Public Document Pack

Health Overview and Scrutiny Panel

Wednesday, 22nd June, 2011
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Antelope House, Brintons Terrace,
Southampton, SO14 OYG

This meeting is open to the public

Members

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

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PUBLIC INFORMATION

Role of the Audit Committee

The Committee has responsibility for:-

- providing an independent assurance to the Standards and Governance Committee on the adequacy of the risk management framework and the internal control and reporting environment including (but not limited to) the reliability of the financial reporting process and the statement of internal control;
- satisfying and providing assurance to the Standards and Governance Committee that appropriate action is being taken on risk and internal control related issues identified by the internal and external auditors and other review and inspection bodies; and
- specifically, the oversight of, and provision of assurance to the Standards and Governance Committee on, the following functions:-

  - ensuring that Council assets are safeguarded;
  - maintaining proper accounting records;
  - ensuring the independence, objectivity and effectiveness of internal and external audit;
  - the arrangements made for co-operation between internal and external audit and other review bodies;
  - considering the reports of internal and external audit and other review and inspection bodies;
  - the scope and effectiveness of the internal control systems established by management to identify, assess, manage and monitor financial and non-financial risks (including measures to protect against, detect and respond to fraud).

Southampton City Council's Six Priorities

- Providing good value, high quality services
- Getting the City working
- Investing in education and training
- Keeping people safe
- Keeping the City clean and green
- Looking after people

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.

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

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

Dates of Meetings: Municipal Year 2011/12

2011	2012
Weds 22 June	

CONDUCT OF MEETING

Terms of Reference

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

Business to be discussed

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

Rules of Procedure

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

Quorum

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

Disclosure of Interests

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

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Personal Interests

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

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

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

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

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

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

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

A Member must disclose a personal interest.

Continued/……

Prejudicial Interests

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

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

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

There are some limited exceptions.

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

Principles of Decision Making

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

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

In exercising discretion, the decision maker must:

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

AGENDA

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

1 ELECTION OF VICE-CHAIR

To appoint a Vice-Chair to the Scrutiny Panel for this Municipal Year.

2 APOLOGIES AND CHANGES IN PANEL MEMBERSHIP (IF ANY)

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

3 DISCLOSURE OF PERSONAL AND PREJUDICIAL INTERESTS

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

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

4 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.

5 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.

6 STATEMENT FROM THE CHAIR

7 ESTABLISHING THE SHIP PCT CLUSTER

Report of the Director of Corporate and Support Services- Ship Cluster, requesting that the Panel note the establishment of cluster working across PCTs in Southampton, Hampshire, Isle of Wight and Portsmouth, attached.

8 UPDATE FROM SOUTHERN HEALTH NHS FOUNDATION TRUST (FORMERLY HAMPSHIRE PARTNERSHIP FOUNDATION TRUST) ON CHANGES TO ADULT AND OLDER PEOPLE'S MENTAL HEALTH SERVICES

Report of the Head of Consumer Experience and Engagement, Southern Health NHS Foundation Trust, requesting that the Panel note and comment on proposals to relocate Adult Mental Health Services in the Southampton area and to note the consultation activity in relation to Older People's Mental Health, attached.

9 HEALTHWATCH SOUTHAMPTON AND TRANSITIONAL LINK SUPPORT ARRANGEMENTS

Report of the Head of Integrated Strategic Commissioning, Health and Adult Social Care, providing details on progress towards the establishment of a local *HealthWatch* pathfinder project and new support arrangements for Southampton's LINk (S-LINk) that will continue to be a statutory requirement during the period of transition, attached.

10 SOUTHERN HEALTH NHS FOUNDATION TRUST QUALITY ACCOUNT 2010/11

Report of the Interim Deputy Director of Governance (MH&LD), Southern Health NHS Foundation Trust providing details on the Hampshire Partnership Foundation Trust Quality Account 2010/11, for comment, attached.

11 SOUTHAMPTON UNIVERSITY HOSPITALS TRUST QUALITY ACCOUNT 2010/11

Report of the Director of Nursing, SUHT, providing details on the draft Quality Account 2010/11 for SUHT, for comment, attached.

Tuesday, 14 June 2011 HEAD OF LEGAL AND DEMOCRATIC SERVICES

DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	ESTABLISHING THE SHIP PCT CLUSTER
DATE OF DECISION:	22 JUNE 2010
REPORT OF:	ROB DALTON, DIRECTOR OF CORPORATE AND SUPPORT SERVICES, SHIP CLUSTER
STATEMENT OF CONFIDENTIALITY	

BRIEF SUMMARY This paper updates members on the establishment of cluster working across PCTs in Southampton, Hampshire, Isle of Wight and Portsmouth. It is the same paper that was considered and agreed by the SHIP PCT Cluster Board on 6 June, 2011. Also attached is a profile 'snapshot' of the new SHIP PCT cluster and its four constituent PCTs, with an emphasis on key facts and information.

RECOMMENDATIONS:

(i) To note the establishment of the PCT cluster and the establishment of its headquarters in Oakley Road, Southampton.

REASONS FOR REPORT RECOMMENDATIONS

1. To ensure members are aware of the current position in relation to the SHIP cluster and NHS Southampton City.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None – the establishment of PCT Clusters was required by central government.

DETAIL (Including consultation carried out)

3. A paper setting out proposals for how best to configure governance arrangements for PCTs in the SHIP area (NHS Southampton City, NHS Hampshire, NHS Isle of Wight and NHS Portsmouth) has been presented to, and approved by, the four PCT Boards separately at their public Board meetings. The four PCT Boards have agreed to establish a joint committee (Cluster Board) with their PCT partners in the SHIP area, as required by national direction, working under a specified scheme of delegation.

The creation of clusters is intended to:
• sustain management capacity, and a clear line of accountability, and provide greater security for the delivery of current PCT functions in terms of statutory duties, quality, finance, performance, QIPP and NHS Constitution requirements through to March 2013;
• provide space for developing GP Commissioning Consortia to operate effectively;
• provide a basis for the development of commissioning support arrangements, allowing current commissioners and new entrants to develop a range of commissioning support solutions from which consortia and the NHS Commissioning Board can secure expert support;
• similarly, provide space for new arrangements with local authorities, and particularly Health and Wellbeing Boards to develop;
• provide a mechanism to enable high quality NHS staff to move to new roles

in consortia, commissioning support arrangements and the NHS Commissioning Board, including minimising unnecessary redundancy costs; and

• support the provider reform element of the transition particularly in terms of ensuring progress with the FT pipeline through commissioning plans.

RESOURCE IMPLICATIONS

Capital/Revenue

4 None

Property/Other

5 None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

6 The '*Operating Framework for the NHS in England 2011/12'* set out how Primary Care Trusts (PCTs) would be expected to meet the challenges set out in the White Paper and its associated policy documents. The '*PCT Cluster Implementation Guidance*' set out how existing PCTs would be retained as statutory organisations to avoid adding to disruption from reorganisation. It also stated that there would be a consolidation of management capacity, with single executive teams, each managing a cluster of PCTs. These new clusters would not be statutory bodies, nor were they to be permanent features of the landscape, but they would be necessary to sustain PCT capability and enable the creation of the new system.

7 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. The SHIP PCT Cluster will continue to work with Overview and Scrutiny Committees across SHIP to ensure that it fulfils its statutory requirement to consult with the Committees and to maintain the excellent working relationships already in place.

Other Legal Implications:

8 None

POLICY FRAMEWORK IMPLICATIONS

9 None

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	E-mail:	rob.dalton@ports.nhs.uk		

KEY DECISION?

WARDS/COMMUNITIES AFFECTED:	City-wide

SUPPORTING DOCUMENTATION

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

Appendices

1.	SHIP Cluster Board: Establishment and Governance Arrangements (N.B. Appendix 2 – Draft Standing Orders is not included but is available on SHIP PCT websites)
2.	SHIP Cluster Profile

Documents In Members' Rooms

Integrated Impact Assessment

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

Other Background Documents

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

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

SHIP PCT Cluster
Serving Southampton City, Hampshire,
Isle of Wight and Portsmouth City

SHIP CLUSTER BOARD: ESTABLISHMENT AND GOVERNANCE ARRANGEMENTS

Introduction

This paper:

- reminds Cluster Board members of the policy context for the establishment of PCT clusters
- confirms that the four SHIP PCT Boards have formally approved proposals to establish a SHIP Cluster Board and associated governance arrangements as set out in the paper 'SHIP Cluster Governance Arrangements'
- informs the SHIP Cluster Board about progress with the development of governance arrangements
- seeks approval for Standing Orders and Committee Terms of Reference.
- updates the Board on work to approve SFIs based on the national model.

Policy context

The publication of '*Equity and excellence: Liberating the NHS*', and associated policy documents; the '*Operating Framework for the NHS in England 2011/12*'; and the '*PCT Cluster Implementation Guidance*' have resulted in a range of policy and organisational changes.

The '*Operating Framework for the NHS in England 2011/12'* set out how Primary Care Trusts (PCTs) would be expected to meet the challenges set out in the White Paper and its associated policy documents and the '*PCT Cluster Implementation Guidance*' set how existing PCTs would be retained as statutory organisations in order not to add further to disruption from reorganisation. It also stated that there would be a consolidation of management capacity, with single executive teams each managing a cluster of PCTs. These new clusters would not be statutory bodies, nor were they to be permanent features of the landscape, but they would be necessary to sustain PCT capability and enable the creation of the new system.

The creation of clusters is intended to:

- sustain management capacity, and a clear line of accountability, and provide greater security for the delivery of current PCT functions in terms of statutory duties, quality, finance, performance, QIPP and NHS Constitution requirements through to March 2013;

- provide space for developing GP Commissioning Consortia to operate effectively;

- provide a basis for the development of commissioning support arrangements, allowing current commissioners and new entrants to develop a range of commissioning support solutions from which consortia and the NHS Commissioning Board can secure expert support;

- similarly, provide space for new arrangements with local authorities, and particularly Health and Wellbeing Boards to develop;

- provide a mechanism to enable high quality NHS staff to move to new roles in consortia, commissioning support arrangements and the NHS Commissioning Board, including minimising unnecessary redundancy costs; and

- support the provider reform element of the transition particularly in terms of ensuring progress with the FT pipeline through commissioning plans.

SHIP Cluster Governance Arrangements

A paper setting out proposals for how best to configure governance arrangements for (PCTs) in the SHIP area (NHS Southampton City, NHS Hampshire, Isle of Wight NHS PCT and NHS Portsmouth) has been presented to, and approved by, the four PCT Boards separately at their public Board meetings.

The four PCT Boards have agreed to establish a joint committee (Cluster Board) with their PCT partners in the SHIP area, as required by national direction, working under a specified scheme of delegation. This is predicated on the basis that each of the PCT Boards maximises the responsibilities and functions it delegates to the Cluster Board, whilst ensuring these are consistent with the continuing requirement to meet its legal obligations in the interim or until legislation dictates.

The underpinning principle for the efficient and effective operation of the Cluster arrangements will be that, although the PCT Boards will retain statutory accountability for such matters during the transitional period, the PCT Boards will formally delegate:

- operational/operating functions to a SHIP Cluster Board, as a joint Committee of the PCT Boards, supported by the SHIP Cluster Executive Team

- responsibility for commissioning to the SHIP Cluster Board

- responsibility for provider functions should, in the case of the Isle of Wight, be delegated to a provider committee of the Isle of Wight PCT until April 2012 when it is envisaged provider services will have attained independent provider trust status.

PCT Cluster accountability

The South Central Strategic Health Authority as produced a document which sets out the key areas of work for which PCT clusters will be held accountable during 2011/12. It will form the basis of an agreement between each PCT Cluster Chief Executive and Board, and the SHA. A copy of the agreement is attached at Appendix 1.

Creating a new framework for governance

The paper 'SHIP Cluster Governance Arrangements' made it clear that considerable adjustments would need to be made to each PCTs' corporate governance frameworks (Standing Orders, Standing Financial Instructions and Scheme of Delegation) in order to ensure compliance with the Secretary of State's requirements relating to the establishment of cluster working, and with the continuing demands of existing legislation. This work will continue and the necessary papers will be presented to each PCT for consideration and approval in due course. Standing Orders and Standing Financial Instructions have been or will be developed for the SHIP Cluster.

a) Standing Orders

Draft Standing Orders have been developed and are presented for approval at Appendix 2.

b) Standing Financial Instructions

Draft Standing Financial Instructions are being developed and will be presented for approval as soon as possible. These will be based on the national model template.

Board Meetings Calendar

A Board calendar setting out the dates of meetings; deadlines for papers; date, time and venue of all cluster board meetings; membership and quoracy arrangements; and administrative support and other contact details will be developed and published widely.

Board Business Schedule

A schedule of forward business will be developed for the Cluster Board and, over the coming weeks, for each of its committees. This will be mapped against the work needed to support the delivery of national objectives (finance and performance expectations) and local business arrangements.

Committees

Across SHIP, it has been agreed that each PCT Board will establish a new core committee structure, comprising three sub-committees:

- a Cluster Board (as a joint sub-committee with PCTs in SHIP)
- an Audit Committee
- a Remuneration Committee

The Cluster Board will also establish two NED-led sub-committees:

- Audit Committee (x4 Audit Committee Chairs)
- Remuneration Committee (x4 Remuneration Committee Chairs)

In addition, the Cluster Board will also establish sub-committees covering:

- Corporate Business, covering general executive, assurance and legal compliance matters
- Clinical Governance, covering patient safety and quality; and
- Board of Clinical Commissioners, covering common commissioning strategies and approaches

It is further recommended that the Cluster Board establishes GPCC committees as sub-committees of the Board in order to provide emergent GPCCs with direct access and line of accountability to it.

a) Committee Chart

A committee chart is attached as Appendix 3.

b) Committee Terms of Reference

Terms of reference have been drafted for the following Cluster Board committees:

- Audit
- Remuneration
- Clinical Governance
- Board of Clinical Commissioners
- Corporate Business
- GPCC committee (template)

These are attached as Appendices 4a to 4f. It is proposed that the draft Terms of Reference are approved by the Cluster Board for consideration and further development by the individual Committees at their first meetings and revised Terms of Reference are submitted to the Cluster Board for final approval.

c) Committee Calendar

A committee calendar setting out the dates of meetings; deadlines for papers; date, time and venue of meetings; membership; quoracy; and administrative support will be developed and published widely.

d) Committee Business Schedule

A schedule of forward business will be developed for each committee.

House Style Manual

Under clustering arrangements, each individual PCT retains its own name and NHS logo. These should continue to be used on correspondence and communication that relate only to that individual PCT. When Southampton City PCT, Hampshire PCT, Isle of Wight PCT and Portsmouth City tPCT are working together they are to be known as the **SHIP PCT Cluster.**

Recent Department of Health guidance states “that if more than two PCTs are forming a cluster the national NHS logo should be used with any approved cluster name as a title. Explanatory text should be added to any communications to ensure accountability is clearly understood”.

It is considered that all communication by the SHIP PCT Cluster – written, verbal, electronic – should adhere to the following communications principles - they should be clear, cost-effective, straightforward, modern, accessible, honest and respectful.

A House Style Manual is being developed for use within the SHIP Cluster, which will include templates for:

- letters
- emails
- compliment slips
- business cards
- Cluster Board papers
- agendas
- minutes.

It is considered important that documents and communications likely to have a wide circulation within the SHIP area (e.g. reports, minutes of meetings, discussion papers, emails) and all documents and communications being sent to external stakeholders (e.g. letters, minutes, reports, board papers, emails) adhere to the house style. This assures readers that the document is clearly from the NHS, and specifically from the SHIP Cluster.

Business Management Standards

‘Best practice’ business management standards will be applied to all Cluster Board and Committee meetings.

Board & Committee Manual

The Board and Committee Manual will comprise all legal, statutory and best practice documentation, including:

- Accountability Agreement (with SHA)
- Establishment Agreement
- Standing Orders
- Standing Financial Instructions
- Scheme of Reservation and Delegation for the Cluster Board
- Committee Terms of Reference
- Executive Director portfolio information
- Cluster profile

This manual will be compiled and made available in electronic form shortly and will be circulated in hard copy form (as requested) to all Cluster Board members and the Cluster executive team.

Assurance Framework and Risk Register

It is proposed that each organisation 'completes' as soon as possible a baseline Assurance Framework and Strategic Risk Register (AF&SRR) in order to compile a cluster-wide AF&SRR. This will be based on existing documentation. All relevant national and SHA guidance will be used in order to ensure that the composite AF&SRR complies with the requirements of A Grade status.

An audit of risk policies and strategies will be undertaken to ensure that risk issues are identified, escalated, managed and reviewed at appropriate locations and by appropriate individuals across the new and emerging NHS landscape within the Cluster.

Policy Profile & Audit

It is expected that there will be single policies developed for the cluster on a number of relevant issues. The identification of key policies required by the cluster will be undertaken and a transition timetable developed. The cluster will make best use of intranets and electronic sources of distribution.

Audit & Actions Programme

The Audit Committee will oversee all actions relating to internal audit programmes and external assessments taking place across the cluster. It is proposed that a single centralised system is adopted to merge all actions (outstanding or otherwise) in order to service the Audit Committee effectively. It is also intended that this register provides a means through which other actions (ie, those not captured via individual audit programmes or risk registers) can be monitored during transition.

Clinical & Safety Policy

Work will be undertaken as a priority to review whether existing systems deployed currently by PCTs can be aggregated to provide the Cluster with single forms of assurance on safeguarding and patient safety issues. Whilst seeking to ensure effective and appropriate forms of assurance for cluster working, no changes will be pursued that hinder or disable reporting and management arrangements until any aggregated system can be formulated, agreed and constituted. Until then, the Cluster Board and its committees will be asked as appropriate to review assurances compiled on an individual PCT basis.

Other governance processes

A number of other processes and procedures that require adherence to strict governance protocols are currently managed in different ways by the Cluster's member PCTs. A number of have already been identified as of concern by cluster NEDs during the governance consultation process and cover such matters as primary care contractor performance panels, complaints and freedom of information requests. Others relate to the responsibilities of nominated individuals (Caldicott Guardian, senior decision maker on DoL issues). Discussions will be held with

directors, nominated directors and portfolio holders to determine the most appropriate means to manage these responsibilities and provide any required governance support to them.

Individual Funding Request Policy

Previous interest has been shown by the Individual Funding Request (IFR) team currently servicing Hampshire and Southampton, to extend this service to include Portsmouth and the Isle of Wight. IFR administration would, therefore, be provided centrally. A transition plan is required to ensure that a single policy is adopted which retains the flexibility to meet the needs of 'Not normally purchased' treatments in each locality as there is currently no uniformity across the cluster. It is proposed that the single centralised administrative function be provided by the current Hampshire team across the cluster by 1 September 2011. A single team would ensure consistent approaches to funding requests across the cluster and strong governance arrangements for this important and sometimes contentious area of commissioning activity.

GP Commissioning Consortia governance development

It is proposed that a governance profile is developed for each GP Commissioning Consortia. This will be designed to ensure that consortia begin to think about and work to basic governance standards and provide an initial form assurance to the Cluster Board that governance matters are being addressed in a consistent manner. This governance profile should be seen as emerging and will need to be adapted to suit the needs of individual GPCCs and national requirements relating to registration but, in the first instance, will cover:

- Accountability Agreement
- Statement on financial procedures
- Consortia Committee Chart
- Consortia committee memberships
- Consortia Business Calendar.
- Committee ToRs
- Consortia map and locality profile

It is proposed that the Director of Corporate Affairs provides business support services and general governance advice to emerging consortia.

Legal Services

The SHIP Cluster will need to determine how best to obtain legal services. There are currently a number of firms providing services to PCTs across the cluster, including Capsticks, Bevan Britten and Beachcrofts. Whilst specialist advice on specific matters may still need to be obtained from particular solicitors, it is often effective to build single relationships with a single firm on general legal matters. This develops improved levels of understanding and intelligence. It is proposed to review legal arrangements across the cluster to this effect. As it is planned that the Cluster will be disbanded in 2013, it is not intended to follow a formal tendering process for legal services and, instead, the cluster will develop these arrangements on an ad hoc basis. As a result, in order to ensure that legal costs are managed, it is likely that

requests for general legal advice will be channelled through an approved point within the Corporate Affairs Directorate.

Business Resilience Plan

The development of the Cluster represents a programme of considerable change within the local NHS. Whilst this programme will yield opportunities for more effective joint working and build stronger support arrangements, it will be important to ensure that resilience plans are reviewed and remodelled in a single form to reflect cluster working and potential business continuity risks.

Recommendations

The SHIP Cluster Board is asked to;

- **Accept** this report and **comment on** the development of governance arrangements
- **Approve** the Standing Orders
- **Accept** arrangements for the development of the Standing Financial Instructions
- **Approve** the revised Board committee structure
- **Approve** the draft Terms of Reference for referral to individual Committees for consideration and further development at their first meetings and to receive revised Terms of Reference for final approval at a future meeting of the Cluster Board.

Appendix 1

PCT cluster accountability

This document sets out the key areas of work for which PCT clusters will be held accountable during 2011/12. It will form the basis of an agreement between each PCT Cluster Chief Executive and Board, and the SHA.

In each case the Cluster will be expected to work closely with the SHA and key partners to meet these accountabilities. This list is not intended to be exhaustive – the document is the start of a process to achieve an effective transition and a smooth handover of responsibilities during the second half of 2011-12.

Finance, performance and QIPP

- Ensure each PCT within the Cluster meets its statutory duty to break even and leaves no legacy debt at the end of 2011-12;
- Deliver the 2011/12 Operating Plan for each PCT and meet performance targets;
- Agree and apply a governance and performance management framework with emerging GP Commissioning Consortia (GPCC);
- Make required reductions in running costs
- Ensure QIPP requirements for 11-12 are understood across the Cluster, and agree with local GPCCs, Local Authorities, and other stakeholders a single QIPP plan to 2014/15 across the cluster
- Ensure GPCCs agree their own QIPP plan for 2011/12 and understand which elements they are leading on;
- Lead the QRO planning and contracting round for 2012/13 working alongside GPCCs.

Reform

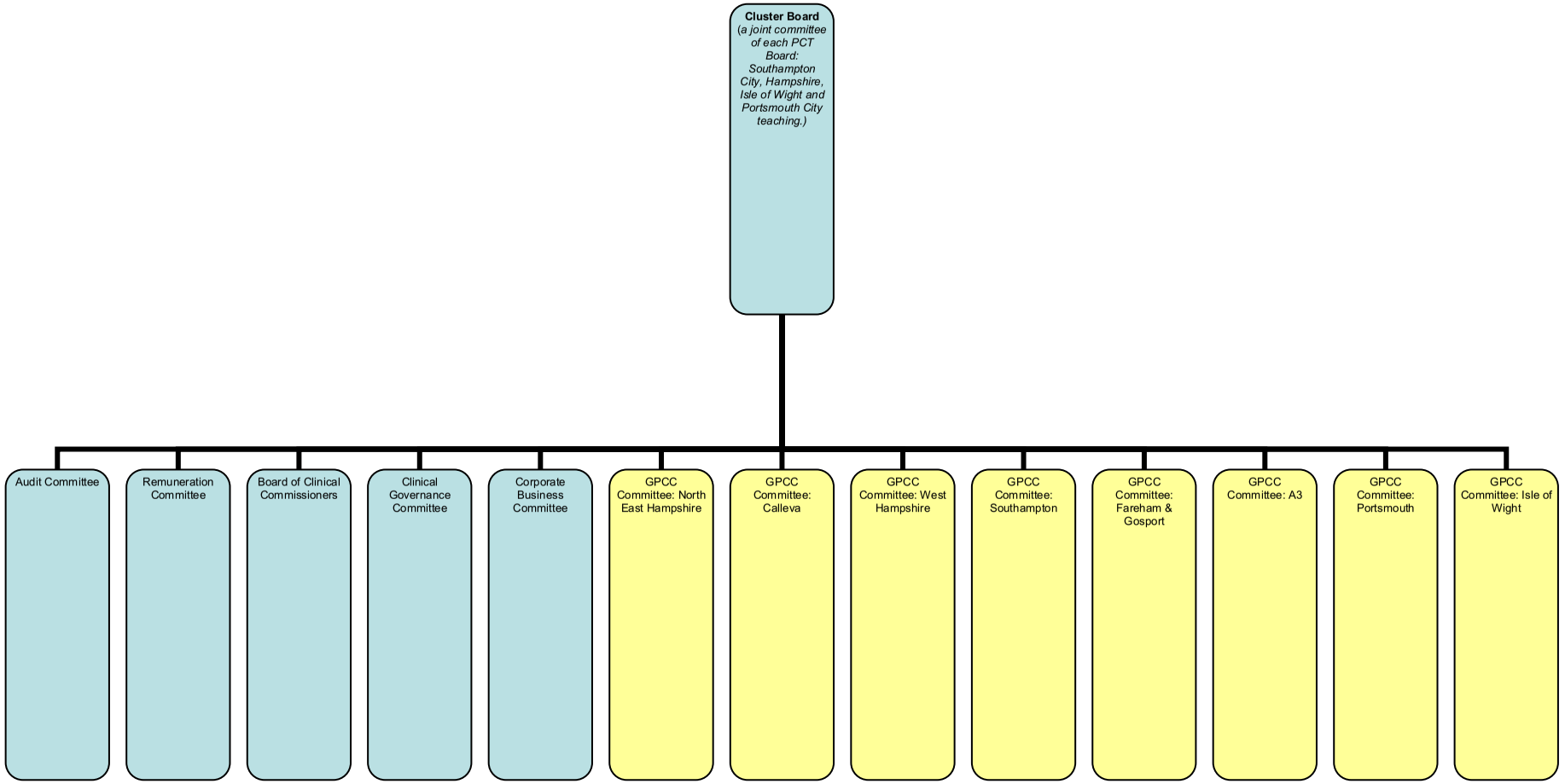
- Support all emerging GPCC to be pathfinders by Sept 2011, in full shadow working mode by 1 April 2012, and ready for authorisation at that point wherever possible;
- Ensure commissioning support services are developed to serve consortia within the cluster area;
- Ensure effective mechanisms are in place for the patient voice to be heard by the commissioning system, and promote 'no decision about me, without me'
- Work with local authorities and the SHA to establish shadow Health and Wellbeing Boards during 2011-12
- Prepare for the transfer of specific commissioning functions to the NHS Commissioning Board – primary care commissioning, prison health, and specialised commissioning and military health;
- Work with NHS Trusts to support their trajectory through the FT pipeline as set out in the 31st March Tripartite Formal Agreements;
- Consult on, and implement, the Safe and Sustainable service recommendations covering trauma, vascular surgery and stroke services to achieve best outcomes;
- plan a future model for public health delivery and a staged transfer of responsibility for public health services to local Councils

Governance

- put in place effective and efficient governance mechanisms, spanning their constituent Boards;
- ensure clear mechanisms for quality assurance are in place during transition, supported by visible clinical leadership
- ensure appropriate staffing structures are in place to deliver the key programmes of work, with a continued focus on leadership development and appropriate support for these staff through the transition.

Appendix 3

OUTLINE CORE COMMITTEE STRUCTURE for the SHIP CLUSTER



SHIP PCT Cluster
Serving Southampton City, Hampshire,
Isle of Wight and Portsmouth City

CLUSTER AUDIT COMMITTEE
TERMS OF REFERENCE

1 CONSTITUTION

1. The Cluster Audit Committee is established as a Non-executive committee of the SHIP PCT Cluster Board, a joint Committee of the PCT Boards, and has those executive powers specifically delegated to it by the Board within the Cluster Board Scheme of Delegation and in these Terms of Reference, which will be reviewed annually by the Cluster Board.

2. PURPOSE

2.1 The purpose of the Committee is to provide the Cluster Board with an assurance and scrutiny function.

3. RESPONSIBILITIES

3.1 The responsibilities of the Committee are to:

- assist the Cluster Board in delivering its responsibilities for the stewardship of funds within its control
- ensure an appropriate level of control is in place through the development of the Audit programme for member PCTs as appropriate and through the management of the Assurance Framework/Strategic Risk Register for the Cluster Board
- work to develop common approaches to audit management and reduce to a minimum the range and number of audit matters that should be dealt with by PCT Audit Committees
- liaise with the Audit Committees of the individual PCT Boards.
- <…item…>
- <…item…>
- <…item…>

4. SCOPE OF AUTHORITY AND DECISION-MAKING

4.1 The Committee is required to work in accordance with these Terms of Reference and the SHIP PCT Cluster Board's Standing Orders, Standing Financial Instructions and Scheme of Delegation.

4.2 The Committee will work to the professional and legal standards required of its members.

4.3 The Committee will ensure that it reports to the SHIP PCT Cluster Board on any matters which properly fall within the Board's 'Schedule of Matters Reserved to the Board'.

5 MEMBERSHIP, QUORUM AND ATTENDANCE

5.1 The Committee will have the following membership:

- x4 PCT Board Audit Committee Chairs.

5.2 The Chair will be a PCT Board Audit Committee Chair appointed by the Cluster Board, or, in their absence, as deputising chair, one of the Cluster Audit Committee members nominated by the Cluster Audit Committee Chair.

5.3 The meetings will be quorate when there are 3 members present, one of whom shall be the Committee Chair or the nominated deputising chair.

5.4 The Committee must be quorate when any decisions are made or votes taken.

5.5 The Cluster Director of Finance & Performance and the Director of Corporate Affairs will normally be present. The Cluster Chief Executive and other Cluster Executive Directors may be invited to attend when the Committee is considering matters that fall within the area of responsibility for that Director.

5.6 Representatives of External Audit, Internal Audit and the Local Counter Fraud Service may be invited to attend for specific items with the prior agreement of the Chair or the nominated deputising chair.

5.7 Others may be invited to attend for specific items with the prior agreement of the Chair or the nominated deputising chair.

6.0 FREQUENCY

6.1 Meetings will normally be held four times a year. Additional meetings can be called by the Cluster Audit Committee Chair.

7.0 MANAGEMENT

7.1 Decisions will generally be made on the basis of consensus. In certain circumstances it may be necessary for all members to vote, normally by a show of hands.

7.2 In the case of an equality of votes, the chair shall have a second vote which will be the casting vote.

7.3 The Committee Chair will provide reports on the work of the Committee to Part I or Part II of the SHIP Cluster Board meeting according to the nature of the business to be reported.

7.4 The Committee shall receive support services from the Director of Corporate Affairs.

7.5 The agenda and any papers shall normally be circulated to members 5 working days before the date of the meeting.

8.0 REPORTING ARRANGEMENTS

8.1. The Cluster Audit Committee will report to the SHIP PCT Cluster Board. The approved Minutes of the Committee will be submitted to the Board.

9.0 SUB-COMMITTEES

9.1 The following committees and sub-committees will report to the Committee:

- <…item…>

The minutes of the following meetings will also be received by the Committee:

- <…item…>

10.0 KEY RELATIONSHIPS

10.1 The Committee will establish and maintain relationships with the following key stakeholders:

- <…item…>
- <…item…>
- <…item…>

Date SHIP PCT Cluster Board Approved:
Date for Review:
Reviewed:
Date Revision Approved:

Draft 2

SHIP PCT Cluster
Serving Southampton City, Hampshire,
Isle of Wight and Portsmouth City

CLUSTER REMUNERATION COMMITTEE
TERMS OF REFERENCE

1 CONSTITUTION

1. The Cluster Remuneration Committee is established as a Non-executive committee of the SHIP PCT Cluster Board, a joint Committee of the PCT Boards, and has those executive powers specifically delegated to it by the Board within the Cluster Board Scheme of Delegation and in these Terms of Reference, which will be reviewed annually by the Cluster Board.

2. PURPOSE

2 The Committee will be the source of advice to the Cluster Board on matters relating to the employment and remuneration of the Cluster Board Executive.

3. RESPONSIBILITIES

3.1 The responsibilities of the Committee are to:

- be the source of advice to the Cluster Board on setting pay for the Cluster Chief Executive and the Cluster Board Executive Team.
- assist the Cluster Chair to evaluate the performance of the Cluster Chief Executive, and, through the Cluster Chief Executive, evaluate the performance of the Cluster Board Executive
- scrutinise any termination payments, taking account of advice and guidance as appropriate, and in liaison with any 'grandparent' organization
- via effective joint working, to minimize the range and number of issues which must be dealt with by individual PCT remuneration committees
- liaise with the Remuneration Committees of the individual PCT Boards.
- <…item…>
- <…item…>
- <…item…>

4. SCOPE OF AUTHORITY AND DECISION-MAKING

4.1 The Committee is required to work in accordance with these Terms of Reference and the SHIP PCT Cluster Board's Standing Orders, Standing Financial Instructions and Scheme of Delegation.

4.2 The Committee will work to the professional and legal standards required of its members.

4.3 The Committee will ensure that it reports to the SHIP PCT Cluster Board on any matters which properly fall within the Board's 'Schedule of Matters Reserved to the Board'.

5 MEMBERSHIP, QUORUM AND ATTENDANCE

5.1 The Committee will have the following membership:

- x4 PCT Board Remuneration Committee Chairs.

5.2 The Chair will be the PCT Cluster Chair, or, in their absence, one of the Cluster Remuneration Committee members nominated by the PCT Cluster Chair.

5.3 The meetings will be quorate when there are 3 members present, of whom there should be the Remuneration Committee Chair or, as deputising chair, the nominated Remuneration Committee member present.

5.4 The Committee must be quorate when any decisions are made or votes taken.

5.5 The Cluster Chief Executive and Cluster Director of Human Resources will normally be present. Other Cluster Executive Directors may be invited to attend when the Committee is considering matters that fall within the area of responsibility for that Director.

5.6 Others may be invited to attend for specific items with the prior agreement of the Chair or the nominated deputising Chair.

6.0 FREQUENCY

6.1 Meetings will normally be held four times a year. Additional meetings can be called by the PCT Cluster Chair.

7.0 MANAGEMENT

7.1 Decisions will generally be made on the basis of consensus. In certain circumstances it may be necessary for all members to vote, normally by a show of hands.

7.2 In the case of an equality of votes, the chair shall have a second vote which will be the casting vote.

7.3 The Committee Chair will provide reports on the work of the Committee to Part I or Part II of the SHIP Cluster Board meeting according to the nature of the business to be reported.

7.4 The Committee shall receive support services from the Director of Corporate Affairs.

7.5 The agenda and any papers shall normally be circulated to members 5 working days before the date of the meeting.

Appendix 4b

8.0 REPORTING ARRANGEMENTS

8.1. The Cluster Remuneration Committee will report to the SHIP PCT Cluster Board. The approved Minutes of the Committee will be submitted to the Board.

9.0 SUB-COMMITTEES

9.1 The following committees and sub-committees will report to the Committee:

- <…item…>

The minutes of the following meetings will also be received by the Committee:

- <…item…>

10.0 KEY RELATIONSHIPS

10.1 The Committee will establish and maintain relationships with the following key stakeholders:

- <…item…>
- <…item…>
- <…item…>

Date SHIP PCT Cluster Board Approved:
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Draft 2

SHIP PCT Cluster
Serving Southampton City, Hampshire,
Isle of Wight and Portsmouth City

CLUSTER CLINICAL GOVERNANCE COMMITTEE
TERMS OF REFERENCE

1 CONSTITUTION

1. The Cluster Clinical Governance Committee is established as an executive committee of the SHIP PCT Cluster Board, a joint Committee of the PCT Boards, and has those executive powers specifically delegated to it by the Board within the Cluster Board Scheme of Delegation and in these Terms of Reference, which will be reviewed annually by the Cluster Board.

2. PURPOSE

2.1 The purpose of the Committee is to provide the Cluster Board with an assurance and scrutiny function in relation to patient safety and quality.

3. RESPONSIBILITIES

3.1 The responsibilities of the Committee are:

- To provide an assurance to the Cluster Board on all matters concerning duties, obligations and responsibilities relating to patient safety and quality.

4. SCOPE OF AUTHORITY AND DECISION-MAKING

4.1 The Committee is required to work in accordance with these Terms of Reference and the SHIP PCT Cluster Board's Standing Orders, Standing Financial Instructions and Scheme of Delegation.

4.2 The Committee will work to the professional and legal standards required of its members.

4.3 The Committee will ensure that it reports to the SHIP PCT Cluster Board on any matters which properly fall within the Board's 'Schedule of Matters Reserved to the Board'.

5 MEMBERSHIP, QUORUM AND ATTENDANCE

5.1 The Committee will have the following membership:

- Cluster Medical Director
- Cluster Director of Nursing
- Cluster Director for Commissioning Development
- Cluster Director of Human Resources
- Cluster Director of Corporate Affairs

- Cluster Board Director of Public Health
- Nominated/Aligned Directors
- X4 Non-Executive Directors.

5.2 The Chair will be the Clinical Governance Committee Chair appointed by the Cluster Board, or, in their absence, one of the Cluster Clinical Governance Committee members nominated by the Cluster Clinical Governance Committee Chair.

5.3 The meetings will be quorate when there are at least one half of the members appointed present, of whom there should be the Clinical Governance Committee Chair or the nominated Clinical Governance Committee member Chair present.

5.4 The Committee must be quorate when any decisions are made or votes taken.

5.5 Others may be invited to attend for specific items with the prior agreement of the Chair or the nominated Clinical Governance Committee member Chair.

6.0 FREQUENCY

6.1 Meetings will normally be held six times a year. Additional meetings can be called by the PCT Cluster Chair.

7.0 MANAGEMENT

7.1 Decisions will generally be made on the basis of consensus. In certain circumstances it may be necessary for all members to vote, normally by a show of hands.

7.2 In the case of an equality of votes, the chair shall have a second vote which will be the casting vote.

7.3 The Committee Chair will provide reports on the work of the Committee to Part I or Part II of the SHIP Cluster Board meeting according to the nature of the business to be reported.

7.4 The Committee shall receive support services from the Director of Corporate Affairs.

7.5 The agenda and any papers shall normally be circulated to members 5 working days before the date of the meeting.

8.0 REPORTING ARRANGEMENTS

8.1. The Cluster Clinical Governance Committee will report to the SHIP PCT Cluster Board. The approved Minutes of the Committee will be submitted to the Board.

Appendix 4d

9.0 SUB-COMMITTEES

9.1 The following committees and sub-committees will report to the Committee:

- A

The minutes of the following meetings will also be received by the Committee:

- A

10.0 KEY RELATIONSHIPS

10.1 The Committee will establish and maintain relationships with the following key stakeholders:

- A
- A
- A
- A

Date SHIP PCT Cluster Board Approved:
Date for Review:
Reviewed:
Date Revision Approved:

Draft 1

SHIP PCT Cluster
Serving Southampton City, Hampshire,
Isle of Wight and Portsmouth City

BOARD OF CLINICAL COMMISSIONERS

TERMS OF REFERENCE

1 CONSTITUTION

1. The Board of Clinical Commissioners is established as an executive committee of the SHIP PCT Cluster Board, a joint Committee of the PCT Boards, and has those executive powers specifically delegated to it by the Board within the Cluster Board Scheme of Delegation and in these Terms of Reference, which will be reviewed annually by the Cluster Board.

2. PURPOSE

2.1 The purpose of the Committee is to:

- approve -
  - common commissioning strategies and approaches
- advise on or approve matters relating to -
  - specialist services commissioning
  - primary care contracting
- promote -
  - clinical and wider stakeholder engagement in commissioning
  - good practice in clinical commissioning

3. RESPONSIBILITIES

3.1 The responsibilities of the Committee are to:

- ensure there are no conflicts of interest imposed on its members when decisions or advice are sought on commissioning matters
- work with and support GPCCs to manage and account for their responsibilities under local Accountability Agreements
- work with the emerging Health and Well-Being Boards to ensure the effective transition to GP Commissioning by ensuring close working with partners, stakeholders and the third sector to deliver the joint commissioning agenda
- work with and support the National Commissioning Board on appropriate commissioning matters
- maximise clinical engagement in commissioning and QRO plans.
- provide a forum for decisions relating to clinical networks.
- <…item…>
- <…item…>
- <…item…>

Appendix 4d

4. SCOPE OF AUTHORITY AND DECISION-MAKING

4.1 The Committee is required to work in accordance with these Terms of Reference and the SHIP PCT Cluster Board's Standing Orders, Standing Financial Instructions and Scheme of Delegation.

4.2 The Committee will work to the professional and legal standards required of its members.

4.3 The Committee will ensure that it reports to the SHIP PCT Cluster Board on any matters which properly fall within the Board's 'Schedule of Matters Reserved to the Board'.

5 MEMBERSHIP, QUORUM AND ATTENDANCE

5.1 The Committee will have two parts. The second part will be held as required by the chair or deputising chair and will consider matters relating to primary care contracting. The first part will consider all other matters. The membership and quoracy arrangements for these two parts will differ.

5.2 Part I membership:

- Cluster Chief Executive (Chair)
- Cluster Director of Finance & Performance
- Cluster Director for Commissioning Development
- Cluster Medical Director
- Cluster Director of Nursing
- Executive lead for specialist commissioning
- Cluster Nominated Director x8
- GPCC executive representative x 8
- Cluster Board Director(s) of Public Health (*to be agreed*)

5.3 Part II membership:

- Cluster Chief Executive (Chair)
- Cluster Director of Finance & Performance
- Cluster Director for Commissioning Development
- Cluster Medical Director
- Cluster Director of Nursing
- Executive lead for primary care contracting
- Cluster Nominated Director x8
- Cluster Board Director(s) of Public Health (*to be agreed*)

5.4 The Clinical Commissioning Committee Chair (the Chair) will be appointed by the Cluster Board. In the absence of the Chair, one of the Cluster Clinical Commissioning Committee members nominated by the Chair shall deputise for him or her.

5.5 The Committee will receive advice as required and directed by the Chair or deputising Chair from any executive director of the Cluster. Others may be invited to attend for specific items with the prior agreement of the Chair or the nominated Chair.

5.6 Part I meetings will be quorate when there is (i) at least one half of the

members appointed present, of whom there should be the Clinical Commissioning Committee Chair or deputy, three nominated directors and three GPCC executive representatives present; and (ii) at least one representative (or a nominated deputy agreed in advance with the committee chair) of each of the 8 GPCC areas.

5.7 Part II meetings will be quorate when there is at least one half of the members appointed present, of whom there should be the Clinical Commissioning Committee Chair or deputy and three nominated directors present.

5.8 The Committee must be quorate when any decisions are made or votes taken.

6.0 FREQUENCY

6.1 Meetings will normally be held every calendar month (x12). Additional meetings can be called by the Chair of the Board of Clinical Commissioners or nominated deputy.

7.0 MANAGEMENT

7.1 Decisions will generally be made on the basis of consensus. In certain circumstances, it may be necessary for all members to vote - normally by a show of hands.

7.2 In the case of an equality of votes, the chair or nominated deputy shall have a second vote which will be the casting vote.

7.3 The Committee Chair will provide reports on the work of the Committee to Part I or Part II of the SHIP Cluster Board meeting according to the nature of the business to be reported.

7.4 The Committee shall receive support services from the Director of Corporate Affairs.

7.5 The agenda and any papers shall normally be circulated to members 5 working days before the date of the meeting.

8.0 REPORTING ARRANGEMENTS

8.1. The Board of Clinical Commissioners will report to the SHIP PCT Cluster Board. The approved Minutes of the Committee will be submitted to the Board.

9.0 SUB-COMMITTEES

9.1 The following committees and sub-committees will report to the Committee:

- <…item…>

The minutes of these meetings will also be received by the Committee. In addition, the Committee shall receive minutes from:

- <…item…>

Appendix 4d

10.0 KEY RELATIONSHIPS

10.1 The Committee will establish and maintain relationships with the following key stakeholders:

- <…item…>
- <…item…>
- <…item…>

Date SHIP PCT Cluster Board Approved:
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Date Revision Approved:

Draft 4

SHIP PCT Cluster
Serving Southampton City, Hampshire,
Isle of Wight and Portsmouth City

CLUSTER CORPORATE BUSINESS COMMITTEE
TERMS OF REFERENCE

1 CONSTITUTION

1. The Cluster Corporate Business Committee is established as an executive committee of the SHIP PCT Cluster Board, a joint Committee of the PCT Boards, and has those executive powers specifically delegated to it by the Board within the Cluster Board Scheme of Delegation and in these Terms of Reference, which will be reviewed annually by the Cluster Board.

2. PURPOSE

2.1 The purpose of the Committee is to provide an assurance and scrutiny function in relation to the governance arrangements for ensuring that PCTs are able to meet their statutory duties.

3. RESPONSIBILITIES

3.1 The responsibilities of the Committee are:

- to provide assurance to the Cluster Board with regard to controls, risk management systems and to ensure that the constituent PCTs discharge their statutory duties.
- <…item…>
- <…item…>
- <…item…>
- <…item…>

4. SCOPE OF AUTHORITY AND DECISION-MAKING

4.1 The Committee is required to work in accordance with these Terms of Reference and the SHIP PCT Cluster Board's Standing Orders, Standing Financial Instructions and Scheme of Delegation.

4.2 The Committee will work to the professional and legal standards required of its members.

4.3 The Committee will ensure that it reports to the SHIP PCT Cluster Board on any matters which properly fall within the Board's 'Schedule of Matters Reserved to the Board'.

Appendix 4e

5 MEMBERSHIP, QUORUM AND ATTENDANCE

5.1 The Committee will have the following membership:

- Cluster Chief Executive
- Cluster Director of Finance
- Cluster Medical Director
- Cluster Director of Nursing
- Cluster Director of Human Resources
- Cluster Director of Corporate Affairs
- Cluster Board Director of Public Health
- X4 Non-executive Directors (not PCT or Audit Chairs).

5.2 The Chair will be the Cluster Chief Executive, or, in their absence, one of the Cluster Corporate Business Committee members nominated by the Cluster Chief Executive.

5.3 The meetings will be quorate when there are at least one half of the members appointed in attendance, of whom there should be present the Cluster Chief Executive or, as deputising chair, the nominated Corporate Business Committee member Chair; and a Non-executive Director.

5.4 The Committee must be quorate when any decisions are made or votes taken.

5.5 Others may be invited to attend for specific items with the prior agreement of the Chair or the nominated Chair.

6.0 FREQUENCY

6.1 Meetings will normally be held four times a year. Additional meetings can be called by the Corporate Business Committee Chair.

7.0 MANAGEMENT

7.1 Decisions will generally be made on the basis of consensus. In certain circumstances it may be necessary for all members to vote, normally by a show of hands.

7.2 In the case of an equality of votes, the chair shall have a second vote which will be the casting vote.

7.3 The Committee Chair will provide reports on the work of the Committee to Part I or Part II of the SHIP Cluster Board meeting according to the nature of the business to be reported.

7.4 The Committee shall receive support services from the Director of Corporate Affairs.

7.5 The agenda and any papers shall normally be circulated to members 5 working days before the date of the meeting.

Appendix 4e

8.0 REPORTING ARRANGEMENTS

8.1. The Cluster Corporate Business Committee will report to the SHIP PCT Cluster Board. The approved Minutes of the Committee will be submitted to the Board.

9.0 SUB-COMMITTEES

9.1 The following committees and sub-committees will report to the Committee:

- <…item…>

The minutes of the following meetings will also be received by the Committee:

- <…item…>

10.0 KEY RELATIONSHIPS

10.1 The Committee will establish and maintain relationships with the following key stakeholders:

- <…item…>
- <…item…>
- <…item…>

Date SHIP PCT Cluster Board Approved:
Date for Review:
Reviewed:
Date Revision Approved:

Draft 2

SHIP PCT Cluster
Serving Southampton City, Hampshire,
Isle of Wight and Portsmouth City

<…NAME …><GPCC COMMITTEE>

TERMS OF REFERENCE

1 CONSTITUTION

1. The Committee is a combined non-executive and executive sub-committee of the SHIP Cluster Board. It has those executive powers specifically delegated to it by the Cluster Board within the Scheme of Delegation and in these Terms of Reference, which will be reviewed by the Cluster Board to the schedule set out below.

2. PURPOSE

2.1 The Committee will be the strategic commissioning body of the SHIP Cluster Board on matters relating to the < …….. area …….. > . Its purpose will be to:

- develop and confirm the strategic commissioning priorities for the < …….. area …….. > and, thereby, the <… name …> commissioning consortium;
- oversee the development of strategic and operational plans to deliver national and local priorities and ensure appropriate underpinning infrastructure plans such as finance, IT, capital development and workforce are in place;
- ensure processes are in place to track progress of all plans, ensure intended outcomes are achieved and risks managed effectively;
- direct change and work programmes through the commissioning resource available to the Cluster and GPCC, both directly and indirectly; and
- develop the <… name …> GP Commissioning Consortium and ensure its authorisation by the National Commissioning Board by April 2013.

3. RESPONSIBILITIES

3.1 The responsibilities of the Committee are to:

- oversee the development of the Cluster's Quality, Innovation and Productivity Plan (QIPP) including the Financial Strategy and annual Operating Plan, ensuring they fit with the GP Commissioning Consortium's strategic and clinical priorities;
- oversee the development of the specific clinical strategies and supporting programmes;
- monitor delivery of the QIPP, Financial Strategy and Operating Plan;

- develop prioritisation criteria and business case processes to support strategic planning processes;
- prioritise commissioning proposals to ensure resources are used to focus on areas of highest priority and strategic fit;
- establish and monitor commissioning activities/projects on behalf of the Cluster Board;
- refer to the Cluster's Clinical Commissioning committee for review matters which impact on the effective working of neighbouring (emergent) GPCCs or other SHIP (emergent) GPCCs;
- manage the provider market in accordance with best and legal practice, developing and implementing policies and strategies to support this, such as procurement policy;
- develop mechanisms and ensure appropriate and meaningful engagement with patients and the public in the development and delivery of the Cluster's commissioning strategies and plans;
- promote patient choice and competition in developing the provider market whilst ensuring services deliver high quality and patient focused services;
- oversee the development and execution of mechanisms to deliver clinical engagement in setting overall strategic direction and in delivery;
- ensure commissioning strategies take into account evidence-based approaches and clinical- and cost-effectiveness, including best practice;
- oversee and direct utilisation of commissioning support to the development and delivery of all plans including utilisation of directly managed support and Cluster resource as well as other sources of support as required; and
- ensure commissioning plans appropriately cover national and regional policies and guidance.

4. SCOPE OF AUTHORITY AND DECISION-MAKING

4.1 The Committee is required to work in accordance with these Terms of Reference and the Cluster's Standing Orders, Standing Financial Instructions and Scheme of Delegation.

4.2 The Committee will work to the professional and legal standards required of its members.

4.3 The Committee will ensure that it reports to the Cluster Board on any matters which properly fall within the Board's 'Schedule of Matters Reserved to the Board'.

5 MEMBERSHIP AND ATTENDANCE

5.1 The Committee will have the following membership:

- x elected GPCC members
- 1 Non Executive Directors of <….. PCT name …..>
- Nominated Executive Director for the <…. area ….>
- Chief financial officer for the <….. area …..>
- Director of Public Health for <… name ….>
- 1 officer of the <…. local authority …>

The Chair of Committee may also co-opt other members in consultation with the Committee. This may include:

- LINK/PPI/Health Watch representative
- Local authority council member(s)
- other clinical representatives of the GPCC or Cluster
- senior management leads for performance, contracting, organisational development and communication/engagement.

5.2 The Chair will be the elected Chair of the <..... consortia name …..>, or, in their absence, another GPCC Executive member identified by the Chair.

5.3 The meetings will be quorate when there are x members present, of whom there should be x GPCC Executive members, and 1 of either the Nominated Executive Director or the Chief Financial Officer

5.4 The Committee must be quorate when any decisions are made or votes taken.

5.5 Deputies may attend meetings in the absence of members but may not vote unless a formal acting up arrangement is in place.

5.6 Others may be invited to attend for specific items with the prior agreement of the Chair or the Nominated Director.

6.0 FREQUENCY

6.1 Meetings will normally be held monthly, with at least 10 meetings a year.

7.0 MANAGEMENT

7.1 Decisions will generally be made on the basis of consensus. In certain circumstances it may be necessary for all members to vote, normally by a show of hands.

7.2 In the case of an equality of votes, the chair shall have a second vote which will be the casting vote.

7.3 The Committee Chair will provide reports on the work of the Committee to Part I or Part II of the Cluster Board meeting according to the nature of the business to be reported.

7.4 The Committee shall receive advice / support services from the Cluster Board's Director of Corporate Affairs.

7.5 The agenda and any papers shall be circulated to members five working days before the date of the meeting.

8.0 REPORTING ARRANGEMENTS

The Committee will report to the SHIP Cluster Board. The Minutes of the Committee will be submitted to the SHIP Cluster Board.

9.0 SUB-COMMITTEES

8.1 The following Sub-committees will report to the Committee:

- Integrated Commissioning Board
- Prioritisation Panel
- Individual Funding Request panels.
- <… item …>

The minutes of the following Boards/Committees will also be received by the Committee:

- Specialised Commissioning Board
- Local Strategic Partnership
- Health & Wellbeing Board (tbc)
- SHIP Cluster Directors/GPCC Leads Group (tbc)
- <…..name…..> Commissioning Committee
- <… item …>

10.0 KEY RELATIONSHIPS

The Committee will establish and maintain relationships with the following key stakeholders:

- SHIP Cluster Executive Group
- Health Overview and Scrutiny Committee / Panel
- Local Strategic Partnership
- Local Area Agreement Delivery Board
- <….. locality …..> Commissioning Committee
- <… item …>

Date PCT Board Approved: tbc
Date for Review: December 2011
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SHIP PCT Cluster
Serving Southampton City, Hampshire,
Isle of Wight and Portsmouth City

SHIP in profile

This paper has been produced to provide a profile 'snapshot' of the new SHIP cluster and its four constituent PCTs with an emphasis on key facts and information. Whilst this first iteration of the document contains some basic background information, the intention is to add further sections and suggestions for these are welcomed.

This paper contains the following:

1. PCT contact details
2. Geographical and political – PCT boundaries, population, councils (including web links from electronic version), MPs
3. NHS and primary care – Spend, GPCCs, primary care and main providers
4. GP consortia by area
5. Health profiles – children and young people
6. Health profiles – adults and life expectancy
7. Patient satisfaction – top five areas from ICM survey
8. Patient dissatisfaction – top five areas from ICM survey
9. Public perception of NHS priorities for the future – from ICM survey
10. Engagement and consultation activity – SHIP-wide and PCT-specific

1 PCT CONTACT DETAILS

NHS Southampton City	**HQ Address**	Trust Headquarters, Oakley Road, Southampton, SO16 4GX		
	Phone	023 8029 6904	**Fax**	023 8029 6960
	Web	www.southamptonhealth.nhs.uk		
	Twitter	http://twitter.com/#!/nhs_southampton	**Facebook**	http://www.facebook.com/NHSSouthampton
NHS Hampshire	**HQ Address**	Omega House, 112 Southampton Road, Eastleigh, Hants SO50 5PB		
	Phone	0238 062 7444	**Fax**	0238 064 4789
	Web	www.hampshire.nhs.uk		
	Twitter	http://twitter.com/#!/NHSHampshire	**Facebook**	-
NHS Isle of Wight	**HQ Address**	St Mary's Hospital, Parkhurst Road, Newport, Isle of Wight PO30 5TG		
	Phone	01983 524081	**Fax**	
	Web	www.iow.nhs.uk		
	Twitter	-	**Facebook**	-
NHS Portsmouth	**HQ Address**	Trust Headquarters, St James' Hospital, Locksway Road, Portsmouth PO4 8LD		
	Phone	023 9282 2444	**Fax**	023 9268 4801
	Web	www.portsmouth.nhs.uk		
	Twitter	http://twitter.com/#!/nhs_portsmouth	**Facebook**	www.facebook.com/NHSPortsmouth

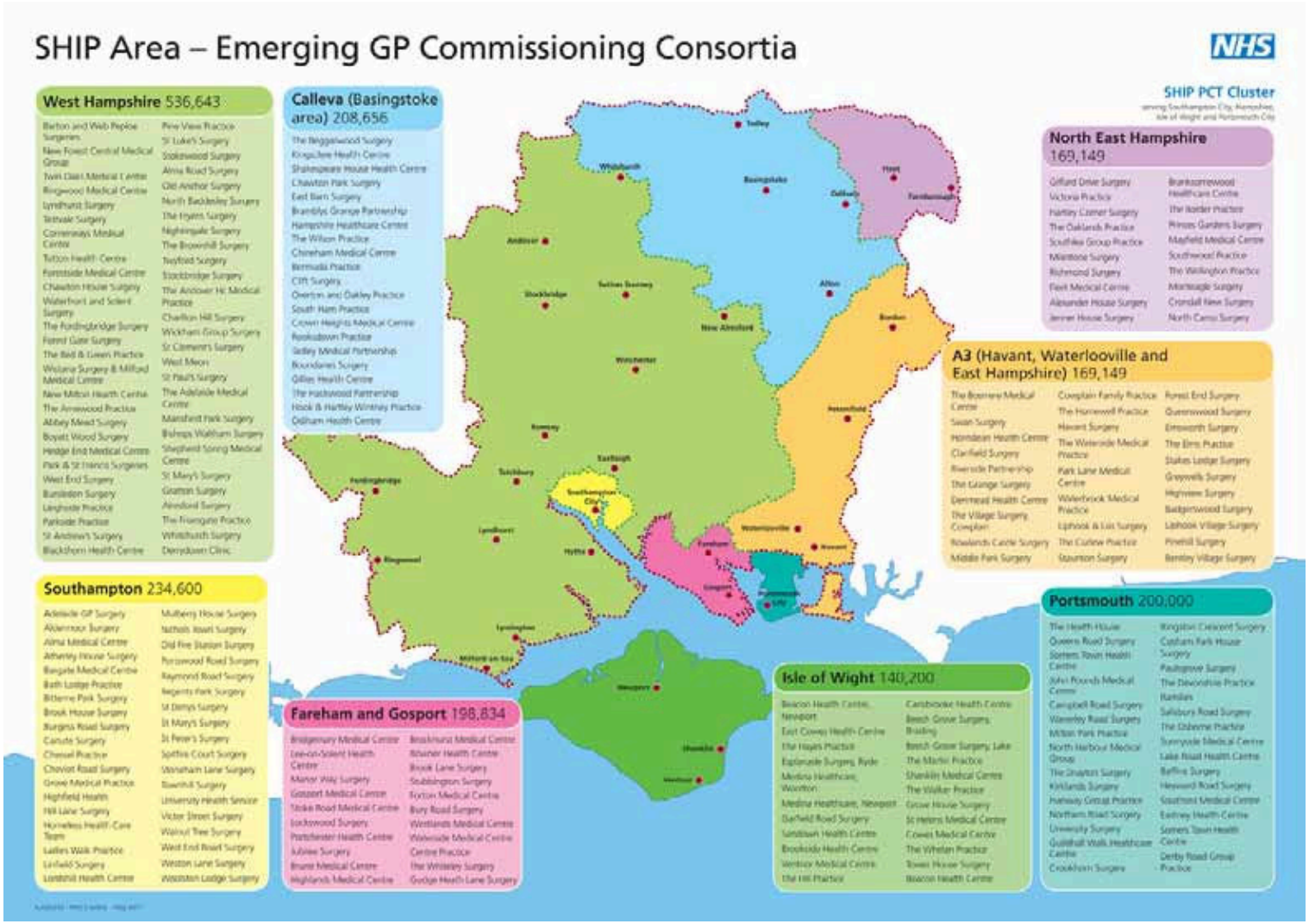
2 GEOGRAPHICAL AND POLITICAL

	PCT Boundaries	Population	Councils	MPs
NHS Southampton City	Shares boundaries with Southampton City Council – from Redbridge to the west, Lordshill, Bassett and Swaythling to the north and Thornhill to the east.	250,000	Southampton City	Alan Whitehead, Soton Test (Lab) John Denham, Soton Itchen (Lab) Caroline Nokes, Romsey/Stn N (Con)
NHS Hampshire	County of Hampshire excluding cities of Portsmouth and Southampton	1,260,000	Hampshire County Council Basingstoke and Deane BC East Hampshire DC Eastleigh BC Fareham BC Gosport BC Hart DC Havant BC New Forest DC Rushmoor BC Test Valley BC Winchester City	Caroline Dineage, Gosport (Con) Chris Huhne, Eastleigh (LD) Damian Hinds, East Hants (Con) David Willetts, Havant (Con) George Hollingbery, Meon V (Con) Gerald Howarth, Aldershot (Con) Mark Hoban, Fareham (Con) James Arbuthnot, NE Hants (Con) Steve Byrne, Winchester (Con)
NHS Isle of Wight	Isle of Wight	140,000	Isle of Wight	Andrew Turner (Con)
NHS Portsmouth	Coterminous with Portsmouth City Council boundaries, incl Paulsgrove, Wymering, Cosham, Drayton and Farlington located to the north of Portsea Island.	200,000	Portsmouth City	Mike Hancock CBE, Ports Sth (LD) Penny Mordaunt, Ports Nth (Con)
		1,850,000		

3 NHS AND PRIMARY CARE

	Spend 10/11	GPCC	Primary Care	Main NHS Providers
NHS Southampton City	£410m	Southampton City GPCC	GP Practices - 37 Dentists - 25 Pharmacies - 45 Opticians - 12	Southampton University Hospitals NHS Trust Solent Healthcare NHS Trust
NHS Hampshire	£1900m	- Fareham and Gosport - A3 (Havant, Waterlooville, part of East Hampshire) - Calleva (Basingstoke/area) - Rushmoor - West (Winchester, Andover, Eastleigh and New Forest)	GP Practices - 146 Dentists - 181 Pharmacies - 231 Opticians - 147	Portsmouth Hospitals NHS Trust Southampton University Hospitals NHS Trust Basingstoke and North Hampshire NHS Foundation Trust* Frimley Park NHS Foundation Trust Southern Health NHS Foundation Trust
NHS Isle of Wight	£267m	Isle of Wight GPCC	GP Practices - 21 Dentists - 33 Pharmacies - 31 Opticians - 18	St Mary's Hospital, IOW (plus PCT provision)
NHS Portsmouth	£415m	Portsmouth GPCC	GP Practices - 28 Dentists - 25 Pharmacies - 39 Opticians - 16	Portsmouth Hospitals NHS Trust Solent Healthcare NHS Trust
				* (acquiring Winchester/Eastleigh Healthcare Trust)
TOTALS	**£2992m**		**GP Practices - 232** **Dentists - 264** **Pharmacies - 346** **Opticians - 193**	

4 GP CONSORTIA BY AREA



5 HEALTH PROFILES 2010: Communities, children and young people

	Deprivation	Children in poverty	Smoking in pregnancy	Physically active children	Obese Children	Teenage pregnancy
NHS Southampton City	55719 24.6%	10752 28.4%	583 17%	9796 41.2%	200 9.3%	203 53.7 per 1000
NHS Hampshire	39420 3.1%	30303 12.4%	1796 13.1%	88511 57.5%	1058 8.6%	789 32.7 per 1000
NHS Isle of Wight	9039 6.6%	5296 22.2%	283 23.8%	8634 51.2%	106 9.9%	94 35.8 per 1000
NHS Portsmouth	38109 19.6%	8568 25.3%	425 16%	10893 53.2%	239 12.5%	164 49.3 per 1000
England average	19.9	22.4	14.6	49.6	9.6	40.9 per 1000

Indicator Notes

Deprivation: local number per year and % of people in this area living in 20% most deprived areas of England 2007
Children in poverty: local number per year and % of children living in families receiving means-tested benefits 2007 **3** Crude rate
Smoking in pregnancy: local number per year and % of mothers smoking in pregnancy where status is known 2008/09
Physically active children: local number per year and % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09
Obese children: local number per year and % of schoolchildren in reception year 2008/09
Teenage pregnancy: local number per year and Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional)
Information from: www.apho.org.uk

6 HEALTH PROFILES 2010 – Adults and life expectancy

	Adults who smoke	Hip fractures over 65s	Male life expectancy	Female life expectancy	Deaths from smoking	Early deaths: heart/stroke	Early deaths: cancer
NHS Southampton City	26%	207 482.5 per 100k	77.6	82.1	354 246.1 per 100k	175 89.3 per 100k	240 124.5 per 100k
NHS Hampshire	18.1%	1437 467.1 per 100k	80	83.3	1721 160.9 per 100k	837 56.7 per 100k	1478 101.7 per 100k
NHS Isle of Wight	21.2%	203 432.6 per 100k	78.8	82.9	256 172.6 per 100k	118 62.2 per 100k	221 117.8 per 100k
NHS Portsmouth	27.2%	176 467.1 per 100k	76.8	82	327 257.2 per 100k	154 88.1 per 100k	229 131.5 per 100k
England average	22.2%	479.2	77.9	82	206.8 per 100k	74.8 per 100k	114 per 100k

Adults who smoke: % adults, modelled estimate using Health Survey for England 2006-2008
Hip fractures over 65s: Local number per year and directly age-standardised rate per 100,000 population for emergency admission 2008/09
Male life expectancy: At birth, 2006-2008
Female life expectancy: At birth, 2006-2008
Deaths from smoking: Local number per year and per 100,000 population age 35+, directly age standardised rate 2006-2008
Early deaths – heart disease. Stroke: Local number per year and directly age standardised rate per 100,000 population under 75, 2006-2008
Early deaths – cancer: Local number per year and directly age standardised rate per 100,000 population under 75, 2006-2008
Information from: www.apho.org.uk

7 PATIENT SATISFACTION – TOP FIVE AREAS % (ICM Sept 2010)

		1	2	3	4	5
NHS Southampton City		Friendliness of staff (79%)	Quality of care and treatment (74%)	Dignity and respect received (70%)	Ability to get a GP appointment when needed (60%)	Access to information about services available (52%)
NHS Hampshire		Friendliness of staff (85%)	Quality of care and treatment (82%)	Dignity and respect received (77%)	Ability to get a GP appointment when needed (72%)	Cleanliness in hospitals (53%)
NHS Isle of Wight		Ability to get a GP appointment when needed (81%)	Friendliness of staff (73%)	Dignity and respect received (71%)	Quality of care and treatment (68%)	Access to information about services available (52%)
NHS Portsmouth		Quality of care and treatment (82%)	Friendliness of staff (81%)	Access to information about services available (80%)	Ability to get a GP appointment when needed (60%)	Appointment waiting times (51%)

ICM Question to which the above relates:
I am going to read out a number of aspects about the NHS in your local area. Using this card, I would like you to tell me how satisfied or dissatisfied you are with each of these locally? Base: All respondents (around 1100 people per PCT)

8 PATIENT DISSATISFACTION – TOP FIVE AREAS % (ICM Sept 2010)

		1	2	3	4	5
NHS Southampton City		Access/registration with NHS dentists (32%)	A&E waiting (28%) / Appt waiting (28%)	Ability to get GP appt (23%)	Clean hospitals (19%) / Waiting lists –ops (19%)	Access to info about services available (12%)
NHS Hampshire		Access/registration with NHS dentists (36%)	Appt waiting (26%)	A&E waiting (24%)	Ability to get GP appt (21%)	Clean hospitals (18%)
NHS Isle of Wight		Access/registration with NHS dentists (30%)	Appt waiting (19%)	Waiting lists –ops (17%)	A&E waiting (16%)	Clean hospitals (13%) / Info about services (13%)
NHS Portsmouth		Access/registration with NHS dentists (31%)	Appt waiting (28%)	Ability to get GP appt (24%)	A&E waiting (20%)	Waiting lists –ops (17%)

ICM Question to which the above relates:
I am going to read out a number of aspects about the NHS in your local area. Using this card, I would like you to tell me how satisfied or dissatisfied you are with each of these locally? Base: All respondents (around 1100 people per PCT)

9 REPORTED TOP PRIORITY AREAS FOR LOCAL NHS PROVISION % (ICM Sept 2010)

		1	2	3	4	
NHS Southampton City		Getting GP appointment when needed (14%)	Shorter waiting – appts (8%) / Longer hours GP surgeries (8%)	Improved access to NHS dentists (7%)	More money (5%) / More nurses (5%)	
NHS Hampshire		Shorter waiting – appts (10%)	Access to dentist (9%) / Longer hours GP surgeries (9%)	Getting GP appointment when needed (8%)	More money (5%)	
NHS Isle of Wight		Shorter waiting – appts (13%)	Improved access to NHS dentists (7%)	Most effective treatment and drugs (7%)	Longer hours GP surgeries (6%) / Dignity and respect (6%)	
NHS Portsmouth		GP appt (16%) / Access to dentist (16%)	Shorter waiting – appts (12%)	Shorter waiting lists – ops (5%)	Longer hours GP surgeries (4%) / More nurses (5%)	

ICM Question to which the above relates:
What three things would you say would most improve the NHS in your local area?
Base: All respondents (around 1100 people per PCT)

10 Engagement and consultation activity – SHIP-wide and PCT-specific

Issue	Brief summary of engagement/ consultation activity	Which PCT / Trust is leading this	What is the time frame (start / end dates)	What are the linkages, if any, to other consultations and are these being addressed in consultation material?
SHIP wide				
Major Trauma	Engagement (or communications?) regarding proposals for units in the major trauma network across the Wessex region.	NHS Southampton City and NHS Hampshire for SHIP	Proposing June 2011 – September/October 2011	Links to Stroke and Vascular Surgery. Propose to keep separate to avoid confusion and affects of issues in other areas e.g. vascular/PHT
Stroke	Engagement (or communications?) regarding proposals for stroke services across South Central	NHS Southampton City and NHS Hampshire for SHIP	Proposing June 2011 – September/October 2011	Links to Major Trauma and Vascular Surgery. Propose to keep separate to avoid confusion and affects of issues in other areas e.g. vascular/PHT
Vascular Surgery	Engagement (or communications?) regarding proposals for vascular surgery services across South Central	Currently SHA	Presentation to Portsmouth HOSP on June 9, 2011. Wider engagement timescale to be determined	Links to Major Trauma and Stroke. Propose to keep separate to avoid confusion and issues in this area affecting the others.
Hampshire Autism Strategy	Early engagement to inform a joint draft Autism strategy for Hampshire residents with Hampshire County Council	Hampshire County Council	May 2011 - 2012	No links
SHIP Equality delivery system	Engaging local interests to inform them about EDS and get feedback.	NHS Hampshire for SHIP and constituent providers	March 2011 to June 2011. Engagement on equality data from Sept to Dec 2011.	Links to all projects.

Issue	Brief summary of engagement/ consultation activity	Which PCT / Trust is leading this	What is the time frame (start / end dates)	What are the linkages, if any, to other consultations and are these being addressed in consultation material?
Adult mental health in Hampshire	Engagement underway with service users, carers and advocate groups on the future model of care for adult mental health in Hampshire.	Southern Health NHS Foundation Trust	April 2011 – July 2011. Report to Hampshire HOSC in July 2011 for decision on formal consultation.	Older people's mental health.
Review of Children's Congenital Heart Services in England	National consultation supported by local activity centred on keeping services at SGH.	National consultation	• Responses required by 1st July 2011 • PCT has reached conclusion and is supportive of Option B. • Substantial local concern about Southampton only appearing in one option and question marks over travel time data used.	
IoW				
Provider Options Appraisal	Work to establish the clinical and financial feasibility of an Island based provider Foundation NHS Trust has been underway since November 2010.	Local - NHS IoW	• November 2010 onwards • Agreement being sought on 31/5/11 to start formal discussions with SHIP PCT Cluster and SHA.	Links made to many national, regional and local changes to NHS and public sector services. Tied in closely to QIPP and reform agenda.
Car Parking	Gauge views on what patients, public and staff on Island would like to do about travel arrangements to and specifically parking at, St. Mary's Hospital, Newport	Local - NHS IoW	• Six week formal consultation ended on 13th May 2011. • Responses currently being collated and reviewed.	None

Issue	Brief summary of engagement/ consultation activity	Which PCT / Trust is leading this	What is the time frame (start / end dates)	What are the linkages, if any, to other consultations and are these being addressed in consultation material?
Quality Account	Consultation on the content of the 2011 Quality Account - mainly focussed on stakeholder groups	Local NHS IoW	May and June 2011	None
Pharmacy Locality Areas	Consultation on the areas allocated to pharmacies - mainly focussed on the pharmaceutical trade	Local - NHS IoW	Due to start in June	None
Portsmouth and south east Hampshire				
Building a bright future for Chase Community Hospital, Bordon.	Inpatient beds at the hospital are underused whilst services such as the Rapid Assessment Service need more suitable accommodation. We are currently engaging with local residents about their views on current and future healthcare in the area. These views will be used to develop future options.	NHS Hampshire	May 16 to June 24, 2011	Other community hospitals in Hants. No links required in documents.
Highview Surgery, Bordon.	Highview Practice was run by a single handed GP who has been suspended by the General Medical Council. The doctor's contract has been terminated and temporary alternative arrangements are in place for	NHS Hampshire	May 16 to June 24, 2011	N/A

Issue	Brief summary of engagement/ consultation activity	Which PCT / Trust is leading this	What is the time frame (start / end dates)	What are the linkages, if any, to other consultations and are these being addressed in consultation material?
	patients. We are engaging with Highview Surgery patients about the future options for access to high quality Primary Care medical services locally.			
A new decade for local health in Portsmouth and south east Hampshire (SE sustainability plan which aims to improve the quality of services for local people while increasing productivity and reducing costs across the NHS in Portsmouth and south east Hampshire.)	Engagement on the plan through discussion with local stakeholders is on-going and updates are available online with a feedback form.	NHS Hampshire and NHS Portsmouth	August 2010 - ongoing	Current and future projects under the Sustainability Programme have individual communications and engagement plans.
Nurturing maternity services development in Portsmouth and South East Hampshire	Developing a potential new maternity service model. A communications and engagement strategy is being developed, including plans for a stakeholder group.	Portsmouth Hospitals NHS Trust	TBC	Part of the Portsmouth and South East Hampshire Sustainability Programme

Issue	Brief summary of engagement/ consultation activity	Which PCT / Trust is leading this	What is the time frame (start / end dates)	What are the linkages, if any, to other consultations and are these being addressed in consultation material?
Fitness for surgery in South East Hampshire	Local clinicians have developed a policy to support patients needing elective surgery to become smoke free. This is based on clinical evidence about increased patient outcomes. Engagement requirements and if this is considered to be a substantial change in service to be tested with Health Overview and Scrutiny Committees.	NHS Portsmouth	TBC (if required)	Part of the Portsmouth and South East Hampshire Sustainability Programme
Closure of Northern Parade Clinic, Portsmouth	NPC will close and land sold to PCC to enable a housing development on site. Some services for children and families run at clinic will move to a refurbished Battenburg Avenue Clinic a mile or so away.	Solent NHS Trust	Near complete as move takes place in June.	Part of the Portsmouth and South East Hampshire Sustainability Programme
Health visiting out of hours in Portsmouth	Developing a proposal to change service model after a review of service requirements, withdrawing HV from OOH role and reinvesting in community HV services including extra clinics.	NHS Portsmouth/Solent NHS Trust	Engagement requirements to be determined over next few months.	Urgent/unscheduled care, sustainability programme

Issue	Brief summary of engagement/ consultation activity	Which PCT / Trust is leading this	What is the time frame (start / end dates)	What are the linkages, if any, to other consultations and are these being addressed in consultation material?
Locks Road Surgery, South East Hampshire.	Partners of the Whiteley and Locks Road Surgery want to consolidate their service at their Whiteley practice and close their Locks Road base. NHS Hampshire has asked the practice to defer any decision to close Locks Road until a more detailed engagement has taken place.	NHS Hampshire working with Hampshire LINk	To commence in Autumn 2011	N/A
Ward G5	A number of recommendations/actions coming out of the IRP review will require local engagement , particularly End of Life Strategy	GPCCs to lead on End of Life Strategy review with PCT support	To be completed in time for 2012/13 commissioning plans	
St Mary's Health Campus, Portsmouth	Development of community health campus on site of St Mary's Hospital, Milton	NHS Portsmouth	Due to open fully early 2012	St Mary's ISTC/Health and Social Care Progamme/Sustainability
St Mary's Portsmouth ISTC contract	Largely communications rather than engagement from this point in – around minor service changes as part of contract renewal to Care UK eg extended opening times, prescription issues	NHS Portsmouth	Contract renewal date is 4th July 2011	Urgent/unscheduled care

Issue	Brief summary of engagement/ consultation activity	Which PCT / Trust is leading this	What is the time frame (start / end dates)	What are the linkages, if any, to other consultations and are these being addressed in consultation material?
Health and Social Care programme: D1 ward QAH, Portsmouth decommissioning	Proposal to develop a new model of service for community based rehabilitation and re-ablement services as part of vision to build a health and social care system in city that supports people to develop and implement their own plans for health and well being. Moving to new model would see Ward D1 at QAH decommissioned	NHS Portsmouth	Full implementation by July 2012	St Mary's Health Campus/need to be aware of possible perceived link by public to G5 in terms of 'decommissioning a ward'
North and mid Hampshire				
Odiham Cottage Hospital, North Hampshire.	Engagement has taken place (Feb – March 2011) on the preferred model of care for healthcare and presented to HOSC in May 2011. Business case is now under development. Ongoing engagement with stakeholder group.	NHS Hampshire	Ongoing engagement with stakeholder group, Hospital Trustees and patients from June to September. Business case to be presented to Hampshire HOSC in September and formal consultation may be required.	Other community hospital projects in Hampshire.
Basingstoke and North Hampshire Hospitals Foundation trust acquisition of Winchester and Eastleigh Healthcare NHS Trust	On-going communication with high level stakeholders and staff/clinical engagement.	Basingstoke and North Hampshire Hospitals Foundation NHS Trust	On-gojng to December 2011. HOSC regularly briefed.	

Issue	Brief summary of engagement/ consultation activity	Which PCT / Trust is leading this	What is the time frame (start / end dates)	What are the linkages, if any, to other consultations and are these being addressed in consultation material?
Southampton and south west Hampshire				
Bitterne Walk-in Centre	Formal consultation completed. Currently communicating implementation of changes due to take place 6th June	NHS Southampton	6th June	Urgent Care
Hythe Hospital	Continued engagement regarding the reprovision of bed-based care to reablement model and the future services and environment on the Hythe Hospital site	NHS Hampshire	September 2010 – October/November 2011	Other engagement occurring separately for other community hospitals. No links required in documents.
Andover Birth Centre/model of care for midwife-led births in North and Mid Hampshire	Engagement on model of care for midwife led births and discussion about future of ABC.	Winchester and Eastleigh Healthcare NHS Trust	January – June 2011-05-27 Full report with proposals due at Hampshire HOSC on July 26, 2011.	Links to previous consultations on midwife lad care in SE and SW Hampshire. Also linked to likely engagement on model of care in SE Hampshire birth centres which will commence later in the year.
Older people's mental health, South West Hampshire.	Formal consultation on future of Linden ward and Willow ward at Tom Rudd Unit Moorgreen Hospital.	Southern Health NHS Foundation Trust.	May 9 – June 17, 2011	Adult mental health engagement.
End of Life Specialist palliative care review	2 Stakeholder workshops Patients Forum Briefings with OSC		April – Apr 2012	Planned Care

Issue	Brief summary of engagement/ consultation activity	Which PCT / Trust is leading this	What is the time frame (start / end dates)	What are the linkages, if any, to other consultations and are these being addressed in consultation material?
Procurement of Home Oxygen Service	Engagement of service users and lay representation on procurement panel	NHS Southampton	June	Planned Care
Review and recommission short breaks for children with complex health needs	Pre- engagement	NHS Southampton	July	Children's services
Development of interface between primary care and ED	Pre-engagement Clinical engagement	NHS Southampton	July >	Urgent Care
Increase usage of MIU	Communications campaign	Solent Healthcare	June	Urgent Care
Neuro Rehab	Commencement of engagement with services users on service redesign	NHS Southampton	May – September	Planned Care

Basingstoke and Deane

updated 28 July 2010

This profile gives a picture of health in this area. It is designed to help local government and health services improve people's health and reduce health inequalities.

Health Profiles are produced every year by the Association of Public Health Observatories.

Visit the Health Profiles website to:

- see profiles for other areas
- use interactive maps
- find more detailed information

www.healthprofiles.info

Population 161,700

Mid-2008 population estimate

Source: National Statistics website: www.statistics.gov.uk

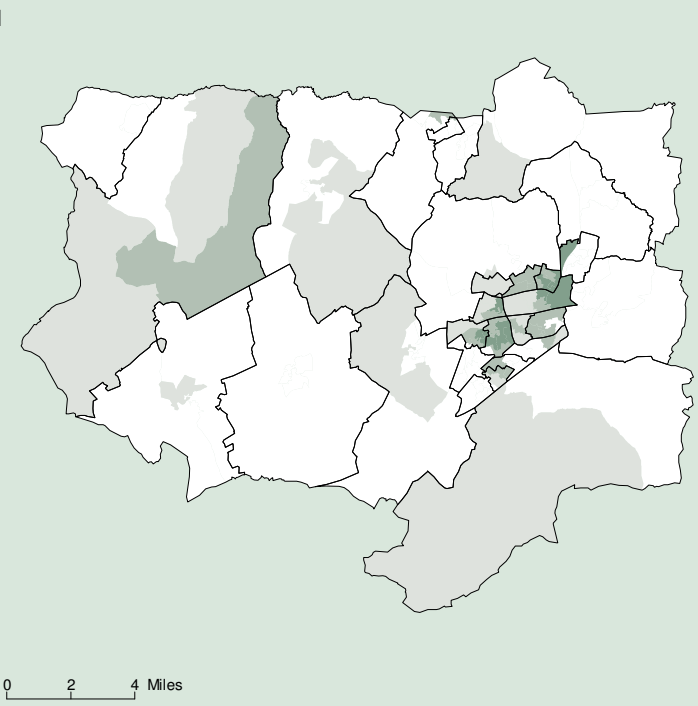
Basingstoke and Deane at a glance

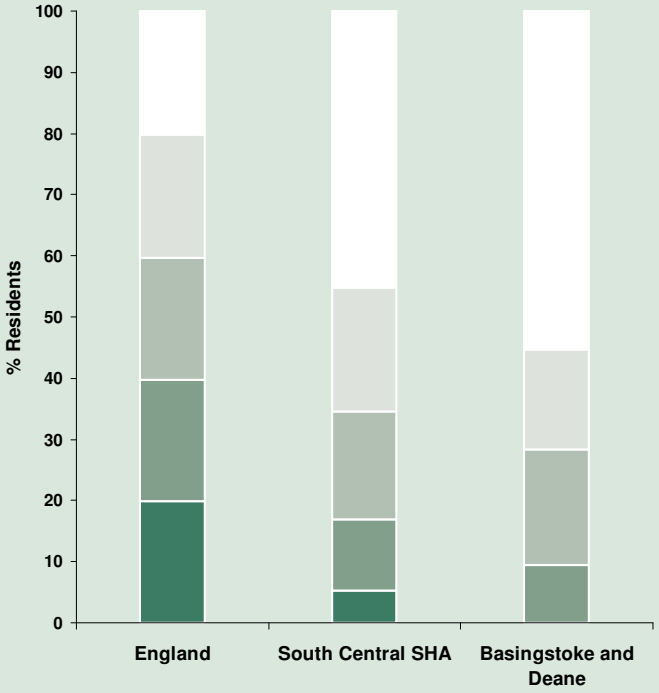
- The health of people living in Basingstoke and Deane is generally good when compared to the England average. Deprivation levels are low and life expectancy for men is better than the England average.
- The rate of violent crime is worse than the England average with over 2,700 recorded incidents in 2008/09.
- There are inequalities in health between areas within Basingstoke and Deane. Life expectancy for men living in the most deprived areas is 4 years lower than for men living in the least deprived areas.
- Over the last 10 years, the death rate from all causes combined, and early death rates from cancer and from heart disease and stroke, have fallen.
- An estimated 21% of adults smoke, similar to the England average and there are over 180 smoking related deaths each year.
- The percentage of children who spend 3 hours each week on physical activity in school is higher than the England average. 10% of children in Reception year are classified as obese, similar to the England average.
- Although the rate of hospital stays for alcohol related harm is lower than the England average, there were nearly 1,600 hospital stays in 2008/09.
- Local priorities highlighted in the Hampshire Local Area Agreement include tackling the rate of death from all causes, child obesity, teenage pregnancy and hospital admissions for alcohol related harm.
- The Hampshire Public Health Annual Report can be found at: www.hampshire.nhs.uk

Deprivation:
a national view

This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.

This chart shows the percentage of the population in England, this region, and this area who live in each of these quintiles.



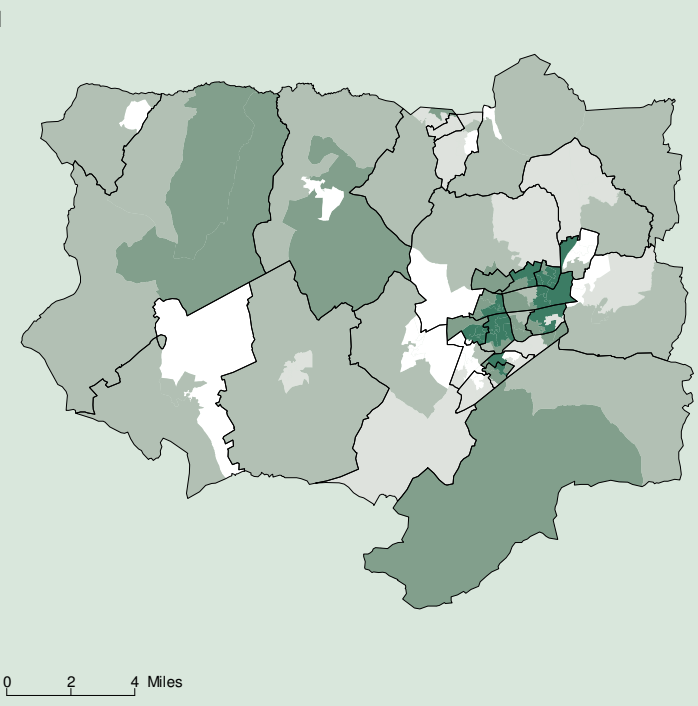


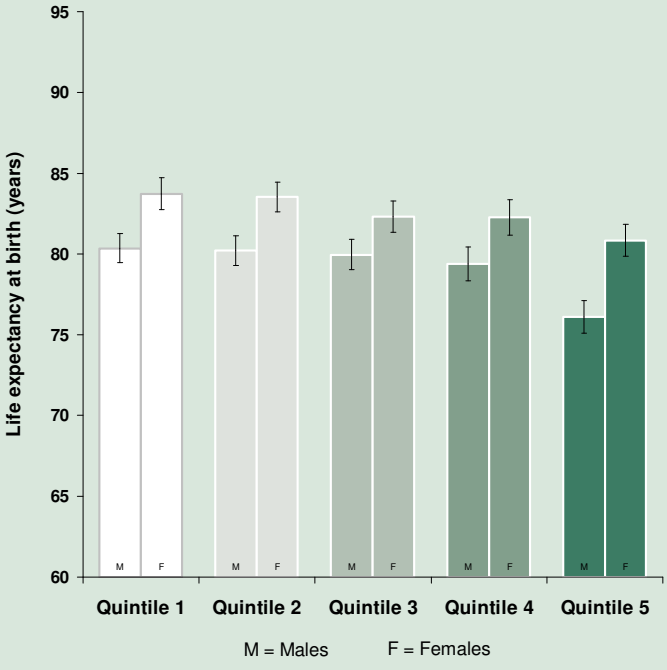
1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities:
a local view

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.

This chart shows the life expectancy at birth for males and females (2004-2008) for each of the quintiles in this area.





95% confidence interval. These indicate the level of uncertainty about each value on the graph. Longer/wider intervals mean more uncertainty.

1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities: **changes over time**

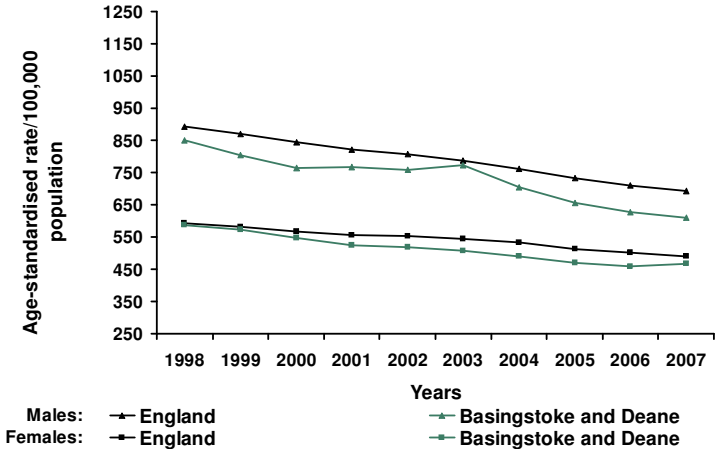
These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

Trend 1 compares rates of death, at all ages and from all causes, in this area with those for England.

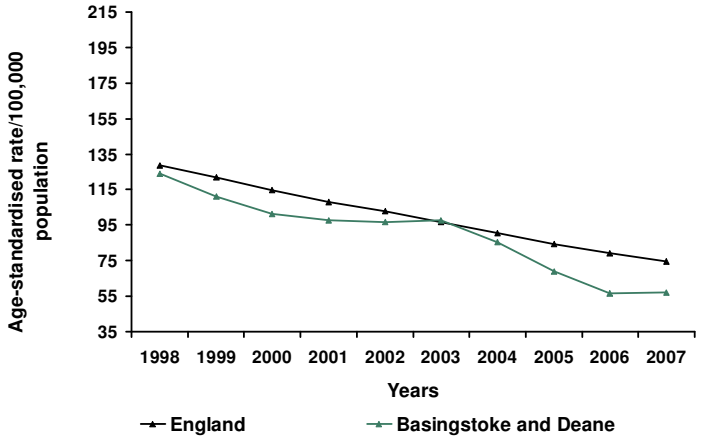
Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

Trend 3 compares rates of early death from cancer (in people under 75) in this area with those for England.

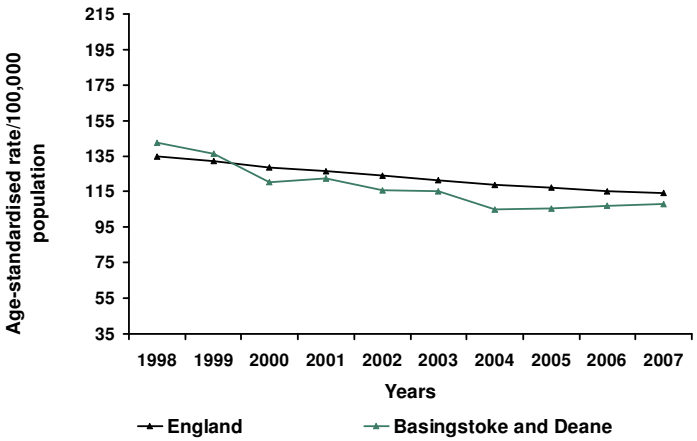
Trend 1:
All age, all cause mortality



Trend 2:
Early death rates from heart disease and stroke

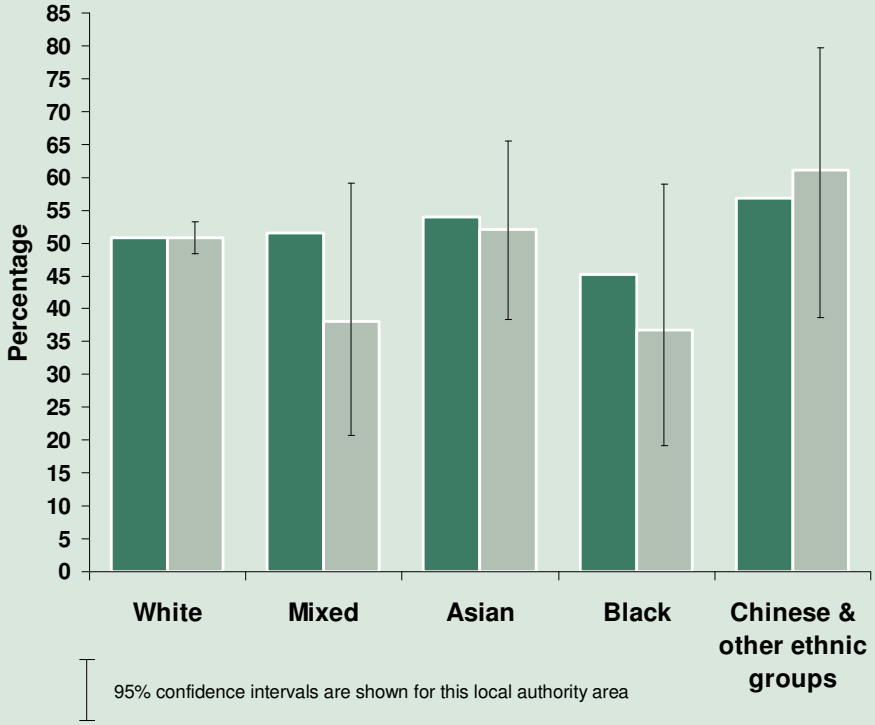


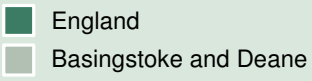
Trend 3:
Early death rates from cancer



Health inequalities: **ethnicity**

This chart shows the percentage of pupils by ethnic group in this area who achieved five GCSEs in 2008/09 (A* to C grades including English and Maths). Comparing results may help find possible inequalities between ethnic groups.





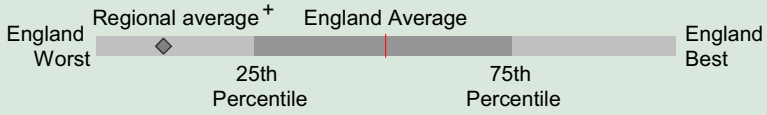
Ethnic Groups	% pupils achieved grades	No. of pupils achieved grades
White	50.8	807
Mixed	38.1	8
Asian	52.1	25
Black	36.8	7
Chinese/other	61.1	11

If there are any empty cells in the table this is because data has not been presented where the calculation involved pupil numbers of 0, 1 or 2. Some further groups may not have data presented in order to prevent counts of small numbers being calculated from values for other ethnic groups or areas.

Health summary for Basingstoke and Deane

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

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



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

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	0	0.0	19.9	89.2		0.0
	2 Children in poverty	3957	12.2	22.4	66.5		6.0
	3 Statutory homelessness	n/a	n/a	2.48	9.84		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	874	50.2	50.9	32.1		76.1
	5 Violent crime	2744	17.1	16.4	36.6		4.8
	6 Carbon emissions	1290	8.1	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	252	13.1	14.6	33.5		3.8
	8 Breast feeding initiation	1564	79.7	72.5	39.7		92.7
	9 Physically active children	11516	57.2	49.6	24.6		79.1
	10 Obese children	156	10.0	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	0.7	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	104	36.4	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	20.6	22.2	35.2		10.2
	14 Binge drinking adults	n/a	20.5	20.1	33.2		4.6
	15 Healthy eating adults	n/a	28.2	28.7	18.3		48.1
	16 Physically active adults	n/a	12.1	11.2	5.4		16.6
	17 Obese adults	n/a	25.2	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	23	14.8	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	1708	16.7	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	1594	880	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	6359	3.93	4.30	6.72		2.69
	23 New cases of tuberculosis	7	4	15	110		0
	24 Hip fracture in over-65s	127	470.0	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	64	18.2	15.6	26.3		2.3
	26 Life expectancy - male	n/a	79.7	77.9	73.6		84.3
	27 Life expectancy - female	n/a	82.5	82.0	78.8		88.9
	28 Infant deaths	6	3.09	4.84	8.67		1.08
	29 Deaths from smoking	186	178.2	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	94	57.0	74.8	125.0		40.1
	31 Early deaths: cancer	176	108.1	114.0	164.3		70.5
	32 Road injuries and deaths	70	43.7	51.3	167.0		14.6

Indicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

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

East Hampshire

updated 28 July 2010

This profile gives a picture of health in this area. It is designed to help local government and health services improve people's health and reduce health inequalities.

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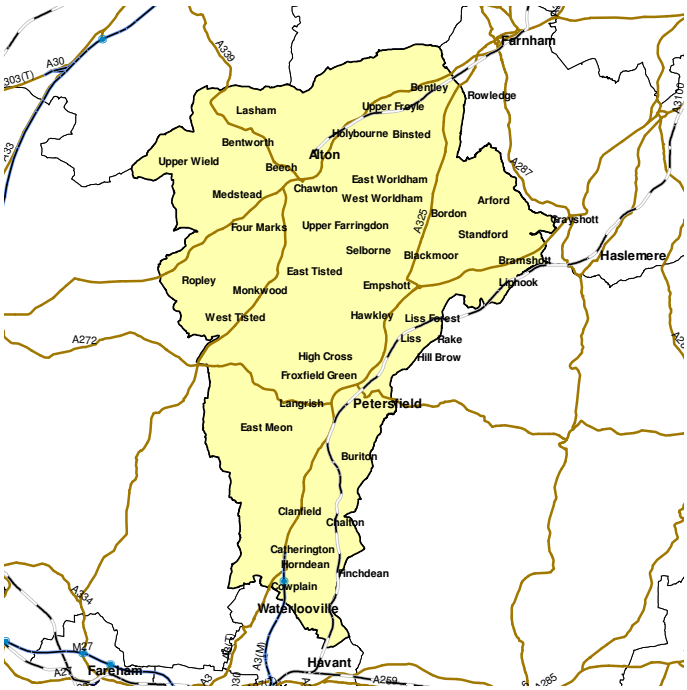
www.healthprofiles.info



Population 111,700

Mid-2008 population estimate

Source: National Statistics website: www.statistics.gov.uk

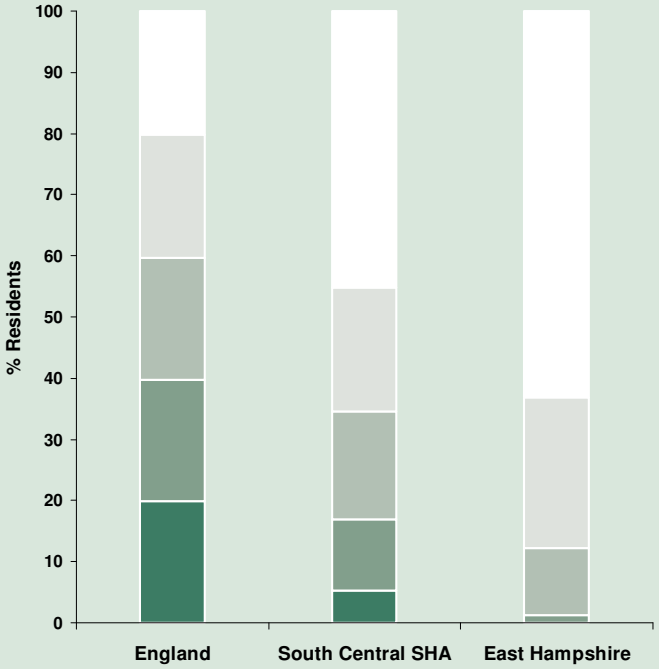
East Hampshire at a glance

- The health of people living in East Hampshire is generally good when compared to the average for England as a whole. The rate of new cases of malignant melanoma skin cancer is higher than the England average.
- There are inequalities in health within East Hampshire. Life expectancy for men from the most deprived areas is nearly 5 years lower than for men from the least deprived areas. For women the gap is nearly 4 years.
- Over the last 10 years, the death rate from all causes, and early death rates from cancer and from heart disease and stroke, have fallen.
- An estimated 15% of adults smoke, lower than the England average. The smoking related death rate is also lower than the England average but there are 140 smoking related deaths each year.
- The percentage of children who spend 3 hours each week on physical activity in school is higher than the England average. 8% of children in Reception year are classified as obese, similar to the England average.
- Although the rate of hospital stays for alcohol related harm is lower than the England average, there were over 1,400 hospital stays in 2008/09.
- Local priorities highlighted in the Hampshire Local Area Agreement include tackling the rate of death from all causes, child obesity, teenage pregnancy and hospital admissions for alcohol related harm.
- The Hampshire Public Health Annual Report can be found at: www.hampshire.nhs.uk

Deprivation:
a national view

This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.

This chart shows the percentage of the population in England, this region, and this area who live in each of these quintiles.

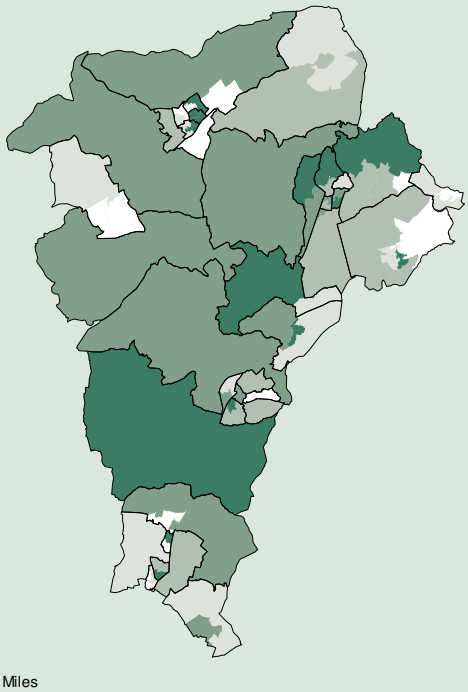


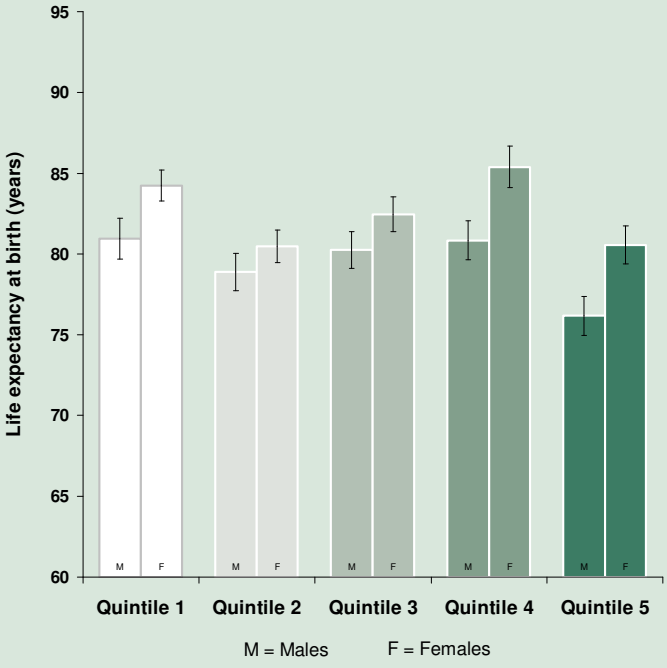
1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities:
a local view

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.

This chart shows the life expectancy at birth for males and females (2004-2008) for each of the quintiles in this area.





95% confidence interval. These indicate the level of uncertainty about each value on the graph. Longer/wider intervals mean more uncertainty.

1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities: **changes over time**

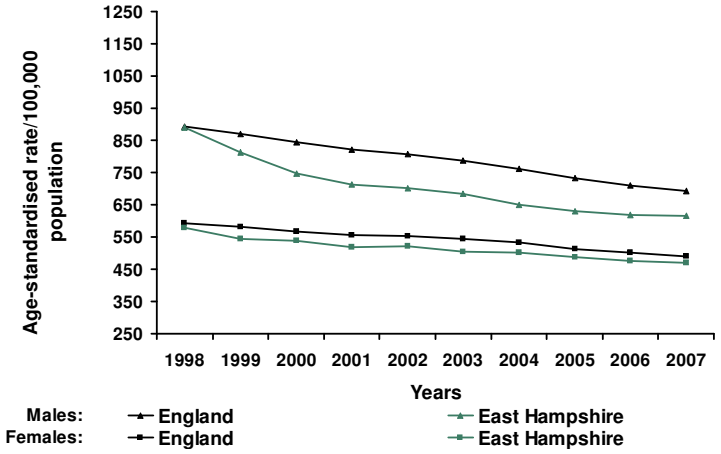
These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

Trend 1 compares rates of death, at all ages and from all causes, in this area with those for England.

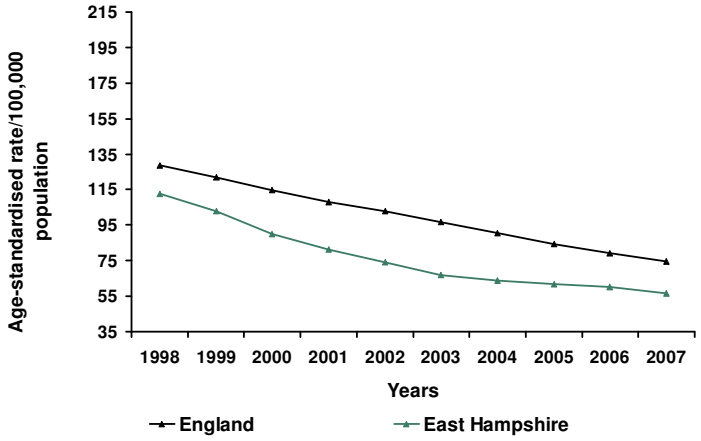
Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

Trend 3 compares rates of early death from cancer (in people under 75) in this area with those for England.

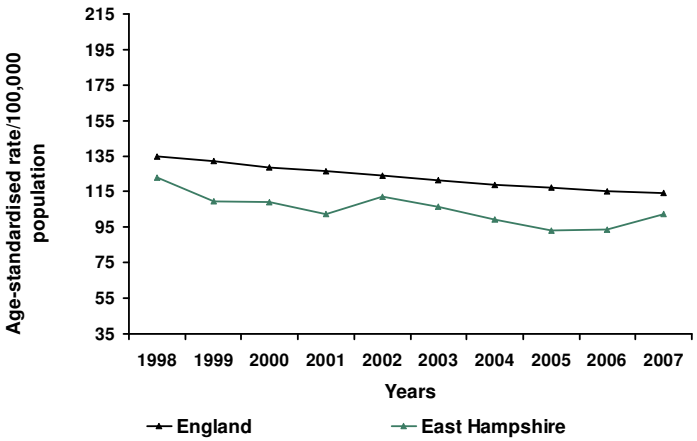
Trend 1:
All age, all cause mortality



Trend 2:
Early death rates from heart disease and stroke

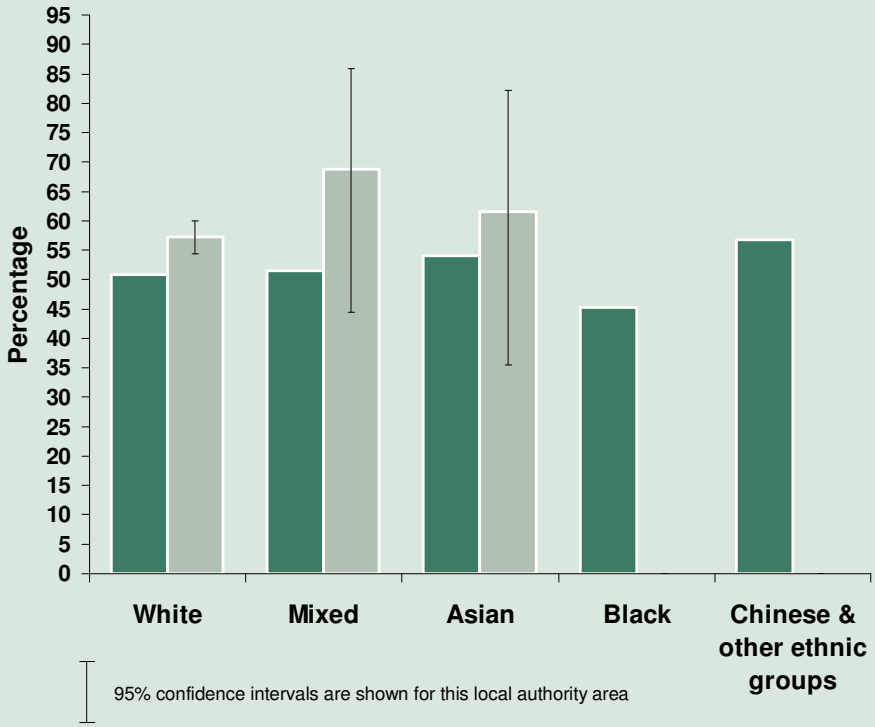


Trend 3:
Early death rates from cancer



Health inequalities: **ethnicity**

This chart shows the percentage of pupils by ethnic group in this area who achieved five GCSEs in 2008/09 (A* to C grades including English and Maths). Comparing results may help find possible inequalities between ethnic groups.



England
East Hampshire

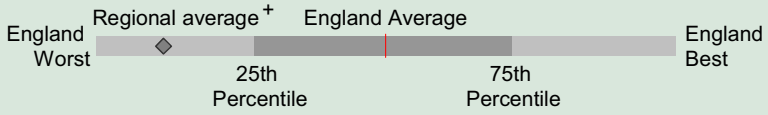
Ethnic Groups	% pupils achieved grades	No. of pupils achieved grades
White	57.2	701
Mixed	68.8	11
Asian	61.5	8
Black		
Chinese/other		

If there are any empty cells in the table this is because data has not been presented where the calculation involved pupil numbers of 0, 1 or 2. Some further groups may not have data presented in order to prevent counts of small numbers being calculated from values for other ethnic groups or areas.

Health summary for East Hampshire

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

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



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

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	0	0.0	19.9	89.2		0.0
	2 Children in poverty	2256	10.2	22.4	66.5		6.0
	3 Statutory homelessness	55	1.23	2.48	9.84		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	747	57.5	50.9	32.1		76.1
	5 Violent crime	1444	13.0	16.4	36.6		4.8
	6 Carbon emissions	879	7.9	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	144	13.1	14.6	33.5		3.8
	8 Breast feeding initiation	895	79.7	72.5	39.7		92.7
	9 Physically active children	8199	62.5	49.6	24.6		79.1
	10 Obese children	78	7.9	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	0.6	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	59	25.9	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	15.3	22.2	35.2		10.2
	14 Binge drinking adults	n/a	18.8	20.1	33.2		4.6
	15 Healthy eating adults	n/a	31.5	28.7	18.3		48.1
	16 Physically active adults	n/a	13.2	11.2	5.4		16.6
	17 Obese adults	n/a	21.6	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	24	20.2	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	895	13.6	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	1460	1040	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	4091	3.66	4.30	6.72		2.69
	23 New cases of tuberculosis	3	2	15	110		0
	24 Hip fracture in over-65s	116	436.5	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	32	9.2	15.6	26.3		2.3
	26 Life expectancy - male	n/a	79.4	77.9	73.6		84.3
	27 Life expectancy - female	n/a	82.4	82.0	78.8		88.9
	28 Infant deaths	3	2.54	4.84	8.67		1.08
	29 Deaths from smoking	140	146.2	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	75	56.8	74.8	125.0		40.1
	31 Early deaths: cancer	132	102.6	114.0	164.3		70.5
	32 Road injuries and deaths	63	57.1	51.3	167.0		14.6

Indicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

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Eastleigh

updated 28 July 2010

This profile gives a picture of health in this area. It is designed to help local government and health services improve people's health and reduce health inequalities.

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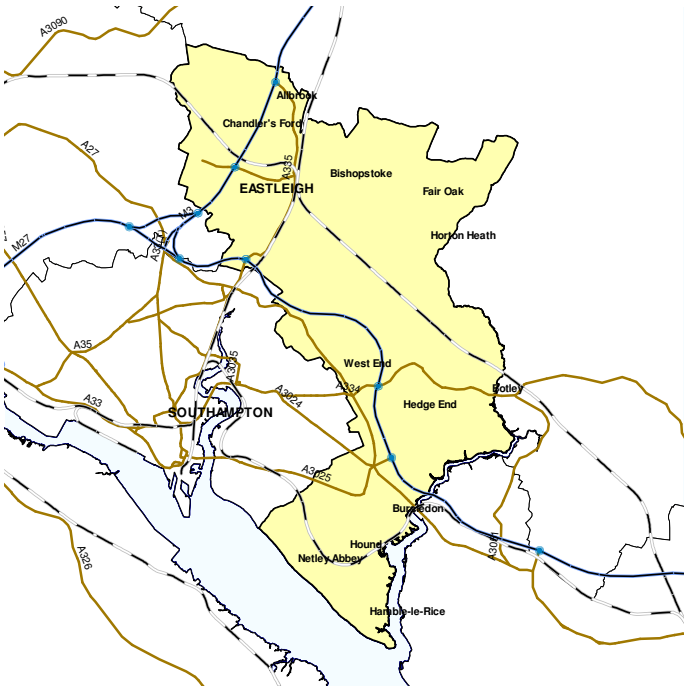


Population 121,000

Mid-2008 population estimate

Source: National Statistics website: www.statistics.gov.uk

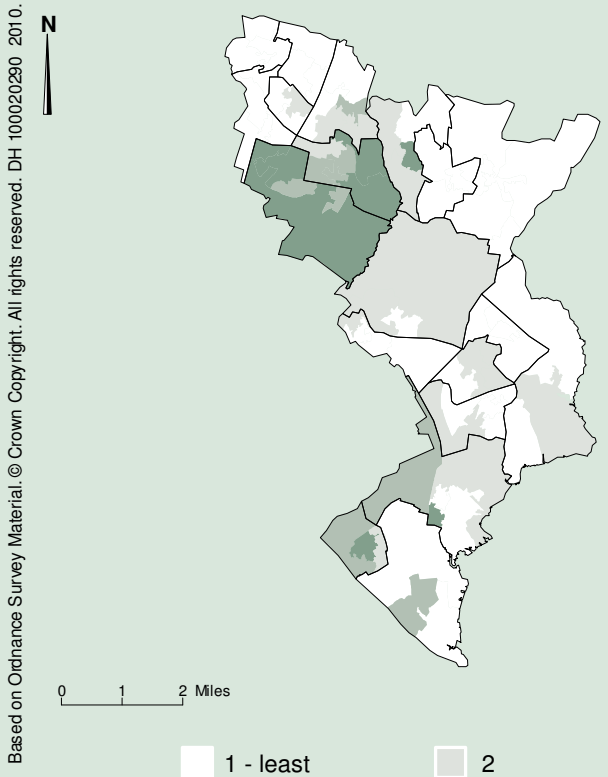
Eastleigh at a glance

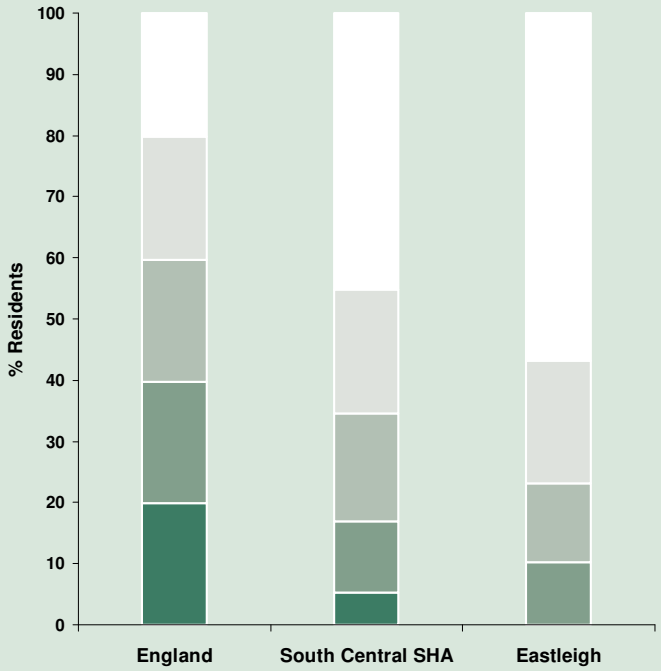
- The health of people living in Eastleigh is generally good when compared to the England average. The rate of new cases of malignant melanoma skin cancer is higher than the England average.
- There are inequalities in health between areas within Eastleigh. Life expectancy for men living in the most deprived areas is 4 years lower than for men living in the least deprived areas.
- Over the last 10 years, the death rate from all causes, early death rates from heart disease and stroke, and from cancer, have all fallen.
- An estimated 19% of adults smoke, lower than the England average. The smoking related death rate is also lower than the England average but there are over 150 smoking related deaths each year.
- GCSE achievement in Eastleigh was better than the England average in 2008/09 with 62% gaining 5 or more higher grade GCSEs (including English and Maths).
- Although the rate of hospital stays for alcohol related harm is lower than the England average, there were over 1,400 hospital stays in 2008/09.
- Local priorities highlighted in the Hampshire Local Area Agreement include tackling the rate of death from all causes, child obesity, teenage pregnancy and hospital admissions for alcohol related harm.
- The Hampshire Public Health Annual Report can be found at: www.hampshire.nhs.uk

Deprivation:
a national view

This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.

This chart shows the percentage of the population in England, this region, and this area who live in each of these quintiles.



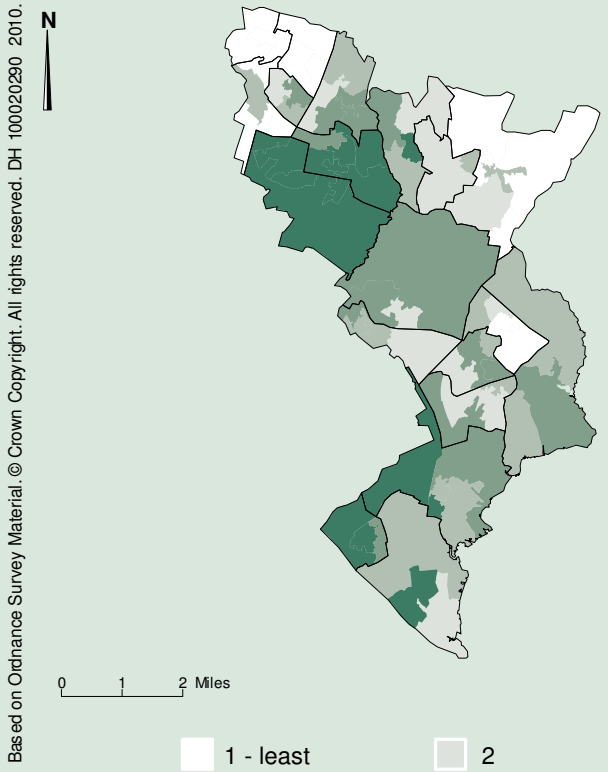


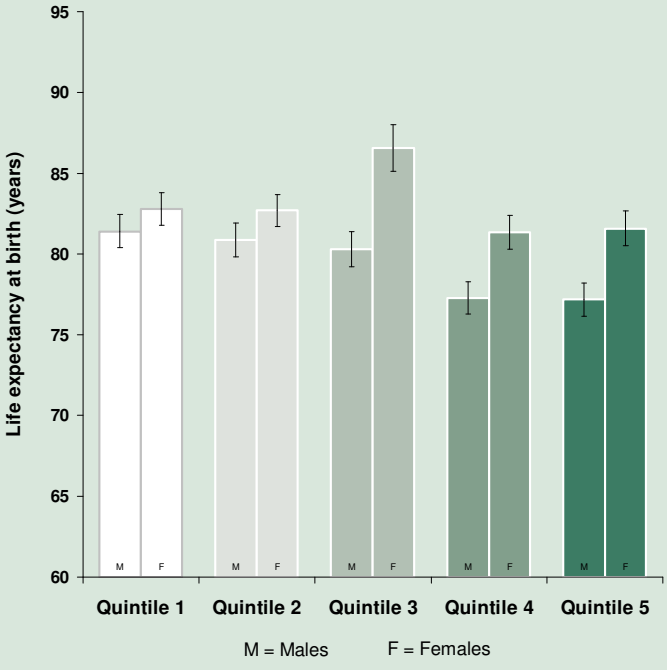
1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities:
a local view

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.

This chart shows the life expectancy at birth for males and females (2004-2008) for each of the quintiles in this area.





95% confidence interval. These indicate the level of uncertainty about each value on the graph. Longer/wider intervals mean more uncertainty.

1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities: **changes over time**

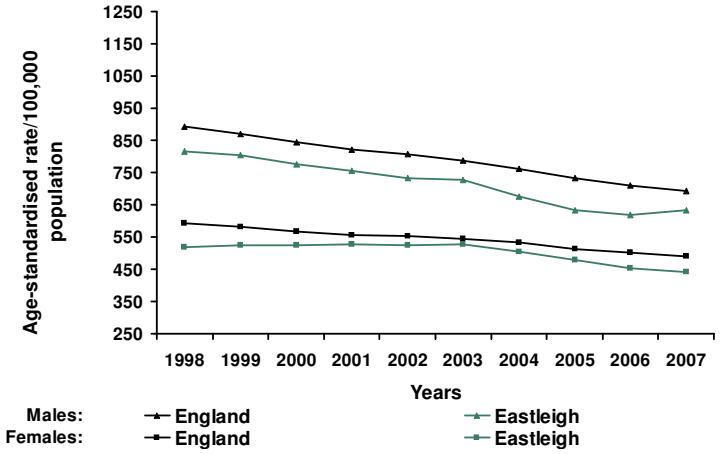
These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

Trend 1 compares rates of death, at all ages and from all causes, in this area with those for England.

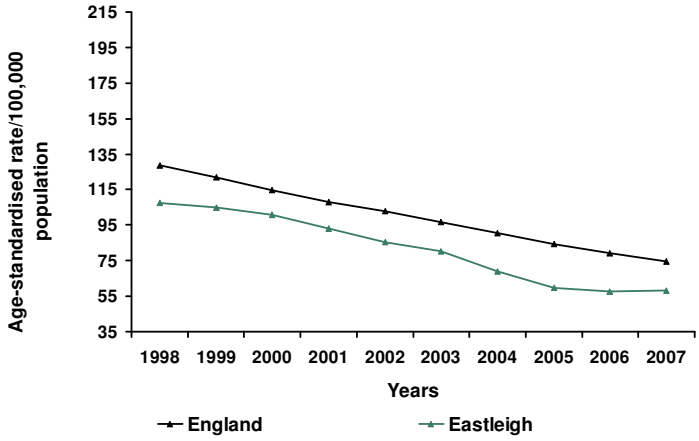
Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

Trend 3 compares rates of early death from cancer (in people under 75) in this area with those for England.

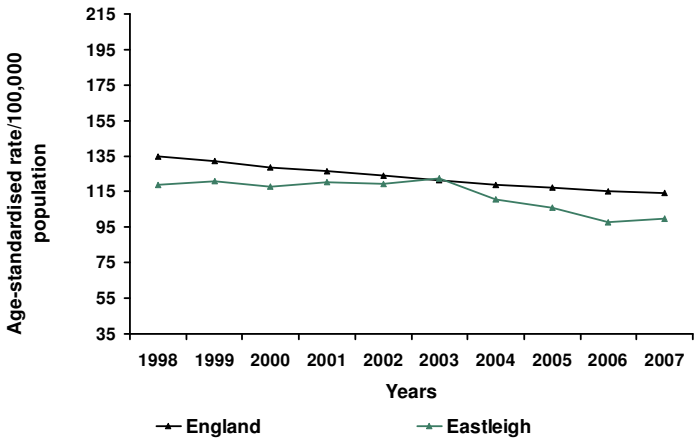
Trend 1:
All age, all cause mortality



Trend 2:
Early death rates from heart disease and stroke

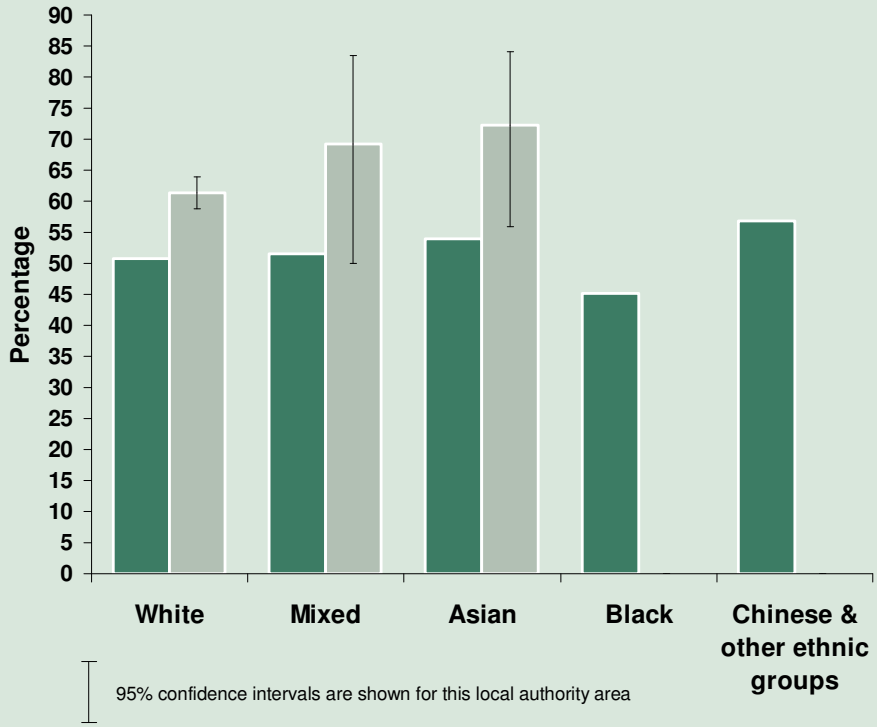


Trend 3:
Early death rates from cancer



Health inequalities: **ethnicity**

This chart shows the percentage of pupils by ethnic group in this area who achieved five GCSEs in 2008/09 (A* to C grades including English and Maths). Comparing results may help find possible inequalities between ethnic groups.



England
Eastleigh

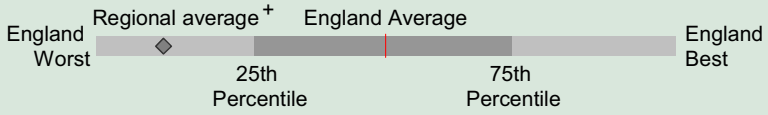
Ethnic Groups	% pupils achieved grades	No. of pupils achieved grades
White	61.4	882
Mixed	69.2	18
Asian	72.2	26
Black		
Chinese/other		

If there are any empty cells in the table this is because data has not been presented where the calculation involved pupil numbers of 0, 1 or 2. Some further groups may not have data presented in order to prevent counts of small numbers being calculated from values for other ethnic groups or areas.

Health summary for Eastleigh

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

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



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

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	0	0.0	19.9	89.2		0.0
	2 Children in poverty	2517	10.9	22.4	66.5		6.0
	3 Statutory homelessness	33	0.67	2.48	9.84		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	963	62.0	50.9	32.1		76.1
	5 Violent crime	1952	16.2	16.4	36.6		4.8
	6 Carbon emissions	647	5.4	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	175	13.1	14.6	33.5		3.8
	8 Breast feeding initiation	1088	79.7	72.5	39.7		92.7
	9 Physically active children	8433	54.6	49.6	24.6		79.1
	10 Obese children	101	9.2	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	0.5	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	74	31.3	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	19.1	22.2	35.2		10.2
	14 Binge drinking adults	n/a	19.0	20.1	33.2		4.6
	15 Healthy eating adults	n/a	27.9	28.7	18.3		48.1
	16 Physically active adults	n/a	11.6	11.2	5.4		16.6
	17 Obese adults	n/a	25.1	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	28	22.7	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	1185	15.7	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	1448	1000	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	4443	3.67	4.30	6.72		2.69
	23 New cases of tuberculosis	4	3	15	110		0
	24 Hip fracture in over-65s	126	486.4	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	62	19.8	15.6	26.3		2.3
	26 Life expectancy - male	n/a	79.4	77.9	73.6		84.3
	27 Life expectancy - female	n/a	83.2	82.0	78.8		88.9
	28 Infant deaths	4	2.87	4.84	8.67		1.08
	29 Deaths from smoking	158	172.1	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	75	58.1	74.8	125.0		40.1
	31 Early deaths: cancer	130	99.9	114.0	164.3		70.5
	32 Road injuries and deaths	52	43.3	51.3	167.0		14.6

Indicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

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

Fareham

updated 28 July 2010

This profile gives a picture of health in this area. It is designed to help local government and health services improve people's health and reduce health inequalities.

Health Profiles are produced every year by the Association of Public Health Observatories.

Visit the Health Profiles website to:

- see profiles for other areas
- use interactive maps
- find more detailed information

www.healthprofiles.info

Population 110,300

Mid-2008 population estimate

Source: National Statistics website: www.statistics.gov.uk

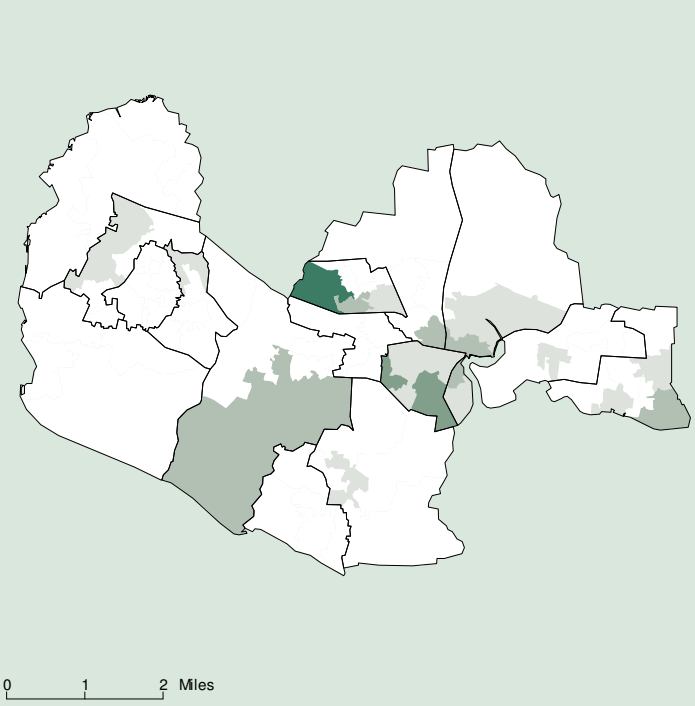
Fareham at a glance

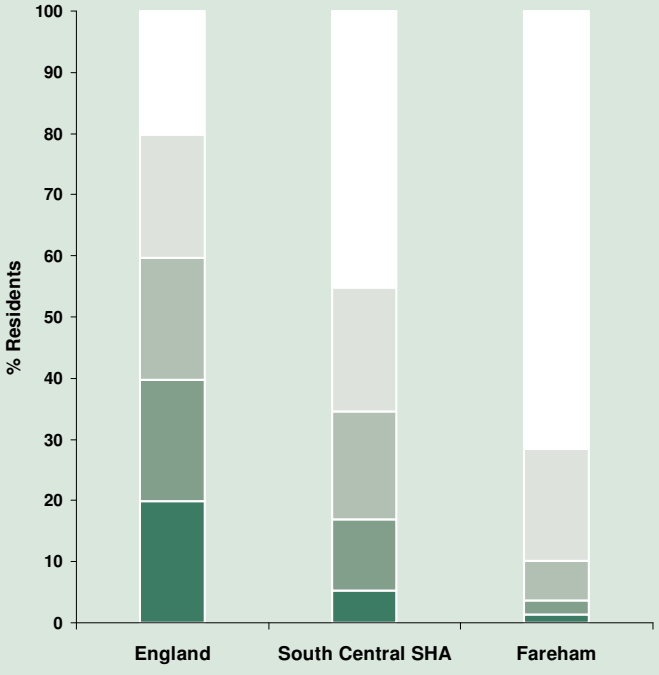
- The health of people living in Fareham is generally good when compared to the England average. Deprivation levels are low and life expectancy is higher than the England average for men and women.
- There are inequalities in health between areas within Fareham. Life expectancy for men living in the most deprived areas is nearly 4 years lower than for men living in the least deprived areas.
- Over the last 10 years, the rate of death from all causes, and early death rates from cancer and from heart disease and stroke, have all fallen and remain lower than the England average.
- An estimated 16% of adults smoke, lower than the England average. The smoking related death rate is lower than the England average but there are over 140 smoking related deaths each year.
- The percentage of children who spend 3 hours each week on physical activity in school is higher than the England average. 8% of children in Reception year are classified as obese, similar to the England average.
- Although the rate of hospital stays for alcohol related harm is lower than the England average, there were over 1,700 hospital stays in 2008/09.
- Local priorities highlighted in the Hampshire Local Area Agreement include tackling the rate of death from all causes, child obesity, teenage pregnancy and hospital admissions for alcohol related harm.
- The Hampshire Public Health Annual Report can be found at: www.hampshire.nhs.uk

Deprivation:
a national view

This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.

This chart shows the percentage of the population in England, this region, and this area who live in each of these quintiles.



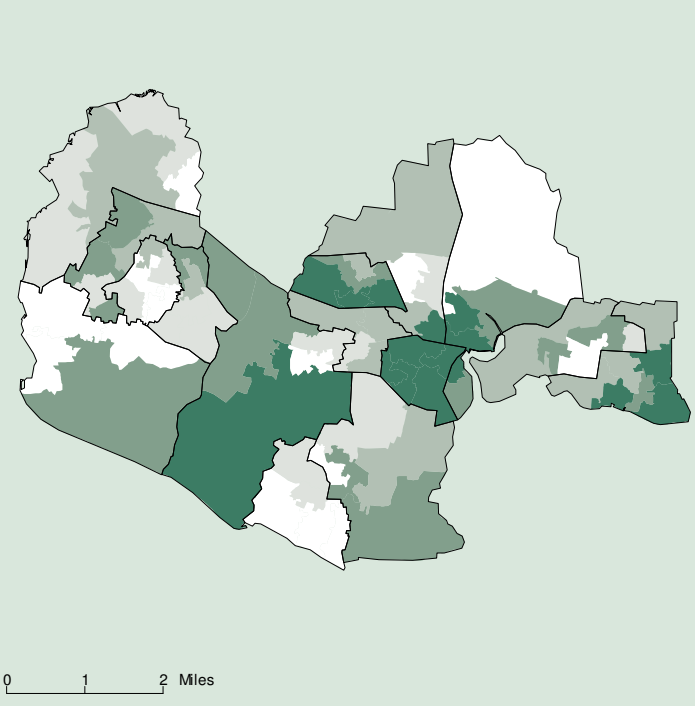


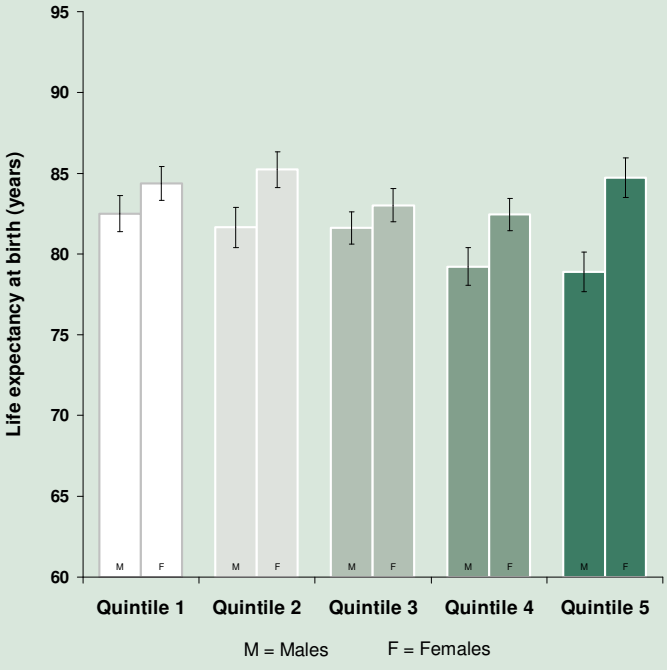
1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities:
a local view

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.

This chart shows the life expectancy at birth for males and females (2004-2008) for each of the quintiles in this area.





95% confidence interval. These indicate the level of uncertainty about each value on the graph. Longer/wider intervals mean more uncertainty.

1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities: **changes over time**

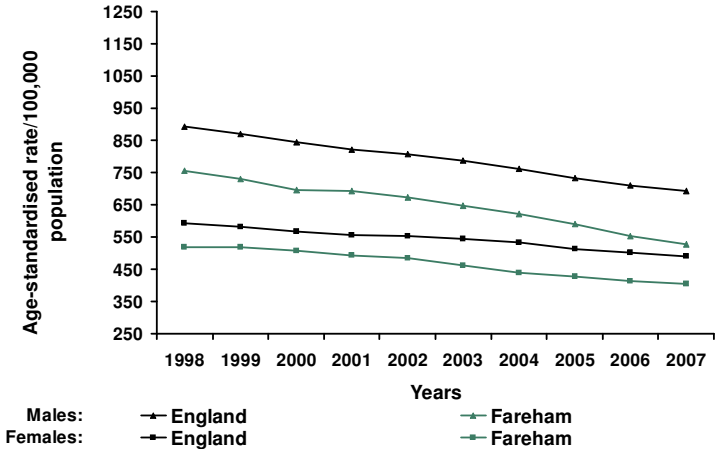
These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

Trend 1 compares rates of death, at all ages and from all causes, in this area with those for England.

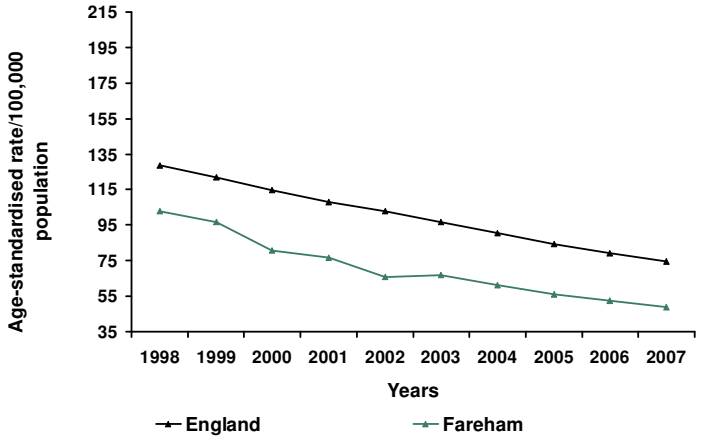
Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

Trend 3 compares rates of early death from cancer (in people under 75) in this area with those for England.

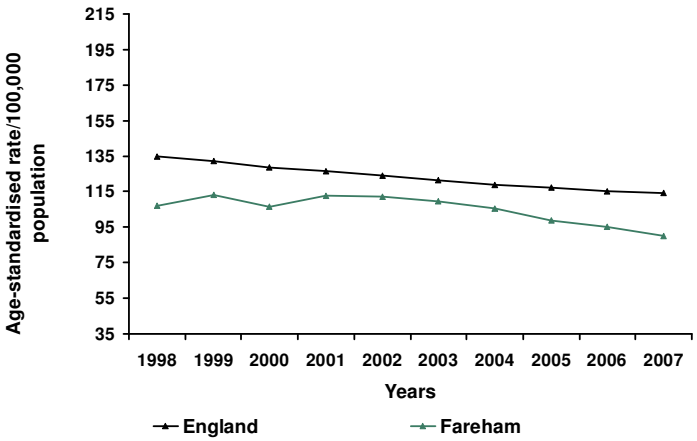
Trend 1:
All age, all cause mortality



Trend 2:
Early death rates from heart disease and stroke

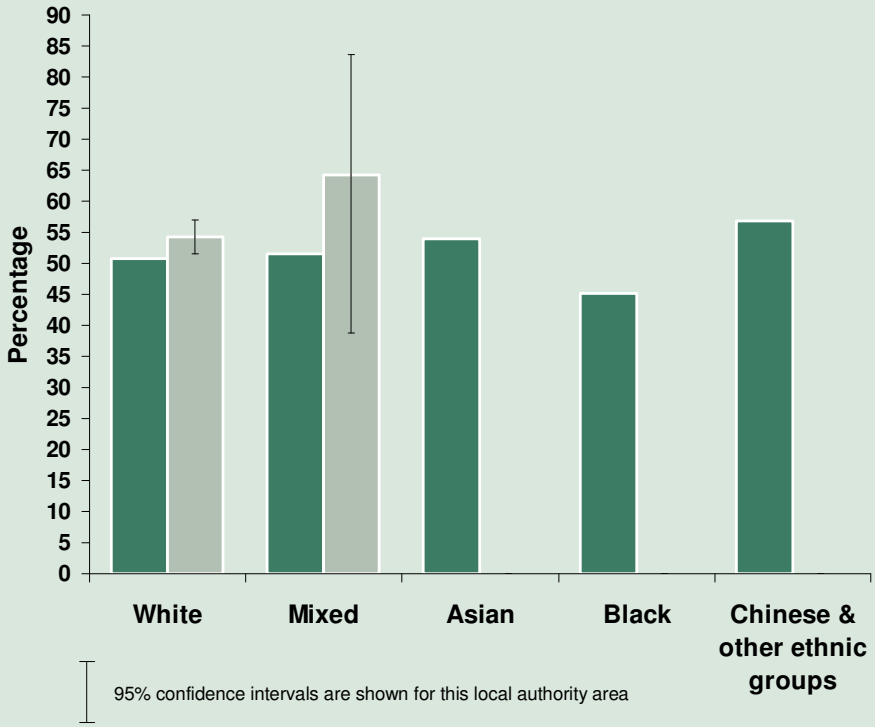


Trend 3:
Early death rates from cancer



Health inequalities: **ethnicity**

This chart shows the percentage of pupils by ethnic group in this area who achieved five GCSEs in 2008/09 (A* to C grades including English and Maths). Comparing results may help find possible inequalities between ethnic groups.



England
Fareham

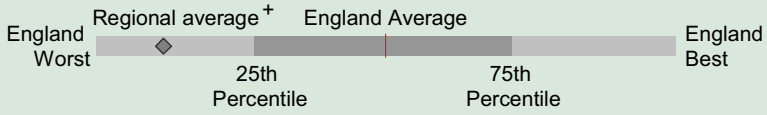
Ethnic Groups	% pupils achieved grades	No. of pupils achieved grades
White	54.2	691
Mixed	64.3	9
Asian		
Black		
Chinese/other		

If there are any empty cells in the table this is because data has not been presented where the calculation involved pupil numbers of 0, 1 or 2. Some further groups may not have data presented in order to prevent counts of small numbers being calculated from values for other ethnic groups or areas.

Health summary for Fareham

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

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



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

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	1473	1.4	19.9	89.2		0.0
	2 Children in poverty	1775	8.8	22.4	66.5		6.0
	3 Statutory homelessness	32	0.72	2.48	9.84		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	707	54.0	50.9	32.1		76.1
	5 Violent crime	1386	12.7	16.4	36.6		4.8
	6 Carbon emissions	597	5.4	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	138	13.1	14.6	33.5		3.8
	8 Breast feeding initiation	858	79.7	72.5	39.7		92.7
	9 Physically active children	7811	55.4	49.6	24.6		79.1
	10 Obese children	93	8.1	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	0.7	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	62	29.9	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	16.4	22.2	35.2		10.2
	14 Binge drinking adults	n/a	16.8	20.1	33.2		4.6
	15 Healthy eating adults	n/a	27.6	28.7	18.3		48.1
	16 Physically active adults	n/a	11.8	11.2	5.4		16.6
	17 Obese adults	n/a	23.4	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	17	14.6	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	930	14.3	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	1704	1200	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	4351	3.94	4.30	6.72		2.69
	23 New cases of tuberculosis	3	3	15	110		0
	24 Hip fracture in over-65s	113	370.6	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	36	11.6	15.6	26.3		2.3
	26 Life expectancy - male	n/a	81.4	77.9	73.6		84.3
	27 Life expectancy - female	n/a	84.1	82.0	78.8		88.9
	28 Infant deaths	3	2.56	4.84	8.67		1.08
	29 Deaths from smoking	146	143.2	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	68	49.1	74.8	125.0		40.1
	31 Early deaths: cancer	121	90.3	114.0	164.3		70.5
	32 Road injuries and deaths	38	34.4	51.3	167.0		14.6

Indicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

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Gosport

updated 28 July 2010

This profile gives a picture of health in this area. It is designed to help local government and health services improve people's health and reduce health inequalities.

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Population 80,000

Mid-2008 population estimate

Source: National Statistics website: www.statistics.gov.uk

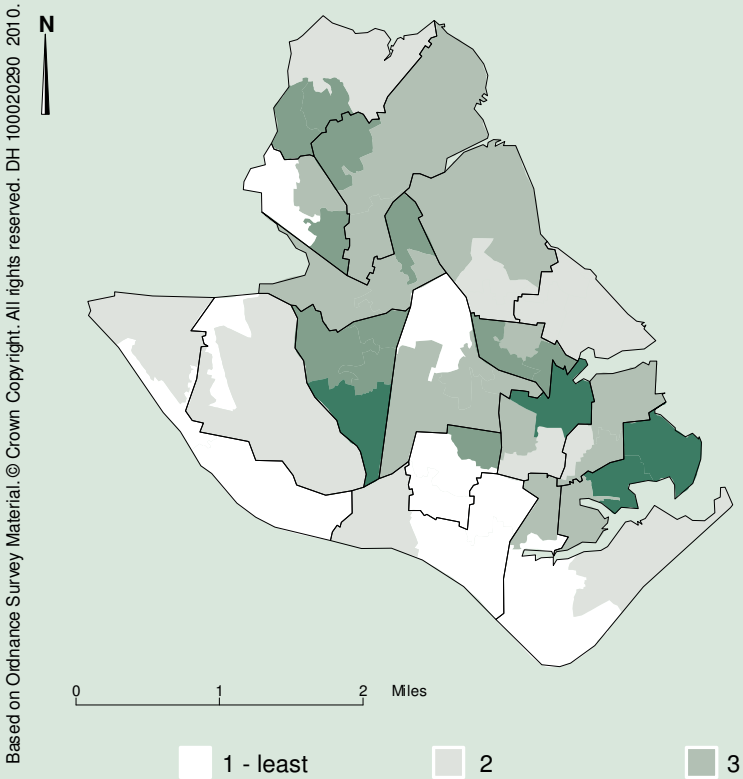
Gosport at a glance

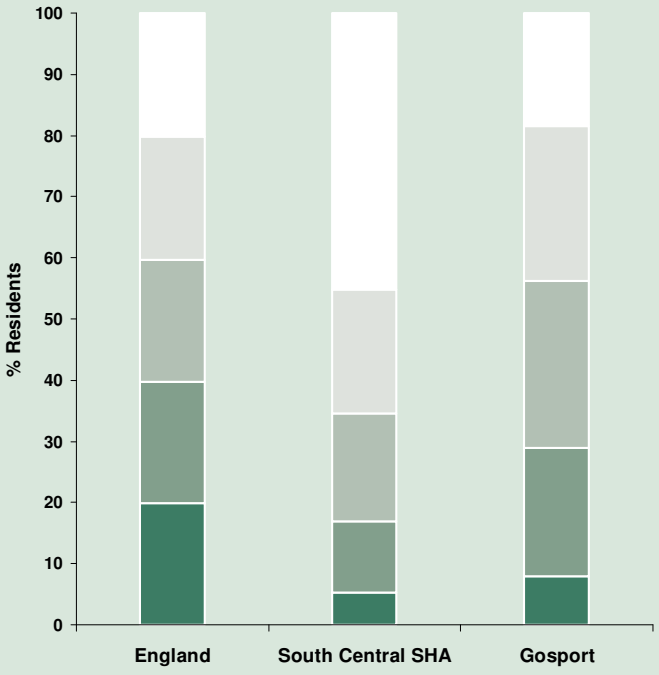
- Indicators of health for people living in Gosport show a mixed picture when compared to the England average. Deprivation levels and the percentage of children living in poverty are better than the England average. However, the rate of violent crime is higher than the England average.
- Overall life expectancy for men and women is similar to the England average. However, within Gosport life expectancy for men from the most deprived areas is 6 years lower than for men from the least deprived areas.
- Over the last 10 years, the death rate from all causes combined, and the early death rates from cancer and from heart disease and stroke, have fallen and are similar to the England average.
- Although the rate of hospital stays for alcohol related harm is similar to the England average, there were over 1,400 hospital stays in 2008/09.
- GCSE achievement was worse than the England average in 2008/09 with less than half of pupils gaining 5 or more higher grade GCSEs (including English and Maths).
- The rate of teenage pregnancy in Gosport is higher than the England average.
- Local priorities highlighted in the Hampshire Local Area Agreement include tackling the rate of death from all causes, child obesity, teenage pregnancy and hospital admissions for alcohol related harm.
- The Hampshire Public Health Annual Report can be found at: www.hampshire.nhs.uk

Deprivation:
a national view

This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.

This chart shows the percentage of the population in England, this region, and this area who live in each of these quintiles.



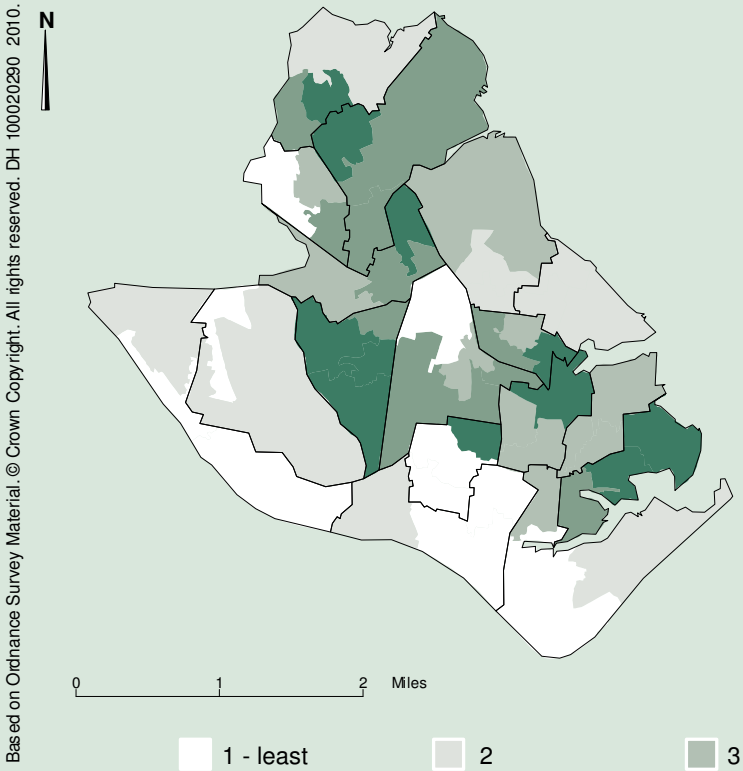


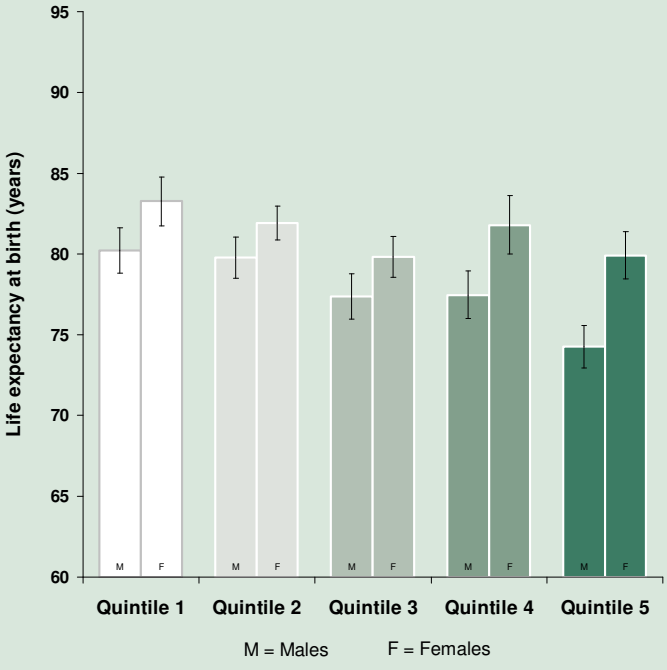
1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities:
a local view

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.

This chart shows the life expectancy at birth for males and females (2004-2008) for each of the quintiles in this area.





95% confidence interval. These indicate the level of uncertainty about each value on the graph. Longer/wider intervals mean more uncertainty.

1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities: **changes over time**

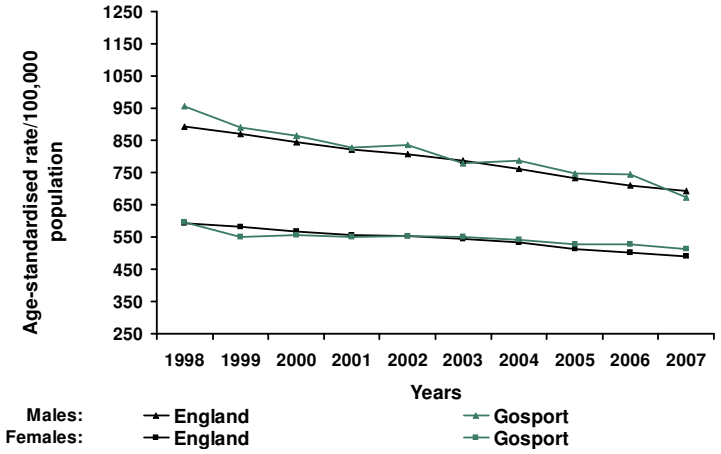
These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

Trend 1 compares rates of death, at all ages and from all causes, in this area with those for England.

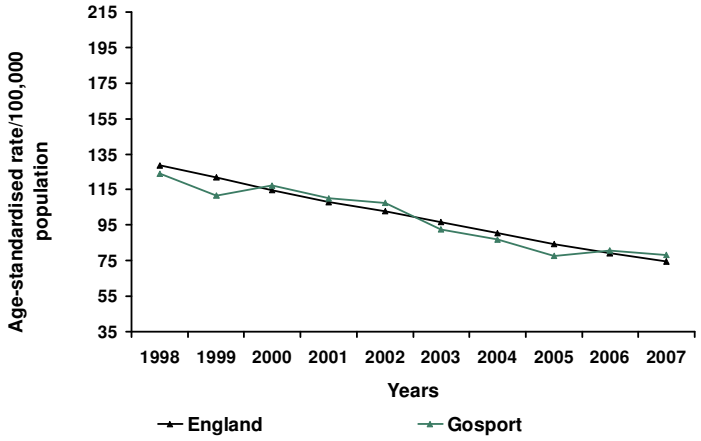
Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

Trend 3 compares rates of early death from cancer (in people under 75) in this area with those for England.

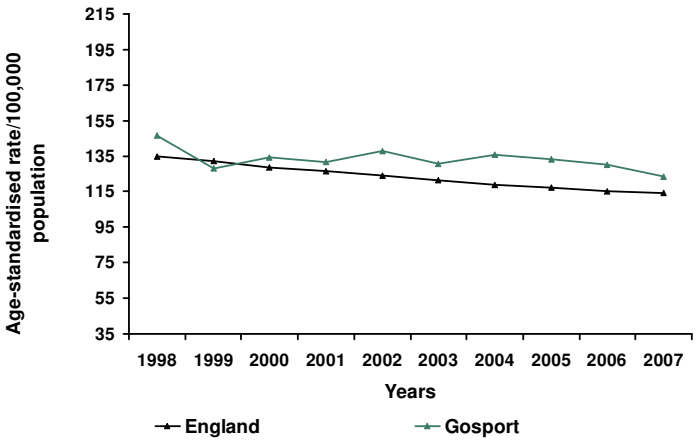
Trend 1:
All age, all cause mortality



Trend 2:
Early death rates from heart disease and stroke

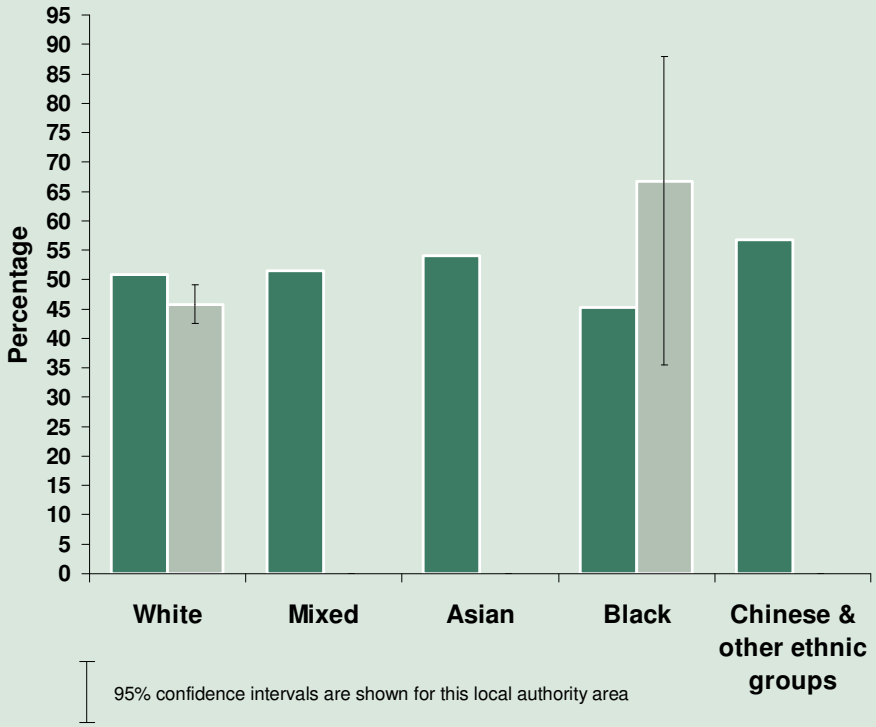


Trend 3:
Early death rates from cancer



Health inequalities: **ethnicity**

This chart shows the percentage of pupils by ethnic group in this area who achieved five GCSEs in 2008/09 (A* to C grades including English and Maths). Comparing results may help find possible inequalities between ethnic groups.



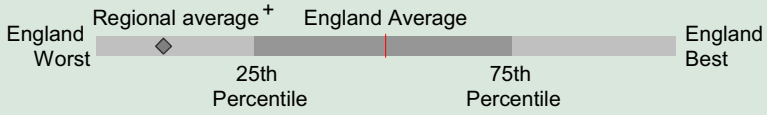
Ethnic Groups	% pupils achieved grades	No. of pupils achieved grades
White	45.8	394
Mixed		
Asian		
Black	66.7	6
Chinese/other		

If there are any empty cells in the table this is because data has not been presented where the calculation involved pupil numbers of 0, 1 or 2. Some further groups may not have data presented in order to prevent counts of small numbers being calculated from values for other ethnic groups or areas.

Health summary for Gosport

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

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



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

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	6135	7.9	19.9	89.2		0.0
	2 Children in poverty	2825	19.0	22.4	66.5		6.0
	3 Statutory homelessness	94	2.85	2.48	9.84		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	411	46.2	50.9	32.1		76.1
	5 Violent crime	1823	23.0	16.4	36.6		4.8
	6 Carbon emissions	364	4.6	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	135	13.1	14.6	33.5		3.8
	8 Breast feeding initiation	837	79.7	72.5	39.7		92.7
	9 Physically active children	5110	52.9	49.6	24.6		79.1
	10 Obese children	90	11.0	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	0.9	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	82	56.7	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	24.3	22.2	35.2		10.2
	14 Binge drinking adults	n/a	20.8	20.1	33.2		4.6
	15 Healthy eating adults	n/a	25.1	28.7	18.3		48.1
	16 Physically active adults	n/a	13.3	11.2	5.4		16.6
	17 Obese adults	n/a	23.3	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	12	16.2	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	1135	23.3	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	1460	1580	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	3472	4.34	4.30	6.72		2.69
	23 New cases of tuberculosis	2	3	15	110		0
	24 Hip fracture in over-65s	87	478.1	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	52	21.7	15.6	26.3		2.3
	26 Life expectancy - male	n/a	78.7	77.9	73.6		84.3
	27 Life expectancy - female	n/a	81.4	82.0	78.8		88.9
	28 Infant deaths	6	5.65	4.84	8.67		1.08
	29 Deaths from smoking	137	222.3	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	69	78.1	74.8	125.0		40.1
	31 Early deaths: cancer	107	123.4	114.0	164.3		70.5
	32 Road injuries and deaths	33	42.1	51.3	167.0		14.6

Indicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

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

Hampshire

updated 28 July 2010

This profile gives a picture of health in this area. It is designed to help local government and health services improve people's health and reduce health inequalities.

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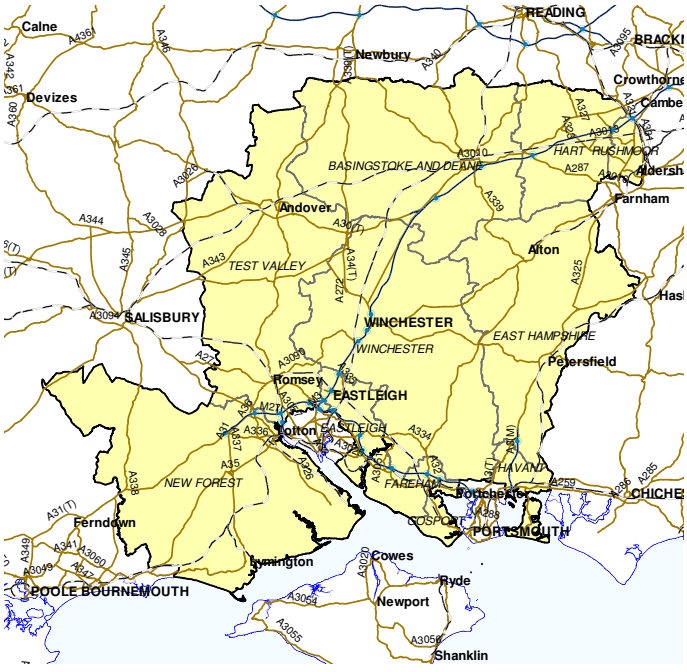


Population 1,285,900

Mid-2008 population estimate

Source: National Statistics website: www.statistics.gov.uk

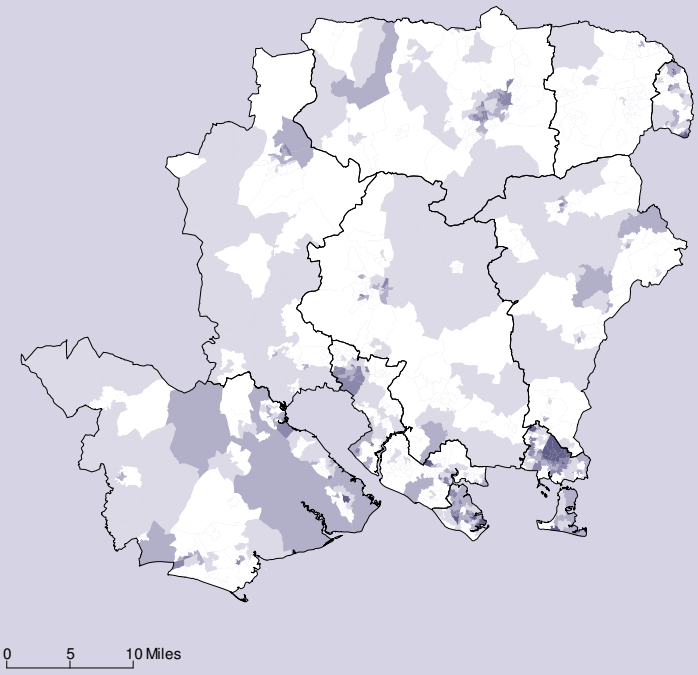
Hampshire at a glance

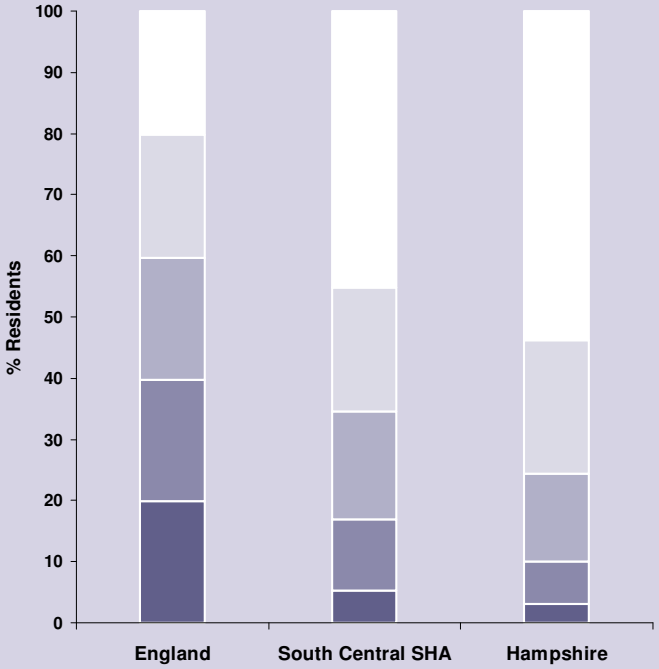
- Hampshire is a prosperous area with low levels of deprivation, violent crime and child poverty. Indicators of health are good when compared to England as a whole. Male and female life expectancy is high.
- There are inequalities in health between areas within Hampshire. Life expectancy for men from the most deprived areas of Hampshire is nearly 5 years lower than for men from the least deprived areas. For women the difference is 3 years.
- Over the last 10 years, the rate of death from all causes combined and the rates of early deaths from cancer and from heart disease and stroke have fallen, and are lower than the England averages.
- An estimated 18% of adults smoke, lower than the England average. While the smoking related death rate is lower than the England average, it is estimated that smoking accounts for over 1,700 deaths each year.
- Although the rate of hospital stays for alcohol related harm is lower than the England average, there were nearly 18,400 hospital stays in 2008/09.
- The rate of new cases of malignant melanoma skin cancer is higher than the England average.
- Local priorities highlighted in the Hampshire Local Area Agreement include tackling the rate of death from all causes, child obesity, teenage pregnancy and hospital admissions for alcohol related harm.
- The Hampshire Public Health Annual Report can be found at: www.hampshire.nhs.uk

Deprivation: **a national view**

This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.

This chart shows the percentage of the population in England, this region, and this area who live in each of these quintiles.



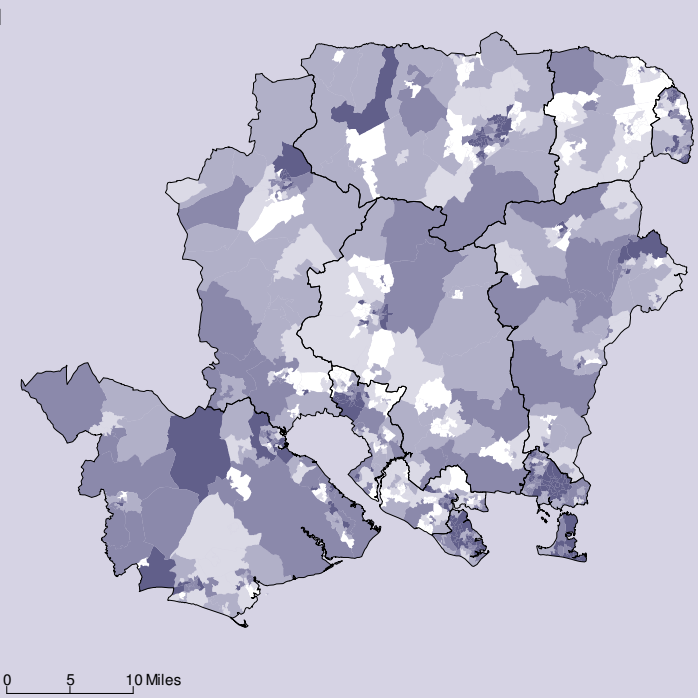


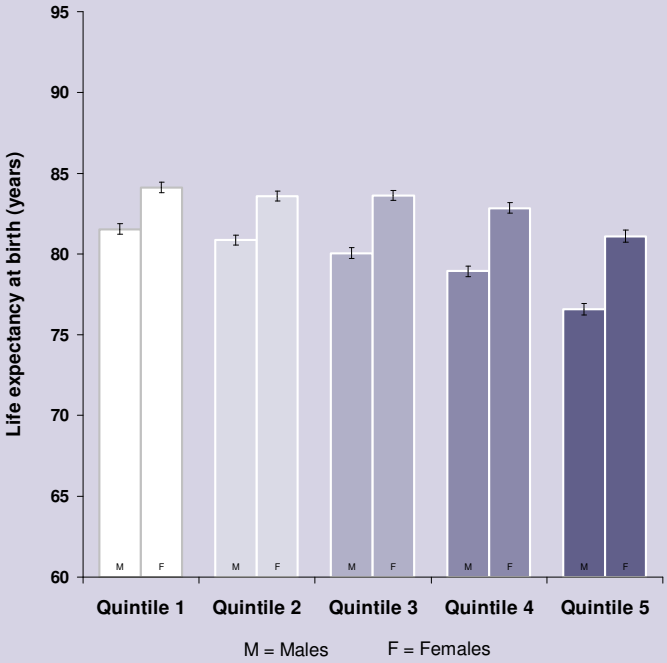
1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities: **a local view**

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.

This chart shows the life expectancy at birth for males and females (2004-2008) for each of the quintiles in this area.





95% confidence interval. These indicate the level of uncertainty about each value on the graph. Longer/wider intervals mean more uncertainty.

1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities: **changes over time**

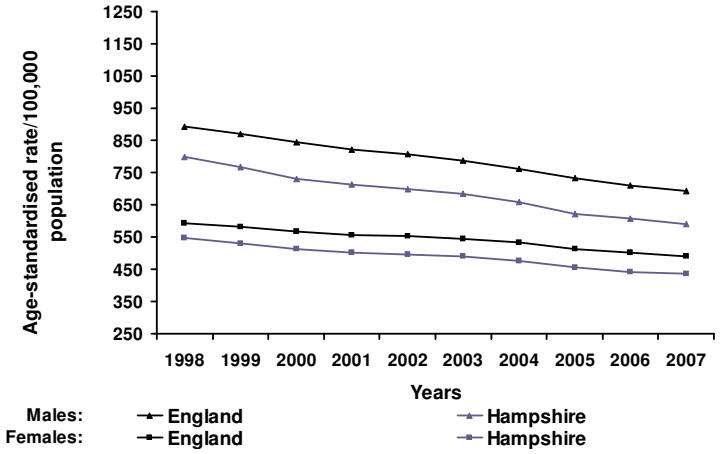
These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

Trend 1 compares rates of death, at all ages and from all causes, in this area with those for England.

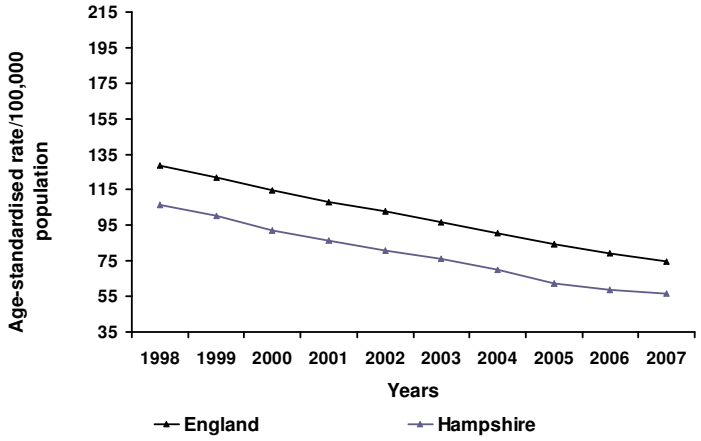
Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

Trend 3 compares rates of early death from cancer (in people under 75) in this area with those for England.

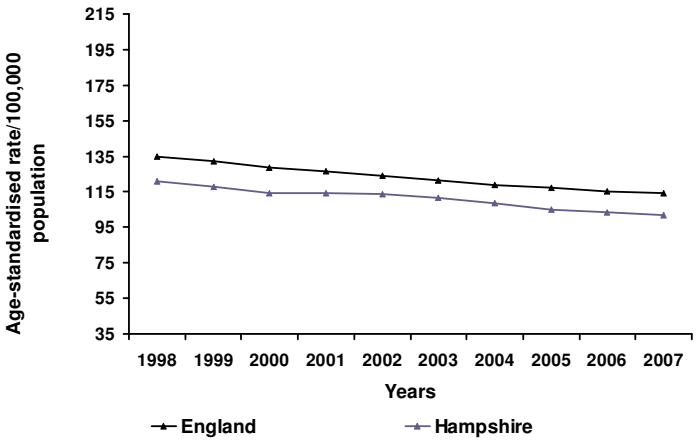
Trend 1:
All age, all cause mortality



Trend 2:
Early death rates from heart disease and stroke

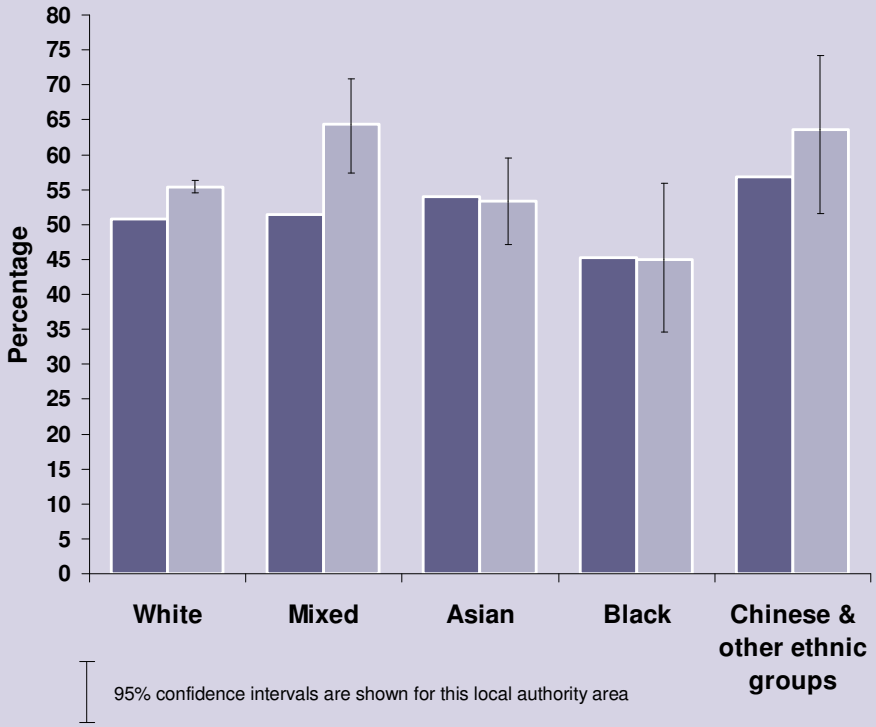


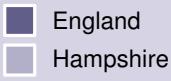
Trend 3:
Early death rates from cancer



Health inequalities: **ethnicity**

This chart shows the percentage of pupils by ethnic group in this area who achieved five GCSEs in 2008/09 (A* to C grades including English and Maths). Comparing results may help find possible inequalities between ethnic groups.





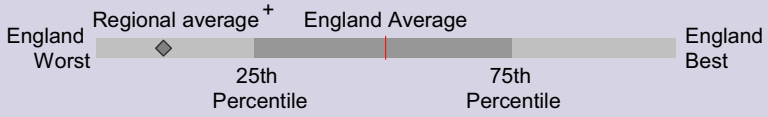
Ethnic Groups	% pupils achieved grades	No. of pupils achieved grades
White	55.4	7,322
Mixed	64.4	121
Asian	53.4	133
Black	45.0	36
Chinese/other	63.6	42

If there are any empty cells in the table this is because data has not been presented where the calculation involved pupil numbers of 0, 1 or 2. Some further groups may not have data presented in order to prevent counts of small numbers being calculated from values for other ethnic groups or areas.

Health summary for Hampshire

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

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



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

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	39420	3.1	19.9	89.2		0.0
	2 Children in poverty	30303	12.4	22.4	66.5		6.0
	3 Statutory homelessness	451	0.86	2.48	9.84		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	7797	55.3	50.9	32.1		76.1
	5 Violent crime	19901	15.6	16.4	36.6		4.8
	6 Carbon emissions	8696	6.8	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	1796	13.1	14.6	33.5		3.8
	8 Breast feeding initiation	11156	79.7	72.5	39.7		92.7
	9 Physically active children	88511	57.5	49.6	24.6		79.1
	10 Obese children	1058	8.6	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	0.7	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	789	32.7	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	18.1	22.2	35.2		10.2
	14 Binge drinking adults	n/a	18.2	20.1	33.2		4.6
	15 Healthy eating adults	n/a	29.0	28.7	18.3		48.1
	16 Physically active adults	n/a	12.7	11.2	5.4		16.6
	17 Obese adults	n/a	22.9	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	243	18.3	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	13140	17.0	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	18359	1150	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	50071	3.89	4.30	6.72		2.69
	23 New cases of tuberculosis	48	4	15	110		0
	24 Hip fracture in over-65s	1437	467.1	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	588	16.4	15.6	26.3		2.3
	26 Life expectancy - male	n/a	80.0	77.9	73.6		84.3
	27 Life expectancy - female	n/a	83.3	82.0	78.8		88.9
	28 Infant deaths	45	3.11	4.84	8.67		1.08
	29 Deaths from smoking	1721	160.9	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	837	56.7	74.8	125.0		40.1
	31 Early deaths: cancer	1478	101.7	114.0	164.3		70.5
	32 Road injuries and deaths	639	50.1	51.3	167.0		14.6

Indicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

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Hart

updated 28 July 2010

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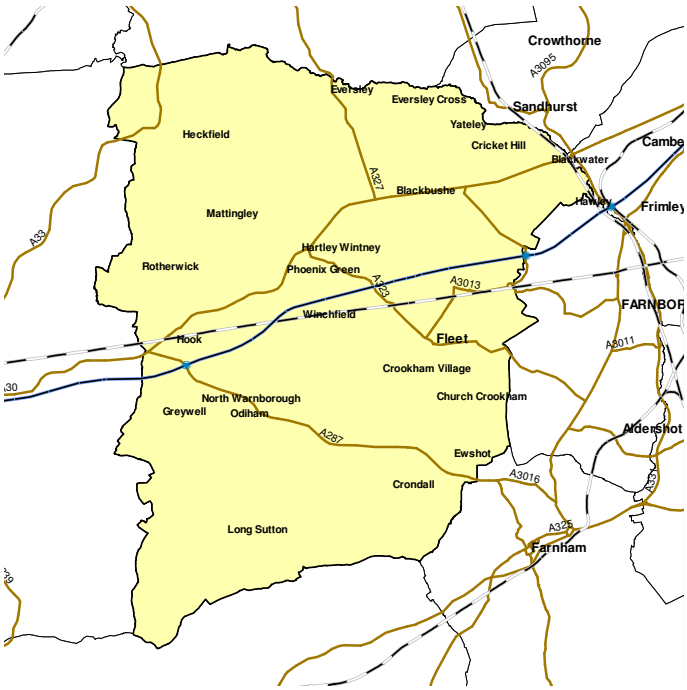

Population 90,600

Mid-2008 population estimate

Source: National Statistics website: www.statistics.gov.uk

Hart at a glance

- Indicators of health for people in Hart, when compared with the England average, are good. Over 90% of local residents live in areas classified as among the least deprived in England. Hart has very low levels of child poverty, homelessness and violent crime. Life expectancy for men and women is higher than the England average.
- There are inequalities in health between areas within Hart. Life expectancy for men from the most deprived areas is over 4 years lower than for men from the least deprived areas.
- Over the last 10 years, the early death rates from cancer and from heart disease and stroke have fallen and are lower than the England averages.
- The proportion of children in Reception year classified as obese and teenage pregnancy rates are lower than the England average. GCSE achievement is higher than the England average.
- Estimated levels of smoking and obesity are lower than the England average and the proportion of physically active adults is higher than the England average.
- Local priorities highlighted in the Hampshire Local Area Agreement include reducing the rates of death from all causes, child obesity, teenage pregnancy and hospital admissions for alcohol.
- The Hampshire Public Health Annual Report can be found at www.hampshire.nhs.uk

Deprivation:
a national view

This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.

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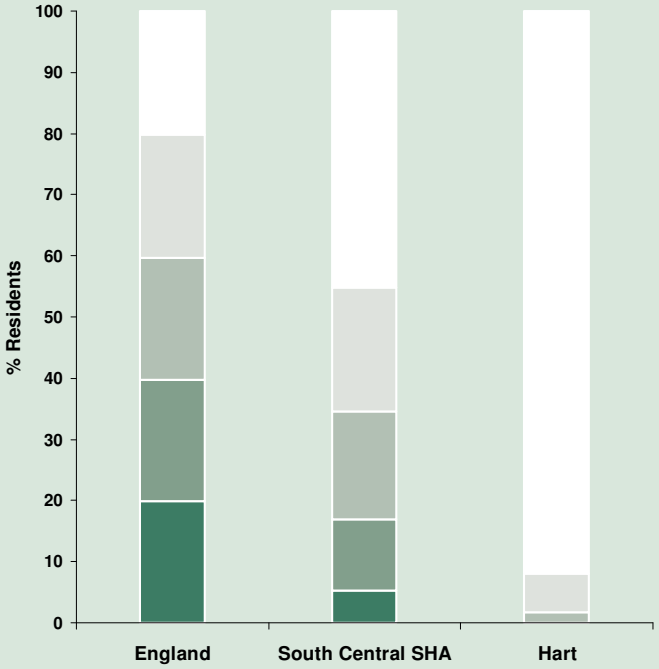
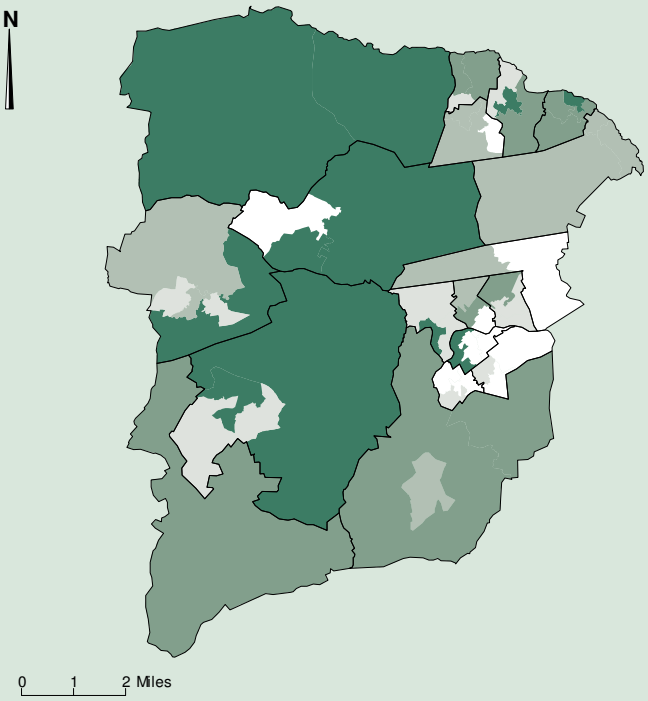


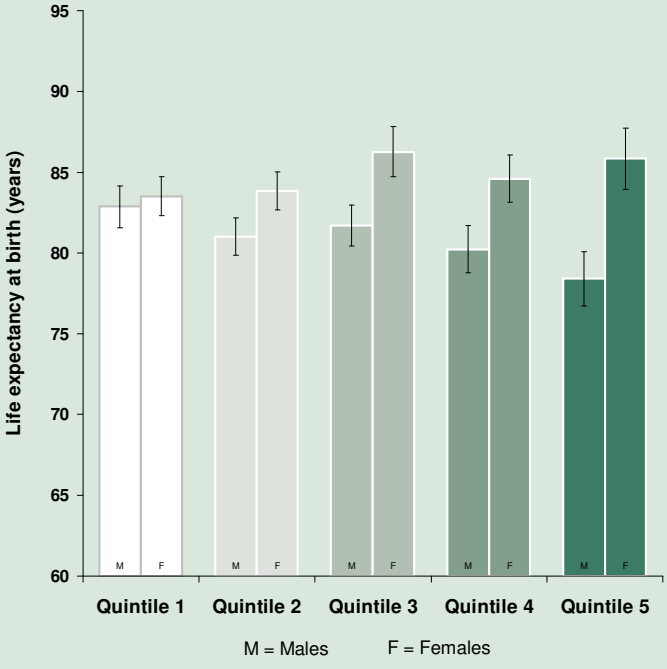
1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities:
a local view

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.



This chart shows the life expectancy at birth for males and females (2004-2008) for each of the quintiles in this area.



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1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

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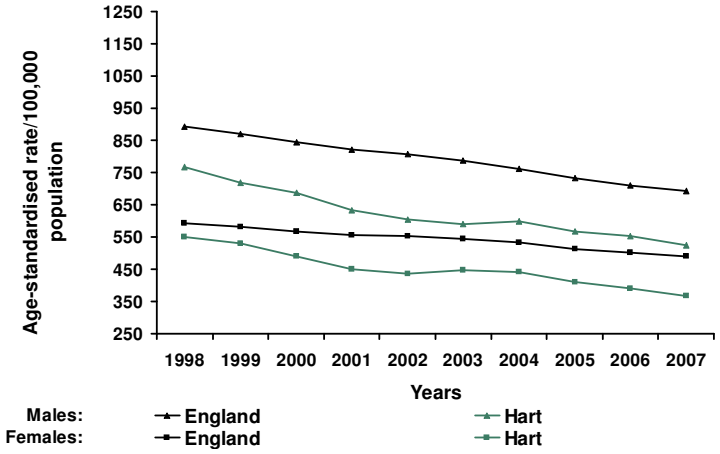
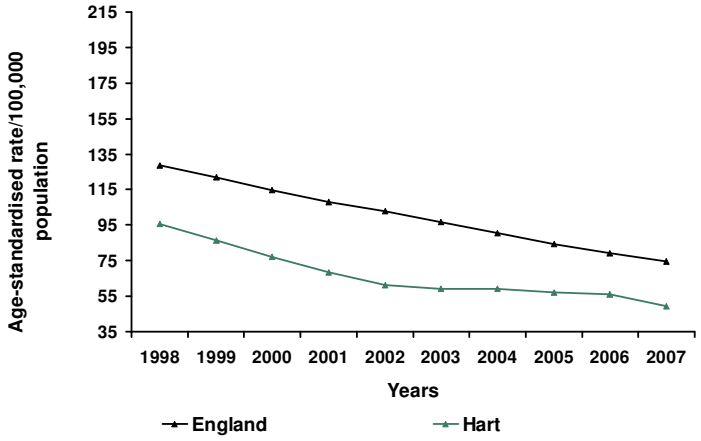
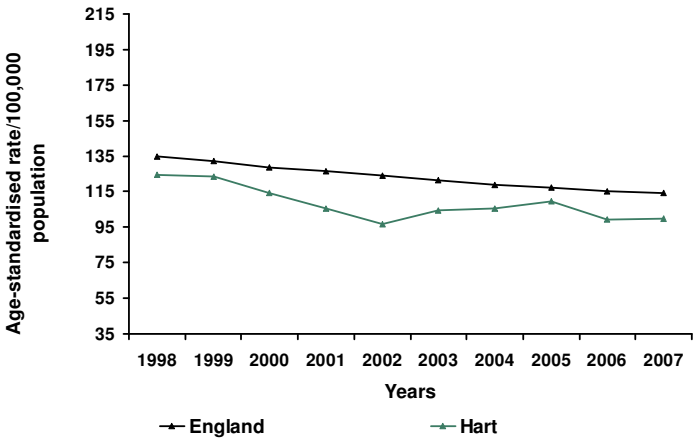


Trend 2:
Early death rates from heart disease and stroke



Trend 3:
Early death rates from cancer



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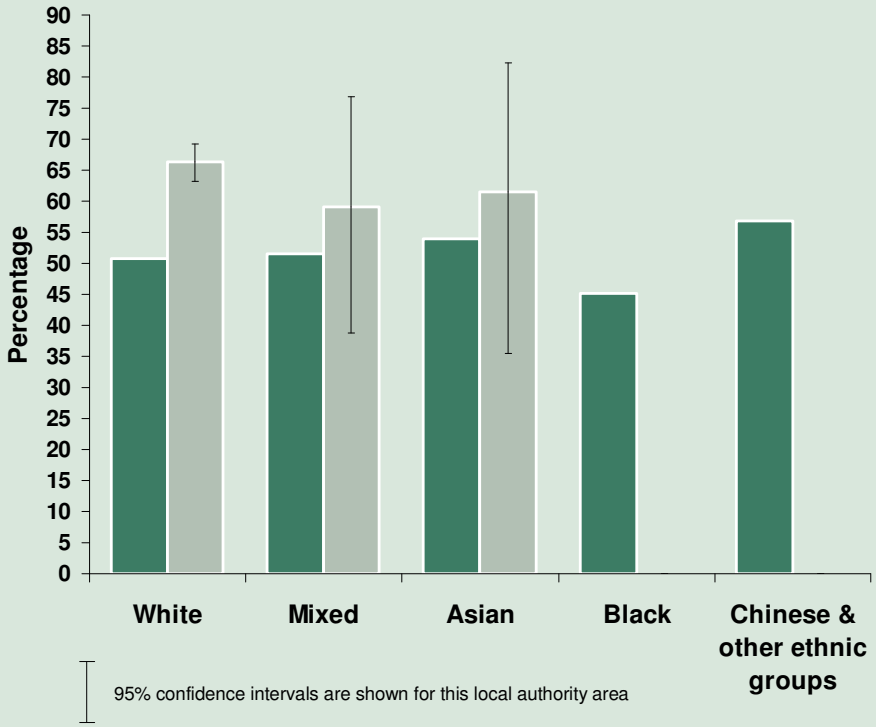

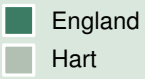

Ethnic Groups	% pupils achieved grades	No. of pupils achieved grades
White	66.3	637
Mixed	59.1	13
Asian	61.5	8
Black		
Chinese/other		

If there are any empty cells in the table this is because data has not been presented where the calculation involved pupil numbers of 0, 1 or 2. Some further groups may not have data presented in order to prevent counts of small numbers being calculated from values for other ethnic groups or areas.

Health summary for Hart

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

- Significantly worse than England average
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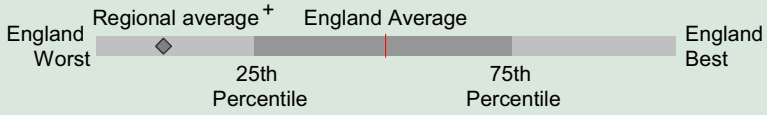

+ In the South East Region this represents the Strategic Health Authority average

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	0	0.0	19.9	89.2		0.0
	2 Children in poverty	1130	6.3	22.4	66.5		6.0
	3 Statutory homelessness	0	0.00	2.48	9.84		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	678	66.3	50.9	32.1		76.1
	5 Violent crime	724	8.1	16.4	36.6		4.8
	6 Carbon emissions	555	6.2	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	134	13.1	14.6	33.5		3.8
	8 Breast feeding initiation	834	79.7	72.5	39.7		92.7
	9 Physically active children	6506	54.9	49.6	24.6		79.1
	10 Obese children	59	5.9	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	0.7	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	34	19.8	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	14.7	22.2	35.2		10.2
	14 Binge drinking adults	n/a	17.3	20.1	33.2		4.6
	15 Healthy eating adults	n/a	28.7	28.7	18.3		48.1
	16 Physically active adults	n/a	14.0	11.2	5.4		16.6
	17 Obese adults	n/a	21.0	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	12	13.5	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	505	9.0	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	1279	1190	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	3039	3.35	4.30	6.72		2.69
	23 New cases of tuberculosis	3	3	15	110		0
	24 Hip fracture in over-65s	82	500.4	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	32	18.7	15.6	26.3		2.3
	26 Life expectancy - male	n/a	81.3	77.9	73.6		84.3
	27 Life expectancy - female	n/a	85.4	82.0	78.8		88.9
	28 Infant deaths	2	1.87	4.84	8.67		1.08
	29 Deaths from smoking	85	139.8	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	47	49.2	74.8	125.0		40.1
	31 Early deaths: cancer	96	100.0	114.0	164.3		70.5
	32 Road injuries and deaths	47	51.9	51.3	167.0		14.6

Indicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

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Havant

updated 28 July 2010

This profile gives a picture of health in this area. It is designed to help local government and health services improve people's health and reduce health inequalities.

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Visit the Health Profiles website to:

- see profiles for other areas
- use interactive maps
- find more detailed information

www.healthprofiles.info

Population 117,600

Mid-2008 population estimate

Source: National Statistics website: www.statistics.gov.uk

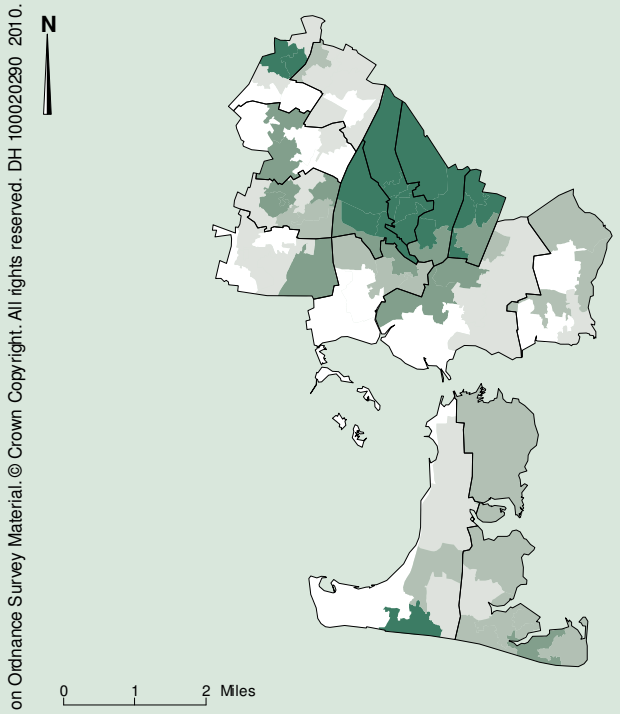
Havant at a glance

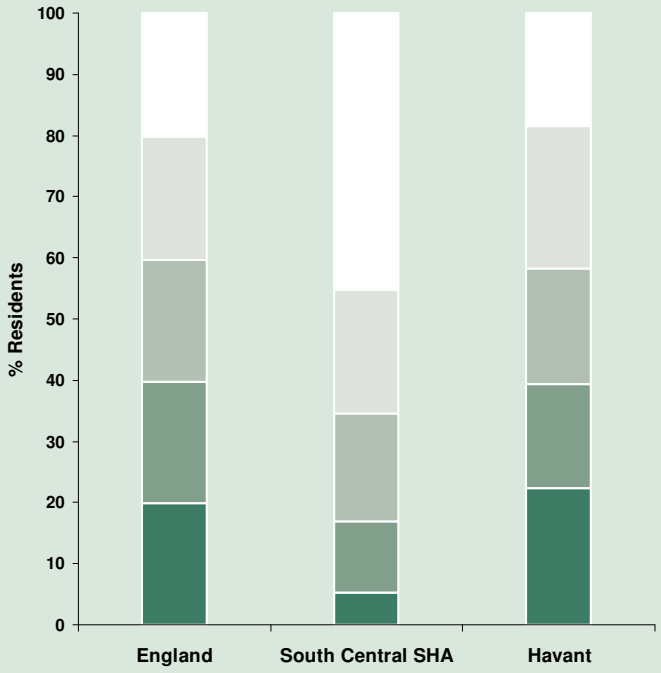
- Indicators of health for people living in Havant show a mixed picture when compared to the England average. Deprivation levels are worse than the England average and almost 5,000 children live in low income households. However, life expectancy for men and women is higher than the England average.
- There are health inequalities within Havant. Life expectancy for men from the most deprived areas is 7 years lower than for men from the least deprived areas.
- Over the last 10 years, the rate of death from all causes has fallen. Early death rates from cancer and from heart disease and stroke, have also fallen and remain similar to the England average.
- The proportion of children who spend at least 3 hours each week on physical activity in school is higher than the England average. 11% of children in Reception year are classified as obese, which is similar to the England average. GCSE achievement is worse than the England average.
- Estimates of smoking and binge drinking are lower than the England average. The rate of new cases of malignant melanoma skin cancer is higher than the England average.
- Local priorities highlighted in the Hampshire Local Area Agreement include tackling the rate of death from all causes, child obesity, teenage pregnancy and hospital admissions for alcohol related harm.
- The Hampshire Public Health Annual Report can be found at: www.hampshire.nhs.uk

Deprivation:
a national view

This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.

This chart shows the percentage of the population in England, this region, and this area who live in each of these quintiles.



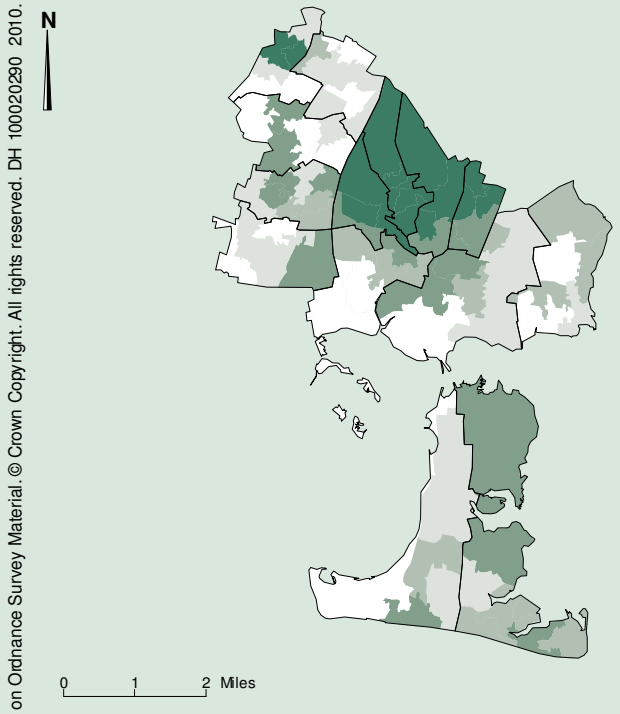


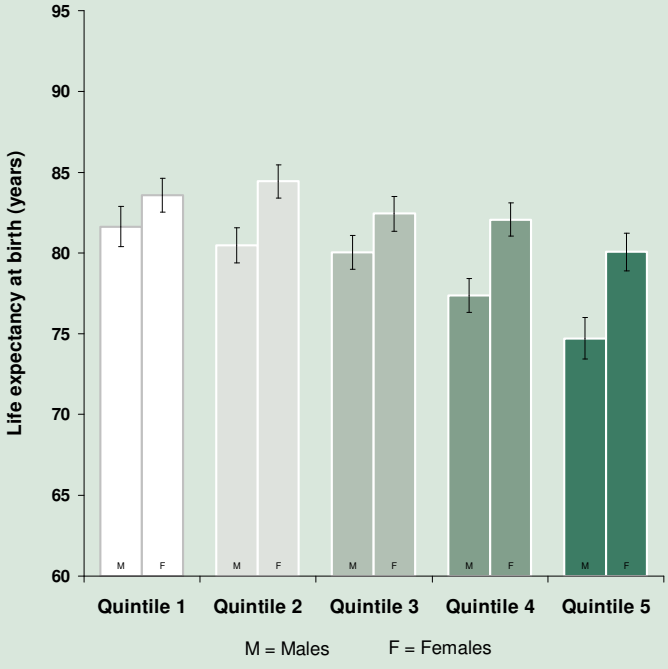
1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities:
a local view

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.

This chart shows the life expectancy at birth for males and females (2004-2008) for each of the quintiles in this area.





95% confidence interval. These indicate the level of uncertainty about each value on the graph. Longer/wider intervals mean more uncertainty.

1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities: **changes over time**

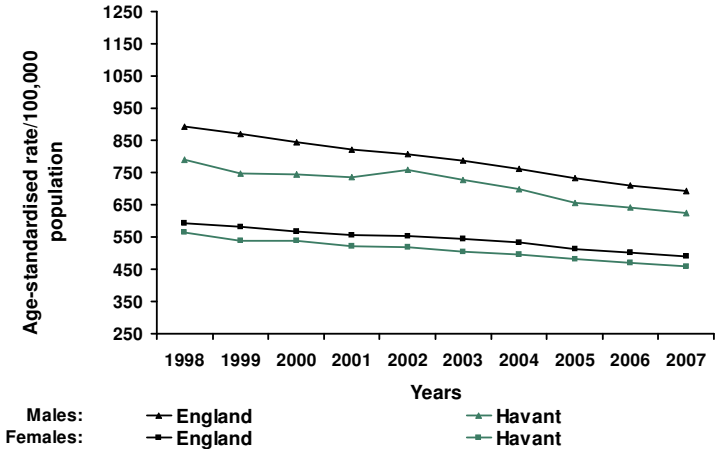
These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

Trend 1 compares rates of death, at all ages and from all causes, in this area with those for England.

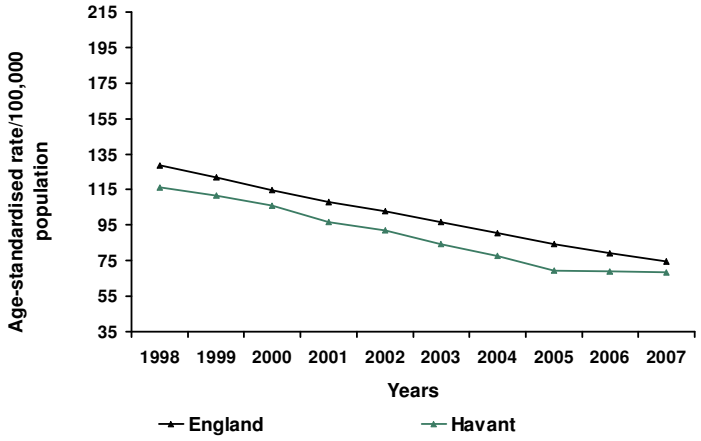
Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

Trend 3 compares rates of early death from cancer (in people under 75) in this area with those for England.

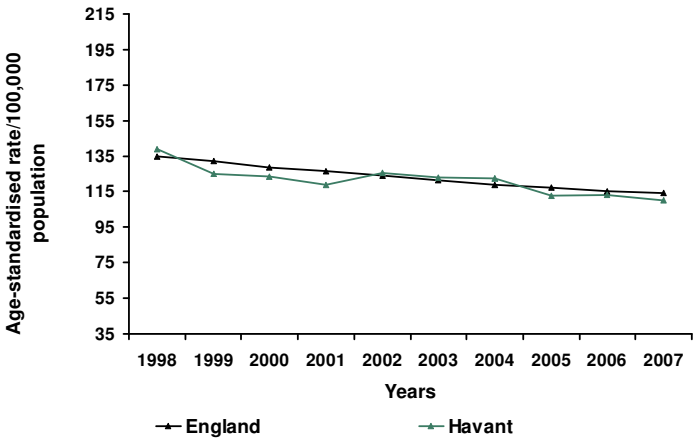
Trend 1:
All age, all cause mortality



Trend 2:
Early death rates from heart disease and stroke

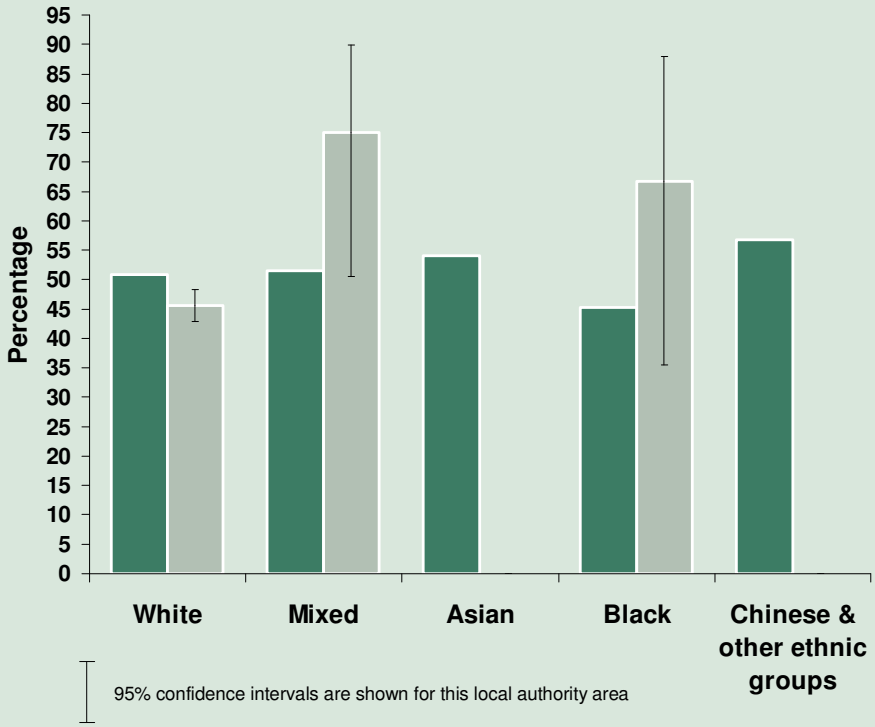


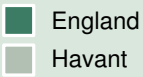
Trend 3:
Early death rates from cancer



Health inequalities: **ethnicity**

This chart shows the percentage of pupils by ethnic group in this area who achieved five GCSEs in 2008/09 (A* to C grades including English and Maths). Comparing results may help find possible inequalities between ethnic groups.





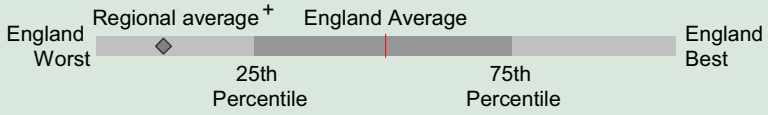
Ethnic Groups	% pupils achieved grades	No. of pupils achieved grades
White	45.6	604
Mixed	75.0	12
Asian		
Black	66.7	6
Chinese/other		

If there are any empty cells in the table this is because data has not been presented where the calculation involved pupil numbers of 0, 1 or 2. Some further groups may not have data presented in order to prevent counts of small numbers being calculated from values for other ethnic groups or areas.

Health summary for Havant

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

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



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

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	26184	22.4	19.9	89.2		0.0
	2 Children in poverty	4994	22.9	22.4	66.5		6.0
	3 Statutory homelessness	95	1.91	2.48	9.84		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	630	45.9	50.9	32.1		76.1
	5 Violent crime	2758	23.6	16.4	36.6		4.8
	6 Carbon emissions	611	5.2	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	155	13.1	14.6	33.5		3.8
	8 Breast feeding initiation	962	79.7	72.5	39.7		92.7
	9 Physically active children	8701	61.9	49.6	24.6		79.1
	10 Obese children	122	11.2	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	1.3	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	97	42.3	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	19.4	22.2	35.2		10.2
	14 Binge drinking adults	n/a	14.6	20.1	33.2		4.6
	15 Healthy eating adults	n/a	24.2	28.7	18.3		48.1
	16 Physically active adults	n/a	10.3	11.2	5.4		16.6
	17 Obese adults	n/a	25.2	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	27	20.9	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	1730	25.4	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	2240	1510	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	5956	5.06	4.30	6.72		2.69
	23 New cases of tuberculosis	4	4	15	110		0
	24 Hip fracture in over-65s	143	451.0	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	76	20.2	15.6	26.3		2.3
	26 Life expectancy - male	n/a	79.1	77.9	73.6		84.3
	27 Life expectancy - female	n/a	82.9	82.0	78.8		88.9
	28 Infant deaths	4	2.86	4.84	8.67		1.08
	29 Deaths from smoking	209	194.7	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	100	68.4	74.8	125.0		40.1
	31 Early deaths: cancer	158	110.0	114.0	164.3		70.5
	32 Road injuries and deaths	37	31.4	51.3	167.0		14.6

Indicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

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Isle of Wight

updated 28 July 2010

This profile gives a picture of health in this area. It is designed to help local government and health services improve people's health and reduce health inequalities.

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Population 140,200

Mid-2008 population estimate

Source: National Statistics website: www.statistics.gov.uk

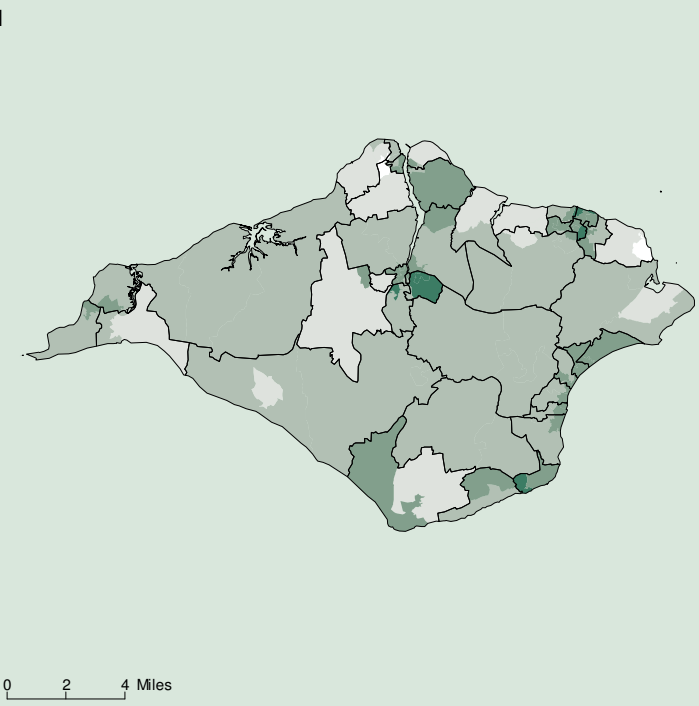
Isle of Wight at a glance

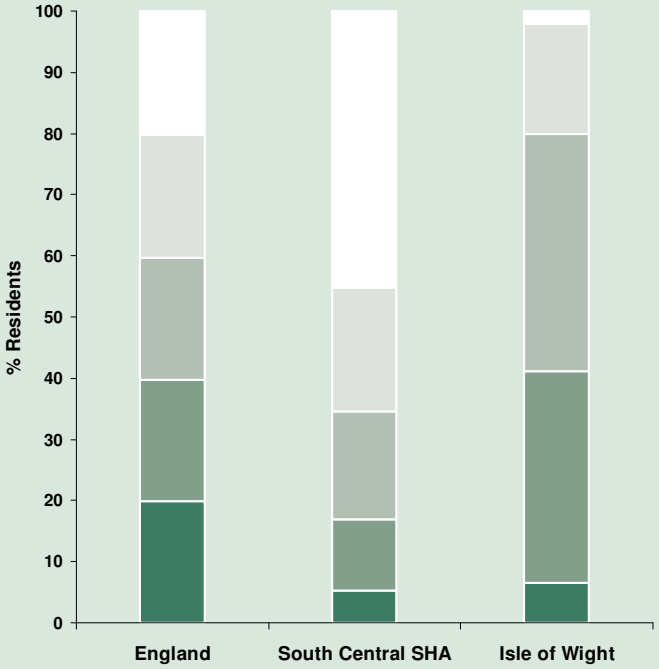
- The health of people living on the Isle of Wight is similar to the England average. Life expectancy and the rate of early death from heart disease and stroke are better than the England averages. The rate of claims for incapacity benefits for mental illness is higher.
- There are health inequalities within the Isle of Wight. Life expectancy for men from the most deprived areas is more than 4 years lower than for men from the least deprived areas.
- Over the last 10 years, the rates of death from all causes, and the rate of early death from heart disease and stroke, have fallen. There are over 250 smoking related deaths each year.
- The rate of new cases of malignant melanoma skin cancer is higher than the England average.
- GCSE achievement is lower than the England average. Breastfeeding initiation is high. Nearly 1 in 10 children in Reception year are classified as obese. The percentage of children who spend at least 3 hours a week on physical activity in school is higher than the England average.
- It is estimated that nearly 1 in 4 adults are obese and 1 in 5 smoke, similar to the England average. Smoking in pregnancy is high compared to the England average.
- Priorities for action identified in the Local Area Agreement for the Isle of Wight are: alcohol, smoking, obesity in children, teenage pregnancies, violent crime, drugs and health inequalities.
- Further information is available at www.iow.nhs.uk

Deprivation:
a national view

This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.

This chart shows the percentage of the population in England, this region, and this area who live in each of these quintiles.



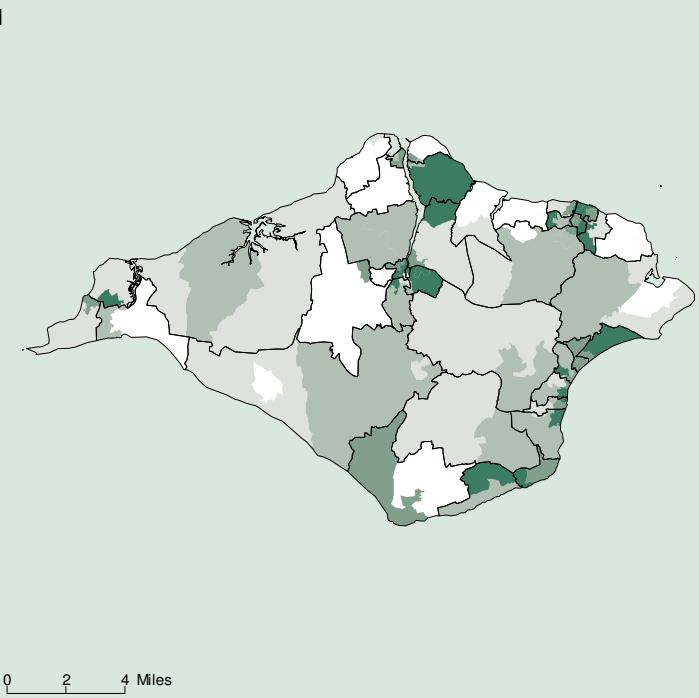


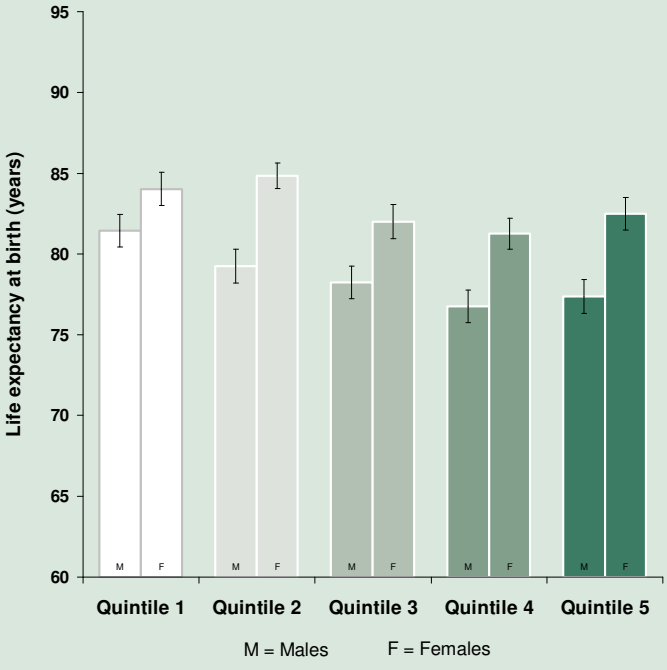
1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities:
a local view

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.

This chart shows the life expectancy at birth for males and females (2004-2008) for each of the quintiles in this area.





95% confidence interval. These indicate the level of uncertainty about each value on the graph. Longer/wider intervals mean more uncertainty.

1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities: **changes over time**

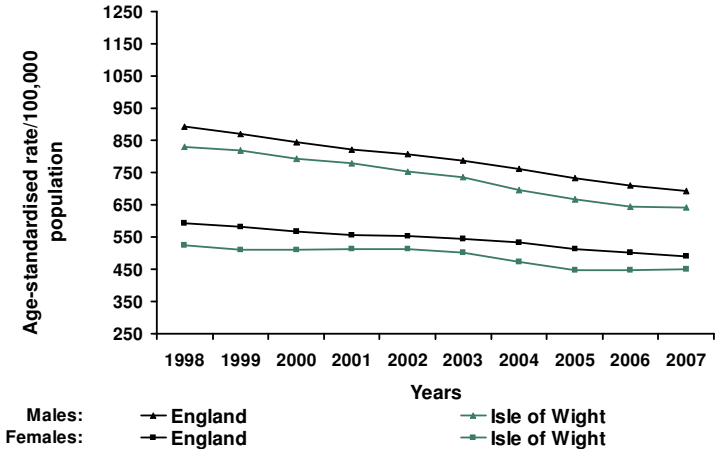
These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

Trend 1 compares rates of death, at all ages and from all causes, in this area with those for England.

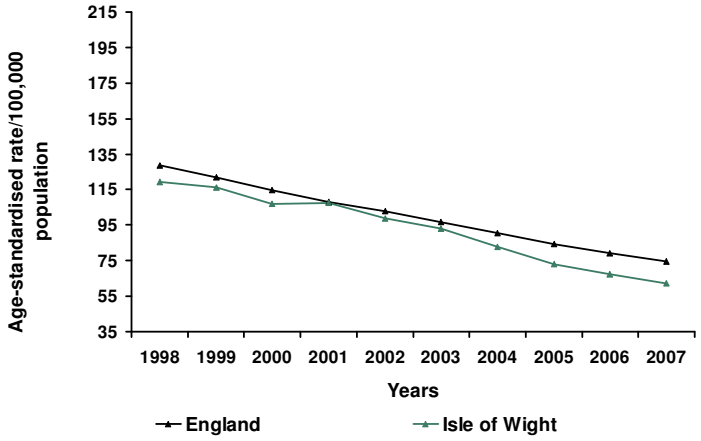
Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

Trend 3 compares rates of early death from cancer (in people under 75) in this area with those for England.

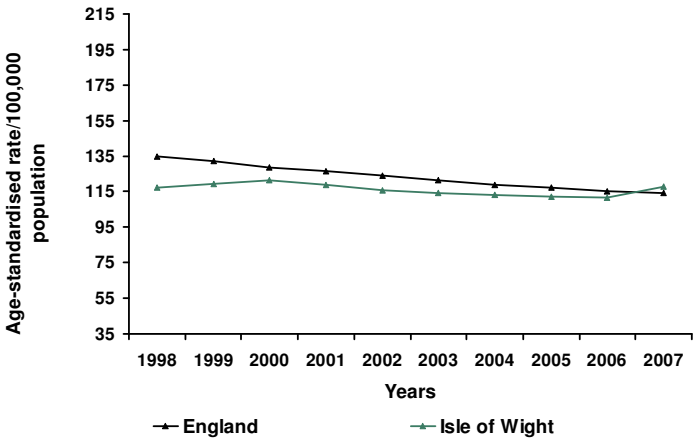
Trend 1:
All age, all cause mortality



Trend 2:
Early death rates from heart disease and stroke

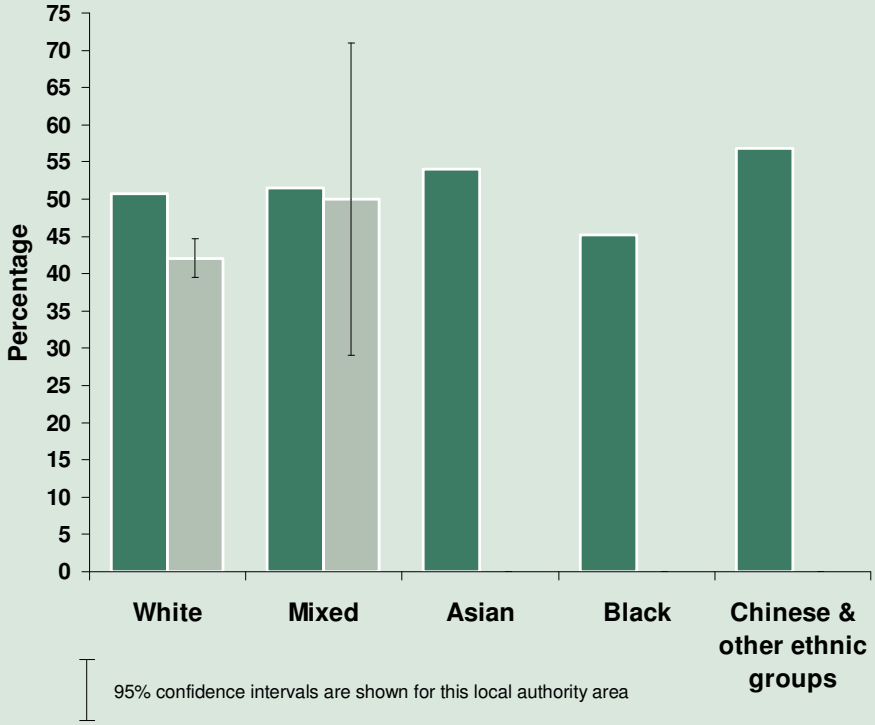


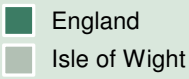
Trend 3:
Early death rates from cancer



Health inequalities: **ethnicity**

This chart shows the percentage of pupils by ethnic group in this area who achieved five GCSEs in 2008/09 (A* to C grades including English and Maths). Comparing results may help find possible inequalities between ethnic groups.





Ethnic Groups	% pupils achieved grades	No. of pupils achieved grades
White	42.1	595
Mixed	50.0	9
Asian		
Black		
Chinese/other		

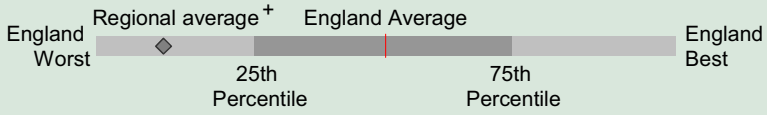
If there are any empty cells in the table this is because data has not been presented where the calculation involved pupil numbers of 0, 1 or 2. Some further groups may not have data presented in order to prevent counts of small numbers being calculated from values for other ethnic groups or areas.

Health summary for Isle of Wight

00MW

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

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



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

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	9039	6.6	19.9	89.2		0.0
	2 Children in poverty	5296	22.2	22.4	66.5		6.0
	3 Statutory homelessness	79	1.29	2.48	9.84		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	629	41.6	50.9	32.1		76.1
	5 Violent crime	2587	18.5	16.4	36.6		4.8
	6 Carbon emissions	773	5.5	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	283	23.8	14.6	33.5		3.8
	8 Breast feeding initiation	944	79.3	72.5	39.7		92.7
	9 Physically active children	8634	51.2	49.6	24.6		79.1
	10 Obese children	106	9.9	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	1.0	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	94	35.8	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	21.2	22.2	35.2		10.2
	14 Binge drinking adults	n/a	13.4	20.1	33.2		4.6
	15 Healthy eating adults	n/a	27.6	28.7	18.3		48.1
	16 Physically active adults	n/a	10.2	11.2	5.4		16.6
	17 Obese adults	n/a	22.6	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	27	18.8	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	2592	32.9	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	1428	784	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	6064	4.33	4.30	6.72		2.69
	23 New cases of tuberculosis	3	2	15	110		0
	24 Hip fracture in over-65s	203	432.6	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	61	11.4	15.6	26.3		2.3
	26 Life expectancy - male	n/a	78.8	77.9	73.6		84.3
	27 Life expectancy - female	n/a	82.9	82.0	78.8		88.9
	28 Infant deaths	4	3.46	4.84	8.67		1.08
	29 Deaths from smoking	256	172.6	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	118	62.2	74.8	125.0		40.1
	31 Early deaths: cancer	221	117.8	114.0	164.3		70.5
	32 Road injuries and deaths	80	57.6	51.3	167.0		14.6

Indicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

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

New Forest

updated 28 July 2010

This profile gives a picture of health in this area. It is designed to help local government and health services improve people's health and reduce health inequalities.

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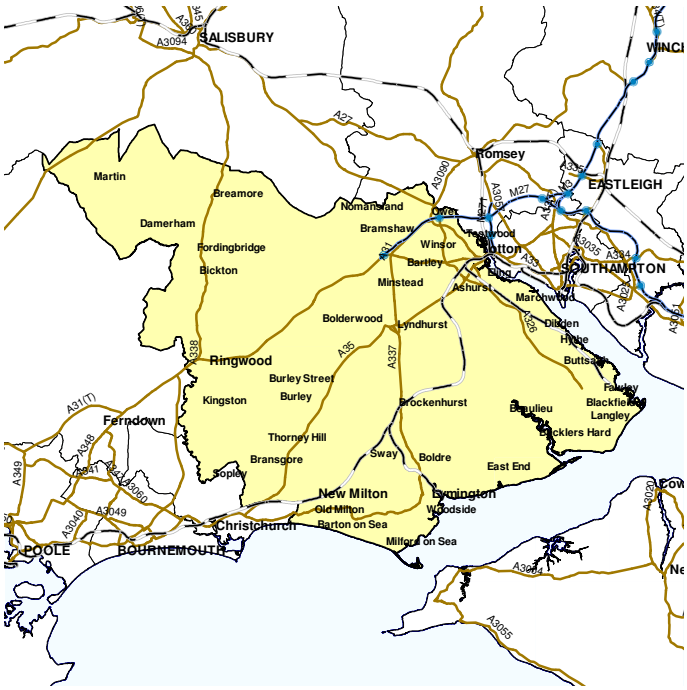


Population 175,400

Mid-2008 population estimate

Source: National Statistics website: www.statistics.gov.uk

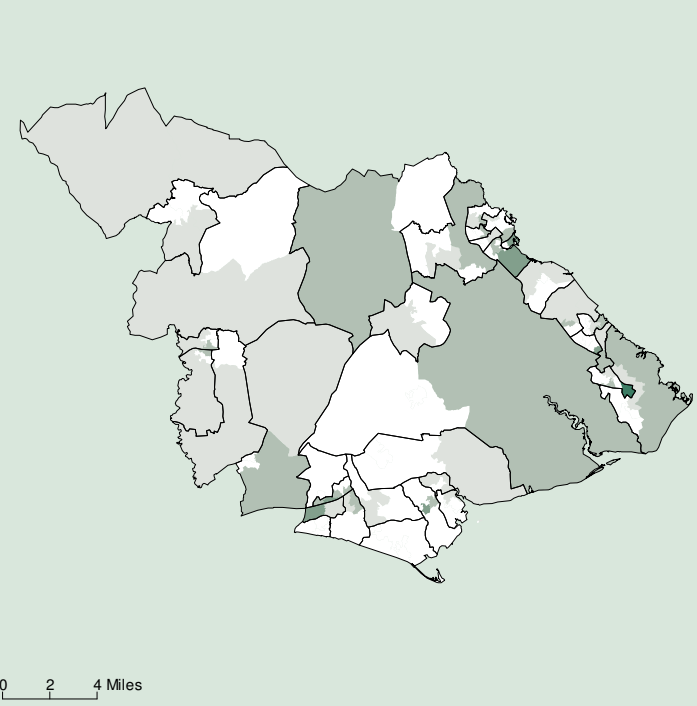
New Forest at a glance

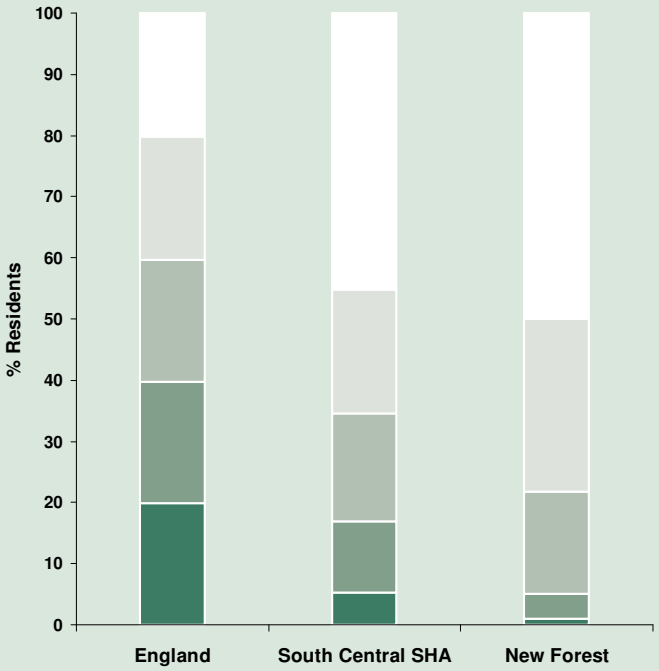
- The health of people in the New Forest is generally better than the England average. However, the rate of malignant melanoma skin cancer and the rate of road injuries and death are worse than the England averages.
- There are health inequalities between areas within the New Forest. Life expectancy for men and women from the most deprived areas is almost 4 years lower than for those from the least deprived areas.
- Over the last 10 years, the rate of death from all causes, and early death rates from cancer and heart disease and stroke, have all fallen.
- Although the level of child poverty is below the England average, there are over 4,000 children living in low income households. The proportion of children in Reception year classified as obese is lower than the England average.
- An estimated 16% of adults smoke, lower than the England average. There are over 260 smoking related deaths in the New Forest each year.
- Although the rate of hospital stays for alcohol related harm is lower than the England average, there were over 2,400 hospital stays in 2008/09.
- Local priorities highlighted in the Hampshire Local Area Agreement include tackling the rate of death from all causes, child obesity, teenage pregnancy and hospital admissions for alcohol related harm.
- The Hampshire Public Health Annual Report can be found at: www.hampshire.nhs.uk

Deprivation:
a national view

This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.

This chart shows the percentage of the population in England, this region, and this area who live in each of these quintiles.



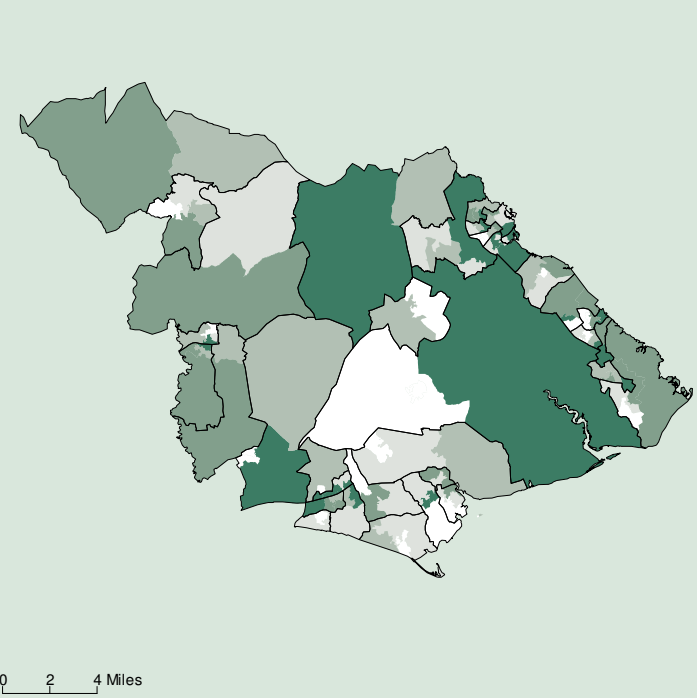


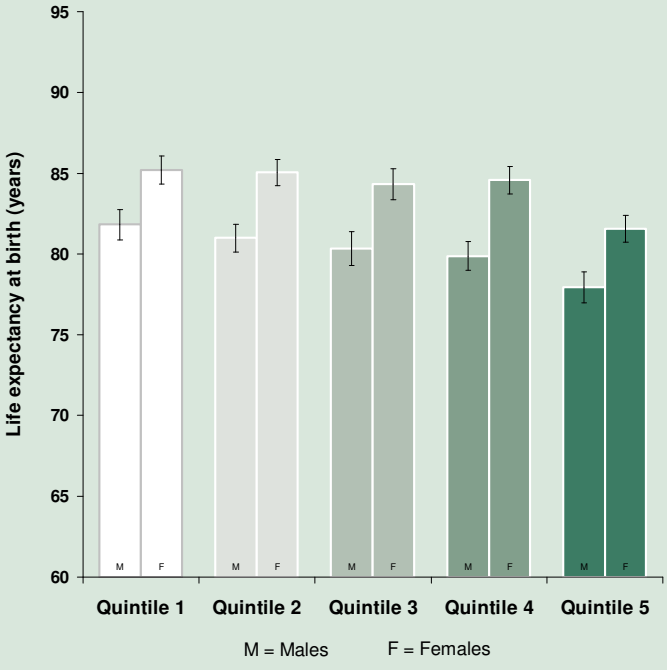
1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities:
a local view

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.

This chart shows the life expectancy at birth for males and females (2004-2008) for each of the quintiles in this area.





95% confidence interval. These indicate the level of uncertainty about each value on the graph. Longer/wider intervals mean more uncertainty.

1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities: **changes over time**

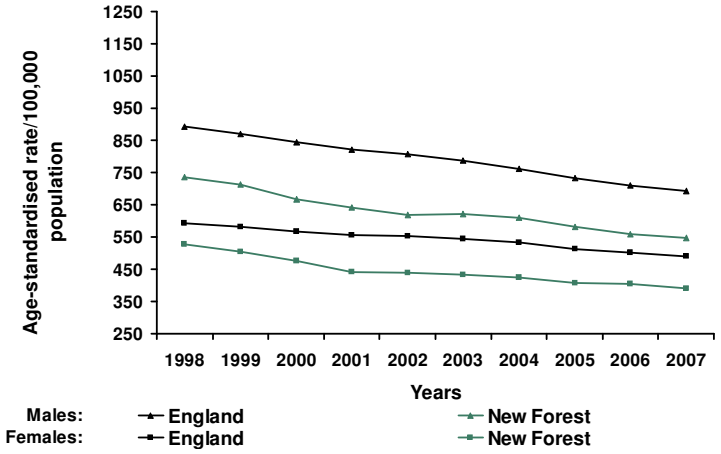
These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

Trend 1 compares rates of death, at all ages and from all causes, in this area with those for England.

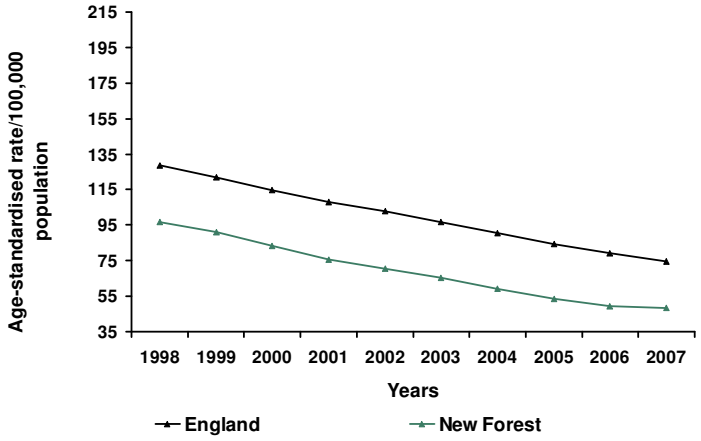
Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

Trend 3 compares rates of early death from cancer (in people under 75) in this area with those for England.

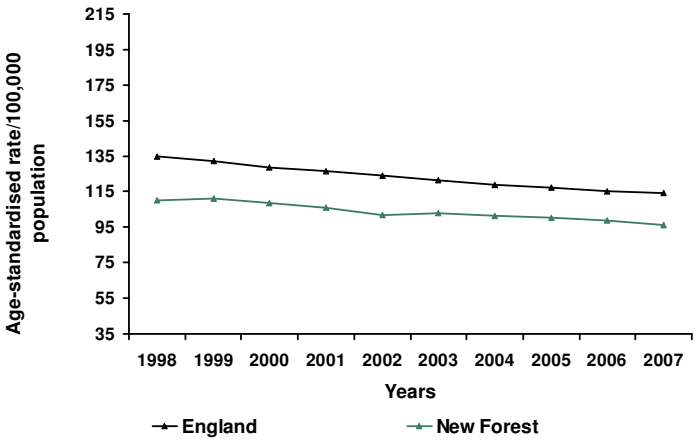
Trend 1:
All age, all cause mortality



Trend 2:
Early death rates from heart disease and stroke

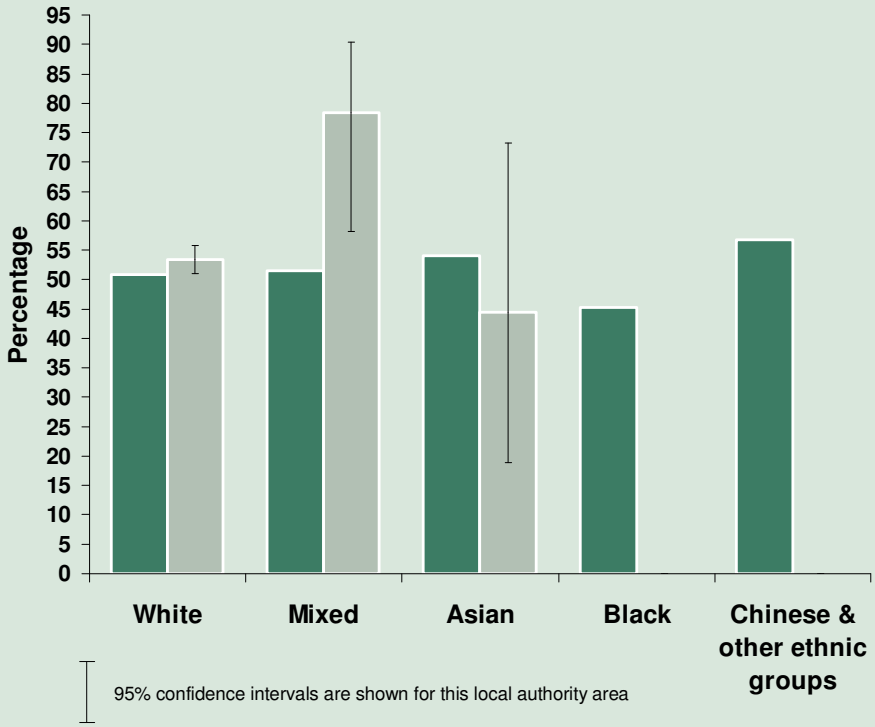


Trend 3:
Early death rates from cancer



Health inequalities: **ethnicity**

This chart shows the percentage of pupils by ethnic group in this area who achieved five GCSEs in 2008/09 (A* to C grades including English and Maths). Comparing results may help find possible inequalities between ethnic groups.



England
New Forest

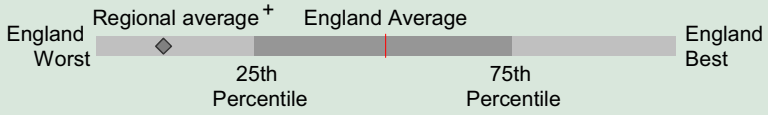
Ethnic Groups	% pupils achieved grades	No. of pupils achieved grades
White	53.4	902
Mixed	78.3	18
Asian	44.4	4
Black		
Chinese/other		

If there are any empty cells in the table this is because data has not been presented where the calculation involved pupil numbers of 0, 1 or 2. Some further groups may not have data presented in order to prevent counts of small numbers being calculated from values for other ethnic groups or areas.

Health summary for New Forest

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

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



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

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	1791	1.0	19.9	89.2		0.0
	2 Children in poverty	4048	13.5	22.4	66.5		6.0
	3 Statutory homelessness	74	0.98	2.48	9.84		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	941	53.4	50.9	32.1		76.1
	5 Violent crime	2109	12.1	16.4	36.6		4.8
	6 Carbon emissions	1341	7.7	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	195	13.1	14.6	33.5		3.8
	8 Breast feeding initiation	1213	79.7	72.5	39.7		92.7
	9 Physically active children	11062	56.0	49.6	24.6		79.1
	10 Obese children	104	7.0	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	0.5	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	92	30.1	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	16.2	22.2	35.2		10.2
	14 Binge drinking adults	n/a	15.7	20.1	33.2		4.6
	15 Healthy eating adults	n/a	32.7	28.7	18.3		48.1
	16 Physically active adults	n/a	12.4	11.2	5.4		16.6
	17 Obese adults	n/a	20.9	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	45	23.2	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	1840	19.0	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	2475	982	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	7351	4.19	4.30	6.72		2.69
	23 New cases of tuberculosis	8	4	15	110		0
	24 Hip fracture in over-65s	312	495.9	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	104	16.5	15.6	26.3		2.3
	26 Life expectancy - male	n/a	80.6	77.9	73.6		84.3
	27 Life expectancy - female	n/a	84.5	82.0	78.8		88.9
	28 Infant deaths	5	3.41	4.84	8.67		1.08
	29 Deaths from smoking	266	132.8	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	116	48.3	74.8	125.0		40.1
	31 Early deaths: cancer	222	96.4	114.0	164.3		70.5
	32 Road injuries and deaths	105	59.9	51.3	167.0		14.6

Indicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

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Portsmouth

updated 28 July 2010

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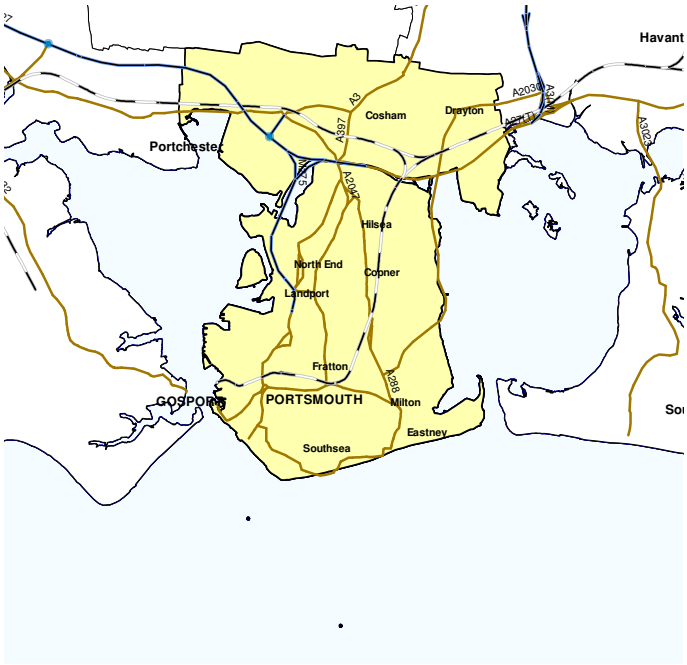


Population 200,000

Mid-2008 population estimate

Source: National Statistics website: www.statistics.gov.uk

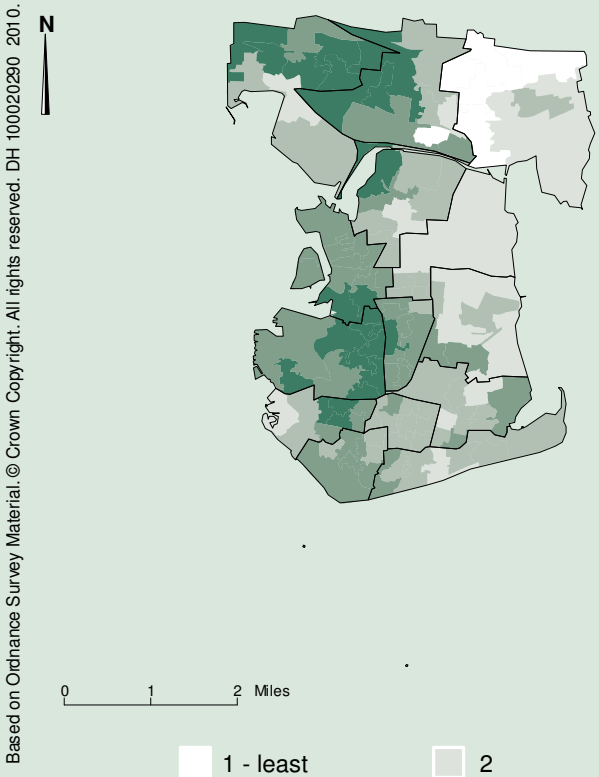
Portsmouth at a glance

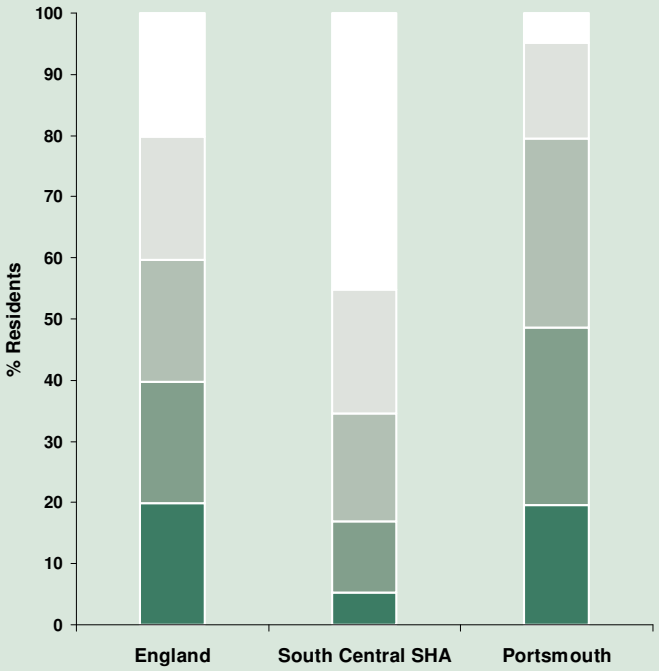
- The health of people in Portsmouth is generally worse than the England average.
- Portsmouth has significant health inequalities. Life expectancy for men living in the most deprived areas is nearly 8 years lower than for men living in the least deprived areas. For women the gap is 4 years.
- Over the last 10 years, the rate of death from all causes has fallen. Early death rates from cancer, and from heart disease and stroke, have also fallen but remain above the England averages.
- Around 8,500 children live in poverty and GCSE achievement is low. The proportion of children in Reception year who are classified as obese is higher than the England average. The teenage pregnancy rate is also higher.
- It is estimated that more than 1 in 4 adults smoke, higher than the England average. There are over 320 smoking related deaths each year.
- The rates of alcohol related hospital stays and violent crime are higher than the England average. Excess winter deaths are higher than the England average.
- Priorities for action identified in the Local Area Agreement for Portsmouth include obesity, physical activity, alcohol related harm, violent crime, smoking, child dental health, teenage pregnancy, tackling health inequalities, educational attainment and road deaths and injury.
- For the public health annual report and further information see www.portsmouthcitypct.nhs.uk

Deprivation:
a national view

This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.

This chart shows the percentage of the population in England, this region, and this area who live in each of these quintiles.



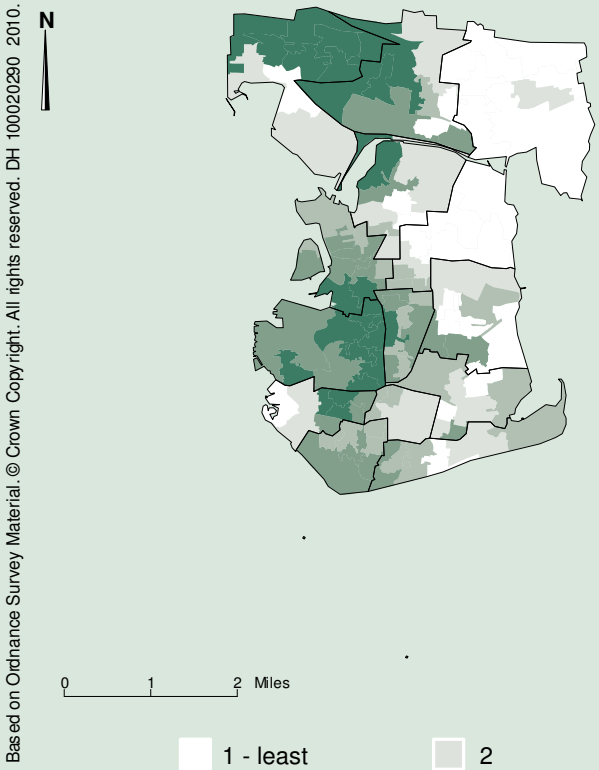


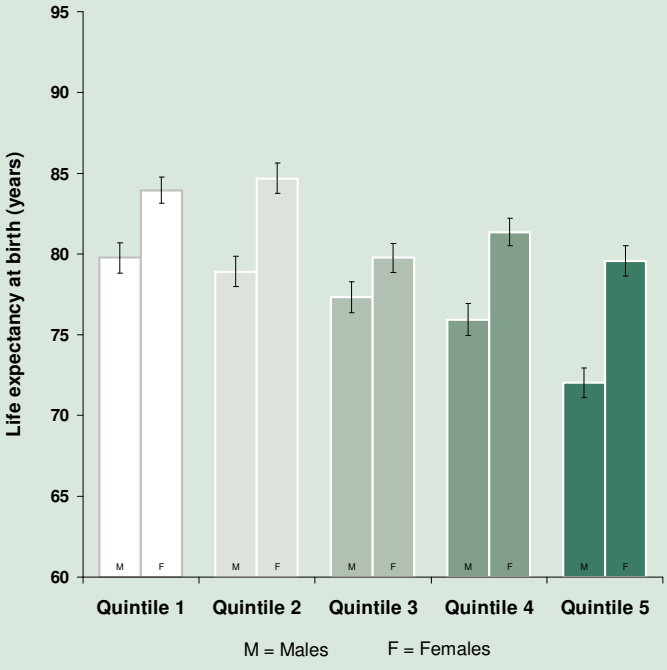
1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities:
a local view

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.

This chart shows the life expectancy at birth for males and females (2004-2008) for each of the quintiles in this area.





95% confidence interval. These indicate the level of uncertainty about each value on the graph. Longer/wider intervals mean more uncertainty.

1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities: **changes over time**

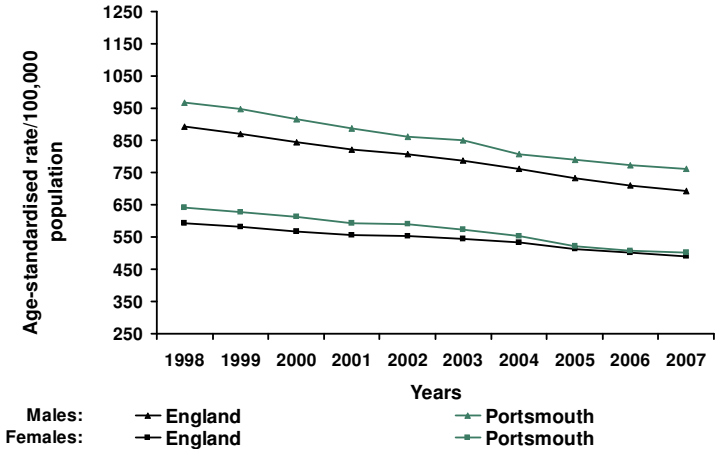
These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

Trend 1 compares rates of death, at all ages and from all causes, in this area with those for England.

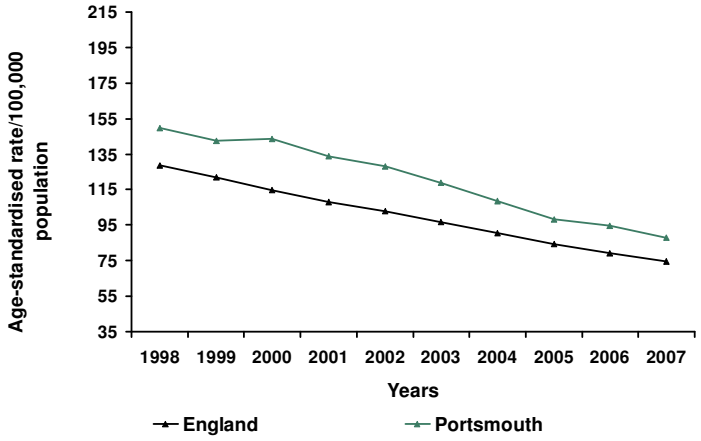
Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

Trend 3 compares rates of early death from cancer (in people under 75) in this area with those for England.

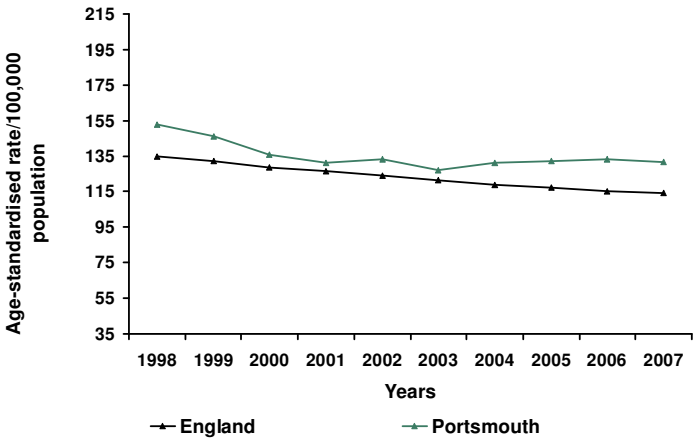
Trend 1:
All age, all cause mortality



Trend 2:
Early death rates from heart disease and stroke

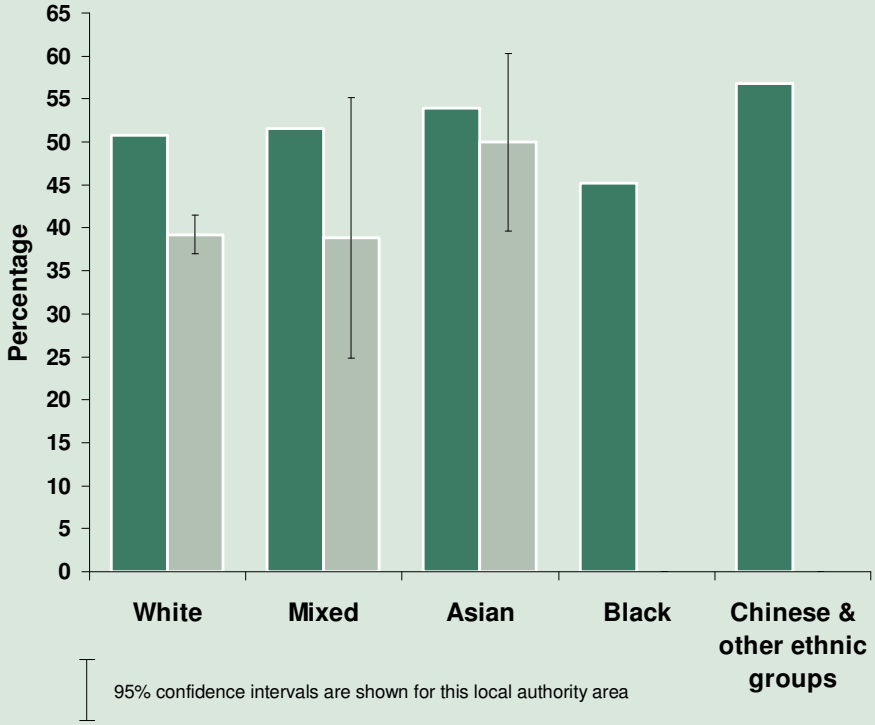


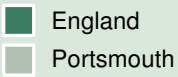
Trend 3:
Early death rates from cancer



Health inequalities: **ethnicity**

This chart shows the percentage of pupils by ethnic group in this area who achieved five GCSEs in 2008/09 (A* to C grades including English and Maths). Comparing results may help find possible inequalities between ethnic groups.





Ethnic Groups	% pupils achieved grades	No. of pupils achieved grades
White	39.2	712
Mixed	38.9	14
Asian	50.0	43
Black		
Chinese/other		

If there are any empty cells in the table this is because data has not been presented where the calculation involved pupil numbers of 0, 1 or 2. Some further groups may not have data presented in order to prevent counts of small numbers being calculated from values for other ethnic groups or areas.

Health summary for Portsmouth

00MR

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

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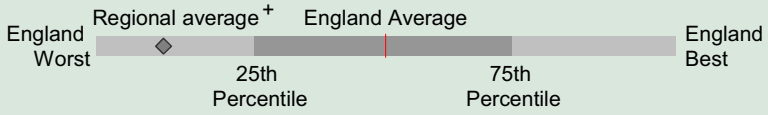
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated



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

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	38109	19.6	19.9	89.2		0.0
	2 Children in poverty	8568	25.3	22.4	66.5		6.0
	3 Statutory homelessness	330	3.95	2.48	9.84		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	788	39.5	50.9	32.1		76.1
	5 Violent crime	4902	24.8	16.4	36.6		4.8
	6 Carbon emissions	1106	5.6	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	425	16.0	14.6	33.5		3.8
	8 Breast feeding initiation	1979	74.5	72.5	39.7		92.7
	9 Physically active children	10893	53.2	49.6	24.6		79.1
	10 Obese children	239	12.5	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	1.1	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	164	49.3	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	27.2	22.2	35.2		10.2
	14 Binge drinking adults	n/a	23.7	20.1	33.2		4.6
	15 Healthy eating adults	n/a	25.4	28.7	18.3		48.1
	16 Physically active adults	n/a	10.6	11.2	5.4		16.6
	17 Obese adults	n/a	22.6	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	36	20.2	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	3725	27.8	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	3913	1900	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	7761	3.88	4.30	6.72		2.69
	23 New cases of tuberculosis	24	12	15	110		0
	24 Hip fracture in over-65s	176	467.1	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	128	24.7	15.6	26.3		2.3
	26 Life expectancy - male	n/a	76.8	77.9	73.6		84.3
	27 Life expectancy - female	n/a	82.0	82.0	78.8		88.9
	28 Infant deaths	9	3.68	4.84	8.67		1.08
	29 Deaths from smoking	327	257.2	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	154	88.1	74.8	125.0		40.1
	31 Early deaths: cancer	229	131.5	114.0	164.3		70.5
	32 Road injuries and deaths	90	45.7	51.3	167.0		14.6

Indicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

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

Rushmoor

updated 28 July 2010

This profile gives a picture of health in this area. It is designed to help local government and health services improve people's health and reduce health inequalities.

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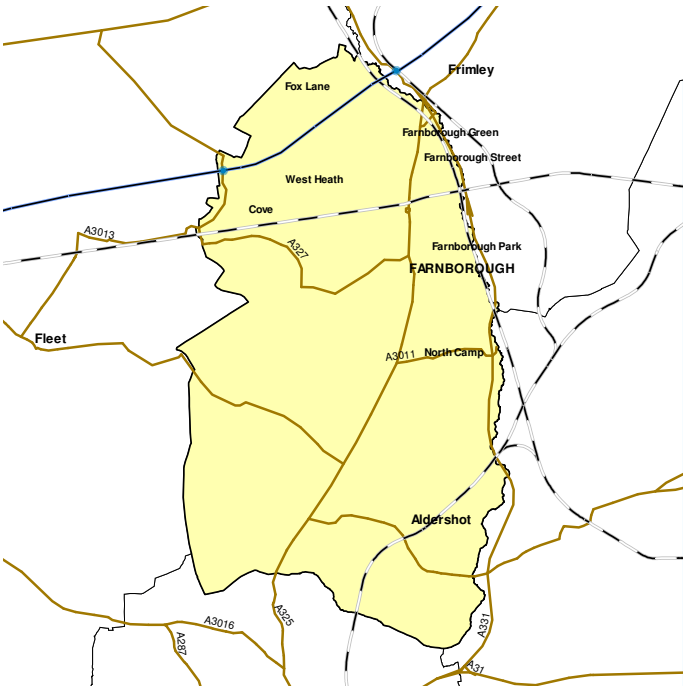


Population 89,600

Mid-2008 population estimate

Source: National Statistics website: www.statistics.gov.uk

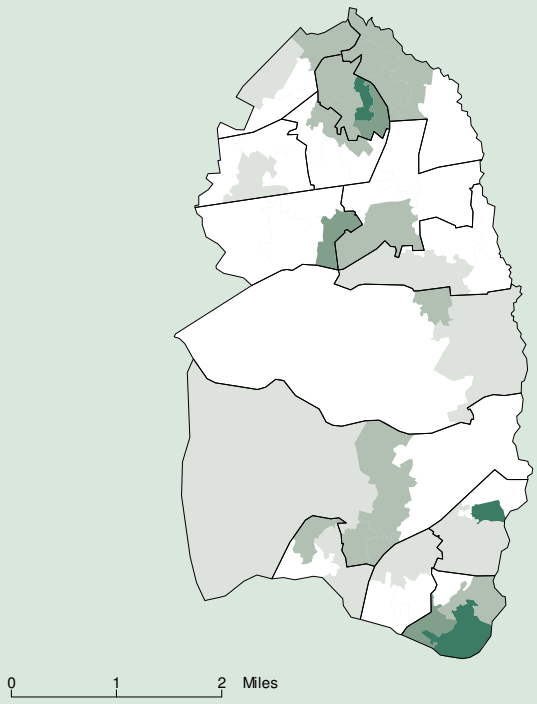
Rushmoor at a glance

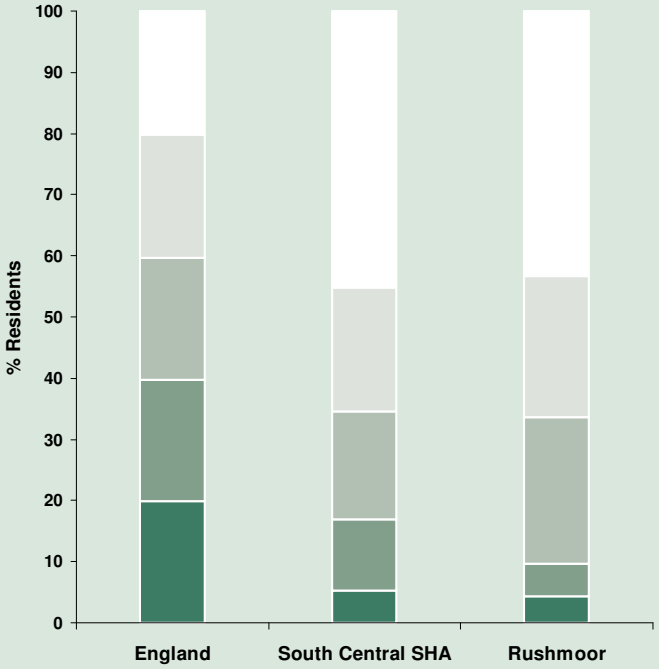
- Overall, health in Rushmoor is similar to the average for England. Deprivation levels and the percentage of children living in poverty are better than the England averages. However, the rate of violent crime is higher than the England average.
- Within Rushmoor, there are inequalities in health. Life expectancy is 7 years lower for men from the most deprived areas compared to those from the least deprived areas. For women the gap is nearly 6 years.
- Over the last 10 years, the early death rate from heart disease and stroke has fallen and is lower than the England average.
- The percentage of children who spend at least 3 hours each week on physical activity in school is higher than the England average. GCSE achievement in state schools is below the England average. The proportion of mothers initiating breastfeeding is higher than average.
- It is estimated that only 1 in 4 adults eat a healthy diet and almost 1 in 4 adults smoke.
- Local priorities highlighted in the Hampshire Local Area Agreement include tackling the rate of death from all causes, child obesity, teenage pregnancy and hospital admissions for alcohol related harm.
- The Hampshire Public Health Annual Report can be found at: www.hampshire.nhs.uk

Deprivation:
a national view

This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.

This chart shows the percentage of the population in England, this region, and this area who live in each of these quintiles.



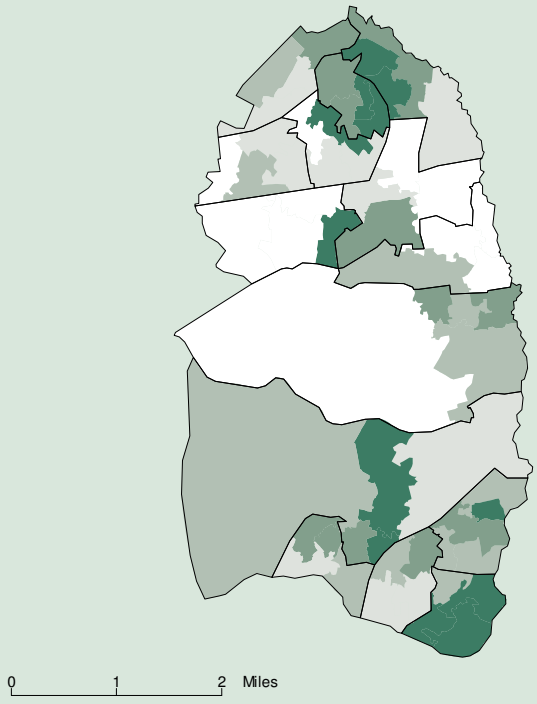


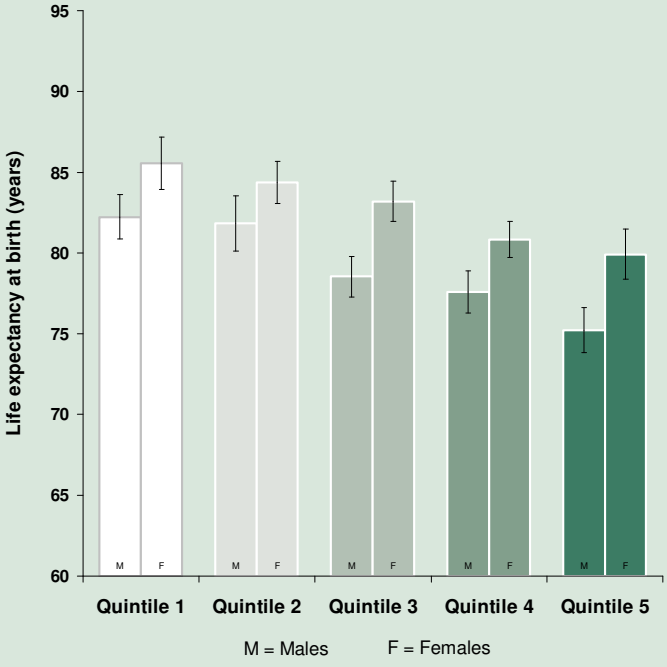
1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities:
a local view

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.

This chart shows the life expectancy at birth for males and females (2004-2008) for each of the quintiles in this area.





95% confidence interval. These indicate the level of uncertainty about each value on the graph. Longer/wider intervals mean more uncertainty.

1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities: **changes over time**

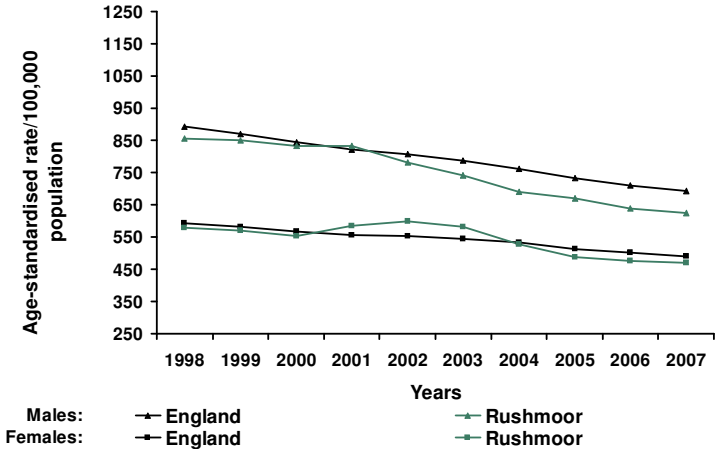
These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

Trend 1 compares rates of death, at all ages and from all causes, in this area with those for England.

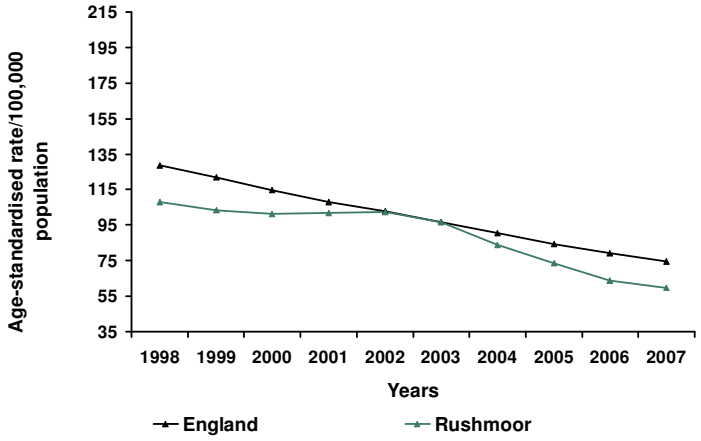
Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

Trend 3 compares rates of early death from cancer (in people under 75) in this area with those for England.

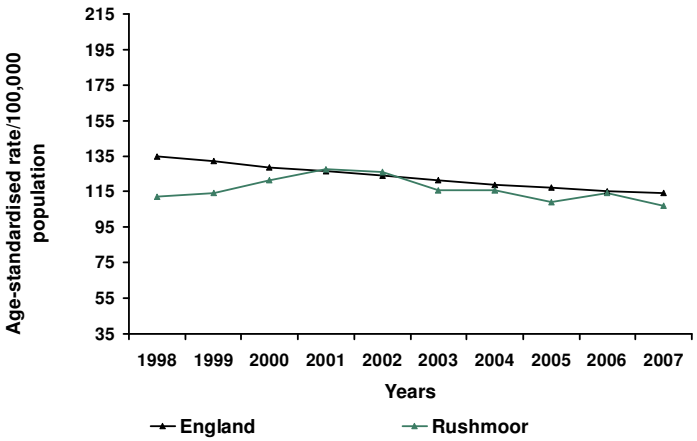
Trend 1:
All age, all cause mortality



Trend 2:
Early death rates from heart disease and stroke

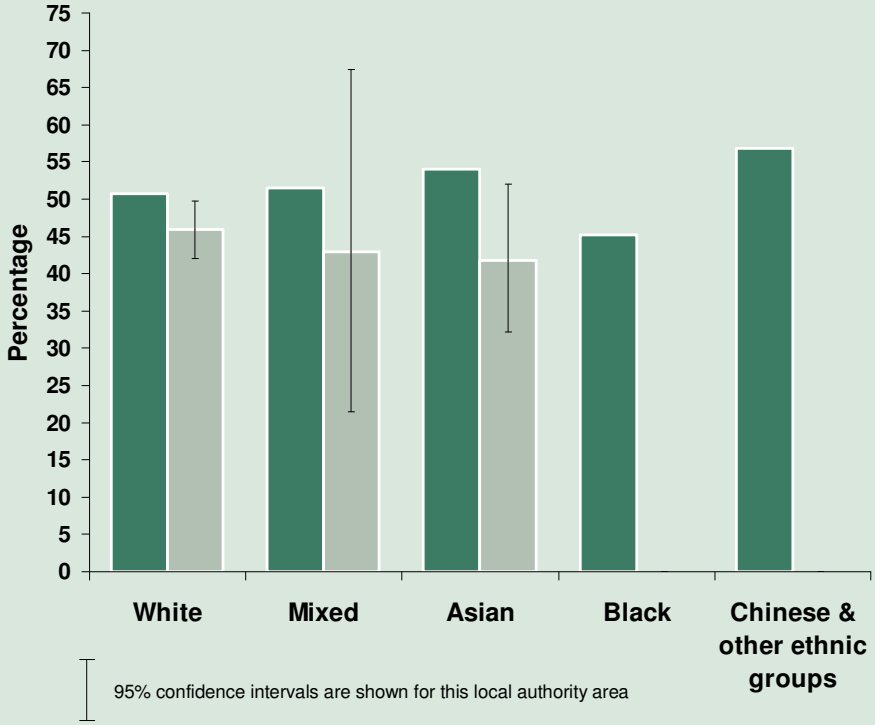


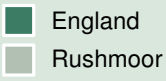
Trend 3:
Early death rates from cancer



Health inequalities: **ethnicity**

This chart shows the percentage of pupils by ethnic group in this area who achieved five GCSEs in 2008/09 (A* to C grades including English and Maths). Comparing results may help find possible inequalities between ethnic groups.





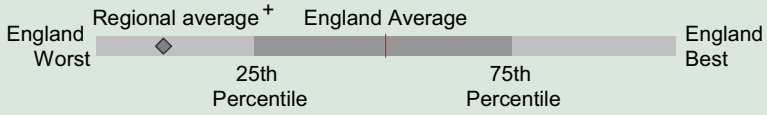
Ethnic Groups	% pupils achieved grades	No. of pupils achieved grades
White	45.9	294
Mixed	42.9	6
Asian	41.8	38
Black		
Chinese/other		

If there are any empty cells in the table this is because data has not been presented where the calculation involved pupil numbers of 0, 1 or 2. Some further groups may not have data presented in order to prevent counts of small numbers being calculated from values for other ethnic groups or areas.

Health summary for Rushmoor

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

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



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

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	3837	4.3	19.9	89.2		0.0
	2 Children in poverty	2718	15.1	22.4	66.5		6.0
	3 Statutory homelessness	20	0.56	2.48	9.84		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	355	45.5	50.9	32.1		76.1
	5 Violent crime	1777	19.9	16.4	36.6		4.8
	6 Carbon emissions	582	6.5	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	162	13.1	14.6	33.5		3.8
	8 Breast feeding initiation	1009	79.7	72.5	39.7		92.7
	9 Physically active children	6013	62.5	49.6	24.6		79.1
	10 Obese children	73	7.8	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	1.0	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	69	41.8	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	23.7	22.2	35.2		10.2
	14 Binge drinking adults	n/a	16.3	20.1	33.2		4.6
	15 Healthy eating adults	n/a	25.9	28.7	18.3		48.1
	16 Physically active adults	n/a	10.7	11.2	5.4		16.6
	17 Obese adults	n/a	25.9	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	8	9.9	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	1120	19.3	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	1800	1910	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	3366	3.76	4.30	6.72		2.69
	23 New cases of tuberculosis	10	11	15	110		0
	24 Hip fracture in over-65s	80	534.7	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	23	11.3	15.6	26.3		2.3
	26 Life expectancy - male	n/a	79.6	77.9	73.6		84.3
	27 Life expectancy - female	n/a	82.6	82.0	78.8		88.9
	28 Infant deaths	3	1.99	4.84	8.67		1.08
	29 Deaths from smoking	110	197.0	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	48	59.9	74.8	125.0		40.1
	31 Early deaths: cancer	87	107.2	114.0	164.3		70.5
	32 Road injuries and deaths	31	34.7	51.3	167.0		14.6

Indicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

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Southampton

updated 28 July 2010

This profile gives a picture of health in this area. It is designed to help local government and health services improve people's health and reduce health inequalities.

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Population 234,600

Mid-2008 population estimate

Source: National Statistics website: www.statistics.gov.uk

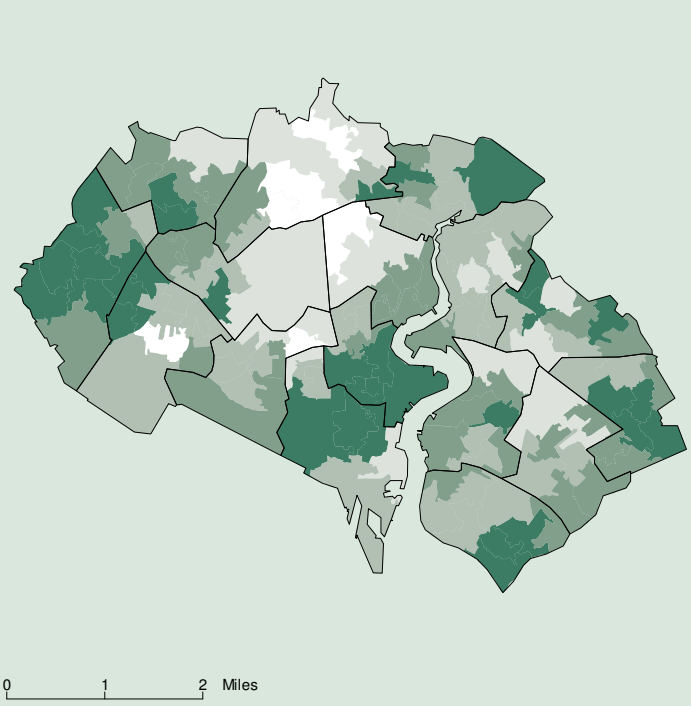
Southampton at a glance

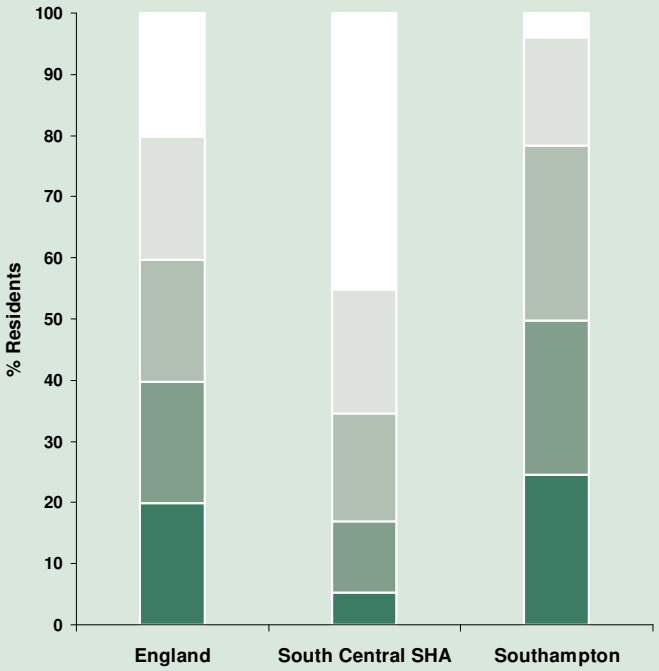
- The health of people living in Southampton is generally worse than the England average.
- Southampton has significant health inequalities. Life expectancy for men from the most deprived areas is over 6 years lower than for those from the least deprived areas. For women the gap is over 4 years.
- Over the last 10 years, the rate of death from all causes for men and women has fallen. Early death rates from cancer, and from heart disease and stroke, have also fallen but remain above the England averages.
- Over 10,700 children live in low income households, and GCSE achievement is below the England average. The percentage of children who spend 3 hours each week on physical activity in school is lower than the England average. The teenage pregnancy rate is higher than the England average.
- The estimated percentage of adults eating healthy food is low, as are adult physical activity rates. It is estimated that more than 1 in 4 adults smoke, and smoking in pregnancy is high compared to England.
- The reported rate of violent crime is one of the highest in England.
- Priorities for action identified in the Local Area Agreement for Southampton include violent crime, drug misuse, obesity, smoking and teenage pregnancy.
- Further information is available from the Annual Public Health Report, the Joint Strategic Needs Assessment, and the Local Health Comparison at: www.southamptonhealth.nhs.uk/publichealth

Deprivation: **a national view**

This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.

This chart shows the percentage of the population in England, this region, and this area who live in each of these quintiles.





1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities: **a local view**

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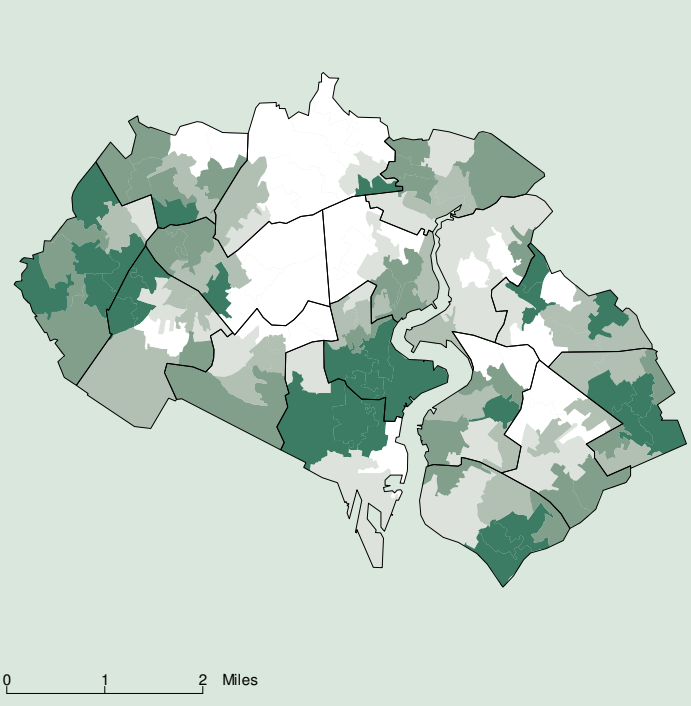
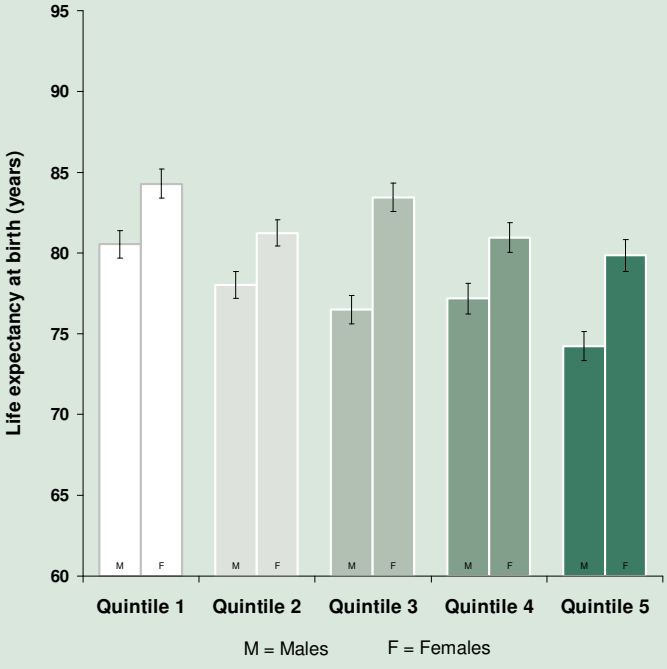
This chart shows the life expectancy at birth for males and females (2004-2008) for each of the quintiles in this area.





95% confidence interval. These indicate the level of uncertainty about each value on the graph. Longer/wider intervals mean more uncertainty.

1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities: **changes over time**

These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

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Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

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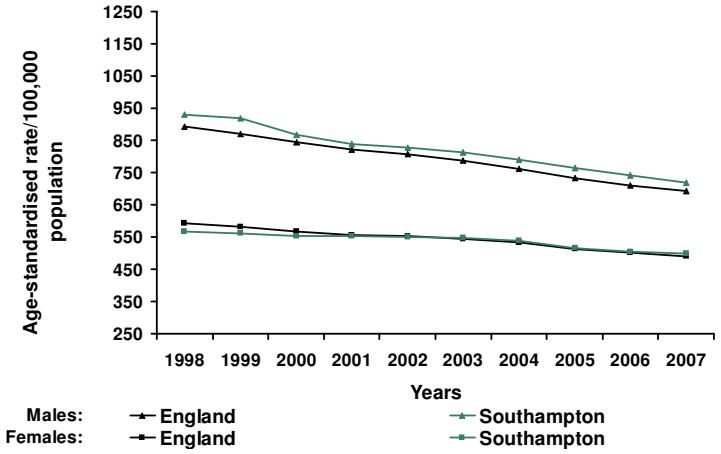
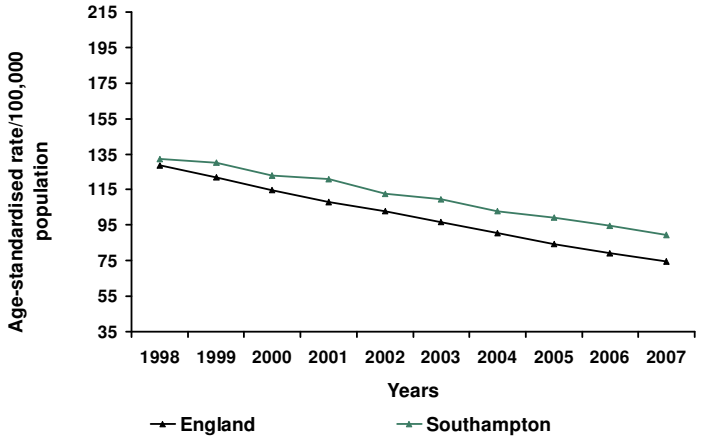
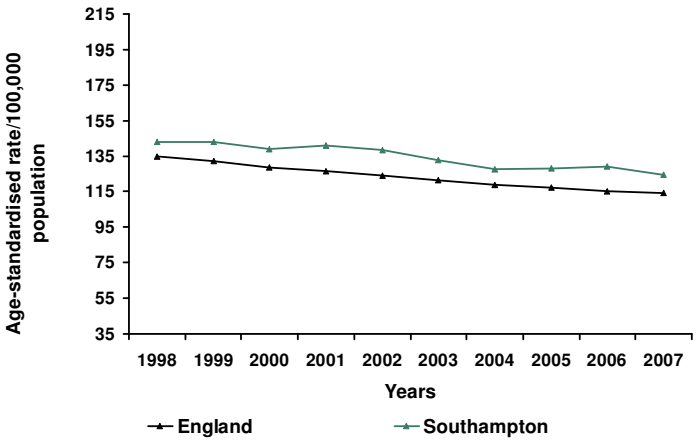
Trend 1:
All age, all cause mortality



Trend 2:
Early death rates from heart disease and stroke

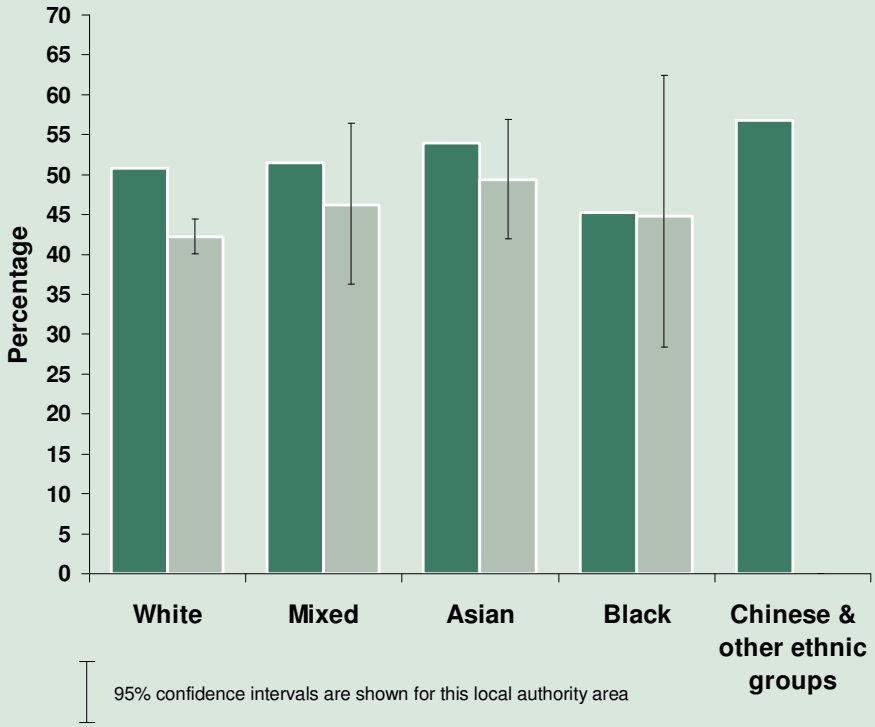


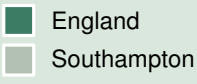
Trend 3:
Early death rates from cancer



Health inequalities: **ethnicity**

This chart shows the percentage of pupils by ethnic group in this area who achieved five GCSEs in 2008/09 (A* to C grades including English and Maths). Comparing results may help find possible inequalities between ethnic groups.





Ethnic Groups	% pupils achieved grades	No. of pupils achieved grades
White	42.2	820
Mixed	46.2	42
Asian	49.4	82
Black	44.8	13
Chinese/other		

If there are any empty cells in the table this is because data has not been presented where the calculation involved pupil numbers of 0, 1 or 2. Some further groups may not have data presented in order to prevent counts of small numbers being calculated from values for other ethnic groups or areas.

Health summary for Southampton

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

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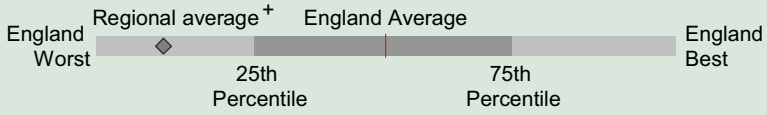
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated



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

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	55719	24.6	19.9	89.2		0.0
	2 Children in poverty	10752	28.4	22.4	66.5		6.0
	3 Statutory homelessness	188	1.92	2.48	9.84		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	972	43.1	50.9	32.1		76.1
	5 Violent crime	8222	35.6	16.4	36.6		4.8
	6 Carbon emissions	1280	5.5	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	583	17.0	14.6	33.5		3.8
	8 Breast feeding initiation	2538	75.9	72.5	39.7		92.7
	9 Physically active children	9796	41.2	49.6	24.6		79.1
	10 Obese children	200	9.3	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	1.1	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	203	53.7	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	26.0	22.2	35.2		10.2
	14 Binge drinking adults	n/a	17.9	20.1	33.2		4.6
	15 Healthy eating adults	n/a	25.4	28.7	18.3		48.1
	16 Physically active adults	n/a	9.2	11.2	5.4		16.6
	17 Obese adults	n/a	22.3	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	40	19.7	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	4650	28.9	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	3259	1360	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	9288	3.96	4.30	6.72		2.69
	23 New cases of tuberculosis	30	13	15	110		0
	24 Hip fracture in over-65s	207	482.5	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	109	18.5	15.6	26.3		2.3
	26 Life expectancy - male	n/a	77.6	77.9	73.6		84.3
	27 Life expectancy - female	n/a	82.1	82.0	78.8		88.9
	28 Infant deaths	15	4.75	4.84	8.67		1.08
	29 Deaths from smoking	354	246.1	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	175	89.3	74.8	125.0		40.1
	31 Early deaths: cancer	240	124.5	114.0	164.3		70.5
	32 Road injuries and deaths	90	39.1	51.3	167.0		14.6

Indicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

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

Test Valley

updated 28 July 2010

This profile gives a picture of health in this area. It is designed to help local government and health services improve people's health and reduce health inequalities.

Health Profiles are produced every year by the Association of Public Health Observatories.

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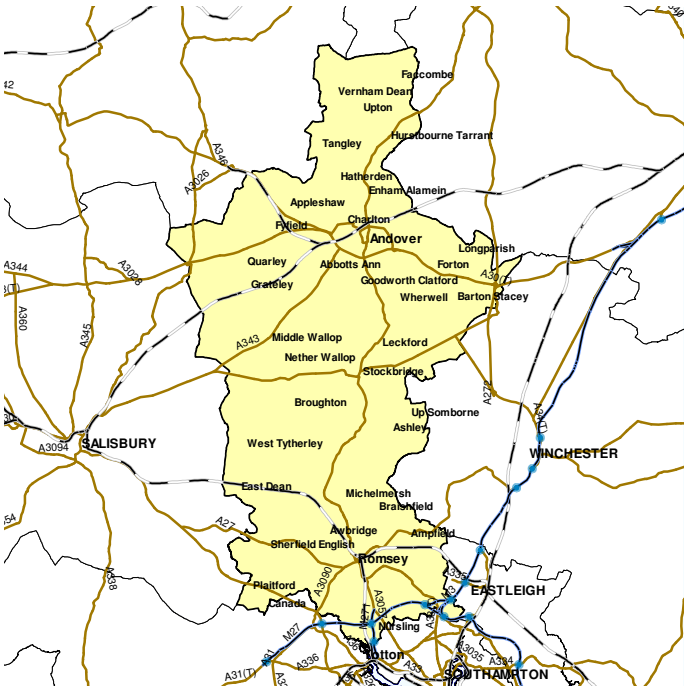


Population 115,400

Mid-2008 population estimate

Source: National Statistics website: www.statistics.gov.uk

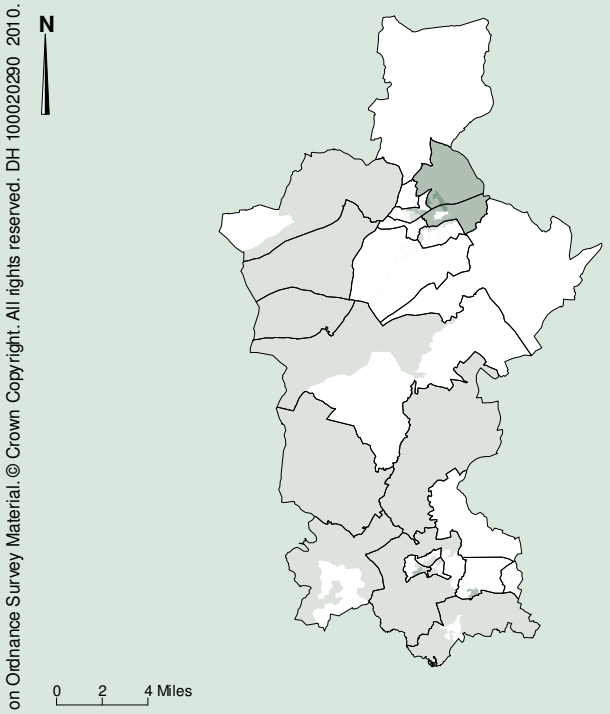
Test Valley at a glance

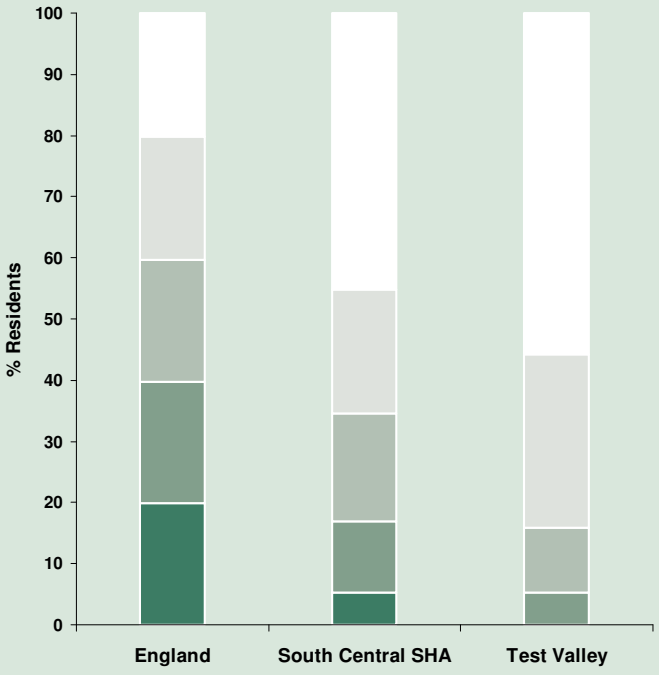
- The health of people in Test Valley is generally better than the England average. Life expectancy is high for both men and women. The rate of early death from cancer is lower than the England average.
- There are inequalities in health between areas within Test Valley. Life expectancy for men from the most deprived areas is around 4 years lower than for men from the least deprived areas.
- Over the last 10 years, rates of death from all causes and of early deaths from cancer and from heart disease and stroke, have all fallen and are lower than the England averages.
- Around 1 in 12 children in Reception year are classified as obese, similar to the England average.
- Although Test Valley has a low rate of child poverty, there are still around 2,300 children living in low income households.
- Estimates suggest that 18% of adults smoke, 19% binge drink and 23% are obese, similar to the England averages.
- Although the rate of hospital stays for alcohol related harm is lower than the England average, there were over 1,400 hospital stays in 2008/09.
- Local priorities highlighted in the Hampshire Local Area Agreement include tackling the rate of death from all causes, child obesity, teenage pregnancy and hospital admissions for alcohol related harm.
- The Hampshire Public Health Annual Report can be found at: www.hamphsire.nhs.uk

Deprivation:
a national view

This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.

This chart shows the percentage of the population in England, this region, and this area who live in each of these quintiles.



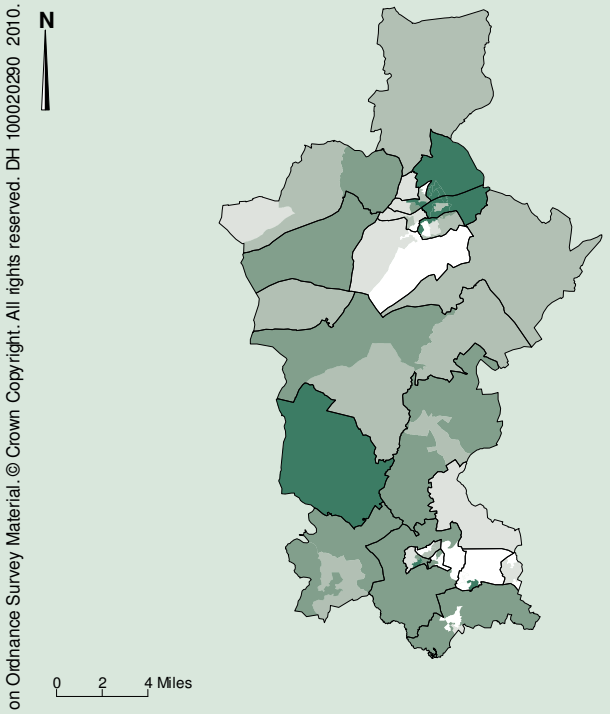


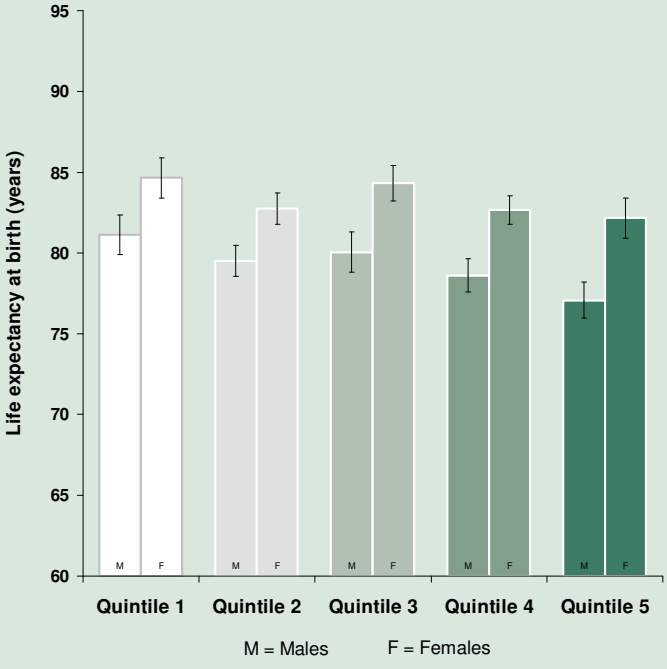
1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities:
a local view

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.

This chart shows the life expectancy at birth for males and females (2004-2008) for each of the quintiles in this area.





95% confidence interval. These indicate the level of uncertainty about each value on the graph. Longer/wider intervals mean more uncertainty.

1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities: **changes over time**

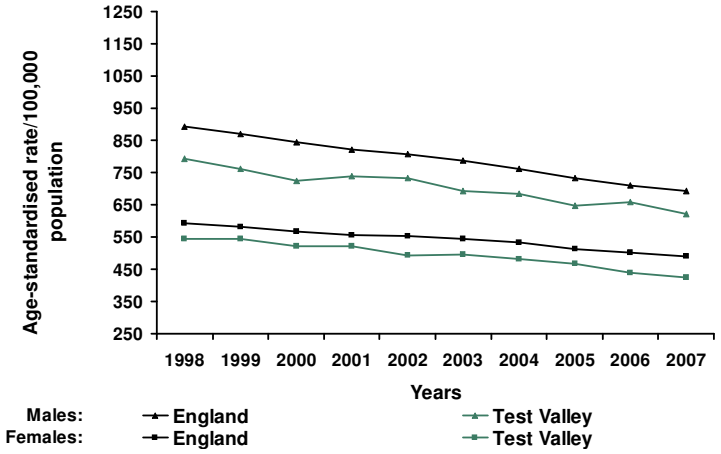
These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

Trend 1 compares rates of death, at all ages and from all causes, in this area with those for England.

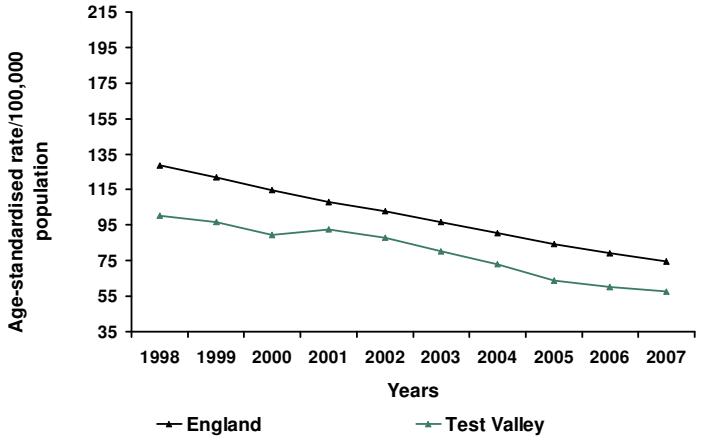
Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

Trend 3 compares rates of early death from cancer (in people under 75) in this area with those for England.

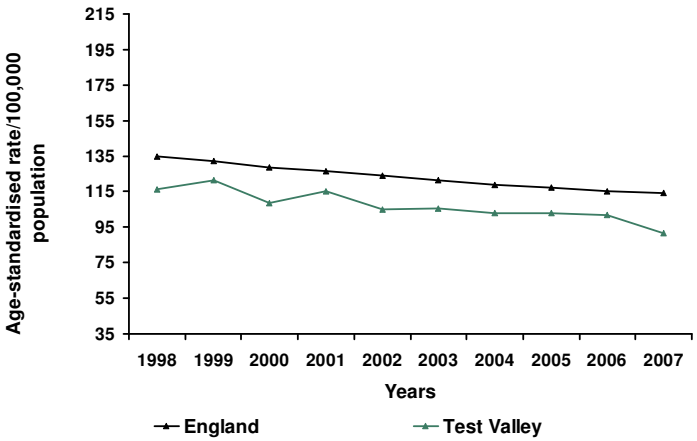
Trend 1:
All age, all cause mortality



Trend 2:
Early death rates from heart disease and stroke

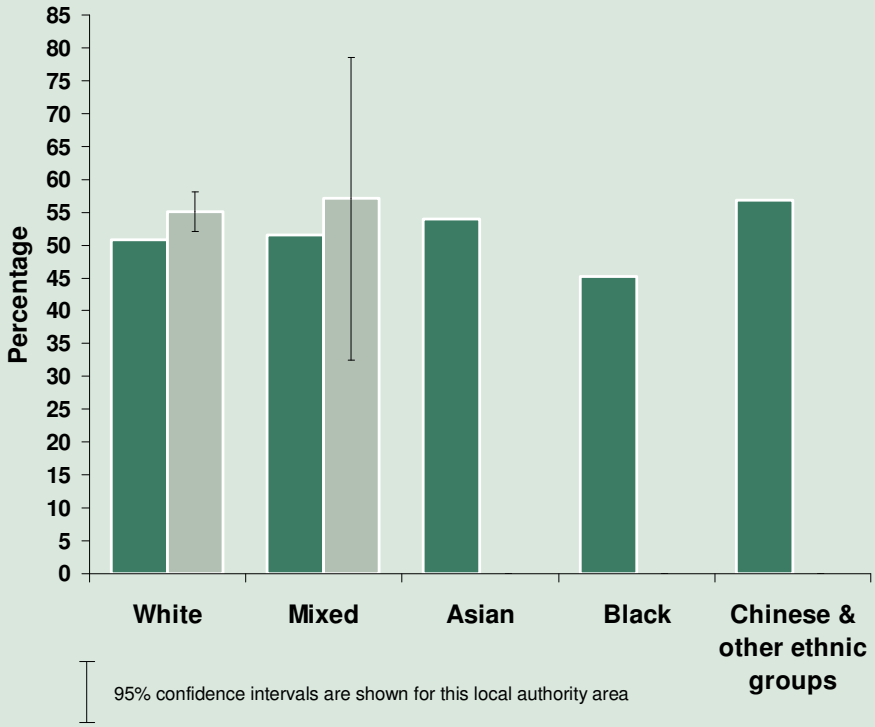


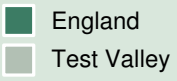
Trend 3:
Early death rates from cancer



Health inequalities: **ethnicity**

This chart shows the percentage of pupils by ethnic group in this area who achieved five GCSEs in 2008/09 (A* to C grades including English and Maths). Comparing results may help find possible inequalities between ethnic groups.





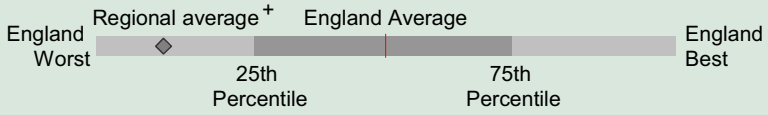
Ethnic Groups	% pupils achieved grades	No. of pupils achieved grades
White	55.1	582
Mixed	57.1	8
Asian		
Black		
Chinese/other		

If there are any empty cells in the table this is because data has not been presented where the calculation involved pupil numbers of 0, 1 or 2. Some further groups may not have data presented in order to prevent counts of small numbers being calculated from values for other ethnic groups or areas.

Health summary for Test Valley

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

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



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

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	0	0.0	19.9	89.2		0.0
	2 Children in poverty	2296	10.0	22.4	66.5		6.0
	3 Statutory homelessness	13	0.28	2.48	9.84		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	619	54.6	50.9	32.1		76.1
	5 Violent crime	1671	14.6	16.4	36.6		4.8
	6 Carbon emissions	896	7.8	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	160	13.1	14.6	33.5		3.8
	8 Breast feeding initiation	994	79.7	72.5	39.7		92.7
	9 Physically active children	7980	58.8	49.6	24.6		79.1
	10 Obese children	100	8.5	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	0.7	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	70	31.5	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	18.1	22.2	35.2		10.2
	14 Binge drinking adults	n/a	19.1	20.1	33.2		4.6
	15 Healthy eating adults	n/a	29.6	28.7	18.3		48.1
	16 Physically active adults	n/a	13.5	11.2	5.4		16.6
	17 Obese adults	n/a	23.0	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	26	21.7	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	998	14.3	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	1420	996	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	4048	3.51	4.30	6.72		2.69
	23 New cases of tuberculosis	4	3	15	110		0
	24 Hip fracture in over-65s	136	531.7	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	46	14.7	15.6	26.3		2.3
	26 Life expectancy - male	n/a	79.6	77.9	73.6		84.3
	27 Life expectancy - female	n/a	83.7	82.0	78.8		88.9
	28 Infant deaths	6	4.76	4.84	8.67		1.08
	29 Deaths from smoking	143	153.9	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	76	57.4	74.8	125.0		40.1
	31 Early deaths: cancer	119	91.4	114.0	164.3		70.5
	32 Road injuries and deaths	67	58.1	51.3	167.0		14.6

Indicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

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Winchester

updated 28 July 2010

This profile gives a picture of health in this area. It is designed to help local government and health services improve people's health and reduce health inequalities.

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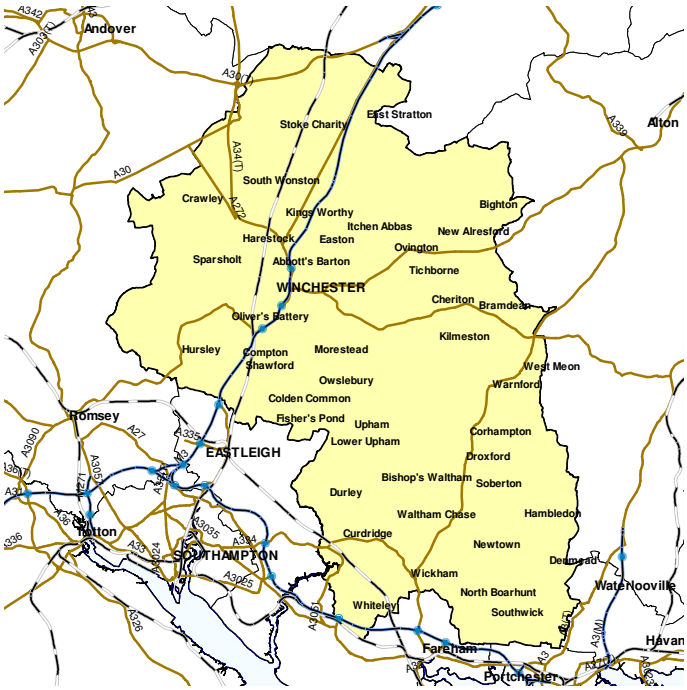


Population 112,700

Mid-2008 population estimate

Source: National Statistics website: www.statistics.gov.uk

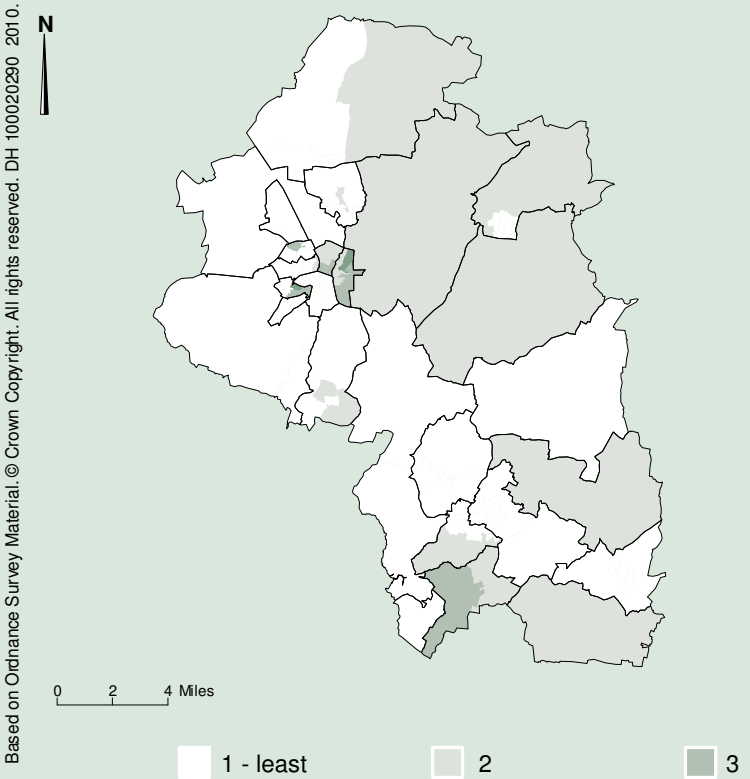
Winchester at a glance

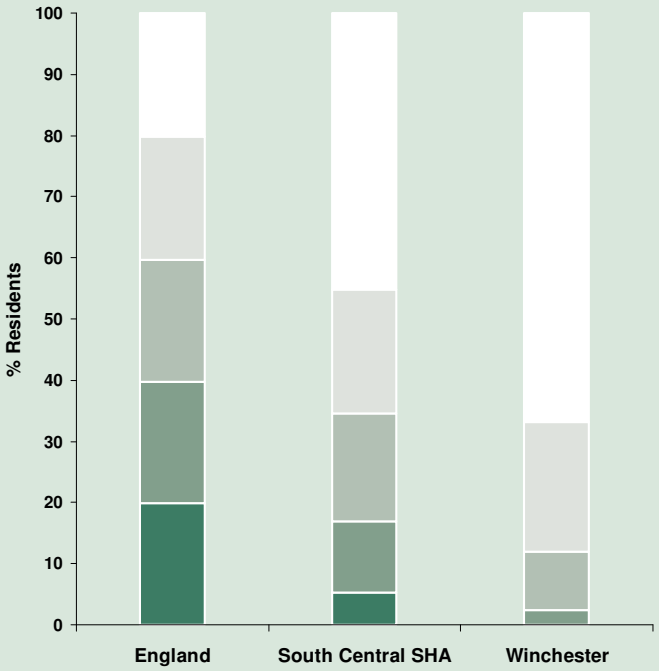
- The health of people in Winchester is generally better than the England average. Over two thirds of residents live in areas classified as among the least deprived in England and life expectancy is high.
- There are inequalities in health within Winchester. Life expectancy for men living in the most deprived areas is 4 years lower than for those living in the least deprived areas. For women, the gap is almost 5 years.
- Over the last 10 years, the rate of death from all causes, and of early death from heart disease and stroke, have fallen and are below the England average.
- The rate of death or serious injury on the roads in Winchester is higher than the England average.
- Although the proportion of children living in poverty is below the England average, there are almost 1,800 children living in low income households in Winchester.
- GCSE achievement in 2008/09 was higher than the England average.
- An estimated 14% of adults smoke, lower than the England average, but there are around 140 smoking related deaths each year.
- The rate of new cases of malignant melanoma skin cancer is higher than the England average.
- Local priorities highlighted in the Hampshire Local Area Agreement include tackling the rate of death from all causes, child obesity, teenage pregnancy and hospital admissions for alcohol related harm.
- The Hampshire Public Health Annual Report can be found at www.hampshire.nhs.uk

Deprivation:
a national view

This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.

This chart shows the percentage of the population in England, this region, and this area who live in each of these quintiles.



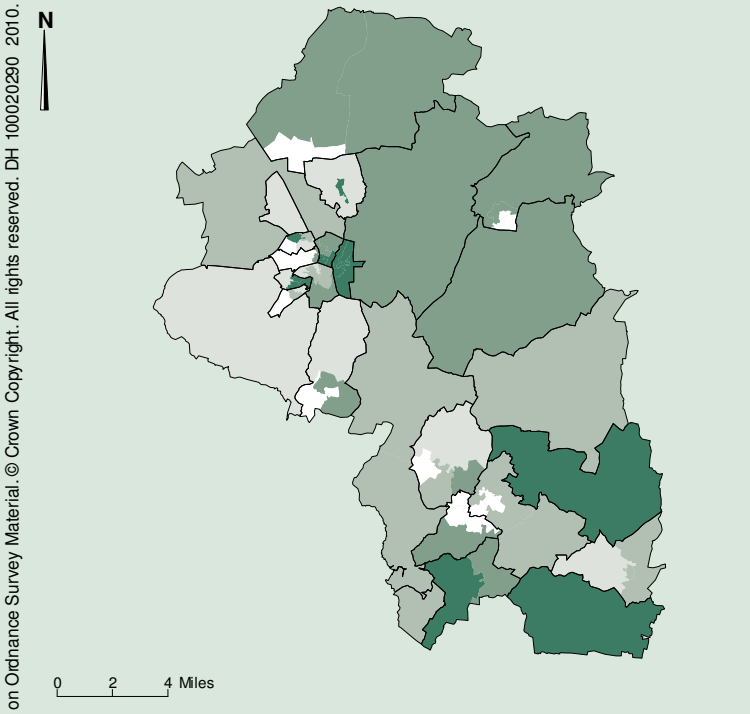


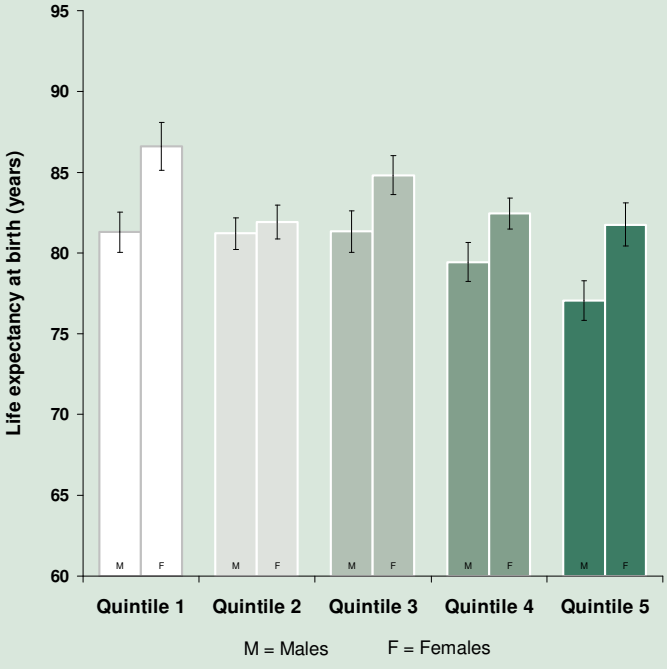
1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities:
a local view

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.

This chart shows the life expectancy at birth for males and females (2004-2008) for each of the quintiles in this area.





95% confidence interval. These indicate the level of uncertainty about each value on the graph. Longer/wider intervals mean more uncertainty.

1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities: **changes over time**

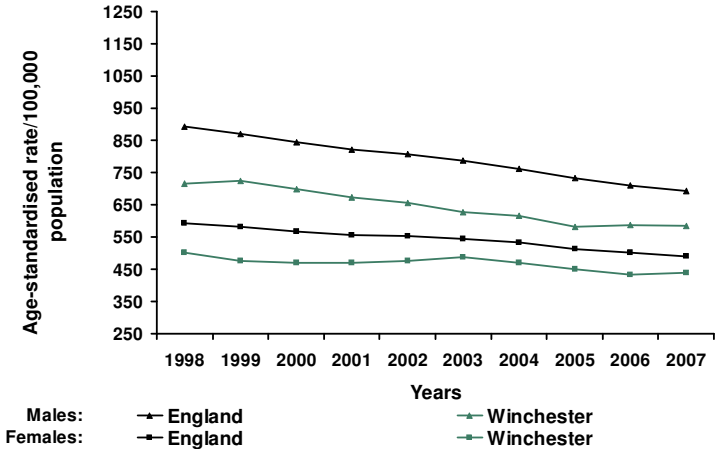
These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

Trend 1 compares rates of death, at all ages and from all causes, in this area with those for England.

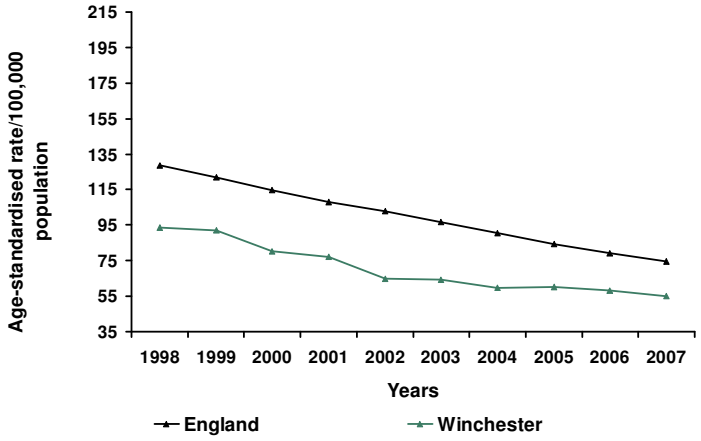
Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

Trend 3 compares rates of early death from cancer (in people under 75) in this area with those for England.

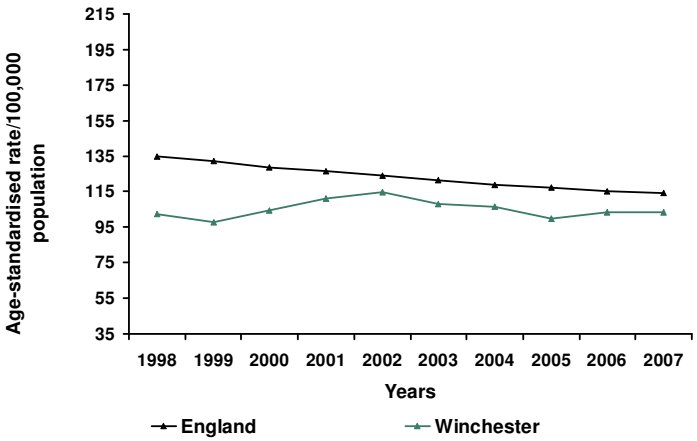
Trend 1:
All age, all cause mortality



Trend 2:
Early death rates from heart disease and stroke



Trend 3:
Early death rates from cancer



Health inequalities: **ethnicity**

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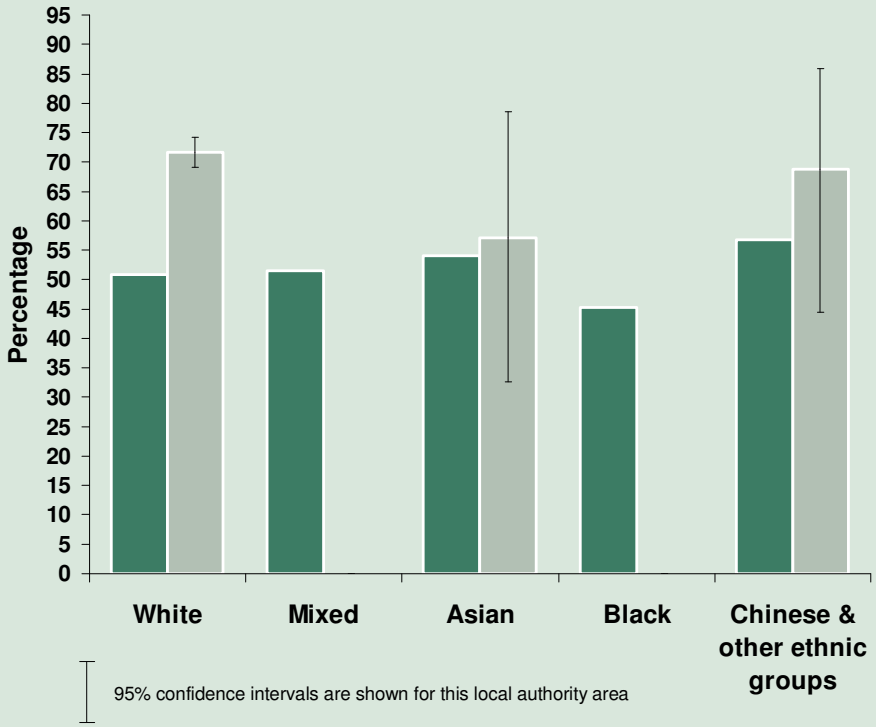
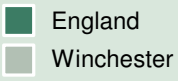




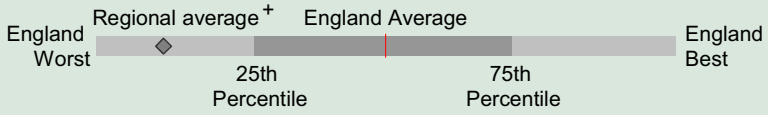
Ethnic Groups	% pupils achieved grades	No. of pupils achieved grades
White	71.7	831
Mixed		
Asian	57.1	8
Black		
Chinese/other	68.8	11

If there are any empty cells in the table this is because data has not been presented where the calculation involved pupil numbers of 0, 1 or 2. Some further groups may not have data presented in order to prevent counts of small numbers being calculated from values for other ethnic groups or areas.

Health summary for Winchester

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

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



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

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	0	0.0	19.9	89.2		0.0
	2 Children in poverty	1788	8.6	22.4	66.5		6.0
	3 Statutory homelessness	32	0.72	2.48	9.84		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	872	71.4	50.9	32.1		76.1
	5 Violent crime	1513	13.6	16.4	36.6		4.8
	6 Carbon emissions	934	8.4	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	145	13.1	14.6	33.5		3.8
	8 Breast feeding initiation	903	79.7	72.5	39.7		92.7
	9 Physically active children	7180	57.1	49.6	24.6		79.1
	10 Obese children	82	8.5	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	0.4	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	45	21.2	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	13.9	22.2	35.2		10.2
	14 Binge drinking adults	n/a	22.2	20.1	33.2		4.6
	15 Healthy eating adults	n/a	33.6	28.7	18.3		48.1
	16 Physically active adults	n/a	13.3	11.2	5.4		16.6
	17 Obese adults	n/a	17.9	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	20	17.6	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	1095	16.2	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	1449	1020	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	3595	3.19	4.30	6.72		2.69
	23 New cases of tuberculosis	1	1	15	110		0
	24 Hip fracture in over-65s	115	407.5	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	62	19.0	15.6	26.3		2.3
	26 Life expectancy - male	n/a	80.0	77.9	73.6		84.3
	27 Life expectancy - female	n/a	83.2	82.0	78.8		88.9
	28 Infant deaths	3	2.77	4.84	8.67		1.08
	29 Deaths from smoking	140	144.8	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	70	55.3	74.8	125.0		40.1
	31 Early deaths: cancer	129	103.2	114.0	164.3		70.5
	32 Road injuries and deaths	97	87.5	51.3	167.0		14.6

Indicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

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

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DECISION-MAKER:	**HEALTH OVERVIEW AND SCRUTINY PANEL**
SUBJECT:	1. ADULT MENTAL HEALTH REDESIGN 2. TRANSFORMING OLDER PEOPLES MENTAL HEALTH SERVICES (VERBAL UPDATE)
DATE OF DECISION:	22 June 2011
REPORT OF:	PAM SORENSEN HEAD OF CONSUMER EXPERIENCE & ENGAGEMENT SOUTHERN HEALTH NHS FOUNDATION TRUST
STATEMENT OF CONFIDENTIALITY Not applicable	
None.	

BRIEF SUMMARY

Following on from previous engagement of the panel in respect of positive developments for services in Southampton, to receive a presentation from Southern Health NHS Foundation Trust Adult Mental Health Directorate in connection with proposals to re locate services in Southampton**.**

To receive a verbal update in connection with Southern Health NHS Foundation Trust's consultation concerning Older People's Mental Health services in the Southampton and South West Hampshire area.

RECOMMENDATIONS:

(i) To note and comment with regard the level and range of current and planned engagement activity in respect of proposals to relocate Adult Mental Health Services in the Southampton area and to advise with regard the need for formal consultation in respect of these proposals.

(ii) To note the consultation activity in relation to Older People's Mental Health and receive a verbal update in relation to the feedback received.

REASONS FOR REPORT RECOMMENDATIONS

1. To enable the panel to advise with regard the requirement to consider formal consultation in respect of the proposals within Adult Mental Health.

2. To be assured that Southern Health have properly and adequately consulted with regard Older People's Mental Health services in the Southampton and South West Hampshire area.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. N/A

DETAIL (Including consultation carried out) None

4. **Adult Mental Health Services**

We wish to engage the panel with regard our proposal to change the use of ten beds in the new purpose-built acute inpatient unit, Antelope House which is located on the Royal South Hants Hospital site. The proposal is that these beds are provided for service users with reablement needs whose illness also means they have challenging behaviour.

This function is currently provided at Abbotts Lodge in Netley where there are 16 beds. The unit is geographically isolated and the quality of the building, and grounds, is poor.

5. Within the service provision operated by Southampton Area, there is a longstanding arrangement for six rehabilitation beds to be provided to Hampshire residents. This dates back to the large hospital closure programme (Knowle Hospital, Fareham). Through this proposal, the provision of these 6 beds would transfer to Hollybank in Havant. With the transfer of 10 beds for Southampton residents to Antelope House and the transfer of 6 beds for Hampshire residents to Hollybank, Havant, the Abbotts Lodge building would no longer be needed.

6. **Older People Mental Health Services**

The panel heard at the last meeting the level and depth of engagement in connection with its proposals for Older People's Mental Health services and a 6 week consultation was agreed. Members will receive a verbal update with regard progress of the consultation.

RESOURCE IMPLICATIONS

Capital/Revenue

7. None

Property/Other

8. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

9. 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:

10. None

POLICY FRAMEWORK IMPLICATIONS

11. None

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KEY DECISION? Yes/No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

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

Appendices

1.	N/A

Documents In Members' Rooms

1.	N/A

Integrated Impact Assessment

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

Other Background Documents

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

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

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DECISION-MAKER:	**HEALTH OVERVIEW & SCRUTINY PANEL**
SUBJECT:	***HEALTHWATCH* SOUTHAMPTON AND TRANSITIONAL LINK SUPPORT ARRANGEMENTS**
DATE OF DECISION:	**22ND JUNE 2011**
REPORT OF:	**HEALTH & ADULT SOCIAL CARE - HEAD OF INTEGRATED STRATEGIC COMMISSIONING**
STATEMENT OF CONFIDENTIALITY	
None.	

BRIEF SUMMARY

This report updates members of the Health Overview & Scrutiny Panel on progress towards the establishment of a local *HealthWatch* pathfinder project and new support arrangements for Southampton's LINk (S-LINk) that continues to be a statutory requirement during the period of transition.

The briefing also outlines plans for Southampton City Council's contribution to a Department of Health-sponsored local *HealthWatch* Pathfinder programme – in partnership with Hampshire County Council, the Isle of Wight Council and Portsmouth City Council – and brief details of the expected outcomes and key milestones (see Appendix).

RECOMMENDATIONS:

(i) To note the new arrangements for supporting Southampton's Local Involvement Network (LINk) from 1st July 2011.

(ii) To note and comment on the plans being put in place for establishing a new local *HealthWatch* organisation for the City to replace the current LINk, following legislation later this year.

REASONS FOR REPORT RECOMMENDATIONS

1. The Local Government and Public Involvement in Health Act 2007 requires local authorities to make necessary arrangements to support a Local Involvement Network (LINk) for their area. This Act remains in force until such time as new legislation (in the form of the Health and Social Care Bill) supersedes it.

2. Following the government's response to the NHS Future Forum's recommendations it is likely that the proposed reforms leading to the creation of local *HealthWatch* organisations as a replacement for LINks will be agreed later this year with an anticipated implementation date of July 2012.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. Both the City Council and the LINk are keen to contract with a local provider of host services for the LINk when the current contract with HAPUK ends in

June 2011; due to the short length of the new contract period and the relatively low contract price it has been possible to secure an exemption from an open tendering exercise and reduce costs associated with this.

4. The Department of Health has encouraged local authorities to take part in a programme of local *HealthWatch* pathfinders and 74 applications have been received including a combined bid from Southampton, Hampshire, Isle of Wight and Portsmouth Councils. The rationale for this collaborative approach (rather than the City Council working in isolation) is to explore opportunities for jointly procuring elements of *HealthWatch*, thereby potentially saving money.

DETAIL (Including consultation carried out)

5. **New Host Arrangements for Southampton's LINk**

Negotiations at an officer level have now been completed between Southampton Voluntary Services (SVS) and members of the S-LINk steering group about the provision of host services for the LINk covering a 9 month period from 1st July 2011 prior to the anticipated establishment of new replacement local *HealthWatch* organisations in 2012.

6. **Southampton, Hampshire, Isle of Wight & Portsmouth (SHIP) *HeathWatch* Pathfinder Programme**

The City Council, working in partnership with the Hampshire & Isle of Wight Local Government Association and Hampshire County, Isle of Wight and Portsmouth City Councils has agreed to establish a collaborative *HealthWatch* Pathfinder programme.

7. The local authorities from across Hampshire and the Isle of Wight have identified four key themes that will form the work programme during the first preparatory phase of local *HealthWatch* development:

A. identifying synergies with other components of the NHS and social care transformation agenda and developing organisational models for each local *HealthWatch* so that they can add real value to the local health and social care economy

B. maintaining and strengthening current LINk activities in order to provide a strong legacy for the incoming *HealthWatch* organisations

C. developing local authority commissioning capacity to enable effective delivery of new *HealthWatch* functions in respect of greater choice

D. exploring options for the joint procurement of new *HealthWatch* functions in respect of an NHS Independent Complaints Advocacy Service

8. During the second (implementation) phase of *HealthWatch* development it will be necessary to use and apply the learning from the above to inform

implementation and transition plans. The key post-legislative themes to address here will be:

E. effective sourcing and procurement of new *HealthWatch* organisations

F. development of the skills and competencies of local individuals and organisations who will be involved in *HealthWatch* by building on the legacy of LINks and other local systems for service user/ patient and public involvement

9. Southampton City Council will take the lead across the SHIP local authority area on how best to procure Independent NHS Complaints Advocacy Services (ICAS) when responsibility for this transfers to local authorities from the DH in 2012/13. This will also entail consideration of how local *HealthWatch* can add benefit to local adult safeguarding procedures.

RESOURCE IMPLICATIONS

Capital/Revenue

10. The Council's budget for supporting LINks and preparing for *HealthWatch* during 2011/12 is £140,600. A further £50,000 is potentially available in the contingency reserve should this be required following legislation.

Property/Other

11. The work programmes for the SHIP *HealthWatch* Pathfinder will be further developed and refined at a stakeholder conference taking place in Portsmouth on 24th June 2011.

12. The timetable that needs to be followed by the City Council in establishing *HealthWatch* Southampton is broadly outlined in the Appendix. It is anticipated that the *HealthWatch* Southampton Transition Project will commence in September 2011 and run in two phases (preparatory and implementation) for a period of about 9 months.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

13. The new contract for providing host service to Southampton's LINk needs to be in place by 1st July 2011.

Other Legal Implications:

none

POLICY FRAMEWORK IMPLICATIONS

none

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KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	ALL

SUPPORTING DOCUMENTATION

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

Appendices

1.	Draft Time Table for the Transition to *HealthWatch* Southampton

Documents In Members' Rooms

1.	none

Integrated Impact Assessment

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

Other Background Documents

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

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

Appendix Draft Time Table for the Transition to *HealthWatch* Southampton

1. Preparatory Phase

week ending	Key Milestone/ Deliverable
24/06/11	Health & Social Care Bill resumes Parliamentary Passage
24/06/11	SHIP *HealthWatch* Pathfinder Project Stakeholder Event in Portsmouth
08/07/11	SHIP *HealthWatch* Pathfinder Project Team finalise work programme
09/09/11	City Council appoints local *HealthWatch* project manager
16/09/11	*HealthWatch* Southampton Sourcing PID/ Outline Business Case issued
23/09/11	Cabinet Member briefed on *HealthWatch* Southampton Sourcing PID
30/09/11	1st Meeting of the SHIP *HealthWatch* Pathfinder Board
14/10/11	1st Meeting of the *HealthWatch* Southampton Transition Team
21/10/11	SHIP Stakeholder Information Day for Parties interested in supplying *HealthWatch* services and formal Expressions of Interest (EOIs) invited
11/11/11	Deadline for receipt of completed EOI Pro Formas
18/11/11	2nd Meeting of the SHIP *HealthWatch* Pathfinder Board
18/11/11	2nd Meeting of the *HealthWatch* Southampton Transition Team
25/11/11	Paper on *HealthWatch* & Adult Safeguarding produced (with ADASS)
09/12/11	Paper on Commissioning ICAS in the SHIP Area produced (SCC-led)
16/12/11	DCLG announces LA Revenue Support Grant Settlement for 2012/13
23/12/11	Financial Assessment for funding *HealthWatch* Southampton completed
30/12/11	Draft Pre Qualification Questionnaires (PQQs) produced
09/01/12	Health & Social Care Bill receives Royal Assent
13/01/12	3rd Meeting of the *HealthWatch* Southampton Transition Team
20/01/12	3rd Meeting of the SHIP *HealthWatch* Pathfinder Board
27/01/12	Tender Documents for *HealthWatch* Southampton finalised in light of Sourcing Strategy/ Final Business Case agreed by Cabinet
03/02/12	*Healthwatch* Southampton PQQs issued to interested Parties
17/02/12	Evaluation of SHIP *HealthWatch* Pathfinder project completed
24/12/12	Agreement on Extension of LINk Host Contracted extended (if required)
05/03/12	4th Meeting of the *HealthWatch* Southampton Transition Team
12/03/12	4th (and final) Meeting of the SHIP *HealthWatch* Pathfinder Board
19/03/12	Shadow *HealthWatch* Southampton established

2. Implementation Phase

week ending	Key Milestone/ Deliverable
30/12/11	Draft Pre Qualification Questionnaires (PQQs) produced
09/01/12	Health & Social Care Bill receives Royal Assent
27/01/12	Tender Documents for *HealthWatch* Southampton finalised in light of Sourcing Strategy/ Final Business Case agreed by Cabinet
03/02/12	*Healthwatch* Southampton PQQs issued to interested Parties
05/03/12	PQQs returned
12/03/12	*HealthWatch* Southampton Tender Evaluation Team agreed
19/03/12	Advertisements for Invitations to Tender (ITT) placed
26/03/12	ITT Documentation and Bidders Packs issued
27/04/12	Deadline for Receipt of Tender Documents
25/05/12	Evaluation of Tenders completed by Panel
15/06/12	Tender(s) awarded to successful Bidder/ Consortium
30/06/12	Southampton Local Involvement Network ceases
01/07/12	*HealthWatch* Southampton is formally established by SCC

DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	TO REVIEW THE HAMPSHIRE PARTNERSHIP FOUNDATION TRUST'S FINAL DRAFT 2010/11 QUALITY ACCOUNT, AND PROVIDE COMMENTS FOR INCLUSION
DATE OF DECISION:	22 JUNE 2011
REPORT OF:	RUTH PULLEN, INTERIM DEPUTY DIRECTOR OF GOVERNANCE (MH&LD), SOUTHERN HEALTH NHS FOUNDATION TRUST
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

Healthcare providers publishing Quality Accounts in June 2011 have a legal duty to send their Quality Account to the HOSC in the local authority area in which the provider has its registered office, inviting comments on the report from the HOSC prior to publication.

The quality account for Hampshire Partnership Foundation Trust is presented to the Health Scrutiny Panel for its review, and comment for inclusion in the 200/11 Account. The former Hampshire Partnership Foundation Trust has become the mental health and learning disabilities services (MH&LD) of Southern Healthcare Foundation Trust and the former Hampshire Community Health Care became the integrated community services (ICS) of SHFT. This Quality Account relates to the MH&LD services.

RECOMMENDATIONS:

(i) To review the draft Quality Account for Hampshire Partnership Foundation Trust, and

(ii) To provide a written statement for publication in HPFT's Quality Account on whether or not the HSP considers, based on knowledge of the provider, that the report is a fair reflection of the healthcare services provided

REASONS FOR REPORT RECOMMENDATIONS

1. Healthcare providers publishing Quality Accounts in June 2011 have a legal duty to send their Quality Account to the LINk and OSC in the local authority area in which the provider has its registered office, inviting comments on the report from the LINk and OSC prior to publication.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None.

DETAIL (Including consultation carried out)

3. HPFT attended the Panel B meeting on 14 October 2010 to update the panel on progress against our 2010/11 plans and the development of our of 2010/11 quality account.

4. The Quality Account for 2010/11 has now been completed in draft and is

attached at appendix 1. HPFT would welcome comment from the Panel for inclusion in the report.

RESOURCE IMPLICATIONS

Capital/Revenue

4 None.

Property/Other

5 None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

6 The National Health Service (Quality Accounts) Regulations 2010 No 279 requires health providers to produce a quality account and that health overview and scrutiny committees are given the opportunity to comment.

7 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:

8 None

POLICY FRAMEWORK IMPLICATIONS

9 N/A

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	E-mail:	Caronwen.rees@southampton.gov.uk		

KEY DECISION?

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

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

Appendices

1.	HPFT Draft Quality Account 2010/11

Documents In Members' Rooms

1.	

Integrated Impact Assessment

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

Other Background Documents

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

Title of Background Paper(s) Relevant Paragraph of the Access to

		Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.		
2.		

Hampshire Partnership NHS
NHS Foundation Trust
(Now part of Southern Health NHS Foundation Trust)

2010/11 Quality Account

Version 1.6

Agenda Item 10
Appendix 1

Contents

Part 1.0

Introduction from the Chief Executive and Chair

Welcome to the Hampshire Partnership NHS Foundation Trust's (herein referred to as HPFT) Quality Account.

A Quality Account is a report which demonstrates the Board regularly reviews and challenges the quality of its services and ensures improvements are made year after year. Quality Accounts should tell you how we have performed and our plans for the coming year. Our Quality Account was written in line with guidance from the Department of Health and Monitor (the NHS Foundation Trust regulator).

This report can only provide a snap shot of the quality improvement work we do each year; if there is anything else you want to know, please ask! We value your feedback, let us know what you think of this report by contacting us on:-

Email: QI.Team@hantspt-sw.nhs.uk

Post: Quality Account Feedback
Southern Health NHS Foundation Trust
c/o Quality & Governance
6 Sterne Road
Tatchbury Mount
Southampton
SO40 2RZ

In order for our quality improvement work to be relevant to the people who use our services and the wider community, we have listened to stakeholders. Our approach to quality is based on "High Quality Care for All" (NHS Next Stage Review). At HPFT we believe the provision of high quality services is the responsibility of every member of staff. High quality care means our services are safe, effective and meet the needs of people using the services, as well as supporting choice. This report reflects our ambition to deliver continuous quality improvement and to develop the measurement of quality as experienced by users of our services.

It is important readers of this report have confidence that the data and information presented within it is accurate, robust and reliable. The information given in this Quality Account has been subject to the Trust's robust quality assurance processes and internal audit. The Trust's Directors are also required to make a collective statement that they have complied with a set of requirements relating to the preparation of the Quality Account and this is provided in Appendix 1.

On 1 April 2011, the HPFT merged with Hampshire Community Health Care (HCHC) to form a new organisation - Southern Health NHS Foundation Trust (SHFT). The former HPFT has become the mental health and learning disabilities services (MH&LD) of SHFT and the former HCHC became the integrated community services (ICS) of SHFT. This Quality Account relates to the MH&LD services. Information relating to the ICS is detailed in the HCHC 2010/11 Quality Account (available via http:www.nhschoices.org.uk). At the end of 2011/12, SHFT will produce a single Quality Account to cover all services.

Finally, we have pleasure in starting our 2010/11 Quality Account with a summary of the key mandated requirements, which is covered in more detail in the main report, this is followed by our review of services and examples of good practice and innovation that staff selected to share with you.

Katrina Percy
Chief Executive

Carol Bode
Chair

26 May 2011

1.1 Summary of the Hampshire Partnership NHS Foundation Trust 2010/11 Quality Account

A Quality Account should tell you how we performed and our plans for the future. Tables 1 – 3 outline our MH&LD performance in 2010/11 and Table 4 outlines our plans for SHFT for 2011/12. These tables summarise the key points of this report.

Table 1 – Summarises the HPFT (i.e. MH&LD) 2010/11 performance against mandated requirements – *Detailed information is provided on page 23*

Indicator / Target	Achieved in 2010/11? ✓ = Yes ! = Nearly X = No	Compared to 2009/10 ↑ = Improved ↓ = Worse ↔ = Same	What we intend to do in 2011/12
Review of Services	✓	↑	Plan in place to ensure all services continue to be reviewed
Participation in national clinical audit	✓	↑	Implement clinical audit programme to maintain improvement.
Participation in national confidential enquiries	✓	↑	Continue to participate in the only national confidential enquiry to which eligible.
Participation in clinical research	✓	↑	Research strategy to be reviewed to ensure enhanced research performance.
Commissioning for Quality & Innovation (CQUIN) payment framework	✓	↔	Negotiate terms of CQUIN with commissioners
Statements from the Care Quality Commission (CQC)	✓	↔	Further develop compliance monitoring programme.
Data Quality	✓	↑	Data quality strategy to be reviewed and implemented.
Information Governance Toolkit	✓	↑	Action plan developed to ensure improvement maintained.
Clinical Coding Error Rates	**N/A**	**N/A**	HPFT was not subject to the Payment by Results clinical coding audit in 2010/11.

Table 2 – Summarises the HPFT (MH&LD) 2010/11 performance against National and Regulator Targets			
Indicator / Target	**Achieved in 2010/11?** ✓ = Yes ! = Nearly X = No	**Compared to 2009/10** ↑ = Improved ↓ = Worse ↔ = Same	**What we intend to do in 2011/12**
% Service users with access to crisis resolution teams	✓	↑	Monitor monthly by Trust Board; and weekly in directorate.
Learning Disabilities (LD) service users with access to physical healthcare services – *indicates if people with LD are able to fairly access healthcare services*	✓	↔	Monitor monthly by Trust Board
Compliance with best practice in mental health services for people with a LD (Green Light toolkit) – *indicates if we are meeting the needs of these individuals*	✓	↔	Monitor monthly by Trust Board.
% Service users contacted by our services within 7 days of their discharge – *indicates if we meet the needs of recently discharged people who may be at risk*	✓	↑	Monitor monthly by Trust Board; and weekly in services.
% Service users on Care Programme Approach (CPA) with a review in 12 months – *indicates if we plan and review people's care*	✓	↑	Monitor monthly by Trust Board; and subject to audit.
% Beds occupied by service users who were not discharged when expected - *indicates if beds are occupied because people are not discharged promptly*	✓	↑	Monitor monthly by Trust Board; and weekly in services.
% Service users with a recorded ethnic code – *indicates if we know the ethnicity of our service users*	✓	↑	Monitor monthly by Trust Board; and subject to audit.
Mental Health Minimum Data Set (MHMDS) data completeness identifiers – *indicates if we contribute to national statistics.*	X	New in 2010/11	This indicator has been modified by Monitor in the 2011/12 Compliance Framework and the Trust is fully compliant with the new indicator.
MHMDS data completeness outcomes - – *indicates if we contribute to national statistics.*	X	New in 2010/11	We anticipate being compliant by the end of June 2011 and this is being monitored at team, service and directorate level.
New referrals to Early Intervention in Psychosis service – *indicates if we meet the needs of people with psychosis*	✓	New in 2010/11	Monitor monthly by Trust Board; and weekly in directorate.
Staff satisfaction – *indicates if staff are satisfied working for HPFT*	✓	↑	Action plan developed with staff side to maintain improvements.
Campus closure - *% people in (or discharged from) LD campus with a discharge plan*	✓	↔	Monitor monthly by Trust Board; and in directorate.

% LD service users with a care plan - *indicates if we plan people's care*	✓	↔	Monitor monthly by Trust Board; and subject to regular audit.
Child and Adolescent mental health services – *indicates if we meet the needs of these individuals*	✓	↔	Monitor monthly by Trust Board; and subject to regular audit.

Table 3 – Summarises the HPFT (i.e. MH&LD) 2010/11 performance against local quality indicators – *Detailed information is provided on page 29.*			
Indicator / Target	**Achieved in 2010/11?** ✓ = Yes ! = Nearly X = No	**Compared to 2009/10** ↑ = Improved ↓ = Worse ↔ = Same	**What we intend to do in 2011/12**
Indicators relating to maximising safety			
Total slips, trips and falls (excludes found on floor) – *indicates if we prevent unnecessary falls*	X	↓	We aim to improve falls assessments to more accurately identify people at risk of falling.
Slips, trips, falls causing severe harm (e.g. fractures, stitches) – *indicates if we prevent severe harm arising when someone falls*	!	↓	We aim to improve assessments after a fall to more quickly identify people needing medical attention.
Patient-to-patient violence and aggression causing harm – *indicates how safe our units are for patients*	✓	↑	We aim to more quickly identify the patients who cause such incidents and put measures in place to stop this occurring
Patient-to-staff violence and aggression causing harm – *indicates how safe our units are for staff*	**N/A**	New in 2010/11	Training package in development to ensure all staff know how to manage people with challenging behaviours
Service user escapes from medium secure units – *indicates if high risk patients inappropriately leave units*	✓	↔	This indicator will continue to be monitored within the Trust but will not be included in the 2011/12 Quality Account.
Indicators relating to improving clinical effectiveness			
Severe (grade 4) pressure ulcers developed since admission – *indicates if we provide appropriate physical healthcare*	✓	↑	Indicator to be revised to include grade 2 and 3 pressure ulcers. Processes for the identification and management of pressure ulcers to be improved with tissue viability team.
Admissions of young people (under 18) to adult mental health units – *indicates if we meet the needs of vulnerable young people*	✓	↑	This indicator will continue to be monitored within the Trust and with Commissioners, but will not be included in the 2011/12 Quality Account.
Infection outbreaks (where an outbreak is more than 2 patients with the same infection) – *indicates if we are keeping people in our services healthy*	**N/A**	New in 2010/11	This indicator will continue to be monitored within the Trust and with Commissioners, but will not be included in the 2011/12 Quality Account.
Duration of closure due to infection outbreaks – *indicates if areas are closed to new admissions due to infection outbreaks*	**N/A**	New in 2010/11	This indicator will continue to be monitored within the Trust, but will not be included in the 2011/12 quality priorities.

Indicators relating to improving the patient experience			
Number of Complaints received – *indicates how satisfied people are with our services*	✓	↑	Year on year improvement demonstrated, this indicator will continue to be monitored within the Trust, but will not therefore be included in the 2011/12 quality priorities.
Number of paired Health of the Nation outcome scores (HoNOS) – *HoNOS is an indicator of effective care*	✓	↑	Year on year improvement demonstrated, this indicator will continue to be monitored within the Trust and with Commissioners, but will not be included in 2011/12 priorities.
Implementation of RiO mental health (an electronic service user record) – *ensures a 24/7 record is available to staff*	✓	↑	RiO fully implemented in mental health and LD services, so this indicator will not be included in our 2011/12 priorities.
Average length of Stay (inpatient units) – *indicates if we keep people in hospital for too long*	✓	New in 2010/11	Indicator to be revised to median length of stay. Major review of services planned for 2011/12 to address excessive length of stay.

Table 4 – Summarises the quality improvement priorities for 2011/12 for Southern Health NHS Foundation Trust - *Detailed information about the mental health and learning disabilities (MH&LD) priorities and indicators is provided on page 19*

Priority 1: Improve safety	**Priority 2:** Improve clinical outcomes	**Priority 3:** Improve patient experience
Chosen because we are making safety a priority, so that avoidable deaths and avoidable harm remain just that… avoided.	Chosen because service users should drive the design and delivery of our care.	Chosen to ensure we always do the right thing at the right time for the right service user to achieve the right outcome.
In MH&LD this will be measured via:- • Service user assaults on staff, patients or visitors • Violence & aggression incidents reported to the Health & Safety Executive (RIDDOR) • Falls in inpatient and TQtwentyone (social care) units • Service users with completed risk assessments • Record of allergies on service users prescription charts • Medication reconciliation • Unexpected deaths **In ICS this will be monitored via *(full details given in the HCHC 2010/11 Quality Account)*:-** • Serious incidents about deteriorating patients • Audit of Modified Early Warning Score (MEWS) • Patient Safety Walkabouts • Pilot of Mortality Trigger Tool at Lymington & New Forest Hospital	**In MH&LD this will be measured via:-** • Service users with recorded employment status • Service users who state they have help to get or maintain employment • Service users who state they have help to obtain benefits or support • Service users who state they had a care review meeting • Service users who state they have been offered a copy of their care plan • Unpaid carers who state they rate their contact with the Trust as 'good'. **In ICS this will be monitored via *(full details given in the HCHC 2010/11 Quality Account)*:-** • Percentage of appropriate service users on an End of Life care pathway • Patient Experience Survey • Audit the use of the Liverpool Care Pathway	**In MH&LD this will be measured via:-** • Pressure ulcers (grade 2 or above) arising after admission • Service users with a physical health assessment • Length of stay in inpatient units **In ICS this will be monitored via *(full details given in the HCHC 2010/11 Quality Account)*:-** • Audit the use of Situation, Background, Assessment Recommendation (SBAR) communication tool • Patient Experience Survey

The priorities above are not the only areas we plan to focus on but these will be our top quality improvement priorities in 2011/12. Progress against them will be reported in next years Quality Account.

1.2 Our review of MH and LD Quality Performance in 2010/11

Indicators monitored by the Board

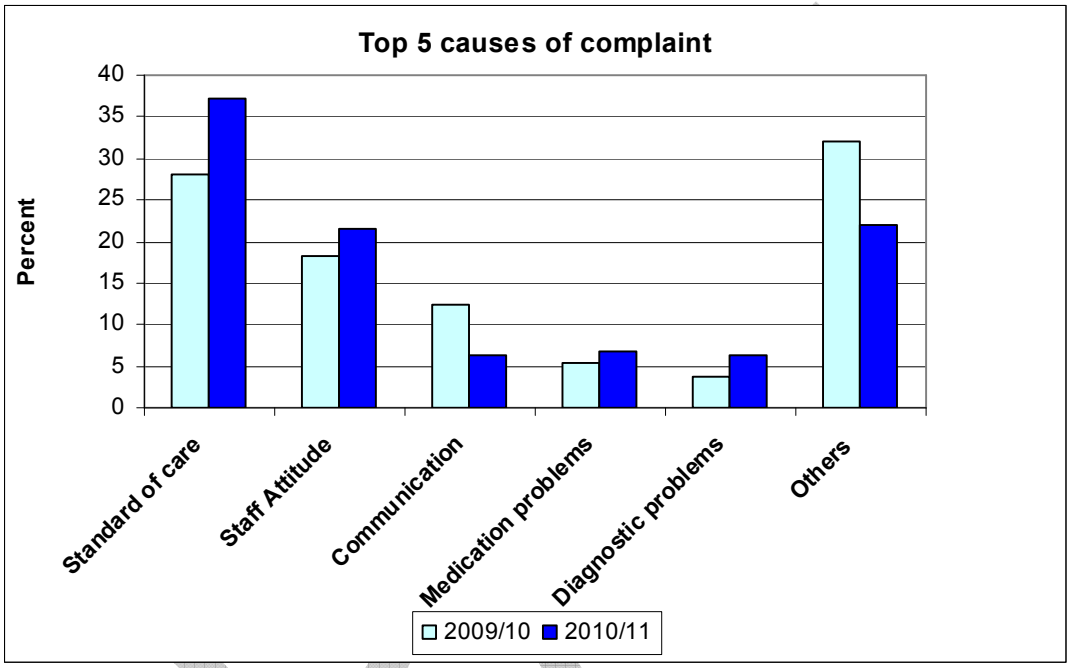
The HPFT Board regularly reviewed information relating to safety, outcomes and patient experience. The table below shows some of the indicators reviewed during 2010/11 and which are not shown elsewhere in this report:-

Indicator	2010/11 Totals	Achieved in 2010/11? ✓ = Yes ! = Nearly X = No	Comments
Suicides	37	✓	Within expected range (up to 9 per month).
Absence without leave (AWOLs) – detained services users who leave units without permission (CQC definition)	48	✓	Within expected range (up to 6 per month).
Infection Control – Number of Clostridium Difficile (C Diff) infections	0	✓	No C Diff outbreaks reported in year.
Infection Control – number of MRSA Bacteraemia infections	0	✓	No MRSA Bacteraemia outbreaks reported in year.
Delivering same sex accommodation – occurrences of men and women admitted to a ward or sharing facilities.	0	✓	Indicates that no men were on women's wards or vice versa.
Number of complaints upheld (e.g. the complainants concerns were agreed by the Trust)	47	N/A	New for 2010/11.
Percentage of complaints responded to within timescale	90.6%	X	In 2009/10, 94.9% of complaints were reported in timescales.
Number of compliments received	191	✓	In 2009/10, 148 compliments were received.
Quality assurance questionnaire – % of services users who state that they are satisfied/very satisfied with our services	95.5%	N/A	New for 2010/11.

Complaints

Not all complaints were responded to in time, as shown in the table above. Complaints regulations require that we agree a response time with the complainant. Some complaints were not responded to within the agreed time due to delays within the Trust or by the complainant.

The chart below shows the top 5 causes of MH&LD complaints for 2009/10 and 2010/11:-



Communication, staff attitude, and nursing/clinical care continue to be the top themes from complaints. This is the same as many other NHS Trusts. We want to see an improvement in these areas. Work is underway to develop customer care training for staff. We will also review learning from complaints, and look at how we can improve learning from other patient feedback such as questionnaires, Patient Opinion; NHS Choices and local and National Patient Survey's. This work has already started and is being monitored by the Trust's Patient Experience Group.

During 2010/11, 12 complainants took their complaint to the Parliamentary and Health Service Ombudsman (P&HSO). The P&HSO was satisfied with the Trust's response to these complaints, as shown below:-

Complaints referred to the Parliamentary & Health Service Ombudsman (P&HSO)		
	Number Referred	**Investigated by P&HSO**
Complaint originally raised in 2009/10	7	None
Complaint raised in 2010/11	5	None

The National Patient Survey

The results of the 2010 NHS Community Mental Health Services User Survey for HPFT were very encouraging. 79% of people who took part rated the care they had received in the last year 'excellent', 'very good' or 'good'. This put the Trust in the top 20% of all mental health trusts for overall satisfaction with care.

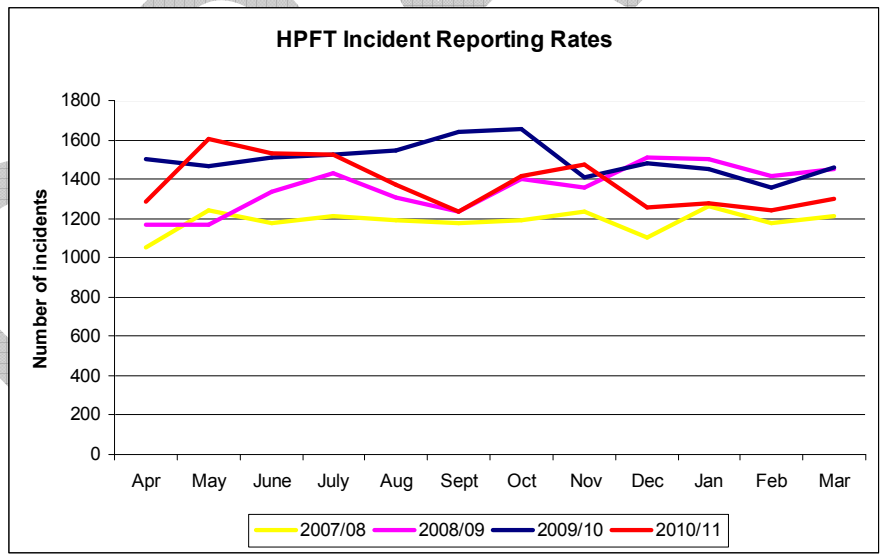
The Trust's performance was also more positive than other mental health trusts in other areas; for example, service users having a review of their medicines and understanding their care plan.

The survey also showed where improvements could be made, such as care review meetings and getting help with financial advice or benefits.

The Trust used this feedback to identify areas for improvement. This involved staff, service users and carers. Progress is monitored by the Trust-wide Patient Experience Group. The survey results, as well as current improvement plans, can be viewed on the Trust website: http://www.hampshirepartnership.nhs.uk/about/your-say/what-youve-already-told-us/

Reporting incidents, accidents and near-misses

Our staff are encouraged to report all incidents, accidents and near misses. Incident reporting has generally increased year on year. The graph below shows the HPFT incident reporting levels since 2007/08.



Reporting patient safety incidents to the National Patient Safety Agency

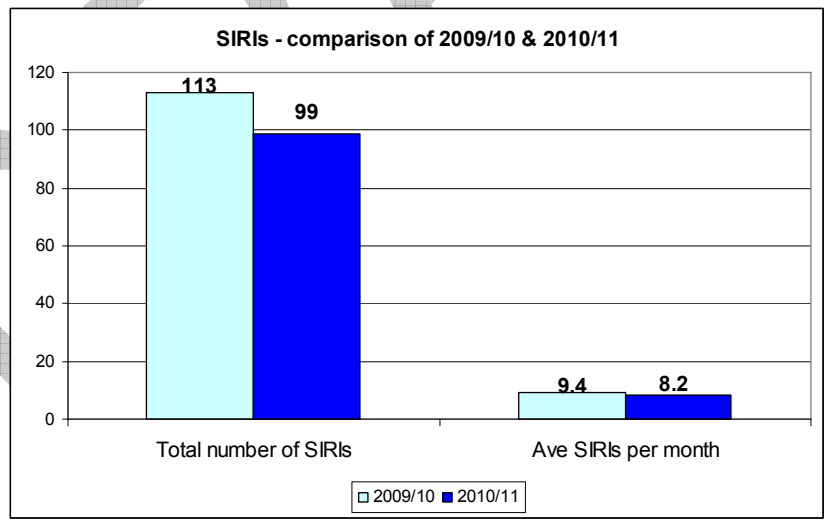
HPFT reports patient safety incidents to the National Reporting and Learning System (NRLS) - this is a national database of patient safety incidents managed by the National Patient Safety Agency. We use this information to test our performance against other NHS organisations. Our performance is shown below:-

Time Period	HPFT Incidents Reported	HPFT % NO or LOW Harm	HPFT Average days to report to the NRLS
April – September 2009	2789	96%	Not known
Oct 2009 – March 2010	2770	96%	Not known
April – September 2010	3101	96.8%	11 days

During the period April to September 2010, out of 56 mental health trusts reporting to the NRLS, we were the 6th highest reporter of incidents; we were also the 6th highest reporter of no or low harm incidents and we were 2nd for reporting incidents to the NRLS in a timely manner. High reporting rates suggest an organisation has a good safety culture.

Serious Incident Requiring Investigation

Serious Incidents Requiring Investigation (SIRIs) include: suicides, homicides, serious drug errors and grade 4 pressure ulcers. Our SIRI numbers for 2009/10 and 2010/11 are shown below:-



Never Events
'Never Events' are serious patient safety incidents which should never happen if good practice and prevention were in place. In 2009, 8 'Never Events' were introduced in the NHS, listed below:-

- Wrong site surgery - (N/A)
- Retained instrument post-operation - (N/A)
- Wrong route administration of chemotherapy - (N/A)
- Misplaced naso/orogastric tube not detected prior to use
- Inpatient suicide using non-collapsible rails
- Escape from secure perimeter of medium or high secure mental health services by patients who are transferred prisoners
- In-hospital maternal death from post-partum haemorrhage after elective caesarean section (N/A)
- Intravenous administration of mis-selected concentrated potassium chloride - (N/A)

Not all of these are applicable (shown by N/A) to the HPFT services. HPFT reported no Never Events in 2010/11.

Implementing National Safety Alerts
The Department of Health's Central Alerting System (CAS) sends alerts and urgent patient safety guidance to NHS organisations so they can take action to prevent harm to patients.

During 2010/11, 183 alerts were issued. 129 of these were relevant to HPFT. We have a robust system in place to distribute alerts and monitor that the action needed to keep patients safe has been taken. The table below summarises the type of alerts we responded to in 2010/11:-

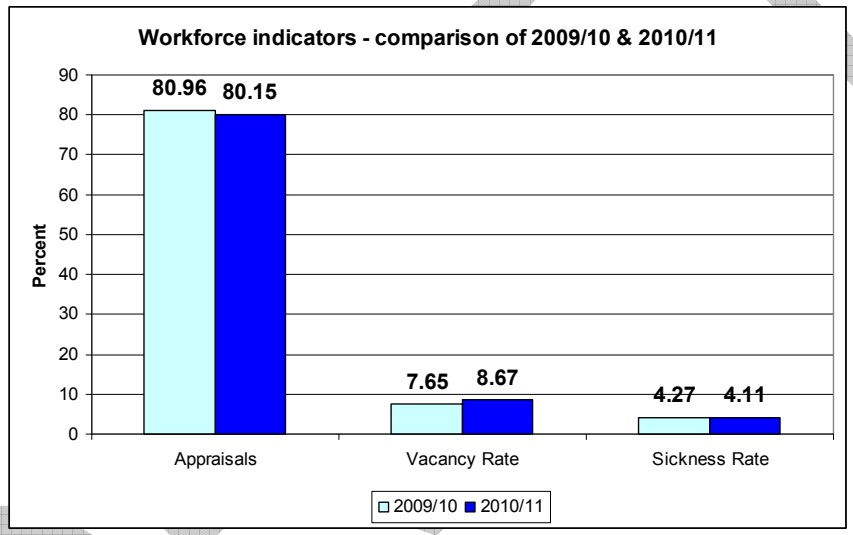
Type Of Alert	Number Issued	Number Actioned or Responded To Within Timescale
Medical Device – alerts about medical equipment such as wheelchairs	106	106
National Patient Safety Agency – alerts about procedures or medication, such as insulin	12	12
Estates – alerts about buildings, such as ceiling tiles	11	11

National Institute for Health & Clinical Excellence (NICE) Guidance

The National Institute for Health and Clinical Excellence (NICE) provides national guidance on promoting good health and preventing and treating ill health. In 2010/11, NICE issued 113 guidelines. 8 were relevant to HPFT, and these are being implemented. Compliance with NICE is monitored by the Trust's Patient Safety Group.

Supporting staff and the National Staff Survey

We test how well we are supporting our staff by reviewing various staff related indicators (some are shown below) and via the results of the annual National Staff Survey.



The National Staff Survey has questions on how staff rate HPFT as a place to work and how satisfied they are. In the 2010/11 National Staff Survey, the Trust did well for staff engagement (a measure of overall satisfaction) compared to other mental health and learning disability trusts (HPFT scored 3.68, the average MH&LD score was 3.64 and our 2009/10 score was 3.62).

Areas where HPFT did well in the National Staff Survey and areas for improvement are shown below:-

Indicators from National Staff Survey – shown as % staff	HPFT score Green = did well Amber = did OK Red = did poorly	Average MH&LD trusts score
Reporting errors, near misses or incidents witnessed in the last month	99%	97%
Suffering work-related injury in last 12 months	4%	8%
Suffering work-related stress in last 12 months	24%	31%
Experiencing harassment, bullying or abuse from staff in last 12 months	11%	14%
Having Equality & diversity training in last 12 months	30%	47%
Working extra hours	71%	65%
Agreeing their role makes a difference to patients	88%	90%
Feeling satisfied with the quality of work and patient care they are able to deliver	71%	75%

Other areas of good practice – chosen by our staff
Other 2010/11 achievements which our staff have chosen to share with readers include:-

- In October 2010 the Trust started an 18 month project – called 'Time to Change' - to reduce stigma and discrimination within the Trust and in 50 partner organisations. If mental health stigma is reduced, people may not fear talking about it and may seek help sooner making their recovery swifter. The overall goal is to achieve changes in the community and in employers.

- Patient Opinion (an independent social enterprise for patients and staff) nominated the Trust to the Department of Health as an exemplar organisation for our work in using service user feedback and for reaching out to some of our service user population who may not have much of a voice.

- The AMH Directorate was chosen as a pilot site in the national ImRoc (Implementing Recovery – Organisational Change) programme.

- Forest Lodge (a Southampton residential rehabilitation unit), participated in an international study of recovery focussed care. Forest Lodge's scores in all seven areas tested were above the average scores for similar units in the UK. Particularly notable were their performance in human rights (21% above the average score) and recovery based practice (20% above the average score).

- HPFT is an important partner in the development of a Joint Working Protocol, developed through Local Safeguarding Children Boards for use by all agencies that may work with vulnerable children and their parents/carers. The protocol provides details of how agencies

should work together with families with problems such as mental ill health or substance misuse. The protocol helps all those involved in safeguarding children understand how they can work together to prevent children from being abused and neglected in families with problems.

- HPFT trialled the use of Failure Modes and Effects Analysis (FMEA), a proactive risk management approach which helps teams to identify areas of high risk in clinical processes. The trial highlighted some high risk areas for the Gosport War Memorial Hospital duty system, which have now been addressed.

- Introduction of weekly physical health clinics in some inpatient units to provide basic information on physical health and screening of basic physical health issues, blood pressure, weight management etc. The clinics also signpost service users to more specialist services. In addition, patients receive an ECG (or electrocardiogram - is a simple and useful test which records the rhythm and electrical activity of your heart) and full physical examination on admission.

- We rolled out improvement toolkits (called The 'Productive' series) in our inpatient and community teams. These toolkits allow teams to use their experience and ideas to improve care.

- In line with the National Dementia Strategy, the OPMH Directorate worked with clinicians, service users and carers to write information leaflets. These include information on dementia, treatments and some practical advice, for example on driving.

Part 2.0

2.1 - MH&LD Quality Improvement Priorities for 2011/12 *(this information was summarised in Table 4)*

In the NHS, quality is viewed as having three elements:-

- **Patient Safety** – we should ensure care environments are appropriate, safe and clean and we will work to the highest clinical standards to reduce, avoid and stop avoidable harm and distress to patients wherever possible.

- **Clinical Outcome** - we should improve our understanding of treatment options and success rates from different treatments for different conditions including clinical measures, possible complications of treatments and measures of clinical improvement.

- **Patient Experience** – we should know what patients think about our services, we should respond promptly and positively to patient concerns and use patients' views to help us to improve and to design new services. Our staff also need to know when patients think they are providing a good service.

The priorities we have identified for 2011/12 are framed around these. For each priority we describe:

- Why we chose the priority
- The measures we will use to test whether we are making progress and why they are regarded as appropriate
- The expected outcome which will result from improved performance

The Trust will agree targets for each measure, regularly monitor progress against these, and report on the level of achievement in the 2011/12 Quality Account.

The following information relates to MH&LD services. Information relating to the ICS measures was summarised in Table 4, and is available in more detail in the HCHC 2010/11 Quality Account.

Priority 1: Improve safety		
Why we chose this priority:	We are making safety a priority, so that avoidable deaths and avoidable harm remain just that… avoided.	
Measures	**Expected Outcomes**	**Reason for including**
• Numbers of assaults to staff, to service users and to visitors resulting in physical harm • Numbers of RIDDOR reported injuries as a result of violence and aggression. (RIDDORs are incidents of certain types of injury which are required to be reported to the Health and Safety Executive under the 'Reporting of injuries, deaths and dangerous occurrences regulations'.	• With good police liaison, increase the number of sanctions taken against assailants, including cautions and prosecutions. • Improved monitoring of physical restraint and rapid tranquillisation (in in-patient units) • Reduction in the incidence of violence and aggression on in-patient units	To improve the quality of care by reducing preventable assaults to staff, service users and visitors. This indicator was chosen by staff.
• Numbers of falls in inpatient units & TQtwentyone settings (excluding found on floor)	• Improved use of falls risk assessment • Reduction in harm resulting from falls	To improve the quality of care by reducing the harm caused by unnecessary falls. This indicator was selected by service users and governors.
• Numbers of service users with completed risk assessments within the previous 6 months	• Improved use of risk assessment • Safer care environments	To improve the quality of care by reducing the potential for patients to harm themselves or others.
• Number of medication prescription charts with completed allergies information	• Reduction in the numbers of medication incidents • Reduce the harm done by medication error.	To improve the quality of care by reducing the harm caused when medication is prescribed which may case allergic reactions.
• Percentage of correct medication reconciliation (i.e. agreement of the medications brought in by service users and prescribed in our units)	• Reduction in the numbers of medication incidents • Reduce the harm done by medication error.	To improve the quality of care by reducing harm caused by medication errors.
• Numbers of unexpected deaths (all causes) of people with serious mental illness aged less than 75. These are deaths of people which were not anticipated, e.g. sudden heart attack, stroke, and road traffic accident.	• Improved understanding of the health of our service users	To improve the quality of care by reducing premature death in people with serious mental illness. This indicator is new for 2011/12.

Priority 2: Improve clinical outcomes		
Why we chose this priority:	Clinical outcomes are about doing the right thing at the right time for the right service user to achieve the right outcome.	
Measures	**Expected Outcomes**	**Reason for including**
• The number of new pressure ulcers (grade 2 and above) developing during admission	• Fewer pressure ulcers developing during admission • Reduction in the harm to patients arising from unnecessary pressure ulcers	If service users get pressure ulcers whilst in our care, it may be a sign that we did not provide them with good, basic care. This indicator has been amended since 2010/11 to now include grade 2 and above pressure ulcers. This indicator was selected following feedback from service users and carers.
• % of service users with a physical healthcare assessment	• Improved understanding of the health of our service users • Improved access for people with mental health and/or learning disability problems to physical healthcare services	The physical health of people with serious mental illness and/or learning disabilities can be poorer than that of the general population. It is therefore vital that we are aware of any physical healthcare needs so we can ensure that they are addressed. This indicator was selected following feedback from service users.
• Median and Mean length of service user stay (excluding leave)	• Shorter length of stay • Improved quality of care	Many service users admitted to mental health hospitals stay for a long time. Reducing the length of stay can improve the service user experience by encouraging people to plan for their discharge and reduce unnecessary time in hospital. During 2011/12 we are improving the accuracy of this indicator by measuring median and mean rather than average length of stay.

Priority 3: Improve the patient experience		
Why we chose this priority:	Although the care we deliver always focuses on our service users, their needs can sometimes be assumed and the powerful role their views can play in improving our services can sometimes be overlooked. Service users should drive the design and delivery of our care.	
Measures	**Expected Outcomes**	**Reason for including**
• % of service users with recorded employment status	• Improved understanding of service user employment issues	Employment of people with mental illness provides an insight into how well individuals are able to manage their condition. These indicators were identified from Governor feedback and are new for 2011/12.
• % of service users who state that in the last 12 months they have received help to get or maintain employment		
• % of service users who state that in the last 12 months they have received help to obtain financial support / benefits	• Improvement in national patient survey scores regarding benefits	This indicator was identified from Governor feedback. In addition, the Trust performs less well than other mental health trust regarding support with benefits in the national patient survey. This indicator is new for 2011/12.
• % of service users who state that in the last 12 months they had a care review meeting to discuss their care plan	• Increase in service user involvement in care planning • Improved service user experience	The Trust performs less well than other mental health trust regarding care review meetings in the national patient survey. This indicator is new for 2011/12.
• % of Service users who state they had been given or offered a copy of their care plan within the last 12 months.		Commissioners have prioritised this in the 2011/12 contract; it is also a theme in complaints and PALS referrals.
• % of unpaid carers that state that they rate their contact with the Trust's services as 'good'.	• Improved carers experience	This indicator was selected following feedback from carers and is new for 2011/12.

2.1 – Mandated Statements

The following statements must be included in all Quality Accounts and therefore allow you to compare our performance with that of other NHS trusts.

2.1.2 - Directors' statement

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Account.

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- The content of the quality account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010-11;
- The content of the quality account is not inconsistent with internal and external sources of information including:
    - → Board minutes and papers for the period April 2010 to June 2011
    - → Papers relating to Quality reported to the Board over the period April 2010 to June 2011
    - → Feedback from Commissioners dated 25/05/2011
    - → Feedback from Governors dated 06/05/2011
    - → Feedback from LINks dated 23/05/2011
    - → The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS complaints Regulations 2009, dated 26/04/2011
    - → The latest national patient survey dated 20/04/2010
    - → The latest national staff survey dated 28/02/2011
    - → The Head of Internal Audit's annual opinion over the Trust's control environment dated 23/05/2011.
    - → CQC quality and risk profiles dated 22/09/2010, 21/10/2010, 18/11/2010, 16/12/2010, 17/02/2011, 16/03/2011 and 21/04/2011.
- The Quality Report presents a balanced picture of our performance over the period covered;
- The performance information reported in the Quality Accounts is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report (both available at www.monitor-nhsft.gov.uk/annualreportingmanual).

To ensure our Quality Account is fair, each month we review performance against key indicators and national targets and Executive Directors and the Assurance Committee review information relating to quality, service user safety and experience. Stakeholders were consulted and involved in a variety of ways, for example:-

- Public Board meetings
- Council of Governors meetings
- Member Constituent meetings
- Strategic exchange meetings with Primary Care Trusts
- Senior managers representing the Trust in Local Implementation Teams
- Non-Executive Directors' involvement in Trust Committees
- User and Carer representation on Trust and Directorate Committees
- Staff representation on Trust and Directorate Committees.

The collection and reporting of the information given in our Quality Account is subject to internal audit by RSM Tenon Limited.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

2.1.2 - Statements relating to the quality of NHS services provided *(this information was summarised in Table 1)*

Review of Services

During 2010/11, the HPFT provided and/or sub-contracted 27 NHS services. The HPFT reviewed all the data available on the quality of care in all of these NHS services. The data reviewed covered the three dimensions of quality – service user safety, clinical effectiveness and service user experience – and there was no impediment to this review.

The income generated by the NHS services reviewed in 2010/11 represents 100 per cent of the total income generated from the provision of NHS services by the HPFT for 2010/11.

Participation in clinical audits:
Clinical audit is a method used to check and improve the quality of services. The method involves sending out questionnaires to services, collating the responses and looking closely at the results to see where improvements can be made.

During 2010/11, five national clinical audits and one national confidential enquiries covered NHS services that the HPFT provides. During 2010/11, the HPFT participated in 60% national clinical audits and 100% confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the HPFT was eligible to participate in and actually participated in during 2010/11 are listed below:-

National Audit / Confidential Enquiry Title	Eligible	Participated
Prescribing Observatory for Mental Health (POMH)	✓	x
National Audit of Schizophrenia	✓	x
National Audit of Schizophrenia Psychological Therapies for Anxiety and Depression	✓	✓
National Audit of the organisation of services for falls and bone health in older people	✓	✓
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	✓	✓

The national clinical audits and national confidential enquiries that the HPFT participated in, and for which data collection was completed during 2010/11, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry.

National Audit / Confidential Enquiry	% of Required Cases Submitted	Reason for Not Submitting Full Number
National Audit of Psychological Therapies for Anxiety & Depression	Audit 1, 2 & 3 – 100% Audit 4 – 40%	Audit 4 abandoned due to internal staffing issues
National audit of the organisation of services for falls and bone health in older people	100%	N/A
National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness	100%	N/A

The reports of two national clinical audits were reviewed by the provider in 2010/11 and the HPFT intends to take the following actions to improve the quality of healthcare provided:-

- Increase public and service user engagement in clinical audit, and raise awareness of specific clinical audits that are taking place within the Trust.

The reports of 40 local clinical audits were reviewed by the provider in 2010/11 and the HPFT intends to take the following actions to improve the quality of healthcare provided:-

- Raise awareness of the importance of making appropriate, high quality risk assessments.
- Work with integrated community services colleagues to improve and establish a shared falls assessment and pathway.
- Work with integrated community services colleagues to improve the physical health assessments for mental health and learning disabilities service users.
- Develop local audits using RiO (an electronic care record)

During 2010/11, there were a number of national clinical audits that HPFT did not participate in because of associated costs. It is anticipated that more national clinical audits will be undertaken during 2011/12. More information is available in the Trust's Annual Clinical Audit Report which can be obtained via QI.Team@hantspt-sw.nhs.uk.

Participation in clinical research

Clinical research is a branch of medical science that determines the safety and effectiveness of medications, devices, diagnostic procedures and treatment regimens intended for human use. The knowledge gained from these trials may be used for the prevention, treatment, diagnosis or relieving symptoms of a disease.

The number of patients receiving NHS services provided or sub-contracted by the HPFT in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 469.

Participation in clinical research demonstrates HPFT's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest treatment possibilities and active participation in research leads to successful service user outcomes.

HPFT was involved in conducting 53 clinical research studies in mental health during 2010/11 involving 140 clinical staff. Information on mortality rates is not routinely kept as part of the Research and Development database, but the Trust is committed to clinical research leading to improved treatments and recovery for service users. Over the last three years, 178 publications have resulted from our involvement in National Institute for Health Research (NIHR) research, which shows our commitment to transparency and desire to improve patient outcomes and experiences across the NHS. Our engagement with clinical research demonstrates our commitment to testing and offering the latest medical treatments and techniques.

During 2011/12, the Trust's research strategy will be reviewed and research will remain a priority. We will report our progress in the 2011/12 Quality Account.

The Commissioning for Quality & Innovation (CQUIN) payment framework.
A proportion of the HPFT income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between the HPFT and our commissioning Primary Care Trusts (PCTs), through the Commissioning for Quality and Innovation payment framework, as shown below:-

	CQUIN Value Available	CQUIN Income Received
Hampshire (lead) for general secondary mental health and learning disability services	480,000	480,000
Southampton (subsidiary to the above)	153,000	153,000
South Coast Specialist Commissioning Consortium for low and medium secure services and in-patient child and adolescent mental health services	272,000	272,000
TOTAL	905,000	905,000

Further details of the agreed goals for 2010/11 and for the following 12 month period are available electronically at: http:www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html or via our website (http:www.southernhealth.nhs.uk).

Statements from the Care Quality Commission (CQC):
The HPFT is required to register with the CQC and its current registration status is registered with no conditions. The CQC have not produced any warning or advices notices relating to the HPFT or its services. The CQC has not taken enforcement action against the HPFT during 2010/11. The HPFT has not participated in any special reviews or investigations by the CQC during 2010/11.

In addition, there were no issues raised by Monitor (the Foundation Trust regulator) in relation to service quality in 2010/11. The Health and Safety Executive (HSE) issued no improvement or prohibition notices to the Trust in the last year.

Data quality

The HPFT submitted records during the period April – December 2010 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS Number was: 99.6% for admitted patient care and 99.8% for out patient care.

The percentage of records which included the patient's valid General Medical Practice code was: 100% for admitted patient care and 100% for outpatient care.

HPFT has now installed RiO (an electronic service user record) across all MH&LD areas. As well as annual accuracy, completeness and validity checks and monitoring the monthly quality of its Secondary Uses Service data, HPFT has started a data quality improvement programme. This programme is aimed at providing clinical staff and managers with monthly feedback on the quality of key data on the system and providing them with support to improve data quality, such as newsletters, advisory notes on how the use of the system can be improved, support tools for caseload management, diary audit and performance monitoring.

Information Governance Toolkit

HPFT Information Governance Assessment Report overall score for 2010/11 was 73% and was graded green. The information governance toolkit is available on the Connecting for Health website (www.igt.connectingforhealth.nhs.uk).

Clinical Coding error rates

HPFT was not subject to the Payment by Results clinical coding audit in 2010/11 by the Audit Commission.

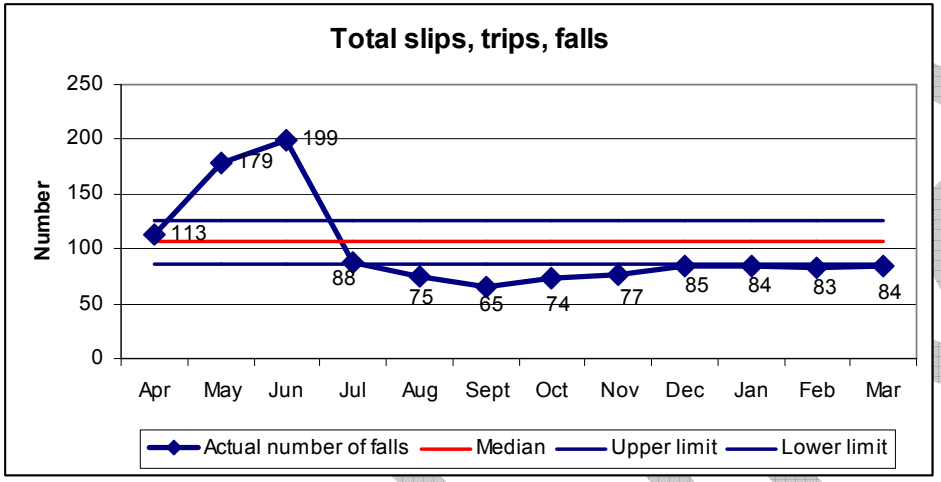
Part 3.0

3.1 - Performance against our MH&LD quality priorities for 2010/11 *(this information was summarised in Table 3)*

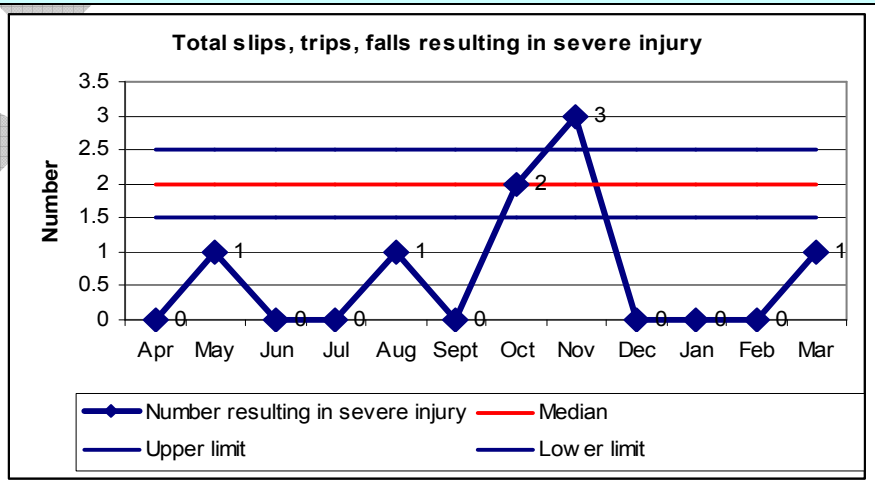
Last year we made a commitment to improve quality in three priority areas. These were included in our Quality Improvement Plan which was monitored throughout the year.

Below shows how we did. We have compared our 2010/11 results with the median, upper and lower limits obtained from HPFT data from 2009/10. The median is the middle number in a set of data and the upper and lower limits indicate the spread of the data. These help us to understand if we did better or worse than in 2009/10. Any targets were set and agreed with commissioners.

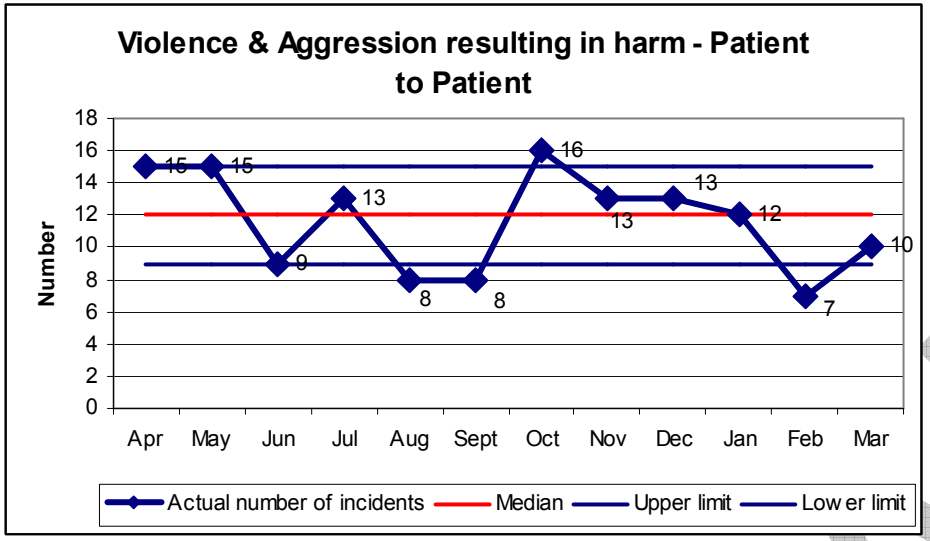
2010/11 results of how we did for Priority 1 : Improve safety

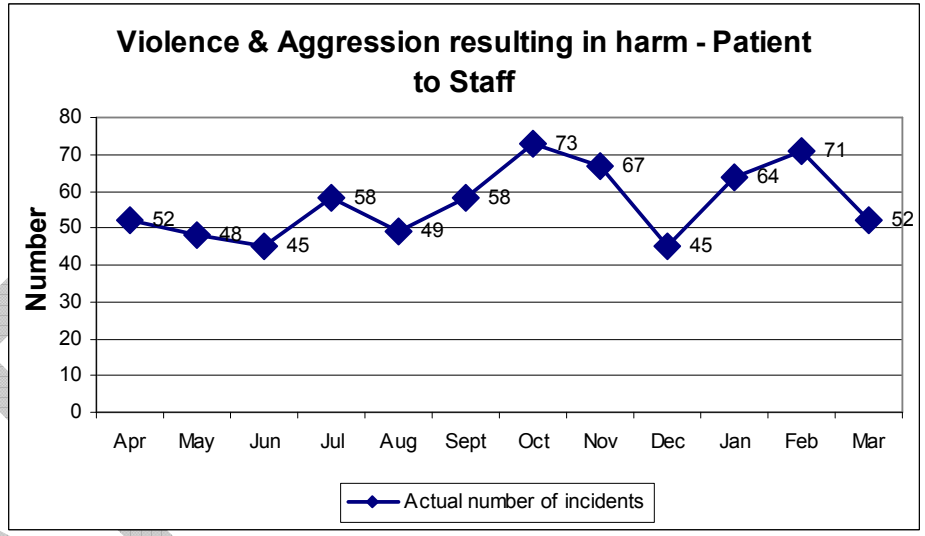


The graph above shows that during 2010/11 the number of falls decreased and was generally lower than in 2009/10. However, we believe the total number of falls was still too high. During 2011/12 we will work with specialist falls teams to improve how we identify people at risk of falling so we can more quickly put measures in place to prevent unnecessary falls. We will report our progress in our 2011/12 Quality Account.



The above graph shows that during 2010/11 there were a total of 8 falls resulting in severe injury (e.g. fracture). We believe this is too high. During 2011/12, we will be improving the assessments of people who have fallen so we can more quickly identify those in need of medical attention. We will report our progress in the 2011/12 Quality Account.





During 2010/11 there was an overall decrease in patient to patient violence and aggression events compared to 2009/10. However, there was still an average of 11 per month. These events are due to a small number of patients and during 2011/12 we will aim to more quickly identify the people who cause such events so we can more effectively put measures in place to stop this occurring. We will report our progress in the 2011/12 Quality Account.

How this indicator was measured was changed during 2010/11, so there is no comparable data from 2009/10 and therefore no median or upper and lower limits. However, improved scores for this topic in the National Staff Survey indicate that process was made during 2010/11.

During 2010/11 there was an average of 57 patient to staff incidents of violence and aggression per month. We believe this is too high. A training package is being developed to ensure all staff know how to respond to and manage people with challenging behaviours. We will report our progress in the 2011/12 Quality Account.

There were other measures for priority 1 (improve safety) which are not suitable to display in graphs. Performance on these was as follows:-

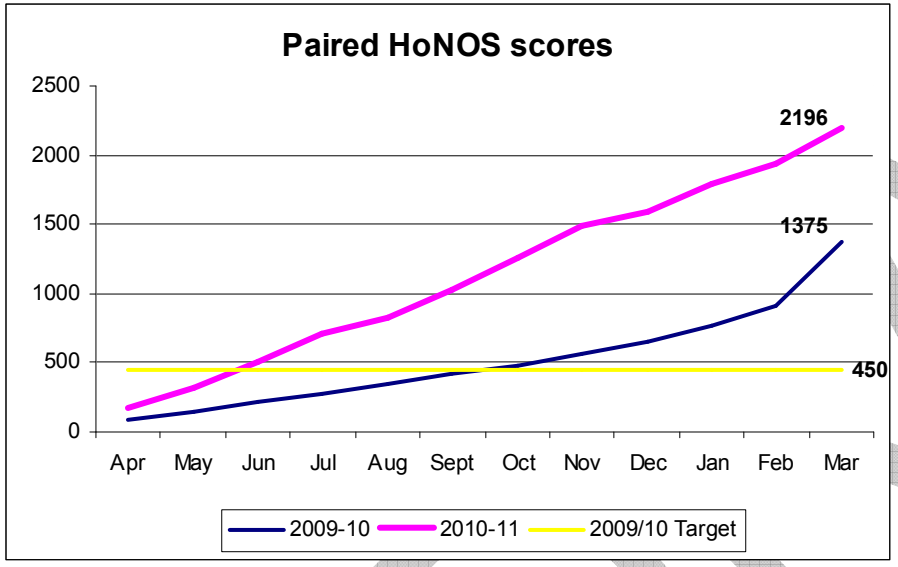
- Launch a revised risk assessment policy
  A new risk assessment and management of patients/service users policy was launched in June 2010 which was supported by an improved risk assessment training package for staff. Implementation of the policy will be subject to audit during 2011/12.

- Undertake a safety climate survey in in-patient wards in the Trust

A staff safety climate survey was piloted in in-patient units during 2010/11 and will be rolled out in all areas during 2011/12.

- Improve the quality of Critical Incident Reviews
  All Critical Incident Reviews (CIR) are now independently reviewed for quality and the majority of recommendations are SMART (Specific, Measurable, Achievable, Realistic and within Timescale). Whilst some improvement in timeliness was achieved in 2010/11 there is still room for improvement and this will continue to be monitored and reviewed during 2011/12.

2010/11 results of how we did for Priority 2: Improve outcomes



Health of the National Outcome Scores (HoNOS) contain 12 scales which are used to estimate severity in a range of severe mental illnesses. The crudest measures of outcomes are paired scores; two total scores for the same patient, one scored at the start of an episode of care and the second at a later point. The chart above shows the steady increase in the numbers of paired HoNOS total scores. This indicator will continue to be monitored during 2011/12; however it will not be included in our 2011/12 quality improvement priorities.

There were no escapes from medium secure units; there were also no escapes in 2009/10.

There were no grade 4 (most severe) pressure ulcers in 2010/11. In 2009/10 there were 4 grade 4 pressure ulcers.

In 2010/11, there were 2 admissions of young people to adult mental health units, compared to 16 such admissions in 2009/10.

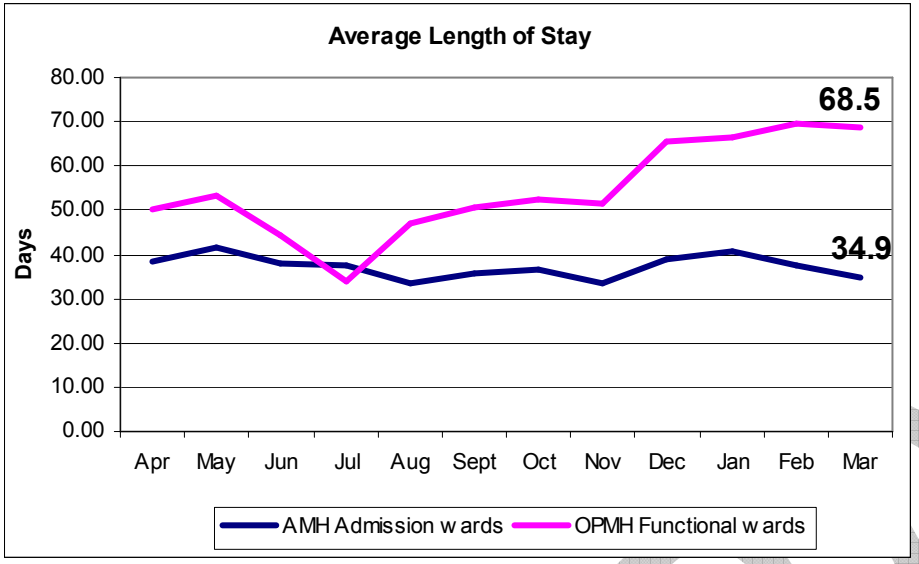
In 2010/11 there were 8 infection outbreaks (where there are 2 or more people ill with the same infection) which resulted in 48 days of ward/unit closure. There is no data from 2009/10.

An electronic patient record was implemented across the MH&LD services during 2010/11 and its use is subject to continuing clinical audit. In addition, during 2011/12, RiO will be implemented in ICS.

The use of HoNOS and HoNOS65+ was implemented in all AMH and OPMH teams during 2010/11. Strategies are in place to improve HoNOS reporting.

The above information has not been shown in graphs.

2010/11 results of how we did for Priority 3: Improve patient experience



During 2010/11 the average length of stay in Adult Mental Health (AMH) units was 37.6 days, whilst in Older Persons Mental Health (OPMH) units it was 54.5 days. This is too high. During 2011/12 a major programme to change how we manage our services will start (subject to public consultation) and this will help to address the length of stay. We will report our progress in the 2011/12 Quality Account.

There were other measures for priority 3 which are not suitable to display in graphs. Performance on these was as follows:-

- Develop a five year strategy for Patient Experience:
  The Trust's Patient Experience group issued "Positive Patient Experience" in November 2010 which is the Trust's vision for patient experience and for the development of service directorate strategies. During 2011/12 this strategy will be reviewed in light of the merger with HCHC.

- Map the current Patient Experience work that is underway within service directorates:
  The mapping exercise was completed within MH&LD services.

- Explore the use of obtaining service user experience feedback using the Developing Recovery Enhancing Environments Measure (DREEM):
  The DREEM tool was piloted within Ravenswood House and Southfield in the Specialised Services Directorate and Becton House within the OMPH directorate during 2010/11. Consideration will be given to rolling the use of this tool out across a broader range of services during 2011/12.

- Identify and agree patient experience indicators for inclusion in the 2010/11 directorate and Trust dashboard:
  A list of patient experience indicators was developed and several were adopted during 2010/11 in directorate and trust dashboards, including some relating to complaints which are outlined elsewhere within this report.

3.2 - Who we involved during the preparation of this report.

Clinicians, managers and analysts were invited to write a list of potential indicators for use during 2011/12. This list was shared with the following stakeholders who were asked for their views. In addition, staff, service users and Governors were invited to select their preferences and make comments and suggestions via a survey on our website. Stakeholders involved in the development of our priorities and measures included:-

- Staff
- Service users and carers
- Governors
- Commissioners
- Southampton and Hampshire Local Authorities (via the HOSC)
- Southampton and Hampshire Local Involvement Networks (LINks)

The Quality & Governance Committee considered the stakeholders comments and survey results and used this information to select the final list of measures to be used.

Our 2011/12 priorities and indicators have been approved by the Board.

All the stakeholders listed above were also given opportunities to contribute to and comment on the development and content of this report.

3.3 - What our Governors, Commissioners, Local Involvement Networks (LINKs) and Health Overview and scrutiny Committees (HOSCs) say about our Quality Account

The HPFT provided stakeholders with an early draft of the 2010/11 Quality Account for their consideration. The HPFT Board took the helpful comments received from stakeholders into consideration and significantly edited and amended the Quality Account. In short, the commentaries that follow below do not relate to the final version of the Quality Account that is presented here. The responses received are published here in full.

The Hampshire HOSC and Hampshire LINK acknowledged receipt of the draft HPFT 2010/11 Quality Account, but declined to provide a commentary.

3.3.1 - Statement from the HPFT Governors:-

During 2010/11 the HPFT Governors were given the opportunity to contribute to the Trust's quality improvement priorities for 2011/12 and the draft 2010/11 Quality Account, some chose to comment. A summary of the comments regarding the draft 2010/11 Quality Account are given below:-

- It is unrealistic to get all Governors to comment and respond in the timeframe required.
- The document is cumbersome
- There is lots of information on what was done well and there is some clarity over where we propose to go but there is no information about how to find this out.
- The summary of the Quality Account (section 2.0) is too complex and contains too much information.
- Some of the graphs in Section 3.1 do not add any value and should be omitted.
- Section 2.1 should show each priority on a separate page
- Consideration needs to be given on how to engage Governors in this agenda more fully in future.

6th May 2011
Anne Belasco
Lead Governor

HPFT response to the Governor's statement.

The Governors contribution to this report has been invaluable as a critical friend and has helped this report to be more accessible. Specifically we:-

- Have edited the document;

- Have made our plans for 2011/12 more clear and stated how and when we will report our progress;
- Have simplified the summary, deleted obsolete graphs (in section 3.1) and put each priority on a separate page (in 2.1);
- Will meet with Governors in June 2011 to ensure more engagement and involvement in the Trust's quality improvement initiatives in future and we will report our progress in the 2011/12 Quality Account.

3.3.2 - Statement from Southampton Local Involvement Network:-

"Southampton LINk is content that the quality account is representative and gives good coverage of the trust's services with no significant omissions. We were particularly please to read several of the statements made under the heading 'Additional areas of achievement and improvement'. For information, we did not find the content easy to follow and whilst we are happy with the general direction of the Trust and its progress, we would have liked to see a little more clarity in some of the explanations. Members of the general public will find this report hard going in places and we would suggest less use of jargon or an explanation of it for future accounts."

23rd May 2011
Harry Dymond
Chair

3.3.3 - NHS Hampshire response to Hampshire Partnership NHS Foundation Trust Quality Account April 2010 – March 2011

NHS Hampshire has reviewed Hampshire Partnership NHS Foundation Trust (HPFT) 2010/2011 Quality Account.

Report Structure

The Quality Account provides information across the three areas of quality as set out by Lord Darzi. These are:

- patient safety
- patient experience
- clinical effectiveness

The account largely incorporates the mandated elements required. There is evidence that the Trust has used both internal and external assurance mechanisms, for example through audit and national surveys.

Priorities

HPFT have outlined their priorities for 2011/12 and provide information as to why priorities have been chosen. These are linked to service user feedback through themes arising from complaints, national priorities, Governor Recommendations and the comparison of performance against other organisations.

Data Quality

Where information permits the PCT is satisfied with the accuracy of the data contained in the account.

HPFT has now installed the RiO computer software system (an electronic service user record) across all areas of the organisation. From this installation it is anticipated that the data quality will subsequently be improved across all services areas.

Clinical Audit and Research
HPFT participated in two out of the four eligible national clinical audits and the one eligible national confidential enquiry. However, 68 local audits were conducted. Outcomes are factored into projected work plans and it is anticipated that service user benefits will be reported in the future.

There has been some participation in clinical research in 2010/2011and NHS Hampshire would encourage this participation to continue.

Clinical Effectiveness
The progress made against the priorities outlined in 2009/10, and measured during 2010/11, is stated. To complement this, examples are given of additional improvements made in year. For example their contribution to the Local Safeguarding Boards and also the work completed within their Adult Mental Health service.

The account references Commissioning for Quality & Innovation Schemes and provides an opportunity to access more information via http:www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html or via the HPFT website.

Patient Safety
A summary of the progress against the patient safety priorities for 2010/2011 has been provided. NHS Hampshire has noted the rationale of why priorities have either been extended or amended for 2011/12.

Patient Experience
The patient experience section details the future priorities for 2011/2012. It is evident that feedback from internal patient experience monitoring and national surveys have been considered in these.

Hampshire Partnership Foundation Trust uses an independent Social Enterprise, called Patient Opinion. The purpose of this organisation is to acquire feedback independently from staff and service users. This has brought particular benefit for those service users who may not have much of a voice or confidence to speak about their experience. This is a very valuable service and NHS Hampshire supports the use of this organisation.

Commissioner Assessment Summary
NHS Hampshire will continue to work in partnership with Hampshire Partnership Foundation Trust to support the improvements outlined in this account.

Appendix 1 – Examples of Service User Stories and Experiences

In the other sections of this report we have shown how we are doing and we have shared our plans for the future. However, we felt it was important that this report also told us about the experiences of people who use our services. We therefore asked some service users and carers to tell us what it is like for them; what we did well and what they wanted us to improve. There follows a selection of their stories and quotes. We would like to thank everyone who shared their experiences with us; we have removed names (or used aliases) and some other information, to maintain confidentiality.

'Luke' started misusing substances in his early teens; he is now 33 years old and was made aware of Self Directed Support (SDS) by a local day service. He was then assessed by the local community drugs team and he identified support and services to meet his needs and aspirations including accessing the gym and learning the guitar. 'Luke' describes his experience of self directed support ….

"I think SDS is one of the best recent developments in the treatment system, as re-integration into society and a more normalised way of living is where I always seem to stumble. Stopping using drugs is the tip of the iceberg in the recovery process, and without some sort of stimulating alternative for the using lifestyle, a snowball is gonna start to look quite attractive if loneliness and boredom is the alternative."

"I've been a patient at Ravenswood {a forensic medium secure adult mental health unit near Fareham} *for just over a year. It used to be a frustrating place to be, as there weren't many meaningful activities. However, some staff have recently trained as gym instructors and so now I have help to access sport and fitness equipment which makes a big difference to how I feel about being here and my future."*

'Joanne' has profound learning disability and has suffered from multiple seizures for a number of years. She frequently had over 15 seizures a month; some lasted several hours and frequently required admittance to A&E {Accident and Emergency}. A review of Joanne's medication involving different professionals has reduced the number of seizures and visits to A&E. Joanne's carers describe their experiences…

"Joanne is now more awake and alert and her swallowing difficulties have improved. She seems so much happier".

"Dorothy {my wife} has dementia; it can be very difficult to deal with. However, the Older Persons Mental Health team have helped her stay at home, where she wanted to be. We don't like it when she is admitted because it can be confusing for us both".

Appendix 2 – An explanation of the abbreviations used in this report

Abbreviation	Explanation
AMH	Adult Mental Health – a part of the Hampshire Partnership NHS Foundation Trust that delivers services to working age adults
CQC	Care Quality Commission – the regulator for health and adult social care services in England
CQUIN	Commissioning for Quality and Innovation, a mechanism for encouraging quality improvement via incentives.
FMEA	Failure Mode and Effects Analysis, a proactive risk management approach.
HCHC	Hampshire Community Health Care, now the Integrated Community Services (ICS) part of the Southern Health NHS Foundation Trust
HPFT	Hampshire Partnership NHS Foundation Trust, now the MH&LD part of the Southern Health NHS Foundation Trust
HoNOS	Health of the Nation Outcome Scale – a tool to measure if the treatments and therapies we provide make a difference to service users lives
HOSC	Health Overview & Scrutiny Committee, part of the Local Authority.
ICS	Integrated Community Services. The part of Southern Health NHS Foundation Trust which was formerly Hampshire Community Health Care
LINks	Local Involvement Networks – an independent organisation with responsibility to represent service users, carers and the local population
MH&LD	Mental Health and Learning Disabilities services - the part of Southern Health NHS Foundation Trust which was formerly HPFT.
MHMDS	Mental Health Minimum Data Set - national statistics all mental health trusts contribute to
NICE	National Institute of Health and Clinical Excellence – an independent organisation that provides national guidance on the promotion of good health and the prevention and treatment of ill health.
NIHR	National Institute for Health Research, an independent organisation with responsibility for research in the NHS
NRLS	National Reporting and Learning System; a national database of patient safety incidents managed by the National Patient Safety Agency
NHS	National Health Service
OPMH	Older Persons Mental Health - a part of the Hampshire Partnership NHS Foundation Trust that delivers services to people aged 65+
P&HSO	Parliamentary and Health Service Ombudsman; undertake independent investigations into complaints about government and the health service
SHFT	Southern Health NHS Foundation Trust. Formed in April 2011 by the merger of Hampshire Partnership NHS Foundation Trust and Hampshire Community Health Care.
SIRI	Serious incident requiring investigation –such as unexpected death, medication errors, grade 4 pressure ulcers.

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DECISION-MAKER:	**HEALTH OVERVIEW AND SCRUTINY PANEL**
SUBJECT:	TO REVIEW THE SOUTHAMPTON UNIVERSITY HOSPITALS NHS TRUST (SUHT) FINAL DRAFT 2010/11 QUALITY ACCOUNT, AND PROVIDE COMMENTS FOR INCLUSION
DATE OF DECISION:	22 JUNE 2011
REPORT OF:	JUDY GILLOW, DIRECTOR OF NURSING, SUHT
STATEMENT OF CONFIDENTIALITY NOT APPLICABLE	

BRIEF SUMMARY

Healthcare providers publishing Quality Accounts in June 2011 have a legal duty to send their Quality Account to the OSC in the local authority area in which the provider has its registered office, inviting comments on the report from the OSC prior to publication.

The quality account for SUHT is presented to the Health Scrutiny Panel for its review, and comment for inclusion in the 200/11 Account, the Account and comments, will be published by 30th June 2011.

(i) **RECOMMENDATIONS:**

(i) To review the draft Quality Account for SUHT, and

(ii) To provide a written statement for publication in SUHT's Quality Account on whether or not the HSP considers, based on knowledge of the provider, that the report is a fair reflection of the healthcare services provided

REASONS FOR REPORT RECOMMENDATIONS

1 Healthcare providers publishing Quality Accounts in June 2011 have a legal duty to send their Quality Account to the LINk and OSC in the local authority area in which the provider has its registered office, inviting comments on the report from the LINk and OSC prior to publication.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2 N/A

DETAIL (Including consultation carried out)

3 The review process to date has included:-

- A workshop was held at SUHT with divisional managers and clinicians on 30th November 2010 to review the priorities that were set for 2010/11, and to begin planning for the 2011/12 priorities.

- This was followed up on the 27th April 2011 when divisional teams reviewed national and local progress, and confirmed local Patient Improvement Framework priorities for 2011/12.

- 26th April Trust Board 1st draft quality account
- 28th April 2011 1st draft quality account for comment to PCT commissioners, Audit Commission, OSC, S.LINKs, Members Council for review and comments (due for return by end June)
- 4th May 2011 1st draft quality account to TEC (SUHT) and cascade to divisions for comment.
- 8th June final draft quality account TEC (SUHT)

RESOURCE IMPLICATION

4 N/A

Capital/Revenue

5 N/A

Property/Other

6 N/A

LEGAL IMPLICATIONS

7 N/A

Statutory power to undertake proposals in the report:

8 The National Health Service (Quality Accounts) Regulations 2010 No 279 requires health providers to produce a quality account and that health overview and scrutiny committees are given the opportunity to comment.

9 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:

10 N/A

POLICY FRAMEWORK IMPLICATIONS

11 N/A

AUTHOR:	Name:	Jane Druce	Tel:	023 80 79 4745
	E-mail:	Jane.druce@suht.swest.nhs.uk		

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	ALL

SUPPORTING DOCUMENTATION

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

Appendices

1.	Quality Account 2010/2011

Documents In Members' Rooms

1.	N/A

Integrated Impact Assessment N/A

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

Other Background Documents N/A

Integrated Impact Assessment and Other Background documents available for inspection at: (attached).

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

Southampton University Hospitals NHS Trust

Our Quality Account
2010/2011

Contents

Foreword

Welcome to our Quality Account for 2010/11. As a hospital Trust, we strive to ensure continuous improvement in the quality of our services for patients. This report sets out our progress and information about the quality of services we provide for this year, and our priorities for quality improvement for the forthcoming year.

The Trust Board is committed to improving quality as a top priority. We define this quality as being world-class providers of patient experience, patient safety and clinical outcomes. We have a proactive and rigorous approach, using our Patient Improvement Framework (PIF) (appendix 1) to prioritise and drive the achievement of quality.

As one of the largest acute teaching Trust hospitals in the UK, it is our responsibility to deliver our service around the needs of our patients and our customers. Over the years we have listened carefully and developed our services based on these needs.

As a measure of our success, in 2010/11 more patients than ever before chose Southampton University Hospitals NHS Trust (SUHT) for their health care needs and despite the highest patient volumes seen, we continue to significantly improve the quality of our services, reduce the infection rates for C-Diff and MRSA, meet national waiting time targets for most specialities and reduce the overall number of complaints.

Our staff experience has significantly improved, evidenced by our staff survey results and we made clear progress in moving towards the 2020Vision with ever-greater levels of work in our defining specialist services.

In conclusion, I want to emphasise the commitment from the entire Trust to a strategy based on quality and safety that will deliver an improved patient experience. This is endorsed not only by the Trust Board but at every level in the organisation.

The improvements delivered over the last year are indicative of the engagement and active participation throughout the Trust. There is recognition of the important positive impact quality improvements have on our patients' experience. We will continue to evolve our quality plans to ensure we deliver an ever improving service.

To the best of my knowledge and belief, and in accordance with the regulations governing quality accounts, the information contained in this document is accurate and can be relied on.

Signed

Chief Executive
Date: 26th April 2011

Introduction to Southampton University Hospitals NHS Trust:

Our Vision

Our 2020Vision is:

'To be a world-class centre of clinical academic achievement, where staff work together to ensure patients receive the highest standards of care, and the best people want to come to learn, work and research.'

To continue to support delivery of our 2020Vision, the Trust has three priorities for our strategic objectives which wholeheartedly place clinical quality as a key priority throughout the Trust. This followed a full review and consultation process during 2010, through Trust Executive Committee and Trust Board, to set our focus for future years:

SUHT: Our strategic objectives for 2010/11

- SO1 Trusted on quality
- SO2 Delivering for taxpayers
- SO3 Excellence in healthcare

The Trust continues to make good progress toward achieving our 2020Vision through the balance of delivering excellence, quality and value to tax payers.

Our Quality Governance Strategy gives clear direction and a shared vision for how we ensure that quality is a priority at all levels in the Trust. It also outlines how Quality Governance is organised within the Trust as part of a whole-system approach to improving standards. Our Patient Experience Strategy and our Patient Safety Strategy support the strategy and our 2020Vision. Our model for delivery is through our innovative Patient Improvement Framework which, since 2007, has set out priorities for patient safety, patient experience and clinical effectiveness.

The framework is clinically supported and driven by our divisions and the board. By listening and learning from patient and staff feedback, and consulting with our commissioners, the priorities are reviewed and updated every year. Improvement programmes with targeted clinical metrics are then developed against these priorities. Our aspiration is to consistently surpass patient expectation.

Quality for patients

Improving performance in clinical quality for 2010/11 has remained a top priority and focus for the board. We are determined to go further and faster to be a high performing Trust. This year has seen some significant achievements, and in particular I would note the following:

1. Improved levels of patient satisfaction: more than 95% patients rated the Trust care good, very good or excellent, and 96% of our patients would recommend us to family and friends

2. A 25% reduction in hospital acquired pressure ulcers

3. 90% of all staff said their role makes a difference to patients. This rises to almost 10 out of 10 nurses saying they feel that their role makes a difference to patients

4. The Trust remains in the top 20% of employers for staff job satisfaction and for having fewer staff saying they intend to leave

5. A further reduction in Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia from 7 cases in 2009/10, to 5 in 2010/11; and in C. Diff reducing from 123 cases in 2009/10, to 89 cases in 2010/11, which places us as a top performer in the country.

6. Improvements in standards for same sex accommodation from 14% patients required to share mixed sex accommodation in March 2010, reduced to 4.7% in March 2011, which has resulted in improved patient feedback

7. In-hospital mortality continues to fall, from 1967 inpatient deaths (excludes Countess Mountbatten hospice) in 2008/09, to 1715 in 2010/11.

8. Unconditional registration with the Care Quality Commission (replaces compliance with the core Standards for Better Health requirements).

We will continue to explore more efficient and effective ways to support care delivery and quality improvement and ensure that this is underpinned by research, innovation and clinical audit. We have set out our top future quality priorities against safety, experience and clinical outcomes, which have been discussed and consulted on widely. The board will monitor progress and drive the delivery of these priorities as part of our quality journey to excellence.

The board would like to congratulate everyone for their hard work and professionalism in delivering such high standards of care, improving patient outcomes and their focus on patient safety. The quality improvements made this year will certainly set a precedent for the next.

Quality for our staff

Supporting our staff is key to achieving success with our 2020Vision. One of our core goals to achieve this is to improve staff experience and strengthen staff engagement. Progress is measured through the results of annual staff attitude surveys, which include questions on how staff rate the Trust as a place to work year on year, and the pride which they take in working here. Examples of our work to increase organisational effectiveness around quality and to embed quality in the Trust in this area include:

Staff Satisfaction and feedback: The findings of the staff attitude survey have also enabled the Trust to prioritise action on improving two-way communication with staff, increasing the take-up of equality and diversity training. Overall staff engagement has increased from below average in 2009 to above average in the 2010 national survey with many areas scoring in the top 20%.

Staff health and wellbeing: A wellbeing forum is now established with staff representation across the Trust, to develop effective ways of identifying and reducing workplace pressures experienced by staff. The Trust's return to health programme, with action plans for all managers to address wellbeing as an integral part of their responsibilities, is now proven to show it reduces overall absence length. The 12 month rolling average rate for absence for the Trust is 3.6% currently.

Leadership: The Trust's education department (IDEAL) delivers the Trust's Learning and Development strategy, with a focus on personal and team development, and building competence in change management and leadership. In 2010 we launched our own Leadership Academy to develop our clinical leaders.

Appraisals: Ensuring that all staff have clear personal objectives and development plans, underpinned by regular review meetings. We have a target of ensuring 85% of staff have appraisals which we are working hard to achieve. There is also an increasing emphasis on the quality of the process which will be audited between 2011/2012.

Through all of this work we want to ensure that our staff have pride in their jobs and are proud to work at SUHT.

Our quality management systems

Progress against each of our strategic objectives is reported to Trust Executive Committee and Trust Board quarterly. Supporting each of the strategic objectives are key priority measures of success, to help us assess our progress towards the 2020Vision. For the strategic objective 1 Trusted on Quality, our measures of success are

- Our NHS Litigation Authority rating
- Our compliance with the Care Quality Commission
- Progress in meeting our Cquin standards
- Managing our bed capacity, and
- Ensuring that we meet the Monitor compliance framework requirements.

These measures are reflected in the sections that follow.

How we monitor and report on quality:

We review the implementation status of all National Institute for Clinical Excellence (NICE) guidance, and National Confidential Enquiries (NCE) to risk assess any development areas at Southampton University Hospitals Trust, and take action to implement recommendations.

There is regular reporting of our Hospital Standardised Mortality Rate (HSMR) to Trust Board. This is also a priority that has been identified for next year.

We continue to support the use of clinical outcome data to assess and improve services with participation in national audits, the patient reported outcome measures programme (PROMS) as well as undertaking local audits to continue our cycle of quality improvement.

We hosted the Trust's fourth annual clinical effectiveness conference in November 2010, celebrating audits that have led to improved patient outcomes, safety and experience, with the National Clinical Director for Trauma as keynote speaker.

The patient improvement framework focuses on patient safety, patient experience and patient clinical outcomes; the Trust sets improvement targets on the quality priorities each year. These common themes are also mirrored in the Trust's committee structures and high level reporting practices. An integrated approach ensures that staff understanding of quality is embedded throughout the organisation and reflected in the Trust's quality dashboards and key performance indicators.

Assurance framework

The Trust Board is accountable for the systems of internal control and risk management. The chief executive is responsible for ensuring the delivery of a high quality service to patients and for the delivery of quality and performance targets.

For operational delivery, this responsibility is delegated to the medical director and the director of nursing for governance and quality and to the chief operating officer for performance targets.

Board engagement

Over the last year, the Trust Board has actively engaged in increasing understanding of the key components of quality, for example through board development seminars; taking clinical visits to the divisions; talking to frontline staff and ensuring the Trust is compliant with the Clinical Quality Commission's (CQC) 'Essential Standards of Quality and Safety'.

The Audit & Assurance Committee now devotes half its agenda to quality issues which require an in-depth review and scrutiny.

The board has developed a 'quality pyramid', which integrates financial and quality high level performance to ensure that effective management of financial resources does not have a negative impact on the delivery of a high quality service.
The Trust Board has reviewed the recommendations of nationally relevant external reports and publications for quality, and taken forward actions as appropriate.

Action for this year is to:

- embed the program of executive quality walk-rounds;
- develop a framework to provide patient stories at Trust Board;
- tackle and report on the five areas that our patients say they feel we could improve;
- develop the new integrated report on complaints, patient feedback and incidents quarterly for Trust Board;
- continue to listen to patients and aim to surpass their expectations.

Board reports

The Trust Board gains assurance on quality in various ways, via: -

- the monthly key performance indicator (dashboard) quality report;
- the monthly rolling program of patient improvement framework reports covering:
    - • patient experience
    - • patient safety
    - • clinical outcomes / effectiveness
    - • the quarterly regulatory assurance report
    - • Board visits to divisions to review delivery of the quality agenda.

In addition, the Audit & Assurance Committee and the Trust Executive Committee receive copies of minutes from the Trust's Quality Governance steering group.

Clinical standards accreditation

The attainment of National Health Service Litigation Authority (NHSLA) standards, which embed safety into practice, is an important achievement for the Trust. We met level 2 for Southampton General Hospital in December 2008, and in Maternity Services in September 2010.

NHSLA is a national body which works to improve risk management practices in the NHS.

The next section explains in more detail our progress to date, and how we plan to achieve the priorities for next year

Our progress and top priorities for quality improvement in 2011/12

This section of our Account discusses our progress in the priority areas we chose last year, and the priorities we have chosen for 2011/12.

How we agree our priorities for quality improvement

Deciding our priorities for improvement is a real team effort. The development of this account has been shared widely both within the Trust with our staff, and with our primary care Trust colleagues and community partners and other key stakeholders.

In March 2007 SUHT Trust Board agreed a Patient Improvement Framework (PIF) and this framework continues to form the basis of our Quality Governance assurance. The PIF is updated and reviewed annually. It is designed to reflect a broad approach to quality, to include national drivers, for example, Lord Darzis' 'High quality Care for All' command paper, and more recently the Department of Health Outcomes Framework for 2011. It also is prioritised to our local community quality priorities included in our PCT commissioner contract, and to our own risk register and assurance framework. This approach helps us to be sure that we focus on the most appropriate areas for our patients. The most recent 2010/11 Patient Improvement Framework is at annexe A.

Communication is a key overarching theme that we continue to work on with our staff and patients. The patient improvement framework update reflects the staff feedback we received during the development of the quality account. To determine these priorities, we began consulting with our staff in November 2010.

We assessed each initiative in terms of:

- impact on quality, considering the improvement in safety, outcomes and experience;
- feasibility, as a reflection of the ease of implementation, resources required and likely time to completion or delivery.

Review of our progress in 2010/11

Patient Safety; our performance in 2010/11:

Thromboprophylaxis – preventing venous blood clots

Our goal in 2010/11 was: To achieve documented risk assessments in 90% of patients for appropriate venous thromboprophylaxis (VTE) by quarter 4.

VTE prevention was identified as a top clinical priority for the NHS in the 2010-11 Operating Framework. It had already been identified as a top safety priority in the Trust. In 2010-11 the Commissioning for Quality and Innovation (CQUIN) payment framework made a proportion of our income conditional on a VTE-related requirement, and a NICE quality standard was issued.

Key requirements for this programme are to:

- ensure all adult patients admitted to the Trust undergo a risk assessment for VTE based on the Department of Health tool [with 90% the required minimum];
- provide preventative measures in accordance with the risk assessment;
- provide information to patients on VTE;
- ensure staff are provided with education and training on VTE;
- audit our performance and ensure improvement where required;
- submit data on performance from all admissions on the national database (Unify).

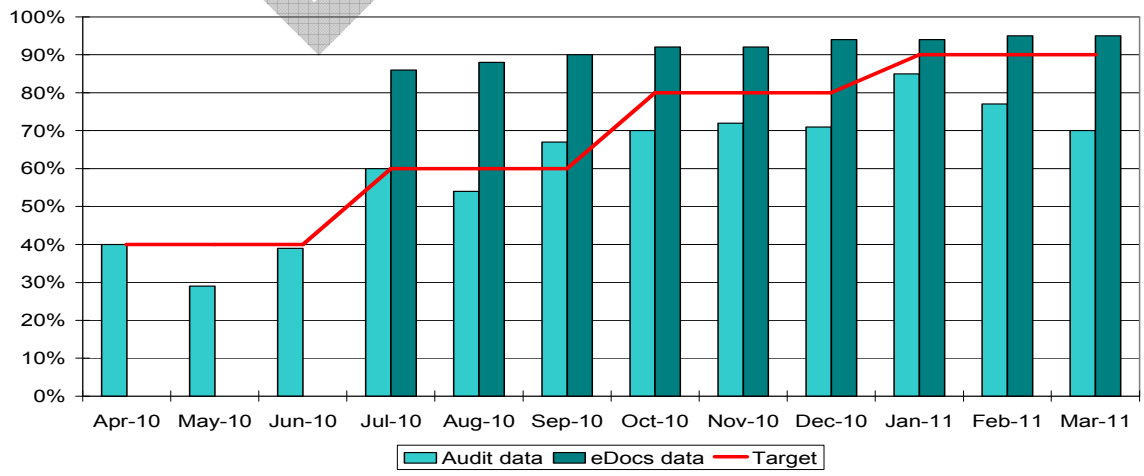
An extensive programme has continued through the year with progress across all six requirements. By March 2011 our e-records demonstrated that 95% of adult admissions undergo a risk assessment but we have not yet achieved e-data submission for all areas, so this is 95% of the patients where we have data. Our Unify submission for year-end, which is based on all our patients was 83.75%.

Manual audits for the year have shown steady improvement on correct prophylaxis (treatment) with an average of 88% receiving appropriate medicine prophylaxis and 85% appropriate mechanical prophylaxis over the final quarter.

SUHT: Our VTE risk assessment progress 2010/11

(sample: patients where e-data is available)

Documented risk assessment on admission



Reducing the incidence of pressure ulcers

Our goal in 2010/11 was: To achieve a 25% reduction in grade 3 and 4 hospital acquired pressure ulcers.

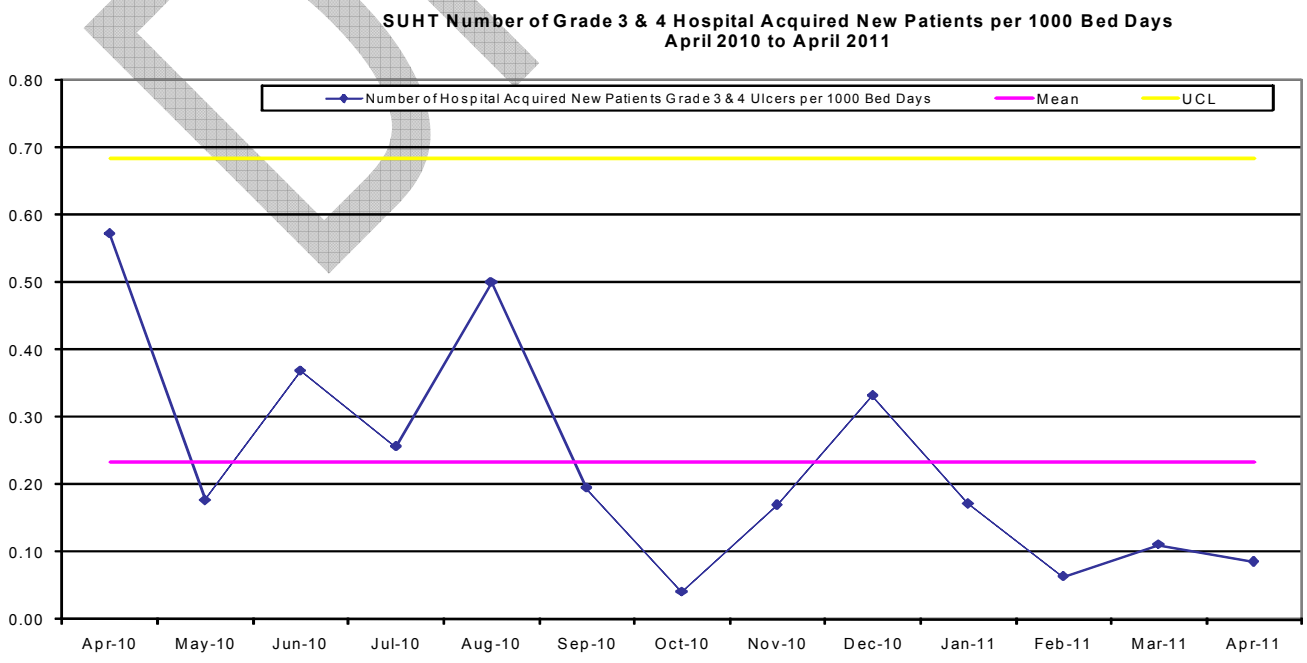
Pressure ulcers are graded using a national system from grade 1 to grade 4. Grade 4 is the most serious. The Trust achieved the 25% reduction in grade 3 and 4 pressure ulcers - 78 incidents compared to total number of 81 for last year. This is a significant achievement and one that has an impact not only on patient safety but also their experience. Such a decrease also reduces cost and increases productivity: a patient with a grade 4 pressure ulcer costs an additional £11,000 through increased length of stay and dressings.

Ward managers and matrons review the occurrence of hospital acquired pressure ulcers, and now present their root-cause analysis detailed investigations to a formal panel meeting. This ensures that lessons are learnt locally, and themes and trends shared across the Trust.

This reduction was achieved over the last six months of the year. In July 2010 we took part in a Department of Health led pilot project to use a new approach to service improvement, called rapid spread methodology. We called our project the Turnaround project. Patients identified as at high risk of developing pressure ulcers through the Braden assessment tool were included in a structured programme of two hourly nurse rounds to address pressure relief and skin care. All our general wards participated in the project and acquired full or partial accreditation dependent on the extent to which they implemented Turnaround. Six wards were given exemplar status for the way in which they embraced the project and their success in achieving no further reported hospital acquired pressure ulcers.

We have also seen a significant reduction in grade 2 hospital acquired pressure ulcers. This is a key quality measure where we have demonstrated significant improvement.

SUHT: Our pressure ulcers reduction progress 2010/11



Patient Experience: Our performance in 2010/11

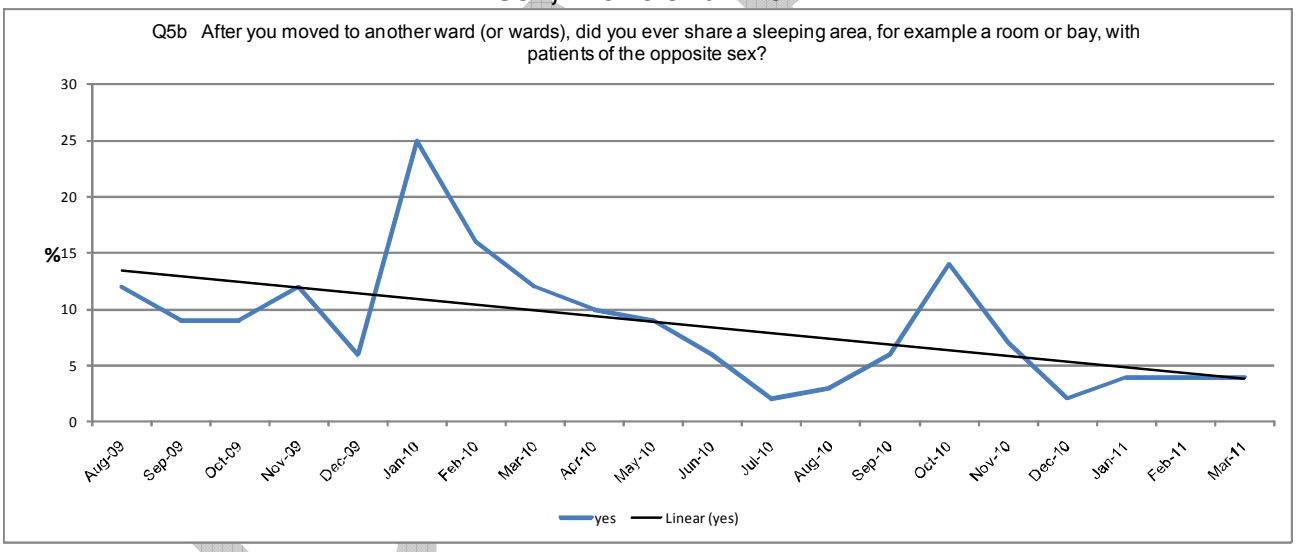
Our goal in 2010/11 has been to ensure patients have the best experience of our facilities, care and treatment as possible. We are delighted to be able to report that 96% of patients consistently expressed high levels of satisfaction with their care and 95% of patients would recommend the hospital to family and friends. 92% of patients reported always being treated with privacy and dignity by our staff. Performance in two of our specific target areas is detailed below.

Same Sex Accommodation

Following our comprehensive improvement programme in 2009/10, we are proud of our sustained achievements in this area. In 2010/11, we have continued to ensure over 99% of inpatient clinical areas are consistently compliant with Department of Health same sex accommodation regulations.

We survey our patients' experience of same sex accommodation with over 200 patients every month. Less than 5% of patients now report sharing accommodation.

% of patients reported sharing ward accommodation with patients of the opposite sex, with trend line.



Complaints

With over 120,000 patient episodes a year, our complaint rate is very low at 0.5%. We have improved our 2010/11 performance in responding to complaints about care and treatment. We have consistently exceeded our 75% target of responding to complainants in the agreed timescales and were over 90% in 9 of the 12 months of this year.

We are also seeing a downward trend in the number of complainants who return dissatisfied after our initial response, indicating an improvement in the quality of our investigations and responses.

We use feedback from all complaints and other patient feedback to improve our services.

Patient Outcomes - Our performance in 2010/11

For 2010-11 there were three priority areas:

- Developing, using and improving on locally led outcome measures;
- Participating in nationally set Patient Reported Outcome Measures (PROMS), with a focus on:
- Reducing the Trust's Hospital Standardised Mortality Rate (HSMR)

We intend to continue with these for 2011-12.

Locally led outcome measures

The Trust has a wide range of services and across all areas there is a need to reflect on outcomes. In 2010 we reported progress in a number of areas, including improving discharge summaries, treating patients who have suffered heart attacks, and stroke care. Updates on these are detailed below along with two further examples of 'locally led' outcome reports received by the board: trauma care and transcatheter aortic valve implantation (TAVI).

Improved discharge summary

We have continued to develop our discharge summaries for GPs and, in audit by our local GP practices, achieved above average levels of completeness and legibility. However, we recognise that there is more work to do to ensure that the summaries reach our GP practices quickly and consistently. We are working closely with our PCT colleagues to develop the use of electronic summaries with GP practices that are currently not able to access the systems available locally.

April 2010 Results of Survey By local GP Practices On Discharge Summaries Received:

SHIP* Provider Trusts	Trust	Trust	Trust	Trust	Trust	SUHT	Trust	MEAN
A Completeness	66%	64%	62%	64%	58%	78%	61%	66%
B Timeliness	16%	26%	9%	21%	52%	11%	50%	20%
C Legibility	93%	84%	88%	100%	88%	99%	99%	92%

*SHIP: Southampton, Hampshire, Isle of Wight, Portsmouth PCT area

Developing a fully functioning heart attack centre

Our heart attack centre is now established, and offers 24 hour and seven day a week emergency angioplasty treatment. An additional consultant has been appointed in 2011, and our plans include expansion to cover patients from Salisbury. In 2011 over 91% of our patients received treatment for their heart attack within the national target time of 90 minutes from arrival in hospital.

Stroke Service update

There has been a focus on stroke in the last financial year. SUHT was seen to be a poor performer a year ago and we have made enormous improvements.

A key indicator is the stroke national vital sign target, which is defined as the percentage of patients spending more than 90% of their time in hospital in a specialist stroke unit. Access to a specialist stroke unit improves outcomes for patients who have suffered a stroke. We have improved from around 40% of our patients spending more than 90% of their time on a stroke unit in April 2010, to 85% patients in March 2011. This is a fantastic achievement and a result of major service redesign.

We now admit stroke patients directly to our acute stroke unit 24/7 and the percentage of patients following this pathway increases month on month. Changes in the overall stroke patient care pathway should show further improvements in the quality of our stroke care; in particular we will be developing early supported discharge for stroke patients, who will be able to have their specialist stroke rehabilitation at home under certain circumstances.

We continue to perform strongly and meet the targets for our 7 day transient ischaemic attack (TIA) service.

As a result of the work we have done on the service, we were the winner of the Service Improvement Award at the Hospital Heroes presentations 2010-11.

Trauma Audit and Research Network (TARN)

TARN provides a national framework for the collection, submission and scrutiny of trauma survival data by hospitals and crucially, supports comparison with other hospitals. The framework allows a common approach across different centres which supports systematic clinical audit. This was taken to the Board as an example of locally led outcome data because of our intention to develop as a major trauma centre.

TARN submissions allow a wide range of reports but a key indicator of outcomes is presented as survival rate. For SUHT for the period January 2009 to December 2010, we had 3.5 additional survivors for every 100 trauma patients treated. This means, allowing for severity and other diseases, our patients did better than would be expected. These results place us in the top third of Trusts participating in TARN.

Transcatheter aortic valve implantation (TAVI)

TAVI is a recently developed intervention that can be used as an alternative to standard surgical aortic valve replacement. The procedure is performed on the beating heart without the need for a sternotomy or cardiopulmonary bypass. TAVI is performed in approximately 35% of the patients referred for possible TAVI treatment. This procedure is considered for patients who would be at too high a risk to undergo conventional aortic valve replacement. A review by the network and specialist commissioning in Nov 2010 concluded that the TAVI programme in SOTON was of a very high standard and comparable to centres with greater experience.

SUHT has a relatively small number of patients so it is not possible to draw statistically significant conclusions. However, indications are that outcomes are broadly in line with those in other UK TAVI centres. One year survival rates appear to exceed those achieved in the PARTNER trial.

SUHT TAVI Outcomes to 2011

	Number/percentage (25 in SUHT)	Benchmark
Procedural success	24	98% (TAVI Registry)
Emergency surgical AVR	1 patient	0.7% (TAVI Registry)
Deferred to apical TAVI	1 patient	
30 day survival	92% (2 patients)	95% (PARTNER trial)
1 year survival	80%	69.3% (PARTNER trial)
Peri-procedural MI	0	1% TAVI Registry)
TIA	0	0.6% (TAVI Registry)
Endocarditis	0	
Pacemaker required	4 (16%)	6% (TAVI Registry)
Creatinine >265	5	
Renal replacement therapy	2	
Stroke	1 (4%)	5% (PARTNER trial)
Vascular surgical repair	1 (4%) (this 88 yr old is still doing well)	16.2% (PARTNER trial)

Patient Reported Outcome Measures (PROMS)

These are nationally defined measures across four surgical interventions, of which SUHT undertakes two: hip replacement; knee replacement. It is expected that the range of interventions included will expand.

Patients are asked about their health related quality of life before and several months after their operation. A disease-specific and a more general measure are used.

SUHT data show similar results to the national picture, with the majority of patients achieving health gains from their hip or knee replacement but with a small number (7% for hips, 11% for knees) reporting a deterioration post-operatively.

SUHT PROMS results April 2009 to July 2010

	Hip replacement		Knee replacement	
	England	SUHT	England	SUHT
Cases included	21,340	109	23,907	111
Improvement in index made – ie what difference the operation made (Index is 0 to 1. 1 being perfect health)	+0.405	+0.400	+0.289	+0.263
Patients who after the operation said: Health improved No change Health worsened	 87.0% 6.2% 6.7%	 86.0% 7.3% 6.4%	 77% 11% 11%	 76% 13% 12%

NB numbers included mean that there are no statistically significant differences between SUHT data and national data.

Hospital Standardised Mortality Rate (HSMR)

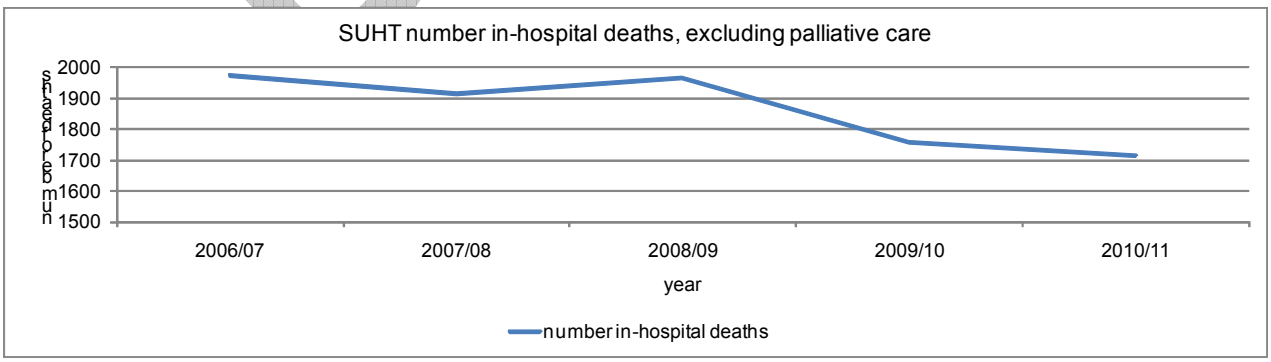
We have made some good progress in improving our Trust patient mortality rate, however there is still more work to do and so HSMR remains our top Outcome priority for the coming year 2011/12.

Our progress last year:

In 2010/11, our Aim was:
To reduce the Trust's overall HSMR to 90 by the end of March 2011 (bench marked against the revised 2009/10 data).

In 2010/11 more patients than ever before chose Southampton University Hospitals NHS Trust (SUHT) for their health care needs. Despite the highest patient volumes seen, the number of patient deaths in the Trust has continued to fall gradually over the past 5 years.

SUHT in-hospital deaths, excluding palliative care 2006-2011



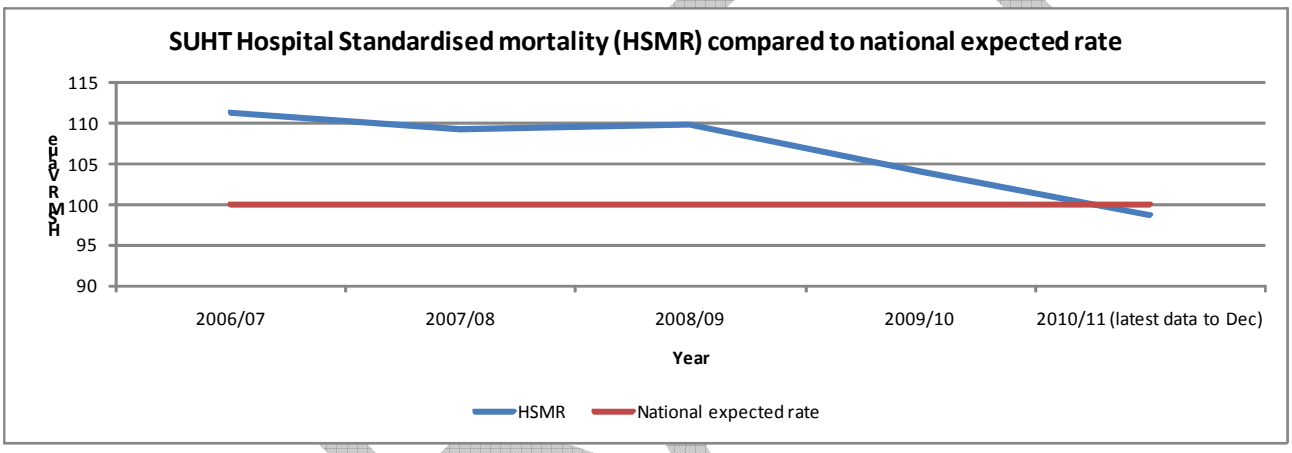
In 2010/11 the Trust treated 129,199 patient admission spells. 1715 deaths represents a percentage of 1.3% of our patients.

Reducing the Trust's Hospital Standardised Mortality Rate

The HSMR is a benchmarking ratio, of observed deaths / expected deaths (x100). It is used as an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect compared to the general population. We can use information presented in this way to help us compare our performance fairly, for example with other hospitals of similar size or type nationally, or in a similar patient catchment area.

Of the two measures relating to HSMR, the Trust is performing above average in terms of the national expected rate (96.7 as against 100); but below the national average of 90. This means that our HSMR will be on the upper edge of the national 'as expected' category for mortality next year. Our priorities for patient outcomes for 2011/12 reflect our emphasis on achieving an HSMR in line with the national average.

Our HSMR results by site from 2005 to 2011, source Dr Foster Intelligence



Our relative risk score is one of the highest for our Trust type, meaning that our patients are scored by Dr Foster as being sicker than average. Southampton is a regional tertiary centre and our patient acuity audits confirm that our patients are expected to be more complex than average.
In-depth review of the clinical data for all our patient groups with a higher than expected HSMR continues. Detailed clinical review with the Dr Foster Intelligence Unit and Imperial College for both the obstetric and palliative care teams has shown no cause for concern. Countess Mountbatten Hospice does have a lower proportion of coded non-elective admissions than would be expected for a hospice facility, being 70% rather than an expected 85%. Changing our approach to coding the patients admitted here will have no adverse effect on their care, but would reflect the standards of care we provide more accurately. However we are not complacent, and our work next year will continue to focus on both clinical development and information systems support, to better understand and improve our mortality rate data.

Our areas of work to improve our HSMR during last year focused on practical developments, and on improving our communications and information systems that support patient care.

Identifying deteriorating patients more quickly

We have improved our processes for the escalation of care for patients showing deterioration, by increased training for the nursing and medical staff. This includes using the modified early warning monitoring system (MEWS) tool. Use of MEWS has increased by nearly 20% since Dec '09, and directly improves planning and care for these unwell patients.
As a result of using the MEWS system, while our % rates of unplanned admissions into general intensive care have increased to higher than the national average, being 31% (nationally 21% [National Confidential Enquiry into Patient Outcome & Death NCEPOD 2005], unexpected deaths and delays in admission to intensive care have all fallen.

Further information about this story can be found in our patient safety report on our website.

Safer surgical operations

We implemented the World Health Organisation 'Safer Surgery Checklist' in all our operating theatres as normal daily practice. Our audits earlier this year showed that the checklist was part of normal practice in all areas except two: emergency and cardiac theatres. Following further work with the relevant teams, the checklist was re-audited. Near full compliance to the checklist has now been demonstrated.

Safety in medicines

We have improved the information we give divisions about incidences relating to medicine reconciliation and allergy recording for their action to maintain improvement. We are also focusing on missed medication doses. We have audited our wards to understand why doses are missed and are then taking appropriate action to prevent these occurrences. A 'Critical Medicines' list has been developed for medication that should not be omitted without medical instruction, and the systems of supply have been reviewed to ensure that a delay in the supply chain is not a cause for missed dose. We have also reduced the number of medicine administration errors.

Improving communications

We are developing an electronic medical handover process, linking to patient acuity monitoring and acknowledgement of test results with better clinical information (primary and secondary diagnoses to support risk stratification) on our electronic patient information systems and electronic discharge summary systems. This will enable clinical staff to focus on the most ill patients first.

Our top priorities for 2011/12

Summary

Safety:

Priority 1: VTE: VTE (venous thromboembolism) prevention was identified as a top clinical priority for the NHS since 2010, and in our Trust. We will continue to work to achieve risk assessments in 90% of our patients for appropriate venous thromboprophylaxis by quarter 4

Priority 2: We want to continue to improve our reduction of pressure ulcers to support our ultimate aspiration to reduce avoidable pressure ulcers to zero. We will aim to reduce grade 3 and 4 hospital acquired pressure ulcers by a further 25% on last year's outturn, and to reduce grade 2 hospital acquired pressure ulcers by 20%.

Priority 3: Is to reduce the number of avoidable falls that result in high harm by 50%.

Experience:

Priority 4: Nutrition and hydration – Patient food, nutrition and hydration is a top priority for us. We will work with our catering provider to ensure over 90% of patients report hospital food to be good, very good or excellent. In addition, we will ensure over 95% of patients receive nutritional screening (MUST) within 24 hours of admission.

Priority 5: Communication – We want to keep patients, relatives and carers fully informed about their treatment and care & involve them in decisions, so we aim to reduce complaints and concerns relating to communication by 20% (from 45 to 36 p.a where communication and information is the primary concern)

Outcome:

Priority 6: Although we have made good progress in reducing our patient mortality rates, there is still work to do, and this will remain a key priority for patient outcomes next year. We will continue to drive down the hospital standardised mortality rate (HSMR) to below the national expected rate by March 2012.

Priorities for Patient Safety for 2011/12

Reducing VTE (venous thromboembolism)
VTE (venous thromboembolism) prevention was identified as a top clinical priority for the NHS since 2010, and in our Trust. We will continue to work to achieve risk assessments in 90% of our patients for appropriate venous thromboprophylaxis by quarter 4

Reducing Pressure Ulcers
To reduce grade 3 and 4 hospital acquired pressure ulcers by a further 25% on last year's outturn and to reduce grade 2 hospital acquired pressure ulcers by 20%.

The rationale for this priority is to continue to improve our reduction of pressure ulcers to support our ultimate aspiration to reduce avoidable pressure ulcers to zero. This is also a contractual requirement and a goal of Safety Express, a DH led initiative in which the Trust is participating.

An annual plan of action will be developed to support the delivery of this improvement priority and will include:-

- continuing with the Root Cause Analysis panels for grade 4 pressure ulcers but also including grade 3s;
- fully implementing the Turnaround process for all wards and securing sustainability;
- a program of audits on nursing practice;
- training and awareness;
- developing the whole health economy pathway;
- participating in safety express.

The Tissue Viability Steering Group will oversee the delivery of the plan and key performance data will be collated on our central database and monitored weekly.

Reducing Avoidable falls
Our aim is to reduce the number of avoidable falls that result in high harm by 50%. This is a contractual requirement, part of our Turnaround project and also a goal of Safety Express.

An annual plan of action will be developed to support the delivery of this improvement priority and will include:-

- the development of a multi-factorial assessment for frail elderly patients;
- patient and public awareness campaign;
- the launch of falls link nurses as advisors and trainers;
- developing the whole health economy pathway;
- participating in safety express;
- the development of Root Cause Analysis panels to review falls where high harm has been sustained.

The Falls Prevention Group will oversee the delivery and monitor the effectiveness of the plan.

Priorities for Patient Experience for 2011/12

PIF Priority	Rationale	Proposed Improvement Target	Measurement Source
Nutrition and Hydration To ensure no needless malnutrition To enhance patient experience of hospital food	• Top priority for SLINKS (PPI feedback) • Feedback from CQC Visit • Achieved amber and red on 2010/11 targets • 2010 National Patient Survey Feedback • Real time inpatient survey feedback • Ombudsman Report into older people	**Target 1**: 95% patients receive MUST screening within 24 hours of admission by year end **Target 2:** 90% patients assessed as high risk via MUST have appropriate nutrition care plan in place. **Target 3:** 90% patients report hospital food to be good, very good or excellent **Target 4**: 95% patients that need help at mealtimes receive this	**Target 1**: Monthly MUST audit on CQD Dashboard **Target 2**: Monthly MUST audit on CQD Dashboard **Target 3**: Monthly real time inpatient survey **Target 4:** Monthly real time inpatient survey
Patients as partners To keep patients, relatives and carers fully informed about their treatment and care and involve them in decisions	• Frequent theme in complaints, PALS and patient feedback that we do not keep patients, relatives or carers sufficiently informed about progress with their care and treatment or involve them in the decision-making about • 2010/11 CQUIN for pt experience – achieved locally but not on national inpatient survey • 2010 national inpatient survey results • Real time monthly survey results	**Target 1:** Achievement of 2011/12 National CQUIN for patient experience **Target 2**: Sustain month on month local performance on the 5 CQUIN patient survey questions **Target 3**: Reduction in level 1/2/3 complaints and concerns relating to poor communication/provision of verbal information by 20%	**Target 1**: Amalgamated score of 5 questions from national inpatient survey • Pt involvement in decisions about their care • Finding someone to talk to about worries and fears • P&D when discussing condition or treatment • Being told about medication side effects on discharge • Pts told who to contact about worries or fears after discharge **Target 2**: Monthly real time inpatient survey **Target 3**: Monthly complaints and concerns data (agree baseline by Div/care group and ward in Q1)

In the patient experience section of our patient improvement framework in 2011/12, we will keep working on previously agreed priorities for discharge and safeguarding vulnerable adults and add a new priority for documentation.

Along with this we will deliver a whole organisation improvement programme for improving customer service and embedding our organisation's values.

Priorities for Patient Outcomes for 2011/12

In 2011/12, our actions will include:

- development of an electronic patient acuity monitoring system for MEWS, to allow better daily review of escalation process and real-time learning;
- continued work to improve the escalation of care for deteriorating patients by developing recognition and the management of deterioration at ward level, and our outreach services to support these patients;
- continuing to support our established processes for detailed medical team review of cases of unexpected deterioration by clinical specialties;
- guidance and an alert system to prevent medication errors when transferring patients to community hospitals;
- collecting better quality information on primary and secondary diagnoses and co-morbidities;
- the development of an eLearning package to improve understanding of appropriate coding and its importance in medical handover and discharge information;
- making data results more accessible for our consultants to review;
- continuing to develop and improve our electronic discharge information for GPs.

Statements of assurance from the board

This section of our Quality Account evidences that:

- we are actively measuring clinical processes and performance (clinical audits);
- we are involved in national cross-cutting projects and initiatives aimed at improving quality, for example, recruitment to clinical trials or through establishing quality improvement and innovation goals with the commissioner using the Commission for Quality & Innovation (CQUIN) payment framework.
- we are performing to essential standards (CQC), as well as going above and beyond this to provide high quality care;

Review of services

During 2010/11 the Southampton University Hospitals NHS Trust provided 24 NHS services and subcontracted 27 services. More information about these can be found on our website www.suht.nhs.uk

Southampton University Hospitals NHS Trust has reviewed all the data available on the quality of care in all 51 of these NHS services.

The income generated by the NHS services reviewed in 2010/11 represents 100 % of the total income generated from the provision of NHS services by Southampton University Hospitals NHS Trust for 2010/11.

Participation in clinical audits

During the period between 1/4/2010 and 31/3/2011, 44 national clinical audits and 1 national confidential enquiry covered NHS services that Southampton University Hospitals NHS Trust (SUHT) provides.

During that period SUHT participated in 84% (37) national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that SUHT was eligible to participate in during the period between 1/4/2010 and 31/3/2011 are as follows:

Confidential Enquiry
Perinatal mortality (CEMACH)

National Audits
Neonatal intensive and special care (NNAP)

Paediatric pneumonia (British Thoracic Society)

Paediatric asthma (British Thoracic Society)

Paediatric fever (College of Emergency Medicine)

Childhood epilepsy (RCPH National Childhood Epilepsy Audit) — Commences May 2011

Paediatric intensive care (PICANet)

Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)

Diabetes (RCPH National Paediatric Diabetes Audit)

Emergency use of oxygen (British Thoracic Society) — No data submitted

Adult community acquired pneumonia (British Thoracic Society) — No data submitted

Non invasive ventilation (NIV) - adults (British Thoracic Society)

Pleural procedures (British Thoracic Society)	No data submitted
Cardiac arrest (National Cardiac Arrest Audit)	
Vital signs in majors (College of Emergency Medicine)	
Adult critical care (Case Mix Programme)	
Diabetes (National Adult Diabetes Audit)	
Heavy menstrual bleeding (RCOG National Audit of HMB)	
Chronic pain (National Pain Audit)	
Ulcerative colitis & Crohn's disease (National IBD Audit)	
Parkinson's disease (National Parkinson's Audit)	TBC
COPD (British Thoracic Society/European Audit)	
Adult asthma (British Thoracic Society)	No data submitted
Bronchiectasis (British Thoracic Society)	Registered for 2011/12
Hip, knee and ankle replacements (National Joint Registry)	
Elective surgery (National PROMs Programme)	
Coronary angioplasty (NICOR Adult cardiac interventions audit)	
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	
Carotid interventions (Carotid Intervention Audit)	
CABG and valvular surgery (Adult cardiac surgery audit)	
Familial hypercholesterolaemia (National Clinical Audit of Mgt of FH)	
Acute Myocardial Infarction & other ACS (MINAP)	
Heart failure (Heart Failure Audit)	
Acute stroke (SINAP)	No data submitted
Stroke care (National Sentinel Stroke Audit)	
Patient transport (National Kidney Care Audit)	
Renal colic (College of Emergency Medicine)	
Lung cancer (National Lung Cancer Audit)	

Bowel cancer (National Bowel Cancer Audit Programme)

Head & neck cancer (DAHNO)

Hip fracture (National Hip Fracture Database)

Severe trauma (Trauma Audit & Research Network)

Falls and non-hip fractures (National Falls & Bone Health Audit)

O neg blood use (National Comparative Audit of Blood Transfusion)

Platelet use (National Comparative Audit of Blood Transfusion

Dementia

A small number of the audits were not on the Trust audit plan last year, but are prioritised for 2011/12 in line with our Trust priorities approach. We chose not to participate in the national acute stroke SINAP audit as this database is still in development nationally, we have local arrangements to collect and use this clinical information.

The national clinical audits and national confidential enquiries that Southampton University Hospitals NHS Trust participated in during 2010/11, are included at appendix 2

The national clinical audits and national confidential enquiries Southampton University Hospitals NHS Trust participated in, and for which data collection was completed during 2010/11, are listed in appendix 2 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The reports of 36 national clinical audits were reviewed by the provider in 2010/11 and Southampton University Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided listed in appendix 2.

“The reports of 93 local clinical audits were reviewed by the provider in 2010/11 and Southampton University Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided, listed in appendix 3.

Research

The number of patients receiving NHS services provided or sub-contracted by Southampton University Hospitals NHS Trust in 2010/2011 (01/04/2010 - 31/03/2011) that were recruited during that period to participate in NIHR supported research approved by a research ethics committee was 12308.

Our commitment to research as a driver for improving the quality of care and patient experience

Participation in clinical research demonstrates Southampton University Hospitals NHS Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

Southampton University Hospitals NHS Trust was involved in conducting 243 NIHR supported clinical research studies in a broad spectrum of medical specialties during 2010/2011.

There were 1073 clinical staff participating in both National Institute for Health Research (NIHR) and non-NIHR supported research approved by a research ethics committee at Southampton University Hospitals NHS Trust during 2010/2011.

Our goals agreed with the commissioners

A proportion of Southampton University Hospitals NHS Trust income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2010/11 and for the following 12-month period are available at www.suht.nhs.uk

We have used the CQUIN framework to actively engage in and agree quality improvements working with our commissioners, to improve patient pathways across our local and wider health economy.

Reflecting our wide patient catchment area, we agreed three CQUIN programmes in operation. These were one standard contract CQUIN held jointly between all our PCT commissioners, coordinated by NHS Southampton, and one for each of our two specialist services commissioning groups in South Central and South West.

SUHT; Our CQUIN priorities for 2010/11

Indicator source	Standard Contract	South Central Specialist	South West Specialist
National	Venous thromboembolism	Venous thromboembolism	Venous thromboembolism
	Patient experience	Patient experience	Patient experience
Strategic Health Authority	Improving Quality Programme	Improving Quality Programme	Improving Quality Programme
Local	Pressure Ulcers reduction	Special care baby unit bed days	Bone marrow transplant survival
	End of Life care	Haemophilia factor VIII	Paediatric cardiac surgery
	Enhanced Recovery programme		Neonatal care
	Smoking Cessation		

The CQUIN targets set were challenging, however we have made significant progress. These areas remain part of our improvement focus for 2010/11.

What others say about Southampton University Hospitals NHS Trust

Statements from the Care Quality Commission

We are successfully registered with the CQC unconditionally. Southampton University Hospitals NHS Trust is required to register with the Care Quality Commission and its current registration status is as follows:

Regulated activity: Surgical procedures
Provider conditions: This regulated activity may only be carried on at the following locations:

- Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA
- Southampton General Hospital, Tremona Road, Southampton, SO16 6YD.

Regulated activity: Treatment of disease, disorder or injury
Provider conditions: This regulated activity may only be carried on at the following locations:

- Countess Mountbatten House, Moorgreen Hospital, Botley Road, West End, Southampton, SO23 3JB
- Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA
- Royal South Hants Hospital, Brintons Terrace, Southampton, SO14 0YG
- Southampton General Hospital, Tremona Road, Southampton, SO16 6YD.

Regulated activity: Maternity and midwifery services
Provider conditions: This regulated activity may only be carried on at the following locations:

- New Forest Birth Centre, Ashurst Hospital, Lyndhurst Road, Ashurst, Southampton, SO40 7AR
- Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA

Regulated activity: Diagnostic and screening services
Provider conditions: This regulated activity may only be carried on at the following locations:

- Countess Mountbatten House, Moorgreen Hospital, Botley Road, West End, Southampton, SO23 3JB
- Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA
- Royal South Hants Hospital, Brintons Terrace, Southampton, SO14 0YG
- Southampton General Hospital, Tremona Road, Southampton, SO16 6YD
- New Forest Birth Centre, Ashurst Hospital, Lyndhurst Road, Ashurst, Southampton, SO40 7AR

Regulated activity: Transport services, triage and medical advice provided remotely
Provider conditions: This regulated activity may only be carried on at the following locations:

- Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA
- Southampton General Hospital, Tremona Road, Southampton, SO16 6YD.

The Trust has also applied for registration for the 'Assessment or medical treatment for persons detained under the 1983 (Mental Health) Act' and is currently awaiting hearing from CQC in respect of these services.

Southampton University Hospitals NHS Trust has no conditions on registration.

The Care Quality Commission has not taken enforcement action against Southampton University Hospitals NHS Trust during 2010/11.

Southampton University Hospitals NHS Trust is not subject to periodic reviews by the CQC.

Southampton University Hospitals NHS Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The Care Quality Commission undertook a planned review of compliance at the Southampton General Hospital site in January 2011 and the hospital was found to be compliant with all 16 of the core Essential Standards of Quality and Safety.

Our data quality

Our scores are close to, or above national average for data quality:

Southampton University Hospitals NHS Trust submitted records during 2010/11 to the NHS-wide Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

— which included the patient's valid NHS number was:
96.6% for admitted patient care;
97.7% for out patient care; and
93.9% for accident and emergency care.

— which included the patient's valid General Medical Practice Code was:
100% for admitted patient care;
99.7% for out patient care; and
100% for accident and emergency care.

The Information Quality and Records Management attainment levels assessed within the Information Governance Toolkit provide an overall measure of the quality of data systems, standards and processes within an organisation.

Southampton University Hospitals NHS Trust Information Governance Assessment Report overall score for 2010-11 was 73% and was graded Green (Satisfactory).

This represents an improvement from 64% in 2009/10

Our patients from overseas and the Channel Islands are not issued with an NHS number, but are included in our results. This group do not affect our results for the GM practice code, because we are able to identify these patients as non –UK citizens, and the Secondary Uses Service acknowledges this.

SUHT recognises that good quality health services depend on the provision of high quality information. Continuing the work undertaken in 2010/11, SUHT will be taking the following actions to improve data quality:

- Performance management of data quality via Trust, Divisional and Clinical Coding and Information Data Quality Groups, and the corporate Information Quality Assurance Team. Key performance indicators on internal and external timeliness, validity and completion of patient data will be reviewed by the group in conjunction with use of the

Dr Foster comparative analysis information. Areas of poor performance will be identified, investigated and action plans agreed for improvement.

- Continue work to reduce data quality problems at the point of data entry through improved system design, changes to software, and delivery of new computer systems.
- Work towards delivering real time admission, discharge and transfer recoding across more ward areas, thereby supporting improved patient tracking and bed management.
- Support the development of training and education programmes for all staff involved in data collection.
- Maintain a programme of regular internal audit, including data quality, information governance and clinical coding audit.
- Continue to maintain and develop improved compliance with the Information Governance Toolkit standards.

Southampton University Hospitals NHS Trust was not subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission.

However the Trust submitted an Internal Audit to Connecting for Health (CFH) in October 2010, as required to support Information Governance requirement 505 and has an established internal clinical coding audit programme, reporting monthly to the Trust Data Quality Steering Group.

Further Information

Please visit our website www.suht.nhs.uk. Here you will find useful further information, including:

Clinical effectiveness annual reports, explaining some of our clinical developments in more detail

Annual reports, which explain how we link our broader financial responsibilities to providing quality patient care

The Statement of Internal control, explaining how our audit and assurance processes are arranged.

In addition, this section includes a summary of our key performance progress, and some examples of the work our teams are engaged in that supports our Trust priorities for quality.

Our Progress and Performance to 2010 11

Key targets	2007/08	2008/09	2009/10	March 2011	2010/11 Targets
A&E patients, % admitted, transferred or discharged within 4 hours (SUHT & Partners)	97.08%	Achieved 98.29%	Achieved 98%	97.0% Full year	**>= 95%**
18 weeks – Admitted patients	76.6%	Achieved >90% in Jan, Feb & Mar 09	Achieved >90% in all quarters	87.2% Full year	Maintain >= 90%
18 weeks – Admitted 95th centile wait	Not measured	Not measured	Not measured	33.9 wks March 11	**<= 27.7 weeks**
18 weeks – Admitted median wait	Not measured	Not measured	Not measured	8.8 wks March 11	**<= 11.1 weeks**
18 weeks – Non admitted patients	91%	Achieved >95% in Jan, Feb & Mar 09	Achieved >95% in all quarters	95.3% Full year	Maintain >= 95%
18 weeks – Non admitted 95th centile wait	Not measured	Not measured	Not measured	23.7 wks March 11	**<= 18.3 weeks**
18 weeks – Non-admitted patients median wait	Not measured	Not measured	Not measured	4.6 wks March 11	**<= 6.6 weeks**
Maximum wait for elective admission	26 weeks national standard achieved	Achieved 3 pts waited >26 wks	Achieved 2 pts waited > 26 wks	Not measured	**Not measured**
Maximum wait for 1st OPA following GP /GDP referral	13 weeks national standard achieved	Underachieved 36 pts waited >13 wks	Achieved 9 pts waited > 13 wks	Not measured	**Not measured**

Maximum waiting times for 15 key diagnostics tests	89 >6 wks at 31/03/08	220 >6 wks at 30/03/09	Achieved 10 pts waited > 6 wks	31 pts > 6wks Full year	Achieve & maintain < 6 weeks
Cancers: 2 week wait (Urgent GP/ GDP referral) to first hospital assessment	99.1%	Achieved 98.98%	Achieved 93%	96.0% Full year	>= 93%
All breast symptoms: referral to first hospital assessment	Not measured	Not measured	Achieved 97.8%	95.8% Full year	>= 93%
Cancers: 31 days (Decision to treat) to first treatment	98.71% (all cancers)	Achieved 99.24% (all cancers)	Achieved 97.3%	97.2% Full year	>= 96%
Cancers: 31 days (decision to treat) to 2nd or subsequent treatment (drugs)	Not measured	97.22%	100% *	99.8% Full year	>= 98%
Cancers: 31 days (decision to treat) to 2nd or subsequent treatment (surgery)	Not measured	97.22%	95.9% *	95.6% Full year	>= 94%
Cancers: 31 days (decision to treat) to 2nd or subsequent treatment (radiotherapy)	Not measured	Not measured	Not measured	97.0% Full year	**>= 94%**
Cancers: 62 days Urgent GP referral to treatment	97%	Achieved 97.09%	Achieved 89%	87.0% Full year	>= 85%
Cancers: 62 days NHS Cancer Screening Service to treatment	Not measured	Not measured	90.2% *	96.6% Full year	>= 90%
Cancers: 62 days Consultant upgraded referral to treatment	Not measured	Not measured	Achieved 95.09%	89.9% Full year	>= 85%
Last minute cancellations: % of elective admissions	1.33% of elective adms	Underachieved 1.3% of elective adms	Failed 1.6% of elective adms	0.9% of elective adms Full year	<= 0.8%
Last minute cancellations not rescheduled < 28 days	15.03% of cancellations	Underachieved 13.8% of cancellations	Underachieved 6.4% of cancellations	5.8% of cancellations Full year	<= 5.0%
MRSA Bacteraemia	36 cases	Underachieved 27 cases	Achieved 7 cases	5 cases Full year	**<= 7 cases**
C.Difficile	525	Achieved 249 cases	Achieved 123 cases	89 cases Full year	**<= 139 cases**

Updates from our services

Our service teams are keen to share the successes that support and add value to our PIF priorities achievements. This section includes a selection of their stories.

Urology Services

Southampton urology provides its services across SUHT, Lymington and by secondment to the ISTC. We provide centralised cancer services for complex renal and pelvic cancer from Winchester and Salisbury, in addition to our local patients. We also provide regional cancer services for metastatic testicular cancer and very complex renal cancers.

Cancer surgery

Around 15-20 patients with metastatic testicular cancer require surgery to remove lymph nodes from around the major abdominal vessels each year. The decision making process is taken through our weekly multidisciplinary team meeting. This includes radiologists, medical oncologists and urologists. A marker of success is the histopathology results of the tissue removed.

Our data show:

Findings	SUHT histopathology results	International review comparison
teratoma differentiated (best treated by removal	78%	30-57%
fibrosis (arguably could have been left)	13%	18-49%
residual cancer	9%	Up to 30%

These figures confirm our excellent decision making processes, which reflect our expertise and long experience with this relatively rare group of patients.

We have a long-established and successful practice in image-guided percutaneous cryoablation of renal tumours second only to Mayo Clinic, Rochester, MN. Our technical success rate is 97% with the MDT deciding on no treatment or alternative treatment in the latter patients. Our patients' average inpatient stay was 1 day. The alternative treatment for these lesions is either partial or total removal of the kidney which means either a 3-4 day stay in hospital or for open surgery, a 5-7 day stay.

Children and Young people surgery

Our paediatric urology colleagues see, treat and correct many young patients with complex urological problems. Some require ongoing specialist care and as these young people approach the age of 18, it becomes increasingly difficult to manage them in paediatrics alongside much younger patients. However, it is equally difficult for them to be plunged into the unfamiliar adult urology service. We have developed a transition clinic where patients are seen by both familiar paediatric team members and adult team members. This transition process has been well received by these young patients and presented to our regional meeting in Oxford.

Enhanced recovery

Enhanced recovery for elective surgery has been popularized by a colorectal group in Denmark and has spread across the surgical community, both by geography and speciality. We introduced the program for radical cystectomy in January 2011. Even at this early stage our length of stay post operatively has fallen from around 15 to around 9 days. This has been achieved by a multimodal approach across primary and secondary care including the allied professionals such as physiotherapy, occupational therapy and stoma care. In addition to the obvious savings, these patients are reporting a much improved overall experience with this major surgical procedure.

Surgical staff development

Finally, we have adopted a close system of mentoring and buddying for the last 3 urological surgical appointments and our Trust has been supportive, where necessary, of joint consultant operating. Surgery is recognised as a 'craft' speciality and our system has protected patients and allowed new consultants to develop without detriment to the patients or the service, by maintaining quality and keeping operative times low.

Liver and Pancreatic Services

The Southampton Hepatobiliary and Pancreatic Surgical Service serves a population of 3.8 million people across Dorset, Hampshire, West Sussex and the Channel Islands. We have an established team of Surgeons, Physicians, Oncologists and Radiologists who work as a team to ensure treatment is tailored to each individual patient. The team benefits from a mix of University and NHS doctors, which allows us to provide cutting edge treatment.

We undertake approximately 200 liver and pancreatic resections each year, with outcomes that compare favourably with other major European centres. We place an emphasis on minimally invasive (keyhole) surgery and Southampton is a pioneering centre for laparoscopic liver surgery. We have the leading experience in the UK and our contribution in this field is recognised internationally. We have demonstrated that the technique is safe for the treatment of colorectal liver metastasis. Our results for specialised chemotherapy treatment of other liver tumours (known as TACE) are amongst the best in the world.

The range of treatment options available in Southampton allows more effective treatment of complex and other locally advanced tumours. We have an increasingly large group of these patients that are now benefiting from treatment by our team. All our patients benefit from the mass of expertise available in a teaching hospital environment and the support of a dedicated intensive care team which allow such a complex service to be delivered safely.

Head and Neck cancer

From a five year audit of all out patient attendances of patients on the head and neck clinic we assessed patients who had been treated with curative intent. Non recurrence rates reported to clinic were 79.3% for patients under the OMF team comparing very favourably with gold standard bench mark data of 80% from Liverpool using similar audit methodology

Facial deformity surgery

From national audit data 96% of patients felt they had benefitted from treatment, increased self confidence in 86%, Improved facial appearance in 88%, better smile in 92%, and better dental appearance for 92% of patients.

Bone marrow transplants

Recently the Specialist Services Commissioners for South Central Strategic Health Authority asked the British Society of Blood and Marrow Transplantation's central bone marrow transplant data registry to analyse the stem cell transplant activity and outcome for our unit from 2002-2007. Our results were compared with the rest of the UK. Our 12 month post transplant survival results were found to be as good as, or better than the national average.

Conclusion

We are proud of the advances we have made in the quality of services we provide. However we are not complacent and know that we are still on a journey to achieve excellence in all areas.

The Quality Account enables us to qualify our progress comprehensively and agree the priorities for 2011. Future accounts will therefore present a quantitative delivery against a forecast.

We see this as an essential vehicle for us to work closely with our Members' Council, our commissioners and the local community on our future quality agenda as well as celebrating our successes and progress.

Annex - statements from primary care trusts, local involvement networks and overview and scrutiny committees.

PCT lead commissioner final support statement:

LINKs final support statement:

OSC final support statement:

(OSC delegated their response to LINKS, see above)

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PCT quality account development feedback

NHS
Bournemouth and Poole

Bournemouth and Poole Teaching Primary Care Trust
Canford House
Discovery Court Business Centre
551-553 Wallisdown Road
Poole
Dorset
BH12 5AG

Tel: 01202 541400

11 May 2011

Our ref: FR/ep

Judy Gillow
Director of Nursing, Midwifery & Patient Services
Southampton University Hospitals NHS Trust
Tremona Road
Shirley
Southampton
SO16 6YD

Dear Judy

Thank you for providing Andrea and me the opportunity to comment on your draft quality account for 2010/11. Our comments overall are that this is an excellent report; it is very clear and concise and flows well. It will represent an excellent resource for patients and therefore we would not change any aspect of it. Compared to other Trusts' draft accounts that we have reviewed, we have found this document much easier to read and the general 'flow' is easier for people who may have less understanding of health and complex medical terminology.

There are a couple of comments on the document itself. On page 5, the second to last paragraph, is this the staff attitude survey, as when you read it, it refers to staff satisfaction and staff attitude; just the terminology, you may want to be consistent.

Priority 3, on page 19: the sentence needs to be finished in this table as it is a little brief at present.

Throughout the document we picked up a number of 'typos', the Trust did not have a capital 'T' in all situations, and 2020Vision sometimes had a gap and sometimes did not.

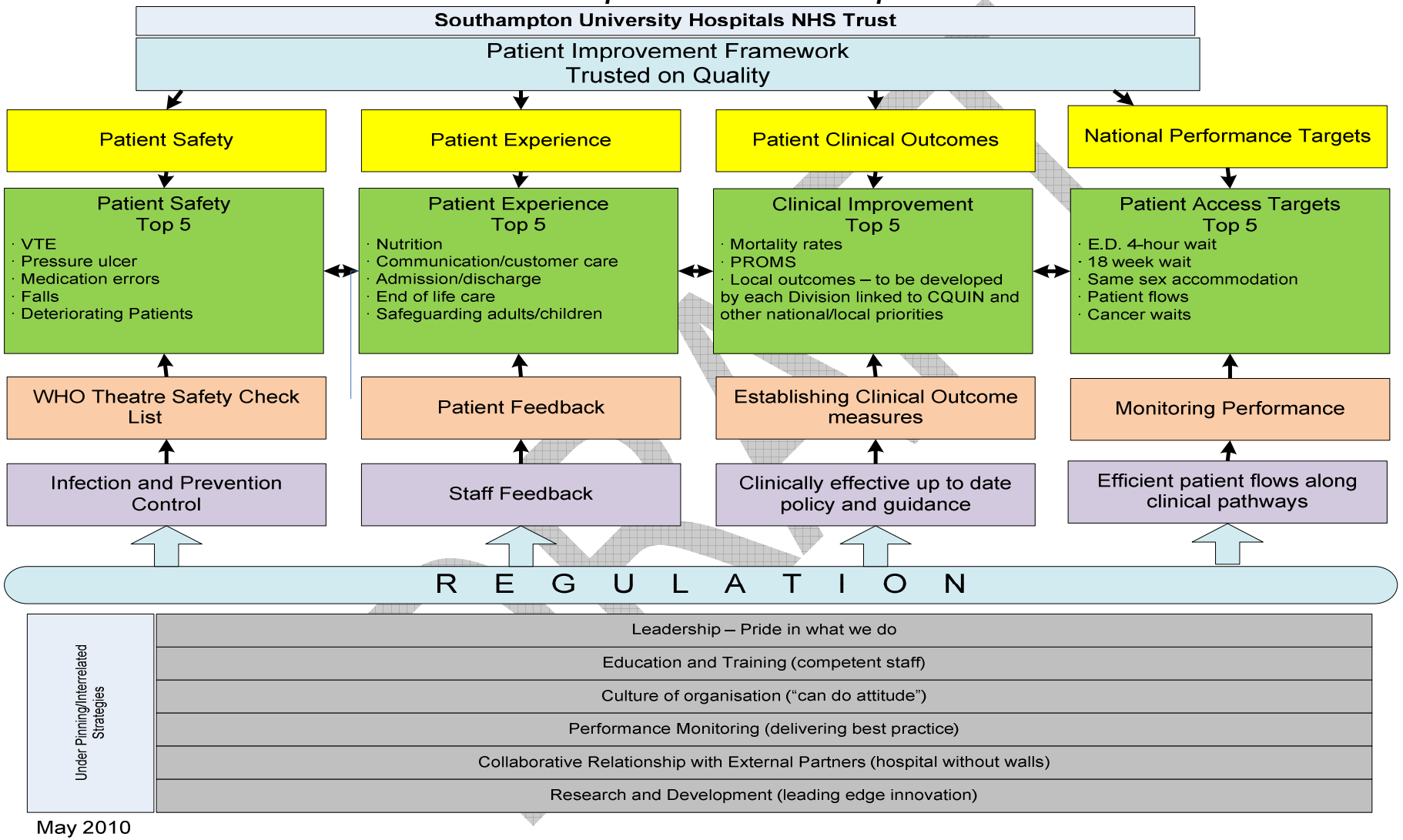
I hope you find our comments useful. Thank you for the opportunity for commenting.

Yours sincerely

Fiona Richardson
Deputy Director of Specialist and Tertiary Commissioning
NHS Bournemouth and Poole

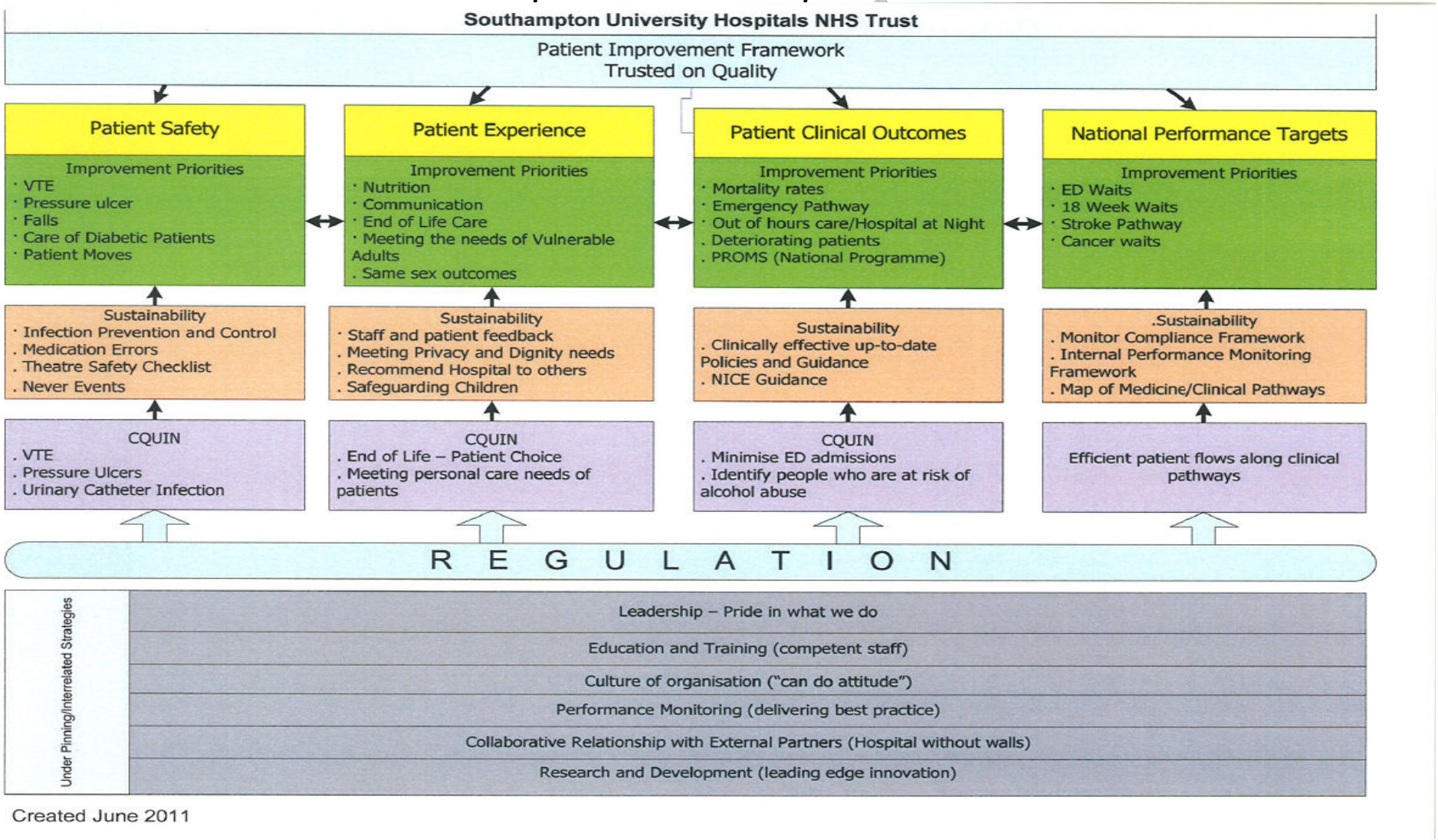
cc
Andrea O'Connell, Deputy Director of Quality Improvement, NHS Bournemouth and Poole

Our Patient Improvement Framework priorities in 2010/11



May 2010

Our draft Patient Improvement Framework priorities in 2011/12



Created June 2011

Appendix 2

National Clinical Audits and National Confidential Enquiries 2010/11

	The number of eligible national clinical audits and national confidential enquires that Southampton University Hospitals NHS Trust participated in during 2010/11, is 36 and these are as follows:	Number of cases submitted	Number of cases required if known	Percentage of cases - the number of cases submitted	National audit report published 2010/11?	National audit report reviewed by local specialty	Description of actions
1	TARN Trauma audit and research network	285	498	58%	Yes	Yes	Multi specialty morbidity and mortality meeting held approximately monthly. Actions around CT scanning and imaging priorities, blood transfusion (Code Red policy), trauma team call out. Areas of notable performance and areas to improve all discussed. Data and actions also discussed in Trauma Working Group. Data submission to be improved by additional input staff and Consultant Lead with time in job plan.
2	British Thoracic Society - Paediatric pneumonia	46	1	>100%	Yes	Yes	Need to better document collection of microbial specimens and report findings.
3	British Thoracic Society - Paediatric asthma audit	69	3	>100%	Yes	Yes	None - maintaining excellent outcomes well above national standards.
4	National Comparative blood transfusion audit - retrospective audit of use of platelets	40	40		No	No	Will depend on the results of the report. To be reviewed at Transfusion Committee.
5	National Comparative blood transfusion audit - O negative	44	40		Yes	No	Actions to be agreed following discussions of final site-specific report.

6	Stroke - National sentinel stroke audit	72	72	100%	Yes	Yes	A number of actions are already in place, responding to other monitoring systems; Vital Signs, Accelerated Stroke Improvement markers, eg: direct admissions of acute stroke patients within 4 hours 24/7 from ED to the acute stroke unit F8, commenced March 2011. All acute stroke patients to spend >90% of admission on F8 will also be achieved through direct admissions. Cardiac monitoring equipment is in the process of being ordered to allow acute stroke thrombolysis on F8 24/7 and there is funding for an additional stroke consultant post to develop a stroke consultant on call rota to support this. Radiology staff and ward staff are aware of the need for a CT brain scan within 24 hours of an acute stroke admission. A new referral process is being used to ensure this. A band 7 speech and language therapist has been appointed to the stroke unit. One of her roles will be to upskill the ward nurses to be able to swallow screen acute stroke patients within 4 hours of admission to the acute stroke unit. A ward sister has implemented the new Trust urinary continence pathway to improve our performance and documentation in this area. The stroke team plans to devise an acute stroke integrated care pathway to improve care and documentation of agreed multi-disciplinary therapy goals within 5 days of admission.
7	National falls and bone health audit	34	60	57%	No	No	We have an internal system of audit to improve falls risk assessments and to reduce the rates of avoidable inpatient falls and injuries, our most recent actions included starting the SGH turnaround project and introducing an updated version of the falls risk assessment tool. We are participating in a whole health economy review with local partners (Hampshire Oversight Scrutiny Committee) to determine how rates of falls in those who have recently accessed acute services could be reduced.
8	Dementia	41	40	103	Yes	Yes	The audit report has been reviewed by a SUHT based multiprofessional group including Elderly Care and Psychogeriatric professionals with the aims of (a) completing the development of a care pathway/bundle for elderly patients with confusional states and dementia (b) reviewing arrangements for determining the appropriate location of care, minimising bed movement and accessing specialist psychogeriatric review of acutely unwell elderly patients with dementia (c) reviewing the arrangements for accessing patient records for patients with dementia when they are admitted under the care of acute physicians.
9	College of Emergency Medicine - Paediatric Fever	50	50	100%	Yes	Yes	Audit results presented at Emergency Department meeting. Reported in quartiles for individual variables.
10	College of Emergency Medicine - Vital signs in majors	50	50	100%	Yes	Yes	Audit results presented at Emergency Department meeting. Reported in quartiles for individual variables.
11	College of Emergency Medicine - Renal colic	50	50	100%	Yes	Yes	National audit results from CEM for 2010 were for a previous set of audits relating to: Pain in children - Continue good practice. introduction of pain sticker system to ensure re-evaluation of pain after analgesia. Adult asthma - ongoing SHO education and new system in majors to ensure early, full recording of all vital signs Neck of femur fracture management - focus on delivering timely analgesia to these patients by re-organising how all patients are received into majors.

12	Adult Cardiac Interventions BCIS - Coronary Angioplasty	All undergoing PCI	As above	100	Yes	Yes	Continue to provide high quality service as indicated by audit results.
13	MINAP including acute Myocardial Infarction and Coronary syndrome.	All Acute Coronary Syndrome	As above	100	Yes	Yes	Review of cases who did not receive reperfusion therapy to ensure they were appropriately managed.
14	NLCA NATIONAL LUNG CANCER	457	100%	>90%	Yes	Yes	Submissions of full records 191; treatment only records 266; TOTAL = 457 (though this number may vary dependent on being able to enter the treatment data into records which have been uploaded by other Trusts with their diagnosis data) Our local IT system (HICCS) is being improved to make it more user-friendly to enter data. Ideally this data would be collected at the MDT which has not been possible. For the 2009 calendar year our raw numbers are about right but insufficient patients have accurate staging, performance status, CNS contact details,FEV1 etc. Importantly some palliative operations were sent to LUCADA as radical operations making our lung resection rate too high. Much of the data is sent to LUCADA in the week before the deadline for submission which makes checking its accuracy impossible. These problems are being ironed out slowly but even in 2011 we are not sending data in real time and some important variables are not possible to input at the MDT.
15	HEART FAILURE AUDIT	140	20 per month	58%	Yes	No	The care group needs to appoint a second consultant cardiologist with an interest in heart failure and to expand inpatient heart failure service. A business case has been submitted. CQUIN will help drive this.
16	VSGBI NATIONAL VASCULAR DATABASE - PERIPHERAL VASCULAR SURGERY (data collected on index procedure: varicose veins / aneurism / lower limb / amputation)	CAROTID LAST YEAR 107, AAA 92, AMPUATIONS 9, LOWER LIMB BYPASS 50+	100%	CAROTID 100%, AAA 100%, LOWER LIMB BYPASS 70% APPROX, AMPUTATION < 20% APPROX	Yes	Yes	Data collection has been prioritised and there is a backlog of lower limb bypass and amputation data.
17	NATIONAL DIABETES AUDIT (CONTINUOUS) PAEDIATRIC	200	200	100%	Yes	Yes	Compare outcomes locally with national outcomes
18	NATIONAL HIP FRACTURE DATABASE	643		100%	Yes	Yes	Increased percentage of patients reviewed by Ortho-Geriatricians within 24 hours Review of Falls and Osteoporosis risk factors DEXA scanning in appropriate patients to identify osteoporosis Improved discharge planning with MDTs Two weekly dedicated NOF operating lists on Tuesdays and Thursdays to improve door to theatre time

19	ICNARC CMPD: ADULT CRITICAL CARE	1433	1433	100%	Yes	Yes	Excellent results no action required
20	RCP National audit of the Management of Familial Hypercholesterolaemia			100%	Yes	Yes	Organisational audit completed. Casenote audit Completed. Site specific report published and action plan developed. Presentation made to Trust at Core Brief.
21	National Joint Registry	988		95%	Yes	Yes	Met regularly with representative from joint registry. Achieving 100% consent to be included with the audit. Backlog down to approximately 50 from around 400 last year. Feedback indicates 95% completeness of data. Post op traceability of replacements. Purpose to identify patients if recall were required. Cost £25 levy per replacement. Great success for nurses and matrons collecting the data. Plans to capture the data at outpatients in future - directly from surgeons. SUHT submitted 988 cases in 2010-11. Trust compliance figures are available through the NJR StatsOnline service on the NJR website.
22	PROMS hips	425 pre-op cumulative	563 pre-op cumulative	75%	Yes	Yes	Sept 16 2010 report indicates SUHT submitting 67.3% (Eng ave 66.9%) hips and for knees submitting 70.9% (Eng ave 68.6%). Recent results show improved participation. On the quality measures SUHT close to England average - this will become more meaningful with increased data. On average quality of life improved more for knee replacements than for hips. Working hard to encourage patients to participate and reduce the number declining completion of questionnaire. Information leaflets in several different languages have recently been made available to patients.
23	PROMS knees	516 pre-op cumulative	668 pre-op cumulative	77%	Yes	Yes	Sept 16 2010 report indicates SUHT for knees submitting 70.9% (Eng ave 68.6%). Recent results show improved participation. On the quality measures SUHT close to Eng ave-will become more meaningful with increased data. On average quality of life improved more for knee replacements than for hips. Working hard to encourage patients to participate and reduce the number declining completion of questionnaire. Information leaflets in several different languages have recently been made available to patients.
24	Head and Neck Cancer (DAHNO)	89	Aim for 100%	>90%	Yes	Yes	Quartiles shown by variable and reviewed locally. The submission numbers are: full records 54; treatment only records 35; TOTAL = 89. There were 17 records which could not be uploaded as they did not have an NHS number, 16 came from the Channel Islands and they do not submit to DAHNO
25	National Bowel Cancer Audit (NBOCAP)	286	Aim for 100%	>90%	Yes	Yes	Data is being collected via local IT system (HICSS) prior to upload to national database. Data completeness report reviewed. 2 year data-lag on published NBOCAP reports. As at Dec 2010 submitted (patients diagnosed from 1 Aug 09 to 31 July 2010. The submission deadline was 06/12/2010 and the report includes patients diagnosed between 1 August 2009 and 31 July 2010 The numbers are: 286 records

26	RCP/VSGBI National Carotid Interventions	106	Aim for 100%	Aim for 100%	Yes	Yes	Submitted approx.106 (100%) of cases for period 1 Apr 10 to 31 Mar 11. Outcomes data indicates SUHT doing well with 1/2 average stroke rate (compared with national average) following discharge after carotid surgery. (Feedback from GM July 10) Run by VSGBI through RCP. Annual formal report published.
27	NCASP Congenital Heart Disease (including paediatric surgery)		Aim for 100%	Aim for 100%	Yes	Yes	Each year every centre has an independent validation visit during which case ascertainment is maximised by checking the CCAD returned data against theatre and catheter laboratory log books.
28	NCASP Adult Cardiac Surgery CABG	>1500	Aim for 100%	>95%	Yes	Yes	SUHT operates one of top 5 busiest practices in the country. SUHT risk-adjusted outcome data suggests our outcomes are in the top 5 in the country. All individual surgeons perform as expected or better than expected when adjusted for risk. Reference: Care quality commission website (heart surgery in the UK).
29	CMACE Perinatal Mortality- continuous data collection. Reports published 2 years after data collected		100%	100%	Yes	Yes	First report published 2010 and disseminated to care group. Results discussed in neonatal unit. Compliance with recommendations being assessed and non-compliance to be reviewed in annual review of National Confidential Enquiries. Linked report published March 2011for 2009 data. No site-specific report.
30	NNAP National Neonatal Audit Programme		100%	100%			Data collection via local IT system, Badgernet.
31	Paediatric Intensive Care Audit Network (PICANET)		Aim for 100%	>90%	Yes	Yes	Site specific interim reports published twice a year. Summary for latest report published August 2010 attached. We admitted 2259 patients over last 3 year period. This makes us the 9th largest unit by number of admissions. Our risk-adjusted standardised mortality rate is 0.73 over this time. Of the larger units (those admitting more than 2000 patients) this is the best outcome data.
32	British Pain Society (BPS) pain database. 3 year project launched November 2009.			Aim for 100%	No	No	SUHT participated in the pilot stage. National project lead is based at this Trust. Work in progress.
33	RCOG National audit of heavy menstrual bleeding against NICE CG44. 4 year project.			Aim for 100%	No	No	PROMS data collection started. SUHT participated in the organisational audit. 12 Months of administering the questionnaires from 1/2/11 to 31/1/12. Collecting patient related outcome measures.
34	RCP National audit of Inflammatory Bowel Disease (NCAPOP)			Aim for 100%	No	No	Adult and paediatric elements of National IBD Audit underway with data inputting up to August 2011.
35	British Thoracic Society (european project) COPD Audit	105		100%	No	No	SUHT submitted organisational data and above required sample for case note data. 105 records. Data collection ends 1 April. Report available September 2011.
36	British Thoracic Society - Adults Non-invasive ventilation				Yes	Yes	The Trust submitted 3 months' data for March / April / May 2011. Report imminent.

Data will be submitted to these 5 eligible national audits in 2011, however no data submitted for these yet during 2010/11:

37	INFLAMMATORY BOWEL DISEASE RCP ADULT CROHNS & UC				No	No	Data collection is in progress until August 2011.
38	NATIONAL DIABETES AUDIT (CONTINUOUS) ADULT				No	No	This audit has been added to the 2011-12 annual audit programme. The care of Diabetic patients has been identified as one of the top 15 priorities for the Trust in 2011-12.
39	PARKINSON'S UK				No	No	Registration is imminent and the Trust plans to participate in this audit in 2011-12.
40	CARDIAC ARREST AUDIT				No	No	SUHT started contributing data on 1st April 2011. All cardiac arrest forms have been aligned to the national database to ensure we collect all the required data.
41	SINAP Stroke national programme						The SINAP programme database is currently being revised and this Trust plans to participate once the final SINAP is launched later in 2011. Local outcomes are reviewed.

The Trust did not participate in the following 5 eligible national audits during 2010/11:

42	British Thoracic Society - Pleural Procedures	This audit was not part of the National clinical audit and patient outcomes programme (NCAPOP) or an acute contract requirement and therefore not automatically included in the audit plans for the organisation at the start of 2010-11 when setting out 'must do' priorities for national clinical audit.
43	British Thoracic Society - Adult community acquired pneumonia	SUHT registered. No data collection as consultant lead submitting to local SHA pneumonia study for CQUIN therefore decision not to duplicate data collection.
44	British Thoracic Society - Bronchiectasis	This audit was not part of the National clinical audit and patient outcomes programme (NCAPOP) or an acute contract requirement and therefore not automatically included in the audit plans for the organisation at the start of 2010-11 when setting out 'must do' priorities for national clinical audit.
45	British Thoracic Society - Emergency use of oxygen	This audit was not part of the National clinical audit and patient outcomes programme (NCAPOP) or an acute contract requirement and therefore not automatically included in the audit plans for the organisation at the start of 2010-11 when setting out 'must do' priorities for national clinical audit.
46	British Thoracic Society - Adult asthma audit	No data submitted as monitored locally.

In addition to the 26 'eligible' national audits listed above, which the Trust participated in, SUHT also participated in a further 22 national audits (including an additional four national confidential enquiries)

Local clinical audits 2010/11

The number of local clinical audits that Southampton University Hospitals NHS Trust reviewed reports for during 2010/11, is 93 and these are as follows:
The number of local clinical audit that Southampton University Hospitals NHS Trust participated in during 2010/11, is 83 and these are as follows:

	Audit title	Actions
1	Nutrition on ICU	The audit showed that feeding was being established within 24 hours in less than half of patients being admitted to GICU. Numerous delays occurred which prevented adequate calorific intake, some of which could be minimised. Recommendations would include highlighting the deficiencies through education, increasing the awareness among both medical staff and nursing staff to ensure early assessment of nutrition needs and minimise unknown causes of delays or interruptions in feeding. In patients with non-functioning GI tracts, parenteral nutrition could be considered earlier.
2	Timely anaesthetic involvement in care of high risk mothers	Advertise correct method for MAPP referrals and importance of informing anaesthetist on arrival to labour ward for MAPP patients and BMI >40. Plan to do this via theme of the week distributed to all staff at PAH. Look into possibility of electronic referral mechanism linked into e docs.
3	Elective caesarean section list timings	Suggest multidisciplinary proforma formalising pre operative routine, Establish methods to improve turnaround times
4	Re-audit of peri-operative hypothermia	Encourage feedback from recovery nurses to individual anaesthetists. This will be aided by completion of formalised recovery handover
5	Monitoring of alarm settings in outpatient departments	Education of anaesthetic practitioners (ODPs) and new anaesthetists joining department
6	Peri-operative analgesia in orthopaedic day surgery	Form working group.
7	Checking pregnancy status in paediatric surgery patients	1. Survey APA to gain national information 2. Survey surgeons and nurses with in SUHT to gain local opinion 3. Create a multidisciplinary group to discuss methods of improving care
8	Re-audit of laryngeal mask airway cuff pressures	Purchase additional cuff pressure manometers to enable 100% availability

9	NICE CSG SP Discharging patients from community palliative care service	Present findings to team at Countess Mountbatten House (CMH). Caseloads under more scrutiny due to staff shortages. Inform GPs re discharge procedure and re-referral process. Clarify re-referral procedure amongst CMH staff
10	NICE CG 92 Re-audit on primary prophylaxis for venous thromboembolism in CMH	To trial Yellow Risk Assessment for Venous Thromboembolism (VTE) – Adults form. Get Yellow Risk Assessment for Venous Thromboembolism (VTE) – Adults form To Add Yellow Risk Assessment for Venous Thromboembolism (VTE) – Adults form to admissions pack To re-audit after some time
11	Nutrition - feeding in GICU - ? Repeat or duplicate registration of ZAUD1819	Highlight the deficiencies through education. Increase awareness among both medical staff and nursing staff to ensure early assessment of nutrition needs and minimise unknown causes of delays or interruptions in feeding. Parenteral nutrition could be considered earlier in patients with non-functioning GI tracts.
12	Appropriate indication for initiation of haemofilteration in ITU	Add in indication for haemofilteration as tick boxes (as per ADQI) to daily GICU RRT plan. Add in Wight and volume exchange to the GICU RRT plan
13	Compliance with MRSA decolonisation in Critical Care	1. Drug charts pre-printed with chlorhexidine and bactroban 2. Include within nursing care bundle paper work a section asking if decolonisation treatment has been administered and if not then why? 3. Include decolonisation status on the critical care discharge letters. 4. Include chlorhexidine & bactroban in the default equipment for each bed space. 5. Education & training. 6. Clarity regarding decolonisation on re-admission. 7. Re-audit later this year
14	Missed doses	Unsigned doses of clexane to be brought to attention of matrons. Audit to focus solely on doses of clexane not given (February 2011)Train band 4 nurses to administer doses Reminders to staff to ensure reasons given or codes used. To be done at ward level and on training days Antibiotics to be obtained from the other wards as required.
15	Reasons for extended stay on colorectal enhanced recovery programme	Liaise with Stoma Care sister to formulate plan D/W E7 ward physiotherapists Liaise with hospital discharge team re early completion of referral paperwork in preassessment. Work with Anaesthetics. Continued re-audit of compliance.

16	Colorectal HMR audit	Juniors to be provided with Standards when commencing colorectal surgery. Teaching regarding general completion of discharge summaries to be provided to junior doctors during their induction period. Regular review of discharge summaries by senior clinicians.
17	ERALS compliance with protocol	Patient Education on importance on nutrition drinks and mobilisation. Medical and Nursing Staff education update. Review of protocol.
18	Recurrence of hernia following laparoscopic hernia	To review factors may increase the recurrence rate (Used materials, Mesh size and fixation). Conducting a study about Open repair in SGH for comparison.
19	Early antibiotics in sepsis	Continue to increase awareness of the importance of early directed goal therapy in septic patients, among nurses and doctors during every formal teaching session. RAT/triage nurses to highlight patients who meet the criteria of having sepsis. Stress the importance of managing septic patients in the resuscitation room. Encourage clinicians to adhere to Trust guidelines when prescribing antibiotics
20	Majors area pain management	For discussion at consultant meeting in early September 2010. As a result of that meeting the department has set up a working party to address the issues. We feel a whole-department approach is needed. There is also a new Pain Protocol which has been developed and approved for use during the year. This will now be implemented alongside an education programme for nursing and medical staff.
21	Reducing risk in patients admitted to CDU	Further implementation of CDU checklist
22	Pain management in children attending ED	Education of paediatric nursing staff and triage staff to improve awareness of sticker system. Use of advice sheets in triage and paediatrics ED encouraging parents to request further analgesia when necessary. Encourage increased recording of pain scores with each routine set of observations each patient has done.
23	Vital signs in Majors patients	This together with the renal colic and previous pain audits, has resulted in a plan to re-organise how patients are received into the majors area of the department. We aim to address several issues with this: 1.Time to initial observations 2. A system to ensure communication of abnormal observations and recording of action taken 3.Timely administration of analgesia to patients in pain. Changes will be introduced during the next few months. Our new pain guideline, which was planned for autumn 2010, has been delayed and is expected to be able to be introduced in a similar time frame.

24	NICE CG 47 Fever in children	Continue teaching the NICE/CEM guidelines as gold standard within the department. This is part of SHO induction every 6 months. Continue to promote a full set of early observations for febrile children as above via ED Paediatrics Special Interest Group, next meeting Feb 2011. Triage nurse education is key to this. PSIG is responsible for change management. It is recognised that the triage nurse cannot triage efficiently if s/he has to perform a full set of observations in addition to the triage role, since this delays triage of the next patient(s), so although completing observations at triage might seem an easy way to achieve the standard, it is not practical. Therefore febrile children should be sent through to the paediatric area for observations to be taken. They may then sit in the waiting room if clinically appropriate.
25	Analgesia on majors in ED	This together with the renal colic and vital signs in majors audits, has resulted in a plan to re-organise how patients are received into the majors area of the department. We aim to address several issues with this: 1.Time to initial observations. 2.A system to ensure communication of abnormal observations and recording of action taken. 3. Timely administration of analgesia to patients in pain. The new pain pathway will also be implemented. Introduction of these new initiatives is in the week beginning March 7th 2011.
26	CDU VTE prophylaxis	There is now an electronic prompt on Symphony to record VTE risk. It is not possible to go past this screen without filling in the data. Changes to the way patients are received into the “Majors” area of ED on March 2011 means that all patients will now have a formal Trust drug chart, thus ensuring continuity between there and CDU
27	NICE CG 109 transient loss of consciousness	Continue to teach syncope on SHO induction, highlighting the NICE guidelines. Use the planned change in how patients are received into the majors area of the department to further improve the recording of a full set of observations and an ECG.
28	Management of renal colic in ED	This together with the vital signs and previous pain audits, has resulted in a plan to re-organise how patients are received into the majors area of the department. We aim to address several issues with this: 1.Time to initial observations. 2. A system to ensure communication of abnormal observations and recording of action taken. 3.Timely administration of analgesia to patients in pain. Changes will be introduced during the next few months. Our new pain guideline, which was planned for autumn 2010, has been delayed and is expected to be able to be introduced in a similar time frame.
29	Driving advice in TIA	Start aspirin 300mg once aday. Advise not to drive for 1 month Fax form to referring clinician
30	NICE CG 101 Pneumococcal and influenza vaccination in pts with COPD	To add a function to e-Docs, whereby when a diagnosis of COPD is entered on a discharge summary, a note automatically appears as a prompt for GPs to ensure that their patient is up to date with influenza vaccinations.

31	Drug allergy alert	Education (reminding) of junior doctors about specifying details of allergy when clerking a patient with known allergies. We suggested this to be included during induction of new junior Doctors joining the Trust and the ward pharmacists will help reminding doctors in the wards to record specification of allergy if details were not specified on admission: Our colleagues from pharmacy department were happy to look at this and take the leading role in order to implement the changes. '"The future Drug charts"-We suggested that the future drug charts to include(details/specification of allergy) in the drug allergies section. If in future the Trust adapts the t e-prescribing the details of allergy will automatically be requested and included.
32	To assess in what proportion of Dermatology audits audit cycles are actually completed	Actions 1. To review previous dermatology audits and attempted to determine whether in fact they were completed and if so inform the audit department of the results. 2. To attempt to determine whether completing any of the incomplete audits would be worthwhile and if so, attempt to do this. 3.To encourage the dermatology department to register all audits with the Audit department and to complete the audit cycle 4.To re-audit our completion/registering of audits in the future
33	Medical review of AMU patients within 24hrs prior to transfer to ward	Insertion of sentence in nursing handover sheet. - 'has this patient had a medical review in the last 24hrs? if not please seek medical review'.
34	Audit of correction of Hypermetropia in children	Need to consider whether to adopt a guideline or to treat pts on an individual basis, depending on: Degree of Hypermetropia Family History Family preference Careful review for sign of sq/reduced VA Review for change in hypermetropia If treating pts on an individual basis, is there a level of hypermetropia which should always be corrected without any signs of sq/reduced VA eg +8/ +9DS?
35	Descemet stripping endothelial keratoplasty audit of the first three years procedures (2007-10)	Increase numbers. Accept tertiary referrals.Tighten up data collection. 'Refraction / topography / cell counts. Re-audit to chart benefits of experience.

36	Macroproplactin results following polyetheylene glycol (PEG) precipitation	In view of the nonspecific way PEG reduces protein solubility, variable reactivity of macroprolactin in immunoassay, and low reactivity of DxI with macroprolactin, prolactin results should be reported directly from the DxI without the need for PEG treatment prior to analysis. In cases where results do not agree with clinical presentation, imaging study should be considered or the sample should be reassessed with GFC, which is the gold standard.
37	Myelodysplastic syndrome - European guidelines	Consensus interdepartment agreement on relevant investigations were noted after presentation. MDT form to be altered to address this. Uptake of erythropoietin stimulating agents for low risk patients Improved awareness of consideration for iron chelation in suitable low risk patients. 'Improved awareness of consideration for iron chelation in suitable low risk patients This is to be addressed after bone marrow meetings and MDT chair on review of patients referred. Allocation in new consultant job plan
38	Radiographer autonomous reporting - Adult WIC 18 month review	Continue CPD and mentorship as currently
39	Compliance with IRMER procedure N - determine radiation injuries	To be discussed at new IRMER delivery group and action list agreed there.
40	NICE CG 89 Safeguarding Children. Annual results of (SHA) audit	Actions: Training programme on improving staff documentation in the context of SUHT CP/Safeguarding Proforma to be developed and delivered by J March-McDonald by December 2010. Develop new course evaluation forms. Memo to Education Leads. Continue to promote in all training sessions. SUHT CP/Safeguarding Administrator to continue to promote via training bookings.

41	**Records management** in child liaison psychiatry	A single point of storage to be made available for open, frequently used notes. Closed and infrequently used notes to be held at the Nursling notes storage for request when required. All Paediatric Liaison letters to be saved to edocs. "Child Mental Health Team" or other suitable title to be used to make team's involvement clear. 'Paediatric Liaison Team to observe basic filing standards in order to secure notes within file. These standards will be met by use of the standard issue NHS file.Use of a front sheet for contact details inserted within the notes. The Paediatric Liaison Team to check the form proposed within Appendix B to ensure this meets the needs of the team. Paediatric Liaison Team to observe nationally agreed standards of note keeping – use of black ballpoint pen, date & time each entry using 24 hour clock, sign & print name, designation and contact details at the end of each entry. Paediatric Liaison Team to have protocol to request generic Paediatric file for review at the time of referral. Paediatric Liaison Team to design a sticker to use within generic Paediatric file highlighting their involvement and the existence of separately held notes.
42	Use and care of cuffed endotrachael tubes in PICU	Results of the audit will be presented to all PICU staff and stakeholders, including paediatric and cardiac anaesthetists. Charts on the recommended CETT sizes will be displayed on intubation trolleys in PICU and distributed throughout theatres. Training updates on cuff pressure measurements on PICU will be provided where necessary.
43	NICE CG 29 Paediatric pressure ulcer risk form following major orthopaedic surgery	It is clear that incidence of pressure ulcers in this population is low. But nurses should follow government recommendations and document patient care and interventions. Recommendations from Essence of Care benchmark(BM) for prevention and management of pressure ulcers (2010) and NICE CG27 should be followed
44	NICE CG 32 Re-audit malnutrition screening in adult orthopaedic pts	Training for clinical staff on revised paperwork Revision of MUST care plans. Actions in the process of being implemented.
45	Enhanced recovery in Gynaecology and Oncology	Raise awareness: Convincing our colleagues and staff to break from surgical tradition Audit & re-audit Monitoring of outcomes e.g. readmission rate Circulate information Transfer experience to other surgical areas ?Obstetrics

46	Neonatal care audit	To start system of SHO reviewing unacknowledged results list pre evening handover and discussing as appropriate at end of handover 1.Trainees' filters on equest to be set to neonatal medicine/surgery and Burley Babies2.To audit this specifically
47	NICE CG 93 Operation of Donor Breast Milk Bank @ PAH	Observe and maintain standards to 100% in line with NICE guidelines
48	Are we using growth charts appropriately in NNU?	Provide training on how to measure head circumference accurately and formally assess competency To be discussed with Matron regarding obtaining new WHO charts Use of Leicester incubator baby measuring device.
49	Neonatal care audit - are we acknowledging results in a timely manner	Part of SHO/Registrar induction. Discuss with IT regarding ANPs. Burley ward manager already informed. Theme of the week to be discussed with consultants. Increased awareness during induction. Ensure appropriate acknowledgement rights are set up. When discharging/transferring a patient, the doctor/ANP is responsible for acknowledging all results. Introduce system for highlighting results - needs further discussion. To be discussed with seniors. At end of PN shifts, SHO is responsible for acknowledging all outstanding results on Burley Babies and feeding back to Burley staff re any inappropriate results coded as Burley Babies. 'Inform Consultants and registrars via audit presentation.
50	Thromboprophylaxis following caesarean section	The need for thromboprophylaxis, dose and timing should be discussed for every patient in theatre by the whole multi-disciplinary team Creation of a laminated form with the various indications and recommended doses for clexane be available in theatre to guide this discussion
51	NPSA Trust Wide Snap Shot Audit of Missed Doses	Outcomes & recommendations in process of being disseminated to Divisions & Care Groups so that policies, procedures and practices can be changed to address shortfalls. This will result in improved patient safety and reduced costs by avoiding re-work and corrective actions. A follow-up audit will be undertaken. Emergency cupboard stocklist amended. Staffnet page - education and Training resource sorted.
52	Re-audit Pharmacy record keeping for controlled drugs	Actions in hand. Escalation: a) Link to risk register required NO – this demonstrates low risk b) Suggested timescale for repeat audit within 13 months.

53	Current physiotherapy practice in Respiratory Centre against BTS Bronchiectasis guidelines	•To develop a new Bronchiectasis leaflet from Physiotherapy that would include airway clearance techniques and an explanation of the diagnosis. '•Review all new Bronchiectasis patients in 3 months. •Education of staff on the Guidelines and need for including the BTS standards in their care. •Education on more detailed noted on HICCS. Leaflet has been written and passed through clinical governance. The consultants have approved its use and we are now in the process of getting patient feedback and quotes to have the leaflet printed properly according to SUHT guidelines.
54	Barriers to Critical Care Rehabilitation	1. Continue current patient referral system 2.Re-audit in 6 months to monitor impact of daily sedation hold protocol 3.Record more detailed reasons when patients are deemed too medically unwell for rehabilitation on a regular basis. Repeat audit imminent.
55	NICE CG 68 Nil by mouth compliance	·Liaise with the Stroke consultants about documenting the need for CVA patients to be NBM on admission and request they cascade this information to ED doctors ·Training for AMU and ED medical and nursing staff regarding the rationale for stroke patients being kept NBM and reinforcing that this means no food/fluid or medication unless clearly documented (including a rationale) by the consultant or senior registrar. The results have been discussed with consultants. Training for medical staff is an ongoing AMU goal.
56	NICE CG 17 Review of number of voice pts with reflux and/or asthma	Leaflet produced for patients. Reflux Symptom Index (RSI) and patient experience used to assess and review patient symptoms Leaflets made available for ENT consultants Reviewing compliance of patients taking Dyspepsia medication Guidance for patients on step down approach to taking medication More thorough assessment of LPR related symptoms. Leaflet has now been developed for patient and consultants and shared. Ongoing training of relevant staff.

57	Accessibility of communication environment on paediatric wards	Leaflet produced for patients. Reflux Symptom Index (RSI) and patient experience used to assess and review patient symptoms Leaflets made available for ENT consultants Reviewing compliance of patients taking Dyspepsia medication Guidance for patients on step down approach to taking medication More thorough assessment of LPR related symptoms. The Speech and language therapy (SLT) service will advise staff on children's communication needs, if the child is already known to the SLT service. Speech and language therapy to liaise with catering and ward staff about the format of new children's menus. The catering arrangements have changed since this audit was done and it is therefore timely to implement changes before this process is finalised. Makaton training arranged for May 2011. Ongoing work on format of menus.
58	Patients not receiving reperfusion therapy for ST-elevation myocardial infarction	Continue current practice. Consider reviewing the way coding is done for STEMI patients as 5/35 did actually have PPCI.
59	Bivalirudin and/or heparin in pts undergoing primary PCI treatment of acute stemi	Recirculate the bivalirudin and heparin guidance Encourage nursing staff to check/crosscheck bivalirudin bolus and infusion doses according to the estimated patient weight (it is not feasible to formally weigh STEMI patients pre PCI)
60	Independent & supplementary non medical prescribing	Diligent record keeping of INMP Repeat audit regularly Monitor feedback from Pharmacy, Wards & GPs.
61	Audit of rivaroxaban prescribing, compliance & side effects in orthopaedics	To continue as per the existing guidelines and re-audit in 1 year or sooner if problems develop.
62	Trauma list audit - efficient use	To improve access to theatres for trauma patients and thus operate when required and reduce length of stay. 'We will create 2 additional lists in core hours for trauma from our existing resource and close the evening list down to delivery efficiencies for theatres.
63	Timing of check Xray in post hip hemiarthoplasty	Presented to M&M. Include in Induction.
64	Saving Lives HII 1 Central Venous Catheter Care.	Jan 11: Central venous catheter care - Audits completed July 2010 and January 2011. July's audit remained at 100% for insertion and 99% for ongoing care. Only 1 area of suboptimal performance required to implement actions. January 2011 audit data not yet analysed.
65	Saving Lives HII 2 Peripheral Intravenous Cannula Care	Jan 11: Peripheral intravenous catheter - Audits completed June 2010 and December 2010. June 2010 audit showed a reduction in compliance compared to February 2010 audit. December 2010 Trust compliance for insertion is at 95% compared to 94% in June 2010, compliance for ongoing care is 94% compared to June 2010 audit of 95%.

66	Saving Lives HII 3 Renal Dialysis Catheter Care	Jan 11: Renal Dialysis Care - Audits completed April 2010 and October 2010. Compliance remains at 100%, no actions required.
67	Saving Lives HII 4 Surgical Site Infection. Acute contract.	Jan 11: Surgical site infection - Audits completed May 2010 and November 2010. Reduction in compliance seen for preoperative care; 95% compliance in May and 90% compliance in November. Reduction in compliance for perioperative care from 100% in May to 95% in November. Areas of sub optimal performance required to implement actions and re-audit as per infection prevention audit programme. Infection Prevention Team provided intensive support to areas scoring less than 85% in November's audit, matrons required to provide support and monitoring to areas scoring between 85 - 94%. MRSA patient held record being introduced across Trust. MRSA awareness week carried out June 2010 to raise awareness and education.
68	Saving Lives HII 5 Ventilated Patients (Q27 - accepted alternative)	Jan 11: Ventilated patients - Audits completed April 2010 and October 2010. Compliance remains at 100% for observations and 99% for ongoing care.
69	Saving Lives HII 6 Urinary Catheter Care	Jan 11: Urinary catheter care - Audits completed Aug 2010, next audit due end Feb 2011. Compliance for insertion remains at 98%, compliance for ongoing care has shown a reduction from 98% in March 2010 to 92% in August 2010. Areas of sub optimal performance required to implement actions and re-audit as per infection prevention audit programme. No intensive support provided to areas, however this will take place for areas scoring below 85% in Feb 11 audit.
70	Saving Lives HII 7 Clostridium difficile	Jan 11: Clostridium difficile - same as below.
71	Saving Lives HII 8	Jan 11: Saving Lives HII 8 Cleaning and decontamination - New audit, first audit completed October 2010. Trust score of 91% for patients in non contaminated area and 95% for patients in infected area. Areas of sub optimal performance required to implement actions and re-audit as per infection prevention audit programme, matrons required to provide support and monitoring to areas scoring between 85 - 94%. Results discussed at Trust Environmental Operational Steering Group. Cleaning and decontamination launch and focus in July 2010.
72	Hand Hygiene Compliance in Clinical Areas	Jan 11: Clinical hand hygiene - Audits carried out quarterly; June, Sep, December 2010, next audit due end March 2011. Junes compliance at 99%, Sep at 97% and Dec at 98%. Areas of sub optimal performance required to implement actions and re-audit as per infection prevention audit programme. Infection Prevention Team carrying out intensive support and education to areas scoring less than 85% in December's audit, matrons required to provide support and monitoring to areas scoring between 85 - 94%. Audit assurance checks undertaken on areas of optimal performance. Hand hygiene awareness week completed May 2010 to raise awareness and education. Hand hygiene policy updated and relaunched.
73	Hand Hygiene Compliance during medical ward rounds	Jan 11: Medical hand hygiene - Audits carried out quarterly: May, Aug, Nov 2010, next audit due end Feb 2011. Mays compliance at 91%, Aug at 97%, Nov at 96%. Areas of sub optimal performance required to implement actions and re-audit as per infection prevention audit programme. Hand hygiene awareness week completed May 2010 to raise awareness and education. Hand hygiene policy updated and relaunched.

74	NICE CSG SP End of Life (Liverpool Care Pathway)	Ward support when an LCP is started to ensure staff are competent in using the paper work and documentation of relevant assessments. Contact Clinical Educators re existing education programmes for LCP education. 'Liaise with the ward clerks in medicine, cancer care and medicine for older people to document contact with GP after the patient has died on the LCP. This will be modelled on the work that is being undertaken by the ward clerk at Countess Mount Batten House Hospice in contacting the GP and documenting this has been done. Attendance at Care of the Elderly Consultant ward round. Support and education around symptom management for patients under their care.
75	Audit of registered new procedures 2009/10 - Standards for Better Health	Proposals received by Clinical Effectiveness that have not come from the governance lead, will be sent to the governance lead. DGMs add the discussion of new procedures as a standing item to divisional governance board meetings. Check proposal forms to ensure governance group approval and policy followed. Repeat audit for 2010/11 proposals.
76	Trust-wide Re-Audit of Consent Process 2010/11	Consent policy tweak - patient to receive pink copy. Actioned. Reinforce the need for anaesthetist's discussion with patients. Divisional Governance Managers (DGMs) to review results with CE manager and agree specific areas to improve. Specialist medicine to audit an additional 10 cases in next three months. Written information – high level of positive patient feedback. To increase availability of written information for more procedures.
77	Trustwide **Essence of Care** Audit of Privacy & Dignity (b/f)	For Action Planning – Care Group Use of curtain or door signs, importance of closing curtains, ask patients what they prefer to be called, hand wipes before and after meals, answering of call bells, storage of patient property, track patient moves and ensure patients told why being moved, review reasons for noise at night, remind medical staff to ensure confidentiality, privacy and dignity when having confidential conversations. For Action Planning – Corporate. Consider admissions “welcome to our ward” letter/ward orientation sheet. Report hyperlinked.
78	Trustwide **Essence of Care** Audit of Nursing Assessment & Documentation	Draft report lists the following recommendations / requirements: care group action plans to be established by each area's E of C leads; Trust to confirm revised RCP guidance on including an addressograph on every side of the pages in the patient’s records; progress feasibility of developing a standardised abbreviations list with IG lead; implement new transfer documentation (already completed by PC); feedback MUST results to relevant nutritional staff for inclusion in wider Trust plans.

79	Monthly nutrition screening Trust wide MUST audit (continuous)	MUST nutrition screening audit tool has been developed and launched as a continuous Trust wide monthly data collection audit. Results discussed at local led by project lead. Action: to provide all divisions with their results monthly to enable benchmarking. May cycle is 4th monthly cycle and shows statistically significant improvement compared to previous 3 months which indicated a steady rise in compliance. Repeat audit cycles to continue.
80	Monthly Trust wide audit of thromboprophylaxis (continuous)	The audit findings indicate significant improvements in appropriate thromboprophylaxis and documentation since the audit commenced. Documented risk assessment rose from 25% in Feb 2010 to 85% by Jan 2011. Appropriate pharmacological prophylaxis rose from 66% in Feb 2010 to 85% by Jan 11.
81	Repeat audit of ERALS Enhanced Recovery programme - national audit tool - local audit. Prostatectomy, hysterectomy, cyctectomy, colectomy, knee replacement, hip replacement	Patient Education on importance of nutrition drinks and mobilisation. Medical and Nursing Staff education update. Review of protocol.
82	Trustwide **Essence of Care** Audit of Hygiene Personal and Oral	Invite university representative and NVQ training representatives to future essence of care group to determine student and support worker education in personal hygiene. Confirm Trust position on nursing staff performing nail care and remind wards of need to keep nail care equipment available. Complete work on template for ward introduction booklet to indicate same sex facilities. Confirm availability of podiatry service and commence discussions with commissioners to extend. Launch Trust wide standards of care for personal hygiene (as part of clinical accreditation project)
83	Controlled Drug Orders	Remind all areas of need to avoid crossings out.

Report reviewed - actions to be agreed:

84	Pain relief in children following groin surgery	Actions to be agreed
85	Measurement of ETT cuff pressures on CIC U	Actions to be agreed
86	Response to referrals 2010 SGH	Actions to be agreed
87	Response to referrals 2010 CMB	Actions to be agreed
88	Radiotherapy for malignant spinal cord compression	Actions to be agreed

89	Laparoscopic distal pancreatectomy	Actions to be agreed
90	Follow up of babies with antenatal renal pelvic dilatation	Actions to be agreed
91	Re-audit of patient outcome follow up RACPC	Actions to be agreed
92	Safety + efficacy of surgery for cerebral metastases	Actions to be agreed
93	Trustwide WHO Theatre checklist audit 2010	Audit remains active. May 11- draft report for completed audit - insufficient numbers. Operationally difficult therefore re-audit imminent. Sample = Number of patients over two days' data. Some obvious areas of improvement required: Action: 2/30 operating theatres to improve their 'time-out' check. Where compliance is <90% theatres will be expected to repeat audit within short timescale as an action.

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