COUNTY OF HEREFORDSHIRE DISTRICT COUNCIL

MINUTES of the meeting of Health Scrutiny Committee held at The Council Chamber, Brockington, 35 Hafod Road, Hereford on Thursday, 15th March, 2007 at 10.00 a.m.

Present: **Councillor W.J.S. Thomas (Chairman)**

Councillors: Mrs. W.U. Attfield, G.W. Davis, J.G. Jarvis, Brig. P. Jones CBE, G. Lucas, R. Mills, Ms. G.A. Powell and J.B. Williams

In attendance: **Councillors W.L.S. Bowen and R.M. Wilson. Mr J Wilkinson, Chairman of the Primary Care Trust's Patient and Public Involvement Forum was also present.**

93. APOLOGIES FOR ABSENCE

Apologies were received from Councillors Mrs E.M. Bew and T.M.James.

94. NAMED SUBSTITUTES

There were no named substitutes.

95. DECLARATIONS OF INTEREST

There were no declarations of interest.

96. MINUTES

RESOLVED: that the Minutes of the meeting held on 2nd March, 2007 be confirmed as a correct record and signed by the Chairman.

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

There were no suggestions from members of the Public.

98. UPDATE ON EMERGENCY PLANNING ARRANGEMENTS FOLLOWING THE OUTBREAK OF LEGIONNAIRES DISEASE IN HEREFORD IN NOVEMBER 2003

The Committee received an update on emergency planning arrangements following on from the Committee's Review of the response to the outbreak of Legionnaires disease in Hereford City in 2003.

A previous update had been given to the Committee in September 2005. The Emergency Planning Manager presented his report on developments since that time. He highlighted that the development of the West Mercia Local Resilience Forum (LRF) had considerably enhanced the sharing of information between the Category 1 Responders (the Council. Ambulance Service, Fire Service, Health Protection Agency, Primary Care Trust (PCT) and the Police). Protocols had been agreed which more clearly defined the respective roles of agencies in managing an infectious disease outbreak. This had resulted in increased resilience and he

considered that arrangements for dealing with emergencies were now stronger than in 2003

He noted that whilst Legionnaires disease itself was not assessed as one of the highest risks in both national and local terms requiring a specific emergency response plan there was an annual assessment of risk was made by the local risk Group.

One issue which was outstanding was finalising a Memorandum of Understanding (MoU) between the Council and the Health Protection Agency (HPA) dealing with the protocols for dealing with infectious diseases. This was currently in draft form and had not been progressed by the Agency because of national work on a new MoU taking account of changes to PCTs and Strategic Health Authorities. Whilst the absence of the local MoU had not hindered the Council's ability to work with the HPA he considered that it would be worthwhile to put it in place.

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

- Responding to a question, the Emergency Planning Manager said that although organisations and structures were constantly changing, the current plans and training should prevent this disruption being a hindrance. The LRF was a useful mechanism for keeping agencies updated.

- It was suggested that the response to the legionnaires outbreak had been strengthened because of good local knowledge and working relationships. The Emergency Planning Manager acknowledged this but added that the arrangements with the major agencies agreed by the LRF at regional level were replicated at a local Hereford level. A local focus had been retained and there were local training events.

- The Emergency Planning Manager agreed to look into the possibility of offering Members the opportunity to observe future emergency planning exercises.

- The Chief Executive (Acting) of the PCT was invited to comment and concurred with the Emergency Planning Manager that arrangements for collaboration between key organisations had been strengthened.

- The Chief Executive of the Hospitals Trust was asked about the Hospital's state of readiness taking into consideration the pressures an avian flu pandemic for example would generate. He advised that as part of the Local Resilience Forum the hospital would be able to draw on assistance from across the Region. He was mindful of the importance of keeping plans refreshed and the Hospital's Major Incident Plan had recently been reviewed.

- A further question was asked about the arrangements for ensuring that lessons learned across the Country were shared. The Emergency Planning Manager advised that the Regional Resilience Forums reported to the Cabinet Office and information was co-ordinated and Regions kept informed of developments and they in turn informed local agencies.

- The Chief Executive (acting) of the PCT commented on the requirements on the PCT to declare any incidents, analyse them and take account of any lessons learned from them.

RESOLVED:

That (a) the emergency planning update be noted;

(b) an update on the preparation of a Memorandum of Understanding between the Council and the Health Protection Agency dealing with the protocols for tackling infectious diseases be made in six months time;

and

(c) consideration be given to offering Members the opportunity to observe future emergency planning exercises.

99. LOCAL DELIVERY PLAN

The Committee received an update on the Primary Care Trust's Local Delivery Plan.

Mr Simon Hairsnape, Chief Executive (Acting) of the Primary Care Trust (PCT) gave a presentation on the Local Delivery Plan 2007/08 (LDP).

He commented first on the national funding picture noting that 2007/08 was the last of 3 years of significant funding growth (around 9% per year) which had brought funding roughly into line with European average investment of 9 % Gross Domestic Product. He explained the basis on which funding was allocated to PCTs and that Herefordshire had been allocated £233 million in 2007/08 (£1,309 per patient.) This was to cover hospital services, community services, primary care (e.g. GP services) and prescribing.

The LDP, which had now been agreed with the West Midlands Health Authority set out the PCT response to national requirements and local targets. Priorities for 2007/08 were:

- Reducing waiting times from when a GP referred a patient for treatment to the start of treatment to 18 weeks by December 2008. (This represented a significant contrast to the position where patients had had to wait 6-9 months for an out-patient appointment and up to two years for treatment.) Herefordshire had opted to implement this early so that 90% of people would be treated within 18 weeks by December 2007. It would require a huge increase in capacity and redesign of services to achieve the target

- Reducing the incidence of healthcare acquired infections. (Although the number of cases was not large in health terms there was an issue of public confidence in the system to address.)

- Reducing health inequalities and promoting health and well-being (with particular focus on 48 hour access to Genito-urinary Medicine (GUM) clinics). (Money allocated to the Health Promotion Service had been ring-fenced. A joint Director of Public Health was to be appointed.)

- Improving financial 'health'. (Whilst Herefordshire's financial position had generally been good it was again an area where it was important to ensure public confidence.)

He reported that following the requirement for the NHS to achieve financial balance in 2006/7 there was a requirement to achieve a national £250M surplus in 2007/8.

This was in the context of reduced growth from 2008/9 onwards and a requirement that cash releasing efficiency savings of 2.5% would be achieved for all services.

He also drew attention to the introduction of the system of payment by results which was based on paying nationally fixed 'average' prices for each episode of care rather than negotiating prices locally. This aimed to reward productivity and efficiency in that if a hospital could attract more patients or provide care cheaper than the national tariff, they would gain. It was also intended to play a key part in achieving other areas of system reform such as choice, and achieving the 18 week waiting time target from GP referral to the start of treatment.

He referred to the 'Non-NHS Contracts' for the delivery of long-term and palliative care through contracting with the private and independent sectors.

In relation to further system reform to increase choice and competition he commented on the national drive for greater 'plurality' of providers to increase capacity, drive competition, increase innovation and responsiveness to patients.

He also commented on the target that 80% of patients should report they were being offered a minimum of 4 choices by their GP when they are referred to hospital services. Currently this was not something which appeared to be being met in Herefordshire with only 30% of patients claiming to be offered this level of choice. Comparative information for patients to help them make choices was basic at this stage, often resting on GP recommendation.

In conclusion he stated that 2007/08 was another important year for the PCT with the Government's expectation that national targets set out in 2000 would be met. There would be organisational reform with the development of a Public Service Trust for Herefordshire and decisions on the management of provider services. The PCT's decision to seek to achieve the target of delivery of reducing waiting times from GP referral to the start of treatment to 18 weeks by December 2007 was also a challenge. Whilst the financial position in Herefordshire had historically been reasonable there would still be some difficult decisions to take. Improved public engagement was also an objective with a mismatch between the level of public satisfaction expressed with services, most people indicating that they were "generally satisfied" and the improvements that the PCT considered had been delivered.

In the ensuing discussion the following principal points were made:

- The implications of seeking to reduce waiting times from GP referral to the start of treatment to 18 weeks by December 2007 were discussed. Mr Hairsnape said that making sufficient capacity available was the key challenge rather than providing the finance in 2007/08. An "unscheduled care" project was underway to seek to manage workload so that the capacity to undertake elective care was maximised. However, the tighter financial circumstances expected in future years made it important that progress was made this year. He added that if the PCT achieved the 18 week target and met its financial targets and public health targets it would be one of the highest performing PCTs in the Country.

- It was asked how the PCT intended to finance the delivery of the target to reduce waiting times from GP referral to the start of treatment to 18 weeks by December 2007 and why it believed it could do so in 2007/08 given the difficulty in paying for operations it had faced at the end of 2006/07. Mr Hairsnape said that once the waiting list had been reduced it did not need as great a level of resources to keep it at that level. There were also potential financial gains in that once the shorter waiting time was achieved patients would seek to be treated locally

rather than elsewhere. He added that the principal reason for funding issues arising in 2006/07 had been that the PCT had had to pay £6.1 million in 2006/07 to the Strategic Health Authority to help offset financial pressures elsewhere in the NHS. It was expected that at least a proportion of this money would be returned to the PCT particularly if it could demonstrate that it was performing well.

- Mr Woodford, Chief Executive of the Hospitals Trust, confirmed that the 18 week target had the potential to benefit the hospital in that treating more patients would generate more income. The Chairman of the Trust emphasised that achieving the target depended on the Hospital, the PCT, Social Services and the voluntary sector working working together. To succeed the project would require that patients did not stay in the hospital or community hospitals longer than necessary but returned to home as soon as they could safely do so.

- A question was asked about instances of patients being discharged and not subsequently being notified of aftercare appointments. On behalf of the PCT it was stated that it was now the case that a lot of follow up appointments were no longer necessary. Discussions had taken place with the GPs on this point to agree a policy. What was important, however, was that if a follow up appointment was not required this was clearly communicated.

- On behalf of the Hospitals Trust it was acknowledged that the hospital booking centre had been under pressure, in part because of the introduction of a new computer system. Direct booking by GPs across all services would be rolled out by mid-summer which should reduce pressure on the centre. The Chief Executive said that he would be pleased to look into any specific cases if the details were forwarded to him.

- In response to a question about payment by results Mr Hairsnape confirmed that whilst the PCT was paid slightly more per patient than the average, reflecting the County's demographic profile, with a higher number of older people, no account was taken of the County's rurality, despite the PCT continuing to make the case to Government that delivering services in a rural County cost more.

- Mr Hairsnape also commented briefly on the resources which had been put into NHS pay. He acknowledged that these had been significant but had helped in addressing recruitment and retention difficulties. He added that GPs were now delivering a wider range of services and that good performance was being rewarded.

- It was asked whether the proposed increased levels of activity created the risk of an increase in the number of infections being acquired within the hospital. Mr Woodford replied that there was a proven link between activity levels and infection rates. Targets had been set to reduce the number of cases of MRSA and C. Diff. In 2003/04 the hospital had very few cases and improving on that level was very difficult. It was explained that all elective care patients were screened before entering the hospital. Where cases were found the aim was to isolate those cases. This was a challenge in a relatively small hospital with a small number of wards. The ideal would be to achieve an occupancy level of about 85%. Prescribing policy was also being changed recognising the link between some antibiotics and the spread of C. Diff. It had to be acknowledged, however, that visitors to the hospital needed to heed notices about the need to take appropriate steps to preserve cleanliness such as washing hands in accordance with the instructions on the notices posted around the hospital.

100. RESPONSE TO SCRUTINY REVIEW OF THE GP OUT OF HOURS SERVICE

The Committee considered the response by the Primary Care Trust (PCT) to the findings of the scrutiny review of the GP out of hours service.

The report prepared by the PCT set out the response to the Committee's recommendations approved in September 2006 all of which had been accepted by the PCT.

Mr Hairsnape, Chief Executive (Acting) of the PCT commented that the service now provided was clearly very different to that which had existed before GPs had been able to opt out of providing out of hours cover. The new out of hours service had improved significantly since its inception but the PCT considered there was room for further improvement. However, the service in Herefordshire was one of the higher performing services in the Country and was meeting key Government targets.

The service was not popular although the number of complaints had reduced. It was acknowledged that there could be several reasons for this reduction including that people had simply got used to the service rather than it necessarily meeting their requirements.

A major project on unscheduled care was underway which would include the out of hours service.

He drew the Committee's attention to the publication on 14th March, 2007 of a report by the Public Accounts Select Committee: The Provision of Out of Hours Care in England. He noted that whilst the report focused on the preparation for the new service its performance and its costs there was one specific reference to Herefordshire. In giving evidence to the Select Committee Sir Ian Carruthers, Acting NHS Chief Executive had said, "There are examples where early involvement of GPs, for example in Hereford, to name one, has made sure that there are very effective arrangements".

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

- Mr Wilkinson as a Member of the PCT's out of hours steering Group advised that the Group monitored performance closely and had seen a great improvement take place.

- Replying to a question about the ability of the service provider's drivers to locate patients in remoter parts of the County Mr Hairsnape said that an experienced group of drivers was now in existence which was familiar with the County.

- A Member stated that the experience in part of the north of the County was that the out of hours Service was still in need of improvement.

- That the service was still relatively new and unfamiliar but the service provider had clearly demonstrated a willingness to seek to learn from experience and improve.

It was proposed that the Committee should receive a further update in due course.

RESOLVED: That the response of the Primary Care Trust to the Review be noted and a further update made in six months time.

101. RESPONSE TO SCRUTINY REVIEW OF COMMMUNICATION IN THE LOCAL HEALTH SERVICE

The Committee considered the response to the findings of the scrutiny review of the Local Health Service's communications strategy and procedures.

Reports had been received from both the Hospitals Trust and the Primary Care Trust setting out their responses to the review's recommendations approved in September 2006.

The Chairman of the Review Group which had undertaken the review observed that the topic of effective communication was wide-ranging and there was no perfect solution to it and the issue was also to that extent an ongoing one. The Group had therefore tried to focus on some key issues.

Mr Woodford, Chief Executive of the Hospitals Trust, agreed that the issue was an ongoing one and outlined a number of steps the hospital had taken to improve communication. Areas identified for further work included: sympathetic communication with the patients; and the link to the Patient and Public Involvement Forum on which he would be happy to provide a future update to the Committee

Mr Hairsnape, Chief Executive (Acting) of the Primary Care Trust (PCT), reported that the PCT had accepted the Review's recommendations. The PCT was a large organisation and recognised the importance of communicating well and treated it as a key management responsibility. A range of methods were used and new approaches tried. Some new processes had been implemented as a direct result of the Review. In response to comments on the role of Councillors and Parish Councils in delivering information to the community he added that the PCT continued to be willing to attend community meetings as part of the communication process.

RESOLVED: That the response of the Hereford Hospitals NHS Trust and the Primary Care Trust to the Review be noted and a further update made in six months time.

102. WORK PROGRAMME

The Committee considered its work programme.

The following additions to the programme were agreed: updates on progress regarding the Public Service Trust and the Hospital Trust, progress by the Hospitals Trust, in particular, in relation to the review of Communications, a further report on the out of hours service having regard to the project being undertaken on unscheduled care and a report on progress in developing a Memorandum of Understanding between the Council and the Health Protection Agency dealing with the protocols for tackling infectious diseases.

RESOLVED: that the Committee's work programme be approved and reported to the Council's Strategic Monitoring Committee.

The meeting ended at 12.01 p.m. **CHAIRMAN**