Public Document Pack

Health Overview and Scrutiny Panel

Thursday, 29th March, 2012
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Capozzoli (Chair)
Councillor Daunt
Councillor Parnell
Councillor Payne
Councillor Thorpe
Councillor Turner
Councillor Willacy

Contacts
Karen Wardle
Democratic Support Officer
Tel: 023 8083 2302
Email: karen.wardle@southampton.gov.uk

Caronwen Rees
Policy & Performance Analyst
Tel: 023 8083 2524
Email: Caronwen.rees@southampton.gov.uk

PUBLIC INFORMATION

Southampton City Council's Seven Priorities

- More jobs for local people
- More local people who are well educated and skilled
- A better and safer place in which to live and invest
- Better protection for children and young people
- Support for the most vulnerable people and families
- Reducing health inequalities
- Reshaping the Council for the future

Fire Procedure – in the event of a fire or other emergency a continuous alarm will sound and you will be advised by Council officers what action to take.

Access – access is available for the disabled. Please contact the Democratic Support Officer who will help to make any necessary arrangements.

Public Representations

At the discretion of the Chair, members of the public may address the meeting about any report on the agenda for the meeting in which they have a relevant interest.

Smoking policy – the Council operates a no-smoking policy in all civic buildings.

Mobile Telephones – please turn off your mobile telephone whilst in the meeting.

Dates of Meetings: Municipal Year 2011/12

2011	2012
Weds 22 June	Thurs 19 January
Tues 26 July	Thurs 29 March
Thurs 15 September	
Thurs 10 November	

CONDUCT OF MEETING

Terms of Reference

The terms of reference of the Audit Committee are contained in Article 8 and Part 3 (Schedule 2) of the Council's Constitution.

Business to be discussed

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

Rules of Procedure

The meeting is governed by the Council Procedure Rules as set out in Part 4 of the Constitution.

Quorum

The minimum number of appointed Members required to be in attendance to hold the meeting is 3.

Disclosure of Interests

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

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Personal Interests

A Member must regard himself or herself as having a personal interest in any matter

(i) if the matter relates to an interest in the Member's register of interests; or

(ii) if a decision upon a matter might reasonably be regarded as affecting to a greater extent than other Council Tax payers, ratepayers and inhabitants of the District, the wellbeing or financial position of himself or herself, a relative or a friend or:-

  (a) any employment or business carried on by such person;

  (b) any person who employs or has appointed such a person, any firm in which such a person is a partner, or any company of which such a person is a director;

  (c) any corporate body in which such a person has a beneficial interest in a class of securities exceeding the nominal value of £5,000; or

  (d) any body listed in Article 14(a) to (e) in which such a person holds a position of general control or management.

A Member must disclose a personal interest.

Continued/……

Prejudicial Interests

Having identified a personal interest, a Member must consider whether a member of the public with knowledge of the relevant facts would reasonably think that the interest was so significant and particular that it could prejudice that Member's judgement of the public interest. If that is the case, the interest must be regarded as "prejudicial" and the Member must disclose the interest and withdraw from the meeting room during discussion on the item.

It should be noted that a prejudicial interest may apply to part or the whole of an item.

Where there are a series of inter-related financial or resource matters, with a limited resource available, under consideration a prejudicial interest in one matter relating to that resource may lead to a member being excluded from considering the other matters relating to that same limited resource.

There are some limited exceptions.

Note: Members are encouraged to seek advice from the Monitoring Officer or his staff in Democratic Services if they have any problems or concerns in relation to the above.

Principles of Decision Making

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

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

In exercising discretion, the decision maker must:

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

AGENDA

Agendas and papers are now available via the City Council's website

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

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

2 DISCLOSURE OF PERSONAL AND PREJUDICIAL INTERESTS

In accordance with the Local Government Act, 2000, and the Council's Code of Conduct adopted on 16th May, 2007, Members to disclose any personal or prejudicial interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Democratic Support Officer prior to the commencement of this meeting.

3 DECLARATIONS OF SCRUTINY INTEREST

Members are invited to declare any prior participation in any decision taken by a Committee, Sub-Committee, or Panel of the Council on the agenda and being scrutinised at this meeting.

4 DECLARATION OF PARTY POLITICAL WHIP

Members are invited to declare the application of any party political whip on any matter on the agenda and being scrutinised at this meeting.

5 STATEMENT FROM THE CHAIR

6 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 19th January 2012 and to deal with any matters arising, attached.

7 WOODSIDE LODGE RESIDENTIAL HOME

Report of the Cabinet Member for Adult Social Care, providing an update on the implementation of actions following an inspection by the Care Quality Commission of Woodside Lodge Residential Home, attached.

8 UPDATE ON VASCULAR SERVICES

Report of the Executive Director of Adult Social Care and Health, updating the Committee on vascular services in January 2012, attached.

9 PUBLIC HEALTH ANNUAL REPORT 2011

Report of the Director of Public Health, for the Panel to note the Public Health Annual Report 2011, attached.

10 ADULT MENTAL HEALTH REDESIGN UPDATE ON ABBOTTS LODGE TRANSFER

Report of the Head of Engagement, Southern Health NHS Foundation Trust, providing the Committee with an update on the relocation of services from Abbotts Lodge, Netley Marsh to Antelope House on the Royal South Hants Hospital site, attached.

Wednesday, 21 March 2012 HEAD OF LEGAL, HR AND DEMOCRATIC SERVICES

HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 19 JANUARY 2012

Present: Councillors Capozzoli (Chair), Daunt, Parnell (Minute no's 21-26 only) (Vice-Chair), Thorpe, Turner (Minute no's 19-24 only) and Pope (Minute no's 19-24 only)

Apologies: Councillors Fitzgerald and Payne

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

The Panel noted that Councillor Pope was in attendance as a nominated substitute for Councillor Payne in accordance with Council Procedure Rule 4.3.

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

RESOLVED that the Minutes of the meeting held on 10 November 2011 be approved and signed as a correct record.

21. **ADULT MENTAL HEALTH REDESIGN**

The Panel considered the report of the Head of Engagement, Southern Health NHS Foundation Trust for the Panel advising on the update proposals to relocate services from Abbotts Lodge, Netley Marsh to Antelope House located on the Royal South Hants Hospital site. (Copy of the report circulated with the agenda and appended to the signed minutes)

The Panel received an update from Trevor Abbotts, Southampton Area Manager, Southern Health Foundation Trust.

The main points from the report and update included the following:

- The adult mental health services provided at Abbotts Lodge, Netley Marsh would transfer to Antelope House. The service provided reablement for clients with challenging behaviour;
- Antelope House was considered a more suitable location for the service and offered a more modern environment. It was explained that the location of Abbotts Lodge was isolated and it was felt that it could delay the process of integration back into the community;
- 11 clients were currently based at Abbotts Lodge. It was anticipated that 4 people would be transferred to Antelope House. The other 7 would have left as part of their proposed care plan;
- Residents and carers had been sent two letters regarding the proposals and been given the opportunity to have meetings with the Unit Manager to discuss the proposals either individually or collectively;
- It was anticipated that the clients would transfer to Antelope House in mid March 2012, if approval to move the service was granted.

The Panel expressed concern regarding the lack of detail in Appendix 1 regarding consultation and engagement of clients and carers in relation to the proposed move. It was explained that the main concerns for both the clients and the families involved was

in relation to the care plans and the move back into the community. People were concerned and apprehensive about what the future held. This would happen regardless of whether the facility moved or not.

The Panel sought reassurance that care would not be affected by the move.

RESOLVED:

(i) that the level and range of engagement opportunities offered, particularly to service users and their carers be noted;

(ii) that Southern Health Foundation Trust be advised that the Panel would wish to see the shortcomings previously identified in the consultation process on the service relocation as important learning points that could be used to improve engagement with service users, families and carers in future proposals for service re-design and relocation; and

(iii) that an update be provided at a future meeting.

22. **UPDATE ON VASCULAR SERVICES PUBLIC CONSULTATION**

The Panel received and noted the report and presentation of Sarah Elliott, Director of Nursing, Ship Cluster updating the Panel on the progress towards public consultation on vascular services and to consider submitting a further response to the consultation. (Copy of the report circulated with the agenda and appended to the signed minutes)

The main points from the report and presentation included the following:-

- that the commencement of the consultation had been delayed;
- three options for vascular surgery had been reviewed by a national panel of experts. They concluded the network model for Southampton General Hospital and Queen Alexandra Hospital in Portsmouth to share vascular services across both hospital sites would be the most sustainable model;
- Portsmouth had requested a stand alone option be considered, however it was felt that the network option would still the most viable;
- Outpatients would be able to attend their local clinic;
- It was not known whether the consultation would include only the network option or both that option and the Portsmouth stand alone option. A decision was expected in the near future;
- A letter would be sent out shortly from Debbie Fleming, Chief Executive of the SHIP PCT Cluster, to all interested parties providing an update on the situation.

The Panel requested that the cost of parking be considered with the proposed centralisation of the service.

RESOLVED

(i) to note the update on progress towards public consultation on vascular services;

(ii) that an update be provided at a future meeting to enable the Panel to consider whether to submit a formal response to the consultation

(iii) that Councillors be made aware of the consultation so they could make the public aware of the issue and encourage them to respond.

23. **SINGLE POINT OF ACCESS AND OUT OF HOURS GP SERVICE**

The Panel considered the report of the Associate Director Urgent Care and Out Of Hours, Solent NHS Trust updating Members on the Solent NHS Trust on the Single Point of Access and Out of Hours GP Service. (Copy of the minutes circulated with the agenda and appended to the signed minutes)

The Panel received an update from David Meehan, Solent NHS Trust regarding the Single Point of Access and Out of Hours service. The main points included:-

Single point of access

- Solent NHS Trust Single Point of Access (SPA) was launched in April 2011 to enable patients to more easily contact community teams and health professionals to make urgent community referrals through a single telephone number;
- SPA would provide a direct point of access for calls into Solent community services from 111, from September 2012;
- Over 100 services were provided through the SPA.

Out of hours

- The out of hours services during Christmas and Near Year 2010-11 was unable to meet the increased peak demands. This lead to a large number of answered calls building;
- There were 17 Performance Indicators for the performance of the GP out of hours service, rated red, amber or green. During early 2011 only half the performance indicators were met (i.e. green). The service however had been improved to 100% green from June-December 2011;
- Christmas 2011: an average of 360 calls had been received an hour which were dealt with within an appropriate time period. It was reported that the improved service was due to improved early planning and financial incentives to encourage GP's and nurses to work unsociable hours;
- All customer complaints were reviewed and fewer complaints were being received, which indicated an improved service.

The Panel noted the improvements made to the GP's Out of Hours service and they looked forward to the higher standards being maintained.

RESOLVED

(i) that the update from the Solent NHS Trust on the Single Point of Access and Out of Hours GP service be noted; and

(ii) that the Panel be notified in any event of any significant deterioration in respect of the out of hours performance indicators.

24. **SOLENT NHS TRUST JOURNEY TOWARDS FOUNDATION TRUST**

The Panel considered the report of the Director of Strategy, Solent NHS Trust, regarding the proposed development for Solent NHS Trust's progression towards Foundation Trust and explored and examined these proposals in terms of the pathway towards Foundation Trust. (Copy of the report circulated with the agenda and appended to the signed minutes)

The Panel received an update from David Meehan, Solent NHS Trust regarding the move towards Foundation Trust status.

The Panel noted and discussed the following points:-

- Membership: the aim was to recruit 10,000 Members. Work was being carried out with the local authority, voluntary sector, LINKS to encourage membership. Sharing Membership between the numerous Trusts was also being investigated;
- Membership also included children aged 14 or over and whether this was a good idea. It was reported that youth groups had been enthusiastic and keen to be engaged;
- Consultation in Southampton was being carried out at West Quay later in January. Community groups were being targeted. In March the 12 week consultation would commence on the Foundation Trust application;
- The process to become a Foundation Trust was a challenging one. It was acknowledged that the goals and deadlines had been met on time to date. Targets had been set for the level of membership;
- The steps taken by the Solent NHS Trust in the consultation process was seen as positive.

RESOLVED

(i) that the proposed development for Solent NHS Trust to progress towards Foundation Trust was noted;

(ii) that further information be provided to the Panel on engagement activities with young people in the consultation process;

(iii) that an invite be sent to all Councillors seeking suggestions of community groups which could be targeted as part of the consultation and potential membership to the Foundation Trust; and

(iv) that a letter be sent to Solent NHS Trust stating that the Panel supports the proposed engagement process.

25. **ESTABLISHMENT OF LOCAL HEALTHWATCH IN SOUTHAMPTON**

The Panel received and noted the report of the Executive Director for Health and Adult Social Care, updating Members on developments since June 2011, seeking a view on how HealthWatch should be developed in Southampton and identify if and how it would engage with local HealthWatch as it developed. (Copy of the report circulated with the agenda and appended to the signed minutes)

The Panel received a verbal update from Martin Day, Health Partnerships and Strategic Business Manager, Health and Adult Social Care and the following points were noted:

- that £5,000 was available to support pathfinder activities;
- economies of scale would be investigated for commissioning of services to achieve value for money, e.g. the complaints advocacy service;
- that the deadline for the introduction of a local HealthWatch for Southampton had been delayed until April 2013;
- procurement of services would need to commence from June 2012;
- local views would need to be sought on what stakeholders want from HealthWatch;

- there were various options for the governance arrangements which would need to be investigated. One consideration was membership and the need to make local HealthWatch as inclusive as possible;
- that the knowledge and experience from LINKS needed to be captured and taken forward into local HealthWatch.

RESOLVED that a further report on the establishment of a local HealthWatch be brought back to a future meeting when more information is available on the possible structure for Southampton HealthWatch.

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DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	WOODSIDE LODGE RESIDENTIAL HOME
DATE OF DECISION:	29TH MARCH 2012
REPORT OF:	CABINET MEMBER FOR ADULT SOCIAL CARE AND HEALTH
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

This paper provides an update on the implementation of actions following an inspection by the Care Quality Commission of Woodside Lodge residential home.

RECOMMENDATIONS:

(i) That the Committee notes the information within the report and considers any further questions.

REASONS FOR REPORT RECOMMENDATIONS

1. To respond to a request from the Health Overview and Scrutiny Panel.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. There are no alternative options as compliance with the Care Quality Commission's regulations is compulsory.

DETAIL (Including consultation carried out)

3. In October 2011, the Care Quality Commission (CQC) carried out a routine inspection of Woodside Lodge Residential Home ('Woodside') and followed this, in November, with a report that identified a number of compliance concerns specifically in relation to outcomes relating to Outcome 1 – Respecting and involving people who use services; Outcome 4 – the care and welfare of people who use services; Outcome 13 – Staffing and Outcome 16 – Assessing and monitoring the quality of service provision. As a result of this report CQC asked that a compliance action plan be submitted within 14 days of receipt of the report. It must be stressed that CQC did not express any concerns about the safety of the service and did not consider that any immediate enforcement action was necessary.

4. At the time of the inspection the home had up to eight people who required care which would normally be provided by a nursing home rather than a residential home. Woodside is not registered to provide nursing home care but, with the shortage of nursing home placements in the City for people with dementia and because of the genuinely caring approach of the team at Woodside, they had agreed to continue to provide care which was actually beyond their remit and their registration.

5. This issues identified during the inspection were taken very seriously by all concerned in the service. Following the inspection but prior to receipt of the report, the service manager and home manager immediately identified actions to rectify the issues that had been verbally identified during the inspection visit. This included arranging for two extra staff to be on duty during both morning and afternoon shifts, reviewing all care plans, undertaking more

thorough hand over sessions and requesting care management assessments of all those people who might need nursing home care.

6. Within the required fourteen days following the receipt of the inspection report a very comprehensive action plan was identified which, amongst other more routine items, contains the following key actions:

- Review all menus and display, note and update food and fluid charts
- Review and undertaken any additional training in dementia care
- Regularly reiterate the dignity and choice statement and to make sure this is included in inductions of new staff and with all agency staff.
- Auditing all care plans to make sure they are person centred and they address individual life choices as far as possible. This will also reflect the findings of a questionnaire which was sent to all relatives and carers to identify any knowledge that some of the residents with extreme dementia might not be able to say themselves.
- The manager would monitor staff interaction on a regular and frequent basis.
- Undertake refresher training in risk assessment, recording practice and nursing home assessment process
- Activate plans to move on all residents who had needs beyond that for which the home is registered.
- Ensure continuity of staff from agencies if full staffing is not available and ensure their induction and hand over includes reference to the code of conduct expected of them.
- Produce, circulate and analyse the results from feedback questionnaires to carers, family and professionals.

7. All of these actions are complete or in hand and many are ongoing in order to ensure that good practice is maintained.

8. During the week of the 27th February 2012, CQC returned to monitor the compliance with the action plan. This visit was, as is usual, unannounced. The report following this unannounced follow up visit was received on the 15th March and the report identifies that CQC has now judged Woodside to be compliant with Outcomes 1, 13 and 16 and one just one minor concern about Outcome 4 which will be immediately addressed. The concern expressed was that, although all care plans addressed the majority of needs of all people using the service, they do not always evidence that staff have addressed actions to meet all needs.

9. Woodside does not have a full complement of residents as it has been deemed appropriate to hold some void beds whilst the action plan is completed. CQC have identified that the staffing is sufficient to meet the needs of the reduced number of residents but have identified that the Council will need to ensure this continues to be so once the home is full.

RESOURCE IMPLICATIONS

Capital/Revenue/Property/Other

10. There are currently no resource implications. However, Woodside is currently over spending its staffing budget. Care will be required to ensure this does not continue to occur especially as occupancy increases.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

11. Residential homes are provided under part 3 of the National Assistance Act.

Other Legal Implications:

12. None

POLICY IMPLICATIONS

13. The provision of high quality care to people with dementia in the community is in accordance with the Council's stated aims of meeting the needs of older people and promoting independence.

AUTHOR:	Name:	Jane Brentor, Head of Provider Transformation	Tel:	023 8083 3439
	E-mail:	jane.brentor@southampton.gov.uk		

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	Potentially all.

SUPPORTING DOCUMENTATION

Non-confidential appendices are in the Members' Rooms and can be accessed on-line

Appendices

1	Action plan for Woodside Lodge 17.2.2012

Documents In Members' Rooms

	None

Integrated Impact Assessment

Do the implications/subject of the report require an Integrated Impact Assessment (IIA) to be carried out?	Yes

Other Background Documents

Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)	
1.	Report to 17 November 2011 meeting of the Overview and Scrutiny Management Committee: http://www.southampton.gov.uk/modernGov/mgConvert2PDF.aspx?ID=7017	

Action plan for Woodside Lodge 17.2.2012

Regulated activity	Regulation		Outcome	How the regulation is not being met
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010		Outcome 01: Respecting and involving people who use services	People are not offered a choice or treated with dignity or respect.
Plan of action	Completed by whom	Target Completion	Comments	Date completed
1. To review winter/summer menus. Send questionnaires to families.	Cooks and Manager.	December 2011	To discuss options with cook and put together a questionnaire for the residents and their families to ensure all residents' likes and dislikes are taken into account and menus drawn up accordingly. Staff continue to support individuals to choose their meals from a choice each day and to look at alternatives if they do not wish to eat their choice at meal times.	Winter questionnaire sent out 8th Dec 2011. On target for December completion. Most have been returned, meeting to be arranged with Cook to plan new menu's.
2. Dignity and choice statement has been given to all staff and is currently read out at all handovers.	Care Co-ordinators.	On-going.	Care Co-ordinators to read statement produced and monitor staff interactions with the residents. To be discussed during staff supervisions/meetings. Management team to be aware at all times and model appropriate behaviour.	This will be continued at handover until end of December. Document to be incorporated into all agency inductions and newstaff induction.

Agenda Item 7
Appendix 1

3. To review the programme for the annual training from the Dementia Training Company.	The Dementia Training Company, Care Co-ordinators, Care Staff and Manager.	January 2012	To arrange a date with Tim Forester Morgan and discuss format of training, including delivery and evaluation to ensure that staff's interaction with and understanding of residents is appropriate at all times.	Planning meeting has taken place - Training booked for 11.01.12, 7/2,21/2,7/3,27/3 and 10/4
4. To review current activities and send a questionnaire to all families to see what activities their relative may like to do. Once information is received revise activities rota.	Care Co-ordinators and Manager.	December 2011 May 2012	Manager to discuss with care co-ordinator who takes the lead on activities and to produce a questionnaire for the residents and families. Once information received to then review activities programme. Evaluation of new programme to see residents' response within six months.	In view of additional Christmas activities – questionnaire and review will take place in March.
5. All staff to be made aware of the personal care protocol and for this to be added to the agency staff induction process.	Care Co-ordinators.	On-going	Care Co-ordinators to discuss with care staff during supervisions and manager to discuss at all staff meetings. Management team to monitor.	In place. Document to be incorporated into all agency inductions and new staff induction.
6. Nutritional Care protocols as above.	Care Co-ordinators.	November 2011	As above.	In place.

7. Ensuring all paperwork reflects outcome 1 more clearly.	Care Co-ordinators, Care Staff and Manager	November 2011 + on-going	Currently all paperwork being reviewed. Care plans will be amended by hand as and when changes occur on a daily basis to ensure that accurate information is available for all staff with a target that they are typed up within a month of any changes.	Initial review and changes in place. On-going monitoring/training with staff. Recent SIPS visits on the 4th Jan and 2nd Feb 2012 we have received very positive feedback on the improvements in this area.
8. Review Dignity Audit and work of Dignity champions.	Manager and Dignity champions	January 2012 on-going	Discuss current issues with champions and look at ways to ensure that future audits are more robust in monitoring to ensure that residents' dignity is maintained at all times.	Dignity Audit completed 12th Dec 2011 and regular audits completed every 3mths. Results to be shared in meeting with all staff.
9. Dignity training for all staff to be refreshed.	Manager and L&D	February 2012	Previous training to be updated with current examples and refreshed for all staff to ensure that they are aware of their part in ensuring residents' dignity is maintained.	Booked (09.02.12, 16/2/12 and 22/02/12)
10. Monitoring of staff interactions and care of residents	Manager and Care Co-ordinators	November 2011 + on-going	Manager to work with care co-ordinators to ensure that they have a presence on the floor as much as possible to model appropriate behaviour and to support staff when any change in approach is needed.	Work continuing. Recent SIPS visits on the 4th Jan and 2nd Feb 2012 we have received very positive feedback on the improvements in this area.

Regulated activity	Regulation		Outcome	How the regulation is not being met
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010		Outcome 04: Care and welfare of people who use services	Assessment and care plans do not identify peoples individual care needs and do not ensure people receive safe care in a dignified manner which respects their privacy.
Plan of action	Completed by whom	Target Completion	Comments	Date completed
1. To deliver refresher training around reporting and recording.	Management and L & D	December 2011	Training content to be reviewed to include examples from current paperwork. Documentation to be monitored to ensure needs are identified and met appropriately.	Booked (04.01.12; 06.01.12 and 09.01.12) Now completed with all staff. Coordinators to monitor daily and manager to monitor monthly. Recent SIPS visits on the 4th Jan and 2nd Feb 2012 we have received very positive feedback on the improvements in this area.
2. Re-visit 'Look @ me' documents with all families.	Care Co-ordinators and Manager	November 2011	To ensure we have received all information possible to be able to reflect each residents needs effectively and hence deliver appropriate care and support.	Letter sent to families with a copy of the "Look at Me" document enclosed 8th Dec 2011. Most have been completed and returned. Given to Coordinators to ensure information has been incorporated into care plans.
3. See plan of action 5 in outcome 1.	See above	See above	See above.	
4. To review nursing home	Manager	December 2011	To be discussed at Providers	In place.

admissions procedure			Services Management Meeting in November.	
5. To refresh in-house risk assessment training.	Manager and Care Co-ordinators	January 2012	Manager and all co-ordinators to review all moving and handling and general risk assessments to ensure these reflect individual resident's personal needs and that those needs can be met safely.	On-going as files are audited.
6. Food and fluid sheets have been amended and are now kept in dining room to ease completion.	Care Co-ordinators	On-going	Monitored regularly throughout the day but especially following meal times and drinks rounds. Staff are reminded about the importance of reporting and recording on these sheets at the start of each shift to ensure that residents receive appropriate fluid and nutritional intake.	Sheets are monitored daily by Coordinators and monthly by Manager.

Regulated activity	Regulation		Outcome	How the regulation is not being met
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010		Outcome 13: Staffing	The staffing levels do not ensure people receive safe and appropriate support and care at all times.
Plan of action	Completed by whom	Target Completion	Comments	Date completed
1. Residents needs and re-assessments.	District Nurses and Care Management.	October 2011	All residents which were identified as now requiring nursing home placements have been assessed and are currently waiting placement. Manager to continue to liaise with families and care management to ensure that these residents are supported to more appropriate placements as soon as possible in order to ensure safe and appropriate placements and to reduce the impact on staff of caring for people with inappropriately high needs.	Assessments complete and appropriate moves either have taken place or being arranged.
2. Increase in staffing levels	Care Co-ordinators	On-going	Staff levelling has increased by 2 AM and 2 PM while we wait for placements as described above and to ensure all residents needs are met appropriately across the home.	Due to low numbers of residents staffing levels have returned back to normal, although one resident who is waiting nursing home placement is currently having 1:1.
3. Review agency induction/refresher to remind them of their code of conduct which is expected of them whilst on duty.	Care Co-ordinators.	On-going	All regular agency staff to be given refresher induction training which will include the revised personal care and nutritional care protocol to	Completed and will be monitored.

			ensure appropriate care and support is delivered consistently.	
4. Ensure continuity of agency staff if needed.	Care Co-ordinators	On-going	Care co-ordinators liaise directly with agency providers to ensure where possible continuity is provided to ensure consistent care and support for residents.	In place.

Regulated activity	Regulation		Outcome	How the regulation is not being met
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010		Outcome 16: Assessing and monitoring the quality of service provision	The service has some systems in place to monitor the quality of service that people receive, but this does not include direct feedback from people using the service or their relatives. The systems are not effective as we identified that people are not receiving safe, well planned care.
Plan of action	Completed by whom	Target Completion	Comments	Date completed
1. Questionnaires to permanent residents and families.	Admin and Manager	December 2011	Questionnaires to be reviewed during the Provider Services Management Meeting in November before sending out.	In view of questionnaires previously referred to, this will be postponed to early February 2012. Due to sent out by the 24th February 2012.
2. Questionnaires to be sent to professionals.	As above	December 2011	As above	As above.
3. To produce spreadsheet once questionnaires are returned.	As above	February 2012	Questionnaires will be reviewed on their return for any immediate issues. The spreadsheet will reflect questionnaire outcomes and any further actions required to improve the services delivered at Woodside. This will then lead to an action plan to address issues raised.	To be put together March/April 2012.

4. QA process across all 5 homes to be reviewed.	Provider Services Management Team	March 2012	The aim is to enhance the process by use of a computerised system to assist the compilation of statistics in a published form to inform all stakeholders and to facilitate any development plans.	

General Actions				
Plan of Action	Completed by Whom	Target completion	Comments	Date completed
1. Process to be drawn up to clarify actions required to facilitate nursing needs assessments for residents when required.	Manager	November 2011	Process to support all staff to be aware of reporting increased needs of residents so that appropriate actions can be taken. This will ensure all residents are appropriately placed and their needs met.	In place.
2. Meetings to be arranged to update all staff.	Manager	November 2011	To ensure that all staff are aware of the issues that have been raised, the action plan and their part in moving forward with the changes in the care and support of the residents.	These have taken place and further updates will be through regular programmed meetings.
3. Occupancy levels at the home.	Manager	November/December 2011	When those residents currently awaiting nursing care are placed, vacancies will be held for a short period to allow staff to continue with this action plan.	In hand.
4. Concerns around residents medication running out.	Coordinators and Manager	On-going	New stock checking control measures have been put in place. All staff have received training regarding these new measures.	On-going and to be discussed in coordinator meetings and supervisions.

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DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	UPDATE ON VASCULAR SERVICES
DATE OF DECISION:	29 MARCH 2012
REPORT OF:	DIRECTOR OF ADULT SOCIAL CARE AND HEALTH
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

The Health Overview and Scrutiny Panel received an update on vascular services in January 2012. Public consultation was due to start the following week. The consultation did not take place as a decision was taken to maintain the status quo.

RECOMMENDATIONS:

(i) To note the decision to continue to commission the historical vascular service in Hampshire.

(ii) To consider whether they require any further information or future update on this service.

REASONS FOR REPORT RECOMMENDATIONS

1. To update members on the vascular services consultation and to provide the Panel with an opportunity to submit feedback.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. The consultation document will detail the full range of options that have been considered.

DETAIL (Including consultation carried out)

3. At the Panel meeting on 19 January 2012 the Panel received an update from SHIP Cluster regarding progress with change to vascular surgery. Members requested an update in due course.

The SHIP Cluster the wrote to the panel on 2 February 2012 (appendix 1) providing feedback on negotiations around a network vascular service model, and their decision to continue to commission the historical vascular service in South Hampshire. A further update paper provided by SHIP is attached at appendix 2.

Also attached at appendix 3 is recent performance information on vascular surgery in Hampshire.

RESOURCE IMPLICATIONS

Capital/Revenue

4. N/A

Property/Other

5. N/A

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

6. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

AUTHOR:	Name:	Caronwen Rees	Tel:	02380 832524
	E-mail:	caronwen.rees@southampton.gov.uk		

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Non-confidential appendices are in the Members' Rooms and can be accessed on-line

Appendices

1.	Letter dated 2 February
2.	Briefing Paper
3.	Performance information

Documents In Members' Rooms

1.	N/A

Integrated Impact Assessment

Do the implications/subject of the report require an Integrated Impact Assessment (IIA) to be carried out.	Yes/No

Other Background Documents

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

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

Southampton, Hampshire
Isle of Wight & Portsmouth

Headquarters
Oakley Road
Southampton
Hampshire
SO16 4GX

Tel: 023 8072 5600

2 February 2012

Dear Colleague,

VASCULAR SERVICES

In my last update I promised to write to you as soon as I had received feedback from the Trusts with regards to their discussions about local vascular services.

Since the beginning of this process the PCT Cluster and local Clinical Commissioning Groups (CCGs) have listened to the concerns that have been raised about the original proposals to transfer all complex vascular activity to Southampton. In response, we modified the original proposal and asked the Trusts to work together to consider how a truly collaborative network for vascular services across the two hospital sites might work, ensuring that as much vascular activity as clinically safe is retained at Queen Alexandra Hospital.

The Trusts have been working hard to achieve this, and we have made every effort to facilitate these discussions. Unfortunately, I regret to have to report that the Trusts have been unable to reach an agreement.

The PCT Cluster and local CCGs recognise that both Trusts are working to develop services for their patients, amidst a range of challenges and different pressures. Therefore, whilst we are very disappointed with this outcome, we respect the differing positions of the two organisations.

As commissioners of vascular services, there are now limited options available to the PCT Cluster and local CCGs. We do not wish to consult local people on a model which the Trusts have said that they cannot implement. We could of course decommission vascular services from both Trusts and consult upon alternative models of care. However we believe this would be very disruptive for the organisations and the wider health system, and as such, would not in the best interests of the population at this time. The other alternative would be to push ahead with a consultation on the original 'network' model whereby all vascular complex activity is moved to Southampton General Hospital. However we have listened carefully to the views of local stakeholders and communities and are very clear that this option does not have the support of the Portsmouth and south east Hampshire community.

A positive outcome from the detailed debate and discussion with the Trusts, CCGs, HOSCs, other stakeholders and local communities over recent months is that we are now much clearer on certain aspects of the vascular service at Queen Alexandra. We acknowledge that Queen Alexandra Hospital is a large acute centre with a very large stroke service and we have also clarified the following key issues:

1. Outcomes at PHT for planned activity are better than the European average,
2. Vascular cover is required at QAH to support other specialities (including OOHs),
3. PHT does not serve the requisite 800,000 population but the number of operations performed does meet the vascular society guidelines.

This clarity has provided us with some reassurance that Portsmouth Hospitals NHS Trust is close to meeting the Vascular Society of Great Britain & Ireland (VSGBI) standards and the NHS South Central service specification and for this reason we have decided to continue to commission the current service at this time. As the service will remain unchanged we will not proceed with public consultation.

We remain committed to ensuring that the service at Queen Alexandra meets all the local and national standards not just the majority of them. This will allow us to be confident that people in this area are receiving the same quality of service as patients elsewhere in Hampshire and the Isle of Wight. We know that PHT currently does not have enough vascular surgeons to run the recommended 1 in 6 rota, nor does it currently serve a large enough population to comply completely with the VSGBI guidelines.

With this in mind, the SHIP PCT Cluster and local CCGs will be working with PHT to ensure that they have adequate consultant cover from April 2012, when the current arrangement with Chichester comes to an end.

We also know that there is a lot of change going on across the patch, and future GP referral patterns are unclear so we will continue to work with PHT to ensure that the activity levels at the Trust are maximised to ensure adequate volumes to meet the Vascular Society Guidelines. The situation will be kept under review as part of our on-going regular monitoring.

The existing network run by University Hospital Southampton NHS Foundation Trust already meets the service specification, so we're confident that people living in Southampton and south west Hampshire are already served by a vascular service meeting all current standards and we will continue to commission this service.

Finally I would like to stress that although we have not been able to secure an agreement between the Trusts at the current time, this review has been a very valuable listening exercise. We have received a great deal of useful and constructive feedback that has helped us to better understand the population that we are serving. All the views received to date have been carefully recorded and will be very valuable as we move forwards.

I hope that you will agree that we have made every effort to act on your views and ensure that our commissioning intentions for vascular services addressed the issues raised. We will ensure that all the feedback gathered will be taken into account in the future commissioning intentions of local CCGs and the new National Specialist Commissioning team.

The engagement exercise has allowed us to engage in real debate with yourselves and local communities about the sustainability of vascular services and we will continue to have discussions with local groups about this important matter as we move forwards.

I hope that this letter clarifies the position of the PCT Cluster and CCG commissioners. However, if you have any further specific queries, please do not hesitate to contact me.

Yours sincerely

D.M. Fleming (Mrs)
Chief Executive
SHIP PCT Cluster

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Southampton, Hampshire
Isle of Wight & Portsmouth

Vascular services update March 2012
Southampton and Hampshire HOSCs

Background

The SHIP PCT Cluster and its component CCGs are fully committed to commissioning a vascular service that offers all local patients the best outcomes.

In order to achieve this a Vascular Review process started in April 2010 when the NHS South Central Cardio Vascular Network prepared a specification for vascular services. In December 2010, proposals were received from Southampton University Hospital NHS Trust (UHS) and Portsmouth Hospitals NHS Trust (PHT) about how they would go about delivering a vascular service in line with the specification. These proposals were reviewed by an expert panel of independent clinicians, GPs and lay members. The panel concluded that Portsmouth Hospitals NHS Trust did not meet the specification at that time and a 'hub and spoke' model between Southampton and Portsmouth vascular services with emergency and planned complex arterial vascular surgery carried out at Southampton was the best model to meet the specification.

The SHIP PCT Cluster Medical Director facilitated some discussions between vascular surgeons and interventional radiologists across UHS and PHT with the aim of developing such a model and at the time these discussions appeared productive.

The Cluster and the Network then arranged a second Expert Panel in October 2011 to consider the output from these discussions and a proposal from PHT to develop a network with St Richards Hospital, Chichester. Having considered the proposal the Panel concluded it was "aspirational" as West Sussex Hospitals NHS Trust had not given their support to the proposal. Again the Panel's recommendation was that a single vascular service offered from the two hospital sites would provide the best chance for long term sustainable vascular services for local people.

Subsequently a third expert panel was held on the 5th January 2012 to consider a "standalone" proposal prepared by PHT which the panel felt could meet the specification if recruitment to planned posts were made and PHT were able to attract patients from West Sussex. However, the panel reinforced the benefit of a network between UHS and PHT to provide a sustainable service for the future.

During January both Trusts worked hard to develop an acceptable network model, and the PCT Cluster have made every effort to facilitate these discussions. Unfortunately the Trusts were unable to reach an agreement.

Involving local people and stakeholders

Between August and September 2011 an engagement exercise took place to test emerging options with local people. Over 6000 people commented on the proposals and a full report of this engagement is available at http://www.southamptonhealth.nhs.uk/yoursay/safe-and-sustainable/

The engagement exercise identified concern about the original proposals to move all complex emergency and elective arterial vascular surgery to Southampton General Hospital. In particular there were concerns about the implications for other services (such as renal and

cancer) at Queen Alexandra Hospital, Portsmouth and also a plea to recognise that Queen Alexandra Hospital was a large centre,

Local people also told us they wished to see a truly collaborative network model, with surgeons and interventional radiologists working across both sites, with some major vascular operations and complex interventional radiology retained at Queen Alexandra Hospital. In response the PCT Cluster expressly asked the Trusts to work together to ensure that as much vascular activity as was clinically safe was retained at Queen Alexandra Hospital.

While these discussions took place the PCT Cluster embarked on preparations for a public consultation. In the pre-consultation phase which ran throughout January a further 500 local people and stakeholders were directly engaged in discussion about the options that were under development. A detailed record of this activity is available on request. Stakeholders were also regularly updated through a series of letters.

During January 2012 both Trusts actively engaged in discussions with the local CCGs and the Cluster about how to work together to develop an appropriate partnership across the two hospital sites, whilst ensuring that the national clinical standards and guidelines that uphold patient safety continued be met.

However in early February the Trusts reported to us that they had been unable to reach an agreement about how a truly collaborative model would be delivered. The PCT Cluster concluded that it could not conduct a public consultation on a model which the two hospitals were not fully committed to and as such had little choice but to cancel the plans for consultation. The Cluster wrote to all stakeholders on February 2, 2012 to inform them of this decision.

Decision not to proceed to public consultation

A positive outcome from the detailed debate and discussion with the Trusts, CCGs, HOSCs, other stakeholders and local communities was that we developed a thorough understanding of the views of the community and its stakeholders. At the same time we were able to extend our knowledge of the vascular service at Queen Alexandra and its relationship with other specialties. We have acknowledged that Queen Alexandra Hospital is a large acute centre with a very large stroke service and we have also clarified the following key issues:

1. Outcomes at PHT for planned activity have improved since the initial review began and are better than the national target for 2013;
2. Vascular cover is required at QAH to support other specialities;
3. PHT does not serve the requisite 800,000 population but the number of operations performed does meet the Vascular Society guidelines.

This information provided us with some reassurance that Portsmouth Hospitals NHS Trust was very close to meeting the Vascular Society of Great Britain & Ireland (VSGBI) standards and the NHS South Central service specification. In addition we were conscious that the guidelines for vascular services and interventional radiology had evolved during the period of the review and were in the process of being refined by the various professional bodies. This combination of factors led to our decision to continue to commission the current service at this time.

Next steps

The PCT Cluster remains convinced that a network arrangement between UHS and PHT would provide a sustainable solution to meeting the needs of patients to deliver the outcomes for vascular patients we are seeking. As a result of the two Trusts being unable to agree this

collaborative model we are continuing to commission the existing services. This does not represent an acceptance of Portsmouth Hospitals NHS Trusts' 'standalone model' but rather is designed to maintain the status quo of service configuration for now.

Portsmouth Hospitals NHS Trust firmly believe that their vascular services can meet the Vascular Society of Great Britain standards and the local specification for vascular services and this is a firm requirement of the PCT Cluster's contract with the Trust in the next year.

Portsmouth Hospitals NHS Trust has historically relied upon St Richards Hospital, Chichester for support with its vascular rota but this arrangement is due to finish at the end of March 2012 when St Richards' consultants join the Brighton vascular network.

In order to ensure that Portsmouth Hospitals NHS Trust and indeed University Hospital Southampton NHS Foundation Trust and Frimley Park NHS Foundation Trust continue to achieve optimum outcomes for patients accessing vascular surgery, the PCT Cluster, CCGs and the Specialised Commissioning team has committed to close monitoring of adherence to the Vascular Society of Great Britain guidelines.

A clinical governance framework has been developed which will ensure effective monitoring of workforce, activity and clinical outcome requirements.

The information will initially be reviewed by the GP Cardiovascular lead for South East Hampshire CCG, one of the Clinical Governance leads for Fareham and Gosport, Portsmouth and South East Hants CCGs and the Specialised Commissioning group for comment and recommendation to the SHIP PCT Cluster's Clinical Governance Committee.

A Patient Reference Group has also been established and meets bi-monthly. It includes representatives from Portsmouth, Southampton and South Eastern Hampshire. This group will be asked to share patient experience feedback with the Cluster's Clinical Governance Committee on a regular basis.

Decision required

The Committee is asked to note the arrangements for monitoring of vascular services and advise when a further update is required.

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Mortality Rates for AAA Surgery in SHIP

Why is there a concern?

- Outcomes for abdominal aortic aneurysm (AAA) surgery are worse in this country than elsewhere in Europe where the mortality rate in 2008 was 7.9% in the UK compared to 3.5% in Europe
- National guidelines aim to halve the mortality rate for planned AAA surgery within 30 days of treatment in the UK to 3.5% by 2013.

What are the new standards?

- *Now* 6% or less people die within 30 days of planned surgery
- *By 2013* 3.5% or less people die within 30 days of planned surgery

Please note that over one year our local hospitals see between 50 and 80 patients. One or two deaths can therefore make a big difference to annual mortality figures. This means that in one year figures could look very good and in another quite poor. For this reason the figure of the last 100 cases is chosen as the benchmark by the national professional body for vascular surgeons. The local population may generally sicker in some areas and this may affect the probability of higher mortality rates in those areas.

How are we doing locally?

Provider of Services	Numbers of AAA planned operations in 2009/10	2010/11Mortality Rate (percentage)	Mortality Rate last 100 cases
University Hospitals Southampton Foundation NHS Trust (UHSFT)	76	0%	
Portsmouth Hospitals NHS Trust (PHT)	47	2.2%	2%
Frimley Park Hospital Foundation NHS Trust (FPHFT)	85	2.3%	
England Average	5.6% open surgery, 4,1% all types of AAA surgery		

This is from information provided by the trusts themselves in autumn 2011; England average from the AAA Quality Improvement Programme report July 2011

All hospitals are using new technology which involves less open surgery and this has the potential to further improve survival rates. Independent experts have reviewed the outcomes and have stated that they are all satisfactory.

What about emergency surgery?

- There is no national standard for outcomes for emergency AAA surgery
- Annual numbers of operations are much lower and more subject to fluctuation as noted above
- The national average figure is 33% and locally our figures are 33% (UHSFT), 59% (PHT) and 28% (FPHFT)
- The national AAA screening programme aims to detect abdominal aortic aneurysm earlier with a simple ultrasound test. This should mean that over time nearly all operations will be planned

What about other vascular surgery?

- There is no national standard for outcomes for other surgery
- There were 52 inpatient deaths last year following carotid surgery to prevent strokes, recorded for England by the national agency Hospital Episode Statistics
- There were 3 deaths last year from carotid surgery across Southampton, Hampshire, Isle of Wight, Portsmouth, Berkshire, Buckinghamshire and Oxfordshire and over 500 operations were performed
- AAA Elective Mortality Rates for the financial year 2010/11provided by Trusts to the cardiovascular network, November 2011

NHS South Central figures

AAA Elective Mortality Rates for the financial year 2010/11provided by Trusts to the South Central cardiovascular network, November 2011

Trust	Number	Deaths	%	3 year
Buckinghamshire HT	34	0	0	1.4%
Heatherwood and Wexham Park FT	19	1	5.2	
Royal Berkshire FT	16	0	0	
University Hospitals Oxford	111	none in 30 days 1 after 30 days	0	
University Hospitals Southampton FT	76	0	0	
Portsmouth HT	47	1	2.2	2%
Frimley Park FT	85	2 (EVAR)	2.3*	

- Please note that on such a low volume procedure one year activity will not be a statistically significant sample. Except where an asterisk is shown, It is also unclear if 30 day mortality rates are quoted. The network tried to obtain validating information from the national vascular database but was refused due to poor data quality in the mortality field.

DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	PUBLIC HEALTH ANNUAL REPORT 2011
DATE OF DECISION:	29 MARCH 2012
REPORT OF:	DIRECTOR OF PUBLIC HEALTH
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

This report introduces the Director of Public Health's Annual Report.

RECOMMENDATIONS:

(i) The HOSP notes the Public Health Annual Report 2011/12

REASONS FOR REPORT RECOMMENDATIONS

1. The Director of Public Health must produce an annual report each year.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None

DETAIL (Including consultation carried out)

3. Below is a summary of the Public Health Annual Report 2011. The full report is being taken to the Board of the Southampton Clinical Commissioning Group on 28th March 2012; copies of the full report will be made publicly available after that time.

4. **Introduction**

The health of Southampton people continues to improve, but there are still too many who are missing out. This continues to be the conclusion as we assess the health needs of our city, the disease trends and then factors that affect our health.

The 2011 annual report explains the changing public health system in England and the impacts of this locally. It provides an overview of the health of Southampton through key facts and innovative visual presentations. The main body of the report examines three key issues from the Joint Strategic Needs Assessment (JSNA) – lung health, suicide and fuel poverty – and makes recommendations for tackling these.

5. **The new public health system for England**

The Health and Social Care Bill proposes major changes to the public health system for England, originally described in the White Paper: *Healthy Lives, Healthy People*. To ensure public health is responsive to the different needs of each community, the government aims to create local freedom, accountability and ring-fenced funding. From April 2013 local public health leadership and responsibility will be returned to and strengthened within local government.

Health and wellbeing boards, based in local authorities, will provide a forum to bring together NHS commissioners, councils and elected councillors with patient champions, to join up the public health agenda with the wider work of the NHS, social care and children's services.

These changes will give three key roles to Southampton City Council:

1. Leading for public health
2. Public health commissioning functions
3. Specialist public health and population healthcare advice and expertise to local commissioners including the Southampton City Clinical Commissioning Group.

6. **Lung health**

Poor lung health affects more people than is often recognised. As well as causing premature death, people with lung disease tend to have a poor quality of life in its later stages and the cost to individuals, families and society is high. Much lung disease can be prevented and, if picked up early, outcomes can be greatly improved.

On average 105 Southampton residents die each year from chronic obstructive pulmonary disease (COPD).

The Department of Health is in the process of finalising a strategy for COPD services in England. Key aims of this strategy include recommendations on achieving enhanced early warning and interventionist approaches designed to either stop people getting COPD, or on improving outcomes for those already diagnosed with the condition. Locally we need to develop programmes and initiatives to incorporate these national strategy objectives.

7. **Suicide**

As well as the personal, family and community tragedy that suicide represents, it is a marker of levels of distress in society. Understanding the causes and trends can lead to more focussed action - to improve awareness, identify those most at-risk of being overwhelmed by their personal circumstances, and to provide effective interventions.

Over the period 2008-10 there were an average of 26 suicides every year amongst Southampton residents.

National and local data suggest that prevention efforts should be at the level of society and the NHS. Societal measures include better employment, education and housing. Access to means of suicide can be reduced by safety adaptations of the physical environment. However, a local audit found, many individuals take their lives within their homes.

A workshop was held in July 2011 to present the findings of the local coroner's audit and to map out a way forward for suicide prevention. The output from the day was a plan for 'Action Against Suicide' (AAS) in the city.

8. **Cold homes and fuel poverty**

Housing affects health in many ways. Overcrowding, poor ventilation, damp and lack of adequate heating are recognised to lead to more respiratory and other illnesses. Cold homes and fuel poverty are linked to excess deaths in winter months. Despite good progress in improving the quality of local housing, many people still face the consequences of cold homes, and more remains to be done to help them.

In 2006 10% of households in Southampton were in fuel poverty whereas by 2009 the figure had risen to over 12%.

10. **Progress on recommendations**

An audit of recommendations from each annual report is maintained by the Public Health Team in Southampton and this year's report includes a summary of progress.

11. **Southampton's health at a glance**

Southampton is a diverse city where…

- In just a few years there has been a change in the number of babies being born to city residents each day from seven in 2003 to nine in 2009
- Five Southampton residents die each day
- In 2010 there were over 5,000 people in the city aged over 85 years – by 2017 this will have risen to more than 6,000
- Over 3,200 pupils in Southampton schools speak a first language other than English
- According to its demographic and socio-economic characteristics, the UK cities considered most similar to Southampton are Bristol, Portsmouth, Exeter and Norwich
- Southampton covers an area of 5,181 hectares of which over 20% is open space.

12. Improvements in health and wellbeing over the past decade include...

- Compared with 10 years ago, men are 19% and women are 3% more likely to live to the age of 75 (the probability of survival to age 75 in 1997-99 was 56% for males and 74% for females, in 2007-09 the figures were 67% and 77% respectively)
- Compared with 10 years ago, male life expectancy is four years longer and women's life expectancy is two years longer
- Death rates have fallen by 22% (342 fewer deaths each year in the city)
- Deaths from heart disease have fallen by 49% (202 per year fewer)
- Deaths from stroke are 38% lower

- Cancer death rate has fallen by 9%
- Smoking prevalence is estimated to have fallen from 32% to 22% over the past decade
- Since 2003/04 smoking in pregnancy has reduced from 25.1% to 19.5% whilst breastfeeding rates have increased from 69.6% to 74.5%
- Every day now an average of 15 eligible women are screened for breast cancer, 25 for cervical cancer and a further 23 eligible adults screened for bowel cancer

Educational attainment has improved – in 2005 34.6% of Southampton pupils gained 5 or more GCSEs at grades A*-C (including English and Maths), and by 2011 this had increased to 51.7%.

13. However, many challenges remain for our city including…

- Men from the most deprived areas of Southampton have a life expectancy eight years less than men from the least deprived areas
- In Southampton there is one teenage conception every two days
- Every day a Southampton resident dies from a cause related to smoking
- Every day in Southampton an average of three people are newly diagnosed with cancer
- Gross annual pay for full-time workers in Southampton was just over £23,000 on average in 2010, compared with a national average of over £26,000
- Every 13 hours there is a net gain of one additional person to Southampton GPs' diabetic risk registers
- Only 31.7% of adults access NHS dentistry with extra provision being under-used.

RESOURCE IMPLICATIONS

Capital/Revenue

14. None

Property/Other

15. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

16. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

17. None

POLICY FRAMEWORK IMPLICATIONS

18. None

AUTHOR:	Name:	Dr Andrew Mortimore	Tel:	023 8083 3204
	E-mail:	Andrew.mortimore@southampton.gov.uk		

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Non-confidential appendices are in the Members' Rooms and can be accessed on-line

Appendices

1.	None
2.	

Documents In Members' Rooms

1.	None
2.	

Integrated Impact Assessment

Do the implications/subject of the report require an Integrated Impact Assessment (IIA) to be carried out.	Yes/No

Other Background Documents

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

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.		
2.		

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DECISION-MAKER:	SOUTHAMPTON HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	ADULT MENTAL HEALTH REDESIGN UPDATE ON ABBOTTS LODGE TRANSFER
DATE OF DECISION:	29 MARCH 2012
REPORT OF:	PAM SORENSEN HEAD OF ENGAGEMENT SOUTHERN HEALTH NHS FOUNDATION TRUST
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

Following on from previous engagement of the panel, to receive an update and brief verbal presentation from Southern Health NHS Foundation Trust Adult Mental Health Division in connection with the re location of services from Abbotts Lodge, Netley Marsh to Antelope House on the Royal South Hants Hospital site. The service provides reablement for clients whose illness also means they have challenging behaviour.

RECOMMENDATIONS:

(i) To note the successful transfer of clients and the service from Abbotts Lodge to Antelope House.

REASONS FOR REPORT RECOMMENDATIONS

1. To be assured that the transfer of service was uneventful and in the best interests of clients.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. N/A

DETAIL (Including consultation carried out) None

3.

- As explained in previous reports, Abbotts Lodge was geographically isolated leading to a level of social exclusion for clients and lone working concerns for staff. The quality of the building and grounds was poor for this client group. The unit at Antelope House provides the same level of care for clients but in an environment that better suits this client group.
- 8 clients were transferred to Antelope House on 19 March 2012. Extra staff were on hand to provide consistency and any reassurance needed during the move. The move was smooth with no reported incidents or concerns.
- Of the eight who were transferred, three were expected to move into their new accommodation but it was not ready in time. They hope to move imminently as soon as the accommodation is ready. Five will remain on Abbey Ward until their long term plans for accommodation are put in place.
- The Trust will of course continue to engage with clients and their

carers to ensure the best possible care and treatment.

RESOURCE IMPLICATIONS

Capital/Revenue

None

Property/Other

None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

Other Legal Implications:

None

POLICY FRAMEWORK IMPLICATIONS

None

AUTHOR:	Name:	Pam Sorensen	Tel:	023 8087 4058
	E-mail:	Pamela.Sorensen@southernhealth.nhs.uk		

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Appendices

1.	None

Documents In Members' Rooms

1.	None

Integrated Impact Assessment

Do the implications/subject of the report require an Integrated Impact Assessment (IIA) to be carried out.	Yes/No

Other Background Documents

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

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