HEREFORDSHIRE HEALTH & SOCIAL CARE COMMUNITY
Final document – March 2006

STROKE SERVICES DEVELOPMENT IN HEREFORDSHIRE

1. INTRODUCTION

1.1 The evidence, guidance and models to support the development of an integrated stroke services have been available for at least 5 years. In particular the Older People's National Service Framework makes the establishment of such an integrated service one of the it's standards. Herefordshire has been slow moving towards establishing such a service. Some elements are in place but many are not.

1.2 The purpose of this paper is to brief the Older People's Programme Board on the work that has taken place recently in the development of stroke services and seek approval to progress specific action in the following areas:
- Prevention
- Acute Intervention
- Rehabilitation
- Longer Term Support

2. RECENT DEVELOPMENTS

2.1 Hereford County Hospital dedicated 10 beds for acute stroke care in August 2005. All patients requiring rehabilitation were then transferred to one of the community hospitals/intermediate care units in Herefordshire.

2.2 In October 2005, Dr Jenkins (Consultant Geriatrician) and Trish Jay (Director of Clinical Development, Lead Executive Nurse) undertook a review of current stroke services against existing national guidance including the National Service Framework for Older People (See Appendix 1). This work was part of the action agreed by the Neurology Clinical Implementation Team.

2.3 The Review made various recommendations, which were widely consulted upon for a six week period ending at the beginning of January 2006. The recommendations were based on the reorganisation of existing resources (noting that additional resources were not forthcoming) in a format, which would improve current patient/user outcomes; however it must be noted that this is will not achieve all the national guidance. The recommendations and the action plan presented here, following consultation are therefore seen as a pragmatic, incremental step towards the ideal service.

3. OUTCOME OF THE CONSULTATION

3.1 There were 28 responses to the consultation paper circulated, from colleagues across the Primary Care Trust, Herefordshire Hospitals Trust, the Voluntary sector, carer representative, Herefordshire Social Services, general practitioners.

3.2 There was a range of comments. The action plan reflects the strongest emerging themes, although not every point made by every responder.

The key themes arising from the consultation responses.

1. *Agreement with the consultation paper that stroke services in Herefordshire need improving. Some comments highlight particular needs; others express their concerns about the current service quality.*

2. *Factual amendments suggested are not fundamental to the consultation issues.*

Prevention

3. *The work on prevention was acknowledged to be important, with suggestions that there should be more emphasis on the management in this area. Also training for primary care staff.*

Acute services.

4. *The recent establishment of the acute unit was welcomed and the responses suggested ways of addressing the shortfalls identified in the consultation paper. A further issue of vision assessment was also identified.*

Rehabilitation Services

5. *The consultation paper suggested significant service redesign and it is not surprising therefore that this section prompted most detailed responses.*

6. *Acceptance of the evidence of the effectiveness of a specialist rehab unit and support for the concept of establishing one. There was one alternative view expressed in favour of using more than one base in order to have flexibility and to maximise use of community hospitals)*

7. *No challenge to the criteria of what would make an effective specialist rehab unit.*

8. *A consensus among practitioners in the relevant fields that Hillside most fully meets the criteria set out in the paper. The nature of the responses reflected the fact that the consultation paper had pointed strongly to the use of Hillside for this purpose, without specifically naming it, or addressing any issue consequent to this development.*

9. *Therefore the responses raised the following issues about the implications of developing Hillside as the stroke rehab unit:*
   - *A view that we would merely be re-arranging our inadequacies and that without resources for equipment, adaptations and acquisition of specialist skills, we would re-badge an existing service but not really meet the definition of a specialist stroke service.*
   - *The likely length of stay and impact on patient flows elsewhere in the system.*
   - *How the needs of current users of Hillside could be met and how the development of step-up intermediate care could alternatively be accommodated.*
   - *Arrangements for medical cover*
   - *Process of working with Herefordshire Council and the Section 31 Board.*

Longer term Care and Support.

10. Those aspects of longer term care that the consultation paper recommended, such as use of the Expert Patient Programme, were welcomed. There was a strong comment to initiate planning for longer term support at an earlier stage than phase 3; there were offers from the voluntary sector and older people's wider reference group to be involved in this development work.

Resources

11. The paper and its recommendations were based on the underlying assumption that it sought an incremental development within existing resources; the service outcomes may fall short of the standard we would like, but will be pragmatically achievable and better than what we've got at the moment. The assumption of no new resources was not stated explicitly and some responses challenged why it had been made and the realism of being able to make any improvements without some costs.

3.4 The action plan identifies a timetable to plan longer term community based support, and identifies a lead person for each step (see Appendix Two).

4. PROPOSED NEXT STEPS

4.1 Noting the significant feedback on the consultation, an action plan has been drawn up to progress the recommendations in the Review. The rationale for the identified action and further explanation of some points is outlined below:

4.2 **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'[1].

The area of action identified is to improve the GP referral to Transient Ischaemic Attack (TIA) clinics. If there is increased referral then the number of dedicated slots for TIA assessment would also need to increase to ensure the waiting time of one week from referral was met.

4.3 **Immediate Care, including care from a specialist stroke team**

'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'[2].

The acute stroke service continues to develop since the dedicated beds for stroke care were allocated at the County Hospital, and Stroke Association Training can taken place for staff. Further work is now planned to:

- Develop the nursing skills
- Look at direct and rapid access to the beds, rather than admission via A&E and then to a Medical Admissions unit, prior to moving to one of the designated stroke beds.

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

- Improve the access to CT scans out of hours, including a review of whether direct referral by GPs would be beneficial.
- Determine appropriate vision assessments

4.4 Early & Continuing rehabilitation

'The evidence indicates that early, expert and intensive rehabilitation in a hospital stroke unit improves the long-term outcome for patients'[3].

4.4.1 Bed Analysis

It is important to calculate how many people would require rehabilitation. This analysis has been completed based upon current admissions to the County Hospital (based upon figures for 2004 & 2005); and acknowledges that the English national average length of stay for stroke patients is 28 days.

314 Average yearly admissions:

83	Average who go home within two weeks
46	Average died within two weeks
20	Average number going to Powys Hospitals (mostly within 2 weeks)
67	Average severe strokes (who would continue to go to Community Hospitals)
98	Average requiring acute rehabilitation

Some severe stroke patients will go on later to have acute rehabilitation (estimated to be 20 p.a); also patients who have had a stroke in the past may benefit from a further episode of acute rehabilitation (estimated to be 7 p.a).

This would then assume that approximately 125 patients would require acute rehabilitation stay on average 4-6 weeks (2 week LOS at the County Hospital and 4-6 week length of stay at the designated unit) then this would equate to 4,375 stroke rehabilitation bed days per annum.

This equates to 4,693 bed days at 95% occupancy, and would require 12 beds.

4.4.2 One unit for in-patient stroke rehabilitation: The key recommendation in this area was that one of the existing community in-patient units should be designated for specialist stroke rehabilitation. Since the consultation period, there is agreement that the Community Hospitals (Meeting - 11th January 2006), people who have had severe strokes will continue to go to a community hospital/unit nearest to their home.

The unit that currently meets all the acute rehabilitation criteria outlined in the Consultation document is **Hillside Intermediate Care Unit.** The proposed model based on an analysis of admissions is:

Stroke Services

- Intensive rehabilitation at Hillside would be targeted at stroke patients who could benefit from short term intensive rehabilitation (no more than 6 weeks). (31% of all acute stroke admissions – 98 people per year)

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

- Some severe stroke patients may benefit from a period of intense rehabilitation after a period in the community hospital and some people who have gone home will benefit from a subsequent spell of rehabilitation (estimated as additional 27 people per year)

- Patients who needed longer term rehabilitation would still be discharged from the County Hospital to community hospitals as at present. (21% of admissions – 67 people per year).

- A medical lead for Hillside with stroke specialism would be identified. Existing staff would be given the training to acquire additional skills

- This model would need 12 beds allocated (not ring fenced) for stroke patients.

Intermediate Care

- Hillside will remain an intermediate care unit, discharging people within six weeks after a period of intense rehabilitation; it will also be equipped with the specialism and support to work with stroke patients.

- Step up admissions into Hillside will continue to be implemented to realise the benefits of this approach.

- The reduction in six beds for the City & South Rural patients would be mitigated by full use of all 22 beds, access to community hospital beds (as current practice), and a review of access arrangements by other members of the Multi-disciplinary Team directly to all 126 intermediate care/community hospital beds.

4.4.3 Impact on Hillside's current service pattern

The Hillside Intermediate Care Unit opened in November 2003, as a jointly funded new service of 22 beds for intermediate care for people living in Hereford City and the PCT South Rural Locality (Golden Valley area).

The occupancy for 2004/05 was 84 %, and for the first six months of the year 81%. This occupancy level is considerable less than the community hospitals whose average occupancy is well over 90%. Increasing the average occupancy rate from 84% of 95% would means an increase from an average of 18 to 21 beds occupied at any one time.

Intermediate Care is nationally defined as 'involving short term interventions (rehabilitation) typically lasting no longer that 6 weeks'. Noting that the assumption is that stroke patients would on average stay 4-6 weeks, then the rehabilitation provided to patients who require acute rehabilitation would still meet this criteria.

The practice populations of the City & South Rural areas accounted for 56% of stroke admissions 2001-04.[4] Therefore 56% of the beds allocated to stroke rehabilitation in the unit are likely to be for the same population as before.

[4] Profile of Herefordshire GP Practices. P Stebbing May 2005

If it were agreed by the various Boards that Hillside would have allocated (not ring fenced) stroke rehabilitation beds then:
Of the 12 beds for stroke care:

- *6-7 beds – there would be no change in accepting patients for rehabilitation from City & South Rural areas*
- *5-6 stroke patients are likely to be from outside original Hillside priority catchment area*
- *reduction in general intermediate care provision would be 6 beds.*

Other patients from the City & South Rural areas requiring intermediate care would be transferred to other Intermediate Care/Community Hospital Units (as is the current practice). Work will be undertaken to review of access arrangements by other members of the Multi-disciplinary Team directly to all 126 intermediate care/community hospital beds.

4.4.4 Other areas of development

Others areas of development were highlighted in the Consultation document, these will be taken forward in later phases of work and include out-patient rehabilitation and community rehabilitation.

4.5 Longer Term Support

'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].

There is a significant work required to take this area forward. The initial step must be to understand the needs in Herefordshire, the limited current services, and how resources can be used more effectively, as well as looking to additional funding support in the future.

5. IMPLEMENTATION RISKS

In redesigning services, within current resources there are always inherent risks, as stated earlier this paper and plan outlines pragmatic actions, which are an incremental step towards the ideal service. The major risk associated with the development of Hillside Intermediate Care Unit to have dedicated beds for stroke rehabilitation, is the change management which will require significant management input including liaison with staff side to successfully implement the changes. Also it is important to note the rehabilitation model is based on the latest figures and relevant clinical assessment but the impact will have to be proven empirically.

6. RECOMMENDATIONS

The Overview and Scrutiny Committee is asked to:

[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)

- Note the work that has been completed to date
- Support the specific action outlined in the Action Plan to improve all aspects of stroke care
- Support the option to develop allocated acute stroke rehabilitation beds at Hillside Intermediate Care Unit and support the further work outlined in the action plan.

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