Lothian Stroke MCN
Stroke Rehabilitation Pathway Development Subgroup

Wednesday 29th August 2018
MINUTES

Present:

Mark Smith (chair)	Consultant AHP/Physiotherapist
Morag Medwin (minutes)	Co-ordinator, Stroke MCN
Audrey Bruce (AB)	Lead Stroke Nurse, CHSS
Wendy Cameron	Physiotherapist, RIE
Cathy Cheyne	Physiotherapist, ECSS
Linda Gibson (LG)	Occupational Therapist, ECSS
Sheena Glen	Edinburgh CHP Neurorehabilitation Services, OT Clinical Lead
Jo Gouick (JG)	Consultant Clinical Neuropsychologist
Janine Hackett (JH)	Occupational Therapist Manager, AAH
Belinda Hacking (BH)	Consultant Clinical Psychologist, WGH
Pauline Halliday	Clinical Specialist Occupational Therapist, RIE
Fiona Johnson	Team Lead Physiotherapist, WGH
Dr Sarah Keir (SK)	Consultant Stroke Physician, WGH
Ryan Martin (RM)	Health Development Officer, Edinburgh Leisure
Lesley Morrow (LM)	Quality Improvement Manager
Jane Shiels (JS)	Specialist Physiotherapist, AAH
Colin Watson (CW)	Senior Analyst, Analytical Services

action

1. Welcome, introductions and apologies for absence

Apologies were noted from Billie Flynn, Clinical Services Manager, RIE. Also unable to attend were Fergus Doubal and Roslyn Mozer, consultants at RIE and AAH respectively.

Introductions were made around the table for this inaugural meeting. The group was asked to consider if there were other colleagues that should be invited to join the group.

2. Purpose of meeting

MS explained the remit and role of the previous group – Community Service Development Subgroup, from 2004 to 2013. It had been set up to kick start the provision of community services for those with stroke, and had managed to fulfil its aims. The group had patient and carer representatives, and latterly completed its workplan. At that time it was decided to wind up the group but there had always been the aspiration to reform more specifically around the rehab pathway when the time was right.

3. Rehabilitation Pathway Development Subgroup Draft Work Plan

The draft workplan for this group was circulated to the group and there was discussion on the objectives:

- Although a pan-Lothian service is ideal, this group will explicitly focus on Edinburgh pathways in the first instance.
- 'Inpatient stroke unit settings' should be amended to 'inpatient settings' as not all stroke patients are necessarily receiving care in stroke units.
- There are further issues with the set up of the four localities within Edinburgh as they all currently have different ways of working, and there are many parallel pieces of work ongoing.

action

- This group needs to recognise existing work and how we can feed into it, from a stroke-specific perspective.
- SK is liaising with CHSS to provide training for patient/carer representatives to enable them to be involved in future co-production work with hospital and community services.

It was agreed that the main aims of the group were to get patients back to their normal place of residence where possible and lower length of stay in hospitals, through delivery of adequate doses of therapy in hospital and community settings, utilising community rehabilitation, early supported discharge and discharge to assess models as appropriate.

4. Acute Division ISUs perspective – RIE/WGH/SJH

The group expressed concern with ongoing issues regarding delivery of rehabilitation on acute sites. There are an increasing number of admissions and bed pressures at acute sites, and quick decisions are made (perhaps too quickly) on patients coming through RIE. It's still unclear what the IJBs currently provide in the community as they are still evolving.

SK suggested 'stroke rehabilitation' be known as 'neuro recovery' and that it should be recorded if inpatients received an inadequate dose of rehabilitation. She has seen patients being discharged to no planned rehabilitation, and asked what evidence can be provided to prove that there is a lack of community rehabilitation, and suggested that BASP standards could be used. Noted that details of rehab are recorded on TRAK, but the amount of time taken (dose) is not recorded, although there is the facility to do this. Therapists explained that at RIE and WGH there is only 5/7 cover for therapy, and less when they are on weekend call, as weekday shifts are then not always covered, but not necessarily by stroke specialists when they are.

Agreed that a spreadsheet will be developed so that therapists can log the dose of rehab that is given. MS requested that the teams use the six categories of rehabilitation case mix that have been agreed, and suggested that the priority patients will be those in #3 & 4.

1. Patients with TIA/minor stroke discharged within 48 hr who may not need to come into ISU from the front door
2. Actively unwell and unfit for rehab (some of whom will be likely to die within 4 weeks)
3. Rehab – 'fast track' patients (to community rehab on an accelerated pathway, inreach/D2A)
4. Rehab – stroke specific (need to be on ISU, may become category 3)
5. Rehab – non-stroke specific (could go to alternative rehab settings, eg MOE)
6. Finished and delayed (could move off the ISU to wait with appropriate support/guidance)

MM and CW will provide this spreadsheet for the teams to use, and therapy teams to identify the dataset required. **MM, CW AHPs**

5. Edinburgh IJB/REAS perspective

LG and BH shared with the group the work that they have been involved with in relation to the Edinburgh Strategic Commissioning Plan for Learning and Physical Disability Services. They are chairing a subgroup of the Edinburgh

action

Disabilities Reference Group on pathways, which is not stroke-specific, and this group will feed into it. They are hoping that learning from this group will be able to be applied to other conditions.

JS, JH, MS and LG are involved with the Integrated Rehabilitation Collaborative (chaired by Allister Short), which is currently mapping therapy provision across Lothian. This group hopes to inform the future AAH bed base model and scope the need for services which are non specialist and can be delivered closer to home in line with the policy agenda. The focus is on transition from hospital to community, and the group is working to determine what a good pathway will look like. A commissioning plan is to be completed by December 2018 – which will focus on the early pathway and look at identifying gaps.

Noted that Edinburgh Intermediate Care Service had been disbanded, but is now to be reinstated again as an Edinburgh-wide service. Apparently a questionnaire was circulated to colleagues, but the majority of this group was not aware of it. With the split of these services into separate localities there are problems with a decrease in critical mass. It was suggested that the successful Parkinson's support service could be used for other models, eg orthopaedic, respiratory.

The Edinburgh IJB has four localities (NE, NW, SE & SW) and a hosted services section. The localities each have a hub and two clusters. The hubs and clusters each have managers. The hubs are specifically concerned with hospital discharge and anticipatory care (prevention of admission), having an intended intervention period of community rehabilitation for up to six weeks. The AHPs (OTs and PTs formerly from ICS) are currently based within the four hubs. The clusters are arranged around GP practices and are most concerned with care and reablement, having council OTs specialising in aids and adaptations to people's homes and promoting a self management approach.

ECSS

LG updated the group. The service has 1.5 PT, 2 OT and 15 support workers for the "weekly intensity for Lothian". She noted that the original pathway of hospital → Intermediate Care (IC) → ECSS worked well, but now there is no IC service and this is problematic, as they did lots of domiciliary care. ECSS find it difficult to cope with all of the patients discharged, and some are falling into a black hole. Over the winter period there was a three month wait for some patients into their service, but it is now a three week wait.

7. Patient/Carer perspective

LG noted that engagement opportunities for service users are ongoing, and there are open sessions arranged throughout August and September. The group wasn't aware of these, and the information will be forwarded by LG for circulation. There are future plans for co-production by service users, but these will be facilitated groups. **LG, MM**

8. CHSS Stroke Nurses

AB updated the group. The stroke nurses have been re-arranged so that there is one part-time nurse at AAH and two full-time at RIE. There are about 1000 patients discharged annually in Lothian with stroke, but nurses are only

action

seeing about 750 who return to their own homes. They have identified, and are now aware of, a number that decline the service or are readmitted to hospital. There is a QI project underway at SJH to determine the best way to capture all the discharged patients. She surmised that not all the patients discharged from the front door are referred to the service.

She noted that the carer project at WGH, led by Lyndsay MacAlpine, should have been amplified across Lothian. During its course, there were fewer care packages required and an increase in service user experience.

9. Neuropsychology

JG updated the group. The single waiting list across Lothian is working well for patients. When the DCN moves to RIE site, there will be further changes to the psychologist attached to that unit. There is an overall lack of psychology provision, but the CHSS stroke nurses are key to identifying patients and working with them. She also noted that the neuropsychology team are engaged with the stroke MCN Training and Education Subgroup.

10. Exercise after stroke

RM updated the group. There were initially nine people trained to REPS level 4 in stroke, but there are only four remaining in Edinburgh Leisure. They are actively working with partners, and have invested in bringing staff in-house rather than ongoing funded projects. They have started multi-condition 'get active' classes, and are developing further classes that can be run by REPS level 3 staff: strength and balance; cardio; active yoga; seated yoga; active cycle etc. There are 22 classes per week, with 260 people taking these 30 – 40 minute classes, and available at concession prices. There are still four stroke-specific classes operating at Drumbrae, Leith, Portobello and Gracemount Leisure Centres. Staff taking these classes are 90% trained to REPS level 3.

11. Scottish Stroke Care Audit - Rehabilitation

Following on from the Rehabilitation Sprint Audits carried out in 2016, which were concerned with the first 72 hours post stroke, the SSCA is focussing on the in-hospital and community rehabilitation elements of the stroke pathways across Scotland. The Scottish Stroke Improvement Plan will be adapted to reflect this in due course. As such, the work of this group will be timely in aspiring to meet the requirements of the new audit. MS has been seconded part time to assist the Scottish Government in this work.

12. Any other business

There was no further business.

13. Dates of future meetings

Tuesday 4th December, 10.00 – 12 noon
Royal Commonwealth Pool (Sir Paul Heatly room)