Agenda Item 7

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date:	**8th March 2012**
By:	**Assistant Chief Executive**
Title of report:	**Stroke Care in East Sussex – Progress Report**
Purpose of report:	**To consider progress with implementation of the recommendations arising from HOSC's Review of Stroke Care in East Sussex and wider stroke strategy**

RECOMMENDATIONS

HOSC is recommended:

1. **To consider and comment on the progress report from NHS Sussex on behalf of local health and social care organisations (appendices 1-4).**
2. **To request a further progress report in March 2013.**

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.

1.2 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 .

1.3 All the HOSC recommendations were accepted and were integrated into the various workstreams comprising the East Sussex Stroke Care Strategy. The strategy also incorporated a large number of other recommendations arising from national and local reviews, notably the National Stroke Strategy Quality Markers.

2. Progress update

2.1 HOSC last received a report on progress with stroke care in June 2011. NHS Sussex has provided a further update on progress with the HOSC recommendations and wider stroke strategy (attached at appendix 1). This report has been produced with input from East Sussex Healthcare NHS Trust, the Sussex Stroke Network and Adult Social Care.

2.2 Sarah Blow, Interim Chief Operating Officer and Alistair Hoptroff, Programme Lead for Stroke and Long Term Neurological Conditions from NHS Sussex, together with Dr James Wilkinson, Divisional Director, Flowie Georgiou, Associate Director – Unplanned Care and Jenny Darwood, Clinical Service Manager – Stroke from East Sussex Healthcare NHS Trust will be in attendance at the HOSC meeting to present the update and take questions.

SIMON HUGHES
Assistant Chief Executive, Governance and Community Services

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

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

Appendix 1

Progress on implementation of recommendations for Stroke Care in East Sussex

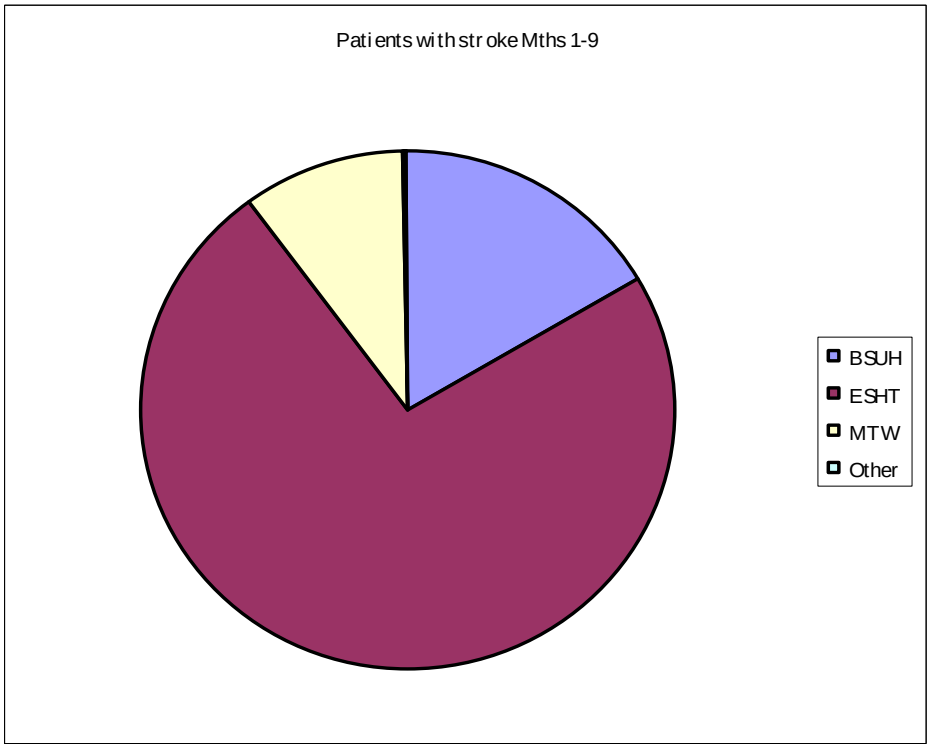
8th March 2012

1.0 Background

1.1 HOSC last received an update on strategies for improving stroke services, including implementing HOSC's recommendations, in June 2011.

1.2 This paper aims to provide a further progress report on the actions taken over the past eight months, and wherever possible to report directly on actions that were then being planned.

1.3 East Sussex residents access stroke services from a broad portfolio of providers some of which provide countywide services with other services provided for defined regions within East Sussex. The pie chart bellows shows the proportion of our residents accessing acute health services following a stroke.



East Sussex Healthcare NHS Trust ("ESHT") is the county's principal acute provider with Maidstone and Tunbridge Wells NHS Trust ("MTW") serving those in the north of the county and Brighton and Sussex University Hospitals ("BSUH") NHS Trust serving those in Havens and Lewes. The majority of community services are county-wide although currently the Early Supported Discharge and the Irvine Community Stroke Rehabilitation Beds are earmarked for ESHT's acute stroke patients.

1.4 Progress on delivering the actions agreed following the peer review of stroke services has been slow with the result that a Performance Notice was served on ESHT in December 2011 (attached as Appendix 2). In response, ESHT have agreed

with commissioners a further action plan (attached as Appendix 3). This report will summarise the progress made since December 2011 as well as the performance for the first period from April to the end of September 2011. Where helpful, supplementary data and reports will be drawn on to inform HOSC of performance in recent months.

1.5 This progress report is structured around the four workstreams that cover the full breadth of stroke services within East Sussex. Progress on improving each workstream will be covered within the relevant section.

1.6 It remains the case that progress continues to be slow in delivering the East Sussex stroke strategy. The challenges faced by our main provider in East Sussex, ESHT, with regard to bed pressures, organisational structure changes, maintaining delivery of quality health services whilst realising significant savings, together with undertaking a full clinical strategy review has presented a difficult backdrop to delivering upon the improvements.

2.0 Awareness, prevention and primary care

2.1 HOSC recommendations for this workstream:

i.) 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.

ii.) 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.

iii.) 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.

iv.) 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.

v.) 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.

vi.) Urgent action should be taken to remedy all staffing shortages and to bring staffing standards up to National Stroke Strategy guidelines.

vii.) 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.

2.2 HOSC is asked to note the following updates in respect of these recommendations as well as the progress already made and noted in the June 2011 progress report.

- The 27th February 2012 saw the relaunch of the national FAST campaign for a 1 month period .It will be based on the materials and messages from the first campaign, and informed by evaluation of the previous rounds The objectives of the campaign are still to raise awareness of the symptoms of stroke and to encourage the public to call 999 immediately if they identify any one of the leading stroke symptoms

- Atrial Fibrilation ("AF") prevalence in East Sussex is higher than national average and, as well as identifying those at risk, it is important to ensure that they are treated with anti-coagulants, for example Warfarin, rather than simply rely on aspirin. The following table shows the cases of AF identified in each of the emerging East Sussex Clinical Commissioning Groups ("CCGs").

	AF			
CCG	**%** of total no. with AF	**Count**	Pop	% of E Sx Pop
High Weald	10%	989	90,000	16%
Havens & Lewes	5%	512	71,000	13%
CCHC (E'bourne)	33%	3,143	194,000	35%
ESDW (anon)	12%	1,102		
Hastings & Rother	40%	3,827	195,000	35%
Total		**9,573**	**550,000**	

Note:

1. ESDW figure based on 27 GP Practices that have submitted data via Chart Online. 7 Anon Practices – which are G81016, G81036, G81037, G81040, G81045,G81088,G81097 where there is no authorised user to grant permission to view the data with the ODS code.
2. H&R figure based on 23 GP Practices that have submitted data via Chart Online. 4 Anon Practices - 2 GP Practices unknown and submitted their data themselves, the remaining 2 are Seddlescombe Hse and Little Ridge where there is no authorised user to grant permission to view the data with the ODS code.

Sussex Stroke Network have a service improvement manager working with GP practices using the GRASP AF tool to support GPs in the identification of patients with AF and ensuring adequate anticoagulation. Currently there has been an uptake of 37% GP practices Sussex-wide.

- GP education session across Sussex have had stroke and AF as part of the programmes this last year with stroke consultants or GPs with special interest leading the sessions

3.0 Acute phase

3.1 HOSC recommendations for this workstream:

i.) 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.

ii.) *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.*

iii.) *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.*

iv.) *Urgent action should be taken to remedy all staffing shortages and to bring staffing standards up to National Stroke Strategy guidelines.*

v.) *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.*

vi.) *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.*

3.2 The majority of East Sussex residents access acute services provided by ESHT with 17% utilising BSUH and 9% MTW. The following table summarises performance against three key acute performance metrics for these providers for the period April to September 2011.

Provider Dashboard (perf. Mths 1-6)			
	BSUH	ESHT	MTW*
90% Stay[1]	82%	51%	72%
Direct admissions[2]	70%	15%	n/a
50% scans within 1hr[3]	28%	15%	n/a
*Note: MTW data is months 1-9; Direct Admissions and Scans data is unavailable. 1. Stroke patients spending 90% of their hospital stay on a stroke unit (target 80%) 2. Stroke patients being directly admitted to the hospital's stroke unit within 4 hours 3. Stroke patients receiving a scan within 1 hour of arriving at hospital (target 50%)			

3.3 HOSC is asked to note the following updates in respect of these recommendations as well as the progress already made and noted in the June 2011 progress report.

- 24/7 thrombolysis is currently available at both Conquest and Eastbourne. Further improvements to the service through establishing the out of hours rota have yet to be made but are expected to be in place by the end of March 2012. Establishing a sustainable rota has proved challenging. The expected utilisation of telemedicine during the year may well help resolve this challenge whilst the expected recruitment of additional stroke specialists will ameliorate the issue. The rota will ensure Consultant led thrombolysis via the utilisation

of telemedicine will commence from 31st March 2012. This rota is comprised of nine Consultants who fulfil the clinical criteria as laid out in the Thrombolysis Service Specification developed by the Sussex Stroke Network which draw upon national best practice.

- Stroke scanning at East Sussex Healthcare NHS Trust ("ESHT") was highlighted by the external peer review and, whilst the current level of above 80% being scanned within 24 hours is well above target, further improvement is expected. ESHT is prioritising the requirement for increasing the proportion of patients receiving scans with one hour. There is presently agreement for patients with stroke symptoms to be scanned within one hour on Monday to Fridays within normal 'office' hours with those patients assessed as highest risk also receiving a similarly prompt scan out of hours. Radiology are currently scoping a plan to deliver the one hour service 24/7.

- Direct admission to the stroke units remains an operational issue. Current performance is 27.5% which represents an improvement on the 15% level for April to September 2011. Delivering the improvement has necessitated a full review of the previous pathway initialised on the 28th June 2011. Following weekly analysis of each direct admission breach a new direct admission pathway was ratified and implemented from 7th February 2012. The focus of the key changes is to ensure all patients with stroke symptoms are assessed in the Emergency Department by an appropriately trained stroke nurse with key responsibility for guiding stroke patients directly to the stroke units within four hours. Additional funding for nursing staff has been approved to support this stroke nurse/coordinator role. Following ESHT restructure in October 2011 a new Clinical Service Manager dedicated to Stroke has been appointed.

- ESHT have ensured that the staffing gaps previously identified for normal working hours have been covered by appropriately trained locums (Appendix 4) Following the requirements to support a seven day service ESHT have undergone a full review of Allied Health Professional ("AHP") staff, benchmarked against national guidance. This has been coordinated through all services supporting stroke care and a business case has been prepared to provide substantive posts which will be considered by the ESHT board at the end of February 2012.

- The Sussex Stroke Network will work with the developing Sussex Rehabilitation Network (objective to ensure co-ordinated rehabilitation planning covering not just stroke, but head injury, trauma etc) to ensure the needs of younger individuals are included as part of the work on complex neuro rehabilitation pathway. First meeting of this group is March 14th 2012

- The stroke units within East Sussex Healthcare NHS Trust ("ESHT") have previously undertaken patient questionnaires to inform evaluation of the services provided. In addition to this ESHT will have a rolling program of audits.

3.4 The Peer Review made a number of recommendations including:

- Direct admission to the Stroke Units;
- Improvements in the provision of out of hours thrombolysis in particular in respect of clinical rota and potential use of telemedicine

- Stressing the need to improve the number of patients spending 90% of their stay on specialist stroke wards
- Recruitment of additional Stroke Consultants;
- Appropriate and timely application of scanning, particularly Magnetic Resonance Imaging ("MRI").

3.5 The first two recommendations have already been covered. Two Stroke Consultant posts have been advertised with successful recruitment to one of the posts. This Consultant commenced in October 2011 bringing the complement up to three. The remaining post has been repeatedly advertised with no success. The post is presently being covered by an NHS locum and will be re advertised end of April 2012. The management and executive team report that there have been difficulties in successful recruitment for consultants and it has been cited that uncertainty around the Trust Clinical Strategy has made the post less attractive. The requirement for modality change for MRI has not yet been possible due to high requirement for this modality and subsequent capacity issues. As part of the new pathway and links with the change of CT requirements for stroke; radiology is working through all stroke requirements.

A Peer Group Revisit by Dawn Goode (National Clinical Advisor, NHS Improvement) was made in October 2011; with the following additional recommendations:

- Clinical Champion/leadership for Stroke to be strengthened; and
- Benchmarking of nursing and AHP establishment against National Guidance

3.6 The current performance with regard to 90% stay on stroke unit remains poor with performance between 50 -54%. Disappointingly the provision of rehabilitation beds has not demonstrated the step increase as anticipated. To gain greater understanding of the issues relating to this ongoing poor performance, an audit of all patients admitted during quarter 2 was undertaken. This highlighted the following issues.

- Direct admissions not working effectively
- Coding and data issues
- The need for timely access to acute and stroke rehabilitation beds.

Consequently the following actions have been taken.

- Direct admissions have been detailed previously within this update.
- Coding and data review meetings are held fortnightly by the Clinical Service Manager and Stroke Consultant.
- 'Keep bed free on stroke unit' (keeping a bed free on the stroke unit at all times for new admissions) was initiated in February 2012. ESHT are working on plans to increase the provision of stroke rehabilitation beds from 12 to 18 with an anticipated start date in March 2012.
- Early Supported Discharge (ESD) commenced on the 1st February 2012. This service is provided 7 days a week for Eastbourne and 6 days for Hastings areas (once full recruitment is attained the service will increase to 7 days). ESHT are pleased to report that in the first two weeks of operation 9 patients were discharged with support of this service. ESD will be reported through the monthly ASI (Accelerating Stroke Improvement) metrics.
- With the initiation of all of the above elements it is anticipated that there will be an increase in the proportion of time spent on the stroke units.

3.7 The ESHT Stroke Improvement Steering Group has been running on a 6 weekly basis since June 2011 facilitated by the Sussex Stroke Network ("SSN") and has wide stakeholder involvement. In December a performance notice was issued by NHS Sussex and this has further supported ESHT in making clear what actions need to be taken and delivered in set timescales. It remains the case that progress continues to be slow in delivering the East Sussex stroke strategy. The challenges faced by our main provider in East Sussex, ESHT, with regard to bed pressures, organisational structure changes, maintaining delivery of quality health services whilst realising significant savings, all whilst undertaking a full clinical strategy review present a difficult backdrop to delivering upon the improvements. However with a new management structure in place and clinical leadership there is an expectation that the weekly figures submitted to SSN as part of the performance notice will begin to show an improvement.

3.8 The current focus of ESHT's actions is to deliver a best practice stroke pathway through both acute and community provision providing the foundations of the future service model for stroke services at the Trust. The future provision of a high quality clinically and financially sustainable service is part of the development of the Trust's clinical strategy and a number of options for future service design and configuration are under consideration. All options are founded on the requirement that the best practice stroke pathway, which is being developed currently, is maintained and improved upon.

4.0 Community rehabilitation, discharge

4.1 HOSC recommendations for this workstream:

i.) 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.

ii.) Urgent action should be taken to remedy all staffing shortages and to bring staffing standards up to National Stroke Strategy guidelines.

iii.) 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.

iv.) 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.

v.) 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.

vi.) 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.

vii.) *Community neuro-psychologist/psychological counsellor roles should be developed to provide rapid response to referrals from community teams and inpatient units.*

viii.) 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.

ix.) 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.

x.) 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.

4.2 HOSC is asked to note the following updates in respect of these recommendations as well as the progress already made and noted in the June 2011 progress report.

- At present the system in place may not be providing equality of access to community stroke services due to reliance on a manual process of referral for stoke patients not on the stroke ward, however in the future it is in envisaged that direct access and Early Supported Discharge will support this. In the interim period an automated process to retrospectively audit all stroke patients being discharged from a non-stroke ward were managed through by the multi-specialist stroke unit team.

- ESHT have ensured that the staffing gaps previously identified for normal working hours have been covered by appropriately trained locums (Appendix 4). Following the requirements to support a 7 day service ESHT have undergone a full review of Allied Health Professional (AHP), benchmarked against national guidance. This has been coordinated through all services supporting stroke care and a business case to provide substantive posts will be considered by the ESHT board at the end of February 2012.

- Dedicated specialist stroke rehabilitation beds have been established located at the Irvine Unit in Bexhill.

- There has been an expansion of the community teams to cover the northern part of East Sussex. Now that ESHT includes the community provision, there is an opportunity to review how services across the community and acute sector work together and improve integration.

- ESHT offer a number of contact points for patients seeking information about their care or condition. All stroke patients returning home are provided with

information including the Stroke Association's information line via the community stroke service commissioned from the Stroke Association.

- The Sussex Stroke Network is setting up a Network Patient and Public Involvement Partnership Group. The first meeting is due to be held 30th April 2012. There is an expectation that this can link with the East Sussex Steering Group to support engagement of patients, carers and their advocates in service development.

5.0 Community integration, long-term support, end of life

5.1 HOSC recommendations for this workstream:

i.) Urgent action should be taken to remedy all staffing shortages and to bring staffing standards up to National Stroke Strategy guidelines.

ii.) 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.

iii.) 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.

5.2 ESHT has successfully expanded its palliative care consultant workforce and now has consultant cover working between St Wilfred's Hospital and Eastbourne DGH and consultant cover working between St Michael's Hospice and the Conquest Hospital. The conversion of the current ward format to create additional side rooms is completed on the Eastbourne site; this is an ongoing programme with plans for provision of side rooms at the Conquest Hospital.

5.3 The Stroke Association was appointed to provide support to stroke survivors and carers on a countywide basis through a competitive tendering process and were awarded a 3 year contract (September 2009- October 2012).

HOSC are asked to note the following updates in respect of these recommendations as well as the progress already made and noted in the June 2011 progress report:

Between 1st April 2011 to 29th December 2011, 150 referrals were received by the service, an average of 17 referrals per month. The caseload at the end of the 3rd quarter 2011-12 was 326.

- 150 new clients received a home visit and 37 received a repeat visit
- 68 people out of the 150 referrals accessed communication support
- 7 structured exercise and peer support groups were run, supporting 129 people improve their physical well-being through exercise and emotional well-being through peer to peer support.
- 5 carers attended support groups.
- 445 people were discharged from the service at the end of the 3rd quarter.

All service users receive a home visit and one to one support with respect to:

- **Care navigation** – personalised support to access local services, these include:
    - Housing related support services;
    - Local social opportunities;
    - Local transport solutions;
    - Debt management;
    - Information and advice;
    - Counselling;
    - Referral back to GP where additional needs have been identified;
    - Services provided by the third sector;

- **One to one support** for stroke survivors with complex needs that need more intensive support; and
- **Emotional and psychological support** for the stroke survivor and their carer;

Where appropriate, service users can then access:

- **Chair and circuit based exercise groups** run by freelance personal trainers in local gyms in the following areas: Crowborough, Hailsham, Eastbourne and Bexhill.
- **Communication support groups** run in the following areas: Ore, Bexhill, Eastbourne, Uckfield and Newhaven.
- **Communication plus**. One to one support provided for people who need additional support to overcome barriers associated with aphasia.

5.4 The community stroke support service was funded via a central government grant and by the Primary Care Trusts. A review of the service has identified the need to continue long term support for stroke survivors and their carers and a number of recommendations including:

1. Embedding the community stroke support service within the pathway so that it is all patients who are likely to require long term support are referred;
2. Increasing the presence of the service in Crowborough and Uckfield, particularly links with rehabilitation teams;
3. Improving outcome based monitoring and reporting via the Stroke Association through embedding patient level outcome; and
4. The Stroke Association has restructured to increase services in north Wealden and enhanced their Customer Relationship Management System to incorporate personalised outcome monitoring.

In order to continue the service from October 2012, resources will need to be identified to continue funding the service from both local authority and PCT. When identified the current contract will be:

a) Extend by one year until October 2013, conditional on evidence that the community stroke support service will increase productivity, efficiency and effectiveness; and then
b) Re-commission the service via the commissioning grants prospectus.

Appendix 2

Sussex Commissioning Support Unit
36-38 Friars Walk
Lewes
East Sussex
BN7 2PB

Mark Inman
Senior Assistant Director for Financial Management
East Sussex Healthcare NHS Trust
By Email

Date 19th December 2011.

Dear Mark

CONTRACT QUERY NOTICE: Issue 1 - 2011/12

Thank you for your response (05/12/11) to the Performance Notice regarding Stroke issued by NHS Sussex (29/11/11.)

The commissioners would like to reflect that this was discussed as part of the Stroke Improvement steering group meeting 06/1211. Andy Horne acknowledged the reasons behind the Performance Notice which was also supported by all members of the meeting. The commissioners would also like to acknowledge completion of an action plan to resolve this issue.

At the aforementioned meeting it was agreed that some further points of clarification and assurance would be helpful to ensure that the Trust's response fully addresses the issues raised in the Performance Notice. This letter, and accompanying attachments, identifies these additional points all of which were discussed and actions agreed at the East Sussex Healthcare NHS Trust steering group meeting earlier this week.

It is hoped that East Sussex Healthcare NHS Trust will be able to respond speedily with regard to the points raised particularly given the discussions and agreements at East Sussex Healthcare NHS Trust Stroke Improvement Steering Group.

Yours sincerely

(by email)

Adrian Bryan
Contract Manager: East Sussex Healthcare Trust

cc: James Gibbons
Jane Hentley
Dr David Hughes
Graham Griffiths
Sarah Blow
Julia Dutchman-Bailey
Dr Andrew Foulkes
Deborah Tomalin
Sarah Valentine

Appendix 3 **N.B Embedded documents available on request from Claire Lee (01273 481327)**

NHS Sussex – ESHT Performance Notice, Stroke Content 29th * November 2011. ESHT Actions

	Performance Issue	Actions Sought	Timetable	ESHT ACTION / Updated from ESHT steering Group meeting on 6th December 2011	Delivery Date & Responsible
A. Leadership and Engagement					
	A1. Inadequate Managerial Clinical Leadership for Stroke within the Trust.	a. The Trust are asked to confirm the Managerial and Stroke Clinical lead arrangements as to who will be recognised as the driving force for change within the Trust, be accountable and take ownership for delivery at both sites.	30 November 2011 30 November 2011	Dr Rahmani has been invited to become Clinical Lead. Job Plan review planned to facilitate cross site lead responsibilities AH agreed to provide further assurance regarding the delivery of effective clinical leadership across both sites.	31st Dec James Wilkinson Nik Patel December 2011
		b. Support should be galvanised from the other consultants, the Nursing and Therapies staff, again at both sites.	30 November 2011	Already in place. The Stroke Implementation has been in place for 1 month with lead representation from all therapies, covering all sites (including Irvine and Community)	Achieved
		c. A Job Description should be drawn up and signed and agreed by the individual taking control of Stroke Clinical Leadership and Nursing leadership for Hyper Acute and AHP leadership.	31st January 2012	Following restructure there is a new senior management and nursing structure with identified responsibilities for stroke. The AHP have a dedicated role within neuro rehab. Continued monitoring through monthly meets, and appraisal process.	Achieved
		d. ESHT are required to deliver an action plan for meeting the above challenges. A 'Stroke Coordinator' role needs to be developed to ensure patients are pulled through the agreed Stroke care pathway		Review present role of Stroke Thrombolysis Nurse to incorporate stroke coordinator responsibilities.	Jan 2012 Lucy Scragg Linda Brown

B. Data & Assurance						
	B1. Trusts data promises not fulfilled	a. ESHT have fully signed up to the Data requirements agreed by the SSN Data Group. The Trust should have in place the various protocols for collecting and reporting on those areas of performance required for ASI and Vital Signs as well as making use of an agreed Stroke Coding Proforma – if ESHT does not have one available then the Proforma attached should be used. b. One electronic system of data capture should be developed for the Trust which is capable of reporting activity at both sites. c. A regular audit of data should be carried out by the Service manager and the Clinical lead to verify the breaches and develop Action Plans to target the areas of operation where the pathway has broken down. There should be a cyclical and methodical system of dealing with trouble areas and improvements made towards achieving the best practice targets.	30 November 2011  Stroke Proforma.x 31st December 2011 31st December 2011	To review present systems to ensure robust reporting mechanism Initiation of monthly coding validation group. Dedicated coders time to ensure robust validation and reporting JD to instigate weekly coding and validation meetings with coders, clinicians and managers for immediate action. To review present data collection systems with the aim to develop central electronic solutions where possible Monthly audit group comprising of CSM, Clinical, Nursing, AHP lead to perform RCA on each breach. Appropriate action plan developed. Weekly as above JD to provide weekly data to Mark Tearle at Sussex Stroke Network by the end of December 2011: • Time to ward and breach reasons • No. Admissions to stroke unit and breach reasons • Stroke Outliers • LoS on Stroke Ward • No. of bed-days for non-stroke patients on the Stroke wards Data should be delivered to Mark Tearle by email on Monday at or before 12	Achieved James Gibbons Nick Turner Jenny Darwood Jan 2012 James Gibbons Nick McNeillis Dr Rahmani Dr Conrad Coding Team Jenny Darwood TBC James Gibbons Nick Turner Benchmark Audit completed Nov 2011. Monthly Audits to commence end December Jenny Darwood Lucy Scragg, Dr Rahmani Dr Conrad

				noon. MT will then forward to the ESHT Stroke Improvement Steering Group. JD to provide monthly validated ASI and vital signs data via the national stroke improvement web tool and to provide Thrombolysis data to Vincent Hau, SSN on a quarterly basis to ensure consistency of data between provider and commission. Immediate action.	
C. Resources and Organisation					
	C1. Organisation of Stroke Care failing and Trust Action Plan not implemented.	As a matter of urgency ESHT are required to fully sign up to the Trust's latest Action Plan (October) (some target areas currently not delivered) as previously agreed (attached). Priority areas include: Develop and implement a Hyper Acute phase of care along the pathway meeting the national Hyper Acute Stroke Unit (HASU) guidance. Ensure a Direct Admission's policy is in place which is signed up to by all those involved along the patient pathway.	Immediately  Stroke Service Improvement Proje 31 January 2011 30 November 2011	Review present pathway to ensure all aspects of guidance is incorporated, identifying any improvements required to meet required guidance. Re launch Trust Direct Admissions Policy for Stroke.  H:\Stroke Network Meetings\Admission P Review impact off Fast Track pilot, ensuring good practise shared and implemented within  H:\Stroke Pathway\ Pilot for fast track adı ESHT.	End December 2012 Jenny Darwood Clinical Leads. Lucy Scragg Immediate End December 2011 14th December 2011

		CT scan within 1hr/24hrs for appropriate patients. Ensuring that patients received 90% of their stay on a Specialist Stroke Unit. ESHT will be measured against these priority areas and are expected to meet the necessary targets as dictated on the attached ASI and Vital Signs performance Measures	31 January 2012 31 March 2012 ASI & Vital Signs ESHT Performance	Review present Trust escalation policy in relation to Stroke beds Review, modify present pathway to ensure all patients attending Emergency Department with stroke symptoms receive CT scan prior to transfer to Stroke Unit. AH agreed to provide assurance with regard to the Trusts commitment and capability to deliver prompt scanning against the agreed national targets by 31st January 2012. Monitor effectiveness of delivery of actions from breach RCA.	31st Jan 2012 Clinical Leads Radiology & Stroke Jenny Darwood Graham Rayner Clinical Leads CSM
	C2. The distributed nature of the Trust's 12 stroke beds does not allow for effective care (Irvine Unit).	The Trust's 12 stroke rehabilitation beds must be brought together as originally agreed with the commissioner and the Trust which was originally planned for implementation in April 2011. This means that the beds should be cohorted as a dedication Stroke Unit and staffed accordingly.	1 December 2011	This has been achieved. Continued monitoring to ensure cohorting remains in place	Achieved

	C3. It is not clear from the current performance at ESHT that the Stroke Unit has the necessary Specialist skills required to run a dedicated unit for Stroke Patients with the necessary and proven skills developed against national benchmarks.	Re-examine and develop previous staffing reviews and ensure adequacy and safe levels of staffing. Specifically staffing skill mix should be considered for: • The acuity of patients at the Hyper Acute and Acute phase of care. • Consultants providing 24/7 cover and have daily presence on the ward. • Nursing to cover 24/7 • Therapies moving to a 7 day a week service	1 January 2012	Review of staffing reviews for nursing & AHP underway. ESHT to provide evidence of reviews and progress report against staffing benchmark. 24/7 Nursing in place Deliver a plan for introduction of 24/7 Consultant cover. Develop plan to implement 7 day service for therapies LS/LB to have developed an Action Plan for 7 day working from the staffing review (AHP/Nursing/Consultant) End of December 2011	End December Lucy Scragg Linda Brown Integrated Services Division
	C4. 24/7 Thrombolysis Service is failing to meet the agreed Service Specification (SSN).	a) The trust is required to develop and provide a 24/7 Specialist Stroke Consultant Rota. The Trust also needs to explore the possibility of using other local providers to support a 24/7 Specialist Stroke Consultant Rota.	1 April 2012	Plan is in place to deliver 24/7 specialist rota for 1st April 2012. Option 1: 1: 9 rota ESHT only Option 2: Explore partnership working with neighbouring trust (ie Worthing)	End March 2012

		b) Facilitate the use of telemedicine per the specification to support the 24/7 Specialist Stroke Consultant Rota.	1 April 2012	See embedded Trust action plan	 H:\Stroke Pathway\ Copy of Stroke Servic
	C5. Delayed Transfers of Care due to lack of integrated working between Health and Adult Social Care.		Provide Adult Social Care support that can work across the whole pathway in conjunction with Health. • Acute Stroke Unit • Irvine Unit • Community Stroke Teams • Early Supported Discharge.		1 January 2012 (ESD for 1st February 2012)

*** Amended to the date received from the PCTs**

AHP STAFFING LEVELS FOR ACUTE STROKE BEDS – FEBRUARY 2011 AND SEPTEMBER 2011 **Appendix 4**

The shortfalls stated relate to the delivery of a 7 day service

	Recommended staffing levels per 20 beds*	**Actual Feb.'11 EDGH**	**Shortfall Feb. '11 EDGH**	**Actual Feb.'11 CQ**	**Shortfall Feb. '11 CQ**	**Actual Sept.'11 EDGH**	**Shortfall Sept.'11 EDGH**	**Actual Sept.'11 CQ**	**Shortfall Sept.'11 CQ**
Occupational Therapy	**4.0 wte**	**1.8 wte** (0.8 wte B6; 1.0 wte B5)	**2.2 wte**	**2.0 wte** (1.0 wte B7; 1.0 wte B5)	**2.0 wte**	**1.8 wte** (0.8 wte B6; 1.0 wte B5)	**2.2 wte**	**2.0 wte** (1.0 wte B7; 1.0 wte B5)	**2.0 wte**
Physiotherapy	**4.0 wte**	**3.0 wte** (1.0 wte B7; 1.0 wte B6; 1.0 wte B5)	**1.0 wte**	**3.0 wte** (1.0 wte B7; 2.0 wte B5)	**1.0 wte**	**2.0 wte** (1.0 wte B7;1.0 wte B5)	**2.0 wte**	**2.0 wte** (1.0 wte B7;1.0 wte B5)	**2.0 wte**
Speech & Language Therapy * *Business Case to CME Feb '12 for additional 1.0 wte SLT cross site and 1.0 wte B4 SLT assistant.	**1.5 to 2.5** - depending on whether patients with tracheostomy are accepted	**1.0 wte** (B6) only covering 0.4 of stroke	**0.5 to 1.5 wte**	**1.0 wte** (B5)	**0.5 to 1.5 wte**	**1.0 wte** (0.4 B6 and 0.6 agency B7)	**0.5 to 1.5 wte**	**1.0 wte vacancy** daily cover provided by rest of SLT team. 1.0 wte B5 appointed November 2011	**1.5 to 2.5 wte**
Dietetics	**0.5 to 0.75** depending on proportion of patients on enteral feeding	**0**	**0.5 to 0.75**	**0**	**0.5 to 0.75**	**1.0 wte** (B7)	**None**	1.0 wte (B7)	**None**

***Ref**: Specialist Neuro-rehabilitation services – providing for patients with complex rehabilitation needs. Professor Turner-Stokes September 2010*

Note: There are 23 stroke beds at EDGH (Wilmington Stroke Unit) and 20 beds at The Conquest (Egerton Stroke Unit) – The beds numbers at EDGH have been rounded down to 20 to calculate the shortfall **Michele Fleming, Head of AHP Services, 31 January 2012**