Service Specification No.	03/CVDS/0004
Service	Community Stroke Specialist Practitioner Service
Commissioner Lead	CCP for Cardiovascular Disease & Stroke
Provider Lead	Helen Persey
Period	1st April 2013 to 31st March 2014
Date of Review	To be Agreed

NHS Outcomes Framework Domains & Indicators

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	*

1. Purpose

1.1 Aims

The aim of this service is to provide a Stroke Specialist Practitioner service to NHS Dorset registered patients, their families and carers.
The post holders will aid the transfer of care from hospital to home, coordinate and oversee the provision of care and rehabilitation in the community and manage a caseload of patients who have a history of stroke.
The post holders will develop stroke skill and knowledge throughout NHS Dorset Community Health services and deliver education and training to carers.

1.2 Evidence Base

- The National Stroke Strategy. DOH 2007
- The National Service Framework for Long- term Conditions. DOH 2005
- The National clinical guideline for Stroke, third edition. RCP 2008
- Our health, our care, our say. DOH 2006
- Transforming Community Services
- Quality Innovation Productivity and Prevention (QIPP)

1.3 General Overview

- To receive referrals from the Acute Trusts (newly diagnosed Stroke) and Primary and Community Care (past history of Stroke with new symptoms) for Stroke patients.
- To actively work to facilitate the transfer out of hospital for patients with a history of Stroke in a timely manner.
- To offer education and training to family members and carers.

- To assess risk factors and promote secondary prevention measures in all referred patients
- To review and monitor newly diagnosed stroke patients at six months and one year post discharge as a minimum.
- To coordinate care and rehabilitation on an individual basis as required
- To refer patients to supporting services e.g. Stroke Association support groups, NHS and social care services
- To support the ethos of self-care and self-management

1.4 Objectives

- To facilitate a timely and supported transfer of care from acute to community services for newly diagnosed stroke patients, their families and carers

- To support patients and carers as they return home by coordinating care and rehabilitation
- Alongside other community and primary care team members, prevent readmission to hospital especially within the first month following discharge
- To act as a single point of access for stroke services within the community
- To support patients with a history of stroke in accessing services and support as new symptoms arise.
- To advise patients, their families and carers on risk factors and secondary prevention of stroke.
- To provide information, both written and verbal, to patients, their families and carers in a timely and effective manner with particular reference to aphasia friendly communication.
- To work closely with social services employed stroke coordinators to provide long term support for patients and carers.
- To inform and be actively involved in the development of Stroke Specialist Community Rehabilitation across NHS Dorset.
- To be an active member of the Pan Dorset Stroke Network Board.
- To share local initiatives and Best Practice locally, regionally and nationally.

1.5 Expected Outcomes

- Reduced length of stay in acute stroke units
- Increased numbers of Early Supported Discharge
- Reduced numbers of readmission within the first month of discharge
- Review at 6 months and one year post discharge and annually as appropriate
- Increased public and patient awareness of risk factors and secondary prevention
- Increase awareness of primary prevention in patients families and the general public
- Support for patients and families/carers as they adapt to a new way of life
- Case manage as a single point of access for other services

PROVIDE

2.1 Service Description

The service will be situated within the remit of the Community Services Manager working alongside Community Matrons, Nurses and Community Rehabilitation Teams and will be integrated into the future provision of Stroke Specialist Community Rehabilitation Teams.

The service will initially be split with one post holder in the West and one post holder in the East

of NHS Dorset, covering the North and the Isle of Purbeck between them.

The post holders will work closely with clinicians on the Acute Stroke Units to receive referrals for patients registered with an NHS Dorset GP to facilitate discharge in a timely and coordinated manner.

Referrals will also be received from primary care, community health services, social services and the Stroke Association for patients in the community with a history of stroke as appropriate.

The post holders will deliver advice on risk factors and promote secondary prevention measures in all referred patients.

The post holders will work closely with family, carers and the public to promote primary prevention measures.

2.2 Accessibility/acceptability

- All newly diagnosed stroke patients with an NHS Dorset registered GP will be referred to a Community Stroke Specialist Practitioner.
- Patients and families/carers will be visited at home or seen in a clinic dependant on need.
- Clinic areas and amenities will be wheelchair accessible
- Patients will be reviewed by the Community Stroke Specialist Practitioner as needed on an individual basis.

2.3 Whole System Relationships

There will be a close working relationship with patients, their family and carers, the Acute Stroke Teams, Stroke Specialist and generic Community Rehabilitation Teams, Primary Care practitioners including GPs and Community Matrons, Stroke Coordinators, other support services for Stroke patients and carers e.g. communication support and social support and the Stroke Association.

2.4 Interdependencies

- Patients and family/carers
- Secondary care
- Primary care
- Community rehabilitation services
- The Stroke Association
- Support groups for those who have had a stroke and their carers
- NHS Dorset Commissioners

2.5 Relevant Clinical Networks and Screening Programmes

- Dorset Stroke Network Board
- Out of Hospital Care sub group of the Dorset Stroke Network board
- NHS South West review of the local implementation of the National Stroke Strategy

3. Service Delivery

3.1 Service Model

The post holders will establish a single point of access for stroke patients, their families and carers within their localities.
All patients will be referred by the acute/rehab stroke teams in secondary, primary care or community services.
Each patient will receive an assessment of risk factors and advice on secondary prevention appropriate to their needs.
Agreed 'patient centred' goals and review dates will be established.
There will be integrated working with other health and social care professionals as well as the voluntary sector, in particular the Stroke Association to enable the patient, their family and cares to reintegrate into the community.
The post holders will deliver stroke specific training and advice to family, carers, health and social care staff and residential care staff as required.

3.2 Pathways

- The Post Holder will be a Nurse or Allied Health Professional with extra skills and knowledge of Stroke (see job description)
- Referrals to the service will be received from Secondary care (newly diagnosed stroke), Primary and Community care and the Stroke Association.
- All newly diagnosed Stroke patients registered to an NHS Dorset GP will be referred to the service on admission to the ward.
- The Post Holders will attend case conference on the Stroke Unit as appropriate to pick up new referrals, coordinate discharge and meet patients and family/carers prior to discharge
- Patients will be given written confirmation of further contact from the community stroke specialist practitioner prior to leaving hospital.
- Advice and information on risk factors and primary prevention will be given to each patient in a format that is understood (aphasia friendly and in plain English/appropriate language)
- Patient centred goals will be established
- Patient held notes/care plan/health record/information will be kept by each patient at home to enhance integrated working with other services and utilising the ethos of 'self care'.
- Referral to supporting services will be made according to individual need.
- Patient and family/carers health needs and risk factors will be reviewed at 6 months and one year as a minimum

4. Referral, Access and Acceptance Criteria

4.1 Geographic coverage/boundaries

- All patients will be registered with an NHS Dorset GP

4.2 Location(s) of Service Delivery

- Initially, the posts will be split between East and West NHS Dorset

4.3 Days/Hours of operation

- The hours worked will be spread throughout the Monday – Friday working week.

4.4 Referral criteria & sources

All patients with health needs related to Stroke.

Referrals will be received from;

- Acute Stroke Unit
- Rehabilitation Stroke Unit
- Community rehabilitation team
- Primary care team
- Community services
- Stroke coordinators
- The Stroke Association

4.5 Referral route

- Notification of hospital admission of newly diagnosed stroke patients will be faxed to the post holder daily.
- The post holder will paper triage the referrals
- Patients, their families/carers will receive a written (aphasia friendly) appointment and contact details prior to leaving hospital

4.6 Exclusion Criteria

- Non NHS Dorset residents
- Patients without a confirmed diagnosis of stroke

4.7 Response time and prioritisation

- Faxed referrals will be paper triaged on each working day
- Prioritisation will take place according to patient, family/carer need

5. Discharge Criteria & Planning

- Patients goals will be reviewed in timely fashion according to individual need
- Management plans will be established with the patient, their family/carer
- The patients GP and other relevant health and social care professionals will receive a copy of individual management plans.
- Patients, their family/carer will keep a copy of their management plan
- There will be open access on an SOS basis back to the Community Stroke Specialist Practitioner.
- All patients, family/carer will complete a questionnaire at the point of discharge which will inform future service delivery
- All patients, family/carer will be invited to become involved in the Dorset Stroke Network Patient and Public Involvement levels of involvement to comment on and influence change in service delivery for those with a history of Stroke across Dorset

6. Self-Care and Patient and Carer Information

- Information, whether written or verbal will be presented in an aphasia friendly manner
- Patients and family/carers are encouraged to adopt a ‘self care’ ethos of ‘adding life to days and not days to life.’
- Open access to the Stroke Association library of fact sheets and resources for patients,

their family/carers

7. Quality and Performance Indicators	*Quality and Performance Indicator(s)*	*Threshold*	*Method of Measurement*	*Consequence of Breach*
HCAI Control				
Service User Experience	Participant and family member/carer to complete an evaluation form Participants to be invited to join the Dorset Stroke Network Patient and Public Involvement (PPI) levels of involvement.		Initiated by the community stroke specialist practitioner periodically and at discharge. Dorset Stroke Network PPI Lead to provide information and support to potential members. PPI lead to report activity to commissioners.	
Improving Service Users & Carers Experience	Service user representation on the different PPI levels of involvement Completion of evaluation form by participant, family/carer		Audit number of PPI representatives Evaluation forms to be audited quarterly and annually. Resulting changes to provision to be recorded and re evaluated	

Unplanned admissions	Active promotion of supported discharge will reduce unplanned readmissions. Single point of access and SOS review will reduce unplanned admissions later in the pathway		Audit of unplanned admissions and readmissions quarterly and annually	
Reducing Inequalities	This service will ensure that all stroke patients, their family/carers will have access to stroke specific support		Data collection and audit of numbers of referrals and outcome data	
Reducing Barriers	All newly diagnosed stroke patients, their family/carer will have a single point of access to stroke specific services. All information should be presented in an		Audit of patients, family/carers reasons for not attending review or completing agreed goals to inform further service provision/redesign Use of Aphasia	

	aphasia friendly/plain English/alternative language format.		friendly/plain English/alternative language literature	
Improving Productivity	Delayed transfer of care from secondary care to the community. Patients, their family/carer will be empowered to reintegrate into family, social and working life		Audit of delayed discharges and reasons. Audit of patient centred goals re integration into the community	
Access	Open access for all NHS Dorset registered patients with a history of stroke		Audit numbers and sources of referrals annually with particular relevance to age, gender, ethnic background	
Personalised Care Planning	All patients will hold personalised care plans/health record		Audit use of personalised care plans plus patient, family/carer satisfaction	
Outcomes	Clinical, lifestyle, psychological and quality of life outcomes will be identified for individual participants as well as the service as a whole		Review of patient notes and annual audit of outcome measures	
Additional Measures for Block Contracts:-				
Staff turnover rates				
Sickness levels				

Agency and bank spend				
Contacts per FTE				

8. Activity

Activity Performance Indicators	*Threshold*	*Method of measurement*	*Consequence of breach*

Activity Plan

There will initially be one Community Stroke Specialist Practitioner in the East of the County (already in post) and one in the West of the County (new post).

Each post holder will be line managed and accountable to the Community Services Manager in that area.

In time, the post of Community Stroke Specialist Practitioner will be integrated within the Community Stroke Specialist Rehabilitation Team.

9. Continual Service Improvement Plan

As part of the monitoring and evaluation procedure, the provider and commissioner will identify a plan and method to measure continuous service improvement.
Unmet needs will be identified and brought to the attention of the commissioner.
Service Improvement/development is an integral part of service provision and will be monitored through

- Service user and carer involvement
- Service user and carer feedback
- Risk assessment and management
- Quarterly meetings and reports to the commissioner

10. Prices & Costs

The post holder is to be employed at Band 6 for 22 hours per week

10.1 Price

Basis of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value
Block Arrangement/Cost and Volume Arrangement/National Tariff/Non-Tariff Price_____*		**£**		**£**
2009 Quality Payment				
Total		**£**		**£**

**delete as appropriate*

10.2 Annual Contract Value by Commissioner

Total Cost of Service	Co-ordinating Commissioner Total	Associate Commissioner Total	Associate Commissioner Total	Associate Commissioner Total	Total Annual Expected Cost
£	**£**	**£**	**£**	**£**	**£**