

**National Institute for Health and Clinical Excellence**

**NICE Quality Standards Consultation**

**Closing date: 15<sup>th</sup> January 2010**

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Are you happy to be named as a consultee to the Quality Standard on the NICE website? <input checked="" type="checkbox"/> Yes	

The personal data submitted on this form will be used by the National Institute for Health and Clinical Excellence (NICE) for the purpose specified. The information will not be passed to any other third party and will be held in accordance with the Data Protection Act 1998.

Please provide comments on the draft Quality Standards on the form below. When feeding back, please note the draft quality statement number and indicate whether you are referring to the statement, measure or audience descriptor.

In order to guide your comments, please refer to the general points for consideration on the NICE website as well as the specific questions detailed within the Quality Standards.

Please add rows as necessary.

Draft Quality Statement No.	Comments about statements, measures and audiences.
e.g. Stroke 1	e.g. Comment about Stroke QS 1.
QS1	This standard fails to identify the need for a <b><u>pathway to specialist intensive neurorehabilitation services for a proportion of people with complex disability needs due to stroke. These services are led by specialist Rehabilitation Medicine consultants.</u></b> People with stroke requiring these services will often be younger, working or in education, with family responsibilities and will have complex needs that cannot be met by routine rehabilitation services. In the "What the patient expects" section palliation is listed inappropriately before later rehabilitation in the community and this should be changed.
QS 2	As currently written this standard does not specify what happens between Day 1 and Day 5. It does not specify that patients should be seen by a Consultant physician in Rehabilitation Medicine though it implies that the team members are part of a specialist rehabilitation team. Specialist Rehabilitation teams should include or have ready access to a specialist physician trained in Rehabilitation Medicine. As for QS 1 there should be a link in the care pathway for younger patients or those with particularly complex need to be referred early to specialist Rehabilitation Medicine consultant for access to a specialist intensive service. Evidence has found they have most to benefit in the early days and weeks after stroke onset.
QS4	This standard fails to identify the need for a care pathway that directs the younger stroke survivor or those with particularly complex needs to a specialist Neurorehabilitation Unit led by a trained Rehabilitation medicine consultant. This will also be geographically defined and have a coordinated and expert MDT. This is not a duplication of services. Most current stroke services do not have the staffing or expertise for the intensive rehabilitation of younger people or of those with very complex needs. Use of a scale that measures NEED for rehabilitation could be employed to capture or describe this population. Eg Rehab Complexity Scale
QS5	This standard should include, for the commissioners, the potential for re-entry of the patient to either a local geographically defined stroke specialist service if required, or a specialist intensive neurorehabilitation service if particularly complex or younger etc and with special goals to meet., that cannot be met by any community team. A further period of specialist intensive inpatient treatment may be required. Specialist referral may also be required for specific impairments eg spasticity, contracture prevention, pain management This acknowledges a need for a safety net and a facility for objective reassessment by the relevant specialist. Out of district referrals may be required by those with specific educational or

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	vocational needs caused by the stroke.
QS8	Any stroke service anywhere should be using its resources to achieve person centred goal acquisition. Time alone is easy to measure but may not be the most efficient or effective way of delivering relevant treatments that allow the patient to achieve carefully selected goals. Auditing this goal of 45 min/therapist/working day may be sufficient now to highlight skill shortages, eg S&LT, psychology and may always be required for this purpose. There should in addition be a goal achievement measure eg COPM, Canadian Occupation Performance Measure to audit the effectiveness of delivered services.
QS14	Depression is very common after stroke and evidence suggests it peaks at 6 months post stroke. It seems to be increasingly common practice to start stroke patients on anti depressants in the first few days after onset when tearfulness due to grief and lability are probably at their worst. Little evidence to support this practice. Clinically more important to screen for depression as they are approaching leaving rehabilitation. Perhaps this standard should be amended to include a measure for depression at 2 points in time after stroke.
QS16	Important standard which will reveal a shortage of S&LT input to most stroke services.
QS17	It appears to be "normal" practice for stroke patients to be catheterised during their progress through the acute phase of their treatment. This produces infection, unhappy bladders and unhappy patients. Providing dignified bladder assessment and continence care on stroke units will increase staffing and possibly equipment requirements (Nurse time and bladder scanners) This will improve care of stroke patients but I suspect has not been costed.

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**PLEASE NOTE:** The Institute reserves the right to summarise and edit comments received during consultations, or not to publish them at all, where in the reasonable opinion of the Institute, the comments are voluminous, publication would be unlawful or publication would be otherwise inappropriate.

This draft quality standard contains a number of quality statements and measures. It is however intended that the final standards will contain a maximum of 5-10 statements of quality. Which statements from the maximum number presented in the draft quality standard most represent the ambitions required to drive up improvement for high quality care? Please identify your prioritised 5-10 statements.

Statement	1st	2nd	3rd	4 <sup>th</sup>	5th
1	X				
3		x			
2			x		
12				x	
13					x
8					
19					
17					


**Comments** The major omissions from these standards are

- A standard that describes the intention to allow those people with stroke with complex needs, often but not always younger, still in work, or young parents, or even in education, access to specialist neurorehabilitation services run by Consultants accredited in Rehabilitation Medicine with multi disciplinary teams including PT, OT, S&LT, Psychologist etc, where intensive treatment programmes are the norm. There is no pathway or standard described here which will determine that Commissioners maintain a purchasing intention to support these people's needs appropriately. Where there are specialist Rehabilitation Medicine services currently available in the country approximately 40 – 50% of their patients have had stroke. Commissioners must support these current programmes which rehabilitate numbers of younger people with stroke and those with stroke and complex needs.
- A standard that supports the intention to allow re-access to specialist rehabilitation services as per need later on, perhaps after simpler physical needs are met, but vocational need, social emotional and educational needs are still emerging
- Complex pain syndromes emerge later after stroke onset and are not mentioned at all, similarly depression, most often seen at 6 months.