Stroke Pathway Redesign Update

Executive Summary

In January 2012, the SHA of Midlands and East presented a paper proposing a fundamental review of the stroke services across the Midlands and East region (NHS Midlands and East, 2012). The report emphasised the emerging benefits arising from changes to stroke services implemented in London. The London review resulted in services focused on fewer sites.

Baseline data was gathered on stroke services including the assessment of all other recent reviews of stroke services across the region, and the analysis of activity, performance and outcomes data for each provider.

The review provided guidance and made recommendations about the best approach to delivering improvements in stroke services and to ensure that best practice was implemented an evidence-based best practice specification for the whole stroke pathway was produced.

The phases of care for stroke patients identified across the whole pathway are:

The decision making related to the implementation of proposals and specifications for the seven phases of care then rested with individual CCGs.

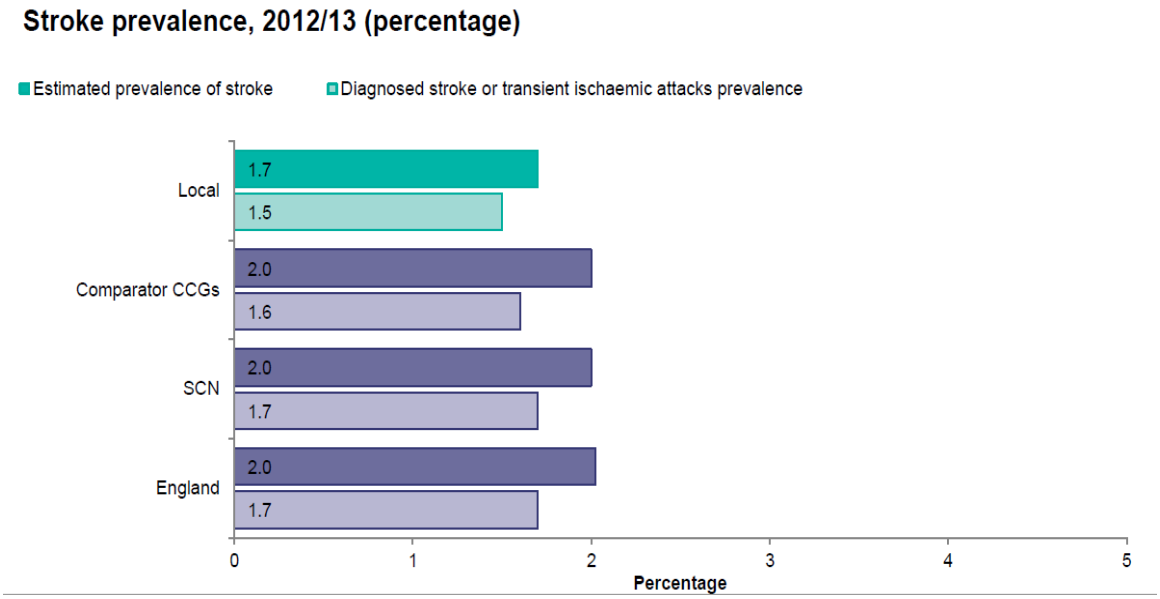
HVCCG confirmed transformation of the stroke pathway as a priority and agreed a stepped model of change to the stroke pathway to improve clinical outcomes for stroke survivors, reducing longer–term dependency and agreed ***initial work plans would focus on provision of care closer to home through improved access to stroke specialist care in the community.***

To provide leadership for strategic development of the whole stroke pathway for the people of HVCCG a multi-agency Stroke Leadership Group has been convened to ensure delivery of an integrated pathway. The resulting collaborative working across organisational boundaries by West Hertfordshire Hospital Trust (WHHT), Hertfordshire Community Trust (HCT), Hertfordshire County Council (HCC) and the Stroke Association to deliver improvements in stroke care is to be positively acknowledged.

This document highlights progress across HVCCG from the start of the review in June 2012.

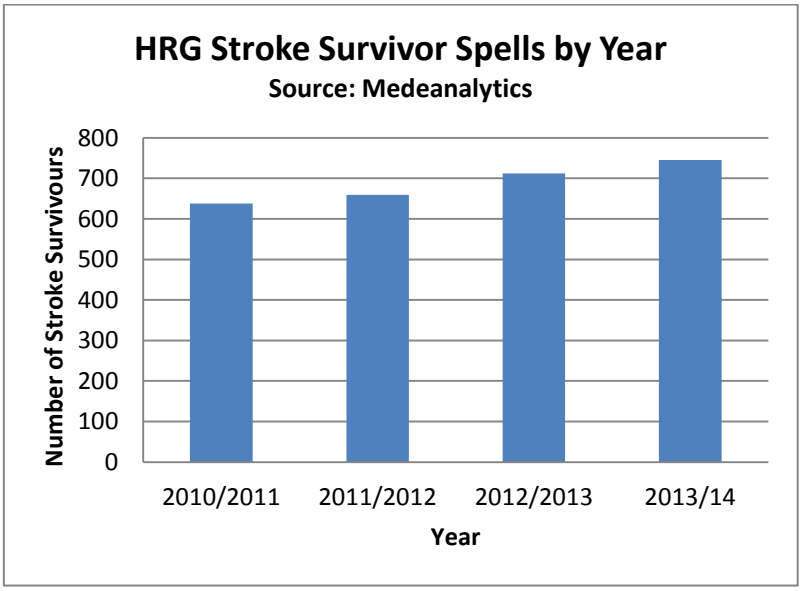
Section 1: Background

HVCCG has an estimated 1.7% stroke prevalence, which is lower than England (2%). Stroke is the highest cause of adult disability in the UK costing the NHS over £3 billion a year.



[1] Health & Social Care Information Centre (HSCIC) Quality and Outcomes Framework (QoF) 2012/13 (Public Health England Cardiovascular Disease Profile – Stroke August 2014)

In HVCCG 2013/14, there were 833 stroke events and 745 stroke survivors[2], 80% of which were via West Herts Hospital Trust. Data currently indicates a year on year increase in stroke survivors:



There is robust evidence that the clinical outcomes for stroke survivors are improved by organised[3] and specialist stroke services working in partnership with existing community services. The anecdotal feedback from patients and carers[4], locally, is frustration, isolation and abandonment, particularly during transfers of

[1] Health & Social Care Information Centre (HSCIC) Quality and Outcomes Framework (QoF) 2012/13 (Public Health England Cardiovascular Disease Profile – Stroke August 2014)
[2] CSU HRG data
[3] NICE Stroke rehabilitation Guidelines 2013
[4] Verbal communication with Hertfordshire Community Stroke Project Lead

care. Stroke rehabilitation has been proven as effective[5] if part of whole systems pathway of care which includes:

- Rapid access to an acute stroke unit and seamless transfers of care
- Rehabilitation in a dedicated stroke inpatient unit and subsequently from a specialist stroke team(s) in the community.
- Stroke Specialist early supported discharge for people able to transfer from bed to chair independently or with assistance, in a safe and secure environment, with standards of care equivalent to a stroke unit. This service is suitable for 40% of all stroke survivors
- Access to robust information, advice and support and holistic reviews

As a result of the Midlands and East Stroke Review 2012, an external expert advisory group developed a service specification that set out the criteria that the different parts of the stroke pathway need in order to deliver high quality care to patients.

The phases of care for stroke patients are:

HVCCG stroke pathway plans address all of the above and an update on progress and improvements are highlighted in Section 2 and next steps detailed in Section 3.

Section 2: Progress Update

…. 'Where We Were', 'Where We Are Now' and 'Where We Need To Be'

2.1 'Where We Were'

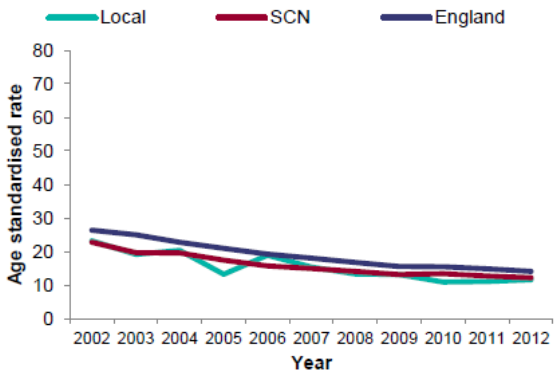
2.1.1 Mortality: Deaths from stroke, 2002 – 2012, (rate per 100,000 people) has been reducing.

The under 75 years mortality rate due to stroke in HVCCG was 11.6 per 100,000 in 2012. This is similar to the rate for England (14.1).

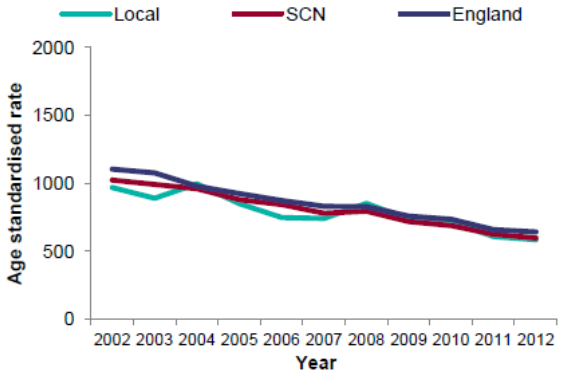
The over 75 years mortality rate due to stroke in HVCCG was 585.5 per 100,000 in 2012. This is similar to the rate for England (642.4).

[5] NICE 2013

Early mortality under 75, 2002-2012 (rate per 100,000 people)



Later mortality over 75, 2002-2012 (rate per 100,000 people)



Source: Office for National Statistics, Mortality statistics, 2013

2.1.2 Acute Phase - 'Where We Were'

The Midlands and East Stroke Specification recommended an average overall hospital stay of 10 days. Once medically stable and with manageable risks patients could be supported in the community with specialist stroke services.

Up until implementation of HVCCG Stroke improvement plan, the average length of stay at WHHT remained at 16 days[6] each year.

There were also challenges for West Herts Hospital Trust to meet national stroke performance targets and although performance was improving there remained issues which were attributable to insufficient/lack of community service.

2.1.3 Community Rehabilitation - 'Where We Were'

Specific Community stroke rehabilitation had not been commissioned and had evolved as part of Hertfordshire Community Trust (HCT) and Hertfordshire County Council (HCC) services. There was no defined pathway of delivery which led to inequalities across HVCCG.

HCT cared for stroke patients after their acute hospital stay within the Integrated Community Teams and Community Neurological service and in two types of beds:

- ***Specialist neurological rehabilitation beds*** (6 beds) – stroke patients with complex presentations
- ***Intermediate care beds*** (non-specialist beds dispersed across HVCGG, not ring-fenced) - stroke patients with less complex needs.

Although there were the beds detailed above, the main issues were:

  - insufficient numbers of stroke specialist beds for HVCCG population
  - intermediate care beds were not supported by stroke specialists: in 2012/13, 65% of patients received rehabilitation in intermediate care beds, which did not meet stroke quality standards.

[6] CSU data

- the average length of stay for a stroke survivor in an intermediate care bed was 44 days and 53 days in a specialist neurological bed.

Additionally, HCC commissioned the Stroke Association to provide 'Life after Stroke' Information Advice and Support Services and Communication Support Groups. This service was not based with other stroke service providers and evidence suggests that co-location would maximize potential.

2.2 'Where We Are Now'

In this section the following is outlined:

- internal improvements at the acute trust (WHHT) and
- work-streams in progress to support further improvements in the pathway.

2.2.1 Acute Phase: *Summary of acute trust (WHHT) improvements against quality standards*

There have been some significant changes and improvements across HVCCG since the inception of the Midlands and East Stroke Review:

- Increased number of consultant posts - from 1 to 3.
- Increased number of nursing posts (*including stroke nurse specialist*) - from 68 to 108, now staffed according to stroke service standards.
- Increased numbers of therapy posts – 16 to 20.
- More patients accessing a stroke bed within 4 hours of admission (see data in *Appendix 1*).
- Continuing improvement on the 90% stay on a stroke unit measure (*see data in Appendix 1*).
- Increase in numbers of patients thrombolysed (*see data in Appendix 1*).
- Increase in numbers of patients thrombolysed within 3 hours (door to needle time) (*see data in Appendix 1*).
- The average length of stay for stroke patients at WHHT has reduced from a static **16 days** per year for previous 3 years to **12 days** for 2014/15 (*see data in Appendix 1*).

2.2.2 Community Rehabilitation: *New CCG Investment*

The key areas that HVCCG identified as needing investment were Specialist Stroke Bed capacity, Early Supported Discharge and 6 month reviews.

Investment to support transformation of the stroke pathway was confirmed by HVCCG for the following three areas:

October 2013: £130K per annum:

a) to upgrade therapy input into 10 community beds to enable meeting of national standard for rehabilitation of 45 minutes of therapy, 5 times a week.

March 2014: £638k per annum:

b) to provide an Integrated Specialist Stroke Early Supported Discharge Service (ESD) for HVCCG which will include Community Coordination and

c) 6 month Review Service for **all stroke patients**, as required by the National Outcomes Framework 2015/16.

2.2.3 Community Rehabilitation: *Reconfiguration of Community Stroke/Neurological Rehabilitation Beds*

NICE guidance 2013 states that: *"People with disability after stroke should receive rehabilitation in a dedicated stroke inpatient unit and subsequently from a specialist stroke team within the community."*

HVCCG stroke patients, who were currently dispersed across the area in non-specialist stroke beds, are now being cohorted in 10 specialist beds at Langley House, Watford.

Medium term plans include relocating the 6 specialist/complex neurological community rehabilitation beds from Holywell ward, St. Alban's City Hospital also to Langley House, creating a '***dedicated 16 bedded Specialist Neurological and Stroke Rehabilitation Unit for Herts Valleys'***.

Outcomes to date include:

- reduced length of stay for stroke patients at WHHT (16 days to 12 days),
- improved flow through WHHT stroke unit, no patients waiting in an acute stroke bed for a community stroke/neurological rehabilitation bed (June to September 2014).

2.2.4 Community Rehabilitation: *Early Supported Discharge*

HVCCG and Hertfordshire County Council (HCC) jointly agreed to commission a local integrated health and social care stroke early supported discharge service (ESD).

The service will be required to:

- Provide a single point of access to support the coordination of all in-patient transfers of care/discharges and enable establishment of a stoke register.
- Maintain an annual rolling stroke register.
- Deliver Early Supported Discharge, rehabilitation packages for up to 6 weeks to 40% of stroke survivors across acute and community in-patient bed bases, with a coordinated approach to health and social care support.
- Provide the holistic 6 month stroke reviews for **all stroke survivors**, a requirement in NHS Outcome Framework, CCG Indicator Set.

Outcomes to date include:

- service on target to go-live on 27th October 2014,
- WHHT, HCT, HCC and Stroke Association working in collaboration to improve outcomes for stroke patients.

2.4.5 Long Term Care and Secondary Prevention: *Provision of 6 month reviews*

HVCCG and Hertfordshire County Council (HCC) jointly agreed to commission provision of 6 month holistic health and social care reviews for **all stroke survivors** across HVCCG, monitored nationally as a CCG indicator in the NHS Outcomes Framework.

CCG Indicator: Improving recovery from stroke:

- *Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months*
- *Proportion of patients who receive a follow-up assessment 4-8 months after initial admission to identified unmet need.*

Outcomes to date include:

- service on target to go-live on 27th October 2014,
- WHHT, HCT, HCC and Stroke Association working in collaboration to improve outcomes for stroke patients.

2.2.6 HVCCG Stroke Leadership Group

HVCCG has convened a multi-agency Stroke Leadership Group, chaired by Dr Clare Dyer (Watford GP and HVCCG GP Speciality Lead for Stroke) to provide leadership for strategic development of the whole stroke pathway for the people of Herts Valleys CCG and ensure delivery of:

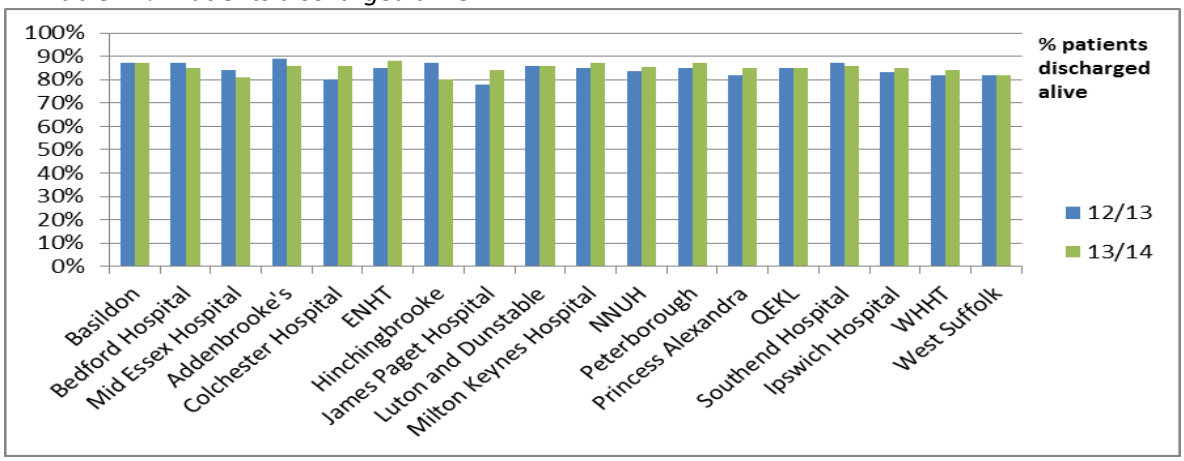
- an integrated pathway (enhancing collaborative working across organisational boundaries)
- a whole system approach to integrated ways of working focused on patient/carer outcomes
- an evidence based approach to commissioning the integrated pathway, in line with national guidance.

2.2.6 Mortality

30-day stroke mortality data is only calculated by Health & Social Care Information Centre (HSCIS). The latest data are from 2011/12 (*see above 2.1.1*). The next publication is not due until February 2015. To try to establish a view of mortality across the patch, 'discharged alive' data has been used, where available. *It should be noted that this data was not collected for the full year in 2011/12 for those Trusts who use the Network Records database so for comparison the data from 2012/13 and 2013/14 has been used for all Trusts.*

There is little change in the numbers of patients discharged alive. The percentage of patients has remained fairly static over the past 12 months, the average is currently 84% (*see table 1 below*).

Table 1: % Patients discharged alive



Source: Network Records and individual Trusts

Section 3: Next Stage

4.1 'Where We Need To Be'

The original intention of the Midlands and East Review was to "achieve a step change improvement in the quality of stroke and TIA services and outcomes" (NHS Midlands and East, 2012). This updates identifies the improvements that have been achieved. However, it is also true that the objectives have not been fully met. There is still some way to go to have a consistent "fully integrated, end-to-end stroke service", "implement the recommendations of the National Stroke Strategy" and to "meet the service standards and specifications set by the Royal College of Physicians and NICE guidelines" (NHS Midlands and East, 2012).

In this section, priority areas for 'next steps' are outlined.

4.1.1 Primary Prevention and Pre-Hospital Phase: *Stroke Prevention Pathway*

Priority 2016/17 - HVCCG Stroke Leadership will now progress to development of strategic objectives and work-plan for the prevention element of the stoke pathway including review of services for Transient Ischaemic Attacks (TIAs).

There are other preventive workstreams that will have impact on stroke and HVCCG Stroke Leadership Group will work with other groups leading on these areas. In particular controlling Atrial Fibrillation (AF) can lower the risk of stroke and therefore links and close working relationships are being established between HVCCG Stroke Leadership group and HVCCG Cardiology Group.

4.1.2 Acute Phase: *Hyper Acute Stroke Units (HASUs)*

The current work programme has supported WHHT as the main provider of acute stroke care for the majority of HVCCG patients (80%). Future work plans will support other acute providers of

stroke care for the rest of HVCCG patients (including Luton & Dunstable NHS Trust, Barnet & Chase Farm Hospital and East & North Hertfordshire NHS Trust).

Further to the Midlands and East Stroke Review 2012/13, CCG Accountable Officers across Bedfordshire, Hertfordshire & Milton Keynes agreed to consider how acute stroke services could be reconfigured and requested that the East of England Cardiovascular SCN complete a review of Stroke provision with options for provision of Hyper Acute Stroke care. The 'Options Appraisal' is currently with the Accountable Officers to agree and plan next steps with the Stroke Clinical Advisory Group (SCAG).

The 'Options Appraisal' will be subject to review by HVCCG Locality Boards, Patient & Public Involvement Committee and Clinical Commissioning Executive, with an expectation that recommendations and request for a decision will be presented to HVCCG before the end March 2015.

4.1.3 End of Life Care

The joint HVCCG and HCC strategic objectives for End of Life Care will be aligned and incorporated as a key element of the whole stroke pathway. The strategic objectives are:

- *People have chance to discuss their end of life wishes and preferences (advance care planning)*
- *Positive experience of end of life care*
- *Reduction in avoidable hospital admissions during last year of life*
- *People die in their preferred place*

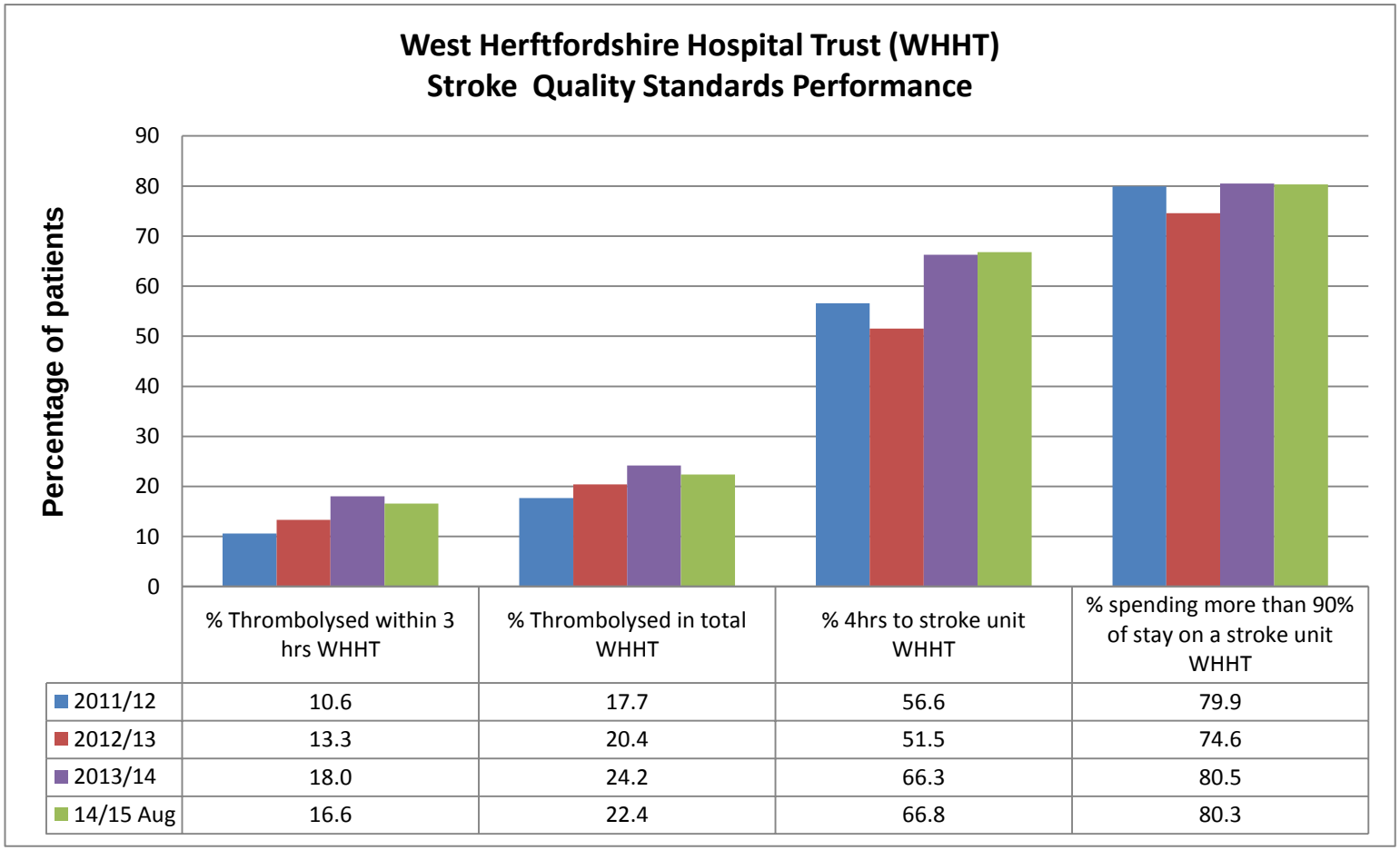
4.1.4 Joint Strategic Needs Assessment (JSNA)

Work has recently started to develop a 'live' Stroke section on the JSNA. This will include a complete set of indicators, metrics and intelligence, providing evidence that will support:

- identifying population needs,
- monitoring impact on patient outcomes,
- identifying service gaps and
- improving commissioning decisions.

HVCCG are also embarking on joint a piece of work with Bedfordshire and Milton Keynes via the Stroke Clinical Advisory Group (SCAG) to develop outcomes measures across the area.

4.1 Stroke Quality Standards Performance data



	% Thrombolysed within 3 hrs WHHT	% Thrombolysed in total WHHT	% 4hrs to stroke unit WHHT	% spending more than 90% of stay on a stroke unit WHHT
2011/12	10.6	17.7	56.6	79.9
2012/13	13.3	20.4	51.5	74.6
2013/14	18.0	24.2	66.3	80.5
14/15 Aug	16.6	22.4	66.8	80.3

4.2 West Hertfordshire Hospital Trust (WHHT) – Acute Stroke Average Length of Stay

Provider: **(WEST HERTFORDSHIRE HOSPITALS NHS TRUST - RWG)**

Year (Discharge Date)	HRG	Avergage Length of Stay (ALOS) *
2011/2012		
	AA22Z - Non-Transient Stroke or Cerebrovascular Accident, Nervous system infections or Encephalopathy	16
	AA23Z - Haemorrhagic Cerebrovascular Disorders	16
Total: 2011/2012		**16**
2012/2013		
	AA22Z - Non-Transient Stroke or Cerebrovascular Accident, Nervous system infections or Encephalopathy	15
	AA23Z - Haemorrhagic Cerebrovascular Disorders	17
Total: 2012/2013		**16**
2013/2014		
	AA22A - Non-Transient Stroke or Cerebrovascular Accident, Nervous System Infections or Encephalopathy with CC	16
	AA22B - Non-Transient Stroke or Cerebrovascular Accident, Nervous System Infections or Encephalopathy without CC	4
	AA23A - Haemorrhagic Cerebrovascular Disorders with CC	18
	AA23B - Haemorrhagic Cerebrovascular Disorders without CC	3
Total: 2013/2014		**16**
2014/2015		
	AA22A - Non-Transient Stroke or Cerebrovascular Accident, Nervous System Infections or Encephalopathy with CC	12
	AA22B - Non-Transient Stroke or Cerebrovascular Accident, Nervous System Infections or Encephalopathy without CC	4
	AA23A - Haemorrhagic Cerebrovascular Disorders with CC	14
	AA23B - Haemorrhagic Cerebrovascular Disorders without CC	1
Total: 2014/2015		**12**

** without Day Cases*