Greater Manchester, Lancashire and South Cumbria
Strategic Clinical Networks

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Background

- Service evaluation community stroke services (June 2014)

-Inc staffing levels
- Capacity
- Estimated demand
- Outcomes of team
- Comparison inpt LoS
- Operational hours
- Individual CCG recommendations

- HoC acknowledge and mandated:

- Recommended stroke rehabilitation model
- Outcome based service specification
- Financial modelling

Actions

- Seconded clinical lead 32PAs to deliver outputs
- Established steering group (inc LA, social services, vol sector, CCGs, pts, AHP, nurses, GP, consultant)
- Developed integrated stroke rehabilitation model
- Developed outcome based service specification
- 2 rounds of consultation
- Support from CSU for financial modelling

Integrated stroke rehabilitation model

- Based on national work “Stroke rehabilitation in the community: commissioning for improvement”
- Most cost effective of 5 models nationally
- Integrated with re ablement
- One team seeing all discharges
- In reach to acute to support discharge
- Contact within 72hrs
- 6 month time limit
- 6 month review
- Referral to survivorship

	Option 1 Stand-alone ESD	Option 2 ESD with CST/ CNRT	Option 3 Integrated ESD within CST	Option 4 Integrated ESD with CNRT	Option 5 ESD hybrid
Timeframe of rehabilitation	Usually six weeks	Typically six weeks ESD then referral on to the community stroke, or neurology team for continued rehabilitation of approximately three months	Typically goal directed approach, so available for as long as required (range three months to one year)	Typically adopt a goal directed approach, so the services are available for as long as required (range three months to one year)	Usually time limited (range six weeks to 12 weeks)
Proportion of patients who fit criteria	Up to 40%	Up to 100% of rehabilitation patients	Up to 100%	Up to 100% of patients	Varies depending on individual criteria but usually there are higher percentages of patients than traditional ESD models, but lower than 100%
Number of pathways from acute provider to home	Two – ESD and non ESD	Two – ESD and non ESD	One pathway for all patients, through a coordinated discharge/rehabilitation process led by the team	One pathway for all patients; coordinated discharge/rehabilitation via the team	Two pathways, ESD and non ESD pathway
Stroke dependency level catered for	Mild to moderate dependency levels	All dependency levels catered for, mild to complex severe	All dependency levels, from mild to complex severe	All dependency levels of stroke patients mild – complex severe, and neurological patients	All dependency levels of stroke patients mild to complex severe
Potential patient wait	•Yes – to access the service, if the team does not contain a dedicated social worker there may be waits for care package/enablement • Yes - potential waits between cessation of ESD and access to generic rehabilitation depending on capacity of generic services	•Yes – potentially to access the service, if the team does not contain a dedicated social worker there may be waits for care package/enablement to access either component from acute care • Yes - potentially between ESD and follow on rehabilitation depending on the capacity of stroke and neurology community teams	•Usually no wait and immediate access to supported discharge/rehabilitation. •Typically these services coordinate and lead the transfer from hospital to home	•Usually no wait and immediate access to supported discharge/rehabilitation. •Typically these services coordinate and lead the transfer from hospital to home • Where the team does not include a dedicated social worker, there may be delays accessing service from acute care awaiting packages/enablement support • There is an example of wait of up to three weeks for non ESD patients within this group	•Yes, potentially a wait for the non ESD patients who do not fit the criteria • Yes, potentially a wait for follow on rehabilitation depending on the capacity of follow on rehabilitation teams in intermediate care services
Groups of stroke patients unable to access service	• Complex/ severe dependency cohorts of patients • Care home based patients • Community based patients who have not been admitted to acute care first (declined)	Usually all groups of patients can access rehabilitation via the ESD and non ESD pathways including ESD/Non ESD from acute care, care home and community based locations	All groups of patients can access timely rehabilitation including, ESD/non ESD from acute care, care homes, and community-based patients	All groups of patients can access the service including, ESD/non ESD from acute care, residential care and community based locations	Patients who do not meet the criteria • Community-based patients who have not been admitted to acute care

	Option 1 Stand-alone ESD	Option 2 ESD with CST/ CNRT	Option 3 Integrated ESD within CST	Option 4 Integrated ESD with CNRT	Option 5 ESD hybrid
Additional support infrastructure that may be needed	• Follow on access to a community stroke/neuro/ generic team for continued rehabilitation • Community stroke/neuro/generic team for patients who do not meet the criteria • Social care enablement/care packages: seven day patient support to enable early discharge and intensive daily rehabilitation	Social care enablement/care packages providing seven day patient support to enable early discharge and intensive daily rehabilitation	Social care enablement/Health domiciliary rehabilitation support staff: Seven day patient support to enable early discharge and intensive daily rehabilitation	Social care enablement/Health domiciliary rehab support staff, or seven day patient support to enable early discharge and intensive daily rehabilitation	Social care enablement/health domiciliary rehabilitation support staff, to provide seven day patient visits to enable early discharge and intensive daily rehabilitation • Follow on support from community stroke/neurology teams or generic rehabilitation teams
Stroke skilled management for whole rehabilitation pathway	No - only for duration of service (two to six weeks) with referral onto generic services	No - only for the length of the service (typically six weeks – three months). Further referral can be made onto generic services	Multidisciplinary stroke skilled therapy for whole pathway, including staff from intermediate and social care	Yes - multidisciplinary stroke skilled therapy for whole pathway	Usually time limited for as long as the service is provided. This may cease on transfer into the community, depending on other local services' availability for example, community stroke/neurology or generic intermediate care services
Cost per patient	Between £2,580 and £1,132	Between £1,157 and £1,868.95	Between £1,336 and £2,502	£770	£5,162

Stroke Survivors living in the community who need CST 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

Community Stroke Team (CST)

Core Multidisciplinary Team (MDT)

- Clinical Psychologist/Neuro Psych
- Occupational Therapist
- Physiotherapist
- Speech and Language Therapist
- Nurse
- Social worker
- Rehabilitation support workers
- Access to consultant stroke/GP for med support post discharge

CST 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 CST with stroke ward including weekends to support discharge planning
Holistic assessment: cognition, dependency in ADL, family support, risks, environment
Provide joint health and social care plan before discharge
Medically unstable, severely impaired or complex physical/cognitive would have in patient rehab or specialist neuro rehab centre input until manageable at home

Provide joint H&S care plan before d/c

Discharge

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

Pathway 1 (50-70% pts)
Therapy at home with CST support
Telephone call to patient/carer within 24hrs for triage and management planning
Assess at home within 48 - 72 hours
Treatment begin with 24 hrs of assessment for ESD pts and within 7 days for non ESD pts
Therapy intensity as per need or able tolerate (target 45 mins over 5 days week)
Intervention provided by CST for up to 6 months

Pathway 2 (10-15% pts
Therapy at home with joint CST & Re-ablement rehab support package
- Seen for joint assessment at home by CST and re ablment team within 24 hours of discharge to develop management plan
- CST provide treatment and management plans with therapy practice via re ablement workers
- Therapy intensity as per need with 7 days rehab/up to 3 therapy/care visits a day provided by re ablement service/CST
- CST Review goals/visits weekly with max 6 weeks re ablment support available
- Step down to pathway 1 if needed

Pathway 3 (10-15% pts)
Discharged to residential intermediate care bed (IC)
CST carry out assessment of patient and management plan at the IC unit within 24 hours of discharge
Assessments by relevant CST MDT professions carried out within 7 days and therapy as needed
CST In reach to provide management plans/therapy/support IC staff/contribute to MDT meetings
IC bed available for up to 6 weeks
Step down to pathway 1 or 2

Pathway 4 (10-15% pts)
Discharged to residential/nursing home
Telephone call to res home within 24hrs for triage and management planning
Assess within 48-72 hours of discharge
Treatment begin within 7 days of assessment
Therapy provided daily over 6 days week as per need
Management plan/reintegration if needed to include seating/mobility/swallow/spasticity/ prevention of contractures and shoulder pain

Support services

- **Orthotics/orthoptics/wheelchair services**
- **Spasticity clinic: Botox, Consultant review**
- **Specialist inpt neuro rehab centre**
- **Return to work services**
- **Long term conditions services with self management/expert programme**
- **Befriending/peer support/respite**

Voluntary services/carer support

Rapid assessment Team

- Access to immediate support for CST 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

Communication Support Group

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 CST for review if needed

SCN Stroke Day - poster v3.pdf - Adobe Reader

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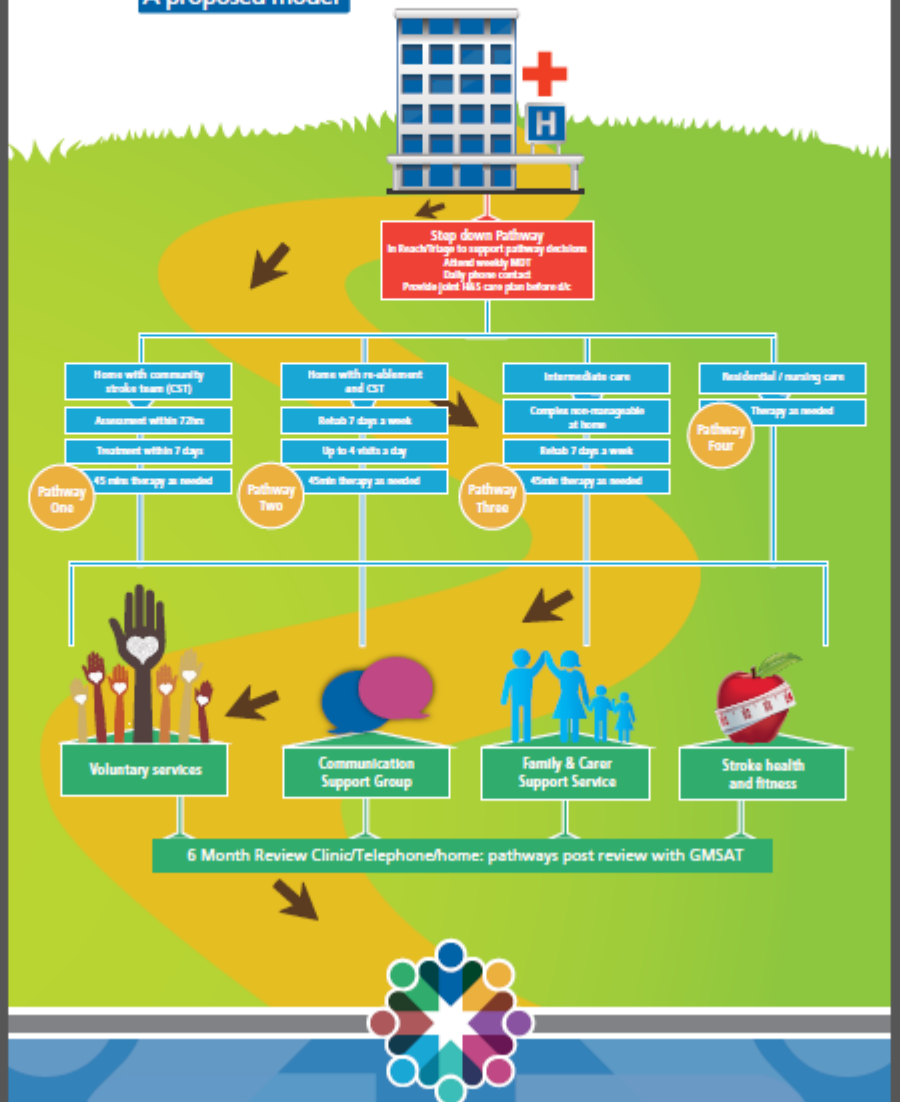
Integrated Community Stroke Rehabilitation: A proposed model

NHS
Greater Manchester, Lancashire and South Cumbria
Strategic Clinical Networks



Outcome based service specification

Stand alone and embedded in end to end stroke service specification

Steering group first consultation

- linked to NHS Outcomes Framework
- thresholds

	Outcome	
1	Equitable access to specialist stroke rehabilitation in the community for **ALL** stroke patients regardless of dependency levels utilising health, social care and voluntary resources in an integrated approach for better outcomes..	Domain 3 -Helping people to recover from episodes of ill health or following injury
2	Reduction in hospital length of stay and use of hospital rehabilitation beds.	Domain 3 -Helping people to recover from episodes of ill health or following injury
3	Immediate access to specialist CST intervention for **ALL** stroke patients leaving hospital with options of between 48- 72 hour contacts for assessment/management plan post discharge depending on need as per NICE Guidance.	Domain 3 - Helping people to recover from episodes of ill health or following injury
4	Reduction in GP use and duplication of referral or assessment by other generic community teams via telephone contact within 24 hours of discharge to patients/carers to make contact, triage and set assessment date based on need and patient wishes.	Domain 3- Helping people to recover from episodes of ill health or following injury Domain 4 - Ensuring that people have a positive experience of care
5	No increase in 28 days re admission rates with possible reduction in re admission rates due to early intervention and support from the CST.	Domain 3 -Helping people to recover from episodes of ill health or following injury

6	100% of patients screened post discharge for mood and cognition as per quality standard; with access to psychological interventions as needed through a stepped care model and support of IAPT.	Domain 2 - Enhancing quality of life for people with long-term conditions Domain 3 -Helping people to recover from episodes of ill health or following injury
7	Increase in the number of joint health and social plans for patients on discharge from acute to the community	Domain 2 - Enhancing quality of life for people with long-term conditions Domain 4 - Ensuring that people have a positive experience of care
8	Reduction in time on CST caseload due to exit strategies via communication support group, family carer support and stroke specific exercise class	Domain 2 - Enhancing quality of life for people with long-term conditions Domain 3 - Helping people to recover from episodes of ill health or following injury
9	Reduce dependency levels: Proportion of patients who improved as measured by MRS, NEADL and MBI following discharge from CST team	Domain 2 - Enhancing quality of life for people with long-term conditions Domain 3 - Helping people to recover from episodes of ill health or following injury
10	Increase in functional independence as measured by an appropriately recommended stroke measure i.e. FIMFAM	Domain 2 - Enhancing quality of life for people with long-term conditions Domain 3 - Helping people to recover from episodes of ill health or following injury
11	Prevent avoidable disability via early intervention to maximise ability to remain in home environment with monitoring of proportion of people who remain at normal place of residence following discharge from the CST.	Domain 2 - Enhancing quality of life for people with long-term conditions Domain 3 - Helping people to recover from episodes of ill health or following injury

12	Reduce the burden of care for families/carers and improve quality of life as measured by appropriate quality of life tool or carer strain index.	Domain 2 - Enhancing quality of life for people with long-term conditions Domain 3 - Helping people to recover from episodes of ill health or following injury
13	100% of new stroke patients will receive a health and social care review 4-6 months post hospital discharge to highlight any medical, physical, psychological or psychosocial problems that need further targeted intervention and coordinate care	Domain 2 - Enhancing quality of life for people with long-term conditions Domain 3 - Helping people to recover from episodes of ill health or following injury Domain 4 - Ensuring that people have a positive experience of care
14	Proportion of patients with stroke whose carers have: a named contact for stroke information; written information about patient's diagnosis and management plan; and sufficient practical training to enable them to provide care.	Domain 2 - Enhancing quality of life for people with long-term conditions Domain 4 - Ensuring that people have a positive experience of care
15	GPs will receive a discharge summary following CST input and 6 month review outcome for all patients.	Domain 4 - Ensuring that people have a positive experience of care
16	Increase in the CST performance on the national SSNAP audit.	
17	Proportion of patient's reporting positive experience as measured by friends and family test or patient satisfaction surveys	Domain 4 - Ensuring that people have a positive experience of care

“Are there any national plans for new stroke rehabilitation measures (SSNAP) or recommendations (NSS)?”

Implementation

- Consultation with all commissioners and services managers as pathway developed
- Face to face discussion with CCGs and service managers
- Request for actions to mitigate risk via HoC

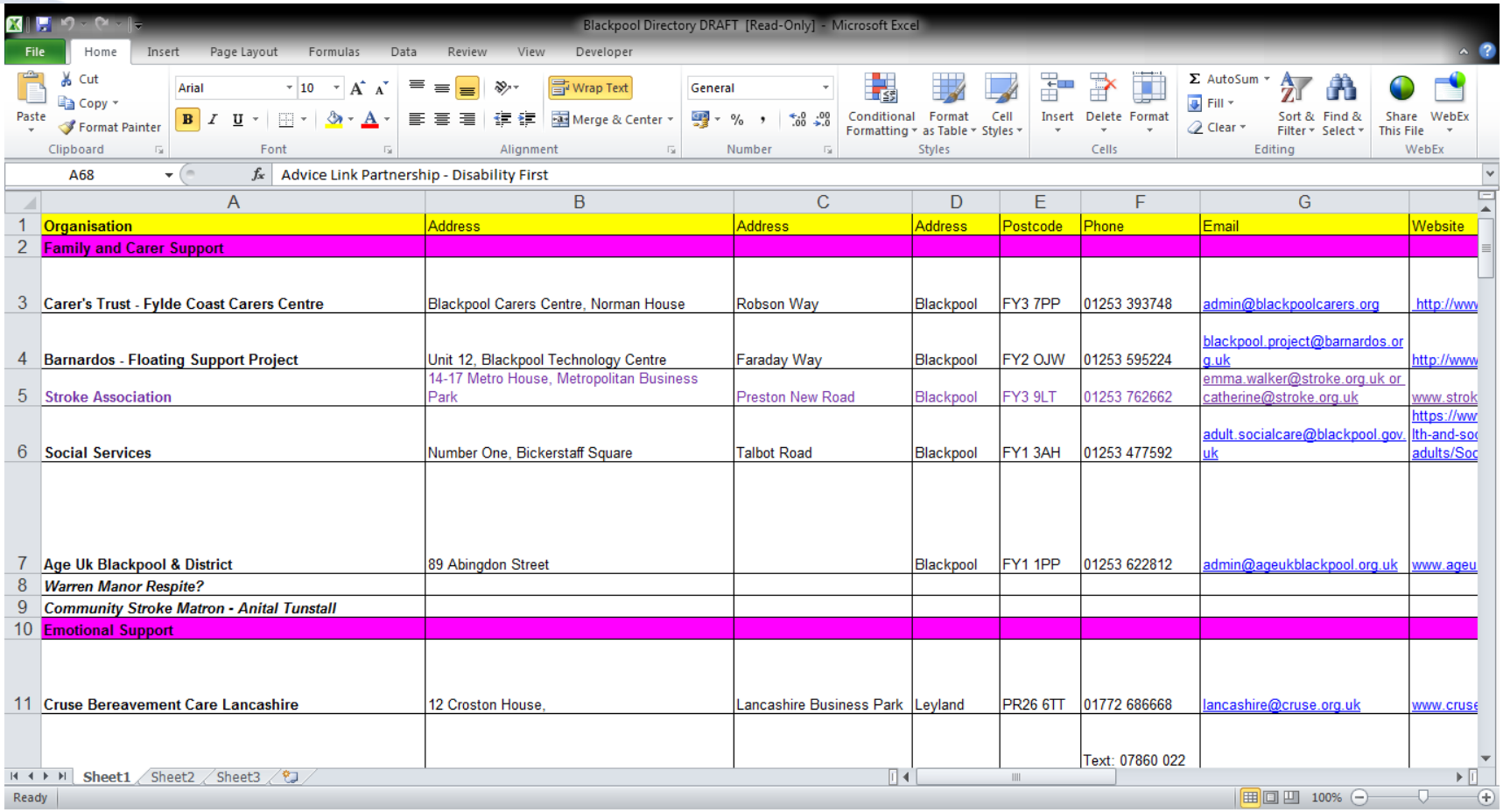
Survivorship

- Exit route from community stroke rehabilitation
- Maintains flow of pts
- Supports 6 months intervention
- Inequity highlighted in report to HoCs
- Seconded Stroke Association to:
  - Review current services
  - Deliver report with recommendations for service improvement (minimum commissioning)
  - Develop directory for each CCG

Directory

- Assimilation to PLANS (GM- CLAHRC on line self assessment tool for pts)
- Categories:
  - Family and carer support
  - Emotional support
  - Communication
  - Stroke clubs / peer support
  - Work, volunteering, learning
  - Healthy living and stroke prevention
  - General health
  - Exercise and leisure
  - Transport
  - Advice, advocacy and information
  - Self management

- Information in directory:
  - Organisaiton
  - Address
  - Phone number
  - Email
  - Website
  - Social media
  - Opening hours
  - Referral process
  - Service overview
  - Service specifics
  - funding



	A	B	C	D	E	F	G	
1	**Organisation**	Address	Address	Address	Postcode	Phone	Email	Website
2	**Family and Carer Support**							
3	**Carer's Trust - Fylde Coast Carers Centre**	Blackpool Carers Centre, Norman House	Robson Way	Blackpool	FY3 7PP	01253 393748	admin@blackpoolcarers.org	http://www
4	**Barnardos - Floating Support Project**	Unit 12, Blackpool Technology Centre	Faraday Way	Blackpool	FY2 OJW	01253 595224	blackpool.project@barnardos.org.uk	http://www
5	**Stroke Association**	14-17 Metro House, Metropolitan Business Park	Preston New Road	Blackpool	FY3 9LT	01253 762662	emma.walker@stroke.org.uk or catherine@stroke.org.uk	www.strok
6	**Social Services**	Number One, Bickerstaff Square	Talbot Road	Blackpool	FY1 3AH	01253 477592	adult.socialcare@blackpool.gov.uk	https://ww lth-and-soc adults/Soc
7	**Age Uk Blackpool & District**	89 Abingdon Street		Blackpool	FY1 1PP	01253 622812	admin@ageukblackpool.org.uk	www.ageu
8	***Warren Manor Respite?***							
9	***Community Stroke Matron - Anital Tunstall***							
10	**Emotional Support**							
11	**Cruse Bereavement Care Lancashire**	12 Croston House,	Lancashire Business Park	Leyland	PR26 6TT	01772 686668	lancashire@cruse.org.uk	www.cruse
						Text: 07860 022		

“Core” survivorship recommendations

- Communication support
- Exercise group

http://www.gpcwm.org.uk/wp-content/uploads/file/COMMISSIONING/2012/Stroke%20rehabilitation%20in%20the%20community_commissioning_for_improvement_july2012.pdf