**Social Care and Health**
**Overview and Scrutiny Committee**

**Agenda Item**
**No. 7**

**25th September 2025**

**Transformation of Stroke Rehabilitation Services in Walsall**

## 1. Aim

This report has been produced to inform the committee of the proposed transformation of Stroke Rehabilitation Services in Walsall

## 2. Recommendations

The Oversight and Scrutiny Committee are asked to support the proposed transformation of Stroke Rehabilitation Services and support the view that the proposal does not constitute a substantial service change.

## 3. Background/Context for Change

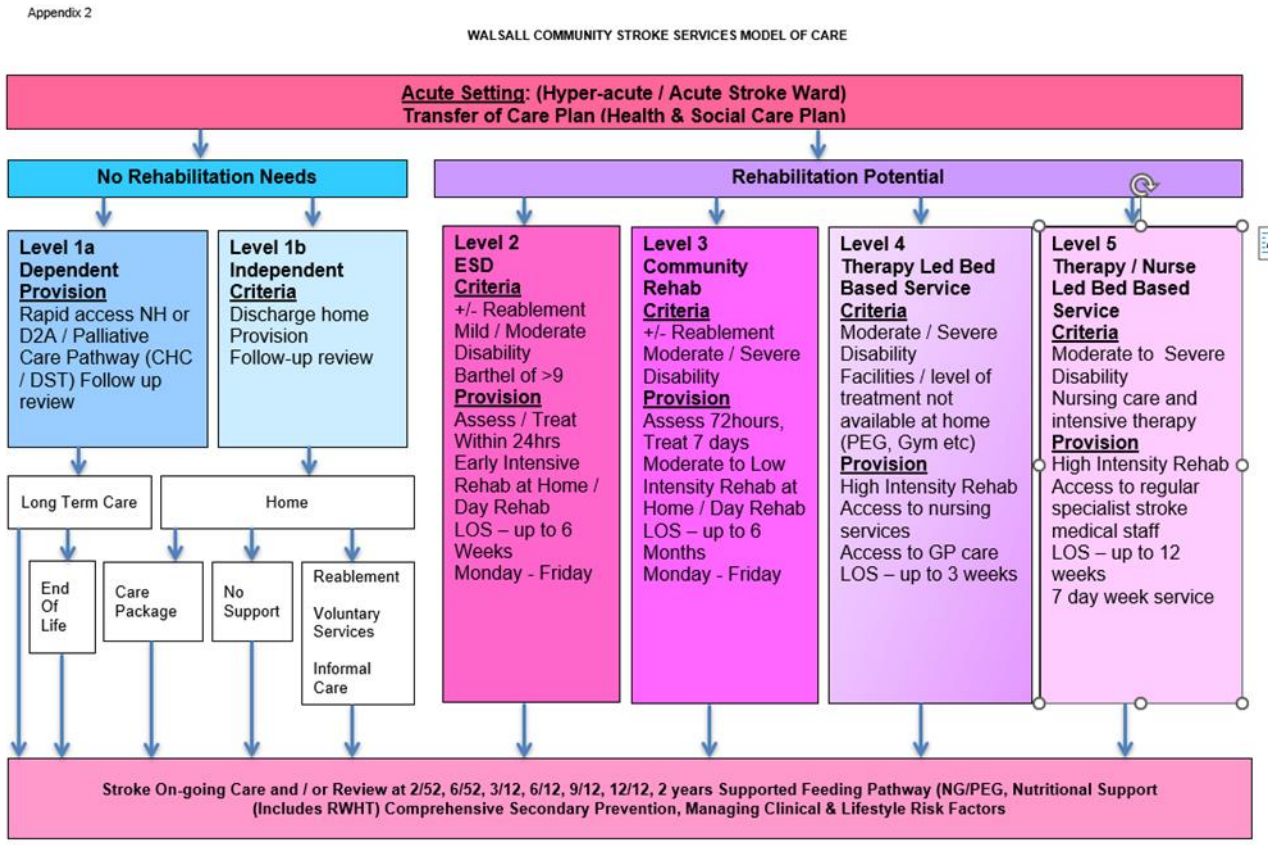
Walsall residents currently receive their acute and post-acute stroke care at New Cross Hospital in Wolverhampton. When deemed medically fit for discharge, patients who require ongoing bed-based rehabilitation are referred to the stroke rehabilitation unit, currently located at Holly Bank House in Walsall. Patients receive person-centred and goal-focused rehabilitation in individual rooms that can be adapted to meet their rehabilitation goals. The care is multi-disciplinary with nursing and therapy staff working collaboratively to optimise rehabilitation potential. When deemed ready for discharge, patients are seamlessly referred to the Walsall Community Stroke service who continue their rehabilitation in the home environment.

The driver for change is the evidence base which demonstrates the outcomes from delivering 7-day stroke rehabilitation services in patient's homes in the community, which will provide a more enhanced service for the Walsall population. The recommended national service model for an integrated community stroke service (ICSS) advocates delivering early community specialist stroke rehabilitation via a specialist MDT structure thus shifting the care from bed-based settings to the home and community. The underpinning principle is that this model of care produces the best outcomes for patients. Through the transformation of Walsall Stroke Rehabilitation services, there is an opportunity to provide this best practice model for Walsall patients.

A second driver for change, is that for a number of years, there have been concerns about the sustainability of the current service at Holly Bank House due to the building being not fit for purpose, and the significant costs associated with making the building healthcare compliant and the extensive maintenance costs given the age of the building. The building is owned by Walsall Metropolitan Borough Council with Walsall Healthcare NHS Trust having an informal tenancy arrangement. Given that the costs of both making the building healthcare compliant and the ongoing maintenance costs are prohibitive in the long term,

different location options have been explored to secure the longevity of the service. The location option that is recommended provides the opportunity to release funds to invest in a more enhanced model of care for patients in their own home.

### 3.1 Current Service




Pathways:

- Level 1A - for patients with no rehabilitation potential. Reviewed within 2 weeks of discharge.
- Level 1B – for patients who are independent with no rehabilitation needs. Reviewed within 2 weeks of discharge.
- Level 2 -Early Supported Discharge (ESD) for patients with mild to moderate disability requiring active rehabilitation. ESD assessment and treatment will commence within 1 working day of discharge from the acute care unit.
- Level 3 - Community Rehabilitation for patients with moderate to severe disability treated in their own home and/or outpatient setting. Patient will be assessed within 72 hours and treatment commenced within 7 days.
- Levels 4 & 5 (Community Based Inpatient Rehabilitation Unit) for patients with moderate to severe disability where it is unsafe or impractical for treatment to be carried out in the patient's own home/usual place of residence. Assessed and treatment commenced within 1 working day.

The Walsall Community Stroke service provides a combined model of Early Supported Discharge (ESD) integrated within Community Stroke Service. The services operate during working hours from Monday-Friday. The Specialist

Community Stroke Service consists of a core multidisciplinary team who have the knowledge, skills, and behaviours to work in partnership with people who have had a stroke, and their families and carers to manage the changes experienced as a result of a stroke. The service is delivered by a multi-professional team who have completed recognised specialist training in rehabilitation. The interdisciplinary team comprises: Specialist Nurses, Occupational Therapists, Physiotherapists, Psychologists and support workers. They support holistic discharge planning and provide goal-led rehabilitation which is planned in collaboration with the service user.

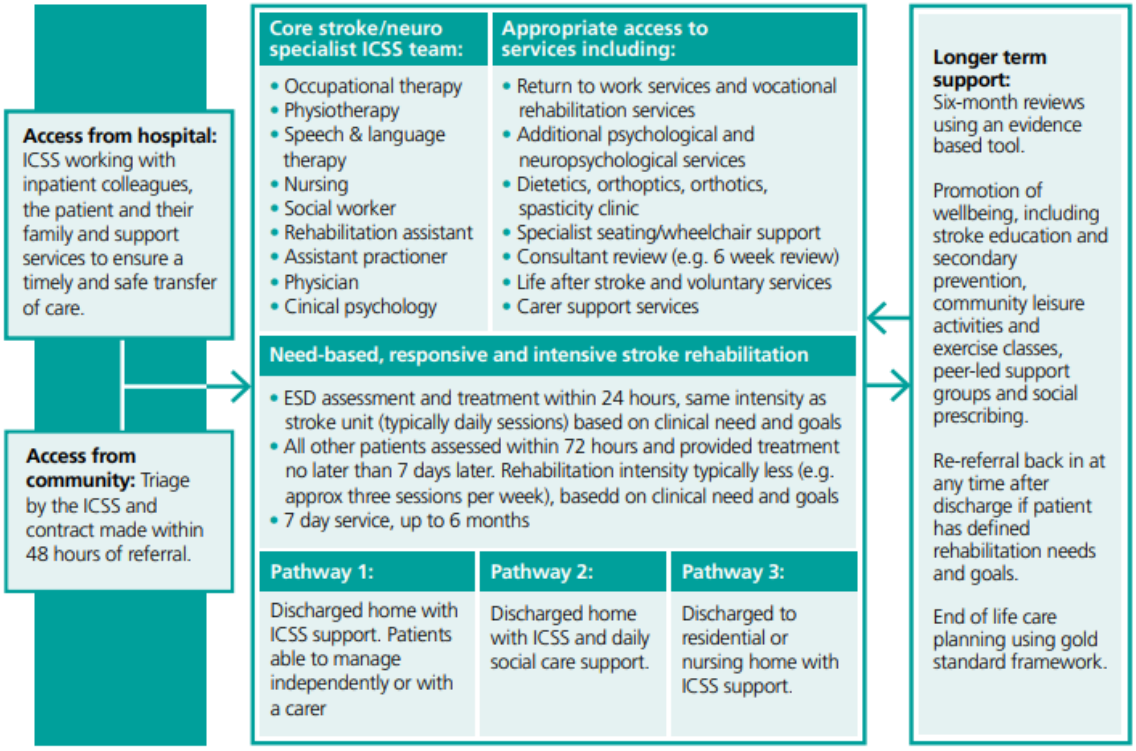
The relevant professions will review the service user as per the time frames referenced above. Goals will be established with the patient and a therapy package agreed in terms of the frequency and intensity of sessions. Goals are continuously reviewed, with adjustments made to the care/rehabilitation plan as needed. Planning for discharge from the service commences from the initial assessment, ensuring independence is promoted, and goals are continually reviewed. On discharge, service users are referred and/or signposted to other services when indicated. They can be re-referred to the service for a further episode of rehabilitation within 2 years of having their stroke, provided the area of need is related to the stroke.

On average, 350-400 Walsall residents are treated on the hyper acute ward at The Royal Wolverhampton NHS Trust per year. Of these, on average 15% require a rehabilitation bed and are therefore admitted to the Stroke Rehabilitation Unit (SRU) at Holly Bank House. The remaining 85% are discharged from the hyper acute ward to home or to an alternative location (i.e. nursing or care home) and referred to the Walsall Community Stroke Service. On average this amounts to one patient per week. The team will triage the referral and assign them to the appropriate pathway (level 1a, 1b, 2 or 3) according to their presentation and need. For those needing a rehabilitation bed, the average length of stay is approximately 37 days meaning around 125 admissions are possible across the year. In addition to the referrals from the hyper acute ward, the Community Stroke team also receive around 100 non-acute stroke referrals from clinics.

The Walsall Community Stroke Service currently meet the key performance indicators around access to each level in the pathway, but they are currently unable to deliver the frequency and intensity of therapy sessions needed due to capacity in the service. The new model will provide an opportunity to invest in additional therapeutic staff to support patients in their own home.

## Proposed New Service Model

The Integrated Community Stroke Service (ICSS) model is part of the recommended National Stroke Service model. The ICSS co-ordinates transfer of care of stroke survivors from hospital and, through a specialist, MDT structure, provides early, effective and community specialist stroke rehabilitation and disability management to all stroke patients leaving hospital who need it. The ICSS brings existing service configurations together, including early supported discharge and community stroke rehabilitation, into one integrated seamless service.




**Pathways:**

- Pathway 1: Discharged home with ICSS support. Patients able to manage independently or with a carer. ESD assessment and treatment within 24 hours, same therapy intensity as stroke unit (typically daily sessions) based on clinical need and goals.
- Pathway 2: Discharged home with ICSS and daily social care support (reablement up to 4 calls a day for 6 weeks). Patients assessed within 72 hours and provided treatment no later than 7 days later. Rehabilitation intensity typically less (e.g. approximately three sessions per week), based on clinical need and goals.
- Pathway 3: Discharged to residential or nursing home with ICSS support. Patients assessed within 72 hours and provided treatment no later than 7 days later. Rehabilitation intensity typically less (e.g. approximately three sessions per week), based on clinical need and goals.

Below are the key features of the ICSS model:

**Responsive and intensive rehabilitation**
National clinical guidelines recommend that people with stroke should be offered and/or participate in at least 45 minutes of each appropriate therapy every day, at a frequency that enables them to meet their rehabilitation goals, and for as long as they are willing and capable of participating and showing measurable benefit from treatment.

The therapy the ICSS offers should be based on clinical need tailored to goals and outcomes and be agreed and communicated with stroke survivors and their carer or family members.

Patients with stroke who have mild-to-moderate disability and who have been identified as eligible for ESD should be offered assessment and treatment within 24 hours. Stroke rehabilitation should be offered at the same rehabilitation intensity as stroke unit care (typically daily sessions).

Patients deemed not eligible for ESD should be assessed within 72 hours of discharge from hospital and provided with treatment no later than seven days after their assessment, or earlier if based on clinical judgement and patient choice. The intensity of the community stroke rehabilitation intervention is typically lower than that offered to ESD patients (e.g. about three sessions per week) but should be established between the stroke specialist and stroke patient and based on clinical need tailored to goals and outcomes. Patients who have ongoing rehabilitation needs and goals should be offered seamless continuity of therapy – from ESD intervention to lower intensity community stroke rehabilitation, tailored to goals and outcomes.

**Needs based**
ICSS should be provided for up to six months with the option for re-referral after discharge if rehabilitation needs and goals are defined, and with access to support services on discharge.

**Carer support, community integration and participation**
The ICSS should work with the voluntary sector to develop appropriate life after stroke and support services – extending the ICSS pathways to support the long-term needs of patients and their carers/families. This should ensure provision of effective support and information as part of the rehabilitation process and encourage self-management where appropriate. Patients should be made aware of and offered options to promote their wellbeing, including stroke education and secondary prevention, community leisure activities and exercise classes, peer-led support groups and social prescribing. The Beacon Centre in Wolverhampton currently offers supportive sessions to stroke patients to enable their continued rehabilitation.

**Rehabilitation goals and self-management**
Self-management programmes should be embedded throughout the ICSS. Personalised plans for all patients should include personalised rehabilitation goals to allow patients to take ownership of their rehabilitation. These goals should be reviewed regularly with the patient and, where appropriate, their carers throughout the treatment period to promote and support the wellbeing principle. The ICSS or another commissioned service provider should provide a six-month review of needs and goals using an evidence-based tool.

**Seven days a week service**
Monday to Sunday (exact hours of service should be locally agreed). Discharges at weekends should be planned by the inpatient team in collaboration with the ICSS to ensure that the ICSS can visit and assess the patient within 24 hours if required (ie for ESD patients).

**Discharge from the ICSS**
A phased approach to discharge is undertaken over a six month period post discharge from hospital or six months post referral for community referrals or new patients, with regular intervals for review and extensions for those who are still achieving goals but require further rehabilitation based on clinical reasoning. There is an option for patients to be re-referred back in at any time after discharge if they have defined rehabilitation needs and goals.

Discharge is agreed when a patient's goals are met or they are deemed no longer to be making meaningful progress, or the patient declines the service. Patients can re-refer themselves back to the ICSS at any point post discharge for assessment of need and the ICSS will help determine the most appropriate pathway or referral to other services and support.

On discharge, the ICSS will make patients and carers aware of and enable them to access stroke information and appropriate support groups or services and exercise pathways, to ensure longer-term support and re-integration is successful and needs led. This provides an opportunity to work with wider voluntary sector services to provide ongoing support. The ICSS should send a discharge summary to the GP, patient and onward services within a week of discharge.

**Proposed service development**
The transformation of services proposed would see the bed-based rehabilitation for patients moved to West Park Hospital in Wolverhampton as a combined model for Walsall and Wolverhampton patients. This would be a consolidated service in partnership with The Royal Wolverhampton Hospitals NHS Trust and provides the opportunity to develop a centre of excellence for our population. The hyper-acute pathway for both Wolverhampton and Walsall residents is already delivered at New Cross Hospital and therefore bed-based rehabilitation at West Park would be a continuation of the patients care.

The consolidation of bed-based rehabilitation services will enable funding to be released to invest in expanding the community stroke rehabilitation teams in Walsall providing enhanced model of care closer to home. The expansion of this team will enable more patients to be cared for directly at home following their acute episode of care and shorten the length of stay in bed-based rehabilitation with more of their rehabilitation being conducted in the patient's home environment. Clinical evidence supports the delivery of home-based rehabilitation where clinically appropriate as it produces better outcomes for patients. Additional capacity is available at West Park should it be required.

The creation of an ICSS would bring the following benefits:

- A small reduction in the number of rehab beds for needed for Walsall patients due to an increase in service users being able to access the required level of rehabilitation in the community.
- A reduction in the number of rehab beds needed due to being able to support discharge at weekends.
- A reduction in the length of stay improving flow through the rehabilitation beds.

- Patients can be discharged from the hyper acute and rehab bedded unit 7 days a week which will support flow and timely discharges.
- Access to a complete interdisciplinary team with all relevant professions in the community, thus optimising outcomes and an MDT approach to rehab.
- Access rehab beds more quickly due to interventions delivered at West Park which currently aren't offered at Hollybank i.e. IVs, oxygen therapy.
- Increased intensity/frequency of sessions in the community environment resulting in improved quality of life, reduced burden on family and carers, reduction in care needs/packages of care and optimising outcomes.
- Reduction in delayed discharges due to integration of a social worker in the team thus reducing length of stay and improving flow through the beds.
- Improvement in psychological well-being of patients and their family unit due to being discharged home more quickly.
- Improved access to community services, particularly for those who have returned to work, due to 7-day working.
- Efficiency for the wider health economy. For example, we would anticipate a reduction in GP appointments for the service user and their carer due to enhanced support and a reduction in the length of time a package of care is needed for due to optimising physical outcomes and independence. This will be monitored regularly to ensure optimum outcomes are being achieved.

The proposed transformation of services presents an opportunity to invest in the community model. By investing in the community offer patients will be discharged home or to alternative community setting (e.g. care home), regardless of their disability, as soon as their ongoing needs can be safely met in the community setting supported by the Integrated Community Stroke Service (ICSS). The ICSS model ensures that all discharged stroke patients are seen in a timely way by an integrated multidisciplinary team (MDT) which is inclusive of all key professions in stroke care and accessible 7 days a week. The ICSS model is evidence-based and is considered to be best-practice for patient outcomes. It also supports the national agenda of the home first model.

## 4. Engagement

We recognise that any change of service or service location requires a level of engagement with stakeholders, including impact on carers accessibility, travel analysis, visiting costs and continuity of care. This work has commenced with both with the staff working within the service and the commissioners of the service at Black Country ICB. The ICB have indicated they are supportive of the proposal and through their evaluation have given a view that the proposal does not constitute a substantial service change. We recognise the proposal will have an impact on patients and their carers/families. In order to consider the potential impact a health inequalities impact assessment, travel analysis and travel mapping exercises have been undertaken. In addition, where changes to services are being proposed, providers have a duty to work with the ICB and ensure the involvement of patients and the public. An outline stakeholder engagement plan has been

developed that has identified the key stakeholders, the objectives of engagement, the channels that would be used and the potential timeline. As there is a view that this proposal does not constitute a substantial service change the intention would be to have a “conversation” with the public regarding the proposal and with a particular focus on organisations that support patients and their families who are impacted by stroke and patients and their families themselves.

Walsall has a Family and Carer Support Service. Carers can be referred to this service for support and guidance in navigating local resources, including access to the Walsall Carers Hub and carers assessments.

## 5. Reducing Inequalities

It is expected that given the levels of deprivation across many areas of the Black Country the incidence of stroke will continue to rise over the coming years. This will place an additional burden on the services provisioned for to manage this condition. It is therefore imperative that local health services deliver the optimum outcomes that can be achieved for this group of patients as to not do so will place additional financial burden on the local health economy through for example the provision of care. The transformation proposed will enable Walsall to deliver services in accordance with the most recent national guidance which evidences the delivery of the best outcomes for patients, and provide a greater opportunity for collaboration for the voluntary sector to support patients in their community.

It is recognised that the proposed transformation is a significant change to the provision of services for Walsall residents. Walsall Healthcare NHS Trust supported by the Black Country Integrated Care Board will engage with residents of Walsall on the proposed change in services as an integral part of the overall proposal.

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