HEALTH SELECT COMMISSION

Venue: **Town Hall, Moorgate Street, Rotherham S60 2TH**

Date: **Thursday, 8th March, 2012**

Time: **9.30 a.m.**

A G E N D A

1. To determine whether the following items should be considered under the categories suggested in accordance with Part 1 of Schedule 12A (as amended March 2006) to the Local Government Act 1972

2. To determine any item the Chairman is of the opinion should be considered later in the agenda as a matter of urgency

3. Apologies for Absence

4. Declarations of Interest

5. Questions from members of the public and the press

6. Communications

7. Minutes of previous meeting (Pages 1 - 7)

8. Health and Wellbeing Board (Pages 8 - 14)
   - minutes of meeting held on 18th January, 2012

9. RDaSH Quality Account (Pages 15 - 29)
   - presentation by RDaSH

10. Health Inequalities Scrutiny Review BMI>50 (Pages 30 - 57)

11. Tobacco Control Update (Pages 58 - 83)
    - reports by Alison Illif and Simon Lister, NHSR

12. Date and Time of Future Meeting:-
    - Thursday, 19th April, 2012 @ 9.30 a.m. at the Town Hall, Moorgate Street, Rotherham

HEALTH SELECT COMMISSION
26th January, 2012

Present:- Councillor Steele (in the Chair); Councillors Barron, Beaumont, Blair, Dalton, Goulty, Turner and Wootton.

Councillor Wyatt was in attendance at the invitation of the Chair.

Apologies for absence were received from Councillors Beck, Jack, Beck, Hodgkiss, Janet Dyson, Jim Richardson and Russell Wells.

40. DECLARATIONS OF INTEREST

There were no declarations of interest made at the meeting.

41. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no members of the public or the press present at the meeting.

42. COMMUNICATIONS

British Heart Foundation - Heart Town
Councillor Wyatt reported that Rotherham had recently signed an agreement with the British Heart Foundation (BHF) to become a Heart Town. This was a joint initiative between the Council and NHSR and a 5 year programme of events and activities with support from the BHF to tackle the growing rate of heart disease in Rotherham.

Councillor Wyatt asked for any interest from Select Commission Members to join the Heart Town Steering Group, the first meeting of which would take place ion 6th February at 10.30 a.m. at Oak House. Councillors Barron and Beaumont put their names forward.

43. MINUTES OF PREVIOUS MEETING

The minutes of the previous meeting held on 8th December, 2011, were noted.

44. HEALTH AND WELLBEING BOARD

Resolved:- (1) That the minutes of the Health and Wellbeing Board held on 7th December, 2011, be noted.

Councillor Wyatt reported that at the meeting held on 18th January, 2012, the Board had considered a forward plan highlighting the key achievements that had to be made in the next 12 months,

(2) That the Health and Wellbeing Board's forward plan be submitted to this Select Commission.

45. RFT QUALITY ACCOUNTS

Hilary Fawcett, Quality and Standards, Rotherham Foundation Trust, gave the following powerpoint presentation to the Select Commission:-

Selecting Priorities: Method
- Consultation process LiNKS, O&Ss, public
- Evidence based
- Risk based
- Linked to CQUINs
- Quality Committee prioritisation process

Quality Accounts Improvements 2012/13
- Patient Safety
  - Continue to aim for 95% high risk prescriptions, opiates anticoagulants, antibiotics prescribed as per protocol
  - Expand work on communication incidents: handover/hand-off to encompass OOH scenarios and deteriorating patient
  - Continue to monitor and reduce the risk of any Never Events
  - Increase number of health assessments for looked after children
- Patient Experience
  - Increase the number of nutritional assessments across integrated organisation
  - HV first visit carried out within 10-14 days
  - Increasing compliance with 95% of key measures of End of Life care pathway
- Clinically Effective
  - Reducing admission rates for long term conditions
  - Reducing re-admission rates from care homes within 30 days
  - Reducing weekend mortality rates from April, 2 012 baseline
  - Community occupational therapy assessments carried out within 28 days of referral
- KPIs
  - Linked to Improvement Programmes
  - On-going: Mortality, fluid balance and VTE, falls
  - CQUINs, national priorities

What we would like to know
- Any questions?
- Do you agree with the topic selection?
- Written agreement and identification of Indicator by 17th February

Discussion ensued with the following issues raised/clarified:-

- The Standard set for 2011/12 had not been achieved in full – the focus would be retained on those Indicators but refined and expanded to ensure they encompass Community Services also
- Evidence suggested that nationally mortality rates (deaths in hospitals) increased at the weekend. Many factors contributed to this e.g. unplanned admissions more than likely through A&E. Analysis was required of the data, however, this was not a specific problem in Rotherham
- Significant improvement in the rate of falls. All patients at risk have an assessment and action taken if perceived to be at risk
- Care Quality Commission had conducted a survey in 2011 focussing on 2 areas – Respect and Dignity of Patients and Nutritional Needs of Patients. It highlighted a lot of good practice but also some issues of those not able to feed themselves and staff not having the time to sit and feed them

- Essential the focus on services in the community were not lost as well as those provided in hospital – ongoing review of the services to ascertain how the pathways could be improved and ensure equality of service
- The Health Service had/was suffering budgetary cuts the same as local government. The targets were existing targets that were being worked towards with less resources

Resolved:- (1) That the report be noted.

(2) That a response be submitted on behalf of the Select Commission in accordance with the 17th February, 2012 deadline.

46. HEALTH INEQUALITIES SCRUTINY REVIEW - DRAFT RECOMMENDATIONS

Kate Green, Scrutiny Officer, and Councillor Steel, Chair of the Review Group, presented the draft recommendations of the Health Inequalities Obesity: BMI>50 Review Group as follows:-

Overview
- Part of a project with the Centre for Public Scrutiny
- Funded by the Department of Health to look at the rate of return on investment of Scrutiny
- Rotherham's review looked at the quality of life and services provided for people with a BMI over 50

Review Question
- How can we improve co-ordination between services so as to improve the quality of life and care of people with a BMI>50 and who are housebound and unable to get out of their home unaided, and what would be the 'Return on Investment' of service co-ordination and improving their quality of life and care?

What we did
- Review group of 4 Elected Members and 1 Scrutiny Co-optee
- Expert Advisor from the CfPS providing up to 5 days support
- Stakeholder session to help scope the review and gather information from professionals
- Interviews with professionals and 1 individual within the community
- Questionnaires gathering information from professionals

What we found out
- Total number of individuals in the 'cohort' was unknown
- Varied degree of co-ordination between services and organisations
- Individuals often only found out about in an emergency situation
- Information and data was difficult to share but would be a huge benefit to Ambulance/Fire Service etc.
- No data sharing protocol specific to the group
- Individuals often could not be discharged from hospital due to inappropriate access/equipment at home – increased bed days
- Awareness of the issues was good across agencies but services were not centrally co-ordinated

– Professionals may not always be aware of the range of services on offer locally which would be of benefit to individuals

Recommendations

– Service Improvement
  To establish a negotiation session between relevant strategic officers/organisations to create an action plan to implement the recommendations of the review, including timescales, lead roles and reporting mechanisms and to report back to the Health Select Commission. 4 objectives of the Group to consider:-

  Develop a 1 page tick box form to obtain consent from individuals to share information and ensure professionals received appropriate training on how to use this
  Develop protocols for joint working and local data sharing specific to this group of people
  Briefings for professionals to raise awareness of the range of services available locally for this target group of people
  Consider options for central co-ordinating this agenda, either through an appropriate central co-ordinator post or central database/or way of sharing information
– Securing Commitment
  To recommend that Cabinet and the Health and Wellbeing Board takes a lead in securing commitment to action on the recommendations and receive monitoring of implementation reports through an appropriate forum e.g. NHSR-led Obesity Group
  Report to go to Improving Lives Select Commission to raise awareness across other agendas
– Prevention
  To agree a joined-up approach to tackling obesity in Rotherham through the Health and Wellbeing Board, acknowledging that treatment and prevention need to work together and ensuring it features as a high priority in the joint Health and Wellbeing Strategy

Next Steps

– Discuss and agree recommendations
– Final report to be presented to Select Commission in March
– Once approved by Cabinet, submit to Health and Wellbeing Board

Discussion ensued with the following issues highlighted/clarified:-

- It was known that there were 614 people in the Borough that fell into the category and this should be included in the report, however it was noted that it was not always clear in terms of where these people were in the Borough
- Equality of experience of the individuals was really important
- The review had been carried out with a number of partner organisations. It became apparent that there was a need to work more closely with agencies such as the Fire and Ambulance Services, to help improve the quality of life for those with a BMI>50, who very often were not known about until an emergency situation and they required assistance getting out of their house.

- It was important for assessments to be carried out so that the emergency services had the correct and appropriate equipment to deal with any situation

The Chairman thanked all who had provided background information for the review and made themselves available for interview, including colleagues from NHS Rotherham, the Foundation Trust, GPs and Fire and Ambulance Services.

Resolved:- That the full report be presented to the Health Select Commission in March for consideration and approval, before being submitted to Cabinet and the Health and Wellbeing Board

47. SCRUTINY WORK PROGRAMME

Kate Green, Policy and Scrutiny Officer, submitted an updated work programme for the Select Commission.

The Overview and Management Board was seeking feedback on the following discussion points:-

– Were the Select Commissions focussing on the 'right' issues in the 'right' way?
– Views on the approach and process
– Views on the work programme – was the balance 'right' – was it achievable?
– What could be done differently or better within current resources?

Discussion ensued with the following issues raised:-

- Reintroduce the mentoring scheme between Co-optees and Scrutiny
- Volunteers within the hospital setting
- Scoping of future reviews to be considered by the Health and Wellbeing Board
- Work programme was not set in stone and any emergency issues could be considered.

Resolved:- (1) That the work programme be noted.

(2) That the Overview and Management Board be informed of this Select Commission's satisfaction with the new scrutiny arrangements.

(3) That the issue of volunteering be raised at the Overview and Management Board.

48. DATES AND TIMES OF FUTURE MEETINGS:-

Resolved:- That meetings be held during 2011/12 on the following dates commencing at 9.30 a.m. in the Town Hall:-

8th March, 2012
19th April

Minute No. 45 RFT Quality Accounts

Information supplied by Hilary Fawcett, Head of Clinical Governance, Community Health, in response to queries raised at the meeting:-

Falls rates in Rotherham

The RFT has one of the lowest falls rate in the UK. Falls are consistently monitored as part of the Quality Accounts and this will be on-going for the coming year. The number of falls recorded on the Trust incident reporting system has varied over 2011/12 . Following a peak in November, there has been a marked decrease in December, lower than the equivalent month last year. While some further improvements have been seen in relation to completion of falls assessments, it is recognised that further work is needed to consistently remain at or below the target level set for last year. We are also working with the community, NHS Rotherham and social service to develop a more robust intergrated falls service with a full review of integrated care pathways. This work is being led and monitored by a Falls Steering Group. We have also led on a collaborative workshop with Sheffield and Doncaster in sharing our learning in relation to falls.

Weekend Mortality rate
Proposed quality indicator – to reduce weekend mortality rates from April 2012 baseline.

To put this into context, a study carried out by University College London has found that patients are 'more likely to die in hospital if they are admitted at weekends' following a review of 14 million admissions to English hospitals.

The study found a pattern relating to admission day but the reasons for this are unknown and the assumption cannot be made that this relates to staffing levels or availability of senior staff. For example, it is possible that the figure is affected by the death of severely ill patients admitted as an emergency at the weekend. Patients with less severe illness would potentially wait until the following Monday before seeing a Doctor / admission. There are no planned admissions at weekends, all admissions therefore are patients who are potentially seriously ill.

The inclusion of this proposed indicator in the Quality Accounts is not to suggest a specific problem in Rotherham, but to ensure that the outcome of this study is taken into account in the ongoing detailed monitoring of all deaths which already takes place. If necessary, any identified themes or trends which arise through this monitoring process will be addressed. This will be the specific responsibility of the Medical Director.

Role of volunteers

I also agreed to look into an additional query raised about the role of volunteers in the hospital and whether they had involvement with supporting patients at mealtimes.

Volunteers do carry out wide ranging roles across the Trust, with the scope of their involvement detailed in the Volunteer Strategy and role outlines. They do assist with mealtimes, for example delivering /removing trays, providing drinks, helping with hand cleansing. They do not directly feed patients, which is considered to be the responsibility of the professional staff on the ward. Their role in supporting mealtimes means that the ward health professionals and support staff are able to focus on supporting patients and ensure nutritional needs are met.

HEALTH AND WELLBEING BOARD
18th January, 2012

Councillor Wyatt	**IN THE CHAIR**
David Barker	Communications, RMBC
Anne Charlesworth	Head of Alcohol & Drugs Strategy Team, NHS Rotherham
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Councillor Doyle	Cabinet Member, Adult Social Care
Chris Edwards	NSHR/RCCG
Kate Green	Scrutiny and Policy Officer, RMBC
Caroline Hill	RDaSH
Martin Kimber	Chief Executive, RMBC
Councillor Lakin	Cabinet Member, Safeguarding Children and Adults
Shona McFarlane	Director of Health and Wellbeing, RMBC
Mike Pinkerton	Rotherham Foundation Trust
Dr. David Polkinghorn	CCG
Dr. John Radford	Director of Public Health
Joyce Thacker	Strategic Director, Children and Young Peoples' Services, RMBC
Alan Tolhurst	NHS South Yorkshire and Bassetlaw
Dr. David Tooth	Chair, Rotherham CCG
Janet Wheatley	VAR
Dawn Mitchell	Committee Services, RMBC
Councillor Jack	Observer

Apologies for absence were received from Christine Boswell, Matt Gladstone and Brian James.

S35. BRITISH HEART FOUNDATION

Prior to the start of the meeting, it was noted that the Council had signed up to become a British Heart Foundation Heart Town.

Jo Ward (National Ambassador, Mending Broken Hearts Appeal), Lauren Mallinson (Fund Raising Volunteer Manager) and June Thomas (Lead Volunteer) introduced themselves to the meeting and gave a brief outline of their involvement with the initiative.

S36. MINUTES OF PREVIOUS MEETING

Agreed:- That the minutes be approved as a true record.

Arising from Minute No. S23, it was noted that the Armed Forces Community Covenant was to be signed by the Council and partners on 20th January, 2012.

Arising from Minute No. S24 (Mexborough Montague Hospital), it was reported that emergency light access to beds had ceased on 8th December, 2011. The beds were still open but their access had changed with emergencies now being via Doncaster and Bassetlaw hospital. There were lessons to be learnt in terms of the consultation.

S37. DRINKING ALCOHOL IN ROTHERHAM

Anne Charlesworth, Head of Alcohol and Drug Strategy Team, Public Health, gave the following powerpoint presentation:-

- Specialist Alcohol Commissioning Feedback highlighting the strengths in Rotherham
  - Strong commissioning profile which had facilitated excellent engagement across primary care
  - Integration across all substance misuse provision raising the skills and competencies of the workforce
  - Embracing a clear recovery orientated vision at both strategic and delivery level
  - Clear clinical pathways supported by regular and robust negotiations with partners
  - A shared sense of responsibility had been fostered which had improved joint working
  - Improving outcomes despite significant increases in demand

- Benchmark activity

- Latest initiatives
  - Call it a Night website
  - Picking up young people presenting at A&E and ensuring School Nursing follow up (or specialist services if aged 16-18 years)
  - Alcohol Awareness Week
  - Staff training
  - Identifying alcohol use levels via Police Custody Suite
  - Street Pastors

- Alcohol Services
  - 1 of 4 areas undertaking National Payment by Result pilot for Department of Health
  - Increased target to include 'problem' drinkers and more 'Tier 2' intervention
  - Staff numbers reduced
  - Primary Care Scheme now included all but 5 practices
  - Lifeline continued to exceed targets to offer assessments and interventions
  - Case management of high impact users of hospital and ambulance services
  - Improved collaboration between hospital care and specialist services

Discussion ensued on the presentation:-

- Yorkshire and the Humber was the worst region in the country for young drinkers but the number had increased nationally
- Those that presented at hospital were normally known to other services
- Evidence showed that the relative costs of alcohol and the amount of alcohol consumed at home had exceeded expectations. Scotland had brought in unit pricing and taxation which was a very good first step
- Need to refresh the commitment of all partners
- Research in the big cities had ascertained that young people found drinking

alcohol enjoyable and enjoyed the sensation of getting drunk
- Key source of alcohol was from the home followed by purchase by an older person
- The definition of "binge" drinking was actually ½ of the weekly limit i.e. 7 units
- Need to be included in the JSNA and HWB Strategy
- The need for partners to review outcomes from the measures implemented and improve future targeting

Anne was thanked for her presentation.

Resolved:- That the CCG evaluate the effectiveness of existing actions to improve impact and report back to this Board thereon.

S38. ROTHERHAM COLD WEATHER PLAN

John Radford, Director of Public Health, submitted, for information, the winter planning arrangements for health and social care in Rotherham. It incorporated Rotherham's response to the Cold Weather Plan, issued in October, 2011. The Affordable Warmth Strategy was currently being refreshed and had been incorporated into the document ensuring all plans were integrated.

It was noted that the Plan had also been considered by the Adults Board.

Resolved:- (1) That the Rotherham Winter Plan be endorsed.

(2) That the arrangements that had been put in place to cover winter pressures and extreme weather be noted.

(3) That the year round arrangements in place via the Affordable Warmth Strategy be noted.

S39. PIP BREAST IMPLANTS

The Chairman reported that the Cluster was in the process of producing a local statement which would cover the issues of concern of Rotherham women who may be affected.

There was 1 provider in the local area who currently was not giving clear advice to patients. However, any woman who had worries associated with their breast implant(s) should consult their GP.

S40. CHILDREN AND YOUNG PEOPLE'S PLAN 2010-13 PROGRESS REPORT

Joyce Thacker, Strategic Director of Children's and Young Peoples Services, presented, for information, a progress update on activities identified in the Children and Young People's Plan (CYPP) as published by the Children's Trust Board in July, 2010.

The CYPP set the strategic priorities for the work of partners on the Trust Board and provided the framework for commissioning decisions as well as 9 areas of focus for priority action. 6 action plans had been published to

accompany the Plan, however, the Trust Board had recently revised them and would be disestablished in light of changed statutory requirements and the need for more streamlined working practice across the Children and Young People's Partnership.

The CYPP identified 'four big things' that would be central to business of the Partnership – keeping children and young people safe, prevention and early intervention, tackling inequalities and transforming Rotherham learning.

The CYPTB Commissioning Plan would respond to the identified priority areas. The Commissioning Team had commenced a needs analysis, a summary of which was attached to the report submitted.

The areas of focus that fell outside the priorities were looked after children, understanding and responding to the needs of migrant communities, 14-19 and post-16 opportunities for young people with learning difficulties and disabilities. These were being monitored elsewhere.

Resolved:- (1) That the progress made against the key areas of focus identified in the Children and Young People's Plan be noted.

(2) That efforts be made to ensure that the Health and Wellbeing Strategy was aligned with the Children and Young People's Plan.

(3) That the governance arrangements, in particular for the areas of focus most closely linked to the health and wellbeing agenda, giving babies the best start in life, obesity and alcohol, be noted.

S41. NHS OPERATING FRAMEWORK

Chris Edwards, Chief Operating Officer, NHS Rotherham, presented, for information, a briefing on the Operating Framework for the NHS 2012/13, the first full year of the transition to the proposed new structure for the NHS and believed that its focus would help the NHS shift into implementation mode.

Rotherham's interpretation of how it would be operated in practice would be part of the 2012/13 Strategic Plan.

Resolved:- That the report be noted.

S42. NHS NATIONAL OUTCOMES

Chris Edwards, Chief Operating Officer, NHS Rotherham, directed Board Members to the stated website for early sight of the NHS Outcomes for 2012/13. How they were to be integrated into Rotherham would be included in the forthcoming Strategic Plan.

John Radford reported that Public Health had new Outcomes Indicators also, the majority of which would prove extremely difficult to measure. They did offer a different emphasis in terms of equality of care which was important in terms of people's perceptions but would be difficult to capture.

The Council's responsibility to Public Health Framework had yet to be published.

The Social Care Outcome Framework was published.

Resolved:- That the report be noted.

S43. HEALTH AND WELLBEING BOARD WORK PROGRAMME AND SUPPORT AND DEVELOPMENT PLAN

Shona McFarlane, Director of Health and Wellbeing, presented the draft work programme for the Board's first year of operation.

The Plan had been developed to address the challenges set out by the network of early implementers of Boards which had identified a number of challenges which Boards were facing.

The work programme was underpinned by a support and development plan which used the Good Governance Institutes Board Assurance Prompt toolkit to becoming an exemplar Board by December, 2012. It set out the key actions that needed to be delivered in the first 12 months of the Board focusing on ensuring that it was fit for purpose and could deliver its core functions:-

- Assess the needs of the population through the Joint Strategic Needs Assessment
- Agree and produce a Health and Wellbeing Strategy to address needs which commissioners would need to have regard of in developing commissioning plans for health care, social care and public health
- Promote joint commissioning
- Promote integrated provision, joining up social care, public health and NHS services with wider local authority services
- Involvement in the development of CCG commissioning plans
- Provide advice to the NHS Commissioning Board in authorising CCGs

The report set out:-

- Overarching crosscutting 'impact' performance measures
- Work Programme Year 1 (October, 2011-September, 2012)
- Development Excellence Plan
  Purpose and Vision
  Strategy
  Leadership of the local healthcare economy
  Governance
  Information and intelligence
  Expertise and skills

Discussion ensued on the document as follows:-

- The team leading on the development of the HWB Strategy had asked for agreement to the attached Indicators for them to map the outcome measures and develop the Outcome-based Performance Indicator Framework that would support the Health and Wellbeing Strategy
- The impact measures were the minimum Indicator Sets (as recommended by the Department of Health etc.) which would underpin the work of Boards

nationally
- The final draft of the JSNA was awaited which would then require discussion/approval of agencies to the amendments proposed
- The indicator suite contained a requirement for safety incidents in hospital to be reported - it was noted that safety incidents were not just reported by hospitals
- How could meaningful public engagement be undertaken – discussion required before June, 2012
- The CCG would soon be presenting a Single Integrated Plan (SIP) which would address the health needs of the population. In the meantime there should be a strategic co-ordinated approach and not organisations producing individual plans
- The need for clarity of the relationship between the Board and LSP

Resolved:- That the work programme and support and development plan be approved.

S44. EARLY IMPLEMENTER NATIONAL LEARNING SETS

Shona McFarlane, Director of Health and Wellbeing, presented a report on Accelerated Learning Sets, launched by the Government in November, 2011, to help emerging Health and Wellbeing Boards work together on the biggest challenges that faced them on their way to statutory running from April, 2013.

More than 90 out of 152 emerging HWBs from across England were represented in the 11 Learning Sets. The Sets were focussed on themes that early implementers had said were of most interest and importance to HWB members including:-

- Improving the health of the population (2 Sets)
- Bringing collaborative leadership to major service reconfiguration (2 Sets)
- Creating effective governance arrangements
- How do we 'hard wire' public engagement into the work of the Board
- Raising the bar on JSNA's and joint health and wellbeing strategies
- Improving services through more effective joint working
- Making the best of collective resources

Each Learning Set included members from local government and NHS organisations with a nominated lead, policy lead and appointed facilitator.

Rotherham was represented on the Learning Sets by Shona who was Set Lead for "Brining collaborative leadership to major service reconfiguration"

Outputs from the Sets would be published in March but the Communities of Practice website was providing a virtual engagement mechanism in the meantime.

Resolved:- (1) That the report be noted.

(2) That Board members be encouraged to join the Department of Health Communities of Practice website for further information, dialogue and debate.

S45. APPOINTMENT TO HEALTH AND WELLBEING BOARD

The Chairman reported receipt of 2 requests for representation on the HWBB.

Discussion ensued on the requests.

Resolved:- (1) That the Board consider the issue of a Reference Group of Special Interest to which a representative from South Yorkshire Fire and Rescue Service could be invited.

(2) That the Chamber of Commerce be invited to attend future meetings in the capacity of observer.

S46. COMMUNICATIONS

The Chairman drew attention to the fact that there were 22 Parish Councils in the Borough of Rotherham the majority of which would produce newsletters/bulletins, websites etc. that could be used as a means of communication.

Janet Wheatley, Voluntary Action Rotherham, reported that they also had a network that they send out to weekly that could be used.

S47. DATE OF NEXT MEETING

Resolved:- That a further meeting be held on Wednesday, 29th February, 2012, commencing at 1.00 p.m.

ROTHERHAM BOROUGH COUNCIL - REPORT TO MEMBERS

1.	**Meeting:**	**Health Select Commission**
2.	**Date:**	**8th March, 2012**
3.	**Title:**	**Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) - Quality Accounts**

4. Summary

Coalition Government White Papers set out the vision of putting Quality at the heart of everything the NHS does and a key component of the Quality Framework is the continuing requirement for all providers of NHS Services to publish Quality Accounts.

As part of the process of putting together their Quality Accounts, providers consult with overview and scrutiny committees to enable them to review and supply a statement as to whether the report is a fair reflection of services.

The presentation attached with this report presents the 2011/12 Quality Account produced by RDaSH for consideration and comment by the Health select Commission.

5. Recommendations

That the Health Select Commission:

- **Notes the Quality Accounts being presented by RDaSH**
- **Considers and comments on the proposals for inclusion in the final published accounts for 2011/12**

7. Proposals and details

RDaSH are seeking comments from overview and scrutiny committees within the Rotherham, Doncaster and South Humber local authority areas on their Quality Accounts for 2011/12.

Full details of the quality accounts are outlined in the attached PowerPoint presentation which will be presented at the March meeting. RDaSH would like the Rotherham Health Select Commission to consider these and provide formal comments for inclusion in their published accounts.

The presentation also covers the process that RDaSH will undertake in developing their accounts for 2012/13, which the Health Select Commission will also have the opportunity to comment on.

8. Finance

There are no direct financial implications associated with this report.

9 Risks and Uncertainties

Any risks and uncertainties associated with the accounts for 2011/12, as well as for 2012/13, will be picked-up and discussed by RDaSH in their presentation.

10 Background Papers and Consultation

RDaSH Quality Account presentation – attached with this report

RDaSH Quality Accounts available here (please note this is a 40 page document): http://www.rdash.nhs.uk/wp-content/uploads/2010/06/DP6138-6799-Quality-Accounts.pdf

11 Contacts

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Rotherham Health Select Commission

‘Quality Matters’

Introduction

- What is a Quality Account?
- 2011/12 Performance
- Review of Quality Markers 2011/12
- Process for 2012
- Quality priorities for 2012/13
- Next Steps

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leading the way with care

What is a Quality Account?

- Coalition Government White Papers set out the vision of putting Quality at the heart of everything the NHS does
- Key component of the Quality Framework is the continuing requirement for all providers of NHS Services to publish Quality Accounts
- This is our opportunity to enable the OSC to review and supply a statement as to whether “the report is a fair reflection” of RDaSH services
- 2011/12 is the fourth Quality Account produced by RDaSH

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2011/12 Performance

Monitor

- Governance – Amber/Red (at Quarter 3)
- Finance – 4 (Good) (at Quarter 3)

Care Quality Commission (CQC)

- Registered with no conditions

Commissioning for Quality Indicators (CQUIN)

- Achieving 9 of 9 indicators (at Quarter 3)

Review of Quality Markers 2011/12

Three domains of Quality:

- Patient Safety
- Clinical Effectiveness
- Patient Experience

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Examples of quality improvement work

Patient Experience	Patient Safety	Clinical Effectiveness
Improving access	Changes in practice through lessons learned	Access to supervision
Improving care through patient feedback	Care coordination	Implementing evidence based practice
Patient involvement in service development	Environmental safety/accessibility	Staff engagement in clinical effectiveness activity
Respecting, involving and empowering patients	Personalised care planning	
Making service/treatment information available	Records management	
	Safeguarding	

Process for 2012

- Consultation with OSC – presentation/draft Quality Account for comment
- Engagement with Trust User Carer Partnership Council – regular agenda item/draft Quality Account for comment/development of Quality Markers for 2012/13
- Engagement with Trust Council of Governors – regular agenda item/draft Quality Account for comment/development of Quality Markers for 2012/13
- Draft Quality Account to Trust Clinical Governance Group

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Quality priorities for 2012/13

Developed by:

- User Carer Partnership Council
- Council of Governors
- Business Divisions
- Board of Directors

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Board of Directors Quality Priorities

The 3 quality improvement priorities identified by the Board of Directors are:

- Personalised Care Planning
- Record Keeping
- Clinical leadership roles and responsibilities

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Council of Governors (CoG) Quality Priorities

CoG has identified the following priorities for 2012/13:

- Personalised care
- Effective, knowledgeable, personalised communication from all of our staff
- Continuously improve communication with, and feedback from, people who use the service through a wide range of methods

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User Carer Partnership Council (UCPC) Quality Priorities

- Attitudes shown by staff towards people who are diagnosed with a personality disorder
- Service user carer involvement in staff selection and recruitment
- 7 day follow up from discharge, support on discharge from wards
- Embedding WRAP, mapping what there is and where it is. Connecting discharge and community WRAP Groups
- Access to services (maintaining progress on accessibility and responsiveness).
- Provide information to UCPC on analysis of complaints; trends and lessons learned.
- Increase meaningful activities on the wards

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Next Steps

- Receive OSC comments for inclusion in the Quality Account – 8 March 2012
- Report to Clinical Governance Group – 19 March 2012
- Report to Board of Directors – 29 March 2012
- Report to Council of Governors – 16 May 2012
- Report to Monitor – 31 May 2012
- Review by Audit Commission – April 2012

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Thank you

Any questions

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ROTHERHAM BOROUGH COUNCIL - REPORT TO MEMBERS

1.	**Meeting:**	**Health Select Commission**
2.	**Date:**	**8 March 2012**
3.	**Title:**	**Health Inequalities Scrutiny Review – BMI>50**
4.	**Directorate:**	**Resources**

5. Summary

Rotherham has been involved in a programme of work with the Centre for Public Scrutiny (CfPS) to look at the way in which scrutiny can be used to help tackle health inequalities at a local level.

Being part of this project involved undertaking a scrutiny review looking at an issue in relation to health inequalities; Rotherham chose to look at the quality of life and services provided for people with a BMI over 50.

Following the draft recommendations of this review being presented to the Health Select Commission at their previous meeting in January, the full report is now attached for final approval before being submitted to Overview and Scrutiny management Board.

6. Recommendations

That the Health Select Commission:

- **Notes the report of the scrutiny review**
- **Agrees for the report and recommendations to be submitted to the Overview and Scrutiny Management Board for final approval prior to going to Cabinet and/or Heath and Wellbeing Board**

7. Proposals and details

The CfPS recognised the potential of scrutiny in better understanding local health concerns and set out to demonstrate the active and vital role that it can have in helping councils and their partners narrow the gaps and improve the health of local people through a programme of work looking at doing scrutiny reviews.

Following an initial phase of the programme, a document called 'Peeling the Onion' was published, which explores scrutiny as an important and effective public health tool and presents a practical toolkit for development areas to use and test out in the second phase of the programme. Six local authority areas were involved in the second phase, including Rotherham.

A review group made up of members and co-optees from the Health Select Commission agreed to undertake their review to look at people with a BMI over 50. The overarching aims of the review were agreed as the following:

- To improve the lives of people with a BMI over 50, ensuring they have dignity and respect and effective, equitable access to services
- To make recommendations for multi-agency consistency in relation to how people with a BMI over 50 and considered housebound are supported and cared for

Full details of the activity which took place, the findings and recommendations are included in the attached report. Members of the Health Select Commission are asked to consider the findings presented in the report and agree for this to be submitted to the Overview and Scrutiny management Board, prior to it going to Cabinet and Health and Wellbeing Board.

Health Select Commission members are also asked to note the reflection and learning gained from being part of this project and the scrutiny review model tested, and consider how they may use elements of this model when undertaking future reviews.

8. Finance

There may be financial implications associated with the some of recommendations, which it is proposed, will need to be considered by the liaison group identified under recommendation one of the review.

9 Risks and Uncertainties

As identified by the review findings, services in relation to people with a BMI >50 are not always as fully coordinated as they could be and there are issues with the sharing of data and information. If some of these issues could be addressed through simple measures, there could be a positive outcome and improved quality of life for people out in the community, as well as potential efficiency savings for organisations.

10 Background Papers and Consultation

Peeling the Onion – Learning, tips and tools from the Health Inequalities Scrutiny Programme (2011):

http://www.cfps.org.uk/what-we-do/tackling-health-inequalities/

http://www.cfps.org.uk/userfiles/file/CfPSPeelingonionfin%5B1%5D(1).pdf

Scrutiny Review of Health Inequalities: people with a BMI>50 – report of the Health Select Commission (attached)

11 Contact

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Rotherham Metropolitan Borough Council

DRAFT

Scrutiny Review of Health Inequalities: Improving the quality of life and services provided for people with a body mass index > 50

Report of the Health Select Commission

February 2012

Scrutiny Review Group:
Cllr Brian Steele (Chair)
Cllr Hilda Jack
Cllr Judy Dalton
Peter Scholey (Co-optee)

CONTENTS

1. EXECUTIVE SUMMARY

Rotherham has been involved in a programme of work with the Centre for Public Scrutiny (CfPS) to look at the way in which scrutiny can be used to help tackle health inequalities at a local level. The CfPS recognised the potential of scrutiny in better understanding local health concerns and set out to demonstrate the active and vital role that it can have in helping councils and their partners narrow the gaps and improve the health of local people.

The programme was funded by Local Government Improvement and Development and the Department of Health to develop innovative solutions to long-standing inequalities. The programme was designed in two phases; phase one of the programme concluded in March 2011 with the publication 'Peeling the Onion' with the second phase, which Rotherham took part in, running from August 2011 to January 2012. The second phase was undertaken to test out the learning and scrutiny review model which was suggested by the development areas in the initial phase of the programme.

The objectives of stage two were:

- To promote the role of scrutiny as an effective public health tool and the use of the publication 'Peeling the onion' as a guide to undertaking a review of health inequalities
- To present scrutiny as a more outcome focused solution, with clear links to the Marmot[1] objectives and the wider determinants of health
- To demonstrate the ability to forecast the impact of recommendations and the value of scrutiny reviews through developing a rate of return on investment

1.1 Summary of Review Scope

The review was undertaken in a series of stages, which had been identified through the previous phase of the programme and included; shortlisting a range of topics to prioritising the issues, stakeholder engagement and actually undertaking the review.

A review group made up of members and co-optees from the Health Select Commission agreed to undertake their review to look at people with a BMI over 50. The overarching aims of the review were agreed as the following:

- To improve the lives of people with a BMI over 50, ensuring they have dignity and respect and effective, equitable access to services
- To make recommendations for multi-agency consistency in relation to how people with a BMI over 50 and considered housebound are supported and cared for

1.2 Summary of Key Findings

A range of activity took place to gather data and information from various organisations in terms of service provision and costs, as well as gathering the views and experiences of a range of professionals working in this field and individuals out in the community.

The key findings from the review are summarised below:

- As of 30 March 2011, 5,909 people had been identified on GP practice registers in Rotherham with BMI over 40 and 793 people had been recorded as having a BMI over 50
- There are likely to be additional cases with no recorded BMI, making the total numbers in Rotherham not entirely known

[1] 'Fair Society, Healthy Lives' Marmot Review of Health Inequalities, 2010

- It is not necessarily known where all the people are; there may be small numbers of people known to each organisation, but not all organisations know all the people – if information was shared, this could benefit organisations by increasing their knowledge of the issue within the community
- There is an issue around sharing data and information between organisations and data protection issues can prevent relevant information being shared
- There is inconsistency in the policies and procedures within all organisations in relation to this group of people; although there may be protocols in place these are not always joined up between services
- Although some services do have a system in place there is uncertainty around who coordinates this and how
- Assessments are generally only completed when there is a problem, meaning patients are often not identified until there is an emergency
- There needs to be a way of identifying and supporting people before they become isolated and their weight increases to this level
- The obesogenic[2] environment needs to be considered, particularly for certain groups such as people who are physically disabled or those with learning difficulties
- It is important to raise awareness of the healthy weight services available to people in Rotherham, particularly with professionals who may come into contact with individuals on a day to day basis – to encourage use of services
- Being unable to get out of the house unaided greatly affects a person's quality of life; always needing assistance could leave them isolated and unable to be spontaneous
- Being properly assessed and having the appropriate assistive equipment in a person's home could really improve a person's quality of life and independence

1.3 Summary of Recommendations

Recommendations were developed around three main themes:

1) Service Improvement

To establish a negotiation session to create a 'SMART'[3] action plan to implement the recommendations of the review, including timescales, lead roles and reporting mechanisms, to report back to the Health Select Commission. The role of this group session would be to consider the following sub-recommendations:
a) Develop a one-page tick-box form to obtain consent from individuals to share information and ensure professionals receive appropriate training on how to use this
b) Develop protocols for joint working and local data-sharing which will ensure more integrated service provision
c) Consider options for centrally coordinating this agenda, either through an appropriate central coordinator post or central database/ or way of sharing information
d) Briefings for professionals to raise awareness of the range of services available locally for this target group of people

2) Securing Commitment

For Cabinet and the Health and Wellbeing Board to take a lead in securing commitment to action on recommendations and receive monitoring of implementation reports through an appropriate forum, i.e. NHSR led obesity group.

[2] 'Obesogenic' refers to an environment that promotes gaining weight
[3] SMART criteria – Specific, measurable, attainable, relevant and timely

3) Prevention

To agree a joined-up approach to tackling obesity in Rotherham through the Health and Wellbeing Board, acknowledging that treatment and prevention need to work together and recommending that this features as a high priority in the joint Health and Wellbeing Strategy, based on evidence from the Joint Strategic Needs Assessment.

2. BACKGROUND TO REVIEW

The Centre for Public Scrutiny (CfPS) recognised the potential of scrutiny in better understanding local health concerns and set out to demonstrate the active and vital role that it can have in helping councils and their partners narrow gaps in health inequalities. With funding from Local Government Improvement and Development and the Department of Health, the Health Inequalities Scrutiny Programme was created to develop innovative solutions to long-standing inequalities. The programme was designed in two phases; with phase one of the programme concluding in March 2011.

The programme was created as traditionally scrutiny reviews have focused on tangible services; yet it was believed that scrutiny had a real role in helping an area better understand the inequalities that they faced and actions that they could take to tackle these issues. The programme had two main objectives which were to recruit Scrutiny Development Areas to help to develop solutions to long-standing inequalities and produce a document that showcased the learning from these areas and helped other councils to carry out similar reviews.

Following the first phase, the document 'Peeling the Onion' was published which explores scrutiny as an important and effective public health tool. It looked at the journey undertaken by each of the scrutiny reviews in phase one and presents the practical application of scrutiny for the development areas to use in phase two.

Rotherham was involved in phase two of the project. This phase built on the success of phase one, recognising the key role that local authorities will have for public health, health improvement and reducing inequalities, and ensure that scrutiny contributes to the evolution of Joint Strategic Needs Assessments and the production of joint health and wellbeing strategies.

The objectives of stage two were:

- To promote the role of scrutiny as an effective public health tool and the use of the publication - "Peeling the onion."
- To use "Peeling the Onion", as a guide to undertaking a review of health inequalities – understanding the key attributes of a review, what a good review needs to have and follow the stories of the ten original Scrutiny Development Areas (SDAs)
- To present scrutiny as a more outcome focused solution, with clear links to the Marmot objectives and the wider determinants of health
- To demonstrate the ability to forecast the impact of recommendations and the value of scrutiny reviews through developing a rate of return on investment

Six local authorities were involved in this stage in total, including:
Rotherham
Adur, Worthing and Arun Councils
Haringey
Liverpool
Sheffield
Tendring

The project took place between August 2011 and January 2012, with the conclusions of each of the development areas being presented at an action learning event early February 2012.

3. METHODOLOGY

The key attributes of a scrutiny review of health inequalities that were highlighted in 'Peeling the onion' included: leadership; vision and drive; local understanding; engagement; partnership; being systematic; and monitoring and evaluation. To incorporate all of these elements each of the reviews undertaken by the development areas were made up of four key stages:
Stage 1 – Shortlisting topics
Stage 2 – Prioritisation
Stage 3 – Stakeholder engagement
Stage 4 – Undertaking the review and calculating a rate of return (RoI)

This report discusses each stage in turn, looking at what was undertaken and learnt in relation to the chosen topic for Rotherham, as well as the learning from the actual process of undertaking the review using this model and a reflection on how well each stage worked.

3.1 Stage 1 - Shortlisting topics

A shortlisting meeting was held with the review-group members. Prior to this meeting taking place a number of documents such as the Joint Strategic Needs Assessment (JSNA) were circulated. The review-group members were asked to consider the available information in relation to health inequalities in Rotherham and come to the meeting with 2 or 3 topics they would like to look at for the purpose of the review.

The members came with a number of specific ideas including those from personal, family or constituent experience, for example the treatment of prostate cancer for older men and mental health. In total 6 issues were proposed and it was valuable to be able to build on the personal experience of review-group members. In order to make the prioritising stage manageable these were reduced to a final short-list of 3 topics:

- Drug and alcohol use in young people
- Alcohol and mental health
- Obesity – BMI>50

3.2 Stage 2 – Prioritisation

The second stage involved taking the 3 short-listed topics and developing 'impact statements' for each one, an example statement for the chosen topic is included as appendix A. The Impact Statements were based on the 6 policy objectives of Marmot:

- giving every child the best start in life
- enabling all children, young people and adults to maximize their capabilities and have control over their lives
- creating fair employment and good work for all
- ensuring a healthy standard of living for all
- creating and developing sustainable places and communities
- strengthening the role and impact of ill-health prevention

The review-group then used these impact statements to undertake scoring using a Scoring Matrix (appendix B). This impact statement indicated that looking at the issue of BMI> 50 would be likely to have the most impact among the 3, in terms of the specific, time-limited scrutiny review project.

The process of prioritising the topics enabled interesting and unusual aspects of the topics to emerge rather than the 'usual suspects'. The focus was therefore on a specific question to ask and impact to pursue, rather than just gathering information and it was useful to start thinking about impact and information sources at an early stage.

3.3 Stage 3 – Stakeholder engagement

Once the review-group had agreed their chosen topic, a stakeholder event was held to help scope out the review; looking at the broader issues and to consider the review's key lines of enquiry.

The event was well attended by a range of stakeholders, including:

- NHS Rotherham (PCT)
- Rotherham Foundation Trust
- Adult social care services (RMBC neighbourhoods and Adult Services)
- South Yorkshire Fire and Rescue
- Yorkshire Ambulance Service
- RDaSH (mental health services)
- Rotherham Institute of Obesity (GP lead)

3.3.1 Wider Determinants of Health Wheel

The purpose of all of the reviews undertaken as part of this programme was to address an aspect of health inequalities and part of this process was to consider the chosen topic in relation to the wider determinants of health. The wider determinants also known as the social determinants of health have been described as 'the causes of the causes'. They are the social, economic and environmental conditions that influence the health of individuals and populations. They include the conditions of daily life and the structural influences upon them. They determine the extent to which a person has the right physical, social and personal resources to achieve their goals, meet needs and deal with changes to their circumstances, and may include housing, physical environment, social networks amongst others things.

A 'wheel' was developed as part of the wider project with the CfPS to use when engaging with stakeholders and this was a new and innovative approach to undertaking scrutiny reviews. Stakeholders were invited to help scope the review at the very early stage, rather than simply being invited for an interview once the review scope had already been agreed – which could make it very difficult to build into the scope new issues and themes based on stakeholder experiences and views.

The wheel was used to ask the stakeholders what would be the 'helps' and 'hinders' in relation to the coordination of services for and the experience of, people with BMI > 50. The wheel included segments for each 'determinant' of health, including: education, housing, culture/leisure, environment, transport and employment, which were then divided into layers, for the individual, the community and organisations. Using post-it notes, stakeholders were asked to consider what the issues were and what could potentially help in relation to each segment, an example of these are described below:

- In relation to transport, issues were raised around getting to hospital, community services and GPs, as well as generally getting out and about which added to social isolation
- In relation to employment, the issues raised were around the high level of unemployment in this group due to mobility/health problems which often resulted in financial exclusion
- In relation to communities, the issue of social isolation and not being able to fully participate in the community was raised as a huge issue
- In relation to culture and leisure, because of isolation, mobility and transport issues and financial problems, many culture and leisure activities were not accessible for this group of people
- In relation to the natural environment, many people were unable to access outside and green spaces due to transport and mobility

The issues raised suggested a link between all the segments with each one being associated with another, and all add together to create a complex mix of problems which can really prevent an individual from accessing support and getting out and about.

Other issues were also raised in relation to the individual and their ability or readiness to change, including:

- A resistance to change and lack of motivation
- Lack of specialist psychological support for people
- Embarrassment associated with going out of the house
- Lack of stimulation and no purpose to get out and about
- Lack of personalised approaches to health and social care
- Lack of knowledge from the individual in relation to health risks and services available

Undertaking this activity and the discussions that followed began to draw out some potential issues and areas for consideration in relation to the chosen topic, including:

- Within the wider ‘cohort’ of people with a BMI>50, there were a number of smaller groups, including:
  1. Those who are immobile/housebound and known to service providers – but resist help
  2. Those who are immobile and known to service providers – and accept help
  3. Those who are isolated and not known to service providers
  4. Those not yet immobile but at risk of becoming so
- It was felt by stakeholders and the review group that it was crucial to decide which cohort the review wanted to focus on as different questions and witnesses would be required and there would be different measures of impact
- There was no obvious patient representative group in relation to this group of people (if looking at those who were considered housebound) and therefore contacting and getting the views and experiences from individuals could potentially be difficult

Based on these discussions, the review-group agreed that the cohort which was of particular interest for the purpose of this scrutiny review was those individuals with a BMI > 50 who were considered housebound (defined by those unable to get out to see their GP unaided).

Based on this defined group, a number of issues were considered, including:

- We don't necessarily know where all these people are – there are possibly 2/3rds not known to any service providers
- We only hear about people in a crisis situation, when the fire/ambulance service may be called out
- There is no monitoring or check-ups following specialist equipment going into someone's home, unless there is a problem
- There is a lack of data sharing between delivery organisations and there are no data sharing protocols specific to this group

The stakeholder engagement process also enabled participants to meet and hear from each other for the first time and created new relationships and commitments to get together and discuss the topic and issues further.

3.4 Stage 4 – Undertaking the review and calculating the rate of return

Following the engagement session with stakeholders and reflection of the review-group, the overarching review question and final review scope was agreed:

How can we improve coordination between services so as to improve the quality of life and care of people with a BMI>50 and who are housebound and unable to get out of their home unaided, and what would be the 'Return on Investment' of service coordination and improving their quality of life and care?

3.4.1 Scope of Review

The overarching aims of the review were agreed as the following:

- To improve the lives of people with a BMI over 50, ensuring they have dignity and respect and effective, equitable access to services
- To make recommendations for multi-agency consistency in relation to how people with a BMI > 50 and considered housebound are supported and cared for

The key objectives of the review, to deliver these aims, included:

- To understand what services were available to people with a BMI>50 and how they were delivered and coordinated
- To understand the relationships between organisations involved with this group
- To gather the views and experiences of individuals within the community, with a BMI>50, in relation to the services they received and their perceived quality of life
- To make recommendations based on the gathered information in relation to service delivery and improving the quality of life of individuals

To deliver on these objectives, a range of activity took place:

- Desk-based research and information gathering
- Review-group discussions and reflection
- Electronic questionnaires to professionals
- Face to face interviews with professionals from various organisations
- Interviews with individuals out in the community

3.4.2 Key Lines of Inquiry

Professionals

The review-group agreed they wanted to collate the views of professionals working in this field, asking them a number of questions in relation to service delivery, coordination and relationships between organisations. In an attempt to gather as many views as possible, an electronic questionnaire was sent to all the professionals who attended the stakeholder session. The questions or 'key lines of inquiry' were developed as a result of the stakeholder session and review-group reflection.

A number of professionals also expressed interest in attending a meeting with the review-group to talk through some of these questions and issues and felt they could offer their views much better in person than the electronic questionnaire. This was welcomed by the group, and resulted in some really valuable discussions which helped form the recommendations.

The key lines of enquiry for this group were as follows:

1. How are services for people with a BMI>50 coordinated at the moment and how could coordination be improved?
2. How are risks and information shared between organisations?
3. What are the relationships between the relevant organisations involved with this group of people?
4. What do you think would improve the quality of life for people with a BMI>50
5. How do you feel we can best measure such improvements?

Individuals

It was also considered key to the review to gather the views and experiences of individuals out in the community, who were part of this cohort. The key lines of inquiry for this group were as follows:

1. What would improve your environment?
2. What is your experience of accessing health/social care services?
3. What would improve your access to care?
4. What would improve your quality of life?

At the stakeholder session, it was highlighted that due to a lack of patient representative groups for this group of people, getting contact details and consent to contact individuals could be difficult. A way around this had originally been suggested; for professionals to ask for consent from people they were aware of through their profession and ask if they would be happy for an elected member to contact them to speak to them about their experiences and quality of life. Although it was deemed unnecessary to obtain ethical approval for this type of scrutiny review, there were still ethical issues in relation to consent and confidentiality and as a result only two interviews with individuals took place. These were with people out in the community who were known to members of the review group from their constituencies, and were willing to talk about their experiences and views. Consent was obtained from the individuals before an informal interview took place, and it was explained to them that their responses would be used for the sole purpose of the scrutiny review and in making recommendations for improving service provision and coordination. Their views have been anonymised for the purpose of this report.

4. FINDINGS

4.1 Obesity data and information

The review-group made the decision to look specifically at people who have a BMI of 50 or more, because of the likely health and lifestyle issues that this weight presented. Individuals with a BMI over 50 are considered likely to be housebound and require specialist care and support and are also very likely to experience social isolation due to not being able to get out of the house.

Obesity or a high BMI has a number of definitions used by various organisations which have been developed from the World Health Organisation values, from severe obesity to super obese, which includes those with a BMI over 50. The term 'Bariatric' is used to describe the field of medicine that focuses on the treatment of obesity and its associated diseases. A Bariatric patient can be defined as someone who has limitations in health and social care due to physical size, health, mobility and environmental access, and will have needs that are in excess of the safe working load and dimensions of any supporting surface, e.g. mattress, toilet frame or commode. The agreed Rotherham weight is at 127kgs (20 stones) for the purposes of moving and handling. Nationally the BMI is defined as being in excess of 40, or 35 with associated health problems.

As of 30 March 2011, 5,909 people had been identified on GP practice registers in Rotherham with BMI over 40 (3.7% of those with a recorded BMI), and 793 people recorded as having a BMI over 50 (0.5% of those with a BMI recorded). However there are likely to be additional cases with no recorded BMI, making the total numbers in Rotherham not entirely known. Obesity nationally and in Rotherham is predicted to rise, with projections indicating that by 2050 there will be around 50% of the population classed as obese (with a BMI of 30+), which suggests that numbers of people with a BMI over 40 or 50 plus will also continue to rise.

Obesity is covered in the Joint Strategic Needs Assessment in the chapter on 'Lifestyle and Risk Factors' and is therefore acknowledged as an important issue for Rotherham and there has been a large amount of work to date to reduce levels of obesity in adults and children. But, there has not been as much focus on obesity in relation to those who have a much higher BMI who are housebound. The Rotherham Institute of Obesity was established to form part of the middle tier of intervention for adults and children with weight problems, as part of the overall Rotherham obesity strategy. It has a multidisciplinary team approach to tackling weight by providing specialists in all aspects of the current thinking in weight management. The criteria for accessing this service are having a BMI > 40 or BMI > 30 with increased health risks. However, this service is in effect a 'walk-in' service, therefore does not currently reach out to those who would be considered housebound and who would need assistance getting into the centre.

4.2 Information and data from partner organisations in relation to service provision and costs

4.2.1 Yorkshire Ambulance Service bariatric capacity and data

Yorkshire Ambulance Service (YAS) have invested in new national specification ambulance vehicles with bariatric capability specifically for Accident and Emergency (A&E)**,** currently there are 83 of these vehicles in service across Yorkshire.

YAS Patient Transport Service also has 19 bariatric-capable stretcher vehicles in use across Yorkshire, with a dedicated vehicle at Wakefield and Rotherham.

There is a single vehicle also based at Rotherham that is equipped with and capable of carrying a wheelchair which allows 245kg (40 stone) and a 600mm (24") seat.

YAS data shows that between April and September 2011 there were:

- 4 admissions to A&E (3 of them emergency admissions, 1 routine)
- 53 South Yorkshire patient transport service journeys, 2 of which were in Rotherham

4.2.2 South Yorkshire Fire and Rescue

The call outs received by South Yorkshire Fire and Rescue (SYFR) are generally to assist YAS with the lifting and moving of people, this has in the past required the attendance of specially trained teams including the technical rescue team consisting of 5 staff who carry the required equipment. SYFR have also provided hydraulic platforms to rescue people from bedroom windows and in exceptional circumstances a forklift truck has had to be used. SYFR have never costed the call outs although suggest it would easily cost in the region of £1,000 to £2,000 depending on the time taken and equipment used.

SYFR have had a number of firefighters injured while carrying out such rescues, usually muscular skeletal injuries including back and muscle strains. As with any emergency situation the risk for injury to staff is minimised but the rescue of people in these circumstances tends to be problematic due to the limited space in traditional built houses especially in hallways and stairs. Between October 2009 and January 2012 there have been 5 reports of injury on duty through bariatric incidents, with the total days lost to sickness being 13, at a cost of £2115 in wages paid whilst on sick, which roughly equates to £423 per incident.

People with a high BMI are one of the groups most at risk from fire due to mobility problems. If information can be passed to SYFR they are able to carry out a home visit which can provide advice and equipment that will assist the individual should a fire occur. This visit would also assist with gathering information about the home that can be added to the SYFR emergency mobilising system to assist crews with information about the occupier and allow a degree of pre planning to take place especially around which crews to mobilise to the address in an emergency, saving vital minutes.

The cost of a home safety visit, including staff time and any equipment fitted is usually in the region of £170, and clearly the cost of prevention measures such as these greatly out weigh the cost of a response from an SYFR perspective.

4.3 Findings from Questionnaires and Interviews

4.3.1 Professionals

Nine questionnaires were received back, and included a good mix of views from a range of organisations and services. The review-group also undertook a number of interviews with professionals who had expressed an interest in speaking to the members in person, these included: the GP representative from Rotherham Institute of Obesity (RIO), a representative of South Yorkshire Fire and Rescue and the RMBC Director of Health and Wellbeing (adult services). A summary of their answers to the questions and the questionnaire responses are below:

Highlighted issues:

- There is inconsistency in the policies and procedures within all organisations in relation to this cohort; although there may be protocols in place these are not always joined up between services
- Although some services do have a system in place the replies highlighted the uncertainty around who coordinates this and how
- There is a risk assessment form specific to the needs of people with a BMI over 50 which has been developed previously within one partner organisation, however this is not used by all organisations and there is no central coordination of this to keep an accurate record and ensure confidentiality
- Assessments are generally only completed when there is a problem, meaning patients are often not identified until there is an emergency
- There is an issue around sharing data and information between organisations and data protection issues can prevent relevant information being shared
- Different data collection systems in organisations do not necessarily 'talk' to each other making sharing of information difficult
- There needs to be some sort of data collection to fully appreciate the extent of the issue – before any kind of education/awareness raising can be carried out fully
- If the fire service were aware of where people were they may be able to respond to emergencies much better/more appropriately
- There may be small numbers of people known to each organisation, but not all organisations know all the people – if information was shared, this could benefit organisations by increasing their knowledge of the issue within the community
- While social care staff are aware of those customers who have needs related to their weight, and risk assessments and care plans are developed accordingly, this issue is not recorded separately on the electronic records, SWIFT, so numbers cannot be easily ascertained electronically
- When a social care assessment takes place, information is currently shared appropriately with other partner agencies involved with the individual's care accordingly across organisations

Potential solutions:

- One point of contact/designated post to coordinate the management/care of patients to enable a personalised service
- Improved IT/Database of information which could be shared across organisations
- Obtaining consent from patients/individuals by use of a tick –box form could enable data sharing and a form has been produced in the past which has been used previously, but unsure as to whether this is still in use or being managed
- Dedicated unit to bridge the gap between hospital and home
- Early intervention, support and guidance
- Improved preventative care with pre-alerts to health carers
- Better coordination and continuity of services
- Drawing on experience from the 'Every Contact Counts' and 'Hotspots' initiatives, which ensures that whoever goes into see an individual shares the information where it is needed
- Ensuring information is available to all professionals to show who/which services should be contacted in certain situations, as well as to show what is available

- If a social care workers assessed an individual and their needs were in relation to their weight and mobility issues associated with that, then recording and sharing this information with emergency services could assist organisations in emergency situations, which does not currently happen as a matter of course
- Ensuring the relevant people were aware of groups/meetings to ensure multi-agency involvement
- Developing an appropriate care pathway for this group, to ensure they receive the right care and support when needed
- A data sharing protocol (agreed between all organisations), specific to this group would ensure information is shared respectfully and confidentially between organisations

Other issues discussed

- There needs to be a way of identifying and supporting people before they become isolated and their weight increases to this level
- The obesogenic environment needs to be considered, particularly for certain groups such as people who are physically disabled or those with learning difficulties
- There needs to be psychological support available for people who are isolated due to their weight
- It is important to raise awareness of the healthy weight services available to people in Rotherham, particularly with professionals who may come in to contact with individuals on a day to day basis – to encourage use of services
- It was also noted that this group are usually relatively young (under 65) and if they cannot be looked after in their own home for any reason, there are very few places for them to go; there is very little residential provision for the under 65s in terms of physical disabilities

4.3.2 Individuals

Two interviews took place with individuals in the community, their views and experiences were gathered by a face to face interview with an elected member (member of the review-group) which was scribed, and one interviewee also consented to a short video being made, which was also transcribed (the transcript of this is attached as appendix C). Their responses to the questions are summarised below:

- Interviewees' experiences of accessing care services was generally positive
- Having appropriate equipment in a person's home, such as a hoists, specialist beds, slide sheets and hand/support rails, are essential for promoting independence and quality of life
- Simple things such as easy access to a telephone are hugely important when a person is not very mobile, so that they are able to contact services/support when needed
- Other adaptations are also a huge benefit, such as having French doors fitted to enable easy access in and out of the house (due to larger wheelchairs etc), which is also a benefit to emergency services (ambulance/fire services)
- Pressure areas were suggested as more of a problem to one individual following a stay in hospital
- Being unable to get out of the house unaided hugely affects quality of life; always relying on assistance of other people getting into a wheelchair or out of the house for example meant everything has to be arranged in advance, leaving individuals isolated at times and unable to be "spontaneous"
- Getting out and about if they wished to was suggested as difficult due to cost of transport and leisure activities, although one had received support from RIO, they felt that if they didn't lose weight they would be "knocked" off the course

Obtaining the views of individuals was seen as an important element to this review, however because of the difficulties presented in gaining consent, it was not possible to interview more than two individuals. The main difficulty for this particular review was the lack of a patient-representative group which would have given the review-group a forum to contact individuals. The review-group have subsequently sought advice from NHS colleagues in relation to contacting individuals and aware that there are certain protocols and procedures which they need to follow and will consider other potential options when undertaking future reviews of this nature.

5. RECOMMENDATIONS

Based on the findings set out above, the review-group developed a set of recommendations to address some of the issues which have been presented. It was agreed that to accurately reflect the findings, the recommendations needed to be divided into three elements: service improvement, securing commitment and prevention.

An action plan for the recommendations is presented as appendix D to this report.

5.1 Recommendation 1) Service Improvement

This is the main recommendation resulting from the review, it was decided that there were a number of specific tasks needed to improve service coordination and information sharing, however there needed to be further consideration by the relevant representatives of organisations to look at how these could best be delivered.

In consultation with colleagues in NHS Rotherham, it was agreed to establish a one-off multi-agency negotiation session with key officers to create a 'SMART' action plan to implement the specific tasks being recommended by the review. This would need to include timescales, lead roles and reporting mechanisms and to report back to the Health Select Commission the best way to implement the actions.

This group would be asked to consider the following sub-recommendations:
a) To develop a one-page tick-box form to obtain consent from individuals to share information and ensure professionals received appropriate training on how to use this
b) To develop protocols for joint working and local data-sharing specific to this group of people.
c) To consider options for centrally coordinating this agenda, either through an appropriate central coordinator post or central database/ or way of sharing information
d) To look at options for providing briefings for professionals to raise awareness of the range of services available locally for this target group of people

5.2 Recommendation 2) Securing Commitment

The second recommendation was to ensure commitment to this agenda through Cabinet and the Health and Wellbeing Board, asking them to take a lead in securing commitment to action on recommendations and receive monitoring of implementation reports through an appropriate forum.

It was noted through the review that an NHSR led obesity strategy group was already up and running. It is being recommended that further exploration of whether this group could take the lead for this agenda and provide regular reports back to the Health Select Commission and/or Health and Wellbeing Board as appropriate, as part of their existing reporting mechanisms.

5.3 Recommendation 3) Prevention

The scope of this particular review was to look at individuals with a high BMI and to support them through appropriate service provision to help improve their quality of life. However, undertaking the review and speaking to various experts and professionals in this field, it was clear that the prevention agenda needed to remain a strong focus and it was important not to lose sight of this. It is therefore being recommended the Health and Wellbeing Board agree a joined-up approach to tackling obesity in Rotherham, to ensure continuation of the successes made on the prevention agenda so far. It is also important to acknowledge that treatment and prevention need to work together and ensure that this features as a high priority in the joint Health and Wellbeing Strategy.

6. RETURN ON INVESTMENT

The CfPS programme was funded by the Department of Health to look at the value of doing scrutiny and come up with recommendations for developing a rate of return on investment of scrutiny reviews.

Producing a calculation for the rate of return proved difficult for this topic as there were a range of complex issues and potential costs associated with this issue and this meant it was difficult to suggest where the scrutiny review could really add value in terms of cost savings. An attempt to demonstrate the value of the review and recommendations is presented in the table below which shows potential impacts, savings and benefits in relation to the main recommendation around service improvement.

Recommendation 1. Service Improvement	**Potential Impacts/Benefits/Savings**
a) Develop a one-page tick-box form to obtain consent from individuals to share information	• organisational benefits/savings from better co-ordination using a paper form-based system plus a co-funded co-ordinator • savings from single rather than multiple assessments
b) Develop protocols for joint working and local data-sharing specific to this group of people.	• New /improved range of inter-agency contacts and ways of working • Greater awareness of issue at agency level • Multi-agency influence on budgets and workplans/priorities, resulting in efficiency savings
c) Consider options for centrally coordinating this agenda, either through an appropriate central coordinator post or central database/ or way of sharing information	• Improved service user experience and dignity through having a single point of contact • Better coordination of services by having a single contact to ensure continued joint working and savings from duplicated and/or inappropriate deployment of services
d) Briefings for professionals to raise awareness of the range of services available locally for this target group of people	• Improved quality of life score for individuals, through being supported to access more services available to them

However, what was noted was how the act of undertaking the review had created a platform for various representatives of organisations to discuss the potential issues and make contacts to help improve coordination of their services. This was seen as a huge value in doing scrutiny reviews and although difficult to quantify, it was still an extremely valuable outcome.

It was also suggested that through better coordination of services and better data/information sharing, a number of potential benefits and cost savings could be gained, although these would be long-term and difficult to relate directly to the undertaking of the review:

- Potential savings from wasted/duplicated call outs from ambulance/fire services
- Potential savings from lift injuries to fire and ambulance services
- Better system and pathway of care across all agencies could result in efficiency savings
- Potential bed days saved and the costs associated with that, through a better system and pathway of care to enable appropriate discharge from hospital

7. REFLECTION ON REVIEW MODEL

The review was undertaken to test out a model of doing scrutiny reviews, as well as to look at an issue which would be beneficial to Rotherham. A summary of the review-group reflection is therefore presented below which highlights some areas of potential good practice for undertaking future scrutiny reviews, as well as some of the issues.

7.1 What went well?

- The stakeholder event was a positive experience with good representation across all relevant organisations
- The session was innovative and an opportunity to fully explore potential issues and draw out areas for the review-group to look at
- The session was also an opportunity to help scope the review, which is not usually done and enabled partners to come together in a common environment to discuss issues and possible solutions

7.2 What could have gone better?

- Access to ‘real’ people/service users was a problem for this review and resulted in only one interview taking place
- There were ethical issues which needed to be explored further with the relevant officers from various organisations

7.3 Learning from this review

It has been agreed that the scope of reviews in relation to health and wellbeing will be taken to the Health and Wellbeing Board in future, to assist getting buy-in from all partner organisations – which may help ensure approval and support when contacting relevant officers and managers for reviews in future. A number of the issues highlighted above, such as accessing ‘real’ people and service users, ethical issues and the role and purpose of a scrutiny review, will also be raised at the Health and Wellbeing Board to help scrutiny built strong relationships with the relevant partners in the future.

The review model tested by this scrutiny review has also been acknowledged by the members as good practice for future reviews of a similar nature. The members of the review-group have suggested that various elements of the model could be used as and

when it makes sense to use them and where they may add value, such as prioritising topics, impact statements and holding a stakeholder session.

The findings of this review were presented at an Action Learning event which took place in London on 3rd February, which was led by the Centre for Public Scrutiny. This event was an opportunity to share learning from each of the development areas and talk through some of the potential issues of undertaking scrutiny reviews in relation to health. The outcome of this event will be published in a document mid-2012.

8. THANKS

The review-group would like to thank all the professionals who took part in this review, through either completing the electronic questionnaire or attending for interviews. A special thank you also to the individuals in the community who gave consent to be interviewed. This review would not have been possible without the support and views given by all those involved.

The members would also like to acknowledge the hard work of the professionals working in this area and hope the agenda continues to develop through the implementation of their recommendations and the continued support of staff within all organisations.

9. CONTACT

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Appendix A – Impact Statement

Issue 1. Obesity – BMI >50

Questions to consider:

- How could you measure this?
- How could you measure the Marmot readiness indicator?
- Are measures / information available – very, reasonably or scarcely?
- How much influence do you think the review could have – High, Medium, Low.
- How could you structure dissemination to have most influence?

Key questions	Responses
Giving every child a good start in life?	NA
Enabling all children, young people and adults to maximise their capabilities and have control over their lives?	It is likely that within a few years, being overweight or obese will overtake smoking as the major cause of preventable ill health. Obesity is an important risk factor for many chronic diseases, including heart disease, stroke and some cancers. It is a major cause of Type 2 diabetes and the psychological and social burden of obesity can be significant. Social stigma, low self-esteem and a generally poorer quality of life are common experiences for many overweight and obese people. Severely obese people are likely to be completely dependent on carers for all or most of their daily activities We have data relating to the whole of Rotherham by age group, however we have a lack of data at a lower Area Assembly/Ward level. We could try and get the data from GP's/NHS Rotherham. The Lifestyle survey area is available for the NRS target areas, ie. Deprived areas Data is available for those with BMI over 50 – would need to establish if they could be contacted This could make a big impact as the figures are high for obesity in the future. If we could reduce the figure by 10% for 2050 this will be 28,000 fewer obese people.
Creating fair employment and good work for all?	Likely to be out of work – tackling this issue and working to prevent obesity could have an impact on getting people into employment – but this is potentially a long-term outcome. 'Prevention' of overweight and obesity could help prevent people going off on long-term sick in the first place – this could be measured through the economic plan and specific indicators relating to worklessness

	Low impact initially for this review – as it is a longer-term outcome
Ensuring a healthy standard of living for all?	Could measure % of overweight/obese people on means tested benefits - This data could be gathered reasonably, based on the known individuals with a BMI over 50 Medium impact – could support those not receiving benefits to access and take them up, improving their quality of live. Ensuring all people with high BMI receive care services
Creating and developing healthy and sustainable places and communities?	
Strengthening the role and impact of ill health prevention?	This topic can be measured by deprivation and income levels, as the higher the level of economic deprivation the more likely people are to be obese. There is a lack of data at ward/SOA level which may be difficult to get hold of – although those with a BMI + 50 are known and could be contacted. Prevention interventions in these areas of deprivation could have a high influence and impact.
What ideas do you have about how you will measure the difference made by your scrutiny review?	Could influence more support and advice for those with severely high BMI levels – to help then reduce their weight and enable them to participate in society. Prevention at earlier stages of obesity to prevent people's weight rising – particularly focusing on area of deprivation, where they may be more likely to have a higher BMI. Could be measured by numbers of BMI + 40/50 in deprived areas Helping people to manage conditions associated with obesity; diabetes for example, could relieve pressure on services
What do you think would be the value of doing the review? High, medium, low.	Although only a small number of people across the whole borough – the impact could be high Could potentially look at ways of preventing these higher BMI rates in the first place and look at specific issues which these people face and how best to tackle and support them

Appendix B – Scoring Matrix

Impact considerations for each topic shortlisted

Impact considerations	**Topic 1 (obesity)**	**Topic 2 (Mental health & Alcohol use)**	**Topic 3 (Drug use in young people)**
How high a priority is the topic within the JSNA? High, medium or low	**High** – obesity as a whole features strongly as an issue	**High** - For mental health broadly Alcohol specifically – not featured (but this could be a gap)	**Low** - This topic does not figure highly in the JSNA (which may indicate a gap in the JSNA)
How available are measures and Info (Very, Reasonably or Scarcely)	**Very** – lots of work already in relation to obesity issues and specific interventions	**Scarcely** for alcohol specific issues linked to mental health – would need more work to establish what is available	**Scarcely-reasonably** for some data and measures **Very** - available for NEETS info and data
How much influence is the scrutiny review likely to have? High, medium or low	**High** – although lots of interventions and work already going on, there is nothing focusing on those which BMI 50+	**Low** – due to the issues, complexities and nature of this type of review	**Medium** – although an important issue, not sure of the impact which would be made
Overall, what is the likely value of the review (High, medium or low)?	**High**	**High -** If a larger review could be done **low** In this instance	**Low** - Potentially too broad an issue to add real value

Appendix C – Transcript from interview with individual in the community

I = Interviewer
P = Participant

I. Ok [name] tell me about what experience you have of accessing health and social care services
P. Well actually I haven't had much problems at all, I just get on the phone and ring numbers that I want, and they've always been quite good with me
I. and what about if you have to go into hospital, what happens then?
P. Now this is where I'm waiting now for an ambulance, cos they have to find me the bariatric ambulance
I. Ok, what's a bariatric ambulance Audrey?
P. It's for people over 25 stone, well 25 plus I think it is
I. Ok then, and so what happens when the ambulance gets here?
P. They are very good, they generally come and they use, bring their thing in and use a slide sheet to slide me from one bed to other
I. To the trolley, and is that, are they careful to cover you?
P. They are very careful, they cover me with, it's all done…I'm never uncovered at all.
I. That's wonderful isn't it, does it hurt you at all to be transferred like that?
P. I get…yes, but there's no other way of doin it
I. Ok, and what happens when you get to the hospital end?
P. Exactly the same thing, I, but I have not told you but sometimes they send for another ambulance so they have four people here instead of two. So, they are quite good
I. Oh that's really good, and then, so you're going into hospital this afternoon are you?
P. I am, in going in next, I should imagine, couple of hours
I. Ok and do you know which ward you're going on to?
P. No, I haven't a clue.
I. So do you think you're going to the accident and emergency?
P. I will go in that end yes, but they generally find me a ward by the time I get there
I. Ok, and how do you find it on the ward?
P. They've always been very good with me, I've not, never had no problems
I. Ok, and what happens to your care package when you go into hospital?
P. Er, it is always put to one side and I've always got the same girls back after, because there's always that chance…
I. that what?
P. That they've changed the carers when I come home, but otherwise it's just more-or-less same, they just come in for me when…
I. So do you see the social worker, do they help with the discharge?
P. Do you know, I don't know, I think hospital just ring [care provider] and let them know that I'm coming home

Appendix A RECOMMENDATIONS

	Recommendation	Purpose	Lead	Completion Date	Review Date
1. Service Improvement					
	Establish a negotiation session to create a 'smart' action plan to implement the recommendations of the review, including timescales, lead roles and reporting mechanisms and to report back on this session to the Health Select Commission	To consider the recommendations of this review, looking specifically at a,b,c & d below and consider the most appropriate reporting route to ensure implementation (i.e. obesity group) To further explore options for coordination between services and information/data sharing	NHSR Obesity Lead & Scrutiny Officer	**April 2012**	**January 2013**
a)	Develop a one-page tick-box form to obtain consent from individuals to share information and ensure professionals receive appropriate training on how to use this *Or, consider rolling out and promoting more widely the previously developed bariatric risk assessment form* *Consider options to include as part of HotSpots assessment*	To enable data and information sharing between organisations	Joint Liaison Group to consider; could be role of Central Coordinator post	**April 2012**	**January 2013**
b)	Develop protocols for joint working and local data-sharing specific to this group of people.	To ensure key data and information is shared appropriately between organisations to enable better service provision, care and support for individuals within the community, as well as better	Joint Liaison Group to consider who should lead this	**June 2012**	**January 2013**

		coordinated and therefore more cost effective service delivery. An agreed protocol would ensure data is shared respectfully and with a common purpose; being mindful of confidentiality.			
c)	Consider options for centrally coordinating this agenda, either through an appropriate central coordinator post or central database/ or way of sharing information *Note: this does not need to be a new post, but for options to be considered to add this to an existing, appropriate post where resources would allow*	To ensure this agenda continues to develop and provides a single point of contact for individuals and professionals to ensure all aspects are coordinated	Joint Liaison Group	**June 2012**	**January 2013**
d)	Briefings for professionals to raise awareness of the range of services available locally for this target group of people	This would ensure whoever goes into an individuals home is able to talk to them about other services which may be of benefit or interest to them	Joint Liaison Group to consider options for leading this work	**Ongoing from March 2012**	**March 2013**
2. Securing Commitment					
a)	For Cabinet and the Health and Wellbeing Board to take a lead in securing commitment to action on recommendations and receive monitoring of implementation reports through an appropriate forum, i.e. NHSR led obesity group	To raise awareness across all organisations, implement the recommendations and monitor improvements	Chair of Review Group and lead Scrutiny Officer to report to Cabinet/HWBB	**May 2012**	**April 2013**
b)	Report to go to Improving Lives	To raise awareness in terms of prevention of obesity (specifically	Chair of Review Group and lead	**May 2012**	**April 2013** (to be

		in children – following on from the obesity review)	Scrutiny Officer		reviewed through Health Select Commission in the first instance)
3. Prevention					
	To agree a joined-up approach to tackling obesity in Rotherham through the Health and Wellbeing Board, acknowledging that treatment and prevention need to work together (i.e. treatment of overweight, should be seen as bariatric 'prevention') and ensuring this features as a high priority in the joint Health and Wellbeing Strategy	To ensure a continued focus on obesity prevention in children and young people to prevent them becoming obese adults, and to ensure that adults receive obesity prevention support as well as the bariatric treatment needed.	Health and Wellbeing Board	**June 2012 (in line with the development of the local strategy)**	**April 2013**

ROTHERHAM METROPOLITAN BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**HEALTH SELECT COMMISSION**
2.	**Date:**	**8 March 2012**
3.	**Title:**	**Tobacco Control Update**
4.	**Programme Area:**	**Public Health**

5. Summary

RMBC will have responsibility for delivering a comprehensive tobacco control strategy from April 2013, a part of the transfer of Public Health under the Health and Social Care Act. This presentation gives Health Select Commission members an update on the current key tobacco control issues in Rotherham and the performance of NHS Stop Smoking Services.

6. Recommendations

- **That the Commission note the presentation's content and provide views and comments on the Tobacco Control programme in Rotherham**

- **That the Commission make a response to the consultation on plain packaging when launched**

- **Members of the Commission are invited to play an exemplar role in the implementation of the Tobacco Control programme and enlist the support of fellow elected members, the communities you represent, voluntary and community organizations and business leaders to take forward the Tobacco Control agenda.**

7. Proposals and Details

Background

Tobacco control remains a key public health priority at a local and national level. It is estimated that 23.9% (10/11[1]) of the Rotherham adult population smoke. This is higher than the national average, 20.7% and the Yorkshire and Humber average, 22.8%. As in other areas, smoking is Rotherham's single greatest cause of preventable illness and early death.

The Department of Health's (DH) vision is to reduce the prevalence of smoking amongst adults to 18.5% by 2015[2]. Achieving this ambitious target requires a comprehensive tobacco control strategy including not only clinical interventions (such as effective stop smoking support for patients) but also economic, legislative and environmental action together with partnership working on the tobacco control agenda. In 2011 the DH published a new national Tobacco Control Strategy – Healthy People, Healthy Lives, A Tobacco Control Plan for England, which outlines a comprehensive approach to tobacco control aimed at reducing the number of deaths from smoking related diseases and substantially reducing healthcare costs associated with smoking including inspirational targets and six key actions.

Table 1: Healthy People, Healthy Lives – A Tobacco Control Plan for England

Three Strategy Themes and Aspirational Targets	Six key actions to meet the Government's aspirational targets
1. Reduce smoking prevalence among adults in England. *To reduce adult (aged 18 or over) smoking prevalence in England to 18.5% or less by the end of 2015.*	*1. Stopping the promotion of tobacco* - Implement the tobacco display provisions in the Health Act 2009 for large shops from April 2012 and for all other shops from April 2015. - Continue to defend tobacco legislation against legal challenges by the tobacco industry, including legislation to stop tobacco sales from vending machines from October 2011. - Encourage local areas to consider action to further protect young people from exposure to smoking so they do not see it as normal behaviour, reducing the likelihood of them becoming smokers. *2. Making tobacco less affordable* - Continue to follow a policy of using tax to maintain the high price of tobacco products at levels that impact on smoking prevalence. - Support the development of evidence-based marketing campaigns by local authorities to reduce illicit tobacco use in their communities. *3. Effective regulation of tobacco products* - Encourage and support the effective local enforcement of tobacco legislation, particularly on the age of sale of tobacco products. *4. Helping tobacco users to quit* - Provide stop smoking services that are tailored to the needs of their communities and reach out to people from high smoking prevalence groups, in particular, people with routine and manual jobs.
2. Reduce smoking prevalence among young people in England. *To reduce rates of smoking among 15 year olds in England to 12% or less by the end of 2015.*	
3. Reduce smoking during pregnancy in England.	

To reduce rates of smoking throughout pregnancy to 11% or less by the end of 2015.	*5. Reducing exposure to second-hand smoke* - Encourage smokers to change their behaviour so that they do not smoke in their homes or cars. *6. Effective communications for tobacco control* - Motivate tobacco users to think about quitting. - Encourage communities to see not smoking as the norm.

Tobacco control and local councils - lead strategic role from 2013

From 2013 local councils will take a lead strategic role in improving tobacco control in their communities as they have been granted "direct responsibility for tobacco control in a public health context, as well as enforcement and regulation."[3] This strategic responsibility means that councils play a fundamental role in taking forward tobacco control action required to drive down smoking prevalence. This is mainly due to their powers of enforcement, networks of existing services and partnerships, comprehensive knowledge of local communities and multiple direct contact points with local residents.

The local authority public health function will have responsibility for the smoking-related indicators within the public health outcomes framework[4]. These indicators are:

- Smoking status at the time of delivery
- Smoking prevalence – 15 year olds
- Smoking prevalence – adult (over 18s)

Current tobacco control activity in Rotherham

Rotherham follows the World Bank's six strands for effective tobacco control:

1. stopping the promotion of tobacco
2. making tobacco less affordable
3. effective regulation of tobacco products
4. helping tobacco users to quit
5. reducing exposure to secondhand smoke
6. effective communications for tobacco control

This paper will summarise current activity for each strand.

Stopping the promotion of tobacco

This strand of activity is largely delivered through national and international legislation which has, to date, banned all tobacco advertising, sponsorship of sporting events and advertisements larger than A5 size within shops, pubs and clubs. Legislation will also result in the point of sale display ban with tobacco products being hidden from sale in large stores from April 2012 and smaller shops from April 2015.

Promotion, as opposed to advertising, still exists through the media's publishing of photographs of celebrities smoking, and characters in film and television programmes as smokers.

Tobacco companies can also promote their products at commercial events such as music festivals/concerts if they enter a deal with the organisers to be the sole

supplier to that event (Imperial Tobacco has been the sole supplier the Leeds music festival). They are also increasingly using social media to promote their products without actually advertising.

Cigarette packets remain the main form of promotion of the tobacco companies' brands; as a result increasingly sophisticated packaging has been introduced to tempt consumers, particularly young people, to purchase particular brands. A consultation is due to be launched in spring 2012 about the introduction of plain packaging of tobacco products in England. The aim of the proposal is to reduce uptake of smoking among young people, rather than reducing the prevalence of adult smokers. Australia is the only country to have introduced such legislation and plain packs are not due to be introduced there until December 2012.

Stopping the promotion of tobacco products is linked in the national plan with preventing the uptake of smoking by children and young people. Approximately 8% of 11-15 year olds in Rotherham are 'regular' smokers (smoke daily or weekly)[5]. Studies have shown that young people who smoke repeatedly attempt to quit and around 70% of young smokers express a desire to stop shortly after taking up the habit. The Local Government Group[3] recommends that local authorities should place an emphasis on preventing all young people from taking up smoking. Evidence also shows that children in lower social classes start to smoke in greater numbers and at an earlier age than those from higher social classes, and therefore services should prioritise these young people.

Local policy to reduce the number of young people who smoke includes action to enforce the age of sales legislation (from 16 to 18 years of age) and restrictions on where tobacco is sold. All Rotherham secondary schools are encouraged to run the Smokefree Class activity with their year 7 and 8 pupils each year and participation to date has been high. A new Smokefree Class resource for primary school children is in development. All school nurses are trained so they can support pupils to quit, although there is little evidence that stop smoking interventions for young people are effective.

Making tobacco less affordable

This strand requires a combination of national and local action. Duty rates on tobacco products are set by Government and there is evidence that increased prices are effective at reducing prevalence. Young people, pregnant women and people from lower socio-economic groups are particularly sensitive to price.

However, duty increases and impact of high tobacco pricing can be undermined by the availability of cheap and illicit tobacco. Illicit tobacco is currently available in our communities at less than half the price of their duty paid equivalent. Children and young people frequently access cheap and illicit tobacco as it is unregulated; they are particularly likely to access 'fag houses' where sellers are not interested in age of sale legislation and will sell single cigarettes. Counterfeit products often contain high levels of contaminants and levels of chemicals far higher than are found in standard cigarettes – some contain up to six times the levels of lead and three times the level of arsenic.

The sale of cheap cigarettes is often seen as a 'Robin Hood' crime; however, we are not talking about people bringing some additional packs of duty free cigarettes back from their holiday and selling to family and friends, but large scale manufacture of

counterfeit tobacco products and import of illicit tobacco. This is often carried out by organised gangs and brings criminality and antisocial behaviour into communities. More deprived communities are often targeted, which contributes to health inequalities.

Trading Standards and HM Revenue and Customs (HMRC) lead the action to tackle cheap and illicit tobacco in the community. Public health works with Trading Standards locally in promotion of the service and tip line. There is potential for joint commissioning of publicity around cheap and illicit tobacco across South Yorkshire.

Effective regulation of tobacco products

Trading standards teams lead on the regulation of tobacco products. There are several aspects to this work:

- Tobacco products sold in the UK must adhere to certain standards. Trading Standards can carry out routine and reactive action to check whether tobacco products are genuine or counterfeit, seize counterfeit products and prosecute offenders.
- Tobacco products cannot be sold to anybody aged under 18 years. Trading Standards carry out test purchase activity on a routine and reactive basis. Retailers can be prosecuted for underage sales. Rotherham retailers have had good adherence to test purchasing, with low failure rates.
- Selling tobacco from vending machines was made illegal on 1 October 2011. All existing machines had to be put out of use from that date, even if they were not removed. Rotherham Trading Standards has stated adherence to this legislation has been high.

Rotherham Trading Standards regularly seizes counterfeit or smuggled cigarettes and hand rolling tobacco from retail outlets and private addresses across the borough. In one six-month period over 3000 packs of cigarettes or tobacco were seized. Larger seizures are the responsibility of HMRC.

Helping tobacco users to quit

This year (2011-12) the Strategic Health Authority (SHA) set NHS Rotherham a target of nearly 3,000 smoking quitters. As four referrals are required to achieve one quitter, 12,000 referrals are needed to achieve the SHA target. 12,000 referrals represent 25% of all the smokers in Rotherham. To put these numbers in some context only about 6% of smokers access NHS Stop smoking services each year.

Furthermore nicotine is recognised as an addictive drug. The Royal College of Physicians describe cigarettes as *"….. highly efficient nicotine delivery devices and are as addictive as drugs such as heroin or cocaine*." [6]

To illustrate just how addictive nicotine is, consider the following statistics:

- 60% smoke again post MI (40% within 2 days)[7]
- 50% smoke again post Laryngectomy[8]
- 50% smoke again post Pneumonectomy[9]
- 80% women do not stop smoking during pregnancy[10]

Stop smoking interventions represent extremely cost effective ways of reducing ill health and prolonging life. The cost of the most expensive stop smoking intervention

(specialist service) comes out at £873 per life year gained, compared to the cost of a typical medical intervention of £17,000 per life year gained (Thorax,1998)[11]. As there is a large smoking gradient across the social classes (i.e. smoking rates are much higher among lower socio economic groups) stop smoking interventions also offer a way of reducing health inequalities.

NHS Rotherham commissions stop smoking services from Rotherham NHS Stop Smoking Service (RSSS) and via a Locally Enhanced Service (LES), provided mainly GP practices and a smaller number of pharmacies and dentists.

RSSS is a highly accessible service, it provides stop smoking support via:

- Quit Stop (16 Bridgegate, Rotherham)
- Stop Smoking Centre (Rotherham Hospital)
- A dedicated service for pregnant women
- A dedicated telephone service (most of which is out of hours)
- One to one and group sessions across Rotherham (including out of hours)

It also:

- Trains and supports the network of Locally Enhanced Service advisors
- Supports others across the health community to deliver stop smoking interventions
- Delivers a range of promotional activities
- Manages the reporting of stop smoking data, including DH mandatory reports

Since 2004 the number of quitters delivered by RSSS has doubled; at the same time the number delivered by the LES has nearly trebled. Last year (2010-11) Rotherham achieved the third highest number of quitters per 100,000 of population in the region, delivering well over the England and regional averages. Taken together RSSS and the LES delivered nearly double the SHA target and exceeded the local PCT Stretch target.

RSSS also delivered the second highest number of pregnant women quitters in the region, an achievement the service is very proud of. Only Sheffield delivered more, however Sheffield has double the number of pregnancies. Therefore Rotherham delivered a far higher number of quitters per pregnancy.

The budget allocated to RSSS in 2010-11 was £586,000 (DoH Information Centre 2011). The cost per quitter came in at £222, just over the national average of £220. However the Information Centre calculate cost per quitter by dividing the local stop smoking service (LSSS) budget only (the LES budget is not included in the DH return) by the number of LSSS and LES quitters. Therefore as the ratio of LSSS to LES activity may vary considerably between PCTs this metric is not a reliable measure of the relative cost effectiveness of each LSSS. The figures also do not take account of the cost of medication.

It's also worth noting that there is considerable variance in NHS Stop Smoking Service budgets, the budget for Hull Stop Smoking Service for the same period was £1,359,000 (a town with a similar sized population to Rotherham).

Reducing exposure to secondhand smoke

Rotherham's smokefree homes and cars programme was launched in the summer of 2008 and now has more than 4700 homes signed up. The scheme highlights the risks of secondhand smoke to children, friends and family members as well as the increased fire risk associated with smoking in the home (cigarettes are the main cause of fatal house fires). People who sign up to the scheme to make their home and car smokefree are also offered a referral to stop smoking services and a free home safety check from South Yorkshire Fire and Rescue. The Smokefree Homes project is delivered through a partnership approach with children's centres, health visiting, Rotherham NHS Stop Smoking Service and South Yorkshire Fire and Rescue among the partners who promote the scheme.

Children who live with smokers and who are exposed to smoking in the home see it as a social norm, and are more likely to become smokers themselves. This likelihood increases with the number of smokers in the household.

De-normalising tobacco use: Social Norms Programme
The Yorkshire and Humber Directors of Public Health Network has approved the development of social norms initiative as part of a comprehensive approach to reducing smoking prevalence. The social norms programme aims to strengthen the Smokefree community norms in the region, increase the proportion of Smokefree homes and increase the long term quitting success rates at 12 months.

International evidence shows that strengthening positive attitudes and behaviour around not smoking and Smokefree environments at a community level, encourages young people not to start smoking, protects non-smokers, especially children from the harm caused by passive smoke. Furthermore it sustains the motivation of ex-smokers to stay stopped.

Rotherham is one of a number of pathfinder areas in the Yorkshire and Humber Region to take part in the programme. Locally this work is shortly to start with the development of a Community Stakeholder Group in Treeton. A community coordinator will be appointed, hosted by Voluntary Action Rotherham, and will work with the existing community networks within the village to promote the campaign messages.

Effective communications for tobacco control

Communications and social marketing are required across all tobacco control activity. Nationally the Department of Health has recently re-started its tobacco marketing activity, although at a far reduced intensity than before. It will be running small scale campaigns throughout 2012/2013. Locally we have very limited funds to invest in marketing activity so the work tends to be focused around certain key times, such as New Year and National No Smoking Day. Activity includes face-to-face publicity in the town centre, Facebook and Google ads, infomercials on Rother FM and posters/displays in healthcare settings and schools.

Broader communications activity, including publicising case studies of people who have quit or made their home smokefree, schools-related activity, and the availability of support to quit continues throughout the year.

8. Finance

In addition to the cost to the NHS, smoking has a huge financial cost to society. Smoking is estimated to cost the NHS up to £5 billion each year, or 5.5% of the total NHS expenditure in 2005-6.[12]

Tobacco also impacts on the wider economy. Action on Smoking and Health (ASH) estimates that the total annual cost of tobacco to Rotherham's economy is £71.9 million, taking into account smoking breaks, smoking litter, house fires, passive smoking, sick days and output lost to early death, as well as the cost to the local NHS[13].

9. Risks and Uncertainties

If Rotherham does not continue to deliver a comprehensive tobacco control programme then we are unlikely to reduce smoking prevalence. The recent falls in smoking at delivery rates could be reversed and health inequalities could worsen. The risk to communities from illicit tobacco and those that smuggle and sell it would increase.

The local authority will have responsibility for delivering key aspects of the Public Health outcomes framework, including the three measures related to tobacco. The future health premium payment for local authorities is likely to be linked to achievement on the outcomes framework.

10. Policy and Performance Agenda Implications

Tobacco control remains a key priority in improving health and reducing inequalities. The comprehensive actions needed to reduce prevalence require sustained effort and resource commitments from the Local Authority, NHS Trusts and other organisations and partners if the potential benefits are to be experienced.

11. Background Papers and Consultation

1. Figures quoted are Integrated Household Survey 10/11 data. Please note that this is an experimental ONS dataset: http://www.lho.org.uk/Download/Public/16678/1/MA2009_MA%202010%20IHS_updateNov11.xls

2. DH (2011) Healthy People, Healthy Lives, A Tobacco Control Plan for England

3. Local Government Group (2011). Reducing health inequalities through tobacco control, a guide for local councils.

4. DH (2012) Improving outcomes and supporting transparency. Part 1: A public health outcomes framework for England, 2013-2016

5. Rotherham Young People's Lifestyle Survey, RMBC, 2011

6. Nicotine Addiction in Britain. A report of the Tobacco Advisory Group of the Royal College of Physicians, February 2000.

7. Bigelow GE, Rand CS, Gross J, Barling TA, Gotlieb SH. Smoking cessation and relapse among cardiac patients. In: Tims FM, Leubefeld CG (eds). Relapse and recovery in drug abuse. 1986; 167-171. NIDA Research Monograph. Rockville, MD:

US Department of Health & Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental health Administration, National Institute on Drug Abuse.

8. Himbury S, West R. Smoking habits after laryngectomy. Br Med J 1984; 291: 514-515.

9. Davison G, Duffy M. Smoking habits of long-term survivors of surgery for lung cancer. Thorax 1982; 37: 331-33.

10. Action on Smoking and Health. Fact sheet No. 7. Smoking, sex and reproduction. May 2004.

11. Smoking cessation guidelines and their cost effectiveness. Thorax 1998; Vol 53 Supplement 5, part 2, S11-S16

12. Tobacco Control (2009) Allender S Balakrishnan R Scarborough P Webster P Rayner M. The burden of smoking-related ill health in the United Kingdom. 0, 1-7.

13. ASH, The case for local action on tobacco www.ash.org.uk

12. Contacts

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Rotherham NHS Stop Smoking Service

Annual Report 2010-11

Simon Lister

Service Manager

Contents **Page**

Rotherham NHS Stop Smoking Service Mission Statement
To provide high quality and value for money stop smoking services to people who live or work in Rotherham.

Introduction
Smoking remains the largest cause of preventable illness and premature death in the UK, in Rotherham smoking results in about 500 premature deaths per year. Stop smoking interventions are proven to be both effective and cost effective ways of reducing illness and preventing premature deaths.

Aim of report
The aim of the report is to highlight the achievements of Rotherham NHS Stop Smoking Service (RSSS) over the last year and to consider the challenges currently facing the service.

RSSS is specialist service that provides support for anyone who lives or works in Rotherham. The service provides one to one, drop-in, group and telephone support. Sessions are delivered in a number of venues across Rotherham (including the Quit Stop in the town centre) during the day, evenings and Saturday mornings. The service also provides:

- A dedicated service for pregnant women and their partners
- A dedicated service within secondary care which includes the Stop Smoking Centre in the Rotherham Hospital foyer
- Training and support for a large network of intermediate advisors working predominantly in primary care.
- Brief intervention and very brief intervention training for staff across the health community
- Promotional work
- Data management for all specialist and Locally Enhanced Service providers

Service Objectives
Rotherham NHS Stop Smoking service is commissioned by NHS Rotherham. The service specification contains a number of very challenging objectives including:

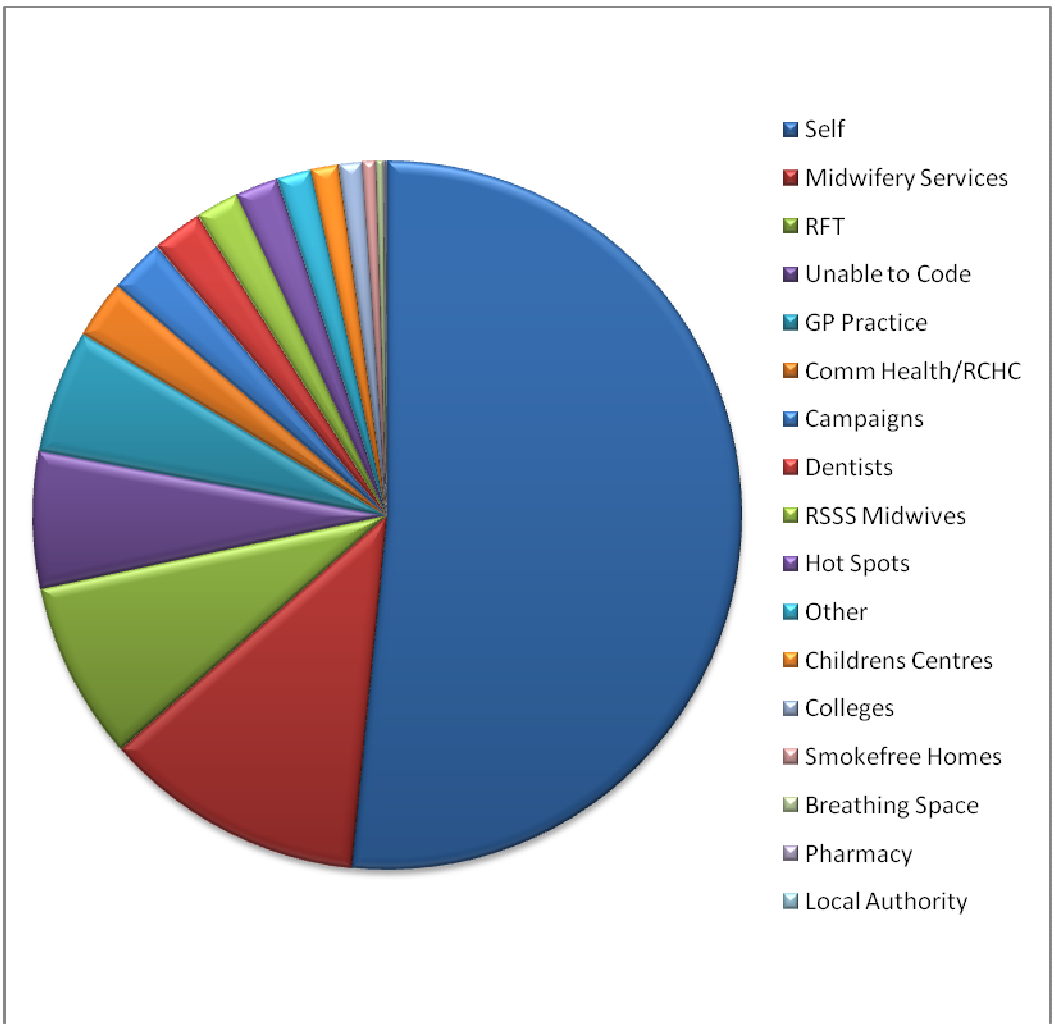
- Meet the specific 4-week quitter target (1,550/annum)
- Meet the specific pregnant women 4-week quitter target (160/annum)
- achieve an average of 50% conversion rate
- CO monitor 85% of patients who stop smoking
- Support the achievement of the LES target (1,000/annum)
- Contribute to the reduction of health inequalities by targeting specific groups e.g. routine and manual groups, pregnant smokers, young people, Black Ethnic and Minority groups (BME), patients suffering with mental health and deprived communities.

The service specification for 2010-11 contained significant financial penalties should the service not meet the 4-week quitter, pregnant women 4-week quitter and conversion rate targets. These penalties have subsequently been removed.

Performance Data

Referral source (N= 6,572 RSSS only)

The single largest referral source by far is 'self' followed by the midwifery service and the Rotherham NHS Foundation Trust (TRFT). The midwifery service has an opt-out referral system whereby all smoking pregnant women are referred unless the specifically ask not to be. Although GP practices account for the fourth largest source of referrals, previous audits have demonstrated a very large variance in referral rates between practices. Referrals from pharmacies and RCHS remain disappointing



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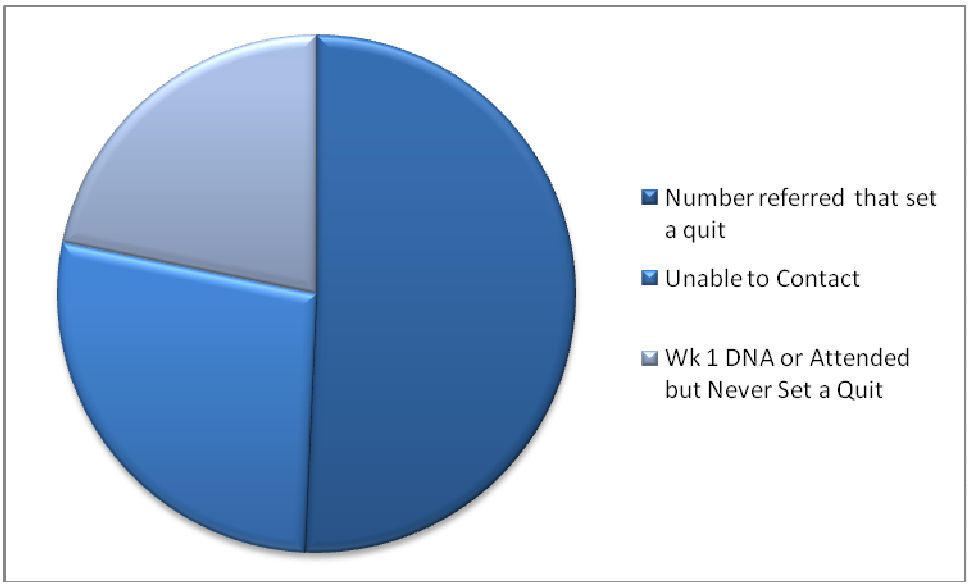
Ratio of referrals to quitters

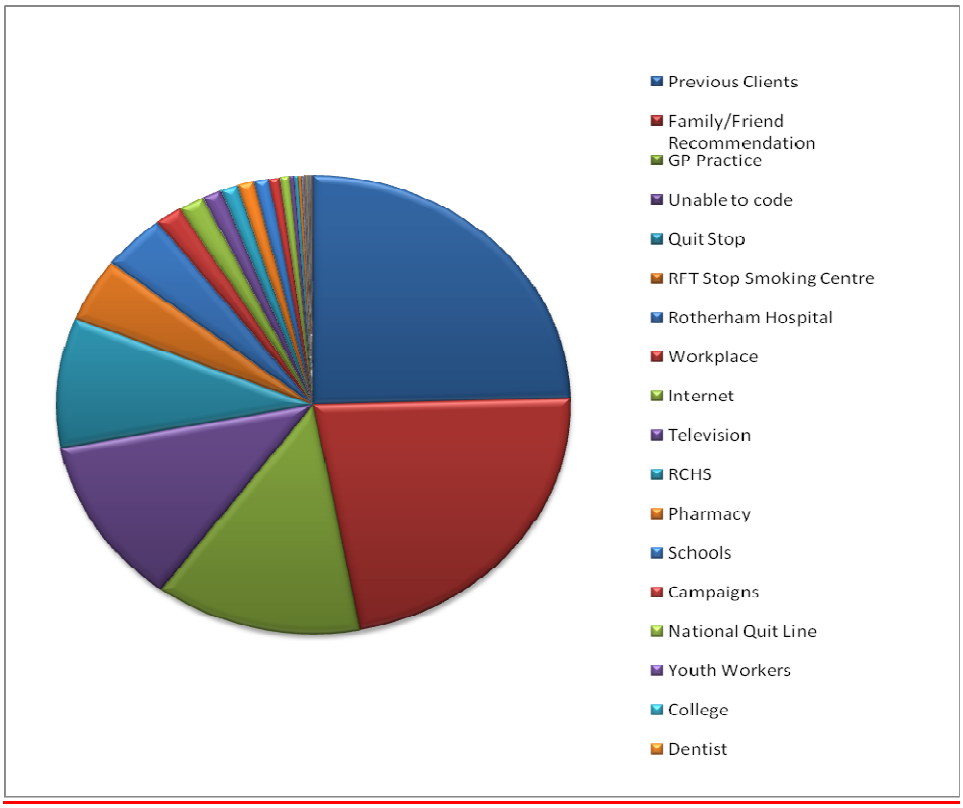
Of the 6,572 referrals received by RSSS, only about half (3,333) attended and set a quit date. RSSS was unable to contact 1,807 and a further 1,432 were contacted but did not attend or attended but did not set a quit date. RSSS needs to develop interventions to increase the ratio of quitters to referrals.

Since last year some progress has been made with this issue. RSSS has introduced digital pen technology and trained 28 out of 44 LES advisors to input data directly onto quitmanager (the services database). This has freed up some administration time (previously data was collected on paper forms and manually inputted onto the database) to facilitate the implementation of an improved referral management system. RSSS has also been working with the provider of quitmanager to develop a sophisticated referral management system and has developed a number of resources (letters and leaflets) that will mailed out to clients. It is intended that clients will also receive text message appointment reminders and it is hope that the system will be implemented early in the New Year.

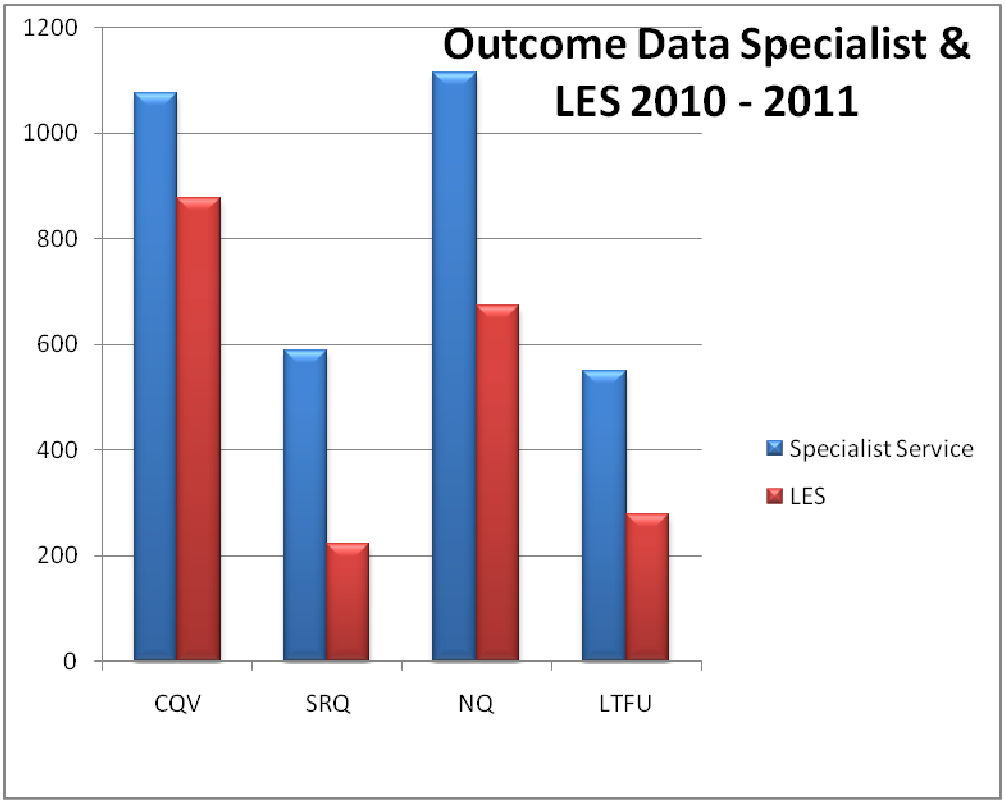


Self referral awareness source (RSSS only)

The main awareness source for self referrals are previous clients and friend and family, which accounted for nearly half of all awareness source. RSSS has recently introduced a 'member get member' scheme to maximise the number of referrals from this route. Self referrals that have found out about the service the Quit Stop and the Stop Smoking Centre in the RFT make a significant contribution to the total number of self referrals, the two 'shops' are therefore represent an important part of the service marketing. GP's make up the bulk of awareness source for the remainder of self referrals with some from RSSS internet and direct marketing campaigns.



Outcome data (all outcomes by specialist and LES)

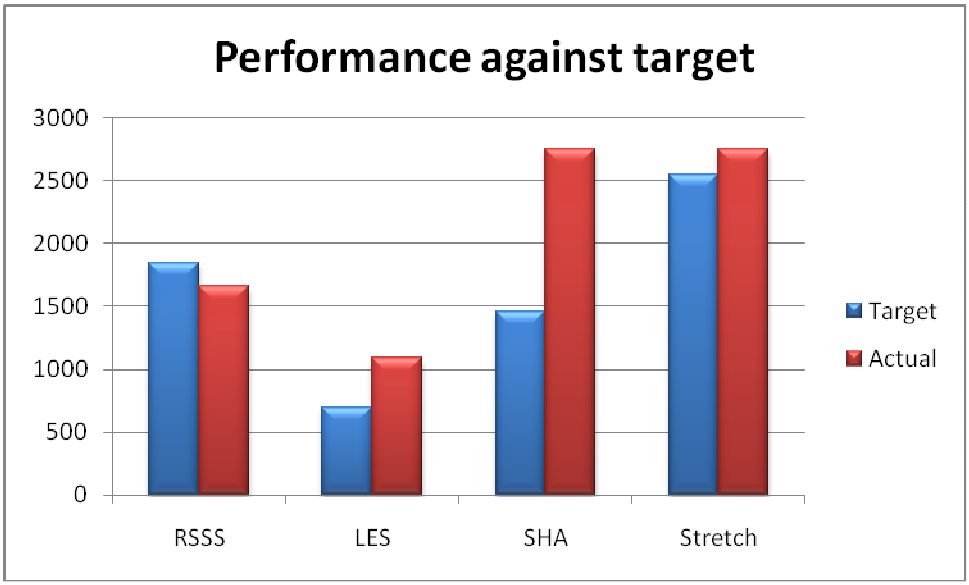


CQV = CO verified quitter, SRQ = Self report quitter,

NQ = Not quit, LTF = lost to F/U

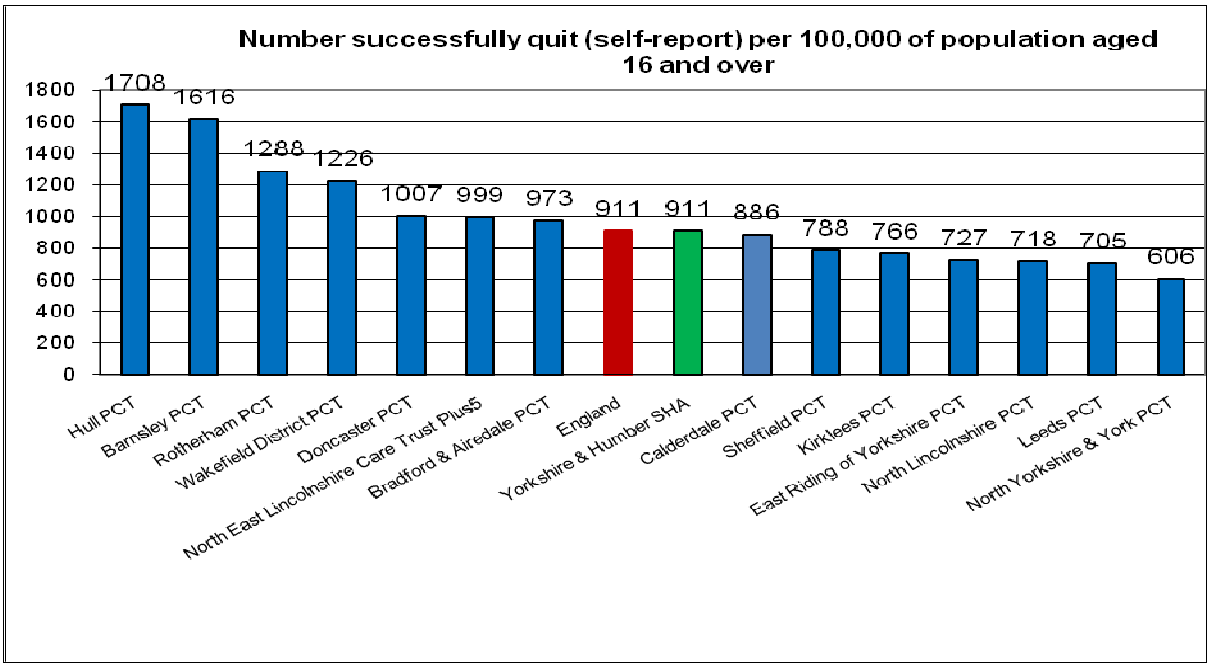
Overall quit rates in 2010-11 for RSSS and the LES were 50% and 53.4% respectively. RSSS quit rate has improved from 46.6 % in the previous year, the LES quit rate had decreased slightly from 57.7% in the previous year.
RSSS has a higher ratio of self report quitters than the LES 35% and 20% respectively. The probable explanation for this is that RSSS provides a dedicated telephone service whereas the LES provides face to face support only.
In 2009-10 RSSS had significantly higher 'Lost to Follow-up' rates (22% against 7%) than the LES. To address this RSSS introduced an initiative whereby follow-up was conducted by the out of hour's telephone service. In 2010-11RSSS reduced its lost to follow-up rates to 16.5% whereas the LES lost to follow-up rate increased to 13.3%.

Performance against target
RSSS failed to meet the local 4 week quitter target by 10% (1662 actual, against 1850 target), the LES exceeded its target delivering 1089 quitters against a target of 700. However in 2010-11 there was a reduction in RSSS advisor staff by nearly one third as temporary contracts came to an end and staff were not replaced. This was matched by a reduction in the number of RSSS quitters. Taken together the Specialist service and LES exceeded both the Strategic Health Authority and local stretch 4 week quitter targets.

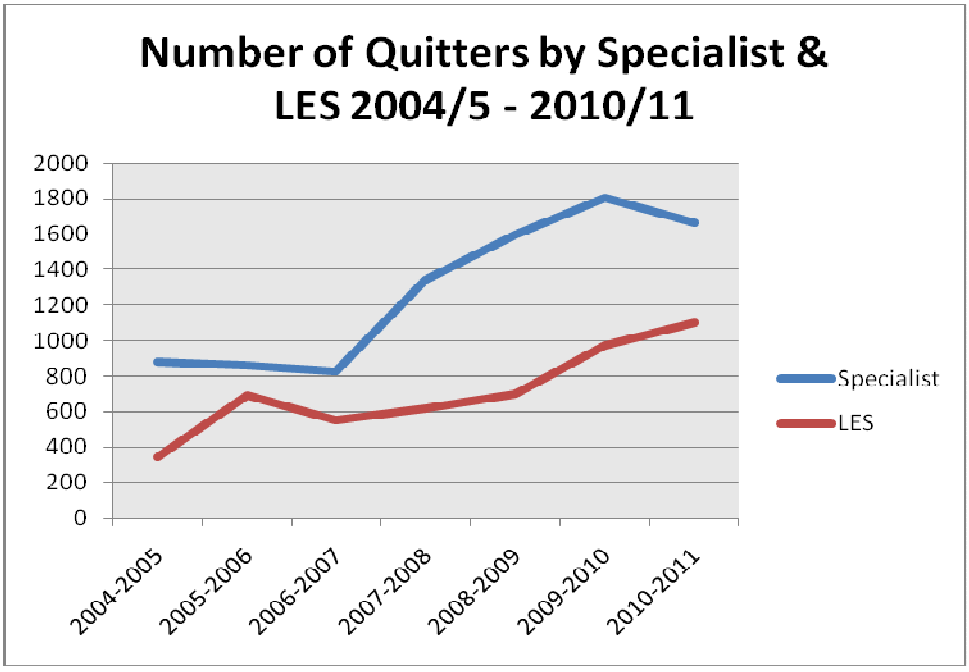


Number successfully quit (self-report) per 100,000 of population aged 16 and over, by PCT 2010-11

The chart below shows comparative quitter data by PCT across the region for 2010-11 (includes both RSSS and LES activity). Rotherham compares very favourably with other PCT's in the region in terms of quitters per 100,000 of population, delivering well over the England and regional averages.

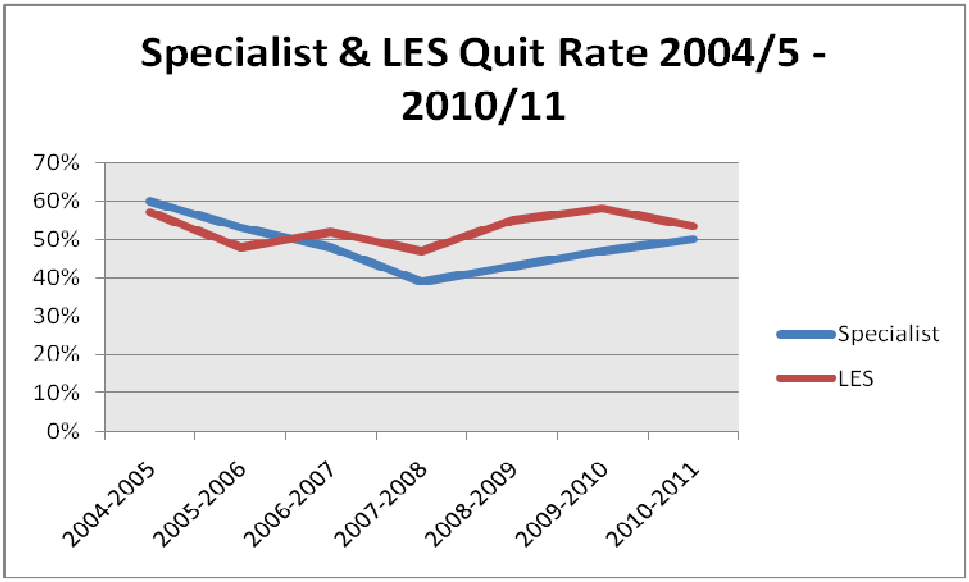


Number of Quitters Over Time by Specialist and LES



Between 2005-10 the number of RSSS quitters per year more than doubled but activity has dipped in the last year, at the same time LES quitter activity per year has nearly trebled.

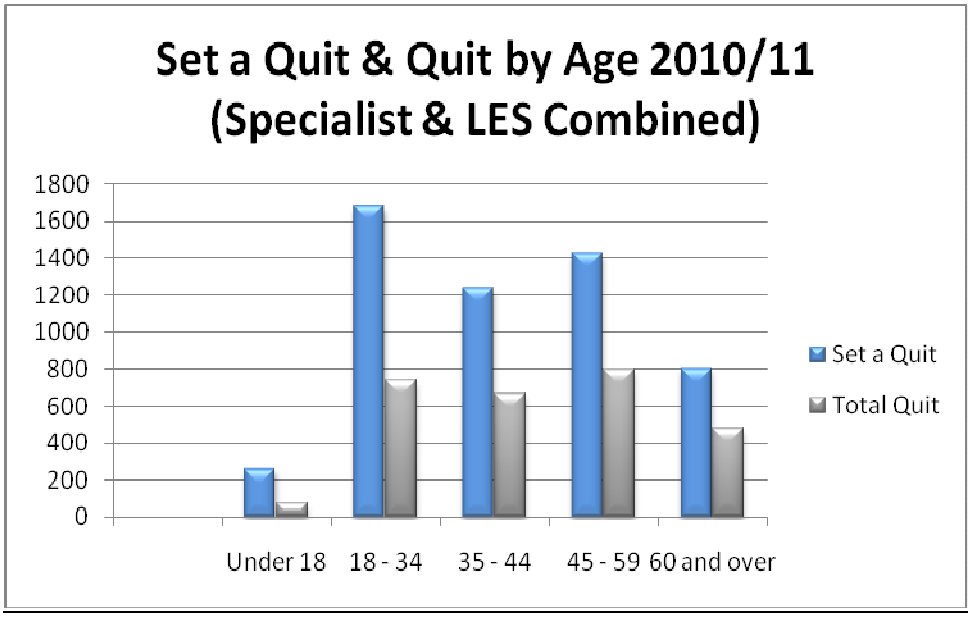
Specialist and LES Quit Rate Over Time by Specialist and LES



In 2010-11 the quit rate for the specialist service was slightly lower than that of the LES (50% compared to 53%). This represents an improvement for RSSS of nearly 4% on the previous year, the LES quit rate reduced slightly over the same period. The specialist service previously had quit rates of 60% but this has declined over recent years, however the quit rate has improved since its low point in 2007-8. It is noteworthy that the reduction in quit rate has occurred at the same time as the dramatic increase in the absolute number of quitters delivered by the Specialist Service. This has been associated with interventions aimed at increasing access to meet increasing quitter targets.

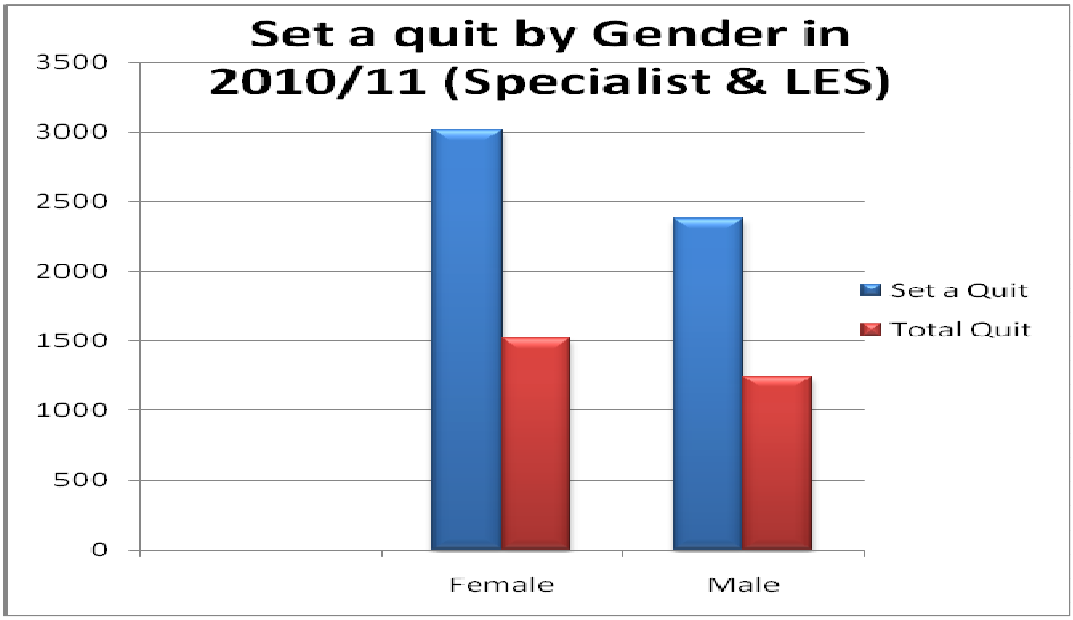
Set a quit and quit by Age in 2009/10 (Specialist and LES combined

A similar number of clients quit across age groups 18-59, however quit rates were lower in the 18-34 age group. Not surprisingly few clients aged under 18 quit and the quit rate in this group was very low (see graph below).



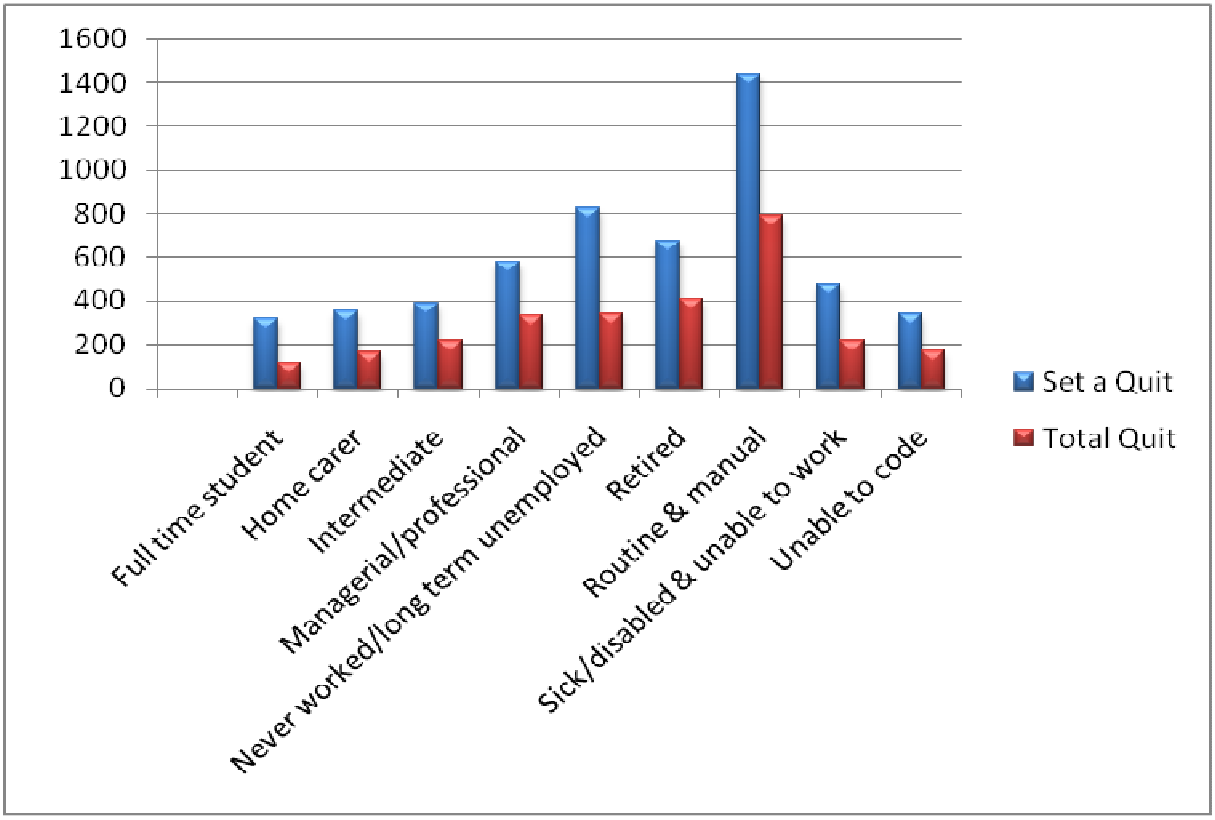
Set a quit and quit by Gender in 2009/10 (Specialist and LES)

Significantly more women attend stop smoking services and quit compared to men but men have a slightly higher quit rate. The differences in attendance and quit rates due to gender remain unchanged from last year. The targeting of pregnant women with 3 WTE staff could at least partially explain why there are more women quitters.



Set a Quit and Quit by Occupation

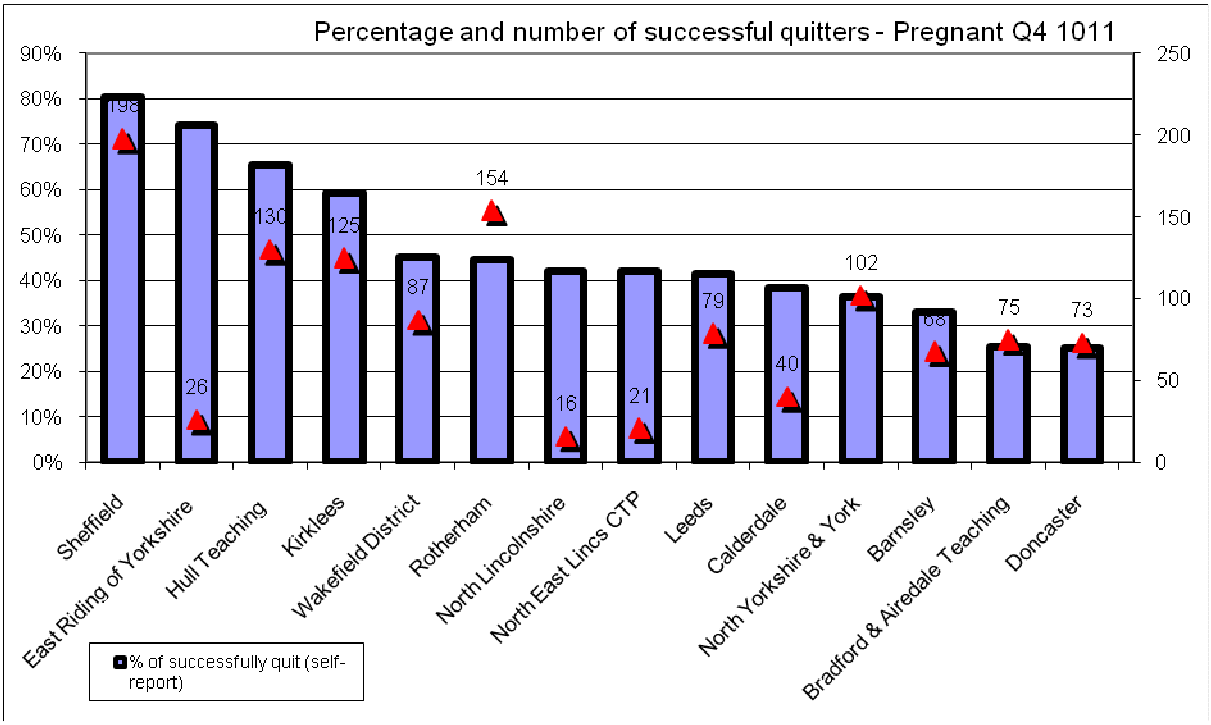
Routine and manual workers (R&M) are a key target group for stop smoking services. The above graph would suggest that R&M smokers are being effectively targeted within Rotherham.



Pregnant Women

In 2010-11 RSSS delivered 161 pregnant women quitters against a target of 160, increasing from 143 quitters in the previous year. It is worth noting that RSSS delivered the second highest number of pregnancy quitters in the region (Sheffield recorded the highest), a significant achievement for a service covering an area the size of Rotherham (the discrepancy in graph below and total number of pregnant women quitters was due to delays in reporting).

RSSS has continued to work closely with NHS Rotherham and TRFT maternity services to deliver the Rotherham smoking in pregnancy pathway. The pathway is the first in the country to integrate RSSS within maternity services such that all pregnant smokers are seen by the RSSS specialist midwife whilst attending their maternity outpatient appointment.



Primary Care and the Locally Enhanced Service

RSSS provides support for staff in primary care (mainly GP practices and pharmacies) to deliver stop smoking interventions including the Locally Enhanced Service (LES).

The LES delivered 1089/2751 (40%) of the total quitters in 2010-11, compared to 975/2783 (35%) in the previous year.

In 2010-11 there were 34 GP practices, 32 pharmacies and 5 dental surgeries delivering the LES. However there was a large variance in performance between providers, providers did not always have a service level agreement with NHSR and access to stop smoking services was not equal across the borough. Therefore last year RSSS identified that it needed to work more closely with NHSR to improve the co-ordination of RSSS and LES delivery and to improve the performance management of the LES, this work is ongoing.

Quit-Stop

The Quit-Stop is located at 16 Bridgegate in Rotherham town centre. The Quit-Stop is open Monday to Saturday, one to one appointments and drop-in sessions are available. It delivered X/1662 (Y%) of all Rotherham NHS Stop Smoking service's quitters and therefore represents a very important part of the service. The quit rate was Z%.

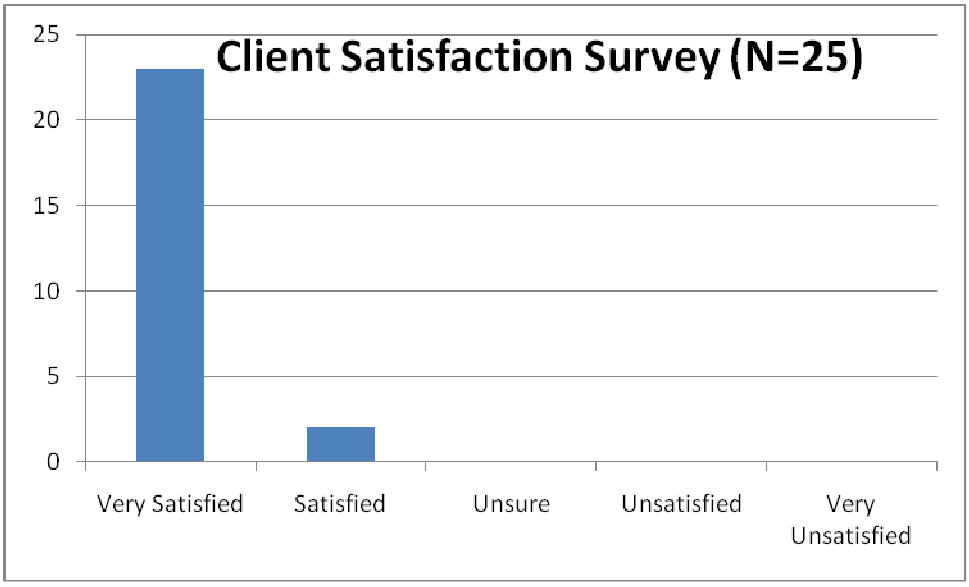
Community Sessions
For most of 2010-11 RSSS delivered between 10-12 daytime sessions and 6 evening sessions per week. However as there was greater demand for evening sessions the balance has changed to 8-10 day time and 8 evening sessions per week. Taken together the community sessions supported X clients to set a quit and Y to quit, giving a quit rate of Z%.

Rotherham Hospital
RSSS provides support for patients, visitors and staff via the Stop Smoking Centre, located in the Health Information area within the recently redeveloped main concourse of Rotherham Hospital. The facilities in the health Information area are much improved from the previous unit and include a private consultation room. The centre is open Monday to Friday 9am-5pm to match the outpatient department opening times. In 2010-11 the centre in the hospital supported 315 clients to set a quit date, 134 quit giving a quit rate of 43%.

Telephone Service
RSSS introduced an out of hours, pro-active telephone support service in January 2010, operating Monday to Thursday 5-8pm. The service is the first and only of its kind in the region and has proven very successful. In 2010-11, it supported 269 clients to set a quit date, of these 169 quit, giving a quit rate of 63%. The CO validation rate for the telephone service is 24%, hence some work is needed to increase the number of clients attending at the 4 week quit point and blowing into a CO monitor.

Patient and Public Engagement
Stop Smoking Services, unlike all other NHS services are constantly under pressure to recruit clients in order to meet very challenging quitter targets. RSSS developed a comprehensive marketing plan which included a combination of stakeholder activation and various forms of direct marketing, including internet, face to face and the Quit-stop window campaigns (see appendix 1). RSSS also contributed significantly to the development NHSR website and since the reorganisation of service structures in 2011 RSSS has developed content within the TRFT internet and intranet sites.

Levels of client satisfaction with RSSS are consistently very high with 100% of clients within a survey reporting they are very satisfied or satisfied with the service they received.



Staff Training and Development

RSSS strongly believes in staff development. In addition to the corporate Personal Development Review process RSSS has adopted the regional Tobacco Control Office continuing professional development pack for all specialist and advisor staff. In the last year all RSSS advisor and specialist staff also completed Stage 1training with the NHS Centre for Smoking Cessation Training and RSSS was compliant with local mandatory training standards.

Challenges and Aspirations

2010-11 was a very challenging year for RSSS. During the year the service lost nearly a third of its advisor and half of its administration establishment due to temporary contracts coming to an end and staff not being replaced. At the same time the 4 week quitter target was increased from 1500 to 1850. These changes led to a review of the service structure with consequent changes to roles and responsibilities and a review of service provision. This has meant that RSSS no longer provides specific workplace or young people sessions as these clients are able to access the service through other routes.
CRES/CIP ?

Looking ahead 2011-12 will be another very challenging year for RSSS, in common with all NHS services. The main challenges for the service are:

1. Meeting 4 week and pregnancy quitter targets
2. Maintaining a quit rate of 50% or above
3. Improve CO validation rates to 85% or above

In addition to the above quitter and quality targets the service will be expected to deliver a 7% budget reduction as part of the RFT cost improvement plan on top of the previous years CIP/CRES.
NHSR intend to put the service out to tender in 2012-13

Aspirations

1. Be the provider of choice for NHSR
2. Improve referral management systems
3. Increase the ratio of group sessions to one to one and drop-in
4. Maintain the improvement in the co-ordination and performance management of the LES
5. All staff complete NCSCT stage 2 training
6. Work with GP pathway lead to include referral to stop smoking services in all chronic disease pathways
7.

Date	Venue	Paper referrals	General Enquiries/Signposting
11th May 2011	Bus Station	10	5
16th May 2011	DVC (with GASP)	19 (2 for Linda)	-
18th May 2011	Maltby JSC	5	12
25th May 2011	Aston Cust Service Centre	5	3
1st June 2011	Co-Op Kiveton	8	11
8th June 2011	Bus Station	3	12
15th June 2011	Maltby JSC Woodside (Men's Health Day)	2 0	5 2
22nd June 2011	Catcliffe Children's Centre	0	8
29th June 2011	Wath DC Leisure	1	10
06 July 2011	Kiveton Co-op	1	3
13 July 2011	Bus Station	21	14
10th Aug 2011	Bus Station	10	8
24nd Aug 2011	Aston CSC	3	5
31st Aug 2011	Greasbrough Co-op	6	3

12th Sept 2011	Bus Station	10	16
21st Sept 2011	Maltby JSC	8	5
17th Oct 2011	Tesco @ Wath	1	12
19th Oct 2011	Maltby JSC	1	5
24th Oct 2011	Aston CSC	2	3
16th Nov 2011	World COPD Day (BS)	Tbc	Tbc