HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 11 September 2007.

PRESENT: Councillor Dryden (Chair), Councillors Biswas, Elder and Rooney.

OFFICIALS: J Bennington and J Ord.

PRESENT BY INVITATION: South Tees Hospitals NHS Trust:
Simon Kendall, Consultant Cardiothoracic Surgeon/Chief of Service
Jeanette Holden, Acting Divisional Manager
Annette Johnson, Cardiac Rehabilitation/ Outpatient Services Manager.

Kat Smith, Centre for Public Policy and Health, Durham University.

**** APOLOGIES FOR ABSENCE** were submitted on behalf of Councillors Bishop, Lancaster and P Rogers.

**** DECLARATIONS OF INTEREST**

No declarations of interest were made at this point of the meeting.

**** MINUTES**

The minutes of the meeting of the Health Scrutiny Panel held on 20 August 2007 were taken as read and approved as a correct record.

It was noted that the revised terms of reference for the current review on life expectancy focussing on cardiovascular diseases would be submitted to the next meeting of the Panel.

LIFE EXPECTANCY AND CARDIOVASCULAR DISEASE- SOUTH TEES HOSPITALS NHS TRUST

The Scrutiny Support Officer submitted an introductory report to the evidence to be sought from the South Tees Hospitals NHS Trust relating to the treatment of Cardiovascular Disease (CVD) in Middlesbrough.

The Chair welcomed representatives of South Tees Hospitals NHS Trust who provided information on the range of CVD procedures, which included the following: -

- 3 Dedicated Catheter labs - work was ongoing to compile a business case for the acquisition of a mobile lab in order to meet unmet demands;
- 3 Dedicated Cardiac Theatres;
- Coronary Care Unit – Cardiac Intensive Care- state of the art Unit;
- Cardiology – surgical wards
- Cardiac Investigations;
- Dedicated Outpatients Department;
- Dedicated team of specialist nurses – thoracic surgery- recent development involved certain procedures of work traditionally undertaken by doctors now carried out by trained specialist nurses;
- Cardiac Rehabilitation / Heart Failure Service
- Rapid Access Chest Pain Clinic which had been established for some years dedicated to patients with recent onset of chest pain within 12 weeks – Unit meeting targets (100%);
- Arrhythmia Care Team dealing with patients with abnormal heart rhythms;
- Senior Arrhythmia Care Co-ordinator -Pilot scheme by Middlesbrough and Redcar & Cleveland PCTs in establishing clinics in communities;
- Research and Audit Team – compilation of necessary evidence.

As part of the region's tertiary services statistical information was provided on the development of the revascularisation programmes including Percutaneous Coronary Intervention and Coronary Artery Bypass Grafting both programmes of which had increased from 2003/4.
The National Service Framework for CHD gave target intervention rates for revascularisation procedures per million population (PMP). Statistics from 2004/05 demonstrated that the PMP in respect of Middlesbrough showed that the target had been exceeded. The Unit was considered to be very efficient having good links with GPs and community nurses and provided appropriate outcomes for the investment made.

A brief summary was given of the Cardiac Rehabilitation Service a nurse led service with a multi-disciplinary team, which included: -

- Phase 1 in hospital
- Phase 2 – post discharge
- Phase 3 – rehabilitation course
- Phase 4 – maintenance programme in the community run by local voluntary support groups such as Take Heart working closely with leisure services
- Heart Failure Management Programme, which offered an exercise and information programme.

The Team provided a secondary and outreach service working closely with the PCT to provide an efficient and effective service. Rehabilitation was one facet of the overall package of treatment.

Comparative statistics were provided of increased PCT activity between March 2005/06 and March 2006/07 and also information on four post code areas of TS3, TS5, TS6 and TS7 in Middlesbrough which reflected the highest number of referrals to rehabilitation. The post codes of TS1 and TS2 were shown to have the lowest number of referrals.

Details were provided of patients attending Cardiac Rehabilitation on the basis of more than 1 visits, 50% visits and in comparison with the national average and the percentage of men and women for the period March 2005/06 and March 2006/07. Although it was acknowledged that there was scope to encourage more patients to attend the services, Middlesbrough was shown to be above the average percentage of 40%. Whilst a mixed group attended rehabilitation sessions it was noted that women for various reasons were less likely to attend and that compliance was also less for people having had heart attacks rather than by planned service.

Reasons for non-attendance were divided into categories of no reason, medically inappropriate, not interested and transport being an issue. Smokers were identified as the largest group of attendees.

As part of the rehabilitation package reference was made to secondary prevention and in particular aspirin, ACE 1, Bblocker and STATIN, which had shown significant, increase especially in the last 7 years.

It was noted that there differences of opinion regarding the suggestion that STATINS should be used on a regular basis. It was considered by some that the cost implications and the need for further research on potential of any side effects should be explored further.

In conclusion, it was acknowledged that from a National Service Framework perspective, which set out clear standards for prevention and treatment of CHD all clinical chapters were being addressed and targets being met and in some cases exceeded. The JCUH was a specialised regional service providing what was regarded as an excellent service. It was considered, however, that further investment was required in terms of Chapter 7 of the NSF relating to cardiac rehabilitation in particular reducing heart disease in the population and preventing CHD in high-risk patients.

In overall terms the current culture tended to focus on the traditional health care of concentrating on the presented problem rather than focussing on identifying people with potential risks and early detection. Further work was required not necessarily just at GPs to raise awareness and gain access to those persons having high risk factors.

AGREED that the local NHS representatives be thanked for the information provided which would be incorporated in the overall review.

LIFE EXPECTANCY AND CARDIOVASCULAR DISEASE – PUBLIC POLICY

The Scrutiny Support Officer submitted an introductory report on the evidence to be sought from the School of Health & Public Policy from the University of Durham to assist the Panel in exploring public policy questions pertaining to Life Expectancy and Cardiovascular Disease (CVD).

The Chair welcomed Kat Smith, Centre from the Public Policy and Health, Durham University who focussed on the following elements: -

a) a brief overview of the research evidence around social determinants of health;
b) specific issues around worklessness and economic activity;
c) recent policy approaches to health inequalities and the difficulties in basing policy on research;
d) barriers for effective commissioning for public health.

It was felt that the meaning of health inequalities was unclear and covered a number of areas including socio-economic/class; area-based, and other forms of inequalities such as ethnic and gender related. There were several ways of conceptualising health inequalities by health disadvantage (poor health in poor areas), health gaps and health gradients (across society).

The information provided included the Dahlgren and Whitehead's model of determinants of health, which covered the following aspects; individual lifestyle factors, social and community network, and general socio-economic, cultural and environmental conditions.

The key ideas relating to social determinants of health were regarded as follows:-

- material and economic determinants of health such as income and housing;
- psychosocial determinants of health such as hierarchy of jobs;
- lifestyle behavioural determinants of health and the importance of socio-economic context;
- the role of health services;
- contextual factors- immediate environment;
- life-course approaches to health and the importance of early years/transition points;
- social mobility – (in 1980's poor health was seen as a result of poor income);
- discredited ideas.

Some of the key areas in the post-1997 policy context were considered to be as follows: -

a) a commitment to reducing health inequalities;
b) lack of clarity around aims and lack of policy coherence having a range of policies and different objectives;
c) an emphasis on individual lifestyle behaviours and increased 'choice' on personal responsibilities increased by the 'Choosing Health: Making Healthy Choices Easier' White Paper;
d) emphasis on secondary prevention and smoking cessation but it was considered there was insufficient focus on long term targets;
e) policies aimed to tackle wider determinants tend to be targeted, area-based interventions.

It was considered that there were a number of difficulties in basing policy and practice on research evidence which included no direction to provide clear policy; currently more research on casual pathways than on interventions; dominance of a medical model of health; and political and economic constraints.

The commissioning for health and well being was considered to be widely supported by many PCTs and local authorities but faced a number of difficulties such as: -

- incoherent policy context (payment by results and practice-based commissioning)
- lack of appropriate workforce skills to tackle new direction;
- limited resources and the dominance of clinical agendas within the NHS;
- barriers to collaborative working between PCTs, LAs and others for a number of factors including several reorganisations;
- concerns about availability and use of evidence;
- public awareness/involvement in terms of health care and especially preventative measures.

In conclusion the Panel acknowledged that tackling preventative measures and raising awareness for people with high risk factors was regarded as a huge challenge. Socio-economic factors such as dealing with obesity was regarded as one of the main undertakings and key policy target. It was felt that there should be more evidence-based practice and that the co-ordination between policy development and service providers could be improved.

AGREED that Kat Smith be thanked for the information provided which would be incorporated in the overall review.

SCRUTINY REVIEW – IMPLEMENTATION OF RECOMMENDATIONS

In a report of the Scrutiny Support Officer details were provided of progress achieved with the implementation of agreed Executive actions resulting from the consideration of Scrutiny reports since the last update to the Panel.

Since the implementation of the monitoring system, the Health Scrutiny Panel had produced a total of 80 recommendations, of which 63 should have been implemented by July 2007. It was confirmed that 58 recommendations had been implemented, 3 partially completed and 2 which had not been implemented.

NOTED

**** OVERVIEW AND SCRUTINY BOARD UPDATE**

In a report of the Chair of the Health Scrutiny Panel, Members were advised of the key matters considered and action taken arising from the meeting of the Overview and Scrutiny Board held on 28 August 2007.

NOTED