HEALTH AND WELLBEING BOARD

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

Date: **Wednesday, 28th November, 2012**

Time: **1.00 p.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 - 9)

4. Communications (Pages 10 - 25)
   - Rotherham Tobacco Control Alliance Annual Report (Pages 10 - 23)
   - Community Alcohol Partnership s (CAPs) progress as of End October 2012 (Pages 24 – 25)

5. Health and Wellbeing Needs of BME Communities in Rotherham
   - presentation by Nizz Sabir, Rotherham Council of Mosques

6. The Role of the Local Optometric Profession
   - presentation by Nizz Sabir, Rotherham and Barnsley Local Optical Committee

7. Health and Wellbeing Performance Management Framework (Pages 26 - 35)
   - presentation by Kate Green, Policy Officer

8. Overarching Information Sharing Protocol (Pages 36 - 51)

9. Public Health Responsibilities in relation to Sexual Health (Pages 52 - 55)

10. Exclusion of the Press and Public
    Resolved:- That, under Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt information as defined in Paragraph 4 of Part I of Schedule 12A to the Local Government Act 1972 (information relating to any consultations or negotiations, or contemplated negotiations, in connection with any labour relations matters).

11. Unscheduled Care Review (Page 56)

12. Date of Next Meeting

- Wednesday, 16th January, 2013

HEALTH AND WELLBEING BOARD
31st October, 2012

Present:-

Members:-

Ken Wyatt	Cabinet Member for Health and Wellbeing **In the Chair**
Jo Abbott	Public Health Consultant
Karl Battersby	Strategic Director, Environment and Development Services, RMBC
John Doyle	Cabinet Member, Adult Social Care
Phil Foster	NHS Commissioning Board
Brian James	Rotherham Foundation Trust
Paul Lakin	Cabinet Member, Children, Young People and Families Services
Shona McFarlane	Director of Health and Wellbeing
David Polkinghorn	Rotherham Clinical Commissioning Group
Janet Wheatley	Voluntary Action Rotherham

Officers:-

Kate Green	Policy Officer, RMBC
Fiona Topliss	Communications, NHS Rotherham
Howard Woolfenden	Director of Safeguarding, Children and Families, RMBC

Together with:-

Robin Carlisle	Rotherham Clinical Commissioning Group
Nick Hunter	Chief Officer, Rotherham Local Pharmaceutical Committee
Mike Wilkerson	Chief Executive, Rotherham Hospice

Apologies for absence were received from Chris Bowell, Tom Cray, Andrew Denniff, Chris Edwards, Martin Kimber, John Radford, Joyce Thacker,

S32. MINUTES OF PREVIOUS MEETING

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

Arising from Minute No. S29 (Rotherham HealthWatch), it was reported that the specification for HealthWatch commissioning had been agreed.

S33. COMMUNICATIONS

Welfare and Benefit Reform Roadshow
The Rotherham Partnership Governance Board was to host the above Roadshow at RCAT on 30th November, 2012. The Welfare and Benefit Reforms would affect Rotherham greatly and had become a priority for the Partnership. Organisations would be welcome to send a representative if they so wished.

Fluoridisation
The Health Select Commission had set up a small group of Members to look at the consultation arrangements for Fluoridisation.

S34. JOINT COMMUNICATIONS PLAN

Fiona Topliss, NHS Communications, reported that a meeting had taken place with the Council's Communications lead to discuss the above. A report would be submitted to the next Board meeting.

Due to the diminishing resources of both organisations, it was important to work together to maximise what was available and avoid duplication.

Resolved:- That a report be submitted to the next meeting of the Board.

S35. HEALTH AND WELLBEING MEMBERS' GROUP

The notes of the first regional network for Health and Wellbeing members meeting held on 1st October, 2012, in Wakefield, were submitted for information.

S36. POLICE AND CRIME COMMISSIONER

The Board considered a report submitted by Marie Carroll, Partnership Officer, South Yorkshire Joint Secretariat, on the role of the Police and Crime Commissioner.

The Commissioner, unlike the Police Authority, would not be a statutory partner on Community Safety Partnerships (CSPs) but must co-operate with and have regard to their priorities in the Policing area. Chairs of all CSPs could be called together to discuss specific issues and may require a CSP to provide a written report around a specific issue if the Commissioner was not satisfied that it was meeting its duties.

The Police Authority had developed an awareness raising campaign which endeavoured 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 (http://www.southyorks.gov.uk/thinkpcc/home.aspx).

As part of the wider "& Crime" element of their role, Commissioners would consider the impact other partnerships, statutory boards and criminal justice organisations/partnerships may have on policing and crime in that area.

The Police and Crime Commissioner was obligated to publish a 5 year Police and Crime Plan by March, 2013, setting out the priorities for policing and crime in the force area. This would be key in holding the Chief Constable to account for delivery against the Commissioner's priorities and would outline allocation of resources along with local priorities. Consultations with partners and partnerships were ongoing and the priorities of other organisations and/or partnerships, where available, would be taken into consideration. A copy of the Rotherham Health and Wellbeing Strategy had been provided for consideration.

It was noted that the Commissioner would be attending a Board meeting in the New Year.

Resolved:- That the report be noted.

S37. NORTH TRENT NETWORK OF CARDIAC CARE AND NORTH TRENT STROKE STRATEGY PROJECT

Dr. Phil Foster presented the annual report of the major Cardiac and Stroke work undertaken by the Network from April, 2011 to March, 2012, highlighting key achievements and outcomes:-

Cardiac Care

- Collaborative project with the Yorkshire and the Humber Specialised Commissioners, the West Yorkshire and North East Yorkshire and Northern Lincolnshire Networks to develop 3 Clinical Thresholds for Revascularisation – aim to develop a set of clinical guidelines and thresholds, based on evidence-based best clinical practice, to reduce the variation

- As a result of the above, guidelines and thresholds developed and agreed and to be implemented during 2012/13

- The Network User Group now influenced the development of Network strategic plans in order to improve the experience and outcomes for future cardiac patients

- Reviewing and developing Heart Failure Services, closer working with the tertiary centre on the PPCI pathway and efficient tertiary centre referral

- Agreed procedures for the introduction of new drug treatments and improving the patient/carer engagement and interaction

- Focus on improving the patient experience in relation to the Heart Failure pathway

- Provides peer support and guidance for managers

- Close work with the Stroke Strategy Project

- Successfully implemented NICE Guidance for a range of drugs including Ticagrelor and development of a clinical consensus approach towards the implementation of NICE guidance for new oral anticoagulants

Stroke Strategy Project

- Successful implementation of the Peer Review process

- Introduction of 24/7 acute thrombolysis service across North Trent

- Stroke Telemedicine project introduced in February, 2010, to support delivery of the Hyperacute Stroke Pathway specifically thrombolysis

- For the period 9th January-30th June, 2012, 94 patients had been admitted out of hours, 17 patients benefitted from an analaysis of thrombolysis and 7 patients were thrombolysed with an age range from 23 years to 89 years

- National Stroke Strategy launched in December, 2007, providing a national quality framework through which local services could, over a 10 year period, secure improvements across the stroke pathway against quality markers

- All 5 local hospitals had achieved accreditation for their Stroke Assurance Framework plans

- Stroke Improvement Programme launched in 2009 as a national initiative designed to accelerate improvement of services across the whole pathway of stroke and TIA care

- Work on stroke fell into 3 domains – prevention, acute care, post hospital and long term care

Resolved:- That the report be received.

S38. HEALTH AND WELLBEING STRATEGY

Kate Green, Policy Officer, presented the final version of the Joint Health and Wellbeing Strategy including the outline implementation plan which included the role of the Health and Wellbeing Strategy Steering Group and proposals for the Health and Wellbeing Board's work plan.

The document had been amended following the consultation, mainly the language, but also the inclusion of "Ageing and Dying Well" within the Live Course Framework and also an acknowledgement that people died over the whole life course and not just over 65. The actions were now all listed under their respective Strategic Priority and not given a specific year to be achieved; it would be for the individuals within that workstream to determine how their actions would be achieved/prioritised as long as they were within the 3 year Strategy.

Each of the 6 Strategy priorities now had a strategic lead who would co-ordinate and provide leadership to the workstreams, ensure work plans aligned and implement new ways of working to bring about culture change.

The Steering Group was made up of the 6 lead officers plus representatives from the Council's Policy, Performance and Commissioning Team, Public Health and the NHS. The Group would co-ordinate and lead the Strategy implementation plan, be accountable to the Board and provide assurance in relation to delivering Strategy outcomes.

The draft work plan had been developed from the outcomes of the self-assessment process and feedback from the Department of Health representative.

Due to it being a "living" document there would not be a significant number of copies produced but a current version would be available on the website.

Discussion ensued on the need for the Board to receive the 2013 Public Health Commissioning Plan although it was acknowledged that the settlement for Public Health was still awaited. The statutory duties would be included but

until the funding was known nothing else could be planned.

Resolved:- (1) That the Joint Health and Wellbeing Strategy be approved for submission to Cabinet for recommendation to Council for adoption.

(2) That the format of the 2012/13 Health and Wellbeing Board work plan be approved.

(3) That the Strategy implementation plan be noted.

(4) That the 2013 Public Health Commissioning Plan be submitted to the January, 2013 Board meeting.

S39. 'END OF LIFE'

Mike Wilkerson, Chief Executive, Rotherham Hospice, stated that he had been invited to the Board to address how the Board could help deliver end of life care and was pleased to see the inclusion of “Dying Well” in the Joint Health and Wellbeing Strategy.

The end of life experience for some was not always appropriate; patients were sometimes admitted to Casualty when it would have been better for them to have remained at home.

Discussion ensued with the following issues raised/highlighted:-

- There had been stories in the press recently about Liverpool Care Pathway. It was used in the Hospice and by the Rotherham Foundation Trust as well as in people’s homes

- The vast majority of people wanted to remain at home to die but that was not being delivered

- Care packages (including Liverpool Care Pathway) had been thought out very carefully and adapted to the patient. The patient and their carer(s) signed up to it

- Feedback from the Patient Representative Group was good - it allowed people to die with dignity and ideally at home

- Very effective tool for the last days of a patient’s live and allowed families to be actively involved in the care

- Dying was 1 of the remaining taboo subjects and people should be encouraged to talk about it and what they wanted to happen when their time came

- There should be a common approach

- As well as the medical aspect there were the emotional and practical issues, such as wills and probate, which were not talked about and assumption that everyone knew what to do and where to go. A package of care encompassing all the aspects was required

- The Pathway was really a checklist/reference point which highlighted the important elements to address for patients and carers

- Rotherham Case Management pilot for End of Life Care for those most at risk of admission to hospital

- The Hospice was working with the CCG on Integrated End of Life pathway

- Acknowledgement that some died in hospital because they were frightened to die at home or their carers were frightened/could not cope

Brian James felt that there was a need for a discussion/review on how partner agencies could improve co-ordination around this topic. Robin Carlisle reported that the Unscheduled Care Group had carried out such a review in the Summer, the results of which were to be submitted to the Group shortly.

Resolved:- (1) That the inclusion of "Dying Well" in the Joint Health and Wellbeing Strategy be noted.

(2) That the outcome of the Unscheduled Care Group review be submitted to a future meeting of the Board.

S40. COMMUNITY PHARMACY IN ROTHERHAM

Nick Hunter, Chief Officer, Rotherham Local Pharmaceutical Committee, gave the following powerpoint presentation:-

Introduction to the Profession
Medicines
- Medicines still the most common therapeutic intervention but 30-50% were not taken as intended and 4-5% of hospital admissions were due to preventable adverse effects of medicines. However, 41% of patients: little or no explanation of side effects
- 961.5M NHS prescriptions dispensed in England by community pharmacies (2011) – 3.8% increase on previous year

Pharmacist Education
- 23 Schools of Pharmacy
- 4 year MPharm Degree
- Pre-registration year in practice
- GPhC Exams
- Registration

Rotherham Local Pharmaceutical Committee
- Body recognised in statute since the beginning of the NHS
- Support community pharmacists in doing their job
- Work with the NHS to co-ordinate local service provision
- Coterminous with RMBC
- Provide expertise and experience
- Elected by local professionals

Pharmacy and the NHS
- Community pharmacies are independent contractors
- Each pharmacy enters into a 'contract' with the NHS
- Control of entry
- Only a handful of pharmacies without NHS contracts
- Terms of Service set down in legislation

Working Together
- Community pharmacies located in the heart of every community
- Unique access to the well
- Support development of the JSNA and PNA
- Understanding of the profession

Community Pharmacy in Rotherham
- 63 pharmacies
- Half were national multiples
- Quarter were regional multiples
- Quarter were independents
- NHS income accounted for >90% of turnover

Pharmacy Support Staff
- Medicines Counter Assistants
- Dispensers
- Pharmacy Technicians
- 'Checking Technicians'

Essential Services
- Dispensing
- Repeat Dispensing
- Support for self-care
- Signposting patients to other healthcare professionals
- Healthy Lifestyles service (Public Health)
- Waste medication disposal
- Clinical governance including audit

Public Health Campaigns
- Early diagnosis
- Stopober
- Early detection of bowel cancer
- Breastfeeding

Advanced Services
- Medicines Use Review
- New Medicine Service

Public Health/Wellbeing Services
- Sexual health
- NHS Health Check

- Weight management
- Stop smoking services
- Immunisation
- Alcohol screening and support
- Substance misuse

Discussion ensued with the following highlighted:-

- Contracted for 6 Public Health campaigns a year – get smarter and plan ahead - South Yorkshire approach?

- It was originally supported by Department of Health grants to pilot a number of aspects 1 of which was to create a brand or image to enable marketing for using pharmacies for more than collecting prescriptions

- National programme but very much for local delivery and local use as to what went in it with a national set of quality criteria

- 900 consultations a day in the community pharmacies for lifestyle advice

- The Pharmacy Needs Assessment by Statute had to be done, traditionally, under the PCT. That was transferring with Public Health into the Local Authority. The Medicine Management Team would have worked on it but they were staying with the CCG to look at commissioning the work

- From a NHS Commissioning Board point of view, the relationships between Public Health, Local Pharmaceutical Committee and the Clinical Commissioning Group would be quite challenging and the Board had a role to play in holding the system to account

- Wastage of prescriptions/repeat prescriptions was a big issue

- There were no sites currently in Rotherham operating electronic patient prescription

Nick was thanked for his presentation.

S41. ANY OTHER BUSINESS

Robin Carlisle, CCG, presented an update on Rotherham Clinical Commissioning Group's 2013 Annual Commissioning Plan.

Discussions had commenced with its members practices, the public, stakeholders and providers on the Annual Plan.

It was expected to receive the annual mandate for the NHS Commissioning Board around the 12th December, 2012, which would set out national expectations on the Clinical Commissioning Group and financial and contracting rules. Around the same time, the Group also expected to receive its financial allocation.

It was hoped that it would be submitted to the January Board meeting for approval.

S42. DATE OF NEXT MEETING

Agreed:- That the next meeting of the Health and Wellbeing Board be held on Wednesday, 28th November, 2012, commencing at 1.00 p.m. in the Rotherham Town Hall.

ROTHERHAM BOROUGH COUNCIL – REPORT TO HEALTH AND WELLBEING BOARD

1.	**Meeting:**	**Health and Wellbeing Board**
2.	**Date:**	**28 November 2012**
3.	**Title:**	**Annual report of the Rotherham Tobacco Control Alliance 2011/2012**
4.	**Directorate:**	**Public Health**

5. Summary:

Rotherham Tobacco Control Alliance is the strategic partnership group that leads on

- prevention of smoking uptake
- smoking cessation
- protection of the community from secondhand smoke
- regulation of tobacco products

The accompanying annual report outlines the activity undertaken by the Alliance and its constituent partners during 2011/2012.

6. Recommendations:

That the Health and Wellbeing Board note the content of the report.

7. Proposals and Details:

Rotherham Tobacco Control Alliance would like to highlight the following key messages to the Board:

- The number of 4-week quitters through NHS services was the highest ever achieved in the borough. Smoking prevalence, however, remains at 24%
- Smoking at delivery rates reduced to under 20% for the first time, and the service helped 194 women stop smoking during pregnancy
- Smoking rates among young people (11-15 year olds) are higher than the national average
- The availability of cheap and illicit tobacco remains an issue and undermines other work to reduce tobacco use
- Performance measures will change in 13/14 from 4-week quitters to smoking prevalence reduction
- Almost all tobacco-related funding is currently invested in stop smoking services

8. Finance:

N/A

9. Risks and Uncertainties:

Despite the good performance of our stop smoking services for a number of years, smoking prevalence has remained static at around 24%, a problem common across the region. As a result, a comprehensive review of tobacco control investment and commissioning priorities is underway across South Yorkshire, supported by the University of Sheffield, to identify how we should be directing the available resources to best achieve a reduction in prevalence. This work is expected to report in early 2013.

10. Policy and Performance Agenda Implications:

There are three smoking-related indicators in the Public Health Outcomes Framework:

- Smoking prevalence among 15 year-olds
- Smoking prevalence at the time of delivery (smoking in pregnancy rate)
- Smoking prevalence among adults

11. Background Papers and Consultation:

N/A

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Rotherham Tobacco Control Alliance Report of activity 2011-2012

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Introduction

Smoking remains the main cause of preventable morbidity and premature death in England, leading to an estimated annual average of 86,500 deaths between 1998 and 2002[i] .

A wide range of diseases and conditions are caused by cigarette smoking, including cancers, respiratory diseases, coronary heart and other circulatory diseases, stomach and duodenal ulcers, erectile dysfunction and infertility, osteoporosis, cataracts, age-related macular degeneration and periodontitis. Following surgery, smoking contributes to lower survival rates, delayed wound healing and post-operative respiratory complications [ii].

Research commissioned by Action on Smoking and Health (ASH) has shown the cost to the NHS of treating diseases caused by smoking is approximately £2.7 billion each year.[iii] A report by the Policy Exchange[iv] estimated the total cost to society of smoking as being £13.74 billion, including the cost to the NHS as well as lost productivity from smoking breaks, increased absenteeism, cleaning smoking litter, cost of cigarette-related fires and the loss of economic output from the death of smokers and passive smokers.

Smoking is costly to the individual, with tobacco products being 33% less affordable in 2010 than they were in 1980[i]. People from routine and manual working groups will have lower incomes than the general population this increasing unaffordability is more likely to increase their use of illicit tobacco, including unregulated products with higher levels of contaminants.

In Rotherham, the oversight of tobacco control activities is the responsibility of the multi-agency Rotherham Tobacco Control Alliance.

Smoking behaviour in Rotherham

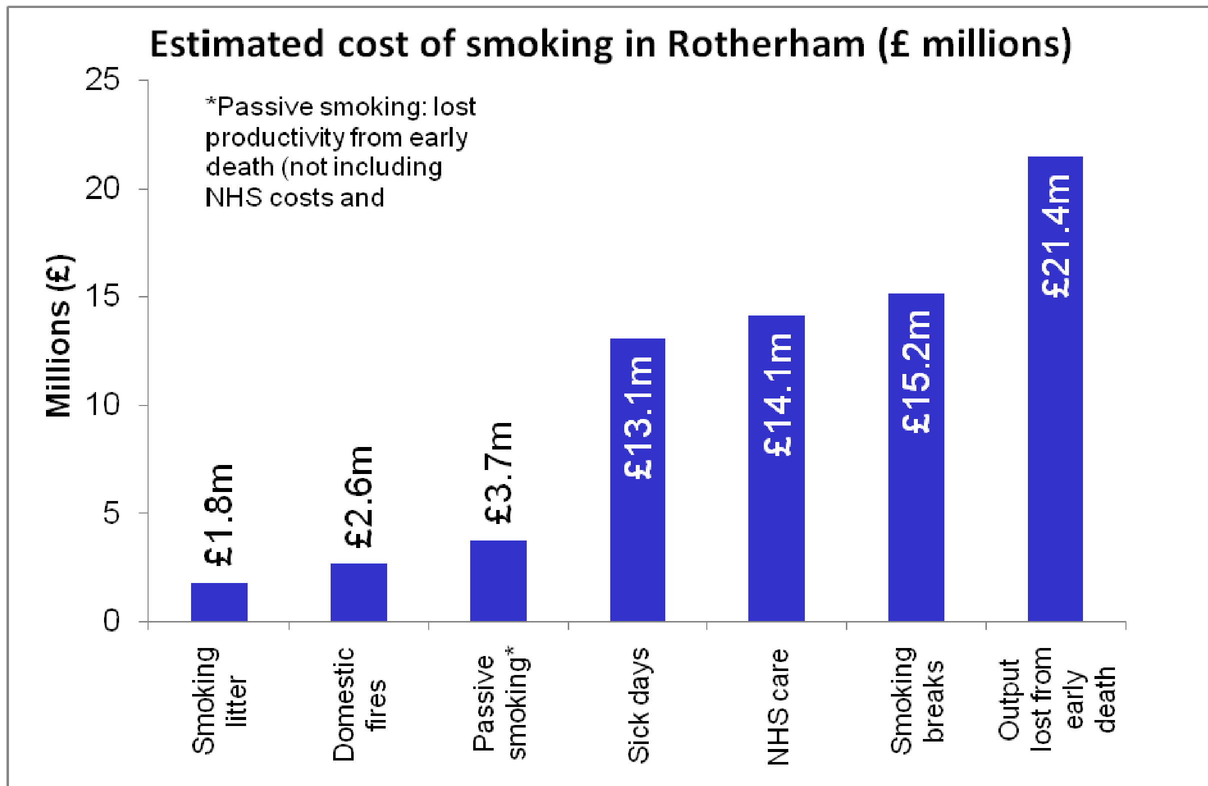
In Rotherham, more people than average for England are regular smokers. The local smoking rate, at around 24%, has been static for a number of years, and the drop seen in national smoking prevalence following the introduction of smokefree legislation in 2007 was not reflected locally. However, smoking rates vary widely across the borough, from a low of 9% up to a high of 45%.

Historically Rotherham has always had a high number of women who continue to smoke during pregnancy. This hit a high during 2009-10 of 27% - seventh highest rate in England. A new approach to managing smoking during pregnancy was introduced in February 2010 and this has shown a significant impact, with fewer than 20% of women still smoking at the time of delivery during 11/12.

The cost of smoking locally has been estimated as £71.9 million each year. Rotherham smokers spend around £81.5m on tobacco products, which contributes £62.1m to the Exchequer[v]. Pro-smoking groups often argue that the taxes they pay on tobacco more than covers the cost of NHS treatment, but these arguments are flawed in two key respects:

- The cost to the NHS is not the only societal cost of smoking (see figure 1)

- Not all tobacco is duty paid, therefore the shortfall in funding is almost certainly greater than suggested by the £9.8m from the above figures.



Such data, however, often mask a vital message regarding smoking and one we should more often celebrate: **most people in Rotherham do not smoke.**

Stop smoking services

Rotherham provides a range of support for people wishing to stop smoking. Rotherham NHS Stop Smoking Service (RSSS), which is part of Rotherham NHS Foundation Trust, runs stop smoking groups across the borough, and provides one-to-one and telephone support 6 days a week. It also runs Quit Stop, the stop smoking shop in the town centre, and a stop smoking centre at Rotherham Hospital. Most people who quit smoking with NHS support do so with RSSS.

In 2011/2012 the service had its most successful year in terms of 4-week quitters, supporting 1805 people to stop smoking.

Some GP practices, pharmacies and dentists also provide support to their patients to quit, and a further 999 achieved a 4-week quit through these enhanced services.

Before 2011/2012 any GP practice, pharmacy or dental practice who wanted to offer stop smoking support was able to do so. This had resulted in some parts of the borough having so many providers

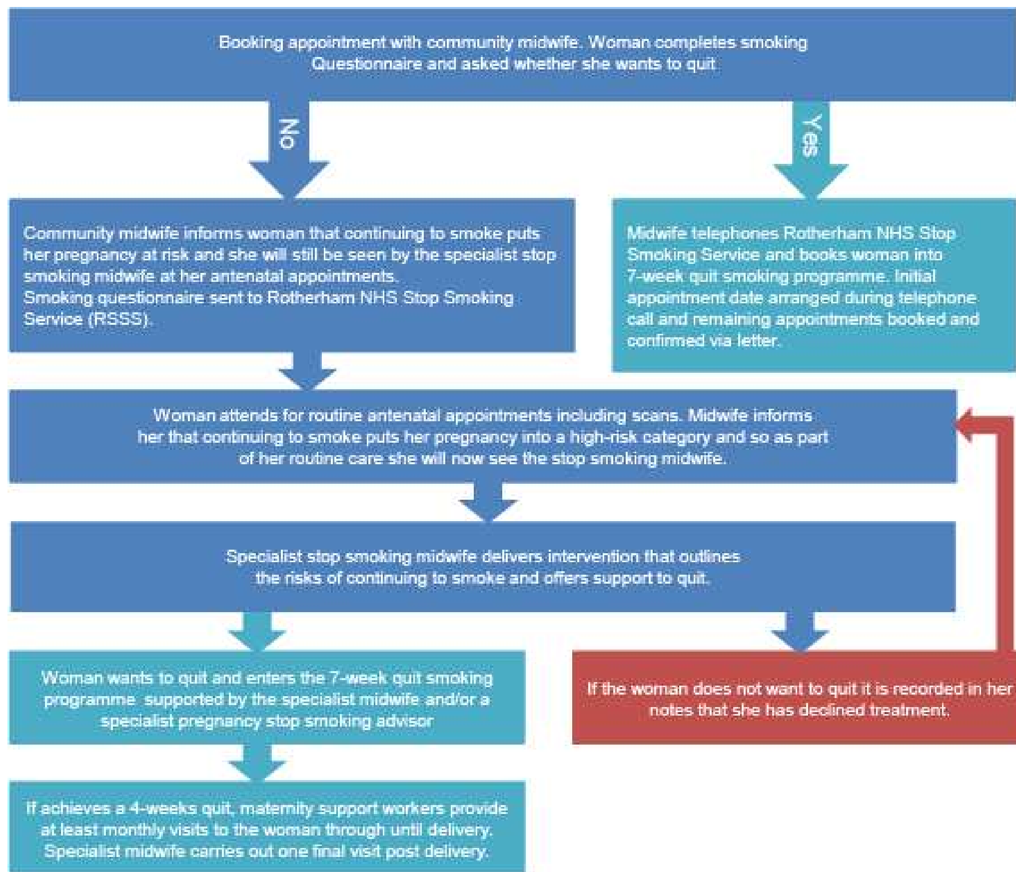
of support that the advisors were unable to support the minimum numbers required to maintain competency. We also found that there were some gaps in coverage. We therefore invited all GP practices, dental practices and pharmacies who wished to offer stop smoking support to submit an expression of interest and awarded agreements based on need in the area and capacity to meet minimum contract requirements. We also introduced a more robust performance review process for these enhanced providers to ensure that people wishing to stop smoking could be assured of the quality of the service they received.

Smoking in pregnancy

The new approach to tackling smoking in pregnancy, embedding smoking cessation advice into routine antenatal care, really began to demonstrate impact during 11/12, despite a reduced capacity within the pregnancy team due to staff movements. Pregnancy support is delivered by two stop smoking specialist midwives and one pregnancy advisor within RSSS. The team is supported by maternity health workers in maintaining contact with women following a successful quit attempt through until delivery.

Since February 2010 all pregnant women who smoke see the stop smoking midwives as part of their routine antenatal care, even if they have previously declined support to stop (figure 2). These women receive a candid explanation of the additional risks to their health and that of their unborn baby as a result of their smoking, following which they are informed that the stop smoking programme is part of their recommended treatment for this risk factor. If they still do not want support to stop this is recorded in their notes as declining recommended treatment.

Figure 2



In 2011/2012 the smoking in pregnancy team supported 194 pregnant women to achieve a 4-week quit. The smoking at delivery rate during 11/12 had dropped to 19.8%, the lowest rate ever achieved in the borough and another large drop on the previous year (10/11 rate: 22.4%).

The Rotherham approach to managing smoking in pregnancy continued to create interest across the country, with one of the specialist midwives appearing in a BBC3 programme *Misbehaving Mums to Be* in May 2011, and securing coverage in local and national media. In addition, an academic article describing the work was published in a peer reviewed journal, the *British Journal of Midwifery,* in early April 2012[vi].

Prevention of uptake

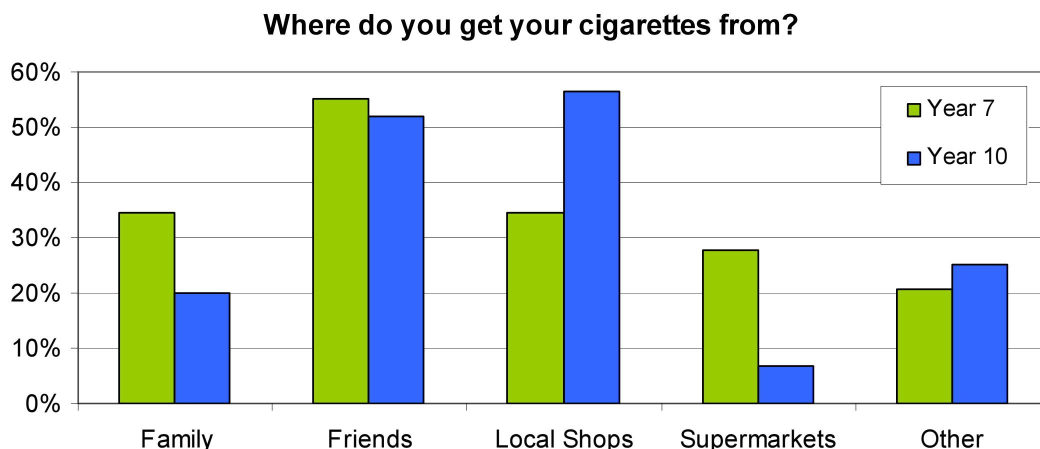
Each year Rotherham pupils in years 7 and 10 complete a lifestyle survey. This provides us with data on smoking behaviour that we can compare with national trends. In the 2011 survey when asked if they smoked cigarettes, 84% of Year 7 and 52% of Year 10 pupils had never tried cigarettes. Seven per cent of Year 7 pupils had tried smoking once and not done it again, compared with 26% of Year 10 pupils. Currently, only 2% of Year 7 pupils smoke regularly compared with 14% of Year 10.

Figures for England in 2011 were lower; only 5% of the 11-15 year olds who completed the national survey were regular smokers (smoked every day or every week) compared to 8% of Rotherham

pupils. As in Rotherham, the proportion who smoked increased with age from less than 0.5% of 11 year olds to 11% of 15 year olds[vii].

Rotherham pupils who identified themselves as smokers were then asked where they got their cigarettes from (figure 3).

Figure 3



Most Year 7 and Year 10 pupils get their cigarettes from their friends, however a large number also get their cigarettes from the local shops which raises issues around the selling of cigarettes to underage young people (see *protection of our community* below). This also seems to be the case for supermarkets, particularly with Year 7 pupils. A high proportion of Year 7 pupils are also getting cigarettes from family members. Of those that smoke, only 6% of Year 7 and 23% of Year 10 pupils want help to stop smoking.

The Smokefree Class activity pack was again promoted in secondary schools in the borough. Ten schools requested packs. The activities focus on the benefits of being a non-smoker and use a social norms approach to promote a smokefree lifestyle. Whilst aimed at year 7 pupils, many schools have chosen to run the activities across multiple year groups.

A Masters in Public Health student on placement at NHS Rotherham carried out a project to develop a smokefree class resource for primary school use. Following academic research into appropriate approaches with this age group, a series of 10 classroom activities has been developed and will be rolled out to all primary schools in the borough to use. Each of the activities can be carried out as a stand-alone lesson, or form part of a themed series of lessons.

At the end of the year the Department of Health launched a consultation on the introduction of standardised packaging. There is research evidence that by removing all brand marketing from packets tobacco products become less attractive, particularly to young people, and that this may reduce the number of young smokers. Standardised packaging also increases the impact of health warnings and reduces misleading beliefs about certain cigarettes being less harmful as a result of the colours of packaging used (colours previously associated with 'low tar' or 'lite' products). Rotherham Tobacco Control Alliance(along with the Health and Wellbeing Board and the RMBC Health Select Commission) submitted a response to the consultation supporting the proposals.

Protection of our community

Secondhand smoke contains the same substances as the smoke inhaled by active smokers. Passive smoking has been shown to cause lung cancer and heart disease, and probably to cause COPD, asthma and stroke in adults. It is harmful to children, causing sudden infant death, pneumonia and bronchitis, asthma, respiratory symptoms and middle ear disease.Smokefree homes and cars schemes are intended to reduce the exposure of children and non-smokers to secondhand smoke.

The RotherhamSmokefree Homes initiative continued during 11/12 and at the end of the year there were around 4,500 households signed up to the scheme. By making a smokefree homes pledge a household commits to not allowing smoking anywhere in their home or car. National figures suggest that increasing numbers of people do not allow smoking anywhere in their home. The Omnibus Survey found in 2008/2009 that 69% of people did not allow smoking in the home. Whilst those who have never smoked (81%) or given up smoking (78%) were more likely to ban smoking in the home, current smokers also impose restrictions, with 33% banning smoking anywhere in the home and 43% only allowing smoking in some rooms or at some times[viii].

Rotherham is participating in a Yorkshire and Humber-wide pilot project using a social norms approach to increasing smokefree areas. ‘Social norms’ is an environmental approach aimed at not just the individual but the entire community context in which individuals live. It is a highly cost effective way of reaching large numbers of people, correcting misperceptions of the prevalence of a problem behaviour (e.g. smoking), and promoting the healthier ones instead (e.g. being Smokefree).

The social norm theory states that much of people’s behaviour is influenced by their perception of how other members of their social group behave and their tendency to over-estimate the level of 'bad' behaviours. If people think harmful behaviour is the norm, e.g. everyone smokes; they are as individuals more likely themselves to engage in that behaviour. By educating a community that in fact the usual practice among their peers is the healthy version, e.g. three out of four people do not smoke, the behaviour of all can be affected in a positive manner.

Each PCT area was asked to identify one discrete community, with good existing social networks where the approach could be tested. In Rotherham we selected Treeton as our pilot site as it differed demographically from many of the communities identified elsewhere. A community survey to ask about smoking behaviours and beliefs, and what the respondent considered the community’s smoking behaviours and beliefs were, was carried out in March 2011. A marketing campaign to correct misperceptions and celebrate smokefree spaces is scheduled for September 2012.

A key strand in any tobacco control strategy is the tackling of cheap and illicit tobacco. Within England it is illegal to:

- sell all forms of tobacco and tobacco related products to a person under 18 years of age - Children and Young Persons (Sales of Tobacco) Order 2007[ix]
- sell illicit tobacco. (Tobacco that is either counterfeit or has evaded UK taxation)

Locally, the Trading Standards team with Rotherham Metropolitan Borough Council lead the work to reduce the availability of cheap and illicit tobacco by carrying out test purchases to identify retailers selling to under 18s, and seizures of counterfeit products. Their interventions, however, depend on

intelligence from the local community of sources of such products, and obtaining this intelligence is always a challenge when many residents see it as a victimless crime, with the only loss being to the Treasury. As an Alliance we need to continue to raise the awareness of the links between illicit tobacco and organised crime, and of the increased risks in smoking unregulated tobacco products, often with far higher levels of contaminants than standard cigarettes.

The future

There are significant changes ahead with the implementation of the Health and Social Care Act and the move of public health to a local authority responsibility. Alongside this reorganisation there are changes to the targets, with a move away from 4-week quitters towards prevalence measures among adults, pregnant women and 15-year olds.

Across South Yorkshire overall smoking prevalence has remained static over recent years, despite Stop Smoking Services that have delivered high numbers of 4-week quitters. We recognise that the approach taken to achieve 4-week quitter targets is therefore not appropriate for a prevalence reduction programme, and that we need to focus investment and expertise in a wider range of tobacco control activity. With colleagues from public health teams in Barnsley, Doncaster and Sheffield, and supported by the School of Health and Related Research at the University of Sheffield, Rotherham Public Health has been participating in a review of tobacco control investment priorities to identify where increasingly scarce funding is best directed to deliver a reduction in smoking rates. The group is scheduled to report key recommendations to Directors of Public Health in late 2012/early 2013.

Performance tables

Number of people setting a quit date and successful quitters by ethnic category and gender

Ethnic category and gender	Males setting a quit date	Females setting a quit date	Total persons setting a quit date	Males successfully quit	Females successfully quit	Total persons successfully quit
White						
British	2,117	2,977	**5,094**	1,130	1,473	**2,603**
Irish	16	12	**28**	8	5	**13**
Any other White background	58	85	**143**	25	43	**68**
Sub-total	**2,191**	**3,074**	**5,265**	**1,163**	**1,521**	**2,684**
Mixed						
White and Black	7	3	**10**	3	1	**4**

Caribbean						
White and Black African	2	1	**3**	2	0	**2**
White and Asian	4	5	**9**	2	4	**6**
Any other mixed background	2	5	**7**	1	2	**3**
Sub-total	**15**	**14**	**29**	**8**	**7**	**15**

Asian or Asian British

Indian	11	5	**16**	5	3	**8**
Pakistani	59	13	**72**	29	5	**34**
Bangladeshi	0	0	**0**	0	0	**0**
Any other Asian background	13	5	**18**	7	3	**10**
Sub-total	**83**	**23**	**106**	**41**	**11**	**52**

Black or Black British

Caribbean	1	4	**5**	1	0	**1**
African	9	1	**10**	6	0	**6**
Any other Black background	0	1	**1**	0	0	**0**
Sub-total	10	6	**16**	7	0	**7**
Other ethnic groups						
Chinese	2	0	**2**	1	0	**1**
Any other ethnic group	16	10	**26**	9	4	**13**
Sub-total	18	10	**28**	10	4	**14**
Not Stated						
Not Stated	21	50	**71**	10	22	**32**
Total	2,338	3,177	**5,515**	1,239	1,565	**2,804**

Number of pregnant women setting a quit date and outcome at 4 week follow-up	**Number**
Total number setting a quit date in the quarter	**399**

Number who had successfully quit (self-report)	194
Number who had not quit (self-report)	157
Number not known/lost to follow-up	48

Number who had successfully quit (self-report), where non-smoking status **confirmed** by CO validation	135

Rotherham Tobacco Control Alliance members

During 2011/2012 the following people were members of the Rotherham Tobacco Control Alliance

- Cllr Ken Wyatt (Chair – from May 2011)
- Cllr John Doyle (Chair – until May 2011)
- Cllr Jo Burton
- Cllr Judy Dalton
- Dr John Radford, Director of Public Health
- Joanna Saunders, Head of Health Improvement
- Alison Iliff, Public Health Specialist
- Simon Lister, Manager, Rotherham NHS Stop Smoking Service
- Alan Pogorzelec, Trading Standards Manager, RMBC
- Kay Denton Tarn, Healthy Schools Consultant, RMBC
- Amanda Thomson, South Yorkshire Fire and Rescue
- Fiona Middleton, Rotherham NHS Foundation Trust

The following people attended meetings as guests/alternates:

- Peter Jones, South Yorkshire Fire and Rescue
- Dennis Ager, Regional Tobacco Control Coordinator, West Yorkshire Trading Standards
- Lauren Ellis, Student
- VibhavariKhadam, Student

[i]Twigg L, Moon G, Walker S (2004) The smoking epidemic in England. London: Health Development Agency.

[ii] US Department of Health and Human Services (2004) The health consequences of smoking: a report of the Surgeon General. Washington DC: USA.

[iii]Callum C, Boyle A, Sandford A (2010) Estimating the cost of smoking to the NHS in England and the impact of declining prevalence. Health Economics Policy and Law.doi: 10.1017/S174413310000241

[iv] Nash R, Featherstone H (2010) Cough Up: Balancing tobacco income and costs in society. Policy Exchange

[v] 'Reckoner' spreadsheet for calculated estimated local costs (ASH, 2011)

[vi]Fendall L, Griffith W, Iliff A, Lee A, Radford J. (2012) Integrating a clinical model of smoking cessation into antenatal care. *British Journal of Midwifery*, Vol. 20, Iss. 4**,** 06 Apr 2012, pp 236 - 243

[vii] NHS Information Centre (2012) Smoking, drinking and drug use among young people in England 2011. London: NatCen Social Research

[viii] NHS Information Centre (2012) Statistics on Smoking: England 2012.

[ix] HM Government (2007) *The Children and Young Persons (Sales of Tobacco etc.) Order 2007.* Available from http://www.legislation.gov.uk/uksi/2007/767/contents/made

Health and Well Being Board (HWBB)
Community Alcohol Partnerships (CAPs) progress as of End October 2012

Following the HWBB meeting where the CAPs were initially discussed the same paper went to the Safer Rotherham Partnership for further ratification. This resulted in some lengthy discussion both in and outside of the meeting on the delivery and time commitment of the Area Partnership Managers involved, this has now been resolved and discussions in local areas have begun.

A meeting was held between the Area Partnership Managers and the 2 Public Health representatives that will be co-ordinating the CAP roll outs, clarity was gained of everyone's roles and expectations.

The estimated launch date for both areas is end of January 2013, an initial review will be held in July 2013 this will then inform the next steps for the existing CAP's. 2 further deprived areas will then be identified for the CAP roll out.

The CAP was presented to the Dinnington NAG, Councillors were fully supportive of CAP.

The Alcohol Strategic Partnership Meeting was held 26th October, the group were updated on the progress so far and their responsibility within the process reiterated.

Public Health representatives and CAP regional lead met with SYP analysts to agree the initial benchmarking required and issues to measured. The CAPs are specifically in place to address anti-social behaviour by young people but, we anticipate the knock on to be wider. As ASB issues are often seasonal the analysts has suggested 2 years data are used to benchmark. They are to also provide 'hot spot' areas and crimes in each of the localities. The key areas agreed so far are ; ASB highlighting all youth and/or alcohol, Crime (Damage, Shoplifting of alcohol , any offences where alcohol was an aggravating factor, alcohol related violence including domestic and youth related offences) plus NHS A+E admission data, Environmental Health / warden data - Litter offences and possibly Designated Public Place Orders, Section 27 orders and Drink Banning Order data. For the future we have made a request via CI Womersley that call handlers within SYP are prompted to ensure that each crime is noted as adult or young person and if alcohol has played a part

The CAP Regional Lead has identified the lead retailer (likely to be Tesco in Dinnington and Co-op in East Herringthorpe) He is to approach the companies at Head Office level to report that the CAPs will be delivered and that their support is requested in delivering the staff training to the other licensed premises within the area.

Next steps;
The Schools will be a key part of the CAP delivery, the Alcohol Education Trust (in partnership with CAPs) will supply a full pack of teaching aids for 11 – 16 year olds, this will be tied to local provision (such as www.callitanight.co.uk) and care pathways. Consideration also needs to be given to the RCAT college campus in Dinnington.

Partnership Buy In Event – this will be held before Christmas, all key stakeholders will be invited and presented with the concept of the CAP and the information

gleaned from the analysts work, as part of this event we will also do a scoping exercise of what agencies may have been missed and what agencies can offer. This will then be followed by a full action planning meeting in January prior to the launch. RASG supply posters and other literature

Residents (adult and young people) will be consulted via questionnaires, we anticipate that both CAPs will use the same key questions and add a couple of localised questions, the outcomes will become part of the benchmarking.

Rotherham Metropolitan Borough Council
Where Everyone Matters

Performance Management Framework

Health and Wellbeing Board

28 November 2012

Outcomes

Rotherham Metropolitan Borough Council
Where Everyone Matters

- To improve health and reduce health inequalities across the whole of Rotherham
- To bring about lower concentrations of people suffering from poverty and multiple deprivation

Aims of PMF

Rotherham Metropolitan Borough Council
Where Everyone Matters

- To evidence progress in tackling the 'Big Issues' set out in the JSNA
- To highlight any emerging issues and identify strategic interventions required
- To ensure the public can see we are managing efficiently and effectively

Tackling the 'Big Issues'

Rotherham Metropolitan Borough Council
Where Everyone Matters

- Over 100 national outcome framework measures, with organisational performance management
  - NHS Outcomes Framework
  - Public Health Outcomes Framework
  - Adult Social Care Outcomes Framework
  - Commissioning Outcomes Framework
- We need to focus on national measures which will track improvement against the 'Big Issues' in Rotherham

Prioritisation

Rotherham Metropolitan Borough Council
Where Everyone Matters

- JSNA identifies the 'Big Issues' in Rotherham
- We compare badly against our statistical neighbours on many measures
- Identified a small set of 'Priority Measures' to target our actions in the next three years

"Attempting to do too much, tackling a single issue such as alcohol would be enough of a challenge" **(John Wilderspin, DH)**

Accountability

Rotherham Metropolitan Borough Council
Where Everyone Matters

- Health and Wellbeing Board Priorities
  - Smoking
  - Alcohol
  - Obesity

  (Dementia)
- Rotherham Partnership Priorities (as part of the 'Poverty' work-steam)
  - NEETS
  - Fuel Poverty

Rotherham Public Health
NHS Rotherham and RMBC

Key:

- (green) Significantly better than England average
- (blue) Not significantly different from England average
- (red) Significantly worse than England average
- (dark grey) No significance can be calculated

England Key:

JSNA Big Issues - 1. Starting Well

	Indicator (baseline period)	Base Number	Base Value	Eng Avg	Eng Worst	England Range	Eng Best
1	Low birth weight of term births (2010)	275	8.5	7.3	11.5		3.9
2	Infant Mortality (under 1 year) (2010)	16	5.0	4.3	10.0		0.5
3	Perinatal Mortality (2010)	26	8.0	7.4	14.7		1.3
4	Smoking at delivery (2010/11)	659	23.0	13.7	32.7		3.1
5	Breastfeeding initiation (2011/12 Q4)	496	62.6	73.7	42.5		95.7
6	Breastfeeding at 6-8 weeks (2011/12 Q4)	212	29.2	46.9	15.8		83.2
7	Under 18 conceptions (2008-10)	245	49.3	38.1	64.9		10.8
8	Obese children (Reception) (2010/11)	248	8.3	9.4	14.6		6.4

JSNA Big Issues - 2. Developing Well

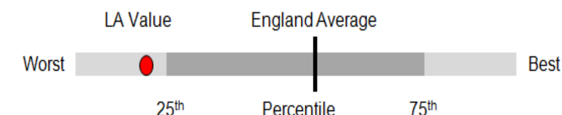
	Indicator (baseline period)	Base Number	Base Value	Eng Avg	Eng Worst	England Range	Eng Best
1	Pupil absence (2010/11)	2312	6.4	5.8	7.1		4.8
2	16-18 year olds NEET (end 2011)	760	7.6	5.5	10.4		0.9
3	5 GCSE A*-C incl Eng/Maths (2010/11)	1979	56.7	58.4	40.1		79.9
4	Hospital stays for alcohol harm (2010/11)	6686	2209.5	1895.2	3275.8		909.9
5	Obese children (Year 6) (2010/11)	637	21.6	19.0	26.4		10.7
6	Under 18 conceptions (2008-10)	245	49.3	38.1	64.9		10.8
7	Hospital stays for self harm (2010/11)	498	206.8	212.0	509.8		49.6
8	Injuries in under 18s (2010/11)	703	126.6	124.3	235.1		69.7
9	Emergency readmissions (2010/11)	not avail	12.8	11.8	14.5		8.1

Rotherham Public Health
NHS Rotherham and RMBC

Key:

- Green: Significantly better than England average
- Blue: Not significantly different from England average
- Red: Significantly w orse than England average
- Dark grey: No significance can be calculated

England Key:



JSNA Big Issues - 3. Living and Working Well

	Indicator (baseline period)	Base Number	Base Value	Eng Avg	Eng Worst	England Range	Eng Best
1	Adults smoking (2010/11)	not avail	23.9	20.7	33.5		8.9
2	Mortality from respiratory disease U75 (2010)	not avail	27.6	23.7	57.6		4.5
3	Hospital stays for alcohol harm (2010/11)	6686	2209.5	1895.2	3275.8		909.9
4	Mortality from liver disease U75 (2010)	not avail	14.4	14.7	35.0		4.9
5	Successful completion of drug treatment (2010/11)	172	11.8	13.3	32.5		4.8
6	Prevalence of diabetes (2010/11)	12262	6.0	5.5	8.1		3.3
7	Mortality from cardiovascular disease U75 (2010)	213	71.3	64.7	118.4		28.7
8	Obese adults (2006-08)	n/a	27.6	24.2	30.7		13.9
9	Physically active adults (2009-11)	104	10.4	11.2	5.7		18.2
10	Children in poverty (2009)	12010	24.0	21.9	50.9		6.4
11	Fuel Poverty (2010)	19796	18.2	16.4	29.1		4.6
12	People with MI/disability in settled accommodation (10/11	1270	66.6	70.7	3.6		91.8

JSNA Big Issues - 4. Ageing Well

	Indicator	Base Number	Base Value	Eng Avg	Eng Worst	England Range	Eng Best
1	Hip fracture in 65s and over (2010/11)	260	455.7	451.9	654.6		324.0
2	Excess Winter Deaths (2010/11)	166	20.7	18.7	35.0		4.4

What should we report?

Rotherham Metropolitan Borough Council
Where Everyone Matters

- Exception reporting to HWBB, based on the Board's 'Priority Measures'
- Form and frequency of reporting need to be agreed
  - Suite of measures that should be presented each meeting
  - Spine chart not sensitive enough to show scale of reduction
  - In depth consideration of a single issue each meeting
- Not all outcomes from the national frameworks have to be reported considered if not deemed local priorities based on evidence (JSNA)
- Other national measures managed through other partnership/organisational arrangements

Features of the PMF

Rotherham Metropolitan Borough Council
Where Everyone Matters

- SMART targets and action plans
- Accountable lead managers for all measures
- Reporting and communication framework:
  - ALL measures monitored and reported to the right people (across agencies)
  - 'Exception Reporting' to HWBB
- Addressing poor performance quickly and effectively
- Reality checked through customer feedback

Agenda Item 8

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Health and Wellbeing Board**
2.	**Date:**	**31st October, 2012**
3.	**Title:**	**Overarching Information Sharing Protocol**
4.	**Directorate:**	**All**

5. Summary

The Overarching Information Sharing Protocol (OISP) was originally approved in December 2009. This is a multi agency protocol and is used by many organisations within Rotherham as evidence and compliance to Information Sharing best practice. The previous OISP was owned by the multi agency Rotherham Information Governance Group. Given recent organisational changes this group no longer meets and it is hoped that the Health and Wellbeing Board accept ownership of the protocol.

The OISP is part of a three tier model enabling partner organisations to utilise well established appropriate and transparent information sharing systems (either manual or electronic). Processes place the service user at the centre of how their information is processed in accordance of their rights to privacy and confidentiality. It is a statement of the principles and assurances that govern information sharing

This protocol must **NOT** be seen as a legal document that allows all information to be shared between organisations. Indeed all information sharing must be undertaken in a manner that is in accordance with the Data Protection Act, Human Rights Act, common law duty of confidentiality and any other specific statute that authorises or restricts disclosure.

6. Recommendations

The Health and Wellbeing board are asked to:

- **Accept ownership of the OISP**
- **Approve the minor amendments**

7. Proposals and Details

The previous version of the OISP has been well received and widely used within Rotherham to facilitate trust in allowing the sharing of information, but it was aimed at operational information sharing.

Minor amendments have therefore been made to reflect the need of organisations to share information at a strategic level in order to:

- Improve the well being and life opportunities through educational, health and social care opportunities
- Protect peoples and communities
- Support people in need
- Reduce crime
- Reduce violence
- Prevent Health inequalities
- Provide seamless provision of children and young people's services
- Enable service users to access universal and specialist services
- Enable staff to meet statutory duties across organisations
- Prevent and detection of crime
- Improve data integrity and information quality
- Investigate complaints
- Manage and plan services
- Commission and contracting services
- Developing inter agency strategies

8. Finance

None – Protocol is already being used

9. Risk and Uncertainties

None – Protocol is already being used

10. Policy and Performance Agenda Implications

More effective strategic multi agency information sharing can only contribute to the Policy and Performance agenda

11. Background and Consultation

The OISP has already been approved by:

- RMBC
- NHS Rotherham
- The Rotherham NHS Foundation Trust
- Voluntary Action Rotherham
- Children and Young Peoples Consortium
- South Yorkshire Police

Report Author: **Gary Walsh**
Title: **Information Governance Officer**
Contact Number: **01709 822671**

Overarching Information Sharing Protocol

Integrated working to improve outcomes for the people of Rotherham

Version Number: 3.0

Review Date: December 2014

Author: Gary Walsh, Information Governance Officer

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1 Introduction

1.1 Background

This protocol complements and supports wider national guidance, professional body guidance and local policies and procedures to improve information sharing across services in Rotherham.

Government policy places a strong emphasis on the need to share information across organisational boundaries in order to ensure effective co-ordination of services, specifically in ensuring that there are integrated health and wellbeing services across the locality. Agencies arranging services to people within Rotherham are continually processing information about them. At times a single agency working with an individual may identify a range of issues that need to be addressed, some of which are outside its scope or expertise. Conversely, more than one agency could become involved with a service user but they are unaware of each other.

These agencies will be gathering the same basic information, undertaking similar assessments, producing and implementing plans of action that are appropriate to the agencies perceived response rather than the whole need of the individual. As a result there is often unnecessary duplication of effort, poor co-ordination and a lack of a coherent approach to the particular issues facing an individual which could be potentially detrimental.

The Health and Social Care Act states that Health and Wellbeing Boards, will need to look more widely at issues such as crime reduction, violence prevention and reducing offending along with the wider responsibility of ensuring there are integrated health and wellbeing services.

In these circumstances it has been recognised that a multi agency response is the best way of ensuring that service users receive the type and level of support most appropriate to their needs. In order to achieve this it is essential to have in place a framework that will allow the sharing of relevant information between professionals, when it is needed, with a degree of confidence and trust.

For the government statement on Information Sharing Protocols please see Appendix B.

1.2 **Summary**

The protocol is an overarching framework for sharing information between agencies which provide services to the people of Rotherham. It focuses on the sharing of personal information about service users. The protocol:

- Outlines the objectives and principles being achieved through the Rotherham Information Sharing Framework
- Summaries the legal background on information sharing
- Provides practical supporting guidance on how to share information

- Provides a framework within which services can develop service level information sharing protocols
- Includes arrangements for the monitoring, review and approval of the protocol

The protocol and supporting guidance provides the following benefits:

- Helping to promote information sharing
- Helping to ensure compliance with legislation and guidance
- Raising awareness of the key information sharing issues
- A comprehensive document that is relevant to all information sharing arrangements, allowing service level information protocols to focus on day to day specific information exchanges
- Establishes clear lines of responsibility

1.3 Purpose of the protocol

This protocol provides an overarching framework that enables partner organisations to utilise well established, appropriate and transparent information sharing systems (either manual or electronic) and processes that place the service user at the centre of how their information is processed in line with their rights to privacy and confidentiality.

It is a statement of the principles and assurances which govern information sharing by ensuring clarity and consistency in practice and in accordance with the:

- Data Protection Act 1998
- Human Rights Act 1998
- Common Law Duty of Confidentiality
- Caldicott Principles
- Any other relevant legislation and guidance

and upholds the rights of all the parties involved in a fair and proportionate manner. The key provisions of the above acts are summarised in HM Government national guidance, Information Sharing:

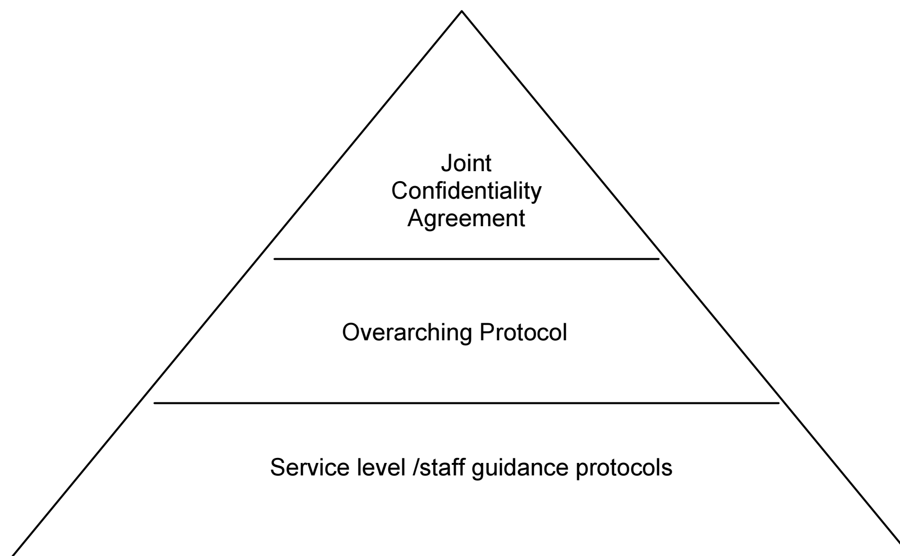
1.3.1 Rotherham Information Sharing Framework

This protocol forms part of the wider Rotherham Information Sharing Framework which aims to deliver a planned and structured approach to information sharing at all levels across the partner organisations. This will be achieved through Rotherham's information sharing framework.

The diagram below illustrates how the Rotherham Joint Confidentiality Agreement provides a high level agreement which identifies a common set of principles under which organisations share information. It commits those who sign it to facilitate the sharing of information whilst protecting the rights of the individual.

A middle tier of overarching information sharing protocols underpins this. At this level information sharing communities are established, the type of

information shared is defined and the purpose for which it is shared is identified. This protocol is an overarching protocol, in which children and young people's services are identified as an information sharing community. The third tier is made up of specific information sharing procedures and staff guidance, which can be used at service level to help staff make day to day decisions and support good practice. They are detailed information sharing agreements between individual agencies within the information sharing community at an operational level.



1.3.2 Other Protocols and contractual arrangements

Where other 'protocols' already exist between organisations then, if appropriate, this protocol and associated service level protocols will run concurrently with them and parties can continue to adhere to existing protocols.

If it is a requirement to disclose personal service user information between organisations as part of a funding/contractual arrangement then all parties (including NHS Independent contractors) should be made aware of this as part of the funding/contractual process. It is a recommended that all new partnerships entered into should be covered by an appropriate service level information sharing protocol.

1.4 Objectives of the protocol

The objectives in relation to this information sharing protocol are to:

- Facilitate the lawful and appropriate sharing of information between all organisations and departments in an efficient and effective manner
- To encourage commitment by all agencies to work together to develop information sharing arrangements and working practices that will improve outcomes

- To reduce uncertainty as to the legal basis upon which information can be shared and help foster a shared understanding of legal and statutory duties
- To help organisations and professionals to understand when you need to get consent before sharing information and when you can share without consent or knowledge of the service user
- To develop consistency in information sharing
- To help organisations to develop clear service level protocols that set out the basis upon which they share information and of their respective responsibilities and duties

1.5 <u>Information Sharing Principles</u>

This section sets out the general principles governing the sharing of information as set out in the Rotherham Joint Confidentiality Agreement. They are:

Staff at the initial point of contact with a service user should: -

- Explain the purpose of information collection
- Explain that information may need to be shared between partner organisations
- Seek consent for sharing of such information

A service user's request that information is not shared must be respected unless: -

- Disclosure is in the public interest, including for the purpose of prevention or detection of crime, apprehension or prosecution of offenders
- Disclosure is to protect the vital interest of the service user
- Disclosure is enabled by legislation

All agencies should: -

- Facilitate the exchange of information wherever such exchange is lawful
- Ensure that collected data is complete, accurate and relevant to the care of the individual
- Disclose the minimum amount of relevant information on a strict need to know basis only
- Notify the data owner of information that is discovered to be inaccurate or inadequate for purpose
- Rectify inaccurate or inadequate data and notify all other recipients who should ensure the correction is made
- Ensure that shared information is physically secure, and password protected where held on electronic systems
- Ensure that, as part of their ongoing development, staff are made aware of their responsibilities and rights in respect of service user information
- Ensure that information is readily available to service users on their rights in respect of personal information held including complaints procedure

- Ensure that alleged breaches of confidentiality are investigated under their respective agencies complaints procedures, liaising with partner agencies where shared information or care is involved
- Work together to develop frameworks, procedures and protocols for the sharing of information and to facilitate partnership arrangements

1.6 Purposes for which information may be shared

"Whilst the law rightly seeks to preserve individuals' privacy and confidentiality, it should not be used (and was never intended) as a barrier to appropriate information sharing between professionals. The safety and welfare of children is of paramount importance, and agencies may lawfully share confidential information about the child or the parent, without consent, if doing so is in the public interest. A public interest can arise in a wide range of circumstances, including the protection of a child from harm, and the promotion of child welfare. Even where the sharing of confidential medical information is considered inappropriate, it may be proportionate for a clinician to share the fact that they have concerns about a child."

The Protection of Children in England: A Progress Report
Lord Laming (March 2009)

"*The key factors in deciding whether or not to share confidential information are necessity and proportionality, ie whether the proposed sharing is likely to make an effective contribution to preventing the risk and whether the public interest in sharing information overrides the interest in maintaining confidentiality. In making the decision you must weigh up what might happen if the information is shared against what might happen if it* is not *and make a decision based on professional judgement."*

Information sharing: Guidance for practitioners and managers
HM Government (2008)

"*The Director of Public Health will work closely with local partners and the new Police and Crime Commissioners to promote safer communities. And he/she will engage with wider civil society to enlist them in fostering health and wellbeing. In short the Director of Public Health will be the critical player in ensuring there are integrated health and well being services across the locality."*

Public Health in Local Government: The role of the Director of Public Health. Health and Social Care Act 2012

This protocol applies to the sharing of information between organisations for the following purposes:

- Improve the well being and life opportunities through educational, health and social care opportunities
- Protect peoples and communities
- Supporting people in need
- Crime reduction
- Violence reduction

- Preventing Health inequalities
- Provide seamless provision of children and young people's services
- Enabling service users to access universal and specialist services
- Enabling staff to meet statutory duties across organisations
- Prevention and detection of crime
- Data integrity and information quality improved
- Investigating complaints
- Managing and planning services
- Commissioning and contracting services
- Developing inter agency strategies
- Performance management and audit
- Research relating to clinical, educational or social care objectives

Information Sharing Protocols are not required before frontline practitioners can share information about a person. By itself, the lack of an Information Sharing Protocol must never be a reason for not sharing information that could help a practitioner deliver services to a person.

2 Parties to the protocol

The Rotherham Health and Wellbeing Board will own Rotherham Overarching Information Sharing Protocol on behalf of their respective organisations. Participating partners commit their organisation to following the approach to information sharing which is detailed within.

3 Statutory powers and duties relevant to information sharing

The legal basis that underpins this protocol to facilitate the lawful sharing of information Appendix A

The powers and duties identified, when taken together, create a framework for the sharing of information between different groups of professionals and agencies including the voluntary sector and professionals working across service area and local authority boundaries. Used pro-actively, they can facilitate the collection and sharing of information in many of the situations where people are most in need of help and targeted services. These situations are not limited to those where risks have materialised or where the client is at risk of imminent or serious harm. Indeed it is a responsibility to share information in order to prevent risk materialisation.

However, we must ensure that information is shared in a lawful way and that we do not infringe the right of the service user to privacy.

The issue of consent is fundamental to appropriate information sharing.

Even if there is no legal requirement to obtain consent before sharing information it is often good practice to do so. This might be done for example when it has been decided that a service should be offered to the client and their voluntary cooperation is needed. Consent will always be needed at the

stage where services are offered unless there are child protection concerns where there is a statutory duty to intervene.

In most cases telling the client, family, young person or their carers that information has been shared about them or seeking their consent will help build up a relationship of trust.

In some situations consent will be required to comply with the Data Protection Act 1998 to entitle you to use personal information. In other cases it will be a matter of professional judgement as to whether your primary aim of securing the best outcome for the young person is more likely to be achieved if you seek permission to share information or not.

But there are many situations where you can and must share information legally without obtaining the consent of the client, family, young person or their carers. For example where doing so would:

- Place a child at increased risk of significant harm
- Place an adult at increased risk of serious harm
- Prejudice the prevention, detection or prosecution of a serious crime
- Lead to unjustified delay in making enquiries about allegations of significant harm or serious harm.

All information sharing must be undertaken in a manner that is compatible with the requirements of the Freedom Of Information Act , the Data Protection Act, the common law duty of confidentiality and the Human Rights Act , and any other specific statute that authorises or restricts disclosure Service level protocols will be developed which will set out the specific procedures to be followed to ensure these requirements are met.

4 Implementation of the protocol

4.1 <u>Development Process</u>

This protocol has been developed by the Rotherham Metropolitan Borough Council's Information Governance Officer.

4.1.1 Formal approval of the protocol and associated responsibilities

Partner agencies, will be requested to approve and adopt the overarching protocol formally.

4.1.2 Dissemination

4.1.3 A number of copies of the protocol will be provided to all partner agencies for circulation to relevant staff.

4.1.4 Partner agencies will ensure copies of the protocol are available to members of the public through their Freedom of Information Publication Schemes.

4.1.5 Review

Reviews will be carried out every two years:

4.2 Reporting breaches

4.2.1 Breaches should be reported to following each organisations internal policy

4.2.2 If an organisation receives a complaint about an information disclosure from a service user this should be investigated in accordance with the organisation's complaints procedure. If any disciplinary action is felt to be necessary this will be an internal matter for the organisation concerned.

4.3 Adoption of the protocol

The parties to the Overarching Information Sharing Protocol agree that the procedures detailed in the document provide a secure framework for the sharing of information between their respective organisations in compliance with their professional responsibilities.

Agencies that are party to this protocol will undertake to:

- Implement procedures within their organisations to ensure confidentiality of service user related information is in line with the Joint Confidentiality Agreement
- Ensure that staff adhere to the procedures and structures set out in this protocol
- Implement and audit compliance with this protocol within their organisations
- Ensure that where these procedures are adopted, no restriction will be placed on the sharing of information other than those specified within this protocol
- Ensure that all service level protocols established between partner agencies are consistent with this protocol

5 Document Control

Status	Final
Version Number	1
Author(s)	Susan Gray Information Sharing Officer, Children and Young People's Services
Date effective from	June 2006
Review date	May 2007

Document Revision Record				
Version	Description of change	Reason for change	Author	Date
1.1	Document Refresh & Review	Legislative Update & Refresh	Gary Walsh	Nov 2008
2.0	Document Changes Review	Final Comments from Rotherham District Information Governance Group	Gary Walsh	Dec 2008
2.1	Update to include Lord Laming references and include Safer Rotherham Partnership	To widen coverage of protocol to include Safer Rotherham	Gary Walsh	June 2009
3.0	Update to become more generic and include new Public Health Responsibilities	To widen coverage and include Public Health resposibilities as detailed with Health and Social Care Bill	Gary Walsh	Jan 2012

Appendix A: Statutory powers and duties relevant to information sharing

The legal basis that underpins this protocol and the duties and powers to facilitate the lawful sharing of appropriate information between agencies are summarised below. Details of the key legislation and guidance affecting the sharing and disclosure of information are set out in HM Government national guidance, **Information Sharing: Further Guidance on Legal Issues**

The key pieces of legislation that allow information sharing to take place and determine the extent to which it can be shared are:

- The Children Act 1989 (sections 17, 27, 47)
- The Children Act 2004 (sections 10, 11)
- The Education Act 1996 (sections 13 and 434)
- The Education Act 2002 (section 175)
- Learning and Skills Act (sections 117 and 119)
- Education (SEN) Regulations 2001 (Regulation 6 and 18)
- Children (Leaving Care) Act 2000
- Protection of Children Act 1999
- Immigration and Asylum Act 1999 (section 20)
- Local Government Act 2000 (Part 1, section 2 and 3)
- Criminal Justice Act 2003 (section 325)
- National Health Service Act 1977 (section 2)
- The Health Act 1999 (section 27)
- The Adoption and Children Act 2002
- The Crime and Disorder Act 1998 (sections 17, 37, 39 and 115)
- Housing Act 1985 & 1988 (schedule 2, grounds 2 & 14)
- The Protection from Harassment Act 1997
- The Homelessness Act 2002
- The Civil Evidence Act 1995
- The Crime and Disorder Act 1998 (section 115)
- Common Law Powers of Disclosure
- The Rehabilitation of Offenders Act 1974
- The Human Rights Act 1998 (article 8)
- The Data Protection Act 1998 (sections 29(3) & 35(2))
- Housing Act 1996 (sections 135, 152 & 153)
- Mental Health Act 1983
- The Law of Confidentiality
- The Health and Social Care Act 2001/2008
- *The Health and Social Care Bill*
- Limitation Act 1980

A good deal of information can be shared within the existing legal framework. But there is considerable confusion among agencies and practitioners about this. Sometimes, fear of breaking the law means practitioners share less than they can - and not enough to ensure the service user's needs are properly met.

Appendix B: Statement on Information Sharing

Sharing personal information: How governance supports good practice Agreements and Protocols (Aug 2008)

This statement aims to summarise how information sharing governance can support good practice at the front-line and to clarify the role of information sharing protocols.

To provide effective and efficient services, agencies and practitioners need to share personal information, particularly when it would help prevent an individual's life or life chances being jeopardised. Practitioners recognise the importance of information sharing and there is much good practice. However, it appears that in some situations they feel constrained from sharing personal information by uncertainty about when they can do so lawfully. In addition, practitioners need to understand their organisation's position and commitment to information sharing and to have confidence in the continued support of their organisation where they have used their professional judgement and shared information professionally.

This statement will be relevant to information officers and implementation managers who are responsible for information sharing governance or protocols. It will also help to provide clarity to practitioners at the front line who have to make case-by-case decisions about sharing personal information and for the managers and advisors who provide support them in this decision making.

Information sharing governance frameworks

It is good practice to establish an information sharing governance framework to provide clarity to all staff of the organisation's position on information sharing. An information governance framework must always recognise the importance of professional judgement in information sharing at the front-line and should focus on how to improve practice in information sharing within and between agencies. These should be communicated to the frontline so that practitioners have confidence in their organisation's commitment and support for professional information sharing.

An information sharing governance framework would be expected to include:

- An **Information Sharing Code of Practice**, which outlines the principles and standards of expected conduct and practice of the organisation and staff within the organisation. The Code of Practice establishes the organisation's intentions, commitment and level of acceptability of practice of sharing information.
- **Information Sharing Procedures**, which describe the chronological steps and considerations required after a decision to share personal information has been made, e.g. the steps to be taken to ensure that information is shared securely. Information Sharing procedures set out, in detail, good practice in sharing personal information.
- **Privacy, confidentially, consent (service users)** The organisation should have in place a range of processes and documentation for service users including 'Privacy/Confidentiality Statement', 'Fair Processing Notice', 'Consent', 'Subject Access'. Relevant staff within the organisation must understand these processes and be able to access documentation when required.

Applicability of Information Sharing Protocols (ISPs)
There has been some uncertainty about the applicability of ISPs to information sharing practices at the front line. This section aims to provide clarity on this issue.

An ISP is sometimes taken to mean a document that sets out principles and general procedures for sharing information. However there are also definitions and templates for ISPs that include detailed specification of what data fields will be shared, what the storage and archive principles are, etc. The latter type of ISP is designed to support bulk or regular sharing of information between IT systems or organisations.

Although neither type of ISP is required for information sharing at the front-line, the first is good practice and is covered in the definitions of Codes of Practice and Procedures above; the second is unsuitable for front-line practices. It is misunderstandings around what is involved in an ISP and a potential reliance on ISPs over professional judgement that we are seeking to address.

Where practitioners have to make decisions about sharing information on a case-by-case basis that are not clearly covered by statute, the decision to share or not share information must always be based on professional judgement. It should be taken in accordance with legal, ethical and professional obligations, supported by cross-Government information sharing guidance and informed by training and experience.

Information Sharing Protocols are not required before frontline practitioners can share information about a person. By itself, the lack of an Information Sharing Protocol must never be a reason for not sharing information that could help a practitioner deliver services to a person.

This approach is supported by the Information Commissioner's Office – see below:

"*All organisations can accomplish information sharing lawfully by adhering to governing legislation and the principles of the Data Protection Act whether an Information Sharing Protocol is in place or not. An Information Sharing Protocol is a useful tool in some circumstances. It is not a legal requirement.*

There are two distinct types of information sharing. Organisations may share large amounts of data with one or more partner organisations on a regular basis, or practitioners may share information with each other on an ad hoc basis as individual situations require.

An Information Sharing Protocol is a useful tool with which to manage large scale, regular information sharing. It creates a routine for what will be shared, when and with whom and provides a framework in which this regular sharing can take place with little or no intervention by practitioners.

It is not a useful tool for managing the ad hoc information sharing which all practitioners find necessary. Most importantly it is not intended to be a substitute for the professional judgement which an experienced practitioner will use in those cases and should not be used to replace that judgement." Information Commissioner's Office

Agenda Item 9

ROTHERHAM BOROUGH COUNCIL

1	**Meeting:**	**Health and Wellbeing Board**
2	**Date:**	**28th November, 2012**
3	**Title:**	**Public Health Responsibilities in relation to Sexual Health**
4	**Directorate:**	**Public Health**

5. Summary

This paper summarises the sexual health services commissioning responsibilities of Local Authorities in relation to the expected delivery measures as outlined in the Public Health outcomes framework for England, 2013-2016. The paper also outlines the responsibility Local Authorities have in relation to the Health Protection of the population by the development of local plans and capacity to monitor and manage acute incidents to help prevent transmission of sexually transmitted infections (STIs) and to foster improvements in sexual health.

6. Recommendations

1. That the Rotherham Sexual Health Strategy Group is reformed to produce an updated, comprehensive strategy for Rotherham to be agreed by March, 2013.

2. That Rotherham's sexual health contracts are reviewed in relation to efficiency, effectiveness, relevance to local need and performance against Public Health outcome measures – prior to April 2013.

3. That a briefing session is arranged for Elected Members and relevant senior officers to introduce and explain the complexities of the sexual health agenda

7. Background

On 1st April 2013 Local Authorities will become responsible for commissioning comprehensive open-access accessible and confidential contraception and STIs testing and treatment services, for the benefit of all persons of all ages present in the area. Local Authorities will also have a statutory requirement to protect the health of their geographical population from threats such as those from outbreaks of infection.

The commissioning of sexual health services is to be one of the mandated areas of work transferring to Local Authorities as the Government sees STI testing and treatment services as a central part of protecting health and believes that high-quality services must be available in all areas, tailored to meet local needs.

The 2010 white paper Healthy Lives, Healthy People outlines the Governments aim to work towards an integrated model of service delivery for sexual health services. The Department of Health is also working with the Health Protection Agency to take forward plans to improve quality and cost-effectiveness in the National Chlamydia Screening Programme (NCSP) which is moving towards the integration of screening offices into locally commissioned sexual health and primary care services. Local commissioners have been asked to undertake work to identify overall costs and how these can be streamlined in the future to form part of the 'core' sexual health service.

8. Proposals and Detail

From 1st April 2013 Local Authorities are mandated to ensure that their local populations receive effective provision of contraception and appropriate access to sexual health services. Furthermore, they are also mandated to ensure that there are plans in place to protect the health of the population (for example, in relation to STI outbreak). There are also three outcome delivery measures in relation to sexual health outlined in the Public Health outcomes framework for England, 2013-2016:

Working towards achieving a diagnosis rate for Chlamydia of 2,400 – 3,000 per 100,000 population (adults aged 15-24)

working towards a reduction in the proportion of persons presenting with HIV at a late stage of infection (based on a CD4 count of <350 cells/mm3)

working towards a reduction in teenage conceptions

In Rotherham there has been an overall reduction in diagnosis of Chlamydia, Warts and Syphilis from 2010 to 2011 and an increase in Herpes and Gonorrhoea. Levels of Gonorrhoea in the population is a marker for rates of unsafe sexual activity so the increase is a concern especially as 60% of those newly diagnosed in Rotherham in 2010 were under 25. Teenage pregnancy has fallen due, in part, to the success of Long Acting Reversible Contraception (LARC) but this may have led to a decrease in the use of barrier contraception thus leading to an increase in STIs. There is a need for Rotherham to have an updated comprehensive Sexual Health Strategy which incorporates both teenage pregnancy and health protection.

The most recent data for HIV new diagnosis shows an overall increase in cases from 2001 to 2011 by 47% but we are seeing a decrease over the last twelve month period. Rotherham does not see many late diagnoses of HIV but we do, at present, fund a locally based support group to help people to access services which impacts on our figures.

Chlamydia diagnosis rate was introduced in 2011 as a performance indicator based on outcome. The initial target, for effective intervention, is 2,400 positive tests per 100,000 eligible population. Rotherham has achieved this first target with a diagnosis rate of 2,604 per 100,000 population since the programme has been commissioned from our local services. However, analysis of the data shows that there is still a cohort of the population who are sexually active and not accessing services who need to be specifically targeted.
At present NHS Rotherham (NHSR) commissions sexual health services from well managed, successful local providers and it is proposed that for the first year of transfer of responsibility/budget to the Local Authority these contracts are maintained.
It is proposed that the Rotherham Sexual Health Strategy Group is reformed to produce an updated, comprehensive strategy for Rotherham which takes into account the mandated duties of the Local Authority, the Public Health outcome delivery measures and the needs of the local population.
It is further proposed that all the sexual health contracts are reviewed in relation to efficiency, effectiveness, relevance to local need and performance against Public Health outcome measures. Comprehensive Service Level Agreements for sexual health services are being developed by a Regional team (taking into account national work on tariffs) and it is proposed that Rotherham adopts these as best practice models.
It is also proposed that a briefing session be arranged for Elected Members and relevant senior officers to introduce and explain the complexities of the sexual health agenda.

9. Finance
The following services are currently contracted with NHSR, representing an overall spend of over £3,000,000*:

Genito-Urinary Medicine (GUM)/Contraception and Sexual Health (CaSH) services at Rotherham Foundation Trust (RFT) - covers a wide range of testing and treatment payments as well as staff and health promotion/education – very broad based, mixture of block contract and payment by results on a tarriff

Chlamydia Screening Programme – currently commisioned from the Rotherham CaSH service on a block contract

Out of area services – we currently fund sexual health services in a variety of neighbouring areas (payment by residency – part of the ‘choice’ agenda)

GP Locally Enhanced Services (LES) – Locally negotiated NHS contract for specific services that are additional to the GP National Core contract. Contract value negotiated with Local Medical Committee. Individual contract with each general practice. At present we have the following contracts available: the fitting of LARC, fitting of Intrauterine Coils, Chlamydia testing

Health Improvement - including HIV prevention work, contraception out reach and social marketing

Pharmacy LES - Locally negotiated NHS contract for specific services that are additional to the Pharmacy National Core contract. Contract value negotiated with Local Pharmaceutical Committee. Individual contract with each general pharmacy. At present we have a contract in relation to the provision of Emergency Hormonal Contraception (EHC)

(*excludes spend on teenage pregnancy)

10. Risks and Uncertainties

Following contract review and tendering processes there is a risk of lack of continuity of care should the contracts not be awarded locally. Sexual health services also operate screening programmes which contribute to surveillance as well as disease management and disruption in service provision could affect the level of knowledge in relation to STI prevalence.

11. Policy and Performance Agenda Implications

At present we receive monitoring information from the Health Protection Agency in relation to STI prevalence data which is sourced from the GUM laboratory data and the quarterly returns to the National Chlamydia Screening Programme. This is changing to show Local Authority/ward data to allow us to track trends and monitor performance on a local level. Rotherham has a Sexual Health Strategy which forms the framework for our commissioning of services but this needs to be revised this year to reflect the changes in outcome measures and the services we are mandated to provide.

12. Background Papers and Consultation

Public Health outcomes framework for England, 2013-2016.
Public Health in Local Government, 2011
Sexually Transmitted Infections, Report for South Yorkshire (Health Protection Agency), 2012

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By virtue of paragraph(s) 4 of Part 1 of Schedule 12A
of the Local Government Act 1972.

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