Hyper Acute Stroke Unit (HASU) Arrangements for Bradford, Airedale, Wharfedale and Craven

Patient and Public Engagement Report

September 2015

Report produced by
Appendices

Appendix 1: Stroke communications and engagement action plan .............. 26
Appendix 2: Summary of finding from existing data ........................................... 28
Appendix 3: Stakeholder analysis ................................................................. 32
Appendix 4: Discussion group schedule ......................................................... 34
Appendix 5: Survey questionnaire ................................................................. 37
Appendix 6: Patient leaflet ........................................................................... 38
Appendix 7: Findings from one to one interviews with Airedale, Wharfedale and Craven patients/carers ............................................................ 39
Appendix 8: Findings from Bradford CCGs patient stories ................................ 44
Appendix 9: Stroke, carers and ‘at risk’ discussion groups .................................. 46
Appendix 10: Findings from discussion groups .................................................. 47
Appendix 11: Findings from survey questionnaire .............................................. 55
Appendix 12: Findings from patient leaflet feedback forms .................................. 68
Appendix 13: Findings from social, digital and traditional media ...................... 70
EXECUTIVE SUMMARY

Background
A local partnership of hospital providers and GP commissioners have been working together to improve stroke services for people living in Bradford, Airedale, Wharfedale and Craven. This work, coupled with the difficulties Airedale General Hospital (AGH) has had providing a hyper acute stroke unit (HASU), due to a national shortage of stroke consultants, resulted in a decision to relocate the existing HASU at AGH to Bradford Royal Infirmary (BRI). The creation of a single HASU for the whole district will ensure that anyone who has a stroke receives consistent and safe care.

This decision was discussed in some detail by both Bradford Metropolitan District Council’s Health and Social Care Overview and Scrutiny Committee and North Yorkshire County Council’s Scrutiny of Health Committee. In light of the evidence presented on best national practice, and the recruitment issues at AGH, both Committees accepted it would not be appropriate to have a formal 12 week consultation and, supported instead the proposal for a public engagement exercise.

The engagement exercise, carried out in line with the ‘Communication, Engagement and Equality Strategy’ and action plan, aimed to:

- communicate the change in HASU arrangements
- understand the impact the change would have on local people
- find out what was important to people when accessing stroke services
- identify areas for potential service improvements

Engagement Process
A range of methods including; patient/carer interviews, patient stories, discussion groups, a survey questionnaire and patient leaflet feedback forms were used. This enabled both quantitative and qualitative data to be collected from as broad a range of people as possible.

Social, digital and traditional media was used to raise awareness of the changes to stroke services and publicise the ways in which people could share their views to ensure everyone had an opportunity to take part. The CCGs and hospital providers also shared information with key stakeholders and staff, using newsletters, bulletins and their websites.

A range of engagement activities took place over a nine week period, from 13 July to 11 September 2015, and over 300 people’s voices (views, opinions, insights, comments, experiences and suggestions) were heard.

Benefits and Challenges
The engagement process identified a number of benefits and challenges in relation to creating a single HASU.
The benefits were identified as:

- having access to a 24/7 specialist facility with more stroke consultants and specialised staff on one site
- better and quicker care/treatment for stroke patients and families and improved patient outcomes
- the ability of a larger and more specialised centre to attract more funding
- more expertise, resource and staff to enable patients, carers and families to be kept better informed and given more advice and support
- not being transferred to another hospital.

The challenges were identified as:

- the time, cost and distance of travel for family and friends to visit their relatives at the BRI, particularly for those living in the Airedale, Wharfedale and Craven areas
- the effect the extra distance could have on the treatment and outcomes for stroke patients in Airedale, Wharfedale and Craven
- the difficulties and cost associated with parking at the BRI
- the impact the change would have on existing services at BRI, which are already seen to be stretched in terms of both capacity and facilities.

**Key Themes**

The engagement exercise identified five key themes in relation to both people’s concerns and suggestions for improvement. These are detailed below:

1. **Discharge and aftercare**
   
   Concerns were raised about aspects of discharge, rehabilitation and aftercare. These covered a wide range of specific issues including a reported under provision of speech therapy and physiotherapy; gaps in the provision of emotional support for patients, carers and family members, along with a lack of consistency when providing aids and adaptations to patients.

   It was suggested there should be an increased focus on re-enablement and recovery and that more resources be put into rehabilitation and aftercare services as getting the right information and support were deemed important to aid patient recovery and relieve anxiety and stress for patients and carers.

2. **Travel, transport and parking**

   The distance, time and cost to travel, along with the challenges of parking at BRI, were a concern. People were worried not only about how the extra journey time could affect the treatment and outcome for stroke patients living in Airedale, Wharfedale and Craven but also how this would impact on the ability of carers and families to visit their loved one at this critical time, particularly those reliant on public transport.
Suggestions to address the concerns highlighted included providing help with travel costs for immediate family members e.g. a travel card, extended or open visiting times in order to avoid peak travel times, and some level of concession for parking.

3. **Treatment and care**

   There were concerns about moving the existing HASU at AGH to BRI and the impact, the additional distance, time and potentially different levels of service could have on the treatment and outcome of stroke patients living in Airedale, Wharfedale and Craven. Concerns were also raised for those people who self-present at AGH A & E not realising they are having a stroke; then having to be transferred to BRI before receiving treatment.

   Suggestions proposed in relation to improving treatment and care included improving ambulance response time, ensuring there is a sufficient number of acute beds and creating a joined up fast track service from 999 and arrival through to assessment, tests and treatment.

4. **Staff**

   Whilst there were many positive comments in relation to staff and the care they provide, especially on Ward 5 at AGH, there were concerns about inadequate staffing levels, particularly specialist stroke staff and how staff shortages can result in delayed response time and limited contact time for patients. Also raised was whether general and agency nurses had the level of knowledge and skill, required for stroke care. There were also concerns raised in relation to the poor attitude of some staff and the impact of this on the patient/carer experience.

   It was suggested that more specialist stroke staff were needed and that stroke training should be provided for general and agency nurses and, A & E staff.

5. **Information and Communication**

   The need for improved information and communication between staff, patients and carers and between departments and across organisations were highlighted. In particular was the need of stroke patients and carers’ to understand what has happened to them/their loved one during and after the stroke. Also raised was the need for appropriate forms of communication to be used with those patients whose ability to communicate has been impaired by the stroke.

   It was suggested more information and advice about strokes and after care was required and that the patient information currently provided is reviewed to ensure it is easily understood and fit for purpose.
Recommendations
A total of 16 specific recommendations, detailed below, are proposed to address the concerns and suggestions highlighted by the key themes.

1. Form a time limited task group with representatives from all relevant organisations involved in providing and commissioning rehabilitation and aftercare services including patient and carer representatives to:
   - review the discharge process and rehabilitation and aftercare services,
   - develop a standardised, uniform and seamless rehabilitation and aftercare service,
   - ensure patients and carers receive a tailored discharge and aftercare plan which is flexible and specific to their changing needs

2. CCGs together with Bradford Metropolitan District Council and North Yorkshire County Council look into commissioning a wider range of integrated community rehabilitation and aftercare services in line with needs analysis and following national best practice guidance. Work with patients and carers in designing expanded range of services.

3. Review visiting times on the HASU to avoid them coinciding with peak travel times.

4. Review the cost of parking to ascertain if some level of concession could be provided for immediate family members visiting their relatives on the HASU.

5. Explore if transport links between Airedale, Wharfedale and Craven areas can be improved e.g. establish the demand for a special bus to run between AGH and BRI to coincide with visiting times.

6. Establish a system to monitor the time it takes for patients from Airedale, Wharfedale and Craven to reach the HASU when compared with patients from Bradford, and ascertain if this is related to any difference in the patients’ treatment and outcomes. Take remedial action if any differences are found.

7. Monitor the outcomes of stroke patients from Airedale, Wharfedale and Craven compared to stroke patients from Bradford.

8. Use data from the Sentinel Stroke National Audit Programme (SSNAP) to compare the performance of the single HASU against the two previous HASU's at BRI and AGH to cover:
   - the time from calling 999 to arrival on the HASU,
   - the time from arrival in A & E at either AGH or BRI to being admitted to a HASU bed for patients from both Bradford and Airedale Wharfedale and Craven
9. Review the impact of the change on patient treatment and outcome and provide feedback to participants of this engagement process.

10. Staffing levels, training and mechanisms for dealing with staff shortages should be reviewed across the HASU to ensure the service achieves a standard of care commensurate with a centre of excellence.

11. Review the staffing levels and training of staff involved in the treatment, care, rehabilitation and aftercare of stroke patients, their carers and families, to ensure sufficient numbers of well trained staff in stroke care are available to support them throughout their full stroke journey and care pathway.

12. People recovering from stroke, their carers and family members are particularly vulnerable, ongoing feedback by questionnaire should be sought, and intermittent more intensive feedback by questionnaire and interview should be carried out to ensure the standards of care, and services provided by staff are effectively monitored and reviewed.

13. Review current information provided to stroke patients, carers and families to:
   - ascertain if it meets the needs of patients, carers and family members,
   - identify any gaps,
   - ensure it is easily understood, relevant and appropriate.

14. Explore the possibility of co-designing a Stroke Folder with and for stroke patients and their carers that includes information and resources they deem important and necessary.

15. Prepare and publish a formal response to the questions raised during discussion groups and circulate this to the 15 discussion groups that participated in the engagement process. Produce a plain English summary version of this report and circulate to all who contributed to the engagement exercise. Publish both the full report and plain English summary report on relevant websites, conventional and social media, and make it available in other formats as requested.

The Partnership are asked to:

1. Agree, prioritise and own the recommendations.
2. Discuss the recommendations further to ensure they are meaningful, unambiguous clear proposals underpinned by ‘SMART’ (Specific, Measurable, Attainable, Realistic, Timely) objectives, where possible.
3. Formulate an action plan for implementation.
4. Provide timely feedback to participants of the engagement process so that people are aware of the outcome of sharing their views and, how these will be used to inform and influence stroke services.
1. BACKGROUND

Hyper Acute Stroke Units (HASU) provide 24 hour a day intensive care for people in the first crucial hours after a stroke. Until August 2015, people having a stroke in Airedale, Wharfedale and Craven received hyper acute stroke services at Airedale General Hospital (AGH) whilst people in Bradford received theirs at Bradford Royal Infirmary (BRI). In 2014, AGH treated over 300 confirmed strokes and BRI treated over 600.

For some time, AGH has had problems providing a hyper acute stroke service due to a national shortage of stroke consultants. In England, the shortage means that about 46% of consultant posts are vacant. As a result, despite trying to recruit, AGH has not been able to secure a permanent consultant team. Since March 2014, people living in Airedale, Wharfedale and Craven who have a stroke during evenings and weekends and who require hyper acute stroke services, have been transferred to the HASU at BRI which does have a permanent consultant team. Following treatment on the HASU, which is usually between 24 and 72 hours, Airedale, Wharfedale and Craven patients are transferred back to AGH for the rest of their care.

A local partnership has been working to improve stroke services for people living in the area. The Partnership includes hospital providers (Airedale NHS Foundation Trust and Bradford Teaching Hospitals NHS Foundation Trust), and GP commissioners (NHS Airedale, Wharfedale and Craven, NHS Bradford City and NHS Bradford District Clinical Commissioning Groups). The Partnership has been supported in their work by NHS England, the Yorkshire Ambulance Service and the Strategic Clinical Network for Stroke. They have been using national best practice guidelines which state that an effective HASU needs a minimum of 6 stroke consultants, trained in thrombolysis available 24 hours, seven days a week to treat 600 or more suspected strokes per year.

To deliver to national best practice the decision was taken to move the two existing hyper acute stroke beds from AGH to BRI in order to create a single HASU at BRI for the whole district.

This decision was discussed in some detail by both Bradford Metropolitan District Council’s Health and Social Care Overview and Scrutiny Committee and North Yorkshire County Council’s Scrutiny of Health Committee. Both raised a number of questions and issues which representatives of the Partnership responded to, presenting the evidence on national best practice. In light of this evidence and the recruitment issues at AGH both Committees accepted it would not be appropriate to have a formal 12 week consultation and supported instead the proposal for a nine week public engagement exercise.

The single HASU has now been operating since 1 August 2015 and in line with national recommendations, has six beds to treat the number of confirmed strokes in the district. It will deliver emergency stroke care all year round with six specialist stroke consultants available on a 24/7 rota to provide patients with critical diagnosis and treatment. The single
HASU will ensure delivery of the best possible outcomes for patients who suffer a stroke and provide high quality, safe and resilient care.

The diagram below shows the way the service will work for patients living in the Airedale, Wharfedale and Craven areas from August 2015. Patients living in Bradford needing care on a HASU, will continue receiving services at BRI. Patients living in the outlying areas of Bradford, Airedale, Wharfedale and Craven will be taken by ambulance to the nearest hospital with a HASU. This could be the BRI or alternatively Leeds, Harrogate or Blackburn, for example.

Acute stroke and rehabilitation services will continue to be delivered at AGH and BRI.

2. ENGAGEMENT PROCESS

2.1 Aim and Objectives
The primary aim of the engagement process was to communicate the change in HASU arrangements and understand the impact this would have on local people. It also aimed to find out what factors are important to people when accessing stroke services and identify areas for improvement.

The objectives were to:

- explain how stroke services would look in the future and why the change is necessary
- communicate how the change would affect services for people living in the Bradford, Airedale, Wharfedale and Craven areas
- gain people’s views on current stroke services provided at both AGH and BRI
- understand what is important to people when accessing stroke services
- identify any issues not previously considered
- identify areas for potential service improvement
- accurately report on the views of local people and feedback how those views will be used by the Partnership to influence the stroke service
As part of the engagement process, a detailed communications and engagement action plan was developed as detailed in appendix 1.

2.2 Use of Existing Data
Existing data evidencing patients’ , carers’ and public views about stroke services in Bradford, Airedale, Wharfedale and Craven was gathered from a variety of sources. This was analysed and a summary of the findings are included as appendix 2.

2.3 Methodology
The engagement process was conducted over a nine week period from the 13 July to 11 September 2015.

A stakeholder analysis, as detailed in appendix 3, was completed to identify the people, groups and organisations who may have an interest in the changes to stroke services.

A variety of engagement methods, as detailed below, were used to enable both quantitative and qualitative data to be collected from as broad a range of identified stakeholders as possible.

- one to one interviews
- discussion groups
- survey questionnaire
- patient leaflet feedback form
- social, digital and traditional media to promote the questionnaire and seek more views

One to one semi structured, face to face or telephone interviews, were conducted with stroke patients or their carers who lived in the Airedale, Wharfedale and Craven areas.

In addition stroke patients’ stories, gathered during 2013 -2015 by NHS Bradford City and NHS Bradford Districts CCGs, were also used.

Discussion groups, using the discussion group schedule, as detailed in appendix 4, were held with stroke groups, carers groups and ‘at risk’ groups, who were both willing and able to engage in the process during the specified engagement period. A short film explaining the reasons for the changes in stroke services was made by the NHS and shown at a number of the discussion groups, where time and format of the group allowed.

A survey questionnaire, as detailed in appendix 5, was developed and made available electronically via survey monkey and in hard copy. This was advertised and promoted widely and featured alongside information about the changes in stroke services.

A patient leaflet, as detailed in appendix 6, was produced which explained the changes to services and included a feedback form, returnable via a freepost address.
Social, digital and traditional media was used to publicise and raise awareness of the changes to stroke services and to market the survey questionnaire and patient leaflet as widely as possible. Information featured on the websites of AFT, BTHFT, and the three CCGs and was advertised and promoted via internal newsletters and bulletins as well as externally in the local press and on local radio stations.

In addition, approximately 30 groups detailed on the stakeholder analysis were sent an email about the changes to stroke services, which detailed how they and their members could get involved. This included a direct link to the survey questionnaire and to NHS Airedale, Wharfedale and Craven (AWC) CCG’s ‘have your say on stroke services’ webpage which included a link to the patient leaflet.

People were also given the opportunity to feed into the engagement process by emailing their views to engage@awcccg.nhs.uk, telephoning AWC CCG or by sending their views in writing, via a freepost address, to the Patient Advice and Liaison Service (PALS). This was advertised and promoted in the same ways as both the survey questionnaire and patient leaflet.

3. SUMMARY OF FINDINGS

3.1 One to One Interviews

Five people, three stroke patients and two carers, took part in the one to one interviews. The detailed findings can be found in appendix 7.

On suffering a stroke all patients were first taken to the Accident and Emergency (A & E) department at AGH where three were then admitted to the HASU. The remaining two patients were transferred to the HASU at BRI for initial treatment and then transferred back to Ward 5, the acute stroke ward at AGH.

The interviewees were asked to rate their HASU experience. The knowledge, skills and attitude of staff, along with the support given to carers and families, were rated as good or excellent. The communication between staff and patients, along with sharing information between hospitals and services were rated as satisfactory or above and all stated that they received the information, support and advice they needed when leaving hospital.

Interviewees were also asked to identify areas that worked well or could be improved, along with the potential benefits or challenges of creating a single HASU. The details are shown below.

The areas identified as working well, were:

- physiotherapy services whilst in hospital
- home assessment when discharged
- staff on Ward 5, along with the treatment and care given
The areas identified for improvement, were:

- support following discharge from hospital
- information and communication, in particularly interviewees highlighted a desire to know and understand exactly what had happened to them/their loved one during and following the stroke
- treatment and care, with an extended wait in A & E and a transfer back to AGH in the early hours of the morning being specifically highlighted

The potential benefits of the single HASU identified, were:

- not being transferred to another hospital
- having access to a 24/7 specialist facility with specialised staff

The challenges of the single HASU identified, were:

- parking at the BRI and the proximity of the facilities to the main hospital building
- travel and transport - the time, cost and distance for family and friends to visit their relative at the BRI, especially for those using public transport and, the impact the extra distance to travel could have on the treatment and outcome of stroke patients in Airedale, Wharfedale and Craven

Finally interviewees were asked what would help to make the service run well. Detailed below is a summary of the suggestions made. A full list of the suggestions made can be found in the detailed findings included as appendix 7.

Suggestions to make the service run well:

- more physiotherapy after discharge from hospital
- a more consistent approach to the provision and fitting of aids and adaptations
- improve the quality of home care services, reduce variability of care workers
- ensure the single HASU at BRI replicates the warmth, friendliness and high visibility of the staff on Ward 5 at AGH

In addition, four stroke patients, who shared their experience previously with the Bradford CCGs, highlighted areas that worked well and suggested some improvements. The detailed findings can be found in appendix 8.

Two patients received treatment at the BRI, one of whom was subsequently transferred to St Luke’s Hospital. One patient received treatment at Calderdale Hospital before being transferred to the BRI and then to St Luke’s Hospital for rehabilitation. The remaining patient received treatment at AGH.

The areas identified as working well, were:

- support from GP Practices
- aids and adaptations
The areas identified for improvement, were:

- support following discharge from hospital, for example: social services, speech therapy, along with emotional support and access to benefits
- information and communication
- staffing levels
- waiting times in accident and emergency

### 3.2 Discussion Groups

A total of 15 discussion groups, attended by 249 people, were held with a range of stroke, carers and ‘at risk’ groups. The detailed findings can be found in appendix 10.

Firstly, groups were asked to discuss what might be good about the change in the stroke service, and what potential benefits for patients, carers, families and friends this change may bring.

The following benefits were highlighted:

- more consultants and specialised staff on one site
- move to BRI is seen as positive and good in principle though Bradford groups were generally more in favour than those groups in Airedale Wharfedale and Craven
- more benefits for people in Bradford as a result of the single HASU been located at BRI
- better and quicker care/treatment for stroke patients and families and improved patient outcome
- ability of a larger and more specialised centre to attract more funding
- more expertise, resource and staff to enable patients, carers and families to be kept better informed and given more advice and support

Secondly, groups were asked what concerns they thought patient, carers, families and friends might have about the change in service and what might be less good about the new model.

The following concerns were highlighted:

- **Travel and transport for carers’ and families** – carers/families may struggle to travel to the HASU to visit their loved ones, especially the elderly, those living in rural areas and people using public transport. Both cost and travel time were seen to be problematic.

- **Travel and transport for stroke patients** – how the extra distance might affect the treatment and outcome for stroke patients in Airedale, Wharfedale and Craven. There was also concern for those who attended A & E at AGH not realising they were having strokes; then having to be transferred across to BRI.

- **Parking at BRI** - the difficulties and costs associated with parking at the BRI.

- **Support following discharge** – the insufficient information and support for patients and carers following discharge from hospital e.g. benefits advice, speech therapy and
information about local voluntary organisations. It was suggested more resources be invested into discharge, rehabilitation and aftercare, which is considered to be important to aid recovery and relieve stress.

- **Impact of the changes on BRI** – concerns about whether BRI has the capacity and facilities to cope with additional patients. The availability of beds at BRI were highlighted as a particular concern.

- **Staffing levels and skills** – concerns about the number of specialist stroke staff, especially specialist nurses, and the lack of knowledge and skills of general and agency nurses, required for stroke care. Also whether BRI has sufficient staffing levels to cope with the extra demand.

- **Location of the single HASU** - some groups suggested the single HASU should have been located at AGH rather than BRI, highlighting the importance of keeping services local and, the recent investment and refurbishment of the A & E department.

- **Quality of services at BRI** - it was suggested that communication and staff attitudes need to be reviewed, to improve patient experience.

Finally, the groups were asked what would help to make the service run well. Detailed below is a summary of the suggestions made. A full list of the suggestions made can be found in the detailed findings included as appendix 10. This also includes details of the 21 questions raised during the discussion groups which the Partnership are recommended to respond to (see section 4, page 23).

**Suggestions to make the service run well:**

- improve information and invest in more community rehabilitation and support services that last longer, for example physiotherapy, speech therapy, emotional support for both stroke patients and their carers and the provision of voluntary and community sector support services
- provide help with travel costs for immediate family members, provide some level of concession for parking, extend visiting hours
- increase the numbers of stroke specialist staff in all areas, drive up standards
- improve ambulance response times
- improve information and communication, both on the ward and for and after discharge

**3.3 Survey Questionnaire**
The questionnaire had two sections:

- the patient’s stroke experience in part A
- the changes to local stroke services in part B

The survey was started by 50 people and completed by 40 people. The detailed findings can be found in appendix 11. Nineteen stroke patients and 16 carers completed Part A. Following this they were expected to complete part B, along with the 5 respondents who were neither stroke patients nor carers. However only 34 did so.
Part A
The stroke patients and carers were asked to rate their experience on the HASU and the areas below were rated as satisfactory or above, by the majority of respondents:

- communication between staff and patients/carer/family
- the knowledge, skills and attitude of staff
- information sharing between hospital and with other services
- support given to carers and families

Those surveyed were asked if they received the information, support and advice they needed when leaving hospital. Less than half said they did, the remainder either said they did not or only partly. The respondents who answered no or felt they had received only some information, were asked to identify what more they needed. Two important areas were identified:

Support following discharge from hospital:
- support groups
- emotional support
- mobility aids
- medication

Information and communication:
- more information about how strokes can impact on the mental and physical health of both patients and carers
- information in formats easily understood by patients whose ability to read and write has been impaired
- benefits advice
- better communication between staff and patients/carers

Respondents were asked to identify areas that worked well or could be improved, based on their own experience of stroke treatment and care.

Areas identified as working well:
- **Quality of treatment and care** – six positive comments related to AGH, 4 related to BRI and 2 related to the rehabilitation ward at St Luke’s Hospital.

Areas identified for improvement:
- **Treatment and care** – the negative attitude of some staff and a need for staff to have a better understanding of stroke symptoms and its effects were highlighted.
- **Information and communication** - more information and advice about strokes and after care was recommended, as was better communication across services and departments and between staff and the carer/family.
• **Support following discharge from hospital** - more local services for stroke survivors, and improvements in the quality of care packages and speech therapy were highlighted, together with the need for an ongoing assessment of patients’ needs.

• **Staffing levels** - staff shortages hence busy staff, resulting in delayed response times and limited contact time for patients.

**PART B**

Respondents were asked about the potential benefits and challenges of creating a single HASU.

**Potential benefits of the single HASU identified were:**

- patients will be seen quicker, improving their outcomes
- the move to BRI is positive and good in principle
- stroke specialists and skilled staff will have access to 24/7 specialist services

**Potential challenges of the single HASU identified were:**

- **Travel and transport for carers’ and families** - the time, cost and distance of travel for family and friends to visit their relatives at the BRI, particularly for those living in the Airedale, Wharfedale and Craven areas and, reliant on public transport.

- **Travel and transport for stroke patients** – The effect the extra distance to travel could have on the treatment and outcomes for stroke patients in Airedale, Wharfedale and Craven.

- **Parking at the BRI.**

Finally, respondents were asked what would help to make the service run well. Detailed below is a summary of the suggestions made. A full list of the suggestions made can be found in the detailed findings included as appendix 11.

**Suggestions to make the service run well:**

- increase the numbers of specialist stroke staff in all areas
- provide stroke training for A & E staff, general and agency nurses and GPs
- improve communication both between health professional, patients, carers and families and department and services
- increase the focus on re-enablement and recovery
- ensure care and support is in place upon discharge and provide information about support services available in the community
- ensure the post hospital stroke care pathway runs in conjunction with the voluntary sector.
3.4 Patient Leaflet Feedback Form
A total of 14 people returned the patient leaflet feedback form. The detailed findings can be found in appendix 12.

Respondents were asked what they thought would be the benefits and challenges of the change in service. Improved and more efficient treatment and care for patients was highlighted as the main benefit, whilst the travel and transport to, and the parking at, BRI, was identified as the main challenge. There was particular concern surrounding the distance to BRI, both in terms of how this could affect patients’ treatment and outcome, and the ability of carers and families to visit their loved ones.

Respondents were also asked what would help to make the service run well. The following suggestion were made:

- for patients, carer and families to be kept informed of what is happening at each stage of the stroke journey
- for staff to use simple, non-medical terms when communicating with patients, carers and families
- more information and support on discharge from hospital
- a fully staffed service, with a sufficient number of beds

3.5 Social, Digital and Traditional Media
There were seven responses received via social, digital, and traditional media. The detailed findings can be found in appendix 13.

A number of comments were made, as detailed below:

- Three people highlighted concerns about the change to a single HASU at BRI, suggesting travel, transport and parking would be an issue. They were particular concerned as to how this could affect patients treatment and outcome, and carers’ and families’ ability to visit their loved one.
- Two people criticised the use of the term “stroke victims” in an article published by the Telegraph and Argus, suggesting “stroke survivors” would have been a more appropriate term
- One person commented on the inadequate provision of physiotherapy and speech therapy following discharge
- One person enquired if psychological support would be integrated into the review of stroke services.
- One person complemented the excellent service they had received on Ward 5 at AGH
4. Key Themes and Recommendations

Analysis of the data gathered from the above engagement methods highlighted a number of key themes. These are detailed below, along with recommendations to address them.

4.1 Discharge and Aftercare

Concerns were raised about aspects of discharge, rehabilitation and aftercare. These covered a wide range of specific issues which are detailed below but generally highlighted the need to ensure:

- better information is made available which clarifies the rehabilitation and aftercare services available to patients and carers
- rehabilitation and aftercare services available are provided to all patients and carers that need them
- rehabilitation and aftercare services be provided in a consistent and timely fashion
- patients and carers, who are at their most vulnerable as a result of the stroke, do not have to struggle to access information and support that will aid their recovery
- information about services in the voluntary and community sector is made readily available and easy to access
- more focus is placed on re-enablement and recovery

It was suggested that more resources be put into rehabilitation and aftercare services as getting the right information and support were deemed important to aid patient recovery and relieve anxiety and stress for patients and carers.

“Once discharged and back at home I felt ‘abandoned’. I think the nurses are doing a good job once you are in hospital but once you are out, you are left on your own.”

*Stroke Patient*

“Once discharged from hospital, the message we got was ‘go home and get on with it’.”

*Stroke Patient and their Carer*

“There is no help to move on once your scheduled treatment is complete.”

*Stroke Patient*

“Treating stroke is so much more that dealing with an acute event...I would like to see the service commissioners more interested in the whole pathway.”

*Survey Respondent*

4.1.1 Emotional Support

The data suggests there is currently a gap in terms of the provision of emotional support for patients, carers and family members. Having access to this type of support was considered important in terms of both helping patients, carers and families to deal with the impact and longer term effects of stroke and improve their experience.
“Both stroke patients and their ‘family carers’ need much more emotional support to deal with the emotional side of living with a stroke.”  
Partner and Carer

“I had a couple of breakdowns and am still on anti-depressants.”  
Partner and Carer

“I think emotional support for stroke patients is really important. In the months following my stroke I got really depressed and seriously considered suicide as it seemed the only way out.”  
Stroke Patient

### 4.1.2 Speech therapy

The data suggests there is an under provision of speech therapy services. Although speech therapy seems, in the main, to be provided to those patients requiring it, concerns were raised in terms of the quality, amount and duration of the provision.

“My wife got a ration of speech therapy once a week for six weeks but would have benefitted from more, but like all services it is stretched and you are limited to what you can have.”

“The Speech Therapy service is poor after discharge into the community. My husband was asked to fill in lines to match words with symbols which was useless. He needed practice speaking and I had to do this myself.”

“My husband needed additional support from the speech therapist but all they did was go through reading easy books with lots of pictures.”

“My husband needs support in speech which he is really struggling with but he didn’t get this support. They need to recruit more speech therapist in the community”.

Partners and Carers

### 4.1.3 Physiotherapy

The data suggests excellent physiotherapy services are provided whilst in hospital. However the picture of provision following discharge is sketchy with some patients receiving little or no physiotherapy services, despite them suggesting it was necessary to aid their recovery and improve their experience.
“The physiotherapy I received in hospital was excellent and the physio staff were incredible.”  

*Stroke Patient*

“I felt I needed physiotherapy either at home or as an outpatient but it was left to my family and friends to motivate and support me to regain my fitness.”  

*Stroke Patient*

### 4.1.4 Home Assessments, Aids and Adaptations

Home assessments on discharge from hospital were highlighted as an area that worked well. However following the home assessment a lack of consistency in relation to the fitting of adaptations and provision of aids was highlighted. Whilst some experienced a good service, with adaptations being fitted quickly and a range of aids being provided. Others were discharged without aids even when requested, and some had to arrange for adaptations to be completed themselves.

“Prior to discharge the occupational therapist did a home assessment following which workmen fitted hand rails inside and out, fitted adaptors to the toilet and fitted a chair in the shower.”  

*Partner and Carer*

“I had to borrow a wheelchair from my wife’s place of work, a walking stick from my sister and a friend offered me the use of his deceased father’s mobility scooter. Without these I would have really struggled.”  

*Stroke Patient*

### Recommendation:

1. Form a time limited task group with representatives from all relevant organisations involved in providing and commissioning rehabilitation and aftercare services including patient and carer representatives to:
   - review the discharge process and rehabilitation and aftercare services,
   - develop a standardised, uniform and seamless rehabilitation and aftercare service,
   - ensure patients and carers receive a tailored discharge and aftercare plan which is flexible and specific to their changing needs

2. CCGs together with Bradford Metropolitan District Council and North Yorkshire County Council look into commissioning a wider range of integrated community rehabilitation and aftercare services in line with needs analysis and following national best practice guidance. Work with patients and carers in designing expanded range of services.
4.2 Travel, Transport and Parking

The distance, time and cost to travel, along with the challenges of parking at BRI were identified as one of the biggest problems associated with the change in service. There was concern in relation to how the extra distance would affect the treatment and outcome for stroke patients (see section 4.3 below), and the impact travel, transport and parking would have on the ability of carers and families to visit their loved ones at this critical time.

There was particular concern about:

- those needing to travel to BRI from the Airedale, Wharfedale and Craven areas via public transport as multiple buses would be needed, resulting in lengthy travel times and high costs
- both the cost of travel and travel time, particular during peak periods, which coincides with visiting times
- the additional stress and anxiety travel, transport and parking issues will place on carers and family members at a time which is already highly stressful

“Family members will be restricted to short visits or no visits while the patient is under critical care.”

“It takes 3 buses to get to the BRI, so 6 buses return - that’s a lot and it will be expensive and time consuming and it would take up a whole day in travelling.”

Discussion Group Attendees

“Travelling time for relatives to visit is a concern, if you don’t have your own transport you would have to get 4 buses from where I live in Glusburn to the BRI.”

Survey Respondent

“Parking at BRI is a nightmare and it’s getting more expensive.”

Discussion Group Attendee

Recommendations

3. Review visiting times on the HASU to avoid them coinciding with peak travel times.

4. Review the cost of parking to ascertain if some level of concession could be provided for immediate family members visiting their relatives on the HASU.

5. Explore if transport links between Airedale, Wharfedale and Craven areas can be improved e.g. establish the demand for a special bus to run between AGH and BRI to coincide with visiting times.
4.3 Treatment and Care
There were concerns about moving the existing HASU at AGH to BRI, in order to create a single HASU at BRI, and the impact, the additional distance, time and potentially different level of service could have on the treatment and outcome of stroke patients living in Airedale, Wharfedale and Craven.

“Will they get the treatment they need on time? I know they say it will be quicker but in practice will it?”

“What about people who just turn up at A & E at AGH, precious time will be lost and most people don’t know.”

“It takes a long time to get to BRI and people who have a stroke need the attention quickly.”

Discussion Group Attendees

“I am concerned the delay in having to travel all the way to BRI, particularly if it’s a time of day when traffic is heavy, might negatively affect the outcome for the patient.”

Survey Respondent

Other concerns raised included:

- placing additional pressure on existing services at BRI which are already seen to be stretched in terms of both capacity and facilities
- bed shortages with some suggesting the availability of beds on the stroke ward, neurology ward and A & E at BRI is a problem
- the general quality of services at the BRI
- the length of waiting times in A & E

“It will put a lot of strain on Bradford and does the BRI have the facilities to cope”

“Will there be enough beds for everybody? BRI has been struggling to keep up with delivering good services”

“What about if BRI doesn’t perform well? It doesn’t have a good reputation”.

“How will A & E cope as that’s not going to be any bigger”

Discussion Group Attendees
Recommendations

6. Establish a system to monitor the time it takes for patients from Airedale, Wharfedale and Craven to reach the HASU when compared with patients from Bradford, and ascertain if this is related to any difference in the patients’ treatment and outcome. Take remedial action if any differences are found.

7. Monitor the outcomes of stroke patients from Airedale, Wharfedale and Craven compared to stroke patients from Bradford.

8. Use data from the Sentinel Stroke National Audit Programme (SSNAP) to compare the performance of the single HASU against the two previous HASU’s at BRI and AGH to cover:
   - the time from calling 999 to arrival on the HASU,
   - the time from arrival in A & E at either AGH or BRI to being admitted to a HASU bed for patients from both Bradford and Airedale Wharfedale and Craven

9. Review the impact of the change on patient treatment and outcome and provide feedback to participants of this engagement process.

4.4 Staff

Whilst there were many positive comments in relation to staff and the care they provide, particularly on Ward 5 at AGH, there were concerns raised in relation to the attitude, skill and numbers of staff across BRI and AGH.

These included:

- staff on the wards being very busy which on some occasions led to delayed responses in meeting patients’ needs
- the pressure staff are under resulting in limited contact time with the patient, with physiotherapists and speech therapists in particular, being highlighted
- the inadequate number of specialist nurses
- whether BRI has sufficient staffing levels to cope with the extra demand
- the remaining capacity of skilled staff at AGH
- staff shortages and the impact this has on the patients’ experience
- general and agency nurses not having the knowledge and skills in stroke care that is required
- the need for staff to have a better understanding of stroke symptoms and the effects
- the poor attitude of some staff
“When needing the toilet the response was quite delayed due to a very busy ward…”

“I was not cleaned up on a couple of occasions but they were very short staffed.”

Stroke Patients

“When I was a patient on ward 5 the nurses were all overworked and some were short with me.... I wanted to go to the toilet but there was no one available and I had to wait a long time which wasn’t good”.

“They should make sure that there are more trained personnel on the wards who know what they are doing specific to stroke”.

Discussion Group Attendees

“I think A & E nurses should know more about the symptoms of a stroke... They put his symptoms and behaviour down to being drunk but he wasn’t he had only had a couple of glasses of wine.”

Partner and Carer

“Nurses were busy all the time, and some of the nurses were a bit aggressive”

Survey Respondents

**Recommendations**

10. Staffing levels, training and mechanisms for dealing with staff shortages should be reviewed across the HASU to ensure the service achieves a standard of care commensurate with a centre of excellence.

11. Review the staffing levels and training of staff involved in the treatment, care, rehabilitation and aftercare of stroke patients, their carers and families to ensure sufficient numbers of well trained staff in stroke care are available to support patients, carers and families throughout their full stroke journey and care pathway.

12. People recovering from stroke, their carers and family members are particularly vulnerable, ongoing feedback by questionnaire should be sought, and intermittent more intensive feedback by questionnaire and interview should be carried out to ensure the standards of care, and services provided by staff are effectively monitored and reviewed.
4.5 Information and Communication

The capacity of stroke patients to process and understand information, coupled with the stress and anxiety brought about by the stroke and its longer term impact make it necessary for stroke services to review both the information provided to patients and carers and the communication between staff, patients and carers.

Particularly highlighted were the need for:

- staff to explain to patients and carers what has happened to them or their loved one as they often have no recollection of the event due to the stroke itself and/or the stress they are under at the time
- staff to recognise if the patient’s ability to communicate is impaired as the result of the stroke and use appropriate methods of communication
- improved communication and information flow between departments and across organisations
- more information about the impact of stroke on the mental and physical health of both patients and carers

“I think the sister when asked did not want to tell me what had happened to me because I had been close to death and she didn’t want to frighten me but it was really important to me to know what had happened to me.”

Stroke Patient

“Staff kept asking him if he wanted tea or coffee but he couldn’t respond to that due to the aphasia. If they had shown him tea and coffee he could have made a choice.”

Partner and Carer

“There are people in different places – consultants, the GPs, the Stroke Association, social services, the benefits people, but there was no-one drawing it together, drawing together packages of care and communicating with each other across the organisations.”

Stroke Patient

A number of questions were raised especially in the discussion groups, relating to both the HASU and broader stroke services.

Some discussion group attendees were also unhappy that the changes to hyper acute stroke services were made before the engagement process was completed. Whilst understanding, with only one locum stroke specialist remaining at AGH, the change had to be made they did question why the NHS had left it so late to engage with the public, patients and carers.

There was also some general scepticism in relation to how much, if at all, their views and suggestions would inform and influence both the HASU and broader stroke services.
Recommendations

- 13. Review current information provided to stroke patients and their carers to:
  - ascertain if it meets the needs of patients, carers and family members,
  - identify any gaps,
  - ensure it is easily understood, relevant and appropriate.

- 14. Explore the possibility of co-designing a Stroke Folder with and for stroke patients and their carers that includes information and resources they deem important and necessary.

- 15. Prepare and publish a formal response to the questions raised during discussion groups and circulate this to the 15 discussion groups that participated in the engagement process.

- 16. Produce a plain English summary version of this report and circulate to all who contributed to the engagement exercise. Publish both the full report and plain English summary report on relevant websites, conventional and social media, and make it available in other formats as requested.

5. CONCLUSION

The engagement process has identified five key areas to improve stroke services in Bradford, Airedale, Wharfedale and Craven and sixteen recommendations have been proposed.

It is suggested these recommendations be the focus of further work and be:

- agreed, prioritised and owned across the Partnership
- discussed further to ensure they are meaningful, unambiguous and clear proposals
- turned in to ‘SMART’ (Specific, Measurable, Attainable, Realistic, Timely) objectives where possible
- formulated into an action plan for implementation

The Partnership is asked to provide timely feedback to participants of the engagement process so that people are aware of the outcome of sharing their views and how these will be used to inform and influence stroke services.
6. ACKNOWLEDGEMENTS

The Partnership would like to thank:

- Patients, carers, families and the wider public that took the time and effort to share their views and experiences so honestly and openly via the one to one interviews, discussion groups, survey questionnaire, patient leaflet and social, digital and traditional media.
- The stroke, carer and ‘at risk’ groups that enabled and supported discussion groups to be held with their members and service users.
- Healthwatch Bradford and District for their expertise and support in planning and implementing the engagement process, producing the survey questionnaire and for co-ordinating and facilitating the discussion groups.
- Bradford Older People’s Alliance (BOPA) for supporting and enabling discussion groups to be held with a number of ‘wellbeing cafés’ across the district.
- Colleagues in NHS Airedale, Wharfedale and Craven, Bradford City and Bradford Districts CCGs, Airedale Hospital NHS Foundation Trust, Bradford Teaching Hospitals NHS Foundation Trust and Yorkshire and Humber Commissioning Support, for assisting the engagement process.
## Appendix 1: Stroke communications and engagement action plan

### AWC & Bradford Stroke Communications and Engagement Action Plan

<table>
<thead>
<tr>
<th>Activity</th>
<th>Lead (s)</th>
<th>May 15</th>
<th>June 15</th>
<th>July 15</th>
<th>Aug 15</th>
<th>Sept 15</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Produce a Communications, Engagement and Equality (CEE) Strategy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Draft CCE Strategy</td>
<td>Louise Stordy/Tracy Higgins</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Draft Communication and Engagement (CE) Action Plan</td>
<td>Tracy Higgins</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sign off CCE Strategy and CE Action Plan</td>
<td>Helen Farmer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. Source existing intelligence on stroke services which can be used to evidence patient and public views</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact PAs and Complaints in BTHFT, ANSHFT, AWC, Bradford City and Bradford Districts CCG’s and NHS Yorkshire and Humber CSU with request for existing data on patient feedback related to stroke services collected during the last three years including NHS Choices and Patient Opinion</td>
<td>Helen Farmer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gather information on existing local or national surveys or engagement exercises relating to stroke services conducted during the last three years</td>
<td>Louise Stordy/Tracy Higgins</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Analyse the intelligence in order to identify key messages, gaps in client groups or questions</td>
<td>Tracy Higgins</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3. Identify target audience for engagement activities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Create a plan of stakeholders</td>
<td>Louise Stordy/Tracy Higgins</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete a stakeholder analysis to identify target audience for engagement activities</td>
<td>Engagement Team</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gain agreement to utilise existing channels to read and test communication and engagement materials</td>
<td>Helen Farmer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree target groups</td>
<td>Helen Farmer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4. Prepare to communicate with patients, carers, families and the wider public</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Create a summary document detailing the reasons for changing the service and how people can get involved which can be adapted for different audiences</td>
<td>YHCS Comms Team</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supply a slide deck that can be used for engagement activities</td>
<td>YHCS Comms Team</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Produce briefings for relevant audiences e.g. staff, public, partners</td>
<td>YHCS Comms Team</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop clearly defined diagrams of current model of delivery and the new model of delivery</td>
<td>Louise Stordy/Helen Farmer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Produce a video of clinician explaining the new model for use at engagement activities</td>
<td>Helen Farmer/Provider leads</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Produce a sheet of FAQ’s and answers for use at engagement activities</td>
<td>YHCS Comms Team</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop a media release and provide quotes</td>
<td>YHCS Comms Team</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Test out communication materials utilizing agreed existing channels and amend if necessary</td>
<td>Louise Stordy/Tracy Higgins</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sign off all communication materials developed</td>
<td>Helen Farmer/Fiona Stephens</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## 4. Prepare for engagement activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify employed or commissioned staff to undertake engagement activities</td>
<td>Helen Farmer</td>
</tr>
<tr>
<td>Agree mechanisms for engagement</td>
<td>Tracy Higgins/Flora Stephens</td>
</tr>
<tr>
<td>Develop engagement tools appropriate to the target audience e.g. survey, focus group schedule, interview schedule</td>
<td>Engagement Team/YHCS Comms Team</td>
</tr>
<tr>
<td>Test out engagement tools utilizing agreed exiting channels and amend if necessary</td>
<td>Louise Stordy/Tracy Higgins</td>
</tr>
<tr>
<td>Sign off engagement tools</td>
<td>Helen Farmer/Flora Stephens</td>
</tr>
<tr>
<td>Agree non pay budget</td>
<td>Helen Farmer</td>
</tr>
<tr>
<td>Book meeting venues, catering, facilitators, speakers and interpreters as required</td>
<td>Engagement Team</td>
</tr>
<tr>
<td>Develop evaluation form for use at engagement activities</td>
<td>Tracy Higgins</td>
</tr>
<tr>
<td>Develop diversity monitoring forms</td>
<td>YHCS Equality Team</td>
</tr>
<tr>
<td>Develop a calendar of engagement activities</td>
<td>Engagement Team</td>
</tr>
</tbody>
</table>

## 5. Communicate with stakeholders and the public:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upload information onto partners websites with option for people to give their views</td>
<td>YHCS Comms Team/Provider Comms Leads</td>
</tr>
<tr>
<td>Media briefings for local press e.g. T &amp; A, Keighley News, Craven Herald</td>
<td>YHCS Comms Team</td>
</tr>
<tr>
<td>Regular communication to advise CCG staff and member Practices</td>
<td>Sue Jones/Helen Farmer</td>
</tr>
<tr>
<td>Disseminate summary report and engagement activity timetable to interested third sector organisations, PPG’s and networks, Healthwatch and other key stakeholders</td>
<td>Tracy Higgins/YHCS Comms Team</td>
</tr>
</tbody>
</table>

## 6. Deliver engagement activities:

| Specifics of the engagement activities to be delivered over a nine week period are still to be finalised. Ideas include: | Provider leads |
| Face to face and telephone interviews with service users and carers   | Provider leads |
| Focus groups with stroke groups, carers groups, high risk groups and key interested third sector groups | Provider leads |
| Survey questionnaires, comment cards and public meetings for the wider public | Provider leads |
| Provider staff engagement activity to be discussed and agreed with ANHFT and BTHFT | Provider leads |
| Provider staff engagement activities to be delivered                  | Provider leads |

## 7. Collate and analyse data received from engagement activities:

| Collate the evaluation forms from each activity                        | Engagement Facilitator               |
| Collate the diversity monitoring forms from each activity              | Engagement Facilitator               |
| Collate the findings from each engagement activity                    | Engagement Facilitator               |
| Analyse the data from all engagement activities to identify key themes | Tracy Higgins                         |

## 8. Produce a final report and provide feedback on engagement activity and next steps to participants:

| Produce final report                                                   | Tracy Higgins/Louise Stordy          |
| Sign off final report                                                  |                                      |
| Report on the findings of the engagement activities and how they will be used to both Bradford and North Yorkshire HOSSC | CCG and Provider Committees           |
| Develop a summary document of engagement activity                      | Tracy Higgins/Louise Stordy          |
| Check the summary document utilizing agreed existing channels          | Tracy Higgins/Louise Stordy          |
| Circulate the summary document to participants of the engagement process | YHCS Comms Team                      |
| Media release for local press e.g. T & A, Keighley News, Craven Herald at the end of the programme detailing the findings of the engagement activity | YHCS Comms Team                      |
| Upload the report findings to partners websites                        | YHCS Comms Team/Provider Comms Leads |
Appendix 2: Summary of finding from existing data

Existing data evidencing patients, carers and public views about stroke services in Bradford, Airedale, Wharfedale and Craven was gathered from the sources below.

- **Airedale Stroke Unit Satisfaction Survey (May 2014 to April 2015)** - An annual review of the ‘real time’ patient satisfaction survey was carried out in order to establish areas of good practice and also areas in which the stroke service could be improved. In addition to reviewing the data from this survey, the Friends and Family test (FFT) scores for the same period were also analysed in order to establish any trends with satisfaction ratings by users of the service.

- **North Yorkshire Healthwatch Enter and View Visit to Airedale Foundation Trust (November 2015)** - The purpose of the ‘Enter and View’ visits is to find out about local services and identify areas for improvement. This visit included the stroke ward at AGH.

- **Quality Walk Round Report (May 2014)** - An unannounced walk round, to gain first hand assurance of the quality of care being delivered, was undertaken on the stroke ward at AGH and reported on.

- **Engagement in Craven by the Stroke Association and North Yorkshire County Council (March 2014)** – The Stroke Association was commissioned by North Yorkshire County Council (NYCC) to carry out a patient engagement exercise, within the Craven area. The comments and experiences from the project were forwarded to Airedale, Wharfedale & Craven CCG to inform future commissioning. Two events were held, one in Skipton and one in Sutton to receive feedback from patients and carers about their stroke journeys, the discharge process and care in the community.

- **Engagement on the Clinical Commissioning Group’s (CCG) five year business plan (March 2014)** – People were asked to list health priorities and placed stroke 8th on the list (30% of people engaged listed stroke in the top three priorities).

- **NHS Airedale, Wharfedale and Craven CCG’s Grassroots Reports (Q1 2013/14 to present)** - Feedback about stroke was received in April-June 2013.

- **Patient Opinion Website (June 2009 and June 2014)** – Most of the feedback is prior to 2014 so may not reflect the current status of the stroke care at AFT.

- **NHS Bradford City and Districts CCG engagement on community stroke services (May – June 2014)** - Feedback from patients, carers, communities and support services identifying gaps and areas for improvement.
The data gathered was analysed and a summary of the findings is detailed in the tables below:

Table 1

<table>
<thead>
<tr>
<th>Positive feedback about stroke services at AGH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff and culture</strong></td>
</tr>
<tr>
<td>Kind, polite, encouraging, supportive and professional approach by staff.</td>
</tr>
<tr>
<td>Staff have the time to give patients and carers individual attention.</td>
</tr>
<tr>
<td>Staff respect patients’ privacy and dignity.</td>
</tr>
<tr>
<td>Good team work between staff and other departments.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Information and involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keep patients and carers informed at every stage of their care.</td>
</tr>
<tr>
<td>Involve carers in the patients’ treatment and care.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficient, effective and coordinated processes, which mean that patients are seen quickly for diagnosis.</td>
</tr>
<tr>
<td>Good communication and record sharing between departments, which means that patients don’t have to repeat their details and symptoms.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practicalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide a dignity room and dignity pack (containing clothes and toiletries).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thorough home assessments on discharge.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rehabilitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A holistic approach to cardiac rehabilitation, covering exercise and advice on diet and drugs.</td>
</tr>
</tbody>
</table>

Table 2

<table>
<thead>
<tr>
<th>Positive feedback about stroke services at BRI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff and culture</strong></td>
</tr>
<tr>
<td>Kind, supportive and professional approach by staff on acute wards.</td>
</tr>
<tr>
<td>Staff on acute wards have the time to give patients and carers individual attention.</td>
</tr>
<tr>
<td>Staff are caring and understanding of patient and carer needs.</td>
</tr>
<tr>
<td>Staff are knowledgeable and skilled.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Information and involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keeping patients and carers informed at every stage of their care.</td>
</tr>
<tr>
<td>Involve carers in the patient’s treatment and care.</td>
</tr>
</tbody>
</table>
Processes
Efficient processes, to ensure that patients are seen quickly for diagnosis.
Good communication and record keeping.

Practicalities
Provide a dignity room and dignity pack (containing clothes and toiletries).

Discharge
Patients and carers involved in discharge planning.
Good engagement with support organisations to provide discharge support.

Table 3

<table>
<thead>
<tr>
<th>Recommendations to improve stroke services across Bradford, Airedale, Wharfedale and Craven</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access and early intervention</strong></td>
</tr>
<tr>
<td>Ensure that service access is equitable and out reaching.</td>
</tr>
<tr>
<td>Provide patient led education about awareness, recognising signs and managing long term conditions.</td>
</tr>
<tr>
<td>Promote awareness of local services and what they provide.</td>
</tr>
<tr>
<td>Understand local demographics and tailor approaches to meet need and overcome barriers to access.</td>
</tr>
<tr>
<td>Ensure better access to hospitals and transport for wheelchair users.</td>
</tr>
<tr>
<td><strong>Information and involvement</strong></td>
</tr>
<tr>
<td>Information should be given in a written format as well as verbal.</td>
</tr>
<tr>
<td>Ensure that information is available in a range of accessible formats so people with different needs can access information, e.g. BSL, language, audio, visual aids.</td>
</tr>
<tr>
<td>More information about medications, especially on discharge.</td>
</tr>
<tr>
<td>More information about post stroke seizures and other health issues.</td>
</tr>
<tr>
<td>More help and support on life after stroke along with practical advice on entitlements e.g. benefits, blue badges, access bus, home adjustments, safe and sound alarm system.</td>
</tr>
<tr>
<td>More involvement and engagement with carers and family members affected, for example, children or dependents.</td>
</tr>
<tr>
<td>More flexible visiting hours on the stroke ward.</td>
</tr>
<tr>
<td><strong>Seven day working</strong></td>
</tr>
<tr>
<td>Maintain the same level of service on weekends, ensuring the required number of consultants and staff are available.</td>
</tr>
</tbody>
</table>
**Input from allied health professionals**
Provide physiotherapy sessions more than once a day.
More speech therapy and occupational therapy.
Increase mental health support and access to counselling for patients and their families.
Better and more involvement from chaplaincy services.

**Environment and travel**
Help patients with mobility issues to get around the hospital.
Ensure that follow-up appointments and support groups are accessible as transport is an issue.
Ensure the ward environment is calm and supportive.

**Staffing**
Increase staffing levels to ensure the ward runs at its best.
Make staff available to take patients to the toilet or shower.

**Discharge**
Provide patients with advanced warning of discharge and the opportunity to see a consultant beforehand.
Ensure everyone is given a home assessment that covers social care and caring responsibilities.
More consideration of social factors when discharging e.g. caring responsibilities.
More contact from health services following discharge especially to review medication and help access more support.
Ensure discharge planning includes wider community support for the patient, carer and family.

**Rehabilitation and support**
Better review of support equipment to aid rehabilitation, e.g. appropriate wheelchairs.
Better use of local facilities and groups to promote social rehabilitation and challenge stigma.
Ensure that volunteers are skilled and supported.
More peer support opportunities.

**Processes**
More integration between health and social care and between different departments in the local authority.
Better official communication channels for information to support joint working across agencies.
Clear policies and procedures in place to support the delivery of high quality care.
## Appendix 3: Stakeholder analysis

<table>
<thead>
<tr>
<th>High Impact</th>
<th>Direct Service Users and Carers</th>
<th>At Risk Groups (Age/Ethnicity/Deprivation/Lifestyle)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Direct Service Users</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Patients due to be discharged from AGH Acute Stroke Unit (Stroke Coordinator has identified 2/3 patients)</td>
<td>1. Bangladeshi Community Centre – Keighley (Men’s Group)</td>
</tr>
<tr>
<td></td>
<td>2. Existing AGH patients receiving rehabilitation services (Stroke Coordinator has identified 1/2 patients)</td>
<td>2. KAWACC – Keighley Association Women’s and Children’s Centre (Women’s Group)</td>
</tr>
<tr>
<td></td>
<td>3. Patients who have been transferred from AGH to BRI (2 Stroke Coordinator has identified 2 patients)</td>
<td>3. Sangat Centre – Keighley</td>
</tr>
<tr>
<td></td>
<td>4. 4 Patient Stories provided by Bradford District and Bradford City CCGs</td>
<td>4. LACO Project, Thornbury Centre</td>
</tr>
<tr>
<td></td>
<td><strong>Stroke Groups</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Ilkley Stroke Club - Clark Foley Centre</td>
<td>5. Phase 3 Project (Based in BD3 predominantly South Asian but mixed in terms of heritage and gender)</td>
</tr>
<tr>
<td></td>
<td>2. Shipley Stroke Clubs x2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Wibsey Stroke Support Group/Promoting Excellence in Stroke (Just one group as linked)</td>
<td>6. Bradford &amp; District Older People’s Alliance (BOPA) - umbrella organisation need to disseminate information via BOPA and discuss accessing a number of Wellbeing Cafés highlighted below</td>
</tr>
<tr>
<td></td>
<td>6. Headway Bradford – Shipley (Need to check if this service directly works with stroke patients)</td>
<td>9. Hindu Cultural Society</td>
</tr>
<tr>
<td></td>
<td><strong>Carers Groups</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> agreed to do direct engagement activity just through carers resource as this organisation is commissioned by the CCGs to provide a service across North Yorkshire and Bradford</td>
<td>12. South Craven Over 50’s Forum</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13. South Asian Women’s Group, Broughton Road</td>
</tr>
<tr>
<td></td>
<td></td>
<td>14. Glusburn Older People’s Luncheon Club</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15. Gargrave Senior Citizens’ Phoenix Social Club</td>
</tr>
<tr>
<td><strong>Low Impact</strong></td>
<td><strong>Interested Groups</strong></td>
<td><strong>Wider Public View on Service Change</strong></td>
</tr>
<tr>
<td>----------------</td>
<td>----------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td></td>
<td>1. Patient Participation Group (AWC/BD/BC)</td>
<td>1. Existing community events across the district July – August.</td>
</tr>
<tr>
<td></td>
<td>2. Bradford Council and AWC Health Navigators</td>
<td>2. Wider public (via press, media, social media)</td>
</tr>
<tr>
<td></td>
<td>3. Remaining Wellbeing Cafés</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Practice Health Champions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Champions Show the Way</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. Health and Wellbeing Forum/Health and Wellbeing Hubs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. Healthwatchers and Volunteers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8. Craven Mental Health Forum</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9. Community Centres - Glusburn, Sutton, Grassington and Wrigglesworth</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10. Carers Connection</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11. The Memory Club – Keighley</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12. Diabetes Patient and Public Forum</td>
<td></td>
</tr>
<tr>
<td></td>
<td>13. Diabetes UK Northern and Yorkshire</td>
<td></td>
</tr>
<tr>
<td></td>
<td>14. Roshni Ghar - Keighley</td>
<td></td>
</tr>
<tr>
<td></td>
<td>15. Council for Voluntary Services (Keighley &amp; Ilkley Community and Voluntary Action, Bradford, Bingley and Shipley, Craven)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>16. Age UK, North Craven, South Craven, Bradford &amp; District</td>
<td></td>
</tr>
<tr>
<td></td>
<td>17. CEE Community Champion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>18. Keighley and District LGB Group</td>
<td></td>
</tr>
<tr>
<td></td>
<td>19. Alzheimers Society /Craven Alzheimers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>20. Keighley Healthy Living Network</td>
<td></td>
</tr>
<tr>
<td></td>
<td>21. Keighley &amp; District Disabled Peoples Centre, Temple Row</td>
<td></td>
</tr>
<tr>
<td></td>
<td>22. North Craven Strollers Walking for Health Group</td>
<td></td>
</tr>
<tr>
<td></td>
<td>23. Skipton Retired Mens Group</td>
<td></td>
</tr>
<tr>
<td></td>
<td>24. Skipton and Craven Action for Disability (SCAD)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>25. Mosques – Jami Madinah, Markazi Jamia and Shahjalal</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>High interest</th>
<th>Low interest</th>
</tr>
</thead>
</table>
Appendix 4: Discussion group schedule

Materials:
- Video
- Pathway Models
- CCG leaflet, “A single hyper acute stroke unit (HASU) to improve stroke care”
- FAQ sheets if separate
- Flip Chart
- Pens
- Sticky notes
- Information leaflet about the F.A.S.T test
- Evaluation form
- Petty cash, claim form

Format
- Introduction - Discussion topic, including role of Healthwatch – Commissioned piece of work, which will be owned by the CCG
- Confidentiality – What will happen with the data?
- Identify who we have in the room: carers/people who have had a stroke
- Housekeeping for this venue
- Complete equality monitoring forms

Ground rules for discussion

To allow our discussion freely, I would like to go over some suggested ground rules:

1. Let’s respect each other and talk one at a time and avoid any side conversations.
2. If there is something you would like to add to the discussion while someone is speaking, please write this down on the post – it notes provided.
3. Everyone doesn’t have to answer every single question but it would be great to hear from everyone here as we go through the session.
4. This is an open discussion, and there are no right or wrong answers just different opinions. Say what is true for you even if you are the only one who feels that way.
5. What we hear stays in the room and we respect each other’s experiences.
6. Please say if you need a break.

For high risk groups only - start the conversation with

- What is your understanding of stroke services?
- Who knows about the Face, Arm, Speech, and Time (F.A.S.T) Test (have information to circulate if possible)
- Play the video and answer initial questions of clarification
Discussion Topics

1. What impact do you think this change will have on patients?

   1a) what do you think may be good about the change in service, what might be the benefits for patients?

   1b) Can you tell us what concerns you have about the change in service, what you think may be less good about the new model?

2. What impact do you think this change in service will have on carers, families and friends?

   2a) what may be good about the change in service for carers, families and friends?

   2b) what may be less good about the new model for carers, families and friends?

3. Now you have heard everyone’s views, is there anything more you would like to raise in relation to the change in service that you think may impact on patients, carers and families?

4. What do you think would help to make the service run well for patients, carers and families?

5. Are there any comments you would like to add?
- Leave participants a questionnaire to share their individual stroke experience, **REMOVE equality monitoring form from the questionnaire.** Offer them the opportunity to fill it out now and give it back or go through it 1:1 with one of the facilitators / scribes.

- Take down details of individuals who would be happy to follow up with telephone interview/one to one after the focus group, for ongoing Healthwatch work (outside of the stroke project)

- **Evaluation Forms  - complete and collate back**
Appendix 5: Survey questionnaire

https://www.surveymonkey.com/r/strokeservices
Appendix 6: Patient leaflet

Appendix 7: Findings from one to one interviews with Airedale, Wharfedale and Craven patients/carers

A total of five people were interviewed; three stroke patients and two carers, who cared for a family member who had suffered a stroke. Four males, two aged 65-74 and two aged 75-84, and one female, aged 25-34, were interviewed. All interviewees were White British and heterosexual. Two considered themselves as having a disability. Four did not belong to a religion, and one identified as a Christian.

Of those interviewed, two recognised the symptoms of the stroke using the Face, Arm, Speech, and Time (FAST) test. Two interviewees confirmed that the ambulance arrived within 5 minutes, two between 10 – 15 minutes, and one within 30 – 60 minutes.

All patients were taken to the Emergency Department at AGH. Two patients, one of whom had their stroke out of hours, were transferred to the HASU at BRI. The other three patients were admitted to the HASU at AGH. Interviewees were asked how much time elapsed between falling ill and being admitted to the HASU. Two had no recollection, one confirmed it was 1 – 2 hours, and for the remaining two patients it was 3 hours. The two patients who initially received their HASU care at BRI were transferred back to Ward 5 at AGH; one after 12 hours and the other after 3 days. The length of time spent on the HASU ranged from 12 hours to 3 days, and the total length of stay in hospital ranged from 13 days to 12 weeks.

Interviewees were asked to rate their experience on the HASU in a number of areas, the results are shown in Figure 1 below.

Figure 1
All interviewees rated the knowledge and skills, and attitude of staff as good or excellent. Similarly, the support to carer/family was rated good or excellent by those interviewees able to comment based on their experience. The communication between staff and patient and the information sharing between hospitals/services were rated satisfactory or above.

When asked, all those interviewed stated they were given the information, support and advice they felt they needed when leaving hospital.

Interviewees were asked, based on their experience, what had worked well and what areas needed improvement.

**Areas that worked well:**
Four or more interviewees identified the following as working well:

- physiotherapy services whilst in hospital
- staff on Ward 5, along with the treatment and care given
- home assessment on discharge from hospital

> “The physiotherapy I received was excellent and the physio staff were incredible.”
>
> “Ward 5 is a wonderful ward and does some brilliant work. The nursing staff are superb.”
>
> “Prior to discharge the occupational therapist did a home assessment following which workmen fitted hand rails inside and out, fitted adaptors to the toilet and fitted a chair in the shower.”

Quotes from patients/carers

**Areas that could have been improved:**
Interviewees identified the following three areas for improvement:

A) Support following discharge from hospital
A range of support and services required following discharge from hospital were highlighted by four interviewees.

These included:

- **Physiotherapy** – whilst excellent services were provided in hospital three interviewees received little or no physiotherapy once discharged from hospital, despite them suggesting it was necessary to aid their recovery and improve their experience.

- **Aids and adaptations** – three interviewees highlighted a lack of consistency in relation to the fitting of adaptations and provision of aids, following discharge from hospital. One experienced a good service, with adaptations being fitted quickly and a range of aids being provided. One was discharged without aids though they had...
been requested, but did have some adaptations fitted, one had some aids provided but had to arrange for some adaptations to be completed themselves.

- **Social Services** - two interviewees suggested the quality of the care provided by social services could be improved, for example the care provided by individual carers differed significantly.

- **Speech Therapy** – one interviewee highlighted that although speech therapy was beneficial, they believed the number of sessions provided were not sufficient to meet the patient’s needs.

- **Emotional support** - one interviewee suggested access to emotional support for both stroke patients and carers would help improve both their experiences.

  - “I felt I needed physiotherapy either at home or as an outpatient but it was left to my family and friends to motivate and support me to regain my fitness.”
  
  - “I had to borrow a wheelchair from my wife’s place of work, a walking stick from my sister and a friend offered me the use of his deceased father’s mobility scooter. Without these I would have really struggled.”
  
  - “The carers we had ranged from very good right through the spectrum to very poor.”
  
  - “My wife got a ration of speech therapy once a week for six weeks but would have benefitted from more, but like all services it is stretched and you are limited to what you can have.”
  
  - “Both stroke patients and their ‘family carers’ need much more emotional support to deal with the emotional side of living with a stroke.”

Quotes from patients/carers

B) **Information and communication**

Three interviewees suggested information and communication between staff, the patient and the carer could be improved. They highlighted a desire to have a better knowledge and understanding of what has happened to them or their loved one, as they often have no recollection of the event due to the stress they are under at the time.

  - “I think the sister when asked did not want to tell me what had happened to me because I had been close to death and she didn’t want to frighten me but it was really important to me to know what had happened to me.”

Quote from patient
C) Treatment and care
Two interviewees believed their treatment and care could have been improved. The first related to the patient being transferred back to AGH at 1.30 am, following treatment on the HASU at BRI. On arrival there was no bed available on Ward 5, the acute stroke ward, so the patient was admitted to Ward 2, where they spent over 12 hours before being transferred to Ward 5.

The second related to the patient being left alone in the waiting area of the Emergency Department for 45 minutes, following arrival at AGH by ambulance, before being triaged and treated.

“I was very anxious about being left in the waiting area for 45 minutes before being triaged as I was 90% sure I was having a stroke.”

Quote from patient

Benefits and challenges of a single HASU
Interviewees were asked, based on their experience, what the potential benefits would be of going to the nearest HASU.

Two main benefits were highlighted:
- not having to be transferred to another hospital
- having access to a specialist facility with specialised staff, regardless of the day and time people have their stroke

The problems or challenges patients, carers and families might face as a result of the change taking place, the following were highlighted:

- **Travel and Transport** – four interviewees identified the time, cost and distance for family and friends to get to the BRI to visit their relative as a problem. It was suggested this would be exacerbated for those that do not have access to their own means of transport and need to use public transport.
- **Parking** – two interviewees identified the availability of parking facilities at BRI and the proximity of the facilities in relation to the hospital as a problem.

Table 1 below details what interviewees think will help to make the stroke service run well for patients, carers and families. The suggestions have been organised under themes, with the number in brackets showing the number of interviewees that highlighted this theme.
Table 1

**Suggestions to help make the service run well**

**Staff and Services (4)**
- Ensure the HASU service at BRI equates to that at AGH by replicating the warmth, friendliness and high visibility of the staff on Ward 5.
- Speed up the process for getting patients through the initial phase of treatment.

**Information and Communication (1)**
- Improve communication with relatives by explaining what is happening to their loved one throughout their stroke journey, including what tests and treatments they are receiving and why.

**Travel, Transport and Parking (1)**
- Change visiting times so they do not coincide with when the traffic is at its heaviest.
- Review the cost of parking.

**Discharge and Aftercare (1)**
- Provide or increase physiotherapy sessions following discharge, either at home or as an outpatient, where both the patient and clinician agree it would aid or speed up recovery.
- When accessing physiotherapy as an outpatient consider whether transport needs to be provided for those patients who have reduced mobility and/or do not have access to their own transport and would struggle using public transport.
- A consistent approach to the provision of aids to assist mobility. Have a stock of mobility aids that can be given to patients on discharge which they can hand back when they are no longer required.
Appendix 8: Findings from Bradford City and District CCG’s patient stories

Four stroke patients’ stories, collected by Bradford City and Bradford District CCGs during the period 2013 to 2015, were provided as part of the stroke engagement process. Full equality monitoring data was not available but two of the stories were from female patients, one aged 65 and one age unspecified, and two were from male patients, aged 53 and 56. Three patients had their stroke in 2012 and one in 2013.

Two patients received their stroke treatment at BRI, of whom one was subsequently moved to St Luke’s Hospital. One received their stroke treatment at Calderdale Hospital before being transferred to BRI and subsequently to St Luke’s Hospital for rehabilitation. One received their stroke treatment at AGH.

Areas that worked well
The following two areas were identified as working well:

- **Support from GP Practices** – two patients highlighted the positive and supportive service they had received from their GP Practice and GPs in particular.
- **Aids and adaptations** – two patients commented positively about the range of aids provided and the number of adaptations fitted in their homes.

Areas that could have been improved
From the patients’ stories, the following four areas for improvement were identified:

A) Support following discharge from hospital
The following support and services required following discharge from hospital were highlighted by three patients:

- **Accessing Benefits** - two patients needed support to access benefits, one welfare benefits and the other a disabled parking permit.
- **Emotional Support** – two patients highlighted the need for more emotional support to be made available to both their partners who were now their carers, as well as close family members.
- **Speech Therapy** - one patient requiring speech therapy had to pay privately as a result of none being provided.
- **Social Services** - one patient who received support from social services felt it could have been improved, suggesting that although a set time for carers to attend had been agreed this was not adhered to.

“I think when you are discharged having had a stroke you should be given a temporary blue badge for six months which could be signed off by your consultant.”

*Quote from patients*

“I had a couple of breakdowns and am still on anti-depressants.”

*Quote from the partner and carer of the patient*
“He was discharged without a swallow test. We paid for a speech therapist who said he did need one as he could choke.”

Quote from the partner and carer of the patient

“It was arranged for the carers to come once a day between 10 and 11 am. The first morning they came at 8am when he was still asleep.

Quote from the partner and carer of the patient

<table>
<thead>
<tr>
<th>B) Information and communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two patients, who received their care at BRI or a combination of BRI, St Luke’s and Calderdale Hospitals, suggested information and communication could have been better. One highlighted their frustration with the lack of communication and information flow between departments within the same organisation and across partner organisations. The second highlighted the importance of staff, when communicating with patients, being aware that as a result of the stroke the patient’s ability to communicate may have been impaired.</td>
</tr>
</tbody>
</table>

“There are people in different places – consultants, the GPs, the Stroke Association, Social Services, the benefits people, but there was no-one drawing it together, drawing together packages of care and communicating with each other across the organisations.”

Quote from patient

“Staff kept asking him if he wanted tea or coffee but he couldn’t respond to that due to the aphasia. If they had shown him tea and coffee he could have made a choice.”

Quote from the partner and carer of the patient

<table>
<thead>
<tr>
<th>C) Staffing Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two patients, who received all or some of their treatment at BRI and St Luke’s Hospital highlighted a problem in relation to staff shortages and how this impacted on their experience.</td>
</tr>
</tbody>
</table>

“I was not cleaned up on a couple of occasions but they were very short staffed.”

“The lack of porters was apparent. One was so busy that he took me to the wrong ward and after the brain scan I waited for two hours to be taken back to the ward.”

Quotes from patients

<table>
<thead>
<tr>
<th>D) Waiting times in A &amp; E</th>
</tr>
</thead>
<tbody>
<tr>
<td>One patient taken to BRI waited four hours in A &amp; E and one patient taken to Calderdale Hospital waited four and half hours in A &amp; E before being admitted to the stroke ward.</td>
</tr>
</tbody>
</table>
### Appendix 9: Stroke, carers and ‘at risk’ discussion groups

<table>
<thead>
<tr>
<th>Group</th>
<th>Date</th>
<th>Time</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. African/Caribbean Wellbeing Café</td>
<td>Wednesday 15th July</td>
<td>1.00 to 3.00 pm</td>
<td>St Pauls Church, BD8</td>
</tr>
<tr>
<td>2. South West Stroke Group (Bradford)</td>
<td>Monday 20th July</td>
<td>1.00 to 3.00pm</td>
<td>The Salvation Army, Holroyd Hill, Wibsey</td>
</tr>
<tr>
<td>3. Keighley Wellness Support Group</td>
<td>Wednesday 22nd July</td>
<td>10:30 to 1:30pm</td>
<td>Sight Airedale, Albert Street, Keighley, BD21 2AT</td>
</tr>
<tr>
<td>4. Ukrainian Centre Keighley</td>
<td>Friday 24th July</td>
<td>12:30 to 3:00pm</td>
<td>Ukrainian Centre Henry Street, Keighley</td>
</tr>
<tr>
<td>5. Creative Arts Stroke Recovery Group</td>
<td>Tuesday 28th July</td>
<td>10:30 to 12:30pm</td>
<td>Delius Arts and Culture Centre, 29 Great Horton Road, Bradford, BD7 1AA</td>
</tr>
<tr>
<td>6. Shipley Stroke and Carers Club</td>
<td>Thursday 6th August</td>
<td>12:30 to 2:30pm</td>
<td>Howarth Road Methodist Church</td>
</tr>
<tr>
<td>7. Black Health Forum</td>
<td>Tuesday 11th August</td>
<td>11.00 to 1.00 pm</td>
<td>Mary Seacole Court 89 Park Road Bradford, BD5 0SW</td>
</tr>
<tr>
<td>8. Hindu Cultural Society of Bradford - Community Day Centre</td>
<td>Thursday 13th August</td>
<td>11:00 to 12:30 pm</td>
<td>Hindu Temple Leeds Road, Bradford, BD3</td>
</tr>
<tr>
<td>9. Keighley Wellbeing Café - Keighley Healthy Living Centre</td>
<td>Monday 17th August</td>
<td>1:00 to 2:00 pm</td>
<td>Airedale Church Centre, North Street Keighley, BD21 3AF</td>
</tr>
<tr>
<td>10. New Horizons</td>
<td>Tuesday 18th August</td>
<td>1.00 to 3.00 pm</td>
<td>St Marys Church, Green Lane Wyke, Bradford, BD128QH</td>
</tr>
<tr>
<td>11. Sangat Centre</td>
<td>Monday 24th August</td>
<td>11:00 to 12:30 pm</td>
<td>Sangat Centre Marlborough St, Keighley BD21 3HU</td>
</tr>
<tr>
<td>12. Glusburn Luncheon Club</td>
<td>Wednesday 26th August</td>
<td>12 to 1.00 pm</td>
<td>The Baths Hall Glusburn Institute Colne Road BD20 8PJ</td>
</tr>
<tr>
<td>13. South Asian Wellbeing Café</td>
<td>Thursday 27th August</td>
<td>10:30 to 2:30pm</td>
<td>Grange Interlink, Summerville Road Bradford, BD7</td>
</tr>
<tr>
<td>14. Eastern European Wellbeing Café</td>
<td>Friday 28th August</td>
<td>12:30 to 1:45pm</td>
<td>Central Hall Keighley</td>
</tr>
<tr>
<td>15. Keighley Association Women &amp; Children's Centre (KA WACC)</td>
<td>Monday 7th September</td>
<td>11.00 to 12.30 pm</td>
<td>Marlborough St, Keighley, BD21 3HU</td>
</tr>
</tbody>
</table>
Appendix 10: Findings from discussion groups

Fifteen discussion groups were held with a range of stroke, carers and ‘at risk’ groups between the 15th July and 7th September 2015 (see appendix 9).

1. Demographics of attendees
A total of 249 people attended the discussion groups. Of these, 74% (184) completed equality monitoring forms, of whom 63.6% (117) were female, 35.3% (65) were male and 1.1% (2) preferred not to say. 81% (149) were heterosexual and 19% (35) preferred not to say. 81% (149) identified with the sex assumed at birth, 18.5% (34) preferred not to say and 0.5% (1) did not identify with the sex assumed at birth.

Of the 184, 15.2% (28) classified themselves as carers and 40.8% (75) identified as having a disability. 85.3% (157) belonged to a religion and of the 149 that stated their religion, the highest proportion 72.5% (108) were Christians with the next highest proportion 24.8% (37) belonging to the Islamic faith.

Figure 1 shows the age range of the 74% (184) attendees who completed equality monitoring data, with the highest proportion 28.8% (53) falling within the 75-84 age group.

Figure 1

![Age range](image)

Figure 2 shows the ethnic backgrounds of the 184 attendees who completed equality monitoring data, with the highest proportion 40.8% (75) being White British.
It can be seen from figure 3 below that the highest proportion of attendees who completed equality monitoring data, 19.6% (36), lived in the BD21 area.

2. Responses to discussion groups questions
Three main areas were covered in the discussion groups.

Firstly, groups were asked to discuss what might be good about the change in the stroke service, and what potential benefits for patients, carers, families and friends this change may bring.

The following responses are presented in order of the number of groups (shown in brackets) that highlighted this as a benefit of the change in service:
• more consultants and specialised staff on site and all under one roof (9)
• move to BRI is positive and good in principle (3)
• more benefits and better for those people living in Bradford (3)
• better and quicker care and treatment for the stroke patient with families having a better chance of their loved one surviving (2)
• a larger and more specialised centre may be able to attract more funding for staff, equipment and other services e.g. support after discharge (2)
• more expertise, resources and staff will give more scope for the patient, carers and families to be kept informed about what is happening and to be given better advice and support (2)

Secondly, groups were asked what concerns they thought patient, carers, families and friends might have about the change in service and what might be less good about the new model.

The following responses are presented in the order of the number of groups (shown in brackets) that highlighted this as a concern about the new model:

**A) Distance, travel time and cost of travel for carers and families (13)**
Thirteen groups suggested carers and families would struggle with travelling to the BRI to visit their loved one during their stay on the HASU. There was specific concern for the elderly, those people living in the outlying areas of Airedale, Wharfedale and Craven and those who are reliant on public transport. Both the cost of travel and travel time, particularly during peak periods, which visiting times often coincide with, were a cause of concern. Attendees were also worried about the additional stress and anxiety distance, travel and cost would place on carers and family members at a time that is already highly stressful. It was suggested that all the above, together with other family commitments, may result in carers and family members not being able to visit their loved one in hospital at this critical time.

“Family members will be restricted to short visits or no visits while the patient is under critical care”.

“It takes 3 buses to get to the BRI, so 6 buses return - that’s a lot and it will be expensive and time consuming and it would take up a whole day in travelling.”

“Travelling is going to be a big problem for some people, particularly older people and people who don’t drive”

“I wanted to accompany my dad, who has dementia in the ambulance to the BRI but I couldn’t leave my children at home for too long so he had to go by himself”

Quotes from attendees
B) Distance and travel time for patients and the effect this may have on their treatment and outcome (11)
Eleven groups raised concerns about how long, in reality, it would take patients from the Airedale, Wharfedale and Craven areas to get to the HASU at BRI. They were worried about the delay in treatment that might occur as a result and how this might affect the patient’s outcome. Concern was also raised in relation to patients who might present at AGH not knowing they are having a stroke and who then need to be transferred to the BRI.

“Will they get the treatment they need on time? I know they say it will be quicker but in practice will it?”

“What about people who just turn up at A & E at AGH, precious time will be lost and most people don’t know”

“It takes a long time to get to BRI and people who have a stroke need the attention quickly.”

Quotes from attendees

C) Parking (10)
Ten groups highlighted the difficulties and cost associated with parking at the BRI. Two of which also referred to the distance of the car parks from the hospital and the difficulties those with mobility issues could encounter, especially if due to the high cost of parking they have to park further away where parking is free.

“Parking at BRI is a nightmare and it’s getting more expensive”.

“Not everyone could afford the parking charges even for the short term”.

“It’s impossible to park at BRI.”

Quotes from attendees

D) Impact of the changes on BRI (8)
Eight groups raised concerns about the ability of the BRI, both in terms of capacity and facilities, to cope with the increased pressure that will come from managing the additional patients. It was suggested availability of beds in the stroke ward, neurology ward and in A & E is a problem. It was felt that moving the HASU from AGH to BRI would put additional pressure on existing services at BRI which were deemed to be already stretched.

“It will put a lot of strain on Bradford and does the BRI have the facilities to cope”

“Will there be enough beds for everybody? BRI has been struggling to keep up with delivering good services”

“How will A & E cope as that’s not going to be any bigger”

Quotes from attendees
E) Staffing levels and skills (6)
Six groups highlighted concerns in relation to the number of specialist stroke staff available now and in the future. It was suggested that there were inadequate number of specialist nurses and that general and agency nurses do not have the knowledge and skills in stroke care that is required. There were also apprehensions about whether BRI has sufficient staffing levels to cope with the extra demand and, about the remaining capacity of skilled staff at AGH.

“When I was a patient on ward 5 the nurses were all overworked and some were short with me and some aggressive which upset me – I didn’t think it was their fault as they had too much to do but there weren’t enough of them, but I was poorly. I wanted to go to the toilet but there was no one available and I had to wait a long time which wasn’t good”.

“They should make sure that there are more trained personnel on the wards who know what they are doing specific to stroke”.

“Will there be sufficient staff to cover the extra beds at the BRI as when you are at BRI you often get the impression they haven’t got enough nurses”

Quotes from attendees

F) Location (5)
Five groups suggested that the single HASU should have been located at AGH rather than BRI, with one highlighting the importance of keeping services local.

“The single HASU should have been located at Airedale which is a more modern hospital and whose A & E department has just been refurbished”.

“There is nothing positive to say about this change. Airedale hospital is an excellent hospital with fantastic staff and the service should have stayed here”.

Quotes from attendees

G) Quality of services at BRI (4)
Four groups raised concerns about the general quality of services at the BRI, suggesting that communication and staff attitude need to be addressed in order to improve the patient experience.

“Facilities at BRI are poor, there is less privacy and it is a noisy environment and you can experience poor attitude from staff”.

“What about if BRI doesn’t perform well? It doesn’t have a good reputation”.

Quotes from attendees
In addition, two groups raised concerns about the potential of a bigger unit, with more people, reducing the quality of treatment and, one group was concerned about the lack of information and consultation in relation to the decision to relocate the single HASU to BRI.

2.1 Additional concerns not directly related to the change in service
Concerns were also raised in relation to stroke services, which the change to a single HASU does not aim to address. These include:

A) Support following discharge (9)
This was raised as an area of concern by 9 of the discussion groups. The data suggests that whilst more information and support on discharge is required across the patch, there is less information and support following discharge for stroke patients in Bradford than Airedale, Wharfedale and Craven.

It was felt there was not sufficient information and support for patients and their carers once discharged from hospital e.g. benefits advice, information about local voluntary organisations and groups that could support patients and carers. It was suggested that more resources should be put into this area as getting the right information and support were deemed important to aid recovery and relieve anxiety and stress.

- **Speech Therapy** – Three groups highlighted the quality of speech therapy and the inadequate level of speech therapy services following discharge as areas of concern.

  "Once discharged and back at home I felt ‘abandoned’. I think the nurses are doing a good job once you are in hospital but once you are out, you are left on your own”.

  "Once discharged from hospital, the message we got was ‘go home and get on with it’"

  “The Speech Therapy service is poor after discharge into the community…. He needed practice speaking and I had to do this myself”

  “My husband needs support in speech but he didn’t get this support. They need to recruit more speech therapist in the community.

  *Quotes from attendees*

B) Childhood Strokes (1)
One group highlighted concerns about childhood strokes and the need for awareness to be raised amongst both NHS frontline staff and the general public that strokes can happen to people of all ages.

Finally, the groups were asked what would help to make the service run well. As shown in Table 1 a number of suggestions were proposed which have been organised under themes, with the number in brackets showing the number of groups that highlighted this theme.
<table>
<thead>
<tr>
<th><strong>Discharge and Aftercare (10)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide a seamless service beginning in hospital and continuing after discharge that incorporates help and support into the care pathway.</td>
</tr>
<tr>
<td>• Increase and improve information and support upon discharge.</td>
</tr>
<tr>
<td>• Invest more resources to support patients and carers after discharge.</td>
</tr>
<tr>
<td>• Give more consideration to both the practical and emotional support needs of patients and their ‘family carer’.</td>
</tr>
<tr>
<td>• Increase the length of time support is provided.</td>
</tr>
<tr>
<td>• Provide more information and advice on the community based support services available.</td>
</tr>
<tr>
<td>• Provide more home based support such as physiotherapy and speech therapy.</td>
</tr>
<tr>
<td>• Provide longer term post stroke care e.g. set up gym facilities for stroke patients where patients, supported by the carers and supervised by trained staff, can exercise and continue with long-term physiotherapy.</td>
</tr>
<tr>
<td>• Recruit more speech therapists in the community.</td>
</tr>
<tr>
<td>• Provide a time limited badge (like a blue badge) for those patients left disabled as a result of their stroke.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Travel, Transport and Parking (6)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide help with travel costs for immediate family members and carers coming from the Airedale, Wharfedale and Craven areas e.g. travel passes.</td>
</tr>
<tr>
<td>• Make parking free or provide some level of concession.</td>
</tr>
<tr>
<td>• Extend or have open visiting times.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Staff and Services (5)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Recruit more experienced stroke consultants and specialist stroke nurses.</td>
</tr>
<tr>
<td>• Increase the numbers of skilled specialist staff.</td>
</tr>
<tr>
<td>• Enable patients to anonymously provide an evaluation of the care they have received so that variations in the standards of care provided can be identified sooner.</td>
</tr>
<tr>
<td>• Increase provision of ambulance services to avoid delays in treatment for those patients coming from the Airedale, Wharfedale and Craven areas.</td>
</tr>
<tr>
<td>• Improve response times to get to A &amp; E and at A &amp; E.</td>
</tr>
<tr>
<td>• Invest more money into prevention to reduce the number of people having a stroke and speed up the recovery of those that do.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Information and Communication (5)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide more information and advice whilst on the ward, as having a stroke is a worrying and traumatic experience.</td>
</tr>
</tbody>
</table>
2.4 Questions raised at discussion groups
The following questions were raised during the discussion groups. It is recommended that a response to these questions is provided and published by the Partnership.

1. How many doctors does BRI have? Will this be enough to cope with more people using the service?
2. How many stroke consultants are there at BRI at the moment and how many will there be when the 2 units are brought together into a single one?
3. How do they know they have the correct numbers of staff for this type of unit?
4. Will there be enough consultants and specialist staff in Bradford if they are unable to recruit for Airedale?
5. Will it be a stroke consultant or a stroke nurse who sees the patient in A & E?
6. Why are consultants leaving? Is it the working conditions or pay?
7. Who will be left at Airedale if all the consultants are going to be in Bradford?
8. Are the doctors left at AGH consultants or doctors and will they have the experience for stroke?
9. Are 6 HASU beds enough?
10. Will there be more beds? And if demand increases will this have an impact on the service? I.e. waiting times etc.
11. What is the capacity of the HASU unit in Halifax?
12. Will the additional travel time impact on the timescale of patients receiving thrombolysis? What is the recommended timescale for patient to start thrombolysis?
13. What happens to someone who has a stroke whilst already in AGH? Will they have to be transferred over to Bradford?
14. Will there be more ambulances on standby as a result of the change?
15. Can ambulance personnel or paramedics have any way of ascertaining whether the stroke is a clot or a bleed so as to make treatment quicker? Is there any equipment they could use at the point of contact?
16. Is it all to do with making financial savings?
17. Why are you engaging with us now if you have already decided on the change and it is happening from August?
18. Will the fortnightly family & carer meetings on Ward 5 continue?
19. What support can you offer people in terms of helping to ensure the service runs well for patients, carers and families?
20. Apart from more doctors, what extra care are patients getting at BRI which they couldn’t get at Airedale?
21. What about if BRI doesn’t perform well?
Appendix 11: Findings from the survey questionnaire

The survey questionnaire was split into two sections; Part A referred to the patient’s stroke experience, and Part B referred to the changes to local stroke services.

Respondents who had suffered a stroke, and respondents who care/have cared for someone who has had a stroke were requested to complete both sections of the survey. Alternatively, those who had neither suffered a stroke nor cared for anyone who had suffered a stroke were requested to complete only Part B.

1. Demographics of respondents
The survey questionnaire was started by a total of 50 people. Ten of whom only completed the first question, hence have been excluded from the analysis. Of the remaining 40 respondents, 37.5% (15) had attended a discussion group, thus were already included in the discussion group equality monitoring data. The remaining 62.5% (25) of respondents completed the survey via web link, and hence should have completed equality monitoring data. However, three respondents did not.

Of the 22 who completed equality monitoring data, 54.5% (12) were female, 36.4% (8) were male and 9.1% (2) preferred not to say. 77.3% (17) identified as heterosexual, 4.5% (1) as other and 18.2% (4) preferred not to say. 90.9% (20) identified with the sex assumed at birth and 9.1% (2) preferred not to say.

Of the 22, 63.6% (14) classified themselves as carers, and 27.3% (6) identified as having a disability. 40.9% (9) stated that they belonged to a religion, and of these 9, 55.6% (5) belonged to the Christian faith, 22.2% (2) belonged to the Islamic faith, and 22.2% (2) specified their faith as other.

Figure 1 shows the age range of the 22 respondents who responded via web link. The highest proportion fell within the 45-54 age range 31.8% (7), and the 65-74 age range, 27.3% (6).
Figure 1

![Age range chart](chart1.png)

Figure 2, shows the ethnic backgrounds of the 22 respondents with the highest proportion, 81.9% (18) being White British.

Figure 2

![Ethnicity chart](chart2.png)

Figure 3 shows that the highest proportion of respondents, 18.2% (4) lived in the BD22 area.
2. Results of the survey questionnaire – Part A

Of the 40 respondents, 47.5% (19) were patients who had suffered a stroke, and 40% (16) care/cared for someone who has had a stroke, hence 87.5% (35) of total respondents were expected to complete Part A.

As anticipated the day, time and date of patients’ most recent strokes varied significantly across individuals. However, from the 24 people who recollected the day of their stroke, the data shows that 25% (6) of patients had their stroke on a Monday, and 25% (6) on a Friday, highlighting that, in this sample, these were the days that strokes most frequently occurred.

Similarly, out of the 18 respondents who were able to recall the time of the stroke, 38.9% (7) had their stroke between 6am and 12pm.

Of the 35 respondents. 28.6% (10) identified the symptoms of stroke using the Face, Arm, Speech, Time (FAST) test. Figure 4 below shows the range of actions the respondents took when they or the person they care/cared for developed stroke symptoms. Hence, more than one action may have applied per respondent. As detailed, the majority of those surveyed 42.9% (15) called 999. Of the 25.7% (9) of respondents that selected other reasons included they were already in hospital or they took an Aspirin.
Over half of the respondents, 54.3% (19) reported that they or the person they care/cared for went to AGH when the stroke happened. Just over a quarter, 25.7% (9) went to BRI, and 20% (7) attended other hospitals. Overall, this was the local hospital for almost all, 91.4% (32), of the patients in the sample.

Figure 5 shows it took the vast majority of patients under an hour to get to hospital, with 48.6% (17) arriving in under 30 minutes, and 28.6% (10) arriving in 30 to 60 minutes.

The subsequent questions in Part A focused on the patients experience on the HASU, and the treatment and care they received. At this stage, 2 of the 35 respondents did not continue with the questionnaire, leaving a total of 33 respondents for part A.
The highest proportion of respondents, 78.8% (26) stated that themselves or the person they care/cared for was already at a hospital with a HASU, thus did not need to be transferred to another hospital. Whilst 18.2% (6) were unsure, 3% (1) recalled being transferred to another hospital via ambulance.

Figure 6 shows the tests and treatments, sometimes multiple, that patients received on arrival at the HASU. Over half of patients, 54.5% (18) received a CT scan on arrival, and 21.2% (7) of patients received thrombolysis.

Of the 33 respondents, 27.3% (9) stated that themselves or the person they care/cared for received tests or treatment prior to arrival at the HASU, and that in most cases this was administered by the ambulance crew. A greater proportion, 45.4% (15) received no tests or treatment prior to arrival, whilst 27.3% (9) were unsure of whether they had.

When asked how long they or the person they care/cared for were under the care of HASU, 9.1% (3) stayed 1 day or less, 9.1% (3) stayed 1-2 days, 15.2% (5) stayed 2-3 days, and the remaining 66.7% (22) did not fall within these time frames.

The respondents who had a stroke, or who care/cared for those that have had a stroke were asked to rate their experience on the HASU. The detailed result can be found below in figure 7. Of the 28 responses, 92.9% (26) rated the communication between staff and themselves, and the knowledge and skills of staff as satisfactory or above. Of the 29 responses, 96.6% (28) rated the attitude of staff as satisfactory or above. Of the 24 responses, 83.3% (20) rated the information sharing between hospitals and with other services as satisfactory or above. Of the 27 responses, 88.9% (24) rated the support to the carer/family as satisfactory or above.
As shown in Figure 8, 42.4% (14) of the 33 respondents were discharged home following a stay on the HASU. 24.3% (8) of patients were moved to an Acute Stroke Unit. 33.3% (11) were not discharged or moved to an acute stroke ward.

Those surveyed were asked whether they or the person they care/cared was given the information, support and advice they felt necessary when leaving hospital. Of the 33 respondents, 45.4% (15) felt they had, 27.3% (9) felt they had not, and 21.2% (7) felt they had partly received what they deemed necessary. 6.1% (2) of respondents stated not applicable.
The sixteen respondents who answered partly or no to the question above were asked to describe what they or the person the care/cared for needed once they left hospital. Of these sixteen, 14 directly addressed the question asked and the following two themes were highlighted as areas of importance:

A) Support following discharge from hospital

Eleven respondents mentioned a range of support and services that were needed following discharge from hospital. These included:

- **Support groups** – Three respondents mentioned support groups for carers and patients, with one specifically highlighting the need for local support groups for younger people who have had a stroke.
- **Emotional support** – Two respondents suggested that both stroke patients and carers having access to emotional support was important.
- **Mobility aids** – Two respondents highlighted the need for mobility aids following discharge.
- **Medication** – Two respondents felt they needed more assistance with medication following discharge.

The remaining respondents individually suggested more support was needed in relation to the following:

- social services, in regard to accessing and maintain funding for care
- physiotherapy
- speech therapy
- home assessments
- financial support
- practical support

It is worth noting that two respondents specifically noted the positive support received from Carers Resource.

---

”"I think emotional support for stroke patients is really important. In the months following my stroke I got really depressed and seriously considered suicide as it seemed the only way out.””

“I had no help after leaving the hospital – like I said I had to put myself into a medical nursing home and I had no medication assistance via the hospital.”

“Thank goodness for the Carers Resource.”

Quotes from respondents
B) Information and communication
Six respondents highlighted the need for better information and communication throughout the stroke journey. Specifically mentioned was the need for:

- More information regarding the impact stroke can have on the mental and physical health of both patients and carers.
- Information to be provided in formats that can be understood by patients whose ability to read and write has been impaired.
- Benefits advice.
- Better communication between staff and patients/carers.

“I needed information I could understand, in the right format, as I was left unable to read or write...I was given no information at all that I could understand.”

“There was not a lot of communication in relation to the date my husband was being discharged...I just went to visit him as normal and on arrival was told he was going home.”

Quotes from respondents

Based on their own experience of stroke treatment and care, respondents were asked what worked well, what could be improved, and how this might be done. Of the 29 respondents, 28 directly answered the question. Sixteen of the respondents commented on what worked well, 21 suggested improvements. However, no respondents directly addressed how the improvements suggested might be achieved. Below is a summary of the findings.

Areas that worked well
Of the 16 respondents who stated what worked well, the following was identified:

- **Quality of treatment and care** – Twelve respondents commented positively on the quality of treatment and care they received:
  - Six respondents complemented AGH, particularly in relation to the treatment they received leading to an excellent recovery.
  - Four respondents complemented BRI, specifically the excellent care provided by hospital staff.
  - Two respondents spoke positively of their time on the rehab ward at St Luke’s hospital.

“Based on family members visiting BRI HASU the care and skill of hospital staff was excellent. The patient was closely monitored, medication was administered efficiently and all relevant scans were carried out.”

“Treatment on the AGH HASU was excellent and was certainly responsible for the good recovery made by my husband.”

Quotes from respondents
**Areas that could be improved**

Of the 21 respondents that suggested areas for improvement, the following four areas were identified:

A) Treatment and care

Seven respondents believed their treatment and care could have been improved. Three respondents felt a quicker service, available 24/7, was required. Three respondents commented negatively on the attitudes of staff, and two respondents suggested that staff needed to have a better understanding of stroke symptoms and the effects.

> “I was looked after well in that I didn’t die at BRI. I was left in my own excrement when soiled and even when I let staff know they didn’t change me, and I became sore as they ignored me.”

> “I think A & E nurses should know more about the symptoms of a stroke...They put his symptoms and behaviour down to being drunk but he wasn’t he had only had a couple of glasses of wine.”

Quotes from respondents

B) Information and communication

Six respondents suggested that information and communication could be improved. Three respondents recommended that more information and advice should be provided about strokes and what happens afterwards. Three respondents also highlighted the need for better communication between staff and the family/carer, as well as between different services and departments.

> “Once on the stroke ward there were some holes in communication, especially updating me at a time when my husband couldn’t speak.”

> “My outpatient stroke appointment was good but no printed information was given to take away.”

Quotes from respondents

C) Support following discharge from hospital

Five respondents highlighted that support and services following discharge from hospital could be improved. Two respondents believed speech therapy was not as helpful as it could be. One respondent criticised the quality of the care package provided to them, and another felt than an ongoing assessment of the patient’s needs was required, following which a flexible package of care should be put in place. One respondent also felt more services should be available locally for stroke survivors.
“Seventeen months later my husband still cannot talk.”

“Once the six week care package that was put in before leaving hospital had finished, I have done all the caring myself.”

Quotes from respondents

D) Staffing levels
Three respondents highlighted a number of problems associated with staff shortages, throughout the stroke journey. Two respondents stated that ward staff were always busy leading to delayed responses. One respondent complemented the aftercare, for example from the physiotherapists and speech therapists, but noted how contact time was limited due to them being under pressure.

“...the response was quite delayed due to a very busy ward...”

“Nurses were busy all the time, and some of the nurses were a bit aggressive”

Quotes from respondents

3. Results of the survey questionnaire – Part B
Of the 40 respondents, 12.5% (5) were neither patients who had suffered a stroke nor care/cared for someone who had a stroke. These respondents were expected to complete part B, together with the 33 patients or carers who also completed Part A. Thus, a total of 38 respondents were expected to complete Part B. However 4 of the respondents from Part A did not proceed, leaving a total of 34 respondents.

Respondents were asked, based on their experience, what they felt the benefits would be of going to the nearest HASU. Thirty respondents answered the question, with 22 directly providing potential benefits. The following responses are presented in order of the number of respondents that believed this to be a benefit:

- patients will be seen quicker leading to better outcomes (12)
- stroke specialists and skilled staff will be available 24/7 and will have access to the specialist facilities needed to use their expertise (4)
- the move to BRI is positive and good in principle (4)

“It is good that there is an updated stroke unit, with skilled staff and stroke specialists on hand 24 hours 7 days a week, giving the best care available.”

“Treatment will be administered, based on the severity of the stroke, a lot quicker because the unit has enough staff and consultants.”

Quotes from respondent
Respondents were asked what problems or challenges patients, carers and families may experience as a result of the change. Of the 33 respondents to this question, 29 highlighted the following challenges that are presented in order of the number of respondents (shown in brackets) that raised these concerns:

A) Distance, travel time and cost of travel for carers and families (20)
Twenty respondents highlighted that carers and families may struggle to travel to the BRI to visit loved ones. There was particular concern for those travelling via public transport from the Airedale, Wharfedale and Craven areas. In many cases, multiple buses would be needed to reach BRI, resulting in lengthy travel times and high costs. Some suggested this could result in carers and families being unable to visit their loved ones in hospital at this critical time.

“It will require 3 bus journeys to Bradford, and another 3 to return. Hopeless.”

“Travelling time for relatives to visit is a concern, if you don’t have your own transport you would have to get 4 buses from where I live in Glusburn to the BRI”

Quotes from respondents

B) Distance and travel time for patients and the effect this may have on their treatment and outcome (8)
Eight respondents were concerned about the delays in treatment for patients having to travel to the BRI from the Airedale, Wharfedale and Craven areas. They highlighted that this could negatively affect patient outcomes, especially for patients needing thrombolysis which must be carried out within a specific time frame.

“It is potentially too far for some patients to travel if they live on the far side of Keighley and outwards. Can they get the treatment (thrombolysis) in time when travelling such a journey?”

“I am concerned the delay in having to travel all the way to BRI, particularly if it’s a time of day when traffic is heavy, might negatively affect the outcome for the patient.”

Quotes from respondents

C) Parking (8)
Eight respondents believed parking would be an issue at BRI.

Table 1 below details what respondents think will help to make the stroke service run well for patients, carers and families. Of 29 responses, 26 directly addressed the question. The suggestions have been organised under themes, with the number in brackets showing the number of respondents that highlighted this theme.
Table 1

**Suggestions to help make the service run well**

**Staff and Services (13)**

- Increase the number of stroke staff.
- Increase training for A & E staff on the symptoms of stroke.
- Increase training for (ward) staff on the needs of stroke patients, specifically so they are able to recognise signs of distress when the patient’s ability to communicate is impaired.
- Provide stroke training for GPs to improve expertise locally.
- Provide more help for patients suffering with incontinence.
- Create a joined up fast tracked service from the 999 stage through to assessment and scans, and subsequently treatment.
- Ensure the number of acute beds is sufficient.
- Maintain the local stroke services at Airedale.
- Allow a family member to stay overnight with patients who are unstable /until they are stable.
- Improve outpatient services.

**Information and Communication (6)**

- Improve and increase communication between health professionals and patients, carers and families.
- Improve communication between departments and services.
- Provide carers with more information, to enable them to correctly support the stroke patients.
- Increase the number of staff that are able to speak languages other than English.
- Designate one person per patient to communicate with the family, providing any information or answering any questions they may have regarding the treatment of their family member.

**Discharge and Aftercare (5)**

- Increase the focus on re-enablement and recovery.
- Ensure care and support is in place upon discharge.
- Ensure the post hospital stroke care pathway runs in conjunction with the voluntary sector.
- Provide information on discharge about the services available in the community.

**Travel, Transport and Parking (3)**

- Make parking free at hospitals.
- Improve parking facilities at BRI.
- Improve transport links to BRI.
A wide array of other comments were provided by 24 respondents. Detailed below are those which were highlighted by more than one respondent:

- Eight respondents expressed concern with the change. The reasons for this concern included the shrinking services at Airedale and the increased distance to BRI and the impact this could have on both patient outcome and family visiting.
- Four respondents commented on support following discharge, highlighting the lack of follow up support and suggesting that the depth of expertise in the voluntary sector should be drawn up more.
- Two respondents were happy with the change to a single HASU at BRI.
- Two respondents questioned the relevancy of consultation after the decision has already been made.

“For F.A.S.T, time is of the essence for strokes. The extra time from Skipton will be 30 minutes. How will adding 30 minutes time improve things? It won’t and it cannot.”

“Our excellent AGH appears to be shrinking rapidly into 2nd class, losing expertise which has been delivered expertly and efficiently.”

“Treating stroke is so much more than dealing with an acute event...I would like to see the service commissioners more interested in the whole pathway.”

Quotes from respondents
Appendix 12: Findings from the patient leaflet feedback forms

There were a total of 14 responses to the patient leaflet. Of these 14, 64.3 % (9) had experience of a stroke, either as a stroke patient or as a carer of a stroke patient, 28.6% (4) had not and 7.4% (1) did not state.

It can be seen from figure 1 below that the highest proportion of respondents, 28.65% (4), lived in the BD20 area.

Of the 14 responses, 42.3% (6) of respondents highlighted that the main benefit of the change in service would be improved and more efficient treatment and care for patients. The main challenges of the change in service were highlighted as travel, transport and parking, by 28.6% (4) of respondents.

“I think it is a good idea and hopefully will provide a much more efficient and safer way of treating stroke patients.”

“Treatment will of course be good, but it is the environmental and social effects that will have a detrimental effect and impact on family visiting and patient recovery time.”

Quotes from respondents

When asked how the change to stroke services would affect them or their families, 35.7% (5) of respondents commented, with some highlighting more than one issue. Of the 5 respondents, 80% (4) highlighted that travel, transport and parking was an area of concern. 60% (3) of the respondents expressed concern about having to travel to the BRI from the Airedale, Wharfedale and Craven areas. They questioned how this would impact on both the treatment and outcome for the stroke patient, and on carers and family members’ ability to visit their loved ones. Furthermore, 60% (3) of respondents also commented on the cost
and difficulty of parking at BRI. 20% (1) of respondents however were glad that a better stroke service would be available to them and their family at what is a very difficult time for both.

“Airedale is our local hospital and my previous experience of BRI was not positive. Parking is abominable and we have had cars broken into there previously.”

“The expenses and difficulty of travel will mean many elderly patients may die alone.”

“I am glad that more thought has been put into providing a better stroke service for them and their families as it is a horrible time for both.”

Quotes from respondents

71.4% (10) of respondents highlighted what they thought would help to make the service run well for patient, carers and families. Responses included the following:

- **Communication** – 35.7% (5) of respondents suggested communication needed to be improved, highlighting the need for patients, carers and families to be kept informed of what is happening at each stage of the stroke journey. 7.1% (1) of respondents also commented on the need for medical staff to be fluent in simple non-medical English.
- **Location** – 28.6% (4) of respondents suggested that the single HASU should have been located at AGH.
- **Information and support on discharge** – 14.3% (2) of respondents highlighted the need for improved information and support on discharge from hospital.
- **Staff and service** – 7.1% (1) of respondents commented that the HASU needed to be fully staffed and have a sufficient number of beds.

“Communication is the key. Nurses/Doctors should keep you informed each step of the way with what is happening. This is particularly hard work for the family as I felt I had to constantly ask what was happening.”

“Also essential is proper support for stroke groups, victims and carers, and better connected discharge plans...”

Quotes from respondents
Appendix 13: Findings from Social, Digital and Traditional Media

Two people fed their views in by email, one via Healthwatch Bradford and District and one via the engage@awcccg.nhs.uk address. The main area of concern for both related to travel, transport and parking and how this would impact on both the treatment and outcome for the patient, and carers’ and families’ ability to visit their loved ones. One of the two people also commented on the inadequate provision of both physiotherapy and speech therapy following discharge from hospital.

“I have real concerns about the transfer time from Ilkley to BRI, even by emergency ambulance, I feel this would take much too long.”

Quote from email

One person tweeted NHS Airedale, Wharfedale and Craven CCG to enquire if psychological support would be integrated into the review of stroke services. It was confirmed as an integrated care pioneer, the CCG keeps psychological, physical and social needs at the forefront of service planning and that stroke is no exception.

One person fed in their view of the excellent service they had received on Ward 5 at AGH via NHS Choices and detailed in NHS Airedale, Wharfedale and Craven CCG’s Grassroots Report Quarter 1 2015-2016. They praised the professional, courteous, caring, kind and committed attitude of staff and the high class level of care they received.

Three comments were logged in relation to an article “Have your say on restructure of care for Bradford stroke victims’ in the Telegraph and Argus published on line on the 23rd August 2015. Two referred to the reporter’s use of the words stroke victims, suggesting they should instead be referred to as ‘stroke survivors’. The other referred to the travel and traffic in relation to having to travel to the BRI to access the single HASU and how this may impact on the treatment and outcome for patients.