Maidstone and Tunbridge Wells NHS Trust

Kent Health Overview Scrutiny Committee

Stroke Rehabilitation Service

Situation and Background:

Stroke rehabilitation is most commonly provided in a community setting however Maidstone and Tunbridge Wells NHS Trust (MTW) has historically provided it from the acute bed base. When the COVID pandemic struck the NHS was asked to consider moving all non-essential activity out of hospital. In addition, in July 2020 Medway Maritime's acute stroke service closed with 78% of the activity transferring to Maidstone Hospital. It was therefore imperative to introduce new stroke rehabilitation pathways away from the acute site so that MTW could expand its' existing acute bed base.

Two new pilot pathways were developed and started taking patients in November/ December 2020 for a 6-month period. The pathways are an innovative home care rehabilitation service (10-16 places) in collaboration with Hilton Nursing Partners and a community hospital inpatient 8-bedded specialist stroke rehabilitation facility at Sevenoaks Hospital, which is part of Kent Community Health Foundation Trust (KCHFT). It was agreed that the Home Stroke Rehabilitation pathway would be the default pathway, with patients requiring more complex or intense rehabilitation needs being transferred to Sevenoaks Community Hospital.

The home service has 3 levels of support delivered through an integrated care model comprising Hilton staff, MTW staff and KCHFT staff.

Support Category	**Level of Care**
Recovery	Requires up to 4 daytime visits of less than one hour each
Moderate	Requires double handed visits and may require night support to a designated time
Intensive	Requires 24 hours support for an anticipated time of up to 7 days then steps down support. In the event a longer period of time is considered appropriate the Trust's lead therapist can agree a further 48 hours. Thereafter a further increase in 24 hours care will need to be agreed with the MDT and the patient pathway reviewed.

The pathway was designed for a maximum of six weeks home support with a sliding scale of input over the period (intensive, moderate and recovery as described above), although patients could enter the pathway at any stage. Patients were discharged into the care of their GP as they were

deemed medically fit for discharge. Home care is provided by Hilton and patients were discharged with an MTW prescribed therapy plan with clear goals.
MTW therapists worked with the patients and carers virtually or by face to face contact in the home to deliver, supervise and monitor the therapy inputs and achievement of goals. Virtual Therapy sessions were managed using the Attend Anywhere software. KCHFT (Kent Community Health Foundation Trust) and CNRT (Community Neuro Rehabilitation Team) were involved in the pathway to ultimately take over care once the rehabilitation phase was over.

A community hospital inpatient 8-bedded specialist stroke rehabilitation facility was set up at Sevenoaks Hospital to provide stroke rehabilitation to the more dependent stroke patients including those with severe cognitive and/or physical impairment and dysphasia. Nurse staffing was provided by Kent Community Health Foundation Trust (KCHFT) and was supported by a senior nurse from MTW as well as a regular presence from the stroke CNS team members. Therapy and medical support were provided by MTW therapists and stroke consultants. A consultant ward round is undertaken twice weekly on site and weekly MDT meetings are in place. MTW Therapy staff are on site at Sevenoaks to work with patients and nursing staff. Governance is managed between KCHFT and MTW to ensure all elements of the service provision (nursing, medical cover, therapies, IT, recording, imaging, support services and training) were in place. It is to be noted that the 8 beds at Sevenoaks were not new capacity but part of the rehabilitation bed base already in play at Sevenoaks hospital. It is imperative that the MDT (which included KCHFT) ensured the beds were used effectively. Social services and CNRT were involved in the pathway to support ongoing care

Assessment:

The pilots were initially evaluated in June 2021 using 5 key criteria:

- financial performance;
- clinical service delivery;
- quality of care;
- patient experience; and
- stakeholder feedback.

The pilots improved bed capacity and patient flow for the Acute Stroke Unit at Maidstone. A total of 112 patients were cared for on the new pathways during the period of the pilot (72 at home and 40 at Sevenoaks). This released 2351 bed days for the stroke unit, reducing the length of stay for MTW stroke patients and releasing capacity in the acute Trust to manage flow more effectively.

Patient and staff feedback were positive overall and the quality of care and patient outcomes were good. Challenges identified included the speed of the implementation during a Covid-19 pandemic; delays in discharges from the pathway due to Social Services referrals and Kent Enablement at Home (KEAH) capacity and processes; developing changes in decision-making processes within the MDT and board rounds; therapy and nursing staffing models and record keeping and sharing across I.T. systems.

	Home Rehab (23.11.20 – 31.5.21)	**In-patient Community Hospital** (7.12.20 – 6.6.21)	**Totals**
Number of patients in the service each week	10-12	8/9	18-21 per week
Total number of admissions	72 Recovery 54 Moderate 10 Intense 8	40	112 patients
Total discharges	61	31	92 patients
Total number of bed days	1307	1044	2351
Average Length of Stay (days)	21.4	34 Range 7-71	
Wasted beds days per month (delays from referral to actual transfer)	Unknown	64 Av. 3.5 days per patient based on May data	
Delays to discharge from service (no. of patients)	6 patients Total of 68 days Bridging required due to delays in POCs. Range 2-33 days per patient.	11 patients No. of days unknown 4 waiting nursing home, 6 POCs, 1 housing	17 patients
Number of patients transferred back to	7 patients Decline in health/	11 patients 0-2 per month	18 patients

MTW	mobility/infection		
Failed referrals to service	4 (total) (not medically fit for discharge or alternative social care provider) 93.5% conversation rate	Estimated 3 per month (Based on May data - discharged 7/8 days after MFFD to Home Pathway)	
Number of complaints	0	1 Resolved	
Number of incidents	8 Falls x 5 Skin integrity x1 Other 2	8 Falls x 5 Food/swallowing x2 Pressure ulcer x 1	No serious incidents

A presentation of the pilot scheme and evaluation was given to the Integrated Stroke Delivery Network Stroke Rehabilitation Sub-Group on 1st September 2021.

Recommendation:

Subsequently MTW decided to formalise the new pathways and went through a procurement process. Both pathways remain in place and are fully funded. The challenges identified above have been the focus of the improvement work over the last year with positive outcomes. For example, MTW and KCHFT now use the same bed management system, the MDT meetings have been streamlined with all partners attending and all staff have undertaken stroke competency assessments. Patient and staff feedback continue to be positive and regularly monitored. These pathways are now embedded and viewed as business as usual. Other acute providers are now considering the home rehabilitation service and are being supported by the ISDN.

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