

**20XX/YY NHS STANDARD CONTRACT FOR
ACUTE, AMBULANCE, COMMUNITY AND MENTAL HEALTH
AND LEARNING DISABILITY SERVICES (MULTILATERAL)**

**SECTION B
THE SERVICES –
COMMUNITY STROKE REHABILITATION
SPECIFICATION 20XX/YY**

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SECTION B PART 1 - SERVICE SPECIFICATIONS

Service specification number	
Service	Community Stroke Rehabilitation
Commissioner Lead	
Provider Lead	
Period	
Date of review	

1. Population Needs

1.1 National and local context

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.

Stroke is defined as a clinical syndrome, of presumed vascular origin, typified by rapidly developing signs of focal or global disturbance of cerebral functions lasting more than 24 hours or leading to death (World Health Organization 1978). 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. It is accepted that 85% of strokes are due to cerebral infarction, 10% due to primary haemorrhage and 5% due to subarachnoid haemorrhage. The risk of recurrent stroke is 26% within 5 years of a first stroke and 39% by 10 years (Mohan et al 2011). – Royal College of Physicians

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 to how to provide a seamless transfer of care and access to services over the long term.

Add local data here – eg

- X people have been diagnosed with Stroke or TIA (Year 20XX/XX)
- X adults will have a repeat Stroke or TIA every year
- The risk of a recurrent Stroke is 30-43% within five years
- X people are living with a moderate or severe disability resulting from a Stroke
- X% of deaths in [area] are the result of Strokes

Stroke survivors' rehabilitation continues after the initial time spent in acute in-hospital rehabilitation. Early Supported Discharge (ESD) services enable a percentage (generally 40%) of Stroke survivors to leave hospital earlier and receive intensive rehabilitation at home. Those for whom ESD is not appropriate should also be able to access rehabilitation services that enable them to develop a greater quality of life and independence following stroke. Stroke survivors for whom it is appropriate should be able to access community stroke rehabilitation services following discharge from a stroke unit, following ESD or on discharge from a community stroke bed or outpatient service.

Community stroke rehabilitation services are defined as services delivered predominantly within the stroke survivor's normal place of residence.

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The type of intervention delivered by a community stroke rehabilitation service is distinct from, and complimentary to, that offered by an ESD Service.

Therapy based rehabilitation services for stroke survivors living at home after stroke increases the likelihood of stroke survivors being independent in the activities of daily living. Home based rehabilitation is more effective than centre-based (eg. Outpatient clinics) for functional benefits in the first six months post discharge from an in-patient setting.

The East Midlands Strategic Clinical Network has supported the implementation of community stroke rehabilitation services for all stroke survivors for whom it is appropriate in the East Midlands.

Community stroke rehabilitation services are provided by teams of therapists with support from nurses, doctors and social care staff, who, by working collaboratively, and with the stroke survivor and carer(s), allow stroke survivors to receive rehabilitation at home. Services increase independence and quality of life for the patient, and support the carer(s) and family.

Community stroke rehabilitation services should work alongside community rehabilitation inpatient and rehabilitation outpatient services that are commissioned for complex and dependent patients to continue to support patients who return home with stroke related rehabilitation goals.

It is recognised that there are multiple possible models for delivery of services.

NHS Outcomes Framework Domains and Indicators

Domain 1	Preventing people from dying prematurely	X
Domain 2	Enhancing quality of life for people with long term conditions	X
Domain 3	Helping people to recover from episodes of ill health or following injury	X
Domain 4	Ensuring people have a positive experience of care	X
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm	X

1.2 Evidence base

- The National Stroke Strategy
- NICE clinical guideline 162 – Long term rehabilitation after Stroke
- Royal College of Physicians Clinical Guidelines for Stroke (fourth edition) 2012
- The National Sentinel Stroke Audits;
- The National Service Framework for Older People Standard 5;
- The Accelerated Stroke Programme;
- The implementation of evidence-based rehabilitation services for stroke survivors living in the community: the results of a Delphi consensus process (2013) - Fisher et al - Clinical Rehabilitation 27(8) 741–749
- NHS Midlands and East Stroke Services Specification
- Health and Wellbeing Board Joint Strategic Needs Assessment
- [NAME] CCG priorities

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2. Scope

Aims and objectives of service

- € To provide timely access for all eligible stroke survivors, to a stroke specialist community rehabilitation service which will deliver the best possible outcomes for the stroke survivor and allow local NHS providers and commissioners to use resources effectively within the health economy
- € To deliver stroke specialist community rehabilitation services predominantly at the stroke survivor's place of residence, in partnership with them, their families and carers in order to maximise rehabilitation potential
- € Support stroke survivors to fulfil identified achievable measurable and agreed rehabilitation goals
- € To provide support to the families and carers of stroke survivors
- € To reduce premature admission into long term care
- € Signpost or transfer to relevant services for example [local examples here - "strokeability", exercise groups, charitable support groups]
- € To provide services 7 days a week
- € To ensure that stroke survivors achieve maximum possible independence – including return to driving, work and leisure activities
- € All transfers of care are managed in a person-centred and timely way

Service description

Community stroke rehabilitation services will:

- € Consist of stroke specific staff with expertise in home-based stroke rehabilitation for those with complex needs, providing rehabilitation in the stroke survivor's place of residence (including care homes), workplaces and locations of leisure activities. The team will have access to specialist equipment (for example in outpatient rehabilitation facilities) when appropriate for the stroke survivor's therapy
- € Promote self-care, health promotion and reducing dependency
- € Be delivered for as long as the stroke survivor has stroke related, identified, agreed and achievable goals
- € Provide assessment within 72 hours with therapies beginning within 7 days of referral
- € Involve specialist assessment and provide treatment based on achieving an individually tailored goals
- € Work to agreed clinical governance and risk management policies
- € Develop a comprehensive multidisciplinary team (MDT) plan in liaison with up and downstream services to ensure seamless transition of patients between them
- € Support partnership working with Local Authority, health and voluntary sector to promote a rehabilitation approach to stroke care by all agencies involved
- € Ensure seamless transfer between services if a stroke survivor needs to move to an alternative provider
- € Provide information to stroke survivors and carers at the point of need including a named contact and telephone number for the service provider
- € Provide training as required to paid and unpaid carers including those in care homes. Training should include communication and the facilitation of mobility and personal care assistance
- € Support the locality stroke strategy group

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- € Assess and treat stroke survivors admitted to intermediate care beds (step-down from hospital) where appropriate
- € Support data entry to the Sentinel Stroke National Audit Programme Dataset for ESD and Community Rehab teams

A clinical group is established with overall responsibility for the organisation and standards of services. This group will monitor service delivery and report performance to Key Performance Indicators.

A 5% variation on monthly performance against minimum criteria will trigger escalation to the commissioner through the contract and performance routes. An action plan will be submitted within 7 days advising how and when the minimum criteria will be achieved and sustained.

Failure to provide this information or implement any plan without reasonable justification could result in a review of the associated service contract.

The service model will be as follows:

Features of the Team

- € Defined team leadership
- € Stroke specialist – skills and competencies acquired through stroke specific training and who predominantly treat and manage stroke survivors
- € Multidisciplinary
- € The core community stroke rehabilitation team should include representation from the following disciplines, who have stroke specialist skills
 - € Occupational Therapy
 - € Physiotherapy
 - € Speech And Language Therapy
 - € Nursing
 - € Social work
 - € Clinical psychologist / mental health support
 - € Rehabilitation assistants
 - € Administration
- € The team has access to services for
 - € Mobility and movement e.g. – Gait lab, Functional Electrical Stimulation, Hydrotherapy, Wheelchair services
 - € Emotional and Psychological issues e.g. – Sex Advisors, Family counsellors
 - € Driving assessment centres
 - € Swallowing e.g. – specialist nutrition team
- € The team has access to and support from with the ability to refer to
 - € Interpretation services

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- € Clinical Psychology
- € Access to facilities with specialist equipment to aid rehabilitation – for example, rehabilitation gym equipment in an outpatient setting
- € Dieticians
- € Orthotics
- € Orthoptics
- € Vocational rehabilitation
- € Hearing services
- € Mental Health services
- € Spasticity management
- € Pharmacy
- € Stroke Association / Different Strokes / other voluntary organisations locally
- € Consultant Stroke physician
- € Community respiratory therapists
- € Community geriatrician
- € Podiatrists

Features of the Service

- € Provided to all stroke survivors over the age of 18 (16 – 18 year old patients should be permitted to choose to access adult services)
- € There should be an MDT approach with Acute and ESD services to plan onward referral from these services to community stroke rehabilitation
- € Provision of consistency of staff attending stroke survivors – stroke survivors to see the same and as few staff as possible whilst maintaining frequency of therapies
- € Available to stroke survivors registered to GPs in [area] who are able to receive community stroke rehabilitation to achieve stroke related, agreed goals within their place of residence. Referral routes should include but not be limited to
 - € Discharge from an acute stroke service
 - € Discharge from an Early Supported Discharge service
 - € Discharge from an Outpatient service
 - € Referral back in following 6/12 month review
 - € Self-referral
 - € GPsA definitive diagnosis of Stroke is required.
- € Available to accept and assess patients 7 days a week, 52 weeks of the year
- € Therapies should be available 5 days a week
- € Patients will be assessed for capacity and compliance with therapy
- € Intensity and duration of the intervention should be established between the stroke specialist and the stroke survivor and be based on clinical need tailored to goals and outcomes
- € The intensity and duration of each therapy session should be based on clinical need tailored to goals and outcomes
- € Stroke survivors will have a single point of contact
- € Initial assessment and on-going review of the stroke survivor is carried out by an appropriate stroke specialist trained team member within 72 hours of referral
- € Therapies will begin within 7 days of referral

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- € A weekly MDT will review goals of stroke survivors
- € Specific, Measurable, Realistic, Achievable and Timely personalised goals will be agreed with the stroke survivor if possible (and carer where appropriate) which are reviewed (every 4 – 6 weeks)
- € Stroke survivors will be encouraged and supported to self-manage through practice between rehabilitation sessions including exercise and functional tasks
- € Access to and liaison with other services to plan the on-going psychological, mental health and social care needs of the stroke survivor
- € Work in partnership with social care to provide the support required to enable the stroke survivor to be cared for in the most appropriate setting for the individual
- € Active therapy at a level appropriate for achieving agreed rehabilitation goals for as long as the stroke survivor is continuing to benefit from the therapy, is progressing towards their SMART goals and is able to tolerate it
- € Review of home environment (unless onward referral from ESD team who have already completed this) by an occupational therapist (or suitably trained team member) to adapt to stroke survivors needs where the stroke survivor remains dependent in some activities (RCP 2012 3.8.1 D)
- € A carer's assessment should be offered for each carer with links to carer and family support organisations made. Carer burden scale or similar assessment should be completed.
- € There will be a clear pathway for provision of information and support to all stroke survivors and their carers following transfer from hospital. This will ensure
 - € Continuity of contact across the pathway to facilitate seamless transfer of care between services
 - € Staff providing information and support liaise with social services to monitor the implementation of any agreed care plans
 - € The content of information provided to stroke survivors and carers should be in a format that is accessible and specific to the phase of recovery and appropriate to their needs at the time
 - € Information is delivered in an interactive rather than a passive manner providing the opportunity for stroke survivors and carers to ask questions and be empowered to problem solve
- € Stroke survivors are made aware of available options to promote wellbeing, including peer-led support groups, community activities and professional psychological therapies including IAPT and community mental health services
- € Telephone counselling support available for 3 months (RCP 2012 – 3.8.1 C) for patients who can access this form of communication. Other services should be available and signposted for patients at discharge who are unable to access telephone counselling.
- € Specialist stroke rehabilitation, support and any appropriate management plans will address the following issues either directly or by seamless onward referral where required: (RCP 2012 – 6.4 to 6.46)
- € Specialist assessments for
 - Medication management
 - Equipment and environmental controls
 - Technology use
 - Lifestyle advice / secondary prevention
- € Mobility and movement (including exercise programmes, gait retraining, mobility aids, orthotics and splinting)
- € Environmental controls
- € Upper limb rehabilitation

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- € Management of spasticity and tone including include access to splinting, orthotics and medical interventions such as botox
- € Sensory impairment screening and sensory discrimination training
- € Falls prevention (including assessment of bone health, progressive balance training and aids)
- € Cognitive rehabilitation (including addressing impairment in attention, memory, spatial awareness, perception, praxis and executive function)
- € Communication – e.g. provision of impairment based / functional programmes to support communication, including assessment / provision of low / high tech AAC support as identified, home based computer therapies
- € Everyday activities including provision of daily living aids and equipment (eg dressing, washing, meal preparation)
- € Emotional and psychosocial issues (eg depression, adjustment difficulties, changes in self-esteem or efficacy, emotionalism)
- € Swallowing (including swallowing rehab, maintenance of oral and dental hygiene)
- € Skin integrity (ie pressure care and positioning)
- € Nutrition (including specialist nutritional assessment, nutritional support)
- € Visual disturbance
- € Continence (bladder and bowel)
- € Social interaction, relationships and sexual functioning (including psychosocial management or medications)
- € Pain (assessed regularly using validated score, referred to specialist where indicated)
- € Return to work (including referral to specialist in employment of vocational rehabilitation) and education
- € Driving
- € Financial Management and accessing benefits
- € Discharge will be by MDT based on agreed local protocol with confirmation of discharge sent to the patients GP within 24 hours

Ongoing Health Care

- € The team will develop and maintain strong links with secondary and primary care in relation to follow-up appointments 6 weeks, 6 months and annually after discharge
- € Transfer of stroke survivors from community stroke rehabilitation services to non-stroke specialist care should be based solely on the stroke survivor's needs, through assessment by the community stroke rehabilitation team
- € Timely transfer from a community stroke rehabilitation service should be planned and be based on on-going goals. Transfer to other services for long term support should be facilitated
- € 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 and secondary prevention
- € The team will facilitate referrals to the End of Life Care pathway where appropriate
- € The team will work in partnership with the East Midlands Strategic Clinical Network as appropriate and will provide data / information as agreed to support open and transparent reporting of service structure, process measures and patient outcomes published in regional report cards. The team will input timely and accurate data to SSNAP and maintain local databases as required to facilitate operational management of the service.

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Ongoing Social Care

The team will work in partnership with local authorities and social care teams to:

- € Investigate and monitor all safeguarding concerns and issues identified to the service
- € Signpost social care services to eligible stroke patients and carers
- € Ensure that all carers understand how to access to a formal Carer's Assessment

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 stroke survivors and carers in accessing appropriate self help and support groups
- € Provide carer information/education
- € Signpost stroke survivors and carers to appropriate local stroke support organisations.

The service is available to all stroke survivors across the [locality] who meet the eligibility criteria outlined below.

2.3 Acceptance and exclusion criteria

- € Stroke survivors will have a definitive diagnosis of Stroke – local discussions will be required to determine how patients with functional stroke are managed
- € The service is available to all stroke survivors who are discharged to their normal place of residence – providing rehabilitation can be delivered safely
- € The residential environment must be considered safe and appropriate for delivery of therapies designed to meet agreed patient goals
- € Stroke survivors who have had a stroke whilst out of their locality should have access to community stroke rehabilitation services for assessment and treatment on returning home
- € There will be a direct pathway of referral from the Stroke Units as outlined in the Stroke Strategy and from ESD and Outpatient services as well as from all other possible referral sources (as above)
- € Rehabilitation goals must be identifiable
- € The stroke survivor must be medically stable
- € Services must be able to maintain open access for reassessment of previously discharged stroke survivors with Stroke related identifiable needs and new goals. This availability must be made clear to all stroke survivors on discharge.

Caveats

- € Rehabilitation should not be provided in unsuitable home environments as identified by relevant clinical and/or social care risk assessment

€ Interdependencies with other services

The service model must align closely with stroke units and Early Supported Discharge teams from

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which patients are to be discharged. 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
- € Wheelchair services
- € Respite care
- € Night sitting service
- € Mental Health services
- € Psychology Services
- € Other rehabilitation services
- € Care Home Services
- € Transport services (to enable access to clinics, groups etc)
- € Department for Work and Pensions
- € Driving assessment centres
- € Occupational / Vocational health services

It is recommended that access routes to these services are documented along with contact details

3. Applicable service standards

3.1 Applicable national standards

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

- € NICE clinical guideline 162 – Long term rehabilitation after Stroke
- € Sentinel/SSNAP Audit Standards
- € Accelerated Stroke Indicators
- € Stroke Integrated Performance Measures
- € National clinical guideline for stroke fourth edition 2012

3.2 Applicable local standards

The following local standards are applicable for the delivery of this service

- € NHS Midlands and East stroke services specification
- € Service specific outcomes / recommendations of the EMCVN review of ESD services

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4. Key Service Outcomes

The following outcomes will be delivered by the community stroke rehabilitation service:

- € Access to specialist stroke care in the community
- € No wait transfer into service (from either Acute care or referral on from ESD)
- € Facilitate goal planning and self-management with return to function where appropriate
- € Prevent avoidable disability
- € Maximise ability to remain in home environment
- € An increase against N125 Indicator: Achieving independence for Older People through Rehab / Intermediate Care
- € Reduce the burden of care for families and carers
- € Maximise independence in activities of daily living
- € To provide secondary prevention lifestyle management advice and to support stroke survivors to achieve and maintain the change

5. Location of Provider Premises

The providers premises are located at:

6. Individual Service User Placement

Insert details including price where appropriate of individual service user placement.