SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	03/CVDS/0041
Service	**Six Month Stroke Reviews**
Commissioner Lead	Cardiovascular Clinical Commissioning Programme
Provider Lead	
Period	2013.14
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Patients and carers report a lack of support after leaving hospital. This can be regarding stroke specific issues or general issues and concerns. The UK Stroke Survivor Needs Survey (2010) identified that people who had survived a stroke had unmet needs with 49% identifying at least one unmet need.

Quality Marker 14 of the National Stroke Strategy states that:

- *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 6 weeks of discharge home or to care home and again before six months after leaving hospital.*

The Accelerated Stroke Improvement measures were developed in 2010. One of which is:

- *The proportion of stroke patients that are reviewed at six months after leaving hospital (95% by April 2011)*

Local data shows that 1,499 patients were discharged from hospital following a Stroke into Dorset Clinical Commissioning Group localities in 2011/12.

The provision of stroke specific reviews has been identified by patients and their carers in enabling them to highlight and discuss stroke specific problems later in the care pathway.

National guidance supports the use of a standardised tool which covers individual physical, emotional and social assessment and referral or signposting to appropriate services.

The review allows for the provision of secondary prevention messages and will be delivered by providers with stroke specific knowledge.

The provision of six month reviews for patients discharged from hospital following a stroke is supported by the following national evidence;

- The National Stroke Strategy. DOH 2007
- The National clinical guideline for Stroke, fourth edition. RCP 2012
- Accelerated Stroke Improvement measure 8. Assessment and review. NHS Improvement 2011
- The Stroke Association
- CCG Outcomes Indicator Set 2013/14. Domain 3, Helping people to recover from episodes of ill health or following injury; improving recovery from Stroke

N.B This list is not exhaustive and the Provider is contractually obligated to review evidence base on a continual basis.

Service users and clinicians have been actively involved in the development of this service specification as a sub group of the Dorset Stroke Network and latterly the Dorset Stroke Service Delivery Group.

2. Outcomes

2.1 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**	

2.2 Local defined outcomes

- 100% patients to be offered a review between four and eight months post hospital discharge
- 95% uptake of offer in a full year
- Identification of unmet needs in 50% of patients who take up the offer of a review
- Improved Quality of Life outcomes measured by EQ5D5L to measure and report the change between 6 week review and 6 month.
- Patient Reported Experience Measure (PREM) using the Friends and Family Test

3. Scope

3.1 Aims and objectives of service

Many patients and carers report that they face new problems later in the stroke care pathway, often after the 'rehabilitation' phase had finished, leaving them feeling

unsupported and at times isolated and vulnerable.

The aim of this service is to ensure that all patients returning to live in the Dorset CCG localities who have had a stroke are offered a structured stroke specific review of their physical, social, cognitive, psychological and emotional needs in the community six months after leaving hospital with streamlined referral or sign posting to appropriate services and support as required including integration back to work, family life and social activities.

This specification does not include a carers review but specifies onward referral if issues are identified at the six month review.

3.2 Service description/care pathway

Reviews should take place in a setting in which the patient/carer feels at ease and as close to home as feasible e.g. community clinic, patient's home, telephone call. Individual patient choice of venue and time should be considered.

The six month South Central Community Stroke Review tool is the stroke specific review tool of choice for this service as this links with the six week review undertaken by secondary care.

The provider will pick up all patient details at discharge from hospital.

The provider will contact all patients within one month of discharge alerting each patient to the offer of a review at six months.

The provider will contact each patient at four months post discharge to agree date, time and venue for the review with the six month South Central Community Stroke Review tool.

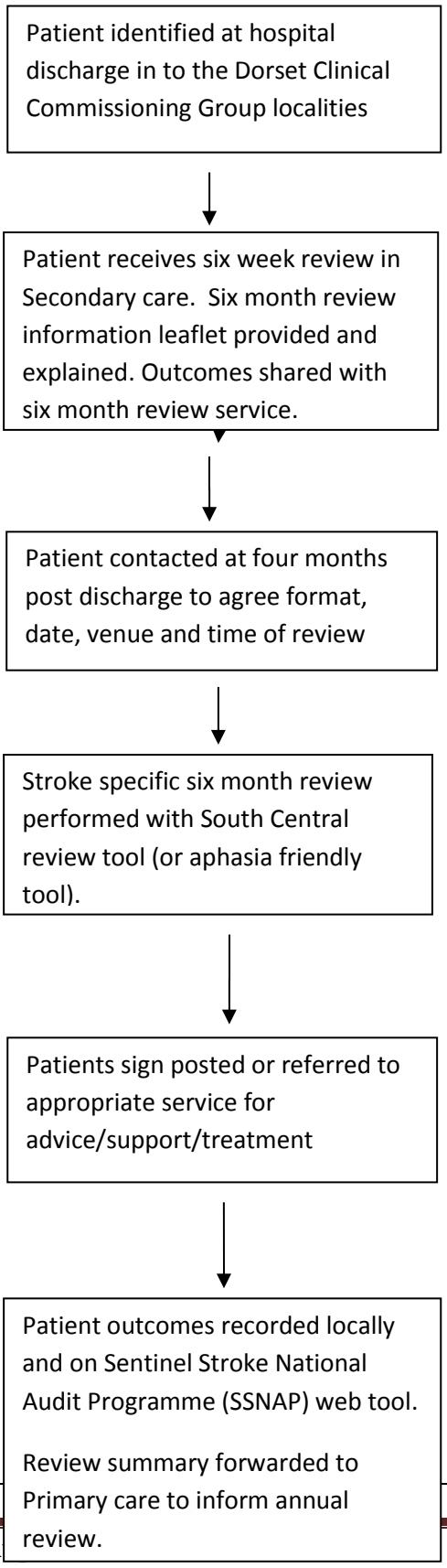
The outcomes of the review will be acted upon with signposting, referral or advice as required.

The provider will be responsible for the collection of local data and outcome measures including the upload to the (SSNAP) web tool.

A summary/care plan will be given to the patient with a copy to the patient's GP.

The six month review will link with the annual review to be undertaken in Primary care.

Pathway


Patient identified at hospital discharge in to the Dorset Clinical Commissioning Group localities
Patient receives six week review in Secondary care. Six month review information leaflet provided and explained. Outcomes shared with six month review service.
Patient contacted at four months post discharge to agree format, date, venue and time of review
Stroke specific six month review performed with South Central review tool (or aphasia friendly tool).
Patients sign posted or referred to appropriate service for advice/support/treatment
Patient outcomes recorded locally and on Sentinel Stroke National Audit Programme (SSNAP) web tool.
Review summary forwarded to Primary care to inform annual review.

Referral for a carers review will be undertaken if issues are identified at the six month review.

3.3 Any acceptance and exclusion criteria and thresholds

All stroke patients discharged in to the Dorset CCG localities will be offered a six month review including those patients resident in care homes.

Patients discharged out of these localities will be referred to the appropriate review team within their CCG area.

3.4 Interdependence with other services/providers

The service will maintain and develop constructive working relationships with a range of relevant staff and organisations particularly:

- Acute hospital stroke teams discharging patients to Dorset CCG localities
- Community hospital stroke teams
- Community Rehabilitation Teams
- Stroke Early Supported Discharge teams
- GPs and practice staff for annual reviews and to pick up referrals for patients moving/returning to the area
- The Stroke Association staff
- Community matrons
- Social Services for carer's assessments, housing and home adaptations
- Talking Therapy teams
- Community Mental Health teams
- Carers and family members.
- Commissioners

The success of this service is dependent upon;

- Patients being identified at discharge from hospital
- The coordination of community services in contact with the patient at four to six months post discharge.
- The coordination of data returns via the Sentinel Stroke National Audit Programme.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The Accelerated Stroke Improvement measure;

- *The proportion of stroke patients that are reviewed at six months after leaving hospital (95% by April 2011)*

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- The National Stroke Strategy. DOH 2007
- Accelerated Stroke Improvement measure 8. Assessment and review. NHS Improvement 2011
- The National clinical guideline for Stroke, fourth edition. RCP 2012
- Cardiovascular Disease Outcomes Strategy – Improving outcomes for people with or at risk of cardiovascular disease. Department of Health, 2013

4.3 Applicable local standards

The three data metrics that the provider of the six month stroke review service will be expected to report on a regular basis are:

- Clinical outcomes and process using the Euro Qol measurement tool, EQ-SD-5L to measure change from 6 week assessment.
- Patient related outcome measures
- Patient experience

The provider is required to submit quarterly reports as a baseline to the commissioner, for the first 6 months of the service, which includes the following data:

% of patients accepting a review							
% of patients resident in nursing/care home accepting a review							
% of patients reviewed with aphasia review tool							
% of patients receiving a review in clinic							
% of patients receiving review at home (incl. nursing/care home)							
% of patients receiving a							

review by telephone							
% of patients signposted/referred to voluntary support services							
% of patients signposted/referred to health services							
% of patients signposted/referred to Social care services							

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

The Provider's Premises are located at:

This service is to be provided for patients registered with a Dorset Clinical Commissioning Group GP and will be delivered in appropriate venues to meet the needs of people living in localities of North Dorset, Mid Dorset, West Dorset, Weymouth and Portland , East Dorset, Purbeck, Poole, Christchurch and Bournemouth.
Delivered within either;

- A clinic setting
- Individually at home
- By telephone

7. Individual Service User Placement