**Six Month Reviews for Stroke Survivors – Service Specification Template**

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| **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. **Aims**

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

* 1. **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. **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. **Outcomes**

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| ***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.

1. **Scope**
   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.

* 1. **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].

* 1. **Whole System Accessibility / acceptability**

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

* 1. **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.

1. **Service delivery**
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2. 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.
3. The six month review service provider will use the [Greater Manchester Stroke Assessment Tool (GM-SAT)](http://clahrc-gm.nihr.ac.uk/stroke/GM-SAT_The_Greater_Manchester_Stroke_Assessment_Tool-1.pdf) which is an evidence based tool to identify individuals’ unmet needs, post stroke, from across health, social and emotional care domains.
4. Any unmet needs which are identified will be addressed by providing advice, additional support, referral or signposting to appropriate services.
5. A review which includes only stroke secondary prevention would not be considered to be acceptable.
6. 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.
   1. **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.

1. **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]

1. **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.

1. **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.

1. **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.

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| **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 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 provider | Quarterly | Service Name |
| 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 |

1. **Activity**
2. **Currency and prices**

*Adapted with thanks, from the NHS East Midlands Strategic Clinical Networks and Senate 6 Month Review Information Pack.*