Lancashire Teaching Hospitals-Chorley & South Ribble District General Hospital

Peer Support Visit
26 March 2010

Feedback Report

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North Cumbria University Hospitals NHS Trust
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</table>
Background

Chorley & South Ribble Hospital is part of the Lancashire Teaching Hospitals NHS Foundation Trust (LTHTR) and serves a population of 390,000.

Medical services are commissioned by NHS Central Lancashire. The Trust also encompasses Royal Preston Hospital where stroke patients are also admitted. A separate peer support visit took place at the Preston site in February 2010 as stroke patients here follow a different pathway.

Social Service input to the Trust and community comes from Lancashire County Council.

The Hospital expects to admit approximately 200 stroke cases per year from the population served. The majority of these will come as emergency cases. Stroke patients will usually be admitted via the Emergency Department (ED) and then transferred to the Acute Stroke Ward. Between 9.00 am and 9.00 pm the lead nurse on the Acute Stroke Ward is bleeped when a stroke patient is admitted to the ED and will endeavour to ensure that the patient is admitted to the stroke ward into the designated “hot bed”. However, patients may be admitted to MAU “out of hours” and then transferred to the Stroke Ward once a bed becomes available. There is no stroke thrombolysis service available at present.

In the National Sentinel Stroke Audit 2008 the Chorley site scored below average in all the nine key indicators of stroke care. The Peer Support Team were aware that changes to the process of care for stroke patients had occurred since then. The visiting team was also aware that a thrombolysis service for acute ischaemic stroke has not been developed.

Since then the Trust has opened a Stroke Unit on the Chorley site and is participating in the 90:10 project and other research projects. The Trust has appointed a Stroke Specialist Nurse who currently works across both sites but will be restricted to Preston when the Preston Thrombolysis for acute ischaemic stroke pilot starts in April.

The visiting team were interested to see how much stroke care had developed since 2008 and in what ways the Network could assist with future improvements.
Introduction

A team from the Cardiac and Stroke Networks in Lancashire & Cumbria visited Chorley & South Ribble District General Hospital (CDH) on 26 March 2010. The purpose of the visit was to allow exchange of good practice between various departments and Trusts within the Network. The team visiting Chorley included a Consultant Physician/Clinical Lead for the Stroke Network, Physiotherapists, Occupational Therapists, Nurses, Service Managers, Commissioning Managers, Dieticians and Service Improvement Managers, representing eight organisations within the Stroke Network.

The day comprised meetings with service managers and clinicians from CDH and local Social Services and then visits to all departments in the Trust which have input to the stroke patients’ journey. In addition, members of the visiting team met with representatives of the Community Services which input to stroke care. The day concluded with a feedback session to representatives of the Trust, including members of those departments visited during the day, the Chief Executive, Chief Operating Officer, the Medical Director and Trust Managers.

Everyone involved in the visit valued the warm welcome that was extended to the visiting group by the staff at CDH and were impressed with the individuals who provide the care in all the departments visited.

The report is based on questionnaires completed by each department visited prior to the visit and the information from the meetings and feedback that the team received during the day. The team did not look at any individual patient notes or formally interview patients of their experience.

We hope that the report will be helpful to the team in Chorley in further developing their services.

National Sentinel Audit Results

The National Sentinel Audit is completed in alternate years and the last iteration was in 2008. During the last round of the audit there was 100% participation by hospital Trusts. This has allowed benchmarking of services compared to standards set in the Royal College Guidelines for the management of stroke. The audit is in two parts; organisation and process. Organisational measures include for example the number of stroke beds, direct admission to a stroke unit, the provision of thrombolysis as well as composition of stroke teams.

Clinical processes are measured through a retrospective review of the notes of the first 60 patients admitted with stroke from April 2008.

The report shows the Chorley was in the lower quartile for all the summary results for both process and organisation. In addition, there had been no significant improvement between 2006 and 2008. There was no stroke unit on site in 2008 and it is no surprise that care was less organised and length of stays for stroke patients were longer than the average.
## National Sentinel Audit Results - for Trusts within the Network

**Table 2: Summary of key organisational results by hospital including waiting time for scan, presence of neurovascular/TIA clinic and involvement with patients**

<table>
<thead>
<tr>
<th>Site name (name of trust or hospital within a trust)</th>
<th>Average CT scan waiting time weekdays</th>
<th>Average CT scan waiting time weekends</th>
<th>Average MRI scan waiting time weekdays</th>
<th>Average MRI scan waiting time weekends</th>
<th>Neurovascular clinic</th>
<th>TIA Service</th>
<th>Neurovascular clinic average waiting time</th>
<th>All high risk TIA patients seen and investigated within</th>
<th>All low risk TIA patients seen and investigated within</th>
<th>Patient/carer views sought on service</th>
<th>Report produced within 12 months analysing</th>
<th>Overall position in 2008</th>
<th>Overall position in 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blackpool Fylde &amp; Wyre Foundation Trust</td>
<td>5-24 hours</td>
<td>&gt;48 hours</td>
<td>&gt;48 hours</td>
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<td>Yes</td>
<td>14</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>East Lancashire Hospitals NHS Trust</td>
<td>5-24 hours</td>
<td>&gt;48 hours</td>
<td>&gt;48 hours</td>
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<td>Yes</td>
<td>10</td>
<td>No</td>
<td>No</td>
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<td>No</td>
<td>No</td>
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<tr>
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<td>25-48 hours</td>
<td>&gt;48 hours</td>
<td>&gt;48 hours</td>
<td>Yes</td>
<td>Yes</td>
<td>14</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<td>Yes</td>
<td>10</td>
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<td>No</td>
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<td>25-48 hours</td>
<td>&gt;48 hours</td>
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<td>Yes</td>
<td>7</td>
<td>No</td>
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<td>No</td>
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<td>No</td>
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<td>No</td>
</tr>
<tr>
<td>UHMBT – (Royal Lancaster Infirmary)</td>
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<td>25-48 hours</td>
<td>&gt;48 hours</td>
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<td>Yes</td>
<td>N/A</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<td>UHMBT – (Westmorland General)</td>
<td>5-24 hours</td>
<td>25-48 hours</td>
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<td>Yes</td>
<td>Yes</td>
<td>2</td>
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<td>No</td>
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<td>5</td>
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<td>Yes</td>
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<td>No</td>
<td>No</td>
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</tr>
<tr>
<td>NCA – (West Cumberland)</td>
<td>0-4 hours</td>
<td>5-24 hours</td>
<td>25-48 hours</td>
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<td>0</td>
<td>Yes</td>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

This table includes average estimated waiting times for scans, whether the trust has a neurovascular/TIA clinic and involvement with patients. The total organisational score is an aggregated score across all domains. The best organised 25% of hospitals are in the upper quartile designated by the symbol ✷, the least well organised hospitals for stroke care are in the lower quartile designated with the symbol ⚠️, the middle half lie between the two designated by the diamond ■.

**Key:**
- Upper Quartile ✷
- Middle Half Interquartile Range ■
- Lower Quartile ⚠️
The process audit can be summarised by analysing the “nine key process indicators”. Scores for these key indicators correlate well with the total audit score.

Table 3: The 9 key indicators for all hospitals

<table>
<thead>
<tr>
<th>Site name (name of trust or hospital within a trust)</th>
<th>Number of cases in the audit</th>
<th>Screening for swallowing disorders &lt;24 hours after admission (%)</th>
<th>Brain scan within 24 hours of stroke (%)</th>
<th>Physiotherapist assessment within 72 hours of admission (%)</th>
<th>Occupational therapy assessment within 4 working days of admission (%)</th>
<th>Patient weighed during admission (%)</th>
<th>Patient's mood assessed by discharge (%)</th>
<th>Rehabilitation goals agreed by the multidisciplinary team (%)</th>
<th>Aspirin or clopidogrel by 48 hours after stroke (%)</th>
<th>Patients spent at least 90% of stay on a stroke unit (%)</th>
<th>Overall position in 2006</th>
<th>Overall position in 2008</th>
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</thead>
<tbody>
<tr>
<td>National Results %</td>
<td>(11369)</td>
<td>72%</td>
<td>59%</td>
<td>84%</td>
<td>66%</td>
<td>72%</td>
<td>65%</td>
<td>86%</td>
<td>85%</td>
<td>58%</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>Network Results %</td>
<td></td>
<td>65%↓</td>
<td>48%↓</td>
<td>76%↓</td>
<td>45%↓</td>
<td>58%↓</td>
<td>54%↓</td>
<td>79%↓</td>
<td>80%↓</td>
<td>54%↓</td>
<td>6%↓</td>
<td></td>
</tr>
<tr>
<td>Blackpool Fylde &amp; Wyre Foundation Trust</td>
<td>(58)</td>
<td>50%</td>
<td>32%</td>
<td>84%</td>
<td>24%</td>
<td>61%</td>
<td>58%</td>
<td>69%</td>
<td>90%</td>
<td>77%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>East Lancashire Hospitals NHS Trust</td>
<td>(62)</td>
<td>72%</td>
<td>55%</td>
<td>80%</td>
<td>66%</td>
<td>64%</td>
<td>11%</td>
<td>48%</td>
<td>87%</td>
<td>62%</td>
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<td>LTH Foundation Trust – (Chorley)</td>
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<td>16%</td>
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<td>42%</td>
<td>41%</td>
<td>35%</td>
<td>55%</td>
<td>35%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LTH Foundation Trust – (Royal Preston)</td>
<td>(51)</td>
<td>72%</td>
<td>71%</td>
<td>66%</td>
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<td>91%</td>
<td>92%</td>
<td>82%</td>
<td>52%</td>
<td>19%</td>
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</tr>
<tr>
<td>UHMBT – Furness General Hospital</td>
<td>(42)</td>
<td>50%</td>
<td>51%</td>
<td>86%</td>
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<td>41%</td>
<td>32%</td>
<td>0%</td>
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<td>(63)</td>
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<td>43%</td>
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<tr>
<td>NCA – Cumberland Infirmary</td>
<td>(59)</td>
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<td>81%</td>
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<td>NCA – West Cumberland</td>
<td>(53)</td>
<td>79%</td>
<td>65%</td>
<td>89%</td>
<td>31%</td>
<td>86%</td>
<td>65%</td>
<td>97%</td>
<td>91%</td>
<td>58%</td>
<td>11%</td>
<td></td>
</tr>
</tbody>
</table>

Key: **Upper Quartile** [Green] **Middle Half Interquartile Range** [Beige] **Lower Quartile** [Red]

Above National % ↑
Below National % ↓
Overview of the Chorley & South Ribble District Hospital Stroke Pathway

Patients are admitted as emergency cases via the A&E Department or from their General Practitioner via the Medical Admissions Unit.

In line with National recommendations the hospital has recently made changes to its patient stroke pathways admitting, wherever possible, directly to the Acute Stroke ward. The ward has made progress facilitating this new pathway and there is now a designated "hot bed" for stroke patients. However, "out of hours", patients may still get transferred to the Medical Admissions Unit. The preferred pathway is for patients to be transferred rapidly from the Emergency Department to the CT scanner and thence to the stroke ward (Rookwood A) at all times.

There is no stroke thrombolysis service available in the Trust at present but plans are in place to start at the Preston site on 1 April 2010. At present, there are no plans to start a thrombolysis service for acute ischaemic stroke at the Chorley site.

Emergency Department

Visiting group:
Paul Davies – Consultant Stroke Physician & Network Clinical Lead North Cumbria University Hospitals NHS Trust
Linda Dunn – Ward Manager, University Hospitals of Morecambe Bay NHS Trust
Natalie Park – Service Improvement Manager, Cardiac & Stroke Networks in Lancashire & Cumbria

The ED in Chorley is busy and the staff are keen to progress in Acute Stroke care. The Department has a Consultant on site every day with cover provided by an on-call 24/7 middle grade registrar overnight. Both the Consultant and Junior doctors rotate between the EDs in Chorley and Preston.

The nursing staff felt that in general the department had enough staff; however, it is often difficult to release people for training, not all the staff are ROSIER trained for this reason. The Stroke Specialist Nurse has good links with the Department, however, she only covers the Chorley site for two half day sessions per week and, once thrombolysis starts at the Preston site, she will not be able to offer any cover at the Chorley site.

The ED staff feel there are no barriers to changes in developing the stroke service and are enthusiastic to progress. Good progress with the stroke pathway has been made – there is evidence of the FAST test (Face, Arm, Speech, Time) and ROSIER tool (Recognition Of Stroke in the Emergency Room) being used in the department by the medical staff which will improve identification of stroke patients. More training is being arranged for nursing staff.

The Department use a clerking pro-forma for stroke and TIA admissions. Stroke patients are triaged and given amber alert. From 9.00 am -9.00 pm stroke patients are assessed by the Ward Manager who outreaches from the Stroke Unit and the patients can then be fast tracked to the “hot bed”. Usually, they can manage to get patients to the hot bed, although they sometimes have to wait for a patient to be moved first and sometimes have no choice but to send patients to the Medical Assessment Unit. The staff highlighted issues with the hot bed frequently being filled with patients who do not have a stroke diagnosis.

The Department use a referral form for a daily rapid access clinic for TIA which is at the Preston site.
The CT scanner is situated directly opposite the ED. Patients are usually scanned at the request of a Consultant or middle grade medical staff in the ED. The staff felt access to CT head scan out-of-hours was good.

The staff know that a pilot for a thrombolysis service for acute ischaemic stroke is coming to the Preston site and are keen to see a similar development at the Chorley site. One of the Consultants in the ED said he would welcome a thrombolysis service for acute ischaemic stroke at Chorley.

The visiting team felt that while progress had been made at Chorley ED with the stroke pathway, they highlighted a need for the lead stroke physician to link with ED and for the ED nursing staff to be included in any meetings regarding stroke as they need to be part of the planning process.

**Imaging**

**Visiting Group:**
Paul Davies – Consultant Stroke Physician & Network Clinical Lead North Cumbria University Hospitals NHS Trust
Linda Dunn – Ward Manager, University Hospitals of Morecambe Bay NHS Trust
Natalie Park – Service Improvement Manager, Cardiac & Stroke Networks in Lancashire & Cumbria

The Visiting team met with three Radiographers. The Department is situated on the ground floor level next to the ED. They have one MRI scanner and one CT scanner (16 slice). All Band 5 Radiographers are able to perform an un-enhanced CT brain scan.

**CT Head scans**
In working hours, CT head scans for stroke patients are performed in the next available slot. The images are reported by the designated Consultant Radiologist.

Out-of-hours the on-call medical team or ED team need to request a CT head scan from the on-call Specialist Registrar in Radiology. The Department has resident Band 5 Radiographers who are capable of procuring an un-enhanced CT head scan out-of-hours. The images are reported by the on-call registrar at the time, but a second Consultant report follows.

**MR Imaging**
There are large demands on the single MRI scanner. However, the Department can usually obtain an MRI head scan for a patient with stroke or TIA the next working day following a request. We were made aware the department was reviewing its MR imaging protocols for stroke and TIA to try and shorten the scanning period.

**Carotid Ultrasound/Dopplers**
There are only two lists a week which can include patients for carotid ultrasound.

Out of hours – the Department highlighted that possibly it may be simpler to send scans remotely (outsource) and for scans to be read on call. The team reported delays receiving referrals however, once a referral is received they will offer the next slot. They are able to offer Carotid ultrasound scanning – two lists per week (unfunded service).

The Imaging Department has made progress with the stroke pathway, and is trying to provide a CT head scan as soon as the Department is aware of the patient. In addition, the Department is implementing a new electronic request system for CT head scans which will include information specifically for stroke patients, such as time of onset and the ROSIER score. The visiting team complemented the department on this innovative request system, presently the request is backed up by a phone call from the requesting physician.
Medical Assessment Unit (MAU)

Visiting group:
Paul Davies – Consultant Stroke Physician & Network Clinical Lead North Cumbria University Hospitals NHS Trust
Linda Dunn – Ward Manager, University Hospitals of Morecambe Bay NHS Trust
Natalie Park – Service Improvement Manager, Cardiac & Stroke Networks in Lancashire & Cumbria

The Medical Assessment Unit is a 29 bedded unit with an average 25 - 30 patients admitted in a 24 hour period. The Unit has two Acute Physicians – one of whom has an interest in stroke and does a TIA clinic. Two “low risk” TIA clinics are held at Chorley each week. “High risk” TIA patients are referred to Royal Preston Hospital where there are neuro-vascular clinics each weekday.

The Ward Manager also acts as a Site Manager and while he feels he has a good overview of what is happening, he did not feel directly involved in stroke innovations or developments. The Medical Assessment Unit receives many fewer stroke patients as most are now going directly to the ASU.

Most of the nursing staff on MAU are dysphagia trained but do not have full competencies. The staff on the MAU are not aware of the ROSIER tool for diagnosing stroke. The ward is visited by therapy staff (Occupational Therapists each week day and physiotherapists only when a patient is referred). Patients assessed on MAU are not counted as admission for the first 24 hours.

The charge nurse highlighted that it was difficult to access social care services when trying to discharge patients with mild non-disabling stroke who do not go to the Stroke Ward.

Acute Stroke Unit (Rookwood A)

Visiting Group:
Paul Davies – Consultant Stroke Physician & Network Clinical Lead North Cumbria University Hospitals NHS Trust
Nick Roberts – Stroke Consultant - East Lancashire Hospitals NHS Trust
Sharon Doyle – Service Improvement Manager, Cardiac & Stroke Networks in Lancashire & Cumbria
Linda Dunn – Ward Manager, University Hospitals of Morecambe Bay NHS Trust

The Acute Stroke Unit (Rookwood A) is a 24 bedded unit with one designated “hot bed” and a total of six beds dedicated to stroke (four side units). The remainder of the ward is designated for elderly care. Stroke patients may be admitted to the unit via ED, MAU, or another medical ward. There are no designated therapy areas within the ward.

The Consultants lead four ward rounds per week between them, which may occur at variable times. There did not seem to be a cross-cover arrangement between the two Consultants to cover periods of leave. The consultants do not attend the MDT on the Acute Stroke Unit.

Nursing Staff

<table>
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<th>Band</th>
<th>Number</th>
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</tr>
<tr>
<td>Band 6</td>
<td>3</td>
</tr>
<tr>
<td>Band 5</td>
<td>11</td>
</tr>
<tr>
<td>Band 3</td>
<td>11</td>
</tr>
<tr>
<td>Band 2</td>
<td>8</td>
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</table>
The lead nurse carries a stroke bleep, so that the ED can inform them when a stroke patient needs admitting, the ward will then endeavour to free the “hot-bed” and bring the patient to the ward from the ED, ideally after the CT head scan. The ward estimate that 45-50% of stroke patients admitted via A&E get to the “hot-bed” in this way.

The ward has started taking GP referrals from MAU. These patients are coded in yellow – seen within an hour or coded in red and seen straight away. The staff stated that sometimes there is sometimes a difficulty getting scans after 9.00 pm but most are done within 24 hours.

The team offer an outreach service to stroke patients on other wards and will pull stroke patients through from MAU, as soon as a bed becomes free. However, there are frequently stroke patients outlying on other wards. All the trained nurses are dysphagia trained.

The Acute Stroke Unit does not at first sight seem to have the capacity to take all stroke patients. Staff reported that, despite direct admissions, there are frequently outlying patients. They also said that discharge planning could also be a problem and would welcome more urgency from social services to try and release beds sooner. The ongoing National Sentinel Audit will provide some data on length of stay which can be benchmarked against current National averages. However, the Trust could look at its own PAS data for stroke codes and see if prolonged length of stays were contributing to the low capacity for stroke beds.

**Multi-Disciplinary Team Meeting**

The MDT meeting is nurse led. If the Stroke Specialist Nurse is not available the MDT meeting is not held. The lack of senior medical input means that selection of patients for transfer to Rookwood B is left to the nurses and therapists. On occasions patients who do not require rehabilitation are transferred to Rookwood B. No specific goal setting is made at this meeting.

There are not any specific stroke leaflets on ward due to infection control measures, but there are laminated folders of Stroke Association information leaflets which can be printed off the ward computer. The ward does not have any direct links with The Stroke Association.

The ward uses a patient tagging system which alarms if patients go off the ward.

The visiting team felt the nursing staff had ideas to develop stroke services further. The Stroke Unit staff were keen to develop a thrombolysis service for acute ischaemic stroke. However, this would require further sustained improvement in stroke care at Chorley, the development of five day a week Consultant ward rounds, Consultant time to attend the MDT, training of medical and nursing staff, and the appointment or designation of a lead Consultant for stroke.

There will be no Specialist Nurse input from April as she will be based purely at the Preston site.

The ward feels that it would benefit from more trained nurses with an understanding of stroke care, they feel they require better equipment, for cardiac monitoring, and an ECG machine. In addition a hoist tracking system throughout ward would be of benefit.
Acute Rehabilitation (Rookwood B)

Visiting Group:
Nick Roberts – Stroke Consultant - East Lancashire Hospitals NHS Trust
Louise Jones – Modern Matron, University Hospitals of Morecambe Bay NHS Trust
Siobhan Neild – Speech & Language Therapist - East Lancashire Hospitals NHS Trust

The team were welcomed by the sister who introduced each member of the team to a patient.

Patient feedback –
- positive about environmental factors
- Patient on ward had written essays about his and other patients’ experiences
- To have one stroke unit with dedicated therapy team

Rookwood B is directly upstairs from Rookwood A. Rookwood B is a general rehabilitation ward for elderly and young rehabilitation and also takes occasional acute admissions. It is not specifically a stroke rehabilitation unit.

On the ward, space is limited and many rooms have dual functions, for example, the day room is used as an MDT room and is also used as a store room. Nevertheless, the general ward environment seems to be good. However, the ward lacks sufficient equipment for moving and handling, e.g. there is only one hoist between 24 patients and there is insufficient specialist seating to meet the needs of patients. The ward has no links with The Stroke Association.

Both Consultants have beds on Rookwood B.

Nursing Staff

<table>
<thead>
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<td>Band 3</td>
<td>11</td>
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<tr>
<td>Band 2</td>
<td>8</td>
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</table>

Only some of the staff are dysphagia trained. The night staff find it difficult to attend dysphagia training. One of the Band 6 nurses has completed a Stroke Diploma. At present, the Stroke Specialist Nurse visits the ward two afternoons per week. We believe this access will be cut in April when thrombolysis commences in Preston.

Access to Rehabilitation
Patients are mainly referred from Rookwood A by word of mouth by therapists or by the Consultants. There are no referral criteria at present.

Discharge planning
The Registered Nurses complete the Sections 2 forms and the healthcare screening both of which are quite lengthy processes, the ward nurses now complete all the discharge planning documentation which was previously completed by case managers.
**Multi-Disciplinary Team Meeting**
Each Consultant attends a weekly MDT on Rookwood A; discussing all patients under their care. The MDT is attended by nurses and therapists.

The therapists and nurses hold monthly meetings to try and develop stroke care. Currently no senior management is involved in this meeting but the team feel well supported by the acting Head of Medicine. The team would like to:

- Find more time for physiotherapy
- To train HCAs to continue therapy
- Explore the option of having a single specialised acute stroke and rehabilitation unit

**Speech and Language Therapy**

**Visiting group:**
Siobhan Neild – Speech & Language Therapist - East Lancashire Hospitals NHS Trust
Rachel Fleming – PCT Commissioner – NHS Cumbria

**Staffing**

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<tbody>
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<tr>
<td>Band 6</td>
<td>3</td>
</tr>
<tr>
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Within the Speech and Language Team there is a real drive to see improvements but there are some frustrations with delays in the progress.

The Speech and Language Therapists are trained to offer assessment and therapy for stroke patients with communication and/or swallowing problems. The team provides 11 sessions to cover Rookwood A & B as well as all other stroke patients outlying on other wards and MAU.

Referrals are made by fax Monday – Friday and the team are seeing patients within the time standards set in the Sentinel Audit. However, they feel that too much of their time is spent on swallowing assessments and not enough of their time can be given to communication therapy. The team also takes referrals from primary care and have good communication with the Community Rehabilitation Team.

The team have provided dysphagia training and all the nurses on Rookwood A are dysphagia trained and competencies achieved; on Rookwood B only some staff are dysphagia trained but the level meets the needs. There are particular difficulties training night-staff and the Speech and Language Therapists offer early or late sessions for night staff, but nursing staff turnover tends to be high.

They expressed concerns about a reorganisation in which Speech and Language Therapy would be managed by the Acute Trust and feared that it may limit access from primary care.

The team have good MDT collaborative working with all the other therapies on both Rookwood A and B. On Rookwood B the MDT invite families to be involved and help plan discharge their relatives discharge.
The team have good working relationships with Occupational Therapists and have started a Luncheon Club, which has a positive benefit for patients. The Team expressed that they felt there was no direct leadership for stroke developments and they felt there were barriers to training and joint communication with Preston.

**Dietetics**

**Visiting group:**

Louise Jones – Modern Matron, University Hospitals of Morecambe Bay NHS Trust
Natalie Park – Service Improvement Manager, Cardiac & Stroke Networks in Lancashire & Cumbria

<table>
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</tr>
<tr>
<td>Band 3 Assistant</td>
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* Cover Preston Site

The Dietetic Department at Chorley offer a five day service, with one Band 5 to cover the whole hospital and dietetic assistant Band 3 0.3 WTE who does reviews only. The team link in with the Band 7 & Band 6 nutritional and Specialist Nurse who cover both sites.

The Dieticians are not able to attend the Stroke MDT meetings due to their staffing levels and there are particular pressures with annual leave cover as the Chorley team have to cross-cover the Preston site. The team are aware changes are happening within the stroke pathway but do not feel directly involved.

Referrals for dietetic advice are made by phone and the patients are seen within 24 hours of referral.

They feel they have a very good relationship with Rookwood A and B. There is good continuity from the stroke ward to the rehabilitation ward on Rookwood B.

The MUST documentation is used on the Stroke Ward and audited monthly.

For stroke patients that are unable to swallow, Naso-Gastric tubes are usually passed within 24 hours and some senior staff on Rookwood A can insert bridles. Access to PEG feeding tubes is good at the Chorley site.

The team on Rookwood A weigh all stroke patients on admission and reweigh again usually on Saturdays. (Bed Scales are on order – awaiting delivery).

There is not as yet an established feeding regime and emergency feeding protocol, however, the team are in the process of developing protocols for managing patients over weekends and out of hours.
**Physiotherapy**

**Visiting group:**

Elaine Day – Service Improvement Manager, Cardiac & Stroke Networks in Lancashire & Cumbria  
Karen Waywell – Occupational Therapist, Blackpool Fylde & Wyre Hospitals NHS Foundation Trust  
Pauline Gorrill – Physiotherapist – East Lancashire Hospitals NHS Trust

**Staffing**

**Acute Physiotherapy Team**

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The Acute Physiotherapy Team is not stroke specific. The team covers four medical wards and MAU as well as Rookwood A (six or seven beds for acute stroke). There is no clinical lead physiotherapist for stroke. The service is run by the Band 6 (supported by Band 7). The rotational Band 6 is not specialised in stroke specific skills.

**Rehabilitation Team Rookwood B**

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<td>Band 6</td>
<td>1</td>
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<td>1 part time</td>
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<tr>
<td>Band 2</td>
<td>1 part time</td>
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</tbody>
</table>

On Rookwood B the Band 7 Physiotherapist is more specialised in stroke but the post only covers Rookwood B. There are difficulties around cover for leave as there is no-one else with specialist skills, cross-cover is available but this is not specialised and has an impact on the quality of the rehabilitation services.

Referral to the Acute Physiotherapy Team seems to be haphazard. Some wards provide written referrals; other referrals come by word of mouth from other therapists, or the stroke ward manager who carries the stroke bleep. The Acute Stroke Team aim to see the patient the next working day from referral. There is a variation in the timeliness of referrals from different wards. The Physiotherapy Team report they are consistent in assessing patients within 24 hours from referral, but they feel this has proved detrimental to the amount of therapy input they can offer each patient over their hospital admission.

The Acute Physiotherapy Team are prioritising the assessment of stroke patients on MAU over providing rehabilitation on this ward. However, stroke patients are admitted to MAU less frequently since the new Stroke Pathway has been implemented.

Patients are seen for rehabilitation only three times per week, the length of a therapy session varies between 20 – 60 minutes. There is no capacity to meet the 45 minute therapy per day as recommended in the National Stroke Strategy Quality Markers.
On Rookwood B a weekly therapy round is held, which includes all the therapists, and there are two MDT meetings - both Consultant led, where weekly goals are determined. Due to the Consultants’ decision to keep patients longer, they are achieving better patient outcomes as patients are going home rather than to care homes. Rookwood B does have a small gym facility but this is limited.

The Physiotherapists have training needs for stroke. A basic level of neuro training has been undertaken but this was not stroke-specific. The team expressed that training is difficult to access as it is often held at Preston.

They are presently holding in-house training for the introductory Bobath course which is being attended by some of their staff.

**Occupational Therapy**

**Visiting group:**
Elaine Day – Service Improvement Manager, Cardiac & Stroke Networks in Lancashire & Cumbria
Karen Waywell – Occupational Therapist, Blackpool Fylde & Wyre Hospitals NHS Foundation Trust
Pauline Gorrill – Physiotherapist – East Lancashire Hospitals NHS Trust

**Staffing**

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</thead>
<tbody>
<tr>
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<td>1.76 WTE</td>
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<td>Band 3</td>
<td>1.7 WTE</td>
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The Occupational Therapy Team is not a stroke specialist team. Due to staffing levels the focus is on initial assessments and discharge planning. Time for rehabilitation is limited. The Occupational Therapists have good working relations with the Physiotherapists and Speech and Language Therapists and sometimes complete joint therapy sessions.

They see all patients on Rookwood A, which includes six stroke beds, 18 generic beds, and 12 rehabilitation beds on Rookwood B plus any outlying stroke patients. The average caseload for the team is 35 – 40 patients.

The team are assessing patients within the Sentinel Audit standard time. They are trying to implement a standardised approach for cognitive assessment with colleagues at Preston. The Occupational Therapists only have the capacity to see patients once per week. Assessments of stroke patients can take from 45 minutes to two hours.

The Occupational Therapists are piloting visiting the MAU each day to identify patients that may have had a stroke to see if they can improve the speed of referrals.

The Occupational Therapists are dysphagia trained and screen stroke patients for swallowing difficulties on MAU if they have not been screened by the nursing staff. This was not good use of their knowledge and skills, especially when they can only offer one rehabilitation session per week to a patient.

The team is involved in the MDT meetings on both Rookwood A and B.

The Occupational Therapists have limited resources in terms of space and equipment. They can utilise the Day Room or Relative Room, or use the Belmont Day Unit for therapy.
The team used to have stroke coordinator who had set up training programmes (weekend activities) for all therapists but this is no longer available. They do, however, have access to training. At present they have access to courses in Introductory Bobath, perceptual cognitive courses, dysphagia courses and thrombolysis training.

Discharge Planning
The Occupational Therapy team complete home visits and environmental visits to further assess patients and assist discharge. There are no problems ordering equipment. The Occupational Therapists are able to do a “back-up” visit on the day of discharge or for up to two weeks after discharge but only for equipment issues. The Occupational Therapists say that communication with Community Team is good.

Community Stroke Teams

Visiting group:
Sharon Doyle – Service Improvement Manager, Cardiac & Stroke Networks in Lancashire & Cumbria
Rachel Fleming – PCT Commissioner – NHS Cumbria
Kathy Blacker – Associate Director, Cardiac & Stroke Networks in Lancashire & Cumbria

Patients may be transferred into a variety of rehabilitation settings following discharge from hospital. Some of these community services are run by the PCT (Acquired Brain Injury teams) and some by Social Services (Intermediate Care Team). Most of the community rehabilitation is generic rather than stroke specific. The Stroke Association Family and Carer Support Workers were not available at the time of the visit but we believe there are plans to commence a service.

The Acquired Brain Injury (ABI) Team
There are two ABI teams serving the catchment population of CDHI. The teams are referred approximately 370 patients a year. Stroke makes up only a part of this.

Criteria for admission to ABI services:
- Stroke survivors have to have had their stroke within six months.
- 16 years of age and above
- Must have multi-disciplinary needs

The teams include Occupational Therapists, Physiotherapists, and Speech and Language Therapists and generic rehabilitation assistants. Once rehabilitation is started, patients are reviewed every five weeks. Patients are discharged once goals have been achieved.

The team have pathways and protocols and are enthusiastic about stroke rehabilitation. However, the team is not strongly integrated with the hospital stroke units and is probably less efficient and effective because of this. There is no coordinator for referrals into community or a single point of access for the team. They aspire to a seamless transfer of care from hospital to the community but have insufficient capacity to pick up patients early enough after discharge, often taking ten days. In addition, there are delays between initial assessment and commencing rehabilitation. They do not have the capacity to fulfil the role of an Early Supported Discharge Team for stroke patients as they currently exist. In addition, there is no potential to in-reach or attend multi-disciplinary meetings.
**Intermediate care Team**

The Intermediate Care Team is a generic rehabilitation team with no specialist stroke skills. They provide rehabilitation to stroke patients in both a domiciliary setting and also in rehabilitation beds based in residential homes.

The Team includes Social Workers, Occupational Therapists, Physiotherapists, Speech and Language Therapists, Technical Instructors and Support Workers.

Referrals are made by therapists in the acute hospital and patients have to be assessed by a Social Worker before being accepted by the Intermediate Care Team which can add to delays in discharge.

Occupational Therapists within the Intermediate Care Team carry out the initial assessments and pass on to Band 4 support workers to carry out rehabilitation programmes. Occupational Therapists are not doing any vocational rehabilitation. They stated that they were trying to address this issue.

The Intermediate Care Unit (managed by the local authority) has 21 beds offering generic therapy and support staff. However, because the beds are in Local Authority care home settings some of the moving and handling practices are different to those used in health settings. This was reported to cause problems at times. In some of the locations, rooms were not large enough to accommodate hoists.

**Domiciliary Physiotherapy**

Domiciliary Physiotherapists receive referrals from primary care, the ABI team and from the hospital therapists. Patients must need only physiotherapy and cannot be referred until more than six months after the onset of the stroke. Patients are seen in their own homes or in a monthly out-patient clinic in Ribbleton. The therapists and patients agree goals and continue therapy until the goals have been achieved. The team reports that transferring patients into the ABI team is relatively easy if other rehabilitation professions are required.

The community based therapists had a different perspective to the degree of communication about patients and the discharge planning process to those in the Acute Trust. The community based therapists reported a lack of good communication and felt that they were expected to provide an unrealistic service that had been promised to the patient on discharge by the acute services. However, there is no single referral point into these “stand–alone” community services and it seems unclear who should be referred into which service and when the process of referral should start. The community therapists said that patients were frequently referred into the “wrong service” and had worries that some patients with rehabilitation needs were not being referred at all.

There is limited statistical information on stroke patients being collected in the community and they are unsure of average length of stay in community services for stroke patients.
Summary

The Peer Support Visit to the stroke services at Chorley and South Ribble District General Hospital was the fifth in a series planned by and for the Lancashire and Cumbria Stroke Network. The purpose of these visits is to review service provision at all sites within the Network so that clinicians, managers and commissioners may benefit from an external view. It is our hope that the visitors will have been viewed as critical friends rather than inspectors and that their findings will aid local teams to enhance the care offered to service users.

The visiting team highlighted that progress was being made at Chorley with many committed and enthusiastic staff members but they often felt they were left “out of the loop” in stroke development as many changes seemed to be happening at Preston but not at Chorley. Many staff had ideas of how to improve the stroke service but there is no clear stroke development group at Chorley with the authority to make the necessary changes.

The National Stroke Strategy (2007) has highlighted the need for good acute stroke care. Reference is made to direct admission to stroke units and for access to thrombolysis for acute ischaemic stroke twenty four hours per day, every day. The Trust Board need to decide urgently how they are going to provide access to thrombolysis for stroke patients in the Chorley catchment area. The Royal Preston Hospital has recently started providing a thrombolysis service for acute ischaemic stroke. The Trust has the option of providing a local equivalent service in Chorley or organising a service that ensures patients with suspected acute stroke are initially transferred to Preston for the hyper-acute stage of the management of stroke.

The Stroke Unit at Chorley has made many improvements over the service reported in the 2008 National Sentinel Audit. However, to be able to provide thrombolysis for acute ischaemic stroke, it will need to progress further. Processes to allow pre-alert of suspected stroke patients by NWAS will be needed, rapid triage in ED, rapid access to CT scanning are nearly in place or could be negotiated with the relevant departments. However, rapid access to a stroke physician, daily stroke physician ward rounds on the ASU and weekly MDT meetings on the Stroke Unit are not in place at present, and this needs to be addressed whether or not thrombolysis for acute ischaemic stroke is to be delivered at the Chorley site. The Acute Stroke Unit at Chorley does not currently meet the five key characteristics of all stroke units identified by the National Sentinel Audit, or the six key characteristics of an Acute Stroke Unit. These characteristics are:

All Stroke Units
- Consultant physician with responsibility for stroke
- Formal links with patient and carer organisations
- Multidisciplinary meetings at least weekly to plan patient care
- Provision of information to patients about stroke
- Continuing education programmes for staff

Acute Stroke Units
- Continuous physiological monitoring (ECG, oximetry, blood pressure)
- Access to scanning within 3 hours of admission
- If not three hours, access to 24 hour brain imaging
- Policy for direct admission from A&E
- Specialist ward rounds at least five times a week
- Acute stroke protocols/guidelines

The Chorley site needs a Clinical Lead for Stroke. The Lead needs to be able to communicate effectively with colleagues in Emergency Medicine, Radiology, Vascular surgery, and the leads in the therapy departments. The Clinical Lead needs to champion changes to bring the stroke services in Chorley into line with the British Association for Stroke Physicians Stroke Service Specification (April 2010) and NICE Quality Standards for Stroke Care (July 2010).
The Clinical Lead needs to be part of an education programme to keep all professions involved in stroke care up to date. The Clinical Lead would need to champion audit within the stroke service. The Clinical Lead would need to lead a multi-disciplinary group including managers who could implement changes within the stroke service at Chorley.

We understand that over time many new services have been developed at the Preston site and Chorley is expected to follow suit. While there are benefits from sharing protocols and guidelines across the sites, the Staff at Chorley should be part of the team developing these and not just having them imposed upon them. The Chorley stroke team are maturing and have their own ideas about how the stroke service could be developed locally, and need to be able to voice their opinions and need support to implement changes.

A number of staff commented that it was difficult to get to “in-house” stroke training that was frequently delivered at the Preston site. Ways need to be explored to deliver the stroke training to both sites and to repeat sessions to maximise the number of staff that can attend.

Many of the staff we spoke to would like to see a single combined stroke unit (hyper-acute, acute and rehabilitation) on the Chorley site. There would be advantages in training, and supervision of many staff and communication problems and difficulties in selecting patients for transfer to the rehabilitation ward would be reduced. Furthermore, specialist equipment would not have to be duplicated. A demand and capacity exercise would have to be undertaken to ensure that the unit had adequate beds to meet both direct admissions and 90% stay within a stroke unit with additional consideration for appropriate space for rehabilitation with provision of quiet rooms for therapy and sufficient storage of equipment. Nevertheless, many staff thought that a single ward for the totality of stroke care would provide many advantages over the use of half of two wards that is in place now.

The frequency of therapy provided by physiotherapy and occupational therapy is low. The recent NICE Quality Standards for stroke are expecting 45 minutes of therapy per day from each required therapy discipline, five days per week. It will take time to achieve this level of therapy and trusts will need to look at how this is done with a combination of qualified staff and assistants. However, therapy is not provided on a daily basis at Chorley and this should be the first aim.

Feedback from the community rehabilitation services highlighted difficulties in the provision of rehabilitation to stroke patients after discharge from the acute hospital. The most effective discharge team is a Specialist Early Supported Discharge Team for stroke patients (ESD) which commences rehabilitation immediately after discharge and rehabilitation is provided by stroke specialist therapists at the same intensity as if the patient was still in hospital. Areas with an ESD have shown shorter lengths of stay in the Acute Trust and better rehabilitation outcomes. Currently in Chorley, patients can be discharged with rehabilitation being provided by a number of non-specialist teams. The community teams are not able to commence rehabilitation immediately after discharge. It would appear that there is confusion about which patient should be discharged with which team. There may be some merit in a mapping exercise with both the acute and community stroke teams to identify which patients are transferred where and try to identify if any redesign of the processes would provide a better outcome for the patients.
Recommendations

Areas of good practice

- Use of FAST and ROSIER in ED
- Pro-forma for Stroke and TIA
- Good access to CT
- Electronic Request System for Radiology
- Resident Radiographers can produce CT head scans out of hours
- High proportion of direct admissions to the acute stroke unit from ED
- Staff from Acute Stroke Unit outreach to ED to “pull” patients through
- Well motivated staff

Suggestions for further work

- Need a Trust Board decision on whether Chorley Hospital will provide a thrombolysis service for acute ischaemic stroke or whether patients with suspected stroke will be transferred to Preston.
- Develop the role of Lead Stroke Physician
- Develop a Stroke Service Improvement Group for Chorley that includes all relevant professions and links in with the Preston group
- Perform a Demand and Capacity assessment for number of stroke beds required.
- Explore option of a single Stroke Unit
- Replace Stroke Specialist Nurse on Chorley site
- Review MRI sequences for stroke and TIA patients to reduce scanning time
- Work with Lead Physician in stroke to develop daily one-stop TIA clinic at Chorley site
- Develop stroke pathway to ensure direct admission to Acute Stroke Unit
- Develop acute stroke consultant ward rounds to five days per week
- Develop weekly MDT meeting attended by representatives of all staff and consultant
- Improve frequency of therapy sessions to once per day
- Review levels or equipment for moving and handling
- Review levels of specialist seating
- Make in service training for stroke more accessible for all professions
- Improve discharge planning and transfer to community rehabilitation services
- Explore development of early supported discharge team for stroke patients
# Appendix 1

## Peer Support Visiting Group

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<th>Role</th>
<th>Name</th>
<th>Organization</th>
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<tr>
<td>Consultant Stroke Physicians</td>
<td>Dr Paul Davies</td>
<td>North Cumbria University Hospitals NHS Trust/Cardiac &amp; Stroke Networks in Lancashire &amp; Cumbria</td>
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<tr>
<td></td>
<td>Dr Nick Roberts</td>
<td>East Lancashire Hospitals NHS Trust</td>
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<td>PCT Commissioner</td>
<td>Rachel Fleming</td>
<td>NHS Cumbria</td>
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<tr>
<td>Service Development &amp; Improvement Managers</td>
<td>Natalie Park Sharon Doyle</td>
<td>Cardiac and Stroke Networks in Lancashire &amp; Cumbria</td>
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<tr>
<td>Superintendent Radiographer</td>
<td>Sharon Timperley</td>
<td>University Hospitals of Morecambe Bay NHS Trust (Royal Lancaster Infirmary)</td>
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<tr>
<td>Stroke Manager</td>
<td>Chris Walbank</td>
<td>Blackpool, Fylde &amp; Wyre Hospitals NHS Foundation Trust</td>
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<tr>
<td>Stroke Ward Manager/Modern Matron</td>
<td>Linda Dunn Louise Jones</td>
<td>University Hospitals of Morecambe Bay NHS Trust</td>
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<tr>
<td>Physiotherapist</td>
<td>Pauline Gorrill</td>
<td>East Lancashire Hospitals NHS Trust</td>
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<td>Occupational Therapist</td>
<td>Karen Waywell</td>
<td>Blackpool, Fylde &amp; Wyre Hospitals NHS Foundation Trust</td>
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<td>Speech and Language Therapist</td>
<td>Siobhan Neild</td>
<td>East Lancashire Hospitals NHS Trust</td>
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<tr>
<td>Community Stroke Rehab Team Leader/Clinical OT</td>
<td>Katie Davies</td>
<td>NHS Blackburn with Darwen</td>
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<td>Dietician</td>
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<tr>
<td>Deputy Regional Manager</td>
<td>Katherine Staley</td>
<td>The Stroke Association</td>
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