SSNAP Post-acute Organisational Audit 2021

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14th December 2021

SSNAP | Sentinel Stroke National Audit Programme

KING'S College LONDON

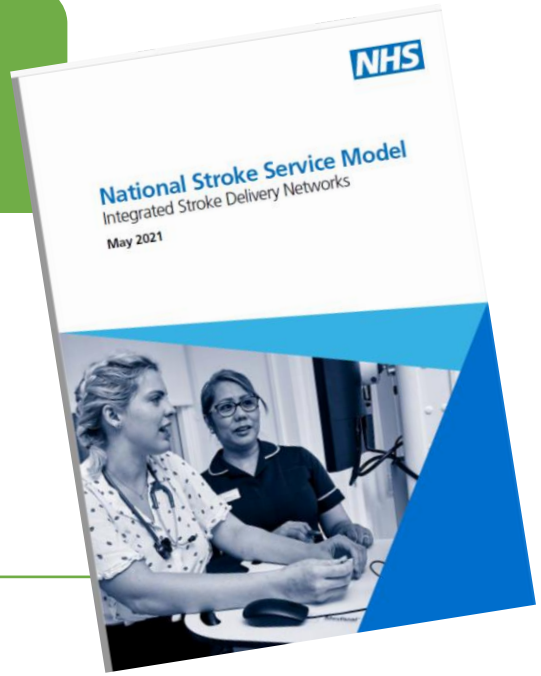
Outline of the session

Overview of the PAOA

- Headlines

Zooming in:

- Inpatient rehabilitation
- ICSS (including ESD)
- Vocational Rehabilitation



Post-acute organisational Audit: outputs available

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Results > Post-Acute Organisational Audit 2021 > National

- Clinical audit
- Acute Organisational Audit
- Post-Acute Organisational Audit
- Post-Acute Organisational Audit 2021
  - National
  - Dashboard
- Results (new)

National Results - Post-Acute Organisational Audit 2021

Full Results Portfolio

Shows post-acute stroke service provider level results by named participant benchmarked against the national average #SSNAPorg

Download Full Results Portfolio

Data only portfolio for all post-acute providers here:

Public Report

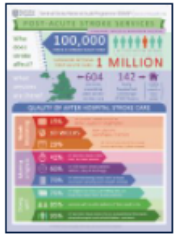
Presents key nation
Post-acute stroke se
It includes appendi
participating #SSNA

Download Public report

Download Public report appendices

The national report can be downloaded from here:

Infographic



Provides a concise one page visualisation of the key findings from the
acute stroke service provid
based on service organisati
2021

Download infographic

Infographic can be downloaded from here:

664 teams

Caseload of

112,174 from

1 April 2020 to 31 March 2021

Workforce of

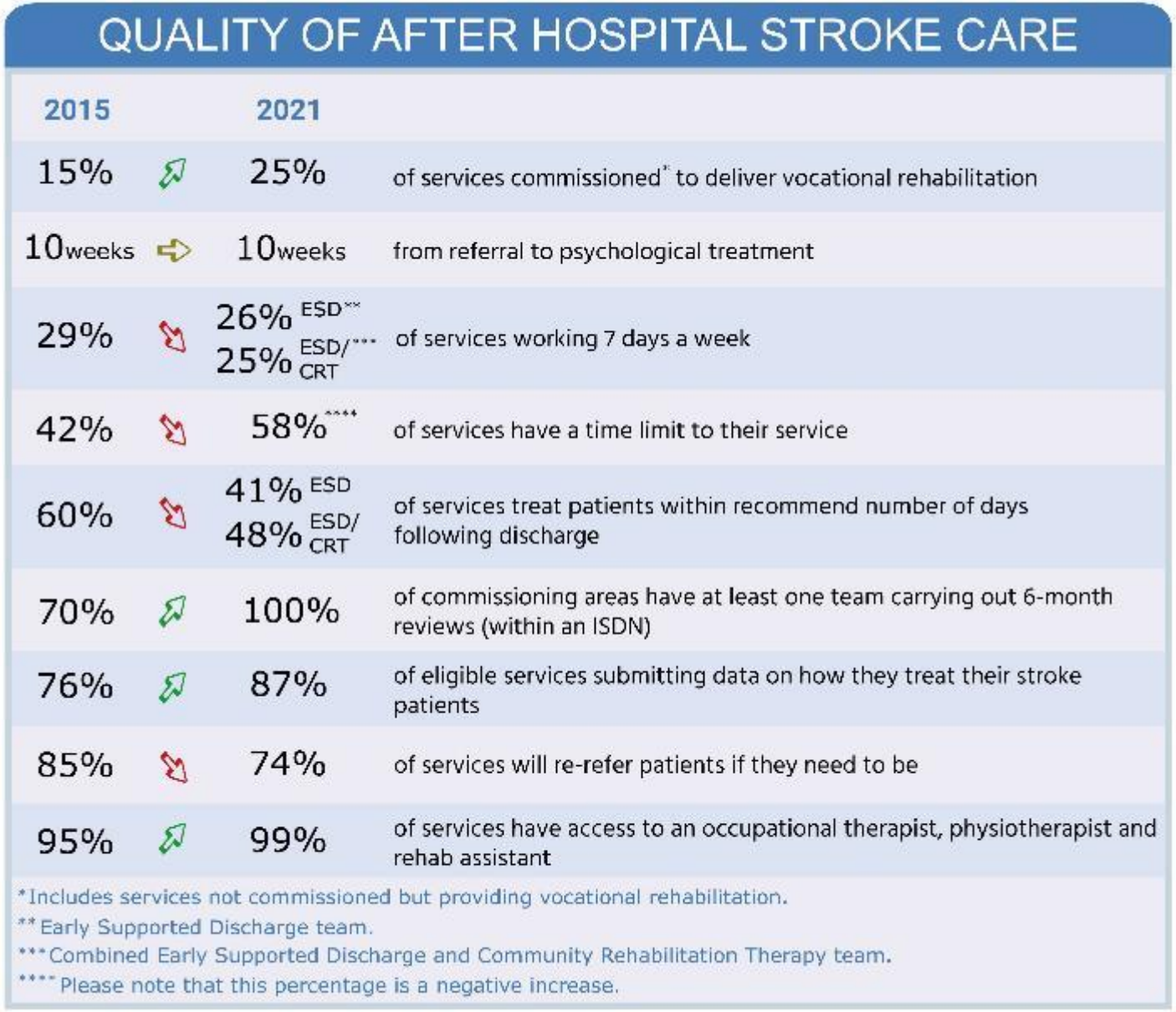
6710.85 WTE

How our approach differed this time

- Engagement events with each ISDN
- Broadened 'other acute provider' category
- Inclusion of specialist commissioned (level 1 and 2) inpatient units
- Impact of COVID

Comparison of 2015 and 2021 performance

Figure 1.1: Comparison of 2015 and 2021 performance



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Key Performance Indicators

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Data period 01/04/2021 – 31/03/21

Key indicators

Figure 1.4: Percentage of Post-acute Inpatient Teams and Community-based Multidisciplinary Teams

*Two points achieved for this KI

**One point achieved for this KI

***Community based Multidisciplinary Teams include Early Supported Discharge Teams, Community Rehabilitation Teams and Combined ESD/CRT.

Note: Not all KI's are relevant to all service types (KI 7,8,9,12)

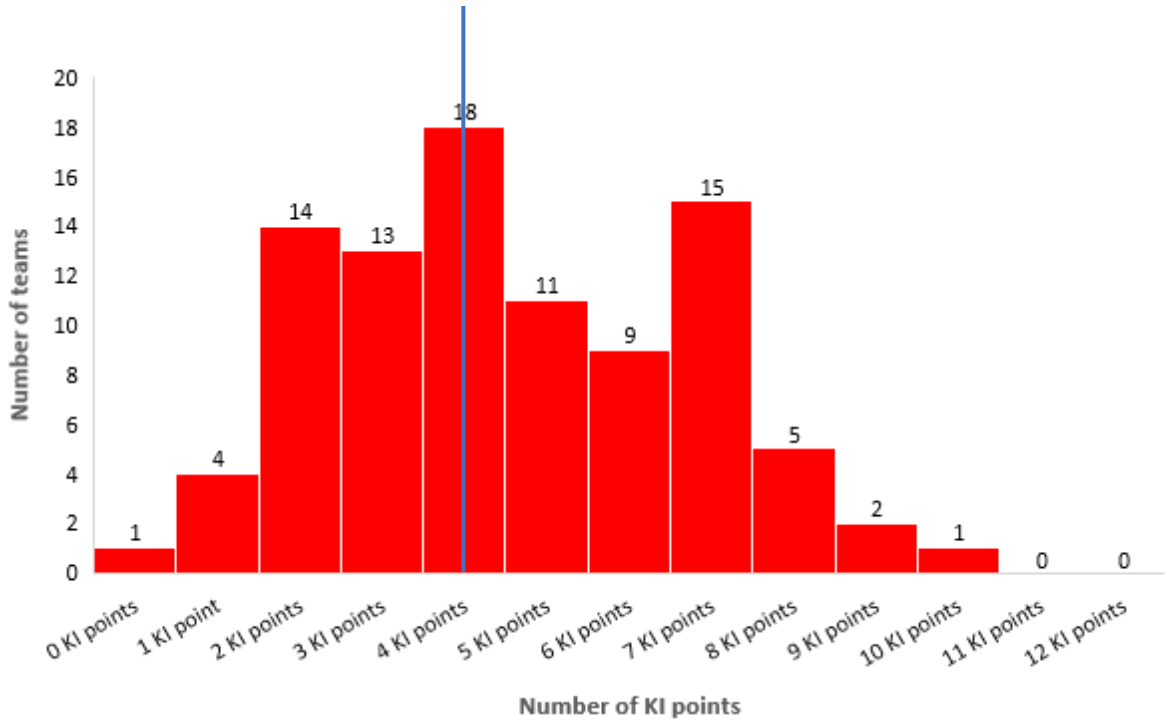

Figure 1.2: Post-acute inpatient team total KI performance

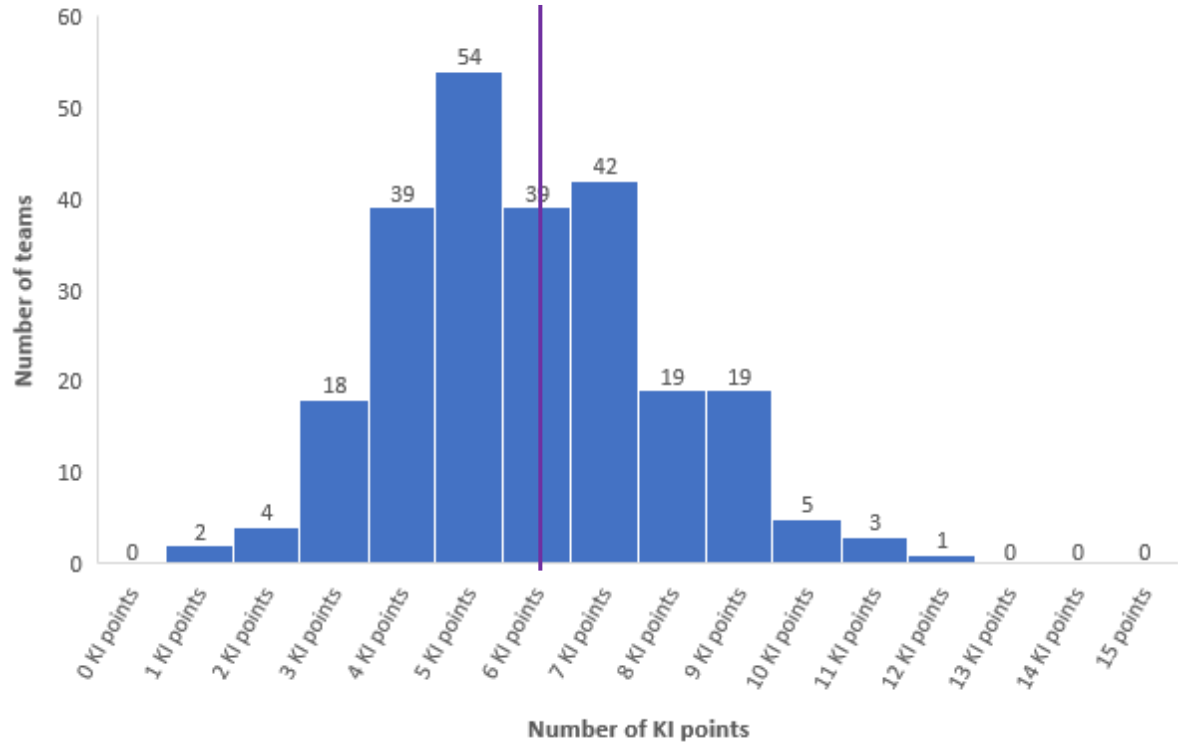

Figure 1.3: Community-based multidisciplinary team total KI performance*

Key indicator	Integrated Stroke Delivery Networks who meet this key indicator (n=20)
KI15: Access to commissioned vocational rehabilitation	**50% (10/20)**
KI6: Provision of 6-month reviews	**50% (10/20)**
KI7: Provision of formally commissioned support services	**35% (7/20)**

Key Performance Indicator

Table 1.2: Integrated Stroke Delivery Network Key Performance Indicators

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Participation

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Participation

Table 2.1: 2021 Post-acute Organisational Audit Participation (number of teams responding)

Service type	Count
Post-acute inpatient team	**93**
Early Supported Discharge team	**88**
Community Rehabilitation team	**86**
Combined ESD/CRT	**71**
6-month assessment provider	**78**
Single discipline service	**66**
Other post-acute provider	**182**

Table 2.2: Reported caseload numbers by service type in 2015 and 2021

Service type	2015	2021
Post-acute inpatient teams	**11,713**	**12,898**
Community-based multidisciplinary teams (Early Supported Discharge, Community Rehabilitation team, Combined ESD/CRT)	**57,291**	**68,086**
Outpatient	**9273**	**Not collected***
Single discipline service	**10,388**	**31,190**
Total	**88,885**	**112,174**
Other post-acute provider	**53,092**	**Not reported****

*Outpatient services reported as a standalone/single discipline service in 2021

**Other post-acute providers from PAOA 2021 not reported as per the 2015 definition.

Staff in participating services

Table 2.3: Total reported WTE and percentage per clinical discipline per service type

Clinical discipline	Post-acute inpatient teams (n=2886.4)	Community-based multidisciplinary teams: ESD, ESD/CRT, CRT (n=3469.8)	6-month assessment providers (n=150.3)	Single discipline service (n=204.3)	Total reported WTE (n=6710.85)
Occupational therapy	**9.3% (267.3)**	**23.2% (803.7)**	**5.8% (8.7)**	**8.7% (17.8)**	**16.4% (1097.5)**
Physiotherapy	**9.8% (283.8)**	**26.8% (928.2)**	**6.9% (10.4)**	**23.9% (48.8)**	**18.9% (1271.2)**
SLT*	**3.7% (108.2)**	**8.3% (287.4)**	**2.9% (4.4)**	**44.6% (91.2)**	**7.3% (491.2)**
Psychology**	**1.5% (44.1)**	**2.5% (87.8)**	**0.5% (0.8)**	**8.5% (17.4)**	**2.2% (150.1)**
Dietician**	**0.8% (21.9)**	**0.7% (25.14)**	**0.9% (1.4)**	**0.5% (1.1)**	**0.7% (49.5)**
Social worker**	**0.4% (12.9)**	**0.6% (19.1)**	**0% (0)**	**0% (0)**	**0.5% (32)**
Doctor	**4.8% (139.8)**	**0.1% (4.3)**	**7.8% (11.8)**	**0% (0)**	**2.3% (155.9)**
Nurse	**58.7% (1694.8)**	**7.2% (249.3)**	**55.3% (83.2)**	**0% (0)**	**30.2% (2027.3)**
Rehab Assistant	**10.9% (313.6)**	**30.7% (1064.9)**	**18.1% (2.2)**	**13.7% (28)**	**21.1% (1418.7)**
Family and carer support worker**	**0% (0)**	**0% (0)**	**11.6% (17.5)**	**0% (0)**	**0.3% (17.5)**

*Speech and language therapy

**Under-represented clinical disciplines

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Integrated community services

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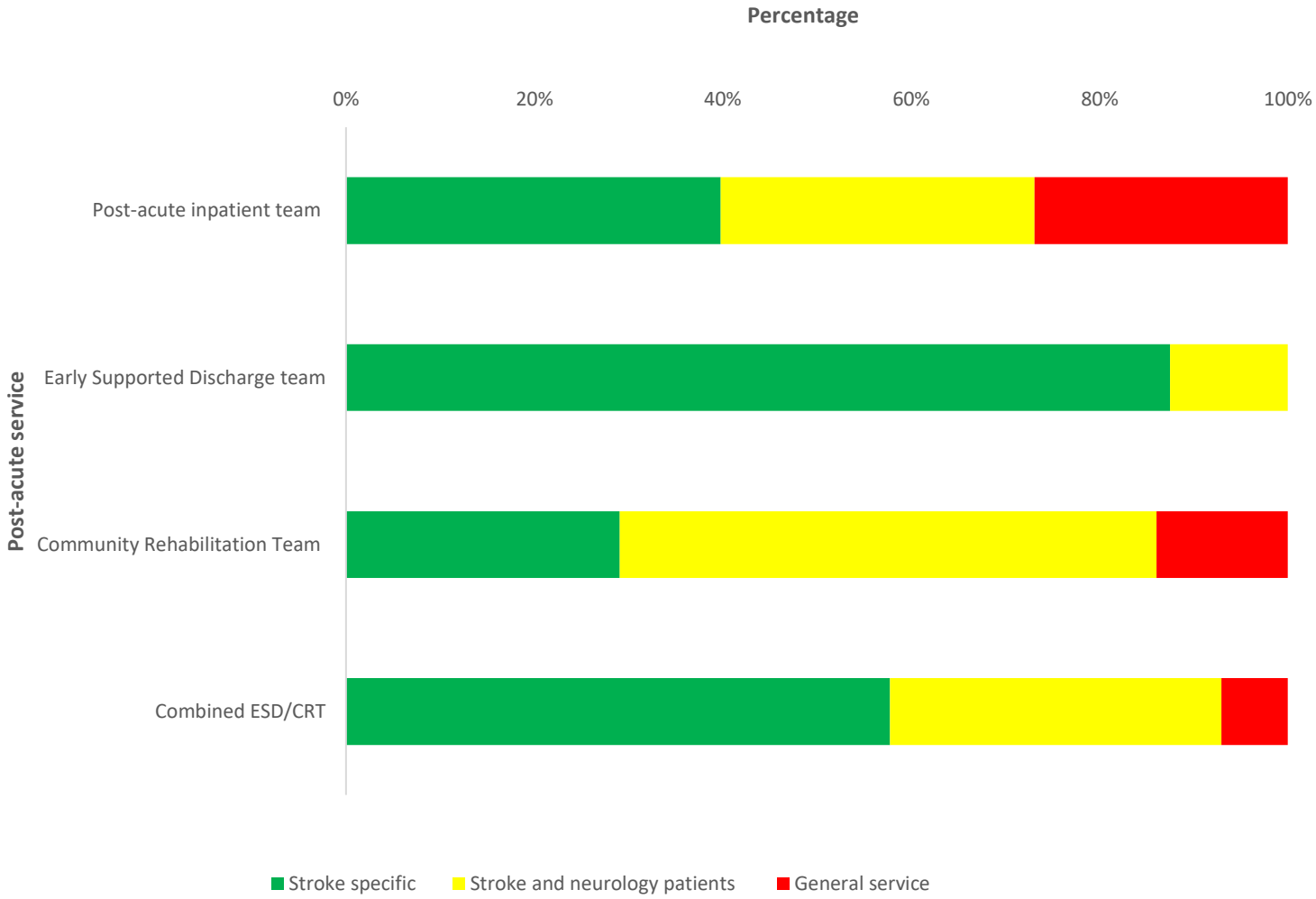
Resources and configurations

Figure 3.1: Post-acute service specificity



4.1 Seven day working

Standard: The service delivers rehabilitation 7 days per week.

We asked providers to tell us how many days per week their service was provided.

Table 4.1: Number of days per week service provided

Service type*	<5 days per week	5 days per week	6 days per week	7 days per week
Early Supported Discharge team **(n=88)**	**1.1% (1)**	**64.8% (57)**	**8.0% (7)**	**26.1% (23)**
Community Rehabilitation team **(n=86)**	**1.2% (1)**	**83.7% (72)**	**1.2% (1)**	**14.0% (12)**
Combined ESD/CRT **(n=71)**	**0% (0)**	**53.5% (38)**	**21.1% (15)**	**25.4% (18)**
Single discipline service **(n=66)**	**31.8% (21)**	**66.7% (44)**	**1.5% (1)**	**0% (0)**

4.2 Waiting times

Standard: First contact and treatment is to be provided within 24 hours for patients receiving Early Supported Discharge.

Table 4.2: Waiting time for treatment

Service type	Median waiting time for treatment (days)
Early Supported Discharge team **(n=88)**	**2**
Community Rehabilitation team **(n=86)**	**14**
Combined ESD/CRT **(n=71)**	**4**
Singe discipline service **(n=66)**	**37.5**

3.5 Staff and patient ratios (community-based services)

Standard: Services meet resource recommendations in the ICSS model.

We investigated whether services met the recommended ratios of staff and patients.

Table 3.3: Staffing levels: whole time equivalent of staff per 100 patients

Discipline	Recommended level of staffing per 100 patients (whole time equivalent)	Early Supported Discharge teams (n=88) who met this threshold	Community Rehabilitation teams (n=86) who met this threshold	Combined ESD/CRT (n=71) who met this threshold	National median of staffing per 100 patients (whole time equivalent)	Inter-quartile range
Occupational therapist	**1.0**	**34.1% (30)**	**20.9% (18)**	**22.5% (16)**	**0.79**	**05-1.2**
Physiotherapist	**1.0**	**37.5% (33)**	**27.9% (24)**	**28.2% (20)**	**0.89**	**0.6-1.3**
Speech and language therapist	**0.4**	**46.6% (41)**	**29.1% (25)**	**33.8% (24)**	**0.45**	**0.3-0.7**

Combined ESD/CRT teams (n=71)					
Shared clinical caseload	One management structure	Single point of access/referral route	Flexible staff	No internal re-referral required	No criteria met
91.5% (65)	**90.1% (64)**	**91.5% (65)**	**91.5% (65)**	**71.8% (51)**	**1.4% (1)**

Service configuration (community-based services)

Table 3.1: Combined ESD/CRT Rehabilitation Teams Criteria

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Inpatient services

Points of interest

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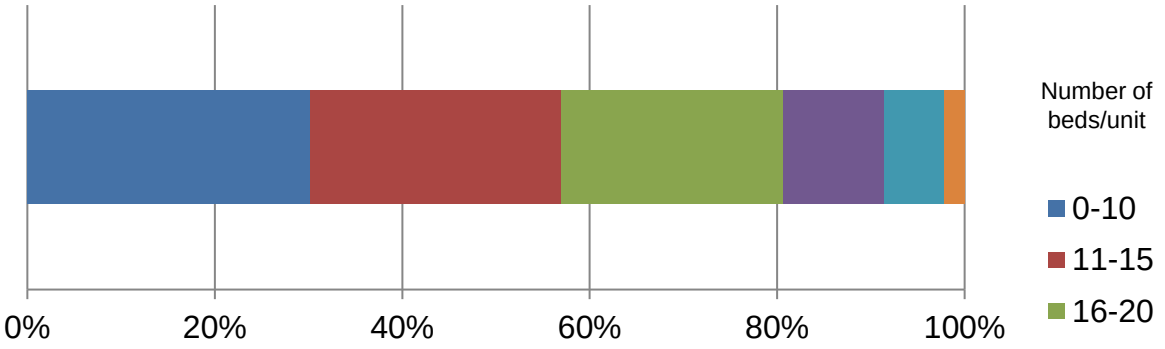
Specialist commissioned rehabilitation unit*	Count
Level 1a Physical disability	**1**
Level 1b Mixed	**3**
Level 2a Supra district	**2**
Level 2b Local	**6**
Total	**12**

*For definitions of service types: http://www.ukroc.org and https://www.bsrm.org.uk/downloads/specialised-neurorehabilitation-service-standards--7-30-4-2015-forweb.pdf

Specialist commissioned units

Table 2.5: Participation of specialist commissioned rehabilitation units



	Number of Services
0-10	28
11-15	25
16-20	22
21-30	10
31-50	6
50+	2

Post-acute Inpatient provision

Figure 2.2: Size of post-acute inpatient units by bed numbers

	2015	2021
Number of post-acute inpatient teams participating in the post-acute audit	**116**	**93**
Number of post-acute inpatient beds that can be used by stroke patients	**2,007**	**1,587**

A comparison of 2015 and 2021 beds

Table 2.4: Number of Post- acute Inpatient teams and beds

Table 3.4: Inpatient staffing levels

Disciplines	Recommended whole time equivalent per 5 beds	Percentage of teams who met the recommended whole time equivalent (n=93)	National median of whole time equivalent per 5 beds	Interquartile range
Occupational therapist	0.81	49.5% (46)	0.81	0.6-1.08
Physiotherapist	0.84	47.3% (44)	0.8	0.67-1.14
Speech and language therapist	0.4	37.6% (35)	0.38	0.29-0.47
Clinical psychologist	0.2	21.5% (20)	0.18	0.13-0.41
Dietitian	0.15	19.5% (18)	0.14	0.10-0.17
	Recommended level per stroke bed	**Percentage of teams who met the recommended level per bed(n=93)**	**National median of whole time equivalent per bed**	**Interquartile range**
Nurse	1.35	71% (66)	1.58	1.27-2.12

Nursing Skill mix for inpatient services

Table 3.5: Nursing skill mix; median percentage of nursing bandings across all Post-acute Inpatient Teams

Nursing band	Median percentage of nursing bandings (n=93)
Band 1	**0%**
Band 2	**37%**
Band 3	**8%**
Band 4	**0%**
Band 5	**32%**
Band 6	**10%**
Band 7	**4%**
Band 8a	**0%**
Band 8b	**0%**
Band 8c	**0%**

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Vocational Rehabilitation

Points of interest

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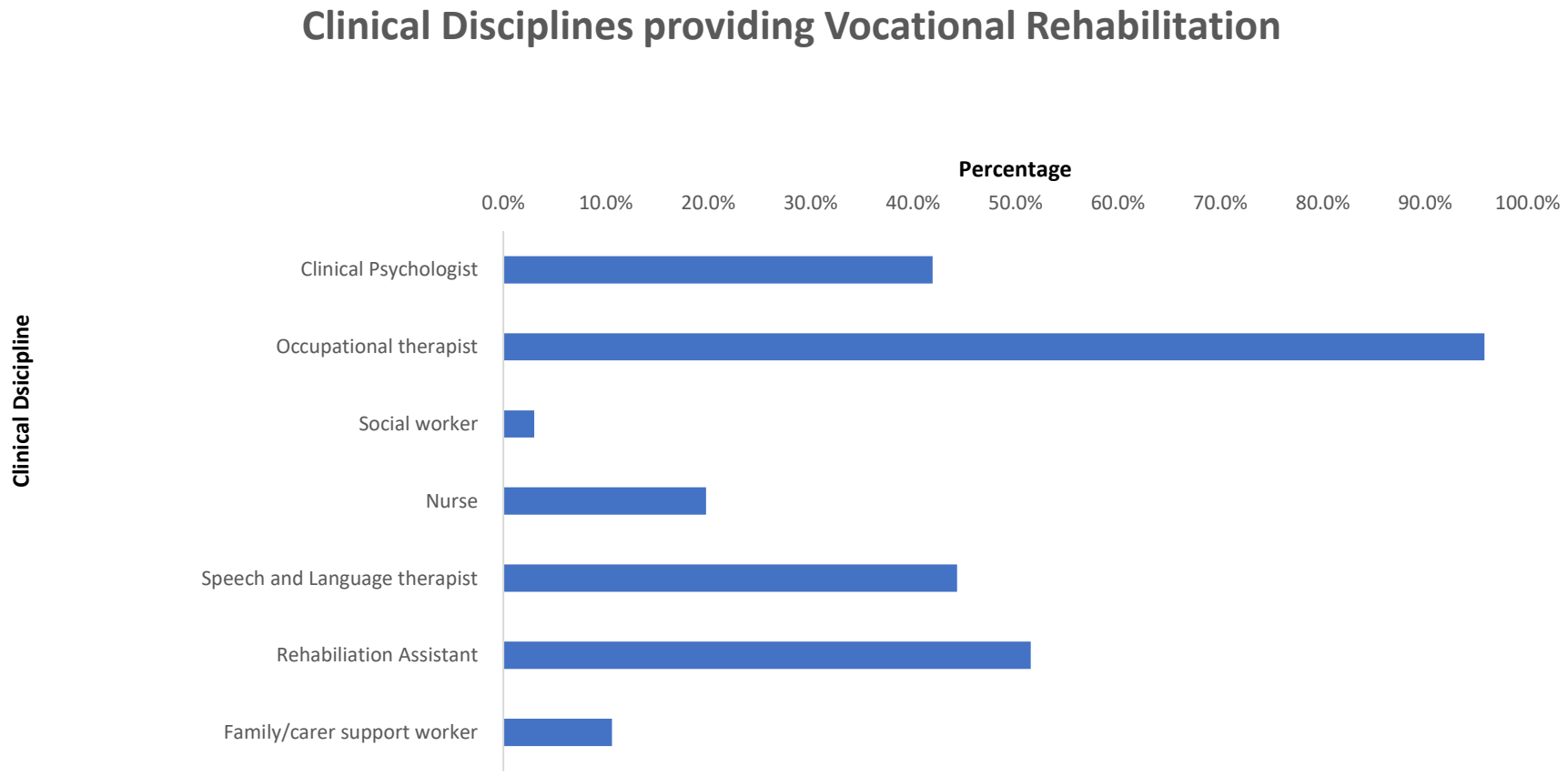
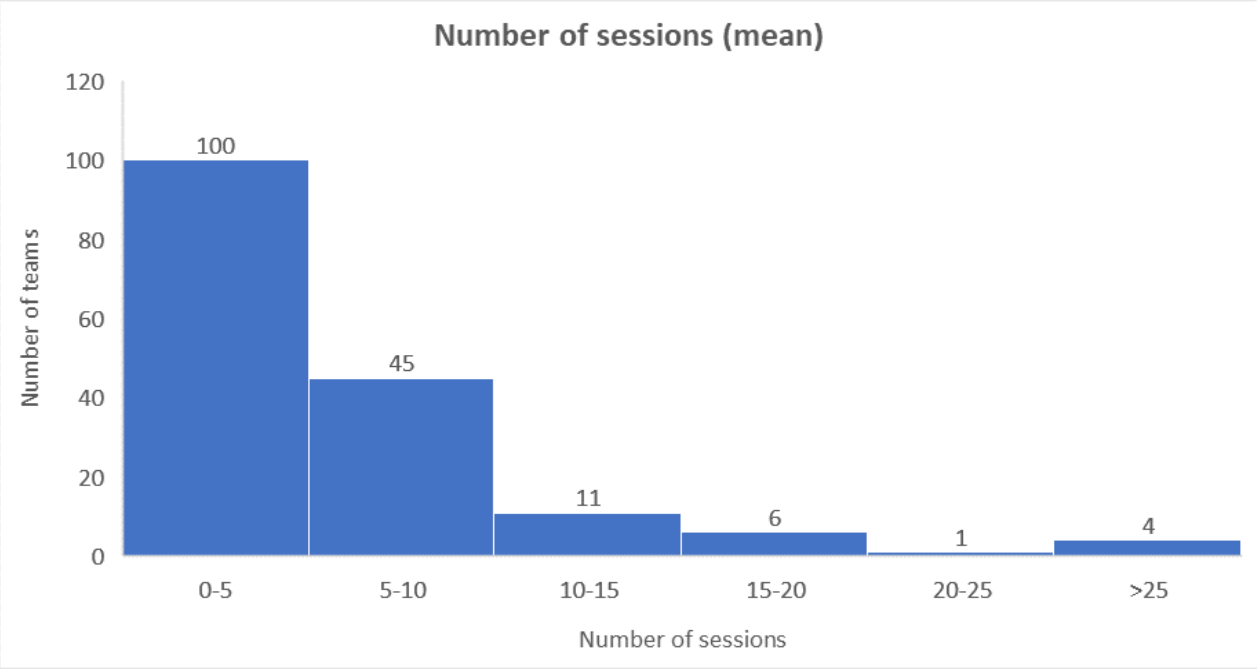
Vocational Rehabilitation commissioning

Table 7.3: Vocational rehabilitation commissioning (percentage per service type)

Service type	Yes, service commissioned and provided	Service provided but not commissioned	Service not provided but provider has access to VR	No VR available
Post-acute inpatient teams **(n=93)**	**5.4% (5)**	**7.5% (7)**	**63.4% (59)**	**23.7% (22)**
Early Supported Discharge team **(n=88)**	**11.4% (10)**	**37.5% (33)**	**33.0% (29)**	**18.0% (16)**
Community Rehabilitation team **(n=86)**	**14.0% (12)**	**44.1% (38)**	**30.2% (26)**	**11.6% (10)**
Combined ESD/CRT **(n=71)**	**23.9% (17)**	**38.0% (27)**	**22.5% (16)**	**15.5% (11)**
Single discipline service **(n=66)**	**7.6% (5)**	**16.7% (11)**	**37.9% (25)**	**37.9% (25)**

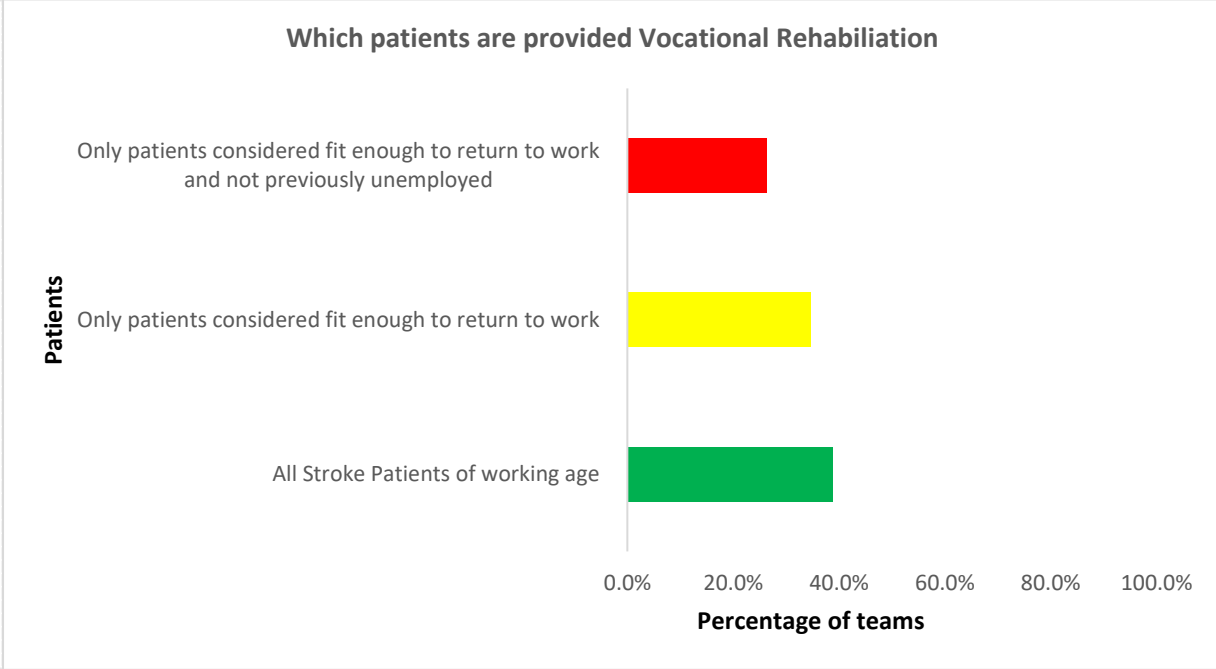


Clinical disciplines providing vocational rehabilitation



Duration of vocational rehabilitation sessions

Average number of vocational rehabilitation sessions provided to patient



Who is offered vocational rehabilitation

Criteria for vocational rehabilitation services

Summary of key findings and recommendations

Here we summarise positive (✓) and negative (✖) findings under key recommendations together with some additional recommendations (➔) featured in the report.

Key recommendation 1: All inpatient and community rehabilitation services providing rehabilitation for people with stroke should meet recommended staffing levels with appropriate access to all disciplines required.

✓ Stroke or stroke/neuro specific services are the predominant type of post-acute service provided.

✖ Staffing levels: Less than 50% of inpatient services have the recommended levels of any of the core disciplines.

✓ Staffing levels: The majority of inpatient services (71%) meet recommended nurse staffing levels.

➔ Inpatient nursing skill mix: Use of band 4 staff who can autonomously undertake some nursing and rehabilitation tasks and increasing the numbers of nurses above band 7 level could increase workforce capacity.

➔ Inpatient medical care: Use of lower grade stroke specialist medical staff for post-acute inpatient teams, supported by advanced or consultant practitioners (nurses or allied health professionals), could be a more efficient use of workforce.

✖ Staffing levels: Fewer than a third of community-based multidisciplinary teams met recommended staffing levels.

✖ Under-represented disciplines: Psychologists, dietitians, orthoptists, social workers and family and carer support workers were all under-represented in hospital and community-based teams.

➔ Care homes: Access to Life after Stroke services (such as communication, emotional and peer support) should be improved for patients in care homes.

Key recommendation 2: All community-based services should adopt the Integrated Community Stroke Service model and deliver needs-based rehabilitation 7 days a week starting promptly after discharge.

✖ 7-day services: There is still a predominance of 5-day services in community-based multidisciplinary teams.

✖ Waiting times: Over a third of Community Rehabilitation teams have a waiting time of more than 2 weeks to commence therapy.

✓ Re-referrals: A high proportion of teams (80%+) of each service type (apart from Community Rehabilitation teams) accept re-referrals.

✓ Care homes: High proportions of Early Supported Discharge (ESD), Community Rehabilitation teams (CRT) and Combined ESD/CRT teams provide rehabilitation for patients in care homes.

Summary of key findings and recommendations continued

Key recommendation 3: Effective and specialist multidisciplinary team working should be promoted by all team members and supported by senior managers and leaders.

✓ There is a good breadth of non-medical leadership with a high proportion of teams led by core therapy disciplines.

✖ The lack of designated leadership for Community Rehabilitation teams is likely to impact on the service quality.

✓ Attendance by clinical psychologists at multidisciplinary meetings could be an effective method for psychology staff to provide an educational and consultatory role.

➔ Every team requires a designated team leader.

➔ Every post-acute service should hold weekly multidisciplinary team meetings attended by all disciplines and should attend acute multidisciplinary team meetings.

Key recommendation 4: Staff, patients and family members should have dedicated (protected time) and access in their workplace and at home to education, information and training relating to stroke care, offered by reputable national bodies.

✖ Carer training: Insufficient training is provided for carers across all service types.

✖ Nurse training: Fewer inpatient nurses than therapists had access to training.

➔ Patient information should be adapted appropriately for those with aphasia, cognitive or visual difficulties. Training should be delivered on an individual patient basis, groups, in person or virtually.

➔ The Stroke Specific Education Framework (SSEF) (https://stroke-education.org.uk/), should be reviewed for all staff and staff should be released for training (including nurses).

Key recommendation 5: Vocational Rehabilitation should be available for all patients who need it and should be formally commissioned in line with evidence-based recommendations.

✖ The majority (71%) of teams are providing vocational rehabilitation without it being formally commissioned.

➔ Eligibility for vocational rehabilitation should be standardised, such as anyone who wishes to return to or take up paid or unpaid work after their stroke.

➔ Vocational rehabilitation should be detailed in service specifications, with associated reporting metrics and patient outcome data, to ensure optimal delivery is maintained regardless of provider type.

Summary of key findings and recommendations continued

Key recommendation 6: Six-month reviews should be conducted using a standardised tool and offered to all patients. Reviews should cover stroke secondary prevention, stroke recovery and disability management as well as reviewing unmet clinical and social care needs.

✖ Only half of ISDNs met the 6-month review key indicator.

→ The skill-mix of staff delivering reviews should be considered, such as lower grade staff supported by advanced or consultant practitioners (nurses or allied health professionals) for a more efficient use of workforce.

→ Lack of social worker involvement in 6-month reviews is a missed opportunity.

Key recommendation 7: Services should use process and standardised patient outcome measures to guide clinical delivery and service improvement. This should be as part of participating in SSNAP, their local and regional systems and research.

→ Full participation in the SSNAP clinical audit is vital for data to be representative to drive local and national improvement.

→ Participation in stroke rehabilitation research needs to be prioritised.

✓ A wide range of standardised outcome measures are being used routinely.

→ Use of a common set of outcome measures (including patient reported outcome measures), collected across the stroke care pathway, would enable ISDNs and regions to drive the process of quality improvement in stroke rehabilitation and evaluate services objectively.

Areas requiring further investigation and research

Commissioning and configurations of inpatient services: Inpatient pathways differ across the country with varying access to inpatient rehabilitation and specialist commissioned rehabilitation beds. This needs to be explored more fully to understand the optimal pathway; however, it is likely that configuration of bed-based provision may need to differ according to local population, rurality and configuration of acute and community services. It will be important to amalgamate data with the upcoming SSNAP Acute Organisational Audit to clearly understand what changes there have been in overall bed numbers.

Swallow assessments: Further investigation into the competencies of staff who are trained in swallow assessment is required, as well as the impact on other professionals completing swallow assessments such as speech and language therapists.

Remote delivery of rehabilitation to augment face to face therapy: This should be properly evaluated as a method to increase the intensity of rehabilitation.

Education, information and training: Further exploration is required to understand what resources are used, how information is adapted appropriately for those with aphasia, cognitive or visual difficulties, and whether training is delivered on an individual patient basis, in groups, in person or virtually.

Vocational rehabilitation (VR): Research evidence is required to inform effective and timely delivery of VR, including appropriate dose/schedules, staff resource implications (e.g. occupational therapists) and the interplay with rehabilitation focussed on non-vocational goals.

Time for rehabilitation to take the stage