Report on the Integrated Stroke Care Workshop

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REPORT OF THE INTEGRATED STROKE CARE WORKSHOP

Monday 13th November, 2.30pm, Chief Executive Boardroom, Level 4,
East Wing, Darent Valley Hospital, Dartford.

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Background

The Stroke Project has been underway since October 2000. This workshop represented the first mechanism where by issues surrounding the project have been addressed by the multi-disciplinary stroke team and the Darent Valley Hospital Staff. Approximately 35 members of staff attended the workshop, demonstrating the high level of interest and ownership.

Currently, the hospital receives an average eight or nine new stroke admissions a week. The turnover is such that patients suffering from stroke account for around 22-23 occupied beds in the acute hospital at any point in time. In the past the Acute Trust had had a lead Stroke Physician responsible for 20 designated stroke beds within a stroke unit. In that system many (but not all) cases of acute stroke admitted under the General Physicians would have been referred to the stroke unit and had their acute care and acute rehabilitation provided on site in that unit. At that time the overall number of beds occupied by cases of stroke was around 28-29.

Recently there has been a reconfiguration of services and the retirement of the former lead Stroke Physician. The new system is such that cases of acute stroke admitted under the General Physicians will generally remain within the ward where they are admitted until discharge. A successor to the lead stroke physician takes up his appointment in January. On current strategy, the lead stroke physician is to provide a specialist consultation service to other clinicians, but is not expected to have a unit for taking over the care of such patients. In place of some of the elements of the former system there is a community based stroke team and there are six new community based stroke care beds at the Livingstone. These are overseen by a General Practitioner with an interest in stroke care. In fact the Acute hospital has seen a bed reduction of 20% (500 beds reduced to 400) and the proportion of occupied beds represented by stroke has seen a concomitant reduction of 20% (c.28.5% reduced to 22.5%). At the same time the Livingstone, with 6 stroke care beds and c.100% occupancy, in the community, can be said to have accounted for the reduction in acute care provision.

The Stroke team therefore is the subject of interest in that with its services in start–up mode and the establishment of PCT managed intermediate care services due in January. There is a certain expectation that these community focused services should be able to take more of the stroke burden out of the acute unit. This is especially hoped for in the face of evidence that shows how a substantial proportion of acute unit occupied bed days identified as stroke cases

are occupied by patients no longer in need of acute care. It is however also acknowledged that much of the 'bottle neck' relates to a relative shortage and perhaps contracting stock of nursing home beds in the community. It is a legitimate fear, therefore, that the dis-investment from acute care and reinvestment into community health care might be better spent by redirecting some of it to social care enhancing the provision of nursing home beds.

Introduction

The workshop consisted of two sessions. The first session involved dividing the attendees into six groups, namely: the stroke strategy, acute care management, rehabilitation, hospital utilisation, discharge management and the stroke team. Within these divisions the attendees considered aspects of the stroke project which they deemed to be 'excellent' (representing best practice in action), 'satisfactory' (those things which appear to be going to plan, but which bear scrutiny to assess that they are optimal) and those 'needing attention'. These aspects were recorded and presented by an elected raconteur from each group. A definitive list was then constructed from all the groups responses with any repetitions omitted.

The second session involved the six groups pairing up and discussing the issues raised in session one under the headings of: action (what action is to be taken), responsibility (who should be responsible to take the action) and time frame (when should the action be taken).

Session One

The Issues

There was good positive discussion in all groups and a number of issues were examined. The presentations allowed for further debate between all the attendees. Various issues were replicated, but there were differing opinions surrounding some issues as to what was currently in place, and what was believed to be working at various points on the care continuum for stroke patients.

Aspects of Excellence:

The Stroke Team – who are dedicated, multi-disciplined, enthusiastic, approachable people offering specialist advice and expertise. The team was also thought to be easily contactable between the hours of 9-5, however this lead to discussions over the out-of-hours access and the location of various members of the team (on/off site eg. OT/Physio).

The Concept – the idea of the stroke team was believed to be an excellent concept by one group and representative of a very positive initiative. Concerns were expressed over whether the delivery of this concept was quite as effective as desired, although it was acknowledged that the stroke project had good potential.

Quick Response – Some groups expressed this as an excellent feature, but not all attendees were in agreement as discrepancies were highlighted between the referral, assessment, CT scans and admission times. Although it was suggested that once all the tests etc had been completed then the stroke cases were dealt with quickly. One group identified the fast

response of being able to assess new CVA's within 24 hours. Again this lead to discussion over the whether the time frame of 24 hours included admitting the patient or not.

Liaison – this was deemed to be an excellent aspect by a number of groups. In particular those involved with dietetics and speech and language believed that having the same employer and coverage of the acute and community sectors lead to excellent liaisons. Close liaisons and communication was emphasised between members of the stroke team and GP's, DN's, community multi-disciplinary services and the discharge co-ordinator. One group identified that a key worker for each patient with which they could liaise was a positive aspect.

The Referral Process – a small clarification appeared to be required on this area as to whether a completed form was required or just a phone call was needed for referral. Various attendees mentioned that they were unsure whether a form had to be filled in as they had not completed one to date and if not then would this be detrimental for auditing purposes. Within this issue area it was deemed that the appropriateness of GP referrals was excellent, as was the referral from physiotherapists.

Fast Track Rehabilitation – factors such as immediate acceptance of CVA patients by the Livingstone was emphasised as being a very positive issue. The good rehab in DVH was also emphasised as a positive issue. The policy of being able to look after stroke patients at home by having the total involvement of the family was categorised as an 'excellent' aspect.

Other issues – three aspects which were identified under the heading of 'excellent' included the prevention of hospital admissions, the evaluation of patient progress including goal centred care and valid outcome measures and outpatient accessible CT scans taking place within the 48 hours. Again there was a question over the amount of time between referral, the CT scan taking place and actual diagnosis for admission.

Aspects which are satisfactory

This appeared to be a difficult category to slot issues in to as they either appeared to work in which case they were categorised in to the 'excellent' list or they failed to deliver what was expected in which case they were in the 'needing attention' list. However a number of issues were stated by some of the groups.

One issue which appeared to be defined as satisfactory was the speed in which cases are dealt with, however one group specified that although the patients were accepted quickly there is still a delay in the discharges and a large number remaining in DGH.

Other satisfactory aspects include improving links with physiotherapy staff and supportive ward staff. The final aspect which was highlighted was that the criteria was agreed and working, but members with in the group stated that the criteria may need re-visiting at certain points in time.

Aspects which need attention

A large number of issues were highlighted in this particular section and which produced a great deal of discussion. The issues detailed are as follows:

CT Scans - the main concern under this issue appeared to be the delay in getting the CT scan performed. Over and above the difficulties in organising for CT scans to be conducted out-of-hours or over a weekend (due to no service being available during these times), a number of groups also mentioned the difficulties in obtaining the doctor's signature for the CT scan. This results in delays in acceptance by the stroke team and blocking of beds by those patients who are then diagnosed as not having had a stroke. Some staff were under the impression that CT scan was essential for diagnosis of stroke and that this was a cause of delayed referral. This lead to some debate whether or not those patients who had clearly suffered a stroke should need to wait for a CT scan or whether they could be referred directly. Presumably they don't but this is a communication block.

Acute Beds - There are six Livingstone acute beds available for stroke care under the lead stroke G.P. There are c.8-9 new cases of stroke admitted to the acute hospital each week. Each stroke case is admitted under the on-call physician of the day. Subsets of these will be onwardly referred to the lead stroke physician and to the rehabilitation service. All admissions diagnosed as stroke should be referred to the stroke team. Currently there are some noticeable variations between physicians both in the actual uptake of the referral service and in the lead time from diagnosis to referral.

(Action opportunity – investigate the variations in physician use of the services and options for increasing uptake where appropriate.)

Rehabilitation Beds and Community Beds. - The numbers of both rehabilitation beds and community beds are perceived to be lower than desirable. Some observers at the workshop have suggested that a lack of access (or perceived lack of access)to beds in the community for people no longer needing acute medical care is still a significant cause of delayed discharge. Some observers reported that the number of available nursing home beds in the community, to which rehabilitated stroke patients can be discharged, is contracting. This problem is thought to be more critical for the patients requiring slow stream rehabilitation rather than the fast stream ones.

(Action opportunity - A short term alternative in the form of further provision of intermediate care facilities should be considered. Various opportunities under joint investment planning present themselves. It may be that the volume of slow stream rehabilitation patients warrants further development of specific facilities. It may be appropriate to review the available 'hotel' function beds if there is truth in the suggestion that patients' no longer requiring acute medical care. There is a possibility to consider a model(used elsewhere) which involves clinicians certifying continuing need for medical care after a certain length of stay in hospital, (case mix adjusted). If, after the time in question, the doctor certifies that there is no longer a need for acute medical care, the onus for the patient's care is transferred elsewhere. This might require the availability of non-NHS residential beds on site or a joint investment agreement with the local authorities concerned)

Criteria and Referral Process – a number of issues arose under this heading, some of which revolved around the inappropriateness of referrals, especially to the Livingston and the

amount of time wasted on non-CVA referrals. Delays in referring patients were thought to be due to uncertainty over the initial diagnosis. It was acknowledged that few referrals came directly from GP's and that many GP's were still referring directly to physiotherapists and occupational therapists. One group identified that the patients being admitted directly to the wards from MAU and A&E needs attention.

(Action opportunities – A public relations exercise into Primary Care which is aimed specifically at developing ownership of the concept by GPs. The decision to refer lies with the GP and the principles for initiating changing practice need to be addressed along with the PR exercise. Audit of A&E & MAU referrals to provide evidence to support or refute perceptions of delays.)

Therapist referrals - Concern over the progress in following up referral to physiotherapists and OT's for out-patient treatment was expressed. There was some discussion over the issue of patients remaining in hospital simply because they did not have access to physiotherapists and OT's every day if they were out in the community, although they were deemed well enough to be discharged.

(Action opportunity – a small audit of discharge delayed patients using an AEP instrument or similar should reveal if this is actually taking place.)*

The Livingstone - Questions over the doctor's understanding of the referral criteria and process at the Livingstone was expressed, with concerns about the rigid nature of the criteria for referral, the criteria by which the patients severity of CVA is measured and the unrealistic nature of the goals to be achieved within 3 weeks to fulfil the criteria (eg. Sitting balance). The timing of the initial assessment and what is meant by being 'medically stable' were also raised as issues which need to be addressed.

(Action Opportunity - Education strategy for Doctors in question. Review of goals and criteria where there appears to be a mismatch) Other issues raised in regard to this facility were the lack of a gym, the inappropriate environment and lack of space and the poor access to equipment at the Livingstone. There were also a human resource needs specified. These are a specialist medical carer / stroke consultant, a counsellor, a psychologist, and a family support worker. It is considered that these are needed to provide quality care in this environment.

Communications and Management – One aspect of the programme which was considered to require attention was the lack of co-ordinated information on patient care, diagnosis and medical and nursing management. Improved communication between teams was emphasised and in particular those communications between CST and acute workers. It was also specified that there was a need for the medical and nursing management to be consistent between the wards and that the national guidelines should be adhered to.

(Action Opportunity – Consideration of a guideline implementation programme and developing concensus towards the adoption of a common evidence based Stroke clinical pathway, which in particular has medical clinician and GP ownership.)

Stroke Team – Some of the attendees felt that a lack of knowledge and awareness exists about the Stroke Team and one group were unaware of the results that the Stroke Team's judgement had been based on. The Stroke Team assessment report was not widely

disseminated and copies were requested by some of the attendees. Additionally various attendees at the workshop felt the criteria of the stroke team was not being utilised and the stroke project group negotiations/agreement were being completely ignored.

Resources – Concern was expressed that the resources specifically directed at the management of Transient Ischaemia attacks were inadequate and that more could be done in this area in terms of improving patient care, preventing severe illness and improving the efficiency of this aspect of health care expenditure.

(Action opportunity – A rapid appraisal of the evidence for Stroke prevention through TIA management and economic evaluation of specific strategic options.)

Session Two

The issues derived from the 6 groups of attendees at the workshop were combined to form 3 separate lists under the original headings of 'excellent', 'satisfactory' and 'needing attention'. The groups of attendees paired up to consider the list of issues needing attention. The issues were examined and then suggestions made as to the action that needs to be taken, who is to take the responsibility and the time frame in which the action is to take place.

Group one

ISSUE	ACTION	RESPONSIBILITY	TIME FRAME
Referral mechanism	Point of ref. Should be A&E, MAU, NIC, surgery	Directorate, nurse managers	Immediately
Communication breakdown	Increase awareness	CST	Immediately.
	CST. ICP →	DVH, CST →	6 months
CT Access	Increased reporting faster	CT Department (Radiologist)	Immediately
Livingstone	More beds, Slow stream beds	PCT	Now immediately
Out of Area	Liaise with Bexley teams	PCT, CST	3 months
Medical staff knowledge	Stroke consultant.	DVH	In process Jan 2001
	CST Presentation	CST	Rotation – 6 monthly
Out of hours access	On call team	CST	3 months
Access equipment, OT bureau	More accessible	PCT, OT, CST	3 months
Lack of TIA resources	Refer to intermediate care team	DVH	By Jan 2001
Review criteria	Audit	Quality and audit dept	6 months – 1 year
Delayed discharge	Increased community resources £ Working together as one health team.	Health Authority Social Services Government	Ongoing
	Develop current nursing homes	CST, PCT	

Group two

ISSUE	ACTION	RESPONSIBILITY	TIME FRAME
Referral Mechanism	ICP	Audit	Long term
	Nominated person on each wards COE meetings Doctors inductions	Acute sector	
Communication	Inform ward of allocated key worker	Stroke team	Immediately
	Physio's and OT's to document progress and named therapist	Acute sector	
	List of therapist bleeps	Acute sector	
Livingstone (medical cover)	Physician Gym	PCT	?
Slow Stream Rehabilitation	Slow stream facility	PCT and acute sector	?
	More stroke beds at Livingstone	HA	
	More N. H. beds	HA	
Access to equipment/adaptations	Fast track access to technician	PCT, SS, KCC	?
	Team technician		

Group three

ISSUE	ACTION	RESPONSIBILITY	TIME FRAME
Referral Mechanism	Co-ordinated referral from each ward	Pam and A&E/MAU	?
Communication	Develop integrated notes	Sarah (Audit) CLINKS	ASAP
	Ward named/primary nurse	Pam	
CT Scan	Increase capacity review criteria for management and reporting	CLINKS (Ann)	?
Livingstone	Training Programme for nursing staff	Chris/Debbie	?
	PR work with GP's	Debbie	
Slow stream rehabilitation	Research alternatives provision	Monica/Debbie	On going
	Bid for funding intermediate beds	Monica/Debbie	
Good knowledge of the system	Review/evaluation from key staff	Rosie/Debbie	3 months
	Develop link nurse role	Ann	
Bexley patients	Liaise with PCG's / HA/ Social Services	Monica/Bill/John (400 bed meeting)	?