Implementing Evidence Based Community Stroke Services

Dr Rebecca Fisher & Professor Marion Walker
University of Nottingham (CLAHRC NDL)

Damian Jenkinson & Ian Golton (NHS Stroke Improvement Programme)
Orientation

- Research into practice
- Stroke Rehabilitation & organisation of services
- Consensus: distillation of the evidence base (one step beyond a Cochrane systematic review)
- ‘Implementation’ research – perspectives of service providers, commissioners, stroke survivors and carers
- Stroke specialist services following discharge from hospital
Overview

- Guidelines for the implementation of evidence based community stroke services
- Current evidence and practice
- Consensus on the Early Supported Discharge of stroke patients
- Consensus on the organisation of Community Stroke Services
Evidence: Community Stroke Rehabilitation

“Patients receiving rehabilitation at home within one year of stroke onset are more likely to have a better outcome in terms of independence and achievement of maximum level of function in all aspects of daily life”

“Appropriately resourced ESD services provided for a selected group of patients can reduce long term dependency and admission to institutional care as well as reducing length of hospital stay”

*Lancet 2004; 363: 352-356*
14 trials: heterogeneous interventions
1617 patients

*Cochrane Systematic review 2005*
11 trials; 1597 patients
Services “need to improve the care and support they provide in the longer term. We have found wide levels of variation both between and within different PCTs in the accessibility and quality of care and support provided to people after they have been transferred home. The level of variation we have found is a concern…”

Care Quality Commission: Supporting Life after Stroke 2011
• National Stroke Strategy, RCP guidelines, Accelerated Stroke Improvement Programme

• Proportion of patients supported by a stroke skilled Early Supported Discharge team (40% by April 2011)
ESD Consensus

- Does the intervention Early Supported Discharge work? – Yes
- How do you set up an ESD service in practice?
- What are the key messages from the literature?
- ESD consensus: list of statements - guidelines for service providers and commissioners
- Defines core components of evidence based ESD services

Fisher et al 2011, Stroke 42:1392-1397
Developing a Consensus

• Generate a list of statements grouped within a framework
• Modified Delphi technique
• Multistage iterative process – consensus panel indicate level of agreement to statements
• Multiple rounds – panel members review their responses in light of group response

• Framework and scope
• Source of statements
• Consensus Panel: Anonymous

"'Consensus' is Latin, Parsloe. It means you agree with me."
• Ten ESD trialists involved (P Langhorne, B Indredavik, C Wolfe, M Power, H Rodgers, L Holmqvist, E Bautz-Holter, N Mayo, C Anderson, O Morten Rønning)

• Consensus threshold: 75% agreement or disagreement (strongly agree + agree), (disagree + strongly disagree)

• Median or Mode response
ESD Consensus: Team composition

- Team Composition
- Stroke specialist, multidisciplinary
- **For 100 patients per year caseload:**
  - OT (1.0), Physio (1.0), SALT (0.4)
  - Physician (0.1), nurse (0-1.2), social worker (0-0.5), *rehab assistant* (0.25)
An early supported discharge team should plan and coordinate both discharge from hospital and provide rehabilitation and support in the community.

- Key worker, co-ordinator, weekly meetings
- An early supported discharge team should be based in the hospital.

*Interpretation: need strong links between acute trust and ESD team; as an extension of acute phase of stroke pathway*
Eligibility criteria

- Live safely at home, based on practicality and disability (barthel score 10/20 to 17/20)
- Patients eligible for early supported discharge would be able to transfer safely from bed to chair i.e. can transfer safely with one with an able carer, or independently if living alone.
- Both hospital staff and ESD team staff should identify patients for ESD
Existence of other community services

- Local considerations for implementation
- Commission ESD as part of stroke care pathway
- What happens after ESD?
- Consider link/impact on social care
- ESD and Community Stroke care provision
ESD Service Specification

ESD/Service Spec/002/06.10

NHS

East Midlands Cardiac and Stroke Network

PROJECT DOCUMENTATION

SERVICE SPECIFICATION

EARLY SUPPORTED DISCHARGE SERVICE

NHS Improvement

Stoke

JOURNAL OF THE AMERICAN HEART ASSOCIATION

A Consensus on Stroke Early Supported Discharge,
Rebecca Fisher, Catherine Gaynor, Micky Kerr, Peter Langhorne, Craig Anderson, Erik Bautz-Holter, Bent Indredavik, Nancy Mayo, Michael Power, Helen Rodgers, Ole Morten Ranning,
Lotta Widen Holmgvist, Charles Wolfe, and Marion Walker
STROKE/2010/606285 VERSION 2
Article Type: Original Contributions
Develop a consensus on how to implement effective, evidence based, community stroke services

Commissioning and organisational perspective

- What is an effective community stroke team?
- How should outpatient services fit into the pathway?
- What about stroke survivors who aren’t eligible for ESD?
- What happens after ESD?
- When to withdraw stroke specialist care?
- NHS, social care, voluntary sector audiences
Community stroke care pathway

First six months – post hospital discharge

- Stroke
- Acute setting: HASU, SU
  - Outpatient rehabilitation services
  - Community rehabilitation team
  - ESD
  - Medium term stroke inpatient rehabilitation
  - No rehabilitation

Long term care

- Nursing home
- GP
- Voluntary organisations
- Third Sector
- Local authority

- Long term care
Consensus framework

- Organisation of community stroke services
- Stroke specialist care beyond hospital
- Decision making about pathways of care according to need
- Provision of information
- Community Stroke rehabilitation team:
  - intervention
  - model of team
  - access and transfer of care
  - performance indicators
- From healthcare to reintegration
Consensus panel

- Purposive sampling –26 panellists
- Criteria: National perspective, published research in topic area and/or leadership in stroke care, knowledge of evidence base and policy
- 10 Academic researchers
- 15 Stroke service Leads or Commissioners
- 1 Stroke survivor
- Geography: East Midlands (9), South West/Coast (5), London (4), Yorkshire (3), West Midlands (2), Glasgow (2), Northumberland (1)
Community Stroke Services

**Organisation of community stroke services**
- Defined stroke strategy group (e.g. Stroke network)
- Health, social care, voluntary sector, stroke patient group representation
- Clear service specifications

**Stroke Specialist Care**
- Stroke specific training and competencies
- Teams predominantly treat stroke patients
- Clear and documented reasons why stroke patients are referred to non-specialist community services (e.g. intermediate care)
• Decision making – stroke severity
  – Importance of joint-decision making and information sharing across organisations
  – Different pathways depending on stroke severity

• Provision of information
  – Clear pathway of information provision and definition of who is responsible for delivery
  – Accessible format specific to phase of recovery
  – Interactive and problem-solving approach (not just passive dissemination)
Community Stroke Services

- **Community Stroke Team: Intervention**
  - Initial assessment in 72 hours
  - Intensity and length of intervention based on clinical need and tailored to goals
  - ESD (higher intensity) distinct but complementary intervention

- **Community Stroke Team: Model**
  - OT, PT, SLT, Nurse, Social Worker, Rehab Assistant, Clinical Psychologist
  - *WTE?? Is ESD delivered as part of the service or separately?*
Community Stroke Team: Access

- Need clearly defined stroke-related rehab goals
- *Patients not able to participate in goal setting (psychological, communication or cognitive issues) are supported*
- *Some teams offer ‘adjustment to disability’ support*
- *Avoid “unlimited and unfettered access”*

Community Stroke Team: Performance Indicators

- Standardised outcome measures
- Patients and Carers
- Intervention length and caseload
Healthcare to Integration

- Voluntary sector, third sector, local authority services need to be integrated into network of services available
- Planned withdrawal of stroke specialist care and need to address participation (reintegration into community)
- Teams offering specialist rehabilitation, disability management and participation – reluctance to hand over responsibility
- Training of other services by stroke specialist staff
- GP responsible for key medical decision making
- Importance of co-ordination and provision of reviews
Community Stroke Services

• Commissioning services tailored to patient clinical needs and goals
  – Need clear service specification (access, intervention length)
  – Also need flexibility (importance of 6 month reviews and integrated pathway)
• Define stroke-specific rehabilitation in the community
  – Stroke specialist staff treating predominantly stroke
  – Clearly defined stroke-related goals for patients determining access and discharge to and from services
  – Participation addressed by other longer-term services

Walker, Sunnerhagen, Fisher et al 2012. Stroke online
Finally...

• Robust evidence base for the effectiveness of stroke specialist care following discharge from hospital
• Consensus documents distil the evidence base and provide guidelines for implementation of services
• Need to commission community stroke services that (a) provide high intensity ESD rehabilitation to mild to moderate stroke patients (b) provide slower stream rehabilitation for ongoing rehabilitation needs relating to stroke
• Need a whole pathway approach to stroke care
Thanks to the Team

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Thank you for listening

rebecca.fisher@nottingham.ac.uk
www.clahrc-ndl.nihr.ac.uk
Twitter: @CLAHRC_NDL