South Yorkshire, Bassetlaw and

Mid Yorkshire

Regional Stroke Services

Patient Flow Policy

V11 FINAL DRAFT – Patient Flow Policy

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Date Written	During 2019
Approved by	HASU Implementation Group Individual Trusts/SYB Health Executive Group
Date of Approval;	HASU Implementation Group 23/4/2019 **See Appendix 1 – Individual Trusts**
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Target Audience:	Trust Staff

1. Introduction and Purpose

The Stroke Services Pathway for patients in South Yorkshire, Bassetlaw (SYB) and Mid Yorkshire relies upon the timely, safe and appropriate transfer of patients between provider Trusts. This policy explains how patients with stroke, Transient Ischaemic Attack (TIA) or a Stroke Mimic will flow within the agreed pathway. The policy articulates the standards expected to ensure that patients are transferred and discharged safely within agreed timescales and that they are always cared for in the appropriate place.

2. Scope

The scope of this policy is region wide across South Yorkshire, Bassetlaw and Mid Yorkshire. Those who provide the following services are expected to adhere to this policy:

- Emergency Ambulance Services
- Emergency Departments
- Regional Hyper Acute Stroke Services
- Neurological Assessment Units
- Acute Stroke Services
- Inpatient Stroke Rehabilitation Services
- Early Supported Discharge Services
- Community Stroke Rehabilitation Services
- Patient Transport Services

3. Aims

- To support safe, effective patient flow and automatic seamless transfer of patients between services within the region with clinical priority being the key determinant of when and where a patient is treated and cared for.

- To support a collaborative approach to patient flow across providers within the region fostering a 'one service' ethos with automatic transition between services and organisations. Enabling the emphasis to be on automatic patient flow rather than waiting for permission or agreement ahead of movement.

- To enable capacity and flow to be proactively managed as a coordinated system, with no action to be taken by any constituent part of the region that could undermine the ability of another part without appropriate prior discussion.

- To provide equitable access to comprehensive stroke care and tertiary treatments in a timely manner, delivered as close to home as possible.

- To outline the transfer and discharge pathways for the different patient groups who present to hospital.

- To maximise the efficient use of resources, including stroke beds, non-stroke beds, outpatient appointments and staffing.

- To support a positive patient and carer experience of care.

- To outline the escalation process in response to delays in flow and discharge, and assist the effective implementation of escalation procedures.

4. Organisations Committed to this Policy

The organisations that have been involved in the development of this policy and have declared their commitment to it are listed in Appendix 1.

5. Stroke Services in South Yorkshire, Bassetlaw and Mid Yorkshire

SYB patients flow between key stroke services, in a seamless pathway, from symptom onset through to discharge (Figure 1).

Figure 1: Stroke Services Pathway

Hyper Acute Stroke unit (HASU) care for stroke patients in SYB is delivered at SYB Regional HASU centres in Sheffield, Doncaster, with some SYB residents receiving HASU care at Pinderfields in Mid Yorkshire. From here, patients are transferred to a local Acute Stroke Unit (ASU), Stroke Rehabilitation Unit (SRU) or discharged home with or without community based rehabilitation. Local ASU care is provided by all acute hospital provider Trusts within the region. Patients will be transferred to the ASU or SRU that is closest to their Clinical Commissioning Group area as determined by their GP.

A definition of each hospital based service and their location is provided in Appendix 2.

6. Communication Between Providers

All providers will work together to ensure that patients flow seamlessly between services. This will involve ongoing proactive communication and collaboration. A daily teleconference call will enable forward planning and provide oversight of this communication.

7. Managing Capacity and Demand

All providers will contribute to the effective management of demand and capacity, using the Daily Teleconference Call to communicate information on admissions and expected discharges to enable forward planning.

7.1 Daily Teleconference Call

The Daily Teleconference Call will run according to the agreed Standard Operating Procedure (SOP). It will take place 7 days per week at 9.30am with representation from each place and will focus on demand and capacity for:

- HASUs in Sheffield, Doncaster and Mid Yorkshire
- Local ASUs in Rotherham and Barnsley
- Early Supported Discharge (ESD) / Community Stroke Team (CST) in Rotherham and Barnsley
- Interfacility transport for repatriation

The daily telecall will have a pivotal role in forward planning and providing oversight of communication to facilitate cross boundary patient flows. Agreed escalation procedures will be used where delays and issues with flow or discharge occur. Delays will be logged and reasons for the delay agreed on the daily call as appropriate. A delay occurs when a patient has not transferred within 24 hours of the HASU Team confirming that the patient is ready for transfer. For more details see the Daily Teleconference Call SOP.

7.2 Capacity Issues

Services should be open to admissions at all times and there should always be availability of HASU and ASU beds for new admissions 7 days a week, 365 days per year. SRU, ESD and CST capacity is also essential to facilitate patient flow out of HASUs and ASUs. If a service has reached capacity this should be managed locally in the first instance and escalated in accordance with local procedures. If capacity issues cannot be resolved locally, these should be logged at the Daily Teleconference Call and escalated in line with agreed escalation procedures. When a service is experiencing significant challenges resulting in considering the potential to divert new patients to other HASU units this will be carried out in accordance with the agreed local policies and procedures with decisions made at an Executive Level. All services will have Business Continuity Plans in place which would be activated appropriately.

8. Patient Pathways and Flow

Most patients will present to hospital where there is a Regional HASU in accordance with the Pre-Hospital Pathway. The patient will be assessed, investigations commenced and a clinical impression made.

8.1 Strokes

Patients with stroke will be admitted to a HASU Bed. When the patient's immediate management has been commenced a clinical decision will be made to determine when the patient is ready to transfer to an ASU at their local hospital or requires discharge.

Patients will **be repatriated** to non-HASU hospital ASUs / SRUs when they are **clinically deemed to be no longer in the hyper acute phase and all of the first 72 hour SSNAP care bundle has been undertaken** including assessment by all relevant therapy disciplines (it is fully expected that all therapy assessments will be completed however if there are exceptional circumstances, the therapy assessment alone would not delay transfer). This decision will be made by the patients' HASU Consultant with support from the multidisciplinary team and it will be communicated to the appropriate non-HASU hospital ASU or SRU. A Local ASU bed or SRU bed will be allocated and the date and time of transfer jointly agreed.

Practical arrangements to transfer patients will take place within normal day-to-day working through proactive dialogue between units. The Daily Teleconference Call will enable forward planning and provide daily oversight of the cross boundary flows for stroke patients.

Where a patient can be discharged directly from HASU appropriate local follow up arrangement will be made (Appendix 3).

People dying of stroke should have timely transfer of care to a hospital close to home, their own home (including a care home) or a hospice according to what is clinically appropriate and practically possible and the wishes of the person and their family/carers.

8.2 Stroke Mimics

Stroke Mimics may be identified at point of initial assessment (in the ED or NAU) or following admission to a HASU. A clinical decision will be made regarding the most appropriate care pathway for these patients. Where stroke is excluded in ED or the Neuro Assessment Unit a clinical judgement will be made and the patient may be:

- **Discharged home** direct from Emergency Department (ED) - or Neuro Assessment Unit (NAU) +/- appropriate outpatient referrals being made. If the outpatient referral is non-urgent, then the Trust may advise the patient's GP to make the onward referral. Providers will as appropriate utilise processes for HASUs to be able to access urgent outpatient/ambulatory care facilities for patients at Barnsley and Rotherham Hospitals.

- **Referred to which ever speciality is appropriate at the HASU Trust**, which may or may not result in the patient being admitted. If the patient requires further inpatient care but no longer requires treatment at the HASU site then the patient should be referred to the appropriate speciality at Barnsley or Rotherham hospital. That patient should be accepted and transferred immediately.

- **Repatriated from the NAU / ED to Barnsley or Rotherham Hospital** – the responsible doctor/clinician should **refer the patient directly to the appropriate speciality at the receiving hospital** and the patient will be directly admitted to their medical assessment unit or other relevant ward of the speciality referred to and not go through the ED at the receiving site.

Where a patient has been identified as a stroke mimic whilst on HASU or another ward clinicians will utilise their clinical judgement as to when it is clinically appropriate to repatriate the patient to their local hospital. It is very **unlikely to be clinically appropriate** (or to offer a good patient experience) to **repatriate patients with stroke mimic conditions for very short periods of time.** Patients with a very short predicted length of stay will be cared for at the hospital of initial assessment until time of discharge. If a longer stay is anticipated then patients should be repatriated at the earliest clinically appropriate opportunity. Patients will not be repatriated via the ED but a provisional diagnosis must be made by the HASU Trust and the patient referred directly to the appropriate speciality of the receiving hospital. Where a patient can be discharged directly from the HASU site, appropriate local follow up arrangement will be made by the discharging team (Appendix 4).

8.3 Transient Ischaemic Attacks (TIAs)

Patients whose **symptoms have resolved** by the time of initial assessment by the Regional HASU team and who are felt to have had a **transient ischaemic attack,** will be assessed, receive appropriate urgent investigation, treatment and advice by a doctor before being urgently referred to their local TIA service. Here they will receive urgent assessment and investigations within 24 hours of referral by a specialist clinician.

Prior to discharge from the Regional HASU site, the patient's appointment should be fixed and the time/date given to the patient. While a system is being set up to facilitate 24/7 remote booking of clinic appointments, as a temporary measure the HASU will arrange for the local clinic to contact the patient the following morning with an appointment time. The HASU Trust will confirm that the local clinic has picked up the referral and offered the patient an appointment the following day for patients who have not had full initial investigations. The patient will be advised not to drive until seen in clinic.

If a patient has been admitted to the Regional HASU site and then identified as a TIA they will be assessed by a specialist physician and receive appropriate investigations (e.g. carotid Dopplers) and commencement of secondary prevention measures within 24 hours while on the ward and be discharged with appropriate follow up locally (Appendix 4).

8.4 Self-Presenters to Emergency Departments (ED)

Some patients will continue to self-present to EDs not located with a regional HASU. It is expected that initial assessments of self-presenters with symptoms of stroke will take place at the arriving hospital if symptom onset is within 48 hours contact will be made with the nearest HASU and urgent transfer arranged as appropriate.

For those presenting with symptom onset greater than 48 hours to Barnsley or Rotherham ED direct admission to the ASU should be arranged as this is co-located.

For those presenting whose symptoms resolve and are thought to have had a TIA, a referral to their local TIA clinic should be made.

8.5 Inpatient Strokes

It is expected that hospitals will provide assessment and appropriate care to patients who have a stroke whilst already an inpatient. Advice should be sought from the nearest HASU unit (Barnsley will seek advice from the Mid Yorkshire HASU and Rotherham will seek advice from the Sheffield HASU) and if deemed clinically appropriate a transfer arranged to a regional HASU. If not, patients should be managed locally with internal transfers to local stroke services where deemed appropriate.

8.6 Thrombectomy

Patients requiring Thrombectomy will be assessed, referred, transferred and repatriated in accordance with Regional Thrombectomy Policies and Procedures.

9. Transfer and Discharge Timeframes

All patients, once assessed as clinically fit for **transfer** should be transferred. Transfers to local ASUs should be timely with arrival planned prior to 10pm, unless in exceptional circumstances. Planning for transfers should commence as soon as possible and transfer dates and times should be agreed as soon as the patient has been assessed as ready for transfer.

All patients once assessed as clinically fit for **discharge** should be discharged and the HASU team will ensure the following prior to discharge:

- Follow up services and equipment arranged and are in place as appropriate (liaising directly to arrange equipment)
- Onward referrals made
- Patient and their carer are aware of all follow up arrangements

10. HASU Site Length of Stay

On average patients will require **hyper acute care for up to 72 hours** (length of stay 0 – 3 nights) but the duration of hyper acute care needs to be tailored to the individual **clinical needs of the patients**. Some patients will be stable enough and have had all of their assessments undertaken well within 72 hours and

be able to be discharged or transferred to an ASU in under 72 hours. Others will require a longer period of hyper acute care.

Patients should **not be repatriated** to non-HASU hospital ASUs / SRUs until they are **clinically deemed to be no longer in the hyper acute phase and all of the first 72 hour SSNAP care bundle (Appendix 5) has been undertaken** including assessment by all relevant therapy disciplines.

Where a patient from Barnsley or Rotherham has a planned discharge date with a total length of stay of 4 or 5 days, then the patients should **remain on the HASU site and be discharged directly home, rather than being repatriated for a very short duration**. This will be closely monitored to ensure that any implications on patient flow are identified early, particularly the identification of delays for those patients with a planned discharge date with a total length of stay of 4 or 5 days. A clear discharge plan should be in place for these patients and delays escalated as per the escalation processes and logged on the Daily Teleconference Call.

Patients awaiting repatriation or discharge directly home, who are deemed to be now clinically outside of the hyper acute window and who have had all of the initial nursing and therapy assessments completed may be moved as per the HASU Trust local policy whilst awaiting onward transfer/discharge.

The Regional HASU site will actively monitor HASU length of stay and where individual or general issues occur they will be escalated appropriately.

11. Patient Flow into Inpatient Rehabilitation, Early Supported Rehabilitation and Community Stroke Team Services

Stroke patients requiring ongoing inpatient rehabilitation at a SRU, ESD or CST will be referred directly from the Regional HASU or local ASU in accordance with the agreed criteria as outlined in the SYB and Mid Yorkshire Directory of Services.

11.1 Transfers to Inpatient Rehabilitation

A clinical decision will be made and where a patient requires inpatient rehabilitation they will be transferred once assessed as clinically fit for transfer.

11.2 Discharge with ESD or CST

Patients requiring ESD or CST will be discharged home with a plan for assessment / intervention at home. For ESD patients this will be delivered within 24-48 hours of referral. For CST patients this will be delivered within 72 hours. Delays in these pathways will be escalated as per the escalation processes and logged via the teleconference call. All referrals will be made using the SYB Regional Stroke Services Transfer of Care Document. The document has been designed to be transferred via secure nhs net.

11.3 Transfer of Patient Information

To support seamless patient flow all clinical records will be transferred in line with the 'Regional Stroke Services Transfer of Clinical Records Policy'. Transfer of information will occur adhering to local and regional Information Governance Guidelines.

12. Communication with Patients and their Carers

12.1 On admission to the HASU

- The views of the patient and their consent will be sought, to establish the extent to which they wish carers and others to be involved in the planning and delivery of their care.

- The patient and their families/carers will be told about the **role of the HASU and that their care will be transferred after the hyper acute period to local units if necessary.**

- They will be given the 'SYB Stroke Pathway Patient and Carer Information Leaflet'.

12.2 Involvement in Decision Making and Care Planning

Patients and their families/carers will be informed and are active participants in discussions throughout the care pathway on a regular and timely basis. If the person with stroke agrees/consents, family/carers should be **actively involved** in day to day care, rehabilitation and decisions about the planning and delivery of their care. Table 1 details how patients and their families/carers will be involved:

Table 1: Patient and Carer Involvement in Decision Making and Care Planning
Patients and their families/carers will be **informed of and involved in decision making** regarding: • Their condition, their prognosis and situation • What is likely to happen to them next e.g. how soon they will be seen, frequency of contact, contact information for the new team, how goals will be carried over • Who is taking care of them and who is responsible for their care • What they need to be doing to facilitate their care and recovery (e.g. advice and information about exercises or other activities that they can practice independently) and to decrease their risk of further strokes • What are their views and concerns about their current and future care

12.3 Transfer of Care, Discharge and Follow Up

Patients and their families/carers will be made aware of the pathway upon admission to HASU and as appropriate the plans for transfer of care and/or discharge arrangements. Patients will be offered copies of written communication between organisations and teams involved in their care.

Table 2 details the information and advice stroke patients and their families/carers will be offered prior to discharge.

Table 2: Information and Advice For Stroke Patients and their families/carers
Prior to discharge patients and their families/carers should be given: • Information and offered contact with relevant statutory and voluntary agencies • Information about services available to support people who have had a stroke and how to access them, including practical or emotional support, peer support groups • Information / opportunity to have a carers assessment of their own needs • Written information about their diagnosis and management plan • Guidance regarding any prescriptions – verbally and supported by written information • Advice about driving • A named contact person for information and advice • Guidance on how to seek help if problems develop • Details of follow up plans

13. Interfacility Transport

13.1 Repatriation

Effective patient flow along the Stroke Pathway relies upon the efficient, effective and safe movement of patients using patient transport services.

Where patients are repatriated from a Regional HASU site to a local hospital this will take place in line with Interfacility Transport Policies, taking into consideration the acuity of the patient. Wherever possible transport will be pre-booked in advance of a transfer taking place.

The specification for core Patient Transport Services outlines that journeys can be pre-booked anytime up until 6pm the day before the planned journey, and changes to existing bookings can also be facilitated until this time. Transport that has been pre booked may need to be cancelled if circumstances change.

For 'on the day' discharges/transfers it is also expected that timeliness should be in line with the requirements set out in the core specification for Patient Transport Services with most patients (99%) collected no later than 120 minutes after their booked ready time.

Transport delays will be escalated via the escalation process (Appendix 5) and logged on the Daily Teleconference Call.

13.2 Mechanical Thrombectomy

Transport for patients following the Mechanical Thrombectomy Pathway will be requested and take place in line with the Regional Mechanical Thrombectomy policies.

14. Roles and Responsibilities

14.1 Receiving Trust / Clinical Team

In all cases the clinical team at the receiving service must:

- Accept the patient's transfer / referral into the service to facilitate automatic transfer
- Agree the date and time of transfer /discharge
- Arrange for a bed to be available for the patient's admission (applicable to ASU / SRU)
- Arrange for the clinical team to carry out the appropriate assessments on arrival
- Ensure that all relevant clinical and handover information has been received prior to transfer
- Ensure that they are ready to receive patients within agreed timescales in accordance with this policy
- Utilise agreed escalation processes and seek local resolution where capacity issues arise in order to accept referrals and facilitate patient transfer.

14.2 Transferring Trust / Team

Once a patient's transfer or discharge has been agreed it is the responsibility of the transferring / discharging Trust's team to:

- Provide all relevant clinical details and arrange for the transfer of documentation / records
- Arrange TTOs and transfer patients with any non-stock drugs
- Complete the Transfer of Care Document as part of the handover. Form 1 is for transfers from HASU to Inpatient Stroke Services and Form 2 is for transfers to Community Stroke Services and Early Supported Discharge. See Appendix 7.
- Arrange transport via the agreed booking process
- Confirm the date and time of transfer
- Ensure the patient and family are advised of the plan and transfer details
- Escalate and log any delays experienced in the transfer process.

14.3 Trust Management Teams

If delays and issues are encountered Trust management teams will support the Clinical Teams in line with agreed escalation processes.

14.4 Trust Site / Flow Teams

Trust site / flow teams will support the Clinical Teams / Trust Management Teams to manage any issues related to demand and capacity, according to agreed internal and regional escalation processes.

15. Delays and Issues with Patient Flow: Escalation

It is imperative that patients are transferred between sites/services or discharged when they are ready in order to maintain patient flow. Patient flow and the quality of patient care may be negatively affected when there are issues with:

- Delayed transfers
- Delayed discharges

Contributing factors to delayed transfers and discharges may include:

- High demand and/or limited capacity within services
- Transport delays
- Social Care provision delays
- Equipment provision

These issues will be escalated in accordance with local escalation procedures and those within this Policy.

15.1 Readiness for Transfer or Discharge

A patient is ready for transfer or discharge when:

- The 72 Hour SSNAP Care Bundle has been undertaken including assessment by all relevant therapy disciplines
- All appropriate hyper acute investigations have been completed
- A clinical decision by the HASU consultant has been made that the patient is ready for transfer or discharge, and
- The patient is safe to transfer or be discharged.

The clinical team at the receiving service must clinically accept the patients transfer / referral into the service without delay and agree the time of transfer.

Where a patient is transferring from a Regional HASU to a local ASU at another site or being discharged they need to be clinically safe to travel using the most appropriate transport. Where a patient is transferring from a Regional HASU to an on-site ASU this is not a factor in need of consideration.

When a patient is identified as ready for transfer:

The Regional HASU Team will:

- Identify the patient as ready for transfer and communicate this to the ASU / SRU team by telephone
- Record the time (clock start) on local Electronic Patient Records / patient administration systems
- Log the date/time of the communication between HASU / ASU / SRU
- Send the receiving team a completed Transfer of Care Document as appropriate for the transfer with the patient's clinical details
- Patients transferring will be discussed and noted at the Daily Teleconference Call, but this will not delay the automatic transfer of patients between services

The ASU / SRU team will:

- Accept the patient's transfer / referral into the service to facilitate automatic transfer
- Review the received Transfer of Care Document and seek clarity if required
- Arrange for a bed for the patient
- Agree the date and time of transfer
- Arrange for the clinical team to carry out the appropriate assessments on arrival
- Communicate any issues with arranging a bed
- Utilise agreed escalation processes and seek local resolution where capacity issues arise in order to accept referrals and facilitate patient transfer.

15.2 Delayed Transfer

As soon as a patient is ready for transfer and this has been communicated to the receiving team and they have accepted the referral the 'clock' starts. If a patient does not transfer within 24 hours of this time this would constitute a delay. The referring and receiving team must agree that there has been a delayed transfer of care. For stroke patients the following information should be logged at the Daily Teleconference Call:

- Date and time of when the patient was ready for transfer and when this was communicated
- The date and time of when the delay occurred
- The reason for the delay (category to be agreed)
- Agreed actions to overcome the delay and any escalation procedures carried out
- Date and time of actual transfer

For stroke mimic patients the same information will be collected by the Clinical Operations team as part of the escalation process for delayed transfers. Any delays to transfer should be dealt with according to Trust escalation processes via Clinical Operations and Chief Operating Officers.

A delay report for both stroke and stroke mimics will be collated by the HASU Trust each month and submitted to the CCG as part of the reporting schedule. This will inform the financial reimbursement process.

15.3 Delayed Discharge

If a patient is waiting to be discharged home to a supported care facility (care home) or a community hospital, or awaiting care and they are ready to leave but are still occupying a hospital bed, they may be reported as a 'delayed transfer of care' (DTOC) under national guidance. Internal transfer delays are not reported under national DTOC guidance. Where a patient is being directly discharged from a HASU and there is a delay in discharge that constitutes a DTOC the patient will be transferred to their local hospital.

15.4 Escalation of Delayed Transfers and Discharges

Where delayed transfers and discharges occur which cannot be immediately resolved they should be escalated according to the agreed escalation process (Appendix 6).

15.5 Issues with Demand and Capacity

In the first instance any concerns or issues that cannot be resolved locally should be raised in the Daily Teleconference Call where the teams can work together to find a suitable solution. If a solution is not possible from within the Stroke pathway teams this should be escalated according to the agreed escalation process (Appendix 6).

When escalating issues teams need to consider:

- The nature of the problem
- The impact of the problem – both locally and regionally, it's severity and the duration of the impact
- Possible solutions
- Sources of support to help resolve the issue – locally and regionally

15.6 Transport Delays

There will be a collaborative approach to resolving any delays attributed to delays in transport. Where delays are due to transport they should be escalated according to the agreed escalation process (Appendix 6.2).

15.7 Social Care Delays

There will be a collaborative approach to resolving any delays attributed to delays in social care provision. Where delays are due to social care they should be escalated according to the agreed escalation process (Appendix 6.3).

16. Monitoring: Patient Flow and Policy

A collaborative approach will be taken to monitoring patient flow and the application of this policy. The SYB Hosted Network will have a key role in this. The Daily Teleconference will support the collection of data on delays and issues.

Where it is deemed that a transfer to any service within the pathway has been inappropriate the concerned team should contact the transferring unit to discuss their concerns. Where a concern is considered serious this should be reported as a Clinical Incident, in line with local policies, so that it can be investigated and learning gained. The Hosted Network will lead on regional forums where learning can take place from such incidents and any general issues regarding flow.

Delays and timeframes for transfer and discharges will be carefully monitored. The Daily Teleconference Call will play a key role in this. HASU Trusts will collate data on stroke internal transfer delays and report these as directed. This will inform a financial reimbursement mechanism between Trusts.

Clinical Case Reviews will take place on a regular basis as part of Regional Forum / Debrief Meeting supported by the Hosted Network Structure to determine and share lessons learnt which will inform future developments of the pathway.

This Policy, its application and use will be reviewed at 1 and 3 months post implementation to establish if further amendments may be required.

Appendix 1: Policy Commitment

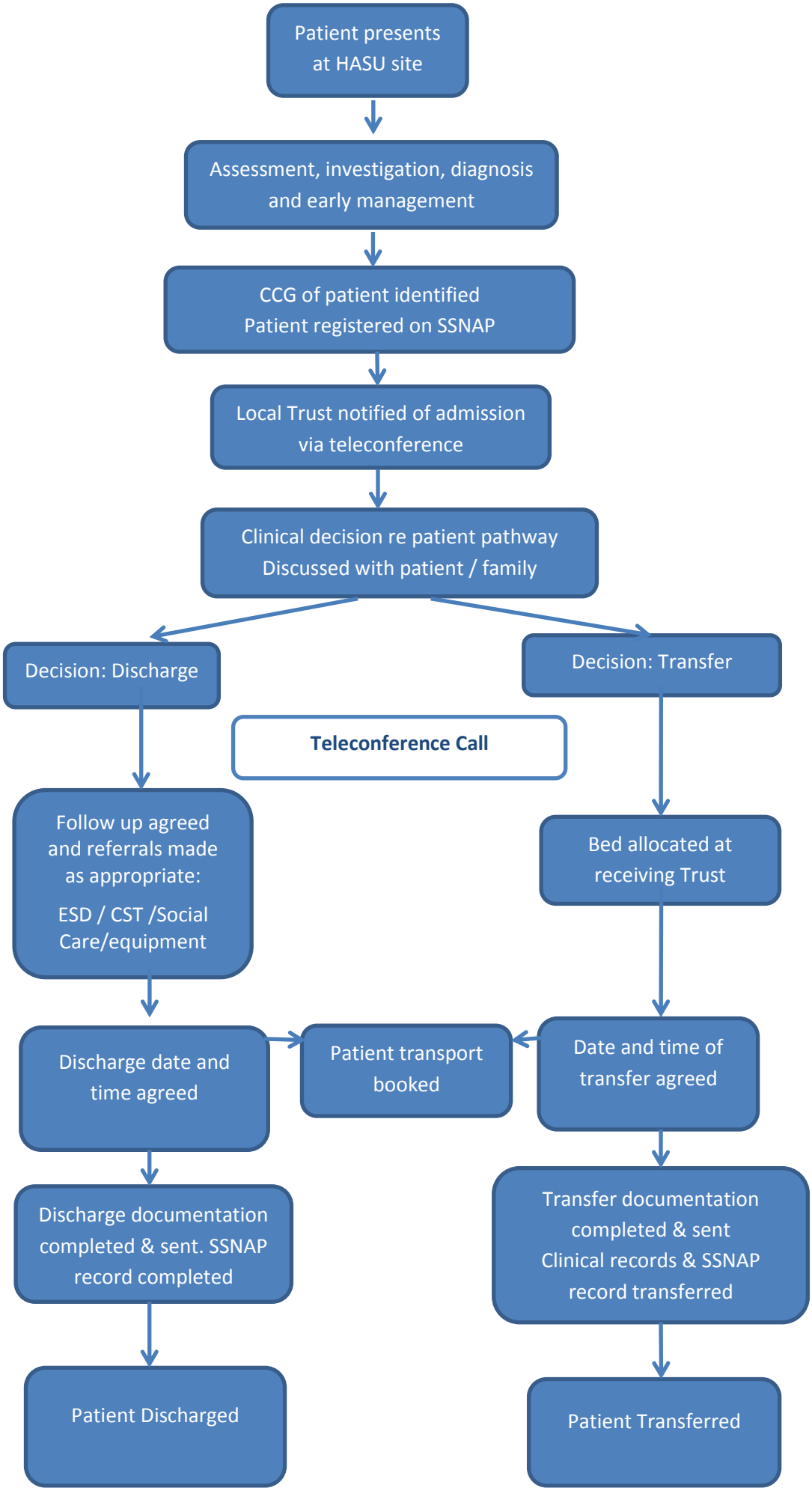
Organisation	Executive Approval Given By	Date
Sheffield Teaching Hospitals NHS Foundation Trust	Neurosciences Clinical Governance Meeting Trust Healthcare Governance Committee	14.06.2019 Put forward for 15.07.2019
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Divisional Clinical Governance Meeting	12.06.2019
The Mid Yorkshire Hospitals NHS Trust	Mid Yorkshire Hospital Stroke Board	14.06.2019
Barnsley Hospital NHS Foundation Trust	Central Business Unit Monthly Governance Meeting	31.05.2019
The Rotherham Hospital NHS Foundation Trust	Trust Clinical Governance Committee	2.05.2019
South West Partnership Foundation NHS Foundation Trust	Governance Meeting	10.07.2019
Yorkshire Ambulance Service NHS Trust 999 and Patient Transport Services	Clinical Governance Meeting	TBC.05.2019
Chesterfield Royal Hospital NHS Foundation Trust		
Nottinghamshire Healthcare NHS Foundation Trust		
Rotherham, Doncaster and South Humber NHS Foundation Trust		
East Midlands Ambulance Service NHS Trust		
Thames Ambulance Service (TBC)	N/A	

Appendix 2: Regional Stroke Services and Service Definitions

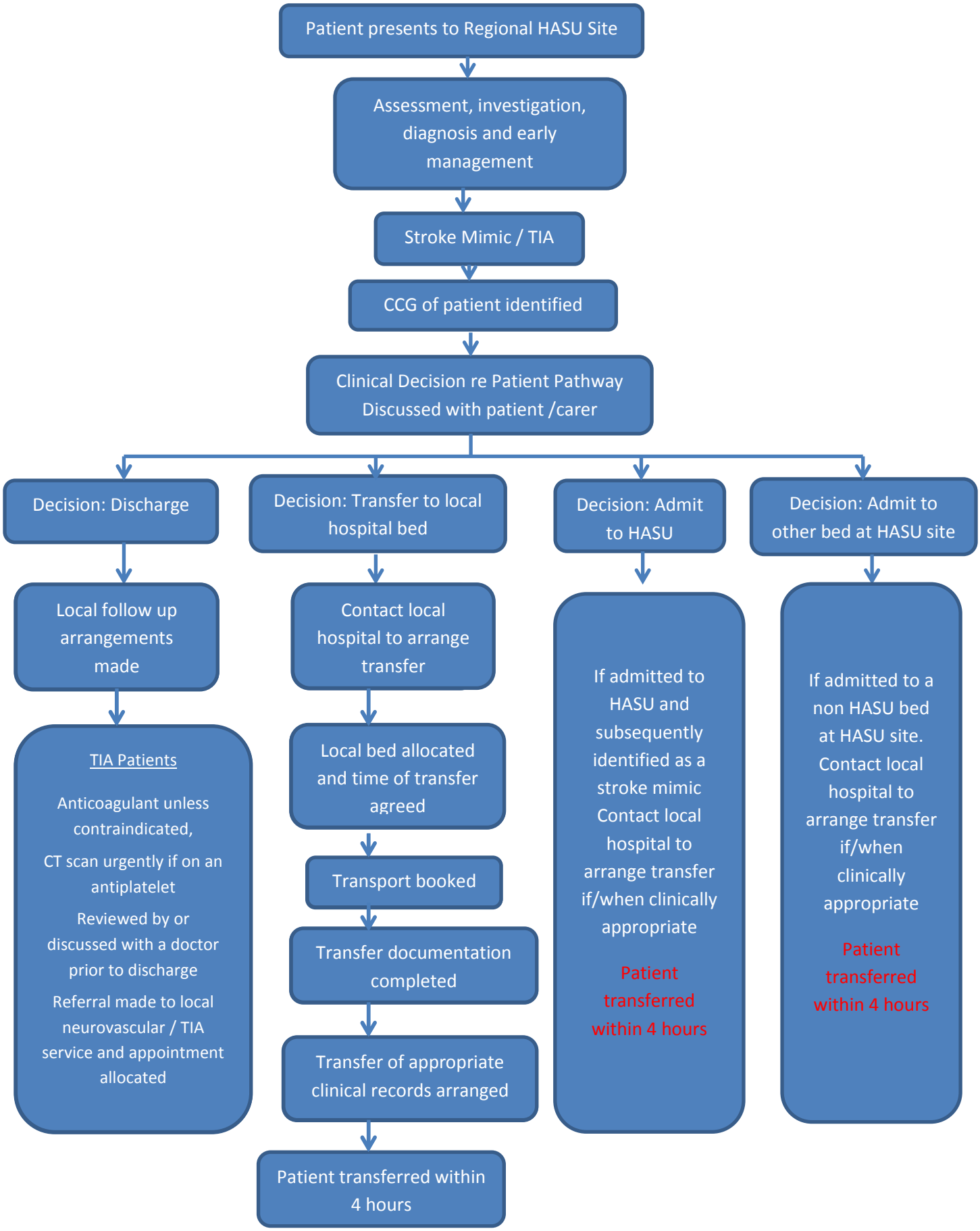
Neurological Assessment Unit (NAU)	Regional Hyper Acute Stroke Unit (HASU)	Local Acute Stroke Unit (ASU)	Stroke Rehabilitation Unit (SRU)
Patients in Sheffield present to a Neurological Assessment Unit which provides early investigations, assessments and management to stroke patients. Care in this unit is provided by the Neurological Assessment Unit team which consists of a neurological and stroke specialist multidisciplinary team led by a Neurologist or Stroke Physician. Once stroke is confirmed or still suspected patients are then transferred to a HASU bed.	Includes, but is not limited to, the initial assessment, investigation and management of patients who have had a stroke. Patients will require brain imaging, thrombolysis if clinically indicated and neurological and physiological monitoring until they are stable. Patients who are potential candidates for carotid interventions will receive carotid imaging (Doppler +/- angiography) and vascular surgical review while on the HASU as clinically indicated. Patients will receive the first 72 hour care bundle as defined in national clinical guidelines and SSNAP (e.g. stroke nurse assessment, swallow screening, SALT, physiotherapy, OT assessments) and after initial therapy assessment will commence therapy as clinically indicated while on the HASU. On average patients require hyper acute care for up to 72 hours (LOS 3 days). Some patients will be stable enough and have had all their assessments undertaken before 72 hours and be able to be discharged or transferred to an ASU in under 72 hours. Others will require a longer period of hyper acute care. Patients requiring mechanical thrombectomy will be transferred to a neuroscience centre for the procedure.	ASUs provide sub-acute specialist stroke unit care which includes ongoing management of stroke and early rehabilitation. Patients are transferred to ASUs directly from HASUs. Care in these units is provided by the ASU team which consists of a stroke specialist multidisciplinary team typically led by a Stroke Consultant.	Stroke Rehabilitation Units provide specialist rehabilitation after the acute phase of stroke. They have dedicated beds for stroke patients and are supported by a stroke specialist multidisciplinary team. SRU's may be combined with other beds such as general rehabilitation beds or acute stroke unit beds.

Regional Stroke Services						
Hospital Site	**Hospital Trust**	**Stroke admission route (most common)**	**Neurological Assessment Unit (NAU)**	**Regional Hyper Acute Stroke Unit (HASU)**	**Local Acute Stroke Unit (ASU)**	**Stroke Rehabilitation Unit (SRU)**
Barnsley Hospital	Barnsley Hospital NHS Foundation Trust	Transfer In	**X**	**x**	**√**	**X**
Bassetlaw Hospital	Doncaster and Bassetlaw Teaching Hospitals Foundation Trust	Transfer in	**X**	**x**	**X**	**√**
Doncaster Royal Infirmary	Doncaster and Bassetlaw Teaching Hospitals Foundation Trust	ED	**X**	**√**	**√**	**x**
Kendray Hospital	South West Yorkshire Partnership NHS Foundation Trust	Transfer	**X**	**x**	**X**	**√**
Montagu Hospital	Doncaster and Bassetlaw Teaching Hospitals Foundation Trust	Transfer in	**X**	**x**	**X**	**√**
Pinderfields Hospital	The Mid Yorkshire Hospitals NHS Foundation Trust	Direct to HASU	**X**	**√**	**√**	**√**
Rotherham Hospital	The Rotherham Hospital NHS Foundation Trust	Transfer in	**X**	**x**	**√**	**√**
Royal Hallamshire Hospital	Sheffield Teaching Hospitals NHS Foundation Trust	Via NAU	**√**	**√**	**√**	**x**
Stroke Pathway Assessment Rehab Centre (SPARC)	Sheffield Teaching Hospitals NHS Foundation Trust	Transfer in	**X**	**x**	**X**	**√**
Barnsley Hospital	Barnsley Hospital NHS Foundation Trust	Transfer	**X**	**x**	**√**	**x**

Appendix 3: Patient Pathway: Patients admitted to HASU Site



Appendix 4: Stroke Mimics and TIAs: Patient Pathway



Appendix 5: First 72 hour Care Bundle

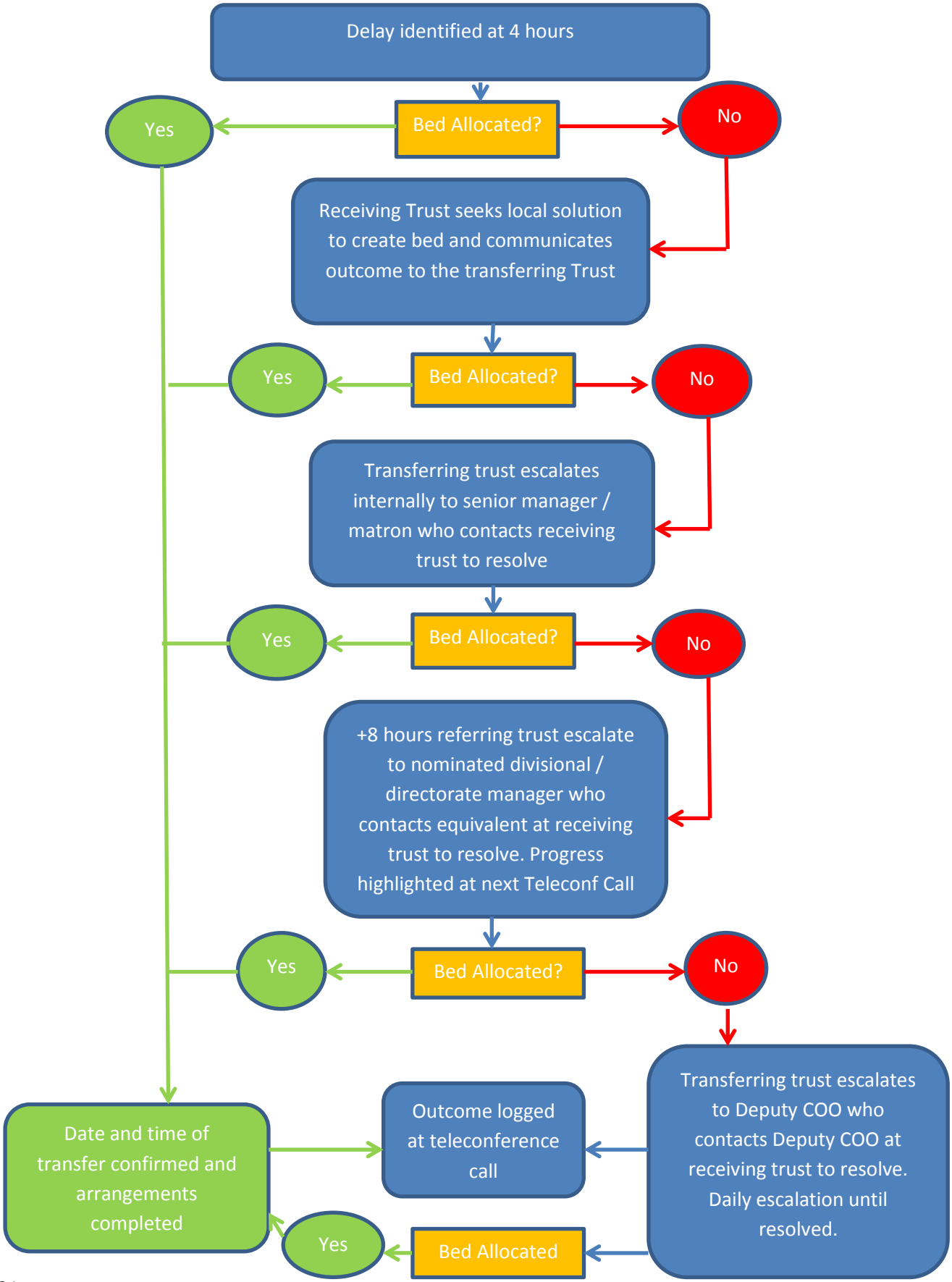
The First 72 Hour Care Bundle as detailed in the Sentinel Stroke National Audit Programme includes:

- Assessments by a stroke nurse
- Assessment by a Stroke Consultant within 14 hours
- Patients will be assessed and managed by stroke nursing staff and at least one member of the stroke therapy team within 24 hours of admission to hospital.
- Swallow screening (within 4 hours of admission) with ongoing management plan for provision of adequate nutrition.
- Patients who fail swallow screen to be assessed by Speech and Language Therapist within 24 hours
- Patients are assessed by all relevant members of the Stroke MDT within 72 hours.
- Hyper acute treatments including thrombolysis, thrombectomy, management of acute physiology as appropriate
- Palliative care decisions if appropriate

Appendix 6: Escalation of Patient Specific Delays

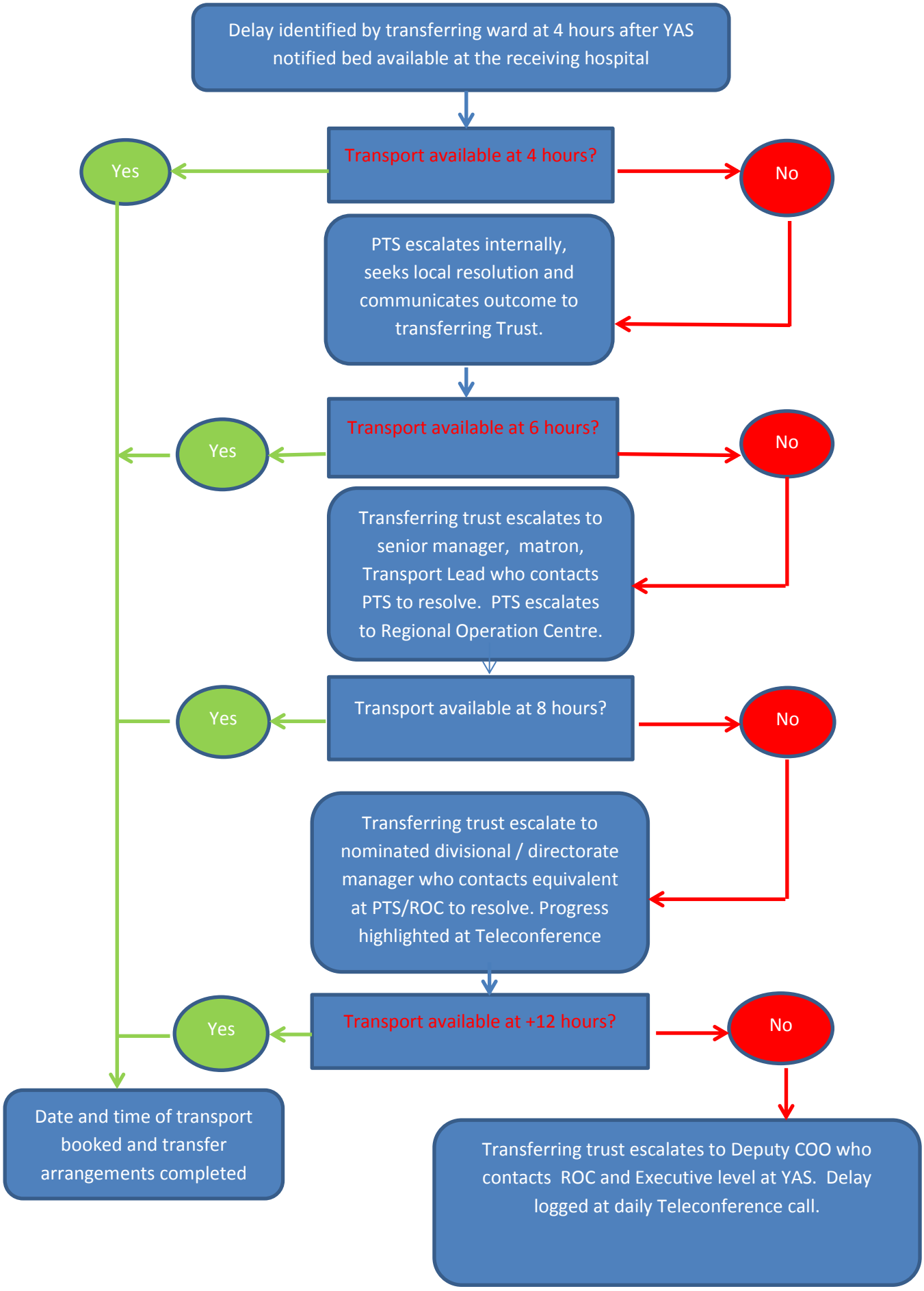
6.1 Delayed Transfer: Escalation Process

To be used when the Regional HASU team have communicated readiness to transfer, the receiving team have accepted the patient for transfer and there are delays of more than 4 hours in obtaining a bed or agreed transfer date as per patient flow policy



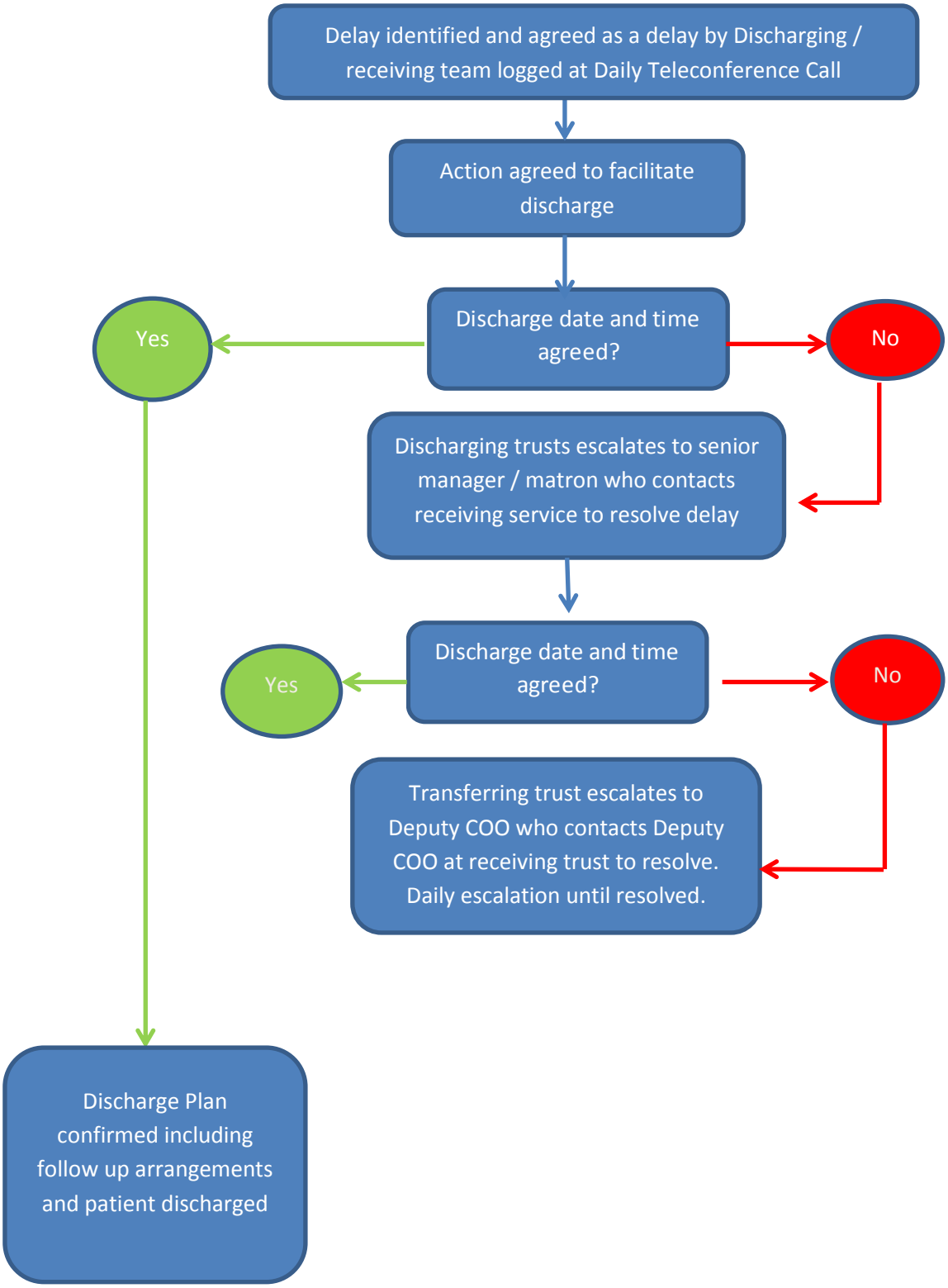
6.2 Delayed Transport: Escalation Process

To be used when the Regional HASU team have communicated readiness to transfer, the receiving team have accepted the patient for transfer, a bed is available and there are delays of more than 4 hours in obtaining transport.



6.3 Delayed Discharge: Escalation Process

To be used when a patient is ready for discharge and there are delays of more than 24 hours in securing community based services that are essential for discharge. E.g. ESD, Community Stroke Team, Social Care



Appendix 7: South Yorkshire, Bassetlaw and Mid Yorkshire Stroke Pathway TOC Form 1

HASU to Inpatient Stroke Service (ASU/SRU) Transfer of Care Form V3

Guidance Notes: *Please complete this summary transfer of care document for transfers from a* ***Regional HASU to inpatient stroke services (Acute Stroke Unit – ASU or Stroke Rehabilitation Unit – SRU) at another site*** *only.*

SECTION 1: PATIENT DETAILS	
PERSONAL DETAILS	
Full Name:	NHS Number:
Date of Birth:	Next of Kin:
Address:	Preferred Contact Number:
Ethnicity:	Religion:
Date and Time of Admission to HASU:	SSNAP ID:
GP DETAILS:	
Address including postcode:	Telephone no:

RESUS STATUS

DNAR in place: □ YES □ NO Date of Issue: Review Date:

ReSPECT Documentation in place: □ YES □ NO

Agreed ceiling of care:

Patient Details completed by (Name) :	**Signature:**
Designation:	**Date / Time:**

SECTION 2: HASU TO ASU TRANSFER ONLY

Referring Regional HASU: □ STH □ DBTH □ MYT	**Receiving Inpatient Stroke Service:** □ BHFT □ TRHFT □ SWYFT

Referring Consultant:

MEDICAL SUMMARY

Date and Time of Stroke: **Type of Stroke:**

Immediate Management: □ Thrombolysis □ Thrombectomy

Relevant details:

Investigations completed: □ MRI □ CT □ Bloods □ Carotid Doppler

Current Medical Status and Neurology:

Key current medical management information:

Medication: □ TTO / Electronic Prescription Attached / Transferred with patient record **Allergies:**

Completing Doctor Name:	**Signature:**	**Date / Time:**

Transfer of Care continued: Page 2

Patient Full Name: **NHS Number:**

NURSING SUMMARY

Key current nursing management/treatment information:	**Nutrition:** IDDSI Food Descriptor: IDDSI Fluid Level: □ NG in situ □ PEG in situ
Infection control status:	**Identified Risks:** *(e.g. agitation, falls, safeguarding, DoLS)*
Pressure Care/Tissue Viability Issues:	**Current NEWS (2) Score:** **Current GCS:**
Current Mobility:	
Seating Requirements:	

Completing Nurse: **Signature:** **Date / Time:**

THERAPY SUMMARY

Admission Barthel: **Professions required:** □ OT □ PT □ SLT □ Dietetics □ Psychology

Details:

Completing Therapist: **Signature:** **Date / Time:**

SECTION 3: TRANSFER OF CARE / REFERRER DETAILS

Date and Time Communicates to receiving unit that patient is ready for transfer:	**Communicated at Daily Teleconference Call:** □ Yes □No
Agreed Date and Time of Transfer:	**TOC Checked and Sent by:** **(Name/signature/designation/contact email or tel number)**

Appendix 7: South Yorkshire, Bassetlaw and Mid Yorkshire Stroke Pathway TOC FORM 2

Early Supported Discharge and Community Rehabilitation Transfer of Care Form V6

Guidance Notes: *Please complete this summary transfer of care document for referrals to Early Supported Discharge, Intermediate Care, Community Rehabilitation or Review Services only. This document is designed to be completed electronically but can be completed by hand and scanned to be sent electronically. Electronic referrals must be sent via a secure email such as NHSMail.*

SECTION 1: PERSONAL DETAILS:	
Full Name:	NHS Number:
Date of Birth:	Next of Kin:
Address:	Preferred Contact Number:
Ethnicity:	Religion:
Date of Current Admission:	Date of Transfer/Discharge:
SECTION 2: GP DETAILS:	
Address including postcode:	Telephone no:

SECTION 3: REFERRAL DETAILS:		
Referring Organisation: STH / DBTH / MYT / BHFT / RHFT / SWYFT **delete as applicable*		
Name of Consultant/referrer:		
Has patient consent been gained for the referral? YES / NO **delete as applicable*		
Does the patient have capacity to consent? YES / NO **delete as applicable*		
If the person does not have capacity, was the decision made in a best interest meeting? YES / NO		
If no, give details:		
DNACPR in place: YES /NO Date of issue: Review date: ReSPECT Documentation in place: YES / NO		
Referral destination: **delete as applicable*	**Service required:** **delete as applicable*	**Professions required:** **delete as applicable*
○ Barnsley	○ Early Supported Discharge	○ Clinical Psychology
○ Bassetlaw	○ Community Stroke Team	○ Dietetics
○ Chesterfield	○ Intermediate Care	○ Medical
○ Doncaster	○ 6/52 review	○ Nursing
○ Rotherham	○ 6/12 review	○ Occupational Therapy
○ Sheffield	○ Other	○ Physiotherapy
○ Other/OOA		○ Speech & Language Therapy
		○ Social care
		○ Other

SECTION 4: MEDICAL HISTORY:
Date of Stroke: Relevant Details of Stroke: (Thrombolysis / CT / MRI / Diagnosis)
Past Medical History:
Current Medication: TTO / Electronic Prescription Attached / Transferred with patient record **delete as applicable*
Allergies or Sensitivities:
Known Risks: *(e.g. Falls / Infection / Safeguarding Concerns)*
Social History/Circumstances:
Other Services Involved and Onward Referrals to date: (*e.g. Social Care / Orthotics / Spasticity Clinic / Splinting / FES / Wheelchairs)*

SECTION 5: PATIENT PRESENTATION:
Medical Status: BP/Pulse: Observation record attached? *YES/NO* **delete as applicable* Respiratory status: Skin Integrity/ Waterlow Score:

Infection status (MRSA, Clostridium Difficile, Loose stools):

Nutrition, Eating, Drinking and Swallowing:
Dysphagia: YES/NO *Delete as applicable and expand:*
Enteral feeding: YES /NO *Delete as applicable and expand:*
MUST score:
IDDSI Framework (*delete as applicable)
Fluids: 0 Thin (normal) 1 Slightly thick, 2 Mildly thick, 3 Moderately thick, 4 Extremely thick
Diet: 7 Regular (normal), 6 Soft & bite sized, 5 Minced & moist, 4 Pureed, 3 Liquidised.

Communication:
Aphasia: YES/NO Receptive / Expressive *Delete as applicable and expand:*
Dysarthria YES/NO *Delete as applicable and expand:*
Other:

Continence:
Catheter YES/NO *If YES state rationale for catheter in situ:*

Physical Ability:
Modified Rankin Score: Transfer ability:
Mobility:
Upper/Lower Limb Function:
Tonal issues:

Functional Ability:
Current Barthel Score:
Assistance required for Washing / Dressing / Toileting:

Cognition:
Assessment completed: MOCA / OCS / Other *Delete as applicable and detail relevant score:*
Other assessment/relevant details:

Behaviour and Emotions:
Mood assessment and relevant score:
Any special requirements / considerations:

Sensory:
Vision: Referred to / assessed by Orthoptist: *Delete as applicable*
Hearing:
Touch/proprioception: Other:

Known Risks: *(e.g. falls, safeguarding*

Other relevant information:

SECTION 6: IDENTIFIED PATIENT NEEDS / GOALS:

1.
2.
3.

Secondary Prevention:

SECTION 7: EQUIPMENT AND CARE PROVISION REQUIRED BEFORE TRANSFER:

Equipment in place:	**Equipment outstanding:**	**Action/date:**

Care Package in place: ***Relevant details***

SECTION 8: REFERRER DETAILS:

Date / time Communicated to receiving service that patient is ready for transfer / discharge: **Date / time TOC completed:** **Date/time TOC Sent:**	**Communicated at Daily Teleconference Call:** YES / NO
Agreed Date and Time of Transfer/Discharge: *(if known)*	**TOC completed by:** (*Name / signature / designation / contact email or tel number)*

Please attach any additional relevant information/documents.