UPDATE ON STROKE SERVICES IN HEREFORDSHIRE

1. INTRODUCTION

1.1 Stroke has a major impact on people's lives. It starts as an acute medical emergency, presents complex care needs, may result in long-term disability and can lead to admission to long-term care.

1.2 Each year 130,000 people in England and Wales have their first stroke, and 30,000 people go on to have further strokes; at any one time there are approximately 250,000 people who have had a stroke. It is the single biggest cause of severe disability and the third most common cause of death in the UK and other developed countries[1].

1.3 In Herefordshire, the care of people with stroke was reviewed during 2005, and a number of proposals were consulted upon and then implemented.

1.4 This paper provides an update on the work that has taken place since March 2006.

2. PREVENTION

'The prevention of stroke depends on reducing risk factors across the whole population as well as in those at relatively greater risk of stroke[2].

2.1 Number of deaths from Stroke (ICD 10 160 – 169)

Previous data had shown a higher level of mortality from stroke in Herefordshire compared to other areas.

Although it is too early to determine any statistical significant changes, early data demonstrates some positive early trends in the number of deaths occurring from stroke every year.

2002	2003	2004	2002-04 baseline	3 yr Averages	2005	2006(to May 06)
180	182	161	523	**174**	**131**	**53**

2.2 Actions to reduce the risk factors for stroke

Actions to reduce the risk factors for stroke in the population are being actively addressed in Herefordshire, and have been assisted through the implementation of the new GMS Contract. The improvement in most of the Quality & Outcomes Framework (QOF) results for 2004/05 and 2005/06 demonstrate this:

[1] Stroke Association (2004)

[2] Department of Health (2001) NSF For Older People

Indicator	Q 4 2004/05 March 05	Exclusion % as at March 05	Q 4 2005/06 March 06	Exclusion % as at March 06
Diabetes				
The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less.	**65%**	8.7%	**71%**	7.5%
The percentage of patients with diabetes, whose last measured total cholesterol within previous 15 months is 5 mmol/l or less.	**72%**	10.7%	**81%**	9.1%
Coronary Heart Disease				
The percentage of patients with coronary heart disease, in whom the last blood pressure reading (measured in the last 15 months) is 150/90 or less.	**84%**	5.1%	**86%**	3.7%
The percentage of patients with coronary heart disease, whose last measured total cholesterol (measured in last 15 months) is 5 mmol/l or less.	**73%**	12.1%	**79%**	9.0%
Stroke				
The percentage of patients with a history of TIA or stroke, in whom the last blood pressure reading (measured in last 15 months) is 150/90 or less.	**97%**	9.8%	**83%**	6.5%
The percentage of patients with a stroke shown to be nonhaemorrhagic, or a history of TIA, who have a record that aspirin, an alternative antiplatelet therapy, or an anti-coagulant is being taken (unless a contraindication or side effects are recorded).	**63%**	34.7%	**95%**	25.4%

2.3 Other areas of recommended action included:

Transient Ischaemic Attack Clinics
There was action to determine the GPs current referral patterns and whether the access was satisfactory. Some work has been attempted to look at referral rates by practice, but the current information systems make this difficult.

The access to the service is now by 'Payment by Results' which means if there is an increase in need, then Hereford Hospitals Trust will be paid according to referrals.

3. IMMEDIATE CARE, INCLUDING CARE FROM A SPECIALIST STROKE TEAM

3.1 *'All patients who may have had a stroke will usually require urgent hospital admission. They should be treated by specialist stroke teams within designated stroke units*[3]*.*

Within the County Hospital, there continues to be 10 beds dedicated to acute stroke care on Frome Ward. This service commenced at the beginning of August 2005 and has a dedicated stroke team. A nursing team work across the wider ward area.

3.2 During May and June 2005, a Listening Exercise was completed by the Involving People Team to determine the experiences of stroke survivors. A total of 30 people (stroke victims and carers) participated and a further six who do not attend meetings were visited individually at home. One of the topic areas discussed was their initial treatment. There was mixed feedback, with some patients stating that their care was good, where as others felt that they had to wait too long for Consultant assessment and investigations.

Although some people said their initial rehabilitation and therapy had been good, others had been on wards where little was available and thought more therapeutic staff were needed.

3.3 <u>Progress on implementation of recommendations</u>

a) Access to CT/MRI out of normal office hours has been reviewed with Dr Peter Wilson and access is available if requested.

b) Nurses in the hospital have had training offered on assessment of dysphagia.

c) A standard information pack has been developed for patients and carers.

d) Vision assessments for stroke patients was discussed at the county Ophthalmology Stakeholder Day and awareness raised in terms of the importance of vision assessments for these patients.

4. EARLY & CONTINUING REHABILITATION

4.1 *'The evidence indicates that early, expert and intensive rehabilitation in a hospital stroke unit improves the long-term outcome for patients*[4]*.*

4.2 <u>In-patient Rehabilitation at Hillside Intermediate Care Unit:</u>

[3] Department of Health (2001) NSF For Older People

[4] Lincoln, NB (2000) Five year follow up of a randomised controlled trial of a stroke rehabilitation unit, BMJ, 320p359 (Category: B1)

It was recommended and agreed in March 2006, that specific beds would be allocated for acute stroke rehabilitation with Hillside Intermediate Care Unit. Other patients requiring longer term rehabilitation would continue to be admitted to community hospitals across the county, and transferred back to Hillside if required.

A detailed implementation plan was actioned during April to June, to ensure that staff had the required training, clear pathways of transfer between the County Hospital and the unit were in place and the required equipment was available.

The unit commenced taking stroke patients on 3rd July 2006. At any one time there are approximately 5-6 patients who have had a stroke on the unit. There have been 16 stroke patients admitted to the unit between July and the end of September 2006. The average length of stay for 14/16 has been less than six weeks (one patient stayed 41 days and another 53 days).

The review of the stroke care at the monthly Hillside Management Group has been positive.

4.3 Bed Occupancy

There were concerns initially that allocating beds to acute stroke rehabilitation at Hillside would reduce the available beds for other local people who needed admission for intermediate care. This has been closely monitored, and excluding the 11 days when the unit was closed due to an outbreak of diarrhoea and vomiting during August, the occupancy has been 93% with available beds for admission. Detailed bed availability information is contained in Appendix 1.

5. LONGER TERM SUPPORT

5.1 'Recovery from stroke can continue over a long time, and rehabilitation should continue until it is clear that maximum recovery has been achieved. Some patients will need ongoing support, possibly for many years. Following a stroke, any patient reporting a significant disability at six months should be re-assessed and offered further targeted rehabilitation if this can help them to recover further function'[5].

5.2 Work completed

A significant amount of work has been completed on the longer term support available for people who have survived a stroke. Peter Sowerby (IMPACT Officer) has led this work in partnership with other colleagues. The following has been achieved:

- Stroke Survey to determine needs for longer term support: 305 people responded. Full report available.
- Listening exercise conducted by IMPACT.
- District Nursing service providing formal follow-up for stroke patients using the Single Assessment Process.
- Consultation paper written on future developments in longer term support, and feedback collated.

[5] Werner, R. A. & Kessler, S. (1996) Effectiveness of an intensive outpatient rehabilitation program for postacute Stroke patients. American Journal of Physical Medicine and Rehabilitation; 75: 114- 120 (Category: B1)

- Action Plan and draft investment plan (See Appendix 2).

6. CONCLUSION

6.1 Significant progress has been made over the last six months to improve the prevention of strokes, but also the treatment and rehabilitation within the county. There is now a clear plan which has been informed by people who had a stroke on the longer term support they require.

There is obviously much more that needs to be done, but we feel that the work completed to date can be actively built upon.

Dr Colin Jenkins
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October 2006

AVAILABLE BEDS AT HILLSIDE 1.7.07 – 30.9.06 Appendix 1

Date	Beds available	Date	Beds available	Date	Beds available
		01.08.06	0	02.09.06	8
01.07.06	0	02.08.06	0	03.09.06	6
02.07.06	0	03.08.06	0	04.09.06	4
03.07.06	0	04.08.06	0	05.09.06	3
04.07.06	0	05.08.06	1	06.09.06	3
05.07.06	0	06.08.06	0	07.09.06	1
06.07.06	0	07.08.06	1	08.09.06	3
07.07.06	0	08.08.06	2	09.09.06	1
08.07.06	0	09.08.06	1 possible	10.09.06	1
09.07.06	0	10.08.06	1	11.09.06	2
10.07.06	1	11.08.06	0	12.09.06	0
11.07.06	2	12.08.06	2	13.09.06	2
12.07.06	1	13.08.06	3	14.09.06	2
13.07.06	1	14.08.06	2	15.09.06	4
14.07.06	0	15.08.06	2	16.09.06	3
15.07.06	0	16.08.06	2	17.09.06	4
16.07.06	0	17.08.06	1	18.09.06	4
17.07.06	1	18.08.06	1	19.09.06	4
18.07.06	1	19.08.06	1	20.09.06	2
19.07.06	3	20.08.06	0	21.09.06	1
20.07.06	3	21.08.06	0	22.09.06	0
21.07.06	4	22.08.06	2 - D&V Closed to admission	23.09.08	0
22.07.06	5	23.08.06	2 - D&V Closed to admission	24.09.06	0
23.07.06	3	24.08.06	4 - D&V Closed to admission	25.09.06	1
24.07.06	2	25.08.06	5 - D&V Closed to admission	26.09.06	2
25.07.06	3	26.08.06	5 - D&V Closed to admission	27.09.06	2
26.07.06	5	27.08.06	6 - D&V Closed to admission	28.09.06	2
27.07.06	4	28.08.06	6 - D&V Closed to admission	29.09.06	1
28.07.06	0	29.08.06	7 - D&V Closed to admission	30.09.06	2
29.07.06	1	30.08.06	8 - D&V Closed to admission		
30.07.06	1	31.08.06	8 - D&V Closed to admission		
31.07.06	1	01.09.06	10 - D&V Closed to admission		

Appendix 2

Longer Term Stroke Support – Action Plan completed August 2006

	What	Who	Why	Timescale
	Within existing resources			
1.	Establish link nurses and 6 month reviews using SAP and Signposting forms	District nurses	Provide first step of systematic review and co-ordination post discharge	Initiated by July 2006
2.	Prepare patient information pack for discharge	Jenny Powell/involving people	Systematise info given at point of hospital discharge.	Work initiated by July 2006; to complete by September 2006
3.	Develop PCT stroke intranet section to link together all information	Colin Jenkins/ Peter Sowerby	Give accessible info resource to all professionals to support better info giving, referral and signposting.	To complete by March 2007
4.	Publish and communicate consultation results to raise awareness of issues	Pete Sowerby	Prompt better awareness and practice	September 2006
5.	Explore with GP practices how their regular contacts with stroke patients can address patient needs through signposting and referral and input to practice nurses	Peter Sowerby/ Trish Jay	Fuller advantage will be taken of the contacts with practices to meet needs of estimated 1000 existing stroke patients in the community	September-December 2006
6.	Explore funding for Family Support with voluntary sector eg small grants scheme	PS + ?	Address isolation and signposting issues	
7.	Joint Benefits team to target stroke club members and Headway members to offer full benefits review and signpost to other services within the signposting scheme.	Sue Wilce – Joint Benefits Team Stroke clubs/Joint Team/ Headway	Address financial issues/ signposting at least for those easily identifiable stroke patients.	Visit each group by 1 March 2007
8.	Repeat survey in 18 months with people who survived a stroke within that period	Link nurses/involving people	Will monitor impact of service developments of link nurses/Hillside, using 2006 survey as a baseline.	February 2008
9.	Encourage use of the ongoing Expert Patient's Programme by (a) including information about it in discharge information pack (point 2 above) and for link nurses to use as part of 6 month review; (b) continuing to raise staff awareness.		More patients to be more confident and better informed about likely issues.	Starting at once and ongoing.
	Investment priorities			
	Prepare specific, costed proposals to improve services and input to Programme Board, PCT and	Peter Sowerby (with input from PCT and social	Establish a strong specific case for investment in stroke	Initial proposals by November 2006; process complete by

	What	Who	Why	Timescale
	council commissioning processes	care colleagues such as Trish Jay, Paul Ryan)	services	March 2007
	Priorities for above are:- 1. Therapists (might include specialist support workers eg dysphasia) 2. Family support 3. Psychology			