Public Document Pack

Health Overview and Scrutiny Panel

Tuesday, 26th July, 2011
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Committee Rooms 1 and 2 - Civic Centre

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

Southampton City Council's Seven Priorities

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

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

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

Public Representations

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

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

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

Dates of Meetings: Municipal Year 2011/12

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

CONDUCT OF MEETING

Terms of Reference

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

Business to be discussed

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

Rules of Procedure

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

Quorum

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

Disclosure of Interests

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

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Personal Interests

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

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

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

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

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

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

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

A Member must disclose a personal interest.

Continued/……

Prejudicial Interests

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

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

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

There are some limited exceptions.

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

Principles of Decision Making

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

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

In exercising discretion, the decision maker must:

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

AGENDA

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

1 ELECTION OF VICE-CHAIR

To appoint a Vice-Chair to the Scrutiny Panel for 2011/12 Municipal Year.

2 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

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

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 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 22nd June 2011 and to deal with any matters arising, attached.

8 JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

Report of the Executive Director of Health and Adult Social Care and the Director of Public Health, requesting that the Panel comment on the details of the proposed findings and the arrangements for the publication of the Joint Strategic Needs Assessment for the period 2011-2014, attached.

9 SOUTHAMPTON UNIVERSITY HOSPITALS TRUST - FOUNDATION TRUST APPLICATION

Report of the Director of Communications and Public Engagement , SUHT, for the Panel to note the progress with SUHT's Foundation Trust Application and request their support for the Application, attached.

10 TRANSFORMING OLDER PEOPLE'S MENTAL HEALTH SERVICES : PUBLIC CONSULTATION - FINAL REPORT AND RECOMMENDATIONS

Report of the Head of Consumer Experience and Engagement, Southern Health NHS Foundation Trust (SHFT) attaching a copy of the SHFT's report to Board which provides a summary of the public consultation on the proposed closures of Linden Willow Wards at the Tom Rudd Unit, Moorgreen Hospital, attached.

Monday, 18 July 2011 HEAD OF LEGAL AND DEMOCRATIC SERVICES

HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 22 JUNE 2011

Present: Councillors Capozzoli (Chair), Daunt, Payne, Thorpe and Turner

Apologies: Councillors Fitzgerald and Parnell

1. **ELECTION OF VICE-CHAIR**

RESOLVED that this item be deferred.

2. **ESTABLISHING THE SHIP PCT CLUSTER**

The Panel considered the report of the Director of Corporate and Support Services - Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP). Cluster, requesting that the Panel note the establishment of cluster working across Primary Care Trusts (PCTs) in SHIP area. (Copy of the report circulated with the agenda and appended to the signed minutes).

The Panel received a presentation from Debbie Fleming, Chief Executive of the NHS Southampton, NHS Hampshire, NHS Isle of Wight and NHS Portsmouth (SHIP) Cluster.

Main themes of the presentation included:

- PCTs were due to be abolished on 31 March 2013 and the aim of the clustering was to ensure PCTs continued to be resilient during the transition, as well as aid the establishment of GP consortia, Health and Well Being Boards and future arrangements for public health
- there was no choice to making changes – this was mandated following legislative changes set out in the White Paper 'Equity and Excellence: Liberating the NHS', and its associated policy documents 'Operating Framework for the NHS in England 2011/12', PCT Cluster Implementation Guidance'
- there was however a choice for PCTs on which other PCTs they could cluster with - there had been a great deal of successful joint working previously between the four local PCTs which had agreed to work as a cluster during the transition to the new GP-led commissioning system
- SHIP was the third largest cluster in the country and would have a combined allocation of £2.9 billion commissioning health care for nearly two million people across the four local authority areas
- that the previously robust arrangements in Southampton were recognised and valued. The cluster headquarters had been established in Southampton in a deliberate move to switch the emphasis from Hampshire.
- Sandy Hogg, Nominated Director/Executive Lead for Southampton City at NHS Southampton City had been appointed as the representative for Southampton on the cluster board
- There were many developments moving the cluster and associated governance arrangements forward and much had already been done following the

appointment of the cluster board and Chief Executive earlier this year, work on delivery was progressing. However, further guidance was expected from the Department of Health

- A cluster HQ executive team and the 4 PCTs would increasingly work together under the joint Board, supported by a single management team. The first meeting of the cluster board had taken place on 6th June. The priorities for the SHIP Cluster were:
    - Focusing on delivery, so that financial and operational performance is maintained, along with safe, high quality services. Work must continue to drive out unnecessary duplication and waste, so that all patients receive the right care, in the right place at the right time, thus delivering savings for the local health system
    - Facilitating the establishment of the new GP Clinical Commissioners (GPCCs), including all the support services that they will need in the future
    - Supporting the development of the new Health and Well-being Boards and the transfer of the Public Health function into each of the local authorities
    - Working with local NHS Trusts so they all achieve Foundation Trust status by 2014
    - Continuing to commission services that will in future become the responsibility of the National Commissioning Board (for example, primary care commissioning and specialised commissioning).

The Panel discussed issues arising from the presentation, including that of adequate representation for the interests of Southampton on the cluster board. The Panel highlighted their concern at the apparent lack of representation for Southampton on the board having only 1 in 13 places whereas Hampshire and Portsmouth had 8 and 3 respectively. It was clarified that executive appointments had been made on the basis of ability and appropriate skills set rather than location / PCT representation. There were 3 non-executive appointments per Trust on the cluster board, representing a 25% share. A detailed breakdown of the appointments to other posts was given.

The Panel also questioned the method of consultation used. It was explained that the cluster were enacting national policy and that there whilst there had been no consultation as such, there had been a great deal of joint working and internal staff consultation / sharing of information although there was no obligation to do so.

The challenge of bringing together three disparate areas and dealing with issues such as deprivation were acknowledged.

The mechanism for dealing with disputes and problems that might arise and decisions made by the cluster board was discussed in detail

RESOLVED that the report and presentation be noted.

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

The Panel considered the 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. (Copy of the report circulated with the agenda and appended to the signed minutes).

The Panel received a presentation from Dr Lesley Stevens, Clinical Director and Dr Tom Schlich, Clinical Service Director of Southern Health NHS Foundation Trust, Adult Mental Health Directorate, in connection with proposals to relocate Adult Mental Health Services in the Southampton area.

Pam Sorenson, Southern Health NHS Foundation Trust, was present and with the consent of the Chair, addressed the meeting.

The presentation included an outline of current services and the background leading up to the changes, main themes included:

- The need to ensure patient independence and provide choice and empowerment in patient care through individualised packages of care
- A focus on recovery
- Greater flexibility in service responses to need
- Alternatives to in-patient care
- The importance of the issue of the use of acute beds

Current services through integrated Health and Social Care Services included Acute Care, Community Services and Rehabilitation:-

- The Acute Care Pathway consisting of possible residential or more intensive care was outlined
- The Community Services Pathway involved:
    - Community Mental Health Teams linked to GPs
    - Early Intervention
    - Assertive Outreach
- The Rehabilitation Pathway included in-patient beds provided at Abbotts Lodge, Forest Lodge, Crowlin House, Milton House and links with supported accommodation. A lot of services had been built up in the past ten years in this area of service.

The proposed Future Model of Service was described in detail, some of the main points included:-

- Single point of access to services consisting of: 24 hour duty service including 24 hour phone service (a service not currently available), advice and signposting to other services including initial assessment, counselling, which would provide a better service for patients, carers and GP referrals

Benefits of the new model were:

- Simplified assessment
- Integrated community service
- Personalised, recovery focused and local care
- Rapid 24 hour access
- Partnership with carers
- Closer working with other care providers

The Panel noted that whilst there had been no formal consultation with service users there had been involvement throughout the process of developing the proposed new model.

The Panel were provided with a verbal update on the consultation activity in relation to proposals affecting provisions for Older People's Mental Health in the Southampton area.

Harry Dymond, Southampton Local Involvement Network, was present and, with the consent of the Chair, addressed the meeting.

The Panel noted that five events had been held in May that had provided direct feedback to the effect that there was general support for the proposals however, the main issue related to access and travel implications for service users which the Panel felt needed to be further addressed. The consultation was now at an end and the feedback currently being analysed. A further update on the consultation would be brought to the next meeting of the Panel on 26th July 2011.

RESOLVED

(i) that having had regard to the level and range of engagement activity in respect of proposals to relocate Adult Mental Health Services in the Southampton area, formal consultation in respect of these proposals was not necessary; and

(ii) that Southern Health have properly and adequately consulted with regard Older People's Mental Health services in the Southampton and South West Hampshire area.

4. **HEALTHWATCH SOUTHAMPTON AND TRANSITIONAL LINK SUPPORT ARRANGEMENTS**

The Panel considered the report of the Head of Integrated Strategic Commissioning, Health and Adult Social Care, providing details on progress for Southampton City Council's contribution towards the establishment of a Department of Health-sponsored local HealthWatch pathfinder project – in partnership with Hampshire County Council, the Isle of Wight Council and Portsmouth City Council – and new support arrangements for Southampton's LINk (S-LINk) from 1st July 2011 that will continue to be a statutory requirement during the period of transition. (Copy of the report circulated with the agenda and appended to the signed minutes).

Harry Dymond, Southampton Local Involvement Network, was present and, with the consent of the Chair, addressed the meeting.

The Panel were informed that the start date for HealthWatch had slipped from 1st July 2011 to October and that Southampton Voluntary Services would take over host services support for S-LINk – the Panel had been appraised on proposals at an earlier meeting.

RESOLVED

(i) that the report and presentation regarding the new arrangements for supporting Southampton's Local Involvement Network (LINk) and 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 be noted; and

(ii) that the Panel acknowledged the value of the arrangements outlined and identified the importance of protecting Council funding to Southampton's LINk in particular those funds identified for supporting LINks and preparing for HealthWatch during 2011/12 (£140,000).

5. **SOUTHERN HEALTH NHS FOUNDATION TRUST QUALITY ACCOUNT 2010/11**

The Panel considered the report of the Interim Deputy Director of Governance (Mental Health and Learning Disabilities), Southern Health NHS Foundation Trust, providing details on the Hampshire Partnership Foundation Trust Quality Account 2010/11. (Copy of the report circulated with the agenda and appended to the signed minutes).

Harry Dymond, Southampton Local Involvement Network, was present and, with the consent of the Chair, addressed the meeting.

The Panel received a presentation from Dr Huw Stone and Ruth Pullen, Southern Health NHS Foundation Trust, regarding the Trust's Quality Account.

The Panel discussed issues arising from the presentation including that of the accessibility of the report and, whilst acknowledging that it was written in line with guidance from the Department of Health and Monitor (the NHS Foundation Trust regulator), the Panel welcomed the development of a more accessible public summary of the document.

RESOLVED that the report was a fair reflection of the healthcare services provided.

6. **SOUTHAMPTON UNIVERSITY HOSPITALS TRUST QUALITY ACCOUNT 2010/11**

The Panel considered the report of the Director of Nursing, Southampton University Hospitals NHS Trust (SUHT) providing details on the draft Quality Account 2010/11 for SUHT. (Copy of the report circulated with the agenda and appended to the signed minutes).

The Panel received a presentation from Judy Gillow, Director of Nursing SUHT regarding the draft Quality Account.

The Panel noted that a summary version of the report, to include patient stories, would be made available to the Panel for the July meeting.

The Panel also noted and discussed the following points:-

- the high patient satisfaction scores achieved by the Trust
- the progress being made on reducing the incidence of pressure ulcers and that this remains a key priority for 20011/12.
- that problem areas had been indentified in the Quality Account and that plans were in place to address them
- the Panel were supportive of the priorities identified for 2011/12.

RESOLVED that the Panel were content that, to the best of its knowledge, the Southampton University Hospitals Trust's Quality Account for the 2010/11 was a fair reflection of the healthcare services provided by the Trust.

DECISION-MAKER:		Health Overview and Scrutiny Panel		
SUBJECT:		Joint Strategic Needs Assessment		
DATE OF DECISION:		26th July 2011		
REPORT OF:		Executive Director of Health and Adult Social Care and Director of Public Health		
AUTHOR:	Name:	Martin Day, Directorate Strategic Business Manager	Tel:	023 8091 7831
	E-mail:	Martin.day@southampton.gov.uk		
STATEMENT OF CONFIDENTIALITY				
None				

SUMMARY

The Scrutiny Panel considered the consultation draft of the Joint Strategic Needs Assessment (JSNA) at its meeting on 8th September 2010. Since that time the comments received during the consultation process have been analysed and major themes identified. The key issues arising out of these themes have been summarised, and this summary is now presented to the Scrutiny Panel.

RECOMMENDATIONS:

(i) That the Scrutiny Panel notes and comments on the proposed findings of the JSNA and the arrangements for the publication of the Joint Strategic Needs Assessment covering the period 2011 – 2014.

REASONS FOR REPORT RECOMMENDATIONS

1. The Council has a duty to produce a Joint Strategic Needs Assessment in consultation with the Primary Care Trust (PCT).

CONSULTATION

2. A number of consultation activities were undertaken in autumn 2010. These included a series of meetings with stakeholders, including a presentation to this Scrutiny Panel in September, web-based consultation and the publication of a document entitled “Health Matters”, which included a response form to enable individuals to express their views.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. None. The local authority and the PCT are under a legal duty to produce and Joint strategic Needs Assessment.

DETAIL

Background

4. The JSNA sets out to identify the ‘big picture’ for health and wellbeing and is a statutory requirement of the PCT and City Council to produce. The JSNA defines a needs assessment as ‘*a systematic method for reviewing the health and wellbeing needs of a population, leading to agreed commissioning priorities that will improve health and wellbeing outcomes and*

reduce inequalities. Department of Health JSNA Guidance p.7 (2007).

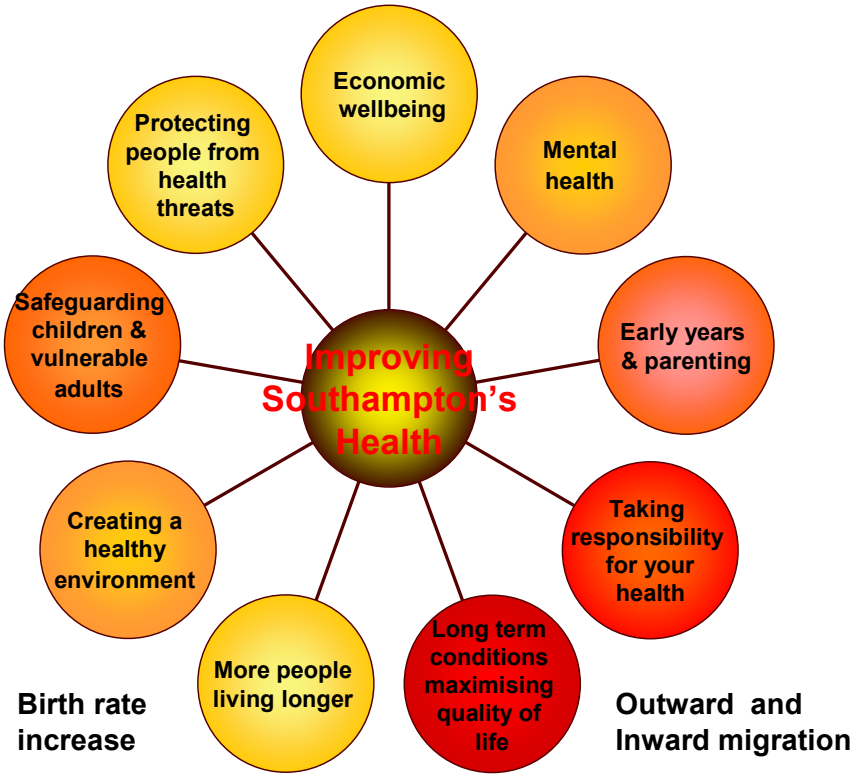
5. The government has been pursuing major reforms to the NHS, public health and adult social care over the past year. However the JSNA has continued to be seen as a vital process, and central to the NHS and local authorities being able to undertake informed and effective commissioning decisions. Subject to the passage of the Bill, production of the JSNA will, in future, be the joint responsibility of the local authority and the local clinical commissioning group (the new local health commissioning agency the replaces the GP commissioning consortium proposed in the 2010 NHS White Paper and the original Health and Social Care Bill), through the new Health and Wellbeing Board. It will need to inform the Joint Health and Wellbeing Strategy (again, to be a joint responsibility between the local authority and the clinical commissioning group through the Health and Wellbeing Board). The Health Scrutiny Panel will be able to challenge commissioning plans if it believes they do not reflect the evidence provided through the JSNA.

   The first JSNA covered the period 2008 – 2011. During 2010 work was undertaken to review and update the assessment. A consultation draft JSNA was produced in the summer of 2010, and over a period of almost 5 months, key stakeholders were consulted, and the responses have generated. This scrutiny panel (then called Scrutiny Panel B) received a presentation and considered the consultative draft document at its meeting on 23rd September. No specific recommendations on the consultation document were made at this meeting.

6. The new arrangements for health structures and the role of the JSNA present a real challenge. The JSNA needs to be reliable, relevant and available throughout its lifetime. To respond to these challenges it is proposed that rather than be a paper document, the JSNA should become a web-based resource. This has been undertaken by several other local authorities cited in best practice reviews and it has several advantages. It will not become out of date soon after publication and it can be updated regularly and take account of the latest data. New datasets can be added if major new issues and challenges arise. This will assist commissioners in making higher quality informed decisions. It will also be available to any interested parties at all times. Furthermore, it saves the expense of publishing a large document that may end up sitting on shelves, as early on its life newer information may be available elsewhere.

   Another issue the new JSNA will address is to detail assets already available. This is in response to a series of comments made during the consultation process that presenting only the needs meant the investments already being made were not being reflected. Adding these to the JSNA will add value, as by making this information available to commissioners, they will be able to identify resources provided by other organisations, or other parts of their own organisation, that they were not aware of, thereby potentially achieving additional synergies, more effective commissioning decisions, and better value for money.

It was also felt necessary to produce a more accessible and concise account of the issues that have come out of the JSNA review process. To this end, an executive summary has been produced which draws the evidence into 9 key themes. This helps the council and the NHS identify in broad terms areas of significant need that will require investment to improve health outcomes and reduce health inequalities. The 9 themes are set out in the diagram below:



The executive summary document is attached as Appendix 1 to this report, and members will receive a presentation at the meeting highlighting some of the key data and feedback from the consultation process.

FINANCIAL/RESOURCE IMPLICATIONS

Capital

15. There are no capital implications contained in this report.

Revenue

16. There are no direct revenue implications in this report. The JSNA will inform future commissioning decisions to ensure the effective use of such revenue budgets as are approved by the council.

Property

17. There are no property implications contained in this report.

Other

18. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

19. The Local Government and Public Involvement in Health Act (2007) places a duty on upper tier local authorities and PCTs to undertake Joint Strategic Needs Assessment.

Other Legal Implications:

20. None.

POLICY FRAMEWORK IMPLICATIONS

21. None.

SUPPORTING DOCUMENTATION

Appendices

1.	JSNA Executive Summary

Documents In Members' Rooms

1.	Non

Background Documents

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

Background documents available for inspection at:

KEY DECISION? Yes

WARDS/COMMUNITIES AFFECTED:	All

JSNA Executive Summary

Background and context

The purpose of this document is to help professionals, services and communities themselves to improve the health and wellbeing of Southampton's population through clearly identifying local needs. " Gaining Healthier Lives in a Healthier City" is Southampton's second Joint Strategic Needs Assessment (JSNA) and will cover needs for 2011-14. The JSNA sets out to identify the 'big picture' for health and wellbeing. The JSNA defines a needs assessment as '*a systematic method for reviewing the health and wellbeing needs of a population, leading to agreed commissioning priorities that will improve health and wellbeing outcomes and reduce inequalities.* Department of Health JSNA Guidance p.7 (2007). The picture of health and wellbeing in the city set out in this JSNA has been informed by a wide range of data sets (available through the JSNA data compendium web site: www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/public-health-data/jsna/data/ and through stakeholder and public engagement.

This document summarises the key themes and issues that have emerged from a five month consultation and engagement process with the public, voluntary sector, health and social care stakeholders and elected representatives. www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/public-health-data/jsna/consultform/ and the Health Maters magazine http://www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/public-health-data/jsna/health-matters-2010/ published in July 2010. Feed back has been received on what are seen as the main priorities for attention and investment which have been matched against the data to inform conclusions from this analysis.

Maintaining a needs assessment is a dynamic iterative process rather than a product and builds on the first JSNA, published in 2008. The local data compendium lies at the heart of that process. The data will be used to inform future commissioning decisions and spending priorities. The data compendium will be regularly updated with current data during the lifetime of this second JSNA as new data sets and analysis become available. This assessment also integrates the six key recommendations from Sir Michael Marmot's report Fair Society (2010), www.marmotreview.org/ probably the most important evidence based commentary on health for a generation.

This version of the JSNA will inform developments during a time of substantial change for the NHS and the city council. The Primary Care Trust will cease to exist after March 2013, and the new GP Commissioning Consortium will then take over responsibility for commissioning most of the health services required for local people. The public health function will transfer to the local authority at the same time that Public Health England is established. This JSNA will help to inform commissioning decisions during the tightest public spending environment in a generation.

This summary illustrates that improving health and wellbeing in a city such as Southampton will not simply be about delivering more health and social care services. It recognises that enabling people to live healthier lives is as much about helping people maximise their own individual potential and, helping them to create a safe and pleasant environment to live in, as it is about improving the quality and accessibility of services. Ultimately each individual has a personal responsibility to make mature and sensible decisions for their own health and to help their children to make good decisions about diet, exercise, drugs, alcohol and sexual health.

Many people are shocked by the scale of health inequalities that exist in Southampton in 2011. We have a highly valued NHS and the overall health of the population in the city has improved greatly over the past 50 years. Yet in the wealthiest part of Southampton, in Bassett, a man can expect to live to 80.6 and women 84.0 years, while a few kilometres away in Bitterne, one of the cities poorer wards, male life expectancy is 75.3 and female 79.9 years. These differences in life expectancy of 5.3 and 4.1 years respectively for men and women are significant enough not to be a coincidence. Dramatic health inequalities are still a dominant feature of health in Southampton (adapted from Marmot 2010).

Health inequalities are not inevitable and can be significantly reduced. They stem from avoidable inequalities in society: of income, education, employment and neighbourhood circumstances. Often inequalities present before birth set the scene for poorer health and other outcomes accumulating through the course of our residents lives.

Within this JSNA an initial attempt has been made to describe some of the health assets which include factors or resources which enhance the ability of individuals, communities and populations to maintain and sustain health and well-being. These assets can operate as protective and promoting factors to buffer against life's stresses. Indeed, asset based community development (ABCD) presents an evidence-based framework to help practitioners recognise that as well as having needs and problems, communities also have social, cultural and material assets. These are what help them overcome the challenges they face. The asset approach does not replace investment in improving services or tackling the structural causes of health inequality. While it may help reduce demands on services in the long term and bring about more effective services, it is not a no-cost or a money-saving option.

Other major developments in train that affect future services are the recommendations from the Munro Review of Child Protection (2011) and the changes in autonomy of schools and their funding.

The government has indicated that the JSNA is to remain a key tool for informing commissioning decisions. The Health and Social Care Bill proposes placing a duty on the City Council and GP consortium to work jointly to produce future versions of the JSNA. This would then inform the production of a Joint Health and Wellbeing Strategy. This will be the overarching framework from which the commissioning plans for the NHS, social care, public health and other services would be developed.

A GP commissioning consortia is being established for the city which will shape services and drive improvements locally, within a national framework and with support and guidance from the NHS Commissioning Board. This will create an integrated system between consortia and the Board, which supports the delivery of national accountabilities as well as local priorities. Local consortia will also work closely with the Health and Wellbeing Board to ensure commissioning is joined up between the NHS, public health and social care.

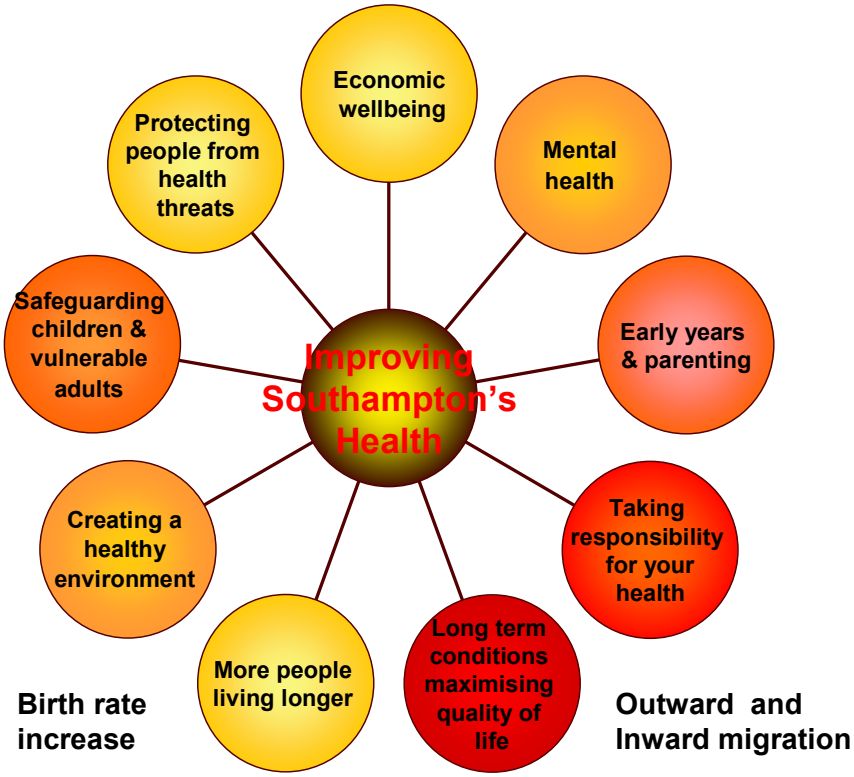
A key challenge from central government will be to ensure a developing focus on prevention at a time when public sector budgets are being cut back and statutory service provision is under pressure. Some of the needs identified through the JSNA process provide the basis for identifying where some of the most cost-effective preventative actions might be taken.

Our commissioning framework aims to:

1. Put people at the centre of commissioning
2. Understand the needs of populations and individuals
3. Share and use information more effectively
4. Assure high quality providers for all services
5. Recognise the interdependence of work, health and well-being
6. Develop incentives for commissioning for health and well-being
7. Make it happen through capable leadership and local accountability

Following extensive public and stakeholder consultation nine key themes for a healthier population have been identified. These are underpinned by a good understanding of Southampton's changing population – each theme also dovetails to the Marmot 2010 main policy recommendations in a 'Fair Society, Healthy Lives' to ensure consistency with national requirements of local services.

Figure 1 JSNA 9 Key themes



Main policy recommendations from *Fair Society, Health Lives*: (Marmot 2010)

A. Giving every child the best start in life (highest priority recommendation) – what happens during early years (starting in the womb) has lifelong effects on many aspects of health and well-being from obesity, heart disease and mental health, to educational achievement and economic status. Later interventions, although important, are considerably less effective where good early foundations are lacking. That is why this review proposes a rebalancing of public spending towards the early years, more parenting support programmes, a well-trained early years work force and high quality early years care.
B. Enabling all children, young people and adults to maximize their capabilities and have control over their lives – educational achievement brings with it a whole range of achievements including better employment, income and physical and mental health. Evidence suggests it is families rather than schools that have the most influence on educational attainment therefore building closer links between schools, the family, and the local community are important to reducing educational inequalities.
C. Creating fair employment and good work for all – being in employment is protective of health; conversely unemployment contributes to poor health. Jobs need to offer a decent living wage, opportunities for in-work development, good management practices, the flexibility to enable people to balance work and family life, and protection from adverse working conditions that can damage health.
D. Ensuring a healthy standard of living for all – having insufficient money to lead a healthy life is a highly significant cause of health inequalities. Standards for a minimum income for healthy living (MIHL) need to be developed and implemented – the calculation includes the level of income needed for adequate nutrition, physical activity, housing, individual and community interactions, transport, medical care and hygiene.
E. Creating and developing sustainable places and communities – many policies which would help mitigate climate change would also help reduce health inequalities – for instance more walking, cycling and green spaces. The Marmot review proposes common policies to reduce the scale and impact of climate change and health inequalities. Good quality neighbourhoods can make a significant difference to quality of life and health – this relates both to the physical environment and to the social environment. Social support, within and between communities is critical to physical and mental well-being.
F. Strengthening the role and impact of ill-health prevention - many of the key health behaviours important for the development of chronic disease follow the social gradient: smoking, obesity, lack of physical activity, unhealthy nutrition and drug misuse. The review argues for more funding to prevent ill health (currently it is only four percent of the NHS budget) and action to treat drug misuse as a medical problem. The NHS alone cannot tackle the social causes of ill health; action must come from families, schools, employers and government.

Theme 1 – Improve Economic Wellbeing

"Whilst many parts of the city are enjoying economic success, for a number of families, vulnerable adults and older people on fixed incomes, making ends meet is a daily struggle". (Consultation response)
Wages in Southampton are falling behind England and the South East average

Marmot recommendations C - *Create fair employment and good work for all* and D - *Ensure healthy standard of living for all* (Marmot 2010)

The benefits of reducing health inequalities are economic as well as social. The cost of health inequalities can be measured in human terms, years of life lost and years of active life lost; and in economic terms, by the cost to the economy of additional illness. (Sir Michael Marmot 2010)

Low average wages and high average house prices are key drivers behind the need to improve economic wellbeing as a means of reducing health inequalities and contributing to improved health. The first city priority, "to achieve sustained economic growth", and the economic development challenges, provide a focus to deliver higher levels of economic wellbeing.

People on lower incomes living in the most deprived areas in the city have shorter lives than those in the more affluent areas, with premature deaths (under age 75) 62.5% higher and increasing, the life expectancy of men being lower by 3.5 years and widening, and for women by 1.4 years and narrowing.

Deprivation is a significant issue in Southampton with the City being ranked as the 4th most deprived local authority in the South East and 81st out of the 326 local authorities in England according to the Index of Multiple Deprivation (IMD) 2010 In April 2010 12.6% of the working age population were claiming 'out-of-work' benefits compared to 9.5% across the South East region. In 2009 the estimated average weekly earnings for a full-time employee in Southampton were £441.60 or £95 a week less compared with a South East average of £536.60. Nearly 28% of Southampton's children are classified as living in poverty.

The landmark Marmot review "Fair Society, Healthy Lives" published in 2010, provided evidence showing the clear link between economic wellbeing and health, with inequality in illness accounting nationally for productivity losses of £31-33 billion per year, lost taxes and higher welfare payments in the region of £20-32 billion per year and additional NHS healthcare costs in excess of £5.5 billion per year.

The city has been successful in attracting major businesses into the city over the past 10 years. Having established businesses and new key players in the city economy is important for maintaining a reputation which will continue to attract other companies to supply a continuing flow of new employment opportunities. The data suggests that local people are losing out to people living outside the city when it comes to getting the better paid jobs. Traditionally the city has relied heavily on the public sector, with the local authority, NHS and universities providing employment for approximately 36,400 people (ONS 2009). The 2010 public spending review is yet to impact fully upon the city.

For Southampton to remain competitive it is essential to focus on improving the skills and educational attainments of city residents, and reduce the gap between those

achieved in the city and in neighbouring areas, as unemployment rates are highest amongst those with no or few qualifications. Special attention needs to be paid to ensure that people with disabilities and mental ill-health, young people, and other vulnerable and excluded groups are not trapped in a cycle of low-paid, poor quality work and unemployment.

Addressing these needs contributes to the following city challenges:

- Encourage higher levels of employment and economic activity
- Tackling deprivation in specific areas of the city
- Health at work

Theme 2 Improve mental health

"Mental health affects everything we do, our drive, our motivation, our self-esteem and this rubs off on those around us".(Consultation response)
There are high levels of both severe and common mental health problems in Southampton

Marmot recommendations C - *Create fair employment and good work for all,* E - *Create and develop healthy sustainable places and communities* and F - *Strengthen the role and impact of ill health prevention* (Marmot 2010)

Mental health is everyone's business, yet when we are well we rarely think about it. Good mental health and resilience are fundamental to our physical health, our relationships, our education, our training and our work to achieve individual and collective potential. Good mental health is the foundation for wellbeing and effective functioning both for individuals and their communities. Mental wellbeing is about our ability to cope with life's problems and make the most of life's opportunities; it is about feeling good and functioning well, as individuals and collectively.

Mental ill health takes the largest portion of NHS funding in the city. Poor mental health is a big issue in terms of funding for the local NHS and social care and in terms of the misery it causes individuals, families and communities.

We know that at least one in four people will experience a mental health problem at some point in their life and one in six adults have a mental health problem at any one time. Self harming in young people is not uncommon (10-13% in the UK) of 15-16 year olds have self harmed. Almost half of all adults will experience at least one episode of depression during their lifetime and one in ten new mothers experience postnatal depression. About one in 100 people has a severe mental health problem, with around 60% of adults living in hostels having a personality disorder.

In 2009/10 there were 2,561 people in Southampton recorded on GP Registers as suffering from severe mental illness. City GPs also recorded 1,257 patients on dementia registers and 23,388 on depression registers. The number of 18-64 year olds in the city with a common mental health disorder is projected to rise to 30,223 in 2030. Depression is the most common mental health problem of later life. At any given time 10-15% of over 65s will be depressed (NSF for Older People, 2001). There is considerable unmet need. One in 4 older living in the community have symptoms that are severe enough to warrant intervention, but only one third of older

people with depression ever discuss this with their GP. Only half are diagnosed and treated with anti-depressants.

In the period 2007/08 to 2009/10 the number of people in Southampton on dementia registers increased by over 17% but this change reflects improved recording, changing demographics as well as increased prevalence.

Over the period 2007 to 2009 there were 78 deaths from suicide (or undetermined injury) involving Southampton residents. In comparison with similar cities Southampton has a relatively low suicide rate of approximately 8.2 per 100,000 population. However, this is higher than England and each case represents a tragic and potentially avoidable death.

A review of recent evidence suggests that building the following actions into day to day lives is important for wellbeing, for example:

- connecting with the people around us, with family, colleagues and neighbours. Building these connections will support and enrich our lives
- becoming or remaining active - exercising makes people feel good. Most importantly, discover a physical activity to enjoy and that suits individual level of mobility and fitness.
- taking notice – be curious and be aware of the world how it feels. Reflecting on experiences will help appreciate what matters in life
- learning new things help us feel more confident as well as being enjoyable
- give time – seeing ourselves linked to the wider community can be incredibly rewarding and creates connections with the people around.

(New Economics Foundation 5 Ways to Wellbeing [2008]).

The new Mental Health Strategy *No Health Without Mental Health* (2011) is a cross government strategy for people of all ages, with the ambitious aim to mainstream mental health in England. Locally a multi-agency approach will be addressing the key objectives identified in the Strategy

There are some positive developments in the city – e.g. Steps to Wellbeing Service which is improving access to psychological therapies (IAPT) addressing mild to moderate depression and anxiety continues to develop.

Addressing these needs requires

- choice of psychological therapies available for those who need them
- reduce stigma and discrimination which can result in people with mental health problems not seeking help and unable to engage in ordinary life
- provision of better support for women's mental health during pregnancy and the post-partum period
- societal effort to reduce social isolation thereby reducing risk of depression particularly in older people
- better integration of physical and mental health

Theme 3 Improve early years experience/ better parenting and family support

"Adults should practice what they preach and eat a balanced diet and more fruit so they stay healthy!" … "*Giving children love, affection and time is key."* (Consultation responses)
High levels of inequality prevent many children and young people gaining the best start in life

Marmot recommendations A - *Give every child the best start in life* and F - *Strengthen the role and impact of ill health prevention* (Marmot 2010)

The collective ambition of local agencies working with children, young people and families for the long term wellbeing of every child and young person in the City is set out in the 2009-12 CYPP. Underpinning these priorities is a commitment to address the following needs based priorities;

Raising attainment and transforming the way we organise schools; creating buildings which support the aspirations of children, young people and the wider community.

Historically, the results of children attending Southampton schools have been lower than the results achieved nationally at every stage of measured education. Results for Southampton school children have started to close significantly at the end of Foundation Stage (age 5) and are at or above the national average at Key Stage 1 (age 7). Whilst the gap is closing at Key Stage 2 (age 11) and Key Stage 4 / GCSE (Age 16) there is still some way to go before the results of children attending Southampton schools reach national averages in these latter stages.

Reducing the numbers of young people who are not in education, employment and training (NEET) and improve the numbers of young people who have the right qualifications and skills for a successful adult life. Since levels of 16-18 year NEET started to be measured and became a local authority responsibility, levels in Southampton have been above both national levels and those in comparator authorities. As is the case for GCSE performance, there remain gaps in the performance of children and young people on both Level 2 and Level 3 qualifications at age 19. The City does perform relatively strongly in relation to closing the gap in the percentage of young people from low income households progressing to Higher Education.

Reducing the gaps in outcomes for children and young people from priority neighbourhoods and from socially excluded backgrounds when compared to city averages. There has been significant progress in closing the gap in attainment between young people from priority neighbourhood areas and the City Average in the last three years. The City also performs generally well in relation to the relative educational performance of children and young people with Special Educational Needs, and for children and young people from minority ethnic communities.

Increasing the numbers of young people who take part in positive activities rather than getting involved with crime or anti-social behaviour. There have been significant developments in the scope for children and young people to get more involved in positive activities as a consequence of extended school provision, though results from the Tellus4 survey in 2009 did not indicate strong performance. There have been significant gains in relation to virtually all areas of Youth Offending, and levels of first time entrants to the Criminal Justice System have fallen particularly sharply.

Reducing teenage pregnancy has long been seen as a proxy measure of low aspirations among young people. Southampton has historically been a relatively poor performer in relation to teenage pregnancy rates. In recent years, targeted action with young people in schools and the community does seem to have resulted in a sustained reduction in teenage pregnancy rates for the City. 2009 figures published in February 2011 show a rate of 49.2 per 1,000, and 3rd out of 11 similar

cities, compared to 65.6 per 1,000 in 2001, when Southampton was 10th out of 11 similar cities.

Improving the oral health among children and young people.
By the age of 12 years Southampton children experience significantly higher rates of dental decay (37%) compared to South Central (28.9%) and England (33.4%). This not only reflects data from when children are young (dental health age 5 has historically indicated problems in Southampton), but is significant as this is our first assessment of the population in relation to the oral health adult teeth

Each of the priorities in the CYPP is based upon ongoing needs assessment, set out in the JSNA data compendium.

Theme 4 Taking responsibility for health

"There's not enough P.E in school. Some schools also have embarrassing P.E uniforms so girls start to get into the habit of hating P.E at an early age 'cos of the way they feel when they're in the uniform." (Consultation response)
Lifestyle choices such as smoking, alcohol, diet and low levels of physical activity are responsible for much ill health in Southampton

Marmot recommendations B - *Enable all children, young people and adults to maximise their capabilities and have control over their lives* and E - *Create and develop healthy sustainable places and communities* (Marmot 2010)

Taking responsibility for health and lifestyle are important from cradle to grave; even pre-pregnancy diet, alcohol, smoking and drug consumption and levels of physical activity can have an impact on a child yet to be conceived. Much of the modifiable disease prevalence within Southampton reflects the poor lifestyle choices that many in the City population make.

In Southampton 23.4% of children in reception classes are overweight and a further 10.7% obese; this increases to almost 33.4% overweight by year 6 with 20.2% obese. The standard for obesity in 1990 was 5%. Only 41% of children in the city participate in more than 3 hours of sport a week. Unless parents, our schools and wider society supports these children to have a healthy weight, this will further impact on diseases such as diabetes, cancers and coronary heart disease in later life. Diabetes is increasing by 6% per annum in the city and much of type II diabetes is preventable or the onset can be delayed, but is affecting more children. At any time there are now between 20 and 40 patients in the general Hospital weighing over 30stones. Balancing dietary intake of food against the physical expenditure of energy requires rebalancing to improve health potential of all those who are overweight.

Excessive alcohol consumption is impacting negatively on the city population; there are 41.4 alcohol-attributable deaths per 100,000 amongst males in Southampton compared to a national average of 36.1. In addition to this there are 129.4 alcohol-specific hospital admissions for under 18s per 100,000 in Southampton compared to a national average of 72.3. This misuse costs Southampton around £12 million per annum and puts strain on emergency department resources as well as the abuse and violence suffered by staff. Younger adults are being diagnosed with alcohol induced liver damage increasing hospital demand, some requiring organ transplants.

Southampton is estimated to have smoking prevalence of 22.57% in adults aged 18 years and over, which is significantly higher than the national average of 20.99% (2009-10). However, data from GP records of adults aged 16 years and over shows a rate of 21.35%. Smoking costs the NHS locally £49.8 million and reduces disability free years due to sickness and disease. Each day there is a death due to a smoking related disease, whilst many more young people start the habit.

In common with the rest of the region, drug misuse prevalence is apparently highest among the 25-35 year age group. However, the use of so-called "recreational" drugs is reported to be growing within the under 18 year old age range and also the 18-25 age range, with an increasing number of individuals presenting at the open access services for assistance with stimulant and "legal high" usage.

There are some really positive developments happening in Southampton and continued investment will be required to maintain these improvements. For example, breast feeding initiation has increased to 75% (from 69% in 2008/9). Cardiovascular disease checks are now carried out by all GP practices for 40 – 75 year olds offering support for lifestyle changes.

Addressing these needs requires:

- increasing physical inactivity across the lifespan, particularly in childhood to create a healthy active blueprint for life
- reduce alcohol consumption – the most robust evidence is to increase taxation on each unit of alcohol
- stopping the inflow of young people recruited as smokers
- assisting every smoker to stop their dependence on tobacco and protecting families and communities from tobacco related harm
- re-focus drug treatment services on the need to plan for recovery and re-integration, thus improving the rate of planned exits from treatment

The NHS and City Council cannot maintain a health and social care safety net without Southampton's people playing their part in making sustainable lifestyle changes and reducing the burden of need.

Theme 5 Living with long-term conditions -maximising the quality of life

"Preventing and reducing the burden of long term conditions, particularly those that drastically reduce the quality of an individual's life, have to be a priority, together with better support for carers." (Consultation response)
More people are living with long term conditions in Southampton whose quality of life could be improved

Marmot recommendations B - ***Enable all children, young people and adults to maximise their capabilities and have control over their lives*** **and D -** ***Ensure healthy standard of living for all*** **(Marmot 2010)**

Preventing the onset of disease and disability through adopting healthy lifestyles was a need expressed throughout our consultation. One positive consequence of wider improvements in health and well-being achieved over recent decades has been that more people are living longer. Living longer poses challenges for health and

wellbeing services. In Southampton disability free life expectancy is lower than the national average at 60.9 years for men and 63.4 years for women compared with 61.7 years and 64.2 years respectively. Disability free life expectancy highlights inequality in the average number of years a person could expect to live free of an illness or health problem that limits their daily activities.

According to the Department of Health (2010) long term conditions represent 69% of health and care spend, 77% of inpatient bed days, 55% of GP appointments and 68% of outpatient and emergency department appointments. This care transcends organisational boundaries of social care, primary, community and hospital care. Increasing numbers of people have more than one long term condition yet face an increasingly fragmented specialised response.

Around 86,000 people in Southampton are estimated to be living with long term health conditions, such as asthma, diabetes, heart disease, hypertension, dementia, epilepsy and severe mental illness; these conditions are not curable, but treatable and require on-going treatment and monitoring. A further 2,395 people require regular case management to co-ordinate their complex treatment and care needs. Approximately half of those with a long term condition (LTC) report that this condition limits their daily activities or work and many of those who responded to our public consultation stated that long-term stress was an issue detrimental to their wellbeing.

There are an estimated 1,900 children and young people (4.3%) living in Southampton with moderate or severe disabilities. Males make up two-thirds of this group and females a third. The majority of these children live in priority neighbourhoods, with deprivation an additional burden to these children and their family. Their disabilities are generally chronic, limiting and include learning disabilities, physical disability, autistic and sensory disorders.

Proactive disease or case management of long-term conditions can make a real difference to people with a single condition or a range of problems that threaten their health and wellbeing. Some of these patients will be case managed by their GP practice whilst others are case managed by the Complex Care Teams (Joint Health and Social Care teams including Community Matrons). Those who had self-care plans reported that they felt more in control.

End of life care is about enabling people to live their life to the end with dignity and having their choices recognised. Not all people will be able to plan for their death, but for a number of people, particularly with a long-term condition, planned care will enable them to experience a peaceful and dignified death.

In summary these needs were to:

- stay independent, socially engaged and physically active
- be in control and manage my illness
- have better support for carers
- be offered improved care at the end of life and treated with dignity
- ensure that palliative care is extended to people with other diseases besides cancer to ensure equity of access depending on need(e.g. heart failure, COPD)
- have timely bereavement counselling available in all GP practices
- improved integration between health and social care could provide better co-ordination.

Theme 6 More people living longer

"Older people can do fun things too… to stay healthy – if they can't afford 'wi fit' at home, they could come to our youth club – maybe?" (Consultation response)
The ageing profile of Southampton is likely to increase the number of people living with disabilities, as people tend to pick up disabilities through injury or degenerative conditions as they get older

Marmot recommendations D- *Ensure healthy standard of living for all* and E - *Create and develop healthy sustainable places and communities* (Marmot 2010)

Average life expectancy across the city is below the average for England. In 2007/2009 the average life of men was 78.4 years against the England average of 78.25, and for women it was 82.4 years against an England average of 82.31 years.

The fastest growing sector of the population is that aged 65 years and over, with the over 65's set to increase by 14% between 2010 and 2017 whilst the number of people over 85 years is forecast to grow from 5,183 to 6,034.

The ageing population is placing an increasing demand on both health and social care services. For example with joint replacements due to disease and or injury, the number of hip replacements performed increased by 31.9% over 5 years from 2004/05 to 2008/09, while in the same period the number of knee replacements performed increased by 16.3%. Many of those having suffered a fall and fractured hip never get fully back the independence that they previously enjoyed. The chances of having cancers generally increase with age. Within hospital care medical and surgical cancer therapies increase between 4-5% with new patients each year.

Between 2003/04 and 2007/08 the number of people aged 65 and over receiving social care services rose from 181.8 per 1,000 to 194.7 per 1,000, an increase of 7.1% over 5 years. This contrasts with the England average, which fell from 159.1 per 1,000 in 2003/04 to 149.6 per 1,000 in 2007/08, and meant the number of older people receiving social care services was 30% above the average for England by 2007/08. These figures correlate with the lower number of years of disability-free life experienced by people in the economically most deprived neighbourhoods. The number of older people with dementia receiving services grew by 14% between 2004/05 to 2008/09. Whilst new drugs are being developed, the demands for dementia support and care are expected to increase in line with the growth on the population aged over 85.

Long term conditions in later life tend to become more complex and may become multiple, requiring more reactive and proactive and health and social care and carer input as discussed earlier. Within these tight economic constraints, primary, acute and social care services will be under pressure to meet expressed demand, but meeting needs effectively will require smart commissioning to ensure the most vulnerable, including the frail elderly, have a voice.

Age-related macular degeneration (AMD) is the leading cause of sight loss in the western world but only half of adults have heard of it. This was borne out by a poll of more than 4,000 people on behalf of the College of Optometrists. Results indicated a lack of awareness of the condition, with people also unaware that diet and smoking is linked to eye disease.

The key need to be addressed for the current adult population is to

- encourage people to achieve the healthiest possible lives so they can enjoy the highest possible quality of life in old age. Consequently they would then create a lower demand for services when they are older.
- enable those who have reached older age and who require assistance to have choice to access to the appropriate type of good quality accommodation, so they can live independent lives in a community setting for as long as possible.
- use the personalisation of social services to provide an opportunity for those in need and eligible for services to select the style of support that suits their life and expectations, and this will have a significant impact on the existing provision of care, particularly that supplied by the local authority.
- increase the opportunities offered by telemedicine and telecare to maintain older peoples independence at home
- provide access to good quality information and advice for those people in need of support who are not eligible for local authority funded services
- to further integrated discharge and re-ablement teams across health and social care to support those older people who have undergone treatment in hospital
- expand the 24/7 palliative care provision for those who wish to remain at home.

In summary there needs to remain good public health population wide intelligence and analytical function to enable the future health and wellbeing board to perform its oversight of health and social care commissioning.

Theme 7 – Creating a healthier environment

"Lack of green, safe areas and access to low cost sport….overcrowding and poor housing conditions, (Consultation response)
Ensure the physical environment in local areas helps to promote walking, cycling and safe local recreation and play.

Marmot recommendations E - *Create and develop healthy sustainable places and communities* (Marmot 2010)

The environment in which people live has a major influence on health outcomes. Southampton is the 21st most densely populated area in England and Wales, with 47.4 people per hectare (2009), there are strong links between density of population and deprivation. A good home environment provides security, affordable warmth and adequate ventilation. A good work environment minimises risk of the development of long-term illnesses and injuries. A healthy external environment contributes to reduction of crime and improved public safety, lower levels of pollution, access to public transport, access to places for safe play, exercise and recreation. Over time, the development of a more sustainable environment at home, work and externally should contribute to better physical and mental health in the city.

Southampton's position as a major port for the import of goods into the country means a continuing need for a high quality Port Health service. This provides protection not only to residents of the city, but the UK as a whole and Europe.

Southampton City Council has a leading role to play in addressing the issues set out above. The decent homes programme has brought about substantial improvements

to the 18,000 council homes in the city. However, there are major health issues created by poor housing conditions in the privately owned, and private rented sectors. Fuel poverty created by poor insulation and rising energy prices is a major health and wellbeing issue for many residents in the city.

Effective transport planning provides opportunities for access to public transport and provides safe spaces for walking and cycling. The forthcoming review of the Local Transport Plan needs to maximise their potential to improve exercise and activity levels and improve air quality. It also needs to secure adequate public transport at the right times to reduce social isolation, which will then contribute to improved mental health.

Future development plans need to incorporate guidance produced by the National Institute for Health and Clinical Excellence on promoting and creating built environments that encourages and supports physical activity, and planners will need to work with developers to ensure that new developments minimise the opportunity for, and fear of, crime and anti-social behaviour. The maintenance and improvement of existing parks and open spaces and maximising the opportunity for the development of new areas will provide opportunities for people to exercise and socialise.

The council has responsibility for 6,000 places of work and 1,800 food premises in the city. Ensuring compliance with health and safety and pollution legislation reduces the risk of injury and illness and levels of sickness, worklessness and long-term absence from work.

Once the Public Health service is transferred to local government in 2013 it will provide further opportunities for the council to improve its focus on health issues and outcomes.

Theme 8 - Improving safeguarding for children and vulnerable adults

"Good parenting and a stable safe home life…with support from family and an engaged community". "Reducing Social isolation" (Consultation responses)
High numbers of vulnerable families living under pressure means that more children and adults are at risk of harm, and safeguarding needs are high in the city

Marmot recommendations A - *Give every child the best start in life* and B - *Enable all children, young people and adults to maximise their capabilities and have control over their lives* (Marmot 2010)

The 2004 Children Act was created to improve arrangements for effective joint working between public bodies and other service providers in regulating official intervention in family life to meet the interests of vulnerable children. The Act also made changes to laws that pertain to children who are particularly dependent on the actions of public bodies for their wellbeing, notably in relation to children in care, children subject to child protection plans and the handling of crimes against children. It was a central part of the national response the Victoria Climbie Inquiry. A range of outcomes related to vulnerable children are set out in the Every Child Matters framework. These are covered in the JSNA data compendium, but they identify

vulnerability relating to factors such as child poverty, child protection, neglect, abuse or exposure to crime, drugs or alcohol.

The Association of Directors of Adult Social Services published its national framework for safeguarding standards in 2005 and these have been developed and implemented in Southampton. A safeguarding adults policy has been published jointly by Southampton City Council, Portsmouth City Council and Hampshire County Council, and a summary has been made available in leaflet form and as a web document.
www.southampton.gov.uk/living/adult-care/safeguarding-adults-from-abuse/

The Council and its statutory partners have put in place and delivered a major programme of safeguarding awareness training relating to people working with children, young people and vulnerable adults. Safeguarding training is now integrated into induction for the workforce. All relevant employees and volunteers working closely with children, young people and vulnerable adults should be subject to Criminal Records Bureau (CRB) checks. They should also know how to act upon and respond to concerns relating to a child's wellbeing.

In relation to children and young people a number of statutory services exist to ensure that those most vulnerable to abuse, neglect or harm are protected, that those in the care of local authorities and their partners are well provided for, and are supported in entering adult life in their turn well placed to achieve economic wellbeing and to become effective parents. For vulnerable adults the key policy drivers are to;

- ensure that safeguarding practices are fully aligned to the coalition government's Vision for Social Care,
- take actions to increase awareness of safeguarding issues with people who fund their own care and
- increase the number of staff within the independent sector who have accessed training on safeguarding awareness.
- ensure there are adequate resources to investigate safeguarding referrals from people with learning disabilities.
- ensure that teenage and young adults are properly supported when they transfer from children to adult care.

In 10 out of 15 performance measures for children in care, outcomes are improving in 2010-11. Performance in relation to the timeliness of reviews in Child Protection cases also remains strong. Despite this, the number of children and young people needing specialist social care support has risen sharply since September 2008. For example;

- The number of children subject to Child Protection Plans has more than doubled from 106 (a rate of 24.9/10,000) to 252 (58.1/10,000) in December 2010.
- The number of children in local authority care has risen from 283 (a rate of 65.2 per10,000) to 382 (88.0 per10,000) in December 2010.

Theme 9 Protecting people from threats to health

"Preventing diseases is important, vaccinations, school health – make sure sexual health is included" (Consultation response)
Vaccination coverage continues to miss some vulnerable children; sexually transmitted disease including HIV continues to increase in the city year on year

Marmot recommendations A - *Give every child the best start in life* and F - *Strengthen the role and impact of ill health prevention* (Marmot 2010)

Throughout a lifespan there may be many threats to health; this high level assessment will focus on some of the key threats and their mitigation. After clean safe water, immunisation is the most effective public health intervention in the world for saving lives and promoting good health. Immunisations protect the individual, family and the community from the effect of illness, morbidity and mortality, being very cost effective and safe.

The UK national childhood immunisation programme is delivered mainly through primary health care services. The uptake of vaccines in Southampton is relatively high when compared with national data, just below 95% coverage, although there is considerable variation across the city. This reflects a national picture where differences in uptake are associated with a range of social, economic, maternal and infant related factors.

Sexually transmitted infections (STI's) continue to increase in the city with the 16 to 24 age group having over half the burden of disease. Sexual Health Services are treating 50% more people with ano-genital herpes now than in 2005 and 64% increase in chlamydia treatment over the same period. Uptake rates for chlamydia screening remain low in the city so the true burden of disease may be even higher. Ano-genital herpes is the most common ulcerative STI in the UK. It is incurable but can be managed with antiretroviral drugs to prevent further outbreaks and transmission to others. Genital herpes can cause severe systemic disease in the immuno-supressed and is associated with a greater risk of acquiring HIV. It may also cause severe problems in neonates if transmitted from mother to child during birth.

Blood borne viruses - Human Immunodeficiency Virus (HIV) continues to be one of the most important communicable diseases in the UK. It is an infection associated with serious morbidity, high cost of treatment and care, significant mortality and high number of potential life years lost. HIV can lead to the development of AIDS but if detected early can be managed with antiretroviral therapies reducing the incidence of AIDS and preventing early death. From 2004 to 2009 the city has seen an increase of 60% in people diagnosed with HIV and accessing services, 1.57 per 1,000, higher than the South Central Strategic Health Authority average of 1.13 per 1,000 (Office of National Statistics mid 2008 estimates). This does not take into account undiagnosed prevalence, thus the actual rate may be higher. This is very worrying as currently there remains no cure for HIV and drug costs alone to mediate the symptoms cost the city around £1.9million a year.

Hepatitis B and C remain serious public health issues with potentially grave complications, shortening life expectancy. Much of the burden of this disease is undiagnosed. Hepatitis B and C are potentially preventable, as is much of the associated morbidity with timely identification and treatment.

Health Care Acquired Infections (HCAIs) remain a continuous threat and emphasis needs to be placed on the health economy wide efforts to tackle HCAI's. These are infections that are acquired (by patients or staff) following admission to hospital or as a result of healthcare interventions in other healthcare facilities.

Tuberculosis is a growing problem nationally and an issue locally predominantly, but not exclusively, through migration. The typical TB sufferer in the city becomes unwell within the first ten years of arrival. This latent TB requires vigilance to ensure the public know how to access treatment and screening services and requires vigilance on the part of GP practices and occupational health services to be TB aware.

Protection from environmental hazards can be exemplified by that of U/V radiation (sunlight) whereby excessive exposure may give rise to skin cancers. Since 2003 there has been an increase of 100% in malignant melanomas, thankfully the number of people involved is small but prevention is better than cure.

A changing population underpins the above key themes needs

"Southampton as a rich vibrant city has to continue to respond to the changing population and their needs, including the impact on birth rate and migration" (Consultation response)
The city enjoys a diversity of people which enriches our population, but the pace of population change challenges service delivery

Marmot recommendation D- *Ensure healthy standard of living for all* (Marmot 2010)

In 2010 the total population of Southampton is estimated to be 237,470[1] with 264,573 people registered with GP practices. The profile of the City's population differs from the national average because of large number of students; over 17% of Southampton's population is aged between 18 and 24 years compared to just 9.5% nationally.

Southampton is a diverse City; in 2007 it was estimated[2] that 17.3% of residents were of an ethnic group other than White British compared to 16.4% nationally. This is a higher proportion than in most of the Cities considered 'most similar'[3] to Southampton. The annual school census in the City in 2010 revealed that 26.4% of pupils were from an ethnic group other than White British. In 2009/10 32% of live births in Southampton (where ethnicity was known) were non-White British or Irish. Looking at trends in ethnicity of live births, it is the other White background which has risen most significantly in recent years; rising from 8% on 2006/07 to 12% in 2009/10.

Those children under 5 years proportionately use the NHS more than other children. Growth in this group has particularly impacted on maternity and paediatric care and health visitor services. A quarter of all paediatric non-elective admissions are for those children under 4 years of age. Typically a GP sees each pre-school child six times a year and school aged children two or three times.

The number of pupils whose first language is not English has risen from 8.4% in 2007 to 12.7% in 2010 with 54 languages other than English spoken in city schools. In 2007 there were 427 pupils whose first language was Polish by 2010 this had risen to 902.

[1] Hampshire County Council 2010-based Small Area Population Forecasts (Alternative version) – provisional as at February 2011.
[2] ONS experimental statistics
[3] ONS 2001 Classification of Areas

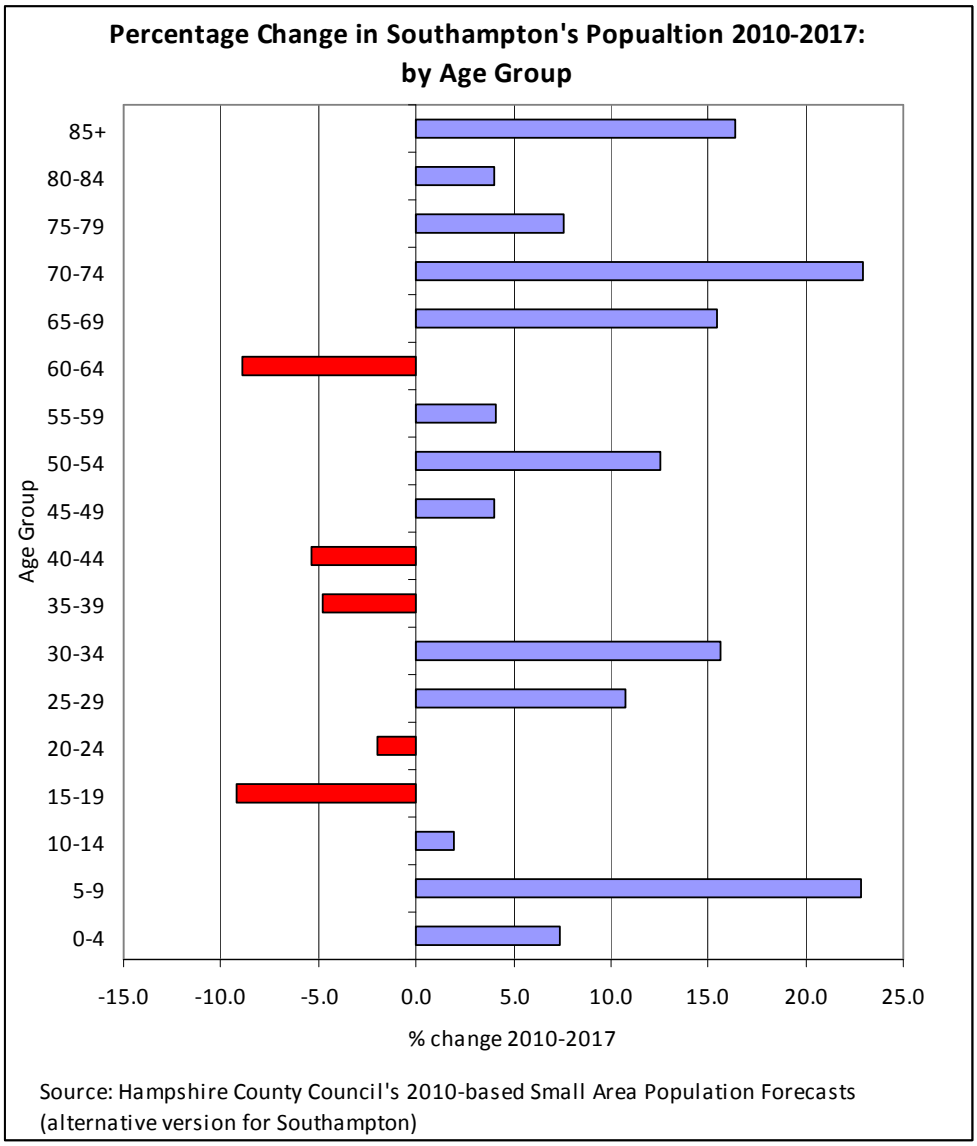
There are many uncertainties around current and future population numbers. There will be a national Census this year (2011) which, if good coverage is achieved, will provide some clarity. However, the results are unlikely to be available until 2012/13 at the earliest. In the meantime, the latest data produced by Hampshire County Council (HCC)[1] provides the best available forecast of the population. These forecasts are based on the planned completions of residential dwellings in the City; they predict an increase in dwellings of 6.4% between 2010 and 2017. Bargate, Woolston and Bevois are the wards set to see the biggest increases in dwellings.

The increase in dwellings across the City translates to a population increase of 11,176 (4.7%) over the same period. It is the older population that will grow proportionally more over the next few years as discussed earlier. Importantly the proportion of the population of working age is steadily declining and this may impact on the informal and community care available to the changing population structure.

According to the HCC forecasts the number of births will increase by 8.5% over the forecast period. However, local monitoring of births at SUHT reveals that since 2004 there has been an average year-on-year increase of about 5% suggesting that despite improvements in the HCC methodology and the use of local fertility assumptions they may still be underestimating the very significant increases in fertility in the City. Between 2003 and 2010 general fertility rates in the City have increased from 48.4 to 56.3 per 1000 females aged 15-44. In 2010 Bitterne ward had the highest fertility rates in at 91.0 per 1000.

A population forecast for the Southampton showing age group changes until 2017 is below. People in age groups 5 to 9 years and 70 to 74 years show the largest increase over 20%, whilst 15 to 19 year and 60 to 64 years show the largest decrease around 8%.

Southampton population changes by age group 2010 to 2017

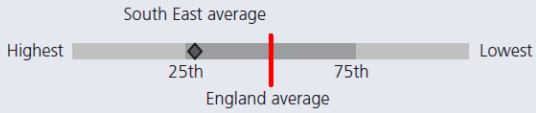


The disease prevention profile that follows is illustrative of the way data can be presented in the JSNA

Health Summary for Southampton

The chart below shows how performance on prevention in this PCT compares to the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which is shown as a bar. The average result for England is shown by a red line, which is always at the centre of the chart. A red circle indicates that this area is significantly worse than England for that indicator. A green circle shows a significantly better performance, but it may still indicate scope for improvement.

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



Domain	Indicator	Local Number	Local Value	England* Median	England* Worst	England Range	England* Best
Pregnancy	A1 Antenatal booking before 12 weeks	2843	72.0	82.3	45.8		100.0
	A2 Smoking in pregnancy	553	n/a	14.9	31.4		4.4
	A3 Screening for infectious disease - Hep B	6186	91.7	*96.5*	*68.7*	No England values available	*100.0*
Infants	B1 Newborn bloodspot screening - PKU	3243	100.0	*99.9*	*97.4*	No England values available	*100.0*
	B2 Breastfeeding initiation	2512	n/a	72.0	39.9		93.0
	B3 Breastfeeding at 6-8 weeks	1233	37.1	41.6	14.7		80.6
	B4 Newborn hearing screening	3054	89.4	94.7	64.2		98.3
Children	C1 Immunisation - MMR	2923	91.0	89.2	73.0		96.7
	C2 Immunisation - PCV	2878	89.6	89.3	63.9		97.4
	C3 Child obesity aged 4-5 years	200	9.3	9.5	14.7		5.9
	C4 Childhood injury	715	166.6	119.9	215.3		68.5
Young people	D1 Immunisation - HPV	924	81.0	78.6	0.3		97.9
	D2 Chlamydia screening	7468	15.6	23.0	8.3		40.8
	D3 48-hour access to GUM clinic	8425	89.4	89.3	69.1		99.6
	D4 Alcohol-specific hospital stays	157	122.5	62.4	168.6		19.8
Adults	E1 Breast cancer screening	10374	71.9	77.5	50.9		84.8
	E2 Cervical cancer screening	44780	75.6	79.3	66.4		85.4
	E3 Bowel cancer screening					Data not available until 2011	
	E4 Diabetic retinopathy screening	8441	91.9	91.4	70.8		98.5
	E5 Successful smoking quitters	1814	923.6	899.6	405.7		1933.9
	E6 Smoking quit rate	1814	50.9	49.1	31.1		69.8
	E7 Smoking status recorded	45919	93.8	95.3	93.3		97.4
	E8 Hepatitis B immunisation in prisoners	n/a	n/a	*36.8*	*3.3*	No England values available	*54.1*
	E9 Hypertension	n/a	11.4	10.7	13.8		8.3
Older people	F1 Warm Front Grants	926	3.9	4.9	0.4		15.6
	F2 Hip fractures	198	466.1	482.2	660.9		327.8
	F3 Immunisation - Flu	22816	73.6	72.4	64.9		78.2

* Where England values are unavailable South East data ranges are presented in purple italics

Notes (numbers in BOLD refer to the above indicators)

A1 % of women who have seen a midwife, or a maternity healthcare professional, by 12 weeks and 6 days of pregnancy 2009/10 **A2** % of mothers smoking at time of delivery 2009/10 **A3** % of pregnant women receiving a hepatitis B test 2008/09 **B1** % screening coverage for phenylketonuria (PKU) in newborns 2008/09 **B2** % of mothers initiating breastfeeding 2009/10 **B3** % of mothers breastfeeding at 6–8 weeks 2009/10 **B4** % hearing screen complete by 4/5 weeks after birth 2009/10 **C1** % of children immunised against measles, mumps and rubella (MMR) by their 2nd birthday 2009/10 **C2** % of children immunised with the pneumococcal conjugate vaccine (PCV) by their 2nd birthday 2009/10 **C3** Prevalence (%) of obesity among children in Reception (aged 4–5 years) 2008/09 **C4** Emergency hospital admissions caused by unintentional or deliberate injuries to under 18s per 10,000 population 2009/10 **D1** % children (school Year 8 girls) receiving human papillomavirus (HPV) vaccinations 2008/09 **D2** % 15–24 year old population tested for chlamydia 2009/10 **D3** % first GUM attendances seen within 2 working days 2009/10 **D4** Persons aged under 18 years admitted to hospital with alcohol-specific conditions, crude rate per 100,000 2006/07 to 2008/09 **E1** % women aged 53–64 years screened for breast cancer in last 3 years 2008/09 **E2** % women aged 25–64 years with less than 5 years since last adequate cervical smear test 2009/10 **E3** No data available until 2011 **E4** % of patients with diabetes who have a record of retinal screening in the previous 15 months 2009/10 **E5** Successful quitters at 4 week follow up as % of those setting a quit date 2009/10 **E6** Successful smoking quitters per 100,000 population aged 16 years and over 2009/10 **E7** % patients with any or any combination of the following conditions: coronary heart disease, stroke or transient ischaemic attack, hypertension, diabetes, chronic obstructive pulmonary disease, chronic kidney disease, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the previous 15 months 2009/10 **E8** % uptake of hepatitis B vaccinations in prisons, within 31 days of reception 2009/10 **E9** Percentage point difference between modelled estimates of the prevalence of hypertension and reported prevalence by GPs 2009/10 **F1** Warm Front Grant qualifying referrals rate per 1000 population 2009/10 **F2** Emergency hospital admissions for hip fracture, directly age-standardised rate per 100,000 persons aged 65 years and over 2009/10 **F3** % persons aged 65 and over immunised against influenza 2009/10.

A guidance document is available alongside this profile to provide additional information for each indicator

SOUTHAMPTON www.sepho.nhs.uk

DECISION-MAKER:	**HEALTH OVERVIEW AND SCRUTINY PANEL**
SUBJECT:	SOUTHAMPTON UNIVERSITY HOSPITALS TRUST – FOUNDATION TRUST APPLICATION
DATE OF DECISION:	26 JULY 2011
REPORT OF:	ALISON AYERS, DIRECTOR OF COMMUNICATIONS AND PUBLIC ENGAGEMENT SUHT
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

SUHT is in the final stages of applying to become a Foundation Trust. Its application began in 2007 but was paused for 12 months due to issues with the Trust's financial position in January 2010

RECOMMENDATIONS:

(i) To note progress with SUHT's Foundation Trust Application.

(ii) To agree the Panel's support for the Foundation Trust Application.

REASONS FOR REPORT RECOMMENDATIONS

1. To inform the scrutiny panel of the Trust's progress with its FT application
2. To seek support for the Trust in embarking on this change to its status and governance arrangements.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3 None.

DETAIL (Including consultation carried out)

4 A three month public consultation was held at an early stage in the application process and this began in October 2007. Since then the Trust has recruited a thriving membership and held elections to form a shadow Members' Council. The Trust continues to consult with its members via this Council.

Details of the current position are set out at annexe 1.

RESOURCE IMPLICATIONS

Capital/Revenue

5 N/A

Property/Other

6 N/A

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

7 N/A

Other Legal Implications:

8 None

POLICY FRAMEWORK IMPLICATIONS

9 None

AUTHOR:	Name:	Alison Ayres	Tel:	023 8079 6241
	E-mail:	Alison.Ayres@southampton.gov.uk		

KEY DECISION? Yes/No

WARDS/COMMUNITIES AFFECTED:	

Appendices

1.	*Briefing for Southampton City Council Health Scrutiny Panel Southampton University Hospitals NHS Trust Foundation Trust Application July 2011*

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)

Southampton NHS
University Hospitals NHS Trust

Briefing for Southampton City Council Health Scrutiny Panel
Southampton University Hospitals NHS Trust
Foundation Trust Application
July 2011

1. What is a Foundation Trust

1.1. NHS Foundation Trusts have a greater degree of managerial and financial freedom, which enables them to adapt services to meet the needs of their patients and the local community. They are 'public benefit corporations, with less central government control and more freedom to act locally. Hospitals that are already NHS Foundation trusts are recognised for stronger finances, better governance, patient focus and more innovation- which closely matches our own aspirations.

1.2. There is a greater emphasis on ensuring that staff, patients, carers and the public have a say in the way the hospital is run. NHS Foundation Trusts remain firmly part of the NHS, and deliver care according to the NHS principles.

2. Why do we want to become a Foundation Trust

2.1. We see achievement of Foundation Trust status as key continuing to drive forward our 2020Vision. We expect that becoming a foundation Trust will increase our local accountability, and support continued innovation to improve care for our patients support enhanced access, flexible capacity and investment according to patients needs. The new governance arrangements that being a foundation Trust brings will empower patients and carers to ensure that we provide services that are suited to their needs. The Foundation Trust framework facilitates community engagement.

3. Membership

3.1. Members are central to the model on which Foundation Trusts are based. Our Members Council has been in place since 2009 and serves as the link between the Trust and the community.

4. Role of Members

4.1. Our members hold a key role with a number of responsibilities. The Members Council is chaired by the chair of the Foundation Trust, and represents the interests of the local community and Trust membership. It has an advisory role providing views to the Trust Board of Directors on the future development plans of the hospital, and has a key role in consulting with members to find out their views.

Our Members Council includes

7 members who are appointed to the Members Council by the Trusts key stakeholders,
4 members drawn from staff constituencies including a doctor, a nurse, wider clinical, and non clinical staff
13 Council Members drawn from public, patient and carer constituencies made up from:

Southampton city-5 members
New Forest, Eastleigh and Test Valley- 4 members
South of England region- 3 members
Islands- 1 member.

4.2. The full details of all the council Members can be found on our website: members' council and information about the Council members for Southampton City area is included at appendix A.

5. The Foundation Trust Application Process

5.1. SUHT reactivated its Foundation Trust application on 31 March 2011. The application has been reactivated with full support from our commissioners, Strategic Health Authority and the Department of Health. The Monitor assessment process has included a detailed review with us of our 5 year business plan, financial, quality, and operational performance. This remains on schedule and appears to be progressing positively. However the final outcome will not be known until October 2011.

5.2. We will ensure that the health scrutiny panel remain informed about our application progress.

Appendix A

The Council Members for Southampton City

From www.suht.nhs.uk website page:
http://www.suht.nhs.uk/AboutTheTrust/NHSFoundationTrust/MeetyourCouncilMembers/SouthamptonCity.aspx

	**Rosie Bynam** I am currently a Specialist Practice Nurse with 45 years of nursing experience. I first came to Southampton General Hospital in 1968 and worked at the Wessex Neurological Centre as a Ward Sister. Then on F level, for 8 years before becoming a Community Health Advisor to the elderly. I also have been a volunteer, meeting and greeting patients at The Macmillan Centre once a week for the last 3 ½ years. I therefore have a long association with the Trust . I will bring to this role a wealth of experience with the welfare of the patient being paramount. **Declaration of Interests**: None **Political Party**: None **Financial or other interest in the Trust**: None
	**Pamela Aihie** I am a medical practitioner having recently retired. I have been part of the NHS all my working life with experience in most branches of medicine before specialising in Public Health and management. I am a resident of Southampton having joined my family here. I have been disabled for many years with a mobility problem so I have good experience of the NHS from the patients point of view. I feel I could put my knowledge to good use in the capacity as a member of the Council. **Declaration of Interests**: None **Political Party**: None **Financial or other interest in the Trust**: None
	**Sue Daniel** I have lived in Southampton for over 30 years. I'm married with three adult children and care for an elderly relative. My career has been in nursing, initially as a paediatric ward sister and later working in the community for the Primary Care Trust. I recognise the challenges that face an ever changing NHS in ensuring cost effective, timely and fair access to quality services for all ages, ethnicities and abilities. To this aim I am particularly keen to see more co-operative and joined up working between Hospital and community care. I welcome the opportunity to become an elected member. **Declaration of Interests**: None **Political Party**: None **Financial or other interest in the Trust**: None
	**Professor Colin Pritchard** After more than 40 years with the NHS, as Practitioner, Health Authority member and Professor in psychiatric social work, only when I became an emergency surgical patient did I really understand the patient's perspective! My current research spans cancer and neurological disease; 'patient-focused' outcomes related to understanding staff stresses that lead to patient risk in theatre, and, research that identifies the patient's agenda contributing to improved services. As an 'informed patient' I can ask the right questions and believe I would be a good representative for fellow patients and citizens, strengthening the patient's perspective as well as understanding staff pressures. **Declaration of Interests**: None **Political Party**: Labour **Financial or other interest in the Trust**: None

Val Thorpe
My name is Val Thorpe I am married with three grown-up children. I believe the NHS does a great job, however, it could improve in certain areas. I would like the opportunity to help work toward change. For instance I would like to see a return to single sex wards. I would like to see better care for the elderly, I have witnessed both lack of nourishment and ill thought out home assessments. I have had personal experience of losing a loved one to MRSA. I would like to see a zero tolerance approach adopted to save lives.

Declaration of Interests: None
Political Party: None
Financial or other interest in the Trust: None

Appendix B

Further information about Monitor

Taken from Monitor website www.monitor-nhsft.gov.uk/

From 'Guide to Monitor' published 8th March 2010

What is Monitor's role?

There are three main strands to our work:

1. Determining whether a trust is ready to become an NHS foundation trust

The Secretary of State for Health recommends to Monitor NHS trusts that are ready to enter our assessment process.

We then undertake a thorough and independent assessment of each NHS trust, looking at three important criteria:

1. Is the trust well governed?
2. Is the trust financially viable?
3. Is the trust legally constituted?

When our assessment is complete, Monitor's Board decides whether or not to authorise the applicant as an NHS foundation trust. A list of current applicants is available on our website: www.monitor-nhsft.gov.uk.

We are concerned with how the board is running the trust.

2. Ensuring that NHS foundation trusts comply with the conditions they signed up to

Monitor is responsible for monitoring the performance of NHS foundation trusts. We do not hesitate to intervene when problems occur, which an NHS foundation trust cannot resolve on its own.

Once authorised, all NHS foundation trusts are subject to their terms of authorisation – a detailed set of requirements they must operate within. These are available for each NHS foundation trust in the foundation trust directory on our website. All of the rules and regulations we apply to foundation trusts are set out in our *Compliance Framework*, including how we will intervene if an NHS foundation trust breaches, or risks breaching, its terms of authorisation.

Monitor's primary focus is on the governance of foundation trusts – we are concerned with how the board is running the trust and how it is cooperating with other bodies, for example its commissioners.

How we regulate NHS foundation trusts

We operate a risk-based regulatory system, which means that we intervene when we have concerns, but do not interfere with the day-to-day management of trusts that are performing well.

Each year, all NHS foundation trusts are required to submit their rolling three-year plans to Monitor. The plans set out what improvements the trust intends to make to its services, including priorities for how they intend to improve the quality of care they provide, a three year financial forecast, and whether the trust has identified any potential risks that will affect compliance with its terms of authorisation during the next twelve months.

Once we have analysed these plans, we assign two risk ratings to each NHS foundation trust. The risk ratings indicate our view on whether or not the NHS foundation trust is at risk of breaching its terms of authorisation. The categories of risk rating are:

- **governance:** is the trust being sufficiently well managed to deliver high quality services, is it meeting national targets and core standards set by the Government, and is it delivering all of the services it has a legal obligation to provide (under contract with its commissioners); and
- **finance:** whether or not we have any concerns about the financial performance of a foundation trust.

These categories are broad enough to cover a diverse range of issues that could affect the overall performance of an NHS foundation trust. In assessing governance risk ratings, Monitor will also consider other relevant information, such as significant trends in complaints and evidence of other patient safety or critical concerns.

During the course of the subsequent twelve months we monitor each NHS foundation trust's performance against its annual plan. All risk ratings are updated every three months to reflect our latest assessment of the trust and are published on our website and in quarterly reviews, which also provide a snapshot of performance issues across the NHS foundation trust sector.

We work with a network of organisations to ensure we have access to a broad range of information on NHS foundation trust performance and expert advice. The Care Quality Commission, as the regulator of clinical quality, has primary responsibility for reviewing the quality of care across the NHS, and provides information to Monitor which we use to inform our views on governance within existing foundation trusts and applicant trusts.

DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	TRANSFORMING OLDER PEOPLES MENTAL HEALTH SERVICES
DATE OF DECISION:	26 July 2011
REPORT OF:	PAM SORENSEN HEAD OF CONSUMER EXPERIENCE & ENGAGEMENT SOUTHERN HEALTH NHS FOUNDATION TRUST (SHFT)
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

To receive a copy of SHFTs report to Board which provides a summary of the public consultation on the proposed closures of Linden and Willow inpatient wards (functional and organic respectively) at the Tom Rudd Unit, Moorgreen Hospital, West End.

RECOMMENDATIONS:

(i) To note the report

(ii) To approve SHFTs proposal to close Linden and Willow Wards at the Tom Rudd Unit

REASONS FOR REPORT RECOMMENDATIONS

1. To enable the Panel to conclude that the consultation as carried out by SHFT and the findings of the report, support the development of Older Peoples Mental Health Services in Southampton.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. None

DETAIL (Including consultation carried out)

3. Please see report and attachments for details

RESOURCE IMPLICATIONS

Capital/Revenue

5. None.

Property/Other

6. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

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

Other Legal Implications:

7. None

POLICY FRAMEWORK IMPLICATIONS

8.

AUTHOR:	Name:	Pam Sorensen, Head of Consumer Experience & Engagement, Southern Health NHS Foundation Trust (SHFT)	Tel:	023 8087 4058
	E-mail:	Pamela.Sorensen@HantsPT-SW.NHS.UK		

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.	Board Report
2.	Appendix 6.1 – Consolidated Feedback Analysis

Documents In Members' Rooms

1.	Appendices 2 – 8

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)

Southern Health NHS Foundation Trust

Board Report

Date: 16 June 2011 Author: Amanda Horsman

For: Foundation Trust Board

Subject: Executive Summary

1. Purpose of report and alignment to strategic goals

This report provides a summary of the public consultation on the proposed closures of Linden and Willow inpatient wards (functional and organic respectively) at the Tom Rudd Unit by:

- *Outlining the background to the Trust consulting on the proposals*
- *Summarising the feedback received during the consultation period*
- *Making recommendations regarding the next steps to be taken by the Trust*

2. Context

2.1 The proposed closure of two inpatient wards at the Tom Rudd Unit on the Moorgreen Hospital site reflects the strategy within the Older Peoples Mental Health Service Directorate to move from bed-based services and focus on support in the community that provides personalised care based on individual need *(OPMH 5 Year Service Strategy 2010* "Planning Together for the Future"). This also reflects the diminishing need for beds within the directorate with a significant proportion (up to a third) of beds being unoccupied at any given time. Background information is shown at appendix 1.

2.2 Hampshire Overview and Scrutiny Committee (HOSC) were briefed in September 2010 of proposals and Southampton Scrutiny B panel on 13 January 2011 and it was agreed that further work should be carried out regarding the proposals.

2.3 Between November 2010 and March 2011 the Older Peoples Mental Health Service Directorate carried out a significant amount of engagement work with service users/carers staff and other external stakeholders relating to the in-patient wards at the Tom Rudd Unit and the strategy for Older Peoples Mental Health Services. The Trust also held four engagement events between January and March 2010 under the banner "Planning Together for the Future" as an opportunity to engage further with the general public and discuss the service strategies and plans. The drop in events were successful in building the Trust's reputation and providing useful feedback for service development purposes. Details of this engagement are shown at appendix 2. The feedback that the Trust received from the above engagement work was included within the consultation document and was used to shape the proposals that were put forward.

2.4 The Trust ensured that throughout this period both the HOSC and Scrutiny B panel were kept fully informed and updated, providing both informal and formal feedback

on progress at HOSC meetings held on 25 January, 29 March, 7 April and the 24th March 2011. The work completed by the Trust was acknowledged by the HOSC at their 29 March 2011 meeting where it was agreed to hold a six week formal consultation regarding the proposed changes to Tom Rudd Unit (as opposed to the maximum 12 week formal consultation period).

2.5 In April 2011 the consultation paper and process was agreed by the Boards of NHS Hampshire, NHS Southampton City and Southern Health NHS Foundation Trust (previously Hampshire Partnership NHS Foundation Trust).

2.6 Following the publication of the four key tests for service reconfiguration originally described within the revised NHS Operating Framework published 21 June 2010 *(detailed guidance since provided DoH - Service Reconfiguration 29 July 2010),* the Trust has undertaken a self assessment in order to assure itself through its engagement and consultation log that it has met the criteria.

The four tests cover:

- Support from GP Commissioners
- Clinical Evidence Base
- Strengthened Public and Patient Engagement
- Patient Choice

Details of this are shown at appendix 3

3 Report on the public consultation

3.1 The public consultation commenced on the 9 May 2011 with five public events held on 13 May, 17 May, 18 May, 23 May and 26 May 2011. Staff were formally advised of the proposals on 9 May 2011 with meeting held for inpatient and facilities management staff on that date. This presentation is shown at appendix 4.

3.2 A detailed 'Timeline and Action Plan' was developed and maintained before, during and after the consultation (see appendix 5).

3.3 Information relating to the public events and the proposals was widely circulated across key stakeholders. These included briefings, flyers and copies of the main and summary consultation documents which detailed the methods by which feedback could be provided.

3.4 The five public events were well supported by Older Peoples Mental Health Service Directorate with additional attendance from Governors and Southampton and Hampshire LINks representatives.

3.5 Storyboards were used detailing the proposals, and an area set aside for a presentation based on the storyboard content and then followed by a Question and Answer session. The format was generally well received.

3.6 The presentations worked well and generated a good number and range of questions. The presence of senior clinicians to answer questions was well received by members of the public.

3.7 Responses to the consultation were received in a variety of formats. The majority of feedback was received at the public events led by the Clinical Director, Director of Operations and Deputy Director of Operations from the Older Peoples Mental Health Service Directorate. Other feedback was also received via feedback forms and correspondence.

Some themes to emerge included:

- Support for closing under unutilised beds with in the directorate
- Agreement for developing our community services and moving away from bed-based provision
- Some concerns relating to services being cut back by other agencies and the potential impact on carers and relatives
- The difficulties for some patients and their carers of travelling to the Western Community Hospital

3.8 At its 24 May 2010 meeting the HOSC received a progress report on the consultation period.

3.9 The Trust analysis of the formal consultation has been externally validated by Hampshire LINks and a report produced. This report is shown at appendix 8.

4 Key issues, risks, opportunities and actions

As detailed in appendix 6 feedback was received from a variety of sources including responses from members of the public and local councils. This feedback was collated and highlighted some emerging themes which were described in the analysis and forwarded to Hampshire LINks for validation. Not withstanding Hampshire LINks' recommendation the Trust has noted the following concerns and proposed to strengthen the existing arrangements as described below.

4.1 Improved understanding of mental health issues in primary care and acute care

The Older Persons Mental Service Directorate has good existing links with GPs and will look to strengthen these further. Each surgery in the Southampton and the South West Hampshire area has a designated psychiatrist and community mental health team to work with. The Older Persons Mental Service Directorate has already run some training events for GPs and will continue to do this through 2011 in order to raise awareness of mental health needs in older people.

The Directorate has recently increased psychiatric liaison into Royal Hampshire County Hospital, Winchester, and will look to increase liaison into Southampton General Hospital as part of these plans. The Directorate is also planning a series of educational events to be held across acute hospitals during 2011.

4.2 Better information for service users and carers

The Directorate has recently updated all its information for service users and carers and this is given out to people when they attend for appointments. The Trust website has also recently been updated.

4.3 The need for people to remain independent for as long as possible with support from family and friends to achieve that

People told the Directorate that they wish to stay living in their own homes as long as possible, however there is a need to ensure that service users and their carers are supported for this to happen. Clinical staff in the directorate work closely with carers, paid carers and Hampshire County Council Adult Services as well as a range of voluntary organisations and try to ensure that individuals are signposted to all the care support that can be provided for them.

4.4 Concern for those who would need transport from rural areas

It is acknowledged that there will be an additional travelling burden for some patients and their carers and family members who will have to travel greater distances as a result of the proposed ward closures. Not all of these individuals have their own transport and would rely on public transport. The numbers of individuals who would be affected negatively by the changes is very small and the Directorate plans to work with members of Eastleigh Borough Council to develop a travel plan to support these individuals. It is acknowledged that a significant amount of care is provided to individuals within their own homes. An additional clinic has been set up at Blackfield Surgery in Eastleigh Southern Parishes where a consultant psychiatrist holds a monthly clinic. Outpatients clinics and memory clinics will continue to be held at the Tom Rudd Unit and Newtown House Eastleigh. There are plans to provide additional memory clinics in or in the vicinity of the Western Community Hospital.

4.5 Concern for carers

The Older Persons Mental Service Directorate values the role that carers and families perform in the care of patients; our staff will ensure that carer assessments continue to play an important role in ensuring that carers' needs are identified alongside those of the service user. As part of developing good practice the clinical teams within the service involve carers as part of care planning. There are carers' groups that are well established across the whole Directorate and in particular carers of people with memory problems have special groups that can be attended to meet their specific questions and needs, as part of 'Memory Matters' courses.

4.6 The need for public awareness and reducing stigma

It is acknowledged that there are significant number of individuals living in the community who have either memory problems of functional mental health problems who have not had a formal diagnosis. Public awareness has increased since the publication of the National Dementia Strategy and the Directorate has noticed an increase in referrals for memory assessments. Southern Health NHS Foundation Trust has a "Time To Change" campaign manager. The "Time To Change" is a national campaign which aims to reduce stigma around mental health.

4.7 Health use of the Moorgreen Hospital Site

Many individuals have been concerned about the removal of services from the Tom Rudd Unit site. A significant amount of money has been spent on upgrading the Tom Rudd Unit where the Community Mental Health Team for East Southampton is based and the Memory assessment clinic is also based there. There are no plans to move these services away from the Tom Rudd Unit site. Proposals are underway to reutilise some of the vacant ward space to develop an inpatient learning disabilities unit.

4.8 Development of a group to oversee changes

A time linked reference group will be established to incorporate key stakeholders to oversee changes.

Appendices

1. **Background information**
2. **Write ups from the four engagement events and activity record**
3. **The four tests**
4. **Presentation from public events**
5. **Timeline**
6. **Analysis of the feedback received from the Public Consultation In-Patient bench marking data**
7. **Inpatient benchmarking data**
8. **LINks Report**

A COPY OF APPENDICES 2 TO 8 ARE AVAILABLE IN THE MEMBER'S MEETING ROOMS.

Appendix 1

Planning Ahead, Working Together

Background Information

Contents

1. National Guidance – Evidence Base

1.1 The proposed changes to services reflect the key statements of the following documents:

1.1.1 Darzi – High Quality Care for All and NHS Constitution

- High quality care that is personal, effective and safe
- Focused to reflect the needs and preferences of patients, families and carers.

1.1.2 National Dementia Strategy

- Increased awareness
- Early diagnoses and intervention, high quality care and support.

1.1.3 Our Health, Our Care, Our Say

- Services based in community settings
- Links to primary care with pathways to specialist secondary care.
- Promoting early intervention and prevention

1.1.4 Everybody's Business

- Integrated mental health services to support both the patient and the carer

1.1.5 No Health without Mental Health

- Mental well being is as important as physical health
- Services accessible to all who use them
- Based on best available evidence
- Focused on recovery in the discussion with the service user
- National service framework for older people
- Non age discriminator
- Person centered

2 Local commissioning strategies

- Hampshire Joint Commissioning Strategy for Older People's Mental Health Services (2008)
- NHS Southampton City and Southampton City Council also produced a five-year Joint Dementia Vision (2009)

3 Benchmarking information

The Trust commissioned Consilium to undertake benchmarking information regarding bed usage within this organisation based upon the national picture. The report is shown at appendix 7 and this demonstrates that against both the national picture and best practice there are opportunities to close a significant number of inpatient beds

within the Older Persons Mental Health Directorate of Southern Health NHS Foundation Trust.

4 Ward Usage

Including Leave

	Q1	Q1	Q1	Q2	Q2	Q2	Q3	Q3	Q3	Q4	Q4	Q4
	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Linden	454	384	426	345	345	306	278	308	336	411	305	286
Willow	380	362	338	446	147	299	318	299	203	280	177	204

Excluding Leave

	Q1	Q1	Q1	Q2	Q2	Q2	Q3	Q3	Q3	Q4	Q4	Q4
	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Linden	339	265	319	309	314	277	264	273	298	375	266	227
Willow	320	300	274	332	146	277	311	300	203	278	169	203

5 Staff

Clinical staff

- Number of clinical staff affected 22.4 wte
- Number of vacant posts available for redeployment 14.87 wte
- Number of staff who have applied for MARS 3.66

Non clinical staff

- Number of non clinical staff affected 24.33 wte
- Number of vacant posts available for redeployment 19.7 wte
- Number of staff who have applied for MARS 2.82 wte

6 Engagement with target groups

Target Group	Engagement carried out
Service Users & Carers	22 November 2010, Eastpoint, 30 November 2010, Crossfield Hall Romsey
Staff	Strategy Workshop 21 July 2010 Regular staff meetings and updates Special Briefings 8 November 2010, 31 January 2011, 9 May 2011, 13 May 2011
General Public	Public Consultation Events 13 May, 17 May, 18 May, 23 May and 26 May 2011
PCT Commissioners	Regular update Meetings and Engagement planning.
Local Authorities	Regular update Meetings
Other Stakeholders	Dementia master class 22 March 2011

Voluntary Organisations	Eastleigh & Southern Parishes Older Peoples Forum 18 January 2011, 1 February 2011, Eastleigh Borough Council 20 January 2011, 10 February 2011, 2 March 2011, 7 June 2011 Test Valley Borough Council 8 February 2011
Governors Groups	23 March 2011

(Please refer to appendix 2 for a full list of engagement activity)

7. Key impact events

Details	Comments
Change in Accessibility/Service Delivery	Beds will always be available for those who need them
Impact on the Wider Community	No risk. If a person is unwell and assessed as requiring inpatient care a bed will be available
Financial and other Factors	Some impact experienced by carers/relatives as a result of potential increase in travel

Appendices 2 to 8 are available as hard copies in the members meeting room.

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Analysis of the feedback received from the Public Consultation on Older Peoples Mental Health Services covering Southampton and South West Hampshire

1. Introduction

1.1 This report analyses the feedback received as a result of the public consultation on the proposed closures of Linden Ward, a 17 bedded Functional ward (for people with severe depression, psychosis, schizophrenia or bi-polar disorder) and Willow Ward, an 18 bedded Organic ward (for people with a dementia) both based in the Tom Rudd Unit on the Moorgreen Hospital site, West End, Southampton.

1.2 The purpose of this report is to collate the various formats of feedback received, analyse this feedback and summarise key themes.

2. Background

2.1 Following a period of extensive engagement which included conversations with Hampshire Health Overview and Scrutiny Committee, Southampton Health Overview and Scrutiny Panel (formerly Scrutiny B panel), written and verbal briefings to GPs, Local councillors, Local Authorities, LINks (Local Involvement Networks) and Voluntary Organisations, together with service users, carers and our staff, the public consultation ran for six weeks from 9 May 2011 until 17 June 2011.

2.2 As a direct result of feedback received during engagement which made it clear people wished for events to be held within the areas most likely to be affected, five public events were held as follows:

- Friday, 13 May 12.30pm – 2.30pm West End Parish Hall, West End
- Tuesday, 17 May 12.30pm – 2.30pm Crossfield Hall, Romsey
- Wednesday, 18 May 5.30pm – 7.30pm Central Hall, Southampton
- Monday, 23 May 5.30pm – 7.30pm St Andrew's Centre, Dibden Purlieu
- Thursday, 26 May 5.30pm – 7.30pm Hamble Village Hall, Hamble-le-Rice

2.3 The consultation was also publicised via local media e.g. Daily Echo, GPs, local councillors, local authorities, the Trust website, to all local NHS organisations, MPs, circulation of email and flyers to voluntary and third sector organisations, Local Involvement Networks (LINks) etc.

2.4 Attendance (excluding Trust employees) at each public event was:

- West End 21
- Romsey 5
- Southampton 6
- Dibden Purlieu 3
- Hamble-le-Rice 9 Total: 44

2.5 Responders to the consultation had a variety of formats in which to provide feedback. These were:

- During Q&A sessions at the public events
- During a bespoke Q&A session with the Eastleigh and Southern Parishes Older People's Forum, West End
- During a bespoke Q&A session at the Tom Rudd Unit for Eastleigh Borough Council (EBC) members
- Completion of the feedback form at a consultation event
- Completion of a downloaded feedback form via the Trust website
- Writing to the Engagement Office using the freepost address
- By e-mail to the Engagement Office e-mail address
- By telephoning the Engagement Office

3. Analysis of feedback

3.1 Feedback was received as follows:

- Seven Q&A session write ups
- Seven feedback forms
- Four replies via e-mails and letter

3.2 The formal public consultation was preceded by a significant amount of engagement work which had sought views on the provision of services for older people with a mental health diagnosis. Feedback received from this engagement work was included within the consultation document and had shaped the proposals that were put forward.

Q&A sessions

3.3 The summary of the Q&A sessions and five detailed write ups are contained in the attached Appendices (1 – 10).

3.3.1 The above mentioned write ups have been summarised and categorised within the summary document, reflecting feedback which was received from carers, service users, general public and organisational representation e.g RCN, EBC, Solent Mind, Carers Together.

3.3.2 Carers expressed:

- Early diagnosis was key
- A need for improved follow up
- A need for improved support
- The need for the service to find uncomplicated ways of engaging with other professional and voluntary sector agencies
- A need for more 'joined up' thinking to include social services

3.3.3 Service Users expressed:

- A need for early diagnosis
- Better information and sign-posting to other forms of support
- GPs need to be more person centered and use sign-posting to other forms of support
- A need for regular follow up
- Staff need to listen more and explain more
- A need for information to be shared with them and relevant others
- A wish to be more involved with discussion around their options

3.3.4 General Members of the Public expressed:

- Concern for those living alone
- GPs need to learn to be less afraid of people with mental health problems and like them more
- GPs need to ask more questions re lifestyle and wellbeing as well as questions about physical health
- A need to increase involvement of services users in their options
- A need for early diagnosis and increased follow up
- A need for people to remain independent for as long as possible with support to family and friends to achieve that
- GPs to support carers groups in the community
- Nurses to recognise mental health problems sooner
- A need for increased awareness in the community of what support can be offered

3.3.5 Organisational representatives (e.g. Third sector, voluntary sector) expressed:

- Administration needs improving (if more care in the community is to be successful)
- People need to know the ways they can express concerns when anxieties arise
- Concern for those who would need transport from rural areas
- A need to share information between professionals
- How will the changes be monitored and evaluated
- Concern for staff if redundancy is likely
- Concern at the potential loss of experience and expertise
- Was there an intention to increase staff working in the community
- What additional training for staff will there be
- Will psychiatric liaison in Acute hospitals increase

Feedback

3.4 Four questions were included within the feedback forms. The summary from returned feedback forms is outlined in Appendix 9:

Pam Sorensen – Head of Consumer Experience and Engagement
Amanda Horsman – Director of Operations (Older Peoples Mental Health)

June 2011

Appendix 6.1

Analysis of the feedback received from the Public Consultation on older peoples mental health services within Southampton and South Hampshire

Summary and Analysis from Q&A sessions (5 Public Consultation Events, 1 Eastleigh & Southern Parishes Older Peoples Forum, 1 EBC meeting)

Questions posed to presenters	Initial Trust response at Public Event
Public Events	
- Could we have further clarification of the use of the Tom Rudd Unit?	- There are currently two in-patient wards, a base for the multi-disciplinary community mental health team, an out-patient facility which holds various different clinics, the base for the Memory Services and the Research Centre. The proposal is to close the two in-patient wards and use the Western Community Hospital as an alternative.
- What is the current use of Western Community Hospital?	- Western Community Hospital currently has Adult Services with 'older people'/ Physical health beds e.g. Stroke . OPMH has three wards there with a high majority of these beds are not used. Our proposal is to bring the in-patient service together so that they are used most efficiently.
- Who employs the staff that work at the Western Community Hospital?	- Our staff are employed to work at the Western Community Hospital.
- Could we have more clarification of the commitment to provide travel?	- It has not yet been confirmed and ideas are welcome. We organised a similar service in Andover when services changed there. We are open to solutions and have got a commitment to our patients to make it easier for them. We have opened discussion with Eastleigh Borough Council and wish to work with them in an effort to minimise cost and inconvenience.
- How much of the savings from closing the wards will actually be re-invested?	- Our service has a requirement to make 20% savings similar to all government departments. Our main focus is on efficiency and quality and with this in mind we need to develop priorities. Some of the money has already been spent by introducing new services. I can confirm a lot will go to towards reaching our target savings.
- How does Early Diagnosis fit in the financial situation?	- Early diagnosis has been recognised in the Dementia Strategy and it is recognised it is not being diagnosed early enough. Inevitably this could have an impact on the drug budget, with expensive drugs being prescribed earlier, but it has to be understood that it is not all about medicating patients. There are other therapies, help and support.
- When will we see results?	- To develop an ideal gold standard service is beyond reality. Unfortunately, prioritisation is required. We use the information gained through engagement to see where to focus our energy. We are trying to get the best value for money out of limited resources.
- Home treatment is good but will the support be there for those that need it?	- All of our services are free. We need to be aware that we cannot change the government demands and savings.

- How do we know that the community services provided will meet the needs required?	- Currently evaluation of the Andover Redesign of Services shows a good response e.g the number of emergency admissions from nursing homes is practically zero following the introduction of dedicated liaison from the team.
- The argument is well made, however, where does the money come from? And will the money saved follow patients into the community?	- An important challenge is how the Trust and its partners steer their way through these difficult financial times - there is no easy solution. Concern about the future of our growing aged population has driven the Trust to think hard about what resources are available and how they can be used efficiently. One of the ways is the use of early diagnosis to keep people as well as possible for as long as possible and to stop people losing their independence and being admitted to hospital.
- If someone gets referred to Linden ward because they are ill, in 3 to 4 weeks they will be back in the community. Where will they go if the ward is closed?	- Although the two wards at the Tom Rudd Unit will close, if someone needs to go into hospital they will go to the Western Community Hospital which has three specialist mental health wards and is situated on the west side of the city.
- Will there still be sufficient bed capacity?	- Anybody who needed an acute psychiatric admission would get one. The Trust knows that it has ample capacity.
- What publicity was there for these meetings?	- A large mail out was undertaken and five public events arranged. It was specifically focussed on this area. Flyers inviting people to these events were sent to all main stakeholders, local councillors and local voluntary organisations. Information was also in the local press.
- Is the name change to help 'pull the wool' over the public's eyes?	- No. It is important to focus on what was trying to be achieved. The services offered to service users by Southern Health FT have come on leaps and bounds but there is still more that the Trust wants to do. It is important not to be distracted by the name change.
- Are Community Health Teams going to be divided up?	- It is not the intention that the CMHT for OPMH will merge with physical health teams – they are both specialist services responding to different needs.
- Which southern parishes had been engaged with?	- Meetings have taken place with Eastleigh Borough Council, at which there was representation from southern parishes.
- Are there good links with the councils? Are you knitted together well enough?	- NHS Southampton City has given £3.2 million to the local authority for the provision of re-ablement services. Some of that money would be to support people to have 6 weeks of free care to support them at home for older people with dementia and mental health problems. It was agreed that working together is very important. One of the things Southern Health is doing is looking at the services they have been providing for a long time and checking if they are really getting value from them.
Eastleigh & Southern Parishes Older Peoples Forum	
- Can we have a chart that shows where the different NHS organisations sit because it is confusing for older people?	- It was agreed an organisational structure chart for the NHS would be sent to the Forum but it was highlighted this was subject to change following the recent 'White paper' proposals.
- Transport is an issue. How will you support those who need to travel to The Western?	- Transport was a concern being raised during engagement and consultation. Early discussion has taken place with Eastleigh Borough Council with a view to working with their transport services and supporting some funding. There is a real commitment to supporting those for who travel would cause difficulty.

- How will you work with services provided by the councils? - How will people on their own access the Memory Matters service? - By closing the wards aren't you forcing people into having to pay for Care Homes?	- It was agreed that in the difficult financial climate we are all facing it was even more important that we worked more collaboratively with colleagues, not just in councils but with third sector and voluntary organisations. There are already good examples of this in the Trust and there is a commitment to build on that. - It is recognised that we need to look more closely at how people access different NHS services and work more closely with GP and other primary care colleagues so that potential problems can be highlighted sooner. This was especially important for people who lived alone. - The wards at the TRU are intended for those who need assessment and are not intended as long stay wards. Closing the wards will not mean that we are forcing people into care homes which they may need to pay for. In addition, we are confident that for those who need admission for assessment, there are enough beds at The Western or at Melbury Lodge.
Eastleigh Borough Council (EBC)	
- Do the wards at TRU meet the single sex accommodation criteria? **-** Is there enough capacity at the Western? **-** Do Southern Health provide respite care and could they from this site? **-** Travel for carers is important. Will you provide it? **-** Are you underestimating requirements in relation to increased longevity? - If dementia is diagnosed earlier, won't that increase demand on beds? - How will you manage the relationship with HCC and adult social care when they are facing cuts and how much has been built into the planning if social services raise the threshold for access to support? - Will any staff be made redundant? - Will you ensure there is feedback post consultation?	- Yes but the facilities are not as good as those at the Western where there are single rooms. - Yes. We are confident there is enough capacity at the Western and at Melbury Lodge. - Southern Health does not provide respite care. Across Hampshire we have a small number of service users who have been in our beds for a long time and a decision was taken not to relocate them but staying in hospital is not ideal for service users. - We recognise from the feedback we have already received that transport will be an issue for some people who may have to travel further should relatives need admission. We are working with EBC to see how we can work with them to support those who may need transport. We are committed to this. - No. Whilst we know people are living longer we also know there is more we can do to prevent people having to be admitted. Increased services in the community, closer working with primary care colleagues and access to services such as memory matters will mean fewer admissions. - No. Increased early diagnosis will allow people to access services that will prevent deterioration. We will provide Memory Clinics in more locations and increase awareness of other services such as iTalk (talking therapies) which will help people at an early stage. - We recognise the difficult financial climate we are all working in and that it is even more important that we work more collaboratively with colleagues, including third sector and voluntary organisations. There are already good examples of this in the Trust and there is a commitment to build on that. - We hope that no clinical staff will be made redundant. Some people are taking the opportunity to move on but we feel there are enough jobs for those who want them. We have held posts open in other units for this purpose. - Yes. We will produce a report that will be available on our website and would be pleased to send copies to those whose details we have been given.

Appendix 6.2

Public Consultation Event 13 May 2011 12.30 pm – 2.30pm
West End Parish Hall, West End

Questions and Answers

Could we have further clarification of the use of the Tom Rudd Unit?

There are currently two in-patient wards, a base for the multi-disciplinary community mental health team, an out-patient facility which holds various different clinics, the base for the Memory Services and the Research Centre. The proposal is to close the two in-patient wards and use the Western Community Hospital as an alternative.

Our aim is to provide the best care for the people who need it, looking at the best practice for the needs of the population in that area. The current need for beds in that area is lower than the number we are providing. The reduction in the need has been as a result of developing high quality services in the community.

What is the current use of Western Community Hospital?

Western Community Hospital currently has Adult Services with 'older people'/ Physical health beds e.g. Stroke. OPMH has three wards, again a high majority of these beds are not used. Our proposal is to bring the in-patient service together so that they are used most efficiently.

Who employs the staff that work at the Western Community Hospital?

Our staff are employed to work at the Western Community Hospital.

I would like to highlight my concern that the contact with families maybe difficult due to travelling further

This has been recognised and a piece of work has been completed around mileage. It has shown that for some people it will be better and for some people it will be worse. Discussion will be held with local travel companies to see if we can organise a suitable arrangement. However we have started to provide services in the community e.g. local GP surgeries to meet needs closer to home.

Could we have more clarification of the commitment to provide travel

It has not yet been confirmed and ideas are welcome. We organised a similar service in Andover when services changed there. We are open to solutions and have got a commitment to our patients to make it easier for them.

It is very easy to be blasé. Admire the promotion of independency and helping people live in their own homes.

Respite provisions and day care centres, reduction in these adds more pressure on the carers.

Respite has been an ongoing problem. We are working with our partners to provide efficient respite care. However we do need to recognise that in the current climate this is almost impossible, what we would expect is that once savings have been made and services have been developed, we will then be able to focus more energy on these.

Carer support is vital to the recovery of a patient

There are accessible services which do work with both Carers and patients. There is an obvious need and we plan to have further discussions with Adult Services provided by Local Authorities.

How much of the savings from closing the wards will actually be re-invested?

Our service has a requirement to make 20% savings which is similar across all government departments. Our main focus is on efficiency and quality and with this in mind we need to develop priorities. Our total beds as a service are 232, every week it is shown that between 60-80 beds are empty which is a lot of wastage for the service.

It has to be understood that some of the money has already been spent by introducing new services. I can confirm a lot will go to towards reaching our target savings.

The number of empty beds has been the result of introducing other services and additional developments in community. Most of the savings have been from closure of wards across the NHS.

It has to be said that also we have been able to grow in numbers in terms of our medical staff. We will be appointing a New Consultant of Psychiatry which will impact on the services we are able to provide and response times.

How does Early Diagnosis fit in the financial situation

Early diagnosis has been recognised in the Dementia Strategy and is a challenge nationally. Dementia is not being diagnosed early enough. Inevitably this could have an impact on the drug budget, with expensive drugs being prescribed earlier, but it has to be understood that it is not all about medicating patients. There are other therapies, help and support. It is hoped that if we start treatment earlier the impact of the illness at the later stages will not be as severe.

We are aiming to do more partnership working with GP's to pick this up.

It has been highlighted that there are training issues at Southampton General Hospital in terms of 'general' staff recognising mental health problems. This issue has been ongoing for some years now.

We as an organisation fully agree and understand. We have implemented a liaison service, however the service can only see patients who have been referred to them.

Together with the commissioners we are in the process of putting together a training package for 'general' staff at Southampton General Hospital

When will we see results

We are waiting for confirmation and commitment of figures from our commissioners.

To develop an ideal gold standard service is beyond reality. Unfortunately, prioritisation is required. We use the information gained through engagement to see where to focus our energy. We are trying to get the best value for money out of limited resources.

I would like to note that there are things you can't buy.

We are pleased to hear Learning Disability may be using the site instead.

Home treatment is good but will the support be there for those that need it. I have experienced that there is only support if you pay for it privately.

All of our services are free. We need to be aware that we cannot change the government demands and savings.

Concerns about ill people being treated at home and not going to Hospital. Care at home does provide some uncertainties

If we go ahead with our proposals there will be enough beds to meet the needs of the population. No one who is assessed as requiring a period in hospital will be left at home.

Dr McCormack gave an example of a patient where hospital didn't seem appropriate even though the patient was very ill. The benefit of treating the patient at home gave them choice and some independence to do things that they enjoy doing in the comfort of their own home. However the negative is that the patients' carer is managing them 24/7. Hospital care would have been more beneficial for the carer, but not necessarily the patient.
The need for a balance between best of care with what we have was reiterated.

How do we know that the community services provided will meet the needs required?

Currently evaluation of the Andover Redesign of Services shows a good response e.g the number of emergency admissions from nursing homes is practically zero following the introduction of dedicated liaison from the team.

Andover MIND working in partnership is a positive partnership

We have a good wealth of evidence that this will work

The NHS has grown into a service that has moved from telling people what they need, to trying to work with and listen to people about what they want, however we are constantly striving to improve.

Need to think about and address the impact on carers. Carers are the experts.

Completely agree

Memory matters and memory clinics are very good. Services in the community, which services will these be?

Currently working with Adult Services to develop further partnership working with the carer assessments making them accessible across both services.

We are trying to develop interaction that can be recorded with both patients and carers.

Develop an effective comments and feedback method from patients and carers.

Hoping to develop carer involvement in care planning.

Hoping to have a better support system for carers so that they don't find out about support available to them by accident. There is a review of information (leaflets) taking place to ensure they are easy to read and straight forward.

Dementia advisor post was appointed in the Andover Redesign, hoping to develop a similar post throughout the other services.

I would like to confirm that adult services are happy to work in partnership with us but they are also in the same position as us in terms of having to make savings.

We are considering the 'single access point' between Adult Services and OPMH

There has been a project in Hampshire established for co-working and integration across services, which is proving to be positive.

Concerns are with Care Agency staff and their drug administration skills

Again this would be dealt with through our joint working with adult services.

A few years ago an Alzheimer's Survey was carried out amongst GPs. It showed that 30% of GPs didn't know how to refer a patient with dementia.

This is a strong issue and we are looking at educating GP workers (nurses, GPs, etc) to improve early diagnosis.

Appendix 6.3

Public Consultation Event 17 May 12.30pm – 2.30 pm
Crossfield Hall, Romsey

Questions and Answers

Which southern parishes had been engaged with?
Meetings have taken place with Eastleigh Borough Council, at which there was representation from southern parishes.

Is it the whole of the Tom Rudd unit that is being closed?
It is proposed that the two inpatient wards based at the Tom Rudd unit are closed and transferred to the Western Hospital in Southampton.

What will these two wards be used for?
The Learning Disabilities directorate are exploring the opportunity of using the wards as a unit for people with Learning Disabilities.

Tom Rudd is a stand alone unit with two inpatient wards, it also is the base of the memory clinic, memory research centre and community mental health teams. All these services will remain at Tom Rudd.

Concern was expressed about the rest of the Moorgreen Hospital site and that most people would expect to have health services provided from this site.

Dr McCormack informed that the main Moorgreen Hospital was not fit for purpose as an inpatient facility.

It would be better for outpatient services to be provided locally at Moorgreen, at present patients have to travel great distances to get outpatient treatment such as physiotherapy.

It was agreed that having treatment locally was always the best option, however due to financial constraints it was not always possible for this to be provided.

Admitting a patient with dementia to hospital can result in the deterioration of their condition and they can lose their skills to live independently very quickly. It is therefore always better, as far as possible, to keep people out of hospital in an environment they know well.

From the public's point of view do they think we are going to consultation and has the decision already been made?

Amanda Horsman stressed that the closure of the two wards at the Tom Rudd unit is a proposal within the consultation and a decision has not been made.

Diane Wilson from NHS Hampshire informed that there are very clear national drivers that bed based services do not improve long term health prospects for the vast majority of people.

What are the public going to get when the wards are closed? Will these sites eventually be used for housing etc and not for health services?

There is a proposal that the wards will be used for the assessment and treatment of people with learning disabilities who are currently receiving treatment out of area but are Hampshire residents.

Amanda Horsman agreed that these are really difficult times financially, not only for the NHS but also for its partner agencies. The expectation is to provide good quality services for less money.

There is talk about trying to get elected council members on to the various partner agency groups, which would be a good thing.

Dr McCormack informed the group that recently the Audit Commission looked at Older People's Mental Health (OPMH) services in Hampshire and Southern Health has more beds per population than most other OPMH services around the country. In comparison, Southern Health is also fortunate that it has well resourced community mental health teams. The Trust needs to see how it can best use the money it receives and there is a view that some could be taken out of underutilised inpatient beds.

From the clinicians point of view it is better if people live at home and it is better for people to stay in their own homes, but often the carers are elderly themselves and in reality social services are also being cut and will not be able to support the carers adequately.

Dr McCormack admitted that this is a dilemma. The population is living longer and that the likely number of people with dementia will grow significantly. As a community we need to work out how people can live their lives well with dementia. There is no way, neither is there a need, that beds can be provided for all dementia sufferers.

What happens if the carers become ill?

We recognise the essential role that carers make to the ongoing support of their relative. That is why, within the proposals we are enhancing support for carers and working with our partner agencies to provide as comprehensive support as possible for carers.

How early can you detect Alzheimer's?

Dr McCormack informed that at present in the population there are a group of people who have memory problems who health providers do not know about and this has been called the 'diagnosis gap'. Southern Health is working with the PCT's to look at how GPs and community nurses can be trained to pick up on people who have a memory problem so they can be further assessed and treated appropriately.

Is there anything significant we can do about it?

There are treatments available that will help to prevent/delay more serious symptoms. There is also significant risk of other mental health problems such as depression or anxiety and these also need to be treated. Looking after your heart and circulation may contribute as you thrive better if you look after your physical health.

Southampton is running a group for people with mild cognitive impairment, who do not have established dementia, to help them understand why their brain changes. This is one of a number of services that Southern Health provides.

Providing all these services at home is a good thing, but would it be possible to reduce the number of different people who provide these services as this can be distressing and confusing for the patient?

Dr McCormack accepted that it was better for the patient to build up a relationship with their support workers and that they can become distressed when support workers are ill or on holiday. Working more closely with partner agencies is one of the priorities of the development of community services.

Appendix 6.4

Public Consultation Event 18 May 5.30pm – 7.30pm
Central Hall, Southampton

Questions and Answers

Are there good links with the councils? Are you knitted together well enough?

Adrian Littlemore (NHS Southampton City) responded that their trust has given £3.2 million to the local authority for the provision of re-ablement services. Some of that money would be to support people to have 6 weeks of free care to support them at home for older people with dementia and mental health problems. They are working with Jane Brentor who is the services manager for Southampton City Council.

It was agreed that working together is very important when times are hard. One of the things Southern Health is doing is looking at the services they have been providing for a long time and checking if they are really getting value from them.

Dr McCormack said at the moment the trust is financing hospitals beds that are not being used and that it was the intention to offer a better level of community service and not waste more money.

How much of the resources are you going to put into preventative work around education and helping diagnose people and providing help with understanding the implications of dementia and mental health problems?

Amanda Horsman informed that one of the areas that Southern Health is particularly interested in are liaison services in acute hospitals. There are a number of people in acute hospitals whose mental health needs are not being diagnosed.
Southern Health has link workers in place who are able to pick up on the mental health problems of patients in acute hospitals.

Paul Hopper, consultant psychiatrist, said that one of the things we are guilty of is assuming people understand what older people's mental health services do and wait for people to contact us. Part of our role is going to be liaising with GPs and people in primary care generally to provide information and guidance.

A representative from Southampton Voluntary Services said that certain communities with mental health problems and dementia are 20 years behind counterpart communities and a lot of work needs to be done to help these communities to come to terms with all of the symptoms of the patient. She explained her own personal situation with her father who has Alzheimer's and that being part of a minority ethnic group some of the diagnostic tests used were not appropriate.

Dr McCormack responded with information regarding a national campaign called Time to Change, run by Rethink, which aimed to raise awareness of mental health problems. Southern Health is hoping to do a variation on the Rethink campaign to raise understanding and awareness of memory problems and mental health problems in older people, and break down some of the suspicion that surrounds it. Southern Health is hoping to begin this work in the coming months.

A representative of Age Concern informed the group they are planning to have a conference on dementia in September. In addition to that Age Concern are thinking about how they might get all the organisations together to understand what they all do and play to peoples' strengths so services are not duplicated. He said that there is a lot of benefit gained from people working together.

He said that Age Concern Southampton was not part of Age UK but was a separate smaller charity.

He explained that Age Concern has groups of volunteers that visit people in their own homes but sometimes they feel a little bit out of their depth and wanted to think about how these volunteers can work with the professionals. Volunteers need appropriate training in order to be able to signpost people to the right services. He informed that Age Concern were not equipped to provide proper support services for people with dementia or mental health problems and would like advice on training volunteers.

Amanda Horsman said that Southern Health provide the clinical part of the care but that this is only a small part of the support required for patients to lead every day lives in their own homes. There are resource implications in terms of what the voluntary sector can do especially with the changes in contracting and procurements and GP commissioning. It is just as important to keep these low level types of care resourced.

A meeting with Southern Health and representatives from Age Concern Southampton to discuss joined up working is being organised.

Dr McCormack gave an example of joined up working which is taking place in Andover, where they have in place a dementia advisor who is funded by Andover MIND.

The representative from Age Concern said that early diagnosis is very important and listening to what the person with dementia wants. He said that he had learned that people with dementia sometimes live in a different time zone and that you need a fundamental understanding of what it is like in order to help sufferers appropriately.

The representative from Southampton LINK said that GP's do have access to alternative tests that are appropriate for ethnic minorities.

The representative from Southampton Voluntary Services asked about the role of the GP in making people aware that there are certain conditions that can lead to the onset of dementia or Alzheimer's disease and being able to predict whether someone will get dementia. Is there anything that can be done with the data that has been collected?

Dr McCormack said that it would be great if we could get everyone to believe the messages given out about healthy living and the serious conditions that could be prevented by living a more healthy life. There are certain conditions that make people at a greater risk of developing dementia and looking after our hearts and circulation is one of the things you can do. Also raising awareness and engaging with people if they are concerned about themselves but not frightening people.

A member of the public asked if it would it be a good idea to call people in to have regular memory tests/check ups every year?

Dr McCormack said that GPs are referring more people and there will be a greater number of people with mental health needs in the future. It would not be practicable to see all people presenting with memory problems and it can be initially difficult to diagnose whether it was part of normal ageing process or something more serious. The process at the moment is that the GP will refer a patient that they are concerned about and if the assessment shows this is not a serious condition the patient would be referred back to the GP. If anyone is worried about memory or mental health problems they should go to their GP.

Dr McCormack said that a group for people with minimal cognitive impairment had been running locally to help them understand how you can live well with memory problems.

Dr Paul Hopper said for people with smaller areas of memory difficulty there are exercises to help improve function and there are other treatments that Southern Health provides.

The representative from Southampton Voluntary Services said that education is very important and raising awareness of prevention and managing the early stages of dementia.

Dr McCormack said that Southampton was fortunate that it had a memory research centre, part of which is a national research programme for brain tests. The research centre at Southampton is very active in looking at dementia and trying to understand what causes it and what is making it worse.

The representative from Southampton Voluntary Services expressed her concern about staff in acute hospitals being trained in being able to recognise whether a patient has dementia.

Sandra Craddock, Modern Matron from Southern Health, responded that Southern Health is looking into how colleagues in acute hospitals can be trained to recognise the signs and symptoms of dementia and provide basic care for patients. Dr McCormack said that very often symptoms are not recognised until a longer conversation is had with the patient so it can be difficult to tell whether someone has dementia at first. The provision of some training for staff in acute hospitals is one of the things being worked on in conjunction with Southern Health's commissioners.

The representative from Southampton LiNks asked about treating people in the community and the use of the Mental Health Act Community Treatment Order and Guardianship.

Dr McCormack responded that the use of community treatment orders, where patients are treated in the community under stringent conditions, and guardianship is very limited. Managing the risk for people with dementia is something discussed with the family and patient in order to decide whether the risk to that person outweighs the benefits of staying at home. When the risk outweighs the benefits then 24hour supported living could be an option.

Appendix 6.5

Public Consultation Event 23 May 5.30pm – 7.30 pm
St Andrews Centre, Dibden Purlieu

Questions and Answers

A representative from Your Voice Advocacy said that whilst she was on board with the principle of what Southern Health was trying to achieve, by providing more community services, there were some issues that she would like to pick up.

Feedback she had received back from people who have stayed at the Western Hospital is that it is very noisy and echoed when people moved about etc. This can be very disturbing.

Michelle Edwards thanked her for that information and said that a solution to reduce the amount of noise would be looked into.

The representative from Your Voice Advocacy highlighted the difficulty in obtaining Continuing Health Care (CHC) funding. She said that the checklist is mostly around physical assessment and there is not much included about the difficulties of dementia. She asked if this could be made easier.

Adrian Littlemore, commissioner for OPMH services for NHS Southampton City informed that CHC guidance is national guidance and has national formats that NHS Southampton City cannot vary. Mental health problems are taken into account but physical health assessment is more significant.

The representative from Your Voice Advocacy asked if there were enough quality nursing homes available in Southampton.

Adrian Littlemore responded that as a city Southampton has contracted with BUPA to set up a nursing home, and as it is new there have been some 'teething' problems. He said that he believed that working in partnership with BUPA the quality of care could be improved. There is also money being invested in re-ablement funding. This works through social care services after hospital admission. There will be rehabilitation staff to assess the right kind of package of care for people and handover to long term care.

Dr McCormack said that she agreed that Continuing Healthcare was a bit of a minefield. She said that Southern Health would continue to work together as professionals within the set of rules to ensure that decisions are made in a timely manner.

Diane Wilson agreed that it was a very bureaucratic process and the test is a primary need for health care but there is no guidance about what that is. NHS Hampshire no longer make decisions about the long term care of patients while they were still in hospital but have re-ablement beds where they can be assessed more effectively.

A member of the public said that, whilst he had a lot of respect for the degree of professionalism in mental health services he felt that there was a level below that. He gave an example of an elderly lady who could not make her GP understand the problems she was having. He felt that this problem needed to be solved more effectively and that GP's do admit that they are not as well informed as they could be on mental health matters. He also expressed concern about the introduction of PBC's if GP's were not better informed about the mental health system.

The same member of the public went on to say that he had experience of somebody with hearing problems who received different types of hearing aids from different hospital authorities, one was not appropriate but the other one was just what was needed. He expressed concern that different levels of care would be received from different hospital authorities.

Dr McCormack said that these were important points. She explained that if you look across the country there is a difference between the number of people that are known to have dementia and the estimated number of people who have dementia. This continues to be a problem and is called the 'diagnosis gap'. The average GP sees a very small number of people who have dementia and mental health problems in older people may not be uppermost in their minds. The difficulty is that sometimes there are other illnesses such as depression and anxiety that may not present themselves in the same way in an older person as it does in a young adult. Alerting staff in primary care to the possibility of mental health problems in older people is something Southern Health are trying to work towards.

Dr McCormack gave an example of how it may be possible to help recognise mental health difficulties in older adults by explaining a scheme that has been introduced in Oxford which was trying to identify alcohol problems in older adults. This is done by asking questions when people come in for their flu jab and this can help pick up problems.

The member of the public said that talking about mental health problems can help to reduce stigma and increase understanding.

Dr McCormack told the audience about the government's Time to Change (TTC) campaign which aims to reduce stigma around mental health and said that Southern Health have a TTC campaign manager. This campaign, however, does tend to focus on working age adults and she said that Southern Health were looking at undertaking a similar campaign highlighting mental health problems in older adults.

The Southern Health governor said that people do not want to go to their GP and admit that they have a mental health problem.

Dr McCormack informed the group that a project has recently started in Southampton. A group has been set up in conjunction with commissioners, for people with minimal cognitive impairment. This is a professional term for people with minor memory problems and aims to help people understand what is causing their memory problems and what they can do to keep their minds active and keep themselves physically well.

The member of the public said that there may be more stigma about mental health problems for people from deprived backgrounds and therefore the mental health services are not as good.

Dr McCormack responded that there will be people who do not have contact with the health services because of their deprived situation and they tend to use health services less than people who are more articulate. These people are sometimes termed as 'hard to reach' and as a trust we need to help them feel that they can ask for help.

The representative from Your Voice Advocacy asked if the Community Health Teams were going to be divided up?

Dr Mc Cormack responded that Dr Paul Hopper, Clinical Director for Southampton OPMH, is looking at the way we organise services around Southampton because they are working to have one inpatient unit and manage the medical staff differently. The Trust will ensure that the community teams are working in conjunction with physical health teams.

Adrian Littlemore said that NHS Southampton have a virtual wards service which is a hospital like service based around GP practices.

Jane Elderfield said that it is not the intention that the CMHT for OPMH will merge with physical health teams – they are both specialist services responding to different needs.

The governor representative said that she was in agreement with the way forward that the Trust was taking and was pleased that progress towards the goal of better community services was being made. She went on to describe a situation that occurred last week at a group where she was giving a talk about Time to Change and the stigma that surrounds mental health problems. One lady told her how she had kept the fact that her husband had dementia hidden and how it would have helped to be able to talk about it.

The governor representative said she endorsed everything that had been said at the meeting.

The member of the public said that there had been a heated discussion at a PBC meeting about the adult commissioning and older peoples commissioning side of health care. He did not think that the care that younger people received should be different from the care that older people received but that older people had very different needs to those of the younger population.

Dr McCormack responded saying that this was a timely statement and that there has been quite a lot of information lately about services being ageless and that do not discriminate on age. There is a piece of work being done with colleagues in Adult Mental Health to look at what is a 'best fit'. For example, AMH colleagues have far more experience of conditions like schizophrenia, so should the patient come over to OPMH services just because they have reached their 65th birthday? Dr McCormack posed the question; what is the best way of providing really good health services that do not discriminate on the basis of age and use resources really efficiently?

Jane Elderfield said this project had not started yet and it was not straight forward. It will be looking at the care pathways.

Appendix 6.6

Public Consultation Event 26 May 5.30pm – 7.30 pm
Hamble Village Memorial Hall, Hamble-le-Rice

Questions and Answers

I understand that people are getting help in their own homes but the price is going up. A friend of mine who has someone come in twice a day has just received a letter informing her that the price will be going up.

Dr McCormack responded that all of the services provided by Southern Health FT are free and community staff do go into peoples' homes to provide treatment and support. For the provision of help with daily activities, such as washing, dressing etc, Adult Services have to work within a very constrained budget. There is general concern by everybody that people will have to pay more but it would be the same if that person went into nursing care.

Adrian Littlemore said that there is a national review of long term care and how it should be structured and what support should be provided by the State.

A representative from Eastleigh Southern Parishes Older People's Forum (ESPOPF) said that they had received a presentation and a workshop about this consultation. The argument is well made, however, where does the money come from? And will the money saved follow patients into the community? She made the following points:

1. **This is yet another new organisation**
2. **The effect of demography shows using services are a real issue**
3. **It is interesting that what Southern Health FT is proposing reflects a general trend in the whole of the NHS**
4. **Do we pay for community services?**
5. **Research has been done by ESPOPF called Pills and Perils which showed that people could not push the pills out of the packet - this needs to be seriously looked at.**
6. **Another research project was called 'In the Dark' which was research into how older people get information and how it is presented. This should not be by another leaflet.**
7. **Respite care - carers need respite care and need respite that is safe. What are the plans for respite care for people with learning disabilities and dementia?**

Dr McCormack responded that the National Health Service (NHS) has been providing respite care less and less over the last few years. Twenty years ago there were big hospital wards for respite, but what has been realised is that not all people who needed respite care actually needed hospital care. There has been a consistent move, in conjunction with Adult Services, towards providing respite care in nursing and residential homes. The concern now is - what care is available, and at what price? Dr McCormack agreed that it was very important that carers/patients who needed respite care were able to access it.

An important challenge in the next three to four years is how the Trust and its partners steer their way through these difficult financial times and there is no easy

solution. When the national dementia strategy was published the suggestion was that there would be money available for the implementation of this strategy. No one has given the NHS any extra money. Concern about the future of our growing aged population has driven the Trust to think hard about what resources are available and how they can be used efficiently. One of the ways is the use of early diagnosis to keep people as well as possible for as long as possible and to stop people losing their independence and being admitted to hospital.

Comment - the support available is like "pie in the sky" and it is just not available. What happens to people who cannot pay for the support? He quoted an example of carers who attend to a neighbour of his. They come four times a day for 10 mins each time and must spend a lot of time travelling around. He said he thought that the Trust was showing a rosy picture of things and that Southern Health FT should realise things will be a lot worse than suggested.

Dr McCormack said that the realisation is very hard for staff at Southern Health FT too. There are things that the Trust would want to do if it had the resources available. Dr McCormack described the work that had been taking place developing OPMH services in the Andover area. She explained about the role of the dementia advisor who is funded independently by Andover MIND. The advisor works with all the Trusts partners to help identify people in the community who are having memory problems. She is proactive in finding out what help is available and what benefits might be available for them.

Dr McCormack acknowledged that the Trust would not be able to do everything it wanted to in an ideal world; however she acknowledged that some things could be done better.

Comment - with the increasingly aged population the resources are not being up graded.

Dr McCormack responded that Southern Health FT is looking at the prediction of the demographic data of the population in Hampshire and trying to see what the Trust's services would look like. The New Forest has very little predicted growth in the population but in the north of Hampshire there is a high growth predicted. The Trust needs to build a service now that will provide what is needed in 5 to 10 years time.

A member of ESPOPF and the Alzheimers Society said that for people like her the future was a very frightening prospect with a difficult illness that is so progressive.

Dr McCormack agreed and said that not very long ago if people went to the doctor complaining about their memories it was a common response that loss of memory came with getting old. There is still quite a lot of fear and stigma around memory problems and this is why people do not come forward. There are positive things that people can do to combat symptoms of dementia and keeping a healthy heart and circulation is important. The Trust runs a group for people with minimal memory impairment where patients are encouraged to use the healthy part of their brain to get around the memory problems they have.

Amanda Horsman said that the outpatients and memory clinic areas of the Tom Rudd Unit have been refurbished and there is designated patient parking. It would be a nonsense to move these services away from this site. As well as seeing people on site Southern Health FT staff are working for a high proportion of their time with people in their own homes.

Comment - when land is sold off it is gone for good.

Dr McCormack confirmed that Southern Health FT will continue to run outpatient services from the base at the Tom Rudd Unit and it is just the two inpatient wards that the Trust is proposing to close. If the plans go ahead for use of the wards for assessment of people with Learning Disabilities there is even greater reassurance that the Trust will keep clinical services at the Moorgreen Hospital site, in addition to the OPMH services which will remain there.

Comment by representative of ESPOPF - the dementia advisor would be a preferred way of communicating information to older people. The 'In the Dark' research showed that the best way of getting information to older people was by face to face communication.

Gilda Newsham, Governor from Southern Health FT, said she had been working with the Alzheimer's Society for 13 years and that it has been a pleasure to work in liaison with the health services and other groups. The Alzheimer's Society she is associated with provides a befriending service which can help people suffering with dementia stay in their own homes. She added that because the volunteers are not part of Adult Services they are accepted more and are good listeners. The Alzheimer's Society runs courses for new volunteers on how to listen. She said that what people want is a responsive service. It is important to work in partnership with residential and nursing homes as respite can be found locally in one of these homes and is something for the future.

Amanda Horsman described the service in Andover which has a psychiatric nurse who provides advice and support in nursing homes. The excellent work this nurse does has resulted in a reduction in the number of people having crises and therefore patients not being admitted into hospital. She said that this role needs to be implemented in this area as well.

Question - Is it possible to improve the status of nursing and residential homes as the places that are available vary so much. There should be guidance and training for management and their responses should be audited. There should not be patients in homes that are not appropriate.

Dr McCormack informed the audience that the Trust is just starting a piece of work at Oaklands Nursing Home, which caters for the mental and physical health needs of patients. The work is about the use of medication and the impact it might have on the quality of life of individuals, this would include how medication is reviewed, what else goes on during the day and the type of training care staff have.

Question - is there any training for carers in homes? Are they qualified?

Diane Wilson responded that nursing homes are regulated by the Care Quality Commission. Hampshire County Council provide training right across nursing, residential and rest homes, but turnover of staff is quite high. There is a massive programme of work right going on across Hampshire.

A member of the audience said that an example of the nursing home is BUPA. It pays a lower rate than other nursing homes and then staff move on once they are trained.

Diane Wilson admitted that there is an issue about how they can keep trained staff.

Comment - these individuals are hard to find and the problem is growing. They asked if the carers that are employed had to do training/qualifications.

Dr McCormack responded that these staff are required to keep their registration up-to-date and would be trained in patient care.

Question - how much do carers in nursing/residential homes learn about mental health problems?

Dr McCormack acknowledged that there are concerns about how staff in acute hospitals recognise that patients have mental health problems and that mental health problems, in general, can remain hidden. When people are depressed they may not tell anyone and it is not necessarily obvious that they have a mental health problem. Care staff in residential homes and acute hospitals also face this challenge. Southern Health FT would like to increase the awareness of mental health need, including both memory problems but equally importantly, of anxiety and depression amongst staff working in acute hospitals which would improve the chances of knowing how to help that individual.

Gilda Newsham said that there is training available for staff at residential and nursing homes in the New Forest through the Alzheimer's Society. She agreed that there needs to be consistent training throughout the area. Although care provision has improved a lot in residential and nursing homes there is a long way to go and it needs to be more consistent. The challenges in Southampton are that there is a high concentration of nursing and residential homes and it would be a big task to make a major impact.

Comment - there are a lot of things available to go to through the Alzheimer's Society for people who live at home that are not available in a care home.

Gilda Newsham responded that there are things available in some care homes but she agreed that not all of them provide the services they could.

Question - Is there an increasing role for the private sector in terms of providing services?

Diane Wilson responded that, whether it is a private health provider or the NHS the funding still comes from the same place. All commissioners are encouraged to look at a range of providers. NHS Southampton City and NHS Hampshire are choosing to purchase (commission) services from Southern Health FT.

Question - If someone gets referred to Linden ward because they are ill, in 3 to 4 weeks they will be back in the community. Where will they go if the ward is closed?

Dr McCormack said that although the two wards at the Moorgreen Hospital will close, if someone needs to go into hospital they will go to the Western Community Hospital

which has three specialist mental health wards and is situated on the west side of the city.

Question – Will there be still be sufficient bed capacity?

Dr McCormack responded that the Trust has looked really carefully at the proposals and anybody who needed an acute psychiatric admission would get one. The Trust knows that it has ample capacity.

Amanda Horsman said that Southern Health FT is talking with Eastleigh Borough Council about what to put in place regarding transport difficulties to the Western Community Hospital.

Dr McCormack said that the Trust had looked very carefully at the services it provides compared to other providers around the country. OPMH has a high number of inpatient beds and has more than most other providers, it therefore makes sense to take some of the finance out of these beds.

Comment - One of the audience said that when her sister was in hospital and was admitted to the wrong ward MENCAP intervened and helped find a more appropriate place for her to be this was an example of how important it was that the voluntary sector work with the NHS.

Question - what would you like us to write on the feedback forms?

Dr McCormack said it was important everyone writes down what they think. She added that professionals have to careful that they do not assume they know what patients/public want. What works depends on the area, and what works in one community may not necessarily be appropriate in another one.

Comment - A member of ESPOPF said she was encouraged by the hard work and the thinking that was going into the proposals and the fact that the Trust was listening.

Question - What publicity was there for these meetings?

A large mail out was undertaken and five public events arranged. It was specifically focussed on this area. Flyers inviting people to these events were sent to all main stakeholders, local councillors and local voluntary organisations.

Question - Is the name change to help 'pull the wool' over the public's eyes?

Dr McCormack said no it wasn't to try and confuse people and that the NHS is constantly changing. She said it was important not to worry about the changes but focus on what was trying to be achieved. The services offered to service users by Southern Health FT have come on leaps and bounds but there is still more that the Trust wants to do. It is important not to be distracted by the name change.

Comment - Pam Sorensen came to do a workshop at the Eastleigh and Southern Parishes Older People's Forum and I asked for a structure chart showing the different parts of the NHS and where different trusts sit. It is important that we know who to contact if there is an issue to address.

Amanda Horsman said she would follow this up.

Appendix 6.7

Eastleigh Southern Parishes Older Peoples Forum
17 May 2011

Questions and Answers

- Can we have a chart that shows where the different NHS organisations sit because it is confusing for older people?	- It was agreed an organisational structure chart for the NHS would be sent to the Forum but it was highlighted this was subject to change following the recent 'White paper' proposals.
- Transport is an issue. How will you support those who need to travel to The Western?	- Transport was a concern being raised during engagement and consultation. Early discussion has taken place with Eastleigh Borough Council with a view to working with their transport services and supporting some funding. There is a real commitment to supporting those for who travel would cause difficulty.
- How will you work with services provided by the councils?	- It was agreed that in the difficult financial climate we are all facing it was even more important that we worked more collaboratively with colleagues, not just in councils but with third sector and voluntary organisations. There are already good examples of this in the Trust and there is a commitment to build on that.
- How will people on their own access the Memory Matters service?	- It is recognised that we need to look more closely at how people access different NHS services and work more closely with GP and other primary care colleagues so that potential problems can be highlighted sooner. This was especially important for people who lived alone.
- By closing the wards aren't you forcing people into having to pay for Care Homes?	- The wards at the TRU are intended for those who need assessment and are not intended as long stay wards. Closing the wards will not mean that we are forcing people into care homes which they may need to pay for. In addition, we are confident that for those who need admission for assessment, there are enough beds at The Western or at Melbury Lodge.

Appendix 6.8

Eastleigh Borough Council Members 7 June 2011 7.00pm – 9.00pm
Tom Rudd Educational Room, Tom Rudd Unit, Moorgreen

Questions and Answers

- Do the wards at TRU meet the single sex accommodation criteria?	- Yes but the facilities are not as good as those at the Western where there are single rooms.
- Is there enough capacity at the Western?	- Yes. We are confident there is enough capacity at the Western and at Melbury Lodge.
- Do Southern Health provide respite care and could they from this site?	- Southern Health does not provide respite care. Across Hampshire we have a small number of service users who have been in our beds for a long time and a decision was taken not to relocate them but staying in hospital is not ideal for service users.
- Travel for carers is important. Will you provide it?	- We recognise from the feedback we have already received that transport will be an issue for some people who may have to travel further should relatives need admission. We are working with EBC to see how we can work with them to support those who may need transport. We are committed to this.
- Are you underestimating requirements in relation to increased longevity?	- No. Whilst we know people are living longer we also know there is more we can do to prevent people having to be admitted. Increased services in the community, closer working with primary care colleagues and access to services such as memory matters will mean fewer admissions.
- If dementia is diagnosed earlier, won't that increase demand on beds?	- No. Increased early diagnosis will allow people to access services that will prevent deterioration. We will provide Memory Clinics in more locations and increase awareness of other services such as iTalk (talking therapies) which will help people at an early stage.
- How will you manage the relationship with HCC and adult social care when they are facing cuts and how much has been built into the planning if social services raise the threshold for access to support?	- We recognise the difficult financial climate we are all working in and that it is even more important that we work more collaboratively with colleagues, including third sector and voluntary organisations. There are already good examples of this in the Trust and there is a commitment to build on that.
- Will any staff be made redundant?	- We hope that no clinical staff will be made redundant. Some people are taking the opportunity to move on but we feel there are enough jobs for those who want them. We have held posts open in other units for this purpose.
- Will you ensure there is feedback post consultation?	- Yes. We will produce a report that will be available on our website and would be pleased to send copies to those whose details we have been given.

Appendix 6.9

Response received to questions posed within the consultation document:

Do you agree that the services we provide in the future should deliver the following?

- Early diagnosis and improved follow up and support for people with dementia and other conditions including depression
- More support and care offered to older people with mental health needs and their carers at home which may be intensive at times
- Improved care in nursing and residential homes

Yes – Please give your reasons

- Earlier diagnosis allows the carer/family to come to a gradual acceptance of the condition and time to resource organisations that provide advice/support whilst dementia is at an early stage. Some people are adverse to providing care. In such circumstances other forms of care in the community need to be accessed. Adequate sign-posting, information and awareness of outside funding (PPF or direct payment) are vital if care is to remain in the community and residential care settings avoided.
- Early diagnosis and improved follow up
- To maintain independence for as long as possible and to be looked after by friends and family for as long as possible.
- Having a mother with dementia, I know that early diagnosis and treatment are crucial. Support and care in home is important but so is recognising when home is not the safest or best option. There is too much pressure on relatives to provide the support and care. Cost also a factor.
- These conditions are life changing. Whether critical long-term or progressive, the services suggested are essential. Care at home may need to be intensive but I fear for those living alone. Quality of administrators at the top needs improving, management standards agreed and enforced, staff training improved and outcomes audited. A report back facility for staff, patients and families when anxieties rise. More transparency is essential, not 'confidential' secrecy and 'hush up'.

No – Please give your reasons

Do you have any views on services we should develop in partnership with other agencies e.g. Adult Services, voluntary sector, GPs?

- In order to make Southern Health work as the needs of people increase and live longer, there is a need for GPs to become more 'person centred' in their dealings with older people and to sign post to the third and voluntary sector where appropriate. This is a time to utilize what we have, collaborate services and meet individual need.
- Keep all necessary groups informed of patient needs "share" information to get the best information for them.
- Carers groups set up in the community, supported by GP surgeries, social services. Improve training needs for GPs and practice nurses to recognise the mental health problems sooner and to know what support can be offered.
- More "joined up thinking". I am seeing the work load of the community psychiatric nurse at first hand. Before my mother's diagnosis, my father also had dementia and getting any help from social services (including emergency cover or respite) was difficult. Developing partnerships is fine. Action is what is needed.
- GPs need to learn to like people with mental health problems and be less afraid. Their introductory regime with all new patients should not only include testing and recording their physical stats, but friendly enquiries about sleeping, ex-service history and life style etc.

Do you have any thoughts or ideas on other things we can do to improve our services to local people?

- Listen more and explain each condition. Concerned at what to expect from the prognosis. Stop wrong synopsises – explain medication and possible side effects. Follow up – follow up – and follow up again – older people need to feel they are cared about or they become extremely isolated and afraid.
- Get them to be involved opening their options.
- Increase the awareness in the local community of what can be offered.
- More visits by CPNs and/or support staff. Also to provide more day centre facilities at a reasonable cost to the user. More cohesion between mental health, Adult services, GP. (Budgets a problem!!). When a sudden problem occurs there needs to be some where family/carers can go for help (practical help not just kind words).
- Collaboration with the very well-informed voluntary sector could bring vast benefits. Social and self advocacy for the learning disabled; social and interest groups for early demented and depressed e.g. singing, craft, dancing and outings. Also opportunities for those with long-term mental health problems to be with others they feel comfortable with. People need people. I've seen all these work. They benefit subjects and carers and enliven them.

Do you support the proposal to close Willow Ward and Linden Ward at the Tom Rudd Unit on the Moorgreen Hospital site in order to develop improved community mental health services?

Yes – Please give your reasons

- I support more mental health care in the community. Institutilisation is not the answer, teaching and supporting peoples mental/physical health in the community empowers the person to live independently – but knowing support is there if one needs it. It also promotes public awareness and acceptance of mental health, eliminating ignorance and fear.
- More efficient and effective use of beds providing the services left are efficiently and effectively supported.
- I know Tannersbrook and would be satisfied to see community mental health residential beds transfer to the Western. Problems of getting elderly and frail carers and loved ones from across rural Hampshire to the Western Hospital Southampton must be taken on board in strictly financial terms.

No – Please give your reasons

- This does need to be monitored regularly or people may slip through the loop – again follow up is needed as needs increase and people live longer
- Linden Ward gave me breathing space and someone to turn to in a non judgmental way 24/7. Location handy for patients and visitors this side of Southampton.
- No. Not everyone can be treated in the community. A lot of older people live on their own and there comes a time when they cannot stay in their homes (sometimes only temporarily). I suspect even more pressure will be applied to family and carers. From my experience this leads to stress and illness within the family/carer. I feel very strongly that to close these wards is a retrograde step. More about money than what is needed.

Appendix 6.10

Analysis of the feedback received from the Public Consultation on older peoples mental health services within Southampton and South Hampshire

Summary of 'other' consultation correspondence received

Date received	Correspondence from and type	Comments
22 May	Carer - Email	In my opinion a lot of what is proposed is all about saving money. I accept there is always a case for efficiency and effectiveness savings but I am not convinced that this is what your proposals are demonstrating. I am in favour of trying to keep dementia sufferers in their own homes for as long as possible but the lack of help and support puts too much pressure on carers and families. I am against the closure of Linden & Willow Wards. I believe that there is a demand for these beds but that the demand is being kept in medical hospitals.
13 June	Royal College of Nursing - Letter	RCN Conclusions: There are a considerable number of staff at risk of redundancy if the proposal is taken forward. We are concerned at the potential permanent loss to the service and the Trust, of Nurses and Health Care Support Workers who have a considerable amount of experience and expertise. It is unclear how an increase and improvement in Community Mental Health services is to be achieved? Have the Trust got confidence that the other agencies refereed to in the document have sufficient resources to enable the provision of the services required by the potential increase for their services? How will the proposals, if implemented, be monitored and evaluated?
16 June	EBC - emailed report	The Council is particularly concerned for those patients and carers/family members who will have to travel greater distances as a result of the ward closures, not just for those who have the means (e.g. their own car) to make those journeys, but especially for those who rely on public transport. The Council is unhappy that the Trust has not been able to provide accurate mileage data,

		even though this was requested before and during the consultation. Revised and corrected data still needs to be provided. The figures so far provided indicate that the numbers of people affected negatively by the changes (i.e. those who would need to travel a greater distance to Western Community Hospital) are very small. Given the low numbers it should not be prohibitively expensive for the Trust to provide enhanced (i.e. subsidised) transport for patients and carers/family as discussed with representatives of the Trust. The Council agrees that providing services for patients and carers in their own homes and in community-settings is generally preferable to providing services in remote settings, as long as pathways of care for those in need of specialist, acute and inpatient care are not thereby made more difficult. Patients should be able to access the right level and setting of care at all times. This includes discharge from, as well as admission to, inpatient care; discharge from hospital must continue to be properly planned and implemented across providers and in partnership with patients and carers The Trust should invest the savings from the ward closures in those community settings, and demonstrate the shift in investment transparently. This is an area which the liaison group should be set up to monitor. The group should include representatives of Eastleigh Borough Council, GPs in Eastleigh borough, patients/services users/carers groups. More detail needs to be provided about the proposed alternative use of the ward space in the Tom Rudd unit. The Council supports many of the aspirations of the Trust in providing improvements to community-based services. However it is difficult to evaluate their effectiveness and impact without further detail, for example: (a) Where will extra clinics / Memory Clinics be provided? (They need to be accessible for people in Eastleigh's southern

		parishes) (b) Where improvements are based on raising awareness and closer working or support to other parts of the healthcare network (GPs, nursing and residential homes, the voluntary sector, adults services providers), what does that mean in practice? While closer integration between mental and physical health provision is to be much welcomed, it is expected that the institutional integration of the two Trusts since April 2011 could be a lengthy process leading to potential delays in benefits for patients. The Council has some concern for the 58 staff affected by the proposals, as many of them are local Eastleigh Borough residents. For those who are redeployed to other sites there will extra travel required. The Council takes mental health of its residents very seriously and already provides a range of services: Supporting the development and implementation of the Increasing Access to Psychological Therapies (IAPT)/i-talk service, including identifying premises, linking to BME (Black and Minority Ethnic) groups in the borough, such as the Asian Welfare and Cultural Association and Eastleigh Gurkha Nepalese Association Implementation of a mental health strategy Hosting an Equality and Inclusion Community Development Officer**,** which has led to the set up of the: Eastleigh BME Mental health and Wellbeing Network Providing a range of services which improve social, environmental and economic determinants of mental health: Countryside, Streetscene, Planning, Benefits, Economic Development, Community, Local

		Areas, Sports and Active Lifestyles, Community Safety. The Trust needs to work closely with Adults Social Care to ensure that there is access to good quality and responsive respite care.