Stroke rehabilitation in the community: commissioning for improvement

An information resource for providers and commissioners of stroke rehabilitation and early supported discharge services in the community
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Executive summary

Early supported discharge (ESD) can be the impetus for change to rehabilitation in the community. Identifying existing local services, and joining up specialist and non-stroke specialist expertise creates the foundations of an effective service.

- Community rehabilitation services should be organised around local patient need
- Community services should be commissioned for all stroke survivors not just ESD to avoid inequity
- Considering the perspectives of all stakeholders can mean taking a flexible approach
- ESD requires a process of financial flow to follow the patient and clear budgetary movement to release and redirect revenue
- Identify quality community data and protect resources to sustain the process.

‘Achieving sustainable improvement will also mean taking on the challenge of service change, to provide services closer to patients wherever appropriate and to improve integration between services……real change can be achieved where managers and clinicians work together with courage and skill where change is needed in the interest of patients and taxpayers for example to the organisation of care for long term conditions eg the configuration of stroke services. As well as truly clinically led commissioning and a robust and diverse provider sector, service change requires the right environment at local level, an environment in which patients, the public and communities are highly engaged.’

The development of community rehabilitation including early supported discharged (ESD) services for stroke survivors provides both a challenge and an opportunity. Over the last five years many good community rehabilitation services have been developed that can demonstrate positive impact on the experience and outcomes for stroke survivors in their locality. Sustainable and effective services put the patient at the heart of the service, and make year on year improvement in outcomes. They bring financial savings across the pathway and for social care, and continue to develop in line with the aspirations of the stroke strategy for meaningful life after stroke and long term integration by embedding their service within their local community.

Discussions around ESD offer local communities an opportunity to examine and review their existing services and the local pathway of rehabilitation in the community for all stroke survivors. Where this is done in the context of a whole integrated system, ESD can be a catalyst for change and improvements in the community for all stroke survivors.

‘Stroke rehabilitation in the community - commissioning for improvement’ provides key stakeholders with information to support them with the process of developing rehabilitation services for stroke survivors in the community. It includes examples of good practice, and information about service models implemented in England. It explores factors which influence local commissioning and identifies tools to assist with the process of commissioning and funding of rehabilitation for stroke survivors in the community. This is particularly important at this time of major change within the NHS. A different commissioning landscape is emerging along with a new outcomes framework and positioning of stroke within long term conditions.

For stroke community services this may mean starting off small and a step by step process. It requires stakeholders to look at the wider pool of people who impact on the local stroke survivors’ environment, many of whom are not exclusively stroke skilled, and how this can be addressed. With education and training, support and time, the pool of stroke skilled people within a community across health, social care, the voluntary sector and local support organisations can be widened. By bringing these people together with clinical communities, patients and commissioners, cost effective and meaningful rehabilitation in the community can be delivered.

Chapter 1: Setting the scene for stroke rehabilitation in the community

‘Stroke costs the country £7 billion, with £1.7 billion spent on community costs, which includes nursing home care for stroke survivors’

National Audit Office, 2010

The current situation

Stroke rehabilitation works. Specialist coordinated rehabilitation, started early after stroke and provided with sufficient intensity, reduces mortality and long-term disability. Whilst there is robust evidence showing the benefits of ESD services, and a consensus to guide the implementation of evidence-based ESD service, there is currently a lack of academic literature that can be easily used to guide service provision after ESD, or for stroke survivors for whom ESD is not beneficial. This is being addressed by work carried out by Collaborative Leadership in Applied Health Research and Care Nottinghamshire, Derbyshire and Lincolnshire (CLAHRC NDL) and NHS Improvement - Stroke and will be reported on in a separate publication.

Consequently the evolution of rehabilitation services in the community, including ESD is patchy, variable and inconsistent, reflecting local attempts to make it work; reconciling the evidence, recommendations and guidelines with local need and local financial context.

‘There is a wide variation in the availability of rehabilitation and community services. Some areas have early supported discharge services, responsive community stroke rehabilitation teams and vocational rehabilitation services. Other areas have no dedicated community stroke service.’

The Care Quality Commission (CQC, 2011) reported across a number of aspects of ESD and community rehabilitation services and concluded: ‘The overall picture is one of inconsistency, waits between transfer home and commencing community rehabilitation and lack of specialist access. They comment ‘these differences suggest that clearer guidance is required on what constitutes ESD’.

The NHS Improvement - Stroke team has developed a clear understanding of the challenges and rationale behind the local development of stroke rehabilitation services, through working with clinical teams, commissioners, networks and service providers. Services range from effectively embedded stroke rehabilitation pathways demonstrating good outcomes and value for money, to virtually non-existent access to even generic rehabilitation services. It is clear that the term ESD is often misinterpreted; it is used instead of ‘community rehabilitation’ with the mistaken assumption that the terms are synonymous and some services have adapted ‘early’ into earliest. For clarity in this document community rehabilitation refers to the rehabilitation patients receive on leaving hospital and includes rehabilitation for patients both appropriate for and not eligible for ESD, pertaining to the commissioning process. The services have been differentiated where necessary throughout the document.

4 Supporting life after stroke, Care Quality Commission, 2011.
Existing evidence and guidance to support rehabilitation in the community

Early supported discharge
There is research evidence supporting the implementation of ESD services including work by Langhorne\textsuperscript{6,7} and the ESD consensus work from CLAHRC. The latter states that ESD teams should be stroke specific and multidisciplinary, offering co-ordinated and planned discharge from hospital and continued rehabilitation when patients are settled at home. The intervention is beneficial for a subset of the patient population; those of mild-to-moderate stroke severity. Strong links are required between the acute service and the ESD team, with both hospital staff and ESD team members identifying patients. To measure effectiveness, ESD teams should use standardised assessments to monitor stroke severity, dependency, activities of daily living and satisfaction as well as the impact of the ESD service on length of stay and readmission rates.

Healthcare for London (HfL) guidance describes ESD as enabling a seamless transfer of care from hospital to home. This gives stroke patients the opportunity to continue rehabilitation, while being supported in their own surroundings and with input from a specialist stroke team.

They recommend an intensity of ESD and state, ‘for the time 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. While initial assessment of the stroke survivor is carried out by qualified professionals, some care may be delivered by therapy assistants under the supervision of a qualified professional. Following this initial intensive period, the therapy regime then reverts to the level of normal community rehabilitation.’

The Royal College of Physicians\textsuperscript{8} (RCP) guidance around intensity states, ‘ESD is designed to give eligible stroke patients rehabilitation in their own home at the same intensity as inpatient care.’

The National Stoke Strategy\textsuperscript{2} (2007) comments that, ‘the number of patients suitable for ESD will also vary according to eligibility criteria, but in trials an average of 41\% of patients were found to be suitable.’

‘The team went about achieving my aims and whilst doing so made it fun for me and I looked forward to their visits. They set about working with me and filling me with confidence and enjoyment and I soon made very quick progress. While I know I had to put in a lot of effort, their kind friendly nature I would say played a big part. The greatest pleasure and credit I could give them was my progress. If anyone wants to know if the scheme works they only have to look at my happy progress.’

\textit{Taken from a patient’s thank you letter}

\textsuperscript{6}Langhorne et al, 2005.
\textsuperscript{7}Langhorne et al, 2007.
\textsuperscript{8}National Clinical Guidelines for Stroke, RCP, 2008.
Rehabilitation in the community
The National Stroke Strategy, National Institute for Health and Clinical Excellence (NICE) quality standards for stroke, RCP clinical guidelines and HFL include guidance around the commissioning of rehabilitation in the community, to assist with understanding the whole rehabilitation pathway. London has additional guidance, Life after Stroke; commissioning guide. NHS Commissioning support for London 2010 which focuses on how services should be configured to support stroke survivors in the period of their lives following their acute rehabilitation.

a) Pathway configuration and design
The RCP (2008) recommend whole pathway commissioning stating, ‘commissioning organisations should ensure that their commissioning portfolio encompasses the whole stroke pathway.’

HFL states, ‘community rehabilitation should be a simple, coherent service that is easy to navigate. This service should have a single point of entry, no waiting lists and be accessible to all stroke survivors. It should be designed around the needs and goals of the individual, so the stroke survivor is assessed by a specialist stroke multidisciplinary team who will determine the best use of the team’s resources. Community rehabilitation teams should also assist appropriate stroke survivors to access vocational rehabilitation.’

The NICE quality standards for stroke set specific measures for frequency and intensity of rehabilitation and access times. They make no distinction between ESD and non ESD services.

The National Stroke Strategy focuses four quality markers, around rehabilitation in the community, QM 10 rehabilitation; QM 12 seamless transfer of care; QM 15 participation in community life, and QM 16 return to work.

b) Shaping of the pathway for commissioning rehabilitation in the community
The National Stroke Strategy comments that some people may move into care homes, but can still benefit from rehabilitation, depending on individual needs. Depending on the model of delivery adopted, commissioning for care homes may be relevant for community services that include ESD and non ESD components.

In its guidance on support for London, NHS Commissioning states that, ‘all staff in nursing homes, care homes and residential homes should be familiar with the common clinical features of stroke and the optimal management of common impairments and activity limitations. Although this population has long gone without the access to quality stroke and social care services that they need and deserve, local commissioners need to organise services to ensure that this population can also receive the care they need’.

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c) The use of specialist and non-specialist services
The National Stroke Strategy states, ‘specialist teams may be more important in the early stages of rehabilitation, while generic teams can be appropriate for the later stages. However, the configuration of community teams is less important than ensuring that these teams are multidisciplinary and all staff have the right specialist skills to help rehabilitate people who have had a stroke.’

HfL guidance indicates that, ‘every primary care trust (PCT) should commission a community rehabilitation service for stroke patients, delivered by staff with specialist stroke skills. Service configuration should be locally determined. Every PCT should commission an early supported discharge service for people who would benefit. This service should include staff with specialist stroke skills and must meet all of the performance standards.

d) The process
HfL expresses how this can be delivered:
- Where effective community rehabilitation teams are in place ESD services should be offered. ESD services should have appropriate staffing levels to provide ESD for suitable patients
- Every PCT should ensure access to a specialist stroke community rehabilitation service before developing an ESD service
- An ESD service is an addition to effective community rehabilitation.
- An ESD service could be provided by an appropriately resourced community stroke rehabilitation team
- There may be benefits to having the ESD team and community rehabilitation team in one location. If appropriate, this would allow for the sharing of resources, such as social workers, speech and language therapists, clinical psychologists; improved communication between professionals on the stroke pathway; and a more seamless transition of care for the client between services.
**Tariff progress for stroke**

NHS Improvement continues to work with the DH Payment by Results team (PbR) on ways to support the flow of funding into the rehabilitation part of the pathway.

Stroke is part of HRG4, (Health Resource Group) a group of tariffs that can be unbundled ie making it possible to separately report, cost and remunerate the different components within a care pathway. Unbundling provides a mechanism for moving parts of a care pathway such as rehabilitation away from the traditional hospital setting. They do not receive a separate tariff. It is challenging for stroke because of the difficulties identifying a specific point at which acute care ceases and rehabilitation begins. In most cases there is a degree of overlap.

Unbundling is useful where it supports changes to care pathways but excessive unbundling carries risks, such as inadvertently creating a fee-for-service system where every service is commissioned and billed for separately. More detail around local work on unbundling is available in Chapter 5.

‘Equality and Excellence: Liberating the NHS’ (DH 2010)\(^{11}\) also announced plans to accelerate the development of currencies and tariffs for community services. Community services have lacked some of the building blocks such as national data flows that allow the consistent capture of a classification or currency, and this has impeded the move away from block contracts.

‘Transforming community services: currency and pricing options for community services’\(^{12}\) recognises the challenges progressing this work nationally and helps the NHS to create new local currencies and better pricing.

PbR stroke guidance for 2012-13 is to carry forward existing guidance from 2011-12. This includes an aspiration for local unbundling, local negotiations and process improvements around managing tariff so that the flow of funds follows the patient from acute into the rehabilitation parts of the pathway.

More information to understand the tariff process\(^{13}\) can be found at: www.dh.gov.uk/health/2012/02/confirmation-pbr-arrangements and in relation to unbundling, at www.improvement.nhs.uk/stroke/Stroketariff/Stroketariff1pathways/tabid/260/Default.aspx

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\(^{11}\)Equality and Excellence; Liberating the NHS. Department of Health, 2010.


\(^{13}\)A simple guide to Payment by Results .Department of Health, 2011.
Commissioning for stroke rehabilitation - guidance

1. National Stroke Strategy
2. NICE Quality Standards for Stroke
3. RCP National Clinical Guidelines for Stroke
5. Life after stroke; Commissioning guide. NHS Commissioning support for London

Commissioners may choose to establish key performance indicators as part of a tendering processor to incentivise provider performance through the mechanism of Commissioning for Quality and Innovation CQUIN payment framework.


An example of CQUIN to support stroke rehabilitation can be found here: www.improvement.nhs.uk/stroke/ESD/ESDsupporting commissioning/tabid/168/Default.aspx

Decisions on commissioning should also take account of the cost effectiveness of the service, plus any related costs, and include attention to stakeholder views, including the views of patients.

The RCP (2008) set the context, responsibilities and the challenge for commissioners of stroke services stating, ‘rehabilitation services are best delivered as close to the patient’s own environment as is compatible while ensuring the patient’s care and well-being, and taking into account the cost consequences of the pattern of service delivery. Commissioners are key in determining the overall organisation of stroke rehabilitation services, but must exercise this power taking into account evidence and maintenance of core services.’

Commissioning organisations must commission a service capable of delivering specialist rehabilitation at home in liaison with inpatient services, as recommended in the guidelines.

• Consider the overall organisation of services delivered to their population
• Specialist services in relation to the overall population need, rather than specifically in relation to stroke.
Understanding what good looks like

Defining what a good service looks like can be problematic as there are many different models of community stroke rehabilitation and ESD services currently in place England with a variety of delivery methods, and a range of outcome metrics and data reporting.

Often the more established ESD services were set up before the stroke strategy was published, but not branded as such. They were created on a foundation of good strategic level support, adopting pragmatic solutions to local needs and using existing local resources available at that time. They have been supported to undergo evolutionary development to become today’s mature ‘community stroke rehabilitation services’ incorporating ESD.

They are not always badged as ESD services, but incorporate its key principles, together with strong leadership with clear vision, clarity of purpose and evidence for efficacy. They are well integrated with other local providers e.g. social care, leisure services, the voluntary sector and other community rehabilitation services, facilitating effective throughput of patients. These holistic services can also demonstrate through their data, successful patient outcomes. They have good staff retention, are flexible in the services that they provide, have proven to be sustainable over time and have credibility within and outside of their organisations.

Portsmouth and Blackburn community stroke rehabilitation services are examples of this approach. Their definition of early relates to the earliest possible opportunity for every patient.

More detail about these services can be found at: www.improvement.nhs.uk/stroke/CommunityStrokeResource/CSRRehabilitationservicemodelsincludingESD/tabid/213/Default.aspx

However, this is not the case everywhere. In some areas, especially more rural and remote places, services are non-existent, or delivered by generic intermediate care teams often with a strong admission avoidance focus and limited stroke expertise.

‘Rehabilitation after stroke works’ (National Stroke Strategy, 2007). It is acknowledged that patients who access rehabilitation are more likely to experience an improved quality of life and better functional outcomes; however translating this into the delivery of a quality community stroke or ESD service in practice becomes more complex where the provision of the rehabilitation service is shared or crosses the pathway between primary, secondary care and social care.
**Developing a good service - the process**

The process begins with defining and agreeing the desired purpose of a stroke rehabilitation service within the community and how this will be measured through key performance measures both clinical and service. This helps with understanding what existing local services provide, where the gaps are and what might need to be done to build a service from scratch or to improve or transform existing community services to be fit for supporting stroke survivors and delivering ESD. In many instances the local discussions around how to implement ESD have been the catalyst for change across the community rehabilitation pathway for all stroke patients and have galvanised local communities into delivering improvement.

A business case should be developed in support of securing a properly commissioned community rehabilitation service, within whatever model is agreed locally.

An example of a business case can be found at:  

The purpose and aims of the community rehabilitation for stroke, including ESD services should be informed by attention to current evidence, national policies and guidelines. It can be enriched by learning about examples of good practice, and practical evidence available from other sources, such as the NHS Improvement community stroke resource at:  
and the Department of Health publication 'Transforming community services (rehabilitation) enabling new patterns of provision' at:  

A detailed service delivery model can be planned and produced based on a local service specification. This will vary depending on local demographics, patient population needs and approach to specialist commissioning. Engagement and contribution from patients and carers is essential as part of the process of building the detail within the model. It should also include suitable metrics to collect.

Partnership working with secondary care stroke services and social care can support the design of a pathway and ensure that the service model selected is relevant and cost effective for all, and meets patient needs. Cardiac and stroke networks are often ideally placed to coordinate this process.

An example of a service specification for community rehabilitation, including ESD, can be found on the South London Cardiac and Stroke Network website at:  
www.slcsn.nhs.uk/research.html

More examples can be found on the NHS Improvement website at:  

**11** Transforming Community Services: Enabling new patterns of provision DH 2009
**What influences and shapes the selection of a local model for ESD**

There are a number of factors that affect the selection of a model for ESD in addition to the evidence base and guidelines:

- Ability to align and contextualise the research and evidence to local need
- The local perspective and interpretation of ESD
- The local impact of shorter length of stay in acute care and the demand for more rehabilitation at home
- The flavour of exiting community services - skills, content, remit and their potential for shaping to be able to deliver effective ESD
- Geography - urban, rural or remote
- Leadership within the community, presence/absence of a voice at strategic level
- Relationship between health and social care within stroke services.

When the local stakeholder group have agreed their local approach and the plan for delivery, an action plan can then be devised for implementation. It should align with the local key performance indicators (KPIs), national indicators and four domains within the NHS Outcomes Framework (2011) and should include contingency planning, review, and opportunity for remedial action. Local stakeholder groups should ideally include the providers of community rehabilitation and ESD services, local commissioners and patient service users and social care, working together to agree local delivery.

Examples of KPIs can be found at [www.improvement.nhs.uk/stroke/ESD/ESDsupportingcommissioning/tabid/168/Default.aspx](http://www.improvement.nhs.uk/stroke/ESD/ESDsupportingcommissioning/tabid/168/Default.aspx)
Models of delivery

A range of models is emerging across England to deliver the principles of ESD. This includes acute based, community based, and hybrid models, that broadly fall into one of five categories.

1. Stand-alone/acute outreach
   ESD only
2. ESD with community
   stroke/neurology team service
3. Integrated ESD within
   community stroke team service
4. Integrated ESD within
   community neurology team
   service
5. ESD hybrid

These are detailed in the following tables and include cost per case information, derived from the skill mix information and referral detail, provided by the teams who have shared their service model details with NHS Improvement - Stroke. The posts have been costed at the midpoint of the Agenda for Change band in all cases inclusive of on costs (national insurance, pension etc.). Non pay costs, travel expenses and fixed asset costs have not been included in the calculations as these have not always been available, so the staffing costs act as a proxy for the cost of the service. Where two teams share the pathway, such as models three and four the costs should be added together to give a pathway cost.

The costing model (see ‘Useful tools to support the process, (Page 29) will allow commissioners and providers to cost services more accurately including the local costs where they are known. The costs of services used here are indicative and relate to the configuration and integration of the services as a comparator to the five groups of services that have been noted in the community and are real commissioning solutions.
**Model 1**

**Stand-alone ESD/outreach ESD from acute providers with follow on rehabilitation available from generic community services if required**

There are relatively few of these compared with other models. This may reflect challenges with funding additional discrete smaller services. They tend to be more prevalent in denser populated urban cities and where there are large city hospitals. There are examples of services that have started in this model being adapted or merged into models three and four after a period of time.

## FACTORS FOR CONSIDERATION

<table>
<thead>
<tr>
<th><strong>Timeframe of rehabilitation</strong></th>
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</thead>
<tbody>
<tr>
<td>Usually six weeks - some teams provide two weeks, or the estimated time of acute rehabilitation, but in the patient’s home.</td>
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<table>
<thead>
<tr>
<th><strong>Proportion of patients who fit criteria</strong></th>
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<tbody>
<tr>
<td>Up to 40%</td>
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<table>
<thead>
<tr>
<th><strong>Number of pathways from acute provider to home</strong></th>
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</thead>
<tbody>
<tr>
<td>Two – ESD and non ESD</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Stroke dependency level catered for</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild to moderate dependency levels</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Potential patient wait</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes – to access the service, if the team does not contain a dedicated social worker there may be waits for care package/enablement</td>
</tr>
<tr>
<td>Yes - potential waits between cessation of ESD and access to generic rehabilitation depending on capacity of generic services</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Groups of stroke patients unable to access service</strong></th>
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</thead>
<tbody>
<tr>
<td>Complex/severe dependency cohorts of patients</td>
</tr>
<tr>
<td>Care home based patients</td>
</tr>
<tr>
<td>Community based patients who have not been admitted to acute care first (declined)</td>
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<table>
<thead>
<tr>
<th><strong>Additional support infrastructure that may be needed.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow on access to a community stroke/neuro/generic team for continued rehabilitation</td>
</tr>
<tr>
<td>Community stroke/neuro/generic team for patients who do not meet the criteria</td>
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<tr>
<td>Social care enablement/care packages: seven day patient support to enable early discharge and intensive daily rehabilitation</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Re referral access</strong></th>
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</thead>
<tbody>
<tr>
<td>Normally one discrete episode of care post discharge without capacity to accept rereferral</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Stroke skilled management for whole rehabilitation pathway</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>No - only for duration of service (two to six weeks) with referral onto generic services</td>
</tr>
</tbody>
</table>

## COSTS

Cost per case range between £2,580 and £1,132
Model 2
ESD services with a pathway into a community stroke team or a community neurology services

Frequently created before the National Stroke Strategy, these community services are more mature and established services, which have been shaped and developed further. They work alongside ESD teams, (out-reach or in-reach). Many services initially of this category have subsequently been developed into model three or four. Typically reasons for this are insufficient cohort of patients to justify a separate ESD service, perceived expense of the ESD component and where the model was deemed to be creating a two tier service for stroke patients locally. The model offers all the components of model one with additional opportunities from specialist follow on rehabilitation.

FACTORS FOR CONSIDERATION

Timeframe of rehabilitation
• Typically six weeks ESD then referral on to the community stroke, or neurology team for continued rehabilitation of approximately three months

Proportion of patients who fit the criteria
• Up to 100% of rehabilitation patients

Number of pathways from acute to home
• Two – ESD and non ESD

Stroke dependency level catered for
• All dependency levels catered for, mild to complex severe

Potential patient wait
• 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

Groups of stroke patients unable to access service
• 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

Additional support infrastructure that may be needed
• Social care enablement/care packages providing seven day patient support to enable early discharge and intensive daily rehabilitation

Re referral access
• Normally one discrete episode of care post discharge

Stroke skilled management for whole rehabilitation pathway
• No - only for the length of the service (typically six weeks – three months). Further referral can be made onto generic services

COSTS

Cost per case range between £1,157 and £1,868.95
Model 3
ESD is delivered within an integrated community stroke team

Typically these services originated from an existing community stroke team that could demonstrate an ability to deliver ESD elements effectively, or where setting up a separate ESD service might compromise staffing of an existing performing community service. It is more prevalent in urban/rural mix areas with district general hospitals, and in rural areas with higher stroke populations. It is one of the most comprehensive models including all the components of models one and two with additional elements. Most of the teams in this model have re-enablement/health care, domiciliary support workers to support with delivery of seven day rehabilitation including multiple visits a day for up to six weeks.

**FACTORS FOR CONSIDERATION**

- **Timeframe of rehabilitation**
  - Typically goal directed approach, so available for as long as required (range three months to one year)

- **Proportion of patients who fit criteria**
  - Up to 100%

- **Number of pathways from acute provider to home**
  - One pathway for all patients, through a coordinated discharge/rehabilitation process led by the team

- **Stroke dependency level catered for**
  - All dependency levels, from mild to complex severe

- **Potential patient wait**
  - Usually no wait and immediate access to supported discharge/rehabilitation. Typically these services coordinate and lead the transfer from hospital to home

- **Groups of stroke patients unable to access service**
  - All groups of patients can access timely rehabilitation including, ESD/non ESD from acute care, care homes, and community-based patients

- **Additional support infrastructure that may be needed**
  - Social care enablement/Health domiciliary rehabilitation support staff: Seven day patient support to enable early discharge and intensive daily rehabilitation

- **Re referral access**
  - Yes - usually these services accept re referral back into the service post discharge

- **Stroke skilled management for whole rehabilitation pathway**
  - Multidisciplinary stroke skilled therapy for whole pathway, including staff from intermediate and social care

- **Additional components**
  - Examples of managing patients in intermediate care beds
  - May offer review services
  - May offer specialist additional services e.g. FES, spasticity clinics

**COSTS**

Cost per case range between £1,336 and £2,502
**Model 4**

**ESD delivered within an integrated community neurology service**

These services have a wider remit to include neurological conditions therefore have experience and skills with management of with very complex presentations. They tend to be more prevalent in rural, less urban areas, or where there are issues recruiting (specialist) staff or smaller stroke populations. Some of the services in this model have re-enablement/health care domiciliary support workers to support with seven day rehabilitation, multiple visits a day for up to six weeks. A comprehensive model offering all the components of models one, two and three and additional elements.

### FACTORS FOR CONSIDERATION

| **Timeframe of rehabilitation** | Typically adopt a goal directed approach, so the services are available for as long as required (range three months to one year) |
| **Proportion of patients who fit criteria** | Up to 100% of patients |
| **Number of pathways from acute provider to home** | One pathway for all patients; coordinated discharge/rehabilitation via the team |
| **Stroke dependency level catered for** | All dependency levels of stroke patients mild – complex severe, and neurological patients |
| **Potential patient wait** | 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 |
| **Groups of stroke patients unable to access service** | All groups of patients can access the service including, ESD/non ESD from acute care, residential care and community based locations |
| **Additional support infrastructure that may be needed** | Social care enablement/Health domiciliary rehab support staff, or seven day patient support to enable early discharge and intensive daily rehabilitation |
| **Re referral access** | Yes- usually these services accept re referral back into the service post discharge |
| **Stroke skilled management for whole rehabilitation pathway** | Yes - multidisciplinary stroke skilled therapy for whole pathway |
| **Other benefits** | Examples of managing patients in intermediate care beds. May offer review services. May offer specialist additional services e.g. FES, spasticity clinics. Experience with complex case management |

### COSTS

Cost per case £770
Model 5
Hybrid ESD – supporting more complex patients

This model is emerging from the evolution of established and successful ESD services. Irrespective of their starting model, these ESD services have develop into bigger community stroke teams by widening criteria, demonstrating the ability to safely manage more complex patients and ensuring a comprehensive fit within the community pathway. In many circumstances these are community providers. They frequently operate through an in reach approach and typically offer input from four times a day (ESD phase), seven days week, reducing to weekly visits by the time of exit.

FACTORS FOR CONSIDERATION

Timeframe of rehabilitation
- Usually time limited (range six weeks to 12 weeks)

Proportion of patients who fit criteria
- 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 pathways, ESD and non ESD pathway

Stroke dependency level catered for
- All dependency levels of stroke patients mild to complex severe

Potential patient wait
- 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
- Patients who do not meet the criteria
- Community-based patients who have not been admitted to acute care

Additional support infrastructure that may be needed
- 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

Re referral access
- Normally one discrete episode of care post discharge

Stroke skilled management for whole rehabilitation 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

Additional components
- May include six month and one year review services

COSTS

Cost per case £5,162
Practical help with understanding your local services

There are many documents and resources to assist with the process of identifying what you need to know to understand your current services and help with any planned improvements.

- ESD Toolkit

- Community Stroke Resource

- Tariff Support

- DH Tariff Guidance
  www.dh.gov.uk/health/2012/02/confirmation-pbr-arrangements

- Stroke Association
  www.stroke.org.uk/information/our_publications

- Different Strokes
  www.differentstrokes.co.uk

- Social Care for Stroke

- Mind the Gap

- Equality for all: Delivering safe care seven days a week, produced by NHS Improvement
  www.improvement.nhs.uk/SevenDayWorking/tabid/218/Default.aspx

- Psychological care after stroke, produced by NHS Improvement - Stroke
  www.improvement.nhs.uk/stroke/Psychologicalcareafterstroke/tabid/177/Default.aspx

- Care Quality Commission (CQC) report
  www.cqc.org.uk/public/reports-surveys-and-reviews/reviews-and-studies/services-people-who-have-had-stroke-and-their

- Delivering Quality, Innovation, Productivity, Prevention (QIPP)
  www.improvement.nhs.uk/qipp

- Measurement tools and practical modules
  http://system.improvement.nhs.uk/ImprovementSystem/Login.aspx?
  ReturnUrl=%2fImprovementsystem%2fdefault.aspx

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14Mind the Gap: Ways to increase access to therapy and rehabilitation. NHS Improvement, 2011.
15Equality for all: delivery of safe care seven days a week. NHS Improvement, 2012.
16Psychological care after stroke: Improving stroke services for people with cognitive and mood disorders. NHS Improvement, 2011.
Opportunities to realise economic benefits through community rehabilitation

Creating well organised services
Well organised high quality services are the most cost efficient. Commissioners have a particularly important role in ensuring that services are appropriately organised. Some of the efficiencies that can be achieved arise from altering where and how services are delivered (RCP 2008). In many instances there will be potential costs associated with start up or with changes in practice, but the evidence suggests that well organised services generally deliver an equal or better outcome at about the same cost (HfL 2009).

Effective stroke rehabilitation can bring wider economic benefit (HfL 2009) in terms of hospital readmissions, reduction in hospital length of stay, reduced GP consultations and inappropriate further secondary care referrals. More costly interventions such as management of pressure damage and venous ulcers or surgical treatment of joint contractures may be engendered through a failure to provide timely rehabilitation. Enabling a greater degree of independence at home has an impact on the costs of community support from health and social services.

The Blackburn community stroke team demonstrated savings for social care by reducing the amount and frequency of care packages. In 2010 final packages of care for patients undergoing community rehabilitation with this team were reduced by 240 hours of care per week, equating to savings of £93,600 per year.

Stroke care coordinators from health and social care within South Tees have developed joint partnership working to review the care needs of stroke survivors in care home settings at around six months to ensure an equitable service provision to all stroke survivors. They were able to demonstrate savings of £36,000 by returning two patients from care homes to their own home, and a reduction in nursing resources and medication costs by identifying and managing potential complications in other patients.

More details are available at: www.improvement.nhs.uk/stroke/CaseStudies/CasestudiesQM14/tabid/151/Default.aspx

Investment for future savings
Following the National Audit Office review of stroke services in 2010, the House of Commons Public Accounts Committee recognised that ESD could deliver better outcomes and save costs through bed closures, after initial investment to establish the service. CLAHR research reports that ESD reduces mean hospital length of stay by about six days, however the trials were done when average hospital length of stay was considerably longer. Translating the research into practice, the NHS Camden - stroke REDS team reduced the average length of stay by ten days for 32% of people with new stroke in Camden in 2009. Five hundred and eighty acute and inpatient bed days were saved, leading to potential savings of £307,161 in acute bed day costs. The Camden team estimate savings of more than £200,000 or £83,000 per 100,000 population. Reducing hospital length of stay indicates only potential cost savings if the bed is subsequently used again. Closure of beds is needed to realise actual cost savings.

Supporting people with stroke back to work through rehabilitation and joint working with the Department of Work and Pensions, vocational rehabilitation schemes and employers is another opportunity to realise savings for the wider health economy as well as the obvious personal benefits to individuals and their families. Where stroke survivors are of working age and with support could return to work, costs result from failure to support this area of rehabilitation. The Confederation of British Industry (CBI) estimates that the cost to the economy of a working day lost to sickness is approximately £77 (2008).

Working for a healthier tomorrow\(^\text{18}\), advised that, ‘Healthcare professionals should consider a return to appropriate work as an important outcome in the treatment and support of patients where possible. The NHS is currently considering patient pathways for those with major long-term conditions. For those of working age, this should, where appropriate, include a consideration of work-related health and the steps necessary to help the patient to move back into employment’.

A study of 3,000 younger stroke survivors by Different Strokes\(^\text{19}\) (a stroke charity for younger stroke survivors) found that 75% of the respondents wanted to return to work, and gave a range of reasons why this was not possible. These included being forced to retire by their employer, being unable to drive or use public transport, fear of losing benefits and feeling unable or not fit enough to do their previous job.

A more recent study also suggests that stroke survivors who have not returned to work, might have been be able to do so with more support. Of the 339 people in the study who were in employment immediately before they had a stroke, only 59 (17%) were known to be in employment one year on. Appropriate rehabilitation and longer term support specifically focused on improving stroke survivors’ fitness for work, had the potential to achieve higher rates of return to employment.

An innovative service led by occupational therapy in West Park Hospital was able to demonstrate successfully returning 50% of their clients to employment in 2010. With shorter waiting lists and speedier access clients were able to retain and return to existing employment.

More information can be found at: www.improvement.nhs.uk/stroke/CommunityStrokeResource/CSRLifeafterstroke/CSRLifeafterstrokereturntowork/tabid/246/Default.aspx

The Department of Health’s Workstep employment support programme for people with disabilities is delivered by Bootstrap Enterprises in partnership with Blackburn with Darwen Borough Council. This service is accessed by the local community stroke team for support with return to work.


Reinvesting the funding
Review of current commissioning arrangements in light of the evidence and guidance and assessing whether the right service is being provided in the right place may enable some investment to be redirected towards commissioning more suitable services for the population. The experience in some London PCTs suggests there is potential for cost savings through simplification and redesign of existing processes to ensure that only effective and efficient treatment is given (HfL 2009). Consideration to moving resources between providers may enable savings to be made.

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\(^{19}\) Getting back to work after stroke. Different Strokes and the Stroke Association, 2006.
The Portsmouth community stroke service resulted from the closure of an inpatient fast stream stroke rehabilitation ward. Pay and non-pay costs were redirected to develop a community stroke rehabilitation team (CSRT), for Portsmouth City and south of East Hants. Inpatient stroke rehabilitation was retained in the form of a 20 bedded slower stream stroke ward. Around £2,000 per patient was saved initially in 2004 with savings of £3,748 for each patient per year in social care costs. The team manage more than half of all stroke patients discharged from hospital, contribute to the year on year fall of hospital length of stay and demonstrate positive clinical outcomes.

Useful tools to help understand the local picture

Estimating the financial benefits of improved rehabilitation is difficult because there is little evidence to support rigorous cost/benefit analysis. This can complicate the commissioning picture for community services, where funding is tied up in block contracts, and where there is an absence of robust data collection or outcome measurement.

The costs of training a generic team to support stroke patients

NHS Improvement - Stroke is working with the UK Forum for Stroke Training (UKfST) to identify more specific detail around the costs associated with developing a generic community team to meet the aspirations within the National Stroke Strategy for stroke patients. The information will be available on NHS Improvement – Stroke website.

Unpicking block contracts

Anglia Heart and Stroke Network have undertaken work across their health community to unbundle the block contract, to try to understand the distribution of cost of stroke across the pathway. They wanted to understand the contribution towards stroke care in hospital and in the community from the block contract and to understand the contribution of the block contract to support the tariff payment. Therefore they developed an approach for quantifying the amount of funding dedicated to stroke in both the hospital and community setting. This has proved invaluable when working with commissioners and providers to improve the provision of stroke specific services in the community. As a result, a cost modelling tool was developed that allows providers to recognise the interdependencies between staffing, income, bed occupancy rate and length of stay. Using this, it is possible for providers to understand exactly the cost window in which they are operating and to identify what funding is available to follow the patient at any point of transfer to another setting during the episode of care.


Scenario generator tool

Scenario generator is a modelling tool that uses pathway design to map against population projections and prevalence, together with data entered on duration, capacity and costs, to predict future requirements for services, giving detail year on year down to step (or intervention) level.


NHS Northamptonshire used this method in 2010 to model different clinical scenarios to best evaluate the impact of the Stroke Specific Community Rehabilitation Team including an ESD. Excel was used to do further analysis of the results and to create a simpler way to model the data once the pathway had been designed. It was also used to present results.
**Bed modelling tool**
In Essex, a stroke bed capacity and ESD impact evaluation model has been used by commissioners to understand and support their work around commissioning ESD services. It can be applied to community rehabilitation models.


**Data gathering**
It is crucial to gather as much stroke specific data as is available for analysis to work out the patient flows in the acute stroke unit and the income that this currently generates from tariff. Clinical engagement is essential at this stage so that teams can provide additional information that cannot be captured through Secondary Uses Service (SUS) data i.e. mimic stroke data and bed consumption for those patients that do not end up being coded as AA22z or AA23z in the data set.

Assumptions then need to be made around the impact that the ESD service will have on the acute bed length of stay. It is advisable as per the model tool to establish a best case scenario, baseline impact and a worst case scenario in order to reassure the acute trust of the impact by cohort rather than on a case by case basis; the benefits of ESD on the acute stay will only be realised when it has impacted on length of stay.

**Staff calculator tool**
The UKfST have created a workforce calculator. This electronic tool can assist users to work out staffing and skill mix requirements to deliver services and support calculations around amount of clinical time available from varying skill mix combinations.

More information is available at: http://breeze01.uclan.ac.uk/SSEF/

More information to support workforce analysis and design can be found on the NHS Improvement - Stroke website at: www.improvement.nhs.uk/stroke/Increasingaccessstotherapy/IncreasingaccessstotherapyMeasuring/tabid/301/Default.aspx

**Developing an integrated approach between health and social care**
Where health and social care services work together to facilitate a smooth return home for patients it can help people recover quickly, reduce the pressure on the individual and their family and prevent unnecessary readmissions to hospital or care homes (National Stroke Strategy, 2007). Involving social workers in the multidisciplinary team at an early stage is an effective way to achieve this.

To achieve safe and timely discharges of patients from the acute sector into ESD/community stroke services it is essential that health teams integrate with social care teams. Ideally stroke skilled social workers should be embedded into the ESD with an inreach role onto the acute stroke unit, to enable early identification of patients needing social care packages and the mitigation of social circumstances that may preclude timely discharge.

A key role of the social worker should be to elicit the support of reablement teams to work alongside the ESD team at the point of discharge for these patients. Those receiving ESD support should not be restricted from accessing reablement funding and support. ESD teams may work alongside reablement colleagues to ensure the patient is getting the therapeutic care they require to develop their rehabilitation plan. The simultaneous benefit of this is that reablement colleagues learn stroke specific skills and handling by working alongside the experienced ESD clinicians and rehabilitation workers.
As organisations are required to facilitate and commission services, greater integration of health and social care from the centre is essential.

In **North East Essex**, social work colleagues have been part of the ESD team since its inception and commencement, and reablement packages have been successfully put in place for the six week period directly after discharge. Social care colleagues reported that by working in this integrated way the size and complexity of social care packages has reduced. The packages have become less complex for stroke patients and are easier and quicker to arrange.

In **Stoke on Trent**, the city council’s adult social services team has redesigned the stroke care pathway from rehabilitation into the community.

Details of their experiences can be found at: www.improvement.nhs.uk/stroke/CaseStudies/CaseStudiesQM15/tabid/152/Default.aspx

**Care homes**

The National Stroke Strategy also recommends that ‘commissioners should also consider providing training on stroke to a wider range of organisations that come into contact with individuals who have had a stroke, for example care home staff. Allied health professionals and stroke voluntary organisations are particularly well placed to carry out this training.’

Where true integration has occurred team are becoming up-skilled and the patient receives the progression they require through all daily tasks which enables higher levels of independence and reduced impairments. Cost can be calculated around the reduction in size of care packages and carer burden, savings would directly benefit social care budgets and thus would be sufficient to fund a social worker per ESD team on an invest to save basis.

A small scale study carried out using the Northwick Park dependency assessment for 71 patients in **Leeds** where there is established joint working between the community stroke team and the intermediate care and enablement teams produced an average reduction between start and end care costs of £271 per person per week.
Chapter 3: Planning for improvement

Making any changes to existing community service either to include ESD, or to deliver a new pathway for stroke survivors requires a thorough understanding of where you are now, where you want to be, sign up, and a realistic action plan. Adopting a clear and transparent approach can encourage all stakeholders to buy in. This is especially important where services are currently being delivered by community hospitals, or where a new service has implications for acute providers, requiring them to ‘let go’ of patients much earlier in their stay.

Achieving agreement between acute and community providers around ‘risk’ may require much discussion and hard work to build professional trust across the pathway. Anecdotal evidence suggests that this is one of the biggest obstacles to improving timely flow into ESD and community rehabilitation services. Engaging social care in the process can be very challenging, but where services have persevered and have achieved joined up working with social care within the hospital stroke multidisciplinary team, it has produced positive effects on patient community rehabilitation experience.

In some instances, it may be necessary to develop confidence within acute service providers and among commissioners in the ability of community services to step up to the task of delivering ESD. This can be assisted by benchmarking existing community services and obtaining relevant performance data.

Community stroke services that can demonstrate a service model offering all patients a timely service with flexibility to deliver appropriate levels of frequency and intensity based on need (a pathway approach) with robust data measurement of outcomes are more likely to make a persuasive case for delivering ESD within their service.

Engaging stakeholders

Commissioners
The evidence states that ESD can save money, although its primary rationale is around delivering better outcomes for patients. Most services report that the major costs are those associated with managing patients with more complex needs and disabilities; patients typically with a longer length of stay in hospital and in community rehabilitation with more expensive care costs. Greater impact on costs may therefore be achieved through improved opportunities for these patients within community rehabilitation; thereby reducing hospital length of stay and offering a more effective community service that will achieve more in less time – thus delivering an overall shorter total pathway length of stay and lower final package of care costs.

Clinicians
The question for clinicians is how to deliver the best outcomes for patients in their care with the resources that are available. This involves consideration of the research evidence, understanding local resources (both existing and potential), alongside the intended outcomes of the ESD service. Opportunities to identify how to increase access to therapy, intensity and frequency (such as demand and capacity work) should be explored.

There will be an expectation that any additional resources to an existing community team to support ESD will be required to demonstrate maximum effect across a range of quality standard related metrics and not just more of the same. Community services that can offer clear pathways for patients according to need are better able to demonstrate this.

Patients and carers
The NHS operating framework (2011) says, ‘Patients and carers should feel that services are integrated and co-ordinated. The need for good systematic engagement with staff, patients and the public is essential so that service delivery and change is taken forward with the active involvement of local people. Organisations should also listen closely to patient feedback and complaints, using this information to improve services’.

Successful services are those that understand their local needs. Consequently they have selected a service model that works because it is locally relevant. Within their model are clear exit strategies that are relevant to their service users, and actively support meaningful social integration. This has been achieved through fully including patients and carers in service design. These services have embedded themselves within the local community and constantly seek opportunities to further consolidate this.
In Haringey, the stakeholders worked from the back of the pathway, forwards. They worked with patients and carers to identify and agree local priorities for stroke survivors and then developed a range of options in the community. For some, stroke clubs offer long term support while for others they are a springboard to further groups and activities that are less stroke specific and more broadly integrated.

Social care
Local authorities are facing an unprecedented financial and service demand challenge. They may wish to see evidence that any money they spend realises real benefits, either in cost savings or reduced demand. This is not just about value for money. With less to spend and tighter fiscal pressures they will want to know what will be realised in the short to medium term from an investment, even if this is jointly with health. A local authority will need to be able to clearly see benefits for their organisations in joint working with community rehabilitation services.

Opportunities and benefits from integrating health and social care across the stroke pathway

**ACUTE CARE AND REHABILITATION**
- Effective communication to jointly identify future care and rehabilitation needs.
- May avoid repetition and duplication of effort.
- Enables more efficient use of social care time on ward.
- Potentially improves patient and carer experience.

**TRANSFER FROM HOSPITAL**
- Establishment of clear joint health and social care plans.
- May reduce frequency and quantity of delayed discharges.
- Enables shared use of community resources between health and social care.
- Potentially improves patient and carer experience.
- Improved carer support to manage the stroke patient’s transition home.

**COMMUNITY REHABILITATION AND INTEGRATION**
- Effective joint rehabilitation/enablistment.
- Promotes access to stroke skilled training and support for social care staff and enables greater competence of care agency and care home staff.
- More timely integration into the community.
- Facilitates more effective use of intermediate care beds for stroke.
- Enables reduction in levels of care packages required.
- May lead to increase in patients returning home from care home beds.
- Increase in number of patients remaining in own home for longer.
- Enables reduction in number of re-referrals for additional care.
- Potentially improves patient and carer experience.

**REVIEW**
- Joint review at six months.
- Increases numbers of patients returning home from initial placement to care homes.
- Enables reduction in number of re-referrals for additional care.
- Fewer complications.
Stroke rehabilitation in the community: commissioning for improvement

There are no quick fix solutions or prescriptive answers around securing engagement and commitment from all stakeholders. Successful outcomes in terms of an agreed service specification and model are derived from locally agreed definitions and plans, using the evidence as a starting point. Understanding where you are and what already exists may be challenging, but can yield benefit. Many areas have more potential than may be apparent initially, so effort spent finding out what already exists is worthwhile. It may take time to reach agreement locally around the shape and vision for community rehabilitation but when it is achieved, clear plans can be developed to move the service forward.

Some working examples

- Evidence highlighting benefits of joint training for health and social care staff on the stroke pathway
- Savings due to a joint commissioning approach, funding a well-resourced ESD team, including therapy service provision integrated with an enabling care approach to provide intensive stroke rehabilitation within the person’s home: £315 per week saving in social care packages
- Evidence of joint working to enable timely discharge for the more complex stroke patients
- Improved patient experience and quality of life
- Achieving the aspirations of the stroke strategy for in-patient intermediate care around delivering better outcomes when professionals with stroke expertise are part of the rehabilitation team and specialist input remains
- Joint working to reduce long term care home placement: Potential five patients per year case studies (Blackburn/Leeds).

In Northampton, they used process mapping with a QIPP twist to engage all stakeholders and develop a pathway for their community stroke rehabilitation service. More information is available at: www.improvement.nhs.uk/stroke/CaseStudies/CasestudiesQM10/tabid/147/Default.aspx

Northumbria have developed a strategy for including patients and carers throughout their pathway including education of staff. More information is available at: www.improvement.nhs.uk/stroke/CaseStudies/CasestudiesQM4/tabid/141/Default.aspx

Further resources are available from the Improvement Leaders’ Guides produced by the NHS Institute for Innovation and Improvement at: www.institute.nhs.uk/Products/ImprovementLeadersGuidesBoxSet

Tools to support the process

There are many tools and techniques that can assist with analysing services and to help plan for improvements. These include process and value stream mapping, understanding capacity and demand, using measurement or improvement and involving patients and carers.

In NHS Camden used demand and capacity work to support the business case for their ESD service model. More information is available at: www.improvement.nhs.uk/stroke/Increasing accesstherapy/IncreasingaccesstherapyMeasuring/tabid/301/Default.aspx#workforce

More details with supporting evidence for these examples are available on the NHS Improvement – Stroke website at: www.improvement.nhs.uk/stroke/ESD/tabid/160/Default.aspx
Measuring for improvement

- Establish a baseline - this avoids dependence on assumptions about improvement priorities
- Engage all key stakeholders - including Clinical Commissioning Groups, at the outset
- Measure what matters - agree meaningful measures at the outset and include in initial commissioning intentions
- Develop reliable systems for data collection including technical solutions
- Protect resources to collect accurate and reliable data.

Why measure
To understand the current state of the service.

Establishing a true baseline of current service delivery is a major part of service improvement. Unless the pre change position is known, it will be difficult to know if changes are an improvement and have had any impact on the process or outcomes for patients. The baseline is a measure of how well the pathway is working, in terms of efficiency, effectiveness and patient and carer experience.

To understand the direction of travel
Regular monitoring and analysis of information will inform the impact of any changes on the service. It can inform decisions about whether adjustments to the service are needed.

To determine progress
When data is used as continuous feedback about the effectiveness of the service and any improvements, it objectively demonstrates what progress is being made in terms of benefits, return on investment, avoiding the need for assumptions.

Aligning stroke data with the outcome domains

<table>
<thead>
<tr>
<th>Domain 1 Preventing people from dying prematurely</th>
<th>Domain 2 Enhancing quality of life for people with long term conditions</th>
<th>Domain 3 Preventing people from dying prematurely</th>
<th>Domain 4 Ensuring that people have a positive experience of care</th>
<th>Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information about the under 75 mortality rates from cardiovascular disease will apply to stroke</td>
<td>Includes measure of ‘the proportion of people feeling supported to manage their condition’ and ‘health related quality of life for carers’</td>
<td>Measures ‘improving recovery from stroke’ using the modified Rankin score at six months</td>
<td>Generic patient experience measures of hospital and primary care are included</td>
<td>No stroke related indicators</td>
</tr>
</tbody>
</table>

An effective system for capturing and analysing information is essential to understand how well a service is functioning and to establish the impact of changes and proposed improvements. Establishing systems, and then analysing the information, can be challenging in a busy clinical environment.

Further information can be found on the measuring for local improvement pages of the NHS Improvement – Stroke website at: www.improvement.nhs.uk/stroke/MeasuringforImprovement/Measuringforlocalimprovement/tabid/188/Default.aspx
The Stroke Sentinel National Audit Project (SSNAP) audit
This is the new national stroke audit intended to be the single source for all national stroke data, and incorporates National Institute for Health and Clinical Excellence (NICE) quality standards for stroke. It will include core data about every stroke patient, mainly about their acute care but importantly for community rehabilitation teams will include data about joint care planning, psychological care after stroke, early supported discharge and six month reviews. Some patient reported measures are planned to be included.

More information is available at: www.rclondon.ac.uk

The commissioning outcomes framework (COF)
This will be an accountability framework for clinical commissioning groups (CCGs) to enable the NHS Commissioning Board to identify the contribution of CCGs to achieving the priorities for health improvement in the NHS Outcomes Framework. The COF will contain a number of indicators developed from NICE evidence-based.

The measure which has the most significance for community rehabilitation teams is the modified Rankin score at six months - a functional recovery score. This measure is planned to be collected in the SSNAP audit.

What are the strategic, regional indicators?
These indicators currently determined by Strategic Health Authorities, will subsequently be determined by CCGs and will potentially be based on the COF. These indicators tend to be more locally defined and can include:

• Key performance indicators used to incentivise provider performance when used in association with incentive payments, such as the CQUIN scheme
• The need for commissioners to align service specifications with NICE quality standards.

What should local databases include?
Effective local service delivery is dependent upon accurate information about the quality of the service. Services with robust data collection processes, and regular evaluation using the information will be able to demonstrate outcomes and unmet needs and understand the clinical and cost effectiveness of the service. Availability of this information articulates the value of the community rehabilitation team and supports the future commissioning of the service.

Local databases should be:
• Simple - collect only data which is important and will be regularly used to develop the service where possible be consistent with national stroke data requirements to avoid duplication
• Robust - take steps to validate the data
• Patient-focused - include regular patient and carer feedback about their experience of the service

• Part of the team culture - involve all of the team in the collection, validation or use of the data for improving the service
• Shared - make the information openly available for staff and patients to understand the level of care provided and intentions for improvement.

Lancashire Healthcare NHS Trust community stroke team in Blackburn have developed a community dashboard to collect and report on key stroke rehabilitation data in order to evaluate and manage their service.

More information on this can be found at: www.improvement.nhs.uk/stroke/Increasingaccesstotherapy/Increasingaccesssto therapyMeasuring/tabid/301/Default.aspx

Team level
The CLAHR ESD consensus (2011) recommends the use of standardised assessments to monitor stroke severity, dependency, activities of daily living and satisfaction as well as the impact of the ESD service on length of stay and readmission rates.

Some examples of outcome measures used by individual services are detailed within the community stroke resource, www.improvement.nhs.uk/stroke/CommunityStrokeResource/tabid/204/Default.aspx
Effective leadership, management and workforce

Leadership and management

‘Clinicians with leadership skills have the greatest ability to deliver better services for patients and foster innovation, quality and safety.’

National Allied Health Professional leadership challenge, DH, 2010

An effective strategic profile for any rehabilitation service requires that the service is led by an individual who can influence the decisions of senior managers and commissioners. This impacts positively on service outcomes and the progress of the service locally. Anecdotal feedback and learning from the national rehabilitation projects 2009-10\(^{11}\) and 2010 -11\(^{14}\) showed that strong leadership within community rehabilitation is crucial to success.

In most places these services are led by an allied health professional (AHP), working with business managers at operational level. The absence of a medical lead may be viewed as a disadvantage.

However, many of these services demonstrate strong leadership from AHPs who have access and a voice at the highest strategic level where they can articulate how their service aligns with national policy drivers and the bigger picture. They may not operate within their team as the most expert clinician, but have skills in effective service management and financial acumen, and confidence with data management.

Many community services have evolved from a core group of clinicians. They have grown over time into bigger services, with senior clinical staff juggling additional administrative responsibilities that could reasonably be carried out by less expensive non-clinicians. Typically vacancies are used as opportunities to revisit the staffing matrix, and improve the number of unqualified staff rather than in improving administrative support.

Community rehabilitation teams commonly report difficulties in the establishment, funding and maintenance of administrative support, yet there is an essential requirement for any service to run smoothly, in managing the transfer of information between secondary and primary care, and between health and social care.

Similarly the increasing essential requirements of data reporting and audit necessitate the provision of adequate and appropriate support. These requirements should be built into the specifications for stroke rehabilitation services in the community in order to make the most effective use of clinical resources, and meet the administrative demands.

Workforce

‘Specialist teams may be more important in the early stages of rehabilitation, while generic teams can be appropriate for the later stages. However, the configuration of community teams is less important than ensuring that these teams are multidisciplinary and all staff have the right specialist skills to help rehabilitate people who have had a stroke.’

National stroke strategy 2007

\(^{11}\)Going up a Gear: Practical steps to improve stroke care. NHS Improvement, 2010.
\(^{14}\)Mind the Gap: Ways to increase access to therapy and rehabilitation. NHS Improvement, 2011.
Anecdotally, some stroke services report difficulties in reconciling this with their commissioner focus on strategic implementation programmes for transforming community services.

Commissioners may have invested money in developing their intermediate care services and can need persuasion that these generic intermediate care services cannot, with some training deliver the bulk of supportive rehabilitation within the community, for both ESD and non-ESD services. Stroke services and providers will need to be able to articulate clearly the evidence base for staffing and how this can align with local services cost effectively. It is crucial to gain agreement among all stakeholders about how the opportunities from existing community and intermediate care staff can be realised, without compromising the need for ESD or community services to comprise stroke skilled staff, including stroke specialists.

Further discussions between all stakeholders may be needed in these situations, to agree the pathway for rehabilitation in the community, and how ESD fits with this. Teams, including commissioners, may find it useful to talk with, or visit other services who have resolved this, and using resources such as workforce pathway analysers and the stroke specific education framework can also inform the process. It may then be possible to agree the local definitions around stroke specific, stroke exclusive and stroke skilled and develop a specification to deliver an appropriate, safe service.

Establishing the current pathway and associated costs will help commissioners understand how their current resource is used, and provide an opportunity to refocus this resource in stroke skilled care.

**Rural workforce**

In more rural areas the emphasis has been on developing services that can deliver the best outcomes for patient care within the resources that are available. In some, but not all areas, a modest additional investment to support ESD may be available. Their preference may be on identifying and developing skills within any part of their existing resources to support an equitable service for all stroke patients. This can include social care staff.

Agenda for Change allows for the creation of new job roles, multi-skilling of staff outside of traditional professional boundaries, the devising of new ways of working and the redefining of the skills and knowledge of staff to meet patient needs rather than focusing on the grades of staff. This alters the balance around content and structure of teams, allowing teams to be specialised and skilled beyond traditional professional boundaries, according to local needs, and also leads to a greater mix and overlap with non-health providers of care, with greater emphasis on partnership working between different agencies.

In turn, staff time can be optimised. By integrating provision, patients with needs that can be met by less highly skilled staff can access these individuals, freeing the time of more highly skilled clinicians to attend to patients with more complex needs.

Education and training are essential to underpin the roles of the whole team and staff should hold appropriate competencies for the delivery of care for which they are responsible, particularly in rural areas.

Useful information is available at:

- http://ukfst.org
- www.improvement.nhs.uk/stroke/Increasingaccesstotherapy/IncreasingaccesstotherapyMeasuring/tabid/301/Default.aspx#workforce

24 Department for Communities and Local Government. 2006.
Chapter 4: Examples of innovations in stroke rehabilitation in the community

Buy in and ownership of a service may play a significant part in access to and uptake of ESD services.

Improving access and uptake

Some ESD services, predominantly of model type one and two, report difficulty achieving the 40% uptake of ESD. Anecdotally a number of factors are thought to be relevant to this.

Acute provider confidence in the ability of community teams to ensure patient safety so early in the process.

• This can occur where acute therapy teams have limited community experience and the ESD service is community provider based and when the selected model requires hospital based therapy teams to identify suitable patients and the community team to provide the service. It may be due to historical perceptions of community services associated with long waiting times for access, and traditionally providing a ‘supportive’ rather than ‘rehabilitative’ function creating reluctance or hesitation within the acute providers. Possible solutions include closer joint working and rotation of therapy staff between services.

When the service is delivered by an acute outreach service in a trust that already has a short length of stay and where there is already a responsive community stroke service.

• These services have found it difficult to identify a cohort of patients suitable for an additional ESD service. This is typically resolved through merging ESD with the existing community stroke/neurology service.

Therapist anxiety around perceptions of role loss and a changing job emphasis in the hospital setting.

• In some areas where whole pathway reconfiguration has been undertaken these staff have been encouraged to recognise that this work is more relevant in a community setting, and have been supported to move into services where rehabilitation is the priority.

There are instances of ESD services having been commissioned initially as model type one or two that have evolved into models type three and four. These models allow a greater cohort of patients to access earlier supported discharge within the principles of ESD from within a community rehabilitation team with stroke skills.

Haringey initially had two rehabilitation teams in the community for stroke; the ESD (seven day team) for eligible patients and stroke (five day team) for patients with less intensive needs. The teams have now merged into one service that can see all patients leaving hospital through an approach that includes working with an enablement team for support with the intensive rehabilitation work. Analysis of their data had shown them that there was not a need for two separate teams due to insufficient patient numbers for ESD (less than 40%) requiring seven days intensive rehabilitation. By reconfiguring the service model into one team over five days, supported by enabling care over seven days, they are able to see all patients. This model is more effective, exceeds the 40% standard and has delivered cost savings.

One ESD service within Greater Manchester found that that their criteria only enabled them to recruit 20% of stroke patients. The rest of the patients had long waits for the other community rehabilitation services (either generic or neurology single profession services) which they felt was not equitable or acceptable. They reorganised the services so that all patients could access the same team, but via two streams, one for ESD and the other, a stroke specific hospital to home. Patients can have six weeks ESD over five days or both depending on need. The team are currently working on a closer working partnership with the local authority re enablement team. All patients can now access timely stroke skilled community rehabilitation with the result that referral rates have increased and the service is delivering more with no change in funding.
Using telemedicine

The use of telemedicine to support rehabilitation is in its infancy, so there has been little time to establish a reliable evidence base to support its use. However, there is some evidence that occupational therapy, physiotherapy and speech and language therapy assessments can be undertaken reliably using telemedicine technologies.25 Telerehabilitation, including telephone follow up care and teleconferencing and may provide an alternative when direct follow up is impractical.26 Other studies have demonstrated using gaming technologies as an adjunct to rehabilitation.27 The inspiration for much of the work is taken from rurally challenged areas such as Australia who are adopting telemedicine within rehabilitation; much can be applicable to remote rural services in England.

Providing stroke services in rural areas

Rural areas account for approximately 9.5 million residents or 35.6% of the UK population and present their own challenges to providers of community rehabilitation services. They have a higher proportion of elderly residents than urban areas and therefore a higher proportion of stroke patients. They tend to have poorer transport infrastructures, and are less densely populated, resulting in greater travel times from work base to patient homes and between patients. Additionally, they may have more challenges around the recruitment of staff, especially those from the allied health professions, although staff that are recruited do tend to stay for longer spells.

The national picture is of most rural and remote areas struggling to find solutions to delivering the aspirations of the national stroke strategy. A pragmatic approach adopting the principles of ESD, within an equitable service, delivered by stroke skilled people offers a positive way forward.

The principles of planning the service are no different from those previously described. The difference lies in how delivery can be achieved from within a smaller number of qualified practitioners, across a wider geography.

For most, a stroke exclusive community and ESD service is cost prohibitive, and in the very rural and remote areas, a community neurology service is not viable. In these situations looking at how to best enable existing generic teams has to be considered.

High quality care and services for people with stroke or at risk of stroke need to be delivered by staff with stroke specialist knowledge. The challenge is how to ensure capability, capacity, and collaborative working both within stroke teams and across providers and commissioners so that there is an overall focus on delivery of high quality stroke care and services for stroke survivors.

This requires an identified person to be responsible for leading service delivery and development, including development of staff as well as developing mechanisms for, and an ethos of, shared responsibility. (National Stroke Strategy, 2007). Education, training and support with oversight from a stroke lead can facilitate the delivery of appropriate rehabilitation for stroke patients in these circumstances. They can coordinate the pathway and opportunities for stroke patients, and provide the specialist expertise.

Partnership working with social care and integration with all existing services is essential for long term sustainability. Building relationships with the local hospital-based stroke team can facilitate peer support, stroke expertise and improved coordination.

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**Key considerations within a rural community service for stroke**

Planning and coordination of staff activity is therefore essential to ensure effective utilisation of resources, when delivering any rural community services to allow for:

- Inreach and liaison with acute providers
- Attendance at multidisciplinary team meetings (MDTs)
- Journey planning and timetabling visits
- Clustering of workload around localities
- Flexible working patterns to support home working for data inputting, note writing and other activities.

**Possible models**

Some very rural and remote areas are considering adopting the hub and spoke model approach, through several small hubs of highly skilled generalists with additional stroke training aligned very closely with local community services with a defined stroke lead and overseen by strong leadership with a strategic voice.

Examples of provision of follow up rehabilitation in truly remote areas can be found in New South Wales, specifically and more widely across Australia.

Information about the models of provision can be found at:


The Australian view is that community rehabilitation can be equally effective if delivered in the hospital via outpatients, or day hospital, or in the community.

They have adopted pragmatic solutions and their experiences can offer useful lessons to services struggling to deliver stroke skilled services in some of the remote rural areas of England. This includes identifying the key principles for effective ESD within community rehabilitation and establishing how this may be achieved by better utilisation of existing resources, and through more extensive and specialist education and training.

In **Cumbria** work has been undertaken to implement ESD in a very rural area through an existing generic community team. Through limited resources of the stroke supported discharge service to support the existing generic community team they are managing the more complex stroke patients outside the criteria for ESD. To achieve this they have focussed on cross training and providing specialist support to the existing community generic team and outpatient neurology services. This has been achieved through a certified education programme of up-skilling for all of the rehabilitation support workers. Consequently there is an increase in referrals to the generic community team, which they feel is due to more local confidence in the service, and the appreciation of the support from the stroke supported discharge service. These staff in reach to provide assessment and make the decision about which pathway is suitable. Those patients appropriate for slow stream rehabilitation are referred to the neurology therapists who also support the generic community team. This creative and pragmatic approach makes good use of local resources, demonstrates effective team work, communication and a cost effective use of education.
In rural Dorset, community rehabilitation services are piloting a strategy to deliver ESD across a huge geographical area, covered by ten small, community rehabilitation teams. Their data show that each week one or two new patients could be transferred from the acute hospital to any of these teams, therefore each team needs to be prepared to “catch” the ESD patient. They have adopted an integrated approach with the local stroke unit to jointly identify suitable patients, and share the transfer process. The stroke unit specialist staff are available during the two-week ESD period for additional support as required. The ESD pilot Lead needed to identify therapists who had sufficient stroke or neurology training and experience within each of these generic teams to devise a programme of education and a mechanism of support for them. To support the service requirement for 45 minutes of therapy, they had to devise a similar approach to developing their support for staff to deliver stroke therapy and care, including competency-based online packages. It is envisaged that qualified therapists will visit the patient as often as required for assessment and therapeutic intervention. They will devise sufficiently detailed intervention plans and goals to allow the support staff to deliver functional activities and therapy up to four times per day, with availability seven days a week. The ESD Lead oversees the process of the pilot implementation, coordinating activity and measuring the impact on patients, acute providers and the community teams, across a range of metrics, and data gathered during the first six weeks of the pilot shows very favourable results.

**Capitalising on pathway redesign**

Some successful ESD and community stroke services have developed on the back of bigger local changes associated with local pathway redesign or service reconfiguration, turning potential threats into opportunities and successes.

Major changes in the location and configuration of stroke rehabilitation were planned across Northumbria. This afforded an opportunity to develop an ESD service in the community to support the new pathway. The service was designed by a wide stakeholder group including patients to include a range of bespoke support, provided by stroke skilled staff - that could be supported to enrich the rehabilitation opportunity for patients in their home. The service reduced length of stay in acute care by seven days and contributed significantly to a release of £500,000 back to commissioners.
Chapter 5: Commissioning stroke rehabilitation in the community

The practicalities

While studies have concluded that the opportunity savings from hospital bed days released is greater than the cost of the ESD service, releasing these savings can be difficult. Many areas are undertaking this work, but it is complex and requires recognition of the many potential implications for acute services beyond those for stroke.

For many community services, the cost of rehabilitation is tied up within block contracts. For others, costs can be specifically identified. Some services collect data showing the allocation of resources within the different complexity groups, for example services in Camden and Blackburn. Such services have the potential to cost their service interventions based on severity of disability (see ‘Measuring for improvement, page 30). However, for most community rehabilitation teams, it is not possible to identify costs, or cost the value of the service due to an absence of metrics, or the sensitivity of data collected.

Traditionally stroke patients have had long lengths of stay in an acute setting and in community rehabilitation beds. Evidence now shows that stroke patients benefit from a less institutionalised approach to care and that delivering rehabilitation in the patient’s own home (an enriched environment) improves outcomes. The principle of splitting the stroke tariff is designed to allow the financial flows to follow the patient through their patient journey and associated pathway of care, supporting this.

The acute tariff for stroke (AA22z and AA23z HRG) is driven by the collection of reference costs and mandatory data. Reference costs capture the value of the resources (cost) in the acute setting that provides support for a patient with a particular health problem. For stroke this is divided into an infarct related stroke (AA22z) or a haemorrhagic stroke (AA23z). Tariffs include staffing costs, overheads, investigations and hotel costs.

The collection and statistical analysis of all associated data across acute hospitals in England is a major task. It is compounded by the variance in returns that reflect different pathways of care and access to local services. Therefore, tariffs are derived from the costs associated within the financial year, three years prior to the year of refresh/release of the tariff. So, 2009/10 costs inform the 2012/13 tariffs.

Three years ago a substantial amount of rehabilitation was being delivered in the acute setting because lengths of stay were significantly longer than now. The National Stroke Strategy (2007) raised the profile for stroke but few ESD services were established and the medical model of care, rather than therapy or rehabilitation prevailed.

The rehabilitation costs were included within the acute tariff. However, where ESD services or stroke skilled community teams exist, patients are leaving the acute environment much earlier resulting in some tension around allocation of the resources currently contained within the tariff.

The tariff splitting process is designed to reflect the localised approach to a pathway of care.

There is no simple answer resolving where a tariff should be split but it should be determined by the localised arrangement of services and financial analysis of health care systems. Work between commissioners and providers to analyse the commissioner spend and provider costs, and capacity and demand work within the acute stroke pathway, should be completed before any local discussions about splitting the tariff are instigated.

A potential starting point is the tariff for the first three days of the stroke pathway; where patients may or may not receive thrombolysis. In regions where stroke services have shared 24/7 thrombolysis that crosses PCT boarders, financial flows have been agreed to support repatriation of patients to step down facilities, when medically fit. Details around how this has been achieved in Anglia are available at: www.improvement.nhs.uk/stroke/Stroketariff/Stroketariff1pathways/tabid/260/Default.aspx
Unbundling the stroke tariff

There are three approaches to unbundling tariffs that are applicable and have been used with stroke:

- **Unbundling the acute tariff based on the cohort that are suitable for and access ESD only**
- **Unbundling the acute tariff based on overall average length of stay on the acute stroke unit**
- **Splitting the acute tariff on a patient by patient basis.**

Another alternative is to agree a nominal percentage split that reflects the first three days of care that is accurately costed to reflect the interventions that need to take place during that time. This relates to the repatriation work done in the East of England and in the East Midlands. PbR guidance in 2008/09 indicated that a percentage tariff split to 55:45 would be appropriate to reflect the acute care of stroke patients and the sub-acute rehabilitation phase (time and motion studies should be conducted to evidence this split if reference costs are not collected to specifically capture rehabilitation in the VC04 Group 3 definition).

Therefore percentages may vary as in the following worked examples.

**1. Unbundling the tariff based on the cohort that are suitable for and access ESD only**

This is based on a tariff that is unbundled with a percentage ratio of 48:52, where 48% of the tariff is retained by the provider and 52% of the tariff is retained by the commissioner in order to fund rehabilitation including an ESD service. NB. 100% of eligible patients here relates to patients that meet the ESD criteria, therefore approximately 40% of all stroke patients.

<table>
<thead>
<tr>
<th>No. of eligible patients</th>
<th>No. of patients accessing the service</th>
<th>Percentage of eligible patients accessing the service</th>
<th>Total cost of service required for eligible patients</th>
<th>Unbundled from tariff (per patient)</th>
<th>Per patient cost of service</th>
<th>Per patient saving</th>
<th>Full service/full year saving</th>
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<td>414</td>
<td>100%</td>
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<td>£2,113.80</td>
<td>£1,257.00</td>
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<table>
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<th>LA Funding Social Worker</th>
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<tr>
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<td>414</td>
<td>165.6</td>
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<td>414</td>
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Including Social Worker Funding Social Worker ESD team staffed to see 100% eligible patients

<table>
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<th>No. of patients accessing the service</th>
<th>Percentage of eligible patients accessing the service</th>
<th>Total cost of service required for eligible patients</th>
<th>Unbundled from tariff (per patient)</th>
<th>Per patient cost of service</th>
<th>Per patient saving</th>
<th>Full service/full year saving</th>
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</table>
2. Unbundling the acute tariff based on overall average length of stay on the acute stroke unit

This approach takes into account the short stay tariff referenced in HRG4 and applies the national tariff to those patients with the national average length of stay. It is based on a population where the average length of stay for eligible patients is 16 days and the average reduced length of stay for eligible patients is eight days. The example has therefore been calculated assuming the average resulting length of stay for eligible patients is eight days.

NB. 100% of eligible patients here relates to patients that meet the ESD criteria, therefore approximately 40% of all stroke patients.

A letter template has been created to support the process of retrieval and redistribution of the tariff following adoption of this method. It is based on a practical example that has been used by commissioners with their local acute provider. It may be a useful start point for commissioners considering how to begin this process.

3. Splitting the tariff on a patient by patient basis

Through this approach the tariff is split on a patient by patient basis. Costs are derived proportional to the length of stay for the individual through all pathway options developing multiple trim points within the pathway. This includes staged commencement of excess bed days to disincentivise patients being held longer in the acute setting than needed be. This is a pragmatic approach, through developing a proportional cost in line with the reduction of average length for the unit, and has been used successfully. The short stay tariff would be paid in line with PbR guidance.

<table>
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<th>Time period</th>
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<th>Cumulative % tariff</th>
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<td>0% (funded by A&amp;E tariff with high cost investigation)</td>
<td>0%</td>
</tr>
<tr>
<td>0-3 days (fixed tariff)</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>4-7 days (bed day)</td>
<td>Up to 32%</td>
<td>52%</td>
</tr>
<tr>
<td>Post 7 days (bed day)</td>
<td>Up to 48%</td>
<td>100%</td>
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<tr>
<td>Post 18 days</td>
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<td>XBD</td>
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The process for achieving unbundling of the stroke tariff

**Step 1**  Ensure Clinical Commissioning Group (CCG) executive sign up and support for the intention to split the stroke tariff. The process of splitting the tariff is challenging and strong negotiation is required.

**Step 2**  Express the intention to split the stroke tariff to the acute trust and to the wider health economy via the process of commissioning intentions by 1st October in order to effect the commencement of the next contractual year 1st April as this constitutes the required six months’ notice to change to commissioning and financial arrangements.

It is advisable to split the tariff in advance of commissioning local ESD or stroke specific community service.

**Step 3**  Work closely and in partnership with the acute trust to amicably achieve a tariff split. The principle of this process should be to ensure sustainability in the acute stroke unit but a financial contribution to the ESD service.

**Step 4**  Evaluate and understand the local stroke pathway fully in terms of data, financial flows (block contracts or unit prices cost per case payment structure), resource allocation, contractual framework and provider performance along with patient experience.

**Step 5**  Split the tariff locally and ensure this is added to the acute hospital contract by variation to an existing contract or captured in Section B.
Ensure that there is:

1. A clear strategy to monitor the effect of ESD and the stroke community service on acute stroke length of stay and the rehabilitation service outcomes. A minimum data set is required for both services.

2. A method of flagging up in SUS* the patients that have qualified for a tariff split, if the chosen approach is that of an individualised patient approach to financial flows. Otherwise acute average length of stay analysis will drive financial movements.

3. Key performance indicators that are clearly articulated to monitor quality in acute and community services.

4. A process of financial flow with clear budgetary movement, to release and redirect revenue.

**Achieving quality and value through procurement**

Commissioners secure services to meet the health needs of their local populations, seeking to deliver the best combination of quality to patients and value for taxpayers. Procurement enables this by securing services through transparent engagement with providers, normally culminating in the award of a new contract to a new provider or the award of a new contract to an existing provider.

Procurement is an integral part of the commissioning cycle. It must be transparent (open and fair) demonstrate proportionality (procurement proportionate to the value, complexity and risk of the service being procured), demonstrate non-discrimination and equality i.e. open to all appropriate providers to compete on an equal opportunity basis, with due diligence checks accordingly. The provision of health care must be compliant with European procurement laws and open and competitive tender is deemed appropriate following a thorough contestability assessment.

An effective procurement process can help to improve quality and ensure value for money. This is particularly pertinent in times of austerity, when there is a need to deliver savings, to preserve stroke specificity and simultaneously deliver improvements and increase productivity. Whatever the local rationale for procurement, it can also be an effective tool for opening up the market to a wider range of providers. A more competitive market is seen to increase choice for patients, as well as encouraging improvements in service quality and innovation.29

Where service redesign is not possible and procurement is required, fully executed and successful procurement documentation may help to guide commissioners through the procurement process.

An example of procurement documentation, to support commissioning where service redesign is not possible, can be found here: www.improvement.nhs.uk/stroke/ESD/ESDsupportingcommissioning/tabid/168/Default.aspx

More information can be found at: www.ccpanel.org.uk/content/DH.pdf

A new strategy for NHS procurement is being developed and will be published at the end of March 2012.

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*Secondary Uses Service. A national data warehouse managed by NHS Connecting for Health. It provides anonymous patient based data for purposes other than direct clinical care.
Conclusion

- ESD can be the impetus for change to rehabilitation in the community
- Agreeing a local definition of ESD is prerequisite to developing a service
- Identifying existing local services and joining up specialist and non-stroke specialist expertise creates the foundations of an effective service
- Community rehabilitation services should be organised around local patient need
- Considering the perspectives of all stakeholders can mean taking a flexible approach
- Community services should be commissioned for all stroke survivors not just ESD to avoid inequity
- Identify quality community data and protect resources to sustain the process
- ESD requires a process of financial flow to follow the patient and clear budgetary movement to release and redirect revenue.

Developing an ESD service can be complex. It supports patients to move from a hospital setting back into their homes, and therefore means building effective relationships with colleagues across the pathway between acute care and the community and between health and social care services. Early on, care needs to be taken to ensure that all stakeholders have a common understanding of what the service can achieve and how it interacts with existing services. This buy in is crucial to success and sustainability.

There is no one size fits all model, or off the peg solutions to each challenge, and despite the existence of an evidence base, agreeing a commissioning model and establishing the funding mechanisms can be far from straightforward. Despite these challenges, ESD services have and continue to be developed. As a result, more stroke patients are experiencing an improved pathway of rehabilitation in the community, reduced time in the pathway and better outcomes.

The creation of an ESD service can be the impetus for change to stroke rehabilitation in the community. Irrespective of the model selected, simply having discussions around implementing ESD and including all potential stakeholders can be a means of focussing attention on the existing pathway for community rehabilitation services for stroke, and how ESD can improve this. ESD can be the catalyst for change and improvements in community services for all stroke patients. In some localities it has provided the missing link joining up acute and community providers, and health and social care.

Different models are emerging to fit in with local need and existing quality services. Identifying those existing local services, and joining up specialist and non-stroke specialist knowledge are the foundations of an effective ESD service. Achieving an agreed local definition of ESD is prerequisite to agreeing the local pathway and how ESD will fit and improve it. These processes can be challenging but also enlightening, as they may result in the identification of a much greater potential pool of resources that can be realised and harnessed to support improvements to the pathway for all stroke patients, and the evolution of a service that is more relevant to local needs. This in turn enhances buy in, uptake of the service, cost effective use of resources, value for money and therefore, the sustainability of the service.

This process is important in resolving the tensions between the need to minimise costs for commissioners and local authorities, and the aspirations for achieving clinical excellence and ownership of the service among clinicians and providers. Attention to the evidence and guidance can provide the framework and a willingness to adapt this to local needs, can help to align and realise local resources. Successful services have typically required some degree of pragmatism by all stakeholders, but without any compromise of patient outcomes and safety.
Local finances and perspective on managing the tariff can influence the process significantly. Organisations have tackled this challenge in various ways, and some are now beginning to split the tariff. But understanding the full impact of this on services, the pathway, or how monies released have been used to fund ESD, is still in its infancy.

Good quality data is crucial for all stages of the process. The value of reliable data, to inform the process of commissioning ESD should not be underestimated. Access to baseline data, can facilitate the planning, selection and costing of a model for ESD and support the mechanisms for evaluation. Where services have undertaken work to collect this information, it has provided clarity and facilitated the process of developing and framing their ESD services.

Although the challenges are many, they can be resolved through a mixture of engagement, discussion, transparency, pragmatism and determination. In this way successful ESD services can be commissioned and delivered offering stroke survivors better outcomes in the community.

‘Achieving sustainable improvement will also mean taking on the challenge of service change, to provide services closer to patients wherever appropriate and to improve integration between services.... real change can be achieved where managers and clinicians work together with courage and skill where change is needed in the interest of patients and taxpayersfor example to the organisation of care for long term conditions eg the configuration of stroke services. As well as truly clinically led commissioning and a robust and diverse provider sector, service change requires the right environment at local level, an environment in which patients, the public and communities are highly engaged.’

References


5. Supporting life after stroke. Review of services for people who have had a stroke and their carers. Care Quality Commission, January 2011.


Stroke rehabilitation in the community: commissioning for improvement
NHS Improvement

NHS Improvement’s strength and expertise lies in practical service improvement. It has over a decade of experience in clinical patient pathway redesign in cancer, diagnostics, heart, lung and stroke and demonstrates some of the most leading edge improvement work in England which supports improved patient experience and outcomes.

Working closely with the Department of Health, trusts, clinical networks, other health sector partners, professional bodies and charities, over the past year it has tested, implemented, sustained and spread quantifiable improvements with over 250 sites across the country as well as providing an improvement tool to over 2,000 GP practices.

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