NHS
South West

South West Strategic Health Authority

Clinical Review of Stroke Services Visit 15 July 2010

Dorset County Hospital NHS Foundation Trust
and
NHS Dorset

1. Introduction

1.1 The publication of the National Stroke Strategy in December 2007 set out a framework of quality markers for raising quality of stroke prevention, treatment, care and support over a ten year period. Across the South West Strategic Health Authority it is agreed that this strategy has a high priority for improving patient care and will be delivered by 31 March 2011.

1.2 A clinical review for the South West Strategic Health Authority was undertaken between May and August 2008 where all acute and community providers of stroke services were visited. These visits were followed up with action plans for the health communities to implement allowing the South West to deliver the National Stroke Strategy by 31 March 2011. There have been many advances in stroke care across the region since the clinical review in 2008 but there are still areas within the National Stroke Strategy which require more focussed attention.

1.3 As a result of reviewing the January 2010 stroke action plans, the clinical Review Team recognised the need to re visit a selection of health communities. The visits are an opportunity for the providers and commissioners of stroke services to update the clinical Review Team on progress made since 2008 and the direction of travel to ensure delivery of the National Stroke Strategy by 31 March 2011.

1.4 Provided in this paper is the feedback from the visit undertaken within NHS Dorset. It is anticipated that progress against the recommended actions will be provided alongside the quarterly returns of the stroke action plans by NHS Dorset. In addition there are several actions which need addressing urgently and will require returns at regular intervals between the beginning of August and September 2010.

Feedback and areas of concern

1.5 The Review Team recognises and appreciates the effort and input provided from all of those involved to host the visit of stroke services across the pathway. While visiting with the clinicians in the service is it worth noting the amount of dedication and continued effort in delivering as good a level of care as possible in the context of the ongoing financial difficulties both within Dorset County Hospital NHS Foundation Trust and NHS Dorset.

1.6 As part of the visit, the Review Team is able to benchmark the current level of service against the report from the visit in 2008 as well as noting any difference in the service on the most recent organisational Sentinel Audit 2010. The drivers of the National Stroke Strategy and Accelerated Stroke Improvement programme have significantly raised the bar in the delivery of stroke services nationally.

1.7 The Review Team would like to commend the Dorset County Hospital NHS Foundation Trust for moving to delivery of a 24/7 thrombolysis service based on telemedicine. This is a large step forward from the previous visit in 2008 and the team noted that the involvement from radiographers, including the investment in the Computed Tomography Training Phantom, has continued positively. The pre-alerting by South Western Ambulance Service NHS Trust is good and the Emergency Department medics are making a crucial contribution to the expanded service, and should continue to be supported in doing this through appropriate clinical support, feedback and education - see section 3 below.

1.8 A significant change was noted in the increased public and patient involvement – the Patient Carer Public Involvement process engaged in by the Primary Care Trust is commendable. In addition the patient-level feedback has been introduced and is well utilised.

1.9 There was also evidence presented of timely access to Computed Tomography scanning with a large majority of patients receiving their scans within the first 24 hours. In addition the access to carotid surgery was described as very rapid with most patients receiving surgery within the timescales in current national guidance.

1.10 Community services show some good joined-up working between stroke co-ordinators working in the community, the Local Authority social care and voluntary sector. In addition, the communication pathway represents close working between Speech and Language Therapy and the voluntary sector to develop care for patients with communication disability, including developing a peer-led service.

1.11 The proposal presented for timely discharge streamlining the pathway and to ensure that stroke specialist care is provided across the area represents good progress. It is clear that this is not Early Supported Discharge in its fullest form, but will provide an improved level of care for patients once they have left the acute and inpatient rehabilitation services provided at Dorset County Hospital NHS Foundation Trust.

Areas of concern

1.12 There are two very prominent areas of concern that were apparent on the review visit that will need addressing urgently if Dorset County Hospital NHS Foundation Trust is to continue providing acute stroke services:

- first, the Review Team were very concerned by the lack of interest from the NHS Trust senior management in the strategic approach to stroke. It became evident during the visit that the Clinical Lead for Stroke at Dorset County Hospital NHS Foundation Trust had not been requested by the Board or Executive group of the NHS Trust to report to them in person either on the outcome and action plan following the original 2008 Strategic Health Authority review, or on the results of the National Sentinel Audit in any previous round. This obliged the Review Team to conclude that the complete disengagement above directorate level with the Stroke Service indicated that the Dorset County Hospital NHS Foundation Trust does not see stroke as a priority;

- second, the Review Team were very disappointed by the lack of a coherent plan of implementation in response to the Strategic Health Authority review in 2008 other than the work put in with the network to effect 24/7 thrombolysis. In some respects the service had deteriorated in the interim, such as in the matter of direct access to the Stroke Response Unit on Hardy Ward. This deterioration in the service provided to people with stroke was reflected in the performance of the NHS Trust in the organisational component of the National Sentinel Stroke Audit, falling from the top quartile in 2006 into the middle half in 2008 and now in 2010 just 1% above the bottom 10% of stroke services in the country.

1.13 In light of these findings it was important to record at the feedback meeting the stated intention of the Medical Director, on behalf of the Trust Executive, to renew the commitment of Dorset County Hospital NHS Foundation Trust to the stroke service as core business. This statement obviated for the time being the need for NHS Dorset to investigate the option to commission services for people in Dorset with acute stroke from another provider.

1.14 Overall, there must be much greater strategic engagement and collaboration between Dorset County Hospital NHS Foundation Trust and NHS Dorset on stroke, and there must be a mechanism for the Board – including the new Finance Director and Chief Executive – to monitor and direct an urgent improvement in the performance of the stroke service. For a service with so much that needs to be achieved, there must be a joint planning group between the Dorset County Hospital NHS Foundation Trust and NHS Dorset with senior executive representation, and better engagement with the network.

1.15 Actions that need to be taken are:

- interest and engagement at Dorset County Hospital NHS Foundation Trust board level required which includes a regular and meaningful flow of information and communication between senior management, clinicians and the NHS Trust board;

- a report and action plan for improvement against the 2010 National Sentinel Stroke Audit results to be presented at the September Board meeting with the new chief executive in place;

- joint planning group developed with senior executive chairmanship, accountable to both organisations and responsible for developing and agreeing a joint strategy for implementation of the National Stroke Strategy within an agreed timescale, and restoration to the top quartile of the National Sentinel Stroke Audit.

1.16 The Review Team feedback and recommendations are outlined below and follow along the patient pathway.

2. Pre Hospital Care

2.1 The service for high-risk Transient Ischaemic Attacks, who may represent up to 50% of all Transient Ischaemic Attack referrals, is precarious and ad hoc and is not sustainable in its current form. There is no dedicated space for providing the assessment of high risk patients and currently a room or space has to be found from anywhere in the hospital at short notice. This is not a clinically appropriate way to manage this high risk group, who require a systematic approach which ensures reliable access to specialist clinicians and diagnostics. Nationally, some providers have resorted to a policy of emergency admission for high-risk Transient Ischaemic Attacks if that is the only method that ensures sufficiently rapid access to appropriate expertise and diagnostics. Dorset County Hospital NHS Foundation Trust need to consider with their commissioners and the network if a rotating arrangement of clinics in Dorset is a more appropriate model that guarantees sufficiently rapid access to a complete assessment. If the decision is made to continue to provide the neurovascular service locally then management plans for high risk Transient Ischaemic Attacks need to be put on an operationally robust footing.

2.2 Co-ordinated action between the Primary Care Trust and Dorset County Hospital NHS Foundation Trust is required to minimise delays in referral of suspected stroke and Transient Ischaemic Attacks from primary care. It is clear that there needs to be better engagement and training within primary care and with general practitioners, for example utilising a standard referral and assessment form such as that used in the Avon Gloucestershire Wiltshire and Somerset Network area. This form should also be used with ambulance referrals into the neurovascular service.

2.3 Recommended actions:

- consider with commissioners and the Dorset Cardiac and Stroke Network the most clinically appropriate management process for high risk Transient Ischaemic Attacks across the Dorset area, which prioritises speed of clinical assessment and diagnostic access over convenience;

- where clinics are to be provided at Dorset County Hospital NHS Foundation Trust ensure that are allocated to a designated area, with appropriate, timely diagnostic support in line with national guidance (NICE Clinical Guideline CG68);

- recommend use of a standard Transient Ischaemic Attack referral form for general practitioner and ambulance as can be accessed through the cardiac and stroke network;

- improved engagement and training with primary care colleagues.

3. Thrombolysis

3.1 It was a positive improvement that patients are able to be thrombolysed 24/7 at Dorset County Hospital NHS Foundation Trust as of 1 July 2010. The NHS Trust is to be commended on implementing this service for their patients.

3.2 It was of concern that currently the thrombolysed patients are cared for on the High Dependency Unit without clarity on the competency and skill level of those with clinical responsibility for these patients. This should preferably be with a physician who themselves has ongoing clinical experience of hyper-acute stroke care and thrombolysis. Failing that, it should be a medic who has received recent continuing professional development training in hyper-acute stroke care and thrombolysis. .

3.3 Numbers of thrombolysed patients remain small and this creates the obligation for long-term governance oversight of the thrombolysis service. Due note should be taken of the effect of small numbers; it would be some time before any deviations from expected outcomes became evident, thus creating the need for long-term monitoring via Stroke Improvement National Audit Programme or Safe Implementation of Thrombolysis in Stroke – Monitoring Study (SITS-MOST).

3.4 Recommended actions:

- hyper-acute competencies on the High Dependency Unit need to be addressed. This should be in co-ordination between the Clinical Nurse Specialist for Stroke and the senior nursing leadership on High Dependency Unit;

- medical responsibility for stroke patients on the High Dependency Unit needs to be clear. This responsibility of care should be taken by someone with recent experience of thrombolysis;

- all clinicians involved with the thrombolysis rota and including radiology and the ambulance service should meet regularly to review the operation of the pathway, particularly unfamiliar aspects such as the use of telemedicine, and process and outcome measures.

4. Direct Admission and Emergency Medical Unit

4.1 Nationally the care of stroke patients has progressed considerably and providers are moving away from using the Emergency Medical Unit as a first admission point as this is no longer an appropriate environment for the care of hyper-acute stroke patients. The Review Team note that the relevant stroke specialist skills are not present on the Emergency Medical Unit at Dorset County Hospital NHS Foundation Trust.

4.2 There are examples of models of care which are outdated especially where there is no process or training in place for nursing staff to undertake swallow screening. This can lead to a nasogastric tube being used unnecessarily if a patient is admitted outside office hours, e.g. just before a Bank Holiday weekend. It is strongly recommended that Dorset County Hospital NHS Foundation Trust move to a model of direct admission to a hyper-acute unit on Hardy Ward in order that appropriate care can be provided 24/7 for all admissions, and in order to achieve the 2010 NICE Quality Standard for Stroke.

4.3 In supporting this change in practice the best practice tariff will deliver a financial reward of over £110,000 based on the number of 322 patients with stroke admitted to Dorset County Hospital NHS Foundation Trust. Put simply, the optimal treatment for acute stroke is admission to an acute stroke unit with appropriately trained and skilled staff.

4.4 General practitioner referrals to the medical take with suspected stroke should be triaged with a Recognition Of Stroke In the Emergency Room scale and those that are positive should be admitted immediately to the Acute Stroke Unit. Examples of on line training can be found via NHS Bristol as they have commissioned this from the University of Western England, Bristol.

4.5 Processes for requesting and performing plain Computed Tomography for acute stroke outside office hours are a hindrance to effective working and represented an outmoded model of practice. The hurdle of consultant-to-consultant referral for cases of Recognition of Stroke in the Emergency Room scale -positive suspected stroke should be removed.

4.6 Recommended actions:

- direct admissions from Emergency Department to the Acute Stroke Unit should be implemented urgently;

- methods for the assessment of safe swallowing in suspected stroke should be implemented in line with the NICE Quality Standard;

- further training with general practitioners on triage of suspected stroke utilising the nationally recognised tool Recognition of Stroke in the Emergency Room scale;

- agree and implement a streamlined process for requesting plain Computed Tomography head scans for cases of suspected stroke. Use of the Recognition of Stroke in the Emergency Room scale as a trigger to an expedited request is recommended.

5. Bed Management

5.1 The Review Team found that although the bed management process was working hard on managing the large volume of patients coming into the hospital on the day of our visit there were nine non-stroke patients on the acute stroke ward and three stroke patients elsewhere in the hospital. The priority of stroke patients being admitted directly to the stroke ward to receive the best quality care and clinical outcomes is in clear need of addressing within the acute NHS Trust.

5.2 A discussion on mixed sex accommodation took place and clarity is provided here to Primary Care Trust stroke leads and the network managerial and clinical leads:

- following the Department of Health guidance issued May 2009 and the NHS South West breaching of standards guidance issued in March 2010 there is clear guidance available for 100% compliance with Delivering Same Sex Accommodation to protect the privacy and dignity of all patients;

- the executive management team in the hospital should support operational and admission polices for the Acute Stroke Unit. This will allow them to:

    * meet the markers of a quality stroke service by the direct admission of all patients with stroke to the Acute Stroke Unit as outlined in the National Stroke Strategy;

    * comply with Delivering Same Sex Accommodation guidance.

5.3 Recommended actions:

- bed management policy for admitting stroke patients directly to the Acute Stroke Unit is raised to executive level and reconciled with the current approach of the NHS Trust to mixed sex accommodation in other clinical priority areas, and driven forward;

- policies for management of stroke patients to include provision during winter pressures to ensure that the stroke ward continues to be able to admit directly.

6. Acute Stroke Unit

6.1 The Review Team was impressed with the continued drive for improvement and delivery of appropriate care from clinical teams on the Acute Stroke Unit and the calm environment which will be beneficial for staff and patients alike.

6.2 While the number of beds has been increased to 24 since the 2008 review visit this appeared to be a nominal rather than operational change and the unit was still having difficulty in ensuring all patients with stroke were on the unit - see Section 5. The service may find that once community discharge teams are in place the number of beds specific to stroke can again be reduced. This would represent a positive impact of a collaborative, whole system approach to the stroke pathway.

6.3 Although all hospitals have difficulties with storage of equipment, it was noted that the corridor on Hardy Ward was lined with hoists. While these need to be close at hand for ease of use it is recommended that regular checks are undertaken to ensure that adequate cleaning is completed in this area.

6.4 The Review Team found that a hospital-wide review of the registered to unregistered skill mix of nursing had reduced the number of unregistered nurses on the morning and evening shift. The skill mix and numbers of staff need to be carefully considered on a stroke unit to ensure there are enough support staff available to provide for the high dependency for basic care required for this group of patients.

6.5 Although the therapy staff the Review Team met were committed to providing a high level of care, the numbers of staff are low, particularly physiotherapy and unfilled vacancies are resulting in low levels of Speech and Language Therapy. Currently the therapy access is at most 30 minutes per day for Physiotherapy and Occupational therapy and three times a week maximum per patient for speech and language therapy.

6.6 The Review Team were pleased to find that a social worker specific to the stroke unit is employed by the hospital as this staff member can influence and support the earlier discharge of patients and ensure that appropriate care is set up for patients in their homes. There was a concern raised about the continuance of this post when the current post holder leaves, when to allow the post to lapse would be financially counterproductive. It is recommended that this role is maintained in order to continue with the positive impact on discharge and patient care.

6.7 In reviewing the medical cover for the stroke service the current 5 PAs of stroke physician input is unchanged from the 2008 Review and is not adequate for the number of patients served or the needs of a hyper-acute stroke service. The Trust are again advised to consult specialty-specific guidelines on senior medical staffing for a modern stroke service (available from the British Association of Stroke Physicians website and provide an action plan to redress the shortfall.

6.8 The continued difficulties in access to Continuing Health Care and residential care for younger patients is one that will need to be worked through by commissioners and local authorities in conjunction with the acute providers.

6.9 Recommended actions:

- review the numbers of therapy staff, nurses and skill mix in order to meet the 2010 NICE Quality Standard for Stroke with regard to access to skilled nursing and therapy staff;
- ensure funding is secured to maintain the Social Worker post on the unit;
- ensure adequate cleaning is undertaken around and under the corridor space where hoists are stored;
- review consultant sessional time for acute stroke in line with the British Association of Stroke Physicians recommendations for consultant staffing and provide an action plan to redress the shortfall;
- commissioners to work alongside the local authority and acute providers to ensure timely access for Continuing Health Care and residential care is addressed.

7. Community and Early Supported Discharge

7.1 Currently there is a proposal from NHS Dorset to amalgamate stroke skilled and specialist personnel into teams based around a small number of community hospitals. This development will improve the process of discharge of patients from Dorset County Hospital NHS Foundation Trust and improve the clinical support for patients in their homes.

7.2 NHS Dorset presented the Review Team with an incremental approach, based on what is achievable in the current financial climate. This was accepted, but the result of this approach would be that the provision fell short of Early Supported Discharge teams with the potential to have a significant impact on inpatient lengths of stay. Whilst the proposed configuration of services would improve access to stroke-skilled therapy outside the acute stroke unit beyond what is currently available, the overall impact on patient flow along the pathway would appear to be limited.

7.3 Recommended action:

- NHS Dorset needs to be clear about the milestones in their incremental approach, and avoid overestimating the early impact of the proposed changes.

8. Across the Stroke Pathway

8.1 Across the Stroke Pathway within the acute hospital and in provider services, the in-house training needs to be more firmly linked to stroke-specific competencies, which themselves need to be developed, delivered and assessed. It is recommended that the competencies are developed at a network level and that sharing between networks takes place.

8.2 The Stroke Care Co-ordinators funded by the Local Authority stroke-specific funding were regarded as a positive development in long-term support for stroke survivors.

8.3 Data quality along the pathway is poor, but particularly so in the community, and this may be affecting the planning of the community rehabilitation provision. This needs to be linked to the Acute Stroke Unit to better predict demand for and capacity of the early supported discharge teams. The regional data set has been developed by the Peninsula Heart and Stroke Network and is available for use locally in an Access database format. It is recommended that this is reviewed and completed on an ongoing basis as the information will support commissioners and service redesign across the full pathway.

8.4 The Review Team observed that much of the practice along the Stroke Pathway represented models of practice that have now been superseded. There was much to gain from both managers and clinicians visiting other sites in England who had been able to achieve more in modernising stroke services in line with national guidance. This would allow all concerned with delivering the pathway to adjust their expectations in line with what is possible in a modern stroke service.

8.5 Recommended actions:

- in-house training needs to be more firmly linked to stroke-specific competencies, which themselves need to be developed, delivered and assessed;
- NHS Dorset to review the data used to plan the inpatient provision for stroke-specific rehabilitation, taking particular account of demographics and dependency, as this may oblige a different configuration of inpatient and community rehabilitation services;
- NHS Dorset and Dorset County Council to review the means by which the Stroke Care Co-ordinator service can be continued at the end of the funding period without any loss of continuity of the service;
- managers and clinicians responsible for delivering the service along the whole pathway to arrange at least one visit to a top-10% stroke service in England, and to discuss with Dorset Cardiac and Stroke Network the means to support such a visit.

Recommended actions for NHS Dorset

Recommended actions	Progress/time frame
Strategic Level	
Interest and engagement at Dorset County Hospital NHS Foundation Trust board level required which includes a regular and meaningful flow of information and communication between senior management, clinicians and the Trust board.	Reply by 26 July 2010 to letter from the Strategic Health Authority to Paul Sly Chief Executive NHS Dorset.
A report and action plan for improvement against the 2010 National Sentinel Stroke Audit results to be presented at the September Board meeting with the new chief executive in place.	Confirmation by 13 August 2010 that this will be presented at the September board.
Joint planning group developed with senior executive chairmanship, accountable to both organisations and responsible for developing and agreeing a joint strategy for implementation of the National Stroke Strategy within an agreed timescale, and restoration to the top quartile of the National Sentinel Stroke Audit.	Confirmation by 31 August 2010 that this is being put in place with regular meeting dates set.
Pre-hospital care	
Consider with commissioners and the Dorset Cardiac and Stroke Network the most clinically appropriate management process for high risk Transient Ischaemic Attacks across the Dorset area, which prioritises speed of clinical assessment and diagnostic access over convenience.	Confirm by 17 September 2010 on timings for development and implementation across the network.
Where clinics are to be provided at Dorset County Hospital NHS Foundation Trust ensure that are allocated to a designated area, with appropriate, timely diagnostic support in line with national guidance (NICE Clinical Guideline CG68).	
Recommend use of a standard Transient Ischaemic Attack referral form for general practitioner and ambulance as can be accessed through the cardiac and stroke network.	

Recommended actions	Progress/time frame
Improved engagement and training with primary care colleagues.	
Thrombolysis	
Hyper-acute competencies on the High Dependency Unit need to be addressed. This should be in co-ordination between the Clinical Nurse Specialist for Stroke and the senior nursing leadership on High Dependency Unit.	Confirmation of competency levels with relevant action plans in place by 13 August 2010.
Medical responsibility for stroke patients on the High Dependency Unit needs to be clear. This responsibility of care should be taken by someone with recent experience of thrombolysis.	
All clinicians involved with the thrombolysis rota and including radiology and the ambulance service should meet regularly to review the operation of the pathway, particularly unfamiliar aspects such as the use of telemedicine, and process and outcome measures.	
Direct Admissions and Emergency Admissions Unit	
Direct admissions from Emergency Department to the Acute Stroke Unit should be implemented urgently.	Primary Care Trust to review data on admissions and patient flows regularly to be assured of direct admissions to Acute Stroke Unit.
Methods for the assessment of safe swallowing in suspected stroke should be implemented in line with the NICE Quality Standard.	
Further training with general practitioners on triage of suspected stroke utilising the nationally recognised tool Recognition of Stroke in the Emergency Room scale.	
Agree and implement a streamlined process for requesting plain Computed Tomography head scans for cases of suspected stroke. Use of the Recognition of Stroke in the Emergency Room scale as a trigger to an expedited request is recommended.	

Recommended actions	Progress/time frame
Bed Management	
Bed management policy for admitting stroke patients directly to the acute stroke unit is raised to executive level and reconciled with the current approach of the NHS Trust to mixed sex accommodation in other clinical priority areas, and driven forward.	
Policies for management of stroke patients to include provision during winter pressures to ensure that the stroke ward continues to be able to admit directly.	
Acute Stroke Unit	
Review the numbers of therapy staff, nurses and skill mix in order to meet the 2010 NICE Quality Standard for Stroke with regard to access to skilled nursing and therapy staff.	
Ensure funding is secured to maintain the Social Worker post on the unit.	
Ensure adequate cleaning is undertaken around and under the corridor space where hoists are stored.	
Review consultant sessional time for acute stroke in line with the British Association of Stroke Physicians recommendations for consultant staffing and provide an action plan to redress the shortfall.	
Commissioners to work alongside the local authority and acute providers to ensure timely access for Continuing Health Care and residential care is addressed.	
Community and Early Supported Discharge	
NHS Dorset needs to be clear about the milestones in their incremental approach, and avoid overestimating the early impact of the proposed changes.	

Recommended actions	Progress/time frame
Across the pathway	
In-house training needs to be more firmly linked to stroke-specific competencies, which themselves need to be developed, delivered and assessed.	
NHS Dorset to review the data used to plan the inpatient provision for stroke-specific rehabilitation, taking particular account of demographics and dependency, as this may oblige a different configuration of inpatient and community rehabilitation services.	
NHS Dorset and Dorset County Council to review the means by which the Stroke Care Co-ordinator service can be continued at the end of the funding period without any loss of continuity of the service.	
Managers and clinicians responsible for delivering the service along the whole pathway to arrange at least one visit to a top-10% stroke service in England, and to discuss with Dorset Cardiac and Stroke Network the means to support such a visit.	