

**2012/13 NHS STANDARD CONTRACT  
FOR ACUTE, AMBULANCE, COMMUNITY AND MENTAL HEALTH  
AND LEARNING DISABILITY SERVICES  
(MULTILATERAL)**

**SECTION B**

**THE SERVICES – STROKE EARLY  
SUPPORTED DISCHARGE  
SPECIFICATION 2012/13**

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**SECTION B PART 1 - SERVICE SPECIFICATIONS**

<b>Service Specification No.</b>	
<b>Service</b>	<b>Early Supported Discharge Service (ESD)</b>
<b>Commissioner Lead</b>	
<b>Provider Lead</b>	
<b>Period</b>	
<b>Date of Review</b>	

**1. Population Needs**

**1.1 National/local context and evidence base**

Stroke is the third largest cause of death in the United Kingdom, and a third of people who have a stroke are left with long term disability, the effects of which can include aphasia, physical disability, loss of cognitive and communication skills, depression and other mental health problems. It affects between 174 and 216 people per 100,000 population in the UK each year (Mant *et al* 2004), and accounts for 11% of all deaths in England and Wales. The risk of recurrent stroke within five years of a first stroke is between 30% and 43% (Mant *et al* 2004).

Approximately a third of those having a stroke will die as a result, if not immediately, within 3 months. Recovery can continue for many years after an individual has had a stroke, so it is important that consideration is given on how to provide a seamless transfer of care and access to services over the long term. The most common transfer, and the most stressful to patients, is that from hospital inpatient care back to their home. *'Early supported discharge teams are effective both in terms of clinical benefit and resource use and yet only 22% of trusts have one. One of the common complaints of patients is that they feel abandoned when they leave hospital. The failure to provide specialist community stroke teams may be contributing to this perception'*, (National Sentinel Stroke Audit for 2006). Communication between services is often poor with inadequate information being delivered too late. Currently around half of stroke survivors receive rehabilitation to meet their needs during the first six months following discharge from hospital. This number falls to around a fifth in the following six months. However there is a need for quality and productivity improvements to be made not just within individual NHS organisations, but also at the interfaces between primary secondary and intermediate health care and social care, and with empowered stroke survivors. At the heart of this is the importance of transforming patient pathways, leading to the integration of services and in some cases, the integration of organisations. Where organisational change takes place, it is not necessarily one organisation taking over another, but creating new services with patients and their needs at the centre.

The National Stroke Strategy, published in 2007 by the Department of Health, pulls together the key evidence and outlines what needs to be done to create effective stroke services in England. The strategy sets a framework of Quality Markers (QM) for raising the quality of stroke prevention, treatment, care and support. QM 10 states that stroke services should *'Enable patients who have been admitted to hospital with a diagnosis of stroke to have early, fully supported specialist stroke care safely transferred and delivered within their normal home environment'*. The Royal College of Physicians Sentinel Audit, 2009, also highlighted the need for community based stroke services. Continuing on from work undertaken as part of the NHS Next Stage Review (NSR) into the Stroke Pathway, the East Midlands Cardiac and Stroke Network are reviewing the service provision which will enable patients to have specialist stroke care within their home environments. This will provide the means for QM10 to be achieved for all areas, and, within the timescales recently announced for the

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Accelerated Stroke Programme.

The chosen approach is to implement Early Supported Discharge (ESD) teams for each trust across the East Midlands. ESD services are provided by teams of nurses, therapists, doctors and social care staff, who, by working collaboratively, and with the patient and families, allow stroke patients to leave hospital earlier, receive intensive rehabilitation at home where appropriate, reduce the risk of re-admission into hospital for stroke related problems, increase independence and quality of life for the patient, and support the carer and family.

The East Midlands Cardiac and Stroke Network have developed a model of care that will incorporate the needs of the region, in-line with national and international guidance. The Accelerated Stroke Programme has set a target date of April 2011 for implementation of the service, at which time 40% of eligible patients (i.e. 16% of the stroke population) having a Barthel score of greater than 9 will have access to ESD services. The following document sets out the specification for the model of care proposed, which ensures that all eligible stroke patients are identified in the acute stroke unit, with rehabilitation being delivered in the individuals place of discharge (e.g. own home, relatives home or residential care) to an agreed therapy plan with goal setting. This service model reflects the continued need for acute rehabilitation and the provision of ongoing stroke rehabilitation for as long as is needed where appropriate.

### 1.2 Evidence Base

- The National Stroke Strategy;
- The Cochrane Review of ESD;
- Royal College of Physicians Clinical Guidelines for Stroke 2008;
- The National Sentinel Stroke Audits;
- The National Service Framework for Older People Standard 5;
- The Accelerated Stroke Programme;
- Revised ESD Consensus Statement prepared by Prof. Marion Walker and Dr Rebecca Fisher of the Collaborative Leadership and Research in Health Care (CLAHRC), for NDL;
- Evaluation tool to assess the implementation and effectiveness of ESD in practice in rural and mixed settings developed by Collaborative Leadership and Research in Health Care (CLAHRC), for NDL;
- The East Midlands Public Health Observatory (EMPHO) previous and future demand modelling;

## 2. Scope

### 2.1 Aims and objectives of service

- Eligible patients will have access to ESD to give the best possible outcomes for the patients and allow local NHS providers and commissioners to use resources effectively within the health economy.
- To ensure a whole system approach that raises standards across the whole stroke pathway by establishing a recommended model and limit point.
- To establish a recommended model for ESD services across the East Midlands to include specialist stroke multidisciplinary teams, who will support stroke patients on discharge from acute care to their place of residence in order to fulfil identified achievable measurable and agreed rehabilitation goals, and offer support and guidance to their carers and families. In most instances this will occur in a time limited framework. The team will signpost, or transfer to relevant NHS, Social Service and voluntary sector services for ongoing support.
- To show a reduction in length of hospital stay, thereby increase the proportion of patients spending at least 90% of their time on a stroke unit.
- To ensure timely discharge of all eligible stroke patients.
- To ensure equity of access to an ESD.
- To reduce hospital re-admission rates.
- To reduce premature admission into long term care.

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- To provide 7 days a week service for eligible stroke patients.
- To ensure that people who have had a stroke achieve maximum independence.
- To include capacity for ongoing patient and carer evaluation of service.
- All transfers of care being managed in a person-centred and timely way.

## **2.2 Service description**

The ESD will:

- Only accept a patient to the service following discussion and agreement that the patient has a confirmed diagnosis of stroke;
- Referrals from acute stroke pathway will be accepted for all patients satisfying the eligibility criteria;
- Be delivered within place of residence;
- Be a 7 days a week service;
- Be time-limited dependent on local stroke service specification;
- Be free of charge to the service user;
- Provide a rapid same-day response where possible;
- Develop a proactive approach with timely case identification;
- Involve specialist assessment, active therapy, treatment, or opportunity for recovery, working to a structured individually tailored goal orientated treatment plan;
- Ensure effective treatment planning and co-ordination with seamless handover;
- Identify a key worker to liaise with the family and carers;
- Work to any agreed clinical governance policies that exist;
- Facilitate timely discharge from hospital through active intervention, and rehabilitation following a hospital stay;
- The ESD will develop a comprehensive multidisciplinary team (MDT) plan in liaison with acute health care providers at the time of discharge from acute care.
- To support partnership working with Local Authority, health and voluntary sector to support delivery of quality mainstream home care, domiciliary care and day care services.
- Ensure seamless transfer between services if a patient needs to move to an alternative provider;
- Information should be given to patients and carers about: the contact information for a named ESD Key Worker; the ESD service and the disease process e.g. what has happened to them, why and what they do beyond the service.

**The service model will be as follows:**

### **Features of the Team**

- Coordinated
- Stroke specialist with appropriately trained and experienced team members
- Multidisciplinary
- Comprise as a minimum and based on consensus data – For 100 patients per year caseload:
  - Occupational Therapy (1.0);
  - Physiotherapy (1.0);
  - Speech And Language Therapy (0.4);
  - Physician (0.1);
  - Nurse (0-1.2);
  - Social worker (0-0.5);
- Will meet weekly as a minimum
- Will set team and/or patient centred uni-professional goals
- Will deliver prevention, minimisation and management of complications
- Continual monitoring, re-assessment and treatment by stroke specialist team, to address continued impairments and limited activity, taking into account the patients psychological, emotional and cognitive needs.
- Commitment of the team for ongoing training and education.

### **Features of the Service**

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- Delivers stroke rehabilitation in the patients' place of residence.
- Delivers time limited interventions, the length of which is influenced by the existence and type of other community based stroke services operating in the area.
- The service will be provided for 7 days a week, promoting independence using intensive rehabilitation techniques when assisting with activities of daily living up to 4 times daily, subject to consensus.
- The team will arrange for a review to be carried out if specialist equipment is ordered during or after their intensive rehabilitation.
- The MDT will undertake personalised comprehensive planning for transfer from ESD. This will include assessment of social situation/support mechanisms, participating in home visits, equipment provision and review, provision of relevant training for informal carers, utilisation of psychological decisions support tools, leisure and occupational needs and referral to other agencies.
- The team will facilitate the involvement and education of informal carers and support staff as to their individual needs. A Carers' Assessment referral may need to be triggered if appropriate.
- The team will facilitate access/referral to specialist services when the need is identified.
- The team will train carers and other support staff to recognise and manage the common causes of illness that often result in avoidable admissions i.e. constipation, urinary tract infection etc.
- Individual teams will have the opportunity to use their own therapy outcome measures as appropriate.

**Ongoing Health Care**

- The team will develop and maintain strong links with secondary and primary care, specifically in relation to follow-up appointments 6 weeks, 6 months and annually after discharge dependent on local service specifications, and the availability of other specialist provider services.
- The service will align and interface with the Intermediate Care Services for physically frail and vulnerable older people.
- The service will develop links to local initiatives relating to long-term conditions.
- The service will develop links with local support groups and third sector providers.
- The service will facilitate, as appropriate, positive lifestyle changes.
- The team will facilitate referrals to the End of Life Care pathway where appropriate.

**Ongoing Social Care**

The team will work in partnership with social care to:

- Undertake regular reviews of social care needs, at least 6 monthly and annually, in line with statutory guidance.
- To investigate and monitor all safeguarding concerns and issues identified to the service.
- To promote self directed support to eligible stroke patients and carers
- To ensure that all carers have access to a formal Carer's Assessment.
- To ensure patients are assessed and have access to a need based home care package
- To support patients with access to residential social and/or nursing care.
- To deliver structured education programmes across the whole stroke pathway.

**Ongoing Voluntary Sector**

The team will work in partnership with the voluntary sector to:

- Support the psychological well being of stroke survivors and carers.
- Support patients and carers in accessing appropriate self help and support groups.
- Provide carer information/education.
- Signpost patients and carers to appropriate local stroke support organisations.

**2.3 Population covered**

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The service is available to all stroke patients across the east midlands who meet the eligibility criteria outlined below.

#### **2.4 Any acceptance and exclusion criteria**

- There will be a direct pathway of referral from the Stroke Units as outlined in the Stroke Strategy.
- Transfer dependency will be that patients can transfer safely from bed to chair i.e. can transfer with one, able carer, or independently if living alone.
- Most patients eligible for ESD will have a Barthel of greater than 9.
- Within 24hrs of identification eligible patients will be referred to the ESD services.
- Rehabilitation goals must be identifiable.
- Referral is from an acute healthcare professional following comprehensive assessment.
- The patient must be medically stable with appropriate medical investigations completed.
- These patients must be able to safely transfer from bed to a chair (subject to Consensus).
- The patient/carers must give consent to ESD referral.
- For patients discharged alone to a private address they must be able to maintain their own safety independently.
- The ESD will inform the acute service and the patient/carers, of the rehabilitation and package of care they will be receiving when entering the service.

#### **Caveats**

- The patient cannot be discharged until necessary care, equipment and transportation are in place. Responsibility for this must be clearly defined locally.
- Unsuitable home environment based on relevant clinical and/or social care assessment.

#### **2.5 Interdependencies with other services**

The service model must align closely with the acute stroke unit from which patients are to be discharged, and with Community Stroke Rehabilitation services where they exist, or to whom they will be discharged to. To enhance this service, interdependency must be taken into account and there should be referral to, and close working with other agencies including:

- All trusts providing stroke services;
- Smoking Cessation Services where relevant;
- Community Services;
- Social Care;
- Voluntary services,
- Independent Sector;
- Orthotics;
- Primary Care;
- Home care service;
- Day care services;
- Community equipment;
- The Mobility Centre;
- Respite care;
- Night sitting service;
- Mental Health services;
- Psychology Services;
- Other rehabilitation services;
- Care Home Services;
- Lifestyle changes;

### **3. Applicable Service Standards**

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### 3.1 Applicable national standards e.g. NICE, Royal College

The following national standards are applicable for the delivery of this service:

- NICE stroke quality standard (June 2010)
- Sentinel/SSNAP Audit Standards
- Accelerated Stroke Indicators
- Stroke Integrated Performance Measures
- National clinical guideline for stroke third edition (July 2008)

### 3.2 Applicable local standards

## 4. Key Service Outcomes

The following outcomes will be delivered by the ESD service:

- Improved patient/carer satisfaction.
- Reduced readmission rates.
- Reduced length of stay in hospital following diagnosis of stroke.
- Improved scores in the relevant sections of the National Sentinel Audit for each individual service provider.
- Patients and/or carers to agree setting of patient centred goals.
- An increase in the proportion of patients spending at least 90% of their time on a stroke unit.
- Improve patient functional outcomes (e.g. Barthel) at discharge from ESD.
- 95% eligible patients with Barthel > 9 accepted into ESD services.
- Reduction in long term use of Social Care.
- Reduction in stroke patient/carer depression.

## 5. Location of Provider Premises

The Provider's Premises are located at:

- Nottingham University Hospitals NHS Trust
- University Hospitals of Leicester NHS Trust
- Derby Hospitals NHS Foundation Trust
- Sherwood Forest Hospitals NHS Foundation Trust
- Chesterfield Royal Hospital NHS Foundation Trust
- Northampton General Hospital NHS Trust
- Kettering General Hospital Foundation Trust
- United Lincolnshire Hospitals NHS Trust

## 6. Individual Service User Placement

**[Insert details including price where appropriate of Individual Service User Placement]**