

Does having a collaborative stroke pathway work to improve patient flow and experience

Richard Lee – Stroke Clinical Lead Physiotherapist

INTRODUCTION

- The Northamptonshire Stroke Pathway consists of Northampton General Hospital, Isebrook Hospital and Community Stroke Team
- SSNAP guidance recommends acute stroke patients are admitted straight into a Hyper-Acute Stroke bed with Sentinel Stroke National Audit programme auditing services with target of admission within 4 hours. Northampton General were working to approximately 40% of expected target
- A Multi Agency Discharge Event (MADE) was carried out across Northamptonshire looking at community rehab beds aiming to improve efficiency and to improve flow that would have a positive impact for acute hospitals within the county.
- Following on from this a task and finish group was set up to review Stroke Patients requiring these beds. As recommended by the NHS Long Term Plan 2023 trusts and services should look at a new way of working that will draw together people, capabilities, resources, activities and leadership to collectively deliver greater value for the NHS and for patients.
- Current method of working was for patients requiring ongoing inpatient rehab to be referred to Isebrook, this would then be accepted without any discussion between stroke specific professionals. Patients would then be transferred as and when a bed became available with an email handover provided for therapy staff to follow.

PURPOSE

Focus on guidelines and trust challenges to reduce LOS for patients requiring extended inpatient rehab

Feedback from patients who had experienced the whole pathway, via patient forums, told us that they felt like we were not one pathway, everyone did it differently, and this contributed to anxiety pre and post transfer impacting experience, quality of rehab and potentially extending LOS

Improve door to HASU bed time in accordance with SSNAP Guidance

Reduce Length of stay at both NGH and Isebrook

Improve communication across the pathway, encouraging connections amongst professionals

Improve patient experience of transition between aspects of the pathway. Aiming to have patients feel like we are one connected pathway

METHOD

Initial meeting with professionals across pathway

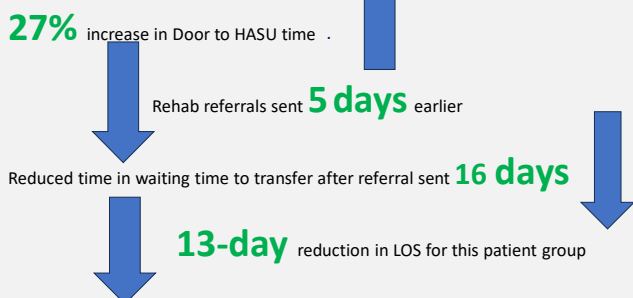
Agreed to commence weekly MDT aiming to review patients requiring extended rehab to identify needs / suggest alternative discharge options

Shared contact details and installed verbal handover instead of email

Review of processes at NGH, earlier discussions with patients, relatives and submission of Discharge Referrals

Identified challenges community hospitals face with complex social issues such as housing, linked into complex d/c nurse and council leads to support these issues

Results



- ✓ Increased staff confidence + communication across the pathway
- ✓ Enhanced awareness of stroke pathway with higher management teams
- ✓ Opened new links to social service leads for support with complex social issues
- ✓ Approx 20% patients referred having discharge plans reviewed and changed
- ✓ Aim to repeat patient forum to re-evaluate patient experience

DISCUSSION/IMPLICATIONS

Having a collaborative pathway works to improve patient flow and experience

By reviewing current processes and being encouraged to have blue-sky thinking we have been able to introduce a different way of working to review our patient's needs. This has highlighted different challenges at each stage of the pathway which have then been escalated to higher management for support, but also allowed for understanding amongst professionals to be supportive and work in ways to make a patient's journey run smoother. This has been demonstrated with our reduced LOS for this patient cohort, and improved times for door to HASU bed admissions.

We are aiming to hold a repeat patient forum in the coming months to receive patient feedback on the pathway and changes implemented.

By doing this piece of work we raised the profile of the Stroke Pathway at NGH and have been supported in other new ideas such as extended leave to support discharge planning for patients with cognitive impairments and had the opportunity to present the work on the CEO Briefing.

Therapists at Isebrook have reported verbal handovers and weekly updates on patient progress via the meeting to have improved their ability to understand patients' needs sooner

References

NHS Long-term Plan (2023) NHS Long Term Plan » A new way of working. <https://www.longtermplan.nhs.uk/online-version/chapter-7-next-steps/a-new-way-of-working/#:::text=7.7.,of%20the%20long%20term%20Plan.>

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Northampton General Hospital
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