Agenda Item 9

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date:	**16th September 2010**
By:	**Director of Governance and Community Services**
Title of report:	**Review of Stroke Care in East Sussex – Progress Report**
Purpose of report:	**To consider progress being made on 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 a further monitoring report in March 2011.**

1. Background

1.1 In June 2008 HOSC established a Review Board to examine stroke care for East Sussex residents. 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. Report and recommendations

2.1 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.

2.2 HOSC received a response to the recommendations in July 2009 from NHS East Sussex Downs and Weald/NHS Hastings and Rother 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. All the HOSC recommendations were accepted and were integrated into the various workstreams comprising the East Sussex Stroke Care Strategy, 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.

2.3 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.

3. Progress updates

3.1 In March 2010, HOSC received the first update on progress with implementing the recommendations arising from the review, and the implementation of the wider stroke strategy. HOSC welcomed the progress which had been made, including improvements in the availability of scanning, the introduction of 24/7 thrombolysis (clot-busting drugs) at Eastbourne and Hastings

hospitals from 1 April 2010, and national and local awareness-raising work through the FAST campaign. HOSC also noted that vascular health checks were being rolled out through GP surgeries and work was ongoing to develop plans for improving the availability of specialist community and inpatient rehabilitation. A key challenge at that time was the recruitment of suitably trained staff to support stroke services across the county.

3.2 Jane Strong, Programme Lead for Stroke and Long Term Neurological Conditions, NHS East Sussex Downs and Weald/Hastings and Rother, has provided a further update on progress with the HOSC recommendations. This is attached in tabular format at appendix 1. The table shows the last update in March 2010 and the current situation in September 2010 to enable HOSC to track progress. Jane and her colleague Nicky Murrell, Assistant Director of Strategy, will be in attendance at the HOSC meeting to present the update and take questions.

4. Issues to consider

4.1 HOSC may wish to clarify aspects of the progress update or further explore progress on specific recommendations. The Committee could concentrate particularly on the development of rehabilitation, as this has been an area of focus since the last update, for example:

- How early supported discharge is being developed to facilitate timely discharge to appropriate rehabilitation
- How the model for rehabilitation will cater for a broad range of need - for example, patients requiring long-term 'slow stream' rehabilitation and younger stroke patients
- What the role of the Irvine Unit in Bexhill will be, within the overall model for rehabilitation, and what will make it a 'centre of excellence'.
- Whether psychological support will be available as part of inpatient rehabilitation.
- How specialist stroke care will be provided within a generic rehabilitation team approach.
- Whether sufficient staff with the required specialist skills are available to support the new model of care.
- How the outcomes for stroke patients will be evaluated to ensure the effectiveness of the new approach to rehabilitation.

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

HOSC Review of Stroke Care - Response to Recommendations – update 16th September 2010 HOSC

HOSC Recommendation		Last update in March 2010	**September 2010 Update**
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.**	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.	Early reporters of stroke symptoms continue to rise within the acute hospitals allowing patients to be seen and treatment to commence within 3hrs. Many patients or those who engage help are reporting being more aware of stroke symptoms. Although no robust data is available anecdotal evidence suggest that more than 60% of those who raise the alarm quickly do so due to their increased knowledge due to the 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.**	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 services. A direct access policy to the stroke unit is aiding this process and work will continue until the practice becomes fully established.	South East Cost Ambulance service (SECAmb) continues to report 97% of patients with stroke like symptoms are assessed using the FAST test. Awareness training continues with SECAmb, GPs and hospital staff to ensure they are able to assess patients with stroke like symptoms rapidly. Education is now underway with community and adult social care teams to increase their knowledge and symptom recognition. The direct access policy is now in place within the Acute Trusts, which is enabling the vast majority of patients to go directly to the stroke units

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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.**	**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 patients seen within 24hrs. Systems are now in place for onward collection of TIA data	Alongside the stroke network we are working to adopt the SYNAP data base. Currently Brighton are a pilot site, this is discussed at the clinical forum. It is envisaged that when the final format for data collection has been agreed, it will be rolled out throughout Sussex. TIA services have continued to improve, 86% of high risk TIA patients are now seen and treatment commenced within 24hrs of onset of symptoms. This exceeds the NHS vital sign target of 70%. Reported reasons for TIA patients not being seen within 24hrs are consistent – some patients choose not to accept the appointment. Further work and analysis is to be undertaken to understand and resolve this issue. BSUH year to date performing at 59%, however improved to 79% at June 2010
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.**	**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	Health checks are in place across primary care and to date over 10,000 vascular health checks have been carried out in higher risk patients. Medicines management is currently part of the PCTs' transformation programme. This will

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		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 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)	review and promote the use of preventative medication, and the programme is due to complete March 2011. The work of the Cardiac and Stroke transformation teams are working closely with GPs to ensure early identification of stroke risk factors (particularly an irregular pulse) to ensure that robust pathways are in place to deal with the outcome of these checks
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.**	**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 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.	Thrombolysis 24/7, is now fully implemented in East and Mid Sussex. To date there have been no patients suitable for thrombolysis out of hours, however many have been assessed for suitability. A new model of stroke care has been agreed by the stroke programme board and is now the major part of the stroke transformation programme. Currently work is underway to ensure that areas, (particularly specialist care in the acute phase and provision of early specialist rehabilitation) identified as a priority within the new model are correctly resourced, with regard to levels of staff and training. Currently the PCT is engaged in the stroke transformation programme which has identified this part of the pathway as a priority

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6	**The PCTs should commission for the provision of all diagnostic investigations for stroke patients to National Stroke 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.**	**Work Stream 2** There is still some difference 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.	Stroke scanning times continue to improve. Currently 75% of patients are scanned within 24hrs of admission at ESHT and 78% of patients at BSUH The Scorecard continues to be utilised by both the Acute Trust and the PCT, it has provided many occasions for quick fix solutions to be implemented to improve both quality and performance. Work in this area continues with the Stroke Association now being represented on the Stroke Programme Board. The Stroke Programme Board regularly report to the Improving Life Chances board to ensure that changes made to the service are inline with their work.
7	**All stroke patients' discharge from hospital should be managed by the multi-specialist stroke unit team. There should 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.**	**Work Stream 3** The service specification has been reviewed and will be 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	A new stroke service model has been agreed, and service specifications reflect the model, however some finer detail will need to be added particularly around early supported discharge as the programme moves forward. End of life care stroke patients are now routinely offered end of life care beds.

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		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.	A major change programme is underway to reduce average length of stay in the acute unit from 25 days to 10. Initial scoping has been completed to understand the staffing levels and criteria required to deliver this. A review of patient flows against the criteria is underway. It has been agreed that the centre of excellence for community stroke services will be the Irvine unit at Bexhill. The changes will be implemented in a phased approach which will see an average length of acute stay gradually reduce to 10 days by April 11 at the latest
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 reach the stroke team and all stroke patients should be allocated to a stroke specialist consultant who will oversee their care.**	**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 discharge at 10 days. Achieving this priority is of great importance so work will continue to ensure this target is met.	ESHT continues to achieve approximately 60% of patients having direct admission. Currently 48% of patients spend 90% of their in patient stay in the stroke units. This has improved from 21% in April 2009 but must reach the standard of 80% of patients remaining in a stroke unit for 90% of their stay. This unlikely to improve until more capacity is provided in the community, thus reducing average length of stay and increasing capacity in the acute units. (see above) It is anticipated that this will be fully achieved by May 2011 At BSUH 71% of patients spend 90% of their time on the stroke unit
9	**Urgent action should be taken to remedy all staffing shortages and to bring staffing standards up to National Stroke Strategy guidelines.**	**All Work Streams** Recruitment within this sector is nationally difficult. However with the advent of thrombolysis, more interest in this field may develop.	Recruitment into the acute units is beginning to improve. The vision agreed in principle between provider units is that staff will rotate throughout the whole

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		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.	pathway (Acute, community beds and community teams). This will allow all staff have an appreciation of all areas of the service, and increase knowledge skill and experience.
		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.	Training continues in all areas.
		The Stroke Network has regular clinical forums, which are well attended by Acute and Community staff.	The stroke network regularly notifies all areas regarding regional and national training.
		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.	Several staff have attended this module, which will run again this September.
		It is possible that education/knowledge and skill mix could be a Commissioning for Quality and Innovation (CQIN) measure in the future, which will only assist this fundamental requirement.	These are yet to be confirmed, however many of the key performance indicators in the draft service specification are based around knowledge and skills.
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.**	**Work Stream 3** 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.	The model that has been agreed around early discharge into rehabilitation as described above will be commissioned and will meet the rehabilitation needs of all stroke patients. This will take a phased approach with a planned start in October/Nov 2010 The model ensures that patients who are in rural areas or on the boarders can access services equitably.
11	**There must be options available for longer-term rehabilitation. A pathway**	**Work Stream 3**	

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	for patients requiring 'slow-stream' rehabilitation should be developed, supported by appropriate bed provision based on needs analysis.	The patient's 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.	The needs of all stroke patients will be met within the new model, which is needs-led based on goal orientated care. Patients will be able to access the rehabilitation service at a time when most benefit will be gained. All patients will be able to access the life after stroke programme offered by the Stroke Association, which will enable them to continue their rehabilitation and support life long if required.
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 outside Sussex should be avoided.**	**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 rehabilitation	Please see response to 7, 8,9,10 as the needs of all stroke patients will be addressed by overall plans for stroke 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.**	**Work Stream 3** As for 12	As for 12
14	**Community neuro-psychologist/psychological counsellor roles should be developed to provide rapid response to referrals from**	**Work Stream 3** Currently undertaking costing exercise/needs analysis.	Peer support is available through The Stroke Association and Different Strokes. Roll out of 'Improved Access to Psychological

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	community teams and inpatient units.	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 community and primary care led by Mental Health Commissioners is underway	Therapies' in community and primary care led by Mental Health Commissioners is underway and stroke patients can access this service via their GP
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.**	**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.	The model allows access back into the service which is most appropriate, either to stroke or more generic community services, dependant upon the need. Within the community model, stroke will be integrated within general rehabilitation teams whilst remaining specialist in its provision. This unique approach allows patients and carers the opportunity to access a wider range of services.
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.**	**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.	The community support service has been functioning for just over six months however full capacity of the service has not yet been reached, and this has allowed the service to mature and develop, with staff and volunteers gathering knowledge and skill. It is envisaged that as patients leave the Acute Trusts earlier, the use of the service will spiral.
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.**	**Work Stream 4** As Above. All staff have now been recruited and are undergoing, the induction programme. Patients will be able to access the service,	As Above. Pathways are in place to ensure smooth transition from health staff to community support services

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		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.**	Completed	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.**	**All Work Streams** 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 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 July 2009.	The Sussex Stroke Network has patient representation on its Board and individuals are also involved in various sub projects and work streams. The community support teams provide patient feedback, to the programme lead regarding patient evaluation of stroke services. Each of the Trusts have a patient forum, it is planned that the rehabilitation unit (Irvine) will also run a patient and carer forum.
20	**HOSC should monitor progress against the recommendations in this report, and wider aspects of the PCTs' stroke strategy**	March 2010 report received. Updates scheduled for September 2010 and March/June 2011.	Further update March/June 2011