MIXED-METHODS FEASIBILITY AND STAFF ACCEPTABILITY STUDY

Feasibility and staff acceptability of delivering Psychoeducation within a matched-care model in stroke rehabilitation

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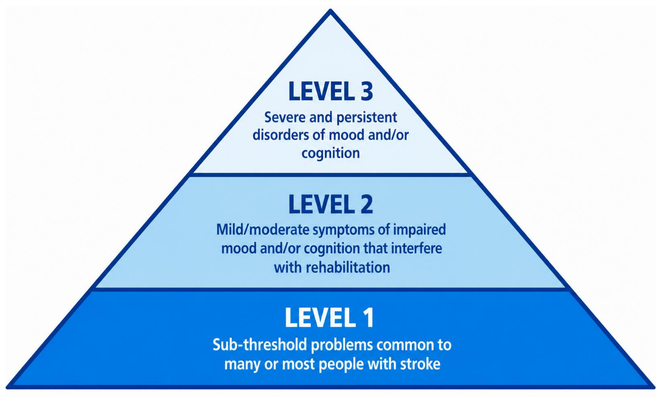
INTRODUCTION

Psychoeducation can improve stroke survivor outcomes[1], but specialist psychology capacity is limited[2]. A matched-care model is recommended, whereby, after specialist assessment, trained non-psychology clinicians provide 'level one' support, with specialist input reserved for complex needs[3] .This requires clinicians to work in a transdisciplinary way[4]. However, there is little research on clinician views of delivering 'Level one' interventions in this model. This feasibility and acceptability study examined whether a single, individualised psychoeducation session could be integrated into routine post-acute stroke rehabilitation and whether delivering it was acceptable to a non-psychology multidisciplinary team (MDT). Acceptability was understood using the Theoretical Framework of Acceptability (TFA)[5].



Matched care model for psychological interventions after stroke
Adapted by NHS improvement from IAPT model with input from Professor Allen House and Dr Posy Knights[6]

METHODS

Design and setting

This mixed method quality-improvement study analysed frequency of the intervention-delivery and qualitative data collected from a clinician focus group. It was conducted on an 11-bed post-acute stroke rehabilitation ward in South East England.

Participants

Four physiotherapists, two occupational therapists, three speech and language therapists and one psychologist were trained to deliver the intervention. Five clinicians: three physiotherapists, one occupational therapist and one speech and language therapist participated in the focus group. Each had delivered the intervention at least three times.

Feasibility analysis

Feasibility was assessed from the proportion of intervention opportunities successfully delivered, reasons for non-delivery and uptake by professional discipline. Delivery data were summarised descriptively by discipline.

Staff acceptability analysis

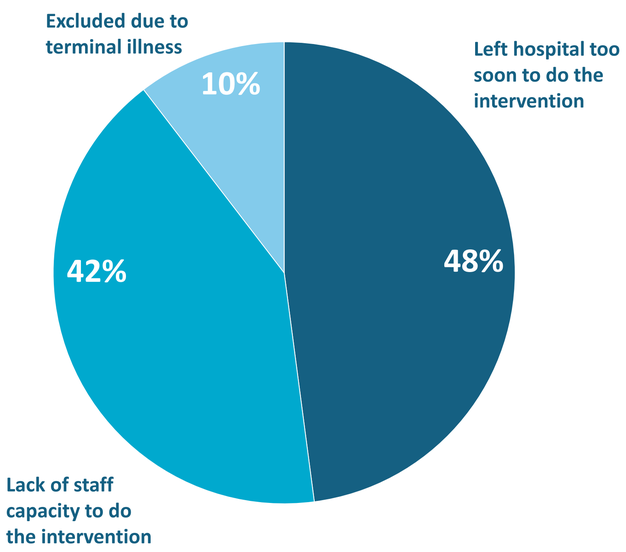
Staff acceptability was explored using a semi-structured focus group informed by all seven TFA constructs. Two researchers used hybrid inductive and deductive thematic analysis[7], independently coding the transcript before mapping relevant codes to the TFA and resolving differences by consensus.

RESULTS

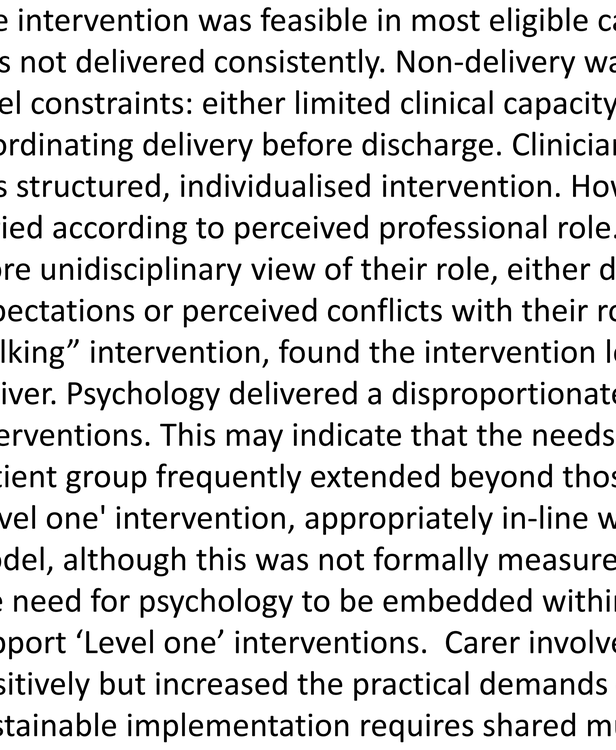
The intervention was feasible under routine NHS conditions

The intervention was delivered on 83 of 131 possible occasions (63.4%).

Reasons for the intervention not taking place



Delivery of the intervention by discipline



The intervention was acceptable to staff but conditional

Five themes described why acceptability varied across roles and service conditions:

1 The intervention overlapped with and extended usual practice.

It formalised discharge conversations, prompted carer involvement and consolidated information that might otherwise be omitted.

2 Professional role and workflow shaped acceptability.

Fit was stronger where discharge-focused discussion aligned with routine work; physiotherapists described greater opportunity costs and competing expectations.

3 Individualisation and therapeutic relationships were central.

Knowledge of the patient supported complex conversations, although having clear separation in roles could sometimes offer clearer boundaries with patients.

4 Carer involvement added value and implementation burden.

Carers were important when cognition or communication limited retention, but arranging attendance required additional coordination.

5 Sustained delivery required central coordination.

Clinicians wanted clear allocation, reminders, accessible printed materials, refresher training and ongoing opportunities for consultation .

DISCUSSION

The intervention was feasible in most eligible cases, although it was not delivered consistently. Non-delivery was due to service-level constraints: either limited clinical capacity or difficulties coordinating delivery before discharge. Clinicians generally valued this structured, individualised intervention. However, acceptability varied according to perceived professional role. Clinicians with a more unidisciplinary view of their role, either due to patient expectations or perceived conflicts with their role in conducting a "talking" intervention, found the intervention less acceptable to deliver. Psychology delivered a disproportionate number of interventions. This may indicate that the needs of this complex patient group frequently extended beyond those anticipated for a 'Level one' intervention, appropriately in-line with a matched care model, although this was not formally measured. This indicates the need for psychology to be embedded within the MDT to support 'Level one' interventions. Carer involvement was viewed positively but increased the practical demands of delivery. Sustainable implementation requires shared multidisciplinary ownership, with clearly allocated responsibility for coordination, reminders and materials, supported by ongoing training and psychology consultation.

REFERENCES

1. Crocker, T. F., Brown, L., Lam, N., Wray, F., Knapp, P., & Forster, A. (2021). Information provision for stroke survivors and their carers. *Cochrane Database of Systematic Reviews*, (11).

2. Intercollegiate Stroke Working Party. (2021). *National clinical guideline for stroke* (2021 update/online ed.). Royal College of Physicians.

3. National Clinical Guideline for Stroke for the UK and Ireland. London: Intercollegiate Stroke Working Party; 2023 May 4. Available at: www.strokeguideline.org. (accessed on 27.08.26)

4. Karol, R. L. (2014). Team models in neurorehabilitation: structure, function, and culture change. *Neurorehabilitation*, *34*(4), 655-669.

5. Sekhon, M., Cartwright, M., & Francis, J. J. (2017). Acceptability of healthcare interventions: an overview of reviews and development of a theoretical framework. *BMC health services research*, *17*(1), 88.

6. NHS Stroke Improvement. (2012). *Psychological Care after Stroke: Improving Stroke Service for people with mood and cognitive disorders*.

7. Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.