HEALTH SELECT COMMISSION

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

Date: **Friday, 1st February, 2013**

Time: **1.00 p.m.**

A G E N D A

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

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

3. Apologies for Absence

4. Declarations of Interest

5. Questions from members of the public and the press

6. Communications

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

8. Health and Wellbeing Board (Pages 8 - 14)

    - Minutes of meeting held on 16th January, 2013

9. Health and Wellbeing Policy and Organisational Changes (Pages 15 - 21)
   – report and presentation by Councillor Wyatt, Cabinet Member for Health and Wellbeing

10. "Taking on Inequalities in Health and Wellbeing Locally. How Health and Wellbeing Boards can lead the way" (Pages 22 - 31)
    – Conference held in Leeds on 17th January 2013
    report back from Councillor Hoddinott

11. Regional Health Scrutiny
    - presentation by Cath Saltis

12. Update on work programme – Access to Healthcare Services

13. Date and time of the next meeting: -

- Thursday, 7th March, 2013, to start at 9.30 a.m. in the Rotherham Town Hall.

HEALTH SELECT COMMISSION
6th December, 2012

Present:- Councillor Steele (in the Chair); Councillors Beaumont, Beck, Goulty, Hoddinott, Middleton and Wootton, Vicky Farnsworth (Speak Up) and Robert Parkin (Speak Up).

Apologies for absence were received from Councillors Barron, Dalton, Roche and Peter Scholey.

38. DECLARATIONS OF INTEREST

There were no declarations of interest made at the meeting.

39. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

40. COMMUNICATIONS

Childhood Obesity
Deborah Fellowes, Scrutiny Manager, reported that the Select Commission had received a request from the Self Regulation Select Commission to look at Childhood Obesity.

The Select Commission had received a Corporate Plan Outcomes report which focussed specifically on the issue and, despite work across all agencies, remained on a red indicator. The Health Select Commission had been requested to consider the Service recommendations together with the relevant Cabinet Member at the appropriate point in time.

Resolved:- That a Working Group consisting of Councillors Beaumont, Beck, Hoddinott and Steel meet to consider the Service recommendations.

Environment and Climate Change Strategy Group
Resolved:- That Councillor Beck represent the Health Select Commission on the above Group.

41. MINUTES OF PREVIOUS MEETING

Consideration was given to the minutes of the previous meeting of the Health Select Commission held on 25th October, 2012.

It was noted that a response had been submitted with regard to the Government Consultation – Water Fluoridation Schemes (Minute No. 35 refers).

Resolved:- That the minutes of the previous meeting be agreed as a correct record for signature by the Chairman.

42. HEALTH AND WELLBEING BOARD

Consideration was given to the minutes of the meeting of the Health and Wellbeing Board held on 31st October, 2012.

Resolved:- That the minutes of the Health and Wellbeing Board meeting be noted.

43. ROTHERHAM FOUNDATION TRUST

Rotherham Foundation Trust

Matthew Lowry, Acting Chief Executive, Rotherham Foundation Trust, attended the meeting to discuss the recent press headlines with regard to potential job losses at Rotherham District General Hospital.

The scale of the financial challenge faced by the Foundation Trust was driven by 2 factors; an assumption made nationally that the contracts the Trust was commissioned for would make an efficiency saving each year of 5% and secondly (2) an agreed Strategy with commissioners, particularly with the NHSR and the emerging CCG, that it needed to shift the balance away from the hospital. A combination of the 2 was creating a sizeable financial challenge for the Trust.

The hospital had to save £50M over 4 years and were nearing the end of the second year; to date, £20M of savings had been made. Currently plans were being drawn up and as yet no formal announcement had been made with regard to redundancies. The Trust was working very closely with the staff side and Trades Union and expected to start the formal consultation process with staff on 14th December, 2012 as to how to try and make savings within the organisation for 2013/14.

There were a number of areas where the Trust did less work and, therefore, needed to reduce its capacity to reflect that situation as well as commissioners commissioning less work. It was also important to recognise that where savings were sought, it was based upon very detailed and focussed work within the organisation and balanced between the need to make savings whilst maintaining the quality of service. Discussions with commissioners were imperative for their help and support to manage transition from the historical model health care and the model service moving forward.

Discussion ensued with the following issues raised:-

- The efficiency savings of 5% was a national position and would be a challenge. In terms of the further savings, some were unique to Rotherham. Rotherham was at the upper end of the reliance on bed care and the town's historical model of care was admission to hospital. There was now an opportunity to make the transition with the help of the commissioners

- It was hoped that the vast majority of the £3-4M services leaving the hospital would transfer into funding for services in the community – negotiations were currently underway. As a minimum it would be expected

to be £1-2M. The Trust was pressing very hard to invest as much in the community as possible which would enable the pace of change. There was a need to move services away from the hospital to the most appropriate setting

- It would be a decision for the local Clinical Commissioning Group

- Services potentially moving from the hospital included a number of out patient services and tests that could be conducted in GP surgeries or by Community Nursing staff in the patient's own home

- There were a number of long term conditions where patients repeatedly went to hospital. This was an opportunity for work to take place with the patient in their own homes/GP practice and provide the same level of care but would be more convenient for them

- There were a number of discreet services where consideration would be given to outsourcing i.e. non-clinical back office services. The best use of resources available to the Trust had to be found

- 3 issues had to be balanced – control, quality and value for money – all really important and each had to be taken into consideration for every individual service

- There was no intention to outsource cleaning and the laundry service

- Close work was taking place with the Trust's main commissioners i.e. NHS Rotherham and the Clinical Commissioning Group to identify what services the hospital provided and what it could safely cease. A good example was the 25,000 follow up outpatient appointments that could be done differently or not at all.

- Work with hospital clinicians to identify things that could be safely done in a Primary Care setting

- The level of reliance upon urgent care in Rotherham was high compared to other areas of the country

- The vast majority of the costs for Electronic Patient Records had been 1 off Capital. There were some licence costs for the software but that had also applied for the range of different softwares previously operated. It was recognised that there had been issues with the new system which had been made a priority for resolution

- A proportion of the savings would come from Management and Administration (10%) but it should also be noted that it was also expected to make savings across the entire organisation including medics and nursing staff. Where savings to front line services were made, it would be as a result almost entirely of the Trust doing less work e.g. follow up outpatient care

– The Trust had engaged external expertise to help with the 2013/14 plan

– The future of the Walk in Centre was a matter for the Clinical Commissioning Group

The Chairman thanked Matthew for attending the meeting.

Resolved:- (1) That the Acting Chief Executive attend a future meeting of the Select Commission once it had been agreed which services would be transferring into the community.

(2) That a letter be sent to the Clinical Commissioning Group enquiring what funding would be transferred from the Hospital into the community.

Quality Accounts

Dr. Patricia Bain reported that previously annual progress reports had been given to the Select Commission and its predecessor prior to decision making as to which quality improvement programmes the Trust should include in the following year's Programme. It had been decided that progress should now be reported bi-annually and in time to fully consider the Programmes of work, their current status and what Programmes the Commission would consider for inclusion in the 2013/14 Quality Accounts.

Good progress had been made in meetings the targets for 2012/13 and the Trust was confident that they would all be achieved by March, 2013. She particularly highlighted:-

Quality at a Glance Measures
– Q1 reflected 1 MRSA bacteraemia – agreed to be community acquired
– Rate of patient safety incidents per 1,000 admissions had increased although the % where serious harm was caused had decreased
– Nutrition assessment performance dropped below baseline whilst completion/calculation of fluid balance charts had increased
– SHMI (CHKS Live – in hospital deaths only) had increased slightly
– Overall IR1 - reporting was down although still likely to exceed the target of increased reporting year on year if volumes continued at the present rate

Improvement Programmes
– Medications Management had improved on 2nd audit with only 2 areas not reflecting improvement
– Safety Thermometer data submissions reflected on the Trust intranet
– Liverpool Care Pathway metrics reflected an improvement
– Dementia CQUIN due to commence data capture in Q3

CQUINS and Mandated National Quality Board Indicators
– Safety Thermometer monthly data submissions had been successful so far
– Slight improvement for inpatient CQUIN and Community Universal Services template
– Performance against the relevant domains of Indicators, selected by the National Quality Board, was generally on par or exceeding National Peer performance

- Hip surgery Patient Reported Outcomes Measures slightly below national average
- C.Difficile rates – strong performance
- Reporting of patient incidents per 100 admissions had increased but below the national average

Internal and National Benchmarking – Safety Thermometer

- Falls performance internally good with only Urology falling below 95% no harm target
- Community North Team the only team not to achieve the 95% target in relation to pressure ulcers
- Several locations within Acute and Community had not achieved targets in relation to Urinary Tract Infections
- Falls resulting in harm also performed strongly against national and SHA cluster peers

- Overall Harm Free Care – slightly behind national and SHA cluster peers

Discussion ensued on the report with the following issues raised:-

- Better position than last year – important to maintain the improvements during the period of change

- The number of pharmacy staff had been increased on the Ward

- Care Pathways – a common complaint was when someone did not fit into a certain Pathway and could be waiting some time for a diagnosis

- The Trust was moving to provide a diagnostic 7 days service rather than the current 5 days. It would not only apply to tests but also have experienced decision makers being on the Wards for longer periods Monday-Friday and consultants available at weekends as well

- Staff training

Dr. Bain requested that the Select Commission consider where it would wish to see the focus next year.

Resolved:- (2) That the Select Commission consider where it would wish to see the Trust focus it works in 2013/14.

44. UPDATE ON HEALTH SELECT COMMISSION REVIEWS

The Chair and Deborah Fellowes, Scrutiny Manager, provided updates on the 2 Scrutiny Reviews that were currently taking place.

The Residential Scrutiny Review Group had 1 more scheduled meeting to take place before it commenced formulating its findings and recommendations. It was anticipated that a final report would be submitted to the Commission shortly.

The Autistic Spectrum Disorder Review Group had completed all its scheduled meetings which had included visits to both Aughton Early Years and Winterhill School. It was anticipated that the Review would be completed in the New Year with a report to the Commission shortly after.

Resolved:- That the programme and timescales of the 2 Reviews be noted.

45. WORK PROGRAMME - UPDATE

Deborah Fellowes, Scrutiny Manager, gave a verbal update on 2 issues that would be the Select Commission's next areas of focus e.g. discharge arrangements from hospital and access to healthcare, both of which had been raised at Minute No. 43.

It was the intention to commence the work early in the New Year once the previous 2 reviews were complete.

The Chairman reported that he had requested that the Select Commission be fully involved in the CCG's intention with regard to the future of the Walk in Centre before consultation commenced. It was suggested that a representative of the CCG be invited to the January meeting to discuss their proposals as well as the new 111 service.

Resolved:- That a representative of the CCG be invited to the January meeting to inform the Select Commission their proposals with regard to the Walk in Centre.

46. REVIEW OF CHILDREN'S CONGENITAL CARDIAC SERVICES IN ENGLAND: UPDATE

Councillor Ali reported that the Joint Health Overview and Scrutiny Committee had referred the Joint Committee of Primary Care Trust's (JCPCT) decision with regards to Review of Children's Congenital Cardiac Services in England to the Secretary of State for Health.

The Joint Health Overview and Scrutiny Committee had referred the decision on the basis that it was not in the best interest of local health services across Yorkshire and the Humber nor the children and families they served. The referral was made in accordance with the provisions set out in the Health and Social Care Act (2001) (as amended) and the associated Regulations (specifically Regulation 4(7)) and current Department of Health Guidance.

Their conclusions were:-

- The range of interdependent surgical services, maternity and neonatal services were not co-located at proposed alternative surgical centres available to Yorkshire and the Humber children and their families
- The dismantling of the already well established and very strong cardiac network across Yorkshire and the Humber – and the implications for patients with the proposed Cardiology Centre at Leeds essentially working across multiple networks
- The current seamless transition between cardiac services for children and adults across Yorkshire and the Humber

- Considerable additional journey times and travel costs – alongside associated increased accommodation, childcare and living expense costs and increased stress and strain on family life at an already stressful and difficult time
- The implications of patient choice and the subsequent patient flows resulting in too onerous caseloads in some surgical centres with other centres unable to achieve the stated minimum number of 400 surgical procedures

Throughout the process, concerns had been expressed about the availability and timeliness of information and the lack of transparency about the decision making process. The Joint Committee had reported it had not been able to consider all the information identified as being necessary to conclude its review and that all Joint Committee members felt that they had been unreasonably denied access to non-confidential information believed to be relevant to the review and the associated decision making processes. A complaint had been lodged with the Information Commissioner's Office regarding the lack of disclosure.

Along with the Joint Committee (Yorkshire and Humber), a number of other Health and Overview Committees had subsequently referred the decision to the Secretary of State for Health. On the basis of the referrals, the Secretary of State had asked for the Independent Review Panel to examine the Joint Committee of Primary Care Trust's decision making process.

Following the Joint Committee's decision, a legal challenge was initiated by the Children's Heart Surgery Fund (now being taken forward by Save Our Surgery (SOS) Ltd.). The legal challenge was based on the premise that the decision making process was inconsistent and flawed. The hearing of the Judicial Review was deferred pending the outcome of the Independent Review Panel.

Resolved:- (1) That the report and referral of the Joint Committee of Primary Care Trust's decision by the Joint Health Overview and Scrutiny Committee to the Secretary of State for Health be noted.

(2) That the Select Commission make a submission to the Independent Review Panel outlining its concerns about the review process.

47. DATE AND TIME OF THE NEXT MEETING: -

Resolved:- That a further meeting be held on Thursday, 24th January, 2013, commencing at 9.30 a.m.

HEALTH AND WELLBEING BOARD
Wednesday, 16th January, 2013

Present:-
Members:-

Councillor Ken Wyatt	Cabinet Member, Health and Wellbeing **(in the Chair)**
Karl Battersby	Strategic Director, Environment and Development Services
Tracy Clarke	RDaSH
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Councillor John Doyle	Cabinet Member, Adult Social Care
Chris Edwards	Chief Operating Officer, Clinical Commissioning Group/NHS Rotherham
Councillor Paul Lakin	Cabinet Member, Children, Young People and Families
Shona McFarlane	Director of Health and Wellbeing
Dr. David Polkinghorn	Rotherham Clinical Commissioning Group
Clare Pyper	Children, Young People and Families, RMBC
Dr. John Radford	Director of Public Health
Dr. David Tooth	Rotherham Clinical Commissioning Group
Janet Wheatley	Voluntary Action Rotherham

Officers:-

Kate Green	Policy Officer, RMBC
Tracy Holmes	Communications, RMBC
Fiona Topliss	Communications, NHS Rotherham

Also present:-

Anne Charlesworth	Partnership Lead, Public Health
Gordon Laidlaw	Rotherham NHS

Apologies for absence were received from Chris Boswell, Phil Foster, Martin Kimber, Matthew Lowry and Joyce Thacker.

S54. MINUTES OF PREVIOUS MEETING AND MATTERS ARISING

Resolved:- (1) That the minutes be approved as a true record subject to the following clerical correction:-

S48 (Health and Wellbeing Performance Management Framework) Resolved:- That each meeting of the Health and Wellbeing Board consider two Priority themes (Smoking, Alcohol, Obesity, Dementia, NEETS and Fuel Poverty), with the Priority theme's Lead Officer invited to attend the relevant meeting.

Arising from Minute No. S49 (Overarching Information Sharing Protocol), discussion ensued on how the matter was to be progressed.

Resolved:- (2) That each Board member ensure their organisation had signed off the Protocol and report accordingly to the next Board meeting.

(3) That the Overarching Information Sharing Protocol be submitted to the Cabinet for approval.

Arising from Minute No. 53 (Unscheduled Care Review), it was noted that arrangements had been made for an Elected Member Seminar to be held on

13th February, 2013.

S55. COMMUNICATIONS

(a) Challenge on Dementia/Dementia Strategy
The Board noted a letter that had been sent to Chairs of Health and Wellbeing Boards from the co-Chairs of the Health and Care Sub-Group requesting commitment to the Dementia Challenge and assistance in taking the agenda forward.

Dementia was 1 of the Board's Priorities in its Health and Wellbeing Strategy.

Central Government had announced that Clinical Commissioning Groups had to have a Dementia Strategy and included on its website. Due to the timescale given, there had been insufficient time to co-ordinate across the health and social care community. A draft Strategy had been published on the CCG website by 31st December, 2012, in line with the Yorkshire and Humber Strategic Health Authority requirement.

(b) Friends and Family Test
The Board noted the forthcoming mandatory 'Friends and Family' Test and Rotherham Foundation Trust's implementation plans to achieve full coverage of prescribed areas. From April, 2013, a short survey had to be completed upon a patient's discharge, or within 48 hours of discharge, to ascertain their rating of care about the Ward/Department they had spent the most time in. The Trust would be required to submit data returns which would be published nationally.

The report set out the actions the Trust would undertake to fulfill this requirement.

(c) Conference
'Tackling Health Inequalities in the North' – 8th March, 2013 – Durham
Details of the above conference were submitted for the information of the Board.

(d) ROSPA Big Book of Accident Prevention
Copies of the above were circulated to Board Members.

(e) Local Medical Committee
The Chair reported receipt of a request from Dr. Thorman, Secretary of the Local Medical Committee, seeking representation on the Board.

Discussion ensued on the request. It was felt that there was GP representation on the Board through the CCG which could reflect General Practices' views and beliefs. It was a public meeting that was open to members of the public to attend and observe if they so wished.

Resolved:- (1) That Dr. Thorman be thanked for his interest in the Board but the request for representation be declined at the present time.

(2) That a copy of the Board minutes be supplied for information.

(Dr. Tooth declared an interest in the above and did not take part in the

discussion.)

S56. ROTHERHAM CLINICAL COMMISSIONING GROUP ANNUAL COMMISSIONING PLAN

Dr. Tooth presented the draft CCG Annual Commissioning Plan which it was required to formally submit to the NHS Commissioning Board Area Team by 25th January, 2013. The core aim was to ensure that the needs of the citizens of Rotherham, as set out in the Joint Strategic Needs Assessment and reflected in the Health and Wellbeing Strategy, were captured.

Unfortunately, due to the timescale for submission it had not been possible to include any Public Health, Council etc. commissioning proposals as the timelines had not corresponded.

It was queried whether it would be possible for the Council and Public Health commissioning proposals to be submitted to the Board before the end of March to ensure alignment with the Health and Wellbeing Strategy?

The Council had to formally set its budget first but work was well advanced on its commissioning intentions to which Public Health would now be added. There was a opportunity to identify areas where it was possible to pool budgets for better value for money or more consistent outcomes delivered by commissioning more intelligently.

It was noted that a number of agencies had already submitted their feedback on the document.

Resolved:- That the Rotherham Clinical Commissioning Group Annual Commissioning Plan be endorsed for submission to the NHS Commissioning Board Area Team.

S57. PERFORMANCE MANAGEMENT FRAMEWORK

Further to Minute No. 48 of the previous meeting, John Radford, Director of Public Health, reported that it had been hoped to submit a suite of Indicators for consideration to the meeting, however, it had proved to be more difficult than envisaged. He gave the following presentation:-

System Change

- System accountability
- Local delivery prevention interventions
- NHS, RMBC, Commissioning Board and CCG
- Engagement private and third sector
- Public engagement
- Resources
- Service Activity
- Behaviour Change
- Mortality
- Commissioning for outcomes
- Profile \ media \ social media
- Disease Information

Outcomes Framework Annual Reporting
- Local Priorities agreed by Board.
- Align with Outcome Frameworks
- Need to agree specific outcomes for each priority
- Identify specific outcome measures that will progress over time
- Board to review its progress

Local Priorities
- Need to identify local (outputs) measures that help monitor progress bi-monthly throughout 3 year period of the strategy
- Report back next time with proposed outcome and output measures

The Board then received Anne Charlesworth's presentation (see Minute No. 58 Priority Measure: Alcohol) and discussion on the possible Performance Indicators for that Priority.

Discussion ensued on the way forward for all 6 Priority Themes:-

- The Board had agreed 6 Priorities that would make the biggest difference to the health and wellbeing of Rotherham citizens and reduce health inequalities
- Definition of the desired outcomes for each Priority required
- Need to decide where to focus activity and then outcome measures and outputs would follow
- Better definition of what want to achieve
- Engagement and commitment from all partners to drive the agenda within their Services

Resolved:- That each of the 6 Priority Leads submit a suite of Indictors for their respective Priority Theme to the next Board meeting.

S58. PRIORITY MEASURE: ALCOHOL

Anne Charlesworth, Partnership Lead, Public Health, gave the following presentation on the Alcohol Priority:-

The Vision
- 1 in 4 of Rotherham's adults drink above recommended safe levels
- To challenge the culture of binge drinking
- To deliver the messages about risks to those adults who drink at risky levels

Rotherham Adult Population
- Drinking above low risk levels 26.2% (51,569)
- Drinking at harmful levels 5.3% (10,432)
- Depend upon alcohol 3.6% (7,068)

National Strategy
- Change behaviour so people think it was not acceptable to drink in ways that cause themselves or others harm
- Reduce alcohol-fuelled violent crime

- Reduce the number of adults drinking above NHS guidelines
- Reduce the number of people binge drinking
- Reduce the number of alcohol related deaths
- Sustain reduction in both the numbers of 11-15 year olds drinking and the amounts they consume

Local Strategy

- Programme of alcohol social marketing interventions using the 'single message' including E-learning packages and workplace interventions
- Trialling Community Alcohol Partnerships
- Identification of premises which cause problems and taking effective partnership action
- Identifying individuals who cause repeated issues e.g. using Fixed Penalty Notices to attend alcohol awareness

Treatment System Priorities

- To increase numbers seen in primary and secondary care by:-
  Increased screening in GP practices – now also in Health Check
  Re-commission Tier 2 provision and include more work on population awareness, screening and workplace initiatives
  Gaps in provision against NICE Guidance
  Keeping waiting times low
  Payments by Results – Rotherham was 1 of only 4 pilots

Alcohol-related Hospital Admissions

- 53,689 alcohol-related hospital admissions – significantly higher than the national average. Between 2010-11 and 2011-12 Rotherham's rate had increased
- 28,827A&E – the relative position in terms of all 326 local authorities had remained the same (in the highest 25% of rates)
- 6,587 In-patients – Mortality from chronic liver disease – Rotherham's rate was similar to England (not statistically different)
- 18,257 Out-patients – In 2010-11 Rotherham's rate was lower than England but increase in 2011-12 and was now higher than England (but still similar). Rotherham ranked in the highest 50-70% of all local authorities (Quartile 3)

Hospital

- Hospital-based services – one of the Department of Health 'hi impact changes'
- Already have an A&E pathway targeting young people
- 1 specialist nurse working on admissions
- Work with Ambulance Service and RFT on 'frequent flyers' and high volume users of hospital front line services. Some were already known to services but not all
- Protocol which allowed those detoxing to be discharged early to their GP
- CCG proposing to invest in a new Service.

Opportunities

- Every organisation had to recognise the costs of alcohol and contribute to prevention

- The Public Health budget may offer opportunities to increase prevention – there had been no budget for this in the past
- How was each organisation addressing the issues through the themes:-
  Prevention and Early Intervention
  Expectations and Aspirations
  Dependence to Independence
  Healthy Lifestyles
  Long Term Conditions
  Poverty

Discussion ensued on possible outcomes that could be measured including:-

- Number of parents who children were included on the Child Protection Register/come into care due to alcohol related conditions
- Danger that the specialist treatment services would not be able to cope with the increased referrals
- Indicators important in terms of how Services were delivered
- Measure self-harm, behaviour in Town Centre, effect of families by domestic violence
- Every patient use Audit Check

The Board discussed this item and the previous item together. Please see Minute No. S57).

S59. EXCLUSION OF THE PRESS AND PUBLIC

Resolved: - That, under Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt information as defined in Paragraph 3 of Part I of Schedule 12A to the Local Government Act 1972 (as amended 2006 – information relates to finance and business affairs).

S60. ROTHERHAM HEALTH WATCH

Clare Burton, Operational Commissioner, presented an update on the recent OJEU tender process for Healthwatch Rotherham.

A preferred provider was not appointed as there had been no bids of sufficient quality to move to the awarding of a contract. A proposed way forward was set out in the report submitted to ensure that there was a Healthwatch Rotherham in place by the 1st April, 2013.

Resolved:- (1) That the outcome of the OJEU tender process be noted.

(2) That the proposal to re-tender the Service, as set out in the report submitted, be approved.

(3) That further progress reports be submitted in due course.

(Janet Wheatley and Gordon Laidlaw disclosed disclosable pecuniary interests in the above item and withdrew from the meeting.)

S61. DATE OF NEXT MEETING

Resolved:- That a further meeting of the Health and Wellbeing Board be held on Wednesday, 27th February, 2013, commencing at 1.00 p.m. in the Rotherham Town Hall,

ROTHERHAM BOROUGH COUNCIL - REPORT TO MEMBERS

1	**Meeting:**	**Health Select Commission**
2	**Date:**	**1 February 2013**
3	**Title:**	**Update on health and wellbeing policy and organisational changes**
4	**Directorate:**	**Resources**

5. Summary

Rotherham is making excellent progress in meeting the requirements and organisational changes set out in the Health and Social Care Act 2012.

The local Health and Wellbeing Board has been in operation for over 12 months and has been observed by the Department of Health, with positive feedback received. The local Clinical Commissioning Group has received authorisation to begin operating their statutory responsibilities from April 2013 and the development of the local Health and Wellbeing Strategy has demonstrated strong partnership working and collaboration between all health and wellbeing partners.

This report summarises the national policy drivers and how Rotherham is implementing the required changes, demonstrating the enthusiasm locally to work together to drive change and improve the health and wellbeing of Rotherham people.

6. Recommendations

For the Health Select Commission:

- **To note the policy and organisational changes being implemented nationally and locally**

- **To consider how the local health scrutiny function can support implementation of the changes; ensuring all health and wellbeing partners are delivering the best possible outcomes for local people**

7. Proposals and details

7.1 National policy context and organisational developments

The government's agenda for change in relation to health and wellbeing was set out in the Health and Social Care (HSC) Act 2012, which puts clinicians at the centre of commissioning and gives new focus to patient and public involvement, public health and the local authority.

The Act takes forward the areas of Equity and Excellence: Liberating the NHS white paper (July 2010) which required primary legislation, covering key areas such as:

- Strengthening commissioning of NHS services through local GP-led Clinical Commissioning Groups
- Strengthening public health services by transferring responsibility to Local Authorities
- Increasing democratic accountability and public voice through establishment of local Health and Wellbeing Boards and local HealthWatch organisations

NHS Commissioning Board

The NHS Commissioning Board (NHSCB) plays a key role in the Government's vision to modernise the health service. Its main aim is to secure the best possible health outcomes for patients by prioritising them in decision making.

The NHSCB was formally established as an independent body, at arm's length to the Government, on 1 October 2012 and has taken on initial statutory responsibilities (it will take up its full statutory duties and responsibilities from 1 April 2013). The most important of these responsibilities is the authorisation of clinical commissioning groups (CCGs) which are the drivers of the new, clinically-led commissioning system introduced by the HSC Act 2012.

Public Health England

Public Health England has been established to reduce health inequalities and protect and improve the nation's health and wellbeing. It will take up its full powers on 1 April 2013, when it will jointly appoint Directors of Public Health with local authorities.

Healthwatch

Healthwatch England is the new, independent consumer champion for health and social care in England. Their purpose is to argue for the consumer interest of all those who use health and social care services.

The Healthwatch network will be made up of 2 levels:

- Healthwatch England will work at a national level and support the establishment of local Healthwatch organisations. They will use local experiences of care to influence national policy
- Local Healthwatch will begin work in April 2013 and there will be a Healthwatch organisation covering every local authority area in England. They will take the experiences that people have of local care and use them to help shape local services

Work is underway in Rotherham to develop commissioning arrangements for a Local Healthwatch and tendering has begun to ensure arrangements are in place by 1 April 2013.

7.2 Local Implementation

Health and wellbeing Board

Local authorities are leading the coordination of health and wellbeing through the creation of high-level 'Health and Wellbeing Boards' (HWBB). Key responsibilities of board's include:

- Producing a Joint Strategic Needs Assessment
- Developing and publishing a Joint Health and Wellbeing Strategy
- Improving local population health and reducing health inequalities
- Integrating health, social care and public health

Rotherham's HWBB was established in September 2011, as a sub-committee of the council. The board is chaired by the Cabinet Member for Health and Wellbeing and brings together key decision makers from Social Care, Public Health, NHS and GPs, to address issues of local significance and to seek solutions through integrated and collaborative working.

The HWBB will be the single strategic forum to ensure coordinated commissioning and delivery across the NHS, social care, public health and other services directly related to health and wellbeing, in order to secure better health and wellbeing outcomes for the whole Rotherham population. The HWBB will advocate for and act as ambassador for Rotherham collectively on local, regional, national and international forums.

In September 2012 the HWBB underwent a self-assessment process following 12 months in operation. This allowed members of the board to reflect on their progress to date; looking at partnerships, strategy and performance, to ensure the board was best placed to take on statutory responsibilities from April 2013. This involved observation of the board by the national Director of Health and Wellbeing Boards (Department of Health), who provided positive feedback about how Rotherham was responding to the requirement to establish a HWBB and working in partnership with the NHS and CCG to develop local strategy.

Rotherham Clinical Commissioning Group

The Rotherham CCG was established in January 2011. It is led by local GPs and every Rotherham General Practice is a member. The CCG is made up of a number of committees and boards:

- The Strategic Clinical Executive group is made up of 8 GPs and is responsible for producing plans to improve health and health services locally
- The GP Reference Committee, is made up of a further 8 GPs and is responsible for communication and engagement between the CCG and all 150 GPs in Rotherham.
- CCG decisions are made by the CCG Committee, which is currently accountable to the Department of Health through NHS South Yorkshire and Bassetlaw Board.

The CCG is to be an independent statutory body from April 2013. At that point the CCG Committee will become the CCG Board, whose membership will include lay members, GPs, senior managers, a nurse, a hospital consultant and Rotherham's Director of Public Health.

Rotherham CCG has produced a Single Integrated Plan 'Your Life, Your Health'. The plan outlines the CCG's vision, values and priorities for the forthcoming years. Its purpose is to ensure performance, finance, quality, efficiency, workforce and IT plans are consistent with each other and aligned with the requirements of the NHS Operating Framework 2012/13 and the local Health and Wellbeing Strategy.

In December 2012 Rotherham CCG had its authorisation confirmed, which will be effective from April 2013. The authorisation process, led by the NHS Commissioning Board, was designed to ensure that the CCG meets safe thresholds to enable them to assume full statutory responsibility.

Public Health

Local Authorities will take on statutory duty for public health in April 2013. Rotherham has made progress on this, with public health staff now located within the council whilst the transition takes place. No decision has been made around the long term structural model. A lift and shift approach has been employed. The Director of Public Health reports directly to the Chief Executive in relation to his statutory functions. The Public Health team currently sit alongside staff from Neighbourhoods and Adult Services because the work is most closely aligned with these services but as a separate discreet grouping to 'look and learn' about the work undertaken by the team.

The Secretary of State for Health announced in January that there would be £2.7 billion ring fenced public health funding for 2013/14 and £2.8 billion for 2014/15. For Rotherham this equates to a public health grant of £13,790 for 2013/14 and £14,176 for 2014/15.

The public health grant is provided to give local authorities the funding needed to discharge their new public heath responsibilities. It is therefore vital that these funds are used to:

- Significantly improve the health and wellbeing of local populations
- Carry out health protection functions which are delegated from the Secretary of State
- Reduce health inequalities across the life course, including within hard to reach groups
- Ensure the provision of population healthcare advice

Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy

Local authorities, as members of HWBBs have a duty to work with CCGs and other partners to undertake Joint Strategic Needs Assessments (JSNAs). JSNAs provide a comprehensive assessment of the current and future health and social care needs and assets of the local community. Based on the evidence and data within JSNAs, Joint Health and Wellbeing Strategies (JHWSs) are required to be published, which demonstrate the local strategy for meeting the identified needs in the local area. Under the Health and Social Care Act 2012, JSNAs and JHWSs must inform local

authority commissioning plans, and therefore will have an impact on how the public health grant is spent.

The purpose of the JHWS is to:

- Set the strategic priorities for collective action for the Health and Wellbeing Board to improve the health and wellbeing of local people
- Demonstrate how the needs and issues identified within the JSNA and other local knowledge will be tackled
- Support Health and Wellbeing Boards to tackle the wider determinants of health and wellbeing - such as housing and education
- Enable commissioners to plan and commission integrated services that meet the needs of their whole local community
- Service providers, commissioners and local voluntary and community organisations will all have an important role to play in identifying and acting upon local priorities

Rotherham published its JHWS in 2012, which sets out the strategic priorities of the local HWBB. The priorities have been developed to bring about culture change and changes to the way we deliver services across Rotherham, to improve people's health and wellbeing:

1. Prevention and early intervention
2. Expectations and aspirations
3. Dependence to independence
4. Healthy lifestyles
5. Long-term conditions
6. Poverty

Implementation of the strategy is now well under way, with a lead officer from the council, pubic health and NHS, appointed to provide strategic leadership to each of the 6 priorities which are now 'workstreams'.

A local Health and Wellbeing Steering Group, accountable to the HWBB, is now in place to coordinate and provide strategic overview to the implementation stage. All 6 workstream leads, plus supporting officers from RMBC policy and performance, public health and the CCG, sit on the steering group which is chaired by the RMBC strategic Director lead for health and wellbeing.

The HWBB have also agreed a set of 'priority measures' taken from the 'Big Issues' within the JHWS. The board will consider one of 6 agreed measures at a single meeting; using the collective intelligence of all HWBB partners to drive change and actions required to tackle the issues. The 6 measures are:

1. Alcohol
2. Dementia
3. Obesity
4. Smoking
5. NEETS
6. Fuel Poverty

A performance management framework (PMF) is now being developed, which will ensure appropriate reporting to the HWBB on a suite of key locally determined

indicators for each of the priority measures above. The PMF will also ensure the board receives regular monitoring of the shared indicators from the NHS, social care and public health national 'Outcomes Frameworks'. Reporting to the board will also demonstrate how the strategy workstreams will contribute to achieving improvements in the 6 priority measures.

7.3 Health Scrutiny

In July 2012 the Department of Health (DH) published a consultation on proposed changes and regulations for local authority health scrutiny.

The changes proposed in the consultation will update the arrangements and regulations already in place for health scrutiny, with the purpose of ensuring the interests of patients and the public are at the heart of the planning, delivery and reconfiguration of health services.

A response to the consultation was published December 2012 and provides an overview and analysis of the responses received. The new arrangements for health scrutiny will build on the existing system including:

- Extending scrutiny to all providers of NHS care, whether they're from a hospital, a charity or an independent provider
- Requiring organisations proposing substantial service changes and the local authorities scrutinising those proposals to publish clear timescale for decision-making, so patients know when they can expect changes
- Requiring local authorities to take account of the financial and clinical sustainability of services when considering NHS reconfiguration proposals
- Seeking the help of the NHS Commissioning Board in liaising with local authorities and commissioners to secure local agreement on some service reconfigurations and ensuring that proposal for change meet the Secretary of State's "four tests"

The DH is now developing regulations in the form of a new statutory instrument for health scrutiny. It is intended that these will be laid before Parliament early in 2013 and come into force in April 2013.

8. Finance

There are no direct financial implications associated with this report.

9. Risks and Uncertainties

The health and wellbeing architecture both locally and nationally has and continues to change considerably. Statutory responsibilities of the local CCG, HWBB, local Healthwatch and public health function will all begin as of 1 April 2013 and although Rotherham has made good progress and developed strong local partnerships, it is yet uncertain how all the new arrangements will work together.

The Health Select Commission will need to ensure the new regulations are understood and being implemented appropriately, as it will play a key role in the

continued development and success of the new health and wellbeing architecture. Health scrutiny will also need to develop relationships and work closely with the HWBB and local Healthwatch to ensure the best possible outcomes for Rotherham people.

10. Policy and Performance Agenda Implications

The information in this report relates to national and local health and wellbeing policy developments and governance.

Local priorities in relation to health and wellbeing are demonstrated in the JHWS 2012 – 2015.

11. Background Papers and Information

Health and Social Care Act

RCCG Single Integrated Plan Your Life, Your Health

Rotherham's Joint Strategic Needs Assessment 2011

Rotherham's Health and Wellbeing Strategy 2012 – 2015

Healthwatch England

12. Contact

Kate Green
Policy Officer
Kate.green@rotherham.gov.uk

13. Glossary

HSC	Health and Social Care Act 2012
NHSCB	NHS Commissioning Board
CCG	Clinical Commissioning Group
HWBB	Health and Wellbeing Board
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
NEET	Not in education, employment or training
DH	Department of Health

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Health Select Commission**
2.	**Date:**	**1st February 2013**
3.	**Title:**	**Taking on inequalities in Health and Wellbeing locally – How Health and Wellbeing Boards can lead the way.**
4.	**Directorate:**	**Resources**

5. Summary

Councillor Emma Hoddinott attended this conference, held in Leeds on 17th January 2013. Her summary of the information provided is attached.

6. Recommendations

That members note the content of the attached summary paper.

7. Proposals and Details:

See attached paper.

8. Finance

None.

9. Risks and Uncertainties

None

10. Policy and Performance Agenda Implications

The information discussed at the conference has clear implications for Rotherham's own Health and Wellbeing Board and Joint Health and Wellbeing Strategy.

11. Background Papers and Consultation

See attached paper for references.
Conference papers available at following link:

http://www.wakefield.gov.uk/HealthAndSocialCare/HealthServices/JPHU/MindingTheGap/conferences.htm

Contact Name : Deborah Fellowes, Scrutiny Manager
Deborah.fellowes@rotherham.gov.uk, tel ext 22769.

Councillor Emma Hoddinott.

Taking on inequalities in Health and Wellbeing locally
How Health and Wellbeing Boards can lead the way

Hilton Hotel, Neville Street, Leeds
Thursday, 17th January 2013

I attended the above conference and was one of a handful of Councillors from across the region who attended. The majority of attendees were those that worked in or with health. I sat on a table with members of Public Health England, Sheffield Voluntary Sector, members and support for the Sheffield Health and Wellbeing Board.

The speaker for the day was Professor Chris Bentley (www.hinstassociates.com). Yes - just one man - all day! I was sceptical but the day was very informative and Chris Bentley's knowledge of examples all over the country was fascinating. His background is interesting and you can read it here: http://www.hinstassociates.co.uk/associate/associate-6

Too Pink and Fluffy

Chris started off by referring to a recent article where he was described as Health and Wellbeing Boards as being 'too pink and fluffy'. The rest of the day expanded on that point and drawing key lessons about what needs to happen to make a difference to health inequalities. It's not easy; you've got to be hard-nosed about it; but the alternative is the new health and wellbeing boards could just become a talking shop.

Social injustice is killing on a grand scale

We were taken through the Bridging the Gap in a Generation report and then the Marmot Review. As a newcomer to health inequalities these were useful cornerstones to the issue. Some sobering points from the report were

- Life expectancy has shot up since 1970s to 2000s. 5 years has been added, the fastest improvement in human existence.

- However though it has improved for all socio-economic classes, the gap between non-manual and manual workers has not narrowed. Social class still matters more than where you live.

- When you look at the number of years people expect to live in good life, the difference in class is more stark. The most deprived are a long way behind and will require more resources to make a difference.

- The best start in life is important. It is too late to tackle inequalities at school, resources must focus on the first few years of life. Marmot gave a list of interventions which have been developed further.

- Skills development has an effect on health. Employment is positive for health outcomes, but the quality of the employment matters just as much.

- Indirect taxes hit the poorest hardest. Increased tax on fags and booze compound the problem, as people end up spending more of their disposable income on tax. The VAT rise increases inequality.

- The role of government is important in tackling health and social problem. Those that are more redistributive can address inequalities. Scandinavian countries do this post-earnings, Japan does this pre-earnings. This theory is developed further in The Spirit Level.

Miles on the Clock

There was a useful analogy when looking at what you could do about health inequalities. Health inequalities were described to us as miles on the clock; some things like poverty or smoking mean you clock up the miles a lot quicker.

Local authorities have a lot of levers to try and prevent us clocking up those miles. Licensing (the smoking ban has had a positive influence on health outcomes), by-laws, welfare benefits, trading standards and environmental health are examples.

The example of Warrington and the alcohol harm reduction strategy was given. Details in their Joint Strategic Needs Assessment (JSNA) can be found here.

Be bold

Key factors in successful interventions were they were large scale, consistent and long term. Be consistent and bold. There was a danger that commissioning could follow fads and fashions and have a project piecemeal approach.

The most successful programmes delivered to the whole of the population but changed their scale according to the different needs of certain groups. We explored the dangers of Commission Group approaches in leaving gaps which in turn would not deliver the bigger population outcomes needed.

It is complex

Chris Bentley described the new structures and we had an interesting discussion on our table about the different approaches of boards and clinical commissioning groups across Yorkshire. Budgets and power were interesting factors that may upset the proposed balance of the new structures.

Health and Wellbeing boards were diverse; some had brought in policing, housing, leisure and environmental representatives.

Are you driving change or just a talking shop?

There was a real danger that Health and Wellbeing Boards would become a talking shop. An example was given of a board that just meets four times a year. That wouldn't work unless there was a substructure for change.

Boards needed to have sufficient challenge and be asked the questions:

- How are you going to demonstrate the change you've made?
- Who is accountable for that change?

There was a discussion about the buzzwords 'integration' and 'partnership working'. The evidence showed that you still had to have a programme manager accountable, as diffused responsibility did not bring about change.

The support networks for Health and Wellbeing Boards are patchy across the country. In our region there was little support for boards but the Clinical Commissioning Groups did have a support network.

Use your intelligence

We were taken through some worked examples of how Boards had come to their priorities, using statistics coupled with grassroots information. They had used the Slope Index to see where they were an outlier (worse than average). For example, Kent has focused a section of their strategy on a deprived area that had worst outcomes then there should be, as they felt they could make the biggest difference there.

Characteristics of successful boards

Eight points were given to achieve outcomes that need to be addressed by boards.

1. Governance: who is running the show? (a strategic forum or performance driver)
2. Programme Planning : who is accountable (responsible and empowered)
3. Information Governance :sharing intelligence (data flows; communications strategy)
4. Joint Strategic Needs Assessment (bottom-up and top-down)
5. Priority setting: how does it really work? (evidence, ethics, politics)
6. Setting targets : locally relevant and meaningful (measurable, ambitious, do-able)
7. Select interventions : strongly evidence based (offer major contribution to change required)
8. Develop business plan : economic case for change (cost benefit; cost utility; return on investment;)

Christmas Trees

Chris Bentley spent a while explaining where we can intervene to be successful. This is based on his Christmas Tree model. A video explanation can be found here : http://vimeo.com/21023658

A key learning is that the board has to have Partnership, Vision and Strategy, Leadership and Engagement to be successful in the three sides of the Christmas tree - systematic and scaled intervention through services, systematic community engagement and service engagement with the community.

That's the theory what does it look like in practice

This is where the day got exciting, real life of examples of the theory working in practice. The first example was from Doncaster regarding lung cancer. There was problem with people with lung cancer not presenting early enough and therefore there was a higher than normal mortality rate (the data). Through talking to local people (the intelligence) it appeared that people didn't know anyone who had lung cancer, unlike other forms such as breast cancer and didn't know what the symptoms were. There were myths such as only smokers get it, and you've got to be seriously ill probably on oxygen to have lung cancer – an image gleaned from anti-smoking adverts. They therefore undertook a programme systematically and on a large scale to engage with the community about the symptoms and dispelling some of the myths. They also encouraged GPs to do more chest x-rays when people did present, as again the data and intelligence showed Doncaster GPs used them less than average.

They also highlighted the importance of making every contact count. Whoever was dealing with that individual they would raise the issue and refer them if needed. This happened not just in the NHS, but with people outside in social care or housing.

Another key point was that they started with staff first, as they were part of the population.

Partners on Health and Wellbeing Boards – I'll scratch your back if you scratch mine

The benefits to the members of the boards should be clear. An example was between a Housing provider and a Clinical Commissioning Group where an agreement could be sought if the housing provide helped find people they engaged with who had coronary heart disease this year, next year the Clinical Commissioning Group would help the housing provide find people with cold, damp homes next.

Improving consistency and quality of services can have an impact on outcomes

Particularly long terms conditions, looking at the consistency and quality of them can improve outcomes quickly. An example from Wakefield and Bolton was given where there were inconsistencies in the number of patients with diabetes where the blood sugar was under control. Specialists / nurses and GPs sat down together with the the worst patients to look at how they could control the patients blood sugar levels. This up-skilled the GPs and nurses in the management of these conditions and had a big impact on outcomes.

What can you do if you give a pensioner new central heating but they don't use it?

There are four points in the chain where intervention can break down. You could be delivering fantastic interventions giving pensioners new heating systems but if they don't get to the right pensioners, or they are worried about turning them on due to heating costs you are not solving the problem of cold damp housing, even though you make think you are.

The example of Coronary Heart Disease in the UK were given, a disease where 10.2 million people are at risk

5.7 million people have it

↓ **A**

2.6 million people are aware they have it

↓ **B**

2.3 million people are eligible for treatment

↓ **C**

1.3 million people are on treatment

↓ **D**

1 million people are compliant with their treatment

Between each point (A, B, C and D) there is drop off people being successfully treated, and it is at these points that interventions can make a difference and increase on only 1 million people who are getting successful treatment.

Access to Services

My ears pricked up this bit, as we have discussed this as health scrutiny. It looks like it will be easier than I thought as there are easy models to use to carry out a Health Equity Audit.

There are a number of reasons why people do not present to services. Professor Angela Tod at Sheffield Hallam University (http://www.shu.ac.uk/research/hsc/about-us/angela-mary-tod) has identified the main factors.

- Geographical e.g. distance from clinic / practice; complex journey
- User unfriendly service access : frosty; bureaucratic reception; cultural / interpreter problems; perceived discrimination; appointment systems; access delays; opening hours; cost barriers
- Community knowledge, understanding, beliefs and expectation: about condition; about service; about life; stigma.
- Personal beliefs and skills: demotivation; low expectations; low self-confidence; poor literacy; low-IQ etc.

Strategies to address these issues need to explore each of these elements systematically.

Community Engagement

The final part of the day focused on intervention through communities. We explored common pitfalls in community engagement, such as :

- There is no such thing as hard to reach groups – there are individuals and families that don't join groups.

- The voluntary / community sector is diverse. There are big national charities working to contract to one person volunteers.

- The voluntary / community sector does not equate to a free option.

- Interventions that involve communities bidding favour those communities that have established infrastructure, which does not necessarily equate to need.

Depending on the structures in communities there is a hierarchy of engagement from Information to Devolved Power. (See Arnstein's Ladder of Engagement : http://www.rkpartnership.co.uk/documents/Arnstein%27s%20Ladder.pdf)

The Sound of Silence

There was brief discussion about Health and Wellbeing Boards and community engagement. For those in local authorities these will sound familiar, that small groups with personal experience are often more vocal than the silent majority. We shouldn't underestimate what that silence tells us, and resources should be spent equally, not just on those who oppose decisions.

It is going to b e be difficult for boards, they will have difficult decisions to make, but it is important to engage people in helping them understand the reasons for those decisions.

Summary
Well, I didn't expect this report back to go onto seven pages, but I think it's testament to the quality and relevance of the day. I have been able to retain a lot of information and it is useful for not just looking at health inequalities but challenges in other council services too.

It is easier to focus on the service, and it's easy to fall in the trap of thinking if we are delivering the service all right, everything is resolved. It is much harder to look at changes in outcomes, and questioning access to the service, how it works, it's quality and consistency, but it is this approach that will deliver the change needed.

This reinforces the need for robust challenge within the Health and Wellbeing Board and brings us back to the opening quote – there is danger that they could become 'too pink and fluffy'.

It also shows the need for good health scrutiny and the committee needs to focus on the impact the new infrastructure is having on health inequality outcomes.

The challenge is huge in Rotherham and interventions will be need to be on an industrial scale across the population to make a difference to outcomes. The responses to the consultation on health inequalities sums up the challenges very well: http://www.rotherham.gov.uk/download/6766/health_inequalities_consultation

Points for Consideration

- The Health Scrutiny Committee should continually scrutinise the impact of the Health and Wellbeing Board on outcomes in the Health and Wellbeing Strategy
- The Health Scrutiny Committee uses the research on access to services by Prof. Angela Todd as a basis for it's spotlight review on access to health services.
- Deprivation plays a major role in health outcomes. Health Scrutiny should be included in reviews that look at poverty and deprivation.
- From April 2013 all commissioners and providers of publicly funded healthcare and social care will be covered by health scrutiny. RMBC needs to make sure it's level of resourcing for health scrutiny can meet this increase in responsibility.
- It is in the council's interest to reduce health inequalities as there are intrinsic links with demand on other services.
- By considering in the gaps in interventions (A,B,C,D), health scrutiny could help find savings for local authority public health spending.
- The relationships between the Heath and Wellbeing Board, Health Scrutiny and Healthwatch will be important.

Cllr Emma Hoddinott

Expert warns some health and wellbeing boards are too "pink and fluffy"

Adrian O'Dowd LONDON

Some of the new bodies that bring together the NHS, public health, and local authorities to coordinate health services in England lack the "stiffness of spine" to make actual improvements in healthcare, MPs have been told.

The local health and wellbeing boards were discussed during an evidence session of the parliamentary communities and local government committee on 7 January.

Chris Bentley, an independent consultant on population health who has been working with local authorities on health, said, giving evidence, that he was sceptical of the positive effect that health and wellbeing boards would make when they became fully operational from April.

Trying to close the gap in health inequalities between people from the most deprived areas and the most affluent was difficult, he said.

"Looking at the way the new arrangements are coming into place, I am a little worried that they don't have the kind of firmness or the stiffness of spine that is going to be necessary to drive forward measureable change at population level from local authorities," said Bentley.

"That [change] is happening in a number of places that I have been working with, but I wouldn't say it was universal. There are some areas where I would say the arrangements are a bit 'pink and fluffy' and are not going to necessarily enable people to drive forward changes. Nowhere I have seen has got it perfect yet."

Many boards were planning to hold only four meetings a year, he said. "If you are only going to have four meetings a year, you've got to have some sort of pretty durable structures that can do things between the meetings."

Cite this as: *BMJ* 2013;346:f156

Leeds surgical team performs first hand transplantation in UK

Susan Mayor LONDON

A surgical team has reported encouraging results of the United Kingdom's first hand transplant operation, which used a new technique to amputate the recipient's non-functioning hand during the procedure, enabling the surgeons to accurately rebuild nerve structures to the transplanted hand.

The team at Leeds General Infirmary carried out the complex eight hour operation on 27 December 2012, after a donor limb became available. Its tissue matched one of the two patients listed to receive a hand transplant, 51 year old Mark Cahill, who was unable to use his right hand because of severe gout.

"This operation is the culmination of a great deal of planning and preparation over the last two years by a team including plastic surgery, transplant medicine and surgery, immunology, and rehabilitation medicine," said Simon Kay, the consultant plastic and reconstructive surgeon who led the operation.

"The team was on standby from the end of November awaiting a suitable donor limb, and the call came just after Christmas," he explained. "It is still early days, but indications are good and the patient is making good progress."

Hand transplantation was pioneered in Lyon, France, in 1998. Kay works closely with the transplant team in Lyon, where several successful hand transplantations have been carried out. But this was the first time that a patient's hand had been amputated during the procedure to attach the transplanted hand.

Two surgical teams worked at nearby hospitals at the same time, one removing the donor's hand while a second amputated the patient's hand. They mapped the nerves, blood vessels, and tendons very precisely before transplantation, marking them up on each hand.

LEEDS INFIRMARY

Simon Kay (left) used a new technique to transplant a hand for Mark Cahill (right)

This enabled them to connect the nerves, blood vessels, and tendons and bones in the patient's wrist very accurately to those in the donor hand. After attaching the bones and some tendons, the team connected the blood vessels to restore circulation to the transplanted hand. The remaining tendons were then connected and the nerves repaired.

A hospital spokesman said that the patient could not yet feel the transplanted hand but that he could move the fingers slightly. The spokesman said, "The team considers that the transplant is doing better than some other similar transplants at this stage," adding that it was too early to comment on the success of procedure, given the risks of transplantation.

Cite this as: *BMJ* 2013;346:f79