Stroke OGIM - 2021

Why change is needed

- Due to changing demographics, the number of people having a stroke will increase by almost half, and the number of stroke survivors living with disability will increase by a third by 2035.
- Advances in treatment are not universally available.
- Changes to the hyperacute elements of the pathway have improved patient outcomes however these gains are not being realised due to the fact that rehabilitation is not standardised for all patients across County Durham.
- Although investment has been made for community-based therapy, there is still more to do to achieve standards of early supported discharge as well as sustained therapy within an acute setting.
- Therapy provision could be enhanced to ensure a more consistent approach across acute and community settings.
- Inequality exists within the current model of care, accessibility into services is disparate and requires bolstering mainly inpatient based therapy provision.

Objectives

- To provide high quality specialist care to all patients, improving quality of life following a stroke.
- Ensure that supported discharge and high quality, consistent rehabilitation is embedded into pathways.
- To ensure a sustainable, multi-professional specialist workforce across the service.

Goals

- All patients who can benefit from mechanical thrombectomy and thrombolysis receive it.
- Services are configured to ensure that high quality specialist care is the norm for all patients.
- The stroke workforce are well equipped to deliver specialist interventions and high quality rehabilitation.
- To develop a person-centred model of care that delivers care closer to home.
- To minimise variation, reduce inequalities and maximise the health outcomes of our local population.
- To develop a service which retains and attracts an excellent workforce.
- To ensure care is accessible and responsive to people's needs.

COVID - 19

COVID-19 has had a significant impact on specialist stroke services across the County. During 2020 there were fewer stroke admissions, however activity is now back to pre-COVID levels and the challenges of managing the pandemic as well as delivering high quality stroke services is challenging. There are impacts on models of care due to managing COVID vs non-COVID patients whilst already challenged staffing levels are further impacted by the pandemic.

- **Short Term** – emergency stroke services maintained in light of COVID to ensure resilience. Services have adapted pathways to ensure patient needs are met whilst also following latest Government guidelines. Remote technology has been used particularly in relation to ongoing review appointments and where appropriate will continue to do so.
- **Medium Term** – ensuring ongoing delivery of acute and community-based specialist stroke services whilst managing broader demands on the overall health and care system
- **Long Term** – ensuring all future plans for service transformation are quality assured in line with COVID guidance and good practice is maintained throughout.

Triple Aim Outcome Measures

Health Outcomes	Patient Experience Outcomes	Workforce Outcomes
1. Admissions for stroke.	1.Percentage offered a 6-month review.	1.Percentage of consultant vacancies TBC.
2. Rates of aspiration pneumonia post stroke.	2.Length of stay across inpatient stroke units.	2.Percentage of satisfaction at work – staff survey TBC.
3. Death rate from stroke.	3. Time to thrombolysis waiting time.	3.Percentage of nursing and therapy vacancies TBC.

Initiatives

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRAG
1. Health Inequalities						
Ensure standardised model of care is rolled out across CDD for Atrial Fibrillation.						
To utilise existing commissioned services focussed on prevention across NHS, social care and voluntary sector organisations to identify opportunities for AF screening						
To review equity of access to stroke services following potential change in model of care.						
2. Health Behaviours (Alcohol, Tobacco, Nutrition and Physical Activity)						
Continue to actively use the SSNAP data to review any service improvements and best practice. Active stroke consultant recruitment.						
Finalise plans to enhance hospital-based specialist rehabilitation.						
Implement community-based stroke service and measure improvements against baseline information as part of 12-month review of service.						
Review model of care for inpatient rehabilitation against baseline measures.						
3. Personalised Care						
To review the utilisation of the shared decision-making model throughout the pathway.						
4. Mental Health and Learning Disabilities						
To review and continue to develop acute and community-based stroke rehabilitation to include access to psychological therapies as per NICE guidance.						
To ensure there are reasonable adjustments made to ensure equity of access as part of the pathway.						
5. Children						
Ensuring that families and children who are affected by stroke are communicated with effectively						
6. Digital						
To ensure all clinical and performance systems interact with one another, particularly in relation to the Stroke Association and their delivery of the 6-month review service.						
To continue implementing the Trust Electronic Patient Record System as part of overall pathway.						
7. Finance						
To review appropriate use of resources ensuring that any savings are reinvested in workforce and additional investment in community services realises benefits.						
8. Integration						
Review contracts with stroke association as an integrated approach.						
Ensure integration of health and social care processes have a positive impact on patient outcomes i.e. ensure discharge planning and implementation is done holistically.						
9. Cultural Change						
To review effectiveness of increased investment in community stroke services and change in culture of working practice by comparing quality and performance against baseline. In particular to assess average length of stay to ensure a more seamless pathway and early discharge.						
To work with teams across acute and community as well as social care to create a culture of “one team” to ensure seamless transitions for patients and their families.						