

Minutes of the **Professional Executive Committee** held in **Meeting Room 1, Wynford House, Lufton Way, Yeovil, Somerset**, on **Thursday 1 July 2010**

Present	Donal Hynes	Chairman
	Caroline Gamlin	Joint Director of Public Health
	Carolyn Nation	Head of Musculoskeletal Interface Service, Somerset Community Health
	Dr Harvey Sampson	General Practitioner
	Dr Geoff Sharp	General Practitioner
	Lucy Watson	Acting Director of Nursing and Patient Safety
Apologies:	Paul Goodwin	Director of Finance and Performance/Interim Director of Commissioning
	Jan Hull	Deputy Chief Executive and Director of Strategic Development
	Miriam Maddison	Corporate Director – Community, Somerset County Council
	Ian Tipney	Chief Executive
In Attendance:	Ann Anderson	Deputy Director of Strategic Development
	Paul Bearman	General Manager, Wyvernhealth.com
	Anthea Brooks	Secretariat
	Sue Davies	Deputy Director of Primary Care Development
	Alison Henly	Deputy Director of Finance and Performance
	Rachel Levenson	Associate Director of NSF Developments (PEC/095/2010 and PEC/096/2010)
	David Slack	Director of Primary Care Development

PEC/086/2010 APOLOGIES

Apologies were received as above. The Chairman welcomed Ann Anderson, Deputy Director of Strategic Development representing Jan Hull and Alison Henly, Deputy Director of Finance and Performance.

PEC/087/2010 REGISTER OF MEMBERS INTERESTS (ENCLOSURE A)

The Committee **noted** the Register of Members' Interests

PEC/088/2010 DECLARATION OF INTEREST SPECIFIC TO THE AGENDA

No Declarations of Interest were received

PEC/089/2010 MINUTES OF MEETING HELD ON 27 May 2010

The Minutes of the meeting held on 27 May 2010 were **agreed** as a correct record

Matters Arising

Action Sheet

The Chairman stated that he would approach those individuals whose names have actions against them in order to get these signed off before the next meeting

PEC/090/2010 FINANCE AND PERFORMANCE REPORTS FOR THE PERIOD 1 APRIL 2009 – 31 MARCH 2010 (ENCLOSURES C AND D)

The meeting **received** the Finance and Performance Reports for the period 1 April 2009 – 31 March 2010 from the Deputy Director of Finance and Performance. As the reports were the same as verbally reported on at the last meeting it was agreed to discuss any issues arising from them. The following points were noted

- the Taunton and Somerset NHS Foundation Trust contract is still unsigned but it is hoped to remedy this situation in the coming week
- a capacity review of orthopaedic activity has been completed and the report is being finalised after which it will be presented to the NHS Somerset Board and the Taunton and Somerset NHS Foundation Trust Board. It was agreed that the report should be presented to the Professional Executive Committee at a later date for information
- a trajectory has been agreed with Taunton and Somerset NHS Foundation Trust to meet the 18 week RTT target by the end of July
- the Primary Care Trust has agreed that it will not be removing any vital signs or existing commitments in terms of RTT targets from contracts and will continue to work with providers to make sure there are no reductions in standards
- the Primary Care Trust supports the maintenance of the current targets until further ones are developed, this includes the 24 hour access in primary care and four hour waits in accident and emergency units as well as the 18 week target. Monitoring of these targets will continue

- it was noted that under 'New Builds' in the Performance Report construction began at Burnham Medical centre (Berrow Branch Surgery) in June 2010 with completion expected at the end of March 2011 not December 2010 as indicated in the report
- it was noted that under the scorecard the percentage of eligible staff receiving an appraisal for the year to date had dropped and a concerted effort has been made across all directorates to improve this position by the end of June. Each Directorate now reports monthly and Somerset Community Health has implemented a nine month appraisal cycle
- it was noted that slot availability is something which causes poor experience for patients. It was agreed that the Deputy Director of Finance and Performance would investigate whether anything could be done to improve this situation and a report would be made available at a future meeting

The Professional Executive Committee **noted** the Finance and Performance Reports as at 31 March 2010.

PEC/091/2010 QUARTER 4/ANNUAL REPORT FOR PATIENT SAFETY AND PATIENT EXPERIENCE QUALITY MONITORING (ENCLOSURE E)

The meeting **received** the Patient Safety and Patient Experience in Key NHS Provider Units report for the period 1 January 2010 to 31 March 2010 and full year position from the Acting Director of Nursing and Patient Safety who highlighted the following points:

- following the publication of the Health Care Commission report in March 2009, NHS Somerset implemented Patient Safety and Patient Experience Quality Monitoring with NHS providers where Somerset is the lead commissioner
- a proforma has been developed with agreed quality metrics and the data collected is discussed at these meetings. The focus is on themes and elements noted in the Health Care Commission report and the Francis Report from the enquiry into Mid Staffordshire
- the report is not provided to benchmark the providers against each other but to provide assurance on key patient safety and patient experience measures
- the process of quarterly monitoring meetings is now well established and enables closer monitoring of safety and quality of services together with discussions around key issues to a depth that was not previously possible

- the report includes a summary of the issues that have been discussed and a detailed section for each Trust
- data for the quality metrics is shared quarterly between the provider and the Directorate of Nursing and Patient Safety
- workforce and training measures will be included by all providers from April 2010 as part of the agreed quality dashboard indicators
- items discussed include infection rates, falls, medication incidents and emergency readmissions
- there has been a focus on the timeliness of reporting and closure of incidents reported on STEIS in line with required standards in the new National Patient Safety Agency (NPSA) National Framework for Reporting and Learning for Serious Untoward incidents. Performance against agreed standards is improving in all providers
- lessons learned from incidents will now be shared across the health community in the NHS Somerset 'safety Net' newsletter and its distribution has been widened to maximum effect
- the Nursing and Patient Safety Directorate monitors the timeliness of provider's responses to Safety Alerts via the Central Alerts System (CAS) and discussions take place at the quality meetings about actions taken
- patient experience is reviewed and any themes or trends lead to actions being taken with evidence of change presented to the commissioner on request. This section will be strengthened in future reports
- compliance with single sex accommodation requirements is monitored
- levels of nurse sickness and nursing staff turnover are monitored as a proxy for staff morale and quality of care. Levels of mandatory training are reviewed and the achievement of annual appraisals and provision of personal development plans are considered against the target in the contract which is set at 95% from April 2010. All Trusts achieved in excess of 85% during 2009/10.

In the discussion that followed it was noted that:

- Clostridium Difficile infection in Somerset Community Health increased over the four quarters of 2009/10 but remained within

their trajectory. However it was noted that this was cumulative and in future will be reported on a quarter by quarter basis

- the number of incidents involving ligatures and ligature points in Somerset Partnership NHS Foundation Trust was noted. Changes to improve privacy and dignity including the increased provision of single rooms can have an adverse effect on the number of this type of incident and doors with vision panels have now been installed
- it was noted that the move from Orchard Lodge to the new purpose built facility in Bridgwater will mean that patients will be located in an environment which has been designed to manage their safety
- from April 2010 incidence of pressure sores will be reported in accordance with the Chief Nursing Officer publication in February 2010 and will include all hospital acquired sores of grade 2 and above per 100 bed days – this move is welcomed
- Somerset Community Health will be reporting separately the numbers of patients transferred with pressure sores and those who acquire sores after admission
- the numbers of patients with pressure sores has increased at Yeovil District Hospital NHS Foundation Trust who have now appointed a tissue viability nurse and a training programme for the management of wound care and pressure ulcers has been introduced
- the suicide death rate target will be checked. It was noted that the rate mentioned is only for patients who die whilst receiving mental health care and does not include those patients who commit suicide elsewhere in the community

The Professional Executive Committee **noted** the report.

PEC/092/2010 PRESCRIBING REPORT FOR MARCH 2010 (ENCLOSURE F)

The meeting **received** the Prescribing Report for March 2010 (Enclosure F) from the Director of Primary Care Development who highlighted the following points:

- the final position for 2009/10 was an underspend of £2,446,050
- for the quarter ending March 2010 the NHS Somerset prescribing cost growth rates was 2.52%, for the same period the SHA cost growth rate was 3.15% and the national cost growth rate was 3.12%

- no forecast outturn is published at this point in the year but looking at the year on year growth of around 6% this would be significant and will be monitored very closely in the coming months
- the scorecard created for this year has been altered slightly
- the spend on morphine will be reduced with the intention of using the money saved for the new pain control service

In the discussion that followed it was noted that:

- requests for Fentanyl type preparations tend to come from the Medical Advisors to the hospices and the Associate Director, Medicines Management is monitoring this
- there is a recommendation that opioids are not used for anything other than cancer related pain
- a Somerset wide prescribing meeting is to be held next week which will be the first time that the prescribing leads from each practice have met.

The Professional Executive Committee **noted** the report

PEC/093/2010 ANNUAL REPORT OF THE SOMERSET PRESCRIBING FORUM (ENCLOSURE G)

The meeting **received** the Annual Report of the Somerset Prescribing forum (Enclosure G) from the Director of Primary Care Development who highlighted the following points:

- the report provides information on the activity of the prescribing forum for the year 2009/10 which meets bi-monthly
- the forum is well attended by pharmacists from across the county and is chaired by the Director of Primary Care Development
- medical representation has not been strong and further general practitioner representatives are required. However there is regular attendance by the LMC and the Chair of the Drugs and Therapeutic committee at Yeovil District Hospital NHS Foundation Trust and occasional attendance from the Chair of the same committee at Taunton and Somerset NHS Foundation Trust
- there is engagement with WyvernHealth.com

In the discussion that followed it was noted that

- the strength of the group lies in its links with secondary care around use of high cost drugs and excluded drugs
- WyvernHealth.com may want to become more involved with this aspect of the forum.

The Professional Executive Committee **noted** the report

PEC/094/2010 NHS SOMERSET AND SOMERSET COMMUNITY HEALTH HEATWAVE PLAN (ENCLOSURE H)

The Professional Executive Committee **received** the NHS Somerset and Somerset Community Health Heat Wave Plan (Enclosure H) from the Joint Director of Public Health who highlighted the following points

- the NHS Somerset and Somerset Community Health Heatwave Plan takes into account all aspects of the national guidance and details how work will be undertaken with local partners to ensure health and social care services raise awareness of the risks relating to severe hot weather and prepare organisations and individuals (especially vulnerable groups) to help reduce those risks
- the Heat Health Watch system operates from 1 June to 15 September 2010 and there are four levels of response based on the threshold day and night-time temperatures as defined by the Met Office
- response to a heat wave will be governed by the actions needed at each of the four alert levels
- with effect from 1 June the Emergency Planning Coordinator supported by the Consultant in Public Health (Health Protection) will upon receipt of a heatwave alert from the Department of Health trigger a cascade to key internal individuals and external partner agencies
- leaflets are sent out by the Department of Health to various NHS agencies including GP practices, hospitals, pharmacies and care homes
- the heatwave plan, fact sheets and a covering letter details actions required at each level is also sent to general practitioners, pharmacists, dentists, urgent care, community nursing teams, health visitors and community hospitals

In the discussion that followed it was noted that:

- the Joint Director of Public Health agreed to check the information given out to make sure adequate information about the intake of fluids and removal of layers of clothes was included
- there is no awareness of any mechanism in place for practices to run a search to identify those people who may be at risk
- the key actions would be to identify those at risk by asking practices to prepare a list and then agree what information to give them should a heatwave happen
- it was agreed that a pilot scheme could be run in one or two practices to assess how easy it would be to create a list of patients at risk
- consideration to be given to communicating to general practitioners that the heat wave plan exists via the LMC newsletter

The Professional Executive Committee **approved** the Cascade System and the Action Plan for the NHS Somerset and Somerset Community Health Heatwave Plan.

PEC/095/2010 DEVELOPMENT OF PRIMARY ANGIOPLASTY SERVICES ACROSS THE AVON, GLOUCESTER, WILTSHIRE AND SOMERSET NETWORK (ENCLOSURE I)

The Professional Executive Committee **received** the Development of Primary Angioplasty Services Across the Avon, Gloucester, Wiltshire and Somerset Network report (Enclosure I) from the Associate Director for NSF Developments who highlighted the following points:

- the report describes the proposed model of care for the delivery of 24/7 primary angioplasty services across the Avon, Gloucester, Wiltshire and Somerset Cardiac and Stroke Network
- NHS South West has undertaken a review of all proposed plans to deliver 24/7 PPCI services across the South west region working with the three Cardiac and Stroke Networks
- four options for service delivery have been considered and a distributed model with two 24/7 and three week days centre is the network's preferred model for commissioning
- the University Hospitals Bristol NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust have provided a 24/7 PPCI service since December 2009 providing care for the

majority of the network and a 7.00 a.m. to 7.00 p.m. week day service will soon be available at the Royal United Hospital Bath NHS Trust

- South Western Ambulance Service NHS Trust currently transports all Somerset patients who could potentially benefit from this service to Taunton and Somerset NHS Foundation Trust with the exception of East Mendip patients who are taken to the Royal United Hospital Bath NHS Trust between the hours of 9.00 a.m. and 5.00 p.m. Monday to Friday.
- a joint meeting was held of the Avon Gloucester, Wiltshire and Somerset network cardiac clinical reference group comprising cardiologists, general practitioners and other professional leads and the Executive Steering Group with senior commissioner representation from all Primary Care Trusts where a decision was made to support a distributed model
- the distributed model commissions two 24/7 centres (Bristol and Taunton) serving the majority of the network and weekday centres in Gloucester, Swindon, Bath and Salisbury
- within this model it is proposed that primary angioplasty be the principle model of treatment
- patients will be offered primary PCI at their local hospital initially between the hours of 9.00 a.m. and 5.00 p.m. with commissioners and providers working towards extending the hours to 7.00 a.m. - 7.00 p.m. by December 2010
- out of hours and on a 24/7 basis the majority of the network is to be served through Bristol and Taunton with other centres such as Oxford, Reading, Southampton and Bournemouth (March 2011) providing services to patients at the network boundaries
- call to balloon times within 120 minutes are recommended for all patients with a maximum of 150 minutes

In the discussion that followed it was noted that:

- patients in some areas will need an explanation as to why they are being taken to Taunton rather than the nearest District General Hospital
- monitoring of the time it takes patients to reach the appropriate facility is being done on a monthly basis with the vast majority of patients reaching hospital well within the 120 minutes target

- Taunton are also receiving patients from North Dorset as well as receiving more air ambulances
- across the South West some centres have requested additional funding to set up this service whilst others have agreed to carrying out the service within existing resources
- the network will be monitoring and collecting data on the call to balloon time and will be reporting back to the Primary Care Trusts

The Professional Executive Committee **noted** the content of the report and **supported** the proposed model

PEC/096/2010 RECONFIGURATION OF LOCAL IMPLEMENTATION TEAMS IN SOMERSET (ENCLOSURE J)

The Professional Executive Committee **received** the Reconfiguration of Local Implementation Teams in Somerset report from the Associate Director of NSF Developments who highlighted the following points:

- the report sets out a proposal to replace the current Local Implementation Teams (LITs) structure with the establishment of commissioning groups for specific disease pathways. Service developments will be informed by stakeholder events
- LITs were developed to implement the National Strategic Frameworks, Strategies and other national policies relating to specific disease areas however it is recognised that to ensure effective commissioning of disease specific pathways a new model for engagement should be considered
- a new model of commissioning groups for disease areas is being proposed and clinical engagement will be enhanced through the development of networks and stakeholders events
- currently there are eight LITs in place for mental health, older people, long term conditions, respiratory, stroke, coronary heart disease, diabetes and cancer in addition there are commissioning groups in place for dementia and diabetes. A commissioning forum for children and young people and maternity services is in the process of being developed
- the proposed groups will be smaller and more focused than the current LITs, improving communication and enabling a shared understanding of priorities for service developments
- The commissioning groups will consist of relevant NHS Somerset and WyvernHealth.com representatives. Where joint

commissioning arrangements are in place Somerset county Council will be involved

- continuing engagement with clinicians and other stakeholders including patients and carers will be essential and to facilitate this it is envisaged the virtual networks will be maintained and stakeholder events arrangement

In the discussion that followed it was **noted** that

- strong clinical leadership will be required in these groups and there was a recommendation that the membership should be reconsidered with this in mind
- there is a recognition that some of the present membership of the LITs have skills and expertise which are not being used appropriately
- consideration to be given to whether all the groups in the previous LIT areas are required where reduction in services or changes in service provision may mean that some may not be needed in the future conversely there may be groups required that are not mentioned
- the groups will need to align to QIPP and feed into the cancer, cardiac and stroke networks
- the amount of NICE guidance needs to be reviewed and consideration should be given to monitoring this through other forums such as through virtual groups or the quality monitoring system
- some thought to be given to managing the process and expectations of the people within these groups and how they stay involved
- reports from groups should come through the Professional Executive Committee for consideration.

The Professional Executive Committee **approved** the report

PEC/097/2010 CONSULTATION PAPERS FOR THE ADULT AND CHILDREN'S HEALTHY WEIGHT HEALTHY LIVES STRATEGIES (ENCLOSURE K)

The Professional Executive Committee **received** the consultation papers for the Adult and Children's Healthy Weight Healthy Lives Strategies (Enclosure K) from the Joint Director of Public Health who highlighted the following

- following the adult obesity peer review in January 2010 the draft Healthy Weight Healthy Lives Adult Obesity Strategy and Action Plan has been updated to include the recommendations from the review
- in line with this the draft Health Weight Healthy Lives Children's and Young Peoples Obesity Strategy had been refreshed
- both strategies are about to enter their consultation phase
- funding has been allocated through the Choosing Health budget to support the implementation of the strategies. However due to the multi agency nature of the strategy difficulties arise in predicting future spend due to the current financial pressures facing the public sector. The papers therefore highlight the priority groups to be targeted and the reasons why

Adults

- the following are the priority areas for action
 - * people who live in areas of high health and social need
 - * men
 - * people aged 16-34
 - * people at increased risk of developing type 2 diabetes
 - * people with learning difficulties
- recommendations to be taken forward for possible change are
 - * challenging behaviours, beliefs and motivation for behaviour change
 - * focusing on food and drink intake, access and availability
 - * developing opportunities and increasing the uptake of physical activity, exercise and sport
 - * shaping the living environment to encourage healthier lifestyles
 - * developing support for people wishing to lose weight
- the Action plan has been approved by the Primary Care Trust Directors and Somerset County Council and has been sent back to the Health Authority
- the County Council has agreed funding for the first year but not funding was guaranteed for subsequent years

Children

- the following are the priority areas for action:
 - * children and young people who live in areas of high health and social need

- * transition between educational and life stages
 - * children under 5 and their families
 - * children and young people with disabilities and complex needs
- recommendations to be taken forward for possible change are
 - * challenging behaviours, beliefs and motivation for behaviour change
 - * focusing on food and drink intake, access and availability developing opportunities and increasing the uptake of physical activity, exercise and sport
 - * shaping the living environment to encourage healthier lifestyles
 - * developing support for children and young people who are already overweight or obese
 - the action plans indicate the amount of work which is being done already and a lot of positive things are coming back from some of these programmes
 - it is important that these actions are done in conjunction with Somerset County Council

In the discussion that followed it was noted that

- when looking at the shift of resources at Local Authority level and across Somerset consider engagement around consortium population based type work which would be a way of taking responsibility for delivery at individual practice and consortium level
- consider practice/consortium engagement with this strategy and approach and understand what is happening with other partners
- in terms of delivery at the moment the Health Trainers are targeting areas of deprivation.

The Professional Executive Committee **noted** the report

PEC/098/2010 A REVIEW OF MORTALITY RATES IN SOMERSET AND EXCESS WINTER MORTALITY IN SOMERSET – A REVIEW (ENCLOSURE L)

The Professional Executive Committee **received** a presentation on a review of mortality rates in Somerset from the Joint Director of Public Health who highlighted the following points:

Mortality Rates in Somerset

- the paper is in draft form and when finalised will be presented to the Board
- the paper arose from Non Executive Directors interest in mortality rates in general practice and how deaths were reported in primary care
- data on mortality rates by GP practice was assessed for 2007, 2008 and 2009. There is year on year variation in rates between GP practices but the three practices with the highest rates in 2007, 2008 and 2009 were all different (i.e. nine different practices with the higher rates over three years)
- examination of mortality rates by practice alone is not robust enough to identify poor practice
- the Hospital Standardised Mortality Ratio (HSMR) at Taunton and Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust were both reported as below 100. It was noted that the figure for Yeovil was raised in one quarter and the Trust has investigated this. These figures are considered on a quarterly basis
- concerns were expressed in the Francis Report about the validity of HSMR data as an indicator of safety and effectiveness and a recommendation has been made that there should be an independent working group set up to examine and report on the methodologies in use at national level
- there is no national system for community hospitals
- an audit was done on Somerset Community Hospitals from April 2008 to March 2009 and a mortality rate of 7.7% was noted. During April to June 2009 the rate fell to 6.5%
- there was an audit of patients notes at Frome, Crewkerne and Burnham the result of which indicated that no deaths were preventable
- the review noted good communication between staff and families regarding end of life care plans however there was some learning identified regarding record keeping and identification of deteriorating patients

- each month the Primary Care Trust downloads the primary care mortality file. The annual mortality file from the Office of National Statistics is available in July following deaths registered in the previous year but this is not for individual GP practices
- to date there is no method advocated nationally to monitor mortality rates at general practitioner level
- it should be recognised that in some practices patients are registered to a practice rather than a general practitioner and general practitioners working as locums or through the Out of Hours service would be especially difficult to record. The number of hours each general practitioner works may also have to be factored in
- a suitable reference population would need to be established to enable appropriate comparison of each practice
- the location of communal establishments such as nursing homes would need to be considered
- mortality rates depend on factors such as age, deprivation ethnicity and the underlying case mix. Even after standardisation for age there may still be some residual effect as the direct standardisation method is usually based on a European Standard Population which contains a lesser proportion of older people compared to the UK and even more so for the South West and Somerset
- analysis of mortality rates have not demonstrated that the methodology is robust enough to detect another Shipman

In the discussion that followed it was noted that:

- the information contained on the primary care mortality file could be used to reconcile deaths at local level back to GP practice – more information will be included in the presentation on this subject
- in only 16.5% of deaths is the certifying general practitioner the patients registered general practitioner – it was agreed to remove this statistic from the presentation
- during 2009 the lowest number of deaths by practice was six (0.48%) of the practice population which was the smallest practice in Somerset and the highest death by practice was 221 (1.47% of the practice population) and this was the third largest practice

- deprivation data was added but made no significant difference
- standardisation for age should consider expected deaths for the various age ranges - under 75, 75-85 and over 75 and consider trends as well
- consideration to be given to using the primary care scorecard to provide information about the clinical practice of general practitioners
- all general practitioners have to be registered on the General Practitioner Performance list before they can deliver services and checks are always made to make sure that appraisals have been undertaken. Primary Care Development work closely with locum agencies and the LMC and from time to time discuss any issues which are raised via the performance indicators
- there does not appear to be any information in this data which gives cause for concern
- the primary care mortality file will include deaths of all patients in the community including those deaths which have occurred in hospital and therefore deaths which would not have involved the general practitioner
- consideration to be given to looking at disease registers such as CHD and COPD to identify patients who are on these registers
- the complexity of the task needs to be understood and also that there are systems and processes in place which may need to be improved
- it was noted that there is a much more detailed recording arrangement now for the use of controlled drugs and there is also a much more rigorous system for the signing of cremation forms following the Shipman report
- the Board will be provided with reassurance that the information has been considered and revised and there is nothing to give cause for concern
- consideration will be given to the level of information provided to practices. When the Adastral system End of Life Care Register is rolled out across practices reports on patients who have died at home will be provided from the End of Life Care coordination Centre by practice

Excess Winter Mortality in Somerset – a review

- the highest numbers of extra winter deaths in England and Wales was in 1999/2000 followed by 2008/09
- there is some evidence to suggest that these excess deaths may be preventable and factors suggested include healthcare spending, socioeconomic circumstances and protection from cold
- excess winter deaths (EWD) are calculated by measuring the difference in the number of deaths during the winter months and the average in the summer months
- the Excess Winter Deaths Indicator (EWDI) is a ratio calculated by dividing the EWD by the average of the summer deaths
- there is no association with rurality
- falls have the highest EWDI although small numbers, circulatory disease accounts for the highest number of excess winter deaths followed by respiratory disease
- generally the EWDI is higher in the South West when compared to the England average. There are suggestions that the EWDI varies between the different counties across the South West
- a review of the available data does not suggest any clear causes for the excess deaths during the winter months with no clear associations with deprivation or fuel poverty. The burden is mostly seen in older women
- the data is not standardised for age and sex and the EWDI will be at least to some extent dependent on the proportion of older people in the population as most winter deaths affect older people.

In the discussion that followed it was noted that:

- data needs to be age and sex standardised
- measures to tackle fuel poverty alone are not sufficient
- consideration to be given to educational programmes aimed at behavioural change to encourage adequate protection outdoors and maintaining appropriate temperature indoors
- consider further target work to look at levels of heating inside homes and insulation

- consider mapping deaths against average temperatures including hours of sunshine, days of sub-zero temperatures and the prevalence of icy conditions
- consider links possibly with cold, wet miserable winters when people do not undertake a lot of outdoor activity
- consideration to be given to recommending that indoor temperatures should be raised above the current level and the leaflets amended accordingly
- consider sending out information to patients when 'flu injection invitation letters are sent out
- if after age and sex standardisation of the data the Somerset level is still high then consideration will be given to a further review
- any further comments to be directed to the Joint Director of Public Health

The Professional Executive Committee **noted** the reports

PEC/099/2010 ANY OTHER BUSINESS

There was no other business to discuss

PEC/100/2010 DATE AND TIME OF NEXT MEETING

The next meeting of the Professional Executive Committee will be held on Thursday 5 August 2010 at 2.00 p.m. in Meeting Room 1 at NHS Somerset, Wynford House, Yeovil