HEALTH SELECT COMMISSION
Thursday, 19th April, 2012

Present:- Councillor Jack (in the Chair); Councillors Barron, Beaumont, Beck, Blair, Burton, Dalton, Goulty, Steele and Wootton and Victoria Farnsworth (Speak-Up).

Councillors Doyle, Sharman and Wyatt were also in attendance at the invitation of the Chair.

Apologies for absence were received from Jonathan Evans, Peter Scholey and Russell Wells.

58. DECLARATIONS OF INTEREST

There were no declarations of interest made at the meeting.

59. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

60. COMMUNICATIONS

There was nothing to report under this item.

61. MINUTES OF PREVIOUS MEETING

The minutes of the previous meeting held on 8th March, 2011, were noted.

It was noted that the Health Inequalities Scrutiny Review BMI>50 (Minute No. 55 refers) was to be considered by Cabinet on 25th April. Disappointment was expressed at the front page head line in the previous week's local press taken from the report which could further isolate this subject group.

62. HEALTH AND WELLBEING BOARD

The minutes of the Health and Wellbeing Board held on 29th February, 2012, were noted.

2 workshops had since been held to develop the Health and Wellbeing Strategy which included the Joint Strategic Needs Assessment.

Councillor Wyatt, Cabinet Member for Health and Wellbeing, then gave the following powerpoint presentation on tackling health inequalities and responding to change:-

Health and Social Care Act

- Received Royal Assent on 27th March, 2012 took forward the areas of Equity and Excellence: Liberating the NHS (July 2010) which required primary legislation
- Covered 5 themes
  Strengthening commissioning of NHS services
  Increasing democratic accountability and public voice

Liberating provision of NHS services
Strengthening public health services
Reforming health and care arms length bodies

– Highly controversial and included significant changes to the way things were done

Health and Wellbeing Board

– Local authorities would lead the co-ordination of health and wellbeing through the creation of high level 'Health and Wellbeing Boards
– Key responsibilities included:-
Joint Strategic Needs Assessment
Joint Health and Wellbeing Strategy
Improving health and reducing health inequalities
Integrating health, social care and public health
Productivity and efficiency

Rotherham's Board

– Now established as a Sub-Committee of the Council, Chaired by the Cabinet Member for Health and Wellbeing
– Direct reporting links to the LSP as well as links to other local Boards (including Adults, Children's)
– Terms of Reference agreed and work plan being developed

Vision for Health and Wellbeing

– For everyone in Rotherham to be happy and healthy and have the adequate resources to participate in their community

Core Membership of the Board

– Cabinet Member for Health and Wellbeing (Chair)
– Cabinet Member for Adult Services
– Cabinet Member for Safeguarding Children and Adults
– Director of Public Health
– Chief Executive, RMBC
– Strategic Director of Neighbourhoods and Adult Services
– Strategic Director of Children and Young People's Services
– Strategic Director of Environment and Development Services
– Chair of Clinical Commissioning Group (CCG)
– Chief Operating Officer, CCG
– Chair of PCT Cluster Board (until April, 2013 when position will be reviewed)
– Voluntary Action Rotherham
– Rotherham HealthWatch (once in place 2013)

NHS Commissioning

– Devolved responsibility for the majority of commissioning to local Clinical Commissioning Groups
– Supported and held to account by an independent national NHS Commissioning Board
– Rotherham Clinical Commissioning Group now established
– CCG had a statutory place on the Health and Wellbeing Board

Public Health

- Local authorities would take on statutory duty for Public Health
- Full transfer of responsibilities and resources by April, 2013
- Ringfenced budget allocation provided in 'shadow' form April, 2012
- Directors of Public Health jointly appointed between local authority and Public Health England from April 2013
- Director of Public Health to be added to the list of statutory Chief Officers in the Local Government and Housing Act (subject to Parliament)
- Director of Public Health had a statutory place on the Health and Wellbeing Board

HealthWatch

- HealthWatch England would be the national voice of patients and the public to be established October, 2012
- Local authorities required to procure a local HealthWatch by April, 2013
- Work underway to develop commissioning arrangements for a Rotherham HealthWatch
- Existing LINks being supported to continue to deliver a service in the meantime

Overview of Key Activity

- NHS Commissioning Board Special Health Authority established October, 2011
- NHS Commissioning Board in place by October, 2012
- PCTs abolished 2013
- PCT Clusters now in place until 2013 to support transition
- Clinical Commissioning Groups take on statutory responsibilities from April, 2013
- Public Health England established 2013
- Local authorities take on Public Health responsibilities April, 2013
- Local Health and Wellbeing Boards in shadow form by April, 2012, and take on statutory responsibilities April, 2013
- HealthWatch England established October, 2012
- Local HealthWatch to be in place by April, 2013

63. PUBLIC HEALTH TRANSITION

Dr. Nagpal Hoysal, NHSR, gave a powerpoint presentation on the Health and Social Care Act 2012 and the local authority duties and responsibilities as follows:-

Cause of Disease

- 60% of the causes of the disease burden in Europe was caused by 7 risk factors:-
  High blood pressure (12.8%)
  Tobacco (12.3%)
  Alcohol (10.1%)
  High blood cholesterol (8.7%)
  Overweight (7.8%)
  Low fruit and vegetable intake (4.4%)

And physical inactivity (3.5%)
- Diabetes, which was directly related to obesity and lack of exercise, was also a major risk factor and trigger for cardiovascular disease
- Risk factors frequently cluster and interact – particularly in disadvantaged socio-economic groups

Public Health 2012 Act
- SoS duty as to protection of public health
- Duties as to improvement of public health were functions of local authorities and SoS
- Each local authority must take such steps it considered appropriate for improving the health of people in its area

Duties as to improvement of Public Health Local Authority Functions
- Providing information and advice
- Services or facilities designed to promote healthy living
- Services and facilities for the prevention, diagnosis or treatment of illness
- Providing financial incentives to individuals to adopt healthier lifestyles
- Providing assistance (including financial assistance) to help individuals minimise any risks to health arising from their accommodation or environment
- Making available the services of any person or any facilities

Mandatory Services (Public Health White Paper)
- Ensuring NHS commissioners receive the Public Health advice they need
- National Child Measurement Programme
- NHS Health Check assessment
- Appropriate access to sexual health services

Discretionary
- Tobacco Control and Smoking Cessation Services
- Alcohol and Drug Misuse Services
- Public Health Services for children and young people aged 5-19 (including Healthy Child Programmes 5-19) (and in the longer term all Public Health Services for children and young people)
- Interventions to tackle obesity such as community lifestyle and weight management services
- Locally-led nutrition initiatives
- Increasing levels of physical activity in the local population
- Public Mental Health Services
- Dental Public Health Services
- Accidental injury prevention
- Population level interventions to reduce and prevent birth defects
- Behavioural and lifestyle campaigns to prevent cancer and long term conditions
- Local initiatives on workplace health
- Comprehensive Sexual Health Services
- Local initiatives to reduce excess deaths as a result of seasonal mortality
- Public Health aspects of promotion of community safety, violence prevention and response

- Public Health aspects of local initiatives to tackle social exclusion
- Increasing levels of physical activity in the local population
- Supporting, reviewing and challenging delivery of key Public Health funded and NHS delivered Services such as Immunisation and Screening Programmes
- Local initiatives that reduced Public Health impacts of environmental risk

Commissioning Agencies and Structure

- Local Authority
  Social Care
  Public Health
  Environment
- Clinical Commissioning Group
  Hospital and Community Services Commissioning
  Some GP services
  GP Group + Governing Body
- NHS Commissioning Board
  Establish CCGs
  General Practice contracts
  Commissioning support to CCGs (initially)
  GP Group + Governing Body
- Public Health England
  Health protection
  Screening
  Emergency response
  vaccination
- Health and Wellbeing Board
  Joint Strategic Needs Assessment
  Joint Health and Wellbeing Strategy
- HealthWatch England
  Public involvement in health and social care
  Local HealthWatch
  Independent advocacy

64. ROTHERHAM CLINICAL COMMISSIONING GROUP UPDATE

Sarah Whittle, NHS, gave the following powerpoint presentation on the Clinical Commissioning Group:-

The Health Bill/Act

- Abolished Primary Care Trusts by April, 2013
- Clinical Commissioning Groups (CCGs) formed in shadow form from 1st October, 2011
- Fully authorised by April, 2013
- Public Health responsibilities to transfer from NHS to RMBC (April, 2013)
- GP/Dentist/Pharmacists' contracts and special commissioning to be managed by National Commissioning Board (currently Cluster)
- HealthWatch to be formed to promote the views of patients and service users
- NHS Commissioning staff in Rotherham reduced by 48%

Budget
- NHS Rotherham £460M
- RMB Public Health £20M
- Rotherham CCG £330M
- NHS Commissioning Board – GP/Dentists/Pharmacists £120M

CCG Structure
- CCG Committee/Board
- GP Reference Group
- Strategic Clinical Executive
- Operational Executive
- Strong clinical focus

CCG Authorisation – 6 domains
- Clinical focus and added value
- Engagement with patients and communities
- Clear and credible plans
- Capacity and capability
- Collaborative arrangements
- Great leaders

Finance
- Need to generate £75M of efficiencies over the next 4 years
- Expected make the efficiencies by:-
  Managing long term conditions patients more efficiently and cost effectively
  Making sure only appropriate patients were referred to hospital
  Making GP prescribing more efficient and cost effective
  Reducing commissioning staff by the Government target of 48%

Partnerships with RMBC
- Local Strategic Partnership
- Health and Wellbeing Board
- Adults Board
- Long Term Conditions/Unscheduled Care
- Children and Families Partnership
- Think Family
- Safeguarding
- Public Health

65. IMPLICATIONS OF THE HEALTH AND SOCIAL CARE BILL ON THE FOUNDATION TRUST

Peter Lee, Chairman of the Rotherham Foundation Trust, gave a powerpoint presentation on the implications for the Trust, its Directors, Governors and members of the Health and Social Care Act 2012:-

Where we start from
- Combined hospital and community services
- Income £225M from 1 year contract
- Over 4,000 staff

- Cost improvement programme 2012/13 (£14M)
- FRR – 3 (1-5) and Governance – Green (green/amber/red)
- Lowest waiting times
- Infection control record – excellent

New Commissioning Regime
- Present position – Primary Care Trust until April, 2013
- Future position – Clinical Commissioning Group from 2013
- Transitional arrangements exist
- CCGs – locally managed and directed – all primary care providers had to be members – regulatory supervision – obligations to be transparent
- CCGs – mandated to continuously improve services – reduce inequalities – promote patient involvement and patient choice – innovation – research and the integration of health and social care

New Initiatives
- Promotion of Section 75 NHS Act 2006 arrangements
- Every provider of health services would need to be licensed
- Changing role for Monitor (Foundation Trust regulator)
- Increasing role of Council of Governors
- Duty to promote the NHS Constitution
- Caps and conditions to non-NHS income
- Foundation Trust Board meetings to be held in public

New Roles and Responsibilities – Governors
- To hold the NEDs individually and collectively accountable for the performance of the Board
- To represent the interests of the members (as a whole) and the interest of the public
- To require the Directors to attend Council of Governors to supply information regarding the performance of their duties and functions
- Any amendment to the Constitution of the Trust regarding the powers or duties of the Governors (or their role) was subject to a Members' vote. More than 50% of those voting must be in favour and the motion must be put by a member of Council of Governors
- Any other amendments to the Constitution of the Trust were subject to more than 50% of the Directors voting in favour and more than 50% of those Governors actually voting being in favour
- Constitution could be changed to specify partnering organisations which may appoint one or more members of the council

New Roles and Responsibilities – Directors
- General duty to act with a view to promote the success of the Trust so as to maximise benefits for the members (as a whole) and for the public
- Must supply Governors with meeting agendas prior to their meetings and minutes as soon as practicable after meetings
- Constitution must be amended to provide for meetings to be open to the public and may provide for exclusion of the public for special reasons
- Obligation to promote the NHS Constitution to members of the public in discharging the Trust's functions

- Ensure that the Governors were equipped with the skills and knowledge required in their capacity as such, to discharge their duties
- Accountability to Governors (all Directors) for performance of their functions and duties and the requirement to attend at Council, if requested by Council, to supply information and answer questions regarding their functions and performance of their duties
- Constitutional changes require Governors approvals
- What was a significant transaction may be defined in the Constitution of the Trust (or not) (and not by Monitor) and entry into such a transaction would be subject to approval by more than 50% of the Governors actually voting
- Governors' influence over mergers, acquisitions, separations and dissolutions – any proposal was subject to approval by 50% of the Governors
- Obligations regarding the "complexion" of the membership
- Obligation to hold an annual meeting of its members (open to the public)

Members

- Change to an obligation (not an option) upon the Trust to secure that the actual membership of any public constituency was representative of those eligible for such membership
- In deciding which areas were to be public constituencies (or in deciding whether there was to be a patients constituency) Trusts must have regard to the need for those eligible for such membership to be representative of those to whom the Trust provided services
- Obligation to provide a members' annual meeting

66. ACHIEVING AN EFFECTIVE HEALTH AND WELLBEING STRUCTURE IN ROTHERHAM

A question and answer sessions on the 4 presentations ensued as follows:-

Was the culture of the Health and Wellbeing Board built upon principles of transparency, involvement, accountability, trust and respect between the Health and Wellbeing Board members?
There were a number of requests from a range of organisations wanting to join the Board. However, there was a need for the membership to be focussed and ensure that the representatives were able to represent their organisations and on their behalf as written into the Terms of Reference.

There had to be wider engagement with the community as it would be one of the tests of success or failure as to how effective the engagement with communities was.

There were good examples of work in the Health Inequalities Strategy and the 2 recent workshops had tried to be as inclusive as possible by inviting the wider representative groups rather than just Health and Wellbeing.

With regard to the relationship with Scrutiny, Rotherham had been involved in various projects with the Centre for Public Scrutiny; looking at scrutiny within the context of the health reforms and how to develop successful working relationships.

How would the Board work together as well as with the people who actually used services to tackle difficult issues such as Service reconfiguration? How could Scrutiny best support this?
Any Service changes, in accordance with procedure, had to be submitted to the Select Commission for comment.

With regard to the required wider engagement activities, there was a need to use all the mechanisms in place such as the Foundation Trust network. Rotherham had some very good engagement groups across the Local Authority and Health but there was duplication and a need to know what each partner was consulting on; communication was seen as key to ensuring this happens.

Do you feel Health and Wellbeing partners were able to identify potential conflicts straightaway and were there agreed ways of dealing with them?

Strong partnership working would help ensure that conflicts are easily dealt with, in an open and honest manor.

Having a comprehensive and jointly agreed Joint Strategic Needs Assessment and Health and Wellbeing Strategy would also ensure a common purpose and agreed goals, which should reduce any potential conflicts and issues between agencies.

A key message from the 2nd Health and Wellbeing workshop had been the importance of a joined up approach on communications.

What evidence was there that health and wellbeing partners worked well together outside of formal Board meetings?
The Joint Service Centres were an example where GPs and Council worked alongside but there was a need for further joint work as resources diminished. This was critical to the transition of Public Health and protocols required.

Other good examples of good joint working included: learning disability services, mental health and the Early Help agenda with children and families.

There were concerns that joint working was not always as effective as it should be, issues such as not having co-located teams and IT systems that did not 'talk' to each other presented potential difficulties with joint working.

With respect to IT systems, in June, 2012, the Trust was commencing its roll out of its Electronic Patient System which would completely transform the way patient information was available cross the health community. The Trust was investing a huge amount of money in the system and confident of the results that would be achieved in terms of economy and efficiency.

There would be increased pressure on the different organisations due to competition and possible dilemmas between wanting to work together and having to follow the competitive route

With regard to competition, the issue was about maintaining value for money whilst making sure the system provided quality services. The CCG would have the obligation to achieve that. Health and Wellbeing Board members had to recognise that there may be a conflict of interests in their capacity of providers.

The Section 75 powers enabling money to be moved around the system to deliver services would be good for Rotherham.

Good housing conditions was crucial to the health and wellbeing of the population. To what extent had housing been included in discussions?
The Strategic Director of Neighbourhoods and Adult Services was a member of the Health and Wellbeing Board and also a member of the Adults Board.

How could the Health Select Commission work with the Health and Wellbeing Board and wider health partners to understand the issues in Rotherham and help improve services and experiences for local people in the most effective way?

How could Elected Members most effectively open up a dialogue and build strong working relationships with health and wellbeing partners including GPs and the Clinical Commissioning Group, the Foundation Trust and other NHS providers, Public Health and Social Care?
GPs held a lot of intelligence for their area that had to be used as a community resource. There had to be commissioning for areas rather than just for their practice.

Elected Members needed to think about the new shape to the services and in respect of their lines of communication, the public pound and stretching it as far as it could go. Avoiding duplication and challenging the empires was key to success.

The current CCG was made up of GPs and was a heavy doctor based group. How would the CCG take advice on commissioning other services?
The powerpoint slide had not shown the full Committee. It was currently made up of 4 GPs, 2 from the strategic and commissioning executive and 2 from the GP Reference Group and 4 lay members together with NHS Rotherham Managers, a Consultant GP and a Nurse Consultant. It had still not been agreed what the CCG Board would look like and was been discussed at a national level.

How was the £75M over the next 4 years and the 48% reduction in staff to be made?
The 48% was of 150 staff and the redundancies had been factored into the £75M. However, there would be a low number of compulsory redundancies.

There would be consultation when it was known precisely where the savings would be but the majority of the savings would be coming through working in different ways and transforming services.

The hospital was used as a "refuge" at the moment and not being used as efficiently as it should. Education was required as to what A&E was for and whether it was more appropriate to go to the pharmacy, GP or Walk in Centre. Quite often a patient stayed in hospital for far longer than was required and would have received more appropriate care in the community.

The savings could start at the beginning from a patient attending their GP and was 1 of the reasons why GPs had been given the lead role in commissioning. There were ways of making savings on prescribing branded drugs versus generic drugs that did the same job and were sometimes cheaper. Repeat

prescriptions was also a costly matter with many patients automatically receiving drugs they no longer took/needed.

67. COUNCILLOR JACK

This was Councillor Jack's last meeting as Chair of the Select Commission. She thanked officers for their support.

Members wished Councillor Jack best wishes for the future.

68. DATE AND TIME OF FUTURE MEETING:-

Resolved:- That a further meeting be held during on 31st May, 2012, commencing at 9.30 a.m. in the Town Hall.