SECTION B PART 1 - SERVICE SPECIFICATIONS

Service Specification No.	
Service	**Six month Stroke Reviews**
Commissioner Lead	**Mark Callingham/Nichola Arathoon**
Provider Lead	
Period	**2012/2013**
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, Bournemouth and Poole localities (Dorset Clinical Commissioning Group) 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.

2. Scope

2.1 Aims and objectives of service

Many patients and carers report that they face new problems later in the 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, 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.

2.2 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 Greater Manchester Stroke Association Tool (GM SAT) or the South Central Community Stroke Review tool are the stroke specific review tools of choice for this service.

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, venue, time and choice of provider.

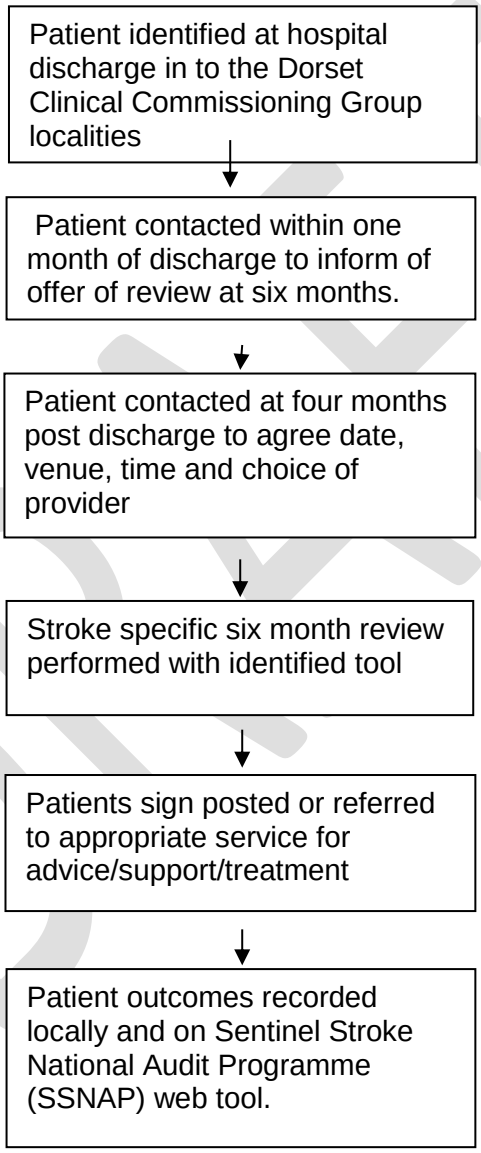
If the patient is known to a community stroke practitioner in health, social care or the voluntary sector, the patient should be given the choice to receive their stroke specific review from this service. NB the practitioner must be stroke skilled and utilise one of the stroke specific review tools identified in this specification.

If the patient is not known to a community stroke practitioner the accountable provider will carry out the stroke specific review.

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

The accountable provider will be responsible for the collection of local data and outcome measures including the upload to the Sentinel Stroke National Audit Programme (SSNAP) web tool.

Pathway



2.3 Population covered

1,499 patients were discharged in to the Dorset Clinical Commissioning Group population following a stroke in 2011/12.

Provider	Locality	No. of Patients
DCH - Dorset County	East Dorset	4
	North Dorset	42
	Purbeck	12
	West Dorset	126
	Weymouth & Portland	107
DCH Total		**291**
PHT - Poole Hospital	Christchurch	1
	Compass Commissioning Group	30
	East Dorset	72
	North Dorset	6
	Parkstone	59
	Poole Bay	68
	Poole Central	135
	Poole North	107
	Purbeck	55
	West Dorset	4
PHT Total		**537**
RBH - Royal Bournemouth	Christchurch	114
	Compass Commissioning Group	285
	East Dorset	103
	North Bournemouth Commissioning Group	19
	North Dorset	1
	Parkstone	2
	Poole Bay	42
	Poole Central	2
	Poole North	2
RBH Total		**570**
SFT - Salisbury	East Dorset	4

	North Dorset	35
	Poole Central	1
SFT Total		**40**
Yeovil	North Dorset	58
	West Dorset	2
	Weymouth & Portland	1
Yeovil Total		**61**
Grand Total		**1,499**

2.4 Acceptance and exclusion criteria

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

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

Referral route

Electronically at hospital discharge

Response time and prioritisation

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, venue, time and choice of provider.

All reviews to take place at six months post discharge from hospital.

2.5 Interdependencies with other services

Whole System Relationships

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

- Acute hospital stroke teams
- Community hospital stroke teams
- Community Rehabilitation Teams
- Stroke Early Supported Discharge teams
- GPs and practice staff.
- The Stroke Association staff
- Community matrons

- Social Services.
- Carers and family members.

Interdependencies

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

Relevant Clinical Networks and Screening Programmes

- Cardiovascular Clinical Commissioning Programme.
- Stroke Service Delivery Group

3. Applicable Service Standards

The Accelerated Stroke Improvement measure;

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

4. Key Service Outcomes

Expected Outcomes

1. A Single Point of Access in to the service with locality provision of the service.
2. Integrated, joined up service within the Dorset CCG localities
3. All patients to be offered a review at six months post hospital discharge
4. 95% uptake of offer in first year
5. Identification of patient unmet needs
6. Sign posting or referral to appropriate service and support
7. Reduced dependency on health services later in the stroke pathway
8. Provision of the service within a community setting or by telephone

5. Location of Provider Premises

Geographic coverage/boundaries

The service will be offered to all Dorset CCG registered patients discharged from hospital following a stroke

Location(s) of Service Delivery

There is no set location for this service with patient choice taken in to consideration for choice of venue; community clinic, patient's home, telephone call.

Days/Hours of operation

The operating times should reflect and accommodate wherever possible patients personal circumstances and commitments and their choice of venue and time of appointment.

6. Individual Service User Placement