ITEM NO. 22

SURREY
COUNTY COUNCIL

THE LOCAL HEALTH AND SOCIAL CARE DELIVERY PLAN: THE STROKE PATIENT PATHWAY PROJECT AS AN EXAMPLE OF SERVICE DEVELOPMENT IN PARTNERSHIP

SURREY COUNTY COUNCIL
LOCAL COMMITTEE IN WAVERLEY
30 JANUARY 2004

KEY ISSUE:

The report gives the Committee a flavour of the benefits of joint working in health and social care.

SUMMARY:

The report sets out the background to the Local Health and Social Care Delivery Plan in Guildford and Waverley and describes the Stroke Patient Pathway Project as an example of good practice. In April 2003, project was commenced by Guildford and Waverley Primary Care Trust and the Royal Surrey County Hospital. The project aims to develop a quality and timely service for patients based on best practice. With funding from the Local Delivery Plan, the project will establish new patient services and facilities including a 20-bedded stroke unit and community stroke team.

RECOMMENDATION:

That the Local Committee in Waverley should endorse the continued involvement of the County Council in the Stroke Patient Pathway Project, in particular in the long term support and follow up group.

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1. BACKGROUND

1.1 In October 2002, a revised planning framework for health and social care was introduced based on the production of a Local Delivery Plan (LDP). This replaced the annual Services and Financial Framework (SAFF), Health Improvement Programme (HIMP), Joint Investment Plans (JIPs), and Children's Services and Community Care Plans.

1.2 The plans specify how national targets and agreed local priorities will be met over a three year period, supported by a three year financial allocation. The local LDP for 2003/6 addressed thirteen priority areas with associated targets:

1. Improving access to emergency care
2. Improving access for planned care
3. Cancer
4. Coronary heart disease
5. Mental health
6. Older People
7. Life chances for children
8. Improving the patient experience
9. Reducing health inequalities
10. Drug misuse
11. Physical facilities
12. Workforce
13. Information, Management and Technology

Primary Care Trusts (PCTs) are responsible for coordinating the production of the LDP in conjunction with patients, public, partners and staff. In Guildford and Waverley, many of the priorities were developed by working groups in various disciplines and the PCT worked closely with the County Council. This is reflected in the title of the local plan, the Local Health and Social Care delivery plan (LHSCDP).

1.3 An example of a service development planned in the LHSCDP within the Older People area is the Stroke Patient Pathway Project. This project will develop new services for patients while enabling the PCT and acute Trust to meet national standards and targets.

2. THE STROKE PATIENT PATHWAY PROJECT

2.1 Introduction

Each year 110,000 people in England and Wales have their first stroke and 30,000 people go on to have further strokes. It is the single biggest cause of severe disability and the third most common cause of death in the UK and other developed countries.

There is strong evidence that people who have sustained a stroke are more likely to survive and recover more function if admitted promptly to a hospital based stroke unit with treatment and care provided by a specialist coordinated stroke team. There is also good evidence that effective and systematic programmes of prevention can identify those at risk and reduce the future incidence of stroke.

The National Service Framework (NSF) for Older People states that by April 2004:

- All acute Trusts which care for people with stroke to have a specialised stroke service.
- All PCTS to ensure that every general practice can identify and treat patients identified as being at risk of a stroke.

2.2 Project Aims and Objectives

In April 2003, the Stroke Patient Pathway project was commenced by Guildford and Waverley PCT and the Royal Surrey County Hospital (RSCH). The project aims to develop a quality and timely service for patients based on best practice.

The objectives of the project are:

- To develop a stroke patient pathway based on best practice from a patient developing their first symptoms to reaching their optimum recovery.
- To develop an equitable and timely service
- To improve patients' experience
- To develop new ways of delivering care

The project aims to deliver:

- A stroke unit which will be able to admit 90% of the stroke patients who require hospital admission
- A specialised stroke team with a single lead consultant
- A community stroke team to enable early supported discharge as part of the intermediate care system
- A stroke register and preventative therapy service to patients who have suffered from a stroke and to those at risk of a stroke

2.3 Project Structure

In May 2003, a workshop was held with stakeholders from across the local health and social care community to map the current stroke pathway and identify issues. Following a second event in July, seven project groups were set up to examine key parts of the patient pathway and implement parts of the NSF standards:

1. Acute Stroke Pathway
2. Acute Stroke Unit
3. Community Stroke Pathway
4. Community Stroke Team
5. Long Term support
6. Transient Ischemic Attacks (TIA) and Stroke Prevention
7. Information and Communication

The project is managed jointly by project managers at the RSCH and PCT, and is overseen by a Steering Group. Regular reports are submitted to the modernisation boards of the Guildford and Waverley PCT and RSCH, and the Guildford and Waverley Local Implementation Team for Older People. The core membership of the project groups and Steering Group is shown in Appendix One. Additional members are co-opted to the project groups for specific discussions or project work.

2.4 Project Milestones

The project aims to achieve the following deliverables by April 2004:

- Community Stroke Team
- Acute Stroke Unit
- Specialised stroke team with a single lead consultant
- Stroke Register

The project groups will cease meeting regularly when their objectives are achieved, an integrated stroke service is established and the complete pathway is implemented. However, it is envisaged that the Steering Group will continue meeting on a longer term basis to review the operation of the stroke service and identify areas for future development.

2.5 Use of Funding

Funding has been allocated in the Local Health and Social Care Delivery Plan for the acute stroke unit and community stroke team.

The acute stroke unit will be located on an existing ward at the RSCH. The funding will be used to recruit and employ additional staff to provide improved treatment, rehabilitation and care that meets the NSF standards. Training will be purchased for existing and new staff. Specialist equipment designed for the needs of stroke patients will also be purchased for the ward.

The community stroke team is a new initiative designed to provide support and rehabilitation to patients in their own home when discharged from hospital. The funding is being used to recruit staff to the team and to contribute towards the running costs e.g. travel expenditure.

2.6 **Progress to Date**

i. Acute Stroke Pathway

This group is producing a pathway in the format of a checklist to be followed by staff. Members of the group have completed the following sections of the pathway: Ambulance, emergency admission, physiotherapy, Speech and Language Therapy (SALT) and Occupational Therapy. They have agreed how documentation and patient information can be shared between the ambulance service, A&E and the wards. The SALT team have run a training course for hospital staff to enable them to undertake a basic swallow assessment on stroke patients.

ii. Acute Stroke Unit

This group has looked at alternative staffing models for the unit and extended roles, for example for health care assistants. A proposal for staffing has been drafted and is out to consultation at the Trust. An equipment list has been drawn up with priorities identified and sponsors are being sought for some items. An information centre for patients and relatives is being set up on the ward.

iii. Community Stroke Pathway

This group is reviewing the admissions process for rehabilitation and intermediate care beds in the community hospitals. They have evaluated the current transfer process from the RSCH to community hospitals and are devising new multi-disciplinary documentation and working practices.

iv. Community Stroke Team (CST)

The CST was operational from 7th October and is offering stroke patients support and rehabilitation when they are discharged from RSCH, Milford and Haslemere hospitals. The team is continuing to advertise and recruit staff as they have not yet reached their full staffing establishment.

v. Long term support

This group will start in 2004 with a lead from social services or primary care to develop guidelines for follow up care and identify support systems for patients and carers.

vi. TIA and prevention

The referral system for rapid access to the TIA clinic has been set up and a stroke/TIA register in general practice has been established.

vii. Communication and Information

This group is writing a communication strategy and establishing a consortium of sponsors to fund the production of patient information. They are providing continuity across all the project groups for patient information, data analysis and audit.

2.7 Examples of Benefits for Patients

- Reduced length of stay in hospital resulting from improved rehabilitation and treatment.
- Rehabilitation and support provided at home by the Community Support Team.
- Enable patients to re-access services directly if their condition changes, for example, patients can access clinics without another admission to hospital.
- Improved long term support and follow up for patients and carers, for example reviews at six month following discharge from hospital.
- Patients will be 'monitored' through the stroke register which will support the management of their care and avoid crisis events.
- Access to more information and literature in hospital and whilst receiving care at home, for example a pack on services in the local area.
- Greater patient satisfaction with services delivered
- Patients being treated in the right place at the right time by the most appropriate health or social care professional

2.8 Partnership working with the County Council

The stroke care pathway project has been used as an example to illustrate where the LHSCDP process has ensured funding into one of the key areas (as defined nationally). This project is very much a joint project and the amount of partnership working is evident and necessary for it to produce positive outcomes.

The project acknowledges the valuable contribution of County Council representatives at the stroke mapping workshop and the ongoing participation of staff from the Adults and Community Care Service in the project groups.

We would welcome a representative from the Council to take the lead on the long term support and follow up project group, and to actively contribute to the information and communication project group by providing information on local services.

Appendix One

A) Membership of the Stroke Pathway Project Groups

1. Acute Stroke Pathway

Valerie Black	Occupational Therapy, RSCH
Adrian Blight (Sponsor)	Elderly Care Consultant, RSCH
Karen Cable	Medical Assessment Unit, RSCH
Charlotte Cadman	Physiotherapy, RSCH
Gillian Chapman	Speech and Language Therapy, RSCH
Amanda Dean	A&E Development Nurse, RSCH
Rachael Futers	Radiology Service Development, RSCH
Elizabeth Gradwell	Physiotherapy, Community
Jan Harbour	Community Liaison
John Reed	Surrey Ambulance
Betty Tainsh	Social Services
Jo Treanor	Stroke Nurse Specialist, RSCH

2. Acute Stroke Unit

Adrian Blight	Elderly Care Consultant, RSCH
Gillian Chapman	Speech and Language Therapy, RSCH
Joy Davis	Dietetics, RSCH
Els Drewek (Sponsor)	General Manager for Medicine, RSCH
Deborah Hughes	Physiotherapy, RSCH
Eithne Oliphant	Human Resources, RSCH
Jane Shipp	Occupational Therapy, RSCH
Karen Walmsley	Finance Department, RSCH
Jenny Watkins	Matron Elderly Care, RSCH

3. Community Stroke Pathway

Val Black	Occupational Therapy, RSCH
Brian Gale	Physiotherapist, Community
Joanne Greaves	Physiotherapist, Farnham Hospital
Mary Kelly	Occupational Therapy, Community
Brian Mayers	Social Services
Sarah Morrison (Sponsor)	Speech and Language Therapy, Community
Rose Parry	Operational Manager Community Hospitals
Sarah Pettyfer	Occupational Therapy, Community
Denise Rooney	Nurse Consultant, Stroke Unit, Farnham

4. Community Stroke Team

Val Black	Occupational Therapy, RSCH
Charlotte Cadman	Physiotherapy, RSCH
Brian Mayers	Social Services
Rose Parry	Operational Manager Community Hospitals, PCT
Sarah Wardle (Sponsor)	Older Persons Development Manager, PCT
	Community Liaison Team
	Community Stroke Team

5. Long Term support

Nigel Andrews	Housing and Health, Guildford Borough Council
Chris Dunstan	Woking Community Hospital

6. TIA and Stroke Prevention

Adrian Blight	Elderly Care Consultant, RSCH
David Eyre Brook	GP lead

7. Information and Communication

Charlotte Cadman	Physiotherapy, RSCH
Mr and Mrs Gould	Patient and carer representatives
Rose Parry	Operational Manager Community Hospitals, PCT
Sarah Pettyfer	Occupational Therapy, Community
Denise Ronney	Nurse Consultant, Farnham Stroke Unit
Sylvia Taylor	District Nurse
Jo Treanor (Sponsor)	Stroke Nurse Specialist, RSCH
Sarah Wardle	Older Persons Development Manager, PCT

B) Membership of the Stroke Pathway Project Steering Group

Adrian Blight	Lead Clinician
Els Drewek	General Manager for Medicine, RSCH
David Eyre Brook	Lead GP
Rachel Hinxman	Project manager, PCT
Maggie Ledwidge	Project manager, RSCH
Brian Mayers	Social Services
Sarah Morrison	Speech and Language Therapy, Community
Jon Reynolds	Commissioning Manager PCT
Jo Treanor	Stroke Nurse Specialist, RSCH
Sarah Wardle	Older Persons Development Manager, PCT
Michael Wilson	Executive lead, RSCH