HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 25 July 2011.

PRESENT: Councillor Junier (Vice-Chair) (In the Chair); Councillors Cole, Davison, Harvey and Purvis.

OFFICERS: J Bennington and J Ord.

**** PRESENT BY INVITATION:** Dr Edward Kunonga, Joint NHS Middlesbrough/Middlesbrough Council Acting Director of Public Health.

NHS Middlesbrough:
Vicky Holt, Nurse Facilitator, Public Health
Sue Perkins, Head of Health Improvement
Gill Robinson, Nurse Facilitator, Public Health.

**** APOLOGIES FOR ABSENCE** were submitted on behalf of the Chair, Councillor Dryden and Councillors Lancaster and Mawston.

**** DECLARATIONS OF INTEREST**

There were no declarations of interest made at this point of the meeting.

**** MINUTES**

The minutes of the meeting of the Health Scrutiny Panel held on 4 July 2011 were submitted and approved as a correct record.

MATTERS ARISING – JAMES COOK UNIVERSITY HOSPITAL – DESIGNATION AS A MAJOR TRAUMA CENTRE

Further to the meeting of the Scrutiny Panel held on 4 July 2011 the Scrutiny Support Officer confirmed that a report on the Panel's findings in respect of the James Cook University Hospital being designated as a Major Trauma Centre would be submitted to the Overview and Scrutiny Board at its meeting to be held on 26 July 2011.

Confirmation was also given that a letter had been forwarded to the Chief Executive of NHS Tees with regard to the programme of investment for such services.

NOTED

CARDIOVASCULAR DISEASE – SOUTH ASIAN POPULATION

The Scrutiny Support Officer submitted a report the purpose of which was to introduce representatives of NHS Tees to provide a briefing on Cardiovascular Disease (CVD) in the South Asian Population.

In the background report submitted it stated that in early May 2011, the BBC Asian Network had aired a radio documentary entitled the Asian Death Wish relating to the issue of heart disease (and diabetes) within the South Asian Community. It highlighted how traditional diets, a lack of exercise and genetic factors made those in the South Asian Community more susceptible to heart problems and less likely to recover from heart problems than the general population.

It was noted that according to the Office of National Statistics Population Estimates, published on 18 May 2011, people whose ethnic origin was South Asian, made up 6 to 6.5% of the Middlesbrough population. As such, the Panel had agreed that the issue was one of importance for Middlesbrough and the planning and provision of local health services.

By way of introduction Dr Edward Kunonga provided background information on CVD which was caused by disorders of the heart and blood vessels and included stroke, heart failure,

hypertension, deep vein thrombosis and diabetes. Whilst CVD was the main cause of death in the UK it was the main preventable disease. Reference was made to a number of factors which increased the risk of CVD including certain lifestyle factors such as smoking, a high level of 'bad' cholesterol, not taking regular exercise, obesity and genetic history of heart disease.

It was acknowledged that there were excellent health services and James Cook University Hospital had been listed as one of the top 40 hospitals in the UK over the last six years. It was recognised however that this was only part of the overall solution in tackling CVD. The main issues involved raising awareness to the services available for early detection of the disease and encouragement of the wider population to lead healthier lifestyles.

Statistical information was provided which demonstrated that over a period of ten years Middlesbrough with 53.5% had exceeded the Government national target of 50% in terms of reducing the number of deaths from CVD. Members suggested that more could be done to raise awareness to publicise such a positive result. Much work had been undertaken in an endeavour to reduce some numbers but it was acknowledged that some groups had continued at the same level and others declined.

Graphical information was provided on the three main challenges to tackle in terms of CVD.

The first challenge related to emergency presentation to health services which indicated that such numbers for all ages (2009/2010) especially in males had been very high in comparison with the level shown for England. The Panel agreed that such figures clearly demonstrated the need for continued work to ensure that patients were effectively engaging with health services before requiring secondary care.

The second challenge was identified as 'finding the missing thousands' of those not seeking advice or presenting themselves to GP practices at earlier stage. The Panel was advised of a campaign which was currently being planned in an endeavour to reduce such a gap. It was recognised however that this would be a difficult challenge in Middlesbrough in getting the message across of the benefits of the services currently available and preventative measures which could be pursued.

Challenge three related to a number of lifestyle risk factors mainly smoking, binge drinking, obesity and unhealthy eating. Graphical information was presented which demonstrated that Middlesbrough together with the North East was shown to be above the estimated percentages for adults as indicated in the Health Survey for England 2006-2008. It was also noted that in terms of smoking Middlesbrough had a higher percentage than the North East and the English average. A summary was provided of the main local challenges in relation to the indigenous population.

In response to Members' questions regarding patient engagement confirmation was given of the work being undertaken by the PCTs and GP practices in this regard to ensure that patients received the most appropriate support and advice. It was recognised however that there were currently some variations to the extent to which this was carried out across GP practices.

Information was provided of indicative statistical information of the BME population profile for Middlesbrough as estimated in 2007. Such figures showed that the South Asian population was the greatest proportion of the BME population in Middlesbrough with the higher percentages living in the University, Gresham, Linthorpe, Park and Acklam Wards. In terms of the younger population it was reported that approximately 16% of children were from the BME population.

It was pointed out that the local health picture was based on national research and that more accurate information would be available next year following the recent Census.

From national research CVD in the South Asian population was shown to be:-

- a higher prevalence of T2DM and CVD;
- occurs at an earlier age and associated with premature death;
- diabetes prevalence was nearly fivefold higher than the indigenous population with 40% remaining undiagnosed;

- novel risk factors and cultural and socioeconomic factors;
- urban lifestyle/migration such as diet, sedentary lifestyle further enhanced the underlying non-modifiable risk factors.

Other risk factors were reported as:-

- lifestyle, social and cultural risk factors;
- health beliefs, language difficulties, issues around education and communication;
- socioeconomic status;
- inequalities in access to health care;
- lack of knowledge about health services and poor expectations.

A summary was provided of the main local challenges to the South Asian population which included:-

(a) Prevention –how to encourage more people to adopt healthier lifestyles in a culturally acceptable and enjoyable way;

(b) engagement with primary care services – how to ensure early engagement with primary care services and have early detection and treatment of diseases (health seeking behaviours, culture, social norms, increasing awareness and raising expectations);

(c) how to avoid emergency admissions and secondary care being the initial engagement with health services (effective partnerships between patients and health service);

(d) how to ensure equitable access and benefits from the excellent health services (prevention, treatment and rehabilitation) available locally (awareness, prevention, early detection and effective management, compliance, information, interpreter services);

(e) how to tackle the root causes of such problems- equal opportunities.

In terms of the future direction an indication was given of targeted approaches to ensure better engagement with patients and raising awareness. The Panel agreed that as Ward Councillors there was a role to play in helping to raise awareness to services available and increase take-up of such services. The appointment of a Member Champion in this regard in respect of the South Asian population was also suggested.

Reference was made to the appointment of a BME Community Development Worker and work being undertaken to organise suitable activities and events with a view to assisting in increasing awareness to problems associated with CVD and availability of appropriate services. Initiatives involving a Town wide approach with other stakeholders were also being pursued to track 'missing patients' and raise awareness to the benefits of the services currently available.

AGREED as follows:-

1. That Dr Edward Kunonga and representative from NHS Middlesbrough be thanked for the information provided.

2. That further consideration be given as to the extent of evidence to be obtained on the topic but that in the first instance further information be sought on the perspective of local GPs in terms of raising awareness and identifying persons from the South Asian population at risk of CVD.

NATIONAL HEALTH POLICY DEVELOPMENTS

The Scrutiny Support Officer submitted a detailed report which appraised the Panel of the current progress on the Government's Health Reforms.

In response to intense public debate about the Health and Social Care Bill the Government had announced on 6 April 2011 a pause in the parliamentary process to 'listen and reflect'. Such an

exercise had been undertaken by the NHS Future Forum which published a report on 13 June 2011. Such a report included a series of recommendations as outlined in the report submitted.
The report submitted outlined a summary of the Government's response to the report of the NHS Future Forum. The Government intended to make a number of modifications to the proposed GP Commissioning Consortia, including changing their names to 'Clinical Commissioning Groups'. Such a change reflected that they had wider memberships including at least one registered nurse and one specialist doctor. The Government also expected them to access appropriate social care advice. The Government had confirmed that they would only be allowed to assume commissioning responsibility when the NHS Commissioning Board was confident that they were ready and able. It had also been confirmed that the deadline of April 2013 was not fixed as previously indicated. Confirmation had also been given that Clinical Commissioning Groups would be responsible for commissioning emergency and urgent care services as well as services for unregistered patients. Clinical Commissioning Groups would have a duty to promote integrated health and social care.

Reference was made to the role of a Clinical Senate which would take a detailed overview of health and healthcare for any given local population and provide a source of expert advice on how services best fit together.

In terms of Local Health and Wellbeing Boards both the NHS Future Forum and the Government supported the idea of strengthening such organisations to enable them to be a 'focal point for decision-making about local health and wellbeing'.

With regard to the enhanced role of Health Scrutiny the Government had stated that 'Members of health and wellbeing boards will be subject to oversight and scrutiny by the existing statutory structures for the overview and scrutiny of local authority or health functions. The existing statutory powers of local authority overview and scrutiny functions will continue to apply. In line with the principles of the Localism Bill, local authorities will have greater discretion over how to exercise their health scrutiny powers.

In terms of choice and competition the Government intended to amend the Health and Social Bill to prohibit any future policies to increase or maintain the market share of any particular sector or provider. Such a change would complement the Government amendment already made to the Bill to prevent Monitor form setting different prices for providers because they are public or private sector.

It was also noted that the Government had given an assurance that more had to be done to 'guard against providers competing on price for NHS services and being able to cherry-pick the profitable, 'easy' cases, as this could undermine quality, and potentially destabilise services.' The report outlined a series of additional safeguards to develop standardised pricing 'currencies'.

In relation to the proposed timetable for implementation the Secretary of State had indicated that the Clinical Commissioning Groups would take control of commissioning from April 2013 following authorisation by the NHS Commissioning Board. Health and Wellbeing Boards would also take on their full statutory powers and PCTs would be abolished by April 2013. It was also aimed for completion of the Foundation Trust pipeline by April 2014.

The report submitted also provided information about the emerging NHS Commissioning Board which would have a crucial role to play in the reformed NHS organisational structure the core functions.

AGREED as follows:-

1. That the Scrutiny Support Officer be thanked for the comprehensive report.

2. That regular updates on the Government's Health Reforms be provided as and when required.