South East Coast Strategic Clinical Networks

South East Coast

Strategic Clinical networks

Stroke 6 Month Reviews

Commissioning Information Pack

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1. Introduction

1. Introduction

The South East Coast Cardiovascular Strategic Clinical Network (SEC CVD SCN) is committed to working with stakeholders to gain feedback and develop our work programmes in order to ensure we can help our member organisations deliver the best possible care and patient outcomes.

Following participation in a national survey, significant variation was identified in terms of equity of access to stroke six month review services across the SEC.

Following further consideration by both the CVD SCN Cardiovascular Steering Group and the CVD SCN Stroke Clinical Advisory Group, equitable access to six month reviews for stroke survivors was identified as a priority area for our own health services and populations, and a task and finish group was set up in November 2013.

The aim of the task and finish group was to support the introduction of six month reviews for all stroke survivors in the South East Coast.

The task and finish group comprised of patients, carers, clinical commissioning group members and third sector organisations, as well as a wide range of healthcare professions from acute and community trusts, private, and social enterprise providers - all of whom were directly involved in developing and shaping the included Commissioning Advice and Service Specification Template documents. We would like to express our sincere thanks to the group for their input, passion and advice on this important subject.

In addition, we would also like to thank the East Midlands Strategic Clinical Network and Academic Health Sciences Network joint initiative, for giving us permission to adapt elements of their Stroke 6 Month Review Information Pack in the development of these documents.

We hope this information pack will be of use to you, and will ultimately help in the commissioning of six month review services for patients in your area.

Best wishes,

Dr David Hargroves
SEC CVD SCN Clinical Lead for Stroke

2. Commissioning advice

2. Commissioning Advice

The CCG Outcomes Indicator Set for 2014/15 sets out a requirement for all stroke survivors to receive a follow up assessment between 4 and 8 months after initial admission to hospital following a stroke.

This guidance is intended to be used in conjunction with the generic Six Month Review Service Specification by commissioners to aid in their decision making and tendering discussions with providers to ensure a quality service for all stroke survivors and their carers.

1. The Case for Change

Background

The National Audit Office's report ''Progress in Improving Stroke Care" (2010) contrasted the great improvements in acute stroke care with the poor quality of life after stroke. This report made particular reference to review processes:

"We found variations in approaches to these reviews and a lack of clarity about who should lead them, their objectives, where they are recorded, the role of the patients' GPs in the reviews and how they are implemented."

The CQC review of stroke services (2011) found that most Primary Care Trusts had systems in place for reviews at six weeks, but that systems for reviews later in the pathway were not well developed. They noted that even where such systems are in place, it was not always clear who was responsible for ensuring that reviews took place.

Benefits and Outcomes associated with carrying out Reviews

There is not yet a strong evidence base regarding the benefits of stroke reviews. However, anecdotal evidence from areas where reviews are being delivered suggests that benefits might include:

- Reduced GP and stroke consultant appointments
- Avoidance of hospital admission (avoiding escalation of problems)
- Identification of secondary prevention needs (e.g. undiagnosed atrial fibrillation, hypertension, medications management) and the modification of risk factors Improved quality of life
- Potential to improve access to voluntary sector support services (by highlighting areas where voluntary services can meet needs)
- Continuity of care and reassurance
- Increased understanding about stroke and/or TIA, improved ability to cope and self-manage, increased independence
- Identification of mood and relationship issues that otherwise might be missed or not mentioned
- Identification of carer needs
- Reduced duplication between services and Improved joint working across agencies
- Opportunities for improved data collection processes, audit, improving performance monitoring and inform service development needs

From the 2009 Stroke Rehabilitation Guide: Supporting London Stroke Commissioners to Commission Quality Services in 2010/11" and work by the SEC Cardiovascular Strategic Clinical Network Support Team.

Current Position

It is evident that the provision of 6MR across SEC is variable and not in place in all areas (no services in 12 of the 20 Clinical Commissioning Groups). Where CCGs have policies in place about carrying out reviews these tend to reflect good practice.

Monitoring Progress

The Sentinel Stroke National Audit Programme SSNAP data completion will be a key enabler in ensuring Commissioners know how many eligible patients are receiving reviews and that reviews are driving improvements in outcomes. However there is inconsistency across providers in terms of registration and completion of data in SSNAP. SSNAP collects data on the whole care pathway from initial arrival at hospital, through any inpatient settings where stroke care continues, to ESD and community rehab (if provided) and up to a six month follow-up appointment. Commissioners should encourage the post-acute providers to register the post-acute teams on SSNAP and enter data.

2. What is a six month review?

The South East Integrated Stroke Service Specification states that all stroke survivors should receive a review at 6 weeks, 6 months and 12 months and then annually that facilitates a clear pathway back to further specialist review, risk factor screening, advice, information, support and rehabilitation where required is provided.

The National Stroke Strategy describes a good assessment process for someone who has just had a stroke as involving a multidisciplinary person-centred assessment of the individual's needs and signposting to other services, e.g. housing or transport.

The same document further reminds us that it will be important to bear in mind that those who have had a stroke may have additional communication or cognitive support needs to be able to participate in the assessment. People for whom English is not their first language and those with literacy difficulties may also have different requirements and services need to be flexible enough to meet their needs.

A number of nationally recognised, standardised tools are available that ensure patients receive a suitably in-depth review. They are designed to cover the breadth of potential on-going or new needs the stroke survivor might have, including:

Medicine management	Exercise	Daily activities	Sleep pattern
Medicine compliance	Vision	Mobility	Diabetes
Blood pressure	Hearing	Falls	Driving
Anti-thrombotic therapy	Communication	Mood	Transport and travel
Weight Management	Swallowing	Anxiety	Activities & hobbies
Memory & Concentration	Nutrition	Emotionalism	Work
Alcohol	Cholesterol	Personality changes	Money and Benefits

Smoking	Pain	Sexual Health	House and home
Healthy eating	Continence	Fatigue	Carer needs

It is therefore recommended any new six month review services being established should be commissioned on the basis that the nationally recognised Greater Manchester Stroke Assessment Tool (GM-SAT) is used, to ensure a quality review. Where existing services are currently using other tools, we would recommend either adoption of the GM-SAT, or that a comparison against the GM-SAT tool is undertaken to demonstrate equitable coverage of the same areas, as a minimum standard.

3. Possible models for delivery

In considering what model to select for delivery of six month reviews, consideration should be given to how the provision of six month reviews will sit within the overall stroke pathway for local patients. Commissioners and providers should seek absolute clarity around the following factors:

a. How will patients be identified and referred to the six month review service provider?
Not all Stroke survivors are treated in an acute hospital setting. Of those who are, some may experience their stroke whilst away from home and be treated in an acute hospital outside the area that the CCG is responsible for.

Some stroke survivors are discharged home from acute care with no apparent immediate need for therapies. Some go to an Early Supported Discharge (ESD) service. Of those who access ESD some are discharged and others move on to a Community Stroke Rehabilitation service. Some patients go straight to Community Stroke Rehabilitation. These are by no means the only routes a stroke survivor may take through services available to them.

- In the first instance, the discharging organisation will ultimately be responsible for immediately sending the patient discharge 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.
- People who have received treatment for stroke out of area are also eligible for this service in their own area. In these cases:
    - The discharging organisation will be expected to notify the provider of the six month review service of these patients when they return to their normal residence in [area].
    - As a secondary measure, the patient's GP will also be expected to notify the provider of the six month review service of these patients when they return to their normal residence in [area]
- Procedures should also be established by the six month review service provider to accept eligible patients normally resident in [area] wishing to directly self-refer.

b. Information / data sharing
Commissioners and providers of stroke services will need to agree arrangements for patient information to be shared to facilitate a seamless pathway of care. Considerations are:

i. The provider of the six month review service will require discharge information from the last service to support the patient – whether that is acute, ESD or community rehabilitation
    - A structured discharge document with agreed minimum dataset should be used

ii. The provider of the six month review service will require information captured at the patient's six week review
iii. Informing the GP of the patient's review date also would enable the GP to contact the patient to provide an up to date medications list and check blood pressure, pulse and cholesterol levels
iv. Providers of six month review services will also be registered to the Stroke Sentinel Audit Programme (SSNAP) web tool and ensure processes are in place to confirm all reviews undertaken are entered into the database.

c. Who might deliver the six month review service?
In deciding who to award a contract to, commissioners should consider how the six month review service will be delivered for the patient

i. Location of review – there must be sufficient flexibility within the service to enable review meetings to take place at a location suitable to, and driven by, the patients' needs. In costing a service commissioners and providers should seek to model the number of each of the following they will need to plan for:
    - **Patients' home or usual place of residence (e.g. care home)** – enables the person conducting the review to observe how well the patient is coping in their home environment. They may be able to suggest aids the patient had previously not considered or felt necessary (e.g. grab rails, ramps).
    - **Clinic or other appropriate setting** – following consideration, it may not be deemed safe or appropriate for the reviewer to visit the patient's home, or other locations may be more convenient to the patient. Other suitable locations should therefore be considered, as per the wishes of the patient.
    - Whilst face to face reviews should always be offered as the preferred method of review, as the location of the review will be driven by patient need, the secondary option of a telephone review may also be offered if there is a clear preference on the part of the patient e.g. if the patient has recovered and has returned to work they may not want to take time off for the provider of the six month review service to visit them at home.

d. Extent of the six month review service
In deciding what model of six month review service to select, commissioners should consider the extent of the proposed service provision. Questions to assist are:

i. Do you want the six month review service provider to complete the review and make referrals only? Under these circumstances the commissioner may wish to monitor the volume and quality of referrals to each of the other services involved. For example, how many patients referred back into a Physiotherapy service have further rehabilitation potential? The cost of each onward referral should be factored into decisions.
ii. Do you want the provider of the six month review service to provide advice to patients? In what areas is the service provider qualified to offer advice? For example, health and wellbeing, stroke prevention, exercise, emotional support. Consider whether longer appointments with more highly qualified reviewers who can manage some of the patient's needs during the review provides a better patient experience and is more cost effective.
iii. Do you want the provider of the six month review service to be capable of resolving any of the identified unmet needs? In what areas is the service provider qualified to resolve unmet needs? Six month reviews are sometimes delivered by Stroke Specialist Community Rehabilitation Teams. They can be well placed to assess the patient's potential for further therapy and refer them back into the service. They can also assess when a patient does not have potential therefore possibly avoiding a referral that less qualified reviewers might make. However, the review process itself

should not be regarded as a treatment session. It is also recognised that no single individual would be able to provide expert advice for every eventuality, therefore having the skills to refer appropriately is of critical importance, whether the reviewer is clinical or not.

e. Training and capability

Whilst commissioners are unlikely to specify the precise nature of staff training they should seek to be reassured that staff undertaking reviews are:

i. appropriately trained based on the clinical needs of the patient
ii. appropriately trained in the required communication skills – including supporting patients with aphasia and other communication difficulties
iii. appropriately trained to recognise emotional and psychological need in addition to understanding the patient's physical needs and longer term consequences of stroke
iv. supported by a multi-disciplinary stroke specialist team
v. capable of identifying unmet needs and the services the patient will need to be referred to
vi. capable of identifying new needs and the services the patient will need to be referred to
vii. capability and access to referral processes to all services the patient will need to access

The provider of the six month review service should also be set up to support people for whom English is not their first language and those with literacy difficulties may also have different requirements.

An editable version of this document is available in Appendix A

3. Service Specification Template

3. Service Specification Template

Care pathway / Service	
Commissioner Lead	
Provider Lead	
Period	

1. Purpose

Stroke is a long term condition and survivors will experience changes in their needs over time. Six month reviews for stroke survivors help to identify any unmet needs at this point and signpost stroke survivors to any appropriate, targeted support that is available to meet their needs.

Support in the form of a six month review is required to ensure appropriate, tailored support is provided to assist re-integration into the community and maximise the quality of life experienced by stroke survivors, their carer/s and families.

The South East Coast Integrated Stroke Service Specification highlighted the need to improve long term care through the implementation of 6 month reviews for stroke survivors. This specification directly outlines how 6-month reviews are to be delivered as part of the overall stroke pathway.

Six month reviews will provide a link from hospital to home and will facilitate work with local services to provide the necessary rehabilitation and recovery support to improve patient outcomes in secondary prevention and signpost patients and carers to services relevant to their needs. The provision of six month reviews will help reduce pressure on individuals and their families and prevent unnecessary readmissions to hospitals and care homes.

1.1 Aims

To offer 100% of patients notified to the provider of the six month review service a six month review.

1.2 Evidence Base

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

Key Drivers	Descriptor/Standard
National Service Framework for Older People (2001) (5.27)	Recovery from stroke can continue over a long time, and rehabilitation should continue until it is clear that maximum recovery has been achieved. Some patients will need on-going support, possibly for many years. These people and their carers should have access to a stroke care coordinator who can provide advice, arrange reassessment when needs or circumstances change, coordinate long term support or arrange for specialist care. Following a stroke, any patient reporting a significant disability at six months should be re-assessed and offered further targeted rehabilitation, if this can help them to recover further function.
National Stroke Strategy QM14 (2007)	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. This is followed by an annual health and social care check, which facilitates a clear pathway back to further specialist review, advice, information, support and rehabilitation where required
Care Quality Commission review on stroke care (2011)	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	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
NICE (CG162) Stroke rehabilitation guideline: Long term rehabilitation after stroke (2013)	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	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

Established in 2010, the Accelerating Stroke Improvement (ASI) programme was a national initiative designed to ensure that maximum implementation of the Quality Markers in the National Stroke Strategy (2007) was achieved. Although the programme has now closed, the three major domains of emphasis for this programme of work were:

- Joining Up Prevention
- Implementing Best Practice in Acute Care
- Improving Post Hospital and Long Term Care

The programme was guided by a set of nine national metrics, which included:

Metric 8: Proportion of stroke patients that are reviewed six months after leaving hospital (target: 95% by April 2011)

1.3 Aims and Objectives

In line with the Clinical Commissioning Guidance Outcomes Indicator Set: To offer 100% of stroke survivors an opportunity for a review 4-8 months after initial admission to hospital following a stroke to discuss their recovery and rehabilitation progress and offer further opportunities for functional improvement and wider support.

1.4 Outcomes

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

Locally defined outcomes:-

Stroke survivor outcomes

- Greater involvement in identifying and planning to address their on-going needs
- Access to a wide range of information about NHS, voluntary, community and social services that will contribute to achieving stroke related goals
- Feeling supported and more confident
- Will be less likely to be readmitted to hospital

- Will be less likely to have another stroke
- Improved health & general well being
- Reduced GP appointments
- Reduced dependency

Carers outcomes

- Support carers improved health & general well being
- Reduced GP appointments
- Carers have back up plans in place

Community outcomes

- Reduced readmissions
- Reduced dependency on social services
- Improved health & wellbeing

To support these aims and objectives the provider of six month reviews should:

- Provide a high quality, evidence-based service that is responsive to patient, carer and family needs using a nationally recognised and standardised tool to document the review.
- Adhere to all national, regional and local requirements, standards and protocols that are relevant to long term care for stroke survivors.
- Provide adequate capacity to ensure all required timeframes are met and that the pathway operates effectively, as per agreed protocols.
- Support open qualitative and quantitative service feedback that enables all providers and the commissioner to have a shared understanding of how the entire stroke pathway is performing.
- Work collaboratively with other stakeholders involved in the stroke pathway; particularly
    - Appropriate secondary care services/specialities
    - All Trusts delivering stroke services
    - Local providers of rehabilitation services
    - Voluntary services
    - Nursing and residential home providers
    - General practice
    - Primary care providers
    - Clinical networks
    - Social care services and domiciliary care providers as appropriate
- Work with commissioners to further develop high quality local services
- Operate in a way that represents best value and in line with contractual expectations
- Ensure there are clear audit trails to monitor and track performance and outcomes for patients and carers and report on metrics.

2. Scope

2.1 Service description

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

The review will take place at a location appropriate to the patient and carer needs, taking account of example of mobility needs, transport options and aphasia [the Commissioner and provider may

wish to agree a statement clarifying the possible locations and whether there is a default location unless patient need requires an alternative].

The six month review service provider will:

- Offer a review of each stroke survivor's health and social wellbeing between 4-8 months after admission to hospital following stroke to encompass the following:
    - Medicines/general health needs
    - Mood, memory, cognitive & psychological status
    - On-going therapy & rehabilitation needs
    - Social care needs, carer's needs, benefits & finance, driving & transport
- Ensure reviews result in signposting stroke survivors and their carers to services that would benefit them in Stroke specialist rehabilitation, community service such as peer support, group opportunities, befriending, and voluntary sector opportunities
- Identify carer needs.

Training and Competence
The provider of the six month review service should be able to provide evidence of a skilled and competent workforce. Reviews will be carried out by the most appropriately trained member of the service based on patient clinical need.

The provider of the six month review service will have access to a Stroke Multi-disciplinary team covering acute and post-acute Stroke services to provide support and advice as required.

2.2 Accessibility / acceptability

Six month reviews will be offered to 100% of people registered with a GP in [AREA] who have been diagnosed as having had a stroke by a secondary care physician and identified to the provider of the six month review service.

Reviews will occur between 4-8 months after admission following a stroke.

Reviews will be primarily offered during office hours (SPECIFY) with some provision available during evenings and at weekends to accommodate patient and carer availability.
[the commissioner and provider may wish to specify the nature of the appointment system here].

2.3 Whole System Accessibility / acceptability

The provision of a six month review service is an integral part of developing the wider stroke pathway.

2.4 Interdependencies

Efficient running of the six month review service will require that good relationships are established and maintained between secondary care, primary care, respective internal departments, the GP and other referrers to ensure that referrals are sent appropriately and in a timely fashion.

3. Service delivery

3.1 Service delivery

a) The six month review service is for all adults 18 and over, living in [area], who are registered with a [area] GP and who have had a diagnosis of stroke.

b) The six month review service provider will use the Greater Manchester Stroke Assessment Tool (GM-SAT) which is an evidence based tool to identify individuals' unmet needs, post stroke, from across health, social and emotional care domains.
c) Any unmet needs which are identified will be addressed by providing advice, additional support, referral or signposting to appropriate services.
d) A review which includes only stroke secondary prevention would not be considered to be acceptable.
e) A document summarising the outcome of the six month review and a referral plan should be produced as a result of the review, copies of which should be held by the patient so that all other health care professionals can access it with the patient's permission. Patients / carers should also be provided with contact details of who to contact for more information.

3.2 Accessibility

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

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

Access to an interpreting service must be available for patients with language needs, including British Sign Language.

4. Referral, Access and Acceptance Criteria

4.1 Geographic coverage/boundaries

All patients registered with [area] GPs will be able to access the six month review service.

4.2 Pathway

[The commissioner and provider may wish to include a graphical representation of the pathway as an appendix to this document]

4.3 Referral criteria & sources

All patients registered with [AREA] GPs discharged from hospital following a stroke.

4.4 Referral routes

- In the first instance, the discharging organisation will ultimately be responsible for immediately sending the patient discharge notification to the provider of the six month review service to confirm discharge date, ensure all eligible patients are referred, and enable the review provider to effectively plan when to contact the patient.
    - A structured discharge document with agreed minimum dataset should be used
- People who have received treatment for stroke out of area are also eligible for this service in their own area.
    - The discharging organisation will be expected to notify the provider of the six month review service of these patients when they return to their normal residence in [area].
    - As a secondary measure, the patients GP will also be expected to notify the provider of the six month review service of these patients when they return to their normal residence in [area]
- Procedures should also be established by the six month review service provider to accept eligible patients normally resident in [area] wishing to directly self-refer.

4.5 Exclusion criteria

[Include any local exclusions]

5. Discharge criteria and planning

Where patients require follow-up appointments, signposting or referral to other services or referral to outpatient clinics, this should be coordinated by the provider of the six month review service.

The key outcomes of the review will be provided to the patient in writing and, with their permission, shared with their GP and acute trust Multi-Disciplinary Team. The GP and acute trust Multi-Disciplinary Team will be informed of the review in every case.

Communication of outcomes will be shared with the GP and acute trust Multi-Disciplinary Team within 1 week of the appointment and where possible, this will be done electronically.

6. Continual Service Improvement / Innovation Plan

The commissioners expect that providers will work collaboratively with relevant partners to develop and implement any continual improvement plans required.
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.

6.1 Reports

Reports and data will be provided as mutually agreed between the providers and the commissioner. At a minimum the performance information listed in section 7 of this document must be provided.

7. Performance Targets – Quality, Performance & Productivity

In addition to the clinical data captured by the GM-SAT, it is expected that the six month review service provider will capture and monitor to patient level:

- Types of unmet needs identified
- Volume of unmet needs identified – captured by type
- Volume of referrals – captured by service
- Volume of signposted / recommended services – captured by service
- Age profile of patients seen

Where national standards or targets exist, they must be met.

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)	Quarterly	Service Name

	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.		
Improve patient experience	Local wording to be agreed between the Commissioner and provider	Quarterly	Service Name
Informed patients	100% of people receive a written copy of the outcomes of their 6-month review	Quarterly	Service Name
	Proportion of people undergoing 6-month review who received written information on advice, guidance and signposting to relevant services and support available, tailored to their individual needs – if clinically appropriate	Quarterly	Service Name
Complaints	Local wording to be agreed between the Commissioner and	Quarterly	Service Name

	provider		
Agreed patient goals sent to patient/carer within 1 week of the review (where possible, information is sent to the GP and acute trust Multi-Disciplinary Team electronically)	100% of review outcomes are sent to the patient and/or carer, GP and acute trust Multi-Disciplinary Team within 1 week of review	Quarterly	Service Name

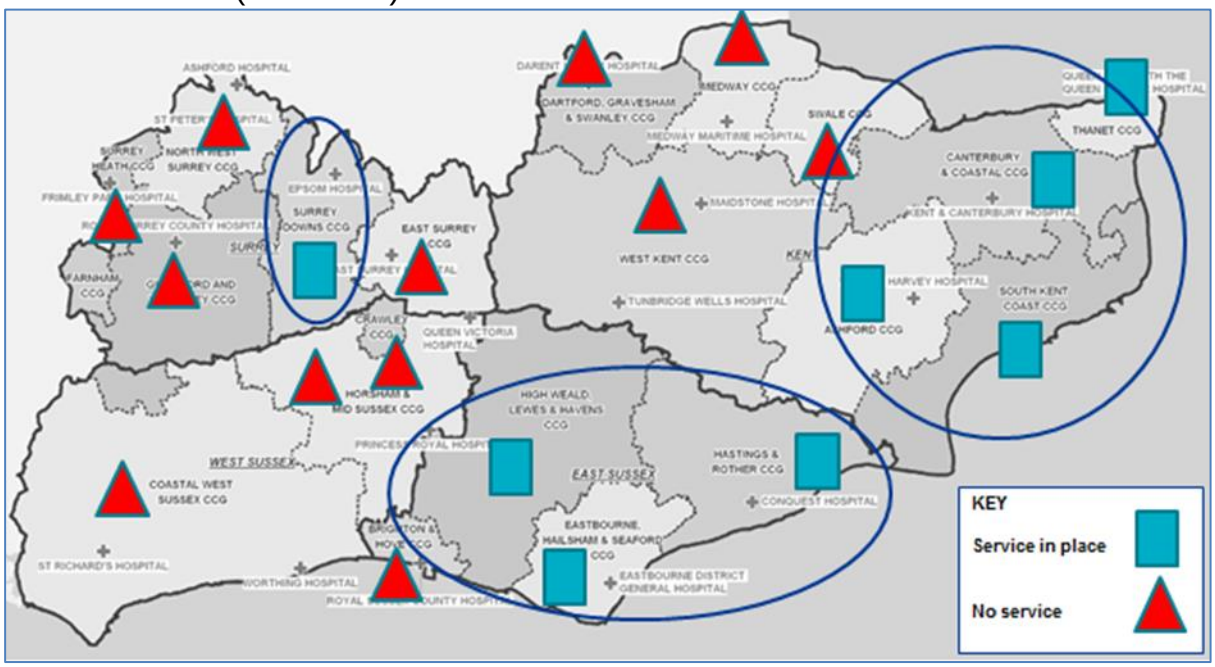
An editable version of this document is available in Appendix B
Service Specification Template

4. Current Six Month Review Providers

4. Current Six Month Review Providers

Local data and variance

Currently, only 8 of the 20 CCGs across the SEC commission 6 month review services for stroke survivors (see below):



The three organisations providing 6MRs currently are:

- Kent Community Health – operating in East Kent
- CSH Surrey –operating in Central Surrey
- The Stroke Association – operating in East Sussex

Six month reviews were also previously available in other areas of the SEC, however these services are no longer being commissioned. These included:

- West Surrey (Virgin Care)
- East Surrey (First Community Health & Care CIC)
- Medway (Medway Community Health)

Current service and cost Information

Appendix C provides contact details for current providers as well as basic service info and outline service costs.

5. Data Sharing Information

5 Data Sharing Information

Data sharing of patient information is a key enabler in ensuring the best possible service is provided to recipients of stroke six month reviews.

The following documents have therefore been included, for reference / consideration when setting up your own cross-organisational data sharing documentation.

We would like to thank the East Midlands Strategic Clinical Network and East Midlands Academic Health Sciences Network joint initiative for sharing these documents with us.

Privacy Impact Assessment template Appendix D

Privacy Impact Assessment Overview Appendix E

What is a Privacy Impact Assessment? Appendix F

Data Sharing Guidance for Discharge Organisations Appendix G
A data sharing guidance document, to be used by discharging organisations, has also been included, to ensure consistency of information is shared with those organisations involved in providing six month review services.

6. Clinical Guidelines and Policy Documents

6. Clinical Guidelines and Policy Documents

The provision of a six month review service for stroke survivors is supported and driven by a number of national guidelines/standards. Links to the main documents, along with the locally-produced South East Coast Integrated Stroke Service Specification document, have been provided below:

South East Coast Integrated Stroke Service Specification Appendix H

National Stroke Strategy 2007
Life after Stroke (Quality Marker 14, Assessment and Review)
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_081059.pdf

Royal College of Physicians National Clinical Guideline for Stroke (Fourth Edition) 2012
Key Recommendations (Sections 7.1.1C and 7.4.1A)
http://www.rcplondon.ac.uk/sites/default/files/national-clinical-guidelines-for-stroke-fourth-edition.pdf

Royal College of Physicians Commissioning Concise Guide for Stroke 2012
Commissioning in relation to the long-term consequences of stroke (Section 2.5.1)
http://www.rcplondon.ac.uk/sites/default/files/documents/stroke_commissioning_guide_web.pdf

NICE (CG162) Stroke rehabilitation guideline: Long term rehabilitation after stroke (2013)
Long-term health and Social Support (Section 1.11.5)
http://www.nice.org.uk/nicemedia/live/14182/64098/64098.pdf

NHS CCG Outcomes Indicator Set Technical Guidance 2014/15
Improving recovery from stroke (Section C3.8)
http://www.england.nhs.uk/wp-content/uploads/2013/12/ccg-ois-1415-tech-guid.pdf

7. Six Month Review Tools

7. Six Month Review tools

Links to the Greater Manchester Stroke Assessment Tool (GM-SAT), as well as supporting evidence for the use of this tool, have been provided below:

Greater Manchester Stroke Assessment Tool (GM-SAT) Assessment Tool Proforma
http://clahrc-gm.nihr.ac.uk/cms/wp-content/uploads/GM-SAT_proforma.pdf

Greater Manchester Stroke Assessment Tool (GM-SAT) Self-Assessment Questionnaire
http://clahrc-gm.nihr.ac.uk/cms/wp-content/uploads/GM-SAT_self-assessment.pdf

GM-SAT The Greater Manchester Stroke Assessment Tool Reviewee Summary Report
http://clahrc-gm.nihr.ac.uk/cms/wp-content/uploads/GM-SAT_summary-report1.pdf

Greater Manchester Stroke Assessment Tool (GM-SAT) Algorithms (for local adaption)
http://clahrc-gm.nihr.ac.uk/cms/wp-content/uploads/GM-SAT_algorithms.pdf

Easy Access (Aphasia Friendly version) of the GM-SAT

http://clahrc-gm.nihr.ac.uk/cms/wp-content/uploads/GM-SAT_CSR_low.pdf

Additional GM-SAT Resources are available on the link below, including:

- Leeds assessment of neuropathic symptoms and signs (self-complete) (S-LANNS)
- Malnutrition universal screening tool (MUST)
- Abbreviated Wimbledon self-report scale
- Training Video
- Evaluation Report

http://clahrc-gm.nihr.ac.uk/resources/gm-sat/5/

8. Taking things forward

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The SCN will continue to engage its stakeholders to ensure that Commissioning Groups are aware of these documents, which we hope will help to facilitate future commissioning of stroke six month reviews.

More information

If you would like further information on the Stroke workstream, or have specific queries about stroke six month reviews, please contact Mark Trickey, Quality Improvement Lead (Email: m.trickey@nhs.net; Mobile 07717 727 305).

For any general queries about the SCN, please contact the Admin Team in the first instance (Email: england.secscns-admin@nhs.net; Telephone 01293 729 154).

Appendices

The appendices will be provided in a separate Pdf. document with links to editable documents on the South East Coast Strategic Clinical Networks Website.