South London
Cardiovascular and Stroke Network

SSNAP's Acute Organisational Audit Report 2012: Performance Summary for South London

The Sentinel Stroke National Audit Programme (SSNAP)'s Acute Organisational Audit looks at how stroke services across the capital are organised. The audit focuses on eight key domain areas:

1. Acute care organisation
2. Organisation of care
3. Specialist roles
4. Inter-disciplinary services
5. TIA / Neurovascular services
6. Quality improvement, training and research
7. Team working
8. Communication with patients and carers

Appendix A *provides a definition for each of these eight key domain areas.*

An overall organisational score is also calculated, based on performance seen within each of the eight domain areas.
The 2012 audit captured information as of the 2nd July 2012. All eligible trusts in England, Wales and Northern Ireland participated in the audit. A number of trusts on the Isle of Man and Guernsey also participated.

The results of the audit are captured by applying a scoring framework which allows each trust to be scored for each of the domain categories. A score between 0 – 100 was awarded to each trust, for each domain, with 100 being the optimal score of attainment. From here, trusts were split into three performance groups, based on their scores, for each domain. The three possible performance group options are; Lower Quartile, Middle Half, and Upper Quartile.

This report presents the local data for trusts within South London. It demonstrates the domain scores for each trust, and the performance group the trust finds itself in, based on the awarded domain scores. In addition, comparator data from 2010 is provided to demonstrate areas of improvement / weakness, as well as a median national score to enable better performance benchmarking. Key areas of improvement are highlighted at a local level, with the proposed national recommendations for 2012/13 onwards also put forward.

South London: Performance for 2012

Site Name	D1 – Acute care organisation	D2 – Organisation of care	D3 – Specialist roles	D4 – Inter-disciplinary services	D5 – TIA / service	D6 – Quality improvement, training and research	D7 – Team working	D8 – Communication with patients and carers	Total organisational score	*Overall position 2010*	Overall position 2012
South London Healthcare NHS Trust	93.8	60	77.5	65	100	100	95.8	84.4	84.6	*Lower Quartile*	Upper Quartile
Kings College Hospital NHS Foundation Trust	100	100	100	67.5	100	96.4	100	100	95.5	*Upper Quartile*	Upper Quartile
Lewisham Healthcare NHS Trust	100	50	81.3	80	75	92.2	83.3	84.4	80.9	*Lower Quartile*	Upper Quartile
Guys and St Thomas' Hospital NHS Foundation Trust	93.8	40	75	52.5	75	85.7	79.2	93.8	74.4	*Middle Half*	Middle Half
St George's Healthcare NHS Trust	100	100	97.5	65	100	89.3	95.8	89.1	92.1	*Upper Quartile*	Upper Quartile
Kingston Hospital NHS Trust	100	90	50	52.5	75	85.7	87.5	59.4	75	*Middle Half*	Middle Half
Croydon Health Services NHS Trust	100	100	100	55	75	96.4	91.7	90.6	88.6	*Upper Quartile*	Upper Quartile
St Helier Hospital	100	100	87.5	60	100	92.9	100	100	92.5	*Upper Quartile*	Upper Quartile
National Median	68.8	65	70	52.5	87.5	80.4	87.5	81.3	73.3	*N/A*	N/A

Key Areas of Performance Improvement

South London Healthcare NHS Trust:

- The overall organisational score has moved from resting in the Lower Quartile in 2010, to the Upper Quartile in 2012.
- Only one domain area reported a position that was lower than the national median. This was domain area 2; organisation of care.

Kings College Hospital NHS Foundation Trust:

- Retained its Upper Quartile position across 2010 – 2012.
- 75% of domain areas scored 100%.
- No domain areas attracted a score that was lower than the national median.

Lewisham Healthcare NHS Trust:

- The overall organisational score has moved from resting in the Lower Quartile in 2010, to the Upper Quartile in 2012.
- The overall organisational score was greater than national median; however three domain areas reported performance lower than the national median. These domain areas were; D2 (organisation of care), D5 (TIA / neurovascular service), and D7 (team working).

Guys and St Thomas' Hospital NHS Foundation Trust:

- The trust has held its score from 2010 to 2012, and is currently placed within the Middle Half performance group.
- The overall organisational score was greater than national median; however three domain areas reported performance lower than the national median. These domain areas were; D2 (organisation of care), D5 (TIA / neurovascular service), and D7 (team working).

St George's Healthcare NHS Trust:

- Retained its Upper Quartile position across 2010 – 2012.
- All domain areas scored higher than the national median positions.

Kingston Hospital NHS Trust:

- The trust has held its score from 2010 to 2012, and is currently placed within the Middle Half performance group.
- The overall organisational score was greater than national median; however three domain areas reported performance lower than the national median. These domain areas were; D3 (specialist roles), D5 (TIA / neurovascular service), and D7 (team working).

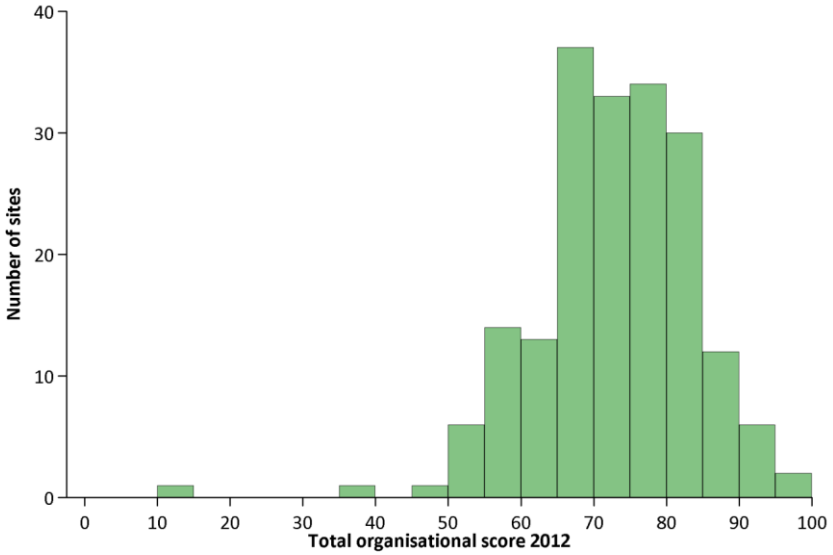
Croydon Health Services NHS Trust:

- Retained its Upper Quartile position across 2010 – 2012.
- Only one domain area reported a position that was lower than the national median, domain area 5; TIA / neurovascular services.

St Helier Hospital:

- Retained its Upper Quartile position across 2010 – 2012.
- 62.5% of domain areas scored 100%.
- No domain areas attracted a score lower than the national median.

No South London trusts were placed into the Lower Quartile performance group following the 2012 Acute Organisational Audit. This is due to the fact that all trusts within South London were awarded an overall organisational score that was greater than 66.6. The graph below illustrates the national distribution of overall organisational scores for all participating trusts:



National Recommendations for Performance Improvement

The author's of the SSNAP Acute Organisational Audit report propose a number of key recommendations to support performance improvement across stroke units. These recommendations are outlined below, and trusts are invited to consider the implication and practicality of initiating these recommendations within their own operational pathways:

1. Quality of care should be audited against national standards in all hospitals, including community hospitals.
2. All organisations treating stroke patients should be collecting information and producing a report on patient experience at least once a year.
3. Seven day working for therapists is to be encouraged but should be done in a way that ensures that the overall quality of the service does not fall. If it means that staff are spread so thinly that there are never sufficient staff to deliver high quality care, then an alternative solution should be sought.
4. Every patient who might benefit from early supported discharge should have access to a team regardless of the hospital to which they are admitted or the address at which they live.
5. Rehabilitation should only end when the patient is no longer benefiting from it. Stroke/neurology rehabilitation teams should be available and staffed at a sufficient level to ensure that patients maximise their potential recovery.
6. All patients should be treated in a hospital that has the skills and facilities to deliver thrombolysis and other aspects of hyper-acute care.
7. All patients should be admitted directly from the emergency department to a specialist stroke unit.
8. All stroke units should as a minimum be able to deliver the key standards of care defined in this report.
9. All organisations providing stroke care should identify, support and train the individuals who have the skills and expertise to be inspirational leaders for the service. These individuals may not necessarily come from the ranks of the medical profession.

Appendix A

Key Domain Area	Definition
D1 – Acute care organisation	A stroke patient should always be cared for on a stroke unit that has the necessary equipment and procedures in place and is staffed with trained, multidisciplinary clinicians. Patients seen within 4 and a half hours of developing symptoms should be considered for thrombolysis. Not all patients are suitable and giving the treatment to unsuitable patients can be dangerous. However when given to the right patients, at the right time and in the right way, it can dramatically reduce the risk of long term disability.
D2 – Organisation of care	All patients with suspected stroke should be admitted directly to a speciality acute stroke unit, unless they need more intensive care for example on an intensive care unit. Community-based stroke-specialist rehabilitation teams, such as Early Supported Discharge Teams, can provide better and potentially more cost-effective outcomes than exclusively hospital-based rehabilitation for stroke patients with moderate disabilities.
D3 – Specialist roles	Stroke is a complex disease and is best managed by staff with specialist knowledge and experience both in the initial phase where diagnosis and acute treatment is a priority, and subsequently during the period of rehabilitation. All patients who are dying from their stroke should have care provided by staff experienced in recognising the need for palliative care and delivering it.
D4 – Inter-disciplinary services	Effective multi-disciplinary working is the most important aspect of stroke care. Staff should co-ordinate their treatments, involve patients and carers in the process and be able to provide as much therapy as the patient can tolerate.
D5 – TIA / neurovascular services	High risk TIA patients should be seen, investigated and treated initially within 24 hours of onset of symptoms. For low-risk TIA patients, the time frame is one week.
D6 – Quality improvement, training and research	High quality leadership is the cornerstone for developing and delivering high quality stroke services. Poor quality services inevitably have poor quality clinical and or managerial leaders.
D7 – Team working	Effective communication between all the stroke team members is vital. Expertise from nursing, medical and all the therapy professions including clinical psychology is required.
D8 – Communication with patients and carers	Patients and carers should be provided with comprehensive information about the services they may need and how to access them on discharge from hospital, as well as on how to present further strokes.