Health Education England

Evidence Brief: Community Rehabiliation Teams and Roles

Contents

Produced by the HEE Knowledge Management team Evidence Briefs offer a quick overview of the published reports, research, and evidence on a workforce-related topic.

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Evidence Brief: Community Rehabilitation Teams and Roles. Katie Nicholas. (September 2022). UK: Health Education England Knowledge Management Team

There may have been an update to this Evidence Brief - to check you are reading the most current version please see the links below:

- Complete Evidence Brief list – link for HEE staff
- Complete Evidence Brief list – link for External staff

Key publications – the big picture

Community Rehabilitation Toolkit
Source: NHS RightCare
Publication date: March 2020
This NHS RightCare system toolkit will support systems to understand the priorities in community rehabilitation care and the key actions to take. It provides opportunity to assess and benchmark current systems to find opportunities for improvement. It is produced with reference to an expert group of stakeholders and is supported by NICE. Wider consultation has taken place with patient representatives, clinicians, social care organisations, professional bodies and other key stakeholders (see acknowledgements page).
See “Match workforce to population needs”

The NHS Long Term Plan
Source: NHS
Publication date: January 2019
A new NHS offer of urgent community response and recovery support
1.8. Over the next five years all parts of the country will be asked to increase the capacity and responsiveness of community and intermediate care services to those who are clinically judged to benefit most. Extra investment and productivity reforms in community health services will mean that within five years all parts of the country will be expected to have improved the responsiveness of community health crisis response services to deliver the services within two hours of referral in line with NICE guidelines, where clinically judged to be appropriate. In addition, all parts of the country should be delivering reablement care within two days of referral to those patients who are judged to need it. This will help prevent unnecessary admissions to hospitals and residential care, as well as ensure a timely transfer from hospital to community. More NHS community and intermediate health care packages will be delivered to support timely crisis care, with the ambition of freeing up over one million hospital bed days. Urgent response and recovery support will be delivered by flexible teams working across primary care and local hospitals, developed to meet local needs, including GPs and specialty and associate specialist (SAS) doctors, allied health professionals (AHPs), district nurses, mental health nurses, therapists and reablement teams. Extra recovery, reablement and rehabilitation support will wrap around core services to support people with the highest needs.

3.77. Implementation and further development of higher intensity care models for stroke rehabilitation are expected to show significant savings that can be reinvested in improved patient care. This includes reductions in hospital admissions and ongoing healthcare provision. Out of hospital, more integrated and higher intensity rehabilitation for people recovering from stroke, delivered in partnership with voluntary organisations including the Stroke Association, will support improved outcomes to six months and beyond. The existing national stroke audit (SSNAP) provides high quality information on the acute and inpatient rehabilitation care of stroke patients to improve stroke services. An update to SSNAP will provide a comprehensive dataset that meets the needs of clinicians, commissioners and patients by describing the quality of care provided for stroke patients from symptom onset through to rehabilitation and ongoing care

Case Studies

Community Rehabilitation Case Study
Source: Chartered Society of Physiotherapy
My name is Sarah Daniel and I am the Director of MOTIONrehab Limited. MOTIONrehab have provided Neurological Rehabilitation across Yorkshire and Humberside for nearly 13 years. The delivery of our rehabilitation was predominately in the private sector, providing neurological physiotherapy in our clinic bases, people's homes or residential homes. In 2017, I was reflecting on the services we provided and considering whether we were maximising rehabilitation outcomes for our clients. At the time it was widely acknowledged that UK was experiencing a growing population of individuals with long-term rehabilitation needs as a consequence of stroke and other long-term conditions. Whilst I recognised that the NHS had a statutory obligation to meet the rehabilitation needs of the local population in line with The NHS Long Term Plan and other NICE guidelines and care pathways (e.g. Stroke Guidelines) the delivery model seemed less than optimal and there appeared to be an opportunity to improve rehabilitation services. I understood that the NHS had acknowledged that through Public Private Partnerships they could achieve the delivery of innovative, efficient, cost-effective treatment within modern facilities, whilst minimising their financial risk if they partnered with the private sector. With this in mind, I saw an opportunity to develop MOTIONrehab and innovate the delivery of rehabilitation to the benefit of both private and NHS patients.

Long Covid Community Rehabilitation Service, Leeds
Source: BDA (The Association of UK Dieticians)
Publication date: July 2021
The Leeds Long Covid Community Rehabilitation Service, commissioned by NHS Leeds Clinical Commissioning Group (CCG), is a partnership between Leeds Community Healthcare NHS Trust and The Leeds Teaching Hospitals NHS Trust.
It has been developed to help people in Leeds who are experiencing new, long-lasting problems 12 weeks or more after a confirmed or suspected COVID-19 infection which are significantly impacting how they are able to function in day-to-day life. The service is Allied Health Professional-led, with a team of physiotherapists, occupational therapists and dietitians, working with specialist consultants including a cardiologist and respiratory specialists, as well as a rehab consultant and temporary rehab registrar.

HEE Star

More resources and tools are available in the **Community** section of the HEE Star

Statistics

You can find relevant statistics on the Health and Care Statistics Landscape

HEE National Data Programme

HEE staff can look at the National Data Warehouse (NDL) SharePoint site to find out more about datasets and Tableau products.

Published Peer Reviewed Research

Transitions from healthcare to self-care: a qualitative study of falls service practitioners' views on self-management.
Item Type: Journal Article
Authors: Killingback, Clare;Thompson, Mark A.;Chipperfield, Sarah;Clark, Carol and Williams, Jonathan
Publication Date: 2022
Journal: Disability & Rehabilitation 44(12), pp. 2683-2690
Abstract: PURPOSE: The aim of this study was to understand the views of falls service practitioners regarding: their role in supporting self-management of falls prevention; and a transition pathway from National Health Service (NHS) exercise-based falls interventions to community-run exercise programmes. METHOD: Semi-structured interviews were conducted with physiotherapists, nurses, and rehabilitation assistants (n = 8) who worked in an NHS falls service. Data were analysed using thematic analysis. RESULTS: Certain aspects of supporting patients in self-management were deemed to be within or beyond the scope of falls service practitioners. Challenges in supporting transition to community-run programmes included: practitioner awareness and buy in; patient buy in; and patient suitability/programme availability. CONCLUSION: Practitioners sought to be patient-centred as a means to engage patients in self-management of falls prevention exercises. Time-limited intervention periods and waiting list pressures were barriers to the promotion of long-term self-management approaches. A disconnect between falls service interventions and community-run programmes hindered willing practitioners from supporting patients in transitioning. Unless falls risk and prevention is seen by healthcare providers as a long-term condition which requires person-centred support from practitioners to develop self-management approaches, then falls services may only be able to offer short-term measures which are potentially not long lasting.IMPLICATIONS FOR REHABILITATIONFalls rehabilitation practitioners need to take a person-centred approach to engage patients in self-management of falls prevention exercises. Providing information and signposting to exercise opportunities such as community-run programmes following falls service interventions should be viewed as being within the scope of the role of falls service practitioners. Rehabilitation practitioners should consider viewing falls risk as a long-term condition, to promote longer-term behavioural change approaches to ongoing engagement of exercise for falls prevention.

Evaluating the impact of a training program to support transitioning from the hospital to the community for people after stroke: a community case study
Item Type: Journal Article
Authors: Lui, Michelle;McKellar, Katherine;Cooper, Shari;Eng, Janice J. and Bird, Marie-Louise
Publication Date: Jan 05 ,2022
Journal: BMC Health Services Research 22(1), pp. 30
Abstract: BACKGROUND: The transitions in care along the stroke recovery path are challenging, particularly in finding mechanisms to continue one's recovery once at home. We aim to evaluate the impact of training physiotherapists and fitness instructors from one regional community together to deliver an evidence-based group exercise program starting in the hospital and transitioning to the community using an implementation approach. METHODS: The evidenced based exercise program Fitness and Mobility Exercise (FAME) for stroke was chosen as the intervention. Data from interviews with stakeholders (community centre and health authority hospital staff including a physiotherapy navigator) was transcribed and themes evaluated using the RE-AIM (Reach, Efficacy, Adoption, Implementation, Maintenance) framework. These data were supplemented by information collected as a quality assurance project within the health authority. RESULTS: Two programs

were established; one in the community centre (run over 15 months by fitness instructors) and one in the regional hospital (run over 12 months by a rehabilitation assistant under the direction from a physiotherapist). Transitions in care were facilitated by implementing the same evidence-based group exercise class in both the hospital and community setting, so people living with stroke could seamlessly move from one to another. An existing physiotherapist navigator service also was valued as a support for the transitions between the two centres for people with stroke. The hospital group accessed group-based physiotherapy service on average 31 days earlier than they were able to in a one-to-one format. CONCLUSIONS: This case study described the implementation of the Fitness and Mobility Exercise (FAME) program in one community and the use of a physiotherapist navigator to assist transition between them. After a community training workshop, FAME programs were established within the health authority and the community centre. FAME program participants within the health authority benefited from reduced wait times to access hospital outpatient physiotherapy service. Improvements in function were measured in and reported by the people after stroke attending either the health authority or community centre FAME groups.

Home-based rehabilitation programme compared with traditional physiotherapy for patients at risk of poor outcome after knee arthroplasty: the CORKA randomised controlled trial.
Item Type: Journal Article
Authors: Barker, Karen L.;Room, Jonathan;Knight, Ruth;Dutton, Susan;Toye, Francine;Leal, Jose;Kenealy, Nicola;Maia Schlussel, Michael;Collins, Gary;Beard, David;Price, Andrew James;Underwood, Martin;Drummond, Avril;Lamb, Sarah and CORKA Trial group
Publication Date: 08 27 ,2021
Journal: BMJ Open 11(8), pp. e052598
Abstract: OBJECTIVES: To evaluate whether a home-based rehabilitation programme for people assessed as being at risk of a poor outcome after knee arthroplasty offers superior outcomes to traditional outpatient physiotherapy. DESIGN: A prospective, single-blind, two-arm randomised controlled superiority trial. SETTING: 14 National Health Service physiotherapy departments in the UK. PARTICIPANTS: 621 participants identified at high risk of a poor outcome after knee arthroplasty using a bespoke screening tool. INTERVENTIONS: A multicomponent home-based rehabilitation programme delivered by rehabilitation assistants with supervision from qualified therapists versus usual care outpatient physiotherapy. MAIN OUTCOME MEASURES: The primary outcome was the Late-Life Function and Disability Instrument (LLFDI) at 12 months. Secondary outcomes were the Oxford Knee Score (a disease-specific measure of function), Knee injury and Osteoarthritis Outcome Score Quality of Life subscale, Physical Activity Scale for the Elderly, 5 dimension, 5 level version of Euroqol (EQ-5D-5L) and physical function assessed using the Figure of 8 Walk test, 30 s Chair Stand Test and Single Leg Stance. RESULTS: 621 participants were randomised between March 2015 and January 2018. 309 were assigned to CORKA (Community Rehabilitation after Knee Arthroplasty) home-based rehabilitation, receiving a median five treatment sessions (IQR 4-7). 312 were assigned to usual care, receiving a median 4 sessions (IQR 2-6). The primary outcome, LLFDI function total score at 12 months, was collected for 279 participants (89%) in the home-based CORKA group and 287 participants (92%) in the usual care group. No clinically or statistically significant difference was found between the groups (intention-to-treat adjusted difference=0.49 points; 95% CI -0.89 to 1.88; p=0.48). There were no statistically significant differences between the groups on any of the patient-reported or physical secondary outcome measures at 6 or 12 months. There were

18 participants in the intervention group reporting a serious adverse event (5.8%), only one directly related to the intervention, all other adverse events recorded throughout the trial related to underlying chronic medical conditions. CONCLUSIONS: The CORKA intervention was not superior to usual care. The trial detected no significant differences, clinical or statistical, between the two groups on either primary or secondary outcomes. CORKA offers an evaluation of an intervention utilising a different service delivery model for this patient group. TRIAL REGISTRATION NUMBER: ISRCTN13517704.

Large-scale implementation of stroke early supported discharge: the WISE realist mixed-methods study.
Item Type: Journal Article
Authors: Fisher, Rebecca J.;Chouliara, Niki;Byrne, Adrian;Cameron, Trudi;Lewis, Sarah;Langhorne, Peter;Robinson, Thompson;Waring, Justin;Geue, Claudia;Paley, Lizz;Rudd, Anthony and Walker, Marion F.
Publication Date: 2021
Journal: Health Services and Delivery Research 9(22), pp. (November 2021)
Abstract: BACKGROUND: In England, the provision of early supported discharge is recommended as part of an evidence-based stroke care pathway. OBJECTIVES: To investigate the effectiveness of early supported discharge services when implemented at scale in practice and to understand how the context within which these services operate influences their implementation and effectiveness. DESIGN: A mixed-methods study using a realist evaluation approach and two interlinking work packages was undertaken. Three programme theories were tested to investigate the adoption of evidence-based core components, differences in urban and rural settings, and communication processes. SETTING AND INTERVENTIONS: Early supported discharge services across a large geographical area of England, covering the West and East Midlands, the East of England and the North of England. PARTICIPANTS: Work package 1: historical prospective patient data from the Sentinel Stroke National Audit Programme collected by early supported discharge and hospital teams. Work package 2: NHS staff (n=117) and patients (n=30) from six purposely selected early supported discharge services. DATA AND MAIN OUTCOME: Work package 1: a 17-item early supported discharge consensus score measured the adherence to evidence-based core components defined in an international consensus document. The effectiveness of early supported discharge was measured with process and patient outcomes and costs. Work package 2: semistructured interviews and focus groups with NHS staff and patients were undertaken to investigate the contextual determinants of early supported discharge effectiveness. RESULTS: A variety of early supported discharge service models had been adopted, as reflected by the variability in the early supported discharge consensus score. A one-unit increase in early supported discharge consensus score was significantly associated with a more responsive early supported discharge service and increased treatment intensity. There was no association with stroke survivor outcome. Patients who received early supported discharge in their stroke care pathway spent, on average, one day longer in hospital than those who did not receive early supported discharge. The most rural services had the highest service costs per patient. NHS staff identified core evidence-based components (e.g. eligibility criteria, co-ordinated multidisciplinary team and regular weekly multidisciplinary team meetings) as central to the effectiveness of early supported discharge. Mechanisms thought to streamline discharge and help teams to meet their responsiveness targets included having access to a social worker and the quality of

communications and transitions across services. The role of rehabilitation assistants and an interdisciplinary approach were facilitators of delivering an intensive service. The rurality of early supported discharge services, especially when coupled with capacity issues and increased travel times to visit patients, could influence the intensity of rehabilitation provision and teams' flexibility to adjust to patients' needs. This required organising multidisciplinary teams and meetings around the local geography. Findings also highlighted the importance of good leadership and communication. Early supported discharge staff highlighted the need for collaborative and trusting relationships with patients and carers and stroke unit staff, as well as across the wider stroke care pathway. LIMITATIONS: Work package 1: possible influence of unobserved variables and we were unable to determine the effect of early supported discharge on patient outcomes. Work package 2: the pragmatic approach led to 'theoretical nuggets' rather than an overarching higher-level theory. CONCULSIONS: The realist evaluation methodology allowed us to address the complexity of early supported discharge delivery in real-world settings. The findings highlighted the importance of context and contextual features and mechanisms that need to be either addressed or capitalised on to improve effectiveness. TRIAL REGISTRATION: Current Controlled Trials ISRCTN15568163. FUNDING: This project was funded by the National Institute for Health Research (NIHR) Health Services and Delivery Research programme. [Abstract]

The role of the nurse in the community stroke rehabilitation team: a personal perspective Abstract only*
Item Type: Journal Article
Authors: Townshend, Brenda
Publication Date: 2020
Journal: British Journal of Neuroscience Nursing 16, pp. S6-S8
Abstract: Excellent patient care often requires the collaboration of a range of health professionals, and stroke patient rehabilitation is no exception. Brenda Townshend offers insights from her personal journey as a nurse in a London-based community stroke rehabilitation team.

Training of mid-level rehabilitation workers for community-based rehabilitation programmes.
Item Type: Journal Article
Authors: Ghosh, R.;Palanivelu, V.;Tebbutt, E. and Deepak, S.
Publication Date: 2020
Journal: Disability, CBR and Inclusive Development 31(4), pp. 191-216
Abstract: Purpose: There is a lack of trained rehabilitation professionals, especially in the small towns and rural areas of low and middle income countries. In India, a cadre of mid-level rehabilitation workers, the Rehabilitation Therapy Assistants (RTAs), are being trained by Mobility India, a Non-Governmental Organisation (NGO). This paper aims to assess impact of their training and experiences after the training. Method(s): Data were collected from 3 different initiatives connected with the trained RTAs: an impact assessment of their training; interviews with RTAs during an evaluation; and a survey of 188 RTAs trained between 2002 and 2019. Result(s): RTAs were shown to have good skills to provide rehabilitation interventions in the field and are appreciated by clients and other stakeholders. Most of the RTAs work for NGOs in CBR programmes, and in private hospitals and clinics. There does not seem to be a role for them in government services in most countries. The number of trained RTAs remains small in spite of the large needs. This may be due to lack of an accreditation system for RTAs and the low priority given to rehabilitation services in general in some countries. Conclusion(s): The results provide useful information to strengthen RTA training courses. Training RTAs to provide rehabilitation services in smaller towns and rural areas of low and middle income

countries can have a good impact through CBR programmes. However, this impact remains circumscribed to small areas where NGOs are active. Changes are needed in health systems for the inclusion of mid-level rehabilitation workers in primary health care services. Copyright © 2020, Action for Disability Regional Rehabilitation Centre. All rights reserved.

Recruitment challenges in stroke rehabilitation randomized controlled trials: a qualitative exploration of trialists' perspectives using Framework analysis. Abstract only*
Item Type: Journal Article
Authors: McGill, Kris;McGarry, Jodie;Sackley, Catherine;Godwin, Jon;Nicoll, Avril and Brady, Marian C.
Publication Date: Aug ,2020
Journal: Clinical Rehabilitation 34(8), pp. 1122-1133
Abstract: OBJECTIVE: To explore the underlying reasons for recruitment difficulties to stroke rehabilitation randomized controlled trials from the perspective of trialists. DESIGN: A qualitative study using semi-structured interviews and Framework analysis. PARTICIPANTS: Twenty multidisciplinary stroke rehabilitation trialists across 13 countries with a range of clinical and research experience. METHODS: Twenty semi-structured telephone interviews were carried out. Purpose ful sampling ensured a range of opinions were gathered from across the international stroke rehabilitation research community. Using Framework analysis, the analytical framework was formed by three researchers and tested before being applied to the total dataset. RESULTS: Three themes described the trialists' perception of the underlying reasons for recruitment difficulties: (i) decision making, (ii) importance of recruiters and (iii) a broken system. Trialists described frequently disregarding evidence in favour of prior research experiences when planning randomized controlled trial recruitment. All felt that the relationship between the research and clinical teams was vital to ensure recruiters prioritized and found value in recruitment to the trial. Experienced trialists were frustrated by the lack of reporting of the reality of running trials, research governance demands and the feeling that they had to deliberately underestimate recruitment timeframes to secure funding. CONCLUSION: Stroke rehabilitation trialists described recruitment difficulties which may be related to their experiential based recruitment decision making, a lack of understanding of how best to incentivize and maintain relationships with recruiters and unrealistic bureaucratic expectations both in terms of gaining funding and research governance.

A randomised controlled trial of an exercise intervention promoting activity, independence and stability in older adults with mild cognitive impairment and early dementia (PrAISED) - A Protocol.
Item Type: Journal Article
Authors: Bajwa, Rupinder K.;Goldberg, Sarah E.;Van der Wardt, Veronika;Burgon, Clare;Di Lorito, Claudio;Godfrey, Maureen;Dunlop, Marianne;Logan, Pip;Masud, Tahir;Gladman, John;Smith, Helen;Hood-Moore, Vicky;Booth, Vicky;Das Nair, Roshan;Pollock, Kristian;Vedhara, Kavita;Edwards, Rhiannon Tudor;Jones, Carys;Hoare, Zoe;Brand, Andrew, et al
Publication Date: Dec 30 ,2019
Journal: Trials [Electronic Resource] 20(1), pp. 815
Abstract: BACKGROUND: People with dementia progressively lose cognitive and functional abilities. Interventions promoting exercise and activity may slow decline. We developed a novel intervention to promote activity and independence and prevent falls in people with mild cognitive impairment (MCI) or early dementia. We successfully undertook a feasibility randomised controlled trial (RCT) to refine the intervention and research delivery. We are now delivering a multi-centred RCT to evaluate its clinical and cost-effectiveness. METHODS: We will recruit 368 people with MCI or early dementia (Montreal Cognitive Assessment score 13-25) and a family member or carer from

memory assessment clinics, other community health or social care venues or an online register (the National Institute for Health Research Join Dementia Research). Participants will be randomised to an individually tailored activity and exercise programme delivered using motivational theory to promote adherence and continued engagement, with up to 50 supervised sessions over one year, or a brief falls prevention assessment (control). The intervention will be delivered in participants' homes by trained physiotherapists, occupational therapists and therapy assistants. We will measure disabilities in activities of daily living, physical activity, balance, cognition, mood, quality of life, falls, carer strain and healthcare and social care use. We will use a mixed methods approach to conduct a process evaluation to assess staff training and delivery of the intervention, and to identify individual- and context-level mechanisms affecting intervention engagement and activity maintenance. We will undertake a health economic evaluation to determine if the intervention is cost-effective. DISCUSSION: We describe the protocol for a multi-centre RCT that will evaluate the clinical and cost-effectiveness of a therapy programme designed to promote activity and independence amongst people living with dementia. TRIAL REGISTRATION: ISRCTN, ISRCTN15320670. Registered on 4 September 2018.

Frailty: An in-depth qualitative study exploring the views of community care staff.
Item Type: Journal Article
Authors: Coker, J. F.;Martin, M. E.;Simpson, R. M. and Lafortune, L.
Publication Date: 2019
Journal: BMC Geriatrics 19(1), pp. no pagination
Abstract: Background: Frailty is seen across various health and social care settings. However, little is known about how healthcare professionals, particularly those who provide care for older adults living in the community view frailty. There is also a dearth of information about the extent to which a shared understanding of frailty exists across the various disciplines of care. Such an understanding is crucial across care professionals as it ensures consistent assessment of frailty and facilitates interdisciplinary working/collaboration which is a key component in the management of frailty. This study aimed to explore: (i) how community care staff from various specialties viewed frailty; (ii) whether they had a shared understanding; and (iii) how they assessed frailty in everyday practice. Method(s): Semi-structured interviews were conducted with a purposive sample of 22 community care staff from seven specialties, namely: healthcare assistants, therapy assistants, psychiatric nurses, general nurses, occupational therapists, physiotherapists and social workers, recruited from four neighbourhood teams across Cambridgeshire, England. Interviews were analysed thematically. Result(s): There was a shared narrative among participants that frailty is an umbrella term that encompasses interacting physical, mental health and psychological, social, environmental, and economic factors. However, various specialities emphasised the role of specific facets of the frailty umbrella. The assessment and management of frailty was said to require a holistic approach facilitated by interdisciplinary working. Participants voiced a need for interdisciplinary training on frailty, and frailty tools that facilitate peer-learning, a shared understanding of frailty, and consistent assessment of frailty within and across specialities. Conclusion(s): These findings underscore the need to: (i) move beyond biomedical descriptions of frailty; (ii) further explore the interacting nature of the various components of the frailty umbrella, particularly the role of modifiable factors such as psychological and socioeconomic resilience; (iii) care for frail older adults using holistic, interdisciplinary approaches; and (iv) promote interdisciplinary training around frailty and frailty tools to facilitate a shared understanding and consistent assessment of frailty within and across specialities. Copyright © 2019 The

Author(s).

Developing a holistic, multidisciplinary community service for frail older people. Abstract only*
Item Type: Journal Article
Authors: Featherstone, Amanda
Publication Date: 11 29 ,2018
Journal: Nursing Older People 30(7), pp. 34-40
Abstract: This article explores the development of an ambulatory community service that demonstrates multidisciplinary working to meet the diverse needs of frail older people and their carers. The service comprises advanced nurse practitioners, a pharmacist, a community navigator, consultants, occupational therapists, physiotherapists, a nurse, rehabilitation assistants, a healthcare assistant and an administrator. This multidisciplinary team (MDT) serves adults with complex medical and rehabilitation needs who are being discharged from hospital, staying in bedded rehabilitation units or living at home by offering assessments, investigations and rehabilitation, where appropriate closer to home. The aims of the service are to: keep people well, prevent unplanned hospital admissions, promote health and well-being, reduce the risk of falls, enable independent living and provide rehabilitation. Personalised care plans are developed with patients and their carers. Advanced nursing practice is demonstrated in assessment, investigation, diagnosis, management, referral and non-medical prescribing. Development of this MDT is required to support and promote integrated, evidence-based work. Such development leads to integrated care across communities, and bridges gaps between patients and carers, GPs, home, residential and hospital-based services, and the voluntary, statutory and non-statutory sectors.

A modelling tool for capacity planning in acute and community stroke services
Item Type: Journal Article
Authors: Monks, Thomas;Worthington, David;Allen, Michael;Pitt, Martin;Stein, Ken and James, Martin A.
Publication Date: 2016
Journal: BMC Health Services Research 16, pp. 530
Abstract: Background: Mathematical capacity planning methods that can take account of variations in patient complexity, admission rates and delayed discharges have long been available, but their implementation in complex pathways such as stroke care remains limited. Instead simple average based estimates are commonplace. These methods often substantially underestimate capacity requirements. We analyse the capacity requirements for acute and community stroke services in a pathway with over 630 admissions per year. We sought to identify current capacity bottlenecks affecting patient flow, future capacity requirements in the presence of increased admissions, the impact of co-location and pooling of the acute and rehabilitation units and the impact of patient subgroups on capacity requirements. We contrast these results to the often used method of planning by average occupancy, often with arbitrary uplifts to cater for variability.Methods: We developed a discrete-event simulation model using aggregate parameter values derived from routine administrative data on over 2000 anonymised admission and discharge timestamps. The model mimicked the flow of stroke, high risk TIA and complex neurological patients from admission to an acute ward through to community rehab and early supported discharge, and predicted the probability of admission delays.Results: An increase from 10 to 14 acute beds reduces the number of patients experiencing a delay to the acute stroke unit from 1 in every 7 to 1 in 50. Co-location of the acute and rehabilitation units and pooling eight beds out of a total bed stock of 26

reduce the number of delayed acute admissions to 1 in every 29 and the number of delayed rehabilitation admissions to 1 in every 20. Planning by average occupancy would resulted in delays for one in every five patients in the acute stroke unit.Conclusions: Planning by average occupancy fails to provide appropriate reserve capacity to manage the variations seen in stroke pathways to desired service levels. An appropriate uplift from the average cannot be based simply on occupancy figures. Our method draws on long available, intuitive, but underused mathematical techniques for capacity planning. Implementation via simulation at our study hospital provided valuable decision support for planners to assess future bed numbers and organisation of the acute and rehabilitation services.

Centralising acute stroke care and moving care to the community in a Danish health region: Challenges in implementing a stroke care reform.
Item Type: Journal Article
Authors: Douw, Karla;Nielsen, Camilla Palmhoj and Pedersen, Camilla Riis
Publication Date: Aug ,2015
Journal: Health Policy 119(8), pp. 1005-1010
Abstract: In May 2012, one of Denmark's five health care regions mandated a reform of stroke care. The purpose of the reform was to save costs, while at the same time improving quality of care. It included (1) centralisation of acute stroke treatment at specialised hospitals, (2) a reduced length of hospital stay, and (3) a shift from inpatient rehabilitation programmes to community-based rehabilitation programmes. Patients would benefit from a more integrated care pathway between hospital and municipality, being supported by early discharge teams at hospitals. A formal policy tool, consisting of a health care agreement between the region and municipalities, was used to implement the changes. The implementation was carried out in a top-down manner by a committee, in which the hospital sector--organised by regions--was better represented than the primary care sector-organised by municipalities. The idea of centralisation of acute care was supported by all stakeholders, but municipalities opposed the hospital-based early discharge teams as they perceived this to be interfering with their core tasks. Municipalities would have liked more influence on the design of the reform. Preliminary data suggest good quality of acute care. Cost savings have been achieved in the region by means of closure of beds and a reduction of hospital length of stay. The realisation of the objective of achieving integrated rehabilitation care between hospitals and municipalities has been less successful. It is likely that greater involvement of municipalities in the design phase and better representation of health care professionals in all phases would have led to more successful implementation of the reform.

Community stroke rehabilitation teams: providing home-based stroke rehabilitation in Ontario, Canada.
Item Type: Journal Article
Authors: Allen, L.;Richardson, M.;McIntyre, A.;Janzen, S.;Meyer, M.;Ure, D.;Willems, D. and Teasell, R.
Publication Date: Nov ,2014
Journal: Canadian Journal of Neurological Sciences 41(6), pp. 697-703
Abstract: BACKGROUND: Community stroke rehabilitation teams (CSRTs) provide a community-based, interdisciplinary approach to stroke rehabilitation. Our objective was to assess the effectiveness of these teams with respect to client outcomes. METHODS: Functional, psychosocial, and caregiver outcome data. were available at intake, discharge from the program, and six-month follow-up. Repeated measures analysis of covariance was performed to assess patient changes

between time points for each outcome measure. RESULTS: A total of 794 clients met the inclusion criteria for analysis (54.4% male, mean age 68.5+/-13.0 years). Significant changes were found between intake and discharge on the Hospital Anxiety and Depression Scale total score (p=0.017), Hospital Anxiety and Depression Scale Anxiety subscale (p<0.001), Functional Independence Measure (p<0.001), Reintegration to Normal Living Index (p=0.01), Bakas Caregiver Outcomes Scale (p<0.001), and Caregiver Assistance and Confidence Scale assistance subscale (p=0.005). Significant gains were observed on the strength, communication, activities of daily living, social participation, memory, and physical domains of the Stroke Impact Scale (all p<0.001). These improvements were maintained at the 6-month follow-up. No significant improvements were observed upon discharge on the memory and thinking domain of the Stroke Impact Scale; however, there was a significant improvement between admission and follow-up (p=0.002). All significant improvements were maintained at the 6-month follow-up. CONCLUSIONS: Results indicate that the community stroke rehabilitation teams were effective at improving the functional and psychosocial recovery of patients after stroke. Importantly, these gains were maintained at 6 months postdischarge from the program. A home-based, stroke-specific multidisciplinary rehabilitation program should be considered when accessibility to outpatient services is limited.

Multi-disciplinary team meetings in stroke rehabilitation: an observation study and conceptual framework
Author(s): Tyson et al.
Source: Clinical Rehabilitation 28(12) pp. 1237-1247
Publication date: 2014
Objective: To explore how multi-disciplinary team meetings operate in stroke rehabilitation. Design: Non-participant observation of multi-disciplinary team meetings and semi-structured interviews with attending staff. Setting and participants: Twelve meetings were observed (at least one at each site) and 18 staff (one psychologist, one social worker; four nurses; four physiotherapists four occupational therapists, two speech and language therapists, one stroke co-ordinator and one stroke ward manager) were interviewed in eight in-patient stroke rehabilitation units. Results: Multi-disciplinary team meetings in stroke rehabilitation were complex, demanding and highly varied. A model emerged which identified the main inputs to influence conduct of the meetings were personal contributions of the members and structure and format of the meetings. These were mediated by the team climate and leadership skills of the chair. The desired outputs; clinical decisions and the attributes of apparently effective meetings were identified by the staff. A notable difference between the meetings that staff considered effective and those that were not, was their structure and format. Successful meetings tended to feature a set agenda, structured documentation; formal use of measurement tools; pre-meeting preparation and skilled chairing. These features were often absent in meetings perceived to be ineffective. Conclusions: The main features of operation of multi-disciplinary team meetings have been identified which will enable assessment tools and interventions to improve effectiveness to be developed.

Implementing evidence-based stroke Early Supported Discharge services: A qualitative study of challenges, facilitators and impact.
Item Type: Journal Article
Authors: Chouliara, N.;Fisher, R. J.;Kerr, M. and Walker, M. F.
Publication Date: 2014
Journal: Clinical Rehabilitation 28(4), pp. 370-377
Abstract: Objectives: To explore the perspectives of healthcare professionals and commissioners working with a stroke Early Supported Discharge service in relation to: (1) the factors that

facilitate or impede the implementation of the service, and (2) the impact of the service. Design(s): Cross-sectional qualitative study using semi-structured interviews. Data were analysed by two researchers using a thematic analysis approach. Setting(s): Two Early Supported Discharge services in Nottinghamshire. Participant(s): Purposive sampling identified 35 key informants including practitioners, managers and commissioners. Result(s): The identified facilitators to the implementation of evidence-based services were: (1) the adaptability of the intervention to the healthcare context, (2) the role of rehabilitation assistants and (3) cross-service working arrangements. Perceived challenges included: (1) lack of clarity regarding the referral decision making process, (2) delays in securing social care input and (3) lack of appropriate followon services in the region. Most respondents perceived the impact of the services to be: (1) reducing inhospital stay, (2) aiding the seamless transfer of care from hospital to the community and (3) providing intensive stroke specific therapy. Commissioners called for greater evidence of service impact and clarity regarding where it fits into the stroke pathway. Conclusion(s): Early Supported Discharge services were perceived as successful in providing homebased, stroke specific rehabilitation. Teams would benefit from capitalising on identified facilitators and developing strategies to address the challenges. The remit and impact of the services should be clear and demonstrable, with teams strengthening links with other health and social care providers. © The Author(s) 2013.

The role of the community stroke rehabilitation nurse. Abstract only*
Item Type: Journal Article
Authors: McGinnes, Alison;Easton, Sarah;Williams, Jane and Neville, Janet
Publication Date: 2013
Journal: British Journal of Nursing 19(16), pp. 1033-1038

Abstract: There is strong evidence for early supported discharge (ESD) following stroke, but there is no evidence on how these services should be organized or the best models of care. ESD teams rarely include a community stroke rehabilitation nurse. A service development project was undertaken in Portsmouth Hospitals NHS Trust's community stroke rehabilitation team to identify and explore the unique contributions of community stroke rehabilitation nurses in an established ESD team. When the team was set up, the nurses had inpatient stroke rehabilitation skills, but no community experience. This novel approach, which involved taking specialist hospital nurses into the community, meant there was a steep learning curve and, unfortunately, there were no role models to support their development. During these early days, it became apparent that intensive stroke rehabilitation within an interdisciplinary ESD team required effective and timely nursing intervention, the development of skills to support interdisciplinary working and a greater understanding of the roles of all team members. Locally and nationally, questions were being asked pertaining to the nurses' role, which precipitated this project. Through a series of journal club sessions, the interdisciplinary team reviewed the evidence base of the nurse role in stroke rehabilitation. The team were able to evaluate findings against current practice. The project confirmed that the community stroke rehabilitation nurse provides a unique and fundamental role to the team that strengthens the model of interdisciplinary teamworking.

A supportive home visit program for older adults implemented by non-professionals: Feasibility and effects on physical performance and quality of life at one year - A pilot study.
Abstract only*
Item Type: Journal Article
Authors: Niemela, K.;Leinonen, R. and Laukkanen, P.
Publication Date: 2012

Journal: Archives of Gerontology and Geriatrics 54(3), pp. e376-e382
Abstract: Knowledge of supportive home rehabilitative procedures is needed to improve the independent home training and psychosocial wellbeing of older people. The primary focus of this study was to assess the feasibility of a home visit program involving the use of non-professional home rehabilitation assistants (HRAs) support among elderly. The secondary objective was to investigate the effects to physical performance and health-related quality of life (HRQL) of older people. A controlled intervention study was implemented at two war veterans' rehabilitation centers in Finland. The study included 22 long-term unemployed people aged 26-58 years, who were educated in HRA tasks and 417 community-dwelling persons aged 65-99 years, who participated in 10-28 days of inpatient rehabilitation. The intervention group (IG) received 10-14-month physiotherapist-supervised HRA home visit program. The control group (CG) received no home visit intervention. Additional information was collected to assess the feasibility of the intervention. Structured interviews were carried out. Physical performance was evaluated through several validated tests, pain with the Visual Analog Scale (VAS), and HRQL with the Leipad questionnaire. The HRAs adopted their supporting role through the social activation of the rehabilitees and continued to study to become practical nurses. At 10-14 months, HRQL among women (p= 0.029) and chair rising among men (p= 0.028) improved in the IG but declined in the CG. The supportive home visit program was feasible and improved the HRQL in women and chair rising in men. This model could motivate long-term unemployed people to educate themselves. © 2011 Elsevier Ireland Ltd.

Evaluating new roles for the support workforce in community rehabilitation settings in Queensland. Abstract only*
Item Type: Journal Article

Authors: Wood, Angela J.;Schuurs, Sarita B. and Amsters, Delena I.
Publication Date: Feb ,2011
Journal: Australian Health Review 35(1), pp. 86-91
Abstract: INTRODUCTION: Alternative workforce models need to be explored to adequately meet the future health care needs of the Australian population. A new role for the support workforce, to optimise their contribution in community rehabilitation in Queensland--the advanced community rehabilitation assistant (ACRA)--was developed on the basis of service activity mapping and gap analysis. OBJECTIVES: Evaluation of a trial of the new ACRA role at six pilot sites in Queensland. PARTICIPANTS: ACRAs, health professionals and rehabilitation clients. METHODS: Transcripts of semistructured telephone interviews conducted with ACRAs, health professionals and rehabilitation clients were thematically analysed. The nature of the role as well as perceived strengths and weaknesses were explored. RESULTS: The presence of an ACRA was generally seen to diversify and expand local service capacity. The major challenge was the initial intensity of instruction that was required from supervising health professionals. CONCLUSIONS: ACRAs have potential to be valuable resources in the provision of community rehabilitation services. The challenge of meeting each new ACRA's preliminary training needs requires further consideration. A critical mass of people trained to this role may be required to ensure sustainability. Further trial and evaluation is needed to investigate the role more thoroughly over time and in different settings.

Competency Frameworks

Allied Health Professions' Support Worker Competency, Education, and Career Development Framework
Source: HEE
This framework enables employers, networks, integrated care systems (ICSs) and services effectively plan, develop, and deploy their AHP support workforce. It provides guidance on training, education and competencies for AHP support workers and demonstrates a clear pathway for recruitment and progression, with common and transferrable skills across eight domains.

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