healthwatch North Somerset

Community Stroke Service Survivors Experiences 2015-2017

your voice counts

Contents

Acknowledgements

Healthwatch North Somerset would like to thank all the stroke survivors who responded to the Healthwatch North Somerset questionnaire requesting feedback about their experiences.

Healthwatch North Somerset would like to also thank the North Somerset stroke support agencies, service providers and stakeholders including North Somerset Community Partnership, University Hospitals Bristol NHS Foundation Trust, Weston Area Health Trust Speech and Language Outpatients Unit, Carers Support Alliance and North Somerset Stroke Association.

Your valuable contributions are much appreciated.

Background

Strokes are a major health concern both nationally and in North Somerset. Each year in the UK, over 100,000 people have a stroke and annually around 95,000 people are admitted to hospital with an acute stroke. In the UK strokes are the fourth largest cause of death, additionally 1.2 million people are living with a lifelong disability having survived a stroke[1]. Every year the NHS in England spends £1.7 billion on stroke care.

There are no current figures for stroke prevalence in North Somerset but in 2015 the prediction was that 4,844 people in North Somerset would suffer a stroke. Due to changes in the demographic makeup of the county, it is predicted this number could rise to 5,844 people in 2020[2].

Healthwatch North Somerset began to focus on the experience of stroke survivors in direct response to the feedback, queries and intelligence gathered in 2014/2015. We reported on stroke survivor's experiences of accessing community stroke rehabilitation services and therapies following their discharge from hospital in the Healthwatch North Somerset 'Special Enquiry: Community Stoke Services' Report which was published in April 2015. The Report made four recommendations based on stroke survivor's experiences.

In 2017 Healthwatch North Somerset reviewed feedback received after 2015 about experiences from stroke survivors. We also received enquiries from previous stroke survivors who queried whether the recommendations made in the 2015 Report had been implemented and whether there was evidence of any impact on the experiences of more recent stroke survivors who had been discharged from hospital into North Somerset Community Rehabilitation Services and Therapies between 2015 and 2017.

Healthwatch North Somerset listens to patient experiences and makes recommendations that inform commissioners and providers about local people's views and experiences, promotes good practice and identifies areas for service improvement. This report was

[1] State of the Nation: Stroke Statistics 2017

[2] APHO 2011,www.n-somerset.gov.uk/wp-content/uploads/2015/11/disease-prevalence-models

instigated in direct response to feedback, queries and intelligence gathered from stroke survivors, stakeholders and professionals in North Somerset.

Aims and Objectives

The aim of this report is to collate the experiences of stroke survivors who were discharged into North Somerset Community Stroke Services over the past two-years (2015 to 2017).

The original intent was to compare the findings of stroke survivors discharge and post discharge experiences between 2015 to 2017, with the experiences documented in the 2015 Healthwatch North Somerset 'Special Enquiry: Community Stroke Services' Report[3]. The objective was to see if there had been improvements in stroke survivors experience of being discharged into North Somerset Community Services over the last two years

We unexpectedly found on receipt of completed questionnaires from stroke survivors, that 16 of the thirty-eight respondents who completed the survey had been discharged into North Somerset Community Services following a stroke over two-years ago. This feedback enabled a comparison between the experiences of respondents from the 2015 report directly with the twenty-two respondents who experienced discharge into Stroke Community Services over the last two-years.

The four recommendations in the Healthwatch North Somerset 2015 Report 'Special Enquiry: Community Stroke Services' have been used as the framework for our research and to measure the impact of those recommendations made.

Recommendations from the 2015 Healthwatch North Somerset 'Special Enquiry: Community Stroke Services' Report

1. The development and implementation of relevant resources to be provided to support North Somerset stroke patients and their carers from North Somerset before discharge from a Bristol hospital.

2. The development and implementation of a North Somerset Stroke Early Supported Discharge service (ESDT) to ensure timely community support after discharge from hospital.

3. To develop awareness of stroke patients needs and implement best practice when speaking to and booking appointments at GP practices in liaison with the North Somerset Stroke Association.

4. The development and implementation of a process for follow-up appointments with GPs after discharge to ensure every patient receives the same support service regardless of which surgery they are registered with.

[3] Healthwatch North Somerset 'Special Enquiry: Community Stroke Services'

Planning

The focus of this report is to review the experiences of stroke survivors discharged by hospitals into North Somerset Stroke Community Rehabilitation Services over the last two-years, 2015 – 2017.

Healthwatch North Somerset used the following national guidelines to provide background and context to the report:

Best care guidance for hospital discharge was sought from the 'Stroke in Adults' Quality Standard and 'Stroke Rehabilitation in Adults' Pathway developed by the National Institute of Health and Care Excellence (NICE)[4].

The NICE Guidelines for Stroke Rehabilitation[5] indicate that wherever possible and it is safe to do so, stroke survivors should be discharged from hospital back into their homes as soon as possible. This is called Early Supported Discharge. According to the NICE Guidelines Early Supported Discharge of stroke survivors should be carried out with a full health and social care assessment, and patients should receive timely access to a range of multidisciplinary skills and support to continue to aid their rehabilitation.

'Early Supported Discharge should be part of a skilled stroke rehabilitation service and should consist of the same intensity of therapy and range of multidisciplinary skills available in hospital. It should not result in a delay in delivery of care'[6].

Guidance was also provided on best practice for recovery and rehabilitation by the National Institute of Health Research which published findings in March 2017 called 'Roads to Recovery'[7].

The National Institute of Health Research advise that following discharge from hospital, stroke survivors should have ongoing access to therapies if required, such as occupational therapy (OT), and physiotherapy and speech and language therapies (SLT)[8].

Weston General Hospital Stroke Unit follows the NICE guidelines and advise North Somerset stroke survivors that;

"Planning for discharge will start as soon as you are admitted, and the team may approach you for information. Before discharge assessments and decisions will be made with you about any support you may need in the community such as on-going therapy, care package, meals on wheels etc. If you have a small stroke with no disabilities, then you are likely to be discharged quickly. If you have mild difficulties, then you may be discharged with support from the community services. If you have a major stroke, then you may be in hospital for a longer period of rehabilitation"[9].

This report acknowledges the current climate in which the NHS is experiencing significant financial pressure and change. There is ongoing work in North Somerset to implement the

[4] NICE Guidelines Stroke rehabilitation in adults
5 National Institute Health Research/themed reviews/ Road to Recovery/Recovery and Rehabilitation www.dc.nihr.ac.uk/themed-reviews/Roads-to-recOVERy-final
[6] NICE Guidelines Stroke rehabilitation in adults
[7] NICE Guidelines Stroke rehabilitation in adults
[8] National Institute Health Research/themed reviews/ Road to Recovery/Recovery and Rehabilitation www.dc.nihr.ac.uk/themed-reviews/Roads-to-recOVERy-final
9 http://www.waht.nhs.uk/en-GB/Our-Services1/Hospital-Units/Stroke/

Sustainability and Transformation Partnership (STP) objectives in the combined STP footprint of Bristol, North Somerset and South Gloucestershire (BNSSG). The STP includes the re-design of services aimed at delivering more effective care at scale and with cost savings. There is also a proposed merger of North Somerset, Bristol and South Gloucestershire Clinical Commissioning Groups (BNSSG CCG).

The STP may significantly change the way health services are delivered to the people of North Somerset. This report reflects the impact and influence of the recommendations made in the 2015 Healthwatch North Somerset 'Special Enquiry: Community Stroke Services', during a time of enormous service upheaval.

What We Did

Based on the recommendations of the Healthwatch North Somerset 'Special Enquiry: Community Stroke Services' Report (2015) a list was compiled of specific issues addressed in that report to focus on.

It was considered a questionnaire would be the most appropriate and effective way to elicit feedback from stroke survivors as this review sought to compare similar information to that collected in 2015. Additional benefits of using questionnaires to collect feedback are that information can be collected from people in a short period of time and in a relatively cost-effective way. It also ensures the comparable information can be collected regardless of who provides the feedback, this enables ease of quantifying the feedback.

Weaknesses in using questionnaires for this type of review are that they do not allow for additional insight and there is a possibility that the right questions may not be asked. These issues were taken into consideration and it was decided a questionnaire for this particular review was appropriate.

A questionnaire was constructed (see Appendix 1) aimed at eliciting the experience of stroke survivors who had used stroke services in North Somerset between 2015 to the end of October 2017.

To ensure the questions in the questionnaire were relevant and fit for purpose we worked with the Stroke Network who provided an initial review of the draft questionnaire. When it was agreed that the questionnaire was fit for purpose it was then forwarded by email to members of the Stroke Association network for distribution among their contacts.

Paper copies of the questionnaire were printed and were distributed to Portishead Stroke Survivors Group, Alliance Carers Trust and Weston General Hospital Speech and Language Service. Healthwatch North Somerset visited Nailsea and Weston Stroke Survivors Groups where copies of the questionnaire were distributed, further information was provided on the purpose of the review as well as offering an opportunity to ask questions.

North Somerset Stroke Community Services and Therapies

Healthwatch North Somerset approached service providers to determine the current range of Community Stroke Services being offered to stroke patients in North Somerset and the process stroke patients go through to access these services.

This was done by contacting key personnel at:

- North Somerset Community Partnership (NSCP)
- Weston Area Health Trust Speech and Language (Weston Area Health Trust SLT (Speech and Language Therapy) Outpatient Lead
- North Somerset Clinical Commissioning Group (CCG)
- University Hospitals Bristol NHS Foundation Trust (UHB).

North Somerset Community Partnership (NSCP) are commissioned to deliver community rehabilitation and therapy services which includes, where appropriate to the patient's needs: Discharge to Assess Service (assessment of older patient's rehabilitation and care needs in their home or residential environment within two hours of discharge from Hospital), Physiotherapy, Occupational and some Speech and Language Services and a Specialist Stroke Nurse.

North Somerset stroke patients are provided with a 'Stroke Passport' to record all relevant and up-to-date information of their rehabilitation progression. The Passport is mostly provided by Weston General Hospital Stroke Unit to their patients when they are being discharged.

At the time of this report community services in North Somerset are mainly accessed through a multi-agency led North Somerset 'Single Point of Access' Team (SPA) which includes the 'Professional Assessment Team' (PAT) and other health and social care professionals.

At the time of this report Speech and Language referrals have a separate pathway (see Appendix 2) which comprises of all referrals being sent electronically by the discharging hospital to be jointly triaged by Weston General Hospital and North Somerset Community Partnership. The Weston General Hospital Speech and Language Outpatients offer both individual and group therapy.

All hospitals refer North Somerset stroke discharge patients to the North Somerset Single Point of Access (SPA). Those patients with more complex needs as identified by the 'Professional Assessment Team' (PAT), who base their assessment on the evidence they receive from the hospital, will be referred to NSCP's 'Community Neurology Team'. The afore mentioned team includes a Specialist Stroke Nurse, physiotherapy, occupational therapy and speech and language therapy.

The North Somerset Stroke Association works closely with NSCP and Weston General Hospital Stroke Services. Their trained volunteers offer advice, information and a range of one to

one or group communication or social support. These services can be accessed through self-referral; referral or signposting by a GP; referral from North Somerset Adult Social Care; the Single Point of Access (SPA) Team; Specialist Stroke Nurse; the Community Neurology Team or the Weston General Hospital Speech and Language Team.

North Somerset Council Leisure Centres, in partnership with NSCP, deliver specific stroke rehabilitation sessions. These sessions are also accessed through referral or signposting as mentioned above.

See Appendix 3 for a list of community stroke support services developed by a Stroke Association volunteer who is also a stroke survivor.

Information Gathering

Healthwatch North Somerset approached key service providers either by email or face-to-face to gain a deeper understanding of the provision of services in North Somerset.

The following is a synopsis of the information gathered:

The Integrated Discharge Service Lead at the University Hospitals Bristol NHS Foundation Trust informed us that the Trust was in the initial stages of creating a discharge site on their intranet, this will allow staff to pick a subject and get up to date guidance and information.

In a written response from the North Somerset Clinical Commissioning Group Transformation Director, we were informed that NSCP are fully engaged in the development of the future Bristol, North Somerset, South Gloucestershire (BNSSG) single pathway for stroke survivor's community rehabilitation, with the intention of improving North Somerset stroke survivors experience. We were also advised that NSCP have "implemented an improved model for their rehabilitation services locally, this includes a 'Discharge to Assess Service' which enables older patients to have their rehabilitation and care needs assessed in either the patient's own home or in a residential setting". This service should commence within two hours of the patient being discharge from hospital.

In a meeting with the North Somerset Community Partnership (NSCP) Rehabilitation Lead and the Lead Stroke Physiotherapist we were informed that as the agency who are contracted to provide the Community Support and Therapy Services to North Somerset stroke survivors, they wanted to find the best ways to use their current resources to the most effect in the interim period before the BNSSG pathway was fully developed. In order to achieve this, NSCP decided to first conduct an audit to identify what and where the gaps were for stroke survivors when they were discharged from hospital into community care, rehabilitation therapies and services. Using the results from the audit, NSCP decided that to have the widest effect the Lead Occupation Therapist and Lead Physiotherapist, working closely with the North Somerset Stroke Specialist Nurse, would carry out the following activities:

- The Specialist Stroke Nurse is advised of all the North Somerset stroke hospital admittances in all the surrounding hospitals to follow up and assess the number of people from North Somerset who have experienced a stroke. In liaison with the Lead Occupational Therapist and Physiotherapist and in

attendance at some multi-disciplinary team meetings, the Specialist Stroke Nurse endeavours to ensure that by discharge, stroke survivor referrals have been sent to the Single Point of Access (SPA) and that the Professional Assessment Teams (PAT) have the right information to effectively assess the needs of each individual stroke survivor.

- The Lead Occupational Therapist and Physiotherapist attend Weston and South Bristol Stroke Rehabilitation Wards and along with the specialist nurse liaise and attend weekly discharge multi-disciplinary meetings in the hospitals to discuss North Somerset patients care needs and who best to refer them to on discharge.

- The Lead Occupational Therapist and Physiotherapist will also work with patients on the Stroke Rehabilitation Unit at Weston General Hospital and South Bristol Hospital, this means that even if patients must wait for physiotherapy when they get home, they will have exercises to carry on with and will know that the physiotherapist will be visiting them at some point in the future.

- The Lead Occupational Therapist and Physiotherapist rarely find they get referrals from the other hospital acute stroke wards but do act as advice and information points for them.

- The Lead Occupational Therapist, Physiotherapist and Specialist Stroke Nurse educate and share their expertise with the community therapists and clinical staff, so they can be more skilled in assessing and meeting physiotherapy needs effectively.

- The Occupational Therapist, Physiotherapist and Specialist Stroke Nurse Leads now work as advisors to the Single Point of Access (SPA) triage team, which improves assessments made by the Professional Assessment Team (PAT) and helps to alleviate the historic problem of patients who have not been assessed as having more complex needs feeling unsupported and abandoned on discharge.

- The Specialist Stroke Nurse acts as the point of contact for all known stroke survivors in North Somerset and carries out the patients six-month and 12-month reviews.

We also met with the Outpatient Lead from the Speech and Language Department at Weston General Hospital who shared the ‘Stroke Speech and Language’ pathway which they co-deliver with NSCP (see Appendix 2).

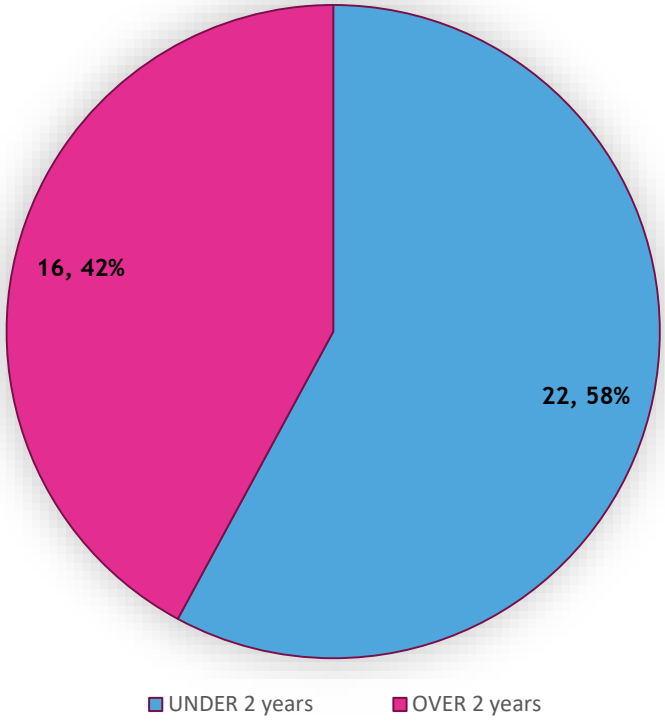
Findings

A total of 80 Questionnaires were distributed with a response rate of 38 completed Questionnaires (47.5%).

22 (58%) of the respondents stated they had experienced a stroke in the last two-years (2015 to 2017); 16 (42%) of the respondents stated they had experienced a stroke more than two-years ago.

Throughout this report the two groups of stroke survivors will be referred to on the comparison charts as the UNDER 2 years and the OVER 2 years respectively.

When did respondents experience a stroke?

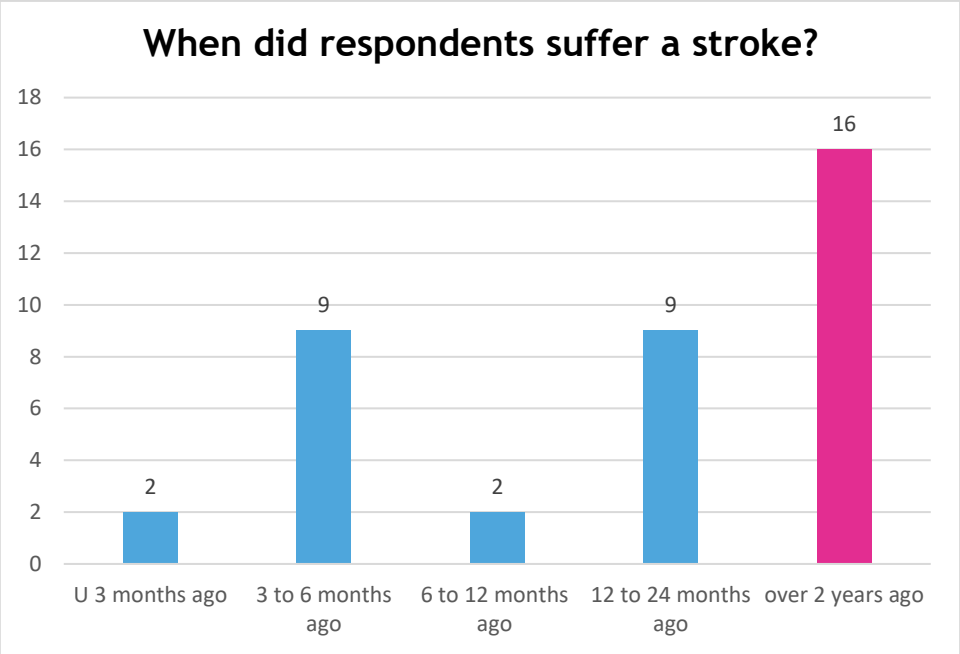


Questionnaire Responses

Before Discharge

Questions 1 to 7 relate to Experience of Hospital Care

Q1. When did you have your Stroke?

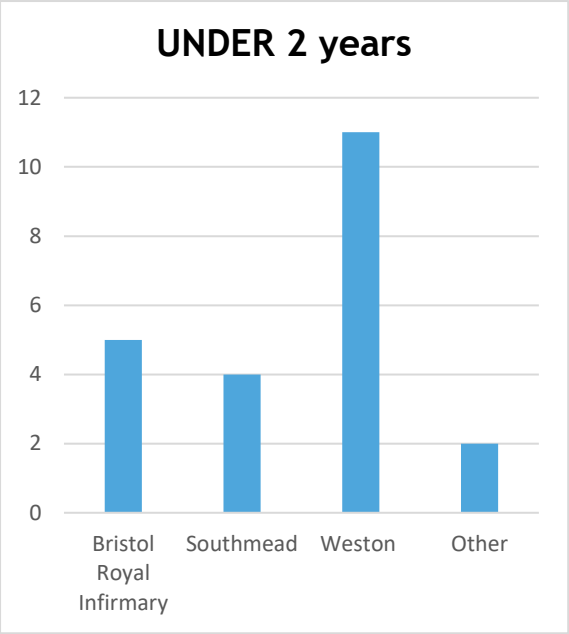


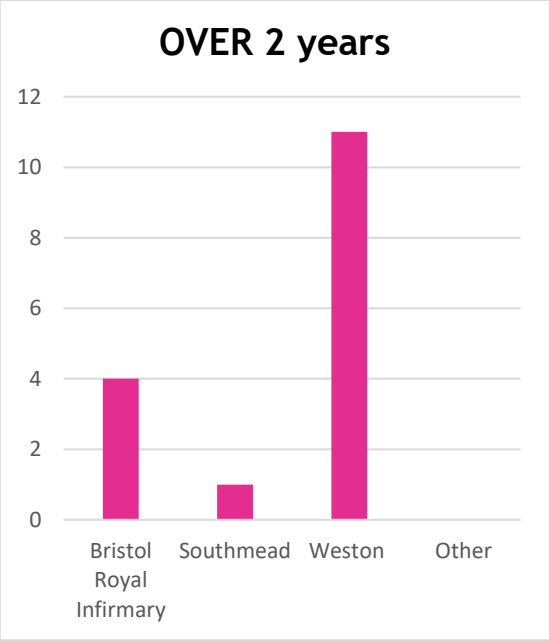
In the UNDER two-year group, the data indicated that most respondents had experienced a stroke either three to six months or 12 to 24 months prior to completing the questionnaire.

The total number of respondents (22) having had a stroke in the past two-years is higher than the group responding who had experienced a stroke OVER two-years ago. This could suggest there has been an increase in people experiencing a stroke which fits with the Public Health England 2011 predictions based on demographic change in North Somerset.

This feedback provides a good comparison between recent survivors of stroke and those having experienced services for stroke rehabilitation OVER two-years ago.

Q2. Which Hospital/s did you receive your stroke treatment in?



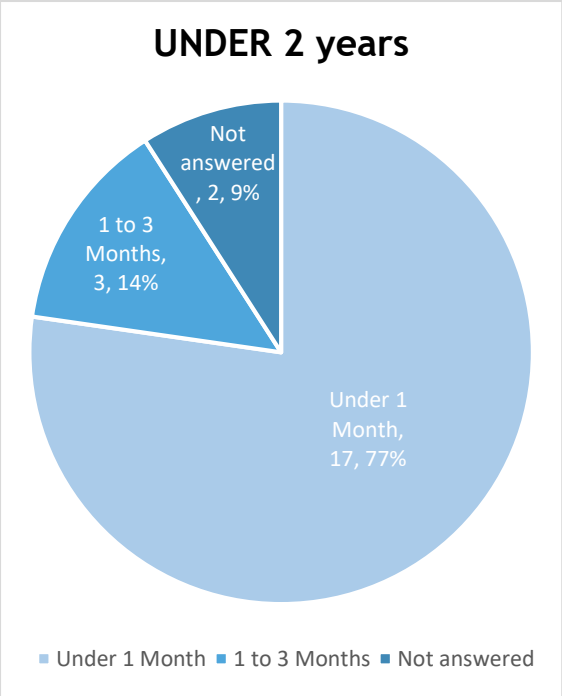


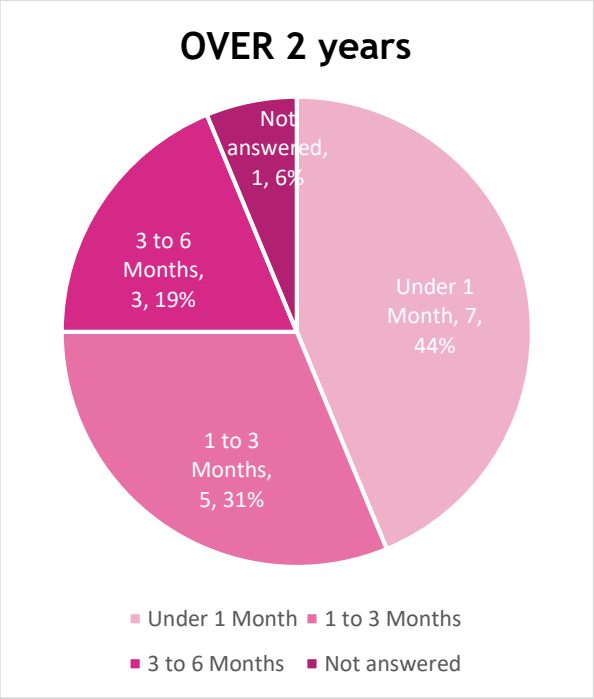
There was no significant difference in which hospital the two groups received their acute stroke treatment.

Professionals advised that North Somerset patients who experience a stroke have access to three specialist wards/units (Bristol Royal Infirmary, Southmead Hospital and Weston General Hospital). Which hospital patients go to relates to personal choice, time of day and capacity.

Professionals explained that Bristol Royal Infirmary and Weston General Hospital had Acute Stroke Wards, but Southmead Hospital has a Hyper Acute Stroke Unit and can administer thrombolytic (clot buster) treatment OVER 24 hours, while Bristol Royal Infirmary and Weston General Hospital have more restricted hours in which they can administer the thrombolytic treatment.

Q3. How long did you spend in Hospital?



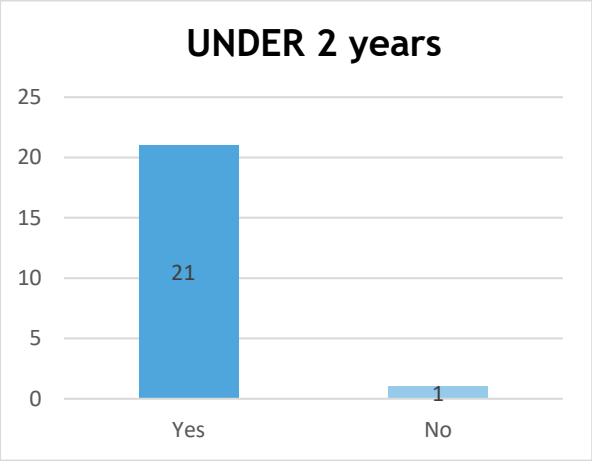


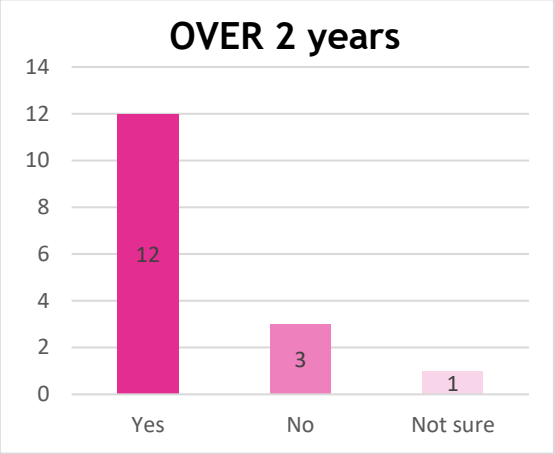
Findings show that the OVER two-year group had a slightly longer stay in hospital than the UNDER two-year group. The more current shorter hospital stays could be attributed to the recently implemented 'Discharge to Assess' scheme for all appropriate patients (from all hospitals).

However, we were advised by the medical stroke professionals that at the time of compiling this report there is limited stroke specialism among the 'Assess to Discharge' teams. This issue is something that the NSCP Rehabilitation services including the Lead Occupational Therapist, Lead Physiotherapist and Specialist Stroke Nurse are working to resolve by offering training to skill up clinical staff and therapists to raise awareness of stroke survivor's specific needs.

We were informed by the NSCP Rehabilitation Lead that discharging stroke patients from hospital, as soon as it is safe to do so is a priority, which follows the NICE Guidelines.

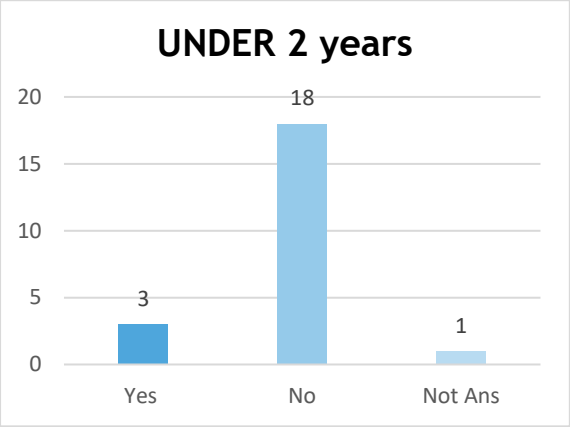
Q4. Were you on a specialist stroke ward?

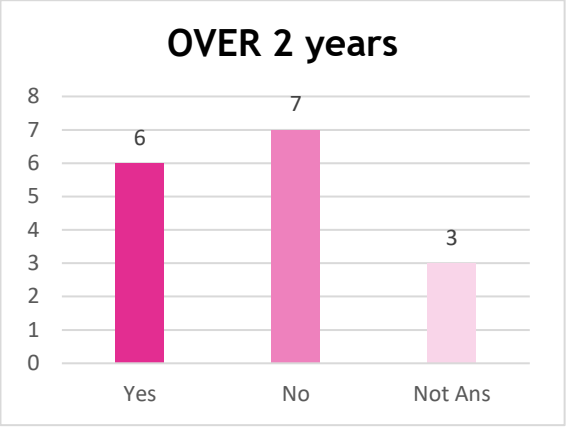




Most patients in both the groups reported that they were treated on a Specialist Stroke ward.

Q5. Did you receive rehabilitation?

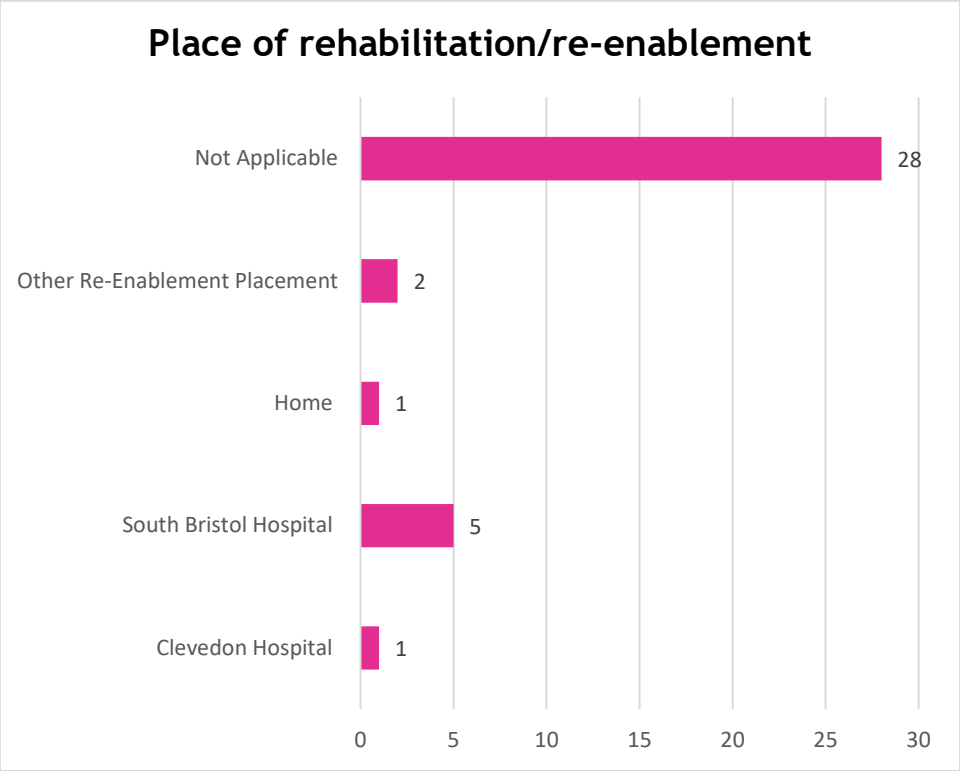




A much higher number (18 out of 22) in the under two-year group responded that they had not received specific rehabilitation care.

However, after talking to medical staff it appears that at Weston General Hospital acute stroke care and rehabilitation occurs on the same ward which is known generally as the 'Stroke Ward'. This could result in stroke survivors not realising that they had moved on to rehabilitation care as opposed to the acute care they had first received. NSCP advised that a small number of patients are sent to South Bristol for rehabilitation.

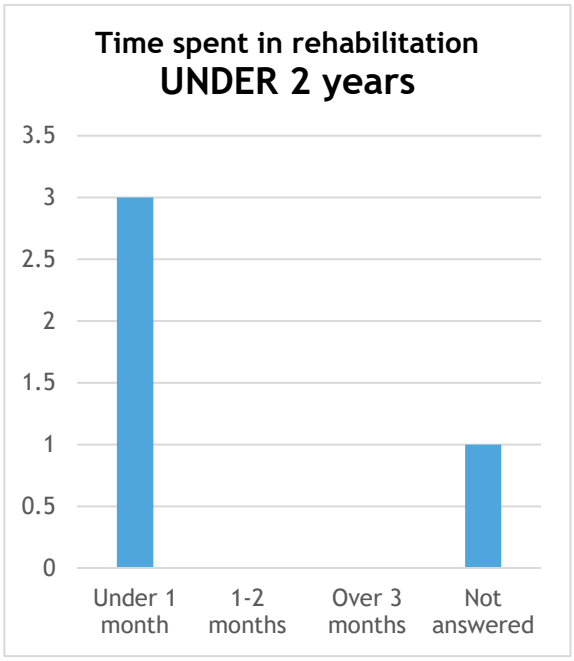
Q6. Where were you transferred for rehabilitation/re-enablement?

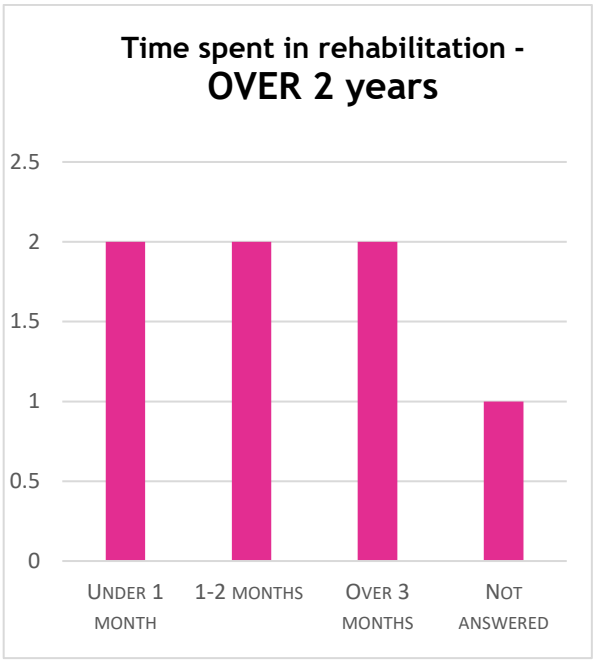


The responses to question six which includes both groups of stroke survivors, could indicate that those who said 'Not applicable' may not have differentiated between the acute care and rehabilitation care they received while on the hospital ward.

See the comments from question seven for a more detailed explanation.

Q7. How long did you spend in the rehabilitation/re-enablement?





The low number of positive responses (total of 9) to questions six and seven from both the UNDER and OVER groups showed that many of the stroke survivors thought they had not received rehabilitation before they were discharged into the community.

As mentioned previously in Question five, this could be attributed to the fact that a lot of the stroke survivors who completed the Questionnaire received their rehabilitation at Weston General Hospital. At Weston General Hospital the acute care and rehabilitation is provided on the same ward which is known generally as the Stroke Ward.

Similarly, patients from Bristol Royal Infirmary and Southmead Hospital who are repatriated to the Weston General Hospital Stroke Ward, may not have been fully aware that they were there to receive rehabilitation treatment.

When asked about their experience of care in hospital or after discharge the following comments were made by the responders:

"My experience of the Stroke Ward at Western General Hospital was positive, and I have greatly appreciated the staff there and the quality of care."

"Family would have like to have been kept in the picture."

"I was very well looked after (at Weston General Hospital). I can't speak highly enough of the care I received."

"The gap between leaving hospital and receiving follow up physiotherapist and Speech Therapy (ST) especially ST was too long and very discouraging."

"The Occupational Therapist (OT) and ST at Hengrove were superb."

"Hengrove really helpful with organising the transition to a home environment and persuading North Somerset service to continue to provide home speech therapy."

"… (had) very little physiotherapy, some speech and language but this happened on the ward (Weston General Hospital) which was very noisy and distracting."

"South Bristol Community Hospital team were amazing and very supportive to me and my family."

Experience of Discharge from Hospital/rehabilitation

Questions 8 to 14 relate to discharge and after-discharge care / rehabilitation

The UNDER two-year group responses to Questions 8 to 14 which relate directly to the stroke survivors experience of discharge and after discharge experiences are RAG (Red, Amber, Green) rated as follows:

- **Red** for deterioration in the stroke survivors discharge experience and access to Community rehabilitation therapies and services when compared to the OVER two-year group responses.

- **Amber** for no change in the stroke survivors discharge experience and access to Community rehabilitation therapies and services when compared to the OVER two-year group responses.

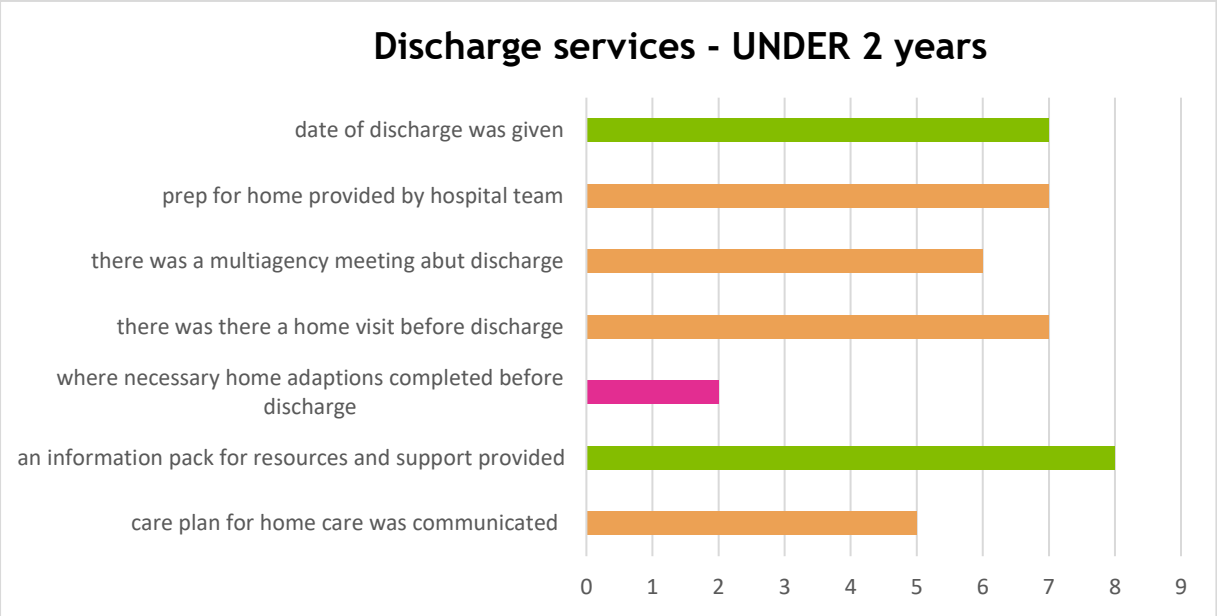
- **Green** for improvement in the stroke survivors discharge experience and access to Community rehabilitation therapies and services when compared to the OVER two-year group responses.

Q8. Which services did you receive before discharge from hospital or rehabilitation?

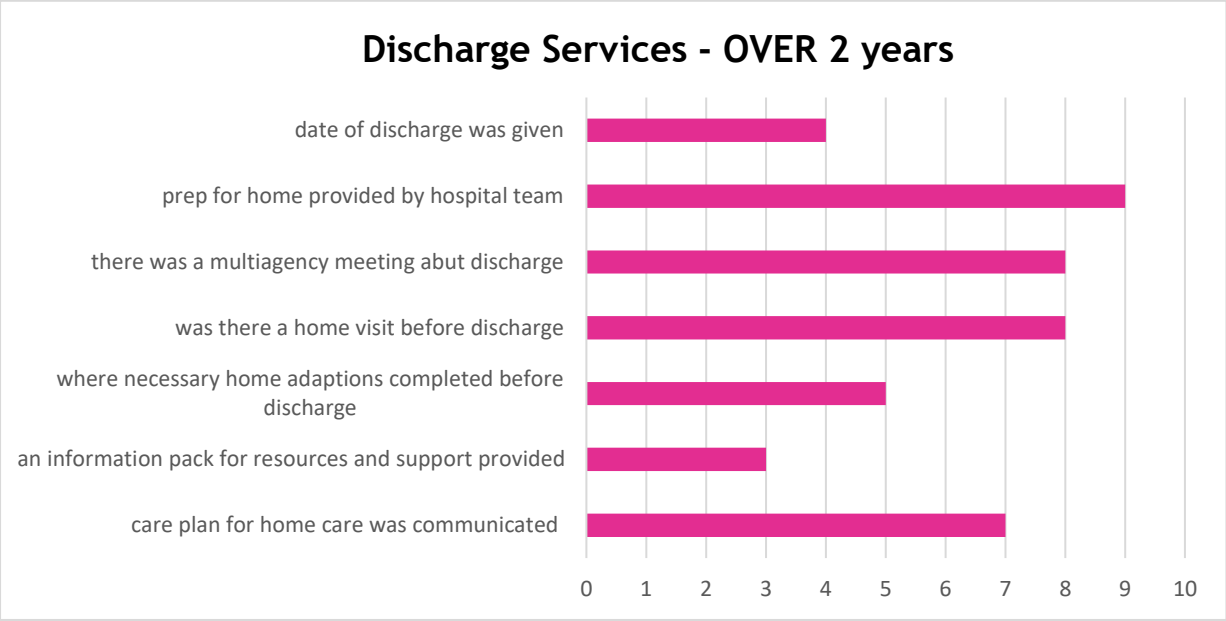
The experiences of 22 respondents who experienced a stroke in the UNDER two-years group, when asked what elements were included in their discharge from hospital or rehabilitation are indicated in the chart below.

There were 14 'no answer' responses.

The UNDER two-year responses have been RAG rated in direct comparison to the responses from the OVER two-year group which is directly below.



The experiences of 16 respondents who suffered a stroke OVER two-years ago when asked what elements were included in their discharge from hospital or rehabilitation are indicated in the chart below. There were 8 'no answer' responses.



- In both groups of respondents most of the patients responded that they had a home care plan communicated to them before discharge. No Change

- Nearly all the stroke survivors in the UNDER two-year group received discharge information on the community resources and support they could access in their area, compared to just over a quarter receiving information packs in the OVER two-year group. Improvement

- Half the respondents in the OVER two-year group reported having necessary home adaptions completed before they returned home, while only a quarter of those in the UNDER two-year group advised that they had necessary adaptions completed before returning home. Deterioration

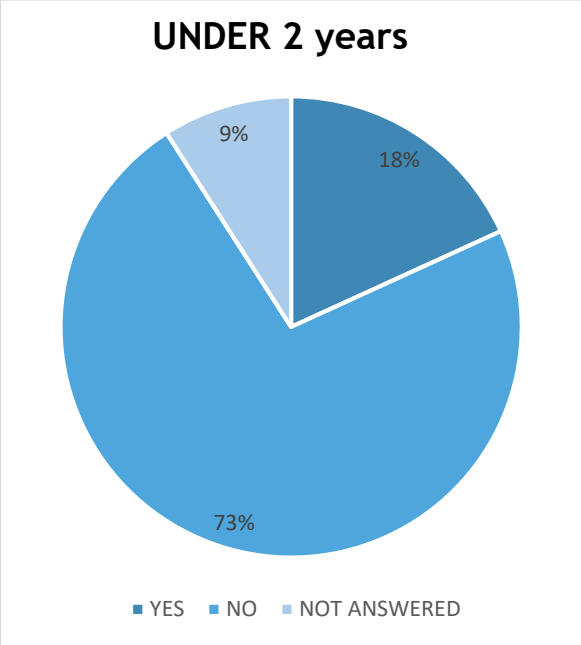
- Over half of both groups reported that a professional had completed a home visit before the Stroke Survivor had been discharged. No Change

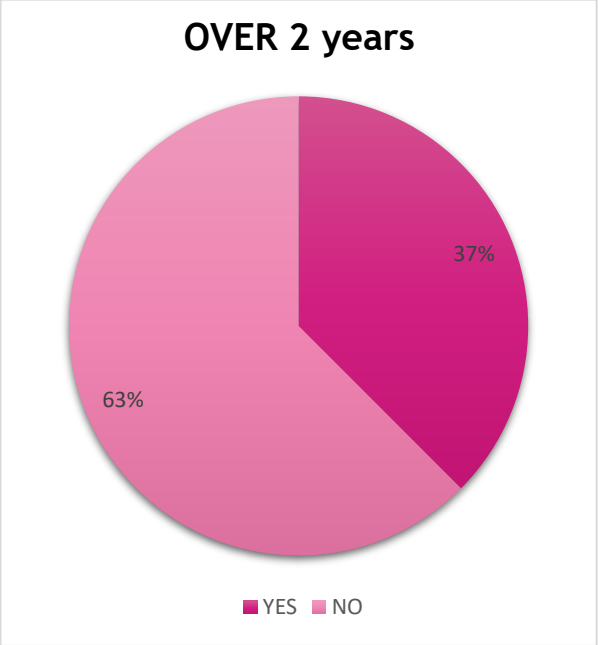
- Over half of both groups reported there had been a multi-agency meeting in the hospital before they had been discharged. No Change

- Three quarters of both groups reported they felt they had been prepared by the hospital for their return home. No Change

- Half of the UNDER two-year group received their discharge date beforehand, while slightly less than half in the OVER two-year age group reported being told their discharge date in advance. Improvement

Q9. Did you get a follow up appointment with a GP post discharge?

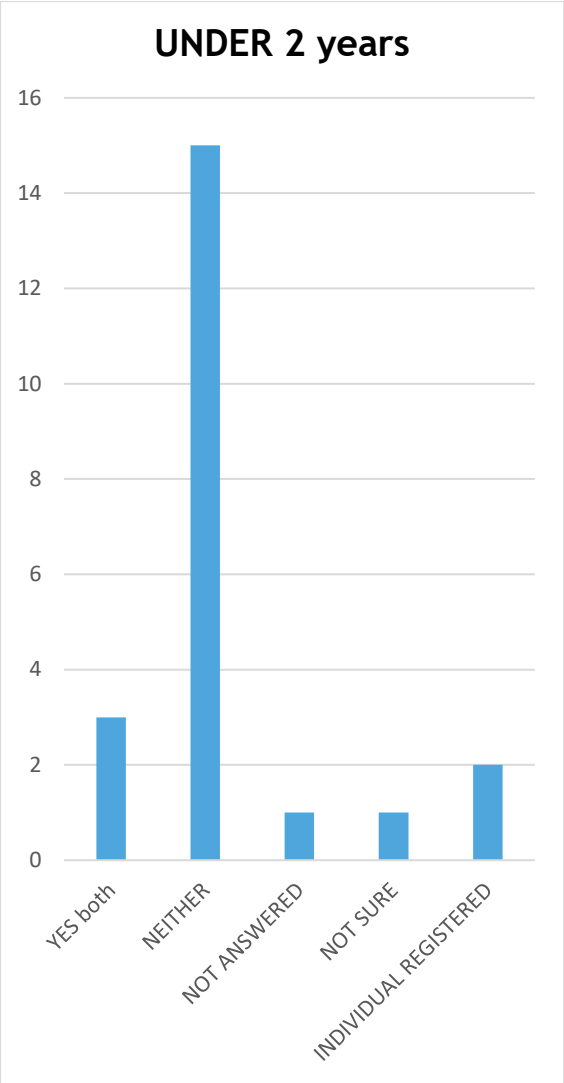


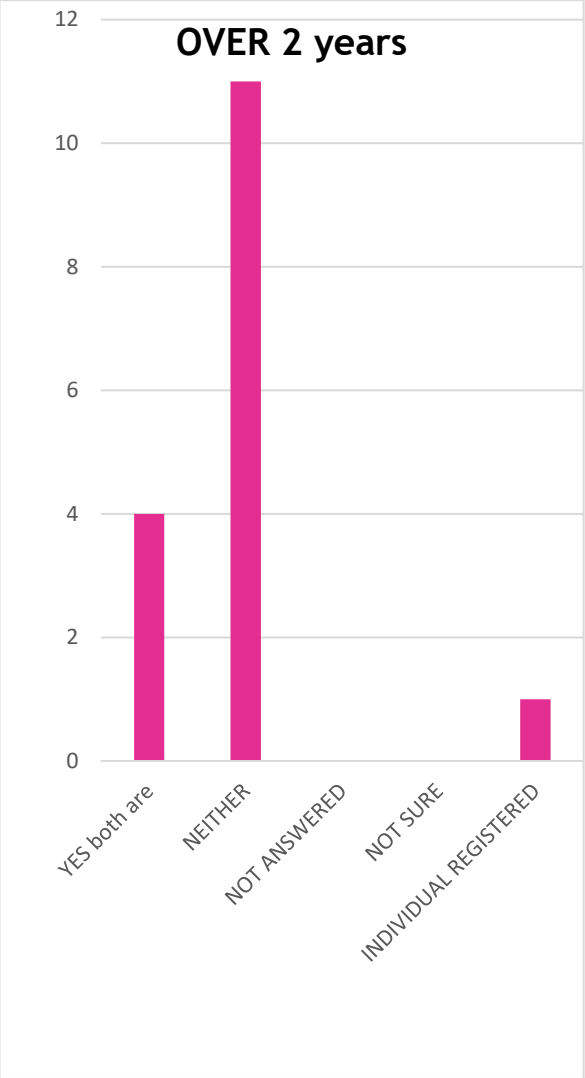


Only 18% of the 22 respondents in the UNDER two-year group reported getting a follow up appointment with their GP; compared to 37% of respondents in the 16 OVER two-year group.

This could suggest that it is more difficult now for stroke survivors to get a follow up appointment with their GP. Deterioration

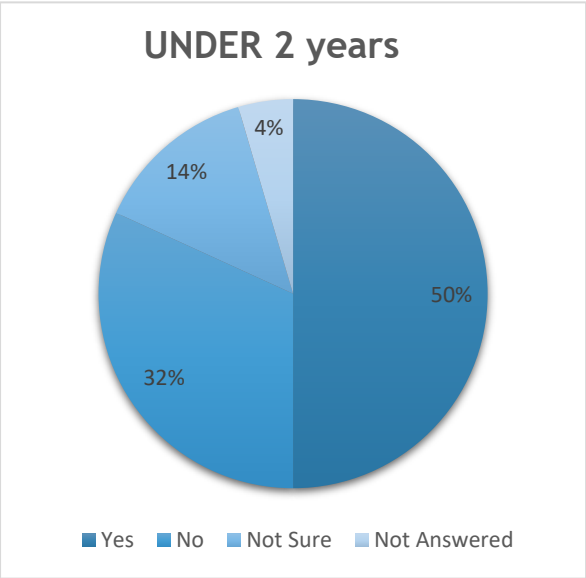
Q10. Were you and/or your carer made aware that your carer should be registered with the GP as a carer and that you should both have priority when booking an appointment with your GP?

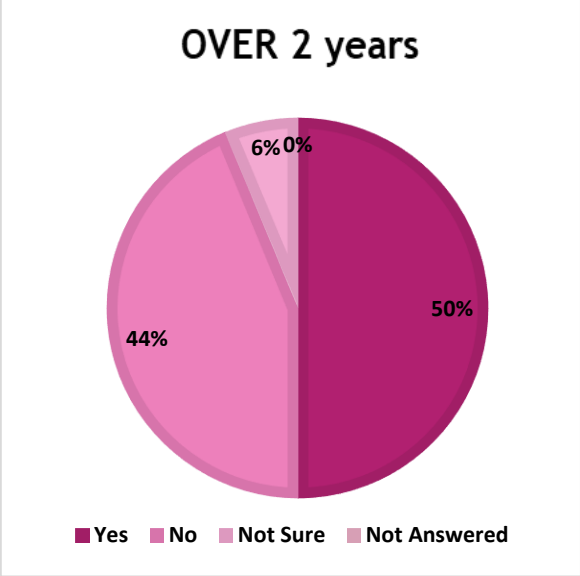




Both groups generally reported that they did not know that either themselves or their carer would have priority access for GP appointments. No Change

Q11. Overall do you feel that staff and your GP at the Surgery understand the impacts of a Stroke?

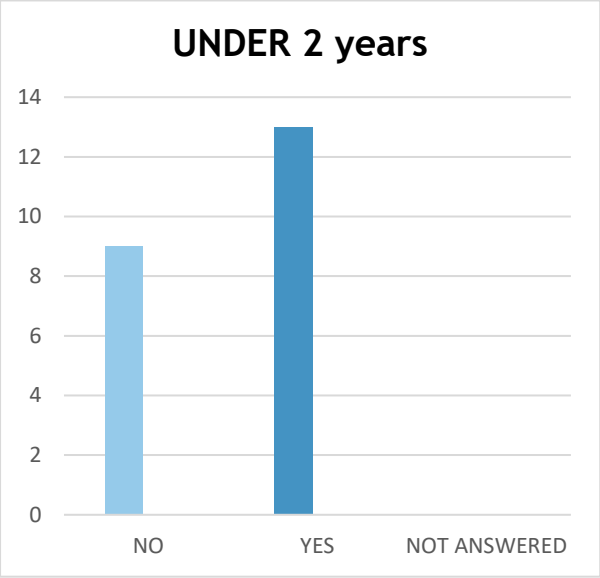


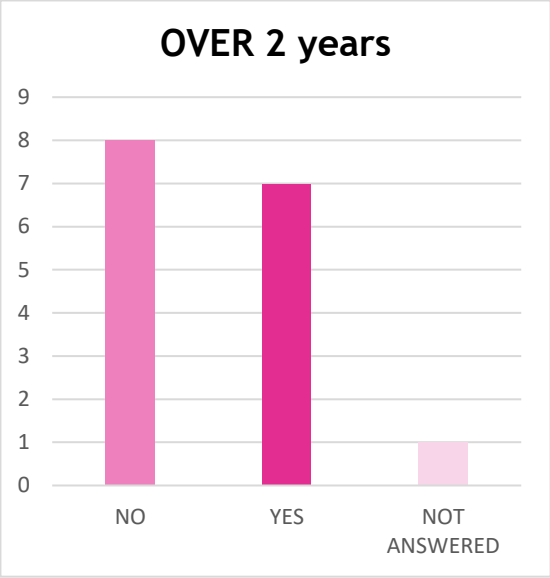


32% of the UNDER two-year group advised they thought that medical and other staff were not aware of the impact of a stroke, compared to 44% in the OVER two-year group.

This result could show a general improvement in staff awareness. However, 14% of the UNDER two-year group were not sure, opposed to only 6% in the OVER two-year group. Improvement

Q12. Did you receive timely access to community support services on discharge?





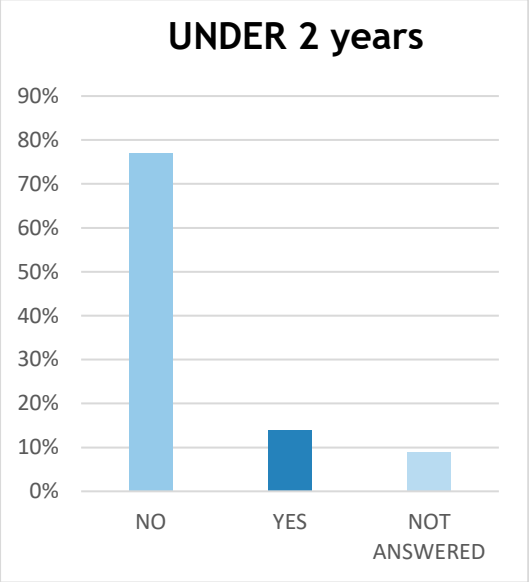
Thirteen of the 22 respondents in UNDER two-year group felt the length of time they had needed to wait for community support services was reasonable. However, nine respondents felt they had waited too long.

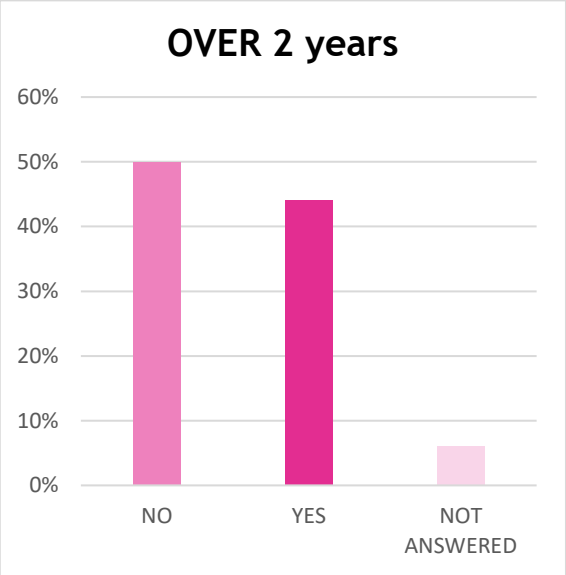
The responses from the UNDER two-year group compared to the OVER two-year group show an overall improvement, as only seven of the 16 respondents in the OVER two-year group stated that they had received community support in a reasonable time.

Eight of the Over two-year group commented that they had waited for what they considered was an unreasonable length of time.

The improvement in waiting times to access community support could be attributed to the work done by the NSCP rehabilitation team which includes seeing and working with patients while they are still on the stroke ward and giving the survivors exercises to carry on doing at home while they are waiting for the community physio to start work with them. Also, 'Discharge to Assess' team could be having a positive impact on this result. Improvement

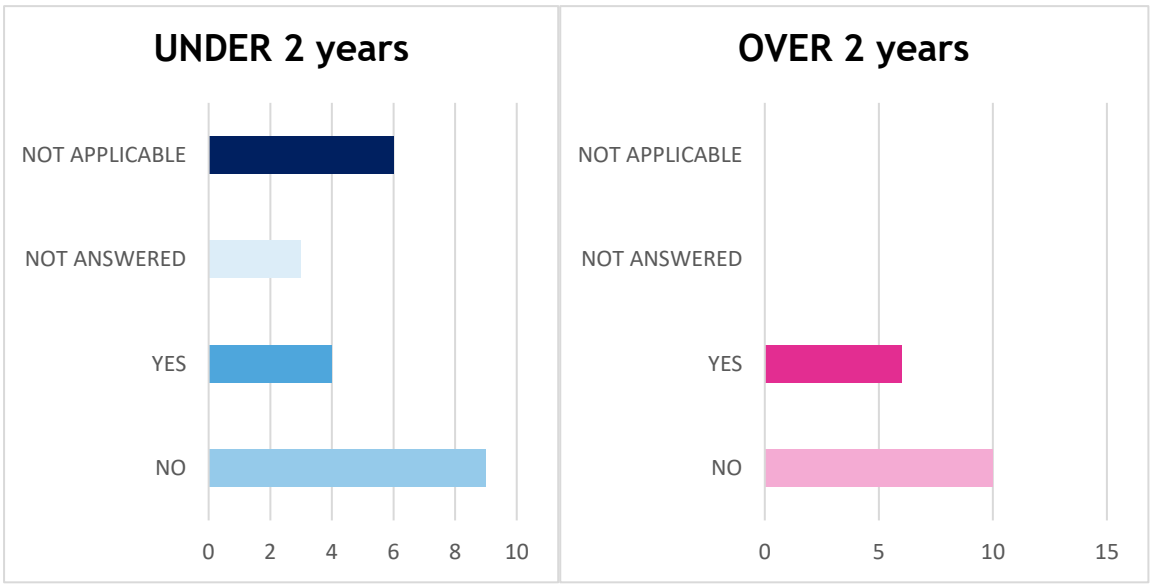
Q13. Did your Carer receive timely help to access carer support services?





Responses to question thirteen show that carers in the UNDER two-year group (nearly 80% compared to 50% of OVER two-year) felt that they did not receive support or information about carer services within what they considered to be a reasonable time following them becoming a carer for a Stroke Survivor. Deterioration

Q14. Did you get any adaptions you needed in your home done soon after returning home?



The responses to this question shows that there has been an overall fall reported in the number of respondents who had necessary adaptions carried out soon after they returned home.

Within the thirteen applicable respondents in the UNDER two-year age group, only four answered that they had had necessary adaptions completed soon after returning home.

In the OVER two-year age group six of the sixteen respondents said they had received necessary adaptions completed at their home soon after leaving hospital.

This decline could be due to there being an increase in the number of stroke survivors in North Somerset at a time when due the current national financial situation, services and funding are being stretched. Or it could be due to people considering that they required adaptions that were not being assessed as necessary by the NSCP rehabilitation team or the 'Discharge to Assess' team. Deterioration

Further comments on discharge into the community:

Respondents who had a stroke UNDER two-years ago:

"Hospital staff agreed on discharge with appropriate care package in place. Social Services could not provide that package when required so wife had to arrange for it be provided privately. Payment was subsequently reimbursed."

"Felt isolated and unsupported after discharge from Hospital. No follow up afterwards. Once speech therapy commenced progress was made and very beneficial. This came to an end due to budget cuts…From personal experience GP's did not understand stroke impact."

"When we were in receipt of the necessary help it was excellent. The help is out there but not always easy to know how to access it."

"Sent home from hospital with no support at all. Husband acted as carer but he had no support either."

"I have to say that I was very well treated and No complaints at all 10 out of 10."

"Very stressful waiting and not knowing when to expect support. D2A discharged us we then had no support or knowledge of when community Neuro team would be in contact or what they would offer for 10-12 weeks which was too long as didn't know what was happening. I am lucky to have a family to support me but would feel it would have been a very difficult period without them."

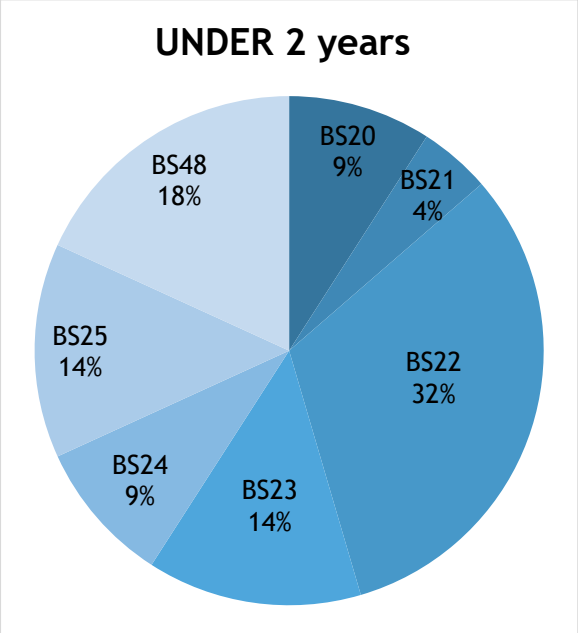
Respondents who had a stroke OVER two-years ago:

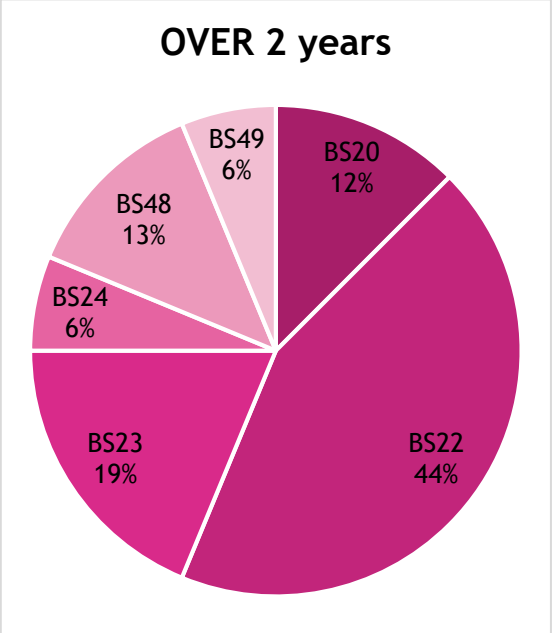
"The Speech Therapists that visited us at home were excellent and very helpful"

"The Hengrove Team and my social worker were helpful and supportive. They fought for physiotherapy at home but there was a huge delay for Speech Therapist (was) offered 6 months after discharge, mostly groups sessions."

Questionnaire Demographics

Area Respondents lived in

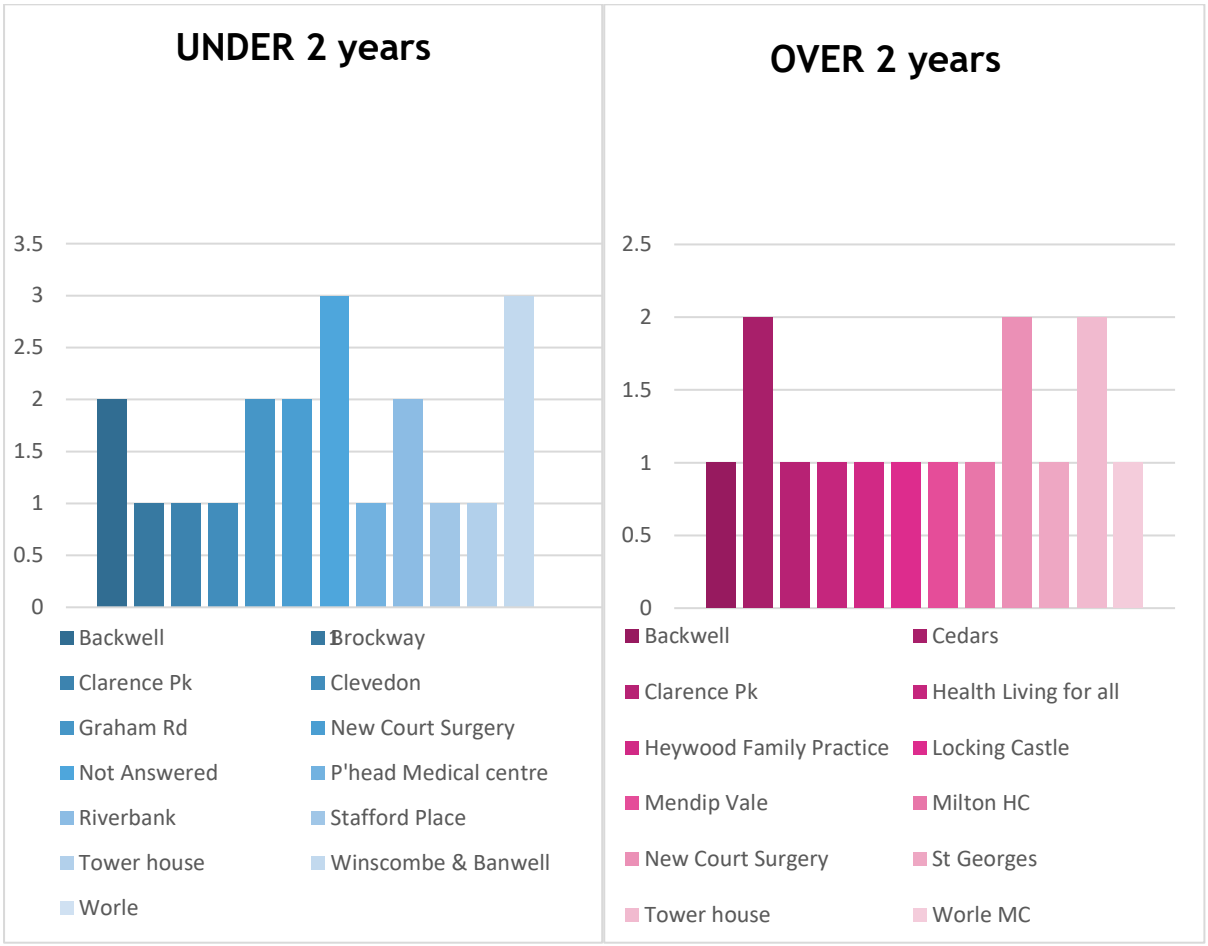




There was very little difference between the two respondent groups of Stroke survivors (those who experienced a stroke under two-years ago and those who experienced a stroke OVER two-years ago), relating to the areas that they lived in at the time they experienced their stroke, with the highest number in both groups residing in the BS22 area.

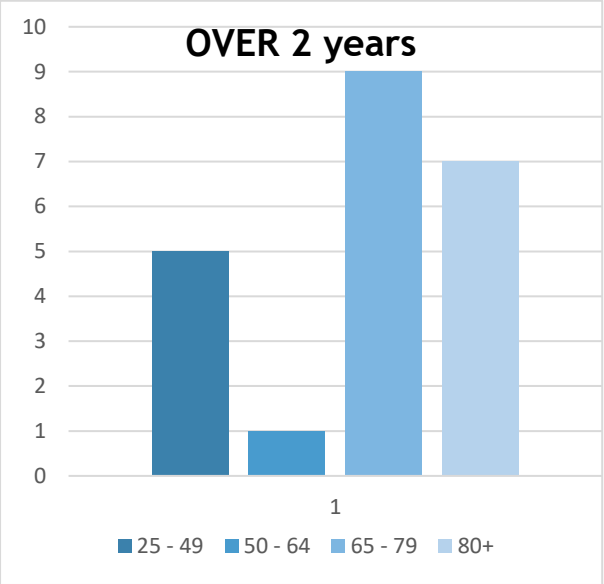
The high number of people who responded from the BS22 area may be in relation to the high number of responses that came from the BS22 Stroke Network Group attendees that Healthwatch North Somerset attended as part of the data gathering.

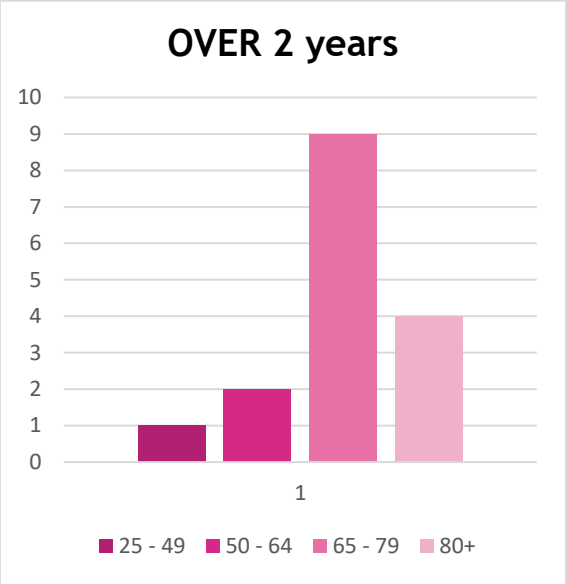
Respondents' GP Surgeries



There were some differences in the number of GP surgeries the two respondent groups attended, with more surgeries recorded for the under two-years group, however this could be a result of the higher number of respondents in this group so may not be particularly significant.

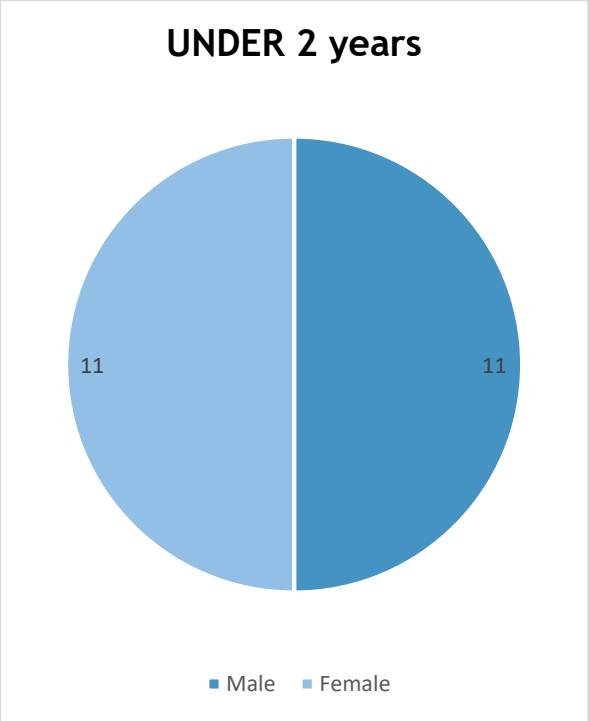
Age Range of Respondents

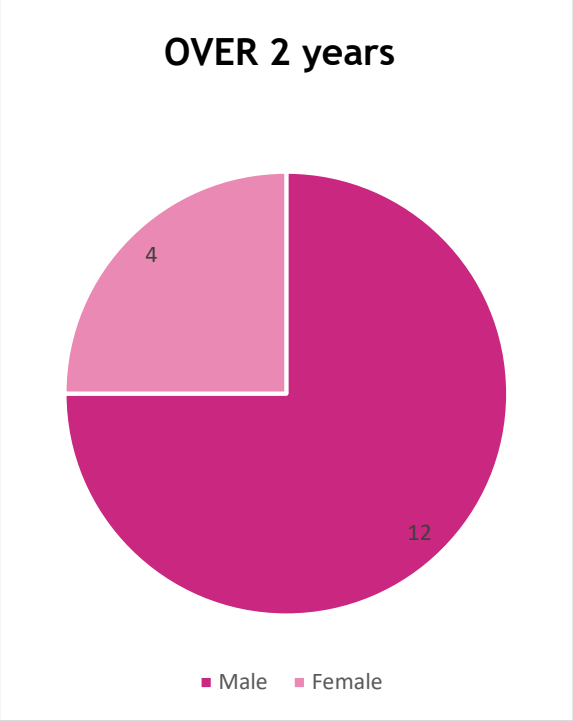




There is a rise in the number of people who experienced a stroke in the age groups 25 – 49 and 80+ in the under two-year group, when compared to the OVER two-year group. This could be related to the higher number of respondents in the UNDER two-year age group.

Sex of Respondents





There was roughly a 50:50 split between male and female respondents who experienced a stroke in the UNDER two-year group.

This was significantly different to the OVER two-year group where over two thirds of the stroke survivor respondents where men.

Conclusion

By investigating the responses from the clinical professionals, stroke survivor's responses to questionnaires and by using the four recommendations made in the 2015 Healthwatch North Somerset 'Special Enquiry Community Stroke Services report. This report concludes that there has been very little overall improvement or change in the stroke survivors experience of being discharged into community services within the last two-years.

Where there has been a 'no change' result, the experience was not necessarily good for stroke survivors in the first instance. For example, the high number of responses from both groups reporting that they did not know that they could get priority appointments with their GP's.

There have been some small improvements highlighted in this report, for instance in the slight rise in the respondents from the under two-year group who reported having timely access to information before discharge and access to community services and therapies after discharge. This improvement could be related to the work NSCP have carried out to use their resources effectively including the Lead Physiotherapist, Lead Occupational Therapist and Specialist Nurse working in hospitals with staff and patients before discharge, and acting as advisors, educators and triage support to the Discharge to Assess Teams, Single Point of Access (SPA) and Professional Assessment Teams (PAT).

Also, the partnership working between NSCP and the Weston General Hospital Outreach Speech and Language Teams could also have brought about a positive improvement for some stroke survivors.

Unfortunately, the report findings do show there has been a deterioration in some services in the last two-years. For example, the number of respondents in the UNDER two-year group who reported not getting a follow up appointment with their GP.

Also, there was evidence that carers consider they did not receive support and information quickly enough to help them when they take on the role of carer for a stroke survivor.

It is acknowledged that this report was carried out in a time of flux with North Somerset CCG is in the process of merging with Bristol and South Gloucestershire to form BNSSG CCG in April 2018. The Bristol, North Somerset and South Gloucestershire Sustainability Transformation Partnership (STP) is currently in the process of being developed and implemented. The STP will include single pathways for services including stroke rehabilitation across the STP footprint. There is a planned aim to bring about effective resource management and equity of experience for all stroke survivors in the STP area in terms of access to community support required to meet each stroke survivors needs.

It is also noted that the North Somerset Community Partnership are experiencing year on year financial cuts to their budgets but have used their current resources to develop and implement some good practice.

Recommendations

Healthwatch regulations stipulate that service providers and commissioners have a duty to respond to local Healthwatch reports and recommendations within 20 working days, in writing, to acknowledge receipt and to explain what action they intend to take; or if they do not intend to take action they must explain why. (Health and Social Care Act 2012: Addendum to summary report: issues relating to local Healthwatch regulations).

Healthwatch North Somerset recommends the following based on the findings in this report. We believe that the following recommendations made in the original report still stand and are achievable, affordable and evidence based.

1. Due to the current development of BNSSG pathways it is important that there is continued development and implementation of relevant resources to be provided, to support to North Somerset stroke patients and their carers before they are discharged from a Bristol hospital or from Weston General Hospital stroke ward.

2. It is recommended that GP's have a process in place to ensure stroke survivors and their carers are aware and can utilise their priority for GP appointments. This process should include staff training and a system to flag up vulnerable patients and their carers.

3. The continued development and implementation of a BNSSG Early Supported Discharge Service (ESDT) to ensure timely access to community support after discharge from hospital for all patients including stroke survivors who live in North Somerset but may be treated at a Bristol Hospital.

4. To develop a BNSSG wide strategy to ensure that there is an awareness of stroke survivor carer's needs and resources are made available to provide rapid support and information for carers.

5. It is recommended as part of the BNSSG stroke pathway, a process is developed to ensure stroke survivors receive follow-up appointments with their own GPs after discharge. This process should ensure every patient receives the same support service regardless of which surgery in the BNSSG footprint that they are registered with.

Providers Response

North Somerset Community Partnership
P O Box 237
Castlewood
Tickenham Road
Clevedon
BS21 6FW

Karen MacVean

Engagement Officer

Healthwatch North Somerset

Tel: 01275 885203

Date 15th March 2018

Dear Karen,

I and colleagues in the rehabilitation services have very much welcomed the opportunity to review the North Somerset Community Stroke Service Survivor's Experience Report.

We are pleased to see that during the information gathering for the review you were able to include details of the excellent work our NSCP rehabilitation teams are undertaking, within current resources, to improve the pathway for stroke patients. It is recognised that this is in advance of the BNSSG STP plans relating to early supported discharge. The changes to the service have only been in place for the last six months and as the sampling was undertaken in October 2017, the responses may not represent the full benefit of these changes.

Within this follow up report you note the small number of improvements reported particularly the improvement in timely access to community support services. Given a larger sample size and time for the full impact of NSCP's service improvements to be realised, we would expect to see further progress on this.

As the report identified NSCP now have a designated stroke specialist physiotherapist and a stroke specialist occupational therapist in addition to the specialist nurse. Together they work to improve the support for stroke patients on discharge home from hospital into North Somerset. They regularly participate in the multi-disciplinary meetings at South Bristol Community Hospital and Weston General Hospital stroke rehabilitation wards which allow them to identify those most in need

of contact before discharge and of specialist input on return home. Whilst there is still no commissioned Early Support Discharge team for stroke patients in North Somerset, NSCP continues to work together with the BNSSG stroke group to develop the future plan for stroke services across the area.

The report has highlighted the need to ensure that information is provided to carers on discharge regarding support services. The stroke team are in the process of updating the Stroke Passport mentioned in the report, and will ensure that information for carers is included in the document and in the ongoing service improvement work.

Where respondents were asked to comment on access to timely adaptations in their home, it is worth noting that often these would not be the responsibility of NSCP and would more often be provided by the community equipment service or North Somerset Council. The team have however included this in the action plan for improvements so that patients and carers have a point of contact if they are concerned that equipment or home adaptations are delayed.

Many of the report recommendations relate to timely access to GP support and information – for both patients and carers. Whilst this is not something NSCP can directly deliver we work closely with our GP colleagues and have included actions to remind GPs when patients are discharged, and also to provide additional information on the support available to patients and carers in our literature.

The results and the information contained within the follow-up report are welcomed and NSCP will continue to work closely with our partners across the system to improve the pathway for stroke patients and their families and carers.

In light of the comments in the report and your recommendations an action plan has been drawn up and is appended for your information.

If you have any further questions or comments please do not hesitate to contact me.

Yours sincerely

Judith Brown

J.A. Brown.

Chief Executive Officer
North Somerset Community Partnership

North Somerset Community Partnership C.I.C., Castlewood, Tickenham Road, Clevedon, BS21 6FW
Company Registration Number: 07569496 www.nscphealth.co.uk

Chief Executive : Judith Brown Chair : Linda Nash

Community Stroke Survivors Experience 2015-2017 HealthWatch Action Plan

Key

R	Not progressing
A	Progression delayed
G	Progressing as planned
B	Completed

Date of Meeting	Subject	Action Required	RO (s)	Deadline	Comments	Date of Update	Update	RAG rating
Report 28th Feb 2018	Support for North Somerset Stroke survivors and their carers before they are discharged from hospital	*NSCP to attend multi-disciplinary team meetings at SBCH, Weston and UHB and NBT when able to identify NS stroke patients approaching discharge with the aim of meeting as many pre-discharge as possible. Review and update of stroke passport and other information resources given to patients and carers at point of discharge and ensure consistent supplies and dissemination.*	Janet Miller Helen Ellis Rosie Owen	July 2018				
Report 28th Feb 2018	Ensure stroke survivors and carers are aware of their right to have priority appointments with GP	*Stroke therapist or nurse to update EMIS with a reminder to GP when a patient gores home and ensure it is in our info/stroke passport that they should have priority appointments and a carers assessment. Information to be shared with Stroke Association service to ensure wider dissemination*	Janet Miller Helen Ellis Rosie Owen	May 2018				
Report 28th Feb 2018	Timely access to ESD	*NSCP attendance at all meetings. Remain an active part of the ESD group.*	Nicki Carr Janet Miller Helen Ellis Rosie Owen	April 2018 attendance at next meeting. Ongoing engagement				
Report 28th Feb 2018	BNSSG wide strategy to include awareness of stroke survivors' carers needs	*Ensure the recognition of care for carers is included in the BNSSG strategy- feedback at next meeting and in our patient information/passport with signposting to carers groups etc*	Janet Miller	April 2018 to feedback to BNSSG group and July 2018 for completion of review of the passport				
Report 28th Feb 2018	Ensure stroke survivors receive follow up appointments	*Ensure we have a process for advising GPs when a patient is discharged from hospital and reminding GPs to follow up- explore possibility of EMIS note/alert*	Janet Miller Helen Ellis Rosie Owen	May 2018				

1

[redacted]

Date of Meeting	Subject	Action Required	RO (s)	Deadline	Comments	Date of Update	Update	RAG rating
			Phil Weale					
Report 28th Feb 2018	Stroke survivors and carers reported a gap between hospital discharge services (D2A) and ongoing community rehabilitation with little advice on when support may be received	*All patients who are transitioning between services and their carers to have a named contact to ensure they feel supported and where possible a time frame for when to expect the following service visit. NSCP to investigate the use of voluntary services to act as an interim during this time.*	Ben Curtis D2A Janet Miller Helen Ellis Rosie Owen	June 2018				
Report 28th Feb 2018	Stroke survivors reported equipment was not received in a timely way – if at all	*Ensure patients are advised of equipment ordered and that they know if any council adaptations are planned. NSCP to act as a broker between patients and other services to ensure timely information and guidance*	Janet Miller Helen Ellis Rosie Owen	May 2018				

About Healthwatch North Somerset

Healthwatch North Somerset's statutory duty and remit, which is laid out in The Health and Social Care Act 2012, is to provide a voice for people who use health and adult social care services, by:

Influencing

- Giving People opportunity to have a say about their local health and social care service, including those whose voice isn't usually heard.
- Taking public views to the people who make decisions – including having a representative on the Health and Wellbeing Board.
- Feeding issues back to Government via Healthwatch England and the Care Quality Commission (CQC).

Signposting

- Providing information about health and social care services in the local area. Advising people on where to go for specialist help or information (signposting).
- Helping people make choices and decisions about their care.
- Working closely with other groups and organisations in the local area.

Further Information

- North Somerset Stroke Passport
www.northsomersetccg.nhs.uk/media/medialibrary/2014/05/stroke_passport.pdf

- North Somerset Single Point of Access (SPA)
http://nsod.n-somerset.gov.uk/kb5/northsomerset/directory/service.page?id=QJHZsP85fYs

- North Somerset Stroke Association
www.stroke.org.uk/

- State of the Nation: Stroke Statistics 2017
www.stroke.org.uk/resources/state-nation-stroke-statistics

- APHO 2011
www.n-somerset.gov.uk/wp-content/uploads/2015/11/disease-prevalence-models

- Healthwatch North Somerset 'Special Enquiry Community Stroke Services'
www.healthwatchnorthsomerset.co.uk

- National Institute Health Research/themed reviews/ Road to Recovery/Recovery and Rehabilitation
www.dc.nihr.ac.uk/themed-reviews/Roads-to-recovery-final

- NICE Guidelines Stroke rehabilitation in adults
www.nice.org.uk/

- National Institute Health Research/themed reviews/ Road to Recovery/Recovery and Rehabilitation
www.dc.nihr.ac.uk/themed-reviews/Roads-to-recovery-final

- Weston Area Health Trust
www.waht.nhs.uk/en-GB/Our-Services1/Hospital-Units/Stroke/

- North Somerset Community Partnership
www.nscphealth.co.uk

- North Somerset Council
www.n-somerset.gov.uk/

- North Somerset CCG
www.northsomersetccg.nhs.uk

- University Hospitals Bristol (UHB) Foundation Trust
www.uhbristol.nhs.uk/

- Weston Area Health Trust
www.waht.nhs.uk/

- Carers Support Alliance
www.alliancehomesgroup.org.uk/care-and-support-services/our-support-services/support-for-carers/

- North Somerset Stroke Association
www.stroke.org.uk/finding-support/north-somerset-stroke-recovery-service

- National Institute of Health Research
www.nihr.ac.uk/

Appendix 1: 2017 Questionnaire

Stroke survivors Experience 2017

Details you provide in this questionnaire will be used anonymously in our findings, we are collating information to inform service providers of their user's experience of being a Stroke Survivor in North Somerset in comparison to the recommendations that Healthwatch North Somerset made in the Community Stroke Special Enquiries Report 2015.

All information you give us is anonymous and treated sensitively to avoid personal identification.

First Part of your Postcode (i.e. BS48) ……..…….

GP Surgery/Health Centre Attended ……

Your Age……. **Your Sex……..……**

BEFORE DISCHARGE

1. **When did you have your stroke?** (please tick answer)
   a) Under 3 months ago
   b) 3 to 6 months ago
   c) 6 to 12 months ago
   d) OVER 12 months ago please state ……
2. **Which Hospital/s did you receive your Stroke treatment in?** (please tick answer/s)
   a) Weston General
   b) Bristol Royal Infirmary
   c) Southmead
   d) Taunton
   e) Other (please give name) ……..……..
3. **How long did you spend in the hospital?** (please tick answer)
   a) Under 1 month
   b) 1 to 3 months
   c) 3 to 6 months
   d) OVER 6 months please state how long ……..…..
4. **Were you on a Specialist Stroke Ward?** (please circle your answer)

   YES / N0
5. **Did you get transferred to a Stroke Rehabilitation Centre or a Re-Enablement Placement**? (please circle your answer)
   a) YES, please answer question 6
   b) If No, please go straight to Question 8 (Experience of Hospital Discharge)
6. **If you answered YES to the above question, please could you tell us where you were transferred to?** (please tick answer)
   a) Hengrove
   b) Clevedon
   c) Re-enablement Placement (please give name) ……
7. **How Long did you spend in the rehabilitation/Re-enablement**? (please tick your answer)
   a) Under 1-month
   b) 1 to 2 months
   c) 2 to 3 months
   d) OVER 3 months please state ……..……..……..…….

Have you any further comments?

EXPERIENCE OF DISCHARGE FROM HOSPITAL/RE-HABILITATION

8. Did you receive any of the following before you were discharged? (please tick which answers apply)**: -**

a) Date of discharge given in advance
b) Practical preparation by the Hospital Team for you and your carer/s in readiness for discharge i.e. what to expect, how to best keep healthy and support on-going recovery
c) Received a visit from or attended a multi-agency meeting with - North Somerset Early Discharge Service (ESDT) - Social Services – Social Care provider – Health Care Professionals including - Voluntary Sector organisations.
d) Home visited before discharge by Physio or OT to check suitable /recommend adaptions if needed
e) Adaptions to Home completed before discharge
f) Information pack about what and how to access resources including financial and support available to you once you are home
g) Made aware of any care plan or package being put in place for you
h) None of the above-mentioned
i) Other (please state) ..... **9. Did you get a follow up appointment with your GP after you were discharged from hospital?** (Please circle your answer)

YES / NO

10. Were you and/or your carer made aware that your carer should be registered with the GP as a carer and that you should both have priority when booking appointments at your GP?

YES / NO

11. Overall do you feel that staff and your GP at the Surgery understand the impact of a Stroke? (Please circle your answer)

YES / NO

12. Did you get timely access to a Community Support Services package on your discharge i.e. Occupational Therapist, Physiotherapist, Speech Therapist, Voluntary Sector Support Organisations? (Please circle your answer)

YES / NO

13. Did your Carer get timely support to access to carer support? (Please circle your answer)

YES / NO

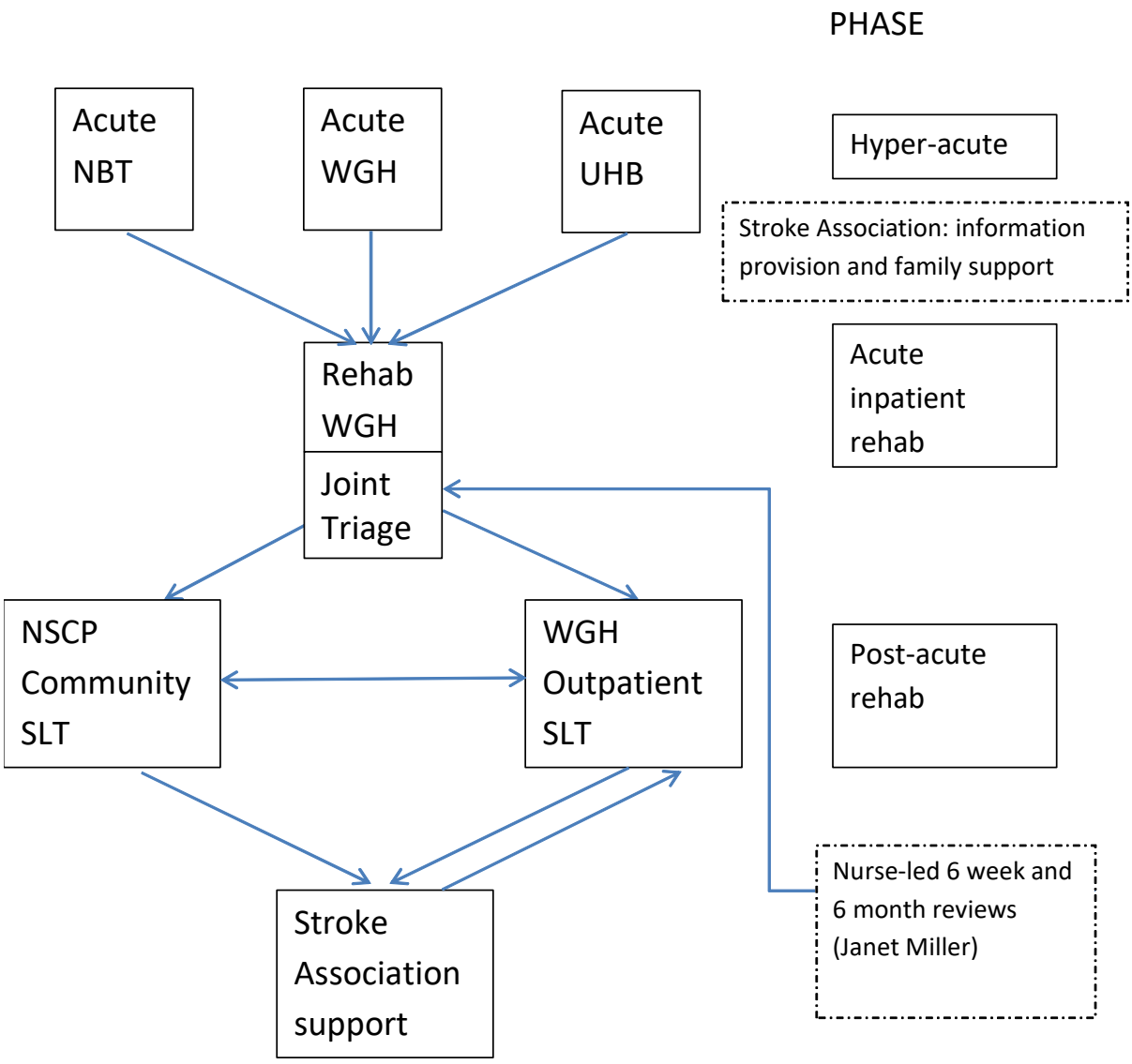
14. Did you get any adaptions you needed in your home done soon after returning home (Please circle your answer)

YES / NO

Have you any further comments?

Appendix 2: SLT Stroke Pathway - general

Permission has been given to use this stroke pathway document by the Speech & Language Therapist Outpatient Lead, Weston General Hospital on the 22nd of February 2018



Acronyms

SLT – Speech and Language Trust

NBT – North Bristol Trust

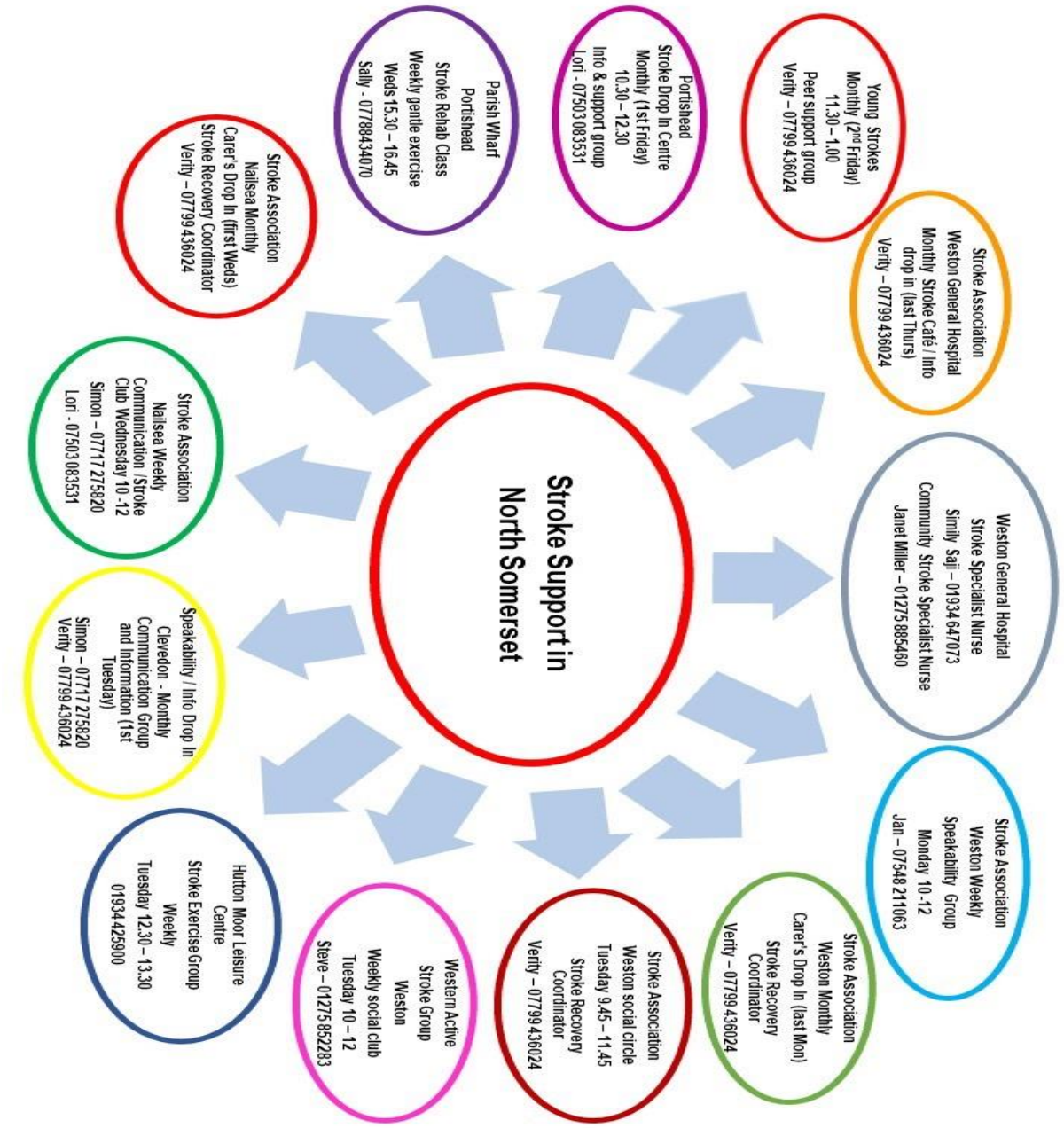
WGH – Weston General Hospital

UHB – United Hospital Board

NSCP – North Somerset Community Partnership

Appendix 3: Stroke Support in North Somerset

Permission was provided by North Somerset Stroke Association on the 27th February 2018



About Healthwatch North Somerset

Healthwatch North Somerset is an independent watchdog that gives the people of North Somerset a voice to improve, shape and get the best from local health and social care services.

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