NHS
London
Strategic Clinical Networks

Six Month Stroke Reviews: A Commissioning Guide

London Stroke Strategic Clinical Leadership Group

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1. Background

Stroke is a long term condition in which survivors experience changes in their needs over time. Assessments at six months following stroke are essential to identify those patients who need further treatment and to ensure that services provided are appropriate to the patients' needs. These assessments are mandated in England as part of the Clinical Commissioning Group Outcome Indicator Set (CCG OIS)[1].

This document is intended to support commissioners in their requirement to offer six month reviews to all applicable stroke survivors. It details the provision of six month reviews in London at the time of writing, and recommends how these assessment services ought to be structured and delivered as part of the stroke pathway.

The provision of a six month review service for stroke survivors is driven by the following national guidelines/standards:

Key Drivers	Descriptor/Standard
National Stroke Strategy QM14 (2007)[2]	People who have had strokes and their carers, either living at home or in care homes, are offered a review from primary care services of their health and social care status and secondary prevention needs, typically within six weeks of discharge home or to a care home and again six months after leaving hospital.
Care Quality Commission: Supporting Life After Stroke(2011)[3]	Regular reviews after transfer home provide a key opportunity to ensure people get the support they need.
Royal College of Physicians (RCP) National Clinical Guidelines for Stroke (2012) Fourth Edition 7.1.1C and 7.4.1A[4]	Any patient with residual impairment after the end of initial rehabilitation should be offered a formal review at least every 6 months, to consider whether further interventions are warranted, and should be referred for specialist assessment if: • new problems, not present when last seen by the specialist service, are present • the patient's physical state or social environment has changed Patients and their carers should have their individual practical and emotional support needs identified: • before they leave hospital • when rehabilitation ends or at their 6-month review • annually thereafter

[1] NHS ENGLAND. (2013) *CCG Outcome Indicators Set 2014/15-at a glance*. [Online] Available from: http://www.england.nhs.uk/ccg-ois/. [Accessed 1 July 2015].
[2] DEPARTMENT OF HEALTH. (2007) *National Stroke Strategy*. [Online] Available from: http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081062. [Accessed 2 July 2015].
[3] CARE QUALITY COMMISSION. (2011) *Supporting Life After Stroke: A review of services for people who have had a stroke and their carers.* [Online] Available from: http://www.cqc.org.uk/content/services-people-who-have-had-stroke-and-their-carers. [Accessed 2 July 2015].
[4] ROYAL COLLEGE OF PHYSICIANS. (2012) *National Clinical Guidelines for Stroke – fourth edition*. [Online] Available from: https://www.rcplondon.ac.uk/resources/stroke-guidelines. [Accessed 2 July 2015].

NICE (CG162) Stroke rehabilitation guideline: Long term rehabilitation after stroke (2013)[5]	Review the health and social care needs of people after stroke and the needs of their carers at 6 months and annually thereafter. These reviews should cover participation and community roles to ensure that people's goals are addressed.
CCG Outcomes Indicator Set 2013/14 and 2014/15[1]	Domain 3 – Helping people to recover from episodes of ill health or following injury Improving recovery from stroke / People who have had a stroke who • receive a follow-up assessment between 4-8 months after initial admission

Table 1: National guidelines and standards requiring or recommending reviews at six months following stroke.

What is a six month review?

"The review was definitely valuable as me and my husband did not feel that we were left out in the dark after my stroke." *Stroke Patient, 2015*

Stroke survivors should receive reviews at 6 weeks, 6 months, and 12 months, and then annually as required, regardless of the patient's home situation or disability. These reviews facilitate a clear pathway to further specialist review, secondary prevention strategies, advice, information, support, and rehabilitation where required, via access to a multi-disciplinary team. The only patients exempted are those who have died, those under age 18, and those who do not have a GP.

The National Stroke Strategy describes a good assessment process as involving a multi-disciplinary, person-centred assessment of the individual's needs as well as signposting to other services e.g. housing or transport.

Six month reviews provide the support and follow up care instrumental to patients with long term conditions. These reviews enable providers to identify and plan for ongoing or previously unmet needs, grant access to a range of information about NHS, voluntary, community and social services, and provide emotional support for both patients and carers.

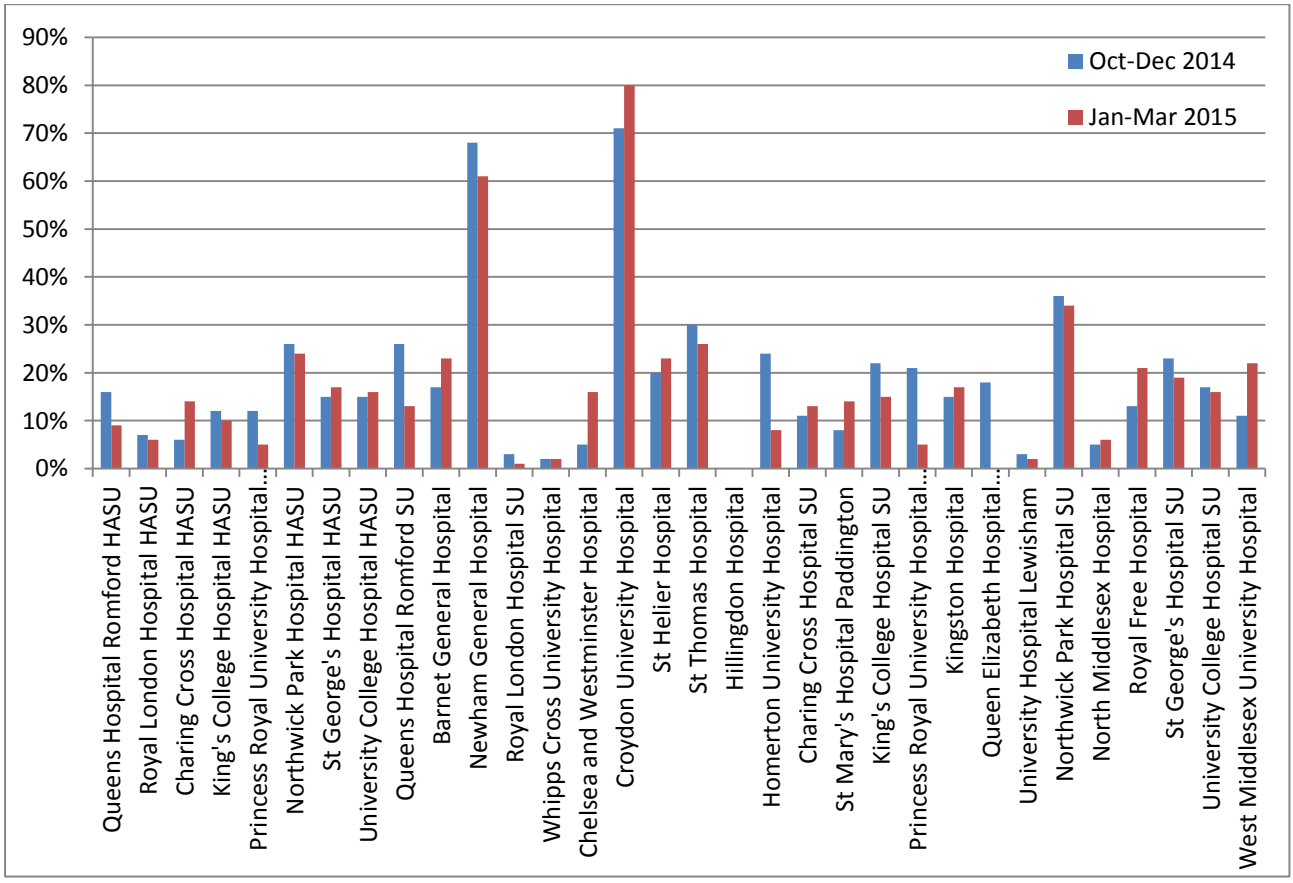
Section Three provides the service specification of a six month review.

[5] NICE. (2013) *Stroke rehabilitation guideline: Long term rehabilitation after stroke* [Online] Available from: http://www.nice.org.uk/guidance/cg162. [Accessed 2 July 2015].

2. Provision of reviews across London

2.1 Current provision of six month reviews in London

Information on stroke care provision can be obtained via the Stroke Sentinel National Audit Programme (SSNAP).[6] This is a prospective database of all stroke admissions in England and Wales. This data provides information on the percentage of patients receiving a six month review following discharge from HASUs and SUs in London.



NB Queen Elizabeth Hospital Greenwich has combined with University Hospital Lewisham for Jan-Mar 2015 data.

Figure 1: % of HASU and SU patients in London receiving a six month review Oct-Dec 2014 and Jan-Mar 2015 (SSNAP)

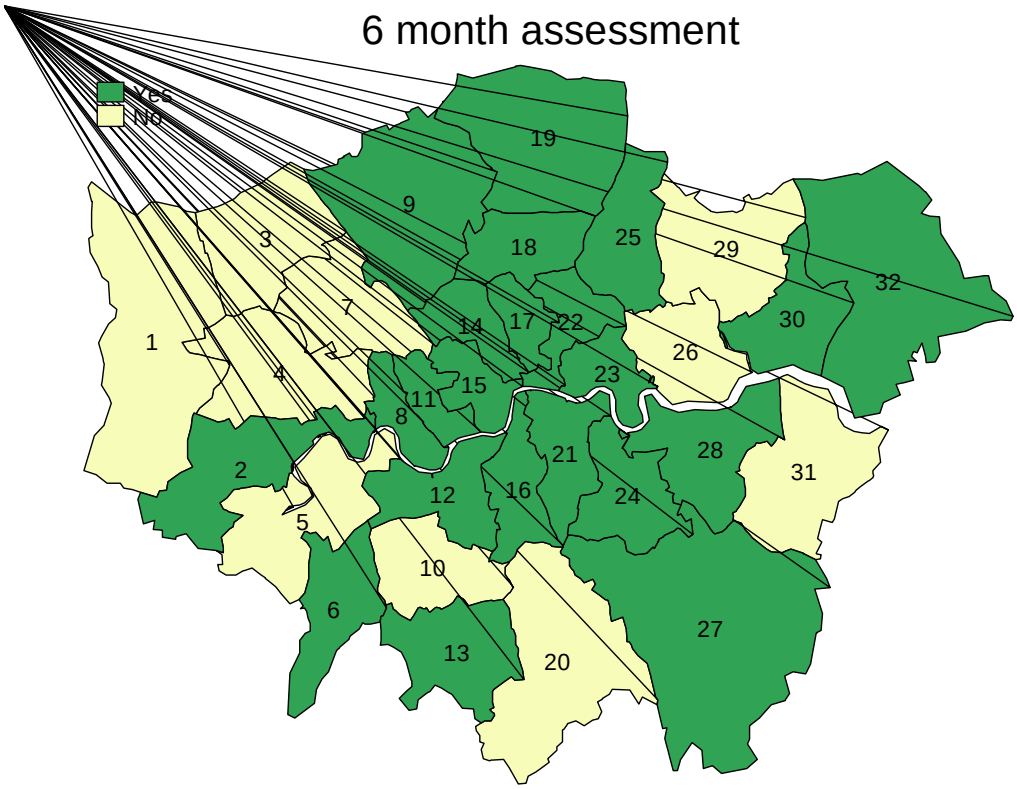
Overall only 16% (mean) of patients received a review. In 10 stroke units in London fewer than 10% of patients received a review. There has been little improvement in review provision over the last two quarters.

SSNAP data also provides information on the provision of six month reviews per provider and the numbers of patients receiving, declining, or not receiving a review. See Appendix One.

[6] ROYAL COLLEGE OF PHYSICIANS. (2015) *Sentinel Stroke National Audit Programme.* [Online] Available from: https://www.strokeaudit.org/ [Accessed 2 July 2015].

2.2 Clinical Commissioning Group's (CCGs) commissioning of six month reviews

SSNAP also completed a post-acute organisational audit in 2015, for which CCGs provided data on commissioned six month review services.



Source: SSNAP post-acute stroke service commissioning audit 2015
Region: London SCN

Figure 2: Commissioning of six month reviews in London (SSNAP)[6]

There are 10 CCGs indicated here that do not currently commission six month review services in London.

In addition to the information gained via this SSNAP audit, the Stroke Association are also commissioned to provide six month reviews in five boroughs not represented on this figure: Barnet, Greenwich, Hounslow, Islington and Redbridge.

There is a discrepancy in some CCGs between that which is reported as commissioned and the SSNAP audit results for six month reviews. For example, Newham and Croydon CCGs reported that they do not commission a service, however table 1 indicates that reviews are being conducted and SSNAP data entered.

3. Service specification

"Speaking with someone who knew not just medical side but also the social side of the impact – someone who could talk about the effects – cleared up concerns." *Stroke Patient, 2015*

When choosing or evaluating a model to implement locally, commissioners should carefully consider how the model will sit within the entire stroke pathway.

3.1 The review meeting

The provider of the six month review service will work with patients and carers to assess progress and needs 4-8 months after a patient's stroke. The review meeting will typically require a 30-60 minute appointment dependent on individual patient and carer requirements.

The review will take place at a location appropriate to the patient's and carer's needs, taking account of mobility requirements, transport options, and communication or cognitive difficulties. Face to face reviews are the preferred method, however telephone reviews may be offered in line with patient preference or where a face to face review is not appropriate or safe. A review in the patient's home however allows the reviewer to observe how the patient is coping in their home.

Reviews should be primarily offered during office hours, as agreed locally, with some provision available during evenings and at weekends to accommodate patient and carer availability.

The review should use a standardised tool to identify individuals' post stroke unmet needs across health, social and emotional care domains. The review must cover the following areas:

- Medicines, secondary prevention strategies, general health needs
- Mood, memory, cognitive and psychological status
- On-going therapy and rehabilitation needs
- Social care needs, benefits and finance, driving, and transport
- Needs of the carer(s)

A previous workshop undertaken with patients and carers in London in 2011 identified a range of areas that may be included in a six month review. See Appendix Two.

Any unmet needs which are identified will be addressed by providing advice, additional support, referral or signposting to appropriate services. These may include stroke specialist rehabilitation, social care, peer support, group opportunities, befriending, and voluntary sector support.

Several models of six month reviews currently exist within London. When choosing a provider, commissioners will need to consider the extent of the service they wish to provide. This will include the level of clinical advice provided to patients, expertise in referring to other services, and the signposting of patients and carers to local statutory, social and voluntary sector providers. Section Four describes some of these models in more detail.

3.2 Following the review

A document summarising the review's outcomes and recommendations should be produced as a result of the review. Copies should be sent within two weeks of the review to the patient and, with the patient's consent, the patient's GP and relevant multi-disciplinary team. Patients / carers should also be provided with details of whom to contact for more information.

All six month review providers should be required to enter clinical information into the SSNAP database with accurate data including patients who were not contactable, declined the review, or did not attend. See Appendix Three for the current SSNAP minimum dataset.

3.3 Training and competence

The provider of the six month review service should be able to provide evidence of a skilled and competent workforce. The reviewer should have access to a stroke multi-disciplinary team covering acute and post-acute stroke services to provide support and advice as required. Support structures must include access to rehabilitation, carers' support, and financial advice.

In addition to access to a multi-disciplinary team, the reviewer must have knowledge and skills around:

- The clinical needs of stroke patients
- Communicating with patients who have aphasia and other communication or cognitive difficulties
- Recognising the emotional and psychological needs of stroke patients
- Identifying new or unmet needs and which services to refer to
- The referral processes for all appropriate services
- Communicating with patients for whom English is not their first language

As no individual can be expected to provide expert advice for every eventuality, it is of critical importance that the reviewer possesses the skills to refer appropriately.

"I didn't say much due to my speech, but I was very happy with it all." Stroke *Patient, 2015*

Review staff must have the necessary skills to communicate with patients with aphasia, cognitive difficulties, and other communication difficulties resulting from their stroke. Access to an interpreting service must be available for patients with translation needs.

3.4 Data sharing

Commissioners and providers will need to agree data sharing arrangements to facilitate a seamless pathway of care. The six month review provider will require the patient's discharge information as well as the information captured at the patient's six week review.

Best practice tip: If notified of the review date, the patient's GP can provide the reviewer with an updated medications list and current cardiovascular health information.

3.5 Eligibility and accessibility

The six month review service is for all adults 18 and over, living in the commissioning area, who are registered with a GP and who have had a diagnosis of stroke. Patient exclusion criteria for a six month review are:

- Patients under age 18
- Patients who died within six months of initial admission for stroke
- Patients who are not registered with any GP
- Patients who declined their six month review
- Patients who were uncontactable, following the agreed escalation procedure

The provider and commissioner should agree the nature of the appointment and escalation system. In the event of an uncontactable patient, the London Stroke Strategic Clinical Network recommends the following escalation procedure:

1. Provider calls the patient or designated carer twice
2. If no response, provider sends letter to patient
3. If no response, provider sends letter to GP after one month of no response

The six month review service provider must ensure that no patient is discriminated against based on age, disability, race, culture, religious beliefs, sexual orientation or income levels.

For patients who are abusive or threatening, appropriate measures must be taken to ensure staff undertaking reviews are safe.

3.6 Referral routes

There are a number of pathways that a stroke patient may have followed. A patient applicable for a six month review may:

- Have been discharged from either a hyper acute stroke unit (HASU) or a stroke unit (SU)
- Have been discharged to an Early Supported Discharge (ESD) service, to a community stroke team, to a care home (which they may or may not have lived in previously) or to their own home without rehabilitation
- Have had their stroke while away from home and been treated outside their CCG area
- Wish to self-refer

The discharging organisation is responsible for sending notification to the six month review provider to confirm discharge date, ensure all eligible patients are referred, and enable the review provider to effectively plan when to contact the patient.

3.7 Whole system accessibility / acceptability

The provision of a six month review service is an integral part of developing the wider stroke pathway. Efficient running of the six month review service will require that good relationships are established and maintained between secondary care, primary care, and other referrers to ensure that referrals are sent appropriately and in a timely fashion.

3.8 Continual service improvement / innovation plan

Commissioners should expect providers to work collaboratively with relevant partners to develop and implement continual improvement. The six month review service provider will review, and where appropriate and after discussion with commissioners, update their service in line with any new national guidance. Reports and data will be provided as mutually agreed between the providers and the commissioner.

3.9 Performance targets: quality, performance and productivity

In addition to the clinical data captured in the review and uploaded to SSNAP, it is expected that the six month review service provider will capture and monitor emergent trends among patients, such as with unmet needs. This information will allow the CCG to intervene or consider new services at pivotal places in the care pathway. Where local standards or targets exist, they must be met.

The following table lists recommended metrics that providers should capture.

Objective	Indicators	Frequency	Provided by
Ensure patients have equitable and appropriate access to treatment CCG OIS 2014/15 C3.8 (SSNAP Data)	Title: People who have had a stroke who receive a follow up assessment between 4-8 months after initial admission (ASI 8/ SSNAP) (target = 100% at 6 months) Definition: The percentage of people who have a follow-up assessment between four and eight months after initial admission for stroke. Numerator: Of the denominator, the number of patients who had a follow-up assessment between four and eight months after initial admission for stroke Denominator: The number of stroke patients entered into SSNAP excluding: • patients who died within six months of initial admission for stroke • patients who decline an appointment offered • patients for whom an attempt is made to offer an appointment but are untraceable as they are not registered with a GP	Quarterly	Service name
Improve patient experience	Local wording to be agreed between the Commissioner and provider	Quarterly	Service name
Informed patients	100% of patients and/or carers to receive a written copy of the outcomes of their 6-month review within 2 weeks of the review	Quarterly	Service name
Informed primary care	100% of GPs to receive a written copy of either: • the outcomes of the review within 2 weeks of the review where patient consent has been given • notification that the patient was uncontactable following the agreed escalation procedure • notification that the patient did not attend the review within 4 weeks of the intended review date	Quarterly	Service name
Complaints	Local wording to be agreed between the Commissioner and provider	Quarterly	Service name

Table 2: Recommended quality metrics

4. Differing models of service provision

"I think he found it valuable to think about things that were annoying me and we hadn't been able to talk about. For both of us it was the support offered that would make our life easier." *Stroke Carer, 2015*

In preparing this report, the London Stroke Strategic Clinical Network aimed to obtain information about differing service models and differing service providers. Service providers in 11 CCG areas were approached (Lambeth, Southwark, Greenwich, Bexley, Lewisham, Tower Hamlets, Brent, Barnet, Islington, Redbridge and Harrow); however information was only obtained from two providers working across four CCG areas (The Stroke Association for Barnet, Islington, and Redbridge CCGs, and the stroke coordinator for Harrow CCG).

Providers were asked to complete two standardised surveys. One asked provision questions of the provider, while the other asked quality of care questions of patients and carers. These surveys are included in Appendices Four and Five.

Two models of reviews were undertaken in these services - in person and telephone reviews. The differences in these models are summarised in table 3.

Provider	Review method	Benefits/challenges of this model	Provider role	All stroke patients included?	Tool used	Time per patient	GP information
Stroke Association for Islington, Redbridge and Barnet CCGs	In person	Benefits: - includes carers needs - blood pressure checks - able to deal with language or cognitive difficulties Challenges: - administrative time and travel time - coordination of visit with carers	Barnet – part-time post Islington and Redbridge – 6 week support & 6 month reviews	Barnet and Redbridge – excludes nursing home residents Islington -all	GM-SAT[1]	60-90 mins	Letter or fax
Harrow CCG stroke coordinator	By telephone	Benefits: - time efficient - easily accessible Challenges: - difficulty with those with language impairment or non-English speaking	6 week, 6 month & 12 month reviews	All stroke patients	Flexible but includes Barthel and modified Rankin score	30-45 mins	Letter

[1]Greater Manchester Stroke Assessment Tool (GM-SAT)

Table 3: In person and telephone review models

Referrals to all these services were from: acute stroke units, information and advice services, community therapy teams and SSNAP data.

Common reasons cited that patients do not receive a six month review are: patient deceased, declined by patient (patient unwell or returned to usual function), patient moved out of borough and patient non-attendance having agreed review initially. There seemed to be no mechanism for six month review providers to be informed of patients who had died since hospital discharge.

The Harrow Stroke co-ordinator made several attempts by phone and by post to contact patients and offer a review at six months. If no contact was made, a further attempt was made at 12 months post-stroke.

Both sets of providers commented on some shared challenges:

- Managing realistic expectations of the client, e.g. around receipt of further rehabilitation
- Client not wanting to follow up review recommendations, e.g. visiting GP regarding secondary prevention advice
- Uncertainty that recommendations have been acted upon by GPs
- Accessing further support for the patient such as dealing with social isolation
- Time to complete SSNAP record

4.1 Indicative costs

Indicative costs are challenging to provide given the variation in stroke patients requiring reviews per year per CCG (range 102-333 per quarter based on Jan-Mar 2015 SSNAP data). CCGs will need to consider the required number of stroke patients requiring six month reviews during commissioning. Three models could be utilised; stand-alone commissioning for six month reviews for a single CCG; joint commissioning between 2 CCGs or joint commissioning to provide both six week and six month stroke reviews. Example costs were provided by 2 providers – The Stroke Association and Harrow CCG.

Stroke Association – 1 WTE:

- £23,710.85 - £25,796.73 (outer London weighting)
- £25,254.85 - £27,340.73 (inner London weighting)

Harrow CCG – 1 WTE (Both six week and six month reviews)

Band 7 £35,511- £45,403 (outer London weighting)

4.2 Contract monitoring

Typically the contracts for six month reviews were monitored by CCGs quarterly via written reports and meetings with service providers.

5. Recommendations

"A fantastic service. We know others who live in different boroughs that have not had this support and this is very sad. Hopefully there will be a similar service like this all over someday soon. It is good to know that someone is looking out for you, following you for a year. We were even told that even after the year we could still contact our stroke co-ordinator which again is so comforting to know." *Stroke Patient, 2015*

- 100% of eligible patients with stroke should be offered a review at six months following their stroke.
- 100% of CCGs should commission six month reviews.
- GPs should be involved in the outcomes of reviews as well as ongoing care. Information sharing should be transparent and flow in both directions between primary care and the review provider.
- Data sharing agreements must be in place between the provider and the patient's GP to ensure that the provider does not attempt to contact deceased patients.
- Data sharing agreements may also be needed where a provider is outside of the NHS to enable information transfer such as discharge summaries.
- Due to the volume of reviews in each CCG area, commissioners may consider sharing reviewer posts with other CCGs or with other responsibilities, such as six week stroke information and advice posts.
- This report found that in many CCGs, SSNAP data did not mirror the actual provision of services. All commissioners are advised to thoroughly review the six month review service they commission to ensure national and local requirements are met, and that all future data entered into SSNAP is correct.

6. Appendices

Appendix One: Six month reviews completed Jan-Mar 2015 (SSNAP)

Provider	Applicable patients	Reviews completed
Barking and Dagenham	166	38
Barnet	333	74
Bexley	208	17
Brent	189	85
Bromley	293	72
Camden	159	47
Central London (Westminster)	103	6
City and Hackney	168	6
Croydon	290	87
Ealing	278	1
Enfield	283	18
Greenwich	179	17
Hammersmith and Fulham	119	23
Haringey	172	3
Harrow	185	148
Havering	274	88
Hillingdon	251	1
Hounslow	212	56
Islington	139	54
Kingston	133	43
Lambeth	197	29
Lewisham	189	5
Merton	138	19
Newham	154	41
Redbridge	270	6
Richmond	154	3
Southwark	206	40
Sutton	161	21
Tower Hamlets	140	1
Waltham Forest	180	11
Wandsworth	225	37
West London	148	16

Table 4: Six month reviews scheduled and completed, as entered in SSNAP, Jan-Mar 2015

Appendix Two: 2011 South London patient engagement event

Feedback from a patient and carer engagement event in South London on issues they felt should be included in six month reviews:

Medical
• Informing patient about correct medication, whether there are more suitable drugs available and what length of time patient can expect to be on the medication • Give patient a clear explanation of medication purpose and side effects and give a clear choice about which medication to take • Secondary prevention information (e.g. diet or healthy eating) • Information about how to react if patient goes back into Atrial Fibrillation • When, where, how, from whom to seek advice • Raising patients/carers awareness of symptoms and effects • Cholesterol check, full health check to ensure patients have no other linked conditions, INR check • Time for patients to discuss worries and fears • Signposting to further support
Physical

• Showing/providing video clips of how to do the exercises would assist with remembering them
• General advice on becoming more active
  ○ Going to the gym, swimming
  ○ Combination of physical and mental stimulation
• Offer support to family
• More frequent physiotherapy and reviews
• Being able to start rehabilitation at a later date if the patient has turned it down when first offered
• Referral to exercise programme at local leisure centres
• Setting goals for personal and physical improvement
• Discussion about the frustration caused by a reduction in mobility
• Communication problems
• Importance of finding out about the person and tailoring help to their needs (i.e. practical help)
• Evaluation of whether the patient needs stair lift/additional household support
• Timely access to household adaptations
• Patients need regular assessment of their independence (whether they can shop/cook/clean etc.)
• Review is an opportunity to look at what care package is in place
• Providing access to domiciliary care/ review if it is needed
• Reviewing current domiciliary provision/access
• Striking the right balance between keeping independence versus accepting help
• Access to assistive technologies/computers

Emotional
• Opportunity to discuss feeling of having had a narrow escape last time and that the consequences would be worse if it happened again • Opportunity to address fears about becoming helpless if patients were to lose lucidity or become comatose • Review to be fixed at a time when patient is not fatigued. There is currently not enough consideration for a patient‟s body clock (e.g. physical therapy at 2pm may not suit the patient who may thus become labelled as depressed).

- Depression can be a big issue and formal screening of mood should take place at 6 months. Need to increase the amount of information provided. A patient‟s level of depression can fluctuate and options for medicating depression, Cognitive Behavioural Therapy or counselling should be discussed where needed
- Emotional support for family and/or carer of impact of stroke to avoid feelings of isolation/stress/anxiety
- Feeling isolated may be due to:
  - Transport
  - Lack of group support
- Therefore signposting to these services must be available as part of the review.
- Help in controlling emotions – techniques for doing this and adapting
- Greater support in working environment
- Need laughter therapy!
- Buddy/befriending
- Good questions to ask:
  - How have you changed?
  - How have your emotions changed?

Leisure and social

- Advice on how patient can get out and about. This is important for their general well-being and to encourage independence. Social activities are enabling and empowering. Compare leisure activities pre and post stroke and link leisure habits assessment with changes to cognitive/physical skills
  - Assess how patient is getting out and about
  - Assistance with getting out to do the things that patient is interested in
- Ability of transport services (including public) to provide appropriate/timely transport (e.g. opportunities to pre-book to avoid waiting for bus and then unable to board as no room for wheel chair)
- Greater communication between NHS and local authorities
- Advocacy (particular for people with communication disabilities)
- Information on transport services/local options
  - Dial a Ride
  - Church groups may offer transport
- COMCAB/dial a ride: patients get subsidised fares, but needs greater publicity
- Discussion/information about the alternatives to driving/transport provision
- When driving licence has been cancelled due to condition that may improve (such as peripheral vision), patients need to know:
  - When can I drive again?
  - What processes must I go through?
- Using time banking system (where you volunteer time to the community and get the same amount of support in return) to support carers
- Provide information on local resources to look up on hobbies or activities regularly to ensure easier access to people/organisations who provide information and advice
- Discussion about short and longer break holidays
- Peer support – Offering opportunities to link into groups networks of people who have gone through a similar experience. („Stroke clubs are really good.“)
- GPs need to be clear about where extra support in the community is available
- Help/support/assistance may be available from other places (e.g. links with church groups)
- Need regular links between tertiary care, GP centres and community groups to ensure that additional care/support post stroke is in place
- Sheltered housing schemes need additional support/need to be looked into
- Social workers should have more knowledge about stroke and the services available
- Provide local information packs for patients. Need to ensure that every borough has this.

Work
• Review needs to be tailored to the individual stroke survivor i.e. needs to cover impact on job for younger people and possible adaptations for return to work • Need to discuss how the patients work has been affected • Communication with employer about progress • General information about what has happened and the severity • Communication with employer about whether role can be adapted to get patient back to work • Linking OTs with employers • Discussion of vocational rehabilitation needs • Talking about finances - Review needs in relation to benefits • Currently a lack of information about financial support available to patients/carers

Appendix Three: SSNAP minimum dataset

SSNAP requires that data be collected and entered for the following metrics. The following data is also required: the date of the review, the discipline of the person conducting the review and whether the review was done by phone, in person, online or by post.

8.2 Was patient screened for mood, behaviour or cognition since discharge using a validated tool? Yes/no/no but

8.2.2 Was the patient identified as needing support? Yes/no

8.2.3 Has the patient received psychological support for mood, behaviour or cognition since discharge? Yes/no/no but

8.3 Where is the patient living? Home/care home/other

8.4 What is the patient's modified Rankin score?

8.5 Is the patient in persistent, permanent or paroxysmal atrial fibrillation? Yes/no/not known

8.6 Is the patient taking (yes/no/not known)

8.6.1 Antiplatelet

8.6.2 Anticoagulant

8.6.3 Lipid lowering

8.6.4 Antihypertensive

8.7 Since their initial stroke has the patient had (yes/no/not known):

8.7.1 Stroke

8.7.2 Myocardial infarction

8.7.3 Other illness requiring hospitalisation

Appendix Four: Survey of providers

1. What percentage of stroke patients in your area do you offer a review to?
2. Which patients are eligible to be offered a review? Who makes this decision?
3. How are patients identified or referred to have a six month review?
4. What are the reasons that reviews are not completed on eligible patients?
5. Tell me about the review itself:
    a. What form does the review take? (GMSAT, etc.)
    b. How long does it take?
    c. Where does it take place?
    d. What are the benefits to doing this type of review?
    e. What are the challenges / difficulties?
6. Please describe any significant challenges and how these have been overcome since the service started
7. What is the staffing complement for your model?
    a. Who administers the review?
    b. What training does the person providing the review have?
8. How much does your model cost?
9. Please provide a guide to costs in WTE of staff with their relevant banding or pay range
10. How are GPs informed of the outcomes of the reviews?
11. How is the contract monitored by the CCG? What is frequency of reporting required by the CCG?

Appendix Five: Survey of patients

1. How were you notified about the review?
2. What happened during your six month review?
3. Were you clear about the purpose of the review and what the outcomes might be?
4. Thinking about the review:
    a. What did you find valuable?
    b. What could have been better?
5. What happened to the information collected from you, after the review?
6. Was your GP involved in or informed about the review?