South London
Cardiac and Stroke Network

SIX MONTH REVIEWS AFTER STROKE

Stroke is a long term condition. As such, survivors experience changes in their needs over time.

Reviews can help ensure patients and carers receive appropriate support and access to services as their needs require.

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BACKGROUND

Stroke is a long term condition. As such, survivors experience changes (both positive and negative) in their needs over time. Reviews can help ensure patients and carers receive appropriate support and access to services as their needs require. This recommendation, reflected in national policy, is drawn from clinical consensus rather than from evidence of benefit.

Key drivers	Descriptor/standard
National Service Framework for Older People (2001)	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 ongoing 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 QM4 (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 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)	Further assessment is offered to those with residual impairments and whose circumstances change through formal, regular review. This provides support to carers if their needs change, to ensure they know how to access further help and resources.
London Stroke Strategy (2008)	For the first 12 months following a stroke, all individuals and carers will have a regular review and assessment of ongoing medical, social and emotional needs both as an inpatient and in the community (delivery by April 2011). GP performance standard: Percentage of patients seen by primary care team at six weeks and six months post stroke, for holistic review of all needs, not just secondary prevention. Targets: full=

	80%; interim = 60%; with yearly reporting
London Stroke Rehabilitation Guidelines (2009)	Every stroke survivor should have access to rehabilitation reviews at defined points during the first 12 months following their stroke(at three, six and 12 months following their stroke). The reviews will be multifaceted and based upon the individual needs of the stroke survivor.
London Life After Stroke Commissioning Guidance (2010)	In line with national guidance and best practice, all stroke survivors should receive a multidisciplinary review at six weeks, six months, 12 months and annually thereafter to assess their needs and aspirations. In order to provide a responsive needs-based service, a review should take place at other times as determined by the needs of the stroke survivor. An accessible, flexible mechanism should be in place for stroke survivors to access the review system easily, such as a stroke navigator. Stroke survivors should be screened and reviewed for common impairments in line with locally agreed protocols. Goals should be set accordingly. Commissioners should work with local GP practices to access stroke survivor data on their QOF registers.
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.

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 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)

There is clearly a strong onus on commissioners to establish robust review processes for stroke patients. However, the lack of evidence to guide the delivery of these reviews raises many questions:

- What should a review consist of?
- Who should lead the review?
- How should it be delivered?
- What are the benefits?
- What are the resource implications?

This guidance therefore seeks to answer these questions, focusing primarily on the six month review due to its inclusion in the ASI programme. This work has been informed by patient and carer engagement activities that have been undertaken in South London, combined with feedback from service models piloted and implemented elsewhere, and work undertaken by the national Stroke Improvement Programme (SIP) team.

CASE FOR CHANGE

The National Audit Office's report 'Progress in Improving Stroke Care' (2010) contrasted the great improvements in acute stroke care with the poor quality of life after stroke. This report made particular reference to review processes:

"We found variations in approaches to these reviews and a lack of clarity about who should lead them, their objectives, where they are recorded, the role of the patients' GPs in the reviews and how they are implemented."

The CQC review of stroke services (2011) found that most PCTs had systems in place for reviews at six weeks, but that systems for reviews later in the pathway were not well developed. They noted that even where such systems are in place, it was not always clear who was responsible for ensuring that reviews took place.

Overall, the review team found that six week reviews were taking place for approximately two thirds of cases they reviewed, and that six month reviews were planned to take place for 44 per cent. Significant differences in these figures were noted between PCT areas.

Where PCTs had policies in place about carrying out reviews these tended to reflect good practice. For example, most set out that people who have had a stroke and their carers should be involved in reviews and that robust tools should be used to assess progress. However, information packs given to people at transfer home often did not include information about reviews or set out their rights to ask for a reassessment should their needs change.

There is not yet a strong evidence base regarding the benefits of stroke reviews. However, anecdotal evidence from areas where reviews are being delivered suggests that benefits might include:

- More progress than expected for stroke survivors in rehabilitation
- Avoidance of hospital admission (avoiding escalation of problems)
- Identification of secondary prevention needs (e.g. undiagnosed atrial fibrillation, hypertension, medications management) and the modification of risk factors
- Improved quality of life
- Potential to improve access to voluntary sector support services (by highlighting areas where voluntary services can meet needs)
- Continuity of care and reassurance,
- Increased understanding about stroke and/or TIA, improved ability to cope and self-manage, increased independence
- Identification of mood and relationship issues that otherwise might be missed or not mentioned
- Identification of carer needs
- Reduced duplication between services

From the 2009 'Stroke Rehabilitation Guide: Supporting London Stroke Commissioners to Commission Quality Services in 2010/11' and work by the SIP team:

Other areas where stroke reviews might demonstrate benefits may include:

- Improved quality and equity of stroke services
- Reduced GP and stroke consultant appointments
- Additional support to carers
- Opportunity to reduce dependency
- Reduce adult services care package and care home placements
- Improved joint working across agencies
- Opportunities for improved data collection processes, audit, improving performance monitoring and inform service development needs

From SIP team work

Goal driven review processes may help to increase patient engagement in recovery and self-efficacy which can support patients to manage their conditions effectively and to affect lifestyle changes.

POST STROKE SERVICE PROVISION IN SOUTH LONDON

The CQC review of stroke services (2011) asked 'Were systems in place for reviews after transfer home?' The following responses were included for the South London boroughs:

Sector	BOROUGH	At / around 6 weeks	At / around 6 months	At 12 months	Annually after that
SEL	Bexley	N	N	N	N
	Bromley	N	N	N	N
	Greenwich	Y	N	N	N
	Lambeth	Y	N	N	N
	Lewisham	Y	N	N	N
	Southwark	N	N	N	N
SWL	Croydon	N	N	Y	N
	Kingston	Y	N	N	N
	Richmond & Twickenham	Y	Y	Y	Y
	Sutton & Merton	N	Y	Y	N
	Wandsworth	Y	N	N	N

The provision of reviews in South London seems to reflect the national trend, with good provision at six weeks, but poor provision of later reviews. It is important to note that acute Trusts provide a six week follow up. Thus, where no six week review provision is indicated above it is likely that this response does not reflect a gap in provision, but rather that the response came from the community team who do not provide this service.

The CQC review indicates that six month, 12 month and annual reviews are provided in some South West London boroughs, but these reviews are not consistently embedded in the stroke pathway for all patients. The Network team are keen to clarify the arrangements that are in place in the local boroughs, and to share learning from implementation of reviews where possible.

SIX MONTH REVIEWS

What should a six month review consist of?

At an event in July 2010 the Network asked 30 patients and carers from South London 'What support is needed six months after a stroke?' This event was followed by a focus group session with a group of seven people with aphasia and their carers in November 2010, facilitated by Connect - the communication disability network. At both sessions we asked people who have been affected by stroke what kind of support in each of the following areas would be required in the following areas as part of a six month review:

- Medical
- Physical
- Emotional
- Leisure and social
- Work

Patients and carers felt that the review process should be a holistic one that addresses medical and emotional needs. They felt that the opportunity to ask questions was particularly important and that some people might benefit from the opportunity to share ideas with other patients. Our patient and carer group emphasised the need for these reviews to be part of a continual process (e.g. from hospital stay right through to annual reviews for as long as is required). They also emphasised the need for all decisions to be made jointly by patient and healthcare staff. Reviews should provide an opportunity to signpost to local services and organisations that can support people following a stroke, and provision of a named or single point of contact was also felt to be important. Detailed responses have been included in Appendix A.

The SIP team reviewed pilots across the country, the results and examples of what reviews could include can be found on the SIP website. The 2011 CQC review of stroke services also gives an indication of areas where access to information could be improved, such as the provision of information about money and benefits. Six month reviews could provide an opportunity to enhance and tailor information provision.

Considerations

- The needs and wants of patients and carers should be used to inform content of six month reviews.
- Reviews should be holistic and tailored to the needs of the individual.
- Examples of review processes in other areas of the country could provide useful insight when establishing local reviews.
- Analysis of local CQC feedback reports can provide insight into information currently given to patients. Gaps that exist could be addressed through the reviews processes.

Who should be involved in delivering the review?

Some suggestions from our patients and carers:

- Health and social care
- GP
- A team approach - Every professional working with stroke patients should be part of the review. This provides a more holistic approach and ensures that no one "falls through the net" (e.g. Lambeth pilot for 12 month reviews).
- Carers should be included in the review process where appropriate.
- One member of our patient audience, reflecting on her experience, noted that no matter who delivers the review, that person must be more knowledgeable about stroke than the patient attending review.

In other areas, pilot projects have demonstrated effective delivery of six month reviews by voluntary sector organisations.

Case study
The Greater Manchester Stroke Assessment Tool (GMSAT) project, run by the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Greater Manchester, in collaboration with the Stroke Association, trained 15 coordinators to use the tool and then tested in 10 pilot sites across England. The results show that our Information, Advice and Support Coordinators were able to identify and address a large number and variety of unmet needs from depression and fatigue to incontinence.

Competencies

In some areas, competencies have been agreed to support the delivery of quality review processes and ensure some standardisation. Further work may be required locally to ascertain the level of competency and skill mix required to implement reviews effectively.

Stroke Reviewer Competencies **South Central Cardiovascular Network** based on Stroke Specific Education Framework for Review (UK Forum for Stroke Education 2010)		
Knowledge and Understanding of:	**6 Week Review**	**6 Month Review**
The assessment and management of problems: psychological and emotional; social and relationship; cognitive and communication; physiological, physical and functional; neurological, visual and sensory impairments and pain; medical.	4	3
Risk factors for further vascular events (e.g. type and aetiology of current event, lifestyle, socioeconomic, cultural, vascular, familial, genetic, concurrent medications, co-morbidities)	4	4

Considerations

Some key areas for consideration when agreeing who might provide reviews:

- What the right balance is within your local area with regard to provision by voluntary organisations and by stroke versus non stroke specialists. Using people with stroke specialist knowledge might prove more costly and may not be the best use of a skilled resource. However, provision by non-stroke specialist may result in a 'step' being added to the process if the reviewer is unable to provide sufficient information and support without referring the patient on. Reviewers may need to undertake communication training to ensure that people with aphasia are able to access reviews equitably.
- Protocols should be in place that clearly set out how to deal with more complex issues arising at review, particularly to support junior and non-specialist staff undertaking these.
- Our patients and carers discussed the role of GPs in providing reviews. Some patients fed back that, in their experience, variances in stroke knowledge by GPs plus communication issues between hospital, GP and community services meant that they may not always best placed to deliver stroke reviews. Reviewers should be able to share information about a broad range of local services across health, social care, and community sectors.
- In a pilot in Camden job satisfaction was found to be low for a skilled stroke professional doing nothing but reviews. To address this, the post holder's role was extended to include a range of other stroke co-ordination/service development tasks.

How are reviews delivered and where should the review take place?

Attendees at the event felt that patients should be able to choose where they feel most comfortable, no matter what location that may be. It was suggested that the location might vary for individuals with differing levels of family and support networks. Suggestions included:

- Home
- Hospital
- GP practice
- Other community setting

Reviews have been piloted using face to face and telephone approaches. Advantages of telephone based reviews include a shorter time and no travel time / costs. However, reviewers may pick up more issues through face to face contact. Also, it is not easy to involve carers in a telephone review. In Surrey, more patients opted for a telephone review than a face to face review when given a choice

In Lambeth, a group based review is currently being piloted by researchers at King's College London for 12 month post stroke reviews. This group is running in a community setting and results will be published shortly.

Tools have been developed and evaluated in several areas of the country to support the delivery of stroke reviews. These have included standardised paperwork for use

by reviewers, web-based resources, and sets of flow charts spanning areas of potential need. Information and examples can be found on the SIP website.

Considerations

- Patient choice
- Travel time for patients and / or staff
- Mobility of patients attending review
- Costs (overheads, travel etc.)
- Communication issues
- Advantages of seeing home environment
- Equipment requirements
- Standardised approaches that ensure that every review covers the same areas regardless of who delivers it.
- Offering a choice of review (e.g. phone versus face to face)

People with communication disabilities often feel "left out" of discussions with healthcare professionals

How can we support patients to access reviews?

We asked patients and carers how they could best be supported to make use of reviews. Cost implications of these recommendations should be analysed with consideration given to the case for change.

- The appointment
  - Transport should be provided for patients where required.
  - Appointments should be flexible, with extra time allotted for questions.
- Information about the review
  - Information about the review should be provided in multiple formats (post, phone, email).
  - Written information following the review to take away is helpful, particularly where there are communication issues, or where carers/relatives are unable to attend the review.
  - Patients should be provided with a key contact that they can contact if required.
- Communication access

Our focus group explained how people with communication disability often feel 'left out' of discussions with healthcare professionals. They felt that they were not able to ask questions and that this meant these were often a frustrating experience. To help ensure that access to reviews is equitable and the opportunity is maximally used, plans should be in place to support communication.

  - Reviewers should be aware of the needs of people with aphasia and have a range of approaches to support communication (e.g. writing materials, aphasia friendly information materials).
  - Communication support / reviewers should be used where possible.
  - Provision of written information pre and post review is important.

- Asking about communication and evaluating progress in this area is important, as well as exploring any feelings of isolation resulting from communication disability.

Considerations:

Information (both verbal and written) provided at and about the review should be accessible to people with communication disabilities and provided in appropriate formats. This should be locally relevant and messages should be consistent with other patient information materials in use along the stroke pathway.

Benefits of providing transport should be considered and potential costs analysed.

Patients have emphasised the importance of having a single point of contact for information.

Information and data processes

- Reviews should be a continual process. As such, information flow at each stage of the review process is important. This can reduce duplication and improve patient experience as each reviewer can build on previous discussions.
- Information from reviews may need to be shared with other professionals (e.g. GPs) and consideration should be given to how onward referrals will be made.
- Call and re-call processes present a challenge when delivering reviews and clear protocols should be developed locally.
- When developing a local model for delivering stroke reviews, commissioners should consider how easily processes can be coordinated. For example, processes may be more easily coordinated using some more centralised models (such as those provided by voluntary sector organisations). A robust approach to monitoring against the ASI metric must be established. Operational guidance for ASI reporting against this metric is included in Appendix C.

Resource implications: Delivering reviews

The costs associated with delivering six month reviews will be heavily dependent on the chosen delivery model and the size of the local stroke population. Analysis from Lambeth and Southwark (total GP registered population in 2008/09 of 289,747 and 258,245 respectively) indicates as follows:

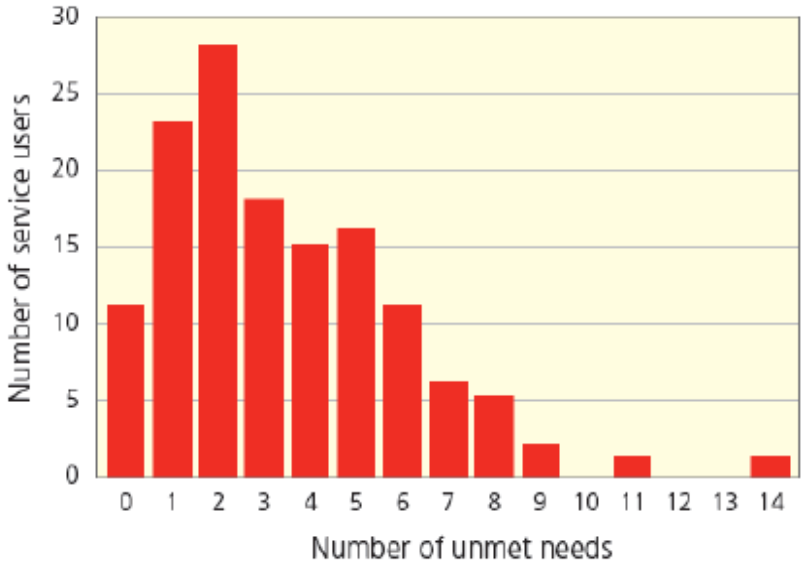
> "Using Information Advice and Support (IAS) workers rather than clinicians is more cost effective. It has been estimated that each review would require an average of 3 hours, including all the 'peripheral' activities such as contacting the service user, travel time, onward referral and follow-up, and data collection. This would require 1050 hours per year, or the equivalent of a full time worker. A FTE band 7 clinician would cost around £53,000.

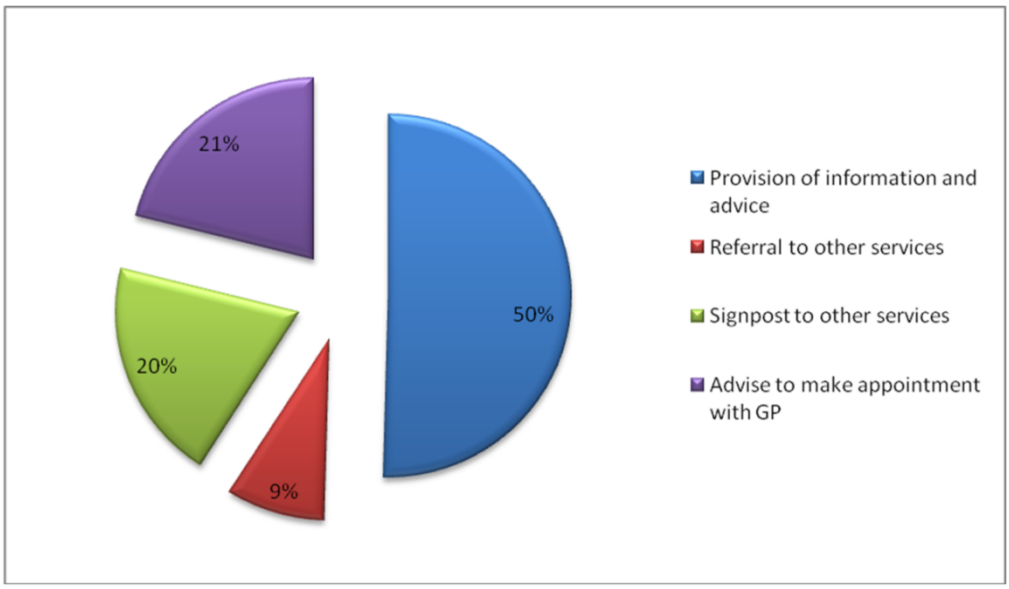
The Stroke Association indicative cost per review, assuming that IAS workers are already employed within the pathway, as in Lambeth, is £45 per review, or £15,750 for reviews across Lambeth and Southwark. However, this cost does not account for the fact that Southwark does not currently employ IAS workers. A conservative estimate of the cost of this option would therefore be £20,000 for implementation across Lambeth and Southwark."

Resource implications: Impact on services

A key consideration for commissioners when looking at review processes is the impact that these reviews have on other local services. These may be cost negative or cost saving (such as reduced GP and stroke consultant appointments) or may have a cost implication (such as identified need for further therapy). The cost implications of onward referral need to be considered in the context of the benefits for patients. Commissioners are advised to undertake a cost benefits analysis, giving consideration to the broader impact of implementing reviews processes.

The CLAHRC GM-SAT project found that the level of unmet need varies from individual to individual, with a range of unmet needs from 0-14. They state that levels of unmet need overall may reflect the quality of broader local service provision.





Work undertaken in Surrey suggested that many needs can be met during the review itself, by providing information and signposting people to local services. They found that over 50 per cent of people had issues addressed during the review. In Camden, it was noted that 30 per cent of people reviewed needed onward referrals or signposting.

Onward referrals from these pilot sites went to a variety of services:

GM- SAT evaluation

	Number of referrals
Audiology	3
Communication support service	3
Continence advisory service	**5**
Counselling service	2
Dietetics	1
Falls clinic	2
Falls prevention service	1
Occupational therapy	**4**
Physiotherapy	3
Psychology	2
Social services	**5**
Speech and language therapy	**5**
Visual impairment service	1
TOTAL	**37**

South Central CSR evaluation

GP
Neurologist
Atrial Fibrillation Team
Cardiac Team
Adult Services
Smoking Cessation
Wheelchair Service
Speech and Language Therapy
Clinical Psychology
Community Therapy Teams

Protocols should be in place to manage gaps in service provision. For example, in areas where no dedicated psychological support for stroke survivors is available, there should be robust arrangements in place to refer patients back to their GP to enable them to access other psychological support services available locally, such as IAPT services, counselling and mental health services.

Where possible, reviews should be used to signpost people to services that would benefit them in the community, such as peer support, group opportunities, befriending, and voluntary sector opportunities. In Telford and North Yorkshire, projects evaluating the impact of Information and Support Workers have described how supporting people to access services in the local community might avoid or reduce other costs related to worsening health and social isolation.

Regular review provides an opportunity to assess care packages already in place, and as such it is important for the process to be joined up across health and social care. In some boroughs, consideration is being given to joint health and social care funding for these reviews, as they are seen as an opportunity to review high cost specialist care packages often associated with stroke.

RECOMMENDATIONS

- Commissioners should seek to ensure that there is provision for stroke reviews for their local population.
- In the absence of a strong evidence base for stroke reviews, the needs and wants of local stroke survivors and their carers should be used to inform service developments in this area.
- Ongoing evaluation should be carried out to assess the efficacy of stroke reviews, and to help inform the evidence base for these.
- Commissioners should review demand and current provision locally and ensure that the reviews process is integrated and aligned with local stroke (and general) services as part of the local stroke pathway.
- Patients and carers should be involved in the design of local review processes to help ensure that services meet their needs.
- Commissioners and providers may wish to review potential approaches to delivery, giving consideration to the following points:
    - How best to support people affected by stroke to access reviews
    - How review processes might best be tailored to meet the needs of the local community
    - Approaches piloted successfully elsewhere and tools / competency frameworks developed
    - An example options appraisal from Lambeth and Southwark is included in Appendix B.

APPENDIX A

Feedback from patients in South London on issues they feel should be included in six month reviews

Medical
• Informing patient about correct medication, whether there are more suitable drugs available and what length of time patient can expect to be on the medication • Give patient a clear explanation of medication purpose and side effects and give a clear choice about which medication to take • Secondary prevention information (e.g. diet or healthy eating) • Information about how to react if patient goes back into Atrial Fibrillation • When, where, how, from whom to seek advice • Raising patients/carers awareness of symptoms and effects • Cholesterol check, full health check to ensure patients have no other linked conditions, INR check • Time for patients to discuss worries and fears • Signposting to further support
Physical

• Showing/providing video clips of how to do the exercises would assist with remembering them
• General advice on becoming more active
  ○ Going to the gym, swimming
  ○ Combination of physical and mental stimulation
• Offer support to family
• More frequent physiotherapy and reviews
• Being able to start rehabilitation at a later date if the patient has turned it down when first offered
• Referral to exercise programme at local leisure centres
• Setting goals for personal and physical improvement
• Discussion about the frustration caused by a reduction in mobility
• Communication problems
• Importance of finding out about the person and tailoring help to their needs (i.e., practical help)
• Evaluation of whether the patient needs stairlift/additional household support
• Timely access to household adaptations
• Patients need regular assessment of their independence (whether they can shop/cook/clean etc)
• Review is an opportunity to look at what care package is in place
• Providing access to domiciliary care/ review if it is needed
• Reviewing current domiciliary provision/access
• Striking the right balance between keeping independence versus accepting help
• Access to assistive technologies/computers

Emotional
• Opportunity to discuss feeling of having had a narrow escape last time and that the consequences would be worse if it happened again

- Opportunity to address fears about becoming helpless if patients were to lose lucidity or become comatose
- Review to be fixed at a time when patient is not fatigued. There is currently not enough consideration for a patient‟s body clock (e.g. physical therapy at 2pm may not suit the patient who may thus become labeled as depressed).
- Depression can be a big issue and formal screening of mood should take place at 6 months. Need to increase the amount of information provided. A patient‟s level of depression can fluctuate and options for medicating depression, Cognitive Behavioural Therapy or counseling should be discussed where needed
- Emotional support for family and/or carer of impact of stroke to avoid feelings of isolation/stress/anxiety
- Feeling isolated may be due to:
    - Transport
    - Lack of group support.
    - Therefore signposting to these services must be available as part of the review.
- Help in controlling emotions – techniques for doing this and adapting
- Greater support in working environment
- Need laughter therapy!
- Buddy/befriending
- Good questions to ask:
    1. How have you changed?
    2. How have your emotions changed?

Leisure and social

- Advice on how patient can get out and about. This is important for their general well-being and to encourage independence. Social activities are enabling and empowering. Compare leisure activities pre and post stroke and link leisure habits assessment with changes to cognitive/physical skills
    - Assess how patient is getting out and about
    - Assistance with getting out to do the things that patient is interested in
- Ability of transport services (including public) to provide appropriate/timely transport (e.g. opportunities to pre-book to avoid waiting for bus and then unable to board as no room for wheel chair)
- Greater communication between NHS and local authorities
- Advocacy (particular for people with communication disabilities)
- Information on transport services/local options
    - Dial a Ride
    - Church groups may offer transport
    - COMCAB/dial a ride: patients get subsidised fares, but needs greater publicity
- Discussion/information about the alternatives to driving/transport provision
- When driving licence has been cancelled due to condition that may improve (such as peripheral vision), patients need to know:
    - When can I drive again?
    - What processes must I go through?
- Using time banking system (where you volunteer time to the community and get the same amount of support in return) to support carers
- Provide information on local resources to look up on hobbies or activities regularly to ensure easier access to people/organisations who provide information and advice
- Discussion about short and longer break holidays

• Peer support – Offering opportunities to link into groups networks of people who have gone through a similar experience. („Stroke clubs are really good.“) • GPs need to be clear about where extra support in the community is available • Help/support/assistance may be available from other places (e.g.links with church groups) • Need regular links between tertiary care, GP centres and community groups to ensure that additional care/support post stroke is in place • Sheltered housing schemes need additional support/need to be looked into • Social workers should have more knowledge about stroke and the services available • Provide local information packs for patients. Information can be sent out via stroke/GP registers. Need to ensure that every borough has this.
Work
• Review needs to be tailored to the individual stroke survivor ie needs to cover impact on job for younger people and possible adaptations for return to work • Need to discuss how the patients work has been affected • Communication with employer about progress • General information about what has happened and the severity • Communication with employer about whether role can be adapted to get patient back to work • Linking OTs with employers • Discussion of vocational rehabilitation needs • Talking about finances - Review needs in relation to benefits • Currently a lack of information about financial support available to patients/carers

APPENDIX B

Lambeth and Southwark Options Appraisal

Option1 – GP led reviews	In this model GPs will trigger and provide the reviews, offering information and advice, and signposting where appropriate and making onward referrals to specialist health services where appropriate. The GP will be responsible for collecting data and information about unmet need.
Option 2 - the dispersed model	In this model reviews are undertaken by health care professionals across the care pathway. • The GP is responsible for identifying patients who are due a six month review and offering a review to those not receiving a review elsewhere. • People who received ESD or MDT treatment will be reviewed at six months, within the community neuro-rehabilitation teams. • People in residential care who were assessed as having no rehabilitation potential at home or in residential care will be offered a follow up review by the stroke specialist services e.g. clinical stroke specialist. • People receiving NHS funded continuing care could be reviewed by the Care Home Support Team (CHST) nurses.
Option 3 – the centralised model	In this model all reviews are undertaken by a stroke specialist worker based within the community rehabilitation service. The reviewer co-ordinates joint reviews, makes onward referrals as necessary and is responsible for collecting data and information about unmet need.

	Option 1 – GP led		Option 2 – across pathway		Option 3 – centralised	
1. A six month review is offered to all stroke survivors	This will not be achieved without additional targets/incentives. It is likely to pose difficulties with people who are unable to access the	1	Centralised co-ordination and monitoring would be required to ensure that all patients are being offered a review	2	Data would need to be collected to ensure reviews offered to all stroke survivors.	3

	surgery or are difficult to engage.					
2. The review is holistic and addresses all areas of need	GP review templates would need to be expanded to include the full range of needs. GPs are unlikely to have the time to undertake holistic reviews.	1	As GPs play a central role this has the same challenges as option 1.	2	A single review tool would be used.	3
3. Standardised to ensure quality and consistency of review and data collection.	Difficulty ensuring that all GPs would need to agree to develop and use a holistic tool and also to collect data from this tool.	1	This has the same challenges as option 1 for those being reviewed by their GP. Standardising across different professional disciplines would pose a challenge.	2	This option allows for standardisation and consistency. The model would need to include arrangements for collection and monitoring of data and information.	3
4. Embedded within the existing stroke care pathways	The reviews would be embedded within the stroke pathway and GPs are able to refer on as appropriate	3	This option is embedded within the stroke care pathway	3	This is fully embedded within the stroke care pathway	3
5. Delivered by people with stroke specialist knowledge	GPs are generalists and most are not stroke specialists. They do not have up-to-date knowledge about practical and social issues and local service provision.	1	Different professionals would be responsible for the reviews, whilst some would be stroke specialist others would not be i.e. GPs and CHST.	2	Reviewers would all be stroke specialist although further discussion is needed to whether they need to be clinically trained.	3

6. There is clarity about roles and responsibilities	GPs have responsibility for patient care in the community, and they have the systems in place which could be adapted to trigger and monitor the reviews	3	This option offers least clarity about roles and responsibilities. Protocols would need to be developed and reviews monitored to ensure that they were being offered.	2	This option provides for clarity	3
7. Information governance arrangements are clear	GPs would collect information but there would need to be some centralised arrangement for collection of data and information.	3	This provides the most challenges for data and information collection. Centralised administration would be required or an IT solution might be possible.	1	Arrangements would be clear and easily managed and monitored.	3
8. Total		**13**		**14**		**21**

APPENDIX C

ASI 8: Assessment and review (from ASI Operational Guidance, Stroke Improvement Programme April 2011)

Proportion of stroke patients that are reviewed six months after leaving hospital.

How does this help patients?

Once people have returned home their needs and circumstances continue to change. People may need support to adjust their lifestyles, to reduce the chance of another stroke, to return to work, to cope with altered roles and relationships and the emotional and psychological impact of stroke.

Background to the measure

The National Stroke Strategy recognises that people who have had a stroke, either living at home or in care homes, should be offered a review of their health and social care status and secondary prevention needs. It sets out a framework for reviews to take place six weeks after leaving hospital following a stroke, and again after six months, and then annually.

The National Audit Office (NAO) found variation in approaches to these reviews and a lack of clarity about who should lead them, their objectives, where they are recorded, the role of GPs in the reviews, and how they were implemented.

Aspiration and rationale

95% of patients with confirmed stroke will be reviewed at six months after discharge from hospital.

Local projects have demonstrated that effective review processes can deliver a range of benefits, including reducing emergency readmissions, improving secondary prevention and providing better support for stroke survivors and their carers.14 The RCP Sentinel Audit 2008 found that 30% of patients were not given a follow up appointment within six weeks of discharge from hospital. The NAO report, 'Progress in improving stroke care' showed that there is no data available on the proportion of patients who have had six months and annual follow ups.

Denominator

Number of people discharged from hospital with a confirmed stroke, who are alive six months following discharge from hospital.

- Exclude patients who have died
- Exclude patients who decline the review or who do not attend an appointment offered
- Exclude patients who live out of the area
- Include all patients, regardless of place of residence (i.e. home, care home intermediate care)

Numerator

Date of stroke	Date of 6m review	When to report
Patient is discharged from hospital on 10th January	Has GP assessment any time between 10th June and 10th August (6 months -/+ 1 month)	End August

Number of patients in the denominator who were reviewed at six months post hospital discharge.

Examples of calculation for this measure:

Tolerance

It is acceptable for the six month review to take place between five and seven months post discharge.

Further guidance and detail

Calculation of six months should be from the date of discharge from the last inpatient setting for acute care or rehabilitation to the patient's final place of residence. If the patient is receiving care only rather than rehabilitation, even if resident in an intermediate care location, the date of discharge from the last *rehabilitation* setting should be used.

If there was an inpatient stay in an acute unit and then a rehabilitation unit, the six months should start from the date of discharge from the rehabilitation unit, regardless of whether the review team who see them cover both units.

The review should be offered to all stroke survivors, even those who may not appear to have a residual impairment. Ideally the six month review should be undertaken by an individual with stroke specialist competencies and training and be part of a locally tailored system. A standardised form will ensure that every review in your area covers the same information, regardless of who delivers it.

Reviews should be a multifaceted assessment of need and should encompass:

- Medicines/general health needs
- Ongoing therapy and rehabilitation needs
- Mood, memory cognitive and psychological status
- Social care needs, carer wellbeing, finances and benefits, driving, travel and transport

A review which included only stroke secondary prevention would not be considered to be acceptable.

Reviews could be carried out at home or in a primary care setting, and could be carried out by social care, however the model of service delivery will need to be decided locally and the content of the review a multifaceted assessment of need.

For continuity, link the information from six week, six month and annual reviews so each reviewer can build on previous discussions. Patients/carers should be given a copy of the outcome of the review and provided with contact details of who to contact for more information.

Include measures that can be used to identify change over time, both for the individual and for the service.

Further information about reviews can be found on the Stroke Improvement Programme
website. www.improvement.nhs.uk/stroke