# Realistic Medicine: Implications for stroke nurses & AHPs

Sarah Keir
Stroke Physician, clinical lead Realistic Medicine
NHS Lothian

REALISTIC MEDICINE NHS Lothian VALUE BASED HEALTH & CARE

# Aims for today

- Realistic Medicine: what and why?
- Exploring value
- How good are we in stroke at doing what is most valuable?
- Things we can change (innovate)

# Realistic Medicine




## VALUE BASED HEALTH & CARE




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# Making best use of resources



# We don’t use our resources well (waste in our system)

- Approx 20% of healthcare makes little or no positive benefit to the individual

- Approx 10% of healthcare causes harm to the patient

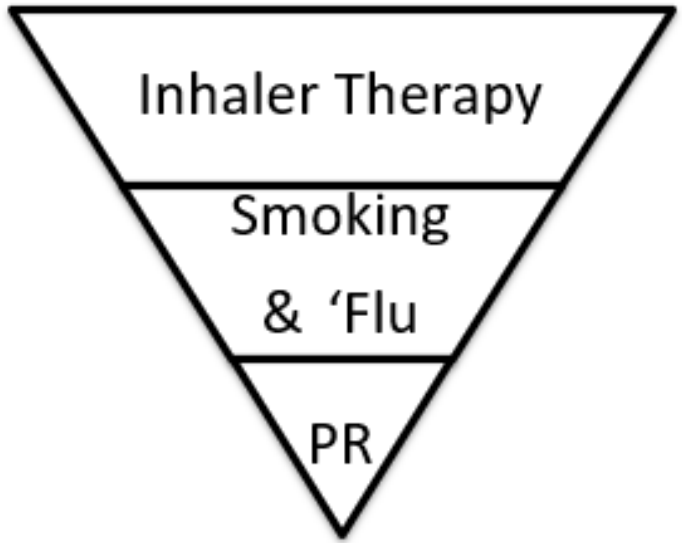
OECD

**Tackling Wasteful Spending on Health**

**more info:** https://doi.org/10.1787/9789264266414-en

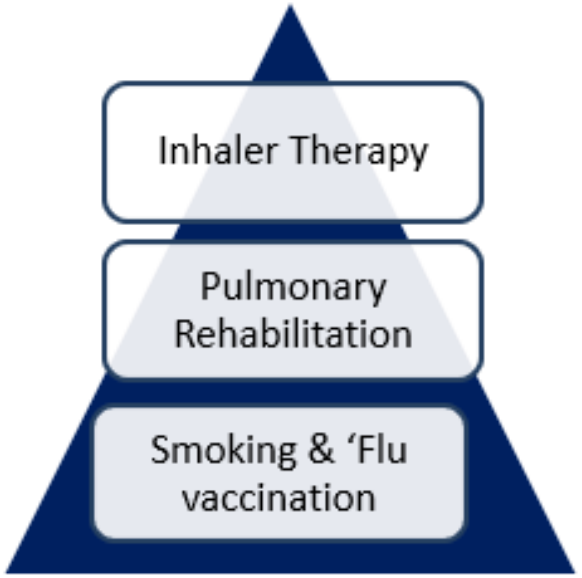
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# How good are we at identifying value?










**Actual Spend**

**Cost per QALY**

Swansea University Prifysgol Abertawe | School of Management Yr Ysgol Reolaeth

Canolfan Gwerth mewn Iechyd Cymru
Welsh Value in Health Centre

Academiau Dysgu Dwys Cymru
Intensive Learning Academies Wales

# Value in stroke

- Over 113,000 strokes every year in the UK (Rothwell et al 2004)
- Over 950,000 stroke survivors among those aged 45 years and over (Geddes et al 1996)
- A quarter of all strokes in the UK happen among people of working age (Stroke Association 2017)
- Stroke can reduce employment prospects and productivity for both patient and family and friends supporting them in an often unpaid caring role
- The UK annual medical research-spend per stroke patient is £48, compared with £241 per cancer patient and £118 per dementia patient (Luengo Fernandez et al 2015)



# Costing methodology

1. Estimated average annual costs per person with either a new or previous stroke in 2015
2. Combined individual-level costs with up-to-date estimates from the literature on stroke incidence and prevalence for the UK population
3. Accounted for where these costs fell: NHS, personal care services, informal carers, society more broadly
4. Projected these 2015 UK cost estimates to future years
5. Explored how the results would be affected by alternative estimates and assumptions.

# The numbers in 2015…

## Average societal cost

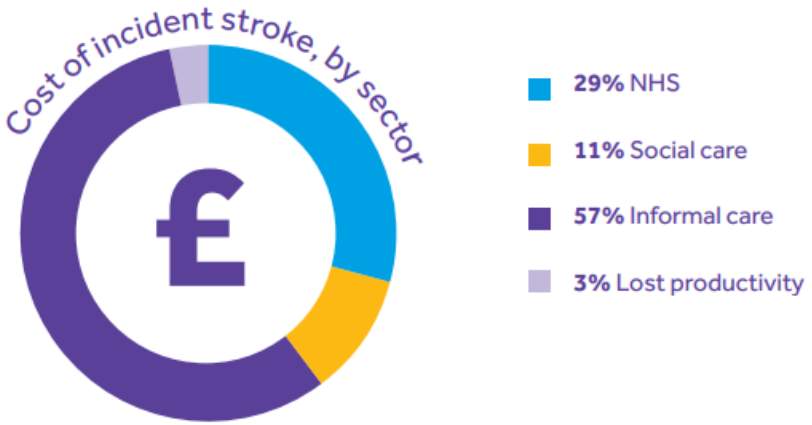
- £45,409 in the first 12 months after stroke (cost of **incident** stroke), plus £24,778 in subsequent years (cost of **prevalent** stroke)
- The average cost of NHS and Personal Social Services (PSS) care in the first year after a severe stroke is almost double that for a minor stroke (£24,003 compared to £12,869)

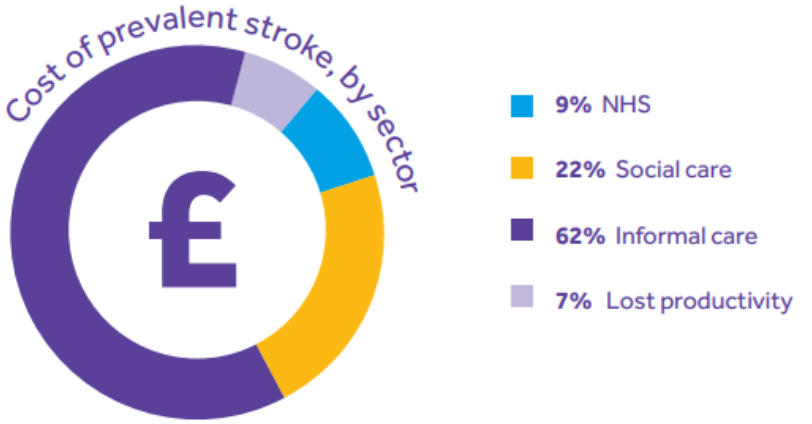
## Aggregate costs for the UK

- £25.6 billion attributed to stroke in the UK per year
- £15.8 billion of this is contributed by informal/unpaid carers, (vs NHS and PSS care costs of £8.6 billion, £3.8 and £5.2 respectively)

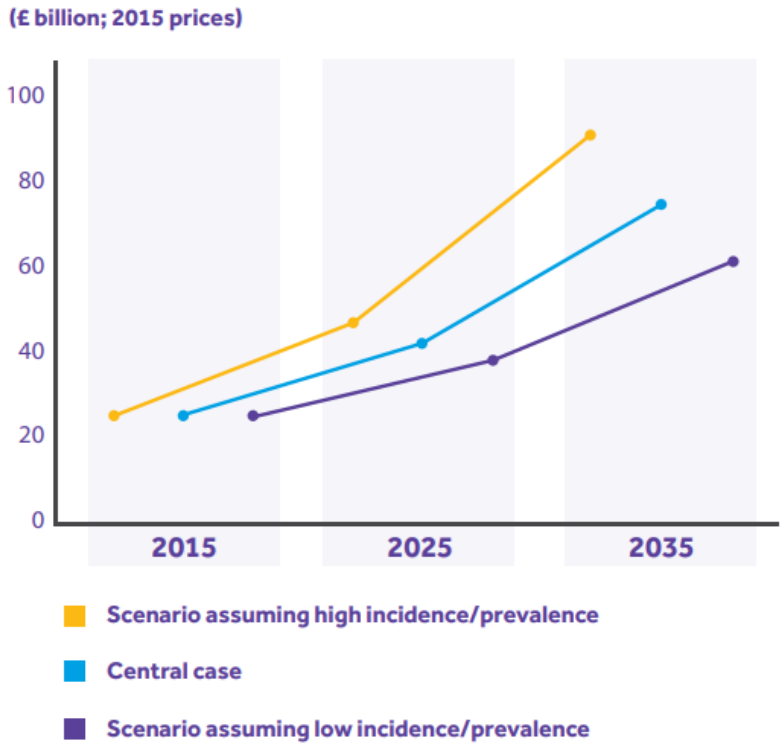
# Stroke burden: where?

- In the acute phase, in the hospitals (NHS)
- After the first year, in the community



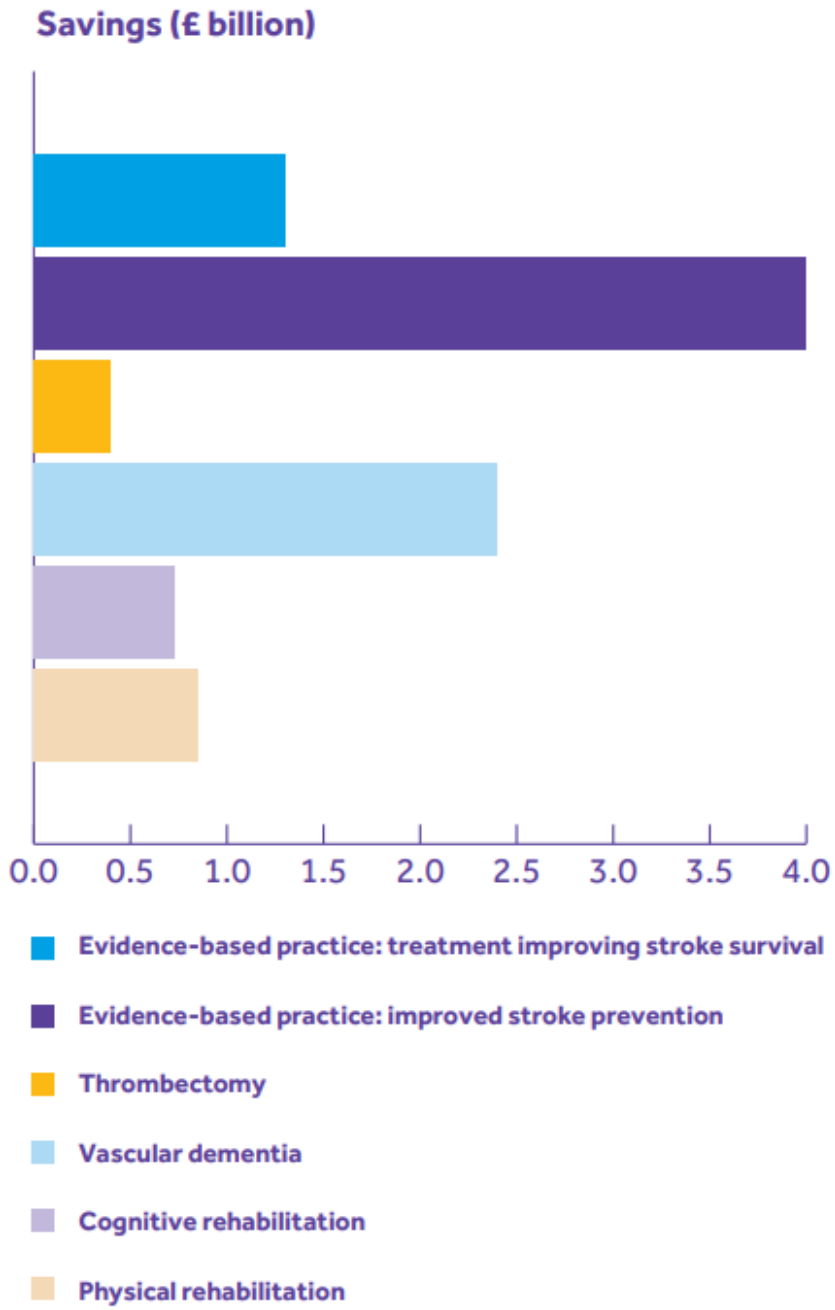
# The projected numbers for 2025 and 2035



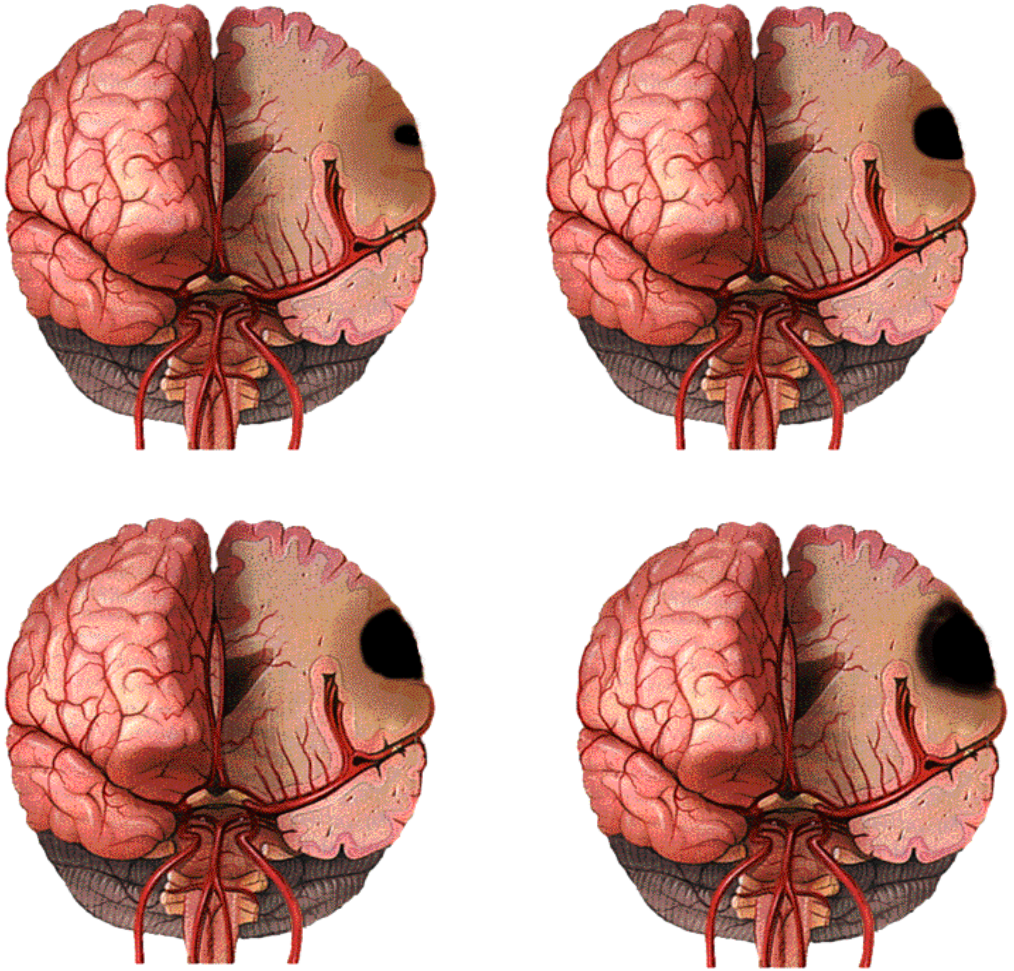

| SCOTLAND | | | |
|---|---|---|---|
| Cost (£million) | 2015 | 2025 | 2035 |
| Health care | 213 | 361 | 615 |
| Social care - Public | 152 | 285 | 542 |
| Social care - Private | 170 | 324 | 624 |
| Social care - Total | 323 | 610 | 1,166 |
| Unpaid care | 988 | 1,515 | 2,574 |
| Lost productivity | 97 | 149 | 218 |
| **Total** | **1,620** | **2,634** | **4,572** |

## Where is the greatest value?

Potential savings to societal costs of stroke in 2035 through £10 million investment in each priority research topic

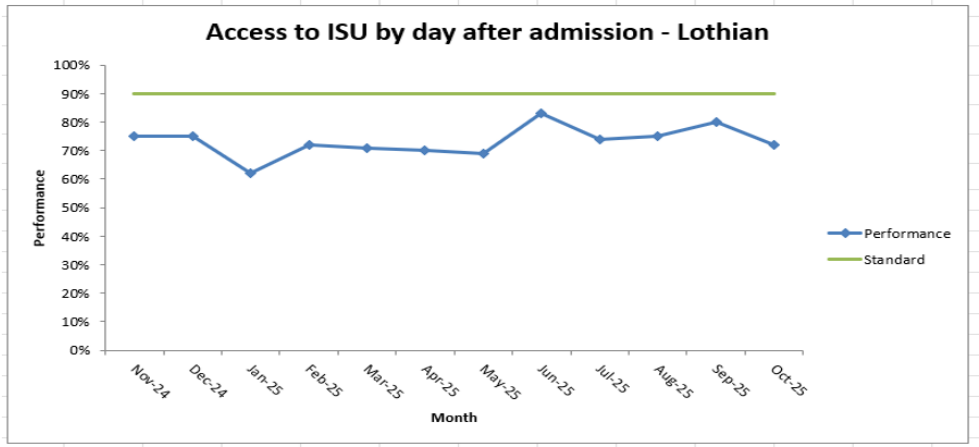


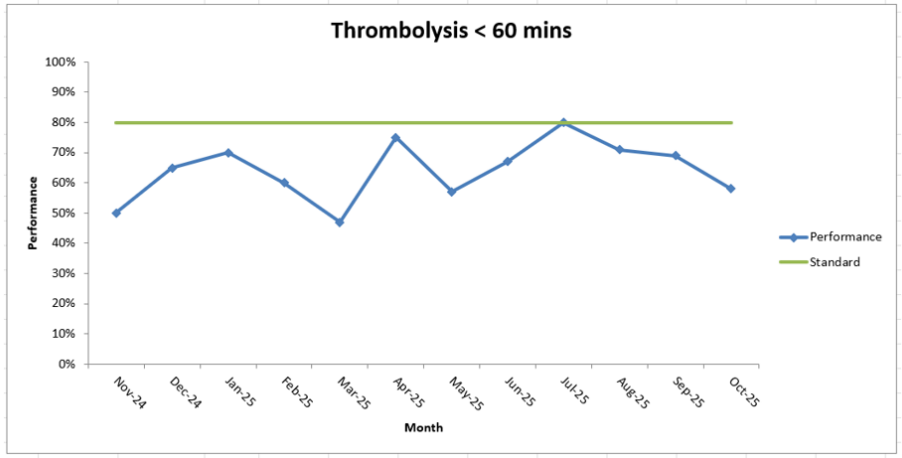
# Evidence-based stroke treatment



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# Stroke treatment: how are we doing?




**‘Every system is perfectly designed to get the results it gets’**



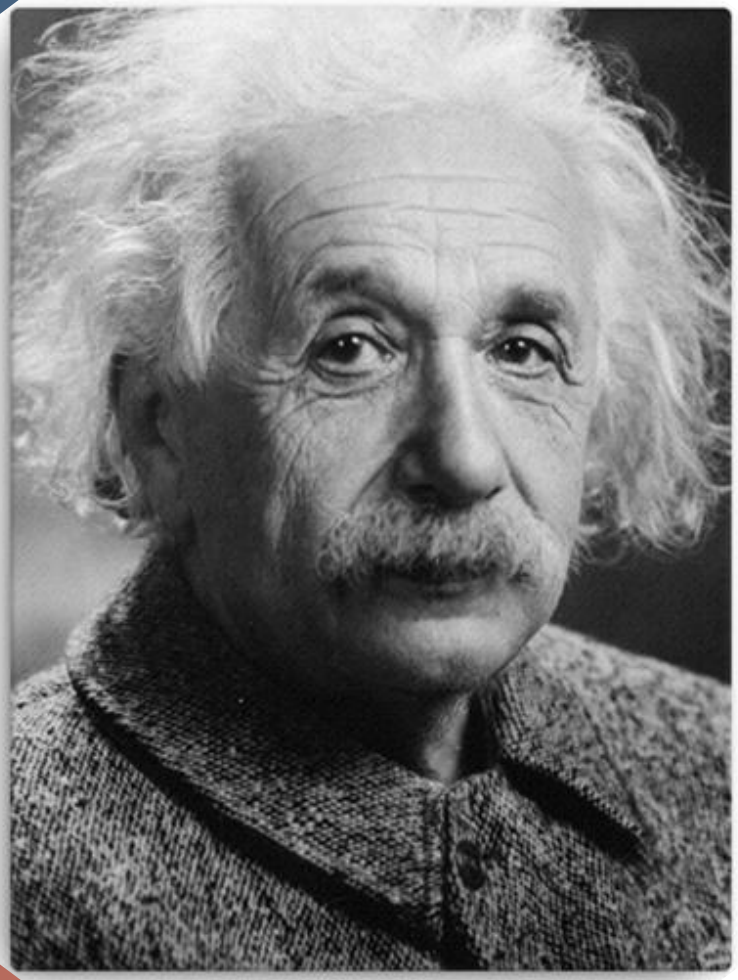


Eighty-five percent of the reasons for failure are deficiencies in the systems and process rather than the employee. The role of management is to change the process rather than badgering individuals to do better.

— W. Edwards Deming —

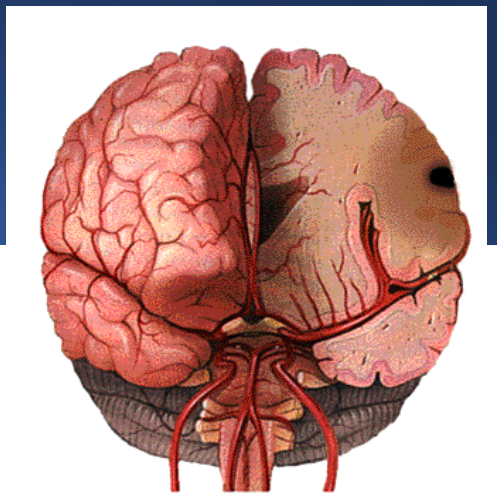
# What are we doing?

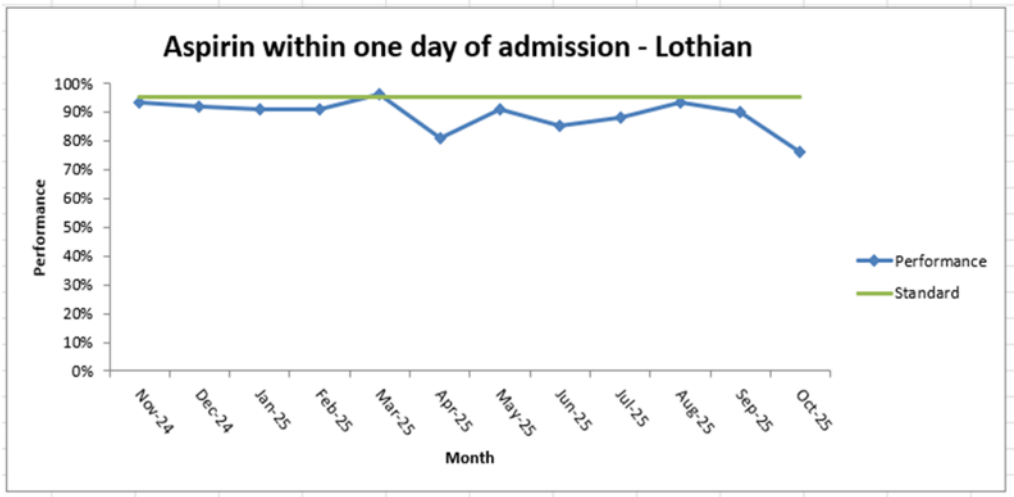
- Are we critically looking at our processes?
- Are we trying to change our process?

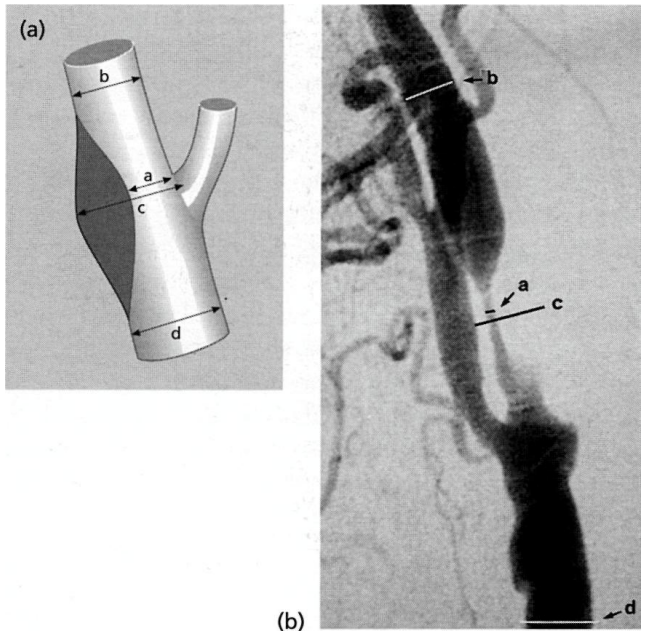


"We cannot solve our problems with the same thinking we used when we created them."

# Stroke prevention: the greatest value






And statins and endarterectomy

and my personal favourite…

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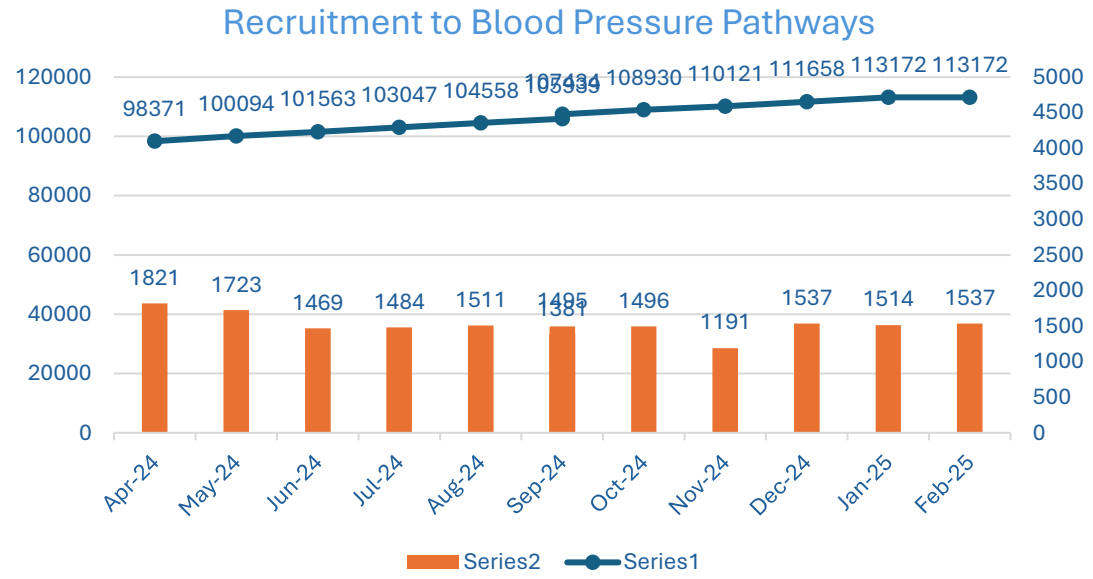
# Digital Home Blood Pressure Monitoring – as at 31 February 2025

**12 Health Boards***

**50% GP Practice****

**113,172 total recruitment**

**21,994 in past 12 months**




## What did people think?

**98%**
Liked it or thought it was ok

**99%**
Found it easy or ok to use

**94%**
Would use it again

*(410 responses received August 2024)*

**29%**
Of Adults in Scotland have **high blood pressure** (Scottish Govt)

**50%**
Of all Strokes and Heart Attacks are caused by **high blood pressure** (BHF)

## Impact:

**Over 400,000**
Appointments saved

**£15.5m saved**
Cost effect over 10 years

*(Michael et al (2019), 2017/18 costs)*

**For every 50,000**
People who routinely monitor BP, up to **745 strokes and 500 heart attacks** could be avoided over a 5-year period *(British Heart Foundation)*

**Avoided appointments** | **Reduced Travel** | **Convenient and saves time** | **Reduced Infection Risk** | **Improved access to services** | **More accurate readings to aid clinical decisions**

*"more patients are taking responsibility for their own health and wellbeing*

***Notes:***

- *All 14 Health Boards engaged With Connect Me in preparation , 12 Boards are fully onboarded and recruiting*

*** GP practices have access to national platform and received training, some 'drop-off' in transition from legacy system hence reduction from previously reported 60%.*

***Data Sources:*** *Florence (self-reported by Health Boards, Inhealthcare, Connect Me standard patient survey, Scale-UP BP evaluation*

# Rehabilitation




- Undervalued
- Need to continue to make the case
- Innovate and celebrate





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# Patient Opinion Of Stroke Services: Ask, Don't Assume

S Keir*,S Borthwick**, M Smith***, F Ryan*, J Mulhern*
*Western General Hospital, Edinburgh, **Speech and Language Therapy and ***Physiotherapy NHS Lothian
contact: sarah.keir@nhslothian.scot.nhs.uk

## Background

Getting patient and carer feedback is challenging, but essential to ensure the quality of a service. We undertook an evaluation of our Stroke Service, with the help of people who have suffered a stroke and their families. The aim was to hear from people who had experienced our services in order to identify unmet and future needs.

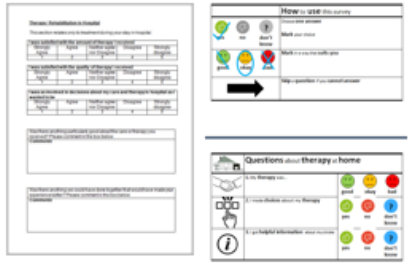
## Methods

• We used multiple survey methods including: generic in-hospital patient surveys, a stroke-specific questionnaire survey given towards the end of the community rehabilitation period, and focussed listening visits to two patient groups: our intensive aphasia study group for stroke survivors, and a group of younger stroke survivors who had created a peer support group with the help of our Community Stroke Services.

• During the survey period, following feedback and input from stroke survivors, particularly those with aphasia, we redesigned the written survey tool to be more user-friendly (figure 1).

•The qualitative comments were collated and frequency word maps were created (figures 2,3).

Figure 1. Left: original survey tool. Right: aphasia-friendly tool



## Results

• The return rate for the in-hospital survey was only 9.7%. For the community-based patients it was 58%.

• The ratings for the questionnaires were generally positive, with patients highlighting the importance of information provision (ideally more than once) and relatives highlighting the importance of support.

Figure 2. Word map: patient opinion




Figure 3. Word map: carer opinion




## Conclusion

• Although feedback was generally positive, there was a clear directive for more information, shared decision-making and carer support.

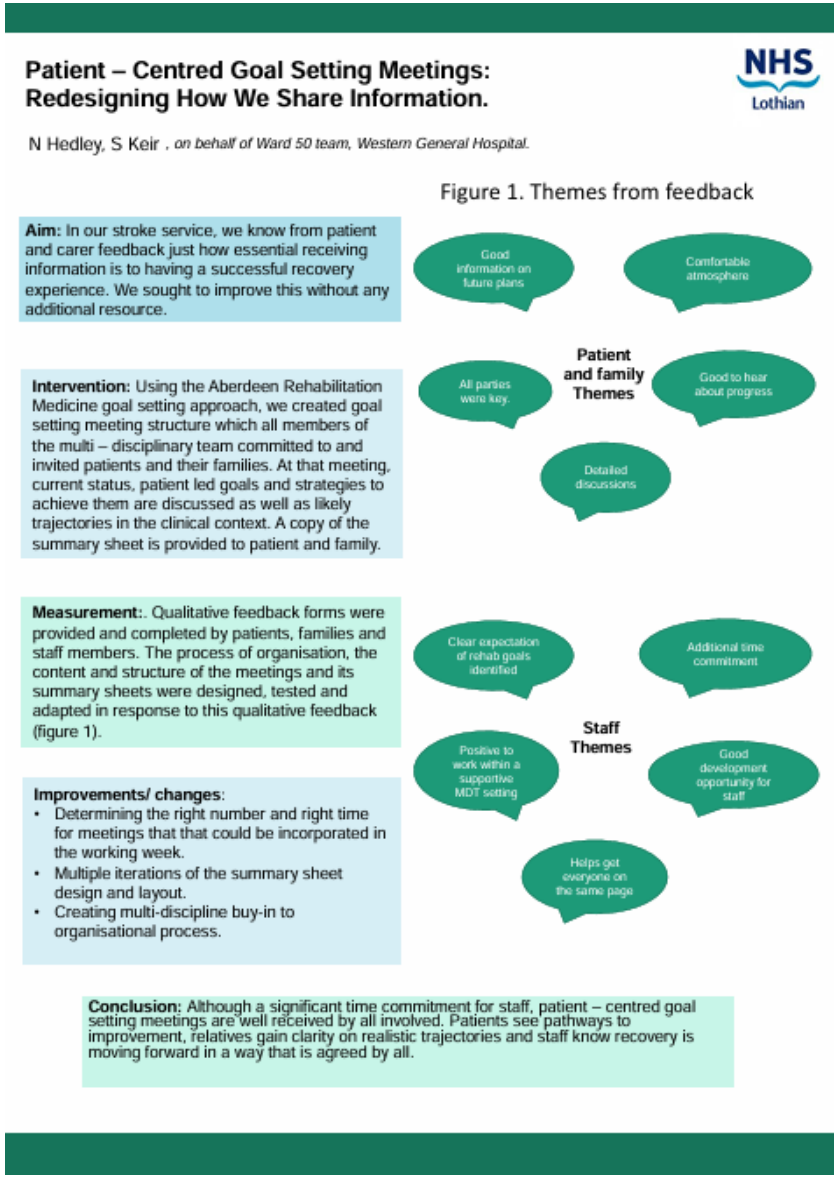
• Designing our services for the future, we must create for our service-providers the time, the tools and variety of spaces required to deliver the amount of information and support each person and their carer needs in a way that works to optimise their recovery.

# Patient-centred care




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# Patient-centred goal-setting meetings



**Patient – Centred Goal Setting Meetings: Redesigning How We Share Information.**

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N Hedley, S Keir , *on behalf of Ward 50 team, Western General Hospital.*

**Aim:** In our stroke service, we know from patient and carer feedback just how essential receiving information is to having a successful recovery experience. We sought to improve this without any additional resource.

**Intervention:** Using the Aberdeen Rehabilitation Medicine goal setting approach, we created goal setting meeting structure which all members of the multi – disciplinary team committed to and invited patients and their families. At that meeting, current status, patient led goals and strategies to achieve them are discussed as well as likely trajectories in the clinical context. A copy of the summary sheet is provided to patient and family.

**Measurement:**. Qualitative feedback forms were provided and completed by patients, families and staff members. The process of organisation, the content and structure of the meetings and its summary sheets were designed, tested and adapted in response to this qualitative feedback (figure 1).

**Improvements/ changes**:
- Determining the right number and right time for meetings that that could be incorporated in the working week.
- Multiple iterations of the summary sheet design and layout.
- Creating multi-discipline buy-in to organisational process.

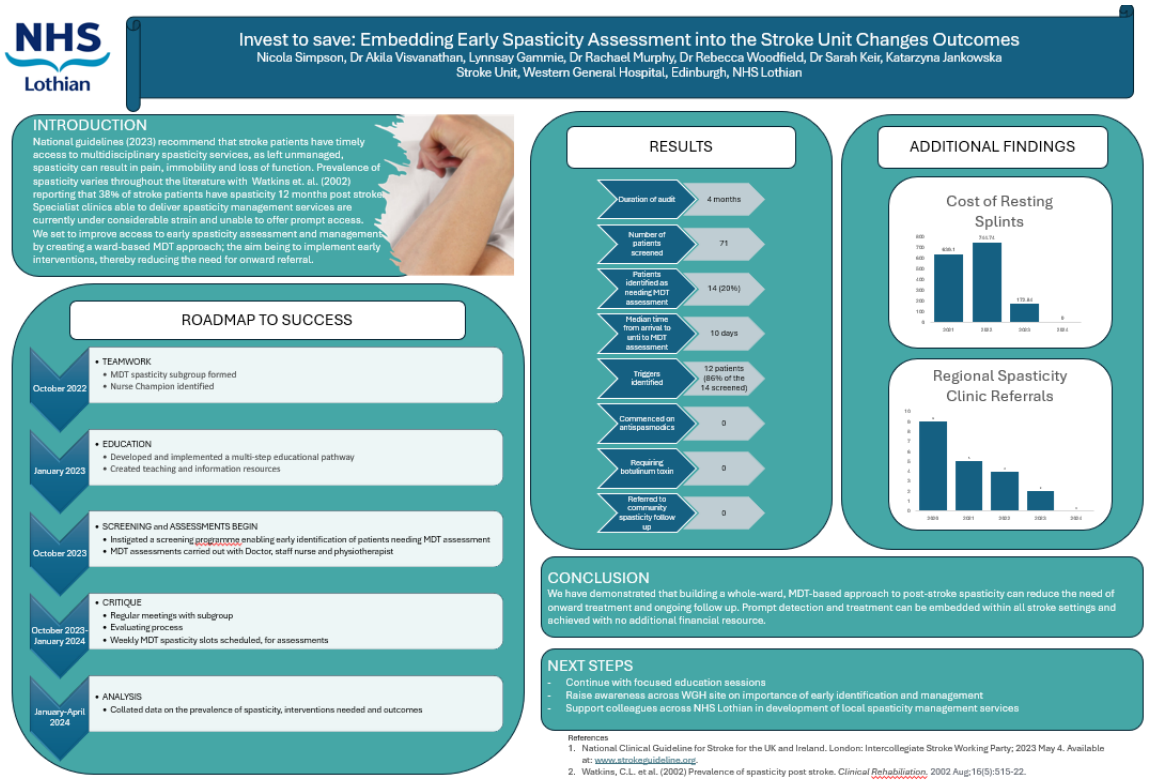
Figure 1. Themes from feedback



**Conclusion:** Although a significant time commitment for staff, patient – centred goal setting meetings are well received by all involved. Patients see pathways to improvement, relatives gain clarity on realistic trajectories and staff know recovery is moving forward in a way that is agreed by all.

- Learned from expert colleagues
- Codesigned with patients and carers
- Team approach to triage and organization
- Improved management of expectations
- Smoother discharge planning

# Decompressing our spasticity service




- Built an educational programme for our stroke unit MDT
- Including patient-based learning sessions with experts
- Incorporated in-the-room MDT assessment into patient rehab programme

# Making Information For Patients Easy to Digest

## What is spasticity?

- Spasticity happens when muscles become stiff or tight
- This may be due to stimuli such as pain or pressure.
- This can happen after an injury to the brain
- Therefore, it is less able to balance muscle stiffness and muscle relaxation appropriately.
- Spasticity can vary from mild to severe



## Spasticity- self help

- Manage pain with appropriate medication regimes for you
- Reduce effect of pressure with good seating and positioning
- Give affected parts of the body a chance to relax by providing good support to the trunk and limbs affected
- When moving a limb or opening a tight hand, use slow supported movements
- Wear comfortable clothing
- Wear comfortable and supportive footwear
- Practice general relaxation techniques e.g. deep breathing



## Helping muscles relax can make spasticity better.



**Encourage movement**

- Encourage normal movement and posture with physiotherapy.
- Give affected parts of the body a chance to relax by supporting the trunk and limb affected. Splinter or casts may help.



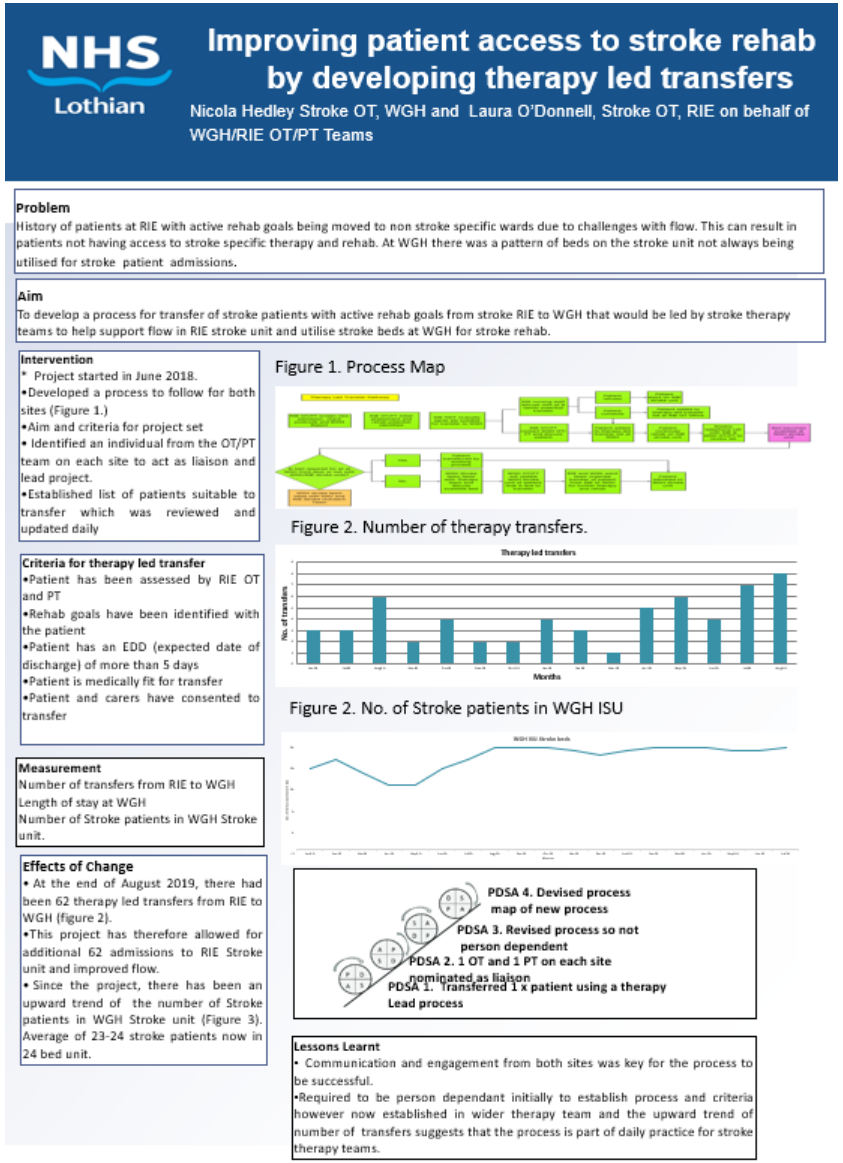
**Ease pain & pressure**

- Reduce pressure from seating by finding a comfortable position.
- Wear comfortable clothes/shoes.
- Use slow supported movements when opening up a hand or moving a limb.



**Reduce worry & anxiety**

- Relaxation - e.g. deep breathing
- Medication for pain and muscle relaxation:
  - Baclofen
  - Gabapentin
  - Tizanidine
  - Dantrolene
  - Clonazepam



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## Improving patient access to stroke rehab by developing therapy led transfers

Nicola Hedley Stroke OT, WGH and Laura O'Donnell, Stroke OT, RIE on behalf of WGH/RIE OT/PT Teams

**Problem**

History of patients at RIE with active rehab goals being moved to non stroke specific wards due to challenges with flow. This can result in patients not having access to stroke specific therapy and rehab. At WGH there was a pattern of beds on the stroke unit not always being utilised for stroke patient admissions.

**Aim**

To develop a process for transfer of stroke patients with active rehab goals from stroke RIE to WGH that would be led by stroke therapy teams to help support flow in RIE stroke unit and utilise stroke beds at WGH for stroke rehab.

**Intervention**

* Project started in June 2018.
•Developed a process to follow for both sites (Figure 1.)
•Aim and criteria for project set
• Identified an individual from the OT/PT team on each site to act as liaison and lead project.
•Established list of patients suitable to transfer which was reviewed and updated daily

**Criteria for therapy led transfer**

•Patient has been assessed by RIE OT and PT
•Rehab goals have been identified with the patient
•Patient has an EDD (expected date of discharge) of more than 5 days
•Patient is medically fit for transfer
•Patient and carers have consented to transfer

**Measurement**

Number of transfers from RIE to WGH
Length of stay at WGH
Number of Stroke patients in WGH Stroke unit.

**Effects of Change**

• At the end of August 2019, there had been 62 therapy led transfers from RIE to WGH (figure 2).
•This project has therefore allowed for additional 62 admissions to RIE Stroke unit and improved flow.
• Since the project, there has been an upward trend of the number of Stroke patients in WGH Stroke unit (Figure 3). Average of 23-24 stroke patients now in 24 bed unit.

Figure 1. Process Map

Figure 2. Number of therapy transfers.



Figure 2. No. of Stroke patients in WGH ISU



**Lessons Learnt**

• Communication and engagement from both sites was key for the process to be successful.
•Required to be person dependant initially to establish process and criteria however now established in wider therapy team and the upward trend of number of transfers suggests that the process is part of daily practice for stroke therapy teams.

# Improving flow

- Coming out of silos
- Trusting colleagues
- Demonstrating benefit

# Summary

- We need to change
- We can’t change everything
- We can change something(s)
- We have the permission to try
- Realistic Medicine is a good place to start



