

A stepped approach to the development of an Integrated Community Stroke Service (ICSS) in the Mid Nottinghamshire Area

Transforming an Early Supported Discharge (ESD) to ICSS – What A Journey!

Step 1

The problem
Large gap in post stroke care provided within Mid Notts that is inequitable to that of other areas

The task
Expression of interest submitted for Stroke Quality Improvement for Rehabilitation (SQuiRe) catalyst funding. Emphasis on outcomes and proving the sustained commissioning of the project in the longer term

Successful with the bid – planning began!

Developing project measures

- Referral numbers
- Monthly admissions
- 6 month reviews
- FIMFAM (therapy outcome measure)
- Care package reduction data
- Patient Qualitative Feedback

Step 2

Criteria changes/liasing with referrers

1. Inclusion of any patient who can complete/ achieve a standing transfer with 2 +/- an aid
2. Removal of criteria stipulating patients must be within 30 days post stroke
3. Extension from a six week service to include up to six months of input
4. All patients completing the rehabilitation journey in one integrated seamless service, working to the national ICSS specification including six-month reviews
5. Self referral within the six month time frame

Step 3

Mass recruitment

ESD	WTE	Recruited further
2.4	Physiotherapist	2
1	Occupational Therapist	3
0.8	Nurse	1
0.4	Clinical psychologist	Vacant
0.9	Speech Therapist	0.8
0	Stroke Assistant Practitioners	3.6
4.4	Rehab Support Worker	1.8
0.53	Admin	0.58

Total ESD staff members 13
Total ICSS staff members 26

The team

Challenges

- Maternity leave
- Death by recruitment!
- Increased waiting list
- Staff training (new and old)
- Development of new competencies
- More complex patients
- Increase in referrals before new staff trained
- Longer sessions with patients
- Patients requiring more qualified input
- Mixed caseload from severe to very mild
- Unable to recruit clinical psychology
- Increased patient need for psychological support
- Red tape for exercise groups

Successes

- Increased referral numbers
- Improved patient outcome measures – FIMFAM data ongoing
- Decreasing need for care packages – data ongoing
- Positive patient feedback results
- Excellent uptake of 6 month reviews
- Introduction of exercise groups
- Increased contact with external providers
- New skills for all staff
- Team working at its best, whole team have 'pulled together'
- Achieving 76.3 % of recent Stroke National Guidelines recommendations fully and 9.7% partially

I have found this service extremely helpful, and without it would not have made such good progress with my recovery

The experience was very good, can't think of anything to add

Could not have been better. All in all, extremely helpful

The journey continues...

Team priorities;

- Recruitment: psychology post
- Training
- Feedback
- Team building
- No waiting list
- Groups
- Band 4s managing non complex assessments

The Future

- Analysing all data collected
- Looking to phase 2 of the project; to open up the criteria to all stroke patients with rehabilitation potential, even those requiring a hoist transfer

A seamless pathway will be more efficient and effective in achieving patient outcomes.

TIMELINE: 2022

TIMELINE: 2023

