APPENDIX A

Stroke Services Update – May 2013

Community Stroke Rehabilitation and Early Supported Discharge

The Rehab team continues to work closely with the Enablement Team to manage people in the community, enabling them to rehabilitate in their own environment and remain at home. The team also undertakes six week reviews post discharge home for all stroke patients.

The team supported 66 new referrals for rehabilitation and 10 ESD direct from HASU in **quarter 2 of 2012/13**; in **quarter 3** they have supported 66 rehabilitation patients and 12 ESD direct from HASU. **78** six week reviews were completed in **quarter 3**. **Quarter 4** data is yet to be finalised. **90%** of patients said they had improved after input from the team in **quarter 3.**

The Community Rehabilitation / Early Supported Discharge team regularly monitor referrals from the HASUs to ensure patients are accessing the appropriate pathway. Any concerns are discussed between the two organisations.

Stroke Navigator:

The navigator supports stroke patients, their families and carers in their discharge home process. A discharge home experience questionnaire is undertaken within ten days of the patient being discharged home. **In the 3rd and 4th quarter of 2012/13 - 77** stroke patients completed the discharge home questionnaire, **70 out of 77** rated their overall journey as good, very good or excellent.

Feedback/issues arising from the discharge home experience questionnaire were fed back to the relevant trusts. Representatives from both North Middlesex Hospital and Barnet and Chase Farm hospital attend a monthly stroke pathway monitoring meeting where these findings are discussed. The feedback process has led to an improvement in patients' experiences.

The navigator provides six weeks review (Non CSRT) to stroke patients. This cohort of patients are either those that leave the HASU and are so high functioning need no community involvement, or patients who are at the other end of the spectrum and not referred to CSRT as no perceived rehab gains are possible. **In the 3rd and 4th quarter of 2012/13 -** 10 stroke patients received the six weeks review.

In **quarter 3 of 2012/13** the navigator received **27 new referrals** while **41 referrals** were received **in quarter 4. 68% of referrals in quarter 4** were from the **acute stroke unit, HASU and the community rehabilitation team, 27% were from family/Self-referrals and 10% from the voluntary sectors.**

Life Role Facilitator:

The Life Role Facilitator helps stroke survivors to re-integrate back into the community through the take up volunteering opportunities. The facilitator also undertakes the six month reviews for all stroke survivors.

In **quarter 3** 36 patients received the six month review, 7 patients returned back to work and 5 took up volunteering roles; in **quarter 4** 28 received the six month reviewed, 9 returned back to work and 3 took up volunteering roles.

Social Support

The service provides community based social support networks for stroke survivors, including awareness and secondary prevention. In the **4th quarter 8 referrals** were made to the team.

Outcome achieved – Stroke survivors

- 4 stroke survivors took part in the Stroke Ambassador development course
- 2 stroke survivors went back to driving

The carer forum which was set up by the social support team is doing well and they are working very closely with the Enfield Carers Centre. The forum is held quarterly.

Outcome achieved – Carers

- Stroke Centre offers respite to carers e.g. time out from caring
- Carers able to return back to work – x2, volunteering - x4 and training – x1

Befriending Scheme at North Middlesex Hospital:

The befriending scheme at North Middlesex Hospital is now up and running and has taken off really well. There are 4 ‘befrienders’ who are all stroke survivors. Each of befriender is assigned to a patient or group of patients on the stroke unit. They assist with activities that support communication, understanding of living with stroke and patient experience.

Post Stroke Reviews:

Six month review post stroke: undertaken by the life role facilitator:
In quarter 4 (Jan-Mar) 2012/13 100% (43) of stroke patients were offered the six month review, 65% (28) of those offered the review received it, 23% did not respond to offer and 9% refused the offer.

Six week review: undertaken by both the CRST and the navigator*
In quarter 3 (Oct-Dec) 2012/13 64% (60) of stroke patients received the six week review, 23% of clients not receiving six week review due to service issues, 1% due to patients choice and 12% was not applicable. Quarter 4 data not yet available

*This cohort of patients are either those that leave the HASU and are so high functioning need no community involvement or patients who are at the other end of the spectrum and not referred to CSRT as no perceived rehab gains possible

Discharge questionnaire: undertaken by the stroke navigator

In quarter 4 (Jan-Mar) 2012/13 100% (28) of stroke patients were offered the 10 day discharge questionnaire and 100% (28) completed the questionnaire. 93% rated their overall journey as good, very good or excellent

Psychological support for stroke survivors and family members

Enfield IAPT lead attended one of the monthly performance review meetings to update key stakeholders about the service. Established regular communication lines and the stroke support worker will monitor. IAPT noted they had received several referrals from the stroke team and were currently reviewing them. The IAPT lead will work with the stroke navigator to set up a workshop for stroke patients to enable more patients to feel comfortable to request for help from the IAPT team.

Referral to neuro-rehabilitation specialist inpatient services

The Community Rehabilitation / Early Supported Discharge team are gatekeeping referrals to ensure patients access the most appropriate pathway.