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Barriers and facilitators in providing home-based rehabilitation for stroke survivors with severe disability in the UK: an online focus group study with multidisciplinary rehabilitation teams

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ABSTRACT

Objectives In the UK, over 20% of stroke survivors leave hospital with severe disability. Limited evidence-based clinical guidance is available to support the rehabilitation of these individuals. Our previous research has focused on establishing consensus regarding the core components of home-based rehabilitation for this under investigated group. This study explores the barriers of providing rehabilitation and identifies strategies to overcome them.

Design Three focus group interviews were conducted with n=20. The context coding framework was employed to organise the transcribed data and to facilitate inductive and deductive analysis and synthesis.

Setting Online, MSTeams, UK.

Participants A purposive sample of 20 National Health Service clinical staff participants, from 3 multidisciplinary teams providing home-based stroke rehabilitation for this population (n=7, 6 and 7).

Results High levels of need were reported across multiple domains for survivors including continence, communication and physical function. Interventions often required multiagency collaboration in order to optimise the available resources and specialist skills. There was lack of clarity regarding who was ultimately responsible for providing components of rehabilitation for stroke survivors with severe disability. Teams provide rehabilitation for this population but are insufficiently commissioned or resourced to fully meet their needs. In-complete and disjointed pathways with resultant healthcare inequalities were commonly reported. Teams used a variety of strategies to overcome these barriers and optimise rehabilitation opportunities. These included upskilling a diverse range of partners to capitalise on the skills and resources across health, social care and voluntary sector boundaries employing multiagency collaboration. Teams established and engaged networks of stakeholders in order to advocate on behalf of stroke survivors.

Conclusions Collaboration and partnership working is important in the delivery of rehabilitation for stroke survivors with severe disability. Commissioners need to be aware that cross-agency multidisciplinary expertise is required, if rehabilitation opportunities are to be realised and existing health inequalities addressed.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ This is the first study to determine barriers and facilitators in providing home-based rehabilitation specifically for survivors of stroke with severe disability.
⇒ Investigating rehabilitation in a real-world setting can be used to inform future implementation.
⇒ The lived experiences of stroke survivors and their carers directed the focus of this enquiry.
⇒ Three diverse community stroke rehabilitation teams were included.
⇒ Team leads being present within the focus groups may have influenced discussion dynamics.

BACKGROUND

Stroke remains the leading cause of disability in the UK.[1] Over 20% of those who leave hospital following a stroke will have a severe disability.[2] These individuals may have a number of impairments affecting a combination of motor, sensory, communication and cognitive functions.[3] This combination of impairments often requires specialist input from multiple professions within the stroke multidisciplinary team (MDT). Stroke survivors with severe disability commonly require assistance with activities of daily living (ADLs) and may be unable to mobilise as a result of their impairments.[3 4] Rehabilitation for these individuals often requires multiple members of the MDT, placing significant burden on services in terms of both the expertise and number of staff required to meet their needs.

In the UK, the average length of hospital admission following stroke is reducing and there is an increasing focus on community-based care.[2 5] Access to existing community teams has, therefore, been expanded to include the rehabilitation of stroke survivors with higher levels of disability, who may have

previously remained in hospital for extended rehabilitation. This has resulted in the evolution of established early supported discharge (ESD) models of rehabilitation, with services adapting to meet this changing demand.[6] However, there is a dearth of research regarding the rehabilitation of this population in the community.[7] The aim of the current study was to inform recommendations to support the provision of rehabilitation for stroke survivors with severe disability across the UK. Defining severe disability following stroke is complex.[4] For the purpose of this study, a score of 4 or 5 on the Modified Rankin Scale (mRS) was used.[8]

Poststroke complications are commonly experienced by stroke survivors with severe disability following discharge from hospital. These include sequela such as pain, contractures and pressure sores that may necessitate specialist expertise outside of the traditional stroke MDT.[9] On discharge from hospital, this population often rely on carers to support their ADLs. These carers may be a combination of formal paid carers, privately funded or

Table 1 CCF, adapted for this study from Rogers *et al*[13]

System level	Characteristic	Definition	
System-level determinants (Wider NHS)	Social environment	Cosmopolitanism	How connected the organisation is with external organisations?
		Peer pressure	Competitive or mimetic pressure to implement intervention*.
	Political environment	External incentives and influence	External incentives to spread the uptake of intervention,* for example, national policy, guidelines or collaborations
	Economic environment	External economic factors within the wider health system which may influence the capacity and resources available to the setting.	
Organisational-level determinants (A single NHS Trust or provider)	Structural characteristics	NHS Trust size/workload	
	Networks and communications	Quality of communication within organisation and relationships among members	
	Culture	The norms, values and assumptions of the organisation and their perceptions of change	
	Compatibility	Is there congruency between values and norms of the organisation and the intervention*?	
	Organisational support	Is organisational support evident?	
	Organisational climate	Staff perceptions of and emotional responses to the characteristics of their organisation	
	Organisational leadership	Are organisational leaders committed to implementing the intervention*?	
	Available resources	The level of resources available within the organisation to complete the intervention* including human (eg, appropriate staffing establishment), financial and technology	
Team-level determinants (multidisciplinary team)	Structural characteristics	Team size/turnover/workload	
	Teamwork	The quality of communication within the team and relationships among its members	
	Culture	The norms, values and assumptions of the team and their perceptions of change	
	Compatibility	Does the intervention* fit with existing workflows of the team?	
	Available resources	The level of resources available to complete the intervention* within the team including human, for example, skills	
	Local leadership engagement	Are team leaders committed and involved in the implementation of the intervention*?	
	Team efficacy	A team's belief in their ability to implement the intervention* effectively	
Individual-level determinants	Self-efficacy	An individual's belief in their ability to implement the intervention* effectively	
	Individual attitudes	Participants perceptions of the advantage and relevance of the intervention*	

*Intervention refers to the provision of rehabilitation to survivors of stroke with severe disability.
CCF, context coding framework; NHS, National Health Service.

Box 1 Team inclusion criteria

Inclusion criteria:
Community stroke rehabilitation team inclusion criteria:
⇒ Integrated community stroke service (as per National Health Service England guidance.[6]
⇒ Stroke specific, with a minimum of 175 stroke patients a year.
⇒ Accept stroke survivors with modified Rankin Scale of 4 or 5.
⇒ Established at least 12 months prior to COVID-19 pandemic.

Individual participant inclusion criteria:
⇒ Minimum of 1-year experience working with this cohort.
⇒ Core member of multidisciplinary team as outlined in Fisher *et al*.[12]
⇒ Representation from a variety of disciplines (to include team lead).
⇒ Provided informed consent.

through social care, and informal carers such as family members or friends. In situations where care needs exceed what is feasible within the home, patients may be discharged to a care home supported by formal paid carers.[10 11]

Our previous research has focused on establishing consensus regarding the core components of home-based rehabilitation specifically for stroke survivors with severe disability in the UK.[12] Using these consensus statements, a panel of stroke survivors and carers prioritised statements to take forward as the focus of enquiry. This study aimed to explore the barriers experienced by community-based stroke MDTs in providing these aspects of home-based rehabilitation for survivors of stroke with severe disability, and identify strategies used by teams to overcome them.

METHODS

Design

This qualitative study involved three community stroke rehabilitation teams. A single focus group interviews was completed with each community stroke rehabilitation team. The context coding framework (CCF) was used to support the organisation, analysis and synthesis of findings from the focus groups.[13] The CCF is a structured framework which supports the implementation process by exploring the influence of context. This approach to describing context supports the transferability of findings within the stroke rehabilitation setting.

Insights from participants were sought at each level: system, organisation, team and individual. A summary of the framework, adapted for this study, is included in table 1.

Table 2 Overview of teams (data extracted from Stroke Sentinel National Audit Programme: Post-acute Organisational Audit [14])

Team	A	B	C
Stroke patients treated in last 12 months	589	197	315
Percentage of patients mRS four or five more in last year*	28%	32%	25%
Access to occupational therapist/physiotherapist/speech and language therapist/clinical psychologist	Yes	Yes	Yes
Access to dietician	Yes—not within service	Yes—not within service	No
Access to social worker	Yes—not within service	No	No
Access to doctor	Yes—not within service	No	No
Access to nurse	Yes—not within service	No	Yes
Access to orthotic/orthoptic/podiatry	Yes—not within service	Yes—not within service	Yes—not within service
Weekly formal multidisciplinary meeting	Yes	Yes	Yes
Service based in multiple locations	Yes	Yes	No
Days per week service provided	5	7	5
Treatment/assessment provided at acute hospital	Yes	No	No
Treatment/assessment provided in care home	Yes	Yes	Yes
MDT meetings attended at local acute hospital	Yes	Yes	Yes
Average days to review/commencement of service	2/4	1/1	1/5
Time limit to service (weeks)	52	26	12

*Additional figure provided by team leads.
MDT, multidisciplinary team; mRS, modified Rankin Scale.

Table 3 Overview of statements explored with focus groups

Core multidisciplinary team (MDT)	
The MDT should consist of:	
► Occupational therapist	► Social care worker
► Physiotherapist	► Dietician
► Psychologist	► Speech and language therapist
► Nurse	► Administrative support
► Rehabilitation support worker/assistant practitioner	► Doctor
Service structure	
The MDT should: ► Form part of an integrated specialist stroke service and complete initial assessment within 1 week of hospital discharge. ► Work in a coordinated manner to provide rehabilitation over 7 days and flexibly to reach the desired level of intensity for patient need. ► Provide the opportunity for patients to receive rehabilitation 5 days a week, if deemed appropriate. ► Provide length of input related to patient rehabilitation needs and goals, with the potential for rereferral if required.	
Specific interventions and MDT skills	
The MDT should: ► Have the knowledge and expertise to anticipate need, as well as manage and prevent secondary complications for this patient group. ► Be able to offer specialist assessments and interventions specific to the needs of this patient group. For example: spasticity, pain, skin integrity and continence, cognition including apraxia, communication, including access to computer software and mood disorders. ► Have sufficient training to recognise psychological problems, escalating as required, to ensure appropriate diagnosis of mood disorders. ► If teams are unable to meet an identified patient or carer need, or more specialist expertise is required, they should access the appropriate service in a timely manner, such as video fluoroscopy and spasticity management clinics.	
Education	
The team should be engaged in the education of: ► Commissioners and healthcare professionals regarding the rehabilitation evidence for this patient group and the resources required. ► Patients, families and carers regarding longer-term self-management and prevention of secondary complications such as shoulder pain. ► Care Home staff, supporting ongoing rehabilitation across domains specific to the patient, including swallowing, positioning and communication as well as enabling participation in leisure activities. Providing practical training and written information, in an accessible format, for non-stroke specialist healthcare professionals, family and carers where appropriate.	

Patient and public involvement

The Nottingham Stroke Research Partnership patient and public involvement group were involved in the design and conduct of this research and directed the focus of this enquiry.

Recruitment

Data from the publicly available Stroke Sentinel National Audit Programme (SSNAP)[14] were used to purposely sample three community stroke rehabilitation teams from different regions of England, East of England, East Midlands and Northern England.[15] Teams which met the inclusion criteria (box 1) were invited to participate through established professional networks, all those approached agreed to participate.

Recruited stroke rehabilitation teams had similar service specifications (table 2) and provided rehabilitation for stroke survivors with severe disability in the community, but varied with regard to rurality and socioeconomic compositions of the populations served (online supplemental file 1).

A score of 4 or 5 on the mRS was used to define severe disability.[8] This was a pragmatic decision as the mRS is collected routinely by stroke clinicians as part of the national audit and therefore would be familiar to participants.

Data collection

A single virtual focus group was conducted with each team via Microsoft Teams. To balance the challenges of facilitation while maintaining representation from across the MDT, groups were limited to seven.[16]

Eligible participants (box 1) were approached via email and following consent were provided with electronic copies of four statements. These were prioritised from the 11 consensus statements, derived in our previous study.[12] A brief overview is presented in table 3.

All groups were facilitated by one member of the research team (LR) with support from FR-B. Both LR and FR-B are female physiotherapists, with experience of working the community setting and have completed postgraduate research degrees. One of

Table 4 Participants and identifiers for each site

Site A		Site B		Site C	
Duration: 81 min		Duration: 75 min		Duration: 92 min	
Participant	Identifier	Participant	Identifier	Participant	Identifier
Rehabilitation support worker	RSW-A	Assistant practitioner	AP-B	Occupational therapist	OT-C
Physiotherapist	PT1-A	Occupational therapist	OT-B	Team lead	TL-C
Physiotherapist	PT2-A	Speech and language therapist	SLT-B	Physiotherapist	PT1-C
Occupational therapist	OT-A	Physiotherapist	PT1-B	Physiotherapist	PT2-C
Clinical psychologist	CP-A	Physiotherapist	PT2-B	Nurse	N-C
Team lead	TL-A	Team lead	TL-B	Speech and language therapist	SLT-C
Speech and language therapist	SLT-A			Therapy assistant	TA-C

the teams was known to both researchers in a professional capacity prior to the study, the other two were not. Each focus group followed the same format and no modifications were made to the interview guide. First, an explanation of the aims of the study followed by an introductory activity and an overview of the statements for discussion. Participants were asked to discuss their experiences of the barriers and facilitators to providing rehabilitation for this patient group in relation to each statement in turn. They were asked to think broadly, considering each of the CCF characteristics across all system levels. Focus groups were recorded using MSTeams.

To gain an understanding of the structure of, and activities undertaken by individual teams, additional data were extracted from the postacute organisational stroke audit (table 2).[14] Additional information regarding the populations served by each team was collected via publicly available data (online supplemental file 1).

Analysis

Focus group video recordings were auto transcribed using MSTeams, cleaned, verified and anonymised by FR-B. A combination of QSR International NVivo and MSExcel were employed to organise data and support analysis. Data extraction was undertaken once all focus groups were complete, initial thematic analysis was undertaken by researchers LR and TC.[17 18] TC is a postdoctoral researcher with a nursing background. LR and TC separately familiarised themselves with the data before coding inductively and organised deductively using the CCF. TC and LR subsequently compared codes, clustering into initial themes through a process of iterative discussion and revision at a latent level until consensus was reached. There were no outstanding areas of disagreement. Separate tables were used for each team to facilitate an in depth understanding of each team before tables were aggregated and data synthesised to gain overall theoretical understanding[13] of the barriers, facilitators and mechanisms involved in providing rehabilitation for this group of patients.

FINDINGS

There were 20 participants across 3 focus groups that took place between July and September 2021, lasting between 75 and 92 min (table 4).

The findings from the focus groups are presented in the following four sections corresponding to the system, organisational, team and individual level determinants of the CCF (table 1).

System-level determinants

This level includes social, political and environmental characteristics that may influence at the wider system (table 1). Economic tensions were alluded to by all teams. These included a constant threat to existing funding as well as the barriers to securing additional resources. One team lead highlighted the consequences of these financial pressures on their team. '*We did originally have a nurse post within the service, but as you know, you get cuts to the budget every year.*' [TL-C] Securing additional resources was described as a '*frustrating*' and '*time-consuming*' process, requiring teams to be persistent, as illustrated by one team lead describing the significant efforts required to purchase IT equipment. '*That's taken four years of battling… we put loads of evidence forward and eventually, we've got them.*' [TL-A]

Organisational-level determinants

Organisational-level determinants may exert influence at an individual National Health Service Trust or provider organisation level. Participants highlighted three main barriers to providing rehabilitation to this population that underpin three main CCF characteristics (table 1).

Networks and communications

This characteristic is defined as the quality of communication within the organisation and relationships among its members. A frequent need for specialist equipment such

as seating was reported for this population. Responsibility for providing such equipment, although often commissioned within the same organisation, required additional detailed referrals to separate teams and incurred waiting lists. These waiting lists prolonged the time that stroke survivors needs remained unmet, contributed to disjointed pathways and were described as leading to '*missed opportunities*' for rehabilitation. One Physiotherapist described the impact on patient outcomes. '*By the time things are in place, goals that would have been appropriate …we've lost range or deconditioned, they've lost that potential.*' [PT-A] Access to pain management was described as a common barrier to rehabilitation, with '*much too-ing and fro-ing to get the patient well managed and optimized with pain relief*' [PT-C]. Concerns were raised that as the first point of contact, general practitioners (GPs) may lack the neurological expertise to effectively manage neuropathic pain. Participants described communication with GPs as challenging, resulting in them feeling 'out of the loop' with clinical discussions regarding pain management, despite many having skills and expertise to contribute.

The benefits of investing in strategic relationships to build mutual understanding within the organisation were highlighted, one team described how such an investment led to greater autonomy. '*The commissioner relationship used to be that we had to submit a request form, but 2–3 years ago they said that I can make that decision… we fostered that. We've worked hard to keep that relationship.*' [TL-C]

Compatibility

Tensions were described between the organisational expectations of services, and the needs of those with higher levels of disability. For example, the SSNAP measures processes of care against evidence-based standards, which organisations aim to meet.[19] One of these standards states that patients receive 45 min of rehabilitation, 5 days a week. Teams described attempts to meet this standard without the necessary staff to progress the more physically dependent stroke survivor. '*That's really hard to deliver, four five times a week…you may be doing that to meet the standards, but you're thinking this isn't actually that effective treatment.*' [PT-A]. However, some participants expressed concerns that more stroke survivors with severe disability may not tolerate the number of sessions that the standards aspire to, and that this intensity standard may be inappropriate for this specific patient group.

There were differences between participating teams regarding the organisational expectations relating to responsibility for providing rehabilitation for this population. This specifically concerned the education of care home staff. Two of the teams, perceived this to be part of their role to varying degrees, however, one team raised concerns regarding the funding of this input. '*I think care homes at the end of the day are responsible for training their own staff so there is a bit of me thinking that potentially they need to be paying for this training.*' [TL-B] Differences were reported in how organisations conceptualise rehabilitation and therefore which activities were perceived to be included. This was evident when comparing the perspective of a Physiotherapist from team B, who described their distinction between treatment and education. 'It would take away from the interventions that we're doing with the patients, yes, they do need the education, but actually…. our role is to intervene and treat the patient.' [PT-B] In contrast, there was much discussion in team A regarding their emphasis on educating carers and how this was perceived as fundamental to optimising rehabilitation opportunities for this patient group.

Available resources

A number of barriers were described as a result of historical commissioning arrangements within organisations. Participants reported services originally commissioned for more independent stroke survivors, as insufficient to meet the needs of those with higher levels of disability, both in terms of staffing establishment and skill mix. For example, teams reported being unable to regularly provide more than a single weekly session with multiple therapists in attendance, limiting their ability to progress those more physically dependent '*If they're really complex and dependent it takes maybe three or four of us to treat them effectively. That's really hard to deliver*' [PT-A]

One team described making a decision to compromise the skill mix of their team in order to improve their capacity. *'The nurse wasn't able to cover the therapy aspect of the role [so] we converted that money into therapy posts'* [TL-C]. However, having recently funded a temporary nursing post, the team lead reflected on the value for this patient group and reported that going forward '*there will be a drive to add a nursing role'* to their establishment. [TL-C]

Team level

At this level, participants reported barriers underpinning two main characteristics, available resources and team efficacy.

Available resources

The specialist skills and expertise of the stroke MDT were the most frequently reported resource across all three teams. Participants described a number of ways in which teams shared expertise in order to optimise rehabilitation opportunities for this patient group. These include interdisciplinary working within their team, in-reach into the acute setting or upskilling others external to their team. All teams alluded to interdisciplinary working, describing an overlap between disciplines in terms of their knowledge and skills.

Participants suggested that in-reaching into the acute hospital prior to discharge prevented this population from losing rehabilitation momentum when transitioning out of hospital. It was reported as most beneficial when undertaken by a consistent individual, in-person and where they had the opportunity to meet the patient prior to discharge '*It was seamless…they could continue the rehab with the carers when they got home and then you wouldn't*

get deconditioning and the effects of not doing that transfer so it is really good.' [PT-C]

Teams described purposely seeking opportunities to upskill a variety of individuals involved in the ongoing rehabilitation of stroke survivors with severely disability after discharge from the stroke MDT. This includes sharing expertise with healthcare professionals, family members or formal carers such as '*joint sessions…to train, advise, give guidance or support to other teams.'* [TL-A] However, the large volumes and high turnover of care staff were reported as a significant barrier to sharing their expertise with formal paid carers. This was specifically reported as problematic in the care home setting, where staffing was often described as lacking consistency. '*It's difficult in care homes to get a key worker … that person changes every day*' [PT-A] One SLT reported facing resistance from care home staff, who were reluctant to engage in training. This tension was described as damaging relations between the MDT and care home staff. '*That becomes quite tricky to get round and it often breaks down relationships within care homes.'* [SLT-C] Similar issues were reported for formal carers going in the stroke survivors' home, however, this was described as more manageable than the care home setting.

Team efficacy

Teams reported optimising their communication with healthcare professionals, stroke survivors and their carers to improve the efficacy of their interventions and focus finite resources. One team allocated team members to specific geographical areas in order to '*crossover with the same patients that we're talking about.*' [PT-B] Another team described how they strategically built relationships with individuals of influence in a care home to enhance their efficacy. '*Building good links with the care home by visiting regularly and having a top-down approach can be really helpful… that just cascades down.'* [OT-C]

Individual level

At this level, participant responses focused on self-efficacy; their personal capabilities to provide and optimise opportunities for rehabilitation for this patient group.

Self-efficacy

Participants demonstrated positive attitudes with regards to their ability to provide rehabilitation opportunities for stroke survivors with severe disability. This was evident across all three teams; examples were given of individuals seeking to maximise the impact of each patient contact. '*Every visit we do, there's the opportunity to educate… we are constantly educating*' [RSW-A]. In some situations, participants perceived a carers lack of stroke expertise as a barrier to their self-efficacy. They described their frustration at being unable to progress rehabilitation if carers lacked stroke experience, instead needing to direct efforts to up-skilling carers. '*[patients] lose that momentum with their rehab…not through any fault, they've[carers] not had the training, it's just that they're not specialist in those areas'* [PT: Team A]

Repetition was the most frequently reported strategy used by individual members of the MDT to optimise rehabilitation opportunities for this patient group. Participants described utilising multiple formats such as written or verbal instructions, photographs and videos for positioning, activities and exercises. For these individuals who may be dependent on carers to support their ongoing rehabilitation, providing multiple opportunities for skill sharing was described as paramount. '*It's just the amount of repetition you have to do, whether it's in a care home or at home. You have to go out a great number of times to be able to capture and make sure people are competent and confident in doing what you've asked them to do' [PT-A]*

DISCUSSION

This study provides insight into how community stroke teams optimise rehabilitation opportunities for stroke survivors with severe disability, the barriers they face, and strategies employed to deliver evidence-based rehabilitation. High levels of need for this population were identified, which teams were insufficiently resourced to meet. Disjointed clinical pathways were evident, with a potential negative impact on outcomes and experiences for this population. Many of the needs for this population are dependent on multiagency input from across health and social care. Findings emphasised the importance of interprofessional team working, cross-boundary working and the need for educating and upskilling staff.

These findings are consistent with previous studies highlighting a number of facilitators to interprofessional collaboration, evident at both team and organisation levels.[20 21] Participants in this study described focusing efforts to establish relationships with key stakeholders such as commissioners, voluntary agencies and health and social care professions to meet the rehabilitation needs of this population.

Effective team-working requires, what Henneman *et al* describe as, 'many types of sharing' including knowledge, values and visions.[22] At a team level, participants in this study described skill sharing as fundamental in optimising rehabilitation opportunities for this population. Examples of this included in-reaching into the acute hospital in order to share expertise. This is echoed in the community stroke literature, by Fisher *et al*[23] who found such in-reaching to be facilitatory to a 'seamless, patient centred pathway'.

Upskilling those instrumental in the ongoing rehabilitation for this population, is not without its challenges. A number of barriers were highlighted by participants within the study with regards to training formal carers, especially those within the care home setting. High turnover within this staff group led to a lack of continuity which frustrated participants owing to the need for repeated training. These findings are consistent with Masterson-Algar *et al*, in which a neutral outcome for an

OT intervention for stroke survivors in care homes was attributed in part to this issue.[24]

A failure to translate evidence-based interventions into practice has been attributed to the complexity of context.[25] The use of the CCF when designing and reporting this study enhances the transferability of findings to a variety of contexts.[14] The CCF enabled the impact of challenges reported at one level, to be explored at another. For example, economic tensions described a system level informed decisions regarding skill mix made at an organisational level. Subsequently, number of strategies were employed at both team and individual levels to overcome these challenges.

In a context of finite resources, teams described making difficult decisions including compromising the available skill mix or staffing. This disproportionately impacts stroke survivors with severe disability and higher levels of rehabilitation need, who may benefit from the skills or the physical support that is lost.[26 27] The Integrated Community Stroke Service model proposes that all survivors of stroke discharged from hospital receive rehabilitation from an integrated MDT, regardless of their disability.[6] Consequently, services originally established to meet the needs of more independent stroke survivors, such as ESD will require sufficient resourcing if they are to meet the needs of the wider stroke population.

Limitations

One team was known to both researchers in a professional capacity prior to the study, which is an acknowledged limitation as this may have impacted the focus group dynamics. It is recognised that the experiences of LR and FR-B may have influenced the focus group discussion as participants were aware of their professional backgrounds. This study was not intended to have generalisable findings, instead the findings from three diverse teams offer insights that may be transferable to other contexts. Power inequalities are acknowledged within focus group research. Researchers sought to facilitate balanced and representative discussions. It is recognised that the individual team dynamics and specifically the presence of a team lead in each group had the potential to influence participation and subsequent findings.

Conclusion

This study builds on our established consensus regarding the core components of rehabilitation for stroke survivors with severe disability in the community. It highlights the need for organisational clarity regarding where responsibility lies for its provision. In the absence of agreement, inequalities in the provision of rehabilitation for this population will persist.

The development of strategic networks aids understanding of the needs of these stroke survivors at an organisational level, which has the potential to influence service provision. However, teams require sufficient resourcing to enable them to meet the needs of stroke survivors with severe disability, in terms of both their skill mix and staffing establishment. Collaboration with health and social care professionals and the voluntary sector optimises rehabilitation opportunities for this population, making efficient use of resources and capitalising on available skills. As a consequence, the specialist expertise possessed by these teams has the potential to influence the outcomes of this population past the point of their direct intervention.

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