Public Document Pack

Health Overview and Scrutiny Panel

Thursday, 21st November, 2013
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Stevens (Chair)
Councillor Chaloner (Vice-Chair)
Councillor Claisse
Councillor Cunio
Councillor Laming
Councillor Parnell
Councillor Spicer

Contacts

Ed Grimshaw
Democratic Support Officer
Tel: 023 8083 2390
Email: ed.grimshaw@southampton.gov.uk

Dorota Goble
Improvement Manager
Tel: 023 8083 3317
Email: dorota.goble@southampton.gov.uk

PUBLIC INFORMATION

Role of Health Overview Scrutiny Panel (Terms of Reference)

The Health Overview and Scrutiny Panel will have 6 scheduled meetings per year with additional meetings organised as required.

- To discharge all responsibilities of the Council for health overview and scrutiny, whether as a statutory duty or through the exercise of a power, including subject to formal guidance being issued from the Department of health, the referral of issues to the Secretary of State.
- To undertake the scrutiny of Social Care issues in the City unless they are forward plan items. In such circumstances members of the halth Overview and Scrutiny Panel will be invited to the relevant Overview and Scrutiny Management Committee meeting where they are discussed.
- To develop and agree the annual health and social care scrutiny work programme.
- To scrutinise the development and implementation of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy developed by the Health and Wellbeing Board.
- To respond to proposals and consultations from NHS bodies in respect of substantial variations in service provision and any other major health consultation exercises.
- Liaise with the Southampton LINk and its successor body "Healthwatch" and to respond to any matters brought to the attention of overview and scrutiny by the Southampton LINk and its successor body "Healthwatch"
- Provide a vehicle for the City Council's Overview & Scrutiny Management Committee to refer recommendations arising from panel enquiries relating to the City's health, care and well-being to Southampton's LINk and its successor body "Healthwatch" for further monitoring.
- To consider Councillor Calls for Action for health and social care matters.
- To provide the membership of any joint committee established to respond to formal consultations by an NHS body on an issue which impacts the residents of more than one overview and scrutiny committee area.

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 2013/14

2013	2014
23 May 2013	31 January 2014
18 July	20 March
19 September	
21 November	

Council's Priorities:

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

CONDUCT OF MEETING

Terms of Reference

Details above

The general role and terms of reference for the Overview and Scrutiny Management Committee, together with those for all Scrutiny Panels, are set out in Part 2 (Article 6) of the Council's Constitution, and their particular roles are set out in Part 4 (Overview and Scrutiny Procedure Rules of the 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 INTEREST

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

DISCLOSABLE PERSONAL INTERESTS

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

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

(ii) Sponsorship:

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

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

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

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

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

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

a) the total nominal value for the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or
b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class.

Other Interests

A Member must regard himself or herself as having a, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

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

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

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

Principles of Decision Making

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

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

In exercising discretion, the decision maker must:

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

AGENDA

Agendas and papers are now available via the 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 PECUNIARY INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary interests in any matter included on the agenda for this meeting.

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

3 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 September 2013 and to deal with any matters arising, attached.

7 PROGRESS REPORT: PUBLIC AND SUSTAINABLE TRANSPORT PROVISION TO SOUTHAMPTON GENERAL HOSPITAL REVIEW

Report of the Head of Transport, Highways and Parking detailing progress made in line with the Panel's inquiry recommendations, attached.

8 SOUTHAMPTON SAFEGUARDING ADULTS BOARD: ANNUAL REPORT 2012 - 2013

Report of the Independent Chair of the Southampton Safeguarding Adults Board detailing the annual report attached.

9 INTEGRATED COMMISSIONING UNIT: PROGRESS, QUALITY AND PERFORMANCE

Report of the Director of Quality and Integration detailing progress of the ICU and how the Council and CCG are maximising opportunities to pool budgets, attached.

10 UNIVERSITY HOSPITAL SOUTHAMPTON: EMERGENCY DEPARTMENT REPORT

Report of the Chief Executive of University Hospital Southampton detailing the Hospital's performance against targets the Hospital's targets relating to the emergency department, attached.

11 SCOPING THE PREVENTION INQUIRY: ENSURING A COORDINATED AND COLLABORATIVE APPROACH TO THE FUTURE HEALTH OF THE CITY

Report of the Assistant Chief Executive, setting considerations relating to the scoping of an inquiry by the Panel, attached.

Wednesday, 13 November 2013 HEAD OF LEGAL AND DEMOCRATIC SERVICES

SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 19 SEPTEMBER 2013

Present: Councillors Stevens (Chair), Claisse, Cunio (For minutes numbers 20-23 only), Parnell and Spicer

Apologies: Councillors Chaloner and Laming

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

The Panel noted that the apologies of Councillors Chaloner and Laming.

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

RESOLVED: that the minutes for the Panel meeting on 18th July 2013 be approved and signed as a correct record.

22. **EXCLUSION OF THE PRESS AND PUBLIC - CONFIDENTIAL PAPERS INCLUDED IN THE FOLLOWING ITEM**

RESOLVED that in accordance with the Council's Constitution, specifically the Access to Information Procedure Rules contained within the Constitution, the press and public be excluded from the meeting in respect of any consideration of the Agenda Item 8. The confidential Report contains information deemed to be exempt from general publication based on Category 1 and 2 of paragraph 10.4 of the Council's Access to Information Procedure Rules.

23. **SOUTHAMPTON LOCAL CHILDREN'S SAFEGUARDING BOARD**

The Panel received and noted the confidential report of the Director of People detailing an update on the Local Board.

The Panel additionally noted that the process to appoint a new Chair would take place in October.

24. **QUALITY ASSURANCE OF HEALTH AND SOCIAL CARE PROVISION**

The Panel received the report of the Director, People outlining work being undertaken to ensure safety and quality in adult health and care provision. Dr Carol Tozer Chair of the Southampton Safeguarding Adults Board (SSAB) addressed the meeting with, the consent of the Chair.

The following was noted:-

- The number Registered Nursing Homes within the City currently have Safeguarding Suspension Status or Safeguarding Caution Status;
- The process these registered homes would have to go through in order to improve their status;
- What support / guidance is provided to homes that have been suspended in order for them to improve their standards;
- How notification of suspension was notified to the public through the Care Quality Commission's website

- The review process for care providers;
- The development of an integrated commissioning unit between the City Council and City's Clinical Commission Group in order to integrate quality assurance standards across the two organisations,
- How Southampton Healthwatch can assist in the notification of providers of care

RESOLVED

(i) that the report be noted, and
(ii) regular exception reports on the quality and safety of health and social care provision in Southampton that highlight key areas of concern and actions be brought to the Panel.

25. **BUILDING ON SUCCESS - LYMINGTON NEW FOREST HOSPITAL - THE NEXT TEN YEARS: LISTENING EXERCISE UPDATE**

The Panel received and noted the report of Programme Director of Clinical Commissioning, outlining the events and responses to date from the Listening Exercise in relation to the Lymington New Forest Hospital Strategic Review.

26. **UPDATE ON THE ESTABLISHMENT OF THE CCG, KEY NATIONAL DEVELOPMENTS AND WORKING WITH THE WIDER HEALTH AND SOCIAL CARE SYSTEM.**

The Panel received and noted the report of the Chief Officer of Southampton Clinical Commissioning Group (CCG), updating the Panel on progress in the establishment of the CCG, key national developments and working with the wider health and social care system

John Richards Chief Officer of the Southampton Clinical Commissioning Group introduced his report and gave a broad outline of the Group's overall budget and undertook to circulate a more detailed financial breakdown to the Panel.

RESOLVED

(i) that the report be noted
(ii) that the Panel requested that a financial breakdown of the Clinical Commissioning Group's contracts be circulated to Panel;

27. **UNIVERSITY HOSPITAL SOUTHAMPTON; UPDATE ON EMERGENCY DEPARTMENT / MONITOR AND THE CHILD HEART SURGERY REVIEW**

The Panel received and noted the report of the Chief Operating Officer and the Director of Communications and Public Engagement for University Hospitals Southampton, updating the Panel on progress to date;

The following was noted:

- That the University Hospital Southampton (USH) Emergency Department did not receive any of the recent additional Government funding, although the neighbouring departments in Winchester and Portsmouth had been successful;
- That a recent close analysis of those attending the Emergency Department had established that the majority of patients did attend the most appropriate provider

when they required medical treatment . It was stressed that the additional work done by partners has sign posted patients correctly;

- That the USH had taken the decision to establish its own emergency funding stream to help cope with any addition funding pressures brought on by for example a cold winter;
- That it was hoped that additional beds would be available this winter that would help to alleviate any problems caused by bed blocking;
- That work with local partner organisations was geared to reduce any potential blocking had been undertaken;
- That there was still a marked increase in emergency cases that reflected the excess consumption of alcohol at weekends and periods like fresher's week for the City's universities;
- That a new pharmacy and procedures had been put into place that were intended to relieve any stress caused by bed block at the hospital by enabling a speeder discharge of patients awaiting drugs.

RESOLVED that the Panel requested further updates on the progress of the Emergency Department at future meetings.

28. **OPERATING PROTOCOL BETWEEN HEALTH AND WELLBEING BOARD, HEALTH OVERVIEW AND SCRUTINY PANEL, AND HEALTHWATCH SOUTHAMPTON**

The Panel received and noted the report of the Director of Public Health, setting out the roles and responsibilities of Health and Wellbeing Boards and local Healthwatch.

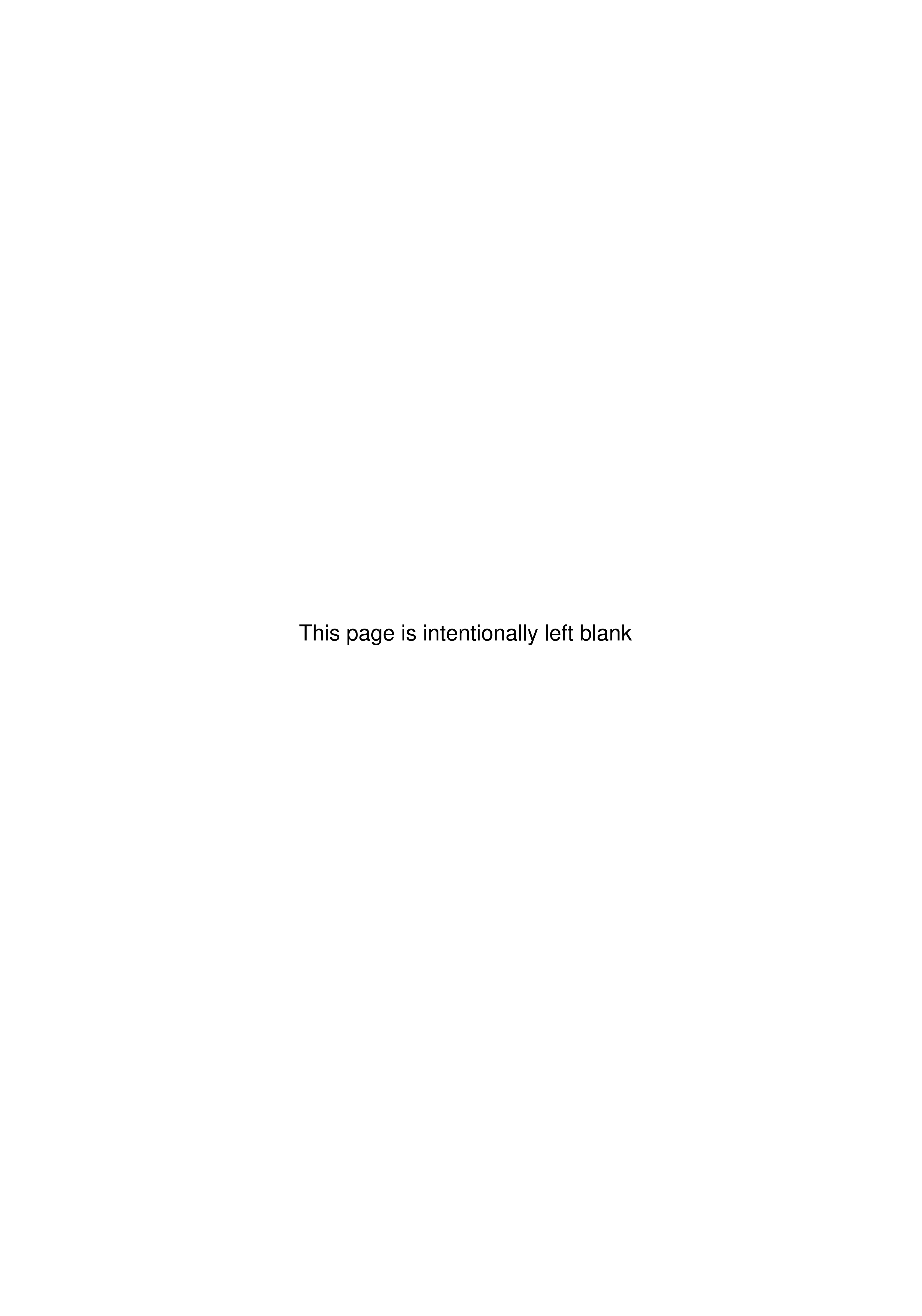
The Panel noted that the

RESOLVED

(i) That the draft protocol set out as Appendix 1 to this report be approved

(ii) That authority be delegated to Director of Public Health, after consultation with the Chair, to make any drafting or other amendments required following consideration by the Health Overview and Scrutiny Panel and Healthwatch Southampton that do not affect the spirit of the intentions of the protocol

(iii) That in the interest of clarification, at a future meeting the Panel a definition of what is meant by the phrase "significant change to service" will be brought to the Panel to consider at a future meeting.



This page is intentionally left blank

DECISION-MAKER:	HEALTH AND OVERVIEW SCRUTINY PANEL			
SUBJECT:	PROGRESS REPORT: PUBLIC AND SUSTAINABLE TRANSPORT PROVISION TO SOUTHAMPTON GENERAL HOSPITAL REVIEW			
DATE OF DECISION:	21 NOVEMBER 2013			
REPORT OF:	HEAD OF TRANSPORT, HIGHWAYS AND PARKING			
CONTACT DETAILS				
AUTHOR:	**Name:**	**Simon Bell**	**Tel:**	**023 8083 3814**
	E-mail:	**simon.bell@southampton.gov.uk**		
Director	**Name:**	**John Tunney**	**Tel:**	**023 8091 7713**
	E-mail:	**john.tunney@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
n/a

BRIEF SUMMARY

To report on the progress made with the recommendations to the Public and Sustainable Transport Provision to Southampton General Hospital Review.

RECOMMENDATIONS:

(i) That the panel note and discuss the progress against their recommendations made to date.

(ii) That the panel agree for a further progress report to be brought to the Health Overview and Scrutiny Panel (HOSP) in March 2014.

REASONS FOR REPORT RECOMMENDATIONS

1. To update the panel on the progress being made with regards to the recommendations in the review.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

n/a

DETAIL (Including consultation carried out)

2. The Health Overview and Scrutiny Panel undertook a Public and Sustainable Transport Provision to Southampton General Hospital Review in 2012/13, with the final report and 17 recommendations agreed at their meeting on 21 March 2013.

3. At their meeting on 20 August 2013, Cabinet accepted all the recommendations that the Council is responsible for delivering and agreed to work in partnership with others to achieve the additional recommendations, as outlined in the HOSP Action Plan.

4. The recommendations from the review are outlined at Appendix 1, with progress reported to date.

5. The panel is invited to note the progress made to date, and considering any comments or issues they may have, agree to have a further update by March 2014.

RESOURCE IMPLICATIONS

Capital/Revenue

6. None

Property/Other

7 None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

8. None

Other Legal Implications:

9. None

POLICY FRAMEWORK IMPLICATIONS

10. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	ALL

SUPPORTING DOCUMENTATION

Appendices

1.	List of recommendations and progress made to date

Documents In Members' Rooms

	None

Equality Impact Assessment

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

Other Background Documents

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

Title of Background Paper(s)		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	Final Report and Recommendations: Review of Public and Sustainable Transport Provision to Southampton General Hospital	

OSMC Summary of Recommendations & Current Status

	Recommendation	Lead Organisation	OSMC Target date for completion	Current Status
1.	***Ensure that staff, visitors and patients are aware of the public and sustainable transport routes to and from the general hospital.***			
	a) UHS to review, improve and provide evidence of the information provided to staff, visitors and patients in relation to travel to the hospital – including in patient appointment letters and the website;	UHS	Sept 2013	UHS will work with SCC to review and improve the information available to those accessing the SGH site with consideration content and method of communication should be informed by the data and information collated by undertaking a survey of patients and visitors as indicated by (10) below. UHS suggest the bus companies have a critical role in publicising sustainable transport options and should be identified as one of the lead organisations in delivering this action. First Hampshire has produced a timetable for access to the hospital for their services.
	b) ***SCC to develop leaflets to publicise sustainable transport options to the general hospital from various parts of the city for distribution at relevant places including the hospital, GP surgeries, libraries, community facilities and the***	SCC	Sept 2013	To be put into work programme to be in place following September service changes (changes traditionally happen in September due to school/University year start). This should be in partnership and joint funded by UHS as part of

Agenda Item 7
Appendix 1

	information provided on the 'My Journey' website.			the Travel Plan for the site. Following a further change to the operator of council supported service S1 this will be delayed until October 2013. ***Update:*** *Following further changes to bus services in early January 2014 it is proposed that information be provided at this date.*
2	***To establish a representative passenger group for public transport in Southampton including service providers (buses and trains), transport users and councilors. The group should meet at least twice a year with scope for extra meetings if required and minutes available publicly.***	SCC	July 2013	SCC liaising with UHS on best way to set up group (including tapping into existing groups). It is anticipated that the group will meet for the first time in September/October 2013. ***Update:*** *This will take place in January where the latest changes to bus service will be discussed*
3	***That UHS ensure there is early engagement with public transport providers, allowing time to consult with the passenger group mentioned in recommendation 2 where possible, over services changes that are likely to affect staff and patient travel – including the proposed extension of working hours at the hospital.***	UHS	June 2013	UHS will ensure this is the case and will work via the passenger group once it has been established. This is delayed until the passenger group is established (see 2 above). ***Update:*** *The latest changes are to First commercial services.*
4	***Bus companies to ensure that bus drivers are encouraged to share information with passengers – for example that it is quicker to wait and get the next bus, as a matter of course, particularly for vulnerable and elderly passengers and for this to be included in mandatory training***	Bus Companies	Sept 2013	New signage to be included at locations highlighted at (5) below will assist in general information as Real Time where provided. Leaflets as set out at (1b) above will also help. In a competitive and unregulated market it is unrealistic to expect private bus operators to encourage passengers to use services of another operator both in terms of commercial approach

				and knowledge of other operators services (e.g. it would be unexpected that B&Q would advise on Homebase products for example). The Customer Service Charter being developed as part of the Better Bus Area Fund project aims to bring a standard approach to customer service including improved driver training. In addition First Group CPC training includes a module written in partnership with the CPC Alzheimer's Society in terms of dealing with elderly and vulnerable people. ***Update:*** *Ongoing training by bus companies*
5	***SCC to work with bus companies, Network Rail and Red Funnel to improve signposting to bus services to the hospital from central station and Town Quay linking into the legible cities and legible bus networks.***	SCC	Sept 2013	New Signs to be installed at Town Quay and Southampton Central station during August 2013 in partnership with Island Line Community Rail Partnership with details of bus routes to Hospital. Totems installed at City Centre Locations with local area maps which shows bus departures and a map to assist in identifying “which bus goes where”. Signs also due to be installed at both sides of Central Station as part of the project, the North Side due to go live August 2013, South Side September 2013 delayed due to electrical connection issues with South West Trains. ***Update:*** *A new totem has been installed on the*

				south side exit from the rail station which gives live bus departures from the bus stops around the station. The north side totem has been erected but is not connected to the power supply yet so is not providing any information. A notice board has been provided on the south-side of the station which gives information on how to get to the station.
6	***SCC and UHS to work together to improve signposting to bus stops and cycle routes in and around the hospital including consideration of a potential cycle route through the cemetery. If this is not deemed appropriate, the Panel would urge the Council and partners to consider alternative routes which are physically segregated from motor vehicles as much as possible.***	SCC/UHS	Sept 2013	UHS approached regarding provision of additional RTI signs/Totems on site at UHS but were viewed unsuitable due to potential infection concerns and land redevelopment issues. Cycle links to be developed with UHS travel plan working group. Current improved routes to the Hospital part of DfT Cycling to Prosperity Bid, award decision due August 2013. Routes in and around the Hospital are on private land and responsibility of UHS through the Travel Plan. ***Update:*** *Confirmation of available funding has not been secured to develop the route across the cemetery*
7	***SCC to work with the UHS to improve bus stop information around the general hospital site to ensure time tables and real-time information are available both in the hospital and at bus stops.***	SCC/UHS	July 2013	UHS approached regarding provision of additional RTI signs/Totems on site at UHS but were rejected due to potential infection concerns and land redevelopment issues. However, a location has now been identified to install the freestanding bus departure display

9				unit. New legible bus network bus stop will be installed in August to improve the information around the hospital. ***Update:*** *Bus stop poles and flags have now been ordered and will be delivered and erected by the end of November 2013*
8	***SCC to priorities improvements to street lighting on Tremona Rd and Dale Rd Junction around bus stops, to ensure that passengers feel safer.***	SCC	July 2013	Under the existing Street Lighting PFI Contract, Coxford Ward, the street lighting for Dale Road has already been up graded to a ' white' light source, 90 Watt, road lighting lantern, using 8 metre mounting height lamp columns. It is planned to continue with the same lighting specification for Coxford Road and Tremonia Road, with the lighting installations being brought forward and completed by Scottish & Southern Energy before the end of the Summer months and the return of the dark evenings. Street lighting in the roads of Dale Road, Coxford Road, and Tremonia Road, will all be exempt from any future Councils Street Lighting Dimming Policy, and will continue to be operated at full brilliance.
9	***All bus companies to feed their live data into the SCC***	Bus Companies	Sept 2013	This is subject to a legal Service Level Agreement being signed between SCC and the

	real time information systems.			bus operator to ensure data on system is of high quality. Bluestar already on system. Unilink due on system August/September. Negotiations with First suggest an October date but this is subject to further negotiation. ***Update:*** *Unilink Information is now live on the system. First should be available in the first quarter of 2014*
10	***SCC, UHSFT, Southampton University, Unison, S-LINkS-LINK and Bus Companies to work together to explore options for undertaking a survey to establish how patients and visitors are currently travelling to and from the general hospital and the results are used to inform future service planning and improve reliability. The results should also be reported back to HOSP and fed into the key local health documents: the Joint Strategic Needs Assessment and the Health and Well-being Strategy, the latter of which, following the Panel's recent review, now is agreed to contain transport as a consideration.***	All	Sept 2013	UHS are developing a new Travel Plan as the previous Travel Plan is no longer being used. The revised version is due to be submitted to SCC for review and approve in March 2014. The timetable by OSMC needs to be amended to reflect this. ***Update:*** *A survey of patients and staff which include information on how they travel is being undertaken during November 2013*
11	***Regardless of decisions taken by bus companies in relation to continuing, or otherwise, to run evening and weekend buses to the General Hospital, the Panel would like SCC to review the effects of the bus subsidy reductions on access to the general hospital six months after they come into effect. A report on the review should be provided to HOSP.***	SCC	Dec 2013	This is due in December 2013. ***Update:*** *A verbal update on service changes and their impact will be given at the meeting.*
12	***At a meeting in the 2013-14 municipal year, HOSP to***	HOSP	Sept 2013	Noted

	consider the Patient Transport Service and other dedicated modes of patient transport in more detail in order to improve understanding of how the services are managed, publicised to patients and concerns with the current service. Commissioners and providers, including the voluntary sector, of the service to be invited. If recommendations are necessary to improve the service, they will be made at that meeting			
13	***UHS to be asked to consider reviewing the zones used in relation to parking permits to consider areas where there are regular direct bus routes which fall outside of the inner zone but provides attractive transport to the hospital within 30 minutes. This should help improve the viability of bus services and encourage sustainable transport use*** *("getting people out of their cars").*	UHS	Oct 2013	UHS zones were designed with available bus routes in mind as below: • Staff living in zone 2 (based on a combined 15 min walk and 30 min bus journey) will be allocated a parking space if they work nights, shifts or travel off and on site several times per day. UHS acknowledge however that these zones were designed three years ago and are willing to consider revising the zones in light of current bus routes. This will need careful consideration and possible consultation with staff prior to any changes being implemented. ***Update:*** *As part of the Hospital travel plan recently submitted they are proposing to look at the zones*

14	***Consideration is given to the development of a bus hub within the general hospital site and how SCC can work with the hospital to facilitate this.***	SCC/UHS	Dec 2013	This is subject to issues on redevelopment proposals and funding opportunities as well as a demonstrated business case. There is a desire amongst both parties to deliver a solution that is being investigated through both through the development control process and in terms of funding in partnership between SCC and UHS with bus operators.
15	***Encourage bus companies to work together to develop a cross company bus ticket for use within Southampton to enable easier travel from the City to the hospital. This should be priced competitively with existing operator day tickets – e.g. First day ticket rather than the Solent Travelcard which covers a greater area and is therefore more expensive. Consideration also be given to how they can work better with train providers on this issue and the promotion of Plusbus add-on tickets.***	Bus Companies	Dec 2013	A Solent Travelcard already exists for this purpose. This is due to transfer to a "smart ticket" in late 2014 with a Southampton only version to be introduced late 2014. Plusbus is a commercial product which allows bus travel on all companies services within to be added to a return or season train ticket at a discount over a Solent or bus operator specific ticket. There are strict rules laid down by both the Competition Commission and DfT on multi-operator ticketing including pricing which is reflected in the existing Solent Travelcard. Specific Multi-Operator tickets to one specific location may be in conflict with these and are not planned to be developed as this will be covered by the Solent Travelcard migration to smartcard referred to above. ***Update:*** *The target date for the introduction of a Southampton version of the Solent Travelcard is July 2014.*

16	***UHS to share their forthcoming travel plan with SCC Transport Officers by April 2013 and ensure that the plan details clear lines of accountability for actions and is refreshed yearly and fully updated every three years. The final plan should also be shared with HOSP. SCC officers to support UHS to complete the implementation of the travel plan. UHS should ensure they share and learn from best practice on travel planning including working with Southampton University.***	UHS	July 2013	UHS are developing a new Travel Plan as the previous Travel Plan is no longer being used. The revised version is due to be submitted to SCC for review and approval later in the year. The timetable by OSMC needs to be amended to reflect this. ***Update:*** *A draft travel plan has now been submitted to the Council*
17	***Chair of HOSP to write to all partners with recommendations, seeking a response on what they accept, what timings they can commit to, and detailing any additional resources they are willing to provide.***	HOSP	May 2013	Noted

This page is intentionally left blank

DECISION-MAKER:		HEALTH AND OVERVIEW SCRUTINY PANEL		
SUBJECT:		SOUTHAMPTON SAFEGUARDING ADULTS BOARD: ANNUAL REPORT 2012-13		
DATE OF DECISION:		21 NOVEMBER 2013		
REPORT OF:		DR CAROL TOZER, INDEPENDENT CHAIR OF THE SOUTHAMPTON SAFEGUARDING ADULTS BOARD		
CONTACT DETAILS				
AUTHOR:	Name:	Carol Valentine	Tel:	023 8083 4856
	E-mail:	carol.valentine@southampton.gov.uk		
Director	Name:	Alison Elliott	Tel:	023 8083 2602
	E-mail:	alison.elliott@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY
n/a

BRIEF SUMMARY

To report on the Southampton Safeguarding Adults Board, Annual Report 2012-13.

RECOMMENDATIONS:

(i) That the Panel note the annual report of the SSAB and consider if there are any issues that may need to be brought forward to a future HOSP meeting.

REASONS FOR REPORT RECOMMENDATIONS

1. To update the Panel on the activity and outcomes of the Southampton Safeguarding Adults Board.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

None

DETAIL (Including consultation carried out)

Carole Tozer, was appointed as the Independent Chair of the Southampton Safeguarding Adults Board (SSAB) in September 2012 and chaired her first meeting in November 2012.

2. The role of the independent chair of the board is to:
   - Provide informed support and challenge to the work of all agencies working with adults at risk in Southampton;
   - Ensure that the SSAB operates effectively (setting clear, evidence informed, priorities for multiagency working and driving progress towards meeting those priorities and targets);
   - Commission Serious Case Reviews where needed (and to ensure that any recommendations are enacted by SSAB members);

- Ensure that the SSAB contributes effectively to broader work and other partnerships devoted to the wider safety and wellbeing of adults at risk.

3. 2012/13 has been an exceptionally busy year. This 2012/13 Annual Report is grounded in the key questions issued by the Association of Directors of Adult Social Services and the Local Government Group in late 2011:
    - How do you demonstrate that people's lives are improved as a result of safeguarding? Are they and do they feel safer and are their circumstances improved?
    - Has safeguarding (and dignity) been subject to some form of independent scrutiny or checking? What has changed as a result?
    - What can you tell your local population about the quality and safety of local services – Personal Assistants, care at home, care homes and hospitals etc?
    - What can you tell your local population about police and criminal justice sectors' responses to safeguarding?
    - How is your SAB demonstrating its effectiveness?

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

4. Carol Valentine, Head of Personalisation and Safeguarding, will present the report to the Panel as the independent chair, Carole Tozer, has stood down and a new independent chair is in the process of being appointed.

5. The Panel is recommended to note the Southampton Safeguarding Adults Board Annual Report 2012/13 and consider if there are any issues that may need to be brought forward to a future HOSP meeting.

RESOURCE IMPLICATIONS

Capital/Revenue

5. None

Property/Other

6. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

7. None

Other Legal Implications:

8. None

POLICY FRAMEWORK IMPLICATIONS

9. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	ALL

SUPPORTING DOCUMENTATION

Appendices

1.	Southampton Safeguarding Adults Board: Annual Report 2012/13

Documents In Members' Rooms

	None

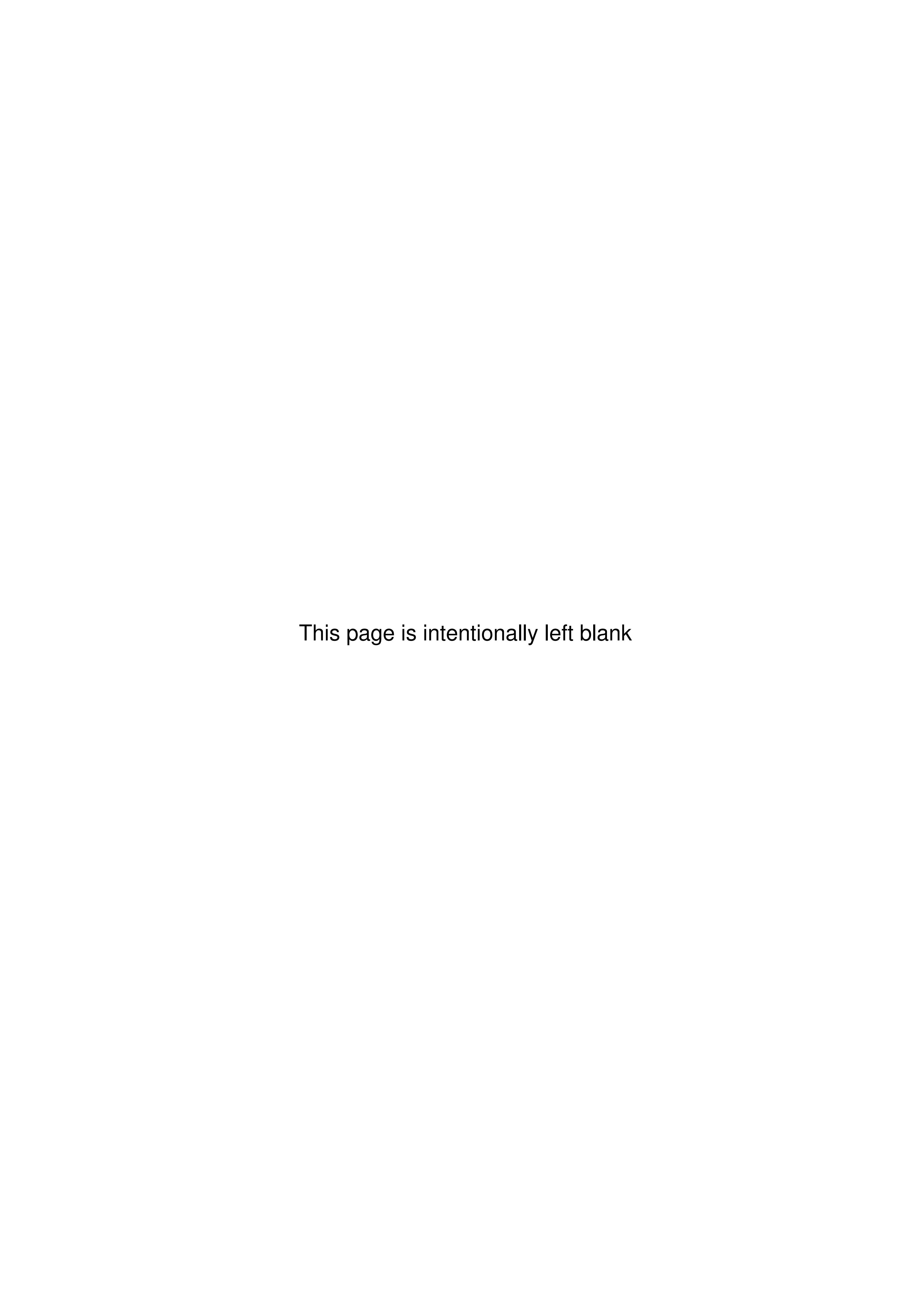
Equality Impact Assessment

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

Other Background Documents

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

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



This page is intentionally left blank

Southampton Safeguarding Adults Board

Annual Report 2012 – 2013

Foreword by the Independent Chair

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

adults at risk. As an independent chair, my role is to add value to the quality and impact of safeguarding adults partnerships and practice locally, focussing clearly on the best interests of adults at risk. It is with this independence in mind that I write this foreword.

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

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

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

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

1) How do you demonstrate that people's lives are improved as a result of safeguarding? Are they and do they feel safer and are their circumstances improved?
2) Has safeguarding (and dignity) been subject to some form of independent scrutiny or checking? What has changed as a result?
3) What can you tell your local population about the quality and safety of local services – Personal Assistants, care at home, care homes and hospitals etc?
4) What can you tell your local population about police and criminal justice sectors' responses to safeguarding?
5) How is your SAB demonstrating its effectiveness?

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

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

Dr Carol Tozer
Independent Chair
SSAB

9 August 2013

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

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

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

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

- personalised safeguarding by focusing on people and the outcomes they want;
- Collaborative leadership as the key to cross agency engagement and effectiveness in the safeguarding agenda;
- Effective interfaces with Health and Wellbeing Boards, Community Safety Partnerships, Safeguarding Children Boards, etc.;
- Access to responsive specialist services so that there are a range of responses and options to support people with difficult decision making;
- Proportionate safeguarding so that our systems are not swamped and we do not miss the really serious concerns;
- Fully integrating commissioning, contracts management, care management review and safeguarding intelligence;
- Availability of good quality local services which prevent abuse and afford people dignity and respect;

- Access to criminal and/or restorative justice so that some people get extra support to challenge and change harmful or abusive situations, and arrange services and supports that meet the outcomes they want and
- Effective preventative work and early intervention to address risks before they reach crisis point.

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

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

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

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

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

- Co-ordinating what is done by each agency represented on the Board for the purposes of safeguarding and promoting the wellbeing of adults at risk in the area of the authority;
- Ensuring the effectiveness of what is done by each such person or body for that purpose and
- Increasing community involvement and awareness of Safeguarding Adults to ensure the principle that 'Safeguarding is Everybody's business' is promoted.

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

3. Who are adults at risk in Southampton?

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

1) *has needs for care and support (whether of not the local authority is meeting any of those needs),*
2) *is experiencing, or is at risk of abuse or neglect,* ***and***
3) *as result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.*

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

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

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

3.5 SSAB has recognised that the number of safeguarding referrals received provides only a narrow window to understand the nature and prevalence of risk/harm experienced by local vulnerable people and for this reason, it has recently introduced an Integrated 'Adults at Risk' Monitoring Tool. The information provided will enable a more realistic picture to emerge and will, over time enable SSAB to monitor the effectiveness of a wide range of processes aimed at safeguarding local people and to target preventive work in key areas based on the intelligence provided.

3.6 SSAB recognises that learning from experience is the key to improving the safety of adults at risk locally. To that end, the Board commissioned a report on the circumstances surrounding the tragic death of Mr A. It developed a robust action plan to improve practice locally and has evaluated how actions have improved safety of vulnerable adults locally. Adult safeguarding was represented on the Domestic Homicide Review Panel regarding Miss Y. The Board also recently reviewed the report and recommendations arising from the report and will be ensuring that action is taken over the next year to

improve safety for those at risk of domestic abuse. During 2012/13, there been four serious case review referrals relating to Southampton residents. None of these resulted in a serious case review being commissioned by the Board as the chronologies provided highlighted that the cases referred did not meet the criteria. However, where chronologies highlighted potential learning, further actions were taken for example, by SSAB commissioning an overarching review of cases in one local NHS trust to identify trends and root causes regarding a number of suicides and another NHS Trust undertaking a trend Serious Incident Requiring Review (SIRI) into a number of serious safeguarding concerns raised regarding one of its services.

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

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

Making a Difference: safeguarding against financial exploitation

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

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

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

Making a difference: safeguarding against 'mate crime'

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

Making a difference: keeping people safe in care settings

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

5. Review of the SSAB Business Plan 2012/13

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. SSAB Actions and Priorities 2013/14

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

Board management:

- Produce a Safeguarding Strategic Plan each financial year setting out how it will protect people at risk of harm and what each member organisation will be doing to implement the strategy. The Strategy will be developed in consultation with Health Watch and the local community.
- Review Board membership to ensure service user and family carer representation, Lead GP, Health Watch, Crown Prosecution Service and the Police and Crime Commissioner.
- Member organisations to conduct the Safeguarding Organisational Self Assessment and collated results reported to SSAB.
- SSAB to participate in the LGA Peer Review.
- At the end of the financial year, publish an annual report in May 2014 on its achievements, members' activity and findings from any Serious Case Reviews.
- Update the SSAB Media and Communications Protocol.
- Produce a SSAB Dispute Resolution Protocol.
- Review Task and Finish Groups to reflect 2013/14 Priorities.

Governance:

- Implement clear reporting arrangements and assurance that safeguarding is embedded in the strategies and plans of the Council and its partners.
- Maintain clear links with the Overview and Scrutiny Committee, Cabinet and portfolio holders.
- Regularly review governance arrangements to anticipate and quickly respond to outside organisational changes.
- Finalise and implement the Serious Case Review (Safeguarding Reviews) process and reporting arrangements.
- Implement a process for keeping track of action plans and implementation of recommendations
- Actively monitor the implementation and impact of local action plans regarding Winterbourne View and the Francis Report.
- Implement a Pilot the ‘Learning Together’ (Systems Learning Approach) for cases with bad outcomes but falling short of SCR criteria.

Robust performance monitoring and quality assurance mechanisms:

- Implementation of the Integrated Dashboard
- Implementation of User Feedback Tool
- Implementation of a multi agency + single agency safeguarding audit programme.
- Development of pan Hampshire approach and shared I statements

Operational Developments

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

Partnership working

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

Workforce Development:

Review the multi agency safeguarding training strategy.

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

8. Recommendations

8.1 SSAB to endorse and ratify the Annual Report.

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

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

- SSAB Independent Chair to present to People Director, Overview and Scrutiny Committee, Council Management Team and Health and Wellbeing Board.
- SSAB member organisations to present to chief officers and relevant strategic forums within their own organisations.

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

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

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		INTEGRATED COMMISSIONING UNIT		
DATE OF DECISION:		21 NOVEMBER 2013		
REPORT OF:		DIRECTOR OF QUALITY AND INTEGRATION		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Stephanie Ramsey**	**Tel:**	**023 80**
	E-mail:	**Stephanie. Ramsey @southampton.gov.uk** **Stephanie.Ramsey@southamptoncityccg.nhs.uk**		
Director	**Name:**	**Alison Elliott, Director of People, SCC** **John Richards, Chief Executive, CCG**	**Tel:**	**023 80832602** **02380296923**
	E-mail:	**Alison.Elliott@southampton.gov.uk** **John.Richards@southamptoncityccg.nhs.uk**		

STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

The development of an Integrated Commissioning Unit (ICU) between Southampton City Council (SCC) and Southampton City Clinical Commissioning Group (CCG) was formally agreed by both SCC Cabinet the CCG Governing Body in October 2013. This approach has been identified by both organisations as a key priority to achieve outcome and evidence based commissioning.

The aim of the remodelling is to develop a structure with appropriately skilled staff who will achieve quality outcomes and efficiency savings through more focussed, integrated work. Redesigning and commissioning integrated services will improve quality and outcomes and result in more effective use of resources and cost avoidance and as a consequence release savings

Overview and Scrutiny Management Committee on 10th October 2013 requested that the Health Overview and Scrutiny Panel monitors progress of the ICU and how the Council and CCG are maximising opportunities to pool budgets.

This report is an initial report on the performance criteria and work programmes prioritised by the ICU and an overview of key quality issues.

RECOMMENDATIONS:

That the panel

(i) Note the progress of the Integrated Commissioning Unit in achieving work programme, performance and finance outcomes

(ii) Considers the issues outlined in this report and, following a discussion, agrees future requirements for the Performance and Quality report to HOSP.

REASONS FOR REPORT RECOMMENDATIONS

1. Overview and Scrutiny Management Committee on 10th October 2013 requested that the Health Overview and Scrutiny Panel monitors progress of the ICU and how the Council and CCG are maximising opportunities to pool budgets.
2. The ICU is being developed and allows for an integrated approach to performance and quality monitoring

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. None

DETAIL (Including consultation carried out)

Background to Integrated Commissioning Unit

4. The Integrated Commissioning Unit has three main aspects:
    - System redesign to achieve the commissioning priorities for system transformation. Assessing need, undertaking consultation with stakeholders, redesigning services and pathways, developing and monitoring specifications.
    - Quality which will integrate the functions across the CCG and SCC and support a stronger, more consistent approach to expectations of and outcomes from providers
    - Provider relationships to allow a much more proactive approach to development and management of providers, build on community assets, work with other commissioners and ensure strong contract management
5. Quality and effective contract management from a quality aspect are key elements to achieving positive outcomes for residents and improvements in core services along with the opportunity to ensure best value and reduced costs. High profile cases nationally and locally, such as Winterbourne, Francis enquiry into Stafford hospital and local serious case reviews, have emphasised the need for this area of work to be well led, co-ordinated and thorough. The staff undertaking this work across the CCG and People Directorate are in the process of being combined as one team responsible for quality monitoring and reviewing
6. The ICU is under the strategic oversight of the Health and Wellbeing Board. The Council and Southampton City CCG have established an accountability structure including an Integrated Commissioning Board with Chief Executive and Director representation. The key commissioning priorities that the Council and CCG wish to work on together have been identified and detailed work and relevant project plans support these. Commissioning principles have been agreed by both organisations. The final accountability remains with Cabinet and the CCG Governing body as appropriate. As part of the accountability structure Health Overview and Scrutiny are overseeing the effectiveness of the unit. The work of the ICU is underway in shadow form and will be formally launched in December once all posts have been through the matching process.

Performance

7. The System redesign workstreams in the ICU are based on the outcomes in the Health and Wellbeing Strategy and are:
   - Promoting Prevention and Positive Lives – to enable more people to live healthier, more active and fulfilling lives and a focus on protecting the vulnerable
   - Supporting families – to support families to take responsibility for their own outcomes, refocusing investment towards those most in need and early targeted intervention
   - Integrated Care for Vulnerable People – to prevent or intervene early to avoid, reduce or delay the use of costly specialist services whilst promoting independence, choice and control in the community through integrated risk profiling and person centred planning process and commissioning to achieve the integration of provision

8. Projects and performance measures have been defined under each of the above workstreams. These are outlined in Appendix 1 along with update on progress.

9. Significant progress has been made in reporting and identifying performance indicators but there are still on-going problems with sourcing data, especially due to difficulties in accessing both SCC and CCG systems. There is a need to further develop indicators to ensure they are linked specifically to ICU performance (as opposed to high level outcomes or specific service level performance). Projects have been reprioritised in relation to delivery of savings, quality/service sustainability, strategic priority or policy / legal imperative.

10. The majority of projects are on target with some slippage for substance misuse, domestic violence and domiciliary care commissioning reviews and tenders, although these present no major implications. A number of potential risks have been flagged many of which relate to capacity within the team whilst structures are still be recruited to.

Quality

11. The ICU is developing an overarching quality reporting framework. The proposal is to provide HOSP ,by exception, the key quality of care issues for the main provider organisations along with actions being taken to improve the issues identified. Progress against all actions will be reviewed at the regular Clinical Quality Review Meetings (CQRM) with the relevant provider.

12. An element of this exception report will be to provide the latest assessment against NHS England CCG Assurance Framework 2013/14

13. Appendix 2 contains the latest self-assessment against the quality section of the NHS England CCG Assurance Framework 2013/14 outlining Southampton City CCG position for August 2013. The framework assesses provider and CCG performance and is it noted that currently Southampton City CCG is reported as Amber/Green. For those areas which the CCG is unable to respond positively action plans are in place – these include MRSA reduction, eliminating mixed sex accommodation, safer surgery action plan all at UHSFT and Serious Incidents Requiring Investigation (SIRI)

management at SCCCG level.

Current performance issues

14. Clostridium difficile infection remains a challenge to SCCCG with 30 cases against a trajectory maximum of 22 for the end of August 2013. A detailed report on the analysis of cases Clostridium difficile within Southampton City CCG has demonstrated that there is no specific link between the cases reported in the first 5 months of this year. An awareness raising campaign is being planned in conjunction with the medicines management team.

15. MRSA Bacteraemia – During September a MRSA case was identified at UHSFT. This has subsequently been confirmed as a contaminant i.e. the patient did not have the infection in their blood stream but on taking the blood sample MRSA probably from the patient’s skin found its way into the sample. This usually indicates poor blood collection technique and UHSFT have taken immediate action to retrain the staff involved in this situation.

16. Patient-Led Assessment of Care Environment or PLACE – Patient led assessments of the care environment are a self-assessment of a range of non-clinical services which contribute to the environment in which healthcare is delivered in both the NHS and independent/private sector in England. The PLACE programme aims to promote the following values and principles

    - Putting patients first
    - Actively encouraging feedback from the public, patients and staff to help improve services
    - Striving to be the basics of quality of care right
    - A commitment to ensure that services are provided in a clean and safe environment that is fit for purpose

17. These assessments were introduced in April 2013 to replace the former Patient Environment Action Team (PEAT) assessments which had been undertaken since 2000. The Key findings from the 2013 assessments were:

    - 1,358 assessments were completed
    - National average score for cleanliness was 95.74%
    - National average score for food and hydration was 84.98%
    - National average score for privacy dignity and wellbeing was 88.87%
    - National average score for condition appearance and maintenance was 88.75%

18. Local providers overall scores are in the table below:

PLACE 2013 Scores	UHSFT	Solent	SHFT	STC
Cleanliness	97.30%	93.83%	98.66%	*100%
Food and Hydration	88.72%	*96.29%	84.56%	*93.91%
Privacy, dignity and wellbeing	90.68%	*93.84%	90.91%	91.05%
Condition appearance and maintenance	*94.16%	92.20%	90.24%	*96.25%

	Lowest quartile
	Below average but in interquartile range
	Above average but in interquartile range
* %	Highest Quartile

19. Eliminating mixed sex accommodation – UHFT have had 5 further breaches during September, with 2 Southampton City CCG patients affected. The Associate Director of Quality has been in discussion with UHSFT about these breaches and also concerns about the number of clinical justified breaches in assessment areas. UHSFT have agreed to review the current method of recording breaches as there have been some concerns that breaches may be over reported. Work is also underway to understand the root causes of the non-clinically justified breaches. Support has been offered to UHSFT to work together to improve this situation.

20. Nursing homes – there continue to be concerns about a number of homes , including some of those with the highest number of beds. This situation coming into the winter is undoubtedly placing additional pressure on the system, both in terms of the ability for patients from hospital and community settings to be placed in nursing homes when needed and the additional support needed from SCC and SCCCG staff in monitoring and supporting these homes to drive up the quality of care provision. It should be noted that 4 of the homes with issues are owned by a national company and work is underway with the regional management team to improve standards of care and management in these homes.

21, A number of actions are currently underway to endeavour to resolve the situation facing this sector, these include

- Regular visits to and meetings with providers who are currently suspended to monitor action plans and drive up standards
- Contract and quality assurance monitoring undertaken by the Quality Assurance Team within SCC. This work forms part of the new Integrated Commissioning Unit and to support this activity SCCCG Quality team is already working with SCC to enhance this process with registered nurses participating in the assurance monitoring visits.
- The Continuing Healthcare team within SCCCG provide one to one support with individual clients, training and support to nursing homes on the provision of aspects of nursing care and monthly meetings with the managers of the Nursing Homes to provide clinical managerial support

and information about the continuing healthcare process. Systems are also being put in place to strengthen contractual processes and link quality requirements to SCCCG priorities for health. This work will be continued and built on further within the new integrated commissioning unit to reduce duplication and set shared standards across both SCCCG and SCC contracts.

- A scheme is in development to provide nursing home registered managers with leadership training. Much of the training that has been provided focuses on particular clinical skills e.g. pressure ulcer prevention, catheter care and managerial tasks, but does not appear to have focused on the managers of these homes as clinical leaders. Using expertise from Health Education Wessex a leadership programme is being developed which will be completed by 31st March 2013 with a focus on developing the leadership skills of the registered managers.
- Safeguarding in provider services team are providing health and social care support to nursing homes monitoring visits and training for staff to support driving up standards
- Learning from good performing homes, a piece of work is being undertaken with one of the nursing homes with sustained good performance to determine what can be learned and where possible transferred to other settings
- Additional resources have been secured for the winter period to support those homes suspended from placements. This support is aimed at advising the registered managers to assist them in regaining placement status in their homes
- A number of homes have commented on the challenges of recruiting registered nurses in Southampton however at this time it is not clear that the main homes with this challenge have proactive recruitment campaigns underway in the city and surrounding area. Support is being provided via the contract meetings including the potential development of holding a city-wide recruitment fair for this sector.
- SCC and SCCCG are working with the Care Quality Commission to ensure that where possible intelligence on these homes is being shared appropriately so the relevant agency can take appropriate action in conjunction with partners.

22. Residential Homes – the ICU have been working closely with G&A Homes in Southampton following poor CQC inspection reports and poor reports following SCC quality assurance visits. Many concerns related to the upkeep of the homes and a lack of investment, but included some concerns about staffing levels. G&A Homes own three Southampton residential care homes and a further home in Eastleigh.

23. We are working with G&A Homes and local staff to resolve the outstanding quality issues – requiring improvement plans, regular meetings with the registered managers and on-going reviews of quality standards

RESOURCE IMPLICATIONS

Capital/Revenue

24. Total savings of £1,495k have been delivered at month 5. The QIPP non-elective admissions projects are currently delivering savings but winter pressures may cause significant pressure towards achieving the year-end savings for the CCG.

Property/Other

25. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

26 A Memorandum of Agreement will be in place between the CCG and SCC outlining key principles covering financial, personnel, accountability, approaches with disagreements and evaluation/outcome measures. Staff will be covered within Section 113 (Pursuant to Section 113 (1A)(b) Local Government Act 1972) agreements

27 The Health and Social Care Act 2012 places a requirement on the NHS Commissioning Board, Clinical Commissioning Groups, Health and Wellbeing Boards and Monitor to encourage integrated working at all levels. The Act encourages local government and the NHS to take much greater advantage of existing opportunities for pooled budgets, including commissioning budgets and integrating provision

Other Legal Implications:

28 None

POLICY FRAMEWORK IMPLICATIONS

29 The work priorities for the unit are informed by the Joint Strategic Needs assessment and align to the Health and Wellbeing Strategy. The work of the unit will contribute significantly to the achievement of outcomes outlined in the Health and Wellbeing strategy and City Council Plan as well as the CCG Strategic Plan

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Integrated Commissioning Unit Performance Update
2.	NHS England CCG Assurance Framework 2013/14 – Southampton City CCG

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No – assessments will be undertaken with each piece of commissioning work

Other Background Documents

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

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

Appendix A

Health Overview and Scrutiny Panel	
Report Theme	Integrated Commissioning Unit (ICU) Performance Update
Date:	11th November 2103
Report Author:	Phil Lovegrove, NHS Southampton City

1 Headline Messages

The establishment of an Integrated Commissioning Unit (ICU) between Southampton City Clinical Commissioning Group (SCCCG) and Southampton City Council (SCC) consultation closed on 31 August and Cabinet and CCG Governing Body approved the proposal. The matching process has now begun and will be finalised by end November .

With regard to performance indicators, significant progress has been made in reporting/identifying indicators but there are still on-going problems with sourcing data due to time constraints in producing other scorecards and difficulties in accessing both SCC and CCG systems. There is a need to further develop indicators to ensure they are linked specifically to ICU performance (as opposed to high level outcomes or specific service level performance). Projects have been reprioritised in relation to delivery of savings, quality/service sustainability, strategic priority or policy / legal imperative as there are currently too many.

Total savings of £1,495k have been delivered at month 5. The QIPP non-elective admissions projects are currently delivering savings but winter pressures may cause significant pressure towards achieving the year-end savings.

The majority of projects are on target with some slippage for substance misuse, domestic violence and domiciliary care, although these present no major implications. A number of potential risks have been flagged many of which relate to capacity within the team whilst structures are still be recruited to (i.e. Buyers team, day-care and residential review, teenage pregnancy strategy).

2 Positive Lives / Prevention Workstream

2.1 Project Updates

Project	Progress Update
1. Diabetes Service Redesign	Locality projects scoped and commissioning intentions being developed. Continue to work with providers to review services as move towards integrated model of care
2. Heart failure services review	Review current service provision with stakeholder engagement - Nov 13
3. COPD Integrated Service	Service specification reviewed and formally submitted to provider for contract sign off
4. Sexual Health Services review	Review commenced; to confirm commissioning intentions by January 2014
5. Teenage pregnancy strategy refresh	Delay - Commissioner capacity but post now appointed to
6. Integrated Substance misuse service tender	PQQ complete, ITT stage about to commence. Aim for new service to commence on 1 April 2014
7. IAPT retender	ITT complete. Aim for new service to commence on 1 April 2014
8. Health Promotion Service Review	Review commenced

2.2 Performance Indicators

Period	Indicator	YTD Actual	YTD Target	+ / - Target	2012/13	+ / - 2012/13
M6	Chlamydia diagnostic rate in young people (15-24)	1702	1933	-231	1303	399
M5	% with a planned exit from drugs service - Opiate	11.1%	11.0%	0.1%	10.0%	1.1%
M5	% with planned exit from Drugs service - non Opiate	53.4%	37.0%	16.4%	32.9%	20.5%
M5	Smokers who set a quit date that have quit at 4 weeks	342	330	12	387	-45
Qtr 1	% successfully achieving health trainer goals	205	154	51		
Qtr 1	NHS Health Check programme - % offered	14.2%	Data not consistent with previous years due to change in delivery			
Qtr 1	NHS Health Check programme - % take up	46.7%				

3 Supporting Families Workstream

3.1 Project Updates

Project	Progress Update
1. School Nursing Commissioning Review	Review in progress. Aim to confirm commissioning intentions by December 2013
2. 0-5 year old commissioning and early help service	Strategy drafted - linked to Children's Transformation Programme. Good progress on development of early help model - proposal drafted and being consulted upon widely.
3. Integrated domestic violence services	There has been a delay in handover of this work to commissioning. Current scoping current position.
4. Prevention and targeted early help - 5-19 year olds	Work has commenced as part of Children's Transformation Programme. Outline model drafted. Workshop sessions arranged for mid-October and mid-November
5. Carers strategy refreshed	Framework drafted; Procurement Timescale set for 23rd September - some slippage but recoverable
6. Joint short break tender	Out to advert. On target for 1 April 14. Review commenced of Kentish Road provision - due November 14.
7. Early Years provision	Numerical target exceeded for Sept 2013. Monitor demand/supply as parents/carers request places.
8. Child Exploitation	Scoping project

3.2 Performance Indicators

Period	Indicator	YTD Actual	YTD Target	+ / - Target	2012/13	+ / - 2012/13
M6	Number of New Referrals to Childrens Social Care	1,916			3,882	
Q1	Number of families turned around by Families Matter	45	Annual Target - 593			
M3	Average Monthly Sure Start Reach	30.8%			25.2%	5.6%
Q2	% New Births registered with Sure Start	65.8%	75%	-9.2%	82.8%	-17.0%
M6	No. of unplanned admissions for asthma, diabetes and epilepsy under 19s	96	84	-12	91	-5
M6	No. of emergency admissions for children with lower respiratory tract infections	41	52	11	50	9

4 Integrated Care for Vulnerable People Workstream

4.1 Project Updates

Project	Progress Update
1. MH redesign (CAMHS and AMH)	Agreement to proceed and look at 4 work areas- Primary care, employment and community integration, supported accommodation, inpatient rehab
2. Implementation Dementia Strategy	All Practices (with exception of Adelaide) have signed up for the DES, GP tutorial and education being delivered in November.
3. LD Complex Needs Housing Business Case	Business case in preparation; Work progressing with housing providers. Finding appropriate housing is now time critical for individuals living in Highlands Unit. Working with BEST RSL to undertake fit and proper tests and other local providers to financially model. CCG identified funding to transfer to SCC to grant fund RSL's to provide appropriate housing. Some slippage but will achieve year-end target.
4. SCC In-house LD respite review (short breaks)	Service review in progress
5. IPCC - locality implementation	Demonstrator site identified and small project team progressing - project manager with dedicated time identified. Nicholstown developing self management focusing on Asian and diabetic patients. New clinical lead now in post.
6. End of life: Delivery of EOL Strategy	3 practices now live with Electronic Palliative Care Coordination Systems (EPaCCS)
7. Telecare/Telehealth strategy	Strategy produced. Operational review underway with IT workshop due late September. Some minor slippage but due to complete by year end.
8. Person centred care/self management	Commissioning Framework complete. CQUIN (quality measure) in place and being monitored. Discussions underway regards a Long Term Conditions Strategy
9. Personalisation	Covers wide scope, agreed action plan to move to implementation. Action plan to be developed. Papers going to DMT and SMT late October.
10. Falls redesign	Evaluation group formed to review of existing pilot, to develop CQUIN for 2014/15 to introduce fracture liaison approach, to maximise outcomes from existing services and improve coordination.
11. Integration Transformation Fund (including review of reablement provision)	Review of existing Social Care Transfer/Reablement funded provision completed. Proposals for ITF due December for HWB in January prior to national submission 31 March 14. PID developed and fortnightly task and finish group meetings in place. Current focus of work is

	on scoping provision and financial modelling.
12. Advocacy reviewed and retendered	Scoping work
13. Review and re-commission Supporting people accommodation & support services	Scoping work
14. Domiciliary Care Tender	Slippage on going out to tender. Specification and packaging of procurement under review and due to complete December 14. Contract start date likely to slip beyond June 14.
15. Re-commissioning sheltered housing	Some slippage - draft strategy circulated and on track to be agreed by Apr 14. Options on extra care being developed
16. Wheelchair re-tender	Agreement reached for collaborative tender across SHIP with West Hampshire CCG acting as Lead in the Procurement. 60% funding has moved to Spec Commissioning which will be part of tender; PQQ issued 30th July 2013. Specification developed. ITT's issued to 5 organisations - ITT Evaluation 06/11-19/11/13
17. Remodel children's continence service	Slippage but on-track to deliver spec by Dec
18. Implementation new JES	New service went live 1 July. Service working through backlog of work.
19. Roll out of CYPDS - 0-25 EHC Plan, local offer, personalisation, integrated 0-25 provision	Workshops held in September and early October on 0-25 service; proposal being scoped and further workshop planned for 21 October. There are problems with capacity to collate health and social care information for local offer which are being discussed (including potential to link in with Children's Transformation work).
20. Children's continuing care package redesign / South East collaborative tender for SEN and CLA	Agreed with Solent that 2 packages will transfer in October; Solent about to commence recruitment Hampshire now identified as lead authority - progressing to plan
21. Deliver CHC Programme Plan	43% of annual reviews completed (aim is 80% by Mar 14. 100% of EMI post 3 month placement reviews has been met.
22. Reviewing above standard cost placements	Scoping work

4.2 Performance Indicators

Period	Indicator	YTD Actual	YTD Target	+ / - Target	2012/13	+ / - 2012/13
M7	Electronic Palliative Care Co-ordination System (EPACCS) in 70% of GP practices	8%	70% by Year End			
Q2	Percentage of CLA in residential placements	2.8%	Benchmarking			
Q2	Number of Children Looked After placed with IFA foster carers	100	Benchmarking			
M6	Number of children whose families are in receipt of direct payments	38			29	
M6	Number of clients with Direct Payments at month end	383			373	
M6	Reduced delayed transfers of care from hospital per 100,000 population	9.8	9.4	-0.4	12	2.0
M5	Unplanned hospitalisation for chronic ambulatory sensitive conditions - proxy (number)	1475	1569	94	1578	103
M6	% DOM clients using non-framework providers	36.1%	25%	-10.5%	33.6%	-1.9%

5 Savings Performance – Month 5

Total savings of £1,495k have been delivered at month 5. The QIPP non-elective admissions projects are currently delivering savings but winter pressures may cause significant pressure towards achieving the year-end savings.

Indicator	13/14 Target	M5 Target	M5 Actual	+ / - Savings Target
NHS Southampton City CCG QIPP Savings				
Non-Elective Admissions				
- Ambulatory Care Sensitive (ACS)	-£28k	-£12k	-£203k	£191k
- End of Live Care	-£27k	-£11k	-£8k	-£3k
- Paediatric Medicine	-£45k	-£19k	-£45k	£26k
- COPD (including Excess Bed Days)	-£310k	-£129k	-£42k	-£87k
Outpatients – Paediatric Medicine	-£18k	-£11k	-£18k	£7k
TOTAL	**-£428k**	**-£128k**	**-£316k**	**£134k**
Southampton City Council Savings				
Review use of Social Care transfer funding via NHS.	-£2,380k	-£992k	-£992k	£0k
Provider Services City Care - reablement services	-£600k	-£250k	-£250k	£0k
Supporting People – staff, supplies and services	-£15k	-£6k	-£6k	£0k
Supporting People - budget reduction	-£85k	-£35k	-£35k	£0k
Adult Disability Commissioning - Advice & Info / Day Care	-£370k	-£154k	-£154k	£0k
Wellbeing - contract for specific support for HIV/Aids	-£33k	-£14k	-£14k	£0k
Mental Health Commissioning - substance misuse	-£105k	-£44k	-£44k	£0k
TOTAL	**-£3,588k**	**-£1,495k**	**-£1,495k**	**£0k**

This page is intentionally left blank

Agenda Item 9

Appendix 2

Appendix B

Southampton City
Clinical Commissioning Group

Are local people getting good quality care? Assessment for Aug-13

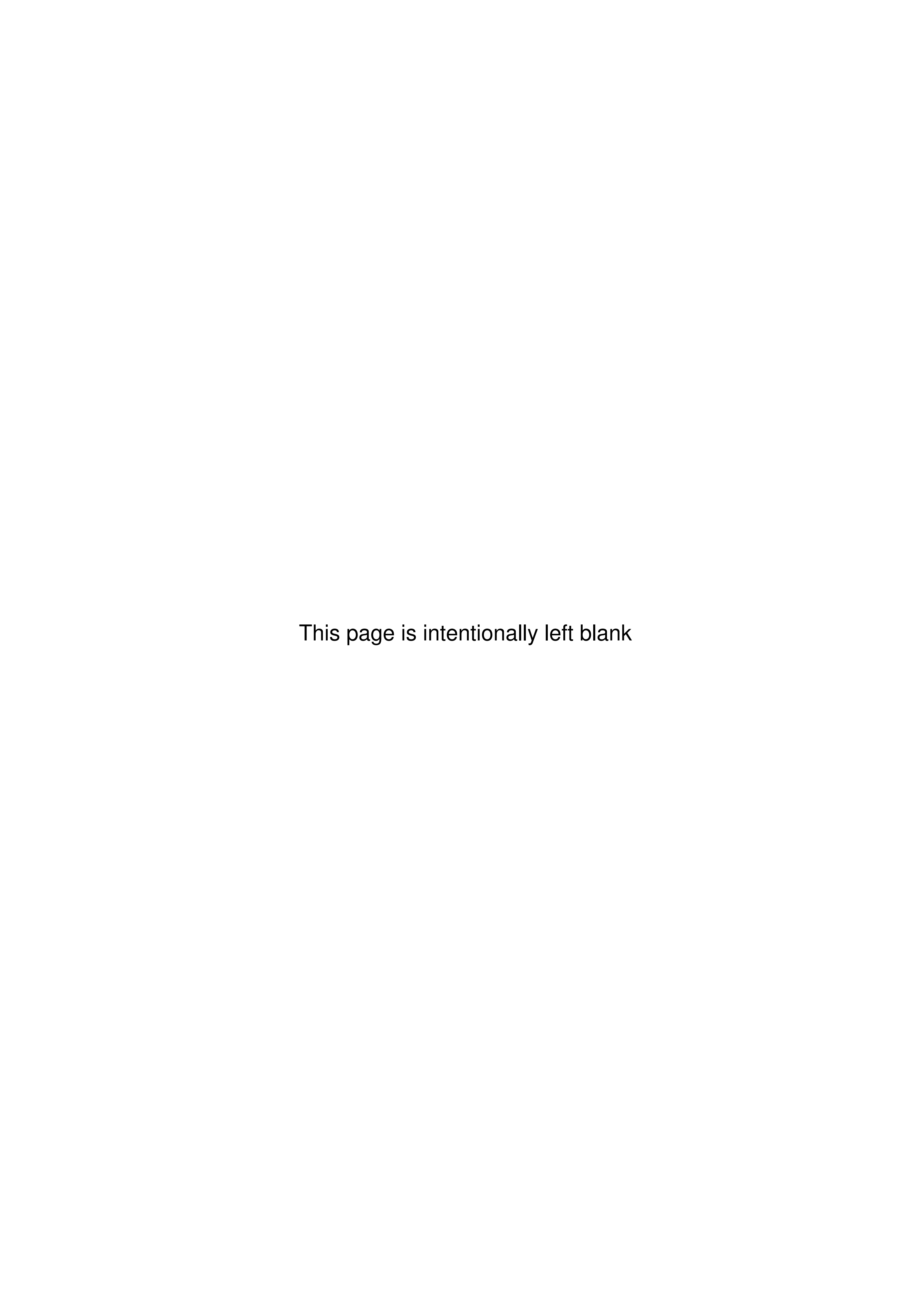
Providers:	UHSFT	Solent	SHFT	SCAS	STC
Has local provider been subject to enforcement action by the CQC?	No	No	No	No	No
Has local provider been flagged as as a quality compliance risk by Monitor and are there requirements in place around breaches of provider licence conditions?	No	N/A	No	No	N/A
Has local provider been been subject to enforcement action by the NHS TDA based on quality risk?	N/A	No	N/A	N/A	N/A
Does feedback from the Friends and Family test/or any other patient feedback indicate any causes for concern?	No	No	No	No	No
Has the provider been identified as a negative outlier on SHMI or HSMR?	No	No	No	No	No
Do provider level indicators from the National Quality Dashboard show that:					
MRSA cases are above zero	Q1 - Yes Q2 - No	No	No	No	No
the provider has reported more C difficile cases than trajectory	No	No	No	No	No
MSA breaches are above zero	Q1 - Yes Q2 - No	No	No	No	No
Does the provider currently have any unclosed Serious Untoward Incidents (SUIs)?	Yes	Yes	Yes	Yes	No
Has the provider experienced any Never Events during the last quarter?	Q1 - Yes Q2 - No	No	No	No	No

CCG:	
Clinical Governance	
Does the CCG have any outstanding conditions of authorisation in place on clinical governance?	No
Has the CCG self-assessed and identified any risks associated with the following:	
Concerns around quality issues being discussed regularly by the CCG governing body	No
Concerns around the arrangements in place to proactively identify early warnings of failing services	No
Concerns around the arrangements in place to deal with and learn from serious untoward incidents and never events	No
Concerns around being an active participant in its Quality Surveillance Group	No
EPRR	
If there was an emergency event in the last quarter, has the CCG self-assessed and identified any areas of concern on the arrangements in	No
Winterbourne View	
Has the CCG self-assessed and identified any risk to progress against its Winterbourne View action plan	No

Overall RAG rating by Month			
Apr-13	Amber / Green	Oct-13	
May-13	Amber / Green	Nov-13	
Jun-13	Amber / Green	Dec-13	
Jul-13	Amber / Green	Jan-14	
Aug-13	Amber / Green	Feb-14	
Sep-13		Mar-14	

Key to RAG rating
Green - all 'NO' responses
Amber/Green – One or more 'YES' responses but action plan in place that successfully mitigates patient risk
Amber-Red – One or more 'YES' responses and no action plan in place / plan does not successfully mitigate patient risk
Red – Enforcement action is being undertaken by the CQC, Monitor or TDA and the CCG is not engaged in proportionate action planning to address patient risk

Note - All Yes answers have action plans in place


This page is intentionally left blank

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		UNIVERSITY HOSPITAL SOUTHAMPTON; EMERGENCY DEPARTMENT REPORT		
DATE OF DECISION:		21 NOVEMBER 2013		
REPORT OF:		CHIEF EXECUTIVE, UHS		
CONTACT DETAILS				
AUTHOR:	Name:	Alison Ayres	Tel:	023 8079 6241
	E-mail:	Alison.Ayres@uhs.nhs.uk		
Director	Name:	Fiona Dalton, Chief Executive UHS		
	E-mail:	fiona.dalton@uhs.nhs.uk		

STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

Following the recent underperformance of the University Hospital Southampton Emergency Department A&E targets Fiona Dalton, USH Chief Executive, will introduce herself to the Panel and give the Panel an update on the progress to date.

RECOMMENDATIONS:

(i) That the panel notes the progress to achieve A&E targets at the University Hospital Southampton, and following discussions with the Chief Operating Officer agrees any issues that may need to be brought forward to a future HOSP meeting.

REASONS FOR REPORT RECOMMENDATIONS

1. As part of the HOSP's terms of reference the panel has a role to respond to proposals and consultations from NHS bodies in respect of substantial variations in service provision.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None

DETAIL (Including consultation carried out)

3. Following a prolonged period of underperformance against the 4-hour A&E operating standard during Q4 11-12 and Q1 12-13, and with encouragement from the CCG, University Hospitals Southampton (UHS) commissioned the national Emergency Care Intensive Support Team (ECIST) to undertake a review of the unscheduled care pathway within trust. The review took place in mid-June 2012 and the trust is now implementing the recommendations. The outcomes and recommendations of this review were reported to the panel on 31st January 2013.

4. Since the initial report Monitor, the health sector regulator, has announced that it is investigating whether the University Hospital Southampton NHS Foundation Trust has breached conditions of its licence due to persistent breaches of their A&E targets.

5. At the last panel meeting on 19 September 2013 the hospital outlined the latest UHS Emergency Department's performance. It was agreed by the panel to receive an update at future HOSP meeting until the situation at the emergency department is resolved. The latest update is attached at Appendix 1. A further update will be given at the panel meeting by Fiona Dalton, UHS Chief Executive.

6. The panel are asked to note the latest performance and consider any issues that may need to be brought forward to a future HOSP meeting.

RESOURCE IMPLICATIONS

Capital/Revenue

12. None

Property/Other

13. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

14. The powers and duties of health scrutiny are set out in the Local Government and Public Involvement in Health Act 2003.

Other Legal Implications:

15. None

POLICY FRAMEWORK IMPLICATIONS

16. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	ALL

SUPPORTING DOCUMENTATION

Appendices

1.	UHS: Update On Emergency Department Performance November 2013

Documents In Members' Rooms

	None

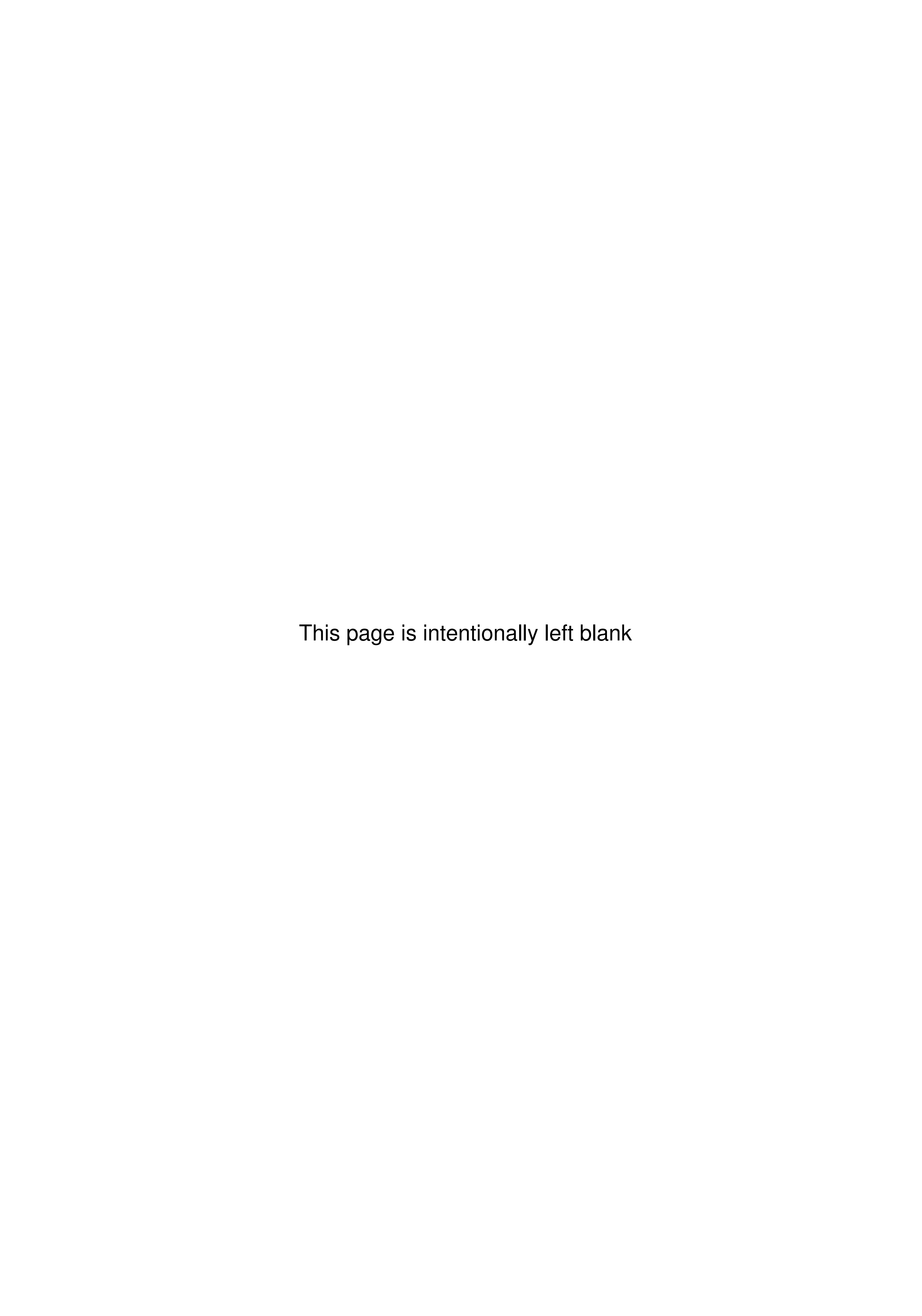
Equality Impact Assessment

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

Other Background Documents

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

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

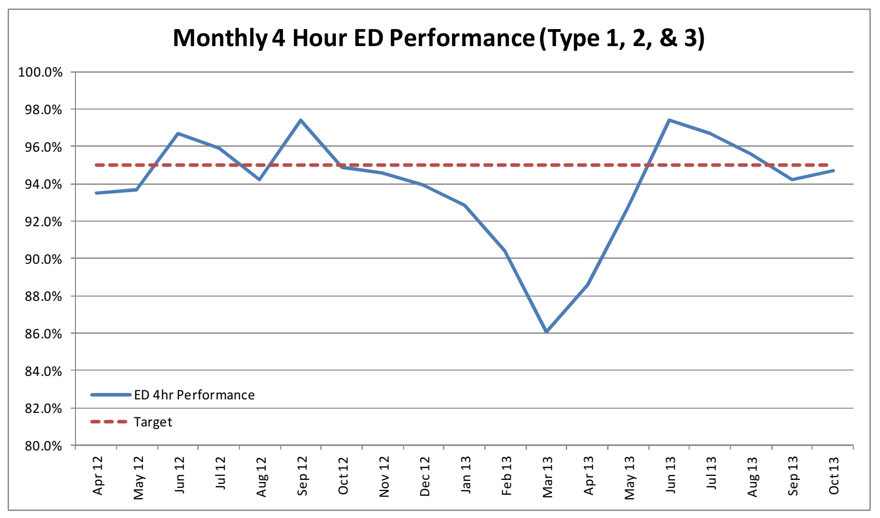


This page is intentionally left blank

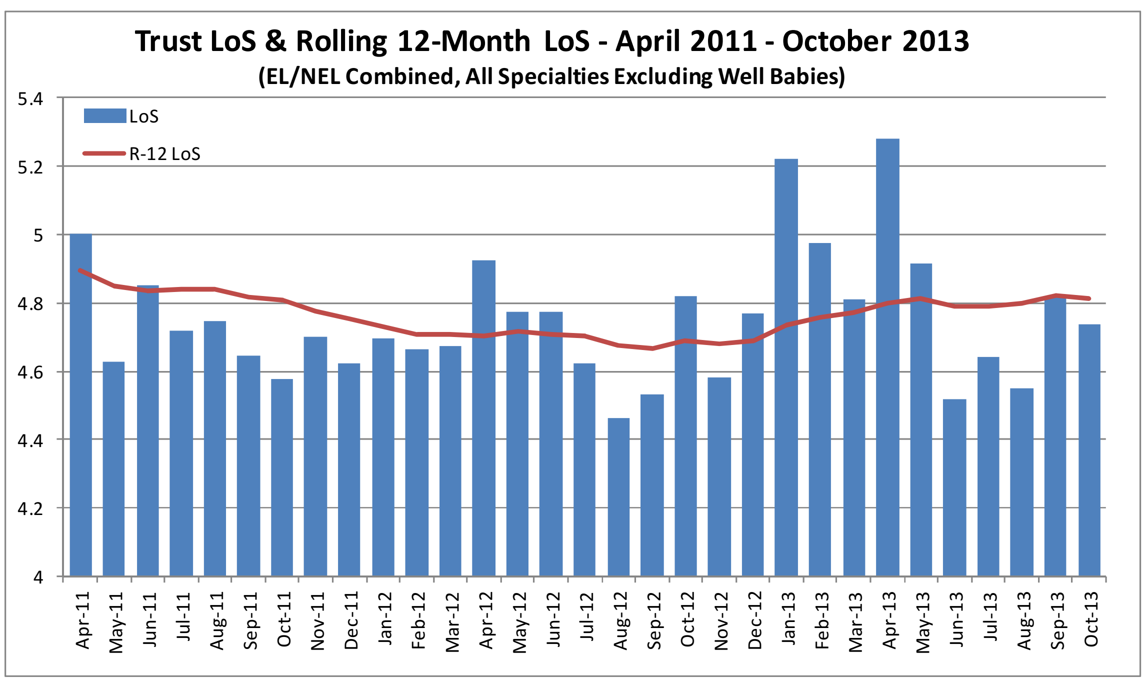
University Hospital Southampton NHS
NHS Foundation Trust

Emergency Department Report for Overview and Scrutiny Panel – November 2013

Following improvement in the ED performance in the last few months, the Trust met the target in the second quarter (July to September) and was just below target for October.

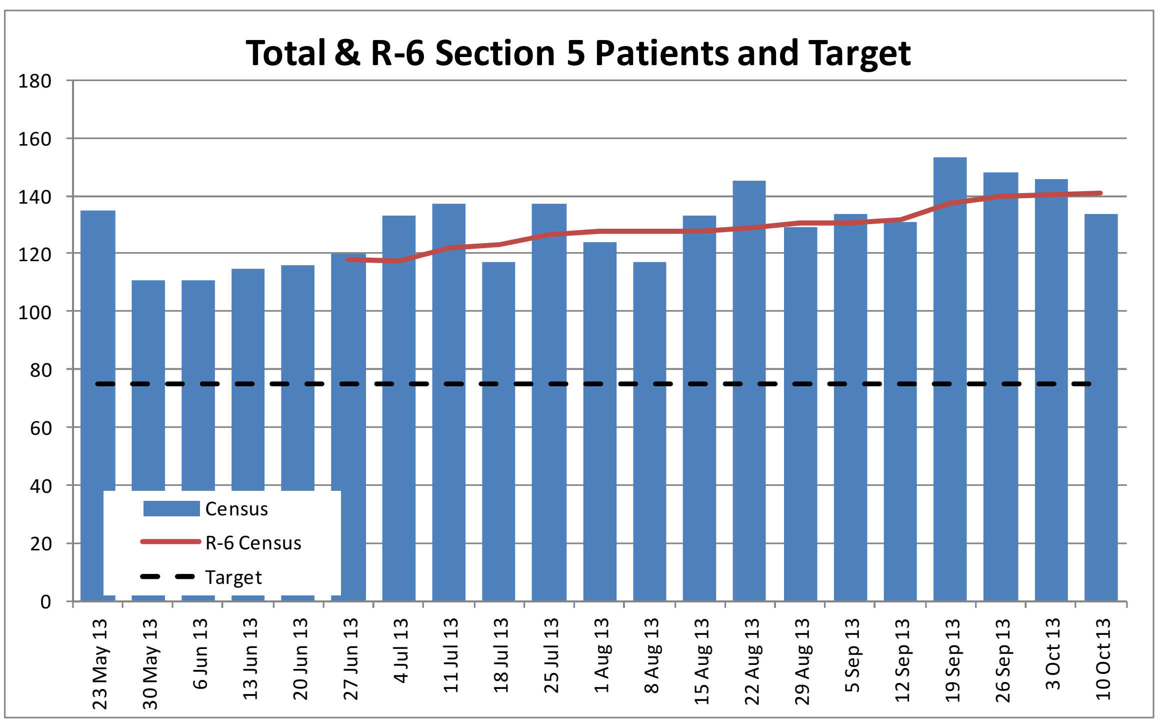


The bed availability situation improved in the hospital during the summer months allowing patients to be admitted in a timely manner. However, we are now experiencing an increasing length of stay and this has put pressure on the hospital system during October and November.



Delayed discharge of care (complex discharges) remains of particular concern. Whilst there has been some improvement in processing patients through the system, patients remain in hospital to undertake clinical and social assessments, or while waiting for the most appropriate facility or placement to become available. On one day recently there were 156 patients (out of 1000) who were medically fit, but not discharged for these reasons. The health and social care system's ambition is to reduce this to 75. The system is averaging about 135 at present. This

is a significant cause for concern and the hospital is very much in need of the Council's support in addressing this.



Approaching winter we have a four point plan to ensure we can continue to deliver a good service to patients;

A) We will open over 50 beds to support an increase in winter acuity and reduce occupancy. This will include a new isolation ward to mitigate the impact of any seasonal Norovirus in the community.

B) We will minimise length of stay by ensuring patients do not have unnecessary waits (for things like X-ray), increase the number of times patients see doctors to ensure their care is always moving forward, improve systems on the day of discharge so that transport and medicines are in place and improve continuity of care for elderly care patients between a hospital admission and care in the community.

C) We will increase the staffing in ED and change our processes so that patients' care can be undertaken as quickly as possible.

D) We will work with our colleagues in social services, community care providers and the private sector to create new services and change processes to reduce delays. In particular we will develop new support services for patients who are non-weight bearing, those with housing issues, bariatric patients and those that need 3 or 4 times a day visits.

Fiona Dalton
Chief executive

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		SCOPING THE PREVENTION INQUIRY: ENSURING A COORDINATED AND COLLABORATIVE APPROACH TO THE FUTURE HEALTH OF THE CITY		
DATE OF DECISION:		21 NOVEMBER 2013		
REPORT OF:		ASSISTANT CHIEF EXECUTIVE		
CONTACT DETAILS				
AUTHOR:	Name:	Dorota Goble	Tel:	023 8083 3317
	E-mail:	dorota.goble@southampton.gov.uk		
Director	Name:	DAWN BAXENDALE	Tel:	023 8083
	E-mail:	dawn.baxendale@southampton.gov.uk		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

This report outlines the proposal for the Health Overview and Scrutiny Panel to undertake a Prevention Inquiry to ensure that there is a proactive and coordinated approach for the future health of the city. At the meeting, the Director of Public Health, Andrew Mortimore, will introduce the case for preventative health care in Southampton. In addition, Alison Elliott, People Director; Stephanie Ramsey, Director of Quality and Integration; and Fiona Dalton, Chief Executive, University Hospital Southampton will highlight the key prevention activities underway and planned within their services, successes to date, alongside issues and barriers to prevention.

RECOMMENDATIONS:

The Panel is recommended to:

(i) Consider the case for preventative health care in Southampton.

(ii) Agree the scope and way forward for the Prevention Inquiry based on the information provided in this report, and following a discussion at the meeting.

(iii) Delegate authority to the Assistant Chief Executive to finalise the draft Terms of Reference, in consultation with the Chair of HOSP, incorporating key issues agreed at the panel meeting, and following further consultation with other key partners.

REASONS FOR REPORT RECOMMENDATIONS

1. To enable the panel to consider the presentations and evidence provided to agree the focus and way forward for the Prevention Inquiry

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2 None

DETAIL (Including consultation carried out)

3. Over the last few years health services have seen dramatic reforms in both their structures and a continued period of reducing budgets. Other issues such as demographic changes with a growing birth rate and an increasing proportion of older people; continued high levels of deprivation and child poverty in parts of the city; and an increase in unhealthy lifestyles leading to preventable diseases are resulting in increasing demand. These factors are creating critical pressures on health services in terms of their capacity to meet this demand alongside rising costs of services, particularly for acute care.

4. Radical transformation in service delivery and a cultural shift in terms of personal and community responsibility are both required in order to avoid a national 'sickness' service that can only afford to support the most vulnerable people or those in need of acute care.

5. The chair of the HOSP is keen for the panel to undertake a Prevention Inquiry into the current activities for prevention across the city's health services from a whole system either focussing on key theme/s or an integrated approach to prevention and care. The aim will be to identify if there are any barriers, gaps or missed opportunities in the system to ensure that a coordinated and collaborative approach is in place for the long-term health of the city.

6. Nationally the case for investing in preventable healthcare has been evidenced repeatedly. The 2004 Wanless report (Executive Summary attached at Appendix 1) made the case for increased spending on healthcare with a particular focus on prevention.

7. The Marmot review (Executive Summary attached at Appendix 2) supports this need for investment in prevention by identifying one of six key policy objectives to 'strengthen the role and impact of health prevention'.

8. The Care Bill 2013 outlines the local authority duty of preventing, delaying or reducing the need for health care and support, placing a greater emphasis on promoting prevention. Clause 2 Preventing The Need for Care and Support is (see Members' room papers).

9. The Joint Health and Wellbeing Strategy (Appendix 3) sets out how Southampton City Council (SCC), Southampton City Clinical Commissioning Group (CCG) and the NHS Commissioning Board plan to address the key health and well being needs of the city. One of the three themes of the strategy is around 'Building resilience and using preventative measures to achieve better health and wellbeing'. Southampton is fortunate to have a strong partnership in place to support its delivery.

10. Health commissioners and providers in Southampton are working on and planning radical transformation and innovation in service delivery to a move towards a more caring, person-centred, self-managed, integrated and preventative health service. A key element of these changes relies on a huge cultural shift towards investing in prevention and early intervention to avoid acute costs for as long as possible and lead to an independent and self-managed approach to health care.

11. The Inquiry should not duplicate or replicate any health prevention reviews already underway but seek to build on existing plans, focussing on the impact on the whole system. Indeed, the panel will not have the capacity, resources or time to devote to an in depth study into prevention. The Prevention Inquiry will need to have a very clear focus and scope to ensure a manageable inquiry that can achieve deliverable recommendations in time to influence the budget cycle for 2015/16.

12. Public Health has developed The Case of Preventative Healthcare in Southampton (Appendix 4) which outlines the evidence behind supporting investment in prevention. It highlights that *smoking, excess alcohol consumption, obesity and physical inactivity are responsible for 42% of deaths from leading causes. Addressing these risk factors alone would clearly have an impact on mortality and morbidity*.

13. The key themes identified in the Public Health report for prevention are:
    - Smoking
    - Malnutrition
    - Obesity
    - Alcohol
    - Vascular and coronary heart disease
    - Healthcare acquired infection
    - Self-care
    - Falls and bone health
    - Sexual health
    - Mental health

14 **Andrew Mortimore, Director of Public Health**, will introduce the key themes of health care prevention to the panel, outlining outcomes already achieved or underway, new thinking in the prevention agenda and potential key areas of focus for the inquiry.

15. The following guests are all involved in the commissioning or delivery of health care in the city, and are acutely aware of the need for prevention work to minimise demand and high costs of acute care. They will each give a brief presentation to the panel highlighting the key prevention activities underway and planned within their services, successes to date, alongside issues and barriers to prevention. These presentations and subsequent discussions will support the panel to consider and agree the scope of the Prevention Inquiry.

16. **Alison Elliott, People Director**, will outline the work underway in the People Directorate, including Public Health, Adult Services, Children's Services and Housing, in delivering and supporting the future of health prevention through in-house services and commissioning and the Transformation Programme. The vital role this directorate plays in the city's wellbeing is underpinned by a need to reduce demand on services through prevention.

17. There are a number of other Southampton City Council services that have an impact and play a key part in health prevention in the city. The panel will also need to ensure that their views are sought during the inquiry.

18. **Stephanie Ramsey, Director of Quality and Integration**, will outline the work underway through Integrated Commissioning to achieve Integrated Person-Centred Care, through prevention and promoting positive lives, supporting families and developing a self-management strategy.

19. **Fiona Dalton, Chief Executive, University Hospital Southampton**, will present to the Panel as a key provider in the city. In addition, the Panel should ensure that other providers in the city have an opportunity to have their say in developing the terms of reference and during the inquiry itself.

20. NHS England also has a key role in health prevention, particularly in its role of commissioning Primary Care (including general practice (GPs), dentists, pharmacy and ophthalmology), alongside public health screening and immunisation. Two recent reports support the potential increasing role of GPs and pharmacies in the prevention agenda.

21. A Proactive Approach: Health Promotion and Ill Health Prevention, commissioned by The King's Fund 2010, identifies the crucial role general practice has to play in promoting health and preventing disease, highlighting "*every consultation is an opportunity to detect early warning signs that could prevent illness and disease*." The report claims that GPs need to be more proactive in improving their work in public health and ill prevention. (See Members Room papers).

22. Now or Never: Shaping Pharmacy for the Future, by the Royal Pharmaceutical Society 2013 (Members Room papers) identifies that pharmacists are increasingly providing services that help people stay well and use their medicines to best effect. However, it claims that "*the pace of change remains slow*".

23. The chair of HOSP has a meeting scheduled with Debbie Fleming, Area Director, NHS England (Wessex) to engage them in the developing Prevention Inquiry terms of reference and programme.

24. Integrated care is much-used in health policy and management circles. The Panel is invited to watch a **short animation by the Kings Fund**, which aims to bring integrated care to life for anyone involved in improving patient care or preventing the need for acute care. The Panel is asked to note this example of a whole system approach to care, using the Integration Transformation Fund, which is being developed by the Southampton Health and Wellbeing Board. Further work will be undertaken to engage the Panel on the ITF.

25. The Panel are recommended to agree a focused and manageable approach to undertaking a Prevention Inquiry. The Panel should consider the below options, alongside other ideas identified at the meeting:
    a) For the inquiry to focus on one or more health prevention theme where the biggest gaps, issues or potential have been identified and consider how to maximise opportunities for coordination and collaboration and recommend a working model for long term improved outcomes and investment for the selected theme/s.
    b) For the inquiry to focus on an overview of the current approach to health prevention and consider options for a long term whole-system approach to early intervention for health care, leading to prevention

becoming everybody's business in the city.

26. The Panel should ensure that Southampton Healthwatch and the Portfolio Holder for Health and Adult Social Care continue to be engaged in the inquiry terms of reference and programme. Other key partners to engage in the emerging Prevention Inquiry Terms of Reference and programme include the voluntary sector, the Community Safety Partnership, the Children's Trust, the Health and Well Being Board and employers.

27. The Panel is invited to have an open discussion on the issues around health prevention with those present and, considering this report and the papers attached, to agree an approach for a focussed Health Prevention Inquiry that adds value to the current activity and future plans in the city and the direction for prevention nationally.

28. Given the need for further consultation with key partners, the Panel are recommended to agree to delegate authority to the Assistant Chief Executive, in consultation with the Chair of HOSP and other partners, to finalise the draft Prevention Inquiry Terms of Reference and Inquiry Programme.

29. The draft version of the Prevention Inquiry Terms of Reference will be emailed to Panel members by mid December for final comments.

30. Notwithstanding that the scope and programme of the Inquiry is still to be agreed, it is however anticipated that additional Panel meetings may be required to complete the final report before the election, with the first meeting of the Inquiry planned in February 2014. Panel members are asked to consider the proposed meeting dates, including those already scheduled, albeit that additional dates are yet to be confirmed:

    20 February 2014

    20 March 2014 (already scheduled)

    2 April 2014

    17 April 2014

    14 May 2014 (Draft final report and recommendations)

RESOURCE IMPLICATIONS

<u>Capital/Revenue</u>

31. The outcomes and recommendations of the Prevention Inquiry will aim to be reported to Cabinet by May 2014 to allow sufficient time to influence the budget cycle 2015/16.

<u>Property/Other</u>

32. None

LEGAL IMPLICATIONS

<u>Statutory power to undertake proposals in the report</u>:

33. 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:

34. None

POLICY FRAMEWORK IMPLICATIONS

35. The outcomes of the Prevention Inquiry will potentially influence council policy documents, in particular the Joint Health and Well Being Strategy.

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	Executive Summary of the Wanless Review (2002)
2.	Executive Summary of the Marmott Review (2010)
3.	The Joint Health and Wellbeing Strategy 2013-2016
4.	The case for preventative healthcare in Southampton, Public Health

Documents In Members' Rooms

1.	http://www.kingsfund.org.uk/sites/files/kf/field/field_document/health-promotion-ill-health-prevention-gp-inquiry-research-paper-mar11.pdf
2.	http://www.rpharms.com/promoting-pharmacy-pdfs/moc-report-full.pdf
3.	Care Bill 2013: Preventing the need for care and support, clause 2: page 2-3

Equality Impact Assessment

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

Other Background Documents

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

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

Report Tracking

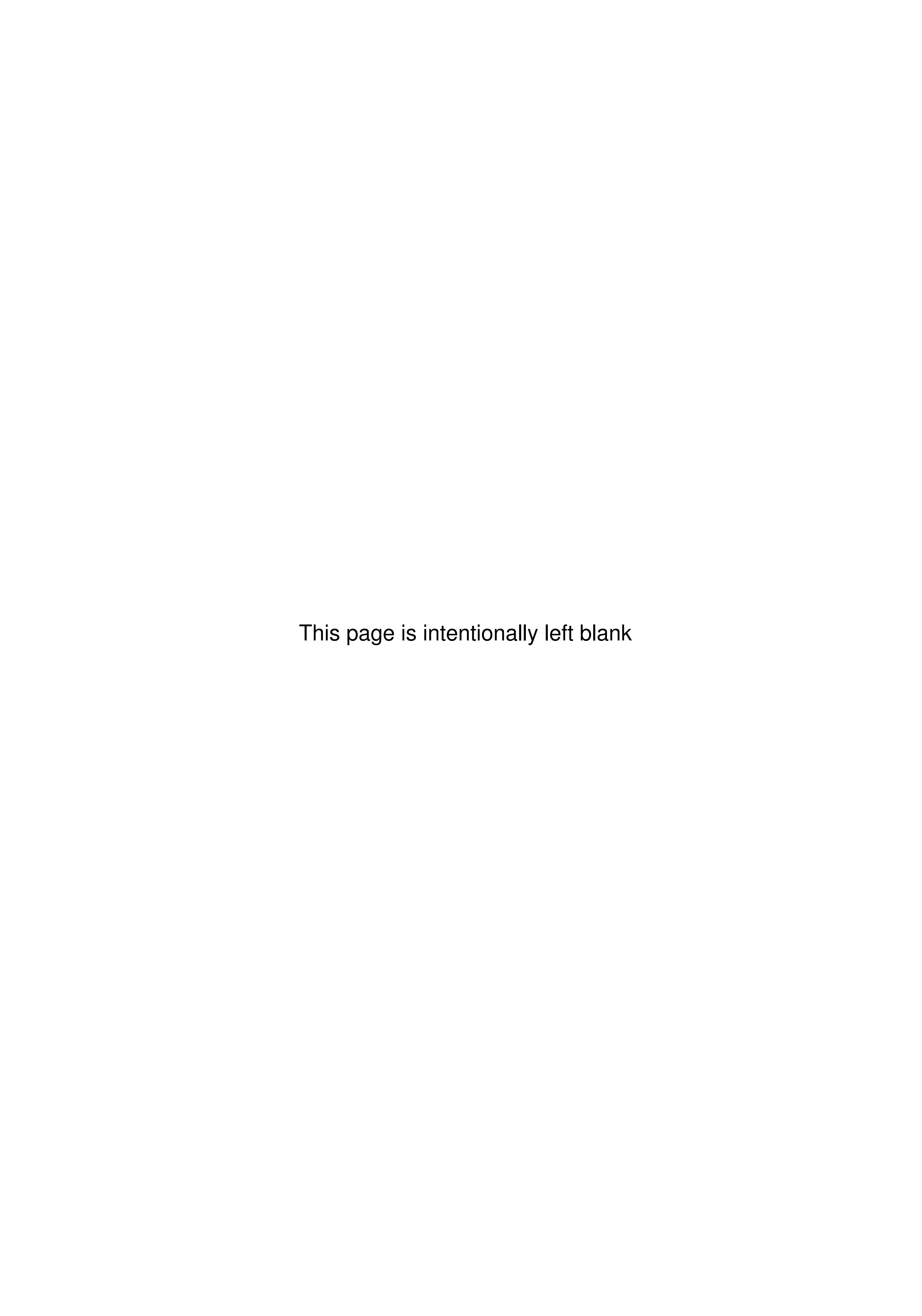
VERSION NUMBER:	2
DATE LAST AMENDED:	12/11/13
AMENDED BY:	D Goble

FOR DEMOCRATIC SERVICES USE ONLY:

DATE AND TIME REPORT RECEIVED: Date [ ] Time: [ ]

CLEARANCE: [ ] [TYPE YES or NO]

Name:


This page is intentionally left blank

Agenda Item 11

Appendix 1

Securing Good Health for the Whole Population

Final Report

Derek Wanless

February 2004

Securing Good Health for the Whole Population

Final Report

Derek Wanless

February 2004

© Crown copyright 2004.

Published with the permission of HM Treasury on behalf of the Controller of Her Majesty's Stationery Office.

The text in this document may be reproduced free of charge in any format or medium providing that it is reproduced accurately and not used in a misleading context. The material must be acknowledged as Crown copyright and the title of the document specified.

Any enquiries relating to the copyright in this document should be sent to:

HMSO
Licensing Division
St Clements House
2-16 Colegate
Norwich
NR3 1BQ

Fax: 01603 723000

E-mail: hmsolicensing@cabinet-office.x.gsi.gov.uk

HM Treasury contacts

This document can be accessed from the Treasury Internet site at:

www.hm-treasury.gov.uk

For further information on the Treasury and its work, contact:

Correspondence and Enquiry Unit
HM Treasury
1 Horse Guards Road
London
SW1A 2HQ

Tel: 020 7270 4558

Fax: 020 7270 4861

E-mail: public.enquiries@hm-treasury.gov.uk

ISBN: 0-947819-98-3

Department of Health contacts

Information on the Department of Health and its work is available on the department's website at:

www.dh.gov.uk

For further information on the Department of Health and its work, contact:

Public Enquiry Office
The Department of Health
Richmond House
79 Whitehall
London
SW1A 2NL

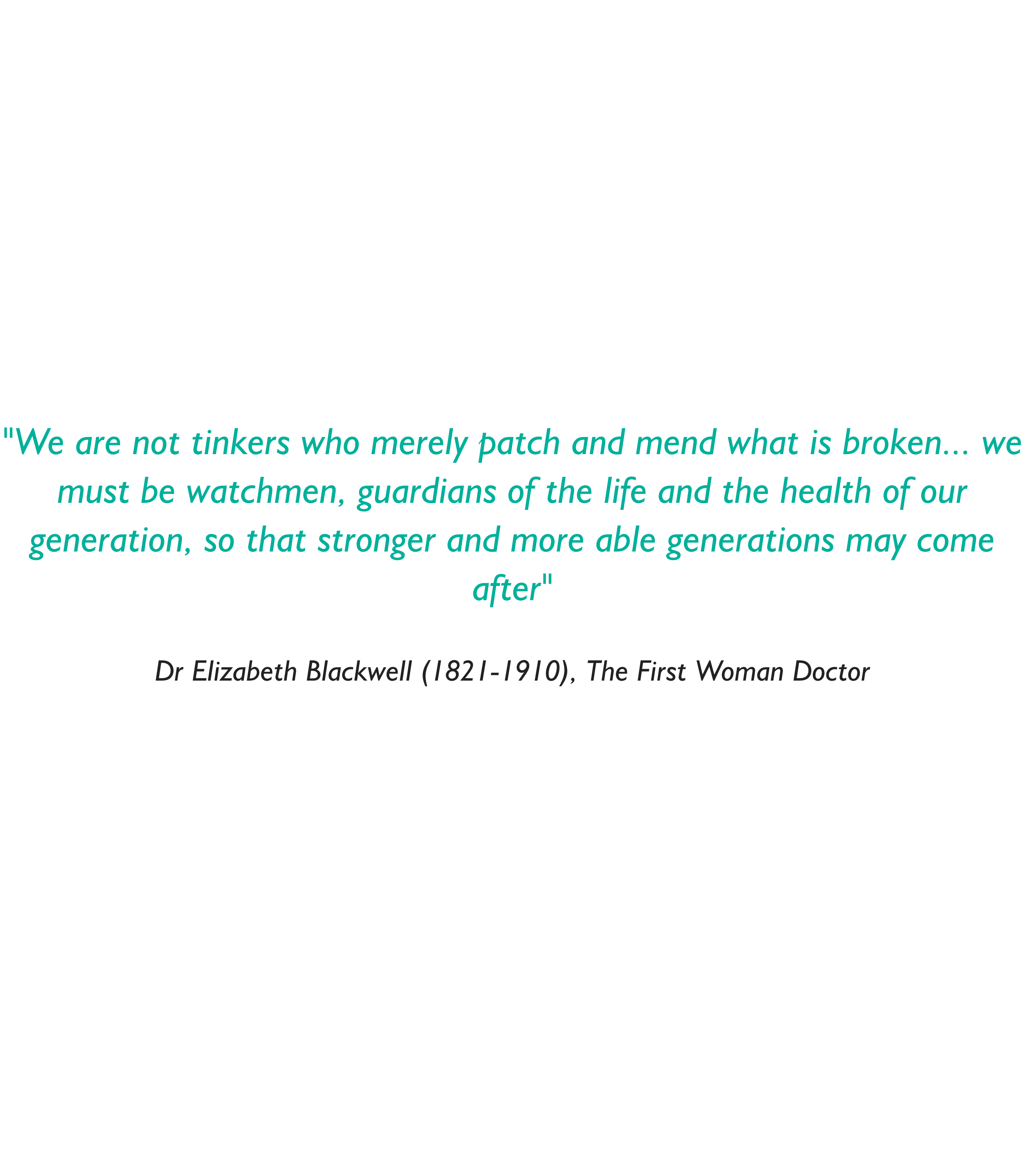
Tel: 020 7210 4850

E-mail: dhmail@doh.gsi.gov.uk

This report was prepared by:

Derek Wanless
Natasha Jones
(Secretary to the Review)

Robert Anderson
Frank Bowley
Sunjai Gupta
John Hall
Ruth Lawson
Bhash Naidoo
Mary Jane Roberts
Harpal Sabharwal
Jeremy Skinner
Lesa Stevenson
Ian Stone
Helena Sweatman



"We are not tinkers who merely patch and mend what is broken... we must be watchmen, guardians of the life and the health of our generation, so that stronger and more able generations may come after"

Dr Elizabeth Blackwell (1821-1910), The First Woman Doctor

CONTENTS

		Page
	Summary	3
Chapter 1	Introduction	11
Chapter 2	Public Health Policy in England: Lessons to be Learnt	23
Chapter 3	Delivery of Public Health	39
Chapter 4	Case Studies	77
Chapter 5	Public Health Evidence	107
Chapter 6	Investing in Public Health	123
Chapter 7	Roles and Responsibilities	149
Chapter 8	Government Levers	167
Chapter 9	Recommendations	183
Annex A	Consultation	187
Annex B	The Department of Health's Public Service Agreement	195
Annex C	PSAs contributing to Health Inequalities Targets	197
Annex D	Population Surveys	199
Annex E	The Economics of Externalities	201
Annex F	Glossary	205
Annex G	Abbreviations	211

SUMMARY

REPORT TO THE PRIME MINISTER, THE SECRETARY OF STATE FOR HEALTH AND THE CHANCELLOR OF THE EXCHEQUER

BACKGROUND TO THE REVIEW

The 2002 report "Securing Our Future Health: Taking A Long-Term View" set out an assessment of the resources required to provide high-quality health services in the future. It was based on first catching up, and then keeping up with other developed countries, which had moved ahead of us over recent decades.

That report illustrated the considerable difference in expected cost depending upon how well our health services became more productive and how well people became fully engaged with their own health. Resources were needed not only to satisfy short-term objectives, particularly access to service, but also to invest in improving supply, by building the capacity of the workforce, improving information technology support and renewing premises, and to invest in reducing demand by enhancing the promotion of good health and disease prevention.

Many of the benefits of engaging people in living healthier lives occur in the long term but there are also immediate and short-term benefits when demand for health services can be reduced, especially in those areas such as acute services where capacity is seriously constrained.

This further review has been focused particularly on prevention and the wider determinants of health in England and on the cost-effectiveness of action that can be taken to improve the health of the whole population and to reduce health inequalities. It was asked to consider consistency of current policy with the public health aspects of the "fully engaged" scenario outlined in the 2002 report. The definition of public health for this review has been drawn very widely; essentially it considers public health to be "the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals."

THE RECENT HISTORY OF PUBLIC HEALTH

This review commissioned a study looking at examples of approaches to public health in other countries. By and large, the key barriers to success overseas are similar to those identified in this report. Chapter 2 looks at the history of public health policy in recent decades. What is striking is that there has been so much written often covering similar ground and apparently sound, setting out the well-known major determinants of health, but rigorous implementation of identified solutions has often been sadly lacking.

There has also been limited assessment of the long-term impact on population health, and inequalities, of key policies such as agriculture or the built environment and this has led to situations difficult to resolve even in the longer term.

That said there have been considerable successes too. Protection against infectious diseases, often major killers in the past, has generally been very effective and remains a vital and successful part of public health. The initial HIV/AIDS campaign was a

powerful and positive case study and changes in behaviour such as seatbelt wearing have been effectively introduced and gained widespread acceptance.

The growing public concern about issues such as obesity, children's diet and smoking in public places seems to signal a change in the current climate for public health. This is a welcome and necessary first step towards public engagement. The announcement of the forthcoming consultation period and of a White Paper on Public Health suggests that the conclusions and recommendations of this Review will be addressed by Government. It is vital that they are and the Review therefore concentrates on the frameworks and processes, which are likely to encourage sustained action. If they are not, yet another opportunity to act will have been missed and the health care services will continue to run faster and faster to stand still.

WHO IS RESPONSIBLE AND WHAT SUPPORT IS NEEDED?

Individuals are ultimately responsible for their own and their children's health and it is the aggregate actions of individuals, which will ultimately be responsible for whether or not such an optimistic scenario as "fully engaged" unfolds. People need to be supported more actively to make better decisions about their own health and welfare because there are widespread, systematic failures that influence the decisions individuals currently make.

These failures include a lack of full information, the difficulty individuals have in considering fully the wider social costs of particular behaviours, engrained social attitudes not conducive to individuals pursuing healthy lifestyles and addictions. There are also significant inequalities related to individuals' poor lifestyles and they tend to be related to socio-economic and sometimes ethnic differences.

These failures need to be recognised. They can be tackled not only by individuals but by wide ranging action by health and care services, government – national and local, media, businesses, society at large, families and the voluntary and community sector. Collective action must however respect the individual's right to choose whether or not to be "fully engaged".

Shifting social norms is a legitimate activity for Government where it has set for the nation objectives for behaviour change. This may take time to achieve, may require careful judgement and it may at some stage be appropriately underpinned by regulation, for example the wearing of seatbelts. The main levers for Government action: taxes, subsidies, service provision, regulation and information are considered in detail in Chapter 8.

Actions should be based on sound principles and good practices such as those suggested in Chapter 7. A framework for assessing priorities is vital and it should help identify which economic instrument seems the most appropriate in each case. Interventions should tackle failures as directly as possible and should ensure total costs are kept to a minimum and are less than the expected discounted benefits. The overall distribution of the impacts of all interventions to address a particular failure should be considered. Individual programmes might worsen inequalities but still be very beneficial at the whole population level; they should be accompanied by campaigns adequately addressing the resulting inequalities. Individuals should balance their right to choose their own lifestyle against any adverse impacts their choices have on others.

To assist the full engagement of the population, advice should be available freely and in formats all find accessible, including the development of internet and telephone

services. The developing NHS Direct brand should be considered for expanded use in this way.

Annual communication about the state of the population's health and of the main determinants of health should be made available at national and local authority levels to encourage understanding. As would be standard practice in marketing any product or service to the public, part of the regular management process should be to obtain feedback from the population and important sub-groups about whether the messages being communicated about public health were being received and understood. Information should also be routinely collected about the acceptability to them of possibly controversial state interventions.

INFORMATION AND RESEARCH

The very poor information base has been a major disappointment as it was when writing the 2002 report. There is a need for significant and continuous improvement if evidence is going to be used to drive decisions. The lack of conclusive evidence for action should not, where there is serious risk to the nation's health, block action proportionate to that risk and, for example for infectious diseases and terrorist threats, a good deal of subjective and experienced judgement is needed.

But generally evidence-based principles still need to be established for public health expenditure decisions. Although there is often evidence on the scientific justification for action and for some specific interventions, there is generally little evidence about the cost-effectiveness of public health and preventative policies or their practical implementation. Research in this area can be technically difficult and there is a lack of depth and expertise in the core disciplines. This, coupled with a lack of funding of public health intervention research and slower acceptance of economic perspectives within public health, all contribute to the dearth of evidence of cost-effectiveness. This has led to the introduction of a very wide range of initiatives, often with unclear objectives and little quantification of outcomes and it has meant it is difficult to sustain support for initiatives, even those which are successful. It is evident that a great deal more discipline is needed to ensure problems are clearly identified and tackled, that the multiple solutions frequently needed are sensibly co-ordinated and that lessons are learnt which feed back directly into policy.

The Review has considered (in Chapter 6) the appropriateness of different methods of economic evaluation. The economic evaluation of interventions in public health does not differ conceptually from the evaluation of other health care interventions. Nevertheless, the body of economic evidence relating to public health interventions is small in comparison to that related to health care. There are practical difficulties but they should be capable of being overcome to produce high quality, convincing evaluations of public health interventions. To achieve the objective of allocating funding more efficiently between health care and public health, it is vital that similar analytic methods are used for both. The National Institute for Clinical Excellence (NICE) has developed its methodology soundly since its establishment and use of its framework for rigorous evaluation of all interventions, covering health care and public health, offers a practical way forward.

Diabetes (Type 2) was investigated in detail to assist the search for conclusions about the management of chronic diseases and to suggest a framework for analysing their cost-effective management. Utilising a framework based on the NICE methodology, a number of interventions can be shown to be cost-effective, at less than £20,000 per quality adjusted life year (QALY), particularly around screening and secondary

prevention, many of which have already been implemented through National Service Frameworks and NICE recommendations. However, the weaker cost-effectiveness evidence base for primary prevention and self-care meant that comparisons with other interventions along the disease pathway were difficult to make.

Health data are essential for monitoring the health of the population and for evaluating the effects of health interventions. Yet the information collected nationally is often poor and there is no regular mechanism by which a Primary Care Trust (PCT) or local authority can gather reliable information on its own population. The information held about individual patients is not yet adequate to provide such local population information comprehensively.

However, there are opportunities to generate evidence from current public health practice, which has much potential for use as natural experiments. If evaluation became an explicit component of their implementation, it would inform the evidence base for public health. To improve understanding of prevalence of disease and to enable pro-active management of personal risk factors, much greater use needs to be made of primary care data systems. The potential of the Electronic Patient Record and new General Medical Services (GMS) contract to begin to collect this type of information and use it to guide both national understanding and local activity must be fully realised. The Public Health White Paper should address the possible threat to public health research, which arises from the difficulty of obtaining access to data to assist the formulation of public policy.

TARGETS AND THEIR ACHIEVEMENT

In recent years, governments have set targets for many determinants of health where behaviour change has been considered desirable and of benefit as well as for the reduction of health inequalities. But those targets do not have comprehensive coverage and have not always met the requirements of stretching ambition and realism. The philosophies behind them have been inconsistent. So, the smoking targets set in 1998 could be considered unambitious while the obesity targets (1992) and the physical activity target (2002) seem highly aspirational. In none of these cases does the target setting process encourage a belief that resource management to achieve improvement will be optimal.

In spite of numerous policy initiatives being directed towards public health they have not succeeded in rebalancing health policy away from the short-term imperatives of health care. So it is not surprising to hear the view regularly expressed that we have a “National Sickness Service”, dealing, as a priority, indeed almost an exclusive focus, with an urgent need to improve short-term access and quality. As a result, public health practitioners generally seem to feel undervalued.

For such a complex organisation, seeking to achieve so many competing objectives, the focus of the NHS on narrowly based access targets has been a very blunt instrument. Unfortunately the same narrow use of targeting has been introduced to public health delivery with the setting of a target for the number of people quitting smoking for four weeks with the help of smoking cessation services. This has been followed up with targets for four week quitters centrally imposed on PCTs with a real danger of distorting local activity.

That is not, of course, to say that reducing smoking levels in England is not very important; it and obesity remain the most important lifestyle determinants of future health. “Fully engaged” was illustrated in the 2002 report by a reduction in smoking

levels significantly higher than the Government's existing target. In addition to an advertising ban and changes in warnings on cigarette packets, resources have been directed at advertising, at prescribing smoking patches and in appointing many local smoking cessation officers but it is impossible to judge if the resource committed is in any sense optimal. The evidence base has not kept pace with the effort and there are weaknesses in the monitoring of performance, the understanding of how much can justifiably be spent, where it should be directed, what workforce is needed to achieve the best possible results and how all the efforts should be co-ordinated. A commitment of adequate resource for monitoring and feedback should be an integral part of the planning of any national programmes to achieve change. If that had been done in the past, it is likely that the imbalance of expenditure on reducing smoking prevalence against the burden of disease associated with it would be less dramatic.

The forthcoming consultation period, ahead of the White Paper, should be used, inter alia, to seek the public's views about the acceptability of different ways of tackling smoking. There are a number of major areas for consideration; a workplace/public place ban, the need to take firmer action over smuggling and counterfeiting cigarettes and the possibility of allowing nicotine substitutes to be more widely available. It is evident from our recent lack of reasonable progress in reducing smoking and the damaging impact that this may have on achieving reductions in inequalities, that the benefits, which success from these firmer actions might produce, would be expensive to achieve by more conventional techniques of education and advice.

Chapter 4 also considers case studies on health inequalities, salt, obesity, falls and physical activity. They are not a comprehensive list of the key public health determinants, but illustrate important general points concerning the implementation of public health policy and practice. A comprehensive view would also consider the role of broader economic factors and other environmental determinants and would deal with issues of health protection including sexual behaviour and infections generally. But the examples considered already show that the Government does not currently have a comprehensive set of objectives for key lifestyle risk factors at the national and local level, and that there is often little evidence on how to reduce their burden.

With respect to health inequalities, targets were set for life expectancy and infant mortality. Although the life expectancy target is stretching, it could be achieved if the promising trend in reductions of coronary heart disease (CHD) and cancer continues but it also requires substantial progress to be made in the most disadvantaged areas. A limit to progress may be encountered if actions fail to target the hardest groups to reach. This is a real danger given that there is so little evidence about what works among disadvantaged groups to tackle some of the key determinants of health inequalities, such as smoking, or about the differential impact of interventions across the socio-economic gradient. In contrast, prospects for achieving the infant mortality target are less easy to assess: although key interventions have been identified, the target is difficult to measure, monitor and tackle at local level where numbers of deaths are often in single figures.

OBJECTIVE SETTING IN FUTURE

The setting of quantified national objectives for changing the prevalence of all the important determinants of health status for the medium and long term would help inform future resource planning projections and immediate decisions. A great deal of research, analytic thinking and consensus building is required to ensure these

objectives are carefully defined and the responsibilities for delivery are understood. They would also be a major input into local decisions. And it is locally that much of the activity needs to be planned and implemented by networks of local authorities, health organisations and community and voluntary groups.

It is recommended that the Government should seek advice about what the objectives for all major determinants of health should be and that these should be subdivided where appropriate to cover important groups within the population, for example by age, ethnicity or social class, particularly those key to achieving the inequality objectives. It is suggested that, for these determinants, it may be appropriate to set three year and seven year objectives and that they should be reassessed regularly, say a year before the three year period is up, in the light of their importance for future health care demands, performance being achieved at home and abroad, evidence of what is working and its cost-effectiveness. It is to be expected that some objectives would be reassessed upwards and others down but that all should be kept close to a trend which represents the best that we can do.

For example, smoking, obesity and physical activity objectives should all be reassessed immediately after the consultation period which is about to begin and the consultation should be used to gauge opinion as well as the desire of the public to tackle the issues. To represent steps towards full engagement, smoking prevalence objectives should be more ambitious than at present, an objective should be set to halt the rise in obesity now with a gathering pace of reductions planned for the medium-term while ambitious but realistic short and medium-term physical activity targets should replace the current aspiration. The new objectives should be fixed for 2007 and 2011. The White Paper should propose the plans to achieve them, detailed costings and research programmes and a structure for periodic reassessment of the objectives for all of the major determinants.

DELIVERY

While recent policy and activity has been directed at strengthening the public health role of the NHS and local government and facilitating partnership working to improve population health, difficulties remain in some areas due to capacity problems, the impact of recent organisational changes and the lack of alignment of performance management mechanisms between partners.

Much of the workload in the health services in achieving local objectives will fall on PCTs. They are relatively new and small bodies and they have a crucial role in ensuring the NHS delivers, particularly in commissioning and in driving behaviour changes in primary care. Each has a Director of Public Health and this is spreading existing resources very thinly, although there is a welcome move to broaden the skill base by introducing non-medical Specialists. PCTs will be vital in making the new primary care contracts work to best effect, including in public health. Given the newness of the structure and that repeated restructuring has tended to weaken the NHS over decades, structural change is not recommended but where it seems locally that the best way forward is to combine PCTs' forces to tackle public health that should not be discouraged. Similar considerations may well apply to their commissioning role but the need to drive behavioural change is an argument for their current size.

Where local authorities and PCTs are co-terminus and have begun pooling resources, for example making joint appointments in public health, the prospects for mobilising resources to tackle issues more forcibly seem better but the structure is too new for this

to be proven. Evidence should be collected quickly to show whether the expected benefits are materialising.

Recent years have seen significant growth in the number of "arm's length bodies" established by Government to tackle particular issues. A review has been instigated by the Secretary of State to consider their future; that review extends beyond public health but the opportunity should be taken in the review to ensure that gaps in activity identified in this report are tackled. Responsibilities should be assigned for:

- developing the cost-effectiveness evidence base on public health;
- researching the practical effectiveness of current activities and interpreting findings for future implementation;
- the educational role, previously played by the Health Education Authority, which has not been picked up by any other body at a time when full engagement requires the public and the health workforce to have more support. There is no single easily accessible source of advice for interested or confused individuals;
- reassessing periodically our national objectives for all major determinants of health and health inequalities; and
- the regulation of nicotine and tobacco.

In addition, the efforts of arm's length bodies should be co-ordinated at a local level (for example, the Health Development Agency, Public Health Observatories and Health Protection Agency) and their relationship with PCTs should be examined by the review.

One of the most important components of the "fully engaged" scenario was the assumption of increasing productivity gains. High productivity must also be a feature of public health activity and measures of productivity will be required in public health, as they are in health care services. Adequate workforce capacity will need to be created with appropriately broad skill mixes. Because more of the activity will be concerned with monitoring, interpreting data, identifying risk, educating people and motivating them to change behaviour, the required mix of skills will change. The role of self-care, the development of "the expert patient", possibly playing a much greater role in assisting other patients, and the role of community pharmacists will also need to be developed to expand overall capacity in the increasingly important management of chronic conditions and take pressure off traditionally skilled people.

In the future, knowledge of genetics and of individual risk factors could have an increasing influence in successfully creating a "fully engaged" population through individualised health promotion and disease prevention. It is assumed that much of this development will take place in primary care, which will change greatly over the next decade if the health services are to move away from dealing predominantly with the sick. Information Management and Technology (IM&T) will be a massive driver of change and the big commitment which is being made to improved technology in the NHS will have, as part of its justification, the possibility of helping the identification of personalised risks from the information stored about the individual. In order to discover how quickly these changes might happen and to help find the evidence about the effectiveness of enhanced risk management, it is recommended that an experiment should be established across a range of primary care units to assess the benefits of additional resource in information systems, in monitoring risk, in varying degrees of

attention and in advisory services. The experiment should be directed towards areas of inequality, given that access to services there is a crucial issue, which must be resolved.

Primary care will not be the only support for individuals. Many organisations will play a part in engaging individuals in thinking about their future health. Employers may for example be able to create business cases for encouraging their employees to consider the mental and physical health risks they face. Some interesting examples were drawn to our attention. None were in the public sector. The NHS clearly should be thinking more about the health of its employees and should pilot exercises to see what benefits it can obtain from taking action to improve their health. Reduced absenteeism and better productivity and staff morale would all be valuable for an organisation under continuing pressure. In keeping with the need to devolve activity to local level, PCTs and Strategic Health Authorities (SHAs) should be encouraged to experiment and lessons should be learnt and disseminated.

Our health services must evolve from dealing with acute problems through more effective control of chronic conditions to promoting the maintenance of good health. This will need to be fully taken into account when resource allocation formulae are revised. The implications for total government spending of these significant shifts in emphasis, which will be reinforced by this Review, cannot be estimated at this stage. My 2002 Report illustrated the potential long-term benefits. While there are areas in which more resources will be required, for example in research and in experimenting with new ways of working, it is also expected that there will be areas where better information will show that adequate value is not being achieved by current spending. In 2002, I recommended a full review after five years incorporating both health and social care. That recommendation remains appropriate as the benefits of a fuller information base and further research become clearer. There is an important role for social care in minimising demand for health care.

I have concluded that all the activity underway could well put us on course for the solid progress scenario but the efficiency of the spending being incurred needs to be kept under close review. A step change will be required to move us on to a fully engaged path. In practice, full engagement will mean achieving the best outcomes that individuals in aggregate are willing to achieve with strong leadership and sound organisation of all the many efforts being made to help them. The main recommendations of this Review are brought together in Chapter 9. They are designed to ensure that, in future, the necessary and justifiable support will be there. They set out the work needed to learn how support can be better provided, and to help find the answers to the many practical questions still unanswered.

Derek Wanless
February 2004

Agenda Item 11
Appendix 2
Fair Society, Healthy Lives
The Marmot Review
Executive Summary
Strategic Review of Health Inequalities in England post-2010

Fair Society, Healthy Lives

The Marmot Review
Executive Summary

Rise up with me against
the organisation of misery
Pablo Neruda

Note from the Chair

People with higher socioeconomic position in society have a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. The two are linked: the more favoured people are, socially and economically, the better their health. This link between social conditions and health is not a footnote to the 'real' concerns with health – health care and unhealthy behaviours – it should become the main focus. Consider one measure of social position: education. People with university degrees have better health and longer lives than those without. For people aged 30 and above, if everyone without a degree had their death rate reduced to that of people with degrees, there would be 202,000 fewer premature deaths each year. Surely this is a goal worth striving for.

It is the view of all of us associated with this Review that we could go a long way to achieving that remarkable improvement by giving more people the life chances currently enjoyed by the few. The benefits of such efforts would be wider than lives saved. People in society would be better off in many ways: in the circumstances in which they are born, grow, live, work, and age. People would see improved well-being, better mental health and less disability, their children would flourish, and they would live in sustainable, cohesive communities.

I chaired the World Heath Organisation's Commission on Social Determinants of Health. One critic labelled the Commission's report 'ideology with evidence'. The same charge could be levelled at the present Review and we accept it gladly. We do have an ideological position: health inequalities that could be avoided by reasonable means are unfair. Putting them right is a matter of social justice. But the evidence matters. Good intentions are not enough.

The major task of this Review was to assemble the evidence and advise on the development of a health inequalities strategy in England. We were helped by nine task groups who worked quickly and thoroughly to bring together the evidence on what was likely to work. Their reports are available at www.ucl.ac.uk/gheg/marmotreview/Documents. These reports provided the basis for the evidence summarised in Chapter 2 of this report and the policy recommendations laid out in Chapter 4.

Of course, inequalities in health are not a new concern. We stand on the shoulders of giants from the 19th and 20th centuries in seeking solutions to the problem. Learning from more recent experience forms the basis for Chapter 3.

While we relied heavily on the scientific literature, this was not the only type of evidence we considered. We engaged widely with stakeholders and attempted to learn from their insights and experience. Indeed, an exciting feature of the Review process was the level of commitment and interest we appear to have engaged in central government, political parties across the spectrum, local government, the health services, the third sector and the private sector. The necessity of engaging these partners in making change happen is the subject of Chapter 5.

Knowing the nature and size of the problem and understanding what works to make a difference must be at the heart of taking action to achieve a fairer distribution of health. We therefore propose a monitoring framework on the social determinants of health and health inequalities in Chapter 5 and Annex 2.

From the outset it was feared that we were likely to make financially costly recommendations. It was put to us that economic calculations would be crucial. Our approach to this was to look at the costs of doing nothing. The numbers, reproduced in Chapter 2, are staggering. Doing nothing is not an economic option. The human cost is also enormous – 2.5 million years of life potentially lost to health inequalities by those dying prematurely each year in England.

We are extremely grateful to two Secretaries of State for Health: Alan Johnson for having the vision to set up this Review and Andy Burnham for continuing to support it enthusiastically. When the report of the Commission on Social Determinants of Health was published in August 2008, Alan Johnson asked if we could apply the results to England. This report is our response to his challenge.

The Review was steered by wise Commissioners who gave of their knowledge, experience and commitment. It was served by a secretariat whose knowledge and selfless devotion to this task were simply inspiring. I am enormously grateful to both groups. One way and another, through excellent colleagues at the Department of Health, working committees, task groups, consultations and discussions, we involved scores of people. I hope they will see their influence reflected all through this Review.

I quoted Pablo Neruda when we began the Global Commission, and it seems appropriate to quote him still:

'Rise up with me against the organisation of misery'

Michael Marmot (Chair)

Terms of Reference

In November 2008, Professor Sir Michael Marmot was asked by the Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. The strategy will include policies and interventions that address the social determinants of health inequalities.

The Review had four tasks

1. **Identify, for the health inequalities challenge facing England, the evidence most relevant to underpinning future policy and action**

2. **Show how this evidence could be translated into practice**

3. **Advise on possible objectives and measures, building on the experience of the current PSA target on infant mortality and life expectancy**

4. **Publish a report of the Review's work that will contribute to the development of a post-2010 health inequalities strategy**

Disclaimer

This publication contains the collective views of the Strategic Review of Health Inequalities in England post-2010, chaired by Professor Sir Michael Marmot, and does not necessarily represent the decisions or the stated policy of the Department of Health.

The mention of specific organisations, companies or manufacturers' products does not imply that they are endorsed or recommended by the Department of Health in preference to others of a similar nature that are not mentioned.

All reasonable precautions have been taken by the Strategic Review of Health Inequalities in England post-2010 to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the Strategic Review of Health Inequalities in England post-2010 be liable for damages arising from its use.

Acknowledgements

The work of the Review was championed, informed, and guided by the Chair of the Commission and the Commissioners.

Report writing team: Michael Marmot, Jessica Allen, Peter Goldblatt, Tammy Boyce, Di McNeish, Mike Grady, Ilaria Geddes.

The Marmot Review team was led by Jessica Allen. Team members included Peter Goldblatt, Tammy Boyce, Di McNeish, Mike Grady, Jason Strelitz, Ilaria Geddes, Sharon Friel, Felicity Porritt, Elaine Reinertsen, Ruth Bell and Matilda Allen.

The Department of Health supported the Commission in many ways. In particular we thank Una O'Brien, Mark Davies, David Buck, Ray Earwicker, Geoff Raison, Maggie Davies, Steve Feast, Martin Gibbs, Chris Brookes, Anne Griffin and Lorna Demming.

We are indebted to the task groups and working committees that informed the Review. They included: Sharon Friel, Denny Vagero, Alan Dyson, Jane Tunstill, Clyde Hertzman, Ziba Vaghri, Helen Roberts, Johannes Siegrist, Abigail McKnight, Joan Benach, Carles Muntaner, David MacFarlane, Monste Vergara Duarte, Hans Weitkowitz, Gry Wester, Howard Glennerster, Ruth Lister, Jonathan Bradshaw, Olle Lundberg, Kay Withers, Jan Flaherty, Anne Power, Jonathan Davis, Paul Plant, Tord Kjellstrom, Catalina Turcu, Helen Eveleigh, Jonathon Porritt, Anna Coote, Paul Wilkinson, David Colin-Thomé, Maria Arnold, Helen Clarkson, Sue Dibb, Jane Franklin, Tara Garnett, Jemima Jewell, Duncan Kay, Shivani Reddy, Cathryn Tonne, Ben Tuxworth, James Woodcock, Peter Smith, David Epstein, Marc Suhrcke, John Appleby, Adam Coutts, Demetris Pillas, Carmen de Paz Nieves, Cristina Otano, Ron Labonté, Margaret Whitehead, Mark Exworthy, Sue Richards, Don Matheson, Tim Doran, Sue Povall, Anna Peckham, Emma Rowland, Helen Vieth, Amy Colori, Louis Coiffait, Matthew Andrews, Anna Matheson, John Doyle, Lindsey Meyers, Alan Maryon-Davis, Tim Lobstein, Angela Greatley, Mark Bellis, Sally Greengross, Martin Wiseman, Paul Lincoln, Clare Bambra, Kerry Joyce, David Piachaud, James Nazroo, Jennie Popay, Fran Bennett, Hillary Graham, Bobbie Jacobson, Paul Johnstone, Ken Judge, Mike Kelly, Catherine Law, John Newton, John Fox, Rashmi Shukla, Nicky Best, Ian Plewis, Sue Atkinson, Tim Allen, Amanda Ariss, Antony Morgan, Paul Fryers, Veena Raleigh, Gwyn Bevan, Hugh Markowe, Justine Fitzpatrick, David Hunter, Gabriel Scally, Ruth Hussey, Tony Elson, Steve Weaver, Jacky Chambers, Nick Hicks, Paul Dornan, Liam Hughes, Carol Tannahill, Hari Sewell, Alison O'Sullivan, Chris Bentley, Caroline Briggs, Anne McDonald, John Beer, Jim Hillage, Jenny Savage, Daniel Lucy, Klim McPherson, Paul Johnson, Damien O'Flaherty and Matthew Bell.

We are grateful to those who have provided us with information, contacts and data. They included: Edwina Hughes, Gemma Gosling, Neil Blackshaw, Jonathan Campion, Nicola Bent, Duncan Booker, Pauline Craig, Neil Pease, Phil Hatcher, Susie Dye, Steve Cummins, Andrew Connor, Clive Needle, Chris Piper, Pauline Vallance, Angela Mawle, Esther Trenchard-Mabere, Keith Williams, Cathie Shaw, Todd Campbell, Paul Edmondson-Jones, Tommy Gorman, Kerry Townsley, Joseph Dromey, Annette Gaskell, Alison Amstutz, Lia Robinson, Karl Wilkinshaw, Rachel Carse, John Joseph, Jake Eliot, Rob Taylor and Michael Hagen.

We thank the members of the Health Inequalities Programme Board and the Health Inequalities Cross-Government Working Group: Anne Jackson, Bill Gunnyeon, Andrew Lawrence, Daron Walker, Gareth Davies, Patricia Hayes, Liz Brutus, Elspeth Bracken, Rachel Arrundale, Kay Barton, Janice Shersby, Simon Medcalf, Jayne Bowman, Savas Hadjipavlou, Jaee Samant, Andrew Elliott, Helen Bailey, Tom Jeffery, Irene Lucas, Sue Owen, Mike Anderson, Stephen Rimmer, Stephen Marston, Helen Edwards, Chris Warmald, Andrew Ramsey, Steve Gooding, Lionel Jarvis, Jonathan Rees, Harry Burns and Chris Tudor-Smith.

We thank the stakeholders who participated in the policy dialogues and open space event and responded to the consultation; a list of participants and respondents can be found on the Marmot Review website at www.ucl.ac.uk/gheg/marmotreview.

We thank our regional partners including Ruth Hussey, Mike Farrar and Danila Armstrong in the North West and in London Boris Johnson, Mayor of London, Pam Chesters and Helen Davies.

The report was copy-edited by Georgina Kyriacou.

We are grateful to UCL for hosting and supporting the Review team and to the thousands of people and organisations who have contributed to discussions with the team, who have attended presentations, provided feedback, thought and comment and helped shape and inform this Review.

The Commissioners

Michael Marmot (Chair)
Tony Atkinson
John Bell
Carol Black
Patricia Broadfoot
Julia Cumberlege
Ian Diamond
Ian Gilmore
Chris Ham
Molly Meacher
Geoff Mulgan

Table of Figures

11 Figure 1
Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999–2003

11 Figure 2
Age standardised mortality rates by socio-economic classification (NS-SEC) in the North East and South West regions, men aged 25–64, 2001–2003

13 Figure 3
Age standardised percentage of women with a General Health Questionnaire (GHQ) score of 4 or more by deprivation quintile, 2001 and 2006

13 Figure 4
The conceptual framework

14 Figure 5
Action across the life course

17 Figure 6
Inequality in early cognitive development of children in the 1970 British Cohort Study, at ages 22 months to 10 years

19 Figure 7
Standardised limiting illness rates in 2001 at ages 16–74, by education level recorded in 2001

21 Figure 8
Mortality of men in England and Wales in 1981–92, by social class and employment status at the 1981 Census

23 Figure 9
Taxes as a percentage of gross income, by quintile, 2007/8

25 Figure 10
Populations living in areas with, in relative terms, the least favourable environmental conditions, 2001–6

27 Figure 11
Prevalence of obesity (>95th centile), by region and deprivation quintile, children aged 10–11 years, 2007/8

Executive summary

Key messages of this Review

1. **Reducing health inequalities is a matter of fairness and social justice. In England, the many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life.[1]**

2. **There is a social gradient in health – the lower a person's social position, the worse his or her health. Action should focus on reducing the gradient in health.**

3. **Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.**

4. **Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.**

5. **Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.**

6. **Economic growth is not the most important measure of our country's success. The fair distribution of health, well-being and sustainability are important social goals. Tackling social inequalities in health and tackling climate change must go together.**

7. **Reducing health inequalities will require action on six policy objectives:**
   - **Give every child the best start in life**
   - **Enable all children young people and adults to maximise their capabilities and have control over their lives**
   - **Create fair employment and good work for all**
   - **Ensure healthy standard of living for all**
   - **Create and develop healthy and sustainable places and communities**
   - **Strengthen the role and impact of ill health prevention**

8. **Delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups. National policies will not work without effective local delivery systems focused on health equity in all policies.**

9. **Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.**

Introduction

Reducing health inequalities is a matter of fairness and social justice

Inequalities are a matter of life and death, of health and sickness, of well-being and misery. The fact that in England today people in different social circumstances experience avoidable differences in health, well-being and length of life is, quite simply, unfair. Creating a fairer society is fundamental to improving the health of the whole population and ensuring a fairer distribution of good health.

Inequalities in health arise because of inequalities in society – in the conditions in which people are born, grow, live, work, and age. So close is the link between particular social and economic features of society and the distribution of health among the population, that the magnitude of health inequalities is a good marker of progress towards creating a fairer society. Taking action to reduce inequalities in health does not require a separate health agenda, but action across the whole of society.

The WHO Commission on Social Determinants of Health which, among other work, was an impetus for the commissioning of this Review by the Department of Health, surveyed the world scene and concluded that 'social injustice is killing on a grand scale'.[2] While within England there are nowhere near the extremes of inequalities in mortality and morbidity seen globally, inequality is still substantial and requires urgent action. In England, people living in the poorest neighbourhoods, will, on average, die seven years earlier than people living in the richest neighbourhoods (the top curve in Figure 1). Even more disturbing, the average difference in disability-free life expectancy is 17 years (the bottom curve in Figure 1). So, people in poorer areas not only die sooner, but they will also spend more of their shorter lives with a disability. To illustrate the importance of the gradient: even excluding the poorest five per cent and the richest five per cent the gap in life expectancy between low and high income is six years, and in disability-free life expectancy 13 years.

Figure 1 also shows the finely graded relationship between the socioeconomic characteristics of these neighbourhoods and both life expectancy and disability-free life expectancy. Not only are there dramatic differences between best-off and worst-off in England, but the relationship between social circumstances and health is also a graded one. This is the social gradient in health. We can draw similar graphs to Figure 1 classifying individuals not by where they live but by their level of education, occupation, housing conditions – and see similar gradients. Put simply, the higher one's social position, the better one's health is likely to be.

These serious health inequalities do not arise by chance, and they cannot be attributed simply to genetic makeup, 'bad', unhealthy behaviour, or difficulties in access to medical care, important as those factors may be. Social and economic differences in health status reflect, and are caused by, social and economic inequalities in society.

The starting point for this Review is that health inequalities that are preventable by reasonable means are unfair. Putting them right is a matter of social justice. A debate about how to close the health gap has to be a debate about what sort of society people want.

Action is needed to tackle the social gradient in health

The implications of the social gradient in health are profound. It is tempting to focus limited resources on those in most need. But, as Figure 1 illustrates, we are all in need – all of us beneath the very best-off. If the focus were on the very bottom and social action were successful in improving the plight of the worst-off, what would happen to those just above the bottom, or at the median, who have worse health than those above them? All must be included in actions to create a fairer society.

We are unlikely to be able to eliminate the social gradient in health completely, but it is possible to have a shallower social gradient in health and well-being than is currently the case for England. This is evidenced by the fact that there is a steeper socio-economic gradient in health in some regions than in others, as shown in Figure 2.

To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism. Greater intensity of action is likely to be needed for those with greater social and economic disadvantage, but focusing solely on the most disadvantaged will not reduce the health gradient, and will only tackle a small part of the problem.

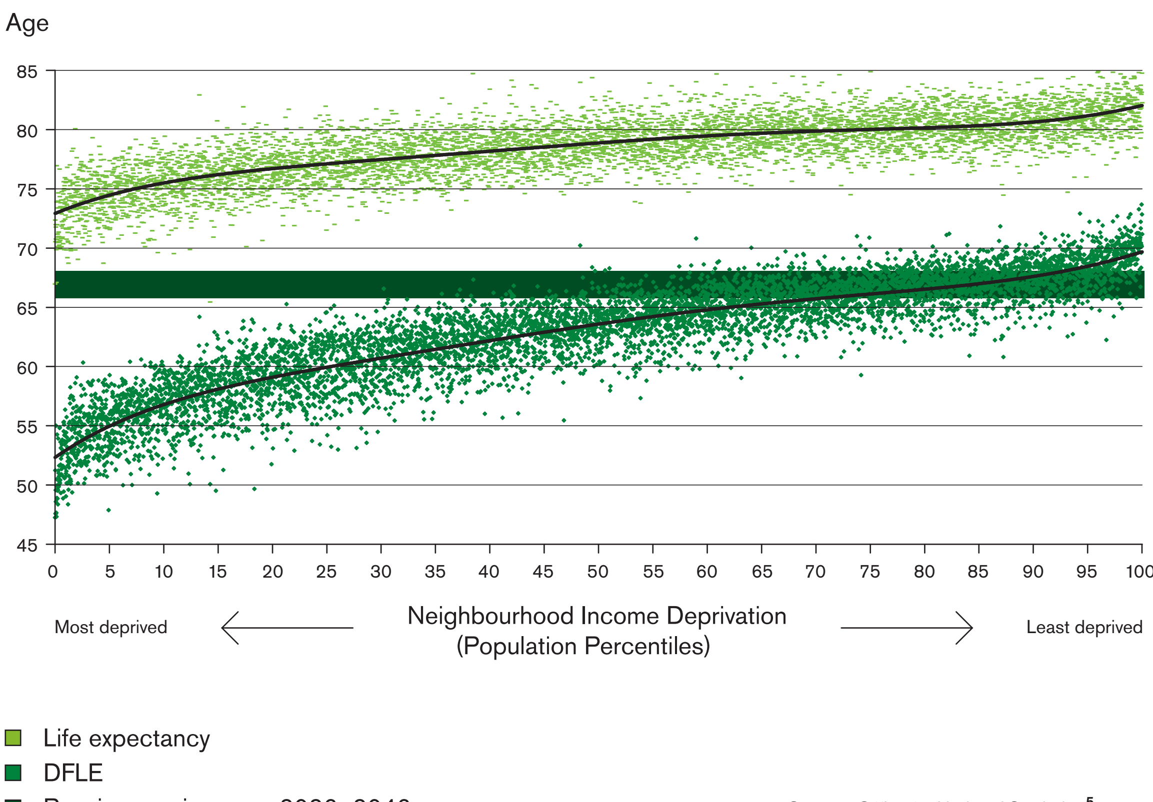
Action on health inequalities requires action across all the social determinants of health

The Commission on Social Determinants of Health concluded that social inequalities in health arise because of inequalities in the conditions of daily life and the fundamental drivers that give rise to them: inequities in power, money and resources.[3]

These social and economic inequalities underpin the determinants of health: the range of interacting factors that shape health and well-being. These include: material circumstances, the social environment, psychosocial factors, behaviours, and biological factors. In turn, these factors are influenced by social position, itself shaped by education, occupation, income, gender, ethnicity and race. All these influences are affected by the socio-political and cultural and social context in which they sit.[4]

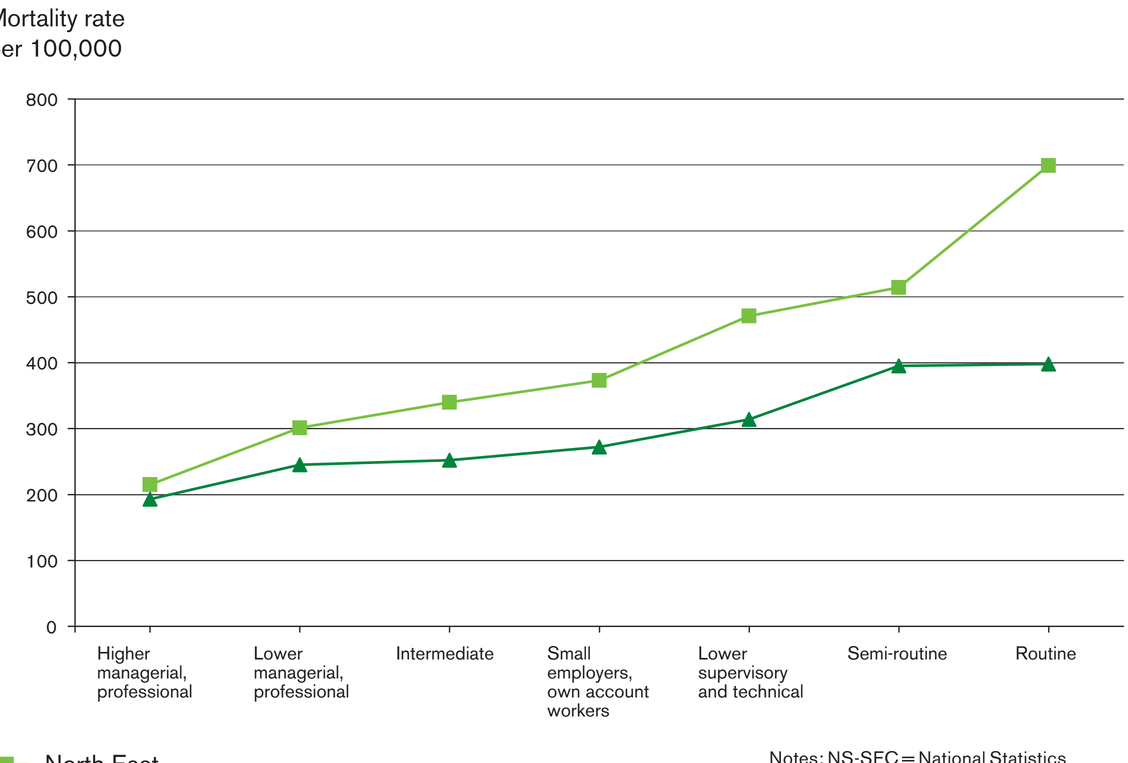
When we consider these social determinants of health, it is no mystery why there should continue to be health inequalities. Persisting inequalities across key domains provide ample explanation: inequalities in early child development and education, employment and working conditions, housing and neighbourhood conditions, standards of living, and, more generally, the freedom to participate equally in the

Figure 1 Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999–2003



Source: Office for National Statistics[5]

Figure 2 Age standardised mortality rates by socioeconomic classification (NS-SEC) in the North East and South West regions, men aged 25–64, 2001–2003



Notes: NS-SEC = National Statistics Socio-economic Classification
Source: Office for National Statistics[6]

benefits of society. A central message of this Review, therefore, is that action is required across all these social determinants of health and needs to involve all central and local government departments as well as the third and private sectors. Action taken by the Department of Health and the NHS alone will not reduce health inequalities.

The unfair distribution of health and length of life provides compelling enough reason for action across all social determinants. However, there are other important reasons for taking action too. Addressing continued inequalities in early child development, in young people's educational achievement and acquisition of skills, in sustainable and healthy communities, in social and health services, and in employment and working conditions will have multiple benefits that extend beyond reductions in health inequalities.

Reducing health inequalities is vital for the economy

The benefits of reducing health inequalities are economic as well as social. The cost of health inequalities can be measured in human terms, years of life lost and years of active life lost; and in economic terms, by the cost to the economy of additional illness. If everyone in England had the same death rates as the most advantaged, people who are currently dying prematurely as a result of health inequalities would, in total, have enjoyed between 1.3 and 2.5 million extra years of life.[7] They would, in addition, have had a further 2.8 million years free of limiting illness or disability.[8] It is estimated that inequality in illness accounts for productivity losses of £31-33 billion per year, lost taxes and higher welfare payments in the range of £20-32 billion per year[9], and additional NHS healthcare costs associated with inequality are well in excess of £5.5 billion per year.[10] If no action is taken, the cost of treating the various illnesses that result from inequalities in the level of obesity alone will rise from £2 billion per year to nearly £5 billion per year in 2025.[11]

As further illustration, we have drawn on Figure 1 a line at 68 years – the pensionable age to which England is moving. With the levels of disability shown, more than three-quarters of the population do not have disability-free life expectancy as far as the age of 68. If society wishes to have a healthy population, working until 68 years, it is essential to take action to both raise the general level of health and flatten the social gradient.

This report is published in an adverse economic climate. We join our voice to those who say that a crisis is an opportunity: it is a time to plan to do things differently. Austerity need not lead to retrenchment in the welfare state. Indeed, the opposite may be necessary: the welfare state in England, the NHS itself, was born in the most austere post-war conditions. This required both courage and imagination. Today we call for courage and imagination again, to ensure equal health and well-being for future generations.

Beyond economic growth to well-being of society: sustainability and the fair distribution of health

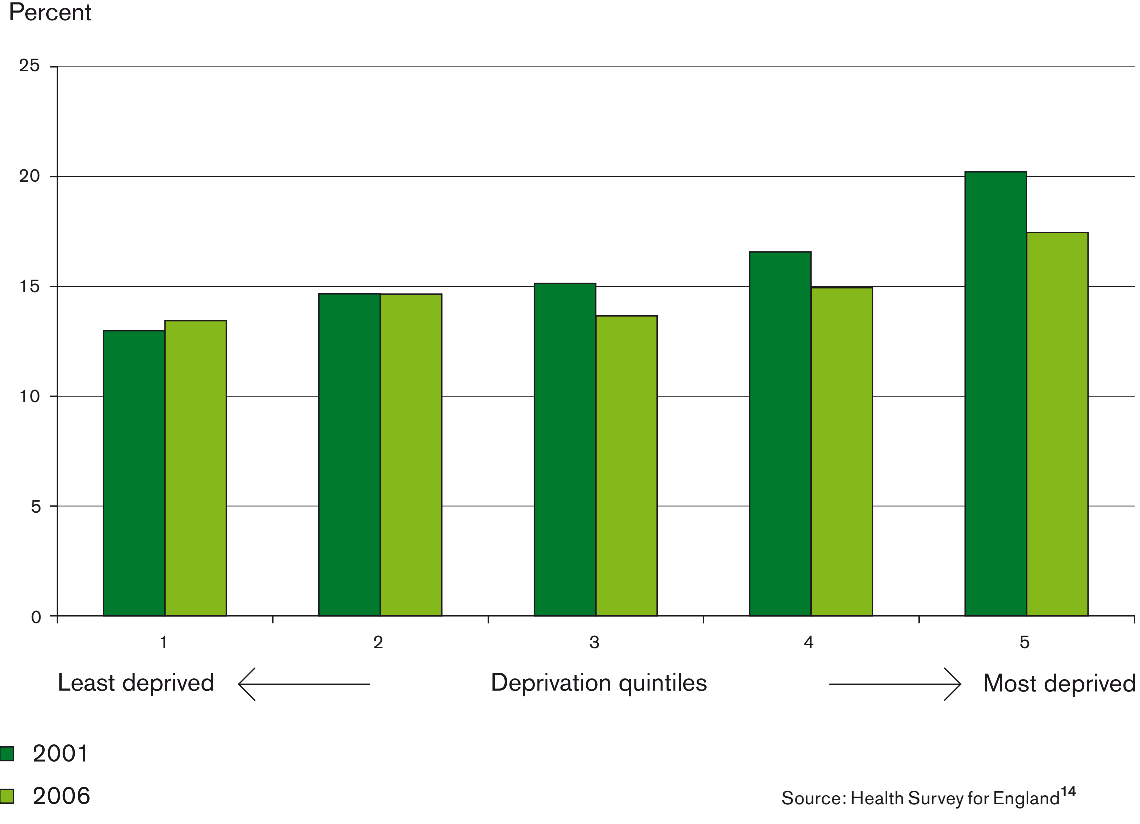
It is time to move beyond economic growth as the sole measure of social success. Not a new idea, it was given new emphasis by the recent Commission on the Measurement of Economic Performance and Social Progress, set up by President Sarkozy and chaired by Joseph Stiglitz, with Amartya Sen and Jean-Paul Fitoussi.[12] Well-being should be a more important societal goal than simply more economic growth. Prominent among the measures of well-being should be levels of inequalities in health.

Environmental sustainability, too, should be a more important societal goal than simply more economic growth. Economic growth without attending to its environmental impact, maintaining the status quo, is not an option for the country or for the planet. Globally, climate change and attempts to combat it have the worst effects on the poorest and most vulnerable. The need for mitigation of, and adaptation to, climate change means that we must do things differently. Creating a sustainable future is entirely compatible with action to reduce health inequalities: sustainable local communities, active transport, sustainable food production, and zero-carbon houses will have health benefits across society. We set out measures that will aid mitigation of climate change and also reduce health inequalities.

Simply restoring economic growth, trying to return to the status quo, while cutting public spending, should not be an option. Economic growth without reducing relative inequality will not reduce health inequalities. The economic growth of the last 30 years has not narrowed income inequalities. And although there is far more to inequality than just income, income is linked to life chances in a number of salient ways. As Amartya Sen has argued, income inequalities affect the lives people are able to lead.[13] A fair society would give people more equal freedom to lead flourishing lives.

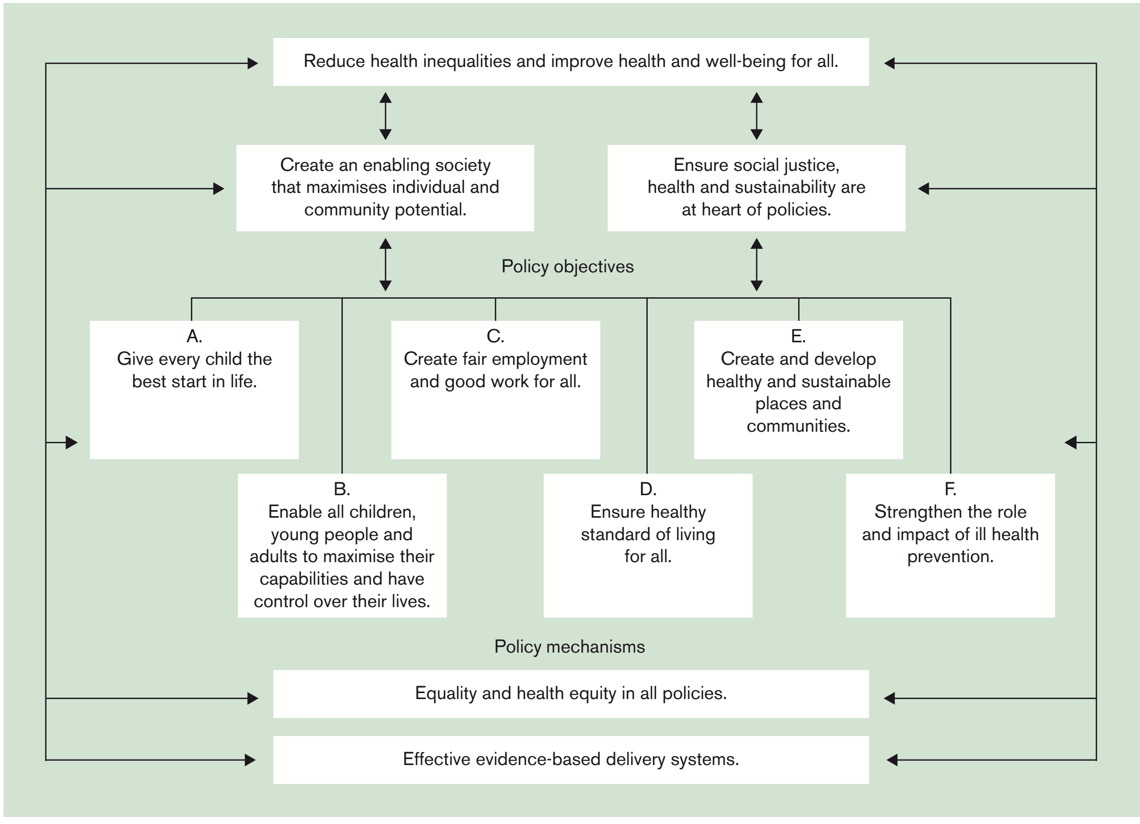
The central ambition of this Review is to create the conditions for people to take control over their own lives. If the conditions in which people are born, grow, live, work, and age are favourable, and more equitably distributed, then they will have more control over their lives in ways that will influence their own health and health behaviours, and those of their families. However, the freedom to flourish is graded. As an example, Figure 3 shows how answers to the General Health Questionnaire are related to deprivation for women in the Health Survey for England in 2001 and 2006 – a score of 4 or more indicates symptoms of mental disturbance.

Figure 3 Age standardised percentage of women with a General Health Questionnaire (GHQ) score of 4 or more by deprivation quintile, 2001 and 2006



Source: Health Survey for England[14]

Figure 4 The Conceptual framework



Six policy recommendations to reduce health inequalities

A framework for action

This Review has twin aims: to improve health and well-being for all and to reduce health inequalities. To achieve this, we have two policy goals:

— To create an enabling society that maximises individual and community potential
— To ensure social justice, health and sustainability are at the heart of all policies.

Based on the evidence we have assembled, our recommendations are grouped into six policy objectives, as shown in Figure 4.

Our recommendations in these six policy objectives are underpinned by two policy mechanisms:

— Considering equality and health equity in all policies, across the whole of government, not just the health sector
— Effective evidence-based interventions and delivery systems.

Action across the life course

Central to the Review is a life course perspective. Disadvantage starts before birth and accumulates throughout life, as shown in Figure 5. Action to reduce health inequalities must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken. That is our ambition for children born in 2010. **For this reason, giving every child the best start in life (Policy Objective A) is our highest priority recommendation.**

Meanwhile, there is much that can be done to improve the lives and health of people who have already reached school, working age and beyond, as demonstrateed by the evidence presented in the following sections. Services that promote the health, well being and independence of older people and, in so doing, prevent or delay the need for more intensive or institutional care, make a significant contribution to ameliorating health inequalities. For example, the Partnerships for Older People projects have been shown to be cost effective in improving life quality.

Figure 5 Action across the life course

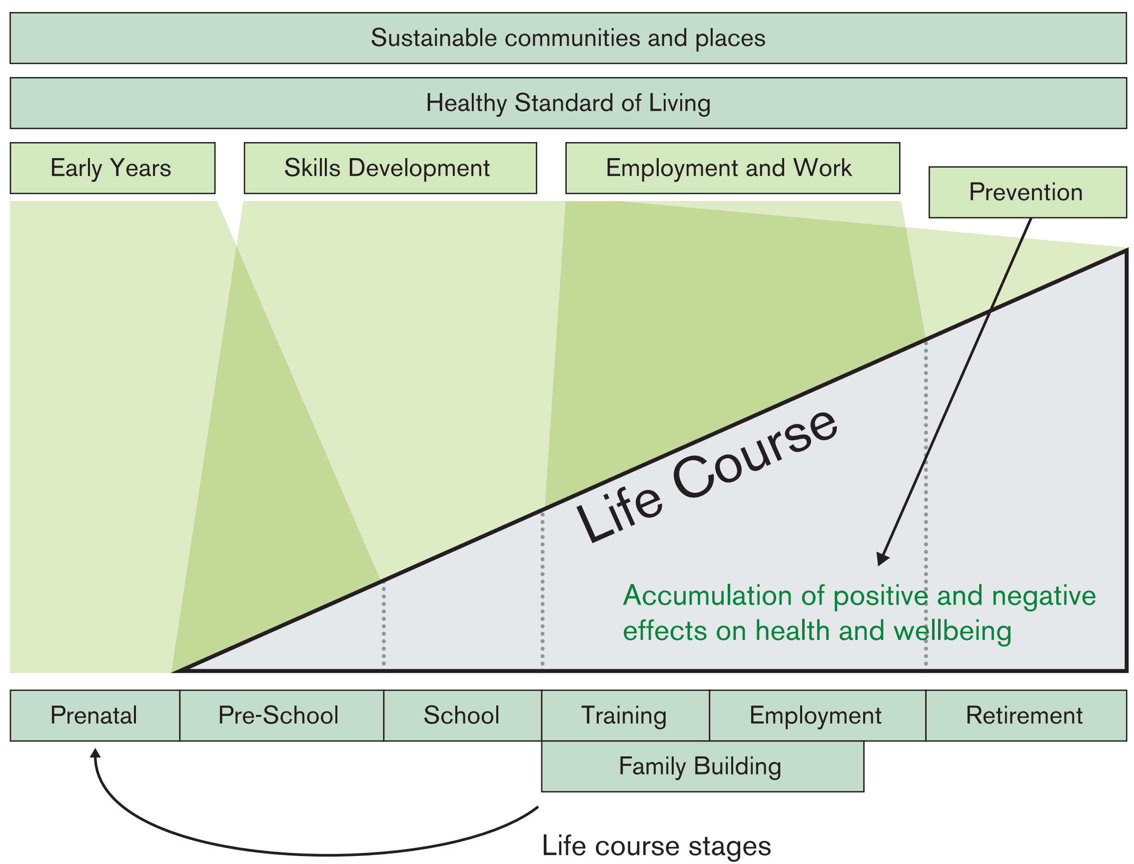


Photo: Anthony Strack/Getty Images

Policy Objective A
Give every child the best start in life

Priority objectives

1. Reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills.
2. Ensure high quality maternity services, parenting programmes, childcare and early years education to meet need across the social gradient.
3. Build the resilience and well-being of young children across the social gradient.

Policy recommendations

1. Increase the proportion of overall expenditure allocated to the early years and ensure expenditure on early years development is focused progressively across the social gradient.
2. Support families to achieve progressive improvements in early child development, including:
   - Giving priority to pre- and post-natal interventions that reduce adverse outcomes of pregnancy and infancy
   - Providing paid parental leave in the first year of life with a minimum income for healthy living
   - Providing routine support to families through parenting programmes, children's centres and key workers, delivered to meet social need via outreach to families
   - Developing programmes for the transition to school.
3. Provide good quality early years education and childcare proportionately across the gradient. This provision should be:
   - Combined with outreach to increase the take-up by children from disadvantaged families
   - Provided on the basis of evaluated models and to meet quality standards.

If you are a single parent you don't get to go out that much, you don't really see anybody.

Quote from participant in qualitative work undertaken for the Review, which explored barriers to healthy lives among specific groups living in Hackney (London), Birmingham and Manchester. See Annex 1 and www.ucl.ac.uk/gheg/marmotreview. The remaining quotes in this summary also come from this work.

Inequalities in early child development

Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being– from obesity, heart disease and mental health, to educational achievement and economic status.[15] To have an impact on health inequalities we need to address the social gradient in children's access to positive early experiences. Later interventions, although important, are considerably less effective where good early foundations are lacking.[16]

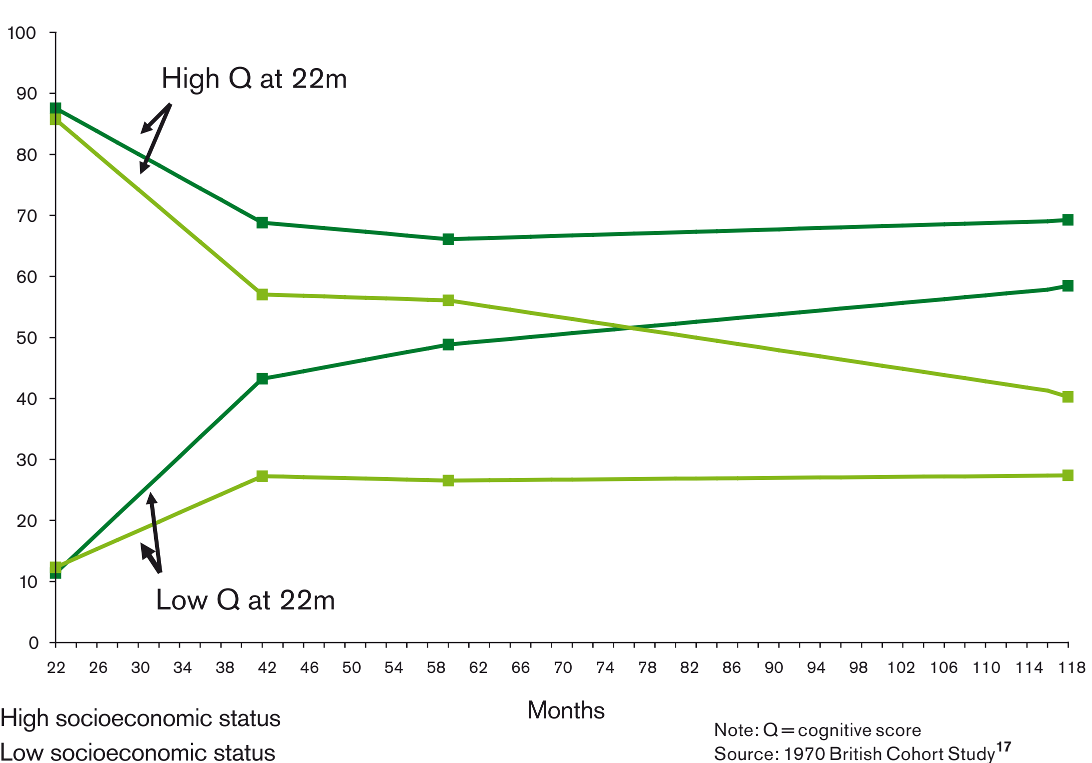
As Figure 6 shows, children who have low cognitive scores at 22 months of age but who grow up in families of high socioeconomic position improve their relative scores as they approach the age of 10. The relative position of children with high scores at 22 months, but who grow up in families of low socioeconomic position, worsens as they approach age 10.

What can be done to reduce inequalities in early child development?

There has been a strong government commitment to the early years, enacted through a wide range of policy initiatives, including Sure Start and the Healthy Child Programme. It is vital that this is sustained over the long term. Even greater priority must be given to ensuring expenditure early in the developmental life cycle (that is, on children below the age of 5) and that more is invested in interventions that have been proved to be effective.

We are therefore calling for a 'second revolution in the early years', to increase the proportion of overall expenditure allocated there. This expenditure should be focused proportionately across the social gradient to ensure effective support to parents (starting in pregnancy and continuing through the transition of the child into primary school), including quality early education and childcare.

Figure 6 Inequality in early cognitive development of children in the 1970 British Cohort Study, at ages 22 months to 10 years



Note: Q = cognitive score
Source: 1970 British Cohort Study[17]

Policy Objective B

Enable all children, young people and adults to maximise their capabilities and have control over their lives

Priority objectives

1. Reduce the social gradient in skills and qualifications.
2. Ensure that schools, families and communities work in partnership to reduce the gradient in health, well-being and resilience of children and young people.
3. Improve the access and use of quality lifelong learning across the social gradient.

Policy recommendations

1. Ensure that reducing social inequalities in pupils' educational outcomes is a sustained priority.
2. Prioritise reducing social inequalities in life skills, by:
   - Extending the role of schools in supporting families and communities and taking a 'whole child' approach to education
   - Consistently implementing 'full service' extended school approaches
   - Developing the school-based workforce to build their skills in working across school–home boundaries and addressing social and emotional development, physical and mental health and well-being.
3. Increase access and use of quality lifelong learning opportunities across the social gradient, by:
   - Providing easily accessible support and advice for 16–25 year olds on life skills, training and employment opportunities
   - Providing work-based learning, including apprenticeships, for young people and those changing jobs/careers
   - Increasing availability of non-vocational lifelong learning across the life course.

If there is no education there are no jobs these days, so it is really worrying. If your children don't get a good education then what's going to happen to them?

(Focus group participant)

Inequalities in education and skills

Inequalities in educational outcomes affect physical and mental health, as well as income, employment and quality of life. The graded relationship between socioeconomic position and educational outcome has significant implications for subsequent employment, income, living standards, behaviours, and mental and physical health (Figure 7).

To achieve equity from the start, investment in the early years is crucial. However, maintaining the reduction of inequalities across the gradient also requires a sustained commitment to children and young people through the years of education. Central to this is the acquisition of cognitive and non-cognitive skills, which are strongly associated with educational achievement and with a whole range of other outcomes including better employment, income and physical and mental health.

Success in education brings many advantages. If we are serious about reducing both social and health inequalities, we must maintain our focus on improving educational outcomes across the gradient.

What can be done to reduce inequalities in education and skills?

Inequalities in educational outcomes are as persistent as those for health and are subject to a similar social gradient. Despite many decades of policies aimed at equalising educational opportunities, the attainment gap remains. As with health inequalities, reducing educational inequalities involves understanding the interaction between the social determinants of educational outcomes, including family background, neighbourhood and relationships with peers, as well as what goes on in schools. Indeed, evidence on the most important factors influencing educational attainment suggests that it is families, rather than schools, that have the most influence. Closer links between schools, the family, and the local community are needed.

Investing in the early years, thereby improving early cognitive and non-cognitive development and children's readiness for school, is vital for later educational outcomes. Once at school, it is important that children and young people are able to develop skills for life and for work as well as attain qualifications.

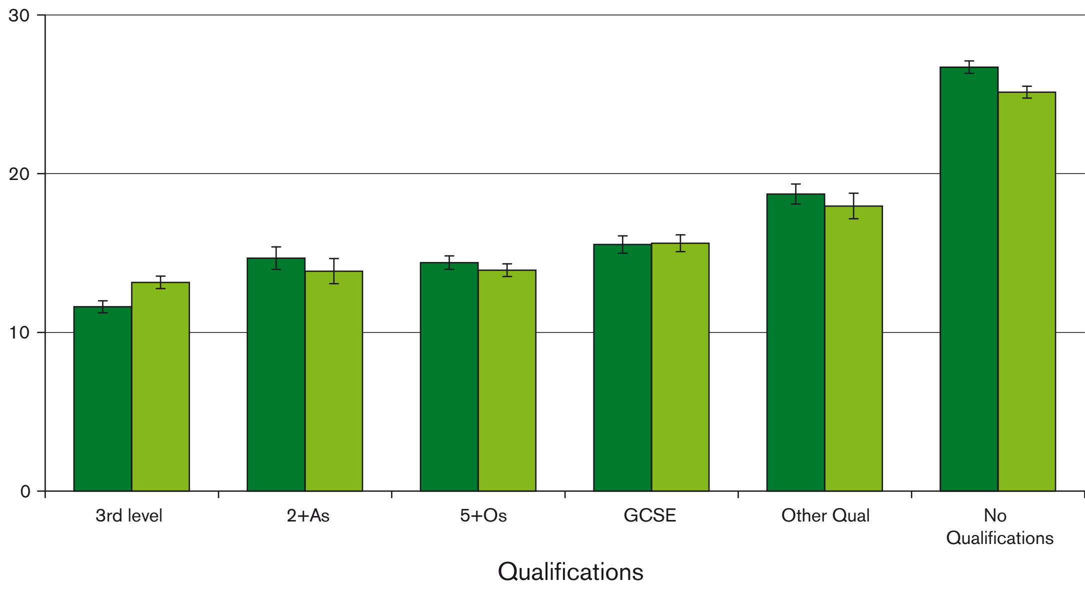
Closer links between schools, the family, and the local community are important steps to this achievement. The development of extended services in and around schools is important, but more is needed to develop the skills of teaching and non-teaching staff to work across home–school boundaries and develop the broader life skills of children and young people.

For those who leave school at 16, further support is vital in the form of skills development for work and training, management of relationships, and advice on substance misuse, debt, continuing education, housing concerns and pregnancy and parenting. Such training and support should be developed and located in every community, designed specifically for this age group.

Central to our vision is the full development of people's capabilities across the social gradient. Without life skills and readiness for work, as well as educational achievement, young people will not be able to fulfil their full potential, to flourish and take control over their lives.

photo: Image Source

Figure 7 Standardised limiting illness rates in 2001 at ages 16–74, by education level recorded in 2001



■ Males
■ Females

Note: Vertical bars (I) represent confidence intervals
Source: Office for National Statistics Longitudinal Study[18]

Policy Objective C
Create fair employment and good work for all

Priority objectives

1 Improve access to good jobs and reduce long-term unemployment across the social gradient.

2 Make it easier for people who are disadvantaged in the labour market to obtain and keep work.

3 Improve quality of jobs across the social gradient.

Policy recommendations

1 Prioritise active labour market programmes to achieve timely interventions to reduce long-term unemployment.

2 Encourage, incentivise and, where appropriate, enforce the implementation of measures to improve the quality of jobs across the social gradient, by:
— Ensuring public and private sector employers adhere to equality guidance and legislation
— Implementing guidance on stress management and the effective promotion of well-being and physical and mental health at work.

3 Develop greater security and flexibility in employment, by:
— Prioritising greater flexibility of retirement age
— Encouraging and incentivising employers to create or adapt jobs that are suitable for lone parents, carers and people with mental and physical health problems.

The only [things] I am concerned [about] are the future of my children, the lack of opportunities for the younger generation and the lack of employment – that is very daunting.

(Focus group participant)

Inequalities in work and employment

Being in good employment is protective of health. Conversely, unemployment contributes to poor health. Getting people into work is therefore of critical importance for reducing health inequalities. However, jobs need to be sustainable and offer a minimum level of quality, to include not only a decent living wage, but also opportunities for in-work development, the flexibility to enable people to balance work and family life, and protection from adverse working conditions that can damage health.

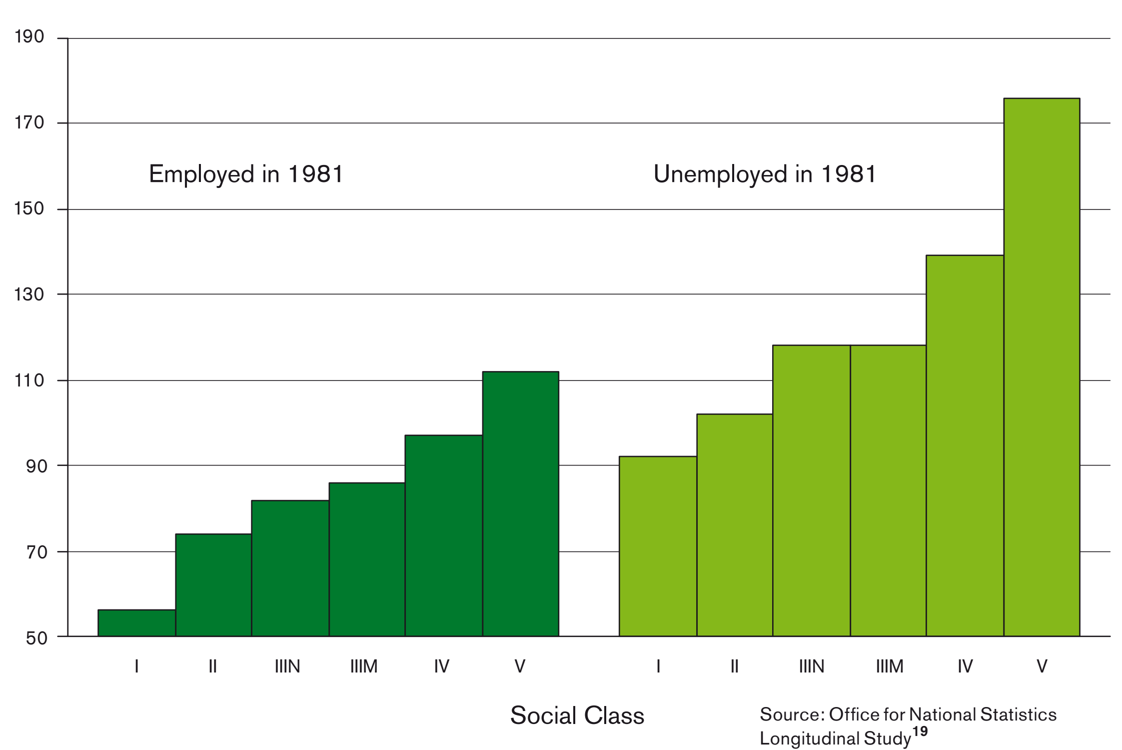
Patterns of employment both reflect and reinforce the social gradient and there are serious inequalities of access to labour market opportunities. Rates of unemployment are highest among those with no or few qualifications and skills, people with disabilities and mental ill-health, those with caring responsibilities, lone parents, those from some ethnic minority groups, older workers and, in particular, young people. When in work, these same groups are more likely to be in low-paid, poor quality jobs with few opportunities for advancement, often working in conditions that are harmful to health. Many are trapped in a cycle of low-paid, poor quality work and unemployment.

The dramatic increase in unemployment in the United Kingdom during the early 1980s stimulated research on the link between unemployment and health. Figure 8 shows the social gradient in the subsequent mortality of those that experienced unemployment in the early 1980s. For each occupational class, the unemployed have higher mortality than the employed.

Insecure and poor quality employment is also associated with increased risks of poor physical and mental health. There is a graded relationship between a person's status at work and how much control and support they have there. These factors, in turn, have biological effects and are related to increased risk of ill-health.

Work is good – and unemployment bad – for physical and mental health, but the quality of work matters. Getting people off benefits and into low paid, insecure and health-damaging work is not a desirable option.

Figure 8 Mortality of men in England and Wales in 1981–92, by social class and employment status at the 1981 Census



Source: Office for National Statistics Longitudinal Study[19]

Policy Objective D
Ensure a healthy standard of living for all

Priority objectives

1. Establish a minimum income for healthy living for people of all ages.
2. Reduce the social gradient in the standard of living through progressive taxation and other fiscal policies.
3. Reduce the cliff edges faced by people moving between benefits and work.

Policy recommendations

1. Develop and implement standards for minimum income for healthy living.
2. Remove 'cliff edges' for those moving in and out of work and improve flexibility of employment.
3. Review and implement systems of taxation, benefits, pensions and tax credits to provide a minimum income for healthy living standards and pathways for moving upwards.

I'm one person who would be better off not working with two kids. I would have more money if I didn't work.

(Focus group participant)

Inequalities in income

Having insufficient money to lead a healthy life is a highly significant cause of health inequalities.[20]

As a society becomes richer, the levels of income and resources that are considered to be adequate also rise. The calculation of Minimum Income for Healthy Living (MIHL) includes the level of income needed for adequate nutrition, physical activity, housing, social interactions, transport, medical care and hygiene. In England there are gaps between a minimum income for healthy living and the level of state benefit payments that many groups receive.

Despite important steps made by the Government to tackle child poverty, the proportion of the UK population living in poverty remains stubbornly high, above the European Union average and worse than in France, Germany, the Netherlands and the Nordic countries. Employment policy has helped, but the UK benefits system remains inadequate.

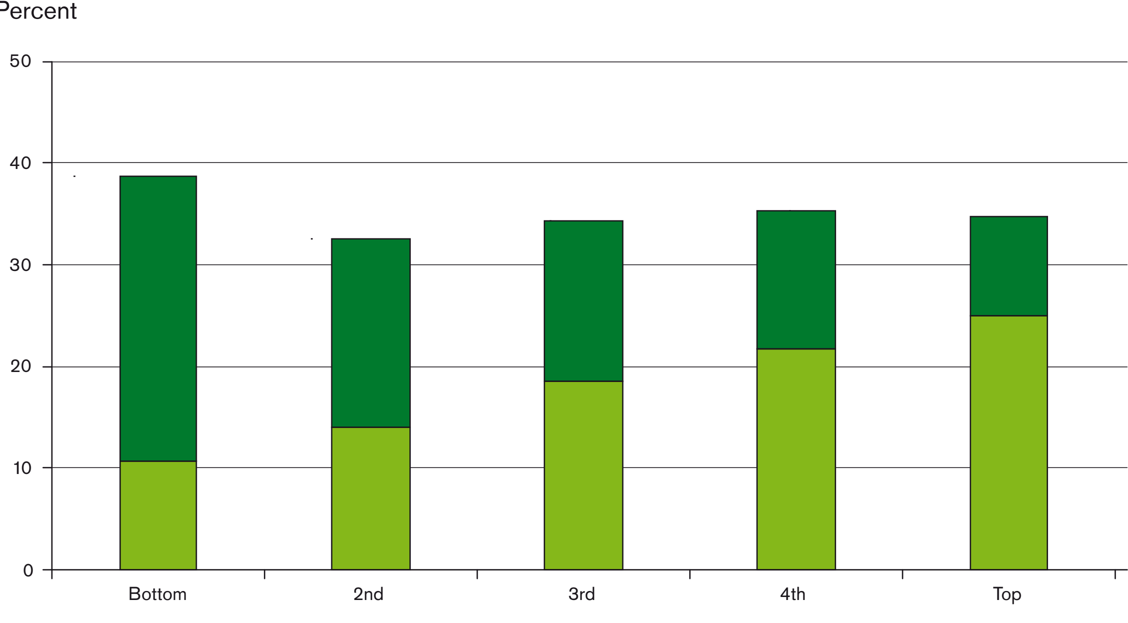
Figure 9 shows that, after taking account of both direct and indirect tax, the taxation system in Britain disadvantages those on lower incomes. The benefits of lower direct tax rates for those on lower incomes are cancelled out by the effects of indirect taxation. People on low incomes spend a larger proportion of their money on commodities that attract indirect taxes. As a result, overall tax, as a proportion of disposable income, is highest in the bottom quintile.

What can be done to reduce income inequalities?

State benefits increase the incomes of the worst off. Since 1998 tax credits have lifted 500,000 children out of poverty. It is imperative that the system of benefits does not act as a disincentive to enter employment. Over two million workers in Britain stand to lose more than half of any increase in earnings to taxes and reduced benefits. Some 160,000 would keep less than 10p of each extra £1 they earned. Lone parents face some of the weakest incentives to work and earn more, because many will be, or worry they will be, subject to withdrawal of a tax credit or means-tested benefit as their earnings rise.

The current tax and benefit system needs overhauling to strengthen incentives to work for people on low incomes and increase simplicity and certainty for families. The Government could do more to redistribute income and reduce poverty without harming the economy by delivering a net tax cut to people who currently face weak incentives to enter work or to increase their low levels of pay. A more progressive tax system is needed, one that includes the direct and indirect incomes that make up a person's income.

Figure 9 Taxes as a percentage of gross income, by quintile, 2007/8



Source: Office for National Statistics[21]

Policy Objective E
Create and develop healthy and sustainable places and communities

Priority objectives

1. Develop common policies to reduce the scale and impact of climate change and health inequalities.
2. Improve community capital and reduce social isolation across the social gradient.

Policy recommendations

1. Prioritise policies and interventions that reduce both health inequalities and mitigate climate change, by:
   - Improving active travel across the social gradient
   - Improving the availability of good quality open and green spaces across the social gradient
   - Improving the food environment in local areas across the social gradient
   - Improving energy efficiency of housing across the social gradient.
2. Fully integrate the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality.
3. Support locally developed and evidence-based community regeneration programmes that:
   - Remove barriers to community participation and action
   - Reduce social isolation.

You can see the deprivation. All you have to do is look outside. It is in your face every day – litter everywhere, rats and rubbish, it is a dump… It feels like people around you have no meaning to life. I keep my curtains closed at times. It doesn't give you a purpose to do anything.

(Focus group participant)

Inequalities in neighbourhoods and communities

Communities are important for physical and mental health and well-being. The physical and social characteristics of communities, and the degree to which they enable and promote healthy behaviours, all make a contribution to social inequalities in health. However, there is a clear social gradient in 'healthy' community characteristics (Figure 10).

People want to get involved with that, people will want to support that, people will want to volunteer for that, people want to get education to fit the role so that can grow and I don't want people from outside of the community to do that, I want people from inside the community to do that because it's up to us. We care about it.

(Focus group participant)

What can be done to reduce community inequalities?

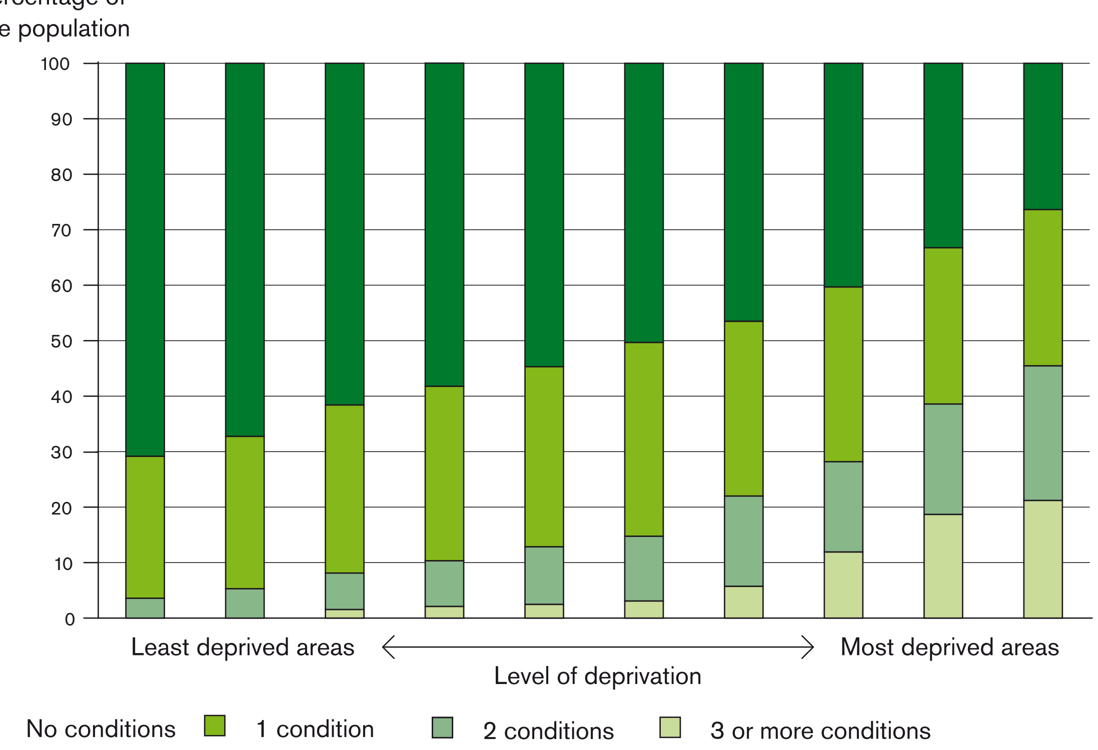
Social capital describes the links between individuals: links that bind and connect people within and between communities. It provides a source of resilience, a buffer against risks of poor health, through social support which is critical to physical and mental well-being, and through the networks that help people find work, or get through economic and other material difficulties. The extent of people's participation in their communities and the added control over their lives that this brings has the potential to contribute to their psychosocial well-being and, as a result, to other health outcomes.

It is vital to build social capital at a local level to ensure that policies are both owned by those most affected and are shaped by their experiences.

Building healthier and more sustainable communities involves choosing to invest differently. For example, the Commission for Architecture and the Built Environment estimates that the budget for new road building, if used differently, could provide 1,000 new parks at an initial capital cost of £10 million each – two parks in each local authority in England. One thousand new parks could save approximately 74,000 tonnes of carbon, based on a 10 hectare park with 200 trees.[22]

Much of what we recommend for reducing health inequalities – active travel (for example walking or cycling), public transport, energy-efficient houses, availability of green space, healthy eating, reduced carbon-based pollution – will also benefit the sustainability agenda.

Figure 10 Populations living in areas with, in relative terms, the least favourable environmental conditions, 2001–6



Environmental conditions: river water quality, air quality, green space, habitat favourable to bio-diversity, flood risk, litter, detritus, housing conditions, road accidents, regulated sites (e.g. landfill)

Source: Department for Environment, Food and Rural Affairs[23]

Policy Objective F
Strengthen the role and impact of ill-health prevention

Priority objectives

1. Prioritise prevention and early detection of those conditions most strongly related to health inequalities.
2. Increase availability of long-term and sustainable funding in ill health prevention across the social gradient.

Policy recommendations

1. Prioritise investment in ill health prevention and health promotion across government departments to reduce the social gradient.
2. Implement an evidence-based programme of ill health preventive interventions that are effective across the social gradient by:
   — Increasing and improving the scale and quality of medical drug treatment programmes
   — Focusing public health interventions such as smoking cessation programmes and alcohol reduction on reducing the social gradient
   — Improving programmes to address the causes of obesity across the social gradient.
3. Focus core efforts of public health departments on interventions related to the social determinants of health proportionately across the gradient.

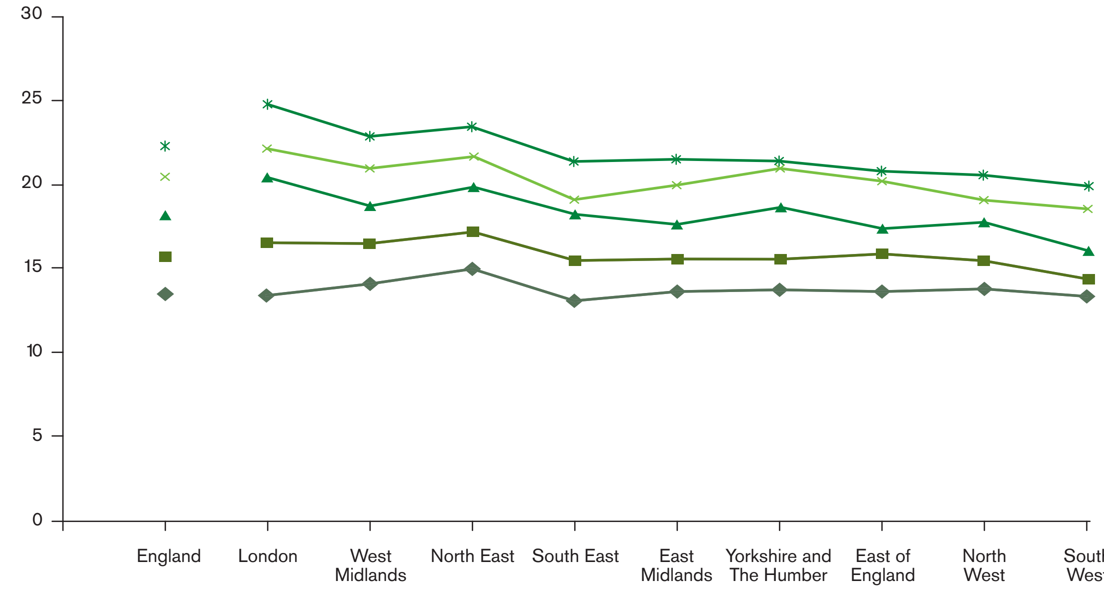
Many of the key health behaviours significant to the development of chronic disease follow the social gradient: smoking, obesity, lack of physical activity, unhealthy nutrition. An example is shown for obesity in Figure 11. Each of the five policy areas of our recommendations are targeted at preventing the social gradient in incidence of illness. In addition, reducing health inequalities requires a focus on these health behaviours.

The importance of investing in the early years is key to preventing ill health later in life, as is investing in healthy schools and healthy employment as well as more traditional forms of ill-health prevention such as drug treatment and smoking cessation programmes. The accumulation of experiences a child receives shapes the outcomes and choices they will make when they become adults.

Prevention of ill health has traditionally been the responsibility of the NHS, but we put prevention in the context of the social determinants of health. Hence, all our recommendations require involvement of a range of stakeholders. Local and national decisions made in schools, the workplace, at home, and in government services all have the potential to help or hinder ill-health prevention.

At present only 4 per cent of NHS funding is spent on prevention. Yet, the evidence shows that partnership working between primary care, local authorities and the third sector to deliver effective universal and targeted preventive interventions can bring important benefits.

Figure 11 Prevalence of obesity (>95th centile), by region and deprivation quintile, children aged 10–11 years, 2007/8



Source: National Obesity Observatory, based on National Child Measurement Programme[24]

Delivery systems

Even backed by the best evidence and with the most carefully designed and well resourced interventions, national policies will not reduce inequalities if local delivery systems cannot deliver them. The recommendations we make depend both on local partnerships and on national cross-cutting government policies.

Central direction, local delivery

Where does responsibility for action lie? There is no question that central, regional, and local government all have crucial roles to play. As we conducted this Review, we formed partnerships with the North West region of England, and with London; both regions are seeking to put the reduction of health inequalities at the centre of their strategy and actions.[25] They will be joined by several other local governments, Primary Care Trusts, and third sector organisations.

The argument was put to us that local practitioners want principles for action rather than detailed, specific recommendations. Local areas suggested they will exercise the freedom to develop locally appropriate plans for reducing health inequalities. The policy proposals made in this Review are intended to provide evidence of interventions that will reduce health inequalities and to give directions of travel without detailed prescription of exactly how policies should be developed and implemented. Similarly, the Review has proposed a national framework of indicators, within which local areas develop those needed for monitoring local performance improvement in their own areas.

Individual and community empowerment

Linked to the question of whether action should be central or local is the role of individual responsibility, often juxtaposed against the responsibility of government. This Review puts empowerment of individuals and communities at the centre of action to reduce health inequalities. But achieving individual empowerment requires social action. Our vision is of creating conditions for individuals to take control of their own lives. For some communities this will mean removing structural barriers to participation, for others facilitating and developing capacity and capability through personal and community development.

There needs to be a more systematic approach to engaging communities by Local Strategic Partnerships at both district and neighbourhood levels, moving beyond often routine, brief consultations to effective participation in which individuals and communities define the problems and develop community solutions. Without such participation and a shift of power towards individuals and communities it will be difficult to achieve the penetration of interventions needed to impact effectively on health inequalities.

Strategic policy should be underpinned by a limited number of aspirational targets that support the intended strategic direction, to improve and reduce inequalities in life and health expectancy and monitor child development and social inclusion across the social gradient.

National health outcome targets across the social gradient

It is proposed that national targets in the immediate future should cover:

- **Life expectancy (to capture years of life)**
- **Health expectancy (to capture the quality of those years).**

Once an indicator of well-being is developed that is suitable for large-scale implementation, this should be included as a third national target on health inequality.

National targets for child development across the social gradient

It is proposed that national targets should cover:

- **Readiness for school (to capture early years development)**
- **Young people not in education, employment or training (to capture skill development during the school years and the control that school leavers have over their lives).**

National target for social inclusion

It is proposed that there be a national target that progressively increases the proportion of households that have an income, after tax and benefits, that is sufficient for healthy living.

National and regional leadership should promote awareness of the underlying social causes of health inequalities and build understanding across the NHS, local government, third sector and private sector services of the need to scale up interventions and sustain intensity using mainstream funding. Interventions should have an evidenced-based evaluation framework and a health equity impact assessment. This would help delivery organisations shape effective interventions, understand impacts of other policies on health distributions and avoid drift into small-scale projects focused on individual behaviours and lifestyle.

Conclusion

Social justice is a matter of life and death. It affects the way people live, their consequent chances of illness and their risk of premature death.

This is the opinion of the Commission on Social Determinants of Health set up by the World Health Organisation. Theirs was a global remit and we can all easily recognise the health inequalities experienced by people living in poor countries, people for whom absolute poverty is a daily reality.

It is harder for many people to accept that serious health inequalities exist here in England. We have a highly valued NHS and the overall health of the population in this country has improved greatly over the past 50 years. Yet in the wealthiest part of London, one ward in Kensington and Chelsea, a man can expect to live to 88 years, while a few kilometres away in Tottenham Green, one of the capital's poorer wards, male life expectancy is 71. Dramatic health inequalities are still a dominant feature of health in England across all regions.

But health inequalities are not inevitable and can be significantly reduced. They stem from avoidable inequalities in society: of income, education, employment and neighbourhood circumstances. Inequalities present before birth set the scene for poorer health and other outcomes accumulating throughout the life course.

The central tenet of this Review is that avoidable health inequalities are unfair and putting them right is a matter of social justice. There will be those who say that our recommendations cannot be afforded, particularly in the current economic climate. We say that it is *inaction* that cannot be afforded, for the human and economic costs are too high. The health and well-being of today's children depend on us having the courage and imagination to rise to the challenge of doing things differently, to put sustainability and well-being before economic growth and bring about a more equal and fair society.

List of abbreviations

DEfRA	Department for Environment, Food and Rural Affairs
DFLE	Disability Free Life Expectancy
GCSE	General Certificate of Secondary Education
GHQ	General Health Questionnaire
MIHL	Minimum Income for Healthy Living
NHS	National Health Service
NS-SEC	National Statistics Socio-economic Classification
ONS	Office for National Statistics

References

1 Frontier Economics (2009) Overall costs of health inequalities. Submission to the Marmot Review. www.ucl.ac.uk/gheg/marmotreview/Documents; Suhrcke M (2009) The economic benefits of reducing health inequalities in England Submission to the Marmot Review. www.ucl.ac.uk/gheg/marmotreview/Documents

3 Commission on Social Determinants of Health (2008) CSDH Final Report: Closing the gap in a generation: Health equity through action on the social determinants of health. Geneva: World Health Organization.

3 Commission on Social Determinants of Health (2008) CSDH Final Report: Closing the gap in a generation: Health equity through action on the social determinants of health. Geneva: World Health Organization.

4 Commission on Social Determinants of Health (2008) CSDH Final Report: Closing the gap in a generation: Health equity through action on the social determinants of health. Geneva: World Health Organization; p.43.

5 Office for National Statistics (2009) Health expectancy at birth. http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=12964

6 Siegler V, Langford A and Johnson B (2008) Regional differences in male mortality inequalities using the National Statistics Socio-economic Classification, England and Wales, 2001-03. http://www.statistics.gov.uk/downloads/theme_health/HSQ40-winter-2008.pdf

7 Frontier Economics (2009) Overall costs of health inequalities. Submission to the Marmot Review. www.ucl.ac.uk/gheg/marmotreview/Documents; Suhrcke M (2009) The economic benefits of reducing health inequalities in England Submission to the Marmot Review. www.ucl.ac.uk/gheg/marmotreview/Documents

8 Frontier Economics (2009) Overall costs of health inequalities. Submission to the Marmot Review. www.ucl.ac.uk/gheg/marmotreview/Documents.

9 Frontier Economics (2009) Overall costs of health inequalities. Submission to the Marmot Review. www.ucl.ac.uk/gheg/marmotreview/Documents.

10 Morris S (2009) Private communication.

11 McPherson K and Brown M (2009) Social class and obesity - effects on disease and health service treatment costs. Submission to the Marmot Review. www.ucl.ac.uk/gheg/marmotreview/Documents

12 Stiglitz J, Sen A, Fitoussi J (2009) Report of the Commission on the Measurement of Economic Performance and Social Progress, available at http://www.stiglitz-sen-fitoussi.fr/en/index.htm

13 Sen A (1992) Inequality Reexamined. Oxford: Oxford University Press.

14 Unpublished statistics provided by the IMPACTsec Research Team, Dept of Epidemiology and Public Health, UCL.

15 Waldfogel J (2004) Social mobility, life chances, and the early years, CASE Paper 88, London: London School of Economics.

16 Waldfogel J (2004) Social mobility, life chances, and the early years, CASE Paper 88, London: London School of Economics.

17 Feinstein L (2003) Inequality in the early cognitive development of British Children in the 1970 cohort, Economica 70: 3-97.

18 Office for National Statistics Longitudinal Study. http://www.ons.gov.uk/about/who-we-are/our-services/longitudinal-study

19 Bethune A (1997) 'Unemployment and mortality' in Drever F and Whitehead M (Eds.) Health inequalities: Decennial supplement, ONS Series DS no. 15. London: The Stationery Office: 156-167.

20 Wilkinson R and Pickett K (2009) The Spirit Level: Why more equal societies almost always do better. London: Allen Lane.

21 Jones F, Annan D and Shah S (2009) The redistribution of household income 1977 to 2006/07. Economic & Labour Market Review 3 (1): 31-43.

22 Bird D (2009) Government advisors demand urgent shift in public investment to green England's cities. London: CABE. http://www.cabe.org.uk/press-releases/public-investment-to-green-cities

23 Department for Environment, Food and Rural Affairs (2007) Sustainable development indicators in your pocket 2007 - http://www.ltnetwork.org/SITE/UPLOAD/DOCUMENT/defra_sustain.pdf pp. 97.

24 The NHS Information Centre (2009) National Child Measurement Programme: England, 2008/09 school year. DH/DCSF. http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/obesity/national-child-measurement-programme-england-2008-09-school-year

25 http://www.london.gov.uk/thelondonplan/ and http://www.nwregionalstrategy.com/

Fair Society, Healthy Lives

The Marmot Review

www.ucl.ac.uk/marmotreview

Published by The Marmot Review
February 2010
© The Marmot Review

ISBN 978–0–9564870–0–1

Healthier Lives in a Healthier City

Southampton's Joint Health and Wellbeing Strategy

2013-2016

March 2013

Healthier Lives in a Healthier City

Southampton's Joint Health and Wellbeing Strategy

Contents

Foreword 3

Section One – Background and Local Context 4

Introduction 4

Consultation 5

Three Key Themes for Southampton's Joint Health and Wellbeing Strategy . 5

How we will ensure that things are improving 6

Section Two – Key Themes to Deliver Change 7

Theme 1 – Building resilience and preventative measures to achieve better health and wellbeing 7

Why this is important 7

Key information from the Joint Strategic Needs Assessment 8

What we will do 8

How we measure the impact of the actions set out in this section 10

Theme 2 – Best start in life 12

Why this is important 12

Existing plans 13

Key information from the Joint Strategic Needs Assessment 13

What we will do 14

How we measure the impact of the actions set out in this section 15

Theme 3 – Living and Ageing Well 19

Why this is important 19

Key information from the Joint Strategic Needs Assessment 19

What we will do 20

How we measure the impact of the actions set out in this section 21

Section 3 – Conclusion 24

Southampton Shadow Health and Wellbeing Board Members 25

Healthier Lives in a Healthier City

Southampton's Joint Health and Wellbeing Strategy

Foreword

We are delighted to introduce this new Joint Health and Wellbeing Strategy for Southampton. It sets out a strategic vision for improving the health of people of in the city and reducing health inequalities. The strategy will inform commissioning plans for the Council and Southampton City Clinical Commissioning Group (CCG) over the coming years.

The process of developing this strategy has been ably supported by our fellow shadow Health and Wellbeing Board members, together with a substantial number of council and CCG colleagues.

We undertook a substantial consultation exercise in the summer and autumn of 2012 to generate a city-wide discussion on what the most important issues were to include in this document. We have been heartily encouraged by the number of individuals and organisations who responded and produced some thought provoking and challenging comments and observations. Consideration of the responses received has resulted in the final strategy document looking substantially different to the consultation document. We would like to place on record our thanks to everyone who responded during the consultation. Your input has really helped to shape the final strategy and made it both more robust and more realistic.

There are a number of major challenges to improving the health and wellbeing of our citizens set out in subsequent pages. The strategy contains challenges to individuals to take responsibility for their own lifestyles that can have major impacts on health, as well as looking to ensure there is adequate care, treatment and support for the most vulnerable members of our society.

Delivering the results needed to meet these challenges will require commitment not only from the Council and the CCG, but also from NHS provider trusts, social care providers, and the host of voluntary organisations who operate in the city. This strategy now provides the overarching framework for action and delivering change. We hope you will identify with it and support us in making sure it delivers our ambition.

Councillor Jacqui Rayment
Cabinet Member for Communities, Southampton City Council and Chair of Southampton Shadow Health and Wellbeing Board

Dr Steve Townsend
Chair, Southampton City Clinical Commissioning Group and Vice-Chair of Southampton Shadow Health and Wellbeing Board

Section One – Background and Local Context

Introduction

This Joint Health and Wellbeing Strategy sets out how Southampton City Council, Southampton City Clinical Commissioning Group (CCG) and the NHS Commissioning Board plan to take action to address the key health and wellbeing needs of the city over a 3 year period beginning in 2013/14. The strategy was developed through Southampton's Shadow Health and Wellbeing Board, and has been adopted by both the Council and the CCG.

The content of the strategy has been informed by the Joint Strategic Needs Assessment (JSNA) and through conversations and feedback with stakeholders and the public. The Joint Strategic Needs Assessment is a process undertaken jointly by the City Council and the former Southampton City Primary Care Trust (PCT) where data on the health of people living in Southampton, their care needs and a number of the key wider determinants that affect health and wellbeing (including housing and employment) are collated, analysed and published. The JSNA is a web-based resource that is periodically updated as new data become available. It can be viewed at
http://www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/jsna2011/?locale=en

Specific challenges highlighted in the JSNA include:

- Demographic pressures, especially the growth in the city's birth rate (around 35% in seven years. Please see data under Theme 2 – Best Start in Life on page 12)
- The increasing proportion of older people and accompanying increase in dementia
- Deprivation and children in poverty – the city is ranked the fifth most deprived local authority in the South East and 81st out of the 326 local authorities in England
- The increase in unhealthy lifestyles leading to preventable diseases
- The need to ensure high quality services for specific care groups, including those living with mental ill health, physical disabilities and learning disabilities
- The need to ensure that provider services are joined up and seamless to create robust care pathways for a 'whole person' approach
- The need to support carers to care and the need for volunteering
- Work stresses and worklessness and the impact on mental health
- Recognising the impact on health of wider determinants (education, poor housing, transport and economic regeneration)

Southampton is in the fortunate position of having operated an effective Health and Wellbeing Partnership for a number of years. This situation provides a strong base from which the statutory Health and Wellbeing Board can launch and deliver its new responsibilities. The former Health and Wellbeing Partnership also produced a Strategy. Learning from that process will be utilised in the delivery of this joint health and wellbeing strategy.

Consultation

A period of consultation and engagement took place over the summer and early autumn of 2012 on a draft Joint Health and Wellbeing Strategy document. The consultation process included:

- Presentations to and debates at a number of key partnerships, including the GP Forum, Southampton Connect, the Children and Young People Trust Board, Southampton Safeguarding Children Board and a detailed workshop session with the Health Overview and Scrutiny Panel
- Public workshop sessions hosted by Southampton Local Involvement Network (LINk)
- Opportunities for on-line feedback on the City Council and PCT websites

Whilst a number of comments were specific to one issue or service, there were several comments made by a significant number of responders and these have been incorporated into this final strategy. These include the views that:

- There were too many proposals for actions in the draft strategy - so the final strategy now contains fewer and more significant proposals, and those that can be classed as "work as normal" have been omitted
- In these times of economic constraint, it was important that the strategy should be realistic and achievable – so an assessment has been undertaken to ensure that funding has been identified for those actions set out in this strategy
- Focus on preventative measures is vital as a means of reducing demand in the future – so prevention is now included as the first theme of this strategy
- It is vital that measures are developed to measure the success and impact of the strategy – so where possible the actions are aligned to the relevant national outcomes frameworks. Where there is no suitable measure in the framework, then a local indicator has been identified

Three Key Themes for Southampton's Joint Health and Wellbeing Strategy

The actions in the strategy are grouped into three themes:

- Building resilience and using preventative measures to achieve better health and wellbeing
- Best start in life
- Living and ageing well

Using these three themes, actions can be linked to the needs identified in the JSNA. They will secure a life course approach to improve health and wellbeing and provide a means of reducing health inequalities. They also provide scope for improved joint working across health and care systems, which develop a shared ambition and vision of success.

The following sections now consider each of these themes in turn. Key data from the JSNA are used to highlight the underlying issues and challenges, and then the actions the strategy will deliver are listed. Finally, the measures that will be used to record the impact the strategy is making are tabulated.

How we will ensure that things are improving

The Government has developed a range of national outcomes frameworks, which have placed a greater emphasis on the use of shared and complementary indicators that highlight shared responsibilities and goals. Those for the NHS, public health and adult social care are now in place, and a framework for children is currently under development. Overlaps across outcomes frameworks recognise the joint responsibilities for contributing to outcomes that different parts of the system can deliver. The Government believes that use of the outcomes framework will provide robust and comparable information, which show how far the system is delivering better outcomes for patients and users, allowing local partners to compare their performance against others.

The strategy shows which outcome measures will be used to measure progress in the actions to be delivered by this strategy.

Section Two – Key Themes to Deliver Change

Theme 1 – Building resilience and preventative measures to achieve better health and wellbeing

Why this is important

Developing a focus on health improvement priorities is essential to help people improve their lifestyles and to reduce suffering from many long-term conditions. The consequences of smoking, alcohol abuse and obesity have serious implications for individuals and are placing growing demands on health and care (and legal) systems and society as a whole. Easy access to improvement and prevention programmes are key to improving quality of life for people affected and to reducing associated serious illnesses.

Work and housing have major impacts on health and wellbeing. The relationship between employment status, income and health is well known with research clearly identifying links between poverty and health. Men aged 25-64 from manual backgrounds are twice as likely to die earlier than those from managerial or professional backgrounds. Sickness absence due to mental health problems costs the UK economy £8.4 billion a year and also results in £15.1 billion in reduced productivity. The evidence for 'good' work benefitting physical and mental health and wellbeing is strong. Work can be therapeutic and can reverse the adverse health effects of unemployment. This is true for healthy people of working age; for many disabled people; for most people with common health problems and for the long-term unemployed and those on prolonged sickness absence.

People living in poor quality or overcrowded housing tend to have poorer health. Appropriate adaptations can help people with disabilities live independently at home which maintains physical and mental wellbeing for longer. Whilst the Council and social landlords have invested in improving the quality of their properties to meet decent homes standards, there is a significant proportion of privately owned and privately rented homes that fail to reach those standards. Public transport is a key enabler for accessing health services, and the Health Overview and Scrutiny Panel is undertaking an important study of public transport access to Southampton General Hospital.

One in four people will have a mental health problem at some time in their lives. People can be more vulnerable to common mental health problems if they have poor physical health, are isolated, in debt or poor housing. There are a number of lifestyle factors that can improve mental wellbeing. These include eating healthily, exercising, having a network of friends and family, drinking in moderation and not misusing drugs. Actions are necessary to promote good mental health and wellbeing in the community; reduce the number of people with common mental health problems, and lessen the stigma and discrimination associated with mental ill health.

Key information from the Joint Strategic Needs Assessment

- 22.3% of adults in the city smoke compared to 21.2% nationally
- £12-13m is spent in Southampton every year treating smoking-related illnesses
- 22% of adults are obese, as are 9% of children in the reception year at schools and 18.9% by year 6
- Hospital admissions for under 18s alcohol specific admissions is 111.8 per 100,000, which is 80% above the national average
- Around 22,900 homes in the city are social rented accommodation and 16,600 of these are owned and managed by the Council
- Southampton has 24,500 privately rented homes of which over 7,000 are Homes in Multiple Occupation (HMO)
- Over 28,000 privately owned and rented homes (38% of the total) do not meet the Decent Homes Standard. 8,500 of these homes are occupied by vulnerable people
- 250 single homeless people are seen each month by the Street Homeless Prevention Team
- The highest proportion of incapacity benefit claims are for mental health problems

What we will do

Smoking and Tobacco Control

- Develop and implement a comprehensive Tobacco Control Plan for the City in conjunction with the Police and Customs, which tackles prevention, provision of smoking cessation support, illicit supply of cheap smuggled tobacco, implementation of tobacco control policies at a local level
- Sustain implementation of the national NHS Health Check programme across the City to support early detection/screening for cardiovascular disease and to tackle lifestyle risk factors

Obesity and Physical Activity

- Identify and implement options determining better health and support healthy lifestyle behaviours leading to improved diet and physical activity in key target groups e.g. health promoting workplaces, breastfeeding friendly environments, healthy early years and childcare settings
- Support initiatives and services that are effective in preventing and managing overweight and obesity in our high risk individuals in the children, young people and adults sectors

Alcohol and Drugs

- Work together with local agencies to reduce detrimental effects of adults' problem drug and alcohol use, particularly parents
- Sustain and expand public education initiatives that raise awareness around alcohol and substance misuse and maintain existing schemes that address underage drinking and associated behaviours, including in school settings
- Develop and expand the current services in Southampton through partnership working approaches that develop 'wrap around' services' (including housing and access to Education, Employment and Training) and link health, social

care, housing, leisure, night-time activities and criminal justice to include tackling alcohol and substance abuse in the young
- Increase numbers accessing both drug and alcohol services. This will enhance numbers achieving recovery from alcohol or other drugs
- Review drug treatment services available, particularly to young people to ensure a best value, high quality treatment system reflective of their drug use patterns
- Increase the range of effective treatment interventions for crack cocaine and stimulant users
- Develop an appropriate suite of abstinence and harm reduction services for blood borne viruses, such as HIV etc.

Housing
- Endeavour to help people to have access to good quality, energy efficient housing that is both affordable and meets their needs. The priorities below aim to provide opportunities to help promote health and wellbeing in the working age population across the city by working with local employers, improving economic wellbeing and helping particularly young people into employment
- Provide a comprehensive homelessness service that supports people to make independent choices about their housing future
- Work with the voluntary and supported housing sectors and the Homeless Healthcare Team to ensure that provision in the city meets the needs of the most challenging people to safeguard both their housing and health needs and reduce the impact on the general population
- Having an additional Licensing scheme for all HMOs in the city to help ensure the conditions in the private rented sector are improved and poor or inadequate housing is brought up to acceptable standards
- Develop local hubs for quality support and care in the city, for example dementia friendly facilities with support activities and interactions for people with dementia from the wider community
- Raise awareness of falls and reduce or prevent trips, slips and falls within Council older people’s accommodation. Good design can do much in this sector

Workplace Health
- Implement a programme of work to support employers in improving the health and wellbeing of their workforce through recognised good practice at work; improve the support for those stopping work due to sickness to get them back into work sooner or to rethink their future job prospects. Harassment and bullying need preventative policies
- Support more vulnerable people into good quality work, such as young people, carers and people with learning disabilities, mental health and long term health conditions and disabilities
- Promote and develop the ‘Time to Change’ campaign to reduce the stigma of mental illness in the workplace

Mental Health
- Adopt a public health approach in the development of strategies which promote wellbeing for the whole population including activities which reduce health inequalities and which promote good mental health across the city
- Ensure early access to psychological therapy/services, such as counselling

and talk, which help people remain in or return to employment
- Develop and implement a suicide prevention strategy across the city

How we measure the impact of the actions set out in this section

The table below shows the outcome framework measures which will be used to track progress on the priorities set out in this section.

Priority	Measure	Outcomes Framework Reference / Local Measure
Smoking and tobacco control		
Implement Tobacco Control Plan NHS Health Checks	• Smoking prevalence • Smoking status • Mortality from respiratory diseases	PH 2.0 PH 2.3 PH 4.7 / NHS 1.2
Obesity and physical activity		
Supporting healthy lifestyles Local weight management care pathways	• Diet • Excess weight in adults • Mortality from cardiovascular diseases • Utilisation of green space for exercise / health reasons	PH 2.11 PH2.12 PH 4.4 / NHS 1.1 PH 1.16
Alcohol and drugs		
Education and awareness Wrap around services Increase number in and completing treatment Review drug treatment services for young people Increase range of interventions for stimulant and crack cocaine users Reduce risk from blood borne viruses	• Alcohol-related admission to hospital • Mortality from liver disease	PH 2.18 PH 4.6 / NHS 1.3
Housing		
Helping young people into employment	• Under 25s unemployment	
Home insulation	• Fuel poverty • Excess winter deaths	PH1.17 PH 4.15
Homelessness prevention	• People with mental illness and/or disability in settled accommodation	PH 1.6
	• Homelessness acceptances	PH 1.15i
	• Households in temporary accommodation	PH 1.15ii

Homeless healthcare	• People with mental illness and/or disability in settled accommodation	PH 1.6
Improved support for dementia in local settings	• Effectiveness of post-diagnosis care in sustaining independence and improving quality of life	ASC 2F / NHS 2.6i
Reduce risk of falls	• Fall and fall injuries in over 65s	PH 2.24
Workplace Health		
Support to employers	• Number of working days lost due to sickness absence	PH 19ii
	• Rate of fit notes issued per quarter	PH 19iii
Helping vulnerable people into work	• Adults with LD in employment	ASC 1E
	• Adults in contact with secondary mental health services in paid employment	ASC 1H
Reduce stigma of mental health in the workplace	• Adults in contact with secondary mental health services in paid employment	ASC 1H
Mental Health		
	• Adopt a public health approach in the development of strategies which promote mental wellbeing for the whole population including activities which reduce health inequalities and which promote good mental health across the city	
	• Ensure early access to "talking therapies" and services which help people retain and return to employment	
	• Develop and implement a suicide prevention strategy across the city	

Theme 2 – Best start in life

Why this is important

Good outcomes in the early years, childhood and adolescence are a strong predictor of the health and wellbeing experiences of individuals throughout their life course. Most children and young people receive the love, care and opportunities they need from their families supported by local community services. However, too many children and young people have needs beyond the ability, capacity and sometimes willingness of their families and/or community-based services to overcome. At these times more specialist services are needed.

Help can take many forms but usually involves elements of challenge as well as support. Its purpose is always to enhance the skills, resources, capacity and positive resilience of individuals, families and communities so that children and young people get the best possible start in life.

Over the last 10–15 years there has been significant, well-conducted scientific research into the type of support that is most effective in improving outcomes and addressing inequalities. Evidence from these studies has led to a number of policy developments including:

- The initiation of the Sure Start Children's Centre programme
- The Family Nurse Partnership
- The health visiting "Call to Action" initiative
- The project to deliver free early education and child care places to vulnerable two year olds
- The development of evidence based parenting programmes
- The "Pupil Premium" (additional funding given to schools so they can support disadvantaged pupils)
- School-to-school partnerships
- Sex and relationship curricula
- On-site school and college sexual health 'drop in' clinics
- The emphasis on whole family approaches including the Families Matter ("Troubled Families") initiative

In addition, a number of significant recent reports, including those produced by Frank Field MP (child and young people's health) and Professor Eileen Munro (safeguarding of children and young people), have reinforced the continuing needs to:

- Shift resources from crisis intervention to prevention
- Improve co-ordination between practitioners, services and agencies in all sectors
- Develop effective and consistent processes for identifying emergent needs and providing early help

The Children and Families Bill 2013 sets out in Part 3 the new system for ensuring that the needs of children and young people aged 0 to 25 with special educational needs and disabilities are identified in a timely way through a multi-agency integrated assessment. The current special educational needs statements will be replaced by

Education, Health and Care Plans and that will be a statutory responsibility for the local authority and CCG to jointly commission services to assess and meet the needs of children and young people with SEND.

Existing plans
The Southampton Children and Young People's Trust (CYPT) Board brings together all key statutory and non-statutory partners from across the city. These include: Southampton City Council, NHS Southampton, schools, colleges, Jobcentre Plus, Hampshire Constabulary, Southampton Council of Faiths and the city's Voluntary Sector to ensure the coordinated delivery of positive outcomes for children and young people. The CYPT Board has developed and works to a set of outcome measures for covering pre-birth, the early years, childhood and adolescence. These measures align closely with national outcomes frameworks or their equivalent for the NHS, Social Care, Public Health and Education, and are organised according to three strategic priorities:

1. To promote health and wellbeing
2. To promote learning, achieving and aspiring for all
3. To keep children safe from harm, abuse and neglect

Key information from the Joint Strategic Needs Assessment

- The child population (0-18 years) in Southampton is 51,284, 16,156 of whom are under 5, 28,965 of school age 5-16 and 6,163 aged 17-18. The pre-school population has seen a particular increase in recent years owing to the rising birth rate – a 36% increase in births over the last 8 years
- There are 12,575 children living in poverty in the city which is 27.5% of Southampton's child population compared to 21.3% in England (in some wards of the city, this figure is as high as 42%)
- 14.1% of school children do not have English as their first language
- There are approximately 460 children living in the care of the local authority at any one time
- 42% of 5 year olds in Southampton have decayed, missing or filled teeth compared to 38% for England. (Based on 2006 dental survey)
- The number of mothers smoking in pregnancy has reduced but the overall figure of 19.4% is still high. (Southampton postcode, UHSFT provider, 2011/12)
- Almost 23% of children in reception classes are overweight and 34% in year 6 classes. 9% of children are classified as obese in reception classes and 18.9% in year 6. (2011/12 figures)
- Southampton's under 18 conception rate was 49.2 per 1000 females aged 15-17 years in 2010 compared to an England rate of 35.4 and 42.5 for the city's ONS comparators
- Southampton's alcohol specific related hospital admissions crude rate was 111.8 per 100,000 under 18s, this is significantly higher compared to the England rate of 61.8
- Whilst breastfeeding initiation rates have consistently remained at around 75% over the past 4 years, maintenance of breastfeeding at 6-8 weeks remains an on going challenge at currently 47.2%

What we will do

The Children and Young People's Trust (CYPT) has developed a local outcomes framework. This sets out its strategic priorities and actions to deliver key outcomes for the city's children and young people. These are outlined below.

Giving every child the best start in life

- Develop and deliver early learning for 2 year olds who are disadvantaged
- Develop an integrated early years service incorporating children's centre provision, family and parenting support services and the Healthy Child Programme
- Develop health visiting and maternity services to achieve optimum health outcomes in the early years and tackle inequalities
- Continue to develop high class education provision, raise attainment faster than comparator cities and improve school attendance rates where they are low

Intervening early when problems occur

- Develop an integrated assessment process for all types of needs which identifies them early and facilitates a holistic multiagency approach to providing good quality education, health and care services
- Shift the focus of provision and resources towards prevention, ensuring that the workforce at all levels and across all agencies is equipped with the skills and knowledge to identify needs and intervene early in situations of risk
- Develop and maintain a stable, skilled, high calibre and experienced safeguarding workforce which is well managed and supported

Supporting children, young people and their families with additional needs

- Increase personalisation and choice through implementation of a core offer and personal budgets, building on the learning from the Government-sponsored SEN and Disability Pathfinder
- Narrow the gap in attainments and outcomes for children with SEN and disabilities, increasing their aspirations, skills and qualifications
- Improve outcomes for children looked-after by the Council (corporate parent) building on the findings from the Integrated Ofsted/CQC inspection
- Develop holistic approaches to support and challenge for the most vulnerable families in the city through the Families Matter programme

Supporting young people to become healthy, responsible adults

- Develop Raising Participation Age support for schools and colleges
- Redesign substance misuse treatment services for young people to improve uptake and compliance with treatment
- Continue to improve sexual health and reduce teenage conceptions through delivery of the Children and Young People's Trust reducing teenage pregnancy strategy
- Make sure young people leaving care are well supported to achieve their aspirations and become independent, self-reliant citizens

The prime role of the Health and Wellbeing Board in relation to ensuring the best start in life will be to support the Children and Young People's Trust in fulfilling the plans outlined in its 'strategic priorities and actions' outcomes framework. The

Board's support will include:

- Oversight of the development and implementation of an integrated commissioning approach for all key partners, particularly the local authority and NHS Southampton. This approach will help ensure the aligning of the work of all partnerships and networks, including that of the Children and Young People's Trust, based on the national outcomes frameworks
- Strengthening and promoting the links between agencies and services so that improved outcomes for children and young people can be enabled and delivered by the Trust even more effectively
- Identification of ways to mobilise the city's business sector, community groups and their representatives to help build community capacity and resilience so that the health and wellbeing needs of children, young people and families are met
- Champion the work of the Trust to continue to raise learning standards generally, and particularly to broaden learning opportunities for 14-19 year olds through apprenticeships, diplomas, GCSEs and 'A' Levels so that Southampton outcomes catch up and surpass levels elsewhere

How we measure the impact of the actions set out in this section

The table below shows the measures which will be used to track progress on the priorities set out in this section. Where measures are local, 2013/14 targets are included. For other local measures baseline information against which targets can be set will be reviewed.

Priority	Measure	Outcomes Framework Reference / Local Measure
Promoting Health and Wellbeing		
	• Low birth weight	PH 2.1
	• Breastfeeding rates at 6-12 weeks	PH 2.2
	• Mothers smoking in pregnancy	PH 2.3
	• Percentage of children immunised by their second birthday for DTaP/IPV/Hib	Local measure CSLCPI16. 2013/14 target 95%
	• Children in poverty	PH 1.1
	• Healthy weight at Year R and Year 6	PH 2.6
	• Tooth decay in children aged 5	PH 4.2
	• Chlamydia diagnosis rates	PH 3.2
	• Smoking prevalence – 15 year olds	PH 2.9

	• Teenage pregnancy rates	PH 2.4
	• Alcohol related admissions (under 18 year olds	PH 2.18
	• Numbers of young people in treatment for substance misuse	Local Indicator - review and establish baseline and target.
	• Numbers of children and young adults treatment for mental health	Local Indicator - review and establish baseline and target.
Promote learning, achieving and aspiring for all		
	• Foundation Stage (age 5) Foundation Stage Progress: good attainment (Readiness for school	CSLCPI4. 2013/14 target 77%
	• Key Stage 1 (age 7) Level 2+ attainment in Reading	CSLCPI6. 2013/14 target 94%
	• Key Stage 1 (age 7) Level 2+ attainment in Writing	CSLCPI7. 2013/14 target 91%
	• Key Stage 1 (age 7) Level 2+ attainment in Maths	CSLCPI8. 2013/14 target 95%
	• Key Stage 2 (age 11) Level 4+ attainment in English and Maths (combined)	CSLCPI10. 2013/14 target 87%
	• Key Stage 4 (age 16) 5+GCSEs or equivalents at A*-C (including English and Maths)	CSLCPI11. 2013/14 target 68%
	• EBacc attainment	Local measure – review and establish baseline and targets
	• Percentage of parents getting their 1st preference in school place (all phases)	CSLCPI14. 2013/14 target 85%
	• The attainment gap for vulnerable Southampton children and young people (FSM, SEN, CLA, EAL) from Early Years Foundation Stage to Key Stage 4	CSLCPI12. 2013/14 target 14/16
	• Percentage of total absence from school	CSLCPI5. 2013/14 target 5.9%
	• Exclusion from school (fixed term and permanent)	Local measure – review and establish baseline and targets
	• Percentage of young	Local measure –

	people NEET	review and establish baseline and targets
	• Children's Centres sustained contact with families in greatest need	Local measure – review and establish baseline and targets
	• Children's Centres – families in greatest need accessing evidence based parenting programmes.	Local measure – review and establish baseline and targets
	• Early Years - percentage of 3 and 4 year olds accessing early years provision	Local measure – review and establish baseline and targets
	• Level 3 attainment at age 19	Local measure – review and establish baseline and targets
Keeping children safe from harm, abuse and neglect		
	• Percentage of Social Care Initial Assessments carried out within 10 days	CSLCPI3. 2013/14 target 95%
	• The timeliness of initial child protection work for vulnerable children	CSLCPI1. 2013/14 target 90%
	• Percentage of Children Looked After with a permanence plan in place	CSLCPI2. 2013/14 target 95%
	• Care leavers in suitable accommodation	Local measure – review and establish baseline and targets
	• Numbers of 'Families Matter' families supported by local agencies and numbers supported in turnaround (rewarded)	Local measure – review and establish baseline and targets
	• Adoption (rate and timescales)	Local measure – review and establish baseline and targets
	• Social care quality assurance audit outcomes • accommodation	Local measure – review and establish baseline and targets
	• Rate of Child Protection Plans against comparators	Local measure – review and establish baseline and targets
	• Rate of Children in Need against comparators	Local measure – review and establish baseline and targets
	• Rate of Children Looked After against comparators	Local measure – review and establish baseline and targets

	• Hospital admissions caused by unintentional and deliberate injury	Local measure – review and establish baseline and targets
	• First time entrants to the youth justice system	CSLCPI113. 2013/14 target 900 (number per 100,000)
	• Young offenders in suitable accommodation	Local measure – review and establish baseline and targets

Theme 3 – Living and Ageing Well

Why this is important

Southampton is following the national trend in that life expectancy continues to increase. It is important that people not only live longer but retain their health and independence for as long as possible. The two are linked. The evidence is that people who retain more control over their lives and remain as independent as they can be stay healthier for longer.

More people are living longer with long-term conditions. A long-term condition is defined as something that cannot be cured at present, but can be controlled by medication and/or other therapies. The scope of the term has increased. Traditionally it included conditions such as chronic lung conditions and heart failure. However, it now includes cancer (because improvements in treatment mean many patients with cancer can survive for some years), chronic mental illness, and some conditions which have been ill-defined by medical science such as chronic fatigue syndrome.

People tend to develop long-term conditions as they become older, and frequently feature more than a single disease process. This means that models of care developed around single diseases may be unsatisfactory, and social care and medical care must be more adaptable to match these challenges.

Key information from the Joint Strategic Needs Assessment

- The number of people over 85 in the City is forecast to grow from 5,200-6,000 between 2010 and 2017 – an increase of over 15%
- In Bassett, the wealthiest part of Southampton, a man can expect to live to 80.6 and women 84.0 years, while a few kilometres away in Bitterne, one of the cities poorer wards, life expectancy is 75.3 and 79.9 years for males and females. These differences in life expectancy of 5.3 and 4.1 years respectively for men and women are significant
- The numbers of people with long term conditions requiring health and social care solutions is increasing and set to grow. Now representing 30% of the population they utilise 70% of NHS and Social Care resources. For example one third of people over 65 years will die with a diagnosis that includes dementia and 25% of hospital beds are occupied by someone with dementia as part of the diagnosis
- There are 7 areas in the city where income deprivation affecting older people is in the worst 10% for England, these are mainly clustered in the central areas of the city with the exception of Weston
- It is estimated that in the winter of 2008/09, 113 people died in Southampton because of cold weather. In the UK, frail, elderly women are the most vulnerable group
- In 2010/11 2,500 people had been identified as suffering from dementia. Of those, 2/3 live in the community, and 1/3 live in care homes
- The number of hip replacements performed increased by 31.9% over 5 years from 2004/05 to 2008/09, while in the same period the number of knee

replacements performed increased by 16.3%

- 202 people per 1,000 aged 65 or over received adult social care services, compared with an England average of 123.5 per 1,000
- During 2010/11 adult social care services undertook the following activities:
  - 9,222 people received community care
  - 837 people were supported into permanent residential care
  - 410 people were supported into nursing care
  - 3,659 new people were assessed
  - 2,047 new people received services

What we will do

Tackling poverty

- Make the most of existing services (voluntary, public and private sector) that offer free or discounted access to leisure, learning, transport and care
- Support the development and use of information advice assistance to help people to maximise their income, ensure winter warmth and improve their quality of life

Prevention and earlier intervention

- Offer an annual health check to carers and promote support networks for carers across the City
- Review tele-care and tele-health services in the City, re-shape and re-launch these so that local people are more aware of the ways in which they can use technology to retain their independence
- Extend re-ablement services so that people can help to regain their confidence and skills after an illness or mental health breakdown
- Promote healthy, active lifestyles through a dedicated team of Activity Coordinators

Being 'person' centred and not 'disease' centred

- Increasing the number of people who can say how best to spend the money allocated for their health and care, either through direct payments or personal health/care budgets
- Joining up health and social care services so that the number of assessments is reduced and a person's experience of moving between professionals is much smoother and less fragmented
- Developing a shared understanding of how best to support people to retain their independence and make changes to practice which improve the achievement of this objective
- Promotion of a focus on recovery rather than simply procedures for admission avoidance and/or hospital discharge when people need any form of secondary care

Care of long-term conditions, including cancer and dementia

- To ensure that the enduring issues for people living with long-term conditions are recognised and that they are supported in the management of their conditions.
- Work with GPs to more accurately achieve earlier diagnosis of those most at risk of experiencing dementia

- More support for people with dementia to remain in their own homes for as long as it is safe for them to do so
- The development of extra-care services for people with long term conditions and those with dementia
- Launching a new approach to provision of aids and adaptations which encourage better access and information for individuals able to fund themselves and improves response times to those requiring equipment to maintain their independence
- Raising awareness amongst all care and health staff about appropriate responses for people with dementia, mental capacity issues including deprivation of liberty guidelines and protocols
- Work with the Clinical Commissioning Group and providers of social care to raise the standard of medicines management across the health and care system
- To improve health outcomes of those living with cancer action will be taken to improve understanding amongst the public about the signs and symptoms of cancer and encourage early checks with their GP

Improve the response to learning disabilities

- Work with the Clinical Commissioning Group to ensure the implementation across GP practices of annual health and dental checks for people with learning disabilities
- Better coordinate and promote services which support people with learning disabilities and their carers across the City
- Encourage partners within the Health and Wellbeing Board to lead by example and produce plans for improving employment of people with learning difficulties
- Involve the Learning Disability Partnership Board which includes people with learning disabilities in the City in shaping all improvements

End of life care

- Increase public awareness and discussion around death and dying
- Map current provision to ensure that appropriate national care pathways are incorporated and audited in hospitals and the community
- Extend palliative care to other diseases besides cancer and ensure access to physical, psychological, social and spiritual care
- Establish an end of life care register accessible to all appropriate service providers (e.g. Out of Hours Service)
- Have timely bereavement counselling available

How we measure the impact of the actions set out in this section

The table below shows the outcome framework measures which will be used to track progress on the priorities set out in this section

Priority	Measure	Outcomes Framework Reference / Local Measure
Tackling Poverty		
Use of and access to	To be developed	Local measure

services		
Advice to maximise income, warmth and quality of life	To be developed	Local measure
Prevention and earlier intervention		
Carer's health check	• Carers who received health checks • Carer reported quality of life	Local measure ASC 1D
Tele-care and tele-heath	• Control over daily life	ASC 1B
Re-ablement services	• At home 91 days after hospital discharge	ASC 2B
Promoting healthy lifestyles	• Excess weight in adults • Physically active adults • Recorded diabetes • Alcohol-related hospital admissions	PH 2.12 PH 2.13 PH 2.17 PH 2.18
Person-centred approach	• Control over daily life	ASC 1B
Direct payments or personal health/care budgets	• Self-directed support • Self directed support at end of period • Direct payments	ASC 1C(i) Local ASC 1C(ii)
Reducing number of separate assessments and improving patient experience across systems	• Overall satisfaction with care	ASC 3A
Retaining independence	• Permanent admissions to residential and nursing homes	ASC 2A
Focus on recovery	• At home 91 days after hospital discharge • Delayed discharges	ASC 2B ASC 2C
Dementia, Cancer and Long-term Conditions		
Early diagnosis of dementia	• Diagnosis rate	PH 4.16
	• Prescription rates for anti-dementia drugs	
	• Prescription rates of anti-psychotic drugs to patients with dementia	
Support for dementia	• Sustaining independence and improving quality of life	ASC 2F/ NHS 2.6(ii)
Staff awareness about dementia	To be developed	Local measure
Developing extra care services	• At home 91 days after hospital discharge	ASC 2B
Provision of equipment	• At home 91 days after hospital discharge • Control over daily life	ASC 2B

		ASC 1B
Improving medicine management	• Prescribing rates for anti-dementia drugs • Prescribing rates for antipsychotic drugs in dementia • Medication reviews for patients	NHS 4.4 (i)
Cancer – screening and treatment	• Under 75 mortality rate from cancer	NHS 1.4 (i) and (ii) / PH 4.5
Improving the response to Learning Disabilities		
Annual health checks for people with learning disabilities	• Client satisfaction • Take up of learning disability health check	ASC 3A
Co-ordination and promotion of services	• Adults with LD living in own home or with family	ASC 1G
Improving employment	• Proportion of adults with LD in employment	ASC 1E
LDPB involved in shaping improvements	• Client satisfaction	ASC 3A
End of life care		
Awareness and discussions around death and dying	• Bereaved carers view of quality of care in last 3 months of life	NHS 4.6
Use of appropriate national care pathways	• Numbers of patients on appropriate recognised care pathways	Local measure
Extension of palliative care to other conditions		
End of life care register		
Availability of bereavement counselling		

Section 3 – Conclusion

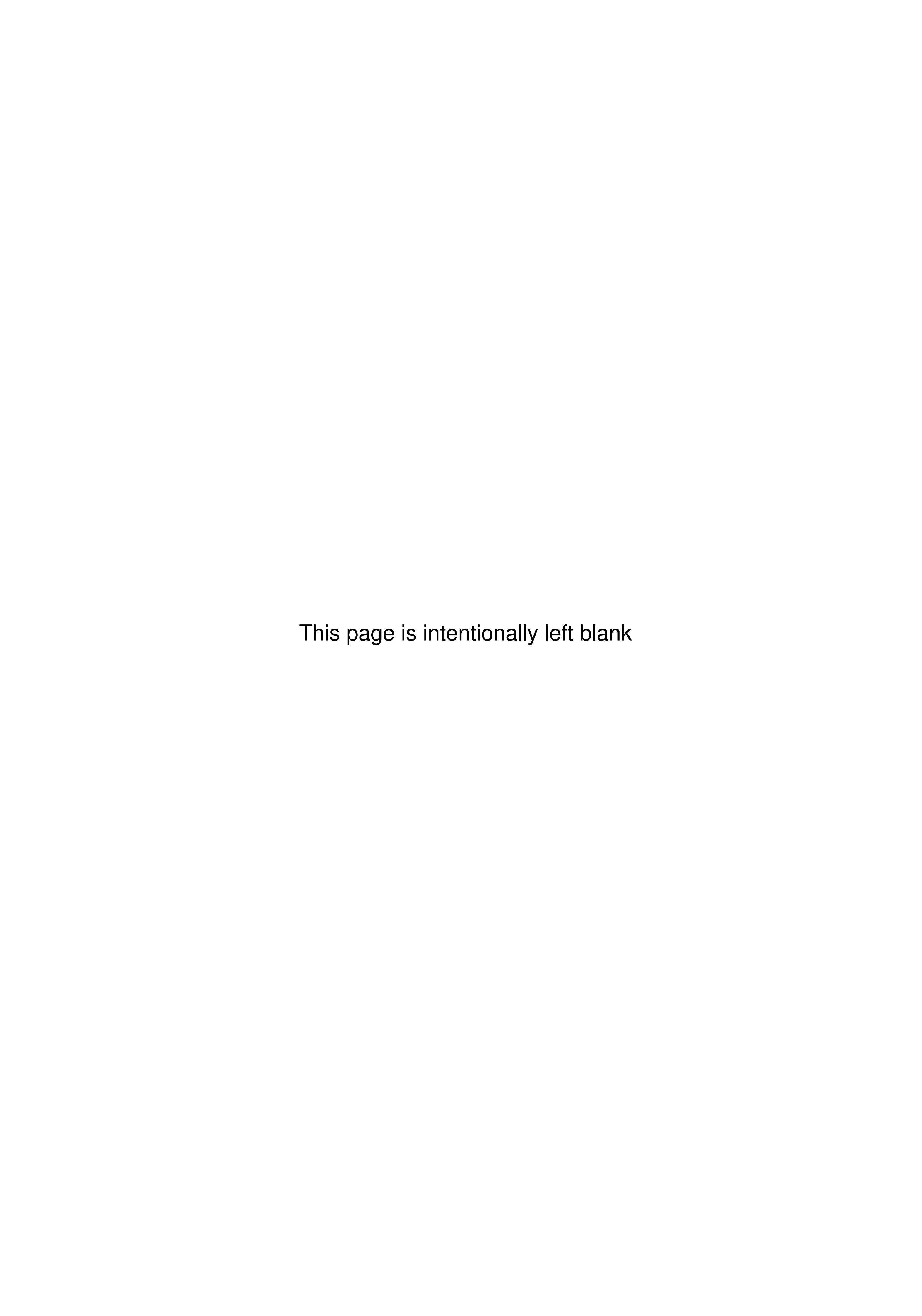
This strategy sets out an ambition to deliver real improvements to health and wellbeing and a reduction in health inequalities at a time of great challenge for both local government and the NHS. Whilst some of the challenges identified in the JSNA will respond to shorter term actions, others will take a generation or more to change. The health and wellbeing board will need to maintain a focus across the varying timeframes relating to different actions set out in this strategy. National circumstances are affecting the health and wellbeing of individuals in a variety of ways, and demand for services and support are likely to rise in the short term. If the board can secure the delivery of the preventative actions set out in this strategy, then there should be scope to reduce demand for some of the high cost treatments and support over a period of time. This should enable more people to live healthier, more active and more fulfilling lives, and provide a greater proportion of resources to support the most vulnerable and needy people living in Southampton.

Both the Council and the CCG are committed to joint commissioning where appropriate as a means of improving the quality of services to users and make commissioning and services more efficient.

The Health and Wellbeing Board will recommend the strategy to the Southampton City Council Cabinet and Southampton City Clinical Commissioning Group and it will be adopted by both organisations. Action plans will be developed to support the delivery of the outcomes, and the Health and Wellbeing Board will review the outcome measures at least annually.

Southampton Shadow Health and Wellbeing Board Members as at 27th March 2013

Councillor Jacqui Rayment (Chair) Cabinet Member for Communities		**Dr Steve Townsend (Vice-Chair)** Southampton City CCG Chair	
Councillor Sarah Bogle Cabinet Member for Children's Services		**Councillor Matthew Stevens** Cabinet Member for Adult Services	
Councillor Peter Baillie Conservative Group Member		**Councillor Maureen Turner** Liberal Democrat Group Member	
Harry Dymond Chair, Southampton LINk		**Dr Stuart Ward** National Commissioning Board Representative	
Dr Andrew Mortimore Director of Public Health		**Margaret Geary** Director of Health and Adult Social Care	
Clive Webster Director of Children's Services			


This page is intentionally left blank

Public Health Briefing Note

NHS Southampton City

NHS Southampton Public Health Information Team

Front Page
.....
Update
.....
Introduction
.....
Smoking
.....
Malnutrition
.....
Obesity
.....
Alcohol
.....
Vascular Disease and Coronary Heart Disease
.....
Healthcare Acquired Infection
.....
Self Care
.....
Falls Prevention and Bone Health
.....
Sexual Health
.....
Mental Health
.....

For more public health information visit:

Hampshire & Isle of Wight Local Health Comparisons

The case for preventative healthcare in Southampton

Written by Mary O'Brien – November 2010
Updated by Helen Cruickshank and Rebecca Wilkinson – October 2012

The public health information team has produced a series of briefing notes which present and explain data on a range of issues. The briefing notes cover topics that are of particular relevance to the population of Southampton City. New and updated briefing notes are added regularly to our website www.southamptonhealth.nhs.uk/aboutus/publichealth/briefings we hope that you find them useful and welcome your comments (contact details below).

Dan King
Public Health Information Specialist
Tel: 02380 832493
E-mail: dan.king@scpct.nhs.uk

Rebecca Wilkinson
Public Health Information Specialist
Tel: 02380 838371
E-mail: rebecca.wilkinson@scpct.nhs.uk

Sarah McCann
Public Health Information Analyst
Tel: 02380 832483
E-mail: sarah.mccann@scpct.nhs.uk

Update

In October 2012 a rapid review of the evidence shows most of the information used in the originally 2010 report is still the most up-to-date. There have, however, been more recent statistics including estimates of the cost of obesity and the savings associated with reducing Healthcare Acquired Infection; these have been incorporated into the relevant sections.

Additionally, there has been intelligence published nationally and locally which can inform the case for preventative healthcare. Most significant has been the publication of a paper by Owens et al (2011) which examined the cost-effectiveness estimates for all public health guidance published by NICE up until June 2010. Of the 200 estimates reviewed, 30 (15%) were cost-saving (i.e. the intervention was more effective and cheaper than the comparator) and a further 141 (71%) were cost-effective using the accepted threshold of £20,000 per QALY. The comparator against which the cost-effectiveness of an intervention is assessed varies from study-to-study (e.g. usual practice, best practice or no intervention).

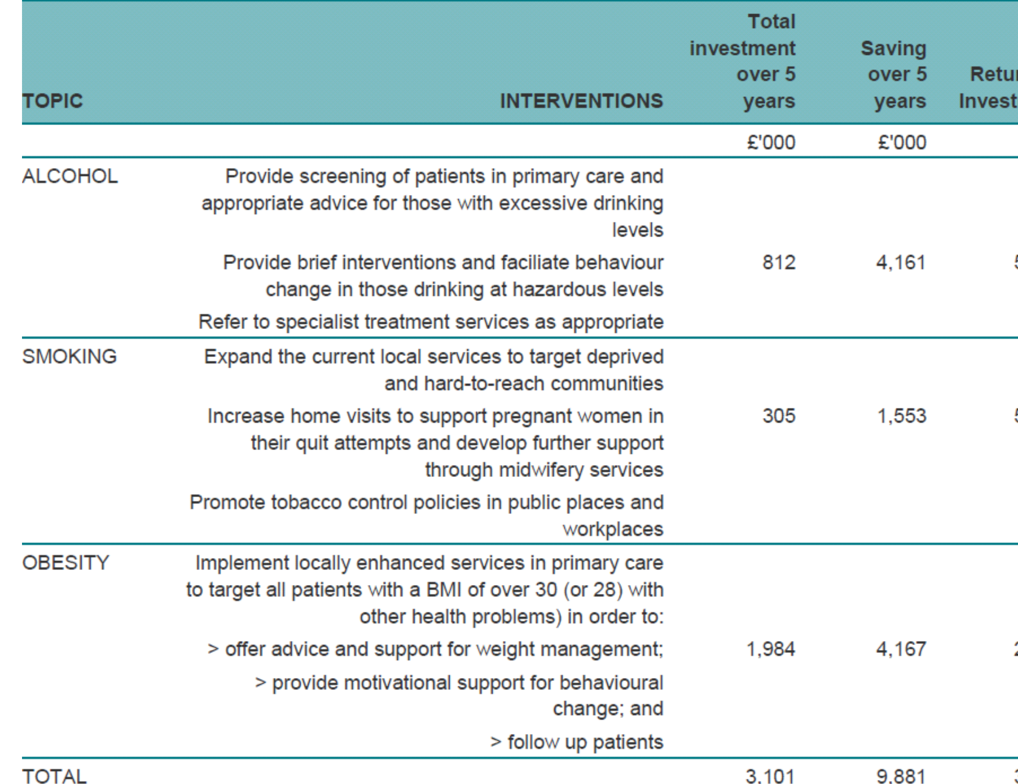
Owens et al (2011) do not suggest priorities for interventions as there is a need to consider demography, local/national policy and so on. However, some examples of cost-saving and cost-effective interventions are as follows:-

Examples of cost-saving interventions (intervention cheaper than comparator)	Examples of cost effective interventions (<£20,000 per QALY)
• Smoking cessation interventions in a range of settings e.g. workplace, pharmacy, dentists • Screening and brief advice by GPs for the prevention of harmful drinking • Workplace interventions for management of long-term sickness	• Exercise prescriptions for increasing physical activity • Life skills training for reducing substance misuse among vulnerable young people • Tailored skill sessions for prevention of sexually transmitted infections and under 18 conceptions

Locally a report was published through the Commissioning Enablement Service in 2010 looking at cost savings that could be made through public health interventions. The report was based on modelling using some fairly crude assumptions (e.g. QOF data, assuming local areas have same risk factors as nationally, evidence from Framingham Heart Study) and attempted to measure the impact of reductions in clinical risk factors on acute admissions for CVD. Estimated gross savings were calculated using HRG and emergency PbR tariffs. The estimated gross saving was around three times the investment for interventions around alcohol, smoking and obesity as summarised below:-

For more public health information visit:

Hampshire & Isle of Wight Local Health Comparisons



TOPIC	INTERVENTIONS	Total investment over 5 years	Saving over 5 years	Return on Investment
		£'000	£'000	
ALCOHOL	Provide screening of patients in primary care and appropriate advice for those with excessive drinking levels			
	Provide brief interventions and faciliate behaviour change in those drinking at hazardous levels	812	4,161	512%
	Refer to specialist treatment services as appropriate			
SMOKING	Expand the current local services to target deprived and hard-to-reach communities			
	Increase home visits to support pregnant women in their quit attempts and develop further support through midwifery services	305	1,553	509%
	Promote tobacco control policies in public places and workplaces			
OBESITY	Implement locally enhanced services in primary care to target all patients with a BMI of over 30 (or 28) with other health problems) in order to:			
	> offer advice and support for weight management;	1,984	4,167	210%
	> provide motivational support for behavioural change; and			
	> follow up patients			
TOTAL		3,101	9,881	319%

Locally we have developed a method for measuring smoking-related admissions at either GP practice or ward level – these are available at www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/profiles – and could be a useful way of measuring the outcome of smoking interventions.

It is worth noting that NICE now publish a ‘costings report’ and template with each set of guidance. This allows calculation of the cost of implementing the guidance for the local population. Additionally, in April 2012 they updated their cost savings guidance and listed dance that was considered to deliver a net saving – see http://www.nice.org.uk/usingguidance/benefitsofimplementation/costsavingguidance.jsp for further information.

Front Page
.....
Update
.....
Introduction
.....
Smoking
.....
Malnutrition
.....
Obesity
.....
Alcohol
.....
Vascular Disease and Coronary Heart Disease
.....
Healthcare Acquired Infection
.....
Self Care
.....
Falls Prevention and Bone Health
.....
Sexual Health
.....
Mental Health
.....

For more public health information visit:

References

Lesley Owen, Antony Morgan1, Alastair Fischer1 , Simon Ellis, Andrew Hoy and Michael P. Kelly, (2011) The cost-effectiveness of public health interventions, Journal of Public Health Volume 34, Issue 1 Pp. 37-45. First published online: September 20, 2011

Commissioning Enablement Service report for South Central PCT Alliance (2010) Productivity Improvement Opportunities OPI1 - Phase 2

Front Page
.....
Update
.....
Introduction
.....
Smoking
.....
Malnutrition
.....
Obesity
.....
Alcohol
.....
Vascular Disease and Coronary Heart Disease
.....
Healthcare Acquired Infection
.....
Self Care
.....
Falls Prevention and Bone Health
.....
Sexual Health
.....
Mental Health
.....

For more public health information visit:

Introduction

Investing in preventative healthcare to avoid future ill health is intuitively sensible in terms of both population health improvement and costs. Direct cost savings for some interventions have been derived at a national level and are widely cited; every £1 invested in contraceptive services yields a saving of at least £11 [1], every £100 spent on self-care measures results in savings of £150[2] for example.

Quantifying savings to the healthcare economy at a local level can be problematic however for the following reasons:

- Increasing Healthcare Costs. To date, overall healthcare costs have only ever increased and this trend is unlikely to change in the foreseeable future. Many of the successes of prevention are masked by increasing cost demands in other areas. Use of diagnostic imaging techniques has increased by over 50% in the past decade and NHS expenditure on drugs has increased by over 60% to £10 billion during the same time period[3]. Thus, although it is estimated that the decline in smokers over the past ten years has resulted in savings of £380 million to the NHS in England[4], such savings are not obviously visible on financial balance sheets.
- Improved Treatment. New and improved treatments are continually being developed and life expectancy overall is increasing. There has been an impressive decrease of 44% in mortality rates from CVD since 1996[5]. During the same period prescribing of drugs for prevention of CVD has increased by almost 300%[6]. Clearly outcomes for patients have improved. It must be noted however that although these and other interventions may be cost effective, they are not all necessarily cost saving.
- Timescales required for interventions to have an impact. The time lag associated with some interventions must also be considered. The benefits of improved maternal health and early years intervention for children for example may not all be seen in the short term and a long term commitment is required to see beneficial outcomes.

In 2002, the Wanless report made the case for increased spending on healthcare with a particular focus on prevention. This sentiment was echoed in the Department of Health's white paper Our Health Our Care Our Say in 2006, advocating reform of health and social care and a greater system shift to prevention. The recently published Marmot review yet again emphasises the need for investment in prevention. Spending on preventative healthcare averages just 4% across England. Treatment of Diabetes alone consumes at least 5% of the total NHS budget.

Smoking, excess alcohol consumption, obesity and physical inactivity are responsible for 42% of deaths from leading causes. Addressing these risk factors would clearly have an impact on mortality and morbidity. An independent report commissioned by the Department of Health to make recommendations on future priorities on health and wellbeing estimates that investment of £3.1

Front Page
.....
Update
.....
Introduction
.....
Smoking
.....
Malnutrition
.....
Obesity
.....
Alcohol
.....
Vascular Disease and Coronary Heart Disease
.....
Healthcare Acquired Infection
.....
Self Care
.....
Falls Prevention and Bone Health
.....
Sexual Health
.....
Mental Health
.....

For more public health information visit:

million at PCT level on measures to reduce rates of smoking, obesity and excessive alcohol consumption would result in healthcare savings of £6.7 million in 5 years[8]. Risk factors have a multiplicative effect. Addressing these major lifestyle risk factors will also therefore have multiple beneficial health effects.

The Marmot review further identifies the impact of health inequalities on healthcare costs. It is estimated that the social gradient seen in health status costs the NHS £5.5 billion per year. The review identifies six policy objectives to reduce health inequalities. Two of these fall very clearly within an NHS remit;

(i) Give every child the best start in life
(ii) Strengthen the role and impact of ill health prevention

Action is required on these policy objectives at a population level and increased efforts are needed to minimise the effects on health inequalities.

The summaries on the following pages provide an indication of the cost burden of a range of conditions. The costs provided are current best estimates and clearly there is some overlap, e.g. costs associated with smoking are also presented as part of the costs associated with vascular disease. Even allowing for this, it's obvious that the PCT and wider healthcare economy is bearing costs associated with conditions that are preventable to a considerable extent by modification of behaviour, lifestyle choices and system processes.

Given increasing trends in rates of chronic conditions and the ageing population, associated costs are set to rise unless action is taken. Tackling the 'big four' modifiable risk factors: smoking, alcohol, obesity and physical activity would provide the biggest win with regards to long term primary prevention. The minimal proportion of PCT budget currently allocated to prevention should be considered in light of the cost burdens identified.

This paper uses the proportion of the national population in 2009[9] that is resident in Southampton to estimate what proportion of national costs or savings are applicable locally. Clearly this is a crude methodology and the results should be interpreted with caution. However, the figures do give a very useful insight into the potential savings that can be achieved in the local healthcare economy by employing preventative interventions.

Please note that the information presented here is the best available at the time of writing.

NHS Southampton City

References

1. Department of Health. Delivering Choosing Health. 2004. http://www.healthlinklibraries.co.uk/pdf/Delivering_Choosing_Health_DH_4105713.pdf
2. HM Treasury. Securing Good Health for The Whole Population (Wanless Report). 2004. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4074426
3. The Health Foundation, University of York. Value for Money in the English NHS, summary of the evidence. 2006. http://www.health.org.uk/publications/research_reports/value_for_money_1.html
4. Department of Health, A smoke free future, a comprehensive tobacco control strategy for England. 2010. http://www.parliament.uk/deposits/depositedpapers/2010/DEP2010-1067.pdf
5. Department of Health. The Coronary Heart Disease NSF, Progress Report for 2008. 2009. http://www.cardiomyopathy.org/assets/files/Progress%20report%202008.pdf
6. British Heart Foundation. Prescriptions used in the prevention and treatment of CVD, 1981 to 2008. 2010 http://www.heartstats.org/datapage.asp?id=9075
7. The Marmot Review. Fair society, healthy lives Strategic review of health inequalities in England post 2010. February 2010. http://www.marmotreview.org/
8. Department of Health. Enabling effective delivery of health and wellbeing, an independent report. February 2010. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111692
9. Office for National Statistics Mid Year Population Estimates 2009 http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=601

NHS Southampton Public Health Information Team

Front Page
.....
Update
.....
Introduction
.....
Smoking
.....
Malnutrition
.....
Obesity
.....
Alcohol
.....
Vascular Disease and Coronary Heart Disease
.....
Healthcare Acquired Infection
.....
Self Care
.....
Falls Prevention and Bone Health
.....
Sexual Health
.....
Mental Health
.....

For more public health information visit:

NHS Southampton City

Smoking

NHS Costs: National

Illnesses attributable to smoking cost the NHS in England £2.7 billion per year. In 2008, over 80,000 people died prematurely from a smoking related disease. Conditions directly attributable to smoking include at least 80% of cases of COPD, 90% of cases of lung cancer and 25% of cases of all cancers. Almost a third of deaths from CVD are attributable to tobacco use.
Smoking amongst manual, semi-skilled workers and the unemployed are higher than amongst higher socioeconomic groups and so is a significant contributory factor to health inequalities.

NHS Costs: Southampton

An estimated £12 to £13 million per year. Smoking prevalence, estimated from the Integrated Household Survey, in Southampton is 21.9 % (not significantly different from the England average of 20.2%).

What Works? Evidence based prevention

The national decline in smokers over the past decade has led to current annual NHS savings of £380million.
Since 2003, 12,500 people have quit smoking through Southampton City PCT's smoking cessation service at an approximate cost to the PCT of £200 per quitter.
Expressed as cost per QALY gained, all smoking cessation interventions are shown to be cost effective and most are cost saving (negative cost/QALY):
Brief interventions delivered in primary care: -£2,169
Nicotine Replacement Therapy: -£933

Scope for local savings

(i) Further reductions in overall smoking prevalence in line with current targets.
(ii) Reduction in prevalence in lower socioeconomic groups
(iii) Reduction in prevalence in hospital settings
(iv) Reduction in prevalence amongst pregnant women

NHS Southampton
Public Health
Information Team

Front Page
.....
Update
.....
Introduction
.....
Smoking
.....
Malnutrition
.....
Obesity
.....
Alcohol
.....
Vascular Disease and Coronary Heart Disease
.....
Healthcare Acquired Infection
.....
Self Care
.....
Falls Prevention and Bone Health
.....
Sexual Health
.....
Mental Health
.....

For more public health information visit:

Co-benefits (links to other areas/conditions)

Impact on chronic conditions and premature deaths as outlined above.

Recommendations

Prioritise spending to fully implement the Tobacco Control Strategy for England and the recommendations of the Marmot review to reduce health inequalities.

References

Department of Health, A smoke free future, a comprehensive tobacco control strategy for England. 2010.
http://www.parliament.uk/deposits/depositedpapers/2010/DEP2010-1067.pdf
Health England, Matrix insight, prioritising investments in preventive health. 2009.
http://healthengland.org/health_england_publications.htm
The Marmot Review. Fair society, healthy lives Strategic review of health inequalities in England post 2010. 2010.
http://www.marmotreview.org/

NHS
Southampton City

Malnutrition

NHS Costs: National

£13 billion

The ‘Malnutrition Universal Screening Tool’ (‘MUST’) has identified more than 10% of the general population aged 65+ years as being at medium or high risk of malnutrition. In hospitalised patients, the same degree of risk is seen in 10-60% depending on medical condition and patients’ age. Similar very high prevalence of nutritional risk are seen in residents of care homes but although most malnutrition is found in the community (>95%), most malnutrition related expenditure occurs in hospital. However, both care settings make a substantial contribution to total costs.
Although the risk of malnutrition is most commonly associated with older people, the majority of people at risk of malnutrition are aged less than 65 years.
At any given point in time, more than three million people in the UK are either malnourished or at risk of malnutrition. The vast majority of these (93%) are living in the community (including 2-3% of whom are in sheltered housing), with 5% in care homes or hospitals. However, given the throughput of patients in hospital, hospital care provides a vital opportunity to identify malnutrition and initiate treatment which can then be continued in the community following discharge.

NHS Costs: Southampton

£49.8 million

What Works? Evidence based prevention

NICE Clinical Guideline on nutrition support in adults includes the following recommendations:

- Screening for malnutrition and the risk of malnutrition should be carried out by healthcare professionals with appropriate skills and training and repeated weekly for inpatients and when there is clinical concern for outpatients.
- People in care homes should be screened on admission and when there is clinical concern.
- Hospital departments who identify groups of patients with low risk of malnutrition may opt out of screening these groups.
- Nutrition support should be considered in people who are identified as being malnourished as well as those considered at being at risk of malnutrition. (Against agreed criteria)
- All acute hospital trusts should employ at least one specialist nutrition support nurse.

- Healthcare professionals should consider using oral, enteral or parenteral nutrition support, alone or in combination, for people who are either malnourished or at risk of malnutrition.
- Healthcare professionals should ensure that all people who need nutrition support receive coordinated care from a multidisciplinary team.
- All hospital trusts should have a nutrition steering committee working within the clinical governance framework.

Scope for Savings: Southampton

In hospital inpatients generally the prevalence of malnutrition has been estimated to be around 25% and using HES data, mortality in adult inpatients is around 4%, which would imply that screening will be very cost effective in most hospital departments.

In terms of interventions that led to an increase in weight, there was also a significant reduction in complications. The cost of weight gain was calculated to be £39/kg gained. As a sensitivity analysis, hospital costs associated with length of stay were included and the result was that screening was cost-saving; however, length of stay was highly variable and not statistically significant. Alternatively, the worst case scenario suggested a cost of £369/kg gained.

Overall NICE CG32 state that evidence from the literature and expert opinion would suggest that malnutrition screening in older hospital inpatients is likely to be cost effective. Screening is also likely to be cost effective for other inpatient groups, except where malnutrition risk and acute background mortality are very low. The cost-effectiveness of screening in other settings is harder to determine.

Recommendations

Implementation of NICE guideline.

References

Bapen. Combating Malnutrition: Recommendations for Action. February 2009. Available at: http://www.bapen.org.uk/
NICE. NICE CG 32 – Nutrition Support for Adults Oral Nutrition, Enteral Tube Feeding and Parenteral Nutrition. 2006. Available at: http://www.nice.org.uk/nicemedia/pdf/CG032NICEguideline.pdf

Front Page
.....
Update
.....
Introduction
.....
Smoking
.....
Malnutrition
.....
Obesity
.....
Alcohol
.....
Vascular Disease and Coronary Heart Disease
.....
Healthcare Acquired Infection
.....
Self Care
.....
Falls Prevention and Bone Health
.....
Sexual Health
.....
Mental Health
.....

For more public health information visit:

Obesity

NHS Costs: National

Direct healthcare costs for treatment of obesity alone are estimated at £1 billion per year. The current annual cost to the NHS of diseases for which elevated BMI is a risk factor is estimated at £5.1 billion. There are wider costs to society and the economy – for example, sickness absence reduces productivity. Foresight's Tackling Obesities: Future Choices report estimated that weight problems already cost the wider economy in the region of £16 billion, and that this could rise to £50 billion per year by 2050 if left unchecked.

NHS Costs: Southampton

£4.5 million annually for obesity alone. For diseases for which elevated BMI is a risk factor £23.4 million.

What Works? Evidence based prevention

The top five policy responses assessed as having the greatest average impact on levels of obesity (Foresight report, 2007) were:

- increasing walkability/cyclability of the built environment
- targeting health interventions for those at increased risk (dependent on ability to identify these groups and only if reinforced by public health interventions at the population level)
- controlling the availability of/exposure to obesogenic foods and drinks
- increasing the responsibility of organisations for the health of their employees
- early life interventions at birth or in infancy.

Cost effective interventions (Health England 2009):

- National mass media campaigns (cost per QALY gained -£3,290)
- Brief GP interventions to promote physical activity (cost per QALY gained -£2,151)
- School based education (cost per QALY gained £599)

Scope for Savings: Southampton

Improved anti-obesity drug management through primary care. Q1 spending in 2009/10 was £31,000 on anti-obesity drugs with only 13% of patients recorded as having achieved a weight loss of ≥5% after 3 months.

Recommendations

Key areas for local action over next 3 years:
Areas for local action with limited or no additional investment required:

- Support and implementation of the Change 4 Life campaign
- Improved support and targeted work within schools as part of the new National Healthy Schools Enhancement Model focusing on Fit 4 Life issues.
- Improved ante & post-natal care, particular for those who are in our 20% most deprived Children Centre areas & those women who are obese

Additional investment in the following areas is needed to achieve impacts in relation to obesity:

- Targeted and intensive support at a Tier 3 level on those who are obese and have other co-morbidities which would significantly benefit from weight loss
- Improved management of obesity in primary care including the implementation of the Let's Get Moving Physical Activity Care pathway
- Improved antenatal care particularly for obese women

Cost of implementing Let's Get Moving, national physical activity pathway is estimated to be £6,189 per surgery. This is based on an assumption that the intervention is undertaken by a healthcare assistant with 500 patients being assessed/year and 80% undertaking the intervention (400 patients). The cost per surgery increases to £6,864 if undertaken by a practice nurse or £19,614 if undertaken by a GP. Total estimated cost for Southampton for all surgeries would be £222,804 – 247,104.

References

Foresight – Tackling Obesities: Future Choices. Government Office for Science. 2007.
http://www.foresight.gov.uk/OurWork/ActiveProjects/Obesity/Obesity.asp
Prioritising Investments in Preventive Health. Matrix Knowledge Group. Health England, 2009.
http://www.healthengland.org/publications/HealthEnglandReportNo5.pdf

NHS Southampton City

Alcohol

NHS Costs: National

Alcohol misuse in England costs £2.7 billion annually in hospital admissions and primary care treatment (2006/07 figures).

NHS Costs: Southampton

£12 million per annum

What Works? Evidence based prevention

Identified highest impact changes:

In primary care:

- New registrants; commission identification and brief advice as per the Direct Enhanced Service (DES) for all newly registered patients
- At risk groups; consider extending coverage through a local enhanced service in primary care to additional at risk groups such as men aged 35-54 years or those patients on existing QoF registers.

In hospital settings:

- Identification and brief advice in A&E and specialist units (e.g. fracture clinics): Commission a specialist alcohol nurse linked to every accident and emergency unit where there is apparent local need

Scope for Savings: Southampton

Provision of the following interventions would require an estimated £812,000 and would provide a best case net saving after 5 years of £3.3 million:

- Screening of patients in primary care and appropriate advice for those with excessive drinking levels
- Brief interventions and facilitation of behaviour change in those drinking at hazardous levels

Front Page
.....
Update
.....
Introduction
.....
Smoking
.....
Malnutrition
.....
Obesity
.....
Alcohol
.....
Vascular Disease and Coronary Heart Disease
.....
Healthcare Acquired Infection
.....
Self Care
.....
Falls Prevention and Bone Health
.....
Sexual Health
.....
Mental Health
.....

- Referral to specialist treatment services as appropriate

Recommendations

Implementation of screening and brief intervention programmes
Investment in early intervention programmes
Support of partnership working on wider determinant of alcohol misuse

References

Department of Health. The cost of alcohol-related harm to the NHS in England. 2008.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_086421.pdf
Department of Health. Signs for improvement – commissioning interventions to reduce alcohol-related harm. 2009.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_102813

Front Page
.....
Update
.....
Introduction
.....
Smoking
.....
Malnutrition
.....
Obesity
.....
Alcohol
.....
Vascular Disease and Coronary Heart Disease
.....
Healthcare Acquired Infection
.....
Self Care
.....
Falls Prevention and Bone Health
.....
Sexual Health
.....
Mental Health
.....

For more public health information visit:

Vascular Disease and Coronary Heart Disease

NHS Costs: National

UK healthcare costs of cardiovascular disease, coronary heart disease and stroke amount to £20.8 billion annually. Treatment of type 2 diabetes costs an estimated £3.2 billion.
Vascular disease accounts for a fifth of all hospital admissions and is the largest cause of chronic ill health and disability. In terms of health inequalities, vascular disease accounts for more than half the mortality gap between rich and poor.

NHS Costs: Southampton

Extrapolation of national costs cited above to Southampton's population: £9.1 million per annum.
Prescribing costs for diabetes alone are £2 million per annum.

What Works? Evidence based prevention

Improved prescribing of statins and anti-hypertensives and reduced prevalence of smoking are significant contributing factors.

The following modifiable lifestyle factors reduce the risk of vascular disease:

- Smoking cessation
- Blood pressure control
- Cholesterol control
- Physical activity
- Maintenance of body weight within normal BMI range

Scope for Savings: Southampton

Primary prevention:

Introduction of the new vascular risk assessment programme across Southampton City PCT will cost an estimated £151,000 per year. Net benefits of this programme have been estimated over a 20 year period. The cost per QALY is approximately £3,500 which falls well below the NICE threshold for interventions.

Secondary prevention:

- It is estimated that someone diagnosed with diabetes at age 45 who does not smoke and maintains HbA1c, blood pressure and cholesterol measurements within current QOF targets and did not have any diabetic complications at diagnosis will require treatment for complications costing over £14,000 over a lifetime. Effective management and secondary prevention is therefore essential both in terms of patient outcome and cost.
- A hypothetical male non-smoker diagnosed with type 2 diabetes at 45 years of age has a 15.2% chance of having a myocardial infarction in the next 15 years. He also has a 2.8% probability of having a stroke and a 2.5% chance of becoming blind.
- CVD accounts for up to 50% of deaths in patients with chronic kidney disease and up to 75% of deaths in patients with type 2 diabetes.

Recommendations

- Interventions aimed at mitigation of modifiable lifestyle factors.
- Implementation of national vascular risk assessment programme.
- Interventions and service improvements for secondary prevention: improved podiatry service for diabetics, improved self-care guidance and support.

References

Department of Health. Putting Prevention First, Vascular Checks, Risk Assessment and Management. April 2008.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_083823.pdf
British Heart Foundation. Health Care and Economic Costs of CVD and CHD. 2006. Available at:
http://www.heartstats.org/datapage.asp?id=101
NICE. Type 2 Diabetes. National Clinical Guideline for Management in Primary and Secondary Care. 2008. Available at:
http://www.nice.org.uk/nicemedia/live/11983/40803/40803.pdf
UK National Screening Committee. The handbook for vascular assessment, risk reduction and risk management. March 2008.
http://www.screening.nhs.uk/vascular
Department of Health. The Coronary Heart Disease NSF, Progress Report for 2008. March 2009.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_096556.pdf

NHS Southampton Public Health Information Team

Front Page
.....
Update
.....
Introduction
.....
Smoking
.....
Malnutrition
.....
Obesity
.....
Alcohol
.....
Vascular Disease and Coronary Heart Disease
.....
Healthcare Acquired Infection
.....
Self Care
.....
Falls Prevention and Bone Health
.....
Sexual Health
.....
Mental Health
.....

For more public health information visit:

Healthcare Acquired Infection

NHS Costs: National

£1 billion per annum

NHS Costs: Southampton

£4.5 million per annum

What Works? Evidence based prevention

HCAI can be reduced for relatively modest investment, and the technologies required to do this are simple (even down to soap and water); but the more difficult challenge is behavioural – strict discipline in operating theatres and surgical wards, hand-washing protocols for a whole hospital – staff and visitors, and environmental re-design – a challenge that can get expensive when wards are badly designed or patient moves are badly managed encouraging infections to move around a clinical site.

Scope for Savings: Southampton

NICE (2011) reported that each 5% reduction in MRSA and *c.difficile* cases will reduce national NHS costs by an estimated £4.9 million annually; this would equate to costs savings of £22,500 in Southampton.

Potential savings and costs for commissioners

- Reduced length of stay and trim points. £250k
- Reduced readmissions following infections £80k
- Better outcomes and health of discharged patients
- Additional costs of look-back exercised prevented (100k – intermittent risk)
- Reduced litigation costs
- Explore potential for not funding “never” HCAI events – (40k)
- Explore potential for CQUIN HCAI fines in contracts (40k)
- Vital signs achieved

Potential savings for providers

- Improved ward productivity (no need for closure, cohorting) (300k)
- Reduced operating list cancellations (200k)
- Better outcomes, shorter length of stay
- Reduced litigation (400k)
- Reduced risk of health act / corporate manslaughter charges (100k+ intermittent)
- Better performance ratings

Recommendations

Optimisation of monitoring and implementation of best practice and performance management.

References

National Audit office: Reducing Healthcare Associated Infections in Hospitals in England, 11 June 2009
http://www.nao.org.uk/publications/0809/reducing_healthcare_associated.aspx

NICE (2011) Prevention and control of healthcare-associated infections
http://guidance.nice.org.uk/PH36/CostingTemplate/xls/English

NHS
Southampton City

Self Care

NHS Costs: National

Annual cost savings of £250 million are estimated as a result of increasing levels of self care of long term conditions. This is based on average intervention costs of £125 per person yielding a saving of £244.

NHS Costs: Southampton

£957,584 annual savings

What Works? Evidence based prevention

There is growing evidence to show that supporting self care leads to:

- improved health and quality of life
- rise in patient satisfaction
- significant impact on the use of services, with fewer primary care consultations, reduction in visits to outpatients and A&E, and decrease in use of hospital resources.

Impact on patients

- better symptom management, such as reduction in pain, anxiety, depression and tiredness
- improved feeling of well being
- increase in life expectancy
- improvement in quality of life with greater independence.

Impact on care services

- visits to GPs may be decreased by 40%
- outpatient visits may reduce by 17%
- A&E visits may be reduced by up to 50%
- hospital admissions can be halved
- hospital length of stay may be halved
- medicines intake is regulated or reduced

NHS Southampton Public Health Information Team

Front Page
.....
Update
.....
Introduction
.....
Smoking
.....
Malnutrition
.....
Obesity
.....
Alcohol
.....
Vascular Disease and Coronary Heart Disease
.....
Healthcare Acquired Infection
.....
Self Care
.....
Falls Prevention and Bone Health
.....
Sexual Health
.....
Mental Health
.....

For more public health information visit:

NHS
Southampton City

Scope for Savings: Southampton

Improved medicines management. Inability to take medicines correctly can be a major reason why people end up moving to a nursing home: as many as 23% of older people move into a nursing home because they cannot manage their medicines. In addition, it is estimated that around 4-6.5% of emergency admissions are due to adverse events from medicines.

Local GP opinion

A brief survey of a few GPs in the West of Southampton asking the question 'In your experience, what simple, practical interventions could improve self help and reduce health service use (including emergency admissions)?' revealed the following recommendations:

Home improvements:
- Grab rails – need improved access to getting these organised rapidly
- Checking slippers, rugs etc for trip hazards
- Tidying up / cleaning around the house 'many people live in chaos or uncleanliness!' (both falls and infection risk)
- Toilet and hot water provision (amazingly some elderly people are still living with outside toilets and no hot water on tap)

Personal aids
- Round neck alarm systems
- Vision aids for elderly
- Days of the week reminders, calendars, 'timetables' esp. for dementia patients

Medication aids
- Large print repeat prescriptions with clear directions
- Medication reviews – not just 'theory' but practical and at home (many patients with cupboards and drawers full of drugs not being taken or being taken incorrectly)

Other interventions
- Improving physical fitness in the elderly – exercises at home / Wii fit etc
- Internet access + IT education for the elderly – may help reduce isolation and decrease falls risk e.g. delivery of shopping
- Toenail cutting for elderly – reducing consultations and possibly falls
- Befriending / tackling loneliness in elderly
- Using volunteer groups to assist with transport to hospital appointments for elderly

NHS Southampton Public Health Information Team

Front Page
.....
Update
.....
Introduction
.....
Smoking
.....
Malnutrition
.....
Obesity
.....
Alcohol
.....
Vascular Disease and Coronary Heart Disease
.....
Healthcare Acquired Infection
.....
Self Care
.....
Falls Prevention and Bone Health
.....
Sexual Health
.....
Mental Health
.....

For more public health information visit:

[Front Page](#)
.....
[Update](#)
.....
[Introduction](#)
.....
[Smoking](#)
.....
[Malnutrition](#)
.....
[Obesity](#)
.....
[Alcohol](#)
.....
[Vascular Disease and Coronary Heart Disease](#)
.....
[Healthcare Acquired Infection](#)
.....
[Self Care](#)
.....
[Falls Prevention and Bone Health](#)
.....
[Sexual Health](#)
.....
[Mental Health](#)
.....

For more public health information visit:

Recommendations

Inclusion of self care support as an integral part of care pathway development.

References

Department of Health. Self Care Support for Long Term Conditions. 2009.
http://www.library.nhs.uk/qualityandproductivity/SearchResults.aspx?catID=15069&pgIndex=1&
Department of Health. Self Care – A Real Choice: Self Support Care – A Practical Option. 2005.
http://www.dh.gov.uk/en/Publicationsandstatistics /Publications/PublicationsPolicyAndGuidance/DH_4100717
HM Treasury. Securing Good Health For The Whole Population (Wanless Report). 2004.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/Publications PolicyAndGuidance/DH_4074426

NHS Southampton Public Health Information Team

Front Page
.....
Update
.....
Introduction
.....
Smoking
.....
Malnutrition
.....
Obesity
.....
Alcohol
.....
Vascular Disease and Coronary Heart Disease
.....
Healthcare Acquired Infection
.....
Self Care
.....
Falls Prevention and Bone Health
.....
Sexual Health
.....
Mental Health
.....

For more public health information visit:

Hampshire & Isle of Wight Local Health Comparisons

Falls Prevention and Bone Health

NHS Costs: National

Direct healthcare costs associated with fragility fractures cost an estimated £2 billion per year (2007)

Nationally the number of falls and hip fractures is rising. With this comes an increasing financial burden on the health services and a huge personal cost to the service user themselves. Many cannot walk again and need residential care, and for others a loss in confidence severely limits their daily activities.
By investing more resources in the falls service (in line with the NSF for Older People), more preventative work could be carried out and hospital admissions for falls and fractures should be reduced.

The Ambulance service has around 290 calls per month for falls of which approximately 60% are conveyed to hospital. Six of the top ten postcodes for falls were nursing or residential homes in 2008/9. In 2008/09 1999 emergency admissions were due to falls with 338 having a fractured neck of femur.

NHS Costs: Southampton

£9 million per annum.
Each hip fracture averted yields a saving of £10,170 in PbR tarrif costs. With 340 hip fracture operations a year in Southampton, the total is £3.45 million.

What Works? Evidence based prevention

In each SHA, an additional investment in falls and bone health of £2 million would, it is estimated, save £5m (net £3m) within one year. It would save 80 lives and maintain the independence of hundreds of older people. At least 200 more people would be able to walk unaided; 240 would be able to dress themselves; 360 could continue shopping a further 140 could sleep through the night without pain.

Scope for Savings: Southampton

Primary prevention:
Preventing falls happening is definitely cheaper than dealing with the effects. Medical treatment, operations, rehabilitation and

NHS Southampton Public Health Information Team

Front Page
.....
Update
.....
Introduction
.....
Smoking
.....
Malnutrition
.....
Obesity
.....
Alcohol
.....
Vascular Disease and Coronary Heart Disease
.....
Healthcare Acquired Infection
.....
Self Care
.....
Falls Prevention and Bone Health
.....
Sexual Health
.....
Mental Health
.....

For more public health information visit:

long term care are all expensive. The figures below show some of the current costs associated with falls and prevention.
Falls service to provide specialist assessment/care and therapeutic intervention to those at risk or have fallen £84kpa

Secondary Care (PBR costs)
SUHT to adopt the best practice tariff for hip fractures (which includes bone health assessment/services and interface with provider arm)

There is an urgent need to invest to save
Social Care /SCC costs

Highways claims in Southampton in a year	>£ 400k
Cost of care in a home for a week	£550
Cost of funding Life to the Full for a year	£35k
Safe access to a senior's home (hedge cutting, front door light, path handrail, fluorescent step strips)	£300
Sloppy slipper exchange	£3k

Secondary prevention:
In each SHA, an additional investment in falls and bone health of £2 million would, it is estimated, save £5m (net £3m) within one year. It would save 80 lives and maintain the independence of hundreds of older people. At least 200 more people would be able to walk unaided; 240 would be able to dress themselves; 360 could continue shopping a further 140 could sleep through the night without pain.
According to the National Falls Audit (2007):

- Even after hip surgery, less than 50% were on appropriate bone treatment
- Only 28% of non-hip patients are given a balance assessment
- After 3 months, after surgery, only a fifth of patients were on appropriate treatment for osteoporosis, 20% of non-hip patients, 16% of hip patients don't have a home hazard assessment
- Only 22% of people recovering from a fracture were recommended exercise

Even after recovering from hip fracture surgery, less than 50% were on appropriate osteoporosis treatment

Recommendations

Many of the causes of falls can be addressed simply, in addition to whatever treatment the faller receives. This includes:

- Diagnose underlying medical conditions including visual and cognitive impairment

- Formal /informal education and advice to 'at risk', community groups and health care professionals
- Review of medicines or new prescriptions
- Assessments of balance and gait;
- Recommendations for exercise;
- Exercise and active ageing;
- Bone strengthening;
- Eyesight tests;
- Adaptations and changes at home;
- Repairs to the pavements
- Footwear review (loose slippers are a factor in 9% of falls nationally).
- Develop a pilot project for Dexa scans with PBC

References

Department of Health. 2009. Fracture Prevention Services, An economic evaluation. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents /digitalasset/dh_110099.pdf
Department of Health. Falls and Fractures. Effective Interventoins in Health and Social Care. 2009. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/dh_103146
Department of Health. 2009. NHS Evidence – QIPP. Fragility Fractures – Prevention. http://www.library.nhs.uk/qipp/SearchResults.aspx?tabID=289&catID=15069&pgIndex= 1&
Royal College of Physicians, Clinical effectiveness and Evaluation Unit. 2007. National Clinical Audit of Bones and Bone Health in Older People. http://www.rcplondon.ac.uk/clinical-standards/ceeu/Documents/fbhop-execsummary.pdf

NHS Southampton City

Sexual Health

NHS Costs: National

The estimated annual cost of sexual ill health in England is in excess of £700 million.
Treatment and care of HIV in the UK costs an estimated £400 million per annum, with the cost of lifetime HIV treatment estimated at £280,000 - £360,000 per person. NHS costs of teenage pregnancy are £63 million per annum.

NHS Costs: Southampton

£3.2 million, including £1.9 million on HIV anti-retroviral therapy.

What Works? Evidence based prevention

Choosing Health (2004):

- For every £1 invested in contraceptive services there is a saving of at least £11 on associated NHS costs.
- A 25% reduction in HIV incidence could save the NHS £500 million annually.
- If teenage pregnancies were reduced by 15% the NHS could save £9.5miliion per annum.

NICE guidance on Long Acting Reversible Contraception:

Annual changes in revenue costs from fully implementing the NICE LARC guideline for England	£ million
Additional cost of switching from oral contraception to LARC	12.7
Saving from unplanned pregnancies avoided	-115.0
Net saving from increased use of LARC	-102.3

Modelling:
In South Central alone an estimated 28,581 women (2008) will have an unplanned pregnancy as a result of oral contraception failure. A switch to LARC could reduce this figure to just 47. An estimated minimum saving of £14,290,500 in 2008 on termination of pregnancy and maternity care costs could be achieved through investment in LARC.
Effective Chlamydia screening is associated with a reduction in pelvic inflammatory disease and ectopic pregnancies, cost-benefit analysis modelling has been completed by the National Chlamydia Screening Programme.

Front Page
.....
Update
.....
Introduction
.....
Smoking
.....
Malnutrition
.....
Obesity
.....
Alcohol
.....
Vascular Disease and Coronary Heart Disease
.....
Healthcare Acquired Infection
.....
Self Care
.....
Falls Prevention and Bone Health
.....
Sexual Health
.....
Mental Health
.....

For more public health information visit:

NHS Southampton City

Every under 18 conception costs the NHS a minimum of £500 per episode of care through termination of pregnancy services or maternity care at £1,500. This does not account for ongoing health and social economy costs throughout childhood and into adulthood. The National Teenage Pregnancy Unit has a robust evidence base in place- for the NHS, improved use of contraception is the area with strongest empirical evidence on impact on teenage pregnancy rates (86% of the reduction in teenage pregnancy rates in the US was directly attributable to increased access and use of contraception by young people).

The cost of HIV care and treatment is rising year on year- this exponential growth could be off-set through greater investment in targeted HIV prevention services (as in the 1980's).

Scope for Savings: Southampton

If Southampton delivered:

- A 55% reduction in teenage conceptions (between 1998-2010) each year we would have saved £25,000 on termination of pregnancy services and £106,500 on maternity care costs alone.
- A switch from oral contraception methods to LARC (at the South Central estimate proportion above), we would save over £500,000 per annum on termination of pregnancy services.
- A halt in new HIV diagnoses (currently 10% increase per annum) would save £250,000 per annum in drug costs alone.

Recommendations

- Increased use of LARC, supporting primary care to 'switch' from oral contraception.
- Increase in Chlamydia screening through investment in primary care services to achieve vital signs target.
- Investment in a preventative framework targeting communities most at risk of HIV.
- Investment in young people-focused contraception and sexual health services to prevent teenage conceptions.

Southampton City

References

Healthcare Commission. 2007. Performing Better? A Focus on Sexual Health Services in England. http://www.cqc.org.uk/_db/_documents/Sexual_Health_full_report_v3.pdf

Health Protection Agency. 2009. HIV in the United Kingdom. http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1259151891830

Department of Health. 2005. Delivering Choosing Health http://www.healthlinklibraries.co.uk/pdf/Delivering_Choosing_Health_DH_4105713.pdf

Department of Health, 2009. Moving forward: Progress and priorities – working together for high-quality sexual health. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103090

Family Planning Association. 2005. Armstrong N and Donaldson C, The Economics of Sexual Health. http://www.fpa.org.uk/media/uploads/professionals/theeconomicsofsexualhealth1.pdf

McGuire A and Hughes D, 1995. The Economics of Family Planning Services, Contraceptive Alliance. http://www.crd.york.ac.uk/crdweb/ShowRecord.asp?LinkFrom=OAI&ID=21996008292

National Chlamydia Screening Programme. http://www.chlamydiascreening.nhs.uk/ps/evidence/index.html

Department for Children, Schools and Families. 2010. Teenage Pregnancy Strategy, Beyond 2010. http://www.everychildmatters.gov.uk/teenagepregnancy

NHS
Southampton City

NHS Southampton Public Health Information Team

Front Page
.....
Update
.....
Introduction
.....
Smoking
.....
Malnutrition
.....
Obesity
.....
Alcohol
.....
Vascular Disease and Coronary Heart Disease
.....
Healthcare Acquired Infection
.....
Self Care
.....
Falls Prevention and Bone Health
.....
Sexual Health
.....
Mental Health
.....

For more public health information visit:

Mental Health

NHS Costs: National

Health and social care for people with mental health illnesses costs an estimated £21.3 billion per annum in England.
1 in 6 of the population will experience mental illness at some stage during their lives. At any one time, just over 20% of working-age women and 17% of working-age men are affected by depression or anxiety.
Mental Illness accounts for more disability adjusted life years lost than any other health condition; 20% as compared to 16.2% for cardio vascular disease, for example.
Just under 46.7 million prescriptions for antidepressants were dispensed in England in 2011; a 3.9 million item (9.1 per cent) increase on 2010

NHS Costs: Southampton

Up to £9.7 million, based on 2009/10 estimates (health plus social care costs).
£1.3 million was spent on prescribing costs for antidepressants between July 2011 and June 2012.

Older people and those with chronic health conditions are at risk of mental ill health. The over 65 population in Southampton is set to increase by 11% between 2011 and 2018, that's an additional 3,800 people falling into this age category. There is a considerable unmet need amongst this population. 20-40% of older people suffer with a mental health problem but only about 4-8% seek professional help.

What Works? Evidence based prevention & timeframe

Children and Young People: 10% of children have a diagnosable mental health condition and 50% of lifetime mental illness is present by the age of 14. Mental health disorders in childhood are associated with depression and anxiety in adulthood.
Early intervention therefore offers clear opportunities for improved patient outcome and long term savings both to the health service and the wider economy.
Older People: Improved identification and earlier intervention.

Scope for Savings: Southampton
Across all mental health disorders, it has been calculated that current treatment averts 13% of the burden, optimal treatment at current coverage could avert 20% of the burden and optimal treatment at optimal coverage could avert 28% of the burden.

Front Page
.....
Update
.....
Introduction
.....
Smoking
.....
Malnutrition
.....
Obesity
.....
Alcohol
.....
Vascular Disease and Coronary Heart Disease
.....
Healthcare Acquired Infection
.....
Self Care
.....
Falls Prevention and Bone Health
.....
Sexual Health
.....
Mental Health
.....

For more public health information visit:

NHS Southampton City

Co-benefits (links to other areas/conditions)

Up to half of people with mental health problems may misuse alcohol or drugs. About 80% of people with alcohol problems have anxiety and depression and over 30% have severe depression.
Depression and anxiety is common in people with chronic conditions such as diabetes, COPD and heart disease.
People with mental illness have higher rates of smoking than the general population.

Recommendations

- In line with New Horizons, the national strategy for mental health, a focus on early intervention
- Improved transition from children to adult services and from adult to older adult
- Improved access for high risk groups and socially excluded

References

Department of Health. New Horizons, a shared vision for mental health. 2010.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_109708.pdf
Centre for Mental Health. 2010. Economic and Social Costs of Mental Health Problems 2009/10.
http://www.centreformentalhealth.org.uk/publications/economic_social_costs__2010.aspx?ID=622
NICE. Depression in Adults: Costing Statement. 2009. http://guidance.nice.org.uk/CG90/CostingStatement/pdf/English