AGENDA

Health Scrutiny Committee

Date:	**Friday 27 March 2009**
Time:	**10.00 am**
Place:	**The Council Chamber, Brockington, 35 Hafod Road, Hereford**
Notes:	Please note the **time, date** and **venue** of the meeting.

For any further information please contact:

Tim Brown, Committee Manager Scrutiny, Tel 01432 260239
E-mail: tbrown@herefordshire.gov.uk

Herefordshire Council

HEREFORDSHIRE COUNCIL

AGENDA

for the Meeting of the Health Scrutiny Committee

To: Councillor JK Swinburne (Chairman)
Councillor AT Oliver (Vice-Chairman)

Councillors WU Attfield, PGH Cutter, MJ Fishley, P Jones CBE, G Lucas, GA Powell, A Seldon, AP Taylor and PJ Watts

Pages

1. APOLOGIES FOR ABSENCE

To receive apologies for absence.

2. NAMED SUBSTITUTES (IF ANY)

To receive details of any Member nominated to attend the meeting in place of a Member of the Committee.

3. DECLARATIONS OF INTEREST

To receive any declarations of interest by Members in respect of items on the Agenda.

GUIDANCE ON DECLARING PERSONAL AND PREJUDICIAL INTERESTS AT MEETINGS

The Council's Members' Code of Conduct requires Councillors to declare against an Agenda item(s) the nature of an interest and whether the interest is personal or prejudicial. Councillors have to decide first whether or not they have a personal interest in the matter under discussion. They will then have to decide whether that personal interest is also prejudicial.

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Whether an interest is prejudicial is a matter of judgement for each Councillor. What Councillors have to do is ask themselves whether a member of the public – if he or she knew all the facts – would think that the Councillor's interest was so important that their decision would be affected by it. If a Councillor has a prejudicial interest then they must declare what that interest is and leave the meeting room.

4. MINUTES 1 - 4

To approve and sign the Minutes of the meeting held on 25 February 2009.

5.	**SUGGESTIONS FROM MEMBERS OF THE PUBLIC ON ISSUES FOR FUTURE SCRUTINY** To consider suggestions from members of the public on issues the Committee could scrutinise in the future.	
6.	**PRESENTATION BY PRIMECARE** To receive a presentation on Primecare's plans for the out of hours service and GP led walk-in health centre.	
7.	**RESPONSE TO THE SCRUTINY REVIEW OF WEST MIDLANDS AMBULANCE SERVICE IN HEREFORDSHIRE** To consider the response to the recommendations made in the scrutiny review of the West Midlands Ambulance Service in Herefordshire.	5 - 22
8.	**WEST MIDLANDS AMBULANCE SERVICE NHS TRUST- UPDATE** To receive an update from the Trust.	23 - 30
9.	**HEREFORDSHIRE PRIMARY CARE TRUST - UPDATE** To receive an update from the Trust.	31 - 32
10.	**HEREFORD HOSPITALS NHS TRUST - UPDATE** To receive an update from the Trust.	33 - 38
11.	**INTEGRATED FALLS PREVENTION AND MANAGEMENT STRATEGY FOR HEREFORDSHIRE 2009-2014** To consider the Integrated Falls Prevention and Management Strategy for Herefordshire 2009-2014.	39 - 66
12.	**SCRUTINY REVIEW OF GENERAL PRACTITIONER (GP) SERVICES IN HEREFORDSHIRE** To consider a scoping statement for the review of GP Services in Herefordshire.	67 - 74
13.	**ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2008** To note the publication of the Annual Report of the Director of Public Health 2008.	75 - 76
14.	**WORK PROGRAMME** To consider the Committee's work programme.	77 - 80

PUBLIC INFORMATION

HEREFORDSHIRE COUNCIL'S SCRUTINY COMMITTEES

The Council has established Scrutiny Committees for Adult Social Care and Strategic Housing, Childrens' Services, Community Services, Environment, and Health. A Strategic Monitoring Committee scrutinises corporate matters and co-ordinates the work of these Committees.

The purpose of the Committees is to ensure the accountability and transparency of the Council's decision making process.

The principal roles of Scrutiny Committees are to

- Help in developing Council policy
- Probe, investigate, test the options and ask the difficult questions before and after decisions are taken
- Look in more detail at areas of concern which may have been raised by the Cabinet itself, by other Councillors or by members of the public
- "call in" decisions - this is a statutory power which gives Scrutiny Committees the right to place a decision on hold pending further scrutiny.
- Review performance of the Council
- Conduct Best Value reviews
- Undertake external scrutiny work engaging partners and the public

Formal meetings of the Committees are held in public and information on your rights to attend meetings and access to information are set out overleaf

PUBLIC INFORMATION

Public Involvement at Scrutiny Committee Meetings

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1. Identifying Areas for Scrutiny

At the meeting the Chairman will ask the members of the public present if they have any issues which they would like the Scrutiny Committee to investigate, however, there will be no discussion of the issue at the time when the matter is raised. Councillors will research the issue and consider whether it should form part of the Committee's work programme when compared with other competing priorities.

Please note that the Committees can only scrutinise items which fall within their specific remit (see below). If a matter is raised which falls within the remit of another Scrutiny Committee then it will be noted and passed on to the relevant Chairman for their consideration.

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Adult Social Care and Strategic Housing

Statutory functions for adult social services including:
Learning Disabilities
Strategic Housing
Supporting People
Public Health

Children's Services

Provision of services relating to the well-being of children including education, health and social care.

Community Services Scrutiny Committee

Libraries
Cultural Services including heritage and tourism
Leisure Services
Parks and Countryside
Community Safety
Economic Development
Youth Services

Health

Planning, provision and operation of health services affecting the area
Health Improvement
Services provided by the NHS

Environment

Environmental Issues
Highways and Transportation

Strategic Monitoring Committee
Corporate Strategy and Finance
Resources
Corporate and Customer Services
Human Resources

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- Inspect minutes of the Council and all Committees and Sub-Committees and written statements of decisions taken by the Cabinet or individual Cabinet Members for up to six years following a meeting.

- Inspect background papers used in the preparation of public reports for a period of up to four years from the date of the meeting. (A list of the background papers to a report is given at the end of each report). A background paper is a document on which the officer has relied in writing the report and which otherwise is not available to the public.

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HEREFORDSHIRE COUNCIL

BROCKINGTON, 35 HAFOD ROAD, HEREFORD.

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HEREFORDSHIRE COUNCIL

MINUTES of the meeting of Health Scrutiny Committee held at The Council Chamber, Brockington, 35 Hafod Road, Hereford on Wednesday 25 February 2009 at 2.00 pm

Present: **Councillor JK Swinburne (Chairman)**
Councillor AT Oliver (Vice Chairman)

Councillors: WU Attfield, PGH Cutter, MJ Fishley, P Jones CBE, G Lucas, GA Powell, A Seldon, AP Taylor and PJ Watts

In attendance: **Councillors PA Andrews, LO Barnett, WLS Bowen, PJ Edwards and TM James**

39. APOLOGIES FOR ABSENCE

Apologies were received from Mr J Wilkinson of the Local Involvement Network.

40. NAMED SUBSTITUTES

There were no named substitutes.

41. DECLARATIONS OF INTEREST

There were no declarations of interest.

42. MINUTES

RESOLVED: That the Minutes of the meeting held on 5 December 2008 be confirmed as a correct record and signed by the Chairman.

43. SUGGESTIONS FROM MEMBERS OF THE PUBLIC ON ISSUES FOR FUTURE SCRUTINY

There were no suggestions from members of the public.

44. WEST MIDLANDS AMBULANCE SERVICE IN HEREFORDSHIRE - SCRUTINY REVIEW

The Committee considered the report of the scrutiny review of the West Midlands Ambulance Service in Herefordshire, commissioned by the Committee in September 2008.

The Chairman thanked the Review Group for their work and the balanced report they had produced. She also thanked the officers of the Ambulance Trust in particular for the open way in which they had responded to requests for information, together with officers of the Primary Care Trust and the Hospitals Trust. She also thanked officers of the Council who had supported the review.

The Chairman of the Review Group was invited to comment on the Review Group's findings. He endorsed the Chairman of the Committee's thanks to those who had contributed to and supported the review. He then commented on the Group's

principal findings and recommendations as set out in the executive summary of the report.

Other Members of the Review Group commented on and highlighted some of the findings they considered to be of particular concern.

In the ensuing discussion the following principal points were made:

- In response to a question about what happened if one of the vehicles from Herefordshire had to travel to Birmingham a representative of the Ambulance Trust confirmed that as soon as the vehicle had completed that one job it was returned to the locality and not retained for assignment to other calls in the Birmingham area.

- Turnaround times at the hospital were a particular concern identified in the Review report. The Ambulance Trust Locality Manager commented that, whilst there were improvements to be made, Hereford Hospital's performance in this respect compared favourably with other hospitals. One of the main problems faced in Herefordshire was the fact that there was only the one acute hospital so if a difficulty arose at that hospital there was no convenient alternative facility to which patients could be taken.

- The resilience of the ambulance service in the county and the importance of regular needs assessments to ensure that the service was resilient was discussed. It was noted that the review recommended additional resource be provided at Ledbury.

- The recommendation that there should be improvement in collaboration and co-location of blue light services was discussed, noting that the national development of a shared radio system would represent one step forward.

- The importance of examining patient outcomes rather than relying simply on the measurement of time-based targets was discussed. It was noted that a national consultation exercise on targets was underway and it was to be hoped that this would address this concern.

- The Chief Executive of the Hospitals Trust commented that bed capacity clearly had a bearing on turnaround times. However, the Trust had already made improvements in turnaround times and he would confirm progress in his formal response to the Review.

- The Review Group had been informed in February that the commissioners of the ambulance service had proposed their own independent review of the service in December 2008, the Committee's own review having been commissioned in September 2008. Assurance was sought and received that this later review, which it was noted was now due to report to the regional commissioners in May 2009, would take account of the Committee's recommendations. The Committee was advised that from Herefordshire PCT's perspective this later review had been prompted amongst other things by concerns about the unit cost of the service and recognition that the needs analysis for Herefordshire needed to be updated.

The Chairman commented, in conclusion, that the review of the Ambulance Service had been undertaken in response to concerns expressed by members of the public. The review had found a service that was generally performing well but had also found there had been some grounds for that publicly expressed concern and the

consequent need for improvement in some aspects of the service.

RESOLVED:

That (a) the findings of the review of West Midlands Ambulance service in Herefordshire be approved unanimously for submission to relevant Health Service bodies;

(b) the response to the Review be reported to the first available meeting of the Committee; and

(c) a further report on progress in response to the Review then be made after six months with consideration then being given to the need for any further reports to be made.

45. GP- LED WALK IN HEALTH CENTRE

The Committee was informed of the award of a contract for the development of a GP-led walk-in health centre for Herefordshire and the provision of the out of hours service to Nestor Primecare.

The Chairman reported that, in response to comments made about the proposed development of the GP-led Health Centre at the Committee's meeting in December 2008, she had met the Director of Integrated Commissioning and the Equitable Access to Primary Medical Care Programme Manager (EAPMCPM) to seek clarification and assurance on a number of points.

The report summarised the history of previous reports to the Committee on the project and the clarification and assurances received in response to questions asked by the Chairman following the Committee's meeting in December.

In the course of discussion the following principal points were made:

- Mixed views were expressed about the advantages of the Centre, its cost and potential effect on existing services. Further clarification was sought in particular on the implications for local GP surgeries within the County of the Centre's ability to register patients. The EAPMCPM emphasised in response that the Centre would only be able to register patients within the Hereford City boundary. People living outside the City boundary would, however, be able to attend the Centre on a walk-in basis. He added that registrations were restricted to 3,000 over the life of the five year contract representing some 5% of the City population. The safeguards outlined in the report reflected the Primary Care Trust's (PCT) aim to avoid destabilising the existing services but provide an additional service, a principal benefit of which would be to reduce pressure on the Accident and Emergency Unit.

- In reply to a question about the views of Hereford City GPs it was replied that the Local Medical Committee (LMC) had invited Nestor Primecare to take part in LMC meetings. The PCT had also been constrained to a degree in the discussions it could have with GPs during the tender process by the fact that a consortium involving some local GPs had submitted a bid for the contract. Since the award of the contract the PCT was now able to discuss the plans more openly with the GPs and explain the safeguards in the contract, the absence of a financial incentive in the contract to increase registrations and the focus of the key performance indicators in the contract on reducing inappropriate A&E

attendances through the provision of walk-in capacity. This had addressed a lot of the GPs' concerns.

- Asked about recruitment of staff the EAPMCPM said that a local GP had been appointed by Nestor Primecare as the GP lead for the Centre. Nestor Primecare's wide contacts should assist in the recruitment drive. Given the economic downturn Members suggested that Nestor Primecare should be encouraged to employ local people where possible.

- The Director of Integrated Commissioning reported in response to a question that it was still hoped that it would be possible to accommodate the Centre on the Hereford Hospital site. Discussions with the Hospitals Trust were continuing.

- It was observed that the provision of a walk-in centre open from 8am until 8pm seven days a week contrasted favourably with provision in the Market Towns and rural areas. It was noted that GPs had the option to provide extended opening hours and at the moment some 50% of GP practices in the County had opted to do so. The range of services offered by GP practices also varied. It was proposed that there should be a scrutiny review of the services offered by GP practices within the County.

The Chairman concluded the discussion by observing that the Committee had been provided with firm assurances that there were safeguards within the contract to prevent the development being to the detriment of existing services. The Committee would have the opportunity at its next meeting to ask Nestor Primecare about its business plan to improve service provision in the County.

RESOLVED:

That (a) the report be noted: and

(b) a scoping report for a scrutiny review of the services offered by GP practices within the County be prepared.

The meeting ended at 3.20 pm **CHAIRMAN**

SCRUTINY REVIEW OF THE WEST MIDLANDS AMBULANCE SERVICE IN HEREFORDSHIRE

Report By: Directorate Support Officer (Health)

Wards Affected

County-wide

Purpose

1. To consider the response to the recommendations made in the Scrutiny Review of the West Midlands Ambulance Service in Herefordshire.

Background

2. In February 2009 this Committee approved the findings of the Scrutiny Review of the West Midlands Ambulance Service in Herefordshire.

3. The Committee agreed that the response to the Review be reported to the first available meeting of the Committee and that a further report on progress in response to the Review then be made after six months with consideration then being given to the need for any further reports to be made.

4. The recommendations made in the Review report are appended for reference together with the response from the Primary Care Trust, which includes input from the West Midlands Ambulance Service NHS Trust and the response from Hereford Hospitals NHS Trust.

RECOMMENDATION

THAT (a) the response to the findings of the review of the West Midlands Ambulance Service in Herefordshire be noted, subject to any comments which the Committee wishes to make;

and

(b) a further report on progress in response to the Review be made after six months with consideration then being given to the need for any further reports to be made.

BACKGROUND PAPERS

- None

Recommendations of the Scrutiny Review of the West Midlands Ambulance Service in Herefordshire – February 2009

Resources

1. That the need for resources be regularly assessed, at least every two years, to take account of factors such as increasing population and changing demographic profile.
2. That, if Malvern is at higher risk of needing ambulances, resources to cover this potential need should come from Worcestershire, not Herefordshire.
3. Following the suggested needs assessment and via agreed commissioning protocols, it is likely that our findings will be supported - that additional ambulances are required, and that at least one is allocated to Herefordshire which should be based in Ledbury where a station with a wide network coverage already exists, and as the only station which does not currently have 24-hour coverage.
4. That commissioners agree enough funding to enable WMAS to properly fulfil its duty of care towards Community First Responders, and to equip and reimburse them according to volunteering best practice guidelines without having to rely on charity.
5. That CFRs could make an even more effective contribution to the service if they were more supportively managed and effectively deployed. However, their contribution should not be a substitute for meeting targets through normal resources, but for achieving added value. The health scrutiny committee looks forward to scrutinising the contribution of the new CFR organiser towards achieving these goals.
6. That a concerted campaign at all levels is conducted to demonstrate the need for “rural-proofing”, and that costs of service provision are equitably shared between localities in the West Midlands region.
7. That scrutiny of the commissioning process for the ambulance service, and the Patient Transport Service (PTS), be conducted. The review group recommends a separate review of the PTS, possibly in collaboration with the Herefordshire LINk (Local Involvement Network).

Pressures on the service

1. That effective measures are implemented to ensure all emergency ambulance arrivals are accommodated safely in the hospital within 30 minutes, and that all other measures to reduce inappropriate use of emergency services and to release beds safely be urgently implemented.
2. That both WMAS and the Hospitals Trust improve, in collaboration with each other, their triaging and ambulance clearance time procedures.
3. That information on collaboration with Wales be sought by the Independent Review, including provision by sister services in Wales of data on the amount and nature of cross-border work.
4. That the health scrutiny committee request a report on the out-of-hours (OOH) service provision in the county.
5. That the OOH provider conduct a comprehensive publicity campaign on the out of hours telephone number.
6. That improvement in collaboration and co-location of blue light services be encouraged.
7. That regular and immediate progress reports on EOC reconfiguration be supplied for scrutiny by Herefordshire’s health scrutiny committee, especially

regarding resource drift – away from the county, and overall - and response performance.

Data and information

1. That commissioners, SHA and DoH measure ambulance service performance by outcome-based indicators as well as response times, for example, by measuring the progress of patients from when an ambulance is called to when they are 'handed over' to a hospital.
2. That all ambulance service response time data be available disaggregated by post code for all localities within WMAS.
3. That targets for rural Herefordshire be considered. These should be realistic without risking diminished performance.
4. That public education on EOC technology (when it is functioning effectively), and about why local knowledge is not needed, be conducted.
5. That public education on life-saving techniques be undertaken within the community, with particular emphasis on schools.
6. That the Patient Report Form and other paperwork where possible be computerised and simplified as a matter of urgency.
7. That data collection by, and dissemination from, WMAS – especially relating to patient outcomes - be greatly improved, as it is currently difficult to obtain a full, reliable picture.
8. That effective triaging of patients, communicated at the earliest stages to hospitals (for example by EOCs, or crews on first seeing a patient) and followed up by further triaging at hospital by senior clinical decision-makers, be implemented as a matter of urgency.

RESPONSE BY THE PRIMARY CARE TRUST AND WEST MIDLANDS AMBULANCE SERVICE NHS TRUST

Councillor K. Swinburne
Chair. Health Overview & Scrutiny Committee
c/o

16 March 2009

Dear Kay,

Scrutiny Review of West Midlands Ambulance Service In Herefordshire

I refer to your letter of the 26th February which enclosed a copy of the above report which was considered by HOSC at the meeting in February. If you recall you requested that I consider the detailed recommendations and to forward a response to the points raised. The responses detailed below have been collated with input from the West Midlands Ambulance Service NHS Trust (WMAS) since we thought it helpful to provide a comprehensive response from the health community rather than the HOSC receive separate responses from both the PCT and Ambulance Trusts. Herefordshire Hospital Trust we understand will be however writing to you separately to address any issues from the County Hospital perspective.

For ease of review we thought it helpful to frame our responses in the same order of your detailed recommendations, as detailed below:

Resources

1 WMAS regularly reviews resources allocated to localities within the regional structure. The achievement of performance standards and maintenance of appropriate resource Unit Hour Utilisation are the drivers for resource level determination. The Independent Review that has been commissioned jointly with the West Midlands PCTs is intended to identify the resource level needed to service the Model of Care agreed by the regional ambulance service commissioning group.

2 The Malvern and Ledbury stations offer mutual support in times of high demand for service as part of the region wide arrangements for support. In terms of ambulance resource, the West Midlands PCTs are collectively requesting WMAS to act as a Regional resource to ensure reliance given peaks in demand therefore the ambulance resource to meet a call to respond could effectively be deployed from anywhere and therefore would not be able to agree to ring fence Herefordshire resources.

3 Ledbury currently has cover on station as follows:

Ambulance: 08.30 – 18.30 hours
Car: 09.00 – 21.00 hours

WMAS have agreed to model how these hours may be altered to provide additional cover, however it is unlikely that a 24 hour resource could be re modelled from the current resources in Ledbury or indeed transferred from other areas within the county.

The Review may identify more appropriate locations for any extra resource identified – this may dependent on the response model and integral rostering and System Status Management rules.

4. WMAS currently provide (via contract funding) training, drugs, some protective clothing and basic kit to Community First Responders (CFR). WMAS have agreed to review what further support may be offered.

5. WMAS are currently advertising for a CFR manager to lead on support and training and recruitment of CFRs. in Herefordshire, where previously the CFR manager provided support for both Herefordshire and Worcestershire. The CFR scheme now is managed and directed at a regional level.

6. Both PCT and WMAS are in agreement with this recommendation. The issue will be addressed as part of the imminent independent review.

7. The PTS service for Herefordshire has recently been subject to a tendering process with the contact now awarded to an idependent contractor Patient First. Further details of the tendering process and the new contract are available on request, however the new provider will be providing the service from the 1st May 2009. Herefordshire LINK is aware of this development and will receive a full briefing on the new service from commissioners shortly.

Pressures on the service

1. The ambulance delay target against which this is measured is 15 minutes rather than 30 minutes as stated in the report. WMAS and the commissioners have agreed to keep this matter under review but current data suggests that this is less of an issue in Herefordshire than in other parts of the West Midlands.

2. The PCT are in agreement with this recommendation. WMAS will work with HHT and the out of hours provider (Primecare) to both review

procedures and agree enhanced arrangements for the handling of category C calls.

3. The PCT are in agreement with this recommendation and will press for this issue to be considered as part of the independent review. WMAS will work with the Welsh Ambulance Service to better understand present cross-border flows.

4. The PCT will provide the requested information on the out of hours service but would request further detail from the review group as to what is required. A new telephone number for the out of hours service has been sourced and will be widely publicised across the county in the coming weeks.

5. Please see 4 above.

6. Significant progress has already been made on greater collaboration with the other emergency within the locality as a whole. Shropshire have arrangements to share all the Fire Services station to enhance strategic standby and are also working with the police on a similar basis. In Herefordshire good progress has been made with Hereford fire station being utilised for standby and Herefordshire police using a shared facility for vehicle maintenance and repairs. As the Ambulance service currently provides station facility's all large conurbations within the county progress would be through the long term estate strategy.

7. WMAS have agreed to provide this information. There is currently no evidence to suggest that there is any resource "drift" from the locality to other parts of the West Midlands. Current figures would suggest that the local service is supported more by resources from Birmingham than the locality supports Birmingham.

Data and information

1. Some outcome measures (eg: thrombolysis, ROSC and FAST tests are already available). The development of Models of Care work will deliver further quality measures as part of the 2009/10 regional contract. A copy of the contract will be supplied when finalised.

2. WMAS will provide this data.

3. All targets are defined by the Department of Health (DoH) and stipulated within a national mandated contract. It is not possible to agree further targets for rural Herefordshire without DoH agreement which is unlikely to be forthcoming.

4. A new computer aided dispatch (CAD) is being introduced shortly into the Ambulance control centre at Millennium Point. The Herefordshire locality has been chosen to introduce these changes first due the experience of the current staff on a similar system which was used at Bransford. If helpful the WMAS have suggested the HOSC could view these changes once fully installed and get a full understanding of the system and technology available.

5. The PCT will take forward this campaign via the Public Health team. Funding has already been provided to the 'Heart Start' campaign.

6. Computer patient report forms have been introduced in the Coventry and Warwickshire locality. The system is currently being evaluated and a roll out of this system is likely in the near future.

7. Please see 3 above. With the introduction of electronic patient records the capturing of clinical outcomes should be considerably more comprehensive and provide data quicker and more reliable than current methods.

8. These recommendations will be taken forward via the co-location of the out of hours service along with the new GP led equitable access centre for the Hereford City with the potential development of a clinical decisions unit at HHT.

I would hope the above will provide sufficient detail to the HOSC committee of the proposed actions following receipt of the report but should more detail be required I am sure PCT officers in attendance at HOSC or colleagues from WMAS, can provide further clarity.

Yours sincerely,

Mr C. Bull
Chief Executive

c.c Dr Akeem Ali
Paul Ryan
Paul Edwards

HEALTH SCRUTINY COMMITTEE MEETING
27th March 2009

HEREFORD HOSPITALS NHS TRUST RESPONSE TO THE WEST MIDLANDS AMBULANCE SERVICE IN HEREFORDSHIRE SCRUTINY REVIEW

1) Introduction

1.1 The Health Scrutiny Committee appointed a panel to undertake a review of West Midlands Ambulance Service (WMAS) provision in Herefordshire. The review concluded in December 2008 and its findings were presented to the Health Scrutiny Committee in February 2009.

1.2 This document represents Hereford Hospitals NHS Trust's response to the relevant content and recommendations of the review.

2) Relevant review issues and recommendations

2.1 The main body of the review report identified a number of issues of relevance to the Trust, under two headings:-

Resources

- The need to improve advance communication between the ambulance service and the hospital as an aid to improved patient triage and diagnosis (page 23 & 24)
- Limitations in the non emergency (PTS) transport service, resulting in delayed patient discharges and potentially bed shortages (page 23)

Pressures on the service

- Lack of clarity as to responsibility for ambulance crew clearance and turnaround (page 23 & 24)
- Bed shortages at the County Hospital impacting negatively on the ability of the Trust to receive patients in a timely manner (page 24)
- A lack of resilience in the A&E service to cope with peaks of demand as experienced in December 2008 (page 24)

2.2 As a consequence of these findings the review team made 3 recommendations of relevance to the Trust:-

- That effective measures are implemented to ensure all emergency ambulance arrivals are accommodated safely in the hospital within 30

minutes, and that all other measures to reduce inappropriate use of emergency services and to release beds safely be urgently implemented
- That both WMAS and the Hospitals Trust improve, in collaboration with each other, their triaging and ambulance clearance time procedures
- That effective triaging of patients, communicated at the earliest stages to hospitals (for example by EOC's or crews on first seeing a patient) and followed up by further triaging at hospital by senior clinical decision makers, be implemented as a matter of urgency

3 Trust response

3.1 The Trust's response, as set out in the action plan attached (Appendix 1), seeks to address the wider issues of service capacity and resilience on the one hand and the specifics of the interface between the hospital and the ambulance service on the other.

3.2 On the broader front, the Trust has already taken or is planning to take a number of actions, particularly in relation to bed capacity:-

- Since the review visit, the Trust has reopened Kenwater Ward to provide an additional 16 beds. These will be retained until their re-provision in the main hospital later in the year
- A systematic review of the flow of emergency patients through the hospital has commenced to ensure appropriate admission, timely treatment and prompt discharge. Central to this initiative is the planned development of a Clinical Decisions Unit, alongside A&E and linked to the proposed Primary Care Centre, which from evidence elsewhere will enable more rapid assessment of patients and reduce inappropriate admissions
- Within the A&E department itself, shift patterns are currently being reviewed to ensure better alignment with peaks of activity and a 3rd consultant is being appointed to strengthen clinical capacity
- The Patient Transport Service has been put out to competitive tender and a new contract has been awarded to an external provider from 1st May 2009.

3.3 With regard to the interface with the ambulance service, this has been enhanced through the enforcement of a clear handover protocol (Appendix 2) and the introduction of a clear escalation procedure for potential stretcher waits (Appendix 3). This mechanism is supported by regular daily reporting to Director level on ambulance handover times (Appendix 4) although it should be noted that there are issues of data accuracy which the Trust is seeing to address with WMAS

4 Conclusions

4.1 The Health Scrutiny Committee is requested to note and as appropriate comment on the Trust's response to the Review report.

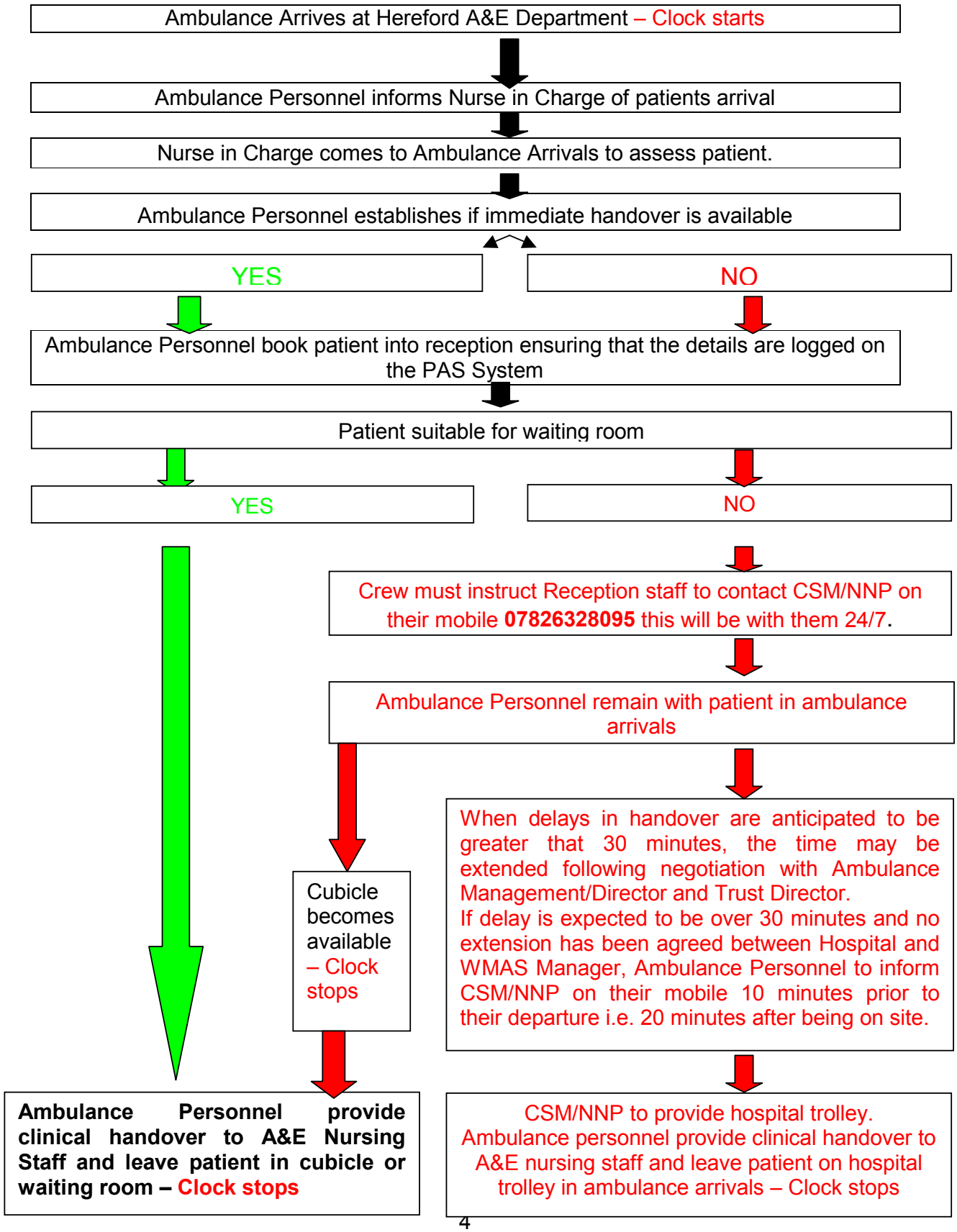
Martin Woodford
Chief Executive
Hereford Hospitals NHS Trust

Hereford Hospitals NHS Trust
Action plan in response to Health Scrutiny Committee Review Report

Area / Recommendation	Actions	Progress / Implementation Date
• The need to improve advance communication between the ambulance service and the hospital as an aid to improved patient triage and diagnosis (page 23 & 24)	• Trust / WMAS to develop improved mechanisms for advance communication and triage	• 31st May 2009
• Limitations in the non emergency (PTS) transport service, resulting in delayed patient discharges and potentially bed shortages (page 23)	• Competitive tendering exercise undertaken for Patient Transport Service (non emergency) – contract let to external service provider	• 1st May 2009
• Lack of clarity as to responsibility for ambulance crew clearance and turnaround (page 23 & 24)	• Handover protocol revised and enforced • Escalation procedure introduced for patient stretcher waits • Revised escalation procedure for A&E waits at 2 hours and early alert system for patients needing admission • Regular reporting and review of handover performance • Formal Executive level review of progress against action plan with WMAS	• Complete • Complete • Complete • Ongoing • Quarterly from 30th June 2009
• Bed shortages at the County Hospital impacting negatively on the ability of the Trust to receive patients in a timely manner (page 24)	• Additional substantive beds (16) opened on Kenwater Ward and built into re-provision plans • Review of flow of emergency patients through the hospital from admission to discharge • Development of a Clinical Decisions Unit with senior front door decision making resource	• Complete • Commenced Feb 2009 • Commenced July 2008 for completion December 2010
• A lack of resilience in the A&E service to cope with peaks of demand as experienced in December 2008 (page 24	• Implementation of revised shift patterns in A&E, matching staffing to peak demand • Recruitment of 3rd A&E consultant	• 30th June 2009 • In progress

Appendix 2

Hereford Hospital NHS Trust
A&E Department
Protocol for Ambulance Handover



Appendix 3

Escalation Procedure – A&E Stretcher Waits
All Ambulance Arrivals Signalled by Crews to Majors Dept. Via Call Bell February 2009

GREEN ALERT

1 empty cubicle in A&E → Nurse in Charge notifies CSM on Mobile Phone → CSM takes steps to identify additional capacity

AMBER ALERT

Patient arrives – no empty cubicle → Nurse in Charge triages patient and re-locates to sub wait or advises on anticipated length of wait – e.g. >15 mins → Nurse in Charge call CSM on Mobile Phone to advise that a wait has been identified

RED ALERT

2nd Ambulance arrives – no resource to cover – escalated to CSM by A&E → CSM to identify resource to cover patient management in conjunction with Head of Nursing (in hours) → CSM to trigger Head of Nursing (Level 3 out of hours) → Level 3 to advise and inform Director on-call (out of hours) Director of Operations (in hours) to sanction additional resource

West Midlands Ambulance Service NHS
NHS Trust

Daily Hospital Handover Report

Date: 11/03/2009
Period: 00:00:00 - 23:59:59

Created: 12/03/2009 13:18 Version: 2

The information presented is a snapshot of performance and is subject to change

Performance

By Category - Using Call Connect Clock Start					
Locality	**Demand**	**A8**	**A19**	**B19**	**C30 & Referrals**
BBC	**887**	77.3	99.3	95.3	88.9
C&W	**288**	81.0	100.0	95.9	99.0
HS&W	**305**	79.1	97.8	97.3	100.0
Staff	**329**	77.3	100.0	97.2	99.1
WMAS	**1809**	78.1	99.2	96.1	94.7

Activity

Over 45 mins
Over 60 mins

By Hospital								
Trust	**Hospital**	**Predicted Cases**	**Actual Cases**	**Delays Over 30 Minutes**	**% Delayed Over 30 Minutes**	**Longest Delay hh:mm**	**Time Delayed (in excess of 30 min) hrs:mm**	**CAD Inc Number ***
Birmingham Childrens Hospital	Birmingham Childrens	13	15	1	6.7	1:05	0:35	BBC: 0899
Dudley Group of Hospitals	Russells Hall Hospital	79	106	31	29.2	1:03	5:00	BBC: 0585
Heart of England	Good Hope Hospital	66	67	4	6.0	0:42	0:28	BBC: 0484
	Heartlands Hospital	104	94	23	24.5	1:21	3:45	BBC: 0376
	Solihull Hospital	23	26	8	30.8	0:47	0:48	BBC: 0828
Royal Wolverhampton Hospitals	New Cross Hospital	91	93	10	10.8	0:55	1:32	BBC: 0934
Sandwell & West Birmingham	City Hospital	68	73	24	32.9	0:47	2:37	BBC: 0655

	Sandwell Hospital	52	63	12	19.0	0:59	2:00	BBC: 1306
University Hospital Birmingham	Selly Oak Hospital	86	76	17	22.4	1:18	5:09	BBC: 0906
	Queen Elizabeth Hospital	9	12	4	33.3	1:02	1:06	BBC: 0530
Walsall Hospitals	Walsall Manor Hospital	65	50	1	2.0	0:30	0:00	BBC: 1000

Hereford Hospitals	Hereford County	31	24	6	25.0	0:40	0:31	SHRP: 0868
Shrewsbury & Telford Hospitals	Princess Royal Hospital – Telford	37	36	9	25.0	1:15	2:01	SHRP: 0671
	Royal Shrewsbury Hospital	40	38	1	2.6	0:50	0:20	SHRP: 0603
Worcestershire Acute Hospitals	Kidderminster Hospital							
	Alexandra Hospital – Redditch	40	39	12	30.8	0:49	1:29	SHRP: 1147
	Worcester Royal Hospital	60	57	13	22.8	0:43	0:52	SHRP: 1003

George Elliot Hospital	George Elliot Hospital	32	26	13	50.0	0:46	1:15	C&W: 0176
University Hospitals Coventry & Warwickshire	St. Cross – Rugby	4	6	1	16.7	0:32	0:02	C&W: 0189
	University Hospital	115	117	26	22.2	0:39	1:36	C&W: 0272
South Warwickshire Hospitals	Warwick Hospital	42	37	14	37.8	0:52	1:38	BBC: 0857

Burton Hospital	Burton Hospital	29	23	0	0.0	0:29	0:00	STAFF: 206
Mid Staffordshire General Hospital	Mid Staffs General	56	53	4	7.5	0:57	0:48	STAFF: 279
University Hospital North Staffordshire	UHNS Hospital	113	111	7	6.3	0:36	0:21	STAFF: 190

	City General	7	5	0	0.0	0:21	0:00	STAFF: 114
	Total	1262	1247	241	19.3		34:02	**

Notes

* BBC: Birmingham & Black Country C&W: Coventry & Warwickshire STAFF: Staffordshire
H&W: Hereford & Worcester SHRP: Shropshire

** Total Time delayed in excess of 30 minutes

This data does capture delays with patients that are cohorted

WEST MIDLANDS AMBULANCE SERVICE NHS TRUST - UPDATE

Report By: Locality Director

Wards Affected

County-wide

Purpose

1. To receive an update from the West Midlands Ambulance Service NHS Trust.

Background

2. The latest chart showing the Trust's performance against response times is attached.

BACKGROUND PAPERS

- None

Further information on the subject of this report is available from
Derek Laird Locality Director on 01886 834200

West Midlands Ambulance Service NHS
NHS Trust

Herefordshire HOSC
Data collated on 9th March 2009 @ 11:00hrs

Herefordshire

KPI Area	Indicator	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	YTD
Category A	Respond to 75% of Category A calls within 8 minutes.	72.6%	72.7%	74.8%	75.1%	71.6%	82.9%	77.3%	76.7%	64.4%	74.1%	73.1%		
Category B	Respond to 95% of Category B Calls within 19 minutes	93.5%	90.2%	91.0%	88.6%	91.7%	88.9%	93.4%	90.6%	87.1%	88.4%	88.6%		
Category C Combined	Respond to Cat C Calls within 30 minutes and to Referral calls within a specified time	99.3%	97.3%	98.5%	97.6%	98.8%	98.2%	98.6%	97.5%	90.8%	92.7%	94.1%		

Hereford, Shropshire and Worcester Division

KPI Area	Indicator	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	YTD
Category A	Respond to 75% of Category A calls within 8 minutes.	77.0%	76.4%	77.5%	74.7%	73.1%	75.5%	76.3%	74.3%	63.8%	72.1%	72.1%		
Category B	Respond to 95% of Category B Calls within 19 minutes	96.1%	95.2%	95.4%	95.5%	94.2%	94.5%	95.6%	94.2%	88.9%	93.8%	93.6%		
Category C Combined	Respond to Cat C Calls within 30 minutes and to Referral calls within a specified time	99.1%	98.0%	98.1%	98.2%	98.6%	98.2%	98.1%	96.9%	91.8%	94.2%	95.6%		

WMAS

KPI Area	Indicator	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	YTD
Category A	Respond to 75% of Category A calls within 8 minutes.	78.9%	78.9%	77.5%	77.5%	77.3%	76.5%	75.1%	72.4%	65.9%	75.2%	75.9%		
Category B	Respond to 95% of Category B Calls within 19 minutes	96.9%	96.9%	96.3%	96.6%	96.0%	95.4%	95.1%	94.6%	90.7%	95.6%	95.9%		
Category C Combined	Respond to Cat C Calls within 30 minutes and to Referral calls within a specified time	97.9%	97.3%	96.5%	97.2%	97.4%	95.8%	95.0%	93.7%	92.2%	96.3%	96.4%		

April 2008

	Cat A 8Min			Cat A 19Min			Cat B 19 Min			Cat C Combined		
	TOTAL	0-8 mins	%	TOTAL	0-19 mins	%	TOTAL	0-19 mins	%	TOTAL	In target	%
HR2	53	41	77.4%	53	52	98.1%	105	99	94.3%	68	68	100.0%
WR13	10	4	40.0%	10	10	100.0%	11	11	100.0%	11	11	100.0%
HR8	22	15	68.2%	22	21	95.5%	44	40	90.9%	43	42	97.7%
HR6	40	30	75.0%	40	38	95.0%	53	50	94.3%	44	44	100.0%
HR4	33	24	72.7%	33	33	100.0%	86	84	97.7%	65	65	100.0%
HR1	56	50	89.3%	56	55	98.2%	81	81	100.0%	71	71	100.0%
HR9	27	15	55.6%	27	26	96.3%	60	55	91.7%	53	52	98.1%
HR7	12	8	66.7%	12	11	91.7%	11	11	100.0%	22	22	100.0%
HR5	6	4	66.7%	6	6	100.0%	9	3	33.3%	22	22	100.0%
HR3	4	0	0.0%	4	3	75.0%	4	1	25.0%	5	5	100.0%
SY8	2	2	100.0%	2	2	100.0%	1	1	100.0%	1	0	0.0%
SY7	1	0	0.0%	1	1	100.0%	1	0	0.0%	1	1	100.0%
WR6							7	7	100.0%	1	1	100.0%
WR14							1	0	0.0%			
GL17							1	1	100.0%			
NP25										1	1	100.0%
TOTAL	266	193	72.6%	266	258	97.0%	475	444	93.5%	408	405	99.3%

May 2008

	Cat A 8Min			Cat A 19Min			Cat B 19 Min			Cat C Combined		
	TOTAL	0-8 mins	%	TOTAL	0-19 mins	%	TOTAL	0-19 mins	%	TOTAL	In target	%
HR1	62	52	83.9%	62	62	100.0%	126	125	99.2%	73	73	100.0%
HR6	36	26	72.2%	36	35	97.2%	57	51	89.5%	37	35	94.6%
HR9	29	17	58.6%	29	26	89.7%	56	54	96.4%	58	55	94.8%
HR4	46	39	84.8%	46	45	97.8%	82	79	96.3%	64	64	100.0%
HR8	22	11	50.0%	22	21	95.5%	38	30	78.9%	31	31	100.0%
HR2	52	43	82.7%	52	51	98.1%	115	108	93.9%	95	94	98.9%
HR7	8	7	87.5%	8	8	100.0%	18	16	88.9%	16	15	93.8%
WR13	7	0	0.0%	7	7	100.0%	9	6	66.7%	11	10	90.9%
WR6	5	2	40.0%	5	5	100.0%	4	4	100.0%	3	3	100.0%
WR15	1	0	0.0%	1	1	100.0%	0	0	0.0%	0	0	0.0%
SY8	1	0	0.0%	1	1	100.0%	1	0	0.0%	2	2	100.0%
HR3	3	0	0.0%	3	1	33.3%	2	1	50.0%	3	3	100.0%
HR5	6	5	83.3%	6	6	100.0%	14	1	7.1%	10	9	90.0%
LD8							2	0	0.0%	2	1	50.0%
NP25							3	2	66.7%			
WR14							1	1	100.0%			
SY7							**2**	**0**	0.0%	5	4	80.0%
TOTAL	278	202	72.7%	278	269	96.8%	530	478	90.2%	410	399	97.3%

June 2008

	Cat A 8Min			Cat A 19Min			Cat B 19 Min			Cat C Combined		
	TOTAL	0-8 mins	%	TOTAL	0-19 mins	%	TOTAL	0-19 mins	%	TOTAL	In target	%
HR1	51	44	86.3%	51	51	100.0%	116	112	96.6%	71	71	100.0%
SY7	1	0	0.0%	1	0	0.0%	3	2	66.7%	1	1	100.0%
HR4	44	37	84.1%	44	43	97.7%	99	96	97.0%	72	72	100.0%
HR2	46	35	76.1%	46	44	95.7%	124	119	96.0%	77	77	100.0%
HR8	21	12	57.1%	21	18	85.7%	41	32	78.0%	28	25	89.3%
HR6	32	22	68.8%	32	30	93.8%	62	54	87.1%	46	44	95.7%
HR9	26	19	73.1%	26	26	100.0%	65	55	84.6%	50	50	100.0%

WR13	6	2	33.3%	6	6	100.0%	14	13	92.9%	7	7	100.0%
HR7	11	10	90.9%	11	11	100.0%	19	19	100.0%	11	11	100.0%
HR5	11	7	63.6%	11	9	81.8%	10	2	20.0%	14	14	100.0%
WR6	2	2	100.0%	2	2	100.0%	1	1	100.0%	7	7	100.0%
SY8	1	0	0.0%	1	1	100.0%	4	4	100.0%	5	4	80.0%
HR3	1	0	0.0%	1	1	100.0%	5	3	60.0%	2	2	100.0%
GL17	1	0	0.0%	1	1	100.0%	0	0	0.0%	0	0	0.0%
NP25	0	0	0.0%	0	0	0.0%	2	2	100.0%	3	3	100.0%
LD8	0	0	0.0%	0	0	0.0%	0	0	0.0%	1	1	100.0%
TOTAL	254	190	74.8%	254	243	95.7%	565	514	91.0%	395	389	98.5%

July 2008

	Cat A 8Min			Cat A 19Min			Cat B 19 Min			Cat C Combined		
	TOTAL	0-8 mins	%	TOTAL	0-19 mins	%	TOTAL	0-19 mins	%	TOTAL	In target	%
HR1	52	42	80.8%	52	52	100.0%	95	95	100.0%	72	72	100.0%
HR2	65	53	81.5%	65	64	98.5%	111	105	94.6%	83	82	98.8%
HR6	38	25	65.8%	38	35	92.1%	49	45	91.8%	50	48	96.0%
HR4	58	51	87.9%	58	58	100.0%	98	95	96.9%	88	86	97.7%
HR7	10	6	60.0%	10	10	100.0%	21	20	95.2%	19	19	100.0%
HR9	35	25	71.4%	35	33	94.3%	55	40	72.7%	63	61	96.8%
HR8	19	11	57.9%	19	18	94.7%	36	26	72.2%	29	29	100.0%
WR13	7	2	28.6%	7	6	85.7%	10	8	80.0%	14	12	85.7%
HR5	9	7	77.8%	9	9	100.0%	17	5	29.4%	15	13	86.7%
SY8	1	1	100.0%	1	1	100.0%	0	0	0.0%	9	9	100.0%
HR3	1	0	0.0%	1	0	0.0%	5	2	40.0%	3	3	100.0%
NP25	2	0	0.0%	2	2	100.0%	1	1	100.0%	3	3	100.0%
WR6	0	0	0.0%	0	0	0.0%	8	8	100.0%	6	6	100.0%
SY7	0	0	0.0%	0	0	0.0%	2	0	0.0%	3	3	100.0%
TOTAL	297	223	75.1%	297	288	97.0%	508	450	88.6%	457	446	97.6%

Aug-08

	Cat A 8Min			Cat A 19Min			Cat B 19 Min			Cat C Combined		
	TOTAL	0-8 mins	%	TOTAL	0-19 mins	%	TOTAL	0-19 mins	%	TOTAL	In target	%
HR1	61	54	88.5%	61	61	100.0%	104	102	98.1%	79	79	100.0%
HR6	37	22	59.5%	37	36	97.3%	61	57	93.4%	49	49	100.0%
HR4	42	34	81.0%	42	42	100.0%	105	102	97.1%	70	69	98.6%
HR2	46	34	73.9%	46	44	95.7%	116	109	94.0%	51	51	100.0%
HR5	13	9	69.2%	13	11	84.6%	12	4	33.3%	18	18	100.0%
HR9	23	11	47.8%	23	22	95.7%	50	46	92.0%	53	51	96.2%
WR6	7	0	0.0%	7	6	85.7%	7	6	85.7%	6	6	100.0%
HR7	19	17	89.5%	19	19	100.0%	23	21	91.3%	28	27	96.4%
SY8	1	0	0.0%	1	1	100.0%	5	4	80.0%	4	4	100.0%
WR13	5	1	20.0%	5	5	100.0%	10	10	100.0%	12	12	100.0%
HR8	22	16	72.7%	22	22	100.0%	44	36	81.8%	24	23	95.8%
NP25	1	1	100.0%	1	1	100.0%	0	0	0.0%	2	2	100.0%
SY7	1	0	0.0%	1	0	0.0%	0	0	0.0%	2	2	100.0%
HR3	0	0	0.0%	0	0	0.0%	7	2	28.6%	4	4	100.0%
LD8	0	0	0.0%	0	0	0.0%	1	1	100.0%	0	0	0.0%
TOTAL	278	199	71.6%	278	270	97.1%	545	500	91.7%	402	397	98.8%

Sep-08

	Cat A 8Min			Cat A 19Min			Cat B 19 Min			Cat C Combined		
	TOTAL	0-8 mins	%	TOTAL	0-19 mins	%	TOTAL	0-19 mins	%	TOTAL	In target	%
HR9	26	20	76.9%	26	26	100.0%	57	46	80.7%	61	58	95.1%
HR1	65	57	87.7%	65	65	100.0%	94	91	96.8%	70	69	98.6%
HR4	50	44	88.0%	50	49	98.0%	83	81	97.6%	61	60	98.4%

HR7	12	12	100.0%	12	12	100.0%	26	24	92.3%	23	23	100.0%
SY7	1	1	100.0%	1	1	100.0%	3	1	33.3%	1	1	100.0%
HR5	14	9	64.3%	14	11	78.6%	8	1	12.5%	25	24	96.0%
HR2	59	52	88.1%	59	58	98.3%	103	96	93.2%	86	86	100.0%
HR6	41	34	82.9%	41	40	97.6%	52	49	94.2%	48	48	100.0%
HR8	9	6	66.7%	9	8	88.9%	37	30	81.1%	32	30	93.8%
WR13	6	3	50.0%	6	5	83.3%	11	9	81.8%	11	11	100.0%
SY8	1	0	0.0%	1	1	100.0%	1	1	100.0%	8	8	100.0%
HR3	4	2	50.0%	4	4	100.0%	7	1	14.3%	3	3	100.0%
WR6	2	1	50.0%	2	2	100.0%	4	2	50.0%	4	4	100.0%
GL18	1	1	100.0%	1	1	100.0%	0	0	0.0%	1	1	100.0%
GL17	1	0	0.0%	1	0	0.0%	0	0	0.0%	0	0	0.0%
NP25	0	0	0.0%	0	0	0.0%	2	2	100.0%	2	2	100.0%
LD8	0	0	0.0%	0	0	0.0%	0	0	0.0%	1	1	100.0%
TOTAL	292	242	82.9%	292	283	96.9%	488	434	88.9%	437	429	98.2%

Oct-08

	Cat A 8Min			Cat A 19Min			Cat B 19 Min			Cat C Combined		
	TOTAL	0-8 mins	%	TOTAL	0-19 mins	%	TOTAL	0-19 mins	%	TOTAL	In target	%
HR4	50	40	80.0%	50	49	98.0%	88	83	94.3%	63	63	100.0%
GL18	1	0	0.0%	1	1	100.0%	0	0	0.0%	0	0	0.0%
HR1	78	68	87.2%	78	78	100.0%	105	105	100.0%	74	72	97.3%
HR2	67	55	82.1%	67	66	98.5%	113	110	97.3%	78	77	98.7%
SY8	3	0	0.0%	3	3	100.0%	3	3	100.0%	2	2	100.0%
HR5	13	11	84.6%	13	12	92.3%	14	5	35.7%	17	17	100.0%
HR7	11	11	100.0%	11	11	100.0%	29	28	96.6%	29	29	100.0%
HR6	30	24	80.0%	30	29	96.7%	48	46	95.8%	52	51	98.1%
HR8	16	6	37.5%	16	13	81.3%	46	39	84.8%	29	29	100.0%
HR9	30	23	76.7%	30	29	96.7%	69	65	94.2%	43	43	100.0%
WR13	10	3	30.0%	10	10	100.0%	15	13	86.7%	23	21	91.3%
WR6	2	1	50.0%	2	2	100.0%	7	6	85.7%	8	8	100.0%
HR3	1	0	0.0%	1	1	100.0%	2	0	0.0%	10	10	100.0%
NP25	1	0	0.0%	1	0	0.0%	4	4	100.0%	1	1	100.0%
SY7	0	0	0.0%	0	0	0.0%	2	2	100.0%	3	3	100.0%
TOTAL	313	242	77.3%	313	304	97.1%	545	509	93.4%	432	426	98.6%

Nov-08

	Cat A 8Min			Cat A 19Min			Cat B 19 Min			Cat C Combined		
	TOTAL	0-8 mins	%	TOTAL	0-19 mins	%	TOTAL	0-19 mins	%	TOTAL	In target	%
HR4	50	36	72.0%	50	50	100.0%	90	87	96.7%	72	70	97.2%
HR7	11	9	81.8%	11	9	81.8%	26	18	69.2%	22	20	90.9%
HR2	61	51	83.6%	61	61	100.0%	108	106	98.1%	80	78	97.5%
HR1	74	66	89.2%	74	74	100.0%	90	90	100.0%	85	85	100.0%
HR8	18	12	66.7%	18	16	88.9%	34	29	85.3%	36	35	97.2%
HR9	31	23	74.2%	31	30	96.8%	53	45	84.9%	35	35	100.0%
HR6	35	28	80.0%	35	35	100.0%	64	60	93.8%	53	53	100.0%
NP25	1	0	0.0%	1	1	100.0%	6	6	100.0%	5	4	80.0%
WR6	3	0	0.0%	3	2	66.7%	5	4	80.0%	3	2	66.7%
HR5	8	7	87.5%	8	2	25.0%	9	1	11.1%	21	21	100.0%
SY8	1	0	0.0%	1	1	100.0%	1	0	0.0%	2	2	100.0%
WR13	7	1	14.3%	7	3	42.9%	5	5	100.0%	12	12	100.0%
HR3	4	1	25.0%	4	1	25.0%	10	3	30.0%	3	2	66.7%
SY7	1	0	0.0%	1	0	0.0%	0	0	0.0%	2	2	100.0%
TOTAL	305	234	76.7%	305	285	93.4%	501	454	90.6%	431	421	97.7%

Dec-08

Cat A 8Min	Cat A 19Min	Cat B 19 Min	Cat C Combined

	TOTAL	0-8 mins	%	TOTAL	0-19 mins	%	TOTAL	0-19 mins	%	TOTAL	In target	%
HR2	118	88	74.6%	118	110	93.2%	134	121	90.3%	98	93	94.9%
HR4	92	69	75.0%	92	87	94.6%	103	93	90.3%	57	53	93.0%
HR9	50	34	68.0%	50	39	78.0%	60	49	81.7%	48	46	95.8%
HR8	30	16	53.3%	30	22	73.3%	57	42	73.7%	31	28	90.3%
HR6	59	31	52.5%	59	45	76.3%	76	64	84.2%	70	60	85.7%
WR13	9	2	22.2%	9	8	88.9%	12	11	91.7%	12	12	100.0%
HR1	108	77	71.3%	108	106	98.1%	137	134	97.8%	162	147	90.7%
SY7	3	0	0.0%	3	2	66.7%	1	0	0.0%	1	1	100.0%
WR6	3	0	0.0%	3	3	100.0%	6	5	83.3%	3	3	100.0%
HR7	17	11	64.7%	17	16	94.1%	21	11	52.4%	20	17	85.0%
SY8	7	0	0.0%	7	5	71.4%	7	5	71.4%	3	2	66.7%
HR3	6	1	16.7%	6	2	33.3%	9	1	11.1%	6	5	83.3%
HR5	15	5	33.3%	15	2	13.3%	12	2	16.7%	14	10	71.4%
NP25	2	0	0.0%	2	0	0.0%	3	3	100.0%	2	1	50.0%
WR15	0	0	0.0%	0	0	0.0%	1	0	0.0%	0	0	0.0%
TOTAL	519	334	64.4%	519	447	86.1%	639	541	84.7%	527	478	90.7%

Jan-09

	Cat A 8Min			Cat A 19Min			Cat B 19 Min			Cat C Combined		
	TOTAL	0-8 mins	%	TOTAL	0-19 mins	%	TOTAL	0-19 mins	%	TOTAL	In target	%
HR1	86	73	84.9%	86	85	98.8%	107	102	95.3%	149	141	94.6%
HR6	64	46	71.9%	64	56	87.5%	63	59	93.7%	57	49	86.0%
HR8	31	16	51.6%	31	24	77.4%	24	20	83.3%	33	30	90.9%
HR7	21	15	71.4%	21	18	85.7%	16	12	75.0%	22	22	100.0%
WR13	3	1	33.3%	3	3	100.0%	8	6	75.0%	9	6	66.7%
HR2	85	67	78.8%	85	81	95.3%	113	106	93.8%	72	66	91.7%
HR3	5	0	0.0%	5	3	60.0%	5	1	20.0%	5	4	80.0%
HR4	66	59	89.4%	66	66	100.0%	86	84	97.7%	76	72	94.7%
SY8	2	0	0.0%	2	1	50.0%	6	3	50.0%	2	2	100.0%
HR9	39	28	71.8%	39	33	84.6%	69	59	85.5%	58	56	96.6%
WR6	6	2	33.3%	6	5	83.3%	6	5	83.3%	1	1	100.0%
HR5	11	5	45.5%	11	3	27.3%	21	7	33.3%	18	17	94.4%
SY7	1	0	0.0%	1	0	0.0%	1	0	0.0%	1	1	100.0%
NP25	1	0	0.0%	1	1	100.0%	2	2	100.0%	3	2	66.7%
TOTAL	421	312	74.1%	421	379	90.0%	527	466	88.4%	506	469	92.7%

Feb-09

	Cat A 8Min			Cat A 19Min			Cat B 19 Min			Cat C Combined		
	TOTAL	0-8 mins	%	TOTAL	0-19 mins	%	TOTAL	0-19 mins	%	TOTAL	In target	%
HR6	45	29	64.4%	45	43	95.6%	47	43	91.5%	48	44	91.7%
HR1	94	79	84.0%	94	90	95.7%	103	100	97.1%	103	98	95.1%
HR5	11	6	54.5%	11	2	18.2%	18	1	5.6%	16	14	87.5%
HR2	94	68	72.3%	94	89	94.7%	97	90	92.8%	68	64	94.1%
HR9	47	35	74.5%	47	43	91.5%	66	59	89.4%	48	47	97.9%
HR4	61	55	90.2%	61	61	100.0%	84	82	97.6%	64	62	96.9%
SY7	1	1	100.0%	1	1	100.0%	2	2	100.0%	3	3	100.0%
HR7	16	11	68.8%	16	14	87.5%	17	14	82.4%	13	12	92.3%
HR8	28	18	64.3%	28	25	89.3%	30	23	76.7%	26	22	84.6%
WR6	2	0	0.0%	2	1	50.0%	4	3	75.0%	2	2	100.0%
LD8	1	0	0.0%	1	0	0.0%	0	0	0.0%	1	1	100.0%
HR3	4	0	0.0%	4	2	50.0%	6	1	16.7%	2	2	100.0%
WR13	9	1	11.1%	9	9	100.0%	13	13	100.0%	8	7	87.5%
SY8	2	1	50.0%	2	2	100.0%	2	2	100.0%	1	1	100.0%
NP25	1	0	0.0%	1	1	100.0%	0	0	0.0%	2	2	100.0%
GL18	0	0	0.0%	0	0	0.0%	1	1	100.0%	1	1	100.0%
TOTAL	416	304	73.1%	416	383	92.1%	490	434	88.6%	406	382	94.1%

HEREFORDSHIRE PRIMARY CARE TRUST UPDATE

Report By: Director of Integrated Commissioning

Wards Affected

County-wide

Provider Services Review

Background

1. The Provider Services Review was initiated to:

   - propose models of care for health and social care services in Herefordshire that would deliver excellent outcomes and user/patient experience;
   - refine the proposed models and identify the workforce activity and financial consequences, to guide investments and service development;
   - propose an organisational configuration that sustainably supports the delivery of the proposed models of care.

2. The first stage of the work, the development of initial proposals for models of care, was completed last year in conjunction with the Health Services Management Centre and reported to the December meeting of this Committee.

Current position

3. Since December, the future service models and high level process maps have been developed and refined in a common format in conjunction with smaller groups of staff. The models of care are high level care pathways, providing an overview of the principles and steps in the individual's journey, and best practice models.

4. To ensure that wider reference groups have the opportunity to comment the models have been posted on both Council and PCT intranet pages since 3rd March, with links to a discussion forum Hard copies have also been made available for display and comment at community venues.

5. From these models key themes and issues to be addressed are being identified. This will inform commissioning and organisational plans.

Next Steps

6. Once the models are agreed a programme plan will be developed to deliver any agreed organisational change and development, as well as the commissioning implications and more detailed care pathway delivery.

BACKGROUND PAPERS

- None

Further information on the subject of this report is available from
Dr Ian Williams, Director of Integrated Commissioning, on 01432 383419

HEREFORD HOSPITALS NHS TRUST - UPDATE

Report By: Chief Executive of the Trust.

Wards Affected

County-wide

Purpose

1. To receive an update from the Trust.

Background

2. A report is attached.

BACKGROUND PAPERS

- None

HEALTH SCRUTINY COMMITTEE MEETING
27th MARCH 2009

CHIEF EXECUTIVE'S UPDATE REPORT
MARCH 2009
HEREFORD HOSPITALS NHS TRUST

1) Introduction

This report provides committee members with an update on the operational and financial performance of the Trust to the end of January 2009 together with a summary briefing on key developmental issues for the organisation.

2) Operational Performance

2.1 Patients treated

Elective inpatient and daycase activity continues its strong performance. Daycase activity in January was the highest level this financial year.

- Daycases: +15.2% on same period in 07/08
- Elective inpatients: +5.9% on same period in 07/08
- New outpatients: +7.8% on same period in 07/08

2.2 Accident & Emergency (4 hour waits)

The national target is that 98% of patients should be seen within 4 hours in A&E. Emergency activity was at a slightly lower level than seen in December but up against last year (1.7%). Performance continues to be strong with 98.0% recorded for the year to the end of January despite significant pressures in December and January which saw performance dip to 96.3% and 96.4% respectively. The current position for March is 99.3% and year end position is predicted to be 98%.

2.3 18 week access target

The national target is that 90% of admitted and 95% of non admitted patients should be treated within 18 weeks from referral by their GP.

The Trust continues to make strong progress achieving 96% and 100% for admitted and non admitted patients respectively at the end of February.

2.4 Healthcare Associated Infections (HCAI's)

The Trust continues its zero tolerance approach to HCAI's, focussing in particular on:-

- Hand hygiene compliance

- MRSA screening for admissions from A&E (78% achieved in December)
- Appropriate antibiotic prescribing
- General compliance with the Hygiene Code

There was 1 case (over 48hours) MRSA bacteraemia during January. Therefore, the total number of MRSA bacteraemia for the period April 2008 – January 2009 now stands at 7 cases. The Trust remains well within the maximum of 12 MRSA bacteraemia cases in 2008/09.

The number of Clostridium Difficile cases was 64 cases (over 48 hours) to the end of January against an SHA set trajectory of 76 cases for the year to date.

2.5 Other Clinical Indicators

The Trust Board is now focusing on a range of other clinical indicators, a selection of which is summarised below:-

- Readmission rates for February 2009 were down to 2.53% compared to 4.74% for February 2008.
- The day-case rate for surgery stands at 73.5% for February 2009 compared with 72.0% for February 2008.
- The Trust's mortality rate (as measured by a risk adjusted index) has fallen from 73 to 72 year to date.

2.6 Standards for Better Health Declaration 2008 – 2009

The Standards for Better Health assurance programme for 2008/09 continues, building towards the Trust's Annual Health Check Declaration scheduled for 30th April 2009.

Self assessment against core standards with appointed leads continues to plan with Trust Board 'sign-off` planned for 27th April 2009. Evidence to date highlights a much improved position compared to last year with 23 out of the 24 core standards now compliant. Element C21 (clean, well designed environments) currently indicates insufficient assurance, however, assurance of compliance is expected by year end.

2.7 Healthcare Commission (HCC) Hygiene Code Inspection

The Trust has now received the final report from the Healthcare Commission following an unannounced Hygiene Code visit in January 2009. The Trust was deemed to be compliant with 4 of the 5 duties and was given six months to rectify relatively minor failings against Duty 4 (The trust must provide and maintain a clean and appropriate environment for healthcare).

2.8 Finance

The Trust reported a surplus of £460k at the end of January although, this was still below the plan at this point in the year. The measures introduced in September are being maintained to correct this, namely:-

- Continued generation of additional income from treating more patients in the latter part of the year.
- Application of cost containment measures for non medical spending (vacancy and order controls).
- Implementation of cost improvement programmes

3) Service and Site Development

3.1 Clinical Decisions Unit

A strategic outline case will be taken to Hereford Hospitals Trust Board on 30th March 2009. The Trust is looking to recruit a dedicated project manager for the scheme which will be linked with the development of the new Primary Care Centre on site. The Trust is aiming to get the new facility up and running within 18 months.

The Clinical Decisions Unit Scheme is important to the Hereford Hospitals Trust because it will enable us to reduce inappropriate admissions and provide more rapid assessment and treatment of patients needing admission. As a consequence, it will impact on the overall requirement for medical beds, enabling the Trust to determine the scale of replacement for the two remaining hutted wards.

3.2 Macmillan Renton Unit &Radiotherapy Services

The closure of Kenwater Ward later this year (the beds will be replaced in the main hospital) will enable work to commence on the new Macmillan Renton Unit with a completion date of 2010. With regards to radiotherapy services, a strategic outline case will also be taken to the Trust Board on 30th March 2009. A set of plans have been developed allowing radiotherapy to be added onto the new Macmillan Renton Unit in order to establish an integrated cancer unit. The provisional date for opening the radiotherapy facility is April 2012.

3.3 Bowel Cancer Screening

The Trust is now able to undertake bowel cancer screening at the County Hospital linked to the current endoscopy service. The Trust was able to demonstrate that it could meet all the pre-conditions required to provide the service, the most significant being guaranteed access to recovery beds in the Daycase Unit.

Martin Woodford
Chief Executive
Hereford Hospitals NHS Trust

INTEGRATED FALLS PREVENTION AND MANAGEMENT STRATEGY FOR HEREFORDSHIRE 2009-2014

Report By: Director of Public Health

Wards Affected

County-wide

Purpose

1. To consider the Integrated Falls Prevention and Management Strategy for Herefordshire 2009-2014.

Background

2. The Committee expressed a wish to review falls in June 2007. Subsequently the Primary Care Trust commissioned its own Review. The Committee received a presentation in December 2007 on falls prevention for older people and the care of people who have fallen. Following an informal meeting of the Committee to consider the subject in 2008 an update on the development of the falls strategy was received in December 2008.

3. A final draft of the Strategy, a copy of which is appended, is to be considered by the Primary Care Trust Board in June 2009.

RECOMMENDATION

THAT the report be noted, subject to any comments the Committee wishes to make.

BACKGROUND PAPERS

- None

Further information on the subject of this report is available from
Dr Arif Mahmood, Consultant in Public Health Medicine Tel: 01432 363945

Hereford Hospitals NHS
NHS Trust

Herefordshire NHS
Primary Care Trust

Integrated Falls Prevention and Management Strategy for Herefordshire 2009-2014

This strategy has been developed by the Falls Strategy Working Group and membership includes the followings:

Dr Arif Mahmood – Chair	Consultant in Public Health
Nicki Howard	Health improvement Manager Older People
Vicky Alner	Consultant Physician in Geriatric Medicine
Vicki Howard	Falls Practioner
Sarah Siloko	Directorate Services Officer (Health)
George Fanning	Interim Services Manager Herefordshire Council
Graham Taylor	Directorate Manager Adult and Older people Services
Peter Stebbings	Intelligence Officer Public Health
Helen Clarke	Voluntary sector - Age Concern
Matt Clarke	Adult services Herefordshire Council
Peter Sowerby	Impact Officer - Older People
Lee Hutchinson	West Midlands Ambulance Service
Jo Macdonald	Head of Physiotherapy
Margy Fowler	Head of Occupational Therapy
Helen Crook	Health Visitor for Older People - Ledbury
Cllr Polly Andrews	Adult Social Care and Strategic Housing Committee
Elspeth McPherson	Voluntary sector - Age Concern
Jacqueline O'Mahony	Private Housing Sector Enforcement Officer
Malcolm Price	West Midlands Ambulance Service
Jo Pawsey	Performance Records Management

Executive Summary

Falls are among the most common and serious problems facing older people. They result from the interaction of multiple and diverse risk factors and Situations, many of which can be prevented/corrected. The National Service Framework for Older people identified nine standard areas, one of which is related to falls (Standard 6) in Older People. The standard aims at preventing falls and reducing resultant fractures and providing effective treatment and rehabilitation for those who have fallen through partnership working among the key stakeholders. NICE (2004) sets out clear guideline for early identification of those at risk of falling by range of health and allied professionals followed by a Multi-factorial Risk Assessment by fall specialists.

An analysis of five year falls data (2003 -2007) show that hospital admissions due to falls have increased by 40% since 2003 and on average there has been 200 hip fractures resultant of falls every year. 30% falls are due slip, trip or stumble and 50% occur in home. There has been no significant seasonal variation. A rapid review of the falls service identified that the service was under-resourced and inequitable. Service mapping against NICE guidelines revealed a number of gaps in the service provision in particular in the community settings.

This strategy aims at reducing the number of people falling in Herefordshire by establishing an integrated falls care-pathway whereby any person who is "at risk" of falling, or has fallen, is able to access appropriate and standardised assessment, high-quality treatment and support from a wide range of service providers in order to promote a better quality of life for the residents of Herefordshire. A tiered pyramid model with three levels of service provision has been developed. It ensures that maximum number of patients will be assessed and treated in the community and only complex cases will have to go to specialist clinics. To translate this model into operational elements an integrated care pathway has been developed. It defines the role responsibilities of the various professional and sets out the explicit criteria to refer the patient to the next service level.

The strategy sets out two key targets to be achieved by 2013-14 which are:

- To reduce the hospital admission rate due to falls by 15% by 2013-14 from the base line rate of 2005 -2007 (i.e. from 1284.8 to 1092.1 per 100,000 population aged 65+ years).

- To reduce the rate of hip fractures resultant of falls by 15% by 2013-14 from the base line rate of 2005-2007 (i.e. from 415.4 to 353.1 per 100,000 population aged 65+ years).

An action plan has been developed to implement this strategy and achieve these targets. The key actions include falls road shows to raise awareness of falls, communication strategy, training for frontline health and social care

workers, periodic case finding in primary care, risk assessment of fallers in various health settings, and availability of falls clinic and falls group at the Hereford Hospital and five community hospitals. Most of the actions are in progress, but the integrated falls service will be fully operational by September 2009.

1. Purpose

This document sets out an integrated strategy for the prevention and management of fall in older people and an action plan to implement it through multi-agency and multidisciplinary partnership working.

2. Background

Falls are among the most common and serious problems facing older people. They result from the interaction of multiple and diverse risk factors and situations many of which can be prevented/corrected. Critically, older people themselves are often not aware of their risks of falling, nor do they report the presence of risk factors to others who might be able to help.

2.1 Risk factors for falls

Several key risks factors are associated with falls and are split into intrinsic and extrinsic factors which relate to an individual's condition or environmental factors respectively.

Intrinsic risk factors

- Balance, gait or mobility problems including those due to degenerative joint disease and motor disorders such as stroke and Parkinson's disease
- Taking four or more medications, in particular centrally sedating or blood pressure lowering medications
- Visual impairment
- Impaired cognition or depression
- Postural hypotension
- Acute/chronic long term conditions

Extrinsic risk factors

- Poor lighting, particularly on stairs
- Steep stairs
- Loose carpets or rugs
- Slippery floors
- Badly fitting footwear or clothing
- Lack of safety equipment such as grab rails
- Inaccessible lights or windows
- Cold homes/inadequately heated homes
- Alcohol intake

2.2 Consequence of a fall

The consequences of a fall can be described in three categories:

Physical Consequences: Discomfort, pain, serious injury, inability to look after oneself, long term disability

Social Consequences: Loss of independence, loss of social contacts, loss of home, move to residential care, financial costs of help/care/hospital, decreased quality of life, changes to daily routine.

Psychological Consequences: Loss of confidence, fear, distress, guilt, blame, anxiety, embarrassment, depression, fear of another fall.

2.3 National Service Framework for Older People

The National Service Framework for Older people identified nine standard areas, one of which is related to falls (Standard 6) in Older People. The standard is as follows:

Aim

To reduce the number of falls which result in serious injury
To provide effective treatment and rehabilitation for those who have fallen

To achieve this:

The NHS, working in partnership with councils, will take action to:

- Prevent falls and reduce resultant fractures or other injuries in their populations of older people
- Ensure older people who have fallen receive effective treatment and rehabilitation and, with their carers, receive advice on prevention through a specialised falls service.

NSF Key Milestones

April 2003: Local healthcare providers should have audited their procedures and put in place risk management procedures to reduce the risk of older people falling.

April 2004: The Health Improvement Plan (HIMP), and other relevant local plans developed with local partners should include the development of an integrated falls service.

April 2005: all local health and social care systems should have established an integrated falls service

2.4 NICE Guidance

Case/risk identification

- Older people in contact with healthcare and local authority housing professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall.

- Health care and housing professionals in contact with older people should ask about their home/home conditions.

- Older people reporting a fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance.

Multi-factorial falls risk assessment

- Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multi-factorial falls risk assessment. This assessment should be performed by healthcare professionals with appropriate skills and experience, normally in the setting of a specialist fall's service. This assessment should be part of an individualised, multi-factorial intervention in line with the Common Assessment Framework for Adults.

- In addition an inspection of their home arranged with the local authority Private Sector Housing Team inspectors, using the Housing Act Housing Health and Safety rating system,(HHRS).

- Multi-factorial assessment may include the following:

    - identification of falls history
    - assessment of gait, balance and mobility, and muscle weakness
    - assessment of osteoporosis risk
    - assessment of the older person's perceived functional ability and fear relating to falling
    - assessment of visual impairment
    - assessment of cognitive impairment and neurological examination
    - assessment of urinary incontinence
    - Must include assessment of home hazards including (HHRS)
    - cardiovascular examination and medication review.

Multi-factorial interventions

- All older people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualised multi-factorial intervention.

- In successful multi-factorial intervention programmes the following specific components are common (against a background of the general diagnosis and management of causes and recognised risk factors):

    - strength and balance training
    - home hazard assessment and intervention including house inspections by Private Sector Housing officers.
    - vision assessment and referral
    - medication review with modification/withdrawal.

- Following treatment for an injurious fall, older people should be offered a multidisciplinary assessment to identify and address future risk, and individualised intervention aimed at promoting independence and improving physical and psychological function.

Encouraging the participation of older people in falls prevention programmes including education and information giving

- Individuals at risk of falling, and their carers, should be offered information orally and in writing about what measures they can take to prevent further falls.

Professional education

- All healthcare professionals dealing with patients known to be at risk of falling should develop and maintain basic professional competence in falls assessment and prevention.

3. Epidemiology of falls and fractures

3.1 National profile

Falls are the most important type of accident and many occur in and around the home, whether it is a private home, sheltered accommodation or residential/nursing care. There may be under representation of the proportion of people who die as the result of a fall, as an elderly person can die several weeks or months after a fall. While precipitated by the fall, the cause of death may not be reported as linked to the fall. (Office of the Deputy Prime Minister (2004), Housing Health & Safety Rating System). The key features of the national falls profile highlighted in the literature are as follows:

- Around 30% of over 65's living in the community will fall per year

- Three times this number of falls remain unreported

- Over 60% of people in nursing homes fall each year

- The rate of falls injury hospitalisation increases exponentially for over 65's with rates being higher in women than men
- 75% of falls-related deaths occur in the home
- Of the categorised falls in older people (over 65 years), 57% were due to falls on or from stairs or steps, 18% were falling from one level to another such as out of bed and 14% were due to slipping, tripping and stumbling
- 40% of care home admissions are as a result of a fall
- Falls at ages under 75 are more often associated with extrinsic factors like uneven pavements, loose carpets, ill-fitting shoes
- Falls at ages over 75 are more often associated with intrinsic or physical factors linked with ageing
- It is estimated that syncope or loss of consciousness is responsible for 5% of falls in older people
- Falls can result in a curtailment of activity, increased isolation and dependence.
- 1 in 5 fallers require medical attention
- Approx. 5% of falls result in fracture
- Over 95% of hip fractures are falls related (spontaneous fractures being very rare.)
- Over 90% of hip fractures occur with older people with osteoporosis

3.2 Herefordshire profile

This analysis covers all Herefordshire resident/registered population admitted to all English provider hospitals. Overall the number of admissions due to falls (defined as the presence of a diagnosis code ICD10 W00-W19 in any diagnosis position) has risen by almost 40% since 2003 and averages approximately 960 per year (Figure 1). However, quarterly analysis of hospital admissions over the period indicates minimal seasonal variation in the number of admissions - an average of 235-255 per quarter (Figure 2). For the purposes of this exercise Spring is defined as March to May etc.

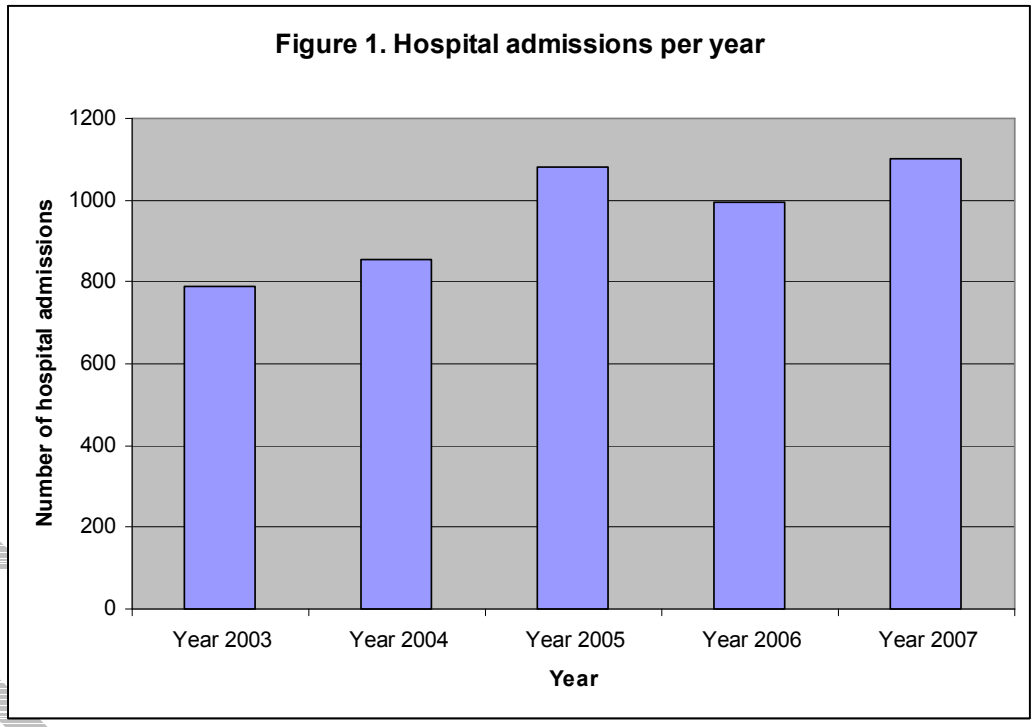


Figure 2: Seasonal Admissions Trend 2003 - 2008

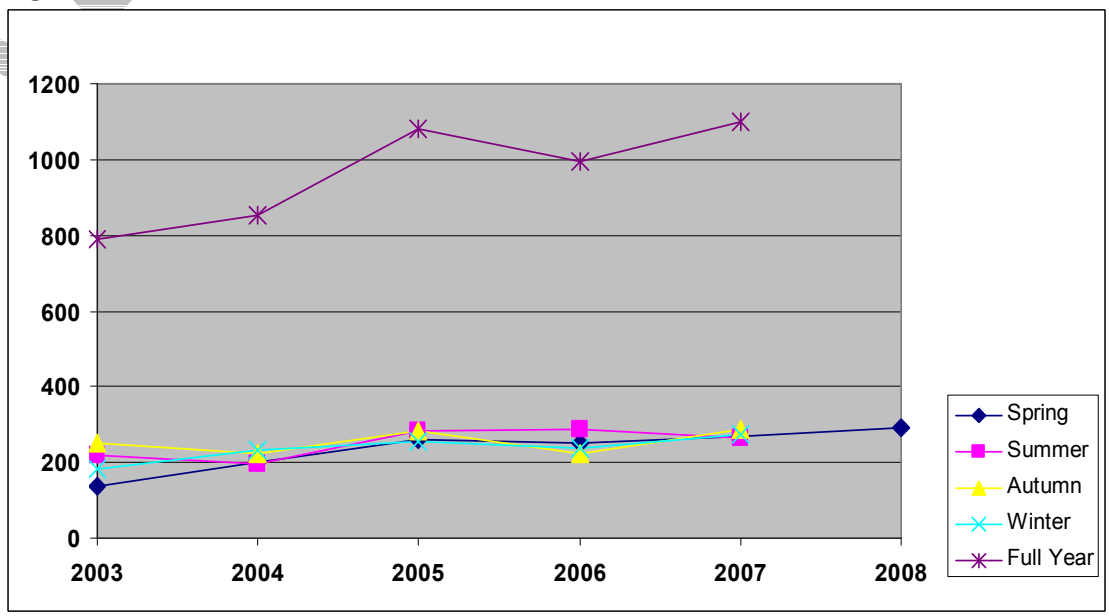


Table 1 provides a breakdown of all falls admissions by cause, as defined by the ICD10 coding classification. Almost a quarter of all falls are coded as due to unspecified causes.

Table 1: Number and Percentage of Falls by Cause (2003 to June 2008)

Cause of fall	Number	Percentage
Slip/trip/stumble	1562	29.8
Unspecified	1291	24.6
Fall on same level	578	11.0
Stairs/steps	488	9.3
Bed	203	3.9
Fall between levels	195	3.7
Playground equipment	186	3.6
Chair	157	3.0
Ice skates etc	118	2.3
Ladder	110	2.1
Collision with or pushed by other person	102	1.9
Building	73	1.4
Tree	37	0.7
Furniture	32	0.6
Ice and snow	29	0.6
Fall while being carried/supported by other person	29	0.6
Wheelchair	24	0.5
Scaffolding	14	0.3
Water diving/jumping	8	0.2
Cliff	2	0.0
ALL TYPES	**5238**	**100.0**

Table 2 provides an analysis of falls leading to hospital admission by venue – almost 50% of all such falls occur in the home. Again, over one fifth of admissions are not adequately coded in order to indicate a specific venue category.

Table 2. Number and Percentage of Falls by Venue (2003 to June 2008)

Venue	Number	Percentage
Home	2601	49.7
Unspecified	1138	21.7
Street	356	6.8
School/Public admin. building	331	6.3
Other	250	4.8
Residential Institution	243	4.6
Sports	196	3.7
Trade/service	82	1.6
Industrial	23	0.4
Farm	18	0.3
ALL VENUES	**5238**	**100.0**

Tables 3-7 below show further analysis of hospital admissions and hip fractures due falls in people aged 65 and over in period of three years from 2003 to 2005. The number of female admissions is almost three times higher

than male admissions in age group 75 and over. Overall, the number of hospital admissions has increased by 10% from 2003 to 2005 (table 3), whereas there has been a 10% drop in hip fractures during the same period (table 6).

Table 3: Hospital admissions due to falls in ages 65 and over by age band and sex

Year	65 – 74		75 – 84		85 and over	
	Male	Female	Male	Female	Male	Female
2005	46	79	59	158	45	166
2006	43	64	62	170	40	163
2007	49	76	69	165	54	193

Table 4: Hospital admissions due to falls in ages 65 and over (EAS Rate/100,000 population)

Year	Number of admissions	EAS Rate/100,00 population
2005	553	1282.8 (1173.1 – 1392.5)
2006	542	1205.0 (1100.5 – 1309.5)
2007	606	1366.5 (1254.4 – 1478.5)
3 year baseline admission EAS rate		1284.8

Table 5: Hospital admissions due to falls in ages 65 and over by residence

Year	Hereford	Ledbury	Leominster	Kington	Bromyard	Ross	Rural	Total
2005	177	35	43	15	23	34	226	553
2006	168	36	36	12	25	30	235	542
2007	190	46	48	8	20	55	239	606
Total	535	117	127	35	68	119	700	1701

Table 6: Hip fracture due to falls in ages 65 and over

Year	Number	EAS Rate /100,000 population
2005	206	462.1 (397.2 – 526.9)
2006	185	395.6 (336.9 – 454.4)
2007	184	388.6 (330.8 – 446.4)
3 year baseline	575	415.4

Table 7: Projected number and percentage of people aged 65 and over in Herefordshire 2005 – 14

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Number	**35900**	**36300**	**37100**	**38000**	**39200**	**40400**	**41600**	**43400**	**44800**	**46300**
Percentage of the total population	**20.2**	**20.4**	**20.7**	**21.1**	**21.7**	**22.2**	**22.8**	**23.7**	**24.3**	**25.1**

4. Our vision

Our vision is to reduce the number of people falling in Herefordshire by establishing an integrated falls care-pathway whereby any person who is "at risk" of falling, or has fallen, is able access appropriate and standardised assessment, high-quality treatment and support from a wide range of service providers in order to promote a better quality of life for the residents of Herefordshire.

The service will be provided to older people irrespective of their gender, ethnicity, culture or disability.

4.1 Aims

The overarching aim of this strategy is to ensure that:

- All relevant persons from the Local Authority and Primary Care Trust who may be in contact with potential fallers have the skills and ability to identify those at risk of falling and refer them to appropriate services through the use of a single agreed assessment tool agreed by all local stakeholders.

- All persons identified as at risk of falling have timely access to a seamlessly integrated local care pathway through which access to a range of services is equitable and timely.

- Those individuals who provide a first point of contact for service users adopt standard protocols and referral criteria as agreed by all relevant agencies.

- To raise awareness and prevent falls in the community and in areas of service delivery by improving the environment in which those at risk are living.

4.2 Objectives

- To ensure safer home environments for older people living in their own home, sheltered housing and care homes
- To ensure safer hospital environments for vulnerable individuals
- To improve the mobility and activity levels of older people in the community
- To ensure systems for improving the safety of medication in relation to preventing falls
- To encourage active healthy living amongst older people
- To ensure all staff have access to relevant falls prevention information / training
- To reduce the number of specific injuries associated with falling
- To support people who have a fear of falling
- To improve screening and treatment for osteoporosis with access to bone density scanning.
- To develop health promotion activities
- To ensure high-quality treatment and rehabilitation services

4.3 Local targets

- To reduce the hospital admission rate due to falls by 15% by 2013-14 from the base line rate of 2005 -2007 (i.e. from 1284.8 to 1092.1 per 100,000 population aged 65+ years).
- To reduce the rate of hip fractures resultant of falls by 15% by 2013-14 from the base line rate of 2005-2007 (i.e. from 415.4 to 353.1 per 100,000 population aged 65+ years).

4.4 Key outcomes

- Reduced falls and associated injuries and fractures
- Co-ordinated risk assessment
- Universally adopted care pathway
- Improved partnership working

- Better standards for effective prevention and rehabilitation services

5. Current falls service provision in Herefordshire

	NICE recommendations	Current provision
1	**Periodic case finding** from healthcare professionals and Private Sector housing officers.	Patchy within GP surgeries Reactive service from Local Authority
2	Use of '**Get up and go test'** to assess gait and balance	Patchy within GP surgeries, but regularly undertaken at falls clinics
3	**Falls Clinics:** Full evaluations for those who have required medical attention after a fall, or who have abnormalities of gait and/or balance, or who fall frequently.	Consultant lead clinics x 2 weekly Practitioner lead clinics x 2 weekly
4	**Exercise programmes:** Successful programmes are typically of more than ten weeks duration with the evidence of benefit being strongest for balance training (with Tai Chi a promising but, as yet, unproven method). Exercise needs to be maintained for sustained benefit.	Falls group run regularly in Hereford, Bromyard and Ross. Other schemes vary across Herefordshire, both in terms of capacity and the extent to which they are tailored specifically to fallers.
5	**Environmental modification:** This has greatest benefit when older patients at increased risk of falls are discharged from hospital. Evidence shows that environmental modification alone without other interventions has no proven benefit .	Carried out by OT's, housing, Local Authority Private Sector Environmental Health Officers intermediate care teams, handymen service, housing environmental officers etc but not usually as part of a broader falls prevention programme. Current capacity is limited and for the local authority, a reactive service .

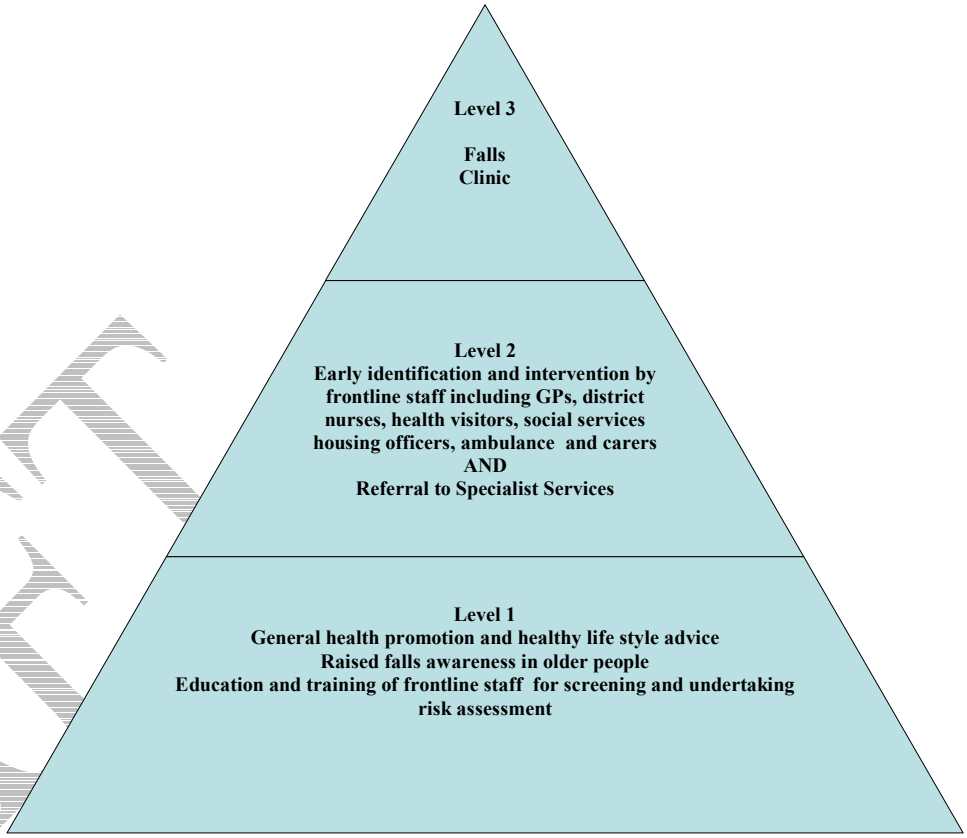
6	**Medications:** Patients who have fallen should have their medications reviewed, modified or stopped as appropriate in the light of the risk of future falls. Particular attention should be paid to older persons taking four or more medications and to those taking psychotropic medications.	Reviewed regularly at falls clinics, but there is a need for a systematic approach to medication review within GP practices.
7	**Assistive devices**: Assistive devices (bed alarms, canes, walkers, hip protectors etc) are effective elements of a multi-factorial programme. Hip protectors do not reduce the risk of falling but the evidence supports their use to prevent hip fractures in very high-risk individuals.	Recommended within falls service if deemed appropriate
8	**Cardiovascular intervention:** Cardiac pacing should be considered for older people with cardiac-inhibitory carotid sinus hypersensitivity who have experienced unexplained falls.	This service is available in the Hereford Hospital and they take referrals from the falls clinic. Excess Cold and Falls hazards . There may be under representation of the proportion of people who die as the result of a fall, as an elderly person can die several weeks or months after a fall. While precipated by the fall, the cause of death may not be reported as linked to the fall. (Office of the Deputy Prime Minister (2004), Housing Health & Safety Rating System) .
9	**Visual intervention:** Patients should be asked about their vision and, if they report problems, their vision should be formally assessed, and any remediable visual abnormalities should be treated. Those with poor vision are not only more likely to fall, they are also more	Visual acuity is assessed in consultant led falls clinic. From primary care and other health care professionals cases are referred to opticians

	likely to suffer fractures as a consequence.	
10	**Footwear interventions**: Although there seem to be no experimental studies relating falls to footwear, some trials report better balance and reduced sway through improved footwear.	Foot care assessment is undertaken in falls clinic. Podiatry assessment is by referral to podiatry clinic.
11	**Oral and written information** should be available for those at risk of falling and their carers.	Information exists in various forms, including personal contacts, a range of leaflets, and Herefordshire NHS website.
12	Maintenance of **basic competences** among health professional dealing with those at risk of falling.	Formal training programme for professional across the board is under development.
	NICE/ RCP requirements on osteoporosis	
13	Implementation of treatment guidance following the selective case finding approach	NICE and RCP are being followed.
14	Provision of DXA (bone densitometry) scanning	DXA Scan has recently been made available and the current capacity is 1200 to 1500 per year and waiting time is 4 weeks**.**
15	Housing intervention	Hazards in the home assessed by local authority Housing Environmental Health Officers in private sector housing team

6. The service model

This service model for falls service will fill the gaps identified in the current service provision, planning for a gradual expansion of those components that are already in place so that the NICE recommendations are implemented.

We propose a tiered pyramid model with three levels of service provision. It ensures that maximum number of patients will be assessed and treated in the community and only complex cases will have to go to specialist clinics. The detail of service provision at three levels is as below:



Level 1

Level One is the foundation of this model. It includes the following:

- General health promotion and healthy life style advice from frontline healthcare professionals such as GPs, Health Visitors, District Nurses, Practice Nurses, Social Care workers, Voluntary Sector workers etc.

- Falls prevention work in the community from a wide range of professionals such as the Herefordshire Council Private Sector Housing Team undertaking HHRS home hazard inspections, leisure services providing strength and balance training in the community, pharmacists recognising medication risks etc.

Level 2

The second level involves early identification and management of falls through following activities in the community:

- Periodic case finding in primary care and offering appropriate intervention

- Risk assessment of fallers in various settings such as GP surgeries, in homes, in care homes, in acute hospitals, or in other community settings

The second level includes those who have initial contact with a faller. The diversity of these initial contacts is a challenge to the falls service since there are so many people who need to understand its processes and purpose. First contact may come, for example, with a home carer, ambulance staff, a district nurse, a GP, a sheltered housing warden, voluntary sector employee, a pharmacist Housing Officer and so on.

Where possible, this first port of call will be able to identify the cause of the fall and reverse it/prevent further falls. The pharmacist may initiate a medication review, the GP may make a referral to optometry, the district nurse may identify postural hypotension and refer the faller to the GP, the housing manager might ensure that proper lighting is introduced to a poorly lit property.

This would trigger therapeutic and practical interventions that could significantly reduce the risk of future falls. For example, assessment by a physiotherapist could lead to a targeted strength and balance training programme while occupational therapist interventions might include adaptations that allow the faller to remain independent in their own homes. The intermediate care team might also refer directly to an appropriate service or to the falls clinic if necessary.

Level 3

Level 3 is the apex of the model. It includes referral to the falls clinic for Multi-factorial Assessment of those:

- fall recurrently, or
- require medical treatment after a fall, or
- demonstrate gait and balance problems, or
- who fell after a loss of consciousness
- fall as a result of complex medical causes

and offering various forms of treatment and specialist interventions such as syncope, balance or audiology clinics.

7. Action plan to implement the model

<u>Level 1</u> – General Health Promotion and specific measures to prevent falls and reduce the likelihood of injury

Action	Outcome	Time frame	Lead
Develop communication strategy – to raise awareness – including Herefordshire Home Check and Signposting services	Consistent message across the health and social care services and other statutory and voluntary organisation	July 2009	Vicky Howard
Falls road shows and other events to raise awareness	A structured programme of awareness raising events across the county	March 2009	Vicky Howard Jo Pewsey
Close working with voluntary sector to deliver key message	Consistent message across the health and social care services and other statutory and voluntary organisation	March 2009	Vicky Howard
Partnership working with local authority Private Sector Housing team to identify and remove/reduce home hazards	Structured framework to raise awareness of identified risks. (The Enforcement of Housing Act requires landlords to make homes safer)	On going work under the Housing Act 2004 and related legislation.	Jacqueline O'Mahony
Wider health promotion work – stop smoking, physical activity, health eating etc.	Healthy lifestyle awareness among older people	March 2009	Health Improvement Manger Older people HPT
Identify people at risk of osteoporosis	Early intervention and treatment DXA scan if deemed appropriate	On going	All GPs and clinicians in secondary care
Develop a falls register for all older people that have fallen or at risk of falling	Centralised electronic falls register for Herefordshire		Vicky Howard Health Improvement Manger – Older people HPT

			The PCT IT Team

Level 2

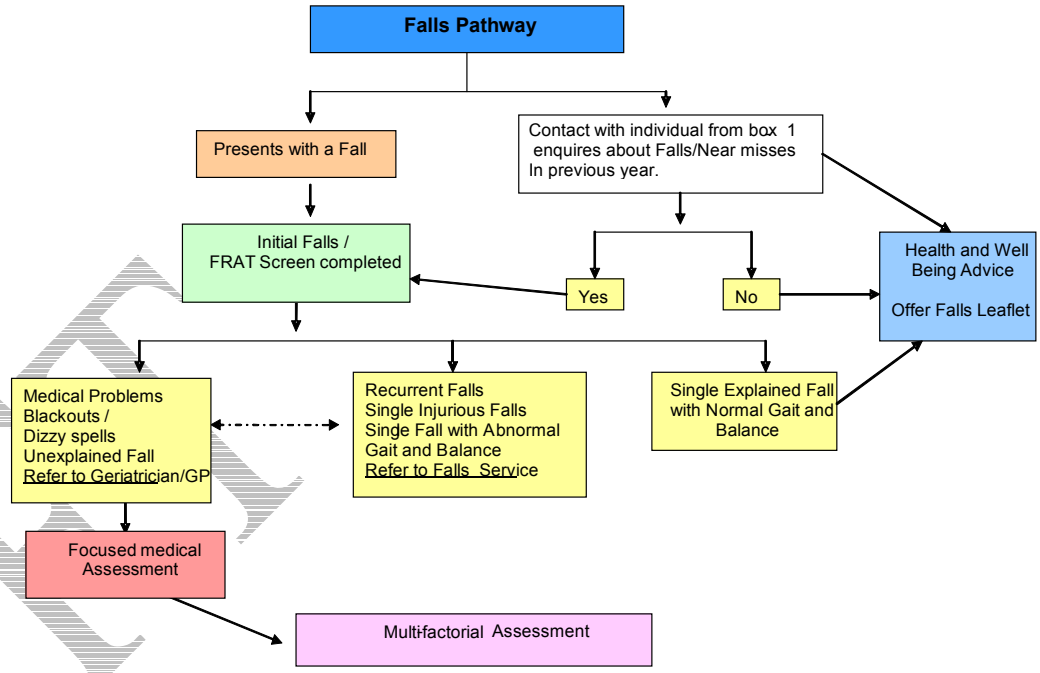
Action	Outcome	Time frame	Lead
Developing a standard training package for front-line staff including FRAT tool and "Get up and Go Test"	Early identification and intervention for potential fallers	March 2009	Vicky Howard Vicky Alner
Provide training for front-line staff who may come in contact with those who have fallen or at risk of falling	Early identification and intervention for potential fallers	March 2009	Vicky Howard Helen Crooke
Developing a standard patient care pathway	Clear referral pathway	March 2009	Vicky Howard Nicki Howard
Periodic case finding in the primary care	Early identification and intervention for potential fallers	Ongoing	Helen Crooke
Risk assessment of fallers in various settings such as GP surgeries, in homes, in care homes, in acute hospitals, or in other community settings	Risk stratification and referral for appropriate management	March 2009	Vicky Howard Vicky Alner
Referral of faller to specialised services such as podiatry, optometry and exercise programme	Early identification and intervention for potential fallers	On going	Vicky Howard
Medication review of the fallers by GPs and other clinicians	Prevention of falls and resultant fractures	On going	Vicky Howard
Assessment by the Occupational Therapists, Private Sector Housing officers, and social care to make the home environment safe	Prevention of falls and resultant fractures Prevention of further falls by ensuring hazards in the home are reduced/removed	On going	Margie Fowler Jacqueline O'Mahony George Fanning

Availability of exercise schemes through falls groups and other voluntary agencies across the county	Health improvement and wellbeing of the older people	Sept 2009	Vicky Howard Health improvement Manager

Level 3

Action	**Outcome**	Timeframe	Lead
Availability of falls clinics at all five community hospitals apart from one at HHT	Easy access to the falls clinic	March 2009	Vicky Howard Vicky Alner
Multi-factorial risk assessment	Specific care plan for the patient	March 2009	Vicky Howard Vicky Alner
Referral to specialised treatments such as for syncope, balance, audiology and cardiology clinics	Specific care plan for the patient	March 2009	Vicky Howard Vicky Alner
New post of 1 WTE OT post and 1 WTE physio post to enhance current service provision by providing specialist assessment and exercise provision	Specific care plan for the patient	September 09	Vicky Howard New OT and Physio

8. Integrated care pathway



Routine Check Completed by

GPs
MIU
Housing depts.
Private Hosusing Sector
DNs / HVs
Physios / OTs
Ambulance service
Voluntary organisations
Social care / carers
Practice nurses
Others

Information Notes Relating to Care Pathway

Box1

Any opportunistic contact with an individual that confirms a previous fall or near miss will need a further appointment if FRAT assessment is not completed at first contact.

1. **Presents with a fall**

   Definition of a fall:
   " An unintentional change in position causing an individual to land at a lower level on an object, the floor or the ground, other than the consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force"

   (Tinetti et al 1997, cited in Feder et al 2000)

   - Treat any injury due to a fall before an individual enters the falls care pathway
   - Treat any acute medical condition before an individual enters the falls care pathway
   - Encourage engagement with carers
   - Consider referral to Private Sector Housing for an inspection if appropriate

2. **Routine Elderly Check**

   Older people in contact with health, social care professionals and housing departments should be asked routinely (at least once a year) whether they have fallen in the last year and about the frequency and characteristics of the fall/falls.

   NICE Clinical practice guideline for the assessment and prevention of falls in older people, 2004)

   - Enquire about falls every 6-12 months
   - Advise medicines review
   - Advise routine eyesight test
   - Advise routine podiatry
   - Advise inspection by Private Sector Housing if appropriate

3. **Health and Well Being**

   Give general advice about

- Lifestyle
- Alcohol awareness
- Healthy eating
- Home safety/housing conditions
- Exercise
- Footwear
- Hearing and sight loss
- Avoiding risk
- Information about voluntary agencies

4. Initial Falls /Osteoporosis Screen/ FRAT Screen

- Take falls history
- Check gait and balance
- Consider osteoporosis risk
- Complete FRAT screen refer as per outcome, high, moderate, low risk
- Complete "Timed Up and Go"

Medical Problem/Unexplained fall

- Reports of loss of consciousness
- Suspected blackouts, unexplained falls, dizziness

- Refer straight to GP/Geriatrician

Recurrent falls/Single Injurious fall/Single fall with abnormal gait and balance

- Recurrent falls e.g. 2 in last 6 months
- Single fall with gait/balance problems
- Single fall with injury
- Refer to Private Sector Housing re inspection if appropriate
- Refer to Falls service

Single Explained Fall

If presenting with a clear single explained fall (e.g. clear slip on ice) with stable gait and balance, give health and well being advice and review in 6-12 months

Multi- Factorial Assessment

This should be performed by a health professional with appropriate skills and experience.

(NICE Clinical guidelines 21, 2004)

Guidance on Falls Prevention may be obtained from the following:-

- National Osteoporosis Society www.nos.org.uk
- RoSPA www.rospa.org.uk
- Leaflets and fact sheets may be accessed from Help the Aged www.helptheaged.org.uk/slipstrips

SCRUTINY REVIEW OF GENERAL PRACTITIONER (GP) SERVICES IN HEREFORDSHIRE

Report By: Directorate Services Officer - Health

Wards Affected

County-wide

Purpose

1. To consider the scoping statement for a review of GP Services in Herefordshire.

Financial Implications

2. The costs of the review will be accommodated within existing budgets.

Background

3. On 25 February this Committee considered a report on the GP led walk in health centre to be provided in Hereford City. It was observed that the provision of a walk-in centre open from 8am until 8pm seven days a week contrasted favourably with provision in the Market Towns and rural areas. GPs have the option to provide extended opening hours and at the moment some 50% of GP practices in the County have opted to do so. The range of services offered by GP practices also varies. It was proposed that there should be a scrutiny review of the services offered by GP practices within the County.

Rationale for the Review

4. The subject proposed for review is considered to be of high importance with a potentially high impact for the Community as a whole. The following reasons support this review:

- The issue is both strategic and significant.
- There is the potential to add value to the Council's and Partner's overall performance
- There is clear potential for effective outcomes
- It is an issue of concern to partners, stakeholders and the Community
- The review is timely and can be resourced.

Considerations

5. A scoping statement for this work is appended.

RECOMMENDATION

THAT (a) the scoping statement as appended be approved;

(b) the Membership of the Review Group be confirmed; and

(c) a Chairman of the Review group be appointed.

BACKGROUND PAPERS

- None

REVIEW:	GP Services in Herefordshire	
Committee:	Health Scrutiny Committee	**Chairman:** Councillor Kay Swinburne
Lead support officer:	Sara Siloko	

SCOPING

Terms of Reference

This review assesses the service levels and subsequent performance of General Practitioner (GP) services in Herefordshire, with particular focus on the provision of extended practice hours and the provision of preventive intervention measures and screening initiatives for their registered patients.

Desired outcomes

- To assess levels of overall service provided to Herefordshire residents by GPs under the Herefordshire Primary Care Trust (PCT) contract in order to:
    - seek assurance that the county's residents are receiving the level of service they need and deserve
    - identify and analyse any particular areas for improvement in the county's GP service provision
- To ascertain the current level of access to GP services across Herefordshire with particular emphasis on identifying issues pertaining to access to out-of-hours across population groups and localities
- Given the increasing emphasis on lifestyle choices and population wellbeing the review will examine GP involvement in preventive activities particularly for the major causes of disease and premature death in the county
- To ascertain the governance arrangements for performance managing and changing the service when necessary
- To ascertain the level of involvement of GPs in planning services

Key questions

- Do all population groups in Herefordshire enjoy a similarly high level of satisfaction as suggested by the overall figures from recent surveys?
- Are there specific population groups dissatisfied about their experience of GP services in Herefordshire.?
- Do all population groups and localities enjoy equitable access to GP services in the county?
- Is access to GP services outside normal working hours similar across rural and urban parts of the county?
- Are there specific areas or population groups experiencing difficulties with accessing GP services in the county?
- Are there specific areas or groups in the county that are disadvantaged by the current arrangements for extended opening hours for GP services?
- Are there national targets relating to preventive services, and if so what are they?
- How are Herefordshire GPs involved in delivering effective preventive actions aimed at reducing diseases and premature deaths due to cancers, stroke and diabetes?
- What specifically are GP practices throughout the county doing to support the effort to reduce smoking, promote sensible alcohol use, and reduce the levels of obesity and sexually transmitted infections?
- How are local GPs currently engaged in the delivery of services such as social care and mental health in their communities?
- What impact will ongoing and planned changes in health and social care service provision - such as the push to reduce numbers in residential care, individualised budgets, etc - have on GP services?
- To what extent are local GP practices involved in identifying and meeting the extended needs of the patient population they serve by using the opportunities offered by Practice Based Commissioning?
- How do GPs in the county interact and support the community hospitals, nursing homes and Intermediate Care Units in their locality?
- How, and how often, do the commissioners of the service assess the needs of the county's population for GP services?
- How are resources to meet these needs allocated to GP surgeries in Herefordshire and how does this process compare with national guidelines?
- What is the process for meeting needs above and beyond those identified in the basic GP contract?
- How are local GP services financed, and how is that money allocated to basic services and

other services?

- What criteria have to be met in order for a GP surgery to agree to provide a new service?
- How does the PCT ensure and monitor that there is equitable access to services for all?
- How does the PCT measure the outcomes for Herefordshire patients?
- Are there any plans locally or nationally (intended or already under way) which will change the preventive and/or screening services provided by GPs for Herefordshire? What are these plans, and when and how will they be implemented?
- Are there any plans intended or already under way to change extended hours GP service provision for Herefordshire? What are these plans, and when and how will they be implemented?
- What feedback do GPs receive from the PCT regarding the results of its annual patient survey?
- If there are discrepancies in service levels in different parts of the county, what action do GP surgeries take, or propose others take, to ensure that more equitable and efficient services can be achieved?
- How does the PCT interact with the Local Medical Council (LMC) and ensure involvement of the local GPs in the planning of future services?
- How could communication between GP providers and the commissioners of services be improved?

Links to the Community Strategy

The review group will identify how the outcome of this review contributes to the objectives contained in the Herefordshire Community Strategy, including the Council's Corporate Plan and other key plans or strategies.

Links to the PCT commissioning of GP services

The review will include questioning of the PCT management on the level of commissioning for GP services and their evaluation of the service provider.

Proposed Methodology
• Desk based review of evidence, data and source documents • Evidence review sessions and briefing from key informants • Briefing from expert witnesses, officers, and selected informants • Identification, collation, analysis and interpretation of locally available data • Visits to model GP practices of renowned excellence outside the county • Visits to a selection of GP practices in the county • Focus group discussions with key informers, community members, patients and selected groups • Obtaining the views of all GP practices directly via written response

Timetable	
Activity	*Timescale*
Agree approach, programme of consultation/research/provisional witnesses/dates	By Friday 10 April 2009
Brief review group	By Friday 24 April 2009
Collect current available data	By Friday 1 May 2009
Collect outstanding data	By Friday 15 May 2009
Analysis of data	By Friday 29 May 2009
Final confirmation of interviews of witnesses	By Friday 15 May 2009
Carry out programme of interviews	During first two weeks of June 2009
Agree programme of site visits	By Friday 15 May 2009
Undertake site visits as appropriate	During June 2009
Final analysis of data and witness evidence	By Friday 10 July 2009
Prepare draft report including options/recommendations	By Friday 17 July 2009
Test assumptions with informants	By Friday 31 July 2009
Prepare final report	By Friday 14 August 2009
Present final report to Health Scrutiny Committee	On 25 September 2009
Implementation of agreed recommendations	

Members	**Support Officers**
Expressions of Interest have been received from Councillors A Seldon, PJ Watts, P Jones, GA Powell, G Lucas and PGH Cutter.	Sara Siloko

ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2008

Report By: Director of Public Health

Wards Affected

County-wide

Purpose

1. To note the publication of the Annual Report of the Director of Public Health 2008.

Background

2. In previous years the Committee has received a presentation on the Annual Report of the Director of Public Health. One reason for this practice was to establish whether there are any key issues of concern that should be incorporated into the Committee's work programme.

3. This year there has been a new approach with a presentation being made to all Members of the Council at a seminar on 27 January 2009 at which the key messages of the annual report were highlighted. The seminar also considered the Joint Strategic Needs Assessment.

4. The Annual Report notes that overall, health outcomes are good in the county. However, there are avoidable differences and demonstrable inequalities. The Director of Public Health has emphasised the importance of focusing on and prioritising preventative and health promoting actions. The Annual Report recommends four key operational tactics to facilitate and create levers to improve health and wellbeing in the county. These are:

   i. Design and implement a GP-led health promotion programme
   ii. Introduce a health promoting hospital programme
   iii. Enhance and reframe local health intelligence functions to create insight for health improvement actions targeted at individuals, families, and communities at large
   iv. Prioritise local investment based on evidence and focused on comprehensive delivery of evidence-led interventions

5. The Annual Report will shortly be circulated to all Members of the Council and will be publicly available.

6. The scoping statement for the review of GP services earlier on this agenda makes reference to the increasing emphasis on lifestyle choices and population wellbeing and proposes an examination of GP involvement in preventative health measures. It is proposed that the Annual Report will further inform the Committee's future work on the preventative medicine agenda following completion of the review.

Further information on the subject of this report is available from
Dr Akeem Ali, Director of Public Health, on 01432 383445

BACKGROUND PAPERS

- None

WORK PROGRAMME

Report By: Assistant Chief Executive – Legal and Democratic

Wards Affected

County-wide

Purpose

1 To consider the Committee's work programme.

Financial Implications

2 None

Background

3 A report on the Committee's current work programme will be made to each of the scheduled quarterly meetings of this Scrutiny Committee. A copy of the work programme is appended.

4 The programme may be modified by the Chairman following consultation with the Vice-Chairman in response to changing circumstances.

5. Should any urgent, prominent or high profile issue arise, the Chairman may consider calling an additional meeting to consider that issue.

6. Should Members become aware of any issues they consider may be added to the scrutiny programme they should contact the Directorate Services Officer (Health) to log the issue so that it may be taken into consideration when planning future agendas or when revising the work programme.

RECOMMENDATION

THAT subject to any comment or issues raised by the Committee the Committee work programme be approved and reported to the Strategic Monitoring Committee.

BACKGROUND PAPERS

- None identified.

Health Scrutiny Committee Work Programme 2009/10

17 June	
	• Updates by Chief Executives of Health Trusts • Monitoring of LINk Performance (& Appointment of observers on the Committee) • ICT – linkages between Health and Social Care (from September 2008) • Consideration of the Ambulance Trust seeking Foundation Trust Status. • Progress reports on EOC Reconfguration (including assurance on resource drift performance) (Ambulance Service Review Feb 2009)
31 July	
25 September	
	• Scrutiny Review of the West Midlands Ambulance Service in Herefordshire – Progress Report
Scrutiny Reviews	• Report of Scrutiny Review of GP Services in Herefordshire
30 November	
22 January	
26 March	
To be scheduled	
	• Provision of services for children with special needs (from April 2008) • Stroke Services – progress report (from June 2008) • Sexual Health – National Support Team Report (from June 2008) • Walk in Health Centre Progress (from September 2008) • Audiology Services – outcome of external review (from June 2008) • Intermediate Care – monitoring of progress (from June 2008) • `Workforce plan including training, recruitment and retention issues for the Primary Care Trust, social care and provider organisations in the independent sector (in response to report on the development of high-performing health and social care services by 2012 to meet the expected future needs of 18-64 year-olds in Herefordshire with mental health problems and physical disabilities.) (from March 2008) • Preventative Agenda • Arising from the Ambulance Service Review – (feb 2009) - Review of the Patient Transport Service – possibly in collaboration with the Local Involvement Network - Progress achieved by the Community First Responder Organiser - Out of hours service provision in the County

	On Hold - • Oral Health/Fluoridation (from September 2008) • Sexual Health
Scrutiny Reviews	• Scoping of work on access to Healthcare in the South Wye – To consider appropriate health care in the South Wye Area in view of the fact of the lower health outcomes for this area and the expanding population. • Access to health 1) for ethnic minorities – Scoping Statement • Access to Health 2) Scoping Statement
Other issues	
• Proposal to look at the long-term implications for people in the county of having an inappropriate diet.	

Further additions to the work programme will be made as required