# HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 30 April 2009.

**PRESENT:**Councillor Dryden (Chair); Councillors Carter, Cole, Lancaster, Purvis and P Rogers.

**OFFICERS:** J Bennington, D David, J Ord and P Stephens.

**** PRESENT BY INVITATION:** Peter Moore, North East Regional Director, Stroke Association.

**** DECLARATIONS OF INTEREST**

No declarations of interest were made at this point of the meeting.

**** MINUTES**
The minutes of the meeting of the Health Scrutiny Panel held on 7 April 2009 were submitted and approved as a correct record.

## STROKE SERVICES REVIEW – STROKE ASSOCIATION

The Scrutiny Support Officer submitted a report the purpose of which was to introduce representation from the Stroke Association to provide a briefing in advance of the Panel commencing its review of Stroke Services.

The Chair welcomed Peter Moore, North East Regional Director of the Stroke Association which was a charity and only national voluntary organisation dealing with strokes. Mr Moore focussed on the different types of strokes, its rates of incidence and other related information.

As part of the background information Mr Moore stated that the Stroke Association's vision and mission were respectively;

'we want a world where there are fewer strokes and all those touched by stroke get the help they need';

'our mission is to prevent strokes and reduce their effect through providing services, campaigning, education and research;'

The Stroke Association had a regional centre one of which was the North East. The main strands of work centred on campaigning for stroke services; encouraging and identifying ways of funding research; and providing information and publicity material examples of which were made available at the meeting.

In terms of statistical background it was noted that currently one person every five minutes had a stroke in the UK and that strokes killed 60,000 people per year and quarter of a million people lived with the consequences of a stroke.

Strokes were the third major cause of death in the UK with 110,000 new strokes a year and 20,000 TIA's (mini strokes). Twenty five per cent of strokes occurred to those under 65 and 300,000 lived with the effect of stroke along with those who cared for them. It was noted that an increasing number of young people between the ages of 20 – 30 years had strokes.

The overall current costs of strokes were identified as follows: -

£2.8 billion in direct costs to NHS which was more expenditure than coronary heart disease;
£1.8 billion costs in lost production and disability;
£2.4 billion in nursing home and personal care.

A stroke was defined as a brain attack when the blood supply to part of the brain was cut off. Blood carried essential nutrients and oxygen to the brain. Without such a blood supply, brain cells could be damaged or destroyed.

The two main types of stroke were identified as Ischaemic stroke, which was the most common type, caused by a blood clot in the brain and a Haemorrhagic stroke caused by a bleed in the brain.

A Transient Ischaemic Attack (TIA) was also known as a mini stroke and occurred when the brain'' blood supply was briefly interrupted.

Details were given of the common problems after a stroke which included problems of weakness, clumsiness or paralysis; swallowing; speech and language; understanding; eyesight; recognising objects and knowing how to use them; concentration of paying attention and remembering; and difficulty in controlling emotions.

Some of the major risk factors and lifestyle issues in relation to strokes included inactivity, age, family history and ethnicity, high blood pressure, heart disease, diabetes, smoking, obesity, unhealthy living, oral contraception & HRT, previous strokes and TIAs, binge drinking and substance abuse.

Reference was made to the Department of Health document, National Stroke Strategy, December 2007, which involved the culmination of the work of six project groups and wide consultation exercise and had resulted in a significant number of recommendations.

Mr Moore reported on the five parts of the strategy.

The first part related to raising awareness the aims of which were to make sure the public and professionals understand what can cause a stroke, the symptoms of a stroke, and what to do if someone has a stroke and to make sure people who have a stroke and their carers are involved in making decisions about treatment and in designing stroke services.

Experience had shown that many people including some GPs did not see stroke as an emergency and there was insufficient information for people with stroke or their carers. It was noted that many people from socially deprived areas and BME communities were more likely to have strokes.

In relation to pathways of care the strategy aims were reported as assessing people who had a TIA quickly to minimise the chances of them having a full stroke and to treat people with suspected stroke as medical emergencies to maximise their chances of making a good recovery.

Current research showed that only a third of people who had a suspected TIA saw the appropriate experts within 7 days and only a few hospitals and ambulance services could deal with strokes quickly and with the right treatments.

In terms of life after a stroke the strategy's aims were to help people who have had a stroke, and their family and carers, have a good quality of life and to make sure people who have had a stroke get the support they needed to live as independently as possible.

Although improvements had been made since the introduction of the strategy it was stated that:

- only about half the people who have had strokes get the rehabilitation they needed to live at home during the first six months after they had left hospital;
- three-quarters of younger people wanted to go back to work after a stroke;
- a third of people who have had a stroke developed depression;
- a third of people had problems with speech or understanding;
- currently about a third of people died within three months of having a stroke.

Reference was made to the part of the strategy headed 'working together' the aims of which were to make sure services continued to improve and that people who had had a stroke or were

at risk of stroke, and their carers got care from people with the right knowledge, skills and experience.

Evidence showed that many stroke units had insufficient staff with the right skills and not everyone got the help with rehabilitation they needed.

The implementation of the Stroke Strategy had led to five demands from stroke survivors for future services;

- Stroke must be treated as a medical emergency at all times;
- all stroke patients must be taken immediately to and spend the majority of their time in a stroke unit;
- all stroke survivors must receive a smooth transition from hospital to home;
- all stroke survivors must receive all the rehabilitation and long-tem support that met their specific needs;
- all transient ischaemic attacks (TIAs/mini strokes) must be treated with the same seriousness as a stroke.

Reference was made to the incidence of stroke in Middlesbrough of 400 per year admissions to the dedicated stroke unit at James Cook University Hospital and 20 – 30 per week covering the South Tees area going through TIA clinics.

Reference was made to the commitment of the South Tees Hospitals NHS Trust stroke services, which included: -

- Stroke Co-ordinator in post to ensure appropriate services in place;
- Dedicated Stroke Consultant;
- Dedicated Stroke unit;
- Community based/acute based Therapy teams;
- 20 Community Hospital rehabilitation Beds at Carter Bequest Hospital;
- dedicated Family Care Support Services provided by Stroke Association, funded by the Primary Care Trust and based at Carter Bequest Hospital;
- Dedicated Communication Support Services;
- Intermediate Care facilities;
- 24 hour Access to Thrombilysis Treatment – Middlesbrough was ahead of other areas in prescribing such treatment which had to be administered within four hours of stroke;
- Multi Agency Rehabilitation review (report and recommendations to be submitted a copy of which would be made available to the Panel).

Members sought clarification on the funding attached to the Stroke Strategy. It was confirmed that Middlesbrough's allocation (ring-fenced) was £90,000 per year over a period of three years from April 2008. Such funding had been utilised on employing a Stroke Co-ordinator and a Dedicated Stroke Social Worker; contribution towards Communication Support Services; and for the implementation of stroke training programmes for such people as residential care workers and home care workers to raise awareness to the needs of patients and carers.

Reference was made to the significant work undertaken by the Panel as part of its review of Life Expectancy with a particular focus on cardiovascular disease in Middlesbrough an important element of which related to the need to pursue appropriate preventative measures. The similarity of such areas of work between CVD and strokes was acknowledged and therefore the Panel was mindful to give careful consideration to the parameters of the proposed scrutiny investigation of Stroke Services.

It was confirmed that Thrombilysis treatment was a drug which had to be administered in hospital after a patient had had a brain scan.

The Panel was keen to seek how JCUH compared with others in the North East region in terms of its stroke services. Mr Moore reported that from his perspective JCUH was one of the best in the region but indicated that other areas had dedicated preventative services and some had better rehabilitation facilities. It was noted, however, that the Multi Agency Rehabilitation Review would help to address such issues.

Specific reference was made to the current public campaign FAST (facial, arm, speech, time) to raise awareness that a stroke was a medical emergency and needed prompt action and early treatment. It was considered that the response to such a campaign had been good and had resulted in an increased number of people going to hospital and receiving Thrombilysis treatment.

The Panel discussed the areas to cover as part of the scrutiny investigation which included focussing on:

a) rehabilitation services;

b) Family Care Support Services;

c) visit by the Chair and one other Panel Member to Carter Bequest Hospital;

d) visit to the Intermediate Care facilities;

e) findings of the Multi Agency Rehabilitation Review;

f) meet with representatives of South Tees Hospitals NHS Trust.

**AGREED** as follows:-

1. The Mr Moore be thanked for the information provided and an open invitation be extended to attend future meetings of the Panel relating to the current scrutiny investigation of stroke services.

2. That the Panel's scrutiny investigation of stroke services cover the aspects as outlined above (a) to (f).

**STRATEGIC PLAN 2008 TO 2011 – REVISION 2009 TO 2010 – CHILDREN AND YOUNG PEOPLE THEME – BE HEALTHY PRIORITY**

The Corporate Performance Team leader presented a report which outlined the content of the Be Healthy strategic priority of the Supporting Children and Young People theme for the 2009/2010 revision of the Council's Strategic Plan.

The views of the Panel were sought on the general approach to addressing the strategic priorities for the above theme and the plausibility of the proposed actions for 2009/2010.

Officers reported upon and the Panel considered each of the planned actions for 2009/2010 to address strategic priorities with specific reference to the following.

a) Reducing the number of conceptions amongst 15-17 year olds (key target NI 112) to reduce the number of conceptions amongst 15-17 year olds against the 1998 baseline of 40%.

The Panel was advised that further information would be included on best practice following analysis of the feedback session from the National Support Team's review of local provision.

An indication was given of initial discussion around increasing the circulation of the C -Card offering an advice and condom distribution service. Reference was also made to further work to be undertaken in primary schools.

b) Tackling Childhood obesity with a key target of NI 56 to reduce the percentage of children in Year 6 which were obese as shown by the National Child Measurement Programme from 24% to 22.5 %.

Reference was made to the planned actions to promote healthy eating through schools by ensuring that all secondary schools met the Nutrient Based Standards for school meals. Details were also provided of work with schools in receipt of Well-being Lottery funding to promote physical activities and healthy eating.

Members questioned the relatively small reduction percentage to achieve and if it was sufficiently challenging. In response it was noted that such a target was a multi agency target set by the Primary Care Trust. Details were provided as to how such data was compiled. Members acknowledged the long term nature of the problems of obese but questioned the reasons for not using and tracking the same cohort of children in obtaining such information. The Panel considered that it would be beneficial to have more details on the collation of information and the reasons for not setting a more challenging target.

c) Improving the availability of mental health services with a key target of NI 51 to increase the effectiveness of local CAMHS services, evidenced by improving the indicator score from 12 to 13.

Officers referred to the planned actions as outlined in the report which focussed on a range of services and identified ways of engaging with people with mental health problems seeking help.

Members specifically referred to the intention to complete a mapping exercise for all tier 1 and tier 2 mental health services available in Middlesbrough and whilst supporting the proposed action questioned the reasons as to why such information was not already known.

The Panel referred to the recent scrutiny review in relation to emotional wellbeing and mental health services and the recommendations for more early intervention and preventative work. Members questioned the lack of specific reference to children looked after within the planned actions in this regard.

d) Reducing Alcohol and drug misuse with a key target of N1 115 of reducing the level of use of alcohol and drugs amongst young people from 9.2% to 9.1% as indicated in the TellUs survey.

Specific reference was made to the importance of the establishment of systems to ensure that pre-CAF checklists were completed by adult drug and alcohol treatment services, to identify young people who may need to enter the CAF process.

e) Increase the opportunities and services for children with disabilities and the key local target of increasing the number of families using the direct payment system by a certain percentage target yet to be set information on which would be given in a later daft of the Strategic Plan to be reported to the Overview and Scrutiny Board.

**AGREED** that the Officers be thanked for the information provided and note the comments of the Panel as outlined.

**PRACTICE BASED COMMISSIONING – EVIDENCE**

The Scrutiny Support Officer submitted a report, which outlined the evidence the Panel had received so far in respect of the review into Practice Based Commissioning.

Further to the meeting of the Panel held on 7 April 2009 the Chair confirmed that had spoken to the Director of Social Care on the Council's perspective and challenges relating to PBC as indicated in a briefing note circulated at the meeting.

In order to further clarify the situation it was suggested that the Director of Social Care, Dr N Rowell, Chairman of Middlesbrough PBC Group and representatives of Middlesbrough Primary Care Trust be invited to attend a meeting of the Panel to discuss the issues raised.

**AGREED** that a further meeting of the Panel be arranged on issues raised in relation to Practice Based Commissioning as outlined.

## OVERVIEW AND SCRUTINY BOARD UPDATE

In a report of the Chair of the Health Scrutiny Panel, Members were advised of the key matters considered and action taken arising from the meeting of the Overview and Scrutiny Board held on 7 April 2009.

NOTED