

Stroke Community Rehabilitation and ESD Service Specification

Care pathway/service	Stroke community rehabilitation (including ESD)
Commissioner lead	
Provider lead	
Period	2013/14
Applicability of Module E (Service requirements)	

1. Purpose

1.1 Aims

To ensure available access to a stroke specialist community rehabilitation team for all as is clinically appropriate.

- Maximise rehabilitation and recovery after illness or injury.
- Minimise premature dependence on long term institutional care.
- Promote independence and prevent inappropriate hospital stays.
- Enable eligible stroke patients to be discharged 'early'* and receive rehabilitation in their own home at the same intensity as inpatient care, thereby enabling more patients to recover and rehabilitate at home.

*See service description 2.1

1.2 Evidence base

Evidence shows that continued co-ordinated multidisciplinary rehabilitation in the community setting improves long term outcomes for patients and can help to reduce hospital admissions (National Service Framework for Long Term Conditions (2005) Quality requirement 4 – Early and specialist rehabilitation).

Services should aim to meet the following standards and guidelines:

- National Service Framework for Older People (2005) especially Standard 5: Stroke
- National Service Framework for Long Term Conditions (2005)
- National Stroke Strategy Quality Markers (2007)
- The Stroke Strategy for London (2008)
- Royal College of Physicians National Clinical Guidelines for Stroke (2008)
- NICE Stroke Quality Standards (2010)
- Stroke Rehabilitation Guide: Supporting London Commissioners to Commission Quality Services in 2010/11
- Any relevant new standards as and when they are published

1.3 General overview

Specialist, co-ordinated community rehabilitation and supported discharge delivered by a multi-disciplinary team (MDT) with highly developed stroke-specific skills; started early after stroke and provided with sufficient intensity reduces mortality and long term disability.

1.4 Objectives

- Enable stroke patients to achieve mutually agreed, realistic rehabilitative goals to maximise their recovery
- Ensure carers and families are involved in the development of stroke services and their needs are considered

- Provide a highly skilled and experienced workforce supported by stroke specialist rehabilitation assistants
- Develop strong relationships with referrers and supporting services, including acute multi-disciplinary meetings, social care, dietetics and voluntary sector organisations

1.5 Expected outcomes including improving prevention

- Improved health and well being outcomes as measured against specific criteria (e.g. quality of life measures*)
- Improved patient and carer experience
- Timely discharge from acute services and seamless transfer from hospital to home
- Reduction in unnecessary hospital admissions
- Reduction in hospital length of stay
- Quality improvements and subsequent achievement of national and local performance outcome measures
- Reduced incidence and/or problems from secondary risk factors (e.g. pressure sores, chest infections, contractures)

*Locally agreed outcome measures to be included in section 8
Outcomes to be quantified locally.

2. Scope

2.1 Service description

The community rehabilitation service should have a single point of entry and be accessible to all stroke survivors. People should be able to re-access the service at any point along the pathway (i.e., not just following an acute inpatient admission). Community rehabilitation is goal-orientated and provides assessment, intervention, rehabilitation and patient education to patients who have had a stroke. Goals will be incorporated into a personalised care plan that allows the patient to take ownership of their rehabilitation and reviewed regularly (every 4-6 weeks) with the patient throughout the treatment period. Where goals have previously been set for patients these should be followed up. Patients should be allocated a named key worker whose role is to monitor the implementation and review of the care plan and progress of any onward referrals to other services.

While initial assessment of the stroke patient is carried out by a qualified professional, some of the care may be delivered by rehabilitation assistants under the supervision of a qualified therapist. Planning of discharge from the inpatient units should begin early in the patients' stay on the unit.

Early supported discharge (ESD) enables appropriate stroke patients to leave hospital 'early' through the provision of intense rehabilitation in the community at a similar level to stroke unit care. For the duration they would otherwise have been receiving inpatient rehabilitation (usually up to two weeks), stroke survivors receive at least five sessions per week of occupational therapy, physiotherapy and speech and language therapy as required. Following the initial intensive rehabilitation period in the community, the therapy regime reverts to a level of normal community rehabilitation as required (i.e., at least three sessions per week of appropriate therapy).

Specialist stroke rehabilitation and support will address the following issues either directly or by onward referral where required:

- Mobility and movement
- Communication
- Everyday activities (e.g. dressing, washing, meal preparation)
- Emotional and psychosocial issues (e.g. depression and adjustment difficulties)
- Swallowing
- Nutrition
- Impaired cognition

- Visual disturbance
- Continence
- Relationships and sex
- Pain
- Return to work

Community rehabilitation teams also assist appropriate stroke survivors to access vocational rehabilitation. Commissioners should review vocational rehabilitation provisions in terms of accessibility, eligibility and process for referral so these services can support those who wish to return to meaningful activities as well as those who are able to return to work.

2.1.1 Interventions

- Patients who have had an acute stroke will receive three sessions per week for the first four weeks of individual sessions of occupational therapy (OT), physiotherapy (PT) and speech and language therapy (SLT) as required and agreed with the patient.
- Patients who have had an acute stroke and are assessed as being suitable for early supported discharge will receive five sessions per week for the first two weeks of occupational therapy (OT), physiotherapy (PT) and speech and language therapy (SLT) as required and agreed with the patient.

2.2 Accessibility/acceptability

The service is for patients aged over 16 who have had a stroke (and/or other neurological condition if commissioning a community neuro service inclusive of stroke). Referrals are accepted from any source: the patients themselves, their relatives, GPs, district nurses, social workers or any other health or social care professional.

The service is available and accessible to all stroke survivors including patients who reside in nursing homes and those in temporary accommodation.

The service must not discriminate on the grounds of race, disability, gender, sexual orientation, religion, belief or age (*N.B. Stroke services are only for those aged over 16yrs of age*).

Services should provide equal access for all and be responsive to diverse needs, free from stereotyping and discriminatory practice.

2.3 Whole system relationships

The service will establish key relationships with the following organisations, agencies and key staff:

- Hyper Acute Stroke Units (HASUs) and Stroke Units (SUs)
- Acute therapy services
- Social care services
- Inpatient rehabilitation units
- Community nursing teams/Intermediate care teams
- General practitioners
- Voluntary organisations (e.g. the Stroke Association, Connect – the communication disability network, carer organisations)
- Nursing and care homes
- Practice nurses and nurse practitioners
- Health visitors
- Clinical nurse specialists (primary and secondary care)
- Out-of-hours services
- Podiatry
- Dietetics

- Orthotics
- Wheelchair and equipment services
- Continuing care
- Community therapy services
- Community mental health teams
- Psychological therapies in primary care
- Counselling services
- Dental services
- Hospice
- Spasticity clinics
- Exercise groups/Gyms

2.4 Interdependencies

Systems and processes must be in place to ensure collaborative working with primary care, secondary care, social care and all relevant people to avoid patients falling through the gaps between agencies. This will also support seamless transition between assessments.

This might include:

- Staff attending hospital stroke unit MDT meetings to assist with discharge planning and discuss patient goals
- In reach/outreach between hospital and community teams prior to discharge
- Named care manager with stroke care experience involved in the community team
- Close working with continuing care services
- Regular MDT meetings in the community with stroke consultant input

2.5 Relevant networks and screening programmes

Providers should have active involvement with the South London Cardiac and Stroke Network, www.slcsn.nhs.uk.

3. Service delivery

3.1 Service model

The configuration of community stroke rehabilitation services is not prescribed. However, an example of a successful service delivery model would be a community neuro-rehabilitation team, with an integrated stroke supported discharge service (for those eligible for early supported discharge as well as those requiring ongoing community based rehabilitation following their inpatient stay), delivered by staff with stroke specialist skills.

The community team includes at a minimum representatives from the following disciplines who have specialist stroke skills as well as generic skills:

- Stroke coordinator or team lead
- Speech and language therapy
- Occupational therapy
- Physiotherapy
- Specialist medical input
- Nursing
- Social work
- Dietetics
- Psychology
- Rehabilitation assistants and enabling carers

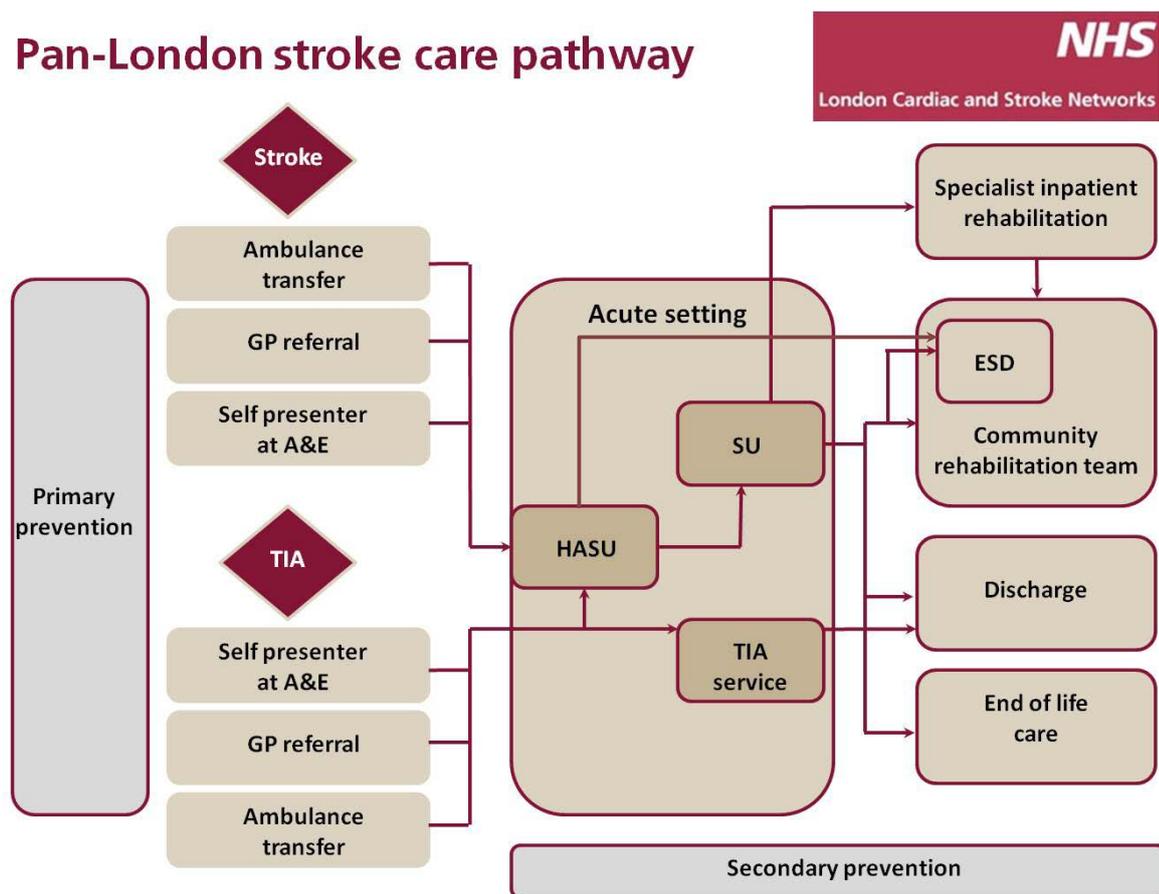
There is no strong evidence concerning optimum staffing quantities for a community stroke team. For ESD, the evidence suggests for 100 patients (2.8 WTE): 1.0 physiotherapist, 1.0 occupational therapist, 0.4 speech and language therapist, 0.1 medical, 0-1.2 nursing, 0.25 assistant, 0-0.5 social work support. Services should have appropriate levels of experienced staff of each profession able to provide clinical leadership across disciplines and supported discharge from acute stroke units for appropriate patients. All staff must have sufficient competence and experience. A stroke competencies framework supporting service delivery should be used across the pathway.

Each patient is assessed individually by a member of the MDT. Length of treatment required is decided after the assessment.

Population-based studies of stroke recovery have shown that the time taken to achieve best functional performance for mild, moderate and severe strokes averages eight, 13 and 17 weeks, respectively. These times vary considerably between patients; some patients continue to benefit from therapy for a year or more. However, the averages provide a useful guide for the duration of contact time to be commissioned. Length of treatment episode should be determined by achievement or non-achievement of jointly agreed goals.

3.2 Care pathway(s)

Pan-London stroke care pathway



* Rebecca J. Fisher et al. Early Supported Discharge, A Consensus on Stroke Stroke. 2011;STROKEAHA.110.606285 published online before print March 24 2011

4. Referral, access and acceptance criteria

4.1 Geographic coverage/boundaries

For local determination.

4.2 Location(s) of service delivery

Community rehabilitation can take place in a variety of settings, such as a patient's defined residence, an outpatient setting or in the local neighbourhood. The service will be flexible to meet each patient's specific needs, wherever practicably possible. Transport provision should be considered for those patients who cannot access outpatient settings. Clinical treatment areas should be easily accessible to all patients. The service should accommodate gender specific requests where appropriate (e.g. for cultural or religious reasons).

4.3 Days/Hours of operation

To be determined locally, however services should link with out-of-hours providers for patients requiring support outside the team's normal operating hours.

4.4 Referral criteria and sources

Patients over the age of 16 who have had a stroke.

Referrals are accepted from any source: patients themselves, their relatives, GPs, district nurses, social workers or any other health or social care professional.

Patients identified for early supported discharge will be referred by an acute hospital – either from a HASU, SU or a specialist stroke rehabilitation unit. Patients must meet the National Clinical Guidelines for Stroke 2008 that states '*patients should only be discharged early (before the end of acute rehabilitation) from hospital if there is a specialist stroke rehabilitation team able to continue rehabilitation in the community from the day of transfer and if the patient is able to transfer safely from bed to chair, and if problems can be safely managed at home.*'

ESD patients must also meet following criteria:

- Over 16 years of age
- Diagnosis of a new stroke following a clinical decision made by a consultant and/or CT scan result.
- Medically stable for discharge home
- Consents to supported discharge with agreement from their carer/s
- Compliant with rehabilitation programme and goals identified prior to discharge
- Able to transfer independently or with support from trained carer
- Suitable home environment as assessed by the MDT

(Patients with cognitive impairment, challenging behaviours or questionable mental capacity will require an appropriate assessment prior to being considered for referral.)

4.5 Referral route

Referral route to the community rehabilitation service may be self-referral, a patient's relative, GP or any other health or social care professional.

The community rehabilitation service should operate through an in reach service into the referring stroke units to identify patients suitable for supported discharge and facilitate the discharge home with the acute stroke team.

Patients identified for early supported discharge will be referred by an acute hospital – either from a HASU, SU or a specialist stroke rehabilitation unit.

4.6 Exclusion criteria

- Under 16 years of age
- Patients not registered with GP in agreed geographical boundary (to be determined locally)
- Medically unstable
- Patients who do not meet the criteria for ESD

4.7 Response time, detail and prioritisation

- ESD treatment programmes should commence within 24 hours of assessment. Non-ESD treatment programmes should be started within seven days of assessment.
- Patients to have outcome measures recorded and a key worker identified within one week of admission to the service.
- Goals to be set and agreed within two weeks of admission to the service.
- All stroke patients will receive cognitive / perceptual screening within one week of admission to the service and full assessment within two weeks if required.
- All stroke patients identified as requiring assessment or intervention to meet adjustment, behavioural or psychological needs to be seen within two weeks of referral. Needs greater than those that can be provided by the team will need to be further referred.

5. Discharge criteria and planning

A formal discharge summary report should be written and copied to the referrer, GP and client (if requested) within seven days of discharge, to inform them of the outcome of assessments, input and discharge status and recommendation for further input and details for any services the client was referred to.

The service should ensure any final referrals to other services are made as necessary and any equipment is ordered and in process.

Patients who have had a stroke and their carers should be followed up and reviewed at six and 12 months post-stroke. Commissioners should determine locally whether they wish to commission the community rehabilitation service to provide these reviews. If the reviews are provided by another agency (e.g. acute hospital, GP and/or voluntary organisation), the community rehabilitation MDT must link into the patient reviews where it is appropriate to do so.

Discharged patients already known to the service are able to self-refer should their condition deteriorate.

6. Prevention, self-care and patient and carer information

- Patients should be supported and encouraged to self-manage their long term conditions wherever possible (e.g. self-management plans for patients and carers, signposting to expert patient programmes).
- Patients and carers should be involved in setting goals and care planning in both the hospital and community settings.
- Services should encourage people to be involved in broader decisions about service development and delivery and the future of stroke services.
- The service should provide translators whenever required in order to support the patient. Documents will be translated into other languages as required.
- Information and education packs should be available for stroke patients and carers, along with support and advice to understand and use it (e.g. lifestyle advice, healthy eating, weight reduction,

alcohol and smoking cessation).

- Many patients within the service will have significant cognitive and language difficulties as part of their condition (e.g. aphasia). The service should tailor any information given to patients to suit their individual communication needs (e.g. use of pictures/diagrams).

7. Continual service improvement/Innovation plan

Description of scheme	Milestones	Expected benefit	Timescales	Frequency of monitoring

8. Baseline performance targets – Quality, performance and productivity

Performance indicator	Indicator	Threshold	Method of measurement	Frequency of monitoring
National – to additionally be submitted to the Network quarterly				
Commissioning Outcomes Framework [†] indicator 2.88 – Timely access to psychological support	Proportion of patients who have received psychological support for mood, behaviour or cognitive disturbance by six months after stroke.	(40%)	Local data	Quarterly
Commissioning Outcomes Framework* indicator 2.89 – Assessment and review	Proportion of stroke patients that are reviewed six months after leaving hospital	(95%)	Local data	Quarterly
Commissioning Outcomes Framework* indicator 2.90 – Access to and availability of ESD services	Proportion of patients supported by a stroke skilled Early Supported Discharge team	(40%)	Local data	Quarterly
London[‡] – to additionally be submitted to the Network quarterly				
London Stroke Strategy RC1 (also NICE Quality Statement 10)	Percentage of patients contacted by a member of community rehabilitation team within 24 hours and	100%	Local data	Quarterly

[†] [Commissioning Outcomes Framework](#) Indicator Programme developed by NICE

[‡] Commissioners will want to pick from this list according to the services commissioned locally. The Network recommend as a minimum collection the number of new patients, and RC2 and RC7 to provide assurance of an efficient and effective service.

	assessed within three days.			
London Stroke Strategy RC2	Percentage of appropriate patients whose treatment programme started within 24 hours (ESD intensity level) or seven days (non-ESD) of assessment	100%	Local data	Quarterly
London Stroke Strategy RC3	Percentage of patients visited at home by community nursing team within 24 hours, where agreed as part of care plan.	100%	Local data	Quarterly
London Stroke Strategy RC4 <i>Providers to record this unless outcomes have already been recorded immediately prior to discharge or using different outcome measures.</i>	Percentage of patients with outcome measures recorded within one week of arrival to, and one week of discharge from, community rehab service	100%	Local data	Quarterly
London Stroke Strategy RC5	Percentage of patients with named support worker inreach/outreach within one week of admission to community therapy service.	100%	Local data	Quarterly
London Stroke Strategy RC6	Percentage of patients with a set of short and long term goals negotiated with them, their family/carers and the rehab team of which they receive a copy, appropriately formatted for their individual needs within two weeks of admission to the community rehabilitation service.	90%	Local data	Quarterly
London Stroke Strategy RC7 <i>Adapted to match format used for intensity/frequency by RCP SSNAP audit</i>	Percentage of appropriate patients receiving 3 hours 45 minutes of each appropriate therapy if in ESD and 2 hours 15 minutes if CNRT level of therapy of OT, PT and SLT.	90%	Local data	Quarterly
London Stroke Strategy RC8	Percentage of patients receiving cognitive/perceptual screening within one week of admission and	95%	Local data	Quarterly

	full assessment within two weeks if required.			
London Stroke Strategy RC9	Percentage of patients previously in work receiving vocational rehabilitation	80%	Local data	Quarterly
London Stroke Strategy RC10	Percentage of patients and family who the community rehabilitation team identify as having a need for further assessment or intervention to meet adjustment, behavioural or psychological needs and who were seen within two weeks of referral by the team.	80%	Local data	Quarterly
Local				
Further to London standard RC4, locally, there should be evidence of a subjective and objective outcome measure recorded. [§]	Percentage of appropriate patients having a subjective and objective outcome measure recorded at admission and discharge.			

[§] It is recommended that teams across the pathway use the same tools where possible. Examples: FIM FAM, GAS, Aus Toms, Stroke Impact ,Stroke self efficacy

Service user experience				
Experience improvement plan				
Reducing inequalities				
Reducing barriers				
Personalised care planning				
Outcomes				
Any additional local indicators				
Performance and productivity				
Insert relevant indicators from Transformation Guides				
Improving productivity				
Unplanned admissions				
Access				
Any additional local indicators				
Additional measures for block contracts				
Staff turnover rates				
Sickness levels				
Agency and bank spend				
Contacts per FTE				

9. Activity

9.1 Activity

Activity performance indicators	Method of measurement	Baseline target	Threshold	Frequency of monitoring

9.2 Activity plan / Activity management plan

9.3 Capacity review

10. Currency and prices

10.1 Currency and price

Basis of contract	Currency	Price	Thresholds	Expected annual contract value
Block/cost and volume/cost per case/other_____*		£		£
Total		£		£

*delete as appropriate

10.2 Cost of service by commissioner

Total cost of service	Co-ordinating commissioner total	Associate total	Associate total	Associate total	Total annual expected cost
£	£	£	£	£	£