

LEEDS STROKE REVIEW



Edition 18 - July 2003 Welcome to the latest edition of "Leeds Stroke Review"

This edition features an article on "A Review of the Stroke and TIA Risk Factor Clinic" by Sally Blundell - Stroke Specialist Nurse, SJUH . "Recent developments at Chapel Allerton Hospital and Randomised control trial evaluation of structured routine follow-up after disabling stroke" by Jo Wood, Stroke Unit Manager, ward 10, Chapel Allerton Hospital. and an article on "Improving Stroke Services in Leeds" by Debbie Neal - Stroke care pathways project manager.

If you would like to submit an article for the next edition of the Leeds Stroke Review please contact Olasupo Ogunyinka at the address below.

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Sally Blundell

A Review of the Stroke and TIA Risk Factor Clinic

This article is an update on the Stroke and TIA Risk Factor Clinic following an article in the Leeds Stroke Database Newsletter, January 2000.

The Risk Factor Clinic continues and has become an established part of the follow up for stroke and TIA patients within neurology.

The stroke specialist nurse role within the clinic can be summarised as follows: -

- Explanation of how a stroke occurs
- Identify patient's risk factors
- Provide information and advice on modifying risk factors
- Psychological support and identification of psychological problems
- Point of contact (telephone no. provided)
- Communication with GP

Other common issues that can be discussed within the clinic are:

- Driving
- Travel
- Sex

- HRT
- Work related problems

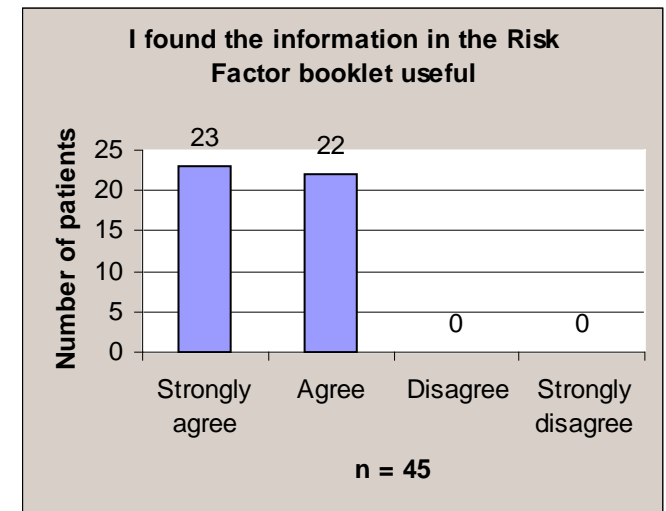
Developments that have occurred within the clinic are the use of a patient held risk factor booklet which provides information on the patient's risk factors and space for the ongoing monitoring of these risk factors by the primary care team.

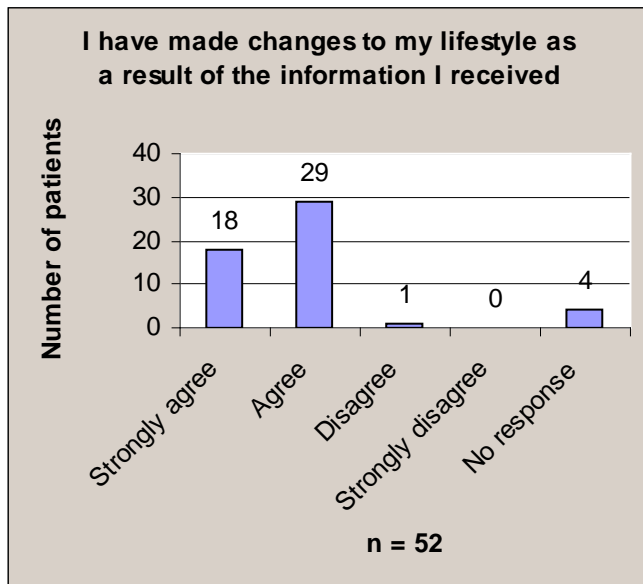
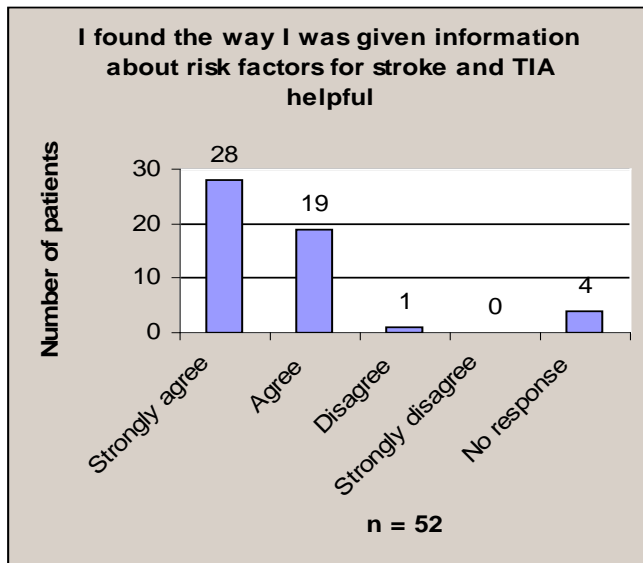
Clinic and Booklet Evaluation

Both the clinic and the booklet were evaluated in 2002. The evaluation comprised a postal questionnaire sent to 100 consecutive patients who had attended the clinic between 2/5/02 and 19/10/02.

The following tables are some of the results (a completed version is available on request).

TABLES





The results demonstrate that there appears to be a high level of satisfaction with both the booklet and the clinic.

Other Developments

Another development within the clinic is the pro forma – a self carbonated form, which details the patient’s risk factors and advice given. It also contains information on results of investigations, details of follow up and recommendations to the GP (following discussions with the consultant). The form is useful as it provides ‘at-a-glance’ information on the patient in a concise way and as the form is hand-written it is an immediate communication with the PCT.

Further Developments

Further evaluation of the clinic will take place and discussions are due to take place with practice nurse facilitators and practice nurse locality leads in order to explore the use of the risk factor booklet within Primary Care.

Sally Blundell
Stroke Specialist Nurse, SJUH



RECENT DEVELOPMENTS AT CHAPEL ALLERTON HOSPITAL

An idea developed at Leeds Neurological rehabilitation event in November 2002 to establish a Leeds Service User Group network. **Erica Thomas** (Voluntary action for Leeds) and **Jo Wood** (Stroke Unit Manager –Chapel Allerton Hospital) are currently developing this group and although it is in its infancy, feedback from its members is encouraging.

The group includes representatives from the stroke Association, M.S. Society, Carers Association, Wheelchair users, Nursing homes and ethnic minorities.



JO WOOD

It is also open to individual service users, some of whom have rare conditions and therefore no group to belong to. The purpose of this group is to guide service providers and the modernisation team within the Acute Hospital Trust and give direction to the community Rehabilitation and Reintegration Service Programme Board.

Our initial meetings are to identify current services which appear patchy, age and location related, to utilise voluntary and community sectors to work with the professional staff with education and information and, to enlist key players within service provision and enrich their views.

The direction and achievements of this group will be published as developed.

**RANDOMISED CONTROLLED TRIAL
 EVALUATION OF STRUCTURED ROUTINE
 FOLLOW-UP AFTER DISABLING STROKE**

The National Service Framework for Older People recommends that disabled patients be re-assessed at six months post-stroke. This routine follow-up process has the potential to address some of the longer-term problems that are frequently reported by stroke patients and their families. However, new research is required to define the content and effectiveness of this process. Over the last two and a half years, the Bradford Elderly Care and Rehabilitation Research Department based at St Lukes Hospital, have been developing a new highly focused “toolkit” which could be used for the stroke review process. This work was supported by funds from The Stroke Association. The toolkit highlights areas such as information provision, medications, pain, mobility and falls, transport, continence, sexual relations, shopping/meal preparation and housing. We are now at a point of performing the randomised controlled trial on the follow-up received post-stroke. Over the next 18 months patients and carers will be recruited, stratified and randomised to intervention or control groups and the “toolkit” will be used to structure the follow up appointment for the intervention group at Leeds and Bradford. Stroke care co-ordinators will perform the follow up reviews ,across the 2 cities. In Bradford any issues/advice will be discussed by a multi-disciplinary Primary Care Team, Leeds networks are slightly different and any information on local Primary Care Team based schemes that have initiatives that stroke patients can be referred to would be gratefully received. This opens up opportunities for greater cross discipline, cross care provider services.

For further details please contact Jo Wood, Stroke unit manager, Stroke Unit, Ward 10, Chapel Allerton Hospital, Leeds LS7.

Jo Wood
Stroke Unit Manager – Chapel Allerton Hospital

IMPROVING STROKE SERVICES IN LEEDS

Improving Stroke Services in Leeds

Over the last year, a detailed picture of existing stroke services in Leeds and opinions of them has been produced through consultation with service providers plus interviews of over 120 service users including carers and stroke survivors from first day post-stroke to more than 5 years after.

Agreement to a city-wide, whole systems redesign of stroke services was reached and signed up to by chief executives at Leeds Teaching Hospitals Trust and the 5 Leeds Primary Care Trusts plus the Director of Social Services.

Following this agreement, a Stroke Services Redesign Workshop was held on 30th January to bring together 130 key stakeholders in stroke, including services users and those from health, social services, housing, the voluntary sector and other community and hospital based services.

Outcomes from this event include:

- Completion of the process map of stroke services in Leeds
- Identifying some of the helps and hindrances to an effective stroke service at present.

- Using patient pathways and experiences to produce a list of suggestions for change
- Prioritising those suggestions for change
- Publicising the new structure for the implementation of the National Service Framework for older people – standard 5 – stroke.
- A list of volunteers willing to be involved in the redesign working groups that will implement change to stroke services.

A list of volunteers willing to act as critical friends to the programme.

- A users and carers group who will be consulted about planned service changes has been set up through Erica Thomas at Voluntary Action Leeds.
- An action plan for change to stroke services has been developed based on those suggestions generated at the Stroke Services Redesign Workshop that scored highly on both impact on the service and ease of accomplishment.

Structure

There are now a number of structures in place to support the redesign of stroke services in Leeds and to ensure changes in stroke services fit with changes planned by other services.

- The Stroke Programme Board is overseeing the Stroke Services Redesign Programme.
- The Stroke Programme Board links with the Older Peoples Modernisation Team and also

with the Modernisation Team – Disability and reports to the Reforming Emergency Care Network.

- All work to modernise services in Leeds is responsible to the Modernisation Executive. How will change happen?

Change will be by a process of ‘PDSA’ cycles:

Plan

Do

Study

Act

This is a well-recognised and tested method of changing things little by little in bite – size chunks, with an overall aim in mind. This allows the spread of good practice and the chance to try out new ideas in a small way before implementing them across the city.

Currently active PDSA change cycles

- Planning a new model for community based rehabilitation for late stage stroke
- Developing stroke care co-ordinator / key-worker role.
- Evaluating stroke care co-ordinator / key-worker role.
- Planning effective pathway from presentation to admission
- Plan a model for effective use of speech and language therapy input into swallow assessment.

- Developing a model for citywide rollout of use of patient held secondary prevention booklets.

Contact details for all these PDSA cycles are given overleaf.

Communications

The Stroke Services Redesign Programme is trying hard to make sure everyone involved is kept informed of developments by using a combination of:

- newsletters such as this one,
- putting articles into existing newsletters such as those produced by PCTs
- E-bulletins and websites.

The following information is now available on: www.leedsstrokedatabase.net or follow the link from the modernisation button on <http://www.lhp.leedsth.nhs.uk/>

- The communication strategy for the Stroke programme.
- The full report from the Stroke Services Redesign day
- Currently active PDSA change cycles.
- Terms of reference, membership and minutes for the Stroke programme board.
- Terms of reference, membership and minutes for the Stroke Programme working group.

Further progress on the Stroke Services Redesign programme will be posted on this web-site.

How can you get involved?

Contact details for currently active PDSA cycles are shown below. If you feel you have something to offer these groups, please contact the lead person.

Jane Savage - Planning a new model for community based rehabilitation for late stage stroke. Tel. 0113 3055083, 3055014.

Debbie Neal - Developing stroke care co-ordinator / key-worker role. Evaluating stroke care co-ordinator / key-worker role. Tel. 0113 3059449 07940 437 477.

Trudie Davies - Planning effective pathway from presentation to admission. Tel. 0113 2062016 07939451074.

Felicity Hudson & Trudie Davies – Plan a model for effective use of speech and language therapy input into swallow assessment. Tel. 0113 3923969 0113 2062016, 07939451074.

Sally Blundell - Developing a model for city-wide roll-out of use of patient held secondary prevention booklets.

If any of the following apply:

- You have a good idea about how to improve things for those with stroke that you would like to try out, but would like support.
- You would like to lead, or be involved in any future PDSA groups
- You are already doing something that is beneficial for those with stroke, which could be rolled out citywide.

Then please contact:

Debbie Neal, Stroke care pathways project manager: 0113 3059449, 07940 437 477.

debbie.neal@leedswest-pct.nhs.uk