Rotherham Metropolitan Borough Council

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

Report of the Health Select Commission

February 2012

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1. EXECUTIVE SUMMARY

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

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

The objectives of stage two were:

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

1.1 Summary of Review Scope

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

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

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

1.2 Summary of Key Findings

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

The key findings from the review are summarised below:

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

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

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

1.3 Summary of Recommendations

Recommendations were developed around three main themes:

1) Service Improvement

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

2) Securing Commitment

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

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

3) Prevention

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

2. BACKGROUND TO REVIEW

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

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

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

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

The objectives of stage two were:

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

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

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

3. METHODOLOGY

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

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

3.1 Stage 1 - Shortlisting topics

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

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

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

3.2 Stage 2 – Prioritisation

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

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

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

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

3.3 Stage 3 – Stakeholder engagement

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

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

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

3.3.1 Wider Determinants of Health Wheel

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.4.1 Scope of Review

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

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

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

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

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

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

3.4.2 Key Lines of Inquiry

Professionals

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

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

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

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

Individuals

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

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

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

4. FINDINGS

4.1 Obesity data and information

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

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

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

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

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

4.2.1 Yorkshire Ambulance Service bariatric capacity and data

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

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

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

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

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

YAS also highlighted that at times there may be 4-6 frontline and Patient Transport Service vehicles in attendance at one patient. This had huge implications for the service, not only in terms of cost for attendance to the patient, but also in relation to the resources being taken up which impacted on the next 999 call.

Responding to people who may have had a fall, but with no injuries, was also an issue being looked at by YAS. Often ambulances were called out to help lift a patient if they had fallen but if they did not need medical care, which could use vital resources. YAS have been working with PCTs, councils and provider services in relation to patient responses in this instance, as often patients need specialist equipment and carers to help prevent falls in the first place. Linking fall prevention with this patient group could help free up critical ambulance and fire service responses.

4.2.2 South Yorkshire Fire and Rescue

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

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

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

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

4.3 Findings from Questionnaires and Interviews

4.3.1 Professionals

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

Highlighted issues:

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

Potential solutions:

- One point of contact/designated post to coordinate the management/care of patients to enable a personalised service
- Improved IT/Database of information which could be shared across organisations
- Obtaining consent from patients/individuals by use of a tick –box form could enable data sharing and a form has been produced in the past which has been used previously, but unsure as to whether this is still in use or being managed
- Dedicated unit to bridge the gap between hospital and home
- Early intervention, support and guidance

- Improved preventative care with pre-alerts to health carers
- Better coordination and continuity of services
- Drawing on experience from the 'Every Contact Counts' and 'Hotspots' initiatives, which ensures that whoever goes into see an individual shares the information where it is needed
- Ensuring information is available to all professionals to show who/which services should be contacted in certain situations, as well as to show what is available
- If a social care workers assessed an individual and their needs were in relation to their weight and mobility issues associated with that, then recording and sharing this information with emergency services could assist organisations in emergency situations, which does not currently happen as a matter of course
- Ensuring the relevant people were aware of groups/meetings to ensure multi-agency involvement
- Developing an appropriate care pathway for this group, to ensure they receive the right care and support when needed
- A data sharing protocol (agreed between all organisations), specific to this group would ensure information is shared respectfully and confidentially between organisations

Other issues discussed

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

4.3.2 Individuals

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

- Interviewees' experiences of accessing care services was generally positive
- Having appropriate equipment in a person's home, such as a hoists, specialist beds, slide sheets and hand/support rails, are essential for promoting independence and quality of life
- Simple things such as easy access to a telephone are hugely important when a person is not very mobile, so that they are able to contact services/support when needed
- Other adaptations are also a huge benefit, such as having French doors fitted to enable easy access in and out of the house (due to larger wheelchairs etc), which is also a benefit to emergency services (ambulance/fire services)
- Pressure areas were suggested as more of a problem to one individual following a stay in hospital

- Being unable to get out of the house unaided hugely affects quality of life; always relying on assistance of other people getting into a wheelchair or out of the house for example meant everything has to be arranged in advance, leaving individuals isolated at times and unable to be "spontaneous"
- Getting out and about if they wished to was suggested as difficult due to cost of transport and leisure activities, although one had received support from RIO, they felt that if they didn't lose weight they would be "knocked" off the course

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

5. RECOMMENDATIONS

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

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

5.1 Recommendation 1) Service Improvement

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

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

This group would be asked to consider the following sub-recommendations:
a) To develop a one-page tick-box form to obtain consent from individuals to share information and ensure professionals received appropriate training on how to use this, and to consider issues in relation to the various organisations' IT systems that do not 'talk' to each other and ways to deal with this.
b) To develop protocols for joint working and local data-sharing specific to this group of people.
c) To consider options for centrally coordinating this agenda, either through an appropriate central coordinator post or central database/ or way of sharing information
d) To look at options for providing briefings for professionals to raise awareness of the range of services available locally for this target group of people

5.2 Recommendation 2) Securing Commitment

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

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

5.3 Recommendation 3) Prevention

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

6. RETURN ON INVESTMENT

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

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

Recommendation 1. Service Improvement	**Potential Impacts/Benefits/Savings**
a) Develop a one-page tick-box form to obtain consent from individuals to share information	• organisational benefits/savings from better co-ordination using a paper form-based system plus a co-funded co-ordinator • savings from single rather than multiple assessments
b) Develop protocols for joint working and local data-sharing specific to this group of people.	• New /improved range of inter-agency contacts and ways of working • Greater awareness of issue at agency level • Multi-agency influence on budgets and workplans/priorities, resulting in efficiency savings

c) Consider options for centrally coordinating this agenda, either through an appropriate central coordinator post or central database/ or way of sharing information	• Improved service user experience and dignity through having a single point of contact • Better coordination of services by having a single contact to ensure continued joint working and savings from duplicated and/or inappropriate deployment of services
d) Briefings for professionals to raise awareness of the range of services available locally for this target group of people	• Improved quality of life score for individuals, through being supported to access more services available to them

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

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

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

7. REFLECTION ON REVIEW MODEL

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

7.1 What went well?

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

7.2 What could have gone better?

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

7.3 Learning from this review

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

The review model tested by this scrutiny review has also been acknowledged by the members as good practice for future reviews of a similar nature. The members of the review-group have suggested that various elements of the model could be used as and when it makes sense to use them and where they may add value, such as prioritising topics, impact statements and holding a stakeholder session.

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

8. THANKS

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

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

9. CONTACT

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Appendix A – Impact Statement

Issue 1. Obesity – BMI >50

Questions to consider:

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

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

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

Appendix B – Scoring Matrix

Impact considerations for each topic shortlisted

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

Appendix C – Transcripts from interviews with individuals in the community

I = Interviewer
P = Participant

Interview 1

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

Interview 2

Individual weighed 26 stone previously and has since lost weight to around 20 stone.

I. What would improve your quality of life?
P. When I was heavier I lived in a house with no gas central heating, no rail on toilet or bath. Now I live here, rail by toilet and 2 on bath and an electric shower over bath. I struggle to get in and out of bath, but I can hold onto sink to steady myself, I used to have a strip wash instead. I used to get stuck in the bath. I had a fall at the old house, because there was a steep step to get in the front door.

I. What is your experience of accessing health/social care services?
P. I had to have an op. It was quite scary, they seem to feel that it was your fault you were fat, as if you were a burden or something. The medical area they have is great, staff are nice. There is a lift if you can't manage the stairs.

I was referred to RIO from diabetes nurse; first 3 or 4 months were quite helpful. I accessed a cooking course and a gym pass after that they just weigh you and if you don't lose weight they knock you off the course. They give you loads of leaflets but if you can't read very good it's not helpful. I lost 1.5 stone with RIO, but managed 4 stone by myself.

I. What would improve your access to care?
P. When I had my fall I just said to myself, I absolutely hate hospitals. I have a complete fear of dentists. I would go if I had no choice, but if I can see to myself I wouldn't bother.

I. What would improve your quality of life?
P. I didn't want to go out because people look at you and [I] think things are expensive like buses. Now I've got a bus pass. The kids used to go to the shops for me, but it was expensive if I didn't get to choose food, now I am more motivated. I would like to go to the leisure centre but it costs £30 a month, so it's expensive.

I wanted to have stomach bypass, but I was talked out of it, they [RIO] said the more you lose, you can do it yourself.

I felt at 26 stone I was on death row. I couldn't get past the gate, I was breathless. Now I just keep going steady and manage the pain.

It's my fault I'm like I am, so I didn't want to access the doctors, because there are people more poorly than me, but I want to do it quickly so I can play with my 8 year old.

Appendix D RECOMMENDATIONS

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

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

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