HEALTH AND WELLBEING BOARD

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

Date: **Wednesday, 31st October, 2012**

Time: **11.00 a.m.**

A G E N D A

1. To determine if the following matters are to be considered under the categories suggested in accordance with the Local Government Act 1972.

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

3. Minutes of Previous Meeting (Pages 1 - 8)

Communications

4. Joint Communications Plan

5. Health and Wellbeing Members' Group (Pages 9 - 11)
   - notes of meeting held on 1st October, 2012 in Wakefield

6. Police and Crime Commissioner (Pages 12 - 14)

7. North Trent Network of Cardiac Care and North Trent Stroke Strategy Project (Pages 15 - 49)

Discussion

8. Health and Wellbeing Strategy (Pages 50 - 65)

9. 'End of Life' (Pages 66 - 71)
   - Mike Wilkerson, Chief Executive, Rotherham Hospice

10. Community Pharmacy in Rotherham (Pages 72 - 74)
    - Nick Hunter, Chief Officer, Rotherham Local Pharmaceutical Committee

11. Date of Next Meeting
- Wednesday, 28th November, 2012 at 1.00 p.m.

HEALTH AND WELLBEING BOARD
5th September, 2012

Present:-

Members:-

Councillor Wyatt	**In the Chair**
Karl Battersby	Strategic Director, Environment and Development Services, RMBC
Tracey Clarke	RDaSH
Tom Cray	Strategic Director, Neighbourhoods and Adult Services, RMBC
Councillor Doyle	Cabinet Member, Adult Social Care
Shaliq Hussain	Voluntary Action Rotherham
Brian James	Rotherham Foundation Trust
Martin Kimber	Chief Executive, RMBC
Councillor Lakin	Cabinet Member, Children, Young People and Families Services
Shona McFarlane	Director of Health and Wellbeing
Jason Paige	CCG
David Polkinghorn	CCG
John Radford	Director of Public Health
Joyce Thacker	Strategic Director, Children, Young People and Families, RMBC
Sarah Whittle	CCG/NHS Rotherham

Officers:-

Clare Burton	Commissioning, Policy and Performance, RMBC
Matt Gladstone	Director, Commissioning, Policy and Performance
Kate Green	Policy Officer, RMBC
Chrissy Wright	Commissioning, Policy and Performance, RMBC

Together with:-

Anne Charlesworth	NHS Rotherham
David Plews	National Commissioning Board
Kathy Wakefield	NHS Rotherham
John Wilderspin	Department of Health

Apologies for absence were received from Chris Boswell, Chris Edwards, Tracy Holmes, Fiona Topliss, David Tooth, Janet Wheatley,

S21. WELCOME AND INTRODUCTIONS

The Chairman welcomed John Wilderspin, National Director, Health and Wellbeing Board Implementation, Department of Health, to the meeting and introductions were made.

S22. MINUTES OF PREVIOUS MEETING

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

S23. COMMUNICATIONS

(a) Communications Plan
It was noted that a meeting was to be held between the Borough Council, NHS Rotherham and hopefully Rotherham Foundation Trust's Communication leads to discuss the development of a 12 month Health and Wellbeing Community Plan linking in possibly with the campaign that pharmacies were contracted to do.

(b) South Yorkshire Police and Crime Commissioner
It was noted that the Officer who would be supporting the Commissioner once appointed was to attend the October Board meeting to discuss how they would relate to the Health and Wellbeing agenda. The February Board meeting had already been logged in the diary for attendance by the Commissioner.

The paper circulated was a document that would be available on the Police and Crime Commissioner's website for any organisation to raise issues with the Commissioner.

(c) "Implementing Health and Wellbeing Boards" Capita Conference to be held in Central London on 17th October, 2010
Anyone interested in attending the above conference should notify the Chairman.

S24. ALCOHOL STRATEGY - LOCAL IMPLEMENTATION

Anne Charlesworth, Drug Strategy Manager, NHS Rotherham, presented a report on the proposed local implementation of the Alcohol Strategy launched by the Government in April.

Following a partnership meeting in July, an action plan had been compiled to deliver all aspects of the Strategy. The key aims were:-

- Develop 'Community Alcohol Partnerships' (CAPs) including Responsible Retailer Scheme
- Make those who caused the harm face the consequences both individuals and premises
- Make 'every contact count' in delivering the culture change required.

Following the first meeting, there had been a disappointing response with regard to individuals committing themselves to the timelines.

It had not been appreciated that the boundaries of the CAPs were slightly different to those identified by the Council as areas of deprivation so there would be a slight amendment. Dinnington had been identified as having significant issues with alcohol. However, with the resources available, there would not be sufficient to do all areas simultaneously.

Discussion ensued with the following issues raised:-

- Whilst under taking the 2 pilot areas give consideration to the 11 deprived areas and Community First due to the overlap. There were approximately 15 areas warranting special attention and also featuring alcohol issues

- If tackling areas of deprivation you were dealing with people that were very difficult to change
- Visibility – it was easy to see street drinking but the problem of home drinking was of much more significance and was not restricted to deprived parts of the Borough
- Modest approach with the resources available. If the Board prioritised alcohol it would have to identify resources across the agencies
- Many associated issues with alcohol misuse – domestic abuse, neglect, anti-social behaviour etc.
- Utilise Elected Members who had local knowledge and Neighbourhood Champions

Agreed:- (1) That Community Alcohol Partnerships commence in Dinnington and East Herringthorpe and rolled out to all 11 Disadvantaged Areas alternative substantial alcohol initiatives were already underway.

(2) That the remaining recommendations set out in the report be referred to the Chief Executive Officers Group for support.

(3) That a further report be submitted in 3 months.

S25. INFECTION PREVENTION AND HEALTH PROTECTION ANNUAL REPORT 2011/12

Kathy Wakefield, Health Protection Manager, presented the Infection Prevention and Health Protection 2011/12 Annual Report.

Whilst there was no legal requirement for commissioning organisations to have a nominated Director of Infection Prevention and Control (DIPC), it was seen as good practice. This function was fulfilled by the Director of Public Health supported by the Health Protection Manager. All providers commissioned by NHS Rotherham had nominated DIPCs or Infection prevention leads and were members of the Strategic Infection Prevention and Control Committee.

The Committee had met throughout the reportable period providing assurance regarding compliance with all relevant Guidance and Quality Management Group, respective contract quality review meetings or relevant member of the CCG. Its purpose was not performance management. An annual programme based on the NHS Operating Framework and local priorities was developed, agreed and monitored by the Committee escalating concerns as appropriate.

Kathy drew attention to:-

- Health Care Associated Infections
  Both the provider (RFT) and NHSR as commissioning organisation had to have an Annual Plan to achieve and sustain a reduction in the number of MRSA bacteraemia and C.difficile infections

- Outbreaks
  Flu like/confirmed Influenza - 4 outbreaks of – 3 in care homes and 1 at a primary school

E.coli 0157 – family outbreak excluding food handlers. No implications for the wider community
Water Quality Incident – a family with raised blood lead levels. Work in conjunction with Health Protection Agency and YWA. No identified ill health affects. Changes made to the practice of reporting from YWA to Environmental Health and the Local Authority

- Influenza
  Slightly higher numbers of GP consultations from early January to mid-March compared to other areas across the region.
  Overall hospital admissions had remained low for the season
  There had been 1 death (Asthmatic patient). The patient had been invited by the GP on 2 occasions for vaccination but had not attended

- Influenza Immunisation Vaccination Programme
  Over 65s – Target of 75% - achieved 76%
  At Risk Groups including Pregnant Women – Target 60% - achieved 53.6%

- Food Borne Illness
  Largely unchanged

- Vaccination and Immunisation
  Continued improvement across all vaccination programmes specifically in relation to the Childhood Programme (0-5 years) and School Booster

- Areas of concern
  MMR – continuing work to encourage uptake particularly 5-24 year olds
  HPV Vaccine – delivered as part of School-based Programme. Failed to achieve 90% (84.4%). Work taking place on a delivery plan with providers
  Pneumococcal Immunisation for the under 65s – review and agreed to continue with programme
  Respiratory Syncytial Virus affecting Younger Children – targeted vaccination programme with 26 children vaccinated (increase of 11)
  Infection Prevention and Control in Care Homes – close work commenced with Contract Monitoring Officers to improve standards across all the care home

Brian James, Rotherham Foundation Trust, reported that infection control remained a high priority for the Trust and was performing well nationally with the support of colleagues in managing infection control but there was no room for complacency.

Discussion ensued on the report particularly on the death of the patient who had failed to attend for influenza vaccination and what efforts the GP practice/how far a GP could go to ensure a patient attended an appointment.

Agreed:- That the Infection Prevention and Health Protection Annual report for 2011/12 be noted.

S26. HEALTH AND WELLBEING STRATEGY

Kate Green, Policy Officer, reported that the consultation period had now closed.

There had been a broad range of feedback – e-mail, engagement with colleagues across partner organisations and the very well attended consultation event hosted by Voluntary Action Rotherham and LINks.

Comments had been positive and the outcomes/approach welcomed and if achieved would have a huge impact on the people of Rotherham. The language used was felt to need some rewording.

There had been concerns, particularly from the VAR event, that the voluntary and community sector had not been mentioned as specific partners within the Strategy document. This had been taken on board, however, it was felt that the Strategy referred to the specific statutory agencies with responsibility for delivering the Strategy; the voluntary and community sector was not necessarily responsible for delivery but were key partners in making sure that it was delivered and supported its implementation. This would be added to the document.

The Strategy would be revised in light of all the comments and circulated to Board members.

A draft document showing the work streams was distributed. There were 6 lead officers together with representatives from the CCG and Commissioning, Policy and Performance. The strategic group had held their initial meeting and would continue to meet to ensure implementation of the Strategy.

Agreed:- That a further report and final strategy document be submitted to the next meeting.

S27. CLINICAL COMMISSIONING GROUP ANNUAL COMMISSIONING PLAN

Sarah Whittle, NHS Rotherham, presented the proposed development and timetable of the 2013/14 Clinical Commissioning Group Annual Commissioning Plan.

It was the intention to produce a CCG Annual Commissioning Plan (ACP) by mid-March, 2013 and an Annual Report by the end of June, 2013.

It was felt that other annual Plans of the Local Authority and Foundation Trust should also be submitted to the Board to ensure they all had the "golden thread" and priorities. Hopefully it would also eliminate any duplication.

Agreed:- That the proposed development of a CCG Annual Commissioning Plan be noted.

S28. NHS COMMISSIONING BOARD UPDATE

David Plews, National Commissioning Board, gave the following update:-

- Andy Buck had been appointed as the leader of the Local Area Team. Other appointments to follow
- Organisational structure to be finalised
- Transferring of functions in progress

- Discussions on roles and responsibilities
- Local Area Team working with National Commissioning Board and Department of Health on indicative Indicator Sets
- The Local Area Team was not a designated body as yet
- The National Commissioning Board would be the commissioning board – there would be a single process across the country to reduce variation in contract
- Local Area Team not just about Primary Care but would have a substantial function in commissioning Specialist Services and the Prison Service

Agreed:- That the update be noted.

S29. ROTHERHAM HEALTHWATCH UPDATE

Clare Burton, Commissioning, Policy and Performance, presented a progress report in relation to commissioning HealthWatch Rotherham together with an update on Government guidance, funding and secondary Regulations as follows:-

Secondary Regulations

- These were still being developed by the Department of Health however Children and Young People were now included in the HealthWatch requirements. The Department of Health's Summary Report key issues were set out as:-

    - The organisation did not need to be a social enterprise but must have the principles of 1 with at least 50% of profit/surplus reinvested to further the social objective
    - The constitution of the organisation must state that the main objective was to benefit the community
    - The secondary regulations would include further criteria about having lay people and volunteers in the local HealthWatch
    - In relation to the contract between the local authority and HealthWatch, the details of the 2008 Regulations would be carried forward with the intention of ensuring that the local HealthWatch operated in an open and transparent way
    - Requirement still for providers to respond to reports, recommendations and information requests including children's social care
    - Referrals to scrutiny committee would be carried forward into HealthWatch
    - 2008 Entry Regulations which set out the duty of Service-providers to allow entry to residential care provision would be carried forward including in relation to "excluded activities" (children's social care)
    - Directions in relation to what should be addressed in the local HealthWatch annual report

- The Regulations would be laid in October (contracts element) and November (enter and view elements) and come into force on 1st April, 2013.

Progress

- The local HealthWatch would be a member of the Health and Wellbeing Board and integral to the preparation of the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy together with any priority setting on which local commissioning decisions would be based. It was proposed that an Elected Member also be a member of the HealthWatch Board of Trustees

- HealthWatch Project Group – The Commissioning Project Group included representatives from the Local Authority and Rotherham Clinical Commissioning Group
    - A vision had been developed and included in the consultation. Information on HealthWatch had been added to the website and 2 surveys issued to members of the public, Health and Social Care Service users, voluntary and community sector network and community interest groups
    - TUPE Arrangements – Discussions had taken place with the CCG with regard to 2 members of staff; other roles that were subject to TUPE would be considered
    - Service mapping – completed
    - Commissioning and Procurement Plan – the Pre-Qualification Questionnaire would be issued on 3rd September, 2012
    - NHS Complaints Advocacy – HealthWatch would be requested to provide at all levels of complaint process to ensure value for money
    - Funding – the current LINKs funding would become available for HealthWatch until 2014/15. Additional funding would be made available to local authorities from 2013/14 to support both the information/signposting functions but also for commissioning NHS complaints advocacy. The Department of Health had issued further guidance on the level of funding which was reduced from the original indication. The revised funding level would be included in the specification and tendering documentation

Discussion ensued on the report. It was felt that HealthWatch would have a big workload without the matching resources so it was imperative that work was not duplicated.

Resolved:- (1) That the progress achieve in relation to commissioning HealthWatch Rotherham be noted.

(2) That the intentions of the Department of Health in relation to the secondary Regulations be noted.

(3) That the proposal for an Elected Member to be a trustee on the Rotherham HealthWatch Board of Trustees be given further consideration.

(4) That the revised level of funding available be noted.

(5) That further reports be submitted on the outcome of the tendering process including the outcome of the evaluation process and the recommended provider.

S30. HEALTH AND WELLBEING BOARD SELF-ASSESSMENT

In accordance with Minute No. 15, Kate Green, Policy Officer, submitted the responses that had been received to the questionnaires completed by all Board members relating to the Board's operation, Strategy and delivery.

The Local Government Association had worked with the NHS Leadership Academy, other national organisations and representatives of Health and Wellbeing Boards to co-produce a new development tool for Boards. It could be used to measure levels of preparedness through a 'maturity matrix' which allowed Boards to track their progress over time.

John Wilderspin praised the Board for having the courage to self-assess as well as doing so before a self-assessment tool had been produced. He particularly drew attention to:-

- Good quality reports
- Clarity of the Terms of Reference
- Too ambitious?
- Do not underestimate the challenge of getting different representatives from different organisations and having similar priorities
- Consider concentrating on achieving a couple of priorities in the first year
- Ask difficult questions

Agreed:- That a special meeting be convened to discuss the self-assessment results and the way forward.

S31. DATE OF NEXT MEETING

Agreed:- That a further meeting of the Health and Wellbeing Board be held on Wednesday, 31st October, 2012, commencing at 1.00 p.m. in the Rotherham Town Hall.

Local Government Yorkshire and Humber

HEALTH AND WELLBEING MEMBERS' GROUP
(LEAD OFFICERS INVITED)

Monday 1st October 2012: 10:00-12:00
The Orangery, Back Lane, Wakefield WF1 2TG

Summary notes from discussions

Vision and priorities

- Common themes around progress in preparing the health & wellbeing strategies locally and feedback received in local consultations
- We've got a 10 year strategy, but is it too ambitious?
- We've developed a wellbeing, not health, strategy, to emphasise that this isn't about health in the old fashioned sense (Calderdale)

Membership of the Board

- Positive messages around the progress made in establishing the boards and development so far
- Discussions around the understanding between Local Authority and NHS leads regarding respective organisations and functions (and issues of engagement)
- It can be difficult to engage NHS colleagues, who often don't turn up to the meetings.
- Some of our members are working, so meetings are in the evening, and this also seems to be a culture shock for the NHS.
- One Board is trying to get named deputies for attendance, so there is some consistency across meetings (Barnsley)
- Providers – some are on boards, some are not, also pressure from providers to be on the board
- The number of councillors on boards varies e.g., in Sheffield there are 4 councillors and 4 GPs on the Board
- The Chair should not be the Leader of the Council, because she/he is too busy
- Leader of the Council should be the Chair, given the importance of the role.
- Difficulties in having the wide group of partners on the board, as everyone wants a seat at the table
- We can't have everyone on the board

- Wider membership of HWB's and inclusion of partners e.g. fire and police and joining up respective roles in terms of impact on wellbeing where do the Police and Fire fit in? Will the PCC change the current approach to crime and wellbeing when they get in?
- The role of housing and economic development with HWB Boards
- Dilemma/overlap between role of the HWB and the LSP
- Varying degrees of GP engagement

Development

- In some areas there have been sessions on how local government works, what elected members do and their roles
- Boards need away days to develop how they will work together
- Sheffield did a speed-dating session between Cabinet and the HWB so that everyone could get to know each other
- Doncaster has had one stock take event and is planning another for mid-October
- Working collaboratively with the Clinical Commissioning Groups and variances across the region
- The need to look at creating mechanisms for HWBs to talk to each other - especially given the sub-regional footprint of the NHS Commissioning Board and Public Health England

Governance

- Positive messages around the progress made in establishing the boards and development so far
- Who signs off what? What is delegated? Who does the Board report to?
- Frequency of meetings varies, in Rotherham and Doncaster the HWBs meet every 6 weeks
- How will we spend our budgets? How will we share risks?
- Those of us involved find the structure difficult to explain to everyone else
- Some meetings are being cancelled so it's hard to judge if progress is being made
- A media protocol for the board has been developed so that messages can be clearly communicated, and it's clear who is doing what (York)

Scrutiny

- Debates around HealthWatch and how this will evolve locally
    - Will it be stifled from the top?
    - LiNKs development was imposed on us
    - How will it work?

Links with scrutiny members and role of scrutiny within the context of the HWBs and how this is not clear in some areas. How will scrutiny work with the new arrangements? Are other councillors clear about the context of HWBs and their roles?

Going forward

- What resources and support will be available after 1st April 2013?
- Would sub-regional, local or regional meetings of members be useful, e.g. based on the clusters?

What the LGA can offer on HWB development:

- An online self assessment tool that helps boards to decide on their progress: see http://www.local.gov.uk/web/guest/health/-/journal_content/56/10171/3638628/ARTICLE-TEMPLATE
- Regional simulation events which bring together boards to work through various scenarios and how they might deal with them.
- Bespoke support for individual councils, based on 4 days support, on a free basis. This can include working with the board to develop vision and values, Master classes on specific issues, stock takes of progress, or other issues that the board identifies

This support is available until March 2013. For more information on the LGA offer please contact Judith Hurcombe at Judith.hurcombe@local.gov.uk or 07789373624

Actions

The actions from the meeting include;

- We invite members to comment on how the session went and what is needed in further sessions (including if this is locally/sub/regionally)
- Circulate the planned work of the Centre for Public Scrutiny working with Scrutiny chairs
- Comparing HWB strategies and common work streams
- Proposal to meet again in the new year ahead of budget setting

Local Government Yorkshire & Humber (LGYH) has offered to convene a follow up meeting in the New Year. For details contact sarah.tyler@lgyh.gov.uk

ROTHERHAM BOROUGH COUNCIL – REPORT TO CABINET MEMBER

1.	**Meeting:**	**Health & Wellbeing Board**
2.	**Date:**	**31 October 2012**
3.	**Title:**	**Police and Crime Commissioner**
4.	**Directorate/ agency:**	**South Yorkshire Joint Secretariat**

5. Introduction

The Police Reform and Social Responsibility Act 2011 received Royal Assent in September 2011 and has brought changes to the policing landscape. The government's intention in making these changes is to move from a culture of bureaucratic accountability to democratic accountability and to shift from central prescription to local discretion. The current tripartite arrangement between the Home Secretary, Chief Constable and Police Authority alters to provide greater local accountability with the introduction of Police & Crime Commissioners (PCCs) who replace Police Authorities and a Police and Crime Panel. At time of writing there is a little less than one month before elections take place. Voters in England and Wales (outside London) will have the opportunity to elect a PCC on 15 November. Uniquely for local elections policing and community safety will be the focus of PCC election campaigns.

6. Recommendations

- **Members note the contents of the report and consider future engagement with the PCC post-election.**

7. Local Implications

The PCC, unlike the Police Authority will not be a statutory partner on Community Safety Partnerships (CSP), but must co-operate with the CSPs and have regard for the priorities of those CSPs in the Policing area. The PCC can call the chairs of all the CSPs in their area together to discuss specific issues and may require a CSP to provide a written report around a specific issue if not satisfied that the CSP is meeting its duties.

The Police Authority has developed an awareness raising campaign which endeavours to engage members of the public and partners around the generalities of the election and what the change in police governance might mean to them and with candidates by providing information on the force and the partnership landscape. A web site has been developed to give a web platform to this information (http://www.southyorks.gov.uk/thinkpcc/home.aspx).

As part of the wider "& Crime" element of their role PCCs will consider the impact other partnerships, statutory boards and criminal justice organisations/partnerships may have on policing and crime in this area. To date South Yorkshire Police Authority has made contact with a variety of organisations/partnerships to begin developing wider links in anticipation of the incoming PCC.

7.1 Police and Crime Plan

The PCC is obligated to publish a five year police and crime plan by March 2013 which sets out the priorities for policing and crime in the force area. This document will be key in holding the Chief Constable to account for delivery against the PCC's priorities and will outline allocation of resources along with local priorities. Consultations with partners and partnerships are on-going; where strategy documents or intelligence assessments which set out the priorities of other organisations and/or partnerships are available they will be taken into consideration as part of the drafting process. As part of this work a copy of the Rotherham Health & Wellbeing Strategy has been provided and will be considered.

8. Election Information

The election will take place 15 November 2012, however subsequent elections will revert to the originally intended timescale, meaning the next election for PCC will take place May 2016.

8.1 Police Area Returning Officer (PARO)

Each Police Force area has a Police Area Returning Officer (PARO), the case of South Yorkshire the PARO is Andrew Frosdick (Barnsley MBC)

8.2 Candidates

Candidate seeking election had until noon on 19 October to register their candidacy, it is our understanding that five candidates in South Yorkshire have submitted for the election, all candidates represent a political party; Labour, Conservative, Liberal Democrats, English Democrats and UKI

9. Contact

Marie Carroll
Partnership Officer
South Yorkshire Joint Secretariat
Tel: 01226 772838

North Trent Stroke Strategy Project

North Trent Network of Cardiac Care

North Trent Network of Cardiac Care & North Trent Stroke Strategy Project

Annual Report 2011/12

Contents

Introduction

This Annual Report provides a review of major Cardiac and Stroke work undertaken by the Network from April 2011 to March 2012, highlighting key achievements and outcomes of the year.

Network Director Report

Welcome to the 2011/12 Annual Report for the North Trent Network of Cardiac Care and the North Trent Stroke Strategy Project.

This report is designed to provide an insight into some of the excellent collaborative work that has been undertaken by Network members during the last 12 months.

Improving outcomes for patients provides the foundation for our annual Cardiac and Stroke Work Programmes. The achievements captured within this report reflect the continued motivation and commitment of Network clinicians, providers and commissioners, supported by the Network Management Team, to reduce inequalities and improve the access to, and quality of, clinical services for Cardiac and Stroke patients across North Trent.

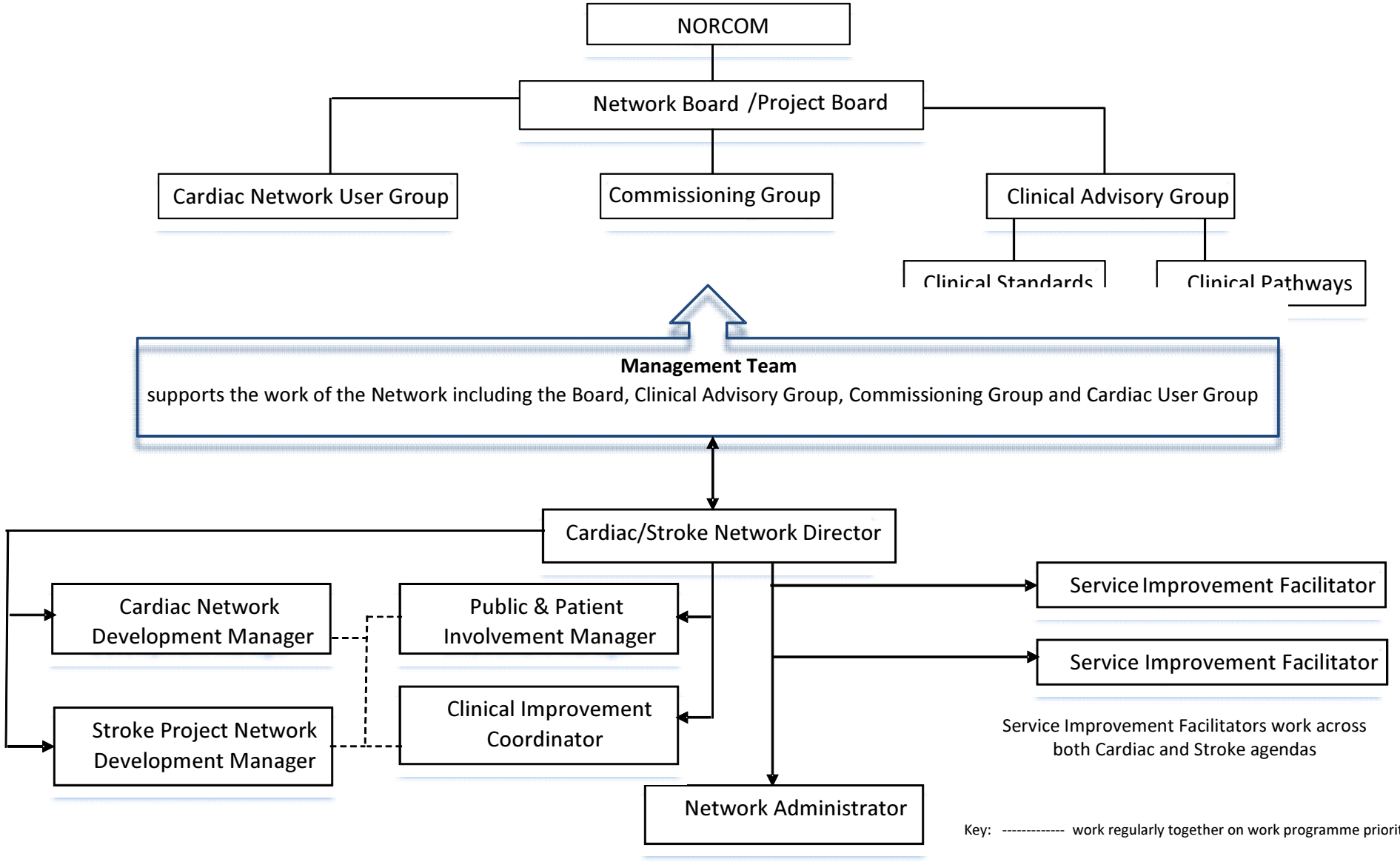
The redesign and improvement of clinical services relies on the collaboration and determination of a wide range of individuals. In particular I would like to take the opportunity to thank both the Network Clinical Leads for their continued support and leadership in managing and delivering significant and complex whole system change. Their leadership coupled with the dedication of the clinicians and managers within our Network Trusts in implementing high quality, collaborative, evidenced based commissioning, has been an essential factor in our success.

The Network is also very proud of the increasing contribution of service users and carers in shaping Cardiac and Stroke services in North Trent. Members of the Cardiac Network User Group now attend the Cardiac Board providing advice and support, and reflecting the experience and views of their members and the wider patient community.

The achievements we describe in Cardiac and Stroke services are all the more significant as they have been delivered during a time of unprecedented organisational change. As we move into 2012/13 I am confident that our Network cohesion, and the dedication and commitment evidenced by Network members and the Network Management Team, will provide the essential basis for continued improvements in services and outcomes whilst the process of transition into the new NHS organisational arrangements emerge.

Clare Hillitt
Network Director
North Trent Network of Cardiac Care/North Trent Stroke Strategy Project

North Trent Network of Cardiac Care and North Trent Stroke Strategy Project
Organisation Structure



Key: ----------work regularly together on work programme priorities

North Trent Network of Cardiac Care

Chairman's Introduction

I am delighted to introduce to you the North Trent Network of Cardiac Care Annual Report for 2011/12.

The Network has had an extremely successful year. This report highlights some of those successes which demonstrate our continued commitment to improving services and outcomes for our patients. The benefits derived from the close collaboration of North Trent commissioners, providers and clinicians working together to improve Cardiac services are clearly visible and I am extremely proud of the high levels of commitment and dedication exhibited in the design, implementation and delivery of Cardiac services for the patients of North Trent. In addition, our excellent relationship with the commissioners of Specialised Cardiac Services and the adjoining Cardiac Networks in West Yorkshire and North East Yorkshire and Northern Lincolnshire ensures a consistent and equitable approach to the development of services across Yorkshire and the Humber.

2011/12 has seen several significant developments and improvements within Cardiac Services across the whole of the healthcare system; in particular I would like to focus on two specific areas.

In late 2010, the Cardiac Network embarked on a collaborative project with the Yorkshire and the Humber Specialised Commissioners and the West Yorkshire and North East Yorkshire and Northern Lincolnshire Networks to develop 3 Clinical Thresholds for Revascularisation. Significant variation in access to intervention for revascularisation had been identified across Yorkshire and the Humber and the aim of the project was to develop a set of clinical guidelines and thresholds, based on evidence based best clinical practice, to reduce this variation. This was a challenging project but through the commitment of clinicians, providers and commissioners, supported by patient experience intelligence, guidelines and thresholds were developed and agreed and will be implemented during 2012/13.

The involvement and engagement of the Network User Group which was established in 2009 has increased significantly over the last two years. With the support of the PPI Manager and the Network Team, the Group has developed and matured and through attendance at Board meetings, they now influence the development of Network strategic plans in order to improve the experience and outcomes for future cardiac patients. This valuable contribution ensures that the public view is actively considered alongside other professional and clinical views in forming plans and developing Cardiac services. I would like to thank the User Group patient representatives in particular for their active engagement in the Board meetings and their commitment to improving our services.

As we look to the future it is important that our collaborative and integrated Network approach to improving patient experience and outcomes is maintained. I am grateful to all Network members and the Network Team who support them for their enduring commitment to improving Cardiac Services across North Trent.

Ian Atkinson
Chair, North Trent Network of Cardiac Care
Chief Operating Officer NHS Sheffield

Public Health Lead Report

Over the last year Public Health has contributed to a number of work streams of Network business.

The Public Health Leads contributed to the development of the first round of disease profiles that have subsequently been adopted nationally. The Network Board has adopted primary prevention as a key area of work and Public Health has supported local areas to review metrics and benchmark themselves. The work on primary prevention has been a major contributor to reduced mortality form cardiovascular disease across the Network.

Public Health Leads have described a methodology to assure the Board that the rate of implantation of cardiac devices across the Network, although lower than many Networks, does not impact on mortality and this is supported by robust implementation of the relevant NICE guidance.

Pubic Health Leads have also highlighted the issues of unequal access to cardiac revascularisation and have worked with commissioners to develop equity profiling as part of routine performance management. In addition the Public Health Leads have sponsored a number of pieces of research looking at reviewing why people with chest pain delay calling 999.

For 2012/13 Public Health will continue to support the Network to implement the NICE clinical guidance on Familial Hypercholesterolemia through a restructured Clinical Advisory Group which now brings together Public Health Leads and clinicians engaged in Cardiac Care across primary, secondary and tertiary services.

Dr Rupert Suckling, Clinical Lead, North Trent Network of Cardiac Care
Deputy Director Public Health, NHS Doncaster

Working with, and as a member of, the North Trent Cardiac Network

Working with local commissioners and providers as part of the North Trent Cardiac Network and Stroke Strategy Board supports the development of quality services for our patients. The collaborative approach that the Network engenders ensures that we share best practise, use resources wisely by avoiding duplication, and develop services that are both affordable and patient focused.

The key achievements of the Cardiac Network over the last 12 months include reviewing and developing Heart Failure Services, closer working with the tertiary centre on the PPCI pathway and efficient tertiary centre referral, agreeing procedures for how we manage the introduction of new drug treatments, and improving the patient/carer engagement and interaction. Rotherham NHS Foundation Trust has found the Heart Failure work of particular interest and the Trust has used the Network resource and links to focus on improving the patient experience in relation to the Heart Failure pathway.

The Network also enables strategic thinking in terms of how policy can be turned into practise. It provides peer support and guidance for managers, facilitating solutions to challenges that might have otherwise been seen as complex problems.

Maxine Dennis, Service Director, Urgent Care

From the standpoint of PCT / CCG local commissioning the Network has been of immense value. It is a well oiled collaborative arrangement through which we can bring about service developments, and respond to new evidence and national policy in a way that brings benefits speedily to a population area of around 1.8 million people. This collaborative network approach to commissioning, and the partner relationships it fosters with provider trusts and service users, is the envy of NHS commissioners in other areas who do not have such arrangements in place. One great example of this in recent years has been the early introduction of primary angioplasty as the principal treatment for heart attacks. In response to emergent new evidence of its benefits, we were able to commence this in the Sheffield area and quickly roll it out to benefit the entire network geography in a systematic way; coordinated across the specialist treatment centre, district hospitals and the ambulance service. The Network has also enabled the establishment of jointly agreed treatment policies, such as for medication and cardiology interventions, to ensure we have consistent access to effective treatments for our population, and thereby reduce the risk of contributing to health inequalities due to differential access to services and treatments. This is why we see the Network as core business and is greatly valued.

John Soady,Public Health Principal

Rotherham NHS Foundation Trust **NHS Sheffield**

North Trent Network of Cardiac Care Cardiovascular Disease Health Profiles

The following Charts and accompanying information are compiled from the CVD health profiles produced for every Network and PCT in England by the South East Public Health Observatory.

There are fifteen CVD key indicators, with those evidenced relating specifically to cardiac activity.

The data relate to the period 2010/11 and the graphs show comparison between the individual health communities across the North Trent Network region.

Key Messages from the Profiles

Early mortality rates from cardiovascular disease (<75 years) are significantly higher than the national rate and have decreased by 44.6% since 1995.

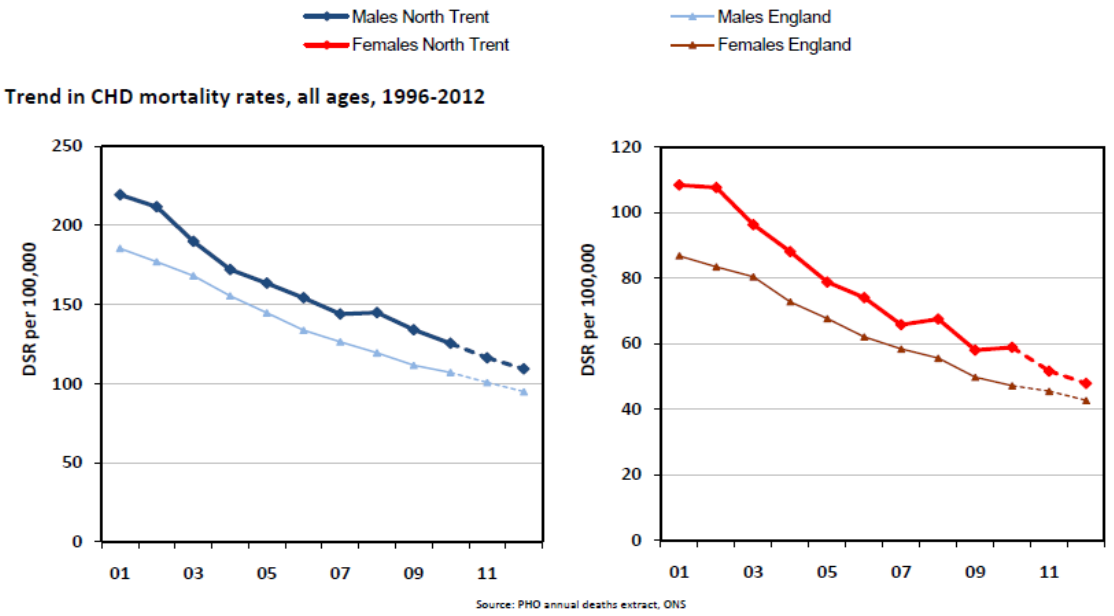
Emergency admission rates for both CHD and Stroke are significantly higher than the national rate.

The mortality rate of STEMI cases within 30 days of treatment in hospital is significantly lower than the national rate.

Rates for revascularisation are significantly lower than the national rate.

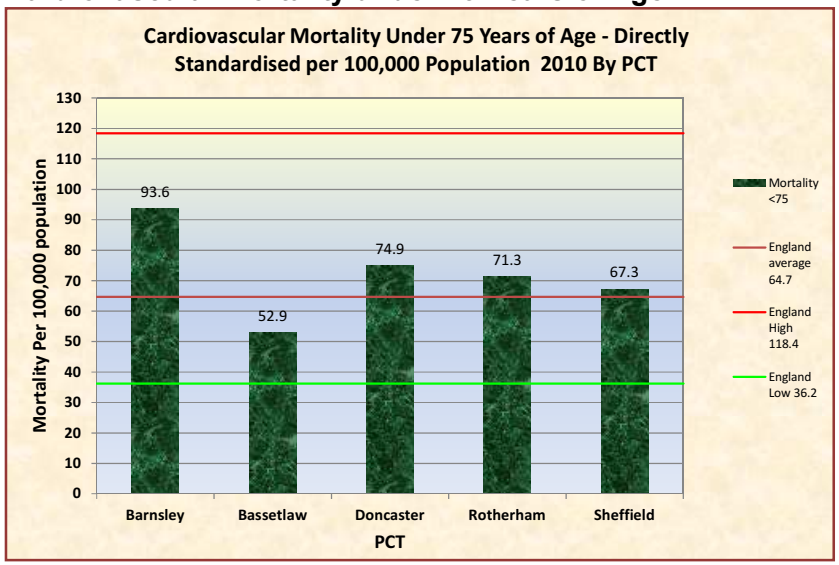
Trends in CHD Mortality Rates

The following graphs show the decreasing trends in mortality for both males and females between 1996 and 2012

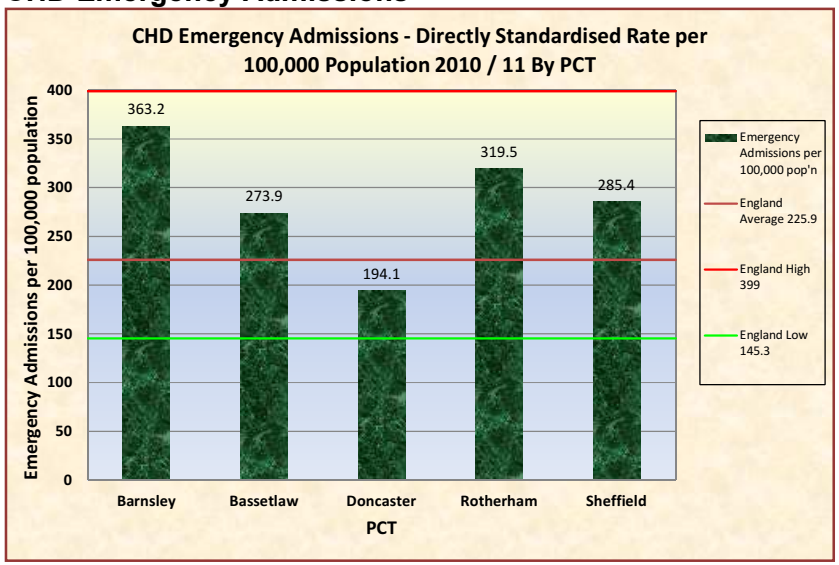


The forecast decrease in the mortality rate for CHD between 2001 and 2012 for North Trent is 50.2% for males and 55.9% for females. For England, the forecast decrease is 48.8% and 50.8% for males and females respectively.

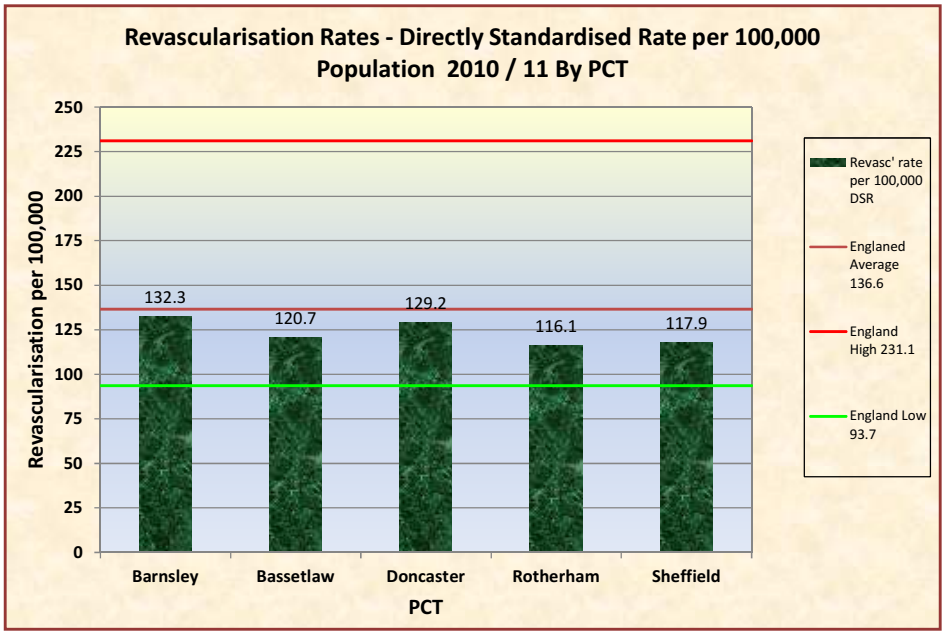
Cardiovascular Mortality under 75 Years of Age



CHD Emergency Admissions



Revascularisation Rates



Clinical Lead Report

2011/12 has been a very productive year during which we have been focused on the need to drive change and innovation. From a clinical perspective, the most challenging project was the Cardiac QIPP project which brought together representatives from primary, secondary and tertiary care across the whole cardiac pathway. The aim of this project was to standardise care for patients with chest pain. The output of this group was agreement on three areas of the chest pain pathway, referral from primary to secondary care, secondary care diagnostics and the decision to proceed to revascularisation. These pathways have been agreed and are being implemented across Yorkshire and the Humber. We look forward to auditing them during 2012/13.

The Cardiac QIPP project and the publication of NICE guidance for new onset chest pain, has also provided the basis for work to commence on the development of a Cardiac Imaging Strategy across North Trent. Following a stocktake of local provision early discussions have taken place regarding the range of modalities available and areas for possible development. In a collaborative project across North Trent, a successful cardiac CT angiography pilot took place and the service is now commissioned in most Trusts demonstrating clear patient experience and clinical benefits and a reduced number of cardiac angiographies within South Yorkshire. Interest specifically in the development of Cardiac MRI has been expressed. This service is currently commissioned as a specialised service.

The Network continues to work closely with colleagues within the Stroke Strategy Project and as such participated in and contributed to the work of the Y&H SHA Stroke Prevention agenda to develop 'Regional Best Practice Guidance in respect of Atrial Fibrillation (AF)', which was published in June 2011. The purpose of this guide was to develop a multi-professional strategy to improve the detection and treatment of AF, to increase the use of evidence based therapy and reduce strokewhich has clear links to objectives within the Arrhythmia section of the Cardiac Work Programme.

The Heart Failure NICE Guidance CG108 and subsequent NICE Quality Standards have led to the development of a Network NICE Quality Standards Assessment Framework and through this a review of local services. Through the support of our well-developed Network User Group and locality based focus groups, views of public and patient expectation and experience in relation to Heart Failure Services have been sought. Feedback obtained about local performance against the quality standards yielded some very enlightening and at times challenging comments and as a result Network providers and commissioners will be using this valuable knowledge when reviewing and improving services.

The Network has continued to successfully implement NICE Guidance for a range of drugs including Ticagrelor and have developed a Clinical consensus approach towards the implementation of the NICE guidance for new oral anticoagulants. Finally we are also hoping to improve access to 24 hour tape recording through the AQP process which should be implemented during 2012/13.

I would like to extend my thanks to all my colleagues for their commitment to the improvement and delivery of high quality Cardiac Care across North Trent and to the Network Team for their support.

Gill Payne
Network Clinical Lead,North Trent Network of Cardiac Care
Consultant Cardiologist, Doncaster & Bassetlaw Hospitals NHS FT

Cardiac QIPP
In line with the National QIPP agenda, the Yorkshire and Humber Specialised Commissioning Group have undertaken a regional Cardiac QIPP project looking at the thresholds for revascularisation. The Cardiac QIPP project included all three Cardiac Networks and identified that there was significant variation in access to intervention for revascularisation across the region, which was not explained by epidemiological factors. The hypothesis was that variation in clinical practice was a significant contributory factor.

The project commenced in November 2010, with the first stage of the Threshold development starting with a Clinical workshop in December 2011. This workshop was attended by approximately 50 clinicians, from primary, secondary and tertiary care in addition to trust managers and commissioners. Following this event, draft documentation was developed to apply to the following decision points:

- Threshold 1: Referral from GP to secondary care clinician (Cardiologist)
- Threshold 2: Referral for diagnostic testing
- Threshold 3: Referral from the Cardiologist to either an interventional cardiologist or cardiac surgeon for revascularisation.

There was a high level of both clinical and non-clinical collaboration and shared working across the region. Each Network led on the process for developing a specific threshold through wider consultation with the attendees of the workshop. The North Trent Network of Cardiac Care led on the development of Threshold 2 and also on testing the feasibility of the implementation of Threshold 3. Gathering relevant PPI experience data was also led by North Trent.Once the thresholds were developed and agreed they were shared for consultation to ensure that the engagement was wider than simply those directly involved in the development.

The result of this work was the agreement of the three thresholds across the three Networks and sign off by the Y&H SCG. In North Trent the Thresholds were integrated into Contracts for 2012/13 and work is underway with primary care for the implementation of Threshold 1. Further work will be undertaken in 2012/13 to monitor and audit the implementation and to measure the impact of the Thresholds.

Cardiac Imaging
In response to the national report, 'Cardiac imaging: a report from the National Imaging Board' published in March 2010, a working group was set up to develop an imaging strategy. A significant amount of work looking at capacity and workforce was undertaken, as well as scoping possible developments in other areas.

During 2012/13, it is anticipated that further work will take place across the North Zone (North of England Networks) to look at Imaging Services and current strategies, and the outcome will be fed back into the Imaging Group.

As part of the local work that has been undertaken within North Trent, CT Coronary Angiography is now routinely commissioned for a defined group of patients A limited Cardiac MRI service is commissioned with the Teritary centre through the Specialised Commissioning Group on a cost per case basis. In 2011/12, 337 CMR Images were performed.

These are significant service improvements. There are debates occurring nationally around the implementation of Cardiac CT due to the lack of a national tariff. Within North Trent however, the excellent working relationships between clinicians, managers and commissioners, has led to the development of anagreed service specification and locally agreed tariff enabling the implementation of a service which prevents a specific cohort of patients from having to undergo an invasive diagnostic procedure.

Heart Failure

Following the publication of the NICE Quality Standards for Chronic Heart Failure, in June 2011, Network agreement was reached on the development of an implementation framework for all Cardiac related NICE Quality Standards. As part of this process, a baseline assessment of Heart Failure Services was carried out across the Network region.

This Network-wide baseline assessment was undertaken in October 2011 and at the same time a specific engagement project was developed in order to understand the current service user and carer experiences alongside this clinical services position. This large scale 'service review' project, completed in March 2012, aimed to provide service user and carer experiences of using the Heart Failure service across the Network.

During 2012/13 individual health community reports will be produced mapping service users' and carers' experiences against the individual quality statements set out in NICE Quality Standards for Chronic Heart Failure. These reports will be shared with health professionals across the six health communities, Network User Group members and all participating service users and carers.

A comprehensive network wide report will be produced and presented to the Network Board. It is expected that actions to review and develop Heart Failure Services will be agreed and implemented locally and progress reviewed annually.

NICE Quality Standards Framework

In December 2011, the Cardiac Network approved a 'NICE Quality Standards Framework' to assess the standard of services within North Trent against each set of Quality Standards.Combining a whole community baseline assessment of current service provision, with work to determine the level of patient experience of a service across the Network, the Framework provides a mechanism to monitor the implementation of the standards and to develop clinical services.

NICE New Drugs: Technology Appraisals

During 2011/12 a number of NICE Technology Appraisals (TA's) were published for new drugs which had implications for cardiac services within North Trent. The first of these was for Ticagrelor, an anti-platelet therapy and more recently new Oral Anti-Coagulants.

In response to these TA's the Network facilitated a coordinated approach to the approval and implementation of these drugs.This collaborative approachsought and successfullyachievedengagement with all relevant parties to ensure a smooth and clear transition for the use of these drugs.

Following the successful implementation of Ticareglor, with clear guidelines and protocols for its use, the Board and NORCOM agreed that a similar coordinated commissioning approach be followed for the implementation of all future TA's.

A more formal process will be developed and documented during 2012/13.

Familial Hypercholesterolaemia (FH)

During 2011/12, the Network continued to work on the development of FH services based on the NICE Clinical Guideline 71, issued in August 2009.It is envisaged that during 2012/13, an agreed Service Model will be developed for consideration by Network commissioners of FH services.

Guidance on the detection and treatment of Atrial Fibrillation

In June 2011, a multi-professional strategy to improve the detection and treatment of AF, to increase the use of evidence based therapy and reduce stroke was published by the Y&H SHA. 'Regional Best Practice Guidance in respect of Atrial Fibrillation (AF)' was published following collaboration across the three Cardiovascular Networks in the Yorkshire and Humber region.

This Regional Prevention Guidance for Healthcare Professionals provides guidance to identify and support people with AF and offer them optimal therapy. This work supports the Arrhythmia work stream of the Cardiac Work Programme.

The guidance will help Healthcare Professionals:

- Raise professional awareness of AF and its role in stroke and scope how Social Marketing can improve the public's awareness of symptoms of AF;
- Improve the detection of AF, via opportunistic pulse checks within other health initiatives;
- Provide guidance on referral from primary to secondary care;
- Improve secondary prevention by detecting AF in patients who already have had a TIA or stroke;
- Identify how to risk stratify AF patients and treat those at risk via the use of oral anticoagulants;
- Address barriers to oral anti coagulation therapy and look at the use of other potential anti-coagulants on the market that may not already have a licence but will do so at some point in the near future;
- Promote, where applicable, the GRASP-AF tool to search Practice Registers and identify AF patients not on optimal management to support medication review;
- Look at how the "Prevention and Lifestyle Behaviour Change Competency Framework" can enable healthcare professionals to support patients with known AF;
- Through clinical audit, recommend how the quality of service provision can be audited and how changes in practice can be measured;
- Look at anti-coagulant clinics and clinical management, the quality of anti-coagulation and need for annual review.
- Look at anti-coagulant clinics and clinical management, the quality of anti-coagulation and need for annual review.

Yorkshire and Humber Congenital Cardiac Network (CCN)

The Y&H CCN is a Network managed by the North of England Specialised Commissioning Group (Yorkshire and the Humber Office) and was established in 2009 to enable clinicians, managers and commissioners across North Trent, West Yorkshire and North East Yorkshire and Northern Lincolnshire to work together to improve congenital cardiac services in the region.

During 2011/12 the CCN made significant progress in a number of areas including:

- A Paediatric Cardiology Outpatients Service Review

- Patient, Parent and Carer representation and involvement
- Delivery of a regional programme of Fetal Cardiac Screening Training

It is anticipated that the decision on the future national configuration of paediatric cardiac surgery services (Safe & Sustainable: Review of Paediatric Cardiac Surgery) will be made during 2012.

Any Qualified Provider – Cardiac Diagnostics - Ambulatory ECG

Following the publication of DH Guidance 'Extending Patient Choice of Provider' in July 2011, PCT Clusters were required to identify 3 or more services to allow the extension of patient choice through Any Qualified Provider in 2012/13. One of the services identified was 24 Hour ECG services. NHS Sheffield led on the development of a cluster-wide service specification and the procurement process on behalf of the South Yorkshire &Bassetlaw Cluster. The North Trent Network of Cardiac Care assisted the development of the service specification in early 2012.

A draft service specification was developed with input from Professor Adrian Davis OBE (DH Lead Advisor on Physiological Science Services and Audiology), Professor Sue Hill OBE (Chief Scientific Officer, Department of Health), Doctor Charles Heatley (GP/PBC Confederation Chair, NHS Sheffield) and Doctor Richard Oliver (Joint Chair of the Clinical Executive, NHS Sheffield). The draft service specification was consulted on widely within the Network and it is anticipated that the final specification will be completed in May 2012. This specification will be shared with the Department of Health and made available for other PCTs / CCGs undertaking similar exercises.

It is envisaged that the procurement process will commence in June 2012 with the service commencing as an AQP service in September 2012.

The anticipated benefits of opening up services to AQP are:

- To give patients the right to choose to be treated in the place that is most appropriate to their needs
- To drive up quality and provide levers for the best quality providers to grow
- To encourage innovation by making it easier for new providers to offer services.

Network partnership approach to Patient and Public Involvement

Patient and Public engagement and involvement activities are on-going within all of the health communities across the Network region. This section aims to highlight some key pieces of work that have been led or supported by the Network Management Team.

The Cardiac model and approach to PPI was developed following stakeholder consultation and co-design and is continuous and sustained. This approach, outlined in the NTNCC Public Engagement and Involvement Model (see P16), enables a rapid response to emerging priorities. Patient and Public Involvement (PPI) activity happens along 4 levels of the involvement continuum as identified in 'Real Involvement – Working with People to improve Services (DH 2008):

Level 1 - giving information
Level 2 - getting information
Level 3 - forums for debate, public participation
Level 4 - partnership working.

This Network wide partnership approach ensures engagement and a close working relationship with the statutory NHS organisations, community groups, interested individuals service users and carers, Voluntary Sector Umbrella Organisations and Local Involvement Networks (LINks).

A 'Friend of the Network' membership scheme holds information that identifies an individuals preferred level of involvement and the method of communicating with them. The hub and spoke communication mechanism, with relevant community groups and public representation from the Network User Group at Board level, ensures that a Network wide public voice has an influence in shaping Network commissioning plans.

Examples of PPI activity that has occurred during 2011/12 includes:

Level 1 – Giving Information

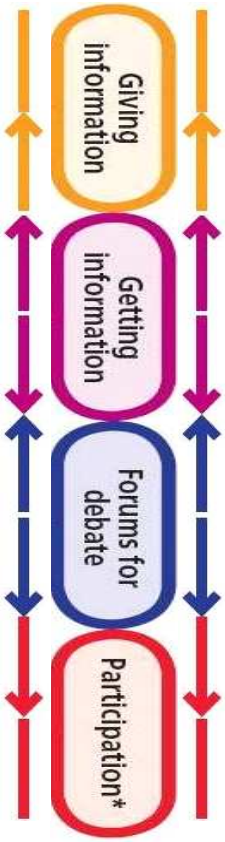
- **NTNCC website** – to enable the public to be informed about the business of the Network and ensure transparency in all PPI activity, the relevant section on the website is maintained and updated regularly. Project reports and the notes from the Network User Group meetings are posted and the site contains direct links through to other sites e.g. Patient Opinion.
- **Bonafide public information sources** – these are given to the public on an on-going basis either as part of specific project work or via the website. The types of information that have been shared this year have included NICE information for the public, NHS constitution, NHS choices and Patient Opinion and information specific to the public consultation project.
- **Communicating Information as specific projects** - Various Network wide communication projects have been undertaken this year for example:
  - Dard e dil– (pain in heart). The production of this DVD was led by the Bradford community development team(Urdu with English subtitles)to help South Asian people to get the urgent help they need if they get chest pain.

Level 2 and Level 3 - Getting Information and Public Participation

- **Cardiac QIPP**– as part of the regional specialised commissioningproject a focus session utilising project questionnaires was held with services users and carers who had recent experience of the cardiac revascularisation pathway.

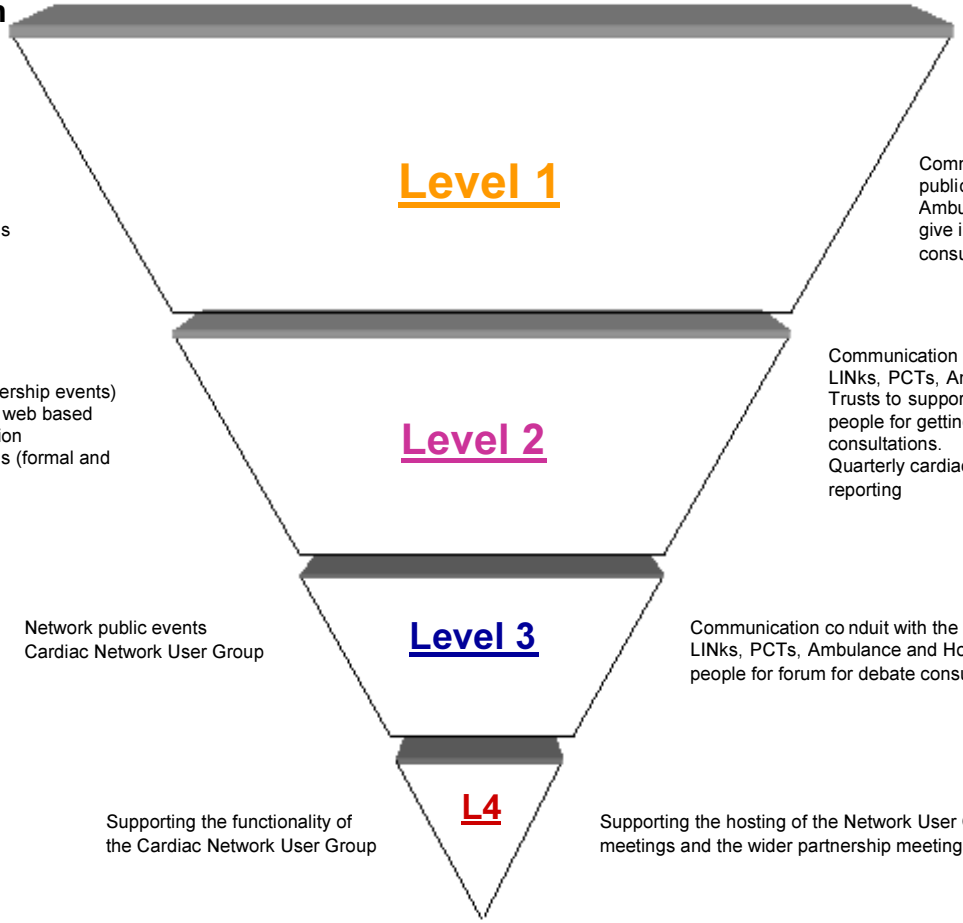
North Trent Network of Cardiac Care Involvement Model

Network Improvement Team coordinated activities



Network website
Network User Group
Annual Network PPI report
Network public consultations (formal and informal)
Network events (inc l. partnership events

Network User Group
Network events (inc l. partnership events)
Ongoing via local LINks or web based platforms e.g. Patient Opinion
Network public consultations (formal and informal)



Communication conduit with the public viaLINks, PCTs, Ambulance and Hospital Trusts to give information about consultations and events

Communication conduit with the public via LINks, PCTs, Ambulance and Hospital Trusts to support consultations and recruit people for getting information consultations.
Quarterly cardiac experience data reporting

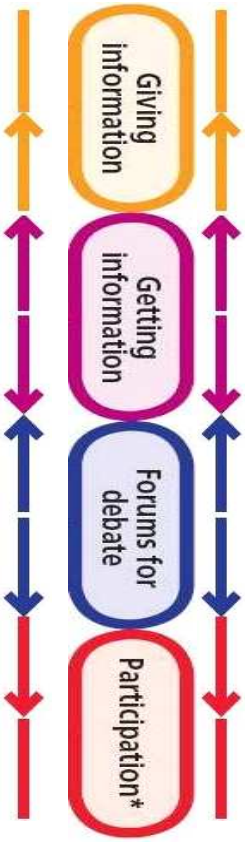
Network public events
Cardiac Network User Group

Communication co nduit with the public via LINks, PCTs, Ambulance and Hospital Trusts to recruit people for forum for debate consultations

Supporting the functionality of the Cardiac Network User Group

Supporting the hosting of the Network User Group meetings and the wider partnership meetings

Partner Organisations co-ordinated activities



- **Working with the National Institute of Health and Clinical Excellence (NICE)** – specific project work is undertaken through the Network User Group that responds to the development of clinical guidance and quality standards. The Network User Group is a registered stakeholder group and individual members apply for lay representative opportunities as and when they arise.During 2011/12 a specific project was undertaken whereby service users attending cardiac rehabilitation sessions were spoken to and their views about preventing a secondary heart attack were captured.
- **NICE Heart Failure QualityStandards**– Network wide agreement resulted in the development of a framework that would ensure a timely response to NICE quality standards. Following a baseline of the clinical service provision, a specific project was undertaken to map service user and carer experiences across the North Trent region. The standard and 13 quality statements were used as a framework at 'Listening to You' events and during semi structured interviews involving 100 service users and carers.Individual health community reports will be written highlighting the emerging themes for the Network and service improvement /development work within the local health communities is currently being planned. It is anticipated that the public engagement exercise will be repeated in 3 years' time offering the opportunity to demonstratethe impact of service improvement on patient experience during that 3 year period.
- **Equity and Excellence consultations** – in response to the emerging plans for the NHS ,'Listening to You' sessions were held to gather public opinion to inform the public consultation exercise.
- **Discovery Interviews** – in their roles as critical friends, Network User Group members identify friends and family members with recent experience of using cardiac services and arrangements are made via the Network PPI Manager for a Discovery Interview to be undertaken. This semi structured 1:1 interview process, grounded in research methodology, gathers an individual's story of care.

Level 4

- **Network User Group** – this group is a formally established sub group to the Network Board, acting as a critical friend to the Network. The hub and spoke service user engagement model enables members to represent their affiliated community group's interest at the Network User Group meeting. This then forms a collective voice which is represented at each Cardiac Board meeting. Specific project work is delegated by the Board to the group. On-going work to support the development of this group and its members has also taken place during 2011/12 resulting in the revision of the terms of reference for the group. The group is continually developing and individuals offer on-going support to the Network
- **Supporting support groups –** a framework for supporting the development or review of cardiac support groups has been agreed at the Network Board. It outlines a sliding level of support that is available for health professionals and members of the public who are considering setting up a cardiac support group.
- **Patrtnership events** - These public events were held in the heart of individual health communities and are driven by people identifying there is a local need .They are co-designed and co-delivered in partnership with NHS statutory organisations, LINks,cardiac support groups and NUG members.

Rachel White
Public and Patient Involvement Manager

North Trent
Stroke Strategy Project

Chairman's Introduction

It gives me great pleasure to introduce the Stroke Strategy Project Annual Report for 2011/12. It has been a privilege to work with colleagues from across the Network to deliver some key improvements for Stroke services during the past year, which has demonstrated the benefits of collaborative working across the North Trent system. It is inspiring to see the dedication and commitment of colleagues to improve services for Stroke patients across the whole of the system working collaboratively to achieve improved outcomes.

The year has seen several significant developments and improvements in Stroke Services across the whole of the system; in particular I would like to focus on recognising the work that has been undertaken by all organisations to implement the Peer Review process. This provides a baseline assessment of the quality and effectiveness of services in delivering good Stroke services to patients. The Peer Review process has been successfully implemented across North Trent and has been helpful in identifying areas to improve what are excellent services across the system.

The introduction of 24/7 acute thrombolysis service across North Trent has been a significant achievement made possible through the co-operation and collaborative working of clinicians and organisations to introduce a tele-medicine solution for out of hours consultations. This initiative has realised significant benefits for patients with increased numbers of patients being thrombolysed and as a result achieving significantly improved outcomes.

The above developments are only two of many initiatives that have taken place across the year in terms of improving aspects of Stroke services. As we look to the future it is important to recognise the need for the North Trent system to continue to work in an integrated way and to collaborate to deliver improvements for patients both within stroke and other disease areas. I would like to place on record my thanks to the Network Team for their hard work and diligence and to all commissioners and providers for the sterling work that has achieved improvements in Stroke services and better outcomes for patients.

Steve Wainwright
Chair,North Trent Stroke Strategy Project
Chief Operating Officer, NHS Barnsley

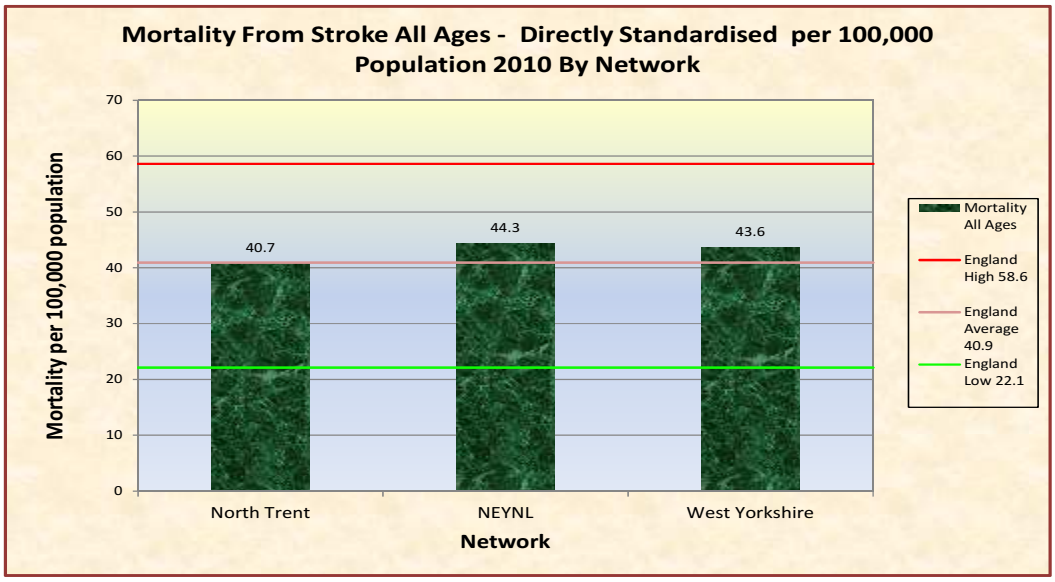
Stroke Related CVD Profiles

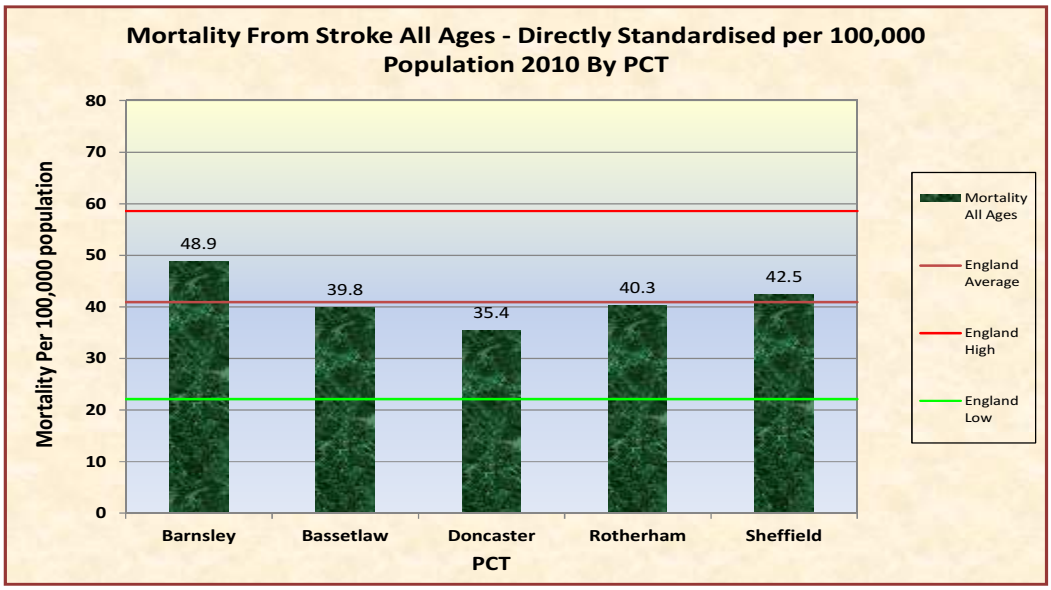
The following Charts and accompanying information are compiled from the CVD health profiles produced for every Network and PCT in England by the South East Public Health Observatory.

There are three Stroke specific indicators out of a total of fifteen CVD indicators; stroke mortality (all ages), Stroke emergency admission rates and percentage of Stroke patients discharged to their usual place of residence.

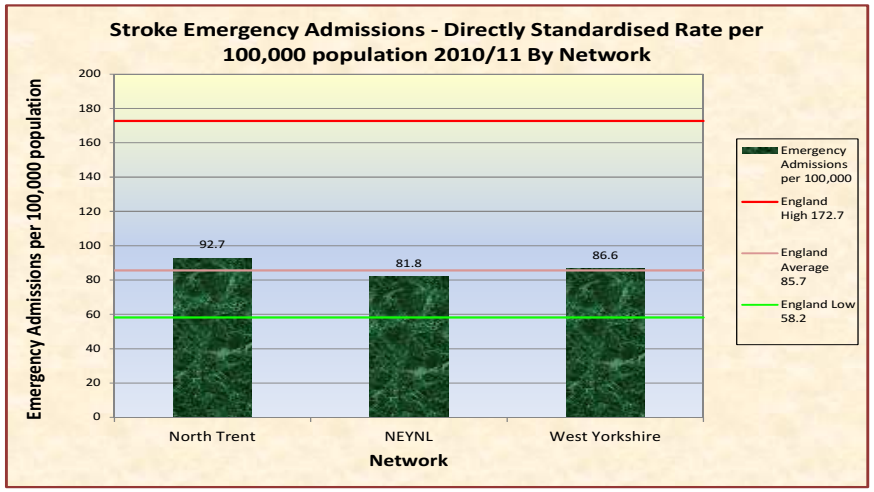
The data relate to the period 2010 / 11 and the graphs show, firstly, comparison between the three Yorkshire and Humber area Stroke networks (North Trent, North East Yorkshire and North Lincolnshire and West Yorkshire) and secondly comparison between the individual health communities across the North Trent Network region.

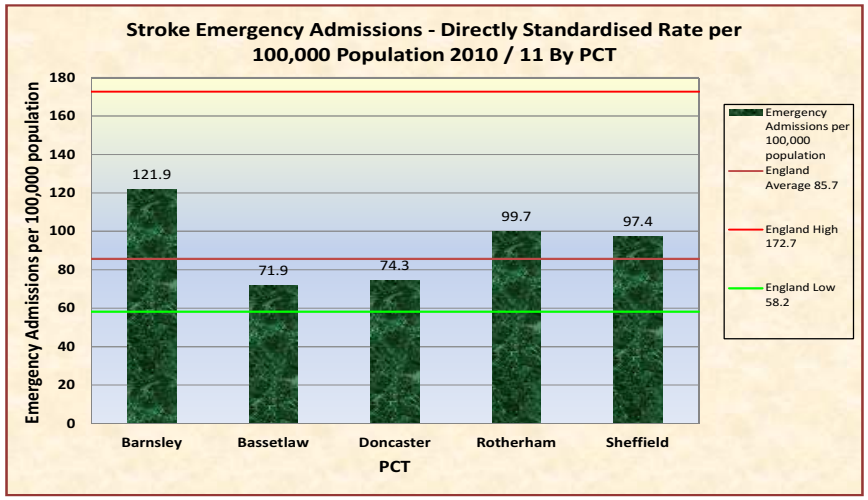
Stroke Mortality





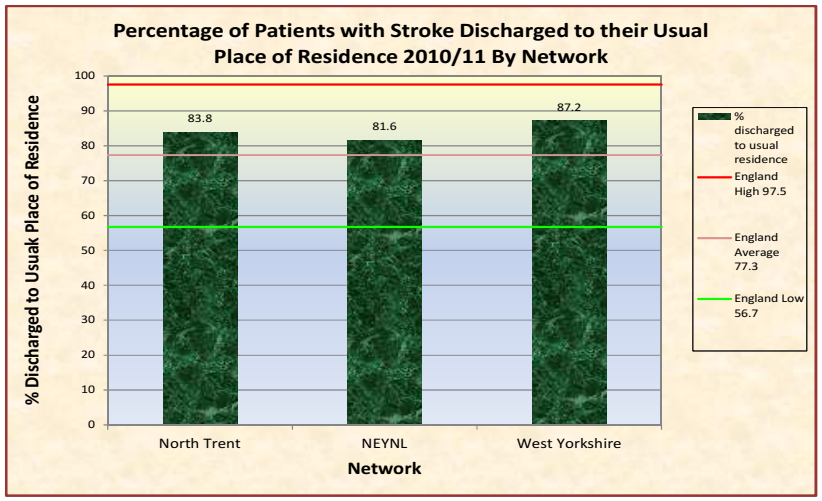
Stroke Emergency Admission Rate

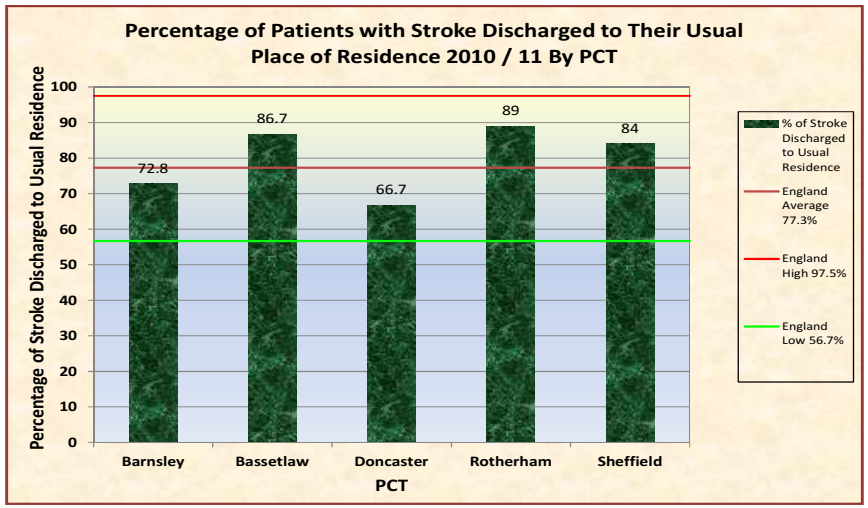




Stroke and TIA Management

The following graphs compare the percentage of patients discharged to their normal place of residence, firstly, by Network and then by individual health communities within the North Trent region.





Clinical Lead Report

During 2011/12, we have been delighted to welcome Drs Gary Pratt, Peter Anderton and Mahmud Sajeed to the Network as Consultant Stroke Physicians. In addition, Dr Sunil Punnoose moved from Chesterfield to Rotherham, Dr Hlaing Ni joined us as Stroke SpR and our congratulations go to Dr Jessica Redgrave in achieving her CCT in Stroke Medicine as part of her neurology training.

The participating hospitals within the Network have continued to demonstrate their ambition to implement the National Strategy for Stroke by achieving high scores in their IPMRs and 'Accelerating Stroke Improvement' metrics, although further work is still required in the areas of discharge and follow up which will form part of the work we will be taking forward in 2012/13. On behalf of the Network I would like to thank all clinicians involved in the care pathway for the work they have done in maintaining such high standards.

All providers of Stroke services in the Network participated in the demanding Y&H Peer Review process last year. Sheffield Teaching Hospitals are to be congratulated for achieving comprehensive (level one) Stroke centre status (the only one in Yorkshire and the Humber) and Chesterfield is now fully accredited as a level two Stroke centre. Subject to follow up review I anticipate Doncaster, Barnsley and Rotherham will achieve level two Stroke centre status within the next six months. We are grateful to a number of external reviewers (Dr Christine Roffe, Professor Helen Rodgers, Dr Charles Sherrington, Dr Indira Natarajan, Dr Tim Cassidy and Dr Peter Humphrey) as well as my co-leads for Yorkshire (Drs Bamford and Coyle) who have given a considerable amount of their time to make this process effective and rigorous and on your behalf I would like to extend our thanks to them for doing this.

The Network was the first in Yorkshire and the Humber to implement telemedicine for out of hours and weekend thrombolysis care through a pilot which commenced in January 2011. This has already had a significant impact on care for people with stroke in that we are now delivering thrombolysis care to 10% of those eligible at night compared with 6% during day time hours. What started as a pilot to assess feasibility will move to a permanent commissioned solution across the Network in July 2012/13. I would like to thank Martin Dawes Ltd., for delivering the information technology solution and equipment on time, Sarah Halstead, Project Lead for Telemedicine in Stroke, the many of you who have trained GIM trainees, acute care and emergency physicians, stroke nurses and others and especially those Clinicians on the rota who deliver this service.

Clinicians within the Network have contributed, through platform and poster presentations, to the UK Stroke Forum in Glasgow, the European Stroke Conference and other national meetings and continue to be active participants in the work of the Trent Stroke Research Network and the Stroke CLARHC.

My thanks go to everyone concerned in delivering Stroke services for their commitment and cross Network collaboration which has been an essential element in our success.

Professor Graham Venables
Clinical Lead, North Trent Stroke Strategy Project
Consultant Neurologist and Clinical Director Neurosciences

Working with and as a member of the North Trent Stroke Strategy Project Board

Martha Mayhew, Assistant Director of Service Improvement
NHS Doncaster

As a commissioner I have found the support of the Network invaluable in supporting service improvement and development. Working in partnership with the Network enables the sharing of best practice both across the region and nationally.

The Network provides health intelligence to inform commissioning decisions and has been instrumental in the development of the North Trent telemedicine thrombolysis service.

During the Stroke service Peer Review, the Network has provided essentialguidance and support to both commissioner and provider throughout the process.

Marie Rowland, Deputy Chief Operating Offier
Barnsley Hospital NHS Foundation Trust

The Stroke Network has provided the support and infrastructure to enable Barnsley Hospital to drive forward a challenging agenda which enables excellent care for Stroke patients to be delivered locally.

Assuring quality and robust service delivery plans has enabled providers within the Network to work as a collective group to establish 'best fit models' and share best practice.

Maxine Dennis, Sevice Director, Urgent Care
Rotherham NHS Foundation Trust

Working with local commissioners and providers as part of the North Trent Cardiac Network and Stroke Strategy Board supports the development of quality services for our patients. The collaborative approach that the Network engenders ensures that we share best practise, use resources wisely by avoiding duplication, and develop services that are both affordable and patient focused.

In terms of the Stroke Strategy Board, there is no doubt that local providers could not have achieved a 24/7 Thrombolysis Service without working together to develop a Network solution. This is truly collaborative working. The last 12 months has also seen a focus on Stroke Accreditation and the Accelerated Stroke Indicators, both of which have supported the drive to improve quality in Stroke Services. The sharing of good practise has provided mutual support to implement new and innovative ideas.

The Network also enables strategic thinking in terms of how policy can be turned into practise. It provides peer support and guidance for managers, facilitating solutions to challenges that might have otherwise been seen as complex problems.

The Yorkshire and the Humber Stroke Telemedicine Project

The Stroke Telemedicine project began in February 2010. The key aim of the project was to deliver a Stroke Telemedicine Solution across Yorkshire and the Humber to support delivery of the Hyperacute Stroke Pathway, specifically thrombolysis. The installation of the telemedicine solution was completed in September 2011.

Following the installation, the North Trent Stroke Network has used the technology to support the development of an inter-trust collaborative thrombolysis rota. This has seen the extension of Stroke thrombolysis provision from a weekday 9am – 5pm service to an out of hours and weekend rota. By July 2012 it will extend to 7 day a week 24 hours a day. Telemedicine has led to better use of the Stroke consultant workforce and more affordable out-of-hours rotas.

The decision was taken in North Trent to conduct a Stroke Telemedicine Pilot Project for out of hour's emergency admissions. The Stroke Telemedicine pilot will run from the 9 January 2012 until 30 June 2012. The following numbers are for the period of 9 January 2012 up to 31 March 2012.

- 94 patients were admitted out of hours
- 17 (18%) patients have benefited from an assessment for thrombolysis
- 7 (41%) patients were thrombolysed with an age range from 23 years to 89 years

Indications are that these figures will continue to improve.

Of the 94 admissions out of hours, 39 patients were not assessed for thrombolysis for non-clinical reasons. Thirty seven of those patients presented late (out of the thrombolysis time window for thrombolysis).

A patient's story

It was a Sunday evening and I had had a headache for about an hour and felt generally unwell. I decided to go to bed and as I got to the top of the stairs my arm felt strange and I subsequently collapsed. My mum rang the ambulance and I was taken to hospital.

I did not know what was wrong with me or even if I might die. When I got to the hospital, although I did not know what was wrong with me it was a great feeling to know that the doctors and nurses knew what to do and I am really thankful for that and would like to thank them all.

This patient is a 23 year man who was assessed and thrombolysed via the telemedicine out of hour's thrombolysis service and he has made a good recovery.

In Yorkshire and the Humber it has been estimated that extending the Stroke thrombolysis service beyond its current in-hours delivery would lead to the prevention of significant disability in 37 people per annum, a saving to the NHS of £350,248 per annum and a saving of £782,907 per annum to social care.

Developing Stroke telemedicine in the Network has provided a powerful lever for driving up the quality of all acute Stroke care; a prerequisite for the delivery of telemedicine care being the delivery of excellent acute Stroke care. It is also proving to be a useful opportunity to explore the potential use of telemedicine in other acute medical care.

There has also been a positive response from clinicians and patients. A patient thrombolysed via telemedicine in February agreed to share his experience/story.

Yorkshire and the Humber Peer Review Accreditation

The improvement of Stroke services continues to be a key strategic priority in Yorkshire and the Humber. The Y&H Stroke Assurance Framework was developed as a result of 'Healthy Ambitions' and through the submission of Stroke Assurance Framework (SAF) plans, PCTs have endeavoured to plan and achieve the quality standards of stroke care which provide their population with a quality Stroke service.

Through Stages 1 and 2 of the SAF process, PCTs along with their Providers developed their plans for improving the core and developmental quality marker standards as highlighted in the Y&H SAF. Plans were subsequently peer-reviewed by regional Stroke Networks, and Red-Amber-Green (RAG) rated with recommendations made for further improvement. All core quality marker standards had to be RAG rated green to achieve an overall green score.

4 out of the 5 PCT's plans were RAG rated amber. Follow up confirm and challenge meetings were held and refreshed SAF plans resubmitted following further recommendations. Since the initial submission in Dec 2009 SAF plans have greatly improved in those PCTs.

In the next stage of the SAF process(Stage 3), Providers (with support from their PCTs) were required to evidence "on the ground" how they were meeting the Stroke quality marker standards, which they had been working towards during 2010.

The outcome of the Stage 3 process was to award an accredited level of Stroke care as highlighted in the SAF. It was anticipated that Providers would wish to be accredited with one of these levels, and they were required to provide detailed evidence to demonstrate that they meet the standards for the relevant level of accreditation.

Stage 3 of the Y&H Peer Review process, supported by Network Teams, commenced in October 2011 and provided an excellent opportunity to examine Stroke services in detail.

Improvements made in Stroke care across the Network as a result of the Peer Review process are evident with 2 Trusts gaining full accreditation and 3 trusts awaiting a decision pending their final review visit.

Network Position at 31.3.12:

	North Derbyshire	**Sheffield**	**Rotherham**	**Barnsley**	**Doncaster and Bassetlaw**
Date of review visit	16th November 2011	6th December 2012	19th December 2011	31st January 2012	2nd March 2012
Position 31.3.12	Provisional accreditation awarded. Review meeting 4th May 2012	Accredited at Level 1	Provisional accreditation awarded. Review meeting June 2012	Decision deferred pending further information. Review meeting May 2012	Provisional accreditation awarded. Review meeting September 2012

Accreditation is an important step in the regional drive to improve Stroke care. Core standards are now in the process of becoming embedded, and it is envisaged that all providers will be providing 24/7 hyperacute care including thrombolysis from 1 July 2012.

Gaining accreditation not only rewards the service, providing the deserved recognition that the quality standards have been met, but provides assurance to its population and promotes credibility amongst peers. It is also important as part of the roll out of the Y&H Telemedicine Project for thrombolysis where a reliance on inter trust working and assurance of the quality of service provision in each participating site isrequired.

Accelerating Stroke Improvement (ASI)

The National Stroke Strategy was launched in December 2007 providing a national quality framework through which local services can, over a ten year period, secure improvements across the stroke pathway against quality markers.

Following the National Sentinel Audit of Stroke 2009 Organisation Audit Report,the Accelerating Stroke Improvementprogramme was launched as a national initiative designed to accelerate improvement of services across the whole pathway of stroke and TIA care, reflecting all 20 quality markers in the strategy.

Through the development of 9 key metrics across the whole patient pathway, *Accelerating Stroke Improvement* was designed to help commissioners and providers work together to determine the best way to improve services. Work on stroke falls naturally into three domains:
• prevention;
• acute care;
• post-hospital and long-term care.

Accelerating Stroke Improvement (ASI) Performance

Data

The following table has been compiled from national comparative data prepared and distributed by the NHS Stroke Improvement team. Data from Quarter four 2011/12 represents the most recent data available.

With the exception of measures 3 and 5 (IPMR metrics), ASI data collection is not mandatory so apparent variance in performance may reflect data completeness issues as well as actual service provision.

Performance summary

North Trent has the highest performance of the three Yorkshire and Humber Networks, exceeding both national target and national performance in seven of the ten measures.

Access to brain imaging is the only area which falls below both target and national performance and will be subject to further discussion in 2012/13.

	Performance Against ASI Metrics as at Quarter 4 2011 / 12 National and Yorkshire and Humber Networks				
	National Performance	Target	North Trent Network of Cardiac Care	North & East Yorkshire and Northern Lincolnshire Cardiac and Stroke Network	West Yorkshire Cardiac Network
ASI 1 Preventable Strokes	62%	60%	64%	92%	42%
ASI 2 Direct Admission to Stroke Ward	56%	90%	73%	60%	65%
ASI 3 Acute Stroke Care **(Also IPMR metric)**	84%	80%	86%	80%	82%
ASI 4a Access to Brain Imaging 1hr	40%	50%	31%	30%	15%
ASI 4b Access to Brain Imaging 24hr	90%	100%	89%	82%	81%
ASI 5 Management high risk TIA clinic appt **(Also IPMR metric)**	73%	60%	94%	75%	55%
ASI 6 Timely access psychological support	39%	40%	57%	67%	0%
ASI 7 Joint Health & Social Care Mgmt	70%	85%	100%	99%	27%
ASI 8 Assessment and Review	37%	95%	95%	12%	33%
ASI 9b Access to ESD	31%	40%	55%	25%	37%

Key

- Above target and above national
- Above target but below national
- Below target but ≤national
- Below target and below national

SINAP

The Stroke Improvement National Audit Programme (SINAP) is a national audit that focuses on the provision of hyperacuteservices. SINAP collects prospective continuous data for patients during the first three days of care. SINAP went live on 4th May 2010. The aims of SINAP are:

- To describe the pathway followed by patients with acute stroke (in the first three days) in hospitals
- To assess the quality of care provided to acute stroke patients during the first three days of care
- To identify the major areas where services need to be improved for acute stroke patients

Data collection identifies all Stroke patients admitted to hospital and documents:

- how patients are admitted;
- how they are evaluated and by whom;
- what investigations they have;
- what immediate treatment they receive; and
- how they are managed during the first

TIA Best Practice Guidance

The Stroke Assurance Framework (SAF), developed in 2009/10 by the three stroke Networks and Y&HSHA, established the blueprint against which commissioners and providers would assure themselves of the development and implementation of Stroke services in accordance with the Quality Markers set out in the National Stroke Strategy (2007).

The need to more formally address Element 'A' (Stroke prevention) of the SAF was identified by the regional Stroke Assurance Framework Working Group (SAFWG). Recognising the gap in this area, and with the increasing significance of the QIPP agenda, SAFWG endorsed a programme of work to provide additional focus in this area in September 2010.

The prevention of Stroke presents significant QIPP opportunities for the regional health economy and aligns neatly with all five domains of the Outcomes Framework requirements and Y&HSHA TIA service performance (IPMR). It also remains one of the key concerns and priorities both regionally and nationally. Following consultation with clinical leaders, the

72 hours after admission.

This process enables local clinicians to be able to continuously assess their performance benchmarkedagainst national performance.

From December 2011 all five acute trusts across the North Trent Network were submitting SINAP data. All Trusts submit this information for all Stroke patients and not just for the minimum requirement of 20.

treatment and management of TIA was identified as a key priority for this work.

A clinically-led, multi-disciplinary, time-limited task & finish group was established to progress this important element of work. The group membership included, Stroke consultants, Neurologists, GP's, commissioners and Networks from across the North Trent region.

Following a rigorous review of all available evidence and guidelines, in conjunction with a wider consultation process, a 'best practice' TIA guidance was developed and completed in June 2011.

As a clinically-led piece of work that represents a consensus in respect of 'best practice', the guidance can be used to help the regional health economy understand how it can best address the Stroke prevention agenda, realise the performance and QIPP potential, and assure itself of consistency of approach.

Network partnership approach to Patient and Public Involvement

The Stroke Strategy Project Board agreed approach to PPI activity was for the majority of projects to occur at a local health community level on a do once and share basis.

An example of this approach is evidenced through the North Trent social marketing project which commenced in 2009 and aimed to raise awareness of Stroke in Black and Minority Ethnic (BME) populations'.

This project was an NHS Sheffield sponsored project supported by the Network. It is envisaged that the outcomes and evaluation will be available across the Network during 2012/13.

The project took an innovative approach to raising awareness of Stroke and its symptoms amongst communities most at risk. Insight was gathered from segmented communities about beliefs and behaviours that might impact on their ability or willingness to seek urgent help

Findings from initial research with key 'at risk' groups across Sheffield, indicated that the focus should be on specific BME communities, co-creating a campaign with the core message of 'time lost is brain lost'.

The campaign – designed and developed by Pakistani, Somali and Yemeni people in Sheffield – involved three key aspects:

- Community events and health checks held at local venues
- Informative materials and bespoke leaflets for each community
- Key information points – both locations and people - in the communities

During the pilot phase of the campaign more than 3,500 leaflets, designed and co-produced by the communities, were distributed and 140 people attended community events.

Work is now continuing to develop a sustainable approach in Sheffield and to share and embed lessons learned within other areas across the Network.

Alongside the co-production approach taken in Sheffield, NHS Doncaster continued its established engagement work with BME communities to increase Stroke awareness. In a comparative evaluation, increases of up to 50% were seen in knowledge of the key symptoms of Stroke and the actions to take and 100% of participants in campaigns in Sheffield and Doncaster knew to call 999 after attending the events.

On-going research by the Collaboration for Leadership in Applied Health Research and Care is taking place to examine the unofficial role of community communicators and how information is transmitted and shared throughout these communities.

Rachel White
Public and Patient Involvement Manager

Member Organisations

Barnsley Hospital NHS Foundation Trust
Chesterfield Royal Hospital NHS Foundation Trust
Doncaster & Bassetlaw Hospitals NHS Foundation Trust
Rotherham NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust

NHS Barnsley
NHS Bassetlaw
NHS Derbyshire County
NHS Doncaster
NHS Rotherham
NHS Sheffield

Yorkshire Ambulance Service
East Midlands Ambulance Service

Contact Details

If you require any additional information,
please contact the Network Office

Clare Hillitt
Cardiac Network Director
clare.hillitt@barnsleypct.nhs.uk

Nicola Brazier
Network Administrator
nicola.brazier@barnsleypct.nhs.uk

01226 433774

ROTHERHAM BOROUGH COUNCIL - REPORT TO MEMBERS

1.	**Meeting:**	**Health and Wellbeing Board**
2.	**Date:**	**31st October, 2012**
3.	**Title:**	**Joint Health and Wellbeing Strategy and Health and Wellbeing Board Work Plan**
4.	**Directorate:**	**Resources**

5. Summary

This report presents the final version of the Rotherham Joint Health and Wellbeing Strategy for the Board's formal approval.

For information, it also outlines the implementation plan which is now underway; including the role of the Health and Wellbeing Strategy Steering Group, and proposals for the Health and Wellbeing Board's work plan.

6. Recommendations

That the Board:

- **Approves the Joint Health and Wellbeing Strategy**
- **Approves the format for the HWBB Work Plan for 2012-13**
- **Notes the Strategy implementation plan**

7. Proposals and Details

The Joint Health and Wellbeing Strategy (JHWS) for Rotherham sets out the key priorities that the Health and Wellbeing Board (HWBB) will deliver over the next three years to improve the health and wellbeing of Rotherham people. It presents a shared commitment to reduce health inequalities locally and will be used to guide all agencies in Rotherham in developing commissioning priorities and plans.

The strategy sits within a suite of documents which will require continued development throughout the lifecycle of the strategy:

- Joint Strategic Needs Assessment – the data and intelligence which inform the Board's priorities and the Strategy, it will become a live document and periodically refreshed and updated.
- Commissioning plans – demonstrating funding and leadership, and all agencies will need to show alignment of these to the Strategy.
- Performance management framework – currently being developed and will inform the performance monitoring schedule for the Board.

7.1 Implementation Plan

Each of the 6 priorities of the Strategy now has a strategic lead officer, who will coordinate and provide leadership to the workstreams; ensuring work plans align and implementing new ways of working to bring about culture change.

Health and Wellbeing Strategy Steering Group

A steering group is now in place, made up of the 6 lead officers, plus representation from local authority policy, performance and commissioning, public health and NHS.

This group will coordinate and lead the Strategy implementation plan. The group will be accountable to the HWBB and provide assurance about progress in relation to delivering the Strategy outcomes.

Membership of the Steering Group:

- Tom Cray, Chair
- Sarah Whittle, Co Chair
- John Radford, Prevention & Early Intervention
- Sue Wilson, Expectations and Aspirations
- Shona McFarlane, Dependence to Independence
- Joanna Saunders, Healthy Lifestyles
- Andy Irvine, Long Term Conditions
- Dave Richmond, Poverty

HWBB Work Plan

The Board's work plan has been developed in draft, building on the outcomes from the self-assessment process and feedback from the Department of Health representative.

The plan is made up of a series of thematic discussions and performance reporting in relation to the Strategy's priorities. It is proposed that the Board will receive the Performance Management Framework at the next meeting (28 November) when the Board will be asked to set out the schedule for considering each of the work streams and performance issues; one per meeting as suggested in the draft plan.

8. Finance

There are no financial implications directly related to the contents of this report.

9. Background Papers and Consultation

Joint Health and Wellbeing Strategy 2012-15 (attached)

HWBB Work Plan 2012-13 (attached)

10 Contact

Kate Green
Policy Officer
Commissioning, Policy and Performance
Kate.green@rotherham.gov.uk

DRAFT Health and Wellbeing Board Work Plan 2012 – 13

HWBB Cycle	Agenda Item/Outcome for the HWBB	Action Required	Lead
31 October 2012	Agree HWBB work plan	Plan developed from outcomes of self-assessment activity and reflection from Board members – including 'excellence plan' for continued annual assessment/review of Board's progress	Kate Green
	Agree and publish Joint Health and Wellbeing Strategy 2012 -15	Final strategy to be presented to Board following consultation activity and amendments	Kate Green / HWB Steering Group
	'End of Life' – Rotherham Hospice	Exploring how the Rotherham Hospice can help the Board achieve its priorities	HWBB / Mike Wilkerson, RH
28 November 2012	Agree Performance Management Framework, including: • Agreed measures for Board to monitor • How performance will be reported • Performance reporting schedule	Develop framework based on national Outcomes Frameworks and Board priorities, and agree a set of 5/6 measures which the Board will monitor at planned meetings. For the Board to also agree the schedule for thematic discussions on each of the priorities – one per meeting.	HWB Steering Group to report (meeting 14 Nov)
	Clear reporting mechanism for the Board in place	Undertake mapping exercise; looking at partnership governance structures to provide a clear reporting mechanism which reports by exception and for purpose, stopping duplicate reporting and clarifying the decision making process.	HWB Steering Group (meeting 14 Nov)
	Unscheduled Care Review	Board to consider the NHS review	Ian Atkinson / Dr Ian Turner
	Health and wellbeing in BME communities	For the Board to explore needs of BME communities in Rotherham; what services are available and delivery issues	HWBB / Nizz Sabir, Rotherham Council of Mosques

16 January 2013	Rotherham CCG Annual Commissioning Plan	For the Board to be presented with the plan and discuss opportunities and alignment with the HWB Strategy	Chris Edwards
	Joint commissioning framework	Develop a joint commissioning framework – to be presented to the Board for discussion/agreement	Chrissy Wright
	Financial planning 2013/14	Commitment to put in place formal financial planning sessions from November 2013 onwards. This meeting to consider how the board wishes to do this in the future, as well as an opportunity for sharing financial information and taking stock of now; ready for budget setting for 2013/14	HWB Steering Group to support (14 Nov)
	1st Thematic Discussion on Strategic Priority (tba)	Workstream update – what is working / any blockers / tensions – schedule of priority reporting to be agreed by Board (Nov meeting)	HWB Steering Group
	Performance Report	Standing item – 5 Big Issues to be agreed by Board in relation to the Performance Mgt Framework, one to be looked at each meeting (issues to be presented and agreed at Nov meeting by Steering Group)	HWB Steering Group
27 February	2nd Thematic Discussion on Strategic Priority (tba)	To be agreed	HWB Steering Group
	Performance Report	To be agreed	HWB Steering Group
	Police and Crime Commissioner	Newly appointed Commissioner to attend Board; providing an update and exploring opportunities for health and wellbeing priorities	HWBB / PCC
April 2013	HWBB taking full statutory responsibility		HWBB
	Public Health fully integrated into local authority		John Radford
	Local HealthWatch in place		Chrissy Wright
	3rd Thematic Discussion on Strategic Priority	To be agreed	HWB Steering Group

	Performance Report	To be agreed	HWB Steering Group
May 2013	4th Thematic Discussion on Strategic Priority	To be agreed	
	Performance Report	To be agreed	
June 2013	5th Thematic Discussion on Strategic Priority	To be agreed	
	Performance Report	To be agreed	
July 2013	6th Thematic Discussion on Strategic Priority	To be agreed	
	Performance Report	To be agreed	
September 2013	HWBB Self-Assessment	For the Board to reflect on progress to date; explore any issues, tensions between the agencies and consider the position within each of the workstreams	HWBB
October 2013	HWBB Annual Report	Compile the Board's annual report– which includes a position statement for all strategic priorities / big issues and self-assessment of the Board - to feed into commissioning/planning and budget setting cycle and inform the Board's agenda going forward	HWB Steering Group - to begin work August – presented to Board Oct
	Financial planning 2014/15	Financial information to be shared by all agencies; for the Board to explore issues and opportunities to inform commissioning and budget setting process	HWBB

2013 Self Assessment Tool

Strategy, Purpose and Vision	
1.	The strategy has influenced the strategic direction of the local authority and partner organisations
2.	Individual commissioning plans of the CCG and local authority align with JSNA/JHWS
3.	Partner organisations can describe how the HWBB will make a difference and a shared and effective communications plan exists
Leadership, Values and Relationships	
4.	Local health and social care resources are understood
5.	Relationships between CCG and local authority are positive and there is ongoing dialogue about commissioning and contracting decisions
6.	Relationships enable members to influence beyond their own organisations
7.	The board empowers the local HealthWatch member to act as an independent effective voice for users and the public
8.	The board can demonstrate that it promotes equality in all its actions, including consultation, priority setting and service improvement and undertakes equality assessment on its plans
Governance	
9.	The board has regular updates on the priorities of the wider local authority, NHS Commissioning Board and key local partners
10.	The relationship between the HWBB and the local authority scrutiny function is clear
11.	An agreement regarding pooling of resources is in place and a risk sharing agreement exists between the local authority and CCG
Measures and Accountabilities	
12.	HWBB informed by real-time intelligence, demonstrating improved outcomes, quality and efficiency across health and social care
13.	Priorities balance improvements in service provision with improvements in population health and wellbeing
14.	The HWBB reviews itself regularly against benchmarks and adapts plans as necessary
15.	HWBB Annual Report demonstrates achievement of outcomes

Rotherham Metropolitan Borough Council
Where Everyone Matters

NHS Rotherham

Rotherham Borough

Joint Health and Wellbeing Strategy 2012 – 2015

Introduction

The Rotherham Health and Wellbeing Strategy sets out the key priorities that the local Health and Wellbeing Board will adopt over the next three years to improve the health and wellbeing of Rotherham people.

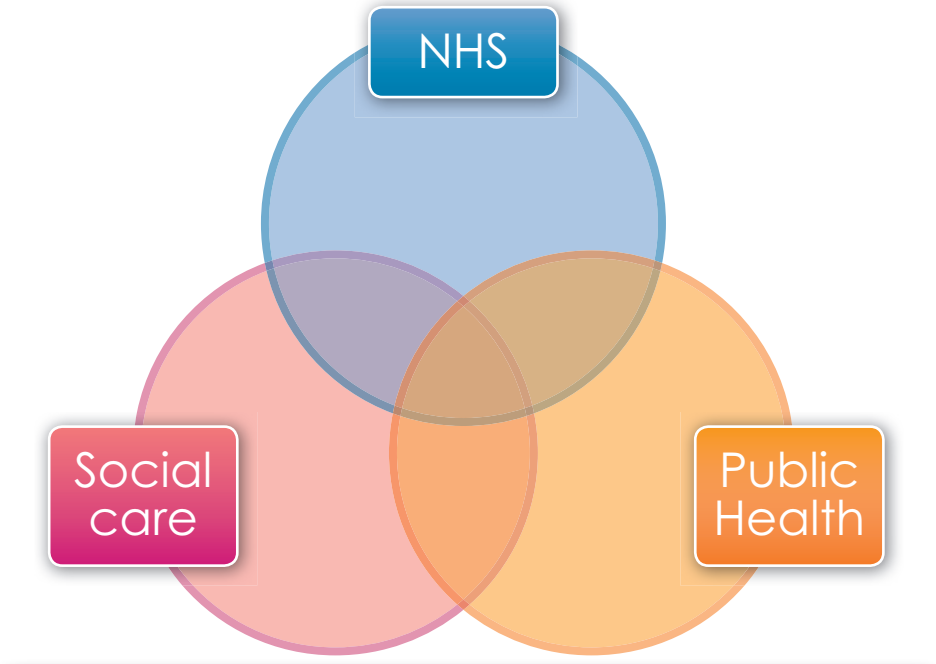
The document brings together the things that impact on people's health and wellbeing into a single, high-level framework. The strategy will be used to guide all agencies in Rotherham in developing commissioning priorities and plans in tackling the major public health and wellbeing challenges facing our communities. The document presents a shared commitment to ensure all Rotherham individuals and families are able to make positive choices to improve their physical, mental health and wellbeing, as well as helping to build strong communities. The strategy should also ensure that public services do everything we can to address the root causes of ill-health.

This strategy will sit within a set of documents which demonstrate the journey from gathering data, to understanding whether we are achieving our goals, these include:

- *Joint Strategic Needs Assessment: our intelligence*
- *Health and Wellbeing Strategy: our vision and how we will achieve this*
- *Commissioning plans: funding and leadership*
- *Performance management framework: evaluating success.*

Integrating Health and Social Care

There are obvious benefits from bringing together planning, funding, and delivery of health and social care. This is demonstrated through the publication of three frameworks of outcomes for the NHS, public health and adult social care. The diagram below shows how these frameworks overlap and how the joint priorities of the Health and Well Being Board presented in this strategy, sit within the centre of it.



The Health and Wellbeing Board brings together the strategic priorities for all three areas to reflect the needs of the Joint Strategic Needs Assessment

Why we need a strategy

Health Inequalities

Deprivation in Rotherham is higher than average and worsening. According to the Index of Multiple Deprivation in 2007, Rotherham ranked 68th most deprived district in England.

In 2010 we had moved to 53rd. Rotherham still ranks amongst the top 20% most deprived districts nationally. The biggest causes of deprivation in Rotherham remain Education and Skills, Health and Disability and Employment. Life expectancy is lower the England average, but there is also a large gap between the least and most deprived areas in the borough; 9.9 years for men and 5.9 for women. Health inequalities in Rotherham are generally worse than the England average and our statistical neighbours.

(source: Health Profile 2011, DH)

The Marmot Review of Health Inequalities ***'Fair Society, Healthy Lives'*** provides evidence that there is a bigger impact on the health for those living in deprivation. The review suggests that there needs to be a focus across different backgrounds as well as across the life course, with appropriate levels of help given to people from different backgrounds to reduce inequalities. It also presents the positive impact of employment for the health and wellbeing of working age people, particularly for an individual's mental health and wellbeing.

Life Course Framework

The Health and Wellbeing Board have agreed a life course framework, which has been adapted from the Marmot life course. The dying well agenda is aligned to ageing well, however we recognise that end of life choices span the life course. The diagram below shows how the life course for this strategy links to the key point in people's lives:

Our Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) takes a comprehensive look at the health and social care needs of Rotherham. We refreshed and published our JSNA at the end of 2011, using factual information and evidence to identify needs.

Our JSNA has told us that the main determinants of health inequalities include deprivation and worklessness, attainment and skills, low birth-weight, infant mortality and mental health, as well as lifestyle factors such as poor diet, obesity, smoking and alcohol use, teenage pregnancy and low levels of physical activity. It also highlighted the ongoing concerns relating to the increased demands due to the ageing population, diversity and caring responsibilities and this poses challenges for service delivery.

Health Inequalities Consultation

To ensure that we fully understand the needs and demands of our local population, we have undertaken a comprehensive consultation on health inequalities with local people. This identified five themes: increased cost of living, quality health services, having the skills for life, Rotherham communities' assets and the look and feel of Rotherham, with an overarching theme of the raising aspirations of Rotherham people and communities.

The most common issues raised included:

- *Families felt challenges in their daily lives led to difficulties in prioritisation and a lack of long-term planning.*
- *Many felt trapped in a cycle of poverty with little prospect of escape.*
- *People felt that young people had poor skills for life and work.*
- *A welfare culture of dependency had become the norm for some people, which was also reflected in rising concerns about welfare reform and expected reductions in benefit.*
- *Low aspirations and expectations were evident across all age groups.*
- *There was little common identity in Rotherham, mainly in the outer areas of the Borough.*
- *Black and Minority Ethnic people still faced discrimination and negative perceptions from services.*
- *Older people often felt isolated and unsafe but also offered untapped potential to help others*
- *People identified the skills they had to offer, but found the opportunity to use them difficulty to find.*
- *People want clear, direct and simple messages on health to encourage people to make changes.*

What we want to achieve

Our Vision:

To improve health and reduce health inequalities across the whole of Rotherham.

Our 'Strategic Outcomes'

The Health and Wellbeing Board have agreed six areas of priority and associated outcomes for the strategy, which represent a desired state for what we want Rotherham to look like in three years:

Priority 1 - Prevention and early intervention

Outcome: Rotherham people will get help early to stay healthy and increase their independence.

Priority 2 - Expectations and aspirations

Outcome: All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community, tailored to their personal circumstances.

Priority 3 - Dependence to independence

Outcome: Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances

Priority 4 - Healthy lifestyles

Outcome: People in Rotherham will be aware of health risks and be able to take up opportunities to adopt healthy lifestyles.

Priority 5 - Long-term conditions

Outcome: Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life.

Priority 6 - Poverty

Outcome: Reduce poverty in disadvantaged areas through policies that enable people to fully participate in everyday social activities and the creation of more opportunities to gain skills and employment.

What we will do - tackle the 'Big Issues'

The Health and Wellbeing Board will prioritise and tackle the 'big issues' highlighted by the JSNA and health inequalities consultation, these are:

Starting Well	• *Low birthweight & high infant mortality* • *High smoking rates in pregnancy* • *Low breastfeeding rates* • *High teenage conceptions* • *High obesity rates* • *High levels of oral disease*
Developing Well	• *Low attainment, skills and aspirations* • *Low levels of physical activity* • *High levels of lifestyle risks – alcohol, smoking, substance misuse, obesity* • *High rates of teenage pregnancy* • *High rates of emotional, behavioural or attention deficit disorders* • *High emergency admissions* • *Meeting the needs of increasingly diverse minority ethnic and migrant communities* • *High levels of oral disease*
Living and Working Well	• *High levels of lifestyle risks – smoking, alcohol, diet, obesity* • *High levels of worklessness and benefit culture* • *Low levels of physical activity* • *Low qualification and skill levels* • *High levels of depression and anxiety* • *High deprivation* • *Rising fuel poverty* • *High rates of disability* • *Increasing need for carer support* • *Meeting the needs of increasingly diverse minority ethnic and migrant communities*
Ageing and Dying Well	• *Increase in age related conditions such as; dementia, mobility & hearing impairment, diabetes, falls* • *High levels of depression* • *Low levels of physical activity* • *Rising number of older & disabled people living alone & feeling isolated* • *Ageing carers and growing care gap* • *High pensioner poverty* • *Rising fuel poverty* • *High demand for acute care* • *High levels of lifestyle risks – smoking, alcohol, diet, obesity* • *Big gap in the life expectancy in least and most deprived areas in Rotherham*

How we will do it

To achieve an improvement in health and wellbeing across Rotherham, the Health and Wellbeing Board have agreed a set of actions to reduce health inequalities.

PE Prevention and Early Intervention

- We will coordinate a planned shift of resources from high dependency services to early intervention and prevention.
- We will focus on motivating people to change behaviours and design our campaigns around prevention and early intervention.
- Service will be delivered in the right place at the right time by the right people
- We will develop a joint approach to maximise the use of assistive technology to benefit people.
- We will develop a common approach to identifying and addressing risks across all services and organisations.

EA Expectations and Aspirations

- We will provide much clearer information about the standards people should expect and demand.
- We will train all people who work towards reducing health inequalities to respond to the circumstances of individual people, families and the local community.
- We will ensure all our workforce routinely prompt, help and signpost people to key services and programmes.
- We will co-produce with Rotherham people the way services are delivered to communities facing challenging conditions.

DI Dependence to Independence

- We will change the culture of staff from simply ‘doing’ things for people to encouraging and prolonging independence and self care.
- We will seek out the community champions and support them with appropriate resources, to take action and organise activities.
- We will support and enable people to step up and step down through a range of statutory, voluntary and community services, appropriate to their needs.
- We will properly enable people to become independent and celebrate independence.

Healthy Lifestyles

- We will work together to understand our community assets; identifying what and where they are across the borough and how we use them effectively.
- We will use the health and wellbeing strategy to influence local planning and transport services to help us promote healthy lifestyles.
- We will promote active leisure and ensure those who wish to are able to access affordable, accessible leisure centres and activities.

Long-term Conditions

- We will adopt a coordinated approach to help people manage their conditions.
- We will develop a common approach to data sharing so we can provide better support across agencies and put in place a long-term plan for the life of the individual.
- We will ensure all agencies work together to make transitions between services for those with long term conditions seamless and smooth.
- We will work jointly to review our eligibility criteria thresholds and ensure we are able to escalate and de-escalate people through services as their needs change.

Poverty

- We will make an overarching commitment to reducing health inequalities, particularly in areas suffering from a concentration of disadvantage.

We will ask the Rotherham Partnership:

- To look at new ways of assisting those disengaged from the labour market to improve their skills and readiness for work.
- To ensure that strategies to tackle poverty don't just focus on the most disadvantaged, but there is action across the borough to avoid poverty worsening.
- To consider how we can actively work with every household in deprived areas to maximise benefit take-up of every person.

Linking the life stages with our strategic outcomes

Bringing about improvement in health and wellbeing is incredibly challenging and we see the need to drive actions forward. We have therefore identified a lead professional who will be accountable for each outcome and life stage.

The table shows the lead professional for each outcome and life stage, but also which agencies will provide the main supporting and advising role for each area. Along with the main statutory organisations, there will be a range or voluntary, community sector and private organisations that we will need to work with to help us achieve our vision.

	Prevention & Early Intervention	Expectations & Aspirations	Dependence to Independence	Healthy Lifestyles Independence	Long-term Conditions	Poverty
Starting Well	Led by Public Health Supported by CCG, CYPS	Led by CYPS Supported by CCG Advised by PH	Led by CYPS Supported by CCG	Led by PH Supported by CCG & CYPS	Led by CYPS Supported by CCG Advised by PH	Advised by All
Developing Well	Led by CYPS Supported by CCG & PH	Led by CYPS Supported by CCG Advised by PH	Led by CYPS Supported by CCG	Led by PH Supported by CCG & CYPS	Led by CYPS Supported by CCG Advised by PH	Advised by All
Living and Working Well	Led by Public Health Supported by CCG & AS Advised by CYPS	Led by AS Supported by CCG Advised by PH	Led by AS Supported by CCG	Led by PH Supported by CCG & AS	Led by CCG Supported by AS Advised by PH	Advised by All
Ageing and Dying Well	Led by AS Supported by CCG & PH	Led by AS Supported by CCG Advised by PH	Lead by AS Supported by CCG	Led by PH Supported by CCG & AS	Led by AS Supported by CCG Advised by PH	Advised by All

AS = Adult Services *CYPH = Children and Young People Services*
PH = Public Health *CCG = Clinical Commissioning Group*

Having agreed Accountable lead professionals will ensure a coordinated approach across all the life stages. This will help us to work towards breaking the 'cycle' of poor health. We see that we cannot simply shift our resources to 'Starting Well' to prevent poor health, but we need to address the determinants of health at each life stage to ensure young people do not become unhealthy adults and adults do not become unhealthy older people.

What Next?

In order to meet the strategic objectives and outcomes we will require a picture of assets and services that we have available across Rotherham. Continuing to develop this will ensure it provides a clear and comprehensive picture of how services in Rotherham are delivered to meet need, based on the Joint Strategic Needs Assessment.

Delivering the Strategy

Six strategic lead officers from the Local Authority and NHS will be responsible for the delivery of each of the strategy's priorities. Their role will be to provide leadership and accountability for each priority workstream, ensuring a workplan is in place to deliver the actions within the life of the strategy. The table on page 8 will be a tool used by the strategic leads to develop their plans, ensuring the right people and agencies are involved.

Commissioning Plans

We will use this strategy to inform commissioning plans for all health and wellbeing partner agencies; including public health, NHS and social care. Commissioning plans will identify who will do the work to help us achieve our goals.

Performance Management Framework

In order to understand whether we have been successful, we will develop a performance management framework using the life stage and strategic outcomes matrix. This will include key indicators from each of the national outcomes frameworks, along with any local measures, which will demonstrate whether we are achieving improvements for each of the big issues, and ultimately our strategic outcomes.

Future Joint Strategic Needs Assessments and the Index of Multiple Deprivation 2016 will also demonstrate whether this strategy has had an impact on deprivation and health inequalities, in line with the national average.

Reviewing the Strategy

The strategy presented here is a three year plan and we will formally review it annually. Over the course of the three years we will continue to build up a much clearer picture of the needs of our population; through our Joint Strategic Needs Assessment, as well as how we commission services. We will also use local people and future developments such as Healthwatch, to help us understand our population's needs and how services are actually delivered. This annual review process will help us recognise how well we are doing and show if we are off track and allow us to change direction as needed.

Rotherham people will remain at the centre of the strategy and a continued consultation plan will ensure that the strategy remains focused on listening to the views and improving the health of all Rotherham people.

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NHS Rotherham is the Rotherham Primary Care Trust

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Health and Wellbeing Board Strategy – Consultation Feedback

"Rise up with me against the organisation of misery"[1], Pablo Neruda

This important call from the Marmot review resonates with us all to deliver better intervention and prevention across society. The response of the Health and Wellbeing Board in the 'Rotherham Borough Joint Health and Wellbeing Strategy 2012-2015' to this call is through a variety of priorities. One area that could be given greater consideration and inclusion in the strategy is that of '**Dying Well**' and what this means to the residents of Rotherham.

In considering the 'Rotherham Borough Joint Health and Wellbeing Strategy 2012-2015', the Marmot Review and adapted 'Life Course Framework', there is also a need to respond to the JSNA in the light of the drivers found in other government's strategies. This feedback has considered the following government strategies, policies, other research and publications:

- Building a Stronger Civil Society (Office for Civil Society, 2010)
- Equity and Excellence: Liberating the NHS (DH, 2010)
- End of Life Care Strategy (DH, 2008)
- End of Life Care Strategy – Quality Markers for End of Life Care (DH, 2009)
- The NHS Operating Framework 2012/13 (DH, 2011)
- The NHS Outcomes Framework 2012/13 (DH, 2011)
- Dying for Change (Demos, 2010)
- Agenda for Later Life 2012 – A Summary of Policy Priorities for Active Ageing (Age UK, 2012)
- Quality Standard for End of Life Care for Adults (NICE, 2011)

The emphasis on building a stronger civil society where voluntary and community organisations are able to mobilise and support people is seen as an important element in achieving the reduction in health inequalities highlighted in the Marmot Review. Indeed, Marmot recognises the importance of the third sector: 'the evidence shows that partnership working between primary care, local authorities and the third sector to deliver effective universal and targeted preventive interventions can bring important benefits.'[2] Empowering communities, opening up public services and promoting social action[3] are all key themes of the government agenda for a 'big society' that mirror the Marmot review. The challenge is connecting these aspects together to deliver real choice, measurable outcomes and a reduction in health inequalities that delivers social justice in action.

To improve health outcomes the current changes to the structure of the NHS build on Lord Darzi's work that aims to 'discard what blocks progress...the overwhelming importance attached to certain top down targets. These targets crowd out the bigger objectives of reducing mortality and morbidity, increasing safety and ***improving patient experience more broadly – including the most vulnerable in our society.***'[4] One aim in the 'Rotherham Borough Joint Health and Wellbeing Strategy 2012-2015' must surely be to improve patient experience for the most vulnerable in our society approaching the end of their lives. Specifically, liberating the NHS should demonstrate increase of choice and control for end of life care and support people's preferences about how to have a good death and work with all providers to ensure people have the support they need.[5]

This aim is translated into the delivery of the NHS Operating Framework for 2012/13 with the aim of improving services for patients: 'putting patients at the centre of decision making in

preparing for an outcomes approach to service delivery, whilst improving dignity and service to patients and meeting essential standards of care'[6]. This move towards quality and outcomes will drive the change in culture required to reduce health inequalities.[7] We see this reflected in the NHS Outcomes Framework 2012/13 through the outcome 'Enhance the quality of life for people with long-term conditions' and the indicators that focus on providing support, enhancing the quality of life for patients and carers and also reducing time spent in hospital[8].

These themes resonate with the Marmot review hoping to empower individuals and communities with a vision of 'creating conditions for individuals to take control of their own lives'[9] and certainly matches the two policy goals[10] identified in the review. This is an essential part of reducing health inequalities and must remain an essential part of the Joint Health and Wellbeing Strategy for Rotherham.

With such emphasis it is easy to miss the simple fact that no matter how much we reduce health inequalities, we all die. The questions we should ask regarding end of life care are 'how do we improve dignity for patients?', 'how do we improve patient experience for the most vulnerable in our society?' and 'how do we empower patients to make choices?'.

What we can do as part of the overall Health and Wellbeing strategy is to consider '***Dying Well***' as an essential part of the life course framework.

Why include Dying Well?

Empowering individuals to take control of their lives and reducing inequalities applies equally to enabling people to make positive choices that help maintain quality of life towards the point of death and choices about where they would like to die. Improving an individual's quality of life can impact in terms of days, weeks, and months more before death, not just upon them, but upon those family and friends around them, reducing anxiety and stress for example, whilst reducing hospital admissions and crisis funding. We can equally see how the inequalities and the reasons for them highlighted by Marmot apply to how people die. It is not hard to see that those with more resources have greater power to determine the levels of care they may receive, when those with little or no resource are dependent upon the ability of society, the NHS, or other voluntary sector providers to deliver their care.

In 2008 the Department of Health published the 'End of Life Care Strategy – Promoting high quality care for all adults at the end of life'. This strategy gives emphasis to the delivery of high quality coordinated care that goes beyond the individual and their preferences for end of life care. It includes support for carers both before and after death recognising the social impact that can be felt through the loss of a loved one.[11] It recognises the inequalities that can exist at end of life for those who are able to access quality services and those who cannot, often the most vulnerable.

The Rotherham JSNA highlights challenges facing us locally through an ageing population[12] where incidences of loneliness[13], increased occurrences of dementia[14], increased death rates from smoking, alcohol and obesity[15], high rates of deaths through cancer[16], alongside a higher rate of hospital emergency admissions[17] all impact on where funding should be directed. To only tackle the health inequalities and provide funding in the Life Course Framework without consideration to the end of life will leave us with a legacy of an ageing and older population where inequalities will still be encountered. These inequalities can be

tackled by working together across Rotherham through collaboration of all partners, with improved and integrated care pathways that are well coordinated.

The Marmot review is clear: '***Services that promote health, wellbeing and independence of older people and, in doing so, prevent or delay the need for more intensive or institutional care, make a significant contribution to ameliorating health inequalities. For example, Partnerships for Older People projects have been shown to be cost effective in improving life quality.***'[18] These projects delivered reduced hospital admissions, provided rapid response services and improved the quality of the user's lives and also delivered improved partnerships between health agencies the voluntary sector.[19] Again this demonstrates the key role the voluntary sector has in delivering the Rotherham Health and Wellbeing priorities. It is able to mobilise society and bring added value into service delivery in a way that the public and private sector cannot.

The 'NICE Quality Standards for End of Life Care for Adults' are clear about the outcomes that end of life care should deliver: 'Enhancing quality of life for people with long-term conditions...that the care for people approaching the end of life received is aligned to their needs and preferences.'[20] Again this aligns with the aims of Marmot to allow individuals to take control of their own lives, at a time when this control can be taken away from them by the very nature of their disease. It promotes wellbeing and independence for older people and improves dignity and quality of life. This also matches the concerns of Age UK in their report summary 'Agenda for Later Life 2012 – A summary of policy priorities for active ageing' where they call for equitable access to provision, dignity and compassion in care, and the ability for older people to retain independence.[21]

Delivering the 16 quality markers[22] identified in the NICE standard for end of life care will begin to address issues of prevention and intervention that can impact on a reduction in the high rate of hospital admissions. It will empower individuals to take control and make choices and will ensure that the legacy of a holistic approach to end of life care continues well into the 21st century in Rotherham. This will enable us to address the issues highlighted in Rotherham's JSNA that will make demands upon our services if we make no response to dying well.

The voluntary sector has a clear role to play in delivering a 'Dying Well' life course element that pulls together the strands of differing agendas across health and social care. We can achieve this through partnership working and by responding to the call by Marmot for courage and imagination[23] to do things differently, to perhaps lay aside organisational differences and protectiveness and to deliver social justice[24]. This is the only way to ensure we reduce health inequalities across the Life Course Framework, up to and including the point of death.

This will mean creative and innovative approaches to delivering end of life care in an integrated and coordinated way that empowers individuals to make choices and ensures their dignity and control are maintained. It will mean providers of health and social care from public, private and the voluntary sector joining together to deliver social justice and reduce inequalities in end of life care and dying, and to ensure those in Rotherham who need the right care, receive it so they can die well. This integrated approach will reduce the need to provide funding at the point of crisis and flows with the prevention and intervention themes of Marmot. Directing funding in courageous and innovative ways will reduce inequalities, reduce

fire fighting, empower individuals, allow choice, retain dignity and enable people to experience dying well.

Including '**Dying Well**' as an additional element of the Life Course Framework for Rotherham will ensure the Rotherham Health and Wellbeing Board gives suitable priority and focus to end of life care in its broadest meaning.

"*Britain needs to create ways for people to live well even as they are dying, otherwise in the decades to come many hundreds of thousands of people will experience unnecessarily distressing deaths. We will die badly in places not of our choosing, with services that are often impersonal, in systems that are unyielding, struggling to discover meaning in death because we are not in surroundings that provide for intimacy and care and find ourselves cut off from the relationships which count most to us. Our challenge is to help people to achieve what is most important to them at the end of life. That will require the creation of a network of health and social supports so that people can die at and closer to home, with the support of their family and friends, as well as pain relief and medical services as they need them.*"[25]

"Rise up with me against the organisation of misery"[1]

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Alison Ellis,
LPC Admin Secretary
100 Widecombe Lane, Clifton,
Nottingham, NG11 9GY

Tel: 07882289083
Fax: 0115 9142965

Community Pharmacy paper to Rotherham Health and Wellbeing Board

31 October 2012

Introduction

Over the next few years, there will be significant reforms in the way public health and social care services are delivered in England. They will be contracted nationally but delivered locally, according to local need. In light of these changes, this paper aims to provide some background to support local commissioning of pharmaceutical services through the Joint Strategic Needs Assessment (JSNA) and Pharmaceutical Needs Assessment (PNA) by demonstrating how primary healthcare professionals in the community have both the expertise and the capability to deliver the change needed to support local populations.

Rotherham Local Pharmaceutical Committee (LPC) seek early partnership working to ensure that the JSNA and PNA support robust joint health and wellbeing strategies and commissioning plans.

The Changing NHS architecture

Dental, optical, pharmacy and general medicine services in primary care are largely provided by independent practitioners (contractors) who contract their services to the NHS, with contracts currently held by PCTs. Changes to the NHS architecture and the abolition of PCTs mean that dental, optical, pharmacy and general medicine contracts will be held centrally by the NHS Commissioning Board from April 2013.

The value of local representative committees

Local representative committees (LRCs) already exist and have existed since the inception of the NHS. They exist to support clinical professionals to do their jobs, advocating on behalf of professionals and, increasingly, working with the NHS to coordinate local service provision. Committees are formed for each of the four primary care contractor professions:

- Local dental committees (LDCs)
- Local optical committees (LOCs)
- Local pharmaceutical committees (LPCs)
- Local medical committees (LMCs)

LPC Chair
Julie Oliver, MRPharmS
E-mail: joliver@weldricks.co.uk

LPC Chief Officer
Nick Hunter, MRPharmS
Email: nickhunter@o2.co.uk
Phone: 07595 069178

Alison Ellis,
LPC Admin Secretary
100 Widecombe Lane, Clifton,
Nottingham, NG11 9GY

Tel: 07882289083
Fax: 0115 9142965

LRCs have three core functions relevant to local authorities:

1. Accessing the clinicians:
Rotherham LPC's area is coterminous with that of the Council meaning that the LPC can provide a ready-made access point to facilitate making contact with the primary care contractor professions in the area.

2. Understanding context:
The LPC is a hub of clinical expertise and knowledge of the local NHS which can be drawn on by the Council and others in the planning and delivery of local healthcare services.

3. Legitimacy:
The LPC members are elected or nominated by their fellow professionals. Their democratic selection and accountability provide them with the legitimacy necessary to represent their contractor profession and the professionals who provide that service.

Community Pharmacy in Rotherham

There are 63 community pharmacies in Rotherham. National research shows 99% of the population, even those living in the most deprived areas, can get to a pharmacy within 20 minutes by car and 96% by walking or using public transport. In Rotherham we believe the proportion of people having access to community pharmacy to be even higher now with the increase in pharmacies opening in the last few years.

Nationally, 84% of adults visit a pharmacy at least once a year, with an average adult visiting a pharmacy 14 times in that year.

An estimated 9,000 visits take place daily to Rotherham pharmacies, of which three-quarters are for health-related reasons. Around one in 10 of these pharmacy visitors get health advice. That's 900 people in Rotherham being given health advice every day. The estate value of this network of community pharmacies would cost the NHS £35M if it had to purchase it.

These pharmacies are located in the very heart of the communities they serve. Uniquely, community pharmacies see people who have no apparent current health need as well as those with existing conditions. These interactions provide opportunities for health interventions that do not exist elsewhere in the NHS. If genuine public health improvements are to be made in Rotherham and elsewhere, engaging with community pharmacy professionals through the LPC network will be of paramount importance.

Local healthcare professionals are best placed to describe the local issues affecting the delivery of services. Frequently the pharmacy team will be recruited from the communities they serve. Only when the problems are fully understood can appropriate solutions be adopted.

LPC Chair
Julie Oliver, MRPharmS
E-mail: joliver@weldricks.co.uk

LPC Chief Officer
Nick Hunter, MRPharmS
Email: nickhunter@o2.co.uk
Phone: 07595 069178

Alison Ellis,
LPC Admin Secretary
100 Widecombe Lane, Clifton,
Nottingham, NG11 9GY

Tel: 07882289083
Fax: 0115 9142965

Rotherham Community Pharmacies already provide specific accredited advice to local residents on stopping smoking, substance misuse and sexual health. They also provide general lifestyle advice and support local public health campaigns.

However, with so many health experts in the community, the Rotherham health economy could benefit even further by commissioning this resource to provide other public health related initiatives such as alcohol brief interventions, NHS Health Checks, weight management advice, early diagnosis referral and many more through local initiatives or the national Healthy Living Pharmacy scheme.

Rotherham LPC can also provide RMBC with advance notice of the concerns of community pharmacists and the impact that these may have on the provision of services. The LPC can bring practical expertise and experience to the development of any local health messaging that RMBC wants to engage in.

Rotherham LPC appreciates there may not be space for a pharmacy seat round the Health and Wellbeing Board table, but suggests engagement through stakeholder workshops and workstream meetings can provide RMBC with the access to the experience and expertise of the LPC and community pharmacy in Rotherham.

Summary

Rotherham LPC seeks further engagement with Rotherham Metropolitan Borough Council to support the development of the Pharmaceutical Needs Assessment and maximising efficient use of the community pharmacy network in the Borough.

Nick Hunter, MRPharmS
Chief Officer
Rotherham LPC