Stroke rehabilitation in the community: commissioning for improvement

Jill Lockhart - NHS IQ
Tracy Walker – Lancashire Care NHS Foundation Trust
EMERGING MODELS OF COMMUNITY STROKE REHABILITATION PROVISION

How Services are Responding to the Challenges of Implementing ESD within our Communities
INTRODUCTION TO THE MODELS

- Over two year period information gained from scoping of current stroke rehabilitation developments nationally.

- Evolved from the development of the models table in the community stroke resource. [link to community stroke models](#)

- Informal discussion with clinicians, commissioners, hospital managers, network leads involved in community stroke.

- Key information on emerging models extracted and summarised to inform publication.

- Increased knowledge of factors influencing design, structure of team, advantages and disadvantages, cost, key relationships gained.
What did we learn? 5 Models

1. **Stand-alone/acute outreach ESD team** only: *follow on rehabilitation available from generic community services if required.*

2. **ESD with community stroke/neurology team service:** with a pathway into a community stroke team or a community neurology services.

3. **Integrated ESD within community stroke team service:** *ESD is delivered within an integrated community stroke team.*

4. **Integrated ESD within community neurology team service:** *ESD delivered within an integrated community neurology service.*

5. **ESD hybrid** – *Support more complex pts than typical ESD patients*
Model 1

What does model offer

• Small teams, one discrete time limited episode of care.

• Up to 40% on pathway from acute to community

• Ensure patients are settled at home and provide short term domiciliary rehabilitation, typically up to six weeks. There are some two week models.

Considerations for this model

• Two tiered pathway for stroke pts. leaving hospital – equity?

• What happens to the stroke survivors with rehab needs post this service?

• Follow on rehab usually into generic services not specialist

• Maybe dependant on social work input to early discharge if care needed/enablement.
Model 2

**What does model offer**

- Two streams of specialist rehabilitation ESD and routine rehab: mild – complex
- Larger proportion of patients can access rehabilitation post discharge
- 3-6 weeks ESD arm followed by longer term input from community *stroke/neuro*
- Some neuro teams work across intermediate care units/step up and down

**Considerations for this model**

- Waiting times/bottle necks between services
- Waiting times for access to specialist rehab for non – ESD group
- Community teams usually mon-fri service
- Social work input needed to set up care packages pre discharge
Models 3&4

**What does model offer**

- One pathway for all stroke patients – mild to severe and nursing home
- Use a category or pathway approach to deciding level of input needed
- One team managing stroke pts working across intermediate care/enablement
- Specialist rehab ranging from 3 months to a year
- Can take step up/down – extended specialist service FES/Neuro pts

**Considerations for this model**

- Adequate staff and skill mix
- Access to home care/re ablement or in house domiciliary rehab assistants
- Smooth coordinated pathways with good stakeholder relationships
Model 5

**What does model offer**
- Greater proportion of patients seen than traditional ESD
- Intensive specialist rehab for six weeks plus then hand on to community teams
- Usually seven day with support from reablement/home care for six weeks
- Offer service to more complex patients.

**Considerations for this model**
- Adequate services to pick up patients for continued rehab
- Short intensive burst of rehabilitation
Do our models fit the Need?

- **ESD 40% Mild to Moderate Patients going home:** models 1, 2, 3, 4, 5
- **People going into Nursing/Residential home:** models 2, 3, 4
- **Specialist Community Stroke Rehab**
- **Lower functioning patients going home/intermediate care beds models 2, 3, 4, 5**
- **Community based stroke survivors:** 2, 3, 4
Influencing factors

The influencing factors

Geography
Finances – existing and potential funding and flow
Commissioner approach
Calibre of existing community services
Stakeholder perspectives
Local relationship dynamics – human dimensions
Summary

ESD is acknowledged to be a component part of community stroke rehabilitation and there is evidence of varying interpretation of what ESD entails.

Awareness that the different models provide varying levels of rehabilitation provision. Selection of a model will depend on local need, funding and resources already available.
Some models maybe be more equitable and cost effective than others. Think about the need first rather than the model – *Pathways of Need*

Joint working with social care has demonstrated increased capacity to support more pts home earlier and reduce care package long term.

Community stroke/neuro teams are successfully working across intermediate care beds to support pts.

Evidence reinvestment of money from acute to community stroke is not happening
Outcomes and Performance in Community Stroke

**Improvements in patient pathway or journey:** Length of stay, how many people return home, how many pts go into rehabilitation beds, re admission rates within 28 days.

**Monthly contract monitoring (schedule 5)** contacts, referrals, DNA and discharges, RTT times. Individual therapists dashboard of activity, face to face and non FF.

**Quarterly CQUIN and Schedule 3 quality targets:** QOL, NICE 72 hr, access to psychological therapies, Modified ranking scale, goals.

**Patient Outcomes and cost savings:** Yearly reports on detailed profile of pts accessing service, pathways used, length of stay, place at discharge, average change in Barthel, NEADL, MAS, Carer strain.

**SSNAP** – Amount of therapy and therapists and professions involved, referral to treatment time, destination at discharge, goals set, MRS at discharge.
Making Data work for our community teams

Length of Stay Data for BWD stroke Patients
Jan - Aug 2013

Jan: 7.5
Feb: 10.4
March: 14.5
April: 8.6
May: 9.5
June: 11.2
July: 13.7
Aug: 4.4

Jan: 18
Feb: 23
March: 20
April: 15
May: 23
June: 15
July: 19
Aug: 19

Jan: 42.8
Feb: 29.5
March: 30.8
April: 47
May: 55.8
June: 36
July: 43.5
Aug: 65
Challenges in Stroke

- Many services on paper records – lots of manual audit
- More & More national and local targets but our IT systems and data collection are not robust to support team with data collection/reporting
- Inputting into many systems with no reports coming out at team level.
- Many different systems locally and nationally – information difficult to access across stakeholders
- Gap in clinicians knowledge/skills in performance and data analysis at team level.
- Collaboration between commissioner/providers about outcomes needed to streamline local and national indicators with clinical input.
- IT infrastructure and performance skilled/educated clinicians are key to demonstrating the quality and effectiveness of our patient care and service delivery.
The new landscape

What else is happening that may influence community stroke services?
Programmes and aspirations

• 7 day services
• Emergency Care
• Integrated Care and Support
• Personalised budgets
• YOC and RRR
• Outcomes framework
• LTC
Things to think about

Pathways – but not condition specific
Generic and specialist debate – finding the right blend
Delivering results – patient experience
carers
the new metrics
Innovation – using telemedicine
finding gaps
The future?

- Strategic models of rehabilitation
- Shared documentation – IT
- Measurement of efficacy – new perspectives
- ‘New look’ Teams
The challenge

How to translate all the learning and positive improvement from the stroke community rehabilitation work and use it to influence, inform, shape and lead the way forward across the new landscape.