ADULT SERVICES AND HEALTH SCRUTINY PANEL

Venue: **Bailey House, Rawmarsh Road, Rotherham. S60 1TD**

Date: **Thursday, 1 April 2010**

Time: **10.00 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. Apologies for Absence and Communications.

4. Declarations of Interest.

5. Questions from members of the public and the press.

For Consideration

6. LINk Work Programme Update (herewith) (Pages 1 - 6)

10.05 am

7. LINk Rotherham Campervan (herewith) (Pages 7 - 8)

10.15 am

8. Scrutiny Review - Breastfeeding for Rotherham: A Healthy Future (herewith) (Pages 9 - 62)

10.25 am

9. Rotherham Community Health Centre (herewith) (Pages 63 - 67)

11.05 am

10. Yorkshire Ambulance Service Quality Account 2009-10 (herewith) (Pages 68 - 100)

11.15 am

11. Suggestion for the 2010/11 Panel Work Programme - For Discussion

11.30 am

For Information

12. South Yorkshire Joint Health Scrutiny Committee held on 18th March, 2010 (Pages 101 - 104)
    Proposed Changes at Sheffield Teaching Hospitals

13. Minutes of a meeting of the Adult Services and Health Scrutiny Panel held on 4th March 2010 (herewith). (Pages 105 - 111)

14. Minutes of a meeting of the Cabinet Member for Adult Social Care and Health held on 22nd February 2010 and 9th March 2010 (herewith). (Pages 112 - 123)

Date of Next Meeting:-
Thursday, 27 May 2010

Membership:-

Chairman – Councillor Jack
Vice-Chairman – Barron
Councillors:- Blair, Clarke, Goulty, Hodgkiss, Hughes, Kirk, Turner, Wootton and F. Wright

Co-opted Members

Mrs. I. Samuels, Kingsley Jack (Speakability), Jim Richardson (Aston cum Aughton Parish Council), Russell Wells (National Autistic Society), Taiba Yasseen, (REMA), Mrs. A. Clough (ROPES), Jonathan Evans (Speak up), Victoria Farnsworth (Speak Up), Mr. G. Hewitt (Rotherham Carers' Forum), Ms. J. Mullins (Rotherham Diversity Forum), Mr. R. H. Noble (Rotherham Hard of Hearing Soc.) and Parish Councillor Mrs. P. Wade

Workplan	Aims	Actions	Partners
Deaf and Hard of Hearing Support in Rotherham Hospital Out patients depts.. **Through engagement with support groups LINkrotherham became aware of the lack of appropriate support for people who are deaf and hard of hearing**	To establish if Rotherham Hospital outpatients departments meet the needs of patients who are deaf or hard of hearing LINkrotherham is aware that this may apply to other Hospital departments and wards. They feel it will be more productive to concentrate on one department, create a 'template 'or questionnaire that can be adapted for other areas within the hospital. It is felt that this is a more manageable approach. Once this area of work is completed, to investigate other areas within the hospital. Such as Accident & Emergency and Wards	Establish a sub group Consult with Support Groups And Health Professionals to create a questionnaire. Establish a joint working protocol with Rotherham Hospital Visit the Audiology department to set a bench mark. Identify suitable out patient departments for visits. Arrange dates / times for visits to enable LINk members to assist patients and staff to complete questionnaires. (100 minimum to be completed) Arrange to have a display stand in the area opposite Boots pharmacy on the days members are visiting the hospital (Make display area eye catching) Collate information and produce a report to be forwarded to Rotherham Hospital. Depending on the findings of the survey re format the questionnaire for use in A&E plus hospital wards.	Hard of Hearing Group (a representative to join LINk as an individual so a CRB check can be obtained . allowing her to visit the hospital to assist in completing the questionnaires) Deaf Group Rotherham Hospital

Work plan	Aims	Actions	Partners
Home care assessments for Ear , Nose and Throat Cancer Patients **There is no Ear, Nose and Throat (ENT) ward at Rotherham Hospital.** **Patients with ENT Cancers are admitted to hospitals in Doncaster or Chesterfield for treatment.** **If they require home assistance the patient has to be re-admitted to Rotherham Hospital for an assessment to be carried out.** **This can cause:-** **Distress to patients, their families and carers.** **Potential conflict between NHS professionals** **Potential Bed blocking by Rotherham Hospital**	Establish a Pathway for Patients with Ear Nose or Throat Cancers LINkrotherham is aware that a similar process may be in place for other patients and it is therefore hoped that once the Pathway has been established it can be adapted for use in other areas. To establish if there is potential for applying a similar Pathway for patients using Choose and Book.	Establish contact with NHS Professional affected by this process Work closely with Rotherham Hospitals Corporate Relations /PPI team to liaise with patients undergoing treatment in Doncaster and Chesterfield Investigate the protocols/ procedures for patients using Choose and Book Work with Adult Social Services to investigate the existing process Contact relevant LINks (Chesterfield and Doncaster) with a view to joint working. Establish a sub group with representatives from all areas.	Cancer Action Rotherham Rotherham Hospital End of Life Care Team MacMillan Nurses North Trent Cancer Registry Social Care Services Chesterfield and Doncaster LINks Chesterfield Hospital Doncaster Hospital.

Workplan	Aims	Actions	Partners
Personalisation **A National Initiative to enable individuals to have a choice in how and what support they receive.** **Through engaging Rotherham residents. LINkrotherham are concerned that people are unsure what personalisation is and how it will affect them.** **At this present time there appears to be no clear definitions for the 3 criteria levels, which in turns determines the level of support provided.**	To establish if the people already receiving support understand Personalisation. To ensure that people who are affected by changes in level of support receive sufficient notification. It is felt that Personalisation will be an ongoing project and the Aims may change as implementation of the programme progresses.	To engage with people receiving support by visiting drop in centres and day clinics to record, through a questionnaire, their views and concerns. Liaise with RMBC departments responsible for implementing the Personalisation programme. Liaise with support groups and voluntary organisations involved in personalisation Arrange visits to day centres and drop in sessions to carry out a survey Collate findings to be included in a report Monitor the outcome of the report Review the Personalisation programme on a regular basis through meetings with RMBC staff.	Support Groups Rotherham Doncaster and South Humberside (RDaSH) Care Trust RMBC Personalisation Representatives of VAR

Workplan	Aims	Actions	Partners
Support for Dementia suffers in Care Homes **LINkrotherham has identified a potential concern regarding the support people with dementia receive in Rotherham Care Homes.** **LINkrotherham feel this is a very delicate subject due to the nature of the condition**.	To establish if the support provided in Rotherham Care Homes meet the needs of people with dementia, their families and carers	Contact RMBC Adult Services Directorate to make them aware of the workplan and ask if they would like to carry out a joint piece of work Contact Home from Home Team with as per the above. Contact Rotherham support groups and voluntary organisations who have experience and understand the needs of Dementia sufferers with the purpose of joint working where possible. Contact the Care Home Liaison Team Liaise with all of the above to create an appropriate format / mechanism to engage dementia suffers, their families, cares and support staff. Decide on the care homes to be visited Arrange dates/ times for visits. The visits to be carried out in a manner that will allow maximum engagement / involvement for patients, families, carers and staff.	Home from Home Team (RMBC) Adult Services Directorate Patients, families and carers Care Homes NHS Rotherham RDaSH Support Groups Voluntary Organisations and Support groups.

Workplan	Aims	Actions	Partners
The lack of a GP Surgery in Laughton Common **LINkrotherham was approached by a representative of Laughton Common Tennant and Residents Association (TARA) regarding the lack of a GP Surgery and Dental Practice in Laughton Common** **The residents of Laughton Common have to register with a GP in either Dinnington or Thurcroft** **Some patients have difficulty assessing these surgeries. Such as Elderly residents , people with restricted mobility, parents with young families.**	To establish if there is a need for a GP surgery within Laughton Common. LINkrotherham is aware that most residents , when asked, would feel a GP surgery was necessary. It was decided to create a questionnaire that would include what facilities they would like within the GP Surgery plus other acceptable options if it was deemed a fully operational surgery was not required.	Contact Laughton Common TARA Contact Laughton Common Pharmacy Create a Questionnaire (see Aims). Consult and engage with TARA , pharmacy and NHS Rotherham Establish from NHS Rotherham the criteria deemed necessary for a GP surgery in a residential area. Conduct surveys , using the agreed questionnaire as follows :- Residents of Laughton Common Residents of adjoining areas. Industrial Estates Establish through RMBC planning if a proposed housing estate will be built at Laughton Common. Wellbeing Events:- to run concurrently with the survey as a means to local engagement and to raise health awareness	Laughton TARA Rother Fed Laughton Common Pharmacy NHS Rotherham RMBC Local Community groups NHS Rotherham Local Businesses. Transport (possible)

Workplan	Aims	Actions	Partners
Patient Involvement. GP Surgeries	To work with a small number of receptive GP surgeries to create a mechanism for patient involvement. To monitor the mechanisms for an agreed. To repeat the process with other local GP Surgeries	Identify receptive GP surgeries. Attend TARGET events to raise awareness of GPs obligation regarding patient involvement Sub group to work closely with GP surgeries to establish their requirements and expectations. Agree criteria for patient involvement. (possible 'recruitment ' of patient representatives) Agree method(s) for patient involvement Report on the findings and share with relevant stakeholders.	GP surgery professionals and staff NHS Rotherham Localised community groups.

BRIEFING NOTE	
For:	Adult Services and Health Scrutiny Panel
Prepared by:	Christine Dickinson, LINk Co-ordinator, LINkRotherham
Date:	1 April 2010
Subject:	**LINkRotherham Campervan**

1 During May 2009 LINkrotherham carried out 3 weeks of public engagement using a VW Campervan. The idea behind the campervan was to go to the people of Rotherham rather than expecting them to come to us.

Throughout the campaign we invited partners and other organisations and projects to join us on the van to promote their own service or project.

The campaign was so successful that we have decided to do it again with a slight twist.

2 The campaign this year will be primarily aimed at evidencing our work plans rather than public engagement. A list of the current projects we are working on is included in section 4 below.

We will be hiring a VW Campervan from 7th June until 18th June.

To celebrate the end of the campaign and the fact that it will be Carers Week we will be holding a town centre event on 18th June. All participants on the van will be invited to attend this event free of charge.

3 If you feel that any of the work listed would benefit your project or community and would like the van to visit a particular area please contact me on the details below.

Alternatively if you have an event planned or know of a burning issue in a community that you think would benefit from having the campervan please let me know.

Although there is no cost for you to use the van we would require help identifying suitable locations.

If you know of any other community group or project that may be interested in working with LINkrotherham please let us know.

4 LINkrotherham Workplan

<u>Deaf and Hard of Hearing</u>
LINkrotherham is currently establishing if Rotherham Hospital outpatients departments meets the needs of patients who are deaf or

hard of hearing.

Home Care Assessments for Ear, Nose and Throat (ENT) Cancer Patients

As there is no ENT ward at Rotherham Hospital cancer patients who have ENT Cancers and require operations are admitted to Chesterfield or Doncaster. If they require home assistance then the patient has to be re-admitted to Rotherham Hospital for a Social Care Assessment to be carried out.

Personalisation

This is a national initiative to enable individuals to have a choice in how and what support they receive. LINkrotherham are concerned that people are unsure what personalisation is and how it will affect them. At the present time there appears to be no clear definitions for the criteria level, which in turn determines the level of support provided.

Support for Dementia Sufferers in Care Homes

LINkrotherham has identified a potential concern regarding the support people with Dementia receive in Rotherham Care Homes.

Lack of GP Surgery in Laughton Common

LINkrotherham is working with Laughton Common TARA (Tenants and Residents Association) regarding the lack of a GP Surgery and Dental Practice in Laughton Common.

Patient Involvement in GP Surgeries

LINkrotherham is working with a small number of local GP's to create a mechanism for patient involvement.

ROTHERHAM BOROUGH COUNCIL – REPORT

1.	**Meeting:**	**Adult Services and Health Scrutiny Panel**
2.	**Date:**	**1 April 2010**
3.	**Title:**	**Scrutiny Review: Breastfeeding for Rotherham: A Healthy Future**
4.	**Directorate:**	**Chief Executive's All wards**

5. Summary

The report sets out the findings and recommendations of the scrutiny review into the social and community aspects of breastfeeding in Rotherham. The report is attached as Appendix 1.

6. Recommendations

That:

a. Members endorse the findings and recommendations of the report.

b. the report is forwarded to Performance and Scrutiny Overview Committee for approval, and future submission to Cabinet.

c. That the response of Cabinet to the recommendations be fed back to this panel.

7. Proposals and Details

7.1 Breastfeeding is a vitally important public health issue, with proven short, medium and long term benefits for both mother and child. However, despite a great deal of effort from the healthcare community and children's centres, Rotherham's breastfeeding rates are still not high enough – particularly in less advantaged areas. Furthermore, the majority of women who stopped breastfeeding wished that they had continued for longer. Through this review, Members therefore wanted to identify what measures could be put in place in order to encourage more women to initiate and sustain breastfeeding.

7.2 Specifically the review looked at:

- what is currently available in Rotherham to support women to breastfeed
- the views and experiences of mothers in Rotherham
- examples of good practice locally and elsewhere
- how existing resources can be best utilised
- how the Council and the wider Rotherham Partnership can play its part in making Rotherham more breastfeeding friendly

7.3 The recommendations from the review are detailed in Section 8 of the review and include:

- Pilot breastfeeding friendly council buildings at all libraries – ideally with a launch during National Breastfeeding week, 21 to 27 June 2010. Evaluate the lessons learned from the pilot by October 2010.
- Develop a phased programme to apply for accreditation to NHS Rotherham's 'Breastfeeding Friendly Rotherham Award' for all buildings that are open to the public, to be completed by May 2012.
- Draft simple guidance for staff to ensure a consistent approach to breastfeeding women – both employees and visitors to council buildings.
- Develop a Rotherham Breastfeeding Manifesto (to make the Borough of Rotherham breastfeeding-friendly) by bringing together all relevant agencies with the shared aim of boosting breastfeeding rates.
- Promote Breastfeeding Friendly Rotherham via the Rotherham Show in September 2010.
- Encourage closer working between health professionals and peer supporters.

7.4 The indicative timetable for the onward consideration of the review and its recommendations is as follows:

16/4/10	Submit report to PSOC
28/4/10	Submit report to Cabinet
End June	Cabinet to respond to report recommendations

7.5 Progress on the review's recommendations will be monitored on a six monthly basis by the Adult Services and Health Scrutiny Panel.

8. Finance

A number of the review recommendations may have financial implications if adopted. This would require further exploration by the Corporate Management Team on the cost, risks and benefits of their implementation.

9. Risks and Uncertainties

Breastfeeding data is collected by and reported on by NHS Rotherham. At the beginning of this review, it appeared that breastfeeding initiation and continuation were both increasing steadily. Whilst the review was being undertaken, a new electronic method of obtaining data direct from GP systems was introduced. Although this method is more robust, there are still some issues to be resolved regarding data completeness. However, so far, the figures show that breastfeeding rates are lower than initially thought. There is therefore a real risk that Rotherham will not meet its breastfeeding targets, which were based on baseline figures from the manual system,

10. Policy and Performance Agenda Implications

Both the Rotherham Community Strategy and the Women's Strategy contain objectives to encourage more women to breastfeed. A joint breastfeeding policy (covering NHS Rotherham, the Rotherham Foundation Trust and Children's Centres) has now been developed, but work now needs to be done to ensure that the policy is put into practice and the Rotherham community and infrastructure supports breastfeeding.

11. Background Papers and Consultation

The report has been circulated to all organisations/individuals that participated in the review for their comments and to check for factual accuracy.

Contact Name:
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Appendix A

Breastfeeding for Rotherham: A Healthy Future

Joint Report of the Adult Services and Health Scrutiny Panel and the Children and Young People's Services Scrutiny Panel

March 2010

Rotherham Metropolitan Borough Council

CONTENTS

INTRODUCTION

The reasons behind this review are really very simple: Breastfeeding matters and mothers need to be supported to choose to feed their babies this way.

It is the single most important public health intervention, which improves the short, medium and long term health of both babies and mothers.

Furthermore, most mothers want to breastfeed, but then stop in the first two weeks due to experiencing problems and receiving insufficient help with them. Of those who continue to breastfeed until 6 weeks, many find society's attitudes and the practicalities of continuing to feed whilst going about their lives, too challenging and give up long before the recommended minimum of six months[1].

This review has gathered a great deal of evidence and expert opinion upon which to base its recommendations. Our recommendations are aimed at the Council, NHS Rotherham and the Rotherham Partnership, as it is only by working together that we can make Rotherham a truly breastfeeding-friendly Borough.

Councillor Jo Burton
Breastfeeding Review Group Chair

[1] World Health Organisation

1. ORIGINAL CONCERNS – WHY MEMBERS WANTED TO LOOK AT THIS ISSUE

Breastfeeding is the single most important public health intervention, resulting in proven short, medium and long term health benefits to both child and mother.

The World Health Organisation recommends exclusive breastfeeding for six months, yet less than 2% of British babies are exclusively breastfed for this length of time. It has been demonstrated that breastfeeding has a major role to play in public health and in addressing inequalities in health in the UK[2]. Despite the overwhelming health benefits and cost savings associated with breastfeeding, UK rates remain unacceptably low. Rotherham's breastfeeding rates are below the national average and Members were concerned about the contribution this makes to the health inequalities already experienced by many Rotherham residents.

Women's ability to breastfeed is constrained by barriers at a range of levels and far from being a matter of choice, breastfeeding is a behaviour that is simply not accessible for many mothers and babies, especially in lower socio-economic groups.

Nationally, more than three quarters of women who stop breastfeeding in the first six months would have liked to breastfeed for longer[3]. At a Rotherham level, this figure is even greater, at 85%[4]. As the benefits increase with the length of time a baby is breastfed, it became apparent that the review should focus on the factors that influenced mothers to either not breastfeed at all, or to give up in the early days or weeks.

Members were also very conscious of how important it is for mothers to be able to breastfeed whilst going about their daily lives. If attitudes and infrastructure are not conducive to breastfeeding, many women will decide that it's simply not worth the effort to continue and will opt for formula feeding as an 'easier' option.

The review group was keen to ensure it added value to the work being undertaken by health professionals – particularly in recent times, rather than duplicating it. It therefore decided to concentrate on two specific aspects:

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[2] Source: Public Health Collaborating Centre on Maternal and Child Nutrition

[3] *Bolling K, Grant C, Hamlyn B et al. Infant Feeding Survey 2005. London: The Information Centre for Health and Social Care; 2007.*

[4] Annual Rotheram PCT Audit of a questionnaire sent to all women who delivered in January 2007

Help and support for breastfeeding women and making Rotherham a more breastfeeding-friendly place.

Throughout the review, Members stressed that they did not want this review to cast negative aspersions on any mother who had opted for formula feeding. Instead, they wished to highlight the evidence-based facts about breastfeeding, to help women make an informed choice and also to make recommendations to help reduce or remove some of the barriers that contribute to Rotherham's relatively low breastfeeding rates.

2. HOW THE REVIEW WAS UNDERTAKEN

2.1 Terms of Reference

The following terms of reference were agreed:

To look at the community and social aspects of breastfeeding, focusing particularly on barriers that may discourage mothers from starting and continuing to breastfeed.

2.2 Methodology

2.2.1 The review was jointly undertaken by members of the Adult Services and Health Scrutiny and Children and Young People's Scrutiny Panels.

The members of the review group were as follows:

Cllr Jo Burton (Chair)	Irene Samuels
Cllr Hilda Jack	Vicky Wilkinson (co-opted)
Cllr John Doyle[5]	Hazel Woodcock (co-opted)
Tracy Guest	

2.2.2 Co-option of Healthcare Representatives

Early on in the review, it became apparent that there needed to be closer working between the review group and healthcare services, which were leading on breastfeeding within the borough. It was agreed that the best way to do this was to co-opt Vicky Wilkinson, Infant Feeding Co-ordinator, NHS Rotherham and Hazel Woodcock, Infant Feeding Co-ordinator, The Rotherham Foundation Trust. This ensured that the review kept up-to-date with developments and that the recommendations it made would be complementary to other organisations' work in this area.

[5] Until May 2009

2.2.3 Approach taken

The review group first received presentations from local health colleagues from NHS Rotherham, in order to gauge the current situation in Rotherham and to understand the various breastfeeding-related initiatives that were being undertaken. It then invited a leading academic in this field to give her views and present a summary of recent research on the subject.

In order to give the residents of Rotherham the opportunity to contribute to the review, the Review Chair invited comments via a press release and subsequent letters in the local press. The excellent response to this reflected the substantial public interest in the subject. Face-to-face discussions took place with groups of mothers who both did and did not breastfeed, with additional views being obtained from a group of younger mothers. These informal discussions were extremely useful in providing the review with real life experiences of Rotherham women and their attitudes to breastfeeding.

It became apparent that several areas that had increased breastfeeding rates, had invested heavily in peer support. A meeting was therefore held with local peer support group, and a representative from the country's leading provider of breastfeeding support was also invited to speak to the group.

The review was supported by Delia Watts, Scrutiny Adviser.

3. LEGISLATIVE AND POLICY CONTEXT

3.1 National Level

3.1.1 World Health Organisation (WHO)

The World Health Organisation's infant feeding recommendation[6] is:

Breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants; it is also an integral part of the reproductive process with important implications for the health of mothers.

[6] As stated in the Global Strategy on Infant and Young Child Feeding (WHA55 A55/15, paragraph 10):

As a global public health recommendation, infants should be exclusively breastfed[7] for the first six months of life to achieve optimal growth, development and health[8]. Thereafter… infants should receive… complementary foods while breastfeeding continues for up to two years of age or beyond. Exclusive breastfeeding from birth is possible except for a few medical conditions, and unrestricted exclusive breastfeeding results in ample milk production.

3.1.2 UNICEF Baby Friendly Initiative (BFI)

The UNICEF Baby Friendly Initiative was launched in the UK in 1994 to encourage maternity hospitals to implement the Ten Steps to Successful Breastfeeding (see Appendix 1) and to practise in accordance with the International Code of Marketing of Breast milk Substitutes. In 1998 its principles were extended to cover the work of community health-care services in the Seven Point Plan for the Promotion, Protection and Support of Breastfeeding in Community Health Care Settings, given at Appendix 2.

The Baby Friendly Initiative works with the health-care system to ensure a high standard of care for pregnant women and breastfeeding mothers and babies. It provides support for health-care facilities that are seeking to implement best practice, and offers an assessment and accreditation process that recognises those that have achieved the required standard. The stages of accreditation are given below:

- A Certificate of Commitment is the first step towards the full award and is assessed by post and via an action planning visit
- Stage 1 assesses policies and procedures
- Stage 2 assesses the staff education programme
- Stage 3 assesses the care provided to pregnant women and new mothers.

3.1.3 National Institute for Health and Clinical Excellence (NICE)

NICE guidance[9] recommends implementing a structured programme that encourages breastfeeding using the Baby Friendly Initiative (BFI) as a

[7] "Exclusive breastfeeding" is defined as no other food or drink, not even water, except breast milk for at least 4 and if possible 6 months of life, but allows the infant to receive drops and syrups (vitamins, minerals and medicines). "Predominant breastfeeding" means that the infant's predominant source of nourishment has been breast milk. However, the infant may also have received water and water-based drinks (sweetened and flavoured water, teas, infusions, etc), fruit juice, or ORS solution.

[8] As formulated in the conclusions and recommendations of the expert consultation (Geneva, 28-30 March 2001) that completed the systematic review of the optimal duration of exclusive breastfeeding (see document A54/INF.DOC./4). See also resolution WHA54.2.

[9] Commissioning a peer-support programme for women who breastfeed - NICE, September 2008

minimum standard that should be subject to external evaluation. It also recommends the adoption of a multifaceted approach or a coordinated programme of interventions across different settings to increase breastfeeding rates, including:

- activities to raise awareness of the benefits of – and how to overcome the barriers to – breastfeeding
- training for health professionals
- breastfeeding peer-support programmes
- joint working between health professionals and peer supporters
- education and information for pregnant women on how to breastfeed, followed by proactive support during the postnatal period.

It also explains how inequalities can be reduced by improving access to breastfeeding support for women in low-income groups and highlights the need to ensure that 'women least likely to start and continue breastfeeding are actively engaged and that all pregnant women and new mothers are offered support for breastfeeding'.

3.1.4 Department of Health Guidelines

The Department of Health guidelines on feeding infants state that the best nutrition for infants is exclusive breastfeeding until 6 months (26 weeks), after which breastfeeding (and/or breast milk substitutes, if used) should continue, along with appropriate types and amounts of solid foods.

In May 2009 a new set of growth charts for newborn babies and children up to four years old were released by the Department of Health. The new charts are based on the growth of breastfed babies and replace current measures which are based predominately on babies fed with formula milk.

The new charts developed by the World Health Organisation and produced for the UK by the Royal College of Paediatrics and Child Health will play an important role in establishing breastfeeding as the norm and will be included in the Personal Child Health Records, which parents of every newborn are given. They will help parents and health-care professionals to identify children at early risk of obesity and provide important reassurance for parents of breast-fed babies, who are likely to gain weight more slowly.

The new charts include parent-friendly instructions and a chart specifically for premature babies. As babies can lose and gain weight at different rates during birth and two weeks, it is recommended that they are not measured during this time.

Government promotion of breastfeeding is further shown in 'Choosing Health: Making Healthy Choices easier'[10] which reiterates the targets for higher breastfeeding rates and calls for collaboration between primary care trusts and local authorities to increase the uptake of breastfeeding. Breastfeeding is also integral to the Change4Life campaign[11] to help make people make healthier choices, as part of the Start4Life strand.

The importance of breastfeeding has been recognised by the Department of Health which issued a target for all Primary Care Trusts to increase the initiation of breastfeeding by 2% per annum from April 2003[12], particularly amongst women from less advantaged groups.

3.1.5 British Medical Association (BMA)

The BMA describes breastfeeding as an ideal 'supply and demand' regulation system. The feeding behaviour of the baby and the quality of the breast milk change with time in a way that may prevent overfeeding, teach the infant how to recognise satiety signals, and regulate energy intake differently from formula-fed infants.

The role of leptin in breast milk may be of particular importance in the early development of both adipose tissue and appetite regulatory systems in the infant, and ultimately on propensity to obesity in later life. Observational studies have shown that breastfeeding is associated with lower rates of childhood obesity. Bearing in mind the absence of leptin in formula milk, this may have important implications for the prevention of obesity in children and in adults.

3.1.6 Breastfeeding Manifesto Coalition

The Breastfeeding Manifesto Coalition[13] was produced in consultation with over twenty UK organisations working to improve awareness of the health benefits of breastfeeding and its role in reducing health inequalities. The Manifesto draws attention to the gaps in UK breastfeeding policy and outlines seven key objectives:

- Implement the Global Strategy for Infant and Young Child Feeding
- Implement best practice into the health service across the UK
- Improve training for health professionals
- Work with employers to create a supportive environment for breastfeeding mothers
- Develop policy and practice to support breastfeeding in public places

[10] Department of Health, November 2004
[11] a government-sponsored social marketing initiative launched in Autumn 2008
[12] Improvement, Expansion and Reform: NHS Priorities and Planning Framework 2003-2006
[13] Launched May 2007

- Include breastfeeding education in the curriculum
- Adopt the World Health Organization International Code of Marketing of Breast Milk Substitutes and subsequent relevant Resolutions

It is currently is developing a national scheme to support mothers to exercise their right to breastfeed when out and about.

3.1.7 Breastfeeding in Public

Discriminating against a woman breastfeeding in public has been unlawful since the Sex Discrimination Act 1975. However, the Equality Bill[14] makes it explicit that mothers can breastfeed in public places such as cafes, shops and public transport and places a duty on the public sector to help mothers to feel confident enough to breastfeed.

Concerns that wording of the clause on breastfeeding would inadvertently undermine the right of a woman to breastfeed a child over six months in public led have now been addressed so that the legislation will protect the right of women to breastfeed regardless of the age of their child.

3.1.8 Breastfeeding in the Workplace

Existing UK law provides women workers with some protection whilst breastfeeding through the following pieces of legislation:

- Management of Health and Safety at Work Regulations 1999
- Workplace (Health, Safety and Welfare) Regulations 1992 and
- European Union Pregnant Workers Directive
- Sex Discrimination Act 1975

This legislation is mostly about facilities for expressing and storing breast milk, rather than the needs of the breastfeeding mother as an employee, which includes the provision of appropriate information about support for breastfeeding; breaks and facilities for breastfeeding or expressing milk; and flexible working hours.[15]

Supporting employees who want to combine work and breastfeeding not only complies with law but also makes business sense through the following benefits[16]:

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[14] At House of Lords Committee Stage, February 2010. The Act will apply to England and Wales. Scotland already has legislation to protect the right of women to breastfeed in public.
[15] Birmingham City Council Children's Nutrition – Mothers Who Wish to Breastfeed, February 2003.
[16] Maternity Alliance Breastfeeding and Work: The employer's guide to law and good practice June 2003.

- Lower Absenteeism – Most mothers of young babies have to take time off work to look after babies when they fall ill. One study found that mothers of formula fed babies took three times more one-day absences to care for a sick baby than breastfeeding mothers[17]
- Improved Staff Retention – A breastfeeding employee is more likely to return to her job after maternity leave if she knows she will come back to a supportive environment, thus avoiding loss of skills and incurring recruitment costs.
- Increased morale and loyalty – Many women experience feelings of guilt when leaving a young baby to return to work. Continuing to breastfeed helps to overcome these feelings and is a simple way to increase morale, job satisfaction and loyalty to the organisation.
- Family Friendly Reputation – Being known as a family friendly employer is good for corporate relations and recruitment. Support for breastfeeding is crucial to enable women to combine work and family and is therefore a key part of an Equal Opportunities Strategy.

3.1.9 Healthy Start Scheme

The Healthy Start Scheme provides weekly vouchers to pregnant women and mothers of children under four who are eligible for benefits. Pregnant women under the age of 18 may also claim the vouchers, which can be spent on milk, fresh fruit, fresh vegetables and infant formula milk.

It supports breastfeeding much better that its predecessor, the Welfare Food Scheme[18] as it allows mothers to exchange the vouchers for fresh fruit and vegetables as well as liquid milk, through general retail outlets. The previous scheme only gave the option of liquid milk or infant formula.

However 15% of those eligible do not use these vouchers.

3.2 Local Level

3.2.1 Public Service Agreement (PSA) Targets

Local authorities and primary care trusts share responsibility for improving health and well-being, part of which is to increase breastfeeding rates[19]. PSA 12 - Improve the health and wellbeing of children and young people[20] –

[17] Cohen R et al Comparison of Maternal Absenteeism and Infant Illness Rates among Breastfeeding and Formula Feeding Women in Two Corporations American Journal of Health Promotion 10: 148 -153 (1995).
[18] 1940 to 2004
[19] The delivery plans for the 2004 White Paper 'Choosing Health: making healthy choices easier', November 2004
[20] HM Government, 2008

includes the specific delivery priorities of increasing breastfeeding at six to eight weeks and the more general aim of "making breastfeeding the norm".

The delivery strategy for this PSA focuses on prevention, early intervention and effective support from practitioners.

3.2.2 The Rotherham Breastfeeding Policy

This was jointly developed by The Rotherham Foundation Trust and Rotherham PCT[21] in 2008. It is based on the Unique UK Baby Friendly Initiative Best Practice Standard, in accordance with NICE[22]. It also covers RMBC Children's Centres (see Appendix 3).

3.2.3 Community Strategy and Local Area Agreement

The Rotherham Community Strategy[23] – has 'improving infant health and reducing infant mortality' as a key aim, with Local Area Agreement improvement targets to increase the prevalence of breastfeeding rates at 6-8 weeks (to 30% in 2010/11 and the recording thereof (to 90% in 2010/11).

This filters down to Area Assembly level through local action plans, for example the Wentworth Valley Action Plan for 'Being Healthy' includes such actions as 'Ensure there is a Breastfeeding friendly space available in the Maltby Leisure and service Centre', as well as contributing to BFI accreditation.

3.2.4 Women's Strategy

The Rotherham Women's Strategy[24] contains two actions relating to breastfeeding:

- All new-build and refurbished premises be women-friendly[25] (part of the definition of which is to be baby/child friendly, providing suitable facilities for feeding/changing). This is linked to objective 4 – achieving – which is to increase women's involvement in planning.
- Increase the number of women who initiate and sustain breastfeeding.

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[21] Now NHS Rotherham
[22] NICE Clinical Guidance 037 Routine Postnatal Care for Women and their Babies, National Institute for Health and Clinical Excellence ,July 2006
[23] Rotherham Community Strategy 2005-2011, updated September 2008
[24] Rotherham – Working together for Women 2007-2010
[25] Objective 2 - Alive

3.2.5 Employment Policies

3.2.5.1 Rotherham MBC

Guidance for women returning to work after long break, such as maternity leave[26] encourages them to 'consider…flexible working options on returning to work'. Managers are asked to 'raise awareness of flexible working options including staged hours during first few weeks of return'.

In addition, following a query to WIN, the worker representative group for women employees, negotiation took place between HR and managers to make a rest room available in Bailey House which is lockable from the inside which can be used by breastfeeding employees to nurse or express milk.

Upon returning to work, breastfeeding mothers must notify their manager, who is required to do a risk assessment[27] as some hazards in the workplace may affect health and safety of new mothers and their babies. If any identified risks cannot be avoided by other means, 'changes have to be made to working conditions or hours'.[28]

Women who intend to express milk whilst at work, are told that 'arrangements can be made with your Manager for a suitable, secure room to be made available for use as there are no designated [rooms] allocated specifically for this purpose'[29].

The Council's guidance[30] reminds managers to ensure that workers who are breastfeeding are not exposed to risks that could damage health or safety for as long as they continue to breastfeed and points out that 'the Regulations do not put a time limit on breastfeeding…..and it is for women themselves to decide for how long they wish to breastfeed, depending on individual circumstances'. It also states that the Workplace (Health, Safety and Welfare) Regulations 1992 require suitable facilities to be provided for workers who are pregnant or breastfeeding to rest.

3.2.5.2 South Yorkshire Police

SYP offers a wide range of flexible work options to officers and staff to provide flexible solutions to individual needs within the constraints of the organisation's needs.

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[26] Hints for a Comfortable Return to Work, WIN (the worker representative group for women employees) Steering Group, Rotherham MBC, 2009
[27] Employee Maternity Checklist, Rotherham MBC
[28] Employee Handbook, Rotherham MBC
[29] Guide to Maternity Provisions, Human Resources, Rotherham MBC, April 2007
[30] Guidance on Protecting the Health and Safety of New or Expectant Mothers at Work, RMBC Economic and Development Services, Health and Safety Section, EDSHS 46 Issue 2 February 2004

Its Maternity Provisions refer only to breastfeeding in relation to the need for risk assessments to be carried out and makes no reference to how the needs of a breastfeeding mother may be accommodated.

However, officers and staff are assisted to integrate back into the workplace by local arrangements not reflected in the Force policies but which are overseen by the local Personnel Department in Rotherham. This includes the affording of 'extra flexibility to help them balance their homelife/separation from child and work' for the 12 weeks after returning from maternity leave.

Nonetheless, Rotherham district does not have many officers or staff still breastfeeding after their return from maternity leave, but those that do are asked specifically and would complete a separate risk assessment so that suitable arrangements can be considered.

4. BACKGROUND

The Department of Health has acknowledged that increases in breastfeeding rates would make a major contribution to the health of the nation.

4.1 National Breastfeeding Rates

Breastfeeding rates in the UK are much lower than in many European countries.

The national Infant feeding survey (IFS) is conducted every five years; the latest data are from 2005. These reports provide information about variations in feeding practice, factors that influence the type of milk and duration of milk feeding. They also detail trends in feeding over time.

The 2005 survey showed:

- Initial breastfeeding rates in 2005 had increased since 2000 (78% in England, 70% in Scotland, 67% in Wales, and 63% in Northern Ireland);
- Only 48% of mothers were breastfeeding at six weeks and 25% at six months;
- 45% were breastfeeding exclusively at one week, 21% at six weeks, 7% at four months and less than 1% at six months.
- Three-quarters of mothers had given their baby milk other than breast milk by six weeks, and 92 per cent by six months.
- Just under half of all mothers who had prepared powdered infant formula in the last seven days had not followed the instructions properly, for example by not using cooled boiled water.

The survey showed that there are strong relationships between the mother's socio-economic status and educational attainment and breastfeeding prevalence – these factors are associated with both initiation rates and

breastfeeding duration. At 7 weeks, nearly twice as many mothers from higher socio-economic groups were breastfeeding, compared with those from lower socio-economic groups[31].

Research also shows that mothers most likely to initiate breastfeeding are those who have breastfed a previous child and are over the age of 30.

4.2 Local Statistics

4.2.1 Data

Primary care trusts need to obtain several pieces of data for each mother and child, some of which are required by the Department of Health for monitoring purposes. The key pieces are:

- Breastfeeding initiation – first breastfeed within 48 hours (or if the baby is given any of the mothers' milk)[32]
- Data completeness/coverage – the percentage of infants for whom feeding status is recorded
- Breastfeeding continuation – a 6-8 week target, which is set locally.
- Feeding method at 6 months.

NHS Rotherham's most up-to-date data on Breastfeeding at 6-8 weeks is given at Appendix 4. The main trends are summarised below:

4.2.2 Breastfeeding Initiation

This is currently at 58.6% in Rotherham[33], with a target of increasing by 2% each year. While the initiation rate has increased from 54.62% in 07/08 to 58.6% in Q3 09/10, exceeding the 2% year on year level, there is a risk that the 60% target for the end of 09/10 will not be achieved.

4.2.3 Data Completeness/Coverage

Until the first quarter of 09/10, feeding status was collected manually, but since then, the information has been obtained from direct from GPs' electronic records systems. This means that the data is more accurate and robust, although the current figure of 77%[34] is a substantial way below the 09/10 target of 90%.

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[31] Prevalence of breastfeeding by mother's socio-economic classification, Hamlyn et al, 2002
[32] Department of Health 2005
[33] January 2010
[34] January 2010

4.2.4 Breastfeeding Continuation

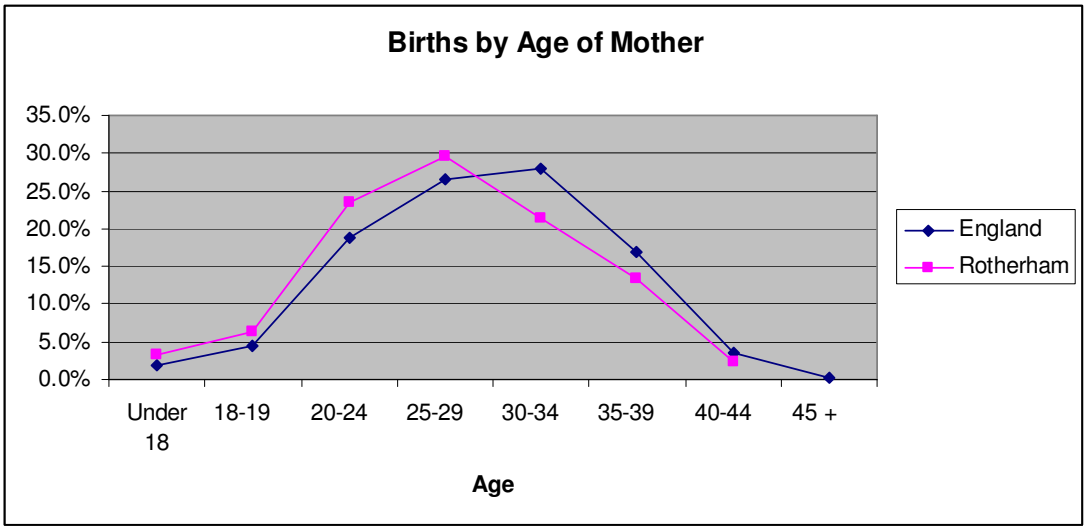
It is reasonable to expect 60% of those initiating breastfeeding to still be doing so after 6-8 weeks. This indicator includes babies recorded as mixed feeding (breast milk and formula milk).

Rotherham has challenging targets of 28% in 2009/10 and 30% in 2010/11. It appeared that the 09/10 target was met in June 2009, but this was when data was still being collected manually. Since then, the data has been drawn from GP Quest system and is more accurate. Unfortunately, this has shown that the prevalence is much lower than expected, with the figures for January 2010 showing that only 24% of babies were being breastfed at 6-8 weeks. However, as the feeding status of only 77% of babies is known (see above section), it is acknowledged that the full picture is not represented by this figure.

4.2.4.1 The World Health Organisation recommends exclusive breastfeeding up to the age of 6 months. However, is difficult to accurately estimate the numbers of mothers in Rotherham who are continuing to breastfeed at this time as NHS Rotherham is not planning to record and collect this data until breastfeeding has increased substantially. There may be some scope for collecting this data at the baby's routine 6-9 month check up.

4.2.5 Maternal Age

Research shows that younger mothers are less likely to breastfeed than older ones. The prevalence of younger mothers Rotherham compared with the England average is shown in the graph below and may be a contributing factor in the Borough's low breastfeeding rates.



Source: Office of National Statistics, 2007

4.2.6 Health Equity Audit: Breastfeeding in Rotherham[35]

This audit was undertaken four years ago and its results were used to inform the breastfeeding strategy and support the Borough's intention to gain UNICEF Baby Friendly status.

Its aim was to identify specific geographical areas with high/low rates of breastfeeding and thus identify where services need to be targeted. It showed that breastfeeding percentages at 10-14 days and 6-8 weeks were higher in the more affluent wards such as Sitwell and Wales and lower in more deprived wards such as Maltby, Rotherham East and Valley. By 6-8 weeks, the percentage of mothers breastfeeding had dropped to 10-20% throughout Rotherham wards.

5. CURRENT DEBATE

5.1 Identifying effective Interventions

A study funded by the Health Development Agency/NICE, published 2007 undertook a systematic review of formal evidence base. In addition it also incorporated the views of people who know the problems, thus moving from 'what works in research' to 'what really works in practice'[36]. This report informed the NICE postnatal care and maternal and child nutrition guidance[37]. It made two key recommendations:

- Each locality should consider the best package of interventions to address the diverse needs of their local population group(s)
- The decision should be informed by the views of practitioners and service users.

Furthermore, it suggested that health sector changes are not enough. In order to create an environment where breastfeeding is the norm, there are key policy and cultural issues that need to be addressed, including:

- Promoting employment practices that support breastfeeding
- Education for schoolchildren
- Facilitating breastfeeding in public.

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[35] Jessica Wilson and Rebecca Atchinson, NHS Rotherham, January 2006
[36] http://www.nice.org.uk/niceMedia/pdf/EAB_Breastfeeding_final_version.pdf
[37] www.nice.org.uk www.nice.org.uk/PH011.

5.2 Health Inequalities

A recent review[38] highlighted the fact that younger mothers, mothers from lower socio-economic groups and mothers with lower educational levels appear least likely to initiate and continue breastfeeding. This was borne out by the evidence gathered for the health equity audit[39] which showed that over a two year period, breastfeeding rates at 10-14 days and 6-8 weeks in the individual Neighbourhood Renewal Areas were almost always lower than the Rotherham average[40].

5.2.1 Education

Breastfeeding promotion is hampered by the language used, for example 'the woman's right to choose to breastfeed', as if it is one of two equal options and that the decision is an informed one. Many women do not understand that it is the only natural way to feed a baby and that feeding with infant formula is inferior. Nonetheless, health professionals do not want to make bottle-feeding mothers feel guilty.

Key messages that need to be conveyed are:

- Breast milk is tailored to the baby's needs
- Formula feeding is riskier – bottle-fed babies are 5 times more likely to be admitted to hospital with gastroenteritis than breastfed ones
- Infant formula cannot be tolerated by the most vulnerable babies – neonatal babies need breast milk, which comes from one of the 17 breast milk banks in the UK, if the baby's own mother is unable to provide it.

5.2.2 To help address this issue, a copy of the 'From Bump to Breastfeeding' DVD[41] is given to every expectant mother in Rotherham. In addition, NHS Rotherham is able to provide a DVD entitled 'So she wants to Breastfeed', which explains the father's role in supporting breastfeeding.

The Children's Centres also produce a range of leaflets around supporting breastfeeding mothers, under the banner 'Babies to Breast'.

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[38] Scientific Advisory Committee on Nutrition
[39] Health Equity Audit: Breastfeeding in Rotherham, Rotherham PCT, January 2006
[40] With the exception of Rawmarsh, which had a higher than average rate at 6-8 weeks
[41] Best Beginnings, 2008

6. FINDINGS

6.1 UNICEF Baby Friendly Accreditation: Rotherham

NHS Rotherham, the Rotherham Foundation Trust (RFT) and Rotherham Community Health Services are working in partnership to achieve UNICEF Baby Friendly Accreditation in hospital and community settings by 2012.

In 2009/10, NHS Rotherham allocated £20,000 Plan to this initiative and the Rotherham Foundation trust provided £8,000 funding to support development and capacity building for UNICEF BFI within the hospital. In March 2010, a further Department of Health grant of £100,000 was provided to support breastfeeding in Rotherham. £20,000 of this is being used to improve training, audit and implementing best practice across the RFT and Community Services.

To date, Rotherham has had its staff education programme assessed and has reached Stage 2.

6.2 Health Benefits of Breastfeeding

6.2.1 Breastfed babies are less likely to:

- develop juvenile-onset insulin-dependent diabetes mellitus
- develop eczema
- develop infections of the ear, chest and gut. Exclusive breastfeeding could prevent 27% of hospitalisations for lower respiratory tract infections and 53% for diarrhoea[42].
- be constipated
- be fussy about new foods
- become obese children, thus lowering their risks of developing coronary heart disease and diabetes in later life.

6.2.2 Mothers have:

- a lower risk of developing breast cancer
- a lower risk of ovarian cancer

"I breastfed for four months, mainly because I'd been told it would help me stay slim."
Becky, Rotherham

[42] Quigley MA, Kelly YJ, Sacker A. Breastfeeding and hospitalization for diarrheal and respiratory infection in the United Kingdom millennium cohort study. *Paediatrics* 2007;119(4):e837-e842.

- increased likelihood of returning to their pre-pregnancy weight (breastfeeding burns up to 500 extra calories a day)
- delayed resumption of menstrual cycle (and so are less likely to conceive at a time when the infant is still placing huge physical demands on the mother). This also helps mothers to maintain their iron stores. [43]

6.3 Financial Benefits

6.3.1 Breastfeeding costs the mother nothing, compared with formula feeding that costs over £400 per year[44].

6.3.2 The protection offered to babies through breastfeeding can lead to significant cost savings in the treatment of some illnesses, as well as reducing the indirect human costs to families which result from anxiety, stress and the disruption caused by hospitalisation.

6.3.3 It was estimated in 1995 that the NHS spends £35million per year in England and Wales in treating gastro-enteritis in bottle-fed infants. For each 1% increase in breastfeeding at 13 weeks, the NHS could save £500,000. A 5% increase in breastfeeding rates could save British hospitals at least £2.5 million every year.[45] Increasing breastfeeding rates would also reduce NHS expenditure on infant formula and teats.

6.3.4 Baby Friendly hospitals report lower incidence of sore and cracked nipples, engorgement and mastitis. This would logically have the effect of reduced GP consultations and prescription costs.

6.3.5 A study carried out in Glasgow which found that breastfed babies have 15% fewer GP consultations during their first 6 months of life than babies fed on artificial formula[46], thus reducing the call on primary care budgets.

6.4 Current Facilities in Rotherham

6.4.1 Retail and Transport

Breastfeeding facilities do exist within the Borough, but provision is, at best, patchy. Within the town centre, dedicated mother and baby rooms are only available at Boots, Tesco

"Tesco is good – especially in Wath."
Clare, Rotherham

[43] NHS Start4Life
[44] Based on one 900g tin of infant formula per week (not including bottles, teats and sterilizer)
[45] National Breastfeeding Working Group. Breastfeeding: good practice guidance to the NHS. Prepared in consultation with the National Breastfeeding Working Group. London: Department of Health; 1995.
[46] McConnachie A et al. Modelling consultation rates in infancy: influence of maternal and infant characteristics, feeding type and consultation history. Br J Gen Pract 2004; 54: 598-603

and at Rotherham Interchange. However, during the review, at least one mother expressed her dissatisfaction with the latter two.[47]

A number of businesses in Rotherham particularly encourage of breastfeeding mothers – one such example being Costa Coffee at Parkgate, which has worked in partnership with NHS Rotherham on a number of Breastfeeding Awareness Week activities. Others, such as the Pantry Green café in Rotherham town centre are happy to accommodate breastfeeding mothers upon request.

"I was feeding [my baby] in a café, no breast visible and being told to go and do that in the toilet."
DP, RMBC Employee

"I breastfed all three of my kids, but not in public. I planned my day around the feeds as I did not feel comfortable breastfeeding out and about in Rotherham."
Sue, Rotherham

As at February 2010, all businesses at Retail World at Parkgate have been provided with information on Breastfeeding Friendly Rotherham initiative and have been asked to sign up to the scheme.

6.4.2 Daycare Nurseries

Most daycare providers who look after children under the age of two[48] offer refrigeration facilities, so that breastfeeding women may bring in expressed milk to be fed to their babies. One nursery also added that should mothers work close by, they are welcome to come to the nursery during the day to feed their babies.

6.4.3 Council Buildings

The Council has a large number of buildings, many of which have been adapted from other uses. The list below explains what facilities and arrangements for breastfeeding are currently in place, as at February 2010.

Generally there are no dedicated breastfeeding facilities in the majority of council buildings and facilities are limited for the general public (often meeting rooms – where available and on request, or baby changing areas).

A list of current Council buildings and their breastfeeding facilities and arrangements is given at Appendix 5.

"I'm a mum of two.... I go to the town centre most days...and am disgusted at the lack of facilities for breastfeeding mothers. Most times I have to feed my daughter on a cold wet bench which is disgusting."
CJ, Canklow

[47] Letter from Claire Jackson, Rotherham Advertiser 19/12/08
[48] Based on a telephone survey of a random sample of 8 providers, June 2009

All Children's Centres, however, positively promote breastfeeding. Where dedicated rooms are not available, most will have quiet areas where women can feed comfortably.

At the time of writing this report there have been early discussions about the possibility of making breastfeeding mothers feel welcome in libraries.

6.5 Proposed Facilities

6.5.1 Civic Building

The new council offices on the former Guest and Chrimes site are due to open in spring 2012. The plans include a 'parenting room', although its exact use is not yet defined. There is still time to ensure that the room meets the needs of all those who wish to use it i.e. staff and public, for nursing babies and for expressing milk.

6.5.2 Rotherham Renaissance

The redeveloped railway station will have a new facilities building including ticket office, passenger lounge, toilet and retail kiosk. However, it is not clear whether this will include a specific mother and baby room.

"There aren't enough breastfeeding friendly places to go. There's often a choice between the toilet or the changing rooms at Primark".
Young mother, Rotherham

6.6 Why Mothers choose to Breastfeed

6.6.1 There is a strong correlation between attendance at antenatal classes and likelihood of a mother breastfeeding. Currently only 10%(?) of pregnant women in Rotherham attend these classes. In order to increase attendance, some classes are now run at children's centres and at weekends[49].

"I probably wouldn't have done it if I hadn't gone to parentcraft classes whilst pregnant"
TO, Rotherham

6.6.2 For some babies with specific health needs, breastfeeding is even more important.

6.6.3 Cultural expectations have a part to play in whether or not a mother chooses to breastfeed. In Rotherham, as elsewhere, mothers from BME communities and newly-arrived EU migrants have higher breastfeeding rates than the Rotherham average. However, once settled here, UK attitudes to infant feeding begin to influence and

"I tried my daughter on a night time bottle, but discovered she was intolerant to lactose. I therefore fed her fully myself. It was good for both of us."
AF, Rotherham

[49] Previously, all were run at Rotherham Hospital, during the week.

breastfeeding reduces.

"It helped that my mum supported me to breastfeed."
CR, Rotherham

6.6.4 Having experience and support from within the family greatly increases the chance that a woman will begin and continue to breastfeed.

6.7 Why Mothers choose not to Breastfeed

"I was a bottle feeding Mum…[and] do not like to see women feeding in public places."

There are significant reasons why women in the UK may choose not to breastfeed or why they stop breastfeeding early[50]:

6.7.1 Attitude of other people

"A middle aged couple sat in front of me in a café, one saw I was breastfeeding, gave me a filthy look and got up and left!"
DP, RMBC Employee

Some women feel that breastfeeding in public was unacceptable and embarrassing, while bottle-feeding is accepted by everybody and in all places. Britain's culture also sexualises breasts (through the media, fashion etc.) and therefore discourages society from accepting breastfeeding as their normal function.

"I found women were very supportive, but men gave me funny looks."
CR, Rotherham

Men's attitudes towards breastfeeding have improved in recent years, with 72% of mothers claiming their partner is happy for them to breastfeed both at home and in public, according to a recent survey[51]. The survey showed a significant change in attitude when compared with an earlier survey[52], which revealed that 50% of men thought women should not breastfeed in a public place. Between the two surveys, the percentage of men who felt uncomfortable about their partners breastfeeding in front of friends and family dropped from 14% to 3%.

A National Childbirth Trust survey in 2005[53] found that 63% of breastfeeding women had been subject to unsupportive comments or behaviour from other people when breastfeeding in public. However, a poll of a representative sample, showed that 84% of adults do not have a problem with

"Having a baby takes away quite a bit of your confidence anyway, so feeding in public where you're not made welcome is even more stressful."
Vicky, Rotherham

[50] McFadden A & Toole G (2006) Exploring women's views of breastfeeding: a focus group study within an area with high levels of socio-economic deprivation. Maternal & Child Nutrition 2: 156-68
[51] Survey of 1,859 mothers commissioned by Kamillosan, 2008
[52] conducted by Royal College of Midwives (RCM) in 1993
[53] A total of 2661 women out of a sample of 4246 women who had breastfed.

women breastfeeding their babies while they are out and about[54].

6.7.2 Attitudes of family and friends

"I got stick from a friend when she saw I was breastfeeding."
AF, Rotherham

The views of family and friends are often a stronger influence than that of health practitioners. Also, women who do not see their peers breastfeeding are less likely to perceive it as 'normal'. As breastfeeding rates have been declining for several decades, it is common for new mothers to have been formula fed themselves and therefore not benefit from practical support from their own mothers.

6.7.3 Lack of Knowledge

"As a teenager I thought that formula was best and breastfeeding was something you did in third world countries"
TO, Rotherham

Although many women know that breastfeeding is supposed to be beneficial, they often could not name any benefits, and were not convinced about them. In many cases, there is little understanding about what is behind the 'Breast is Best' message[55]. This is exacerbated by a lack of familiarity with and exposure to breastfeeding through friends and family. Some women believe that they can formula feed and then go back to breastfeeding.

Generally, breastfeeding workshops are only attended by those who would breastfeed anyway.

6.7.4 Lack of Professional Support

6.7.5 Some women experience difficulty in trying to establish breastfeeding but are unwilling 'to bother the midwife'. Sometimes the advice they receive is contradictory.

6.7.6 Experience

Some women experienced problems ranging from getting the baby latched on, sore nipples, and disturbed sleep. Women, especially younger ones, complained of a lack of freedom to travel/socialise/work. Bottle feeding seems easier.

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[54] NOP survey conducted on behalf of the Department of Health between 24-26 January 2003 amongst 990 people
[55] Promoted by the Department of Health

A recent UK survey[56] showed that:

- half of all breastfeeding women never tried to breastfeed in public during the first few weeks after the baby was born
- Between 4 – 6 months, only 39% of women breastfed in public compared with 67% of women who bottle fed
- When their babies were 4-6 months old, about half (46%) of breastfeeding mothers said they had had problems finding somewhere to feed their babies in public.

"The café in Meadowhall is ok to feed in, but can be freezing."
LW, Rotherham

6.7.7 Concerns about the baby's weight gain

Many women want the reassurance of seeing how much milk a baby has taken.

6.8 Practical Support for Breastfeeding

6.8.1 Breastfeeding Support Staffing

Current staffing comprises:

- Infant Feeding Coordinator 0.6 WTE[57] (employed until March 2011 using Choosing Health[58] funding)
- Project Worker 0.6 WTE (employed until March 2011 using Choosing Health funding).
- Antenatal and postnatal (6 WTE) support workers in Sure Start areas (employed until 2011 funded through NHS Rotherham's Operational Plan).
- Baby Friendly Coordinator, working across Rotherham Hospital (RFT) and Community Services (until September 2011).

All staff from the PCT and Children's Centres have received breastfeeding training. Policy and awareness training is also being given to front-line staff so that they can better understand their role in supporting breastfeeding. Parents receive a copy of the breastfeeding policy in a choice of formats, including Easy Read and translated into other languages, if required.

6.8.2 Midwives

Midwives provide practical support and encouragement for breastfeeding through antenatal classes, whilst in hospital (where relevant) and for 10 days

[56] Bolling K, Grant C, Hamlyn B et al. Infant Feeding Survey 2005. London: The Information Centre for Health and Social Care; 2007
[57] Whole time equivalent
[58] Department of Health, November 2004

post-delivery. In addition, they staff a 24 hour breastfeeding support helpline.

6.8.3 Health Visitors

There is a national shortage of health visitors, so visiting mothers in the most vulnerable circumstances is prioritised. This can mean that other women miss out on essential support to keep them breastfeeding once the midwife's visits stop at 10 days.

To help fill the gap, since December 2009, Rotherham Community Health Services has employed six antenatal and postnatal support workers. Their remit is to support mothers, encourage smoking cessation and also refer breastfeeding mothers to peer support, as appropriate. The antenatal and postnatal support workers have been trained to deliver breastfeeding support and clinical supervision.

6.8.4 Breast Pump Loan

£14,000 was allocated from NHS Rotherham's Operational Plan to fund a breast pump loan scheme until 2009. This made 50 good quality electric breast pumps available for hire from Children's Centres at the very reasonable rate of £10, plus a £10 refundable deposit. Hygiene kits are also provided with each pump. Each participating centre has two or three, and, to date, there have been enough pumps to meet the demand. However, the funding allocated to this project has now been fully spent, so some children's centres have no pumps available for hire.

Rotherham Hospital also lends breast pumps with no charge, but only for periods of one to two weeks.

6.8.5 Peer Support

It has been demonstrated that individual help with the practicalities of breastfeeding reduces early problems and increases the duration of breastfeeding, particularly for first time mothers[59].

"I think people need to know how difficult it is going to be, so that if they have a problem they don't feel it's their fault or that it's not working for them."
AB, Rotherham

One definition of peer support is 'support offered by women who have themselves breastfed, are usually from similar socio-economic backgrounds and locality to the women they are

"I think that if people knew that if they can get past the first 3 or 4 weeks it gets much easier."
AB, Rotherham

[59] Sacker A, Quigley MA, Kelly YJ. Breastfeeding and developmental delay: findings from the millennium cohort study. *Paediatrics* 2006;118(3):e682-e689.

supporting and who have received minimal training to support breastfeeding women. Peer supporters may provide breastfeeding support services voluntarily or receive basic remuneration and/or expenses.[60]

Evidence shows that peer support programmes should be offered to provide information and listening support to women on low before and after a baby's birth to increase initiation and duration rates[61]. Furthermore, the establishment of breastfeeding support groups should be fostered and referrals to such groups made on discharge from the hospital or the clinic[62].

NICE guidance calculates that an effective peer-support programme for an average primary care trust (PCT) with a population of 300,000 would be around 10 whole-time equivalents[63].

6.8.5.1 Peer Support in Rotherham

In recent years, NHS Rotherham has funded training for breastfeeding peer supporters which now operate peer support groups across Rotherham[64]. One-to-one support is provided through drop-in sessions at children's centres. These have had a positive effect, resulting in higher breastfeeding rates than before[65]. The supporters work on a voluntary basis, but are able to claim mileage. For some supporters, childcare is an issue, as they are only able to work if free childcare (often from the Children's Centres own crèche) is available.

Rotherham Central Children's Centre Breastfeeding Peer Supporters is a group of mothers who have been trained by a NCT Breastfeeding Counsellor using the 'NCT peer support – an enabling approach' training model. All have breastfed their own babies and have enthusiasm for and commitment to breastfeeding. The women have different interests, skills and experiences in a variety of breastfeeding areas. Their role is to offer support and information - not to give advice.

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[60] Promotion of breastfeeding initiation and duration - Evidence into practice briefing - Lisa Dyson, Mary Renfrew, Alison McFadden, Felicia McCormick, Gill Herbert and James Thomas, July 2006

[61] Promotion of breastfeeding initiation and duration - Evidence into practice briefing - Lisa Dyson, Mary Renfrew, Alison McFadden, Felicia McCormick, Gill Herbert and James Thomas, July 2006

[62] step 10 of the BFI 'Ten steps to successful breastfeeding',

[63] Commissioning a peer-support programme for women who breastfeed - NICE, September 2008

[64] Rawmarsh Children's Centre, Rotherham Central Sure Start, Rotherham Hospital, Wath Victoria Children's Centre, Rockingham Children's Centre, Thrybergh Rainbow Centre, Mothercare at Parkgate, Kimberworth Community Children's Centre and children's centres at Maltby, Dinnington and Herringthorpe.

[65] e.g. at Rawmarsh, where 21% of babies are breast fed at 6 weeks, compared with the Rotherham average of 16%

The group's aims are:

- To give expectant parents information about breastfeeding and support them to make an informed choice about how they will feed their baby;
- To be available to parents by telephone, home visits, and in groups;
- To raise the profile of breastfeeding in the Sure Start area;
- To support women who choose to breastfeed to enable them to feed for as long as they want to and support the whole breastfeeding family;
- To work together with health professionals in the Children's Centre and surrounding area to promote and support breastfeeding;
- To support breastfeeding mothers through difficulties they may be experiencing, both physical and emotional, in order to help them find a solution which works for them.

Work undertaken so far includes:

- Bumps and Babies – groups for mums and babies up to 6 months at Ferham Centre
- Weekly drop in at the Children's Centre
- Hospital – B10: antenatal workshops, Meg's Room, off B10 corridor: drop in
- GP Antenatal Clinics
- Home Visits
- Well Baby Clinics
- Developed a resource library
- National Breastfeeding Awareness Week
- Monthly sessions in Mothercare.

NHS Rotherham is committed to increasing peer support, allocating funding over a three year period[66]. A further £20,000 has been allocated to widen peer support across all Children's Centres in Rotherham, working with the voluntary and community sector.

6.8.5.2 Peer Support Elsewhere: Little Angels

Little Angels is a breastfeeding support social enterprise established in 2004 to work alongside midwifery care, health professionals and external agencies, providing dedicated support for breastfeeding women in hospital and in the home or through groups. The company employs local women in local communities, reflecting diversities in the population, ensuring true peer support is provided. Full training is provided through the NCT and La Leche League, and can include an NVQ in Advice and Guidance. Wages are £13-14,000 per annum, pro-rata and therefore above the minimum wage.

[66] £6,000 in 2008/09, £26,000 in 2009/10 and £26,000 in 2010/11

Mothers are given advice through antenatal groups and practical support from supporters whilst in hospital. Upon discharge, they will be visited within 48 hours and receive a second visit within 10 days. In addition, they receive weekly telephone contact up to six weeks and additional visits if necessary. A 24 hour helpline is also provided.

The service is funded through service level agreements with individual PCTs, contracts and grants. Pilots in new areas run for up to two years, followed by 3 year contracts awarded after a tendering process. Little Angels currently works in Blackburn with Darwen, Essex, East Lancashire, Chesterfield and Wakefield. Those areas where the organisation has been established for several years[67]have shown a substantial increase in breastfeeding rates[68].

6.9 'Be a Star' Campaign[69]

The 'Be a Star' campaign aims to increase the number of young mothers[70] who choose to breastfeed by showcasing local young mothers. They are photographed in glamorous poses, feeding their babies and explain how and why they have chosen to breastfeed.

The campaign will target over half a million people, using a range of tactics including a radio, outdoor marketing in shopping centres, advertising in bus shelters and on buses, posters in Children's Centres, libraries, colleges, GP surgeries as well as a variety of information leaflets and YouTube viral.

NHS Rotherham has allocated £30,000 funding in 2009/10 for rolling out the 'Be a Star' social marketing campaign in Rotherham. Two young women from Rotherham were given a make-over and photo-shoot, before their images were used for the campaign, which was launched in Rotherham in June 2009.

The 'Be a Star' campaign aims to promote the benefits of breastfeeding to young mothers, their friends, partners and families. The campaign incorporates images of breastfeeding mums styled as the stars of today as identifiable by young mums— super models, actresses, singers, pop idols, celebrities etc. The copy in the advertisements is written from the point of view of the key influencers in our young mum's lives - their parents, their partners, their friends and, of course, their baby.

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[67] Blackburn with Darwen and Wakefield
[68] Blackburn with Darwen increased its 6 week rate from 20% to 49% and its 7 month rate from 4% to 27%
[69] See www.beastar.org.uk
[70] Aged 18 to 25

The campaign has included posters displayed in doctors' surgeries, hospitals, libraries, Children's centres, leaflets containing breastfeeding tips and local support numbers, a blog, local radio campaign and outdoor advertising.

A second phase of the campaign is 'Create a Star' to which NHS Rotherham has allocated £15,000 in 2010/11.

6.10 Breastfeeding Friendly Rotherham[71]

"I think we should have something like the 'Breastfeeding Welcome Here' scheme like they have in Barnsley."
LW, Rotherham

The Breastfeeding Friendly Rotherham Award has been developed by NHS Rotherham to support, protect and promote parents' choice to breastfeed their infants. It encourages organisations to recognise breastfeeding as the best way to feed babies and therefore support breastfeeding through positive guidance. It is open to any premises to which the general public have access.

Breastfeeding Friendly Rotherham consists of two awards, each with its own set of standards.

- The Breastfeeding Friendly Rotherham award is open to any premises that are open to the general public.
- The Breastfeeding Friendly Rotherham Eateries award is tailored to establishments that serve food on their premises.

No particular amenities are required; more important is a positive attitude and willingness to support breastfeeding mums.

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Venues are helped to fulfil the criteria and then assessed using a 'mystery shopper' approach.

Successful facilities are then required to display the Breastfeeding Friendly Rotherham window stickers and are encouraged to promote their amenities by being included in a directory of breastfeeding friendly facilities to be given to all new mothers. Accreditation will be for 3 years with a self assessment appraisal completed annually.

"It's all very well having a mother and baby room at the market, but you have to go all the way to the office to get the key!
CR, Rotherham

[71] Source: NHS Rotherham

6.11 Formula Milk Marketing

Manufacturers of infant milk are prohibited from advertising formula aimed at babies under six months. However, they are permitted to do so for follow-on feeds for older babies and can therefore promote their early infant milk products by association.

Formula manufacturers often get round the legislation by providing free gifts to new mothers, without mentioning infant formula directly. One example of this is the free birth announcement cards given out at registration from Cow & Gate, which enables them to introduce the brand to the home without contravening the legislation.

In Rotherham, the Cow & Gate promotion was not evident. Instead a flyer for a Lloyds Chemist Mum and Baby gift pack is provided to each mother when their baby is registered. The pack contents vary over time, but when checked during the review, were found to compatible with the Breastfeeding Policy, with no promotion of formula or follow on milks, bottles, dummies or teats.

Each mother also receives a two Bounty Packs – one upon the baby's birth and one six months later, distributed through the healthcare system, containing samples and money off vouchers. This is also compatible with the Breastfeeding Policy.

6.12 Data Collection

Breastfeeding initiation figures are collected by the hospital where babies are born.

Breastfeeding continuation figures should be recorded by GPs at the routine check of mother and baby at 6-8 weeks. However, this information is not always collected and other times not passed on to NHS Rotherham, resulting in problems with data quality and collection.

At Cabinet on 10 March 2010, as part of the Local Area Agreement Annual Review, it was noted that:

'There have been significant issues concerning data collection and data quality in relation to the two 'breastfeeding' indicators, which have impacted on reported performance. Without improvements in the way data is collected it will be difficult to clearly ascertain how we are performing on this indicator. It is a problem which both the Alive Theme Board and NHS Rotherham are keenly aware of.'

Until the first quarter of 09/10, the data was recorded manually. From Q2, this has been done electronically, using a QUEST data search of GP records, which should provide more accurate and robust data. However, the more recent figures have shown a drop in recording rates (from 89% in June 2009 to 77% in January 2010. Some of this gap may be due to incorrect coding by GPs, which prevents the QUEST system from extracting the data.

Data recording by GPs has improved, but there are still some practices with large amounts of missing data – often due to mothers attending for their 6-8 week check-up too late to have their feeding status included in the return (which only includes check-ups that have taken place between 5 and 10 weeks).

All practices with missing data were requested to take part in a retrospective audit of breastfeeding data recorded in the first 3 quarters of 2009/10 in order to find out why there is not extractable data for 23% of babies. The results of this will be used to support practices to develop effective systems that deliver complete breast feeding data recording.

However, 77% (Q3) is still well below the end of year target for 09/10 and it the 90% target is unlikely to be achieved by the end of 09/10 (March).

7. CONCLUSIONS DRAWN FROM THE EVIDENCE

7.1 The Costs of not Breastfeeding

7.1.1 Encouraging breastfeeding is the single most important public health intervention. Increased breastfeeding leads to reductions in both acute admissions (such as for gastro-intestinal infection in the baby) and chronic conditions (e.g. childhood diabetes), which currently cost the NHS many millions of pounds each year. Investment in breastfeeding education and support is therefore a small price to pay for the substantial reduction in healthcare bills that result from increasing breastfeeding and continuation rates.

7.2 Attitudes to Breastfeeding

7.2.1 There is general understanding that breastfeeding is best for the health of the baby and child, but not that formula feeding has definite risks associated with it. However, in recent generations, a formula feeding culture has evolved, whereby this is seen as the norm and breastfeeding the 'alternative' choice. There is a strong perception that breastfeeding is 'difficult' and formula feeding, 'easy'.

7.2.2 Many women decide not to breastfeed as they feel embarrassed or uncomfortable about doing so in front of others.

7.2.3 Society's sexualisation of breasts is greatly influenced by media images and, to a certain extent, by fashion. The perception that breasts are somehow 'rude' particularly discourages young women from breastfeeding and also influences the attitudes of those around them. Only by making breastfeeding the norm (as in Scandinavian countries), will this stigma be overcome.

7.2.4 The message that bottle feeding is 'normal' begins very early, with many children's toys and books supporting the idea. Schools currently do little to challenge this view.

7.3 Breastfeeding Initiation

The official measure for this is a breastfeed within the first 48 hours after delivery. However, the trend for women with straightforward deliveries to leave hospital much sooner, makes it not only difficult to obtain accurate data for this measure, but also reduces mothers' access to breastfeeding support at this critical time.

7.4 Support – formal and informal

7.4.1 NHS Rotherham's provision of additional staffing to encourage and support breastfeeding is having positive results. However, many of these staff are employed on fixed term contracts using grant funding and there is a danger that without these posts, it will be difficult to continue to improve and sustain breastfeeding rates across Rotherham.

7.4.2 Although grant funding has been used to purchase breast pumps for loan, the sustainability of this arrangement is at risk as there is no ongoing revenue funding for the hygiene kits that are required for each user. Already there are three new Children's Centres that do not have breast pumps due to shortage of funding.

7.4.3 Despite the availability of peer support, mothers who experience difficulties in the early weeks often choose to abandon breastfeeding rather than seek help. There seems little understanding that, with support to help them over their difficulties, they could go on to successfully breastfeed for as long as they want. Rotherham has good structures for peer support, but they are currently underutilised due to the ways referrals are currently made.

7.4.4 Many mothers in Rotherham are second or third generation formula-feeders, so there is little family support if breastfeeding problems occur.

7.4.5 By choosing to breastfeed, some women feel that they will not be able to fully share the task of looking after their baby with the father – particularly with respect to night feeds. Fathers want to be involved, but do not always understand the benefits of breastfeeding to the baby.

7.5 Making Rotherham Baby Friendly

7.5.1 Historically, the health service has not been particularly supportive of breastfeeding and has given it a low priority. This is changing in Rotherham through the implementation of the Baby Friendly Initiative and good progress is being made towards full accreditation.

"I did feed my daughter everywhere, …simply because the facilities for breastfeeding were not there."
TO, Rotherham

7.5.2 So far, the healthcare community (through Children's Centres) has led the work to increase breastfeeding rates in Rotherham. Through Rotherham Partnership, other partnership organisations, including the Council, must now play their full part in this important task.

7.6 Places to Breastfeed

7.6.1 The shortage of suitable places to breastfeed in the community is one reason why women find it difficult to sustain breastfeeding after the first few weeks.

7.6.2 Most women do not require dedicated breastfeeding facilities (although for some this is essential) – just somewhere quiet and comfortable where they feel welcome.

"It's about attitudes – the McDonalds staff are very good."
CR, Rotherham

7.6.3 The 'Breastfeeding Friendly Rotherham' campaign has great potential to address the shortage of places where mothers feel comfortable about breastfeeding. It is vital that the Council plays its substantial part in this by working towards accreditation for its many publicly-accessible buildings. It could also have a role in encouraging private sector business to be accredited.

7.6.4 The legislative requirement for employers to undertake a 'risk assessment' – implying that breastfeeding is a problem - does little to encourage women to continue breastfeeding after they return to work. Large employers should take the lead by developing a more 'enabling' attitude, to positively encourage women to continue.

8. RECOMMENDATIONS

The overall aim of this review is to encourage women to recognise their right to breastfeed at any time, in any place and to provide support for breastfeeding. More specifically, it wants to actively welcome breastfeeding mothers and encourage breastfeeding in all public areas of Rotherham.

8.1 Rotherham Metropolitan Borough Council

8.1.1 Publicise the Council's support for breastfeeding on the home page of the Council website and also on web pages and literature relating to libraries, leisure facilities, customer service centres etc.

8.1.2 Provide breastfeeding mothers with a private area to breastfeed, if requested. This need not be a dedicated breastfeeding room. Any designated feeding area should NOT be in the toilet area, although baby changing facilities should also be available elsewhere in the building.

"The Council should lead the way by offering discreet areas in its own buildings, where women could breastfeed in comfort."
Member of Women's Network, GROW Rotherham

8.1.3 Pilot breastfeeding friendly council buildings at all libraries – ideally with a launch during National Breastfeeding week, 21 to 27 June 2010. Evaluate the lessons learned from the pilot by October 2010.

8.1.4 Audit all council buildings that are open to the public against the 'Breastfeeding Friendly Rotherham' criteria by October 2010.

8.1.5 Develop a phased programme to apply for accreditation to NHS Rotherham's 'Breastfeeding Friendly Rotherham Award' for all buildings that are open to the public, to be completed by May 2012.

8.1.6 Distribute NHS Rotherham's directory of breastfeeding friendly places[72] via Children's Centres, libraries, customer service centres, tourist information centre etc. and arrange for it to be downloadable from the Council website.

8.1.7 Provide publicity for commercial businesses that hold the Breastfeeding Friendly Rotherham Award, via the Council website.

8.1.8 Develop a Council breastfeeding policy in line with the existing Joint Breastfeeding Policy[73], by December 2010. Base the Council policy on the Children's Centre Breastfeeding Policy Appendix Jan 2010, as given at Appendix 3 of this report.

8.1.9 Make existing staff aware of the Breastfeeding policy via a compulsory e-learning module, notified to staff via team briefings, by March 2011.

8.1.10 Draft simple guidance for staff to ensure a consistent approach to breastfeeding women – both employees and visitors to council buildings.

8.1.11 Provide front line staff should with more in-depth breastfeeding friendly training (covering both policy and guidance) from Children Centres' staff (?[74]) by September 2011.

8.1.12 Include Breastfeeding policy in induction training for Members and officers.

8.1.13 Review and strengthen the Council's planning policy and guidance so that the needs of breastfeeding mothers are considered.[75]

8.1.14 Ensure all refurbished or new-build council buildings incorporate a quiet area for those women who would prefer to breastfeed privately.

8.1.15 Design the planned parenting room in the new Civic Offices[76] so that it meets the needs of nursing mothers and those wishing to express breast milk. Facilities should include comfortable seating, blinds or screens, a lockable door, availability of drinking water and a refrigerator for storing expressed milk. Access should be arranges so that both staff and the public

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[72] In printed form, if produced, or electronically

[73] developed by NHS Rotherham, The Rotherham Foundation Trust and Children's Centres in 2008 and currently being revised.

[74] Check with Yvonne Weakley, Head of C&YP, RCHS

[75] Helen Sleigh – check on existing policy and guidance – emailed 9/10/10

[76] Due to open in spring 2012

are able to use the room. Ensure that signage incorporates the Rotherham Breastfeeding Friendly logo.

8.1.16 Encourage children's centres and all council-run providers of foundation stage education to remove toy feeding bottles from 'home corners' and children's books with a bottle-feeding bias, via a letter from the Cabinet Member for Health and Adult Services, asking for a response to the suggestion by September 2010.

8.1.17 Raise the issue of how best to promote breastfeeding through schools via the summer meeting of the PSHE Co-ordinators' group. Consider piloting the primary school resource that is currently available. Report the outcome of this on this to the Adult Services and Health Scrutiny Panel by September 2010.

8.2 Rotherham Partnership – Alive Theme

8.2.1 Develop a Rotherham Breastfeeding Manifesto (to make the Borough of Rotherham breastfeeding-friendly) by bringing together all relevant agencies with the shared aim of boosting breastfeeding rates. Produce the Manifesto by April 2011.

8.2.2 Become a member of the Breastfeeding Friendly Coalition.

8.2.3 Publicise the Breastfeeding Friendly Rotherham Award through Rotherham News, with a specific focus on successful accreditation of public and private sector facilities and businesses.

8.2.4 Encourage public sector employers[77] to lead by example by:

- providing information to employees on the opportunities to breastfeed or express milk on returning to work - before they go on maternity leave
- holding post-maternity leave return to work interviews with staff, to allow individual issues to be discussed
- wherever possible, supporting employees to continue breastfeeding or giving breast milk on return to work (e.g. by allowing expressing/breastfeeding breaks in addition to the lunch break).

Monitor progress on this recommendation by requesting a current position statement from each employer by September 2010 and monitor progress annually via the Adult Services and Health Scrutiny Panel, thereafter.

8.2.5 Explore the possibility of sponsorship of breast pump hygiene kits through members of the Barnsley and Rotherham Chamber of Commerce by

[77] Council, NHS Rotherham, Rotherham Community Health Services, Police, Fire Service, Yorkshire Ambulance Service

December 2010.

8.2.6 Consider the development of a breastfeeding awareness campaign aimed at men, as part of the next revision of the parenting strategy[78].

8.3 NHS Rotherham

8.3.1 Report the evaluation of the current peer support pilot and any development plans to the Adult Services and Health Scrutiny Panel by September 2010.

8.3.2 Commission from Rotherham Community Health Services, the continuing employment of the six antenatal and postnatal support workers, after existing contracts end in 2011.

8.3.3 Promote Breastfeeding Friendly Rotherham via the Rotherham Show in September 2010.

8.3.4 Report evaluation of 'Be a Star' campaign to the Adult Services and Health Scrutiny Panel[79].

8.3.5 Encourage midwives to register women with their local children's centre before they have their babies.

8.3.6 Encourage closer working between health professionals and peer supporters by asking health professionals to:

- Give mothers and their families information about peer support for breastfeeding;
- Ask women if they would like a peer supporter to contact them to discuss their feeding choices;
- Refer women experiencing difficulties or in need of support
- Involve peer supporters in antenatal groups.

8.4 Monitoring

8.4.1 Monitor progress against the review's recommendations on a six-monthly basis, via the Adult Services and Health Scrutiny Panel, inviting members of the Children and Young People's Scrutiny Panel to also attend.

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[78] Rotherham Parenting Strategy 2009

[79] University of York will be undertaking evaluation at between September 2010 and January 2011

9. THANKS

The review group would like to thank all the witnesses for their time, co-operation and willingness to engage in this process. Their contributions are gratefully acknowledged.

- Professor Mary Renfrew, Professor of Mother and Infant Health, Department of Health Sciences, University of York
- Michelle Atkin, Marketing, PR and Sales Director, Little Angels (Darwen) Community Interest Company
- Hazel Woodcock, Infant Feeding Co-ordinator, The Rotherham Foundation Trust
- Vicky Wilkinson, Infant Feeding Co-ordinator, NHS Rotherham
- Maggie Whitfield, Breastfeeding Lead, Children's Centres, Rotherham MBC (retired early 2010)
- Wendy Hutchinson, Breastfeeding Peer Support Co-ordinator, Rotherham Children's Centres
- Joanna Jones, Women's Network Coordinator, GROW80 and members of the two women's groups at GROW
- Gail Hallsworth, NCT Breastfeeding Counsellor and Breastfeeding Peer Support Co-ordinator, Rotherham Central Children's Centre and the members of Peer Supporters group.

10. INFORMATION SOURCES/REFERENCES

- Commissioning a peer-support programme for women who breastfeed – National Institute for Health and Clinical Excellence, September 2008
- Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households - National Institute for Health and Clinical Excellence, March 2008
- Early life nutrition and lifelong health, BMA Board of Science, February 2009
- UNICEF UK Baby Friendly Initiative: Coordinated introduction of best practice for breastfeeding across a local authority area, UNICEF, 2005
- 'So she wants to Breastfeed' DVD - Mark-It TV
- 'From Bump to Baby' DVD, Best Beginnings

[80] Giving Real Opportunities to Women

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APPENDIX 1

Ten Steps to Successful Breastfeeding

1. Have a written breastfeeding policy that is routinely communicated to all healthcare staff.
2. Train all healthcare staff in the skills necessary to implement the breastfeeding policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding soon after birth.
5. Show mothers how to breastfeed and how to maintain lactation even if they are separated from their babies.
6. Give newborn infants no food or drink other than breast milk, unless medically indicated.
7. Practice rooming-in, allowing mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or dummies to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Source: Unique Baby Friendly Initiative

APPENDIX 2

The Seven Point Plan for Sustaining Breastfeeding in the Community

1. Have a written breastfeeding policy that is routinely communicated to all health-care staff.
2. Train all staff involved in the care of mothers and babies in the skills necessary to implement the policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Support mothers to initiate and maintain breastfeeding.
5. Encourage exclusive and continued breastfeeding, with appropriately-timed introduction of complementary foods.
6. Provide a welcoming atmosphere for breastfeeding families.
7. Promote co-operation between healthcare staff, breastfeeding support groups and the local community.

Source: Unique Baby Friendly Initiative

APPENDIX 3

Children's Centre Breastfeeding Policy Appendix Jan 2010 (To be read in conjunction with the Rotherham Breastfeeding Policy)

Principles

Rotherham Borough Council recognises breastfeeding as the optimum means of infant feeding and recognises it as our duty and responsibility to support breastfeeding through positive policies, staff training and service provision.

This policy is based on the relevant sections of the Rotherham Breastfeeding Policy adopted by The Rotherham NHS Foundation Trust, NHS Rotherham, Rotherham Community Health Services and Rotherham Borough Council.

The policy is based on the UNICEF UK Baby Friendly Initiative Best Practice Standards[1], in accordance with NICE Guidance [2.]

- The Seven Point Plan for the Protection, Promotion and Support of Breastfeeding in Community Health Care Settings, which include Children's Centres

Department of Health Infant Feeding Recommendations 2004 [3], in line with those of the World Health Organisation, are that:

- Breast milk is the best form of nutrition for infants
- Exclusive breastfeeding is recommended for the first six months (26 weeks) of an infant's life
- Six months is the recommended age for the introduction of solid foods for infants
- Breastfeeding (and/or breast milk substitutes if used) should continue beyond the first six months, along with appropriate types and amounts of solid foods

Aims of the Policy

- To ensure that all parents are supported to make an informed decision about breastfeeding based upon accurate, consistent, independent and evidence based information

- To ensure that breastfeeding mothers are supported to initiate and maintain lactation

- To enable all breastfeeding infants to breastfeed successfully in order to achieve adequate nutrition and optimum growth

These are best achieved by multi-agency support and the development of a breastfeeding culture. Good communication between health professionals and other agencies will ensure effective transfer of care from maternity to community services. All personnel have a responsibility to provide support and consistent information, to create a positive environment where more women choose to breastfeed their babies for as long as they wish to.

Benefits

Breastfeeding has a major role to play in promoting health and preventing disease in the short- and long-term for both infant and mother [4]. The longer the period of exclusive breastfeeding, the greater the health benefits to mother and baby. Breastfeeding contributes to several current public health policy strategies and goals:

- Addressing inequalities in health
- Breaking the cycle of deprivation
- Reducing infant mortality
- Reducing preventable infections and unnecessary paediatric admissions
- Halting the rise of obesity in under 11's
- Increasing breastfeeding initiation and duration rates, focussing on women from disadvantaged groups

Communicating the Breastfeeding Policy

- The policy will be communicated to all Children's Centre staff who have contact with pregnant women and new mothers.

- New staff will be orientated to the policy as part of their induction process, within 7 days of starting.

- The Rotherham Breastfeeding Policy and Children Centres Appendix will be available for staff and parents to read.

- The Parents Guide to the Rotherham Breastfeeding Policy will be displayed prominently within all Children's Centres, including any rooms used by pregnant women and new mums.

Staff Training

- All Children's Centre staff who have contact with pregnant women and new mothers and babies will receive breastfeeding awareness training, including information on UNICEF Baby Friendly Initiative Standards.

- New starters are required to receive this training within 6 months of starting employment.

- Managers must ensure that all staff are aware of the breastfeeding policy and of the need to provide a breastfeeding friendly environment and avoid the promotion of infant formula.

Information and Support in Pregnancy

- Educational materials for distribution to parents or display within the centre will be approved by the Children's Centre Breastfeeding Lead/ Community Infant Feeding Team.

- Where mothers need further information or support they will be directed to their midwife, health visitor or a breastfeeding peer supporter.

- Children's Centre promotional leaflets and educational resources will promote breastfeeding as the normal way for babies to be fed.

- It is important to address the needs of all parents regardless of their social, religious and cultural background. Information will be available in relevant languages or a medium accessible to the individual.

- Mother-to-mother support groups and breast-feeding peer supporters play an important role in antenatal information and support.

- Staff will inform mothers about/ refer mothers to targeted community interventions to promote breastfeeding as appropriate.

Supporting Exclusive Breastfeeding

- For the first 6 months, mothers should be encouraged to exclusively breastfeed their babies. Babies should not be given, or recommended to have, water or artificial feeds.

- Mothers of babies receiving supplements should be offered support from a health care professional trained in breastfeeding management or referred appropriately.

- Weaning information should include the recommendation not to introduce solids before 6 months of age

- Mothers will be encouraged to continue breastfeeding beyond 6 months for at least the first year of life

- Information on the appropriate introduction of solid foods will comply with The Rotherham Infant Feeding Guidelines[4].

Maintaining Lactation

- Early initiation has long term benefits for milk production

- Early cessation of breastfeeding may also have adverse consequences for the mother's health

- Management of breastfeeding problems should be in line with TRIFIC Guidelines, NICE Guidance and should include liaison with appropriate colleagues or medical referral when necessary.

- At home, mothers should be encouraged to continue to keep their babies near them, to help recognise their babies' needs and feeding cues

- All mothers will be told and given written information on the benefits, contraindications and potential risks associated with bed sharing, to enable mums to manage night time feeds safely. All information will be in line with current advice from the Foundation for the Study of Infant Death and the Department of Health.

- All breastfeeding mothers returning to work must be given information, in appropriate formats, that will support them to continue breastfeeding.

Baby Led Feeding

- Mothers will be supported to demand feed (baby led feeding) their baby and to feed for as long as the baby wishes to feed.

Use of Artificial Teats, Dummies, Nipple Shields

- Health care staff should not recommend the use of artificial teats or dummies during the establishment of breastfeeding. The appropriate use of dummies for breastfeeding babies later in the postnatal period should also be discussed with parents. Parents who wish to use them should make an informed choice.

- Cup feeding, in preference to bottle, is currently the recommended method for any supplements given to a breastfed baby

- Children's Centre staff will not recommend the use of nipple shields.

Community Support for Breastfeeding

- The Children's Centre Network supports co-operation between health professionals and voluntary support groups whilst recognising that health care facilities have their own responsibility to promote breastfeeding.

- Information on national and local breastfeeding support will be available within Children's Centres.

- Staff will inform mothers of the local breast pump loan scheme and provide details about accessing the service.

- Co-operation between health professionals and voluntary support groups will be encouraged, including involvement in policy development.

- Children's Centres will support the development of the Rotherham Breastfeeding Peer Support Network.

The Promotion of Breast Milk Substitutes

- There will be no advertising of breast milk substitutes, feeding bottles, teats or dummies in Children's Centres. This includes the use of text or logos and prohibits the provision of free samples.

- No promotion of study sessions or educational materials by formula manufacturers is permissible by employees or in facilities covered by this policy

- Staff must not display infant formula logos or such items as calendars, pens, stationery or diaries etc.

- All facilities covered by this policy will be audited annually in line with Baby Friendly Initiative requirements, to ensure compliance with the above points.

- Company representatives will only have direct access to the Obstetrics and Gynaecology Infant Feeding Group, paediatric dieticians, Infant feeding coordinators and other Infant feeding leads. Information or important changes in the constituents of artificial milk will be disseminated, by the above members of staff

- Breast milk substitutes will not be sold on Children's Centre premises.

Facilities for Breastfeeding Mothers

- Breastfeeding will be regarded as the normal way to feed babies and young children and mothers will be supported to breastfeed in all public areas of Children's Centres.

- Comfortable facilities must be available for mothers who prefer privacy to feed or express breast milk. Toilets should not be offered as a place to breastfeed due to issues of hygiene and discomfort.

- Breastfeeding Welcome signs will be displayed in prominent places within all Children's Centres.

- Members of the public who object to a mother breastfeeding will be informed of the policy and advised to move to a different area where they will no longer be in view.

- As employers, Children's Centres will support women to maintain breastfeeding when they return to work.

Monitoring of Policy Compliance

- The policy will be audited annually using UNICEF UK Baby Friendly Audit Tool. Non compliance will be addressed through staff training and via line managers.

- Children's Centres will provide accurate data to NHS Rotherham on breastfeeding promotion activities and service provision across the borough using the E- start system.

References

1. *UNICEF UK Baby Friendly Initiative Audit Tool to monitor breastfeeding support in the maternity services – Appendix 1 Writing and evaluating the breastfeeding policy www.babyfriendly.org.uk*

2. *NICE Clinical Guidance 037 Routine Postnatal Care for Women and their Babies July 2006. National Institute for Health and Clinical Excellence*

3. *Infant Feeding Recommendations. Department of Health 264898 1p 70k Nov 2004*

The Rotherham Infant Feeding Guidelines 2007. The Rotherham Infant Feeding Initiatives Coordinating Group (TRIFIC Group)

APPENDIX 4

NHS Rotherham

Annual Health Check – Risk Assessment Q3 2009/10

Risk Area:	**Breast Feeding 6-8 week prevalence**	**Date:**	**February 2009**
Programme Lead:	**Sarah Whittle**	**Lead Officer:**	**Anna Jones**

Target:

	Q1 (June 2009)	Q2 (September 2009)	Q3 (January 2010)	09/10	10/11	Yorkshire & Humber Average
Breast-feeding initiation	59%	58%	58.6%	60	62	N/A

	Q1 (June 2009)	Q2 September 2009)	Q3 (January 2010)	09/10	10/11	Yorkshire & Humber Average
Data Completeness / Coverage	89%	75%	77%	90%	95%	78.6% (latest June 2009)

	Q1 (June 2009)	Actual (Q2 Apr-Jul 2009)	Q3 (January 2009)	09/10	10/11	Yorkshire & Humber Average
Breastfeeding at 6-8 weeks	28%	23%	24%	28%	30%	36.54% (latest June 2009)

Source: NHS Rotherham, February 2010

APPENDIX 5

Rotherham Council Buildings: Facilities and Arrangements for Breastfeeding
Source: RMBC Asset Management, February 2010

Main Administrative Buildings

- Town Hall, Moorgate Street - Currently being refurbished – no specific facilities are planned in but general meeting rooms may be available on request and subject to availability.
- Civic Building - no specific room and nothing planned
- Norfolk House - quiet room/first aid room that can be used by staff only
- Crinoline House – no current facilities and none planned as the building is being closed in April 2010
- Bailey House - quiet room/prayer room on 2nd and 3rd floors can be used by staff only
- The Eric Manns Building - general meetings rooms but nothing dedicated for feeding – to be used by staff only
- Doncaster gate offices- none dedicated but quiet rooms/meeting rooms for staff only
- Reresby House - none but meeting rooms may be used by staff only

Leisure Centres and Sports Facilities

- Maltby Leisure Centre (part of Joint Service Centre) – the consulting room is available for breastfeeding
- Millside Centre – no current or planned facilities
- Rotherham Leisure Complex, St Ann's Road - baby changing facilities only, which could be used for breastfeeding
- Grange Park Golf Course – (Call 559497)(note: this facility is not managed by the Council)
- Aston Leisure Centre - no dedicated room but have baby changing facilities that can be used for that purpose
- Herringthorpe Athletics Stadium-meeting room but none specific subject to aviliability
- Wath Leisure Centre - no dedicated room but have baby changing facilities that can be used for that purpose
- Thrybergh Country Park - none but meeting rooms may be used, subject to availability
- Ulley Country Park - none but meeting rooms may be used, subject to availability
- Rother Valley Country Park – café may be used for breastfeeding, plus upstairs rooms at watersports centre, if available and on request (Note: this facility is not managed by the Council)

Libraries and Cultural Facilities

- Central Library and Arts Centre - no current or planned facilities
- Civic Theatre - no current or planned facilities
- Aston Community Library- no current or planned facilities as the building is due to close April 2010
- Mowbray Gardens Library - none but meeting room may be used, subject to availability

- Swinton District Library-None but large upstairs meeting room/quiet area may be used, subject to availability
- Wath Library - none but large upstairs meeting room /quiet area may be used, subject to availability
- Thorpe Hesley Library - none but quiet space/meeting room in parish hall may be used, subject to availability
- Kimberworth Park Library - none
- Kimberworth library - none
- Greasbrough library - none
- Maltby Library - none
- Dinnington library – none
- Clifton Park Museum - no dedicated room, but baby changing facilities can be used

Customer Service Centres

- Dinnington Customer Service Centre - no rooms for public use
- Maltby Joint Service Centre - no dedicated room, although there are general meeting rooms that could be used. Facilities may be available in PCT part of building (check?)
- Swinton Customer Service Centre – none/staff only
- Wath Office - none/staff only
- Aston Customer Serviced Centre is due to open April 2010 - no dedicated facilities but meeting room may be used by staff only

Children's Centres

(Note: it is understood that all Children's Centres positively encourage breastfeeding, but the exact details of the facilities and arrangements are not known for all centres)

- Aughton Early Years Centre – dedicated feeding room
- Cortonwood Children's Centre
- Kimberworth Children's Centre
- Rawmarsh Children's Centre - no dedicated room but room available on request
- Rotherham Central Children's Centre
- Stepping Stones Children's Centre - no dedicated room but room available on request
- The Brookfield Centre
- The Sue Walker Children's Centre
- Thorpe Hesley Children's Centre
- Valley Children's Centre
- Coleridge Children's Centre
- Dinnington Children's Centre
- Park View Children's Centre
- Rockingham Children's Centre - no dedicated room but room available on request
- Silver Birch Children's Centre
- The Arnold Centre - a family room is available for feeding if needed
- The Meadows Children's Centre
- The Willow Tree Children's Centre
- Thrybergh Rainbow Centre

- Wath Victoria Children's Centre - dedicated room for breastfeeding

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**ADULT SERVICES AND HEALTH SCRUTINY PANEL**
2.	**Date:**	**1 April 2010**
3.	**Title:**	**Rotherham Community Health Centre**
4.	**Programme Area:**	**Chief Executive's**

5. Summary

This report gives details of a visit to Rotherham Community Health Centre, on March 11 2010, by members of the Adult Services and Health Scrutiny Panel (ASH).

6. Recommendations

That the ASH panel notes this report.

7. Proposals and Details

On March 11 2010, Chair Cllr Jack, co-optee Russell Wells (National Autistic Society) and Scrutiny Officer Ben Knight, were shown around Rotherham Community Health Centre by NHS Commissioning and Change Manager, Duncan Smales and Ben Chico (PCT).

The £12m Rotherham Community Health Centre (RCHC), Greasbrough Road, was developed by NHS Rotherham in order to provide patients with rapid access to a wide range of health services and is part of the delivery of the Better Health, Better Lives strategy.

It also means that some patients can receive care closer to home and avoid the need to go to hospital for some types of treatment. The services are open to all and can be accessed either by referral from a GP or other healthcare practitioner, or by self-referral.

Construction began on the Community Health Centre (hereafter referred to as 'the centre') in September 2007 and it opened to the public in January 2009.

7.1 GP Surgery and Walk-In Service

Located within the centre is Chantry Bridge Medical Practice. The practice, operated by Care UK, is open on week days from 9am-5pm, and offers a range of comprehensive services to registered patients.

Care UK now operates 10 GP surgeries and Walk-in centres across the UK as well as a range of other services, from hospices to assistance for young smokers. Care UK also manage the Diagnostic facility at the centre and provide out-of-hours care (formerly provided by primary care), all other services are provided by Rotherham Community Health Services.

The ASH panel members saw that the facility was extremely well used. The GP surgery already has more than 200 patients registered, many of whom are newly arrived in Rotherham.

A major feature of the new centre is a Walk-in service for treating minor illnesses and injuries. Anyone can walk in without an appointment to see a GP or other healthcare practitioner, whether they are registered at the practice or not, between 8am and 9pm, seven days a week and bank holidays.

The Walk-in facilities are aimed at helping people with busy lifestyles who need access to flexible and convenient health services. It is designed not to replace local GP or hospital services, but complement them by providing a range of treatments to members of the public when their GP practice is closed.

The Walk-in centre is currently used by between 600 and 700 people a week and has a capacity to see up to 1,000. On Saturdays and Sundays the centre regularly receives 150 to 200 patients a day. The centre has a target that all patients will be assessed (triaged) in ten minutes, and will be seen by a doctor within two hours. The number of patients and time-pressures, however, increase when Sheffield Walk-In services shut on Thursday Afternoons.

Staff can work flexibly across the GP and Walk-in services as need demands, and there has been even greater integration of the services from 28th March 2010.

Treatment is available for problems including: eye and nose problems, cuts, wounds, bites, skin complaints and minor burns, as well as providing Emergency contraception and assistance for Women's health problems. A pharmacy (MedicX) is open on site (open until 10pm every day of the year). There is also a call centre for out-of-hours care in the building.

7.2 Diagnostic Centre

The Diagnostic Centre, also operated by Care UK, is part of a government initiative to provide additional, purpose built environments to efficiently and effectively meet the challenge of increasing access to healthcare in the UK.

The Diagnostic Centre is open Monday to Saturday from 8am to 8pm, including all bank holidays and offers a range of diagnostic imaging procedures, X-ray, Ultrasound, Echocardiograms and MRI.

These Diagnostic procedures were previously performed at hospitals. By bringing this facility into the centre GPs can check their suspicions as to the cause of patients' symptoms at the beginning of the process, providing an earlier diagnosis, and putting them in the correct line for appropriate treatment.

The centre does not currently have a plaster room so when minor breaks and fractures are diagnosed the patient has to go to hospital to have the injury put in a cast. The panel members recommended that a plaster room is commissioned for the centre, and this is to be considered.

7.3 **Other Services**

The centre also provides most of the primary care services that were based at Doncaster Gate Hospital:

- Ear Care Centre (including audiology workshops to test and fit hearing aids),
- Speech and Language therapy (including a sound viewing gallery with a two-way mirror for discrete observation of young children with speech problems),

- Community Physiotheraphy,
- Sexual Health,
- Family Planning,
- Phlebotomy (Bloods),
- Podiatory,
- Specialist surgery suite (for use by GPs with Special Interests (GPSI) to perform treatments such as vasectomies).

The Patient Advice and Liaison Services (PALS) Health Advice Centre (previously in the RAIN building) and Community Dental (previously the Ferham clinic at Doncaster Gate) have also moved to the new site. The dental practice has expanded from two to five treatment rooms and is for people who find it difficult to access conventional services, such as children (and some adults) with disabilities, high anxiety, or learning difficulties.

7.4 The Building

The health centre is close to Rotherham Interchange and directly behind Bailey House. Ease of access for members of the public was of primary concern when commissioning the building and there is free car parking for patients on site. Centre staff do not have access to parking spaces to prevent the reoccurrence of problems experienced at Doncaster Gate, where, by 8:30am, staff had sometimes taken all the available parking spaces.

The two storeys of the centre dedicated to treatment are split into four quarters (each for a different specialism) around an open and airy central area designed to maximize natural light into the building. Panel members found that the layout and sign posting was clear and care had been taken to make the centre seem bright and comfortable, with the use of friendly colour schemes and well-designed equipment.

The members heard that practitioners were delighted to be working in the new building and - when compared to the design of Doncaster Gate - the layout had created better team work between the disciplines. Rotherham NHS is also keen to create better communication with the local community by conducting guided tours to groups, such as a recent student party from Wickersley Comprehensive.

8. Finance

There are no cost implications in this report.

9. Risks and Uncertainties

There is potential that the Walk-in service could be misused, by patients or by local practices sending patients there, and the centre could end up doing the work of other services. The GP practices, to which Walk-in patients are registered, however, are currently recorded for internal monitoring.

There are building control concerns regarding the erosion of the river bank directly behind the centre. Commissioning and Change Manager, Duncan Smales, reassured the members that the building was safe, however, he was concerned that the partial banking collapse came so close to the centre. This could possibly result in serious access problems. Discussions were underway between parties, including the leaseholder, developer, builder and British Waterways, to deal with the situation.

The use of the health centre will need to be monitored to ensure that the various rooms are being fully utilised and used for the purposes for which they were initially commissioned.

10. Policy and Performance Agenda Implications

Better Health, Better Lives

11. Background Papers and Consultation

Not applicable

Contact: *Ben Knight, Scrutiny Officer, direct line: (01709) 254452.*
ben.knight@rotherham.gov.uk

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**ADULT SERVICES AND HEALTH SCRUTINY PANEL**
2.	**Date:**	**1st April, 2010**
3.	**Title:**	**Yorkshire Ambulance Service Quality Account 2009-10**
4.	**Programme Area:**	**Chief Executive's**

5. Summary

Scrutiny Panels have been given the opportunity to comment on local health trusts' quality accounts. This report explains the background to quality accounts and explains how scrutiny can contribute to the process.

6. Recommendations

That Members

a. Consider whether they wish to submit comments on Yorkshire Ambulance Service's 2009-10 Quality Account and, if so

b. Agree what points should be made in the Panel's submission.

7. Proposals and Details

7.1 From this year all NHS trusts are required to publish Quality Accounts which provide information for service users and the public on the quality of the services they deliver. Overview and Scrutiny Committees are part of the assurance process and Yorkshire Ambulance Service is required to share a draft version of its 2009-10 Quality Account with all scrutiny committees within Yorkshire.

7.2 Scrutiny committees then have the opportunity to review and supply a statement, for inclusion in a provider's Quality Account. Any statement should indicate whether the Panel believes, based on the knowledge it has of the provider, that the report is a fair reflection of the healthcare services provided.

7.3 The draft 2009-10 Account is appended to this report and aims to:

- demonstrate YAS's commitment to improving the quality of care for the people it serves;
- let people know where and how it has improved its services;
- share its plans to improve its services in the coming year.

7.4 The attached document is a working draft and therefore some data is currently reported only up to February 2010. The full-year picture will be completed by adding March data to the final draft. The final document will be professionally presented and will form part of the Trust Annual Report.

7.5 YAS has suggested that the Panel may wish to consider the following issues, in its response:

- Is the Quality Account a fair picture of YAS's services?

- Does the Quality Account cover all the services the Trust provides?

- Does the Quality Account cover the most important quality issues for the Trust and its patients?

7.6 In line with the DH guidelines, the Panel is asked to provide its response within 30 working days and therefore any response is required by 30 April 2010.

7.7 The Scrutiny Panel has only scrutinised one aspect of YAS's services in the current municipal year. It invited Martyn Pritchard, the trust's Chief Executive and Andy Buck, Chief Executive of NHS Rotherham (which commissions ambulance services) to answer questions on 'Emergency ('999') Services – Performance in Rotherham' on 9 July 2009. The minutes of that meeting are given at Appendix 1. This could provide the basis of the Panel's comments.

8. Finance

There are no financial implications to this report.

9. Risks and Uncertainties

Timescales for completion of quality accounts are very short in this first year as the requirements for the content of Accounts were not published until February. Should the Panel decide that it does not want to comment on the Quality Accounts this year, there will be more opportunities in the year ahead to engage with YAS. However, if the Panel wishes to submit comments, they must be confined to areas where evidence can be provided.

10. Policy and Performance Agenda Implications

Under the Health and Social Care Act

11. Background Papers and Consultation

Yorkshire Ambulance Service Quality Account 2009-10: DRAFT for LINk, OSC and Commissioner Review, March 2010

The Panel's Chair and Vice Chair received a briefing from Yorkshire Ambulance Trust on its Quality Account at a regional health scrutiny event on 17 March 2010.

Contact: *Delia Watts, Scrutiny Adviser, direct line: (01709) 822778*
e-mail: delia.watts@rotherham.gov.uk

Appendix 1

Extract from Adult Services and Health Scrutiny Panel Minutes – 9/07/10

18. Emergency ('999') Services - Performance in Rotherham

Additional documents:

- Briefing - 999 service

Minutes:

Martyn Pritchard, Chief Executive, Yorkshire Ambulance Service and Andy Buck, Chief Executive, NHS Rotherham gave a presentation on the Emergency 999 Services performance in Rotherham.

The presentation drew specific attention to:-

Yorkshire Ambulance Service (YAS), a regional service - in Facts and Figures

- Where the YAS fit with the rest of the NHS
- Working across the region's Partnerships
- Key Measures
- Progress made in 2008
- Clinical Performance Indicators (CPIs)
- Response Times for YAS
- Resources and Investment
- Response times for Rotherham
- Paramedic Practitioner Scheme
- Next Steps
    -
    - What we are doing now
    - How we can work together

A question and answer session ensued and the following issues were discussed:-

- How many hoax calls were made to the Ambulance Service. It was confirmed that there were very few hoax calls, but there were calls which were not true emergencies and could better be dealt with by another service.
- Was the 8 minute response time target, an average time? Confirmation was given that the minimum 8 minute response time had to be met 75% of the time in order to meet the target.
- Did the response refer to a medical person responding within 8 minutes or was it simply that a vehicle arrived within this time? It was confirmed that this would include response by a Community First Responder or a paramedic.
- A query was raised as to whether the Category A 8 minute target which had been achieved by Rotherham was sustainable. Confirmation was given that with more staff, better communication technology and more staff "off station on standby" it was achievable to sustain this target.
- What caused YAS to have registration conditions imposed on it, with respect to managing infection, and had the problem now been resolved? There were two major issues which caused this, one of which was that the trust was implementing infection control practices, but was not recording them adequately. The other was uncertainty about whether voluntary car drivers and St Johns Ambulance were part of the scheme. However the former had since been addressed and guidance had now been issued which clarified that these vehicles were excluded, so the Trust had now been able to declare itself fully compliant and had had its registration conditions lifted.

- Does the commissioning process meet the requirements of 'World Class Commissioning'? 2-3 years ago it was not fit for purpose but work has been undertaken with the 12 PCTs resulting in significant improvements, so that it was now working towards meeting the 'world class' criteria.
- Does NHS Rotherham get value for money for its 999 services? It was believed that the investment made by the 12 PCTs was justified and they were confident that value for money would be obtained once the contract was meeting all its clinical indicators and response targets.
- Why were YAS consistently underachieving on the Cat B, 19 minute target, both across the YAS area and in Rotherham? Cat A calls had always taken priority which had impacted on the target for Cat B. Steps were now being taken to address this issue eg trialling a paramedic practitioner scheme in Rotherham. However, as there was no medical reason for having a 19 minute target, the Government was planning to replace this indicator with a new one from April 2010.
- Would patients be taken to the best hospital for their condition, in an emergency, or would they be taken to the nearest hospital to them at the time? If there was time a patient would always be taken to the hospital that specialised with their condition. However if the situation was that the condition was life threatening then they would be taken to the nearest hospital to be stablised.

Members thanked Martyn and Andy for their presentation.

Resolved:- That the performance against the Patient Transport contract for Rotherham be considered at a future meeting.

Yorkshire Ambulance Service NHS
NHS Trust

Yorkshire Ambulance Service Quality Account 2009-10

DRAFT for LINk, OSC and Commissioner Review

March 2010

Contents

Introduction

For everyone at Yorkshire Ambulance Service (YAS), providing high quality patient care is central to everything we do. Our A&E service saves people's lives and our PTS service is a vital part of a patient's experience of their NHS care. It is crucial that we closely monitor the quality our services so we can see how well they are working and how we can maintain and improve them for the future.

Our Trust Board has overall responsibility for the quality of our services and has made 'Quality' one of our eight strategic aims.

To achieve this, we have invested significantly in improving our services.

A good illustration of the progress we have made over the last three years is the change from 2007-08 when we did not meet 14 of the 42 NHS core standards, to full compliance with all standards from April 2010.

This has been a Trust-wide achievement thanks to the leadership of the Trust Board in setting priorities and the commitment and hard work from operational and support teams.

We know that the quality of care we provide to our patients is attributable to the quality of our staff. That is why we have focused particular attention on training, development and communication.

During January 2009, YAS was required to register with the Care Quality Commission (CQC) for its arrangements relating to the prevention of Healthcare Associated Infection (HCAI). In July, the CQC carried out a comprehensive and unannounced inspection of our work to prevent HCAI and reported that not only that we had complied with all the requirements of the Hygiene Code, but that we were the only ambulance service in England not to have been given recommendations for improvement.

As part of the overall quality rating in 2008-09, the CQC also assessed our achievement of the nationally-agreed Clinical Performance Indicators (CPIs) relating to the quality of care for patients with ST-elevation myocardial infarction, cardiac arrest, stroke, hypoglycaemia and asthma. We were rated as excellent in this clinical assessment, ranking second out of the eleven ambulance services in England.

This year we recruited a director of standards and compliance who is our Trust lead for quality. Steve Page is a registered nurse with senior-level experience and works closely with Medical Director Dr Alison Walker and her clinical team.

A key priority for early 2010-11 will be to make sure we learn from the recent events at other NHS trusts. The Board will be carefully reviewing and acting upon the recently-published recommendations and best practice following Robert Francis QC's report on the outcome of his inquiry into Mid-

Staffordshire Hospitals NHS Foundation Trust and the independent inquiry commissioned by Yorkshire and the Humber Strategic Health Authority into the actions of Colin Norris. We have already reviewed our internal systems for governance and assurance and will be building on these foundations in the year ahead.

We are also working to embed good clinical governance on the front line. The Medical Director's team has worked with staff to establish a Clinical Code of Practice, a ten-point code which captures the responsibilities of all YAS clinicians.

To bring together the different elements of quality we have developed a Quality Strategy for the first time. This sets out how we will achieve our aspirations for quality and how we will involve and engage our staff, commissioners and stakeholders to establish a culture of patient-focus, high standards, collaboration and improvement.

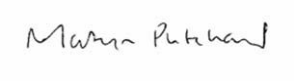
Statement of Accountability

The Trust Board is accountable for quality. It oversees the development and delivery of the Trust's Quality Strategy and ensures it is working for the benefit of our patients.

As Accountable Officer and Chief Executive of this Board, I have responsibility for maintaining the standard of the Trust's services and creating an environment of continuous improvement.

This report is the first Quality Account by the Yorkshire Ambulance Service, in line with the requirements of the Health Act 2009. The Quality Account contains details mandated by the Act and also the measures that we, in conjunction with our NHS and public partners, have decided best demonstrate our work to drive up standards.

As Accountable Officer it is also my responsibility to ensure that the data included in this Quality Account is accurate. I can provide this assurance based on our internal data quality systems and the opinion of our internal and external auditors who have both considered this Account.



Martyn Pritchard
[Date]

Priorities for Improvement

Following discussions with staff, commissioners and stakeholders, the Board has agreed six priorities for 2010-11 as part of our Quality Strategy. The majority of these priorities are also identified within our contracts under the Commissioning for Quality and Innovation (CQUIN) system.

Priority 1 – Safeguarding Children and Vulnerable Adults

Priority 2 – Patient Assessment and Record Keeping

Priority 3 – Maintaining and Improving the Standard of our Clinical Care

Priority 4 – Patient Pathways

Priority 5 – Patient Experience

Priority 6 – Improving the Experience of Patients at the End of their Lives

Monitoring our Achievement

The Board will receive regular reports (at least three per year) at its public meetings on the achievement against these targets. Reporting to the Board, the Integrated Governance Committee focuses in more detail on key areas of quality and, in turn, receives assurance from the Clinical Governance Committee.

Details of Priorities for Improvement

PATIENT SAFETY

Priority 1 – Safeguarding Children and Vulnerable Adults

Safeguarding is a high priority for all health and social care providers. We know that our accident and emergency and patient transport services can play an important role in safeguarding, especially by working together with partner organisations.

Aims:

1. To increase the number of referrals made to specialist services for safeguarding children and vulnerable adults.
2. To ensure the Trust works closely with other agencies to respond effectively to all Serious Case Reviews.
3. To ensure all Independent Management Reports (IMRs) required as part of Serious Case Reviews are completed on time, to the necessary standard and all relevant recommendations are implemented.

Current initiatives 2009-10:

- We have provided access to safeguarding training to all our staff.
- We have increased our dedicated safeguarding leads from one to four, and we have recruited a head of safeguarding.
- We have reviewed all our policies and procedures in light of recent Care Quality Commission recommendations.

New initiatives 2010-11:

- In line with legislation and national guidance we will be providing training for all staff and ensuring those in key safeguarding roles have completed multi-agency training.
- We will ask our staff about their confidence in using referral processes via a survey process.
- We will be looking at the way we handle complaints and incident reports to make sure that we identify all issues relating to the welfare of children and vulnerable adults and report these to our safeguarding leads.

Priority 2 – Patient Assessment and Records Keeping

Taking accurate and complete clinical observations is essential in order for A&E staff to make the right decisions about a patient's treatment and care. Records are an important part of patient safety as ambulance staff hand over care to other providers.

Aims:

1. For every emergency patient's Patient Report Form (PRF) to be fully completed.
2. For no investigation following a Serious Untoward Incident to identify inadequate clinical assessment as a root cause.

Current initiatives 2009-10:

- We have standardised the procedures for clinical record-keeping across the Trust.
- We have introduced a new easy to use PRF which was developed with involvement from clinical staff.
- All PRFs are now scanned and stored electronically which makes it easier to undertake quality audits.

New initiatives 2010-11:

- We will audit completion rates for PRFs every month.
- We will review the quality of clinical information recorded on PRFs on a monthly basis and share the results with staff.
- Learning about clinical audit will be made part of our clinical education programme.

CLINICAL EFFECTIVENESS

Priority 3 – Maintaining and Improving the Standard of our Clinical Care

There are five nationally-agreed Clinical Performance Indicators (CPIs) which relate to conditions where the care of ambulance staff can make a significant difference to patient outcomes. For each indicator there are a number of agreed actions that should be completed for every patient with that condition and we audit our PRFs to identify whether these were carried out. Our performance is reported as the percentage of cases for which our ambulance clinicians carried out theses actions compared to the total number of cases. Our scores are also compared with those of other English ambulance services and a measure calculated for how close we are to the national average score.

Aims:

1. To maintain the current level of achievement of greater than 90% for:
    a. recording of clinical observations for patients with stroke and greater than 95% for:
    b. management of patients with hypoglycaemia
    c. management of patients suffering ST-elevation myocardial infarction (STEMI) heart attacks.
2. To achieve performance that is no worse that 1.8 standard deviations below the average score for all English ambulance services for:
    a. response to patients with cardiac arrest
    b. treatment of patients with asthma.
3. To make improvement against the indicators for patients suffering STEMI heart attacks:
    a. recording of two pain scores
    b. administration of analgesia
    c. recording of peak flow readings for patients with asthma.

Current initiatives 2009-10:

- We have established a clinical leadership programme.
- Medical Director Dr Alison Walker sent a letter to every member of clinical staff providing information about CPIs and a reminder about their responsibilities.

- The clinical team provides regular updates via the weekly *Operational Update* and the new *Clinical Catch-up* bulletins.

New initiatives 2010-11:

- Local clinical and operations managers will be working together to review CPI scores in their areas and develop actions plans for maintaining and improving standards.

Priority 4 – Patient Pathways

In the past, the single role of our A&E ambulance service was to stabilise a patient's condition sufficiently for rapid transport to a hospital emergency department for further treatment.

This is now changing as the health of the nation is changing. More people are living longer, are suffering from long-term and chronic lifestyle-related conditions such as heart disease and diabetes, or suffer falls. We know that the best care for these patients is not always provided by transporting them to hospital and that they can be better supported by referral to specialist teams.

Aims:

1. To increase the percentage of patients referred to the hypoglycaemia care pathway by 5%.
2. To increase the percentage of patients over the age of 65 referred to the falls care pathways.

Current initiatives 2009-10:

- We have worked with partner NHS organisations to increase the number of pathways available across Yorkshire.
- Our two clinical pathways advisers have run road shows to inform our crews and key colleagues in our partner organisations about the new pathways and give them the opportunity to ask questions.
- Pathways are now in place across the whole of Yorkshire to allow crews to refer patients suffering STEMI heart attacks directly to specialist centres providing the gold-standard primary angioplasty treatment.

New initiatives 2010-11:

- We will be increasing the number of referrals into specialist services across the region for diabetic patients with hypoglycaemia and for patients who have fallen.
- We will be working with our partner NHS organisations to develop additional regional pathways for patients with chronic obstructive pulmonary disease and hip fractures.
- We will be developing our 'hear and refer' capability. This is where clinically-trained staff in our 999 communications centres refer patients directly to an appropriate care pathway following comprehensive and careful assessment of their condition over the telephone.

PATIENT EXPERIENCE

Priority 5 – Measuring Patient Experience

Unlike in hospital trusts, there is not a standard national survey of the experience of ambulance service patients. However, we know that it is vital that the Board has a clear picture of what it feels like to be a patient using our services. In particular, by ensuring we hear what our patients are saying we can reduce the risk of missing the warning signs of poor care.

Aim:
To identify new ways to measure the experience of our patients and start recording our level of achievement.

Current initiatives 2009-10:

- Comments cards are available for users of our Patient Transport Service to tell us about their experiences. 130 people have responded and we have taken account of the feedback – both positive and negative.
- The Board receives reports of numbers of complaints, concerns, comments and compliments at every public meeting and of the actions taken as a result.
- Our Patient Services team leads the way in providing a service that is open and easy to access, fair, responsive and supports learning and development.

Future initiatives 2010-11

- We will be undertaking a new survey of users of our Patient Transport Service and people whose calls have been handled by our Access and Response communications centres.
- We will be asking some patients referred to a diabetes pathway by our clinicians to tell us about their experience of the service.
- We will be working closely with patient and public groups; listening to their feedback and involving them in discussions about how we can develop and improve our service.

Priority 6 – Improving the Experience of Patients at the End of their Lives

Palliative care patients at the end of their lives have different needs to those requiring emergency treatment or attending routine hospital appointments.

Aim:
To increase the number of patients requiring palliative care being referred to a district nursing service, following assessment by our crews.

Current initiatives 2009-10:

- We operate a special palliative care ambulance (funded by Marie Curie Cancer Care) for patients in the Leeds area.

Future initiatives 2010-11:

- We will be working closely with other services to develop a regional ambulance service pathway for palliate care patients to be referred into 24 hour district nursing services as an alternative to hospital admission.

Statements of Assurance from the Board

The Health Act 2009 requires the Trust Board to make a number of Statements of Assurance. These are common to all providers, which makes our account comparable with those of other organisations. They state the number of services the Board has reviewed compared to the total number of services the Trust provides and confirm the Trust has participated in research and national audits.

Review of Services

During 2009-10 Yorkshire Ambulance Service (YAS) NHS Trust provided four NHS Services: an Accident and Emergency service, a Patient Transport Service, a GP Out-of-hours call handling service and a Private and Events service.

YAS has reviewed all the data available to them on the quality of care in all four of these services.

The income generated by the NHS services reviewed in 2009-10 represents 100% of the total income generated from the provision of NHS services by YAS.

Research

During 2009-10 Yorkshire Ambulance Service took part in one Medical Research Council-funded research study which collected data on patients. The DAVROS study is led by the University of Sheffield and seeks to develop outcome measures related to patients brought into hospitals via the 999 system. The study will continue into 2010-11 in the York and Hull areas.

YAS staff are also involved in six studies which we have either helped to develop or are contributing to steering groups:

IMPROVE: Immediate management of patient with ruptured aneurysm: open versus endovascular repair. Patients are recruited in emergency departments if they arrive alive with a diagnosis of ruptured AAA. The YAS Medical Director was involved in the protocol development.

ESCORTT: Emergency Stroke Calls: Obtaining Rapid Telephone Triage. YAS involvement limited to consultancy role.

HITS-NS: Head Injury Transportation Straight to Neurosurgery. The YAS Medical Director was involved in the protocol development.

Electronic Patient Report Form (ePRF) evaluation: This study is at the development stage, and aims to assess the role and impact of the ePRF on service delivery with regard to ambulance services, their staff, patients and network of linked emergency and urgent care services. Dr James Gray (Assistant Medical Director until October 2009) and Emergency Care Practitioner Gareth Darnell have been involved in this project which is bidding for funding.

Developing outcome measures for pre-hospital care: The YAS Medical Director has been involved in protocol development for this study which is bidding for funding.

Emergency Ultrasound in the pre-hospital setting: the impact of environment on examination outcomes. Our medical director was a co-applicant, investigator and participant in this study which is now completed.

We have developed research partnerships with:

- the three Comprehensive Local Research Networks (CLRNs) that cover the Yorkshire area which have committed approximately £250,000 to fund projects and posts within our Trust
- higher education institutions including the University of Bradford and the School of Health & Related Research (ScHARR) at Sheffield University
- local Primary Care Research Networks.

From a national perspective we are an active member of the National Ambulance Research Steering Group (NARSG).

We have worked with regional colleagues to improve communication between organisations in relation to patients who have ‘do not attempt cardiopulmonary resuscitation’ orders in place. This work is now being taken forward thanks to a successful bid to the regional Innovation Fund. Approximately £60,000 will be used in 2010-11 to fund a project manager hosted by Bradford and Airedale Teaching PCT.

Looking ahead, we will be developing professional research champions and obtaining support from a research fellow to help us develop research that matches our priorities. We are able to undertake this work due to the CLRN funding.

Part of our research strategy includes the promotion of patient and public involvement. We successfully bid for £500 from the Regional Research Design Service to involve an expert patient in the development of a research proposal in to the use of ultrasound in pre-hospital care. With two local universities, we are currently considering a possible study of patient experiences of their involvement in research.

YAS staff have had three peer reviewed articles published relating to research, audit and innovation activity:

A Walker, J Brenchley, and N Hughes: *Mobile radiography at a music festival* Emergency Medical Journal, Aug 2009; 26: 613.

J T Gray and A Walker: *Is referral to emergency care practitioners by general practitioners in-hours effective?* Emergency Medical Journal, Aug 2009; 26: 611 - 612.

JT Gray and A Walker: *At the sharp end: does ambulance dispatch data from South Yorkshire support the picture of increased weapon-related violence in the UK?* Emergency medicine Journal, October 2009, vol./is. 26/10(741-2), 1472-0205

Participation in Clinical Audit

During 2009-10, two national clinical audits and one national confidential enquiry covered NHS services that YAS provides.

During that period YAS participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that YAS was eligible to participate in during 2009-10 are as follows:

National Clinical Audits:

- Myocardial Ischemia National Audit Project (MINAP) – national database gathering information on all patients who have had a heart attack and who have acute coronary syndromes

- National Infarct Angioplasty Project (NIAP) – audit of patients referred for angioplasty surgical procedure

National Confidential Enquiries:

- Centre for Maternal and Child Enquiries (CMACE) Confidential Enquiry into Head Injury in Children

The national clinical audits and national confidential enquiries that YAS participated in, and for which data collection was completed during 2009-10, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National clinical audit/national confidential enquiry	Number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry
MINAP and NIAP	YAS submits information on specific patients requested by acute trusts rather than submitting a number of cases. There is no system for direct submission of YAS data.
CMACE Head Injury in Children	YAS submits information on specific patients requested by CMACE rather than submitting a number of cases.

The report of two national clinical audits (MINAP and NIAP) were received by the provider in 2009/10. The reports were acknowledge by the provider; however, they are recognised nationally as inaccurate from a pre-hospital perspective as the data is input retrospectively by other organisations.

The reports of two local clinical audits were reviewed by the provider in 2009/10 and YAS intends to take the following actions to improve the quality of healthcare provided:

Local Audit	Agreed actions to improve the quality of healthcare provided
Clinical Performance Indicators measured at local levels within the YAS area	Clinical managers asked to produce action plans specific to each area for every indicator.
Amiodarone usage	Interim audit review identified the need to improve links with acute trusts to receive patient outcome data.
Doncaster patients calling 999 after suffering fits who were not transported to hospital	New referral pathway developed to epilepsy specialist nurses.
Leeds patients who were attended by an emergency ambulance crew after suffering a fall and then referred to intermediate care services	Local intermediate care teams reviewed and developed the use of their assessment tools. YAS agreed that it should continue to support the falls pathway. It was agreed that the two-hour response target was appropriate.
Patients who dialled 999 after suffering a fall, were identified as Category C and referred directly to the South Leeds Intermediate Care team.	YAS is working with partner organisations to rollout the fall pathway should across the Leeds area.

During 2009-10 YAS participated in the following additional national audits:

- Clinical Performance Indicators (CPIs) – STEMI, Cardiac Arrest, Stroke, Hypoglycaemia and Asthma.
- National Audit Office – Progress in improving stroke care.

The reports of these national audits have been reviewed by the provider and YAS has taken or intends to take the following actions:

National Audit	Agreed actions to improve the quality of healthcare provided
Clinical Performance Indicators	Articles in the staff newsletter and individual letters to staff providing information regarding the CPIs, why they are important, the areas that require improvement and how we can improve. Review of patient report forms for clinical quality and completion rates.
National Audit Office – Progress in improving stroke care	*To be added after March CGC meeting*

Goals Agreed with Commissioners

0.5% of YAS's income in 2009-10 was conditional on achieving quality improvement and innovation goals agreed between YAS and any person they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality Innovation (CQUIN) payment framework.

Our 2009-10 CQUIN goals were:

To achieve registration with the Care Quality Commission for management of Healthcare Associated Infections	✓ Achieved
Infection prevention and control is an essential element of patient safety. It includes having effective systems for cleaning vehicles, equipment and premises; staff observing good hand hygiene techniques and clinicians working to best practice guidelines.	

To improve ambulance turnaround times	✓ Achieved
This is the time taken for crews to complete their handover of care to hospital staff, clean and re-stock their vehicle and make themselves available to respond to another call. This is important as it increases the number of patients we can respond to in a timely manner.	

To achieve scores for all nationally-agreed Clinical Performance Indicators that are within two standard deviations of the mean scores of all English ambulance trusts.	✓ Achieved
This shows that patients with five commonly presenting conditions receive a high standard of care from our clinicians and that appropriate records are kept.	

In 2010-11 1.5% of our income is conditional on achieving our CQUIN goals. The majority of these goals are included in the Priorities for Improvement detailed in section 2.

Further details of the agreed goals for 2009-10 and for the following 12-month period are available on request by writing to:

Mr Steve Page
Director of Standards & Compliance
Yorkshire Ambulance Service NHS Trust
Springhill 2
Brindley Way
Wakefield 41 Business Park
Wakefield
WF2 0XQ.

What Others Say About Us
YAS is required to register with the Care Quality Commission (CQC) and its current registration status is TO BE CONFIRMED. YAS has the following conditions on registration: IF APPLICABLE.

YAS has not participated in any special reviews or investigations by the CQC during the reporting period.

Data Quality

Good quality information helps the effective delivery of patient care and is an essential to our work to improve the quality of our care.

"We can only be sure to improve what we can actually measure" – Lord Darzi, *High Quality Care for All*, June 2008.

YAS has made significant effort to develop systems and processes for good data management. This means that both we and our partners can have confidence that the information that we use to measure the quality of our services is reliable and accurate.

Our attainment against the NHS Information Governance Toolkit assessment provides an overall measure of the quality of our data systems, standards and processes.

YAS's score for 2009-10 for Information Quality and Records Management assessed using the Information Governance Toolkit was 50%.

CHECK AGAIN AT 31 March. Score may rise to 10/18 = 55% as requirement 401 (use of NHS Number) is subject to discussion with DH. Score also subject to ratification by IGG.

Our work to improve records management and data quality in 2009-10 included the following:

- We introduced a standard policy and procedure for clinical records management throughout the Trust.
- We put data quality at the heart of our business by adopting a formal information risk management structure. This is led by our Director of Information and Communications Technology who is our *Senior Information Risk Owner*. Managers with responsibility for ensuring the data we hold and manage is safe and used in accordance with best practice have been identified and trained.

The Health Act 2009 requires us to make the following statements:

YAS did not submit records during 2009-10 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

YAS was not subject to the Payment by Results clinical coding audit during 2009-10 by the Audit Commission.

Review of Quality Performance

We have selected the following ten indicators to show the quality of our services in 2009-10.

We monitor our performance against these indicators in addition to our national response time targets:

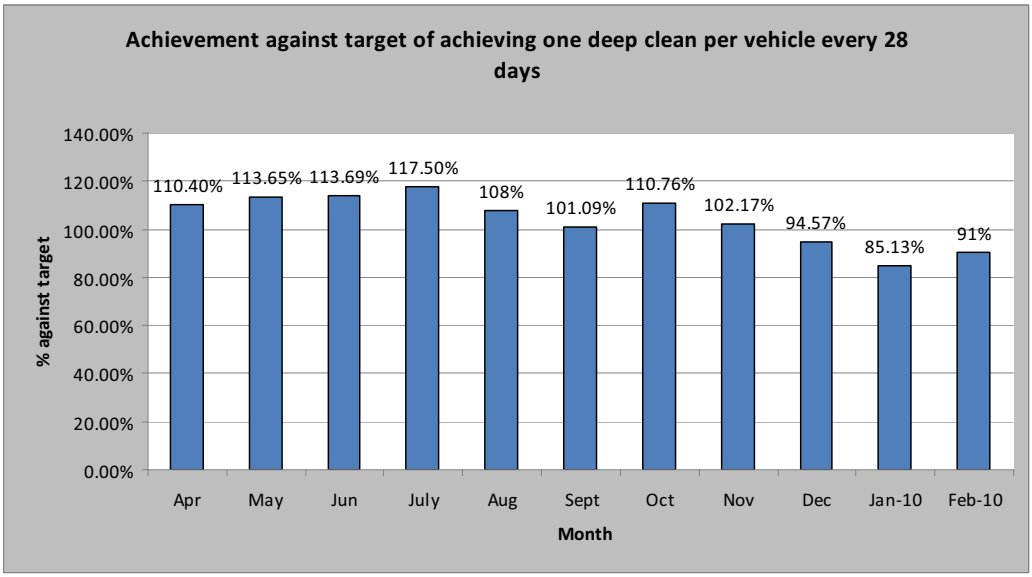
- to respond to 75% of patients with life-threatening conditions (Category A) within 8 minutes
- to respond to 95% of patients with life-threatening conditions (Category A) within 19 minutes
- to respond to 95% of patients with serious conditions (Category B) within 19 minutes.

We report our performance against these targets at every public Trust Board meeting and in our Annual Report.

PATIENT SAFETY

Indicator 1 – Achievement against target of achieving one deep clean per vehicle every 28 days

Department of Health best practice states that every ambulance vehicle should receive a deep clean at least once every 28 days. This is one of the most important ways to reduce the risk of transmission of healthcare associated infections.



The slightly lower number of vehicles cleaned between December 2009 and February 2010 reflects operational pressures, in particular the high demand the Trust experienced during the period of adverse weather conditions and the practical difficulty of removing vehicles from the road during this time.

Indicator 2a – Delivery of Care Quality Commission Recommendations Following Safeguarding Children Review

Requirement	Status
Organisation has clear leadership on safeguarding and managers with dedicated responsibilities	✓ Meeting requirements
Staff have appropriate training	✓ Meeting requirements
Policies and systems are in place	✓ Meeting requirements
Systems for monitoring and assurance are in place	✓ Meeting requirements
Organisation works collaboratively with partner organisations	✓ Meeting requirements
Organisation effectively manages its response to Serious Case Reviews	✓ Meeting requirements

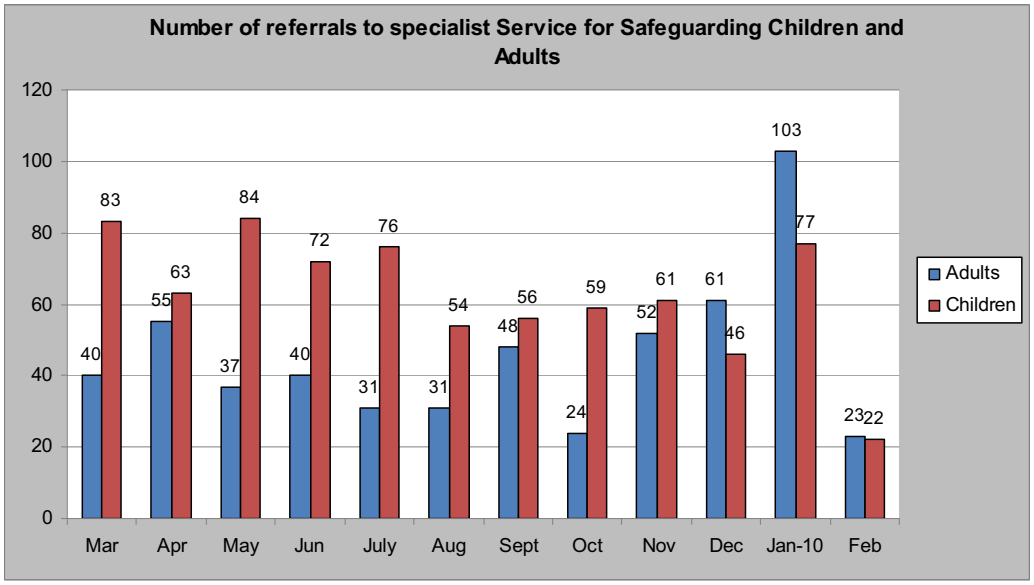
We have published a detailed statement of assurance on our website at http://www.yas.nhs.uk/Publications/publicationlibrary.html

Indicator 2b – Numbers of Referrals to Specialist Services for Safeguarding Children and Vulnerable Adults

The welfare of children and vulnerable adults is an ongoing priority and we aim to ensure that patients in our care are safe and protected by effective intervention if they are thought to be suffering, or likely to suffer significant harm.

The numbers of referrals our staff make to specialist services show how vigilant they are being for signs of neglect and abuse and their confidence in the training they have received.

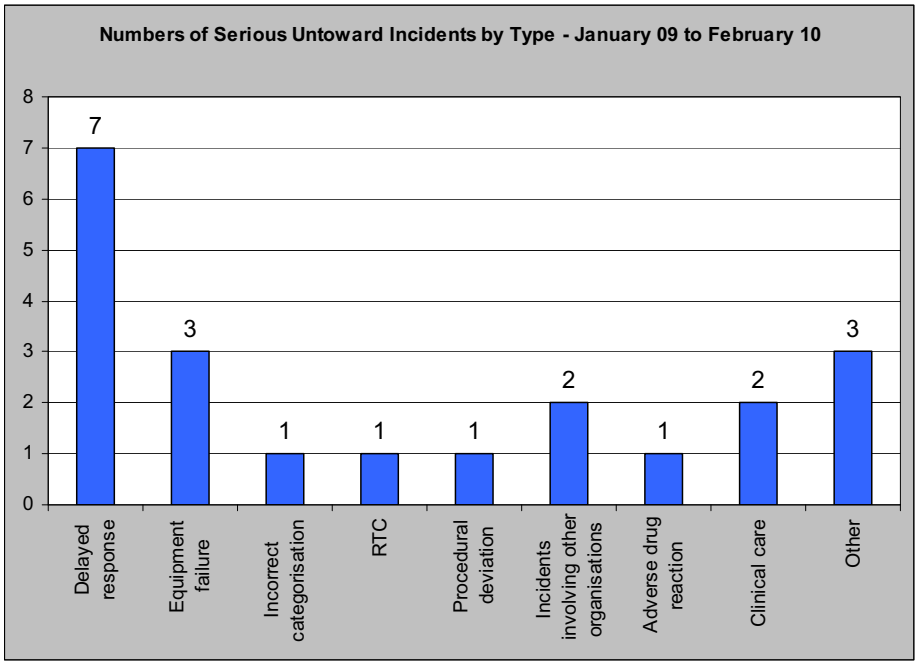
GRAPHS BELOW TO BE UPDATED AT YEAR END. FIGURES FOR FEB ARE PART-MONTH



Indicator 3 – Numbers of Serious Untoward Incidents

If errors are made which put patients at risk or if patients are harmed we report and thoroughly investigate the incident to ensure lessons are learned for the future. The majority of incidents are reported internally according to Trust processes, but in addition, the most serious incidents are reported to our commissioners as serious untoward incidents.

From April 2009 to February 2010 [UPDATE AT YEAR END] YAS reported 21 Serious Untoward Incidents.



The latest report (September 2009) from the National Patient Safety Agency National Reporting and Learning System showed that we reported 37 incidents between 1 October 2008 and 31 March 2009.

Organisations are encouraged to report incidents as a basis for learning and improvement. Numbers of incidents reported are seen as an indicator of whether an organisation has an effective safety culture.

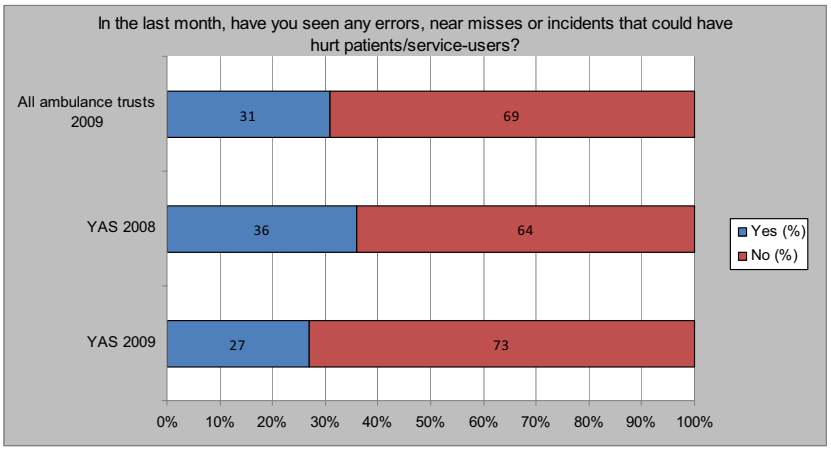
Numbers of incidents referred to the National Patient Safety Agency (NPSA) National Reporting and Learning System: 1 April 2009 – 31 March 2010. (Data from NPSA)

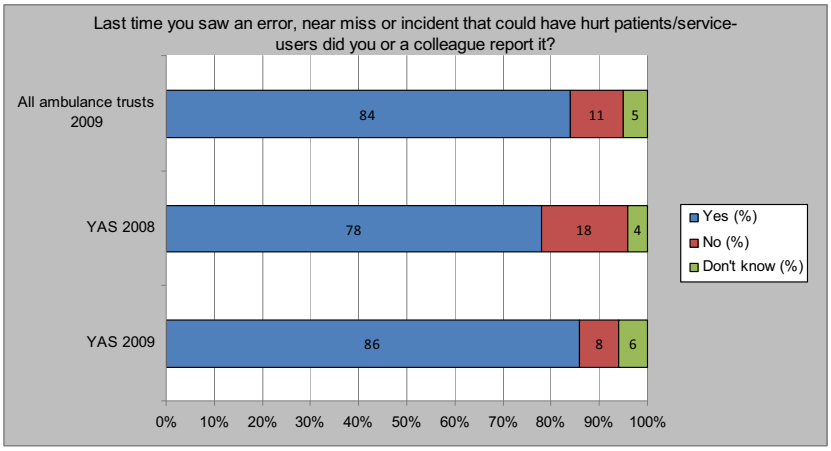
Graph showing number of incidents reported by YAS compared to other ambulance trusts. Data due to be published April 2010

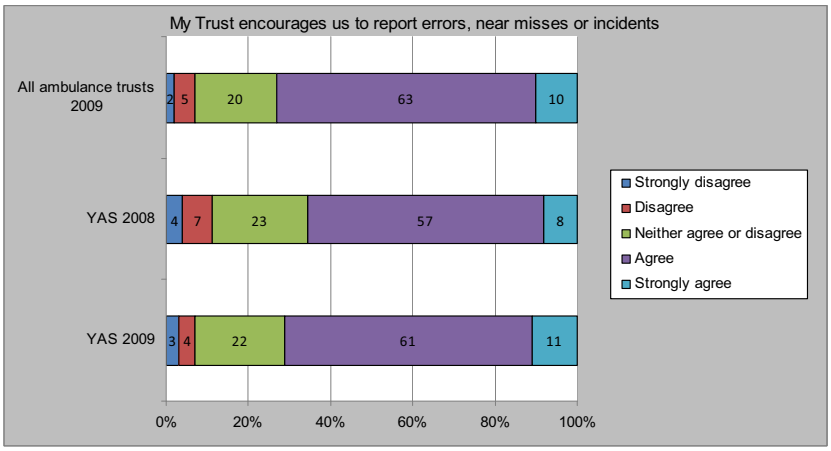
Indicator 4 – Results of 2009 NHS Staff Survey

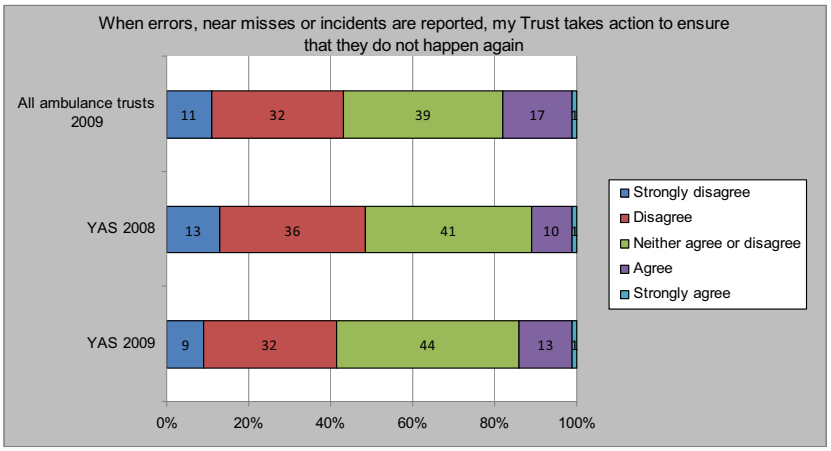
The national NHS staff survey, coordinated by the Care Quality Commission, has been carried out for the past six years.

It provides reliable data about how staff feel about working in our Trust and what staff experience in their working lives. There are a specific set of questions relating to errors, near misses and incidents. The results show how YAS has improved since 2008.


In the last month, have you seen any errors, near misses or incidents that could have hurt patients/service-users?
All ambulance trusts 2009
YAS 2008
YAS 2009
31
69
36
64
27
73
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Yes (%)
No (%)


Last time you saw an error, near miss or incident that could have hurt patients/service-users did you or a colleague report it?
All ambulance trusts 2009
YAS 2008
YAS 2009
84
11
5
78
18
4
86
8
6
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Yes (%)
No (%)
Don't know (%)


My Trust encourages us to report errors, near misses or incidents
All ambulance trusts 2009
YAS 2008
YAS 2009
2
5
20
63
10
4
7
23
57
8
3
4
22
61
11
0%
20%
40%
60%
80%
100%
Strongly disagree
Disagree
Neither agree or disagree
Agree
Strongly agree



CLINICAL EFFECTIVENESS

Indicator 5 – Performance Against Clinical Performance Indicators

As explained in our Priorities for Improvement, there are five nationally agreed Clinical Performance Indicators (CPIs) which relate to conditions where the care of ambulance staff can make a significant difference to patient outcomes. For each indicator there are a number of agreed actions that should be completed for every patient with that condition and we audit our PRFs to identify whether these were carried out. Our performance is reported as the percentage of cases for which our ambulance clinicians carried out theses actions compared to the total number of cases.

Our scores are also compared with those of other English ambulance services and a measure calculated for how close we are to the national average score. The z-score describes how many standard deviations above or below the mean score a trust is positioned. The standard agreed by national ambulance directors of clinical care is that a z-score of minus 2 or above indicates that a Trust is performing within acceptable limits in comparison with other Trusts, whereas a score of below -2 indicates underperformance in relation to the other Trusts.

Results received/published in 2009/10

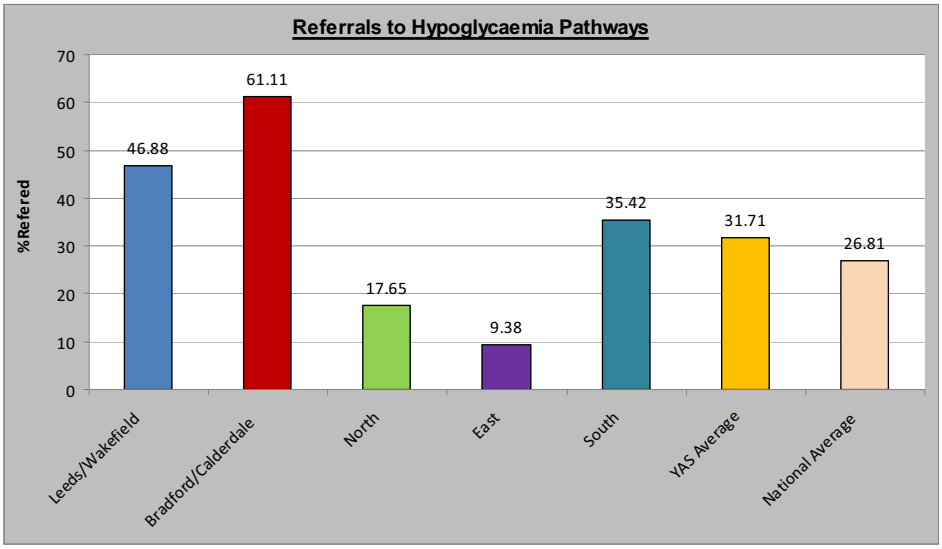
ST Elevation Myocardial Infarction (STEMI)	**Nov 2008 Results %**	**z-score**	**May 2009 Results %**	**z-score**
Aspirin administered	97.37	0.77	95.73	0.71
GTN administered	86.21	0.62	76.07	-0.49
Initial Pain Score	78.81	-0.35	not measured	
Subsequent Pain Score	56.3	-0.56	not measured	
Two Pain Scores Recorded	56.3	-0.48	60.34	-1.10
Morphine alone given	Figures not provided		34.38	-1.29
Analgesia given	55.17	0.02	38.14	-1.50
Cardiac Arrest	**Dec 2008 Results %**	**z-score**	**June 2009 Results %**	**z-score**
ROSC on arrival at hospital *	17.30	-0.01	13.50	-1.04
Defibrillator on scene	100	0.29	not measured	
Advanced Life Support provider in attendance	not measured		94.61	-1.15
Response to cardiac arrest < 4 minutes	10.86	-0.87	20.36	-0.51
Stroke	**Jan 2009 Results %**	**z-score**	**July 2009 Results %**	**z-score**
Face, Arm, Speech Test (FAST) recorded	84.59	-0.18	92.39	-0.08
Blood glucose recorded	90.00	0.97	93.24	0.50
Blood pressure recorded	96.79	-0.53	99.32	0.25
Hypoglycaemia	**Feb 2009 Results %**	**z-score**	**Aug 2009 Results %**	**z-score**
Blood Glucose Recorded before treatment	100	0.48	99.65	0.34
Blood Glucose Recorded after treatment	94.47	-0.39	96.70	-0.03
Treatment for Hypoglycaemia Recorded	96.35	-0.61	99.27	0.43
Asthma	**Mar 2009 Results %**	**z-score**	**Sept 2009 Results %**	**z-score**
Respiratory rate recorded	94.55	-1.09	98.73	0.36
PEFR (peak flow) recorded before treatment	52.78	1.16	45.34	0.94
SpO2 recorded before treatment	78.22	-0.62	86.08	-0.31
Beta 2 agonist recorded	95.45	0.38	98.31	0.78
Oxygen administered	96.50	1.02	94.07	0.31

* The June 2009 ROSC result is currently under review by the national ambulance service audit group as there are some inconsistencies in the data sets submitted, this means that the indicator results my not be directly comparable between ambulance services.

Indicator 6 – Number of Referrals to Hypoglycaemia Pathways
Following a 999 call for a hypoglycaemic episode (where blood sugar has fallen very low), patients across much of Yorkshire are referred to diabetes specialist nurses who provide follow-up care. Referral may not be appropriate for all patients attended, but those referred in this way have reported that it helped them understand the importance of monitoring their blood sugar, how to recognise warning signs of low blood sugar and how to prevent problems in the future.

A total of 1409 patients were referred to diabetic teams by YAS staff in 2009.

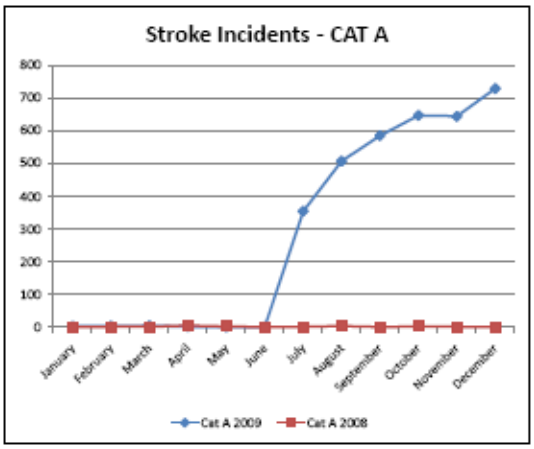
In August 2009 an audit of referrals was carried out as part the data collection for Clinical Performance Indicators. The results are shown below as a percentage of the total numbers of patients with hypoglycaemia attended by YAS crews.



Indicator 7 – Number of Stroke Incidents Classified as Life-threatening Emergencies (Category A)
In the last ten years treatments for strokes, which have been caused by a blood clot, have developed to offer these patients a drug treatment that can almost reverse this disabling condition for some. YAS has agreed pathways to refer these patients for rapid assessment and treatment. This year the number of hospitals with pathways has increased from 12 to 20 (out of the 24 hospitals to which YAS staff take patients).

The patients need to present within three-and-a-half hours of first symptoms so acute stroke is now handled as a medical emergency. This meant a change to the call-handling procedure in our 999 communications centres so stroke is now given the highest priority for response – Category A.

The graph below shows the increase in numbers of patients with stroke identified as Category A since the new pathways have been developed.



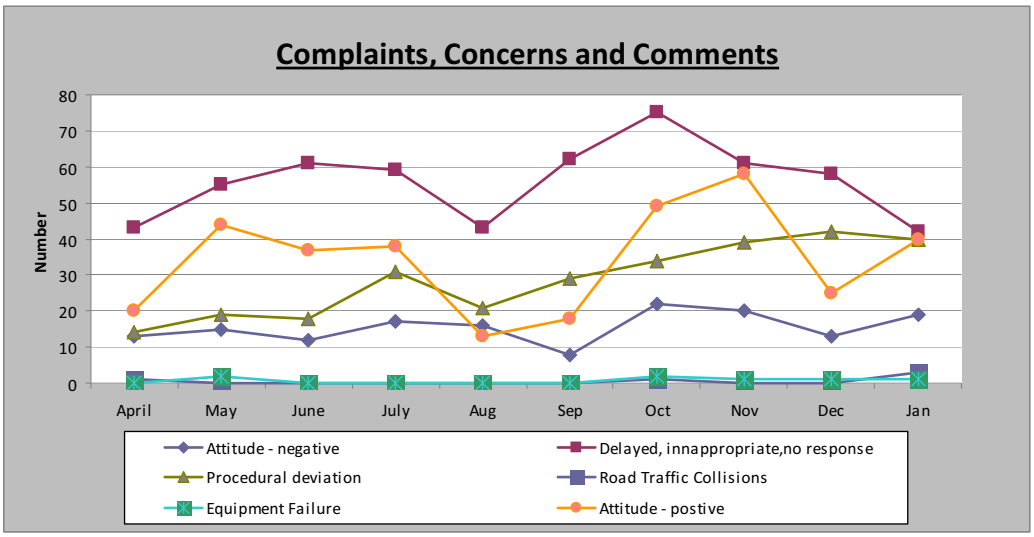
Looking ahead, in association with Sheffield University and NHS Sheffield, we are planning to conduct an audit of the outcomes for patients referred via the Sheffield stroke pathway.

PATIENT EXPERIENCE
Indicator 9 – Number of Complaints, Concerns and Comments
Indicator 10 – Number of Compliments

YAS staff work very hard to get the job right first time but, with busy services, mistakes can happen and problems occur. When people tell us about their experiences we aim to listen, if necessary put things right, and learn for the future.

As well as telling us when things go wrong, we are very pleased when people tell us about a good experience of our services. When someone tells us about the good service provided by a member of our staff their director sends them a personal letter to acknowledge their good service.

	Definition
Complaint	Any expression of dissatisfaction that requires a formal response
Comment	Where a member of the public or a patient wishes to make YAS aware of an event or incident but where they indicate that no further action is required.
Concern	Where a member of the public or a patient wishes to make YAS aware of an event or incident and where they require informal feedback.
Compliment	Any expression of satisfaction with a service made by a customer about the organisation. A compliment may be made about an individual, team or the service as a whole.

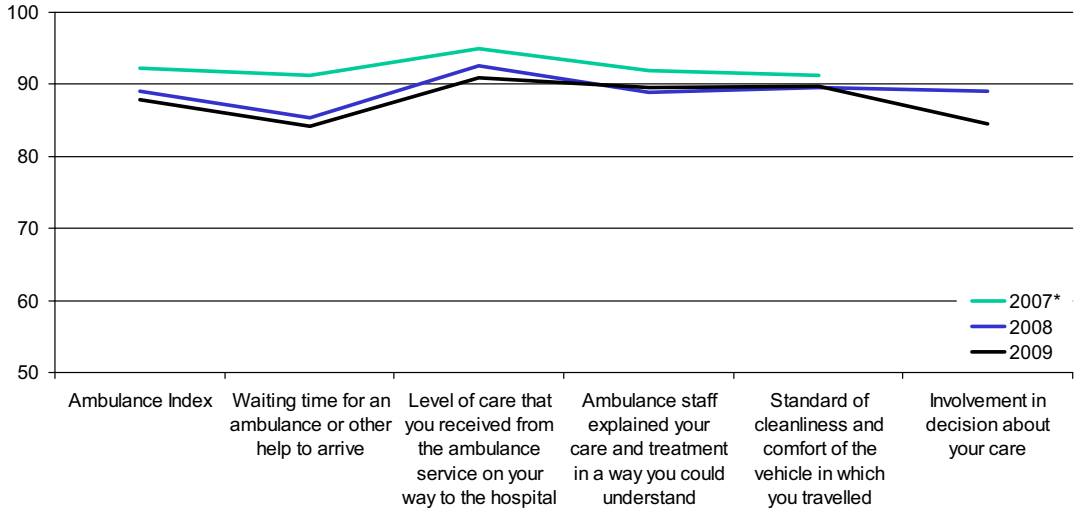


Indicator 11 – Results of Yorkshire & Humber (Y&H) Strategic Health Authority Public Satisfaction Research 2009

This research measured and analysed levels of public and patient satisfaction with NHS services within the NHS Y&H region. It was based on a large-scale quantitative survey followed-up by qualitative research in the form of discussion groups.

Of a 3980 people responding to the survey, 89% said they were satisfied or highly satisfied with the ambulance service. This was the highest satisfaction score for any NHS service in the region.

User satisfaction scores: mean score out of 100%
Base: Total users 2009 (n=179); 2008 (n=116) and 2007 (n=111)



STATEMENTS FROM LOCAL INVOLVEMENT NETWORKS, OVERVIEW AND SCRUTINY COMMITTEES AND PRIMARY CARE TRUTS

To be added following consultation period

SOUTH YORKSHIRE JOINT HEALTH SCRUTINY COMMITTEE

Briefing Meeting held 18 March 2010

PRESENT: **Sheffield City Council**
Councillor Mick Rooney (Chair)
Councillor Clive Skelton
John Challenger, Scrutiny Policy Officer
Dave Ross, Democratic Services

Doncaster Metropolitan Borough Council
Councillor Patricia Bartlett
Councillor Georgina Mullis
David Chorlton, Scrutiny Policy Officer

Rotherham Metropolitan Borough Council
Councillor Hilda Jack
Delia Watts, Scrutiny Adviser

Barnsley Metropolitan Borough Council
Elizabeth Barnard, Scrutiny Adviser

Sheffield Teaching Hospitals NHS Foundation Trust
Chris Linacre, Director of Service Development
Mike Richmond, Medical Director
Gill Guest, Cancer Services Director (Observer)

NHS Sheffield
Alistair Hill, Associate Director

1. **APPOINTMENT OF CHAIR FOR THIS MEETING**

It was agreed that Councillor Mick Rooney would Chair the meeting.

2. **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillors Janice Hancock and Margaret Sheard.

3. **DECLARATIONS OF INTEREST**

Councillor Clive Skelton declared a personal interest as his wife worked for the Sheffield Teaching Hospitals Trust.

4. **'EXCELLENCE AS STANDARD' CONFIGURING SERVICES TO ACHIEVE THE BEST PATIENT TREATMENT AND CARE**

Mike Richmond, Medical Director and Chris Linacre, Director of Service Development (Sheffield Teaching Hospitals NHS Foundation Trust) submitted a briefing paper that set out the rationale and drivers for change, the existing configuration of services, the proposed changes and the benefits and risks. In giving a joint presentation, they highlighted:

- The rational for change was to provide 'optimal patient centred care' taking into account 'best practice', clinical guidance and patient experience and having determined the structure to deliver optimal patient care we need to ensure it is delivered in the most efficient way.

- It was not about major strategic change but refining services.

- The proposals included:

    - General surgery emergencies at Northern General Hospital (NGH)
    - General medical unseen emergencies at NGH
    - Heart attack centre at NGH
    - Major Gastro Intestinal inpatient surgery at NGH
    - Re-profile of Critical Care service with NGH Hub and the Royal Hallamshire Hospital (RHH) Spoke
    - Surgical Clinics/Diagnostics (NGH and RHH)
    - Hyper-Acute, Acute and Rehabilitation Stroke service at RHH
    - Breast and Endocrine Surgery at RHH
    - Service re-alignment of reconstructive Plastic Surgery (Breast, Head and Neck, Skin) at RHH
    - Centralisation of elective Spinal Surgery at RHH

- The ambitious timetable for 2010 was:

    - To implement all changes by 30 November 2010 before winter begins.

    - Made possible by the foundations in place in 2009: third Medical Admissions Unit, Acute Physician team, new Renal modular ward & Dialysis Unit, RHH Theatre Admission Unit and Primary PCI almost complete.

    - Further investment in a surgical Hand Unit, Surgical Assessment Unit and new Burns Unit all at NGH.

- Intermediate Care proposal - Procurement of Community service awarded to Sheffield NHS Intermediate Care Partnership and to start April 2010 and procurement of inpatient facility aimed at April 2012.

- The next steps were:

    - Working through the detailed planning for the proposals.

    - Test the impact on support services.

    - Consult Commissioners formally once the proposals are clear.

    - Consult the Overview Scrutiny Committees in South Yorkshire

and Sheffield in March/April 2010.

- Communications within Sheffield Teaching Hospitals were ongoing, including with LINKS on 18 May 2010.

Mike Richmond and Chris Linacre responded to questions from Members relating to the Burns Unit, the impact on staff, the link with Community Services and the Home Hospital team, the Stroke Unit, bed capacity, the new inpatient facility, funding/costs, continuing care and the hub/spoke model. It was noted that:-

- The Burns Unit was being reconfigured as a purpose designed Burn Care Unit for adults at the NGH including plastic surgery support. This was opportune following the transfer of Paediatric burns to the Children's Hospital.

- The reconfiguration was a transfer of services and there would be no job losses.

- The Primary Care Trust wanted to improve Community Care. Procurement of the Community Intermediate Care Service had been awarded to Sheffield NHS Intermediate Care Partnership and it was intended to be as seamless as possible.

- Each major hospital in the region would have its own Stroke Unit. There was an issue on providing thrombolysis as this required a competent Stroke physician. It had been decided to pool expertise and provide a 24/7 rota across the network area, Sheffield, Barnsley, Rotherham, Doncaster and northern Derbyshire and Bassetlaw with images sent via the internet and a clinical decision made locally.

- During the last 9 months, efficiencies and the length of stay criteria had been reviewed. It was considered that efficiencies could be made and provide some improvements in bed utilisation.

- Until the modelling had been completed, the costs would not be known but it was expected that it would be cost neutral. Phase 1 had seen considerable investment in the new Medical Assessment Unit and acute physicians but phase 2 was expected to be at least revenue neutral. There would be considerable capital expenditure involved. The intention was to improve services and be as efficient as possible and make gains to reinvest in services.

- Continuing care was not central to the reconfiguration of services but was an issue for resolution in the future.

- Work was taking place on what the stroke configuration would look like and the medical and staffing components e.g. 2/3 additional consultants may be required for the 24/7 hyper-acute Stroke Unit plus 2 junior doctors. Work was also taking place in identifying where the wards

would be located at the RHH following their transfer form the NGH. The final staffing costs would be worked out in the next 3/4 weeks.

- There was a hub/spoke model for critical care. It would be based at the NGH but there was commitment to provision wherever the patient was located, so the 'spoke' could be delivered at the RHH.

RESOLVED: That Members (a) were generally supportive of the Trust's re-configuration proposals;

(b) recognised that each of the local authorities concerned could scrutinise the proposals if they so wished; and

(c) requested the Trust, as and when the proposals were finally approved, to write to all Members of the South Yorkshire Local Authorities describing the proposals to assist them in dealing with enquiries from members of the public on the proposals.

ADULT SERVICES AND HEALTH SCRUTINY PANEL
4th March, 2010

Present:- Councillor Jack (in the Chair); Councillors Barron, Blair, Doyle, Goulty and Wootton

Also in attendance were Jim Richardson (Aston cum Aughton Parish Council), Russell Wells (National Autistic Society), Mrs. A. Clough (ROPES), Jonathan Evans (Speak up), Victoria Farnsworth (Speak Up), Ms. J. Mullins (Rotherham Diversity Forum) and Mr. R. H. Noble (Rotherham Hard of Hearing Soc.).

Apologies for absence were received from Councillors Clarke, Turner and F. Wright.

78. COMMUNICATIONS.

The Chair made the following announcements:-

Community Health Centre

Members were reminded that a visit to the Community Health Centre had been arranged on Thursday 11th March 2010 at 10.00 am to view the facilities and services provided. Anyone interested in attending should contact Delia Watts or Ben Knight by the end of Friday 5th March 2010.

Joint Strategic Needs Assessment in Yorkshire and Humber
"Confronting the Challenges: Sharing Lessons, Building Local Solutions"

Members were reminded that the above event was taking place on Tuesday 23rd March 2010 at the Royal Armouries, Leeds from 10.00 am to 4.00 pm. Expressions of interest were sought from Elected Members to Delia Watts or Ben Knight.

Quality Accounts – Joint Meeting with Rotherham LINk

Members were reminded that a joint meeting was being hosted by LINk to look at the draft quality accounts for RDASH and the Rotherham Foundation Trust on Thursday 29th April 2010 at their offices on Coke Hill, Rotherham.

Learning Pool Health and Social Care E-Learning Training

Councillor John Doyle reported on the e-learning package which was available in respect of learning pool health and social care, which included safeguarding. He confirmed that it was a straight forward package which would take between 20-40 minutes to complete with a certificate being issued at the end.

79. DECLARATIONS OF INTEREST.

No declarations of interest were made at the meeting.

80. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS.

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

81. HEALTH SCREENING PROGRAMMES IN ROTHERHAM

Bel O'Leary, Screening Co-ordinator, NHS Rotherham gave a presentation in respect of Health Screening Programmes in Rotherham.

Screening is a process of identifying apparently health people who may be at increased risk of a disease or condition. They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition.

She confirmed that all screening programmes can do harm. The UK National Screening Committee (UK NSC) assess evidence for programmes against a set of internationally recognised criteria covering the condition, the test, treatment options and effectiveness and acceptability of the screening programme, using research evidence, pilot programmes and economic evaluation. This is intended to ensure that they do more good than harm at a reasonable cost.

She reported on the following three screening programmes which were an existing programme, a recently introduced programme and a programme which would be implemented in the future.

<u>Cervical Screening Programme</u>

The NHS Cervical Screening Programme (NHSCSP) is a programme preventing cancer by detecting and treating early abnormalities which, if left untreated, could lead to cancer in a woman's cervix.

The programme aimed to reduce the number of women who develop invasive cervical cancer and the number of women who die from it, by regularly screening all women in the target group.

Women aged 25 to 64 are invited for regular cervical screening on a rolling programme. They are called using a call and recall system from the Open Exeter System of GP registration, mainly via GP Practices and via Sexual Health Services. Samples were currently processed at the laboratory at Rotherham Hospital and the laboratory referred directly to the Colposcopy Unit at the RFT for onward referral of patients as necessary.

Performance

Coverage was now 80% which was lower in areas of high ethnicity,

women who had a learning disability and women between the age of 25 and 34 years.

What we are doing?

High Ethnicity

- Working with health trainers, link workers and health professionals to increase awareness and encourage uptake
- Further work was needed at the mosques with both females and males

Learning disability

- Work around the accuracy of the Learning Disability register had now been completed.
- This would enable us to identify from the Direct Enhanced Service for Learning disability (DES) which women with a learning disability have had a Cervical and Breast screen

Younger Women

- A social marketing initiative was underway to identify why women did not attend for screening

<u>Bowel Screening Programme</u>

The South Yorkshire and Bassetlaw Bowel Cancer Screening Programme was launched in 2008, with people between the ages of 60 and 69 being offered a screen.

A sample kit was sent to the home of the eligible population by the programme call and recall system, requesting two samples of motion to be returned via the post to the laboratories.

Normal results were returned into the standard call and recall and abnormal results were referred to screening unit and offered an appointment with a Specialist Screening Practitioner for further diagnostic testing. If appropriate a colonoscopy was offered, and if cancer was diagnosed, a referral for treatment was made to the local team.

Performance

Coverage for 2009 was 56% which was lower for the same reasons as the Cervical Screening Programme.

The areas of lower coverage were identified and the Specialist Screening Practitioners (SSPs) and the Cancer Health Improvement Practitioner (CHIP) would be doing some work to target:

- General public
- Increasing awareness in Health Practitioners

Abdominal Aortic Aneurysm (AAA) Screening Programme

The Abdominal Aortic Aneurysm Screening Programme was planned to be implemented for December 2011.

There would be 4 elements of the programme:

- Screen
  - The scan would be non-invasive, rapid, repeatable and inexpensive
  - Could be undertaken by a technician or ultrasonographer
  - Would probably be delivered in a Primary Care setting

- Call and recall
  - All men aged 65 would be identified from the practice list and invited to attend
  - Scans would be taken and results sent out
  - Treatment/monitoring would be determined by the result of the scan

- Referral
  - It was expected that this would include normal referral pathway via GPs, but may include referral from the ultrasonographer/technician to the Vascular Surgery Unit

- Treatment/monitoring
  - It was anticipated that it would be delivered in a Vascular Surgery Unit
  - If fit for surgery and agreed, surgical treatment would be given
  - If treatment declined, observation would continue under the care of surgeon, with ongoing management of symptoms and risk factors
  - If unfit for surgery observation would continue under care of surgeon, with ongoing management of symptoms and risk factors.

A question and answer session ensued and the following issues were raised and discussed:

- Why the frequency for screenings increased from 3 years to 5 years from the age of 50. It was confirmed that the risk of abnormal cells developing into cancer dropped considerably after this age.
- Statistics showed that women from struggling families were less likely to attend screening as it was not seen as important. A query was raised as to whether it was possible for a smear test to be done in a person's home. It was confirmed that this was possible but quite difficult.
- A query was raised as to why only men were offered screening for Abdominal Aortic Aneurysm. Confirmation was given that it was most common in men and very rare in women.
- Given that women were living longer, a question was asked about whether there were any plans to extend the cervical screening programme to women over the age of 64. It was confirmed that the chances of a woman over the age of 64 getting cervical cancer was so slim that screening would not be being extended.

- Reference was made to the immunisation programme which was now being offered to teenage girls for cervical cancer and a query was raised as to whether this would stop the necessity for future screening. Confirmation was given that tests would change in the future as a result of this.
- Reference was made to the AAA screening and a query was raised as to whether men would be recalled when they were older to be re-screened. It was confirmed that if the condition was not present at 65 it would not develop thereafter, therefore the screening would not be repeated,
- A remark was made about the screening process for breast cancer and how difficult it was for people who were unable to stand to undergo screening. It was suggested that other ways be found for this screening to be done in order for these people to obtain successful results. It was agreed that this would be looked into.
- Reference was made to the breast screening review which was currently ongoing and a query was raised as to the likely outcomes. It was confirmed that it was looking likely that the age for screening would be extended from 70 to 73 and that screening services would continue to be offered in convenient locations.

82. MINISTRY OF FOOD EVALUATION

Steve Dobson, Research and Statistics Officer and Lisa Taylor, Food Centre Manager gave a presentation in respect of the Ministry of Food Evaluation.

The presentation drew specific attention to:-

- Two key challenges

  - Momentum
  - Outcomes
- Evaluation stages
  - Pre-contemplation
  - Contemplation
  - Preparation
  - Action
  - Maintenance

- Relapse
- Interim results
- Transition breakdown
- Conclusions

A question and answer session ensued and the following issues were raised and discussed:-

- What involvement does Jamie Oliver/production company currently have with the Ministry of Food Rotherham? Confirmation was given that Jamie had not been back since his initial input, although his team did offer support in the form of links from Jamie's website and provision of recipes. It was now very much a Rotherham project.

- What was the current funding situation for the Ministry of Food? There was some of the initial fund left, but as there had been no funding offered since, they were looking at generating their own funding for the future.
- The Ministry of Food project was launched to encourage better habits concerning food and dietary health, but nearly 40% were already long term healthy eaters. A query was raised as to whether the project had been poorly targeted. A comment was made that this still meant that 60% of participants weren't healthy eaters and it was hoped to reach more of this group over time.
- Concerns were raised about the number of people who would not cook because they were scared to use cooking facilities and utensils for fear of hurting themselves. Confirmation was given that part of the project was to train people in the use of equipment in the kitchen and therefore overcome this fear.
- It was felt that it was essential to educate young children to eat healthily before they got into the habit of eating unhealthily. They could then re-educate their family at home. It was confirmed that work was ongoing with small schools who didn't have cooking facilities and also work was being undertaken with parenting groups. In addition there was a health schools initiative being run across all the schools in Rotherham. Courses for children are regularly run at the MOF.
- How were participants identified for the ten-week course? Confirmation was given that so far no advertising had been

necessary as people had been approaching the course.

- Were there any sign-posts/referrals coming from GPs to the course. So far there had been no contact with GPs but they were looking into linking with them.
- What plans were there for continuing and developing the MOF project? It was envisaged that it would grow and become a Social Enterprise.

83. MINUTES OF A MEETING OF THE ADULT SERVICES AND HEALTH SCRUTINY PANEL HELD ON 11TH FEBRUARY 2010

Resolved:- That the minutes of the meeting of the Panel held on 11th February 2010 be approved as a correct record for signature by the Chair.

84. MINUTES OF A MEETING OF THE CABINET MEMBER FOR ADULT SOCIAL CARE AND HEALTH HELD ON 25TH JANUARY 2010 & 8TH FEBRUARY 2010

Resolved:- That the minutes of the meetings of the Cabinet Member for Health and Social Care held on 25th January 2010 and 8th February 2010 be noted and received.

CABINET MEMBER FOR HEALTH & SOCIAL CARE
22nd February, 2010

Present:- Councillor Doyle (in the Chair); Councillors Gosling and P. A. Russell.

Also in attendance were Councillors Barron, Jack and Walker.

H89. MINUTES OF THE PREVIOUS MEETING HELD ON 8TH FEBRUARY 2010

Resolved:- That the minutes of the meeting held on 8th February 2010 be approved as a correct record.

H90. MILLENNIUM DAY CENTRE – TALKING NEWSPAPERS

The Director of Health and Wellbeing presented the submitted report in respect of the closure of the Millennium Day Centre, the impact of service delivery and the way forward for this service over the next year. The report also set out proposals for the relocation of the Talking Newspaper Service to alternative premises by April, 2010.

The Millennium Day Centre relocated to Parklea as a result of the closure of the substantive worksite on the 22nd December 2009. The relocation had been successfully undertaken despite some limitations with the building for delivering rehabilitative services. The Learning Disability Services were due to vacate the premises by the end of February, 2010, which would enable the rehabilitation service to be delivered in accordance with the service level agreement and specification set out by the Joint Commissioning Team.

The NHS Rotherham Capital Board had indicated that they were prepared to release £300,000 in capital funds to assist with the upgrade of the Millennium Day Centre subject to remedial works being completed by the Local Authority on the water and the heating at a cost of £125,000. To date no schedule of dilapidations had been served on the Council. The schedule of dilapidations would set out the remedial requirements that the Council may be liable for under the terms of the lease.

The circumstances in relation to the lease arrangements for the Millennium Centre and the Talking Newspaper tenancy were as follows:-

- The RMBC lease of the Millennium Day Centre will expire on 31st March 2010.
- The Talking Newspaper occupied this centre based on a licence that coincided with the above leasing arrangements.
- Talking Newspaper's occupation of the premises ceases on 30th March 2010; although it was not a requirement to give them official notice, it was felt that it would be courteous to do so.

- The Talking Newspaper had a legal right to remain in occupation until 30th March, 2010. The room they occupied had been specially adapted to enable them to function, including a separate recording studio that was sound proofed and additional electrical sockets had been installed to enable them to deliver their core business. Any move to another building would take up to 2-3 months to facilitate, at an indicative cost of around £15,000.
- It was proposed that they remained in occupation of the rooms at the Millennium Centre until 30th March, 2010 and a decision was made on their future; they had been advised to use bottled water and toilet facilities had been made available for them at the adjacent Breathing Space building.
- This would provide them some security for the centre until it was handed back to the NHS/PCT officially in March, 2010 and any heating and rental cost would be offset against any potential relocation costs for moving the Talking Newspapers operation with immediate effect.
- Weekly checks had been put in place to review the situation and to ensure that the building was maintained and we meet out obligations under the lease.

Discussion took place on the possible availability of alternative premises which might be suitable as permanent accommodation for the Taking Newspaper in the future. It was noted that the release of appropriate funds was first required to facilitate the relocation of this service by the beginning of April, 2010.

Resolved:- (1) That the report be received and its contents noted.

(2) That the action taken in respect of the closure of the Millennium Day Centre, as now reported, be noted.

(3) That, subject to approval being obtained for the release of the appropriate funding and capital requirements, the relocation of the Talking Newspaper service from the Millennium Day Centre to the alternative premises now discussed, by the beginning of April, 2010, be agreed.

(4) That, subject to the satisfactory outcome of the relocation referred to at (3) above, arrangements be made for an official opening of the Talking Newspaper's new premises.

(THE CHAIRMAN AUTHORISED CONSIDERATION OF THE FOLLOWING ITEMS TO ENABLE THE MATTERS TO BE PROCESSED)

H91. E LEARNING COURSE ON SAFEGUARDING

The Cabinet Member for Health and Social Care reported that he had recently completed the Council's e learning course on Safeguarding.

It was agreed that all Members of the Council be offered the opportunity of studying this course.

H92. PROSTATE CANCER - AWARENESS RAISING

The Cabinet Member commended the arrangement, implemented after the idea had been raised via the Council's employee suggestion scheme, whereby information posters are displayed in the male toilets in Council-owned buildings to raise awareness of prostate cancer and providing a contact telephone number for medical advice.

H93. EXCLUSION OF THE PRESS AND PUBLIC

Resolved:- That, under Section 100A(4) of the Local Government Act 1972 of the Local Government Act 1972, the press and public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in Paragraph 3 of Part 1 of Schedule 12A to the Local Government Act 1972 (information relating to financial or business affairs).

H94. SETTING IN HOUSE RESIDENTIAL ACCOMMODATION CHARGES 2010/11

The Strategic Director for Neighbourhoods and Adult Services presented the submitted report in respect of setting in-house residential accommodation charges for 2010/11.

The Council has a statutory duty to set a maximum charge for residential accommodation provided in Local Authority homes which had to reflect the costs of providing residential care including expenditure such as running costs and management overheads.

The report detailed the proposals for increasing the charge to service users for the provision of in-house residential care for the 2010/11 financial year, taking account of inflation.

Resolved:- (1) That the charges for in-house residential accommodation, set out in Appendix 1 of the report now submitted, be agreed.

(2) That these charges be effective from the 4th April, 2010.

H95. CARE QUALITY COMMISSION (CQC) INSPECTION - PROGRESS

UPDATE

Further to Minute No. H71 of the meeting of the Cabinet Member and Advisers for Health and Social Care held on 7th December, 2009, discussion took place on the progress made against the recommendations of the 2008 social care Annual Performance Assessment (APA) inspection and process for Rotherham conducted by the Care Quality Commission (CQC). Specific reference was made to:-

- budget and service-related issues (eg: occupational therapy);

- the inspection's recommendation relating to the number of people with a physical disability and/or sensory impairment who are helped to live at home;

- partnership working with NHS Rotherham.

Resolved:- That the progress update be noted.

CABINET MEMBER FOR HEALTH & SOCIAL CARE
9th March, 2010

Present:- Councillor Doyle (in the Chair); Councillors Gosling, Jack and P Russell

Apologies for absence were received from Councillors Barron and Walker

H96. MINUTES OF THE PREVIOUS MEETING HELD ON 22ND FEBRUARY 2010

Resolved:- That the minutes of the meeting held on 22nd February 2010 be approved as a correct record.

H97. MATTERS ARISING

Millennium Centre – Talking Newspapers

The Director of Health and Wellbeing reported that discussion had taken place with Talking Newspapers and it had been suggested that there was potential for them to stay at the Millennium Centre with our support or to move to a new building with our support. She agreed to bring a report to the next meeting with the options available.

E-Learning Package

The Chair reported that all elected members had been made aware of the E-Learning package on Safeguarding and some had already undertaken it. He urged his advisors and the other members present to make every effort to do it in their capacity as representatives for adult social care and health.

H98. PERSONALISATION: SELF DIRECTED SUPPORT

Shona McFarlane, Director of Health and Wellbeing presented the submitted report in respect of Personalisation, Self Directed Support.

Self Directed Support describes new approaches in the social care system that puts people in control and helps them to design their own personalised support.

A key part of the process was the introduction of a personal budget. Building into the new system was a process for working out the level of resources a customer can access to pay for the support they require to meet their needs. Exactly how the customer chooses to spend their personal budget was flexible and in their control and was documented in a support plan.

In order to fulfil the requirements of a SDS process, new documentation must be introduced; these documents would include:

- Individual Social Care Assessment
- A Resource Allocation System
- Support Plan
- Risk Policy

Individual Social Care Assessment (ICSA)

The ISCA is a needs based assessment tool which assesses eligibility under Fair Access to Care Services criteria.

To fulfil the duty to assess needs, the care manager will complete the ISCA with the customer. The document has been written in a way that ensures the customers needs, aspirations and desired outcomes were at the centre of the assessment.

The ISCA had been combined with the Resource Allocation System and therefore completion of the document allowed an indicative personal budget to be calculated. This was an indication of the level of resources a customer may need to live life as an equal citizen and achieve some or all of their personal outcomes which sit within the 'Outcomes for Adults' framework.

Resource Allocation System

The aim of a Resource Allocation System (RAS) and Allocation Framework was to provide a clear and rational way to calculate the level of resources an eligible person was likely to need to arrange support.

It was not the intention for the RAS to give a precise allocation of funding but rather to be a tool which is sufficient to produce a ballpark figure for the majority of users. The 'indicative allocation' calculated by the RAS can be adjusted up or down accordingly depending on individual circumstances.

The actual amount would not be agreed until a support plan that met the eligible social care needs was completed.

Support Plan

A customer's needs and the outcomes they wished to achieve were identified during the assessment process and recorded within the ISCA. The support plan would map how a person would meet their needs creatively to achieve their outcomes and who would support them in this. It would also identify how the person would manage their resources.

A support plan must be agreed and signed off by the care manager.

Risk Policy

The risk policy would highlight the arrangements that RMBC Adult Social

Care would put in place to address complex risk situations. The policy would include a risk assessment tool and the process for managing risk which involved criteria for referring cases to a Risk Enablement Panel.

The risk panel would exist to guide, advise and support individuals to minimise risks and manage complex risk situations; it would provide a forum where staff could share risk decision making. The panel would aim to seek positive solutions and outcomes for individuals and resolve issues regarding the sharing of risk between individuals. It would be responsible for providing a consistent approach to managing complex risk situations and to take the final decision on issues involving risk.
Safeguarding was a key element of personalisation, and the Risk Enablement Panel would have a key role in preventing abuse, and protecting vulnerable adults from abuse.

An implementation and monitoring plan to roll out the new documentation would be produced and agreed by the Self Directed Support and Personal Budgets group. The group proposed a planned roll out to avoid a negative impact on performance during a critical time of the year. Personalisation Champions within the Physical Disability Team and Sensory Impairment Team would be the first to use the documentation with new customers allocated to them as of 1st March 2010. As of 1st April 2010, the new documentation would be further rolled out to all teams within Assessment and Care Management including the Learning Disability Team.

The documentation, including the RAS would be monitored and reviewed regularly by the Self Directed Support and Personal Budgets group and appropriate amendments would be made.

Discussion ensued and the following points were raised:-

- Reference was made to the general information form at P18 of the report, which did not include information relating to retired people. It was confirmed that this questionnaire was purely to capture information relating to people in employment.
- Concerns were raised about the difference in the pound per point figure for older people and people with learning disabilities. A query was raised about how this would affect them when they reached the age of 65. Confirmation was given that these figures did not relate to benefits received but were in respect of their care package only.
- It was felt there was a need for ensuring safeguarding measures were in place to make sure that the money allocated was being used by the customer.
- Were safeguarding checks in place in respect of people receiving mobility allowances to ensure that the vehicle in question was being used by the customer and not their extended family? Confirmation was given that safeguarding measures were in place for this.

- At what point would existing customers be assessed for this new way of working? All customers would be assessed as part of the annual review of their package.
- If a large number of people decide that they want to provide their own care what impact would this have on spot contracts. It was confirmed that a new framework agreement was to be introduced which would put the onus of service providers to provide a service that our customers wanted.

Resolved:- (1) That the new SDS documentation and operating framework in which this sits be approved.

(2) That regular monthly updates be presented to the Cabinet Member.

H99. ADULT SERVICES REVENUE BUDGET MONITORING REPORT 2009/10

Mark Scarrott, Finance Manager (Adult Services), presented the submitted report which provided a financial forecast for the Adult Services Department within the Neighbourhoods and Adult Services Directorate to the end of March 2010 based on actual income and expenditure to the end of January 2010.

The approved net revenue budget for Adult Services for 2009/10 was £72.9m, which included additional funding for demographic and existing budget pressures together with a number of new investments and efficiency savings identified through the 2009/10 budget setting process.

The previous budget monitoring reports for Adult Services had identified underlying pressures of £2.3m. However after taking account of a number of identified savings and management actions achieved these pressures had reduced and there was a forecast overall net overspend of £42k by the end of the financial year.

The Directorate continued to review planned spend to identify any further potential opportunities to mitigate the remaining forecast overspend.

The latest year end forecast showed the main budget pressures in the following areas:-

- Home Care as a result of delays in shifting the balance of provision to the independent sector (+£623k). The 70/30 split was achieved at the end of July 2009 and the balance had now moved beyond 70/30.
- Increase in residential and nursing care short stays over and above approved budget for clients with a physical and sensory disability

(+£57k).

- Independent sector home care provision for Physical and Sensory Disability clients had increased by an additional 1110 hours since April 2009, a further 74 clients were now receiving a service. This was resulting in an overspend of £372k against the approved budget.
- A significant increase above approved budget in clients receiving a Direct Payment within Physical and Sensory Disabilities and Older Peoples Services (+£473k), reduced by Social Care Reform Grant Allocation of (-£100k).
- Additional one-off expenditure was being incurred in respect of the costs of boarding up, removal of utilities and security costs at the former residential care homes prior to them transferring to the Council's property bank (+£200k).
- Delays in the implementation of budget savings agreed as part of the budget setting process for 2009/10 in respect of meals on wheels (+£318k), laundry (+£160k) and the bathing service (+£40k).
- Increase in costs of Occupational Therapist contacts (+£120k).
- Continued pressure on the cost of day care transport provision for Learning Disability Day care clients reduced by planned delays in recruitment to vacant posts (+£49k).

However, the above pressures had been reduced by :-

- Additional income from continuing health care funding from NHS Rotherham (-£418k).
- Overall underspend within Learning Disabilities Supported Living schemes mainly due to planned delays in the implementation of new schemes (-£189k).
- Savings within independent residential care due to an increase in income from property charges (-£709k) and slippage in intermediate care spot beds (-£40k).
- Savings on the reconfiguration of Extra Care housing (-£340k).
- Planned delay in developing rehabilitation and supported living facilities for clients with a physical and sensory disability (-£157k) plus agreed delay in developing respite care provision (-£157k).
- Underspend within In house Transport Unit due to a reduction in vehicle leasing costs and additional income (-£150k).
- Slippage in recruitment to a number of new posts (-£76k) where additional funding was agreed within the 2009/10 budget process.

The Directorate continued to identify additional management actions to mitigate the outstanding budget pressures above. The majority (93%) of management actions had been achieved (£1.054m) and were included in the financial forecasts. These included additional savings on supported living, residential short stay placements, independent residential care

costs within Older People services and savings from the decommissioning of in-house residential care.

Members had requested that all future reports included details of expenditure on Agency and Consultancy. This report detailed the monthly spend on Agency for Adult Services. There was no expenditure on consultancy to date. Total Agency spend from April 2009 to January 2010 was £382,929.

Resolved:- That the latest financial projection against budget for the year based on actual income and expenditure to the end of January 2010 for Adult Services be noted.

H100. ADULT SERVICES CAPITAL MONITORING REPORT 2009/10

Mark Scarrott, Finance Manager (Adult Services) presented the submitted report which informed members of the anticipated outturn against the approved Adult Services capital programme for the 2009/10 financial year.

Actual expenditure to the mid February 2010 was £464k against a revised programme of £1.2m for 2009/10. The approved schemes were funded from a variety of different funding sources including, unsupported borrowing, allocations from the capital receipts, Supported Capital Expenditure and specific capital grant funding.

A brief summary of the latest position on the main projects within each client group was provided.

Older People

The two new residential care homes opened in February 2009. The balance of funding (£230k) related to landscaping costs, outstanding fees and the cost of any final minor works.

The Assistive Technology Grant (which included funding from NHS Rotherham) was being managed jointly and was being used to purchase Telehealth and Telecare equipment to enable people to live in their own homes. A procurement plan to spend the remaining NHSR funding was currently being finalised and woud now be procured in 2010/11. The RMBC funding was approved and included the purchase of lifeline connect alarms, low temperature sensors and fall detectors within peoples homes.

A small element of the Department of Health specific grant (£13.5k) issued in 2007/08 to improve the environment within residential care provision was carried forward into 2009/10. The remaining balance of funding was being spent within in-house residential care services.

Learning Disabilities

The small balances of funding (£10k) carried forward from 2008/09 were to be used for the purchase of equipment for Parkhill Lodge and within existing supported living schemes.

The refurbishment at Addison Day Centre (Phase 2) was now complete and awaiting final invoices.

Work had now started on the refurbishment of the respite centre at Treefields funded from the Councils Strategic Maintenance Investments fund and would be completed in early May 2010.

Mental Health

A small balance remained on the Cedar House capital budget and would be used for the purchase of additional equipment.

A large proportion of the Supported Capital Expenditure (SCE) allocation had been carried forward from previous years due to difficulties in finding suitable accommodation for the development of supported living schemes.

Suitable properties continued to be identified and spending plans were being developed jointly with RDASH. The possibility of funding equipment purchased for direct payments was also being considered to reduce the current pressures on the mental health revenue budgets. Further options were also being considered to provide more intensive supported living schemes with a range of providers and to fund a range of new assistive technologies for mental health clients, which would support their independence with access to 24 hour support.

Management Information

The balance of the capital grant allocation (£85k) for Adult Social Care IT infrastructure was carried forward from 2008-09 and used with this years grant allocation (£92k) to fund the Adults Integrated Solution as part of introducing electronic care management. The integrated solution would be fully completed by the end of March. The next stage of developing the IT infrastructure to improve systems and data quality was currently being discussed and the balance of funding would be carried forward into 2010-11.

Resolved:- That the Adult Services forecast capital outturn for 2009/10 be received and noted.

THE CHAIRMAN AUTHORISED CONSIDERATION OF THE FOLLOWING ITEM TO KEEP MEMBERS INFORMED.

H101. CQC INSPECTION

Shona McFarlane, Director of Health and Wellbeing updated members on the inspection which had taken place on Monday 8th March 2010.

She reported that a powerpoint presentation had been given to the officers from the CQC which drew specific attention to the improvements made:-

- Raising awareness of issues of potential abuse. Campaigns had targeted people from the BME community and the Lesbian, Gay and Bisexual community. As a result of work in this area awareness had increased by 19%.
- Safeguarding
    - Multi agency plan in place
    - Learning Disabilities and Mental Health customers now mainstream – report on Swift system
- Quality audit on 5 care homes
- Quality Assurance
    - Case file Audits in place
    - Supervision Orders
- Training – Unqualified Social Workers were undertaking training they didn't need to – now only doing first two sets
- Expanding work around physical disabilities
- Improved support for carers
    - Dedicated resources
    - New Carers Cente
    - Crossroads – new service
- Workforce Strategy in place
- Supervision Policy – more effective
- Updates on Personalisation

She confirmed that the inspection was well received and the CQC would continue to monitor progress. A further inspection would take place in July 2010.