Review of Stroke Services in Tameside

Personal and Health Services Scrutiny Panel

July 2012

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Introduction by the Chair

I am very pleased to present this report of a review undertaken by the Personal and Health Services Scrutiny Panel into changes to stroke care and rehabilitation in Tameside and Glossop.

Stroke is a debilitating condition which can affect individuals at any point in life. Successful treatment and rehabilitation depends on early diagnosis and the expertise of specialised health professionals. Tameside has a high rate of stroke compared to our neighbours, underpinned by our high rate of cardiovascular disease (CVD). This Panel's previous reviews into obesity and CVD have examined closely the underlying risk factors leading to stroke and the prevention-based services being delivered in Tameside. They offer a foundation to this review and have informed the Panel's conclusions and recommendations.

The Panel has compiled this review in response to media reports in March 2011 that the Stroke Rehabilitation Unit was to be closed at the award-winning Lakes Care Centre. The Panel invited representatives from NHS Tameside and Glossop to explain the changes and the reasons behind them. In October 2011, the Panel received an update on the redesign of the stroke care pathway in Tameside and Glossop. In this review we are able to evaluate the process from start-to-finish, make conclusions on its success and recommend how further improvements can be achieved in future.

This review is published during a period of unprecedented change in the way in which our local health services are commissioned and delivered. The Panel is reassured that stroke will remain a priority for healthcare commissioners and providers at a local, regional and national level. As part of its overview function, the Personal and Health Services Scrutiny Panel will continue to monitor the effectiveness of stroke care services over the coming months and years.

On behalf of the Panel I would like to thank contributors to the review for their insight, expertise and assistance.

Councillor Brenda Warrington
Chair of the Personal and Health Services Scrutiny Panel

2. Summary

Stroke is a form of cardiovascular disease (CVD), a term covering a range of conditions affecting the heart, blood vessels and circulation. Underlying factors are broad, relating to both lifestyle and genetic determinants.

Tameside has a particularly high rate of admissions and mortality from stroke compared to England as a whole.

While care at the Stroke Rehabilitation Unit at The Lakes was independently regarded as consistently excellent, there was no clear pathway from acute to rehabilitative care for all stroke patients in Tameside and Glossop. This was acknowledged by the Care Quality Commission as an issue and prompted a redesign of services around stroke. This redesign included the closure of the Stroke Rehabilitation Unit, the opening of a new Combined Stroke Unit at Tameside General Hospital and the introduction of the Early Supported Discharge Team and Community Stroke Team managed by Tameside and Glossop Community Healthcare.

The stroke care pathway has been redesigned in line with best practice guidance from the National Stroke Strategy and Royal College of Physicians. According to NHS Tameside and Glossop, this has resulted in reduced hospital stays and improved patient satisfaction levels. The Lakes centre remains open as an intermediate care facility, greatly increasing the number of intermediate care beds available in Tameside. With more care being delivered in the community, the Panel will continue to monitor outcomes to ensure that patients are receiving the highest possible standard of care at each point in the stroke care pathway.

3. Membership of the Scrutiny Panel

(2011-2012)
Councillor B Warrington (Chair), Councillor D Cartwright (Deputy Chair) Councillors R Ambler, M Bailey, J Bowerman, W Bray, J Brazil, D Buckley, M Downs, J Middleton, E Shorrock.

4. Terms of Reference

Aim of the Review:

To assess the impact of changes to the structure of stroke care provision in Tameside, to ensure that residents who have suffered from stroke receive the best possible care.

Objectives:

1. To examine the mechanisms in place to treat and rehabilitate stroke patients in Tameside.

2. To assess whether the changes to stroke care provision in recent months have improved the service.

3. To ensure the effective delivery of stroke care and rehabilitation will remain a priority for commissioners under the proposed healthcare reforms.

Value for Money/use of Resources:

The repurposing of the Lakes Centre in Dukinfield, the opening of the new stroke care unit at Tameside General Hospital and extension of rehabilitative services in the community is intended to result in better quality care and better value for money.

Equalities issues:

Stroke can affect residents from all sections of Tameside's communities. It will consider how effectively stroke care services are treating vulnerable sections of the community.

Tameside Area Agreements:

Agreement, which supports the achievement of Community Strategy aims:
Healthy Tameside

Key Quality of Life Measures	Life Expectancy
	All-age-all-cause-mortality
Supporting Measures	Cardiovascular disease

5. Methodology

5.1 In April 2011, following the announcement in the press of changes to stroke care services in Tameside, the Panel met with Hilary Garratt, Director of Commissioning; Naomi Duggan, Director of Public Affairs; Alison Lewin, Associate Director of Commissioning; and Dr Bal Duper, Medical Director, all from NHS Tameside and Glossop.

5.2 In October 2011, the Panel received an update on the outcome of those changes from Alison Lewin, Associate Director, Primary and Community Services, NHS Tameside and Glossop; Adrian Griffiths, Director of Clinical Services, Tameside Hospital NHS Foundation Trust; Tom Wilson, Director of Commissioning, NHS Tameside & Glossop; John Schooling, Strategic Pathway Partnership Lead (Rehabilitation), Tameside & Glossop Community Healthcare (Stockport Foundation Trust); and Julia Worthington, Operational Lead for SPRINT and Community Stroke Team, Tameside & Glossop Community Healthcare (Stockport Foundation Trust).

5.3 Councillors Warrington, Shorrock and Ambler attend meetings of the Joint Mental Health Overview and Scrutiny Panel for Pennine Care NHS Trust. The Panel's meeting of 20 October received information on a public consultation being conducted by the NHS as part of its Healthy Futures Programme in Bury, Oldham, Rochdale and North Manchester. Information pertaining to services also delivered in Tameside has been included in this report.

5.4 Over the duration of the review, the Panel also met with range of agencies with respect to other areas of its work programme, including its review into cardiovascular disease. Though such meetings may not have covered stroke specifically, they have occasionally raised related risk factors and strategic issues. Relevant contributions have been included in this review.

6. Background of the Review

6.1 This review comes during a period of unprecedented change in the health service. The Health Bill currently being progressed by the Coalition Government will change the way in which health services are commissioned and delivered. At the time of writing, the reforms have yet to be passed through Parliament and as such are subject to change.

6.2 Stroke is a form of cardiovascular disease, a term covering a range of conditions affecting the heart, blood vessels and circulation. It occurs when the blood supply to part of the brain is cut off. Stroke may result in permanent damage to the brain, which can significantly impair speech, movement and cognitive function. Patients require access to specialised acute and rehabilitative care in order to minimise brain damage.

6.3 150,000 people suffer from stroke in the UK every year, from which 53,000 die. It is the third most common cause of death after heart disease and cancer. 450,000 people are currently disabled in the UK as a result of stroke. 20-30% of patients die within a month of suffering a stroke, but this figure is substantially reduced where hyper-acute care is delivered.

6.4 The National Stroke Strategy establishes a quality framework against which local services in England can make improvements, provides guidance to commissioners and informs the expectations of stroke patients and their families. Detailed clinical guidelines around stroke are provided by the Royal College of Physicians and National Institute for Clinical Excellence.

7. Review Findings

2.1.1 From February 2010 to January 2011, 386 patients of NHS Tameside & Glossop were admitted to hospital following a stroke. 148 of these (38%) were transferred to the Stroke Rehabilitation Unit at The Lakes in Dukinfield for ongoing rehabilitation.

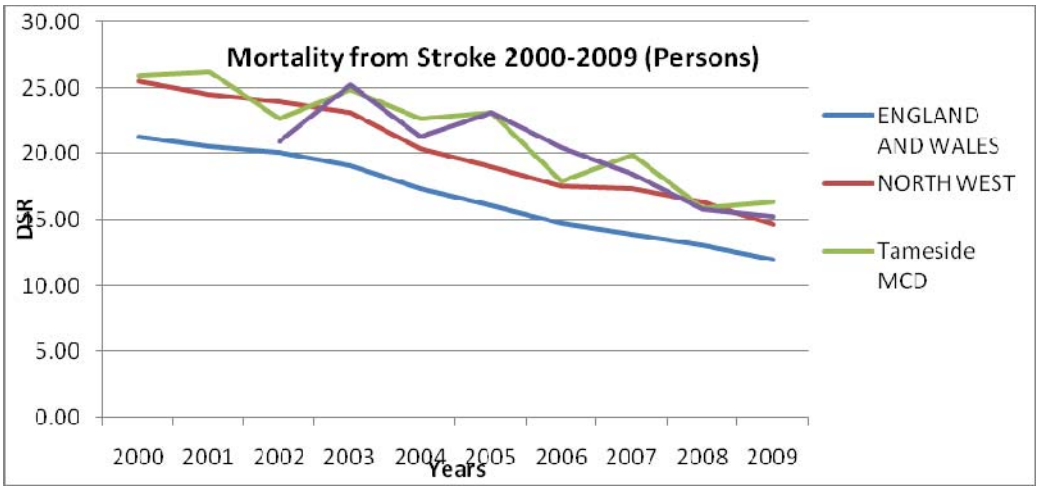
2.1.2 Tameside has a particularly high incidence of stroke, as illustrated in the table below (information from South East Public Health Observatory, 2011). The emergency admission rate for stroke in Tameside & Glossop has increased by 103.9% between 2003/04 and 2009/10. In England, it has decreased by 4.8%, and in North West it has decreased by 3.7%.

	Emergency stroke admissions (per 100,000)	Stroke mortality (under 75s per 100,000)	Stroke patients discharged home
Tameside & Glossop	139.9	16.5	84.2%
England Average	104.2	12.8	78.5%
England Worst	199.6	25.9	56.7%

2.1.3 The table below shows that, since 2000, the number of stroke deaths for people under 75 in Tameside has fallen significantly.

	PERSONS 2000	PERSONS 2001	PERSONS 2002	PERSONS 2003	PERSONS 2004	PERSONS 2005	PERSONS 2006	PERSONS 2007	PERSONS 2008	PERSONS 2009
ENGLAND	11218	10957	10688	10210	9332	8683	7992	7605	7225	6806
NORTH WEST	1897	1833	1794	1744	1539	1436	1330	1337	1259	1159
Tameside MCD	57	58	49	55	51	51	41	47	37	40
Tameside and Glossop PCT	63	67	52	64	55	59	54	50	43	43

2.1.4 The graph below shows how the Directly Standardised Mortality Ratio has also fallen over the same period.



2.1.5 In 2010, the Care Quality Commission looked at 15 aspects of stroke care. A national report was produced, with smaller reports for specific areas. These local reports took the form of a scorecard, with further detailed analysis of specific aspects of the stroke care in each area. The CQC review required the completion of a series of questionnaires and patient tracking exercises by NHS Tameside and Glossop, which included patients who were treated in the Lakes Stroke Rehabilitation Unit.

2.1.6 Each aspect of stroke care was rated on a scale of 1 to 5. A score of 1 means the service is worse than most other areas, with 5 meaning the service is better than other areas.

2.1.7 Tameside and Glossop was rated at 1 for 'providing early supported discharge' and 'for support following transient ischemic attack (TIA, also known as mini-stroke)'. It also received 2 for 'managing transfer home from hospital', for 'staying healthy a year after stroke' and for 'reviewing progress after people have left hospital'. However, Tameside and Glossop performed well in other areas. It was rated 5 for 'working together across health and stroke services' and 4 for 'helping people participate in community life', 'providing support and help for carers' and 'providing end of life care'.

2.1.8 The redesign of the stroke care pathway in Tameside and Glossop addresses the weaknesses identified in the Care Quality Commission report and builds upon the skills in areas where provision is better than other areas.

2.1.9 In March 2011, local media reported that the Stroke Rehabilitation Unit at the Lakes was to close, prompting the Panel to invite representatives from NHS Tameside and Glossop to explain the changes. The Panel believes that more extensive consultation with the public and engagement with patients could have been undertaken prior to the decision being made.

2.1.10 It was agreed that representatives of the relevant organisations delivering the new stroke care arrangements should return to the Panel to update on outcomes following the changes, as part of wider efforts to inform the public.

Conclusions

1. Tameside has a high incidence of stroke. Tameside and Glossop has a higher rate of emergency strokes admissions and a higher mortality rate among under 75s than the England average. However, the mortality rate has fallen since 2000.

2. Prior to the redesign of the stroke care pathway, stroke services in Tameside and Glossop had a number of strengths, including the excellent care delivered at The Lakes Stroke Rehabilitation Unit, collaborative working, end of life care and support for carers.

3. In its broad local report, the Care Quality Commission identified some issues where stroke care provision in Tameside was worse than most other areas and others where provision exceeded the average standard.

4. The changes to the stroke care pathway are intended to address CQC's concerns and build on Tameside's strengths.

Recommendations

1. That Tameside and Glossop's outlying rate of stroke admissions continues to be monitored and work continues to lower this rate.

2. That the public and patient groups are fully consulted in advance of future changes to services.

7.2 The new structure of stroke care and rehabilitation

7.2.1 Greater Manchester & Cheshire Cardiac & Stroke Network (GMCCSN) is responsible for delivering the National Stroke Strategy in the region. Since May 2010, GMCCSN has rolled out the 'hub and spoke' model for emergency response (also known as hyper-acute) and the Accelerating Stroke Improvement programme for long-term care.

7.2.2 The 'hub and spoke' model hinges around the comprehensive stroke centre at Salford Royal, two primary stroke centres at Fairfield and Stepping Hill and a range of local district stroke centres. Patients presenting stroke symptoms within 4 hours of onset are taken to Salford, Fairfield or Stepping Hill for hyper-acute care. When clinically appropriate, they are then referred to their local district centre for continued specialist care and rehabilitation, ideally within 24 hours, but within 3 days for the vast majority.

7.2.3 In addition to the hyper-acute model across Greater Manchester, a reorganisation of stroke care facilities has been initiated along the following lines:

- A full range of acute and rehabilitative services delivered within dedicated stroke wards (known as the Combined Stroke Unit).
- Establishment of a community-based Early Supported Discharge and Community Stroke Team
- The development of a community-based intermediate care unit at The Lakes site.

7.2.4 The Combined Stroke Unit at Tameside Hospital provides for 6-8 Acute Stroke Beds and 16-18 Stroke Rehabilitation Beds. The unit is staffed to Royal College of Physicians standards, including additional therapy staff. Acute beds are located close to Accident and Emergency and the Hospital also undertakes research and improvement projects including ImpRes, G-Master, SOS and Maestro.

7.2.5 The Combined Stroke Unit is an example of best practice in a range of areas. Patients receive 45 minutes active therapy each weekday. This may include physio, occupational, speech and language therapies as appropriate. The Unit meets the National Audit standards linked to multi-disciplinary, patient-focused goals ensuring that patients receive an individualised package of care specific to their clinical needs.

7.2.6 As patients move from acute to rehabilitative care, their needs are managed by the Early Supported Discharge Team (ESDT) and Community Stroke Team (CST), managed by Tameside and Glossop Community Healthcare, a division of Stockport NHS Foundation Trust. The ESDT and CST work together as a multidisciplinary team consisting of physiotherapists, occupational therapists, speech and language therapists, rehabilitation nurses, a clinical psychologist and therapy support staff. The teams are focusing on delivering care in the setting most appropriate for each individual, with the express aim of maintaining the quality and intensity of care patients would receive in hospital. Patients requiring specialist hospital equipment for their ongoing care will continue to be treated at the Combined Stroke Unit, until it is deemed clinically appropriate and safe to return home, with access to appropriate equipment.

7.2.7 Staff from the ESDT/CST hold a daily 'board round' with staff from the Combined Stroke Unit to update on the status of patients. This enables early identification of those patients who would most benefit from an early discharge and supports their smooth transition. A weekly multi-disciplinary team meeting is also held to collaborative plan discharge arrangements for all appropriate patients. Regular meetings also take place to discuss operational matters relating to the whole stroke care pathway.

7.2.9 The average length of intervention from ESDT is 6 weeks, with care delivered to meet Royal College of Physicians guidance. Patients still working towards realistic goals are able to access services from the CST for an average of 8 weeks beyond that. The CST determines the level of intervention based on the individual's clinical need; there is no Royal College guidance on the frequency of therapy input after 28 days.

7.2.10 All therapy is patient-centred, with goals set with the individual, dependent on their ability to do so. Intervention is not purely therapeutic, but also focuses on education to enable and encourage lifelong self-management among stroke patients. Patients are supported, where clinically possible, to live independently and return to work.

7.2.11 All patients score their performance and satisfaction at admission and discharge from the service. This feedback is used as an outcome measure.

7.2.12 Taking the system as a whole, all stroke patients now have access to a broad range of stroke professionals to support their recovery. This support includes specialised doctors and consultants, nurses and healthcare assistants, occupational therapists, physiotherapists, speech and language therapists, a neuropsychologist, social workers and wider support workers provided by the Stroke Association and NHS including dieticians, wheelchair services and orthoptists.

Conclusions

1. The Greater Manchester level hyper-acute model enables stroke patients to receive highly specialised care within 4 hours of onset.
2. The Combined Stroke Unit at Tameside Hospital brings acute and rehabilitative services under one roof, with care designed in line with national best practice standards.
3. The Early Supported Discharge Team and Community Stroke Team work on a multi-disciplinary basis to enable patients to continue their recovery at home as soon as is clinically appropriate, in line with national standards.
4. Coordination and collaboration between different parts of the stroke care pathway is strong. Staff meet on a regular basis to evaluate patient needs and discuss operational issues.
5. All therapy is patient-centred, with goals set with the individual, dependent on their ability to do so. Patients are only transferred from the Combined Stroke Unit to a community setting when it is clinically appropriate to do so.
6. The Lakes Care Centre will remain open and, following refurbishment, is now home to an intermediate care unit, increasing the capacity of intermediate care beds in Tameside and Glossop.

Recommendations

1. That staff from the Combined Stroke Unit, Early Supported Discharge Team and Community Stroke Team continue to work closely together on a daily basis.
2. That as the new stroke care pathway develops, the needs of individual patients are the primary consideration in any changes.
3. That Early Supported Discharge and Community Stroke Teams work closely with relevant community care providers in complex cases where a stroke patient is primary carer for another member of their household.
4. That the stroke care continues to be delivered in line with national best practice as determined by the Royal College of Physicians and National Stroke Strategy.

7.3 How has the new structure worked in practice?

7.3.1 In October 2011, the Panel received an update on the outcome of changes to the stroke care pathway from the Associate Director, Primary and Community Services, NHS Tameside and Glossop; the Director of Clinical Services, Tameside Hospital NHS Foundation Trust; the Director of Commissioning, NHS Tameside & Glossop; the Strategic Pathway Partnership Lead (Rehabilitation), Tameside & Glossop Community Healthcare (Stockport Foundation Trust); and the Operational Lead for SPRINT and Community Stroke Team, Tameside & Glossop Community Healthcare (Stockport Foundation Trust).

7.3.2 The introduction of the hyper-acute Greater Manchester-wide approach has resulted in significantly improved outcomes for stroke patients in Greater Manchester. 55% receive a brain scan within one hour.

7.3.3 The primary stroke centre at Fairfield, Bury has been independently assessed as being among the top 25% of hospitals for stroke care nationally. It is one of only 16 facilities to receive 95% of higher scores for 7 out of 9 indicators in the annual national clinical audit of stroke care, the Sentinel Survey.

7.3.4 The new model acknowledges that while the stroke rehabilitative care at The Lakes was delivered by dedicated staff to an excellent standard, capacity was limited to extend this expertise to all stroke patients. A clear integrated pathway of care for stroke patients over the course of their recovery was not in place across the whole system. The risk of the system becoming 'blocked' and unable to receive new patients has been substantially reduced.

7.3.5 The Panel is assured that the care pathway is well integrated and that staff from the Combined Stroke Unit, Early Supported Discharge Team and Community Stroke Team work together operationally on a daily basis and strategically on a weekly basis. It is important that such links are maintained in order to respond quickly and effectively to patient's needs.

7.3.5 An early patient satisfaction survey for the Combined Stroke Unit, conducted in September 2011, indicated very high levels of satisfaction with specific areas of care and the overall experience. The Panel welcomes that information on patient satisfaction is collected, but notes that this early consultation is based on the small sample size available at that time. Patient satisfaction will need to be monitored more formally as the service develops.

7.3.6 The new care pathway for stroke has significantly reduced the length of time that patients spend in hospital, in line with Royal College and National Stroke Strategy guidance and empirical research, which suggests that outcomes for stroke patients are greatly improved when they are able to receive treatment in their own home.

7.3.7 The table below indicates that, based on similar numbers of patients, the average length of hospital stay is significantly shorter under the new arrangements. This figure represents an average, with discharges based solely on medical need. The figures are indicative of increased capacity in the community care, in line with national guidelines and best practice.

7.3.8 Average length of stay in hospital for stroke patients before and since the service redesign

Acute Stroke and Rehab Inpatient Care	Number of patients admitted (April-August)	Average length of stay
Acute Stroke Unit and Stroke Rehabilitation Unit (2010)	149	July 2010 – 45.6 days
		August 2010 – 40.4 days
Combined Stroke Unit at Tameside Hospital (2011)	144	July 2011 – 21.5 days (85% home)
		August – 17.3 days (79% home)

7.3.9 The Panel considers that reducing the length of stay in itself is not a guarantee of improved outcomes, but is assured that stroke patients are only discharged from hospital when it is clinically safe and recommended to do so. Some patients may be more suitably treated in acute settings for a longer period of time than the average figure, whereas others are able to return home much sooner. The Council must work in partnership with the Early Supported Discharge Team to ensure patients have the necessary equipment and home adaptations to continue their recovery at home.

7.3.10 For the 21 week period between 15th May to 7th October 2011, 22 patients were referred to the Early Supported Discharge Team (ESDT), with an average length of stay of 25.7 days. The longest period spent by any single patient with the ESDT was 42 days. Patients have reported a 23% increase in their personal performance from admission to discharge (from 72% to 95%) and a 33% increase in satisfaction with performance (from 61% to 94%). The Panel is encouraged by these satisfaction rates, which indicate that the team is working effectively with patients to improve their condition and feelings about their condition.

7.3.11 Over the same 21 week period, 78 patients have been referred to the Community Stroke Team (CST), with an average stay of 40.4 days. The longest length of stay with CST was 56 days. Patients have reported at 37% improvement in their personal performance between admission and discharge (from 52% to 89%) and a 41% increase in satisfaction with performance (from 51% to 92%).

7.3.12 The Panel has been assured that there will be no loss of specialist stroke staff or skills in Tameside as a result of changes to The Lakes. Stroke Rehabilitation Unit staff are now employed either in the Combined Stroke Unit, the Early Supported Discharge Team or Community Stroke Team.

7.3.13 The Deputy Chief Executive for Tameside General Hospital has specified that specialist stroke staff in the Combined Stroke Unit will be focused solely on stroke and will not be used for general duties. In extremely busy periods, vacant beds within the Combined

Stroke Unit may be considered for use as a contingency, but staff from the Unit would not be assigned to general duties in these circumstances. The Panel has been informed that, as the commissioner, NHS Tameside and Glossop does not specify how staff are deployed but instead focuses on outcomes. If the outcomes specified by the commissioner are achieved, then this is an assurance that care is being delivered in an appropriate fashion.

7.3.14 The Panel has been assured that the time spent by community-based staff travelling to patients' homes will not reduce the quality or quantity of care they are able to deliver. Tameside and Glossop Community Healthcare has specified that patients will receive a high intensity of care that they would receive in a hospital setting, delivered to Royal College of Practitioners guidance. The Panel acknowledges the social benefits of group activities delivered in a ward setting to patient recovery. It is assured that patients who would benefit from such activities are still able to do so. The Panel will continue to monitor outcomes for patients in this area to ensure that staff time is effectively utilised in the delivery of care.

7.3.15 As the Royal College of Physicians does not offer specific guidelines on the frequency of therapy input after 28 days, it is important that patients can continue to access support from the Community Stroke Team as required. The Panel is encouraged that the pathway allows for this provision.

Conclusions

11. The introduction of the hyper-acute Greater Manchester-wide approach has resulted in significantly improved outcomes for stroke patients in Greater Manchester.
12. The new stroke care pathway aims to ensure all stroke patients have access to the full range of acute and rehabilitative services available in Tameside and Glossop.
13. Early indications show that patients are satisfied with the service provided by the Combined Stroke Unit, Early Supported Discharge Team and Community Stroke Team.
14. The length of time spent in hospital by patients has fallen significantly as a result of the new arrangements.
15. A number of aspects of the service exceed the minimum standard specified by Royal College of Physicians guidelines.

Recommendations

7. That stroke care providers in Tameside and Glossop engage with the relevant bodies at a Greater Manchester level to ensure that a strong link is maintained between hyper-acute services and local acute and rehabilitation services.
8. That patient satisfaction continues to be monitored closely.
9. That the Council works in partnership with the Early Supported Discharge Team to ensure patients have the necessary equipment and home adaptations to continue their recovery at home.
10. That specialist stroke staff in the Combined Stroke Unit are dedicated exclusively to stroke patients.
11. That the time spent by community-based staff travelling to patients' homes will not reduce the quality or quantity of care they are able to deliver.

8. Conclusions

8.1 Tameside has a high incidence of stroke. Tameside and Glossop has a higher rate of emergency strokes admissions and a higher mortality rate among under 75s than the England average. However, the mortality rate has fallen since 2000.

8.2 Prior to the redesign of the stroke care pathway, stroke services in Tameside and Glossop had a number of strengths, including the excellent care delivered at The Lakes Stroke Rehabilitation Unit, collaborative working, end of life care and support for carers.

8.3 In its broad local report, the Care Quality Commission identified some issues where stroke care provision in Tameside was worse than most other areas and others where provision exceeded the average standard.

8.4 The changes to the stroke care pathway are intended to address CQC's concerns and build on Tameside's strengths.

8.5 The Greater Manchester level hyper-acute model enables stroke patients to receive highly specialised care within 4 hours of onset.

8.6 The Combined Stroke Unit at Tameside Hospital brings acute and rehabilitative services under one roof, with care designed in line with national best practice standards.

8.7 The Early Supported Discharge Team and Community Stroke Team work on a multi-disciplinary basis to enable patients to continue their recovery at home as soon as is clinically appropriate, in line with national standards.

8.8 Coordination and collaboration between different parts of the stroke care pathway is strong. Staff meet on a regular basis to evaluate patient needs and discuss operational issues.

8.9 All therapy is patient-centred, with goals set by the individual. Patients are only transferred from the Combined Stroke Unit to a community setting when it is clinically appropriate to do so.

8.10 The Lakes Care Centre will remain open and, following refurbishment, is now home to an intermediate care unit, increasing the capacity of intermediate care beds in Tameside and Glossop.

8.11 The introduction of the hyper-acute Greater Manchester-wide approach has resulted in significantly improved outcomes for stroke patients in Greater Manchester.

8.12 The new stroke care pathway aims to ensure all stroke patients have access to the full range of acute and rehabilitative services available in Tameside and Glossop.

8.13 Early indications show that patients are satisfied with the service provided by the Combined Stroke Unit, Early Supported Discharge Team and Community Stroke Team.

8.14 The length of time spent in hospital by patients has fallen significantly as a result of the new arrangements.

8.15 A number of aspects of the service exceed the minimum standard specified by Royal College of Physicians guidelines.

9. Recommendations

9.1 That Tameside and Glossop's outlying rate of stroke admissions continues to be monitored and work continues to lower this rate.

9.2 That the public and patient groups are fully consulted in advance of future changes to services.

9.3 That staff from the Combined Stroke Unit, Early Supported Discharge Team and Community Stroke Team continue to work closely together on a daily basis.

9.4 That as the new stroke care pathway develops, the needs of individual patients are the primary consideration in any changes.

9.5 That Early Supported Discharge and Community Stroke Teams work closely with relevant community care providers in complex cases where a stroke patient is primary carer for another member of their household.

9.6 That the stroke care continues to be delivered in line with national best practice as determined by the Royal College of Physicians and National Stroke Strategy.

9.7 That stroke care providers in Tameside and Glossop engage with the relevant bodies at a Greater Manchester level to ensure that a strong link is maintained between hyper-acute services and local acute and rehabilitation services.

9.8 That patient satisfaction continues to be monitored closely.

9.9 That the Council works in partnership with the Early Supported Discharge Team to ensure patients have the necessary equipment and home adaptations to continue their recovery at home.

9.10 That specialist stroke staff in the Combined Stroke Unit are dedicated exclusively to stroke patients.

9.11 That the time spent by community-based staff travelling to patients' homes will not reduce the quality or quantity of care they are able to deliver.

10. Borough Treasurer's Comments

There are no direct financial implications as a result of this report, however if the service does not continue to improve and the number of cases increases then the demands and subsequent costs on adult services will increase.

11. Borough Solicitor's Comments

The legislation places a duty on the council to scrutinise the activities of any NHHS provision within thee area to ensure that it is providing the necessary care and health wellbeing to the community it serves. It has been just over a year since this work was commenced and some four months since progress was reviewed. It will bee important for Members to under stand exactly from thee Chief Executive and the Chair of the Trust, who are attending the meeting, what progress has been made and any input the recommendations have had on patient outcomes and next steeps.