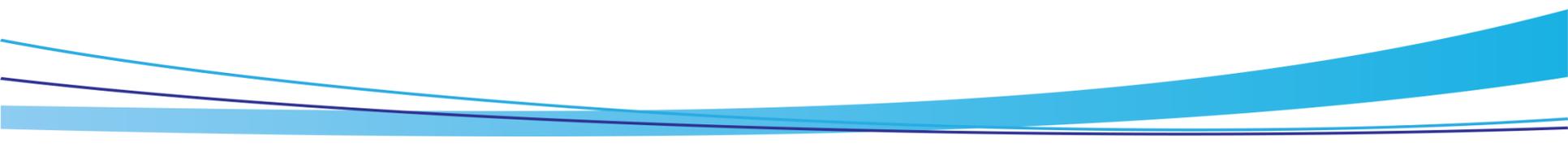


# **Community stroke rehabilitation: The Development of an Integrated Community Stroke and ESD model**

**Tracy Walker Rehabilitation Services Manager  
Pennine Acute Hospitals NHS Trust**



# Background to the Project

- Secondment: Sept 2014 – March 2015 appointed as Clinical Lead for stroke rehabilitation by GM, Lancs & Cumbria Strategic Clinical Network

## Remit:

- Lead and facilitate the production of a equitable community stroke rehabilitation model
  - Lead and facilitate the production a service specification for community stroke rehabilitation which is outcome focused
  - Gap analysis for GM against the model
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# Why the need for change?

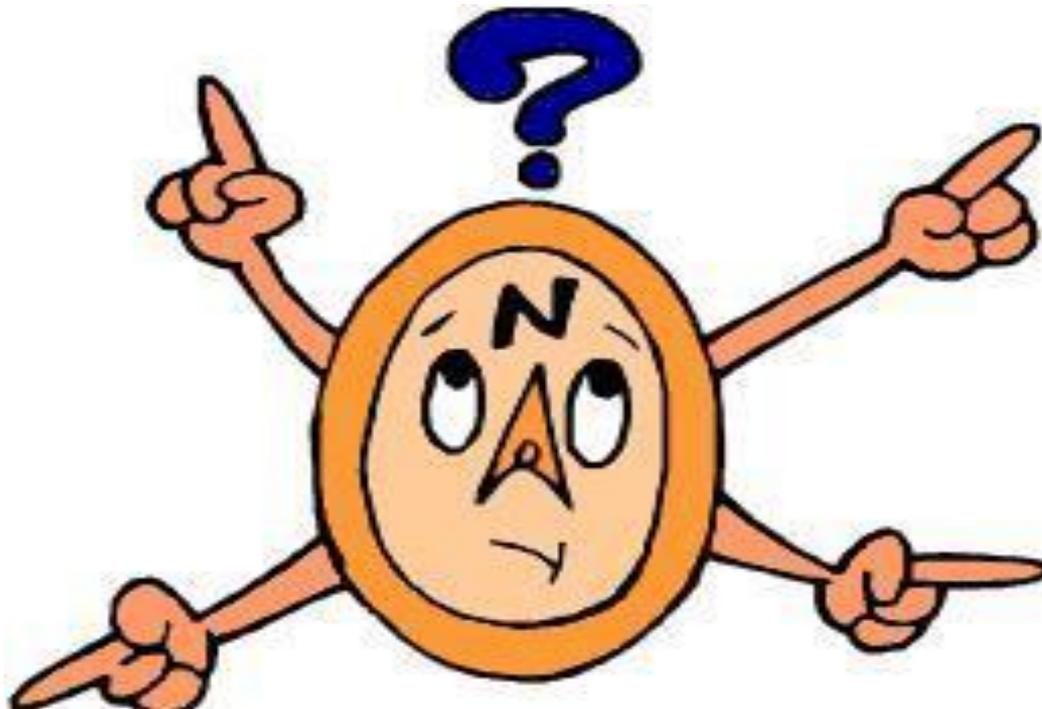
## Centralisation

- Ensure flow from acute beds into the community to improve 90% stay on stroke unit
- Deliver timely access to patients leaving hospital for repatriated patients
- Prevent patients needing repatriation to local stroke unit if able to be supported at home

## National ESD drive

- Evolving models and implementation of Early Supported Discharge across GM
- Variance in commissioning intentions and funding for community stroke rehab in GM
- Concerns were held around the ability of community teams to support centralisation and the lack of equity in community stroke rehabilitation provision across GM currently for both ESD and Non ESD patients
- Having a common model with common standards which is equitable would help in organising our community services and maybe reduce variance in commissioning?

# GM Post Acute Community Stroke Rehab Postcode Lottery



# Phase 1 - Process of model development

## Approach

- Literature on community stroke rehab and ESD
- RCP guidance, NICE quality standards
- Marion walker evidence based com stroke rehabilitation 2013
- Implementation of evidenced based rehab service in community 2013
- Literature on models across country, practice examples
- National Audit office good practice guide
- NHS stroke improvement commissioning guide national models 1-5
- Experience local nationally

## What is the need?

- ESD, have been shown to be only beneficial for survivors of mild to moderate stroke (initial Barthel Index of 10–20)
- Those who experienced a very mild or more severe stroke (<10 Barthel Index) require alternative service provision when they leave the hospital.
- Importance of rehabilitation provision for this often-neglected patient population in residential home
- Patients living with stroke in community

## Keep it Patient Focussed

“clear that stroke specialist care must be provided once stroke survivors leave hospital, and that flexibility around the range of options and services offered is required depending on severity of stroke.” Fisher et al 2013

Acknowledged the importance of collaborative working across health and social care systems



## Phase 2

- Worked with SCN to develop a steering group for the project
- Members across GM, Lancs and Cumbria: First draft sent to the group with model adapted for first round consultation and development of list of outcomes
- Final first draft paper written and send out to including:
  1. A background to the project
  2. Proposed model of stroke rehabilitation
  3. Principles of the model
  4. Details of the proposed pathways
  5. Staffing levels
  6. Outcomes for the service specification
  7. National evidence to support the model and outcomes
- Series of meeting held with key people too discuss the model
- Model detail was updated and visited CST across GM and Lancashire

Feedback gained on:

1. Coordination of discharge (methods, assessment)
2. Rehabilitation pathways (intensity, response time, length of stay, deliverable)
3. Life after stroke exit pathways and relationship with third sector/support services
4. 6 month review (who should carry out this)
5. Outcomes and indicators for service spec
6. Staffing levels including psychology for service spec
7. Is there anything missing from the model

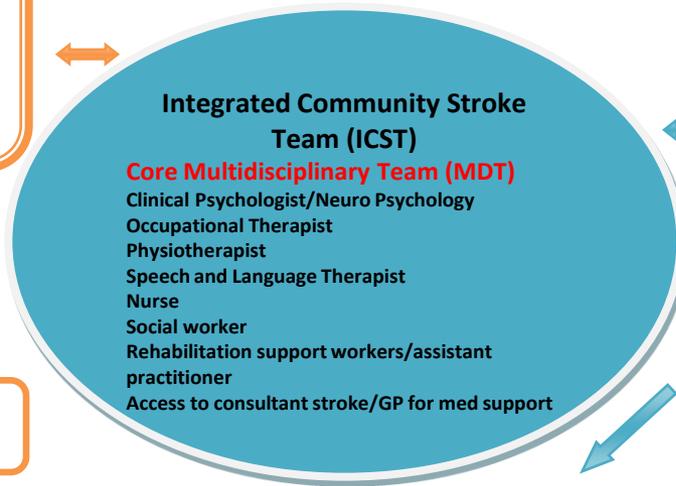
**Key features of new stroke model: Delivering the right care, at the right time by the right people**

**Based on Model 3/4: ESD is delivered within an integrated community stroke or neuro team**

**National publication on commissioning for improvement**

[Models publication NHS Improvement - Stroke](#) (evidence for the benefits of this model)

# Integrated Community Stroke Rehabilitation: A Model of delivery



**Stroke Survivors living in the community who need ICST team assessment (re referral or who had stroke on holiday/out of area)**

Contact patient/carer by telephone within 48 hours of referral for triage and arrange assessment date  
 Assess at home within 7 days

- Specialist CST intervention needed
- Apply appropriate pathway 1-3

**Stroke Survivors Journey from Hospital to Home (stroke hyper acute/acute/rehab)**

ICST In-Reach/Triage to support pathway decisions (see descriptors below for profile of pts on pathways 1-4)  
 Attend weekly MDT, board round, discharge planning meeting  
 Daily phone contact ICST with stroke ward including weekends to support discharge planning

**Discharge**

- When goals met maximum 6 months
- When generic pathways or other life after stroke services deemed appropriate by the ICST
- Self-referral back to ICST if needed in the future

**Pathway 1 (50-70% pts)**  
 Therapy at home with CST support

**Pathway 2 (10-15% pts)**  
 Therapy at home with joint CST & Re-ablement rehab support package

**Pathway 3 (10-15% pts)**  
 Discharged to residential intermediate care bed (IC)

**Pathway 4 (10-15% pts)**  
 Discharged to residential/nursing home

**Support services**

- Orthotics/Orthoptics/wheelchair services
- Spasticity clinic: Botox, Consultant review
- Specialist in pt neuro rehab centre
- Return to work services
- Long term conditions services with self management/expert programme
- Befriending/peer support/respite
- Voluntary services/carer support

**Crisis intervention/rapid assessment service**

- Access to immediate support for ICST if patient deteriorates may step patient up to pathway 2 or 3 if needed

**IAPT level 1-4**

- CST psychologist coordinates input with IAPT for appropriate non complex patients

**Family & Carer Support Service**

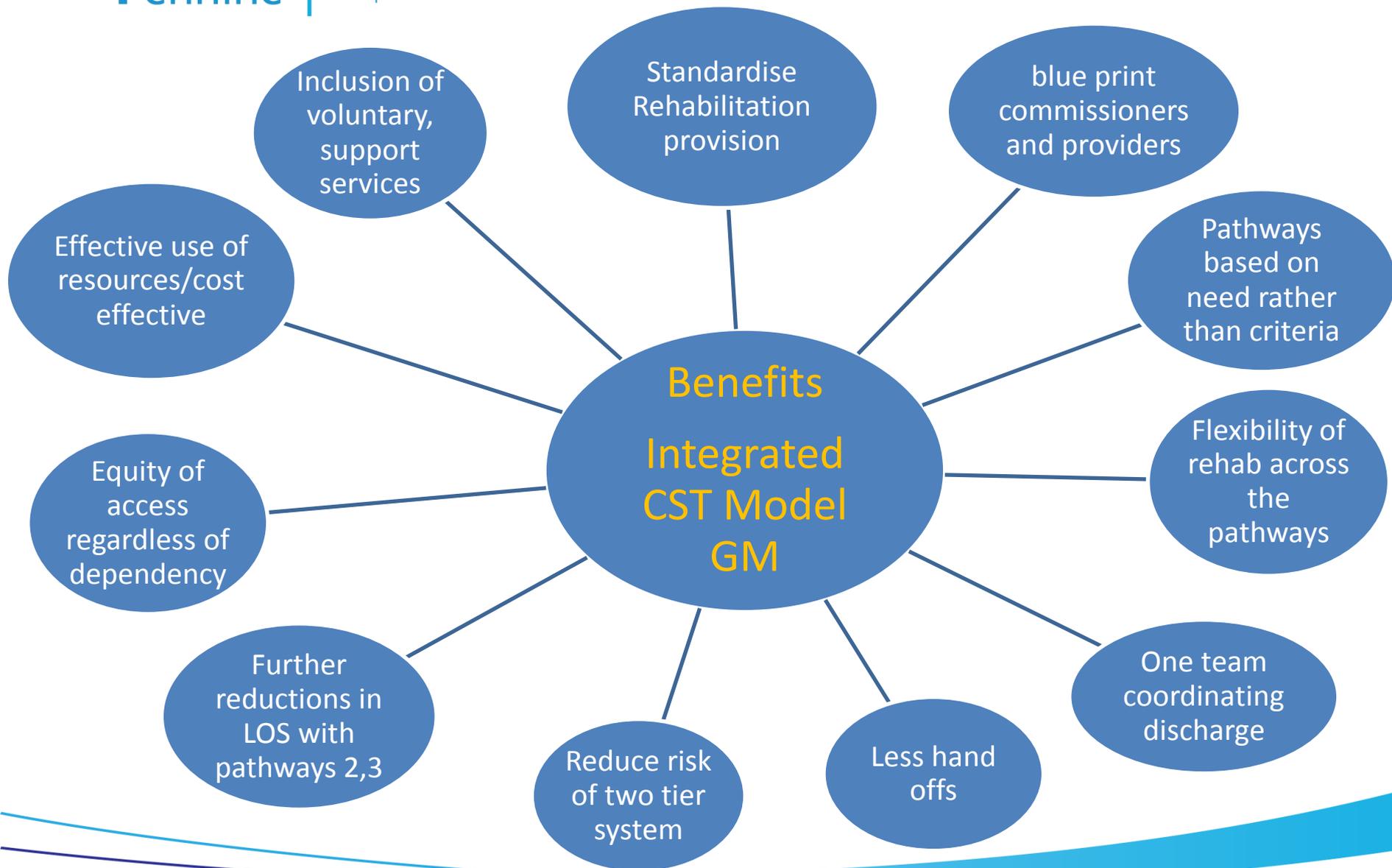
- Attend MDT with CST team or close liaison

**Communication Support Group/social group/access to transport**

**Stroke specific exercise Class**

- Access to health and fitness programmes in the community

**6 Month Review Clinic/Telephone/home visit using GMSAT**  
 Access back to the ICST for review if needed



# The Challenge for Community Stroke Rehab in GM

- Agree common standards and model of service delivery for community stroke rehabilitation and equity of commissioning across GM .
- Provide equity of service to our stroke patients with a flexibility of pathways depending on patient need, extending beyond ESD group which will support centralisation
- Based on best available evidence
- Which are realistic in terms of funding available
- Using all our available resources in the community across health, social care, third sector
- Which deliver the best outcomes for our patients and support health, well being and life after stroke.

# Equity of Community Stroke Rehab Provision in GM ?



## For Information



**Evaluation and  
proposal CS rehab G**



**end to end service  
c Lancs cumbria C**



**psychology  
models for commun**



**draft proposal of  
model**



**Pride in  
Pennine**

Quality-Driven  
Responsible  
Compassionate

The Pennine Acute Hospitals **NHS**  
NHS Trust

**Thank you for listening**

