



Cardiac and Stroke Networks in Lancashire & Cumbria

Stroke Workforce Training Strategy for the Cardiac and Stroke Networks in Lancashire and Cumbria

2009 - 2011

References:	
1	National Stroke Strategy 2007, Department of Health, London V1
2	Stroke Specific Education Framework, 2009, Department of Health Publications, London
3	National Sentinel Stroke Audit Phase 1 Organisational audit 2008, Royal College of Physicians of London
4	Source: Lancashire and Cumbria PCT website 08.06.09
5	Source: http://www.nwstroketaforce.org.uk/generic 23.11.09
6	Prevalence of Stroke and TIA by PCT 2007/2008 Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk or www.nchod.nhs.uk)
7	Effect of urgent treatment of transient Ischaemic attack and minor stroke on early recurrent stroke (EXPRESS study): a prospective population-based sequential comparison Peter Rothwell et al <i>Lancet</i> 2007; 370: 1432–42
8	DOH (2008) Implementing the National Stroke Strategy – an imaging guide p.21
9	http://www.dh.gov.uk/en/News/Recentstories/DH_107996
10	http://www.improvement.nhs.uk/QualityandProductivityChallenge/tabid/61/Default.aspx 06.01.10

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Executive Summary

The Cardiac and Stroke Networks in Lancashire and Cumbria have produced a two year Training Strategy which will inform commissioners, acute trusts, community and social care of the training requirements needed to implement the National Stroke Strategy Network-wide.

The two year Strategy sets out training requirements and key recommendations needed to develop a competent stroke workforce and to ensure that all staff involved in the care of the stroke patient have the requisite knowledge, skills and commitment to implement, maintain and sustain high standards of quality care.

This Training Strategy includes a summary of the following:

- An outline of the infrastructure for training, taking into consideration any conflict of resources whilst tailoring the training to the operational and organisational needs of health and social care services throughout the Network.
- The methodology and results of a Network-wide training needs analysis, which was generated from the Department of Health Educational Framework², and Northwest Task Group recommendations⁵.
- The prevention and detection of stroke is seen as a training priority.
- The Network aim of establishing an approach to stroke training that will deliver an appropriately trained workforce that is cost effective and equitable.

Objectives:

This Strategy will:

- Inform commissioners of the existing national drivers around stroke educational requirements of the multidisciplinary workforce throughout the Lancashire and Cumbria Network, across the whole stroke pathway.
- Identify stroke specific training needs of the multidisciplinary workforce across the Lancashire and Cumbria Network by the use of a training needs analysis document.
- Identify existing training providers and current training provision
- Determine the approach for delivering training that maximises the skills and productivity of the workforce.
- Develop a train the trainer approach to stroke training.
- Develop a methodology for evaluating the impact of training on patient experience and service delivery.
- Provide a programme of training for the stroke workforce that will be sustainable, for both new and existing staff, through collaboration with local clinical skills facilities and Higher Education Institutions (HEIs).

Key Recommendations

- Commissioners need to build training into service specifications.
- There needs to be a commitment at senior level to release staff to attend educational events.
- Training needs are identified across the whole stroke pathway
- Each organisational area needs to produce an action plan highlighting their approach to stroke workforce training. Any action plan would require evaluation methodology to ensure that delivered training has an impact upon practice
- Develop the Train the Trainer approach across the varied settings

Strategic Context

The aim of the Cardiac and Stroke Networks in Lancashire and Cumbria is to secure the commitment of clinical, social and managerial staff to work together with patients to improve the quality of care for people who have Coronary Heart Disease and those affected by stroke. This involves working with and across the many organisations who are involved in offering care.

The Network does not have executive authority or control over the allocation of resources but works closely with Commissioners who have overall responsibility to deliver the National Service Framework for CHD and more recently the Department of Health National Stroke Strategy in 2007⁽¹⁾.

A significant part of the Network's work is to support service improvement. This involves working with clinical and managerial staff to help assess, and when necessary, improve services by using tools and techniques developed specifically for that purpose. This can happen within a single organisation or across the whole of a patient's pathway of care.

Clinical engagement is a really important part of the Network's programme, as the advice offered by clinicians working in Lancashire and Cumbria is crucial to the development of Network-wide evidence based treatment and protocols that are known to be effective.

Involvement and Consultation:

Stakeholder engagement and involvement was considered crucial to the success of the Strategy.

Stakeholders

- North West Ambulance Service (NWAS)
- Primary Care Trusts (PCTs)
- General Practitioners (GPs)
- Acute Trusts
- Clinical Skills Leads
- Community Services
- Local Authorities
- Voluntary and Independent Service Sector
- Higher Education Institutions
- Patient and Public Involvement (PPI)
- Strategic Health Authority (SHA)
- Stroke Improvement Programme (SIP)
- Department of Health (DH)

3 Local Context

The Cardiac and Stroke Networks in Lancashire and Cumbria (CSNLC) have used the following forums to ensure stakeholder involvement throughout the development of the Strategy:

- Cardiac and Stroke Network Board
- PCT Commissioners/CVD Leads Group
- Operational Steering Group
- Stroke Clinical Advisory Group
- Healthcare Professionals Groups
- Development of priority focused Task Advisory Groups (TAGs)
- Development of priority focused patient consultation groups
- North West Ambulance Service Lead

National Stroke Strategy Quality Markers (QM) 18 and 19 state that all people with stroke, and at risk of stroke¹, should receive high-quality care and services delivered by staff with appropriate knowledge and skills. There is no nationally co-ordinated strategic approach to workforce development through education and training². Specialist knowledge has often been developed in an informal ad hoc manner.

It is widely recognised that quality-assured, transferable training and education programmes for stroke, linked to professional roles and career pathways, are needed. The National Sentinel Audit 2008³ review of care provided within acute hospital settings has consistently produced results in the lower quartile in the Lancashire and Cumbria Network.

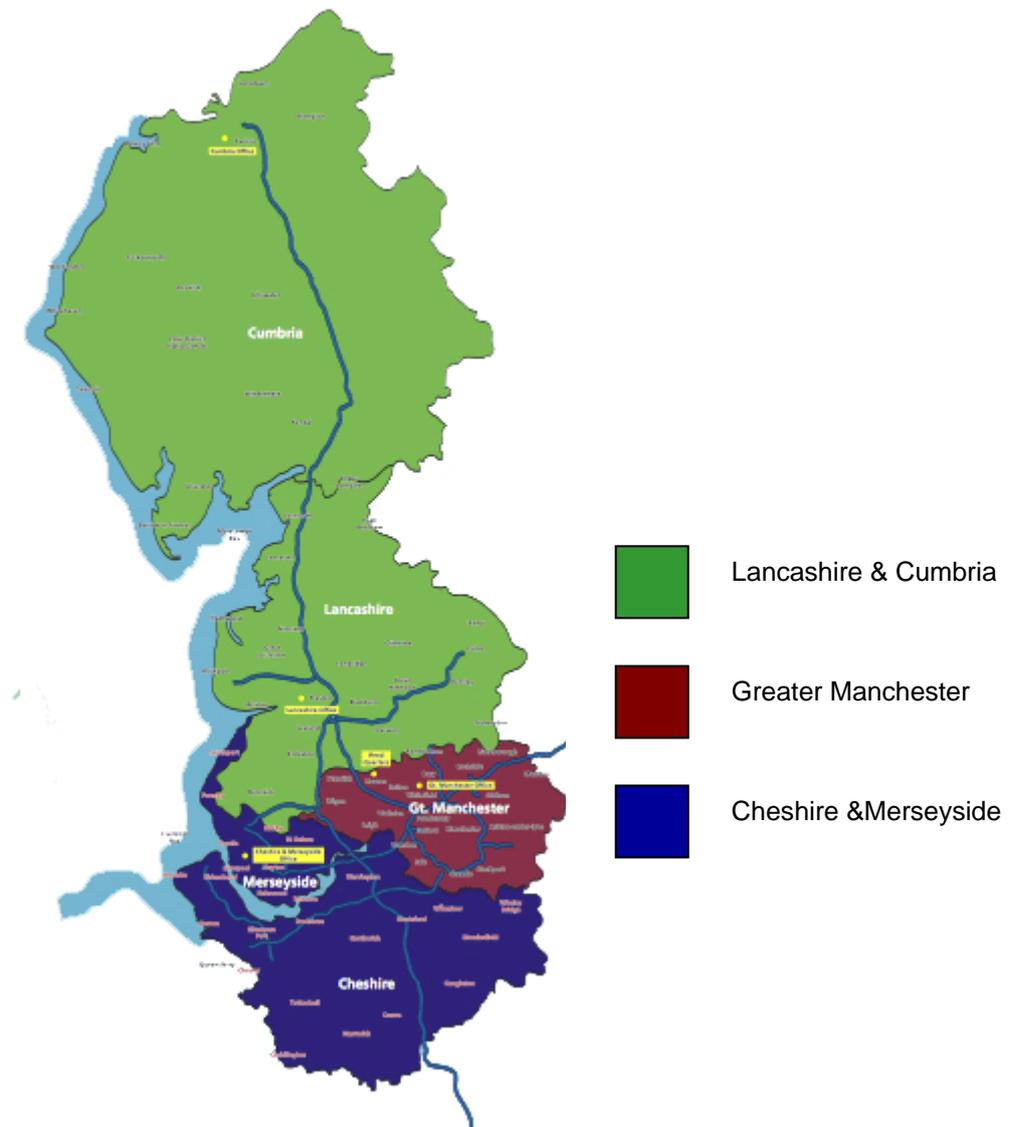
In March 2009 the Network employed a Stroke Practice Development Nurse to scope, develop and implement a sustainable training programme across the stroke workforce that will form the basis of the training strategy. The Training Strategy will provide an infrastructure of standardisation and equity Network-wide.

As part of the Network work programme, Service Development and Improvement Managers (SIMs) have been allocated as links to each health economy, part of their role is to assist in the implementation of a patient stroke pathway.

In order to deliver a robust Training Strategy for the CSNLC, a multifaceted targeted approach is required. This should be tailored to the individual organisational requirements, incorporating a wide range of professional and educational needs.

To achieve a greater public and professional awareness of the symptoms of stroke, there needs to be an educated and responsive pathway commencing in primary care, through the acute setting and into a rehabilitation service within the community, including social and community care settings.

4. Demographics and Scope of Training Requirements



The current registered population of Lancashire and Cumbria is 1,985,300. The following table provides a population breakdown by Primary Care Trust⁴

Primary Care Trust	Population
Blackburn with Darwen	165,000
Blackpool	150,000
Central Lancashire	460,000
Cumbria	500,000
East Lancashire	386,000
North Lancashire	324,300
Total	1,985,300

Prevalence of Stroke and Transient Ischaemic Attack (TIA) by PCT 2007/2008 ⁶

The overall prevalence of stroke and TIA for PCTs within the Cardiac and Stroke Networks in Lancashire and Cumbria is 1.95% of the total registered patient population. Overall this is higher than the average figure for all of England, which is 1.63% of total registered patient population. This demonstrates that all areas of the Cardiac and Stroke Networks in Lancashire and Cumbria have a higher than national level of stroke and TIA prevalence.

Prevalence of Stroke and TIA by PCT 2007/2008 ⁶			
	Number of registered patients	Number of patients on stroke register	% Prevalence
Blackburn with Darwen	164426	2799	1.70
Blackpool PCT	152140	3027	1.99
Cumbria PCT	518293	11285	2.18
North Lancashire PCT	337196	7403	2.20
Central Lancashire PCT	464629	7851	1.69
East Lancashire PCT	387543	7138	1.84
Network Total	2024227	39503	1.95%
Total for England	54009831	881689	1.63

The current stroke pathway in Lancashire and Cumbria

Prevention

Recent initiatives by the Department of Health have aimed to improve public and professional awareness of the risk factors and symptoms of stroke, in line with **QM 1** in the National Stroke Strategy (2007). These risk factors are the same risk factors as those for Coronary Heart Disease. Early detection and treatment of modifiable risk factors have shown to reduce the incidence of stroke and TIA within the community. This is currently being addressed by the Cardio Vascular Risk Assessments programme being implemented within primary care.

The link between Atrial Fibrillation (AF) and stroke has been clearly demonstrated, national and local initiatives are focussing on the early detection and treatment of AF. The Network Cardiac Strategy 2010 – 2015 lays out specific recommendations in regard to AF, following on from these recommendations the Network has commissioned and facilitated further training around Cardio-vascular risk, and the detection and treatment of AF within the primary care sector. The Network have undertaken a national priority project addressing AF in primary and secondary care, which involves training awareness and the implementation of the GRASP – AF tool which can be found on the NHS Improvement Website – www.improvement.nhs.uk

National campaigns such as the FAST initiative have been shown to have a definite impact on public awareness of the signs and symptoms of stroke, along with the required actions needed. The effectiveness of this campaign has been evaluated, and has illustrated an increased awareness of stroke symptoms, and a greater public awareness of what emergency actions to take, The Department of Health's 'Act FAST' campaign has more than doubled (55.5% increase) 999 calls for possible stroke (DOH ⁹).

Previous studies, such as the Express Study⁷ by Professor Peter Rothwell, have highlighted the need to fully assess and treat in a timely fashion, those affected by TIA to prevent a progression to stroke. These developments have led to the setting up of TIA clinics to actively investigate and manage those people affected by TIA

QM 3, 5 & 6 within the National Stroke Strategy give specific guidance on this topic, and all the hospitals within the Network now have TIA clinics.

The National Stroke Strategy, coupled with raised public awareness and expectations, has highlighted the need for robust stroke care pathways to be in place to meet the needs of those affected by TIA, or stroke survivors, along the whole of their care journey.

Pre Acute Care

Each year in Lancashire and Cumbria it is expected that about 4,000 new patients will have a stroke, (3,000 first-ever, 1,000 recurrent or after TIA) and about 1,200 will have a stroke-like episode for which an alternative diagnosis is eventually reached ⁸.

All hospitals within the Network area are served by the North West Ambulance Service (NWAS), who provide all patient transport services. NWAS have agreed protocols in place for the recognition of FAST positive patients, but as yet there is no general Network-wide pre alert procedure to inform local emergency departments of the expected arrival of FAST positive patients. A system of pre alert will provide a mechanism for the timely triage, clinical assessment, imaging, and potential thrombolysis of suitable stroke patients, as stipulated in **QM7** of the National Stroke Strategy.

NWAS staff require stroke awareness training that involves FAST and currently receive this as part of their core training. On-line Response Training through UCLan can also be accessed. FAST training is a key training requirement for first contact personnel such as GP reception staff.

Acute Care

The patient pathway to a stroke unit differs significantly across the Network. Stroke pathways have been adopted at some acute sites; conversely these are varied in content, stages of development and availability of resources.

QM 7 states that all patients with suspected acute stroke are immediately transferred by ambulance to a receiving hospital providing hyper acute stroke services (were a stroke triage system, expert clinical assessment, timely imaging, and the ability to deliver intravenous thrombolysis are available throughout the 24 hour period).

Following Network mapping events in each acute trust it is apparent that the delivery of acute stroke care takes place in a number of settings.

Within the Network only three acute sites currently deliver a 9 - 5 Stroke Thrombolysis Service. The remaining sites are aiming to implement 9 - 5 services in the near future, with an expectation that they will move swiftly to a 24 hour service with the implementation of a Telestroke solution.

The implementation of stroke thrombolysis will require Emergency Department (ED) nursing staff to be able to undertake stroke assessment utilising the 'Recognition of Stroke in the Emergency Room' (ROSIER) assessment tool enabling early recognition of potential stroke thrombolysis patients.

The Emergency Department physicians and stroke physicians will require recognised stroke thrombolysis training and will need training to be able to complete the National Institute of Health Stroke Scale (NIHSS) assessment tool which is a requirement prior to stroke thrombolysis.

Stroke thrombolysis will require specialist monitoring the first 24 – 72 hours; depending on local stroke pathways this may require the patient to be transferred to a specialist area, e.g, Acute Stroke Unit, Coronary Care or High Dependency areas which will result in further local training needs.

Rehabilitation

Due to the varying nature of stroke, the individual's symptoms and subsequent rehabilitation requirements can differ greatly. Rehabilitation commences within the acute phase of the stroke event, and can require the input of various therapists. Rehabilitation can be further extended into community teams and into the social aspects that affect patients' lives after stroke. This will influence the training requirements of all staff that come into contact with stroke survivors, along their rehabilitation pathway.

The TNA undertaken by the Network highlighted that sensory changes (this includes pain and disability in limbs affected by stroke) was the number one training priority, and was specifically requested by therapists.

Neurological trained Occupational Therapists (OT) are in short supply, with the majority of OTs being generically trained. The Network will be commissioning courses to up skill these generic OTs to become more competent and confident in the management of stroke specific disabilities.

Physiotherapists will also benefit from training around sensory changes after stroke, training commissioned by the Network include, for example, training on Functional Electrical Stimulation (FES) for foot drop and assessment and treatment of upper limb problems.

Speech and Language Therapists (SLTs) already have the requisite training, but further specialist training has been commissioned by the Network for enabling and improving support for aphasic stroke patients within the community. At the present time the Network has two SLTs seconded to set up an on-line training package for swallowing assessment post stroke. This formal assessment is an essential early intervention that is often missed due to several factors, including lack of knowledge and available skilled staff with the relevant competency. If this assessment is not formally undertaken this may have a direct affect on patient mortality; poor nutrition and chest infections being two of the main problems.

Dieticians already have the requisite training, including nutritional screening and dietary advice, but may need some further stroke awareness training.

The National Sentinel Audit₃ sets standards for the assessment of all stroke patients:

- OT must assess the patient within four days of stroke onset
- Physiotherapist must assess the patient within 72 hours of stroke onset
- SLT initial swallow assessment has to be done within 24 hours of stroke onset
- Dietician must assess the patient as soon as notified of referral.

Other therapy staff could be involved with the rehabilitation process and are called in as needed for the individual patient, e.g. Podiatrist, Chiropodist, and Opticians. The psychological support required following a stroke is priority number 2 in the TNA, highlighting the importance placed upon this aspect of care and the necessity for urgent training. Recent expressions of interest in the provision of "coping skills" training has highlighted a large demand for training from within the private residential/nursing home sector.

5 Training Needs Analysis

Methodology

The Network developed a Training Needs Analysis tool (TNA), which was widely distributed to primary secondary and social care settings in electronic and hard copy format. The SIMs allocated to each health economy assisted in the collection of data.

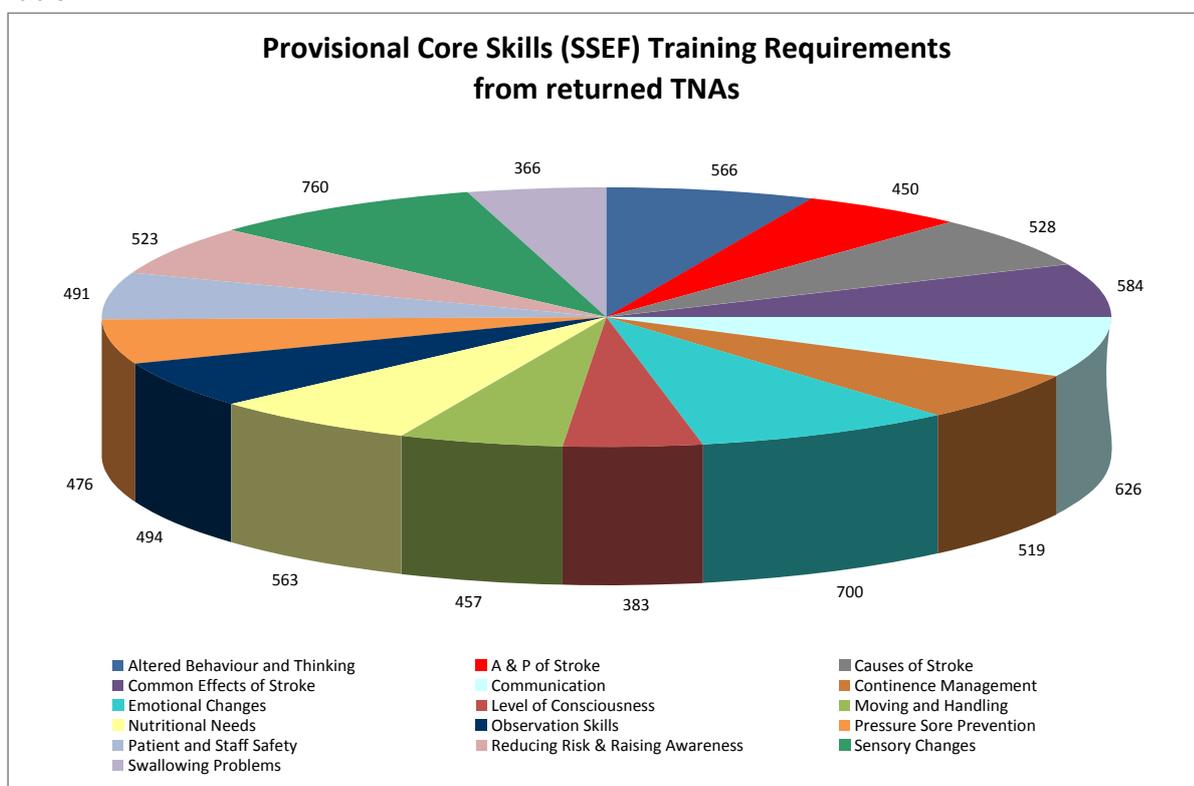
A TNA database has been devised by the Network; forms were returned from over 40 different care settings. Returned forms have been inputted to generate reports which determined training priorities for individual departments and professions.

Quality assurance measures built into the TNA consist of stroke specific core competencies generated from the Department of Health Educational Framework₂ and the recommendations of the North West Stroke Task Force₅. These include:

- Increasing the profile of stroke prevention and management within Primary Care Trusts and Acute Trusts
- Dissemination of evidence based standards for stroke management to health authorities, primary and secondary care, and social care
- Working in areas of high mortality to try to improve prevention and management of stroke, particularly in those areas where stroke mortality rates are rising
- Engaging existing clinical skills delivery teams to deliver stroke training in their local areas in a “rolling programme” format, to ensure a sustainable programme.

Due to the volume and diversity of differing staff groups’ knowledge base, professional and competency requirements, training needs will vary.

Table1



The TNA top priority training requirements were as follows:

1. Sensory changes
2. Emotional changes
3. Communication
4. Altered behaviour and thinking
5. Common effects of stroke

The TNA has identified that the training requirements for each health economy differ greatly, and the level of staff roles, responsibilities, and skills vary.

Overall planning, delivery and evaluation of training has traditionally been on an ad hoc basis; with no recognisable national stroke training infrastructure in place. The recently established Stroke Specific Educational Framework (SSEF) will be the core structure for future educational provision, giving national accreditation to stroke specific courses.

The Network TNA report has provided an indication of the baseline of current training, and has clearly identified gaps in, not just individual knowledge and skills, but in the wider context of whole organisations requiring training around elements of the stroke care pathway.

The Network's approach to training to date has been to offer training to all the care settings mentioned above, with a majority of training based around developments in the acute care setting. This has been strongly influenced by the intention across the Network to introduce stroke thrombolysis. Stroke Thrombolysis Awareness Days have been organised and delivered across the Network to over 200 staff to date in locations near to health economies wishing to deliver thrombolysis in the near future. This course has now been accredited by the Royal College of Physicians (RCP).

Training delivered by Network staff includes the following:

- FAST (face, arms, speech, time)
- ROSIER training
- Thrombolysis Awareness Training
- NIHSS (National Institute of Health Stroke Scale)
- Stroke awareness raising
- Stroke care pathway training
- Basic care requirements

The Network has commissioned and purchased courses from the Higher Education Institutions situated within Lancashire and Cumbria, and other external providers. It was stipulated in the course contract agreements (developed by the Network) that the delivery of these courses must be held at differing locations across the Network to ensure equitable access.

A full and detailed breakdown of these courses is available in Appendix 1.

6. Future Approach to Training

It is essential to develop a Strategy to support organisations to embed training within the operational elements of all stroke services. For this reason the Network propose a combination of the procurement of stroke specific training courses, development of a train the trainer approach across the varied settings and collaboration between stroke teams to provide training. Commissioners will need to be supported when commissioning stroke services where training needs are built into contracts.

It would be impossible for the Network Team to deliver training to all staff involved in stroke care delivery due to size of the workforce requiring continuous training.

Procurement of stroke specific training courses

Network staff will:

- Coordinate training requirements in response to training needs analysis results, national and local requirements, and specific training requests
- Devise individual contracts that contain agreements from the relevant health authority to pay back fees (for staff that do not complete or drop out of course places funded by the Network)
- Organise all aspects of delivered training, including initial course booking arrangements, travel and accommodation requirements, financial control of training budgets, and venue and catering requirements
- Record courses delivered, delegate details, trainer profiles and course evaluations
- Procure courses in line with the NHS Improvement Quality Assurance, Productivity and Prevention agenda¹⁰
- Produce and disseminate reports as required
- Delivery of training utilising “outside training providers” using suitable venues
- Development of e-learning methods of education to promote equity of access, and minimal impact on workforce planning.

Train the Trainer approach

A key part of this approach will be to identify local “stroke training champions” who are from a varied clinical background and have the ability to drive service provision forward.

- Work with Stroke Unit Managers to ensure all units have training programmes that meet requirements of the Sentinel Audit Domain 6 ‘Continuing Education in Stroke₂’.
- Develop a Network stroke competency package that will complement stroke unit training programmes.
- Collaboration with local clinical skills facilities to set up rolling programmes of stroke specific education for new and existing staff. The Network have developed a basic stroke awareness programme (this covers 12 of the TNA priorities) which also contains workbooks and a competency based package and is in the process of being adopted in local clinical skills facilities.
- Identification of “stroke training champions” in stroke teams and services who care for people with stroke such as intermediate care settings, who will take responsibility for the training needs within their area. This role may incorporate facilitation or delivery of training.

Collaboration between stroke teams to provide training

Collaboration and sharing of events will ensure access to training is increased and that standardisation of practice and documentation is enhanced across the Network.

- The establishment of a Network faculty of Stroke and TIA Assessment Training (STAT) trainers.
- Development of Network-wide documentation, policies and procedures to assist in ensuring quality standards of care delivery.
- The development of a Network-wide thrombolysis pathway
- The development of a training programme to support the implementation of Telestroke.

7. Communication Plan

The dissemination of training information needs to be on a multi-functional level to ensure equitable distribution. There are many stakeholders within the Network area, each with individual mechanisms for information delivery. Within the Network training information is disseminated via several groups and individuals, along with other methods of communication including;

- Electronically via emails and information on the CSNLC Website
- Via specific special interest groups
- Via SIMs visiting their own health economies
- Via direct telephone communication
- Word of mouth, from interested parties.

As part of the national and Network awareness raising campaigns, it is envisaged that stroke survivors will be provided with increased knowledge and understanding of stroke, this will increase expectations of the standard of care that is to be delivered. The Network are developing a stroke awareness section on their Website, providing information about stroke and acute stroke care.

Recommendations

In order to develop a skilled stroke workforce there needs to be a higher profile for training and development.

Key Recommendations

- Commissioners need to build training into service specifications
- There needs to be a commitment at senior level to release staff to attend educational events
- Training needs are identified across the whole stroke pathway
- Each organisational area needs to produce an action plan highlighting their approach to stroke workforce training. Any action plan would require evaluation methodology to ensure that delivered training has an impact upon practice
- Develop the Train the Trainer approach across the varied settings

Recommendations along the stroke pathway

Pre acute

- To develop a GP educational programme to raise awareness of stroke and TIA pathways
- The Network to commission and facilitate further training around Cardiovascular Risk, the detection and treatment of AF and the implementation of the GRASP – AF tool within the primary care setting
- To raise awareness of FAST training for first contact personnel such as GP reception staff and NWAS personnel
- To implement a pre alert system for FAST positive patients to enable a timely assessment of thrombolysis suitability.

Acute

- To ensure the ED staff are competent in performing acute stroke assessment, using the appropriate tools, e.g. ROSIER, NIHSS.
- To develop a cohort of trainers to deliver STAT training Network-wide.
- Work with Stroke Unit Managers to ensure all units have training programmes that meet the Sentinel Audit Domain 6 'Continuing Education in Stroke' (p 38 2008)
- Develop a Network stroke competency package that will complement Stroke Unit training programmes.
- Collaboration with local clinical skills settings to set up rolling programmes of stroke specific education for new and existing staff
- Identification of "stroke training champions" in stroke teams and services who care for people with stroke such as intermediate care settings, who will take responsibility for the training needs within their area. This role may incorporate facilitation or delivery of training.

Rehabilitation, Social and Community Care

- Identification of “stroke training champions” in stroke teams and services who care for people with stroke such as intermediate care settings, who will take responsibility for the training needs within their area.
- The Network to commission stroke specific education for therapy staff in rehabilitation settings, in line with the priorities already identified in the TNA.
- Supporting the development of communication networks for aphasic patients within the community setting
- Commissioning of psychological support training
- Work with social care commissioners to build expertise in commissioning care packages that includes stroke specific competencies
- Work with social care to explore the most effective method of delivering stroke awareness training to staff working in local authority settings.

Evaluation

There is wide variation in access to stroke training programmes across the workforce. This has been further highlighted from the Peer Support programme that has been initiated. A sharing environment has been fostered during these visits and links have been forged. As a direct result of a peer support visit a stroke training programme has been set up.

The current process of evaluation of training is undertaken by post event review, coupled with a topic specific evaluations carried out either in house by the Network or as part of a service agreement with outside provider agencies. These results are collected and collated by the Network Team Administration Manager, in electronic format. The evaluation is taken into account when delivering further education events, and is used to modify delivery and presentations as needed. Evaluation of the quality and content of delivered events is taken into account when commissioning future courses.

As a Network, the value of simple post event evaluations is recognised as being of limited value when service delivery change is reviewed. A longer term solution to this issue is the implementation of a formal pre and post event evaluation. This can be undertaken to determine that the education provided by the Network has been converted into relevant change in clinical practice. To ensure sustainability a repeat evaluation should be carried out within an agreed timescale, i.e. 6 – 12 months.

Training records should be kept on an individual basis, and at ward level, but training that has been delivered by the Network will be entered into a central database. This will ensure that a full record of delivered training is available, with the ability to create reports and queries as required. All training that will be provided, funded or hosted by the Network, will be centrally organised and coordinated to ensure consistent quality and relevance

Appendix 1

Course Title: Delivered by External Organisations	Applicable to	National Stroke Strategy Quality Marker	Training Needs Priority	Number of staff trained to date	Cost per Course (excluding venue and catering cost)
Stroke Association Training: Active Communication training	Primary, Acute, and Social Care staff	QM 10, QM 13, QM 15	Priority 3	65	£1000 x 8
Caring for people affected by stroke	Primary, Acute, and Social Care staff	QM 13	Priority 5	65	£1000 x 8
Cardio Vascular Disease Training	Primary care staff	QM 1	Priority 8	200	£2760 x 9
STAT Training	Acute staff, Network staff	QM 8, QM 9	Priority 8	6	£150 x 6
Education for Health Training	Primary care staff, Rehab staff	QM 1 QM 2, QM 13	Priority 1-16	22	£11,995 x 1
UKconnect Communication Training Setting up conversation partnership scheme	Aphasic (stroke survivors) volunteers Rehab Staff Network staff	QM 10, QM 13, QM 15	Priority 3	50	£10,400 x 2 £5000 x 1
Thrombolysis Awareness Training	Acute Staff, including Consultants from A/E and Stroke Physicians NWS Staff	QM 8, QM 9	Priority 8	210	£5860 ÷ 5
Harrison Training;	Acute and Rehabilitation therapy staff	QM 10	Priority 1	12	£5800 x 1
UK National Stroke Forum 2009	Primary, Acute, Network Staff	QM 3	Priority 1-16	27	£5,772 ÷ 27
Peer Review	Staff across stroke pathway in Blackpool and East Lancs	QM 1 - 20	Priority 3,8,11	Variable numbers	£711.00 ÷ 2

University of Cumbria	Acute, Rehab and Social Care Staff	QM 1,6,7,8,9,10,11,12,13	Priority 1 - 16	33 50 places purchased	£31,500.00
Training delivered by Network Staff	Applicable to	National Stroke Strategy Quality Marker	Training Needs Priority	Number of staff trained to date	Cost per Course (excluding venue and catering cost)
Stroke Awareness	CDH Rookwood A	QM 1	Priority 8	20	Network Team costs
	RBH	QM 1	Priority 8		Network Team costs
FAST Training	FGH A/E Receptionists	QM 1	Priority 8	10	Network Team costs
ROSIER Training	CDH A/E Staff	QM 1, QM 5	Priority 4	4	Network Team costs
	RPH A/E Staff	QM 1, QM 5	Priority 4	5	Network Team costs
	FGH A/E Staff	QM 1, QM 5	Priority 4	25	Network Team costs
Thrombolysis Monitoring	RPH Ward 21	QM 9	Priority 5	9	Network Team costs
Care Pathway Training	FGH Ward 23 therapy staff involved in the stroke pathway	QM 4	Priority 1	18	Network Team costs
Training to be delivered 2009 / 2010	Applicable to	National Stroke Strategy Quality Marker	Training Needs Priority	Number of staff to be trained	Cost per Course (excluding venue and catering cost)
Harrison Training;	Acute and Rehabilitation therapy staff	QM 4,8,9,10	Priority 1		£500 per person
FES Training	Acute and Rehabilitation therapy staff	QM 4,8,9,10,14,15	Priority 1		Total cost £6641.25

Psychological training Coping Skills for people affected by Stroke Train the Trainer	Staff responsible for cascading of information across the stroke pathway	QM 1,3,4,10	Priority 2	40	Course £1560 x 2 License for 3yrs £1900 x 1 Network pack CD £3100 x 1 Total £9541
Psychological training Coping Skills	All staff involved with stroke patients	QM 1,3,10	Priority 2	100	Course £2585 x 2
STAT Training	A/E Staff	QM 1,4	Priority 8		Course cost of £50.00
Stroke Awareness	Acute ward staff	QM 1	Priority 8		Network Team Costs
Cardiovascular Disease Training	Primary care staff	QM 1,4	Priority 8		£2760 per course x 4
AF Training	Primary care staff	QM 1,4	Priority 8		Network Team costs
Splinting for Abnormal Tone + Splinting for Abnormal Tone- putting theory into practice.	Acute and Rehabilitation therapy staff	QM 9,10,13	Priority 1	Max 20	£4492.03 X 2 Total Cost £ 8984.06.

Appendix 2

The Cardiac and Stroke Networks in Lancashire & Cumbria have recently employed a Practice Development Nurse for Stroke – - and part of his role will be to develop a Network-wide Training Strategy.

As part of this work, this document will enable him to form an infrastructure for future training requirements and to identify training needs for all Healthcare Professionals involved in caring for stroke patients.

We would be grateful, therefore, if you could complete this form to include requirements for all stages of the stroke pathway, from Primary, Acute, Rehabilitation and Social Care.

The elements of the stroke pathway and the core competencies are taken from the National Stroke Strategy and the Stroke Specific Education Framework (SSEF) documents.

Please do not include training that could be classed as mandatory, stroke specific training only is required

Should there be any other specific training requirements please record these in the comments box.

This document should be returned as soon as possible to :

by email -

by fax to

or by post to: Cardiac and Stroke Networks in Lancashire & Cumbria, Room 176 Preston Business Centre, Watling Street Road, Preston PR2 8DY

Elements of the Stroke Pathway to consider when reviewing your training needs:

1. Awareness raising: stroke as a medical emergency
2. Managing risk: primary and secondary prevention
3. Information, advice and support to those affected by stroke
4. User involvement in care and service planning
5. Assessment (TIA): assessment and management at time of event
6. Treatment (TIA): assessment and management at follow-up
7. Urgent response: pre-hospital assessment and management
8. Assessment (stroke): emergency assessment and management
9. Treatment (stroke): hyper acute assessment and management
10. High-quality specialist rehabilitation
11. End-of-life care
12. Seamless transfer of care
13. Long-term care and support
14. Review
15. Participation in community life
16. Return to work

Organisation

Ward/Area

Acute /Rehab/Social Care (delete as appropriate)

Core Skills/Competencies

Base Core Skills	Level/ Target Audience (e.g. Consultant, OT, Nurse)	Available/ delivered in-house? Y/N	Approximate numbers	Comments
Causes of Stroke				
A & P of Stroke				
Reducing Risk & Raising Awareness				
Common Effects of Stroke				
Level of Consciousness				
Observation Skills				
Moving and Handling				
Pressure Sore Prevention				

Organisation

Ward/Area

Acute /Rehab/Social Care (delete as appropriate)

Base Core Skills (Continued)	Level/ Target Audience (e.g. Consultant, OT, Nurse)	Available/ delivered in-house? Y/N	Approximate numbers	Comments
Patient and Staff Safety				
Communication				
Swallowing Problems				
Emotional Changes				
Nutritional Needs				
Continence Management				
Sensory Changes				
Altered Behaviour and Thinking				
Common Effects of Stroke				
Level of Consciousness				

