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MONMOUTHSHIRE COUNTY COUNCIL

Minutes of the meeting of Adults Select Committee held at County Hall, The Rhadyr, Usk, NP15 1GA on Tuesday, 4th April, 2017 at 10.00 am

PRESENT: County Councillor P. Farley (Chairman)
County Councillor R. Harris (Vice Chairman)

County Councillors: R. Edwards, M. Hickman, P. Jones, A. Wintle, and A. Easson

ALSO PRESENT:

D. Hill – Co-Opted Member
D. Hudson – Co-Opted Member

OFFICERS IN ATTENDANCE:

Claire Marchant	Chief Officer Social Care, Health & Housing
Alison Shakeshaft	Executive Director of Therapies and Health Science[, Aneurin Bevan University Health Board
Julian Hayman	NHS Engagement Team
Anna Palazon	Director of the Stroke Association
Anna Markle	Area Manager, SE Wales, Stroke Association
Rhodri Davies	Head of Influencing and Communications, Stroke Association
Luisa Stokes	Life after Stroke Co-Ordinator
Heidi Matthews	Stroke Survivor
James Cook	Exercise Referral Co-Ordinator
Richard Lee	Executive Director of Operations, Wales Ambulance Service NHS Trust
Louise Platt	Assistant Director of Operations, Wales Ambulance Service NHS Trust
Hazel Ilett	Scrutiny Manager
Wendy Barnard	Democratic Services Officer

APOLOGIES:

There were no apologies for absence.

1. **Declarations of interest**

No declarations of interest were made by Members.

2. **To consider reformed Stroke Services with stakeholders***

Key Issues:

The Chair explained that the purpose of the meeting was to hear contributions from partner services and a stroke survivor to help the Adults Select Committee understand more about Stroke Services in Monmouthshire.

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The Select Committee received a presentation from the Executive Director of Therapies and Health Science, Aneurin Bevan Health Board. Following the presentation, Members asked questions and made observations.

The Committee watched a short film clip demonstrating the importance of quickly recognising the symptoms of a stroke and to act FAST (Face, Arms, Speech, Time to call 999) because the quicker treatment is obtained, the better the outcome.

The Committee heard that services work well together and it was explained that the stroke pathway has been redesigned to make the service better for residents in the Gwent region. Service performance is monitored both internally and by Welsh Government.

Historically, services for stroke patients were provided at 11 different hospitals and allocating specialist members of staff to those sites, to provide the same level of service, was problematic hence the redesign using the best clinical evidence available.

It was explained that most suspected stroke patients, who live in the Gwent area, will automatically be transported to the Royal Gwent Hospital (RGH) where they will be met at front door by specialist stroke team (9am – 5pm, 7 days a week). The patient will quickly have a CT scan, and if it is determined they have suffered a stroke, they will be admitted to the Hyper Acute Stroke Unit (HASU) typically involving 3-4 days stay. Some people will recover quite quickly with some, little or no support and, if medically fit can be discharged home and receive rehabilitation there.

Patients from north of the region will be transferred to Nevill Hall Hospital stroke ward, patients from the west (Caerphilly area) will go to Ysbytty Ystrad Fawr and those in the south east will be transferred to St. Woolos Hospital. The aim is to return the patient home, where recovery is quicker, as soon as possible with the support they need.

The Committee were provided with information about the establishment of a Community Neuro-rehabilitation team which is a multi-disciplinary service for those people medically well but in need of rehabilitation.

It was explained that since January 2016 there has been 7- day per week stroke consultant, nurses, physiotherapist and occupational therapist available.

Monmouthshire residents will no longer be taken to Nevill Hall Hospital and a concern has been raised that it takes longer to travel to RGH both for the patient and for relatives in terms of travel and parking. It was explained that to minimise the impact, the ambulance team will telephone the hospital ahead to notify that a possible stroke patient will be arriving whereupon they will typically be met at the door by the specialist stroke team. An assessment will be conducted and if it's not a stroke, patients suffering a Trans Ischemic Attack (TIA) can benefit from having the necessary tests and the necessary advice straightaway. If it is more likely that a stroke has occurred, the patient will have a CT scan, will be admitted to the HASU and administered Thrombolysis if appropriate. For Monmouthshire patients, after Day 4, they can either be discharged home or be moved to Nevill Hall Hospital.

The Select Committee were advised how performance is measured using Sentinel Stroke National Audit Programme (SSNAP) and Welsh Government Quality Improvement Measures and the specific elements monitored were explained.

The SSNAP results for the RGH indicated improvements that have been recognised by the Cabinet Secretary as the only site in Wales to achieve an "A" identifying it as the flag ship stroke unit in Wales. This point was noted in particular by the Committee.

It was explained that there are still some areas for improvement such as that there are no 24/7 therapy services available at the Stroke Unit and overnight it is more difficult to retain stroke beds. Also thrombolysis rates can be improved. Performance still compares well with the rest of Wales.

Patient centred results also indicate an improvement but also reflect that there is not 24/7 services available. Nevill Hall has scored a "D" relating to the diversion of investment in terms of additional staff etc. to the RGH. These are similar scores to St. Woolos and Ysbytty Ystrad Fawr. It was acknowledged that there is much more to do.

The Welsh Government Quality Improvement Measures were explained and definite improvements observed. Notably, it was confirmed that the aim is to get everyone CT scanned within an hour and performance is at least 50% rising to 70%.

Regarding the Community Neuro-rehabilitation Service, the data this year indicates that 40% of patients are being discharged at 3-4 day with rehabilitation at home. Encouragingly, there have been no re-admissions due to supported early discharge. From September, the team will also support acquired brain injuries, too.

It was confirmed that the HASU will move to the Llanfrechfa Specialist Critical Care Centre when open. Anticipated benefits and future developments were noted. The presentation concluded with an audio clip from a stroke survivor.

The Director of the Stroke Association provided information about the unique work of the charity in wales which is to provide services, conduct research and campaign for better stroke services. It was explained that a stroke can be a misunderstood condition that can occur at any age, has immediate effects that may last a lifetime and affects the whole family. Stroke kills three times more men than prostate and testicular cancer combined and three times more women than breast cancer.

It was confirmed, however, that stroke related mortality is on a downward trend. Ten years ago, Wales was identified as the worst in the UK leading to the WG putting in place a dedicated programme of improvement. It was explained that the majority of improvements have been made at the acute end of the spectrum and lives have been saved. The HASU in the RGH has played a very important role in this aspect. It was also emphasised however that stroke can be treated and prevented.

The Committee was informed that the Stroke Implementation Group was set up in 2014 to oversee the Stroke Delivery Plan which details how services should be developed in each area. It was explained that despite the advances, there is progress still to make as stroke is not only a medical matter. Following treatment, stroke survivors can feel abandoned when they return home and relatives, who have had no warning, often have to learn by themselves. Therefore it is important that local government and other partners are involved.

The Stroke Association provides Life after Stroke services and follows individuals from the ward to home for up to a year providing flexible support (advice and emotional support) for the individual and whole family. Help is also provided to overcome Aphasia and social opportunities are established to assist the recovery journey, and help to avoid a second stroke.

The Association also provides prevention services as more than 60% of strokes can be prevented.

On discharge from hospital, the association works to ensure that every person has a bespoke care plan with a joint approach from local government, health and social services to make sure that they can reach their individual outcomes.

It was explained that the Speak Out for Stroke programme has been particularly successful in Monmouthshire (funded by GAVO and the Big Lottery) which assisted the evolution of the new pathway, working with stroke survivors to dissipate concerns arising from the development of the HASU and the perceived withdrawal of other services and to maximise benefits to individuals.

The Select Committee was informed that services are provided in partnership with the Health Board and local authorities. Unlike other local authorities in the Gwent region, Monmouthshire County Council Social Services has not provided funding to the Stroke Association as the model in Monmouthshire is seen as effective. It was urged that a dialogue on this matter is maintained as the service is provided in Monmouthshire but is subsidised by other authorities and the Health Board.

The Committee heard evidence from a stroke survivor of her experience from when she became ill, her experience of the ambulance service, the treatment she received and rehabilitation in hospital and at home. She explained the practical and emotional issues to deal with and the support provided by the Stroke Association which has given her confidence to join clubs and give everything a try. The Committee Chair warmly thanked the stroke survivor for sharing her personal experience and story. The representative from the Health Board also recognised the contribution of the stroke survivor and emphasised the need to support the Stroke Association to provide vital services to individuals at home.

Member Scrutiny:

A Member questioned a particularly noticeable dip in performance and it was responded that several slides indicate a dip in performance around the same time. This was attributed to the fact that doctors in the emergency department rotate in August/Sept and also the need to ensure that the new staff know about the stroke pathway, particularly out of hours. It was explained that a dip between December and February is due to general demands within the service when it is difficult to retain beds reserved for stroke patients. It is predicted that these figures will improve.

A Member thanked all participants for their contribution to the meeting and expressed the opinion that the information presented had taken some of the fear away. The Member also provided insight through personal experience of how services have changed over the years and queried if there was a particular time of year where there is higher prevalence of strokes occurring. It was also questioned if a drug was administered in the ambulance within the “golden hour”.

It was explained in response that prior to redesign, there were typically 930 confirmed strokes in Gwent. Around 2000 would present with a suspected stroke (a significant proportion would not have suffered a stroke). It was confirmed that since the services were redesigned, figures have fallen e.g. as not supporting the Powys area and some changes in the Caerphilly area destination hospital to Prince Charles Hospital. There are approximately 750 confirmed strokes a year currently. It was agreed that there will be a difference in the service received if the individual arrives outside the hours of 9.00am-5.00pm and it would be preferable to have a 24 hour service. The improvement is having bespoke team available at the front door. The 7 day core service was put in place as most people arrive at hospital during that timeframe. Every effort is made to ensure that whenever possible, two stroke beds should be available overnight and feedback is constantly provided.

The Director of Operations, Wales Ambulance Service NHS Trust explained how the approach to stroke and heart attack with has changed beyond recognition over recent years. For example, heart attack patients are transported to the Cardiac Lab and not to A and E. Additionally, paramedics can diagnose a heart attack based on ECG findings and administer a clot busting drug if appropriate. Conversely, suspected stroke patients must have a CT scan first before the clot buster drug can be used. The importance of taking patients to hospitals where stroke care is available, ensuring that ambulance crews recognise stroke symptoms and that they ring ahead to the destination hospital was emphasised. It was explained that call takers often have poor information provided by callers and some work to refine information gleaned from callers is needed.

It was explained that another challenge for the service is that there is no pathway in Wales for patients suffering a TIA other than to take them to Accident and Emergency and added that it is better for the ambulance crew to refer the patient to a TIA clinic within 24 hours if the symptoms have resolved. It was reported that patients with all conditions have provided feedback that going to hospital is worrying and that, as there are limited numbers of ambulances available, delays can be reduced through not taking TIA patients to hospital, and e.g. other patients with critical conditions can be prioritised.

A Member explained his involvement with the Stroke Association and expressed his disappointment that no officers from Social Services were present to hear the powerful contributions made at today's meeting, and also urged the Council to consider contributing to the organisation noting the isolation that can be encountered in a very rural community. It was suggested that arrangements are made for the Stroke Association to hold an event for Council employees to include blood pressure testing and to highlighting stress in the workplace.

A Member agreed that Social Services should have been represented at the meeting and insisted that the new Adult Select Committee must continue its focus on Stroke Services and that the Chief Officer, Social Care, Safeguarding and Health, and Stroke Association should meet to discuss collaboration further.

A Member congratulated the performance of the RGH and expressed concern regarding the occurrences when there has been 0% of patients administered with Thrombolysis within 45mins and queried if this was a winter issue. It was answered that the evidence shows that the sooner Thrombolysis is given the better but that additionally, after 3-4 hours, the risks outweigh the benefits. It was explained that a number of elements are monitored e.g. time it is thought stroke occurred to the time Thrombolysis can be delivered and results can rely on factors such as how quickly the call is made, how long the transfer to hospital is and how certain of the time it occurred. It was explained that prior to redesign, it was much less likely that a patient would be seen within 45 mins. The graph referred to demonstrated one element but other elements are also recorded such as door to needle under 30 mins and onset to Thrombolysis. The priority is to assess quickly.

It was suggested that future discussions on this subject should include causes of stroke, prevention, education, key stages such as the vital early attendance of the ambulance, the treatment pathway and rehabilitation.

The Select Committee heard from an Officer from Leisure Services, who was also representing service users (who had been invited to participate but had been unable to attend). It was explained that the aim of the service is prevention and secondary care. Patients who have had a TIA or stroke can be referred from the Stroke Association, GP or physiotherapist to the leisure centre to participate in safe and appropriate exercise. The Exercise Referral Team acknowledge that gyms and leisure centres can be daunting for some people and encourage a friendly and

comfortable environment to provided rehabilitation. It was explained that the team members have exercise after stroke or falls prevention qualifications and are dedicated to improving peoples' lives and reducing the strain on medical services.

The Executive Director of Therapies and Health Science, Aneurin Bevan Health Board emphasised the need for partnership working and good relationships; an offer was made to return to provide an update to the Committee.

The Director of the Stroke Association acknowledged the advances made through research and evidence base. It was explained that "FAST" has been most effective campaign. It was confirmed that research is underfunded, and there was a need to campaign to make stroke a medical emergency and a politically important matter.

Chair's Comments:
The Chair recognised that the Select Committee had considered Stroke Services bearing in mind the needs of Monmouthshire residents. The need to build upon the powerful testimony received at the meeting today was emphasised and it was recommended that a series of suggestions are made to the new council to do so.

3. Welsh Ambulance Service NHS Trust

Key Issues:

Richard Lee, Executive Director of Operations, and Louise Platt, Assistant Director of Operations provided a presentation on the Wales Ambulance Services NHS Trust.

It was explained that the most popular reason to call an ambulance in the UK is related to older persons falling and requiring assistance. Capacity is the biggest challenge. The strategic aims were explained and also the three services lines of Emergency Medical Services and Urgent Care Services (Yellow Ambulance), non-urgent Patient transfer (White Minibuses) and NHS Direct Wales.

It was explained that there is an Ambulance Five Step Model which breaks down the service starting with helping patients choose what service is most appropriate for their needs and also the availability of available alternative services. It was confirmed that, regrettably, trivial calls still come through 999 calls. The second step involves the importance of call takers finding out as much as possible about a patient's condition. It was also explained that paramedics and nurses are also utilised to take calls to filter out those patients that don't need an ambulance, and to prioritise as appropriate.

The third step involves deciding the most appropriate health board service to visit a patient. The fourth is to ensure that the most appropriate treatment is provided and finally the fifth option, the decision to take the patient to hospital.

The Clinical Response Model was explained and details of how priorities are drawn were provided. An example of the response to a Red category call was provided explaining that the first response at the scene will be either a paramedic in a car, the fire service, a community first responder or a Police Community Support Officer; second to arrive will be an ambulance. The Ambulance Service Trust is working hard to ensure that defibrillators are available in every community and sought the support of the Council to secure defibrillators in hard to reach areas; the need for no specific training to operate the equipment was emphasised. It was explained

that, unlike the previously available, lengthy course and expensive machinery, a 20 minute course can now be provided for a machine costing less than £1000.

It was explained that Amber category calls (65% of call volume) are responded to by an ambulance on blue lights. It was explained that the ideal response has been defined for every call and the example was provided of a person suffering a suspected stroke who will be sent an emergency ambulance with a two person crew of emergency medical technicians who can conduct a FAST test, and can convey the patient to the appropriate hospital. A patient suspected of having a heart attack will be sent an ambulance with a paramedic to administer an ECG.

Green calls may not necessarily require an ambulance or for whom their GP has requested an ambulance to transport them to hospital, and will not have a blue light response. These patients may be spoken to over the telephone and asked to make their own way to hospital for treatment to free up the availability of ambulances for emergencies. It was reported that performance for Red life threatening calls are regularly out performing England.

In this area, a 3% increase is forecast in calls per annum over the next 5 years assuming that no changes are made to manage the current types of calls received. This equates to the need to recruit many more staff for which there is no budget. Consequently, actions being taken to reduce demand include:

- Management of frequent callers using a multi-agency approach using targeted intervention plans which has reduced the number of calls made.
- Successfully dealing with more calls over the telephone.
- Working with the Police to set up a joint response unit, where a police officer accompanies the paramedic, which has reduced the demand on ambulances requested by them by 75%.
- Placing clinicians in the Police control room in Bridgend releasing Police Officers waiting for ambulance to resume community work and free up ambulances.

It was explained, in relation to management of elderly falls that a mobile multi-disciplinary team of physiotherapists and occupational therapists with paramedics has been created to attend to elderly people who have fallen. This has enabled more people to stay at home. Additionally, the team carries adaptations such as armchair risers to install to prevent future falls.

Evidence of the effect of actions to reduce demand was provided indicating that 3,349 cases were managed differently. The priority is to ensure that the patients transported to Accident and Emergency are those for whom it will make a difference.

Members Scrutiny

Following the presentation, Members asked questions:

A Member expressed her interest that changes have been made by reorganising services instead of requiring more money, and also disagreed with the resources used dealing with people who have consumed excess alcohol and suggested that a different approach was needed. It was also added that ambulance delays can occur in rural areas due to limited knowledge of the area.

In response, it was confirmed that about one third of callers can be reassured that they can make their way to hospital to arrive quicker for treatment e.g. broken wrist. Additionally, crews are encouraged to assess at the scene if the patient can make their own way to hospital, or can travel by taxi to release the ambulance for emergency cases. It was emphasised that the public

should be aware that being taken to hospital will not necessarily result in being seen quicker unless the ambulance crew phones ahead to alert hospital staff. It was explained that all ambulances are fitted with a Sat Nav but the crews will not necessarily possess local knowledge of routes.

The Chair explained that he had recently worked with the Fire and Rescue Service and all fire engines have automated defibrillators. Firefighters with enhanced medical training can attend some Red calls as first responders for immediately life threatening cases on behalf the ambulance service under "Fire Medical Response" - a UK wide scheme.

A Member enquired if there was a defibrillator in County Hall, Usk and suggested that there should be training for Councillors and Officers. It was also suggested that previously available blood pressure testing should be available for staff and Members. The offer of free defibrillator training was made from the Community Defibrillation Team.

A Member asked if there were any views on the suitability of the Abertillery model working in Monmouthshire and also questioned cross border use of ambulances. In response, it was explained that the fire station in Abertillery needed remodelling so the Police Community Support, Fire and Ambulance Services have been centralised. It was added that the ambulance estate plan has been released for the next five years which proposes a smaller number of larger ambulance stations across Wales with deployment points (which can be fire stations).

The example of Monmouth was provided where the Fire and Ambulance stations will be combined in the Fire Station which is in better state of repair. There has also been a demand and capacity review which may result in e.g. a paramedic car being relocated to Usk to be more convenient.

Regarding cross border ambulance collaboration, it was explained that the ambulances referred to from Bristol were private ambulances due to staff shortages. It has now been decided to stop using these companies in Wales as they are not good value for money and not under our direct control. It was confirmed that Monmouthshire and England borders ambulances swap jobs in pre-planned cross border arrangements and further pooling of resources is under consideration.

The Member explained that there are eight defibrillators in Caldicot and training is awaited.

A Member praised the standard of the report and developments and asked what deterrent was available to deal with hoax calls. It was explained that 700 patients have been dealt with under the frequent callers programme in a supportive way and four have received custodial sentences which could also be linked to abusive behaviour towards staff. A Member observed that easier access to GPs could also provide some resolution of demand on ambulance services.

The Chair asked the Head of Social Care and Health if there were any communication issues with residential care homes such as a need to strengthen the message regarding when, and when not, to call an ambulance. It was responded that a lot of work has been undertaken with the care home sector, health board, social services and individual care homes to address variations in approach, management of symptoms and end of life pathways as well as the correct times to call an ambulance.

An offer was made to provide details of the top ten care home frequent callers in Monmouthshire. The aim for dignified deaths in the patient's home setting was explained. The need for advance care plans for natural end of life was emphasised. It was added that extensive work has been carried out on falls prevention to recognise what actions are needed to reduce the risk of falling and to educate people to move safely in their environment.

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It was requested that the issue of the Grassroutes buses being restricted to 50 miles radius meaning, for example that people in Monmouth can't travel to Chepstow is raised at the forum on Friday as this will particularly affect disabled travellers.

The report regarding Usk Prison elderly inmates was deferred until the next meeting and will also be forwarded to Executive Director of Therapies and Health Science, Aneurin Bevan Health Board and to the Director of Operations, Welsh Ambulance Service NHS Trust.

Chairs Comments

The Chair thanked the representatives of the Wales Ambulance Service NHS Trust for their presentation and comprehensive, reassuring answers to questions.

The Chair commented that the Committee recommended that council buildings should be used to site locate defibrillators. It was strongly suggested that there should be a defibrillator sited in Usk County Hall and appropriate training provided.

The Chair drew the attention of the Head of Social Care and Health to the point that Monmouthshire County Council is not financially supporting the Stroke Association and strongly encouraged that discussions are held with County Councillor A. Easson, Ms. A. Shakeshaft, Executive Director of Therapies and Health Science and Ms. A. Palazon, Director of the Stroke Association regarding this point.

It was also requested that a blood pressure monitoring day is arranged for members of staff.

The meeting ended at 1.16 pm

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