Agenda Item 7

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date:	**11th March 2010**
By:	**Director of Law and Personnel**
Title of report:	**Review of Stroke Care in East Sussex – Progress Report**
Purpose of report:	**To consider progress being made in implementation of the recommendations arising from HOSC's Review of Stroke Care in East Sussex.**

RECOMMENDATIONS

HOSC is recommended:

1. **To consider and comment on the progress report from NHS East Sussex Downs and Weald/NHS Hastings and Rother on behalf of local health and social care organisations (appendix 1).**
2. **To request further monitoring reports in September 2010 and March 2011.**

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1. Background

1.1 In June 2008 HOSC established a Review Board to examine stroke care for East Sussex residents. This topic had been identified as a priority for review by the committee at a work planning seminar.

1.2 Councillors Davies, Healy, Martin and Rogers were nominated to form the Review Board. The Board subsequently agreed to invite co-opted representatives from the County Council's Adult Social Care Scrutiny Committee and the non-executive directors of NHS East Sussex Downs and Weald (ESDW)/NHS Hastings and Rother (H&R) to join the Board. It was felt that these perspectives would add to the review process and help ensure that these groups would gain increased awareness of stroke care issues and the developments required. Councillor Forster from the Adult Social Care Scrutiny Committee and John Barnes, then Chairman of NHS East Sussex Downs and Weald therefore completed the Board's membership.

2. Objectives and scope of the review

2.1 The objective of the review was to assess and make recommendations on the stroke care provided to East Sussex residents, with particular focus on awareness and prevention, provision of acute services and the integrated provision of rehabilitation and long-term support.

2.2 To achieve this, the Review Board:

- Researched public and professional awareness of stroke prevention and care;
- Sought the views of patients, carers and professionals in relation to current stroke services and their views on how services could be improved;
- Examined how stroke services in East Sussex compared to best practice and;
- Researched stroke prevalence and outcomes data for East Sussex, with particular reference to identifying areas of health inequality.

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3. Report and recommendations

3.1 The Review Board's findings and recommendations were outlined in the final report which was endorsed by HOSC at its meeting in March 2009. The report has therefore previously been

circulated to the Committee and it is available on the HOSC website www.eastsussexhealth.org or on request from Claire Lee on 01273 481327 or claire.lee@eastsussex.gov.uk.

3.2 HOSC requested a response to the recommendations from NHS ESDW/NHS H&R who had agreed to co-ordinate the responses from other local health and social care organisations through the multi-agency East Sussex Stroke Programme Board which was being established. The response was received by the Committee in July 2009. All the HOSC recommendations were accepted and were integrated into the various workstreams overseen by the Programme Board. These workstreams also incorporated a large number of other recommendations arising from national and local reviews, notably the National Stroke Strategy Quality Markers.

3.3 The Stroke Programme Board invited HOSC to nominate a Member to join the Board in order to oversee progress on implementing the East Sussex Stroke Strategy. Cllr Davies agreed to take on this role, as Chairman of the HOSC Review Board on Stroke Care. The role does not involve participating in decisions of the Programme Board as this is not the role of HOSC. Cllr Davies attends in an advisory and observational capacity.

4. Progress update

4.1 Jane Strong, Programme Lead for Stroke and Long Term Neurological Conditions, NHS ESDW/H&R has provided an update on progress with the HOSC recommendations. This is attached in tabular format at appendix 1. The table shows the original response in July 2009 and the current situation in March 2010. Jane and her colleague Nicky Murrell, Assistant Director of Projects, will be in attendance at the HOSC meeting to present the update and take questions.

5. Issues to consider

5.1 HOSC may wish to clarify aspects of the progress update or further explore progress on specific recommendations, for example:

- What will be the full benefits of introducing the SYNAP database for follow-up care (as mentioned under recommendation 3)? Are GPs fully engaged in this work?
- How will the impact and coverage of the vascular health check programme be assessed? (recommendation 4)
- How will the 24/7 stroke thrombolysis service be delivered from April 2010? (recommendation 5)
- The agreement of a revised service specification for stroke appears to be a major step forward – what is the timescale for providers to be fully adhering to the revised specification? (see recommendation 5 – specification to be agreed in April)
- What benefits have there been from the closer links with Care for the Carers and the Stroke Association mentioned under recommendation 6?
- Provision of sufficient community rehabilitation to enable timely discharge from acute care appears to be an ongoing challenge – how is this being addressed in the short and longer term?
- How will the introduction of the acute stroke module at Brighton University begin to benefit levels of staff expertise? (recommendation 9)
- What are the aims of the community support service provided by the Stroke Association and does it cover the whole of East Sussex? (recommendation 16)

ANDREW OGDEN
Director of Law and Personnel

Contact officer: Claire Lee, Scrutiny Lead Officer
Telephone: 01273 481327

Background paper: Review of Stroke Care in East Sussex: Final Report, HOSC, March 2009.

Appendix 1

HOSC Review of Stroke Care - Response to Recommendations – update 11th March 2010 HOSC

Recommendation		To	Response in July 2009	Timescale	March 11 2010
1	**The public need to be more aware of:** **a) The causes of stroke and what the public can do to reduce risk.** **b) The symptoms of stroke and that calling 999 is the normal action to take on suspecting a stroke.** **The national awareness campaign is welcome but must be complemented by local, targeted work co-ordinated by the PCTs and involving a range of local agencies (e.g. Older People's Partnership Board). The findings from the awareness survey should be used to inform this work.**	NHS East Sussex Downs and Weald (ESDW)/NHS Hastings and Rother (H&R) and partners	**Accepted – Work Stream 1** East Sussex PCT's are working in conjunction with ESHT and Pfizer in delivering a local awareness campaign for September/October 2009. This will be in advance of the next phase of the national campaign which will be in November 2009. It will particularly target the 20 most deprived wards, where rates of stroke are highest.	. Oct 09	Work Stream 1 In September/October 2009 the 20 most deprived wards in East Sussex were targeted for the leaflet drop. The impact of this has been difficult to assess however, anecdotal evidence from the Acute Trust is that patients admitted with 'stroke like' symptoms are recognising that it could be a 'stroke' from the national and local campaigns.
2	**GPs and other front line health and social care professionals need to be more effective at recognising stroke and ensuring an emergency response. It is recommended that the PCTs and Adult Social Care consider ways to increase awareness and training for community and primary care staff and ensure that clear protocols are available and followed.**	NHS ESDW/NHS H&R GPs Adult Social Care	**Accepted – Work Stream 1** As part of the local awareness campaign, it is planned that all front line health and social care staff will be receiving information around the FAST campaign.	Oct 09	Work Stream 1 South East Coast Ambulance Service (SECAmb) are reporting that 97% of patients with 'stroke like' symptoms are assessed using the FAST test. This concurs with findings at the Acute Trust in patients who have 'typical/obvious' stroke syndromes. The programme of education continues within SECAmb. Awareness training in recognising onset of stroke and Transient Ischaemic Attack (TIA) is continuing throughout the Acute Trust and community

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					services. A direct access policy to the stroke unit is aiding this process and work will continue until the practice becomes fully established.
3	**A robust pathway for follow-up care/secondary prevention should be put in place to ensure that all stroke and TIA patients receive regular checks, information and advice in line with National Stroke Strategy standards. This should include the maintenance of robust and consistent registers of stroke and TIA patients at all GP practices.**	NHS ESDW/NHS H&R GPs	**Accepted – Work Stream 1& 2** We have just started working with the Sussex Stroke Network to develop a Sussex -Wide Stroke register that will cover the whole pathway. The first meeting of this group will be on the 23rd July 09. Agreed data, which can be compared nationally and used to measure and improve quality, will be collected during the acute phase, rehabilitation, 6 week, 6 month and annual reviews. This will be fully accessible in primary care. Specialist TIA clinics (including reviews) have been commissioned. Problems with the recruitment of nurses to support these clinics have delayed a full launch, but this has now been resolved.	Ongoing Timescale to be agreed by Sept 09	**Work Stream 1 & 2** Work within this area has been slower than anticipated, as the data group (part of the Sussex stroke Network) have been awaiting the draft version of SYNAP (an electronic data base). The work is now gaining momentum as the proforma has been finalised and a pilot is planned for the summer. This electronic data base can be used to monitor and ensure that all patients receive the necessary follow up. Specialist TIA services: both TIA nurses are now in post (November 09) and clinics are running. There has been some difficulty around data collection for TIA services (Q1-Q3), due to staffing and procedures, which has led to insufficient data being provided. However manual data collection is planned in March 10. It is anticipated that by Q4 the data will be collected as part of the process/service and that we should achieve the national target of 60% of high risk

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					patients seen within 24hrs. Systems are now in place for onward collection of TIA data
4	**A mechanism should be put in place to identify those at higher risk of stroke on practice based 'at risk' registers to ensure regular health checks and preventative medicine.**	NHS ESDW/NHS H&R GPs	**Accepted – Work Stream 1** New vascular health checks are being implemented in primary care across both East Sussex PCT's, These will support other QOF targets in ensuring the proactive management of all patients at risk. The Sussex heart network is also continuing some pilot work with GP surgeries in improving identification of those people with Atrial Fibrillation (a significant risk factor for stroke) and subsequently reviewing their treatment plans	Dec 09	**Work Stream 1** A LES (Local Enhanced Scheme) is now accepted in both ESDW and H&R & Q-Risk Calculator software licenses are now available for non- Emis GP practices to enable patient detection/management. The uptake of health checks is good with 31 out of 33 surgeries signed up in H&R and 33 out of 44 in ESDW. The plan is to get all practices on board and active as quickly as possible which in turn will improve performance. Prescribing preventative medications improves outcomes for patients identified with vascular risk. By March 2011it is planned that 70% of at risk patients will have been checked and be prescribed statins and ace inhibitors. Pulse taking at cardiovascular disease (CVD) checks can identify atrial fibrulation (AF - rapid irregular pulse) and a 5% improvement is planned across individual practice level. The CVD group has decided due to the success of opportunistic pulse taking at the GP surgery in an attempt to identify AF, that a pulse check

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					should form part of CVD check. This will link in with the personalised care plan for each patient with a long term condition. (march 11)
5	**When moving towards 24 hour acute stroke services, progressing the full range of specialist care is essential. This should include, but not be dominated by, 24 hour access to thrombolysis, as thrombolysis will only be appropriate for around 10% of patients.**	Sussex Stroke Network NHS ESDW/NHS H&R Hospital Trusts	**Accepted – Work Stream 2** Both ESHT sites (Conquest and DGH) are offering thrombolysis, Monday-Friday 9-5. A paper outlining the proposals for 24 hour thrombolysis across the whole of Sussex was agreed in March 09 subject to affordability and sustainability. Costed detailed proposals for implementation will be available in summer 09. 24 hour thrombolysis will be available by 2010. The focus has also been on improving hyper acute stroke management for all patients, including those that will not be suitable for thrombolysis and a draft service specification is attached covering the acute care phase.	Jan 2010	**Work Stream 2** In line with the Strategic Health Authority (SHA) pledge we are on schedule to deliver 24/7 thrombolysis by 1st April 2010 on both acute sites. This will be achieved within the best practice tariff for stroke and puts us in a unique efficiency position within Sussex. The service specification for stroke has now been significantly revised providing more detail of how the service and clinical pathway will be delivered from prevention through to life after stroke. This now includes clear pathways and service quality markers. It is anticipated that this will be signed off by the Stroke Programme Board in April and form part of new contracts with providers. It also contains the performance management framework for stroke
6	**The PCTs should commission for the provision of all diagnostic investigations for stroke patients to National Stroke**	NHS ESDW/NHS H&R	**Accepted – Work Stream 2** The main diagnostic test for	March	**Work Stream 2** There is still some difference

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93	**Strategy standards well ahead of the Strategy's 10 year timescale. Patients (and carers as appropriate) should be informed of the outcomes in a way they can understand.**	Hospital Trusts	someone who has experienced a stroke is a CT scan. It is recommended that all stroke survivors have a scan within 24 hours of experiencing symptoms. In the sentinel audit 2008 this was only attained in 36% of patients at the Conquest and 46% at the DGH. This measure has been chosen as one of both PCT's CQUIN (Commissioning for quality and innovation) measures for this financial year and subsequently we are looking to see a significant improvement. The hospital trust (ESHT) is also developing an electronic data capturing system for stroke and TIA patients which will help improve performance Improving communication with patients and their families, lies at the heart of all work streams and will be included within the detailed action plans currently being developed.	2010	between scanning times at the two sites at ESHT and work is continuing to share and improve practice. Scanning times are continuing to improve and it is anticipated that by Q4 we will be in line if not a little above the agreed SHA target of 70% of patients being scanned within 24hrs of admission from current position of 66%. A score card has been introduced which allows instant electronic access to the most recent activity data, covering stroke and TIA. At the moment this data collection is manual. The new system will allow closer monitoring of performance. Closer links with Care for the Carers and the Stroke Association have been established, improving communication pathways and information flows with carers and patients. Currently work is underway to link in with other activity such as the Improving Life Chances strategy implementation, which is aimed at empowering patients and carers.
7	**All stroke patients' discharge from hospital should be managed by the multi-specialist stroke unit team. There should**	Hospital Trusts	Accepted – Work Stream 3 Following on from the East Sussex wide stroke strategy, we	To be agreed at	The service specification has been reviewed and will be

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94	**be a protocol in place to ensure this happens even if, in exceptional circumstances, a patient is on another ward prior to discharge, so that they have the same access to community stroke services as patients discharged from the stroke unit.**		are now in the process of developing a new service model for community rehabilitation: The current average length of stay in the acute units will be halved to 10 days. There will be two dedicated neuro-rehabilitation units. These will be mostly stroke beds but will also take people with other neurological conditions that require similar intensive rehabilitation. In addition there will be 3 community neuro-rehabilitation teams supporting stroke survivors and their families in the community. For H&R there will be one team and the specialist beds will be at the Irvine Unit. For ESDW PCT there will be 2 teams that will ensure full coverage of the PCT. The location of the inpatient unit has yet to be agreed. The community teams will in reach to ensure a smooth discharge to either community teams or beds and the acute trusts will ensure that discharge planning will start within 48 hours of admission.	programme board in Sept 09	finalised by the end of March, Discussions are ongoing with providers regarding inpatient rehab and community service provision. Step-wise change has already commenced for End of Life care for people who have had strokes. It is likely that improved TIA services and 24/7 thrombolysis will result in less patients requiring continued inpatient rehab. We are currently scoping a position/needs analysis at day 10 of the patient's journey. We are also currently in discussion with ESHT and ESCST around criteria for entry to community in patient beds. These will form part of an options appraisal for provision of care from day 10 onwards. It is anticipated that a draft of this appraisal will be discussed at the stroke programme board in April: agreed in principle and then circulated more widely for consultation.
8	**Rapid access to the specialist stroke team is crucial. Acute Trusts should have strategies in place to proactively 'pull' stroke patients into their stroke units. Ideally, there should be a dedicated A&E bay for stroke, a stroke co-ordinator monitoring admissions to ensure they**	Hospital Trusts	**Accepted - Work Stream 2** It is extremely important that wherever possible all people with a stroke are admitted directly from A&E to a specialist acute stroke unit and not onto other wards.	2010/2011	**Work Stream 2** Currently the Trust achieves approximately 60%of patients having direct admission to stroke units. We are currently seeking to create more capacity within community services to support

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	reach the stroke team and all stroke patients should be allocated to a stroke specialist consultant who will oversee their care.		By reducing overall length of stay we will be aiming to ensure that at least 90% of stroke patients are directly admitted into an acute stroke unit		discharge at 10 days. Achieving this priority is of great importance so work will continue to ensure this target is met.
9	**Urgent action should be taken to remedy all staffing shortages and to bring staffing standards up to National Stroke Strategy guidelines.**	NHS ESDW/NHS H&R Hospital Trusts	**Accepted - All Work Streams** We also need to ensure the staff are all equipped with the skills needed to provide high quality stroke care. The new national stroke specific education framework will support us in this.	ongoing	Recruitment within this sector is nationally difficult. However with the advent of thrombolysis, more interest in this field may develop. Education is crucial to ensure staff have the skills, particularly in the care of thrombolysed patients, and community care for profoundly disabled and acute patients. Training is ongoing in both hospitals to bring current staff up to the national guidelines. The stroke specific framework is forming the basis of this education. The Stroke Network has regular clinical forums, which are well attended by Acute and Community staff. Brighton University launched their acute stroke module Feb 2010 which has been designed following consultation with experienced practitioners. This forms part of the service specification requirements. It is possible that education/knowledge and skill mix could be a Commissioning for Quality and Innovation

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					(CQIN) measure in the future, which will only assist this fundamental requirement.
10	**Patients should have access to a phased process of rehabilitation, including availability of inpatient rehabilitation between the acute and community care settings. The PCTs should commission additional and improved community inpatient rehabilitation. This should support consistent access and standards across East Sussex, based on analysis of need.**	NHS ESDW/NHS H&R	**Accepted - Work Stream 3** Please see response to number 7		The work stream plans and service specification have been designed to meet the needs of the patients and carers. The options appraisal which is underway will give us the overall view of what needs to be provided. The first draft of this will be completed by April.
11	**There must be options available for longer-term rehabilitation. A pathway for patients requiring 'slow-stream' rehabilitation should be developed, supported by appropriate bed provision based on needs analysis.**	NHS ESDW/NHS H&R	**Accepted - Work Stream 3** This is very important. There will be some stroke survivors for whom it is not always appropriate to be admitted into the specialist rehabilitation units and also not to stay in the acute stroke units. A new pathway will be developed to enable these people to access appropriate care closer to home, whilst also being monitored and accessing specialist rehabilitation if needed.	2010 Detailed plans to be agreed Sept 2009	The patients journey through the pathway will be dictated by the need of the individual. Service options will provide a robust yet flexible pathway. These are included in the options appraisal and service specification for slow stream rehab. It is anticipated that when the phased approach is completed that patients will be able to access step up, down and sideways services, to ensure their needs are met adequately.
12	**The Sussex Stroke Network should consider the provision of a Sussex-wide service for young stroke survivors and those needing specialist rehabilitation. Longer travel times may be necessary for such specialist care but the need to travel**	Sussex Stroke Network	**Accepted - Work Stream 2 & 3** We will be working with the network, to ensure that all people in East Sussex who experience a stroke have appropriate rehabilitation opportunities. We	2010 Detailed plans to be agreed	**Work Stream 2 & 3** Please see response to 7, 8,9,10 as the needs of all stroke patients will be addressed by overall plans for stroke

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	outside Sussex should be avoided.		are also working closely with the new Sussex rehabilitation centre at PRH and with the development of specialist community rehabilitation units and teams, more younger stroke survivors will be able to access appropriate rehabilitation for their needs within Sussex	Sept 2009	rehabilitation.
13	**The debate on whether stroke or neurological community rehabilitation team models are best practice should be resolved. A consistent patient pathway and model of community rehabilitation for stroke patients should then be introduced across East Sussex. Priority should be given to the north of the county which currently has no specialist service. Additional resources will be required to enable existing teams to meet demand, to expand their remit if appropriate, and to establish a team in the north.**	NHS ESDW/NHS H&R	Accepted - Work Stream 3 The East Sussex wide stroke strategy and the Sussex neuro-rehabilitation strategic commissioning framework has set out a vision for specialist neuro-rehabilitation teams Sussex - Wide. We are now developing a service specification for these teams which will cover the whole of East Sussex as described previously.	Agree-ment at Septem-ber program-me board.	Work Stream 3 As for 12
14	**Community neuro-psychologist/psychological counsellor roles should be developed to provide rapid response to referrals from community teams and inpatient units.**	NHS ESDW/NHS H&R	Accepted - Work Stream 3 We have met with the Sussex Lead psychologist. It is important to have psychology support in the community and to each of the neuro-rehabilitation teams. The psychologists should be able to in-reach to the units but be based in the community to support stroke survivors and their families over the longer term. The psychologists will also support staff in the teams and the volunteers recruited to provide	2010 Detailed plans to be agreed Sept 2009	Work Stream 3 Currently undertaking costing exercise/needs analysis. No formal agreement has yet been made. Peer support is available through The Stroke association and Different Strokes. Roll out of 'Improved Access to Psychological therapies' in

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			peer volunteer schemes and facilitate the exercise and education schemes.		community and primary care led by Mental Health Commissioners is underway
15	**A county-wide approach is needed to cope with deterioration or crises. This should incorporate clear information for patients and carers on what to do and availability of rapid response, short-term, nursing and social care.**	NHS ESDW/NHS H&R Adult Social Care	**Accepted - Work Stream 3 & 4** We need to ensure that if needed stroke survivors and their families are able to access appropriate services including further rehabilitation as required. All stroke survivors will be offered an annual review and as part of this review they will be encouraged to update their personal care plan, this will include named contacts for rapid response.	2010 To be agreed in Sept 09	**Work Stream 3** The patient's journey through the pathway will be dictated by the need of the individual. The service will provide a robust yet flexible pathway. This is included in the options appraisal and service specification, it is anticipated that when the phased approach is completed that patient will be able to step up, down and sideways, to ensure their needs are met adequately.
16	**On returning home or to residential care, patients and carers should have access to a single contact point (a 'helpline') for questions or concerns about their condition or care. This must be available on an ongoing basis, not just while receiving rehabilitation and advice should be available from specialist, qualified staff.**	NHS ESDW/NHS H&R	**Accepted - Work Stream 3** All stroke survivors and their families will be given a clear single contact point when returning home. After their specialist rehabilitation phase, they will be supported by the new community support service and will be offered both an 8 week course in a local venue and also peer volunteer support. These services will be coordinated by a local paid support worker employed by the third sector who will be the point of access. This person will be located with each of the specialist neuro-rehabilitation teams to ensure seamless transfer of care.	2010 Detailed plans to be agreed once tendering process completed	**Work Stream 3** The new community support service provided by the Stroke Association has now commenced, and provides a single contact point for people, and includes befriending, education, signposting and some exercise regimes.

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17	**Support commissioned from the voluntary sector should be on a county-wide basis, and ensure that *all* stroke patients are identified and assisted to access support if required.**	NHS ESDW/NHS H&R Adult Social Care	**Accepted - Work Stream 4** All stroke survivors will be offered peer volunteer support, a community stroke scheme (8 weeks in a local venue and comprising of exercise and interactive education, including support for carers) Those people with communication problems will be offered additional support. This new service has been commissioned East Sussex wide. It is envisaged that there will be 3 paid support workers who will coordinate these services and they will each be based with the specialist neuro- rehabilitation teams	2010 Detailed plans to be agreed once tendering process completed	As Above. All staff have now been recruited and are undergoing, the induction programme. Patients will be able to access the service, through many sources: GP, self referral, therapist or social worker. The stroke support service have also agreed to take referrals for High risk TIA patients.
18	**HOSC should develop a plan to ensure the findings of this review are shared widely with key groups in East Sussex.**	Health Overview and Scrutiny Committee (HOSC)	Accepted – a communications plan was developed following the HOSC meeting in March 2009. The plan has largely been implemented and will be completed by August 2009. Any further opportunities will be taken up and recorded on the plan as and when they arise.	By August 2009	Completed
19	**Mechanisms should be established to ensure the ongoing active involvement of patients and carers in the implementation and evaluation of the stroke strategy. The Health Overview and Scrutiny Committee should indicate its willingness to participate in this process.**	NHS ESDW/NHS H&R	**NHS ESDWH&R response:** **Accepted – All Work Streams** We are really keen to continue the active involvement of stroke survivors and their families and carers in this redesign. A proposal for ongoing engagement will be discussed at the next stroke programme board.	**NHS ESDW/H&R action**: To be discussed at stroke programme board Sept 09	The community support service has been requested to collect and collate patient feedback on the whole patient journey. They will be compiled quarterly and sent to the stroke work stream leads. Any problems can then be addressed. Once the strategy has been fully implemented, it is planned that

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		Health Overview and Scrutiny Committee	The Sussex stroke network is also proposing to set up a patient/carer forum and this will link with local engagement plans. **HOSC response:** Accepted – HOSC agreed its willingness to participate by adopting this recommendation in March 2009. Cllr Davies has agreed to joint the Programme Board on HOSC's behalf.	**HOSC action**: complete	the work stream leads meeting will reform as the local clinical forum as part of the overarching clinical governance for the service. The stroke Network is also undertaking some work around patient and public engagement/involvement which will underlie the work being completed locally. Cllr Davies has attended the stroke programme board since last July. And is involved in regular correspondence.
20	**HOSC should monitor progress against the recommendations in this report, and wider aspects of the PCTs' stroke strategy in 6, 12 and 18 months from its publication. The Committee should make use of the South East Coast stroke dashboard as part of this monitoring.**	Health Overview and Scrutiny Committee	Accepted – time will be set aside at HOSC meetings in March and November 2010 and June 2011 for monitoring reports to be considered.	To be completed by June 2011	March 2010 report as above