NOTTINGHAM CITY COUNCIL

HEALTH SCRUTINY PANEL

MINUTES of the meeting held at LB31 - Loxley House, Station Street, Nottingham, NG2 3NG on 26 November 2014 from 13.30 - 15.07

Membership

Present	Absent
Councillor Ginny Klein (Chair)	Councillor Thulani Molife
Councillor Mohammad Aslam	Councillor Eileen Morley
Councillor Merlita Bryan	Councillor Timothy Spencer
Councillor Azad Choudhry	
Councillor Brian Parbutt	
Councillor Anne Peach	
Councillor Emma Dewinton	

Colleagues, partners and others in attendance:

Linda Syson-Nibbs	-	Screening and Immunisation Lead from NHS England
Simon Castle	-	Assistant Director at Nottingham City CCG
Kirsty Mallalieu	-	Acute Contracts/Cancer Commissioning Manager at Nottingham CCG
John Wilcox	-	Public Health Manager
Jane Garrard	-	Senior Governance Officer
Rav Kalsi	-	Senior Governance Officer

34 APOLOGIES FOR ABSENCE

Councillor Thulani Molife)
Councillor Eileen Morley) Non-Council business
Councillor Tim Spencer)

35 DECLARATIONS OF INTERESTS

None.

36 MINUTES

The Panel confirmed the minutes of the meeting held on 24 September 2014 as a correct record and they were signed by the Chair.

37 BOWEL CANCER SCREENING UPTAKE

The Panel considered a report of the Head of Democratic Services detailing proposals by NHS England relating to factors affecting the uptake of bowel cancer screening in the city and work taking place to improve uptake, particularly amongst groups in the local population who have low uptake rates.

Linda Syson-Nibbs, Screening and Immunisation Lead from NHS England, Simon Castle, Assistant Director at Nottingham City CCG and Kirsty Mallalieu, Acute Contracts/Cancer Commissioning Manager at Nottingham CCG advised the Panel of the proposals and, during discussion, stated the following;

(a) the aim of the NHS Bowel Cancer Screening Programme (NHSBCSP) is to detect bowel cancer at an early stage (in people with no symptoms), when treatment is more likely to be effective. Bowel cancer screening can also detect polyps which are not cancers, but may develop into cancers over time. They can easily be removed, reducing the risk of bowel cancer developing;

(b) the screening programme is offered to both males and females aged 60-74 through an invitation letter sent from the Bowel Cancer Screening Eastern Regional Hub. The following week individuals are sent faecal occult blood (FoBT) testing kit with a pre-paid envelope to return the completed test to the Bowel Cancer Screening Eastern Regional Hub. Current performance of the screening process shows a 50% update (April 2014);

(c) patients with a abnormal FoBT result are invited to an appointment with a specialist nurse in a screening clinic (part of the Screening Centre) to discuss their results. At the consultation, the specialist screening nurse will offer an appointment within two weeks for a colonoscopy. Depending on the findings of the colonoscopy, patients will be offered screening again in two years' time, entered into a surveillance programme or referred for further treatment at a local hospital;

(d) the responsibility to carry out screening has been commissioned locally through NHS England Area Teams since 1 April 2013 who commission immunisation services from a range of providers on behalf of the local population;

(e) the quality and performance of these programmes are monitored through quarterly local Programme Boards chaired by the Screening and Immunisation Lead;

(f) the percentage of 60 – 69 year olds screened dropped both locally and nationally in July 2013 which coincided with a change in which patients were invited for the test. This appears to have been a systemic change where the statistics record the number of invites sent out and not the number of patients. The figures have been distorted by the statistics showing repeat invitations to those who have not responded;

(g) there is a low uptake of screening in the north of the city and further work is currently taking place to identify why this is the case. Nottingham City CCG is actively monitoring screening rates across the city by GP practice on a monthly basis. This information is then scrutinised and analysed to inform targeted practice visits and developing the future strategic direction;

(h) multi-media campaigns, including posters, radio, Sky TV, buses and newspapers have been commissioned to communicate and engage with members of the public;

(i) research with Nottingham Trent University is currently underway as part of a Bowel Cancer Screening Programme research project. Thus far, a literature review has been completed identifying possible barriers to uptake and a total of 13 community researchers recruited. A hundred and sixty three interviews have been completed and submitted as part of the research and a further 226 interviews are being targeted for completion by November 2014. Participation has been encouraged amongst a good mix of English and non-English speaking participants and the final report is due on 14 December 2014;

(j) the next step is for Nottingham City CCG to continue its partnership working with Nottingham City Council in order to promote the screening programme and a steering group has engaged Councillor Norris, Portfolio Holder for Adults, Commissioning and Health to develop a communication plan;

(k) contact with non-responders will continue, either by practice staff or by a commissioned third party such as the Clinical Assessment Unit.

RESOLVED to thank colleagues from Nottingham City CCG and Derbyshire and Nottinghamshire Area Teams for the information and request that an update on the service provision, including details on the Bowel Cancer Screening Programme Research Project, be submitted to the Panel in 12 months.

38 NHS HEALTH CHECK PROGRAMME

The Panel considered a report of the Head of Democratic Services detailing proposals on the NHS Health Check programme. John Wilcox, Public Health Manager, advised the Panel of the proposals and, during discussion, stated the following;

(a) the NHS Health Check Programme is a national risk assessment and risk reduction programme for people aged 40 to 74 and is aimed towards addressing the top seven causes of preventable mortality. The process identifies those at increased risk of developing cardio vascular disease (CVD) and provides a plan of action to enable people to take action to avoid, reduce or manage their risk of CVD;

(b) CVD can make a major differences to life expectancy and can cause premature mortality, morbidity, and carries with it the avoidable costs associated with these diseases. The past few decades have seen an increase in inequality despite an overall downward trend in deaths from CVD, however CVD remains the single greatest cause of morbidity and mortality;

(c) CVD is responsible for a third of deaths and a fifth of hospital admissions and accounts for the largest element of health inequalities. Decreasing trend in deaths from CVD is unlikely to be maintained, due to rise in obesity and increase in younger people with type 2 diabetes;

(d) the top seven causes of mortality that’s preventable through individual behaviour or public health measures include high blood pressure, smoking, cholesterol, obesity, poor diet, physical inactivity and alcohol consumption;

(e) the NHS Health Check Programme has two parts, firstly – risk assessment. Local authorities have commissioned GP's and pharmacies to systematically invite 100% of the eligible population every 5 years to calculate an individual CVD risk score. The second part of the Health Check refers to risk reduction. Responsibility for risk reduction lies both with the CCG in terms of making a clinical diagnosis and local authorities in terms of providing support for lifestyle advice, and where appropriate, onward referrals to services such as smoking cessation, exercise and weight management;

(f) the health checks started in 2009 and the five year cycle reset on 1 April 2013. The number of offers made and the number of health checks received must be monitored by councils and both measures are indicators within the Public Health Outcomes Framework for England 2013-2016;

(g) the first stage of the programme is to establish who requires an invite. Exclusions to the programme cover being outside the eligible age, already being diagnosed with CVD, already on the high risk register or a resident who has had a check within the last 5 years;

(h) the check takes 20–30 minutes and involves personal details and clinical history, physical measurements (including pulse check for AF in those aged 65 and over) and lifestyle questions. The individual's risk of developing cardiovascular disease in the following 10 years is then calculated using an IT software package. The individual is offered advice which will ordinarily include treatment and/or referral to clinical and lifestyle services e.g. smoking cessation based on the result;

(i) the programme does not currently screen for dementia but includes giving information about the signs of dementia, and signposting to appropriate services, for those aged 65 or over;

(j) in 2014/15, of the 73,465 eligible citizens, 17.2% (12,636) of citizens were invited and 8.6% (6,295) of citizens had a health check. These figures are slightly below the national averages of 18.5% for invites and 9.0% for health checks respectively;

(k) overall performance has varied over time with changes in programme delivery and there is not a single cause of low performance, because practices may have structural barriers such as lack of clinic space, staffing shortages or IT changes. Other barriers include attitudinal barriers as some GPs have been swayed by the adverse media coverage and therefore fundamentally disagree with the evidence arguments;

(l) diagnoses within 90 days of a check are considered to be attributable to the check. The proposed model from April 2016 will include a GP led delivery of the programme, including invitations, assessments and referrals. Further work is needed to promote the benefits of the programme.

RESOLVED to thank John Wilcox for the information and request that an update on the service provision be submitted to the Panel in 12 months.

39 WORK PROGRAMME

The Panel considered a report of the Head of Democratic Services relating to the work programme for the Health Scrutiny Panel for 2014/15.

RESOLVED to note the work programme.