HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 22 July 2009.

PRESENT: Councillor Dryden (Chair); Councillors Carter, Dunne, Junier, Lancaster, McIntyre, Purvis (as substitute for Councillor Cole) and P Rogers.

OFFICERS: J Bennington and J Ord.

** **ALSO IN ATTENDANCE:** Corinne Ellis, Stroke Service Improvement Lead, North of England Cardiovascular Network.

****AN APOLOGY FOR ABSENCE** was submitted on behalf of Councillor Cole.

**** 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 1 June 2009 were submitted.

Reference was made to a meeting held with the Chair and Vice-Chair of the Panel and Dr James Gossow, Chair of the Middlesbrough Primary Care Trust, Professional Executive Committee and Colin McCleod, Chief Executive. It was noted that a draft final report in relation to Practice Based Commissioning would be submitted to the meeting of the Panel to be held on 10 August 2009.

AGREED as follows: -

1. That the minutes of the meeting of the Health Scrutiny Panel held on 1 June 2009 be approved.

2. That the information provided be noted.

STROKE SERVICES – SERVICE STANDARDS – REGIONAL PERSPECTIVE

The Scrutiny Support Officer submitted a report the purpose of which was to introduce representation from the North of England Cardiovascular Network (NECVN).

In order to provide background information a briefing paper compiled by the NECVN on behalf of the NHS North East Strategic Health Authority had previously been circulated to Members.

The Chair welcomed Corinne Ellis, Stroke Service Improvement Lead, NECVN. The NECVN was a local organisation comprising clinicians, managers and commissioners from primary care trusts, acute trusts, including tertiary care, and the ambulance services. The NECVN was not a statutory organisation but worked with other local NHS Trusts to improve the way services were planned and delivered for patients and staff.

The improvement and development of stroke services had been devolved from the NHS North East SHA to NECVN given the 8 years experience of the organisation in cross boundary service improvement work in specific areas of work. It was noted however that the performance management of stroke service remained the responsibility of the NHS North East SHA.

Ms Ellis referred to the questions and expanded upon the responses to the following questions as outlined in the briefing paper previously circulated.

<u>What are the service standards currently demanded of Stroke Services that a patient could expect to receive when they suffer a suspected stroke?</u>

It was confirmed that a national 'must do' Tier 1 Vital Sign targets were in place for stroke, which were: -

i) patients who spent at least 90% of their time on a stroke unit;
ii) TIA cases with a higher risk of stroke who were treated within 24 hours.

Such targets had been introduced in 2004 when it had been considered that 56% of people with stroke spent the majority of their time in a stroke unit and 35% of people with all risk of TIA were treated in seven days. The expected position by the end of 2010/2011 was to ensure that 80% of people with stroke spent at least 90% of their time on a stroke unit and 60% of higher risk TIA cases were treated within 24 hours.

Other standards available were in the form of the National Clinical Guidelines for Stroke, which were produced by the Royal College of Physicians who were responsible for the process to support the National Sentinel Audit for Stroke. Such an audit had been active for the last six years and had demonstrated that care had improved significantly although it was acknowledged that there was no room for complacency. Such work included the compilation of comparative information with other regions.

On a regional basis stroke services were considered to be providing excellent care often as a result of the dedication of stroke physicians, stroke unit staff and internal links between A & E, imaging services and stroke unit staff.

Following the publication of the National Stroke Strategy in December 2007 the NECVN were planning to improve stroke services even further to provide up to date, best evidence based practice to all patients and their carers in the North East. The strategy was a ten-year plan although it was intended that the Network plan, which covered the NHS North East and the North Yorkshire and York PCT area of NHS West Yorkshire, was to implement the largest changes within the first three years.

It was noted that in terms of the compilation of data, work was progressing on ensuring a consistent approach on the various definitions.

Are those standards always applied?

The Vital Signs targets were incremental targets, which required an understanding of the level of care already provided and building on streamlining pathways to meet the 2010/2011 targets.

Achieving targets was considered to be an important feature as it allowed services to be measured and compared at national level. Regionally, there were Network standards for hyperacute and transient ischaemic attack care based on National Clinical Guidelines for Stroke and the National Stroke Strategy. Network standards were seen as helping to drive up equity of care across the region and would focus attention on quality of care issues rather than target attaining.

Standards across the region were set high and the NECVN was constantly working towards equity of care to all patients wherever they lived in the region.

What are the areas in need of development in relation to Stroke Services?

The care pathway for a stroke patient once commenced was life long and work undertaken by the Network to date had highlighted that there was a variance in the commissioning and provision of services across the North East.

Overall, stroke care across the North East was considered to be excellent however there were aspects of care, which could be improved upon by everyone to the benefit of the patient and their carers. Such benefits included streamlining care between departments and organisations and reducing waiting times to access services.

Regionally, the focus of work currently being undertaken by NECVN covered the following areas:-

i) Awareness Raising of Stroke and TIA;

ii) Hyperacute services – the first 72 hours of emergency care;
iii) TIA services – timely access diagnosis and treatment;
iv) Stroke Rehabilitation – appropriate and timely access to specialist rehabilitation.

Where would the SHA and commissioners expect to see Stroke Services in the North East in 3 to 5 years?

Reference was made to the National Stroke Strategy, which was a ten-year plan to improve stroke services. It was noted that there would be an intensive drive to improve services as much as possible until March 2011. It was reported that £2.4 million had been earmarked for NHS North East to improve stroke services. Additionally local authorities had received central allocations to improve stroke services from a social care perspective.

By using such finances and re-evaluating the use of current resources it was anticipated that the following improvements would be achieved by March 2011: -

- Improved awareness raising of stroke and TIA leading to rapid assessment, diagnosis and treatment;
- Improved rate of thrombolysis for eligible patients;
- Robust 24 hours hyperacute services and rapid admission to a dedicated stroke unit;
- Improved referral of suspected TIA patients to stroke specialists;
- Improved access to imaging services;
- Reduced waiting times for vascular surgery;
- Timely assessment of stroke and TIA patients for rehabilitation needs;
- Access for all stroke and TIA patients to all aspects of rehabilitation they required, as and when they required it;
- Improved integrated links between health and social care services;
- Better signposting of stroke and TIA patients and their carer needs for long term care and support.

The Panel has noted in 'Our Vision, Our Future' that 63% of units in the North East are compliant with the Royal College of Physicians acute stroke audit standards, which is the best percentage rate in the country.
Does this mean that there are variances in the outcomes for people who suffer Strokes in the North East?

It was acknowledged that stroke was a very complex condition and everyone who suffered a stroke had very individual outcomes such as speech and language difficulties, physical impairment and psychological issues. Many stroke survivors may not be able to return to work or return to what they had previously known as a normal life.

It was noted that there some professionals which were difficult to recruit to for example, speech and language specialists and specialist psychology support.

The Panel was advised that in areas where access to specialist staffing was a problem this would result in different long-term outcomes for patients and levels of disability. Evidence had also shown that the determination of the individual to take personal control of their recovery could have an impact on the outcome of their stroke.

It was confirmed that the Network was working with commissioners and providers alike to address variances in patient outcome.

During the subsequent deliberations Members sought clarification on a number of issues the main areas of which focussed on the following.

Reference was made to the work being undertaken involving South Tees Hospitals Foundation Trust concerning rehabilitation as part of the Multi Agency Rehabilitation review. Depending on the type of stroke and subsequent disabilities, rehabilitation was regarded of key importance especially in the first three months following a stroke in terms of the long-term recovery of a patient.

Members commented on the national Tier 1 Vital Sign targets and standards in place for stroke the definition of which had changed over the last 12 months. Whilst locally a figure of 87% had been achieved the need for further improvements to be made with regard to after-care was reiterated.

Specific reference was made to the benefits of the early administration of Thrombolysis treatment within 3 hours of a patient having a stroke. It was confirmed that funding had been made identified for an awareness campaign with the aim of improving the rate of thrombolysis treatment for eligible patients. The stroke strategy aimed for assessing people who had a TIA as quickly as possible 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 a good recovery.

Fast diagnosis of both the presence and type of stroke was critical. As part of the tests undertaken on patients with TIA a CT scan was carried out, as it was important to determine whether or not a patient had experienced transient ischemic attack or a small stroke in order to prevent a major stroke. It was noted that the National Institute for Health and Clinical Excellence was monitoring such an area in terms of the treatment and the level of service, which should be provided.

Specific reference was made to the public campaign launched in February 2009 of the assessment tool called FAST (facial, arm, speech, time) to raise awareness that a stroke was a medical emergency and needed prompt action and early treatment. The campaign aimed to educate healthcare professionals and the public on the signs of stroke and to encourage people to feel confident in phoning 999 for an ambulance on seeing any of the signs. It was noted that the response to such a campaign had been good and had resulted in an increased number of people going to hospital and receiving Thrombolysis treatment. It was noted however that further improvements could still be made in this regard.

It was acknowledged that the stroke services model at James Cook University Hospital was regarded as being very good and one of the best in the region.

In view of the population profile of Middlesbrough one of the main challenges as seen by the Panel was the need to raise awareness of stroke and TIA and to consider how best to reach those at risk. It was considered that a joint approach should continue to be pursued and that all organisations had a role to play including local authorities, which had a valuable input given their knowledge and work with community groups. Tier 2 of the Vital Sign targets relating to national priorities for local delivery was seen as tackling professionals in seeking improvements by education and appropriate training. Members sought clarification as to what steps other areas had taken in this regard. In response, an indication was given of recent attempts by South Tyneside which included discussions with a wide range of groups and specific advertising in appropriate magazines and local media. It was considered beneficial to share best practice and the outcome of such ventures as appropriate.

In terms of rehabilitation it was felt that although advances had been made it was recognised that further improvements were needed with particular regard to a patient's often complex individual needs and for appropriate services to be available as and when required. One of the current frustrations was an apparent lack of co-ordination and sharing of information between services/organisations throughout a patient's pathway of care often seeing many different people during such a period.

It was acknowledged that single assessments worked well in some areas but it was noted that it was a matter of resources and how different Trusts were structured.

An indication was given of the intention to publish a nation-wide booklet to ensure consistent information regardless of where a person was treated. How to utilise services and improve current links in order to adopt a more holistic approach in treating patients was key in terms of future planning. Although integration with social care worked well joint commissioning of health in conjunction with social care was seen as a possible way forward in appropriate circumstances in seeking further improvements.

The Panel in particular noted the series of improvements as outlined to be achieved by March 2011 and that NECVN was working with Trusts in terms of the changes to services and being resource efficient.

AGREED that Corinne Ellis be thanked for the information and participation in the subsequent deliberations the outcome of which would be incorporated into the overall review.

HEALTH SCRUTINY PANEL FINAL REPORT - CAR PARKING AT JAMES COOK UNIVERSITY HOSPITAL – FORMAL RESPONSE FROM – SOUTH TEES HOSPITALS NHS FOUNDATION TRUST

In a report of the Scrutiny Support Officer the Panel was advised of a formal response received from the South Tees Hospitals NHS Foundation Trust following the publication of the Final Report, Appendix 1 of the report submitted, in relation to car parking charges at James Cook University Hospital.

The Panel's recommendations and the formal response were reported as follows.

i) That a weekly parking ticket be introduced, guaranteeing a maximum amount that people can pay to park at the James Cook University Hospital site.

The Trust confirmed that they would look at the feasibility of introducing a weekly ticket. The Trust acknowledged that although a monthly ticket, priced at £8 was already available it may be attractive for patients and visitors to have access to a weekly ticket, It was intended to explore how other Trusts in the region administered weekly tickets and their charges.

ii) That the 15 minutes for free parking be extended to 30 minutes.

The Trust acknowledged that 30 minutes would allow more time for patients to be dropped off and collected. It was intended to establish how many visitors/patients currently incurred a charge in the car parks for stays of between 15 and 30 minutes and then it was proposed to have discussions with Endeavour on the implications of making a change.

iii) That the Trust explores ways to make the parking charge setting process much less opaque and seeks the views of interested groups, in line with the Department of Health guidance. The Panel would be happy to assist in this.

The Trust indicated that they needed to consider how this could be undertaken. As a starting point they intended to introduce a link onto the Trust's internet site so that members of the public could comment on car parking issues and specifically on the structure of charges. Any subsequent comments received would be taken into account when reviewing changes.

iv) That when subsequent parking pricing reviews are ongoing the Trust Board be involved in the discussions as a formal agenda item, prior to a decision being made.

Confirmation was given that the Director of Planning would discuss with the Board of Directors their views on how they wished to be involved in the decision-making process on car parking charges.

v) That the Trust seeks to publicise the £8 monthly ticket much more assertively and clarifies the price of the monthly ticket. For example, the Trust could include information in relevant patient letters and on car parking ticket machines.

It was confirmed that the monthly ticket was advertised on car parking machines in the north and south car parks and on the entrance doors at the north and south entrances. In addition, each ward and department had been asked to display posters advertising the permit in all patient and visitor areas. An assurance was given, however, that the Trust would check on the consistency of this between wards and departments.

It was noted that the information was also available on the Trust's Internet site. Details included in information sent to patients would be checked and if there was found to be gap an assurance was given that appropriate information would be supplied.

vi) That the Trust clarifies the process for applying a monthly ticket and highlights the process that people can expect to go through. The Panel would also like to see the Trust confirm criteria for such tickets and the identify of the ultimate decision-maker.

The report explained that the patient or visitor needed to speak to a member of staff on the ward they were visiting or the Travel Link Department and they would be given an application form. Such a form would then be signed by a member of staff on the ward/department and a permit would then be issued from the Travel Link Department. The only criteria was that the applicant was a patient or visitor, as members of staff were not allowed to apply for such permits. It had been the deliberate intention to make the criteria very open to ensure that people were not deterred from applying.

In reviewing the process, the Trust had identified a weakness in the accessibility of the Travel Link Office. Although extending the opening hours of the office had resource implications the Trust intended to explore how this could be achieved.

vii) The Panel recommends that James Cook University Hospital investigates whether it has enough disabled parking spaces to meet demand. The Panel would like to hear the outcome of this work.

It was confirmed that the Trust would review the number of spaces against both best practice guidelines and current demand and report back to the Panel.

vii) The Panel would recommend that the Trust investigates the viability of providing car parking spaces for those people who are temporarily immobile due to their condition, or a medical intervention, but who would not qualify for a disabled space. The Panel would like to see evidence of this being done.

It was indicated that the possibility of extending the availability of dedicated car parking to groups of patients and visitors other than those who meet the criteria for disabled parking had been considered and the Trust had decided not to pursue. Such a decision had been taken on the grounds that it would be impossible to draw up clear guidelines as to who did not qualify and it was also potentially very inequitable. Discussion had centred on providing specified parking for cancer patients. Whilst some cancer patients were very ill, others may be physically quite well and mobile during their visits to the hospital and non-cancer patients may be more physically impaired.

It was felt that the Panel's concerns would, to some extent, be addressed by some of the other actions to be undertaken such as if drop-off was made easier for instance as, presumably patients who were 'temporarily immobile' would be driven to the hospital rather than driving themselves.

Confirmation was given however that the Trust would review what other hospitals were doing when examining disabled parking and the weekly ticket to see whether there were any good practices elsewhere which could be considered.

The Trust confirmed that they intended to formally respond to the Panel on the outcome of the work outlined and provide an update by the end of September 2009.

It was confirmed that the Council's Executive at its meeting held on 21 July 2009 had considered the Panel's Final Report and supported the recommendations. Reference was made to comments made at such a meeting including the suggestion for the Panel to consider the submission of a further recommendation to the South Tees Hospitals NHS Foundation Trust to examine a request that free parking is allowed for the family and carers of patients receiving end of life care at the hospital.

In commenting on the governance arrangements of the Trust the Panel was advised that the Chief Executive and the Chair of the Trust had been invited to attend the meeting of the Panel to be held on 10 August to clarify such arrangements.

AGREED as follows: -

1. That the formal response from the South Tees Hospitals NHS Foundation Trust following the publication of the Panel's Final Report in relation to car parking charges at James Cook University Hospital be noted.

2. That an additional recommendation in relation to the above be forwarded to South Tees Hospitals NHS Foundation Trust as follows:-

   ' That the South Tees Hospitals NHS Foundation Trust allows the family and carers of patients receiving end of life care at James Cook University Hospital, free parking for the duration of that end of life care.'

3. That consideration of the new governance arrangements following the South Tees NHS Trust receiving Foundation Trust status be added to the work programme of the Health Scrutiny Panel.

OVERVIEW AND SCRUTINY 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 30 June 2009.

NOTED