



**Stroke Rehabilitation Services
Patient Experience Report.
Seizing the Future Reconfiguration
Phase Two**

October 2010

1.0 Purpose

The purpose of this report, is to provide partners with the outcome of patient and carer experiences of stroke rehabilitation services at County Durham and Darlington NHS Foundation Trust (CDDFT) post Seizing the Future (StF) reconfiguration. It will summarise emerging trends from patient and carer feedback of stroke services since October 2009.

A further comparative report will compare the outcomes of phase one (pre StF) and phase two (post StF) evaluations, providing stakeholders with feedback to identify recommendations for future practice.

2.0 Background

2.1 Seizing the Future hospital service changes

County Durham and Darlington NHS Foundation Trust's Seizing the Future project proposed significant changes to the way local hospital services in County Durham and Darlington are configured. Following the approval of the proposals by NHS County Durham in March, 2009, the service changes were implemented with effect from 1 October, 2009. The changes involved consolidating acute care at Darlington Memorial Hospital (DMH) and the University Hospital of North Durham (UHND) with planned care and rehabilitation being provided from Bishop Auckland General Hospital (BAGH). Patients have access to specialist rehabilitation to improve recovery.

Prior to the 1 October 2009, patients experiencing a stroke were primarily treated at Bishop Auckland Hospital and the University Hospital of North Durham, both of which had designated stroke units. A limited number of stroke patients received acute care at Darlington Memorial Hospital, although most were transferred to Bishop Auckland Hospital at the earliest possible opportunity. As of 1 October, 2009, all patients experiencing a stroke have been treated at the University Hospital of Durham or Darlington Memorial Hospital when they are at their most seriously ill and are then transferred to Bishop Auckland General Hospital for rehabilitation care when they are fit to do so.

2.2 Policy drivers

Both legislation and Department of Health policy reinforces the need for patients, carers and the public to be actively involved in the planning, development and review of local health services. Section 242(1b) of the NHS Act 2006 and the Local Government and Public Involvement in Health Act 2007, highlight the need for service users' to be involved, particularly when the change to local health services is deemed to be significant. Other legal and policy requirements include:

- NHS Constitution
- NHS Operating Framework 2009/10
- World Class Commissioning
- Quality Accounts
- Care Quality Commission standards
- Equity & Excellence; Liberating the NHS. White Paper 2010

3.0 Objectives of patient experience evaluation.

The aims of the patient experience evaluation are to:

- Evaluate the impact of hospital-based stroke rehabilitation service on patients and carers post StF (phase 2).
- Identify areas of improvement as a result of StF reconfiguration.
- Identify potential areas of stroke rehabilitation services requiring further improvement.
- Liaise with all stakeholders to ensure action plans are developed and reviewed to improve or maintain current standards of care.
- A comparative report of phase 1 and phase two outcomes will follow, identifying the impact of StF on Stroke Rehabilitation Services.

4.0 Patient experience evaluation process

4.1 To summarise patient and carer experiences of stroke rehabilitation services, post - Seizing the Future.

4.1.1 Planning and organisations involved

A partnership approach was taken to planning and implementing the patient experience evaluation exercise. CDDFT led the exercise with significant input from The Stroke Association (SA). The SA, Family and Carer Support Service (FACSS) obtained patient and carer feedback in order to ensure objectivity and impartiality throughout.

Commissioners of stroke rehabilitation services were involved in agreeing the content and framework for the exercise. The following service commissioners and/or providers were also informed.

- Durham County Council's (DCC) stroke services co-ordinator
- NHS County Durham and Darlington's older people's services commissioner
- Clinical Director
- Physiotherapy service providers
- Speech and Language service providers

4.1.2 Patient eligibility criteria

Patients who received hospital-based stroke rehabilitation care between October 2009 and March 2010 were invited to participate in the exercise. Their carers were also invited to take part. Invitation letters were sent to 126 patients. This was the total number of patients who had received stroke rehabilitation across CDDFT within the period identified.

4.1.3 Format

Patients and carers were offered various methods of engagement in order to maximise participation. Individuals were invited to take part in one of the following:

- Focus group discussion in North of county
- Focus group discussion in South of county
- Discovery interview - home
- Discovery interview - telephone

4.1.4 Sample size and participation breakdown

Twenty six people took part in total, equating to between 4.3-5.2% of the annual CDDFT throughput of 500-600 surviving patients. This represents a 20.6% response rate to the initial invitations. Participation can be broken down as follows:

Participants

Patients	18
Carers	8

Place of care.

UHND	9
UHND/BAGH	2
DMH	4
DMH/BAGH	3

Method of choice

Focus groups	8
Discovery interview - home	18
Discovery interview - telephone	0

4.1.5 Timeframe

Date	Activity
May 2010	Independent sample received. (n =126)
May 2010	Invitation letters sent to potential participants
July 2010	- North & South Focus groups - home interviews
August 2010	Results of Focus Groups and Interviews received
October 2010	Report
October 2010	Feedback to stakeholders / participants.

4.2 Content of patient experience evaluation

The patient experience evaluation exercise obtained feedback of the patient journey from the point that individuals first experienced stroke symptoms, through to their discharge from hospital.

A thematic framework for both the focus groups and discovery interviews was agreed. This fragmented the stroke patient journey into key sections including:

- The first 24-hours (symptoms, seeking medical attention, tests and diagnosis)
- Roles of professionals (therapy, medical and nursing staff)
- Therapy input (physiotherapy, occupational therapy, speech & language, dietetics and others)
- Individuals involvement in own care (care plan, rehab goals)
- Leaving hospital (discharge process, follow up support)
- Information and communication (at all stages of patient and carer journey)

Standards contained within the National Stroke Strategy underpinned the framework and were used to tailor specific questions.

5.0 Findings

5.1 The First 24 hours

5.1.1 Symptoms:

Patients experienced typical stroke symptoms such as slurred speech, numbness on one side of the body, facial weakness, and dizziness.

*“a flash in the brain”,
“there were no thoughts in my head”.*

The female partners of two stroke victims connected the symptoms to a possible stroke as a direct result of the FAST television awareness campaign. Many participants recognised their experience as being symptomatic of a stroke due to a previous stroke or TIA.

One respondent thought it was a virus, another thought he was hypoglycaemic. One respondent did not recognise the symptoms at all.

5.1.2 Seeking medical attention:

Despite recognising symptoms of a stroke, the significance of immediate action was not taken by all participants. A small number of participants reported waiting to see if symptoms subsided prior to seeking medical help.

One participant did not want to contact any services because it was the weekend. Another recognised the symptoms but waited until the following day as they did not want to admit that it was a stroke. A further participant waited two days to see a doctor despite the fact that they could not walk.

The local GP was primarily the first point of contact for patients and carers in the North (54.5%) and South (42.8%) of the county.

28% of participants (n=2) accessing services at DMH dialled 999 and 9% from UHND (n=1)

One participant from UHND and one from DMH contacted the Telecare and Care Connect services. Both immediately called for an ambulance.

One patient contacted NHS Direct.

One participant from the UHND and one from DMH were taken by family to the Emergency Department. (ED)

All patients and carers who used North East Ambulance Services (NEAS) reported positive experiences of response times, manner and skills of paramedics;

*“superb, could not fault the service”
“knowledgeable about strokes”
“in good hands”.*

Mixed responses were received regarding wait times in ED at both UHND and DMH.

At UHND participants experienced varied wait times ranging from:

*“seen very quickly”
“not seen for 3-4 hours. Left on a trolley in the corridor”*

Similarly at DMH, participants were:

*“seen and transferred to the Stroke Unit very quickly” as well as
“very distressed due to a 2 hour wait”*

5.1.3 Suspected & confirmed diagnosis:

One patient from DMH was given a suspected diagnosis of stroke by a paramedic.

Others were given a diagnosis shortly after presenting at hospital, primarily in ED at UHND and equally in ED or upon admission to the Stroke Unit at DMH. Confirmed diagnosis was given to the majority of patients and carers within 24-hours of presentation at hospital. One patient was diagnosed after a CAT scan at four days.

Patients and carers reported mixed experiences about the timing, delivery and support given at the point of diagnosis. There was a general consensus that giving a suspected or confirmed diagnosis upon presentation at hospital was appropriate for carers and relatives. A number of patients however, felt that the diagnosis was too early as they did not fully comprehend the explanation due to the effects of stroke symptoms.

Some comments from participants at DMH included:

"I was given an initial diagnosis after one hour. This was confirmed after a further forty minutes. This was just right"

"I was told on the Stroke Unit. This was quickly enough. If told sooner there was the risk that it would be inaccurate as test results would not have been available any sooner"

Some comments from UHND include:

"I was told after 3-4 hours and it was confirmed the following day. Timing was late. I would have preferred it sooner"

"I was told the following day. The Dr. used a different word to stroke, so I didn't really understand and had to ask what this meant"

The provision of information at this stage is noted to be limited. Although it was acknowledged that staff on the Stroke Unit at DMH were knowledgeable about strokes, there was very little written information given to patients. Patients and carers also reported very little proactive information-sharing on the part of professionals.

Patients who asked questions however, were all satisfied with the information provided.

At UHND, verbal information was given by medical staff and noted to be of value to the patient. Limited literature was provided. One patient sought his own literature. One patient received information from the Stroke Association and received support from a Family & Carer Support Worker.

There was a significant lack of explanation provided about what to expect during the hospital stay. 64% of respondents at UHND and 71% from DMH, reported receiving no information at all. Comments varied, including:

"Nursing staff didn't explain things. I didn't see them much, only for medication being administered"

"Nurses carried out their observations, but gave no explanation why they were doing these tests / procedures"

"I was always aware of what was happening and why. It was all done very efficiently"

5.1.4 Tests, investigations and admission:

All participants at DMH recalled having a CAT scan. All but two participants from UHND recalled having a CAT scan. The timing ranged from 24 hours to 4 days. Three participants from DMH also received an MRI Scan. One patient recalled receiving no information from hospital staff about the CAT Scan procedure, but was comforted by support received from other patients who had already undergone the procedure.

All remaining patients reported being given explanations as to the reason for the scan. A minority of patients (28.5%) from DMH recalled being given a swallow test as opposed to 45% of patients from UHND.

5.2 Therapy

5.2.1 Physiotherapy:

55% of participants at UHND, had contact with a physiotherapist within 72 hours of admission. They were seen on average once or twice throughout their stay. Some participants from UHND raised concern at the 7.30 am start time for therapy. Flexible times however could be arranged with the physiotherapist.

Sessions lasted approx ½ hour to ¾ hour which was felt to be “just right”. Most participants had not been made aware of the benefits of the therapy at UHND . Such benefits were discussed with those receiving therapy at BAGH.

57% of participants at DMH had contact with a physiotherapist. One recalled receiving therapy seven days per week when they were transferred to BAGH. Sessions lasted approx half an hour, which was felt to be about right.

5.2.2 Occupational therapy:

45% of patients at UHND received some occupational therapy, usually within 36 hours of admission. The therapy lasted approx 20 minutes. One patient received treatment on the day of discharge.

At DMH, 57% of participants received a varied amount of occupational therapy. This ranged from within 36 hours, to a visit prior to discharge. One participant received therapy after transferring to BAGH after 16 days. This consisted of two half our sessions per day. Initially this was felt to be too much “tortuous”. But as improvements were noted, it was felt to be “very good”.

5.2.3 Speech and Language Therapy:

One participant (9%) at UHND reported receiving speech and language therapy during their hospital stay. This included a twenty minute assessment followed by literature sent to the patient after discharge. Two participants reported having a speech impairment but were not seen by a speech and language therapist.

At DMH 43% of participants saw a speech and language therapist. One was seen on two occasions. A further was provided with exercises to practice. Two participants who did not receive speech and language therapy had speech difficulties and felt they should have received therapy.

5.2.4 Dietetics:

There were no participants who were aware of receiving dietetics input as part of their rehabilitation from UHND, DMH or BAGH.

5.2.5 Consultant

Contact with a Consultant varied throughout UHND, from one visit at admission, to a visit most days. Participants who were transferred to BAGH recalled been seen by the Consultant every day.

At DMH contact with a Consultant was more regular, with most recalling seeing a consultant “*most days*”.

5.2.6 Emotional support/mental health:

The level of emotional support varied at UHND.

“I broke down and felt comfortable talking to staff about it.”

“The staff nurse was very nice and stayed with me when I was upset.”

Other participants at UHND, felt that their emotional issues were not adequately addressed, stating that nursing staff were seen to lack understanding. One participant recalled having to move to another bed. The manner of the nurse, with this task, proved to be very upsetting. Another felt like *“excess baggage on the ward”*

At DMH, participants responses varied to the amount of emotional support offered. One respondent felt anxiety was a big problem and there was no support offered from the nurses. Support was available from the Stroke Association. In contrast, a further respondent felt that the amount of support received for emotional problems from the hospital staff was beneficial and helped them feel better.

5.2.7. Information / support regarding benefits of therapy.

27% of participants who attended UHND felt they had not received information regarding the benefits of their various therapies. 18% were unsure if they had received such information and 9% did not receive therapy.

At DMH, 29% of respondents felt they had had the benefits of therapy explained to them. 43% did not receive therapy and two participants could not recall receiving the benefits of therapies. All participants who attended BAGH received information of the benefits of therapies.

Encouragement from the nursing staff to practice skills directed by the therapists was felt to be either lacking or inconsistent at UHND. Comments were raised regarding the lack of support to carry out basic tasks.

“I was left to struggle with my food. I couldn’t open the packets”
“No encouragement from the nurses to practice skills”

One participant from UHND commented that a nurse wouldn’t help him to go to the toilet as it *“might hurt her back”*. Other staff were willing to help.

Another participant at UHND recalled needing to use a wheelchair to go to the toilet. A nurse stated *“you can walk”* The patient fell as the nurse was unable to support him.

At DMH, most respondents felt they were encouraged by the nurses to carry out practical skills directed by therapists.

“They let me get on with it..... but were there if needed”
“Happy with all I received”
“Like your own family looking after you. They were lovely”
“No improvements would be necessary”

5.3 Professionalism

The degree of professionalism perceived by most participants at DMH was positive. The roles of the various professionals were clear to the majority of the participants. All felt that they were treated with dignity and respect at all times. Some could not remember being asked for consent but strongly felt that this was *“not necessary”*.

At DMH participants felt that staff were clear about roles of others and worked well together as a team.

“even the porters were spot on!”
“I had heard that they had come from Bishop Auckland which was the finest stroke unit in the whole area so I know I was looked after by the best staff in the area”

One participant recalled with fondness
“two doctors and nurses in dark uniforms sang happy birthday to me”

One participant at DMH, described “ *the biggest downside to the experience*” was the attitude of one member of staff. This related to a perceived medication error which meant the patient did not receive the correct dosage throughout their stay. The participant describes the nurse as being

*“a little arrogant”
“we know best attitude” and
“dismissive”.*

The degree of professionalism perceived by participants varied at UHND. Most had an understanding of the various roles of staff, although some felt

*“it was a little confusing” and
“difficult to distinguish”*

36% of participants felt they were not treated with dignity and respect from nursing staff at UHND. Some comments from UHND included:

*A nurse saying “Get off me you nasty women”, when trying to get out of bed.
“Some were rude and bad mannered”
“Roughly taken from one bed to another. Dirty shoes put on the bed”
“The doctors yes, but not the nurses” (regarding level of dignity and respect experienced)
“The consultant yes, but I didn’t see the nurses enough to comment”.*

At UHND there were 36% of respondents who could not recall being asked for consent to treatment, although some questioned why this would be required. 27% of participants at UHND were unclear about the roles of staff. Equal participants felt that staff worked well together to those who felt they did not work well together.

*“I never saw two members of different staff work together “.
“The consultant didn’t know the names of any of the nurses”.
“There is a lack of communication” in terms of awareness of basic needs.*

5.4 Involvement in own care.

At UHND, 88% of participants were not involved in, or aware of their care plan. One participant became aware of the care plan when transferred to BAGH. One participant had their goals agreed with the physiotherapist. Another felt involved in their goal setting. The remaining participants could not recall discussing goal setting. Participants did not feel they had a choice in their treatment plan or therapy at UHND but did not feel this to be an issue.

*“No (did not have a choice in treatment plan or therapy) but did not feel this was necessary”
“No, they did what they thought needed doing”
“I had no choice, but I was happy with what I got”*

A few participants felt that they did not receive enough information in order to make choices.

Participants at UHND felt that their views were listened to, highlighting the doctor as being very good at listening to their views. Participants felt their views were definitely not listened to by the nurses and provided examples of this.

A participant at UHND recalled having her hair washed when the nurse was specifically asked not to wash it. Another was told to “*sit there*” when waiting for extra towels.

One participant requested sudocrem, and was told *"it was banned in the hospital"* to be told later it should have been applied.

18% of participants at UHND, felt they were not given enough opportunity to ask questions.

"Did not have enough opportunity to ask questions as I didn't see the nurses enough"

"I asked (questions) but was ignored"

One participant felt enough opportunity was available to ask questions, although staff never pro actively offered any information or explanation.

A mixed response was received at UHND when participants were asked if they had been encouraged to ask questions and ensure understanding. Most felt comfortable asking questions of the consultant, but felt there was *"no rapport"* with nursing staff.

At DMH, there were no participants who could recall having a care plan. Goals were agreed by those receiving physiotherapy. Participants had little expectation of having a choice of treatment and therapy.

"I was happy to take whatever was available. Choice was not expected"

"I was happy with treatment, no need to ask questions"

"Staff are the experts. They will tell me if I need anything done"

"Staff know better, I will do what is required"

All but one participant at DMH felt their views were listened to and always respected. One participant recounted his experience when issues raised about medication were dismissed.

All participants at DMH, felt they had the opportunity to ask questions and they were all encouraged to do so, with further explanation available if required.

5.5 Leaving hospital.

Participants at DMH, were generally positive about the discharge arrangements and degree of choice they experienced. A minority felt they did not really have a choice although were fully informed about what was happening. Most participants had an understanding of the discharge process although many issues were raised about the long wait for medication prior to discharge. The support provided at discharge was seen by all to be good.

"I don't think I could have been better looked after"

"It was more than I expected. I found it very good" (equipment and support offered)

All but one received verbal information about their medication. One found the instructions confusing and had to ask the GP.

All participants at DMH felt their length of stay was just right. The amount of information at discharge at DMH varied considerably. Some recalled information about medication as the only information provided, where others listed a range of information for driving, smoking, exercise, and drinking. Some were provided with verbal instructions and others given exercise sheets to follow. Some were provided with contact details and others could not recall receiving this. Likewise, some were given information for community services where others could not recall receiving this information.

Two participants recalled contacting the hospital afterwards for advice (BAGH and DMH) and both were happy with advice received.

Follow up information varied at DMH with the majority receiving details of follow up appointments. One participant received no follow up details and was grateful to the Stroke Association for arranging the appointments.

Another participant was told that SALT would arrange an appointment. There was no contact for six months and the participant felt that *“this did not do a great deal”*

All but one participant at DMH felt that they had been referred to the most appropriate services. One felt that not enough questions were asked of his level of anxiety and if this had been the case referral to counselling therapy would have been useful. The participant received such support from the Stroke Association. No carers assessment of need was offered at DMH or BAGH.

At UHND, options available to participants in terms of their discharge varied with 55% feeling they had no choice in the arrangements. One participant had asked to go home to be told they needed to wait until the consultant returned from annual leave before a decision could be made. Participants were generally aware of the discharge process although lengthy waiting times for medication on the day of discharge was raised at UHND.

All felt they had the right support and equipment in place at UHND. The amount of information provided to participants varied with little consistency noted. Some appeared to receive very little or no information at discharge relying on the Stroke Association or GP to provide support.

Medication advice at discharge appeared inconsistent at UHND with some receiving both written and verbal advice, and others receiving no advice at all. One participant took the discharge sheet to the GP to clarify. Another recounted the explanation about medication had been given to the care home, but nothing had been discussed with the patient.

Similarly the follow up process was inconsistent at UHND. Some received follow up support and appointments where others had no follow up explained or rehab plan in place. One participant asked the GP to arrange their follow up support.

Most participants felt the length of stay was right with one participant believing their length of stay to be too long.

All but one participant at UHND, had equipment ordered and in place prior to discharge.

None of the participants at UHND could recall having a carers assessment of need offered.

Participants at UHND felt more information should have been sought, regarding home support.

“No one considered or asked how I would get my groceries.”

“I had a home help but no one checked at the hospital that this was in place.”

5.6 Information & Communication.

At UHND the degree of practical information and advice following a stroke, varied. Some felt they were given enough information, where others received no information at all.

The majority of participants felt they had to ask questions and very little information was pro actively given.

“No one sat down and discussed how hard it would be”

A carer reported “I might as well not have been there”

“There were leaflets in the corridor but no one directed you to them”

Those who received information felt it was mostly given verbally, with a minority receiving written information. Some felt they were encouraged to ask questions whereas others felt they nurses were too busy to ask. The amount of information was felt to be minimal.

“Too little information – too infrequent”

At UHND, participants felt the information received was provided at the right time, suggesting more information about medication and stroke prevention would have been useful.

There were no participants at UHND who could recall being informed of any community support groups, education programmes, expert patient programme or the Carers Association.

Some received details of the Stroke Association and were provided with information packs and support which were found to be very useful.

At DMH, all but one participant felt they had received enough practical advice and information. One felt that it would have been beneficial for someone to sit down and discuss the details of the stroke prior to the review appointment after discharge. Equal numbers of participants felt they were offered information as to those who felt they had to ask first.

Information was both verbal and written at DMH, with a lot of praise provided for the Stroke Association information pack. The pack was both *“very useful”* and *“very helpful”*. All participants felt the information was clear and concise although a few medical terms needed further explanation. All participants felt comfortable asking the staff questions

“all the staff were friendly and approachable”
“not a stone was left unturned”

All participants felt they had received the right amount of information at DMH.
“not a lot, but it was enough”

One participant at DMH was provided with the stroke hand held record after discharge, and felt this would have been more useful sooner. Another felt the hand held record should have been given to the carer within 24 hours.

No participants had been made aware of community programmes, educational programmes, Carers Association or expert patient programme by the hospital staff at DMH or BAGH.

Most participants discussed the value of the Stroke Association finding both the information and intervention of the coordinator to be beneficial.

Overall the general opinion of the information and communication from DMH was positive

“The stroke admission experience has restored my faith completely in DMH”
“I cannot understand how anyone could complain about the hospital”
“They are marvellous”

5.7 Travel and transport.

One participant from DMH commented on the travel implications of post StF services. No comments were raised from participants from UHND.

“I could not have been better looked after, it was excellent, but should have been nearer to our own place”

“Travel for distressed relatives needs to be taken into account”

6.0 Conclusion.

The findings of the phase 2 patient evaluation exercise provide information to service users and service providers, of the quality of stroke services post StF. As well as identifying areas of existing good practice, they also highlight a number of potential areas for future review.

CDDFT, in partnership with other agencies involved in the commissioning and provision of stroke rehabilitation care, will inevitably wish to review these, together with the detailed feedback, to identify priorities requiring action.

A comparative report will follow the phase 2 report comparing findings of both pre and post StF outcomes in order to ensure ongoing improvement in the stroke rehabilitation service.

6.1 Areas of good practice – phase two

First 24 hours

- The FAST campaign successful in helping with symptom identification for 2 participants.
- All methods adopted to report stroke symptoms were acted upon appropriately.
- Majority of patients (71%) reporting receiving CT scans within 24 hours at DMH.
- North East Ambulance Service response times and level of care was very positive. Suspected diagnosis given to one participant
- Confirmed stroke diagnoses given to patients and carers within 24 hours of presenting to DMH or UHND.
- General satisfaction of responses to questions asked by participants at UHND and DMH.
- Information and support offered by Stroke Association ie: information packs and FACS received positively at DMH and UHND.

Therapies

- Participants were seen for therapy within 72 hours of admission to UHND(55%) and DMH(57%)
- Flexible physiotherapy sessions could be arranged at UHND.
- Benefits of physiotherapy discussed at DMH and BAGH
- Participants happy with amount of physiotherapy received at UHND,DMH and BAGH.
- Goals agreed with physiotherapists and participants.
- Some physiotherapy sessions available 7 days per week at BAGH
- Benefits of OT discussed at UHND (45%) and DMH (57%)
- Benefits of SALT identified by participants who received therapy.
- Regular contact with Consultant at DMH and BAGH.
- Daily contact with Consultant at BAGH.
- Emotional support positive via Stroke Association at DMH.
- Benefits of all therapies explained at DMH and BAGH
- Generally positive attitude of nursing staff to encourage practical skills directed by therapists at DMH and BAGH.

Professionalism.

- Satisfaction of staff acting in a professional manner was high at DMH.
- Roles and responsibilities were generally clear to the most participants at DMH.
- Participants were generally positive about staff working well as a team at DMH.
- Participants were knowledgeable about their care plans at BAGH.
- Doctors were very good at listening to and responding to views of patients at UHND.
- Participants views were listened to and respected by all staff at DMH.
- Staff offered plenty of opportunities to ask questions and were encouraged to do so at DMH.
- 100% of participants felt they were treated with dignity and respect at DMH

Involvement in own care.

- Awareness and involvement in care planning at BAGH.
- Doctors were very good at listening to views of patients at UHND.
- Doctors were approachable and gave enough opportunities for patients to ask questions at UHND.
- Goals were agreed by those receiving physiotherapy at DMH.
- Generally views were listened to and respected at DMH.
- Generally patients were encouraged to ask questions with full explanations given at DMH

Leaving hospital.

- Awareness and understanding of the discharge process was evident of participants from DMH and BAGH.
- Positive experiences of discharge were recounted at DMH and BAGH.
- Positive comments recounted regarding the equipment and support in preparation for discharge at DMH.
- Advice sought after discharge was noted to be very positive at UHND and BAGH.
- The Stroke Association provided emotional support when not available from hospital colleagues.
- The Stroke Association was available to provide support, to pursue follow up arrangements that had not been completed by hospital colleagues.

Information and communication.

- Participants who received information of the Stroke Association, from UHND, DMH and BAGH received positive feedback and relevant support.

6.2 Potential areas for improvement Phase two

First 24 hours.

- There appears to be a lack of significance attached to seeking early diagnosis or treatment from the patient once a stroke was suspected.
- There was limited or no written information provided to patients or carers at the point of diagnosis at UHND and DMH.
- There is very limited pro active information sharing at DMH and UHND.
- Limited verbal or written information given regarding the expectations of the patients hospital stay at UHND and DMH.
- Limited presence of nursing staff interacting with patients.
- Only 45% of patients received a CAT scan within 24 hours at UHND.
- Swallow tests were performed on 28.5% of participants at DMH and 45% at UHND.
- Many participants felt the timing of the diagnosis of a stroke was inappropriate as they were not able to fully comprehend the information given due to the impact of stroke symptoms at UHND and DMH.

Therapy.

- Generally participants felt they were not made aware of the benefits of physiotherapy at UHND.
- Some participants with speech /language impairment were not seen by SALT and felt they should have been.
- No input noted of dietetics service from participants at UHND, BAGH or DMH..
- Consultant visits varied across the Trust and may require more consistency.
- Emotional needs were not generally identified by staff at UHND and DMH.
- A potential lack of understanding from hospital staff regarding the emotional impact of a stroke at DMH and UHND.
- Lack of information available regarding the benefits of therapies at UHND.
- Lack of nursing support re practical / basic tasks at UHND.
- Negative attitude and interaction of nursing staff reported, especially at UHND, regarding level of support and knowledge of basic needs.

Professionalism.

- Generally participants at DMH, UHND or BAGH could not recall being asked for consent to treatment throughout their stay.
- Participants did not feel it significant that their consent had not been requested.
- Roles and responsibilities were confusing to participants at UHND. Participants felt that staff roles were difficult to distinguish.

- Some participants at UHND, felt they were not treated with dignity and respect and issues pertaining to negative staff attitude were noted. Participants at UHND felt that nurses at did not always listen to the views of patients.
- Participants from UHND felt they should have had more opportunity to ask the nurses questions.
- Consultants were unaware of the names of nursing staff at UHND
- Participants recalled a lack of communication in terms of awareness of the level of support needed to meet basic needs at UHND.
- Participants were unaware of their care plans in both UHND and DMH.
- Participants did not feel it was important that they had a choice in their treatment plan at UHND and DMH.
- 36% of participants at UHND did not feel they were treated with dignity and respect.

Involvement in own care.

- Participants were not aware of, or involved in their own care plans at UHND or DMH.
- Goal setting was generally not discussed at UHND.
- There was limited choice offered in terms of treatment plans or therapies at UHND and DMH
- Patients did not feel that choice of treatment or therapy was necessary.
- Views of patients were not listened to by nursing colleagues at UHND
- There was “no rapport” with nursing colleagues at UHND

Leaving hospital.

- Long waiting times noted for medication prior to discharge across the Trust.
- Information at time of discharge was inconsistent across the Trust ranging from no information at all to a full range of information.
- Some participants relied on their GP or the Stroke Association to make follow up arrangements that had not been completed in hospital.
- Not enough support, knowledge or information was offered regarding the emotional impact of a stroke across the Trust.
- No Carers Assessment of Need was offered at DMH, BAGH or UHND.
- Delayed decisions regarding discharge was noted due to the absence of the consultant at UHND.
- Information regarding medication is inconsistent across the Trust, ranging from no information at all to verbal or written advice, leaving participants to seek GP advice to clarify.

Information and communication.

- Information and advice following a stroke was inconsistent at UHND and DMH
- Little pro active information offered at UHND and DMH
- Written information was available for a minority of patients across the Trust.
- No information was provided of community support groups, or educational programmes across the Trust.
- No details were provided of the Carers Association across the Trust.

7.0 Next steps

7.1 Acting upon the findings

Areas of good practice and potential weaknesses requiring further review and/or action have been identified. Further analysis of the findings will be required by appropriate stakeholders.

It is recommended that the findings are presented to the Clinical Action Team in order to develop meaningful action plans to address areas in need of improvement and to ensure aspects of good practice are maintained and encouraged across stroke services within CDDFT.

7.2 Further engagement activity

CDDFT may wish to explore the benefits of engaging staff, patients and carers in further engagement activities to agree priorities for action and discuss potential solutions.

The use of experience based design tools and techniques, as advocated by the NHS Institute for Innovation and Improvement via

http://www.institute.nhs.uk/quality_and_value/introduction/experience_based_design.html

would be helpful in engaging staff in understanding patients and carers' feelings and challenges at different stages of the pathway and vice versa.

7.3 Feeding back to participants

It is crucial that the patients and carers who have taken the time to participate in phase two of the service evaluation receive feedback as soon as possible. This should demonstrate how their views have been considered and how they have influenced any planned actions and improvements, together with estimated timescales. It would be good to practice to issue participants with regular development reports to demonstrate how the planned actions are progressing.

8.0 Risks

- It is paramount that CDDFT evaluate the effectiveness of the stroke service changes with a view to evidencing positive outcomes from the patients' perspective. This will be an essential part of being able to evidence the success of the service to both commissioners and critics of the StF reconfiguration.
- The results of the patient experience evaluation exercise should be fully considered and actions and resources committed to address and review any emerging issues. This will ensure the Trust will satisfy legislative and policy requirements.
- It is essential that the Trust listens to and provides timely feedback to patients and carers who gave their time to support this project. This will support and encourage future engagement of service users and maintain their confidence in local services.

9.0 Recommendations

- Acknowledge and take ownership of the content of this report.
- Review the feedback from Phase two of the evaluation exercise, agreeing areas for improvement and actions to be taken, potentially via the multi-agency Clinical Action Team
- Commit to feed back progress reports to patient and carer participants at regular intervals
- Agree the timeline and responsibilities for phase two of the evaluation exercise
- Produce a comparative report of phase one and phase two outcomes identifying improvements made and areas to address as a result of StF reconfiguration.

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Appendices:

- Appendix A: glossary of terms

Appendix A: Glossary of terms

Acute	Aspect of care required when a patient is at his/her most ill
BAGH	Bishop Auckland General Hospital
CDDFT	County Durham and Darlington NHS Foundation Trust
DCC	Durham County Council
DMH	Darlington Memorial Hospital
ED	Emergency Department
FACS	Family and Carer Support
FACSS	Family and Carer Support Service
GP	General Practitioner
NEAS	North East Ambulance Service
StF	Seizing the Future project
SA	The Stroke Association
Rehab	Rehabilitation – care provided to aid a patient in regaining pre-illness quality of life
TIA	Transient Ischaemic Attack – a type of minor stroke
UHND	University Hospital of North Durham