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, 6th December, 2007 at 10.00 a.m.

Present: **Councillor JK Swinburne (Chairman)**
Councillor SPA Daniels (Vice Chairman)

Councillors: PGH Cutter, DW Greenow, KS Guthrie, P Jones CBE, G Lucas, A Seldon and AP Taylor

In attendance: Councillors PA Andrews, WLS Bowen and JB Williams

27. APOLOGIES FOR ABSENCE

Apologies were received from Councillors MJ Fishley, GA Powell and PJ Watts.

28. NAMED SUBSTITUTES

Councillor PGH Cutter substituted for Councillor MJ Fishley and Councillor DW Greenow for Councillor PJ Watts.

29. DECLARATIONS OF INTEREST

Councillor SPA Daniels declared a personal interest as an employee of Hereford Hospitals NHS Trust.

30. MINUTES

It was noted that the apologies of Councillor KS Guthrie and the attendance of Mr Wilkinson and Mr Hardy had not been recorded in the Minutes circulated with the agenda papers. An amended set had been prepared for signature by the Chairman.

RESOLVED: That the Minutes of the meeting held on 20th September, 2007 as amended be confirmed as a correct record and signed by the Chairman.

Preparation of Agenda Papers

The Chairman commented on the difficulties experienced in obtaining reports from partner organisations in time for despatch with the agenda papers. This was hindering the ability of the Committee to prepare and perform its role efficiently and effectively and was unacceptable. Also, information was not being published in the public domain at the time at which it should.

The Committee agreed that the Chief Executives of Health partners should be reminded of the importance of submitting information to the Committee and the public in a timely fashion.

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

There were no suggestions from members of the public.

32. MEMORANDUM OF UNDERSTANDING BETWEEN THE COUNCIL AND THE HEALTH PROTECTION AGENCY

The Committee considered an update on the preparation of a memorandum of understanding (MOU) between the Council and the Health Protection Agency (HPA) dealing with the protocols for tackling infectious diseases.

The Committee had received an update on emergency planning arrangements in March 2007, following on from the Committee's Review of the response to the 2003 outbreak of Legionnaires Disease in Hereford. The Committee had noted that at that time an MOU had not been finalised and had requested an update in six months time.

The Emergency Planning Manager presented the update, reporting on developments since the Committee's meeting in March. He confirmed that the HPA had now produced the MOU and although formal ratification was awaited this was imminent. He commented on the content of the MOU itself, copies of which had been circulated separately to Members of the Committee.

The report also noted, on a further point raised by the Committee in March about offering Members the opportunity to observe future emergency planning exercises, that a seminar was being programmed for the New Year following which invitations to Members to observe future emergency planning exercises would be made.

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

- In response to a question about emergency planning exercises the Emergency Planning Manager confirmed that exercises had been undertaken at various levels both strategic and local and gave examples. He referred to plans to involve Members as set out in the report and noted a request for Local Members to be kept informed of exercises in their area.

- Asked if he was satisfied that effective measures were now in place to deal with an infectious disease outbreak the Emergency Planning Manager said that the Civil Contingencies Act 2004 had led to changed arrangements. Looking back at the Legionnaires Disease outbreak there had been some evidence of parallel chains of command and some disjointedness in communication. He considered that the protocols in the MOU addressed these issues. He was also particularly pleased with the appointment of an Emergency Planning Officer for Health who would produce coherent plans on behalf of the Council, the Primary Care Trust and the Hospitals Trust.

The Emergency Planning Manager thanked the Committee for their contribution to taking the production of the MOU forward, bringing the issue to a conclusion.

RESOLVED: That the development of the Memorandum of Understanding between the Council and the Health Protection Agency be welcomed.

33. ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2007

The Committee received a presentation on the Annual Report of the Director of Public Health 2007 and issues arising from it.

Dr Frances Howie, Associate Director of Public Health gave a presentation on the report. She said that she would be happy to report to the Committee in greater depth on any of the key issues.

The presentation focused on general health, health inequalities, risk-taking (smoking, drinking, obesity); and other challenges (ageing, climate change). The main points made in the presentation are summarised below.

General health

Generally health is good in Herefordshire and people have a higher life expectancy compared with national averages.

Childhood mortality rates are low, infant mortality is also low. Standard Mortality Ratios (SMR) are generally below average. However, they are above average in three key areas: stroke, all accidents and land transport accidents.

Although, small in number the statistics for years of life lost showed 7% of all years of life lost up to 75 come from land transport accidents, and 11% from all accidents. There was scope for the Health Service and its partners to influence these areas.

Cancer deaths account for 36% of all years of life lost.

Circulatory diseases account for 24%.

The female SMR for stroke was 133 against the SMR for England of 100 and had proved resistant to change: there had been SMR of 131 in 1993.

Dental health of children is poor. The mean number of decayed, missing or filled teeth in 5-year olds in 2005/2006 was 1.78, compared with 1.02 in the West Midlands. There were significant differences between different social classes.

Health inequalities

These exist in Herefordshire as elsewhere with a 4 year life expectancy gap between the well-off and less well-off quartiles. SMRs are higher in the socio-economically deprived areas. SMR = 133 for men in South Wye (compared with the Herefordshire figure of 100). SMR = 129 for men in 18 most deprived Super Output Areas (SOAs). Gender differences: for women in South Wye SMR =110, and 102 in SOAs.

Perinatal mortality: 4 years data, rate of 4.71 in least deprived quartile; 9.43 in most deprived quartile; and 13.8 in South Wye. Inequalities are reflected at a low age.

Hospital admission rates per 1,000 – men 177.2 for whole county, 234.7 for D18, 248.4 for South Wye. Especially high admission rates for coronary heart disease, respiratory, psychiatric and paediatric from D18 and South Wye.

Key risk taking behaviours (Smoking Drinking, and Obesity) are more likely in the deprived areas. Action directed at these behaviours would have the most significant impact on health.

Risk-taking: smoking

2005 Adult Regional Lifestyle Survey - 21% of adult population in Herefordshire smokes - 25% of men and 19% of women. Highest rate here is among 35-44 year olds (29%) (regional average of 22%).

2006 Teenage Lifestyle Survey (Years 7, 8, 9 and 10) - 10% of 15 year old boys, 25% of 15 year old girls smoke. 44% of children said at least one person at home smokes.

Risk-taking: drinking

Recommended: no more than 21 units a week for men; 14 for women: binge is 8 units a day for men, 6 for women. 17% of adults here (23% of men, 11% of women) drink above those levels. 23% drank at binge levels at least one day a week in the week before the survey (32% of men, 15% of women). Highest binge drinking rates among men aged 18-34. 16% of Year 10 boys and 25% of Year 10 girls got drunk on at least one day in the week before the survey. Hospital admissions are up. Alcohol related admissions: 204 in 2002; 516 in 200. Men account for 70% of these. 46.8% of these come from the most deprived quartile (17.5% in the least deprived). 9 under 16 years in 2002, 30 in 2006. Average 4 females a year aged 14/15 years; 19 in 2006. 2005, 348 admissions; 516 in 2006. Nationally, alcohol is implicated in 70% of stabbings and beatings.

Risk-taking: obesity

Being obese reduces life expectancy by 9 years. Summer 2006, all Reception and Year 6 children were weighed and measured. 8.7% of Reception and 16.3% of Year 6 were obese. 14.2% of Reception and 14.9% of Year 6 were overweight. 22.9% of Reception and 31.2% of Year 6 were either overweight or obese. Correlation between obesity and living in an area of high social deprivation (not evident in terms of overweight). About 58% of adults are overweight or obese. The World Health Organisation states obesity is a global epidemic.

Challenges to health: ageing

20% of the population is 65+ years (35,400). By 2020, this may be 28% (53,000)
Healthy life expectancy has not increased in line with total life expectancy. Rurality (55% in a rural area; 1/5 in market towns, 1/3 in Hereford City). Moderate or severe dementia (7.3% of 65+ have dementia, of which 57% are moderate or severe). Stroke. Hip fracture (780 per 100,000 locally, 565 regionally)

Challenges to health: climate change

The climate is changing: severe weather is becoming more common, temperatures are rising, and there is more flooding. There is an impact on local agricultural employment with an ncrease in skin cancer rates. There are excess deaths from heatwaves (23% increase in mortality among 75+ years in England in 2003). Older people are especially vulnerable.

Conclusion

Dr Howie said that the Primary Care Trust's response to the findings had not yet been dealt with. She emphasised that an adequate response could only be made in partnership with the Council and hoped that it was an aspiration that this work would be facilitated by the work to develop a Public Service Trust.

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

- Noting the health issues affecting 15yr olds it was asked whether any research had been undertaken to see if following the development of the National Curriculum basic health education was being neglected. Dr Howie said that she was not aware of any published research but the Government was strengthening the healthy schools initiative in response to issues that had emerged. Cooking skills and nutritional advice no longer formed part of formal education. In the County the rating for the Healthy Schools Programme had moved from red to green and a part time Community Food Worker had been employed.

- The potential impact of an increased number of people smoking in the street was raised. Dr Howie observed that the aim of legislation on smoking had been to protect the health of workers. Smoking in the street might be annoying to passers by but was not a significant health risk to them. It was to be hoped that smoking in general would reduce over time. In response to further points on smoking she referred back to the fact that 44% of households contained someone who smoked. The Regional objective was to reduce the level but the decline in numbers smoking was slow. She noted that whilst statistical information was collected on admissions for bronchial difficulties, there was no specific data on the effects of passive smoking.

- The issue of obesity was discussed, noting the PCT had employed a Health Skills Co-ordinator and a Health Improvement Manager. Various ways to communicate the risks to people were being explored. Dr Howie also referred to work the PCT was doing with school governors on the new national standards for school meals. She agreed that there was a balance to be struck and there was resistance to take up of some of the healthier meals provided in schools. It was important, however, to make clear that there were a set of principles for a healthy lifestyle and to create an environment that allowed healthy choices to be made. Schools had powers available to them that could help in creating that environment, such as restricting pupils from leaving the school premises at lunchtime, and preventing fast food vendors operate from vans parking on school premises.

- It was acknowledged that there were mixed health messages with stop smoking advisors being sent to leisure centres while vending machines installed there sold unhealthy foods.

- The availability of cheap alcohol in supermarkets and the sale of alcohol to those under the legal age limit was discussed. Dr Howie suggested that this was an aspect where the Council could exert influence through use of its licensing and enforcement powers. Mystery shopping by the Council was the only realistic way to exercise enforcement. She noted that two extra enforcement officers had been employed to enforce the law on sale of tobacco and suggested there might be benefit in targeting illegal alcohol sales in a similar sustained way.

- In response to a question about the link between unwanted pregnancies in the 15-16 age Group Dr Howie noted that when someone reported to a clinic with a sexually transmitted disease or an unplanned pregnancy the clinical staff did not record whether drink was a factor. She added that sexual health was an issue that she would like to report on to the Committee in greater depth.

- A more detailed report on stroke services was requested.

- Regarding the uptake of the MMR vaccine Dr Howie responded that there had been a slight increase in uptake over the previous year to 83%. However, this was still well below the 95% uptake required to achieve herd immunity.

RESOLVED: That further reports be made to the Committee providing greater depth on the following issues: stroke services and sexual health.

34. PRIMARY CARE TRUST UPDATE

The Committee received an update from the Primary Care Trust on various issues.

A report from the PCT was circulated at the meeting. This covered the following issues: the delivery of the target of treating 90% of patients within 18 weeks of referral to the Hospitals Trust; the Reforming Unscheduled Care Project designed to improve the way urgent and emergency (unscheduled) care was planned, delivered and used looking at reducing or avoiding attendance at A&E, reducing emergency admissions and reducing emergency length of stay; the membership of the Professional Advisory Commissioning Executive and the development of the Local Area Agreement and the Local Delivery Plan.

Mr Paul Edwards, Director of Commissioning and Strategy, presented the report.

The summary of progress on delivery of the 18 week target was that there was one major risk (orthopaedics) to the delivery of the admitted patient target but it was still expected that the target would be achieved by the end of December 2007. The target for non-admitted patients was also expected to be achieved. It was noted that issues around the transfer of records to the new computer system installed by the Hospitals Trust were being resolved and data should be available to demonstrate achievement of the targets.

Performance monitoring of indicators relevant to the Reforming Unscheduled Care Project showed that there had been some reduction in emergency occupied bed days, length of stay and admissions. However, there was scope to deliver further change particularly around the avoidance of A&E and the development of alternative pathways.

The Local Delivery Plan for 2008/09 had to be submitted by the end of March 2008 and a report could be made to the Committee then if required.

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

- In response to questions about the 18 week target Mr Edwards reported that about 1,300 patients were involved and 800 had been treated to date within the target. Asked about the cost of meeting the target he said that whilst difficult to quantify precisely it was about £2.7 million. It was a Department of Health target.

  One of the key actions listed in the report to meet the target was to facilitate early discharges including the use of community hospital beds. It was asked how this would be implemented when community hospital beds were themselves full. Mr Edwards said that work was being carried out to look at the patient care system as a whole in order to move patients through the system. More transfers were being achieved year on year. Two extra social workers had been appointed.

- Asked about the rate of readmissions to hospital Mr Edwards said that this was

regularly monitored and that it was not a problem. Readmissions were not in the hospital's interest. He was confident the data was accurate.

- It was asked what communication arrangements were in place to direct patients to the correct source of care. Mr Edwards said that anyone attending A&E inappropriately was given a leaflet, which was widely available, explaining the range of services available. GPs with patients who frequently attended inappropriately were expected to look into the reasons.

- In response to a further question he said that the majority of inappropriate admissions to A&E were not at evenings and weekends but during daytime on weekdays. Maintaining access to primary care was a challenge. The PCT monitored the ability of people to make appointments within 24-48 hours. The scope for practice based commissioning was also kept under consideration.

- Access to pharmacies was also raised, noting that people who found their pharmacist closed might well go to A&E. Mr Edwards said that the issue was in part one of educating people that they could not expect their local pharmacist to be open all the time. The role of Minor Injury Units and pharmacies in supermarkets was part of the picture.

- On behalf of the PCT Public and Patient Involvement Forum it was reported that they were shortly to report to the PCT on the operation of the out of hours service. The conclusion was the service did work although it was not flawless.

- In response to a question Mr Edwards explained the operation of the out of hours service reporting that performance was meeting the national standards.

RESOLVED: That a report on the Local Delivery Plan 2008/09 be added to the Committee's Work Programme.

35. HEREFORD HOSPITALS NHS TRUST - UPDATE

The Committee received an update from the Hospitals Trust on various issues.

A report from the Hospitals Trust had been circulated separately. This commented on infection prevention and control in particular Clostridium Difficile (C Diff) and MRSA; bed occupancy and access targets; communication with patients; and the link to the Patient and Public Involvement Forum.

Mr M Coupe, Director of Business Development, presented the report. He added that there had been one additional case of MRSA since August 2007 but the patient had brought the infection into the hospital.

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

- Reassurance was sought on the position on infection prevention following a report by the Health Protection Agency in the summer that had shown high levels of infection compared with other Trusts. Mr Coupe replied that the Agency's report had not taken into account that the statistics on Hereford Hospital had been flawed because the hospital provided a testing service for all the GPs in the County and those cases had been included in the Hospital's figures. He also referred to a press release issued by the Trust's Chief Executive. Incidences of infection were lower than in the previous year and the Trust was reassured by the current position. He added that where infection did arise the whole health

community needed to work together to control the infection. For example, the Trust needed to consider how best it could support nursing homes and other like facilities.

- He reported that one of two wards closed because of the Norovirus had been opened that day.

- In response to a question about suggestions that staff were not changing uniforms after dealing with cases of infection Mr Coupe said that whilst he could not comment on specific cases the hospital did have a very rigorous infection control policy and systems in place and encouraged all issues to be raised with the management team.

- Asked about bed occupancy Mr Coupe acknowledged that there were times when insufficient beds were available. He referred to a range of steps that could be considered, including shortening lengths of stay, increasing day case numbers and removing blockages in the system. The Trust was reviewing the number of beds needed. Amongst other things this would take account of national guidance on spaces between beds, designed to reduce the risk of spreading infection.

- It was asked whether consideration had been given to screening patients for MRSA prior to discharging them, say, to Community Hospitals. Mr Coupe said that with an average length of stay of 4 1/2 days the vast majority of patients who would manifest MRSA would have already had it when entering the hospital and the benefit of pre-discharge screening for MRSA was therefore questionable.

- It was asked how cleaning arrangements today compared with those in the past. Mr Coupe that there was now a much greater science in monitoring cleanliness than there had been 25 years ago, with a national monitoring regime in place. The Trust's contract with its contractor was monitored. There were systems in place which included a role for the Ward Sister in identifying any problems. It had to be recognised that there would be instances where things did go wrong. The key was to have systems in place that could address them. Hospital environments were now safer on that ground.

- Mr Coupe said that it had to be recognised that there would be outbreaks of infection from time to time. The challenge was to do everything possible to avoid outbreaks and to be able to demonstrate that the Trust had done so.

- In relation to communication with patients, the decision to seek advice on customer service principles from the Regional Customer Services Manager of John Lewis was commented on and the relevance to the hospital environment questioned. Mr Coupe said that the Trust was not entering into a contract with the firm but drawing on its expertise. Amongst other things the Trust expected to learn from the coherent approach to processing complaints and develop ways of changing staff attitudes and behaviours. There were also comparisons to be drawn with John Lewis's status as a co-operative and the Trust's proposed move to Foundation Trust Status.

- The establishment of a focus group of patients on Internal Communication was discussed.

The Committee noted this update.

36. WEST MIDLANDS AMBULANCE SERVICE NHS TRUST - UPDATE

It was reported that a representative from the Trust was not able to attend the meeting as had been expected. No update could therefore be provided.

The Chairman asked to be notified of any particular issues that the Committee wished to bring to the Trust's attention.

37. DEVELOPMENT OF LOCAL INVOLVEMENT NETWORK

The Committee considered progress towards procuring a host for Herefordshire's Local Involvement Network (LINk).

The Senior Community Involvement Officer presented the report. He commented on some of the issues that had been raised at the stakeholder event on 3 December. These had included establishing a clear link to the Council whilst maintaining the independence of the LINk and clarification of the role of the Council as host organisation and the role of the LINk itself. The importance of avoiding duplication in the arrangements would be reflected in the invitation to tender.

RESOLVED: That a progress report be made to the next meeting.

38. REVIEW OF ELDERLY FALLS

The Committee received a presentation on falls prevention for older people and the care of people who have fallen.

A scoping statement for a review of elderly falls had been approved by the Committee in September 2007.

Lillian Somervaille, Public Health Consultant at the Primary Care Trust gave a presentation. The principal points are summarised below.

Why focus on falls?

Every year around 35% of people over the age of 65 and 45% of people aged over 80 will have a fall. Of those that fall 20-30% will suffer moderate to severe injury. Falls result in loss of confidence, increased dependency, isolation, and depression. A history of falls is a good predictor of hip fracture in older people. Someone with osteoporosis and a recent fall is 25x more likely to have a fragility fracture.

Cost

Locally in Herefordshire there is an older population than the national average and this older age group is increasing. A large number of hospital in-patient admissions are due to injury caused by falls. The rate of hip fracture in older people is higher than the national average – and remains high when age and rurality are taken into account. The 2007 Director of Public Health's report calls for a county wide audit to establish the action triggered when an older person attends with a falls related injury. There is a need to work with partners to reduce hospital admissions for hip fractures.

Preventing falls – national picture

Fewer than 1 in 50 older people recorded as having a high risk of falling has a recorded referral to a falls service or exercise programme. Older patients are unlikely to have a computer recorded history of falls. Most patients returning home

from A&E after a fragility fracture were not offered a falls assessment; only 22% were referred for exercise programmes to prevent future falls.

Caring for those who have fallen – national picture

Nearly three quarters of older women with diagnosed osteoporosis and a previous fracture receive the appropriate drugs. After recovery from hip fracture surgery less than 50% were on appropriate treatment for osteoporosis. For the minority of patients attending a falls clinic, the falls and fracture assessments and treatments were improved.

Case Study

Mr W – an 85 year old widower in rural area with frequent falls attendance at Minor Injuries Unit. He eventually agreed to home assessment. The problem was related to chopping firewood to raise income. Following a referral to benefit check it was no longer necessary for him to chop wood. The study highlights desire for independence and that people are entitled to refuse help. Solutions are often not found within the NHS.

What should we do?

Are national findings reflected in local practice? Local benchmarking is needed.
Referral to the falls clinic is very important. Equity profiling is needed to see if referrals to the falls clinic are consistent around the county and if not, why not.

Identification of those at risk of falling - are the right details being recorded in patient records, especially electronically (A&E, MIUs, primary care, ambulance services, other)?

Services in Herefordshire

Key posts are being filled:

- PCT based Health Improvement Manager with responsibility for the health of older people – appointed and commences in January 2008

- Appointment of a specialised falls nurse with County wide remit

The Committee noted the data collection activity being undertaken that would inform further consideration of this subject.

39. MENTAL HEALTH SERVICES - UPDATE

Further to the report to the Committee in September the Committee received an update on developments within the mental health services.

One report had been included in the agenda papers and an additional report had been circulated setting out key changes being implemented following the Future of Mental Health Services Consultation Paper.

The Committee noted both reports.

40. WORK PROGRAMME

The Committee considered its work programme.

The following additions were proposed:

- Arising from the Director of Public Health's report: reports on stroke services and sexual health.

- Local Delivery Plan 2008/09

The Chairman informed the Committee that she was requesting that the number of scheduled meetings should be increased to six to facilitate the conduct of business.

RESOLVED: That the work programme as amended be approved and reported to the Strategic Monitoring Committee.

The meeting ended at 1.05 p.m. **CHAIRMAN**