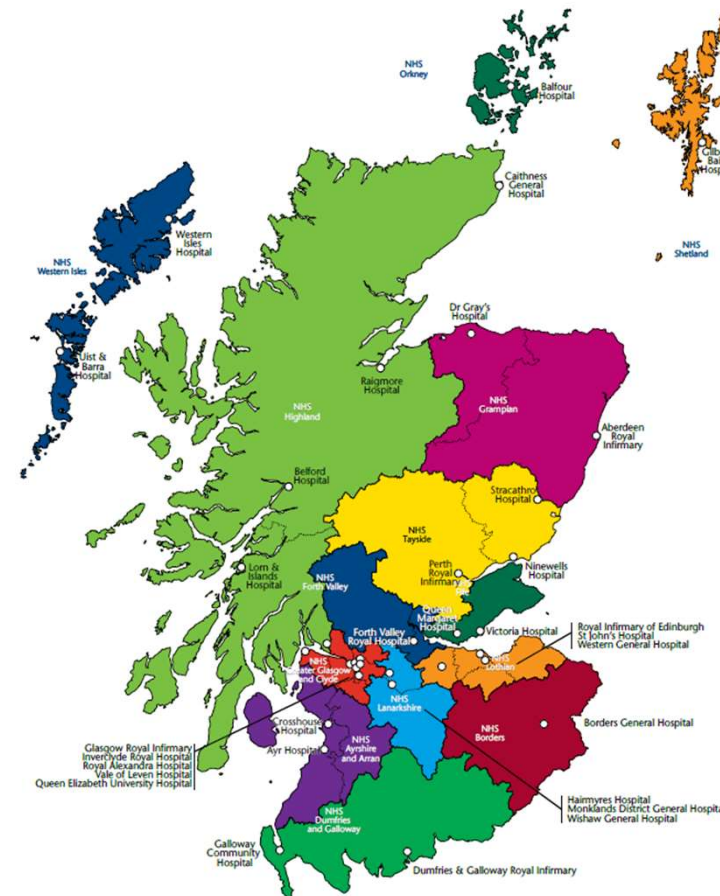


Early Supported Discharge of Stroke Patients: the Scottish perspective

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Research

Benefits of providing specialist stroke rehabilitation to patients in their own home (Langhorne 2017; Outpatient service trialists 2005)



Cochrane Database of Systematic Reviews

Early supported discharge services for people with acute stroke (Review)

Langhorne P, Baylan S, Early Supported Discharge Trialists

Scottish Intercollegiate Guidelines Network

Patients with mild/moderate stroke should be able to access stroke specialist early supported discharge services in addition to conventional organised stroke inpatient services.

ESD teams should consist of a specialist multidisciplinary group including nursing, medical, physiotherapy, speech and language therapy and occupational therapy staff.

Stroke patients in the community should have access to specialist therapy-based rehabilitation services



Scottish Intercollegiate Guidelines Network

Part of NHS Quality Improvement Scotland



Management of patients with stroke:
Rehabilitation, prevention and management of
complications, and discharge planning

A national clinical guideline

Integration is the most significant change to health and social care services in Scotland since the creation of the NHS in 1948 (www.gov.scot)

Everyone is able to live longer healthier lives at home, or in a homely setting

Reducing inappropriate use of hospital services; shifting resources to primary and community care; and supporting capacity of community care.

Expand the multi-disciplinary community care team

Develop and roll out new models of care that are person- and relationship-centred and not focused on conditions alone



**The Scottish
Government**
Riaghaltas na h-Alba



Evidence based characteristics of ESD model

Team composition

- Meet WTE/100 patients thresholds: doctors ≥ 0.1 , nurses ≥ 0.4 , occupational therapists ≥ 1 , physiotherapists ≥ 1 , speech & language therapists ≥ 0.3
- Access to rehabilitation assistants, social worker, clinical psychologist

Stroke specialist training

- Nurses, therapists, rehabilitation assistants

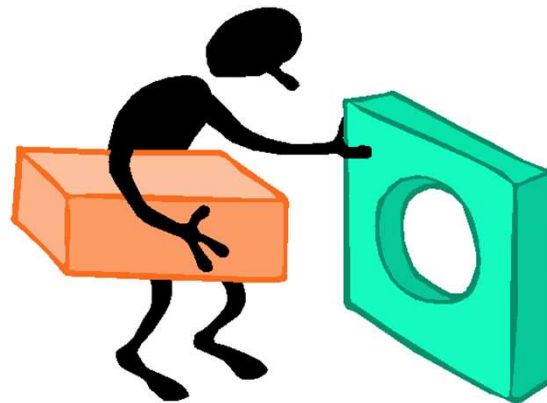
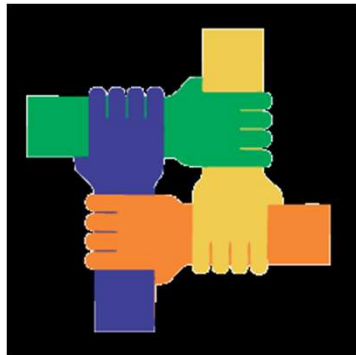
Multidisciplinary team coordination

- Weekly meetings, core team attend, ESD team member attends acute team meeting

General service features

- Stroke specific, waiting time < 24 hours, service > 5 days
- Fisher RJ, et al. A consensus on stroke: early supported discharge. *Stroke*. 2011;42(5):1392-7.
- Langhorne P, Baylan S, Early Supported Discharge Trialists. Early supported discharge services for people with acute stroke. *The Cochrane database of systematic reviews*. 2017;7:CD000443.
- Sentinel Stroke National Audit Programme (SSNAP). Post-acute organisational audit. Public report. 2015

Alignment or Tension?



Implementation of Community Stroke Rehabilitation in Scotland: Chest Heart & Stroke Scotland Action research

- Collaboration with the Scottish Stroke Care Audit team and Scottish Stroke Improvement programme
 - Phase 1: SSCA post-acute audit
 - **Phase 2: qualitative multiple case study**
- To facilitate improvements in the provision of post-acute care in Scotland
- Evidence and policy
- Description of service provision
- Themes across sites
- Recommendations



Aims:

1. To identify the range of post-acute stroke services provided in Scotland
2. To investigate the types of early supported discharge and community rehabilitation service models adopted
3. To identify areas of improvement in provision of post-acute care in Scotland



- [illegible]

Which services stroke patients are referred to on discharge from a stroke unit (May 2016):

Service	Hospitals (28)	Hospitals (28)	Health Boards (14)	Health Boards (14)
	No provision	Some provision (most or occasionally)	No provision	Some provision (most or occasionally)
Early Supported Discharge (ESD)	17	11	6	8
Stroke ESD	21	7	8	6
Generic community rehab	0	28	0	14
Stroke community rehab	19	9	10	4
Other domicillary services	2	26	1	13
Outpatient	4	24	1	13
In-patient rehabilitation	0	28	0	14

-
- The map shows the following Health Forwards and their associated major hospitals:
- North:** Aberdeen Royal Infirmary, Aberdeen City General Hospital, Aberdeen City General Hospital, Aberdeen City General Hospital.
 - South:** Dundee City General Hospital, Dundee City General Hospital, Dundee City General Hospital.
 - West:** Glasgow Royal Infirmary, Glasgow Royal Infirmary, Glasgow Royal Infirmary.
 - Central:** Dundee City General Hospital, Dundee City General Hospital, Dundee City General Hospital.
 - East:** Dundee City General Hospital, Dundee City General Hospital, Dundee City General Hospital.
 - South-East:** Dundee City General Hospital, Dundee City General Hospital, Dundee City General Hospital.
 - South-West:** Dundee City General Hospital, Dundee City General Hospital, Dundee City General Hospital.
 - Glasgow:** Glasgow Royal Infirmary, Glasgow Royal Infirmary, Glasgow Royal Infirmary.
 - Dundee:** Dundee City General Hospital, Dundee City General Hospital, Dundee City General Hospital.
 - Perth:** Dundee City General Hospital, Dundee City General Hospital, Dundee City General Hospital.
 - Aberdeen:** Aberdeen Royal Infirmary, Aberdeen City General Hospital, Aberdeen City General Hospital.
 - Islands:** Dundee City General Hospital, Dundee City General Hospital, Dundee City General Hospital.

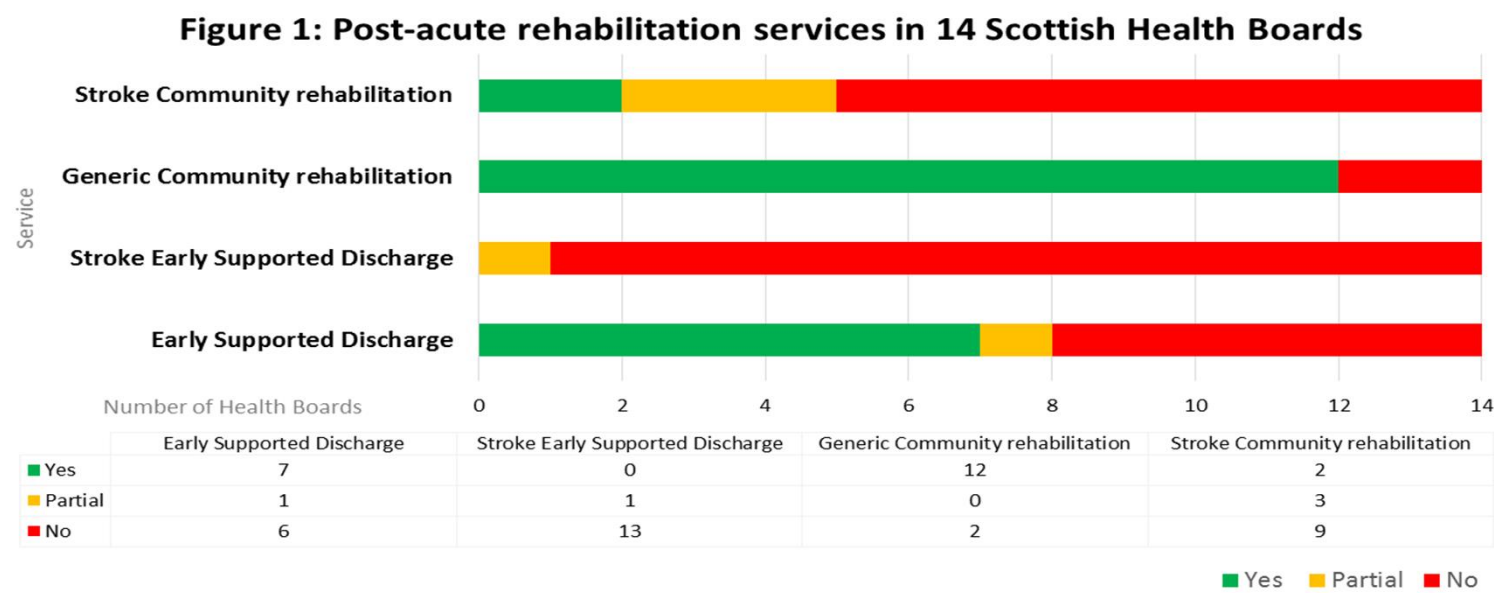
‘Early Supported Discharge’ is delivered by **a multidisciplinary team** who **co-ordinate** discharge from hospital and **provide rehabilitation** for the patient in their own home. Rehabilitation is provided immediately following discharge (**no waiting list**), **on a daily basis** for patients that need it and is usually time limited.

‘Stroke specific Early Supported Discharge’ services are staffed by clinicians who have **specific experience and knowledge of stroke** and who work together to **regularly manage stroke survivors**. Stroke specific Early Supported Discharge has been shown to be most effective for patients who are able to transfer independently or with assistance of one person.

‘Community Stroke Rehabilitation team’ is a multidisciplinary team that provides stroke specialist rehabilitation in the patient’s own home, or usual place of residence. This is **a less responsive and less intense** intervention than Early Supported Discharge and is often provided over a longer period of time.

‘Generic community rehabilitation’ is defined as services that provide rehabilitation to stroke patients in their place or residence as part of a larger patient caseload and by staff who are not stroke specialists.

Do you refer stroke patients to the following community services on discharge from your stroke unit if eligible/suitable for rehabilitation?
(May 2017):



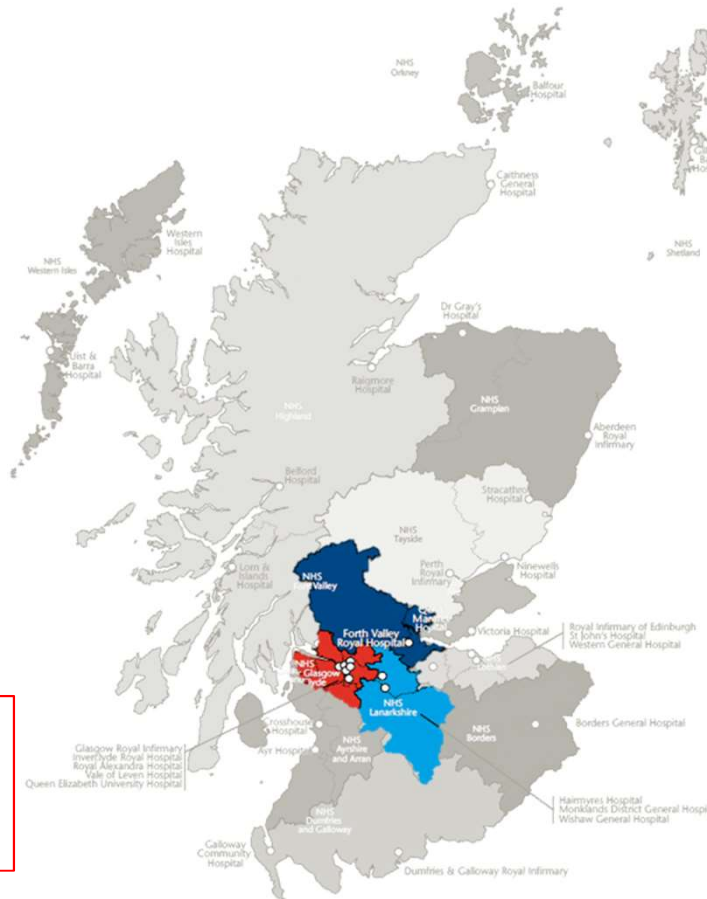
Return for one Health board inferred from 2016 data

-
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Forth Valley

Early supported discharge & community rehabilitation

Greater Glasgow & Clyde Stroke ESD & Community stroke rehabilitation



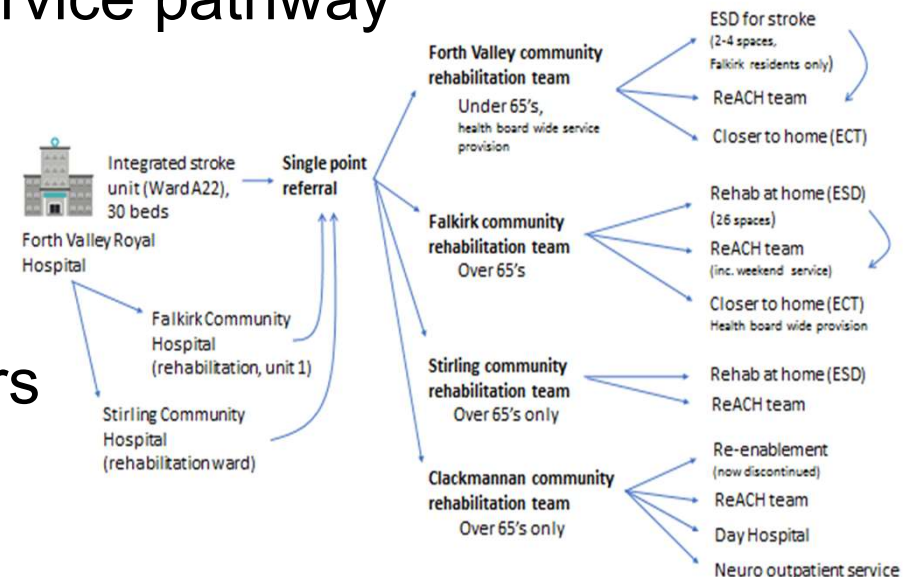
Lanarkshire Early supported discharge & community rehabilitation

	GGC	Lanarkshire	Forth Valley	Total
Specialist Stroke Nurses	1	6	0	7
Physiotherapists	3	1	3	7
Occupational Therapists	3	3	7	13
Speech and Language Therapists	1	0	1	2
Generic Support Workers	1	2	1	4
Stroke consultant	1	1	1	3
Psychologist	1	1	0	2
MCN manager	1	1	0	2
AHP lead	2	0	1	3
Corporate planning	1	0	0	1
Total	15	15	14	44

History of service, Current service model, Data collection/reporting requirements, Current sources of support and guidance, Current strengths and challenges, Staff training, Future service planning



- Pictorial overview of service pathway
- Historical perspective
- Operational hours
- Service description
 - Staffing
 - Rehabilitation drivers
 - Service length
 - Team meetings
 - Onward referral and re-entry



Results (2): Qualitative findings – Main themes

- drivers for initial service implementation,
- details of the community rehabilitation provision,
- current challenges,
- current strengths,
- provision of education and training,
- factors relating to working together as a team,
- monitoring of performance,
- perspectives for future implementation.

Drivers for initial service implementation,

- **Availability of funding and research evidence.** Historical service organisation was still influencing current service organisation, resulting in inequality in service provision.

Community rehabilitation provision

- **Goal setting** was primary driver of multidisciplinary rehabilitation with many services encouraging self-management and family involvement, The duration of input offered varied greatly with some imposing no time limit whilst others offered a time limited service with some degree of flexibility related to goal attainment.

“if you were over 65 we could access them more quickly, versus the ones that were under 65, and we felt that was disadvantaging our younger people”

Current challenges

- **Inequality and gaps in optimal service organisation.** Inequalities related to differences in service provision (e.g. age and/or geographical boundaries). Gaps related to factors such as lack of ESD or stroke nurse provision. Other challenges identified were staffing, wait times, documentation processes and IT systems.

Current strengths

- **provision of a good quality patient-centred care** provided at a patient's home that was valued by the patients and families. Staff were also able to identify documentation processes that were working well.

“We have got patients at the core of how we deliver this service... they are part of our community, I could phone any day for their advice, or for their opinion. And they have very much shaped what we do, so they have told us how important”

Provision of education and training

- Evidence of stroke education was present across all sites. Stroke specific experience and training, access to skilled colleagues and joint working were particularly valued.

Factors relating to working together as a team

- Multidisciplinary working and being co-located were facilitating working together. Supportive management and leadership also had a positive impact.

“it's about the knowledge and skills of the team around the patient, rather than what kind of team they're sitting in”,

“I'm a bit worried about losing my skills in that area (stroke)...you're not dealing with it on a daily basis”

“I think it's so important to have a multidisciplinary team. I think that's essential that we're all based here”

Monitoring performance

Many of the post-acute services were **monitoring performance** for their 'own **benefit**' despite not having a reporting requirement as part of the SSCA.

Perspectives for future service implementation

All sites were **undergoing a review of their service models** with many staff being **involved in service development**. A **variety of factors driving future service reorganisation** were identified.

“[We report] on the acute part of the journey, yes, but not on the back-end of the journey”.

- Address service **inequalities**:
 - review, simplify and unify referral criteria across the health board
 - review and unify service provision across the health board geographical area
 - agree a defined **care pathway** for post-acute stroke care

- Address **stroke specificity**:
 - provision of stroke specific training to community rehabilitation team members
 - assess the feasibility of creating defined and recognised roles for stroke specialist staff in the community (leadership opportunities)
 - create and roll out an educational template for recording levels of stroke specific skills and training
 - conduct a stroke training audit to monitor training levels

- **Audit** post-acute care:
 - audit post-acute rehabilitation against benchmarking criteria and provide feedback
 - include questions about community stroke rehabilitation services in the annual organisational audit
 - conduct a clinical audit to include core community data set that can be compared across health boards

- Assess **alignment between evidence based guidelines and policy**
 - identify common ground
 - Use research evidence to support change within policy frameworks

Progress?

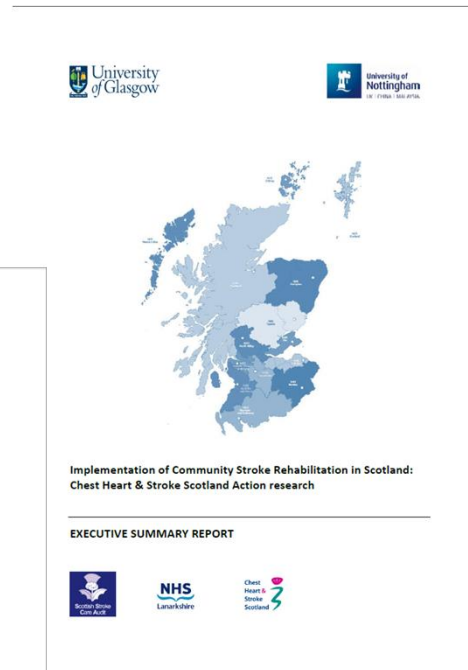
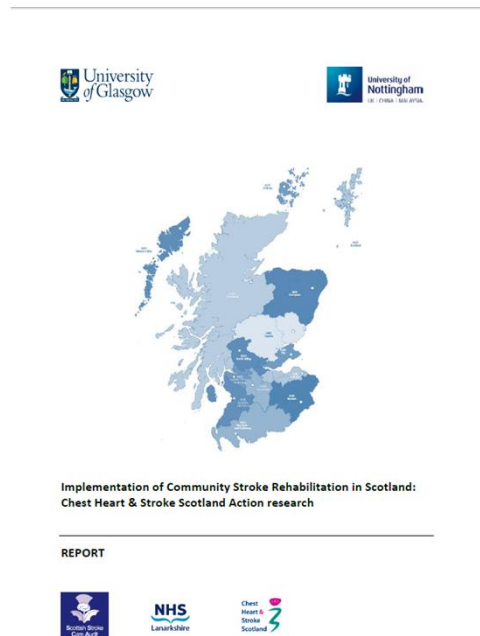
Post-acute care in Scotland

- Generic community rehabilitation: predominant model
- Some examples of community stroke rehabilitation
- No stroke specific early supported discharge
- Challenges in implementing evidence based community stroke care

Scottish stroke care audit of post-acute care

- More challenging than anticipated
- Require more information e.g. less reliance of definition interpretation
 - Average time to first contact
 - Intensity of rehab provided (e.g. daily, twice a week, weekly)
 - Multidisciplinary team composition: PT/OT/SALT/Nurse/Physician

Any questions?

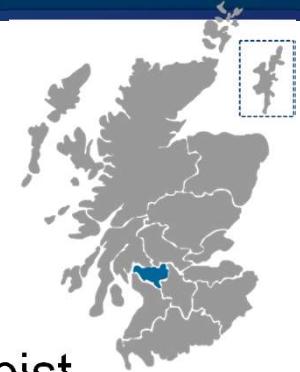


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Community stroke service

- Two geographically located teams: Glasgow & Clyde



Team Composition

- Glasgow: Stroke nurse, Physiotherapist, Occupational Therapist, Speech & Language therapist, Support workers, Psychology
- Clyde: Physiotherapist, Occupational Therapist, Support workers

Weekly MDT meetings

Overall team leader

Service

- Stroke survivors only
- Eligibility criteria: transfer independently or with assistance from one
- 5 days/week
- 8 weeks (max 12 weeks)

Generic Community Rehabilitation services

- Two areas: North & South
- Community Assessment & Rehabilitation Service (North, 2)
- Integrated Community Support Teams (South, 11)



Team Composition

- Physiotherapist, Occupational Therapist, Support workers
- Stroke MCN managed: Stroke specialist nurse, Physiotherapist trainer (stroke specific), Occupational Therapist trainer (stroke specific), Young stroke support worker, stroke psychologist

Meetings

- Weekly (CARS, ICSTs), Monthly (MCN)

Service

- Part of caseload are stroke survivors
- 5 days/week
- Six week service & stroke nurse support up to 1 year

Generic Community Rehabilitation service

- Referrals made through a single point
- Three regional teams: Stirling, Falkirk and Clackmannan
- Falkirk: Rehabilitation and Assessment in the community at home (ReACH) Over 65s and Under 65s
- Stirling, Clackmannan Over 65s



Team Composition

- Physiotherapist, Occupational Therapist, Support workers
- Falkirk Over 65s only: Speech & language therapist (access), Psychology, Dietician

Meetings

- Teams work separately
- Team meetings weekly or every two weeks

Service

- Part of caseload are stroke survivors
- 5 days/week (weekend cover in Falkirk)