Improving Health Outcomes
VOLUME TWO - Full version
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Stroke in West Pennine

Geographical Area covered: West Pennine
Focus: Case studies focusing on the use of national indicators

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Editorial comments on how case study is linked to improving health outcomes: (also published in Volume 1)

Wooff describes how her health authority developed a strategy to reduce morbidity and mortality from circulatory diseases. They chose this area because of high SMRs and wide variations at a subdistrict level. The focus on circulatory diseases as a whole, and the involvement of users, carers and residents in high risk localities in the design of health authority strategies widened the traditional medical model emphasis on prevention. The case study focuses on primary prevention and rehabilitation for stroke.

Primary preventive programmes aim to increase the supply of healthy food choices, no smoking environments and opportunities for exercise. Dedicated workers targeted high risk localities. They attempted to implement changes driven by local residents’ views on the determinants of their health status.

To improve rehabilitation they set up a specialist stroke team with therapists who work both on wards and in the community.

She highlights the value of partnerships, the interdependence of medical and social models of care, the need to include data handling skills within clinical teams and the importance of continuing to review health outcomes.

Abstract (also published in Volume 1)

High SMRs for circulatory diseases as a whole and stroke in particular, underlay a pre Health of the Nation decision to devise a strategy to reduce morbidity and mortality from these diseases. Of particular concern were wide small area variations. Five electoral wards had SMRs in those aged under 65, for stroke, of over 200.

The focus on circulatory diseases as a whole, and the involvement of users, carers and residents in high risk localities in the design of Health Authority strategies, has widened the traditional ‘medical model’ emphasis on secondary prevention of stroke (e.g. identification and treatment of hypertension) to include primary and tertiary preventive measures. Primary preventive programmes aim to increase the supply of ‘healthy’ food choices, no smoking environments and opportunities for exercise. High risk localities have been targeted by dedicated workers who aim to implement changes driven by local residents’ views on the determinants of their health status.

A specialist stroke team with therapists who work both on wards and in the community has been set up. Individual patient health care plans, based on standardised assessment instruments complement community care plans and will be regularly reviewed. This offers a mechanism to ensure that both the requirement for regular medical monitoring and systematic attention to social re-integration and carer needs will be met.

Lessons learnt include recognising that the style and content of the needs assessment process will influence greatly the conclusions reached and the priorities identified. Wide participation in the process will aid implementation as participants share the rationale for the need to change. The value of partnerships, the interdependence of medical and social models of care, the need to include data handling skills within clinical teams and to continue to review outcomes were also highlighted.
Introduction:

Why this clinical area was choosen:

Five year (1987-1991) aggregated standardised mortality ratios (SMRs) for cerebrovascular disease (ICD 430-438) for those aged under 65 were 157 for men and 137 for women (149 overall). These were the second highest in the (then) North Western Regional Health Authority. Compared to equivalent SMRs for all causes of 117, 120 and 118 respectively, it was clear that mortality from stroke was a particular cause for concern. SMRs for under 75s, at 141 1987-1991, were also unacceptably high.

In 1991 the Director of Public Health in Tameside and Glossop Health Authority (which in 1994, together with Oldham Health Authority, became West Pennine Health Authority) had identified circulatory diseases (ICD 390-459) as a priority for public health action before the Government Health of the Nation Strategy was introduced. A project officer (KW) was appointed on a three year contract to produce a strategy to reduce mortality and morbidity. The strategy was to cover options for prevention, treatment and rehabilitation. The emphasis in this case study will be on primary prevention and rehabilitation for stroke. This is not because secondary prevention e.g. via the detection and management of hypertension is not considered to be of vital importance in the strategy, but because others will deal with these issues more fully.

Further information that was required:

Literature examined

A literature review was undertaken. This early orientation process was instrumental in the decision to break up an almost overwhelming task into the manageable if overlapping themes of prevention, treatment and rehabilitation. The aim was to assemble enough information on the prevalence, natural history, risk factors and effectiveness of interventions early on in the process so that local opinion could be considered in the light of evidence from the start.

During the life of the project literature was and still is being reviewed continually. At the beginning of the project, effectiveness reviews such as those presently produced by the Cochrane Collaboration Centres and the NHS Centre for Reviews and Dissemination were scarce, which forced the project manager to consider issues from first principles.


Whilst the above information was required to formulate plans to deal with the nature of needs, the extent of need required some estimate of prevalence to be made. As various sources of information became available e.g. Social Trends, 25 1995 and Health Surveys for England (Breeze et al. 1994), the local context has become clearer. However, a local Lifestyle Survey (Tameside and Glossop H.A. 1992) indicated that 2% of the sample of adults reported that they had had a stroke.

Local data

The Tameside and Glossop population in 1991 was 247,000. Some 6% of Tameside’s population are from minority ethnic groups, the majority from the Indian Sub-Continent. The Jarman UPA score for Tameside in 1991 was 15.6. Given that subdistrict variations would be expected, 5 year aggregated SMRs by electoral ward were analysed. For the years 1986-1990 for those under 65 the range was 0-251. Only seven out of 27 wards had SMRs under the age of 65 of less than 100 and 5 had SMRs over 200.

The Director of Information and the Policy Research Unit of Tameside Metropolitan Borough Council had, between them, produced publications showing small area health and demographic statistics relating to the 1991 census. These materials provided the local socio-economic and demographic context against which particular issues e.g. stroke, could be seen. Of the five wards with particularly high SMRs for those aged under 65 only one had a minority ethnic group population of any size (4%); the wards with the highest Townsend and Jarman deprivation scores were not amongst them.

Local service issues
A Stroke Project Steering Committee was set up early in the life of the project, with the object of securing the involvement of providers, Family Health Service Authority representatives, Local Authority representatives and other non health agencies.

At the beginning of the project there were no agreed protocols covering the identification or treatment of risk factors and no overall strategy for managing stroke. There was no 'lead' clinician in either the acute or priority service Trust concerned with stroke. Stroke patients were treated by general physicians or geriatricians each of whom followed his own treatment and rehabilitation regimen. There was, however, a nurse manager in the care of the elderly department who had wished for some time to improve in-patient stroke services. She now leads the implementation of the strategy in her Trust. There was no system, other than the usual discharge letter, of ensuring continuity of care between hospital and primary care team. The involvement of and referral to Social Services was haphazard. There was no access to health occupational therapy for patients treated by the Acute Trust as their meagre supply was targeted towards orthopaedic cases.

Local information and views on prevention

Given that prevention programmes which are not geared to the perception of need of their target populations or groups are unlikely to be successful, it was felt to be important to elicit the views of our population in general and service users in particular.

An important source of local information was a Lifestyle Survey (1992), conducted by every District Health Authority in the North Western Region in 1992. The aim was to provide baseline information on aspects of lifestyles which were considered to be important determinants of health. Although the sample size of 2% of the adult population was too small to produce reliable small area statistics, a baseline was established which covered the adult population.

Respondents were asked to indicate their view of the importance to health of a variety of items and a summary, which extracts data for respondents with stroke, is shown below:

<table>
<thead>
<tr>
<th>Very Important to Health</th>
<th>Respondents with Stroke (N=51)</th>
<th>All Respondents (N=1957)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psycho-social (e.g. housing, income, employment)</td>
<td>69%</td>
<td>58%</td>
</tr>
<tr>
<td>Physiological/'medical' factors (e.g. smoking, exercise, weight, check-ups)</td>
<td>59%</td>
<td>53%</td>
</tr>
</tbody>
</table>

Although the differences did not reach statistical significance, fewer people who had had a stroke felt that smoking was very important to health than the sample as a whole (69% compared with 75%); they did, however, consider ‘check-ups’ to be very important (69% in the stroke group compared with 44% in the non stroke group).

These findings suggested that tertiary prevention programmes (rehabilitation) should address psycho-social needs; that more effective interventions to help stroke patients to give up smoking should be pursued and that there would be likely to be reasonable support amongst patients for introducing structured medical monitoring programmes.

Public views in high risk localities - primary prevention

Focus groups were conducted by KW and a Local Authority Health Alliance Co-ordinator in a locality with high mortality from circulatory diseases including stroke. The aims were to discover how far the then current national focus on changing individual lifestyles was felt to be relevant to our groups. Sessions (the number varied according to the extent to which participants felt they had covered all their issues) were held with separate groups covering men and women as young parents, in middle age and retired; they were held with existing community centre groups. There were no community centre groups of men aged between 25 and 45 and they were particularly difficult to engage in the process. Eventually a group was assembled by people who had participated in other groups and the meeting was conducted in a the local pub.

A semi-structured format directed discussions around the following:

- what people thought affected their health;
- which they thought were the most important;
- whether they thought things like smoking, exercise, food and alcohol consumption affected their health (designed to test out how far health workers’ views were shared by their target population);
- what services they used and how helpful they found them;
what could be done to improve their health and well-being.

The sessions were tape recorded and a report produced. The group of young women was the most vociferous, the older people the least. Once assembled, the men raised many issues and had some specific proposals which we have been able to act upon. The Health Alliance Co-ordinator was male which helped with the men’s groups and didn’t appear to be a barrier in the younger women’s groups, creches were provided (essential if sessions were to have minimum disruption). Sessions with the older men and women were conducted by people of their own gender.

Although particular concerns varied according to the age and gender of the groups, there was an overwhelming expression of alienation from mainstream health and local authority services. The single exception was people’s relationships with their General Practitioners which were very positive. This positive view, however, did not extend to the whole of the primary care team. Because many people faced day to day problems which needed urgent resolution, the culture of investing in the future which underpins resolutions to adopt ‘healthy lifestyles’ had had little opportunity to develop.

There was a general view that the ‘helping agencies’ erected so many barriers to access that the help they actually gave was limited.

User and carer views - rehabilitation

To ensure that arrangements to improve rehabilitation would be relevant to users’ and carers’ needs, two workshops, dealing with circulatory diseases as a whole, were organised by the project manager. They included users, carers, purchasers and providers of services. Two groups dealt with stroke; users and carers in their own group, with paid workers in theirs. Users and carers who attended a local stroke club were invited to participate: the the paid workers invited were members of the local Stroke Working Party which included primary and secondary care workers. The two groups were separated in order to ensure that the views of users and carers were not overwhelmed by those of paid workers. Each group had a facilitator whose role was to encourage everyone to participate, to ensure the group stuck to the tasts set according to the timetable, to ensure that views were recorded and to ensure someone in the group would present the findings.

Twenty unpaid and 17 paid workers attended the first workshop. A local hotel was used which had good facilities for people with physical disabilities, a ground floor large room with separate adjoining area for refreshments and, importantly, large round tables for group work. Unpaid participants were refunded travel and care costs. The combination of careful ice-breaking exercises, pertinent groupwork tasks, the good physical surroundings and the fact that the exercise was taking place in the context of the Health Authority looking to achieve investment/change within a relatively short timescale were instrumental in making the day a huge success.

Groups were given three questions to consider in turn:

- what would the characteristics of your ideal service be?
- how does/did your actual experience differ from the ideal?
- what are your priorities for change?

Key findings relating to stroke services were:

- the arbitrary nature of the existing services, with people managing to acquire services more by chance than design;
- users carers and paid workers agreed on the need for a co-ordinated specialist multi-disciplinary team to deal with strokes;
- users pointed out more practical needs than the paid workers e.g. for chairs on wards to be suitable for use by people with disabilities;
- several instances of breakdown of standards of care were raised e.g. patient left in lavatory unable to move for a long period. No-one had complained;
- many users and carers felt abandoned when they were discharged from hospital;
- fundamental needs pointed out by users and carers were the real need to be included in the formulation of any treatment and care regimes, much better and continuing information on the nature of the condition, prognosis etc. much more emphasis on practical home support and support for carers and some options for continuing support as their circumstances changed.
The priorities that emerged were a mixture of high and low cost measures with needs for information/participation, the implementation of standards which paid workers thought were already being delivered plus investment in co-ordination and expansion of home support being emphasised.

Some months later, a second half day workshop was held. This time the stroke groups’ task was to decide how to spend a notional sum of £150,000 (money earmarked for developing stroke services). The user/carer group wanted one quarter spent improving ward staffing levels, half on improved therapy services - emphasising home assessments and one quarter on help for carers. Interestingly, the paid workers could not agree how to spend the money, which they said was inadequate.

The workshop method was unsuccessful in involving members of minority ethnic communities. Following advice from link workers, individual semi-structured interview sessions were held by KW with the assistance of Trust Link Workers. Many people were particularly concerned with housing aids and adaptations to cope with their disabilities which probably reflected their relatively poor housing conditions. Whilst they wished for more information about their illnesses, they were not so insistent to be included in plans for treatment and rehabilitation as the workshop participants.

A video showing clips from the second workshop (we didn't think of it for the first one) and interviews with two users and one carer, was produced. It enables those who were unable to take part in the process to see for themselves what users felt and serves to remind commissioners and providers how the consistency and quality of services as well as the quantity, affect individuals and their families.

**Data validity studies:**

**Incidence of acute events**

Estimates of likely incidence were problematic. The application of the Oxford annual incidence figures (Bamford et al 1988) to Tameside and Glossop yielded an expected number of 497 in those aged 45 and over. Estimates by Wade (1992) yielded an expected number of around 600 first-ever cases. Bonita (1984) estimated that first-ever strokes account for 75% of all acute events so an additional 124 or 150 should be added to these figures to calculate the total expected number of acute events in one year. This would give estimates of 621 and 750 respectively. However, in 1991, 805 patients were admitted (we did not use FCES to avoid the potential for inflation) to Tameside General Hospital with a diagnosis of stroke (21% died). Wade et al (1985) had estimated that 25% of all strokes are not admitted to hospital, which (if applied to out admissions data) would yield an expected annual number of acute events of 1072.

Assuming that diagnoses of stroke were not wildly inaccurate (and a recent Trust audit had shown high standards of coding accuracy in general) then either Tameside and Glossop experiences annual event rates at least 43% higher than 'average' or has a high proportion of patients admitted to hospital. Given that mortality ratios are 41% higher in the under 75s than for England we have worked on the basis of the former.

**Consultations with the general public and service users**

The various forms of public and user consultations, although the focus and workshop groups were not scientifically randomly selected, all confirmed theoretical and practical issues highlighted by the literature review. In particular, they confirmed the need to offer a new style of primary preventive work aimed at dealing with broad determinants of health in economically and socially disadvantaged areas. What we did not find was that people had used the formal complaints procedure when things had gone wrong. We could, therefore, not rely solely on the complaints procedure to alert us any service shortcomings.

**Summary findings from initial work:**

**Changes which were made:**

**Primary prevention**

Primary preventive strategies were considered as part of circulatory diseases as whole as the needs for CHD and stroke (and indeed many other illnesses) had much in common. To supplement a small existing health promotion team, three contracts, dealing with promoting smoke-free environments, improving nutrition and increasing exercise were drawn up with briefs to increase awareness and involvement of non health agencies. They have a district wide remit.

The two localities with the highest SMRs were identified as target small areas. A third locality, which
was already experiencing high mortality and which had a high potential risk (47% of its population was of South Asian ethnicity and a cohort of 1960s immigrants were approaching middle age) was also identified for 'special' attention. The first locality based scheme employing one full-time worker started as a 2 year pilot scheme in 1994, funded via the Joint Local Authority and Health Funding mechanism. It has now been funded by the Health Authority. A second scheme started in 1995 in the locality with a high proportion of residents from minority ethnic communities. It has an establishment of two full-time fieldworkers supported by sessional workers and an administrative assistant. It is funded from partnerships with the Local Authority Youth and Community Service, the Health Authority, one year's funding from the NHS Ethnic Health Unit and a Single Regeneration Budget contribution. A part-time worker took up appointment in the third locality in August 1996.

The remit of the locality workers is to work to identify the issues which the local communities themselves feel affect their health and to work to change the systems operated by the relevant statutory, voluntary and independent agencies. Depending on the locality, the emphasis placed on the economic and social determinants of health varies but the brief is to let the needs of the populations concerned determine this emphasis. In this way, needs are assessed continuously.

Because communication skills are of prime importance, as a matter of principle, local people are invited to take part in the recruitment selection process by scoring how well candidates conduct a focus group session aimed at identifying needs.

**Secondary prevention**

Although the thrust of this case study relates to primary prevention and rehabilitation, it should be pointed out that measures to improve the detection and treatment of hypertension in primary care were also being pursued, in particular, via the primary care audit programme. In 1995 two Family Health Service Authorities and part of one other, became part of West Pennine Health Authority. The task of bringing together audit and implementation protocols continues.

**Rehabilitation**

In Tameside a specialist stroke team based in the Community and Priority Services Trust has been funded by the Health Authority, with the Trust contributing by re-providing some specialist care from existing resources. Patients aged under 70, judged to be able to benefit from active rehabilitation, will be either admitted directly or will be transferred from the Acute Unit when the acute phase of their illness has past. Because the prevalence of acute events appears to be particularly high, the service will be restricted to those who have been admitted until we have had the opportunity to review its operation. A specialist interim stroke ward of 18 beds opened in July 1996, with 6 beds designated for use by younger patients. The stroke team will be responsible for delivering specialist follow-up care in the community as well as on the ward. A purpose built facility with 22 beds is planned for 1997. But in the meantime all stroke patients are being treated on a re-designated ward. In 1996, a retiring member of the Care of the Elderly consultant staff was succeeded by a consultant with a special interest in stroke. The arrival of this medical ‘product champion’ will underpin the next stage of developing our treatment services by the introduction and auditing of guidelines concerning treatment of stroke and TIs.

In line with user and carer wishes there will be an emphasis on the provision of home support and a home visit will be made to ascertain needs before discharge where this is required. To support the additional occupational therapy input to the stroke team funded by the Health Authority, an additional occupational therapist has been appointed by the Social Services Department which will shorten waiting times for assessments of home adaptations which may be needed. Personal care plan will be worked out in conjunction with patients and their carers and will complement any care plans which are the responsibility of the Social Services Department. This will include assessment of function, daily living, continence, communication, leisure and social networks, welfare benefits, carer needs and mental health. The aim is to prevent the automatic administration of therapies which are unrelated to users’ priorities (e.g. everyone to have ‘dressing practice’ whether they consider it to be a priority or not) and to ensure that any in-patient therapeutic work reflects the realities of the home situation. Wherever possible, standardised measuring instruments will be used both for monitoring progress and for selecting patients for specialisation follow-up. Those so far agreed will cover function (Mahoney and Barthel 1965) and quality of life (Braxier et al. 1992) to assess progress and the General Health Questionnaire (Goldberg 1972) to trigger follow-up of mental health problems.

Copies of the care plan will be kept in case notes, given to users and sent to GPs. Medical requirements such as regular monitoring and treatment of hypertension will also be included and will help to re-enforce tertiary prevention in the primary care setting by emphasising its importance to patients and encouraging them to use their care plans on an on-going basis. Care plans and assessments will be computerised, be patient based and used to monitor team performance and outcomes. Carers’ needs will be addressed in the plan. Review dates will be built in and caseloads will be reviewed and ‘managed’. This data base will form the basis of a stroke register, but its
extension to cover patients treated in a primary care setting only will be a major undertaking (KW is a past director of a psychiatric case register so has direct experience of the complexities) and will not be attempted until the existing system is well established and a feasibility study carried out. In the meantime, primary care audits can yield information on how far care plans are adhered to over time.

An information pack will be produced which contains information on services, their functions, access arrangements, welfare benefits etc. A user group will be set up to ensure that the partnership between users, careers and providers. In response to users' requests, to contribute to easing any delays in waiting for aids to daily living, the Social Services Department is assembling information sheets on the availability of aids to buy and how to use them. Ways of making this information available via local libraries are being explored.

Implementation will occur in two stages. In the financial year 1995/6 a team co-ordinator was appointed whose responsibilities at this stage covered assessment of strokes admitted to both Trusts; to set up computerised support for the assessment instruments and care plans and to draft an operational policy for the new team. Because the shortage of occupational therapy was particularly acute, recruitment of an additional whole time person, supported by two 'helpers' has gone ahead. The plan is that generic ‘helpers’ will be trained to NVQ level 3 to support all therapy staff. A particular effort to recruit staff with at least one South Asian language has been made. The skill-mix of the rest of the team has been estimated by a combination of local assessments; views of users and carers and literature reviews and will need to be reviewed as the service develops.

Inter Trust arrangements for the transfer of resource from the Acute Unit to the Community and Priority Services Trust have been agreed. Integral to the change has been a Health Authority agreement to purchase other general medical activity in the Acute Trust to replace that lost by transfer of stroke patients. The number of stroke beds being opened has been calculated on the assumption that length of stay will be reduced.

Recent literature on the advantages of specialist acute stroke units (Duncan 1995) and the need to develop a service to deal with stroke patients who are not admitted to hospital, dictate that further work on developing provision is required. The extent to which the specialist team will be able to offer improved services for those who have had stroke in the past will also need to be considered.

How changes will be monitored:

Some of the rehabilitation outcomes to be monitored are process oriented. For example, the proportion of users who have received agreed standardised assessments and the proportion of users who have received home assessments before discharge. Targets for these have been included in the service specification. The use of standardised assessments and mortality statistics will also enable progress (both of individuals and of groups) to be monitored over time.

Length of stay will be monitored on a quarterly basis and the performance of the new service will be compared with that of the old service. Over time, analysis of the standardised instruments will show whether the extent of disability or impairment at time of discharge has changed. This will assist in interpreting whether any changes in length of stay have occurred as a result of changing discharge criteria. Unfortunately, a baseline of disability at time of discharge from the old service was unavailable.

- Primary care audits will show how far the use of care plans has assisted in strengthening the links between primary and secondary care.
- The establishment of a users and carers group offers a structure which will provide on-going feedback on their perceptions of how the service is working.
- Standards in the new Stroke Unit will be monitored by the application of standards set out in the Charter for Disabled People Using Hospitals (Royal College of Physicians et al. 1992).
- Short term outcomes on primary prevention tend to be process measures e.g. the proportion of patients given routine blood pressure checks. Over time, local surveys such as the Lifestyle Survey (op cit) will provide indications of change in lifestyle.

Changes brought about by locality workers and the Forum workers are documented in detailed annual reports. A ‘healthy locality audit’ package is being piloted in one locality which aims to log the presence/absence of ‘healthy’ choices available. The audit parameters include both items considered by local people to be important e.g. reduction of personal debt and the more conventional markers of risk e.g. number of smoke-free public spaces. The aim is to use this to monitor changes over time and to develop the sensitivity of the instrument.
Resource Implication:

Uninterrupted time to consider the implications of statistical evidence, literature and local views was imperative to make sense of all the information, to prepare strategic documents and service specifications. A close working relationship with providers was also key to moving the change process forward. Having a project manager with a specific and exclusive remit to cover circulatory diseases was instrumental in the strategy being able to deal with prevention and rehabilitation as part of a whole. Small sums to support liaison with users, carers and others is essential. The project manager has since become a member of the Public Health Department, and, togeth-er with new responsibilities, continues to work on implementing changes in stroke services.

The size of resources available to invest in services will vary between districts. Investment in new services was possible in our case, but was also supported by the re-organisation of existing provider services. Shifting work from one Trust to another was facilitated by being able to replace the stroke work lost to the Acute Trust by purchasing other activity from it.

Practical lessons learnt:

The value of partnerships with users and the general public
Because the information gained from users and carers supported other published findings, it might be argued that the consultations were unnecessary. Critics might also point out that the users and carers were not selected on a scientifically pure random basis. The response to these arguments is as follows. The fact that psychological and social issues were at least as important as ‘medical’ issues to all public groups was made explicit and made possible a shift in attitudes of some paid workers away from a reliance upon interventions based exclusively on ‘medical’ models. Even when ‘medical’ models were being considered by users, their requirement for a specialist service was in line with the literature. Thus, the question might also be posed whether going straight to the users might not have been more appropriate than wading through the ‘evidence’.

There is a considerable literature which demonstrates that knowledge of ‘scientific’ evidence alone does not bring about behaviour change amongst health professionals (nor indeed in the general public). The shared process of identifying needs also became the shared processes of acknowledging the need to bring about change, identifying priorities for action and generating a sense of urgency and enthusiasm. Because users and carers expressed needs which integrated different intellectual disciplines (e.g. psychological, social and physiological), paid workers, whose training and socialisation tends to emphasise only one of these, were able to see and hear for themselves how each of these disciplines have a distinctive contribution to make to an overall strategy. Further, by maintaining contacts with our users and carers we are able to test out the applicability and practicability of various anticipated operational changes. We also learnt that the absence of complaints about the service did not imply that the service was good. When we have our stroke team data base, we will be able to do a more systematic job in accessing user and carer views. However, our statistically impure sample of users and carers gave us plenty of good information to begin with.

The sequence of the needs assessment process is important
Discussing detailed needs and options for provision with local people is better done when a commitment in principle to develop (or reprovide) services has already been made by funders (or purchasers and providers). However, in order to gain this commitment in the first place, a case must be made and won. The needs assessment process, then, becomes a two stage process - the first gaining agreement in principle, the second, refining the nature of the service change. As will be seen below, it is also suggested that public health should be involved in implementation and monitoring.

The circulatory disease focus emphasised primary prevention
Because the original brief for the project worker covered circulatory diseases as a whole, the range of population risk factors to be considered was wider than if the focus had been on stroke exclusively. Strategies to reduce smoking within communities were, of course, common requirements for reducing the incidence and prevalence of circulatory diseases and stroke. However, secondary prevention in the form of the detection and treatment of hypertension is more important in reducing the incidence and prevalence of stroke than coronary heart disease. A focus on stroke alone, therefore, would have been unlikely to result in the primary preventive strategies which have been implemented. As financial pressures have increased and the initial ‘flavour’ of Health of the Nation has been supplemented by competing pressures on increasing ‘patient activity’ levels and reaching Patients’ Charter standards, the resources to implement the primary preventive strategy would have been unlikely to be available now whereas, the opportunities to influence secondary prevention have probably been strengthened by the current emphasis on the role of primary care - so with hindsight, we are glad we did things the way we did.
Public Health should be involved in implementation and monitoring

Implementation of change must be part of the public health remit. The partnership with providers and consumers in assessing needs forms part of the change process. Leaving implementation to others e.g. contracting departments will sever these links which are necessary if services are to continue to evolve on course. Involvement in monitoring is an extension of the commitment to implementation.

Providers need more IT and data handling and interpretation skills

If providers are to be able to take advantage of the opportunities offered by computer technology to support and enhance their clinical work, they need more multi-skilled staff. It is important for clinical staff to be able both to appreciate the opportunities and to undertake basic system design work in conjunction with more specialist IT colleagues. The use of data to monitor team clinical and operational performance is under-developed. Clinical teams often delegate collection and presentation of data to audit colleagues. The audit may be seen as an ‘add-on’ activity designed to monitor a restricted number of performance parameters. This may actually serve to inhibit the development of a clinical team’s responsibility to use data routinely to maximise beneficial outcomes even though an audit process in itself has value.

Initial service specifications must be reviewed

An illustration of the need for continuing involvement is illustrated by the implementation of the plan to use specific standardised assessment tools at particular points in users’ careers. On piloting the use of the SF 36 (Braxier 1992) quality of life instrument before discharge, the Stroke Team Co-ordinator found that, because patients at this stage were often quite disabled, filling in the questionnaire was inappropriate both because they did not have the opportunity to perform some of their usual activities on account of being hospitalised and also because some patients found recording their loss of quality of life to increase their depression. It has now been agreed to postpone the use this instrument until patients have been out of hospital long enough to have established some form of routine and have a care plan to deal with loss of quality of life - the use of other means of measuring outcomes may also have to be considered.

Health promotion programmes must deal with psycho-social and economic issues as well as ‘medical models’

It was clear from our public consultations that the general public and people who had already suffered from stroke regarded social and economic factors as being at least as important to their health as ‘medical’ factors. In this regard, they reflect wider Public Health perspectives but unless services are geared to act on these issues as well as on ‘lifestyle’ and ‘personal risk factors’ the congruence of user needs and provider input, which is a pre-requisite for successfully bringing about change, will not be achieved. However, more effective negotiations on ways to reduce risk factors for those people who have had a stroke are clearly required as our lifestyle survey showed.

Locality based workers delivered added value, particularly to our primary prevention strategies

Access to people who live in our target localities has undoubtedly been enhanced by the network of locality workers. For example, we have been able to get direct access to local groups in two localities to do work on designing materials aimed at reducing smoking in various target groups. Without the relationships already built up by the community workers, gaining access to and confidence of these groups would have taken many months of work. Involving people in the recruitment of our locality workers has also been instrumental in ensuring that we have people with appropriate communication skills.

Other, wider benefits have followed. The locality workers have been instrumental in the Health Authority being able to take advantage of opportunities presented for funding which frequently demand a short-term response which cannot be achieved unless substantial work has already taken place. They have also been instrumental in activating partnerships with workers from a wide variety of local government, voluntary and commercial organisations.

Conclusion:

References:


Organisational Context:

The contracting framework has encouraged the experimentation of new ways of providing services. We have been able to take particular advantage of this flexibility when contracting for the provision of our newer primary preventive services. None of the locality workers has been a mainstream health worker - probably the result of including local residents in the selection process. The workers providing our nutrition, smoking and exercise and leisure alliance working are a mixture of Trust employees and independent contractors.

By assigning specific responsibility for needs assessment and commissioning as distinct from providing services, the purchaser/provider split has strengthened the public health role and demanded explicit decision-making based on evidence of effectiveness. The extent to which ‘ideal’ models of service can be implemented, however, varies. Local opportunities and threats are disparate.

The amalgamation of health districts into areas covering populations of around 500,000 and spanning different local authorities and trusts, together with parallel mergers of Family Health Service Authorities has made the formulation and implementation of action plans more difficult than when districts were smaller. The only way to ensure effective implementation is to work in partnership with local people, providers and other non-health agencies. Participation in the needs assessment process is part of delivering change as the rationale for change should be shared by both purchasers, providers and users. The changes in personnel and in roles brought about by recent reorganisations have not helped maintain the continuity of involvement this shared process requires.

The disappearance of the regional health authority tier has, whether temporarily or permanently, limited the availability of routine intra-district comparative data on mortality ratios. Electoral ward-based 5 year mean mortality ratios for main causes of death were produced each year by the old region. They were invaluable in tailoring services to locality needs and the last were produced for the five years ending 1990.