Stroke Services in Norfolk

TABLE 1 Updates on recommendations made by NHOSC in July 2014, where implementation is still in progress

Recommendation		To	Response up to December 2015	*Progress at 26th September 2016 as reported by the Norfolk & Waveney Stroke Network Group*
Pre hospital				
7.	That the Norfolk and Waveney Stroke Network seeks assurance from the three acute hospitals in Norfolk that they report back to EEAST on failures to provide pre-alerts of the arrival of stroke patients so the problem can be quantified and appropriately addressed and that EEAST identifies a lead for stroke with whom the hospitals can liaise consistently. (Paragraph 4.12)	Norfolk and Waveney Stroke Network EEAST	**Accepted**: By Nov EEAST had established a new Stroke lead for Norfolk who would attend the Network meetings. In Oct 2015 there were regular dialogues ongoing between NNUH and EEAST and JPUH was undertaking monthly breach interrogation. Information about ongoing liaison with EEAST was still awaited from the QEH in Nov 2015.	There is an **East of England Ambulance Service Trust (EEAST)** area clinical lead in place and issues regarding pre-alerts at each of the acute hospitals are discussed regularly. EEAST are not aware of any concerns or issues but have reported on the increase of stroke assessments being completed more frequently in the ambulance due to patient flow and capacity issues. Assurance has been received from NNUH and JPUH. QEHKL Stroke matron has met with EEAST and they have formulated a pre-alert form to aid communications with direct phone calls from the ambulance crew to ensure that they are met at the front door in Accident & Emergency. This has shown early signs of improving the times. Band 6 staff have been trained up which has shown significant improvements with door to scan timings. Monthly meetings are planned with EEAST to look at any issues arising.

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8.	That the NNUH, JPUH, QEH and EEAST consider what more could be done to enable the ambulance service and the acute hospitals to work together to shorten the diagnosis time for stroke. (Paragraph 4.13)	NNUH JPUH QEH EEAST	**Accepted**: At the Norfolk and Waveney Stroke Network Meeting on 21st October 2014 Network members agreed to hold meetings based around each hospital system and to then collectively share their work at the Network meetings. This was on the agenda for Network meetings in 2015. In October 2015 the Network reported ongoing liaison between EEAST and the NNUH and JPUH. Information about ongoing liaison with EEAST was still awaited from the QEH in Nov 2015.	The outcome from local hospital systems pathway work is discussed regularly at the Norfolk & Waveney Stroke Network where it is a bi-monthly standing agenda item. **QEHKL:** EEAST's East Locality Sector Head has met with the QEHKL Stroke Consultant and some of his team periodically to discuss pathway redesign and any issues. There is a clear line of dialogue for any issues that arise.
Hyper acute and acute				
11.	That the James Paget University Hospitals NHS Trust **urgently** increases the number of stroke specialist consultants in its service. (Paragraph 5.6)	JPUH	**Accepted**: In December 2015 the JPUH reported that despite repeated efforts it not yet been able to fill the third full time stroke specialist post. There remains a severe shortage of appropriate specialist trainees in stroke both locally and nationally. The post has been advertised twice nationally in the last 12 months, including a substantial recruitment bonus. JPUH had also made use of a headhunting agency and a European	NOTE:- NHOSC scrutinised 'NHS Workforce Planning in Norfolk', in July 2015 covering national workforce shortages and the national and local initiatives underway to address them. Norfolk and Suffolk Workforce Partnership / Health Education East of England updated NHOSC on 26 May 2016.

Recommendation		To	Response up to December 2015	*Progress at 26th September 2016 as reported by the Norfolk & Waveney Stroke Network Group*
			recruitment agency, as well as advertising JPUH and the Norfolk area at the British Geriatrics Society conference last year. There had been tentative interest from a couple of local trainees finishing in 2016, but they were not yet eligible to apply. JPUH intended to continue to work with the European agency but suitable candidates were still rare. The hospital had however recruited a locum stroke consultant with extensive stroke specialist experience to work until at least February 2016. This had given increased its consultant staffing from 2.1 WTE to 3.1 WTE. A neurology consultant with an interest in stroke had also been recruited (in 2014) and was an integral part of the team helping to push forward JPUH's involvement in stroke research and education. With regard to improving weekend stroke specialist review, JPUH was waiting for equipment to start on a pilot of telemedicine consultant ward rounds, which if successful could make it possible for the hospital to link more closely with another specialist unit in the long term. It was also continuing to use the	In spite of the national workforce difficulties in stroke, JPUH is pleased to report that JPUH has recruited a new consultant with stroke specialist accreditation to work in stroke and acute medicine from 3rd October 2016. This brings the total number of stroke consultants up to 4. Taking account of their other work this represents 2.6 whole time equivalents devoted to stroke. There remains funding for another 0.5 whole time equivalent consultant in stroke and JPUH will look to advertise this again in 2017, possibly as a shared stroke and geriatrics post. JPUH is currently piloting weekend stroke ward rounds to improve the specialist cover on the stroke unit and continue to participate in the regional telemedicine service for out of hours thrombolysis. Some Telemedicine ward rounds have taken place at JPUH but were

Recommendation		To	Response up to December 2015	*Progress at 26th September 2016 as reported by the Norfolk & Waveney Stroke Network Group*
			successful regional telemedicine service for stroke thrombolysis.	not as beneficial as having an in-person ward round.
14.	That the Norfolk and Waveney Stroke Network undertakes an assessment of how many patients are delayed at acute and community hospitals due to waiting for NHS Continuing Care assessment or funding and establish what the cost is. (Paragraph 5.7)	Norfolk and Waveney Stroke Network	**Accepted**: The acute hospitals and CCGs supported this recommendation but in December 2015 the Network reported that there was difficulty in obtaining data and it was investigating if central Norfolk holds data through its Capacity Planning Group and if NNUH have data. There was no update in the December report regarding the position at the QEH and JPUH.	**NNUH:** North Norfolk CCG has advised that the central CCGs are scoping a Continuing Health Care (CHC) Discharge to Assess model which will be implemented in the NNUH in early January 2017. There is currently a daily call with NNUH, CCGs, Commissioning Support Unity (CSU) CHC service and community to support discharge and flow from the hospital to secure timely discharge to the most suitable setting for patients. For both Norwich CCG and North Norfolk CCG there is a daily call in place which focuses on delays in the NNUHT, covering CHC delays with the CHC team in the community. There is a discharge hub in place as well as discharge co-coordinators on every ward, pushing those ready for discharge through the system, but beds outside of the NNUH are limited due to accessing suitable nursing home beds.

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				Central Norfolk Capacity Planning Group (CPG) is reviewing the stroke pathway. **QEHKL:** West Norfolk now assess patients in the community setting once the patient has stabilised, therefore there are no delays with NHS CHC assessing on discharge. This is following the Discharge to Assess model. **JPUH:** There is a daily conference call with their CCG and Social Care on all delays within the Trust. In relation to CHC there is a 'plan for every patient' with daily board rounds and 2-hourly updates for every patient with the CHC team based within the hospital with case managers supporting the more complex patient. Going forward, the wards will look at completing their own checklist to speed up the process.

Recommendation		To	Response up to December 2015	*Progress at 26th September 2016 as reported by the Norfolk & Waveney Stroke Network Group*
				On 22nd September 2016 on the stroke unit, there were 3 patients awaiting continuing health care assessment, and 3 more who have had their decision but are still awaiting placement. 2 of those were social care and 1 was awarded continuing health care. **NCH&C:** A recent development has involved one of the ward sisters, with suitable experience, completing the Decision Support Tool (DST) on the ward on behalf of CHC in order to create a smoother process and reduce delays. This intervention was agreed with the Commissioning Support Unit.

TABLE 2 – **Progress on recommendations from the 'Review of Stroke Rehabilitation in the Community' report produced by NCC Public Health in November 2015**

Recommendation		**Progress**
1.	Commission outcomes which encourage integrated care and support with long term goal planning and direct routes back into specialised rehabilitation for all stroke survivors	**NNUH:** Central Norfolk has an integrated stroke pathway. This consists of acute care at NNUH and specialist stroke rehabilitation at Beech ward in NCH&C Trust. Early Supported Discharge (ESD) and 6 month follow up are provided by specialist staff at NCH&C, with support from medical staff at NNUH. There is no commissioning in place for re-entry into the stroke service once discharged. Any new event is through the normal channel with patients signposted to the appropriate service i.e. rehabilitation / therapy / gym membership. All agreed that Commissioners need to work with Providers on what is required within the two year commissioning intentions round. **QEHKL:** West Norfolk commissions an integrated pathway for stroke services, with the QEH providing the specialist stroke community rehabilitation for Stroke survivors. The rehabilitation is provided for as long as required to meet the patient's needs, ensuring that the patients are involved with setting their care goals both short and long term. There is a Spasticity clinic in place at QEHKL with all stroke patients allocated a Case Manager.

		JPUH: All patients suitable for early intensive rehabilitation are supported by the ESD team on discharge, and then if they have ongoing needs passed on to the integrated community neuro rehabilitation team. There are strong links between these teams and the stroke unit therapy team. All patients are offered Stroke Association follow up, and we are working on closer links between the ESD team and the Stroke Association support worker. Patients are provided with professionals contact details. Discussions are also ongoing regarding 6 month follow up. Patients may be re-referred to outpatient clinics or to the integrated community neuro team but there is no commissioned pathway back into the stroke unit or to ESD.
2.	Adopt consistent quality and performance indicators across Norfolk, taking the lead from the new NICE quality standards.	All the CCGs and acute trusts will have the same requirements to meet the NICE standards. It is therefore important that all the Norfolk CCGs agree collaboratively what quality standards to use and commission the same stroke services. All agreed that the main top 5 items from the 2013 NICE guidelines to be shared. Sentinel Stroke National Audit Programme (SSNAP) Data is scrutinised by the Norfolk & Waveney Stroke Network meetings. This should be addressed in the forthcoming two year commissioning round. **NNUH:** There is a monthly board report for stroke that consists of key clinical targets. Information is

		also provided to CCGs as per agreement. The clinical team review performance at departmental meetings and conduct a Root Cause Analysis (RCA) to improve patient care. **QEHKL:** The QEHKL report within their Board Report on a monthly basis against all National Stroke indicators. They also provide a quarterly SSNAP audit report. All data against national Stroke indicators are provided to West Norfolk CCG Clinical Quality Team with any issues addressed at the monthly Clinical Quality Review Meetings. **JPUH:** All services are monitored through the contract and quality meetings. The quarterly SSNAP data is provided to the CCG and the JPUH quality meeting and the stroke team attend to give regular updates. There are monthly reports to the Board on key quality indicators and we are aiming to harmonise these as far as possible with the SSNAP dataset.
3.	Increase the number of people reviewed at six weeks, six months and one year.	**NNUH:** Offer a 6 month follow up either in the community or in the acute setting to all stroke patients. All are nurse led and if required, referred to a Consultant when appropriate. Follow up clinic slots have been increased from 1st April 2016. For the community, reviews using the Long Term Stroke Care (LoTS) assessment tool are in place; all patients are being offered a review at 6 months, however take up is low.

		QEHKL: Is restructuring clinics to ensure that all the 6 monthly criteria is covered, and then discharged to primary care. Therapy is also offered. Clinical reviews are taken between 6 – 8 weeks. There is very little take up of 12 monthly reviews, with all stroke patients offered a follow up. **JPUH:** The last audit of stroke follow up showed that 88% of surviving patients attended an appointment at 6 weeks. Virtually all were offered an appointment but some cancelled, particularly nursing home residents who were often too frail to attend. 7% were offered an appointment at 6 months. Under the new proposed model, patients with no residual disability at discharge or who are discharged to a nursing home will receive a telephone follow up at 6 weeks. This model has proved popular with TIA patients. Patients with outstanding medical needs (including young stroke patients requiring specific investigations) will still see a Consultant, but around 50% should be suitable for nurse led follow up. The nurses will have easy access to consultant appointments for any patients who need one. This change should free up enough capacity to allow JPUH to additionally offer a 6 month follow up to all patients, either as a structured telephone call, nurse-led clinic or a consultant clinic appointment according to the patient's needs.

4.	Provide equitable access to screening and assessment for psychological problems.	**NNUH:** Has access to clinical psychologists across the pathways, working in ESD. **QEHKL:** Has clinical psychology in place through the entire stroke pathway; however the treatment programme is limited. Mood and cognitive screening is available. Additional funding has been made available for two extra days of psychology intervention for stroke patients, although no one has been recruited to this vacancy yet. **JPUH:** Has no direct access to a clinical psychologist for stroke patients; however, teams have had some training to offer Level 2 psychology support as part of therapy time. Mood assessments are offered to all patients. There is access to the Colman Hospital and also Livability Icanho in Suffolk who can offer clinical psychology input, but strict referral criteria are applied.
5.	Increase the number of carers receiving regular assessments.	This falls under the remit of the **local authority** with carers' assessments part of the discharge process from the acute trusts. Confirmation has been given that patients are not sent home if the required support is beyond what the carer can provide. NCC Social care has a performance indicator which measures how well carers are supported. It is acknowledged that there is a delay in taking these assessments forward by NCC.

		For Norfolk, the number of carers assessments and reviews in July 2016 (most recent data) was 210, which is up on 200 in June 2016 but down on June 2015 when there were 353 carers assessments and reviews. However, NCC commissions the Carers Agency Partnership to provide a range of services to carers (e.g. short breaks, telephone support, carers groups) and 1260 carers accessed the Partnership's services in June 2016, which is up on June 2015 when there were 1080 carers accessing Partnership services. The amount of people supported by NCC has consistently increased month on month due to a wider range of carers being identified. NCC has agreed to extend funding for 6 whole time equivalent dedicated carers assessors for 1 year from April 2016, but to note that this does not specifically relate to stroke care. There are also carers assessors in Social Care Centre of Expertise (SCCE) who carry out telephone assessments, and also within the mental health team. Clinics are also being set up in surgeries on agreement. The Stroke Association has funding to bring in a more formal assessment (based on the

		Collaborations for Leadership in Applied Health Research and Care - CLARHC), and will be offered in West Norfolk as a pilot in Autumn 2016 and will be focused on carers of stroke. There will be performance indicators on the outcomes.
6.	Provide improved, consistent information for stroke survivors and their families across Norfolk.	**NNUH:** All patients are given the purple plastic wallet containing the Stroke Association Starter pack together with various booklets depending on the individual and the severity of the stroke. The driving leaflet from DVLA is also handed out. **QEHKL:** There is access to all the Stroke Association booklets, with a purple plastic wallet handed out to the patient. There are also team specific leaflets handed out which relate to local services available e.g. post-stroke spasticity, sensory work, splint work. The driving leaflet from DVLA is also handed out. **JPUH:** All patients are currently given the Stroke Association pack at home by the Stroke Association Information and Support worker. At discharge from hospital, a joint care plan (stroke information leaflet) is provided to the patient on discharge which gives details of the therapy teams and contact numbers, as well as the hospital discharge letter. A selection of the Stroke Association leaflets are also handed out according to the patient's type of stroke and these are also freely available for patients and

		families from a display on the ward. There are plans to move to giving out the Stroke Association pack to all patients in hospital. **NCH&C:** On transfer home the patients will share this purple wallet information with the ESD team and any other relevant information is added to the wallet. The inpatient rehabilitation unit has noticed that some relatives may take the wallet home rather than ensure it travels across with the patient. The clinical staff will ask for it to be returned so that information can be added as necessary. Stroke Association leaflets are also handed out, but this varies depending on impairment. Where the Stroke Association is commissioned to provide a service, it can provide information face to face with clients and carers on a wide range of subjects and refer to support groups where appropriate. The Stroke Association also has a website and helpline which anyone can access for support and information. The **Stroke Association** has reported that for: **West Norfolk CCG** area there is: Information Advice and Support 1 full-time equivalent (FTE), Communication Support 0.7 FTE, Long term support 0.3 FTE and Stroke prevention 0.8 FTE.

		Gt Yarmouth and Waveney CCG area there is: Information Advice and support 0.8 FTE It is to be noted that there is no variability of commissioning the Stroke Association Services across the Norfolk CCGs. The Stroke Association is discussing proposals with North Norfolk CCG for a stroke recovery service and six month reviews, and a similar proposal to Norwich CCG.
7.	Embed feedback, satisfaction surveys, friends and family tests (FFT) in quality improvement.	**NNUH:** Feedback is received through acute care and the pathway meetings via the FFT and relatives' clinics. Acute ward: June 2016 – 100%, July 2016 – 100%, August 2016 – 90.91%. Hyper Acute – June 2016 – 100%, July 2016 – 100%, August 2016 – 75%. The above is discussed at departmental clinical governance meetings and actioned as appropriate. There is a monthly relatives' clinic at NNUH where clinical staff are available for any queries and support. There is a monthly cross pathway meeting where staff from NNUH and NCH&C discuss clinical outcomes and areas for improvement. NNUH hold an annual stroke study day with free access to all staff working in stroke in the region. There is also a Stroke Forum at NNUH.

		QEHKL: The results of the monthly FFT test and patient satisfaction surveys are discussed at the monthly QEHKL Stroke meeting with feedback discussed with the health professionals. FFT response rate and likelihood to recommend for the last 3 months are as follows: Response rate for June 2016 - 69.88%; July 2016 - 75.64%; August 2016 - 77.11%. Likelihood to recommend June 2016 - 96.55%; July 2016 - 91.53%; and August 2016- 93.75 %. There is also a Service User group for stroke victims. **JPUH:** FFT responses and comments from the stroke unit are shared weekly and reviewed at the Stroke Clinical Governance meeting. Actions taken are shared with all stroke staff in a monthly newsletter. Feedback of the last 12 months, 93% of patients had a positive experience within JPUH stroke unit. Comments are taken on board - for example following some anonymous feedback from a relative about difficulty obtaining information at the weekend we have created a poster and a new leaflet for relatives explaining the various ways in which families can obtain updates even if they cannot visit during working hours. Annual patient satisfaction surveys in ESD have been revised with a response rate around 50% which is shared with the stroke management team and all stroke staff.

		NCH&C: Patient and Carer questionnaires are sent out. There is a FFT but the response rate for this could be improved, with the format being reviewed. There is a Stroke Forum. Improved engagement through the Patient and Carer group is being developed as the response rate is low. There is local representative in the Norfolk area. On Beech Ward at Norwich Community Hospital, engagement with carers is being looked at more effectively. There is a local organisation which focuses on carers, providing carer support in the Norfolk area. When there are issues flagged by carers, these are discussed in the unit with the carer and / or patient present with lessons learnt and addressed. Work continues with Norfolk Carers. A representative from the Norwich carer group will be attending the Patient and Carers Stroke group in October. A flow chart is being developed to show the process of supporting carers for our stroke patients across the stroke pathway. **EEAST:** There is engagement with all patient groups, including the FFT. There is also a Trust User Group which encompasses stroke patients. **STROKE ASSOCIATION:** The team is based at QEHKL. A national survey is independently circulated; a recent survey reflected a 65% return with good support of the services. Any issues are highlighted and passed back to the co-ordinators.

		The Network also holds events at QEHKL for stroke patients. **HEALTHWATCH:** The Engagement Team attends various events across Norfolk, gathering general information on topical issues in relation to health and social care. There is targeted engagement, looking at specific areas. There is a website where feedback is left; linking into Friends and Family Tests associated NHS informatics. Volunteers link in with specific work. Healthwatch is also commissioned to provide independent reports by the CCGs and NHSE.
8.	Encourage a wide range of Voluntary, Community and Social Enterprise activities, for example peer-led groups, carer and peer-support and community asset mapping.	**NNUH:** There are a number of patient support groups across Norfolk. They provide a variety of services. The details of which along with contact details are given to all patients in the patient pack. We also conduct patient forums within our pathway. NCH&C is organising the next forum on 25th October 2016 where staff from across acute and rehabilitation teams will be attending. **QEHKL:** The Stroke Association run a comprehensive programme of groups / activities in West Norfolk including Long Term Support Groups (for those affected by stroke and their carers), Communication Support Groups, a Healthy Lifestyle Programme, Tai Chi classes, Hydrotherapy sessions, and an Art & Craft Group. The Friends of the Stroke Unit fundraise for, and raise awareness

		of, QEH Stroke Services and have financed equipment, courses and the refurbishment of the TIA Clinic. **JPUH:** The Stroke Therapy Team Leader has been working on improving our links with local stroke groups. Links are already established between the Speech and Language service and several local support groups. There will now be consideration to use group leaders to disseminate developments in the stroke service and to gain feedback from their members. The Stroke Association Information, Advice and Support worker currently makes contact with all patients after discharge and informs them about local stroke groups and other community activities and support organisations. The ESD team will also signpost patients as appropriate. The Stroke Association hold a weekly drop in session on the JPUH site for stroke survivors and their carers which is highlighted to patients on the acute ward and in ESD. The Stroke Specialist Nurses recently ran an information stall hosted by the Heartcare Cardiac Support Group, with similar events hosted by the local stroke support groups. **NCC:** There will be a project supported by Public Health who will scope this exercise with involvement from QEHKL, NNUHT and the CCGs. This has been delayed by restructuring within the Public Health Team. The NHS HERON website provides a

		comprehensive and searchable source of NHS services.
9.	Use standardised communication and assessment tools for transfer between services.	This is an IT issue. IT will be one of the key issues in the Sustainability Transformation Plan, recognising that this will be a challenge for transfer across different services. However, due to the very small numbers of transfers between services this has not yet caused any significant problems. Electronic discharge letters now hold more detail, with ongoing work on the electronic transfer of care letters. **NNUH** refer to the electronic discharge and clinical information as soon as a call is made from **EEAST**, this gives the clinical team an advantage of assessing the patient on arrival. It is not possible to transfer SSNAP records between services. There is no common guideline, however there is increasing commonality regarding radiology and pharmacy.
10.	Improve the SSNAP data compliance.	SSNAP data is being received and reviewed at the Norfolk & Waveney Stroke Network meetings. **NNUH:** Is in the top 5 of the country for annual numbers treated by one stroke unit, with a large volume of stroke patient (1200 / 1250 per year), therefore the data as collected effectively is very meaningful in terms of the numbers.

		QEHKL: CAPTURE STROKE software is now in place, with inputting up to date. Data collection has improved Compliance is improving on stroke care with patients. **JPUH:** consistently in the top band for audit compliance and above average performance on clinical indicators. **NCH&C:** The 6 month follow up figures for NCH&C on SSNAP are consistently low. This needs to be addressed and is considered to be a coding issue.
	Care Homes – training of staff	**NNUH**: NNUH lead the Central Norfolk Stroke pathway and commission services from NCH&C. The current work (see in NCH&C below) NCH&C is conducting is supported by NNUH. **QEHKL:** The QEHKL Community Stroke Team has gained funding from Ipsen to provide a training day (October 19th 2016) for carers in residential and nursing homes, and professional carers who visit patients at home. The training is free, and the course title is 'Caring for Stroke Patients with Spasticity'. The course aims to educate attendees on what is a stroke/spasticity, posture, positioning, equipment, upper limb, splints, stretches. The course is only available to those in the West Norfolk area. Speech Therapy training (a one day's course) is in place in the residential homes, especially around

		dysphagia. The training package will now be shared with NNUH. **JPUH:** Currently not aware of any local work with care home staff but would be interested in using the new NCH&C leaflet to send out with patients discharged from the stroke unit to a care home. **NCH&C:** Feedback from the 6-month follow up around the care home environment resulted in a leaflet being developed 'Ten Top Tips in Stroke Care' to support stroke care. This was a multi-agency venture including the Independent Care Sector and Stroke Association. This has also been included in the monthly newsletter circulated to all care homes within central Norfolk and Suffolk for use by all care home managers and staff. Feedback has been very positive. There is no capacity within the NCH&C teams to free up clinicians to provide training, but the profile of stroke care has been raised. Stroke Care Team Lead is liaising with the Chief Operating Officer Norfolk and Suffolk Care Support, to sustain the benefits of this piece of work and source funding for further training in order to develop the knowledge base of carers of clients who have had a stroke. A Senior Stroke Nurse is supporting this development too, as are other members of the clinical rehabilitation team.

		This leaflet will be made available to other stroke services. This piece of work will be promoted through the Stroke Forum (2017). The Norfolk & Waveney Stroke Network would like this to be promoted through the Norfolk Care Awards in February 2017 together with submission to the Life after Stroke Awards.

No updates are required to the items in the following table.

TABLE 3 - Other recommendations made by NHOSC in July 2014, where completion, implementation or rejection after full consideration was reported to NHOSC on 3 December 2015
(recommendation and paragraph numbers refer to the 'Report of the Stroke Services in Norfolk Task & Finish Group' presented to NHOSC on 17 July 2014)

Recommendation		**Outcome** (as reported to NHOSC on 3 December 2015)
Strategic Overview		
1.	The members of the Norfolk and Waveney Stroke Network commit to regular meetings and to working with the Cardiovascular Strategic Clinical Network and the Clinical Senate to drive co-ordinated improvement of stroke services in the county. (Paragraph 2.7)	**Done** Meetings are ongoing on a two monthly cycle. The local network receives reports from the Strategic Network meetings.
2.	That the NHS England East Anglia Area Team should be involved in the Norfolk and Waveney Stroke Network and that a clinical lead for the Network should be identified. (Paragraph 2.7)	**Done** The Manager has been attending Network meetings. The clinical lead role is shared between the three consultants from the three acute hospitals – this has worked well.
Preventative		
3.	That the Norfolk and Waveney Stroke Network takes up the recommendations of the Health Needs Assessment and oversees collective work between CCGs and Public Health to identify additional data sources and further analyse data in relation to stroke. (Paragraph 3.2)	**Done** Public Health has provided data at CCG level (May 2015). Network meeting in December 2015 considered responses from CCG Accountable Officers.

Recommendation		Outcome (as reported to NHOSC on 3 December 2015)
4.	That NHS England East Anglia Area Team considers the scope for introducing blood pressure checks at dental surgeries and pharmacies. (Paragraph 3.4)	**Done** NHS England passed this on to NCC Public Health for consideration. They advised that those pharmacies that wish to already provide blood pressure checks under the Health Checks contract. Dentists are also able to provide Health Checks if they wish, but none do in Norfolk. The commissioners think that opportunities to reduce risk in vulnerable groups could be better addressed by targeting the following: • Annual health check for people with learning disability • GP physical health check of MH patients • Supported housing residents
5.	That Norfolk County Council Public Health, who are responsible for commissioning the NHS Health Checks in the county, assess the numbers of people who are eligible for a NHS Health Check and the numbers who actually take up a Health Check and make the information available to the NHS England commissioners and GPs on a practice by practice basis to encourage action in the areas of low take-up (Paragraph 3.4)	**Done** The data was presented at the August 2015 Network meeting and then shared with CCGs. The Network has continued to monitor Public Health's future plans for Health Checks.
Pre hospital		
6.	That EEAST reviews the number and location of ambulance bases in Norfolk in relation to travelling times	**Done** EEAST has carried out a review and intended to open a new base at Hoveton but was unable to do so due to staffing issues

Recommendation		Outcome (as reported to NHOSC on 3 December 2015)
	to the hyper acute stroke units with a view to achieving the Stroke 60 standard in all parts of the county. (Paragraph 4.10)	(as at Oct 2015). EEAST pointed out that there are some parts of Norfolk & Waveney where even if an ambulance was close to a patient, they would not reach a hyper-acute stroke unit in 60 minutes. Demand for the ambulance service was above contracted levels and significantly impacting on performance, including Stroke 60 performance in some geographic areas (as at Oct 2015). Ambulance waiting times and turnaround times at hospitals was on NHOSC's agenda in October 2015. Robert Morton, Chief Executive Officer of EEAST pointed out that for thrombolysis what really matters is the overall time from call out to needle, not just time taken for transportation to hospital. NHOSC will examine progress with EEAST again on 13 Oct 2016.
9.	That EEAST focuses on improving its performance by ensuring that double staffed ambulances are first on scene to a higher proportion of suspected stroke patients and that patients are transported to hospital without delay. (Paragraph 4.15)	**Done** (but the desired improvement in performance was not fully achieved) EEAST remodelled its delivery of service in Norfolk by converting 3 rapid response vehicles (RRVs) to double-staffed ambulances (DSAs). Further DSA ambulance hours were also added. The EEAST stroke lead also carried out some work to reinforce the need to reduce time spent 'on scene' by the crew. Performance is still an issue. NOTE:- NHOSC has ambulance response times and turnaround times on its agenda in October 2016 and can raise the issues directly with EEAST.

Recommendation		Outcome (as reported to NHOSC on 3 December 2015)
10.	That the stroke team at the NNUH should be a standalone team, as is recommended in the National Stroke Strategy 2007 and that it should be staffed to the appropriate levels in all the relative disciplines. (Paragraph 5.3.2)	**Done** There is now a standalone team at the NNUH.
12.	That the Norfolk and Waveney Stroke Network reviews that number of stroke specialist staff in post (i.e. people actually in post, not the number of posts in the establishment), and the availability of staff in post in supporting disciplines, to assess the clinical safety of the services. (Paragraph 5.6)	**Done** A spreadsheet compiled by NNUH regarding staffing in the 3 services in Norfolk was seen by NHOSC on 3 December 2015 (also updated with additional QEH information after the meeting and circulated with the minutes).
13.	That the Local Education and Training Board explains what is being done to resolve the shortage of stroke specialist consultants, other stroke specialist staff and staff in other disciplines whose expertise is needed in the stroke care pathway. (Paragraph 5.6)	**Done** HEEoE acknowledged the challenges and explained that stroke as a sub specialty has had difficulty recruiting country wide from Aug 2014 and this, it is in part believed, is linked to changes in the way that at a national level the Specialty Advisory Committee for Medicine for the Elderly no longer credits this as an out of programme experience towards a trainee's CCT. Prior to Aug 2014 HEEoE has always recruited to between 6-8 posts each year; from Aug 2014 intake only 4 of 8 posts have been filled. This issue is being picked up by HEEoE at a national level and HEEoE continues to create training opportunities for stroke as a sub specialty and pursues several rounds of recruitment in order to fill these posts each year. HEEoE can only offer the opportunity it cannot mandate

Recommendation		Outcome (as reported to NHOSC on 3 December 2015)
		trainees to take up these opportunities in what is a competitive process but continues to work with service colleagues to make these opportunities as attractive as possible. NOTE:- NHOSC scrutinised 'NHS Workforce Planning in Norfolk', in July 2015 covering national workforce shortages and the national and local initiatives underway to address them. Norfolk and Suffolk Workforce Partnership / Health Education East of England updated Members on progress on 26 May 2016.
Rehabilitative		
15.	That the Norfolk and Waveney Stroke Network reviews the staffing of stroke rehabilitative services across Norfolk, including the availability of staff in the necessary supporting disciplines (including psychology) to ensure the appropriate level of support. (Paragraph 6.2.4)	**Done** The Network received the final version in November 2015
16.	That the Norfolk and Waveney Stroke Network assesses the relative merits of the three rehabilitative stroke services in Norfolk with a view to commissioning services in future that bring the maximum benefit to the greatest number of patients, within the available overall funding limits. (Paragraph 6.2.6)	**Done** The Network asked Norfolk County Council Public Health to lead on a clinical outcomes based assessment, the report of which was received in November 2015 ('Review of Stroke Rehabilitation in the Community') NOTE:- The report made 10 recommendations, which are considered to supersede and follow on from the NHOSC recommendation. The Network has been asked to update

Recommendation		Outcome (as reported to NHOSC on 3 December 2015)
		NHOSC on progress with these 10 recommendations on 13 October 2016.
17.	That the Local Education and Training Board explains what is being done to improve the availability of trained Psychologists. (Paragraph 7.4)	**Done** HEEoE explained the cycle of commissioning regional programmes as part of the annual investment plan. NOTE:- NHOSC scrutinised 'NHS Workforce Planning in Norfolk', in July 2015 covering national workforce shortages and the national and local initiatives underway to address them. Norfolk and Suffolk Workforce Partnership / Health Education East of England updated Members on progress on 26 May 2016.
Long term		
18.	That Norfolk County Council adult social care, Norfolk Independent Care, Norfolk Community Health and Care and East Coast Community Healthcare meet to consider how more training in the long term care of stroke survivors can be delivered to care home staff in private and public sector care homes across Norfolk, how progress with such training can be tracked and how good practice can be shared across the care home spectrum. (Paragraph 7.7)	**Done** Norfolk Independent Care met with Norfolk County Council, NCH&C and ECCH and developed an action plan to drive forward consistency of training. A task & finish group was convened to support the development of a consistent approach to the training of care workers in relation to the long term care of stroke survivors, to review how training is tracked and to agree a system for sharing good practice.
19.	That the five Norfolk CCGs should work together to commission an integrated prevention, information,	**Done** The Network started by asking Norfolk County Council Public Health to review current commissioning. The 'Review of Stroke

Recommendation		Outcome (as reported to NHOSC on 3 December 2015)
	communication and six month stroke review service across Norfolk. (Paragraph 7.8)	Rehabilitation in the Community' report was received in November 2015. NOTE:- The report made 10 recommendations, which are considered to supersede and follow on from the NHOSC recommendation. The Network has been asked to update NHOSC on progress with these 10 recommendations on 13 October 2016.
The cost of stroke and stroke services		
20.	That Norfolk and Waveney Stroke Network collectively considers whether CCGs and Norfolk County Council could usefully commission research on the overall cost of stroke to the health and social care authorities in the county and robust evaluation of the overall cost effectiveness of the three existing stroke service systems in the county. (Paragraph 8.2)	**Done** This recommendation was partially accepted. The Network acknowledged that such a project would be of considerable interest but was concerned about the cost. It explored the possibility with UEA and Public Health. The conclusion reached in August 2015 was that the costs were prohibitive.
Next steps		
21.	That representatives of Norfolk and Waveney Stroke Network meet with the Stroke Services Task & Finish Group to discuss the recommendations of this report before responding to Norfolk Health Overview and Scrutiny Committee. (Paragraph 10.1)	**Done** The Network met with the NHOSC task & finish group on 19 August 2014.