Middlesbrough Council

Middlesbrough moving forward

AGENDA ITEM: 5

HEALTH SCRUTINY PANEL

10 SEPTEMBER 2009

STROKE SERVICES

A WRITE UP OF THE EVIDENCE RECEIVED SO FAR

PURPOSE OF THE REPORT

1. To appraise the Health Scrutiny Panel of the evidence collected so far regarding Stroke Services in Middlesbrough.

2. To introduce representation from Middlesbrough PCT, in attendance to discuss the evidence collected so far and discuss the development of Stroke Services from a Commissioning perspective.

RECOMMENDATIONS

3. That the Panel considers the evidence outlined below.

4. That the Panel discuss the evidence outlined below with the PCT representation at today's meeting and discuss whether any further evidence is required, before consideration is given to the Panel's conclusions and recommendations.

CONSIDERATION OF REPORT

5. In advance of receiving detailed information from the local NHS pertaining to local stroke services, the Panel felt it would be useful to receive a briefing on essential Stroke information. This included such as the different sorts of strokes, stroke incidence and risk factors.

6. To receive this briefing, the panel heard from the Regional Manager of the *Stroke Association*.

7. The panel heard that the *Stroke Association's* vision and mission were respectively;

'we want a world where there are fewer strokes and all those touched by stroke get the help they need';

'our mission is to prevent strokes and reduce their effect through providing services, campaigning, education and research;'

8. The Stroke Association has a number of regional centres, one of which is the North East. The main strands of work centred on campaigning for stroke services; encouraging and identifying ways of funding research; and providing information and publicity material examples of which were made available at the meeting.

9. In terms of statistical background, the Panel heard that currently one person every five minutes had a stroke in the UK and that strokes killed 60,000 people per year and quarter of a million people lived with the consequences of a stroke.

10. Strokes are the third major cause of death in the UK with 110,000 new strokes a year and 20,000 TIA's (mini strokes). Twenty five per cent of strokes occurred to those under 65 and 300,000 lived with the effect of stroke along with those who cared for them. It was noted that an increasing number of young people between the ages of 20 – 30 years had strokes.

11. The Panel heard that the overall current costs of strokes were identified as follows: -

11.1 £2.8 billion in direct costs to NHS which was more expenditure than coronary heart disease;

11.2 £1.8 billion costs in lost production and disability;

11.3 £2.4 billion in nursing home and personal care.

12. A stroke was defined as a 'brain attack' when the blood supply to part of the brain was cut off. Blood carried essential nutrients and oxygen to the brain. Without such a blood supply, brain cells could be damaged or destroyed.

13. The two main types of stroke were identified as Ischaemic stroke, which was the most common type, caused by a blood clot in the brain and a Haemorrhagic stroke caused by a bleed in the brain.

14. A Transient Ischaemic Attack (TIA) was also known as a mini stroke and occurred when the brain'' blood supply was briefly interrupted.

15. The Panel heard that common problems after a stroke include problems of weakness, clumsiness or paralysis; swallowing; speech and language; understanding; eyesight; recognising objects and knowing how to use them;

concentration of paying attention and remembering; and difficulty in controlling emotions.

16. It was said that some of the major risk factors and lifestyle issues in relation to strokes included inactivity, age, family history and ethnicity, high blood pressure, heart disease, diabetes, smoking, obesity, unhealthy living, oral contraception & Hormone Replacement Therapy, previous strokes and TIAs, binge drinking and substance abuse.

17. The Panel was referred to the Department of Health document, National Stroke Strategy, December 2007, which involved the culmination of the work of six project groups and wide consultation exercise and had resulted in a significant number of recommendations.

18. The Panel was briefed on the five parts of the strategy. The first part related to raising awareness the aims of which were to make sure the public and professionals understand what can cause a stroke, the symptoms of a stroke, and what to do if someone has a stroke and to make sure people who have a stroke and their carers are involved in making decisions about treatment and in designing stroke services.

19. Experience had shown that many people including some GPs did not see stroke as an emergency and there was insufficient information for people with stroke or their carers. It was noted that many people from socially deprived areas and BME communities were more likely to have strokes and to have less awareness on the correct course of action.

20. In relation to pathways of care, the strategy aims were reported as assessing people who had a TIA quickly to minimise the chances of them having a full stroke and to treat people with suspected stroke as medical emergencies to maximise their chances of making a good recovery.

21. Current research showed that only a third of people who had a suspected TIA saw the appropriate experts within 7 days and only a few hospitals and ambulance services could deal with strokes quickly and with the right treatments.

22. In terms of life after a stroke the strategy's aims were to help people who have had a stroke, and their family and carers, have a good quality of life and to make sure people who have had a stroke get the support they needed to live as independently as possible.

23. The Panel was told that although improvements had been made since the introduction of the Stroke Strategy it was stated that:

23.1 only about half the people who have had strokes get the rehabilitation they needed to live at home during the first six months after they had left hospital;

23.2 three-quarters of younger people wanted to go back to work after a stroke;

23.3 a third of people who have had a stroke developed depression;

23.4 a third of people had problems with speech or understanding;

23.5 currently about a third of people died within three months of having a stroke.

23.6 Reference was made to the part of the strategy headed 'working together' the aims of which were to make sure services continued to improve and that people who had had a stroke or were at risk of stroke, and their carers got care from people with the right knowledge, skills and experience.

23.7 Evidence showed that many stroke units had insufficient staff with the right skills and not everyone got the help with rehabilitation they needed.

24. The implementation of the Stroke Strategy had led to five demands from stroke survivors for future services;

24.1 Stroke must be treated as a medical emergency at all times;

24.2 all stroke patients must be taken immediately to and spend the majority of their time in a stroke unit;

24.3 all stroke survivors must receive a smooth transition from hospital to home;

24.4 all stroke survivors must receive all the rehabilitation and long-tem support that met their specific needs;

24.5 all transient ischaemic attacks (TIAs/mini strokes) must be treated with the same seriousness as a stroke.

25. Reference was made to the incidence of stroke in Middlesbrough of 400 per year admissions to the dedicated stroke unit at James Cook University Hospital and 20 – 30 per week covering the South Tees area going through TIA clinics.

26. Reference was made to the commitment of the South Tees Hospitals NHS Trust stroke services, which included: -

26.1 Stroke Co-ordinator in post to ensure appropriate services in place;
26.2 Dedicated Stroke Consultant;

26.3 Dedicated Stroke unit;

26.4 Community based/acute based Therapy teams;

26.5 Community Hospital rehabilitation Beds at Carter Bequest Hospital;

26.6 Dedicated Family Care Support Services provided by Stroke Association, funded by the Primary Care Trust and based at Carter Bequest Hospital;

26.7 Dedicated Communication Support Services;

26.8 Intermediate Care facilities;

26.9 24 hour Access to Thrombilysis Treatment – Middlesbrough was ahead of other areas in prescribing such treatment which had to be administered within four hours of stroke;

26.10 Multi Agency Rehabilitation review (report and recommendations to be submitted a copy of which would be made available to the Panel).

27. Members sought clarification on the funding attached to the Stroke Strategy. It was confirmed that Middlesbrough's allocation (ring-fenced) was £90,000 per year over a period of three years from April 2008. Such funding had been utilised on employing a Stroke Co-ordinator and a Dedicated Stroke Social Worker; contribution towards Communication Support Services; and for the implementation of stroke training programmes for such people as residential care workers and home care workers to raise awareness to the needs of patients and carers.

28. Reference was made to the significant work undertaken by the Panel as part of its review of Life Expectancy with a particular focus on cardiovascular disease in Middlesbrough an important element of which related to the need to pursue appropriate preventative measures. The similarity of such areas of work between CVD and strokes was acknowledged and therefore the Panel was mindful to give careful consideration to the parameters of the proposed scrutiny investigation of Stroke Services.

29. It was confirmed that Thrombolysis treatment was a drug which had to be administered in hospital after a patient had had a brain scan.

30. The Panel was keen to seek how JCUH compared with others in the North East region in terms of its stroke services. Mr Moore reported that from his perspective JCUH was one of the best in the region but indicated that other areas had dedicated preventative services and some had better rehabilitation facilities. It was noted, however, that the Multi Agency Rehabilitation Review would help to address such issues.

31. Specific reference was made to the current public campaign FAST (facial, arm, speech, time) to raise awareness that a stroke was a medical emergency and needed prompt action and early treatment. It was considered that the response to such a campaign had been good and had resulted in an increased number of people going to hospital and receiving Thrombolysis treatment.

A visit to James cook university hospital

32. Before the Panel engaged in detailed conversations with local health and social care professionals, The Chair and Vice Chair (with a support officer) attended a visit at the Stroke Unit at James Cook University Hospital. The

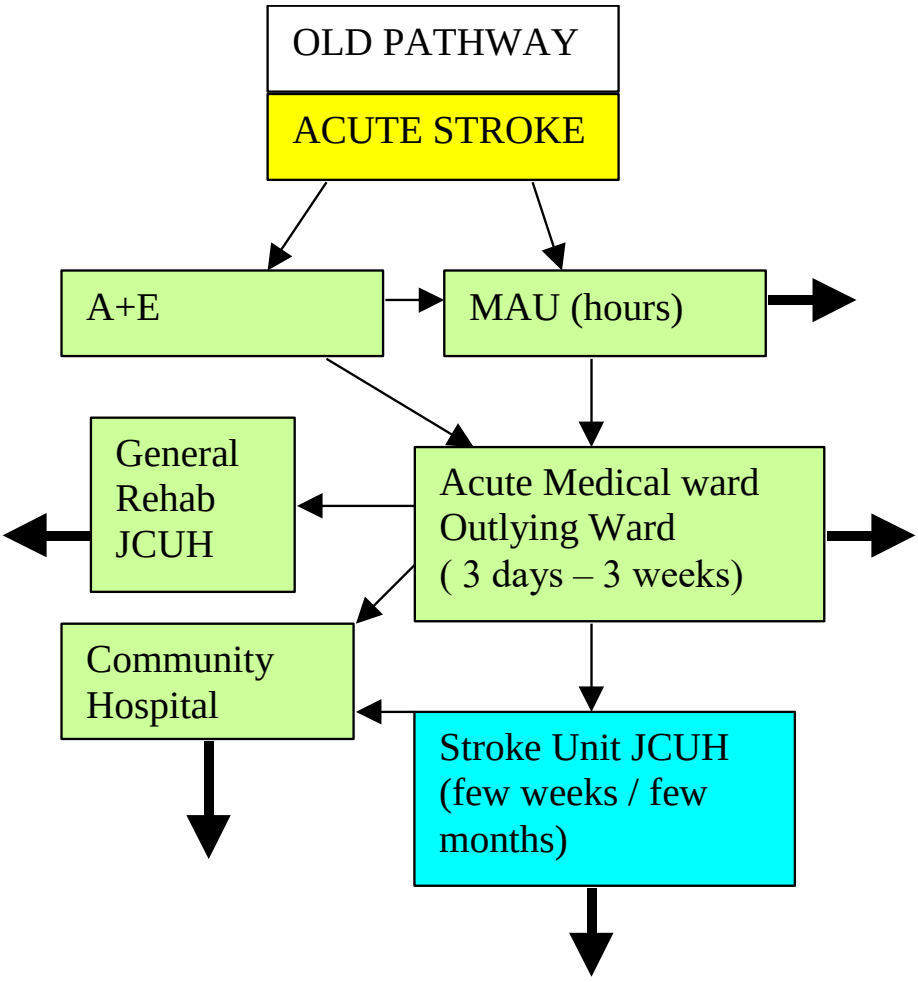
purpose of the visit was for Members to familiarise themselves with the hospital based services for Stroke.

33. Before having a guided tour of Stroke facilities at JCUH, the Chair & Vice Chair of the Panel received a briefing from clinical and non-clinical staff, responsible for the treatment of Stroke and the management of the Stroke Unit.

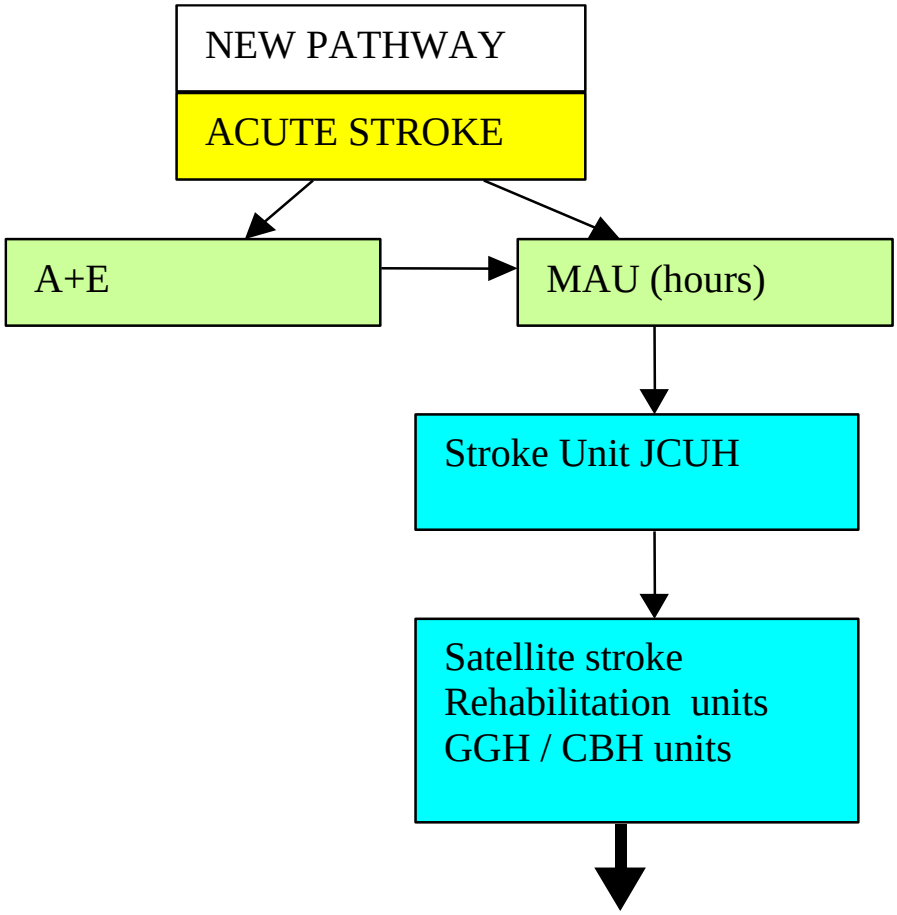
34. Members were given some initial background as to the origins of Stroke Services across the South of Tees area. It was said that prior to 1994, Stroke patients' were managed on a general medical ward and there was no specialist Stroke Unit. In 1994, a 20 bed Stroke rehabilitation ward opened at South Cleveland Hospital, which is now JCUH.

35. By 2002, the reorganisation of hospital services in Middlesbrough was complete and all acute services were concentrated onto a single site, which is now JCUH. Members were also advised that there are also 4 community hospitals across South of Tees with elderly and GP beds.

36. Outlined overleaf is the former 'Patient Pathway' for Stroke patients, which was taken out of operation in 2004 and the new pathway which replaced it.



New Pathway Model

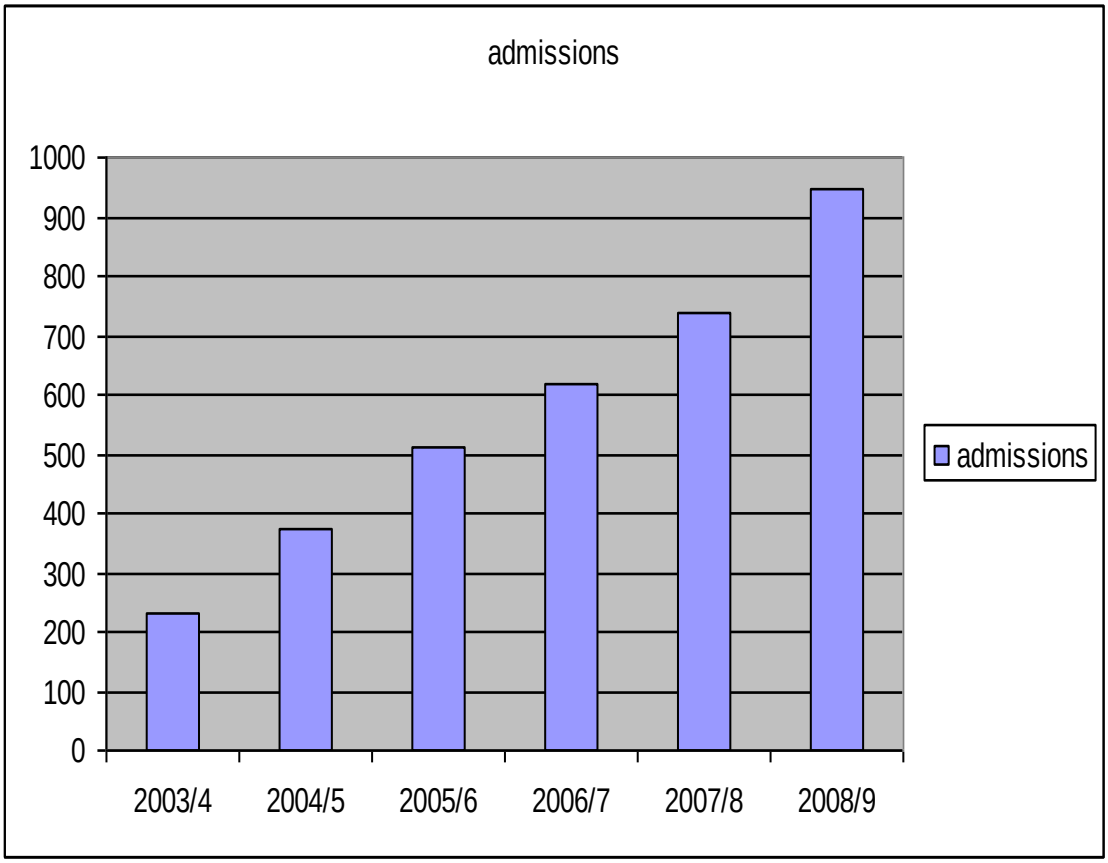

NEW PATHWAY
ACUTE STROKE
A+E
MAU (hours)
Stroke Unit JCUH
Satellite stroke
Rehabilitation units
GGH / CBH units

37. Members were advised that the National Service Framework (NSF) for Stroke had been a significant catalyst for change in addressing Stroke Services and three major pieces of work informed the development of the service. Those were a major Stroke Stakeholder event, an audit of rehabilitation services for older people and the results of the National Sentinel Stroke Audit.

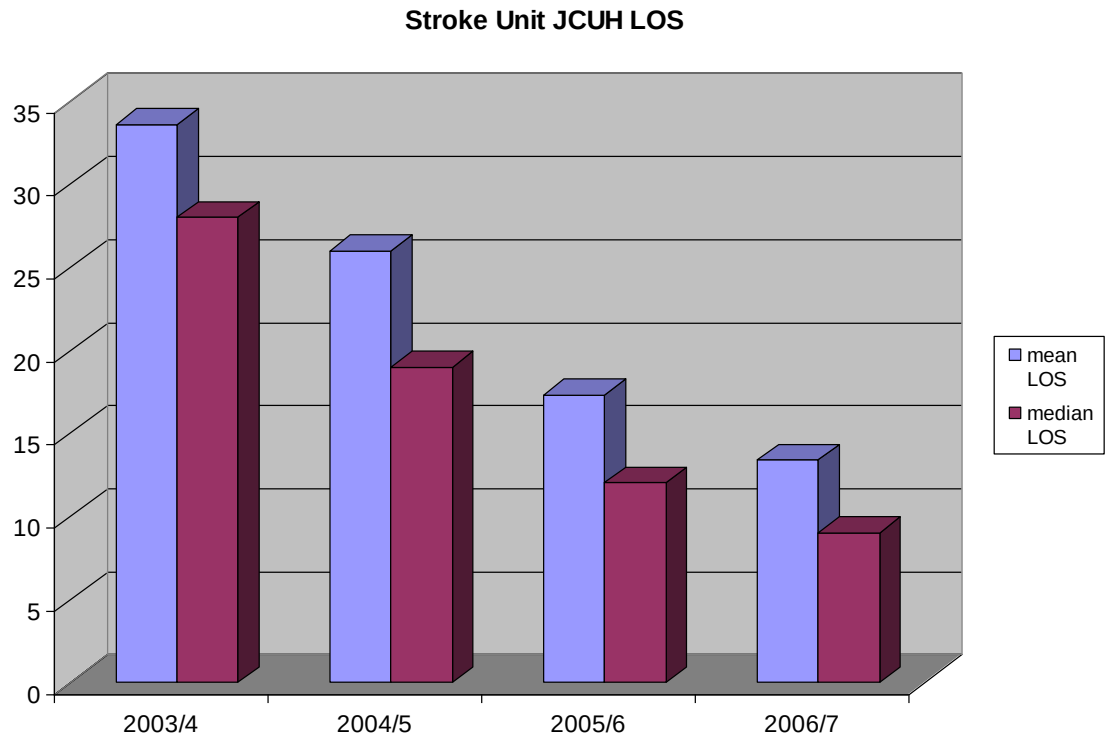
38. Members heard that fundamental aim behind the changes to the Stroke Pathway, was to ensure an increase in the number of suspected Stroke patients accessing specialist stroke services. It was said that this done by changing the role of the Stroke Unit to acute/early rehabilitation. Further, developing stroke rehabilitation services has been identified as a priority. There has been an increase in therapy input into Carter Bequest Hospital and the use of up to 10 beds for stroke rehabilitation.

39. A number of other positive developments were mentioned including the development of a user and carer group, the appointment of a Stroke co-ordinator, a family support worker and daily TIA clinics. The unit also has consistently good performance in the National Sentinel Stroke Audit, whilst offering Thrombolysis (first patient treated July 2007). It also provides a '24/7' Thrombolysis service, which is one of only 37 units out of 210 nation-wide to offer this.

40. The following graph offers some information on the number of admissions to the Stroke Unit. It should be noted that not all admissions actually have a Stroke has some conditions can mimic the symptoms of a Stroke.



41. The following graph indicates that Stroke Unit's Length of Stay (LOS) and demonstrates the increasingly efficiency of the department. The reducing length of stay also highlights the effectiveness of early and assertive treatment such as Thrombolysis. Reducing LOS also highlights the importance of effective and efficient community rehabilitation services, if more of a patient's rehabilitation will take place in the community.



42. The following graph also highlights the improved percentage of patients reaching the Stroke Unit and the substantially increased percentage of patients receiving most of their care on the Stroke Unit and the reduced the delays in transfer.

	Admitted to stroke unit	**> 50% stay on SU**
2002	**50%**	**42%**
2004	**63%**	**60%**
2006	**89%**	**85%**
		>90% stay on SU
2009	**95% *(74% Nat)***	**85% *(58%Nat)***

43. Members were keen to speak to professionals at JCUH regarding the challenges that Stroke still posed and where matters could be improved further. It was said that there are a number of areas which could be improved.

44. Awareness of people to the dangers and symptoms of Stroke remains an area of concern. Only 8.3% of Stroke patients at JCUH receive thrombolysis, which is only useful for Stroke if it is administered in the first three hours after a Stroke. Whilst it is true that thrombolysis only works on certain sorts of Strokes, the Panel heard that another reason for such a low rate of thrombolysis was to do with a lack of awareness in people about Stroke and the lack of speed with which people access specialist assistance.

45. The Panel was interested to hear that for patients from areas of affluence, such as parts of North Yorkshire, the rate of thrombolysis was over 10%, whereas in areas of higher deprivation the rate could be as low as 3 or 4%. This, it was said, is largely attributable to people from the more affluent areas having more awareness of Stroke symptoms and the appropriate course of action when a Stroke is suspected.

46. It was said that not enough people were treating Strokes (or suspected Strokes) as a medical emergency and approaching their GP for advice, when a major factor in dealing with a Stroke is accessing appropriate specialist care as soon as possible. It was therefore emphasised to Members that awareness of Stroke in the public consciousness is probably not where it needs to be and requires a great deal more work.

47. Members also heard the views expressed that people in Middlesbrough are quite well served for Stroke services in an emergency sense. It was said, however, that there are a number of deficiencies in how the local health and social care economy deals with the rehabilitation of people with Strokes, particularly around speech therapy, physiotherapy and Occupational Therapy.

48. Whilst there are facilities in Carter Bequest, it was said that community services to help people after having a Stroke.

49. The Chair & Vice Chair were keen to ask professionals about the sorts of things that were considered to be ‘goals’ for Stroke Services in the future. It was said that a major goal of all involved in the treatment of Strokes should be to increase the awareness of Strokes, the symptoms and the urgency of accessing treatment when a Stroke or TIA has taken place. It was said that a fully functioning and sufficiently resourced hyperacute stroke unit would only really deliver on its potential, if there was a greater awareness of Stroke and those requiring the facilities used them.

50. Members heard that another issue is that not all people entering JCUH with suspected Stroke presently are seen by a Stroke specialist, which is a result of not having a full rota and it was said that this needs to change. Members heard that greater investment would be necessary for this, which would require a business case to be submitted to the PCT, although it could also be argued that extra clinical posts should be funded under the existing tariff.

51. The view was put forward that a specialised Stroke Unit would be advantageous at JCUH, in a similar vein to a Cardiac centre. A principal

feature of Cardiac Units centre of the fact that those entering the hospital via an ambulance with a suspected heart attack would go straight to a cardiac unit, rather than being triaged in Accident & Emergency. A Stroke patient currently goes to Accident & Emergency for triage before arriving at Stroke Unit for appropriate treatment.

52. Members heard that in the view of clinical staff at JCUH, a Stroke Unit would be able to provide a lot of support services to patients, carers and families in addition to the clinical services that would be expected. The Panel has learned that the topic of specialised Stroke Units, where patients would circumvent traditional Accident & Emergency are the subject of some debate and disagreement within those dealing with Strokes, as the Panel explores later in the report.

53. It was emphasised again that Stroke awareness in Middlesbrough is poor and that a lot of people, including some General Practitioners, do not seem to appreciate that Stroke is a medical emergency. It was said that too few people in Middlesbrough present with a Stroke and too many people seemingly dismiss them as 'funny turns', especially when it comes to TIAs. It was stated that a major goal of the service would be to ensure that all high risk suspected TIAs receive an assessment within 24 hours.

54. Members were particularly interested in the BME community and their ability to access Stroke Services, given the BME communities' particular risk factors around such conditions as Diabetes and Hypertension[1].

55. Members heard that, in the view of clinicians, the BME population was significantly under represented in the cases that the unit dealt with, even when it is considered that the BME makes up around 7.5% of the 138,400 population[2], which equates to around 10,300 people. This is an area of concern to Members. It would appear that a significant amount of the population, which has an added susceptibility to Strokes, do not seem to be presenting at the Stroke Unit and accessing the services they require. As such, the Panel can only guess that Strokes are going undiagnosed and

[1] It has been well documented that people from the BME communities have a high representation of health conditions such as diabetes and hypertension as compared to their white counterparts. This means that they run a higher risk of suffering from stroke (e.g. south Asians in UK face higher risks of stroke according to Dr. Pankaj Sharma; General practitioner and 'Hypertension: Diagnosis and Management in Ethnic Minorities, Dr.Neil Chapman, and Geriatric Medicine). Another issue that faces BME communities is that stroke occurs at lower age groups (Stroke Association fact sheets '**Stroke in African-Caribbeans**'). Stroke is the third most common cause of death and the largest cause of disability in the UK It is therefore imperative that these facts be brought to the attention of BME communities so that they can be well informed and to take appropriate measures to prevent it from happening and to access the available services once stroke has happened.
Please see
http://afiyatrust.org.uk/index.php?option=com_content&task=view&id=224&Itemid=56

[2] Figure obtained from the Middlesbrough Local Area Agreement 2008-11, 2009 Refresh.

people are enduring worse health outcomes than necessary. This is a topic that the Panel expressed an interest in exploring further.

56. Following initial briefings and the visit to JCUH, the panel was keen to hear about regional expectations and standards pertaining to Stroke Services. The panel heard from the regional co-ordinator of the North East Cardiovascular Network (NECVN).

57. The panel heard that the NECVN is not a statutory organisation and therefore is not required to deal with performance management type information or deal with financial commitments. The improvement and development of Stroke Services has been devolved from NHS North East (SHA) to the NECVN. The Panel noted that the performance management of stroke services remains the responsibility on NHS North East. As a network, it is most interested in the quality of services that are provided and the outcomes for patients. It was confirmed that the NECVN has a mandate to work across all relevant services.

58. In advance of the meeting, the Panel supplied a number of questions to the NECVN to consider and they were addressed in a paper submitted to the Panel.

59. The first area that the Panel asked about was the service standards currently demanded of Stroke Services that a patient could expect to receive when they suffer a suspected Stroke. The Panel heard that there are national 'must do' targets in place fro Stroke which are considered as Tier 1 under the *Vital Signs* targets. They are:

59.1 Patients who spend at least 90% of their time on a Stroke Unit

59.2 TIA cases with a higher risk of stroke who are treated within 24 hours

59.3 The panel heard that these indicators are considered to be a good proxy for reducing disability and death due to stroke

60. The Panel heard that when the above targets were first established in 2004, it was considered that 56% of people with a strike spent the majority of their time in a stroke unit and 35% of people with a risk of TIA are treated in 7 days. The panel heard that the expected position by the end of 2010/11 is to ensure that 80% of people with stroke spend at least 90% of their time on a stroke unit and 60% of higher risk TIA cases are treated within 24 hours.

61. The panel was told that other standards are also in existence such as the national clinical guidelines for Stroke which are produced by the Royal College of Physicians, in existence since 2000 and updated in 2008. The Royal College of Physicians is also responsible for the process to support the national sentinel audit for Stroke. The Panel heard that this audit has been active for the last six years and has demonstrated that care has improved significantly over this period of time.

62. Whilst this was to be welcomed, the Panel heard that there is no room for complacency. Further, the Panel heard that Stroke data has historically been collected using different methodologies and at times not necessarily recorded properly, which is now being corrected, although some historical data is open to question.

63. The Panel heard that the region's stroke services are providing excellent care which is often down to the commitment and quality of staff within hospitals and their different services. The Panel heard that historically, Acute Trusts have not been particularly good at 'looking around' at what other Trusts do and they have concentrated on themselves, which is a mindset which needs to be challenged.

64. The Panel heard that following the publication of the *National Stroke Strategy* in December 2007 the NECVN is planning to improve stroke services even further to provide up to date, best evidence based practice to all patients and their carers in the North East. This strategy is a 10 year plan however the Network plan (covered by NHS North East and the North Yorkshire and York PCT area of NHS West Yorkshire) is to implement the biggest changes within the first 3 years.

65. The Panel heard that two network standards are subject of a great deal of attention presently around the network. They are the network standards for hyperacute[3] services and TIA care. It was said that network standards around such areas would assist in driving up standards and also help in ensuring equity of care across the area. It was confirmed that the NECVN would be most interested in focusing attention on quality of care issues as opposed to sticking stringently to services 'hitting targets'.

66. The importance of hyper acute services following a stroke was discussed, including the importance of stroke specialist staff seeing stroke patients. Not for the first time, it was emphasised to the Panel that having this specialist advice available when it is needed most has a huge impact on the outcome for a patient from whether or not they survive the stroke up to and including the sort of recovery they can expect to have and the level of disability they may be left with.

67. It was emphasised that the town of Middlesbrough is fortunate to have JCUH on its doorstep, where a '24:7' specialist Stroke service is available, which includes thrombolysis. It was emphasised to the panel that thrombolysis is crucial to counter the early impact of a Stroke as without it parts of the brain can die and be put beyond use. The panel heard that the patient has to receive it within three hours of having a Stroke and the fact that it is available '24:7' in Middlesbrough is very positive for local people. It was said to the panel that a number of other hospitals in the north east only offer it within the hours of nine to five.

[3] By way of definition, it was explained to the Panel that 'hyperacute' refers to the 72 hours immediately after a Stroke.

68. The Panel was keen to hear the views of the NECVN about whether suspected Stroke patients should go into a specialised Stroke assessment unit, or continue to use Accident & Emergency as their 'first port of call'. The panel had previously heard from staff at JCUH that a Stroke assessment centre should be patients' first port of call, similar to what happens with a suspected heart attack patient, who would go straight to a Cardiac Assessment Unit.

69. The Panel heard that a suspected stroke patient should be taken to A&E initially, in the view of NECVN. The reason for this is that suspected Stroke patients require a CT scan, which are only available in hospitals due to the size of the equipment required. This represents a critical difference between heart attack patients, when an ECG can be performed in an ambulance, so the paramedics are in possession of much more information about a patient when it is a suspected heart attack, rather than a Stroke. The Panel heard, therefore, that from a triage point of view that A&E is better and possible stroke patients going to a stroke unit when they may not have a stroke. As such, the Panel noted that there is something of a disagreement between the Stroke Services staff at JCUH and the NECVN about the possibility/merit of a specialist Stroke assessment unit.

70. The Panel was keen to hear the views of the NECVN representative on the challenges facing Stroke services.

Awareness

71. Consistent with the message that the Chair & Vice Chair heard at JCUH, the NECVN told the Panel that Stroke awareness in Middlesbrough was not particularly good and something in great need of improvement.

72. Again, the Panel heard that the NECVN has particular concerns over the level of Stroke awareness amongst the BME community, who are under represented in the groups accessing services, but also at higher risk of having a Stroke due to reasons outlined on page 11.

73. The Panel was also told that another group to improve awareness about was General Practitioners (GPs). The Panel heard that according to best estimates, around 50% of Stroke patients make the first call to the GP for assistance, rather than contacting emergency medical services. As such, the Panel heard it was crucial that those working in General Practice increased their awareness of Stroke, its symptoms and particularly what to do if someone contacts General practice with such symptoms. Overall, it was considered absolutely crucial that the message be emphasised to General Practice that Stroke is a medical emergency.

74. The Panel noted that a tendency to contact General Practice when feeling ill (though a Stroke) was at odds with an increasing tendency for people to present at A&E with (by comparison) fairly minor complaints. It was therefore ironic that in such a medical emergency as Stroke, a substantial number of

people do not utilise the emergency facilities available. It was suggested that perhaps people are not so certain to contact emergency services, as a Stroke does not necessarily cause pain, only something which is often described as a 'funny turn'. Nonetheless, it was described as completely essential that the message be better communicated that people should seek emergency care when a Stroke is suspected.

75. In connection with people seeking emergency services when suffering from a Stroke, mention was made of TIAs. It was said that people having or who have had a TIA should not be admitted into a Stroke unit, although they should certainly have an outpatient appointment. People having undergone a TIA are at greater risk of having a Stroke and should be monitored accordingly.

76. The Panel was interested to hear the views of the NECVN about the BME community and Stroke Services, especially in light of what Members had heard from staff at JCUH.

77. It was confirmed to the Panel that the BME is indeed a high risk group for Strokes, yet is grossly under represented in Stroke Units' case mix. The Panel heard that a big factor in this is a significant lack of awareness in those communities. The Panel was interested to hear about a pilot project in South Tyneside which was conducting a social marketing exercise, to ascertain how best to engage with the BME community on such matters. The Panel will receive copies of that report when completed. It was felt that local authorities could assist the local NHS greatly in engaging with such communities, given their experience in such matters.

78. The Panel was interested to hear about the NECVN and partners would like to see Stroke Services in the next three to five years. The Panel heard that The National Stroke Strategy is a 10-year plan to improve stroke services. There will be an intensive push to improve services as much as possible until March 2011. £2.4 million has been ear marked for NHS North East to improve stroke services. Additionally Local Authorities have received central allocations to improve stroke services from a social care perspective.

79. It was said that the following list is an example of the NECVN's priorities to have implemented by March 2011.

80. By using these finances and re-evaluating the use of our current finances NECVN anticipates the following improvements by March 2011 -

80.1 Improved awareness raising of stroke and TIA leading to rapid assessment, diagnosis and treatment.

80.2 Improved rate of thrombolysis for eligible patients.

80.3 Robust 24/7 hyperacute services and rapid admission to a dedicated stroke unit.

80.4 Improved referral of suspected TIA patients to stroke specialists

80.5 Improved access to imaging services

80.6 Reduced waiting times for vascular surgery.

80.7 Timely assessment of stroke and TIA patients for rehabilitation needs

80.8 Access for all stroke and TIA patients to all aspects of rehabilitation they require, as and when they require it.

80.9 Improved integrated links between health and social care services

80.10 Better signposting of stroke and TIA patients and their carer needs for long term care and support

81. The Panel was interested to hear the NECVN's views about which aspects of Stroke Services were in need of development.

82. The Panel was told, which concurred with other evidence received, that Middlesbrough was quite well provided for in a hospital based care sense, with a '24:7' Thrombolysis service at JCUH. It was said that improvements were required in community rehabilitation, with specific emphasis on specialist therapeutic input such as speech therapy and psychological support.

83. It was mentioned that a significant number of working age people have strokes every year and many of those people will have financial commitments such as mortgages or young families which necessitate a return to some sort of paid employment. It was felt that an improvement in the services to assist people in doing this was very much needed, with some degree of urgency. This would include services like Physiotherapy and Occupational Therapy. The Panel heard that one could not underestimate the importance of psychological therapies in helping people to come to terms with having a Stroke. It was said that people can offer suffer a sense of bereavement, loss or anger over their 'losing' of their previous life, as they may lose some ability to perform certain types of paid employment or pursue certain interests that they could, before the Stroke.

84. It was also said that it should be easier for people to access such services sometime after having had a stroke. The panel heard that many people are not necessarily ready to access such services immediately after a stroke and would prefer to take stock for some time. It was said that unless you take such services upon discharge, there is a perception that it is very difficult to re-enter the system to access those services in, say, six months or a year.

85. The Panel heard that joint commissioning was an area whereby a lot of these improvements could be made and the local health and social care economy's attentions should be focused on joint gap analysis work and then joint commissioning with the benefit of the intelligence gathered about gaps or weak points in services.

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