Practice Based implementation advice

Stroke rehabilitation

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This implementation advice accompanies the NICE clinical guideline (available online at: www.nice.org.uk/guidance/CG162).

It draws from the learning and experience of practitioners working in services to provide support for users who may wish to develop an action plan to implement certain aspects of the guideline. It is not NICE guidance.

This document includes example pathways and signposts to resources from other organisations. While NICE is satisfied that they broadly support the guideline at the point of publication of this document, NICE cannot be held responsible for the content of resources produced by other organisations. Refer to the NICE guideline for any queries or concerns about the relationship between the NICE guideline and the example pathways or resources. Issue date: 2013

National Institute for Health and Care Excellence
Level 1A
City Tower
Piccadilly Plaza
Manchester
M1 4BD

www.nice.org.uk

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Introduction

Stroke is a major health problem in the UK. There are approximately 152,000 strokes in the UK every year\(^1\). Although one in five strokes is fatal\(^1\), most people survive a first stroke, but often have significant morbidity. There are approximately 1.1 million people who have survived a stroke living in the UK and more than half of all people who have survived a stroke are left dependent on others for everyday activities\(^1\).

Despite improvements in mortality and morbidity, people with stroke still need access to effective rehabilitation services.

Stroke mortality rates in the UK have been falling steadily since the late 1960s, with recent reorganisation in acute care leading to further significant improvements in mortality and morbidity. However, stroke commonly affects older people. The burden of stroke may therefore increase in the future as a consequence of the ageing population.

Stroke rehabilitation is a multidimensional process, which is designed to facilitate restoration of, or adaptation to, the loss of physiological or psychological function when reversal of the underlying pathological process is incomplete. Rehabilitation aims to enhance functional activities (in the short term) and participation in society (in the long term) and so improve quality of life.

Key aspects of rehabilitation care include multidisciplinary assessment; identification and measurement of functional difficulties; treatment planning through goal setting; delivery of interventions which may either effect, change or support the person in managing persisting change; and evaluation of effectiveness.

Stroke rehabilitation is a crucial part of the stroke care pathway. Effective stroke rehabilitation services will impact directly on the success and effectiveness of acute stroke services.

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**Current guidelines**

Clear standards exist for stroke rehabilitation, for example in the National Clinical Guideline for Stroke\(^2\). These are reflected in the NICE quality standard and the National Stroke Strategy\(^3\). Overall there is little doubt that the rehabilitation approach described by the standards is effective; what individual interventions should take place within this structure is less clear.

The aim of the Guideline Development Group (GDG) was to review the structure, processes and interventions currently used in rehabilitation care, and to evaluate whether they improve outcomes for people with stroke.

**Purpose of this implementation advice**

This document aims to help users put the guideline recommendations on service organisation into practice. It draws from the learning and experience of services and signposts to resources from other organisations that may help. Users should refer to the NICE guideline for any queries or concerns about the relationship between the guideline and the example pathways or resources.

This document is aimed at clinicians, service leads and those responsible for commissioning stroke rehabilitation services.

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It is important to note that the NICE clinical guideline on stroke rehabilitation makes recommendations about stroke rehabilitation but does not cover the whole stroke rehabilitation care pathway.

This implementation advice does not cover all of the recommendations in the NICE clinical guideline on stroke rehabilitation. After consultation with a range of experienced clinicians and practitioners, we identified the following 4 core areas of the guideline, as having significant implementation challenges and where further information to help users implement the guideline would be useful:

- what does a rehabilitation team look like
- models of care
- components of a rehabilitation programme
- interface between health and social care.

The relevant recommendations are listed in grey boxes throughout this document.

Throughout this document information from the full guideline has been added to provide rationale and information to support the recommendations. When this has been done the exact location within the full guideline has been identified by the page number in brackets for example [page 312].
What does a rehabilitation team look like?

### Relevant recommendations

- A core multidisciplinary stroke rehabilitation team should comprise the following professionals with expertise in stroke rehabilitation:
  - consultant physicians
  - nurses
  - physiotherapists
  - occupational therapists
  - speech and language therapists
  - clinical psychologists
  - rehabilitation assistants
  - social workers. [1.1.3]

- Throughout the care pathway, the roles and responsibilities of the core multidisciplinary stroke rehabilitation team should be clearly documented and communicated to the person and their family or carer. [1.1.4]

- Members of the core multidisciplinary stroke team should screen the person with stroke for a range of impairments and disabilities, in order to inform and direct further assessment and treatment. [1.1.5]

### Related recommendations

- People with disability after stroke should receive rehabilitation in a dedicated stroke inpatient unit and subsequently from a specialist stroke team within the community. [1.1.1]

- An inpatient stroke rehabilitation service should consist of the following:
  - a dedicated stroke rehabilitation environment
  - a core multidisciplinary team (see recommendation 1.1.3) who have the knowledge, skills and behaviours to work in partnership with people with stroke and their families and carers to manage the changes experienced as a result of a stroke.
  - access to other services that may be needed, for example:
    - continence advice
    - dietetics
    - electronic aids (for example, remote controls for doors, lights and...
heating, and communication aids)
◊ liaison psychiatry
◊ orthoptics
◊ orthotics
◊ pharmacy
◊ podiatry
◊ wheelchair services
- a multidisciplinary education programme. [1.1.2]

Relevant quality statements from the NICE stroke quality standard

- **Statement 5.** Patients with stroke are assessed and managed by stroke nursing staff and at least one member of the specialist rehabilitation team within 24 hours of admission to hospital, and by all relevant members of the specialist rehabilitation team within 72 hours, with documented multidisciplinary goals agreed within 5 days.

### Multidisciplinary stroke rehabilitation team introduction

#### Rationale for NICE recommendations

This NICE guideline recommends that people with disability after stroke should receive rehabilitation in a dedicated stroke inpatient unit and details that the core multidisciplinary team in the stroke inpatient unit should have the knowledge, skills and behaviours to work in partnership with people with stroke and their families and carers to manage the changes experienced as a result of a stroke. The guideline then recommends that following inpatient care, the person should receive stroke rehabilitation from a specialist stroke team within the community.

The NICE guideline lists the professionals with expertise in stroke rehabilitation that should comprise the core multidisciplinary team in all stroke rehabilitation services and acknowledges that access to other services that may be need will also be required. Although the exact expertise and skills of the multidisciplinary stroke rehabilitation team may differ depending upon the
model of the service (for example as detailed above, inpatient and community care), this section will consider the stroke rehabilitation multidisciplinary team in more general terms rather than specifically by the model of the service. Where specific service models are mentioned in this section in order to illustrate the point, those reading this document are encouraged to assess how this information could be useful to them locally.

Staffing the multidisciplinary stroke team with professionals with expertise in stroke rehabilitation enhances the seamless transfer of care and is beneficial to the long-term care and rehabilitation of patients with stroke. This is implemented by the REDS service.

The NICE costing report identifies that the National sentinel stroke clinical audit 2010 indicated that hospitals are performing better in respect of multidisciplinary working but that there were areas for continued improvement (see social workers and occupational therapy below).

The steps suggested below may help you to implement the NICE recommendations about the multidisciplinary team

Members of the core multidisciplinary team
This section focuses on members of the core multidisciplinary team where it has been identified that further information would help support implementation.

Social workers and occupational therapy
When reviewing the multidisciplinary team consider the information in the NICE costing report which highlighted the National sentinel stroke clinical audit 2010 identified that access to social workers and occupational therapy could be improved.

Many services believe in order to ensure their position as a core member of the multidisciplinary team, the social workers in the MDT should have receive specialist training in stroke (REDS service) and that they attend the team meetings and ward rounds (appendix A). This specific training ensures that they are able to understand the needs of people who have had a stroke and
therefore plan their social care needs more appropriately for their life after stroke.

**Clinical psychologist**

NICE recommends that there should be a clinical psychologist in the multidisciplinary team. Ideally, this would be a clinical neuropsychologist, but it is acknowledged that there are not enough of these currently available. King’s acute stroke rehabilitation unit (appendix A) and the long-term stroke rehabilitation service at King’s (appendix B) both employ a clinical psychologist with specialism in neuropsychology. Both teams reflect that having a clinical psychologist with specialism in neuropsychology as a member of the multidisciplinary team has a clear direct benefit to patients with specific needs. They have also seen an indirect benefit to all patients, as the clinical psychologist’s neuropsychology expertise can influence the approaches taken by a variety of members of the multidisciplinary team.

**Enhancing the skills and expertise of the core multidisciplinary team**

Consider enhancing the expertise in stroke rehabilitation and knowledge of all the members of the multidisciplinary team by offering rotation opportunities between the different stroke rehabilitation services. This is implemented in the Bournemouth and Christchurch Stroke Early Supported Discharge Team (See the NHS stroke improvement programme chart of national stroke rehabilitation models, page 2, model 1), which enhances staff skills and knowledge by offering healthcare professionals the opportunity to rotate between the inpatient stroke unit, early supported discharge and neurology.

In order to use the workforce in the most effective, safe and cost-effective manner, consider what therapies and interventions could be delivered by assistants under the supervision of qualified professionals (Healthcare for London, [2009]).

The skills and expertise of the team could be enhanced through implementation of an interdisciplinary assessment process. This was undertaken at the Royal Bournemouth Hospital (appendix C) and resulted in development of professional roles, a more flexible workforce, the freeing up of
professional time to enable service delivery in specialist areas and increased interdisciplinary team working.

If access to staff with expertise in stroke rehabilitation is difficult because of geography or other factors, consider innovative ways to develop a core multidisciplinary team with the required knowledge, skills and expertise.

- Consider how expertise can be sought from other teams. For example, the REDS service access medical input from the community rehabilitation team
- Undertake a scoping exercise to identify what skills, expertise and knowledge are available across the locality. For example, this expertise may be in general community rehabilitation teams or inpatient rehabilitation services. Identify:
  ◊ gaps in skills and experience
  ◊ areas of expertise that could be shared
  ◊ areas of overlap in groups of skills possessed across the locality.
  - Using this information, consider developing a tailored workforce development programme to modify job descriptions, access areas of expertise within the area, and start training and development of competencies to address gaps. This kind of workforce and skill development was undertaken in North Lincolnshire and Dorset.

Beyond the core multidisciplinary team - enhancing access to additional expertise and services

It is recognised that there are a range of other services that people may require after a stroke, not covered by the core MDT, but vital in providing a comprehensive service. Rehabilitation services should be aware of the importance of speedy access to a range of additional health professionals such as dietitians, continence advisers, orthoptists, orthotists and pharmacists [page 83]. The King’s long-term inpatient service (appendix B) contract in orthotics and prosthetics services, and King’s acute stroke rehabilitation unit (appendix A) accepted referrals for a clinical psychologist with specialism in neuropsychology from the local Early Supported Discharge team.
Consider developing easy access to ancillary services offered by the nearby acute services, including ophthalmology, neuropsychiatry, older adult psychiatry, orthoptics, podiatry and orthotics.

Although not core members of the multidisciplinary team as recommended by NICE, stroke rehabilitation services consider the following to be part of their multidisciplinary team: discharge coordinators, pharmacists, dietitians, activities coordinators, volunteers and team coordinators (King’s acute stroke rehabilitation unit [appendix A], long-term stroke rehabilitation service at King’s [appendix B]).

Check the availability of local charities and support organisations to see if their input can enhance the qualities of the multidisciplinary rehabilitation team. In areas where this has been done the charity is integral to the service model. King’s long-term rehabilitation service receives input from external services such as the Stroke Association (appendix D) and Headway.

It is anticipated that some of the suggestions above for enhancing skills and expertise of the core multidisciplinary team could also be applicable to enhancing the skills and abilities of those delivering these important additional services.

When looking to enhance access to additional expertise and services it will be important that clear communication and referral routes, with outlined ways of working are developed. This will be expanded upon in the later section on setting up a community stroke rehabilitation service.

**Communication with patients and their families**

It is very important to document and communicate information to patients and their families on the structure of the stroke pathway, what will happen and the responsibilities of individual team members. [page 83].
**Multidisciplinary stroke rehabilitation team – useful resources**

<table>
<thead>
<tr>
<th>Resource</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stroke Improvement Programme</strong>&lt;br&gt;Education of stroke skilled staff webpage</td>
<td>This webpage provides resources to help develop a skilled multidisciplinary staff in the community environment.</td>
</tr>
<tr>
<td><strong>Stroke Specific Education Framework</strong></td>
<td>The aim of the SSEF is to facilitate both the recognition and addition of stroke-specific knowledge and skills to the generic skills that health, social, voluntary and independent care staff already possess. This will ensure nationally recognised, quality-assured and transferable education and learning programmes in stroke.</td>
</tr>
</tbody>
</table>
| **Stroke Improvement Programme, supplementary specialist services** | This webpage provides links and ideas for how services can deliver stroke rehabilitation that can be tailored along the whole of the pathway and be flexible to the patient’s needs. Examples include:  
  - Splinting in neurology  
  - Speciality nurse services  
  - Specialist dietetic services  
  - Functional electrical stimulation  
  - Specialist spasticity management clinics |
Models of stroke rehabilitation care and transfer of care between services

Relevant recommendations

- People with disability after stroke should receive rehabilitation in a dedicated stroke inpatient unit and subsequently from a specialist stroke team within the community. [1.1.1]

- An inpatient stroke rehabilitation service should consist of the following:
  - a dedicated stroke rehabilitation environment
  - a core multidisciplinary team (see recommendation 1.1.3) who have the knowledge, skills and behaviours to work in partnership with people with stroke and their families and carers to manage the changes experienced as a result of a stroke.
  - access to other services that may be needed, for example:
    ◊ continence advice
    ◊ dietetics
    ◊ electronic aids (for example, remote controls for doors, lights and heating, and communication aids)
    ◊ liaison psychiatry
    ◊ orthoptics
    ◊ orthotics
    ◊ pharmacy
    ◊ podiatry
    ◊ wheelchair services
  - a multidisciplinary education programme. [1.1.2]

Discharge planning and transfer of care from hospital to community

- Offer early supported discharge to people with stroke who are able to transfer from bed to chair independently or with assistance, as long as a safe and secure environment can be provided. [1.1.8]

- Early supported discharge should be part of a skilled stroke rehabilitation service and should consist of the same intensity of therapy and range of multidisciplinary skills available in hospital. It should not result in a delay in
delivery of care. [1.1.9]

- Hospitals should have systems in place to ensure that:
  - people after stroke and their families and carers (as appropriate) are involved in planning for transfer of care, and carers receive training in care (for example, in moving and handling and helping with dressing)
  - people after stroke and their families and carers feel adequately informed, prepared and supported
  - GPs and other appropriate people are informed before transfer of care
  - an agreed health and social care plan is in place, and the person knows whom to contact if difficulties arise
  - appropriate equipment (including specialist seating and a wheelchair if needed) is in place at the person’s residence, regardless of setting. [1.1.10]

- Before transfer from hospital to home or to a care setting, discuss and agree a health and social care plan with the person with stroke and their family or carer (as appropriate), and provide this to all relevant health and social care professionals. [1.1.11]

- Before transfer of care from hospital to home for people with stroke:
  - establish that they have a safe and enabling home environment, for example, check that appropriate equipment and adaptations have been provided and that carers are supported to facilitate independence and
  - undertake a home visit with the person unless their abilities and needs can be identified in other ways, for example, by demonstrating independence in all self-care activities, including meal preparation, while in the rehabilitation unit. [1.1.12]

- On transfer of care from hospital to the community, provide information to all relevant health and social care professionals and the person with stroke. This should include:
  - a summary of rehabilitation progress and current goals
  - diagnosis and health status
  - functional abilities (including communication needs)
  - care needs, including washing, dressing, help with going to the toilet and eating
- psychological (cognitive and emotional) needs
- medication needs (including the person’s ability to manage their prescribed medications and any support they need to do so)
- social circumstances, including carers’ needs
- mental capacity regarding the transfer decision
- management of risk, including the needs of vulnerable adults
- plans for follow-up, rehabilitation and access to health and social care and voluntary sector services. [1.1.13]

- Ensure that people with stroke who are transferred from hospital to care homes receive assessment and treatment from stroke rehabilitation and social care services to the same standards as they would receive in their own homes. [1.1.14]

- Local health and social care providers should have standard operating procedures to ensure the safe transfer and long-term care of people after stroke, including those in care homes. This should include timely exchange of information between different providers using local protocols. [1.1.15]

- After transfer of care from hospital, people with disabilities after stroke (including people in care homes), should be followed up within 72 hours by the specialist stroke rehabilitation team for assessment of patient-identified needs and the development of shared management plans. [1.1.16]

- Provide advice on prescribed medications for people after stroke in line with recommendations in Medicines adherence (NICE clinical guideline 76). [1.1.17]

**Long-term health and social support (review)**

- Review the health and social care needs of people after stroke and the needs of their carers at 6 months and annually thereafter. These reviews should cover participation and community roles to ensure that people’s goals are addressed. [1.11.5]

**Relevant quality statements from NICE stroke quality standard**

- **Statement 6.** Patients who need ongoing inpatient rehabilitation after completion of their acute diagnosis and treatment are treated in a specialist stroke rehabilitation unit.

- **Statement 10.** All patients discharged from hospital who have residual
stroke-related problems are followed-up within 72 hours by specialist stroke rehabilitation services for assessment and ongoing management.

- **Statement 11.** Carers of patients with stroke have: a named contact for stroke information; written information about patient's diagnosis and management plan; and sufficient practical training to enable them to provide care.

**Stroke rehabilitation service introduction**

The NICE clinical guideline defines a stroke rehabilitation service as a stroke service designed to deliver stroke rehabilitation either in hospital or in the community.

**Monitoring the effectiveness of the stroke rehabilitation service**

It is important to establish systems for measuring the effectiveness of the service so you can understand the impact of the changes you have made and continue to ensure delivery of a high-quality service. Measurement of the service is beyond the scope of this document but is covered in detail on pages 30–33 of *Going up a gear*, on the NHS Stroke Improvement Programme website Measuring quality, impact and outcomes webpage, or in the Key Performance indicator and C-QUIN documents available on the Stroke Improvement Programme website.

**Involving people with stroke and their families and carers in the planning, development, delivery and monitoring of services**

This element of service will be detailed throughout this document, but this section points to some specific resources. It is important regularly use feedback from patients, their families and carers to inform service development. This is supported by quality Marker 4 of the National Stroke Strategy, which recommends that ‘People who have had a stroke and their carers are meaningfully involved in the planning, development, delivery and monitoring of services. People are regularly informed about how their views have influenced services’. The NHS improvement website contains resources from presentations, case studies and a dedicated webpage which detail how
this could be implemented. Appendix E shows how Bournemouth Social Services use their service users’ views to develop services.

Models of service organisation

The NHS Stroke Improvement Programme\(^4\) website has a dedicated webpage for stroke rehabilitation service models. This page contains links to standards, benchmarking and relevant guidance. In particular this page contains a link to a chart of national stroke rehabilitation models. This chart includes information on service specifications, presentations, outcome measures used, staffing levels, outcome reports, details of operational service delivery and support systems.

For ease of presentation 4 broad categories of service models have been identified below. These are:

- acute inpatient rehabilitation
- continuing specialist inpatient rehabilitation
- community rehabilitation
- early supported discharge.

However, it is recognised that different services are delivered in different ways that reflect the different local needs, geographical requirements, existing services and financial background. The NHS stroke improvement programme chart of national stroke rehabilitation models details many of these models and includes:

- early supported discharge only, acute outreach (model 1)
- collaboration between inpatient services and surrounding community teams (model 2)
- combined early supported discharge and community teams (model 3)
- combined early supported discharge with longer-term rehabilitation, in-reach service to acute (model 4)

\(^4\) NHS Improvement now closed although the website remains live. This NICE document will be reviewed in December 2013 to ensure Stroke Improvement Programme links in this document remain live. NHS Improving Quality (NHS IQ) now exists to bring together the wealth of knowledge, expertise and experience of a number of former NHS improvement organisations.
stroke early supported discharge service within a community rehabilitation team (model 5).

**Acute inpatient rehabilitation**

The NICE guideline defines a stroke unit as an environment in which multidisciplinary stroke teams deliver stroke care in a dedicated ward which has a bed area, dining area, gym, and access to assessment kitchens. There is clear evidence that outcomes for patients with residual disability are better when managed in a dedicated stroke rehabilitation unit in the 2-week period after stroke. The GDG acknowledged that in the rehabilitation unit people would be assessed to see if early supported discharge is suitable for them, or if they should remain on the stroke rehab unit [page 77].

Inpatient rehabilitation in the acute setting should begin as soon as is appropriate for the patient. It is therefore important to ensure that acute stroke units are able to offer access to an inpatient stroke rehabilitation service comprising of professionals with expertise in stroke rehabilitation. For the context of this implementation advice the acute inpatient rehabilitation is considered to be offered for up to 21 days.

The [Stroke Unit Trialists’ Collaboration](#) conducted a review of evidence on organised inpatient stroke unit care to assess the effect of stroke unit care compared with alternative forms of care for patients after a stroke. They concluded that acute stroke patients are more likely to survive, return home and regain independence if they receive organised inpatient stroke unit care, and that this is typically provided by a coordinated multidisciplinary team which operates within a separate stroke ward and can offer a substantial period of rehabilitation if needed. The Trialists’ Collaboration recommended that stroke units should aim to replicate the following core service characteristics identified in the randomised trials:

- coordinated multidisciplinary rehabilitation involving coordinated multidisciplinary team care and incorporating meetings at least once per week
multidisciplinary medical, nursing and therapy staff (therapy staff usually includes physiotherapy, occupational therapy, speech therapy and social workers) with specialist interests in stroke or rehabilitation

routine involvement of families and carers in the rehabilitation process

regular programmes of education and training.

Appendix A provides details of the King’s acute inpatient stroke rehabilitation unit and show how these characteristics are incorporated into their service.

In order to ensure that services are offered to the patients they are most suitable for, undertake an assessment of patients’ needs and decide whether the service will be able to help patients meet their rehabilitation potential and goals.

The assessment process could be enhanced through the implementation of an interdisciplinary assessment process. This was undertaken at the Royal Bournemouth Hospital (appendix C) resulted in improved patient centred care.

**Continuing specialist inpatient rehabilitation (medium term)**

For the context of this implementation advice, Continuing specialist inpatient rehabilitation (medium term) is considered to be offered after 21 days post stroke.

It is acknowledged that offering an inpatient service for people 21 days post stroke rehabilitation may not be available to the majority of patients however, London have undertaken work in order to make this possible for some services in their area.

A small proportion of people with stroke may need continuing specialist inpatient rehabilitation in the medium term. There should be access to non-acute inpatient rehabilitation for people with a high level of dependency who would not benefit from further acute inpatient input but for whom transfer into the community at that stage is not appropriate (Healthcare for London 2009).

This care could be delivered in dedicated non-acute inpatient facilities. Healthcare for London advise that generic settings such as intermediate care
beds are not appropriate for this continuing specialist rehabilitation (Healthcare for London 2009).

You may consider offering this service to stroke patients through a neuro-specialist long-term rehabilitation unit. This is the model offered by King’s long-term rehabilitation service (appendix B), which provides a long-term rehabilitation service for patients with neurological injury including stroke patients who have level 1 and 2 needs.

In order to ensure that patients will have maximum gain from the service, it is important that they undergo thorough assessment to identify their needs.

**Visits and preparation for transfer**

It will be important to help prepare the patient for transition to the community prior to discharge. A range of methods could be used including, sessions dedicated to discussing routines and changes on discharge, ward leave and home visits and organising for the patient to meet the teams they will be having input from prior to transfer. The way in which community and early supported discharge teams could ‘in reach’ and can facilitate the transfer are detailed later in this section.

The early supported discharge team featured in the REDS QIPP case study carry out a home access visit to ensure all equipment is in place and a discharge visit before transferring a person, to ensure the person’s safety at home. However, home visits are not needed for all patients.

Clinical indications for home visits may include:

- the need to assess whether the person can move around their home and manage necessary transfers (for example, from bed to chair) with or without equipment
- cognitive or perceptual impairments in a person being considered for transfer, as these may need to be assessed in the person’s normal environment to help the team decide whether the person can safely return home. [page 121-122]
Home visits or ward leave may be needed to help patients adjust to moving back home if they have altered abilities after their stroke. [page 121-122]

Home visits may not be needed if enough information (measurements, photographs and so on) can be obtained to carry out 'mock-up home visits in hospital' to fully assess a patient's abilities. [page 121-122]

There should be locally agreed situations in which home visits would and wouldn't be conducted, and in what situations professionals other than occupational therapists could conduct them. Although home visits are commonly carried out by an occupational therapist, at times it may be appropriate for the visit to be carried out by other members of the multidisciplinary team (for example a physiotherapist), depending on the reason for the home visit. This could be overseen by an occupational therapist with knowledge of environmental risk assessment, equipment provision and adaptation. [page 121-122]

**Follow up after transfer from inpatient rehabilitation**

It is important for follow-up to be undertaken by the stroke rehabilitation team once the person transfers to the community. This will help to ensure management plans have been followed and to identify any needed further support. This is in line with statement 10 in the NICE Stroke quality standard. [page 122]

**Community rehabilitation**

**Introduction**

Within community stroke rehabilitation services there are a number of models of delivery making it difficult in this generic document to exactly define the characteristics, for example the point in the patient’s care pathway when they would be admitted to a community stroke rehabilitation programme or the average length of patient stay. For the purpose of this document, community stroke rehabilitation is taken to mean the rehabilitation services patients receive on leaving hospital or a stroke early supported discharge service. Sometimes the term stroke early supported discharge service is used
interchangeably with community stroke rehabilitation services. However, early supported discharge is distinct from community rehabilitation because of the intensity and specificity of the early supported discharge service. Therefore, this document has separated these two types of services. Early supported discharge is covered in detail in the next chapter. Although the two types of service have been separated for the purpose of this document it is anticipated that the information and detail in both chapters will be helpful to both types of service and so should be read in conjunction with each other.

Core service characteristics of an inpatient stroke unit are taken from the Stroke Trialists' Collaboration review. The GDG highlighted that although the evidence comes from inpatient stroke units it is equally appropriate for early supported discharge community teams.

Healthcare for London stated that it is important that all areas have an effective community rehabilitation team with specialist stroke skills, who are available to all people for whom it is clinically appropriate. They stated that community rehabilitation should be a simple, coherent and easy to navigate service. This service should have a single point of entry, no waiting lists and be accessible to all people with stroke. It should be designed around the needs and goals of the individual, and the person who has had a stroke should be assessed by a specialist stroke multidisciplinary team that will determine the best use of their own resources.

The Stroke Improvement Programme team have developed 2 documents (Going up a gear and Practical principles for developing a community stroke service) detailing top tips for setting up community stroke rehabilitation services. These are:

- Agree a clear process; agree the shape of the service including designing admission criteria, workforce reconfirmation, metrics and exit strategies, review useful exiting material and resources, visit an established service to see how it is organised. Be mindful of the NICE recommendations that people with stroke who are transferred from hospital to care homes receive assessment and treatment from stroke rehabilitation services to the same standards as they would receive in their own homes. It will be important
that the service is able to offer this. The NICE costing report recognises that this may have a significant resource impact and recommends that this should be reviewed at a local level. The NICE costing report and template provides information to help organisations plan for the financial implication.

- Proactively recruit patients to the community service Community teams found benefit in proactively seeking patients for whom community rehabilitation or early supported discharge would be suitable while they were still in hospital (in-reach). Teams managed to eliminate waiting lists, smoothed the transfer of care, made the service more efficient and better for patients, shortened length of stay, and speeded up access for all people with stroke at the optimum point in their recovery process.

- Develop a flexible, stroke-skilled workforce. This is also discussed on page 11 of this implementation advice. The configuration of the community team is less important than ensuring that there is a specialist stroke team and that the multidisciplinary and that all members have the right expertise in stroke rehabilitation to help rehabilitate people with stroke. The examples showcased discussed innovative ways to ensure suitable skills, such as developing core competencies for bands of staff based on all professionals represented in the team and freeing up the time of those with specialist skills by enhancing administrative support and databases.

- Identify and use all services and delivery partners. Time and resources can be saved by mapping and engaging those who provide existing services, across primary and secondary care, social care and other local authority services, and the voluntary sector, to ensure they are accessible to people with stroke. This process can also uncover untapped existing opportunities for people with stroke and their families and carers, and can lead to efficiency gains. (Going up a gear) (Stroke association appendix D). Where expertise is gained from other teams and services, clear communication, and referral routes, with outlined ways of working, sometimes across services or agencies, should be made available. Stepped care models such as that described in the Stroke Improvement Programme Psychology publication, should be considered to ensure that access to those highly specialised staff is used appropriately by those with the highest needs, with
other levels of the organisation fielding and managing the lower levels of needs.

- Understand the financial flow; hold meetings between all relevant stakeholders, with open discussion possibly needed to understand the existing flow of money and to identify how this could be accessed to support community stroke service. The following principles are listed:
  - clarify existing local patient pathways
  - focus on what is best for patients
  - agree principles of new local service model and tariff structure
  - ensure data systems are in place to monitor patient and financial flows
- Secure buy-in from all stakeholders across the pathway
- Ensure there is joined up working with social care and the ‘real world’.
  Successful services have clear exit strategies for people with stroke that enable real social integration, a joined up approach to goal setting that makes it meaningful and relevant, and a seamless transition from health rehabilitation to social care (more information about integration of health and social care can be found further on in this document)
- Establish robust data collection mechanisms to demonstrate the value of the service, and collect from qualitative and quantitative metrics using simple non-time-consuming processes.
- Find a strategic voice. Strong leadership is needed, and should be integrated within stroke services at a strategic level, maintaining strong links across the pathway.

**Early supported discharge**

**Introduction**

As highlighted above, early supported discharge is distinct from community rehabilitation because of the intensity and specificity of the early supported discharge service. Therefore, this document has separated these two types of services. Community stroke rehabilitation was covered in detail in the previous chapter. Although the two types of service have been separated for the purpose of this document it is anticipated that the information and detail in
both chapters will be helpful to both types of service and so should be read in conjunction with each other.

Early supported discharge services should be able to offer similar intensity of therapy and range of multidisciplinary skills to that available in hospital, with fewer delays to delivery [page 114].

Healthcare for London advise their commissioners that when effective community rehabilitation teams are in place, early supported discharge services should be offered

In a study by Langhorne et al. (2007) reviewing the evidence for early supported discharge they defined an early supported discharge intervention as one that aims to accelerate transfer from hospital with the provision of rehabilitation and support in a community setting. They concluded that for stroke patients in hospital, input from an early supported discharge service (that provides early assessment in hospital, coordinated transfer and post-transfer support) can accelerate their transfer home and increase their chance of being independent in the longer term. The best results are likely to be seen with well-resourced and coordinated early supported discharge teams and with patients with less severe stroke symptoms. They noted that uncertainties remain about the essential characteristics of an effective early supported discharge service, whether they can be effective in more dispersed rural communities, and the balance of cost and benefit in different patient groups. This document will later showcase some innovative solutions in rural communities that have an early supported discharge service.

Setting up an early supported discharge service – developing a business case

The NICE costing report and template for stroke rehabilitation contains comprehensive information to help you calculate the cost implications locally of an early supported discharge service.

Evidence reviewed to develop this guideline suggests that early supported discharge is at least as effective as usual care, and there is evidence that it is
also likely to have lower costs. Early supported discharge represents a cost-effective intervention for stroke patients.

**Setting up an early supported discharge service – steps for an effective service**

The following sources indicate steps to take to develop an effective early supported discharge service:

- Healthcare for London
- Stroke Improvement Programme via their [practical principles of developing an early supported discharge service](#)
- the REDS QIPP case study
- Devon
- Berkshire West Primary Care trust.

They recommend that service providers should:

- Undertake demand and capacity modelling, and work out the number of patients who will be entering early supported discharge pathways. Be mindful of the NICE recommendations that people with stroke who are transferred from hospital to care homes receive assessment and treatment from stroke rehabilitation services to the same standards as they would receive in their own homes. It will be important that the service is able to offer this. The [NICE costing report](#) recognises that this may have a significant resource impact and recommends that this should be reviewed at a local level. The NICE costing report and template provides information to help organisations plan for the financial implication.
- Agree a clear process; agree the shape of the service including the admission criteria, workforce reconfirmation, metrics and exit strategies, review useful exiting material, visit an established service to see how it is organised. It is important that the service is designed to be patient centred and needs led.
- Fit within the stroke pathway:
- Consider if the early supported discharge service could be set up within the framework of a current service, for example within an existing community rehabilitation team.
- It is important that the transition into early supported discharge services from the acute setting is seamless.
- Consider how the early supported discharge service fits within the context of existing services and that it does not destabilise them or disadvantage other groups.

- **Understand the financial flow:**
  - Factor into business models the potential savings documented by case studies of early supported discharge services. Savings are reported from shorter hospital stays, reductions in readmissions, reductions in recurrent cerebral events and associated complications, promotion of patient health and reductions in dependence on ongoing social service packages of care.
  - Joint commissioning in partnership with a wide stakeholder group (considering involvement of charities and support organisations) is seen to be a good model of practice
  - Hold meetings with all relevant stakeholders, with open discussion possible needed to understand the existing flow of money and to identify how this could be accessed to support early supported discharge. The following principles are listed:
    - clarify existing local patient pathways
    - focus on what is best for patients and involve patients and cares in identifying this. For example in some services, patients requested one day off therapy per week and the service was re-planned around this
    - agree principles of new local service model and tariff structure
    - ensure data systems are in place to monitor patient and financial flows.

- **Secure buy-in from all stakeholders across the pathway.**
  - Ensure buy-in of local authorities and commissioners.
  - Include the local stroke unit in the development of the early supported discharge pathway, and consult with them on the referral process.
It will be particularly important to factor into the model clear responsibility for who will meet the social care needs of patients in the early supported discharge pathway, as this is a vulnerable group of people who have high needs on transfer to the early supported discharge service.

- Establish robust data collection mechanisms to demonstrate the value of the service, and collect from qualitative and quantitative metrics including patient satisfaction information and using simple non-time-consuming processes.
- Find a strategic voice. Strong leadership is needed, and should be integrated within stroke services at a strategic level, maintaining strong links across the pathway.

More information and resources can be found on the Stroke Improvement Programme [webpage for key principles for setting up an early supported discharge service](#).

The examples from practice in this document showcase what other organisations have implemented, but it is acknowledged that when developing an early supported discharge service the exact model of delivery will reflect the different local needs, geographical requirements, existing services and financial background. A document from [Stroke Improvement Programme about early supported discharge](#) provides short descriptions of 6 different models of early supported discharge. These models are from urban areas such as Portsmouth, which offers specialist intense interdisciplinary early supported discharge 365 days per year; and rural areas such as Scunthorpe, where there is no access to community stroke-specific care for patients on transfer from the stroke unit and instead the inpatient rehabilitation service has developed outreach services for rehabilitation outside hospital.

**Early supported discharge services in remote and rural communities**

The Stroke Improvement Programme recognises the challenges and barriers to developing specialist stroke rehabilitation early supported discharge services in rural and remote areas, and has developed a [specific webpage for rural and remote areas](#) containing resources to help services overcome the challenges. Stroke Improvement Programme, in their [key considerations](#).
within a rural community service for stroke document, identify that coordinating staff activity is essential to ensure effective utilisation of resources when developing an early supported discharge service in a rural setting. Therefore organisers should allow for:

- in-reach and liaising with acute providers
- membership of multidisciplinary teams
- journey planning and timetabling visits
- clustering workloads around localities
- flexible working patterns to support home working for data inputting, note writing and other activities

Services, including those not specifically in rural or remote areas, may find the innovative solutions and principles detailed in the key considerations within a rural community service for stroke document useful for enhancing their own services further.

Identification of patients for whom early supported discharge would be suitable – suggested actions and examples from practice

Acute and inpatient stroke units refer patients if early supported discharge is suitable for them. Although early supported discharge is suitable for a large number of patients, it is not suitable for all. For some patients, rehabilitation in hospital would be more appropriate. It is important in early supported discharge to maximise the potential the patient can gain, and to ensure that the service is as cost effective as possible only appropriate patients should be referred [page 115].

To mitigate the risks of inappropriately removing patients from the supportive environment of the stroke unit, REDS suggest the following processes are completed or in place before transfer:

- neurological assessment is carried out by early supported discharge team
- access visit is completed to ensure suitable home environment
- equipment is installed
- transfer is facilitated by experienced team
• day- and night-sitting service is available (when needed).

Seamless transfer from acute unit to early supported discharge
Application of the steps to setting up an early supported discharge detailed earlier in this document, for example integrating the early supported discharge service within the current pathway, will assist a seamless transfer.

Below are some more specific steps that services (Berkshire West Primary Care trust, REDS team and Devon) have implemented in order to facilitate a seamless transfer.

• Clear referral processes and treatment pathways should be in place and the transfer date should be clear to all.
• Existing community rehabilitation teams should also be engaged in the early supported discharge process and the patient's GP should be kept fully informed [page 114].
• Consider ‘in-reach’ from the early supported discharge team to the acute unit. This could be achieved by members of the early supported discharge team regularly attending multidisciplinary team meetings and ward rounds, and visiting patients and families.
• In order to speed up the referral process, consider referrals at any time of the day, using:
  – phone, possibly mobile phone to the early supported discharge team leader
  – secure emails
  – if appropriate the community rehabilitation team single point of access instead of referral forms
  – ward rounds when early supported discharge team members are in attendance.
• In order to ensure everything is in place on transfer consider:
  – giving responsibility for the transfer process (checking of medications, belongings, coordinating receipt of discharge summaries and onward referral including outpatient visits) to the early supported discharge team
– visiting the patient at home on the day of transfer
– escorting the patient home and providing the transport.

- Consider a model in which the early supported discharge team is hosted by the acute stroke unit. This hospital outreach model ensures the early supported discharge team works closely with ward-based staff

- It is important that early support discharge teams provide a point of contact for patients and their families. Many early supported discharge teams provide each patient with a keyworker.

**Delivery of the early supported discharge rehabilitation programme**

As identified earlier, the exact model of any rehabilitation programme will depend on local circumstances. Of the case studies reviewed ([Berkshire West Primary Care trust, REDS, Devon](#)) and in the [chart of national stroke rehabilitation models](#) (North Devon Early Supported Discharge Service, page 3, model 3 and Leeds community stroke team page 7, model 3), the following different features of an early supported discharge service were noted:

- daily (at least 1-hour) multidisciplinary rehabilitation at home for up to 6 weeks.
- 07:30 – 21:00, 7 days per week.
- enabling services including day sitting and night sitting
- 6-week-long programmes (although some programmes lasted for up to 16 weeks)
- giving patients a ‘day off’ per week (patient and family and carer requests) and tapering therapy towards the end of the programme in order to avoid an abrupt end.
- delivery of interventions and support by telephone, face to face and groups
- weekly team meetings with therapists and enabling families and carers to review and update care plans.
**Engagement with community rehabilitation teams (transfer of care) – suggested actions and examples from practice**

Note that the suggested actions and examples of practice in this section also relate to the transfer of care from the stroke unit to the early supported discharge service.

It is believed that getting the transfer of care right has an impact on the whole stroke pathway. A review of 2 documents from the Stroke Improvement Programme (Going up a gear and the Case studies from Stroke Improvement Programme projects, page 22) and the QIPP REDS case study has identified steps to improve the quality of transfer:

- Ensure the service is fully integrated with community rehabilitation services, as this enhances the seamless transfer of care and is beneficial to the long-term care and rehabilitation of patients with stroke.
- Communicate with the patient’s GP on transfer to ensure medication adherence by requesting medication repeat prescriptions.
- Manage the health and social care interface (this will be explored in more detail in the Health and social care interface section). Consider basing the stroke health and social care teams in the same building, and preferably in the same room.
- Involve patients in improving transfer of care. Establish the patients’ and their families’ and carers’ perspectives of stroke services and use these views to make significant changes to the service. Use a variety of tools to involve patients and families and carers to see what stage the service is at and what needs to change.
- Provide emotional support for people with stroke and their families and carers. Actively include the patient and family in decisions about leaving hospital at the earliest appropriate opportunity, and nominating a single point of contact for people with stroke after hospital discharge.
- Ensure access to appropriate services, including rehabilitation and community services:
This can be facilitated by integrating the early supported discharge service into community rehabilitation services.

Key working and provision of intervention summaries to all relevant stakeholders (the local stroke unit, GPs, families and carers) facilitates seamless transfer of care to social services or further community rehabilitation.

A champion should be nominated to drive improvement in each organisation.

Consider in reach from charities and support organisations to enhance access to community services. In some services, a Stroke Association (appendix D) worker comes to the multidisciplinary team meetings and will pick up referrals for people needing community support for benefits advice etc.

**Reviews**

When developing the guideline the experts identified that reviews need to be done in order to pick up any problems or difficulties. This is in line with the National Stroke Strategy [page 557].

Following a review of case studies and publications (REDS team, King’s College Hospital long-term rehabilitation service [appendix B], Lambeth community health and Learning from existing work) the following steps helped implementation of the reviews and enhanced their quality and benefit:

- ensuring patient and family and carer input into service development
- developing and implementing a protocol for coordinating stroke reviews with social care services
- identifying joint funding between health and social care
- developing metrics and data collection processes in conjunction with key stakeholders in the stroke pathway
- including measures that can be used to identify change over time
- using the data coming out of reviews to review your service – they may highlight gaps earlier in the pathway
• using standardised forms so that every review in your area covers the same information, regardless of who delivers it
• ensuring that all reviewers have a broad range of stroke-specific knowledge, and offering competency-based training when necessary
• giving patients and their families and carers a copy review outcome and provide details of who to contact for more information
• for continuity, linking the information from 6-week, 6-month and annual reviews so each reviewer can build on previous discussions
• ensuring reviews are integrated within the local stroke pathway and that everyone in the pathway knows their responsibilities at each stage
• having early supported discharge teams conduct the review at 6 months after patients were discharged from the service
• considering referral back to specific components of the rehabilitation services if the patient’s needs are identified, or referral to other rehabilitation services if the patient’s needs cannot be met locally.

Further information from Stroke Improvement Programme including case studies can be accessed on their Stroke review webpage.

Models of stroke rehabilitation care – useful resources

Community stroke care

<table>
<thead>
<tr>
<th>Reference</th>
<th>Summary</th>
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</thead>
<tbody>
<tr>
<td>NHS Stroke Improvement Programme, Community stroke resource</td>
<td>This webpage brings together and shares the learning and information the Stroke Improvement Programme has gathered so far about community stroke services. This collection includes evidence from literature and research, business cases, inspirational presentations and documentation related to community stroke services. It is designed to support innovative practice and the sharing of knowledge across rehabilitation.</td>
</tr>
<tr>
<td>NHS Stroke Improvement Programme, Measuring quality, impact and outcomes in community stroke teams</td>
<td>This webpage contains examples of how community stroke teams are measuring clinical outcomes and providing performance reports to measure the quality and impact of community stroke</td>
</tr>
<tr>
<td>Source</td>
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</table>
| **NHS Stroke Improvement Programme,**  
*Patient and public engagement in community teams and stroke services* | This webpage considers ideas and resources available to assist community teams and stroke services considering how to meet the needs of the local population. |
| **South London Cardiac and Stroke Network,**  
*Community rehabilitation and Early supported discharge service specifications* | This document is for services within the South London Cardiac and Stroke Network, but others may find it helpful. The aim of the document is to ensure access to a stroke specialist community rehabilitation team for everyone it would be clinically appropriate for, and to:  
- maximise rehabilitation and recovery after illness or injury  
- minimise premature dependence on long-term institutional care  
- promote independence and prevent inappropriate hospital stays  
- enable eligible stroke patients to be transferred early and receive rehabilitation in their own home at the same intensity as they would in inpatient care, enabling more patients to recover and rehabilitate at home. |
## Early supported discharge

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>South West London Cardiac and Stroke Network (2009) <em>Early supported discharge service requirements</em></td>
<td>This document details the service requirements for an early supported discharge service in South London. This would be useful for someone looking to develop an early supported discharge service, as it lists suggested standards, details of which patients early supported discharge would and would not be suitable for and the characteristics of a good early supported discharge service.</td>
</tr>
<tr>
<td>NHS Stroke Improvement Programme, <em>Early supported discharge</em></td>
<td>This webpage contains a wide variety of resources to support the development of early supported discharge services, including information about delivery models, commissioning, business cases and economics.</td>
</tr>
<tr>
<td>NHS Stroke Improvement Programme, <em>Stroke commissioning information</em></td>
<td>This webpage provides resources to support commissioning in stroke services relating to early supported discharge, commissioning services to support self-care and commissioning services between health and social care services.</td>
</tr>
</tbody>
</table>
## South London Cardiac and Stroke Network, *Commissioning guidance: six month reviews after stroke*

This guidance from the South London Cardiac and Stroke Network seeks to answer the following questions, focusing on 6-month review:

- What should a review consist of?
- Who should lead the review?
- How should it be delivered? What are the benefits?
- What are the resource implications?

## NHS Stroke Improvement Programme, *Review*

This webpage provides onward links to case studies, projects and evidence about reviews after stroke.

<table>
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<tr>
<td>South London Cardiac and Stroke Network, <em>Commissioning guidance: six month reviews after stroke</em></td>
<td>This guidance from the South London Cardiac and Stroke Network seeks to answer the following questions, focusing on 6-month review:</td>
</tr>
<tr>
<td>NHS Stroke Improvement Programme, <em>Review</em></td>
<td>This webpage provides onward links to case studies, projects and evidence about reviews after stroke.</td>
</tr>
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</table>
Return to work

The NICE stroke rehabilitation guideline makes recommendations on a variety of interventions and components of a stroke rehabilitation programme. It is considered that work is one of a range of participation roles which needs to be considered in a comprehensive rehabilitation programme. Information gathered during guideline development, identified ‘return to work’ as a key area which has significant implementation challenges and where further information to help users implement the guideline would be useful. This document will therefore focus on return to work in this section.

Relevant recommendations

- Return-to-work issues should be identified as soon as possible after the person’s stroke, reviewed regularly and managed actively. Active management should include:
  - identifying the physical, cognitive, communication and psychological demands of the job (for example, multi-tasking by answering emails and telephone calls in a busy office)
  - identifying any impairments on work performance (for example, physical limitations, anxiety, fatigue preventing attendance for a full day at work, cognitive impairments preventing multi-tasking, and communication deficits)
  - tailoring an intervention (for example, teaching strategies to support multi-tasking or memory difficulties, teaching the use of voice-activated software for people with difficulty typing, and delivery of work simulations)
  - educating about the Equality Act 2010 and support available (for example, an access to work scheme)
  - workplace visits and liaison with employers to establish reasonable accommodations, such as provision of equipment and graded return to work. [1.10.5]
- Manage return to work or long-term absence from work for people after stroke in line with recommendations in Managing long-term sickness and
The National Stroke Strategy states that people should be encouraged in their participation roles. This strategy identifies that vocational rehabilitation programmes may enable a person to improve the structure of their day and engage in meaningful occupation while not returning to work [page 549].

Many of the conditions that prevent return to work are not immediately obvious. They include low self-esteem, low confidence, cognitive impairments, fatigue, low mood and depression\(^5\). Vocational rehabilitation services should ensure interventions aimed at treating these conditions, because this can have a significant impact on their ability to return to work [page 549].

For people of working age it is important for them to return to work from a personal perspective but also from a societal perspective. Services aimed at achieving this should explore a person’s needs and any obstacles stopping them from working as soon as possible in order to plan their return to the workplace [page 550].

It is acknowledged that there is a lack of evidence in this area and that there is no systematic way of assessing a person’s capacity for work, which components of a vocational intervention work, or what the duration of an intervention should be. However, there is national consensus around the key elements of vocational rehabilitation; namely analysis of the limitations (which may include visual, cognitive, physical or environmental), the demands of the job, the person’s level of education, tailored interventions, workplace visits and establishing workplace accommodations [page 550].

Experts also believe that it is important to support implementation of policies regarding return to work. Vocational rehabilitation has a role in helping the patient and the employers navigate these processes. Liaison with employers

is a key component of the Brain Injury Outreach Team OT service (appendix F).

Following a review of some vocational rehabilitation services, there appears to be two main ways in which Vocational Rehabilitation is delivered:

- Individualised vocational rehabilitation delivered as part of a person’s rehabilitation by a long term team, which entails more involvement and joint working with the patient and employer, than would be seen in generalized back to work training (see below). The Brain Injury Outreach Team OT service (appendix F) is an example of this.
  - The Brain Injury Outreach Team OT service (appendix F) is an example where vocational rehabilitation goals are set up as part of the rehabilitation plan. They use occupational therapist skills and knowledge of neurological rehabilitation as well as links with the multidisciplinary team, to help the person manage all of their daily activities. The service is not purely for Vocational Rehabilitation, as OT’s will be working across the breadth of their wider role, however for specific patients of working age, work (voluntary or paid) is one of the daily activities that they focus on.
  - The Brain Injury Outreach Team OT service (appendix F) tailors the intensity of the vocational rehabilitation to the needs of the person, within the patients wider rehabilitation programme. This can range from on/off phone advice to 24 months of intervention. The core components to the service are goal setting, activity analysis, education and multidisciplinary team working.

- The second way in which vocational rehabilitation is delivered is with more specialist back to work guidance and assessment, often run by Occupational Therapists working across disabilities and conditions. Vocational Rehabilitation is individualised and vocational goals are set with the service user. Goals may include developing work skills such as being able to concentrate, multitask, manage the daily routine and organising oneself. Vocational Services (Dorset Healthcare University NHS Foundation Trust) (appendix G) is an example of this.
Healthcare for London advise commissioners that community rehabilitation teams should assist appropriate people with stroke to access vocational rehabilitation.

**Vocational rehabilitation – Useful Resources**

<table>
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<tr>
<td>NHS Stroke Improvement Programme, <a href="#">Return to work</a></td>
<td>This webpage provides examples from practice of vocational rehabilitation models for stroke services.</td>
</tr>
<tr>
<td>College of Occupational Therapists <a href="#">Work Matters</a> online learning resource (sound starts when link opened) Additional information about this module can be found <a href="#">here</a></td>
<td>This e-learning package, developed in collaboration with healthcare professionals from across the sector, provides an essential guide for those wishing to learn more about work, vocational rehabilitation, the key drivers and how it relates to practice. It combines interactive materials, video and printable resources to provide users with a unique way to develop their understanding of vocational rehabilitation and the broader ‘work’ question. Learning points and reflective questions are included throughout the resource to ensure that users are engaged and active in their learning. It is an essential guide for anyone wanting to learn more about work, vocational rehabilitation, the key drivers and how it relates to practice.</td>
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Interface between health and social care

Relevant recommendations

Health and social care interface

- Health and social care professionals should work collaboratively to ensure a social care assessment is carried out promptly, where needed, before the person with stroke is transferred from hospital to the community. The assessment should:
  - identify any ongoing needs of the person and their family or carer, for example, access to benefits, care needs, housing, community participation, return to work, transport and access to voluntary services
  - be documented and all needs recorded in the person’s health and social care plan, with a copy provided to the person with stroke. [1.1.6]

- Offer training in care (for example, in moving and handling and helping with dressing) to family members or carers who are willing and able to be involved in supporting the person after their stroke.
  - Review family members’ and carers’ training and support needs regularly (as a minimum at the person’s 6-month and annual reviews), acknowledging that these needs may change over time. [1.1.7]

Transfer of care from hospital to community (please note these were also presented in the models of service chapter)

- Hospitals should have systems in place to ensure that:
  - people after stroke and their families and carers (as appropriate) are involved in planning for transfer of care, and carers receive training in care (for example, in moving and handling and helping with dressing)
  - people after stroke and their families and carers feel adequately informed, prepared and supported
  - GPs and other appropriate people are informed before transfer of care
  - an agreed health and social care plan is in place, and the person knows whom to contact if difficulties arise
  - appropriate equipment (including specialist seating and a wheelchair if needed) is in place at the person’s residence, regardless of setting.
• Before transfer from hospital to home or to a care setting, discuss and agree a health and social care plan with the person with stroke and their family or carer (as appropriate), and provide this to all relevant health and social care providers. [1.1.11]

• Before transfer of care from hospital to home for people with stroke:
  – establish that they have a safe and enabling home environment, for example, check that appropriate equipment and adaptations have been provided and that carers are supported to facilitate independence, and
  – undertake a home visit with the person unless their needs can be identified in other ways, for example, by demonstrating independence in all self-care activities, including meal preparation, while in the rehabilitation unit. [1.1.12]

• On transfer of care from hospital to the community, provide information to all relevant health and social care professionals and the person with stroke. This should include:
  – a summary of rehabilitation progress and current goals
  – diagnosis and health status
  – functional abilities (including communication needs)
  – care needs, including washing, dressing, help with going to the toilet and eating
  – psychological (cognitive and emotional) needs
  – medication needs (including the person’s ability to manage their prescribed medications and any support they need to do so)
  – social circumstances, including carers’ needs
  – mental capacity regarding the transfer decision
  – management of risk, including the needs of vulnerable adults
  – plans for follow-up, rehabilitation and access to health and social care and voluntary sector services. [1.1.13]

• Ensure that people with stroke who are transferred from hospital to care homes receive assessment and treatment from stroke rehabilitation and social care services to the same standards as they would receive in their own homes. [1.1.14]
• Local health and social care providers should have standard operating procedures to ensure the safe transfer and long-term care of people after stroke, including those in care homes. This should include timely exchange of information between different providers using local protocols. [1.1.15]

• After transfer of care from hospital, people with disabilities after stroke (including people in care homes), should be followed up within 72 hours by the specialist stroke rehabilitation team for assessment of patient-identified needs and the development of shared management plans. [1.1.16]

**Joint care planning and reviews**

• Documentation about the person’s stroke rehabilitation should be individualised, and should include the following information as a minimum:
  - basic demographics, including contact details and next of kin
  - diagnosis and relevant medical information
  - list of current medications, including allergies
  - standardised screening assessments (see recommendation 1.2.1)
  - the person’s rehabilitation goals
  - multidisciplinary progress notes
  - a key contact from the stroke rehabilitation team (including their contact details) to coordinate the person’s health and social care needs
  - discharge planning information (including accommodation needs, aids and adaptations)
  - joint health and social care plans, if developed
  - follow-up appointments. [1.2.15]

• Review the health and social care needs of people after stroke and the needs of their carers at 6 months and annually thereafter. These reviews should cover participation and community roles to ensure that people’s goals are addressed. [1.11.5]

**Introduction**

It is considered that managing the interactions between health and social care is essential for getting the transfer of care right.
Through a review of the considerations of the GDG, publications and examples from practice (King’s long-term rehabilitation service [appendix B], Bournemouth stroke coordination project [appendix E], St George’s Hospital, South London Healthcare Trust, REDS and Going up a gear), it is believed that the following steps will help enhance the interactions between health and social care.

**Timely involvement of social care and relaying of information**

- Involving social services as soon as they are needed, to ensure seamless transfer from primary to community care when social needs are identified [page 84 Delphi statement].
- Ensuring it is clear who is responsible for meeting the social care needs of this vulnerable group.
- Developing a local protocol drawn up between health and social care providers to ensure information is being relayed between both agencies before transfer. This will ensure a smooth discharge for the person and their families [page 121].
- Implementing policies for transfer and rapid assessment.
- Providing a single point of contact for people with stroke and their families and carers on transfer will also help ensuring relay of information.
- Integrating social care within the multidisciplinary team. This helps to ensure information is communicated, earlier referrals to social services are made and planning support for transfer is conducted adequately. The ways in which integrations are facilitated include:
  - social workers visiting the stroke rehabilitation unit daily and attending ward rounds and/or multidisciplinary team meetings
  - development of joint health and social care systems if both health and social care input information to people’s multidisciplinary records
  - basing the stroke health and social care teams in the same building, and preferably in the same room.

**Social care assessments**

- Some people with stroke report experiencing distress at the point of transfer and feelings that services are disjointed, with inadequate provision.
These concerns can be addressed through multi-agency planning, supply of equipment and support [pages 114–115].

- A social care assessment to identify needs to support the person and their family or carer after transfer is essential. [page 86]
- As part of the transfer planning it is important that health and social care integrate to fully assess the needs of patients and their family members and carers (including equipment needs) and to develop an agreed care plan. In particular for people referencing accelerated transfer (via early supported discharge) or those going home depending on a large care package, it is important that these assessments take into account the potential for increased burden that early supported discharge may place on carers.
- Consider implementation of a joint health and social care computer system to facilitate integration.
- Consider the benefits of further social services assessment once the person had been transferred. This may allow for a more holistic assessment of the person’s needs than in hospital discharge assessments, as these sometimes focus on risk and safety.

**Joint health and social care plan**

The NICE recommendations on the need for a jointly written discharge plan incorporating both health and social care management are in line with previous recommendations, policies and initiatives in this area:

- CQC review
- Accelerating Stroke Improvement
- National Stroke Strategy
- Progress in Improving Stroke Care

The health and social care plan should document the role of social care and any on-going health or social service provision and should outline requirements going forward, goals and contact details of services. This coupled with a discharge summary should provide summary information on the admission and treatments given in hospital.
The health and social care plan needs to be provided to appropriate health and social care staff (including the person’s GP) and the person who had the stroke. As part of the transfer/discharge documentation, a summary of rehabilitation activities should be included as usual practice [page 121].

Consider developing a health and social care computer system, such as that developed in Bournemouth (appendix H), in which information and data is inputted to the patient’s multidisciplinary records by both health and social care staff. Ideally, such a system should be capable of using inputted data to start producing discharge summaries and joint health and social care plans, input across social care record systems, electronically generate and send referrals to other services and generate and send continuing healthcare documentation. Where this has been implemented in practice, significant time has been saved by the health and social services staff, saving repetition and rewriting from health records into social care assessments and records and has improved the quality of the more holistic information in the assessment documentation.

Where health and social care plans have been implemented in practice, services:

- established a method of identifying people who need a joint care plan
- used feedback from people with stroke to develop a prototype joint care plan
- piloted the joint care plan in hyper acute, acute and rehabilitation settings, and received feedback from people with stroke
- quantified the time involved to undertake joint care plans
- initiated staff training in joint health and social care plans
- key champions were identified
- developed implementation protocols and an evaluation plan focusing on process and quality of care planning.

**Training of family members and carers**

Training and support for family members and carers is extremely important. It is also important to remember that the needs of families and carers of a
person with stroke may change during the person’s recovery. Carer and family training needs should therefore be reviewed at regular intervals [page 86].

It is acknowledged that there are some costs associated with carer training (staff time cost). Business planning should take into account that these interventions will improve the quality of life of the person with stroke, and that the improvement in quality of life is considered likely to outweigh the costs [page 86].

**Provision for people in care homes**

It is very important that people who transfer from hospital to a care home should receive the same level of information, care and treatment as people who are able to return home [page 121]. The [NICE costing report](#) recognises that this may have a significant resource impact and recommends that this should be reviewed at a local level. The NICE costing report and template provides information to help organisations plan for the financial implication.

**Working strategically**

In order to support the steps suggested earlier for integration at multidisciplinary team level it is important that local health and social care is integrated from a strategic perspective. Ways in which this can be achieved include:

- establishing the key differences between health and social care in their ways of working and developing methods to improve joint working and communication. Analysing national drivers and the potential for shared national measures can help establish common themes and objectives to align both with national and organisational agendas
- developing a strategic team which includes a social care commissioner from the county council, a community stroke team leader from the NHS and a lead from the Stroke Association ([Appendix D](#)).
- organising regular short meetings and task groups to tackle specific problems.
**Specialist training of stroke social workers who are part of the multidisciplinary team**

It is important that the social workers working with people with stroke have received specialist training in stroke. This is so that they can deliver the highest quality of service to people with stroke, and to implement the steps identified above such as conducting joint assessments, integration with the multidisciplinary teams and joint health and social care planning. It also gives them a better understanding of issues specific to stroke, such as mood.

**Health and social care interface – useful resources**

<table>
<thead>
<tr>
<th>Resource</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Stroke Improvement Programme, <a href="#">Commissioning services in partnership webpage</a></td>
<td>This webpage contains links to examples of good practice, where stroke services have been commissioned in partnership between health and social care. These case studies are summarised in <a href="#">Going up a gear</a>.</td>
</tr>
<tr>
<td>NHS Stroke Improvement Programme, <a href="#">Social care for Stroke</a></td>
<td>This webpage promotes the sharing of information and resources for staff working with people with stroke in social care, and provides an opportunity to develop national links with others working in the same field.</td>
</tr>
</tbody>
</table>
## General resources to help implement the stroke rehabilitation recommendations

<table>
<thead>
<tr>
<th>Reference</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Health (2007) National stroke strategy</td>
<td>The strategy sets the direction for the development of stroke services in England over the next 10 years. The strategy includes 20 Quality Markers for raising the quality of stroke prevention, treatment, care and support over the next decade.</td>
</tr>
<tr>
<td>Royal College of Physicians Stroke Programme</td>
<td>This website contains links to the Royal College of Physicians Stroke Programme (the link is on the left of the page) which includes audit, stroke peer review, commissioning tools for stroke and information for people with stroke and their families and carers.</td>
</tr>
<tr>
<td>Royal College of Physicians (2012) National Clinical Guideline for Stroke</td>
<td>This guideline provides coverage of stroke care to date, encompassing the whole of the stroke pathway from acute care through to longer-term rehabilitation, including secondary prevention. It includes the Royal College of Physicians recommendations to healthcare professionals on what care should be provided to people with stroke and how this should be organised, with the aim of improving the quality of care for everyone who has a stroke regardless of age, gender, type of stroke, or location. It also has a detailed section on the Royal College of Physicians recommendations for the commissioning of stroke care.</td>
</tr>
<tr>
<td>Commissioning Support for London (2010)</td>
<td>This is a commissioning guide for the post-</td>
</tr>
<tr>
<td>Source</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Life after stroke: commissioning guide</strong></td>
<td>This guide covers acute stroke rehabilitation phase. It covers:</td>
</tr>
<tr>
<td></td>
<td>- regular review and needs assessment</td>
</tr>
<tr>
<td></td>
<td>- provision of information</td>
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<tr>
<td></td>
<td>- empowering people with stroke to take control</td>
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<tr>
<td></td>
<td>- getting involved in community life</td>
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<tr>
<td></td>
<td>- emotional support</td>
</tr>
<tr>
<td></td>
<td>- supporting families and carers.</td>
</tr>
<tr>
<td><strong>NHS Stroke Improvement Programme, case studies</strong></td>
<td>This webpage contains case studies from across the stroke pathway. The cases have been organised by the quality markers published by the Department of Health’s National Stroke Strategy.</td>
</tr>
<tr>
<td></td>
<td>Some of the case studies that relate to stroke rehabilitation have been referred to earlier in this document.</td>
</tr>
<tr>
<td><strong>Healthcare for London (2009) Stroke rehabilitation guide: supporting London commissioners to commission quality services in 2010/11</strong></td>
<td>In the Stroke strategy for London, 5 recommendations were published for London Primary Care Trusts on commissioning stroke rehabilitation services. Subsequent engagement with clinicians and people with stroke has refined these recommendations into the detailed guidance presented in this document. Pages 18–41 contain details of service descriptions and examples of delivery in the 5 recommendation areas: inpatient rehabilitation, community rehabilitation, early supported discharge, support structures and defined review.</td>
</tr>
<tr>
<td><strong>NHS Stroke Improvement Programme, Rehabilitation website</strong></td>
<td>This webpage contains links to the stroke rehabilitation resources developed by the Stroke Improvement Programme team. These include:</td>
</tr>
<tr>
<td></td>
<td>- <a href="#">Mind the gap – ways to enhance therapy provision in stroke rehabilitation</a></td>
</tr>
<tr>
<td></td>
<td>- <a href="#">Going up a gear – practice steps to improve stroke care</a></td>
</tr>
<tr>
<td>NHS Stroke Improvement Programme (2010) <strong>Going up a gear: Practical steps to improve stroke care</strong></td>
<td>The Stroke Improvement Programme's publication draws together the key themes and learning from the <strong>2009/10 projects</strong> and includes ‘top tips’ that have emerged from the projects to help others as they make improvements in stroke care. The examples in this document can be read in detail in the <strong>Improving post hospital and long term care: case studies from the Stroke Improvement Programme</strong> document or on in this <strong>online resource</strong>.</td>
</tr>
<tr>
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</tbody>
</table>
| - the increase access to the therapy webpage  
- Early supported discharge webpage  
- Community stroke resource webpage  
- Unbundling of the stroke tariff online resource webpage  
- Procurement  
- Key performance indicators and C-QUIN  
- Bed modelling tool. |
Other support from NICE

NICE has developed the following tools to help organisations implement this guideline:

- A costing report and template to estimate the national savings and costs associated with implementing the recommendations.
- A baseline assessment tool to help you identify which areas of practice may need more support, decide on clinical audit topics and prioritise implementation activities.

**NICE Pathways.** Our new online tool provides quick and easy access, topic by topic, to the range of guidance from NICE, including quality standards, technology appraisals, clinical and public health guidance and NICE implementation tools. Simple to navigate, NICE Pathways allows you to explore in increasing detail NICE recommendations and advice, giving you confidence that you are up to date with everything we have recommended.

**NICE Evidence.** This is a service that enables access to authoritative clinical and non-clinical evidence and best practice through a web-based portal. It helps you find, access, and use high-quality clinical information.

**The Quality, Innovation, Productivity and Prevention (QIPP) collection.** Is a resource for everyone in the NHS, public health and social care for making decisions about patient care or the use of resources. The collection compromises of QIPP case studies, cochrane quality and productivity topics and links to other tools and resources.

**Shared learning.** Do you have some tips to share with other organisations on implementing NICE clinical or public health guidance? Or would you like to learn from other people’s experiences? If so, NICE’s shared learning database can help.
**ERNIE** (Evaluation and review of NICE implementation evidence) is a database with a source of information on the implementation and uptake of NICE guidance. ERNIE will provide:

- a bank of guidance-specific NICE implementation uptake reports
- references to external literature
- a simple classification system summarising the uptake of NICE guidance.

**NICE quality standards.** NICE has published a [quality standard on stroke](https://www.nice.org.uk/guidance/qs336). This quality standard covers care provided to adult stroke patients by healthcare staff during diagnosis and initial management, acute-phase care, rehabilitation and long-term management. It defines a high standard of care within this topic area. It provides specific, concise quality statements, measures and audience descriptors to provide patients and the public, health and social care professionals, commissioners and service providers with definitions of high-quality care.
Acknowledgements

NICE would like to thank the members of the National Clinical Guideline Centre and the Guideline Development Group, especially

- Louise Clark, Consultant Practitioner Trainee – Stroke (Year 2) Band 7 Neuro Occupational Therapist
- Dr Najma Khan-Bourne, Consultant Clinical Psychologist & Clinical Lead for Neuropsychological Rehabilitation at King’s College Hospital
- Dr Khali Ali, Senior Lecturer in Geriatrics, Brighton and Sussex Medical School

We would also like to thank those who have submitted their case studies to the appendices and:

- Jill Lockhart, NHS Improving Quality
- Dr David Broomhead, Therapy Consultant, Rehabilitation, Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
- Dr Liz Warburton, Consultant in stroke medicine, Cambridge University Hospital NHS Foundation Trust and NICE Fellow

What do you think?

Did the implementation tool you accessed today meet your requirements, and will it help you to put the NICE guidance into practice?

We value your opinion and are looking for ways to improve our tools. Please complete this short evaluation form.

If you are experiencing problems accessing or using this tool, please email implementation@nice.org.uk
Appendices: Case studies

Unless specified, these case studies have been written by the services involved in the format and style which they feel suits their case study best
Appendix A: King’s College Hospital (Hyper acute unit and acute stroke unit)

Key Contacts:

Maurizio Privitelli, Service Manager – Stroke and Rehabilitation Medicine
King’s College Hospital. Email: maurizioprivitelli@nhs.net

Maria Fitzpatrick, Nurse Consultant – Stroke Management, King’s College
Hospital. Email: maria.fitzpatrick@nhs.net

King’s College Hospital has the following inpatient services which offer stroke
acute care and rehabilitation:

**Hyper acute stroke unit (HASU)**

All stroke patients from the local catchment area in south east London are
admitted to King’s College Hospital for hyperacute stroke care. Patients
admitted here tend to stay on this unit for an average of 2 to 3 days. If a
patient has rehabilitation needs, this starts immediately. There is a daily ward
round. Patients are seen by the multidisciplinary team (doctors, nurses,
occupational therapy, speech and language, physiotherapy and dietician) and
are screened, assessed and rehabilitation delivered according to their needs.
Decisions about patient care are made by the multidisciplinary team in
collaboration with the patient and their families and carers. Once stable, the
patients’ needs are considered and the most appropriate rehabilitation
environment recommended. Some patients are eligible to be discharged
home to community rehabilitation at this stage. Approximately 40% of the
patients need further inpatient rehabilitation and are transferred to their local
stroke unit.
The stroke unit

In King’s College Hospital the stroke unit is based with the hyper acute stroke unit. Patients who live within the King’s catchment area are transferred here from the hyperacute stroke unit (HASU)

Length of stay varies from 15-20 days (average)

The stroke unit multidisciplinary team which offers rehabilitation in this unit consists of:

- Consultant Stroke Physician
- Consultant Nurse
- Consultant Clinical Neuropsychologist
- Speech and language therapist
- Physiotherapy
- Occupational therapists
- Rehabilitation Assistant
- Information Assistant
- Community Link person
- Nurses and doctors
- Dietician
- Pharmacist
- Discharge coordinator
- Pathway co-ordinator
- Audit co-ordinator
- Volunteers
- Interact

Overall there is a higher input of therapy staff than medical input compared with the HASU, in line with the London standards for stroke care.

The London standard for staffing as described in Comprehensive Review of Current Stroke Rehabilitation Services in South London (South London Cardiac and Stroke Networks 2009)
With the unit being located in an acute hospital, the acute stroke unit also has access to the ancillary services offered by the hospital including ophthalmology, neuropsychiatry, older adult psychiatry and podiatry.

Social workers will come to see the patient in hospital and will liaise with their patient and family during their inpatient stay.

Currently there is a pilot underway for patients living in one of the boroughs served by this unit where a representative from the Stroke Association visits the patients whilst inpatients to assess what needs the stroke association could assist with. The stroke association then follows the patient when they are discharged into the community.

This unit undertakes a weekly multidisciplinary team meeting chaired by the Consultants. This meeting brings the MDT together to discuss all of the patients. It provides an opportunity to share information and check each of the patient’s progression through the rehabilitation pathways. There are also daily board reviews.

The experience of this team has identified that having a dedicated clinical neuropsychologist, dietician and pharmacist, rehabilitation assistant as core members of the multidisciplinary team has a clear direct benefit to patients with specific needs but also an indirect benefit to all patients as their expertise can influence the approaches taken by a variety of members of the multidisciplinary team.

Information from assessments and treatment and following meetings and discussions with patients, families and carers is fed into the MDM in which decisions are made including setting short term and long-term goals and discharge plans. A representative from the community Early Supported Discharge Team attends the weekly MDM. Communication is prioritised within and between teams.
Outcomes for patients:

1. Discharged home. Patients are discharged home having actively participated in rehabilitation and their full inpatient rehabilitation potential has been achieved. They are referred on for further ongoing rehabilitation from the Early Supported Discharge Team in their own home. All patients discharged into the community will be reviewed in 6 weeks’ time in outpatients by the hospital team.

2. Discharged home. Patients are discharged after a period of assessment and treatment but have been unable to fully participate and make gains in rehabilitation. These are usually very dependent patients who are set up with a full package of care and they are reviewed after a period of time by the community rehabilitation team to see if further rehabilitation is possible.

3. Admitted to a care home/nursing home. Patients are admitted to a care home or nursing home after a period of assessment and treatment but are making no further gains. These are very often highly dependent patients who need full time care.

4. Transferred to Frank Cooksey Rehabilitation Unit which is King’s College Hospital Neurorehabilitation unit for ongoing neurorehabilitation (see later appendix). These are patients who are continuing to improve with rehabilitation and need further inpatient rehabilitation.
Appendix B: King’s College Hospital Long term rehabilitation inpatient service

(Frank Cooksey Rehabilitation Unit [FCRU])

Key Contacts:

Maurizio Privitelli, Service Manager – Stroke and Rehabilitation Medicine
King’s College Hospital. Email: maurizioprivitelli@nhs.net

Dr Julian P Harriss, consultant in Rehabilitation Medicine and Clinical Lead, Rehabilitation Medicine, KCH. Email: julian.harriss@nhs.net, tel: 0208 333 3365

FCRU is located at Lewisham Hospital, two miles distant from the acute stroke unit at Denmark Hill; however, FCRU is still part of King’s College Hospital. FCRU is a specialist-commissioned 17 bedded unit offering complex rehabilitation for level 1 and 2 patients.

Patients who have not yet met their full rehabilitation potential and who have complex needs are formally referred to FCRU using a standard Neuro-rehabilitation consortium form. Their suitability is promptly assessed by the FCRU multidisciplinary team, comprising the RM consultant supported by senior nursing and therapy staff. Each referral is conducted according to precise and valid criteria, intended to establish that each patient has level 1 or 2 rehabilitation needs.

If the Frank Cooksey Rehabilitation Unit is not considered to be suitable for the patient then the assessing team recommend alternative services or facilities which the team believe will better suit the patient's needs.

People who are admitted to FCRU should anticipate an inpatient stay of between two and six months. The aim of this service is to discharge patients back to the community, having maximised their potential to return to pre-morbid vocational and family responsibilities. Objective measures are taken
throughout the patient's stay, goals are identified, and early decisions concerning discharge date and destination are emphasised.

The unit accepts referrals for all patients with neurological injury or illness. On average around 25% of the patients on the unit have had a stroke. Typically patients undergo two weeks of intensive assessment after admission in order to allow the team to development a personalised rehabilitation programme in conjunction it's the patient.

The multidisciplinary team skills meet level 1 and 2 criteria and consists of:

- Consultant RM physician
- Specialist senior nursing staff
- Speech and language therapist
- Physiotherapists
- Occupational therapists
- Clinical psychologists with specialism in neuropsychology
- Activities coordinator
- Discharge coordinator

The unit holds weekly multidisciplinary meetings. The patients on the ward are split into two ‘teams’ and one team is presented each week. This means that each patient is discussed every two weeks.

As with the acute unit, volunteers are key members of the team; they help provide social aspects of stroke rehabilitation to the patients on this unit. Because the unit is located in an acute hospital (Lewisham Hospital) FCRU also has access to many ancillary services including ophthalmology, neuropsychiatry, older adult psychiatry, and podiatry. Orthotics and prosthetics services are contracted with Bowley Close, and an orthotist attends weekly. Spasticity management is delivered by the FCRU consultant. Services from other external organisations are also available, for example the stroke association and Headway. Social workers come to see patients at FCRU if needed, and they often liaise with the patient and family during the
inpatient stay. Facilities available at FCRU include a gym and hydrotherapy pool.

Following inpatient rehabilitation at FCRU most patients are either discharged to the community or referred to a long-term rehabilitation or residential facility in the community. Some patients leave FCRU requiring no further rehabilitation.

All patients are followed up at least once six weeks after discharge in a consultant-led outpatient clinic at King's College Hospital.
Appendix C The Royal Bournemouth Hospital,
Development of an integrated inter-disciplinary assessment process

Main contact: Kelly Saunders and Anna Perrin, Clinical Specialist Physiotherapist and Occupational Therapist, The Royal Bournemouth Hospital.

Emails: Kelly.saunders@bartshealth.nhs.uk and Anna.perrin@rbch.nhs.uk

Aim
The aim of this project was to develop an efficient patient centred therapy assessment process, which could be completed by either profession (OT/PT), to enable timely identification of a stroke patient’s impairments and limitations, to enable early implementation of targeted rehabilitation, as well as improved inter-disciplinary working (PT/OT/SAT).

Objectives
- To reduce duplication between professions in therapy assessments
- Develop improved understanding of profession specific requirements and providing opportunity for staff to develop extended specialist skills
- To promptly identify patients rehabilitation needs and to enable early rehabilitation and decision making regarding care pathway
- To promptly identify the need for ongoing patient referrals (e.g SALT, Orthoptist) by a comprehensive early screening of related deficits.
- Enable development of clinical pathways for assessment and management of key impairments and activities limitations which is consistent with national and professional guidelines
- Increasing the reliability and validity of assessments by agreeing a common process and incorporating outcome measures thus reducing assessor subjectivity and inconsistency.
**Context**

The changing face of stroke care, with increasingly tight resources requires the need for services to ensure efficiency and optimal use of resources. The launch of NICE Quality Standards programme outlined the need to provide an assessment within 24 hours by at least one member of the specialist rehabilitation team and by all members within 72 hours, as well as the need to screen for cognitive and mood impairments.

Through monitoring of our service against these quality standards we were not consistently achieving these. In addition, with the planned introduction of seven day therapy service and Early Supported Discharge it was felt necessary to ensure optimal efficiency of workforce to provide timely assessment, rehabilitation and discharge planning to ensure high quality provision of care, centred on the patients needs.

Prior to this project, an analysis of our service, identified poor compliance with completion of existing assessment documentation by all professionals with a reduced use of standardised assessment and outcome measures. The information being collected by professions was duplicated, which is not in the best interest of the patient and with some patients receiving unnecessary assessment due to reduced inter-disciplinary working.

In addition, there was a delay in undertaking of assessments particularly within Occupational Therapy, and variation based on experience and skill set of treating therapist.

**Methods**

An integrated assessment process was created that consisted of an initial contact screening form, a standardised cognitive assessment (ACE-R/MOCA as dictated by cognitive assessment pathway), a standardised language assessment (Frenchay Aphasia Screening Test; FAST) and a visual assessment (developed in house by OT and orthoptist based on Mary Warren model), as well as an integrated problem and goals sheet. The initial contact screening form was developed to enable relevant information to be captured for patients whether mild or severe in nature and included items around pre-
morbid background, consciousness, sensory and physical impairments as well as functional ability, and included objective measures to enable monitoring of change over time.

Following the completion of the integrated assessment process, patients’ impairments and activities limitations are identified, patient agreed goals are set based around the ICF framework, and where required, further specialist assessments are identified for completion by relevant professions. This has led to the development of clinical assessment pathways and referral processes, based on the identified deficits (i.e. the mood, vision, cognition and upper limb pathway).

This process was initiated and developed by the lead Clinical specialist Physio and OT, piloted by the team and has undergone regular review. A training programme for all professionals was implemented to ensure competency with carrying out extended roles and consistency in performance of standardised screening tools (FAST, ACE-R/MOCA) cognitive screen, Visual assessment) and outcome measures. This then formed part of a rolling induction programme for any new members of staff.

**Results and Evaluation**

The implementation of integrated assessment process resulted in improved identification of patients’ problems and speed in performance of required specialist assessment, with achievement of therapy quality standards. Specifically it led to a 216% increase in referrals to orthoptists (all appropriate) for visual problems after stroke, with a reduction in time to visual assessment of 11 days, and increased responsiveness of orthoptist assessment. There was a 60% increase in Speech and Language Therapist Caseload due to improved identification of patients with language difficulties, specifically those with more subtle communication deficits or right hemisphere syndromes.

This project aimed to improve patient care but also develop professional roles within the management and rehabilitation of stroke patients. Not only was there an increase in inter-professional working and provided a more flexible workforce, there was also development of professionals roles (i.e.
occupational therapy role in cognitive rehabilitation and psychological support), earlier implementation of rehabilitation and a feeling of improved clinical reasoning. This was possible because the integrated assessment process frees up professional time to enable delivery of specialist areas of assessment and rehabilitation.

The assessment process has continued to be reviewed and adapted since its introduction three years ago.

**Key Learning Points**

- The undertaking of an integrated inter-disciplinary assessment process provides improved patient centred care, increased efficiency by freeing up therapists time for specialist assessment/rehabilitation as well as improving inter-disciplinary working.

- An initial concern was raised about creation of ‘generic’ therapists and the loss of profession speciality but this has not been the case. It has increased role understanding, raised professional respect and developed improved definition of professional roles within the stroke care pathway, while providing a more flexible workforce.
Appendix D: The stroke association

Please note: This appendix has been written by NICE. The information has been taken from the Stroke Association website: http://www.stroke.org.uk/

Contact: N/A.

Stroke association provides support and follows patients up 6 months after discharge. They often run clinics in the community.

Our services across England, Wales and Northern Ireland are funded by the NHS or social services and therefore may differ depending on where the patient lives.

Our life after stroke services may include:

- Information, Advice and Support Service: Helps you and your family prepare for the changes that happen because of a stroke, with information about stroke, practical advice and emotional support.
- Communication Support Service: Helps you cope with aphasia and difficulty in using language. Our co-ordinators and volunteers work with you to build up your confidence and help you achieve the best possible recovery.
- Stroke Prevention Services: Support you to change your way of life and reduce your risk of stroke, by offering help and advice on things such as diet and exercise.
- Getting Back to Life Services: After a stroke life is very different and you may need to make big adjustments and deal with daunting challenges. We provide a variety of services that will help you enjoy a better quality of life, return to your community and face the future.
- Carer Support Services: Caring for someone with stroke can be a solitary experience – and a tiring one. We provide carers’ groups that provide information and advice for carers, as well as the invaluable opportunity to socialise with others in the same situation.

The services available in each area can be searched here.
Appendix E: Bournemouth stroke coordination project

Key Contacts: Lynn Branson, Stroke Co-ordinator/commissioner, Bournemouth Borough Council. Email: Lynn.branson@bournemouth.gov.uk

Service model 1
Grant funding was made available to all local authorities for a three year period 2008-11 to support the development of pilot social care services for people after stroke. The Department of Health issued guidelines which directed local authorities on how to utilise the funding, based on the Quality Markers contained within the National Stroke Strategy (2007).

The specialist stroke social work team comprised of three specialist social workers who covered a 32 bedded acute stroke ward. They were not based on the ward but tended to spend most of their time on the ward.

The specialist social work team worked in close collaboration with the multidisciplinary acute stroke team in order to assess the patients’ needs and plan their stroke rehabilitation.

The specialist stroke social workers are involved in the following joint activities with the MDT

- Decision making
- Assessments, including capacity assessments and home assessments.

One of the risks associated with this model is that if the service experiences a high level of Bournemouth stroke patients this could affect the capacity to respond and so maintain the level of service. For a three month period in 2011, this is what happened. This change in the ratio of Bournemouth patients coincided with an agreement to limit delayed transfers of care to two patients and across three hospital sites. Reducing these costs was clearly a priority and so in order to ensure there was the capacity to respond to immediate change, it was decided that the hospital social worker (who was seconded to the stroke team) should return to the team with the responsibility
for inpatient social care support for stroke reverting back to the original team who had a larger reserve of staff who could be drawn upon.

It was decided that the service would become a community stroke service, in-reaching into the hospital to support the transition to the community and in the longer-term. Despite the rationale for the change in service model being cost, the benefits of the new model are detailed below.

**Service model 2**

Since June 2012, there has been a change in service delivery. The specialist stroke social workers were moved out to the community. Stroke inpatients were seen by the general adult inpatient social work team who were based in the hospital. This team effectively helped meet the patients' needs and facilitated discharge when it was appropriate. Upon discharge to the community the specialist stroke social workers assessed all stroke patients and worked to meet their needs.

**Number of patients on caseload and staffing**

Since June 2012, and the change in service delivery – the service has been involved with 253 patients with differing levels of involvement:

- Medium complexity of involvement (assessment) 36%
- Higher level of complexity (Professional Support) 20%
- Carers (assessment/Prof Support and Services) 14%
- Postal information pack only. 30%

There are now two fieldworkers: one stroke social worker and one stroke support and advocacy worker who is employed by a charitable organisation and commissioned by us to provide this service, and part-time team administrator and a Stroke Co-ordinator who has overall responsibility for the team and the commissioning and development of stroke and other social care services.
Service user views

The team frequently utilise questionnaire approaches to gain responses of service users to the Community Care Stroke Co-ordination Services.

Needs frequently identified in the community

Lack of information generally on options that are available, and in formats that people can understand and access. Many people need assistance with navigating the health and social care systems, too. Much of the work involves accommodation: to help maintain tenancies, housing applications, liaising with local authority or private landlords; referring on to other professionals, including those in health and social care; working with self-funders; welfare benefits advice and assistance; appealing Benefit decisions, assistance with detailed form filling; assisting with vocational and employment needs; referring on to Children’s Social Care; assisting with arranging domiciliary care and referrals for rehabilitation, re-enablement and equipment.

The benefits of a service model in which the specialist social workers are based in the community

It was widely accepted, at the time of delivery of service model 1, that people felt ‘abandoned’ after hospital discharge and unless there was ongoing social work involvement, support would not have been readily available. Some would have been hindered by their lack of information about community services, and many would have had needs that continued beyond hospital discharge and the lack of stroke specific support, information, and advice may have impacted on their recovery.

There was a lack of knowledge about the stroke condition and of the particular needs of people who sustain an immediate disability and loss of previous good health. We have received many comments about our level of understanding and knowledge of stroke as well as appreciation for consistency of involvement.

We work with a wide range of stroke and other professionals and have gained an understanding of the network of community services that exist to support people. As a result we can refer on, for example, to stroke consultants for
health advice, specialist stroke nurses for patient education and Stroke Association for grants and information. Previously there would have been no co-ordination of services, repetition for patients and lack of knowledge about whom and where to go to. The team is a useful link for other professionals too.

Opportunities to offer carer’s information, assessment and support were not available, unless these were actively sought by the carer themselves or picked up by other professionals. New caring situations from hospital may have impacted on levels of stress and anxiety and in some cases on the sustainability of the caring role. As situations change over time – there may not have been an easy route for ongoing support and information either.

When based in the hospital the specialist social work team found that the pressure of the need to free up bed spaces in the acute environment meant that the main focus was to facilitate a safe discharge. This often meant that needs which would not compromise safety but may influence quality of life were not addressed before discharge. Now the team are based in the community setting they find they have the time to help address more of the needs of the patients.

**Key principles of both service models**

The key principles of these models are that the specialist stroke social workers:

- Are part of the MDT
- Received specialist stroke training
- Attend stroke MDT meetings
- Have enhanced understanding of mood issues in relation to stroke rehabilitation
- Work on systems which are integrated with the MDT
- Help to reduce delays and the costs associated with these.
Appendix F: The Brain Injury Outreach Team (BIOT)
Occupational Therapy Service, Southern Health NHS Foundation Trust

Covering Portsmouth, Fareham, Locks Heath, Petersfield, Waterlooville, Havant, Hayling Island and Gosport

Main contact: Amy Francis, Occupational Therapist, Brain Injury Outreach Team, Southern Health NHS Foundation Trust. Email: amy.francis@nhs.net

Additional Contacts: Catrine Smith, Becky Goulty, Angela Walsh.

The Brain Injury Outreach Team Occupational Therapy (OT) Service, use their OT skills and knowledge of Neurological Rehabilitation to help the patient manage all of their daily activities. This may include supporting them to gather evidence to make appropriate vocational choices and vocational rehabilitation goals being set as part of a rehabilitation program. This service is offered to people with stroke as well as people with other brain injuries. One of their main aims is to address return to work.

The team

1 whole time equivalent Band 7 Occupational Therapist
1.6 whole time equivalent – Band 6 Occupational Therapist
0.5 whole time equivalent – Band 3 Occupational Therapist Assistant

Outcomes of the total referrals

In 2012 120 patients were referred:

- 41 were supported to explore vocational goals last year. (Amongst their other goals, identified and self-rated through the internationally recognised Canadian Occupational Performance Measure).
- 14 returned to paid employment in 2012.
- 6 have voluntary employment - many with hope to go back to paid work while still being supported by the team.
• 2 found other roles to fulfil their needs including further education, and within their families.
• 2 decided to medically retire.
• 27 of these were ongoing cases whose outcomes had not been concluded.

In 2011 65 patients were referred (with less resources 0.6 B7, 0.2 B6, 0.7 B5, 0.5 B3)

• 19 were supported to explore vocational goals last year.
• 2 gained part time work.
• 4 returned to full time work.
• 3 deteriorated and could not.
• 5 could not return to their previous employment, cognitive impairments and fatigue limited them from being able to learn a novel career so changed the goals during OT intervention.
• 5 were still working with the team. 15 people were on a waiting list who had already identified return to work as a goal.

Intensity of rehabilitation
The intensity offered is dependent upon patient needs and varies from phone advice to 24 months of intervention.

Their average time with closed cases last year was 9 months (not specifically with Vocational Goals).

The maximum intensity the Brain Injury Outreach Team (BIOT), OT can offer is 3 times weekly 90 minute sessions with two Allied Health Professional’s (this is rarely needed or possible).

The minimum intensity they may offer is availability on a 6 month phone review. This allows the patients to have a contact point if needed. Feedback indicates that this is useful at the right point (often towards end of intervention).

Core components to the services interventions
The core components are:
• Goal Setting
• Activity Analysis
• Graded therapy programs
• Education
• Multi – Disciplinary Team (MDT) working
• Liaison with employers and support on work visits.

**Multidisciplinary Team interventions**

The BIOT team recognise that they often need to joint work with Psychology, Physiotherapy & Speech and Language Therapy to achieve the patient's goals.

In addition to attending the Brain Injury Outreach Team Occupational Therapy service, patients may also be attending separate sessions with:

- Socially funded: - Headway, Different Strokes, Sensory Impairment Teams or have a PA for organisation / repetition of activities.
- Physiotherapy.
- Psychology.
- Speech and Language Therapy.
- Other Private Therapy / Relaxation / Exercise Classes.
- Insurance case professionals.

**Future developments**

To enable the team to provide a more responsive and intensive service with stronger MDT links, less exclusion criteria, long-term condition management, training of staff and cover for all kinds of leave. The team proposes that the following compliment of staff would be required:

- 1 whole time equivalent Band 7
- 2 whole time equivalent Band 6
- 1 whole time equivalent Band 5 rotational
- 1 whole time equivalent Band 3
Appendix G Vocational Services, Dorset Healthcare University NHS Foundation Trust

Main contact: Sarah Tilbury, OT lead and Manager of Vocational Services.
Email: sarah.tilbury@dhuf.nhs.uk

Aims of the service
The vocational rehabilitation services:

- Is for people with a variety of injuries or illnesses which affect their capacity to work. This can include back pain; the effects of an acquired brain injury; stroke or sensory loss
- Supports people to help them stay in their current job or to help them find a new job by considering what job they are best suited to.
- Develops practical healthcare solutions to prepare people for going back to work.
- Explores all the options open to people based on their current condition and skill level, so they can find a position that suits their needs.

Referrals
Referrals are received from healthcare professional, for people with illness or injury which affects their capacity to work, who have talked about the possibility of going back to work.

Assessments
The initial assessment is undertaken by an Occupational Therapist. This allows the chance to talk to the individual about their vocational needs and discuss all the different ways the service can provide support.

Treatment plan
The Vocational Services team:

- in collaboration with the service user, will develop a treatment plan by identifying goals, an individualised programme and setting goals. This will
be delivered through identified sessions with the Vocational Services Team.

- work with the individual to gradually build up their skills, confidence and abilities.
- provide a work-like environment in which individuals can regain and practice essential skills such as problem solving, communication, dexterity as well as building up their concentration levels and stamina.

**The team**

The Vocational Services team consists of Occupational Therapists and technical instructors. The team works alongside other treatments the person is receiving.

More information about this service can be found on the [Dorset HealthCare University NHS Foundation Trust website](http://www.dorsethealthcare.nhs.uk).

The most up to date version of the ‘[Vocational Services information leaflet for service users](http://www.dorsethealthcare.nhs.uk)’ is available from the Dorset HealthCare University NHS Foundation Trust website.
Appendix H: Bournemouth joint health and social care computer system

Case study submitted by:
Louise Clark: Consultant Practitioner Trainee- Stroke (Year 2), Band 7 Neuro Occupational Therapist, Wessex Deanery/Royal Bournemouth Hospital.

For any further information about this case study please contact NICE: Implementation@nice.org.uk

Please note this case study describes a pilot project which was being implemented at the time of publication (June 2013).

Aim
Bournemouth Hospital stroke team and social services team co-led a project group to produce an integrated, electronic documentation system to streamline documentation, reduce repetition and save clinical time. The project is still being extensively trialled prior to evaluation to quantify improvements. Roll out is being managed with training and launch events over a 3 month period across the teams and MDT.

Objectives
- To satisfy Accelerating Stroke Improvement metric on Joint Health and Social Care Plans
- For existing detailed information collected in weekly MDT meetings to be utilised to create discharge summaries (reduce duplication and save clinical time)
- For information inputted on the comprehensive MDT discharge summary to automatically export and populate Bournemouth social services assessment document (reduce the time taken for social services to complete assessment)
- For electronic document to automatically email to those included on referrals list, acting as referral to community teams, ESD, district nurses (reduces duplication, clinical time and administration)
• Has included functionality for electronic completion of Continuing Healthcare (CHC) checklist, which will automatically add most recent evidence from MDT document, add up scores and send automatically on saving to relevant organisations (including saving onto social services case record for that patient) depending on negative or positive outcome. This would be saved onto (document explorer) system and accessed by GPs and community teams for future reviews.

• To save discharge summary/joint health and social care plan and CHC documents onto documents system viewable by GPs (same as clinic letters system).

Context

Prior to the introduction of this system, Bournemouth acute stroke, stroke rehabilitation and ESD services were completing detailed discharge summaries for all patients being discharged from the service. These often lengthy documents, were filled in by all professionals involved with the patient, taking up to an hour to complete for complex cases. The same domains of care as those in the discharge summary (eg: mobility, cognition, perception, vision, nutrition, skin, continence, ADLs, mood) were also discussed and documented weekly in MDTs, attended by MDT and social services.

Social services assessment documentation was taking approximately 2 hours per patient and included a lot of duplication of the same domains of care documented in both the MDT and discharge summary documents, inputed onto a separate social services system.

Continuing Healthcare (CHC) checklists were being completed by two members of the MDT taking approx 20-40mins and was then faxed and verified by social services, building in potential for administrative error and delays. The new system would be more compliant with DOH CHC guidance regarding to checklists being completed with both health and social care staff present, with them being completed electronically in the MDT meeting, improving quality and saving time and admin.
Method

The project started with the development of the electronic discharge summary as part of the SIP transfer of care project, then expanded following a group members involvement in SIP CHC work and publication of joint health and social care recommendations.

In house IT agreed to assist in the development of the project, with support from trust service improvement project manager/clinical adoption lead.

A core working party has led the developments and included consultation with the trust board, PPI and plans a cascade training model, with continued IT support from our IT help desk (in house)

Stages of system development

1. Electronic discharge summary converted from word to new software (image now)
2. Development of Electronic MDT documentation
3. Trial imports of data from MDT to discharge summary documents
4. Roll out
5. Mapping exercise of data from system to social services database.
6. Agree information governance between health and social care
    (implementation at this stage at the time of NICE publication)
7. Roll out across social services
8. Development of CHC capability-trial
9. Roll out across social services, health and CCG
10. Enable saving to document explorer and electronic referral system- trial with small number of services
11. Roll out across all systems and services in region
12. Package system and demonstrate to other organisations
13. Trust to look at adaptation and adoption across other clinical services in line with Trusts electronic patient record agenda
Lessons learnt

- Patients and community services appreciate having detailed information regarding their admission, diagnosis and treatment, as well as clear information of ongoing plans and contact numbers.
- This process has made the assessment information more holistic and patient centred, including both health and social information and has improved communication and common language across health and social care (based on the Common Assessment Framework - CAF).
- Barriers between health and social care systems can be removed with communication, IT expertise and well-constructed information governance agreements.
- Making documentation work for multiple purposes is a good way to improve efficiency.
- It is important to make clinical assessment information and care plans available to teams/GPs who have limited access to the detailed inpatient records to aid transition of care and improve continuity.
- Electronic processes can be made to include audit trails and therefore ensure accountability with electronic sign ins and background tracking.
- Electronic automated systems to send referrals and documentation reduces administration, administration errors and delays associated with this, allowing clinicians more clinical contact time with patients.

Evaluation

Expected full implementation and evaluation to be completed by January 2014.