

Joint Strategic Needs Assessment (JSNA) refresh consultation 2010

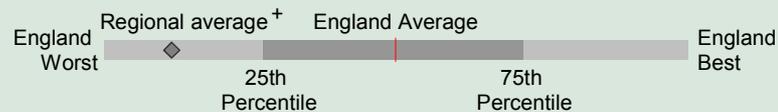
Southampton

Working together to identify and better understand the needs of Southampton people to improve health and well-being



The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the red line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated



⁺ In the South East Region this represents the Strategic Health Authority average

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	55719	24.6	19.9	89.2	[Bar chart showing Southampton significantly worse than England average]	0.0
	2 Children in poverty	10752	28.4	22.4	66.5	[Bar chart showing Southampton significantly worse than England average]	6.0
	3 Statutory homelessness	188	1.96	2.48	9.37	[Bar chart showing Southampton significantly better than England average]	0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	972	43.1	50.9	32.1	[Bar chart showing Southampton significantly worse than England average]	76.1
	5 Violent crime	8222	35.6	16.4	36.6	[Bar chart showing Southampton significantly worse than England average]	4.8
	6 Carbon emissions	1280	5.5	6.8	14.4	[Bar chart showing Southampton not significantly different from England average]	4.1
Children and young people's health	7 Smoking in pregnancy	583	17.0	14.6	33.5	[Bar chart showing Southampton significantly worse than England average]	3.8
	8 Breast feeding initiation	2538	75.9	72.5	39.7	[Bar chart showing Southampton significantly better than England average]	92.7
	9 Physically active children	9796	41.2	49.6	24.6	[Bar chart showing Southampton significantly worse than England average]	79.1
	10 Obese children	200	9.3	9.6	14.7	[Bar chart showing Southampton not significantly different from England average]	4.7
	11 Tooth decay in children aged 5 years	n/a	1.1	1.1	2.5	[Bar chart showing Southampton not significantly different from England average]	0.2
	12 Teenage pregnancy (under 18)	203	53.7	40.9	74.8	[Bar chart showing Southampton significantly worse than England average]	14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	26.0	22.2	35.2	[Bar chart showing Southampton not significantly different from England average]	10.2
	14 Binge drinking adults	n/a	17.9	20.1	33.2	[Bar chart showing Southampton not significantly different from England average]	4.6
	15 Healthy eating adults	n/a	25.4	28.7	18.3	[Bar chart showing Southampton significantly worse than England average]	48.1
	16 Physically active adults	n/a	9.2	11.2	5.4	[Bar chart showing Southampton significantly worse than England average]	16.6
	17 Obese adults	n/a	22.3	24.2	32.8	[Bar chart showing Southampton not significantly different from England average]	13.2
Disease and poor health	18 Incidence of malignant melanoma	40	19.7	12.6	27.3	[Bar chart showing Southampton significantly worse than England average]	3.7
	19 Incapacity benefits for mental illness	4650	28.9	27.6	58.5	[Bar chart showing Southampton significantly worse than England average]	9.0
	20 Hospital stays for alcohol related harm	3259	1360	1580	2860	[Bar chart showing Southampton significantly better than England average]	784
	21 Drug misuse						
	22 People diagnosed with diabetes	9288	3.96	4.30	6.72	[Bar chart showing Southampton significantly better than England average]	2.69
	23 New cases of tuberculosis	30	13	15	110	[Bar chart showing Southampton not significantly different from England average]	0
	24 Hip fracture in over-65s	207	482.5	479.2	643.5	[Bar chart showing Southampton not significantly different from England average]	273.6
Life expectancy and causes of death	25 Excess winter deaths	109	18.5	15.6	26.3	[Bar chart showing Southampton not significantly different from England average]	2.3
	26 Life expectancy - male	n/a	77.6	77.9	73.6	[Bar chart showing Southampton not significantly different from England average]	84.3
	27 Life expectancy - female	n/a	82.1	82.0	78.8	[Bar chart showing Southampton not significantly different from England average]	88.9
	28 Infant deaths	15	4.75	4.84	8.67	[Bar chart showing Southampton not significantly different from England average]	1.08
	29 Deaths from smoking	354	246.1	206.8	360.3	[Bar chart showing Southampton significantly worse than England average]	118.7
	30 Early deaths: heart disease & stroke	175	89.3	74.8	125.0	[Bar chart showing Southampton significantly worse than England average]	40.1
	31 Early deaths: cancer	240	124.5	114.0	164.3	[Bar chart showing Southampton significantly worse than England average]	70.5
	32 Road injuries and deaths	90	39.1	51.3	167.0	[Bar chart showing Southampton significantly better than England average]	14.6

Indicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO₂ emissions per capita (tonnes CO₂ per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

More indicator information is available in The Indicator Guide: www.healthprofiles.info For information on your area contact your regional PHO: www.apho.org.uk

You may use this profile for non-commercial purposes as long as you acknowledge where the information came from by printing 'Source: APHO and Department of Health. © Crown Copyright 2010'.

INTRODUCTION AND EXECUTIVE SUMMARY

A Joint Strategic Needs Assessment, or JSNA, is the vehicle through which Local Authorities and Primary Care Trusts (PCTs) describe the health, care and well-being needs of local populations. The original JSNA was consulted on in 2007 and published in 2008 to cover a three year period. Consultation is now being undertaken on a refreshed or updated JSNA.

A joint NHS Southampton and Southampton City Council JSNA steering group has produced this 2010 JSNA consultation refresh document. Your engagement will help to craft the refreshed JSNA to be published early in 2011. The consultation period for this JSNA refresh runs until the end of October 2010.

In this consultation we discuss the health and social care impact of our current economic recession. The key savings the NHS in Southampton needs to make is £95 million between 2010 to 2014, roughly £2 million a month. Southampton City Council is also challenged to make savings to bridge a budget gap which is currently estimated at £16 million in 2011/12, rising to £41million in 2013/14.

There is a requirement to deliver joint efficiencies and prioritisation of health need within tightening financial constraints. The purpose of this JSNA consultation is to articulate the main health and well-being issues facing the City's populations. It will be for commissioners of health and social care to prioritise needs and mitigate the potential effects of reduced funding, informed by this consultation.

NHS Southampton will manage this by ensuring a strong focus on a patient led NHS that is outcomes driven, with a strong public health lead. We will support GP practices or groups of practices becoming commissioners with clinical evidence underpinning developments. We expect a new White Paper on the NHS imminently. Importantly we need full public engagement to enable us to work together through the challenging times ahead.

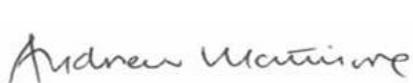
The City Council will consult service users; the wider public, partners, providers and staff on how best to ensure high quality services that provide value for money across all its areas of responsibility. Protection of the most vulnerable will remain a key priority for the Council.

The approach taken for the JSNA Consultation refresh 2010 includes:

- identifying existing data sources to profile the population and their needs (including the views of communities)
- examining policies, strategies and business plans produced by NHS Southampton and City Council to understand existing and planned priorities for services
- analysing available data to understand current and predicted need in terms of health and well-being
- sharing knowledge with partner agencies to develop new insights into the needs of our local population
- benchmarking NHS Southampton's performance against national comparable PCTs and Local Authorities
- identifying inequalities in Southampton
- understanding the aspirations of the population
- identifying priorities for investment and need for change in service delivery ensuring the local community and key partners have a significant input into the JSNA
- establishing clear governance arrangements for the JSNA
- reviewing current plans in light of the coalition government savings

Although we have drawn on many strategic and operational needs assessments, documents and reports, we know we currently have gaps in our understanding. To remain as concise as possible service delivery targets have generally not been included in this report. Further announcements by the Coalition Government on changes in policies and priorities will also be reflected in the final JSNA.

We look forward to hearing from you, as we complete this *Joint Strategic Needs Assessment* and work towards minimising gaps in our knowledge of needs, and to make our subsequent plans for improving health and well-being in Southampton robust and engaging.



Dr Andrew Mortimore
Public Health Director

July 2010



Clive Webster
Executive Director of
Children's Services and
Learning



Penny Furness-Smith
Executive Director of
Health and Adult Social
Care

Alongside this consultation document, a live web-based data repository has been created so that data can be updated and made available throughout the consultation period and beyond.

This database can be found at:

<http://www.southamptonhealth.nhs.uk/publichealth/jsna/data>

Details on how you can feedback comments and suggestions can be found at the end of this document.

CONTENTS

INTRODUCTION AND EXECUTIVE SUMMARY	1
CONTENTS	3
ACKNOWLEDGMENTS	7
ABBREVIATION GUIDE	8
THE SOUTHAMPTON 2010 JSNA REFRESH CONSULTATION	10
What is a Needs Assessment?	10
How Can You Contribute to and Influence the JSNA Refresh?	11
What You Can Do	11
What Happens Next?	11
SECTION 1 - DEMOGRAPHIC OVERVIEW	12
Population	12
Births	14
Ethnicity	14
Religion	14
Deprivation	15
Income and Wealth	15
The Recession	16
Poverty	16
Population Segmentation	17
Caveats around use of Mosaic Data	17
Public Perceptions of the City, Southampton City Council and the NHS; Community Empowerment and Service User Involvement	22
References	23
SECTION 2 - ACHIEVING BETTER HEALTH AND WELL-BEING FOR ALL AND TACKLING HEALTH INEQUALITIES	24
Improving Life Expectancy in the City	24
Monitoring of Population Health Trends	26
Improving the Equity of Health and Well-Being across All Communities	29
Armed Forces Veterans	29
Mental Health	30
Fitness For Work	30
Longer Term Health and Well-Being Conditions	31
Coronary Heart Disease (CHD)	32
Stroke	32
Hypertension	33
Chronic Obstructive Pulmonary Disease (COPD)	33
Diabetes	33
Neurological Conditions	33
Dementia	33
Infectious Disease and Infections	34
Tuberculosis	34
The Human Immunodeficiency Virus (HIV)	34
Health Care Acquired Infections (HCAs)	34
Focusing Strategic Priorities for People in their Later Years in the City	36
Fragility Fractures	36
Disability	38
People Living with a Disability	38
Levels of Disability among Children and Young People	38
Levels of Disability among Adults	38
People Living with Learning Disabilities	39

Severe Disabilities and Complex Health Needs.....	39
Sight Impaired (SI) and Severe Sight Impairment (SSI)	40
Hearing Loss and Deafness	41
Getting the Best Outcomes for People Requiring Unscheduled Care	41
Unscheduled Care	41
Emergency Paediatrics	44
References	45
SECTION 3 - A HEALTHY START TO LIFE: CHILDREN AND YOUNG PEOPLE	47
Focusing Strategic Priorities for Children and Young People in the City	47
Giving Every Child and Young Person the Opportunity to enjoy a Healthy Start in Life and Support in Making Healthy Lifestyle Choices.	47
Low Birth Weight.....	47
Levels of Caesarean vs. Normal Births.....	47
Breastfeeding Initiation and Maintenance	48
Smoking During Pregnancy	48
Childhood Obesity	48
Health Education and Exercise	49
Sexual Health	49
Chlamydia Screening	50
Teenage Pregnancy	51
Child Dental/Oral Health	52
Misuse of Tobacco, Alcohol and Other Substances by Young People	53
Emotional Well-Being	54
Injuries and Accidents	54
Support, Challenge and Empowerment for Parents and Carers	54
Safeguarding Local Children and Young People from Abuse and Neglect	55
Keeping Children and Young People Safe from Abuse, Domestic Violence, Bullying and Harassment.	55
Children and Young People at Risk of Abuse and/or Neglect.....	56
Child Protection Plan Levels	56
Domestic Violence affecting Children and Young People.....	56
Bullying	56
Hidden Harm – Alcohol and Drug use within Families	57
Groups of Children and Young People who often Suffer Poor Outcomes	57
Children and Young People in Care	57
Children and Young People with Complex Health Needs and Disabilities.....	58
Ensuring that Children and Young People Attend School, Achieve Well in Their Learning and Enjoy Growing Up in Southampton	58
Engagement, Enjoyment and Achievement at School.	58
<i>Attainment at Age 5 – End of Foundation Stage</i>	58
<i>Attainment at Age 7 – End of Key Stage 1 (KS1)</i>	59
<i>Attainment at Age 11 – End of Key Stage 2 (KS2)</i>	59
<i>GCSE Attainment at Age 16 – End of Key Stage 4 (KS4)</i>	59
<i>Closing the Attainment Gap</i>	59
School Attendance and Persistent Absence.....	59
Maximising the Positive Contribution that Children and Young People Make to Community Life	60
Engagement in Positive Activities, Crime and Anti-Social Behaviour	60
<i>Anti-Social Behaviour</i>	60
<i>Youth Offending</i>	60
<i>Participation in Positive Activities</i>	60
Maximise the Number of Children and Young People who Achieve Economic Well-Being	61

Equipping Young People for Economic Independence and Success as Adults.....	61
<i>Increasing the Proportion of Young People Progressing into Further Education and Training upon Leaving School.....</i>	61
<i>Increasing Qualification and Skill Levels at Age 19.....</i>	61
<i>Reducing Numbers of Young People not in Education, Employment or Training.....</i>	61
<i>Access for Young People to Suitable Housing and Accommodation</i>	61
Poverty Affecting Children and Young People in Southampton.....	61
Children and Young People Living in Poverty – 0-15.....	61
Children and Young People Living in Poverty – 16+.....	62
References.....	62
SECTION 4 - STAYING HEALTHY THROUGHOUT LIFE: HEALTHCARE AND SUPPORT SERVICES FOR ADULTS.....	64
Ensuring the Best Adult Social Care.....	64
Adults Aged 18 to 64 Years	64
Adults Aged 65 Years and Over	65
Adult Mental Health.....	66
Suicide	67
Mental Health for Older People	68
Ensuring Good, Flexible Support for Carers	70
References.....	71
SECTION 5 - THE SOCIAL, ECONOMIC AND ENVIRONMENTAL IMPACTS ON HEALTH AND WELL-BEING	72
Economic Well-being.....	72
Fuel Poverty and Housing.....	73
Housing	73
Fuel Poverty.....	73
Housing Conditions	75
The Impact of Crime and the Fear of Crime.....	76
Crime Affecting the General Community	76
Crime Affecting Children and Young People	76
Domestic Violence and Hate Crime.....	78
Tackling Alcohol Harm	79
Smoking.....	81
Drug and Substance Misuse	82
Drug Action Team Southampton Adult Drug and Substance Misuse.....	82
Stimulant Users	83
Women	83
Families and Carers of Drug Misusers.....	84
Young People (18-25 years) with Problematic Drug and Alcohol Use.....	84
Black Minority and Ethnic Groups (BME).....	84
Attrition Rates and Treatment Outcomes.....	84
Environmental Health, Consumer Protection, Health at Work and Transport	86
Health at Work and Worklessness.....	87
Local Transport Plans.....	88
Planning.....	88
Carbon Reduction	89
References.....	90
SECTION 6 - PROTECTING OUR HEALTH.....	92
Vaccination Coverage.....	92
The Impact of Vaccination.....	92
Routine Childhood Immunisation Programme	92
Groups at Risk	94
Hepatitis C	95

References	95
SECTION 7 - DELIVERING THE BEST HEALTH CARE OUTCOMES	97
Preventing and Improving the Outcomes of Cancer	97
Prevention	97
Cancer and Inequalities	97
Lung Cancer	98
Bowel Cancer	98
Breast Cancer	98
Cervical Cancer	98
Malignant Melanoma	98
Better End of Life Care	99
Community Pharmacy	100
Dental/Oral Health	101
Obesity, Diet and Physical Exercise	102
Better Outcomes for Vulnerable People with Supported Housing Needs	103
References	104
SECTION 8 - CONCLUSION	105
QUESTIONS FOR JSNA REFRESH CONSULTATION 2010	106

ACKNOWLEDGMENTS

Our thanks go to the following for their involvement and help with this joint strategic needs assessment refresh consultation document:

Editors

Tim Davis, Planning and Performance Manager, Southampton City Council
Martin Day, Directorate Strategic Business Manager, Southampton City Council
Nicola Duffield, Health Improvement and Partnerships Manager, NHS Southampton City
Graham Watkinson, Consultant in Public Health, NHS Southampton City

Joint NHS Southampton City and City Council Project Group

Vicky Boland, Dawn Buck, Sara Crawford, Kate Dench, Chris Hawker, Paul Juan,
Pam Manger and Sam Ray

Joint City Council and NHS Southampton City Data Group

Phil Cox, Paul Fuller, Dennis Gamblin, Vicky Heath, Sarah Hedges, Dan King,
Phil Lovegrove, Vanella Mead, Dave Moody, Rebecca Wilkinson.

Other Contributors

Alison Alexander, Charlotte Bemand, Helen Bennett, Jane Brentor, Kevin Brooks,
Dawn Buck, Robert Coates, Parvin Damani, Jenny Davies, Chrissie Dawson,
Ayo Eni-Olotu, Simon Fraser, E-J Gibbons, Carol Harwood, Karen Hilleard, Charlie Hislop,
Jeyanthi John, Noreen Kickham, Kirsten Killander, Sarah Lawrence, Phil Lovegrove,
Pam Manger, Liz Marsh, Jaki Metcalfe, Mary O'Brien Harriet Quast, Sarah Reed,
Steph Smith, Carole Valentine, Vicky Thew, Matthew Waters, Karen Watts, Joanne Wigley,
Emma Wynn-Mackenzie.

University of Southampton

Professor Paul Roderick.

Southampton University Hospitals Trust

Sue Leamore and Sue Twyman.

Southampton Voluntary Services (SVS)

Jo Ash, Rob Kurn

Graphics

Dan Laming
Sandra Barnett

Website for this JSNA

www.southamptonhealth.nhs.uk/jsna

ABBREVIATION GUIDE

AIDS	Acquired Immune Deficiency Syndrome
ADHD	Attention Deficit Hyperactive Disorder
AMD	Age related Macular Degeneration
ASB	Anti-Social Behaviour
BMI	Body Mass Index
CAF	Common Assessment Framework
CAMHS	Child and Adolescent Mental Health Service
CASH	Contraception and Sexual Health
CDAD	Clostridium Difficile Associated Disease
CHD	Coronary Heart Disease
CIEH	Chartered Institute of Environmental Health
CIP	Southampton City Council Corporate Improvement Plan
CMO	Chief Medical Officer
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardio Vascular Disease
CYPP	Children and Young People's Plan
DAT	Drug Action Team
ED	Emergency Department (Formerly A&E)
FSA	Financial Services Authority
FSM	Free School Meals
GCC	Good Corporate Citizen
GP	General Practitioner
GSF	Gold Standards Framework
GUM	Genito Urinary Medicine
HBV	Honour Based Violence
HCAI	Health Care Associated Infection
HCC	Hampshire County Council
HIV	Human Immunodeficiency Virus
HPFT	Hampshire Partnership Foundation Trust
HPV	Human Papilloma Virus Vaccine
IDeA	Improvement and Development Agency for Local Government
IMD	Index of Multiple Deprivation
IT	Information Technology
IPF	Institute of Public Finance
JSNA	Joint Strategic Needs Assessment
LAA	Local Area Agreement
LARC	Long Acting Reversible Contraception
LCP	Liverpool Care Pathway
LGBT	Lesbian Gay Bi-sexual and Transgender
LOS	Length of Stay
LSP	Local Strategic Partnership
LTC	Long Term Condition
MARAC	Multi Agency Risk Assessment Conferences
MMR	Measles Mumps Rubella
MOD	Ministry of defence
MRSA	Methicillin Resistant Staphylococcus Aureus
MUR	Medication Use Review
NEET	Not in Education, Employment and Training
NHS	National Health Service
NI	National Indicator
NICE	National Institute for Health and Clinical Excellence

NVQ	National Vocational Qualification
NTA	National Treatment Agency
OHP	Oral Health Promotion
ONS	Office of National Statistics
PAU	Paediatric Assessment Unit
PbR	Payment by Results
PCT	Primary Care Trust
PDU	Problem Drug Users
PES	Patient Experience Service
PNA	Pharmacy Needs Assessment
POPPI	Projecting Older People Population Information system
POVA	Prevention of Violence Towards Adults
PPO	Prolific and Priority Offenders
PSHE	Personal, Social and Health Education
QoF	Quality outcomes Framework
SAP	Standard Assessment Procedure
SE	South East
SEEIT	South East England Indicator Tool
SEPHO	South East Public Health Observatory
SI	Sight Impairment
SSI	Serious Sight Impairment
SCC	Southampton City Council
SCPCT	Southampton City Primary Care Trust
SHA	Strategic Health Authority
S-LINK	Southampton Local Involvement Network
SRE	Sex and Relationship Education
STEP	Southampton Teenage Parents in Education and Parenting
STI	Sexually Transmitted Infections
SUHT	Southampton University Hospitals NHS Trust
SWAP	Southampton Warmth for All Partnership
TB	Tuberculosis
UK	United Kingdom
WHO	World Health Organisation

THE SOUTHAMPTON 2010 JSNA REFRESH CONSULTATION

What is a Needs Assessment?

A needs assessment is a systematic method of gathering information about the current and future health, care and well-being needs of a defined population, in order to agree priorities and inform planning and resource allocation to address health inequalities. The first JSNA (2008) informed the actions and targets set out in strategic plans and actions taken by commissioners and other decision makers.

Assessing the needs of the population in order to provide appropriate services is a key role for NHS Southampton and Southampton City Council.

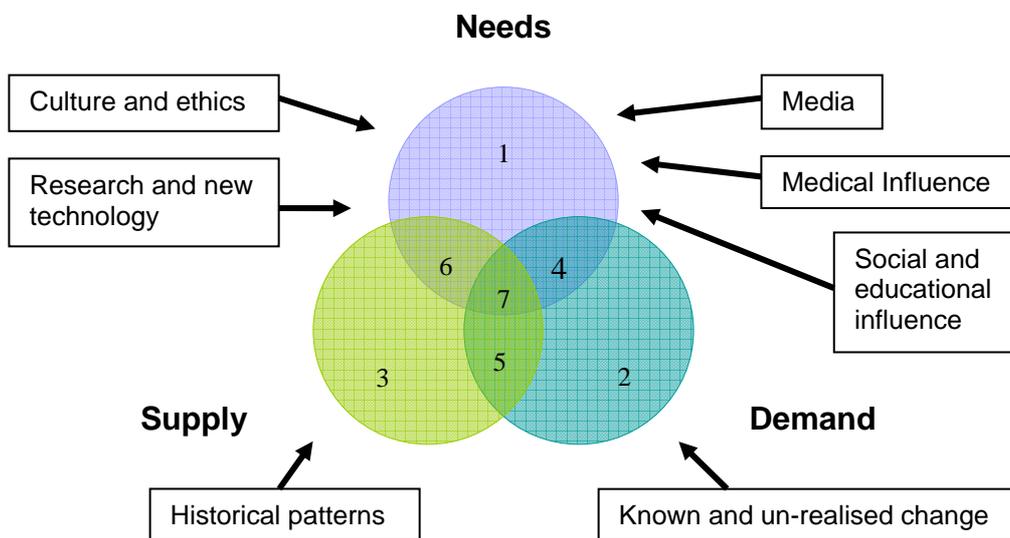
Need is the ability to benefit from an intervention. Need is classified into:

- felt need - anything people consciously lack and desire
- expressed need - a felt need that is made known- people's expectations of services
- unmet need - recognised needs that are not being met by existing services
- normative need - perceptions of commissioners and service providers of the needs of the population
- comparative needs - needs of the target population as assessed by comparing to another similar population.

Need is different from supply and demand, but there are overlaps.

- **Demand** is what people would be willing to pay for in a market or wish to use in a free health care system
- **Supply** is what is actually provided

Figure A.1 Need, Supply and Demand (Conceptual Diagram)



Key:

1. Need but no demand or supply - unrecognised and unmet need
2. Demand but no need or supply - inappropriate demand - may be no effective intervention
3. Supply but no need or demand - inappropriate service
4. Need and demand but no supply - unmet need
5. Demand and supply but no need - inappropriate service
6. Need and supply but no demand - service not accessed - need to increase demand
7. Met needs

A thorough needs assessment should be the starting point for the development of any strategy to tackle health and social care issues and is at the heart of the effective commissioning of a comprehensive and equitable range of high quality services within allocated resources.

The key components of a needs assessment are:

- assessing the incidence and prevalence (how many people need the service/intervention)
- reviewing the effectiveness and cost-effectiveness of services (do they confer any benefit, and if so at what cost i.e. what is the relative benefit)
- mapping the baseline services (changing provision for the better necessitates knowledge of the existing services, both to know which services ought to change and to identify opportunities for the release of resources to enable the change to happen)
- comparing services to what is provided elsewhere to similar populations
- gaining an excellent understanding of the population's expectations and wishes
- seeking and listening to the views of interested parties, including those who provide services
- highlighting potential priorities for developing and transforming services.

How Can You Contribute to and Influence the JSNA Refresh?

The production of a JSNA is a statutory responsibility with a clear role for Directors of Public Health, Children's Services and Adult Social Services to ensure that it happens. However many others have an important role to play in getting the JSNA right so we can deliver better outcomes. Local people and service providers, who are close to their communities, can play a vital role in supplying information to shape the future. Service providers will not only want to shape the JSNA, but also deliver the outcomes on a day-to-day basis in the way they work with their customers (patients and clients) and in how they make referrals to other services.

What You Can Do

At the end of this document we have posed some questions, these are also available online at www.southamptonhealth.nhs.uk/jsna

The deadline date for feed back is **29 October 2010**.

What Happens Next?

Following the consultation we will work with your feedback to produce the refreshed JSNA in the spring for 2011-2014. Our vision for the JSNA is a continuous programme of work that will enable us to better understand the City's changing needs.

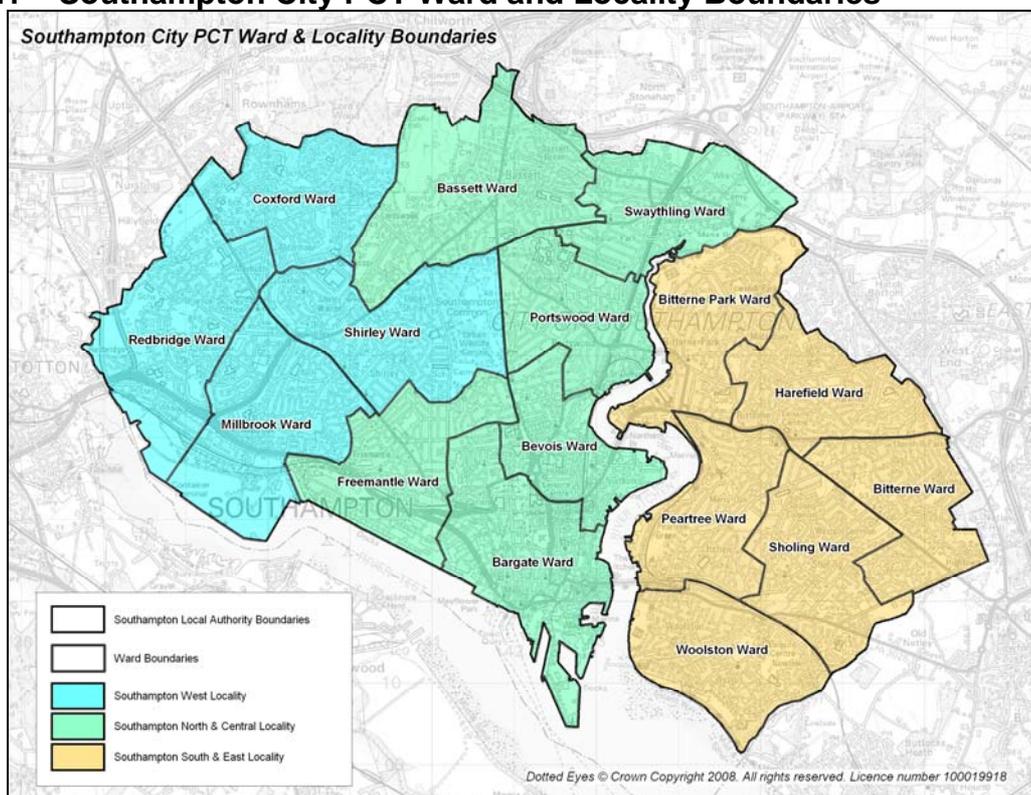
SECTION 1 - DEMOGRAPHIC OVERVIEW

The data underpinning this document has been collated into an online compendium available to all at www.southamptonhealth.nhs.uk/publichealth/jsna/data. This document maps the data sets available so that the reader can link directly across to the data compendium itself which contains a wealth of tables and charts (in MS Excel format).

Throughout the Data Compendium, Southampton has been benchmarked against England and against its peer PCTs and Local Authorities according to the Office of National Statistics (ONS) 2001 Area Classification. This classification was constructed using 42 demographic, housing, socio-economic and health indicators in a clustering procedure that resulted in a classification of which local authorities and PCTs were most similar.

Where appropriate we have also presented data for localities and wards within Southampton; the map below Figure 1.1 shows the boundaries of these within the City. Finally, where possible we have also presented time trend data for the indicators at City level.

Figure 1.1 – Southampton City PCT Ward and Locality Boundaries



Population

The Office for National Statistics (ONS) estimates the 2009 resident population of Southampton to be 236,700. However, Hampshire County Council (HCC) estimate the 2009 population to be around 229,000. Although each source starts from the same base (the 2001 Census) they use different methodologies and, hence, arrive at different estimates of the population.

HCC Small Area Population Forecasts use information on planned residential development plus assumptions about changes in average household size, fertility, mortality and migration

to predict population change over the next eight years from 2008; their forecast for Southampton population in 2016 is 236,700.

ONS also produce population projections for the city (called 'sub-national' projections); the latest figures predict that the population of the Southampton will be 254,100 in 2016. These projections assume a continuation of recent trends in fertility, mortality and migration; they take no account of local development policy, economic factors or the capacity of areas to accommodate population.

These differences demonstrate the uncertainty around current and future population numbers which must be recognised when undertaking needs assessment. This is particularly acute at the moment because it has been nine years since the last national Census, another is due in 2011 which will hopefully provide clarity on this issue.

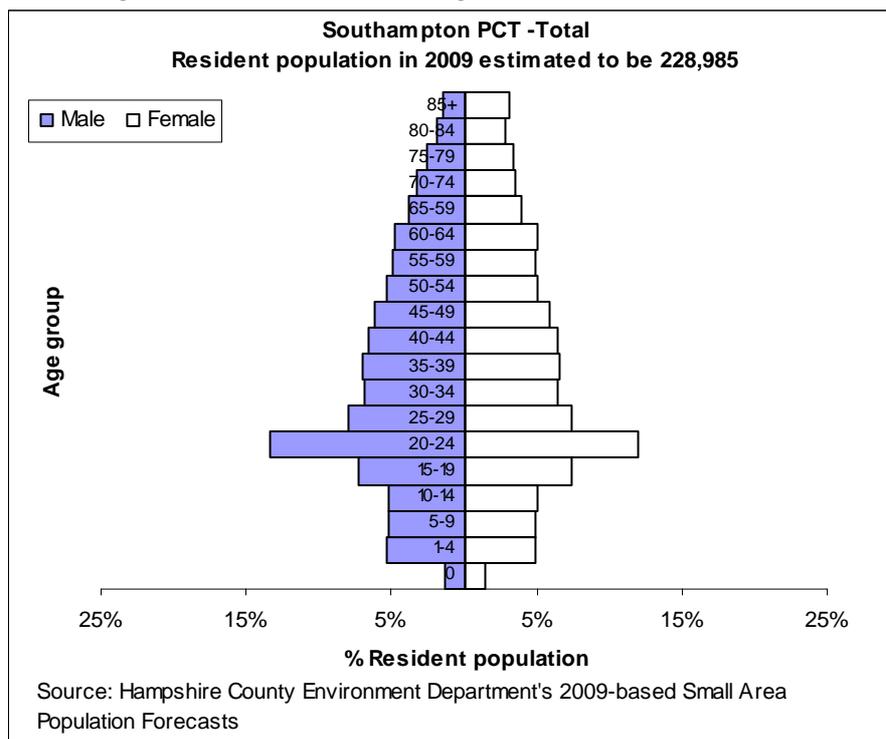
The GP registered population in April 2010 is greater than any resident population estimate at 262,600 (approximately 33,600 greater). This is due to a number of NHS Hampshire residents registering with the City's GP practices.

There are some key differences between the population of Southampton and our South East region as a whole. For instance, Southampton has a large number of students living in the City with 21.3% of residents in the City aged 15-24 years compared to 12.7% across the South East as a whole. The population pyramid for Southampton illustrates this profile in Figure 1.2. below.

The HCC population forecasts are based on planned dwelling developments in the City and these predict the following changes:-

- the 0-19 age group will decrease by 1.4% by 2016
- the 20-39 age group will increase by 2.3% by 2016
- the 40-64 age group will increase by 1.6% by 2016
- there will be an overall increase in the 65+ age group of 16.8% by 2016. This will include a significant rise in the number of "younger" older people (65-74 year olds will increase by 21.6%) and also in the very old (85+ year olds will increase by 20.4% to 6,250 by 2016).
- the North and Central locality will see the most significant increases in population (7.9% over the 2009-2016 period) as the number of dwellings in Bargate and Bevois wards alone are set to increase by 3,700.

Figure 1.2 - Southampton PCT Resident Population 2009



Births

The number of births in Southampton has been rising for a number of years. In 2008 there were 3,279 live births to City residents compared to 2,556 in 2003. Conception rates in the City have been rising in line with the national trend.

The HCC currently forecasts a decrease in babies (under 1 year) between 2009 and 2016 of 3.5%. This seems surprising given the rising trend of recent years, but underlies the difficulty of modelling issues like conception rates that depend on a range of economic and social factors. The current forecasts use national fertility assumptions adjusted with local data. The evidence available still indicates a halt in the trend of increasing births.

For further population data visit www.southamptonhealth.nhs.uk/publichealth/jsna/data/a

Ethnicity

With an estimated 17.3% of residents having an ethnic origin other than White-British in 2007, Southampton has a more diverse population mix than the South East region (13%), England (16.4%) and most of its local authority peers.

In 2008/09 32.2% of births at SUHT (Southampton University Hospitals Trust) were from an ethnic group other than White British or Irish. This proportion was highest in the North and Central locality of the City at 57.3%.

The January 2010 schools census found that 26.4% of Southampton's school children were from an ethnic group other than White-British and the proportion speaking English as a first language has decreased from 91.6% in 2007 to 87.3% in 2010.

Religion

In the 2001 Census 65.5% of Southampton's population indicated a Christian faith; this was lower than the England average of 71.7%. This was followed by 1.9% Muslim and 1.3%

Sikh. 21.6% of people indicated no religious belief; this was greater than the national figure of 14.6%.

Deprivation

Deprivation is a significant issue in Southampton with the City being ranked as the 4th most deprived local authority in the South East and 91st out of the 354 local authorities in England according to the Index of Multiple Deprivation (IMD) 2007. In April 2010 12.6% of the working age population were claiming 'out-of-work' benefits compared to 9.5% across the South East region. In 2009 the estimated average weekly earnings for a full-time employee in Southampton were £441.60 or £95 a week less compared with a South East average of £536.60.

Income and Wealth

The economic recession has had a marked impact on Southampton and its residents. The City as a whole now has just over 12% of its working age population claiming out of work benefits. There are 13 Lower Super Output Areas where this rises to above 25% of the adult population and the worst affected area has a benefit claimant level of nearly 40%. In addition to this the ratio of unemployed residents in the City to job vacancies was 7:1 in April 2009.

Across England the employment rate fell from 74.5% from April 2007 to March 2008 to 73.0% from October 2008 to September 2009. In Southampton the employment rate was 71.7% in the period April 2007 to March 2008, rising to 72.4% between October 2008 and September 2009. Compared to other large cities in Southern England, Southampton has a higher percentage of the working age population which is economically inactive as Table 1.1 below shows.

Table 1.1 Percent of working age people who are economically inactive, October 2008 to September 2009

Comparator Cities	Economic inactivity rate %
Bournemouth	23.8
Southampton	22.1
Portsmouth	22.1
Brighton and Hove	21.2
Plymouth	21.0
Bristol	21.0
Southend-on-Sea	18.3
England	21.0

The variance in economic well-being becomes more pronounced when earnings are examined. The Annual Survey of Hours and Earnings showed 2009 gross weekly pay in Southampton was the lowest in Southern England when compared to its peer group of comparator cities. The gap has widened over time. In 2002 the average gross weekly income was 97.7% of the England average; by 2009 this had fallen to 89.1%.

Table 1.2 Average Gross Weekly Pay 2002 to 2009 England and Southampton

Year	£ England	£ Southampton	£ Difference
2002	397	388	-9
2003	411	391	-20
2004	426	398	-28
2005	437	394	-43
2006	450	398	-52
2007	464	423	-41
2008	485	439	-46
2009	496	442	-54

Table 1.3 Gross Weekly Pay – Full-Time Workers 2009: Southampton and its ONS peers

Local Authority	Gross weekly pay £
Southend-on-Sea	515
Brighton and Hove	500
England	496
Portsmouth	475
Bristol	475
Leeds	465
Bournemouth	460
Sheffield	458
Liverpool	452
Plymouth	446
Southampton	442
Salford	432
Newcastle-Upon-Tyne	422

The Recession

Between March 2008 and March 2009 the number of Job Seekers' Allowance claimants in Southampton nearly doubled from 3,316 to 6,298; a very similar trend was seen nationally. Unemployment amongst people of working age has also shown an increase. For those in work, however, average wages have continued to increase steadily both locally and nationally; for instance, gross weekly pay in 2003 was £388 in Southampton but by 2009 this had risen to £442, but significantly the figures in Table 1.2 show the gap is widening between Southampton and the national average.

Within Southampton the proportion of the workforce employed by the public sector is higher than the national average. As the cuts in public sector expenditure are implemented the rate of unemployment may rise, and the incidence of mental health issues associated with unemployment will be higher. By definition, large economic recessions affect more people. This group will include those with little previous experience of coping with hardship, who may be at greater risk of mental health problems than others 'inured' to financial insecurity.

Poverty

Many families living on a low income have only about £10 per day per person. This needs to cover all of their day to day expenditure, including necessities such as food and transport. It also needs to cover occasional items such as new shoes and clothes, school trips and activities for children, and replacing broken household items such as washing

machines and kitchen equipment. In addition to this, it must pay for all household bills such as electricity, gas and water, telephone bills, and TV licences.

The most recent data is for 2007 and indicates that there were 11,770 children living in poverty in Southampton which is approximately 27% of the total number of children. This rate is significantly higher than the national average of 21.6% and also higher than many of the City's local authority peers. In Bargate and Bevois wards over 40% of children are estimated to be living in poverty.

Population Segmentation

All households in Southampton (102,582 households) have been classified into one of 15 MOSAIC segments according to their social, economic and cultural behaviours. The 15 groups are specific to Southampton because local data has been included in the classification process. Clearly the groups are generalisations; individual households in the City will only 'approximate' to these groups rather than match exactly. The value of the MOSAIC groups is in understanding the characteristics of the City's population in terms their lifestyles and methods of communication that they are most likely to respond to (social marketing). Thus this can provide some valuable insights about the population.

Table 1.4 gives a brief description of each MOSAIC group which is purely intended to highlight the key lifestyle issues.

Caveats around use of Mosaic Data

These descriptions are therefore what sociologists would describe as 'ideal types', pure examples to which individual cases approximate only with various degrees of exactness. They focus on the statistical bias of a type of neighbourhood, on the demographic categories which are more numerous there than elsewhere in the area and which give the neighbourhood its distinctive character. In addition, because the boundaries of postcodes and census output areas do not exactly match boundaries in housing type, it is inevitable that addresses close to the boundary of many output areas may in certain cases not appear to have been allocated to the most suitable category. There are cases too where the same types of neighbourhood will contain people of similar character and behaviour but living in very different types of accommodation according to where in the area they may live.

Experian who produced this data using the Mosaic tool have taken account of a wealth of information from both census and non census sources - such as the electoral register, shareholder and directors' lists, and local levels of council tax. This information is supplemented with information from market research surveys which can be cross tabulated by Mosaic, including the ONS Annual Expenditure and Family Survey, University of Essex's British Household Panel Survey, Research Now's online panel, YouGov's specialist financial survey, GfK NOP's Financial Research Survey, BMRB's Target Group Index Survey, Experian Hitwise's online competitor intelligence, the National Readership Survey and the British Crime Survey.

Table 1.4 Southampton Mosaic Groups

Southampton Groups (Mosaic Segment)	Number of Households in Group	% Households in Group
1. Financially secure older couples living in owner occupied properties	7,157	6.98
2. Elderly singles with low mobility, reliant on public services for support	3,863	3.77
3. Low income older couples approaching retirement, living in low rise council housing	5,810	5.67
4. Childless, young, high rise council tenants with issues of social isolation	10,036	9.78
5. Vulnerable young families or lone parents living on council housing estates	2,174	2.64
6. Middle-aged owner occupiers making some use of public services	5,806	5.67
7. Diverse private renters in older terraced properties	5,640	5.49
8. Middle aged lower income couples & families in right-to-buy homes	12,960	12.63
9. Comfortably-off, families who lead active yet busy lifestyles	10,135	9.88
10. Young couples, new to the area, in privately rented purpose-built flats	6,133	5.98
11. Students living in shared houses or flats near to the city centre	7,632	7.44
12. Transient young singles with weak support networks, living in a mixture of housing	6,329	6.17
13. Students living with like-minded people in halls of residence	5,283	5.15
14. Affluent professionals living in large detached properties out of the city centre	8,620	8.40
15. Well qualified, young professionals living in purpose-built prestigious locations	4,464	4.35

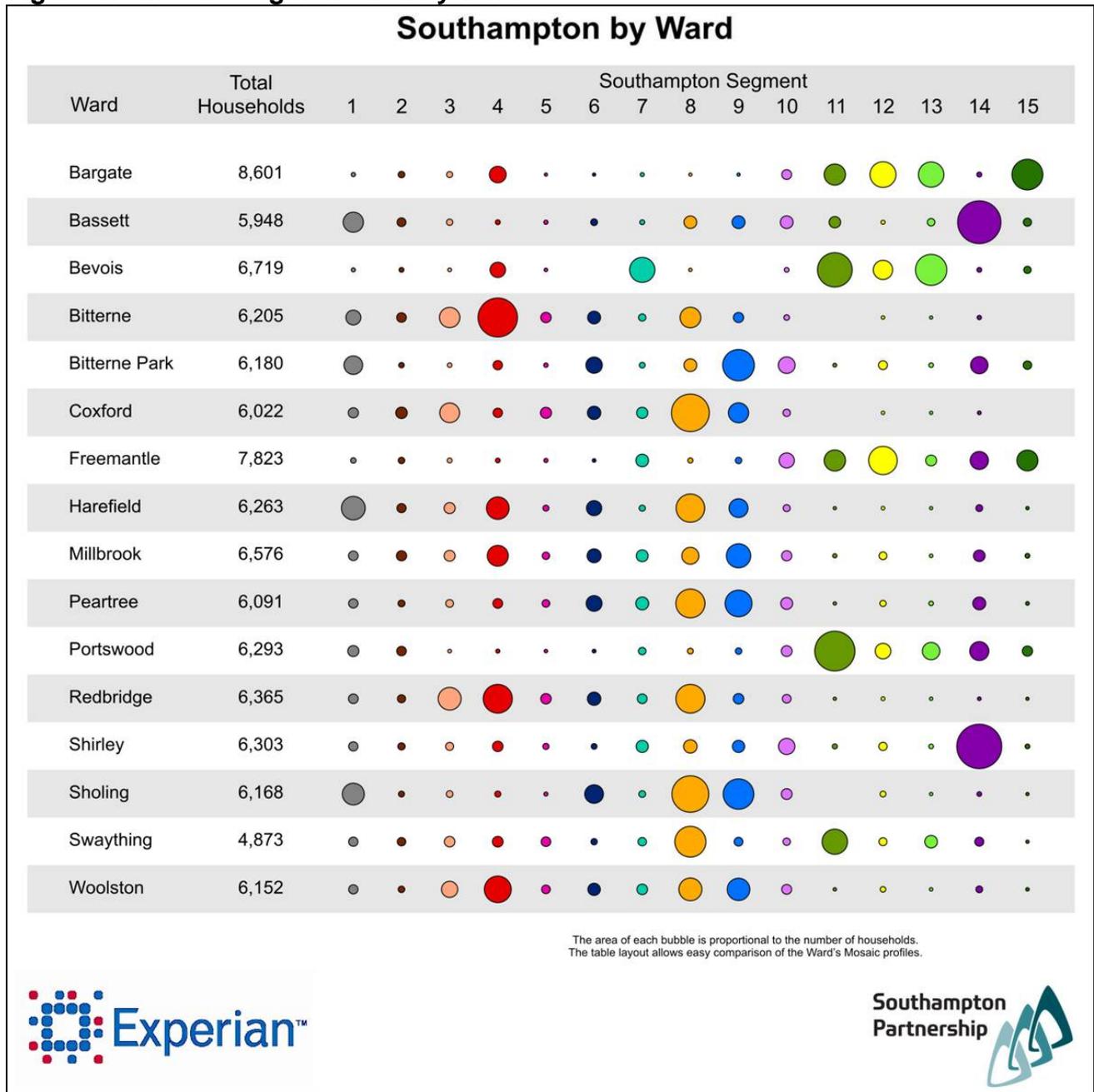
Table 1.5 Mosaic segments specific to Southampton 2010

Segment	% of City's households	Title	Description
1	6.98% 7,157 households	Financially secure older couples living in owner occupied properties	Segment 1 is comprised of pensioners either living alone or with a partner in owner occupied bungalows or semi-detached houses. They are almost exclusively of white origin. Residents have lived in the area for a long period of time around people of similar ages and values which has resulted in strong support networks of friends and family with residents enjoying the areas in which they live. Crime is low as neighbours look out for each other and are not afraid to reprimand youths who cause trouble.
2	3.77% 3,863 households	Elderly singles with low mobility, reliant on public services for support	Segment 2 is comprised of deprived, very elderly, mainly single pensioners living in council owned, purpose-built accommodation or small bungalows. These residents are dispersed across Southampton; their location is more likely to be a result of where their purpose-built accommodation is situated. These very elderly people are likely to have moved into such accommodation due to their increased need for care and decreased ability to cope on their own, or after the death of a partner.
3	5.66% 5,810 households	Low income older couples approaching retirement, living in low rise council housing	Segment 3 consists of couples or singles approaching retirement with some households having older children. Residents in this Segment live in council owned properties within large municipal estates with few exercising their right-to-buy. Relationships and neighbourhoods tend to be stable with length of residency at over 11 years. There may be reliance on extended family members in times of need.
4	9.78% 10,036 households	Childless, young, high rise council tenants with issues of social isolation	Segment 4 consists mainly of young singles and possibly lone parents with young children, living in high rise council rented flats. Social deprivation and isolation are common within this Segment who, if employed, work in low skilled, routine occupations which offer low wages and limited career progression. Residents are likely to have been brought up in their community and friends and family remain to provide support if needed.
5	2.65% 2,714 households	Vulnerable young families or lone parents living on council housing estates	Segment 5 consists of deprived young families and lone parents many with several school age children, living in low rise council estates on the outskirts of Southampton City. Residents within these areas see the main problems as anti-social behaviour, teenagers hanging around and the use/dealing of drugs.
6	5.66% 5,806 households	Middle-aged owner occupiers making some use of public services	Segment 6 consists mainly of comfortably off, middle aged families or couples living in owner occupied, semi-detached or detached properties. Traditional family values and low levels of ethnic diversity are characteristic. Couples have been married for long periods of time and have lived in their homes for over 10 years. Children tend to be of secondary school age or are older and no longer dependent.
7	5.50% 5,640 households	Diverse private renters in older terraced properties	Segment 7 typically contains transient, ethnically diverse people of working age living in old, often poor quality, terraced housing close to the city centre. Low incomes from unskilled manufacturing or administrative positions and little, if any, savings result in residents often finding it difficult to cope financially. Many residents will have a number of dependent children, either within more traditional families or as lone parents.

Segment	% of City's households	Title	Description
8	12.63% 12,960 households	Middle-aged lower income couples & families in right-to-buy homes	Segment 8 is made up of middle-aged families living on moderate incomes in right-to-buy houses or terraces. Blue collar jobs and lower managerial positions are characteristic as few have many formal qualifications, and due to the demand for such work within the local area, unemployment tends to be relatively low. Residents are unlikely to have sizeable savings and some of the families may be finding it hard to cope on their current income, but may not be accessing benefit entitlements.
9	9.88% 10,135 households	Comfortably-off, families who lead active yet busy lifestyles	Segment 9 is comprised mainly of young couples in their thirties or early forties either with one or more dependent young children, although a minority may not have children. They live in owner occupied, relatively new, semi-detached or terraced properties. For many this will be their first home and monthly mortgage repayments will constitute a substantial proportion of their income. They tend to reside in the local area for a significant number of years.
10	5.98% 6,133 households	Young couples, new to the area, in privately rented purpose-built flats	Segment 10 is comprised mainly of young singles or couples in their late twenties or early thirties living in modern, yet small, purpose built accommodation. They rent from private landlords or are owner occupiers. Some ethnic diversity is also present. Many are very new to the local area and so support networks are weak. A range of salaries are earned through professional or administrative occupations.
11	7.44% 7,632 households	Students living in shared houses or flats near to the city centre	Segment 11 is comprised of single university students in their later years, or recent graduates living in privately rented flats, shared houses or terraces close to the city centre. These residents tend to cluster together in areas of similar accommodation within close proximity to the university and city centre. Consequently, once traditional neighbourhoods may have changed significantly. Ethnic diversity is also apparent within Segment 11 as is typical with student populations.
12	6.17% 6,329 households	Transient young singles with weak support networks, living in a mixture of housing	Segment 12 contains many young transient singles living in privately rented poor quality flats or shared houses with the majority close to Southampton city centre. Low incomes result from above average unemployment, or work in minimum wage positions which they find hard to hold down. Residents are also unlikely to be in education or training and have high social needs. Residents in Segment 12 are likely to be ethnically diverse. Worries about race related crime are high and these are not areas in which they enjoy living.
13	5.15% 5,283 households	Students living with like-minded people in halls of residence	Segment 13 are young, single, first year university students living in halls of residence or other privately rented establishments suitable for student needs. Resultantly, they tend to cluster in and around the university itself or in halls of residence further out of town. Although they have low car ownership, they live within close proximity to services or public transport routes which they make frequent use of. Many of these residents are also willing to volunteer, although typically for larger organisations.
14	8.40% 8,620 households	Affluent professionals living in large detached properties out of the city centre	Segment 14 is the most affluent of all of the Southampton Segments. Typically middle-aged families with older children, or couples approaching retirement, they are extremely comfortable on their current salaries. Residents have high levels of disposable income, savings and shareholdings and the majority are owner-occupiers who live in large, detached properties in desirable areas. Adults are very likely to have a degree and the majority are employed in financial or business sectors, or work in more senior positions at the University.

Segment	% of City's households	Title	Description
15	4.35% 4,464 households	Well qualified, young professionals living in purpose-built prestigious locations	Segment 15 is comprised of young, well-educated, single professionals living in purpose-built flats, with some in waterside locations. There are similar proportions of residents who privately rent these flats as are owner occupiers. These ethnically diverse residents are transient and are rarely brought up in the local area resulting in weak support networks of family and friends. Furthermore, due to the nature of their accommodation and long working hours, neighbours are less likely than other segments to interact.

Figure 1.3 Mosaic segmentation by ward



See the caveats around use of Mosaic data on page 17.

Public Perceptions of the City, Southampton City Council and the NHS; Community Empowerment and Service User Involvement

Since 2007, NHS Southampton City has been receiving regular research results on what people in the City think about the NHS both locally and nationally. Over 1200 face to face interviews are currently being conducted by ICM every six months in Southampton and the results are made available to NHS Southampton City. This provides useful intelligence on public perceptions in order to better inform our engagement with local people and where money on services and care gets spent.

The results from the five 'waves' of research since January 2008 have generally shown positive improvements across a range of areas in the local healthcare system. Examples of key findings include:

- the latest research from December 2009 to February 2010 shows that satisfaction with the NHS both locally (79%) and nationally (69%) has grown in Southampton for the fifth straight survey
- the latest research also shows that an extra 3% of people believe they can influence decisions affecting local NHS services in Southampton. However, 44% of people in Southampton disagree with this statement and further work is underway to improve this
- satisfaction with GPs is high, with the latest survey reaching 89%, while satisfaction with NHS Hospitals has improved across the five surveys and is currently (83%). Satisfaction with dentists and pharmacists are also high at 84% and 89% respectively
- awareness of Choice for patient appointments and the extent to which GPs offer Choice remains low in Southampton, although satisfaction at the ease in making an appointment with a GP has increased in the latest survey to 73%
- perceptions of privacy and dignity in hospital care has improved in Southampton, which has the second highest satisfaction rate across the South Central region at 76%.

For more information and to see results from the ICM Research surveys results, please go to www.southamptonhealth.nhs.uk/forthepublic

During the last year NHS Southampton has reviewed its Patient and Public Engagement Strategy to reflect the new legislation around patient and public engagement and its responsibilities as a commissioning organisation. An external advisory panel for Equality and Human Rights has been established. The membership network is growing where people register to ensure that they receive regular opportunities to engage in all Trust activities. A social marketing group has been established and a training programme devised for staff. Social marketing research has been used to inform and remodel Southampton urgent care services.

The NHS Southampton and the City Council have a number of community, seniors, carer, parent and service user involvement groups. The direction of Government policy is to intensify the relationship between the 'stronger community voice' and the way public services are designed and delivered. Therefore public services for people of all ages are working to become more responsive to the expressed needs of service users. This can lead to both better services and improved outcomes.

The Southampton Local Involvement Network (S-LINK) has developed a programme of activity which seeks to capture the public's views on major health and social care issues. In 2009 the S-LINK formulated a response on the behalf of local people to the governments

Big Care debate on proposals for the future funding and delivery of social care. In 2010 the LINK will be undertaking consultation on this draft JSNA with the voluntary sector and the public.

In 2005/06 63.3% of people were extremely or very satisfied with the help from Social Services they received in their own homes. In 2008/09 this was 59.3%. On both occasions this was above the England average of 59.0 and 58.4 % respectively.

To find out more see Southampton City Council web links www.southampton.gov.uk/ and Patient Experience Service.
<http://www.southamptonhealth.nhs.uk/pals>

To ensure demographic change is reflected in health and wellbeing strategies and commissioning plans, there is a need to:

- use shared data more effectively to improve health outcomes
- ensure MOSAIC data and analysis provides clearer insights that can be used to commission better outcomes to narrow the inequalities gap
- continue the support for community, service user and carers' involvement groups, including the Patient Experience Service and the Southampton Local Involvement Network (S-LINK). This will ensure Southampton people are influencing, and are enabled to scrutinize service provision
- improve the engagement of older people, and in particular ensure their voices are heard in consultation, promoting dignity in line with the 'Dignity Challenge', and tackling ageism
- improve engagement of BME seniors groups, particularly Gypsies and Travellers, asylum seekers, refugees and economic migrants
- promote and expand greater user control over health and social care decisions that affect them, their families and communities, ranging from individual budgets (In Control and Supporting People) through to collective models of self-directed care (SECC pilot) and community-led commissioning (e.g. participatory budgeting)
- ensure processes for dialogue with children and young people through Healthy Schools, TellUs (surveys), the City Youth Parliament, School Councils and other channels of communication.

References

Marmot Review (2010) Fair Society, Healthy Lives: a Strategic Review of Health Inequalities in England post 2010. Published by The Marmot Review.

Department of Health and Social Security (1980) Inequalities in Health: Report of a research working group.

<http://www.southamptonhealth.nhs.uk/jsnaconsultation>

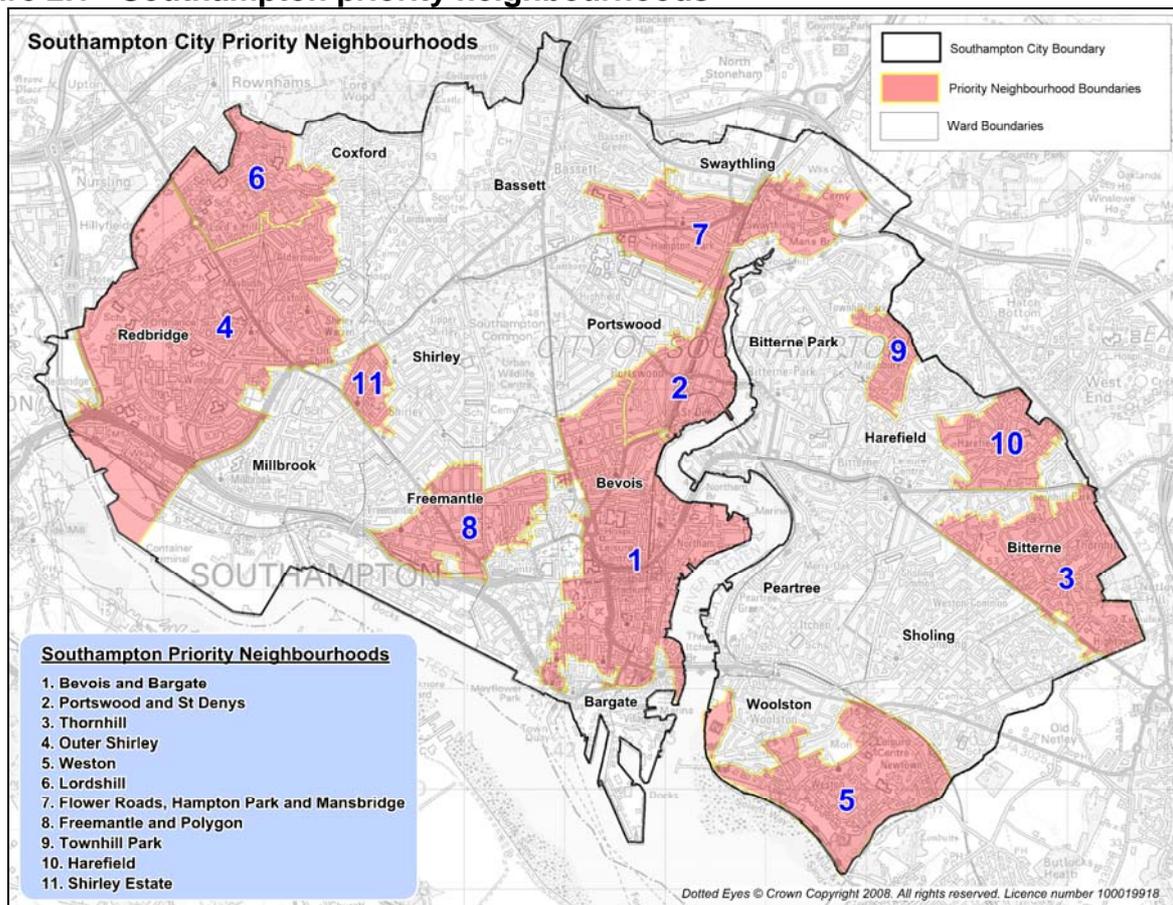
SECTION 2 - ACHIEVING BETTER HEALTH AND WELL-BEING FOR ALL AND TACKLING HEALTH INEQUALITIES

Improving Life Expectancy in the City

Life expectancy at birth for males in Southampton is 77.6 years and for females 82.1 years; neither of which are significantly different from the national averages. Life expectancy in the City has risen in recent years in line with the national trend. The Office for National Statistics (ONS) also calculates disability-free life expectancy (based on 2001 Census figures) and for this measure both males and females in Southampton have significantly lower values than the national average; males in Southampton have a disability-free life expectancy from birth of 60.9 years (compared with 61.7 years for England) and for females in the City its 63.4 years (compared with 64.2 years nationally).

The City has identified eleven priority neighbourhoods¹ based on markers of deprivation where 50% of our population live. Life expectancy for males has been significantly lower in the priority areas than in the remainder of the City for the past few years, the gap is slightly widening. Life expectancy in 2006-08 for males was 76.1 years in priority areas and 79.6 years elsewhere in Southampton, a difference of 3.5 years. The gap in 2002-04 was 3.4 years.

Figure 2.1 - Southampton priority neighbourhoods



¹ Priority areas were defined as the areas most in need of 'action' in Southampton City Council's Neighbourhood Renewal Strategy Pearce, H. (2002) Southampton Local Neighbourhood Renewal Strategy Part 1: The neighbourhood renewal vision for Southampton. See <http://www.southamptonhealth.nhs.uk/publichealth/plans/lhrs>

For women life expectancy in the priority neighbourhoods has narrowed to 1.4 years compared to the rest of the City between 2002-04 and 2006-08. Within Southampton there are marked differences in life expectancy particularly for males; the wards of Redbridge, Woolston, Bitterne and Bevois all have significantly lower male life expectancies than the City average.

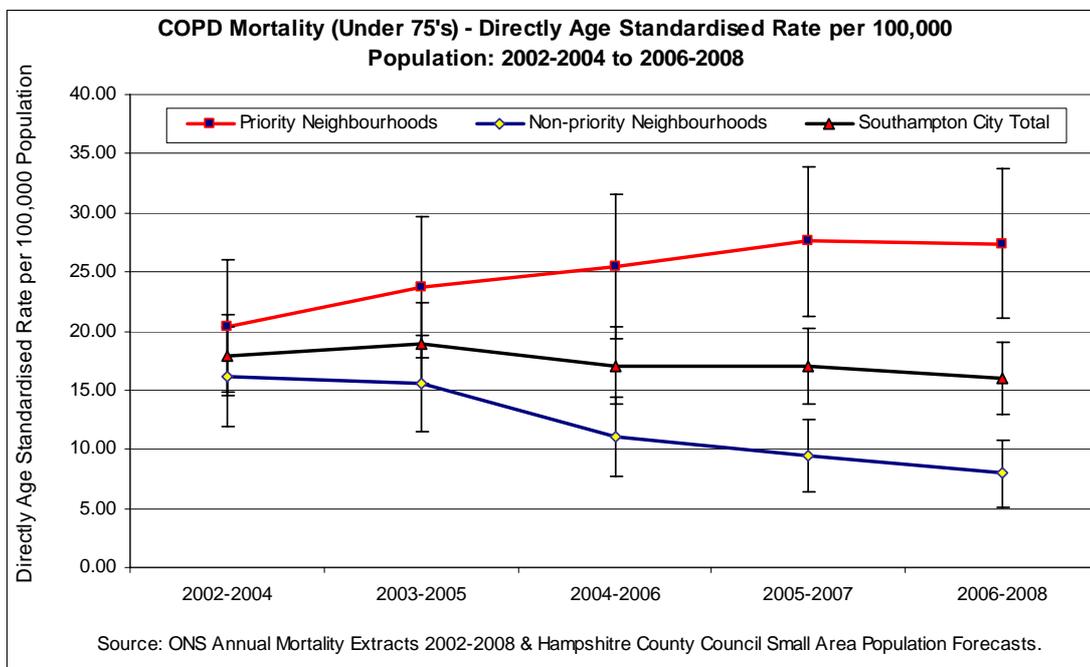
In the priority neighbourhoods:

- life expectancy is lower by 3.5 years for men and worryingly widening and 1.4 years for women and narrowing
- overall mortality rate is 25.7% higher and reducing
- premature (under 75) deaths are 62.5% higher and increasing
- death rate from circulatory disease in people under 75 is 92% higher
- severe mental illness is more common
- teenage pregnancy rates are higher
- low birth weight babies are 17.6% more common
- smoking in pregnancy has shown a 76.5% difference
- breast feeding is less common 71.5% versus 81.7% for other neighbourhoods at first feed

Current strategies have been working to reduce morbidity (ill health) and mortality (death) from the major threats to health in the City, namely cancers, cardiovascular and respiratory diseases. Services to reduce the burden of long term conditions, particularly those that drastically reduce the quality of an individual’s life have also been a priority.

For example, chronic obstructive pulmonary disease (COPD) shows a reduction in death rate overall, but a widening inequalities gap in our priority neighbourhoods. See Figure 2.2.

Figure 2.2 - Southampton City COPD Mortality Under 75’s Age Standardised 2002-2004 to 2006-2008



People with pre-existing respiratory conditions such as COPD and asthma are particularly at risk of premature death; these conditions are prevalent in some parts of the City such as the priority neighbourhood areas where there is a higher prevalence of smoking and nearby major roads with higher levels of air pollution.

Between the 1994-98 baseline and 2006-08 there has been a 24% reduction in the number of Southampton residents killed or seriously injured in road traffic accidents. This compares with a national reduction of 33%.

To find out more see

www.southamptonhealth.nhs.uk/publichealth/briefings and/or the Data Compendium www.southamptonhealth.nhs.uk/publichealth/jsna/data/a

To further improve life expectancy the key health and wellbeing needs are:

- reduce the life expectancy gap particularly in men between the priority neighbourhoods and the rest of the City
- tackle cancer and cardio vascular diseases (CVD) which have been identified as the two major contributors to poorer life expectancy experienced in Southampton
- sustain current investment in disease prevention programmes where there is a robust evidence base of success e.g. physical activity
- increase investment in smoking cessation and tobacco control
- direct future investment and service development towards the primary and secondary prevention of cancer and CVD (including diabetes and stroke) in the local population as a priority
- increase interventions to reduce cardio-vascular diseases (CVD) - tobacco control, cholesterol, blood pressure and weight control and alcohol harm reduction strategies
- ensure best management of heart attacks and atrial fibrillation for all people
- introduce better screening and risk management of COPD to better support ill people and their carers
- improve air quality and reduce exposure to outdoor pollution, mainly caused by traffic, which is associated with bringing forward deaths and hospital admissions.
- continue to reduce road traffic injuries and fatalities
- reduce the violence and harm to health and well-being caused by alcohol misuse
- improve the literacy and numeracy levels of the working age population through work with children, young people and adult learners, so that people are better able to take control of their own health and well-being and enjoy better health literacy
- make better use of community facilities (e.g. pharmacies, libraries) to provide information on staying well.

Monitoring of Population Health Trends

Monitoring of population health trends in Southampton has been carried out comprehensively for many years; see www.southamptonhealth.nhs.uk/publichealth/lhc and www.southamptonhealth.nhs.uk/publichealth/jsna/data

However, increasingly we need to be projecting forward health and wellbeing needs to ensure that current and future commissioned services address and respond to the needs of the whole population, ensuring equity across all sections of society. This is a difficult task, particularly given the uncertainties over current and future population levels mentioned previously. We make use of expert work that has been done elsewhere and apply this to Southampton to address this.

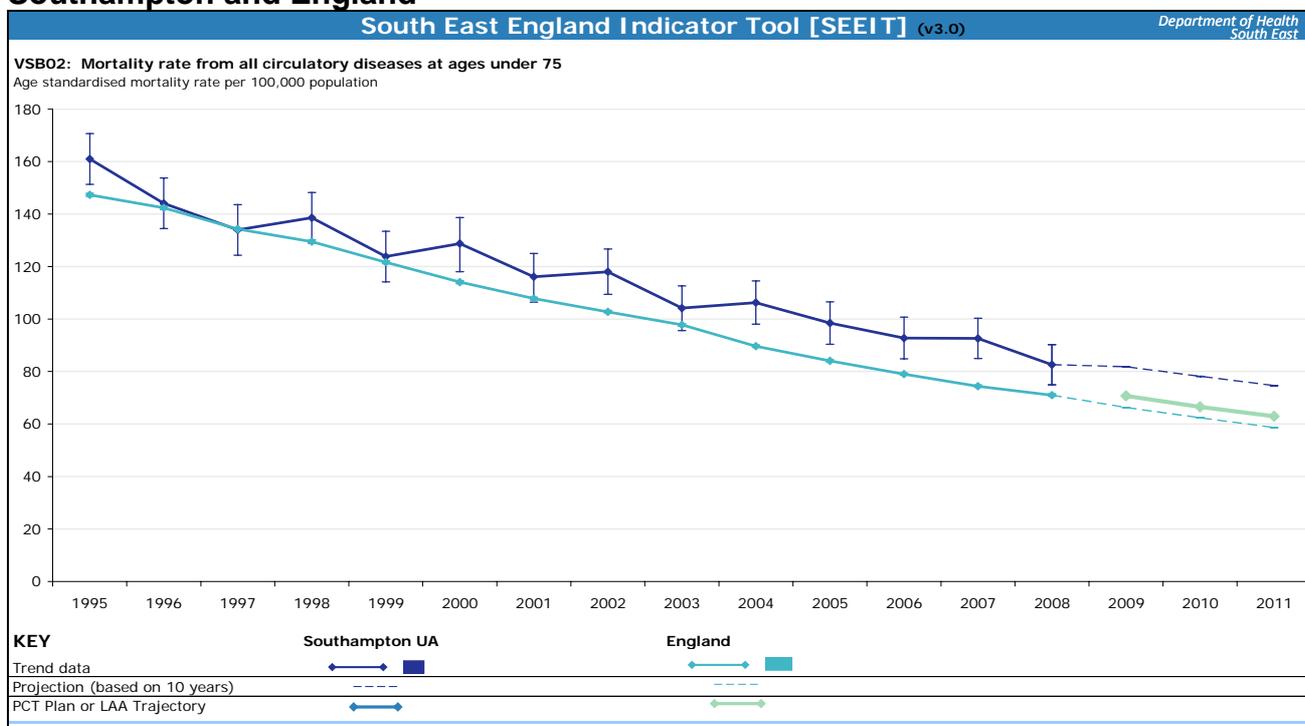
For instance, the Yorkshire and Humberside Public Health Observatory have produced a model which predicts future prevalence of diabetes based on predicted obesity trends and ONS population projections. This model estimated 11,956 diabetes sufferers in

Southampton in 2009 rising to 13,346 by 2015 and 17,631 by 2030². In March 2010 we had 10,016 people with a GP registered diagnosis of diabetes in the City and know our prevalence to be higher.

The numbers of older people in Southampton who are obese (i.e. with a BMI of over 30) is predicted to rise from 7,843 in 2009 to 9,458 in 2025 according to POPPI (Projecting Older People Population Information System)³. POPPI (and PANSI⁴ which is the equivalent for adults 18-64 years) uses the national prevalence rates for many conditions applied to the ONS population projections to indicate future levels of need.

Another trends and projection tool has been produced by the Department of Health South East to help provide a common approach towards analysing the progress towards achieving local health and wellbeing improvement goals; this is called SEEIT⁵. Figure 2.3 below from the SEEIT tool shows that although mortality rates from circulatory disease have been falling, the rates in Southampton are forecast to remain significantly higher than the national average.

Figure 2.3 - Mortality Rates from Circulatory Diseases at ages under 75 years Southampton and England



NHS Southampton has worked with Southampton University Hospitals Trust (SUHT) and NHS Hampshire to agree assumptions on trends in disease prevalence and population changes to predict underlying demand for hospital services, through a planning forum.

The most robust available data on trends in disease prevalence was used. For instance, cancer incidence data for the 1985 to 2006 period was obtained and trends analysed;

² APHO Diabetes Prevalence Model June 2010 www.yhpho.org.uk

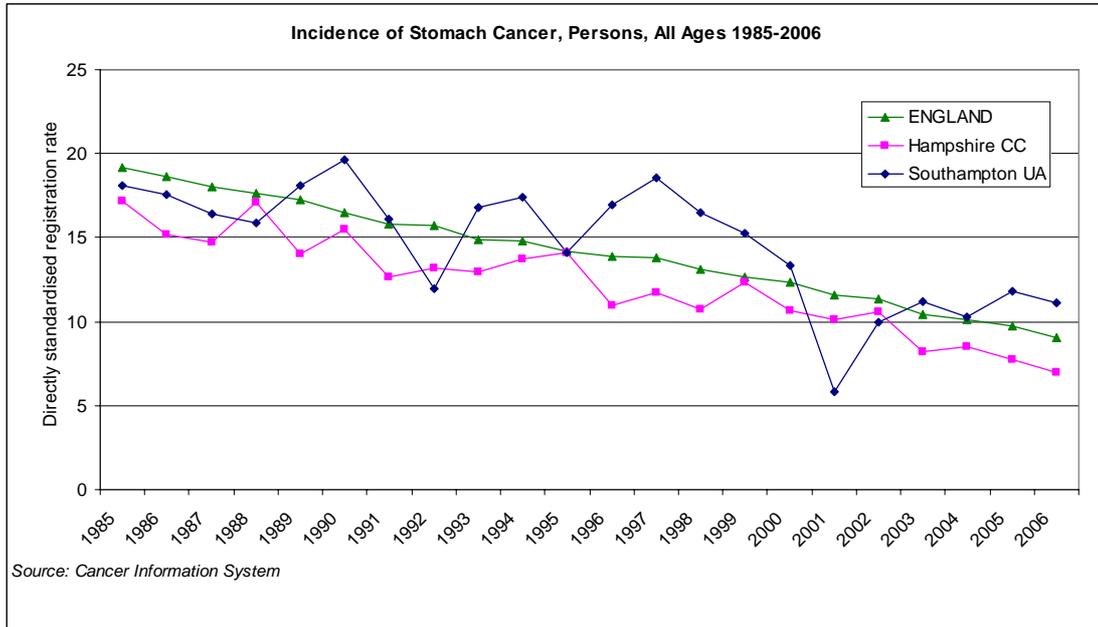
³ Projecting Older People Population Information System www.poppi.org.uk

⁴ Projecting Adult Needs and Services Information System www.pansi.org.uk

⁵ South East England Indicator Tool SEEIT www.sepho.org.uk

Figure 2.4 shows the declining trend in stomach cancer, and has been used as an example of trend data.

Figure 2.4 - Incidence of Stomach Cancer all ages 1985-2006 Southampton, Hampshire and England



For predicted population changes the Hampshire County Council small area forecasts were used as these take into account the planned residential development in an area. These were applied to each specialty by taking an average based on the age profile for that speciality.

The views of clinicians were also incorporated into the process particularly regarding changes in clinical practice but it is harder to define the impact of these changes on activity. Phase 1 of the project is now complete and will inform contract negotiations; this covered 30% of the SUHT activity from Southampton and Hampshire. Phase 2 will aim to bring agreement in forecast activity for the remaining 70% of SUHT workload and work on this began in June 2010.

The establishment of the planning forum has helped to build a common understanding of the underlying trends in the population structure, and to see how this impacts on the demand and access to hospital services. This enables us all to plan more effectively for the future, using common assumptions and measures of health service activity. The refinement of the first year's work will increasingly underpin contract negotiations in future.

In the future we need to build on this work by:

- managing knowledge even more efficiently and also taking on new skills such as actuarial modelling and scenario testing
- obtaining more robust data on future population trends and also local figures on lifestyles and behaviours. Synthetic estimates of disease prevalence and lifestyle characteristics are useful but they do not allow the monitoring of trends over time
- making good use of the social marketing tools such as MOSAIC referred to earlier.

To further improve the management of population health trends the key challenge is to:

- continue to build strong links with our partners in order to develop linked datasets and joint research followed by collaborative publication and dissemination of findings

Improving the Equity of Health and Well-Being Across All Communities

Both NHS Southampton and the City Council are keen to listen and hear the views, ideas and suggestions, of partner organisations and their service users in order to improve its provision and delivery, and its workforce profile and practices to positively work towards eliminating discrimination and further promoting equality.

www.southamptonhealth.nhs.uk/contactus/

Southampton City Council and NHS Southampton are committed to Equality of Opportunity in all their activities, challenging discrimination at all levels of the organisation and in ensuring compliance with all Equalities legislation.

These efforts are supported by legislation with The Equality Act 2010 aiming to harmonise the current discrimination legislation covering Age, Disability, Gender Assignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion/Belief, Sex and Sexual Orientation.

Future commissioning strategies informed by this document will need to be preceded by equalities and other impact assessment procedures operated by the respective organisations. As the draft JSNA is now published for consultation the engagement process has been structured to ensure that all communities, including those that are often harder to reach and are particularly disadvantaged, have the opportunity to respond to the needs identified and contribute details of any additional needs they have identified as missing from this iteration.

A local needs assessment identified the following issues to improve the health of those Black and Minority Ethnic communities within Southampton. There is a need to:

- improve primary care data collection relating to the ethnicity and other equality strands and language ability
- improve primary prevention of cardiovascular disease
- focusing on physical activity, particularly for the most vulnerable Black and Minority Ethnic communities e.g. those from South Asian communities
- improve secondary prevention of cardiovascular disease and the complications of diabetes
- improve access to mental health services to address differences in the diagnosis and treatment of people from different Black and Minority Ethnic Communities
- improve the accessibility to all health and wellbeing services particularly for those experiencing communication barriers to services
- improve engagement and participation of all communities in improving their health and the healthcare they received.

Armed Forces Veterans

There is a need to ensure that GPs, in making referrals for diagnosis or treatment, are aware of the current priority treatment provisions and of their extension to all Armed Forces Veterans who have a condition that is likely to be related to their service.

Acute and mental health trusts and NHS Foundation Trusts need to ensure that clinical staff are aware of the priority treatment for war pensioners (HSG(97)31) and its extension to all veterans, for conditions which are likely to be related to their service, subject to clinical need. The Ministry of Defence has a number of establishments in and around Hampshire, so it is likely than a number of veterans reside in Southampton, unfortunately this data is not available making it difficult to quantify.

To improve the health and wellbeing of armed forces veterans living in Southampton there is a need to:

- ensure that GPs and acute and mental health providers are able to identify and support the specific needs of armed forces veterans
- work with the MOD pensions division (Service Personnel and Veterans Agency) to quantify the number of veterans.

Mental Health

In 'New Horizons,' the Government's vision for mental health, well-being has been defined as 'a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment. Poor mental health is both a contributor to and a consequence of wider health inequalities. It is associated with increased health risk behaviours and increased morbidity and mortality from physical ill health. Promoting good mental health has multiple potential benefits. It can improve health outcomes, life expectancy and educational and economic outcomes and reduce violence and crime.

In 2008/09 there were 2,509 people on GPs' mental illness registers in Southampton (these include people with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses). This gives a crude prevalence rate of 1.0% which is significantly higher than the national average of 0.7% and also higher than many of the City's local authority peers. Crude prevalence rates for the localities within the City have wide confidence intervals, but we can conclude that the rates are significantly higher in the North and Central locality than in the South and East. The Mental Health Needs Index 2000 also highlighted Bevois and Bargate wards as the areas in the City with the greatest need.

The links between poverty, social deprivation and mental health problems are well documented. There is also a strong association between income inequality – relative poverty – and poor mental well-being and health. People with mental health problems tend to have fewer qualifications, find it harder to get work, have lower incomes, may well be homeless and are more likely to live in areas of high socio-economic deprivation. 15% of children in the lowest socio-economic group develop mental health problems, compared with just 5% of children in the highest. Life for many in Black and Minority Ethnic communities can be more difficult than for the majority population, and that is also reflected in the incidence of mental health problems.

Women are more likely to experience common mental health problems such as depression and anxiety – around 20% of women at any one time compared with about 12.5% of men. Half of all women and a quarter of men will be affected by depression at some time in their life and 15% experience a disabling depression. Men have higher rates of suicide and addictions.

Physical health affects our mental health, and vice versa. The most mentally healthy people also have the lowest rates of cardiovascular disease.

Fitness for Work

Evidence shows that work is generally good for an individual's health and well-being and that going back to work can actually aid a person's recovery. On the other hand, staying off work can lead to long-term absence and job loss with the risk of isolation, loss of confidence, mental health issues, de-skilling and social exclusion.

In April 2010 the sick note was replaced by the Fit Note. Doctors are now able to advise people who are on sick leave for over seven days whether, with extra support from their employer they could return to work earlier. They could recommend reduced hours, altered duties or a phased return to work. This system could help stop people from ending up on incapacity benefits.

To find out more see our local health comparisons

www.southamptonhealth.nhs.uk/publichealth/lhc and/or the Data Compendium

www.southamptonhealth.nhs.uk/publichealth/jsna/data

To improve the equity of health and well-being within local communities the key needs are to:

- improve access to accurate and up to date information about changes in the City's population and needs across all services, and improve effectiveness in the use of this information to meet the needs of people living in Southampton
- improve effectiveness in preventing ill health and invest in successful early interventions which are easy to access and understand and based on evidence of effectiveness
- tackle the poor health of homeless people in the City at point of first contact, reviewing health needs as accommodation issues are resolved
- enable Southampton to be a beacon for innovative approaches to health in primary, secondary and tertiary health and care settings with staff promoting health and well-being with every appropriate interaction
- improve our understanding of the needs of different Minority and Ethnic communities within our population, including Gypsies and Travellers, asylum seekers and refugees and new economic migrants, especially around maternity services and children's health
- develop maternal health services that adapt to changing population needs
- provide better support for women's mental health during pregnancy and the post-partum period
- continue to take action to understand and reduce our very high teenage conception rates
- improve access to mental health services to address differences in the diagnosis and treatment of people from different Black and Minority Ethnic Communities
- ensure that mental health needs for people suffering anxiety and or depression are provided
- improve the accessibility to all health and well-being services particularly for those experiencing communication barriers to services
- improve engagement and participation of all communities in improving their health and the healthcare they received.

Longer Term Health and Well-Being Conditions

According to the Department of health (2010) long term conditions represent 69% of health and care spend, 77% of inpatient bed days, 55% of GP appointments and 68% of outpatient and emergency department appointments. This care transcends organisational boundaries of social care, primary and community care and hospital care. Increasing numbers of people have more than one long term condition yet face an increasingly fragmented specialised response.

Around 86,000 people in Southampton are estimated to be living with long term health conditions, such as asthma, diabetes, heart disease, hypertension, epilepsy and severe mental illness; these conditions are not curable, but treatable and require on-going

treatment and monitoring. Approximately half of those with a long term condition (LTC) report that this condition limits their daily activities or work. A further 2,395 people require regular case management to co-ordinate their complex treatment and care needs. Pro-active disease or case management of long-term conditions can make a real difference to people with a single condition or a range of problems that threaten their health and well-being. Some of these patients will be case managed by their GP practice whilst others are being case managed by the Complex Care Teams (Joint Health and Social Care teams including Community Matrons).

The JSNA Data Compendium contains data on long term conditions from two sources; the first is GP registers which are maintained as part of the Quality outcomes Framework (QoF). Whilst it is possible to obtain data on the numbers of people on the registers, data on their age, gender and co-morbidities is not routinely available for analysis. The JSNA Data Compendium includes crude prevalence rates only, as without additional age information standardised rates cannot be calculated. When interpreting this data it should be remembered that the rates are crude and do not take account of the underlying age structure of the population. For instance, the North and Central locality of Southampton has a large number of young and relatively healthy students within its denominator population which will result in lower crude prevalence rates. Trend data from the QoF registers is available but this too needs to be interpreted with caution as changes in recording practice and changes of coding affect data quality.

The second source of data on long term conditions is estimated prevalence calculated by the Eastern Region Public Health Observatory (ERPHO) using national survey data to model prevalence based on local demographic characteristics. ERPHO warn that the assumptions of the model will not apply for areas that differ significantly from a 'typical' population.

As the proportion of older people in the population increases, the management of long term conditions will make an increasing contribution to the overall burden of disease. As people become more burdened with disease, there is often a requirement to require more social care support. Treatment of these conditions is costly both to the NHS and to society; however they and their complications are often preventable. For some patients living with end stage organ failure, transplantation of a healthy organ provides the only opportunity for a healthier life.

Coronary Heart Disease (CHD)

In 2008/09 there were 7,332 people on CHD registers in Southampton giving a crude prevalence rate of 2.8%. The modelled estimate of CHD is higher at 9,822 giving a crude rate of 3.9%. Both sources of data suggest Southampton has lower rates of CHD than many of its local authority peers but, as mentioned previously, these rates take no account of differences in age profile. Looking at locality rates is misleading because of this fact, as the North and Central locality has significantly lower rates than elsewhere in the City but this will be partly due to the large number of students living here. Over the 2004/05 to 2008/09 period there has been a very slight downward trend in CHD prevalence both nationally and locally. GPs across the City are implementing a cardio vascular check to identify people with CVD and risk, those aged between 40 and 74 will be screened every five years.

Stroke

Stroke accounts for around 180 deaths a year (9% of total deaths) in Southampton and causes a disproportionate amount of disability. Many strokes are preventable, with primary prevention offering the greatest potential for achieving benefits in value for money.

Around one in four people die from their stroke in the UK (National Audit Office, 2010). There are disproportionately higher mortality and morbidity in people from lower socio-economic status and BME groupings.

Hypertension

In Southampton there are 27,293 people on hypertension registers but the modelled estimate of hypertension predicts that there are 54,907 sufferers across the City.

Chronic Obstructive Pulmonary Disease (COPD)

There are 4,517 people on COPD registers giving a crude prevalence rate of 1.7% which is significantly higher than the national rate of 1.5%. There has been a rising trend in COPD prevalence rates both locally and nationally over the past few years. Public health estimates of COPD from modelling are much higher at 8,723 people (3.5%).

Diabetes

In the 2008 JSNA we estimated that around 4% of the adult population in Southampton had diabetes, although fewer had been diagnosed. It is estimated that around 10,000 adults would have this condition by 2010 unless they took measures to prevent it. There are now more than 10,000 people in the City living with diabetes (10,016 QoF 31st December 2009).

Neurological Conditions

Neurological conditions can affect all ages and people may experience the onset of a neurological condition at any time in their lives. There is increased prevalence of neurological conditions in older people. Some conditions particularly affect older people and others are life long conditions. The numbers of people with neurological conditions is likely to grow sharply in the next two decades due to improved survival rates, improved general health care and infection control, increased longevity and improved diagnostic techniques. People with neurological conditions can experience difficulties ranging from living with a condition which may weaken or disable them for periods of time through to needing help for most everyday tasks.

Each year 1% of the UK population are newly diagnosed with a neurological condition and 10% of visits to ED departments are for a neurological problem. About one quarter of adults (aged 18-64) with a chronic disability and a third of disabled people living in residential care have a neurological condition.

The national prevalence of Parkinson's disease is 200 per 100,000 and for Multiple Sclerosis its 100-120 per 100,000; applying these rates to Southampton's population would give 470 people with Parkinson's and 260 people with Multiple Sclerosis in the City.

Dementia

Dementia is one of the main causes of disability in later life ahead of cancer, CVD and stroke. Nationally, the incidence (new cases per year) of Alzheimer's/dementia is 25,000 per 100,000 amongst over 65's and prevalence is 1,000 per 100,000; this would equate to about 2,350 sufferers within Southampton City. By 2018 dementia is estimated to cost the UK £27 billion a year and unpaid care supporting someone with dementia saves the economy around £6 billion a year.

Infectious Disease and Infections

Tuberculosis

The re-emergence of tuberculosis (TB) is a public health challenge. More vigilant monitoring across primary care is required, particularly with migrants from TB hotspots (40 cases per 100,000 population like sub-Saharan Africa, parts of Asia, and some London boroughs). In 2009 the City had 15 cases of TB per 100,000 with the majority of these cases having entered the UK before 2004, demonstrating a latent period of infection and the continued need for ongoing robust surveillance in primary, secondary care and by Occupational Health Departments.

The Human Immunodeficiency Virus (HIV)

The Human Immunodeficiency Virus (HIV) is a virus that attacks the body's immune system. A healthy immune system provides a natural defence against disease and infection. In 2010 the worldwide estimate is that about 34 million people have HIV. Around half of these are women, and over two million children have the virus.

The number of people living with HIV is rising each year as a result of more cases being diagnosed and people living longer as a result of more effective medication, and ignorance around how HIV is spread. The term AIDS was first used by doctors when the exact nature of the HIV virus was not fully understood. However, the term is no longer widely used because it is too general to describe the many different conditions that can affect somebody with HIV. Specialists now prefer to use the terms advanced or late-stage HIV infection.

Although the HIV figures in the UK are far lower than those in other parts of the World, concern over the condition remains due to the following:

- it is estimated that in Britain 83,000 people now have HIV, and over a quarter of these people don't know that they have the virus
- the HIV figures are going up, by over 7,000 cases per year
- there has been a dramatic increase in the number of women, who have developed HIV and most of these women have acquired the virus through heterosexual (vaginal) intercourse.

The HIV prevalence rate in Southampton for those aged 15 to 59 years is 1.57 per 1,000, higher than the South Central Strategic Health Authority average of 1.13 per 1,000 (Office of National Statistics mid 2008 estimates).

Health Care Acquired Infections (HCAIs)

Continuing emphasis needs to be placed on the health economy wide efforts to tackle Health Care Acquired Infections which remain a significant public, professional and political concern. These are infections that are acquired (by patients or staff) following admission to hospital or as a result of healthcare interventions in other healthcare facilities. Being in hospital or receiving treatment has always carried a risk of infection. Two infections that have been problematic in hospitals when treating patients with complex medical problems are Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile Associated Disease (CDAD). The transfer of micro-organisms on the hands of healthcare workers, patients and their visitors, is an important factor and much has been done over the last few years to reduce this.

To find out more see

<http://www.southamptonhealth.nhs.uk/ourservices/> or
www.southamptonhealth.nhs.uk/publichealth/jsna/data

To better support people with long term conditions and proactively manage diseases the key health and wellbeing needs are to:

- ensure long term care needs are identified as early as possible and that appropriate care provision is in place to meet these needs
- ensure that everyone with a long term condition has their own personalised care plan by 2011
- develop individual care plans to enable different agencies to anticipate/co-ordinate people's needs more effectively and invest in more Medication Use Reviews (MUR) to increase the benefits of good prescribing by GPs and community pharmacies, for people with long term conditions and complex medications – this can save money
- improve stroke prevention through implementing public awareness and CVD checks in primary care
- improve detection of people suffering from atrial fibrillation and instigate appropriate treatment to prevent strokes
- invest in the prevention of both longer term conditions and complications such as smoking quitters, NHS health checks, alcohol screening and intervention service, probation health trainers, and plans for weight management programmes
- design services to take account of the increase of most long term conditions as people get older
- ensure that different health and social care groups are better co-ordinated or integrated for the planning and delivery of care for people with LTCs and can share information as appropriate to gain the best health and well-being outcomes for the person using the service
- enable better data sharing across health and social care IT systems to improve efficiency and outcomes (with appropriate data security) via Hampshire Health Record, and common assessment framework (CAF) project
- improve the health of those out of work – so that everyone with the potential to work has the support they need to do so
- continue to manage the most common long term conditions predominantly in primary care, to ensure appropriate care closer to home, for example diabetes and chronic obstructive pulmonary disease (COPD)
- invest in a primary /community COPD team to work with GPs, the Quitters Service and community pharmacists to make appropriate self-management/care plans
- ensure effective case management of long term conditions to reduce the need for hospital admission and improve overall health
- continue to provide more effective case management for people with complex needs at the end of their life
- continue to provide more person-centred care closer to home by expanding high quality clinical service across primary care based on the needs of localities
- review the care pathways for some long term diseases to maximise people's treatment options, compliance and health, for example asthma and allergic conditions
- provide better continuity of carers for social care, helping to increase people's confidence in their care and reducing stress
- ensure the public is aware of the need for blood donation and organ donation to enable them to sign up to the organ donation register so that those with life limiting illness could potentially benefit
- continue the investment in, and use of, assistive technology to improve disease management, e.g. tele-health, telecare and remote monitoring
- continue the implementation of measures NHS Southampton and Southampton University Hospitals Trust (SUHT) have in place to closely monitor and control health care acquired infections

- focus on tackling tuberculosis (TB), which has shown itself to be a re-emerging and growing risk to public health and well-being
- ensure early identification and treatment of people with TB and identification of those migrants from high risk TB countries notified by Port Health, and prevention of unnecessary transmission by better targeted screening of all at risk populations across primary care and through Occupational Health departments
- make it easier to inform the Health Protection Agency of notifiable infections/diseases
- increase arrangements in place to ensure GPs, school nurses, midwives, health visitors and Walk-in Centre staff are 'Tuberculosis aware' and understand how to refer patients into the specialist Tuberculosis team within Solent Healthcare
- maintain HIV awareness and education across the population and ensure that access to diagnostics and treatment is available to minimise the growing spread of HIV
- continue to protect people living with HIV from discrimination to ensure they have access to services commensurate with their needs, and are willing to engage with services so that risks to their families and the wider community can be managed.

Focusing Strategic Priorities for People in their Later Years in the City

One positive consequence of wider improvements in health and well-being achieved over recent decades has been that more people are living longer. Living longer poses challenges for health and wellbeing services. In Southampton disability free life expectancy is lower than the national average at 60.9 years for men and 63.4 years for women compared with 61.7 years and 64.2 years respectively.

In February 2010 'A Bright Future in Later Years – Southampton's vision for 2014' was published. With life expectancy improving, it is important that extra years gained also provide quality living. 'A Brighter Future in Later Years' was developed to provide a vision for maintaining and improving the health and well being of the City's older people by preventing the onset of disease and disability through adopting healthy lifestyles. The vision identifies key steps toward delivering 21st century services for the people of Southampton.

In summary these needs were to:

- stay independent, socially engaged and physically active
- be in control and manage their illness to avoid hospital admission and have easier access to services in the community
- be offered improved care at the end of life

To find out more see the Later Years Partnership web site

<http://www.southamptonlateryears.org/>

One of the key issues of an ageing population for public services is the impact that it will have on health and care services in the future. It is necessary to understand older peoples' needs better and meet them through mainstream services and budgets and shift the balance of care towards support and independence.

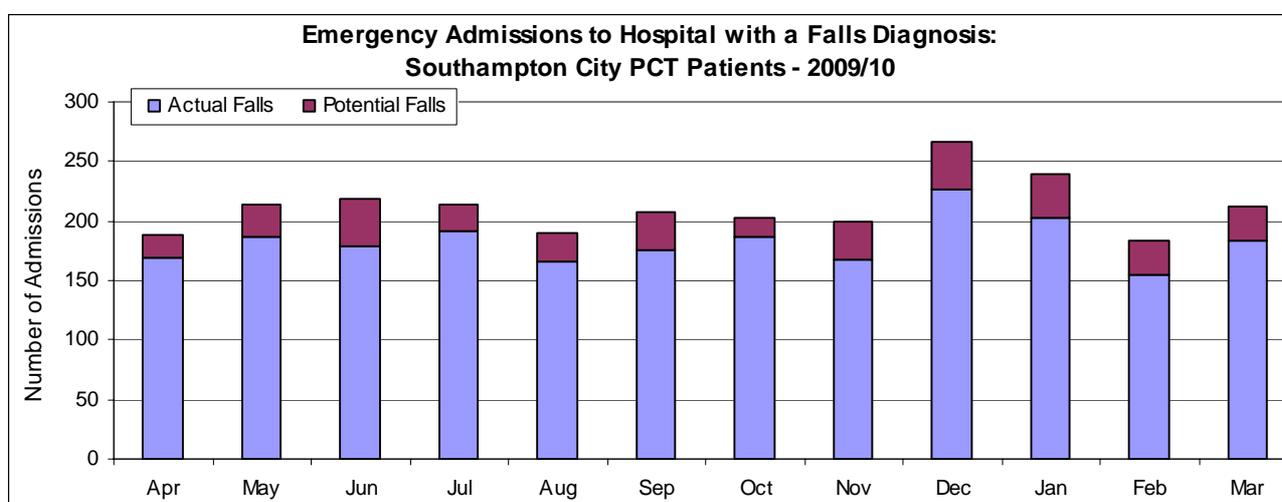
Fragility Fractures

Between 2004 and 2009 there were 1,328 hospital admissions following a fractured hip for people living in Southampton.

Current reporting of the incidence of fractures in older people is limited to fractured neck or femur. However fragility fractures also include areas such as vertebrae, wrist, femur and humerus. Although hip fracture is the most serious and traumatic form of fragility fracture, other fractures may serve as warning signals of bone fragility. According the various guidelines, including the National Osteoporosis Guideline Group, the main risk factor for a fragility fracture is a previous fragility fracture.

The use of fragility fractures based on Hospital Episodes Statistics is a close proxy to the total incidence of fragility fractures. With an ageing population the incidence of falls and potential fractures is likely to increase. Although falls are not good indicators of fragility fractures, they do indicate a need for secondary prevention through falls risk assessments and subsequent bone health checks. Fig 2.5 sets out levels of emergency admissions related to actual or potential falls in 2009/10.

Figure 2.5 - Emergency Admissions to Hospital by Month with a Falls Diagnosis 2009/10



To ensure older people maintain and improve their health, the key health and wellbeing needs are to;

- tackle those issues that affect health and well-being now, but which will impact on demand for services and result in loss of independence in future
- improve disability free life expectancy for men and women to the national average
- ensure access to social engagement and physical activity that specifically meets the needs of older people to deliver health and well-being benefits
- improve the dignity afforded to older people across health and care services
- support active ageing through appropriate leisure facilities
- promote healthy lifestyles, create opportunities, tackle inequalities and improve access to information
- support the Life to the Full work to promote independence with older people
- address the accommodation conditions for older people, especially those struggling to keep their own homes in a good state of repair
- redirect supported housing resources to older people in the community who could benefit significantly from low levels of investment
- develop the Government's Surestart to Later Life initiative for tackling social exclusion, focus on tackling poverty, and improve engagement
- increasing the impact of new highly effective treatments to restore and protect vision in older people diagnosed with Age Related Macular Degeneration (AMD) – the commonest cause of blindness
- focus on reducing falls by older and more frail people in the City by:

- reviewing foot-care services in the City
- identifying hot spots where falls occur and implementing action to reduce risks, for example mending of pavements
- monitoring the incidence of fragility fractures by source of referral
- build on bone health initiatives in primary care to prevent osteoporosis
- reducing the number of older people suffering a hip fracture, currently one every 30 hours, by having falls prevention service and fracture liaison services work with people who fall.

Disability

People Living with a Disability

Disability is inherently difficult to quantify. Many NHS and City Council figures for people living with disabilities are estimates and conflicts exist between the ways data is collected. The reliability of some data is likely to be variable. Although the JSNA is not an encyclopaedia of needs, it can highlight where more data is required to help with meeting these needs. Over time the ageing profile of the City is likely to increase the number of people living with disabilities, as people tend to pick up disabilities through injury or degenerative conditions as they get older.

Levels of Disability among Children and Young People

There are an estimated 1,900 children and young people (4.3%) living in Southampton with moderate or severe disabilities. These disabilities are generally chronic and limiting and include: learning disabilities, physical disability, autistic spectrum disorders and sensory disorders, the most common being moderate learning disabilities (33% of all recorded disabilities). The majority of children and young people recognised as having learning difficulties are of school age and attend mainstream schools (80% with moderate or severe disabilities). Trend data on Disability Living Allowance claims suggests that the number of children and young people with disabilities in Southampton is increasing.

Levels of Disability among Adults

The number of Adults aged 18 to 64 with physical disabilities receiving services is 1,235 (2008). Estimates of the number of disabled people in the City have been produced using national prevalence rates; these suggest there may be around 20,500 adults with a moderate disability and a further 8,757 with a serious disability living in Southampton. Table 2.1 below shows these figures split by age – this includes both loco-motor and personal care disability

Table 2.1 Estimated Overall Prevalence of Disability

Age Group	No disability	Moderate disability	Serious disability
16 to 24	42,902	1,563	448
25 to 34	39,087	1,847	412
35 to 44	27,863	1,972	608
45 to 54	21,348	2,729	744
55 to 64	16,259	3,746	1,392
65 to 74	9,719	3,475	1,304
75 to 84	5,859	3,449	1,900
85 or over	1,359	1,701	1,949
Total	164,396	20,482	8,757

Source: ONS Mid year population estimates 2007 and Health Survey for England 2001

People Living with Learning Disabilities

People with learning disabilities have much higher rates of ill-health than the general population with higher rates of premature death than the population as a whole. It has been suggested that people with learning disabilities are 58 times more likely to die before the age of 50 than the general population.

People with learning disabilities present with a common health needs, however they can find it difficult to recognise, report and describe symptoms of illness. People with learning disabilities can find it difficult to access health services for assessment and treatment. These difficulties can make it difficult for NHS professionals to treat effectively.

Some of the higher rates of ill health include:

- Increased risk of gastrointestinal problems and cancer
- Increased prevalence of epilepsy, estimated that a third of people with learning disabilities have epilepsy (this is at least twenty times higher than the general population), people with learning disabilities have increased rates of epilepsy that is hard to control
- Mental illness is more common amongst both adults and children with learning disabilities, for example Schizophrenia occur in approximately 3% of people with learning disabilities compared to 1% of the general population

High levels of community exclusion are reported by people with learning disabilities; a study by Emerson et al in 2008 reported that one in three people with a learning disability had reported that someone had been rude to them directly about their learning disability and one in ten had been victim of crime.

Evidence demonstrates that health and social services are not yet commissioning or providing services in a way that adequately meets the health needs of people with learning disabilities. The Disability Discrimination Act 1995 places a duty on all health and social care organisations not to discriminate against disabled people or provide them with a poorer quality of service. Organisations are obliged to make 'reasonable adjustments' to reflect the health needs of disabled people.

Severe Disabilities and Complex Health Needs

There are increasing numbers of people surviving infancy and childhood with a range of complex health needs, disabilities and learning difficulties. People with complex needs are also living into older age and require comprehensive health and social care support arrangements to meet their individual needs. Ensuring that services can meet the additional needs of people with multiple conditions is often complex, involves a range of agencies and services and can also be very costly. As increasing numbers of people live into older age with complex needs, there is a need for the whole health and social care system to plan to more effectively use resources for patient centred planning.

There is currently a gap in our understanding about how best to serve the needs of people with learning disabilities who are also living with health conditions that would be responsive to a change in lifestyle.

To find out more about support for children with disabilities, visit the Jigsaw website:
<http://www.southampton.gov.uk/living/scchildren/cwdis.aspx>

To better support people with disabilities, the key health and wellbeing needs are to:

- improve our understanding of the reasons for inequalities in health and social care outcomes for people with learning disabilities, so that people with learning disabilities have better outcomes

- implement Hampshire's Multi-Agency Safeguarding Adults Policies and Procedures protocol so that any safeguarding is appropriately and effectively managed
- reduce the risk of abuse and mental illness to children with disabilities and complex needs, their siblings and older people
- improve effective early access to mental health assessment and treatment for those who need it both in younger and older populations
- improve transition services for young people moving into adult services to ensure they have adequate and appropriate support
- improve primary care awareness and training and set up primary care learning disability registers that would enable more accurate understanding and better planning of resources to meet these needs
- ensure primary care continues to improve further in identifying people with learning disabilities and their needs, particularly where GP practices have not signed up to the Directly Enhanced Service
- ensure that information systems are capable of recording people with learning disabilities so that we have the best information to plan our services and respond to concerns
- fulfil mainstream services legal duties under the Disability Discrimination Act 1995, Disability Equality Duty and Mental Capacity Act 2005 and that they are strongly challenged to ensure that reasonable adjustments are made to services for people with learning disabilities
- find out more about the needs of people with learning disabilities who also have complex health needs, and those requiring intensive health interventions
- further develop specialist services to sustain and support people in their local community, avoiding unnecessary admission or re-admission to hospital or out of area placements
- improve the physical health of those with learning disabilities
- work across agencies to develop services which work towards older people being part of their communities
- move to the care of older people with complex needs being more consistently provided in their own homes with the residential setting being used far less frequently.
- ensure that plans are in place to meet the needs of people with learning disabilities who are aging (older adult services)
- improve secondary care awareness and training and develop care pathways for people with learning disabilities so that services better meet their needs
- ensure that work force planning is undertaken with the learning disabilities partnership board leading
- develop a 'whole system' strategy to address the needs of people who have co-morbid diagnosis of a learning disability and autism.
- ensure that changes in the levels of disability and/or learning difficulty among children and young people in Southampton are understood by service commissioners and providers

Sight Impaired (SI) and Severe Sight Impairment (SSI)

Sight impaired and severe sight impairment replace the terms partially sighted and blind for registration purposes. The GP registered population data in 2009/10 identified 875 people with severe sight impairment. This figure of 875 represents 0.33% of patients registered with a GP in the City. There were 638 registered blind people (SSI) and 730 registered partially sighted (SI) people known to the City Council on 31st March 2010, making a grand total of 1,368 people. This represents a 5.5 % increase in two years.

The cost of sight loss nationally is escalating and estimated to rise to £7.4bn by 2013. Diabetic retinopathy is the principal cause of blindness in working age people. It is clear that the number of people at risk of eye disease in an ageing society will rise sharply over the next decade. Ethnicity is a major factor in relation to eye disease. The Black population has a higher risk than the White population of developing glaucoma, cataracts and age-related macular degeneration (AMD). Asian people are at an even higher risk of developing cataracts and diabetic eye disease. Although sight is the sense most people fear losing, the national expenditure to prevent, detect and treat eye disease is a very small component of the total health care budget.

To improve visual health and reduce health inequalities and social exclusion, there is a need to:

- ensure that eye health is a public health priority and the importance of regular sight tests are promoted
- ensure that disease is detected early in all communities, especially minority ethnic groups
- increase awareness of eye health amongst children, their families and carers
- provide access to the best treatment options on the NHS
- enhance the inclusion, participation and independence of people with sight loss.

Hearing Loss and Deafness

According to the Royal National Institute for Deafness (RNID) one in seven of the population has a hearing loss and 55% of people over 60 are deaf or hard of hearing.

The number of adults registered as deaf in Southampton is 223, which gives a rate of 1.2 per capita, which is lower than England at 1.37. The number of people registered as hard of hearing is 863, a rate of 4.64 per capita and slightly higher than the 4.1 average for England. However, City Council figures suggest that the number of hearing impaired in Southampton is 1,333 as at 31st march 2010. Using Medical Research Council methodology based on prevalence by age group of an average hearing loss (in the better ear) of 35dB or greater we estimate that 19,273 people would benefit from a hearing aid in our GP registered population.

To improve hearing and reduce deafness and social exclusion there is a need to:

- secure access to a comprehensive range of services to prevent hearing loss
- improve the quality, effectiveness and efficiency of services to mitigate deafness
- increase choice for patients and ensure a better experience of care through greater responsiveness to people's needs

Getting the Best Outcomes for People Requiring Unscheduled Care

Unscheduled Care

Unscheduled care or urgent care covers unplanned care ranging from patient attendance at and Emergency Department (ED), walk-in-centres, or minor injuries units; urgent telephone advice sought in and out of hours; emergency hospital admissions; paramedic services; and emergency mental health or social care provision. The unplanned use of dental services also occurs despite many NHS Dentists in the City having patient vacancies on their practice lists.

Getting the right treatment at the right time can mean the difference between life and death, or a full recovery versus life long disability in a number of different emergency situations. The ability to triage (sort through) and resuscitate patients at the scene of an accident is a

vital determinant of outcome and the speed of transfer to an ED or major trauma centre can mean the difference between life and death.

The key factors in getting this right are:

- ensuring the public understands how to self care
- ensure the public understands where best to seek help, for example from a community pharmacy, or their GP practice for advice or treatment
- ensuring the public understands that the emergency department is for urgent and emergency use only.

In the City there is a well developed emergency care system, with a large ED, one Minor Injury Unit and a NHS Walk-in Centre, and 38 general practice and 42 pharmacy outlets across the City. Solent Healthcare hosts the out of hours GP service for the residents of the city and rural catchments in South West Hampshire. The City has a higher volume of drop in centre contacts than most areas nationally.

Major illnesses and emergencies only make up a small part of the demand for unscheduled care. Urgent care services need to provide a high quality, safe, and responsive system of care that can provide a range of entry points for patients including 24 hour access. Over the last decade there has been a steady expansion in the number and range of unscheduled care services, but this appears to have increased unscheduled care demand without improving outcomes.

There is a strong financial and clinical imperative for practice-based commissioners to prevent inappropriate patient use of urgent care services and improve primary and community care of complex patients to avoid admissions.

Each visit to a hospital Emergency Department costs around £90, regardless of whether the patient needs to be admitted. The cost of admitting an elderly patient into hospital following assessment in the Emergency Department ranges from about £1,800 to £4,000 depending on which 'complex elderly' tariff is used.

The demand for unscheduled care services continues to increase in Southampton City. This produces pressures across the health and social care system and also fails to treat people within the most appropriate setting. In 2008/09 Southampton University Hospital NHS Trust had a total of 102,612 patients through the Emergency Department (ED). In 2009/10 this figure had increased to 106,748 and for 2010/11 is forecast to be around 113,000. As a result, the ED is finding a year on year increase in activity finding it challenging to consistently admit, transfer or discharge 98% of patients within four hours. In June 2010 the coalition government relaxed this target to 95%.

A recent study carried out by the Primary Care Foundation has found that 10-30% of ED attendances were primary care in nature and could have been seen in a more appropriate setting of a GP practice. Improvement will require changes across the whole care system and society. Increasing capacity does not necessarily reduce demand – and a comprehensive needs- based assessment is required.

Pressures on the unscheduled care services come from a variety of sources and may be short burst, for example following a spell of cold weather, or more sustained as occurred during the 2009 H1N1 influenza pandemic. The pandemic put pressure on primary, community care and hospital intensive care services.

Causes of emergency admission vary, and the "top ten" local causes are listed in Table 2.2 below.

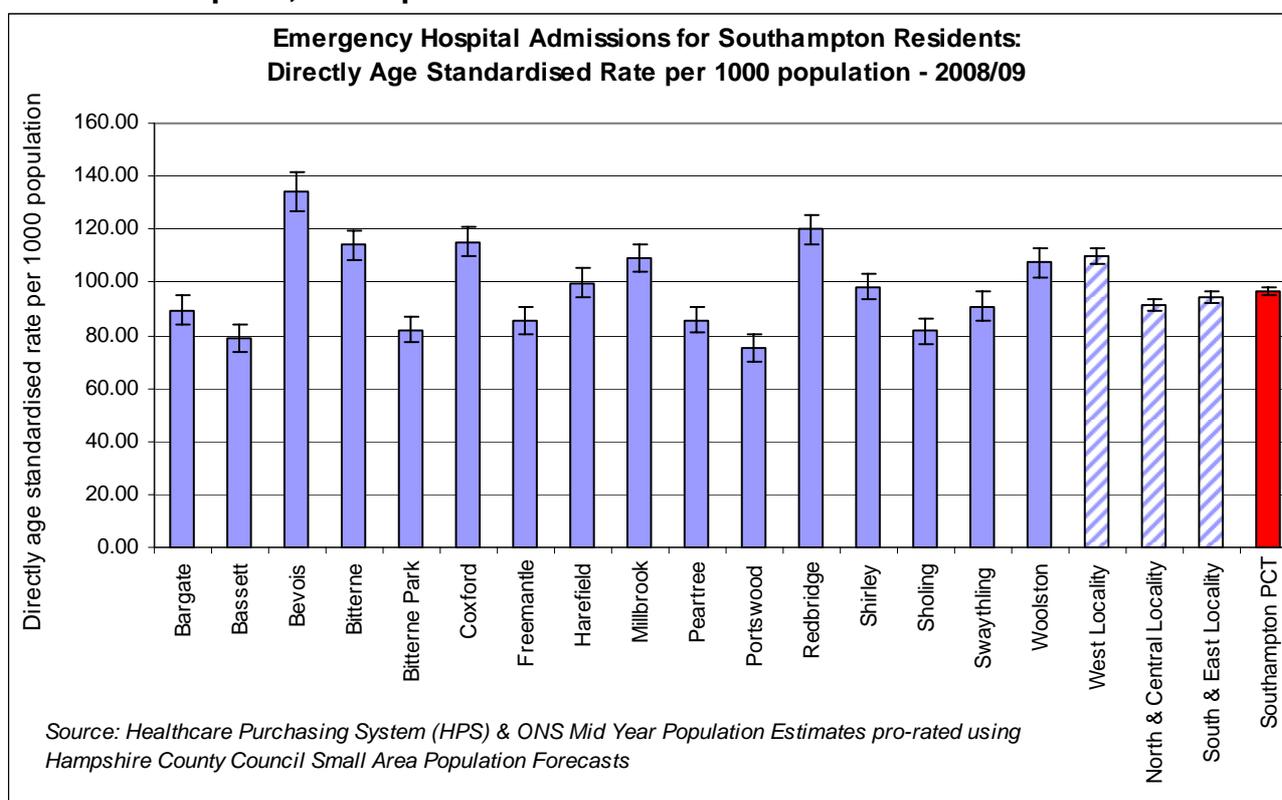
Table 2.2 below illustrates the most common causes of emergency admission (adults and children), which are diverse, spanning urinary and chest infections, cardiovascular diseases, falls and undiagnosed abdominal pains. Viral infections in 2009 will have included some cases of H1N1 influenza.

Table 2.2 Emergency admissions with primary diagnosis 2009/10 Southampton City

Emergency Admissions with Primary Diagnosis 2009-10 (Southampton City PCT)			
Primary Diagnostic Code	Primary Diagnosis Description	Admissions	Rank
N390	Urinary tract infection, site not specified	570	1
R074	Chest pain, unspecified	562	2
R104	Other and unspecified abdominal pain	510	3
J22X	Unspecified acute lower respiratory infection	445	4
B349	Viral infection, unspecified	419	5
R55X	Syncope and collapse	408	6
K529	Non-infective gastroenteritis and colitis, unspecified	402	7
R073	Other chest pain	358	8
J181	Lobar pneumonia, unspecified	335	9
R103	Pain localized to other parts of lower abdomen	330	10

Emergency admissions across Southampton for 2008/09 can be seen in Figure 2.6 by locality and ward. Priority neighbourhoods, proximity to the Emergency Department at SUHT and to some extent different health seeking behaviours are possibly reflected.

Figure 2.6 Emergency Hospital Admissions for Southampton Residents' Age Standardised per 1,000 Population



Emergency Paediatrics

The average cost of an admission to the Paediatric Assessment Unit (PAU) is £807 irrespective of length of stay (LOS). In 2009/10, 80% of admissions had a LOS below 24hrs and 36% less than 4 hours. An audit of admissions with a LOS below 24 hours in May 2009 suggested that up to half of the cases referred to PAU by GPs and WICs could have been successfully managed within the community. Reducing this unnecessary use of a specialist emergency service would save resources, improve capacity and potentially save lives of those who do require specialist emergency care.

It would be unrealistic to suggest cutting admissions by this proportion, but it would not appear to be unduly optimistic to believe that with ongoing education and training, numbers of unnecessary admissions can be reduced.

To find out more see the Southampton City PCT website:

www.southamptonhealth.nhs.uk/ourservices/walkincentre

To ensure the optimal patient care is provided, and people are able to utilise the right services at the right time, there is a need to:

- reduce avoidable attendances to the ED by decreasing excessive alcohol consumption and alcohol related violence
- reduce the number of ED attendances that could be seen more appropriately in another part of the system e.g. by improving public education and developing a single point of contact for out of hours services, integrate care between primary care services, secondary care services and social services
- increase the number of people who are able to see their GP within 48 hours by working with practices to improve access
- reduce admissions from people with long term conditions through the development of evidence based disease management programmes and care pathways. This will include the better use of anticipatory care plans and the complex care teams, which are focusing on identifying and working with those individuals most at risk of hospital admission
- identify and provide better integrated care and support for people who are at high risk of admission or re-admission to hospital
- ensure there is the right mix of services with adequate capacity across the care system to meet need whilst getting rid of duplication and inefficiency
- promote better use of community pharmacies and self-care
- ensure adequate communication and joint working between all partners to improve the delivery and development of services.
- make planned GP appointments more accessible to prevent people having to use (or defaulting to) unscheduled care
- improve access to urgent diagnostics in primary care (e.g. X-Rays, ultrasound, CT scans) which is often unscheduled and hence defaults to the ED
- be sensitive to people with special needs and cultural differences
- expand the contribution of pharmacies in responding to unscheduled care needs
- ensure there is a GP registration point at every place where people receive primary care to improve GP registration
- make the unscheduled care system cohesive, with services working more effectively together to integrate care
- make the system of more simple to use e.g. a single point of access with a New 111 telephone point
- ensure proactive work to roll out asthma pilot across the City and strengthen links

with emergency department and out of hours

- carry out targeted work with high referrers, general awareness raising through tutorials, promotion of advice line and urgent outpatients clinic
- establish health programme campaigns in Sure Start children's centres focussing on managing childhood illnesses
- complete an impact assessment of the urgent outpatients clinic and consultant telephone advice line.

References

A Brighter Future in Later years, Southampton's vision for 2014. (2010) Southampton City Council and NHS Southampton

Branford D, Bhaumik S, Duncan F. Epilepsy in adults with learning disabilities. *Seizure*. 1998; (7):473-7.

Carson D, Clay H, Stern R. Primary Care and Emergency Departments. Report from the Primary Care Foundation, March 2010

Cooke LB. Cancer and learning disability. *Journal of Intellectual Disability Research*. 1997; 41(4):312-316.

Department of Health (2010) Long Term Conditions Gateway reference Number 13921

Department of Health (2009) New Horizons: A shared vision for Mental Health

Department of Health (2010) Consultation on a Strategy for Services Chronic Obstructive Pulmonary Disease (COPD) England

Department of Health (2010) Health Service Guidance HSG(97)31 Priority treatment for war pensioners, NHS Executive re-issued February 2010

Doody GA, et al. 'P'ropschizophrenie' revisited. *Schizophrenia in people with mild learning disability*. *British Journal of Psychiatry*. 1998; 173(2): 145-153.

Emerson E, Hatton C (May 2008) People with Learning Disabilities in England. Centre for Disability Research. Report 2008:1.

Hollins S, Attard MT, von Fraunhofer N, Sedgwick P. Mortality in people with learning disability: risks, causes, and death certification findings in London. *Developmental Medicine & Child Neurology*. 1998; (40): 50-6

National Audit Office, (2010) Progress in Improving Stoke Care.

NICE Technology Appraisal 161, October 2008.

National Osteoporosis Guideline Group. Osteoporosis: Clinical guidelines for prevention and treatment. Executive summary.2008

Neurological Numbers: a brief review of the numbers of people in the UK with a neurological condition. Published by the Neurological Alliance in April 2003.

Royal National Institute of Blind People (2009) Campaign report 29: Cost oversight? RNIB, London

Royal National Institute of Blind People (2009) UK Vision Strategy 2009-2014 RNIB, London

Royal National Institute for Deaf People NHS Hearing Aid Services Commissioning Guidelines- accessed 1 June 2010

http://www.rnid.org.uk/VirtualContent/91875/2696_Care_Trusts.pdf

Service Personnel and Veterans Agency: www.veterans-uk.com

Tel: 0800 169 2277

Sir Jonathan Michael. Healthcare for All; Report of the independent inquiry into access to healthcare for people with learning disabilities. July 2008

Please refer to the questions at the end of this document - the deadline for feedback is Friday 29 October 2010

<http://www.southamptonhealth.nhs.uk/jsnaconsultation>

SECTION 3 - A HEALTHY START TO LIFE: CHILDREN AND YOUNG PEOPLE

Focusing Strategic Priorities for Children and Young People in the City

Southampton's 2009-12 Children and Young People's Plan was agreed by the Children and Young People's Trust Board in 2009. It identifies priorities for services providing or planning services for children, young people and families for 2009-12. The plan is based on a thorough assessment of needs based on the outcomes achieved, consultation feedback and performance against national or local standards and expectations.

The plan identified ten priorities, grouped according to the five key outcome areas set out in the national "Every Child Matters" framework. The Children and Young People Plan sets out how local agencies will work together to improve outcomes and services for all children and young people, whilst also narrowing the gap between those who do well, and those who do least well..

To find out more see the Southampton Children and Young People's Plan 2009-12 see the following link

http://www.youngsouthampton.org/images/CYPP%202009-12_tcm21-235847.pdf

To find out about our review of the first year of the 2009-12 CYPP see the following link

http://www.youngsouthampton.org/images/CYPP%202009-12%20Review%20DRAFT_tcm21-257104.pdf

Giving Every Child and Young Person the Opportunity to enjoy a Healthy Start in Life and Support in Making Healthy Lifestyle Choices.

Low Birth Weight

Low birth weight among infants is strongly linked to poorer outcomes for children as they get older. There has been a fall in the percentage of live births classified as 'low birth weight' (below 1500grams) from 7.1% in 2004/05 to 6.4% 2009/10.

The decline in low birth weight has been more rapid in those parts of the city with the highest levels of economic deprivation where case-loading midwifery teams are based. The rate has declined significantly in these areas from 9.0% to 6.9% over the same period and a narrowing of the gap compared to the rest of the city from 2.8 percentage points to 0.8 percentage points. In 2008, Southampton rate was lower at 6.8% compared to the national average of 7.5% and was the 4th lowest rate out of our 10 statistical neighbours. This indicates that current provision is successfully reducing this problem.

Levels of Caesarean vs. Normal Births

Variations in the level of caesarean births relate more to the effective use of resources than need. The proportion of total births that were normal deliveries in 2009/10 was 62.3%. The proportion that were caesarean section was 20.4%, this has remained relatively stable over the past 6 years, in 2004/05 the rate was 20.5%. To ensure good use of resources there is a drive to reduce unnecessarily high levels of caesarean assisted deliveries.

The percentage of normal births is significantly higher in most deprived areas with case-loading midwifery teams compared to the rest of the City – this is a consistent trend over time. Caesarean birth rates are significantly lower within the most deprived areas compared to the rest of the City.

Breastfeeding Initiation and Maintenance

Year on year there has been a steady increase in the number of mothers initiating breastfeeding from 69.9% in 2003/04 to 76.3% in 2008/09 with the greatest success in the areas of deprivation, leading to a significant reduction in the health inequalities gap. However the rate declined for the first time in five years, to 75.1%, in 2009/10. There are differences between different ethnic communities, and “White British” mothers’ breastfeeding rates are significantly lower than the City average. The challenge is now to maintain breastfeeding after the neonatal period so that more women continue to breastfeed at 6-8 weeks and beyond.

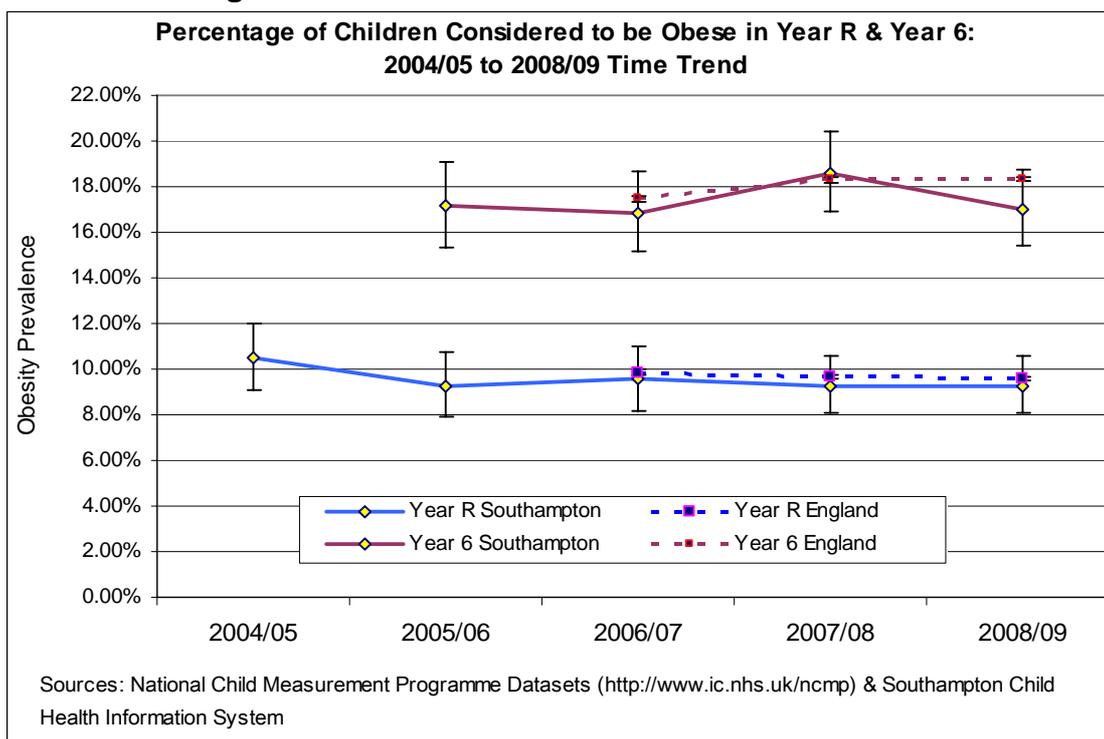
Smoking During Pregnancy

Smoking during pregnancy is strongly associated with a number of health problems for new born children. Southampton has a relatively high rate of smoking among the general population, though there is evidence to suggest that the numbers of mothers smoking at midwifery booking has reduced a little from 20.3% in 2008/09 to 19.6% in 2009/10. However the percentage of mother smoking at 10 – 14 days after the birth of their child has increased from 19.2% to 22.3% over the same period. There are differences between different ethnic communities, and “White British” mothers’ smoking rates are significantly higher than the City average. In 2009/10, 10.2% of mothers who smoked at the time of midwifery booking had a low birth weight baby; this is significantly higher than 3.8% of births to non smoking mothers. Low birth weight often results in more intensive medical care, higher morbidity and delayed development in childhood.

Childhood Obesity

Obesity in childhood is closely linked to obesity in adulthood and a wide range of poor long term physical and mental health outcomes related to poor diet and low levels of physical activity. According to a Citywide survey during the Autumn of 2009, 11% of children in reception classes are overweight and a further 9% obese; this increases to almost 13% overweight by year 6 with 17% obese (i.e. 30% above normal weight). The prevalence of obesity for Year 6 children has reduced from 18.62% in 2007-08 to 17.03% in 2008-09, but has not reached the target of 16.51% set in the Local Area Agreement.

Figure 3.1 - Percentage of Children Considered Obese in Year R and Year 6



The Government's target is to reduce the levels of obesity in these children to level of the year 2000 nationally and local targets have been established that determine the rate of improvement needed to achieve this. The local data above shows that the confidence intervals for year R remain stable, but for year 6 this fluctuates. The obesity gap needs to be narrowed downwards. The Fit for Life strategy is providing the framework to reduce levels of obesity.

Health Education and Exercise

The link between lack of physical activity and poor health outcomes is well documented. 2008-10 has seen a significant increase in the percentage of schools achieving and maintaining the Healthy Schools Standards. The majority (90%) of children and young people participate in 2 hours of high-quality PE and sport a week, and all Southampton schools have travel plans that encourage and promote active travel to and from school, which are increasing the percentage of children not travelling to school by car. Plans to extend the measurement from 2 hours of PE and Sport within the curriculum to include an additional 3 hours of physical activity accessed through extended school and community provision are in progress.

To provide a healthy start to life for more of the city's children and young people, there is a need to:

- increase the number of pregnant women accessing ante-natal care before the end of the twelfth completed week of pregnancy (12 weeks and 6 days)
- provide better choice for mothers-to-be over their place of birth, including: at home, at a stand alone birthing centre, a collocated birth centre or a labour ward
- normalise birth and reduce intervention rates and caesarean births
- develop clearer pathways for low risk groups, vulnerable groups and women with complex pregnancies and capacity to deliver the care they need
- reduce the proportion of low birth weight babies, and increase the proportion of babies still breastfeeding at six to eight weeks
- work with all pre-schools, schools, parents/carers and others services to improve the diet and activity levels of children and young people and reduce obesity
- increase the proportion of children, young people and parents who adopt healthier lifestyles and relationships
- ensure the physical environment in local areas helps to promote walking, cycling and safe local recreation and play
- provide effective early support for families in difficulty

Sexual Health

The process of sexual health service re-design began in September 2008 with the undertaking of a sexual health needs assessment, which was completed in December 2008. This assessment showed that services should be open on more days and provide more user friendly venues. Between January-March 2009 the newly formed Sexual Health Strategy Group developed a vision and described a new model of provision within the Sexual Health Commissioning Strategy 2009-11.

The Sexual Health Commissioning Strategy established the following priority areas of work, responding to clearly expressed needs of the public (over 1,600 service users and members of the public) through:

- the integration of specialist sexual health service provision through a centralised hub and through community spokes in each locality
- extension of young people-focussed services through enhanced outreach, including school and college-based services
- improving evening and weekend access to services
- providing increased choice for patient access and improved public information
- delivering national service targets and required quality metrics including;
 - chlamydia screening target for screening young people aged 15-24 years old
 - maintaining 48 hour access to Genito Urinary Medicine (GUM) provision
 - increasing uptake of Long-Acting Reversible Contraception (LARC) amongst women of all ages and especially young people
 - improving rate of first attendances by young people under 20 to sexual health services
 - improving proportion of terminations delivered under 10week's gestation
 - stabilising new HIV diagnoses
 - developing the capacity of primary care to provide enhanced sexual health services and core sexual health provision.

A copy of the SHNA is available online at: <http://www.protectyourself.nhs.uk/>

Chlamydia Screening

The Chlamydia screening target for 15-24 year olds is 17%; in 2008/09 Southampton screened 13.9% of this age group. Southampton ranked 107th (out of 152 PCTs) across England and the lowest amongst its ONS peers for uptake of Chlamydia screening.

To support young people's access to tailored contraception and sexual health provision and effective Sex & Relationships Education, there is a need to:

- deliver sexual health service re-design so that services:
 - are open on more days
 - offer longer opening hours, including weekends and evenings
 - have reduced waiting times
 - are provided from venues which are easy to find and convenient to access
- engage more men in local community sexual health services through integration with GUM
- improve access to particular neighbourhoods with low service access to contraception and sexual health (CASH) clinic
- engage Black, Minority and Ethnic (BME) communities.
- increase choice and reduce stigma associated with accessing sexual health services
- make services young people friendly through meeting the 'you're welcome quality criteria'
- improve access to the Unplanned Pregnancy Services
- improve access to emergency contraception
- increase access to GUM in the community
- increase uptake of Chlamydia Screening amongst young people aged 15-24 years of age
- increase uptake of Long-Acting Reversible Contraception
- stabilise Sexually Transmitted Infection (STI) rates.
- extend and performance managing contracted services for school and college site access to contraception and sexual health service provision for young people
- deliver the re-design of community-based integrated NHS Sexual Health services through 2010 and beyond

- extend and performance managing contracted services to support schools in the delivery of Sex and Relationships Education
- develop social marketing approaches to support young people's expressed needs surrounding their information, motivation or behavioural skills.

Teenage Pregnancy

Southampton's 2008 under 18 conception rate was 51.4 per 1,000 females aged 15-17 years old. This equates to approximately 5.1% of the under 18 female population conceiving within 2008 (197 young women). Whilst this rate remains significantly higher than the England and South East average it is important to note that the rate of reduction since 1998 remains better than the equivalent rate of improvement nationally and regionally (15.5% compared with 13% respectively). Within Southampton only Bargate ward has an under 18 conception rate that is significantly higher than the City average. Over the 2005-07 period there were 115 conceptions amongst girls aged less than 16.

Analysis looking across 3 years demonstrates that Southampton is maintaining an overall downward trend with a reduction in rates from 2006-2008 of 8.9% compared with 9.1% for England and 9.7% reduction for the South East in the same time period. This rate of reduction needs further accelerating.

The slight increase in conception rates between 2007 and 2008 is matched by an increase in the proportion of conceptions leading to abortion (a rise from 32% to 43% between 2007-2008). The latter is important in demonstrating that many of these conceptions were both unplanned and unwanted, and therefore might have been prevented through effective Sex and Relationships Education support and access to contraception and sexual health provision.

Eight of the City's 16 wards are within the highest 20% nationally (conception rate above 53.3 per 1,000, the City average is 55.8 per 1,000) and all but two wards are above the England average (40.4 per 1,000). Southampton's under 16 conception rate remains significantly higher than national and regional comparators (10.3 per 1,000 compared with 7.9 England average).

Secondary outcomes for teenage mothers under the age of 19 are monitored closely, and experience fluctuation given the small numbers of parents involved. However, there appear to be early signs of improvements in:

- breastfeeding rates
- smoking rates
- previous live births

These improvements must be maintained to impact upon not only the mother's health outcomes but those of her child.

To support teenage mothers and young fathers to achieve better health and social outcomes, reducing cyclical teenage pregnancy, there is a need to:

- embed the Family Nurse Partnership Programme, an evidence-based programme supporting first time teenage parents, throughout the ante-natal period until their child is aged 2 years
- implement recommendations from the Health and Family Support Commissioning Review to ensure equitable access to targeted ante-natal and post-natal provision for teenage parents under 19 within core health and family support services

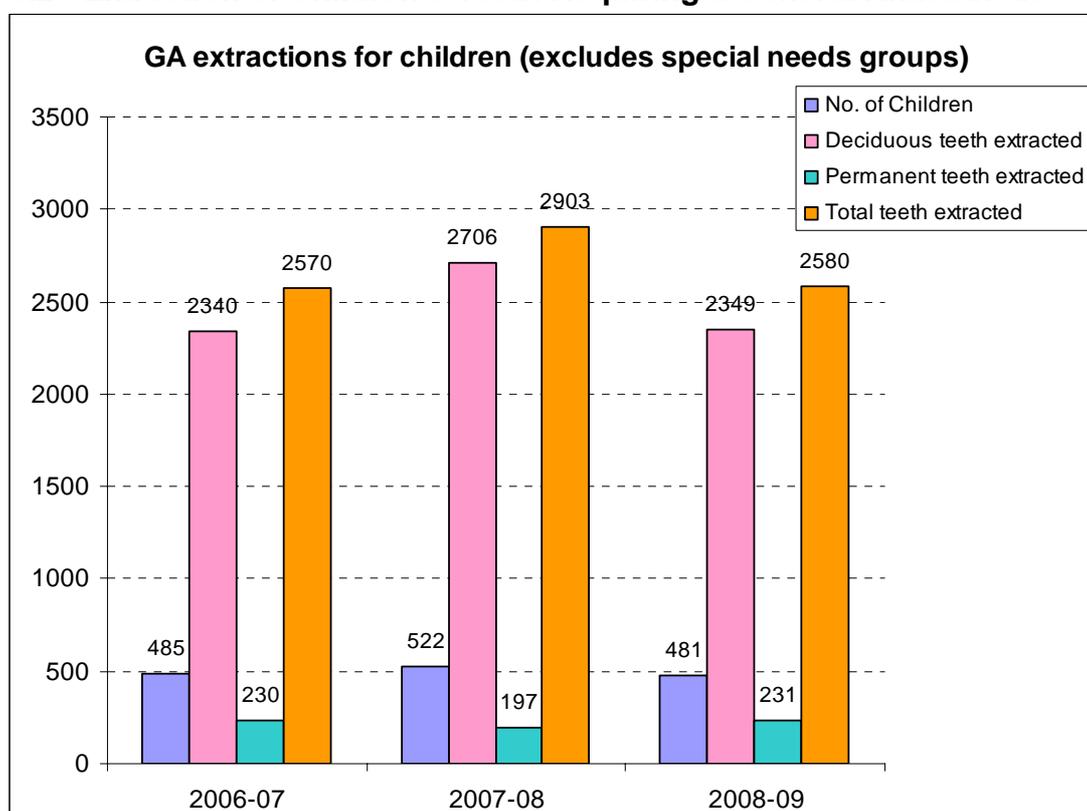
- sustain a focus on teenage parents learning through dedicated and tailored provision from 14-16, 16-19 years and beyond
- support the Parenting Strategy to identify and work with those parents who need most support.

Child Dental/Oral Health

Dental health has been shown to be important in relation to other outcomes for children. Dental decay is a largely preventable disease and prevention would help ensure that children get the best start in life and facilitate the most effective use of NHS resources. Rates of children's dental health are poor compared to other areas in the country. In the 2006 dental survey of 5 year olds, 42% of over 2000 Southampton children surveyed had decayed, missing or filled teeth (dmft) compared to 38% in England. There has been a significant change since 2006 in the way that dental surveys are conducted. Previously, a process of negative consent was used where children could be examined as long as the parent or guardian did not specifically object. Positive consent is now required so any child who does not return a consent form signed by a parent or guardian cannot be examined. In the most recent survey of 5-yr-olds in 2007, many children across the country, including Southampton, who were known to have high levels of dental decay did not return a signed consent form, thereby excluding them from the survey. The information collected locally and nationally was therefore unrepresentative of the population. This highlights the need for a better consent process to enable the collection of useful information.

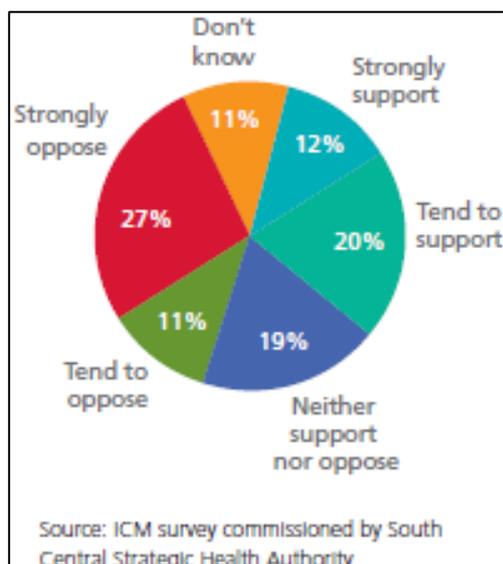
Another more consistent indicator of children's dental health over the last few years is the number of children requiring dental extractions under a general anaesthetic (GA), see Figure 3.2. This has not changed, indicating that there has been no reduction in severe dental caries in the City's children.

Figure 3.2 - Extraction of Children's Teeth Requiring a General Anaesthetic



Oral health promotion programmes (OHP) have achieved small behavioural improvements at local level but no oral health improvement at population level. A water fluoridation scheme proposed by Southampton was supported unanimously by the SHA Board after a public consultation. The consultation included an independently-commissioned telephone survey of a random sample of patients to assess the level of support for the scheme. The results are shown below.

Figure 3.3 Level of Support for Fluoridisation in a Random Telephone Sample of Residents



Chief Medical Office (CMO) Report 2009

A new care pathway for orthodontics is being piloted. An interim evaluation at 12 months has indicated reductions in waiting times in primary and secondary care and some redistribution of cases from secondary to primary care which is encouraging. More orthodontic care has been commissioned to ensure that future need will be met.

To improve oral health there is a need to:

- improve oral health and reduce inequalities, particularly for younger children
- agree a consent process to enable the collection of good quality information on children's dental health to monitor oral health improvement and inform the commissioning of services
- continue the targeted OHP programme in schools and nurseries with emphasis on increasing the availability of fluoride through supervised tooth brushing programmes and topical fluoride varnish applications
- continue with the orthodontic care pathway pilot to ensure that the pathway works efficiently in maintaining waiting times, even with the additional activity in place.

Misuse of Tobacco, Alcohol and Other Substances by Young People

In the 2009 Tellus4 survey young people's substance misuse needs assessment young people in Southampton self-reported drug and alcohol use above that of their counterparts nationally (10.7% of school-age young people compared with 9.8% nationally). Young people in Southampton are demonstrating problematic substance use at age 15 and until 2009/10 too few young people had received support through young people's substance misuse treatment services. Alcohol specific admissions to ED for under 18s in Southampton are the highest in the region and amongst our statistical neighbours. The Health Related Behaviour Questionnaire reports 9% of Year 6 students and 30% of Year 10 students drinking alcohol in the last 7 days.

Modelling has found that key groups of vulnerable young people who typically demonstrate higher levels of risk-taking behaviour are under-represented in treatment services e.g. (young offenders, children looked after, young people with emotional and mental health issues, young people not attending school). Details of the modelling used to show this from the strategic needs assessment will be added to the Data Compendium. Consultation with providers and service users found that services working with these young people lack the skills to be able to identify, assess and screen young people around their substance misuse. Partnership working to effectively support young people needs further development.

Emotional Well-Being

Emotional well-being is important in minimising the risk of children and young people making poor choices in relation to their long term well-being. The percentage of children who enjoy good relationships with their family and friends in Southampton is lower than national average (53% compared to 56%) and below all of our statistical neighbours. The emotional well-being of children in care is also lower than the national average (as calculated through the strengths and difficulties questionnaire). The assessment of the effectiveness of local Children and Adolescent Mental Health Services (CAMHS) resulted in them achieving the maximum score (based on having a full range of services, age appropriate provision, 24 hour care and full range of early intervention support).

Injuries and Accidents

Rates of emergency hospital admissions caused by injuries to children and young people are higher in Southampton than nationally. In 2009 the rate was 151.2 per 10,000 compared to 134.8 per 10,000 in comparable cities and 117.4 per 10,000 in England. However, between 2006 and in 2007 the child road casualty rate was lower for the City than nationally or in its peer authorities.

To provide a healthy start to life for more of the City's children and young people there is a need to:

- reduce levels of teenage pregnancies to levels more comparable with national and similar areas
- reduce the damage caused by alcohol, smoking and other substance misuse to children and young people
- raise public and service providers' awareness of young people's substance misuse services and the levels of alcohol and other substance misuse in Southampton
- review and evaluate current care pathways, to clarify the role and level of service expected from practitioners at all tiers within key services e.g. CAMHS and YOT, and to implement a standardised substance misuse screening tool for professionals working in targeted (tier 2) services
- Improve the ability of ED departments to make direct referrals of young people to appropriate support services

Support, Challenge and Empowerment for Parents and Carers

The majority of children and young people who enjoy good outcomes do so without the support of major targeted or specialist support services, but through the care or their parents or other carers as part of family life. For many of those children who are at risk of poor outcomes, targeted and specialist services find that parents and carers are less able to provide children and young people with the support, guidance, challenge and resilience that they need to enjoy good outcomes.

Whilst there is a strong correlation between socio-economic status and education and parenting skills, the situations which place challenges upon parents are complex and varied. Closer working between professionals in different services has confirmed the importance of the role that services can play in building the capacity of families to develop and make better use of their own resources to overcome the challenges that make them vulnerable to poor health and well-being outcomes. The effectiveness of a variety of programmes, from Sure Start Children's Centres to intensive child protection services has confirmed the need to help parents and carers to recognise and address the contribution that they make to their children's health and well-being.

In terms of meeting statutory demands upon local services, Children and Young People's Plans will be required from April 2011 to set out the arrangements made by Board partners for cooperating to coordinate services for children and young people and adults within their family, driving forward the Think Family agenda across the Children's Trust. This change will require those responsible for commissioning parenting and family support services to secure a coordinated approach, particularly for families at risk. Key components, apart from the relationships with a wide range of services and partners, will include:

- a culture of early intervention within all services that work with children, parents and families
- assessment, particularly the Common Assessment Framework, to enable appropriate targeted support
- safeguarding
- coordinated adult and children's services

In addition to the general drive, it has been recognised that capacity building within families through work with parents often involves overcoming an inter-generational cycle of parental capacity problems. However, it is also being recognised that there are other groups of parents who have particular needs for support in helping their children to achieve good outcomes. This includes groups such as parents with disabilities and/or learning difficulties, chronic illness and people caring for children who are not their own.

To ensure support for parents and carers in helping children and young people to enjoy good outcomes there is a need to:

- continue to improve access to evidence based programmes to enable parents to develop the skills, knowledge and confidence to parent their children effectively
- continue to develop and improve the current provision of individual and family support to enable parents to access appropriate information, advice and guidance and to receive timely assessment and referral to the support needed
- continue to review and improve relevant services and systems to reflect the changing needs of families.

Safeguarding Local Children and Young People from Abuse and Neglect

Keeping Children and Young People Safe from Abuse, Domestic Violence, Bullying and Harassment.

Thresholds and referral processes have been thoroughly reviewed and improved to ensure that more referrals are appropriate and that timely interventions are made. However, this is still indicating that the levels of children and young people who are subject to safeguarding support either as children in need, children and young people in care, or subject to a Child Protection Plan have risen sharply since 2008, more quickly than either nationally or among most comparable areas, and are much higher than comparable areas. Numbers of Child Protection Investigations (Section 47 enquiries) have risen from a baseline of 30 per month in September 2008 to 80 per month in May 2010, with an average level per month of just

under 82 over the six months December 2009 to May 2010. Over the same period the level of children and young people on Child Protection Plans has risen from 24.9 per 10,000 (106 children) to 41.3 per 10,000 (176 children). Levels of reported bullying at school have declined from 51% in 2007/8 to 29.4% in 2009/10 according to the Tellus4 survey of Southampton school children. In relation to racially motivated harassment of children and young people at Southampton schools, there has also been an improvement from 209 reported incidents in schools in 2007-8 to 155 in the academic year 2008-9, though there has been a reported increase of 33% in Special Schools over the same period.

Children and Young People at Risk of Abuse and/or Neglect

Safeguarding social care services exist to support children, young people and families where there is significant reason to believe that children and young people will come to harm if they are left unsupported in their family. There has been an increase over the last two years in the number of referrals requiring assessment by social workers of children and young people at risk of abuse or neglect. There were 1,645 referrals received in 2006/7. This rose to 2,582 in 2008/9. There have also been significant increases in the number of children and young people whose care needs have required that they be taken into care. Increases in both risk of abuse and neglect and numbers of children and young people in care have risen faster than has been the case nationally or for similar authorities.

Child Protection Plan Levels

The numbers of children supported by Child Protection Plans is a measure of levels of extreme need within families for support that can keep a child safe from day to day. The numbers of child protection investigations has more than trebled since September 2008. Consequently, the number of children with a Child Protection Plan (CP) has increased from 24.9 per 10,000 children in September 2008 to 44.6 per 10,000 children in February 2010. As at 31st March 2009, the rate of children subject to CP plans per 10,000 children was 36.5 for our Statistical Neighbour group and 31 for the country as a whole. We have delivered training around early identification of physical indicators of abuse so that hospital and community health frontline staff are better able to identify children at risk of abuse. The impact of this upon previously unmet need may account for some of the apparent sharp rise in need.

Domestic Violence affecting Children and Young People

Domestic violence (DV) is known to profoundly affect the life chances of many of those young people affected by it, though it is also suspected as being often unreported, meaning that the full impact on the well-being of local people is underestimated. Continued progress has been achieved in the year on putting in place support services that identify children and young people at risk of domestic violence. The number of referrals has increased, indicating greater confidence in the support on offer for those that seek help. Hospital and community health services have reviewed their assessment and recording processes to ensure that parents are routinely asked about these issues. In under a year Children's Services have recorded an increase (from 29% to 41%) of children affected by DV. The continuing variance between estimated and known levels of domestic violence and its impact on outcomes means that the continued development of services to identify those children and young people most affected by it continues to be an area of specific focus for 2010-11.

Bullying

Bullying has a strong effect on the mental health of those bullied, and can often damage their outcomes in other areas of life. The percentage of children and young people reporting bullying has reduced from 51% in 2007-08 to 29.4% in 2009-10. Whilst this leaves Southampton just above the national average it represents a significant change in one year, and does compare favourably with the City's statistical neighbours. Anti-bullying

coordinators working in schools to promote good practice and enable closer working together to address the issue have dealt with 115 referrals of bullying incidents involving 88 children and young people. Alongside the decline in reported levels of bullying there has been a reduction of 59% in exclusions from Southampton schools for bullying compared to the previous year. This means there has been only 17 exclusions for bullying compared to 42 in the academic year 2008-9. This is evidence that current provision is having a positive impact on this longstanding issue for children and young people.

Hidden Harm – Alcohol and Drug use within Families

There is well established evidence that children and young people in families where there are problem levels of alcohol and/or drug use suffer poorer outcomes than their peers in families without these problems. As with domestic violence, it is suspected that true levels are higher than reported, and current needs have therefore focussed upon improving the understanding of staff working with children, young people, parents and carers of the impact of 'hidden harms' of alcohol and drug use on children and young people living in families of problematic drug/alcohol users through the launch of a new protocol and training. Ensuring joint working and improving agency responses to families exposed to 'hidden harms' continues to be an area of focus for 2010-11.

To provide confidence that children and young people are safer from abuse, neglect or other harm there is a need to:

- ensure that the needs of children and young people at risk of abuse or neglect are appropriately identified, assessed and met through effective and timely referral and assessment processes
- ensure that child protection practice acts as an effective and timely source of protection for children and young people, and that preventative services reduce the number of families who need to be subject to a Child Protection Plan
- increase understanding of the impact of domestic violence on children and developing services for 'medium risk' cases and children exposed to domestic violence
- work with children and young people, providing accessible support, help and advice to those who have been exposed to domestic violence, increasing safety and helping them to learn the skills to develop healthy future relationships.
- continue to work with schools and others to sustain and further improve on reported levels of bullying
- ensure effective joint working and agency responses to families exposed to 'hidden harm' (domestic violence, substance misuse and alcohol)

Groups of Children and Young People who often Suffer Poor Outcomes

Children and Young People in Care

Compared to other groups, children and young people who have been in care generally achieve poor outcomes and many will have suffered significantly disruptive home lives. Outcomes for this group of children and young people in Southampton are mixed compared to other areas, although, as with other places, this group remains one of the most vulnerable to poor outcomes.

In Southampton there have been improvements in both the short and long term stability of care placements for children and young people in care. The percentage of children whose placement broke down more than three times in a year improved from 12% in 2008-9 to 6.8% in 2009/10. Long term stability has also improved from 74% of children remaining in the same placement for two years or over in 2008/09 to 76%. Targeted and specialist support will continue to be an area of focus for those agencies who are corporate parents

on behalf of the community for these children, who represent one of the most vulnerable groups. This will cover monitoring their health checks, educational attainment and progress, attendance, offending, accommodation and economic participation.

The proportion of care leavers who are not in education, employment and training has also reduced from 63.2 in 2007-08 to 48 in 2009-10 (quarter 4 data). There has also been a fall in the percentage of care leavers in suitable accommodation. Reported levels have dropped from 85% in 2008/9 to 61% in 2009/10, though this includes some young people who are not maintaining contact with the Pathways Team, and who may be in suitable accommodation.

Wherever possible it will also mean working to ensure ongoing participation of children, young people and their families in the planning, development and monitoring of services. All plans agreed at Family Group Conferences have been approved by the local authority. The majority (84%) of family members who provided feedback said that the plans agreed had been 'excellent' or 'good'. High numbers of children, young people (99%) and their parents continue to participate directly in looked after children reviews through attendance at the review meeting or giving their views separately.

Children and Young People with Complex Health Needs and Disabilities

There has been a greater focus on user and carer participation in services for disabled children, in particular through the Aiming High project and individual services feedback loops. 2009-10 saw the publication of a new measure of service feedback from the parents of children with disabilities and complex health needs (NI 54). The indicator covers satisfaction with health, social care and education services. Whilst overall satisfaction levels for Southampton were in line with national and statistical neighbours more work is needed to help identify areas where parents are telling us the services that they most need to improve.

To provide confidence that the care and support needs of the City's most vulnerable children and young people are being met, there is a need to:

- ensure that the care and support needs of children, young people and families receiving specialist services are well understood by other providers of services to them
- ensure that children and young people in care and their families' views and preferences are understood by those working with them and taken into account in reviewing and providing care to them
- ensure that children and young people with disabilities and complex health needs are understood by those working with them and taken into account in reviewing and providing care to them

Ensuring that Children and Young People Attend School, Achieve Well in Their Learning and Enjoy Growing Up in Southampton

Engagement, Enjoyment and Achievement at School.

Attainment at Age 5 – End of Foundation Stage

The percentage of 5 year old pupils achieving 6+ points in Personal, Social and Emotional Development and Communication, Language and Literacy as well as achieving 78 points across all assessment scales has increased from 41.8% in 2008 to 47.9% in 2009. The long-term trend is also very positive with a 15.3% increase from 32.6% in 2006 to 47.9% in 2009 and the gap between Southampton and the national average closed from 12% in 2006 to 4% 2009.

Attainment at Age 7 – End of Key Stage 1 (KS1)

The percentage of 7 year old pupils (end of Key Stage 1) achieving Level 2+ in reading (82.0%), writing (78.0%) and maths (88.6%) increased in 2009 by 1.9%, 2.9% and 0.2% respectively from 2008.

Attainment at Age 11 – End of Key Stage 2 (KS2)

Attainment of 11 year olds at Key Stage 2 remains relatively weak in Southampton compared to the progress being made on other educational attainment indicators. The City's schools compare poorly in terms of Level 4 attainment in English and maths, and in relation to progress in English and progress in maths between Key Stage 1 and Key Stage 2. Improving primary school attainment continues to be an area of specific focus for both schools and the local authority for 2010-11.

GCSE Attainment at Age 16 – End of Key Stage 4 (KS4)

Attainment at GCSE and equivalent 5+ A*-C including English and Maths (end of Key Stage 4) has continued to improve for Southampton pupils in recent years. In 2009 43.1% pupils achieved 5+ A*-C including English and Maths, which represents a 0.8% improvement from 2008 (42.3%). Since 2005 (34.6%) there has been an 8.5% increase to 43.1% in 2009. Standards at Key Stage 4 will continue to be an area of focus for 2010-11.

Closing the Attainment Gap

There has been generally good progress in closing the gap between children who do well and those vulnerable to poor outcomes, particularly at the GCSE (end of Key Stage 4) point marking the end of pupils' statutory education (the gap in 2009 was 22%, a reduction from 2008 of 0.5%). The attainment gap has been closed at KS2 and KS4 for children entitled to free school meals between 2007 and 2009 (the gap in 2009 was 23%, a reduction from 2008 of 1.6%). Children in priority neighbourhoods improved their attainment in GCSE performance in KS4, narrowing the gap significantly between other areas. Since 2007 attainment of pupils living within the priority neighbourhoods has risen by 9.3% regarding the percentage of GCSE or equivalent 5+ A*-C, including English and maths. Since 2007 there has been a 2.6% decrease in the attainment gap between Southampton and the priority neighbourhood average. The gap between Southampton (45.4%) and the priority neighbourhood average (34.3%) has been reduced to 11.1% in 2009.

School Attendance and Persistent Absence

Southampton schools continued to make good progress in reducing persistent absence in 2008/9, though overall City levels still compare poorly to City and statistical neighbours. Secondary persistent absence has reduced over the year by 2.4% (10.1% down to 7.7%). Primary persistent absence has also reduced during the same time by 0.6% (3.6% down to 3.0%). Fewer children and young people are missing school because of fixed-term exclusions. There has been a significant reduction in the numbers of primary and secondary fixed-period exclusions. 25% fewer children and young people are being excluded and fewer days are lost to exclusion. The text message 'Truancy Call' system is being implemented in 50 schools.

To ensure that Southampton children and young people enjoy and achieve more of their potential there is a need to:

- ensure that local schools are supported in improving faster than nationally and in similar areas so that more learners achieve well
- ensure that progress in the attainment of learners living in priority neighbourhoods at the end of key stages is sustained
- ensure that the improvements achieved in improving school attendance and in reducing persistent absence from schools are sustained and spread.

Maximising the Positive Contribution that Children and Young People Make to Community Life

Engagement in Positive Activities, Crime and Anti-Social Behaviour

Anti-Social Behaviour

There has been significant progress in reducing the number of children and young people engaged in crime and anti-social behaviour. This is evidenced by a reduction in the number of reports of anti-social behaviour from the public and a fall in criminal damage (which is often used as a proxy measure for anti- social behaviour).

Youth Offending

The levels of re-offending for young offenders has fallen for the first three quarters of 2009-10, and levels of young people coming into the criminal justice system are significantly reduced. There has been a reduction in the number of children and young people entering the criminal justice system for the first time. First time entrants have reduced over the three quarters of 2009-10 from a rate of 2272 to 1239 first time entrants per 100,000 of population. This compares with a rate of 2164 first time entrants per 100,000 of population in 2008-09. This represents good progress in tackling levels of youth offending that will need to be sustained.

Participation in Positive Activities

During 2009-10, 59.3% of young people reported participating in positive activities (compared with 61.6% for our statistical neighbours) in the TellUs4 survey. Combined funding of £1.2M has been used to commission a range of new positive activities programmes for children and young people to make provision out of school hours and at weekends more attractive and accessible across the City. The impact of these new services will be evident from April 2010.

To maximise the positive contribution children and young people make to community life, there is a need to:

- improve service delivery and efficiency through bringing together staff and resources from different agencies into three City localities to ensure local provision meets local needs and makes best use of locality facilities and resources
- continue to reduce the number of children and young people engaged in anti social behaviour by implementing within each locality area a programme of positive activities on Friday and Saturdays which supports children and young people to participate in more sport, leisure and cultural activities
- work to ensure a continuation of the reduction in children and young people being the victims of crime or entering the youth justice system in partnership with the Safer City Partnership
- improve public recognition of the positive contribution made to community life by children and young people in Southampton by acknowledging their positive contribution and their achievements.

Maximise the Number of Children and Young People who Achieve Economic Well-Being

Equipping Young People for Economic Independence and Success as Adults

Increasing the Proportion of Young People Progressing into Further Education and Training upon Leaving School

The number of 16 year olds progressing into education and training has increased; in 2008-09 there were 90.14% compared to 88.3% in 2007-08. We have maintained performance on the percentage of eligible and relevant young people leaving care with a Pathway Plan over the last two years at 82%.

Increasing Qualification and Skill Levels at Age 19

There has been a sustained increase in the number of young people achieving Level 2 and Level 3 qualifications by the age of 19 and improved success rates of students aged 16-18 across a wide range of qualifications, including work based training programmes. The proportion of young people achieving Level 2 qualifications in 2008-09 was 65.8%; in 2009-10 this increased to 67%. The proportion of young people achieving Level 3 qualification has also risen; in 2007-08 the figure was 39.2% and in 2009-10 it increased to 40%.

Reducing Numbers of Young People not in Education, Employment or Training

There are fewer 16-18 year olds not in education, employment and training than in 2007-08. The proportion of 16-18 year olds not in education, employment or training has dropped from 10.4% to 9.7% in 2009-10. However, this compares with a national figure of 6.4% and a statistical neighbour average of 8.1% for 2009-10. The proportion of care leavers who are not in education, employment and training has also reduced from 63.2 in 2007-08 to 48 in 2009-10 (quarter 4 data).

Access for Young People to Suitable Housing and Accommodation

The number of young people aged 16 or 17 requiring social housing and accommodation has increased. At the same time there has also been a fall in the percentage of care leavers in suitable accommodation. Reported levels have dropped from 85% in 2008/9 to 61% in 2009/10, though this includes some young people who are not maintaining contact with the Pathways Team, and who may be in suitable accommodation.

To maximise the proportion of young people who are on track to achieve good levels of economic well-being there is a need to:

- continue to broaden learning opportunities for 14-19 year olds through apprenticeships, diplomas, GCSEs and 'A' Levels so that Southampton outcomes catch up and surpass levels elsewhere
- reduce the number and level of young people not in education, employment and/or training to much lower levels that compare more favourably with national and similar areas
- understand the housing and accommodation pressures upon young people better so that appropriate provision can be put in place, particularly for the most vulnerable.

Poverty Affecting Children and Young People in Southampton

Children and Young People Living in Poverty – 0-15

Childhood poverty is calculated through measuring the proportion of children and young people living at certain levels below average (median) household income levels. Based on 2007 data, there has been no reduction in the percentage of Southampton's 0-15 year olds who live in the 10% most deprived areas in England. According to national statistics, 27.1%

of children and young people in the City were living in poverty in 2007. Since then there has been an increase in the take up of free school meals entitlement of 3.52%, which represents a 7.88% increase in actual free school meals served. To reduce the effects of growing up in poverty upon the life chances of the City's children and young people services have been working to reduce barriers to parents' working, and to maximise the take-up of entitlements to benefits for families affected by low income (e.g. tax credits and free school meals).

City Council led programmes will support workless adults, including parents and carers, to gain skills and employment and improve their economic prospects. This includes two European Social Fund projects supporting 180 adults into employment in 2010/11, family learning and adult learning programmes supporting the skills, aspirations and wider outcomes of 5,000 people.

An audit and gaps analysis of childcare in the City has been used to develop an action plan for childcare in the City where it is acting as a barrier for parents looking to work. Between March 2009 and January 2010 an additional 409 new childcare places opened and there are 513 settings offering childcare in the City offering 8,719 places.

In addition, a pilot commenced in September 2009 to offer 10 hours of free early learning and childcare for 2 year old children within families experiencing income deprivation and other needs to help reduce the impact of families' economic situation upon their children. This has been funded from the Department of Children, Schools and Families (now the Department for Education) and 94 children were supported in 2009-10. Families potentially eligible for support have also been linked into Children's Centres so that other support can be offered to them. Feedback from families, the settings and children's centres about the benefits of this provision has been positive.

Children and Young People Living in Poverty – 16+

Young people aged between 16 and 18 who live in low income households are being encouraged to develop their skills, qualifications and levels of engagement in their future prosperity, as set out in the needs assessment under Priority 8. For young people entering the workforce, the Future Jobs Fund programme in Southampton has secured funding to provide 282 unemployed 18-24 year olds with opportunities for employment, work experience or training by the end of March 2011 (85 being 12 month, full time apprenticeships). The Future Jobs Fund partnership in Southampton is developing a bid for funding for up to 360 Future Jobs Fund additional jobs (£2.3M).

To maximise family incomes and mitigate the impact of poverty on children and young people, there is a need to:

- improve our data collection and analysis of information of children living in poverty
- undertake a Child Poverty Needs Assessment and develop a local action plan/strategy to tackle child poverty locally
- continue to close the gap between children who do well and those vulnerable to poor outcomes – for example between children entitled to free school meals (FSM) from priority neighbourhoods than in non priority neighbourhoods
- improve take-up of Tax Credits including Child Tax Credit and Working Tax Credits.

References

Wills, A. Responding to Medium and Standard Risk cases of Domestic Violence in Southampton. Report to the Domestic Violence Scrutiny Inquiry, Southampton City Council, 12th February 2010.

Children and Young Peoples Plan 2009 – 2010, Southampton City Council

Sexual Health Needs Assessment 2008, NHS Southampton City, unpublished report

Please refer to the questions at the end of this document - the deadline for feedback is Friday 29 October 2010

<http://www.southamptonhealth.nhs.uk/jsnaconsultation>

SECTION 4 - STAYING HEALTHY THROUGHOUT LIFE: HEALTHCARE AND SUPPORT SERVICES FOR ADULTS

Ensuring the Best Adult Social Care

Adult social care is undergoing a period of service transformation, with new service models being designed that focus on empowering people to 'take control' of the funding that is used to meet their needs, enabling quality social care and support services to be delivered that better realise the outcomes that service users, carers and the community want. However, the growing number of people living longer, benefiting from improved diet, cleaner air and the wider determinants of health, as well as the ability of medical treatments and medication to prolong life, is leading to a steadily growing demand for adult social care services.

Adults Aged 18 to 64 Years

In 2007-08 there were 3,003 people aged 18-64 years receiving social care services in Southampton and of these 2,750 were receiving community services (i.e. in their own homes rather than in residential or nursing homes). Of these adults receiving services, 1,235 had physical disabilities, 1,135 had mental health problems and 510 had learning disabilities.

In 2008/09 65% of learning disabled adults in Southampton were living in settled accommodation which is a similar proportion to national figures and near to the average value compared to the City's local authority peers. 3.4% were in paid employment. To enable these numbers to be translated into trends and compared to other Local Authorities and the national average Table 4.1 below shows the range of services provided to adults aged between 18 and 64 in 2003/04 and in 2007/08. This is set alongside the average for England. Values are per 1,000 of the population within the age range.

Table 4.1 Social Care provided comparisons Southampton and England 2003 to 2008 for Adults 18 to 64 years (rates per 1000 population)

	Southampton		England	
	2003/04	2007/08	2003/04	2007/08
Adults receiving services	17.6	19.0	15.8	17.3
Adults receiving community services	17.3	17.4	14.2	16.0
Adults with learning disabilities receiving services	3.7	3.2	3.8	4
Adults with learning disabilities receiving community services	3.6	2.2	3.0	3.2
Adults with mental health receiving services	4.7	7.2	4.6	5.9
Adults with mental health receiving community services	4.6	6.9	4.2	5.6
Other client groups receiving services	0.9	0.8	0.8	0.6
Other client groups receiving community services	0.9	0.8	0.8	0.6
Adults with physical disabilities receiving services	8.3	7.8	6.6	6.9
Adults with physical disabilities receiving community services	8.1	7.6	6.3	6.7

Source: Referrals Assessment and Packages of care (RAP Tables)

To find out more see Southampton City PCT

www.southamptonhealth.nhs.uk/publichealth/jsna/data/d

Table 4.1 above shows that the adults between 18 and 64 receiving services is approximately 10% higher per 1,000 than the average across England. However, this increases to 22% above the national average for adult with mental health problems receiving services.

Adults Aged 65 Years and Over

Table 4.2 below shows the services provided to older people age 65 and over in 2003/04 and in 2007/08. This is set alongside the average for England for comparison purposes. Values are per 1,000 of the population within the age range.

Table 4.2 Social Care provided comparisons Southampton and England 2003 to 2008 for Adults aged 65 years and over (rates per 1000 population)

	Southampton		England	
	2003/04	2007/08	2003/04	2007/08
Number of older people receiving services	181.8	194.7	159.1	149.6
Number of older people receiving community services	179.2	167.3	130.4	125.6
Number of older people with learning disabilities receiving services	1.6	1.8	1.4	1.7
Number of older people with learning disabilities receiving community services	1.6	0.7	0.9	1.1
Number of older people with mental health receiving services	20.7	31.9	13.6	15.9
Number of older people with mental health receiving community services	20.3	19.6	8.6	10.8
Number of older people in other client groups receiving services	1.9	2.1	9.4	3.8
Number of older people in other client groups receiving community services	1.9	2.1	7.6	3.2
Number of older people with physical disabilities receiving services	157.6	158.8	134.8	128.1
Number of older people with physical disabilities receiving community services	155.4	145.1	113.3	110.5
Number of people receiving services with dementia	14.8*	17.1**	-	-

* Value relates to 2004/05 ** Value relates to 2008/09

Source: Referrals Assessment and Packages of care (RAP Tables)

To find out more see Southampton City PCT
www.southamptonhealth.nhs.uk/publichealth/jsna/data/d

Table 4.2 above shows the number of older people receiving services was 30% above the England average in 2007/08. In real terms the number of older people receiving services grew from 5,720 in 2003/04 to 5,952, giving an average demand of services to 58 additional people year on year. The number of older people with dementia receiving services grew by 14% between 2004/05 and 2008/09, meaning an average increase in services to 16 additional people year on year.

To provide the best health and social care support for adults and older people, there is a need to:

- improve the focus of promoting independence to enable people to optimise their choices for health and well-being through all health and social care interactions
- improve advice and support to people who fund their own care services, or do not meet eligibility criteria, to facilitate access to a range of support services and provide advocacy and monitor outcomes
- improve information and education for those most at risk of falls
- prevention of unnecessary conveyance to hospital particularly when related to falls
- improve information and advice about health and social care services and support for self-help groups and encourage development of self-sustaining peer support and social enterprise
- improve access to support for people with common mental health problems
- provide a greater focus on rehabilitation and recovery services
- increase the use of anticipatory care plans to reduce unplanned access to high level services at times of crisis
- ensure that the capacity of the intermediate care services is responsive to the population need
- improve support and enablement services for older people with mental health problems
- provide flexible community support using the option of personal budgets rather than a buildings-based contract for people with complex needs
- continue to improve transition arrangements for young people moving into adult social care services to improve life chances, particularly for those with emotional difficulties
- improve the number of Extra Care Housing places to increase the options for people who need intensive levels of support in the community and reduce residential care by having more options available and supporting informed decision making
- prevent hospital admissions and improve timely discharge for those with complex care needs by promoting community provision to assist better long term decisions
- improve the pathway of options for housing related support, support at home and specialist housing – integrated with social care options
- work with the voluntary sector to maximise what they can offer to increase efficiency
- encourage healthy living options to reduce health inequalities
- work with pharmacy and other universal community services to reduce need to access higher level services.

Adult Mental Health

One in six of the adult population experiences mental ill health at any one time. Anxiety and depression are common conditions which can affect all age groups.

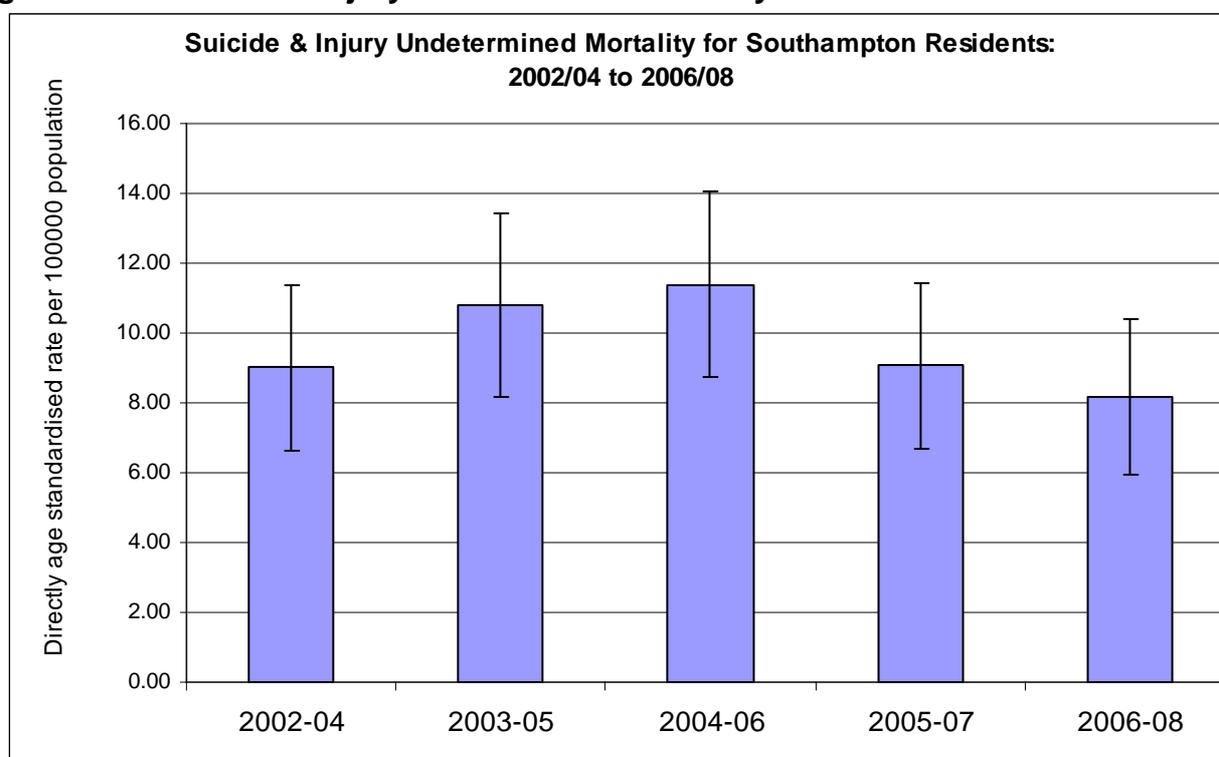
Psychotic disorders are less common and refer to disorders that produce disturbances in thinking and perception of the world and the relationship of events within it. Mental health conditions are poorly understood by the wider community and are often associated with fear and stigma. Individuals can feel debilitated by their condition, also adversely affecting family and social relationships. Depending on the severity and duration of the mental health condition, problems associated with self care, employment, education and housing may also arise. Many people feel excluded from their communities and lack confidence in accessing mainstream resources.

Mental health has been defined as ‘an individual’s ability to manage and cope with the stresses and challenges of life’ (Mental Health NSF DOH 1999). Opportunities to promote mental well-being in the general population need to be maximised, including establishing environments conducive to well-being in work places and educational establishments. General healthy lifestyle recommendations are also relevant to enhancing mental well-being, given the inter-relationship between good physical and mental health (New Horizons DOH 2009).

Suicide

Over the 2006-08 period there were 54 deaths by suicide and undetermined injury to Southampton residents see Figure 4.1 below. This equates to a directly age-standardised rate of 8.16 per 100,000; however, there are very large confidence intervals around this rate which mean there is no significant difference from the national average and no definite trend over time.

Figure 4.1 Suicide and injury undetermined mortality 2002/04 to 2006/08



To ensure that the correct mental health services are provided for patients, and preventative measures are taken, there is a need to:

- benchmark local services to see how well we are doing compared to other areas in the region
- implement Payment by Results (PbR) system within Mental Health services
- review care pathways within specialist mental health services to achieve efficiencies, remove barriers between specialist services and make access for the individual less complex
- give individuals the choice of accessing services through individual budgets and ensure that services are configured to do this and review services in the light of this new system
- improve contract monitoring to focus on outcomes based performance measures
- ensure service users and carers feedback will form part of the contract performance monitoring for all contracts

- work with the newly appointed Commissioner for Carers service to improve services and involvement from carers
- work with commissioners and providers who are responsible for young people and older persons services to ensure transition between services is seamless
- identify opportunities and services to improve access to work for people with mental health problems
- working with other agencies in the City to develop an anti-stigma campaign as part of the national campaign – Time to Change
- working with Public Health to develop strategies which promote mental well-being for the whole population including activities which reduce health inequalities and which promote good mental health in the workplace
- review and update the Suicide Reduction Strategy giving specific attention to the recent impact of the economic challenge.

Adults with Attention Deficit Hyperactivity Disorder

Nationally and locally Attention Deficit Hyperactivity Disorder (ADHD) is not as well recognised in adults as it is in children and adolescents. Consequently in Southampton there is no specific service provided for adults with ADHD. Although there is a decline in the condition as people grow older there does appear to be a growing need for a service although numbers are likely to be small in relation to other mental health services.

There is difficulty in estimating the direct impact of ADHD on families and the wider society although there are significant links between undiagnosed and under-treated ADHD in adults with common yet complex mental health problems. For example, with substance misuse, single parenting, teenage pregnancy, poor social adjustments and unemployment behaviours.

In 2008 the National Institute for Health and Clinical Excellence (NICE) clinical guideline (CG72) recommended delivering care for ADHD sufferers within generic adult mental health services. This is due to the high rate of overlap of ADHD symptoms with those of other common Mental Health conditions and psychiatric disorders.

To find out more about ADHD in Adults see:
www.nice.org.uk/CG072 or NICE Clinical Guideline CG72

To address the needs of people living with ADHD, there is a need to:

- determine the level of need in the City
- determine the cost-effectiveness of a seamless service as outlined in the NICE guideline CG72 from children's to adult mental health care
- design and integrate the right mix of services with adequate capacity across the care system between primary care services, including CAMHS, secondary care services and social services to include a comprehensive assessment.

Mental Health for Older People

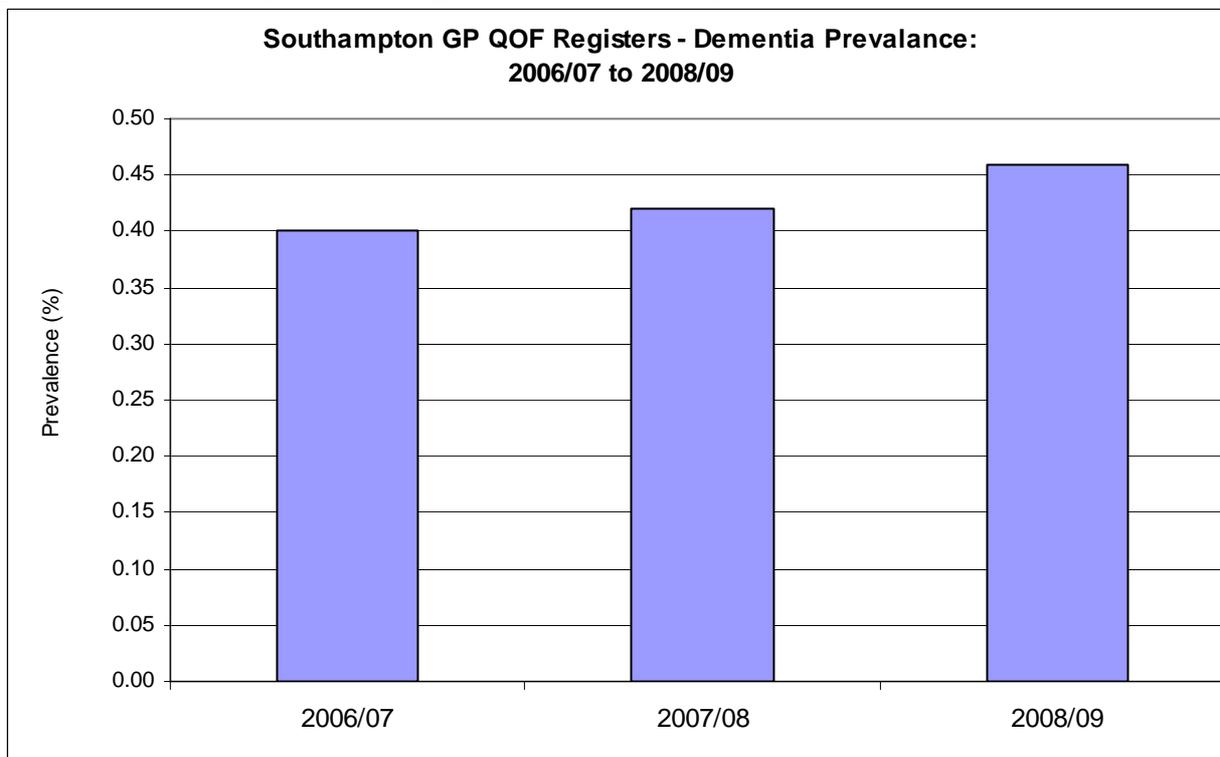
In 2007/08 the rate of older people (65+ years) with mental health problems accessing social services was 31.9 per 1000 compared to just 15.9 across England as a whole. Southampton's rate was the highest amongst its Office of National Statistics (ONS) peers.

The City has provided more Admiral Nurses to support carers and health/support workers than any other area of the UK. In 2009, NHS Southampton City and Southampton City

Council published a joint commissioning vision for people with dementia. This vision set out key plans for improving services and support to people with dementia in the City.

GP registers for dementia recorded 1,022 people in 2006/07 and by 2008/09 this had increased to 1,186 people see Figure 4.2. We know that diagnosis is challenging, especially in the early stages, when presenting symptoms may not be brought to the GP's attention.

Figure 4.2 Southampton GP registered dementia prevalence



In 2008/9 there were 22,482 (8.65%) people on the depression registers. As these registers are relatively new trend data is not yet available.

These relate to crude prevalence rates of 0.5% for dementia and 8.6% for depression, both of which are slightly higher than the national rates. There are no significant differences in dementia prevalence rates between Southampton's localities but the South and East has a significantly higher crude depression prevalence rate at 10.3%.

The 'Projecting Older People Population Information System' (POPPI) predicts 2,558 older people in Southampton will have dementia by 2015. The number of older people predicted to have depression is 2,855. The reductions in social contact through retirement, children leaving home, the death of a partner, or the loss of mobility, are the key determinants of general mental well-being. Isolation and inactivity affect well-being and cause low levels of depression.

To find out more see the data compendium social services chapter at www.southamptonhealth.nhs.uk/publichealth/jsna/data/d

To provide the best health and social care support for adults and older people, there is a need to:

- support mental well-being by enabling older people to remain active, engaged, and free from isolation by:
 - expanding the 'steps to well-being' service for depression and anxiety to outreach to older people in hard to reach groups
 - continuing the free access to swimming for the over 60s.
 - encouraging physical activity and social opportunities
- ensure early assessment and diagnosis of mental health conditions in older adults
- ensure people with dementia are diagnosed earlier, by training health and care workers, GPs and others to recognise the symptoms and to ensure diagnosis
- ensure specialist support services add value to care planning
- ensure that we start from a position that people with dementia should be cared for at home for as long as is possible. This requires generalist services are appropriately equipped to work successfully with people, without inappropriate reliance on specialist support
- provide appropriate information to carers and those with dementia as early as is possible
- ensure that Admiral Nurses are central to the care of the patient and able to identify the problem and signpost to the appropriate service
- increase the numbers of support workers to provide long term key working
- review the current investment in services to support people with dementia and to provide more community based care

It is expected that as the programme is developed, so choices and care will be improved for this group.

Ensuring Good, Flexible Support for Carers

There are large numbers of carers in Southampton caring for relatives, friends or neighbours. The people they care for may be frail, ill, disabled or have a mental health problem, learning disability or issues with substance misuse.

Carers are extremely important within families and communities as they often enable those they care for to live independently for longer. Carers need to be well supported in order to stay mentally and physically well and should be treated with dignity.

In June 2008 the government published a national carer's strategy: "Carers at the heart of 21st-century families and communities". The vision set out in this document is that by 2018, carers will be universally recognised and valued as being fundamental to strong families and stable communities. Support will be tailored to meet individuals' needs, enabling carers to maintain a balance between their caring responsibilities and a life outside caring, whilst enabling the person they support to be a full and equal citizen.

National Indicator Target (NI) 135 measures the number of carers whose needs were assessed or reviewed by the council in a year who received a specific carers service, or advice and information in the same year as a percentage of people receiving a community based service in the year. Unpaid carers save the economy massive amounts of money each year and deserve better societal support.

To find out more visit:

www.southampton.gov.uk/living/adult-care/carers/
www.southamptonhealth.nhs.uk/publichealth/jsna/data/d

To better support carers there is a need to:

- acknowledge that carers are vital to the health and care system and save the local and national economy vast sums of money
- continue to improve our communication with the wide range of carers across the City and learn from them what support they need and use this knowledge to inform service commissioning. Also continue to develop the relationship between ourselves and carer-led organisations to make better use of their expertise
- provide accessible and comprehensive information and advice to carers about what help and support is available to them, particularly at the point of diagnosis or a hospital discharge. This should include information about benefits so that carers do not experience financial hardship as a result of their caring role
- respect and empower carers as expert partners and ensure that they have access to good quality assessments and/or signposting services as appropriate
- review opportunities for the development of new types of support to meet the agenda of the National Carers Strategy including a wider, more flexible range of respite provision
- ensure the effective use of the carers' grant for the benefit of carers' health and well-being. This will include supporting those organisations that provide informal social groups and network links for carers
- enable carers to have a life of their own alongside their caring role by helping them to look at life opportunities which they may wish to maintain or take up
- ensure carers have access to emergency planning support in the event of a crisis
- ensure carers have access to specialist training to ensure their own health and well-being needs are taken into account and they feel better equipped to carry out their caring role. This might be through providing 'lifting and handling' sessions or help with learning how to cope with isolation or stress.

References

Department of Health (2008) Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own.

Department of Health (2009) New Horizons: a shared vision for mental health

Hampshire Multi-Agency Safeguarding Adults Policies and Procedures

<http://www.southampton.gov.uk/living/adult-care/safeguarding-adults/sg-fi.aspx>

NHS Southampton and Southampton City Council (2009) Joint Commissioning Vision for People with Dementia

Please refer to the questions at the end of this document - the deadline for feedback is Friday 29 October 2010

<http://www.southamptonhealth.nhs.uk/jsnaconsultation>

SECTION 5 - THE SOCIAL, ECONOMIC AND ENVIRONMENTAL IMPACTS ON HEALTH AND WELL-BEING

Economic Well-being

As stated in section 1 earlier Table 1.3 on page 16, the average gross weekly pay gap for full-time workers between Southampton and England has widened from £9 a week in 2002 to a £54 a week deficit in 2009.

The relationship between income and health is well documented (Marmot 2010)

National Research identifies the link between poverty and health:

- health inequalities associated with class, income or deprivation are pervasive and can be found in all aspects of health, from infant death to the risk of mental ill-health. The limited information on progress over time (infant death, low birth weight) shows no sign that they are shrinking
- men aged 25-64 from routine or manual backgrounds are twice as likely to die as those from managerial or professional backgrounds and there are also sizeable differences for women
- children from manual social backgrounds are 1½ times more likely to die as infants than children from non-manual social backgrounds
- teenage motherhood is eight times as common amongst those from manual social backgrounds as for those from professional backgrounds.

The Financial Services Authority (FSA) published a paper which examined the way in which the characteristics of individuals and their households relate to their financial capability. Its findings showed that moving from low financial capability (poorer) to average improves psychological well-being by about 6%. This is significant when compared to an 8% deterioration associated with divorce and 10% with unemployment.

The Equality Bill is expected to come into force in autumn 2010. It will place a new duty on key public bodies including local authorities, to consider what actions they can take to reduce socio-economic inequalities people face. The duty will affect how public bodies make strategic decisions about spending and service delivery. It will enshrine in law the role of public bodies in narrowing gaps in outcomes resulting from socio-economic disadvantage.

For further information see:

www.poverty.org.uk/index.htm

To improve the economic well-being of the population, especially those most vulnerable, there is a need to:

- encourage economic development to reduce the levels of deprivation and its associated health and social care consequences
- consider if current responses to deprivation and other need indices that focus resources on small numbers of individuals, rather than City wide needs, is meeting the needs of those who could benefit most
- consider the further development of benefit take up/welfare rights campaigns and other anti poverty initiatives
- to ensure that people can stay or return to work as soon as possible e.g. through the implementation of the 'Fit Note'

- ensure that those who do stop working because of illness or a health condition access advice and support that enables them to claim appropriate benefits or rethink their future job prospects
- tackle worklessness, improve skills and employability
- promote financial inclusion, mitigating poverty and maximise incomes
- promote community cohesion and support the voluntary and community sector
- support key developments in the City that make it more attractive to residents and businesses and ensure these maximise their potential to reduce disadvantage
- reduce deprivation, poverty and worklessness in Southampton
- influence priorities in other strategies and plans, so they can tackle the causes of deprivation and have a direct benefit for people from deprived neighbourhoods and communities in the City
- support and nurture the City's vibrant voluntary and community sector and encourage volunteering.

Fuel Poverty and Housing

Housing

The quality of housing is crucial to health and well-being, especially for the vulnerable, young and old who can be particularly susceptible to poor health associated with inadequate heating and insulation, damp and overcrowding. Poor housing conditions can cause a range of physical and mental illnesses and children growing up in difficult housing conditions are more likely to suffer severe ill-health and disability during childhood/early adulthood.

There are an estimated 98,400 homes in Southampton, broken down in Table 5.1.

Table 5.1 Southampton housing stock type compared to the national %

Tenure	Number	Percentage of total (Southampton)	Percentage of total (national)
Owner occupied	52,000	53%	71%
Privately rented	23,400	24%	11%
Social housing (Council and housing associations)	23,000	23%	18%
Total (all housing)	98,400	100%	100%

Southampton City Council (2008) Private Sector Stock Condition Survey revealed that Southampton's private housing is exceptional because of the size of the private rented sector (over twice the national average).

Southampton City Council is on track to ensure that all of the homes that it lets (council housing) meet the Decent Homes Standard by December 2010.

However, 28,400 private homes are non-decent (37.7% of all homes). An estimated 8,490 of these are occupied by vulnerable people (defined by the Government for this purpose as receiving a means tested benefit) and an estimated 16,000 fail to meet the basic level of insulation required in the Decent Homes Standard. 5,600 of these private homes are considered to have a severe excess cold hazard.

Fuel Poverty

It is estimated that in the winter of 2008/09, 113 people died in Southampton because of the cold weather (unpublished Public Health Excess Winter Mortality NHS Southampton).

These deaths are mainly due to cardiovascular disease, heart attacks and strokes and respiratory illness. The Chief Medical Officer highlights for the UK that frail elderly women are the most vulnerable group (CMO 2010).

Someone living in Fuel Poverty is defined as having the need to spend more than 10% of their income on heating their home. It is caused by a combination of poor energy efficiency (insulation and heating), low incomes and fuel prices. An additional factor relates to under-occupation, usually occurring where a couple or single elderly person still lives in a larger family home, which is now too large for their needs, and cannot be made affordable for them to heat adequately. Although the number of people officially defined as living in fuel poverty has gone down over the last five years and is lower than the national average, the latest estimates are that there are still an estimated 6,000 people in fuel poverty in private homes.

In 2009/10, an estimated 9% of vulnerable, low income households are living in homes with very poor energy efficiency (Standard Assessment Procedure SAP rating of below 35) across all housing tenures and 37% of this household type are living in homes with good energy efficiency (SAP rating of above 65, National Indicator (NI) 187)

The Southampton Warmth for All Partnership (SWAP) is implementing an action plan for reducing fuel poverty. Successes to date include:

- attracting over £3m investment in energy efficiency and heating system improvements resulting in over 1,400 private homes of vulnerable people being improved in 2008/09 and 2009/10 through the Warm Front Grant, topped up where necessary by the Council
- establishing a single freephone number for advice and referrals for managing fuel bills, improving energy efficiency, checking benefit entitlement and keeping warm and well (0800 519 1100)
- improved training and information sharing for all those who are likely to visit fuel poor households

Living in a warm home clearly benefits physical and mental health and well-being. Improving energy efficiency also helps to reduce Southampton's carbon footprint (a measure of the impact our activities have on the environment and, in particular, climate change which includes greenhouse gases produced through burning fossil fuels for electricity and heating).

There is a need to continue delivering programmes and partnership working designed to reduce fuel poverty:

- promoting the take-up of "Warm Front" grants to those eligible for them
- encouraging more households with a person over 70 years to take up the Government's free loft and cavity wall insulation benefit
- encouraging more private landlords to take up free loft and cavity wall insulation from the Council
- improving the multi-agency referral process
- reducing health and well-being inequalities associated with fuel poverty and improving the quality of life of people living in fuel poverty
- targeting older people who live in rented and owner occupied accommodation with no central heating
- targeting vulnerable families with young children
- reducing fuel poverty in line with local and national targets

Housing Conditions

Since 2006, the Housing Health and Safety Rating System has been the statutory way of assessing and dealing with poor housing conditions. Recent research has suggested that investing in housing repairs to eliminate the most serious (Category 1) housing hazards could save the NHS in England in excess of £600m per year. Roys, Davidson and Nicol et al. 2010 estimated that the total cost to society may be greater than £1.5 billion per annum.

The Council and its partners improve housing through housing standards enforcement and by offering loans, grants and practical help to vulnerable home owners. Since 2008, the Council has given over 100 interest free loans to pay for essential home repairs and improvements. This forms part of the programme to remove hazards from private sector homes in the City. There is a need to carry out a health impact assessment of these interventions and to carry out a local cost-benefit analysis, in order to quantify potential savings in health and adult social care costs, starting with tackling excess cold, preventing falls and fire safety. The Chartered Institute of Environmental Health (CIEH) in 2008 estimated that:

- every £1 spent adapting 100,000 homes where a serious fall is otherwise likely to occur saves the NHS £69.37 over 10 years
- every £1 spent improving 100,000 homes where residents are likely to require treatment due to excess cold saves the NHS £34.19 over 10 years
- every £1 spent dealing with overcrowding in 100,000 homes where it is likely to lead to health problems saves the NHS £6.71 over 10 years.

Living in overcrowded accommodation can, both directly and indirectly, have a devastating effect on families. Under-achievement at school can be caused by lack of space for children to do their homework. Absence rates may be higher because of illness associated at least in part with poor living conditions. Older children may spend more time outside the home, on the streets, simply to find privacy and space. Overcrowding may exacerbate stress, depression and in the worst cases domestic violence or breakdown of relationships.

In 2008 Southampton City Council estimated that 357 households living in Council and housing association homes needed a larger home. In addition, it is estimated that between 3,000 and 3,600 households are living in overcrowded privately owned and rented homes. In 2006 12% of all households consider that they live in accommodation that is unsuitable for their needs. As at 1 April 2010, there were 16,042 households on the housing waiting list and with a typical wait of five to seven years for a one bedroom flat and six to seven years for a three bedroom house.

The Council and its partners has approved an updated Housing Strategy for Older People (2009-2014) which sets how it will enable more people to live in appropriate and good quality housing with access to supportive community settings.(National Indicator (NI) 156).

A key objective is to adapting homes quickly and efficiently in order to facilitate independent living at home. Improvements to the aids and adaptations programme and process for adults and children occupying unsuitable homes have been made and the time taken from first enquiry to completed adaptation is being monitored. An estimated 3,900 adaptations are required in private homes at a cost of £21m.

Homeless people and, in particular, people who are street homeless, present with complex needs, including drug and alcohol abuse and physical and mental ill health. In 2009/10 the number of households living in temporary accommodation provided by the Council under the homelessness law was 130 (NI 156). In 2009/10, intervention by the Council utilising

the Homelessness Strategy (2008-2013) with its partners resolved the housing situation of 943 households who considered themselves as homeless.

Intelligence about the distribution of households experiencing poor housing conditions and fuel poverty is improving and the use of market segmentation models, such as MOSAIC, present new opportunities for the PCT and Council to work together to target assistance and to deliver tightly focussed advice on healthy homes and healthy lifestyles.

Health inequalities are often intrinsically linked to housing. In particular, the Marmot Review (2010) recommends improving the energy efficiency of housing across the social gradient. Strong evidence is presented on the health impact of improving energy efficiency and reducing fuel poverty, especially in private housing.

In order to improve health in the City through better housing there is a need to:

- develop a sound local evidence base on the health effects of poor housing and the costs to the NHS of not repairing and adapting properties with improved data sharing on housing and health
- highlight the health effects of poor housing and continue with strategies to reduce the number of non-decent homes, particularly those occupied by vulnerable people, with a focus on energy efficiency and fuel poverty
- jointly explore effective ways of spending budgets on interventions to improve the quality of people's homes, in particular in relation to falls and excess cold
- develop a NHS/City Council cold weather plan to prevent and deal with the health consequences of cold weather above and beyond winter resilience.

The Impact of Crime and the Fear of Crime

Crime Affecting the General Community

Crime and the fear of crime have a negative impact on people's health and well-being.

Crime impacts in a number of ways:

- directly: through violence, injury, rape and other offences against the person
- indirectly: through the psychological and physical consequences of injury, victimisation and isolation because of fear and lack of physical activity as people don't feel safe to go outside or let their children play outside
- as a determinant of illness, along with poverty and other inequalities, which increases the burden of ill-health on those communities least able to cope
- by reducing the effectiveness of our health care systems through violence against staff, damage to patients and property, and revenue lost in replacement, liability/risk, repair and security
- by preventable health burdens, such as alcohol related crime, and drug dependency

Although violent crime, criminal damage and antisocial behaviour continue to be an issue in the City, City crime rates continue to reduce in all other major crime types with a 5% reduction in 2007/08. A further 6% reduction in all crime was seen in 2008/09 and a drop of 14% in 2009/10. The places in the City identified by the Index of Multiple deprivation (IMD 2007) 'crime domain', as highest in terms of recorded cases of crime, are in Bargate, Bassett, Portswood, Millbrook, Woolston, Bevois, and Swaythling wards.

Crime Affecting Children and Young People

The pattern of crime and fear of crime affecting children and young people is subtly different from that for the community as a whole. Acquisitive crime is more likely to be targeted against possessions that are carried with the person rather than kept at home, making them more likely to experience robbery and/or assault than the wider population. Bullying is

recorded much more as a type of crime/disorder affecting children and young people than in the general population.

Young people are much more likely to be subject to violence than older people. As teenagers, young people are far more likely to be reported to the police for causing nuisance or anti-social behaviour when simply meeting in public places than would be the case for adults congregating in the same areas. In Southampton, there are also much higher levels of ethnic diversity among the City's children and young people than in the adult population, increasing the vulnerability of young people to racist hate crime. Finally, children and young people are far more vulnerable to abusive or controlling relationships than adults as they are more dependent upon other adults for their well-being.

In the school age population, the level of bullying is a particular concern and was addressed earlier in section 3.

To find out more see Safe City Partnership Plan at

<http://www.southampton.gov.uk/living/safersouthampton/councilservices/default.aspx>

To sustain and further reduce the impact of crime and fear of crime, there is a need to:

- reduce alcohol related harm and related crime, with a focus on night time economy, violence and sexual violence
- reduce violent crime with action plans for reducing serious violent crimes with an emphasis on the carriage of weapons, offending and repeat offending (domestic violence and sexual offences)
- reduce serious acquisitive crime and re-offending by prolific and other priority offenders (PPO) with action plans for reducing, serious acquisitive crimes (vehicle, burglary, robbery)
- improve children and young people's safety, with action plans for increasing young people's participation in positive activities:
 - improving school attendance and reducing persistent absence
 - reducing the number of young people coming into the criminal justice system
 - dealing effectively with young offenders to reduce re-offending
 - reducing problem misuse of alcohol and other substances by young people
 - reducing the number of children and young people who are victims of bullying and other crimes committed against them by other children and young people
 - reducing the number of children and young people who are victims of crimes committed against them by adults
- tackle anti-social behaviour (ASB) with action plans for reducing perceptions of anti-social behaviour, through reducing nuisance in neighbourhoods affecting residents and local businesses
 - levels of criminal damage
 - arson incidents
- tackle drug-related harm by:
 - improving the treatment availability, quality and throughput of people to quit drugs and/or manage harm
 - disrupting the distribution and supply of drugs within communities
- foster stronger communities by:
 - reducing incidence of hate crimes and improving community cohesion
 - fostering safer neighbourhoods and resident engagement in improving community safety within communities
 - preparedness for civil emergencies

Domestic Violence and Hate Crime

Southampton has higher than the national average for reporting of domestic violence. 5.2% of our City's adult women report domestic abuse to police (3.6% nationally). Domestic violence makes up 17% of violent crime in the City, nationally it makes up 14%. In 2008/09 the police dealt with 4997 incidents related to domestic violence, 1875 of these incidents were subsequently recorded as crimes, 2174 of the incidents were recorded as repeats.

A need has now been identified locally to focus on and improve responses to those experiencing domestic violence who do not meet the threshold for a high risk intervention, but are at risk of escalation and for those who have received a high risk intervention and need of follow-on support to ensure they remain safe. These cases are commonly referred to as medium and standard risk cases.

The City has had an Independent Domestic Violence Advocacy service established since 2007. The service provides specialist support to the highest risk victims of domestic violence in the City. Southampton has focused a lot of work in the area of domestic violence. Examples include the work of the Police Public Protection Unit, the development of the Independent Domestic Violence Advocacy Service and the Multi Agency Risk Assessment Conferences (MARACs). This is resulting in an increase in reporting as well as significant improvements in the safety of victims and reduced rates of repeat victimisation. The number of recorded hate crimes has also increased through measures to encourage reporting. There is a dedicated hate crime and harassment reporting line in place and specific hate crime MARACs. Furthermore a new indicator on domestic violence has been introduced NI 32, which monitors the repeat cases heard at MARAC target is 30% by 2011.

Provision of outreach in Southampton has been extended to cover men, with a drop-in service at the Edge – a local lesbian, gay, bi-sexual and transgender (LGBT) venue.

To find out more see:

Safe City Partnership Plan

<http://www.southampton.gov.uk/living/safersouthampton/councilservices/default.aspx>

Children & Young People Plan – Stay Safe (CYPP)

<http://www.southampton.gov.uk/council-partners/decisionmaking/plans/CYPP/prioritiesforchange/staysafe.aspx>

and/or

The Prevention of Violence towards Adults (POVA)

<http://www.southampton.gov.uk/living/lateryears/elderabuse.aspx>

In order to reduce the incidence and increase awareness of domestic violence and hate crime there is a need to:

- address a range of options to change/explore the lifestyle and culture choices people apply to alcohol
- increase safety, reduce risk and provide an advocacy service to the highest risk victims, in addition to continue providing outreach support and advice to those experiencing domestic abuse
- increase public awareness, understanding and preventive measures (including training) around domestic violence and related issues across all services, targeted at all communities, including children, survivors, perpetrators and professionals
- raise awareness to professional health and social care staff and address so called 'honour'-based violence (HBV)

- provide inclusive and effective services to all people in need of protection from domestic violence, honour based violence, female genital mutilation and forced marriage, whatever their background, age, faith/belief, orientation or ethnicity
- provide for an increased numbers of supported places for refugees including resettlement work
- improve responses to families experiencing domestic violence, especially those who are not identified as high risk and those exposed to 'hidden harm' (including DV, alcohol, substance misuse, mental health) and improve the provision of specific services for those children and young people experiencing and witnessing domestic violence, especially those who are not subject to a Child Protection Plan / social worker involvement but have domestic violence identified within their family
- tackle elder abuse and prevent violence against vulnerable adults improve the protection of older people from deliberate targeted abuse
- continue to tackle hate crimes in the City
- improve the protection of older people from deliberate targeted abuse, within a wider initiative to tackle ageism.

Tackling Alcohol Harm

It is estimated that alcohol related harm costs the NHS £2.7billion each year. Increasing and higher risk drinking has social and health consequences for drinkers and their families, as well as a huge impact on NHS resources. Many thousands of people suffer from chronic illness or die each year directly because of their drinking. These are not just people who are dependent on alcohol or even people who get drunk. They are people who regularly drink at levels that put them at risk of more than 60 medical conditions, ranging from cancer to liver disease and stroke. Many of them are not aware of the risks they are taking. In 2006 alcohol related hospital admissions were calculated at 811,000, 6% of all hospital admissions. The Department of Health data shows there were 863,257 alcohol-related admissions in 2007-08 which is a rise of 51.6% since 2003-04. The previous Government relaxed the licensing laws in November 2005.

According to MOSAIC, groups 7, 10, 12 and 13 (described earlier pages 16 -17) have the highest alcohol-related admissions. Group 7 is a diverse population renting in older terraced properties, group 10 are young couples living in privately rented purpose-built flats, group 12 is transient young people with weak support networks and group 13 is students living in halls of residence. People in Group 10 are particularly interesting as their lifestyles and general health are relatively good. They tend to live in areas such as Bitterne Park, Shirley and Freemantle.

Alcohol related harm is a significant problem in Southampton. Both lifestyle and health data indicate that too many adults and children in the City use alcohol at harmful levels and in ways that put both their health and the health of others at risk. Research by the North West Public Health Observatory shows that the City performs worse in the areas given in Table 5.2 below.

Table 5.2 Issues with Alcohol Southampton and England

Alcohol Issue	Southampton	National Average
Alcohol-attributable mortality amongst males	41.4 *	36.1 *
Alcohol-specific hospital admissions for under 18s	129.4 **	72.3 *
Alcohol-specific hospital admissions for males	393.4 *	373.7 *
Alcohol-related recorded crimes	16.1 **	8.61 **per 1,000
Alcohol-related violent crimes	13.2 **	6.1 ** per 1,000
Alcohol-related sexual offences	0.27**	0.12 ** per 1,000
Claimants of incapacity benefit, working age – whose main reason is alcoholism	232.5 **	130.6**
Synthetic estimates of binge drinking	21.9%	18.0%

*Direct Standardised Rate (DSR) or **Crude Rate (CR) per 100,000

Southampton has the highest rates, in comparison with our neighbours (Bristol, Portsmouth and Plymouth), for 5 of the 8 indicators in Table 5.2, namely: Alcohol specific hospital admissions for under 18s, alcohol related recorded crimes, violent crimes and sexual offences and for the synthetic estimate of binge drinking. Southampton stands out amongst these Cities, particularly in relation to under 18s hospital admissions.

For further information see the North West Public Health Observatory (NWPHO) alcohol profiles: <http://www.nwph.net/alcohol/lape/>

According to the 2006 General Household Survey Southampton has approximately 20.25% of its population drinking at increasing risk levels (more than 2 or 3 units per day female/male respectively) and 5.97% are drinking at higher risk levels (more than 6 or 8 units per day female/male respectively). The Southampton Alcohol Strategy 2009 identified 3 priority population groups who should be targeted through health promotion and service interventions, they are defined as young people starting to drink (14 yrs +), binge drinkers (16-24 yrs) and harmful drinkers (males aged 45yrs+).

There were at least 946 people admitted to hospital with liver diseases in 2007, with over 90% of these due to alcohol related liver disease; of these admissions 49 people died. The liver service at Southampton University Hospitals Trust (SUHT) is increasingly seeing young people with end stage cirrhosis.

To tackle alcohol harm and prevent damage to health and well-being, there is a need to:

- introduce screening and brief intervention programmes for people at risk of alcohol related problems
- broaden the base of treatment by investing in prevention (public health promotion activities) and early intervention services that achieve sustained change in relation to our local drinking culture and behaviour
- ensure agencies collaborate across the health and social system to foster a culture of joint investment, commissioning and integrated, evidence based service provision
- create a service provision culture that ensures fast and effective access to help combined with continuous peer support and guided self help
- raise awareness of the health risks associated with alcohol amongst health and social care practitioners to ensure we are “talking to patients about alcohol” in a way that supports health promotion messages
- recognise the connection between alcohol consumption and a range of chronic and acute health conditions by integrating alcohol information and brief advice with and relevant disease group pathways
- address a range of options to change and explore the lifestyle and culture choices

people apply to alcohol

- reducing the needless health damage and expense related to ill health caused by excessive alcohol consumption over time through more effective prevention approaches/services and information
- addressing some of the cultural issues around binge drinking
- working more coherently across agencies to address some of the significant crime, disorder and anti social behaviour issues relating to alcohol misuse by people of all ages
- working with people who have been irreparably damaged by alcohol to meet their social care and support needs
- reducing the links between excessive alcohol consumption and the health consequences of sexually risky behaviour
- developing better understanding of young people's use of alcohol to help address work between NHS Southampton, the City Council, schools and colleges to reduce the negative effects of alcohol on short and long term health and communities continue to carry out a programme of test purchasing of alcohol to control underage sales
- meeting the Government targets in cracking down on alcohol-related crime and disorder
- positive promotion of access to, and participation in, healthy activities by people during their leisure and recreation time.

Smoking

Smoking remains the single largest cause of preventable premature death. In 2005-07 1,022 deaths in Southampton were estimated to be attributable to smoking. This equates to a directly standardised mortality rate of 243.76 per 100,000 which is significantly higher than the national average of 210.25.

Smoking prevalence is estimated for local authorities by modelling national data and local demographic and social characteristics. Southampton is estimated to have smoking prevalence of 26% which is significantly higher than the national average of 22%.

In 2008/09 54% of smokers who set a quit date had given up smoking at their 4 week check; this is significantly higher than the national average of 50%.

The MOSAIC analysis identified the groups least likely to be successful 4-week smoking quitters, these are groups 3, 4 and 5 which are some of the most deprived groups in the City and are likely to have some of the highest smoking prevalence rates. Being comprised of older people, group 3 is more likely to be receptive to face-to-face and local paper communication whereas groups 4 and 5 would be better contacted through text messages. In particular, MOSAIC Group 4 which is comprised of young adults living in high rise flats in areas such as Bitterne, Woolston and Redbridge. They are likely to lead sedentary lifestyles with high smoking rates, high use of ED services and high alcohol-related admissions. Mental illness and substance misuse are significant issues for this population group.

To find out more see Southampton City PCT

www.southamptonhealth.nhs.uk/publichealth/jsna/data/e

The national Tobacco Control strategy 'A Smokefree Future' published in February 2010 includes three overarching aims:

- stopping the inflow of young people recruited as smokers
- assisting every smoker to stop their dependence on tobacco
- protecting families and communities from tobacco related harm

Since April 2007 nearly 5700 City smokers have been supported through local services to give up. Sustained effort is needed across all 3 MOSAIC groups identified above to continue to reduce the harm to health caused by smoking.

In order to reduce the number of deaths and illness attributable to smoking there is a need to:

- sustain the availability and access to smoking cessation support across the City through the Quitters Service, primary care and community pharmacies
- target smoking cessation support to those neighbourhoods with highest prevalence
- work with Trading Standards and other enforcement agencies to reduce under age sales and to reduce the availability of illicit tobacco
- work together across health and social care to promote smoke free homes and cars as the norm by raising the dangers of second-hand smoke and the need to protect children
- provide training to all practitioners working with children, young people and their families to deliver basic tobacco education and information to signpost to cessation support
- further develop joint working between Health and Education to provide more school-based interventions around smoking prevention, in line with effectiveness evidence (NICE Guidance on School-based interventions to prevent the uptake of smoking among children -2010)

Drug and Substance Misuse

Drug Action Team Southampton Adult Drug and Substance Misuse

In the 2009/10 Adult Substance Misuse Needs Assessment it was found that levels of penetration into the number of Problem Drug Users (PDUs) in Southampton had risen by approximately 7%.

For 2008/09	Number of Patients	Percentage
PDUs in treatment now	580	40.58
In treatment during financial year	262	18.33
Known to treatment but not treated in last year	163	11.40
Not known to treatment	424	29.67
Total	1429	

Therefore:

PDUs not in treatment 2007/8 = 36.94%

PDUs not in treatment 2008/9 = 29.6%

In common with the rest of the region, prevalence is apparently highest among the 25-35 year age group. However, the use of so-called “recreational” drugs is reported to be growing within the under 18 year old age range and also the 18-25 age range, with an increasing number of individuals presenting at the open access services for assistance with stimulant and “legal high” usage.

The “Drug and Action Team Profile – Adult” published by SEPHO 2008/09 provides the following information for Southampton:

- 1015 adults were in treatment of which 63% were new triages (635 individuals) in 2008/09
- 805 clients were problematic drug users (PDUs) - 79% of the adult drug treatment population

- Southampton had 541.3 adults (aged 18-75 years) in treatment per 1,000 population, significantly higher than the south-east rate of 387.6 per 1,000 population
- 70% of adult clients in treatment were male and 30% were female
- 20% (202 individuals) of adult clients were currently injecting drug users
- 578 adults were discharged from treatment, 34% of discharges were successful (20% treatment completed drug free, 14% treatment completed)
- 71% of young people stated alcohol as either a primary, secondary or third drug.

In 2010 the National Treatment Agency (NTA) published “Commissioning for Recovery” which for the first time made explicit that treatment journeys concluded with recovery and re-integration, and that care co-ordinators had to understand what was required to achieve that. Working relationships between drugs services and employment and training services, Jobcentre Plus, accommodation providers and substance services workers are generally good, but much more needs to be done to facilitate a client’s full recovery, re-build self confidence and self esteem and promote independence in a drug free existence.

Stimulant Users

Services for drug users in Southampton have traditionally been opiate based. In 2005/6 a needs assessment of the local stimulant using population was carried out (COCA Southampton Stimulant Report 2005-6) which made recommendations to the Drug Action Team. These recommendations have to date, been only partially carried out. Agency data indicates that the trend towards increasing stimulant use has continued; within services this has manifested in greater numbers of individuals reporting combined crack and heroin use. Anecdotal evidence from treatment services is that the lack of pharmacological interventions for primary stimulant users means that “stimulant only” drug users are not always engaging in treatment. However, the current needs assessment shows that the engagement of stimulant users in Southampton is above both the national and regional rate.

In an attempt to improve services to stimulant users, a Stimulant Forum has been set up and stimulant leads or ‘champions’ have been identified in each treatment service. However, this group has yet to complete mapping and then implementing a cohesive pathway to encourage stimulant users to seek, and to be retained in structured treatment.

Women

Women form only 30% of the estimated treatment naïve population, but represent 49% of the City’s population as a whole and 46.5% of adults of working age. Thus drug presentations in no way accords with the demographic profile. Nevertheless, a sample of treatment naïve clients known to treatment services but not in treatment indicates that the prevalence of women users of crack and heroin may be even smaller than those presenting to services.

A needs assessment for women drug users was carried out in 2007/8. The sample group was small, although the study resulted in some recommendations for action that would result in a more cohesive, holistic pathway for women’s treatment services. Treatment services have attempted to improve provision where possible but have been constrained by available space in premises and lack of additional resourcing.

Work undertaken by the Drug Action Team following the needs assessment included:

- ensuring that all services take into consideration the service users family circumstances on presentation
- an audit of childcare facilities in treatment provider’s premises
- meetings with the local Sure Start managers in order to discuss the possibility of a joint needs assessment and referral system

- DAT supporting a capital bid to Community Safety from Bridge for funds to scope, re-fit and resource an area suitable as a children's play area for service users with small children.

During 2009/10 Southampton DAT has worked closely with the "Think Family" pilot in order to ensure that women and families are able to access appropriate non treatment support services at an earlier stage, and also with the Southampton Harm Reduction Project (SHaRP), an assertive outreach service that is able to target hard to reach women in the community. However, this has not led to any significant increase in the number of women accessing existing services.

In 2010/11, Southampton DAT will consider whether a further needs assessment should be undertaken or whether a detailed action plan based on existing information should be formulated in order to provide an appropriate pathway for women drug users.

Families and Carers of Drug Misusers

Services for families and carers of drug users are to be tendered in 2010. Service needs have been subject to widespread consultation in 2009, resulting in a service review and option appraisal going before the Joint Commissioning Group in January 2010. Southampton DAT will be seeking to achieve the aims and objectives set out by the government in the 2008 Drug Strategy.

Young People (18-25 years) with Problematic Drug and Alcohol Use

Withdrawal of the "No Limits" service, which was designed to bridge the gap between children's services and adult's services, has reduced the level of support available to 18 to 25 year olds. The DASH service (Drug and Alcohol Support and Health Project for Young People) still offers a residual service to this age group. Given that the age group with the largest prevalence of class A usage is from 25-35 years, it is considered likely that children under 18 years are not being identified as substance misusers (or their usage is being accepted as "normal" behaviour i.e. in relation to cannabis use). Few are currently being referred into services for early intervention between the ages of 18-25 years and they then emerge as full blown class A users in the 25-35 age bracket.

Black Minority and Ethnic Groups (BME)

The needs analysis shows that BME clients are being recruited into services. Although retention in treatment has previously been low, information from the current needs assessment is showing that this has improved recently and that Southampton levels of retention are only slightly below regional and national levels. General research shows that the following factors can have a negative influence on successful outcomes for these hard to reach groups:

- attempting to impose the same model of treatment on all client groups
- outreach work that is not targeting vulnerable communities
- lack of cultural competence within the workforce
- fear of stigma within a community
- accessibility of treatment outside normal "office" hours.

Attrition Rates and Treatment Outcomes

Unplanned discharges from all treatment services remain poor. An action plan is in place and a performance improvement cross grade group of staff is meeting to map treatment pathways and formulate solutions for the low rate of planned treatment exits.

To find out more see the Safe City Partnership Plan at:

<http://www.southampton.gov.uk/living/safersouthampton/councilservices/default.aspx>

To reduce the harm from drugs and substance misuse and promote health and well-being, there is a need to:

- continue to engage effectively with those seeking treatment to help manage the harm caused and move to abstinence
- re-focus treatment services on the need to plan for Recovery and Re-integration, thus improving the rate of planned exits from treatment
- continue to maintain high rates of those retained in treatment
- work together with local agencies to help address the detrimental effects of parents' problem drug and alcohol use upon their children
- reduce the use of Class A drugs and the frequent use of any illicit drug
- continue to decrease numbers of drug-related deaths in the City from the peak of 20 in 2006/7
- have a treatment system which is reflective of young people's drug use
- encourage take up of personalised services for drug treatment
- ensure that a new shared care protocol is implemented in order to ensure that there is improved clinical governance of this scheme in 2010/11, administered through the Clinical Governance group which has recently (November 2009) been constituted and is being led by senior clinicians. In addition to increase the efficiency of Shared Care within Primary Care that benefits the treatment system and maximises engagement from under-represented groups
- continue to support community pharmacists in harm reduction services
- liaise with mental health services over shared clients and review the dual diagnosis protocol in 2010
- liaise with prison services, particularly at release
- ensure that service providers offer appropriate and relevant training to staff in order to support the recovery and re-integration focus for services (i.e. ITEP or BTEI)
- improve planned discharges using the National Treatment Agency for Substance Misuse guidance on recovery and reintegration
- to improve treatment pathways including abstinence pathways, access to mutual aid groups and support for families and carers of service users
- continue to improve performance management with a focus on parental status, housing and Treatment Outcomes Profile data compliance and use data to improve delivery of services to clients in Southampton
- ensure that both service users and carers are directly involved in the planning, decision-making and reviewing of services so that the needs of drug users are met
- continue to develop the provision of 'wrap around services' (including housing and access to Education, Employment and Training) in order to support clients to move towards a drug-free life
- ensure that the Drug Interventions Programme is successful in engaging drug using offenders in treatment and supports the delivery of National Indicator 38
- developing and expanding improved care pathways: focus on client centred care planning as the key component to an effective system; expanding consistent structured interventions and care pathways that encourage and enable recovery and personal development
- increase the range of interventions for crack cocaine users and stimulant users in effective treatment
- develop appropriate suite of harm reduction services for blood borne viruses.

Prisoners and Ex-Offenders

Offenders and ex-offenders generally have poorer physical health than the wider population. 80% of prisoners smoke compared to a 22% England average. 33% of male

and 40% of female prisoners have a longstanding physical disability. Mental health problems are a particular issue:

- men and women in prison have a higher proportion of serious mental health problem, including psychosis
- the majority of prisoners have some degree of learning difficulty, with over one in 10 remand prisoners having an IQ under 65
- for male and female prisoners, 27% have been in care as a child, compared to 2% in the general population
- many prisoners are released with no mental health or drug service through-care, no housing or income support, plus rejection and discrimination from families and wider society
- prisoners generally have higher rates of mental illness and self harm and other associated risk factors (e.g. drug and alcohol misuse).

Although Southampton does not have a prison within its boundaries there are approximately 1500 offenders either on a Supervision Order and released from prison on licence, or serving a Community Payback requirement.

To improve the health and well-being of offenders and ex-offenders there is a need to:

- ensure ex-offenders are appropriately registered with a GP who will ensure that their physical and mental needs are addressed
- enable ex-offenders to be signposted into services
- better coordinate services to ensure that a safety net of provision is available for all ex-offenders, especially those newly released.

Environmental Health, Consumer Protection, Health at Work and Transport

The environment is a major determinant of health and influences health inequalities. Regulatory services provided by Southampton City Council contribute to the health of the public by creating healthy workplaces, reducing alcohol-related harm, improving air quality, food standards and safety, preventing and dealing with legally defined nuisances, such as noise, and ensuring consumers are sold safe, properly-functioning products.

The Port Health Service works in partnership with Port Operators and the Health Protection Agency to monitor over 1.2 million standard container movements of cargo and 170 cruise ship arrivals. It maintains the EC Border Inspection Post and carries out checks in line with EC and UK legislation, including checking almost 8,000 containers of imported food every year.

Environmental Health are responsible for:

- 6,000 premises for Health & Safety inspection, enforcement and education
- investigating approximately 130 accidents per year and responding to 200 service requests
- authorising 47 polluting processes, to ensure that health and environmental impacts of each are removed or reduced to acceptable levels
- maintaining a Contaminated Land database of 1,500 sites and ensuring that land is properly remediated when developed
- nearly 4,300 responses to Statutory Nuisance Control requests that include noise, drainage and other nuisances
- licensing and registration of a range of premises for skin piercing activities with approximately 32 new registrations each year

- promoting a programme of interventions to promote food safety in some 1,800 food premises and vessels visiting the Port
- responding to around 60 food complaints annually and taking 250 food samples to determine microbiological quality.

It is important to be able to show that the work of regulatory services has a health impact. Meeting the need for evaluative research and developing and applying impact assessment tools will help ensure an evidence-based approach.

To protect the health, safety and welfare of individuals and the community who live and work in the City, regulatory services there remains a need to:

- provide imported food and feedstuffs control by Port Health inspections, sampling and interventions that protect consumers from hazards imported from the rest of the world
- ensure that ships visiting the Port of Southampton are free from health risks and hazards by the issuing of Ships Sanitation Certificates under International Health Regulations
- continue to carry out food hygiene and safety interventions including sampling information and advice to retail and wholesale food outlets which aim to control food poisoning and infectious disease
- implement and monitor the Air Quality Action Plan and integrate this plan with the Local Transport Plan as the main source of pollution is from road traffic
- continue to control polluting processes by statutory authorisation and respond to industrial and commercial pollution incidents
- continue to maintain the Contaminated Land database including reviewing sites across the City to ensure that harm from previous industrial and commercial activity does not affect the community
- continue to provide a service to respond to statutory nuisance including noise, drainage and hazardous environmental contamination which aims to protect the public from anti-social activity and public health hazards
- enforce tobacco control legislation including smoke-free public venues and the sale of tobacco products to underage young people; provide consumer advice, education and enforcement which is particularly aimed at protecting vulnerable consumers from harm.

Health at Work and Worklessness

Environmental Health aims to ensure that all 6000 workplaces allocated to the council for enforcement in Southampton operate in compliance with the law, and without causing death, injury and ill health to workers and other people.

In addition to this legislative responsibility the issue of health at work has been extended to include taking part in physical activity during the working day. This encourages better health in the workforce which in turn reduces absenteeism and long term conditions in the longer term.

To protect the health and safety of employees working in Southampton there is a need to:

- enforce the Health & Safety at Work Act to ensure safe working practices and to investigate notifiable accidents in these premises. This is to be carried out in partnership with the Health and Safety Executive and focused on businesses that present statistically the highest risk of accidents and ill health
- review NHS Southampton City and SCC policies related to work experience and recruitment practices to maximise opportunities to enter work for disabled people and

others who are currently excluded from work

- work with Local Neighbourhood Renewal partners to tackle issues related to disability and worklessness, inter-generational poverty and to raise aspirations related to entering the world of work, particularly in the Priority Neighbourhood areas
- ensure that SCC and NHS Southampton City adopt healthy workplace policies to enhance and promote the health and well-being of the workforce in organisations from whom they contract.
- promote the spread of the Active Workplaces initiative

Local Transport Plans

The Local Transport Plans 2006-2011 and the Solent Strategy of the Hampshire Local Transport Plan promote three park and ride schemes on the edge of Southampton, as part of a wider integrated approach to transport. These schemes will help to reduce the distance travelled by car, particularly for people without easy access to the public transport network. As well as promoting bus travel the park and ride schemes will enhance citywide air quality.

There is a need to:

- further develop transport facilities to improve access to health services
- further contribute to the prevention of disease and promote health through the Active Travel Plan
- to work to reduce the City Council and NHS carbon footprint
- make sustainable development an integral part of strategic planning and business processes, to develop the City Council and NHS to lead the transition to a healthy, sustainable, low-carbon future.

By April 2011, there is a need for Southampton City Council to work in partnership with Hampshire County Council, Portsmouth City Council and others to produce a new joint transport strategy, which will form part of a new Local Transport Plan.

Planning

At a national and local level planning policies aim to create an environment which contributes towards good health and well-being in the public. The national framework is set out in a series of Planning Policy Guidance notes. The City's key planning documents are the 2006 Local Plan and the 2010 Core Strategy. The key policies and references for health and wellbeing are:

- Chapter 9 of the Local Plan sets out the development policies and proposals for health and care, with the objective of delivering a caring inclusive city where people are free from harm, abuse and neglect and have access to services and amenities, and to maximise the benefits of urban living in promoting health and to offer all sections of the community access to good health. Policy CS10 in the Core Strategy is entitled "A Healthy City". It states that proposals for the intensification of healthcare uses on existing sites in accessible locations will be supported subject to meeting other relevant Local Development Framework policies. New and relocated health facilities should be in accessible locations where there is demonstrated need and should be linked to community hubs where appropriate. Proposals involving the loss of community – based primary health care facilities must demonstrate that adequate alternative provision is made to meet the needs of the community serviced by the facility.
- The 12 principles for fundamental design guidelines in the Core Strategy Policy include requirements that developments promote safe, secure, functional and accessible streets and quality spaces; impact positively on health, safety and

amenity of the city and its citizens; and place 'people first', designing out the risk of crime and promoting development at a human scale.

- CS16 in the Core Strategy set out proposals for housing mix and type. It aims to ensure the provision of adequate family houses and achieve an increase in the provision of homes for senior citizens and disabled people of all ages

Planning policies are seeking to retain the quantity and improve the quality and accessibility of the city's open spaces and help deliver new open space both within and beyond the city to meet the needs of all age groups through:

- protecting and enhancing key open spaces including Southampton Common, central, district and local parks;
- replacing or reconfiguring other open spaces in order to achieve wider community benefits such as improving the quality of open space, or providing a more even distribution across the city;
- safeguarding and, when opportunities arise, extending the green grid ;
- seeking developer contributions to provide high quality, accessible open spaces.

Carbon Reduction

Greenpeace use Southampton as a case study of a city with 'a true commitment to sustainable energy'. The City has a number of sustainable schemes including the Combined Heating and Power plant which provides power to numerous buildings including the Quays swimming and diving centre, the RSH Hospital and the Civic Centre.

In 2008/09 NHS Southampton City's carbon footprint represented 11,143 Tonnes of carbon. Due to recent changes in the NHS estate it is inappropriate to compare with earlier measurements, for example the incorporation of Royal South Hants Hospital estate into the PCT. Changes in emissions from various sources (energy, waste, water, transport and procurement) varied with energy consumption falling slightly in recent years relative to the size of the Trust's Estate with transport emissions falling faster.

The Audit Commission estimates that domestic carbon emissions per capita are 2.2 tonnes and the total carbon emissions per capita are 6.3 tonnes. Southampton City Council has commissioned a PhD student to model the carbon footprint of the whole city.

To deliver low carbon health and social care there is a need to:

- reduce carbon emissions from relevant sources within NHS Southampton City by 10% by 2015 or before (against a 2006/7 baseline)
- Southampton City Council are required to reduce carbon emissions by 40% by 2020 based on 2008/09 baseline reporting of which demands accurate carbon emissions data
- apply the energy hierarchy, which sets the direction for sustainable energy use within the Council and in priority order, the City Council will strive to:
 - eliminate or reduce the need for energy
 - maximise the efficiency of the remaining energy uses
 - supply energy from renewable sources where feasible
- implement the carbon reduction action plans for the two organisations
- act as good examples for other organisations and stakeholders
- embed sustainability as a core aim within policies and procedures
- be a Good Corporate Citizen (GCC) and to progress towards 'Excellent' in the NHS GCC assessment
- ensure that the NHS Southampton City Sustainable Development Management Plan embraces the NHS Carbon Reduction Strategy and all relevant carbon and other

environmental legislation

- use opportunities for joint working presented at in the Energy Partnership (a sub group of the Southampton Partnership) designed to bring together key public and private sector organisations in the city to share best practice on carbon reduction
- ensure that the Plan is fully inclusive and engages with key stakeholders including staff, patients, visitors and local community
- addressing key areas for NHS Southampton and City Council in adapting to climate change to include ensuring that the health and social care infrastructure (GP practices, hospitals, nursing, residential and care homes and day care facilities) are resilient to the effects of heat, gales and floods

For more data on economic, social and environmental issues visit
www.southamptonhealth.nhs.uk/publichealth/jsna/data/e

References

A Smokefree Future 2010 NICE Guidance on School-based interventions to prevent the uptake of smoking among children -2010

Chartered Institute of Environmental Health (CIEH) (2008) *Good housing leads to good health* Watford, HIS BRE Press

Chief Medical Officer 2009 Annual Report. Department of Health (2010)

Health Related Behaviour Questionnaire HRBQ Schools Health Education Unit

Marmot Review (2010) Fair Society, Healthy Lives: a Strategic Review of Health Inequalities in England post 2010, Chapter 4, pp 133-4, published by The Marmot Review, available online at www.ucl.ac.uk/marmotreview

National Indicator (NI) 156 and National Indicator (NI) 187
– definitions contained in HM Government (2008) *National Indicators for Local Authorities and Local Authority Partnerships: Handbook of Definitions, Annex 4 – Local Economy and Environmental Sustainability* London: Department for Communities and Local Government

Roys M, Davidson M, Nicol S, Ormandy D. and Ambrose P. (2010) *The Real Cost of Poor Housing* Watford, HIS BRE Press

SEPHO (2010) 2008/09 Drug and Alcohol Action Team (DAAT) data profiles. Solutions for Public Health

Southampton City Council (2006) *Housing Needs and Housing Market Survey 2006* (unpublished) available online at
www.southampton.gov.uk/Images/Final%20Southampton%20Summary_tcm46-164870.pdf

Southampton City Council (2008) *Private Sector Stock Condition Survey (unpublished)* available online at
www.southampton.gov.uk/Images/Southampton%20Final%20report%202008_tcm46-223114.pdf

Southampton City Council (2008) *The Homelessness Strategy 2008-2013* available online at
http://www.southampton.gov.uk/Images/Homelessness%20Strategy%202008-13_tcm46-209528.pdf

The North West Public Health Observatory Alcohol Profiles by Local Authority
<http://www.nwph.net/alcohol/lape/>

Please refer to the questions at the end of this document - the deadline for feedback is Friday 29 October 2010

<http://www.southamptonhealth.nhs.uk/jsnaconsultation>

SECTION 6 - PROTECTING OUR HEALTH

Health protection is a vast and complex area to cover comprehensively in a consultation document. Two important aspects will be highlighted within this section that of vaccination to prevent disease and hepatitis C.

Vaccination Coverage

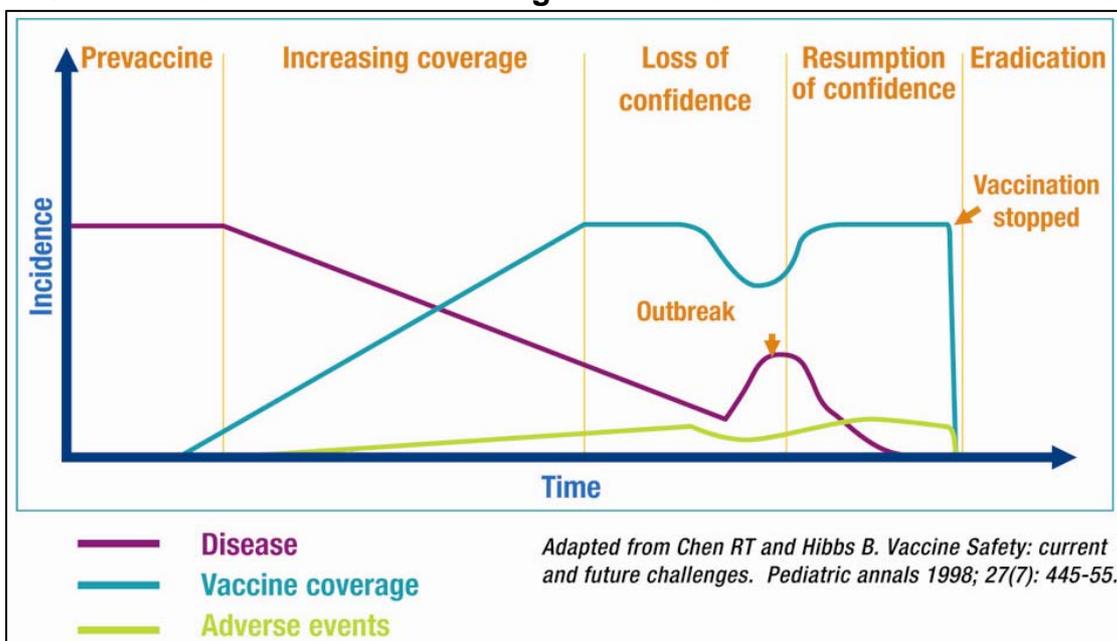
The World Health Organisation (WHO) states that 'it is every child's right to live free from vaccine preventable disease'. The widespread implementation of immunisation programmes over the past 30 years has led to remarkable achievements. The WHO European Region has been polio free since 2002 and in the past decade measles cases in the Region have been reduced by more than 90%.

The World Health Organisation (WHO) Regional Office for Europe
<http://www.euro.who.int/vaccine> accessed 28 April 2010

The Impact of Vaccination

The chart below shows how the introduction of a vaccine has eradicated the targeted disease, it also illustrates how loss of confidence, such as in the Measles, Mumps and Rubella (MMR) vaccine earlier this century (following discredited published research) impacts on uptake. MMR is a very effective and safe vaccine.

Figure 6.1 An illustration of vaccine targeted disease eradication



Nationally the immunisation programme is measured every 3 months. This is called COVER data and measures the number of children who complete vaccination courses at 1, 2 and 5 years. The vaccinations are listed in Table 6.1.

Routine Childhood Immunisation Programme

Each vaccination is given as a single injection into the muscle of the thigh or upper arm.

Table 6.1 Routine childhood immunisations England

When to immunise	Diseases protected against	Vaccine given
Two months old	Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b(Hib) Pneumococcal infection	DTaP/IPV/Hib and Pneumococcal conjugate vaccine (PCV)
Three months old	Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib) Meningitis C (meningococcal group C)	DTaP/IPV/Hib and MenC
Four months old	Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib) Meningitis C (meningococcal group C) Pneumococcal infection	DTaP/IPV/Hib and MenC and PCV
Around 12 months	Haemophilus influenza type b (Hib) and meningitis C	Hib/MenC
Around 13 months	Measles, mumps and rubella (German measles) Pneumococcal infection	MMR and PCV
Three years and four months or soon after	Diphtheria, tetanus, pertussis and polio Measles, mumps and rubella	DTaP/IPV or dTaP/IPV and MMR
Girls aged 12 to 13 years	Cervical cancer caused by human papillomavirus types 16 and 18	HPV
13 to 18 years old	Tetanus, diphtheria and polio	Td/IPV

All the above vaccinations are offered by GP practices except Human Papillomavirus Vaccine (HPV) which was introduced in September 2008, and is currently offered in education establishments.

Table 6.2 Immunisation for at risk neonates

FOR AT RISK NEONATES ONLY		
When to immunise	Disease protected against	Vaccine
Birth	Tuberculosis	Bacillus Calmette-Guèrin (BCG)
Birth	Hepatitis B	Hepatitis B

For more information visit www.immunisation.nhs.uk

In 2009/10 the Southampton vaccination cover (percentage of the population vaccinated) is 95% at age 1 year, 96.5% at age 2 years but drops to 93% at 5 years. MMR coverage dropped but is now recovering at 92.7% by age 5 years.

In 2009 in the South East region Southampton had the highest proportion of Mumps cases, 40 per 100,000 population. The uptake of two MMR vaccines remains below the 95% World Health Organisation recommended coverage for population immunity. There are a large number of older children and young people who have not had two doses of this vaccine.

Table 6.3 Mumps cases in the South East region, January to December 2009 and vaccination coverage

PCT	No of Cases	Cases per 100,000 population	MMR Vaccination Coverage (2 doses)
Southampton City	94	40.07	87.2%
Portsmouth City Teaching	52	26.00	83.8%
Hampshire	146	11.35	86.8%
Isle of Wight	<5	<0	86.4%
South Central SHA	643	15.82	84.6%
South East Total	1087	12.97	82.7%

NB: PCT code was provided by the reference laboratory (n=1,087). Three cases were tested outside the region but were resident in the South East. Eight cases did not have a PCT code provided and therefore could not be mapped to a PCT. Sources: Immunisation Reference Laboratory, CFI, Oct-Dec 09 COVER data and ONS mid-2008 population estimates

The majority of the above cases of Mumps in Table 6.3 were in the 15 to 23 year age group and is likely to include a number of students studying in Southampton from other areas. Mumps may be more severe post-adolescence. This highlights the importance of vaccination and the school leaving boosters so that young people are well immunised for life.

Data on 13 to 18 year olds receiving what is referred to as the 'school leaving booster' is not robust, but is estimated to be less than 60%.

To find out more see Southampton City PCT
www.southamptonhealth.nhs.uk/publichealth/jsna/data/c

Groups at Risk

Evidence has shown that the following groups of children and young people are at risk of not being fully immunised:

- those who have missed previous vaccinations (whether as a result of parental choice or otherwise)
- looked after children
- those with physical or learning disabilities
- children of teenage or lone parents
- those not registered with a GP
- younger children from large families
- children who are hospitalised or have a chronic illness
- those from some minority ethnic groups
- those from non-English speaking families
- vulnerable children, such as those whose families are travellers, asylum seekers or are homeless.

To achieve a successful routine childhood immunisation programme to protect individuals throughout their lives there is a need to:

- continue to promote the importance of vaccination to parents and young people to maintain/increase our cover data to above 95% the acknowledged level of cover to prevent widespread disease transmission
- identify strategies for improving immunisation of those groups shown to be at risk of not being immunised
- upgrade the Child Health Records Departments IT systems to more effectively record and performance monitor vaccination programmes

- improve the uptake of the school leaving booster with GP practices so that young people are protected against vaccine preventable diseases
- ensure that all GP practices who register FE and University students offer vaccinations to those in their care who remain unvaccinated.

Hepatitis C

Hepatitis C is a serious public health issue with potentially grave complications, shortening life expectancy. Much of the burden of this disease is undiagnosed. Hepatitis C is potentially preventable, as is much of the associated morbidity with timely identification and treatment. Hepatitis C is a particular problem among certain groups in the population of Hampshire and Isle of Wight, especially injecting drug users, men who have sex with men, migrants, homeless people and prisoners/offenders. In these groups, prevention measures such as needle exchange and information on the disease, can act to reduce incidence and thus the burden of disease.

The hepatitis C virus can live in blood outside the body for weeks; microscopic amounts can spread this disease, for example on toothbrushes, needles, drug mixing spoons and other objects. If an individual were to share a rolled up note or straw for snorting drugs they risk exposing themselves and others to hepatitis C. The Hepatitis C trust warns that this is especially true if a person's nose is bleeding. Cocaine in particular is very alkaline and corrosive to the thin membranes in the nose. If even tiny drops of blood, too small to see, get onto the straw or note and someone else then uses it, it is quite possible for them to make blood to blood contact through their own nasal membranes and become infected.

It is estimated that in Southampton there are 585 people living with HCV but across Hampshire and the Isle of Wight a total of 4,668 individuals are currently infected with HCV. The health needs assessment on hepatitis C virus in Hampshire and the Isle of Wight predicts that if untreated this would result in 316 avoidable deaths by 2015 across the region.

To raise the dangers of hepatitis C and reduce the increase in the number of new cases diagnosed there is a need to:

- continue prevention efforts to reduce the burden of disease
- improve identification and early detection of our at risk population
- ensure that health and social care pathways are shared across Hampshire and the Isle of Wight
- set up a centralised database at a regional level including: service use; treatment outcomes; cost of treatment; patient profile (age, gender, ethnicity) which could provide actual baseline data used for benchmarking and health service planning.

References

Hepatitis C Virus in Hampshire and the Isle of Wight: A Health Needs Assessment
Dominique Le Touze November 2009

The Hepatitis C Trust www.hepctrust.org.uk/

Department of Health (2005) Face your past. Crown.

Samad et al. Incomplete immunisation uptake in infancy: maternal reasons. Vaccine, Nov 2006, Vol 24, pp 6823-9. Epub.

Peckham et al. Towards better immunisation rates. Practitioner, Oct 1989, Vol 233, pp 1343-4.

Hill et al. Specialist vaccination advice and pockets of resistance to MMR vaccination: lessons from an outbreak of measles. Communicable Disease and Public Health. Dec 2003, Vol 6 pp 330-3.

Please refer to the questions at the end of this document - the deadline for feedback is Friday 29 October 2010

<http://www.southamptonhealth.nhs.uk/jsnaconsultation>

SECTION 7 - DELIVERING THE BEST HEALTH CARE OUTCOMES

Preventing and Improving the Outcomes of Cancer

Prevention

The burden of a disease is measured using directly age standardised incidence rate (per 100,000). The number of people diagnosed with cancer in England is 372 and Southampton is 408 per 100,000 population. Thus we have an additional 36 cancers per 100,000 of our population. In the under 75 age group the figures for England and Southampton are respectively 293 and 322 per 100,000.

Rates of breast and prostate cancer are slightly below the average for England, whereas bowel cancer is above the English average. The incidence of lung cancer is significantly higher across the City with 673 people having this diagnosis between 2003 and 2007. This remains a worrying statistic, especially as the prognosis for this cancer is poor, with a 1 year survival rate of only 22%.

In his report 'Policy and Action for Cancer Prevention' (2009) Professor Sir Michael Marmot focused on food, nutrition and physical activity from a global perspective. This report acknowledged that fifty percent of cancers can potentially be prevented.

A number of factors influence a person's risk of developing cancer and the outcome of the disease. Some of these factors, such as age, genetic makeup and sex, are fixed, but others are lifestyle factors which can be modified, e.g. quitting smoking, eating a balanced diet, reducing exposure to UV rays and increasing physical activity can help to prevent cancer.

Inactivity affects 60–70% of the adult population: that is more people than obesity, alcohol misuse and smoking combined. The potential benefits of physical activity to health are huge. If a medication existed which had a similar effect, it would be regarded as a 'wonder drug' or 'miracle cure' CMO (2010) see Table 7.1 below.

Table 7.1 Physical Activity substantially reduces the risk of common diseases including cancer.

Disease	Effect of Physical Activity
Coronary heart disease	Moving to moderate activity could reduce risk by 10%
Stroke	Moderately active individuals have a 20% lower risk of stroke incidence or mortality
Type 2 diabetes	Active individuals have a 33-50% lower risk
Bowel (Colon) cancer	The most active individuals have a 40-50% lower risk
Breast cancer	More active women have a 30% lower risk
Osteoporosis	Being physically active reduces the risk of later hip fracture by up to 50%

Adapted from the CMO Report 2009 p.23

More effective treatments and better ways of detecting cancer exist than ever before but it is necessary to work to prevent or reduce cancer prevalence. Indeed the National Cancer Survivorship Initiative Vision (2010) highlights that in the UK over 1.6 million people have survived cancer.

Cancer and Inequalities

Deprivation is strongly linked with lung cancer due to the higher prevalence of smoking, while breast cancer is linked with more affluent groups. There are inequalities in survival

rates in most deprived groups for cancers of the lung, colon and breast. We need to ensure there is a good uptake of screening programmes for cancer in Southampton which remains a challenge. We must enable more people to understand how lifestyle choices affect their health.

Lung Cancer

Lung cancer continues to be one of the most common cancers in Southampton, remaining very hard to treat, and the prognosis is poor for most people at the time of diagnosis. Over 95% of cases are related to smoking tobacco, emphasising again the importance of tobacco control and smoking cessation.

Bowel Cancer

One in twenty people are likely to develop bowel cancer in their lifetime. Bowel cancer is the second most common cause of cancer death following lung cancer. In 2008 the Bowel Cancer Screening Programme was introduced for 60 to 69 year olds in the City. This programme offers screening every two years to men and women within this age group. In March 2010 at the end of this first screening round, 47.5% of men and 53% of women had taken up this offer. In wider Hampshire the uptake was 60%.

Breast Cancer

In England breast cancer has a crude incidence rate of 149 cases per 100,000. Since the introduction of breast screening the mortality rate nationally has reduced by 34% in women aged 50 to 70 years. In Southampton the overall uptake rate for breast cancer screening in 2008/2009 was 74.6%, which was a slight improvement on the uptake rate of 72.3% in 2007/8. At the end of 2007, it was announced by the government that the National Breast Screening Programme would be extended to invite women aged from 47 to 73 (current eligible age range 50 to 70). The age range change was to be phased in from April 2008, with full implementation expected by 2012. The age extension will be linked to the introduction of digital mammography. A business case has been developed including the cost of full conversion to digital mammography including staffing costs, and the PCT continues to work with the breast screening unit on implementation plans for this age extension.

Cervical Cancer

Every year, 2,000 women are diagnosed with cervical cancer in the UK. Sadly, approximately 800 die. It is a disease that often affects women in the middle years of life. Infection with human papilloma virus is responsible for 70% of cases. The introduction in 2008 of a vaccine against human papilloma virus for teenage girls promises to markedly reduce the incidence of this disease in the future. The uptake of this vaccine in the City has been good.

Year 8 girls 93% received the first vaccination and 88.8% their third and completed this programme. Catch up programmes are underway hence our data is currently incomplete for this academic year. Vaccinations have taken place in educational establishments by school nurses.

This vaccination programme will not eliminate the necessity of cervical screening for which the uptake in the City is below that for England and our comparator Local Authorities.

Malignant Melanoma

Worryingly the incidence of malignant melanoma is increasing in Southampton and exposure to ultraviolet radiation, including that from tanning beds and lamps, is the single most important avoidable cause.

To find out more see Southampton City PCT:

www.southamptonhealth.nhs.uk/publichealth/screening

www.southamptonhealth.nhs.uk/publichealth/lhc

www.southamptonhealth.nhs.uk/publichealth/jsna/data/b

To prevent cancer and improve health outcomes of those living with cancer there is a need to:

- improve public information and health promotion about lifestyle choices to reduce vulnerability to cancer including quitting smoking, but also diet, alcohol consumption and exercise
- improve public information and health promotion about lifestyle choices that can reduce vulnerability to cancer, appropriate self-observation and what to do if cancer is suspected
- promote sun and sun-bed awareness more proactively to reduce the growing trend in skin cancer which is a largely preventable disease with excess exposure to ultraviolet radiation as a major contributing factor
- continue to offer the HPV vaccine to Year 8 girls and link this information to the cervical screening programme
- increase the number of women participating in breast and cervical screening programmes in the City
- increase the number of men and women aged 60 to 69 participating in the bowel screening programme from 50% to over 60%, which from 2010/11 will include people aged 70 – 74
- improve understanding of the barriers to cancer screening programmes and why some people choose not to be screened
- maintain that all people with a suspected cancer have their first outpatient appointment at a hospital within two weeks of seeing their GP
- improve targeting of prevention services in respect of male-specific cancers
- continue to improve access to radiotherapy waiting times.

Better End of Life Care

End of life care is about enabling people to live their life to the end with dignity and having their choices recognised. Not all people will be able to plan for their death, but for a number of people planned care will enable them to experience a peaceful and dignified death. For others the opportunity to decide where they wish to die is often not planned or is considered too late when it becomes difficult to move the person, for example, back to their home or support them with dignity there.

More palliative care nurses have been provided to better support end of life care at home. Across Southampton the Gold Standards Framework (GSF) is being implemented. This framework is a systematic evidence based approach for optimising the care of people nearing the end of life, delivered by GPs and District Nurses working together. It is concerned with helping people to live well until the end of life and includes care in the final years of life for people with any end stage illness in any setting. Providers are being commissioned to use the Liverpool Care Pathway (LCP) which is an integrated care pathway that is used at the bedside to improve sustained quality of the dying in the last days and hours of life.

There were 1,963 deaths to Southampton residents in 2008 and of these, cancer was responsible for 26.5% and circulatory diseases accounted for 32.5%. Nearly 63% of deaths occurred in an NHS Hospital, 3.2% in a nursing home, 8.6% in a residential care home and 21.7% at the person's own home.

NHS Southampton City held a public engagement event, inviting a number of guests representing the wide spectrum of people in the City. As part of this engagement a workshop was held on End of Life Care. Participants were asked to draw on their own experiences and knowledge to contribute to the development of our vision for a future model.

Feedback from this session told us that:

- individual choice is paramount
- palliative care should be extended to other diseases besides cancer
- bereavement counselling and counselling should be available in all GP practices
- integration between health and social care could provide better co-ordination

Following this event NHS Southampton City will undertake a performance review of current services to establish a service that is accessible to all regardless of diagnosis for end of life care.

To find out more see the Data Compendium at www.southamptonhealth.nhs.uk/publichealth/jsna/data/b

To better support people with end of life care there is a need to:

- increase public awareness and discussion around death and dying
- assess the population need for end of life care services more robustly
- map current provision, including its quality to ensure that the Gold Standard Framework and Liverpool Care Pathway are incorporated and audited
- compare current provision with population need
- extend palliative care to other diseases besides cancer
- ensure that all those approaching the end of life have access to physical, psychological, social and spiritual care
- identify where service improvements are needed
- use the learning from a joint NHS Southampton and City Council review by sharing the data with local partners
- establish a single point of access through which services are co-ordinated
- enable timely access to equipment to support moves from hospitals to home settings
- provide timely discharge to appropriate accommodation of choice
- establish an end of life care register which is accessible to all appropriate service providers eg. Out of Hours Services
- provide timely discharge to appropriate accommodation of choice
- enable timely access to equipment to support moves from hospitals and acute settings
- have timely bereavement counselling available.

Community Pharmacy

Community pharmacies are an essential part of primary care services. Over recent years there has been a move to greater integration of pharmacies within the NHS to improve patient access and choice and to optimise the expertise provided by pharmacists as part of an integrated primary care service.

NHS Southampton is currently undertaking a Pharmacy Needs Assessment (PNA). This involves a review of population health needs with reference to current and potential services provided through community pharmacies. The PNA will then be used as the basis for commissioning services and in determining market entry requirements for new pharmacies.

The aims of the PNA are as follows:

- to describe existing pharmacy service provision in Southampton City
- to identify any gaps in provision of pharmacy services
- to provide a basis for determining market entry for new pharmacies
- to recommend options for improving access, services or patient choice
- to set the vision for pharmacy commissioning

There are 42 community pharmacies across the city providing a range of services in addition to routine prescribing:

- smoking cessation
- medicines use reviews
- health promotion advice
- signposting to other services
- emergency hormonal contraception ('morning after pill')
- palliative care medication service
- methadone and needle exchange

NHS Southampton is keen to hear the public's views on pharmacy services. A copy of the PNA will be available on the trust's website from the end of July and comments from all interested parties are invited via the response form provided (www.southamptonhealth.nhs.uk)

Dental/Oral Health

It is estimated that just under half of residents in Southampton are not accessing regular dental care even though there are dental practices accepting NHS patients across the City. A procurement process is underway for more primary dental care services with a public communications plan in place to raise awareness of the availability of NHS dentistry and how to access it through the Dental Helpline.

The Trust is working to support and increase oral health promotion in general dental practice. Nationally-developed key performance indicators are being incorporated into the new services currently being procured to enable practitioners to record their oral health promotion activity and monitor improvements in their patients. These programmes include monitoring the delivery of topical fluoride varnish applications and provision of fissure sealants as well as advice on diet and maintaining good oral hygiene.

The care pathway for patients who need minor oral surgery, such as the removal of wisdom teeth, has been reviewed and referral guidelines agreed with local dental practitioners. This is designed to ensure that the referral process is transparent and that patients are referred to the right place for their care, whether that is a primary care practice, intermediate care facility or secondary care hospital.

There is also work ongoing with neighbouring Trusts to establish the need for advanced dental restorative care, such as complex root canal treatments and to develop recommendations for the development of an appropriate service.

There is a need to:

- increase awareness of the availability of NHS dental care and the Dental Helpline
- encourage and support oral health promotion activity in general dental practice
- monitor the minor oral surgery care pathway to ensure the referral pathway is being adhered to. Carry out periodic audits of referrals to secondary care to ensure that

patients are being treated in the appropriate location.

- develop a specialist service to manage more advanced restorative care, in collaboration with other three neighbouring Trusts.

Obesity, Diet and Physical Exercise

Attitudes to diet and physical activity mean that many of the City's residents are significantly increasing their risk of poorer health and a shorter lifespan. Unchanged, these activities will prevent today's residents from sustaining the health gains enjoyed in recent decades.

11% of children in reception classes are overweight and 9% obese; this increases to almost 13% overweight by year 6 with 17% obese. These figures for overweight are significantly different as they don't include obese children.

Obesity during childhood is linked to obesity in adulthood and exposes people to a higher risk of poor outcomes in relation to a range of short and long term health conditions. According to modelled estimates 22.3% of adults in Southampton are obese, which is not significantly different from the national average of 24.1%. In 2008/09 there were 18,868 people on GP obesity registers in the City which gives a crude prevalence rate of 9.3%. This disparity and unreliability is also found nationally and suggests that the majority of obese adults are not routinely weighed and recorded on GP systems.

Changes in diets and activity levels can be made by everyone. However it is clear that both diet and exercise are deteriorating. For example, the incidence of children in the City with type 2 diabetes has increased significantly over the last ten years. Tackling obesity will require a shift in cultural and societal values around physical activities. This may need to be supported by planning to enable physical activity to be a put back into daily life and daily habits.

Estimates of healthy eating are modelled from national data; for 2006-08 it is estimated that 25.4% of Southampton adults eat healthily which is not significantly different from the national average of 28.7%. However, a survey by Sport England found that 19.2% of adults in Southampton participate in 30 minutes of moderate intensity sport three times a week which is higher than the national average of 16.6%.

Analysis of the Southampton population using MOSAIC identifies that are two groups less likely to eat 5 or more portions of fruit and vegetables a day. These are older low income couples and young families or lone parents living in council estates mainly on the outskirts of the City (Groups 3 and 5).

To find out more see Southampton City PCT:

www.southamptonhealth.nhs.uk/publichealth/jsna/data/b

and Southampton City Council Leisure Services:

<http://www.southampton.gov.uk/s-leisure/>

To reduce levels of obesity and to ensure better diet and increase in population activity there is a need for action across several areas to:

- raise public and professional awareness of the health consequences of obesity, poor diet and lack of physical exercise for both children and adults and have an ongoing dialogue with people so we can better understand what the barriers are to eating well and being active
- increase the ability of more people being able to cook and in particular get young people interested in food and cooking at an early age – involvement in food

preparation is an important determinant of the quality of a individual's or family's diet

- ensure a wide range of good quality services and activities are accessible to children, young people and families across the City that help to make being active and eating well fun and easy
- support pre-schools, schools, colleges and in childcare settings in increase opportunities for children and young people to experience a healthy diet and good levels of physical exercise as part of their daily lives
- make it easier for people to access affordable, high quality, fresh food in preference to poor quality, energy dense food
- a range of services and support for children or adults that struggle to manage their weight to enable them to achieve a healthy weight
- ensure the environment enables and encourages both children and adults to be more active on a daily basis through making it easier, safer and more enjoyable to walk and cycle regularly
- develop initiatives that improve the diet and eating of seniors, and ensure that good eating and drinking takes place in care and hospital settings
- develop and support targeted prevention strategies and actions aimed at vulnerable groups in local communities
- engage with employers to promote employment practices that recognise the value of a healthy active workforce by considering the workplace in terms of the catering provided, whether through outlets that staff and local people can use or internal access to refreshments such as in tuck shops, vending machines for healthier options for those with a weight problem and encourage activity throughout the working day
- support more people in taking control over improving their own health through active, healthy lifestyles
- encourage healthy living options to reduce health inequalities
- ensure the future of Active Options, and other programmes (such as the senior health mentor programme) under the "Active Southampton" initiative to enable exercise referral to continue and expand to meet need
- improve our understanding of nutrition and obesity in Southampton through work with research partners such as the University of Southampton's Nutrition Biomedical Research Unit
- improve our understanding of peoples lifestyle choices by completing a second lifestyle survey for the City.

Better Outcomes for Vulnerable People with Supported Housing Needs

The Supporting People Programme commissions and funds 'housing related support' in the City. The programme is a partnership between the Council, NHS Southampton and the Probation Service. Approximately 6,000 people in Southampton are receiving services from Supporting People at any one time; 4,000 of these are older people being helped to live in sheltered and other housing. Other groups supported include homeless people, teenage parents and their children, people with learning disabilities living in the community, women fleeing domestic violence and people with alcohol and drug misuse problems. The programme helps to secure good quality housing for many of those otherwise vulnerable to poor health and well-being outcomes.

Significant changes have taken place to many support services in recent years, designed to enable people to remain independent for longer and to develop the skills to achieve independence. New pathways have been developed to support this. Needs assessments have identified the numbers of individuals within each client group requiring support. There

has been a shift away from traditional support based within specific units of accommodation to more flexible models, where support can be delivered regardless of the housing circumstances of the individual.

The programme has linked housing support to helping to achieve the City's objectives. The majority of support services are provided by voluntary sector agencies. Personalisation programmes are being prioritised, to ensure the best possible outcomes for users, putting Southampton at the forefront of this initiative.

Needs mapping has shown considerable levels of need for Supporting People style of services to older people living in the community but outside of sheltered housing.

To find out more visit the Southampton City Council Supporting People web site:
<http://www.southampton.gov.uk/living/adult-care/livingyourlife/supportingpeople.aspx>
And www.southampton.gov.uk/health/default.asp#0

To achieve better outcomes for those people with supported housing needs there is a need to:

- continue to promote personalised support services enabling individuals to make choices to help them meet their objectives and outcomes more quickly and more effectively
- enable quicker resettlement and link people with appropriate educational, training and employment opportunities
- provide support to older people living in the community, but outside of sheltered housing
- better link support for older people to moves to reduce hospital and other acute setting stays
- better understand the long-term needs and options for formerly homeless people with health and other problems as a result of alcohol use over many years, and develop services appropriately
- ensure that people with learning disabilities have the opportunity to live independently.

References

Chief Medical Officer 2009 Annual Report. Department of Health (2010)

Macmillan Cancer Support and the Department of Health 2010. The National Cancer Survivorship Initiative Vision
NHS Southampton End of Life Care strategy

Thomson, CS, Woolnough, S. Wickenden, M, et al. 2010 Sunbed use in children aged 11-17 in England: face to face quota sampling surveys in the National Prevalence Study and Six Cities Study BMJ 2010;340:c877.

Please refer to the questions at the end of this document - the deadline for feedback is Friday 29 October 2010

<http://www.southamptonhealth.nhs.uk/jsnaconsultation>

SECTION 8 - CONCLUSION

The analysis of the City's health and well-being , and the needs identified in this document, indicate that taking the city as a whole, people are living longer and healthier lives and living independently for longer. However, when compared to England and to other cities in the south of England in particular, Southampton experiences a lower level of health and well-being, lower earnings and lower educational achievements.

There is a wide range of diversity relating to these factors within the City. Whilst many people have the means to address their health and care needs, a significant number suffer from poverty, poorer life quality and poorer health outcomes. The needs identified are required to help reduce the inequalities gap whilst improving the overall health and well-being of the City.

The final JSNA which will be adopted by Southampton City Council and NHS Southampton early in 2011 will be a vital tool to assist those making decisions on commissioning and influencing services, against what will be a more limited set of resources to improve the health and quality of life for all citizens: from those just conceived to the end of life.

Your feedback and contributions on this consultation document will ensure that the final JSNA for 2011 to 2014 is as comprehensive as possible.

QUESTIONS FOR JSNA REFRESH CONSULTATION 2010

Questions about Children

1 Do you agree that this document has identified the key needs to maintain and improve children's physical and mental health in Southampton?

Yes No

2 If you answered No, what needs do you believe ought to be included, and why?

3. Do you agree that this document has identified the key needs to improve the safety and well-being of children and young people in Southampton?

Yes No

4. If you answered No, what needs do you believe ought to be included, and why?

5. Are there other health needs not described here you feel we should be investigating for the future?

Questions about Adults

6. Do you agree that this document has identified the key needs to maintain and improve adults' physical and mental health in Southampton?

Yes No

7. If you answered No, what needs do you believe ought to be included, and why?

8. Do you agree that this document has identified the key needs to improve the safety and well-being of vulnerable adults in Southampton?

Yes No

9. If you answered No, what needs do you believe ought to be included, and why?

10. Do you agree that these are the right priorities to support health and care needs of adults between 18 and 64 years in Southampton?

Yes No

11. If you answered No, what do you believe should be the priorities to support health and care needs of adults between 18 and 64 years in Southampton, and why?

12. Do you agree that these are the right priorities to support health and care needs of adults aged 65 and over in Southampton?

Yes No

13. If you answered No, what do you believe should be the priorities to support health and care needs of adults aged 65 and over in Southampton, and why?

14. Are there other health needs not described here you feel we should be investigating for the future?

Thank you.

The deadline date for feedback is Friday 29 October 2010; you can complete this questionnaire online at:

<http://www.southamptonhealth.nhs.uk/jsnaconsultation>

Alternatively, please post your response to:

**FREEPOST RRYC-AUHZ-EHKE
Attn. Emma Wynn-Mackenzie
NHS Southampton City
Oakley Road
Southampton
SO16 4GX**

The seven stages of an active person

	Specific benefits	Key motivating factors	Likely barriers
Pre-school	<ul style="list-style-type: none"> • Communication • Exploration • Motor development 	<ul style="list-style-type: none"> • Parental influence 	<ul style="list-style-type: none"> • Influence of parents and carers
School age	<ul style="list-style-type: none"> • Maintain healthy weight • Develop core skills (e.g. throwing and catching) • Teamwork 	<ul style="list-style-type: none"> • Parental influence • Variety of activities in and out of school 	<ul style="list-style-type: none"> • Access • Promotion of sedentary activities
Adolescence	<ul style="list-style-type: none"> • Bone mineralisation • Reduce risk of mental health problems • Promote healthy habits 	<ul style="list-style-type: none"> • Team and peer influences • Role models 	<ul style="list-style-type: none"> • 'Buddies' • Popular sedentary activities
Young adult	<ul style="list-style-type: none"> • Modify cardiovascular risk factors • Maintain healthy weight • Reduce stress 	<ul style="list-style-type: none"> • Accompanying children 	<ul style="list-style-type: none"> • Motivation • Availability and accessibility of facilities
Middle age	<ul style="list-style-type: none"> • Maintain flexibility • Limit weight gain • Reduce stress 	<ul style="list-style-type: none"> • Weight loss • Accompanying children 	<ul style="list-style-type: none"> • Time • Motivation and prioritisation
50-65 years	<ul style="list-style-type: none"> • Reduce cardiovascular risk • Reduce osteoporosis risk 	<ul style="list-style-type: none"> • Perceived health risks • Improved quality of life 	<ul style="list-style-type: none"> • Perceived inability and lack of fitness • Health concerns
Over 65 years	<ul style="list-style-type: none"> • Social benefits • Improve activities of daily living and mobility • Improve cognition 	<ul style="list-style-type: none"> • Social/enjoyment • Help with injury and disability 	<ul style="list-style-type: none"> • Health concerns

Reference:
2009 Annual Report of the Chief Medical Officer

Further information can be found at:

www.southamptonhealth.nhs.uk/jsna