Generic service specification
Six Month Reviews

Care Pathway/Service	Stroke 6 Month Reviews
Commissioner Lead	
Provider Lead	
Period	

1 Purpose

Stroke is a long term condition and survivors will experience changes in their needs over time. The 6-month review will 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.

The NHS Midlands and East Stroke Service Specification highlighted the need for "stroke survivors and their carers [to be] enabled to live a full life in the community over the medium and long term (>3 months). Support is required from local services 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". It also 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 this overall stroke pathway.

The 6 month review service will provide a link from hospital to home and will 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 service will help reduce pressure on the individual and their family and prevent unnecessary readmissions to hospitals and care homes.

- **Aims**

- To offer 100% of patients notified to the service a 6-month review

1.2 Evidence Base

The service 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.
Royal College of Physicians (RCP) National Clinical Guidelines for Stroke (2008) 7.1.1 and 7.4.1	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 Further therapy following 6 month review should only be offered if clear goals are agreed 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
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.
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

The Accelerating Stroke Improvement (ASI) programme was established in March 2010 as a national initiative designed to ensure that maximum implementation of the Quality Markers in the National Stroke Strategy (2007) is achieved. The three major domains of emphasis for this programme of work are: Joining Up Prevention; Implementing Best Practice in Acute Care and Improving Post Hospital and Long Term Care. The programme is guided by a set of nine national metrics, which include:

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

1.3 Aims and Objectives

To offer 100% patients an opportunity for a review 4-8 months (in line with RCP Sentinel Stroke National

Audit Programme (SSNAP)) 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	✓
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	✓
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

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 must:

- 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 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 service 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 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 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

6-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 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 Relationships

The 6-month review service is an integral part of developing the wider Stroke pathway.

2.4 Interdependencies

Efficient running of the 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

Service delivery

a) The 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 service will use [tool name] 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 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.

Accessibility

The 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 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

Geographic coverage/boundaries
All patients registered with [area] GPs will be able to access this service.

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

Referral criteria & sources
All patients registered with [AREA] GPs discharged from hospital following a stroke.

Referral route

- The stroke survivors GP will be responsible for sending a referral to the service on receipt of the Acute hopsital discharge notification. The failsafe responsibility to ensure all eligible patients are referred to the service is with GPs.
- People who have received treatment for stroke out of area are also eligible for this service. The patients GP will be expected to notify the service of these patients when they return to their normal residence in [area]

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 service.

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

Communication of outcomes will be shared with the GP 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 provider will review and where appropriate and after discussion with commissioners, update their service in line with any new national guidance

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 [tool], it is expected that the service 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	Proportion of stroke patients that are offered a six months review after having a stroke (ASI 8/ SSNAP) (target = 100% at 6 months) Numerator: Number of patients offered a 6-month review 4-8 months following admission Denominator: number of patients referred to the service	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 electronically)	100% of review outcomes are sent to the patient and/or carer and GP within 1 week of review	Quarterly	Service / Name	

8 Activity

9 Currency and Prices