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# 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](http://www.southamptonhealth.nhs.uk/aboutus/publichealth/briefings) we hope that you find them useful and welcome your comments (contact details below).

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## 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)
<ul style="list-style-type: none"> <li>Smoking cessation interventions in a range of settings e.g. workplace, pharmacy, dentists</li> <li>Screening and brief advice by GPs for the prevention of harmful drinking</li> <li>Workplace interventions for management of long-term sickness</li> </ul>	<ul style="list-style-type: none"> <li>Exercise prescriptions for increasing physical activity</li> <li>Life skills training for reducing substance misuse among vulnerable young people</li> <li>Tailored skill sessions for prevention of sexually transmitted infections and under 18 conceptions</li> </ul>

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:-

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TOPIC	INTERVENTIONS	Total investment over 5 years £'000	Saving over 5 years £'000	Return on Investment
ALCOHOL	Provide screening of patients in primary care and appropriate advice for those with excessive drinking levels			
	Provide brief interventions and facilitate 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](http://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/costsavingsguidance.jsp> for further information.

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Lesley Owen, Antony Morgan<sup>1</sup>, Alastair Fischer<sup>1</sup>, 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

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## 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<sup>1</sup>, every £100 spent on self-care measures results in savings of £150<sup>2</sup> 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<sup>3</sup>. 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<sup>4</sup>, 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<sup>5</sup>. During the same period prescribing of drugs for prevention of CVD has increased by almost 300%<sup>6</sup>. 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

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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<sup>8</sup>. 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<sup>9</sup> 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.

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## 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



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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.

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## 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.

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- 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.

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## 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.

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## 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.

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## 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

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- 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

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## 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.



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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.

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Department of Health. Putting Prevention First, Vascular Checks, Risk Assessment and Management. April 2008.

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## 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

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#### 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.

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## 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

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## 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

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## Recommendations

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

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## 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 tariff 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

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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



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- 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

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## 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 £9.5million 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.

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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.

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## 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.

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[Obesity](#)

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[Alcohol](#)

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[Vascular Disease and  
Coronary Heart Disease](#)

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[Healthcare Acquired  
Infection](#)

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[Self Care](#)

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[Falls Prevention and Bone  
Health](#)

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[Sexual Health](#)

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[Mental Health](#)

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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

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