Middlesbrough Council

Middlesbrough moving forward

AGENDA ITEM: 4

HEALTH SCRUTINY PANEL
4 JANUARY 2008

LIFE EXPECTANCY IN MIDDLESBROUGH: CARDIO-VASCULAR DISEASE – DRAFT FINAL REPORT

BACKGROUND

1. It is a powerful symbol of medical progress in Great Britain over the last 150 years or so that the great, dreaded diseases of previous centuries, such as Polio and Tuberculosis, have all but being eradicated. As medicine advances and evolves, so does society, creating a number of new problems for medicine and healthcare systems to tackle. A unique feature of today's great diseases is that a significant proportion of them are inflicted by society upon itself, through the lifestyles it chooses.

2. The Health Scrutiny Panel chose to investigate one of those diseases faced by society, cardiovascular disease (CVD), which the Panel discovered poses significant problems for Middlesbrough. The Panel was keen to establish the present rates of CVD in Middlesbrough, how it compares nationally, the type of services presently available and what could be improved in tackling CVD in Middlesbrough. The Panel was also keen to investigate some of the wider societal issues, which seem to play a part in the prevalence in CVD.

3. The Panel has gathered a large quantity of information, which is detailed where appropriate in this Final Report. Some of the information it has gathered is rather stark, although the Panel would like to emphasis that there is nothing new as such. The themes explored in this Final Report were articulated in such documents as the Black Report[1]. It is a matter of concern to the Panel that such

[1] Socio-economic class has been linked to health inequalities for many years. Edwin Chadwick published his 'General Report on the Sanitary conditions of the Labouring Population of Great Britain' in 1842. This showed that the average age at death in Liverpool at that time was 35 for gentry and professionals but only 15 for labourers mechanics and servants. Although life expectancy has improved for all classes in Britain since this time, inequalities have remained.
The Black Report, published in 1980, showed that there had continued to be an improvement in health across all the classes (during the first 35 years of the National Health Service) but there was still a co-relation between social class, (as measured by the old Registrar General's scale) and infant mortality rates, life expectancy and inequalities in

issues remain in need of attention and improvement. The Health Scrutiny Panel does not seek to sensationalise such an important issue, nor does it wish to employ scare tactics. Nonetheless, the Panel does not apologise for reporting the evidence it has discovered which, at times, provides a number of highly uncomfortable statistics regarding the health of Middlesbrough.

TERMS OF REFERENCE

4. To investigate the topic of life expectancy in Middlesbrough, with a particular focus placed on the historical and present levels of cardiovascular disease (CVD) within the town.

4.1 To establish whether or not there are differing levels of CVD within the town and how Middlesbrough's figures compare nationally.

4.2 To investigate what primary and secondary preventative measures are currently in place to assist people with, or at risk from, CVD.

4.3 To investigate whether there are any steps that could be taken to tackle CVD further, with specific attention being paid to local commissioning arrangements.

4.4 In conducting the review, the Panel will seek evidence from whomsoever the Panels feels can assist it.

MEMBERSHIP OF THE PANEL

5. Cllr Eddie Dryden (Chair), Cllr Tony Bishop (Vice Chair), Cllr Shamal Biswas, Cllr Eleanor Lancaster, Cllr Charles Rooney, Cllr Patricia Rogers, Cllr Jackie Elder, Cllr J Cole and Cllr Hazel Pearson.

METHODS OF INVESTIGATION

6. The Health Scrutiny Panel met between August and November 2007 to consider evidence in relation to the scrutiny review. A detailed record of the meeting proceedings is accessible through the 'Commis' system. The Panel received evidence from a wide range of sources, which is detailed in the body of the report.

INTRODUCTION

7. The average life expectancy in Middlesbrough is 74.1 years for men against a national average of 76.8 years. The average life expectancy in Middlesbrough for women is 78.7 years against a national average of 81.1 years. People in Middlesbrough, therefore, on average die two or three years earlier than the national average.

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the use of medical services. Please see
http://www.ucel.ac.uk/shield/black_report/Default.html#

8. It is important to note, however, that it is not all negative news and there are areas of Middlesbrough which actually exceed the national average of life expectancy. They are Nunthorpe, Marton and Marton West, which represents three out of 23 electoral wards.

9. It must also be noted, however, that there are huge disparities regarding life expectancy within Middlesbrough. According to a set of figures presented to the Panel by the PCT[2], the ward with the lowest life expectancy in Middlesbrough is Middlehaven, with an average of around 64 or 65. Clairville and Beechwood also have average life expectancies of below 70 years. Thorntree's average life expectancy is also around 70 years. At the other end of the scale Nunthorpe has the highest life expectancy of around 82 years, with Marton & Marton West sitting at around 80 years.

10. On this point, the Panel wanted to place on record that in the space of around 5 miles between Nunthorpe and Middlehaven, there was a life expectancy differential of, at times, 15 years.

11. To emphasise the point, people living in the four wards with lowest average life expectancy in Middlesbrough, share life expectancy figures similar to the national averages of countries such as Vanuatu, Saint Kitts & Nevis, Timor-Leste, Samoa, Federated States of Micronesia, Mongolia, Palau, North Korea and Guatemala[3]. Whilst the four electoral wards identified above are the lowest across the town, those wards are by no means alone in having poor life expectancies relative to the England average. People living in the Middlesbrough wards with the highest life expectancy, however, share similar life expectancy with the most affluent countries across the globe.

EVIDENCE FROM MIDDLESBROUGH PRIMARY CARE TRUST

12. At its first evidence gathering meeting, the Panel heard from Middlesbrough PCT. The Panel heard that CVD is the most common cause of death in the UK, accounting for more than 200,000 deaths each year. Approximately half of all deaths from CVD are due to (CHD) and a quarter are due to stroke. CVD is also one of the main causes of premature death: 32% of premature deaths in men and 24% of premature deaths in women are from CVD.

13. Nearly all deaths from CHD are from heart attack (approximately 230,000 occurring nationally each year). Approximately one in three patients die from a heart attack and up to 50% die within 50 days of a heart attack.

14. In the UK, mortality from CVD and CHD has been steadily falling. The Panel heard that a number of factors can explain this, but is certainly due to a combination of primary and secondary preventative practices. The Panel noted that whilst the death rate has been falling, longer overall life expectancy and

[2] Life Expectancy by Middlesbrough wards (NB Experimental data based on people living in area during 1999-2003)

[3] World Health Organization. World Health Statistics 2007. ISBN 978924156340 6. Please see p.22 to 26.
. www.who.int

advancing medicine, mean there are more people than ever before living with established CVD.

15. To focus specifically on Middlesbrough, CVD is the most common cause of premature mortality in Middlesbrough. It is one of the key determinants of life expectancy, with smoking being the most common cause of preventable early death. The Panel heard that environmental factors may contribute to a small number of cases, although it is not statistically significant.

16. It was confirmed to the Panel that Middlesbrough residents have some of the lowest life expectancies in the country and have remained substantially below the England average. Life expectancy continues to increase in Middlesbrough but lags significantly behind the England & Wales average. The Panel also noted that the difference between Middlesbrough life expectancy, England's average life expectancy and the highest (Kensington & Chelsea) is actually widening. That is, the highest life expectancy is growing at a quicker pace than the national average.

	Male	**Female**
Best Life Expectancy Average	82.2 years	86.2 years
England & Wales Average	76.8 years	81.1 years
Middlesbrough Average	74.1 years	78.7 years
Worst Life Expectancy Average	72.5 years	78.1 years

17. As an extension of this point, during the Panel's review of this subject, the BBC published a news story[4] highlighting regional disparities in something called "healthy life expectancies", which denotes the average age before ill health is established. This is different from Life Expectancy, which measures the average age at death.

18. According to a study by the Office of National Statistics (ONS), which carried out an "experimental" study based on death records, population data and censuses, Middlehaven ward in Middlesbrough has the lowest healthy life expectancy in England & Wales at 54.9 years. The ONS report notes that the area with the best healthy life expectancy is Didcot Ladygrove in Oxfordshire at 86 years. For clarity, that means that there is a difference of just over 31 years between Middlehaven and Didcot in healthy life expectancies. Whilst the Panel acknowledges that this was an experimental study, it nonetheless serves the purpose of displaying the substantial inequalities that are there to be tackled.

19. The Panel heard that deaths from circulatory disease and in particular CHD remain the single most common cause of death for people living in Middlesbrough. Indeed, during 2005, there were 472 deaths from cardiovascular disease. Of these, 150 deaths (30%) were below the age of 75 years (104 men and 48 women).

[4] BBC Story can be found at http://news.bbc.co.uk/go/pr/fr/-/1/hi/uk/6985692.stm

20. The Panel learned that over recent years, the mortality rate for CVD in Middlesbrough has reduced in line with regional and national trends. Despite this, the mortality rate remains high and lags behind the England & Wales average. The Panel noted that the death rate from CVD in adults under 75 is almost 40% higher than the England & Wales average. The Panel heard that there are 8200 people in Middlesbrough, who are on a CVD register. Such registers are held by General Practice and a designed to record and monitor people living with CVD.

21. It was confirmed to the Panel that within the Middlesbrough area, significant inequalities exist regarding mortality from CVD. People living within the poorest areas have the greatest risk of death from CVD.

22. In its initial familiarisation with the topic, the Panel was also keen to gather some preliminary information on the risk factors for CVD. The first key risk factor cited was smoking.

23. The Panel heard that in England & Wales, smoking causes approximately 30,000 deaths each year from CVD. On a more local basis, the Panel was advised that smoking causes around 300 deaths per annum. To add context to the risk, the example provided was that men who smoke are three times more likely to die from CVD aged 45 to 64 years and twice as likely to die aged 65-84 years. It was confirmed that there are similar but slightly reduced risks for women.

24. The Panel also heard that there is a strong dose response – the more cigarettes a person smokes, the greater the risk of CVD. For example, a person smoking 40 per day is 10 times more likely to die between the ages of 45-64 years. It was confirmed to the Panel that environmental tobacco ('second hand smoke') increases the risk of CVD by 25%. Non-smokers living with a smoker have a 30% increased risk of CHD.

25. The Panel was reminded of the importance of stop smoking services, as being powerful and cost effective ways of helping people to stop smoking. The example was given that nicotine replacement therapy (NRT) doubles the long term quit rate. The Panel was also interested to learn that stopping smoking at any time of life will be beneficial to a person's health, as stopping smoking results in a 40% reduction in mortality in people with CHD.

26. The Panel was advised that the second key risk factor for CVD is high blood pressure, which is also known as hypertension. It was confirmed that high blood pressure increases the risk of CVD and is directly related to both systolic and diastolic blood pressure levels. It is thought to be the second most important factor next to smoking. An example was given to the Panel in that in adults aged 40-69 years, each 20mmHg increases in systolic blood pressure or 10mmHg increase in diastolic blood pressure, doubles the risk of death from CVD. The Panel noted that high blood pressure is often referred to as the 'silent killer' as it rarely produces symptoms and can therefore go undiagnosed in a significant amount of people. High blood pressure also increases with age.

27. The Panel's attention was also drawn to Diabetes as being a significant risk factor in CVD. Diabetes is raised blood sugar/glucose and its prevalence is increasing. It is more common in older people, Black Caribbean men and women, Indian men and Pakistani women. The Panel heard that men with Type 2 diabetes (not requiring treatment with insulin) have a two to fourfold greater annual risk of CHD, whereas women with Type 2 diabetes have a three to fivefold greater annual risk of CHD.

28. The Panel heard that over 4% of men and 3% of women in the UK (around 1.9 million) have diagnosed diabetes. Approximately 3% of men and 1% of women have undiagnosed Type 2 diabetes. The Middlesbrough population's diabetes rates are similar to the national average.

29. The Panel also noted that family history is also an important risk factor for CVD. Having a first degree relative[5] with CHD or CVD increases the risk of developing the disease.

30. The Panel made enquiries as to other factors, which can be mitigate or exacerbate a risk of CVD, depending on how they are approached.

31. Firstly, the Panel touched upon physical activity. The Panel learned that activities of moderate intensity can protect against CVD. The example was given that running for just one hour a week has been shown to reduce the risk of CVD by up to 40% in men. It was also stated that even fairly moderate physical activity such as walking and gardening could protect against CVD. It was clarified that single long or multiple shorter episodes of physical activity have the same benefit and that exercise has a beneficial impact on HDL[6] ('good') cholesterol and helps to reduce blood pressure.

32. The Panel also considered the topic of diet and its impact on CVD. The Panel heard that saturated fat is the main dietary factor increasing the risk of CVD. It was said that more than 80% of people consume more than the recommended amounts of saturated fats.

33. A diet high in saturated fats increases the blood cholesterol and in particular LDL[7] cholesterol ('bad' cholesterol). It was clarified that not all cholesterol is bad. Low-fat diets and specific drugs can reduce the amount of LDL cholesterol and increase the amount of HDL-cholesterol in the blood, thereby reducing the risk of CVD.

34. The Panel was also advised that increasing the amount of fruit and vegetables intake (i.e. the 5 a day initiative[8]), reduces the risk of CVD and in particular heart attacks. It is also vital, the Panel heard, for people to reduce salt intake to within recommended daily limits. This will lower blood pressure, which is a risk factor for CVD and CHD.

[5] Parent, Sibling or Child
[6] High-density lipoprotein
[7] Low-density Lipoprotein
[8] Please see www.5aday.nhs.uk

35. The Panel heard that overweight and obese individuals are at increased risk of CVD, though by itself this is not a strong risk factor. It is important to note, however, that reducing weight results in improvements in blood pressure, blood cholesterol and glucose.

36. In relation to alcohol the Panel heard that, in moderate amounts, it has been shown to protect people from developing CVD. The maximum benefit for men would be three units a day and women would be one unit a day. The Panel was interested to learn that patients without CVD should be advised that light to moderate consumption confers some protection against developing CVD. Binge drinking can increase blood pressure and has an adverse effect on blood cholesterol, resulting in an increased risk of heart attack.

37. The Panel enquired as to the impact of stress on CVD. It was stated that whilst it is hard to define, there is evidence that depression, social isolation and lack of social support are risk factors for CVD.

Treatment of CVD (Secondary Prevention)

38. The Panel was also advised on a number of treatment methods of CVD.

39. The first one mentioned was that of aspirin and other similar drugs. It was stated that such drugs help prevent blood clots from forming and prevent strokes and heart attacks. The Panel heard that unless specifically instructed otherwise, everyone with established CVD should take long term daily aspirin. It was also stated that some people without CVD but at increased risk of developing the disease would benefit from taking daily aspirin.

40. The Panel also heard about 'statins', which are cholesterol-lowering drugs, very effective at reducing blood cholesterol. In connection to primary prevention, statins are effective in preventing CVD in people who have a 20% risk of developing CVD over the next ten years[9]. All adults over 40 years assessed as having a 20% risk of developing CVD should be considered for treatment with a statin, in addition to taking measures pertaining to their lifestyle.

41. The Panel also heard that statins are effective in the secondary prevention of CVD, by preventing further disease, such as a heart attack, or death. It was stated that all patients with established CVD should be considered for treatment with a statin, in addition to lifestyle measures being taken. On this point, the Panel heard that recently, the 'National Czar' for Coronary Heart Disease has advanced a view that all people over the age of 50 years should be prescribed statins as a matter of course, although it is understood that this is an area of professional debate presently. Statins are, for instance, not without their side effects.

42. It was also brought to the Panel's attention that a significant element of preventing CVD, CHD, strokes and death is the treatment of people with high

[9] The Panel was advised that a risk score can be easily calculated using a standard tool.

blood pressure. It was stated that in addition to treating blood pressure with drugs, the following measures can also reduce blood pressure:

43. Reducing weight, reducing salt intake, reducing alcohol intake, reducing fat intake, increasing physical activity and increasing fruit and vegetable intake.

44. The Panel also received a briefing on some of the methodologies used to treat CVD.

Thrombolysis ('Clot busting' drugs)

45. A heart attack occurs when a blood vessel supplying the heart muscle becomes blocked, usually by a blood clot. Some drugs can be given in the early stages of a heart attack to dissolve the blood clot and maintain the blood supply to the heart to prevent further damage. This treatment is known as thrombolysis. The Panel heard that providing this treatment early improves survival rates and can be given before a patient arrives at hospital, i.e. by a paramedic.

46. The National Service Framework (NSF) for CHD in England specifies that eligible patients with a heart attack should be given thrombolysis within 20 minutes of calling for professional help ('call to needle' time) and should receive thrombolysis within 20 minutes of arriving at hospital ('door to needle' time).

47. It is also suggested that it may be appropriate to provide pre-hospital thrombolysis where local 'call to hospital' times are likely to be over 30 minutes. The NHS Plan in England gives a commitment to train and equip ambulance paramedics to provide thrombolysis.

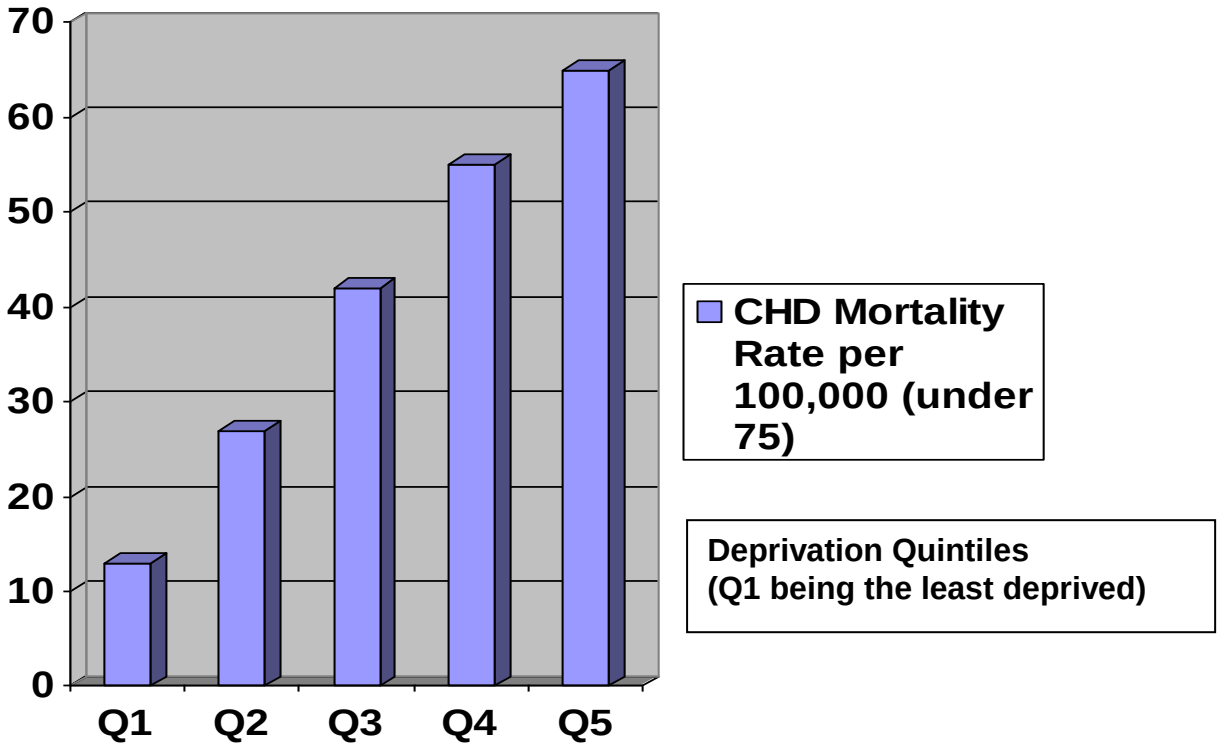
Revascularisation

48. The Panel heard that patients with very severe heart disease or following a heart attack may benefit from treatments that restore the blood flow to the heart muscle.

49. Primary Coronary Intervention (PCI) – PCI is also referred to as angioplasty or stenting. It includes a range of procedures that treat narrowing or blockages in the arteries that supply the heart. A catheter (flexible tube) is inserted into the patient's blood vessel. Once the catheter is situated in the correct position, a stent is inserted where the blood vessel is narrowed. A balloon on the tip of the catheter is then inflated to expand the blood vessel, restoring the blood flow and leaving the stent in place to maintain blood flow. The Panel heard that all stents carry a risk of further blockage in the future.

50. Coronary Bypass Graft (CABG) – The Panel heard that patients with more severe disease may not be suitable for PCI and may require surgery. Coronary artery bypass graft (CABG) is an operation to repair severe narrowing of the coronary arteries. Healthy blood vessels from the leg, chest or arm are used to bypass the blocked or diseased blood vessel.

51. The graph below was supplied by Middlesbrough PCT to highlight the disparities in the death rate from CHD across the scale of affluence and deprivation in Middlesbrough. The Panel heard that around half of the difference between the worst and best (Q5 & Q1 respectively) was due to tobacco use. To illustrate that point, the Panel heard that in the least deprived areas, tend to be around 10% to 15%, whereas the most deprived areas can have smoking rates of around 50%.



52. Following the Panel's consideration of the factual data received, the meeting opened up into a debate around how primary care (particularly GPs) approaches patients who have, or may have CVD.

53. The Panel heard the anecdotal example of a man present at the meeting (the identity of the person has been anonymised) in his late forties attending a GP's appointment in connection with a foot complaint. In that appointment he was not offered any checks related to CVD such as a blood pressure check, even though he was already in the GP surgery. As a man of that age range, he is both in a high risk group, as well as forming part of a 'hard to reach' group for primary care services, yet no steps are taken to proactively engage with him over CVD when he does present. The Panel expressed a hope that this was not a fairly typical example of GP consultations.[10]

54. It was accepted by the witnesses that this cultural element of the NHS had to change and was changing. Nonetheless, GPs have historically done what they

[10] On this point, the Panel has subsequently received representations from the Cleveland Local Medical Committee that this is not a typical example.

were paid to do, although the recent new GP contract is going about addressing that.

55. An example of this increased proactivity in General Practice was given, which was the CHD register. This is a register held in each GP surgery, which lists all those people known about who suffer from CHD. It was confirmed that such a tool was not in existence five years ago.

56. The Panel heard that there is also an obligation on people to be fairly proactive and take up opportunities to have screenings and 'MOT' style health checks when they are offered or advertised. This is especially true in somewhere like Middlesbrough, as the Panel heard that there will be a sizeable cohort of people who are living with CVD that simply do not know about it. Each of those people is living with an undiagnosed risk, which could materially affect their quality and or length of life at any time.

57. The Panel resolved to look at the matter of preventative measures in more detail further into the process and as such those investigations are documented later in this report. Nonetheless, it was accepted that preventative services in Middlesbrough are required to improve and become more systematic.

EVIDENCE FROM SOUTH TEES HOSPITALS NHS TRUST AND UNIVERSITY OF DURHAM

58. Following the above meeting, the Panel next met on 11 September 2007. Before that meeting took place, Members visited the Life Store in central Middlesbrough, to investigate the facilities available for people to drop in and use and take use the facilities for themselves.

59. The Panel was impressed with the range of facilities available at the Life Store and the dedication of the staff involved. In addition to the range of written information and internet access to relevant health websites, the Panel heard about the drop clinics which are operated out of the Life Store, in private consultation rooms. One particular example was a clinic around skin complaints, where six people who attended were actually found to have early stage skin cancer and were referred onto the appropriate specialists.

60. In respect of CVD specifically, the Panel saw and tested out the blood pressure checking machines, which are available on a drop in basis. If blood pressure is identified to be an area of concern, the person is given the necessary information to be referred onto General Practice. The Panel heard that such drop in clinics are often oversubscribed and are accessed by people who do not, for whatever reason, tend to access General Practice. The Panel thought that this was a particular benefit of the Lifestore and felt that it may represent a good example of how imaginative use of NHS funds can engage with people who are otherwise, seemingly not engaged with, in the same proactive manner.

61. Following the visit to the Lifestore, the Panel met with representatives of the South Tees Hospitals NHS Trust. The purpose of this was to hear from the Trust on the services it provides for CVD patients, the

rehabilitation/preventative work it engages in and the frequency that these services are being utilised by people from Middlesbrough.

62. The South Tees Trust started by outlining the services it provides. The Panel heard that the Trust has the use of three dedicated catheter laboratories, where interventional procedures take place, such as Primary Coronary Intervention (PCI). The Panel heard that those labs are working at capacity and the Trust is presently putting together a business for a mobile catheter lab to be commissioned.

63. The Trust also has the use of dedicated cardiac theatres, which are utilised for surgical procedures. The Panel heard that the cardiac theatres have been in existence for 14 years at JCUH and have been very successful in reducing huge waiting lists. Before that point, patients were required to access services in Newcastle or Leeds.

64. The Panel heard that JCUH also houses a dedicated 12 bed Cardiothoracic intensive care for post operative care and the management of seriously ill cardiac and thoracic patients. There is also a 17 bed coronary care unit for the care of all acutely ill cardiac patients – including patients suffering myocardial infarction. It was confirmed that this was 24-hour care and provides such services as angioplasty. The Panel heard that this unit was one of only 5 in the country, with investigations ongoing into the expansion of the service to the North of Tees area.

65. The Panel also heard that there are cardiology surgical wards, together with cardiac investigation facilities and a dedicated outpatients department.

66. The Trust went on to highlight that there are specialist nurses working with thoracic (lungs) surgery. There is a cardiac rehabilitation/heart failure services. The Trust also runs a Rapid Access Chest Pain Clinic (which has a 100% access target met consistently), together with an Arrhythmia (abnormal heart rhythms) Care Team.

67. The Panel also heard of a pilot project, whereby a senior arrhythmia care co-ordinator was out in the community in the south of Tees region, working with patients and carers away from the hospital. The Panel noted the importance placed on research and audit in the function of these services. The Panel accepted that it was critical that medicine and surgery operated according to the best evidenced standards and as such, the service area had to know that what it was doing, which involves the expenditure of large quantities of public money, was having an impact on people.

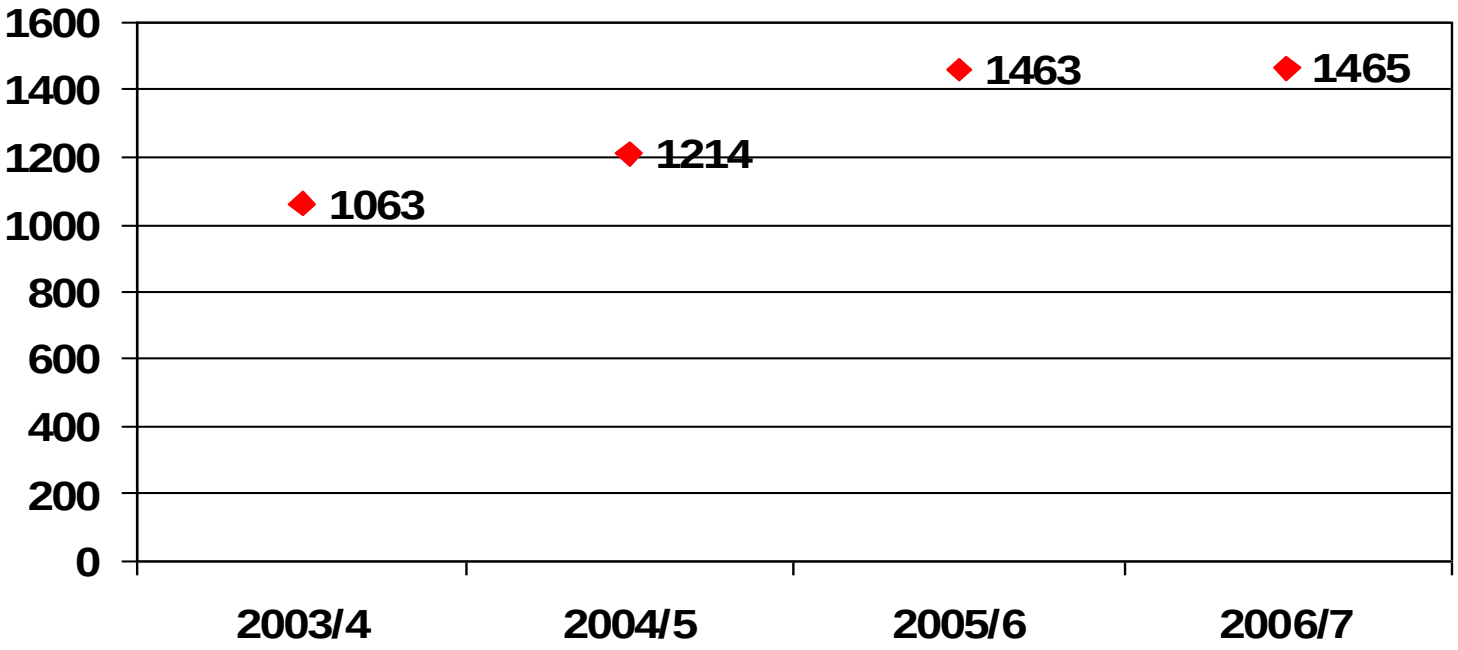
68. The Panel was presented with a quantity of information, which related to a range of procedures on offer and indicated the frequency with which they are used at James Cook University Hospital.

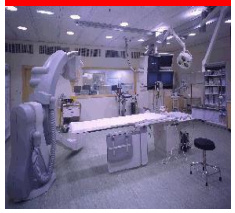
69. The graph on page 13 clearly shows that over the course of 3 / 4 years, the rate of PCI procedures have escalated by around 40% for the area served by JCUH.

Cardiothoracic Services

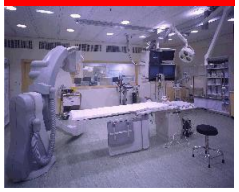
South Tees Hospitals NHS
NHS Trust

Revascularisation Procedures PCI
C2C Network



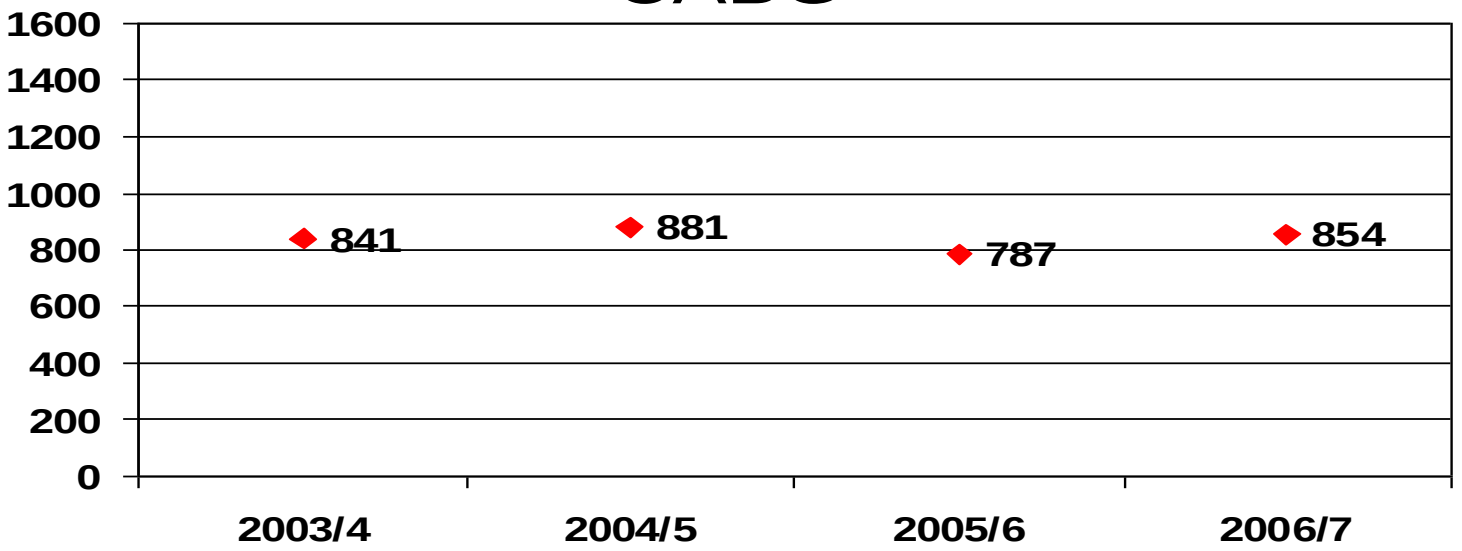


Cardiothoracic Services



South Tees Hospitals NHS
NHS Trust

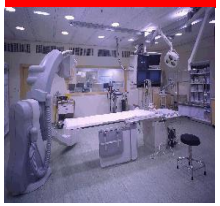
Revascularisation Procedures
C2C Network
CABG

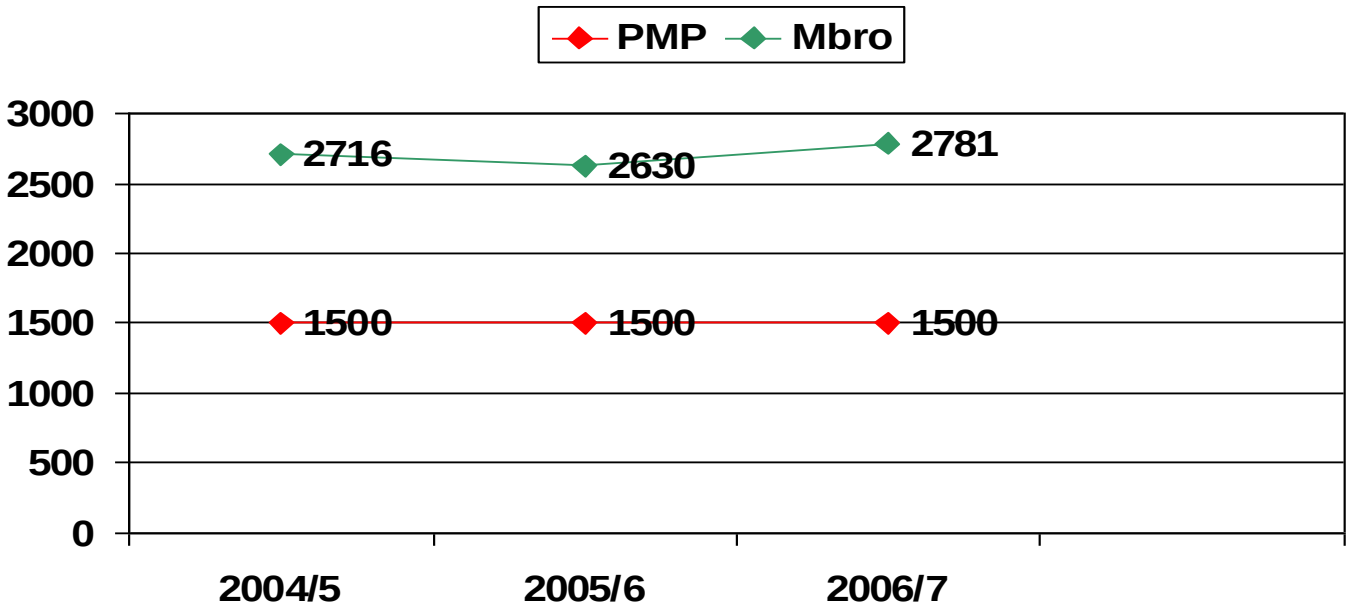


Cardiothoracic Services

South Tees Hospitals NHS
NHS Trust

Revascularisation Procedures PMP





70. Whilst the graph on page 14 shows largely no change in the rates of CABG procedures, the Panel was particularly interested in the graph which is shown on page 15.

71. The numbers are presented on the basis of Middlesbrough's population. The PMP figure, (which remains constant at 1500) is the number of procedures that the NSF[11] says a town with Middlesbrough's population should be averaging. In reality, there is a need for almost double that amount in Middlesbrough.

72. The Panel heard that from one perspective, this was a reassuring statistic as people who were in need of care were receiving the services they required, as Middlesbrough PCT is commissioning effectively for the needs of its population. The Panel understands and accepts this position, which reflects the reality of the local NHS having to deal with the 'here and now'. Nonetheless, in considering the totality of the statistical outlook, the Panel finds it extremely disconcerting that such a need is present in Middlesbrough, which represents double the figure that should be average for Middlesbrough.

73. Whilst statistics of this kind demonstrate the need for and vital role of facilities at JCUH, such a service is nonetheless 'firefighting' to an extent. The Panel feels such data indicates that detailed and urgent consideration needs to be given to programmes, aimed at reducing the proportion of people ever needing to 'walk through the door'. The Panel heard that this was also the view of those working in JCUH, although they can only deal with what they are asked to deal with. The Panel also heard that in the view of the witnesses, the service works very efficiently and ensures that taxpayers get value for money.

74. The Panel moved onto to hearing from the South Tees Trust regarding cardiac rehabilitation services provided by the Trust. Initially, the Panel heard that there are 4 phases in respect of rehabilitation. Phase 1 is when the patient is in hospital, phase 2 is post discharge, and phase 3 is the rehabilitation programme course, which is mostly done in the community. Finally, Phase 4 is known as a maintenance programme, which a local (voluntary sector) support group runs called *Take Heart*. This group provides advice, arranges walking groups and works closely with leisure services. The Panel heard that patients pay to access this service. The Panel was told in quite clear terms that Cardiac Rehabilitation is very much an area 'ripe for growth', which the Panel understands is a matter of discussion between the PCT and South Tees Trust presently.

75. To build upon the points outlined above, the Panel heard that in considering preventative services and on the other hand managing and addressing poor health, a balance is required to be struck in terms of resource allocation. The Panel heard that in the view of the South Tees

[11] Coronary Heart Disease National Service Framework – can be accessed at www.dh.gov.uk

witnesses, that balance is now out of kilter, in favour of an over reliance on acute hospital based care, which is, by definition, after the fact. It was pointed out that such an imbalance within the NHS is reflective of a society which seems too focussed on managing poor health than preventing as much poor health as possible.

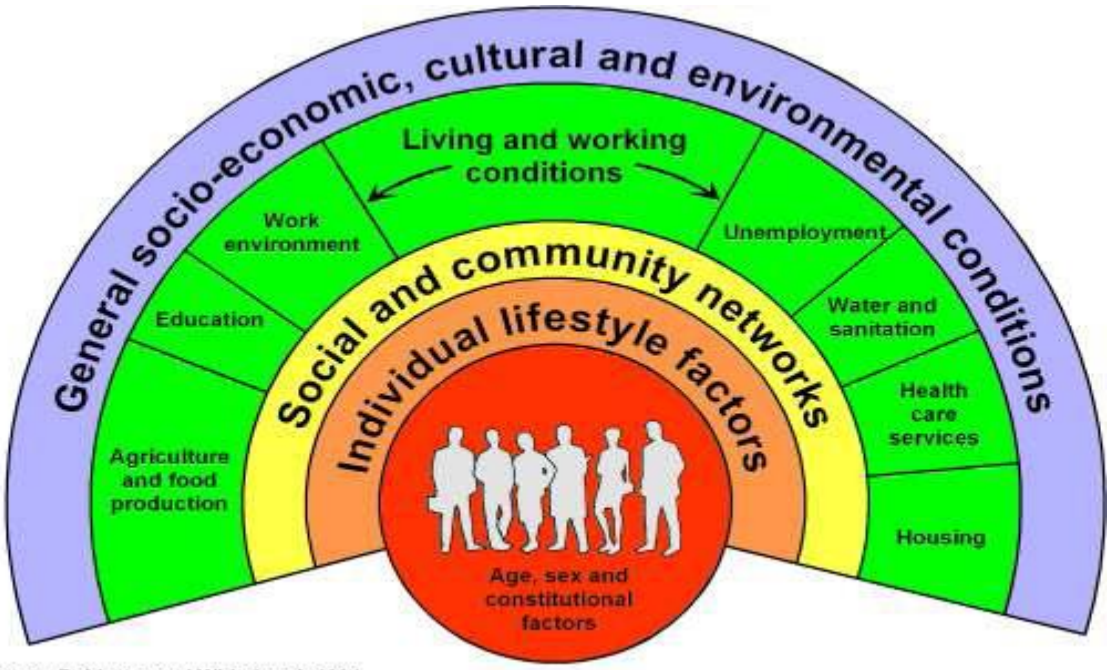
76. The Panel heard that, in the view of South Tees Trust, a concerted effort is needed to tackle childhood obesity as a matter of some urgency. The most appropriate place for this to be co-ordinated from is at PCT level, with any such campaign tackling the matter 'on the front foot', addressing causes of obesity assertively with appropriate funding. If such a course of action is not taken, the Panel heard that in the view of the South Tees Trust, future generations of clinicians will struggle to cope with the sheer magnitude of the legacy of obesity.

77. In considering this topic, The Panel was very keen to acknowledge that whilst Life Expectancy and CVD is an health issue first and foremost, requiring the consideration of substantial health data, the issue also has a clear and distinct socio-economic element. The Panel thought that it was vital to explore this in more detail.

78. To that end, the Panel invited representatives from the University of Durham's Centre for Public Policy & Health to provide their views on four distinct elements. Firstly, to provide an overview of the research evidence around social determinants of health. Secondly, to discuss specific issues around worklessness and economic activity. Thirdly, to cover recent policy approaches to inequalities and the perceived difficulties in basing policy on research. Finally, the barriers for effective commissioning for public health would also be considered.

79. The Panel heard that when discussing health inequalities, it is important to note that there are differing kinds of inequalities. These can be socio-economic/class related, area-based inequalities and other forms of inequalities such as ethnic or gender related. The Panel also heard that it is important to conceptualise health inequalities. There could be health disadvantage, which would tend to prevail in areas of deprivation, health gaps could represent a gap in service within a certain area. The notion of health gradients was also mentioned, where as socio-economic positioning within a society operates on a gradient so do health inequalities. This concept, therefore, dismisses the notion that there are 'have and have nots' or 'healthy and unhealthy' and asserts that it is much less black and white than this.

80. The Panel was interested to see the following diagram, which is Dahlgren & Whitehead's rainbow model of the determinants of health.



Source: Dahlgren and Whitehead, 1991

81. As an extension of the above, the Panel spoke further about some key ideas relating to social determinants of health. The first examples that many would think of are material and economic determinants such as income and quality of housing.

82. Somewhat less obvious are the psychosocial determinants of health, which are of a relative nature. The example was given of a study into civil servants in London. Whilst one could say that all belonged to fairly high socio-economic group, the research found that the higher one was situated in the civil service hierarchy, the healthier people were. This study supports the concept of gradients existing in health outcomes.

83. The importance of lifestyle behavioural determinants of health was also mentioned, which refers to diet and exercise for example. Whilst lifestyle behaviour is fundamentally an individual's choice, research does suggest that those in higher socio-economic groups tend to take lifestyle/public health guidance on board more often than those in lower socio economic groups. The natural consequence of this is a disparity in life expectancy and frequency of illness.

84. The role of health services is also key in determinants of health, as is a concept known as the *inverse care law.* The inverse care law was suggested around 36 years ago by Julian Tudor Hart in a paper for *The Lancet*, to describe a perverse relationship between the need for healthcare and its actual utilisation. Put simply, this means that those who most need medical care are least likely to receive it. Conversely, those with the least need of healthcare tend to use health services more (and more effectively).

85. Although Tudor Hart did not provide hard evidence to support his hypothesis, many others have. There is also plenty of evidence now

from routine health service data – such as the NHS performance indicators and from the surveys of NHS patients.

86. In areas of with high needs, such as inner cities and deprived areas, there tend to be fewer doctors working with higher caseloads and sicker patients. Although GPs are encouraged to work in 'underdoctored' areas through a system of incentives, these have not enticed enough GPs to work in the poorest areas.[12]

87. The Panel was reminded of the importance of early years for children in developing into healthy adults and the importance of foetal development.

88. Another idea that relates to social determinants of health is that of social mobility, or lack of. The Panel heard that this concept was developed in the *Black Report,* whereby those who reside at the bottom of the social scale tend to be the most ill. There is also a debate as to whether poor health follows poor income, or poor income follows poor health.

89. The Panel also discussed the topic of Worklessness, economic inactivity and its relationship with poor health outcomes. The Panel heard that evidence does seem to indicate that work (or at least some sorts of work) is good for people and their health outcomes. The Panel heard that the type of work that people do is also very important. The Panel heard that a lot of jobs that are common in the North East are no better for ones health than not working at all.

90. This discussion emphasised to the Panel the importance of regeneration activities that are presently ongoing within Middlesbrough. Whilst the Panel understands that CVD is fundamentally an issue of health, the impact of significant numbers of well paid jobs being available would provide a major lift to the health of the town. The Panel feels that such a debate on the links between worklessness and poor health demonstrates that whilst regeneration is crucial for the economic health of the town, it is also crucial for the health of the town.

91. The Panel discussed the post 1997 policy climate in respect of health and associated inequalities. The Panel heard that whilst there had been a governmental commitment to reducing health inequalities, a lack of clarity around policy aims and a lack of policy coherence had challenged that ambition. An example of this would be on one hand, the emphasis on individual lifestyle behaviours and increased choice, which is reinforced by the *Choosing Health* document. On the other hand, there is also an increased emphasis on secondary prevention and smoking cessation figures, which are linked to targets. To expand on this, the use of something like a statin for cholesterol levels is quite a short-term measure and to some extent, it represents an intervention after the fact.

[12] Inverse Care Law – John Appleby & Chris Deeming. 21.06.01, Health Service Journal. Can be accessed at www.kingsfund.org.uk/publications/articles/inverse_care_law.html

The Panel heard that there are not enough longer-term targets and longer-term goals.

92. Most of the targets established for such areas of activity refer to fairly short, sharp tactics and are not conceptualised for the long term. The Panel felt that this is perhaps also an example of a government requiring to stand for election every 4 or 5 years and as such, requiring something to 'show' the electors. The Panel heard that even policies aiming to tackle wider determinants of health tend to be targeted, area based interventions, such as the Spearhead[13] areas. The Panel heard that the existence of such time-limited schemes, demonstrates that true public health or preventative work is not yet sufficiently part of the core business of the NHS. Further, if such problems require to be tackled, they cannot be tackled by time-limited schemes, but over a generation or more.

93. The Panel also heard about the difficulties of basing policy and practice on the research available. Firstly, amongst academics there are disagreements over what represents the best intervention methodology. In addition, there is currently more research material available on causal pathways than on interventions, although that is starting to change with systematic reviews of interventions starting to emerge.

94. The Panel also heard that there is still, in the UK, a dominance of the medical model of health. That is the topic of 'health' is associated with hospitals and ill health, seeing the NHS as not a health service per se, but a sickness service. The Panel heard that a more social model of healthcare would focus on keeping people healthy and not having to 'rescue' them from ill health. It was also noted that hospitals and the medical model of healthcare is politically important and some preventative themes of work may not be supported politically of financially due to the 'attraction' and emotive tone of the medical model of care, when elections are to be won.

95. The Panel also heard about a research project completed by the University of Durham, aimed at establishing the barriers to Commissioning for Health & Well Being. The Panel heard that the research team contacted a number of PCTs and Local Authorities around the country and found that shifting commissioning into a more preventative agenda was widely supported. It was felt that an incoherent policy climate, with such agendas as practice based commissioning made it more difficult for PCTs to take a lead on commissioning for health. Further, there was a feeling that workforce skills were in need of development. Essentially, the research highlighted a doubt amongst

[13] These are a group of 88 Primary Care Trusts, identified using information on deprivation, mortality from cancer and heart disease as well as life expectancy to determine the areas who face the greatest health challenges. They were first to pilot initiatives such as health trainers and enhanced Stop Smoking Services, following the Public Health White Paper.

PCTs as to whether sufficient people were sufficiently trained to commission for the new agenda of preventative and earlier intervention.

96. The Panel also heard that limited resources created a problem for commissioning preventative services. The research project revealed that only one PCT that was contacted actually spent its entire public health budget on public health matters. In the other cases, at least part of the public health agenda was used to address budgetary deficits. In addition, the dominance of the clinical agenda within the NHS (i.e. the expense of the local hospital) does not assist in PCTs being able to invest heavily in preventative work.

97. The Panel debated the dominance of the clinical model further with the witnesses in attendance. It was felt that the over reliance on 'after the fact' medical care in the UK was unhelpful and a greater balance needs to be struck. Whilst it is accepted that fire fighting is essential, an over reliance on the matter detracts from preventative services denotes a system storing up problems for itself over the long term.

98. The Panel heard that there is a peculiarly British mindset in relation to healthcare, which is one of people waiting until they become unwell and then expecting to be 'fixed'. It was said that the media and political discourse of the day exacerbates this concept, with most significant health related stories centring on what happens or has happened at a hospital.

99. The Panel also heard that patient consultations often reflect this, with the patient expecting to be able to be supplied a remedy for their ailment to be addressed, looking on the NHS as a paternal or maternal organisation. There is, the Panel heard, not enough emphasis on the patient being required to do things to help themselves, whether that may be lifestyle matters, or 'body aware' type measures. It was also said that evidence based medicine should always be the leading consideration, although in the instance of preventative over reactive medicine, that is not always the case.

EVIDENCE FROM THE CLEVELAND LOCAL MEDICAL COMMITTEE AND BRITISH HEART FOUNDATION

100. The Panel was particularly keen, in considering the topic, that it receive information on the role of General Practice in addressing CVD. To this end, the first witness at the Panel's meeting on 1 October was the Secretary of the Cleveland Local Medical Committee, which represents the interests of all serving GPs across Tees.

101. The evidence commenced with some background information General Practice and the roles they are responsible for. The Panel heard that most GPs are independent contractors, who provide services that are broken down into four components and they are paid depending on what they offer. These are:

102. Essential services – this is the type of service that most people would associate with General Practice. The classic example of this is when someone is unwell or has particular symptoms and approaches the GP as the first port of call.

103. Additional services **–** this covers services such as providing health promotion messages/advice and immunisation.

104. Enhanced services **–** this covers services, which have been traditionally provided in a hospital setting, such as some diagnostic tests.

105. Quality & Outcomes Framework – QOF is the annual reward and incentive programme detailing GP practice achievement results. QOF is a voluntary process for all surgeries in England and was introduced as part of the GP contract in 2004.

106. The QOF awards surgeries achievement points for:

- managing some of the most common chronic diseases e.g. asthma, diabetes
- how well the practice is organised
- how patients view their experience at the surgery
- the amount of extra services offered such as child health and maternity services.

107. The heard that the rollout of the above components, as part of the recently introduced GP contract, represents a move towards a more systematic link to the quality of care provided for patients.

108. By way of further background, the Panel heard that it was important to consider the role of General Practice against a decade of escalating demand for the services that it provides. The Panel was presented with figures, which indicated that in 1995, the average number of consultations per patient per year was around 3.9. In 2006 that had escalated to around 5.2, which represents a 35% increase in the number of consultations per patient per year in General Practice.

109. The Panel heard more in relation to the QOF and how it encourages General Practice to act more proactively than under the old system. This is especially true when considering the contributory factors to CVD and CHD. As such, the QOF offers incentives for General Practice to focus upon such issues as Diabetes mellitus, hypertension (high blood pressure), smoking cessation and secondary prevention of CHD. On the point of smoking, the Panel heard that tobacco use is the main cause of CVD in people, with Middlesbrough being no different. Of more concern, the Panel heard, was the number of people who GPs speak with, who say that they obtain their cigarettes from illegal sources at cheaper prices. The Panel is fully aware that tobacco products bought through legitimate means present a grave risk to the health of those who smoke

them, although evidence would appear to indicate the illegal products are even more dangerous.

110. The Panel was advised of rates of CHD in Middlesbrough for a three-year period ending in 2006/7. Evidence presented to the Panel indicated that in all three years, the Middlesbrough average for CHD was actually lower than the North East region average. Whilst the Panel (and the witness) were surprised at this figure, it was thought that the substantial student population in Middlesbrough would bring the statistics down substantially. It was felt that should students be excluded from a study and the permanent population of Middlesbrough be concentrated on, the rates of CHD would be much higher.

111. The Panel enquired as to what exactly is done in General Practice with reference to Heart Disease. It was confirmed that each practice has a register of patients with CHD and that appropriate investigations are performed with patients at the diagnostic phase. Blood pressure of those on the register should be checked at least once every 15 months and a satisfactory level of blood pressure control should be achieved. People's cholesterol should be measured and kept under the safe score of 5. Drugs are prescribed at appropriate junctures and flu jabs are provided for those at risk groups.

112. The Panel was also advised what General Practice does to tackle diabetes. Again, there is a register of patients with diabetes and patients weight/height ratio is recorded. Levels of diabetic control are taken, specific examinations are conducted and the patient's blood pressure is checked and managed. Kidney function tests and associated treatment is conducted, in addition to cholesterol related measures being taken and the flu jab is also given when appropriate.

113. In respect of Blood Pressure, the Panel heard that there is a register of patients with a high blood pressure, which is measured and managed at a satisfactory level. In relation to smoking, the Panel heard that a record is kept of patients smoking status and smokers receive advice or are referred to smoking cessation clinics when they attend the surgery.

114. The Panel heard that General Practice is doing very well against the targets it is set by central government in respect of CHD, Blood Pressure and Diabetes. In all three domains, over the course of the last three years, General Practice has obtained 90%+ achievement against national targets.

115. Following consideration of the information presented, the meeting opened up into a debate around the points put forward. It was confirmed that General Practice is doing well against the targets set for it and it is getting a lot better at working towards an increasingly public health/proactive agenda.

116. Enquiries were made in respect of the role that Practice Based Commissioning could have in developing preventative services, with GPs placed at the fulcrum of driving such improvements. The Panel heard that in the view of the CLMC, preventative commissioning was developing well for those who require such services and who already have a recognised CVD related complaint.

117. Whilst the Panel thought that such improvements should be applauded, it put forward the view that services are developed and configured to swing into action once a problem has been identified. There are, therefore, still somewhat after the fact and are examples of secondary prevention or preventing matters getting worse.

118. On a hypothetical point, the Panel raised with witnesses the concept of statins (cholesterol controlling drugs) being prescribed to all people over 50's, which has been the subject of professional debate recently. This matter has been floated by the National Clinical Director for Coronary Heart Disease and has been supported by a recent story in *The Times*[14], of a study highlighting the health benefits of such an approach. Essentially, the idea is that all people over the age of 50 should be prescribed statins, to prevent heart disease, even if there is no existing problem with the individual's health. The hope is that this can act as a "shortcut" in preventing heart disease. The Panel heard that, in the view of the CLMC, this is a rather controversial point. Statins are not risk free drugs and can produce side effects. The Panel heard that ultimately, it is a moot point, which is yet to be resolved.

119. Nonetheless, it is a very important matter to be pursued. The article from The Times highlights that statins are currently taken daily by an estimated three million people in Great Britain, with CVD being responsible for 1 in 3 deaths. The Times estimates that the annual cost to the economy is around £26billion a year, with the bulk of that being treatment costs.

120. Whilst there is a current cohort of people with CVD requiring the NHS' full attention, the Panel accepted the CLMC's view that the next generation is absolutely paramount. Further, preventative services need to evolve to a stage where problems are eradicated before they become sufficiently serious and can only be managed. In short, 'prevention' needs to become prevention in the truest sense of the word, rather than having its routes in disease management or rehabilitation. It was accepted that improvements are coming about and the system is improving, although further development is required to make the system truly preventative. On this point, it was also stated that despite the good progress General Practice is making on being more prevention focussed, such services are only delivered to those who visit the surgery. There is, as such, no systematic screening process and by

[14] *"The pill of life: statin benefits last a decade"* October 11, 2007. www.timesonline.co.uk This study showed that people who take statins are protected from heart disease and premature death years after they stop taking them, according to a major study.

definition the preventative services can come across as rather haphazard.

121. It was unanimously accepted, however, that General Practice or indeed the NHS, cannot deliver on such an ambitious programme in isolation. Society as a whole is required to consider the messages it puts across to young people on diet, exercise and living life for the long term. This would also include the exercise and advice facilities that are made available for people. It was emphasised at this point, however, that such messages had to be put out now. The longer society waits, the bigger the public health problem it is storing up.

122. This point was extended when the Panel discussed the idea of undiagnosed disease, which will place a greater burden on the NHS in years to come.

123. As an example of this, it was stated that the rate of diabetes is increasing in the population, with a significant number of people going undiagnosed. The Panel heard that historically, around 2% of the population have had diabetes, although that has now increased to around 3.5% of the population.

124. There are two forms of diabetes. Type 1 diabetes develops if the body is unable to produce any insulin and usually appears before the age of 40. Type 1 diabetes is the least common of the two main types and accounts for between 5-15% of all people with diabetes.

125. Type 2 diabetes develops when the body can still make some insulin, but not enough, or when the insulin that is produced does not work properly (known as insulin resistance). In most cases, this is linked with being overweight. This type of diabetes usually appears in people over the age of 40, though in South Asian and African-Caribbean people often appears after the age of 25. Recently, however, more children are being diagnosed with the condition, some as young as seven. Type 2 diabetes is the most common of the two main types and accounts for between 85-95% of all people with diabetes.

126. According to Diabetes UK, there are currently 2 million people with diabetes in the UK and there are up to another 750,000 people with diabetes who have the condition and don't know it.[15]

127. Following the presentation from the CLMC, the Panel heard from the Director of Prevention & Care at the British Heart Foundation (BHF). By way of introduction, the Panel heard that the BHF is a charity with a UK wide remit and was founded in 1961. Its vision is "a world in which people do not die prematurely of heart disease".[16]

[15] www.diabetes.org.uk/guide-to-diabetes

[16] Please see www.bhf.org.uk

128. The Panel was presented with some statistics specific to Middlesbrough. The Panel heard that, in men, there were 100 deaths from 2003-5 from CHD. In Middlesbrough there are 60.21 deaths per 100,000 men from CHD. For women, that figure is 33 deaths for 2003-5 and 19.47 deaths per 100,000 people.

129. It is, the Panel heard, important to see CVD in its proper context and that it is generally a good news story. Rates of CVD have been falling since the 1970's and continue to fall. It is estimated that 40% of that improvements is down to medical intervention and 60% is due to changes in people's lifestyle. A good example of this is falling number of people who smoke.

130. In this respect, the Panel heard that in the view of the BHF, public policy makers are absolutely crucial to the effort to reduce CVD further. The BHF said that the above figures indicated the importance of the policy environment in bringing about change in the field of public health.

131. The Panel was interested to hear about the BHF's activity in Middlesbrough. The Panel heard that the BHF has invested in one defibrillator for the town and there are 17 schools that run the *Heartstart* scheme, aimed at teaching children from a very young age the importance of heart health, first aid skills and how to stay healthy.

132. The BHF has invested in Community Emergency Life Skills training for Middlesbrough, which is delivered by the Fire Brigade and it has invested in 1 Community Resuscitation Co-ordinator. The BHF has invested in three arrhythmia nurses, who operate with Middlesbrough residents suffering from irregular heartbeats. There is also one BHF shop and a fundraising/volunteer manager.

133. The Panel heard that there are a number of drivers for change with respect to CVD, which now require attention if progress is going to be maintained. Firstly, deaths from CVD are falling, although increasing amounts of people are living with the condition, which brings about its own pressures. It is a disease that is associated with, and tends to be concentrated around, areas of poverty and it is those areas where funds are required to be spent most heavily.

134. Despite the fact that tobacco use is decreasing and that is having an impact on CVD rates, it appears that the topic of obesity has the potential to replace and even surpass the impact of tobacco use on CVD rates. It is estimated that 80% of CVD is preventable. Whilst there are some instances of CVD that are of a genetic nature, most are dependent on lifestyle. Unless lifestyles improve, there will be no corresponding improvement in CVD rates.

135. It was accepted that the NHS can be used to move matters forward in this respect, although the topic of lifestyle and its ramifications is wider than the NHS and society as a whole has a responsibility to face up to

the issue. Part of this is that, it could be argued that a change in the patient/doctor relationship is also required. The Panel heard that in the UK, there is perception of clinicians as maternal or paternal figures that are there to solve any problems when they arise. The Panel heard that it may be that to make inroads in CVD rates, patients need to view themselves as active players in their health and healthcare and not merely the passive recipient of a state funded service. If people can embrace more fully the concept of self-care and take more responsibility for their health, improvements may be forthcoming.

136. On the point of proactive care, the Panel was informed about the Wanless report on Public Health. The 2002 Wanless review estimated that health promotion expenditure is around £250 million per annum. For clarity, that is less than NHS spends in entirety in a day and a half. The Panel felt that these figures was stark to say the least and is a useful illustration of how much the NHS is 'configured' to deal with sickness and ill health, rather than proactively intervening in people's health at an earlier stage.

137. The Panel heard that this approach is compounded by the fact nationally, public health budgets are often the first budgets to be accessed when budgetary pressures are mounting. Whilst the Panel stressed it had no evidence of this happening locally, the fact that it has happened around the country adds weight to the idea of public health promotion and earlier preventative work being a desirable extra of an overly clinically focussed NHS.[17]

138. The Panel heard, however, that there is an increased political ambition at a national level to address health inequalities and the causes of ill health. In his maiden speech[18] as Secretary of State for Health, Rt Hon Alan Johnson MP, has highlighted this theme as a priority for his tenure. In his speech, he highlighted that "for every stop on the Jubilee Line between Westminster and Canning Town, life expectancy goes down by one year."

139. Later in his speech, Mr Johnson went on to say that "Since the 1930s, despite the creation of the NHS, massive social reforms and unparalleled scientific advances, the gap in mortality between professional and unskilled men has more than doubled"

140. Continuing with the BHF's evidence, the Panel heard that to tackle CVD effectively and systematically, it requires the input of a much greater number of agencies and approaches, than simply labelling it an NHS problem for the NHS to solve. Nonetheless, the NHS has a huge role to play.

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[17] This point has also been reinforced by the recently published "State of Healthcare" 2007, by the Healthcare Commission. Can be found on www.Healthcarecommission.org.uk

[18] Speech in the House of Commons, by Rt Hon Alan Johnson MP, Secretary of State for Health, 12 September 2007: The Healthy Society. Can be accessed at www.dh.gov.uk/en/news/speeches/dh_078397

141. The Panel heard that one cannot underestimate the importance of services such as education and social care in educating people and catching people 'further upstream', before more problems develop. On this theme it was argued that by the time people require NHS intervention, the system may be coming into force too late.

142. The Town Planning regime was cited as critical to this theme and specifically whether urban design allows people to lead more active lives. This is also related to a public transport system, which is affordable and allows people a real choice to leave their cars.

143. The Panel also heard that local business and associated regeneration activities are absolutely crucial. There is substantial evidence that well paid employment and associated prospects for young people in the town have a huge impact upon the health of a given area. The Panel heard that affluent areas of the UK also have better health statistics than towns like Middlesbrough. People in wealthier areas are not genetically different, although they do nonetheless live longer. The Panel felt that this not only highlights Regeneration activities as important to the economic health of the town, but also the physical health of the town.

144. The Panel heard about some issues that were, in the view of the BHF, highlights of the recent fight against CVD. It was said that, in respect of tobacco use, smoking cessation services were something of a success story. They had received substantial numbers of people accessing the service and the value for money of the service was very good.[19]

145. It was felt that the new General Practice contract represented a step forward as it encouraged GPs to proactively investigate matters such as hypertension, cholesterol and diabetes and control such conditions if they were identified.

146. Access to Emergency Care was also highlighted as an element of good news in the fight against CVD. It was said that the timeframe between emergency care being called and clinical action being taken (call to needle time) has been improving greatly on a national basis. The Panel heard that, ironically, one of the biggest barriers in people accessing emergency care is themselves. Many people do not know the symptoms of a heart attack and some who do, fail to contact health services hoping that 'it will pass'. As a result of this phenomenon, the BHF launched an advertising campaign known as 'Doubt Kills'.

147. The British Heart Foundation completed its presentation to the Health Scrutiny Panel by outlining its views on what could be described as 'unfinished business' in respect of CVD.

[19] Please see "Stop Smoking Clinics work" for more information on this topic. It can be accessed at http://news.bbc.co.uk/go/pr/fr/-/1/hi/health/7127193.stm

148. The Panel heard that, in the view of the BHF, there is still significant work to do on prevention and preventative services. It was said that, despite the undisputed importance of acute services, the NHS (and probably society as a whole) places too much emphasis on the role of acute care/secondary prevention, at the expense of truly preventative and proactive work.

149. The BHF also advised the Panel that cardiac rehabilitation is patchy from region to region and work is required to bring the area of service up to the same standards across the country.

150. It was said that end of life care in respect of CVD was also in need of improvement. The Panel heard that there had been significant funds invested in end of life care for cancer services, although CVD services had lagged behind. This is despite the fact that CVD is, on average, responsible for more deaths per annum. A shift is needed it was said, as feedback on end of life services in cancer was very positive, but was less so in CVD related services.

151. The Panel heard that in the view of the BHF, there is also still work to do on Chapter 8 of the Coronary Heart Disease National Service Framework. The first seven chapters of the NSF were published in 2000 and concentrated on standards of treatment around disease of the arteries. Chapter 8 was published in 2005 and concentrated on the heart's electrical signals and specifically on a condition known as Arrhythmia.

152. An arrhythmia is an abnormality of the heart's rhythm, either caused by an inherited problem or by an acquired condition that disturbs the electrical impulses which regulate the heart. The heart may beat too slowly, too quickly or in an irregular way. The symptoms a person may experience include palpitations, loss of consciousness, dizziness and breathlessness. In extreme cases, certain types of arrhythmia can cause sudden cardiac death.

153. Cardiac arrhythmia affects more than 700,000 people in England and is consistently in the top ten reasons for hospital admission, using up significant A&E time and bed days. Atrial fibrillation (AF), the most common arrhythmia, affects up to 1% of the population (rising to 4% in the over 65s) and absorbs almost 1% of the entire budget of the NHS. The overall incidence of stroke is about 5% per year in people with AF, so it is a significant cause of mortality in England.[20] The Panel also heard that services for people with, or at risk from CHD as a result of genetic conditions could also be improved on a national scale.

[20] See Chapter 8, Coronary Heart Disease National Service Framework. Can be found at www.dh.gov.uk

154. Following the BHF's initial presentation, the meeting moved forward into an informal discussion of the points raised and questions were put to the two speakers.

155. The debate moved onto the topic of commissioning services and specifically, whether the present balance in commissioning priorities is a correct one, or if the balance is skewed somehow.

156. The Panel heard that, in the view of the witnesses, commissioning is too focussed on the acute sector. Pointedly, it is also still commissioning too much of what is provided, as opposed to what is needed or required. To clarify that point, the NHS and the expenditure of its funds is dominated by the clinical agenda, to the detriment of other areas of service. The Panel noted that this is a concept that has been raised with the Panel elsewhere in this review.

157. In terms of tackling this imbalance, the Panel heard that patient voice and public health intelligence are absolutely paramount in challenging the status quo. An example of the power of a collective patient voice was given with the recent emphasis on hospital cleanliness. It was said that this topic was not one of great managerial or clinical importance, although the public's interest in the matter has pushed the matter forwards, into the political limelight and up the national news agenda. Something similar could be achieved, if the popular consciousness was sufficiently aroused in considering the way that NHS services are planned and paid for.

158. Public Health intelligence is also critical in challenging the prevailing wisdom of service configuration. If public health data can demonstrate, over time, that informed and earlier interventions have a greater impact on a person's health, services can be reconfigured accordingly. If the system 'waits' for people to get ill and then treats them in an acute setting, it is only ever treating symptoms and not the cause. Whilst the role of the acute sector should never be devalued or downplayed, it does appear that more emphasis should be placed on trying to prevent (at least some) people from ever needing acute care. Otherwise the logical prediction would seem to be, with an ever-increasing elderly contingent of the population, that the acute sector would be increasingly stretched.

159. The above two themes of patient voice and public health data are very good examples of how the Commissioning agenda can be more informed than it arguably has been in recent history. In increasing preventative services, there is a cost benefit for the system in that people with problems or potential problems, are easier and cheaper to deal with. There is, it was asserted, also a moral benefit in this approach, in that some people and their families are being spared the trauma of all that is associated with emergency care.

160. As an extension of this point, the Panel explored with witnesses the concept of screening.

161. Mention was made of the increasingly proactive approach that General Practice is taking in checking patients for various conditions and that on a three year cycle, General Practice tends to see around 90% of the population.

162. The Panel heard that whilst such progress was important and should not be devalued, General Practice is nonetheless performing such tasks on an opportunistic basis, when patients happen to be in the surgery for something else. In essence, it is not very systematic.

163. The Panel heard that there is substantial evidence to indicate that proactive screening should take place, for certain sections of the community who may be in certain high risk groups, whether it be age related or any other factor. On this point and following additional research, the Panel actually sees it as something of an anomaly that there is not a screening programme for CVD, yet there is for some cancers.

164. One in four (26%) of all deaths in the UK are caused by cancer, according to Cancer Research UK[21]. According to the British Heart Foundation 39% of deaths in the UK are caused by CVD, making it the UK's biggest killer[22]. Without wanting to reduce the debate to a numbers game, it is clear that a significantly higher proportion of people die from CVD than cancer, in the UK, every year.

165. At this juncture, the Panel wishes to make it absolutely clear that it is entirely supportive of the aims and practices of screening programmes for cancers such as Breast, Cervical and Bowel. Indeed, it has been suggested that Breast screening alone saves around 1,400 lives per year[23]. It is, however, interested in highlighting the apparent anomaly that a bigger killer than cancer, namely CVD, does not have any national screening programmes for people at risk.

166. It strikes the Panel that if an intention exists within health economies to prevent more people from ever needing acute care for CVD, a systematic and targeted screening programme of some description is a vital prerequisite. Otherwise a system is forever relying on screening people in an opportunistic fashion, as and when they present. This sort of approach does nothing to address health inequalities, as there is still a cohort of people who do not access GP services.

167. The discussion moved into discussing the sort of steps that communities can take. The Panel heard that local authorities, as planning authorities, can have a huge impact on determinants of health. Examples were given around ensuring that local people have adequate access to open spaces in new developments, or ensuring that transport links play a part in

[21] Please see http://info.cancerresearchuk.org/cancerstats/mortality/cancerdeaths
[22] Please see www.heartstats.org/topic.asp?id=17
[23] Please see http://cancerscreening.org.uk/breastscreen/#footnote2

encouraging active lifestyles. Mention was made of planning authorities conducting Health Impact Assessments when considering the merits of particular applications. On this point, the Panel heard that if central government was truly dedicated to tackling poor health through all available means, guidance was needed on the role that HIAs can play in considering planning applications. The debate mentioned that a lot of applications, even if rejected at Committee, are often granted on appeal and the local authority is then obliged to cover the cost. It was felt that elected local representatives should be able to exercise more control over their physical environment. An example was given over whether any given town really needs more fast food outlets, although if rejected planning permission will often be granted on appeal. Whilst the Panel understood that planning authorities can be restricted by national guidance and the 'must dos', the above demonstrates how ensuring a healthy population is a much bigger responsibility than that of the NHS.

168. The Panel also broached a wider societal issue, that of diet and people's attitude towards it. The Panel heard that one of the issues causing the greatest concern to the BHF was that of obesity in children. There is now a generation of young people who face the very real possibility of dying before their parents in terms of life expectancy. This would be the first generation to have worse life expectancies than their parents in hundreds of years of medical advances. It is not an epidemic of illness that would cause this, but the way that a generation chooses to live their lives. Whilst there is an element of personal and parental responsibility in this matter, there are significant societal issues that require exposure and exploration.

169. Mention was made of the lack of physical activity in a lot of children's lives and whether facilities are 'up to scratch' or not. It was agreed that this was a separate area of study, although the fairly recent phenomena of proliferating 'no ball games' [24] signs on green spaces was symptomatic of a society not trying hard enough to get children active and away from sedentary activity such as watching television and playing with computers. The Panel heard that a collective responsibility was required to tackle this attitude. Indeed, aside from the moral arguments of this approach in sparing people from ill health later in life, there is also a hugely compelling argument in financial terms. If this issue is allowed to progress unchecked, the NHS will be overwhelmed by the episodes of ill health requiring attention, which will then pose very real political questions over how the NHS is funded. Nonetheless, it is this generation that requires urgent attention. As yet, the wide scale damage of childhood obesity appears to be reversible and this generation is sufficiently 'upstream' to be tackled, although the consensus was that there is no time to lose.

[24] A recent central government initiative looks to be attempting to challenge the 'no ball games' phenomena. Ed Balls, the Children's Secretary, said on December 11th that he wants to move away from the 'no ball games' culture of the past, which curtailed the freedom of children and young people to learn and develop by playing indepedently outside the home. Please see http://www.timesonline.co.uk/tol/news/uk/education/article3037365.ece

170. The Panel also discussed the issue of diet regarding the wider population. It was said to the Panel that high quality, wholesome food is key and its availability is still quite restricted and exclusive. The labelling of food is not explicit enough to allow people to make quick, informed choices over product content. The panel heard that the 'traffic light' system of food labelling is particularly effective in assisting people in making healthy choices, which is in use by certain brands. Nonetheless, there are 'commercial pressures' in existence which dictate that the traffic light system is not in universal use and remains a voluntary system of food labelling. The Panel heard that if this one measure was made mandatory by central government, it would have huge impact on consumer's buying habits and eventually, their health. On the role of central government, the Panel was given a particularly good example of how government policy can influence the diets of its population. In Finland, the government decided to shift some farming subsidies away from dairy products and into berry farming, particularly raspberries. The result was that the store price of such products came down and more people started to eat more healthy options such as berry fruits.

171. The Panel heard that inevitably, socioeconomics have a role to play in the incidence of poor health. It is probably the case that the wealthiest elements of society will also tend to be the healthiest, although there is a fundamental question for society to face. That question is how much of a gap or differential in health outcomes is acceptable for a modern society? Whilst the Panel heard that such a question is ultimate a political one, the BHF's view is that the present gap is unacceptably wide.

172. The Panel heard that aside from health service based interventions, one of the most fundamental things a society can do to improve health outcomes and therefore life expectancy, is give people prospects as generally speaking employment is beneficial for your health in many ways. If people feel they have prospects and a route to those prospects, they tend to be healthier and can make more informed healthy choices.

173. Without those prospects, the notions of choice and people exercising meaningful choice renders 'choice' a middle class agenda. This is because 'choice' assumes that people have the means and opportunities to take advantage of that choice.

174. In terms of developing services, the Panel heard that for maximum effect, localised promotions and programmes should be launched that take cognisance of local problems. In conclusion, the Panel heard that the most important task is to enable people to challenge and make expectations for themselves and their families. In summary it was stated, rather ironically, that it may be to address entrenched inequalities, resources have to distributed inequitably.

EVIDENCE FROM MIDDLESBROUGH PRIMARY CARE TRUST AND MIDDLESBROUGH COUNCIL LEISURE SERVICES

175. At its meeting on 25 October 2007, the Panel took evidence from Middlesbrough PCT on the range of preventative services that are provided in the local community. It was confirmed to the Panel that CVD is the most common cause of death in Middlesbrough and approximately 80% of CVD is preventable. The Panel heard that there are around 8000 people on CHD registers in Middlesbrough. Worryingly, however, the Panel also heard that it is estimated there are around 1200 people living in Middlesbrough who have established, yet undiagnosed CHD. The Panel also heard that it is likely that these people are in the lower socio-economic groups. Of course, it is one matter to estimate and even know that these people exist, although identifying them and taking appropriate medical action is quite another. On this point, the Panel feels that there is little evidence that these people are being sought out, in an assertive and systematic fashion and that methods of doing this should be given urgent thought.

176. Before considering preventative services in detail, the Panel heard that as a principle, whilst James Cook University Hospital is a fantastic facility, it is futile to rely simply on acute facilities as over time, services will be overrun. This is especially do given the topic of childhood obesity that has been labelled as a 'timebomb' and a 'hidden epidemic' amongst others. One only needs to consider the numbers of children now being diagnosed with Type 2 diabetes to consider the future impact upon health services.

177. In terms of existing preventative services, Panel heard about three specific areas of activity of smoking cessation, obesity management/healthy eating and increasing physical activity.

178. In so far as smoking is concerned, the Panel heard that there are now 13 smoking cessation clinics across Middlesbrough with support and advice available. There are also two pharmacies that provide a smoking cessation service. The Panel heard that people who manage to be 'four week quitters' are entitled to one month's free leisure pass, which is usable at Council leisure facilities. On the point of smoking, the Panel heard that of particular concern was cheap cigarettes that are coming into the region through illegitimate routes.

179. General Practice and the Life Store in particular now offer dietary advice for people wishing to lose weight or to keep a healthy weight. This includes GP referrals to leisure facilities and access to weight management classes with appropriately trained professionals.

180. The Panel also heard that endeavours to increase physical activity in the town are ongoing. Specifically, the PCT has appointed a walks co-ordinator. Mention was also made of reduced price leisure centre use in certain circumstances.

181. The Panel made enquires around the work currently being undertaken to assist and identify those in ‘at risk’ groups.

182. The Panel heard that Primary Care (General Practice in particular) engages in opportunistic screening of people, with checks on such matters as Body Mass Index (BMI) and blood pressure. The PCT has engaged in a CVD risk pilot where people are able to attend and be put through a series of checks. The pilot was located in Middlesbrough House. Over 100 people were seen and over 20% of those seen were of a high-risk nature. Nonetheless, the Panel heard that such events still do not attract the lowest socio-economic groups.

183. The Panel was told that the PCT always holds campaigns or promotions to coincide with national events such as national high blood pressure week. On such occasions, representatives from the PCT will pitch information stands in supermarkets, shopping centres and the like and attempt to engage with as many people as possible.

184. Mention was made of the Lifestore and the fact that it offers blood pressure checks and BMI checks on a drop in basis. It also offers health advice on the same basis. The PCT also informed the Panel that some pharmacies across the town now offer cholesterol and blood pressures checks. The Panel also noted that the PCT runs an arrhythmia (irregular heart rhythms) management clinic, which is one of the first in the country. Such clinics can be crucial in the prevention (or at least reduction) of strokes.

185. The Panel also spoke to the PCT about what preventative work is likely to be undertaken in the near future. The Panel heard about an agreement between the PCT and Middlesbrough Council that all employees over 40, would be offered the opportunity to to have a screening in relation to their health, including Blood Pressure checks. Research is currently ongoing, with input from a social marketing expert, on how to entice hard to reach groups to community facilities and to make community based services more accessible.

186. It was said that there is an intention on to increase screening activity in primary care and to make it more systematic. A way of doing this is for the PCT to increase funding for General Practice to pay for this extra activity.

187. The Panel heard that the PCT has an ambition to improve hypertension management, which is an area where people are not always treated to target. The PCT would like to have more of an impact on people’s lifestyle and choices, although no practical examples were given of how the PCT would like to impact upon this.

188. Following consideration of the evidence of the PCT, the Panel moved on to hearing from the Council's Leisure Services and the role that it plays or could play in tackling poor health in the town.

189. The Panel heard that the policy background to leisure services was *The Game Plan*, which was a Government Strategy published in 2002 for sport and physical activity. Its target is to increase from 30% to 70% by 2020 the percentage of the population who participate in 30 minutes of moderate intensity exercise 5 times a week. To build upon that, the Active People Survey 2005/6 shows less than 20% of the adult population in Middlesbrough is physically active more than 5 times per week.

190. It was confirmed to the Panel, therefore, that the aim of Middlesbrough's leisure service was to "make more people more active". The Panel heard, however, that it is not that easy as it sounds and it is probably more of a generational issue.

191. The Panel was informed of the Active Middlesbrough Strategy (2003/8), which was developed with partners and tried to move away from an emphasis on pure sport, as not all people like or want to take part in competitive sport. As a result some people are probably turned off physical activity if competitive sport is the only option.

192. The Panel also heard that the Active Middlesbrough Strategy tried to emphasis the value of physical activity against broader agendas including weight management, mental health and diversionary activity for young people who may otherwise engage in anti social behaviour.

193. The Panel heard that the Sport & Leisure Service has three key aims:

- To contribute to improved health for the people of Middlesbrough
- To help offer sport for sports sake because it is fun and contributes to a positive attitude for individuals and the community
- To offer positive diversionary activity to particularly young people in Middlesbrough.

194. The Panel was told of the facilities that are currently on offer in Middlesbrough which are run by the Council. Those are Acklam Sports Centre, Neptune Centre, Ormesby Sports Complex, Sports Development Service, Claireville Stadium, Middlesbrough Golf Centre, Rainbow Leisure Centre and Southlands Lesiure Centre.

195. The Panel was told that Leisure services' target was to increase participation by 1% per year as a contribution to the Government's Strategy *The Game Plan.* The service currently manages over 1.3 million customer visits per year. Specifically, there are 239,000 visits by young people aged 5 to 17 to take part in coached activities.

196. The Panel was also informed that under 5s are given free swimming in Middlesbrough and during the school holidays, that is extended to young people up to 17 years, with the help of Middlesbrough PCT funding. There are free family sessions at weekends and the service averages 142,000 junior swim visits. On this point, it is noticeable that swimming figures are reduced during school term time, when young people are required to pay.

197. Whilst welcoming the swimming programmes for young people, the Panel thought it hardly surprising that attendance figures reduced when people were required to pay. The Panel wondered, if free swimming during school times was such a success, why was it not extended to specific times throughout the year. The Panel felt that if childhood obesity and the next generation of CVD sufferers was going to be proactively reduced, this was the sort of thinking that was required.

198. The Panel also heard that the Get Active on Prescription has produced over 500 referrals and the weight management programme targets 1000 people. Such programmes as Kidz Power and Teen Tone zone are also important programmes to encourage young people to be active.

199. Mention was also made of the debt owed by the town to the numerous volunteers throughout the town that run sports and activities club for children, often at a cost to themselves, without whom a lot more children would be inactive. The Leisure Service can and does have an important role to play in ensuring such groups receive the publicity they require and deserve. A number of events were also mentioned that encourage physical activity, including Middlesbrough Festival of Sport, Tees Pride 10k and fun run and the Middlesbrough Mela, which is of particular importance given the CVD risks associated with the South Asian Community.

200. Following the presentation, the Panel debated the points raised. The Panel enquired as to how Leisure Services could develop in the future. Reference was made to the fact that the Leisure Service has an income target of £3m per annum, which to some extent required the service to act as a commercial entity, in a commercial marketplace with competitors.

201. Whether this should happen is, of course, a matter for political consideration and political decision making. Nonetheless, the Panel felt that it was an interesting area of debate. If that £3m per annum income target was reduced through subsidy as an example, leisure services could act as more of a public service and less of a commercial beast. The Panel heard that if such a political direction was taken, it could radically alter the services offered by leisure facilities. It was accepted that whilst the pricing of facilities was fairly favourable when compared to private facilities, it was still quite expensive for a family with a limited budget and a couple of children.

202. The Panel accepts, of course, that £3m sounds like a lot of money and it is a lot of money. Nonetheless, when considered relative to the overall expenditure of the local NHS, it does not seem as much. When one considers that Middlesbrough PCT (as a single PCT) spends around £1m every three days at James Cook University Hospital, one looks at the figure differently. Given that a substantial amount of that money expended at James Cook will be on conditions that are largely preventable (particularly CVD), the Panel questions whether using public funds to subsidise services such as leisure, might not be an excellent use of resources. Such an approach would be consistent with national moves to develop the wellbeing element of the NHS and developing it from being a solely sickness service. An approach such as this would enable leisure services to move towards being a public service and move back from having to be a commercial competitor.

203. The Panel accepts that such a move requires a certain amount of political or organisational bravery, as the rewards of such an approach are not instant and will most certainly be deferred to a number of years hence. Nonetheless, the Panel is quite clear that at some point, cycles of poor health need to be broken, unless places like James Cook will be required to work at greater speeds on a greater number of cases, rather like cutting of the Hydra's head[25]. Quite apart from the moral elements of the debate in wanting to prevent ill health, there are also very real financial reasons to shift the focus to preventing as much ill health as possible, as opposed to treating it when it arrives through the door. The North East Strategic Health Authority's vision says as much. "No barriers to health and well being and no avoidable deaths, injury or illness"[26].

A ROUNDTABLE DISCUSSION WITH MIDDLESBROUGH PRIMARY CARE TRUST, SOUTH TEES HOSPITALS NHS TRUST AND CLEVELAND LOCAL MEDICAL COMMITTEE

204. At its meeting on 19 November 2007, the Panel held a roundtable debate, which included representatives from Middlesbrough PCT, South Tees Hospitals NHS Trust and the Cleveland Local Medical Committee. The meeting was conducted around the following three questions:

- What are the current challenges the NHS faces in Commissioning for CVD?
- Where should Commissioning for CVD be in three years?
- Aside from Commissioning, what can the town, and partners, do to tackle CVD?

205. The PCT and the Cleveland Local Medical Committee submitted briefing papers, which can be seen in the background papers to this report.

[25] In Greek Mythology the Hydra had 9 heads and the middle one was immortal. Hercules fought the Hydra with his club, but each time he knocked off a head, two more would grow back.
[26] Can be found at www.northeast.nhs.uk

206. The Panel heard more in relation to the QOF and how it encourages General Practice to act more proactively than under the old system. This is especially true when considering the contributory factors to CVD and CHD. As such, the QOF offers incentives for General Practice to focus upon such issues as Diabetes mellitus, hypertension (high blood pressure), smoking cessation and secondary prevention of CHD. On the point of smoking, the Panel heard that tobacco use is the main cause of CVD in people, with Middlesbrough being no different. Of more concern, the Panel heard, was the number of people who GPs speak with, who say that they obtain their cigarettes from illegal sources at cheaper prices. The Panel is fully aware that tobacco products bought through legitimate means present a grave risk to the health of those who smoke them, although evidence would appear to indicate the illegal products are even more dangerous.

207. It was accepted by all around the table that the NHS had to improve its proactive, public health type services, aimed at preventing ill health as much as possible. The Panel heard that a problem of this approach is that acute care services are a lot easier to evidence the impact of, with public health measures harder to prove impact for the resources expended on them. Further to this, it was suggested to the Panel that acute services will always be en vogue in a politically driven system. Public health measures represent a 'longer game', which will only have an impact if they are supported by successive governments. The Panel was quite clear, however, that the challenges faced does not mean that we should not try to deliver a system that is more public health and well being focussed.

208. The Panel heard that there are two forms of inequity which are of particular relevance to this debate. Firstly, there is inequity between different communities. Those in higher socio-economic groups have better health outcomes and appear to take public health messages on board more often, with stronger results. There are also inequities in services provided in primary care, with CVD screening services for example, rather opportunistic and non systematic.

209. The Panel heard that an excellent first step would be a register of those at risk, although there is a problem in how those people are identified if screening is not systematic. It was felt that a core of services of this type do exist in general practice, although they require development, investment and their propagation so they become the 'industry standard'.

210. In terms of threat to public health, the Panel heard from the PCT that tobacco use remains the biggest present threat to local people's health, with a worrying cohort of young people continuing to take up the habit. There was an element of disagreement on this point, between the South Tees Trust and the PCT. The South Tees Trust told the Panel that childhood obesity will become the biggest threat to health as the 'ticking timebomb' and that steps should be taken now, to prevent the worst of

the predictions materialising. The Panel heard that the PCT felt that presently, smoking remains the biggest threat to public health. Whilst the panel understands the importance of the PCT having to work in the here and now, it still got the impression that as childhood obesity's impacts may be in a number of years it was being discounted to some extent as an immediate priority. The Panel found this troubling, as without such a proactive approach to childhood obesity, the NHS was destined to continue being reactive to the problems that such an epidemic would create over time.

211. An important theme that the Panel wanted to explore was whether current public health steps are operating on a scale appropriate to the needs of Middlesbrough, which has particular challenges, which have been previously outlined. The Panel heard that changes are being made and significant projects are being prepared at present. Indeed, the appointment of a joint Director of Public Health between Middlesbrough Council and Middlesbrough PCT was seen as a significant development and welcomed. Nonetheless, the Panel did not see sufficient evidence, despite asking the question on numerous occasions, that present activity in Middlesbrough was on an "industrial scale", to tackle an "industrial problem". One element of the local NHS, however, that is operating on an industrial scale is James Cook University Hospital. It could be said that this is predictable, in a healthcare system that relies too much on being a sickness service.

212. The Panel heard that South Tees Hospitals NHS Trust is the organisation that deals with those who already have CVD, and in the view of the Trust the Panel heard that there are too many people coming through. Further to that, the Trust was unequivocal in its view that childhood/young adult obesity is a looming danger that could eclipse the health problems caused by smoking and will become the biggest preventable cause of early death.

213. In terms of what can be improved in the acute sector, the Panel heard that there are service gaps in cardiac rehabilitation.

214. The Panel heard of the constant tension faced by the system is wanting to do everything and not having the budget to be able to pay for everything, whilst the Panel is acutely aware that some of the issues facing society are wider than the NHS.

215. An example of this was given in the way children are schooled, with children having to complete a minimum of two hours a week of physical activity, with all schools in Middlesbrough reporting that they do so. Nonetheless, the exam structure in this country is one of children passing exams, the Panel heard that it doesn't matter, in that sense, if it is particularly healthy or fit children who are passing the exams. That said, the Panel heard that schools cannot be held responsible for childhood obesity, although increased options for young people in exercise at school would be welcome.

216. To expand on the theme of limited budgets, the Panel cited an example of the free swimming in school holidays as a good use of resources to promote a healthy living message in young people. The Panel was told that such an initiative does not come cheap. Whilst the Panel has no reason to disagree with this, the Panel would like to suggest that a long term societal reliance on acute care is also very expensive.

217. The Panel asked again as to how far the Middlesbrough locality is away from implementing industrial scale solutions. The Panel heard that progress was being made, although widescale community based activities are probably a year away. This is because the PCT wishes to conduct research on why certain socio-economic groups tend to take more public health messages on board than others. To clarify, it tends to be the most disadvantaged groups that are the hardest to reach.

218. An example of that was used in relation in childhood obesity, in that the best advice indicates that people should focus upon diet and exercise to address the problem. An issue with that, however, is that some people do not take that advice forward and it seems 'unheard'. Failing that, the Panel was told, there is not a huge body of evidence as to what works for obese children in terms of meaningful interventions.

219. The Panel raised with witnesses the topic of making leisure services more accessible and whether such facilities could be subsidised from public health budgets. Whilst the concept was accepted as possible, it was recognised as a major change in how services are funded and public money expended.

220. In conclusion, it was felt that there needed to be a long-term shift of resources towards the funding of preventative medicine and procedures. More work is required on smoking cessation, particularly around preventing illegal cigarettes from reaching the locality. The Panel also heard that the funding of physical exercise should increase to assist all sections of the community in taking exercise. The Panel is quite clear that at some point, the cycles of poor health have to be broken. Whilst it will be extremely difficult to do so and represents new ground for the NHS in many ways, it should not be backed away from.

221. The final thought was that if the Panel could achieve one thing, it should be raising the issue of childhood obesity and starting to suggest ways that it can be tackled. The Panel was told that obesity is a tragedy for children, as they do not have a choice.

Conclusions

222. On the basis of the evidence received, the PCT does not have a clear, tangible and systematic programme for assertively and proactively seeking out CVD in its population.

223. Childhood obesity is a massive threat for the coming years, both in associated costs for the NHS and the health prospects for a significant number of people. As a result, The Panel is of the view that something needs to be done now to prevent the worst predictions coming true. On the basis of evidence received by the Panel, there can be no doubt that childhood obesity is a clear and demonstrable problem and one where the full ramifications are yet to materialise properly. This leads the Panel to believe that Middlesbrough PCT and the local authority is required to take assertive and proactive steps now, in an attempt to minimise the ramifications of what is widely referred to as a 'ticking timebomb'. Should action not be taken, the local community will have wasted the advance warnings at its disposal on the topic. Further, the local NHS will be forced to continue being a reactive system with an excessive clinical focus and requiring ever-greater sums of money to remain in operation.

224. At the commencement of the review, the Panel heard that in respect of CVD, Middlesbrough has an "Industrial sized problem, which requires an industrial sized solution". On the basis of the evidence received, the Panel feels that James Cook University Hospital is operating on an industrial scale, delivering twice as many PCI interventions as would be expected for a town of Middlesbrough's population. The Panel has heard about public health activity, which is aimed at preventing ill health, or at least identifying poor health so it may be managed. The question the Panel has asked itself is whether this activity is appropriate for Middlesbrough and the needs of its population. The Panel's conclusion is that public health initiatives do not operate in Middlesbrough on a scale appropriate to the needs of the town. What preventative services that exist are often funded out of time-limited monies, and are offered on an opportunistic basis, with such non-assertive approaches frequently missing out those most in need. The Panel finds it quite bizarre that CVD is the biggest killer in the country, yet there is no nation-wide systematic screening programme for it, despite certain age groups being at highest risk.

225. The Panel understands fully that there is only so much money and the clinical agenda tends to dominate NHS funds. That is a consequence of a politically led system and to some extent the way our culture views healthcare. Nonetheless, the point must be made that at some juncture, such a reality must be challenged, or the system is forever destined to rely on hospitals, which are expensive, and often represent the last resort for people.

226. The Panel concludes that leisure services in the town are placed in a very difficult position, having to act in two different realms. In one respect, having to act as a public service and in another sense, having to act in a commercial market place competing with private sector operators. As such, the Panel feels that a debate is required within the Council, at a political level, aimed at establishing a consensus around what leisure services should be aimed at doing. Are they a Public Service or a Commercial Operator?

227. The Panel has also noted that (according to the 2008/9 NHS Operating Framework) increased freedoms are being given to PCTs where "in conjunction with their local communities, (PCTs) can set more of their own ambitions rather than having them mainly set by the centre". The Panel would encourage the PCT to embrace this line of thought and assertively seek to further develop a local health economy that delivers on Middlesbrough's needs, in respect of CVD.

228. The Panel notes that Middlesbrough PCT is in receipt of a £12.4million increase in resource allocation for 2008/9, which equates to a 5.4% increase. The Panel would like to see some of these new funds dedicated to developing the local market towards, or directly funding the provision of systematic and comprehensive screening programmes for groups at high risk from CVD. Such new monies could also be used to fund physical activity where financial barriers exist.

Recommendations

229. That the PCT and the local authority investigate the possibility of granting substantial subsidies, on a recurring basis, to leisure services in the town. This is with the aim of making them as cost free as possible for people, with specific reference being paid to young people and the financial barriers they face to becoming active.

230. That the free school holiday swimming is extended to encompass the entire year, with specific swimming pool slots being dedicated to young people's free swimming.

231. That the PCT makes a detailed and public commitment to invest in a package of preventative services befitting of Middlesbrough's needs, as a town with acute CVD problems.

Specifically:

232. That the PCT, as the principal local Commissioner, takes steps to shape the local market by encouraging providers to develop and offer truly preventative services. Such services should be aimed at identifying high-risk groups for CVD, then systematically and assertively offering those groups screening opportunities. This is with the ultimate aim of increasing the number of people effectively managing their CVD. This should, in time, reduce the number of people requiring access to the high cost (and personally traumatic) services provided in the acute sector. The Panel has heard that there could be as many people as 1200 people in Middlesbrough with undiagnosed CVD. It strikes the Panel that attempting to locate those people would be a good place to start.

233. The PCT investigates the possibility of providing 'drop in' screening opportunities in such locations as Pubs, Sports Clubs, shopping centres

and even Middlesbrough Football Club on a matchday. Should capacity be a concern, it is suggested that the PCT look into commissioning external organisations to assist in handling the workload.

234. That the Executive, PCT, South Tees Trust and Health Scrutiny Panel send a joint letter to the Secretary of State for Health calling on all appropriate foodstuffs to be labelled with the nutritional traffic light system, as a matter of legislation.

COUNCILLOR EDDIE DRYDEN
CHAIR, HEALTH SCRUTINY PANEL

GLOSSARY

Cardio-vascular disease (CVD)

Includes all diseases of the heart and blood vessels. The two main diseases are coronary heart disease (CHD) and stroke, but CVD also includes congenital heart disease (i.e. the heart deformities present at birth), valvular heart disease and peripheral vascular disease (e.g. affecting the blood supply to the limbs).

Coronary heart disease (CHD)

Includes the two common causes – angina and heart attack. Angina results in chest pain usually brought on by exercise. It can be mild or severe and generally lasts less than 10 minutes. A heart attack (myocardial infarction or MI) often a similar to angina but lasts for a longer period and has a high risk of death (approximately 1/3 of people with a heart attack die immediately).

Atherosclerosis

The underlying cause of CHD and stroke is a condition known as atherosclerosis or ‘hardening of the arteries’. Blood vessels supplying either the heart or the brain become fully or partially blocked. A heart attack occurs when one of the blood vessels supplying the heart becomes fully blocked (usually by a blood clot or a ‘fatty’ plaque).

Morbidity

Term used to describe the amount of disease or illness from a particular condition within a population.

Mortality

Term used to describe the number of deaths or the death rate from a particular condition within a population.

Primary prevention

Preventing the onset of a particular disease in people who are at risk of developing the disease but show no signs of having the disease.

Secondary prevention

Preventing further or serious complications from a particular disease in people who already have signs or symptoms of the disease.

Premature Death

Death is considered as premature if it occurs below the age of 75 years.

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