Hampshire County Council

NOTICE OF MEETING

Meeting Health and Wellbeing Board

Date and Time Thursday, 15th March, 2018 at 10.00 am

Place Ashburton Hall, Elizabeth II Court, The Castle, Winchester

Enquires to members.services@hants.gov.uk

John Coughlan CBE
Chief Executive
The Castle, Winchester SO23 8UJ

FILMING AND BROADCAST NOTIFICATION
This meeting may be recorded and broadcast live on the County Council's website. The meeting may also be recorded and broadcast by the press and members of the public – please see the Filming Protocol available on the County Council's website.

AGENDA

Approx. Timings

1. APOLOGIES FOR ABSENCE

To receive any apologies for absence received.

2. DECLARATIONS OF INTEREST

All Members who believe they have a Disclosable Pecuniary Interest in any matter to be considered at the meeting must declare that interest and, having regard to the circumstances described in Part 3 Paragraph 1.5 of the County Council's Members' Code of Conduct, leave the meeting while the matter is discussed, save for exercising any right to speak in accordance with Paragraph 1.6 of the Code. Furthermore all Members with a Non-Pecuniary interest in a matter being considered at the meeting should consider whether such interest should be declared, and having regard to Part 5, Paragraph 2 of the Code, consider whether it is appropriate to leave the meeting while the matter is discussed, save for exercising any right to speak in accordance with the Code.

3. MINUTES OF PREVIOUS MEETING (Pages 5 - 10)

To confirm the minutes of the previous meeting

4. DEPUTATIONS

To receive any deputations notified under Standing Order 12.

5.	**CHAIRMAN'S ANNOUNCEMENTS** To receive any announcements the Chairman may wish to make.	
6.	**IMPROVED AND INTEGRATED BETTER CARE FUND UPDATE** (Pages 11 - 20) To receive a report for information regarding the Improved and Integrated Better Care Fund 2017-2019.	10:05am (10 mins)
7.	**PHARMACEUTICAL NEEDS ASSESSMENT** (Pages 21 - 80) For the Board to approve the Hampshire Pharmaceutical Needs Assessment, and to delegate response to pharmacy consolidation plans. This Board is responsible for the PNA and responding regarding pharmacy changes under regulations.	10:15am (10 mins)
8.	**SUICIDE PREVENTION STRATEGY** (Pages 81 - 98) For the Board to approve the Suicide Prevention Strategy for Hampshire. The Board is responsible for this strategy under regulations.	10:25am (15 mins)
9.	**UPDATE FROM THE HAMPSHIRE DISTRICTS HEALTH AND WELLBEING FORUM** (Pages 99 - 104) To receive an update from the Hampshire Districts Health and Wellbeing Forum (sub group of the Health and Wellbeing Board, leading on the Healthy Communities strand of the current Joint Health and Wellbeing Strategy).	10:40am (15 mins)
10.	**UPDATE FROM THE CO-DESIGN, CO-PRODUCTION AND COMMUNITY PARTICIPATION SUB GROUP** (Pages 105 - 112) To receive an update from the Co-design, Co-Production and Community Participation Sub Group of the Board and consider their recommendations.	10:55am (15 mins)
11.	**ANY OTHER BUSINESS** To consider any other business Board Members wish to raise.	11:10am (5 mins)
12.	**DATE OF NEXT MEETING** To note the next meeting of the Board is scheduled for 7 June 2018.	

Close of Meeting

The formal business of the Board is due to conclude by 11.15am. The Board will then go in to a closed workshop, due to conclude by 1.00pm.

ABOUT THIS AGENDA:

On request, this agenda can be provided in alternative versions (such as large print, Braille or audio) and in alternative languages.

ABOUT THIS MEETING:

The press and public are welcome to attend the public sessions of the meeting. If you have any particular requirements, for example if you require wheelchair access, please contact members.services@hants.gov.uk for assistance.

County Councillors attending as appointed members of this Committee or by virtue of Standing Order 18.5; or with the concurrence of the Chairman in connection with their duties as members of the Council or as a local County Councillor qualify for travelling expenses.

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AT A MEETING of the Health and Wellbeing Board of HAMPSHIRE COUNTY COUNCIL held at the castle, Winchester on Thursday, 14th December, 2017

PRESENT

Chairman:
p Councillor Liz Fairhurst (Executive Member for Adult Social Care and Health, Hampshire County Council)

Vice-Chairman:
p Dr Barbara Rushton (Chair, South Eastern Hampshire Clinical Commissioning Group

p Graham Allen (Director of Adults' Health and Care, Hampshire County Council)
p Councillor Roger Allen (Gosport Borough Council)
p Dr Sallie Bacon (Director of Public Health, Hampshire County Council)
p Nick Broughton (Chief Executive, Southern Health NHS Foundation Trust)
p Dr David Chilvers (Chair, Fareham & Gosport Clinical Commissioning Group)
p Steve Crocker (Director of Children's Services, Hampshire County Council)
p Councillor Anne Crampton (Hart District Council)
p Dr Nicola Decker (Chair, North Hampshire Clinical Commissioning Group)
vacancy (NHS England Wessex)
a Shantha Dickinson (Hampshire Fire and Rescue Service)
p Christine Holloway (Chair, Healthwatch Hampshire)
a Michael Lane (Hampshire Police and Crime Commissioner)
a Councillor Keith Mans (Executive Lead Member for Childrens Services and Deputy Leader, Hampshire County Council)
p Dr Sarah Schofield (Chair, West Hampshire Clinical Commissioning Group)
p Councillor Patricia Stallard (Executive Member for Public Health, Hampshire County Council)
p Phil Taverner (Test Valley Community Services, Voluntary Sector Representative)
a Nick Tustian (Chief Executive, Eastleigh Borough Council)
p Alex Whitfield (Chief Executive, Hampshire Hospitals NHS Foundation Trust)
p Dr Andrew Whitfield (Chair, North East Hampshire and Farnham Clinical Commissioning Group)

27. **APOLOGIES FOR ABSENCE**

Apologies were noted from the following:

- Cllr Keith Mans, Executive Lead Member for Childrens Services and Deputy Leader. His Substitute Cllr Roy Perry, Executive Member Policy and Resources & Leader of the Council, was in attendance in his place
- The representative of NHS England (Wessex) was a vacancy. Dr Liz Mearns the Substitute was in attendance
- Michael Lane, Police and Crime Commissioner for Hampshire. His Substitute Superintendent Paul Bartolomeo was in attendance in his place
- Nick Tustian, Chief Executive, Eastleigh Borough Council. His Substitute Patricia Hughes, Chief Executive, Hart District Council, attended in his place
- Shantha Dickinson, Hampshire Fire and Rescue Service. Her Substitute Nigel Cooper was in attendance in her place

28. **DECLARATIONS OF INTEREST**

Members were mindful that where they believed they had a Disclosable Pecuniary Interest in any matter considered at the meeting they must declare that interest at the time of the relevant debate and, having regard to the circumstances described in Part 3, Paragraph 1.5 of the County Council's Members' Code of Conduct, leave the meeting while the matter was discussed, save for exercising any right to speak in accordance with Paragraph 1.6 of the Code. Furthermore Members were mindful that where they believed they had a Non-Pecuniary interest in a matter being considered at the meeting they considered whether such interest should be declared, and having regard to Part 5, Paragraph 2 of the Code, considered whether it was appropriate to leave the meeting whilst the matter was discussed, save for exercising any right to speak in accordance with the Code.

29. **MINUTES OF PREVIOUS MEETING**

The minutes of the last meeting held on 5 October 2017 were reviewed and agreed.

30. **DEPUTATIONS**

No deputations were received at this meeting.

31. **CHAIRMAN'S ANNOUNCEMENTS**

Motor Neurone Disease Charter

The Chairman reported that encouraging local authorities to sign up to the Motor Neurone Disease Charter was part of the current phase of the MND Association's National Campaign, which sought to positively influence outcomes for people in local communities who have MND. As Executive Member for Adult Social Care and Health at Hampshire County Council, she had signed up to the principles in the Motor Neurone Disease (MND) Charter at her decision day on 22 November 2017.

The principles cover:

- People with MND have the right to an early diagnosis and information
- People with MND have the right to high quality care and treatments
- People with MND have the right to be treated as individuals and with dignity and respect
- People with MND have the right to maximise their quality of life
- Carers of people with MND have the right to be valued, respected, listened to and well supported

There were some areas of the MND Charter which were within the influence of partner organisations represented on the Board, such as the Health Service and District and Borough Councils. All five areas of the Charter are consistent with the way that the council seeks to work with its partners to support Hampshire

residents in a personalised, dignified way, that helps people to experience the best quality of life possible.

It was noted that a link to the decision day report about this would be circulated to Members of the Board for further information.

32. UPDATE ON THE HAMPSHIRE SUPPORTING FAMILIES PROGRAMME

The Board considered a report and supporting presentation on behalf of the Director of Children's Services regarding the Hampshire Supporting Families Programme. The Board heard that phase one of the programme had been independently evaluated and was estimated to result in £2.4 million 'costs avoided' per year for the public sector.

It was noted that there was a one page form for nominating families to the programme for GPs to use. It was agreed that the referral form be circulated to Board Members, for awareness raising within their organisations and networks.

It was noted that an interim report on phase two of the programme was due in early 2018, and the Board could be updated if this contained messages relevant to the partners represented on the Board.

RESOLVED:

The Health and Wellbeing Board:
a) Note the continuing work of the Supporting Families Programme
b) Consider the positive outcomes being achieved through the programme for families in Hampshire as a significant contribution towards supporting families with health issues.
c) Note the future direction and next steps.

33. KEY ISSUES AND FINANCIAL CHALLENGES FOR THE NHS AND COUNTY COUNCIL IN HAMPSHIRE

The Board received a presentation from the Director of Adults Services, the Director of Children's Services, the Chief Officer of West Hampshire Clinical Commissioning Group, and the representative of the Chief Officer of the Hampshire Clinical Commissioning Group Partnership.

The Board heard about the financial challenges facing each of the commissioners of health and care services in Hampshire. Adults and Children's services were required to reduce their budgets by 19% by April 2019 (£55.9m and £30.1m respectively). West CCG was targeting to make savings this financial year, but was currently below plan and expecting a break even position by the end of the year. West CCG was targeting savings of £40m for the next year, of which plans to achieve £18m were in place so far. The Hampshire CCG Partnership had a savings target for 2017/18 of £46m (4.2% of their budget) however they were predicting reaching the end of the year with a £9m deficit. The savings target for 2018/19 for the CCG Partnership was £63m.

The Voluntary Sector representative reported that the voluntary sector were also experiencing financial pressures, with a significant fall in grant funding from local authorities in recent years.

Board Members discussed opportunities to make savings such as new models of out of hospital care, and use of multi disciplinary teams. Also discussed were investment in prevention, opportunities for use of technology, and efficiency in back office administration and shared office space.

RESOLVED:

The Health and Wellbeing Board note the financial challenges facing the Hampshire health and care system.

The Health and Wellbeing Board revisit this issue for further discussion at a later date.

34. UPDATE FROM THE HAMPSHIRE DISTRICTS HEALTH AND WELLBEING FORUM

This item was deferred.

35. LOCAL TRANSFORMATION PLAN FOR CHILDREN

The Board considered a report on behalf of the Hampshire Clinical Commissioning Group Partnership regarding the refresh of the Local Transformation Plan for Children & Young People's emotional wellbeing and mental health.

The Board heard that this was a refresh of a strategy previously agreed in 2014, and since then there had been a number of developments including an increase in demand for mental health services for children, and the publication of 'future in mind' a national vision for children's mental health services. The Board was asked to approve the refreshed strategy, noting that the Starting Well sub group of the Board would monitor delivery against the strategy.

Board Members discussed issues experienced in children's mental health services, including waiting times to access services, availability of places to take children in crisis, and availability of tier 4 inpatient beds. It was noted that a green paper had recently been published which included a funding opportunity for mental health support in schools aimed at early intervention.

RESOLVED:

The Health and Wellbeing Board approve the refresh of the Local Transformation Plan for children & young people's emotional wellbeing and mental health.

36. ACHIEVING PRIORITIES FOR CO-PRODUCTION AND COMMUNITY PARTICIPATION

This Item was deferred.

37. **BUSINESS SUB GROUP UPDATE - REFRESHING THE JOINT HEALTH AND WELLBEING STRATEGY**

This Item was deferred.

38. **ANY OTHER BUSINESS**

No other business was raised on this occasion.

39. **DATE OF NEXT MEETING**

It was noted that the next meeting of the Health and Wellbeing Board was scheduled for 15 March 2018.

Chairman,

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HAMPSHIRE COUNTY COUNCIL

Report

Committee/Panel:	Health and Wellbeing Board
Date:	15 March 2018
Title:	Integrated and Improved Better Care Fund Update
Report From:	Director of Adults' Health and Care

Contact name: Karen Ashton / Zara Hyde-Peters

Tel: 01962 845612 **Email:** karen.ashton@hants.gov.uk

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1. Recommendations

1.1 Note the current position with regard to the Better Care Fund and improved Better care Fund policy.

1.2 Note the approach to the application of the IBCF.

1.3 Note that a Deed of Variation to the current Section 75 agreement was executed so that Hampshire meets expected National Conditions for a jointly agreed plan**.**

2. Executive Summary

2.1. The purpose of this paper is to provide a briefing on the latest position relating to the Integration and Better Care Fund 2017 – 2019 and the Improved Better Care Fund 2017 – 2019.

2.2. This paper seeks to:

- set out the background
- update on 2017 - 18 investment plan
- identify key issues

3. Contextual information

3.1 As previously reported the national policy for integration of health and social care delivery remains a national priority supported financially through the Integration and Better Care Fund and improved Better Care Fund (iBCF) announced in the spring budget in 2017. This announcement of an additional £2 billion for adult social care over three years is to target the financial implications of social care pressures[1] in the following areas:

- Meet adult social care needs

[1] https://www.gov.uk/government/publications/the-allocations-of-the-additional-funding-for-adult-social-care

- Reduce pressures on the NHS – including supporting more people to be discharged from hospital when they are ready
- Ensure that the local care provider market is supported

3.2. The additional grant came with a number of conditions, to ensure that the money is spent on adult social care services and supports improved performance at the health and social care interface. The grant was pooled into the Better Care Fund, to support a continuing agreement with the local NHS.

3.3. The Department of Health and Social Care (DH) have developed a set of metrics – including, but broader than, Delayed Transfers of Care – to assess patient flow across the NHS and social care interface.

3.4. These metrics are being considered in the current Care Quality Commission (CQC) system review for which Hampshire is one of 20 targeted areas, focusing on the interface of health and social care. The review does not cover wider council or full extent of social care commissioning. The outcome will support system leaders by providing a tailored response to support rapid improvement.

3.5 In addition Hampshire partners[2] have been offered and accepted support funded and commissioning jointly by the BCF national team, The LGA, NHS England NHS Improvement and provided by Newton Europe. This support is being delivered in parallel with the CQC review. Newton Europe will use their considerable experience and expertise to gather local insight and evidence into the root causes of current delayed transfers of care performance. The outcome will therefore provide the underpinning evidence for future focus and together partners will be able to develop plans to deliver optimum performance for next winter and beyond. The onsite diagnostic work is due to begin on 19th March.

3.6 In the longer term, the Government is committed to publishing a Green Paper explaining proposals for establishing a fair and more sustainable basis for funding adult social care, in the face of the future financial and demographic challenges the country faces.

4. Update on progress for agreeing an investment plan

4.1. All five Clinical Commissioning Groups (CCGs) and Hampshire County Council (the Council) agreed the core BCF and IBCF for 2017 – 2019 in 2017. The approach matched policy guidance for the core BCF to include 1.79% inflation in 2017/18 CCG allocations and 1.9% inflation in 2018/19. This resource is committed to contracted services, contributing some services included in the out of hospital care model including commissioned community health services and core social care.

4.2. For the IBCF, the Council circulated a briefing note in April 2017 that confirmed the funding will be added to existing spending plans to ensure it reaches the frontline quickly and intentions to spread the additional investment across the designated three areas of:

- meeting adult social care needs

[2] Initially covering the populations relating to North Hampshire and West Hampshire CCGs, University Hospital NHS Foundation Trust and Hampshire Hospitals NHS Foundation Trust

- reducing pressures on the NHS - including supporting more people to be discharged from hospital when they are ready
- stabilising the social care provider market

4.3. All investments have taken account of the short-term nature allocations and spending plans for 2018/19 and 2019/20 will reflect the reducing levels of additional support being provided. Plans take account of discussions in the four Accident & Emergency (A&E) Boards at local system level and discussion with nominated CCG leads. A number of principles were applied to the final deployment of funds:

- The funding decisions will be signed off by the Council as per the guidance and subject to separate assurance (as per national guidance)
- The funds will be directed at delivery of social care, including social care for the benefit of health
- The distribution of funds between the three categories of spend is fixed, the application of funds within each category, particularly in respect of the support for the NHS is flexible to target resources accordingly
- The measurement of delivery is determined by the (former) DCLG requirements i.e. number and hours of domiciliary care packages, number of residential placements

4.4 A partnership approach applied to the distribution of funds within the category of support for the NHS.

5. Finance

5.1 As previously reported £22,066,423 of the anticipated core BCF value for 2017/18 (£87,213,539) including £1,533,670 (1.79%) inflation is allocated to social care. A further £10m, is designated to fund Disabled Facilities Grants (DFGs) and allocated centrally to Housing Authorities. For Hampshire Districts and Boroughs Table 1 sets out the distribution. The remaining £54,452,947 will contribute to NHS commissioned community health services. The delayed technical guidance will confirm these financial assumptions.

Funding for the Better Care Fund 2016-17			
Local Authority	**Disabilities Facilities Grant**	**Council**	**BCF contributions to District Councils for DFG**
Hampshire	£10,694,169	Basingstoke & Deane	£1,170,322
		East Hampshire	£1,264,549
		Eastleigh	£989,455
		Fareham	£646,280
		Gosport	£677,493
		Hart	£627,025
		Havant	£1,495,231
		New Forest	£971,750
		Rushmoor	£899,653
		Test Valley	£1,030,556
		Winchester	£921,855

Table 1: Distribution of DFG allocation across Hampshire Housing Authorities

5.2 As part of the Spring Budget £2 billion[3] of additional IBCF funding announced by the Chancellor equated to £37.1 million for Hampshire over three years, to be pooled alongside the core BCF. Table 2 below the allocation each year

Table 2: Allocation on IBCF 2017 - 2020

Local Authority	2017-18 Additional funding for adult social care announced at Budget 2017	2018-19 Additional funding for adult social care announced at Budget 2017	2019-20 Additional funding for adult social care announced at Budget 2017
Hampshire	**17,010,142**	**13,437,051**	**6,697,875**
Neighbouring Local Authority allocations:			
Isle of Wight	3,254,171	2,175,088	1,081,256
Portsmouth	3,997,256	2,537,715	1,258,181
Southampton	4,981,651	3,161,704	1,567,547
Total HIOW	**29,243,220**	**21,311,558**	**10,604,859**

5.3 Whilst additional IBCF temporary funding has provided a three year window for stabilising existing provision and for targeted investment to relieve system pressures has been is welcome, it does not negate the underlying intense financial pressure and constraint within the social care system.

5.4 The short term funding has been added to existing spending plans, allocated in the three specific areas outlined above. All investments take account of the short-term allocations, shown above, and spending plans for 2018/19 and 2019/20 reflects the reducing levels of additional support being provided. The detail of proposals was agreed with CCG partners. Appendix A. sets out summary for 2017/18.

5.5 The approach in each local system has built on the work already being undertaken collectively across the NHS and Local Authority to improve the way people enter, move through, and are discharged from the county's hospitals taking account of recognised best practice outlines in the High Impact Changes[4]. This includes investing in the social care elements, on an "*invest to save"* basis, to develop / maintain schemes across Hampshire that both improve outcomes:

5.6 The investment has been monitored through a return to the (former) DCLG signed off by the Hampshire County Council Section 151 officer (Carolyn Williamson - Director of Corporate Resources).

5.7 As part of the Autumn Budget announcement in November 2017, the Government announced that an additional £42 million of funding would be provided for the Disabled Facilities Grant (DFG), increasing the total annual DFG budget in 2017/18 to £473 million. This additional and complementary grant was transferred directly to lower-tier Local Authorities by the former DCLG. Whilst this additional funding replicates the purpose and flexibilities of the existing DFG that sits within outdated housing legislation, Local Authorities were encouraged to use the funding innovatively by working with others across health and social care.

[3] https://www.gov.uk/government/publications/the-allocations-of-the-additional-funding-for-adult-social-care

[4] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model

6. Performance

6.1. Both the core BCF and the IBCF require demonstration of national conditions and success being measured by nationally determined metrics. For the core BCF these national conditions for 2017 - 2019 are:

- Plans to be jointly agreed;
- NHS contribution to adult social care is maintained in line with inflation;
- Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care; and
- Managing Transfers of Care

6.2 For IBCF Councils have been required to submit quarterly returns signed off by the Local Authority Section 151 Officers (as with the precept), and subject to the following grant conditions:

- The grant can only be used for meeting adult social care needs, reducing pressures on the NGS, including supporting people to be discharged from hospital and supporting the local social care market providers
- The recipient authority must:
  - pool the grant into the local BCF unless the authority has written Ministerial exemption.
  - work with relevant CCGs and providers to meet National Condition 4 (managing transfers of care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017 – 2019; and
  - Provide quarterly reports to the Secretary of State

6.3 Performance metrics for the core BCF were reduced in 2017/18 to cover:

- Delayed transfers of care;
- Non-elective admissions (General and Acute);
- Admissions to residential and care homes; and
- Effectiveness of re-ablement

6.4 Performance for the IBCF for the first quarter was measured on:

- Number of packages of care
- Hours of domiciliary care
- Numbers of residential placement

6.5 In the second quarter iBCF areas were asked to add additional local measures. The Hampshire measures selected relate to our transformation programme:

- Total number of clients receiving permanent residential or nursng care, aged 65 or over
- Total number of clients receiving permanent residential or nursing care, aged under 65
- Percentage of clients accessing reablement as their first service on discharge from hospital.
- Percentage of clients supported by services that help them to live at home
- Percentage of clients living at home following a reablement service
- Percentage of clients surveyed stating that the services they received made them feel safer.
- Number of eligible clients supported to live at home with telecare services

- Number of clients with a learning disability in supported accommodation

6.6 Both the BCF and iBCF schemes are monitored quarterly. The last Q3 returns submitted in January 2018 via NHS England and the DCLG.

7. Legal Implications – Section 75 Agreements

7.1 It is a requirement for local authorities and CCGs to establish one or more pooled funds for delivery of the schemes activity. An existing Section 75 agreement has been amended via a Deed of Variation to reflect agreements.

8. Key Issues

8.1. The most pressing issue for the system continues to relate to our ability to synchronise the overall approach across Hampshire and that this approach supports the collaborative delivery of the wider system vision.

8.2. Whilst we developed our approach on the basis of “steady state” during an initial absence of the technical planning guidance that to some extent created a planning hiatus, further changes have occurred in year at a national government level. The impact to future reporting for the iBCF of social care being incorporated within the DH is unknown at this stage.

9. Future direction and next steps.

9.1. The Government has committed to publishing a Green Paper explaining proposals for establishing a fair and more sustainable basis to put funding adult social care on a more secure footing, in the face of the future financial and demographic challenges.

9.2. It is clear that integration of health and social care remains a high priority. The core BCF and IBCF are components of the Sustainability and Transformation Programme relating to New Models of Care.

9.3. System partners continue to work together through the joint commissioning discussions to understand both the use and the benefits for local people and organisations are understood in the face of an even more challenging financial landscape.

IBCF 2017 - 20									
Allocation	**2017/18 £17.0m**								
	2018/19 £13.4m								
	2019/20 £ 6.7m								
Local systems CCG per capita proportion agreed 14-15 - for infromation only	**2017/18**	**2018/19**	**2019/20**		**F&G 15%**	**SE 16%**	**N 16%**	**NE 12%**	**W 41%**
	£	**£**	**£**	**Total £**	**£**	**£**	**£**	**£**	**£**
Meeting Adult Social Care Needs									
Learning Disability - meeting new emergent cost on national living wage sleep in rates. (Estimate Ref JH)	1,300,000	1,500,000	1,700,000	4,500,000					
Adult Mental Health - Crisis intervention	500,000	500,000		1,000,000					
Prevention & demand management initiatives.(Ref GS 28 04 17)	750,000	TBC	TBC	750,000					
Social Care Transformation: (Ref GS 28 04 17).	1,600,000	TBC	TBC	1,600,000					
Integrated working with SHFT: (Ref GS 28 04 17)	TBC	TBC	TBC	0					
Digital improvement and implementation (Ref GA 15/05/17)	1,000,000	1,500,000	1,500,000	4,000,000					
Total Meeting Social Care Needs	**5,150,000**	**3,500,000**	**3,200,000**	**11,850,000**	**1,775,500**	**1,898,000**	**1,898,000**	**1,422,000**	**4,856,500**
Stabilise the social care provider market									
Carer Support - three phase programme for providers.(Ref NG 01 06 17)	150,000	150,000	150,000	450,000					
Learning Disability - least restrictive practice - increasing provider capability	750,000	1,500,000	0	2,250,000					
Existing demand and price pressure in care market (Ref PA 14/06/17)	4,570,000	3,250,000	2,200,000	10,020,000					
Additional equipment in house residential homes(Ref email KD 06/06/17)	20,000		0	20,000					
			0	0					
Total Stabilise the social care provider market	**5,490,000**	**4,900,000**	**2,350,000**	**12,740,000**	**1,917,500**	**2,044,600**	**2,044,600**	**1,465,200**	**5,268,100**
Reduce pressures on the NHS									
Early Discharge Planning									
Additional short term beds @ HHFT site. Estimated cost	1,000,000			1,000,000					
HCC additional non-chargeable short term beds. Estimated cost	0	1,000,000		1,000,000					
Joint initiatives within the FPH.	300,000	300,000	300,000	900,000					
Fully implement whole system approach to Acute & Community Hospitals (Ref Email GA 18/05/17)	70,000			70,000					
RBCH interim care team (Ref Email DB 24/05/17)	200,000			200,000					
Total	**1,570,000**	**1,300,000**	**300,000**	**3,170,000**					
Systems to Monitor Patient Flow									
SC investment - joint admission prevention scheme - county wide time (Ref KJ & IC)	1,150,000	2,600,000		3,750,000					
Bluebird Care / JET short term (Ref KJ/KA 09/06/17)	150,000			150,000					
Total	**1,300,000**	**2,600,000**	**0**	**3,900,000**					
Multi-disciplinary / DischargeTeams									
Increase system capacity for SE Hants (Ref GA 15/05/2017)	150,000	150,000		300,000					
System response to Medically Fit For Discharge Details TBC (Ref GA 31/05/17)	350,000	350,000	350,000	1,050,000					
Total	**500,000**	**500,000**	**350,000**	**1,350,000**					
Home First / Discharge to Assess									
TEC - expansion and implementation.(ref GS 28 04 17)	TBC	TBC	TBC	0					
Re-ablement hubs: assess feasibility studies and business case development.(Ref GS 280417)	TBC	TBC	TBC	0					
CRT enhancement - transitional care team (Ref Discussed at A&E Board 4 May 2017)	500,000	500,000	500,000	1,500,000					
Seasonal pressures - higher cost care (Ref GA / DC May 2017)	1,500,000			1,500,000					
Total	**2,000,000**	**500,000**	**500,000**	**3,000,000**					
Seven Day Service									
Enbedding improvement in hospital team model - HCC (Ref GA 31/05/17)	100,000	100,000	0	200,000					
Total	**100,000**	**100,000**	**0**	**200,000**					
Trusted Assessor									
Enbedding improvement in hospital team model (Ref GA 31/05/17)	150,000	0	0	150,000					
CHC: Support for day 29 Refunds Guidance implementation (Ref Mtg 05 05 17)	250,000	0	0	250,000					
Total	**400,000**	**0**	**0**	**400,000**					
Focus on Choice									
				0					
Total	**0**	**0**	**0**	**0**					
Enhancing Health in Care Homes									
Dementia care	500,000			500,000					
Total	**500,000**	**0**	**0**	**500,000**					
Total Reduce Pressures on the NHS	**6,370,000**	**5,000,000**	**1,150,000**	**12,520,000**	**969,000**	**2,396,000**	**3,046,000**	**1,662,000**	**4,447,000**
TOTAL SPEND PROPOSED	**17,010,000**	**13,400,000**	**6,700,000**	**37,110,000**	**4,662,000**	**6,338,600**	**6,988,600**	**4,549,200**	**14,571,600**
Total Allocation	**17,010,000**	**13,400,000**	**6,700,000**	**37,110,000**					

CORPORATE OR LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	no
People in Hampshire live safe, healthy and independent lives:	yes
People in Hampshire enjoy a rich and diverse environment:	no
People in Hampshire enjoy being part of strong, inclusive communities:	yes

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

IMPACT ASSESSMENTS:

1. Equality Duty

1.1. The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, gender and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Due regard in this context involves having due regard in particular to:

1.2. The need to remove or minimise disadvantages suffered by persons sharing a relevant characteristic connected to that characteristic;

1.3. Take steps to meet the needs of persons sharing a relevant protected characteristic different from the needs of persons who do not share it;

1.4. Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity which participation by such persons is disproportionally low.

1.5. **Equalities Impact Assessment:**

This is an update, impact assessments will be undertaken when particular decisions are due to be taken.

2. Impact on Crime and Disorder:

2.1. This is an update, impact assessments will be undertaken when particular decisions are due to be taken.

3. Climate Change:

3.1. How does what is being proposed impact on our carbon footprint / energy consumption?

3.2. How does what is being proposed consider the need to adapt to climate change, and be resilient to its longer term impacts?

This is an update, impact assessments will be undertaken when particular decisions are due to be taken.

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HAMPSHIRE COUNTY COUNCIL

Report

Decision Maker:	Health and Wellbeing Board
Date:	15 March 2018
Title:	Hampshire Pharmaceutical Needs Assessment and Procedure for response to pharmacy consolidation applications
Report From:	Dr Sallie Bacon, Director of Public Health

Contact name: Sallie Bacon Director of Public Health
Simon Bryant Associate Director of Public Health

Tel: 02380 383326 **Email** simon.bryant@hants.gov.uk

1. Recommendation(s)

1.1. To approve the Pharmaceutical Needs Assessment 2018 for Hampshire for publication.

1.2. To delegate authority to the Director of Public Health, to make representations to NHS England about pharmacy consolidation applications.

2. Executive Summary

2.1. The purpose of this paper is to enable the Board to sign off the Pharmaceutical Needs Assessment (PNA) and to delegate authority for pharmacy consolidations to the Director of Public Health, in consultation with the chair of the Health and Wellbeing Board.

2.2. The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 set out the requirement for each Health and Wellbeing Board to assess needs for pharmaceutical services in its area, and publish a statement of its first assessment and of any revised assessment. The PNA is a statement of the pharmaceutical needs of the population within the local area. The purpose of the Hampshire PNA is to identify the need and provision of pharmaceutical services (Community Pharmacy) for the Hampshire population.

2.3. The Health and Wellbeing Board has a statutory duty to make a representation to NHS England on consolidation applications of community pharmacies in its area (i.e. where pharmacy businesses on two or more sites propose to consolidate to a single existing site). The Board must respond within 45 days. This paper outlines a proposed process for delegating authority to the Director of Public Health with regard to pharmacy consolidations where it is considered from the PNA analysis

3. Finance

3.1. There are no financial implications from the paper.

4. Pharmaceutical Needs Assessment

4.1. The pharmaceutical needs assessment has been undertaken inline with the regulations. It is a statement of the pharmaceutical needs of the population within the local area in relation to community pharmacy, distance selling pharmacy and appliance dispensing. The purpose of the PNA is to identify the need and provision of pharmaceutical services for the Hampshire population

4.2. This will be used by NHS England to ascertain the need for new community pharmacy services. This examines

a. the population and population growth for Hampshire

b. the proposed housing developments

c. the health of the population

4.3. For the purposes of the PNA the pharmaceutical services are included are;

a. Essential services

b. Advanced services

c. Enhanced services

d. Local pharmaceutical services (LPS)

e. Locally commissioned services

f. Dispensing service provided by medical practices

4.4. The needs assessment is set out in Appendix 1.

4.5. Following approval the PNA will be published on Hampshire County Council website and will include an up-to-date interactive map this enables people to search the areas of Hampshire to identify the location of pharmacy and appliance dispensing services.

5. Pharmacy consolidation

5.1. The Health and Wellbeing Board has a statutory duty to make a representation to NHS England on consolidation applications of community pharmacies in its area (i.e. where pharmacy businesses on two or more sites propose to consolidate to a single existing site).

5.2. This duty is set out in The National Health Service (Pharmaceutical Services, Charges and Prescribing) (Amendment) Regulations 2016.

5.3. This briefing sets out a proposal for meeting this duty

5.4. As specified in the regulations, the Board must provide an opinion to NHS England on whether, if the application were granted, the proposed removal of premises from the pharmaceutical list would or would not create a gap in pharmaceutical services. The decision is informed by the information in the PNA.

5.5. The Health and Wellbeing Board must respond to NHS England within 45 days of being notified of a pharmacy consolidation application. This period may fall outside the usual schedule of Health and Wellbeing Board meetings.

5.6. In order to meet the statutory deadlines for submitting a response, it is proposed that the functions of the Health and Wellbeing Board with regard to pharmacy

consolidation are delegated to the Director of Public Health, in consultation with the Chair of the HWBB.

5.7. Where the Director of Public Health, in consultation with the Chair of the Health and Wellbeing Board, believe the application does not create a gap in provision it is proposed that the Director of Public Health is given delegated authority for making a decision on whether a proposed consolidation is likely to create a gap in pharmaceutical services that could be met by a routine application.

5.8. This will be based upon information provided in the application and in the PNA.

5.9. Where the Director of Public Health, following consultation with the Chair of the Health and Wellbeing Board, believes the application to potentially be create a gap it is proposed that the Director of Public Health will be responsible for electronically circulating relevant information, within 14 calendar days of notification of the application, to:

a) The Executive Member for Public health

b) The Chair of the Health and Wellbeing Board

c) Relevant ward members

d) Relevant Clinical Commissioning Group lead

e) Health Watch

5.10. The Director of Public Health will be responsible for co-ordinating the response to NHS England in consultation with the chair of the Health and Wellbeing board to meet he statutory timescales.

5.11. As part of this process, all those consulted will be required to highlight any potential conflicts of interest which may arise in response to an application.

5.12. NHS England will consider all representations that are received and will arrange an oral hearing to determine the application if a matter is identified on which further evidence is needed.

6. Consultation and Equalities

6.1. A consultation took place on the Pharmaceutical Needs Assessment for 60 days as set out in the regulations between 27th October 2017 and the 31st December 2017. The consultation was open to everyone but was particularly aimed at professionals with an interest in pharmaceutical provision.

6.2. A total of 8 responses were received from organisations and individuals with the comments mainly in agreement that all needs and provision had been correctly.

6.3. Further information, about additional services that are provided in pharmacies that was provided as part of the consultation, was added to the needs assessment . . This is not required as part of the regulations.

6.4. The needs assessment has been amended in line with the comments received

CORPORATE OR LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	yes
People in Hampshire live safe, healthy and independent lives:	yes
People in Hampshire enjoy a rich and diverse environment:	no
People in Hampshire enjoy being part of strong, inclusive communities:	yes

Other Significant Links

Direct links to specific legislation or Government Directives	
The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013	2013
The National Health Service (Pharmaceutical Services, Charges and Prescribing) (Amendment) Regulations 2016.	2016

Section 100 D - Local Government Act 1972 - background documents

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c) Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity which participation by such persons is disproportionally low.

1.2. **Equalities Impact Assessment:**

1.3. Not applicable

2. Impact on Crime and Disorder:

2.1. Not applicable

3. Climate Change:

a) How does what is being proposed impact on our carbon footprint / energy consumption*?* Not applicable

b) How does what is being proposed consider the need to adapt to climate change, and be resilient to its longer term impacts? Not applicable

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Hampshire County Council

Hampshire Pharmaceutical Needs Assessment

2018 - 2021

Version Control

Version	Edited by:	Changes	Date
Draft Version 0.1	DL	Formatting	19/10/17
Draft Version 0.2	DL/SD	Approved for Publication for Consultation Purposes	19/10/17
Draft Version	JB	Amended following consultation	02/01/18
Draft Version			
Draft version			

Table of Contents

Introduction

A pharmaceutical needs assessment (PNA) is a statement of the pharmaceutical needs of the population within the local area. The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 sets out the requirement for each Health and Wellbeing Board to publish a pharmaceutical needs assessment[1].

Hampshire's Joint Health and Wellbeing Strategy has been developed by Hampshire's Health and Wellbeing Board to improve health across the county. This includes ensuring that the right services are delivered where and when they are needed the most, this includes pharmaceutical provision. The PNA assesses the need of pharmacy services and how the provision meets current and future needs.

This PNA replaces the assessment undertaken by Hampshire County Council Public Health in 2014.

Components of the Pharmaceutical Needs Assessment

The PNA contains information on needs and on provision in relation to pharmaceutical services.

The information on needs is taken from the Joint Strategic Needs assessment. The Hampshire Joint Strategic Needs Assessment (JSNA) identifies the current and future health and well being needs of the residents in the area covered by Hampshire County Council.

In the context of the PNA the definition of pharmaceutical services are those contained within the NHS Community Pharmacy Contractual Framework (contract) consists of three levels of services as stated above. These are:

- Essential services
- Advanced services
- Enhanced and locally commissioned services

Accountability

This needs assessment will be signed off by the Health and Wellbeing Board and published by April 2018.

[1] Section 128A of the 2006 Act

Definition of localities

PNA guidance states that sub localities of the Health and Wellbeing Board may be considered to give a more detailed assessment. Given the geography and population of Hampshire, the PNA has used localities that match the district local authority areas. These are at a suitable size to give a meaningful assessment whilst also being small enough to relate to population communities within Hampshire.

Engagement and Consultation

The regulations stipulate that the Health and Wellbeing Board must consult on a draft of their PNA at least once during its development and lists the persons that must be consulted (see Appendix A for details). This consultation is aimed at professionals and agencies. Whilst not aimed specifically at the public their views are welcomed and will be taken into consideration if received.

The consultation is for a minimum period of 60 days.

Maps

All maps are produced under the full OS Crown copyright below.

The Needs

Criteria for the assessment of need

The Department of Health pharmaceutical needs assessment information[2] sets out criteria for the needs assessment. These are as follows; each assessment must have regard, in so far as it is practicable to do so, to the following matters:

a) the demography of its area.
b) whether in its area there is sufficient choice with regard to obtaining pharmaceutical services.
c) any different needs of different localities within its area.
d) the pharmaceutical services provided in the area of any neighbouring Health and Wellbeing Board which affects the area.
e) any other NHS services provided in or outside its area which affect:
    a. the need for pharmaceutical services in its area, or
    b. whether further provision of pharmaceutical services in its area would secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area.

When making an assessment for the purposes of publishing a pharmaceutical needs assessment, each HWB must take account of likely future needs having regard to likely changes to the:

a) number of people in its area who require pharmaceutical services.
b) demography of its area.
c) risks to the health or well-being of people.

The information related to needs is taken from the Joint Strategic Needs Assessment. Hampshire is in the top ten of the largest counties by land area, covering approximately 1,400 square miles which includes 11 district local authorities. These are Basingstoke and Deane, East Hampshire, Eastleigh, Fareham, Gosport, Hart, Havant, New Forest, Rushmoor, Test Valley, and Winchester City.

Defining need in relation to pharmaceutical services?

Some people will make more use of pharmacy services than others; these will include those on long term medicines, older people and the very young. However the main consideration of need is service location and availability.

[2] https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack

Demography

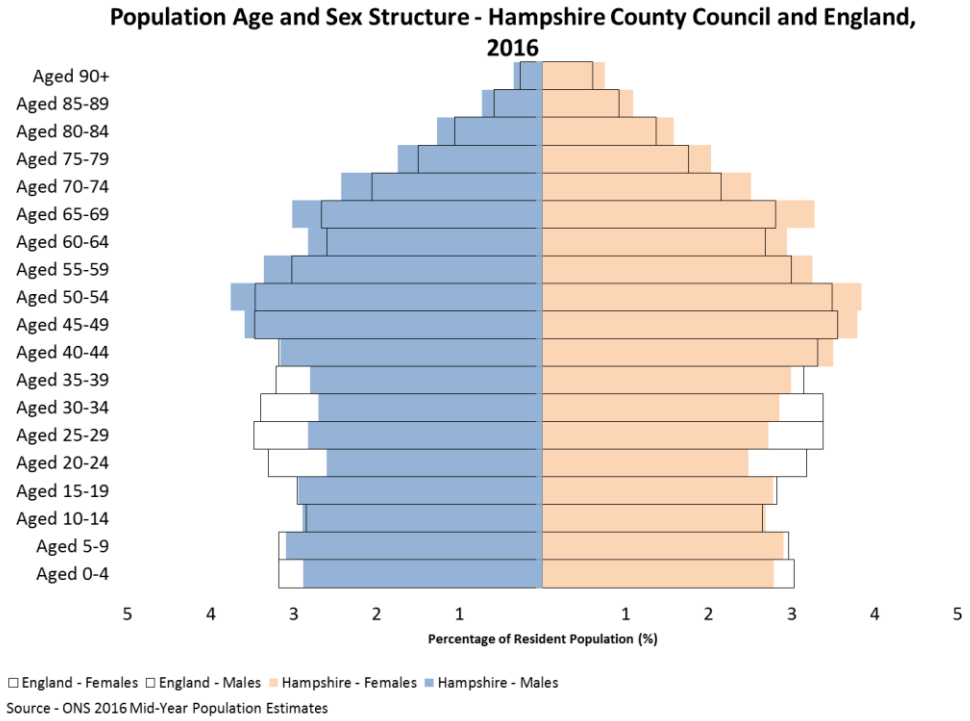
Current population

The population of Hampshire is estimated to be 1.36 million people, making it the third most populous county in England after Kent and Essex. Over the ten year period between the Census of 2001 and 2011 Hampshire's population increased by 6.3%, in absolute numbers this equates to an increase of almost 77,700 people.

The population pyramid presents the latest mid year population estimates available for Hampshire compared to England. The chart shows Hampshire has an older population with a higher proportion of the population aged 45 years and over compared to England. Census 2011 data reported that the average age across Hampshire County is 42 years (highest in the New Forest at 47 years and lowest in Rushmoor at 36 years), compared to the average age nationally of 39 years.

Hampshire has fewer young working aged people (aged 20-39) compared to England as a whole; 22% in Hampshire compared to 27% in England. Young people (aged 0-19 years) make up 23% of the population compared to 24% nationally with Hampshire's older residents (aged 75 years and over) accounting for 10% of the population, compared to 8% nationally. There are just over 15,100 people living in Hampshire who are aged 90 years and over.

Figure 1



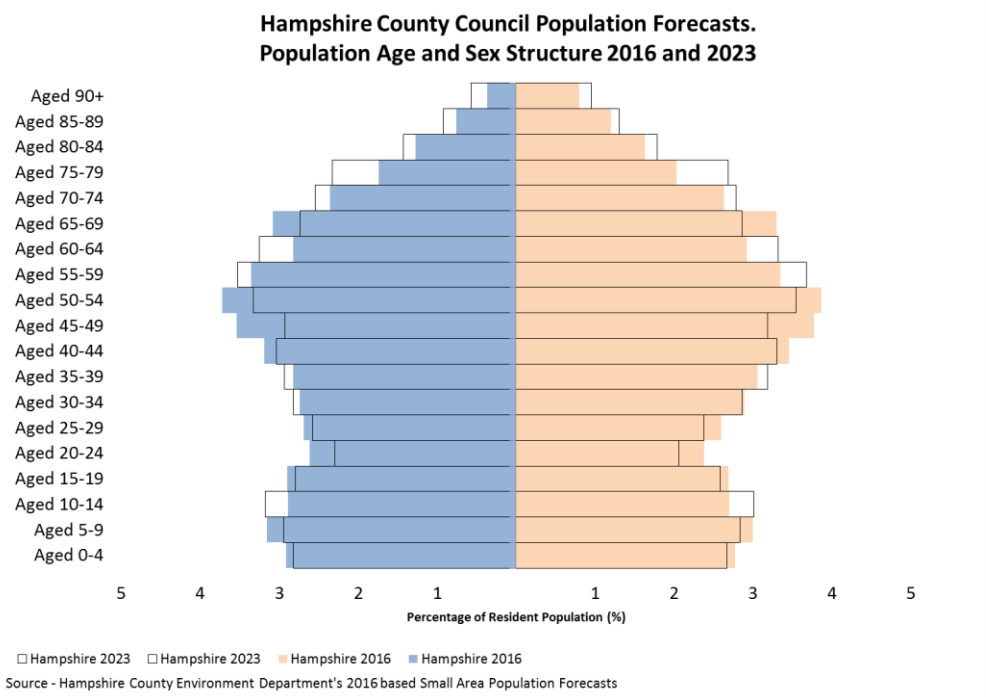
Source - ONS 2016 Mid-Year Population Estimates

The 2011 census reported that 91.8% of Hampshire's population are ethnic group 'White British'; this is much higher than the national figure of 79.8% and a marked decrease from 2001 where 95.4% of the population were 'White British'. However Hampshire has a growing diverse population with growing numbers of people from different backgrounds. 8.2% of the county's population are from a non-ethnic White British background, up from 4.6% in 2001.

Population forecasts

The population pyramid (figure 2) presents the forecast change in the County's population age and sex structure. The population of Hampshire is expected to increase by 7.5% from 1,353,359 in 2016 to 1,455,381 by 2023.

Figure 2



Source - Hampshire County Environment Department's 2016 based Small Area Population Forecasts

Population forecasts suggest a 7% increase in the 0 to 19 years population, the population pyramid illustrates that this increase can be mainly attributable to the 10-14 years cohort.

Looking forward, the ageing of Hampshire's population is set to continue across the county with forecasts suggesting that by 2023 almost 23% of Hampshire's population will be aged 65 or older, 12.0% aged 75 or older and 3.8% aged 85 or older. The proportion of the 85 years and over population is expected to increase by almost 30%, to 54,600 people by 2023.

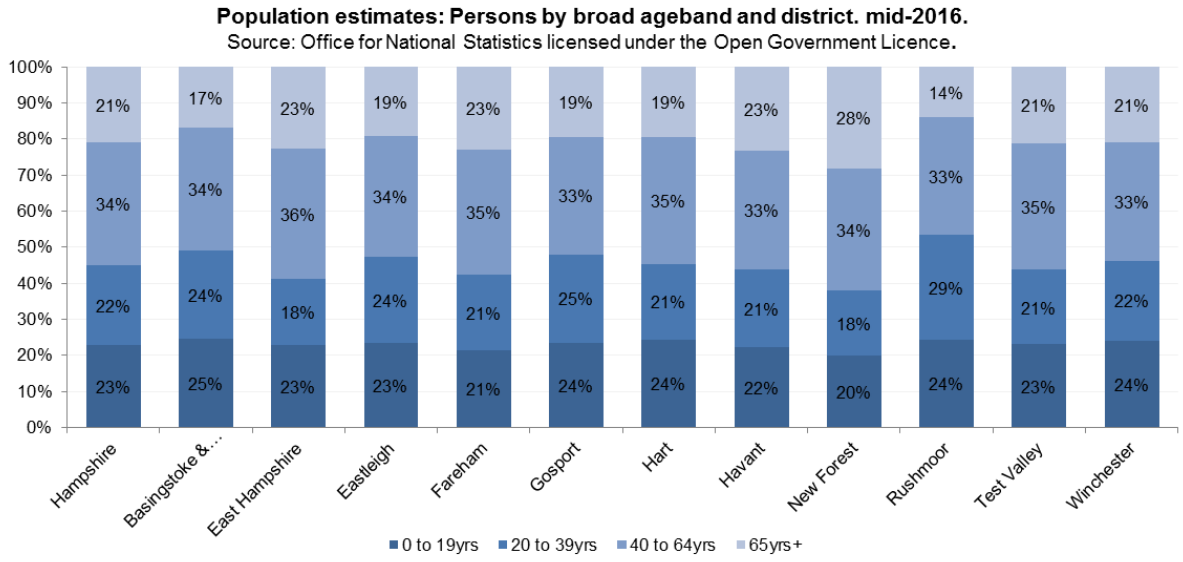
Differences in the population

There is variation in population age structure between districts, for example one in four of Basingstoke and Deane's population are aged 0 to 19 years compared to one in five in the New Forest. Rushmoor has the youngest population structure in the County, almost one thirds of the districts population (29%) are of a young working age (20-39yrs).

Across the districts the level of ageing varies significantly, though all districts have seen their populations getting older. The New Forest has the oldest population structure in the county with the highest number of residents aged 65 and over (n= 50,354), equating to almost one third (28%) of the population compared to just 14% (n= 13,428) of Rushmoor's total population.

The district of Hart has experienced the largest growth across the period 1981 to 2011, its 65 year and older population more than doubling over the period (reaching 15,000 by 2011). Between 2001 and 2011 the population in Hart aged 85 years and over increased by 43%. The latest population estimates suggest there are now 18,213 residents in Hart aged 65 years and over, of which 2,323 are aged 85 years or over.

Figure 3



Looking forward, population data suggest that the most growth over the next few years is forecast to occur in Winchester district where the population is expected to increase by over 16,100 people (equating to a rise of 13.4%) by 2023. In absolute numbers Basingstoke and Deane's population is set to rise by 17,200 which is a population increase of 9.9%. Conversely Gosport's population is only set to increase by 350 people (0.4% increase).

Across all districts the biggest increases are predicted in the 65years and over age group. Population data for two districts, New Forest and Gosport, predict a decrease in the 0 to 64 years population by 2023 of 6% and 4% respectively. In contrast, Winchester's 0 to 64 years population is predicted to increase the most across the County by 21%, followed by Rushmoor 19.3%.

The proportion of Hampshire's population by ethnic groups vary markedly across the county and whilst nine of Hampshire's districts have over 90% of their population defining themselves as being White British; Basingstoke and Deane and Rushmoor, both in the north of the county, fall below the county average. Over 10% of Rushmoor's population are from a non-white British ethnic group, with over 6,120 people identifying themselves as Nepalese.

The age structure of different ethnic group populations varies, and in some cases reflects the length of time communities have lived in the county. When compared to Hampshire's population age structure the White Other, Black, Asian and Other ethnic groups have a much higher proportion of young working age adults, 25 to 40 years. Conversely the Mixed ethnic group has a higher proportion of the young population aged 0 to 19 years. The largest non-white ethnic group within the older population is the Asian ethnic group at 0.8% of the total population aged 65 and over across Hampshire, equating to 1,880 people. The majority of this population live in Rushmoor and Basingstoke and Deane.

New Housing developments and impact on local population dynamics

There is a strong link between dwellings and demographics. From the basic requirement of people for shelter, the County's population forecasts are constrained to the number of dwellings currently available for habitation and those planned over the forecast period to ensure the most robust estimate of the population can be formulated. But the link between dwellings and population goes further with different types of people more likely to live in different types of property and this can also vary by location.

Work carried out investigating the demographics of new housing developments across Hampshire between 2001 and 2011 suggested that recent new housing developments were more likely to house; younger people; more single never married people; those more likely to catch the train to work; they tend to be more ethnically diverse and more densely populated and more likely to be in more urban areas. This is reflected in the population pyramid which presents the demographics of people in the new housing developments, compared to the county as a whole, and suggests that a young working age cohort aged between 25 and 39 years with young children aged 0 to 9 years are more likely to be living in the new housing developments.

Figure 4

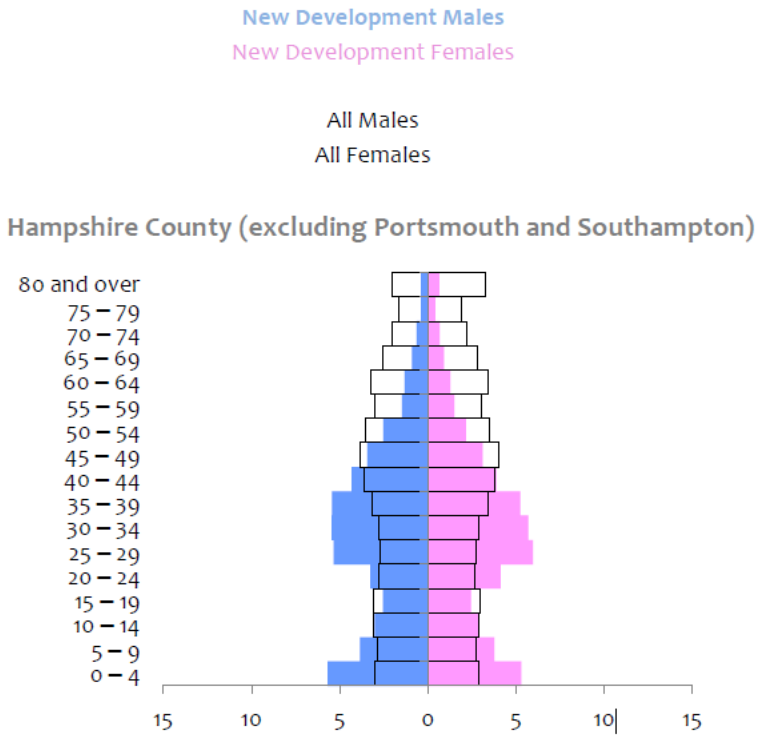


Table one presents the predicted population and dwelling changes over the period 2016 to 2023 for each district and the County overall.

The forecasts are based on future dwellings supply. The dwelling supply information for the period 2016 to 2023 includes all large and small sites with planning permission, or allocated in local plans as at April 1st 2016. Additional dwelling information is obtained from district's Strategic Housing and Land Availability Assessment (SHLAA). The figures are the best projections available as at 1/4/2016 on a site by site basis taking account of the current market conditions.

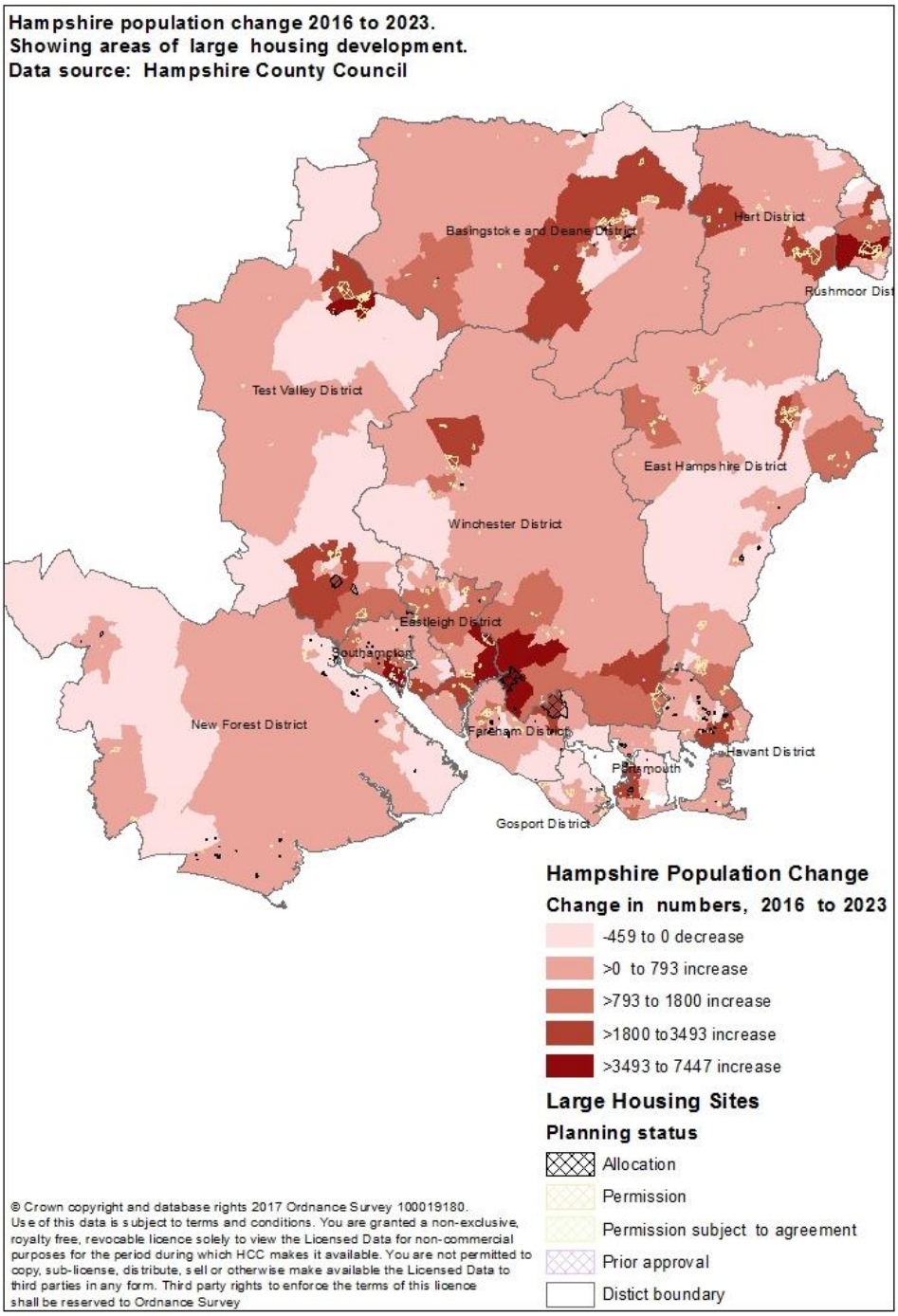
Table one shows that over the next 8 years the number of dwellings is predicted to increase by 9% and the population to grow 8% across the County. Winchester is expected to see the largest relative population growth (13%) attributed to almost 7,500 more dwellings. Basingstoke and Deane has the largest number of new dwellings and population.

Table 1: Predicted population and dwelling changes for each district and the County overall, 2016 to 2023.

	Dwelling Growth (2016 to 2023)		Population Growth (2016 to 2023)	
Area	**Number**	**Percentage change**	**Number**	**Percentage change**
Basingstoke and Deane	8,612	12%	17,207	10%
East Hampshire	5,841	11%	11,010	9%
Eastleigh	7,025	13%	15,118	12%
Fareham	3,103	6%	5,318	5%
Gosport	1,223	3%	351	0%
Hart	3,272	9%	6,386	7%
Havant	3,451	6%	5,541	4%
New Forest	2,315	3%	2,195	1%
Rushmoor	5,831	15%	11,512	12%
Test Valley	5,695	11%	11,212	9%
Winchester	7,439	15%	16,172	13%
Hampshire County Council	**53,807**	**9%**	**102,022**	**8%**

Map one shows the predicted population change between 2016 and 2023 and the main housing development sites (10 homes or more) as at April 20016.

Map 1


Hampshire population change 2016 to 2023.
Showing areas of large housing development.
Data source: Hampshire County Council
Basingstoke and Deane District
Hart District
Rushmoor Dist
Test Valley District
East Hampshire District
Winchester District
Eastleigh District
Southampton
New Forest District
Fareham District
Portsmouth
Havant District
Gosport District
Hampshire Population Change
Change in numbers, 2016 to 2023
-459 to 0 decrease
>0 to 793 increase
>793 to 1800 increase
>1800 to3493 increase
>3493 to 7447 increase
Large Housing Sites
Planning status
Allocation
Permission
Permission subject to agreement
Prior approval
Distict boundary
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Military

Hampshire has a substantial military presence, including Army, Royal Navy and RAF bases. The number of military personnel entitled to Defence Medial Service (MDS) care provides a good indication of the size of the serving population across Hampshire. There are currently a total of 13,250 military personnel entitled to MDS care in Hampshire, with the largest proportion in North East area of Hampshire and Fareham and Gosport. Approximately 550 are Serving Gurkhas.[3]

The pharmaceutical needs of military personnel are in the main met by the military service. However the health needs of families and dependents moving into the area will be the responsibility of the Clinical Commissioning Groups (CCGs) and therefore relevant to this PNA.

Offenders

There is one prison in Hampshire located in the district of Winchester. It is a category B prison with an operational capacity of 690 and is able to take men from the age of 18 upwards. Population prison data from Ministry of Justice for May 2017 report a population of 631.

The pharmaceutical needs of prisoners in Hampshire are met by the services within the walls of those establishments and so are not within the scope of this PNA.

Population Density

Hampshire has a lower population density than the England average with 3.6 people per hectare compared to 4.5 people per hectare for the South East of England and 4.1 across England. Gosport, Rushmoor and Havant remain the most densely populated districts within Hampshire and have population densities much higher than the regional and national averages. There are 24.0 people per hectare living in Rushmoor, 32.6 people per hectare in Gosport, and 21.8 people per hectare in Havant[4].

Rurality

Hampshire is a predominantly rural county, 78% is defined as rural and over one third of the county's area is within National Parks or Areas of Outstanding National Beauty. 22% of the dwellings and population live in the county's rural areas. Hampshire is a large county and so although the minority of the population, just over

[3] Hampshire County Council: Veterans, Reservists and Armed Forces Families Health Needs Assessment
[4] Census 2011 data

one in five, live in a rural area this still equates to nearly 300,000 residents. This is a key variation that needs consideration when assessing pharmaceutical need.

Migration

Migration is complex and there is no legal requirement to inform a single body when someone moves. As such data on migration is much less robust and comes with limitations on its use. Economic migrant data from the Department of Work and Pensions report that between June 2015 and June 2016 there just over 7,000 national insurance number registrations to adult overseas nationals in Hampshire. The majority of these people were from the European Union. Across the county Basingstoke and Deane had the highest proportion of economic migrants (21%) followed by Rushmoor (17%).

General health of the population

The census asks people to rate their general health, whether they have a long term illness or disability. This information gives an insight into both how good the health is of the people of Hampshire. The majority of Hampshire's population (84.1%) reported to have good or very good health, compared to 81.4% nationally. 84.3% of Hampshire's population reported no disabilities, compared to 82.4% nationally.

Across Hampshire 4% of people reported to have bad or very bad health, the highest levels were reported in Havant (5.6%) and lowest levels in Hart (2.7%).

Amongst those who reported having a long term illness or disability that limited their day to day activities a lot (6.7% across Hampshire as a whole, compared to 8.3% nationally), the highest levels were again seen in Havant (8.8%) and lowest levels in Hart at 4.5%.

However, looking at those of working age (16-64 years of age) with a disability which limits their day to day activities a lot, it is still Havant with the highest levels at 3.6% and Hart with the lowest at 1.6%. The county wide figure is 2.5% and again compares favourably with the national level of 3.6%.

Pharmaceutical services

For the purposes of the PNA pharmaceutical services are included are;

- Essential services
- Advanced services
- Enhanced services
- Local pharmaceutical services (LPS)
- Locally commissioned services
- Dispensing service provided by medical practices

A description of these different types of services and how many are in Hampshire follows.

Essential services

These are services which every community pharmacy and dispensing appliance contractor (DAC) providing NHS pharmaceutical services must provide and is set out in their terms of service. For pharmacies these include the dispensing of medicines, disposal of unwanted drugs, promotion of healthy lifestyles, public health campaigns, signposting and support for self-care. All DACs must provide dispensing of prescriptions, delivery of certain appliances, supply of bags and wipes and signposting.

Advanced services

These include pharmacies and DACS. These are services contractors may chose to provide and have to meet certain criteria. For pharmacies these are medicines uses review, new medicine service flu vaccination and NHS urgent medicines supply service. For pharmacies and DACS these are appliance use review and stoma appliance customisation.

Advanced services commissioned nationally but available in Hampshire are;

Medicine Use Reviews (MUR)

Medicine Use Review and prescription intervention service allows accredited pharmacists to undertake structured adherence review with patients on multiple medicines, particular for those receiving medicines for long term conditions. The service helps patients understand their therapy, the best time to take the medicine, discussion about side-effects and adherence with the prescribed regimen, which may identify any problems the patient is experiencing along with possible solutions. The MUR can be conducted on a regular basis, e.g. every 12 months, or on an ad hoc basis, when a significant problem with a patient's medication is highlighted during the dispensing process.

At least half of the MURs provided each year must be for patients who fall within one of the national target groups:

- patients with respiratory disease (e.g. asthma and COPD),
- patients recently discharged from hospital,
- patient taking a 'high risk' medicine (NSAIDs, anticoagulants, antiplatelets and diuretics).

The number of medicine use reviews is capped at 400 per pharmacy.

There are 237 pharmacies in Hampshire which are MUR accredited, providing good coverage across the whole population.

New Medicine Service (NMS)

The service provides support for people, with long-term conditions and who have newly been prescribed a medicine. The aim of the services is to help improve medicines adherence; it is initially focused on particular patient groups and conditions. If a patient is prescribed an anticoagulant (a blood thinning medicine) or a medicine to treat asthma or chronic obstructive pulmonary disease (COPD), type 2 diabetes or high blood pressure for the first time, the NMS is available to provide advice about the medicine.

Research has shown that after 10 days, two thirds of patients prescribed a new medicine reported problems including side effects, difficulties taking the medicine and a need for further information. The NMS has been designed to fill this identified gap in patient need.

The pharmacist will provide the patient with information on their new medicine and how to use it when it is first dispensed. The pharmacist and patient will then agree to meet or speak by telephone in around a fortnight.

At this second stage of the service the pharmacist will discuss with the patient how they are getting on with their new medicine. Further information and advice on the use of the medicine will be provided and where the patient is experiencing a problem the pharmacist shall seek to agree a solution with the patient.

A final consultation (typically 21-28 days after starting the medicine) will be held to discuss the medicine and whether any issues or concerns identified during the previous consultation have been resolved. If the patient is having a significant problem with their new medicine the pharmacist may need to refer the patient to their GP.

There are 212 pharmacies in Hampshire which are NMS accredited, providing good coverage across the whole population. The data presented in table two covers the financial year 2016/17 and suggests there is good uptake of the MUR and NMS service across the county.

Table 2

Local Authority Area	Number of NMS accredited pharmacies	Number of MUR accredited pharmacies	Number of MUR (2016/17)	Number of NMS (2016/17)
Hampshire	**212**	**237**	**70,888**	**17,404**
Basingstoke and Deane	25	26	7,012	2,001
East Hampshire	16	19	5,649	1,188
Eastleigh	21	24	6,082	1,662
Fareham	12	16	4,808	690
Gosport	14	15	5,402	1,093
Hart	15	16	5,169	967
Havant	27	31	9,622	1,587
New Forest	35	36	11,827	4,258
Rushmoor	16	21	5,644	1,938
Test Valley	16	17	4,904	1,083
Winchester	15	16	4,769	937

Enhanced services

Only NHS England can commission enhanced services. The following enhanced services which may be commissioned by NHS England from 1 April 2013 in line with identified needs are:

- Anticoagulation monitoring
- Care home service
- Disease specific medicines management service
- Gluten free food supply service
- Independent prescribing service
- Home delivery service
- Language access service
- Medication review service
- Medicines assessment and compliance support
- Minor ailment service
- Needle and syringe exchange
- On demand availability of specialist drugs
- Out of hours service
- Patient group direction service (not related to public health services)
- Prescriber support
- Schools service
- Screening
- Stop smoking
- Supervised administration
- Supplementary prescribing service

There is also a new advanced service NHS Urgent Medicine Supply Advanced Service (NUMSAS) which, at the point of writing this report, is not running in Wessex. NUMSAS is a pilot service running from 1 December 2016 to 31 March 2018. NUMSAS is a service that manages a referral from NHS 111 to a community pharmacy where a patient has contacted NHS 111 because they need urgent access to a medicine or appliance that they have been previously prescribed on an NHS prescription. The service therefore enables appropriate access to medicines or appliances Out-of-Hours (OOH) via community pharmacy, relieving pressure on urgent and emergency care services by shifting demand from GP OOH providers to community pharmacy.

There is one enhanced service commissioned by NHS England in Hampshire, Wessex Pharmacy Urgent Repeat Medicines (PURM) Service. This service allows participating pharmacies to make emergency supplies (which are usually private transactions) at NHS expense. Normal prescription charges apply unless the patient is exempt in accordance with the NHS Charges for Drugs and Appliances Regulations. The pharmacist will only make a supply where they deem that the patient has immediate need for the medicine and that it is impractical to obtain a prescription without undue delay.

There are 180 pharmacies across the county offering the Wessex PURM service in Hampshire.

Table 3

Local Authority Area	Number of pharmacies offering emergency supply (PURM)
Hampshire	**180**
Basingstoke and Deane	15
East Hampshire	15
Eastleigh	19
Fareham	15
Gosport	14
Hart	11
Havant	26
New Forest	28
Rushmoor	11
Test Valley	11
Winchester	15

Local pharmaceutical services (LPS)

These are services provided under a local pharmaceutical services (LPS) contract and must include dispensing as a minimum.

There is one LPS in Hampshire; this is located in the New Forest.

Locally commissioned services

Locally commissioned community pharmacy services can be contracted via a number of different routes and by different commissioners, including local authorities, Clinical Commissioning Groups (CCGs) and local NHS England teams.

Services commissioned by Public Health Hampshire are detailed below .

Health Check Assessments

The NHS Health Check is a health check-up for adults in England aged 40-74. It's designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia and assesses each patient's cardiovascular risk. Public health commission both core Health Checks (where a patient responds to an invitation letter) or opportunistic Health Checks ….. Across the county every GP practice and an additional 82 pharmacies offer health checks.

Sexual Health Services including emergency hormonal contraception, chlamydia screening, kits and condoms – provides access.

As at January 2018, 162 pharmacies provided emergency hormonal contraception, 181 offered chlamydia screening and 44 provided chlamydia screening kits and condoms. 38 pharmacies offered all three sexual health services.

Supervised Administration Programme (SAP).

The SAP programme is currently delivered through community pharmacies. This requires the pharmacist to supervise the consumption of oral methadone, buprenorphine and other drugs that may be used in the management of drug dependency/ misuse; ensuring that the dose has been administered to the patient where the prescriber has indicated that supervised consumption is appropriate. Pharmacists will also provide support to service users collecting their dispensed prescriptions for methadone and other drugs used in the management of drug misuse/ dependency where supervised consumption is not indicated. As of January 2018 67 pharmacies delivered the SAP programme.

Needle Exchange.

Community pharmacies offer a needle exchange service for injecting drug users. A targeted approach to harm minimisation within a pharmacy setting is currently being piloted, with a small number of pharmacies (10 across Hampshire in areas of high need) offering in addition take-home Naloxone, referrals to community substance misuse services, Blood Bourne Virus testing and mini-health-checks. There are three levels to this service.

- Level 1: emergency packs only, with written information on harm reduction (for example, on safer injecting or overdose prevention).

- Level 2: distribution of ‘pick and mix’ (bespoke) injecting equipment plus health promotion advice (including advice and information on how to reduce the harms caused by injecting drugs).

- Level 3: level 2 plus provision of, or referral to, specialist services (for example, specialist clinics, vaccinations, drug treatment and secondary care), mini health checks, BBV screening.

As of January 2018 42 pharmacies offered a needle exchange service.

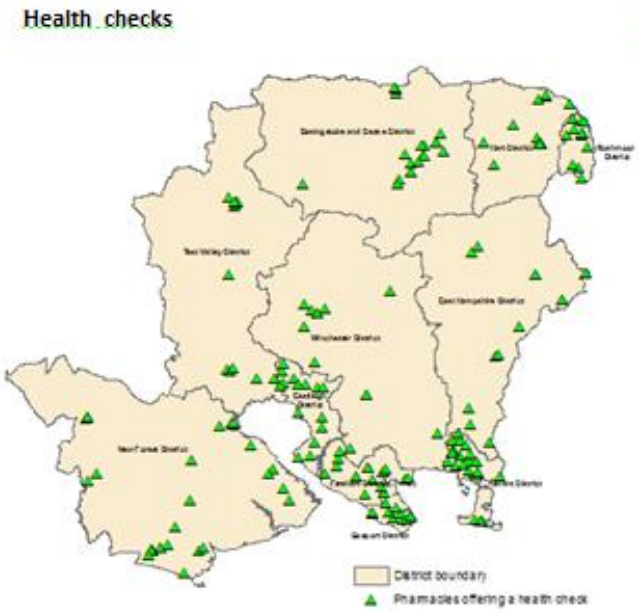
Flu vaccinations

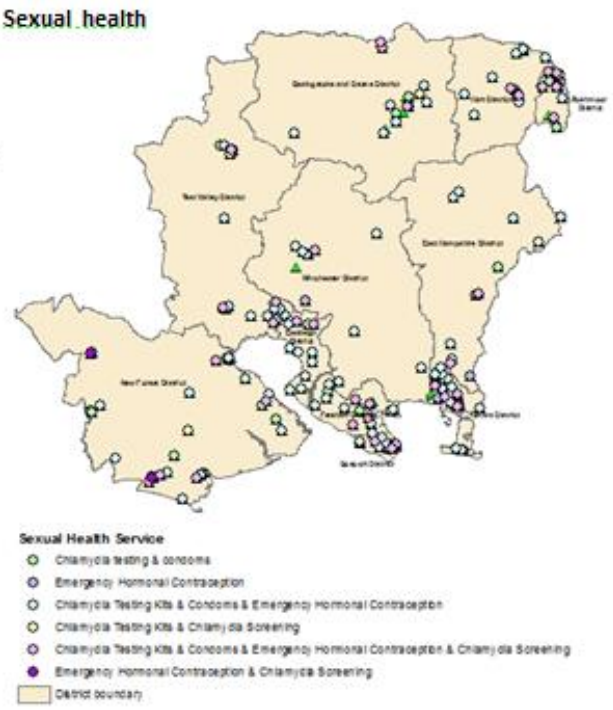
Public Health commission flu vaccinations for eligible staff. As at January 2018, 145 pharmacies across the county offer flu vaccinations. At the beginning of each flu season pharmacies have to sign up again to offer the flu vaccinations therefore the number of pharmacies offering this service may change year on year.

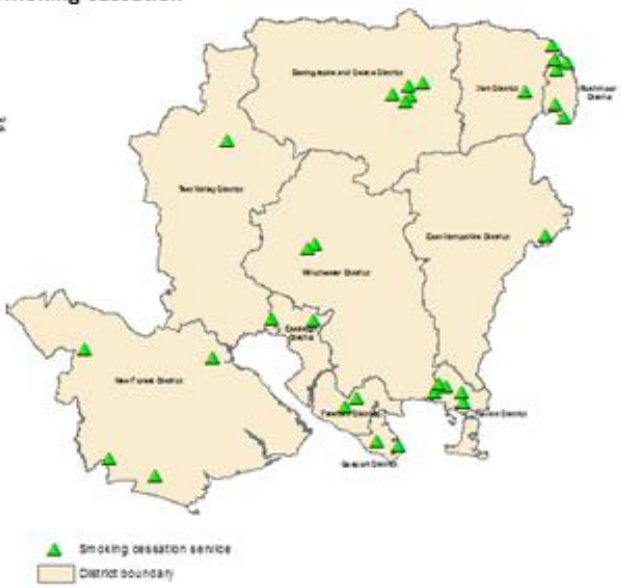
Smoking Cessation.

Smoking cessation services helping people who want to stop smoking are offered in 31 pharmacies across the county.

Map 2: Locally commissioned services







Dispensing service provided by medical practices

Dispensing doctors are general practitioners (GPs) who provide primary healthcare to patients who live in very rural areas. The provision of these services is included in their medical contract with NHS England. For the purposes of the PNA only the dispensing services they provide are included. The dispensing doctors are allowed to dispense the medicines they prescribe for these patients. The provision for doctors to provide pharmaceutical services in certain circumstances has been made in various NHS Acts and Regulations. These circumstances are in summary:

- a patient satisfies the organisation that they would have serious difficulty in obtaining any necessary drugs or appliances from an NHS pharmacist by reason of distance or inadequacy of means of communication (often known as the “serious difficulty” test which can apply anywhere in the country); or
- a patient is resident in an area which is rural in character, known as a controlled locality, at a distance of more than one mile (1.6km) from pharmacy premises (excluding any distance selling premises). The pharmacy premises do not have to be in a controlled locality.

There are currently 28 dispensing doctor practices in Hampshire many serve the rural communities where there is limited access to pharmacy. These will enhance the pharmaceutical dispensing provision by community pharmacies. These are shown on map three.

Map 3: Location of Dispensing GPs in Hampshire

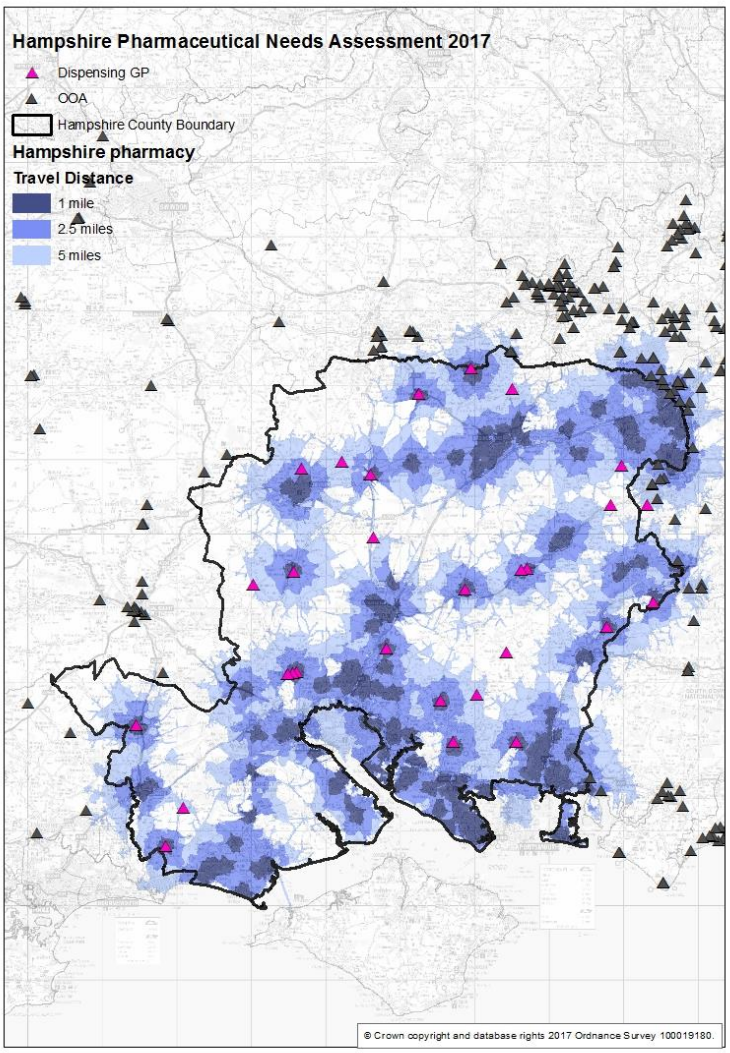


Table 4: Dispensing GPs by LA

Local Authority Area	Number of dispensing GPs
Hampshire	**28**
Basingstoke and Deane	5
East Hampshire	5
Eastleigh	0
Fareham	0
Gosport	0
Hart	1
Havant	0
New Forest	3
Rushmoor	0
Test Valley	6

Pharmaceutical services outside of Hampshire

Hampshire has a number of counties and cities on its borders. These may increase access and choice of pharmaceutical services to those populations living on the edge of Hampshire. The cities to the South and North West of the County provide increased coverage to those people living near Southampton, Portsmouth, Bournemouth and Camberley. These centres also provide out of hours primary care facilities for Hampshire residents. Residents in the East of the County can also access services in West Sussex and Surrey to the North East. This means that prescriptions written out of hours can be dispended in these areas. Map four (page 28) shows all pharmacies including those on the edge of Hampshire.[5]

[5] Based on information from NHS England accessed in June 2017

NHS services provided in or outside its area which affect need

NHS services that affect need are those that require a prescription to be dispensed. For Hampshire these are the GP practices and the Out of Hours primary care services. These are based in the urban centres of Hampshire and its borders.

Table 5: Out of Hours Centres	
Andover War Memorial Hospital, Andover	Basingstoke and North Hants Hospital, Basingstoke
Royal South Hants Hospital, Southampton	Frimley Park Hospital, Frimley, Surrey
New Forest Hospital, Lymington	Chase Community Hospital, Bordon
Totton, Primary Care Centre (Health Centre), Totton	Gosport War Memorial Hospital, Gosport
Royal Hampshire County Hospital, Winchester	Queen Alexandra Hospital, Cosham, Portsmouth
Ringwood Medical Centre, Ringwood	

Pharmacy Contractors

Nationally in 2015 1.08 billion prescription items[6] were dispensed in the community, an increase of 1.8% from 1.06 billion in 2014. Drugs used for diabetes were the most commonly prescribed items. The greatest increase in the volumes of prescribing was for antidepressant drugs[7].

As of June 2017 NHS England (Wessex) has 243 pharmacy contractors on its list in Hampshire. Of these, 6 are Distance Selling Pharmacies not specifically serving the local population but available to anyone within England.

The remaining 237 are pharmacy contractors operating on 100 hour contracts, standard 40 hour contractors or essential small pharmacy Local Pharmacy Services (LPS) contracts.

[6] These are medicines prescribed by a doctor on a script and dispended by a pharmacist
[7] Prescriptions Dispensed in the Community, Statistics for England - 2005-2015 [NS] http://content.digital.nhs.uk/searchcatalogue?productid=20895&q=title%3a%22Prescriptions+Dispensed+in+the+Community%22&sort=Relevance&size=10&page=1#top

Since 2010 the number of pharmacy contracts has grown by 25%. The breakdown of contractor types and the changes since 2005 are shown in table six.

Table 6

Pharmacy Contract Type	Description	2005	2010	2014	2017
Standard 40 hours contract	Open for a minimum 40 hours per week. Starting a new 40 hour pharmacy is restricted based control of entry test	184	201	205	208
100 hour opening	Open for 100 hours. Formerly Starting a 100 hour pharmacy under the former exemption from the control of entry test	1	16	27	27
Essential Small Pharmacy LPS	A pharmacy contracted in a location where a 40 hour pharmacy would not be commercially viable	9	6	4	0
LPS	Services provided under a local pharmaceutical services (LPS) contract and must include dispensing as a minimum.				1
Distance Selling	A registered pharmacy which offers to sell or supply medicines over the internet, or makes arrangements for the supply of such products or provision of such services over the internet	0	4	5	7
Total		**194**	**227**	**241**	**243**
Dispensing practices	Dispensing GPs the provision of these services is included in their medical contract with NHS England.				28

Patient access to pharmacies within Hampshire is good, across England there are 22 pharmacies per 100,000 population (2014)[8]. Hampshire's provision is slightly lower

8

https://lginform.local.gov.uk/reports/lgastandard?mod-metric=3707&mod-area=E92000001&mod-group=AllRegions_England&mod-type=namedComparisonGroup

at 18 pharmacies per 100,000 population. Table seven presents the number of pharmacies per population by county and district.

90% of pharmacies in Hampshire open on a Saturday and there is good 'out of hours' availability across all areas. There are 27 Pharmacies across Hampshire providing a 100 hour pharmacy service and 57 services (24%) are open on a Sunday.

Table 7

Local Authority Area	Number of pharmacies per area	2016					
		Total Population			Population aged 65+		
		Estimated Resident Population	Population per pharmacy	Pharmacies per 100k population	Estimated Resident Population	Population per pharmacy	Pharmacies per 100k population
Hampshire	**243**	**1,360,426**	**5,598**	**17.9**	**285,472**	**1,175**	**85.1**
Basingstoke and Deane	27	174,588	6,466	15.5	29,245	1,083	92.3
East Hampshire	19	117,955	6,208	16.1	26,728	1,407	71.1
Eastleigh	24	129,635	5,401	18.5	24,650	1,027	97.4
Fareham	17	115,423	6,790	14.7	26,381	1,552	64.4
Gosport	16	85,363	5,335	18.7	16,579	1,036	96.5
Hart	17	94,250	5,544	18.0	18,213	1,071	93.3
Havant	31	123,640	3,988	25.1	28,674	925	108.1
New Forest	37	179,236	4,844	20.6	50,354	1,361	73.5
Rushmoor	21	96,327	4,587	21.8	13,428	639	156.4
Test Valley	17	122,044	7,179	13.9	25,871	1,522	65.7
Winchester	17	121,965	7,174	13.9	25,349	1,491	67.1

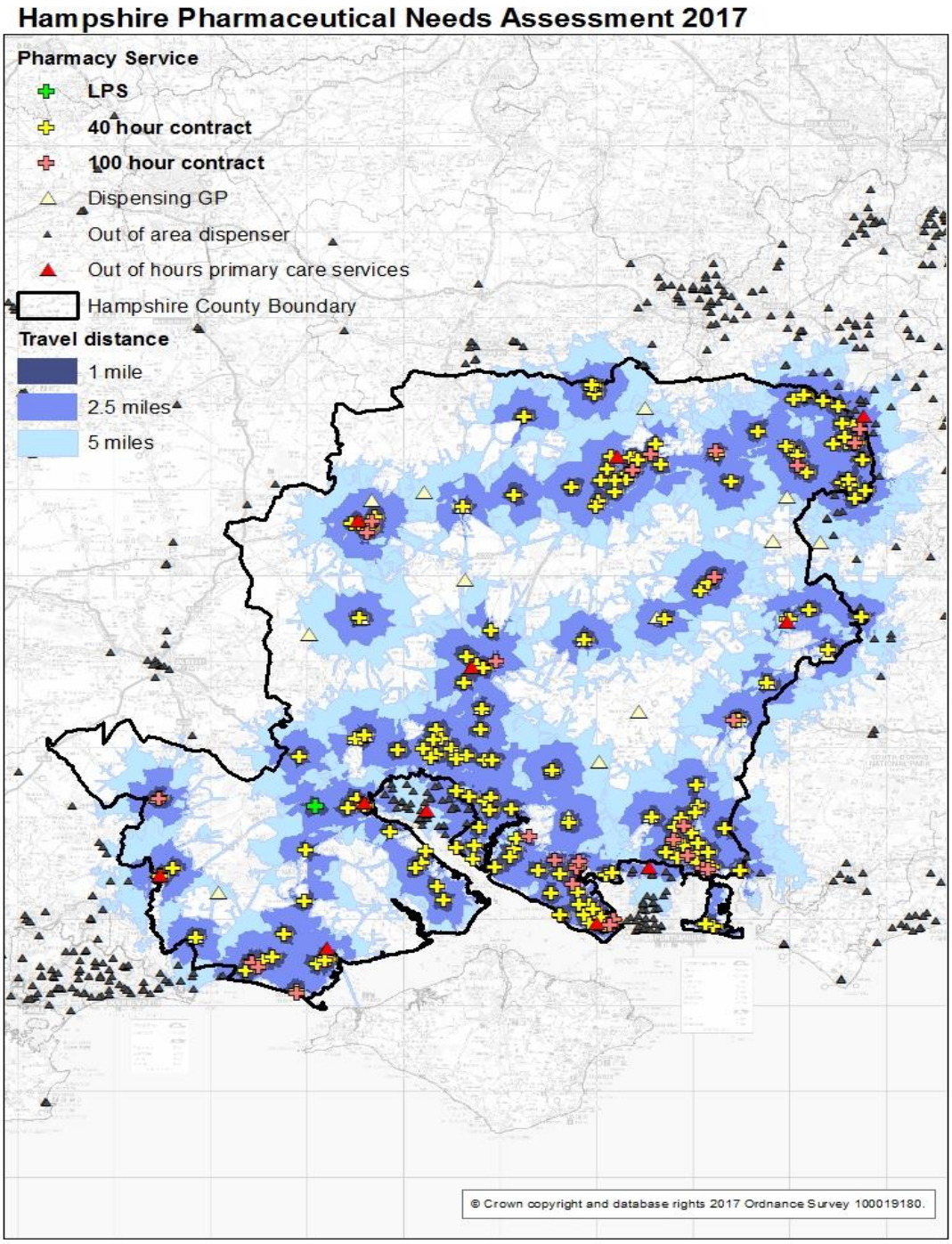
Table 8

Local Authority Area	100 hour contract	40 hour contract	Distance selling	LPS	Total
Hampshire	**27**	**208**	**7**	**1**	**243**
Basingstoke and Deane	2	25			27
East Hampshire	2	16	1		19
Eastleigh		23	1		24
Fareham	4	12	1		17
Gosport	2	13	1		16
Hart	2	15			17
Havant	5	26			31
New Forest	4	31	1	1	37
Rushmoor	2	17	2		21
Test Valley	2	15			17
Winchester	2	15			17

Travel distance

The travel map (map three) highlights those areas which are 1, 2.5 and 5 miles road travel from a pharmacy. 67% of Hampshire is within 5 road miles of a pharmacy. Those outside are very rural areas without roads which are often used for recreation. The areas with higher population density have closer provision of pharmacy.

Map 4



Locality Needs

Detailed locality information is considered under necessary services. A summary for each locality is given below.

Basingstoke and Deane

There are 173,277 people living in Basingstoke and Deane. The district population is slightly younger than the Hampshire population. Basingstoke and Deane has more very young and working age residents and less older people compared to Hampshire. 88.2% of Basingstoke and Deane's resident population are of ethnic group 'White British', those in other ethnic groups increased from 6.5% to 11.8% over the period between 2001 and 2011 census. This is a higher proportion that Hampshire overall (8.2%).

Deprivation is lower than England and Hampshire, however about 4,071 (11.8%) children living in income deprived households, 14,126 people (8.3%) living in means tested benefit households and 3,367 people (9.5%) aged 60+ live in a pension credit household. Pockets of deprivation exist in South Ham, Popley East and Chineham wards in Basingstoke affecting a substantial number of people who are consequently likely to have poorer health.

Life expectancy for men and women is higher than the England average, but lower than Hampshire. Healthy life expectancy at birth data suggests that men will live 13.2 years and women 15.3 years in poor health. This is better than England where 15.6 years for men and 18.2 years for women are spent in poor health.

Future Growth

Over the next six years (2016 to 2021) there is a forecast growth of 12,556 people with the largest increase forecast in the over 75s. Across the county the greatest population growth is forecast to occur in the Basingstoke and Deane district. This may be attributed to the housing development plans. There is a growth of 8,612 dwellings (12% change) predicted in Basingstoke & Deane between 2016 and 2023 with an associated population growth of 17,207 residents (10% change). The proposed housing development sites have good pharmacy cover. With good communication routes these areas of growth are well serviced within 5 miles of a pharmacy.

Figure 5

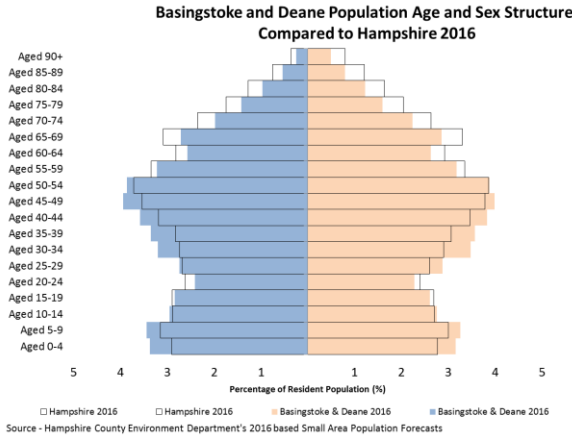
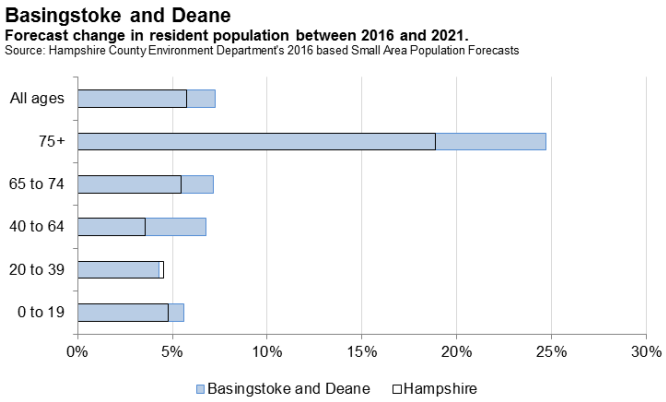


Figure 6



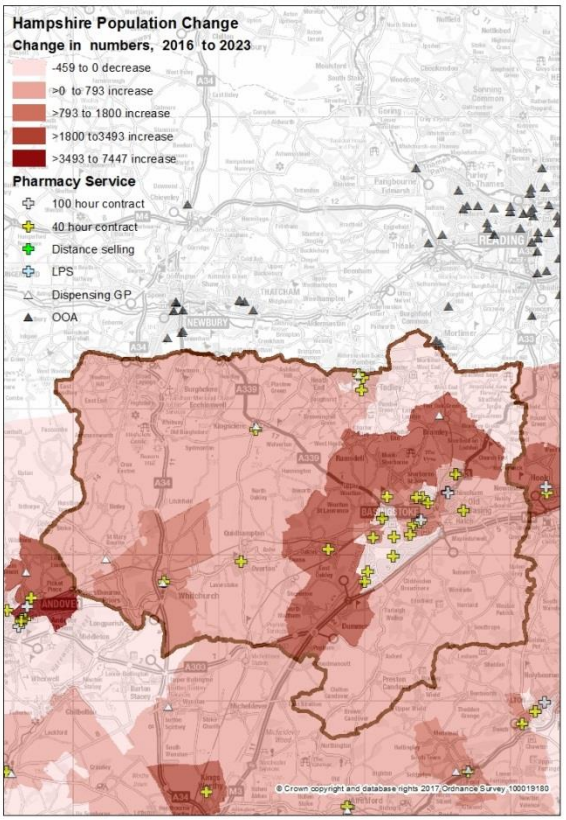
Pharmacy provision

There are 27 community pharmacies throughout this area. This includes two 100 hour pharmacies. Throughout Monday to Friday there is good out of hours provision available. 11 pharmacies are open after 18:30 and a further three opening later into the evening with the latest being 23.00. Additionally two sites open before 8am.

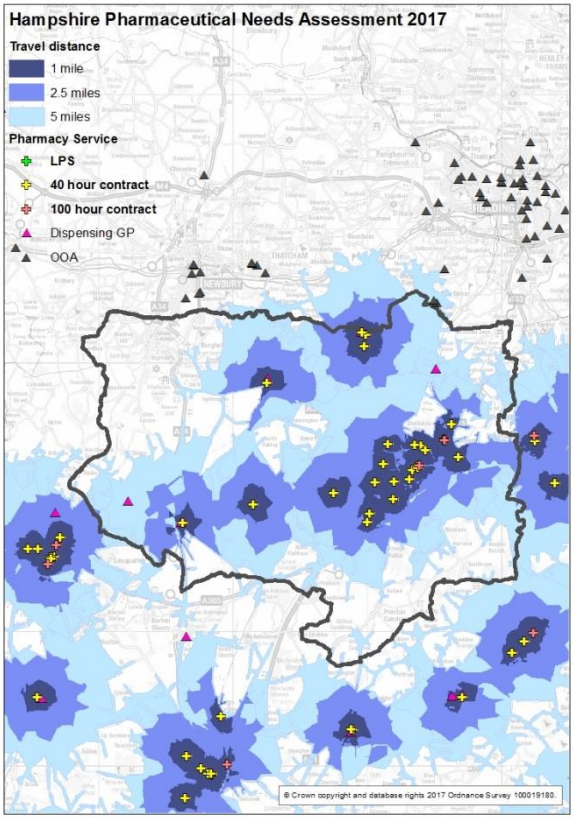
Weekend coverage is comprised of 22 pharmacies with open times covered from 06:30 to 23:00 on a Saturday and nine pharmacies open through the day with four opening into the evening. On Sunday there are seven pharmacies with opening times into the evening up to 21:00.

The out of hours GP provision is based on North Hampshire Hospital Site which is on the edge of Basingstoke Town. There are also five dispensing practices across Basingstoke and Deane.

Map 5



Map 6



Travel distance to pharmacy is good with 65% of the area within 5 miles road travel of a pharmacy.[9] The areas not covered are areas of very high rurality and low population density and low road coverage.

Conclusion

There is good provision of pharmacy cover in Basingstoke and Deane matching current and future planned population growth.

[9] The excludes pharmacy outside the district

East Hampshire

The population of East Hampshire is 119,177. East Hampshire has relatively high proportion of residents aged in their 50s and 60s and a relatively low proportion of young children aged 0 to 9 and young adults aged 20-39 years. 93% of East Hampshire's resident population are of ethnic group 'White British'.

The health of people in East Hampshire is generally better than the England average. Deprivation is lower than England and Hampshire. There are 1,854 (8.6%) children living in income deprived households, 7,917 (6.8%) people living in means tested benefit households and 2,576 (8.2%) people aged 60+ live in a pension credit household.

Life expectancy for men and women is higher than the England average and comparable to Hampshire. Healthy life expectancy at birth data suggests that men will live 12.3 years and women 14 years in poor health. This is better than England where 15.6 years for men and 18.2 years for women are spent in poor health.

Future growth

Over the next six years there is a forecast growth of 8,936 people with the largest increase forecast in the over 75s. There is a growth of 5,841 dwellings (11% change) predicted in East Hampshire between 2016 and 2023 with an associated population growth of 11,010 residents (9% change).

Figure 7

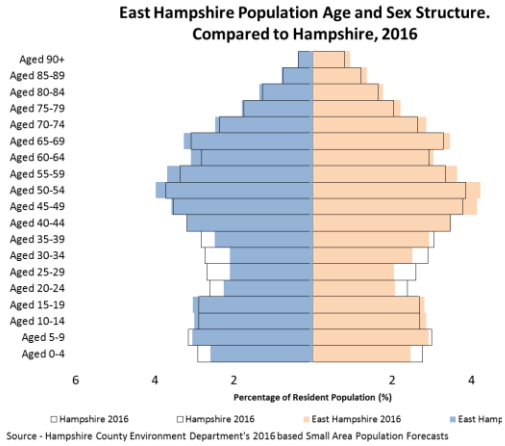
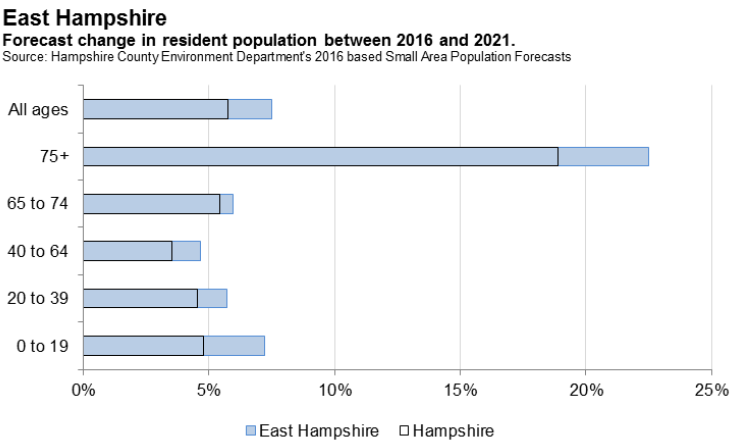


Figure 8



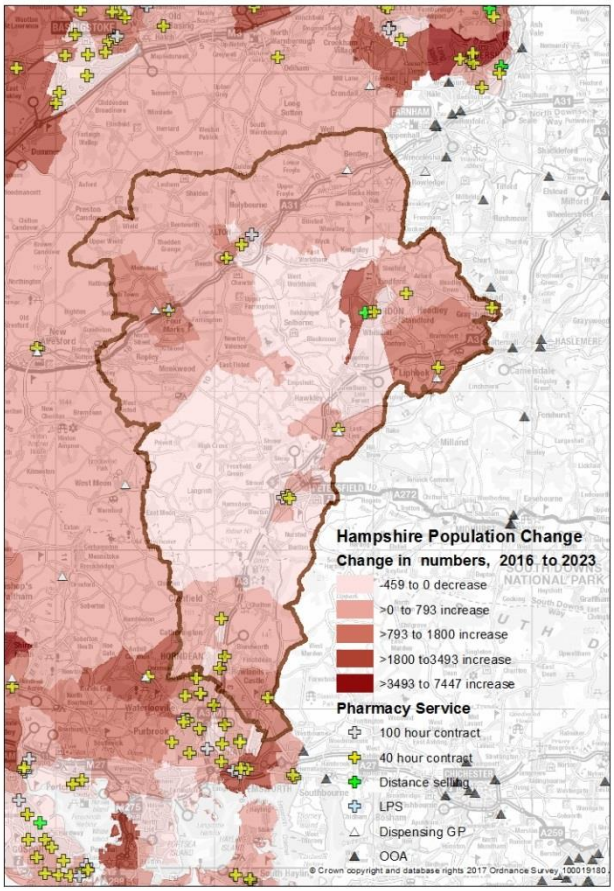
Pharmacy provision

There are 19 Community Pharmacies in East Hampshire, this includes two 100 hour pharmacies and a distance selling provider. Four chemists are open after 18:30. One pharmacy is open every day until midnight from Monday to Saturday. There is early morning provision (open from 07:00) provided by two pharmacies.

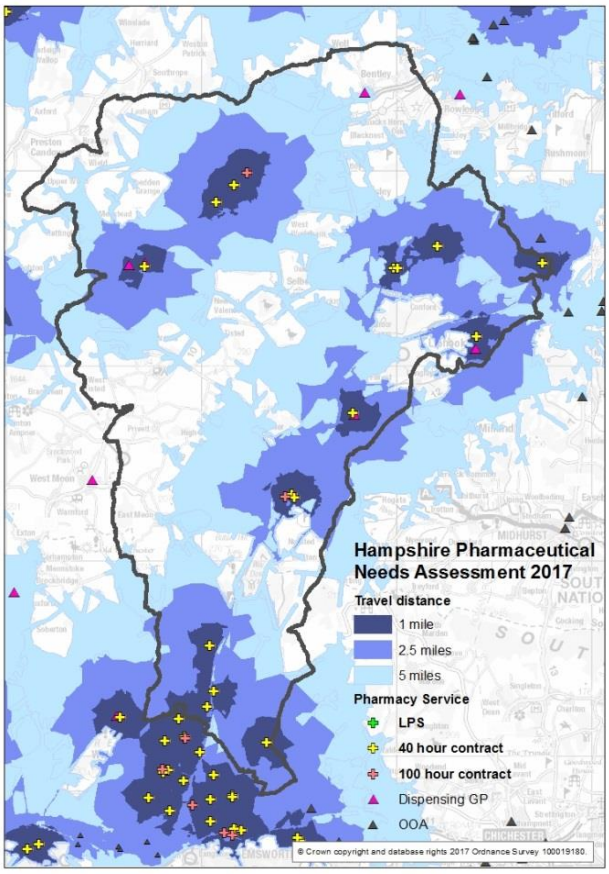
Weekend coverage in the area is good, with 17 pharmacies open on Saturday and out of hours provision within the locality and close by in neighbouring localities. There are four pharmacies open on a Sunday with provision into the early evening. Within the area there is one dispensing practice in near Liss, two in Four Marks and one in Liphook.

72% of the area is within 5 road miles of a pharmacy. Areas further than 5 miles are areas of low population density and low population change. The west of the area is serviced by pharmacies in Winchester and the South is served by Horndean (within East Hampshire) and Havant (outside East Hampshire). The majority of the housing developments are in the towns in the district. With good communication routes these areas of growth are well serviced within 5 miles of a pharmacy.

Map 7



Map 8



Conclusion

There is good provision of pharmacy cover in East Hampshire matching current and future planned population growth. Further provision on a Sunday could be considered to secure better access for patients using the out of hours service in Bordon.

Eastleigh

The population of Eastleigh is 128,873. East Hampshire population age and sex structure is similar to Hampshire, Eastleigh has slightly more young working age (25 to 44 years) and slightly fewer older people compared to Hampshire. 91.8% of Eastleigh resident population are of ethnic group 'White British'.

The health of people in Eastleigh is generally better than the England average. Deprivation is lower than England and Hampshire. There are 2,538 (10.5%) children living in income deprived households, 9,908 (7.8%) people living in means tested benefit households and 2,881 (9.7%) people aged 60+ live in a pension credit household.

Life expectancy for men and women is higher than the England and Hampshire average. Healthy life expectancy at birth data suggests that men will live 13.7 years and women 16.2 years in poor health. This is better than England where 15.6 years for men and 18.2 years for women are spent in poor health.

Future growth

Over the next six years there is a forecast growth of 11,259 people with the largest increase forecast in the over 75s. The forecast increase in the 0 to 74 year olds is greater when compared to Hampshire. There is a growth of 7,025 dwellings (13% change) predicted in Eastleigh between 2016 and 2023 with an associated population growth of 15,118 residents (12% change).

Figure 9

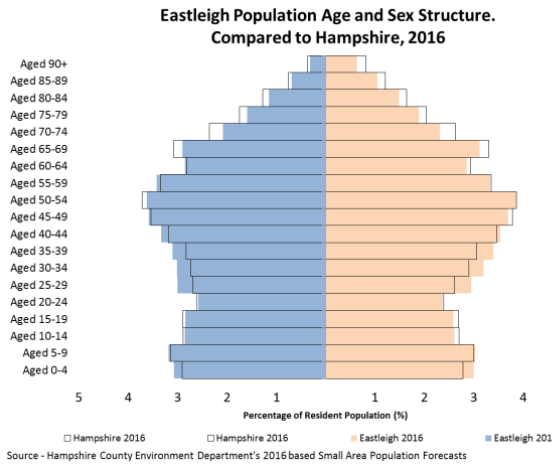
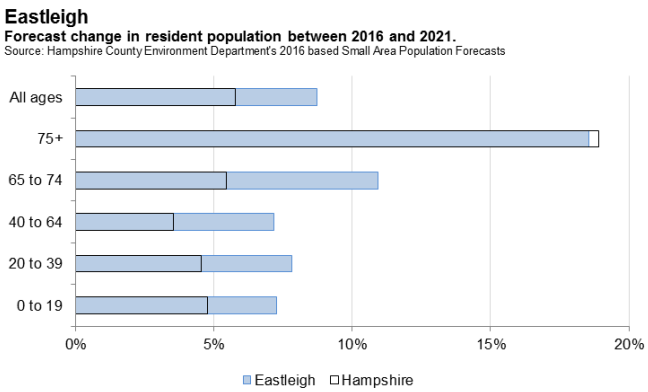


Figure 10

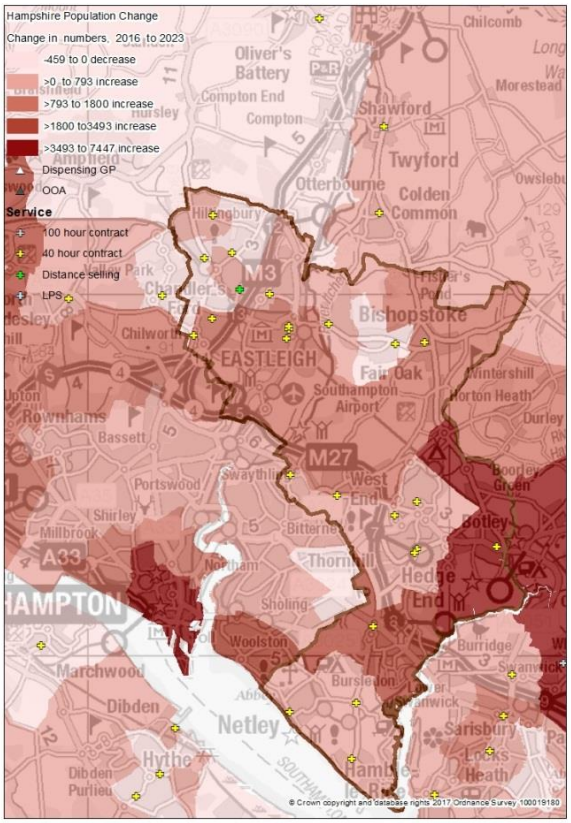


Pharmacy provision

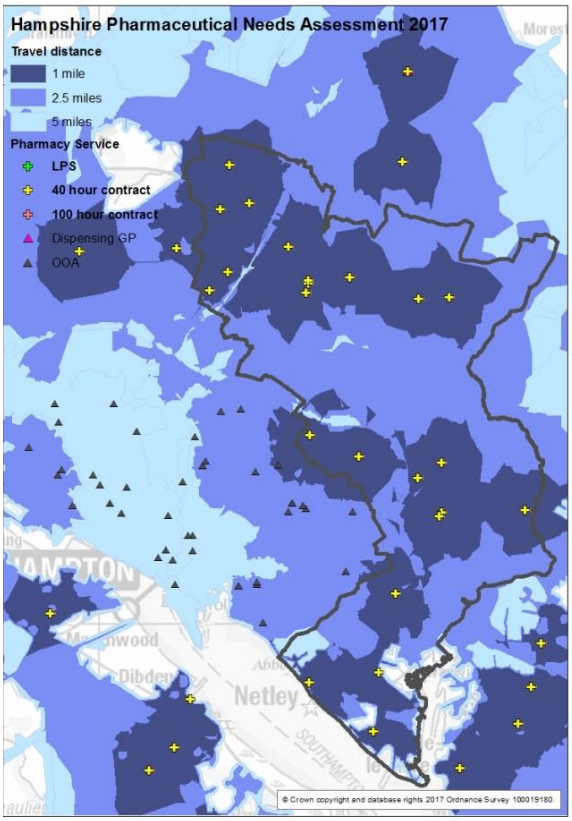
There are 24 pharmacies serving Eastleigh with provision from 08:00 to 22:00 through the week from a variety of sites across the district. 23 pharmacies are a standard 40 hour contract; there is one distance selling pharmacy. Eight pharmacies

are open after 18:30. 23 pharmacies open on a Saturday with two opening into the evening. Six sites are open on a Sunday during the day, the latest closing time is 16:00, with weekend out of hours provision from Southampton, this is the location of the nearest out of hours GP service. 98% of the area is within 5 road miles of a pharmacy.

Map 9



Map 10



Conclusion

There is good provision of pharmacy cover in Eastleigh matching current and future planned population growth.

Fareham

Fareham is an area in the South of Hampshire with a population of 114,058 people. The population structure is slightly older than the Hampshire population as a whole, with fewer younger people aged 0 to 14 years and a greater proportion of older people aged 45 to 74 years. 94.7% of Fareham resident population are of ethnic group 'White British'.

The health of people in Fareham is generally better than the England average. Deprivation is lower than England and Hampshire. There are 1,692 (8.7%) children living in income deprived households, 7,482 (6.6%) people living in means tested benefit households and 2,463 (7.9%) people aged 60+ live in a pension credit household.

Life expectancy for men and women is higher than the England and Hampshire average. Healthy life expectancy at birth data suggests that men will live 12.7 years and women 14.9 years in poor health. This is better than England where 15.6 years for men and 18.2 years for women are spent in poor health.

Figure 11

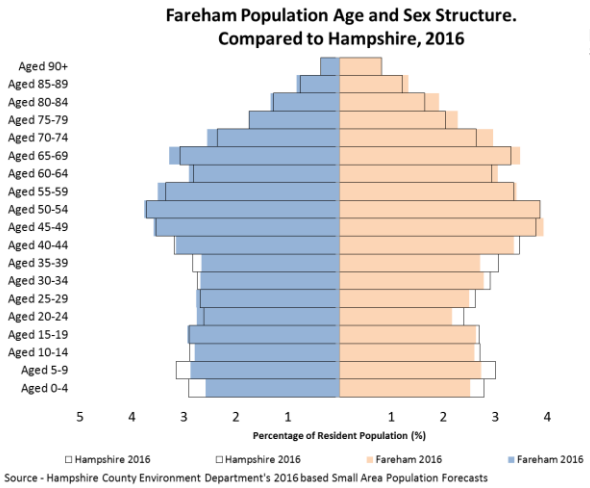
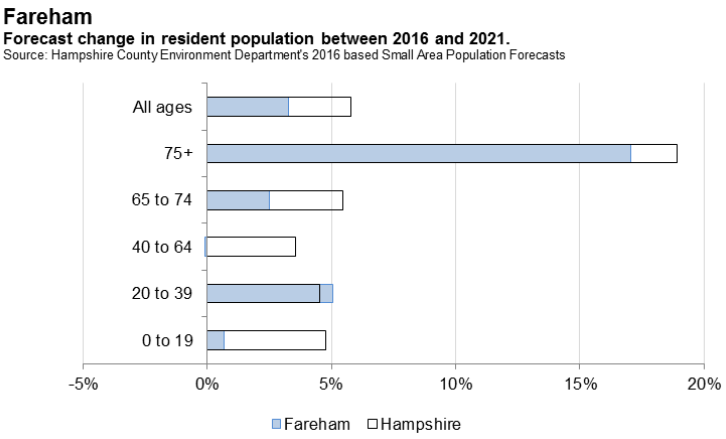


Figure 12



Future growth

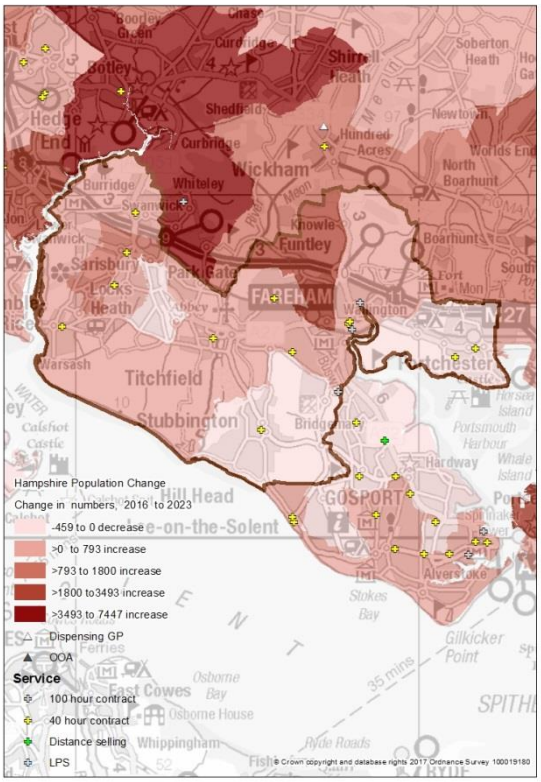
Over the next six years there is a forecast growth of 3,747 people with the largest increase forecast in the over 75s. The forecast increase in the 20 to 39 year olds is greater when compared to Hampshire. There is a growth of 3,103 dwellings (6% change) predicted in Fareham between 2016 and 2023 with an associated population growth of 5,318 residents (5% change). The growth is in areas well served by pharmacies.

Pharmacy provision

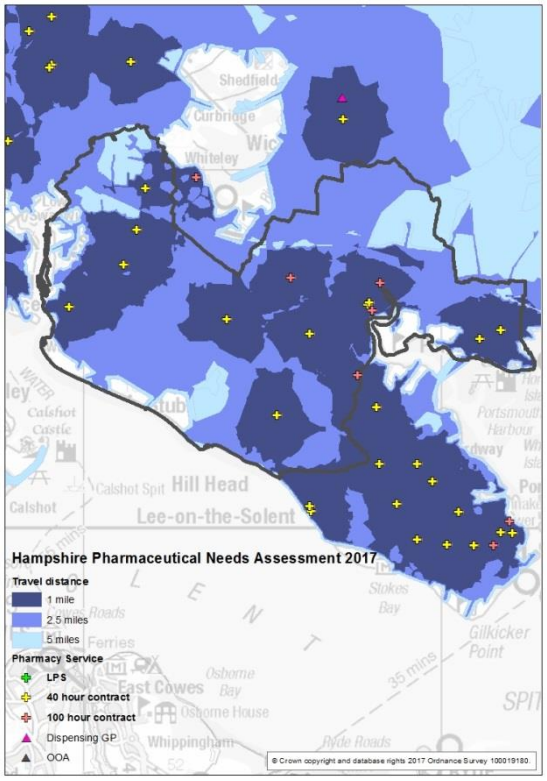
Fareham is served by 17 pharmacies with good weekday provision, six are open after 18:30 with one open until 23:30. Early morning provision is served by four pharmacies. This provision includes four 100 hour pharmacists. There is one distance selling pharmacy located in this locality.

For the weekend all except one pharmacy is open on a Saturday with four open late into the evening. Six pharmacies open on a Sunday with early evening provision. 95% of the area is within 5 miles road travel of a pharmacist.

Map 11



Map 12



Conclusion

There is good provision of pharmacy cover in Fareham matching current and future planned population growth.

Gosport

Gosport is an area of Hampshire in the south of the county with a long history of navel maritime association. Gosport's population of 82,785 and has a younger population age and sex structure than Hampshire. When compared to Hampshire, Gosport has a higher proportion of the very young aged 0 to 9 years and young working age of 20 to 39 years. The district also has a lower proportion of older people aged 60 years and over. 94.4% of Gosport resident population are of ethnic group 'White British'.

The general health of people in Gosport is generally better than the England average. Gosport is one of the most deprived areas in Hampshire with eight areas in the district ranked in the 20% most deprived quintile nationally; however deprivation is lower than England. There are 3,034 (18.7%) children living in income deprived households, 10,434 (12.5%) people living in means tested benefit households and 2,308 (11.7%) people aged 60+ live in a pension credit household.

Life expectancy for men and women is significantly worse than the England and Hampshire average. Healthy life expectancy at birth data suggests that men will live 14.8 years and women 17.1 years in poor health. This is better than England where 15.6 years for men and 18.2 years for women are spent in poor health.

Figure 13

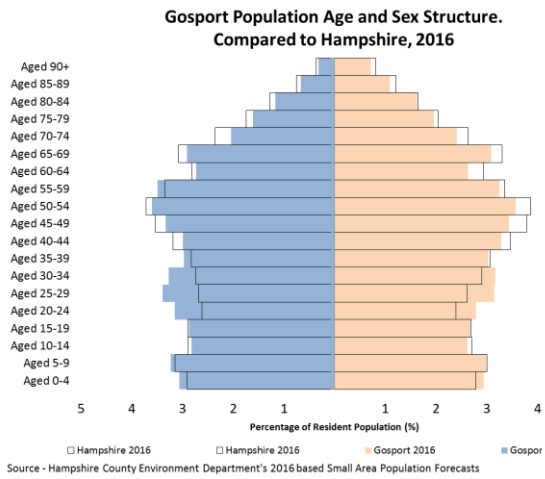
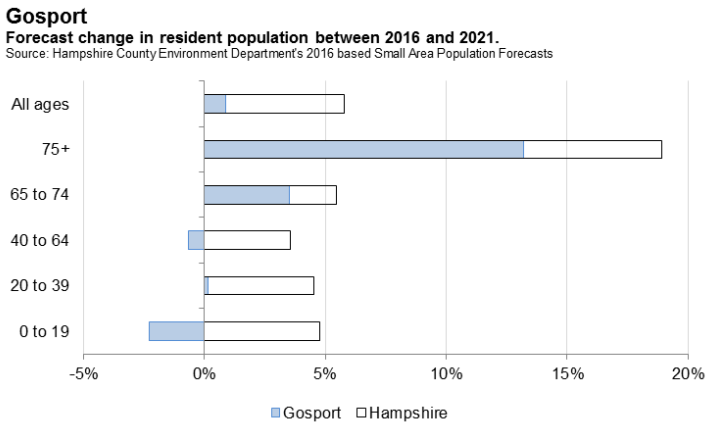


Figure 14



Future growth

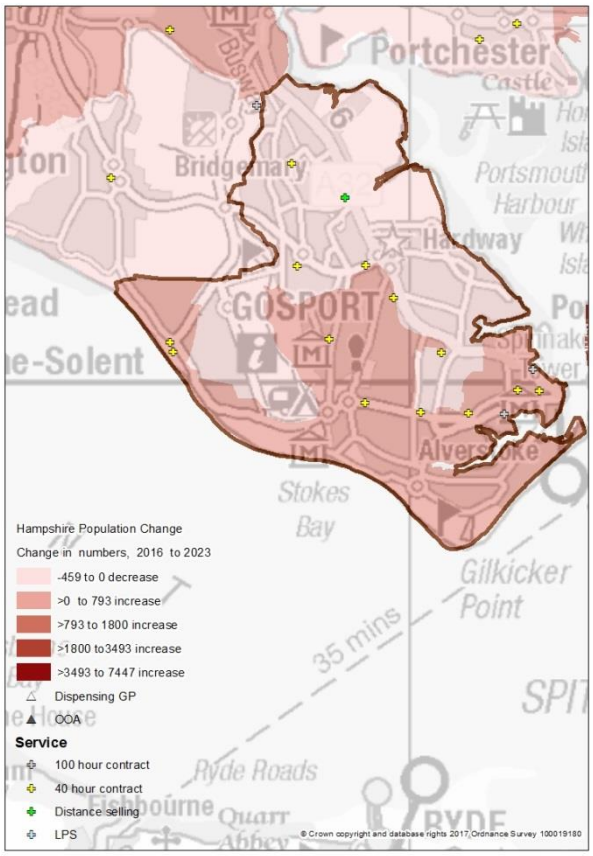
Over the next six years there is a very small forecast growth of 720 people with decreases in the 0 to 19 and 40 to 64 years cohorts. The forecast increase all other age bands is significantly less when compared to Hampshire. There is a growth of 1,223 dwellings (3% change) predicted in Gosport between 2016 and 2023 with an associated population growth of 351 residents (<0% change). The areas of housing growth are all within 5 miles of a pharmacy service.

Pharmacy provision

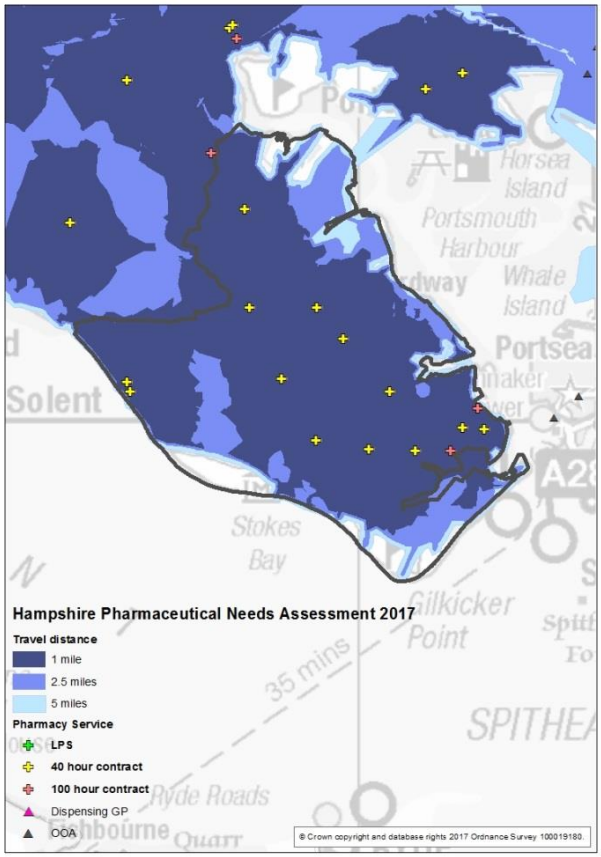
15 pharmacies serve the Gosport area, including two 100 hour pharmacies. Three are open after 18:30. There is early morning provision in the area. 14 of the 15 open on a Saturday with evening provision up to 23:00. Three pharmacies provide provision within the locality on a Sunday including early evening provision. 94% of the borough is within 5 road miles of a service.

Out of hours GP services are provided at Gosport War Memorial hospital for this area with closely aligned pharmacy provision.

Map 13



Map 14



Conclusion

There is good provision of pharmacy cover in Gosport matching current and future planned population growth.

Hart

The population of Hart in the North of the County is 94,951. The district has a younger population with a greater proportion of 0 to 14 years and 35 to 54 years population compared to Hampshire. The current Hart population structure also shows a lower proportion of the older cohorts aged 55 years and over. 90.7% of Hart resident population are of ethnic group 'White British'.

The general health of people in Hart is better than the England average. Hart is the least deprived district in the country, however there are 1,126 (6.1%) children living in income deprived households, 4,283 (4.6%) people living in means tested benefit households and 1,334 (6.2%) people aged 60+ live in a pension credit household.

Life expectancy for men and women is significantly better than the England and Hampshire average. Healthy life expectancy at birth data suggests that men will live 11.2 years and women 13.8 years in poor health. This is better than England where 15.6 years for men and 18.2 years for women are spent in poor health.

Figure 15

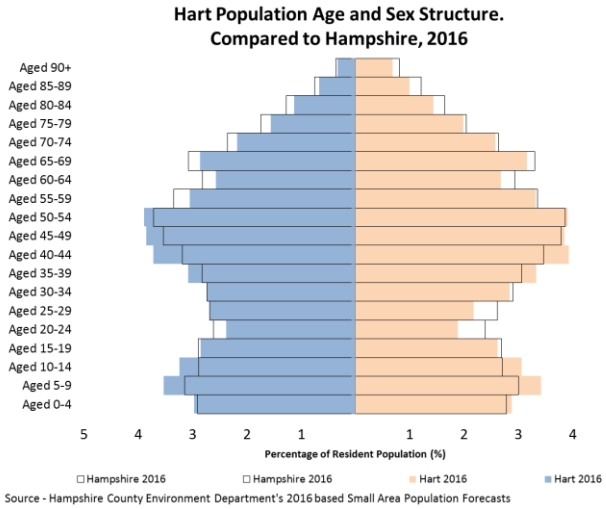
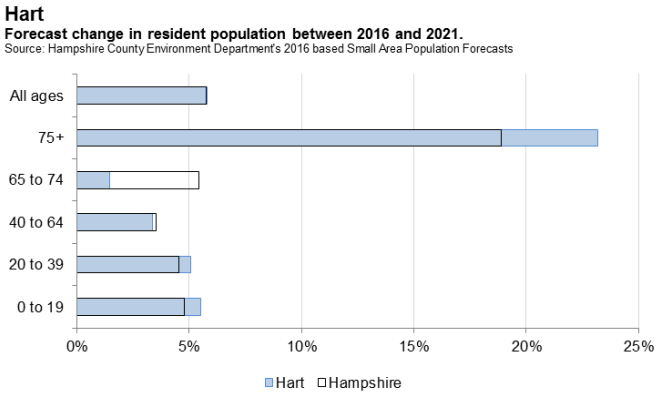


Figure 16



Future growth

Over the next six years there is a forecast growth of 5,511 people with a larger increase forecast in the 75+ years cohort when compared to Hampshire. There is a growth of 3,272 dwellings (9% change) predicted in Hart between 2016 and 2023 with an associated population growth of 6,386 residents (7% change).

Predicted population growth is mainly within the area of 2.5 miles from a pharmacist and all within 5 miles. There is a small area to the West of Hook which is over 5 miles from a pharmacy in Hart or its neighbouring district Basingstoke and Deane; however this area is very rural and is mainly covered by a golf course.

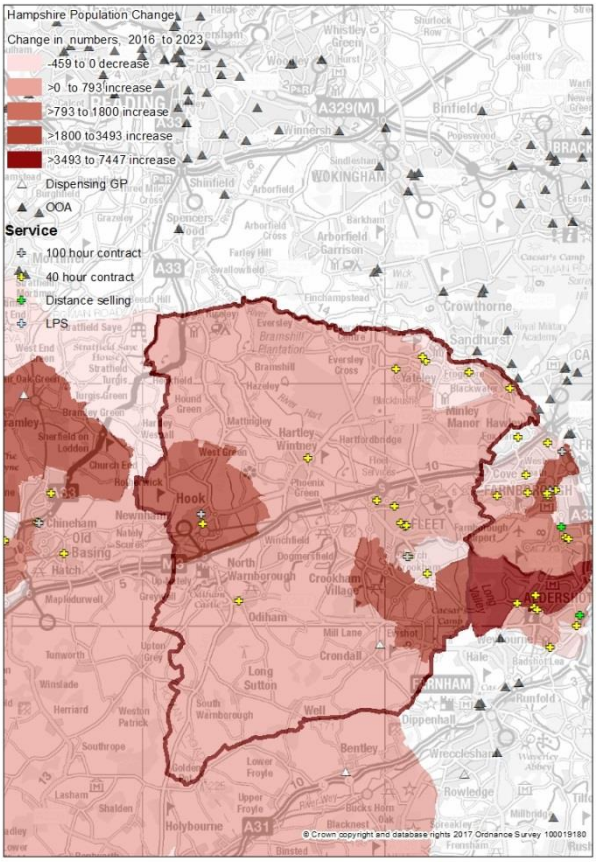
Pharmacy provision

Hart has 17 pharmacies; six are after 18:30 in the week. Two 100 hour pharmacies provide good coverage to the main towns into the late evening, with additional provision in the neighbouring localities. There is early morning provision before 8am.

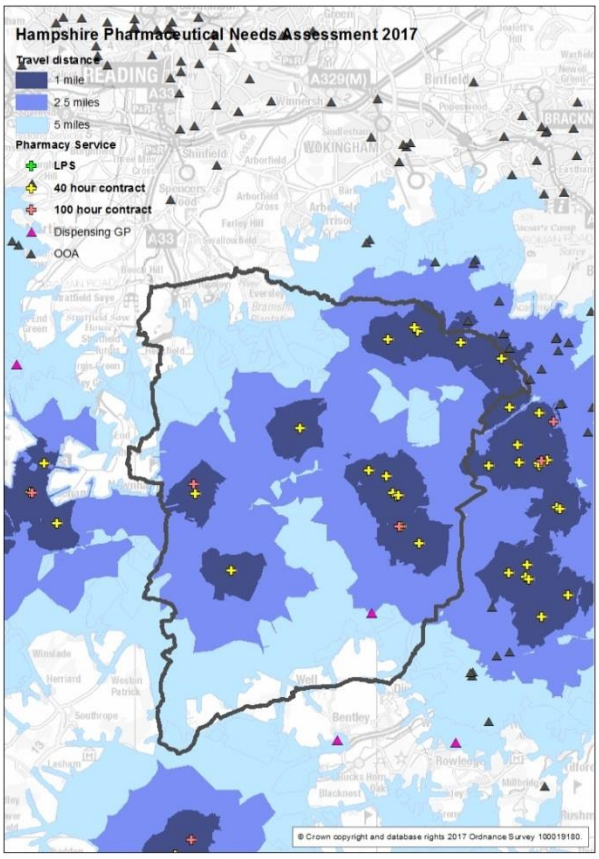
At the weekends provision is covered by all pharmacies on a Saturday and evening provision is available up to 21.30 on one site, with one opening up to 22.30. Four pharmacies open on a Sunday with provision into the evening. 90% of the area is within 5 road miles of a pharmacist.

Frimley Park Hospital and Basingstoke hospital are the bases for out of hours primary care for this area There is pharmacy provision near the out of hours services and within Hart for prescribed medicines. There is a 100 hour pharmacy in Hook and near Fleet and a dispensing practice.

Map 15



Map 16



Conclusion

There is good provision of pharmacy cover in Hart matching current and future planned population growth.

Havant

The population of Havant is 123,719. When compared to Hampshire the current population age and sex structure has a smaller proportion of working age population aged 30 to 54 years and a greater proportion of older people aged 60 years and over. 95.2% of Havant resident population are of ethnic group 'White British'.

The general health of people in Havant is varied compared with the England average and there are significantly more people with a limiting long term illness or disability when compared to England. Havant is the most deprived district in the county and has 18 areas which are ranked in the 20% most deprived national quintile. There are 4,783 (21.9%) children living in income deprived households, 17,651 (14.6%) people living in means tested benefit households and 4,675 (13.7%) people aged 60+ live in a pension credit household.

Life expectancy for men and women is comparable to England and lower than the Hampshire average. Healthy life expectancy at birth data suggests that men will live 14.9 years and women 17.3 years in poor health. This is better than England where 15.6 years for men and 18.2 years for women are spent in poor health.

Figure 17

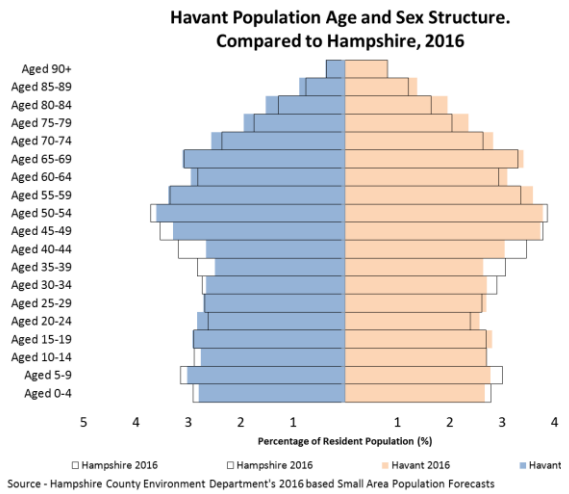
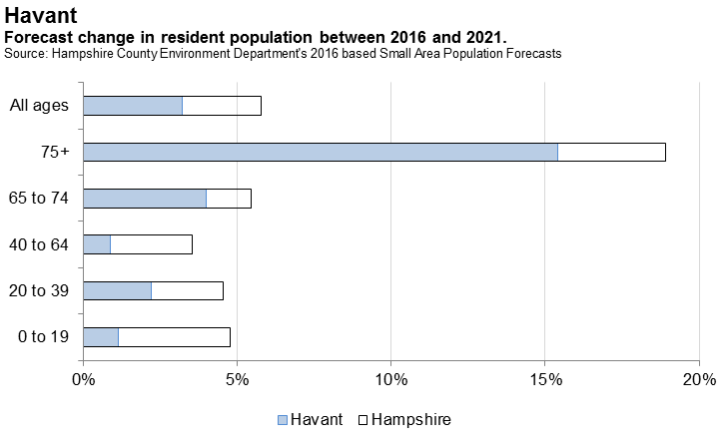


Figure 18



Future growth

Over the next six years there is a forecast growth of 3,990 people with the largest increase forecast in the 75+ years cohort. There is a growth of 3,451 dwellings (6% change) predicted in Havant between 2016 and 2023 with an associated population growth of 5,541 residents (4% change).

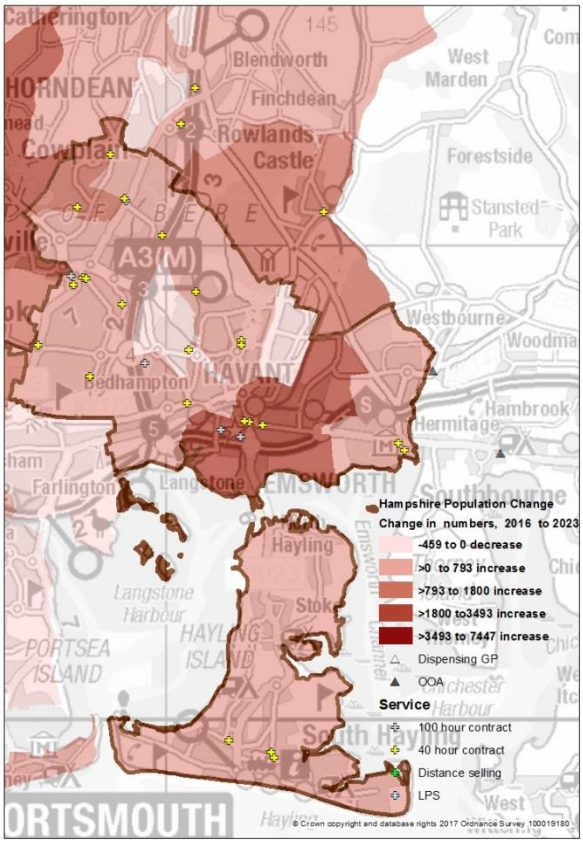
Pharmacy provision

The area of Havant is served by 31 pharmacies in the week with six opening after 18:30 including one open until midnight. There are five 100 hour pharmacies. These are all well distributed throughout the area.

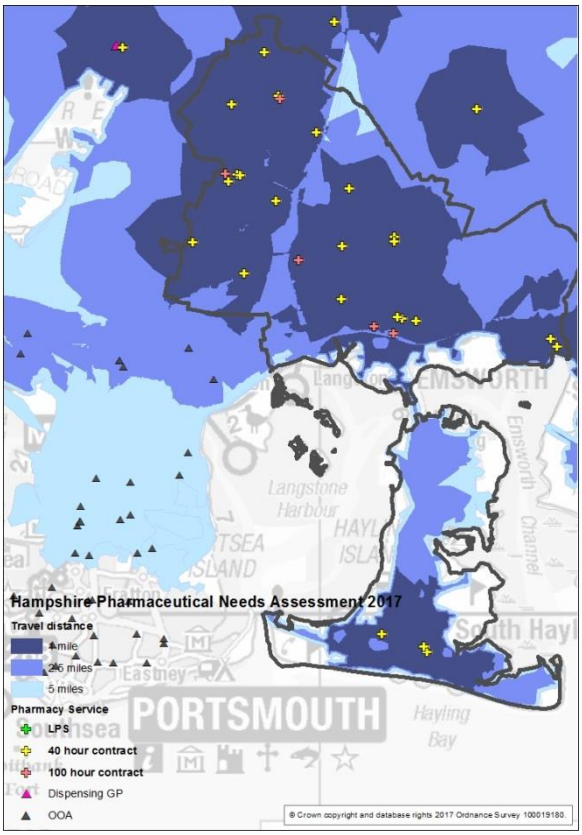
28 open on a Saturday with four open into the late evening. Coverage on Sunday is provided by five pharmacies open during the day. Further pharmacies are in Portsmouth. This is serving a deprived area of Hampshire where good access is essential.

88% of the area is within 5 miles of a pharmacy with a small amount of very rural areas further distance than this. Out of hours GP provision is based in Portsmouth with good out of hours pharmacy coverage provided nearby.

Map 17



Map 18



Conclusion

There is good provision of pharmacy cover in Havant matching current and future planned population growth. The Essential Small Pharmacy provision should be reviewed in line with need taking into account deprivation.

New Forest

The New Forest in the South West has the largest population for a district of Hampshire with 177,335 people. The district has a significantly older population structure than the county overall with a higher proportion of people aged 55 years and over and a lower proportion of all ages between 0 and 54 years. 94.9% of the New Forest population are of ethnic group 'White British'.

The health of people in New Forest is generally better than the England average. Although there is a significantly higher proportion of residents with a limiting long term illness or disability compared to England. Deprivation is lower than England however there are two areas within the New Forest which are ranked in the 20% most deprived quintile nationally. There are 3,604 (12.5%) children living in income deprived households, 15,442 (8.7%) people living in means tested benefit households and 5,308 (9%) people aged 60+ live in a pension credit household.

Life expectancy for men and women is significantly better than England and higher than the Hampshire average. Healthy life expectancy at birth data suggests that men will live 14.1 years and women 15.9 years in poor health. This is better than England where 15.6 years for men and 18.2 years for women are spent in poor health.

Figure 19

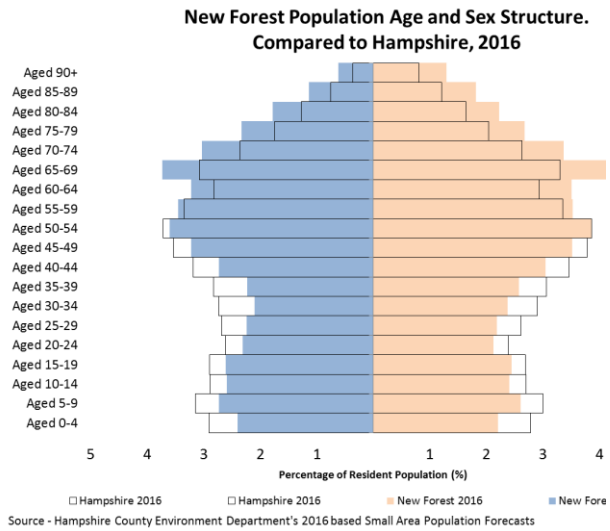
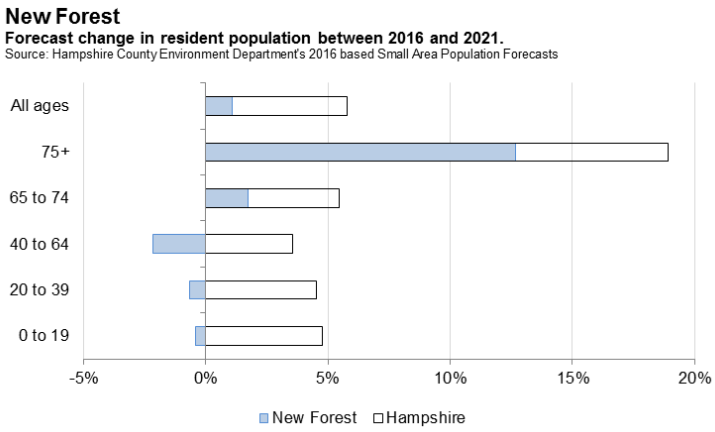


Figure 20



Future growth

Over the next six years there is a forecast growth of 1,925 people with the largest increase forecast in the 75+ years cohort. Population forecasts suggest a decrease in the proportion of 0 to 64 year olds in the New Forest. There is a growth of 2,315 dwellings (3% change) predicted in New Forest between 2016 and 2023 with an associated population growth of 2,195 residents (1% change).

Pharmacy provision

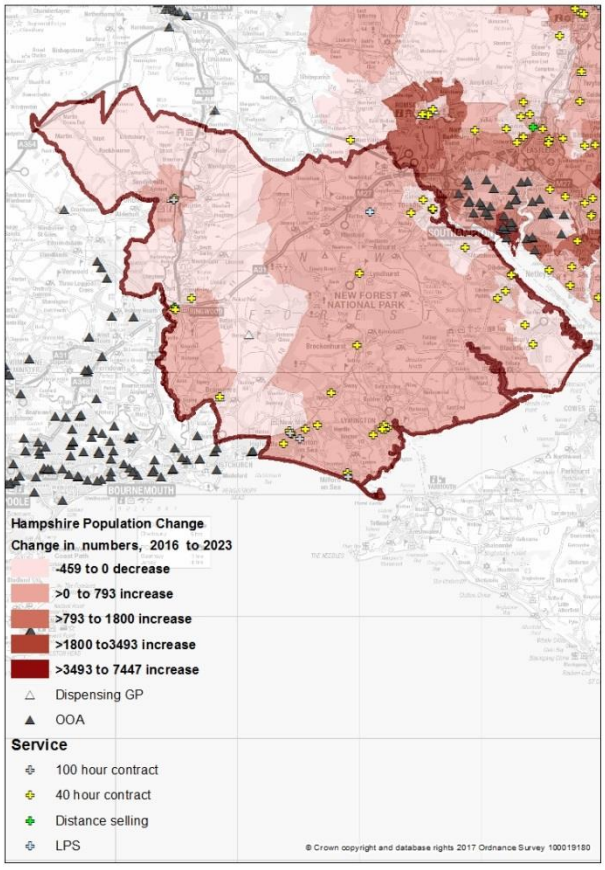
The rural areas of the New Forest have 37 pharmacies with early evening provision throughout the locality; seven are open after 18:30. The four 100 hour pharmacies provide late evening provision in the south west and far west, with the east and north being serviced by other locality and neighbouring authority provision. There is one distance selling pharmacy and one Local Pharmaceutical Service contract. There are also three dispensing practices in the district.

32 pharmacies are open on a Saturday with evening provision up to 22:30. Seven pharmacies provide the Sunday provision with two open in the early evening up to 19:00. This provision is available in the main towns of the New Forest with the far west being served out of the locality in Dorset and Wiltshire, and Southampton.

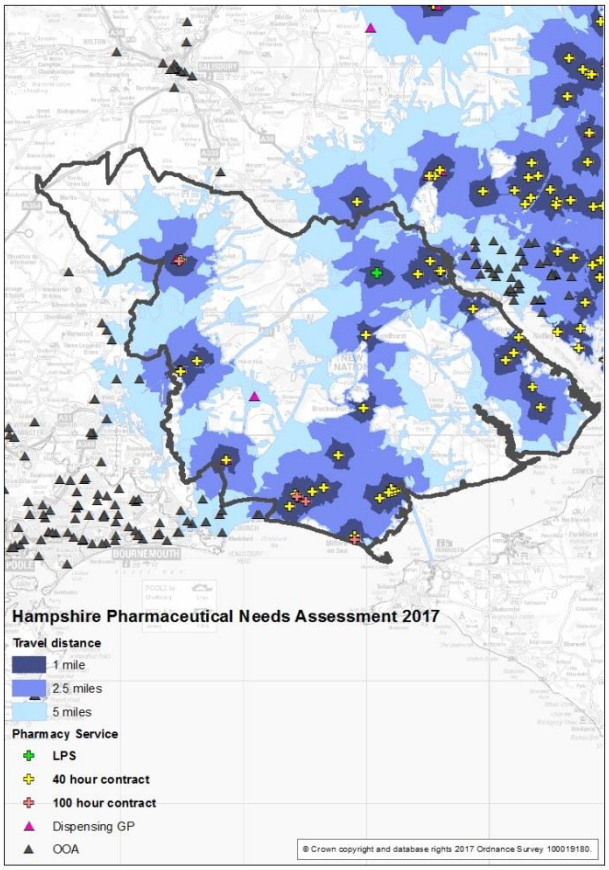
The out of hours services primary care services are based in Totton and Lymington. There is pharmacy provision in this area for out of hours prescription dispensing.

62% of the area is within 5 miles road travel of a pharmacy with very rural areas being further distances.

Map 19



Map 20



Conclusion

There is good provision of pharmacy cover in the New Forest matching current and future planned population growth. The age of this population will need to be taken into consideration when considering pharmacy applications in addition border pharmacies need to be taken into account when considering pharmaceutical needs.

Rushmoor

Rushmoor in the north of the county has 94,739 residents including a large Army base in Aldershot. The population has a significantly younger age population structure than Hampshire, with a higher proportion of 0 to 9 and 20 to 49 year olds and lower proportion of 50 years and over. Over 10% of Rushmoor's population are from a non-white British ethnic group, with over 6,120 people identifying themselves as Nepalese.

The health of people in Rushmoor is varied compared with the England average. Overall deprivation is lower than average, there are two areas within the New Forest which are ranked in the 20% most deprived quintile nationally. However deprivation score affecting older people is significantly worse than England. There are 2,558 (13.4%) children living in income deprived households, 10,256 (10.8%) people living in means tested benefit households and 3,091 (18.6%) people aged 60+ live in a pension credit household.

Life expectancy for men and women is comparable to England and the Hampshire average. Healthy life expectancy at birth data suggests that men will live 13.5 years and women 16.3 years in poor health. This is better than England where 15.6 years for men and 18.2 years for women are spent in poor health.

Figure 21

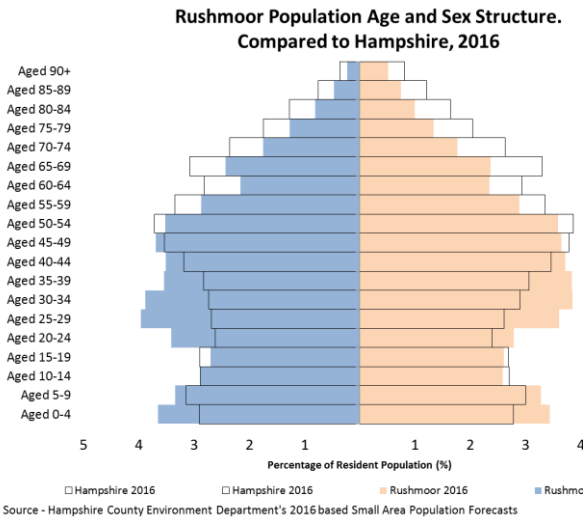
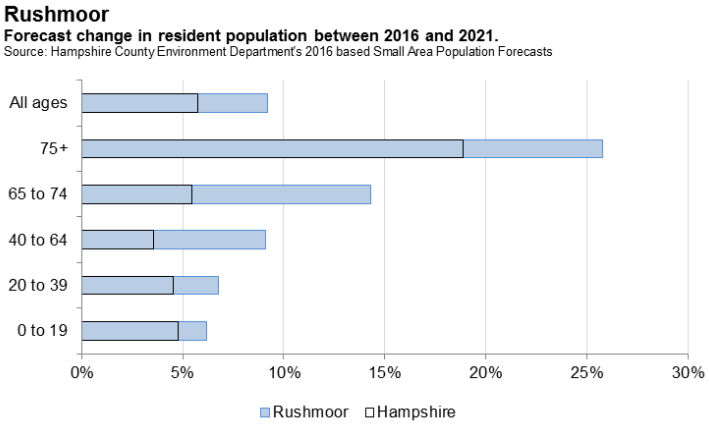


Figure 22



Future growth

Over the next six years there is a forecast growth of 8,724 people with the largest increase forecast in the 75+ years cohort. Population forecasts suggest an increase in all ages across Rushmoor. The forecast change is greater than Hampshire overall. There is a growth of 5,831 dwellings (15% change) predicted in Rushmoor between

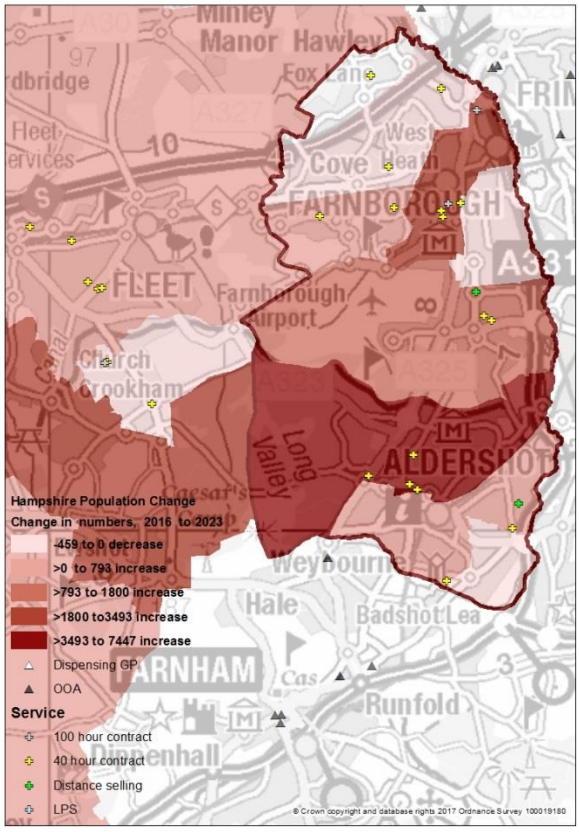
2016 and 2023 with an associated population growth of 11,512 residents (12% change). This represents the biggest percentage change in dwellings and the second biggest population percentage change across the county

The growth in dwellings and population is mainly in the South of the locality which is well serviced by pharmacies.

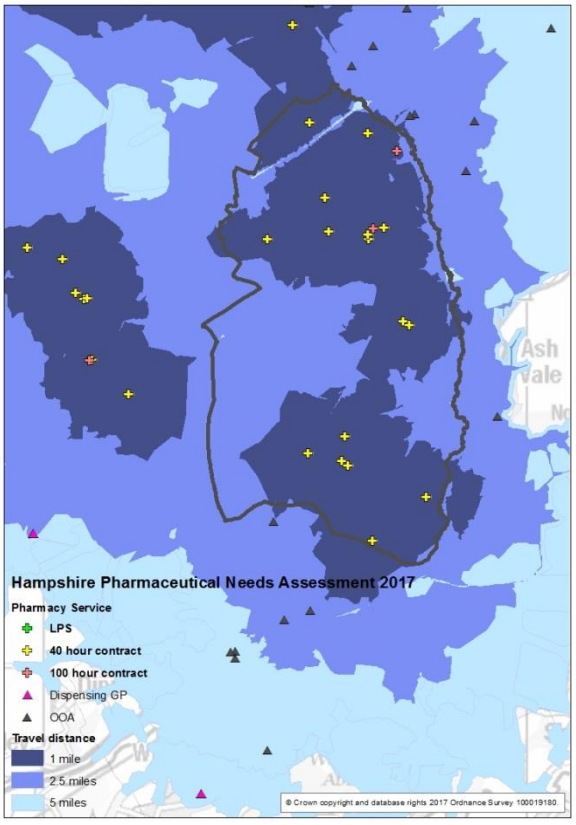
Pharmacy provision

The area has 21 pharmacies with good early evening provision throughout the locality and late evening provision in the week. Six pharmacies open after 18:30 with one opening until midnight. One pharmacy offers early morning provision opening at 07:00. Weekend provision is provided by 16 pharmacies on a Saturday and seven on a Sunday. There is access into the late evening on a Saturday and daytime on a Sunday. 100% of people live within 5 miles of a pharmacy premises. There are two 100 hour pharmacies in the area and two distance selling pharmacies with the local out of hours service provided over the border in Surrey at Frimley Park Hospital.

Map 21



Map 22



Conclusion

There is good provision of pharmacy cover in Rushmoor matching current and future planned population growth.

Test Valley

The population of Test valley is 123,450. Test Valley's population structure is very similar to Hampshire's, there are slightly less people aged 15 to 44 years living in Test Valley compared to Hampshire. 92.6% of the Test Valley population are of ethnic group 'White British'.

The health of people in Test Valley is generally better than the England average. Deprivation is lower than England however there is one area within the Test Valley which is ranked in the 20% most deprived quintile nationally. There are 2,274 (10.4%) children living in income deprived households, 8,895 (7.6%) people living in means tested benefit households and 2,762 (9.1%) people aged 60+ live in a pension credit household.

Life expectancy for men and women is significantly better than England and higher than the Hampshire average. Healthy life expectancy at birth data suggests that men will live 12.3 years and women 15.1 years in poor health. This is better than England where 15.6 years for men and 18.2 years for women are spent in poor health.

Figure 23

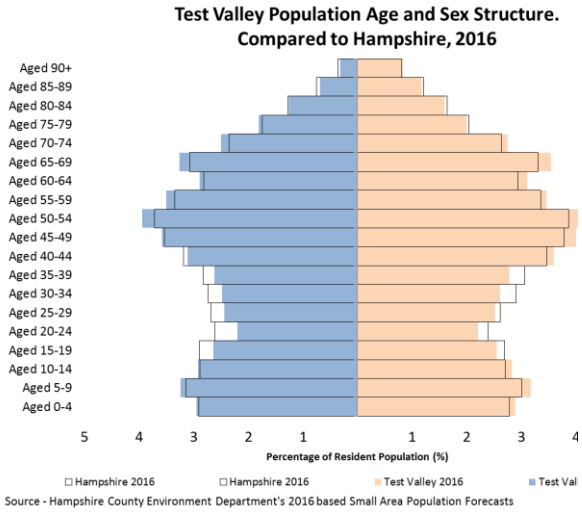
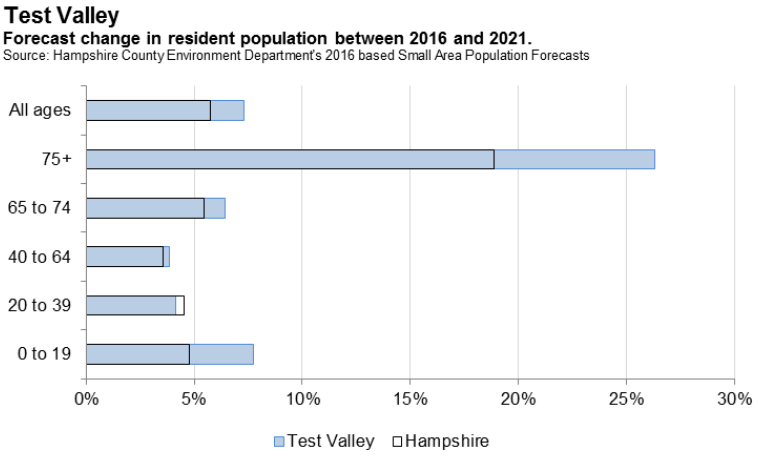


Figure 24



Future growth

Over the next six years there is a forecast growth of 9,007 people with the largest increase forecast in the 75+ years cohort. Population forecasts suggest an increase in all ages across Test Valley. There is a growth of 5,695 dwellings (11% change) predicted in Test Valley between 2016 and 2023 with an associated population growth of 11,212 residents (9% change).

The proposed housing developments are mainly in the Andover and Romsey areas, these have good pharmacy provision

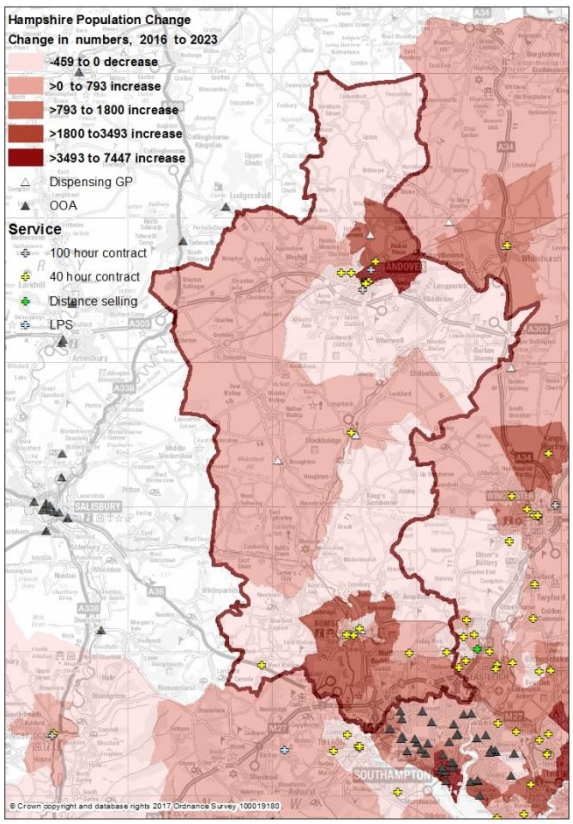
Pharmacy provision

17 pharmacies cover Test Valley through the locality with early evening provision across the patch and late evening provision in the North of Test Valley. The south is serviced by Southampton a short journey from the area. There are two 100 hour pharmacies that serve the locality.

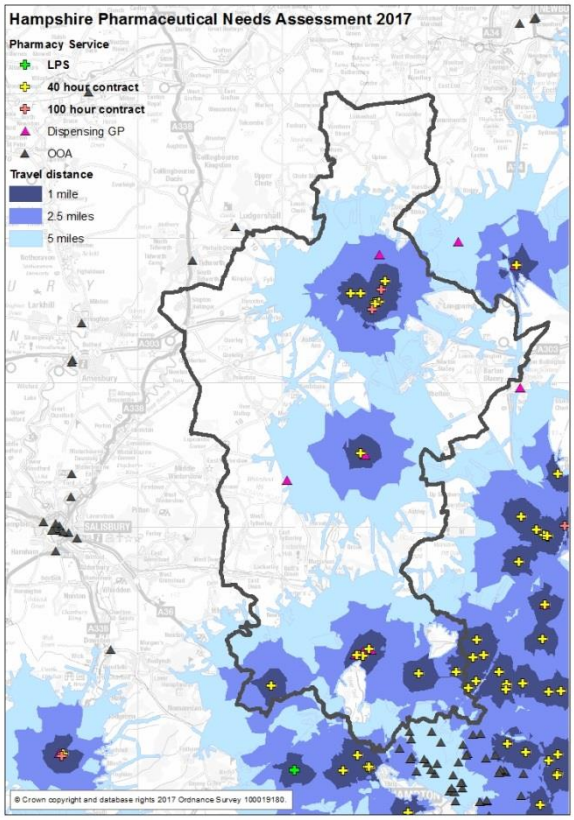
16 pharmacies are open on a Saturday with late evening provision proved by the two 100 hour pharmacies in the North of the area. Four pharmacies are open in the daytime on a Sunday in both the North and South of the locality.

This area also has six dispensing doctors due to the rural nature of the area. This includes three in the town of Romsey. Only 53% of the area is within 5 miles of a pharmacy, however the rural nature of the area means that the areas further from premises are low in population density.

Map 23



Map 24



Conclusion

There is good provision of pharmacy cover in Test Valley matching current and future planned population growth.

Winchester

Winchester is a rural area with a large urban area with a population of 120,975 people. It is a university town, this is represented in the population age structure with a higher proportion of people aged 14 to 24 years when compared to Hampshire overall. 91.8% of the Winchester population are of ethnic group 'White British'.

The health of people in Winchester is generally better than the England average. Deprivation is lower than England and Hampshire. There are 1,734 (8%) children living in income deprived households, 7,741 (6.6%) people living in means tested benefit households and 2,621 (8.7%) people aged 60+ live in a pension credit household.

Life expectancy for men and women is significantly better than England and higher than the Hampshire average. Healthy life expectancy at birth data suggests that men will live 12.4 years and women 14.1 years in poor health. This is better than England where 15.6 years for men and 18.2 years for women are spent in poor health.

Figure 25

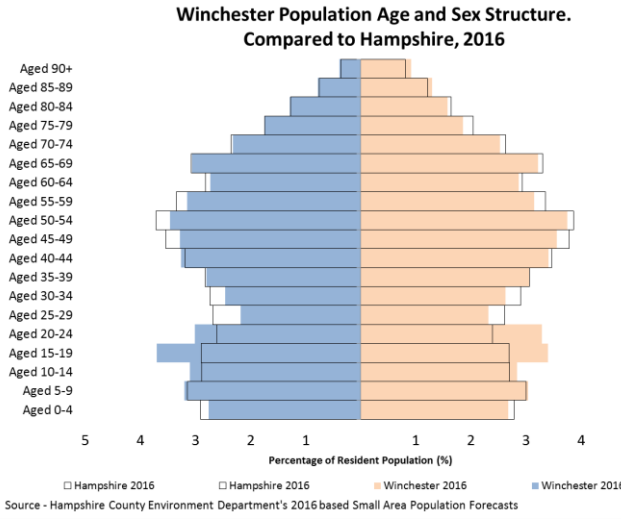
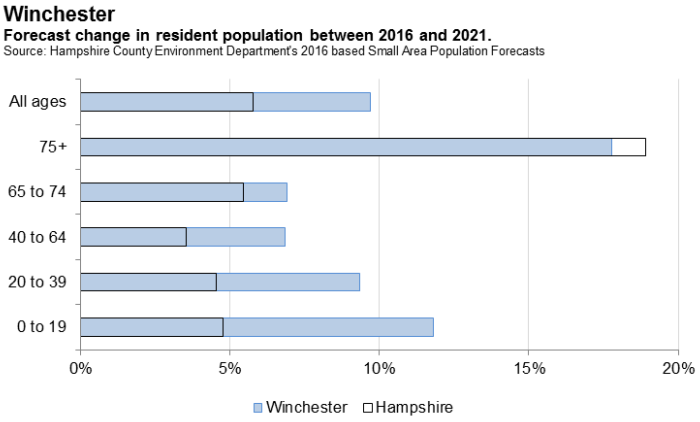


Figure 26



Future growth

Over the next six years there is a forecast growth of 11,737 people with the largest increase forecast in the 75+ years and 0 to 19 years cohorts. There is a growth of 7,439 dwellings (15% change) predicted in Test Valley between 2016 and 2023 with an associated population growth of 16,172 residents (13% change).

Pharmacy provision

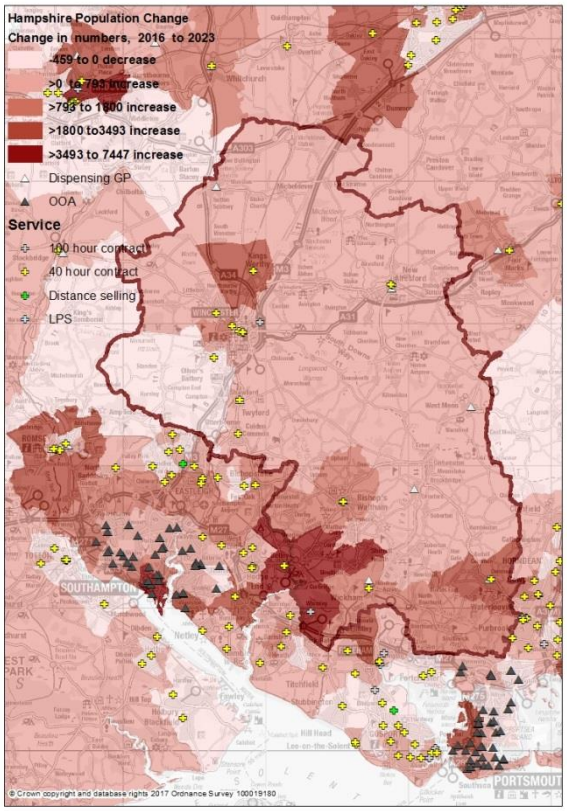
Winchester has 17 pharmacies with weekday early and late evening provision in the main town of Winchester. Five pharmacies are open after 18:30 with one opening

until midnight. There are two 100 hour pharmacies in this locality. The area is serviced by good pharmacy provision in neighbouring localities. This is by pharmacies in Havant and Eastleigh in the South and Basingstoke in the North.

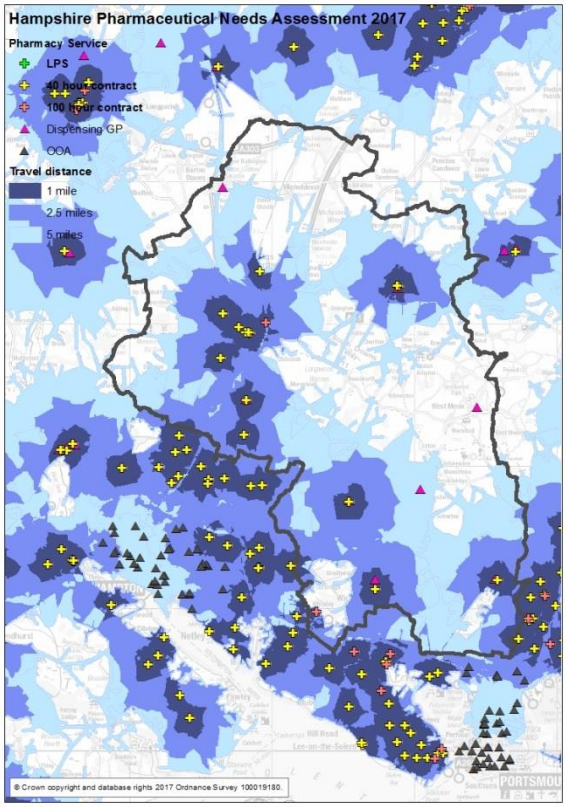
All pharmacies are open on Saturday with evening availability up to midnight. Four pharmacies open in the day on a Sunday are in the district. 64% of the area is within 5 road miles of a pharmacy with the rural population having much further to travel. There are eight dispensing doctors, one serves the rural West Meon area which falls outside the 5 mile travel time zones.

Out of hours provision is based in Winchester hospital.

Map 25



Map 26



Conclusion

There is good provision of pharmacy cover in Winchester matching current need.

Please update the communication log every time you share this paper with an internal or external partner.

PH Communications Log

Lead	Name of Organisation	Communication Type (presentation, letter, email)	Date shared	Purpose	Outcome

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HAMPSHIRE COUNTY COUNCIL

Report

Decision Maker:	Health and Wellbeing Board
Date:	15 March 2018
Title:	Hampshire Suicide Prevention Plan
Report From:	Dr Sallie Bacon

Contact name: Simon Bryant, Associate Director of Public Health

Tel: 02380 383326 **Email:** Simon.bryant@hants.gov.uk

1. Recommendation(s)

1.1 To approve the suicide prevention plan for Hampshire.

2. Executive Summary

2.1 The purpose of this paper is to present the Hampshire Suicide Prevention Plan to the Health and Wellbeing Board for approval. This is a refresh of the plan signed off by the board in June 2015.

3. Contextual information

3.1 Hampshire's rate of suicides is 8 per 100,000 which is comparable to the England rate of 8.4 per 100,000. The suicide audit for Hampshire highlights key issues for preventing suicide locally.

4. Aim

4.1 Achievement of the Five Year Forward View target for reduction of suicide (10% by 2020/21) from a 2015/16 baseline

4.2 This suicide prevention plan outlines the key actions to reduce the risk on suicide in the residents of Hampshire. The report action plan covers the following areas.

a. Reduce the risk of suicide in key high-risk groups
b. Tailor approaches to improve mental health in specific groups
c. Reduce access to the means of suicide
d. Provide better information and support to those bereaved or affected by suicide
e. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
f. Support research, data collection and monitoring.

4.3 Key achievements since 2015

a. Development of a post vention protocol for school and colleges

b. Robust partnership and actions with South Western Railways
c. Development of real-time surveillance process with Police.
d. Design of a programme for schools on LGBT issues

4.4 Hampshire County Council lead was part of the national reference group developing the new guidance.

5. Finance

5.1. There are no financial implications from this paper.

6. Consultation and Equalities

6.1. We have consulted with partner agencies through networks and meetings.

CORPORATE OR LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	yes
People in Hampshire live safe, healthy and independent lives:	yes
People in Hampshire enjoy a rich and diverse environment:	yes
People in Hampshire enjoy being part of strong, inclusive communities:	yes

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

IMPACT ASSESSMENTS:

1. Equality Duty

1.1. The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, gender and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Due regard in this context involves having due regard in particular to:

a) The need to remove or minimise disadvantages suffered by persons sharing a relevant characteristic connected to that characteristic;

b) Take steps to meet the needs of persons sharing a relevant protected characteristic different from the needs of persons who do not share it;

c) Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity which participation by such persons is disproportionally low.

1.2. **Equalities Impact Assessment:**

1.3. Not applicable

2. Impact on Crime and Disorder:

2.1. Not applicable

3. Climate Change:

a) How does what is being proposed impact on our carbon footprint / energy consumption? Not applicable

b) How does what is being proposed consider the need to adapt to climate change, and be resilient to its longer term impacts? Not applicable

Suicide Prevention Strategy for Hampshire 2018 - 2021

Introduction

Suicide can have a profound effect on family, friends and the local community. Every day in England around 13 people take their own lives. The effects can reach into every community and have a devastating impact on families, friends, colleagues and others. Each one of these deaths is a tragedy.

This strategy outlines the Hampshire approach to suicide prevention which requires statutory agencies, the voluntary sector and others, including the media, to work together to reduce the number of suicides and the effect of someone taking their life.

We need to support individuals, groups and communities at risk of suicide, offering effective and acceptable responses which reduce their level of risk. We need to work together to influence those whose actions and policies have an impact on the risk of suicide.

This strategy is in line with national guidance and the All Party Parliamentary Group guidance on suicide prevention.

The following key areas of work have been identified nationally as key to reducing suicide. This strategy addresses each of these aspects;

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring.

This work changes and develops as new issues emerge and as research, practice and partnership plans progress. This plan will take account of the NICE guidance being published in 2018

Overall Aim

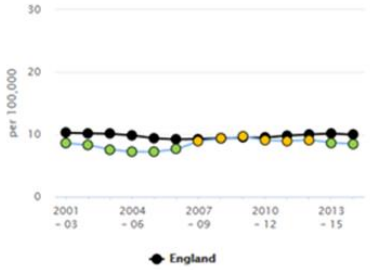
Achievement of the Five Year Forward View target for reduction of suicide (10% by 2020/21) from a 2015/16 baseline

The Hampshire Picture

The latest suicide and injury undetermined mortality rate (2014-16 data) for Hampshire is 8.4 per 100,000 population. This is statistically significantly lower than the England rate of 9.9. Between 2014 and 2016 there were 303 deaths by suicides of Hampshire residents.

The suicide rate is higher for males, with a male: female ratio of 3:1. However, trend data showing a decrease in Hampshire over the last few years, suggest that the male rate is now lower than the national rate. However there has been a flattening of the female rate in Hampshire which is comparable to the national rate.

4.10 - Suicide rate (Persons) Hampshire — Directly standardised rate - per 100,000

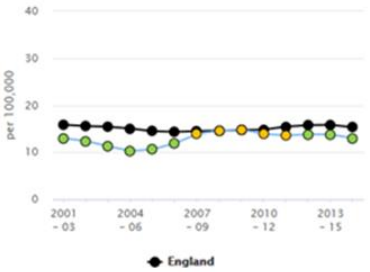


Recent trend: –

Period		Count	Value	Lower CI	Upper CI	South East	England
2001 - 03		280	8.6	7.6	9.7	10.0	10.3
2002 - 04		273	8.3	7.3	9.4	10.0	10.2
2003 - 05		252	7.6	6.7	8.6	9.8	10.1
2004 - 06		242	7.2	6.3	8.2	9.6	9.8
2005 - 07		243	7.2	6.3	8.2	9.1	9.4
2006 - 08		260	7.6	6.7	8.6	8.9	9.2
2007 - 09		306	8.9	8.0	10.0	9.1	9.3
2008 - 10		320	9.3	8.3	10.4	9.3	9.4
2009 - 11		332	9.6	8.6	10.7	9.5	9.5
2010 - 12		316	9.1	8.1	10.1	9.3	9.5
2011 - 13		315	8.9	8.0	10.0	9.9	9.8
2012 - 14		325	9.1	8.2	10.2	10.1	10.0
2013 - 15		313	8.7	7.7	9.7	10.2	10.1
2014 - 16		303	8.4	7.5	9.5	9.8	9.9

Source: Public Health England (based on ONS source data)

4.10 - Suicide rate (Male) Hampshire — Directly standardised rate - per 100,000

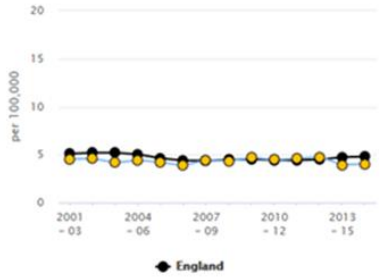


Recent trend: –

Period		Count	Value	Lower CI	Upper CI	South East	England
2001 - 03		204	13.0	11.2	14.9	15.4	15.9
2002 - 04		196	12.4	10.7	14.3	15.2	15.6
2003 - 05		182	11.3	9.7	13.1	14.9	15.4
2004 - 06		167	10.3	8.8	12.0	14.3	15.1
2005 - 07		171	10.6	9.1	12.4	13.7	14.5
2006 - 08		192	11.9	10.3	13.8	13.6	14.4
2007 - 09		228	13.9	12.1	15.8	13.9	14.5
2008 - 10		244	14.6	12.8	16.6	14.2	14.6
2009 - 11		248	14.8	13.0	16.8	14.3	14.7
2010 - 12		234	13.9	12.2	15.8	14.2	14.8
2011 - 13		229	13.6	11.9	15.5	15.2	15.5
2012 - 14		236	13.8	12.1	15.7	15.7	15.8
2013 - 15		239	13.8	12.1	15.7	15.9	15.8
2014 - 16		227	13.0	11.4	14.8	15.1	15.3

Source: Public Health England (based on ONS source data)

4.10 - Suicide rate (Female) Hampshire — Directly standardised rate - per 100,000



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	South East	England
2001 - 03		76	4.5	3.6	5.7	5.1	5.1
2002 - 04		77	4.6	3.6	5.8	5.2	5.2
2003 - 05		70	4.2	3.2	5.3	5.1	5.2
2004 - 06		75	4.4	3.5	5.6	5.2	5.0
2005 - 07		72	4.2	3.3	5.3	4.9	4.6
2006 - 08		68	3.9	3.0	4.9	4.6	4.4
2007 - 09		78	4.4	3.5	5.6	4.5	4.4
2008 - 10		76	4.3	3.4	5.4	4.7	4.5
2009 - 11		84	4.7	3.8	5.9	4.9	4.5
2010 - 12		82	4.5	3.5	5.5	4.8	4.4
2011 - 13		86	4.6	3.7	5.7	4.8	4.4
2012 - 14		89	4.8	3.8	5.9	4.7	4.5
2013 - 15		74	3.9	3.1	4.9	4.8	4.7
2014 - 16		76	4.1	3.2	5.1	4.8	4.8

Source: Public Health England (based on ONS source data)

Source: Public Health Outcomes Framework

Suicide Audit

The annual audit of deaths by suicide continues to help us understand our local picture. Benefits of the local collection of these data, are that it enables us to review available

information on risk factors associated with each case such as mental health service use, GP consultations, long term conditions, criminal record, drug and alcohol use. It can also highlight information on patterns of risk and potential gaps in service provision.

The Hampshire 2017 audit of deaths by suicides has been conducted in partnership with HM Coroners for the suicide cases where the date of death was between 1st January 2016 and 31st December 2016 and the individual was a resident in the Hampshire County area.

Some key themes identified are;

- Potential differences in methods by age band.
    - Similar to all ages, just over half of the young people (aged under 20 years) died by hanging, however a larger proportion of young people (35%) died by either jumping from height or onto train tracks or train when compared with the older age bands.
    - A larger proportion of 40 to 59 years died from an overdose compared to the other age bands.
    - Emerging methods such as helium poisoning and CO poisoning were evident in the older 40 years and over ages.
    - Death by shooting is more common in the over 60 years-and-over age band.
- Primary Care's prevention opportunities
    - One third (n=66) had been to see their GP two weeks before their death. Almost half of these consultations were to discuss mental health issues – such as depression and anxiety, review of medication for depression and poor sleep.
- Location
    - For those deaths which occur elsewhere (not at home) the most common location is a woodland or wooded public area, followed by rail related locations.
- Criminal Justice Contacts
    - People in current or recent contact with the criminal justice service were at risk of suicide. In particular, a number were under investigation for sexual offences.
- Life events/themes
    - For all ages, mental illness was recorded the most, ranging from common mental health disorders such as depression and anxiety to acute conditions such as psychosis and schizophrenia.
    - Four cases of post traumatic stress disorder were recorded.
    - Over one third of people had had relationship problems. This was the most common recorded theme documented affecting over half of those aged under 25 years.
    - One in ten people had sleep problems noted, this ranged from disturbed or poor sleep, sleep apnoea and insomnia.

Reducing the risk of suicide in key high-risk groups

With suicide risk not evenly distributed throughout the population there are some groups at higher risk.

Reducing risk in men, especially those in middle age is particularly important. Men are at higher risk in this middle age group when there are co-existing issues such as debt, social isolation, drugs and alcohol use.

Ideas of socialisation play a particularly important factor in relation to men's mental health. These tendencies include a relative lack of emotional expressiveness, the propensity to "act out" emotional distress, and a reduced willingness to admit vulnerability and seek help. Key factors for men include depression, especially when it is untreated or undiagnosed, alcohol or drug misuse, unemployment, family and relationship problems including marital breakup and divorce, social isolation and low self-esteem.

We have undertaken insight work to understand Men's views on mental wellbeing that has been used to inform the development of a bid for EU funding.

People in contact with the criminal justice system
There are many possible factors as to why someone in the criminal justice setting may be more at risk from suicide. Jails and prisons are repositories for vulnerable groups that are traditionally among the highest risk for suicide, there may be a psychological impact of arrest and incarceration and, furthermore, prisoners are isolated from their family community and support. In partnership with the criminal justice system, multi-agency work has commenced to improve the health and wellbeing of those in the criminal justice system.

Specific occupational groups, such as doctors, nurses, veterinary workers
Depression is at least as common in the medical profession as in the general population, affecting an estimated 12% of males and 18% of females. However, because of the stigma often associated with depression, self reporting likely underestimates the prevalence of the disease in both of the above populations.

Perhaps in part because of their greater knowledge of and better access to lethal means, physicians have a far higher suicide completion rate than the general public; the most reliable estimates range from 1.4-2.3 times the rate in the general population. Although female physicians attempt suicide far less often than their counterparts in the general population, their completion rate equals that of male physicians and, thus, far exceeds that of the general population (2.5-4 times the rate by some estimates).

Farmers and agricultural workers
The key explanatory variables in this group are the presence of physical and mental illness, low rates of treatment, lack of a close confiding relationship, work and financial problems and the availability of firearms. The National Farmers Union (NFU) reports that the average age of farmers in Hampshire is 57 years, indicating an older average workforce than that seen in other occupations. Due to the mechanisation of farming methods they are also more likely, than other occupations, to be sole workers,.

Lesbian, Gay and Bisexual people are at significantly higher risk of mental disorder, suicidal ideation, substance misuse, and deliberate self harm than heterosexual people3. The results demonstrated a two fold excess in risk of suicide attempts in the preceding year in men and women, and a four fold excess in risk in gay and bisexual men over a lifetime. Suicide in these groups is related to isolation and not being able to come to terms with sexuality alongside a fear of discrimination.

Transgender people are of the highest risk of suicide in this group.4 A 2012 survey in Ireland5 reported that 78% of trans people had thought about ending their lives and 40% had attempted suicide. Transgender people may also experience relationship issues with close friends and families, alongside stigma, discrimination and hate crime from the wider community. Risk of suicide compounded by any co-existing mental and physical health. They may also experience long waiting times for NHS gender reassignment services, exacerbating existing difficulties.

Proposed Actions	**When**
Embed learning from work into all themes of mental wellbeing work	Ongoing
Use EU bid for innovative work with men	To be completed by 2021
In partnership with key stakeholders reduce drug related deaths in Gosport through the substance misuse service transformation	From July 2018
Digital support scoped and considered for those at increased risk of suicide, eg Stay Alive app	June 2018
Suicide prevention training for frontline workers	Available from April 2018
Work with the Criminal Justice System on embedding learning from the Rebalancing Act Plan through the Reducing Reoffending subgroup of the Local Criminal Justice Board	Ongoing Refreshed action plan June 2018
Improve equality monitoring in commissioned services and support public health, mental health and other support services to be more LGBT welcoming and inclusive	Sept 2019
Development and distribution of LGBT resource for primary and secondary schools to create more inclusive and supportive school communities	Sept 2018
Further explore work with NHS regarding suicide prevention in medical professions taking forward local research	April 2019
Review need for specific local work with farmers and vets in Hampshire	June 2019
Improve practice and multiagency collaboration in management of dual diagnosis of Severe Mental Illness and substance misuse through area pathway groups.	Ongoing

Tailor approaches to improve mental health in specific groups

Improving the mental health of a local community can impact strongly on reducing suicide rates.

A Joint Hampshire Strategy for Emotional Wellbeing and Mental Health (Children and Young People) set out a number of key actions which will impact on overall wellbeing and reduce risk of suicide. A further strategy is being developed the key themes of this are:

- Emotional wellbeing and mental health of children and young people is every body's business
- Supporting good mental health of parents, child and families from conception to early years (0-5 years old)
- Whole school/education establishment approach to mental health
- Vulnerable Communities
- Reduce rates of Self Harm
- Tier 2 and Tier 3 Child and Adolescent Mental Health Services
- Staff Training and Workforce

A mental wellbeing plan focusing on the adult population is being developed and will be implemented in 2018-21. The themes of the strategy, of which self-help and strengthening communities are a key part are:

- Universal interventions to build resilience and promote wellbeing at all ages with a focus on those at risk of poor mental wellbeing.
- Targeted prevention of mental ill health and early intervention for people at risk of mental health problems
- Early intervention and physical health improvement for people with mental health problems
- Eradicate the stigma and discrimination associated with mental health

The key actions will be outlined in the strategies.

Specific issues related to Suicide prevention are outlined below

Those visiting primary care. Primary care partners supported to ensure they are confident to identify and support those with suicidal ideation.

Depression can cause symptoms of low mood, tiredness, loss of interest, despair and hopelessness that interfere with a person's life. Treatment of depression and other mental illness conditions in primary care, and safe prescribing of painkillers & antidepressants should follow NICE guidance[1,2].

Sleep disturbances in general, as well as insomnia and nightmares individually, appear to represent a risk factor for suicidal thoughts and behaviour.

Relationships. Both divorced and separated males and females have been found to be at an elevated risk of suicide compared to their married counterparts One clear implication of the evidence that relationship breakdown is associated with heightened suicide risk is that, when working with men and women already identified as at risk of suicide, practitioners need to be alert to the possibility that relationship breakdown can be a trigger to suicidal acts.

[1] https://www.nice.org.uk/guidance/cg90/chapter/1-Guidance#care-of-all-people-with-depression
[2] https://www.nice.org.uk/guidance/cg91

For those under the care of mental health service especially in relation to past traumatic events will have safety plans and condition pathway allocated to ensure best practice interventions

A key challenge remains how to encourage those at risk to seek help as early as possible. The inability to express distressing emotion has been viewed as a risk factor for suicide.

Action	
Develop an approach to improving the support for people affected by issues of depression, relationship breakdown and poor sleep, through partnership work with primary care and local support agencies	March 2019
Develop a proposal for STP funding for working in primary care across the South East of England	March 2018
Zero Tolerance to suicide work to be scoped and considered by key mental health agencies	September 2018
Continue developing and disseminating evidence-based suicide assessment (>95% of patients to have a risk summary) and collaborative safety planning in people in contact with mental health services (MyCrisis & SafetyPlans) for all inpatients and those at medium/high risk)	Achieve targets (95%) for safety planning by end 2019
Implement evidence-based pathways for severe mental disorders to meet standards for psychosocial intervention especially for trauma.	Ongoing (95% of patients under mental health service allocated to pathway)

Reduce access to the means of suicide

Reducing access to the means of suicide can be a very effective form of suicide prevention. Whilst some of this work is takes place at a national level other more local work is needed at.

A strong partnership has developed partnerships with the railway industry. Recent guidance concerning suicides on the Highways and in waterways and seas has furthered our partnership with the Marine Coastguard Agency and the Highways leads to support their role in reducing suicide.

Where a possible area of high risk is identified, work is undertaken to understand what mitigating factors can be put in place.

Proposed Actions	**By when**
Further work with Marine Coastguard Agency to scope and understand the issues and develop an implementation plan	To start April 2018
To scope and develop a plan with the Highways team to develop further mitigations and response framework.	To start April 2018
Continue partnership with South Western Railways to identify and review where physical mitigations can be put in place across the rail network serving Hampshire.	Annual review
Continue work to improve safety of mental health inpatient units	Annual review

Provide better information and support to those bereaved or affected by suicide

Support for those affected by suicide is important at this time of sudden loss to enable families and friends to come to terms with the loss.

Nationally the 'Help is at Document' has been produced and this is distributed throughout by the Police in Hampshire to those who are recently bereaved by suspected suicide.

The police in partnership with public health have develop a real time surveillance and support referral process for those who may have been bereaved by suicide and this process will be evaluated and reviewed in the coming year. This started in December 2017 and has enabled rapid support to be deployed.

The strategy group has reviewed all support agencies in Hampshire to ensure that relevant support is available where required. Details of this support is made available by the police, as appropriate, as part of the real time surveillance process.

A postvention protocol has been developed to support educational establishments (Schools and Colleges) following a suspected suicide in their community.

Proposed Actions	**By when**
Evaluate the real time surveillance process	March 2109
Review the venues for Help is at Hand to be distributed	March 2019
Review the offer from support agencies to ensure a robust support offer for people in Hampshire	October 2019
Further disseminate and communicate the school and college postvention protocol, as per the Communications Plan	March 2018
Development of a postvention protocol for workplace settings	December 2019

Support the media to deliver, and the communication of, sensitive approaches to suicide and suicidal behaviour

Cases of suicide can be of interest to local and national media. The reporting of suicides needs careful consideration to minimise the impact it may have on others.

The Samaritans have produced guidelines for media outlets on reporting suicide accurately and with sensitivity. This has been shared with media establishments locally.

Proposed Actions	By when
Review the media response since the dissemination of the media guidelines and agree any further actions	April 2019
Ensure in all communication that words around suicide are appropriate to reduce the stigma created by language	On going

Support research, data collection and monitoring

Local suicide audits are an effective way for authorities to identify and respond to high risk groups in their areas, as well as reveal hot spots. It is best practice for local authorities to work with their CCGs, the coroner and NHS to develop and undertake a suicide audit.

Since 2013 Hampshire Public Health has conducted a suicide audit across all the three coroner offices which cover the Hampshire County area. All cases identified by each office as a suicide or suicides with a narrative verdict are included. The audit informs Suicide Prevention work providing context preceding each death and enables theme and hot spot analysis.

Further work is needed to develop a better understanding of the patterns of suicide, suicidal behaviour and attempted suicide. This is developing in conjunction with key partner agencies.

The real time surveillance programme that started in late 2017 enable public health to quickly be ale to identify trends or hotspots and reduce the potential impact of a suicide.

Proposed Actions	**By When**
Continue the suicide audit and review data from real time surveillance data	October 2018
Work with key agencies (Blue light services, transport agencies) to ensure completeness of information to understand patterns of suicidal behaviour	March 2019

Implementation

- This plan will be taken forward by a multi agency prevention group with sub-groups as appropriate.
- Public Health will lead the suicide audit and data developments in conjunction with partners.
- The group will provide updates to relevant boards including the Adults and Children's safeguarding boards, the Health and Wellbeing Board and the HIOW STP
- Governance and monitoring will be through Public Health SMT

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HAMPSHIRE COUNTY COUNCIL

Report

Committee/Panel:	Health and Wellbeing Board
Date:	15 March 2018
Title:	Update from the Hampshire Districts Health and Wellbeing Forum
Report From:	Councillor Anne Crampton, Chair of the District Forum

Contact name: Cllr Anne Crampton
Email: anne.crampton@hart.gov.uk

1. Recommendation

1.1. That the Hampshire Health and Wellbeing Board recognises the value of access to open spaces in local areas and that the Board's member organisations consider the measures in the report to encourage increased usage of open spaces for physical activity.

2. Summary

2.1. This report provides an update on the work of the District Health and Wellbeing Forum which was set up as a subgroup of the Hampshire Health and Wellbeing Board. It has been established that there should be better two-way communication between the Forum and its parent Board so that the Forum is properly aligned with and delivering against the Hampshire Health and Wellbeing Strategy priorities and so that the Board can understand how its own members can support delivery of health and health inequalities outcomes at district level.

2.2. This report details evidence of the importance of open space for mental and physical health and wellbeing, and highlights a range of approaches for Board members to consider that seek to use open spaces as health assets.

3. Open spaces and health and wellbeing

3.1. The Forum met on 21 November 2017, where it considered presentations by HCC Public Health, Energise Me and Hart District Council in relation to open spaces.

3.2. There is strong evidence linking contact and exposure to the natural environment with improved health and wellbeing e.g. improved physical and mental health and reduced risk of cardiovascular disease.

3.3. There is consistent evidence that having access to recreational infrastructure, such as parks and playgrounds, is associated with reduced risk of obesity among adolescents and increase in physical activity

3.4. Evidence from empirical studies suggest that living in close proximity to green space can improve health, regardless of social class.

3.5. There is also emerging evidence that the availability of blue spaces, such as canals, ponds, rivers, and beaches, has a positive association with health

3.6. Usage of open space is partly determined by proximity. A study of quantities of open space found within urban areas across Hampshire shows that about 20% of urban Hampshire is made up of accessible green space (with variation across districts of between 13% and 34%).

3.7. As well as quantity, the quality of open spaces is important so that areas are considered safe to use, and relevant infrastructure is in place. Research indicates that paved trails in parks are associated with physical activity, and with an ageing population, regular resting places (i.e. seating) can encourage greater levels of gentle and regular exercise. Provision of infrastructure in general should be guided by local consultation with residents. Different groups (men and women, young and old, BME groups, disabled people and residents from relatively deprived communities) have different sets of motivations and barriers to making more use of open spaces.

3.8. District Councils are now reviewing the way their Planning Policy and Development Management functions support health objectives, with the help of HCC Public Health team. Viability of development is a challenge, as is the gathering of sufficient evidence to demonstrate health needs; nevertheless there is emerging research and best practice to draw on, and very welcome support from HCC Public Health colleagues.

4. Encouraging greater use of open spaces

4.1. While those responsible for planning and managing open spaces (district councils, HCC – for Country Parks, and parish and town councils) can provide, maintain and improve open spaces, there is a wider partnership and commissioning dimension if we are to maximise the use of these health assets to address physical and mental health challenges in Hampshire. A report from the Institute of Health Equity (set up by Sir Michael Marmot) stated:

> *"There is a need for far greater communication and collaboration between the natural environment and health sectors, which should also make it easier for the public to identify a coherent 'offer' around the natural environment."*[1]

4.2. The current usage of open spaces provides a good opportunity for increasing participation. A Sport England report found that only 27% of people who are deemed Active are active outdoors, which drops further to only 16% of people deemed Regularly Active being active outdoors.

[1] UCL Institute of Health Equity (2012) Natural Solutions for Tackling Health Inequalities

4.3. Specific projects to encourage use of open space show a good return on investment in health terms. Green Gyms (woodland and open space maintenance activity run by Conservation Volunteers) have been shown to offer a Quality-Adjusted Life Year (QALY) at a cost of £4,000 (with NICE considering interventions cost effective if they offer QALYs at less than £20,000.) Put another way, Green Gyms save £2.55 in health costs (treatment of illness associated with physical inactivity) for every £1 invested. Walking for Health schemes deliver a similar QALY cost of about £4,000.

4.4. The Natural Health Service provides commissionable and evidence-based services which yield a social return on investment of £6.75 for every £1 invested.[2]

4.5. Some evidence suggests that participants in health referral exercise programmes based in outdoor green environments are more likely to continue with their programme than if it is based within a gym or leisure centre. This is consistent with research findings showing that price and distance are barriers to physical activity, and that incorporating exercise into everyday (and local) activity is more likely to yield sustained health benefits.

4.6. The Active Parks programme in Birmingham uses technology to track usage of parks and help link NHS funding (for exercise referral) to maintenance and promotion of parks.[3]

4.7. The Forum discussed the way information about local open spaces needs to be provided to a range of partners who have contact with patients/residents so that this can be used in conversations about self-management (tertiary prevention) as well as more general preventive conversations (primary and secondary prevention), and in the MECC ('Make Every Contact Count') programme. GPs and other healthcare providers should make more use of alternatives to medication for mental illness, including advice to spend time and exercise in green spaces – a form of nature-based social prescribing.

4.8. To encourage a better link between the natural environment and health sectors CCGs and GPs should consider taking up the Physical Activity Clinical Champions Training Opportunity recently launched by Public Health England.

4.9. While it is important that residents can get good local information from trusted clinical and other public servants, increasingly people will look online for information to improve wellbeing. Points of information such as council websites, Get Active Hampshire and Connect-to Support need to be comprehensively populated and kept up to date with information about local opportunities to use open space.

4.10. Greater integration between the education and natural environment sectors is urgently required to help address health inequalities, tackle childhood obesity and improve children's well-being and mental health.

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[2] http://naturalhealthservice.org.uk/wordpress/wp-content/uploads/2016/06/Natural-Health-Service-four-key-facts.pdf

[3] UCL Institute of Health Equity (2012) Natural Solutions for Tackling Health Inequalities

4.11. The Forum also discussed ways that use of local health assets could be more closely incorporated into health commissioning through service specifications. For example weight management, NHS Healthchecks and mental health service specifications could require service providers to be aware of and promote open spaces that are local to their service users.

5. Finance

5.1. Costs of maintaining and improving open spaces largely fall on district, town and parish councils, and Hampshire County Council in relation to some of the larger country parks. (Some capital improvement costs can be met by contributions from development.) Such revenue spending is increasingly under review and constraint due to reductions in government grant. Details above highlight potential 'invest-to-save' opportunities of various different approaches and savings potentially accruing to NHS budgets from greater usage of open spaces.

6. Equalities

6.1. As highlighted above, equality impact research has revealed differential usage of open space and different barriers and motivations of different groups:

- Over 80% of outdoors participants are white British.
- Men are more likely than women to be active outdoors (65% compared to 35%).
- On average 24% of people in the BME population regularly visit the natural environment, compared to 38% of the rest of the population.
- Under 18s' key reason for participating outdoors is 'to have fun with friends', whereas for over 55s it is 'to enjoy the scenery and be close to nature'.

6.2. Such considerations should be taken into account when planning improvements and attempting to increase usage of open space so as not to increase health inequalities.

7. Future direction

7.1. The issue of open spaces provides a good opportunity for better coordinated partnership collaboration: maximising the use of a key health asset, addressing a significant health and wellbeing challenge for Hampshire (physical inactivity and mental ill health, and health inequalities), appreciating the local and everyday lived experience of patients/residents, using our combined workforce to send consistent and united key messages to promote healthy behaviours.

7.2. As in the Birmingham example, and as previously piloted in parts of Hampshire in the 'Beat the Streets' projects, technology is likely to play a greater part in encouraging use of open space.

CORPORATE OR LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	yes
People in Hampshire live safe, healthy and independent lives:	yes
People in Hampshire enjoy a rich and diverse environment:	yes
People in Hampshire enjoy being part of strong, inclusive communities:	yes

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

IMPACT ASSESSMENTS:

1. Equality Duty

1.1. The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act;

Advance equality of opportunity between persons who share a relevant protected characteristic (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, gender and sexual orientation) and those who do not share it;

Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Due regard in this context involves having due regard in particular to:

The need to remove or minimise disadvantages suffered by persons sharing a relevant characteristic connected to that characteristic;

Take steps to meet the needs of persons sharing a relevant protected characteristic different from the needs of persons who do not share it;

Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity which participation by such persons is disproportionally low.

1.2. **Equalities Impact Assessment:**

1.3. See section in the report relating to equalities.

2. Impact on Crime and Disorder:

2.1. Increased use of open space is associated with reduced violence and aggression in individuals and decreases in antisocial behaviour, brought about by natural surveillance.

3. Climate Change:

Use of open space supports a better appreciation of nature and our natural resources. Active travel (by walking or cycling via open spaces) reduces carbon emissions from motor vehicles.

HAMPSHIRE COUNTY COUNCIL

Report

Committee/Panel:	Health and Wellbeing Board
Date:	15 March 2018
Title:	Achieving priorities for co-production and community participation
Report From:	Co- production Group

Contact name: Christine Holloway, Chair, Healthwatch Hampshire and Chair, Co-design, co-production and community participation group

Tel: 07779 283451 **Email:** Christine.Holloway@healthwatchhampshjre.co.uk

1. Recommendations

1.1. That the Hampshire Health and Wellbeing Board use its influence to ensure that there is a commitment from the highest level in both local government and the NHS to effective co-production and engagement in the development of commissioning plans and services, including in the Sustainability and Transformation Partnership and Accountable Care Systems, across:

- all stakeholders: health and care commissioners; the County Council; providers whether statutory, commercial or voluntary sector; service users current and future, and the community groups who work with them to make their views heard
- the entire area of the STP, not just within Hampshire County Council's borders
- health *and* social care *and* well-being.

1.2. That the Board model good practice by involving public and/or service users in the Board's own policy developments.

1.3. That the Board monitor co-design, co-production and community participation (see para 3.4 for how this should be done).

1.4. That the Board ensure that all have access to good practice guidance on co-design, co-production and community participation (see para 3.5).

1.5. That the Board agree that NHS and local authority colleagues need the opportunity to learn by experience as well as being offered good practice guidance and explore ways to resource replication of the Empowering Engagement course successfully piloted in both North East Hants and the Isle of Wight (see para 3.6).

1.6. That the Board invite the STP to facilitate access to findings of previous participation work (see para 3.7).

2. Summary

2.1. The purpose of this paper is to recommend to the Hampshire Health and Wellbeing Board the steps which the Co- production Group considers are needed to implement its agreed priorities.

3. Additional information about the recommendations

3.1. The recommendations listed above have been drawn up after considerable discussion in the Co- production Group.

3.2. The Health and Wellbeing Board is asked to adopt the following, more specific, ways to implement the higher-level recommendations set out in paragraphs 1.1 to 1.6.That the Hampshire Health and Wellbeing Board use its influence to ensure that there is a commitment from the highest level in both local government and the NHS to effective co-production and engagement by:

a) Making co-production one of the priorities of the Health and Care Alliance, and timetabling an agenda item shortly

b) Contributing to the development of the Communications and Engagement Strategy for the STP

c) Contributing to the Communications and Engagement Network

d) Presenting the case for STP communications to have no logo or a shared logo rather than an NHS logo.

The Board may be interested to read the evidence that Healthwatch England submitted to the House of Commons Health Committee inquiry into Integrated care: organisations, partnerships and systems at http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-committee/sustainability-and-transformation-partnerships/written/77260.pdf.

3.3. That the Board model good practice by involving public and/or service users in the Board's own policy developments.

3.4. That the Board monitor co-design, co-production and community participation by:

a. asking all who report or make presentations to Board meetings to explain how they have reflected the views of consumers in the plans or activities they describe
b. adding to the agenda of a future workshop session a briefing/training on what to look for in reports to the Board
c. referring serious concerns to the Health Overview and Scrutiny Committee.

3.5. That the Board ensure that all have access to good practice guidance on co-design, co-production and community participation by:

a. disseminating the following documents as guidance on good practice to be used by the Board itself, subgroups of the Board, agencies on the Board including the County Council, and the sectors that Board members represent (e.g. commissioners, care providers):

- Wessex Voices practical guidance and tools: http://www.wessexvoices.org/wessex-voices-publications.html

- 2017 NHS England statutory guidance on *Patient and public participation in commissioning health and care: Statutory guidance for clinical commissioning groups and NHS England* at https://www.england.nhs.uk/wp-content/uploads/2017/05/patient-and-public-participation-guidance.pdf) – and their previous brief guides at https://www.england.nhs.uk/wp-content/uploads/2014/03/bs-guide-princ-part.pdf)
- NICE quality standards: NICE has produced both a Guideline and Quality Standards for community engagement and health. As with all NICE guidelines, these are based on thorough analysis of current evidence as to what works. They cover community engagement approaches to reduce health inequalities, ensure health and wellbeing initiatives are effective and help local authorities and health bodies meet their statutory obligations. The Guideline includes recommendations on

    - overarching principles of good practice – what makes engagement more effective?
    - developing collaborations and partnerships approaches to encourage and support alliances between community members and statutory, community and voluntary organisations to meet local needs and priorities
    - involving people in peer and lay roles – how to identify and recruit people to represent local needs and priorities
    - making community engagement an integral part of health and wellbeing initiatives
    - making it as easy as possible for people to get involved

b. asking each agency on the Board to recommend these documents to the constituency they represent

c. asking each agency on the Board (including the County Council) to review their own policies and procedures to:

    - check that they cover the points made in these documents
    - identify and report to the Board on any additional good practice they would like to recommend to others.

3.6. That the Board endorse the view of the Coproduction Group that NHS and local authority colleagues need the opportunity to learn by experience as well as being offered good practice guidance, and agrees to explore the possibility of hosting an Empowering Engagement action learning programme at the County Council.

3.7. The Co-production Group has received very good reports of the impact of the action learning Empowering Engagement Programme for STP workstream leads which has been run in N.E. Hampshire and Farnham CCG and on the Isle of Wight as “My Life A Full Life” (more info here: http://www.patientpublicinvolvement.com/news/an-80-increase-in-confidence-as-a-result-of-the-empowering-engagement-programme/). That to facilitate access to findings of previous participation work so that people can build on what has been done elsewhere, the Board invite the STP to arrange shared access to the Patient Experience Library for all commissioners and providers across the STP area to access, possibly a joint subscription or one subscription by one body in the STP area which searches for others.

4. Contextual information

4.1. The Co-design, co-production and community participation group was set up by Hampshire Health and Wellbeing Board in spring 2017. The objectives of the group, refined after discussion by the group, were approved by the Hampshire Health and Wellbeing Board at its last meeting on 5 October 2017. They are:

1. Recommend guidance on community co-design, co-production and participation to the Health and Wellbeing Board, its working groups, its member organisations, and through them to all health and care planners, commissioners and providers.
2. Identify exciting varied examples of good practice in co-design, co-production and community participation in health and social care (including by both Health and Wellbeing Boards, commissioners and providers) and facilitate learning from them for the Board and for all who plan or deliver health and social care services.
3. Facilitate sharing of findings from community participation to reduce duplication and spread learning.
4. Support the Health and Wellbeing Board to demonstrate leadership and good practice in community co-design, co-production and participation by identifying where it is appropriate, advising how it should be done, and monitoring implementation.
5. Support the groups of the Health and Wellbeing Board to demonstrate leadership and good practice in community co-design, co-production and participation by advising how it should be done, supporting them, and monitoring implementation.
6. Respond to requests from the Board and its groups for advice on community involvement in designing or delivering health and social care services.
7. Advise and make recommendations about appropriate approaches on community co-design, co-production and participation to be used as part of the development of the Hampshire JSNA and Health and Wellbeing Board strategy on over-arching “philosophical” questions about the future of health and care services, including questions related to the STP which are best approached across the STP area rather than locally
8. Identify relevant data and service user, CVS and Healthwatch feedback to inform the development of the Health and Wellbeing Board Strategy.
9. Recommend and where appropriate organise Health and Wellbeing Board stakeholder events to support the development of the Health and Wellbeing Board strategy.

4.2. The group agreed three priorities to address first. These are:

1. Provide information and guidance to the HWB Board on good practice in engagement, co-design and co-production both principles and practical tools for delivery (not necessarily specially written by the group) that could be adopted by the HWB Board, the organisations on it, and the constituencies they represent.
2. Provide training / workshop opportunities to encourage understanding, development and embedding of co-design and co-production as the next steps from engagement or communication.

3. Provide HWB Board with assurance that there is consideration and delivery of community participation in design and production within the STP programme, especially but not exclusively in respect of over-arching issues.

4.3. The Group is chaired by Christine Holloway, chair of Healthwatch Hampshire. Its other members are:

1. Christine Dunkley (Healthwatch Champion)
2. Jane Gordon (Engagement Manager, West Hants CCG)
3. Sarah Grintzevitch (STP Communications Lead)
4. Christine Holloway (Chair, HW Hants)
5. Elizabeth Kerwood (Head of Communications and Engagement, Fareham and Gosport, Portsmouth and South Eastern Hampshire CCGs)
6. Liz Kite (Associate Director of Communications and Staff Development, West Hants CCG)
7. Sue Lee (HWB Board Manager)
8. Steve Manley (Manager, HW Hants)
9. Sue Newell (Wessex Voices Project Manager)
10. Nicky Priest (NHS England, Wessex)
11. Phil Taverner (voluntary sector rep on Health & Wellbeing Board; Community Development Worker, Test Valley Community Services)
12. Jane Vidler (Communications Team Leader, HCC)
13. Sharon Ward (Associate Director of Communication and Engagement, NEH&F CCG)

The circulation list for the Group's papers also includes Steve Gowtridge as link on co-production for the County Council's care services.

4.4. The Group decided at its February 2018 meeting to amend the name to "Co-production" group, both to make it shorter and to emphasise that the focus is involving people before plans are drawn up, not consulting them after decisions have been formulated.

4.5. If any Board member would like to receive copies of minutes of the Group or wants to know more, please contact Healthwatch Hampshire on 01962 857357 / Christine.Holloway@healthwatchhampshire.co.uk

5. Finance

5.1. The only recommendation that could incur additional costs would be if the Board decided to fund places for County Council staff on a future action learning Empowering Engagement programme. It is hoped that this might be met from existing staff training budgets.

6. Consultation and Equalities

6.1. The recommendations are based on consultation with representatives of the partners on the Health and Wellbeing Board, including a volunteer with expertise, invited by Healthwatch Hampshire.

6.2. The aim of this report and recommendations is to ensure that systems exist to ensure that all communities contribute to shaping future health and care services.

CORPORATE OR LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	yes
People in Hampshire live safe, healthy and independent lives:	yes
People in Hampshire enjoy a rich and diverse environment:	no
People in Hampshire enjoy being part of strong, inclusive communities:	yes

Other Significant Links

Direct links to specific legislation or Government Directives	
NHS England statutory guidance on *Patient and public participation in commissioning health and care: Statutory guidance for clinical commissioning groups and NHS England*	2017
NICE quality standard	2016

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
Minutes of meetings of the Hampshire Health and Wellbeing Board subgroup on co-production and engagement on 4 May, 23 May, 12 June, 26 June, 31 July, 26 October 2017 and 14 February 2018	HCC

IMPACT ASSESSMENTS:

1. Equality Duty

1.1. The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, gender and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Due regard in this context involves having due regard in particular to:

a) The need to remove or minimise disadvantages suffered by persons sharing a relevant characteristic connected to that characteristic;

b) Take steps to meet the needs of persons sharing a relevant protected characteristic different from the needs of persons who do not share it;

c) Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity which participation by such persons is disproportionally low.

1.2. **Equalities Impact Assessment:**

1.3. The aim of this report and recommendations is to ensure that systems exist to ensure that all communities contribute to shaping future health and care services.

2. Impact on Crime and Disorder:

2.1. No direct link

3. Climate Change:

a) What is being proposed has no impact on carbon footprint / energy consumption

b) What is being proposed has no direct impact on the need to adapt to climate change, and be resilient to its longer term impacts. It is hoped that better community participation will assist health and care organisations to identify where climate change is affecting our communities.

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