AGENDA

Health Scrutiny Committee

Date:	**Thursday, 23rd March, 2006**
Time:	**10.00 a.m.**
Place:	**The Council Chamber, Brockington, 35 Hafod Road, Hereford**
Notes:	Please note the **time, date** and **venue** of the meeting. *For any further information please contact:* *Tim Brown, Members' Services, Tel 01432 260239* ***E-Mail: tbrown@herefordshire.gov.uk***

County of Herefordshire District Council

HEREFORDSHIRE COUNCIL

AGENDA

for the Meeting of the Health Scrutiny Committee

To: Councillor W.J.S. Thomas (Chairman)
Councillor T.M. James (Vice-Chairman)

Councillors Mrs. W.U. Attfield, G.W. Davis, P.E. Harling, Brig. P. Jones CBE, G. Lucas, R. Mills, Ms. G.A. Powell and J.B. Williams

		Pages
1.	**APOLOGIES FOR ABSENCE**	
	To receive apologies for absence.	
2.	**NAMED SUBSTITUTES (IF ANY)**	
	To receive details of any Member nominated to attend the meeting in place of a Member of the Committee.	
3.	**DECLARATIONS OF INTEREST**	
	To receive any declarations of interest by Members in respect of items on this agenda.	
4.	**MINUTES**	
	To approve and sign the Minutes of the meeting held on 16th March, 2006.	(To Follow)
5.	**SUGGESTIONS FROM MEMBERS OF THE PUBLIC ON ISSUES FOR FUTURE SCRUTINY**	
	To consider suggestions from members of the public on issues the Committee could scrutinise in the future.	
6.	**PUBLIC HEALTH ISSUES**	1 - 6
	To consider the specific issues of fluoridation and take up of the MMR vaccine and the progression of the Public Health Agenda.	
7.	**DEVELOPMENT OF STROKE SERVICES IN HEREFORDSHIRE**	7 - 28
	To consider proposals for the development of stroke services in Herefordshire.	
8.	**WHITE PAPER - OUR HEALTH, OUR CARE, OUR SAY; A NEW DIRECTION FOR COMMUNITY SERVICES**	29 - 30
	To advise Members of key messages emerging from the new White Paper “Our Health, Our Care, Our Say: A new direction for Community Services”.	

PUBLIC INFORMATION

HEREFORDSHIRE COUNCIL'S SCRUTINY COMMITTEES

The Council has established Scrutiny Committees for Adult Social Care and Strategic Housing, Childrens' Services, Community Services, Environment, and Health. A Strategic Monitoring Committee scrutinises corporate matters and co-ordinates the work of these Committees.

The purpose of the Committees is to ensure the accountability and transparency of the Council's decision making process.

The principal roles of Scrutiny Committees are to

- Help in developing Council policy
- Probe, investigate, test the options and ask the difficult questions before and after decisions are taken
- Look in more detail at areas of concern which may have been raised by the Cabinet itself, by other Councillors or by members of the public
- "call in" decisions - this is a statutory power which gives Scrutiny Committees the right to place a decision on hold pending further scrutiny.
- Review performance of the Council
- Conduct Best Value reviews
- Undertake external scrutiny work engaging partners and the public

Formal meetings of the Committees are held in public and information on your rights to attend meetings and access to information are set out overleaf

PUBLIC INFORMATION

Public Involvement at Scrutiny Committee Meetings

You can contact Councillors and Officers at any time about Scrutiny Committee matters and issues which you would like the Scrutiny Committees to investigate.

There are also two other ways in which you can directly contribute at Herefordshire Council's Scrutiny Committee meetings.

1. Identifying Areas for Scrutiny

At the meeting the Chairman will ask the members of the public present if they have any issues which they would like the Scrutiny Committee to investigate, however, there will be no discussion of the issue at the time when the matter is raised. Councillors will research the issue and consider whether it should form part of the Committee's work programme when compared with other competing priorities.

Please note that the Committees can only scrutinise items which fall within their specific remit (see below). If a matter is raised which falls within the remit of another Scrutiny Committee then it will be noted and passed on to the relevant Chairman for their consideration.

2. Questions from Members of the Public for Consideration at Scrutiny Committee Meetings and Participation at Meetings

You can submit a question for consideration at a Scrutiny Committee meeting so long as the question you are asking is directly related to an item listed on the agenda. If you have a question you would like to ask then please submit it **no later than two working days before the meeting** to the Committee Officer. This will help to ensure that an answer can be provided at the meeting. Contact details for the Committee Officer can be found on the front page of this agenda.

Generally, members of the public will also be able to contribute to the discussion at the meeting. This will be at the Chairman's discretion.

(Please note that the Scrutiny Committees are not able to discuss questions relating to personal or confidential issues.)

Remits of Herefordshire Council's Scrutiny Committees

Adult Social Care and Strategic Housing

Statutory functions for adult social services including:
Learning Disabilities
Strategic Housing
Supporting People
Public Health

Children's Services

Provision of services relating to the well-being of children including education, health and social care.

Community Services Scrutiny Committee

Libraries
Cultural Services including heritage and tourism
Leisure Services
Parks and Countryside
Community Safety
Economic Development
Youth Services

Health

Planning, provision and operation of health services affecting the area
Health Improvement
Services provided by the NHS

Environment

Environmental Issues
Highways and Transportation

Strategic Monitoring Committee

Corporate Strategy and Finance
Resources
Corporate and Customer Services
Human Resources

The Public's Rights to Information and Attendance at Meetings

YOU HAVE A RIGHT TO: -

- Attend all Council, Cabinet, Committee and Sub-Committee meetings unless the business to be transacted would disclose 'confidential' or 'exempt' information.
- Inspect agenda and public reports at least five clear days before the date of the meeting.
- Inspect minutes of the Council and all Committees and Sub-Committees and written statements of decisions taken by the Cabinet or individual Cabinet Members for up to six years following a meeting.
- Inspect background papers used in the preparation of public reports for a period of up to four years from the date of the meeting. (A list of the background papers to a report is given at the end of each report). A background paper is a document on which the officer has relied in writing the report and which otherwise is not available to the public.
- Access to a public Register stating the names, addresses and wards of all Councillors with details of the membership of Cabinet and of all Committees and Sub-Committees.
- Have a reasonable number of copies of agenda and reports (relating to items to be considered in public) made available to the public attending meetings of the Council, Cabinet, Committees and Sub-Committees.
- Have access to a list specifying those powers on which the Council have delegated decision making to their officers identifying the officers concerned by title.
- Copy any of the documents mentioned above to which you have a right of access, subject to a reasonable charge (20p per sheet subject to a maximum of £5.00 per agenda plus a nominal fee of £1.50 for postage).
- Access to this summary of your rights as members of the public to attend meetings of the Council, Cabinet, Committees and Sub-Committees and to inspect and copy documents.

Please Note:

Agenda and individual reports can be made available in large print. Please contact the officer named on the front cover of this agenda **in advance** of the meeting who will be pleased to deal with your request.

The Council Chamber where the meeting will be held is accessible for visitors in wheelchairs, for whom toilets are also available.

A public telephone is available in the reception area.

Public Transport Links

- Public transport access can be gained to Brockington via the service runs approximately every half hour from the 'Hopper' bus station at the Tesco store in Bewell Street (next to the roundabout junction of Blueschool Street / Victoria Street / Edgar Street).
- The nearest bus stop to Brockington is located in Old Eign Hill near to its junction with Hafod Road. The return journey can be made from the same bus stop.

If you have any questions about this agenda, how the Council works or would like more information or wish to exercise your rights to access the information described above, you may do so either by telephoning the officer named on the front cover of this agenda or by visiting in person during office hours (8.45 a.m. - 5.00 p.m. Monday - Thursday and 8.45 a.m. - 4.45 p.m. Friday) at the Council Offices, Brockington, 35 Hafod Road, Hereford.

Where possible this agenda is printed on paper made from 100% Post-Consumer waste. De-inked without bleaching and free from optical brightening agents (OBA). Awarded the Nordic Swan for low emissions during production and the Blue Angel environmental label.

COUNTY OF HEREFORDSHIRE DISTRICT COUNCIL

BROCKINGTON, 35 HAFOD ROAD, HEREFORD.

FIRE AND EMERGENCY EVACUATION PROCEDURE

In the event of a fire or emergency the alarm bell will ring continuously.

You should vacate the building in an orderly manner through the nearest available fire exit.

You should then proceed to Assembly Point J which is located at the southern entrance to the car park. A check will be undertaken to ensure that those recorded as present have vacated the building following which further instructions will be given.

Please do not allow any items of clothing, etc. to obstruct any of the exits.

Do not delay your vacation of the building by stopping or returning to collect coats or other personal belongings.

PUBLIC HEALTH ISSUES

Report By: Director of Children's Services

Wards Affected

County-wide

Purpose

1. To consider the specific issues of fluoridation and take up of the MMR vaccine and the progression of the Public Health Agenda.

Financial implications

2. None identified.

Background

3. On 30th January, 2006 the Committee considered the Director of Public Health's Annual report 2004/05. The Committee requested further reports on fluoridation and MMR immunisation to allow the Committee to reach an informed view as to what action it could and should take on both these issues.

4. A report prepared by Dr Howie, Associate Director of Public Health, who will be at the meeting to present the report and answer questions, is appended. A presentation will be made on fluoridation.

5. It is proposed also to hold a wider discussion on progressing the Public Health Agenda.

BACKGROUND PAPERS

- None

Further information on the subject of this report is available from Tim Brown, Committee Manager (Scrutiny) on 01432 260239

MMR vaccination

Report of the Associate Director of Health Improvement, Herefordshire Primary Care Trust.

Introduction

In the DPH report 04/5, I drew attention to MMR immunisation rates in Herefordshire. I noted that whilst overall uptake rates have increased in the last year, we have still not reached the national recommended levels, and that this is of particular concern given an increase in MMR notifications. In 04/5, 79% of two year olds were immunised against MMR, compared with a national target rate of 95%. I also drew attention to the variation in rates across the county (ranging from 48% to 90% of GP practices'under 2 years populations.) This issue remains of concern because there is now evidence of a rise in the infections this vaccine is supposed to prevent. For example, in the first 5 months of 2005, there were 207 cases of mumps among the 15 – 24 year old population across Herefordshire and Worcestershire, compared with 102 in the whole of 2004. The DPH report recommended that attention should be focused on improving MMR uptake rates, and that a localised take-up campaign should be delivered through community pharmacists.

In its discussion of the DPH report, the Health Overview and Scrutiny Committee asked for more information about the safety of the MMR vaccine, in the context of the national debates that have taken place. This paper gives a summary of key points as a general briefing for members of the Committee.

Background

The national MMR programme began in 1988, by which time it had been successfully in place in the US for 15 years. The World Health Organisation regards its safety record as 'exemplary', and it is in place in over 100 countries globally, with over 500 million doses having been given.

MMR provides protection against measles, mumps, and rubella, all of which are infectious diseases carrying a risk of serious, possibly fatal, complications. In 1987, for example, 86,000 children caught measles and 16 died. Complications of measles affect 1 in 15 children who have the illness, and include chest infections, fits, encephalitis, brain damage, and death. Since the vaccine was introduced, no child has died from measles. Mumps was the most common cause of viral meningitis before the vaccination was introduced, and its complications included permanent deafness, viral meningitis, and encephalitis. Rubella can seriously damage the unborn child. If caught in the first three months of pregnancy, it causes damage to the baby in up to 9 out of 10 cases, and the damage includes damage to sight, hearing, heart and brain.

The Department of Health recommends that children receive two MMR injections, one at the age of around 13 months, and one between 3 and 5 years. Each of these is a triple vaccine, affording protection against all of the three infections.

Research Controversy

There has been on-going public concern about the safety of the vaccine, led by press reports which are either inaccurate or based on subsequently discredited research. As a consequence of these concerns, fewer parents have taken their children for vaccination,

and population immunity levels have dropped. Unsurprisingly, we now see cases of the infections rising and in circulation in the community.

We have the experience of a similar set of circumstances in the 1970s and 1980s, when major concerns (later found to be unfounded) were publicised about the safety of the whooping cough (pertussis) vaccine. At that time, parents were offered the choice of the diphtheria, tetanus, and polio vaccine with or without the whooping cough element. Coverage of whooping cough vaccine fell from 80% to 30% and coverage from the other vaccinations fell as well. Hundreds of thousands of children caught whooping cough in the course of three epidemics, thousands were admitted to hospital, and around 100 died.

The public controversy about MMR started when the Lancet published a paper by Andrew Wakefield and colleagues (1), suggesting a link between the onset of autism with gastrointestinal features and the giving of the MMR vaccine. In the paper, Wakefield actually concluded 'we did not prove an association between MMR and the syndrome described', and made it clear that the study was based on an investigation of only 12 children. Nonetheless, a dramatic media campaign followed and rates began to drop. Wakefield and Montgomery published a further paper again looking at the adverse effects of the combined MMR vaccine (2), but the Department of Health and the Medicines Control Agency reviewed the paper, finding serious errors, including incorrect analysis of trial results, incorrect reporting of the length and detail of studies, and a failure to identify and analyse all the evidence (3).

Since then, a number of large scale and robust studies have shown no association between MMR, autism, and gastrointestinal problems. For example, a retrospective cohort study of over 500,000 children in Denmark concluded that there was strong evidence against the hypothesis that MMR vaccination causes autism (4). In Finland, another study of over 500,000 children found no association between MMR vaccination and encephalitis, aseptic meningitis or autism (5). A review article based on 12 studies from 5 countries which examined Wakefield's hypothesis found that none of the studies provided evidence of an association between autism spectrum disorders and MMR (6). An American study looked at the incidence of autism in people under 21 in one county of Minnesota between 1976 and 1997 and concluded that MMR was introduced over 20 years before the increase in the rate of autism, which suggested that MMR vaccine did not contribute to the rise (7). In October 2005, a full review article of all existing evidence concluded that the current evidence supports current policies of mass immunisation (8).

Single vaccines

There have been some suggestions that the MMR single vaccine should be replaced by a single vaccine giving protections against each of the diseases. It has been argued that this would give the parent more choice to decide what they feel is right for their child.

The Department of Health will not promote this, since using single vaccines would increase the risks, and we cannot offer a vaccination programme which increases risk. Risk is increased because:

- six separate injections have to be given and research shows that fewer children would complete the course of six injections, leaving more children unprotected;
- children are unprotected in the gaps between injections;
- babies will be particularly vulnerable since they will be at risk from older siblings who remain unprotected between the separate injections. The most dangerous age to catch measles is under one year;

- pregnant women will be at greater risk of rubella infection from their own unprotected children and their friends.

There is no evidence that single vaccines have any advantages over combined vaccines, nor that they have any impact of rates of autism, bowel disease, or any other condition.

Conclusion

It is the firm view of the Department of Health and Herefordshire PCT that the MMR vaccine provides the best protection possible to children, and the PCT will do all that it can to ensure that uptake rates are maximised. The uptake levels are routinely monitored, and results will be published in the DPH report each year.

References

(1) Wakefield A.J. et al (1998) 'Ileal-lymphoid-nodular hyperplasia, non-specific colitis, and pervasive developmental disorder in children' The Lancet 351: 637 - 41
(2) Wakefield AJ and Montgomery SM (2000) 'Mumps, measles, rubella vaccine: through a glass darkly' Adverse Drug Reactions and Toxicological Reviews 19: 265 – 83.
(3) Medical Control Agency/Department of Health (2001) 'Combined measles, mumps and rubella vaccines@ Adverse Drug Reactions and Toxicological Reviews 19: 4).
(4) Madsen KM et al (2002) 'A population based study of measles, mumps and rubella vaccination and autism.' New England Journal of Medicine 347: 1477 – 82.
(5) Makela et al (2002) 'Neurologic disorders after measles-mumps-rubella vaccination.' Pediatrics 110: 957-63.
(6) Wilson K et al (2003) 'Association of autism spectrum disorder and the measles, mumps and rubella vaccine.' Archives Pediatric and Adolescent Medicine, 157: 628-34.
(7) Barbaresi et al (2005) 'The incidence of autism in Olmsted County, Minnesota 1976-1997. Archives of Pediatric and Adolescents Medicine, 159: 37-44.
(8) Demicheli V et al (2005) 'Vaccines for measles, mumps and rubella in children (review)' http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004407/frame.html

Websites

Two websites of interest, which provide further links to more sites, are www.immunisation.nhs.uk, and www.mmrthefacts.nhs.uk.

DEVELOPMENT OF STROKE SERVICES IN HEREFORDSHIRE

Report By: Director of Children's Services

Wards Affected

County-wide

Purpose

1. To consider proposals for the development of stroke services in Herefordshire.

Financial implications

2. None identified.

Background

3. The Primary Care Trust (PCT) commissioned a review of Stroke Service Provision in the autumn of 2005. A consultation paper was then developed on potential ways of improving Stroke Services within current resources.

4. The following documents prepared by the PCT are appended:

   - Report to Hillside Section 31 Board – 13th March 2006 – Proposal for the Development of Stroke services in Herefordshire (Appendix - Herefordshire Health and Social Care Community – Final Document March 2006 – Stroke Services Development in Herefordshire).

   - Report to Herefordshire Primary Care Trust Provider Committee – 15 March 2006 (Appendix - Action Plan – Stroke Services – March 06).

5. The report setting out the proposal for the development of stroke services was sent to the Chairman of the Committee by the Primary Care Trust, noting the role of this Scrutiny Committee in determining whether the proposal represented a substantial development or substantial variation of service upon which the Committee and others should be formally consulted.

6. The Department of Health's (DH) guidance on the overview and scrutiny of Health states that, as provided for in the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002, "Each local NHS body has a duty to consult the local overview and scrutiny committee(s) on any proposals it may have under consideration for any substantial development of the health service in the area of the committees' local authorities or any proposal to make any substantial variation in the provision of such service(s)." There are some exemptions, but in general terms where a substantial variation is proposed the Scrutiny Committee must be consulted.

7. The Regulations do not define how the word “substantial” is to be interpreted. The guidance states that

   “Local NHS bodies should aim to reach a local understanding or definition with their overview and scrutiny committee(s). This should be informed by discussions with other key stakeholders including patients’ forums.

   In considering whether the proposal is substantial, NHS bodies, committees and stakeholders should consider generally the impact of the change upon patients, carers and the public who use or have the potential to use the service.

   More specifically they should take into account…changes in accessibility of services…. impact of the proposal on the wider community…., patients affected…, and methods of service delivery…”.

8. The Chairman has expressed his view that there is much to be gained from the approach being proposed in developing stroke rehabilitation services, utilising current beds more effectively. He has, however, requested that the matter is formally considered by the Committee.

9. The Committee is asked to:

   - consider whether it supports the proposals for the development of stroke services

   - consider whether it thinks the proposals should be subject to a formal consultation process.

10. Trish Jay, the PCT’s Director of Clinical Development and Lead Executive Nurse will be at the meeting to present the proposals and answer questions.

BACKGROUND PAPERS

- None

Further information on the subject of this report is available from Tim Brown, Committee Manager (Scrutiny) on 01432 260239

HILLSIDE SECTION 31 BOARD
13TH MARCH 2006

PROPOSAL FOR THE DEVELOPMENT OF STROKE SERVICES IN HEREFORDSHIRE

1. INTRODUCTION

A review of Stroke Services in Herefordshire took place in autumn 2005 conducted by Dr. Colin Jenkins (Consultant Geriatrician with an interest in Stroke Services) and Trish Jay (Director of Clinical Development and Lead Executive Nurse). This review looked at current services against the Standards for Stroke Services set out in the Older People's National Service Framework Chapter 5. A document was produced regarding the review and proposals on developing the services within the current resources available.

From this review a formal proposal document has been developed (attachment 1). The proposals do have an impact on the current remit of the Hillside Intermediate Care Unit.

2. CONSULTATION TO DATE

2.1 Discussions have been taking place with the Council in relation to the proposal to allocate (but not ring-fence) stroke rehabilitation beds for Herefordshire in Hillside Intermediate Care Unit. The Council have indicated their support for the change, but have required the following action to occur:

- The allocated beds will not be ring fenced only to stroke patients
- That the maximum length of stay of six weeks will apply to stroke patients
- That the 'step up' care pathway will be developed and supported by the PCT
- That a review of access to community hospital beds by members of the MDT be carried out in tandem with the development of stroke services at Hillside'

2.2 The proposal paper in its Draft 3c form has been sent to Councillor Stuart Thomas as Chair of the Overview & Scrutiny Committee asking for his consideration. Any service changes do need to go through the Overview & Scrutiny Committee to determine whether a full public consultation is required. It is noted that this is a service development within current resources and there will be an enhanced level of stroke rehabilitation across the county using the same number of beds, however for some City patients there may be the requirement to have intermediate care within Community Hospitals rather than in Hillside. Outlined in the paper (in paragraph 4.4.2) is clarification on how the beds could be used in the future.

2.3 The proposal paper in its Draft 3c form has also been sent to the Patient & Public Involvement Forum.

3. CONSEQUENCES ON HILLSIDE INTERMEDIATE CARE UNIT

3.1 The proposal to have allocated beds for stroke rehabilitation at Hillside Intermediate Care Unit is a pragmatic solution to using the current resources we have across Community Hospitals and intermediate care provision in Herefordshire. The implications on bed usage have been explicitly reviewed and conclude that 12 beds would be required at any one time.

This proposal would centralise stroke rehabilitation and enable an improved service to patients within the county with this condition. The rationale for proposing Hillside included the following:

- Hillside already has 7 days a week therapy provision (whereas the other units do not)
- Hillside is specially developed for intermediate care and has these facilities available
- Being a central City location then the distance of travel for patients across the county is more equal than if it was located in the north or the south of the county
- Expert consultant medical support for stroke patients can be provided through the current contract of consultant medical support to Hillside
- The City & Rural South locality areas equate to 56% of the population and therefore 6-7 stroke patients should already be admitted to Hillside at any one time.

3.2 The proposed model would result in:

Intermediate Care

- Hillside will remain an intermediate care unit, discharging people within six weeks after a period of intense rehabilitation; it will also be equipped with the specialism and support to work with stroke patients.

- Step up admissions into Hillside will continue to be implemented to realise the benefits of this approach.

- The reduction in six beds for the City & South Rural patients would be mitigated by full use of all 22 beds, access to community hospital beds (as current practice), and a review of access arrangements by other members of the Multi-disciplinary Team directly to all 126 intermediate care/community hospital beds.

Stroke Services

- Intensive rehabilitation at Hillside would be targeted at stroke patients who could benefit from short term intensive rehabilitation

(no more than 6 weeks). (31% of all acute stroke admissions – 98 people per year)

- Some severe stroke patients may benefit from a period of intense rehabilitation after a period in the community hospital and some people who have gone home will benefit from a subsequent spell of rehabilitation (estimated as additional 27 people per year)

- *Patients who needed longer term rehabilitation would still be discharged from the County Hospital to community hospitals as at present. (21% of admissions – 67 people per year).*

3.3 It is anticipated that redesigning the allocation of beds across all the Community Hospitals/intermediate care facilities directly provided by the PCT, would enable increased capacity for in-patient intermediate care rather than reduced capacity. This would also be supported by a review of access arrangements by other members of the Multi-disciplinary Team, following clinical approval, directly to all 126 intermediate care/community hospital beds. The rationale for the mitigation is as follows:

3.4 The Council have proposed that, whilst step up admission processes are being developed across the county, and the review of access to community hospital beds, that there is an interim reduction in the Council's contribution to Hillside Intermediate Care Section 31 budget of £80k to support the expansion of temporary intermediate care beds at Orchard House.

In the longer term it is noted that an increase in beds across the county will not be required as centralising stroke rehabilitation will result in a reduced length of stay for patients, hence releasing future beds.

4. RECOMMENDATIONS

The Hillside Section 31 Board is asked to:

- Consider the proposal for the change of use for Hillside beds, noting that it would have a countywide function for stroke rehabilitation
- Consider the proposal by the Council to reduce the contribution to the Section 31 pooled fund for the running of Hillside for an interim period of time

Trish Jay
Director of Clinical Development – Lead Executive Nurse
<u>Herefordshire Primary Care Trust</u>

Stephanie Canham
Head of Social Care - Adults
<u>Herefordshire Council</u>

O:\Director\Chronic Disease Man\Clinical Networks\stroke\Paper for Hillside Section 31 Board 13'3'06 re Stroke Services.doc

HEREFORDSHIRE HEALTH & SOCIAL CARE COMMUNITY
Final document – March 2006

STROKE SERVICES DEVELOPMENT IN HEREFORDSHIRE

1. INTRODUCTION

1.1 The evidence, guidance and models to support the development of an integrated stroke services have been available for at least 5 years. In particular the Older People's National Service Framework makes the establishment of such an integrated service one of the it's standards. Herefordshire has been slow moving towards establishing such a service. Some elements are in place but many are not.

1.2 The purpose of this paper is to brief the Older People's Programme Board on the work that has taken place recently in the development of stroke services and seek approval to progress specific action in the following areas:

- Prevention
- Acute Intervention
- Rehabilitation
- Longer Term Support

2. RECENT DEVELOPMENTS

2.1 Hereford County Hospital dedicated 10 beds for acute stroke care in August 2005. All patients requiring rehabilitation were then transferred to one of the community hospitals/intermediate care units in Herefordshire.

2.2 In October 2005, Dr Jenkins (Consultant Geriatrician) and Trish Jay (Director of Clinical Development, Lead Executive Nurse) undertook a review of current stroke services against existing national guidance including the National Service Framework for Older People (See Appendix 1). This work was part of the action agreed by the Neurology Clinical Implementation Team.

2.3 The Review made various recommendations, which were widely consulted upon for a six week period ending at the beginning of January 2006. The recommendations were based on the reorganisation of existing resources (noting that additional resources were not forthcoming) in a format, which would improve current patient/user outcomes; however it must be noted that this is will not achieve all the national guidance. The recommendations and the action plan presented here, following consultation are therefore seen as a pragmatic, incremental step towards the ideal service.

3. OUTCOME OF THE CONSULTATION

3.1 There were 28 responses to the consultation paper circulated, from colleagues across the Primary Care Trust, Herefordshire Hospitals Trust, the Voluntary sector, carer representative, Herefordshire Social Services, general practitioners.

3.2 There was a range of comments. The action plan reflects the strongest emerging themes, although not every point made by every responder.

The key themes arising from the consultation responses.

1. *Agreement with the consultation paper that stroke services in Herefordshire need improving. Some comments highlight particular needs; others express their concerns about the current service quality.*

2. *Factual amendments suggested are not fundamental to the consultation issues.*

Prevention

3. *The work on prevention was acknowledged to be important, with suggestions that there should be more emphasis on the management in this area. Also training for primary care staff.*

Acute services.

4. *The recent establishment of the acute unit was welcomed and the responses suggested ways of addressing the shortfalls identified in the consultation paper. A further issue of vision assessment was also identified.*

Rehabilitation Services

5. *The consultation paper suggested significant service redesign and it is not surprising therefore that this section prompted most detailed responses.*

6. *Acceptance of the evidence of the effectiveness of a specialist rehab unit and support for the concept of establishing one. There was one alternative view expressed in favour of using more than one base in order to have flexibility and to maximise use of community hospitals)*

7. *No challenge to the criteria of what would make an effective specialist rehab unit.*

8. *A consensus among practitioners in the relevant fields that Hillside most fully meets the criteria set out in the paper. The nature of the responses reflected the fact that the consultation paper had pointed strongly to the use of Hillside for this purpose, without specifically naming it, or addressing any issue consequent to this development.*

9. *Therefore the responses raised the following issues about the implications of developing Hillside as the stroke rehab unit:*
   - *A view that we would merely be re-arranging our inadequacies and that without resources for equipment, adaptations and acquisition of specialist skills, we would re-badge an existing service but not really meet the definition of a specialist stroke service.*
   - *The likely length of stay and impact on patient flows elsewhere in the system.*
   - *How the needs of current users of Hillside could be met and how the development of step-up intermediate care could alternatively be accommodated.*
   - *Arrangements for medical cover*
   - *Process of working with Herefordshire Council and the Section 31 Board.*

Longer term Care and Support.

10. Those aspects of longer term care that the consultation paper recommended, such as use of the Expert Patient Programme, were welcomed. There was a strong comment to initiate planning for longer term support at an earlier stage than phase 3; there were offers from the voluntary sector and older people's wider reference group to be involved in this development work.

Resources

11. The paper and its recommendations were based on the underlying assumption that it sought an incremental development within existing resources; the service outcomes may fall short of the standard we would like, but will be pragmatically achievable and better than what we've got at the moment. The assumption of no new resources was not stated explicitly and some responses challenged why it had been made and the realism of being able to make any improvements without some costs.

3.4 The action plan identifies a timetable to plan longer term community based support, and identifies a lead person for each step (see Appendix Two).

4. PROPOSED NEXT STEPS

4.1 Noting the significant feedback on the consultation, an action plan has been drawn up to progress the recommendations in the Review. The rationale for the identified action and further explanation of some points is outlined below:

4.2 Prevention

'The prevention of stroke depends on reducing risk factors across the whole population as well as in those at relatively greater risk of stroke'[1].

The area of action identified is to improve the GP referral to Transient Ischaemic Attack (TIA) clinics. If there is increased referral then the number of dedicated slots for TIA assessment would also need to increase to ensure the waiting time of one week from referral was met.

4.3 Immediate Care, including care from a specialist stroke team

'All patients who may have had a stroke will usually require urgent hospital admission. They should be treated by specialist stroke teams within designated stroke units'[2].

The acute stroke service continues to develop since the dedicated beds for stroke care were allocated at the County Hospital, and Stroke Association Training can taken place for staff. Further work is now planned to:

- Develop the nursing skills
- Look at direct and rapid access to the beds, rather than admission via A&E and then to a Medical Admissions unit, prior to moving to one of the designated stroke beds.

[1] Department of Health (2001) NSF For Older People
[2] Department of Health (2001) NSF For Older People

- Improve the access to CT scans out of hours, including a review of whether direct referral by GPs would be beneficial.
- Determine appropriate vision assessments

4.4 Early & Continuing rehabilitation

'The evidence indicates that early, expert and intensive rehabilitation in a hospital stroke unit improves the long-term outcome for patients'[3].

4.4.1 Bed Analysis

It is important to calculate how many people would require rehabilitation. This analysis has been completed based upon current admissions to the County Hospital (based upon figures for 2004 & 2005); and acknowledges that the English national average length of stay for stroke patients is 28 days.

314 Average yearly admissions:

- 83 Average who go home within two weeks
- 46 Average died within two weeks
- 20 Average number going to Powys Hospitals (mostly within 2 weeks)
- 67 Average severe strokes (who would continue to go to Community Hospitals)
- 98 Average requiring acute rehabilitation

Some severe stroke patients will go on later to have acute rehabilitation (estimated to be 20 p.a); also patients who have had a stroke in the past may benefit from a further episode of acute rehabilitation (estimated to be 7 p.a).

This would then assume that approximately 125 patients would require acute rehabilitation stay on average 4-6 weeks (2 week LOS at the County Hospital and 4-6 week length of stay at the designated unit) then this would equate to 4,375 stroke rehabilitation bed days per annum.

This equates to 4,693 bed days at 95% occupancy, and would require 12 beds.

4.4.2 One unit for in-patient stroke rehabilitation: The key recommendation in this area was that one of the existing community in-patient units should be designated for specialist stroke rehabilitation. Since the consultation period, there is agreement that the Community Hospitals (Meeting - 11th January 2006), people who have had severe strokes will continue to go to a community hospital/unit nearest to their home.

The unit that currently meets all the acute rehabilitation criteria outlined in the Consultation document is **Hillside Intermediate Care Unit.** The proposed model based on an analysis of admissions is:

Stroke Services

- Intensive rehabilitation at Hillside would be targeted at stroke patients who could benefit from short term intensive rehabilitation (no more than 6 weeks). (31% of all acute stroke admissions – 98 people per year)

[3] Lincoln, NB (2000) Five year follow up of a randomised controlled trial of a stroke rehabilitation unit, BMJ, 320p359 (Category: B1)

- Some severe stroke patients may benefit from a period of intense rehabilitation after a period in the community hospital and some people who have gone home will benefit from a subsequent spell of rehabilitation (estimated as additional 27 people per year)

- Patients who needed longer term rehabilitation would still be discharged from the County Hospital to community hospitals as at present. (21% of admissions – 67 people per year).

- A medical lead for Hillside with stroke specialism would be identified. Existing staff would be given the training to acquire additional skills

- This model would need 12 beds allocated (not ring fenced) for stroke patients.

Intermediate Care

- Hillside will remain an intermediate care unit, discharging people within six weeks after a period of intense rehabilitation; it will also be equipped with the specialism and support to work with stroke patients.

- Step up admissions into Hillside will continue to be implemented to realise the benefits of this approach.

- The reduction in six beds for the City & South Rural patients would be mitigated by full use of all 22 beds, access to community hospital beds (as current practice), and a review of access arrangements by other members of the Multi-disciplinary Team directly to all 126 intermediate care/community hospital beds.

4.4.3 Impact on Hillside's current service pattern

The Hillside Intermediate Care Unit opened in November 2003, as a jointly funded new service of 22 beds for intermediate care for people living in Hereford City and the PCT South Rural Locality (Golden Valley area).

The occupancy for 2004/05 was 84 %, and for the first six months of the year 81%. This occupancy level is considerable less than the community hospitals whose average occupancy is well over 90%. Increasing the average occupancy rate from 84% of 95% would means an increase from an average of 18 to 21 beds occupied at any one time.

Intermediate Care is nationally defined as 'involving short term interventions (rehabilitation) typically lasting no longer that 6 weeks'. Noting that the assumption is that stroke patients would on average stay 4-6 weeks, then the rehabilitation provided to patients who require acute rehabilitation would still meet this criteria.

The practice populations of the City & South Rural areas accounted for 56% of stroke admissions 2001-04.[4] Therefore 56% of the beds allocated to stroke rehabilitation in the unit are likely to be for the same population as before.

[4] Profile of Herefordshire GP Practices. P Stebbing May 2005

If it were agreed by the various Boards that Hillside would have allocated (not ring fenced) stroke rehabilitation beds then:
Of the 12 beds for stroke care:

- *6-7 beds – there would be no change in accepting patients for rehabilitation from City & South Rural areas*
- *5-6 stroke patients are likely to be from outside original Hillside priority catchment area*
- *reduction in general intermediate care provision would be 6 beds.*

Other patients from the City & South Rural areas requiring intermediate care would be transferred to other Intermediate Care/Community Hospital Units (as is the current practice). Work will be undertaken to review of access arrangements by other members of the Multi-disciplinary Team directly to all 126 intermediate care/community hospital beds.

4.4.4 Other areas of development

Others areas of development were highlighted in the Consultation document, these will be taken forward in later phases of work and include out-patient rehabilitation and community rehabilitation.

4.5 Longer Term Support

'Recovery from stroke can continue over a long time, and rehabilitation should continue until it is clear that maximum recovery has been achieved. Some patients will need ongoing support, possibly for many years. Following a stroke, any patient reporting a significant disability at six months should be re-assessed and offered further targeted rehabilitation if this can help them to recover further function' [5].

There is a significant work required to take this area forward. The initial step must be to understand the needs in Herefordshire, the limited current services, and how resources can be used more effectively, as well as looking to additional funding support in the future.

5. IMPLEMENTATION RISKS

In redesigning services, within current resources there are always inherent risks, as stated earlier this paper and plan outlines pragmatic actions, which are an incremental step towards the ideal service. The major risk associated with the development of Hillside Intermediate Care Unit to have dedicated beds for stroke rehabilitation, is the change management which will require significant management input including liaison with staff side to successfully implement the changes. Also it is important to note the rehabilitation model is based on the latest figures and relevant clinical assessment but the impact will have to be proven empirically.

6. RECOMMENDATIONS

The Overview and Scrutiny Committee is asked to:

[5] Werner, R. A. & Kessler, S. (1996) Effectiveness of an intensive outpatient rehabilitation program for postacute Stroke patients. American Journal of Physical Medicine and Rehabilitation; 75: 114- 120 (Category: B1)

- Note the work that has been completed to date
- Support the specific action outlined in the Action Plan to improve all aspects of stroke care
- Support the option to develop allocated acute stroke rehabilitation beds at Hillside Intermediate Care Unit and support the further work outlined in the action plan.

15th March 2006

Dr Colin Jenkins, Consultant Geriatrician
Hereford Hospitals Trust

Trish Jay, Director of Clinical Development, Lead Executive Nurse
Herefordshire Primary Care Trust

Peter Sowerby, IMPACT Officer
Herefordshire Primary Care Trust

O:\Director\Chronic Disease Man\Clinical Networks\stroke\OP Prog Board paper\OSC Stroke services development Final March 2006.doc

HEREFORDSHIRE PRIMARY CARE TRUST
PROVIDER COMMITTEE

PROPOSALS FOR STROKE SERVICES DEVELOPMENT IN HEREFORDSHIRE

1. INTRODUCTION

1.1 As part of the Neurological Clinical Implementation Team work programme, a review of Stroke Service provision in Herefordshire took place in the autumn 2005. Following this review, a consultation paper was developed on potential ways of improving Stroke Services within the current resources we had in the Health and Social Care community in Herefordshire.

1.2 Feedback on the consultation paper concluded in January, and this was collated into formal proposals for consideration and development, with an associated Action Plan. This information is attached in Appendices 1 and 2.

2. CONSULTATION ON THE PROPOSALS

2.1 Discussions have taken place specifically in relation to the proposal to allocate 12 of the beds at Hillside Intermediate Care Unit for acute stroke rehabilitation. The discussions have taken place:

- At the PCT Community Hospital meeting on 11th January 2006
- At PCT Commissioning Committee meetings
- With Herefordshire Council
- Herefordshire Overview and Scrutiny Committee

The proposal paper has been sent to the Patient and Public Involvement Forum for their comments.

Discussions are also planned at the Section 31 Hillside Intermediate Care meeting on Monday 13th March.

2.2 *Community Hospital Meeting*
Discussion took place about stroke rehabilitation at the PCT Community Hospital meeting on 11th January 2006. Those present agreed that patients with dense strokes should continue to be transferred from the County Hospital to Community Hospitals for their intense nursing care, with supported therapy.

Depending on the progress of these patients they could either continue their care at the Community Hospital or be transferred to Hillside Intermediate Care for intensive stroke rehabilitation if appropriate. This proposal forms part of the patient pathways proposed for rehabilitation within the proposal paper.

2.3 *Herefordshire Council*
Discussions have been taking place with the Council in relation to the proposal to allocate stroke rehabilitation beds for Herefordshire in

Hillside Intermediate Care Unit. The Council have indicated their support for the change, but have required the following action to occur:

- The allocated beds will not be ring fenced only to stroke patients
- That the maximum length of stay of six weeks will apply to stroke patients
- That the 'step up' care pathway will be developed and supported by the PCT
- That a review of access to community hospital beds by members of the MDT be carried out in tandem with the development of stroke services at Hillside

2.4 *Overview & Scrutiny Committee*

The proposal paper in its Draft 3c form has been sent to Councillor Stuart Thomas as Chair of the Overview & Scrutiny Committee asking for his consideration. Any service changes do need to go through the Overview & Scrutiny Committee to determine whether a full public consultation is required.

Councillor Thomas stated that there was much to be gained from the approach that we were proposing in developing stroke rehabilitation services in Herefordshire, utilising our current beds more effectively. He also wished for clarification in a number of areas which was provided.

3. RECOMMENDATION

The Provider Committee are asked to consider the proposal for the development of Stroke Services within existing resources within Herefordshire. Feedback on the proposals from the Provider Committee will be used to inform discussions that will take place at the Commissioning Committee on 21st March 2006.

Trish Jay
Director of Clinical Development – Lead Executive Nurse

15th March 2006

ACTION PLAN – STROKE SERVICES (March 2006)

Area	Task	People responsible	Completion date	Progress
Consultation	• Feedback to those who responded to the consultation document •	P Sowerby	January 2006	
1. Stroke Prevention TIA assessment	• Determine from GPs their current referral patterns	T Jay	April 2006	
	• Complete an analysis on how many patients should be identified on average for TIA clinics	Dr Colin Jenkins	April 2006	
	• Determine a plan if required to increase the TIA service to meet demand	Dr Colin Jenkins/HHT Manager	June 2006	
2. Acute Stroke Care 2.1 Brain Imaging	• Agree with Radiology Department access to CT scanning at weekends and the process	Dr Colin Jenkins & Dr Peter Wilson	February 2006	Meeting took place and informed this plan
	• Determine how many patients GPs would want to directly refer for CT scans form home and why • If appropriate develop a pathway where GPs could refer through the on-call physician for an urgent CT scan – enabling the patient to stay at home	T Jay Dr Jenkins/Dr Wilson	March – April 2006	
2.2 Holistic patient care	• Determine standard information and advice needed by patients. • Provide information to this standard	Jenny Powell	April 2006	
	• Develop training and workforce development plan for nurses, including dysphagia training	Helen Blanchard	April 2006	

Area	Task	People responsible	Completion date	Progress
2.3 Direct Access to Stroke beds	• Review the possibility of direct and rapid access to the stroke beds: ○ Including Ambulance protocols	Dr Colin Jenkins/HHT	July 2006	
2.4 Vision assessments	• Determine appropriate vision assessment for stroke patients • Share national requirements at Optometrist Stakeholder Day • Develop further action	Dr Colin Jenkins working with Ophth Clinical Imp Team	July 2006	
3. Stroke Rehabilitation:				
3.1 Development of proposals identifying Hillside as preferred option as inpatient rehab unit.	• Develop proposal for Hillside to be identified as preferred option for acute stroke inpatient rehab and take to: ○ Older Peoples Programme Board for agreement to go onto to further groups ○ Council discussions ○ Overview & Scrutiny Committee ○ Patient & Public Involvement Forum ○ Take proposal to Hillside Section 31 Board for discussion on the implications for the Section 31 agreement and approval to move forward	Trish Jay/Dr Jenkins/Peter Sowerby	January – February 2006	Feb 06 – Discussion re: stroke services at OP Board Paper to Cabinet member 6/2/06 & response Letter to OSC 24/2 & meeting on 23/3 Letter 24/2 – awaiting response Paper to Section 31 Committee 13/3

Area	Task	People responsible	Completion date	Progress
	○ Take proposal to the PCT Commissioning Committee for support and approval to move forward			Paper to Commissioning Committee on 21/3
3.2 Detailed work on the impacts of preferred option	Determine stroke bed utilisation usage (admissions/bed days) in the following categories: • Acute • Rehabilitation • High dependency care in community hospitals for dense strokes	Trish Jay	January 2006	Within the attached paper
	• Determine impact of changes on patient flow in the wider health and care system and any changes in demand pattern. • Describe likely impact on performance measures (e.g. intermediate care targets)	Trish Jay, Chris Gill, Peter Sowerby Graham Taylor, S Canham	February 2006	Within the attached paper
	Determine numbers & develop proposals for alternative provision for Hillside Intermediate care users:	Trish Jay, Chris Gill, Peter Sowerby Graham Taylor, S Canham	February 2006	Within the attached paper
3.2 If agreed through actions in 3.1 Planning a stroke service development at Hillside	Determine a Project Lead for the changes	Mike Thomas	March 2006	
	Communicate with Hillside staff and manage staff changes including Liaise with staff and staff side representation	Graham Taylor & HR	March 2006	
	Outline a project plan for the changes within a set timescale.	Graham Taylor, Jan Bruton &	April 2006	

Area	Task	People responsible	Completion date	Progress
		Hillside Management Group		
	Identify equipment, adaptations and associated costs	Jan Bruton	May 2006	
	Review & determine future arrangements for medical responsibility for the unit	Dr Dalziel & Dr Jenkins	May 2006	
	Review & determine future arrangements for pharmacy input	Julie Cohn	May 2006	
	Identify workforce requirements: ○ Staffing ○ Training and development ○ Changes to current patterns of work	Hillside Management Group	May 2006	
3.3 Implementation a stroke service development at Hillside	Implement project plan (Above Section 2) as agreed by Section 31 Committee	Graham Taylor	May – June 2006	
	New service operational		June 2006	
4. Longer Term Stroke care	Encourage Stroke patients to go onto the Expert Patient Programme.	EEP Co-ord	March 06	
	Meeting between Stroke Association and PCT/HHT on developing a strategy for Longer Term Support	Trish Jay, Colin Jenkins, Peter Sowerby	January 2006	Completed
	Develop proposal for developing Longer Term Support for patients who have had a stroke: Including outpatient clinics and outreach	Peter Sowerby Older people's wider reference	March - May 2006	

Area	Task	People responsible	Completion date	Progress
	therapy. ○ Consult on proposals	group		
	Take the proposals for discussion and agreement to: ○ Older Peoples Programme Board ○ PCT Commissioning Committee	Peter Sowerby	May 2006	
5 Other areas for development in the future	• Community Rehabilitation • Out-patient/Day Hospital Rehabilitation			

WHITE PAPER – OUR HEALTH, OUR CARE, OUR SAY; A NEW DIRECTION FOR COMMUNITY SERVICES

Report By: Director of Adult and Community Services.

Wards Affected

County-wide

Purpose

1. To advise Members of key messages emerging from the new White Paper "Our Health, Our Care, Our Say: A new direction for Community Services".

Financial Implications

2. There are no direct financial implications.

Background

3. At the end of January 2006 the Department of Health published the White Paper "Our Health, Our Care, Our Say: A new direction for Community Services". The White Paper sets out the Government's framework to develop a Health and Care system that will meet the needs of people in the 21st Century.

4. A full copy of the White Paper is available in the Member's Room. It confirms the direction set out in the Green Paper "Independence, Well-being and Choice" and presents a shift towards:

- Personal and responsive Health and Social Care services that reflect peoples needs and wishes;
- Prevention, Public Health and Well-being;
- Tackling inequalities;
- More focused support for people with long term conditions;
- More services provided out of hospitals, closer to people.

5. The White Paper sets out a new direction for the Health and Social Care system. The proposal is for a radical and sustained shift in the way in which services are delivered – to ensure that they are more personalised and that they fit into people's busy lives. The White Paper identifies the following clear areas for change:

- Personalised care will be driven by better access and more funding following the patient. NHS walk in centres will also be expanded;
- Services will be brought closer to peoples homes through investment in Community Hospitals and facilities and shifting care safely away from hospitals;

Further information on the subject of this report is available from
Geoff Hughes, Director of Adult and Community Services, on 01432 260695

- It is proposed that there will be better coordination with local Council's, improving the way information is shared between Social Services and Health Care providers;
- It is proposed that there will be a shared outcome based performance framework with aligned performance inspection regimes. Local Area agreements should be a key mechanism for joint planning and delivery. There will also be a strengthened role for the Head of Adult Social Care.
- Increased choice will be underpinned by a direct payment or care budget for people to pay for their own home help or residential care, and PCT's will be required to act on the findings of regular patient surveys;
- Prevention and illness will be targeted with several measures, including the establishment of more health care teams to deliver better care across institutional boundaries. A new NHS "Life Check" service will be introduced and a fitter Britain scheme will be launched as part of the build up to the 2012 Olympics.
- Improvements will be achieved through a number of measures including: practice based commissioning which will give GPs more responsibility for local health budgets;
- Shifting resources into prevention, recognising the need to meet future demographic challenges which we face;
- More care taken outside hospitals and into the home;
- Better joining up of services at a local level, encouraging joint commissioning between PCTs and Local authorities;
- Encouraging innovation, to provide greater patient and user choice, to ensure that services are provided to suit people's lifestyles.
- Allowing different providers to compete for services, in particular there are a range of voluntary sector providers who could increasingly provide.

6. The White Paper sets out a clear timetable for implementing these changes the majority of which it sees as being place by 2009.

BACKGROUND PAPERS

- White Paper: "Our Health, Our Care, Our Say: a new direction for Community Services"
- Green Paper: "Independence, Well-being and Choice

Further information on the subject of this report is available from
Geoff Hughes, Director of Adult and Community Services, on 01432 260695