HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 19 November 2007.

PRESENT: Councillor Dryden (Chair), Councillors Biswas, Cole, Elder, Lancaster, P Rogers and Rooney.

OFFICIALS: J Bennington, P Clark and J Ord.

PRESENT BY INVITATION:

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

Middlesbrough Primary Care Trust:
Dr. Peter Heywood Middlesbrough Locality Director of Public Health
Linda Brown, Service Reform Manager
Martin Phillips, Director of Health Systems Development

Dr John Canning, Secretary Cleveland Local Medical Committee

Helen Bateman Williams, University of Manchester.

**** AN APOLOGY FOR ABSENCE** was submitted on behalf of Councillor Bishop.

**** DECLARATIONS OF INTEREST**

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

**** MINUTES**

The minutes of the meetings of the Health Scrutiny Panel held on 25 and 30 October 2007 were taken as read and approved as a correct record.

The Chair requested that the potential additional information to be provided from a former theatre nurse as identified by a Member be referred to the Scrutiny Support Officer in relation to the ongoing updated information to be provided in respect of Healthcare Associated Infections.

NOTED AND APPROVED

LIFE EXPECTANCY AND CARDIOVASULAR DISEASE

In a report of the Scrutiny Support Officer Members were advised of the evidence received so far in relation to the Panel's review of life expectancy with a particular focus on cardiovascular disease.

The Chair welcomed the local NHS representatives and invited a discussion focussing on the current challenges facing commissioning for CVD and what collectively could be pursued to tackle CVD which would assist in formulating the Panel's final report.

In order to assist discussion and provide background information briefing papers had been provided on behalf of the Cleveland Local Medical Committee and Middlesbrough PCT.

The main points raised in the briefing paper of the Cleveland Local Medical Committee was summarised as follows:

a) whilst there were currently significant elements of health promotion and screening the vast majority of the work of the NHS was managing established illness and preventing foreseeable consequences;

b) widely recognised that although linked, major changes in the health of communities were related more to socio-economic factors than the healthcare system;

c) the prime focus of General Practitioners (GPs) was on the needs of individual patients in the context of their family, lifestyle, beliefs and in an endeavour to address patient's health needs in a holistic approach;

d) the current challenges included:

- the need to provide better access for GPs to investigate patients with abnormal heart rhythms without the requirement for referral to secondary care for uncomplicated cases;

- although the management of heart failure was an element of the Quality and Outcomes Framework it was considered to be difficult to identify and manage and therefore it was suggested that the possibility of community based investigations and treatment advice should be explored further;

- difficulties in balancing evidence needs-based care with service demands such as 18 week wait;

- ensuring that a strong list based primary care sector was maintained including the recruitment of GPs and practice nurses;

e) response as to where Commissioning for CVD should be in three years time:

- there was a concern that changes to commissioning of primary medical services would remove the long term personal list based care to be replaced with a long term record based care;

- commissioning for CVD should be firmly based in Practice Based Commissioning supported by a strong public health service which included public health physicians;

- efforts should be made to ensure the redevelopment of the primary health care team;

- any primary screening programme should be part of a properly researched national arrangement;

- improved GP access to appropriate investigations;

- a careful assessment of the benefits of an aortic screening programme;

f) in terms of future action by partner organisations to tackle CVD the main areas were identified as follows:-

- as previously identified the opportunities for the NHS to work with the Authority and others to achieve improvements in social-economic areas should be pursued;

- initiatives to ensure that Middlesbrough was attractive to highly skilled professionals should continue to be developed as this would assist in recruitment;

- the single most significant objective in managing and preventing CVD was identified as stopping smoking;

- it was regarded that whilst the banning of indoor smoking was important other measures were needed including work with HMRC to tackle the prevalence of cheap untaxed cigarettes and appropriate enforcement of the new higher age for cigarette purchase;

- raising awareness to the importance of diet as evidence showed that the diet of many people was poor especially with regard to fat, fruit and vegetable content;

- it was considered that easier access to public transport might increase the exercise taken by many people who currently drove to work.

At the meeting Dr Canning also referred to the importance of work being undertaken with strokes which was a major concern and emphasised the need for heart disease not to be seen in isolation but as part of a holistic approach to a persons health and patient care. The role of an occupational health service within workplaces was regarded as an important element to find ways of easing people back into the work situation following heart attacks and strokes.

In response to clarification sought from Members regarding the current follow-up procedures between secondary care and GPs, Dr Canning confirmed that although improvements had been made in this regard there was scope for further progress in terms of communication and IT issues.

Dr Canning explained the loss in recent years of the Primary Health Care Team, which meant that there was no inter – personal communication between GPs and community nurses. The PCT representatives stated that health visitors were based in localities thus reducing travelling time but still maintaining good communication with practices. As part of the current arrangements precise details were given to the community nurses as to what action was needed which would subsequently be reported and recorded back to the GP practice.

Dr Heywood reiterated that smoking remained the single greatest contributor to health inequalities and premature death in the NorthEast. Reference was made to Fresh North East and in particular their work in partnership with HM Revenue and Customs, Trading Standards and Police to minimise the opportunity for persons accessing counterfeit cigarette products.

Whilst the PCT would continue to support and develop a core stop smoking service especially focussing on the young it was emphasised that others such as GPs, schools, churches, voluntary sector and local authorities had a role to play in what was seen as a community task and responsibility.

Although Dr Heywood acknowledged the high prevalence of obesity and alcohol associated problems as referred to by Members the most significantly high risk was still currently that of smoking.

In response to clarification sought from Members regarding the use of statins Dr Canning expressed the view that changes in diet and lifestyle had a positive effect and that certain patients experienced side effects from the use of such drugs.

The main points raised in the briefing paper of Middlesbrough PCT Commissioning Function were summarised as follows:

a) the following two factors were regarded as placing immense pressure on the health care system over the coming years both locally and nationally;

    - more older people living longer with long term conditions;

    - more relatively younger people in poor living conditions with long term conditions;

b) it was considered that some primary prevention activities were hugely cost effective and could actually impact life expectancy targets in the relatively short term;

c) smoking still remained a priority for the foreseeable future and there was much work to be undertaken in this regard;

d) current challenges included:-

- investing in primary prevention whilst treating legacy of ill health and meeting Government targets;

- evidence and shared information was needed on possible measures in an endeavour to change lifestyle behaviour especially with regard to high rates of smoking, lack of physical activity, rising levels of obesity, unhealthy diet, excess alcohol;

- commissioning the treatable risk factors such as hypertension, high cholesterol levels and diabetes which required increased resources such as staff time and drug costs;

- although NSF and NICE were considered useful in setting national standards for service provision there were problems of inequity in terms of the take up of services as a result of lifestyle and certain population groups;

e) the following measures were put forward in terms of tackling the legacy:-

- systematic and industrial scale primary prevention screening programmes across South Tees using a mixed model approach of community and workplace to identify people at risk of CVD, hypertension, diabetes;

- screening programmes to be commissioned to identify people at risk of diabetes to be offered evidence based interventions to prevent the onset of diabetes;

- extend stop smoking substantially to provide more specialist advisors in pregnancy and as a core service and help support all the commissioned stop smoking services that formed part of the delivery such as pharmacies, GPs and other providers;

- the above was regarded as one of the most cost effective and evidence based interventions that could be offered which would have an early impact on some of the key targets such as life expectancy and CVD;

f) response as to where Commissioning for CVD should be in three years time:

- accessible services in community;
- increased capacity to tackle rising prevalence of certain diseases such as diabetes;
- more emphasis on preventative services such as screening and identifying and engaging with hard to reach groups;
- target the young to give best possible start in life and reduce risks in later life;
- aim to achieve excellence in levels of QOF and reduce variability between practices;
- develop choice of service delivery-patient centres;
- ensure compliance with NSF;

g) in terms of future action by partner organisations to tackle CVD the main areas were identified as follows:-

- addressing life style risk factors;
- continue to develop smoking cessation measures;
- create more opportunities to exercise;
- increase availability of healthy food options;
- tackle alcohol consumption;
- target services in deprived wards ;
- increase take up for blood pressure checks from ‘low uptake’ population groups.

Dr Heywood referred to the importance of current areas of preventative work and the need to develop measures such as systematic programmes in an attempt to identify those persons at risk to ensure that they received appropriate treatment to lessen the risks.

It was considered that the compilation of a register identifying patients at risk not only helped an individual’s health care including checking of blood pressure but also assisted in ascertaining service level and resource requirements. It was acknowledged however

that whilst there were a number of ways in which this could be developed including feeding into a national register there were potential resource implications.

As previously indicated by Chris Briddon, CVD Specialist Nurse, Public Health, identifying persons who were unaware of having symptoms or who hadn't accessed GP services was recognised as a major challenge. Dr Heywood reiterated that as factors affecting lifestyle were not just health related there was a move towards an integrated Health Improvement Team between the Council and the PCT. Such a move was also seen as helping to avoid duplication of work, which was currently being undertaken in this regard.

Members sought clarification as to the possible outcomes of the Health Improvement Team. In response, Dr Heywood indicated that given the numerous factors, which influenced a person's lifestyle, the Team could not be expected to achieve significant differences in a short period of time. It was noted however that with the support of other organisations improvements could be attained in terms of environmental factors over the long term. Reference was made to recent and ongoing discussions regarding ways of further developing the stop smoking cessation programmes and health assessments in the workplace. The Chair referred to a recent scrutiny review following which it had been agreed that the Council undertakes health risk assessments where appropriate.

South Tees Hospitals NHS Trust

As previously outlined Mr Simon Kendall indicated that whilst the specialised unit at JCUH was nationally renowned for being an excellent service further investment was required in relation to cardiac rehabilitation in particular reducing heart disease in the population and preventing CVD in high-risk patients.

Whilst working in Middlesbrough over a period of 13 years, Mr Kendall had observed overall changes in the population especially in terms of people becoming more sedentary in lifestyle. It was considered that this was reflected in the higher levels of child obesity the implications of which were regarded as an immense threat for the future in Middlesbrough and in the UK.

Reference was made to the work of the Cardiac Rehabilitation Service which provided a secondary and outreach service working closely with the PCT. Whilst cardiac rehabilitation was seen as providing a good service and was regarded as a priority there were ongoing discussions to identify any gaps in the service and target certain groups. It was acknowledged that further improvements could be achieved by extending the current options available.

In response to clarification sought from Members regarding the need to pursue systematic screening programmes on an industrial scale the PCT representatives referred to the current constraints and tension in wanting to do everything but having to achieve an appropriate balance and pursuing a 'best fit' approach.

In terms of tackling obesity Dr Heywood acknowledged that this would overtake smoking over a period of probably 20 years. The main priority still remained to be stopping smoking and the need to check high blood pressure, cholesterol levels and diabetes.

Given the huge challenges posed by obesity, Members asked if sufficient measures were being pursued such as extending the current subsidised leisure facilities. Reference was made to the swimming facilities for which under 5 year olds went free and in partnership with Middlesbrough PCT free swimming was provided to young people up to 17 years old throughout the school holidays. Whilst such measures were supported the significant resources required to extend such activities was recognised.

A community based 12 months pilot scheme for an Arrhythmia Clinic in Middlesbrough providing a triage service had received very encouraging initial results. Reference was also made to a Heart Failure Nurse Team, which had been set up with GPs, which would assist in providing definitive diagnosis.
In commenting on the measures being pursued in schools reference was made to a number of initiatives including the Healthy Living Programme; importance of the role of school nurses on a range of issues; Health Improvement Team and extended school schemes. Although

the current target in the national curriculum of a pupil spending a minimum of two hours a week on physical education was considered to be too low there was recognition of the current pressures facing schools such as that of attainment. It was felt that further consideration could be given to broadening the areas of activity in order to encourage greater participation and be more attractive to a wider group of pupils.

It was also felt that interests, which were regarded as normal play activities in previous years outside of school, were now considered by many to lead to anti-social behaviour. Reference was made to the importance of out of school sporting activities such as fun runs, which were organised in partnership with other organisations. It was felt that the possibility of further opportunities to be carried out with family support should be explored.

Members focussed attention on the extent of current prevention measures and the rate at which they were being pursued. Specific reference was made to the following: -

a) compilation of registers in GPs and further work being undertaken in terms of risk assessments;

b) increase in workplace assessments;

c) much needed research was required to be undertaken in order to compile a community database and identify hard to reach groups;

d) given the competing demands it was important to ensure that resources were directed in the appropriate manner and used to promote community activities and achieve greater voluntary involvement;

e) ensure that appropriate staff training was available and undertaken to cope with the treatment and for assessing CVD;

f) specific campaigns were not considered to be successful on their own but had to be part of an ongoing programme of advice and encouragement;

g) one of the current difficulties facing the Council was the need to achieve £300,000 target income whilst at the same time helping to provide subsidies in an endeavour to increase access to leisure facilities to a wider group of people;

h) reference was made to the current strategic review of leisure facilities and the opportunity for easier access to leisure facilities, which was being considered by the Council and the PCT.

In commenting on the range of advice and activities being pursued Members emphasised that one of the most important aspects was to encourage motivation and get the message across to those most in need.

Specific reference was made to a study being carried out in Glasgow, which involved a town wide approach to environmental and regeneration issues and increasing the opportunities for physical exercise. It was suggested that consideration should be given to pursuing a similar course of action.

AGREED that the representatives be thanked for the information and participation in the subsequent deliberations.

OVERVIEW AND SCRUTINY 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 23 October 2007.

NOTED