Buckinghamshire County Council

Minutes Overview & Scrutiny Committee for Health

AGENDA ITEM: 3

MINUTES OF THE MEETING OF THE OVERVIEW AND SCRUTINY COMMITTEE FOR HEALTH HELD ON FRIDAY 25 OCTOBER 2002, IN THE COUNCIL CHAMBER, CHILTERN DISTRICT COUNCIL, COMMENCING AT 10.00AM AND CONCLUDING AT 1.05PM

MEMBERS PRESENT

Buckinghamshire County Council

Mr M C Appleyard (Chairman)
Mrs P Bacon, Mr M Colston, Mr C Jones, Julia Wassell, Mrs P Wilkinson and Mr H Wilson

District Councils

Mrs C Martens	Wycombe District Council
Mrs M Hamilton	Chiltern District Council
Mrs J Kverndale	South Bucks District Council

Others in attendance

Mrs J Woolveridge	South Bucks District Council
Mrs J Hunt	Vale of Aylesbury Community Health Council

Officers

Mr R Edwards
Ms J Hall
Mrs M Yates

APOLOGIES FOR ABSENCE/CHANGES IN MEMBERSHIP

Apologies for absence were received from Mrs G Smith. It was noted that Mrs C Martins replaced Mrs L Clarke for this meeting only.

DECLARATIONS OF INTEREST

Mrs Martins declared an interest as a Non-Executive Director on the Wycombe Primary Care Trust

1 MINUTES

The minutes of the meeting of the Overview and Scrutiny Committee for Health held on Friday 27 September 2002, copies of which had been previously circulated, were confirmed subject to the recording of apologies from Julia Wassell.

2 PRESENTATION FROM DR ROBERT SHERIFF, EXECUTIVE DIRECTOR, PUBLIC HEALTH AND CLINICAL LEADERSHIP, THAMES VALLEY STRATEGIC HEALTH AUTHORITY

The Chairman and committee welcomed Dr Robert Sheriff.

Dr Sherrif explained that he would talk about the role the Thames Valley Strategic Health Authority and its approach to the scrutiny of health.

Dr Sherrif explained that Strategic Health Authorities had come into effect across England in April 2002. The Thames Valley Strategic Health Authorities (TVSHA) role was to hold the performance of the NHS in Oxfordshire, Buckinghamshire and Berkshire to account. The TVSHA wider role was to engage consultation that directly resulted in changes to services and mergers, ie Stoke Mandeville and South Bucks Hospital Trusts and submit recommendations to the Department of Health. The TVHA was also responsible for the development of major capital building.

It was noted that as Primary Care Trusts were responsible for 95% of the budget, it was important that they grew into the new roles as the main functions of health sat with them.

Health Scrutiny

Dr Sherrif reported on the view of the TVSHA and its approach to scrutiny of Health.

He reported that the TVSHA saw health scrutiny as a level in which to consult with local authorities on major changes to delivery of service, capital projects and access to Health, and fulfilling a gap between Health and the public. He anticipated that high-level issues would come to Overview and Scrutiny as a

method of pre-consultation and that the mechanisms within O & S would allow for the big strategic changes to be discussed at the earliest opportunity and for the NHS to gain access into the Local Government arena. He continued to explain there would be continuing changes with smaller hospitals merging as it was becoming increasingly more difficult to provide a full range of services.

Service Quality Issues

Dr Sherrif explained that service quality issues were not about particular services but about hospital housekeeping. He reported part of the Community Health Councils role had been to focus on a particular service and recommend areas for improvement. The TVSHA felt that this role might now fall within the scrutiny function.

Individual Patient Cases

He explained that it was not expected for scrutiny to look at this function. He felt that it would only come to scrutiny if there were a number of queries and complaints on the same topic.

Health Improvements and Inequalities

Dr Sherrif reported that a number of changes had occurred in the six months since the SHA became operational:

1. The SHA had a monitoring role of the PCT in the way public health issues were dealt with.
2. The Executive Director of Public Health was based in Guildford and now contributed towards environmental issues, this was a major change to the role of Health.
3. At PCT level, the Director of Public Health worked with Local Authorities and in some areas had joint appointments enabling work across partner agencies to tackle health inequalities.
4. Issues around health improvements and health inequalities were one of the twelve objectives identified as important issues to address.
5. Bigger issues in health improvement, smoking, health and exercise could be tackled more widely through partner working with local authorities and education.

Theory of Health Improvement

Dr Sheriff gave members an overview on how particular issues and groups were identified and targeted for health improvement. He explained that a view of the whole population was taken rather than targeting high-risk groups. He reported on the different approaches to improving health and the SHA always looked at good practice.

During discussion members welcomed the SHA views as Health Scrutiny being a critical friend with a shared agenda.

During discussion members commented on the SHA view to ensure a co-ordinated approach to health inequalities, especially where weaknesses were identified, and how the role of the Overview and Scrutiny Committee for Health could assist. In reply Dr Sheriff explained that the SHA role was not to ensure that every national target was being achieved in every area, but recognised that things often worked better locally through local priorities. He continued that some areas of work, for example teenage pregnancy, were difficult to move forward, in these circumstances the SHA and PCTs worked together. Dr Sheriff explained that the new arrangements with the introduction of Health Scrutiny opened a new doorway for health to establish and work within local authorities and local government. He explained that prior to the new arrangements the Bucks Health Authority only reached District Council, and County Councils through the Community Health Councils. A direct link had now been established with an avenue open to consult with local authorities and move the agenda on. He hoped that the Scrutiny role was a doorway for debate on bigger issues prior to consultation.

A member explained that Mental Health was a difficult area for local government as often there were crossovers in work with the PCTs. The member questioned how the SHA planned to assist in addressing inequalities in both mental health and other areas. In reply Mr Sheriff reported that an assessment in Public Health was currently being carried out in all PCTs. The results would give a breakdown of the issues and help in identifying good practice. Any gaps in service would also be highlighted.

In reply to a comment on objective one of the Department of Health – Public Service Agreement it was noted that the targets were agreed by the DoH and the Treasury and originated from the National Health Service Plan. He reported that many of the targets were well on the way to being achieved although achieving target 2, waiting in A & E was proving more difficult. Dr Sheriff highlighted the more difficult targets to be the reduction in mortality rates from major killer diseases by 2010, through either county or local targets. He also highlighted infant mortality and life expectancy targets as difficult to achieve. Further discussing targets to reduce the mortality rates of the major killer diseases and the rates of death in Briton compared to France, whose mortality rates for these diseases were lower, it was noted that the published figures normally referred to rates of death at a particular age. In France although the rates of mortality for cancer, stroke and heart disease were lower than the UK, there rates of mortality were higher from road accidents and sclerosis. Other factors needed to be considered when comparing data, similar population as well as the identification and treatment of diseases.

A member commented on the importance of effective partnerships in dealing with the wider determinates of health inequalities. In reply Dr Sheriff reported that good partnership working was most effective where officers worked well together, he felt that joint appointments were a way forward. He also felt that it worked better at local levels, District Councils and PCTs. He continued that a lot of initiatives required partnership working that the SHA were linked into.

In response to a comment on hospital acquired illness it was noted that the hospital's infectious disease team and Public Health were the main drivers.

Dr Sheriff suggested that if elected members received complaints about services, these should be passed on to the relevant CHC. The Overview and Scrutiny Committee would probably only want to address and issue if a large number of complaints were received on the same issue.

In response to a comment on the standards set for Primary Care Trusts it was noted that the PCTs were created to make changes happen in the NHS and were measured for success through the implementation and development of the National Service Frameworks (NSF). By April 2003 PCTs would hold 75% of all money.

In response to comments on the effects the management merger of the two Hospital Trusts would have on the Mental Health Trust (MHT) in terms of service delivery and savings, taking into account the current problems mental health was experiencing, it was reported that no particular issues had been raised that would effect the merger. Dr Sheriff reminded members that the merger was only management and the savings would come from the loss of a Board.

Dr Sheriff concluded that he recognised the benefits of Local Authorities scrutinising Health and welcomed the new mechanism that would allow the TVSHA to bring bigger issues to the fore with Councillors.

The Chairman thanked Dr Sheriff for the informative presentation and for attending the meeting.

3 STEVE YOUNG – CHIEF EXECUTIVE, CHILTERN AND SOUTH BUCKS PRIMARY CARE TRUST

The Committee welcomed Steve Young, Chief Executive of Chiltern and South Bucks Primary Care Trust and Dr Claire Strong, Acting Director of Public Health.

Steve Young gave an overview of the Chiltern and South Bucks Primary Care Trust and how it fitted into the new structure of the NHS within the Thames Valley Strategic Health Authority. In particular the following was noted:

- the CSB PCT structure included, two hospital trusts, South Bucks and Heatherwood and Wexham (11% of referrals were sent to Heatherwood and Wexham); two Mental Health Trusts, Berkshire and Buckinghamshire (some elements of the Berkshire MHT were being transferred over to Bucks) and two ambulance trusts, 2 Shires and Berkshire.
- the PCT covered all wards of South Bucks District Council, all but one ward in Chiltern District Council and 4 wards of Wycombe District Council. It oversaw 21 GP practices and 95 GP's (includes 85 whole time equivalents).

- the PCT had a commissioning budget of £110m; a services provided budget of £8m included Community Nursing, Intermediate Care and the Community Hospitals in Chalfont and Gerrards Cross and Chesham.

It was noted that the PCT had a set of values and a vision which in principle aimed to develop high quality patient-sensitive care and accorded with the NHS Plan to become an excellent organisation in all its core values by, being patient focused, promoting health and equality in an open, innovative and integrated way by providing a quality and inclusive service.

The PCT had a number of challenges and issues to implement that include both national and local targets. He reported that involving the public was a big challenge. Cleanliness was also high on the agenda, and a 'Champion', whose responsibility was to visit hospitals and do spot checks on cleanliness, had been appointed.

Mr Young reported on the NHS Plan and the National Service Frameworks (NSF) for Mental Health, Older People, Coronary Disease and Diabetes that were all national drivers. He reported that the National Institute of Clinical Excellence (NICE) was a statutory driver. The key NHS Plan targets were also noted and included:

- reductions in waiting times for A& E
- targets for category A ambulance call responses by 2003
- targets for appointments with GPs and primary health care professionals by March 2003
- outpatient appointments
- a reduction in patients treated outside target of 62 days from urgent referral with breast cancer
- no breeches inpatients waiting over 15 months, outpatients waiting over 26 weeks
- meet Trust and PCT waiting list manifesto commitment
- implement crisis resolution teams in mental health by December 2002
- met the Drug Action Team targets
- reduce inequalities

The NHS Plan targets were built from the responses of public opinion. He reported that the targets for A & E would be challenging and difficult to meet. Targets for delayed discharges of care had been set both nationally and locally. It was noted that generally the PCT would achieve all its targets, although as the area was rural ambulance response targets were more challenging. Other key challenges for the PCT included:

- The merger of the South Bucks and Stoke Mandeville Acute Trusts
- Issues relating to Mental Health and establishing community based care
- Development of Community Hospitals
- Issues relating to recruitment and retention were being addressed by being more innovative in training, housing and flexible working arrangements

During discussion a member commented on a 'One Stop Shop' in Chalfont and in particular treating patients who were not registered with a Doctor as many often visited A & E. In response, Steve Young agreed that this was a pressure for Accident and Emergency and that the suggestion would need

further thought. A member commented on the Mental Health NSF targets noting more emphasis was required on improving this group's health. In response it was explained that the appointment of a joint funded Mental Health specialist would help in addressing this issue.

Claire Strong, Acting Director of Public Health

Dr Claire Strong, Acting Director of Public Health, Chiltern and South Bucks PCT was introduced and welcomed to the meeting.

Dr Strong reported on the initiatives that the Chiltern and South Bucks PCT had in place and were initiating to reduce health and inequalities in Chiltern and South Bucks Primary Care Trust.

It was noted that 'Saving Lives – Our Healthier Nation' was a key document for addressing inequalities and highlighted the importance of working with partner organisations. The white paper looked at tackling the wider causes of ill health, social and economic environment. It recognised that in areas of deprivation, people were more likely to be ill and die early.

The NHS Plan addressed improving health and reducing inequalities through targets, implementing initiatives to reduce the health gap in childhood and throughout life between socio-economic groups and reducing infant mortality in more deprived populations. It was noted that infant mortality, nationally, was used as a proxy for identifying the socio-economic state of the country. Other important documents highlighting improving inequalities were:

- Tackling Health Inequalities – August 2001, a DoH consultation document looking at four key areas, Infant Mortality, Child Poverty, Smoking and Teenage Pregnancy.
- Chiltern and South Bucks PCT Health Improvement Plan 2002 – 2005, PSA target 11 identified supporting local communities and multi-agency work.
- Local Delivery Plans 2003-2006, published in October 2002, which include the HIMP and SAFF and identified six areas to tackle to make a difference:
    - reducing smoking, particularly in pregnant women
    - Increasing breastfeeding, focusing on women from disadvantaged groups
    - Reducing teenage pregnancies
    - Reducing deaths from coronary heart disease
    - Reducing deaths from Cancer
    - Increasing uptake of flu immunisation in older people

Dr Strong reported that data was collected and ranked to identify the degrees of deprivation and analysed against similar data in Buckinghamshire to identify deprived areas. The data supplied indicated the most and least affluent wards in CSB in terms of public health profile and child poverty.

A number of schemes had been set up locally to address and reduce inequalities, including:

- Welfare Schemes, in conjunction with the Citizen Advice Bureau, in a GP setting
- Parenting and Cooking Skills - £30,000 was raised to help improve health
- Increased access to interpreters in Chesham
- Pond Park and Burnham identified as areas for special support in PSA
- A number of initiatives had also been set up to assist Asian women with a drop in centre run by Health Visitors, English for Health courses and Asian Ladies get Active Project, supported by Health Visitors, looking at activity, healthy eating, coronary disease and diabetes.
- Local residents in an area of Burnham who were in fear of crime approached the Beacon Housing Association and were given a ground floor flat which is being converted to run courses in cooking, IT and women's health.
- The Public Health Resources Unit in Oxford was currently undertaking a Health Needs Assessment in Iver, Iver Heath and Denham.

Dr Strong outlined key partnership groups including multi agency Health For All Steering Group, Community Safety Partnerships and Local Strategic Partnership and Community Plans amongst others. Members noted the success of many of the initiatives; in particular, joint schemes with District Councils. Dr Strong highlighted one particular scheme for a handy van which assisted people with home security and DIY. Since the scheme began in 2000, from 900 referrals, 550 jobs had been completed.

In summary, Dr Strong reported that the area was relatively healthy and wealthy with significant pockets of deprivation in Chesham, Iver, Denham and Burnham. She reported that to make a significant impact on reducing the effects partnership working was important. The key areas associated and identified as making a difference included education, environment, employment, housing, reduction in crime, transport and economic development.

During discussion a member commented on the Welfare Benefit scheme currently run in conjunction with the Citizens Advice Bureau (CAB) and if the scheme included the County Council and its Benefits Welfare Team set up recently in light of Fairer Charging. In reply it was noted that the schemes main link was with the CAB but in order to expand more creative ways needed to be identified. It was noted that the scheme had concentrated on Chesham as this was identified as the most deprived area in the PCT. It was hoped that similar initiatives would be set up in South Bucks District Council area following a Parish survey on local needs. Dr Strong did emphasis the importance of maintaining and building on the Chesham project.

In response to a comment on the differences in the comparative levels of the major causes of illness and death and how this compared locally and among certain groups in the community it was noted that there was difficulty in looking at the differences in mortality in deprived areas as the numbers were small, analysis looked at the most deprived and most affluent and figures based on small numbers were unreliable. It was noted that incidents of child mortality were higher in deprived areas. Figures were based on larger numbers, usually national. It was also noted that the compendium of health indicators annual

report looking at death rates for different areas showed that coronary deaths were steadily declining with Chiltern area appearing slightly healthier than South Bucks.

In relation to a comment on inequalities and comparable areas of the country with similar socio-economic background, it was noted that comparisons were usually only made with adjoining areas. A member commented on the planning of health services in relation to services provided by other agencies, eg, transport. The importance of being involved early with new developments was emphasised and it was reported that CADEX, a meeting of Chief Executives from the County Council, District Councils and PCTs, discussed these points at their regular meetings.

In response to a comment on the success of partnership working to reduce health inequalities, it was noted that partnership working had been successful in the Pond Park scheme, but further consulting was needed to drive initiatives forward. Dr Strong emphasised the need to work closer with young people, reporting that some work with young Asian girls was beginning to address this point. A member commented and emphasised the need to interact and work with Asian Leaders and Community Leaders from other groups including County and District Councillors who can obtain community views on how health improvements in their own area were working.

In response to a comment regarding the cultural, language and religious needs of ethnic minority groups and how the PCT will undertake to achieve this, it was noted previously the initiatives being introduced to assist this group. In relation to mental health for Asians it was reported that this area needed more jointly resourced schemes as it was currently under resources. Steve Young reported that mental health in Bucks was currently being remodelled to become community based to build closer ties with GPs.

The Committee discussed the issues around men's health in general, noting the national challenge to improve the health of men; in particular, access to care was discussed. In response it was recognised that there were issues that needed to be addressed and developed.

The Committee thanked Steve Young and Dr Clare Strong for the informative and interesting discussion.

4 LIAISON WITH PRIMARY CARE TRUSTS

Members discussed how best to liaise with the Primary Care Trusts as it was agreed that relationships needed to be developed. It was suggested that the PCTs be asked to provide information on key issues arising.

The committee agreed that visits to the three PCTs would be arranged and members would be advised accordingly.

5 DATE OF NEXT MEETING

Friday 20 December 2002, Mezzanine Room 1, County Hall, Aylesbury