3	59.9	62.2	60.0	**64.8**	59.1	57.9	49.2	64.4	58.7		
2.13i - Percentage of physically active and inactive adults - active adults	52.0	45.4	57.6	54.6	61.3	59.2	**56.0**	55.4	51.0	63.4	53.5	64.1		
2.13ii - Percentage of active and inactive adults - inactive adults	31.6	39.1	25.6	30.4	26.9	27.6	**30.9**	28.4	33.0	24.9	32.8	20.4		
2.14 - Smoking Prevalence	24.5	26.3	22.9	23.2	23.6	24.0	**22.5**	21.3	22.5	23.7	22.0	19.5		
2.14 - Smoking prevalence - routine & manual	32.5	34.5	34.9	33.0	30.2	33.5	**30.3**	27.6	33.8	33.0	30.8	29.9		
2.15i - Successful completion of drug treatment - opiate users	8.0	8.6	7.0	7.0	7.2	6.7	**8.5**	9.1	8.0	9.2	6.4	7.8		
2.15ii - Successful completion of drug treatment - non-opiate users	55.1	39.8	39.5	37.9	32.6	36.0	**36.0**	38.7	26.6	37.6	39.9	41.6		
2.17 - Recorded diabetes	5.8	5.9	5.5	6.0	5.3	5.5	**5.4**	4.7	5.3	4.2	5.9	5.1		
2.20i - Cancer screening coverage - breast cancer	70.9	68.7	75.4	78.7	74.0	78.7	**69.9**	72.8	73.6	72.7	68.7	73.3		
2.20ii - Cancer screening coverage - cervical cancer	68.2	70.1	72.6	74.6	75.3	75.7	**71.1**	70.5	70.5	71.5	73.6	73.2		
2.21vii - Access to non-cancer screening programmes - diabetic retinopathy	86.3	75.2	86.6	92.0	87.9	77.6	**75.5**	83.3	83.1	81.7	75.0	93.3		
2.22i - Take up of NHS Health Check Programme by those eligible - health check offered	42.5	23.0	12.9	6.1	22.0	6.2	**14.2**	4.7	19.7	13.6	22.4	7.5		
2.22ii - Take up of NHS Health Check programme by those eligible - health check take up	35.6	38.2	47.6	40.8	59.0	65.0	**61.4**	53.1	29.6	43.7	47.1	47.6		
2.23i - Self-reported well-being - people with a low satisfaction score	8.4	6.3	7.0	7.3	6.1	4.5	**4.4**	5.4	6.2	4.9	6.4	6.7		
2.23ii - Self-reported well-being - people with a low worthwhile score	6.0	5.1	6.2	5.4	4.5	5.4	**3.7**	-	-	5.3	-	4.9	-	-
2.23iii - Self-reported well-being - people with a low happiness score	15.2	13.3	11.9	11.5	9.7	10.4	**10.1**	11.8	12.7	12.1	9.9	10.1		
2.23iv - Self-reported well-being - people with a high anxiety score	29.0	22.8	21.0	23.5	21.7	24.1	**23.0**	20.9	17.5	25.4	22.0	20.0		
2.24i - Injuries due to falls in people aged 65 and over (Persons)	2756.2	2575.2	2055.3	1419.1	2193.9	1747.3	**2257.2**	1993.4	2034.8	1981.1	1879.3	1751.8		
2.24i - Injuries due to falls in people aged 65 and over (males/females)	2497.3	2190.9	1588.0	1066.4	1666.9	1307.7	**1763.4**	1541.8	1621.8	1692.4	1383.0	1509.2		
2.24i - Injuries due to falls in people aged 65 and over (males/females)	3015.2	2959.5	2522.5	1771.7	2720.8	2186.9	**2750.9**	2444.9	2447.8	2269.9	2375.6	1994.3		
2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79	1725.8	1556.2	1369.0	842.5	1259.1	1036.1	**1401.6**	1245.8	1234.9	1203.2	1025.8	1048.8		
2.24iii - Injuries due to falls in people aged 65 and over - aged 80+	7393.2	7160.7	5143.6	4013.7	6400.1	4947.7	**6107.4**	5357.1	5634.2	5481.9	5719.7	4915.1		



Indicator	Liverpool	Salford	Newcastle upon Tyne	Sheffield	Leeds	Plymouth	Southampton	Bristol, City of	Portsmouth	Brighton and Hove	Southend-on-Sea	Bournemouth	Portsmouth Compared to England	Southampton Compared to England
Ranked order of deprivation (Index of Multiple Deprivation, 2010)	64.1	46.1	38.4	34.1	28.6	25.9	**25.5**	25.3	23.7	22.5	21.8	15.6		
3.01 - Fraction of mortality attributable to particulate air pollution	4.7	5.5	4.3	5.1	5.2	4.3	**6.3**	5.3	5.9	5.6	5.7	4.9		
3.02i - Chlamydia diagnoses (15-24 year olds) - CTAD	2776.4	3483.0	4385.8	2392.2	3475.3	2117.4	**1879.8**	4413.0	3013.8	4208.6	2362.8	2816.2		
3.02ii - Chlamydia diagnoses (15-24 year olds) - CTAD	1627.4	1794.1	2597.1	1318.5	1831.9	1295.0	**1136.7**	1851.0	1795.7	2337.6	1209.7	1765.0		
3.02iii - Chlamydia diagnoses (15-24 year olds) - CTAD	2241.7	2642.0	3542.9	1851.7	2667.6	1687.7	**1500.2**	3142.3	2373.3	3285.9	1791.0	2290.1		
3.03i - Population vaccination coverage - Hepatitis B (1 year old)	92.9	100.0	100.0	100.0	97.6	100.0	**100.0**	-	81.8	100.0	-	-		
3.03i - Population vaccination coverage - Hepatitis B (2 years old)	100.0	100.0	100.0	92.0	95.1	41.2	**81.8**	-	100.0	-	-	-		
3.03ii - Population vaccination coverage - Dtap / IPV / Hib (1 year old)	96.3	98.4	94.4	94.5	96.8	96.8	**95.3**	96.4	94.1	93.8	96.6	94.9		
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old)	98.1	99.0	96.7	96.7	98.0	98.1	**97.0**	96.7	95.9	94.4	97.0	96.6		
3.03iv - Population vaccination coverage - MenC	95.9	96.1	93.4	90.4	95.1	96.3	**94.3**	95.4	93.6	93.0	95.5	93.9		
3.03v - Population vaccination coverage - PCV	96.4	96.5	94.0	93.8	96.3	96.3	**94.9**	95.8	94.2	93.0	96.3	94.4		
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old)	95.9	98.3	94.5	93.6	95.7	92.0	**93.1**	90.8	92.6	91.1	95.1	92.0		
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years)	88.6	96.3	93.8	95.3	94.7	93.2	**90.5**	90.5	91.7	85.3	95.8	94.9		
3.03vii - Population vaccination coverage - PCV booster	96.2	97.5	93.9	92.6	95.3	93.2	**94.6**	91.9	92.8	89.5	94.1	93.1		
3.03viii - Population vaccination coverage - MMR for one dose (2 years old)	96.0	98.4	93.8	92.3	94.7	92.6	**94.1**	90.7	93.5	92.0	92.5	92.1		
3.03ix - Population vaccination coverage - MMR for one dose (5 years old)	97.3	98.3	95.0	95.1	95.1	95.4	**95.3**	93.1	92.9	93.0	94.3	95.2		
3.03x - Population vaccination coverage - MMR for two doses (5 years old)	91.5	97.0	90.3	88.6	89.6	86.0	**91.2**	83.1	85.2	87.0	91.1	88.1		
3.03xii - Population vaccination coverage - HPV	87.8	82.0	90.6	93.3	92.6	79.9	**89.1**	68.2	87.4	88.9	89.8	84.1		
3.03xiii - Population vaccination coverage - PPV	69.4	67.4	74.0	72.4	72.6	70.9	**70.5**	72.7	67.8	67.9	62.4	70.3		
3.03xiv - Population vaccination coverage - Flu (aged 65+)	77.4	77.1	77.7	75.1	78.7	75.3	**75.5**	75.1	75.2	69.8	69.1	71.2		
3.03xv - Population vaccination coverage - Flu (at risk individuals)	56.6	55.2	55.3	51.3	54.2	54.1	**53.2**	49.7	52.9	51.1	44.6	48.1		
3.04 - People presenting with HIV at a late stage of infection	70.7	50.5	40.8	48.7	51.6	39.1	**48.9**	56.0	54.4	35.9	56.3	32.0		
3.05i - Treatment completion for TB	76.2	91.7	69.8	78.4	81.4	-	**88.2**	87.8	94.1	83.3	89.5	-		
3.05ii - Incidence of TB	10.9	12.0	17.1	15.9	13.8	5.9	**16.5**	19.6	10.2	9.5	11.5	10.4		
3.06 - Public sector organisations w/ board approved sustainable development management plan	80.0	40.0	100.0	85.7	83.3	100.0	**75.0**	100.0	100.0	85.7	80.0	100.0		

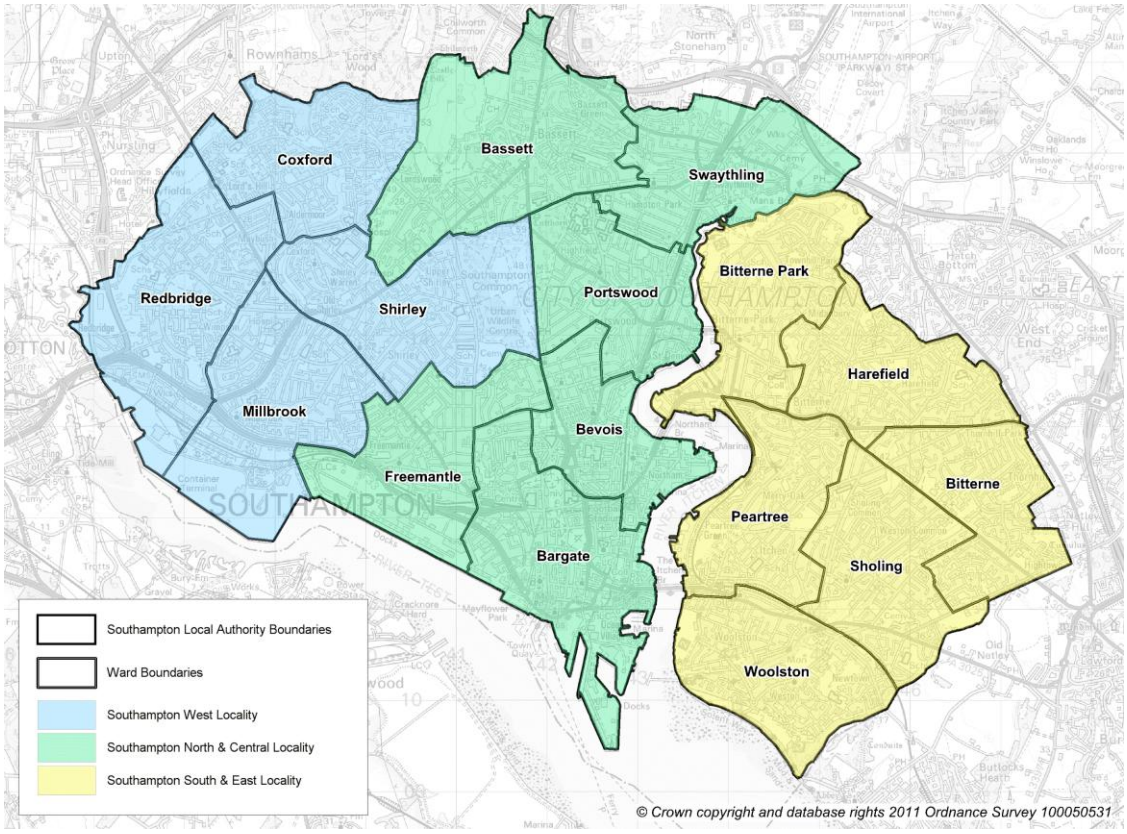
Indicator	Liverpool	Salford	Newcastle upon Tyne	Sheffield	Leeds	Plymouth	**Southampton**	Bristol, City of	Portsmouth	Brighton and Hove	Southend-on-Sea	Bournemouth	Portsmouth Compared to England	Southampton Compared to England
Ranked order of deprivation (Index of Multiple Deprivation, 2010)	64.1	46.1	38.4	34.1	28.6	25.9	**25.5**	25.3	23.7	22.5	21.8	15.6		
4.01 - Infant mortality	4.8	5.2	3.4	4.9	4.6	5.0	**4.3**	2.7	3.0	4.8	4.0	2.7		
4.02 - Tooth decay in children aged 5	1.4	2.0	0.8	1.3	1.2	0.7	**1.1**	0.8	0.8	0.4	0.7	0.9		
4.03 - Mortality rate from causes considered preventable	292.7	283.8	250.2	196.4	219.2	217.2	**222.6**	208.4	230.2	213.9	182.5	200.9		
4.03 - Mortality rate from causes considered preventable	370.7	350.6	318.2	255.1	284.5	276.5	**276.2**	270.1	291.1	272.3	206.2	262.4		
4.03 - Mortality rate from causes considered preventable	220.5	217.2	187.7	140.9	159.1	163.1	**170.4**	149.3	170.3	157.5	160.4	140.7		
4.04i - Under 75 mortality rate from all cardiovascular diseases	114.9	122.5	103.9	89.3	96.0	86.3	**93.8**	86.1	96.3	79.5	83.3	82.4		
4.04i - Under 75 mortality rate from all cardiovascular diseases	163.1	168.6	145.6	127.3	135.3	119.3	**131.6**	120.1	134.5	115.1	121.1	114.8		
4.04i - Under 75 mortality rate from all cardiovascular diseases	69.5	77.0	64.1	53.6	59.7	55.3	**57.7**	53.1	58.8	44.0	47.7	50.7		
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	72.0	86.8	69.3	62.5	66.2	60.7	**60.1**	57.0	63.7	49.3	56.6	52.8		
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	109.7	124.8	105.3	96.2	102.0	87.7	**89.9**	83.0	91.8	77.3	81.3	81.5		
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	36.5	49.3	34.8	30.8	33.1	35.2	**31.7**	31.6	36.2	21.4	33.2	24.6		
4.05i - Under 75 mortality rate from cancer	203.4	182.3	184.1	159.0	165.0	166.1	**161.6**	157.7	167.5	154.8	138.7	143.6		
4.05i - Under 75 mortality rate from cancer	238.9	207.7	212.2	178.1	187.8	189.2	**182.1**	182.0	190.3	168.2	136.1	166.3		
4.05i - Under 75 mortality rate from cancer	170.9	159.2	158.6	141.6	144.7	145.3	**143.0**	134.8	146.3	141.9	142.0	122.0		
4.05ii - Under 75 mortality rate from cancer considered preventable	128.6	118.2	118.1	91.9	100.1	101.0	**98.1**	97.6	101.2	94.3	84.1	85.6		
4.05ii - Under 75 mortality rate from cancer considered preventable	151.7	131.2	133.7	103.3	111.6	113.0	**106.6**	109.6	114.6	104.0	74.6	93.6		
4.05ii - Under 75 mortality rate from cancer considered preventable	107.4	106.8	103.6	81.5	89.9	90.5	**90.4**	86.4	88.6	85.2	93.6	78.1		
4.06i - Under 75 mortality rate from liver disease	33.9	25.9	23.8	17.7	21.2	17.1	**20.5**	19.9	23.4	22.8	17.9	25.6		
4.06i - Under 75 mortality rate from liver disease	43.3	32.6	35.9	24.7	28.3	23.4	**29.0**	29.3	31.4	29.1	18.9	36.6		
4.06i - Under 75 mortality rate from liver disease	25.0	19.0	12.5	10.9	14.4	11.0	**12.0**	10.4	15.5	16.5	17.0	14.2		
4.06ii - Under 75 mortality rate from liver disease considered preventable	30.4	23.5	20.7	15.8	17.9	14.5	**18.3**	18.6	20.4	20.3	16.0	23.1		
4.06ii - Under 75 mortality rate from liver disease considered preventable	39.9	29.8	33.2	22.7	24.7	19.2	**27.1**	28.2	27.9	26.2	18.3	33.7		
4.06ii - Under 75 mortality rate from liver disease considered preventable	21.4	17.3	8.8	9.0	11.4	9.9	-	9.0	12.9	14.3	13.7	12.3		-
4.07i - Under 75 mortality rate from respiratory disease	60.5	64.9	47.4	33.4	42.9	40.1	**42.6**	37.3	41.3	35.4	34.0	32.6		
4.07i - Under 75 mortality rate from respiratory disease	63.7	78.5	53.7	36.3	52.7	46.1	**53.5**	44.3	49.8	40.8	38.5	41.6		
4.07i - Under 75 mortality rate from respiratory disease	57.4	51.9	41.6	30.8	34.1	34.6	**32.2**	30.7	33.5	30.3	30.0	24.0		

Indicator	Liverpool	Salford	Newcastle upon Tyne	Sheffield	Leeds	Plymouth	Southampton	Bristol, City of	Portsmouth	Brighton and Hove	Southend-on-Sea	Bournemouth	Portsmouth Compared to England	Southampton Compared to England
Ranked order of deprivation (Index of Multiple Deprivation, 2010)	64.1	46.1	38.4	34.1	28.6	25.9	**25.5**	25.3	23.7	22.5	21.8	15.6		
4.07i - Under 75 mortality rate from respiratory disease considered preventable	37.1	35.7	28.8	20.1	23.8	21.7	**26.1**	19.3	26.3	23.0	16.4	16.4		
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	33.7	39.4	30.5	22.9	28.0	23.5	**29.4**	23.1	29.1	24.8	18.2	21.7		
4.07iii - Under 75 mortality rate from respiratory disease considered preventable	40.2	32.2	27.2	17.6	20.0	19.9	**23.0**	15.7	23.7	21.2	14.9	-		
4.08 - Mortality from communicable diseases	85.1	86.6	62.3	50.4	65.2	76.9	**54.6**	69.9	54.8	48.6	76.6	54.5		
4.08 - Mortality from communicable diseases	101.9	118.1	72.3	55.8	83.7	93.5	**65.9**	90.4	65.1	61.0	97.6	67.5		
4.08 - Mortality from communicable diseases	75.9	68.3	57.1	47.9	54.2	67.6	**45.6**	58.3	48.2	41.5	66.7	45.9		
4.10 - Suicide rate	7.9	9.5	8.5	6.3	9.2	10.8	**12.5**	10.0	8.1	11.3	6.9	9.3		
4.10 - Suicide rate	13.6	15.8	12.9	10.8	15.3	18.1	**17.1**	16.2	12.3	18.3	-	13.9		
4.10 - Suicide rate	-	-	-	-	3.4	-	**7.9**	4.1	-	-	-	-	-	
4.11 - Emergency readmissions within 30 days of discharge from hospital	13.4	12.2	12.8	12.1	13.2	10.5	**12.2**	11.8	12.5	13.2	12.0	12.1		
4.11 - Emergency readmissions within 30 days of discharge from hospital	14.8	13.3	13.4	12.4	13.9	10.7	**12.4**	12.3	13.0	13.2	12.4	13.4		
4.11 - Emergency readmissions within 30 days of discharge from hospital	12.2	11.3	12.2	11.7	12.7	10.3	**11.9**	11.4	12.1	13.2	11.6	11.1		
4.12i - Preventable sight loss - age related macular degeneration (AMD)	123.3	99.0	131.1	140.4	152.4	123.8	**197.1**	67.8	177.8	119.9	83.9	107.5		
4.12ii - Preventable sight loss - glaucoma	10.1	6.7	16.8	11.6	14.0	6.5	**11.6**	11.4	-	11.7	20.5	8.0	-	
4.12iii - Preventable sight loss - diabetic eye disease	5.4	-	3.7	4.4	3.4	4.5	**8.3**	-	7.9	2.9	6.0	-		
4.12v - Preventable sight loss - sight loss certifications	45.5	31.6	45.5	47.8	55.7	39.0	**69.1**	29.4	54.0	42.1	47.1	37.6		
4.14i - Hip fractures in people aged 65 and over	535.9	488.6	481.7	439.6	440.7	401.5	**450.5**	469.3	478.0	460.6	453.0	542.3		
4.14ii - Hip fractures in people aged 65 and over - aged 65-79	323.6	246.3	253.2	209.0	235.0	207.4	**228.5**	232.3	277.0	236.4	208.6	279.0		
4.14iii - Hip fractures in people aged 65 and over - aged 80+	1491.1	1579.0	1509.5	1477.2	1366.5	1275.0	**1449.3**	1535.9	1382.6	1469.2	1552.7	1727.1		
4.15i - Excess Winter Deaths Index (Single year, all ages)	12.6	10.5	13.1	10.0	20.3	16.1	**21.9**	18.2	20.5	14.9	15.0	24.6		
4.15ii - Excess Winter Deaths Index (single year, ages 85+)	23.9	22.2	12.3	21.7	26.6	34.5	**21.3**	25.6	16.9	14.7	22.1	20.8		
4.15iii - Excess Winter Deaths Index (3 years, all ages)	16.8	6.4	15.7	12.7	16.5	19.5	**21.8**	16.0	23.8	15.0	13.8	13.7		
4.15iv - Excess Winter Deaths Index (3 years, ages 85+)	25.2	20.2	23.6	18.9	27.2	24.1	**29.8**	20.2	23.4	20.0	23.0	13.3		

Appendix 2: Ward Profiles

Introduction

Ward profiles have been produced as spine charts in order to summarise a great deal of information into a relatively succinct format. Spine charts have been used for the health profiles produced by Public Health England (PHE) for a number of years. The profiles have been produced for Southampton's three localities and 16 wards in order to meet a need for more information at these levels.



The Southampton profiles include data for 33 indicators grouped into 7 topics:

1. Demography
2. Economic
3. Healthy Start
4. Lifestyle
5. Community Safety
6. Disability and Poor Health
7. Mortality

Please note that the profiles are attempting to provide information about the population of the locality or ward for health needs assessment rather than being a performance tool.

How to interpret the ward level spine charts

- The red line down the centre of the chart represents the Southampton City average value for each indicator. The data has been normalised which means that values to the left of the red line are 'worse' than the City average and those to the right are 'better' (although note that for the Demography indicators these terms are not appropriate and instead the right side of the line indicates higher values and the left side lower).
- The circles on the chart are the ward values. Circles coloured blue indicate that the ward value is statistically significantly different from the city average. Yellow circles indicate that any difference is not significant and white circles indicate that significance could not be calculated.
- The white diamonds on the spine chart give the locality average.
- The light grey bar for each indicator shows the range of values for the wards in the city (i.e. it stretches from the value for the 'worst' ward to the value for the 'best' ward).
- The darker grey shading shows the range of values for the middle 50% of wards.

Frequently asked questions

Q. Why have you used the terms 'best' and 'worst'?

A. These are the same terms as used in the Public Health England Health Profiles and we have used the same template for our Profiles. However, we do acknowledge that for some indicators (such as the Demography indicators) these terms are not appropriate.

Q. How do you calculate a statistically significant difference?

A. Statistical significance has been measured by calculating 95% confidence intervals around the indicator values. A confidence interval is a range of values that is used to quantify the imprecision in the estimate of a particular value. The width of the confidence interval depends on three things:-

1. The size of the sample from which the estimate is derived (or population size if from a complete dataset). A larger sample means a more precise estimate and, therefore, smaller confidence interval.

2. The degree of variability in the phenomenon being measured. This is often known (or assumed) to follow a certain probability distribution which means that the amount of variability can be built into the confidence interval calculation.

3. The required level of confidence – this is an arbitrary value set by the analyst giving the desired probability that the interval includes the true value. These profiles use 95% confidence intervals which are conventionally used in public health.

The wider the confidence interval, the greater the level of uncertainty of the estimate. When comparing the estimates from two areas, if the confidence intervals do not overlap you can assume a statistically significant difference. However, more caution is needed in interpreting overlapping confidence intervals as this does not always mean no statistically significant difference.

Q. Does the size and demographic breakdown of the population impact on the indicators?

A. Wherever possible indicators are calculated as rates to ensure that the relative size of each ward's population is taken into account when making comparisons. In addition, Directly Standardised Rates have been calculated where relevant to account for the varying age structure between electoral wards.

Q. How have the admissions attributable to smoking been calculated?

A. The total number of smoking attributable admissions is the sum of the Smoking Attributable Fractions (SAF) for all of the admissions with smoking attributable diagnoses. The SAF for each admission is calculated using the relative risk of death (for fatal diseases) or illness (for non-fatal diseases) from these diagnoses for smokers and ex-smokers, and the prevalence of smoking and ex-smoking in the local authority, where the patient resides.

We have used the same methodology as the Local Tobacco Control Profiles see http://www.lho.org.uk/LHO_Topics/Analytic_Tools/Tobaccocontrolprofiles/ The relative risks used are taken from the report published by the NHS Information Centre for Health and Social Care, Statistics on Smoking: England, 2010 https://catalogue.ic.nhs.uk/publications/public-health/smoking/smok-eng-2010/smok-eng-2010-rep.pdf

Q. How can the deprivation indicators be interpreted?

A. The 'Least Deprived LSOA in ward' and 'Most Deprived LSOA in ward' indicators can be read together to show the range of deprivation within a ward. The grey bar represents all LSOA's (Lower Super Output Areas) in the city from the most deprived to the least, whilst the white circle shows the relative position of that ward's most/least deprived LSOA. Therefore, the difference between these two circles represents the range of deprivation experienced within that ward.

Q. Why were these indicators chosen and others of interest not included?

A. Indicators have been chosen to cover a range of topics which as far as possible give the ward level picture of the Public Health Outcomes Framework and the PHE Profiles. Inevitably we are restricted by what data is available to us.

Public Health Ward Profiles: 2012/13

Southampton North & Central Locality

00MSMR - Bargate

Public Health Southampton

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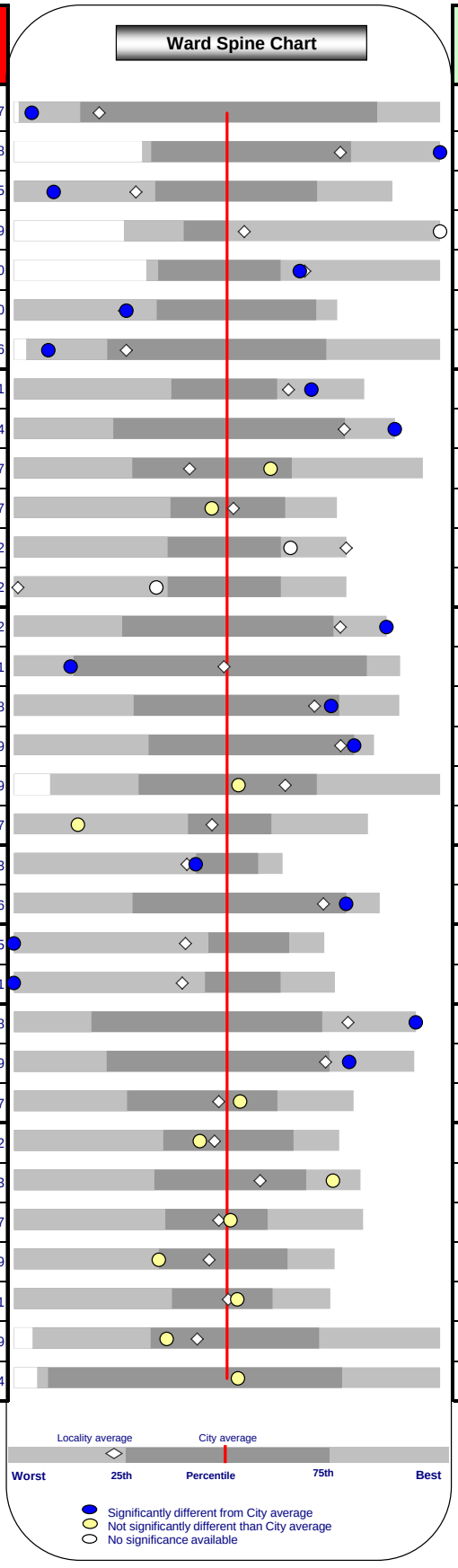
		Indicator	Ward no.	Ward Value	Locality Average	City Average	City Worst	City Best
Demography	1	% Resident Population aged 0-4 years^	829	4.42	5.14	6.50	4.27	8.78
	2	% Resident Population aged 18-24 years^	7543	40.20	29.29	16.88	7.58	40.20
	3	% Resident Population aged over 65 years^	1258	6.71	9.69	12.99	5.25	19.00
	4	Forecast % change in popualtion 2011-18^	2759	14.99	4.10	3.14	-2.59	14.99
	5	% Population from minority ethnic groups^	4317	23.01	23.59	14.08	4.20	40.14
	6	% Population born in the UK^	13542	72.18	71.97	82.42	60.70	93.64
	7	General Fertility Rate^	1007	37.47	47.52	60.53	34.56	88.07
Economic	8	Working Age Claimant Rate	1465	9.53	10.68	13.73	24.31	6.91
	9	Adults with No Qualifications	1931	11.29	14.21	20.96	33.24	11.29
	10	16-18 year old NEET	11	4.58	5.72	5.19	8.17	2.46
	11	Long Term Unemployed	105	6.83	6.08	6.30	13.67	2.50
	12	Least Deprived LSOA in Ward	-	14.43	5.21	24.98	60.32	5.21
	13	Most Deprived LSOA in Ward	-	36.68	59.63	24.98	60.32	5.21
Healthy Start	14	Lone Parent Families	297	3.74	4.69	7.03	11.42	3.74
	15	Child Poverty	615	34.55	25.48	25.31	37.91	15.08
	16	% Smoking in Pregnancy	82	13.90	14.68	18.78	28.78	10.71
	17	% Breastfeeding	502	85.08	84.01	74.92	57.89	86.67
	18	Year R Child Obesity	30	9.15	8.27	9.36	12.69	5.36
	19	Year 6 Child Obesity	38	25.68	20.46	19.88	28.17	14.40
Lifestyle	20	Alcohol Specific Hospital Admissions (DSR)	609	833.26	888.98	638.81	1971.63	291.06
	21	Smoking Related Hospital Admissions (DSR)	312	1367.35	1440.27	1747.38	2426.06	1260.90
Safety	22	Violent Crime	1014	54.25	28.14	21.82	54.25	7.02
	23	Road KSIs	328	602.21	343.35	274.71	602.21	109.17
Disability and Poor Health	24	Limiting Illness	1896	12.33	16.07	22.74	34.48	12.33
	25	DLA Claimants	670	40.29	43.49	56.74	85.39	31.56
	26	Injuries due to Falls (65+)	52	485.12	501.82	495.41	661.77	396.67
Mortality	27	All Age All Cause Mortality (DSR)	563	588.69	577.76	568.54	727.02	485.04
	28	Premature Mortality from Cancer	62	94.18	110.87	118.46	167.23	87.91
	29	Premature Mortality from CVD	47	70.18	72.93	71.01	120.57	39.35
	30	Premature Mortality from Respiratory Disease	26	40.69	31.56	28.34	66.99	8.83
	31	Mortality from Preventable Causes	118	167.77	173.24	173.99	301.11	112.40
	32	Life Expectancy Females	-	81.69	82.09	82.49	79.89	85.34
	33	Life Expectancy Males	-	78.47	78.47	78.34	76.14	80.81



^ The terms 'best' and 'worst' are not appropriate for these indicators instead the right side of the chart indicates the highest value and the left side the lowest.

Public Health Ward Profiles: 2012/13

Southampton North & Central Locality

00MSMS - Bassett

Public Health Southampton

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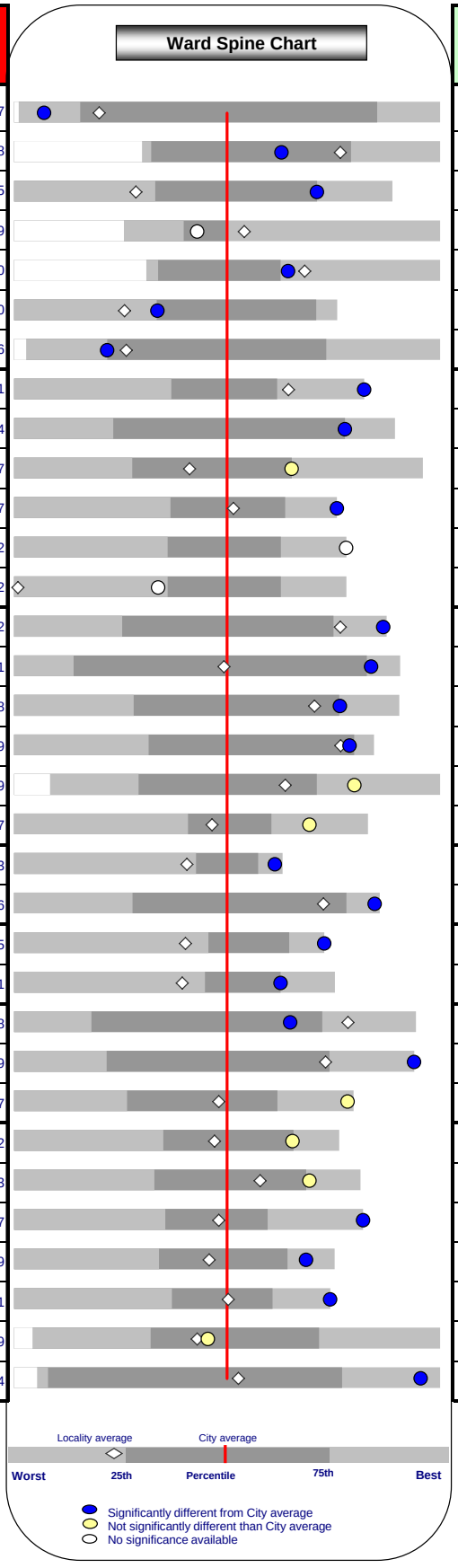
		Indicator	Ward no.	Ward Value	Locality Average	City Average	City Worst	City Best
Demography	1	% Resident Population aged 0-4 years^	661	4.55	5.14	6.50	4.27	8.78
	2	% Resident Population aged 18-24 years^	3321	22.85	29.29	16.88	7.58	40.20
	3	% Resident Population aged over 65 years^	2363	16.26	9.69	12.99	5.25	19.00
	4	Forecast % change in popualtion 2011-18^	215	1.48	4.10	3.14	-2.59	14.99
	5	% Population from minority ethnic groups^	3132	21.55	23.59	14.08	4.20	40.14
	6	% Population born in the UK^	10948	75.34	71.97	82.42	60.70	93.64
	7	General Fertility Rate^	770	45.05	47.52	60.53	34.56	88.07
Economic	8	Working Age Claimant Rate	690	6.91	10.68	13.73	24.31	6.91
	9	Adults with No Qualifications	1789	14.16	14.21	20.96	33.24	11.29
	10	16-18 year old NEET	13	4.29	5.72	5.19	8.17	2.46
	11	Long Term Unemployed	25	2.50	6.08	6.30	13.67	2.50
	12	Least Deprived LSOA in Ward	-	5.21	5.21	24.98	60.32	5.21
	13	Most Deprived LSOA in Ward	-	36.37	59.63	24.98	60.32	5.21
Healthy Start	14	Lone Parent Families	209	3.80	4.69	7.03	11.42	3.74
	15	Child Poverty	360	16.78	25.48	25.31	37.91	15.08
	16	% Smoking in Pregnancy	60	13.48	14.68	18.78	28.78	10.71
	17	% Breastfeeding	377	84.72	84.01	74.92	57.89	86.67
	18	Year R Child Obesity	20	6.97	8.27	9.36	12.69	5.36
	19	Year 6 Child Obesity	42	16.67	20.46	19.88	28.17	14.40
Lifestyle	20	Alcohol Specific Hospital Admissions (DSR)	240	338.83	888.98	638.81	1971.63	291.06
	21	Smoking Related Hospital Admissions (DSR)	354	1276.93	1440.27	1747.38	2426.06	1260.90
Safety	22	Violent Crime	102	7.02	28.14	21.82	54.25	7.02
	23	Road KSIs	83	192.36	343.35	274.71	602.21	109.17
Disability and Poor Health	24	Limiting Illness	1923	19.26	16.07	22.74	34.48	12.33
	25	DLA Claimants	390	31.56	43.49	56.74	85.39	31.56
	26	Injuries due to Falls (65+)	52	401.20	501.82	495.41	661.77	396.67
Mortality	27	All Age All Cause Mortality (DSR)	618	519.78	577.76	568.54	727.02	485.04
	28	Premature Mortality from Cancer	68	99.57	110.87	118.46	167.23	87.91
	29	Premature Mortality from CVD	26	39.35	72.93	71.01	120.57	39.35
	30	Premature Mortality from Respiratory Disease	10	13.99	31.56	28.34	66.99	8.83
	31	Mortality from Preventable Causes	83	112.40	173.24	173.99	301.11	112.40
	32	Life Expectancy Females	-	82.24	82.09	82.49	79.89	85.34
	33	Life Expectancy Males	-	80.59	78.47	78.34	76.14	80.81



^ The terms 'best' and 'worst' are not appropriate for these indicators instead the right side of the chart indicates the highest value and the left side the lowest.

Public Health Ward Profiles: 2012/13

Southampton North & Central Locality

00MSMT - Bevois

Public Health Southampton

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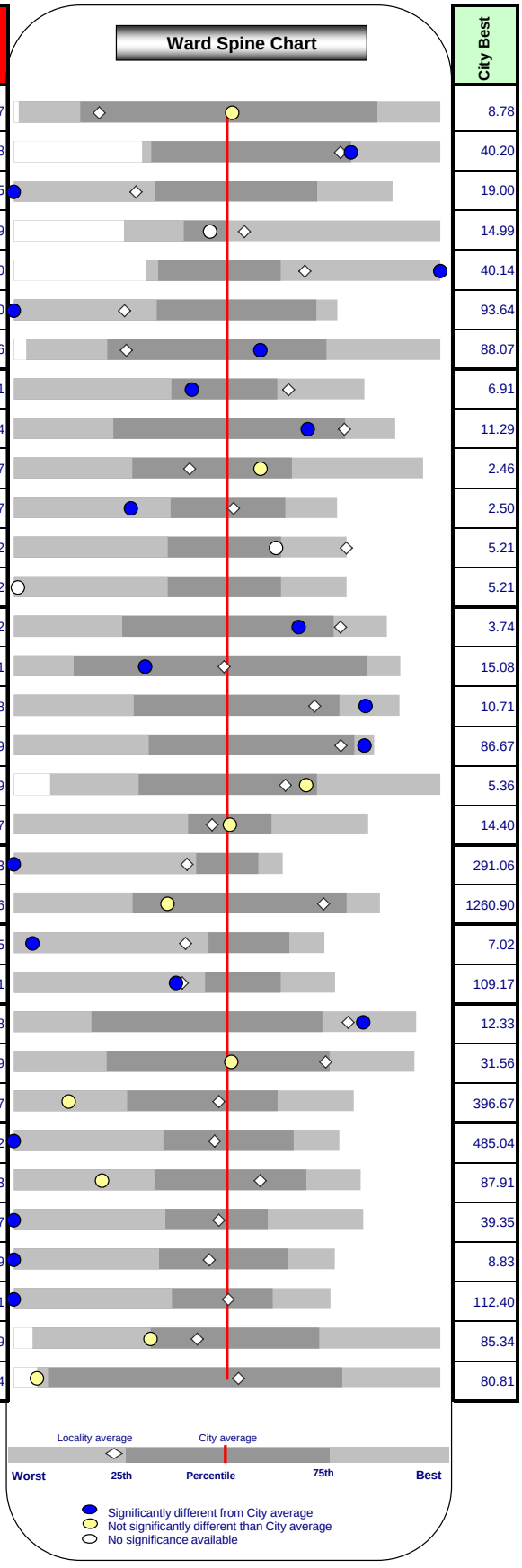
		Indicator	Ward no.	Ward Value	Locality Average	City Average	City Worst	City Best
Demography	1	% Resident Population aged 0-4 years^	1105	6.56	5.14	6.50	4.27	8.78
	2	% Resident Population aged 18-24 years^	5128	30.44	29.29	16.88	7.58	40.20
	3	% Resident Population aged over 65 years^	885	5.25	9.69	12.99	5.25	19.00
	4	Forecast % change in popualtion 2011-18^	362	2.20	4.10	3.14	-2.59	14.99
	5	% Population from minority ethnic groups^	6762	40.14	23.59	14.08	4.20	40.14
	6	% Population born in the UK^	10224	60.70	71.97	82.42	60.70	93.64
	7	General Fertility Rate^	1423	64.85	47.52	60.53	34.56	88.07
Economic	8	Working Age Claimant Rate	2010	15.47	10.68	13.73	24.31	6.91
	9	Adults with No Qualifications	2302	16.31	14.21	20.96	33.24	11.29
	10	16-18 year old NEET	18	4.72	5.72	5.19	8.17	2.46
	11	Long Term Unemployed	125	9.62	6.08	6.30	13.67	2.50
	12	Least Deprived LSOA in Ward	-	16.84	5.21	24.98	60.32	5.21
	13	Most Deprived LSOA in Ward	-	59.63	59.63	24.98	60.32	5.21
Healthy Start	14	Lone Parent Families	344	5.55	4.69	7.03	11.42	3.74
	15	Child Poverty	975	30.14	25.48	25.31	37.91	15.08
	16	% Smoking in Pregnancy	102	12.29	14.68	18.78	28.78	10.71
	17	% Breastfeeding	713	85.90	84.01	74.92	57.89	86.67
	18	Year R Child Obesity	40	7.87	8.27	9.36	12.69	5.36
	19	Year 6 Child Obesity	85	19.77	20.46	19.88	28.17	14.40
Lifestyle	20	Alcohol Specific Hospital Admissions (DSR)	1154	1971.63	888.98	638.81	1971.63	291.06
	21	Smoking Related Hospital Admissions (DSR)	295	1937.05	1440.27	1747.38	2426.06	1260.90
Safety	22	Violent Crime	850	51.40	28.14	21.82	54.25	7.02
	23	Road KSIs	170	353.06	343.35	274.71	602.21	109.17
Disability and Poor Health	24	Limiting Illness	1979	15.23	16.07	22.74	34.48	12.33
	25	DLA Claimants	780	56.17	43.49	56.74	85.39	31.56
	26	Injuries due to Falls (65+)	41	618.93	501.82	495.41	661.77	396.67
Mortality	27	All Age All Cause Mortality (DSR)	410	727.02	577.76	568.54	727.02	485.04
	28	Premature Mortality from Cancer	59	147.05	110.87	118.46	167.23	87.91
	29	Premature Mortality from CVD	51	120.57	72.93	71.01	120.57	39.35
	30	Premature Mortality from Respiratory Disease	27	66.99	31.56	28.34	66.99	8.83
	31	Mortality from Preventable Causes	143	301.11	173.24	173.99	301.11	112.40
	32	Life Expectancy Females	-	81.47	82.09	82.49	79.89	85.34
	33	Life Expectancy Males	-	76.14	78.47	78.34	76.14	80.81



^ The terms 'best' and 'worst' are not appropriate for these indicators instead the right side of the chart indicates the highest value and the left side the lowest.

Public Health Ward Profiles: 2012/13

Southampton South & East Locality

00MSMU - Bitterne

Public Health Southampton

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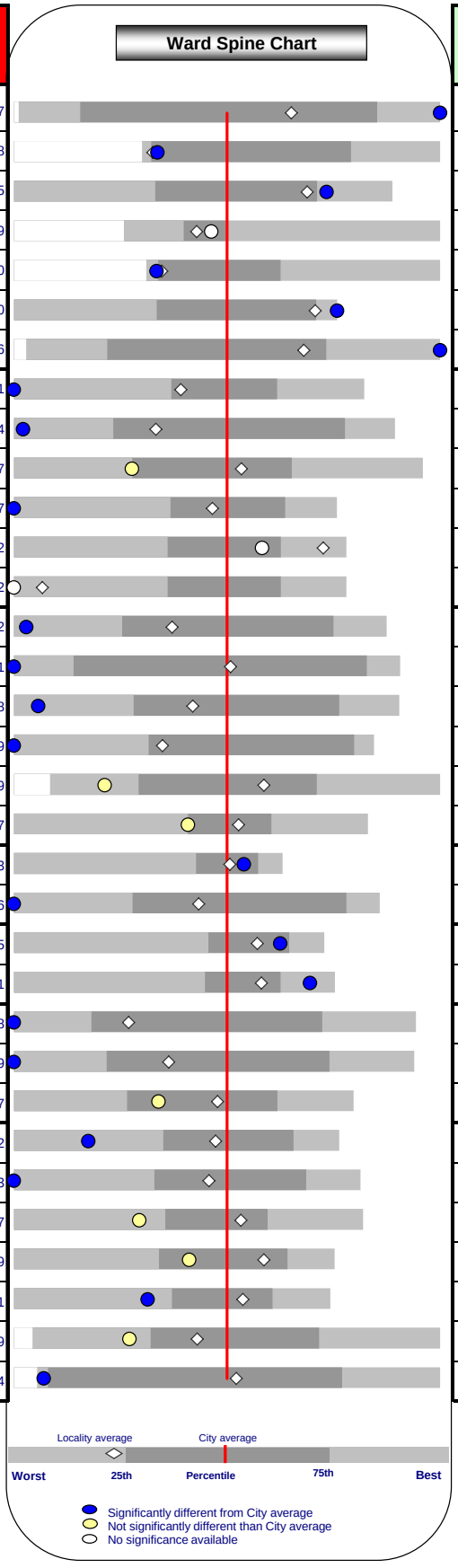
		Indicator	Ward no.	Ward Value	Locality Average	City Average	City Worst	City Best
Demography	1	% Resident Population aged 0-4 years^	1212	8.78	7.19	6.50	4.27	8.78
	2	% Resident Population aged 18-24 years^	1281	9.28	8.76	16.88	7.58	40.20
	3	% Resident Population aged over 65 years^	2292	16.61	15.90	12.99	5.25	19.00
	4	Forecast % change in popualtion 2011-18^	312	2.27	1.46	3.14	-2.59	14.99
	5	% Population from minority ethnic groups^	755	5.47	6.11	14.08	4.20	40.14
	6	% Population born in the UK^	12922	93.64	91.41	82.42	60.70	93.64
	7	General Fertility Rate^	1265	88.07	70.46	60.53	34.56	88.07
Economic	8	Working Age Claimant Rate	2045	24.31	16.02	13.73	24.31	6.91
	9	Adults with No Qualifications	3507	32.71	25.06	20.96	33.24	11.29
	10	16-18 year old NEET	33	6.52	4.99	5.19	8.17	2.46
	11	Long Term Unemployed	115	13.67	6.81	6.30	13.67	2.50
	12	Least Deprived LSOA in Ward	-	19.16	9.03	24.98	60.32	5.21
	13	Most Deprived LSOA in Ward	-	60.32	55.60	24.98	60.32	5.21
Healthy Start	14	Lone Parent Families	675	11.17	8.16	7.03	11.42	3.74
	15	Child Poverty	1395	37.91	25.10	25.31	37.91	15.08
	16	% Smoking in Pregnancy	210	27.63	20.39	18.78	28.78	10.71
	17	% Breastfeeding	440	57.89	69.77	74.92	57.89	86.67
	18	Year R Child Obesity	73	11.66	8.67	9.36	12.69	5.36
	19	Year 6 Child Obesity	95	21.40	19.43	19.88	28.17	14.40
Lifestyle	20	Alcohol Specific Hospital Admissions (DSR)	347	533.12	621.01	638.81	1971.63	291.06
	21	Smoking Related Hospital Admissions (DSR)	548	2426.06	1837.60	1747.38	2426.06	1260.90
Safety	22	Violent Crime	192	13.71	17.21	21.82	54.25	7.02
	23	Road KSIs	61	146.94	221.74	274.71	602.21	109.17
Disability and Poor Health	24	Limiting Illness	2900	34.48	28.15	22.74	34.48	12.33
	25	DLA Claimants	915	85.39	64.57	56.74	85.39	31.56
	26	Injuries due to Falls (65+)	58	548.88	502.80	495.41	661.77	396.67
Mortality	27	All Age All Cause Mortality (DSR)	605	671.62	576.97	568.54	727.02	485.04
	28	Premature Mortality from Cancer	98	167.23	122.59	118.46	167.23	87.91
	29	Premature Mortality from CVD	54	91.39	67.76	71.01	120.57	39.35
	30	Premature Mortality from Respiratory Disease	20	35.19	21.64	28.34	66.99	8.83
	31	Mortality from Preventable Causes	137	221.24	164.51	173.99	301.11	112.40
	32	Life Expectancy Females	-	81.19	82.09	82.49	79.89	85.34
	33	Life Expectancy Males	-	76.21	78.45	78.34	76.14	80.81



^ The terms 'best' and 'worst' are not appropriate for these indicators instead the right side of the chart indicates the highest value and the left side the lowest.

Public Health Ward Profiles: 2012/13

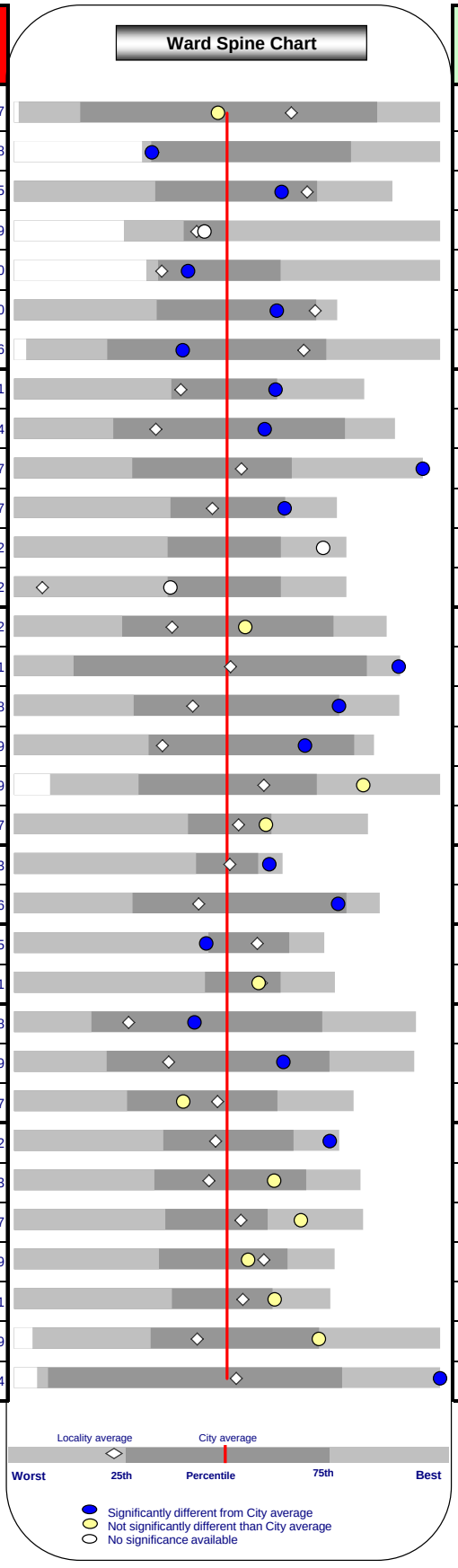
Southampton South & East Locality

00MSMW - Bitterne Park

Public Health Southampton

Main Menu | Metadata | Print

		Indicator	Ward no.	Ward Value	Locality Average	City Average	City Worst	City Best
Demography	1	% Resident Population aged 0-4 years^	899	6.41	7.19	6.50	4.27	8.78
	2	% Resident Population aged 18-24 years^	1215	8.66	8.76	16.88	7.58	40.20
	3	% Resident Population aged over 65 years^	2101	14.98	15.90	12.99	5.25	19.00
	4	Forecast % change in popualtion 2011-18^	275	1.89	1.46	3.14	-2.59	14.99
	5	% Population from minority ethnic groups^	1308	9.33	6.11	14.08	4.20	40.14
	6	% Population born in the UK^	12274	87.51	91.41	82.42	60.70	93.64
	7	General Fertility Rate^	912	54.82	70.46	60.53	34.56	88.07
Economic	8	Working Age Claimant Rate	1050	11.31	16.02	13.73	24.31	6.91
	9	Adults with No Qualifications	2146	18.79	25.06	20.96	33.24	11.29
	10	16-18 year old NEET	11	2.46	4.99	5.19	8.17	2.46
	11	Long Term Unemployed	40	4.31	6.81	6.30	13.67	2.50
	12	Least Deprived LSOA in Ward	-	9.03	9.03	24.98	60.32	5.21
	13	Most Deprived LSOA in Ward	-	34.33	55.60	24.98	60.32	5.21
Healthy Start	14	Lone Parent Families	406	6.65	8.16	7.03	11.42	3.74
	15	Child Poverty	440	15.15	25.10	25.31	37.91	15.08
	16	% Smoking in Pregnancy	79	13.53	20.39	18.78	28.78	10.71
	17	% Breastfeeding	474	81.16	69.77	74.92	57.89	86.67
	18	Year R Child Obesity	31	6.80	8.67	9.36	12.69	5.36
	19	Year 6 Child Obesity	65	18.36	19.43	19.88	28.17	14.40
Lifestyle	20	Alcohol Specific Hospital Admissions (DSR)	277	373.11	621.01	638.81	1971.63	291.06
	21	Smoking Related Hospital Admissions (DSR)	363	1392.95	1837.60	1747.38	2426.06	1260.90
Safety	22	Violent Crime	365	24.97	17.21	21.82	54.25	7.02
	23	Road KSIs	98	225.84	221.74	274.71	602.21	109.17
Disability and Poor Health	24	Limiting Illness	2277	24.53	28.15	22.74	34.48	12.33
	25	DLA Claimants	560	49.14	64.57	56.74	85.39	31.56
	26	Injuries due to Falls (65+)	59	529.46	502.80	495.41	661.77	396.67
Mortality	27	All Age All Cause Mortality (DSR)	507	492.04	576.97	568.54	727.02	485.04
	28	Premature Mortality from Cancer	73	107.63	122.59	118.46	167.23	87.91
	29	Premature Mortality from CVD	37	53.81	67.76	71.01	120.57	39.35
	30	Premature Mortality from Respiratory Disease	17	24.49	21.64	28.34	66.99	8.83
	31	Mortality from Preventable Causes	109	145.47	164.51	173.99	301.11	112.40
	32	Life Expectancy Females	-	83.72	82.09	82.49	79.89	85.34
	33	Life Expectancy Males	-	80.81	78.45	78.34	76.14	80.81



^ The terms 'best' and 'worst' are not appropriate for these indicators instead the right side of the chart indicates the highest value and the left side the lowest.

Public Health Ward Profiles: 2012/13

Southampton City West Locality

00MSMX - Coxford

Public Health Southampton

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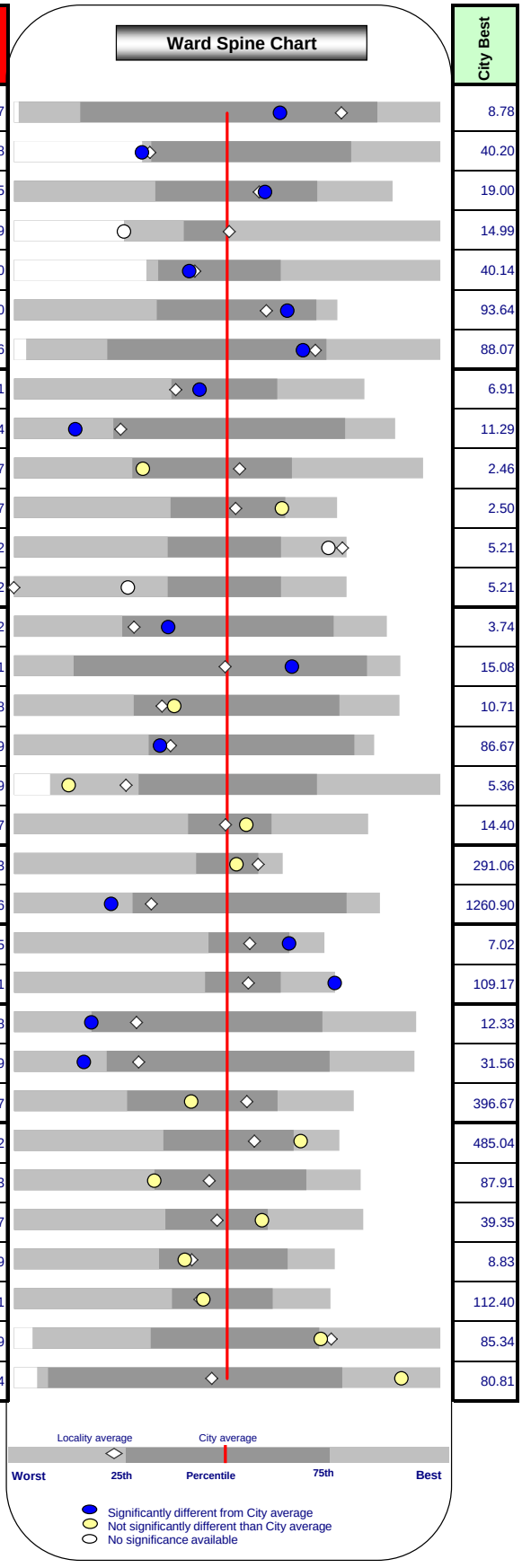
		Indicator	Ward no.	Ward Value	Locality Average	City Average	City Worst	City Best
Demography	1	% Resident Population aged 0-4 years^	993	7.07	7.73	6.50	4.27	8.78
	2	% Resident Population aged 18-24 years^	1065	7.58	8.44	16.88	7.58	40.20
	3	% Resident Population aged over 65 years^	2019	14.37	14.16	12.99	5.25	19.00
	4	Forecast % change in popualtion 2011-18^	Under 5	-2.59	3.26	3.14	-2.59	14.99
	5	% Population from minority ethnic groups^	1328	9.45	10.13	14.08	4.20	40.14
	6	% Population born in the UK^	12438	88.55	86.41	82.42	60.70	93.64
	7	General Fertility Rate^	1010	70.35	71.94	60.53	34.56	88.07
Economic	8	Working Age Claimant Rate	1370	15.09	16.28	13.73	24.31	6.91
	9	Adults with No Qualifications	3310	29.70	27.10	20.96	33.24	11.29
	10	16-18 year old NEET	33	6.37	5.02	5.19	8.17	2.46
	11	Long Term Unemployed	40	4.41	6.01	6.30	13.67	2.50
	12	Least Deprived LSOA in Ward	-	8.15	5.84	24.98	60.32	5.21
	13	Most Deprived LSOA in Ward	-	41.41	60.32	24.98	60.32	5.21
Healthy Start	14	Lone Parent Families	483	8.24	8.95	7.03	11.42	3.74
	15	Child Poverty	715	21.47	25.43	25.31	37.91	15.08
	16	% Smoking in Pregnancy	132	21.26	21.83	18.78	28.78	10.71
	17	% Breastfeeding	432	69.57	70.40	74.92	57.89	86.67
	18	Year R Child Obesity	58	12.34	11.27	9.36	12.69	5.36
	19	Year 6 Child Obesity	79	19.13	19.94	19.88	28.17	14.40
Lifestyle	20	Alcohol Specific Hospital Admissions (DSR)	413	579.42	444.65	638.81	1971.63	291.06
	21	Smoking Related Hospital Admissions (DSR)	567	2116.24	1988.49	1747.38	2426.06	1260.90
Safety	22	Violent Crime	175	12.37	18.37	21.82	54.25	7.02
	23	Road KSIs	46	109.17	242.00	274.71	602.21	109.17
Disability and Poor Health	24	Limiting Illness	2742	30.21	27.72	22.74	34.48	12.33
	25	DLA Claimants	845	75.99	68.62	56.74	85.39	31.56
	26	Injuries due to Falls (65+)	58	523.31	479.89	495.41	661.77	396.67
Mortality	27	All Age All Cause Mortality (DSR)	519	513.82	548.19	568.54	727.02	485.04
	28	Premature Mortality from Cancer	99	135.09	122.54	118.46	167.23	87.91
	29	Premature Mortality from CVD	48	62.88	73.31	71.01	120.57	39.35
	30	Premature Mortality from Respiratory Disease	27	35.99	34.72	28.34	66.99	8.83
	31	Mortality from Preventable Causes	154	188.11	190.18	173.99	301.11	112.40
	32	Life Expectancy Females	-	83.75	83.88	82.49	79.89	85.34
	33	Life Expectancy Males	-	80.36	78.16	78.34	76.14	80.81



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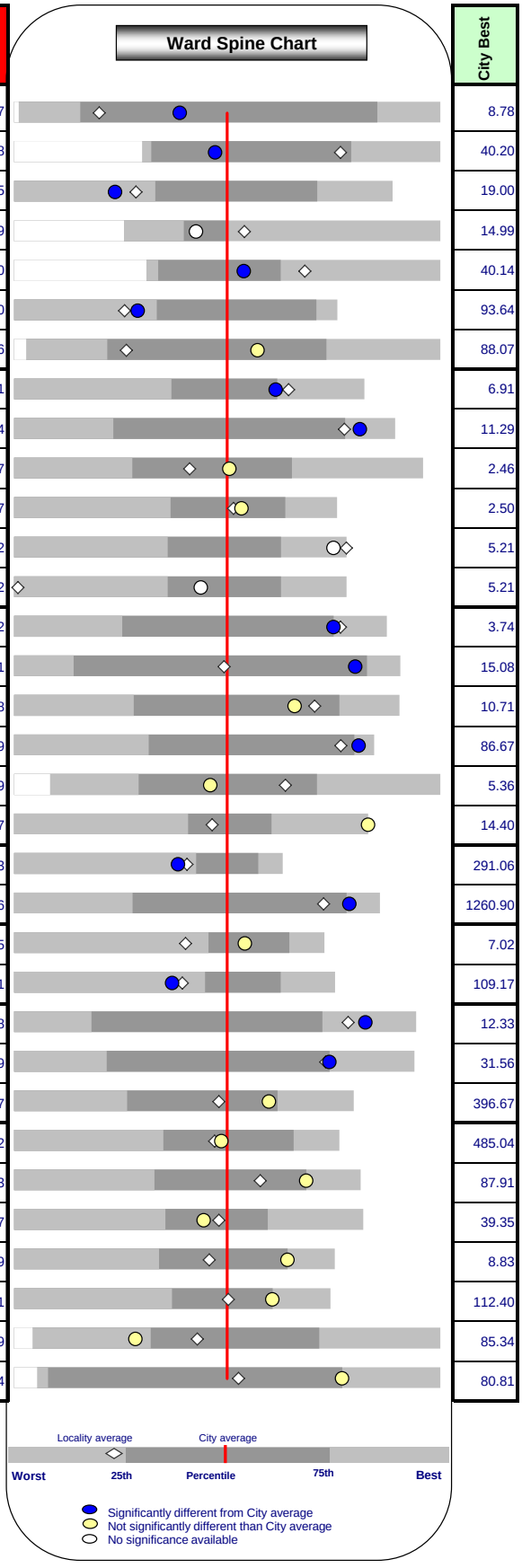
Public Health Ward Profiles: 2012/13

Southampton North & Central Locality

00MSMY - Freemantle

Public Health Southampton

		Indicator	Ward no.	Ward Value	Locality Average	City Average	City Worst	City Best
Demography	1	% Resident Population aged 0-4 years^	956	6.00	5.14	6.50	4.27	8.78
	2	% Resident Population aged 18-24 years^	2482	15.57	29.29	16.88	7.58	40.20
	3	% Resident Population aged over 65 years^	1423	8.93	9.69	12.99	5.25	19.00
	4	Forecast % change in popualtion 2011-18^	222	1.42	4.10	3.14	-2.59	14.99
	5	% Population from minority ethnic groups^	2570	16.13	23.59	14.08	4.20	40.14
	6	% Population born in the UK^	11685	73.32	71.97	82.42	60.70	93.64
	7	General Fertility Rate^	1216	64.48	47.52	60.53	34.56	88.07
Economic	8	Working Age Claimant Rate	1365	11.32	10.68	13.73	24.31	6.91
	9	Adults with No Qualifications	1826	13.31	14.21	20.96	33.24	11.29
	10	16-18 year old NEET	16	5.16	5.72	5.19	8.17	2.46
	11	Long Term Unemployed	70	5.80	6.08	6.30	13.67	2.50
	12	Least Deprived LSOA in Ward	-	7.32	5.21	24.98	60.32	5.21
	13	Most Deprived LSOA in Ward	-	29.31	59.63	24.98	60.32	5.21
Healthy Start	14	Lone Parent Families	355	4.83	4.69	7.03	11.42	3.74
	15	Child Poverty	445	17.73	25.48	25.31	37.91	15.08
	16	% Smoking in Pregnancy	119	15.62	14.68	18.78	28.78	10.71
	17	% Breastfeeding	651	85.43	84.01	74.92	57.89	86.67
	18	Year R Child Obesity	39	9.68	8.27	9.36	12.69	5.36
	19	Year 6 Child Obesity	37	14.40	20.46	19.88	28.17	14.40
Lifestyle	20	Alcohol Specific Hospital Admissions (DSR)	687	945.42	888.98	638.81	1971.63	291.06
	21	Smoking Related Hospital Admissions (DSR)	319	1357.64	1440.27	1747.38	2426.06	1260.90
Safety	22	Violent Crime	299	19.11	28.14	21.82	54.25	7.02
	23	Road KSIs	168	359.08	343.35	274.71	602.21	109.17
Disability and Poor Health	24	Limiting Illness	1824	15.12	16.07	22.74	34.48	12.33
	25	DLA Claimants	580	42.98	43.49	56.74	85.39	31.56
	26	Injuries due to Falls (65+)	49	462.74	501.82	495.41	661.77	396.67
Mortality	27	All Age All Cause Mortality (DSR)	584	572.73	577.76	568.54	727.02	485.04
	28	Premature Mortality from Cancer	65	100.34	110.87	118.46	167.23	87.91
	29	Premature Mortality from CVD	48	76.44	72.93	71.01	120.57	39.35
	30	Premature Mortality from Respiratory Disease	11	17.37	31.56	28.34	66.99	8.83
	31	Mortality from Preventable Causes	108	146.92	173.24	173.99	301.11	112.40
	32	Life Expectancy Females	-	81.27	82.09	82.49	79.89	85.34
	33	Life Expectancy Males	-	79.67	78.47	78.34	76.14	80.81



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Public Health Ward Profiles: 2012/13

Southampton South & East Locality

00MSMZ - Harefield

Public Health Southampton

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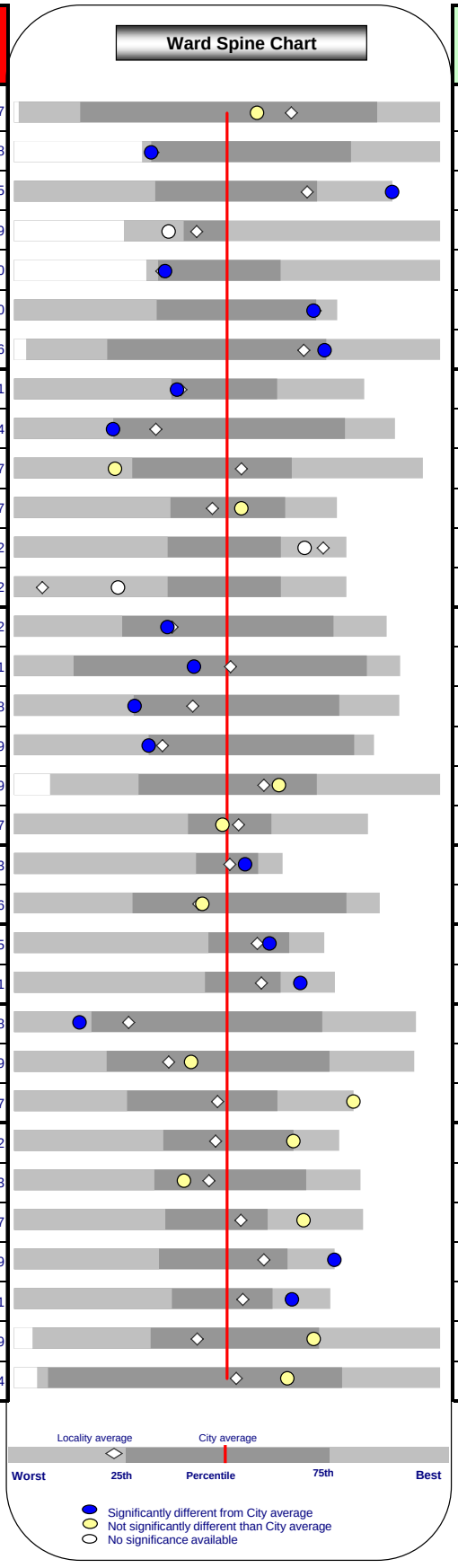
		Indicator	Ward no.	Ward Value	Locality Average	City Average	City Worst	City Best
Demography	1	% Resident Population aged 0-4 years^	958	6.83	7.19	6.50	4.27	8.78
	2	% Resident Population aged 18-24 years^	1206	8.59	8.76	16.88	7.58	40.20
	3	% Resident Population aged over 65 years^	2666	19.00	15.90	12.99	5.25	19.00
	4	Forecast % change in popualtion 2011-18^	Under 5	-0.10	1.46	3.14	-2.59	14.99
	5	% Population from minority ethnic groups^	915	6.52	6.11	14.08	4.20	40.14
	6	% Population born in the UK^	12807	91.25	91.41	82.42	60.70	93.64
	7	General Fertility Rate^	987	73.15	70.46	60.53	34.56	88.07
Economic	8	Working Age Claimant Rate	1395	16.20	16.02	13.73	24.31	6.91
	9	Adults with No Qualifications	3116	27.52	25.06	20.96	33.24	11.29
	10	16-18 year old NEET	34	6.76	4.99	5.19	8.17	2.46
	11	Long Term Unemployed	50	5.81	6.81	6.30	13.67	2.50
	12	Least Deprived LSOA in Ward	-	12.09	9.03	24.98	60.32	5.21
	13	Most Deprived LSOA in Ward	-	43.05	55.60	24.98	60.32	5.21
Healthy Start	14	Lone Parent Families	502	8.26	8.16	7.03	11.42	3.74
	15	Child Poverty	860	27.26	25.10	25.31	37.91	15.08
	16	% Smoking in Pregnancy	135	23.12	20.39	18.78	28.78	10.71
	17	% Breastfeeding	401	68.66	69.77	74.92	57.89	86.67
	18	Year R Child Obesity	41	8.38	8.67	9.36	12.69	5.36
	19	Year 6 Child Obesity	77	20.05	19.43	19.88	28.17	14.40
Lifestyle	20	Alcohol Specific Hospital Admissions (DSR)	364	524.83	621.01	638.81	1971.63	291.06
	21	Smoking Related Hospital Admissions (DSR)	560	1825.46	1837.60	1747.38	2426.06	1260.90
Safety	22	Violent Crime	220	15.34	17.21	21.82	54.25	7.02
	23	Road KSIs	68	161.69	221.74	274.71	602.21	109.17
Disability and Poor Health	24	Limiting Illness	2657	30.86	28.15	22.74	34.48	12.33
	25	DLA Claimants	695	61.56	64.57	56.74	85.39	31.56
	26	Injuries due to Falls (65+)	56	396.67	502.80	495.41	661.77	396.67
Mortality	27	All Age All Cause Mortality (DSR)	658	519.06	576.97	568.54	727.02	485.04
	28	Premature Mortality from Cancer	96	128.27	122.59	118.46	167.23	87.91
	29	Premature Mortality from CVD	40	53.17	67.76	71.01	120.57	39.35
	30	Premature Mortality from Respiratory Disease	7	8.83	21.64	28.34	66.99	8.83
	31	Mortality from Preventable Causes	115	135.12	164.51	173.99	301.11	112.40
	32	Life Expectancy Females	-	83.65	82.09	82.49	79.89	85.34
	33	Life Expectancy Males	-	79.04	78.45	78.34	76.14	80.81



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Public Health Ward Profiles: 2012/13

Southampton City West Locality

00MSNA - Millbrook

Public Health Southampton

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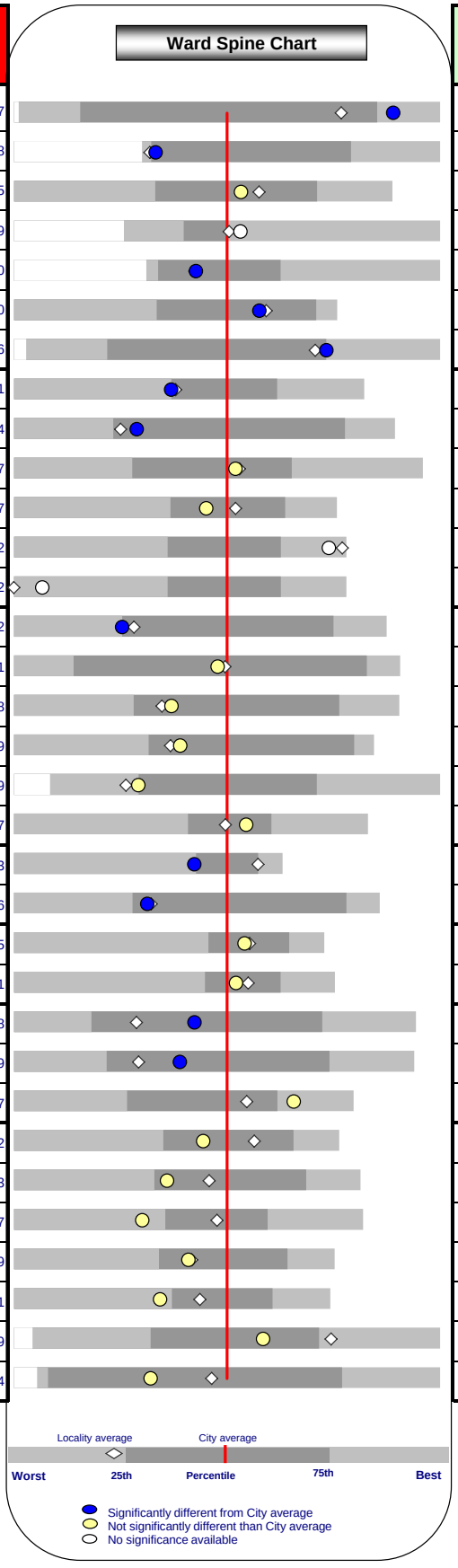
		Indicator	Ward no.	Ward Value	Locality Average	City Average	City Worst	Ward Spine Chart	City Best
Demography	1	% Resident Population aged 0-4 years^	1274	8.28	7.73	6.50	4.27		8.78
	2	% Resident Population aged 18-24 years^	1397	9.08	8.44	16.88	7.58		40.20
	3	% Resident Population aged over 65 years^	2077	13.50	14.16	12.99	5.25		19.00
	4	Forecast % change in popualtion 2011-18^	614	3.89	3.26	3.14	-2.59		14.99
	5	% Population from minority ethnic groups^	1582	10.28	10.13	14.08	4.20		40.14
	6	% Population born in the UK^	13187	85.73	86.41	82.42	60.70		93.64
	7	General Fertility Rate^	1335	73.39	71.94	60.53	34.56		88.07
Economic	8	Working Age Claimant Rate	1645	16.50	16.28	13.73	24.31		6.91
	9	Adults with No Qualifications	3163	26.16	27.10	20.96	33.24		11.29
	10	16-18 year old NEET	27	5.08	5.02	5.19	8.17		2.46
	11	Long Term Unemployed	70	7.02	6.01	6.30	13.67		2.50
	12	Least Deprived LSOA in Ward	-	8.07	5.84	24.98	60.32		5.21
	13	Most Deprived LSOA in Ward	-	55.60	60.32	24.98	60.32		5.21
Healthy Start	14	Lone Parent Families	595	9.19	8.95	7.03	11.42		3.74
	15	Child Poverty	980	25.86	25.43	25.31	37.91		15.08
	16	% Smoking in Pregnancy	164	21.38	21.83	18.78	28.78		10.71
	17	% Breastfeeding	546	71.19	70.40	74.92	57.89		86.67
	18	Year R Child Obesity	74	11.03	11.27	9.36	12.69		5.36
	19	Year 6 Child Obesity	88	19.13	19.94	19.88	28.17		14.40
Lifestyle	20	Alcohol Specific Hospital Admissions (DSR)	596	842.14	444.65	638.81	1971.63		291.06
	21	Smoking Related Hospital Admissions (DSR)	485	2001.17	1988.49	1747.38	2426.06		1260.90
Safety	22	Violent Crime	300	19.13	18.37	21.82	54.25		7.02
	23	Road KSIs	123	260.61	242.00	274.71	602.21		109.17
Disability and Poor Health	24	Limiting Illness	2445	24.52	27.72	22.74	34.48		12.33
	25	DLA Claimants	760	63.06	68.62	56.74	85.39		31.56
	26	Injuries due to Falls (65+)	50	443.27	479.89	495.41	661.77		396.67
Mortality	27	All Age All Cause Mortality (DSR)	585	586.09	548.19	568.54	727.02		485.04
	28	Premature Mortality from Cancer	79	132.16	122.54	118.46	167.23		87.91
	29	Premature Mortality from CVD	55	90.70	73.31	71.01	120.57		39.35
	30	Premature Mortality from Respiratory Disease	21	35.33	34.72	28.34	66.99		8.83
	31	Mortality from Preventable Causes	143	213.80	190.18	173.99	301.11		112.40
	32	Life Expectancy Females	-	82.98	83.88	82.49	79.89		85.34
	33	Life Expectancy Males	-	77.46	78.16	78.34	76.14		80.81



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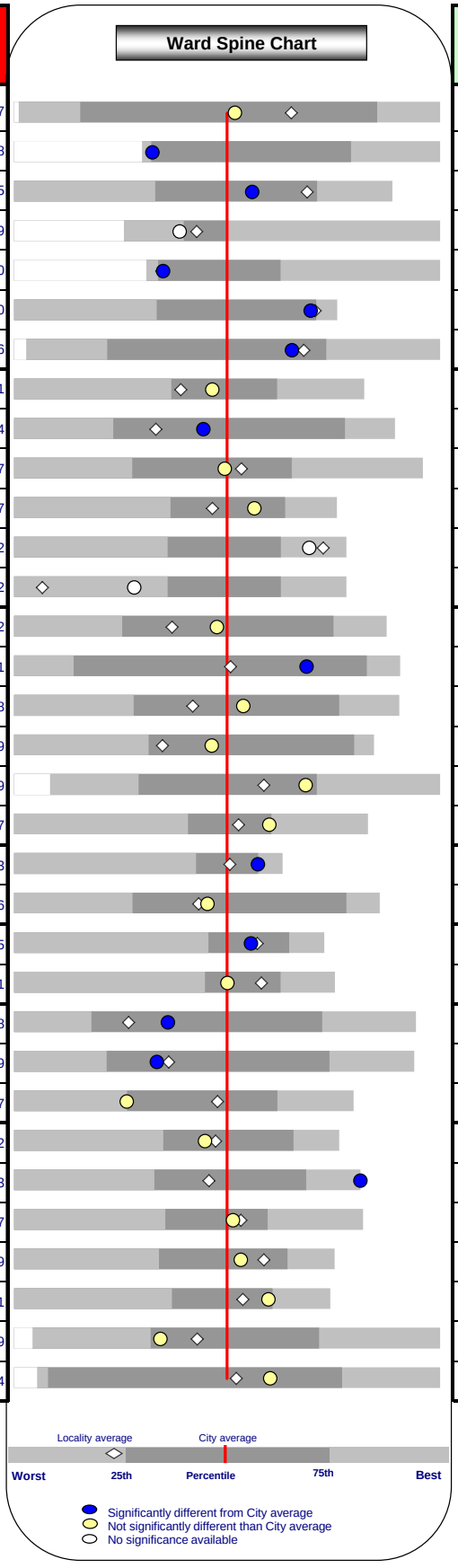
Public Health Ward Profiles: 2012/13

Southampton South & East Locality

00MSNB - Peartree

Public Health Southampton

		Indicator	Ward no.	Ward Value	Locality Average	City Average	City Worst	Ward Spine Chart	City Best
Demography	1	% Resident Population aged 0-4 years^	936	6.59	7.19	6.50	4.27		8.78
	2	% Resident Population aged 18-24 years^	1239	8.72	8.76	16.88	7.58		40.20
	3	% Resident Population aged over 65 years^	1976	13.91	15.90	12.99	5.25		19.00
	4	Forecast % change in popualtion 2011-18^	72	0.52	1.46	3.14	-2.59		14.99
	5	% Population from minority ethnic groups^	893	6.29	6.11	14.08	4.20		40.14
	6	% Population born in the UK^	12918	90.95	91.41	82.42	60.70		93.64
	7	General Fertility Rate^	1016	68.95	70.46	60.53	34.56		88.07
Economic	8	Working Age Claimant Rate	1350	14.45	16.02	13.73	24.31		6.91
	9	Adults with No Qualifications	2539	22.31	25.06	20.96	33.24		11.29
	10	16-18 year old NEET	28	5.22	4.99	5.19	8.17		2.46
	11	Long Term Unemployed	50	5.35	6.81	6.30	13.67		2.50
	12	Least Deprived LSOA in Ward	-	11.31	9.03	24.98	60.32		5.21
	13	Most Deprived LSOA in Ward	-	40.33	55.60	24.98	60.32		5.21
Healthy Start	14	Lone Parent Families	428	7.23	8.16	7.03	11.42		3.74
	15	Child Poverty	655	20.60	25.10	25.31	37.91		15.08
	16	% Smoking in Pregnancy	109	18.02	20.39	18.78	28.78		10.71
	17	% Breastfeeding	446	73.72	69.77	74.92	57.89		86.67
	18	Year R Child Obesity	35	7.88	8.67	9.36	12.69		5.36
	19	Year 6 Child Obesity	74	18.23	19.43	19.88	28.17		14.40
Lifestyle	20	Alcohol Specific Hospital Admissions (DSR)	312	444.89	621.01	638.81	1971.63		291.06
	21	Smoking Related Hospital Admissions (DSR)	445	1809.18	1837.60	1747.38	2426.06		1260.90
Safety	22	Violent Crime	252	18.15	17.21	21.82	54.25		7.02
	23	Road KSIs	113	273.85	221.74	274.71	602.21		109.17
Disability and Poor Health	24	Limiting Illness	2427	25.98	28.15	22.74	34.48		12.33
	25	DLA Claimants	750	66.16	64.57	56.74	85.39		31.56
	26	Injuries due to Falls (65+)	58	573.52	502.80	495.41	661.77		396.67
Mortality	27	All Age All Cause Mortality (DSR)	538	584.78	576.97	568.54	727.02		485.04
	28	Premature Mortality from Cancer	60	87.91	122.59	118.46	167.23		87.91
	29	Premature Mortality from CVD	47	69.61	67.76	71.01	120.57		39.35
	30	Premature Mortality from Respiratory Disease	18	25.81	21.64	28.34	66.99		8.83
	31	Mortality from Preventable Causes	109	149.25	164.51	173.99	301.11		112.40
	32	Life Expectancy Females	-	81.60	82.09	82.49	79.89		85.34
	33	Life Expectancy Males	-	78.84	78.45	78.34	76.14		80.81



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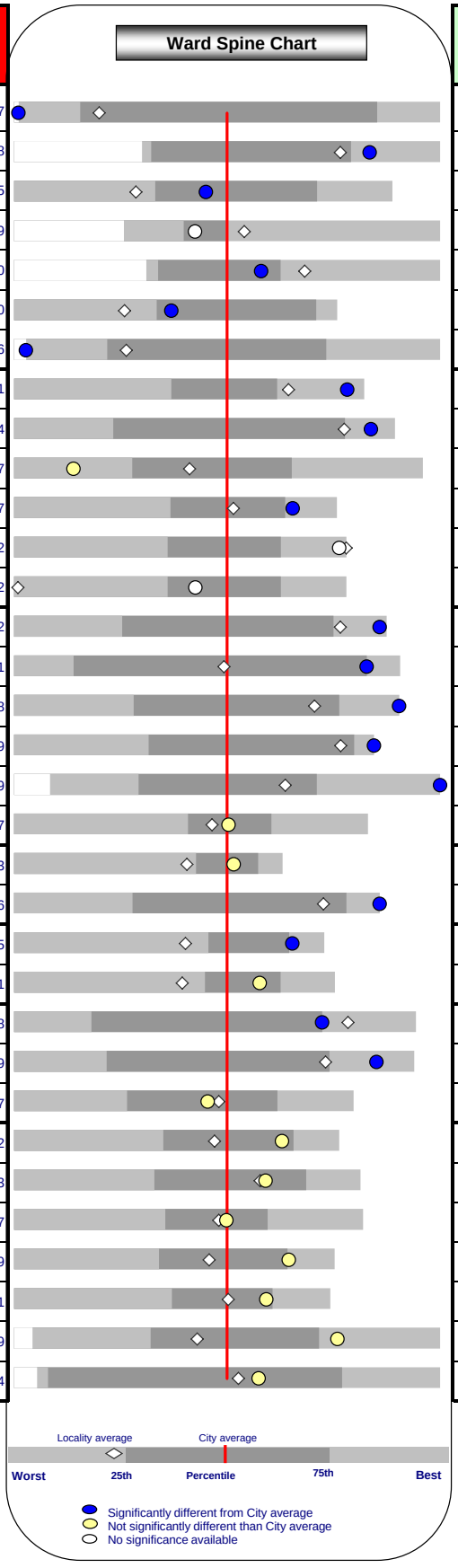
Public Health Ward Profiles: 2012/13

Southampton North & Central Locality

00MSNC - Portswood

Public Health Southampton

		Indicator	Ward no.	Ward Value	Locality Average	City Average	City Worst	City Best
Demography	1	% Resident Population aged 0-4 years^	634	4.27	5.14	6.50	4.27	8.78
	2	% Resident Population aged 18-24 years^	4821	32.51	29.29	16.88	7.58	40.20
	3	% Resident Population aged over 65 years^	1814	12.23	9.69	12.99	5.25	19.00
	4	Forecast % change in popualtion 2011-18^	208	1.36	4.10	3.14	-2.59	14.99
	5	% Population from minority ethnic groups^	2710	18.27	23.59	14.08	4.20	40.14
	6	% Population born in the UK^	11382	76.74	71.97	82.42	60.70	93.64
	7	General Fertility Rate^	744	34.56	47.52	60.53	34.56	88.07
Economic	8	Working Age Claimant Rate	865	7.75	10.68	13.73	24.31	6.91
	9	Adults with No Qualifications	1669	12.67	14.21	20.96	33.24	11.29
	10	16-18 year old NEET	16	7.34	5.72	5.19	8.17	2.46
	11	Long Term Unemployed	45	4.03	6.08	6.30	13.67	2.50
	12	Least Deprived LSOA in Ward	-	6.37	5.21	24.98	60.32	5.21
	13	Most Deprived LSOA in Ward	-	30.20	59.63	24.98	60.32	5.21
Healthy Start	14	Lone Parent Families	230	3.88	4.69	7.03	11.42	3.74
	15	Child Poverty	300	17.05	25.48	25.31	37.91	15.08
	16	% Smoking in Pregnancy	45	10.71	14.68	18.78	28.78	10.71
	17	% Breastfeeding	364	86.67	84.01	74.92	57.89	86.67
	18	Year R Child Obesity	15	5.36	8.27	9.36	12.69	5.36
	19	Year 6 Child Obesity	44	19.82	20.46	19.88	28.17	14.40
Lifestyle	20	Alcohol Specific Hospital Admissions (DSR)	359	595.74	888.98	638.81	1971.63	291.06
	21	Smoking Related Hospital Admissions (DSR)	302	1260.90	1440.27	1747.38	2426.06	1260.90
Safety	22	Violent Crime	181	11.85	28.14	21.82	54.25	7.02
	23	Road KSIs	101	224.28	343.35	274.71	602.21	109.17
Disability and Poor Health	24	Limiting Illness	1952	17.49	16.07	22.74	34.48	12.33
	25	DLA Claimants	475	36.62	43.49	56.74	85.39	31.56
	26	Injuries due to Falls (65+)	54	510.44	501.82	495.41	661.77	396.67
Mortality	27	All Age All Cause Mortality (DSR)	591	527.58	577.76	568.54	727.02	485.04
	28	Premature Mortality from Cancer	57	109.62	110.87	118.46	167.23	87.91
	29	Premature Mortality from CVD	37	71.12	72.93	71.01	120.57	39.35
	30	Premature Mortality from Respiratory Disease	9	17.11	31.56	28.34	66.99	8.83
	31	Mortality from Preventable Causes	91	150.44	173.24	173.99	301.11	112.40
	32	Life Expectancy Females	-	83.97	82.09	82.49	79.89	85.34
	33	Life Expectancy Males	-	78.71	78.47	78.34	76.14	80.81



^ The terms 'best' and 'worst' are not appropriate for these indicators instead the right side of the chart indicates the highest value and the left side the lowest.

Public Health Ward Profiles: 2012/13

Southampton City West Locality

00MSND - Redbridge

Public Health Southampton

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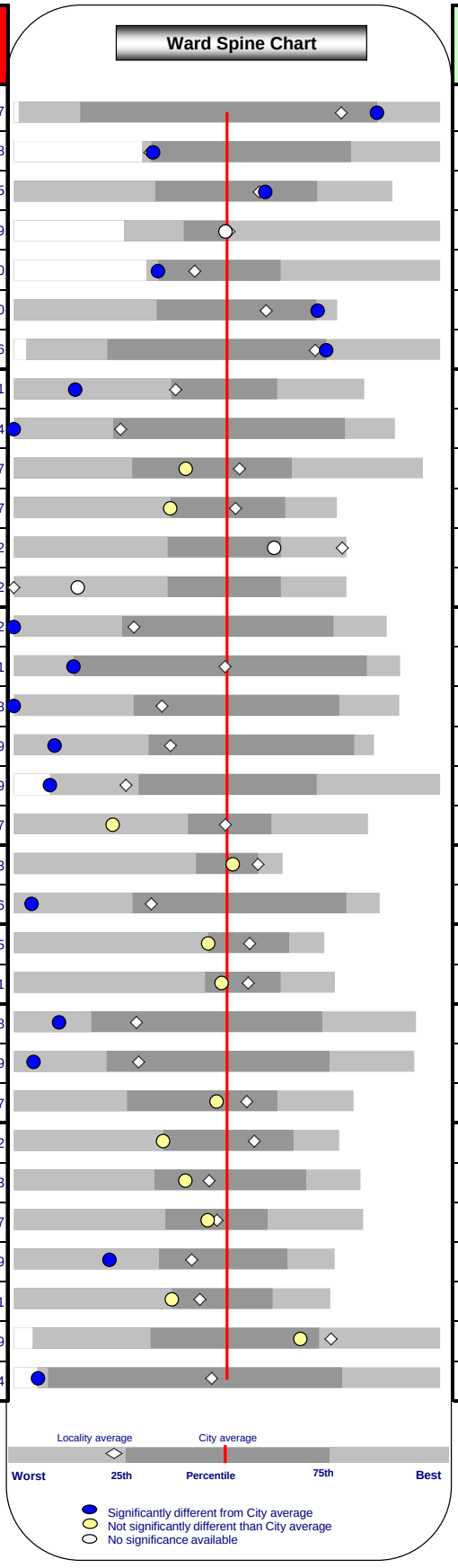
		Indicator	Ward no.	Ward Value	Locality Average	City Average	City Worst	City Best
Demography	1	% Resident Population aged 0-4 years^	1175	8.11	7.73	6.50	4.27	8.78
	2	% Resident Population aged 18-24 years^	1275	8.80	8.44	16.88	7.58	40.20
	3	% Resident Population aged over 65 years^	2084	14.38	14.16	12.99	5.25	19.00
	4	Forecast % change in popualtion 2011-18^	453	3.06	3.26	3.14	-2.59	14.99
	5	% Population from minority ethnic groups^	817	5.64	10.13	14.08	4.20	40.14
	6	% Population born in the UK^	13281	91.66	86.41	82.42	60.70	93.64
	7	General Fertility Rate^	1172	73.37	71.94	60.53	34.56	88.07
Economic	8	Working Age Claimant Rate	1930	21.26	16.28	13.73	24.31	6.91
	9	Adults with No Qualifications	3726	33.24	27.10	20.96	33.24	11.29
	10	16-18 year old NEET	30	5.77	5.02	5.19	8.17	2.46
	11	Long Term Unemployed	75	8.26	6.01	6.30	13.67	2.50
	12	Least Deprived LSOA in Ward	-	17.13	5.84	24.98	60.32	5.21
	13	Most Deprived LSOA in Ward	-	49.72	60.32	24.98	60.32	5.21
Healthy Start	14	Lone Parent Families	706	11.42	8.95	7.03	11.42	3.74
	15	Child Poverty	1315	34.38	25.43	25.31	37.91	15.08
	16	% Smoking in Pregnancy	200	28.78	21.83	18.78	28.78	10.71
	17	% Breastfeeding	425	61.15	70.40	74.92	57.89	86.67
	18	Year R Child Obesity	75	12.69	11.27	9.36	12.69	5.36
	19	Year 6 Child Obesity	108	24.32	19.94	19.88	28.17	14.40
Lifestyle	20	Alcohol Specific Hospital Admissions (DSR)	427	601.72	444.65	638.81	1971.63	291.06
	21	Smoking Related Hospital Admissions (DSR)	612	2369.21	1988.49	1747.38	2426.06	1260.90
Safety	22	Violent Crime	362	24.66	18.37	21.82	54.25	7.02
	23	Road KSIs	125	282.79	242.00	274.71	602.21	109.17
Disability and Poor Health	24	Limiting Illness	2903	31.98	27.72	22.74	34.48	12.33
	25	DLA Claimants	925	82.74	68.62	56.74	85.39	31.56
	26	Injuries due to Falls (65+)	58	503.43	479.89	495.41	661.77	396.67
Mortality	27	All Age All Cause Mortality (DSR)	624	616.01	548.19	568.54	727.02	485.04
	28	Premature Mortality from Cancer	86	127.96	122.54	118.46	167.23	87.91
	29	Premature Mortality from CVD	52	75.46	73.31	71.01	120.57	39.35
	30	Premature Mortality from Respiratory Disease	35	49.63	34.72	28.34	66.99	8.83
	31	Mortality from Preventable Causes	151	206.88	190.18	173.99	301.11	112.40
	32	Life Expectancy Females	-	83.47	83.88	82.49	79.89	85.34
	33	Life Expectancy Males	-	76.15	78.16	78.34	76.14	80.81



^ The terms 'best' and 'worst' are not appropriate for these indicators instead the right side of the chart indicates the highest value and the left side the lowest.

Public Health Ward Profiles: 2012/13

Southampton City West Locality

00MSNE - Shirley

Public Health Southampton

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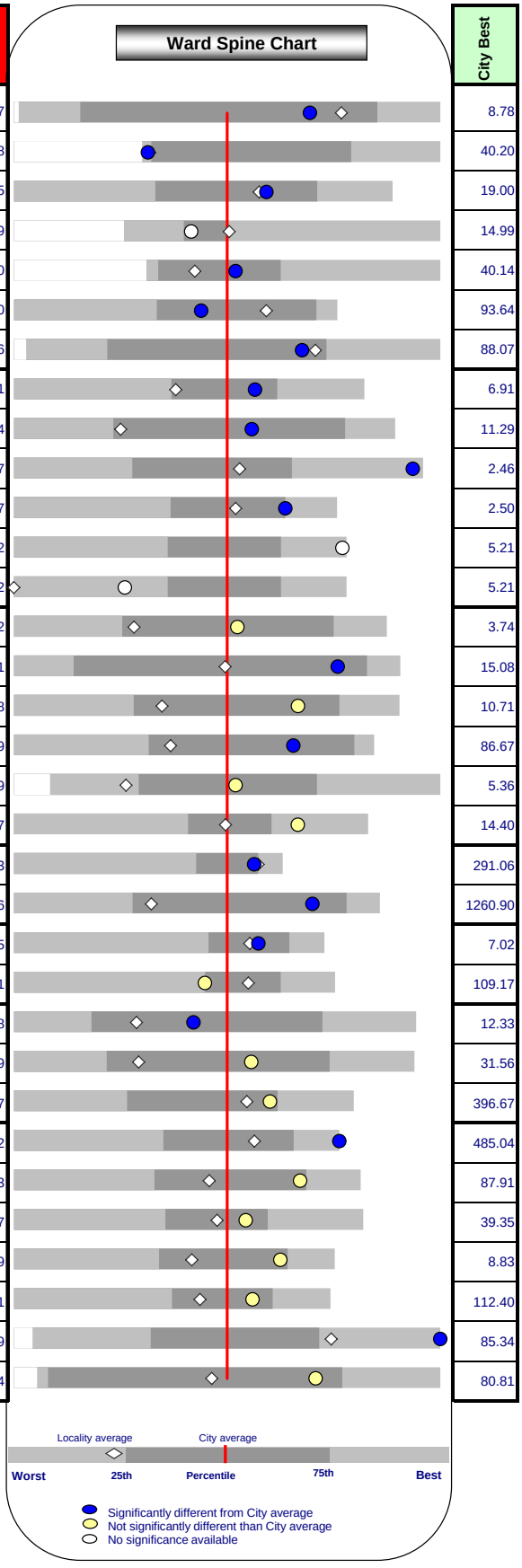
		Indicator	Ward no.	Ward Value	Locality Average	City Average	City Worst	City Best
Demography	1	% Resident Population aged 0-4 years^	1066	7.39	7.73	6.50	4.27	8.78
	2	% Resident Population aged 18-24 years^	1187	8.23	8.44	16.88	7.58	40.20
	3	% Resident Population aged over 65 years^	2081	14.43	14.16	12.99	5.25	19.00
	4	Forecast % change in popualtion 2011-18^	170	1.15	3.26	3.14	-2.59	14.99
	5	% Population from minority ethnic groups^	2184	15.14	10.13	14.08	4.20	40.14
	6	% Population born in the UK^	11508	79.78	86.41	82.42	60.70	93.64
	7	General Fertility Rate^	1077	70.24	71.94	60.53	34.56	88.07
Economic	8	Working Age Claimant Rate	1150	12.34	16.28	13.73	24.31	6.91
	9	Adults with No Qualifications	2238	19.54	27.10	20.96	33.24	11.29
	10	16-18 year old NEET	12	2.60	5.02	5.19	8.17	2.46
	11	Long Term Unemployed	40	4.29	6.01	6.30	13.67	2.50
	12	Least Deprived LSOA in Ward	-	5.84	5.84	24.98	60.32	5.21
	13	Most Deprived LSOA in Ward	-	41.91	60.32	24.98	60.32	5.21
Healthy Start	14	Lone Parent Families	408	6.81	8.95	7.03	11.42	3.74
	15	Child Poverty	640	18.77	25.43	25.31	37.91	15.08
	16	% Smoking in Pregnancy	100	15.46	21.83	18.78	28.78	10.71
	17	% Breastfeeding	519	80.22	70.40	74.92	57.89	86.67
	18	Year R Child Obesity	53	9.20	11.27	9.36	12.69	5.36
	19	Year 6 Child Obesity	75	17.12	19.94	19.88	28.17	14.40
Lifestyle	20	Alcohol Specific Hospital Admissions (DSR)	335	469.21	444.65	638.81	1971.63	291.06
	21	Smoking Related Hospital Admissions (DSR)	408	1475.53	1988.49	1747.38	2426.06	1260.90
Safety	22	Violent Crime	252	17.06	18.37	21.82	54.25	7.02
	23	Road KSIs	135	308.66	242.00	274.71	602.21	109.17
Disability and Poor Health	24	Limiting Illness	2291	24.58	27.72	22.74	34.48	12.33
	25	DLA Claimants	610	53.48	68.62	56.74	85.39	31.56
	26	Injuries due to Falls (65+)	57	461.81	479.89	495.41	661.77	396.67
Mortality	27	All Age All Cause Mortality (DSR)	537	485.04	548.19	568.54	727.02	485.04
	28	Premature Mortality from Cancer	70	101.73	122.54	118.46	167.23	87.91
	29	Premature Mortality from CVD	45	66.66	73.31	71.01	120.57	39.35
	30	Premature Mortality from Respiratory Disease	13	18.65	34.72	28.34	66.99	8.83
	31	Mortality from Preventable Causes	114	158.78	190.18	173.99	301.11	112.40
	32	Life Expectancy Females	-	85.34	83.88	82.49	79.89	85.34
	33	Life Expectancy Males	-	79.37	78.16	78.34	76.14	80.81



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Public Health Ward Profiles: 2012/13

Southampton South & East Locality

00MSNF - Sholing

Public Health Southampton

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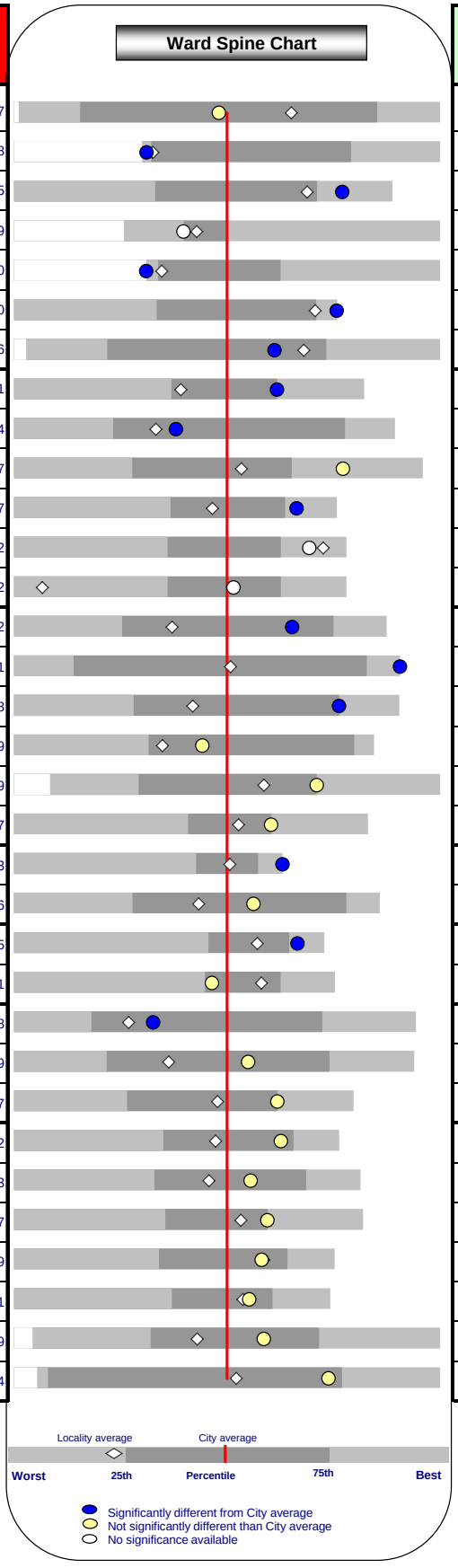
		Indicator	Ward no.	Ward Value	Locality Average	City Average	City Worst	City Best
Demography	1	% Resident Population aged 0-4 years^	902	6.42	7.19	6.50	4.27	8.78
	2	% Resident Population aged 18-24 years^	1135	8.08	8.76	16.88	7.58	40.20
	3	% Resident Population aged over 65 years^	2414	17.18	15.90	12.99	5.25	19.00
	4	Forecast % change in popualtion 2011-18^	104	0.73	1.46	3.14	-2.59	14.99
	5	% Population from minority ethnic groups^	590	4.20	6.11	14.08	4.20	40.14
	6	% Population born in the UK^	13156	93.62	91.41	82.42	60.70	93.64
	7	General Fertility Rate^	988	66.68	70.46	60.53	34.56	88.07
Economic	8	Working Age Claimant Rate	1010	11.24	16.02	13.73	24.31	6.91
	9	Adults with No Qualifications	2736	23.90	25.06	20.96	33.24	11.29
	10	16-18 year old NEET	17	3.57	4.99	5.19	8.17	2.46
	11	Long Term Unemployed	35	3.90	6.81	6.30	13.67	2.50
	12	Least Deprived LSOA in Ward	-	11.33	9.03	24.98	60.32	5.21
	13	Most Deprived LSOA in Ward	-	23.88	55.60	24.98	60.32	5.21
Healthy Start	14	Lone Parent Families	344	5.68	8.16	7.03	11.42	3.74
	15	Child Poverty	450	15.08	25.10	25.31	37.91	15.08
	16	% Smoking in Pregnancy	76	13.52	20.39	18.78	28.78	10.71
	17	% Breastfeeding	410	72.95	69.77	74.92	57.89	86.67
	18	Year R Child Obesity	33	7.67	8.67	9.36	12.69	5.36
	19	Year 6 Child Obesity	69	18.16	19.43	19.88	28.17	14.40
Lifestyle	20	Alcohol Specific Hospital Admissions (DSR)	213	291.06	621.01	638.81	1971.63	291.06
	21	Smoking Related Hospital Admissions (DSR)	436	1662.63	1837.60	1747.38	2426.06	1260.90
Safety	22	Violent Crime	159	11.09	17.21	21.82	54.25	7.02
	23	Road KSIs	125	297.79	221.74	274.71	602.21	109.17
Disability and Poor Health	24	Limiting Illness	2408	26.81	28.15	22.74	34.48	12.33
	25	DLA Claimants	615	53.89	64.57	56.74	85.39	31.56
	26	Injuries due to Falls (65+)	54	455.99	502.80	495.41	661.77	396.67
Mortality	27	All Age All Cause Mortality (DSR)	540	528.30	576.97	568.54	727.02	485.04
	28	Premature Mortality from Cancer	80	113.01	122.59	118.46	167.23	87.91
	29	Premature Mortality from CVD	44	61.60	67.76	71.01	120.57	39.35
	30	Premature Mortality from Respiratory Disease	16	22.02	21.64	28.34	66.99	8.83
	31	Mortality from Preventable Causes	123	160.73	164.51	173.99	301.11	112.40
	32	Life Expectancy Females	-	82.99	82.09	82.49	79.89	85.34
	33	Life Expectancy Males	-	79.52	78.45	78.34	76.14	80.81



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Public Health Ward Profiles: 2012/13

Southampton North & Central Locality

00MSNG - Swaythling

Public Health Southampton

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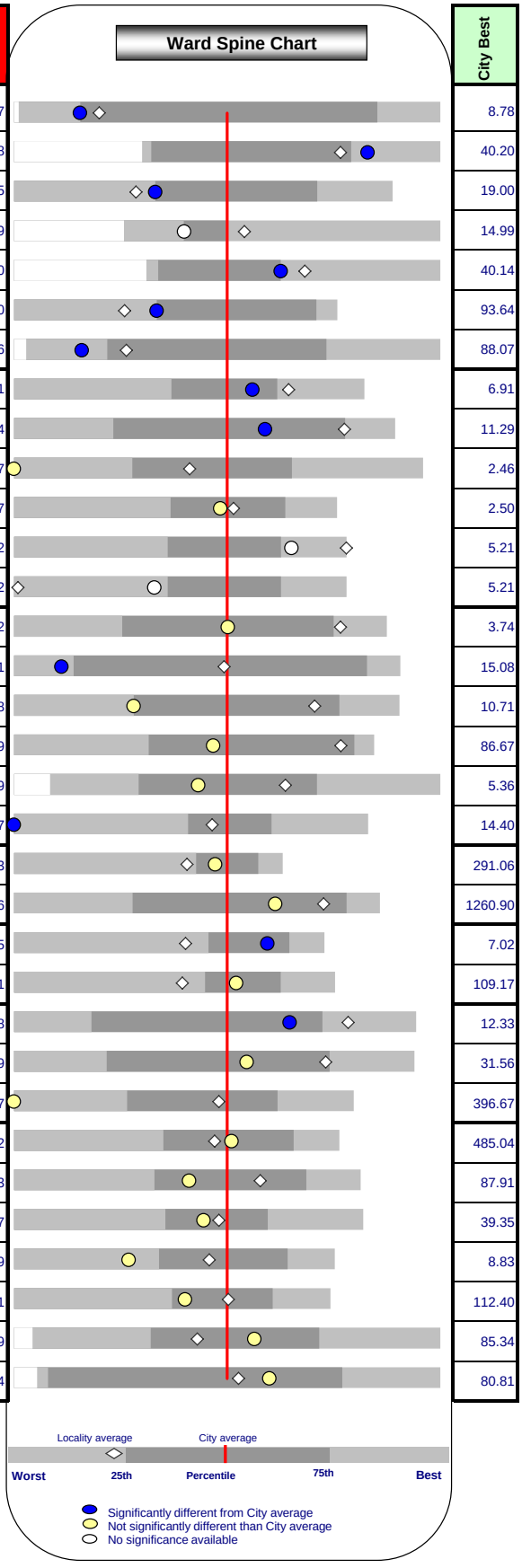
		Indicator	Ward no.	Ward Value	Locality Average	City Average	City Worst	City Best
Demography	1	% Resident Population aged 0-4 years^	674	4.93	5.14	6.50	4.27	8.78
	2	% Resident Population aged 18-24 years^	4408	32.26	29.29	16.88	7.58	40.20
	3	% Resident Population aged over 65 years^	1419	10.38	9.69	12.99	5.25	19.00
	4	Forecast % change in popualtion 2011-18^	106	0.75	4.10	3.14	-2.59	14.99
	5	% Population from minority ethnic groups^	2820	20.64	23.59	14.08	4.20	40.14
	6	% Population born in the UK^	10282	75.25	71.97	82.42	60.70	93.64
	7	General Fertility Rate^	788	41.76	47.52	60.53	34.56	88.07
Economic	8	Working Age Claimant Rate	1240	12.47	10.68	13.73	24.31	6.91
	9	Adults with No Qualifications	2189	18.77	14.21	20.96	33.24	11.29
	10	16-18 year old NEET	30	8.17	5.72	5.19	8.17	2.46
	11	Long Term Unemployed	65	6.54	6.08	6.30	13.67	2.50
	12	Least Deprived LSOA in Ward	-	14.29	5.21	24.98	60.32	5.21
	13	Most Deprived LSOA in Ward	-	37.04	59.63	24.98	60.32	5.21
Healthy Start	14	Lone Parent Families	326	7.01	4.69	7.03	11.42	3.74
	15	Child Poverty	795	35.10	25.48	25.31	37.91	15.08
	16	% Smoking in Pregnancy	107	23.16	14.68	18.78	28.78	10.71
	17	% Breastfeeding	341	73.81	84.01	74.92	57.89	86.67
	18	Year R Child Obesity	32	9.91	8.27	9.36	12.69	5.36
	19	Year 6 Child Obesity	80	28.17	20.46	19.88	28.17	14.40
Lifestyle	20	Alcohol Specific Hospital Admissions (DSR)	383	712.84	888.98	638.81	1971.63	291.06
	21	Smoking Related Hospital Admissions (DSR)	282	1593.81	1440.27	1747.38	2426.06	1260.90
Safety	22	Violent Crime	221	15.68	28.14	21.82	54.25	7.02
	23	Road KSIs	108	260.66	343.35	274.71	602.21	109.17
Disability and Poor Health	24	Limiting Illness	1918	19.29	16.07	22.74	34.48	12.33
	25	DLA Claimants	615	54.09	43.49	56.74	85.39	31.56
	26	Injuries due to Falls (65+)	55	661.77	501.82	495.41	661.77	396.67
Mortality	27	All Age All Cause Mortality (DSR)	396	565.26	577.76	568.54	727.02	485.04
	28	Premature Mortality from Cancer	61	127.16	110.87	118.46	167.23	87.91
	29	Premature Mortality from CVD	37	76.48	72.93	71.01	120.57	39.35
	30	Premature Mortality from Respiratory Disease	22	46.17	31.56	28.34	66.99	8.83
	31	Mortality from Preventable Causes	103	199.09	173.24	173.99	301.11	112.40
	32	Life Expectancy Females	-	82.86	82.09	82.49	79.89	85.34
	33	Life Expectancy Males	-	78.83	78.47	78.34	76.14	80.81

^ The terms 'best' and 'worst' are not appropriate for these indicators instead the right side of the chart indicates the highest value and the left side the lowest.



Public Health Ward Profiles: 2012/13

Southampton South & East Locality

00MSNH - Woolston

Public Health Southampton

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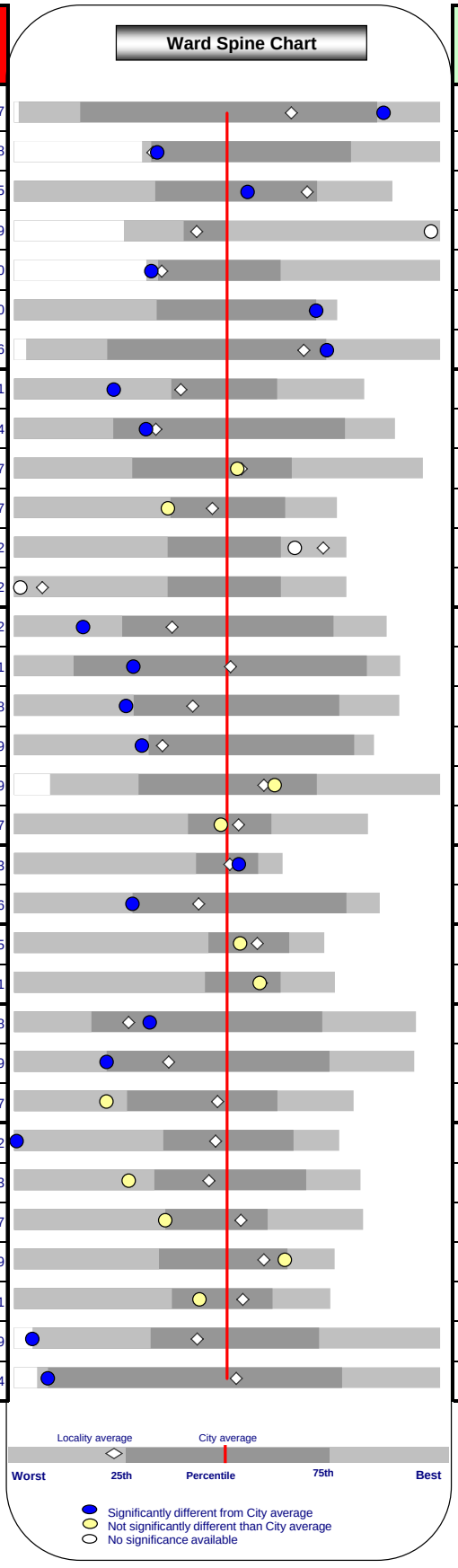
		Indicator	Ward no.	Ward Value	Locality Average	City Average	City Worst	City Best
Demography	1	% Resident Population aged 0-4 years^	1133	8.18	7.19	6.50	4.27	8.78
	2	% Resident Population aged 18-24 years^	1283	9.26	8.76	16.88	7.58	40.20
	3	% Resident Population aged over 65 years^	1904	13.75	15.90	12.99	5.25	19.00
	4	Forecast % change in popualtion 2011-18^	2017	14.50	1.46	3.14	-2.59	14.99
	5	% Population from minority ethnic groups^	671	4.84	6.11	14.08	4.20	40.14
	6	% Population born in the UK^	12677	91.52	91.41	82.42	60.70	93.64
	7	General Fertility Rate^	1216	73.45	70.46	60.53	34.56	88.07
Economic	8	Working Age Claimant Rate	1740	19.35	16.02	13.73	24.31	6.91
	9	Adults with No Qualifications	2804	25.62	25.06	20.96	33.24	11.29
	10	16-18 year old NEET	25	5.05	4.99	5.19	8.17	2.46
	11	Long Term Unemployed	75	8.34	6.81	6.30	13.67	2.50
	12	Least Deprived LSOA in Ward	-	13.72	9.03	24.98	60.32	5.21
	13	Most Deprived LSOA in Ward	-	59.23	55.60	24.98	60.32	5.21
Healthy Start	14	Lone Parent Families	597	9.99	8.16	7.03	11.42	3.74
	15	Child Poverty	1030	30.84	25.10	25.31	37.91	15.08
	16	% Smoking in Pregnancy	166	23.51	20.39	18.78	28.78	10.71
	17	% Breastfeeding	481	68.13	69.77	74.92	57.89	86.67
	18	Year R Child Obesity	43	8.46	8.67	9.36	12.69	5.36
	19	Year 6 Child Obesity	69	20.12	19.43	19.88	28.17	14.40
Lifestyle	20	Alcohol Specific Hospital Admissions (DSR)	378	563.85	621.01	638.81	1971.63	291.06
	21	Smoking Related Hospital Admissions (DSR)	464	2047.98	1837.60	1747.38	2426.06	1260.90
Safety	22	Violent Crime	281	19.82	17.21	21.82	54.25	7.02
	23	Road KSIs	94	224.40	221.74	274.71	602.21	109.17
Disability and Poor Health	24	Limiting Illness	2427	26.99	28.15	22.74	34.48	12.33
	25	DLA Claimants	795	72.91	64.57	56.74	85.39	31.56
	26	Injuries due to Falls (65+)	58	589.40	502.80	495.41	661.77	396.67
Mortality	27	All Age All Cause Mortality (DSR)	690	724.94	576.97	568.54	727.02	485.04
	28	Premature Mortality from Cancer	84	140.91	122.59	118.46	167.23	87.91
	29	Premature Mortality from CVD	51	85.36	67.76	71.01	120.57	39.35
	30	Premature Mortality from Respiratory Disease	11	17.84	21.64	28.34	66.99	8.83
	31	Mortality from Preventable Causes	125	190.36	164.51	173.99	301.11	112.40
	32	Life Expectancy Females	-	79.89	82.09	82.49	79.89	85.34
	33	Life Expectancy Males	-	76.26	78.45	78.34	76.14	80.81



^ The terms 'best' and 'worst' are not appropriate for these indicators instead the right side of the chart indicates the highest value and the left side the lowest.

RESIDENT POPULATION, 2012

Population resident in Southampton City

Age band	Male	Female	Persons	%
0-4	8,200	7,700	15,900	6.6
5-14	12,100	11,500	23,600	9.9
15-24	25,100	23,200	48,300	20.2
25-49	44,200	40,900	85,200	35.6
50-64	17,500	17,200	34,700	14.5
65-74	7,800	8,500	16,300	6.8
75-84	4,500	6,100	10,600	4.4
85+	1,600	3,200	4,800	2.0
Total	121,200	118,200	239,400	100

Source: Office for National Statistics Mid Year Estimate of the Population 2012, © Crown Copyright. (Figures may not sum due to rounding)

REGISTERED POPULATION, 2012

Population registered with Southampton City GPs

Age band	Male	Female	Persons	%
0-4	8,700	8,000	16,700	6.3
5-14	13,200	12,600	25,800	9.7
15-24	24,300	24,600	48,800	18.3
25-49	54,800	45,700	100,400	37.6
50-64	20,900	19,200	40,100	15.0
65-74	9,000	9,200	18,200	6.8
75-84	5,100	6,500	11,600	4.3
85+	1,700	3,400	5,100	1.9
Total	137,600	129,100	266,700	100

Source: Patient & Practitioner Services Authority
(Figures may not sum due to rounding)

BIRTHS

General Fertility Rate and Number of Births

	2009	2010	2011	2012
Live births per 1,000 women aged 15-44				
Southampton	54.1	57.0	63.4	60.2
South East	62.6	64.4	63.8	64.5
England	63.8	65.5	64.2	64.9
Number of live births				
Southampton	3,230	3,448	3,550	3,420

Source: Office for National Statistics, Mid year estimates and Vital Statistics VS1.
© Crown Copyright.

TEENAGE CONCEPTIONS

	2008	2009	2010	2011
No. of conceptions to girls aged under 18				
Southampton	198	188	181	170
Rate of under 18 conceptions per 1000 girls aged 15-17				
Southampton	58.0	54.3	51.7	47.4
South East	33.0	29.9	28.0	26.1
England	39.7	37.1	34.2	30.7

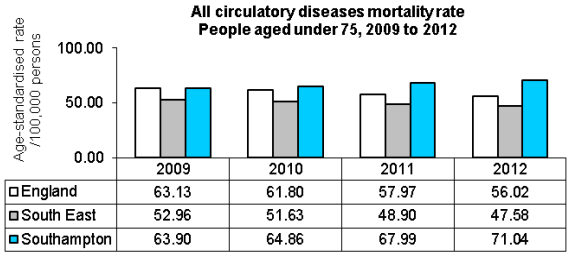
Source: Teenage Pregnancy Unit & Office for National Statistics, © Crown Copyright.

INFANT MORTALITY*

	2008-10	2009-11	2010-12
Number of deaths (in 3 year period)			
Southampton	49	46	43
South East	1,204	1,167	1,126
England	9,260	9,062	8,822
Mortality per 1000 live births			
Southampton	4.9	4.5	4.1
South East	3.8	3.7	3.5
England	4.6	4.4	4.3

*includes deaths of infants aged less than 1 year
Source: Office for National Statistics, Vital Statistics VS1. © Crown Copyright.

CIRCULATORY DISEASE

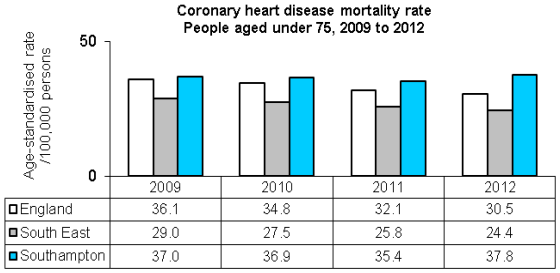


Number of deaths per year

Southampton	127	131	138	149

Source: Compendium of Clinical & Health Indicators Health & Social Care Information Centre © Crown Copyright.

CORONARY HEART DISEASE

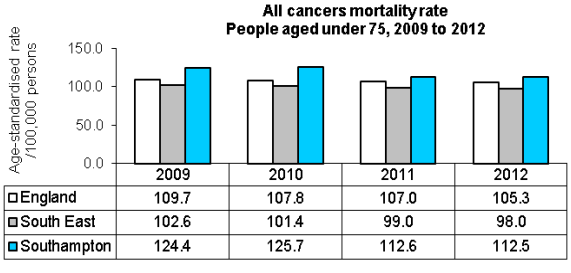


Number of deaths per year

Southampton	73	74	72	79

Source: Compendium of Clinical & Health Indicators Health & Social Care Information Centre © Crown Copyright.

CANCER

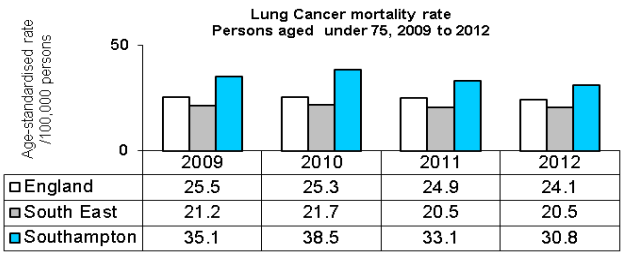


Number of deaths per year

Southampton	247	256	230	234

Source: Compendium of Clinical & Health Indicators Health & Social Care Information Centre © Crown Copyright.

LUNG CANCER

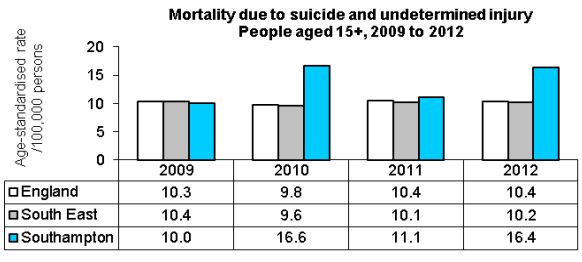


Number of deaths per year

Southampton	69	77	67	64

Source: Compendium of Clinical & Health Indicators Health & Social Care Information Centre © Crown Copyright.

SUICIDE



Number of deaths per year

Southampton	18	32	20	32

Source: Compendium of Clinical & Health Indicators Health & Social Care Information Centre © Crown Copyright.

A Pocket Profile

The Health of the People of Southampton City 2013

Contact

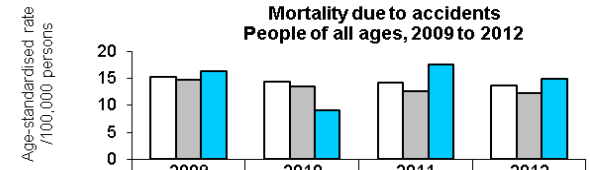
Public Health Southampton
Civic Centre
Lower Ground Floor
Municipal Block – East
Civic Centre
Southampton
SO14 7LT

Email:
rebecca.wilkinson@southampton.gov.uk

For more health information please visit our website:
www.publichealth.southampton.gov.uk

FOR LARGE PRINT VERSION
023 80 833871

ACCIDENTS



	2009	2010	2011	2012
England	15.3	14.3	14.2	13.7
SE Region	14.8	13.48	12.68	12.22
Southampton	16.3	9.0	17.5	14.9

Number of deaths per year				
Southampton	48	30	52	45

Source: Compendium of Clinical & Health Indicators Health & Social Care Information Centre © Crown Copyright.

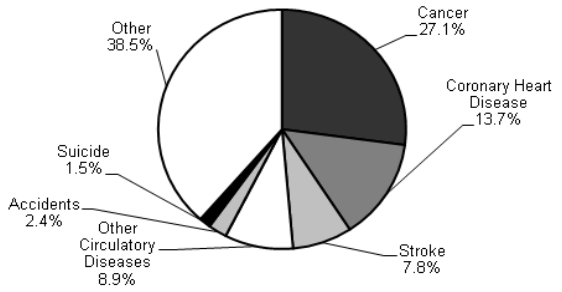
LIFE EXPECTANCY*

Life Expectancy at Birth (years) 2009-11	Males	Females
Southampton	78.6	82.9
South East	80.0	83.8
England	78.9	82.9

*Life expectancy at birth is an estimate of the number of years a new-born baby would be expected to live if they experienced that area's 2009-11 mortality rates throughout their life.
Source: Office for National Statistics, 2013 © Crown Copyright.

MAJOR CAUSES OF DEATH

Southampton Residents 2012 (No. of deaths = 1,846)



Source: Office for National Statistics, Vital Statistics VS3 © Crown Copyright.

JOBS AND UNEMPLOYMENT

Job Seekers Claimant count (as % of working age resident population)

	Southampton	South East	England
Sep 2013	2.7	2.0	3.1
Jun 2013	3.0	2.2	3.4
Mar 2013	3.5	2.5	3.8
Dec 2012	3.2	2.4	3.6
Sep 2012	3.2	2.4	3.7

Jobs Density (no. of filled jobs per working age resident)

	Southampton	South East	England
2011	0.72	0.78	0.80

Source: National Statistics (from Nomis website: www.nomisweb.co.uk)

INDEX OF DEPRIVATION 2010

Ranking of the worst 5 Super Output Areas (SOAs) out of 146 SOAs in Southampton for overall score and each domain

Domain	E01017167 Bitterne	E01017154 Bevois	E01017281 Woolston	E01017207 Millbrook	E01017163 Bitterne	E01017240 Redbridge	E01017280 Woolston	E01017161 Bevois	E01017140 Bargate	E01017137 Bargate	E01017210 Millbrook	E01017237 Redbridge	E01017274 Woolston	E01017145 Bassett	E01017148 Bassett	E01017142 Bargate	E01017257 Sholing	E01017146 Bassett	E01017139 Bargate	E01017227 Portswood	E01017218 Peartree	E01017189 Freemantle	E01017225 Peartree	E01017160 Bevois
Overall IMD Score	1	2	3	4	5																			
Income	2	3	1	4	5																			
Employment	2	3	1			4	5																	
Health		3	1					2	4	5														
Education	1				5						2	3	4											
Housing/Access														1	2	3	4	5						
Crime	1			4						2	3								5					
Environment																				1	2	3	4	5

Also within the 10% most deprived SOAs in England

Source: Index of Deprivation 2010. Department for Communities and Local Government.

EDUCATIONAL ATTAINMENT

	2009	2010	2011	2012
Southampton				
KS2 English	74	77	79	83
KS2 Mathematics	74	78	80	83
5+ GCSEs A*-C	43.1	47.5	51.7	54.4
England				
KS2 English	80	80	82	86
KS2 Mathematics	79	79	80	84
5+ GCSEs A*-C	49.8	53.5	58.9	59.4

Notes:
KS2 = % of children gaining at least level 4 at Key Stage 2
GCSEs = % of 15 yr olds gaining 5+ GCSE/GNVQ grades A*-C inc English and Maths
Source: Dept. for Education www.education.gov.uk

HEALTH IN SOUTHAMPTON CITY

This Pocket Profile summarises the most recent comparative indicators of the health of residents of Southampton.

We have compared Southampton to the South East Region and with the England average.

We hope you find this profile useful and welcome your comments.

Rebecca Wilkinson
Head of Public Health Intelligence

Andrew Mortimore
Director of Public Health

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DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		NHS SOUTHAMPTON CITY CLINICAL COMMISSIONING STRATEGY 2014 – 2019. A HEALTHY AND SUSTAINABLE FUTURE		
DATE OF DECISION:		26TH MARCH 2014		
REPORT OF:		JOHN RICHARDS, CHIEF EXECUTIVE SOUTHAMPTON CITY CCG		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Stephanie Ramsey**	**Tel:**	**02380296941**
	E-mail:	**Stephanie.ramsey@southamptoncityccg.nhs.uk**		
Director	**Name:**	**John Richards, Chief Executive**	**Tel:**	**02380 296923**
	E-mail:	**John.Richards@southamptoncityccg.nhs.uk**		
STATEMENT OF CONFIDENTIALITY				
Not applicable				

BRIEF SUMMARY

Southampton City Clinical Commissioning Group (CCG) has 34 member practices across the City. The CCG is responsible for commissioning local services – hospital and community, but not 'specialised' or primary care, for a registered population of approximately 265,000 people with a budget of £280m.

Southampton City Clinical Commissioning Group (CCG) five year strategy outlines:

- Who the CCG are and what the organisation stands for
- What the city's health needs are (based on public health data)
- What requirements have to be met, as defined by NHS England and regulatory bodies such as the Care Quality Commission (CQC) and Monitor
- What the public have identified they think is important
- Budgets and plans to ensure sustainable finances
- How the CCG plan to deliver health improvements for the city

The strategy sets vision and ambitions for commissioning health services for the population of Southampton. Five clear goals have been identified to focus what the CCG do and help provide a clear work programme. These are:

- Make care safer
- Make it fairer
- Improve productivity (doing more with less)
- Shift the balance - from acute to community and dependence to independence

- Plan our finances for a sustainable future

The strategy is currently under development and being consulted upon. A resume of the strategy can be seen in the Plan on a Page in Appendix 1

RECOMMENDATIONS:

(i) The Board are asked to support the strategic direction outlined and to comment on the priorities and outcomes identified;

(ii) The Board are asked to note the consultation process and that the finalised strategy will be presented for agreement at the Board meeting in May 2014.

(iii) The Board are asked to delegate authority to the Chair of the Health and Wellbeing Board, in conjunction with the Chair of the CCG to agree the final Quality Premium metrics

REASONS FOR REPORT RECOMMENDATIONS

1. The requirement for CCG to produce a plan is set out in the Health and Social Care Act 2012. The detailed expectations are then outlined by NHS England in Everyone Counts – Planning for Patients 2014/15-2018/19

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. Substantial consultation and engagement has been undertaken to identify key priorities and actions.

DETAIL (Including consultation carried out)

3. This is a refresh of the 5 year strategy published in 2012. The CCG along with the Department of Health, NHS England and regulatory bodies respond to changes in health needs and populations, new research and reports (such as the Francis Report), new decisions from central government (such as the drive to join health and social care services), feedback from local people and the developing financial picture. As a result NHS England has asked CCGs to look at their 5 year strategy again to ensure it takes account of such developments and can deliver health improvements for local people. NHS England sent detailed guidance to CCGs about what to include in the revised strategy in December 2013, with several updates and toolkits provided since.

4. The strategic direction of the CCG is to create a healthy and sustainable system with a vision of “a healthy Southampton for all”. The purpose of the CCG’s vision statement is to set out succinctly a memorable statement of the desired future state of health in the City. Achieving this vision is not solely within the direct control of the CCG and is not a short term proposition, but the CCG will play a leadership role within the wider partnerships of the Health and Wellbeing Board and the system of healthcare provision in creating the conditions to bring this about. What is meant by this vision statement is:

    - Healthy: strong and resilient people and communities who can

maximise their potential to live well and prosper, supported by positive relationships and strong institutions based on trustful, open, business-like relationships and mutual interdependence;

- Southampton: our City's future is our purpose, firmly shared with our partners;
- For All: we are determined to tackle the unacceptable inequalities in health and wellbeing.

5. To deliver the vision the CCG will "ensure that care is coordinated, safe, sustainable and designed to meet the needs of the people of Southampton." What this means is that, although the CCG do not provide care directly, it does provide leadership and coordination to the City's health and social care system, set priorities and allocate the resources to make sure that it works together effectively. The aim is to commission care that is 'joined up' to work effectively for people, not fragmented, and that consistently meets high standards of safety and is affordable within the finite resources that are available.

6. The CCG goals are:

- Make care safer
- Make it fairer
- Improve productivity (doing more with less)
- Shift the balance - from acute to community and dependence to independence
- Plan our finances for a sustainable future

The interventions related to these can be seen in the Plan on a Page in Appendix 1

7. To measure the impact of the strategy on improving outcomes a number of measurable ambitions have been developed which are critical indicators of success against which progress can be tracked. These are :

- Improved patient safety and user experience
    - Reduced inequalities in life expectancy
    - Reduced avoidable emergency admissions
    - More older people living independently (91 days after reablement)
    - Fewer permanent admissions to nursing or residential homes
    - Fewer delayed transfers of care (DToC)
    - Reduced injuries due to falls in people over 65
    - 20% productivity improvement in elective care

A number of these are the same of those for the Better Care Fund.

There are also a number of specific targets set for improvements in the quality of the services commissioned and for associated improvements in health outcomes and reducing inequalities. This is the quality premium and

will be based on measures that cover a combination of national and local priorities including elements of those above as well as improving access to psychological therapies; improvements in uptake of and responses to Friends and Family Test and improving the reporting of medication-related safety incidents. A further local measure based on local priorities such as those identified in joint health and wellbeing strategies

Details can be seen in Appendix 2.

8. Consultation on the strategy has been undertaken with patients and the wider public, member practices, partner organisations and providers. This included a Health Conference on 11th March based around the CCG Goals to gain feedback to ensure the views of local people are reflected and to get the strategy right. The event was attended by well over one hundred people across different communities, organisations and sectors who contributed a significant range of ideas, issues and challenges. Some of the themes included:

- Shared information systems
- Appropriately skilled workforce to provide safe care
- Must involve people that use our services and their families
- We recognise the challenges, however we need to get on and do something and set services up
- Need to make a commitment to moving away from silos
- Be proactive and not reactive
- There are no such thing as hard to reach patients – it is the services that are not accessible
- Importance of co-ordination – co-ordinator role
- Role of voluntary services
- Patients want to be informed and involved in all decisions about their care

9. Further details and opportunity to comment on the strategy are available on the CCG website at: www.southamptoncityccg

The final 5 year strategy has to be submitted to NHS England by 20th June 2014

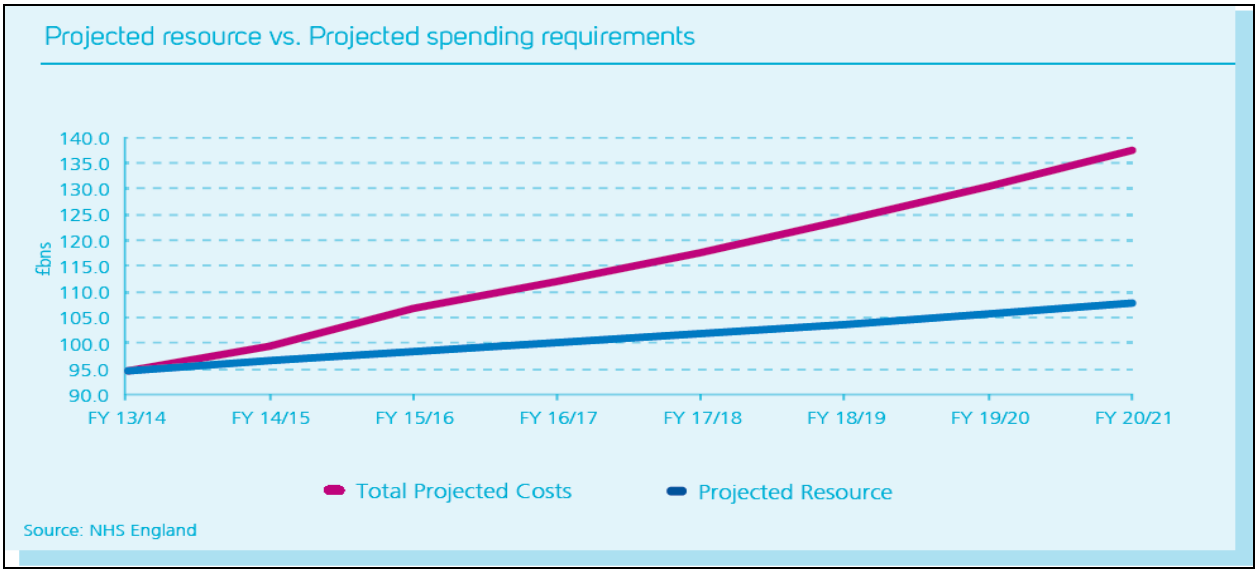
RESOURCE IMPLICATIONS

Capital/Revenue

Health, along with other public sector bodies, is facing a significant financial challenge. Spending on the NHS in the UK as a share of national income has more than doubled since its introduction in 1948, rising by an average of 4.8% in real terms. This period of rapid growth has now come to a halt but funding pressures on the NHS continue to rise.

In July 2013, NHS England launched A Call to Action which set out the challenges and opportunities faced by the health and care systems across the country over the next

five to ten years. This was a call for creativity, innovation and transformation. It will require a significant shift in activity and resource from the hospital sector to the community. The funding and implementation of the Better Care Fund has the potential to improve sustainability and raise quality, including by reducing emergency admissions. There is a need to find ways to raise the quality of care for all in our communities to the best international standards while closing a potential funding gap of around £30 billion by 2020/21:



Property/Other

None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

Health & Social Care Act 2012

Under the National Health Service Act 2006 (as amended by the Health and Social Act 2012), NHS England has the power to make payments to CCGs to reflect the quality of services that they commission, the associated health outcomes and reductions in inequalities.

Other Legal Implications:

NHS England Everyone Counts – Planning for Patients 2014/15-2018/19

Quality Premium: 2014/15 guidance for CCGs

POLICY FRAMEWORK IMPLICATIONS

None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	all

SUPPORTING DOCUMENTATION

Appendices

1.	Plan on a Page
2.	Performance metrics

Documents In Members' Rooms

1.	N/A

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: www.southamptoncityccg

	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	

NHS SOUTHAMPTON CITY CCG STRATEGY

THE VISION: *A HEALTHY SOUTHAMPTON FOR ALL*

NHS
Southampton City Clinical Commissioning Group

OUR MISSION

To ensure that care is coordinated, safe, sustainable and designed to meet the needs of the people of Southampton.

OUR VALUES

These underpin the vision, drive our behaviour and determine what we do and the way we go about it. We try to live up to these values and they provide a compass to guide us at all times.

Patients First, Every Time | Relentless about the quality of care | Respect for others and their dignity
Integrity – be honest and decent | Courage to do the right thing

GOALS	INTERVENTIONS
A. Make Care Safer	**A** Nurture a Diverse Range of Safe, Competent Providers Improved Quality Assurance & Safeguarding Prioritise Quality Development Business-like Contract Management of Accountable Providers
B. Make It Fairer	**B** Reduce Health Inequalities Promote Equality and Diversity Uphold the NHS Constitution
C. Improve Productivity *(Achieving more with less, more effectively)*	**C** Streamline Urgent Care Efficient & Reliable Planned Care Earlier Detection and Diagnosis Services Closer to Home
D. Shift the Balance (Better Care Southampton)	**D** Person Centred Coordinated Local Care Better Discharge and Reablement Engaged & Resilient Communities
E. Sustainable Finances	**E** Strategic Financial Plan Driven by Quality Plan for the Right Capacity Deliver Enabling Plans (IT, Estates and Workforce)

OUTCOMES

- Improved Patient Safety and User Experience
- Reduced Inequalities In Life Expectancy
- Reduced Avoidable Emergency Admissions
- More Older People Living Independently (91 Days After Reablement)
- Fewer Permanent Admissions To Nursing Homes
- Fewer Delayed Transfers Of Care
- Reduced Injuries Due To Falls In People Over 65
- 20% Productivity Improvement In Elective Care

Agenda Item 7
Appendix 1

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NHS Southampton City Clinical Commissioning Group – Quality premium measures 14/15

Brief Summary: This report seeks approval for the submission of local Quality premium measures that require agreement from the Health and Wellbeing Board

Recommendations: That the submissions as detailed below are agreed and responsibility delegated to Chair of Health and Wellbeing Board and the Chair of the CCG to agree the final metrics prior to submission on 4th April 2014.

1. Background

1.1 As part of the planning process for 2014/15 Clinical Commissioning Groups need the approval of local Health and Wellbeing Boards for trajectories of performance for future years related to the Quality premium.

1.2 The 'quality premium' is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

1.3 The total quality premium payment for a CCG will be reduced if its providers do not meet the NHS Constitution rights or pledges for patients in relation to (a) maximum 18-week waits from referral to treatment, (b) maximum four-hour waits in A&E departments,(c) maximum 14-day wait from a urgent GP referral for suspected cancer, and (d) maximum 8-minute responses for Category A red 1 ambulance calls.

1.4 The intention is for the CCG to determine with health and wellbeing partners what specific targets to pursue to achieve improvements in these areas. The quality premium paid to CCGs in 2015/16 – to reflect the quality of the health services commissioned by them in 2014/15 – will be based on six measures that cover a combination of national and local priorities. These are:

- reducing potential years of lives lost through causes considered amenable to healthcare and addressing locally agreed priorities for reducing premature mortality (15 per cent of quality premium);
- improving access to psychological therapies (15 per cent of quality premium);
- reducing avoidable emergency admissions (25 per cent of quality premium);
- addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of FFT in 2014/15 and showing improvement in a locally selected patient experience indicator (15 per cent of quality premium);
- improving the reporting of medication-related safety incidents based on a locally selected measure (15 per cent of quality premium);

- a further local measure that should be based on local priorities such as those identified in joint health and wellbeing strategies (15 per cent of quality premium).

2. Local measures

The measures and the justification for the future trajectories are:

2.1 Potential Years of Life Lost

i) Potential years life lost (PYLL) from ammenable causes in 2014/15

E.A.1	PYLL (Rate per 100,000 population)
2014/15	0

Potential years life lost provides a summary measure of premature mortality. It is a combined indicator on potential years of life lost from causes amenable to healthcare. Causes considered amenable to healthcare are those from which premature deaths should not occur in the presence of timely and effective health care.

Historic performance: has been XXXX

Rationale for submission: XXX

2.2 Improving Access to Psychological Therapies (IAPT)

The primary purpose of this indicator is to measure improved access to psychological therapies services (IAPT) for people with depression and/or anxiety orders. Evidence suggests that, where people with mental illness are able to access psychological therapies, this has a significant impact on their quality of life. Improving access to treatment for those with mental illness is also a vital part of improving parity of esteem between mental and physical ill-health.

Historical performance: The 2013/14 target is 14.3% and the CCG is on track to meet this.

Rationale for submission: For 2014/15 it is proposed that the target be increased to 17.3%, based on this being a key area of work for the CCG.

A breakdown of projection of the year is:

ii) For IAPT, what proportion of people that enter treatment against the level of need in the general population are planned in 2014/15 and 2015/16?

E.A.3	The number of people who receive psychological therapies	The number of people who have depression and/or anxiety disorders (local estimate based on National Adult Psychiatric Morbidity Survey 2000)	Proportion
Q1 2014/15	**1345**	**31105**	4.3%
Q2 2014/15	**1345**	**31105**	4.3%
Q3 2014/15	**1345**	**31105**	4.3%
Q4 2014/15	**1346**	**31105**	4.3%
2015/16	**5381**	**31105**	17.3%

2.3 Friends and Family Test

The NHS Friends and Family Test is part of a systematic approach to improving patient experience and is based on one simple question (would they would recommend hospital wards, accident and emergency units to a friend or relative based on their treatment) that ensures that local hospitals and the public get regular, up to date feedback on what patients think about their services.

It provides a mechanism to identify poor performance and encourage staff to make improvements where services do not live up to the expectations of patients. This leads to a more positive experience of care for patients.

E.A.6 **iv) Which Friends and Family patient improvement indicator have you selected for an improved average score to be achieved between 2013/14 and 2014/15.**	**Please Select an indicator:** **C4.2 Patient experience of hospital care**

Historical performance: Is not yet available for this indicator.

Rationale for submission: Patient experience of hospital care is a key area of work for the CCG Quality Team and is reviewed at Contract Quality Review Meetings

Do you plan to meet all other criteria of the Quality Premium Friends and Family measure? Please set out further details below.

Yes, Friends and Family test is a key focus of the Quality Team.

2.4 Medication Errors

Research shows that organisations which regularly report more patient safety incidents usually have a stronger learning culture where patient safety is a high priority. By improving reporting in the short term the NHS can build the foundations for driving improvement in the safety of care received by patients.

Medication errors are patient safety incidents which actually caused harm or had the potential to cause harm involving an error in the process of prescribing, dispensing, preparing, administering, monitoring or providing medicines advice.

E.A.9 **v) Have you agreed (in conjunction with your Health and Wellbeing Board and NHS England area team) a specified increased level of reporting of medication errors from specified local providers between Q4,2013/14 and Q4, 2014/15? Yes/No**	**Yes/No** Yes

Specified level of increase:

2.5 Local Priority

As part of the planning process, a local priority can be agreed by each CCG with their local Health and Wellbeing Board and NHS England. The local priority should be based on an indicator from the 2014/15 CCG Outcomes Indicator Set issued by NHS England. It is proposed locally that "Emergency re-admission within 30 days of discharge from hospital" is used as this will support the achievement of Better Care priorities and is an area where the outcomes are poor compared to others. A baseline for 2014/15 is currently being prepared by the Clinical Commissioning Group.

3. Quality premium payments

Quality premium payments can only be used for the purposes set out in regulations. These state that quality premium payments should be used by CCGs to secure improvement in:

a) the quality of health services; or

b) the outcomes achieved from the provision of health services; or

c) reducing inequalities between patients in terms of their ability to access health services or the outcomes achieved.

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DECISION-MAKER:		HEALTH & WELLBEING BOARD		
SUBJECT:		SOUTHAMPTON'S RESPONSE TO GOVERNMENT PLEDGE FOR BETTER CHILDREN AND YOUNG PEOPLE'S OUTCOMES		
DATE OF DECISION:		26th MARCH 2014		
REPORT OF:		DIRECTOR OF PUBLIC HEALTH, SOUTHAMPTON CITY COUNCIL		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Andrew Mortimore**	**Tel:**	**023 80833204**
	E-mail:	**Andrew.Mortimore@southampton.gov.uk**		
Director	**Name:**	**Alison Elliott, Director of People**	**Tel:**	**023 80832602**
	E-mail:	**Alison.Elliott@southampton.gov.uk**		
STATEMENT OF CONFIDENTIALITY				
None.				

BRIEF SUMMARY

A Government pledge for better children and young people's health outcomes was published in February 2013. This pledge formed part of the Government's response to the Children and Young People's Health Outcome Forum. It asks that all organisations who have the power to make a difference to children and young people's health and well-being sign the pledge to prevent avoidable ill-health and deaths.

The health and well-being of children and young people in Southampton is a key issue for the City. In comparison with England, Southampton is significantly worse than average for a number of child health indicators. Improvements have been made, but further work is required to reduce avoidable ill-health, deaths and inequalities. A number of strategic partnerships and associated operational groups have been initiated to tackle these issues.

The Children and Young People's Trust has examined the case for improvement and recommends that the Health and Wellbeing Board sign up to the National Pledge for better health outcomes for Children and Young People. As the responsible body, the Board will require assurance from the Children and Young People's Trust Board that actions are being taken to meet this pledge.

RECOMMENDATIONS:

(i) That the Health and Wellbeing Board signs up to the National Pledge for better health outcomes for Children and Young People

(ii) That the Children and Young People's Trust Board is accountable to the Health and Wellbeing Board for delivery and holds an action plan to ensure organisations work in partnership for the benefit of children and young people

REASONS FOR REPORT RECOMMENDATIONS

1. By signing up to the pledge, Southampton City will be signalling its commitment to raise the health and well-being of Children and Young People within the City

2. To strengthen leadership and ensure lines of accountability for delivery

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. Not signing up to the pledge could signal that this issue is not of strategic importance for Southampton City

DETAIL (Including consultation carried out)

4. There is unacceptable variation in health and well-being outcomes for children and young people. Southampton's Children and Young People's Trust Board recognises the degree of need within the City and the unacceptable inequalities therein.

   The Trust Board is guided by the Every Child Matters outcomes. Every Child Matters is based on the principle that all children and young people from birth to 19 years old, whatever their background or their circumstances, should have the support they need to:

   - Be healthy;
   - Stay safe;
   - Enjoy and achieve;
   - Make a positive contribution; and
   - Achieve economic wellbeing.

5. The Government pledge for better health outcomes for Children and Young People has six shared ambitions:

   - Children and Young People are at the heart of decision-making, with the health outcomes that matter most to them taking priority
   - Services, from pregnancy through adolescence and beyond, will be high quality, evidence based and safe, delivered at the right time, in the right place, by a properly planned, educated and trained workforce
   - Good mental health and physical health and early interventions, including for children and young people with long term conditions, will be of equal importance to caring for those who become acutely unwell
   - Services will be integrated and care will be coordinated around the individual, with an optimal experience of transition to adult services for those young people who require ongoing health and care in adult life
   - There will be clear leadership, accountability and assurance and

organisations will work in partnership for the benefit of children and young people

The pledge has been developed to ensure joint commitment and efforts in reducing child deaths, preventing ill health by supporting families, improving mental health, supporting and protecting the most vulnerable and providing better care for those with long term conditions and disability (Appendix 1 Pledge document).

6. Southampton's Children and Young People's Trust Board is aware of the health and well-being needs within the City. As previously documented, Southampton's Child Health Profile (appendix 2) shows that of 32 health and well-being indicators measured, Southampton is significantly worse than the average for England for 14 indicators. These indicators are related to:

- deaths and serious injuries due to road traffic accidents;
- educational attainment;
- number of children living in poverty;
- young people not in education employment or training;
- teenage pregnancy;
- smoking in pregnancy;
- hospital admissions due to alcohol consumption;
- mental health; and
- self-harm admissions.

7. Locally, improvements in child health and well-being indicators have been achieved, such as an increase in educational achievement and reduction in teenage pregnancy. Through developing strategic partnerships and robust planning, greater gains can be made.

8. Before commending the pledge to the Health and Wellbeing Board, the Children and Young People's Trust has examined the case for improvement and conducted an initial assessment of the plans and capacity that there is across the City to meet the pledge commitments.

Appendix 3 is a 'working' action plan which highlights indicators with poor outcomes and associated emerging plans to tackle these issues. Strategic partnerships and associated operational groups developed by Southampton City Council and the Clinical Commissioning Group are actively addressing many of these indicators through their commissioning intentions and service re-design.

9. The recently amalgamated Primary Prevention and Early Help - Pre-birth to 19 years Commissioning Group is currently developing a strategy to inform its work. The overarching aim of the strategy will be that:

- Children and young people get the best start in life.
- They are supported to reach their potential through the most effective and efficient use of Local Authority and Clinical Commissioning Group primary prevention and early help resources.

- Resources will be delivered in partnership with families and other services and agencies across all sectors.

The Commissioning Group will produce progress reports against the action plans for the Children and Young Peoples Trust Board, ensuring remedial action is taken in order to keep progress on track.

10. Further opportunities are planned such as the Big Lottery Funded HeadStart Programme. This will be launched in July 2014 and aims to increase resilience in 11-14 year olds. One year of funding to test new approaches has been secured. A further five years of funding is achievable on the basis of first year results.

11. By signing up to the pledge, Southampton City will be signalling its commitment to raise the health and well-being of Children and Young People within the City. Sign up from the Health and Wellbeing Board will ensure over-arching leadership and accountability on this agenda.

RESOURCE IMPLICATIONS

12. None

LEGAL IMPLICATIONS

13. None

POLICY FRAMEWORK IMPLICATIONS

14. None

KEY DECISION Yes

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	National Pledge
2.	Southampton's Child Health Profile
3.	Working document – action 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.	No

Other Background Documents

None

Better health outcomes for children and young people

Our pledge

ACADEMY OF MEDICAL ROYAL COLLEGES

ADCS Leading Children's Services

Care Quality Commission

Department of Health

NHS CONFEDERATION

FACULTY OF PUBLIC HEALTH

MHRA Regulating Medicines and Medical Devices

Birmingham Children's Hospital NHS Foundation Trust

NHS England

Local Government Association

National Institute for Clinical Excellence

The Information Centre for health and social care

NHS Warrington Clinical Commissioning Group

NHS Health Education England

healthwatch

The British Society of Paediatric Dentistry

Public Health England

RCGP Royal College of General Practitioners

ROYAL PHARMACEUTICAL SOCIETY

Royal College of Nursing

RCPCH Royal College of Paediatrics and Child Health Leading the way in Children's Health

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

solace

tda Trust Development Authority Quality. Delivery. Sustainability.

> “The foundations for virtually every aspect of human development – physical, intellectual, and emotional – are laid in early childhood.”
>
> **(Marmot)**

Children and young people growing up in England today are healthier than they ever have been before. Health care and social changes have had dramatic impacts. Previously common killer diseases are now rare. More children with serious illnesses and disabilities are surviving into adulthood and the infant mortality rate has fallen to less than a quarter of what it was at the beginning of the 1960s.

But international comparisons and worrying long-term trends demonstrate there is room for improvement, with poor health outcomes for too many children and young people compared with other countries. A smaller group of more vulnerable children – such as looked after children – suffer much worse outcomes. The variation in outcomes and quality of healthcare for children and young people is unacceptable. The clear evidence that pregnancy and the earliest years are critical to the future health and wellbeing of children and adults and that evidence-based early interventions can have significant positive impacts does not always inform how services are commissioned.

The need for improvement is not new; numerous reports have highlighted the issues. Individual initiatives have led to improvements in specific areas, but have not resulted in the system wide changes required to improve outcomes. What is new is the opportunity to ensure the focus on outcomes in the new health and care system includes children and young people clearly and explicitly, from conception through to adulthood.

We are committed to improving the health outcomes of our children and young people so that they become amongst the best in the world.

System-wide change is required to achieve this and each part of the system, at each level, has a vital contribution to make. To this end we pledge to work in partnership, both locally and nationally, with children, young people and their families.

Our shared ambitions are that:

1. Children, young people and their families will be at the heart of decision-making, with the health outcomes that matter most to them taking priority.

2. Services, from pregnancy through to adolescence and beyond, will be high quality, evidence based and safe, delivered at the right time, in the right place, by a properly planned, educated and trained workforce.

3. Good mental and physical health and early interventions, including for children and young people with long term conditions, will be of equal importance to caring for those who become acutely unwell.

4. Services will be integrated and care will be coordinated around the individual, with an optimal experience of transition to adult services for those young people who require ongoing health and care in adult life.

5. There will be clear leadership, accountability and assurance and organisations will work in partnership for the benefit of children and young people.

We all have a part to play in promoting the importance of the health of our children and young people.

Through our joint commitment and efforts we are determined to:

- **reduce child deaths** through evidence based public health measures and by providing the right care at the right time;
- **prevent ill health for children and young people and improve their opportunities for better long-term health** by supporting families to look after their children, when they need it, and helping children and young people and their families to prioritise healthy behaviour;
- **improve the mental health of our children and young people** by promoting resilience and mental wellbeing and providing early and effective evidence based treatment for those who need it;
- **support and protect the most vulnerable** by focusing on the social determinants of health and providing better support to the groups that have the worst health **outcomes**;
- **provide better care for children and young people with long term conditions and disability** and increase life expectancy of those with life limiting conditions.

Because

- **the all-cause mortality rate for children aged 0 – 14 years has moved from the average to amongst the worst in Europe**[1]
- **26% of children's deaths showed 'identifiable failure in the child's direct care'**[2]
- **more than 8 out of 10 adults who have ever smoked regularly started before 19**[3]
- **more than 30% of 2 to 15 year olds are overweight or obese**[4]
- **half of life time mental illness starts by the age of 14**[5]
- **nearly half of looked after children have a mental health disorder and two thirds have at least one physical health complaint**[6]
- **about 75% of hospital admissions of children with asthma could have been prevented in primary care**[7]

Building momentum

At national level a new **Children and Young People's Health Outcomes Board**, led by the Chief Medical Officer, will bring together key system leaders in child health to provide a sustained focus and scrutiny on improving outcomes across the whole child health system.

A new **Children and Young People's Health Outcomes Forum** will provide both ongoing expertise in child health and offer constructive challenge to the next phase of this work. The Forum will hold an annual summit involving the CMO to monitor progress on child health outcomes and make recommendations for their improvement.

The Children and Young People's Health Outcomes Forum report and system response can be found at **http://www.dh.gov.uk/health/2012/07/cyp-report/**

For the very first time, everyone across the health and care system is determined to play their part in improving health outcomes for children and young people.

1 Wolfe I, Cass H,Thompson MJ et al. Improving child health services in the UK: insights from Europe and their implications for the NHS reforms. BMJ 2011; 342:d1277
2 CEMACH report 2008
3 Healthy Lives, Healthy People – our strategy for public health in England. Department of Health (2010)
4 Health Survey for England 2010
5 Kessler R, Angermeyer M, Anthony J et al. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. World Psychiatry 2007 Oct; 6(3):168-76
6 DfE Outcomes for children looked after as at 31 March 2012
7 Asthma UK. Wish you were here – England (2008).

Public Health England

Agenda Item 8
Appendix 2

Child Health Profile
March 2014

Southampton

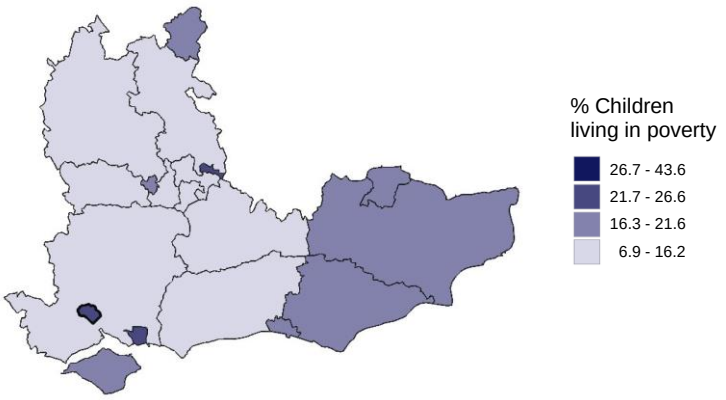
This profile provides a snapshot of child health in this area. It is designed to help the local authority and health services improve the health and wellbeing of children and tackle health inequalities.

The child population in this area

	Local	South East	England
Live births in 2012			
	3,420	107,858	694,241
Children (age 0 to 4 years), 2012			
	15,900 (6.6%)	545,700 (6.3%)	3,393,400 (6.3%)
Children (age 0 to 19 years), 2012			
	57,300 (23.9%)	2,091,900 (24.0%)	12,771,100 (23.9%)
Children (age 0 to 19 years) in 2020 (projected)			
	58,100 (23.1%)	2,233,100 (23.8%)	13,575,900 (23.7%)
School children from minority ethnic groups, 2013			
	6,995 (29.0%)	199,300 (19.3%)	1,740,820 (26.7%)
Children living in poverty (age under 16 years), 2011			
	25.9%	15.1%	20.6%
Life expectancy at birth, 2010-2012			
Boys	78.5	80.3	79.2
Girls	82.7	83.8	83.0

Children living in poverty

Map of the South East, with Southampton outlined, showing the relative levels of children living in poverty.



Contains Ordnance Survey data

Data sources: Live births, Office for National Statistics (ONS); population estimates, ONS mid-year estimates; population projections, ONS interim 2011-based subnational population projections; black/ethnic minority maintained school population, Department for Education; children living in poverty, HM Revenue & Customs (HMRC); life expectancy, ONS.

Key findings

Children and young people under the age of 20 years make up 23.9% of the population of Southampton. 29.0% of school children are from a minority ethnic group.

The health and wellbeing of children in Southampton is generally worse than the England average. Infant and child mortality rates are similar to the England average.

The level of child poverty is worse than the England average with 25.9% of children aged under 16 years living in poverty. The rate of family homelessness is similar to the England average.

Children in Southampton have average levels of obesity: 9.5% of children aged 4-5 years and 20.3% of children aged 10-11 years are classified as obese.

The MMR immunisation rate is better than the England average. The immunisation rate for diphtheria, tetanus, polio, pertussis and Hib in children aged two is better than the England average.

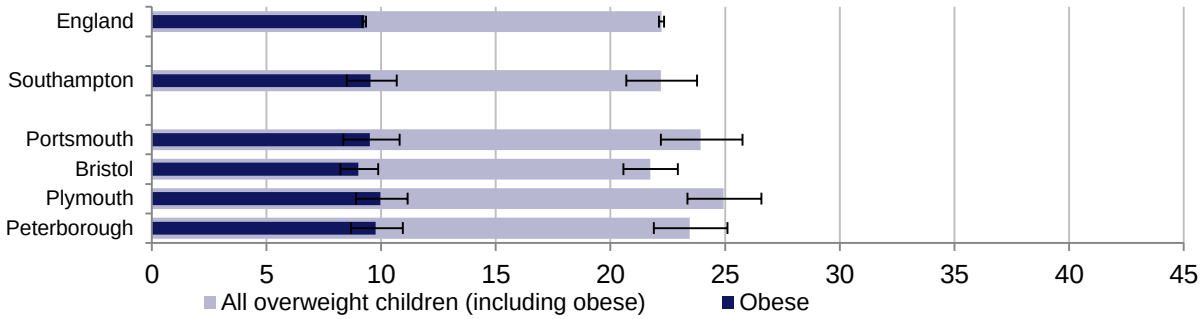
In 2012, there were 1,459 acute sexually transmitted infection diagnoses in young people aged 15 to 24 years. This represents a rate of 30.2 diagnoses for every 1,000 people in this age range which is lower than the England average.

Any enquiries regarding this publication should be sent to info@chimat.org.uk.

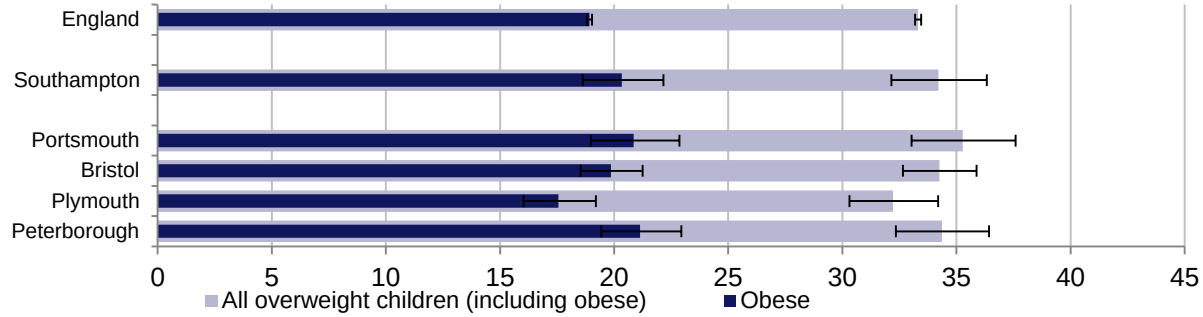
Childhood obesity

These charts show the percentage of children classified as obese or overweight in Reception (aged 4-5 years) and Year 6 (aged 10-11 years) by local authority compared with their statistical neighbours. Compared with the England average, this area has a similar percentage in Reception and a similar percentage in Year 6 classified as obese or overweight.

Children aged 4-5 years classified as obese or overweight, 2012/13 (percentage)



Children aged 10-11 years classified as obese or overweight, 2012/13 (percentage)



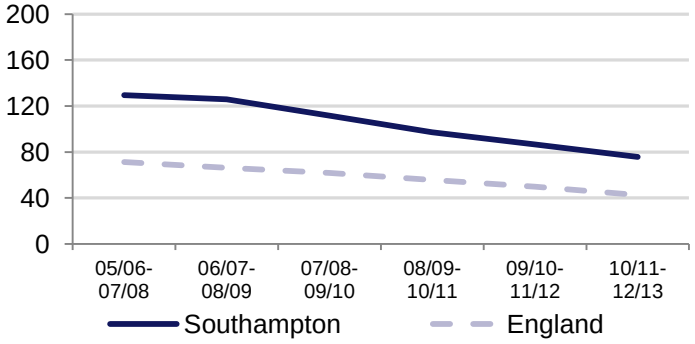
Note: This analysis uses the 85th and 95th centiles of the British 1990 growth reference (UK90) for BMI to classify children as overweight and obese.

I indicates 95% confidence interval. Data source: National Child Measurement Programme (NCMP), Health and Social Care Information Centre

Young people and alcohol

In comparison with the 2005/06-2007/08 period, the rate of young people under 18 who are admitted to hospital because they have a condition wholly related to alcohol such as alcohol overdose is lower in the 2010/11-2012/13 period. The admission rate in the 2010/11-2012/13 period is higher than the England average.

Young people aged under 18 admitted to hospital with alcohol specific conditions (rate per 100,000 population aged 0-17 years)

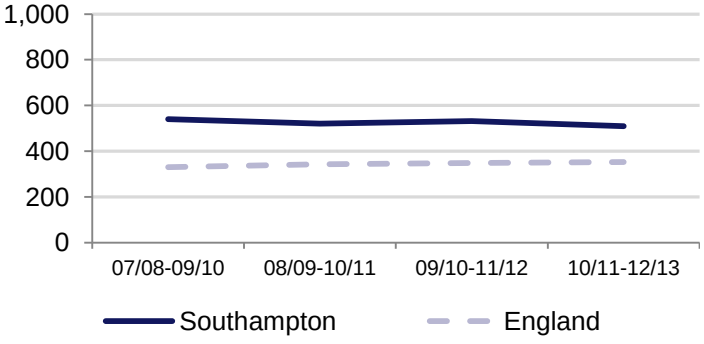


Data source: Public Health England (PHE)

Young people's mental health

In comparison with the 2007/08-2009/10 period, the rate of young people aged 10 to 24 years who are admitted to hospital as a result of self-harm is similar in the 2010/11-2012/13 period. The admission rate in the 2010/11-2012/13 period is higher than the England average*. Nationally, levels of self-harm are higher among young women than young men.

Young people aged 10 to 24 years admitted to hospital as a result of self-harm (rate per 100,000 population aged 10 to 24 years)

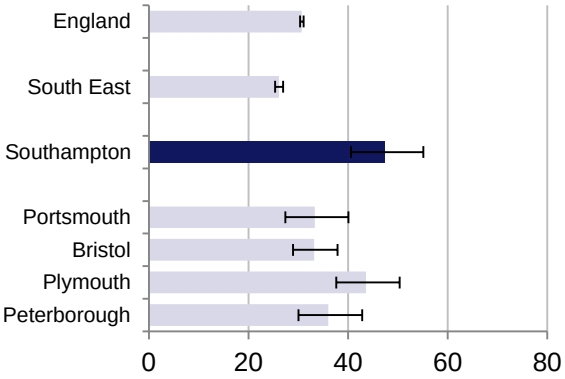


*Information about admissions in the single year 2012/13 can be found on page 4

Data source: Hospital Episode Statistics, Health and Social Care Information Centre

These charts compare Southampton with its statistical neighbours, the England and regional average and, where available, the European average.

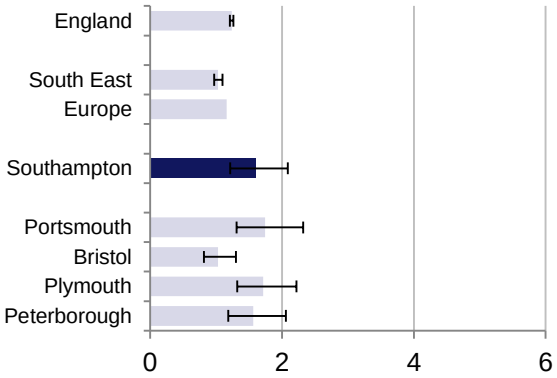
Teenage conceptions in girls aged under 18 years, 2011 (rate per 1,000 female population aged 15-17 years)



In 2011, approximately 47 girls aged under 18 conceived for every 1,000 females aged 15-17 years in this area. This is higher than the regional average. The area has a higher teenage conception rate compared with the England average.

Data source: ONS

Teenage mothers aged under 18 years, 2012/13 (percentage of all deliveries)

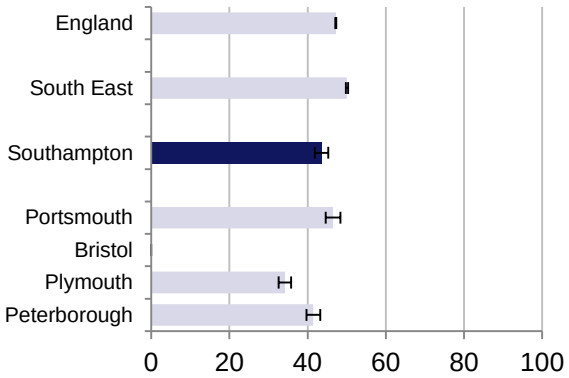


In 2012/13, 1.6% of women giving birth in this area were aged under 18 years. This is higher than the regional average. This area has a similar percentage of births to teenage girls compared with the England average and a higher percentage compared with the European average of 1.2%*.

Data source: Hospital Episode Statistics, Health and Social Care Information Centre

* European Union 27 average, 2009. Source: Eurostat

Breastfeeding at 6 to 8 weeks, 2012/13 (percentage of infants due 6 to 8 week checks)

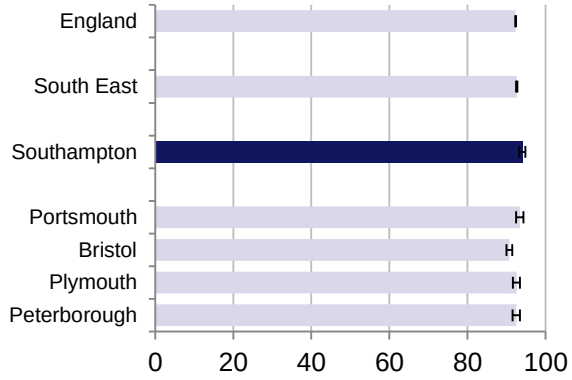


In this area, 43.5% of mothers are still breastfeeding at 6 to 8 weeks. This is lower than the England average. 74.6% of mothers in this area initiate breastfeeding when their baby is born. This area has a lower percentage of babies who have ever been breastfed compared with the European average of 89.1%*.

* European Union 21 average, 2005. Source: Organisation for Economic Co-operation and Development (OECD) Social Policy Division

Data source: PHE

Measles, mumps and rubella (MMR) immunisation by age 2 years, 2012/13 (percentage of children age 2 years)



Compared with the England average, a higher percentage of children (94.1%) have received their first dose of immunisation by the age of two in this area. By the age of five, 91.2% of children have received their second dose of MMR immunisation. This is higher than the England average. In the South East, there were 329 laboratory confirmed cases of measles in young people aged 19 and under in the past year.

Data sources: Health and Social Care Information Centre, PHE

Note: Where data is not available or figures have been suppressed, no bar will appear in the chart for that area.

Southampton Child Health Profile — March 2014

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.

- Significantly worse than England average
- Significantly better than England average
- Not significantly different
- Regional average

	Indicator	Local no.	Local value	Eng. ave.	Eng. worst	Eng. best
Premature mortality	**1** Infant mortality	14	4.1	4.3	7.7	1.3
	2 Child mortality rate (1-17 years)	4	7.8	12.5	21.7	4.0
Health protection	**3** MMR vaccination for one dose (2 years)	3,320	94.1	92.3	77.4	98.4
	4 Dtap / IPV / Hib vaccination (2 years)	3,422	97.0	96.3	81.9	99.4
	5 Children in care immunisations	255	85.0	83.2	0.0	100.0
	6 Acute sexually transmitted infections (including chlamydia)	1,459	30.2	34.4	89.1	14.1
Wider determinants of ill health	**7** Children achieving a good level of development at the end of reception	1,512	50.8	51.7	27.7	69.0
	8 GCSEs achieved (5 A*-C inc. English and maths)	1,210	58.1	60.8	43.7	80.2
	9 GCSEs achieved (5 A*-C inc. English and maths) for children in care	-	-	15.3	0.0	41.7
	10 16-18 year olds not in education, employment or training	430	6.3	5.8	10.5	2.0
	11 First time entrants to the youth justice system	182	968.2	537.0	1,426.6	150.7
	12 Children in poverty (under 16 years)	10,640	25.9	20.6	43.6	6.9
	13 Family homelessness	173	1.7	1.7	9.5	0.1
	14 Children in care	480	104	60	166	20
	15 Children killed or seriously injured in road traffic accidents	15	35.5	20.7	45.6	6.3
Health improvement	**16** Low birthweight of all babies	230	6.7	7.3	10.2	4.2
	17 Obese children (4-5 years)	266	9.5	9.3	14.8	5.7
	18 Obese children (10-11 years)	403	20.3	18.9	27.5	12.3
	19 Children with one or more decayed, missing or filled teeth	-	29.9	27.9	53.2	12.5
	20 Under 18 conceptions	170	47.4	30.7	58.1	9.4
	21 Teenage mothers	51	1.6	1.2	3.1	0.2
	22 Hospital admissions due to alcohol specific conditions	35	75.8	42.7	113.5	14.6
	23 Hospital admissions due to substance misuse (15-24 years)	35	78.9	75.2	218.4	25.4
Prevention of ill health	**24** Smoking status at time of delivery	512	15.2	12.7	30.8	2.3
	25 Breastfeeding initiation	2,505	74.6	73.9	40.8	94.7
	26 Breastfeeding prevalence at 6-8 weeks after birth	1,441	43.5	47.2	17.5	83.3
	27 A&E attendances (0-4 years)	6,209	400.2	510.8	1,861.3	214.4
	28 Hospital admissions caused by injuries in children (0-14 years)	514	130.0	103.8	191.3	61.7
	29 Hospital admissions caused by injuries in young people (15-24 years)	682	141.2	130.7	277.3	63.8
	30 Hospital admissions for asthma (under 19 years)	111	221.4	221.4	591.9	63.4
	31 Hospital admissions for mental health conditions	112	238.0	87.6	434.8	28.7
	32 Hospital admissions as a result of self-harm (10-24 years)	271	400.9	346.3	1,152.4	82.4

Notes and definitions - Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box.

1 Mortality rate per 1,000 live births (age under 1 year), 2010-2012

2 Directly standardised rate per 100,000 children age 1-17 years, 2010-2012

3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2012/13

4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2012/13

5 % children in care with up-to-date immunisations, 2013

6 Acute STI diagnoses per 1,000 population aged 15-24 years, 2012

7 % children achieving a good level of development within Early Years Foundation Stage Profile, 2012/13

8 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2012/13

9 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2013 (provisional)

10 % not in education, employment or training as a proportion of total age 16-18 year olds known to local authority, 2012

11 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2012

12 % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2011

13 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2012/13

14 Rate of children looked after at 31 March per 10,000 population aged under 18, 2013

15 Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2010-2012

16 Percentage of live and stillbirths weighing less than 2,500 grams, 2012

17 % school children in Reception year classified as obese, 2012/13

18 % school children in Year 6 classified as obese, 2012/13

19 % children aged 5 years with one or more decayed, missing or filled teeth, 2011/12

20 Under 18 conception rate per 1,000 females age 15-17 years, 2011

21 % of delivery episodes where the mother is aged less than 18 years, 2012/13

22 Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions, 2010/11-2012/13

23 Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse, 2010/11-2012/13

24 % of mothers smoking at time of delivery, 2012/13

25 % of mothers initiating breastfeeding, 2012/13

26 % of mothers breastfeeding at 6-8 weeks, 2012/13

27 Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2011/12

28 Crude rate per 10,000 (age 0-14 years) for emergency hospital admissions following injury, 2012/13

29 Crude rate per 10,000 (age 15-24 years) for emergency hospital admissions following injury, 2012/13

30 Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma, 2012/13

31 Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health, 2012/13

32 Directly standardised rate per 100,000 (age 10-24 years) for hospital admissions for self-harm, 2012/13

Children and Young People Action Plan to Address Poor Outcomes

Topic	Indicators with poor outcomes in Southampton	What plans will address these?	Who will be involved?	Resource implications
Sexual Health	Acute sexually transmitted infections (including Chlamydia)	Sexual Health Strategy - in progress SN Commissioning Strategy - in progress Solent Diagnostic Delivery Plan	Integrated Sexual Health Service Midwifery Family Nurse Partnership/Health Visitors School Nursing Voluntary Services GPs Pharmacy Schools/Colleges/Universities	Open Access Sexual Health Services funded through Public Health budget. Sexual health promotion currently has limited funding
	Teenage conception rate (age under 18 years)	Teenage Pregnancy Strategy - in progress (part of sexual health strategy) Pre-birth to 19 Commissioning Strategy	See above	Public health budget
	Teenage mothers (age under 18 years)	See above - sexual health strategy Pre-birth to 19 Commissioning Strategy	See above	Public health budget
Education	Children achieving a good level of development at age 5	Pre-birth to 19 Commissioning Strategy, Surestart Business Priorities, Transformation - early help	Children's Centres multi-agency teams, early years team, Voluntary Organisations, public health	CCG budget, children's services budget
	GCSE achieved (5A*-C inc. English and maths)	Transformation - A good education for all, City vision for learning	Children's services, schools, further education colleges	Children's services budget
	Not in education, employment or training (age 16-18 years)	Transformation - A good education for all, City Vision for learning	Children's services, schools, further education colleges, Voluntary Organisations	Children's services budget

Family and home situation	Children living in poverty (aged under 16 years)	Fuel poverty strategy , Pre-birth to 19 Commissioning Strategy, training and employment support part of Ofsted framework, Healthy Start	Southampton Warmth for All Partnership, children's centres working with Department for Work and Pensions - building parental confidence and skills in readiness for return to employment	
	Language issues (i.e. number with English as Additional Language)*	Pre-birth to 19 Commissioning Strategy	Children's centres focus on language development, parents supported to attend ESOL classes, children supported with language development through a number of groups and through ECAT in Early Years settings	There has been reduced funding for ESOL classes in children's centres. They are expensive as need to include a crèche.
	Children in care	Transformation - Good quality care provision for looked after children	Children's services, schools, health, housing, Adult Social Care, Voluntary Organisations, Police	Children's services budget
	Economic wellbeing for care leavers*	Transformation - Good quality care provision for looked after children	Children's services, schools, health, housing, Adult Social Care, Voluntary Organisations, Police	Children's services budget
	Child protection issues*	Transformation - Integrated, co-managed, co-located, seamless services. Establish good practice in core teams, Early Help -4 years and 5-19 years	Children's services, schools, health, housing, Adult Social Care, Voluntary Organisations, Police	Children's services budget
Accidents and Injury	Children killed or seriously injured in road traffic accidents	Sure Start Business Priorities Pre-birth to 19 Commissioning Strategy		
	Hospital admissions due to injury (age under 18 years)	School Nursing Commissioning Strategy - in progress Pre-birth to 19 Commissioning Strategy	School Nursing	
Lifestyle	Children's tooth decay (at age 12)	Embedded in universal under 5s services for weaning, healthy eating etc. Supervised tooth brushing (nursery and year 1), health visiting checks (includes	Oral and dental health promotion programmes School Nursing, health visitors, children's centres, early years settings	Public health dental contract

		siblings)		
	Hospital admissions due to alcohol specific conditions	Substance Misuse tender Substance Misuse Strategic Review	Substance Misuse services	
	Smoking in pregnancy	Tobacco Control Planning University Hospitals Southampton Midwifery service specification Sure Start Business Priorities		
Mental wellbeing	Hospital admissions for mental health conditions	Be Well Early Help model Emotional 1st Aid CAMHs service specification CAMHs Internal Review action plan Suicide prevention strategy Emotional 1st Aid training HeadStart	Self harm rota CAMHs MARP BRS School nursing Steps to well-being (IAPT) Primary Care Education Voluntary Services e.g. No Limits	
	Hospital admissions as a result of self-harm	See above HeadStart	See above	
Crime	Violent crime and domestic violence*	Safe City Partnership Plan		
	Youth offending*	Youth Justice Strategic Plan – statutory Serious Youth Crime Prevention Action Plan – in progress	NHS England Youth Offending Team	NHS England

This table includes those indicators for which Southampton is significantly worse than England in the 2013 CHIMAT profile.

*Additional indicators identified in Tim Davis report on 'agency feedback relating to hypotheses around vulnerability factors and poor outcomes for Southampton children and young people' (25th September 2013)

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DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		TACKLING TEENAGE PREGNANCY		
DATE OF DECISION:		26 MARCH 2014		
REPORT OF:		DIRECTOR OF PUBLIC HEALTH		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Helen Cruickshank/Tim Davis**	**Tel:**	**023 8083 3051**
	E-mail:	**helen.cruickshank@southampton.gov.uk** **tim.davis@southampton.gov.uk**		
Director	**Name:**	**Andrew Mortimer**	**Tel:**	**023 8083 3738**
	E-mail:	**andrew.mortimore@southampton.gov.uk**		
STATEMENT OF CONFIDENTIALITY				
Not applicable				

BRIEF SUMMARY

Teenage conceptions have been declining steadily in England over the last decade. Whilst the teenage pregnancy rate has also fallen in Southampton, the rate of decline has been lower. The City remains a hotspot for having significantly higher rates than the England average and the South East region. Many teenage conceptions are both unplanned and unwanted. Becoming a teenage parent has a high correlation with a range of poor outcomes for both children and their mothers.

In previous years, strong leadership, nationally and locally, on teenage pregnancy facilitated City-wide activity to tackle this important public health issue. The end of the national Teenage Pregnancy Strategy in 2010, and the subsequent loss of dedicated leadership capacity in Southampton, have affected the coordination and drive for improvement on this agenda. In March 2014, a new strategic group was convened in the City to provide a renewed focus on sexual health and this group has identified teenage pregnancy as a priority area.

RECOMMENDATIONS:

(i) That the Health and Wellbeing Board supports the development of a new sexual health plan for Southampton, incorporating teenage pregnancy as a priority.

(ii) The Heath and Wellbeing Board notes the Cabinet Member for Children's Safeguarding, Cllr Chaloner, has been appointed the champion for tackling teenage pregnancy and will be supported by the Cabinet Member for Communities, Cllr Kaur.

(iii) The Health and Wellbeing Board are asked to agree that the Southampton sexual health strategic group will work closely with the Cabinet Member champions on teenage pregnancy issues.

REASONS FOR REPORT RECOMMENDATIONS

1. Southampton has poor sexual health and high teenage pregnancy rates compared to the South East and England. Without a sustained focus on teenage pregnancy, there is a high risk that the decline in under 18 conceptions seen in recent years may falter. This would risk significant social and financial costs for the individuals, their families and the City as a whole in the longer term.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. Not applicable

DETAIL (Including consultation carried out)

3. **National context**

In 1999, a national Teenage Pregnancy Strategy was launched which was in operation until 2010. This provided national leadership and guidance through the Teenage Pregnancy Unit, driving the development of local strategies and effective partnership action. During this period, the under 18 conception rate in England reduced by 13%, with births to under 18s down by almost 25%. Since 2010, whilst there has been no national strategy in place for teenage pregnancy, it remains a public health priority, and is included in the national Public Health Outcomes Framework. Preventing teenage pregnancy is also one of the four priority areas identified in the 2013 coalition document 'A Framework for Sexual Health Improvement in England'. This framework sets out two ambitions:

- That all young people should receive appropriate information and education to enable them to make informed decisions.
- That all young people have access to the full range of contraceptive methods and where to access them.

Although teenage conceptions have been declining, the UK still has one of the highest birth rates among teenage mothers in Europe with only Romania, Bulgaria, Slovakia, Hungary and Malta having higher rates.

4. **Importance of teenage pregnancy**

Around 75% of teenage pregnancies are unplanned and half end in abortion. Teenage pregnancy is strongly associated with poor outcomes for both the mother and the child, including:

- a higher risk of post natal depression and future mental health problems, unfinished education and economic difficulties for teenage mothers compared to older mothers; and
- a higher risk of infant mortality, poor health, low educational attainment and growing up in poverty for the child.

The reasons that teenage conceptions remain higher in some communities than others are complex and can involve a combination of behavioural, familial and social influences, together with some cultural differences. We know that certain groups experience higher levels of teenage pregnancy, and this can provide a basis for targeted prevention work, for example:

young women from deprived areas; children of teenage mothers; young offenders; young women with low self esteem; and young women with low educational achievement.

5. **Teenage pregnancy in Southampton**

In 2012 (the most recent data available from the Office of National Statistics), there were 129 under 18 conceptions, 24 of which were under the age of 16 years, in Southampton. This equates to 34.3 conceptions per 1,000 females aged 15–17 years. This rate has declined steadily over the last decade, but remains significantly higher than the rate in the South East (23.2 per 1,000) and England (27.7 per 1,000) (figure 1). The rate of decline has been slower in Southampton than England, the South East, and most of its statistical neighbours. The under 16 conception rate in Southampton (2010-12) of 8.5 per 1,000 females aged 13-15 years is higher compared to the South East (5.0 per 1,000) and England (6.1 per 1,000).

The most recent ward level data is from 2011, where Redbridge, Millbrook, Freemantle, Woolston and Bitterne had under 18 conception rates that were significantly higher than the England average (figure 2).

6. **Action on reducing teenage pregnancy in Southampton**

The two areas that have been identified as having the largest impact on reducing teenage pregnancy rates are:

1. High quality sex and relationships education (SRE) for all young people
2. Good access to effective contraception for young people who are sexually active.

Alongside SRE and access to contraception there are a number of other activities and interventions, identified through the work of the former national Teenage Pregnancy Strategy, which have proved critical to the effectiveness of local efforts to reduce teenage conceptions, including:

- targeted work to identify and then work with young people at risk of teenage pregnancy through holistic assessment of their risk factors.
- local champions and senior engagement in the local authority and NHS
- investment in training for the wider children's workforce so they have skills and confidence to talk to young people about sex and relationships.
- the collection, sharing and effective use of local data to inform targeted work and provide a timely assessment of progress
- effective targeted support for teenagers who do have children.

7. The last sexual health strategy for Southampton was produced in 2008 and the City's Teenage Pregnancy Action Plan was last reviewed in 2012. Since that time, there has been a significant reduction in overall capacity in relation to leadership around teenage conception. Unaddressed it can only be anticipated that this will potentially result in a deterioration of the progress that was achieved in Southampton on teenage pregnancy.

8. **Current activity**

Southampton's Public Health team and Integrated Commissioning Unit are jointly leading the development of a revised sexual health plan, to be launched in 2014, which will incorporate an updated plan for addressing the City's ongoing teenage pregnancy issues.

As part of the sexual health plan development, a workshop was held in December 2013 to secure the contribution of key stakeholders from a range of organisations across the City. This includes schools, GPs, Solent NHS Trust and a range of voluntary sector partners. A key message from the workshop was the need for a coordinated, evidence-based approach to SRE across Southampton.

The new sexual health plan will provide a framework for activity to improve sexual health outcomes in the City. Teenage pregnancy has been identified as one of the priorities for the sexual health plan and it is proposed that a new teenage pregnancy task group is established to:

- develop a clear plan to encourage City-wide delivery of evidence-based SRE as part of a wider approach to PSHE that supports children and young people in taking greater control over their long term health and wellbeing.
- ensure availability of effective contraception to all sexually active young people.
- deliver targeted work with young people at particular risk, such as children in need, children looked after, children at risk of sexual exploitation and those putting themselves at risk through recreational use of drugs and/or alcohol.
- provide training in age-appropriate SRE for staff working with children and young people.
- support teenage parents, for example through the services commissioned through the Family Nurse Partnership, and those organisations they work with in supporting teenage parents.
- deliver partnership actions, networking and sharing good practice.
- work with services to develop resources linked to self esteem, personal choice and resilience in relation to mental and emotional health and wellbeing through links with the HeadStart Southampton programme.

RESOURCE IMPLICATIONS

9. Most of the financial impact of teenage pregnancy, and parenthood is manifested in increased demand for spending on benefits, supported housing, family nurse partnership and other health services, together with increased risk of families requiring other targeted and specialist services. Rough estimates of the cost of benefit, housing and other additional costs equate to approximately £15k per teenage parent, per year. Spending on acute outcomes, such as services in relation to teenage conceptions, terminations and/or treatment of sexually transmitted infections (STIs) can be reduced through effective upstream approaches including sex and relationship education and accessible contraception for target audiences.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

10. Not applicable

Other Legal Implications:

11. Not applicabale

POLICY FRAMEWORK IMPLICATIONS

12. Health and Well Being Strategy

KEY DECISION? Yes/No

WARDS/COMMUNITIES AFFECTED:	City-wide issue

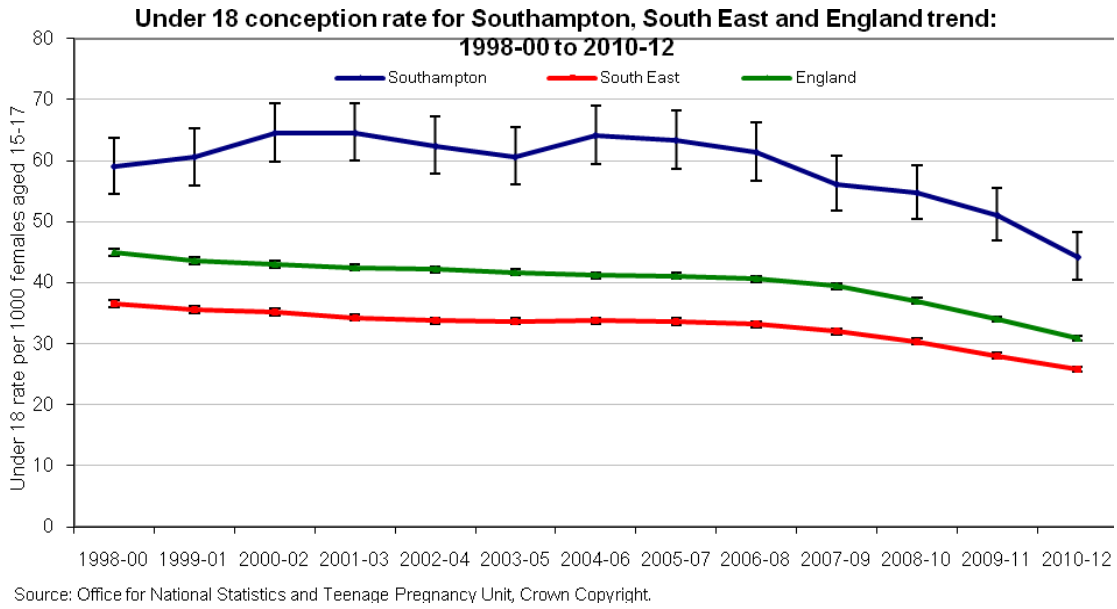
SUPPORTING DOCUMENTATION

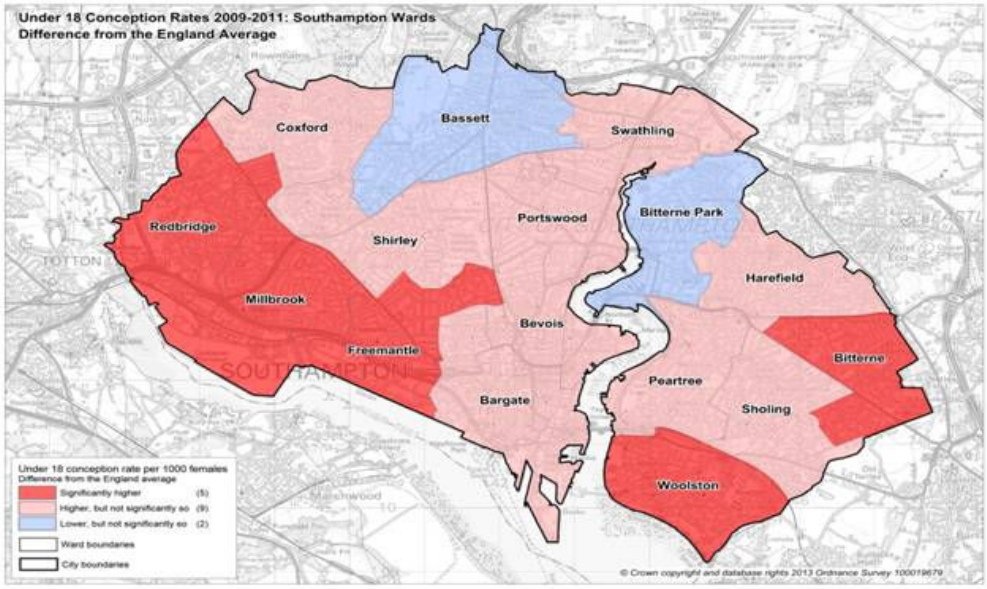
Appendix 1 – trend in under 18 conception rate (attached)

Appendix 2 – conception rates in Southampton compared to England (attached)

Appendix 3 – draft TOR – sexual health strategic group

1.	Figure 1: trend in under 18 conception rate for Southampton, South East and England
2.	Figure 2: conception rates in Southampton wards compared to England average



Documents In Members' Rooms

	N/A

Equality Impact Assessment

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

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)

Terms of reference (DRAFT)

Southampton sexual health strategic group

Purpose of group

- To provide a strategic and coordinated approach to sexual health improvement in Southampton
- To identify, evaluate and set priorities for sexual health improvement, based on changing local need
- To develop and implement a three year sexual health strategic plan, incorporating teenage pregnancy, in line with the national 'Framework for sexual health improvement in England (2013)'
- To facilitate communication and networking in sexual health across Southampton

Important note: The strategic group will not have a role in monitoring the performance of commissioned services; this will take place elsewhere.

Meetings

- Meetings will take place quarterly, initially for one year (to be reviewed at the end of 2014/15)
- The group will be chaired by a Consultant in Public Health and supported with administration by a member of the Public Health team

Membership

1. Public Health, Southampton City Council
2. Southampton City CCG
3. Solent School Nursing
4. Solent Sexual Health Services
5. Primary care representative
6. Safeguarding Children, Southampton City Council
7. Schools representative
8. FE College representative
9. HE representative
10. Voluntary sector representative
11. NHS England (Wessex Region) representative

Communication

The group will develop a communication plan to ensure that stakeholders not directly represented on the group are able to receive information and feed into the strategy.

Accountability

Health and Wellbeing Board

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DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		TOBACCO CONTROL PLAN		
DATE OF DECISION:		26TH MARCH 2014		
REPORT OF:		DR ANDREW MORTIMORE, DIRECTOR OF PUBLIC HEALTH		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Ginny Cranshaw**	**Tel:**	**023 804398**
	E-mail:	**ginny.cranshaw@southampton.gov.uk**		
Director	**Name:**	**Dr Andrew Mortimore**	**Tel:**	**023 803204**
	E-mail:	**andrew.mortimore@southampton.gov.uk**		
STATEMENT OF CONFIDENTIALITY Not applicable				

BRIEF SUMMARY

This Plan has been developed for the city to provide a co-ordinated approach to stop the damage done by smoking to the city's population. The Plan outlines the multi-agency approach, based on evidence based interventions, which is required for effective tobacco control within the city. The Plan was unavoidably delayed in gaining approval by the People Directorate DMT, but this was agreed on 10th March and currently with CMT members for comment. We are asking for ratification of the Plan from the Health and Wellbeing Board, subject to any final recommendations from the CMT which be presented verbally at the meeting.

RECOMMENDATIONS:

(i) That following consultation with the Director of Public Health, the Health and Wellbeing Board agree the Tobacco Control Plan.

(ii) That the Health and Wellbeing Board agree the Public Health Team establish a working group with key stakeholders to deliver the actions outlined in the action plan and report to the Board on progress.

REASONS FOR REPORT RECOMMENDATIONS

1. The Government's Tobacco Control Plan (Healthy Lives, Healthy People: A Tobacco Control Plan for England, DH 2011) requires local areas to implement evidence-based best practice for comprehensive tobacco control based on local priorities, in line with the evidence base and local circumstances.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. Without a strategic approach, there will not be a co-ordinated and informed approach to tobacco control within the city. The consequences of this will be a lack of clear directional travel in tobacco control in the city, and the city will continue to suffer the health and financial impacts of smoking.

DETAIL (Including consultation carried out)

2. Smoking-related mortality amongst people aged 35+ in Southampton is significantly higher than the national average at 236 deaths per 100,000.

3. Smoking is a major cause of health inequalities nationally and in Southampton the smoking prevalence amongst people from 'routine and manual' socio-economic grouping is 36.8%. This is much higher than the prevalence amongst Southampton's total population which is 22.6%. Smoking prevalence amongst Southampton's routine and manual groups is also significantly higher than the national average for that group (30.3%). www.tobaccoprofiles.info

4. Previous tobacco control work was delivered as part of a wider Wessex commissioners group, which has now ceased to operate. However this was not at a sufficiently detailed local level to provide a strategic and joined up approach locally.

5. Stakeholders were invited to a consultation and scoping event at the Civic Centre in July 2013, with an agreement to develop a plan at a local level for the city to ensure a robust and cohesive approach to tobacco control.

6. Benchmarking against other local authorities has demonstrated the need for a strategic approach locally for effective controls.

RESOURCE IMPLICATIONS

Capital/Revenue

7. The ring fenced Public Health Grant provides funding for commissioning of Smoking Cessation services and for wider tobacco control implementation (Smoking Cessation services are currently part of NHS block contract arrangements and contract with local GPs and pharmacists. Tobacco control initiatives are supported through public health grant.

8. Regulatory activity is funded through Trading standards (Environmental Health)

Property/Other

9. There are no property implications for the Council. Smoking cessation services are currently commissioned via Solent Healthcare who provide suitable premises for this work.

LEGAL IMPLICATIONS

10. The policy will support the Council's legal responsibility for the delivery of Public Health. It also supports the legal responsibility of regulatory Services in Services in ensuring compliance with legislation to support this work.

Statutory power to undertake proposals in the report:

11. The Smoke- free (premises and enforcement) Regulations 2006

Children and Young Persons (Sale of Tobacco) Order 2007

The Tobacco Advertising and Promotion (Display) (England) regulations 2010

Other Legal Implications:

12. None

POLICY FRAMEWORK IMPLICATIONS

13 Southampton Health and Wellbeing Strategy

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	SCC Tobacco Control Plan

Documents In Members' Rooms

1.	N/A

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)

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2014
- 2016

Making Southampton a smoke-free city

Tobacco Control Plan

SOUTHAMPTON CITY COUNCIL

Forward

To be confirmed

Contents

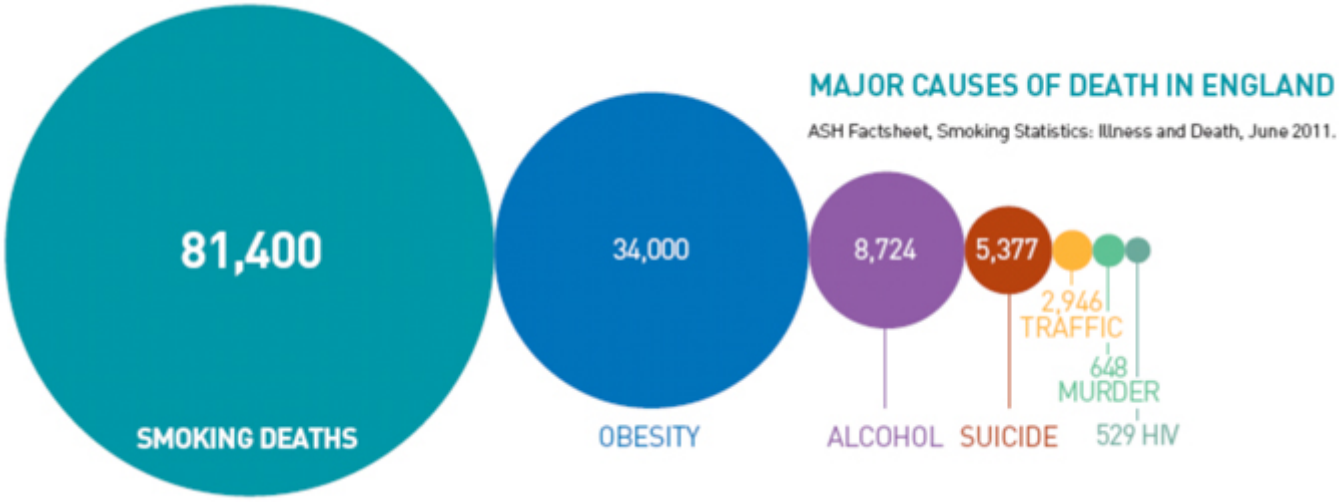
Introduction and purpose

Despite the knowledge of the dangers of smoking, an estimated one in five people still smoke in England. In 2010 the Chief Medical Officer identified tobacco use as the single biggest behavioural risk factor for premature death in England.[i]

The purpose of this plan is to develop a strategic approach at a local level to implement successful tobacco controls across the city of Southampton to minimise the ongoing harmful effects of tobacco. The World Health Organisation (WHO) acknowledges that smoking is the single largest preventable cause of death and disability in the developed world[ii]. Smoking continues to pose one of the biggest risks to public health worldwide, killing almost six million people each year, five million of whom are smokers, and over 600 thousand non smokers who are killed by exposure to second-hand smoke.[iii] Smoking harms nearly every organ of the body and dramatically reduces both quality of life and life expectancy. Smoking causes lung cancer, respiratory disease and heart disease as well as numerous cancers in other organs including lip, mouth, throat, bladder, kidney, stomach, liver and cervix.

Table 1 below shows smoking was responsible for the highest burden of death in England in 2011, a situation that remains unchanged. There are about 10 million adults who smoke cigarettes in Great Britain, including 21% of adult men and 19% of adult women. Smoking prevalence is highest among 20-24 year olds: 30% of men and 28% of women. In 1974, 51% of men and 41% of women smoked cigarettes - nearly half the adult population. Smoking rates are also markedly higher among poorer people. In 2011, 13% of adults in managerial and professional occupations smoked compared with 28% in routine and manual occupations.[iv]

Table 1: Major causes of death in England 2011[v]



Evidence from Southampton's Joint Strategic Needs Assessment[vi] shows the estimated number of adults who smoke in Southampton has increased from 22.2% in 2009 to 22.6% in 2012. Rates are also higher than the national average of 20%. Southampton's Health and Wellbeing Strategy[vii] has identified an increase in unhealthy lifestyles, and included smoking as one of the key challenges that needs to be addressed to improve health in the city. For these reasons there needs to be continued effort and investment to tackle the core strands of tobacco control. These include helping smokers to quit, educating young people about the

dangers of smoking to reduce uptake, and implementing regulatory measures to ensure compliance with legislation in local businesses and effective controls of smuggled and counterfeit tobacco.

An independent survey of public opinion in February 2013[viii] found strong public support for tobacco control measures. A clear majority of people believe that the government is not doing enough or has got tobacco policy about right. Even amongst smokers in England fewer than half (44%) believe that the government is doing too much. The survey found that people in the South East see a need for greater action to control tobacco, particularly in relation to policies that protect children and young people. The survey also found strong support for banning smoking in hospital grounds and 81% of people believe smoking should be banned in cars carrying people aged 18 and under.

Historically, Southampton City Primary Care Trust (PCT) worked collaboratively with partners across Hampshire and the Isle of Wight to develop a Tobacco Control Plan in the region for 2010-2013. The work of this partnership has now been reported on, providing a starting point for Southampton to develop this key working. In producing the first tobacco control plan for the city, in conjunction with the Health and Wellbeing strategy, we can identify opportunities for development and ensure partners across the city are working to the same outcomes to reduce health inequalities and improve the health of our city.

The impact of smoking in Southampton

Smoking prevalence

Although smoking prevalence has decreased nationally, a wide disparity still exists across regions and Southampton compares less favourably, both to the region and the country as a whole. Table 2 below shows the latest Tobacco Control Profile for Southampton City. This demonstrates the significant impact of smoking on the health of residents in the city, how Southampton is performing against the rest of the region and demonstrates the national average in England as a whole. The prevalence of smoking in the city is 22.6% compared to the national average of 20%. 16.6% of pregnant women smoke at the time of delivery compared to the national average of 13.2%, putting both their own and the health of their baby at great risk. In addition, smoking rates are higher among routine and manual workers with rates of 36.8% in Southampton compared to 30.3% nationally.

Table 2 - Tobacco Control Profile for Southampton City 2013 [ix]

	Southampton		Region	England		
	Count	Value	Value	Value	Worst	Best
Smoking attributable mortality	1018	236	181.7	210.6	371.8	125.2
Smoking attributable deaths from heart disease	115	30	24.4	30.3	58.4	14.6
Smoking attributable deaths from stroke	39	9.6	8	9.8	19.2	4.8
Deaths from lung cancer	364	47.1	31.1	37.2	70.3	20.9
Deaths from chronic obstructive pulmonary disease	310	32.3	21.8	25.3	51.6	12.1
Lung cancer registrations	446	58.1	37.9	46.6	86.2	25.1
Oral cancer registrations	72	10.3	8.5	9.5	16.6	3.4
Smoking attributable hospital admissions	2113	1746	1114	1420	2536	726
Cost per capita of smoking attributable hospital admissions	4484057	40.9	32.2	36.9	61.7	14.5
Smoking prevalence - routine & manual	-	36.80%	30.50%	30.30%	49.00%	7.50%
Smoking Prevalence (IHS)	-	22.60%	18.60%	20.00%	29.40%	8.20%
Smoking status at time of delivery	574	16.60%	11.40%	13.20%	29.70%	

Deaths from smoking in Southampton

Men living in Southampton have significantly lower healthy life expectancy, with the average length of time people can expect to live in good health less than the national average (61.1 years compared with 63.2 years)[x]. Smoking is one of the main causes for this, and Table 2 shows that more people die from smoking related deaths in the city than the national average (236 per 100 000, compared to 210.6 in England). Deaths from lung cancer and chronic obstructive pulmonary disease are higher than the national average, and there are more hospital admissions from smoking related illnesses.

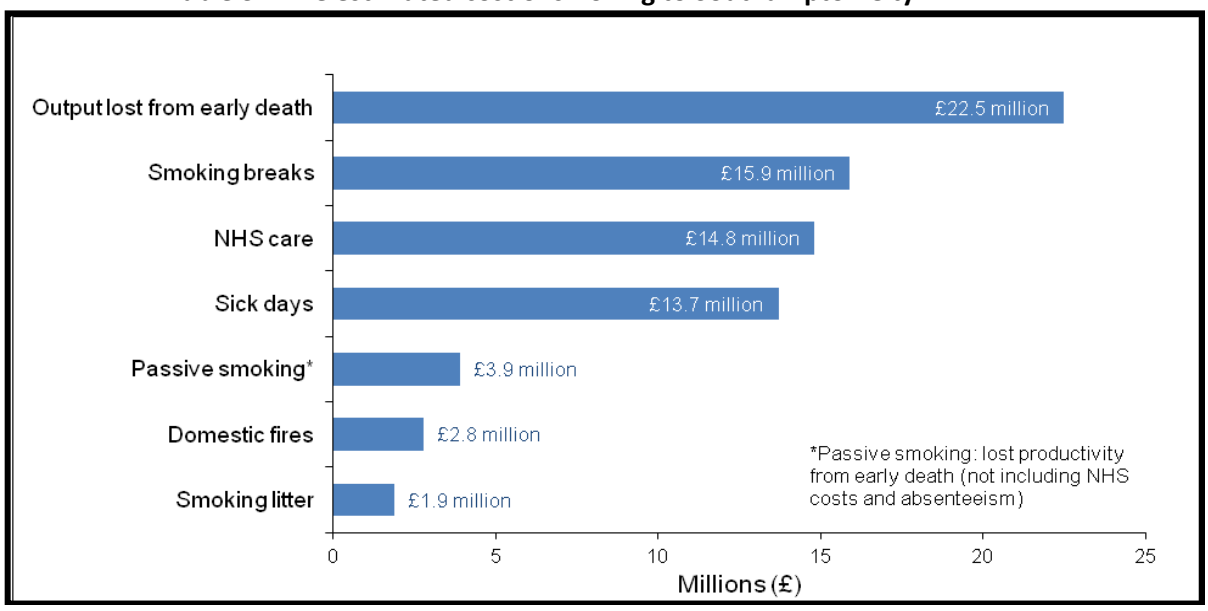
The health risks from second hand smoke

Along with the known health risks to smokers themselves, the health impacts of second hand smoke (SHS) exposure are well documented and people who are exposed to SHS face an increased risk of cancer and heart disease. It is a particular risk to infants and children resulting in increased incidence of upper respiratory tract infections, glue ear and an increased risk of sudden infant death. Exposure to SHS is higher among disadvantaged communities where rates of smoking are higher and also in children whose mothers smoke**.** There are 9,500 hospital admissions and 40 sudden deaths each year in England each year directly attributed to SHS[xi]. There is a significant body of UK and international evidence which demonstrates that smoke-free laws are effective in reducing exposure to SHS. Whilst legislation exists making all enclosed environments smoke free, this law does not relate to people's homes and many, especially children, are still exposed to SHS. Therefore, it makes sense to prioritise work to encourage families to protect children from SHS through smoke-free homes and cars.

The cost of smoking to the local economy

Financial modelling based on national surveys and research has been developed to estimate the cost of smoking. Smoking brings a very high cost to the city in both health and financial terms. Along with the significant personal cost to individuals and their family from poor health and financial burden, there is a considerable economic cost to the city in terms of ill health and costs to local employers. Action on Smoking and Health (ASH) estimate that annually, smoking in Southampton costs our population £70.9m, based on data from national research and surveys.[xii] It is estimated that the city council spends £1.9 million annually clearing up smoking litter, and £2.8 million is spent annually on tackling domestic fires caused by smoking. An estimated £81.1m is spent on cigarettes and tobacco rather than being spent and recycled through our local shops and businesses. Details and the breakdown of wider costs of smoking are shown below in Table 3 and demonstrate a very high financial burden to the city, which is directly attributed to smoking.

Table 3 – The estimated cost of smoking to Southampton City[xiii]



Workplace productivity

Smoking causes a significant cost to both the national and local economy in terms of lost productivity from time off sick and smoking breaks. There are significant potential financial

benefits for employers in implementing and complying with smoke-free legislation. Based on data from national surveys and research, smokers take more sickness leave than non smokers, costing £13.7 million annually to the city. Also it is worth noting that cigarette breaks taken by employees cost Southampton employers £15.9m each year. Employers should encourage and support staff with addiction to tobacco in contacting NHS 'Stop Smoking' services.

The impact of smoking on our health services

Smoking causes a considerable burden for our health services, impacting on primary care and also increasing the number of hospital admissions, especially in the winter months. 1,746 per 100, 000 admissions to hospital in 2010-2011 were directly attributable to smoking (confidence intervals range from 1,670 to 1,825). This is significantly higher than the England average of 1,420 per 100,000 (range 1,415 to 1,424)[xiv]. Based on national modelling, the cost to the local health economy is estimated by ASH to be £1.48m. There is local investment in the Improving Fitness for Surgery programme to try to reduce the significant economic burden of smoking on local NHS services. This initiative aims to help people to stop smoking for four weeks before having non-urgent (elective) surgery. There is evidence this saves money and improves outcomes for patients through quicker healing, less post operative complications and less time spent in hospital. There is also a need to ensure that smoking cessation is integrated into clinical pathways. A high level commitment is required within acute and mental health trusts to support the tobacco cessation agenda in order to realise the potential of the Fitness for Surgery initiative and implement latest NICE guidelines making hospital sites completely smoke free[xv].

Smoking and household fires

Smoking and its materials are the second biggest cause of fires in the home. Fires caused by smoking materials (including cigarettes, roll-ups, cigars and pipe tobacco) result in more deaths than any other type of fire. Local data shows that cigarette fires are more dangerous than other fires, known risk factors include smoking in bed and smoking whilst drinking alcohol. Cigarettes contain chemicals that are designed specifically to keep them burning, even after the smoker falls asleep.

Data from Hampshire Fire Service[xvi] shows there were 890 accidental dwelling fires in Hampshire during 2012-2013, of which 206 (23%) occurred in the Southampton group. Of these, 45 (5%) were caused by smoking materials and 17 (38%) of those were in the Southampton group. The service estimates the cost of these to be £20,930. In 2012-2013 there were three fatalities in dwelling fires in Hampshire due to smoking materials; the cost to society for the three fatalities was £5,262,498. One of these three fatalities occurred in the Southampton group with a cost to society of £1,754,166. During April – October 2013 there were 477 accidental dwelling fires in Hampshire, of which 133 (28%) occurred in the Southampton group. Of the 477 accidental dwelling fires, 28 (6%) were due to smoking materials of which 12 (43%) occurred in the Southampton group. The cost to the service for attending these 12 accidental dwelling fires caused by smoking material was £13,755.

When attending smoking related fires, the fire service is ideally placed to deliver Very Brief Interventions which have an evidence base and are effective in helping people quit smoking.

Health inequalities

Smoking is the biggest cause of health inequalities and the impact of smoking falls mostly on the disadvantaged and vulnerable people in society. Tobacco control was identified in the Marmot Review as a central platform in any strategy to tackle health inequalities. Half of the difference in life expectancy between the highest and lowest income groups can be attributed directly to smoking and smoking-related death rates are two to three times higher in more disadvantaged social groups than in wealthier social groups [xvii].

Table 4 shows the difference in life expectancy and mortality between the most deprived and the least deprived areas in the city. Whilst mortality rates in the most deprived areas from Chronic Obstructive Pulmonary Disease (COPD) have improved by 12%, they are still 203.9% higher than deaths from COPD in the least deprived areas. In Southampton more people smoke in routine and manual classes than in other social classes (36.8% compared to the national average of 30.3%). This rate has in fact increased, and data from the Integrated Household Survey, analysed by the Department of Health and published by Public Health England, shows this rate has increased from 35.4% in 2009 (IHS 2009). Within the city smoking prevalence rates are significantly higher in those areas with the greatest deprivation.

Table 4 - Life Expectancy and Mortality Indicators in Southampton City[xviii]

	Are the most deprived areas improving?	Is the gap narrowing?	
	Change between 2006-08 and 2009-11	Difference between most deprived and least deprived areas	
Measure		**2006-08**	**2009-11**
Life Expectancy for males	Increase of 1.0 years	6.5 years	6.4 years
Life Expectancy for females	Increase of 0.2 years	1.1 years	2.6 years
Mortality – all cause, all age	Decreased 3.9%	40.6% higher	53.25% higher
Premature mortality (under 75) – all cause	Decreased 0.9%	101.6% higher	131.6% higher
Circulatory disease mortality – all ages	Decreased 28.2%	81.1% higher	69.8% higher
Circulatory disease mortality – under 75s	Decreased 41.3%	226.8% higher	184.9% higher
Cancer mortality – all ages	Increased 2.7%	61.2% higher	94.1% higher
Cancer mortality – under 75s	Increased 10.1%	71.9% higher	119.2% higher
COPD mortality – all ages	Increased 12.0%	298.9% higher	203.9% higher

Understanding the psychology behind smoking

Why do people smoke?

The reasons people smoke are complex and varied. Nicotine is a highly addictive drug, which causes addiction in a similar way to heroin or cocaine, making it difficult to stop smoking. Cigarettes are deliberately designed to provide a fast nicotine hit reaching the brain within ten seconds. Nicotine is a stimulant that increases the heart rate, affecting many different parts of the body. It triggers the release of dopamine which is a chemical linked to short term feelings of pleasure. This also means that smokers start to make a mental link between the act of smoking and feeling good. Because of this, smokers can also become addicted to abstract things like the taste of cigarettes or the feeling of smoking, as well as the nicotine itself. People often smoke due to this perceived pleasure from smoking, and also as a way to combat stress, low self-esteem, boredom and to curb appetite and control weight.

People also continue to smoke because of a smoking culture that exists within communities, which normalises smoking. While many see adverts educating them in smoking harms, they continue to be influenced by sophisticated marketing tactics from tobacco companies. While evidence shows that increasing taxation has a direct impact on reducing smoking, the supply of smuggled illegal tobacco undermines this and reduces the financial pressure to stop smoking. Many smokers deny or do not understand the risks and consequences, or may not believe they are placing their health and that of their family at risk.

Three quarters of all smokers say they would like to stop, but fewer than half go on to make an attempt to quit and less than 3% successfully quit each year. Routine and manual workers appear to find it particularly difficult to stop smoking, with quit rates being lower in less affluent groups[xix]

Young people and smoking

It is illegal to sell tobacco products to anyone under 18 in the UK. Despite this, about one in eight children have become regular smokers by the age of 15. Research from Cancer Research UK has shown that trying just one cigarette can make children more likely to start smoking later in life[xx]. Their research also shows that children who smoke often become regular smokers when they are adults. Children smoking are more likely to suffer immediate health consequences such as coughs, increased phlegm, wheezing and shortness of breath and also to take more time off school.

There are a number of reasons why children experiment with smoking. Evidence shows that if a child's parents smoke, they are then three times more likely to smoke themselves. Research shows that advertising can encourage children to start smoking and even adverts that are aimed at adults are attractive to children wishing to aspire to adult behaviour. For this reason direct cigarette advertising is now banned in the UK. Truancy and exclusion are also risk factors for smoking and evidence shows that young people who had been excluded or truanted from school in the previous 12 months were almost twice as likely to smoke regularly compared to those who had never been truant or excluded.[xxi]

Data from the 2012/13 Southampton Pupil Attitude Survey estimates that only 53.4% of children live in a house where neither parent smokes. This survey was completed by over 2,000 pupils from Year 4, Year 6, Year 9 & Year 11 in 26 out of 79 Southampton schools (overall response rate of 24.3%)[xxii]. Estimates show that 870 children start smoking each year in Southampton[xxiii].

NICE guidelines provide clear guidance on the most effective ways to help reduce smoking in young people and state there needs to be a comprehensive broad range of approaches. This includes enforcement work to ensure that shops comply with underage sales and also to control the supply of illicit tobacco. All agencies in the city working with families and young people should ensure that smoking is addressed, in particular in relation to the dangers of smoking in the home and cars. Schools and colleges should incorporate both a whole schools approach and also ensure that smoking is included as part of PSHE work building skills of self-esteem and self worth[xxiv].

How do we help people quit?

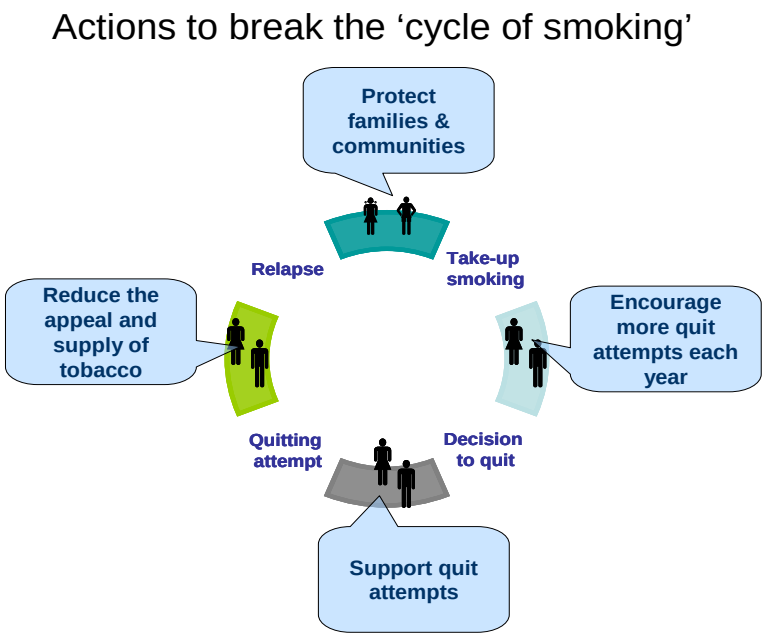
The commissioning of local NHS 'Stop Smoking' services is an essential part of tobacco control, as the most evidence-based support system available. They provide a resource for information on quitting support and expert advice to organisations that want to integrate a stop smoking approach for their workforce. This is also vitally important for the focus on routine and manual smokers. However in order to change the view of smoking as a desirable, everyday activity, helping smokers to stop needs to become integrated into the work of every organisation.

To ensure continuing improvement of Stop Smoking services, the Department of Health has issued updated service and monitoring guidance to ensure adherence to the quality principles and consistency in data quality and data recording. To support this, commissioners in Public Health are currently in the process of investing in Quit Manager which provides a bespoke data management system for smoking cessation. It is the intention that all services commissioned in the future to provide smoking cessation will be authorised to use Quit Manager and this will provide an accurate and robust data management system.

Partnerships and stakeholders in tobacco control

There are many interventions required at a number of different levels in order to break the cycle of smoking. Table 5 shows the different opportunities where actions can be targeted including interventions to help people to quit, to protect families and communities and to reduce the supply of illegal tobacco. Partnership work is essential for tobacco controls to be effective and these partners are drawn from a number of areas. At a local level there are many partners and stakeholders including the regulatory services to reduce the supply of tobacco, children and family services, schools and early years, fire services, pharmacies, primary and secondary care. Southampton City Council is now a member of the Smoke-free Action Coalition, which works at a national level to influence government policy on smoking which forms an important part of tobacco control.

Table 5 – Breaking the cycle of smoking



Tobacco control

Regulatory services have an important role to play in tobacco control and Trading Standards carries out work in the following areas relating to tobacco:

- Ensuring tobacco advertising complies with the restrictions on displays and advertising in shops/pubs by responding to complaints, advice to relevant businesses and inspections of businesses
- Ensuring tobacco products bear the required health warnings
- Preventing sales of tobacco and related products to persons under the age of 18 by the provision of advice to businesses, test purchasing using volunteers and carrying out enforcement action when required
- Preventing the sale of non-duty paid and counterfeit tobacco products by means of inspections, responding to complaints, advice to businesses and seizing illegal products. These are often much cheaper than duty paid/genuine cigarettes.

Environmental Health enforces the smoke-free legislation, which restricts smoking in many public places and workplaces (including public transport and work vehicles). The legislation was introduced in July 2007 following a national and local campaign to raise awareness of the health risks associated with smoking and educating people in control of premises about the new law. 'No smoking' signs must be displayed in premises which are required to be smoke-free and enforcement action can be taken against individuals smoking in these premises. Compliance with the law has been extremely high in Southampton and smoking is no longer permitted in workplaces including pubs, bars and restaurants which reduces exposure to environmental tobacco smoke. This has a positive impact on public health and supports those people who wish to stop smoking.

The role of the City Council and the Public Health Team

As a result of the reorganisation of the NHS in England on April 1st 2013, the responsibility for public health moved from Primary Care Trusts (PCTs) into local authority control. The Public Health Team has transitioned from the PCT and is embedded within the City Council, leading on public health. The council now has a statutory responsibility for improving health and coordinating local efforts to improve the social determinants and protect the public's health and wellbeing. Effective tobacco controls at all levels in the city will contribute towards assisting the council in meeting each of the three key themes of the Health and Wellbeing Strategy, as shown in Table 6:

Table 6 - Three key themes of Southampton's joint Health and Wellbeing Strategy

- Building resilience and using preventative measures to achieve better health and wellbeing
- Best start in life
- Living and ageing well.

Tobacco control activities need to be integrated into local planning to ensure effective partnerships with a number of key agencies. This will help ensure that effective strategies are in place to control the impact of smoking on the city. This plan outlines work with a range of partners on tobacco control measures designed to reduce levels of smoking in the city and the harm caused by tobacco smoke. This includes commissioning citywide Stop Smoking services and supporting action to reduce the availability of cheap and illicit tobacco.

Strategic drivers for Southampton's Tobacco Control Plan

In March 2011, the Department of Health published a tobacco control plan for England[xxv], which set out how tobacco policy fits with the localism agenda. The government is working together with local partners towards three national ambitions to reduce the harm from smoking by the end of 2015:

- Reduce adult smoking prevalence in England to 18.5% or less
- Reduce regular smoking among 15 year olds to 12%
- Reduce smoking throughout pregnancy to 11%.

In January 2012, the government published the 2013-2016 Public Health Outcomes Framework[xxvi], working to achieve two main outcomes of increased healthy life expectancy and reduced differences in life expectancy and healthy life expectancy between communities. To achieve this, the framework included three specific smoking-related outcomes for monitoring:

- Prevalence of smoking among persons aged 18 years and over
- Smoking status at time of delivery per 1000 maternities
- Prevalence of smoking among 15-year-olds.

This plan outlines tobacco control priorities in the city for 2013-2016, focusing on improving the health of the local population and contribute towards helping Southampton to meet these national targets. It will contribute towards improving the health and wellbeing of the residents of Southampton, supporting the aims of the council's *Health and Wellbeing Strategy*[xxvii], which identified smoking and tobacco control as a priority preventative measure. By reducing the spend on tobacco and other products and the associated costs of tobacco control this will also support the economic development strategies for the city.

Action Plan

Aims and key working streams

In line with national ambitions for smoking, the aims of this plan are to work towards achieving the following reductions in smoking rates:

- Reducing smoking prevalence to 18.5% in people aged 18 and over
- Reduce the rate of smoking amongst 15 year to 11% or less
- Reduce the rate of mothers smoking at delivery to 11% or less.

The key working streams of this plan are outlined below fitting with guidelines for commissioning and ensuring that activities and interventions are linked to a strong evidence base. Therefore effective commissioning will provide a return on investment and value for money[xxviii]. It sets out the framework to deliver evidence-based work to support and encourage smoke-free lifestyles, restrict the supply of tobacco and protect people from SHS.

Motivating and assisting every smoker to stop

a) By commissioning specialist services to support all smokers wanting to quit ensuring open access and targeting those in the city's most deprived neighbourhoods
b) Ensuring effective communications around tobacco to ensure a robust approach to working with the media. Communications and public education about smoking can deliver local support for key national campaigns e.g. Stop Smoking day in March, Stoptober and Smoke-free homes.

Protecting families and communities from tobacco related harm

a) Ensuring that local maternity services actively work alongside other partners to reduce smoking rates among pregnant women
b) Reducing exposure to SHS, especially children, by promoting smoke-free environments and raising awareness of the harm caused by tobacco.

Stopping the inflow of young people recruited as smokers

a) Building on existing work to deliver targeted evidence-based interventions to ensure all schools and colleges in the city comply with legislation and have smoke-free policies in place
b) Delivering educational programmes to raise awareness of young people and smoking.

All of the above work is underpinned by effective regulation of tobacco products through:

a) Supporting the work of Trading Standards and Environmental Health, in partnership with the local business community, to ensure compliance with legislation in local businesses
b) Partnership work with Trading standards, Hampshire Constabulary and HMRC to improve local intelligence on illicit, smuggled and counterfeit tobacco
c) Local authority support for the Local Government Declaration on Tobacco Control, and the campaign for plain standardised tobacco packaging through the Smoke Free Action coalition
d) Effective communications (see 9.b).

Draft Action plan for 2014-2015

I. Motivating and assisting every smoker to stop

Area of work	Project	Key Partners	Activity	Expected outcomes and timescales
1. Targeting of key client groups	**Routine and Manual workers**	Local Authority staff Housing Rent arrears Licensing Workplaces	• Focused service delivery in deprived neighbourhoods • Training for staff in Housing dept in VBA[1] • Training for staff in debt/rent arrears in VBA • Training for staff in Licensing in VBA • Workplaces signed up to Workplace Charter	Increased referrals and quitting activity from routine and manual workers.
	Mental Health	Mental Health Services Specialist provider	• Identification of local champions in key Mental Health areas • Delivery of training in brief interventions and level 2 advisor as appropriate • Development of referral pathway within mental health services	Increased referrals and quitting activity from people with mental health problems
	Primary and Secondary care	UHS Primary care Specialist provider	• Refresh/ relaunch of smoking cessation work within UHS settings • Maximise opportunities through NHS Health Checks programme for joint working • Delivery of regular smoking cessation updates to Practice Nurses	Increased referrals to specialist service from secondary care
2. Ensuring systematic	**Making every contact count**	Specialist provider	• Review and update training plan to deliver training on smoking cessations to local	Increased number of trained smoking cessation advisors in

[1] VBA = Very Brief Advice, an evidence based intervention to assist people to quit smoking.

referrals to stop smoking services			organisations in a planned and systematic approach • Launch and co-ordinate Support and Information network for all trained Smoking Cessation advisors	the city. Robust network meeting regularly providing support and information
		Primary care Specialist provider CCG	Support primary care and pharmacies in their delivery of smoking cessation and improving onward referral and engagement by: • Audit of GP practices to identify key issues • Development of action plan from these findings • Pilot project with 7 Healthy Living pharmacies and involvement in the implementation of web data management system for improved reporting • Provision of regular support visits to all practices and pharmacies • Launch and development of smoking advisor network in the city delivering regular planned support meetings and training	Increased quitting activity from primary care and pharmacies, and increased referrals to the specialist services
Policy development	**Policy on e-cigarettes**	Specialist provider Public Health team	Develop agreement across the network on harm reduction and e-cigarettes in line with the MHRA[2]	Consistent network wide disseminated approach to harm reduction
	Protocol on Harm Reduction	PHE	Explore a joint approach to harm reduction in relation to NICE guidance 2013	Protocol developed and services planned for 2014-15

[2] **Medicines and Healthcare Products Regulatory Agency**

	Smoke free hospitals	UHS Specialist provider	Expand work at UHS, gaining high level support, identifying and maximising opportunities for additional areas to increase referrals from: • Seek continued support from Medical Director • Renew site network meetings • Improve referrals from three additional high priority areas: Vascular, Oncology and Paediatrics	Increased referrals to specialist service
		Public Health Team	Southampton Health and Wellbeing Board membership of Smoke free Action Coalition, endorsement of Local Government Declaration on Tobacco Control, and adoption of Southampton Tobacco Control Plan	Southampton City Council a member of the Smoke Free Action Coalition by end 2013 and tobacco control is part of the mainstream public health activity
		Public Health Team	Review of data collection systems and investment in bespoke data management systems to improve service delivery, data quality and reporting mechanisms	Robust electronic system in place city wide by September 2014
Communications	**National campaigns**	SCC Communications Team	Develop joint plans with partners to support No Smoking Day, Campaign for Smoke free homes and Stoptober	Increased promotion of local service provision. Increased referrals and increase in quit rate
Outcome measures: Reduction in smoking prevalence (Public Health Outcomes Framework (PHOF) 2.0)[3]; Reduction in smoking status (PHOF 2.3); Smoking prevalence – 15 year olds (PHOF 2.9); Smoking prevalence – adult over 18s(PHOF2.14)				

2. Protecting families and communities from tobacco related harm

Area of work	Project	Lead Organisations	Activity	Expected outcomes and timescales
Reducing smoking rates in pregnant women	**Smoking in pregnancy referral pathway**	Maternity Services, Health Visitors, Children's Centres, Early years	Work with commissioners of maternity and health visitor services to develop and implement a robust smoking cessation pathway for pregnant women and families with 0-5 year olds	Pathway in place by September 2014
	Midwifery training	Maternity Services, Specialist service	Provision of mandatory training for all midwives in VBA and the use of CO monitors	All midwives trained to use CO monitors by end of 2014
	CO screening	Maternity Services, Specialist service	Implementation of NICE guidelines to introduce routine CO screening in all maternity settings for all pregnant women throughout their pregnancy	All women routinely monitored for CO throughout pregnancy by end of 2014
	Smoke free homes and cars	Children's Centres, Early Years, Public Health team	• Identification of a named champion in each cluster to lead on stop smoking initiatives • Joint commissioning with HCC of bespoke training package for staff to promote Smoke Free Homes • Audit of staff trained in giving VBA • All Sure Start Staff to complete on line training in giving VBA • Promotion of national campaigns in all Surestart venues	Action plan of possible interventions All Sure Start Centre staff trained in giving VBA to promote smoke free homes to clients by end of 2014 Evaluation of training reported
	Smokefree Play	Parks department	• Development and installation of No smoking	All parks displaying no smoking

	Parks	Early years	signage for all enclosed play areas in the city	signs
		Fire service	• Delivery of training in VBA to Fire Service staff • Promotion of fire risks from smoking at house fires • Inclusion of smoking cessation specialist contact details in fire service literature and website • Joint Support for Campaign for Smoke free homes with Children's Centres in Summer 2014	Fires fighters deliver VBA after attending a house fire caused by smoking Fire service support for smoke free homes campaign in 2014
Compliance with Tobacco regulations	**Illegal sales**	Regulatory services Local businesses Police HMRC PHE regional office	• Work with partners to develop systematic gathering of data regarding under age and illegal sales • Investigate allegations of non compliance • Test purchases • Explore possibility of regional wide campaign on dangers of illegal tobacco led by PHE	Comprehensive data capture system Regular test purchases
Outcome measures: **Reduction in women smoking in pregnancy and at time of delivery(PHOF 2.3); Reduction in smoking prevalence (PHOF 2.0); Reduction in Infant mortality (PHOF 1.6); Low birth weight of term babies (PHOF 2.1)**				

3. Stopping the inflow of young people recruited as smokers

Area of work	Project	Lead Organisation	Activity	Expected outcomes and timescales
Schools based	**Schools advisor**	Solent HPS	Co-ordinate Support and Information network	Robust network meetings 2 X

work	**network**	Specialist service Education	for trained Smoking Cessation advisors in schools, delivering regular planned support meetings and training	academic year delivering training to advisors
		Education Solent HPS	Developing a planned sustainable approach to Tobacco Education in schools and Education Centres as part of their Smoke Free Policies	Provision of forward rolling programme outlining delivery of schools based interventions across the city
	Peer education programme	Education Solent HPS	Deliver peer led educational project and other interventions with 2 schools	Peer led project delivered and evaluated in two schools
	Quality mark	Education Solent HPS	Develop Quality mark and encourage schools participation	Uptake of quality mark in schools in the city
	Operation Smoke storm	Schools Solent HPS	Deliver Operation Smoke storm in 2 schools	Project delivered and evaluation report produced
Under age sales		Trading Standards and Environmental Health	• Continue inspections of shops and businesses • Programme of test purchasing using local intelligence in a targeted approach • Respond as appropriate to intelligence about underage sales and illegal tobacco • Support Campaign work with test purchases • Prepare for compliance with closed sales of tobacco across the city with small retailers by end of 2015	Reduction in availability of illegal tobacco through seizures and prosecutions.
Further education	**Social Norms Project**	NIHR University of	• If funding bid is successful prepare plans for social norms projects in FE colleges in	Plans in place to deliver projects in FE colleges and schools across

settings		Southampton University of Portsmouth FE colleges	partnership with Hampshire and Portsmouth during school year 2014-15 alongside research framework • If funding bid is unsuccessful prepare plans for projects in FE colleges during school year 14-15	the city to commence September 2014
Outcome measures: Reduction in smoking prevalence in 15 year olds (PHOF 2.9)				

Implementation and monitoring

The Southampton public health team will lead the implementation of the tobacco control plan for the city, in partnership with partners and stakeholders who will be accountable for relevant elements. Delivery will be monitored by a small group of key stakeholders to provide strategic leadership and direction for the implementation of the plan. Members may be co-opted to the group according to work streams. Quarterly monitoring of the action plan will be the responsibility of this core group. An annual review of progress will take place at the end of each year, providing the framework to develop the action plan for subsequent years. At the end of the three-year timescale of this plan, this group will report on the effectiveness in meeting its outcomes and overall aim. Stakeholders will be accountable to their own relevant boards e.g. healthcare organisations or the local authority cabinet. We should measure their activity as part of this plan, but overall accountability is to the Health and Wellbeing board of Southampton City Council.

Communications and engagement

A communications plan for tobacco control will be developed by Jessica North, Senior Communications Officer – Public Health and Lucy Calvert, Media and Marketing Manager from the council's communication team. The team will then lead on all communications and stakeholders wishing to publicise their work should liaise with them. This will ensure that the population of Southampton receives clear and consistent messages about tobacco control, which are in keeping with national Public Health England (PHE) campaigns.

Messages will vary dependent on audience and age-group. The plan has identified some key target audiences and these will be a priority but the remainder of the public should not be ignored. The public of Southampton can be reached via traditional and digital formats including local press, Stay Connected, the Well and Working programme, social media, radio and advertisements. The messages should continue throughout the three years but will be heavier around key promotional holidays including No Smoking Day.

All communications will publicise the call-to-action for locally commissioned NHS Stop Smoking services. All communications will be shared with Public Health England (PHE) and follow their national statistics and stance. From previously discussed initiatives, our top-line plan and communications will be shared with the south and Wessex regions of PHE including the Isle of Wight and Bournemouth.

Communications, design and branding will need to be consistent throughout the period and should emphasise statistics including smokers are up to four times more likely to quit using these services. Costs should be emphasised when targeting the deprived areas of Southampton. Proven communications techniques have translated the cost of material goods like smoking into long-term events including holidays, a house, a car or savings.

Communication techniques and plans should also be considered within NHS buildings and surgeries themselves to ensure all staff, including admin and secretarial understand the plan and know where to send those interested. This education technique is often the missing link within campaigns so we'll ensure that is not the case with smoke-free Southampton.

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Equality and Safety Impact Assessment

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

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

Name or Brief Description of Proposal	**Implementation of a Tobacco Control Strategy for Southampton City Council**
Brief Service Profile (including number of customers)	The purpose of this strategy is to develop a strategic approach at a local level to implement successful tobacco controls across the city of Southampton to minimise the ongoing harmful effects of tobacco. The strategy outlines the multi-agency approach, based on evidence based interventions, which is required for effective tobacco control within the city. The health benefits will potentially improve the lives of the 22.6% of Southampton's population who smoke, and their families.
Summary of Impact and Issues	Evidence from Southampton's Joint Strategic Needs Assessment[i] shows the estimated number of adults who smoke in Southampton has increased from 22.2% in 2009 to 22.6% in 2012. Rates are also higher than the national average of 20%. Southampton's Health and Wellbeing Strategy has identified an increase in unhealthy lifestyles, and included smoking as one of the key challenges that needs to be addressed to improve health in the city. For these reasons there needs to be continued effort and investment to tackle the core strands of tobacco control. These include helping smokers to quit, educating young people about the dangers of smoking to reduce uptake, and implementing regulatory measures to ensure compliance with legislation in local businesses and effective controls of smuggled and counterfeit tobacco. A detailed action plan outlines a multi-pronged approach to deliver key services to assist people in quitting, protecting families from the dangers of second hand smoke and stopping children and young people from becoming

	smokers.
Potential Positive Impacts	A reduction in the smoking rates in the city will improve the health of the population, resulting in lower death rates, lower incidence of cancer and pulmonary disease, reduction in hospital admissions due to smoking related illnesses, and a reduction in smoking in pregnancy resulting in an improvement in birth outcomes.
Responsible Service Manager	Ginny Cranshaw
Date	12th March 2014

Approved by Senior Manager	Noreen Kickham
Signature	
Date	12th March 2014

Potential Impact

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Age	<u>Children and Young people</u> It is illegal to sell tobacco products to anyone under 18 in the UK. Despite this, about one in eight children have become regular smokers by the age of 15. Research from Cancer Research UK has shown that trying just one cigarette can make children more likely to start smoking later in life. Their research also shows that children who smoke often become regular smokers when they are adults. Children smoking are more likely to suffer immediate health consequences such as coughs, increased phlegm, wheezing and shortness of breath and also to take more time off school. Evidence shows that if a child's parents smoke, they are then three	Ensure that schools are compliant with the Council's smoking policy and are delivering high quality education about smoking, and offering initiatives to support this work. Regulatory services will ensure compliance with the sales of tobacco, including underage spot checks. Initiatives aimed at families to promote awareness of the risks of smoking and the importance of smoke free homes and play areas, alongside proactive smoking cessation support.

	times more likely to smoke themselves. Truancy and exclusion are also risk factors for smoking and evidence shows that young people who had been excluded or truanted from school in the previous 12 months were almost twice as likely to smoke regularly compared to those who had never been truant or excluded. Data from the 2012/13 Southampton Pupil Attitude Survey estimates that only 53.4% of children live in a house where neither parent smokes. This survey was completed by over 2,000 pupils from Year 4, Year 6, Year 9 & Year 11 in 26 out of 79 Southampton schools (overall response rate of 24.3%)[ii]. Estimates show that 870 children start smoking each year in Southampton.	
Disability	There is evidence of increased smoking in people with mental health problems.	Working with mental health services to ensure clients are offered access, and ensuring that smoking cessation services are accessible
Gender Reassignment	No evidence of increased impact	
Marriage and Civil Partnership	No evidence of increased impact	
Pregnancy and Maternity	Smoking in pregnancy rates are higher than the national average.	Working closely with maternity services to achieve a reduction in smoking in pregnancy rates
Race	Smoking rates vary considerably between ethnic groups. In men, compared to the general population, rates are particularly high in the Black Caribbean (37%) and Bangladeshi (36%) populations but these differences are explained by socioeconomic differences between the groups. Among women, smoking rates are low (at	Ensure that smoking cessation services are accessible and provide information on quitting in a range of languages and formats

	8% or below) with the exception of Black Caribbean (24%) and Irish (26%) compared with the general population. Overall, smoking rates among ethnic minority groups are lower than the UK population as a whole	
Religion or Belief	No evidence of increased impact according to religious beliefs	
Sex		Ensure that smoking cessation services target both men and women
Sexual Orientation	There is evidence of increased smoking rates amongst the gay community.	Ensure that smoking cessation services are accessible
Community Safety	Evidence of link to fires in the home due to smoking. Also evidence of risk of fires from electronic cigarettes. Fires caused by smoking materials result in more deaths than any other type of fire. Local data shows that cigarette fires are more dangerous than other fires, known risk factors include smoking in bed and smoking whilst drinking alcohol. Data from Hampshire Fire Service shows there were 890 accidental dwelling fires in Hampshire during 2012-2013, of which 206 (23%) occurred in the Southampton group. Of these, 45 (5%) were caused by smoking materials and 17 (38%) of those were in the Southampton group. The service estimates the cost of these to be £20,930. In 2012-2013 there were three fatalities in dwelling fires in Hampshire due to smoking materials; the cost to society for the three fatalities was £5,262,498. One of these three fatalities occurred in the Southampton group	Working with Hampshire fire safety team to include information on the risks of smoking when attending fires and information and training to fire officers to provide interventions to encourage people to quit.

	with a cost to society of £1,754,166. During April – October 2013 there were 477 accidental dwelling fires in Hampshire, of which 133 (28%) occurred in the Southampton group. Of the 477 accidental dwelling fires, 28 (6%) were due to smoking materials of which 12 (43%) occurred in the Southampton group. The cost to the service for attending these 12 accidental dwelling fires caused by smoking material was £13,755.	
Poverty	Smoking is the biggest cause of health inequalities and the impact of smoking falls mostly on the disadvantaged and vulnerable people in society. Tobacco control was identified in the Marmot Review as a central platform in any strategy to tackle health inequalities. Half of the difference in life expectancy between the highest and lowest income groups can be attributed directly to smoking and smoking-related death rates are two to three times higher in more disadvantaged social groups than in wealthier social groups. In Southampton more people smoke in routine and manual classes than in other social classes (36.8% compared to the national average of 30.3%). This rate has in fact increased, and data from the Integrated Household Survey, analysed by the Department of Health and published by Public Health England, shows this rate has increased from 35.4% in 2009 (IHS 2009). Within the city smoking prevalence rates are significantly higher in those areas with the greatest deprivation.	Provide a multi agency approach to work with agencies such as Sure Start to increase promotion of smoking cessation services
Other Significant	None identified	

Impacts		

[i] Joint Strategic Needs Assessment (2012) Southampton City Council

DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		BETTER CARE SOUTHAMPTON UPDATE		
DATE OF DECISION:		26TH MARCH 2014		
REPORT OF:		DIRECTOR OF QUALITY AND INTEGRATION		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Stephanie Ramsey**	**Tel:**	**023 80**
	E-mail:	**Stephanie.ramsey@southampton.gov.uk**		
Director	**Name:**	**John Richards, Chief Executive** **Alison Elliott, Director of People**	**Tel:**	**023 80**
	E-mail:	**John.Richards@southamptoncityccg** **Alison.Elliott@southampton.gov.uk**		
STATEMENT OF CONFIDENTIALITY				
None.				

BRIEF SUMMARY

The first cut of the Better Care Southampton local plan was submitted on 14 February, following agreement at the Health & Wellbeing Board on 29 January. The plan has been developed with extensive stakeholder consultation, which included three large stakeholder workshops and individual consultations and focus groups with service users and different agencies, including HealthWatch. Feedback from NHS England was received on our submission on 7th March and the plan is currently being reviewed in the light of this feedback with changes being made for the final submission on 4th April 2014.

At the same time, work is underway to implement the system redesign across the three main components of :

- Person centred local coordinated care
- Responsive discharge and reablement – supporting timely discharge and recovery
- Building capacity

This briefing provides an update on progress including the changes being made following NHS England and other feedback and development of the governance structure for implementation.

Work is still underway to finalise the pooled fund amount for 15/16.

RECOMMENDATIONS:

(i) The Health and Wellbeing Board notes progress towards implementation of Better Care Southampton.

REASONS FOR REPORT RECOMMENDATIONS

1. Feedback from NHS England on the first submission was very positive about the model. The areas requiring further amendments relate to the achievability of the approach and the affordability of the model. The work being undertaken to address these issues is described within this Briefing paper. It should also be noted that updated guidance from NHS England will require some changes to the metrics submitted for Delayed Discharges (where number of delayed bed days as opposed to patients are now being counted).

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None. Each Health and Wellbeing Board in England is required to submit and deliver a plan developed jointly by the council and CCGs.

DETAIL (Including consultation carried out)

3. The initial draft plan was submitted to NHS England on 14th February following detailed consultation and cross organisational development of the proposals. This work has been ongoing via the Vulnerable People Board, Task and Finish group, a series of consultation events and the Demonstrator site work in Woolston/Weston. The model was also agreed with Chief Executives from each of the key health provider organisations as well as both SCC and CCG formal governance processes.

4. **Consultation**

Consultation and development is continuing about the model and effective ways of achieving implementation.

Next steps include 3 locality based workshops for front line staff and community and voluntary sector representatives based in different parts of the city to start the sharing of the Better Care concepts, and gain their views and ideas on taking things forward. This mirrors the bottom up, co-production approach that underpins our Better Care plan.

A proposal has been developed to implement the model through 6 local cluster integrated teams across the city. Consultation is continuing on the proposal for 6 clusters

5. **Implementation plan and governance changes**

The draft implementation plan can be seen in Appendix 1. This is currently being developed. The actions are based around a number of key themes and grouped so the governance can also be aligned appropriately. The implementation plan is based on the Kings Fund House of Care Model (Oct 13) and has the following sections:

Person centred, local co-ordinated care – this will be achieved through the development of the cluster teams. An Interagency Operational Group has been developed, comprising senior clinicians and operational managers from all local NHS providers, social care, housing, primary care, voluntary and community sectors as well as commissioners, to facilitate the establishment of cluster teams and processes including risk stratification, and integrated

care planning.

Responsive commissioning – this section sets out all the elements of commissioning changes that will be required, including change to service specifications, contractual requirements and levers, new services to be procured, establishment of the pooled fund and market development.

Organisational processes and developments – this section sets out the cross system changes such as IT developments, accommodation, the single front door, which require cross-organisational infrastructure development.

Engaged and informed service users- this section sets out the communication and engagement work we are undertaking with the public and service users, recognising the significant cultural changes that need to be made. A detailed joint communications and engagement strategy is currently in draft form and is being developed between the City Council and CCG, in partnership with HealthWatch.

Workforce committed to partnership working – this section sets out the significant work that needs to happen to develop our workforce to achieve new ways of working in partnership and delivering a person centred service. This will include training needs analysis and workforce development strategies, again cross agency, as well as workforce planning for the future.

6. **Community development**

The need for cluster "needs assessments" has been identified.

The Demonstrator site work is identifying the processes for pulling together community development activity at locality level, the additional resources needed and the role of the voluntary/ community sector in co-ordinating this activity.

7. **Communications and engagement**

A Communications and Engagement Strategy has been developed. First class communications activity will be hugely significant in helping secure the success of the far reaching change within Better Care Southampton. Without this, the new approaches and new ways of working and thinking could seem imposed, unwelcome, alien and too complex meaning the benefits of change – and commitment to it - could be lost.

8. The purpose of the Communications Strategy and Action Plan is to set out the fundamental approaches and key activities that will help establish and promote Better Care Southampton in a holistic way. The strategy is also necessary to support the positioning and types of bespoke communications activities required for the individual initiatives that are part of the Better Care Programme. The objectives of the strategy are to:

- Ensure consistent approaches

- Promote and win support for change
- Gather people's views

The aim is also to signpost patients, public and staff to resources and local services to promote self-management.

9. Better Care webpage is now on both the City Council and CCG websites, it features a benchmarking survey. This is an interim step whilst more detailed work is undertaken. This will include use of a brand/strap line "Joining up your care", improved information, development of a leaflet and production of localised videos.

10. **Guidance changes**

Further guidance has been released following the initial submission of draft Better Care Fund (BCF) plans, a number of common issues arose that NHS England have clarified. They have updated a number of the guidance documents, including improved clarity around metric specifications. The main impact locally is a change to the Delayed Transfers of Care metric from number of people to number of bed days. This calculation is being finalised.

There is also a spreadsheet which provides a breakdown by council of the £185k contained within the BCF to spend against the Care Bill reforms in 2015/16.

11. **Submission**

The initial draft was submitted on 14th February. The feedback is that it was a very clear plan with a clear vision and very good use of data and highlighting of issues. More detail on how to address the issues was requested. Many elements were assessed a being green (confident that the 4 April plan will fully address this condition) with two as amber (there is time for these concerns to be addressed for the 4 April plan) that relate to the achievability of the approach and the affordability of the model (see Appendix 2)

The final submission will be made on 4th April 2014. There have been changes to the document as a result of both local consultation and NHS England feedback including:

- Changes to risk register (in respect of cultural change, public confidence and the infrastructure as raised at last H&WB Board)
- Changes to reflect feedback from Health Watch e.g. opt in/out for Personal budgets
- Revised details re governance arrangements
- Increased details on community development activity, the additional resources needed and the role of the voluntary/ community sector in co-ordinating this
- Implementation Plan
- Revised performance data

RESOURCE IMPLICATIONS

Capital/Revenue

12.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Southampton City Council	TBC	924,000.00	*1,526,000.00*	*5,457,950.00*
Southampton City CCG	TBC	1,287,000.00	*15,325,000.00*	*52,869,000.00*
BCF Total		2,211,000.00	*16,851,000.00*	*58,326,950.00*

Analytical work is underway to look at finance and activity data to inform pooled fund decisions.

A draft Section 75 agreement also being complied. The finalised pooled fund agreement will be brought to a future Board meeting. It is not required until 2015/16

Property/Other

13. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

14. NHS England Publications Gateway Ref. No.00314

Other Legal Implications:

15. None

POLICY FRAMEWORK IMPLICATIONS

16. Align with Health and Wellbeing Strategy and Council's Policy Framework Plans

KEY DECISION? Yes

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Better care Southampton Implementation Plan

Documents In Members' Rooms

1.	N/A

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	

Better Care Fund Draft programme Plan

Workstream		Profess Lead	project lead	Feb - March 2014	Apr - Jun 2014	Jul - Sept 2014	Oct - Dec 2014 (half year evaluation)	Jan - Mar 2015	Apr - Jun 2015 (end year evaluation)	Jul - Sept 2015	Oct - Dec 2015	Jan - Mar 2016	Apr - Sept 2016	Oct - Mar 2017	Apr - Sept 2017	Oct - Mar 2018
Person centred local coordinated care	**Cluster teams**	TBA	TBA	Definition of geographical clusters and team functions Consultation with frontline staff and patients	mapping of existing resource / scoping of teams cluster meetings in place cluster teams developing integrated risk stratification cluster teams working on shared care plans & accountable professional role Each cluster has established its own action plan		Cluster teams working in shadow form - focus on OP and LTC		Evaluation of cluster team development	ongoing development of integrated model focussing on OP and LTC			Roll out of model to AMH, LD, C&F			
					Test out care navigator role in 2 clusters	Roll out care navigator role and learning to all 6 clusters		Evaluation & learning from care navigator role								
Responsive commissioning	**General**		DC	Ensure existing specifications fit for purpose	Mapping of demand and capacity establish integrated performance framework	Demand and capacity modelling roll out integrated performance framework at cluster level	Demand and Capacity Plan in place									
	Rehab/ reablement		JS		Scope / redesign integrated service	Recommission integrated service			Fully Integrated service in place							
	carers		SJ	Commission additional support services	Establish community based advice, information & carer support service	implement new service contracts										
	Telecare / telehealth		SJ	Finalise business case/ agree direction of travel	Commission telecare/telehealth											
	Pooled fund agreement		DC		Develop pooled fund agreement			sign pooled fund								
	Payment model/ contractual levers		DC													
	community development / asset building		DB		Develop community development/vol sector engagement strategy											
	Personal budgets		SJ	Prepare for extension to all people with CHC	Continued work to promote uptake of PHBs and Direct Payments Establish finance system requirements			Prepare for extension to all people with LTC/MH problems								
	£5 per head investment	Srob		Consultation with practices to agree approach	Negotiations/lead in/ recruitment	Lead in/Recruitment	New services up and running									
	CHC		CA	full implementation discharge to assess approach												
	Nursing/ residential homes		CA	Implement leadership & development programme to maximise NH capacity												
Organisational Processes/ Development	**IT Strategy**			Agree IT strategy for interoperable systems	Develop whole system IT Strategy Information sharing/IG protocol in place				Roll out interoperable solution for sharing care plans							
	Accommodation				identify team base in each cluster	Mobilise team base in each cluster										
	Single front door				Scope and Design single front door	Option appraisal and business case	Implementation single front door		Single front door in place							
	7 day working				Develop plans for implementing 7 day working across the board											
	capacity & workforce planning			all provider organisations to undertake detailed impact assessments	providers capacity & workforce planning											
	Primary care development	S.Town		Primary care development strategy in place												
	Establish new USC DES	S.Rob		Review 13/14 DES Develop DES for 14/15 in consultation with practices	Roll out 14/15 USC DES			Evaluation 14/15 USC DES								
Engaged & Informed patients			EF	Comms & engagement strategy developed	Implementation comms & engagement strategy											
Workforce committed to partnership working					System wide workforce development strategy in place	Roll out workforce development strategy										
					Person centred care planning CQUIN - Providers self assess & develop action plan	Roll out person centred care action plan (CQUIN)										
					Roll out personalisation training - ASC & health											
					Roll out training for personal assts											

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