



## **Special Enquiry Community Stroke Services**

**April 2015**

### **Background**

Healthwatch North Somerset's statutory function 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 an opportunity to have a say about their local health and social care services, 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.

Services to stroke patients after discharge is an issue highlighted to Healthwatch North Somerset by local people and on which we have received a large amount of feedback.

In particular people have advised us that they are concerned about:

1. The delay between discharge and therapist appointments;
2. A lack of relevant information provided on discharge when leaving hospital;
3. A lack of follow up after discharge by local health and social care services.

Around 150,000 people have a stroke in England each year - a quarter of them are of working age.

Based on figures provided by North Somerset Clinical Commissioning Group, in 2014 - 2015, approximately 400 local people were admitted to hospital with a stroke. The prevalence of stroke in North Somerset is 2.27% (4,855 people) based on the GP registered population.<sup>1</sup> Approximately 230 people were referred on to North Somerset community services in 2014 - 2015 <sup>2</sup>.

*(For "What is a stroke" please see Appendix 1)*

There are a number of stroke services offered in the community in North Somerset depending on the needs of the patient. The services available are:

The following information was provided by North Somerset Community Partnership (NSCP) <sup>3</sup>

### **Speech & language Therapy and Physiotherapy**

North Somerset runs a single point of access service (SPA) to manage referrals from local hospitals.

The SPA receives the referrals for triage from the therapy services at Southmead Hospital, Bristol Royal Infirmary and Weston General Hospital. The hospital guidance for the SPA states that the referral should be made on the day of the patients discharge from the hospital. Once triaged the referral is sent to the correct therapy service to be added to their waiting list.

### **Community Nursing Services**

The referral is sent to the community team who will visit the patient to make an assessment of their needs.

### **Stroke Specialist Nurse**

The hospitals refer patients direct to the stroke specialist nurse and the nurse will contact them within 6 weeks of being informed of their stroke.

### **Clevedon Community Hospital Rehabilitation**

A written referral is sent to Clevedon Community Hospital from the nursing and therapy teams at the discharging hospital. Clevedon Hospital staff will then phone the referring hospital to discuss the appropriateness of an admission.

Further information

- NSCP Stroke Care: <https://www.nscphealth.co.uk/services/stroke-care>
- NSCP North Somerset Stroke Passport: <https://www.nscphealth.co.uk/services/stroke-care>

## What we did

Healthwatch North Somerset (HWNS) received unsolicited information from a number of members of the public about Stroke Services in North Somerset. We decided to look closer at the issues raised and evaluate where local people had found difficulties with the stroke service.

We contacted local stroke support groups and asked HWNS members for information and experiences on accessing services.

Interviews with stroke survivors and their carers were conducted by phone, face to face and within focus groups in North Somerset. We also spoke to service providers: Weston General Hospital's Stroke Sister; Bristol Royal Infirmary's Stroke Coordinator and a Physiotherapist; and Southmead Hospital's Stroke Sister and a Physiotherapist. These interviews were in addition to the numerous pieces of feedback on community stroke services and stroke discharge received by HWNS via email, telephone and through our website.

All 25 GP practices in North Somerset were contacted (by email) via the practice managers to ask about their protocol for following up stroke survivors. Two community stroke services in areas bordering North Somerset (Bristol and BaNES) were also contacted to gain a comparison of service provision - they provided us with their service specifications (see Appendices 2 and 3).

Whilst the sample is relatively small (48 individuals and three stroke survivor groups) our study is designed to be qualitative in approach and provide a snapshot view and evaluation of the experiences of stroke patients and carers following discharge after a stroke in North Somerset.

The responses received from each interview and focus group with stroke survivors and carers give an insight into personal experiences, but also highlight those experiences which are shared and could be indicative of wider issues in the service provided.

## National Stroke Guidance

Below are excerpts from the National Stroke Guidance as recommended by professional bodies:

### **NICE (National Institute for Clinical Excellence) Stroke Guidance** <sup>4</sup>

1.1.8 "... *best practice is to offer an early supported discharge service to people with stroke.*" (stroke rehabilitation).

1.1.9 "*Early supported discharge should be part of a skilled stroke rehabilitation service and should consist of the same intensity of therapy and range of multi-disciplinary skills available in hospital.*"

1.8.9 "*Tell the person with communication difficulties after stroke about community based communication and support groups (such as those provided by the voluntary sector) and encourage them to participate.*"

## **Royal College of Physicians Concise Guide for Stroke 2012 <sup>5</sup>**

### **Discharge from hospital – Recommendations 3.8.1**

- *“Early supported discharge should be considered a specialist stroke service and consist of the same intensity and skill mix as available in hospital, without delay in delivery.”*
- *“Patients and carers are given information about and offered contact with appropriate statutory and voluntary agencies”.*
- *“Any continuing specialist treatment required will be provided without delay by an appropriate coordinated specialist multidisciplinary service”.*

### **Commissioning Rehabilitation Services Recommendations 2.4.1**

*Commissioning organisations should commission:*

- *“Early supported discharge to deliver stroke specialist rehabilitation at home or in a care home”.*
- *“Services capable of delivering specialist rehabilitation in outpatient and community settings in liaison with inpatient services as recommended in this guideline.”*

## **What we found**

### **Hospitals**

Healthwatch North Somerset visited and spoke to the Stroke Sister at Weston General Hospital, the Stroke Sister and a Physiotherapist at Southmead Hospital and the Stroke Coordinator and a Physiotherapist at the Bristol Royal Infirmary.

The staff at the two Bristol hospitals told us they find the North Somerset Single Point of Access (SPA) service “difficult to work with”, “disorganised” and “not in the best interests of the patients”.

They advised that there is a particular difficulty when a North Somerset patient is due to be discharged. The guideline which staff are given is to refer the patient on discharge to the Single Point of Access (SPA) Team who will arrange follow up treatment in the community.

However, staff are only allowed to make the referral on the day of the patient’s discharge from hospital. The hospital staff reported that they find this frustrating as they know that the patient will therefore experience a delay in follow up care.

The hospital staff advised that they work around this by sending the information to the SPA on the planned day of discharge and will then often hold the (North Somerset) patient in hospital for a few more days allowing time for the referral to be received and actioned by the SPA Team.

Additionally, staff at Southmead Hospital inform North Somerset patients that they will experience a delay in follow up after discharge as they live in North Somerset. There appears to be inequity between the follow up services offered in North Somerset compared to those offered to patients in other, surrounding areas.

At Weston General Hospital, we were informed that a streamlined service is in operation and the patient cases of those due for discharge are discussed in weekly meetings with the North Somerset Stroke Nurse (from North Somerset Community Partnership).

The Stroke Association for North Somerset visit the Stroke Ward at Weston General Hospital once a month to discuss with patients the help and support they can provide in the community.

Staff at both Bristol hospitals raised the issue of the differences between the North Somerset Stroke discharge pathway process and those for Bristol and Bath and North East Somerset.

Both of these surrounding areas have a Stroke Early Supported Discharge Team (ESDT) for their own areas. The ESDT offers a service to patients allowing them to leave hospital and be treated at home by the team. The team consists of health professionals such as nurses, speech therapists and physiotherapists, who liaise with ward staff from the day a stroke patient is admitted. This ensures that community teams are well prepared for the patients discharge from hospital in advance and the service allows for a seamless transition from the hospital to the home, coordinated with community services.

*“Prompt access to SLT following a stroke (the sooner the better) and a seamless transition with ongoing therapy once a patient is discharged, give the patient much better odds of a good recovery and helps to minimise problems, not just with speaking, but with feeding, swallowing, respiratory problems and aspiration pneumonia, to mention but a few.*

*It is also not rocket science to deduce that this also helps with being able to return to work more quickly, and all these benefits have a knock on effect on patients - and their carer's mental health and wellbeing.”*

*(Speech Therapist, BRI)*

There appears to be a difference in the service provided by North Somerset's Single Point of Access (SPA), which does not advise community services of impending discharge until the day of discharge, the patient then joins a waiting list for community services treatment.

Corroborating the feedback we received from stroke patients, it was confirmed by staff at both Bristol hospitals (Southmead and BRI) that North Somerset patients are either not receiving any information regarding support services locally, or are given a leaflet detailing information about Bristol stroke services, which are not necessarily accessible to North Somerset patients. Staff advised that they did not have any information relating to North Somerset to give out.

*“Having a stroke was terrifying. When I was sent home (from hospital) I was terribly scared. I couldn't speak and I didn't have any information. I sat at home and cried for 3 weeks until someone from the Stroke Association came. They helped me get the support I needed.”*

*(North Somerset Stroke Patient)*

The Stroke Association of North Somerset advised that they visited the Bristol hospitals last year and spoke to staff there who sometimes give out Stroke Passports to North Somerset patients but not support group information, as there is none available that is relevant to North Somerset.

## GP Practices

Healthwatch North Somerset contacted all 25 GP Practices in North Somerset to enquire about policy when contacting patients who had been discharged after suffering a stroke. We received replies from 7 out of the 25 GP practices contacted.

The GP practices that responded advised that stroke patients receive an annual review after discharged from hospital, generally on their birthday. There is variation within the service offered depending on which practice a patient is registered with. Some practices informed us that they will contact stroke patients soon after discharge and invite them to see the GP and others offered only the annual review.

Of the seven practices responding, one practice advised that they are aware of issues that face stroke patients in North Somerset after discharge from hospital and require further treatment in the community for speech therapy or physiotherapy and advised that they considered stroke patients suffer as a result of this.

## North Somerset Clinical Commissioning Group

Representatives from North Somerset Clinical Commissioning Group (CCG) informed us they are aware of the current gaps in service provision and that they are in the process of reviewing the community based stroke services offered in North Somerset. This is part of the reprocurement of community services which is currently ongoing and which will be completed in 2016. North Somerset CCG advised us that this report and the views of service users will be considered when planning the new service specification.

## Speech & Language Therapy at Weston General Hospital

Staff from the Speech and Language Therapy (SLT) and physiotherapy teams at Weston General Hospital advised that they would support the introduction of an Early Stroke Discharge Team (ESDT) in North Somerset, which would enable better support for stroke patients after discharge than the current system. The counties surrounding North Somerset which have as ESDT in place are able to more effectively manage and support their patients.

## The Stroke Association (North Somerset)

The Stroke Association advised us they find it frustrating that patients in North Somerset who have suffered a stroke face delays in accessing community services due to the current stroke discharge system. We were also advised that both Bristol hospitals have been given stroke support information for North Somerset from the Stroke Association but staff were not all distributing it.

All GP Practices in North Somerset were contacted by the Stroke Association in February 2014, offering training in the specific communication needs of and dealing with stroke patients, specifically to offer information around aphasia (*“inability (or impaired ability) to understand or produce speech, as a result of brain damage”*). However, no GP Practices in North Somerset have taken up the opportunity to date.



## Stroke survivors and carers

The majority of the stroke survivors and carers who Healthwatch North Somerset spoke with reported feeling unsupported when discharged and following their return home from a hospital in Bristol. They faced long waits for referrals and appointments following discharge and many have had to chase up appointments for physiotherapy and SLT themselves. Many of the people we spoke to felt distressed recalling their experiences.

They also felt that they were treated differently to Bristol patients when the staff gave out information packs and informed them they could not give packs to North Somerset patients. Some patients were informed by the hospital staff that as they live in North Somerset, there would be a delay in their follow up treatment, which would not happen if they lived in Bristol.

Many people that we spoke to felt that they receive less support than they require from their GP, with most stating that they find it very frustrating when trying to book an appointment due to a lack of knowledge of stroke patients and the difficulties they may face. Stroke patients often require double appointments or extra time and understanding when phoning to book an appointment. This is especially true for those with aphasia.

## Case Studies

The case studies illustrated below are comprised of statements and conversations from members of the public and have been published with their permission. The information provided in the statements has been received in good faith by Healthwatch North Somerset and the views expressed are those of the individual. We acknowledge that the recounting of these experiences may differ to the records of commissioners and providers.

### Case Study 1:

Healthwatch North Somerset spoke to the wife of the case study who had suffered a stroke and with his consent, she gave the following account of their experiences of stroke discharge and follow up services.

The case study first became unwell on the 29<sup>th</sup> August 2014. He lost the ability to speak, his eye and mouth on the left hand side of his face dropped and he seemed very confused.

He was taken by ambulance to Southmead Hospital for a CT scan of his brain. The A&E doctors could not find any bleeding to the brain on the scan and a diagnosis was made of a small stroke or a migraine attack.

He was monitored in A&E for several hours before being discharged. At the time of discharge, his mouth and eye had not returned to normal but had improved and he could now say a sentence of 5-6 words but not in the correct order. No information was provided on discharge and he was advised to make an appointment to see his GP.

On arrival home, he went to bed feeling unwell. The following morning, he was still complaining of a severe headache. After being awake for an hour, he became unable to speak, was blind in his right eye and had lost comprehension of his surroundings.

He was again taken to Southmead Hospital by ambulance and waited in A&E for several hours for another scan as there were concerns around safe radiation levels. The consultant reassured his wife that he considered it would probably only be a migraine as the symptoms were not typical of stroke symptoms. However, the repeat CT scan showed that he did in fact have a substantial bleed to the brain and he was admitted to the stroke ward.

While on the stroke ward, his care was “exceptional” and the nursing staff and the speech and language therapist were “fantastic”.

On discharge from Southmead hospital on the 4<sup>th</sup> September 2014 he was advised by the hospital speech therapist that if he lived in Bristol his speech therapy would recommence within a few days, but as he lived in North Somerset there could be a longer delay before he would be assessed by community services. The therapist gave his wife a quick course in basic speech and language therapy techniques to enable her to help him a little until he could be seen.

The case study received a referral letter dated the 4<sup>th</sup> September 2014, confirming he had been added to the Weston General Hospital Speech and Language waiting list as high priority.

His wife rang the speech therapy team at Weston General Hospital to enquire if there were any other ways she could help her husband while waiting for an appointment, and also to try and find out estimated waiting times. She advised that if any appointment cancellations were made available they could attend at very short notice.

On the 30<sup>th</sup> September, they received a phone call from the speech and language consultant at Weston General Hospital for an appointment. He assumed this was the start of his therapy, however, the meeting was to invite him to be part of an aphasia group therapy session starting on the 22<sup>nd</sup> October.

During this appointment, he was advised this was the treatment he would be offered for his aphasia. His wife was unhappy with this and phoned the speech and language unit to check the information. She was advised that the information given was incorrect and that in depth assessment of his condition was required before relevant therapy was offered. No time frame was offered for this assessment.

After this phone call, his wife phoned the Patient Advice and Complaints Team at Southmead Hospital to complain about the length of the wait for treatment. The Patient Advice and Complaints team put her in touch with their speech and language therapy department on the 6<sup>th</sup> October 2014 who advised it would be possible for him to have speech therapy through them, and that he could be placed on their waiting list. They advised he should be assessed by mid-November. They also advised that they would liaise with the speech and language therapy department at Weston General Hospital to check which list was the shortest and best for him to be on.

The case study received an appointment for an initial assessment at Weston General on 14<sup>th</sup> October 2014. The assessment took place over two days and he began to receive therapy on 11<sup>th</sup> November. He received 6 sessions of Speech and Language Therapy. The family also paid for private speech therapy sessions to aid his recovery.

## Case Study 2:

The case study had a stroke three and a half years ago. She received hospital treatment at the Bristol Royal Infirmary (BRI) and reported that she considered not all of the treatment received in hospital was good.

She recalled that she felt scared and alone and considered her discharge was rushed and was not clearly explained. She and her family needed to ask for information that might help her and it became clear that whilst the Bristol based patients were given written information about



support services and community services on discharge, patients from North Somerset were not unless they asked for it.

She was discharged after 10 days without an assessment of her home situation or discussion about her husband's capacity to care for her. At the time of discharge, she was unable to read or speak and was "terribly scared" when she was discharged. She had lots of unanswered questions regarding her future ability to work, pay the mortgage, or even speak - and did not have any information on where to ask or who to talk to. She felt she would have benefitted with details of contacts to support her with these questions.

She was told that she was not considered a priority for Speech and Language Therapy (SLT) on discharge and it was three weeks before she was seen by the community stroke nurse.

She was puzzled that her GP had not followed her up and she discovered they had not been informed that she'd had a stroke, nor of her hospital stay or discharge from the BRI. She told us that she eventually saw the GP's but had to insist on the monthly appointments she felt were necessary. She had difficulty getting appointments to see the same GP each time to avoid telling her story over and over again. She also discovered she could ask for double appointments, which had not been offered, these helped enormously as she was struggling and "slow and muddled" to speak. She had to ask for all this herself and also for a 6 week check-up, 6 monthly and annual follow up which are requirements of the North Somerset Stroke Review Standards. Her GP was unaware of these standards. She considers there are particular difficulties for people who have suffered strokes in accessing their GP services which include communication, concentration and clarity and that this requires awareness from the practice to enable easier access.

She received ten sessions on the New Life Live It course provided by the South West Active Stroke and Heart (SWASH) group in Weston-Super-Mare. She found it invaluable and gave her lots of the information and contacts she needed including the Stroke Association. The SWASH service is no longer available in North Somerset due to lack of funding.

The case study considered she would have benefitted from more information about support groups, benefits particularly DLA (Disability Living Allowance) and Employment and Support Allowance (ESA). She accessed the information and services she needed though perseverance.

## Summary of feedback received by Healthwatch North Somerset from the public

The following is a summary of the intelligence and feedback received by Healthwatch North Somerset from face to face contact, emails, letters and website. We received feedback and experiences from 48 individuals and 3 stroke support groups (Portishead, Nailsea and Weston) in North Somerset.

Whilst everyone we spoke with had their own unique story to tell but there were a number of recurring themes:

### 1. Provision of information on discharge

A frequently raised concern was the lack of pre discharge information provided to North Somerset patients who are treated at the Bristol hospitals. Healthwatch North Somerset was advised by stroke survivors and hospital staff that patients from other areas were given written information but that nothing was available for North Somerset patients, and that North

Somerset patients are often discharged without knowing who or where to call for help or support.

## 2. Discharge

Stroke sufferers reported a delay of up to 12 weeks after discharge for North Somerset patients for the referral to Community Stroke Services to take effect. During this time, because they had not been given any information, patients didn't know who - or if - anyone is going to follow them up or whether there would be any treatment available. It was also reported that GPs are not always informed of the discharge from hospital.

A number of respondents reported having to take the initiative, finding out, or their carers finding out, often with difficulty, who to speak to and making arrangements for physiotherapy or Speech and Language Therapy themselves.

## 3. Provision of Speech and Language Therapy and Physiotherapy

The majority of feedback from individuals and the three stroke groups reported that they considered stroke patients were provided with insufficient Speech and Language Therapy (SLT) and physiotherapy following a stroke. A number of people reported that they had been unable to regain full speech and were distressed that they were unable to get the words out that they wanted to.

One interviewee advised of the struggle he has. After the allocated six weeks SLT ended his wife has taken over the role of SLT therapist and helps him with the daily exercises. This is frustrating for them both and he continues to struggle.

Another advised that SLT was not offered at all, even though he could not speak clearly. His carer asked for a referral and was told that as he "sounded OK" none would be offered. As a result, they accessed SLT sessions privately and he is now "back to normal".

Healthwatch North Somerset received overwhelming feedback that stroke patients in North Somerset considered the SLT and physiotherapy services were only offered to those deemed to be in greatest need and are designed to return survivors to a basic level of function - rather than to try to help patients regain their pre stroke abilities and to improve the quality of life.

*"I was given six weeks of physiotherapy, and then discharged, even though I still couldn't walk. After a further 15 weeks of paying privately for physio, I can now walk with help. The amount of physio you get should be based on need - they shouldn't just tell you you've had six weeks and that's that."*

*(North Somerset Stroke Patient)*

One person reported that he had six weeks of physiotherapy as he could not walk or use his arms properly. After the six weeks, he was signed off but he was still not able to use one arm. The therapist who treated him said that he needed a lot more physiotherapy but was unable to offer it as six weeks was the standard. He was put back on the list as a 'new' patient, although this was not supposed to occur, so he could have another six weeks physiotherapy.

One patient advised us that he was paying for a personal trainer at a cost of £60 per week as the six weeks offered was insufficient. He wanted to "get back to the person (he) was before the stroke, not just surviving". The additional privately funded support has made an incredible difference and he reports he is now properly fit and healthy again, but at a significant financial cost.

#### 4. Carers and emotional support

People reported that there is no respite backup offered for carers after a stroke, one carer themselves had to go into hospital and there was no one to look after his wife who was struggling after a stroke.

People advised that stroke survivors and their carers also need emotional support – but have found there is no mental health support offered.

*"More people than ever are surviving a stroke and that's a welcome improvement. But many stroke survivors tell us that after all the effort to save their lives they then feel abandoned when they return home. The NHS and local authorities are failing in their responsibilities to provide appropriate and timely support to stroke survivors and their families."*

(Jon Barrick, Chief Executive, The Stroke Association)

## Recommendations

Based on the information provided by stroke patients and their experiences and the feedback that has been received from health professionals and other organisations, Healthwatch North Somerset makes the following recommendations:

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 and implementation of best practice when speaking to and booking appointments of stroke patients needs 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.

# Responses to the Special Enquiry Community Stroke Services report received from Commissioners and Providers

## 1. Weston Area Health Trust

Weston Area Health Trust welcomed the report and are supportive of the recommendations, particularly in regard to the development of an Early Supported Discharge Service in North Somerset.

Weston Area Health Trust provided the following information:

Therapy is not limited to 6 sessions at Weston General Hospital and is based upon individual needs. Weston Area Health Trust set SMART targets and as long as there are identifiable goals in therapy, people are seen for as long as they need to be seen. If this is for a long period of time, sometimes the therapy is broken down to allow a period of consolidation. Patients are not discharged if there are continuing needs.

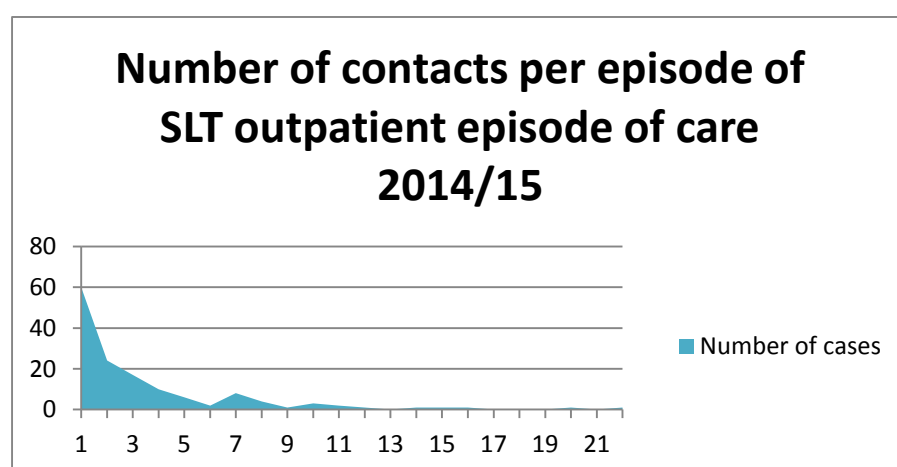
Weston Hospital fast tracks priority patients and waiting times are delivered within and in line with national guidance and standards.

Weston Area Health Trust have provided the following data:

### Weston Area Health Trust Outpatient Speech and Language Therapy episodes of care and number of contacts per episode 2014/15

Number of contacts per episode of care	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
Number of cases	60	24	17	10	6	2	8	4	1	3	2	1	0	1	1	1	0	0	0	1	0	1

Total number of episodes of outpatient SLT care	143
Total number of contacts for all episodes of care	489
Average number of contacts per episode of care	3.4
Range of number of contacts per episode of care	1 to 22



## 2. North Somerset Clinical Commissioning Group



### **North Somerset Clinical Commissioning Group**

**Mrs Eileen Jacques**  
3<sup>rd</sup> Floor  
The Sion  
Crown Glass Place  
Nailsea  
BS48 1RB

**North Somerset CCG**  
Castlewood  
Tickenham Road  
Clevedon  
BS21 6BH

Tel: 01275 885547

Date: 20.08.2015  
Ref:MGA100815

Dear Mrs Jacques

**Re: Healthwatch North Somerset Special Enquiry Community Stroke Services  
April 2015 Report.**

Thank you for forwarding the above report for comment from North Somerset Clinical Commissioning Group (CCG).

The CCG welcomes the report, which provides a valuable insight into some of the issues facing residents of North Somerset following a stroke, particularly around the hospital discharge, follow-up processes and access to local information.

One of the concerns most strongly expressed in the report is an apparent disparity between stroke services in North Somerset and Bristol. North Somerset residents, as part of the stroke pathway, will naturally access certain types of specialist services, such as complex stroke treatment in a hospital out of area, such as Southmead Hospital or the Bristol Royal Infirmary.

It is clear from the report however that more needs to be done to ensure that residents of North Somerset who require treatment out of area are better linked into local services upon discharge, and are supported throughout with consistent local information throughout their stay in hospital and beyond. The CCG recognises this and is working closely with Bristol and South Gloucestershire CCGs to resolve these issues.

The report also highlights concerns around access to stroke rehabilitation within the community, which is an area the CCG recognises needs further improvement. In partnership with NHS England and North Somerset Council, the CCG recently announced North Somerset Community Partnership as the preferred bidder in the tendering process for the provision of community healthcare services for North Somerset. The CCG has worked closely with Healthwatch North Somerset throughout the process and its members have also been involved in scoring the bids submitted by the organisations that tendered.

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Chief Clinical Officer: Dr Mary Backhouse

Governing Body Chair: Kathy Headdon

**Creating the Healthiest Community Together**

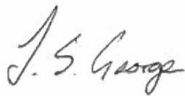


The re-procurement will provide an opportunity to reshape how community health services are delivered in North Somerset. Ensuring that stroke rehabilitation services, including speech and language therapy and physiotherapy, are more responsive to the needs of residents will be a key focus of that work, and a new model of community-based rehabilitation is currently being developed. Services will need to be more focused on a person's individual outcomes, and the provider will be given greater flexibility to ensure patients' health and social care needs are met.

A new whole-service model from the CCG's preferred bidder will be presented to stakeholders on the 3<sup>rd</sup> September 2015. An invitation to this event has been sent to you separately. This will present an opportunity to ask any questions concerning any of the services the preferred bidder would be providing within the period of the new contract.

Finally, I would again like to thank Healthwatch North Somerset, its members and contributors for their work in producing this report. I hope that this response to your concerns provides an assurance that the CCG takes these very seriously and is working hard to ensure that our health services continue to improve for residents of North Somerset.

Yours Sincerely



Jeanette George  
Chief Operating Officer

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Chief Clinical Officer: Dr Mary Backhouse

Governing Body Chair: Kathy Headdon

**Creating the Healthiest Community Together**

### 3. North Somerset Community Partnership

We welcome the feedback contained in the report and recognise that there are gaps in our provision of community rehabilitation to Stroke patients which we are working with our Commissioners to address.

Our vision is to have a new rehabilitation model where there is an emphasis on early assessment and intervention and ensuring patients are seen by the most appropriate clinician from the outset of their rehabilitation journey. We recognise that this will necessitate reviewing all our current pathways for rehabilitation to ensure that referrals are dealt with consistently and at the earliest opportunity, rather than just at the point of discharge, and feel that this will certainly address some of the unnecessary delays in commencing rehabilitation.

We continue to work with our acute partners to ensure that correct information is delivered to patients in their care and the stroke passport distributed effectively. Our stroke specialist nurse visits the acute sites on a regular basis to improve communication and build relationships.

A multi- agency rehabilitation project is being led by our Commissioners with which we are actively involved. We are confident the issues raised will be addressed once the work of this project is finalised.

## 4. University Hospitals Bristol

Carole Tookey  
Head of Nursing/Assistant Chief Nurse  
Division of Medicine  
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Dear Eileen Jacques,

Thank you very much indeed for sharing the Healthwatch North Somerset Special Enquiry Community Stroke Services report, April 2015. The report provides us with invaluable feedback from people who use our services, which enables us to ensure their views are heard and incorporated into service developments as well as giving us the opportunity to review our current practice.

As Head of Nursing for the Division of Medicine, I and members of the UH Bristol Stroke Multi-Disciplinary Team, reviewed and noted the report in particular the example of discharge from UHBristol (case study 2 in the report). I would encourage the patient to contact the UH Bristol Patient Support and Complaints team so that a review of the patients medical records can take place and that learning from this experience can be determined. The Patient Support and Complaints team can be contacted by email at [Pals@UHBristol.nhs.uk](mailto:Pals@UHBristol.nhs.uk) and by telephone on 0117 342 1050  
In addition, UH Bristol will take the following actions:

1. We will ensure that all discharged stroke patients, including those from North Somerset, take a personal hand held copy of their GP discharge summary home with them and that this is available to their GP within 24hrs of discharge (this is the expected Standard and if completed on the system before discharge will automatically be with the GP in this timescale)
2. We have downloaded and printed a supply of the North Somerset Stroke Passport and North Somerset Home from Hospital information and will ensure that all patients discharged to North Somerset have this information in hard copy on discharge
3. Any carers of North Somerset patients that we identify before discharge, will be referred to our Carers Liaison Worker on [carersliaison@uhbristol.nhs.uk](mailto:carersliaison@uhbristol.nhs.uk) or via telephone on 07557 441613 to ensure they have any support they require and appropriate referral onwards into appropriate carer support services in North Somerset
4. We have arranged that our daily Safety Briefing on the inpatient wards, for the next 2 weeks will be about safe and effective discharge of Stroke patients to North Somerset

Thank you for taking the time to share this report with us.  
Yours sincerely

Carole Tookey  
Head of Nursing/Assistant Chief Nurse  
Division of Medicine

## References

1. Health and Social Care Information Centre (HSCIC)  
[www.hscic.gov.uk/qof](http://www.hscic.gov.uk/qof)
2. North Somerset Community Partnership (NSCP)  
<https://www.nscphealth.co.uk/services/stroke-care>
3. National Institute for Clinical Excellence (NICE)  
Clinical Knowledge Summaries <http://cks.nice.org.uk/stroke-and-tia>  
Stroke Pathways  
<http://pathways.nice.org.uk/pathways/stroke#path=view%3A/pathways/stroke/stroke-overview.xml&content=view-index>
4. Royal College of Physicians  
<https://www.rcplondon.ac.uk/resources/stroke-guidelines>
5. Commissioning Rehabilitation Service Recommendations 2.4.1  
[https://www.rcplondon.ac.uk/sites/default/files/documents/stroke\\_commissioning\\_guide\\_web.pdf](https://www.rcplondon.ac.uk/sites/default/files/documents/stroke_commissioning_guide_web.pdf)
6. Commissioning for Value: Pathways on a page  
<http://www.england.nhs.uk/wp-content/uploads/2014/11/cfv-nrth-somerset.pdf>
7. Sentinel Stroke National Audit Programme (SSNAP)  
<https://www.strokeaudit.org/Documents/Results/National/2015/2015-PAOrgPublicReport.aspx>  
<http://www.strokeaudit.org/SSNAP/InteractiveMaps/RCP-Post-Acute-Org2015%5CPhase1/atlas.html>

## Support and Information Resources

### Stroke Association

[www.stroke.org.uk](http://www.stroke.org.uk) (a range of resources including leaflets and details of local stroke support groups can be found on the website)

Telephone: 01275 870328

### Royal College of Speech and Language Therapists

[www.rcslt.org](http://www.rcslt.org)

### Crossroads Care North Somerset (for carers)

[www.crossroadscaresw.org.uk](http://www.crossroadscaresw.org.uk)

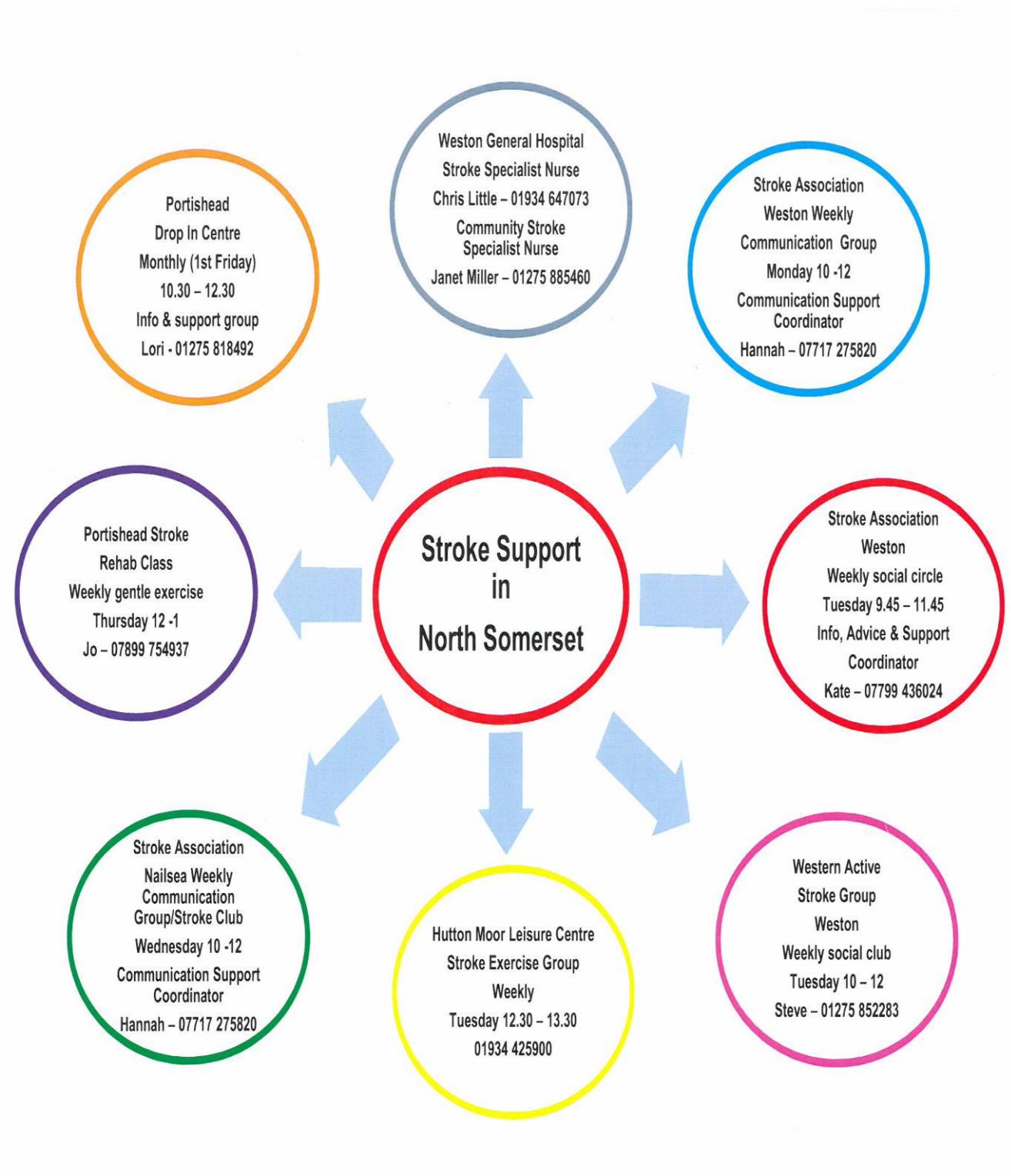
### Home from hospital leaflet

[https://www.n-somerset.gov.uk/Social%20care/older\\_people/Documents/home%20from%20hospital%20leaflet%20\(pdf\).pdf](https://www.n-somerset.gov.uk/Social%20care/older_people/Documents/home%20from%20hospital%20leaflet%20(pdf).pdf)

### Stroke Passport

[www.northsomersetccg.nhs.uk/media/medialibrary/2014/05/stroke\\_passport.pdf](http://www.northsomersetccg.nhs.uk/media/medialibrary/2014/05/stroke_passport.pdf)

Stroke Support Groups in North Somerset



(With our thanks to Lorraine Rowsell for compiling and sharing this diagram of support.)



## Appendix 1

### What is a stroke?

A stroke is caused by the interruption of the blood supply to the brain, usually because a blood vessel bursts or is blocked by a clot. This cuts off the supply of oxygen and nutrients, causing damage to the brain tissue.

The most common symptom of a stroke is sudden weakness or numbness of the face, arm or leg, most often on one side of the body. Other symptoms include: confusion, difficulty speaking or understanding speech; difficulty seeing with one or both eyes; difficulty walking, dizziness, loss of balance or coordination; severe headache with no known cause; fainting or unconsciousness.

The effects of a stroke depend on which part of the brain is injured and how severely it is affected. A very severe stroke can cause sudden death.

For further information, please see:

[www.who.int/topics/cerebrovascular\\_accident/en/](http://www.who.int/topics/cerebrovascular_accident/en/)

## Appendix 2

### BANES ESD Service Specification



#### Sirona Care and Health

#### Community Neuro and Stroke Service – Early Supported Discharge (ESD) BaNES

The ESD team provides specialist assessment and treatment for people following acute stroke. The team inreach into acute and community hospitals working closely with the staff, service user and their carer to provide a seamless transfer of care between hospital and home. The team are able to commission short term care packages to support service users out of hours.

The service operates over 7 days: Monday – Friday 8.00 – 18.00

Weekends and Bank Holidays 8.00 – 16.00

The specialist multidisciplinary team consists of occupational therapists, physiotherapists, specialist nurses, speech and language therapists, psychology, assistant practitioner and rehab assistants who provide intensive rehabilitation at the service users' home or place of residence. Team members share skills and competencies to enable interdisciplinary working which ensures person centred care and a flexible work force. The service is goals led and non-time limited. The team has close working links with stroke consultants, other health, social care colleagues, community and voluntary organisations including the Stroke Association with the Community Stroke Coordinator sitting with the team. Following discharge from ESD service users are offered a review at 6 months from date of stroke and a further review by the Community Stroke Coordinator at 12 months.

#### Referral criteria:

18 years +  
Registered with a BaNES GP  
Rehabilitation needs identified  
Needs can be met at place of discharge  
Safe between care calls

#### 6 week Reviews

The ESD team also provide review for people following stroke who do not require rehabilitation. The specialist nurse is able to visit people at home within 6 weeks of discharge from hospital and provides comprehensive holistic assessment and advice on secondary prevention and healthy lifestyles and can signpost to relevant community and voluntary services. Service users are offered further nursing review at 6 months and with the Community Stroke Coordinator at 12 months,

## Appendix 3

### North Bristol NHS Trust ESD Service Spec

Stroke early supported discharge team

Service Specification

North Bristol NHS Trust

Judith French – Assistant General Manager

Catherine O'Toole – Trainee General Manager

Rebecca Woodward – Team Leader Stroke Discharge Team

Date June 2010

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1. Introduction to Service Specification
2. Definition / Aims of Service
3. Scope of the Service / Referral Criteria
4. Areas in Which Service is Delivered
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6. Service Hours / Response Times / Standards
7. Service Provided to Patients
8. Benefits to Service Recipients
9. Alternative Service Provision
10. Sources of Referral
11. Onward Referrals
12. National Standards and Guidelines
13. Key Relationships
14. Local and National Targets
15. Patient and Public Involvement
16. Review Date

#### **Background**

This operational policy is designed to enable the multidisciplinary team to provide a high quality, evidence based, seamless early supported discharge service to patients affected by stroke, in order to optimise the clinical outcome and care experience for both patients and carers.

The National Stroke strategy (DOH Dec 2007) and clinical guidelines highlight the benefit of ESD for some patients if the equivalent level of support to inpatient care can be provided in their homes. ESD is stated as gold standard expectation in Royal College of Physicians sentinel audit report for NBT in 2009. Furthermore it is the PCT's intention that NBT is the lead for stroke services within BNSSG. ESD has been identified as a priority by NBT as we need to reduce the bed base in preparation for the move to the new hospital.

ESD has been proven as an effective model of service delivery with patients following a stroke if the community team has a specialism in stroke (staffed by stroke specialist team with clinical governance programme and focus on maintaining best practice – qualified and support worker in house training programmes)(Cochrane Stroke Group systematic review Lancet, 2004). The RCP Clinical Guidelines for Stroke 2008 recommends "Patients should only be discharged early (before the end of acute rehabilitation) from hospital if there is a specialist stroke rehabilitation team able to continue rehabilitation in the community from the day of transfer and if the patient is able to transfer safely from bed to chair (all patients where identified as needed are seen on day of DC or within 24 working hours), and if other problems can be safely managed at home". The evidence reports that there is "moderate" evidence that ESD services provide care at modestly lower total costs than usual care for stroke patients with mild or moderate disability (Brady et al 2005) while promoting significant improvement in extended activities of daily living scale, increase in reported satisfaction with services (use of service user questionnaire on DC from service) (Langhorne *et al.* 2005) and reduction in levels of institutionalisation (Larsen et al 2006). Length of hospital admission stay has reportedly been reduced on average by between 8 days (Langhorne *et al* 2005) and 10 days Larsen et al (2006). The greatest benefits were seen in the trials with a co-ordinated multidisciplinary ESD team and in stroke patients with mild to moderate disability.

#### **Service Specification**

This is the Service Specification for the Stroke Early Supported Discharge Service (((with Bristol and south Gloucestershire PCT as the commissioner of the service?????))) and North Bristol NHS trust as the provider of the service.

#### **2. Definition / Aims of the Service**

The Stroke early supported discharge service enables the accelerated discharge of stroke patients to their home (family home) providing specialist rehabilitation and social support in the community comparable to that of an in-patient stroke unit no definitions yet re ESD and frequency of visits needed, we are able to offer 1 to 2 visits daily Monday to Fri for some of the caseload as a maximum. On the whole most people receive one visit a day Mon to Fri from any professional. Service provision is focused around time specific patient goals Goal setting within the 1<sup>st</sup> 3 visits using the goal attainment scale for documentation and as a means of measuring outcome of SDT service and will embrace the needs and ability of their carers Measured through service user questionnaire.

This service will cover the population of Bristol and South Gloucestershire PCT and GP's covered within this catchment area as agreed by local commissioners.

### Team Configuration

Access to medical review: via GP with necessary communication with Consultant Specialist per local agreement

- Team leader 0.5 WTE
- Nursing 0.4 WTE
- Occupational Therapy 1 WTE
- Physiotherapy 2 WTE
- Clinical Psychology NO PROVISION CURRENTLY
- Speech And Language Therapy 0.5 WTE
- Support Workers / Assistants / AP's 1 WTE SUPPORT WORKER
- Admin Support NO PROVISION CURRENTLY

The stroke ESD service will discuss and may accept referrals for patients who meet all of the following criteria:

- a) Confirmed new diagnosis of stroke Age 16 or over
- b) Medically predictable and relevant diagnostics completed however, some tests could be completed in day hospital or as an out-patient if an earlier discharge could be facilitated.
- c) Achievable rehabilitation goals can be identified and will be continued in the patients' own/new home
- d) Demonstrable change in function in the last 2 weeks
- e) Clear and realistic rehabilitation goals identified by therapist and discussed with the stroke discharge team.
- f) Mild to moderate difficulties on discharge
- g) Patients who have shown potential to improve their mobility within the previous week (this can be with 2 people) and can be treated by 1 member of staff when not working on mobility goals.
- h) Not suitable for patients who are transferring with 2 only and the referral is for improving these transfers
- i) Patients do not require 2 members of staff to assist with rehabilitation programme (unless gait related/specific requirements, not on a daily basis-see point g)
- j) More than 1 discipline needed and must be receiving regular input from qualified therapists on the ward.
- k) The home environmental conditions are safe and suitable for rehabilitation as identified by the ward staff and on key working. To go in in pairs if concerns raised.
- l) Patients who are safe at night, or who need the assistance of one carer, which may be a capable spouse, and can appropriately manage between visits
- m) Patients who are able to transfer safely from bed to chair or safely with trained carer
- n) Patients whose continence has been assessed in hospital; as manageable in the home environment with ongoing support and assessment. This may include continence aids or a catheter
- o) Patients whose nutritional needs are able to be managed in the home environment following assessment in hospital (patients with PEG feed may be appropriate if supported by the Community Feeding Service, however those with NG, nil by mouth or on limited non-nutritive oral intake trials will be excluded)
- p) The patient and family give consent to the ESD team coming in and providing rehabilitation at home
- q) The patient lives within catchment area covered by North Bristol NHS Trust (covers part of Bristol and South Gloucestershire) which could include supporting someone within the North Bristol Rehab Centre.
- r) Referrals held on our pending list will be closed.

When the mental capacity of the patient to make a decision re: ESD is in question, the decision for discharge should be made in the best interests of the patient by the MDT following appropriate assessment.

### 4. Areas in which Service is delivered

The stroke ESD Service delivers treatment to patients in their own home or residential settings. (We will consider short term nursing home placements)

### 5. Base

The Stroke ESD Service is based at Frenchay Day hospital.

### 6. Hours of Service / Response Times / Standards

The Stroke ESD Service's operates a 5 days service (Monday – Friday) core hour of 8am and 4.30pm 100% of all patients referred to and accepted by the Stroke ESD will have contact with a member of the team within 24 working hours of discharge.

- The service will provide input dependent upon patient rehabilitation potential and individual time specified goals. GAS goals will be used.
- It is anticipated that this may vary between 1-5 weeks dependent on client need and local agreement.
- Patients should undergo as much therapy appropriate to their needs as they are willing and able to tolerate FOR SOME INDIVIDUALS STAFF LEVELS DO NOT ALLOW AS MUCH INPUT AS THEY ARE ABLE TO TOLERATE, HOWEVER FOR THE MAJORITY OF INDIVIDUALS THAT RESPONDED TO OUR QUESTIONNAIRE THEY FELT THE INPUT WAS "JUST RIGHT".
- In the early stages they should receive a minimum of 45 minutes daily of any therapy that is required (ACHIEVING 45 MINS DAILY BUT NOT OF EACH THERAPY REQUIRED, HOWEVER THIS IS ALSO NOT BEING ACHIEVED AS AN IN PATIENT) (RCP Stroke Guidelines 2008 3.13.1 page 3.9)

## 7. Service Provided to Patients

Following initial screening each professional involved in the rehabilitation programme will:

- Carry out specialist assessments.
- MDT collaboration with service providers should be encouraged SDT KEYWORKER FOLLOWING REFERRAL PRO-ACTIVELY LIASES AND WORKS WITH IN PATIENT STAFF TO FACILITATE AN EARLIER DC WHERE POSSIBLE AND LIASES WITH SOCIAL SERVICE WHERE NEEDED TO FOCUS DC.
- A key worker will be identified to facilitate discharge for each patient and this will be communicated to the patient/carers.
- Patient centred goals (using a standardised format of goal setting e.g. the goal attainment scale (GAS)) will be documented in the patient's notes, following professional assessment with an appropriate treatment plan MEDIAN GAS CHANGE SCALE IMPROVEMENT FOLLOWING SDT INPUT WAS 20, SCORES OVER 10 ARE DEEMED A MEANINGFUL CHANGE.
- Goals within the rehabilitation programme will be evaluated regularly and discussed with the MDT as appropriate.
- The referring agent and relevant others will be updated on the progress of the patient as appropriate during treatment episodes and at the end of the episode A DISCHARGE SUMMARY IS WRITTEN FOLLOWING SDT INVOLVEMENT AND SENT TO SERVICE USER AND ANY AGENCY CONTINUING THEIR CARE.
- Each intervention is recorded in the patient's documentation and on the Trust data collection system.
- An episode of care is ended when the goals are achieved or no further progress / improvement can be made at that time.
- Should the patient experience a new medical problem, the teams would seek support from relevant medical staff to provide a diagnosis for the problem LARGELY THROUGH LIAISON WITH GP.
- A local pathway should be in place in the event of patient medical deterioration for patients while with the Stroke ESD Service. Which states that in an emergency patient should be admitted direct to the ward NO AGREEMENT, CALL 999 ARE READMIT THROUGH ED OR MAU.
- On discharge the patient will be provided with a management plan as appropriate and onward referral to appropriate other services will be agreed and completed 62% OF SERVICE USERS WITHIN SDT REFERRED ON TO OTHER AGENCIES.
- The patient, the referring agent and relevant others will be notified in writing of discharge, outcome of treatment and any onward referral or future plans.

### Direct Intervention:

The following are examples of direct intervention provided by the stroke ESD service:

#### Promotion of health

- Advice and referral regarding smoking cessation, diet, activity, exercise and Driving

#### Improvement of health

- Ongoing assessment, information and advice.
- Splinting LIMITED EVIDENCE FOR THE BENEFIT, NO BUDGET FOR RESOURCING SERVICE, DO USE ORTHODICS SERVICE
- Transfers, mobility work and gait re-education
- Functional assessment and rehabilitation
- Cognitive assessment and rehabilitation
- Exercise programmes PROVIDE A 6 WEEK ONCE WEEKLY EXERCISE GROUP – ACTIVATE BASED WITHIN THE OUT PATIENT PHYSIOTHERAPY, ALSO REFER ON TO EXERCISE ON PRESCRIPTION SERVICES
- Return to work / leisure activities support UNABLE TO OFFER VOCATIONAL REHABILITATION DUE TO TIME LIMIT REFER ON TO ICT, DART OR RETURN TO WORK SCHEMES
- Assessment and intervention for anxiety and mood problems ABLE TO ASSESS NEED FOR FURTHER SUPPORT, LIMITED AVAILABILITY IN COMMUNITY SO REFERR ON TO BASF, CARERS TRUST OR GP
- Emotional support NO CLINICAL PSYCHOLOGY IN THE SDT SERVICE
- Advice/education for patient, carers and family –HAS PROVED A LARGE PART OF OUR INVOLVEMENT, FOR WHICH VERY POSITIVE FEEDBACK RECEIVED 98% SATISFACTION
- Pain management

- Speech language assessment and rehabilitation OFTEN DELAY IN SLT PICK UP AND PROBLEM WITH ONWARD REFERRAL DUE TO 18 WEEK DELAY WITH COMMUNITY SLT, TENDANCY FOR SDT REFERRALS FOR SLT ONLY
- Swallow assessment and rehabilitation
- Sensory assessment including vision / hearing

#### Maintenance of health

- On-going assessment, information and advice.
- Maintenance programmes including splinting, provision of equipment
- Assessment for wheelchairs
- Exercise plans

#### **Indirect Intervention:**

The following are examples of indirect intervention provided by the stroke ESD service:

#### Maintenance of health

- Appropriate referral to other health care professionals/agencies.
- On-going care and support for individuals and their families/carers.

#### Co-ordinating Care:

- Co-ordinating an individual's rehabilitation process and liaison with relatives/carers.
- Provision of equipment, aids and adaptations
- Developing integrated working relationships with partner organisations ensuring effective transfer of care HAS UNDERTAKEN SETTING UP REGULAR MEETINGS WITH S GLOS ICT AND VOLUNTARY SECTORS TO DEISSUE BETTER INTERGRATION
- Establishing and maintaining links with a range of primary and secondary health care providers.
- Developing initiatives to enable patient centred, co-ordinated care that meets the needs of individuals and their families/carers

Early rehabilitation is effective when provided in specialist stroke units, or as part of properly organised early supported discharge and longer term support in the community, according to need.

Components of a multifaceted stroke services provides specialist rehabilitation and support, within the following areas:

- Mobility and movement
- Communication
- Everyday activities e.g. dressing, washing, meal preparation
- Depression and distress
- Swallowing
- Nutrition
- Cognitive difficulties
- Vision and perceptual difficulties
- Continence
- Relationships and sex

#### **8. Benefits to Service Recipients**

- Improvement in health/wellbeing e.g. quality of life measures
- Increased patient functional Independence e.g. goal setting and outcome measures
- Reduction in hospital length of stay e.g. in days
- Effective hospital discharge with seamless transfer of care e.g. reduced readmission rates
- Patient satisfaction of service via patient survey
- Carer satisfaction with reduction in carer strain
- Reduced "hand off's" between services dependent on local configuration.

#### **9. Alternative Service Provision**

Out of area patients will remain on the stroke units DIFFICULTY WITH NBT PTS DC TO UHBristol ESD AND NBT PICK UP FROM UHBristol

#### **10. Sources of Referral**

The stroke ESD service operates an open referral system. Referrals are received from any

Health or Social Care Professional within NBT via written referral sent to team base. Patient referral received from wards 106 at Frenchay and wards 1 at Southmead Hospital. DURING PILOT EXPANDED PICK UP TO INCLUDE OUTLIERS UNDER STROKE TEAM MANAGEMENT



## 11. Onwards Referrals

Staff in the stroke ESD service will refer onto other services as deemed appropriate. This will include referrals to:

- Intermediate care or local community services
- Outpatient physiotherapy / occupational therapy services
- Out of area services
- Other health and social care professionals i.e. Medical/Nursing/Social Care and other AHP's as appropriate.

## 12. National Standards & Guidelines

The Stroke ESD Service will be provided in line with the following National Standards and

Guidelines:

- Professional Standards e.g. CSP, COT, NMC, HPC
- RCP Guidelines Stroke 2008
- National Stroke Strategy 2007
- National Service Frameworks for Long Term Conditions and Older People
- Standards For Better Health
- Mental Capacity Act

## 13. Key Relationships

The Stroke ESD Service work closely with and establish key links with the following:

- GP's
- Consultants and other secondary care staff
- Specialist and District nurses
- Other AHP's i.e. SALT, Dietetics, Orthoptists and Orthotists
- Intermediate Care OFTEN DELAYS WITH BRISTOL ICT PICK UP WAITS OF 4-6 WEEKS EARLY REFERRAL MADE AND ALSO SDT HAVE PICKED UP INDIVIDUALS AND COVERED GAPS BETWEEN DC TO ICT PICK UP TO FACILITATE DC FROM WARD
- Social Services and equipment
- Continence team DELAYS IN COMMUNITY ASSESSMENT AND AID PROVISION
- Stroke Association and other voluntary organisations

## 14. Local and National targets

The Service aims to meet the following targets. These include:

- 100% of patients have a contact by a member of the team within 24 hours of discharge ACHIEVED WHERE IDENTIFIED AS NEEDED
- Aims to facilitate discharge and rehabilitate approx 40% stroke patient Discharges from wards 106 and wards 1 within NBT. 30 % DC BASED ON INTAKE OF 600 STROKE PER YEAR. PILOT NOT FULLY STAFFED FOR THE FULL YEAR, NO BASE FOR START OF PILOT, FEEL WOULD HAVE ACHIEVED THE 40% IF TEAM UP AND RUNNING FULLY STAFFED FOR THE FULL PILOT YEAR
- A maximum of 6 weeks input post discharge. LARGELY ACHIEVED EXCEPT FOR 7 INDIVIDUALS DELAY WITH SLT DC AND ICT PICK UP.
- Annual patient and carer evaluation of the service demonstrating high Satisfaction rates above 75% 70% RATED 10/10, 92% RATED ABOVE 8/10
- Annual documentation audit with 95% of records meeting documentation standards TO BE COMPLETED
- Annual audit of outcome measures demonstrating that 80% of patients have demonstrated improved function ACHIEVED

## 15. Governance

The provider will be responsible for:

- Compliance with current national and local guidance ATTENDANCE AT NATIONAL CONFERENCE, CLINICAL GOVERNANCE PROG AND IN HOUSE INSERVICE TRAINING
- Compliance with Standards for Better Health
- Responding to notices as stipulated by the MRHA.
- Redesigning of patient pathways to meet the needs of service users and Trust. ONGOING
- Implementation of professional standards etc.
- Implementation of appropriate NSF and Nice guidelines.
- Audit against local and national standards.
- Monitoring activity and staff performance.
- Monitoring quality outcomes for interventions with patients and implementing evidence based changes to improve patient outcomes.
- Monitoring complaints and adverse incidents according to Trust Policy

- Competence to practise within stroke.

#### **16. Patient & Public Involvement**

Patient and public involvement will be an ongoing part of service development and improvement.

- An Annual patient and carer questionnaires will be completed in the service assessing satisfaction levels with the current service and seeking opinion on areas for improvement. ONGOING
- Advice and support will be available for all staff, patients, families and carers that interact with the Stroke ESD Service. ONGOING
- Written information will be provided to Service Users where appropriate.
- All written information given to patients will go through the relevant PPI forums for approval prior to use. TO UNDER-TAKE FOLLOWING PILOT AS LEAFLETS ETC MAY NEED TO BE MODIFIED
- The operational manager for the Stroke ESD service will be the point of contact for the PALS Officer in the event of patients raising issues relating to that service.

#### **17. Review Date**

6 month and annual review from initial first date of 01.06.10

#### **Additional Information**

- **Service standards**
- **SDT key worker checklist assessments**
- **Team responsibilities**

# **healthwatch**

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