SCHEDULE 2 – THE SERVICES

A. Service Specifications (B1)

Service Specification No.	
Service	Early Supported Discharge for Stroke Patients v4.1
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Public Health Lead	Ian Diley (Suffolk County Council)
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 National / local context and evidence base

In 2012 The former Midlands and East Strategic Health Authority produced a model service specification which was informed by the following guidance:

National Stroke Strategy (2007) Department of Health.
National Clinical Guidelines for Stroke (2012) Royal College of Physicians
Quality Standards Programme: Stroke (2010) National Institute for Clinical Excellence.
Stroke Service Standards (2010) British Association of Stroke Physicians
Quality and Outcomes Framework for 2012/13 (2011) NHS Employers.
The NHS Outcomes Framework 2012/13 (2011) Department of Health.
A Public Health Outcomes Framework for England 2013-2016 (2012) Department of Health.
The 2012/13 Adult Social Care Outcomes Framework (2012) Department of Health
Supporting Life after stroke (2011) Care Quality Commission

West Suffolk CCG and Ipswich and East Suffolk CCG established a joint Suffolk Stroke Network to examine the specification and submit a template of current and proposed services. Following this review, the Governing Bodies of both CCGs issued a Statement of Intent for Stroke Services which prioritised Hyperacute Stroke Services and Early Supported Discharge as being two key service changes required locally.

In June 2013, the National Institute of Health and Clinical Excellence (NICE) published guidance on Stroke Rehabilitation, which has been taken into account in the preparation of this Service Specification.

2. Outcomes

2.1 NHS Outcomes Framework Domains and Indicators

The implementation of the service described in this specification is anticipated to contribute towards improvement in the following indicators from the NHS Outcomes Framework:

Domain 1	Preventing people from dying prematurely	• Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare
Domain 2	Enhancing quality of life for people with long-term conditions	• Health-related quality of life for people with long-term conditions • Ensuring people feel supported to manage their condition • Improving functional ability in people with long-term conditions • Employment of people with long-term conditions • Enhancing quality of life for carers • Health-related quality of life for carers
Domain 3	Helping people to recover from episodes of ill-health or following injury	• Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months • Proportion of patients recovering to their previous levels of mobility/walking ability at 30 and 120 days • Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation service • Proportion offered rehabilitation following discharge from acute or community hospital
Domain 4	Ensuring people have a positive experience of care	• Improving people's experience of integrated care
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm	• Patient safety incidents reported • Safety incidents involving severe harm or death

2.2 Local defined outcomes

- To ensure that people who have had a stroke achieve maximum independence and reduce reliance on long term care.
- Proportion of stroke patients in receipt of the early supported discharge service reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months
- Proportion of stroke patients in receipt of the early supported discharge service reporting an improvement in Barthel score at 6 months.

3. Scope

3.1 Aims and objectives of service

- To provide a 7-days a week early supported discharge service for eligible patients who have suffered a stroke
- To improve the uptake of early supported discharge services by patients with a Barthel Score greater than 9
- To ensure carers are appropriately educated and trained to recognise common causes of illness that result in avoidable admissions e.g. constipation, urinary tract infection
- To contribute to reductions in hospital re-admission rates
- To facilitate timely discharge from inpatient facilities of all eligible stroke patients
- To facilitate a reduction in length of hospital stay following diagnosis of stroke
- To ensure equity of access to Early Supported Discharge
- To reduce the likelihood of mental health problems in carers and patients
- To include capacity for on-going patient and carer evaluation of early supported discharge services
- To improve patient and carer satisfaction
- To effect transfers of care in a person-centred and timely way
- To facilitate improvements in the overall patient pathway including performances in national audits
- To ensure appropriate access to community rehabilitation services and long-term care provision following early supported discharge, if required"
- To facilitate appropriate interaction between health and social care to maximise patient benefit

3.2 Service description / care pathway

3.2.1. Referral mechanism:

- There will be a direct pathway of referral from the Stroke Units and must be from an acute stroke healthcare professional following comprehensive assessment
- Within 24hrs of the point at which the patient becomes eligible, they will be transferred and discharged to the ESD services. The Acute hospital must notify the service on both the occasion the patient is identified as being likely to meet the referral criteria, and the actual point at which the patient is ready for discharge.

3.2.2. Eligibility criteria (all the following must apply):

- Patients must understand the nature of the service they are being referred into and give consent to participation
- The patient should have a confirmed diagnosis of stroke which is the cause of their present admission
- Transfer dependency will be that patients can transfer safely from bed to chair i.e. can transfer with one able carer, or independently if living alone.
- Patients eligible for ESD will have a Barthel of greater than 9
- Rehabilitation goals must be identifiable
- The patient must be medically stable with appropriate medical investigations completed
- Patients should not have unmet needs with regard to urinary or faecal continence. Where this is an issue, the relevant care package should be in place to treat these effectively.
- Patients should have the ability to raise the alarm if required and support self-nutrition
- The patient cannot be discharged until necessary care, equipment and transportation are in place
- Patients should not knowingly be discharged into an unsuitable home environment based on clinical or social care assessment
- There should be an agreed strategy between the ESD and the Acute Trust in the event of patient

deterioration

If a patient has an NG tube he or she should be considered for acceptance, subject to satisfactory risk assessment. The Acute Trust will not be penalised financially for a readmission for the purposes of inserting a PEG.

3.2.3 Service Operation

The service provider will operate as follows:

- Develop a proactive approach with timely case identification
- Only accept a patient to the service following discussion and agreement that the patient has a confirmed diagnosis of stroke;
- Accept all referrals from acute stroke pathway satisfying the eligibility criteria;
- Deliver the service within the patient's place of residence;
- Deliver the service 7 days a week;
- Provide a rapid same-day response where possible;
- Be time-limited, with the expectation being that the service will be provided for up to 6 weeks for each patient;
- Promote independence using evidence based rehabilitation techniques when assisting with activities of daily living
- Involve all relevant parties in goal setting to achieve optimal function and independence
- Involve specialist assessment, active therapy, treatment, or opportunity for recovery, working to a structured individually tailored goal orientated treatment plan;
- Develop a comprehensive multidisciplinary team (MDT) plan in liaison with acute health care providers at the time of discharge from acute care; to include assessment of social situation/support mechanisms, participating in home visits, equipment provision and review, relevant training for informal carers, psychological decisions support tools, leisure and occupational needs and referral to other agencies.
- Ensure effective treatment planning and co-ordination with seamless handover;
- Establish with the acute trusts a mechanism for identifying where transfers into the early supported discharge service have been delayed
- Identify a key worker to liaise with the family and carers;
- Ensure seamless transfer between services if a patient needs to move to an alternative provider (including referral to specialist treatment);
- Be free of charge to the service user
- Work to any agreed clinical governance policies that exist
- Support partnership working with Local Authority, health and voluntary sector to support delivery of quality mainstream home care, domiciliary care day care services
- Be responsible for raising awareness of the early supported discharge service for stroke patients.

The Service will contain the following disciplines, which will be deployed to care for patients as appropriate:

- Physiotherapists, Occupational Therapists, SLT, Social Workers and Clinical Neuropsychologists.
- Rehab assistance practitioners or generic worker assistants that could be multi-skilled.
- A Consultant with predominant interest in Stroke as defined by at least 5 programmed activities per week, of which 4 must be direct clinical contact.

- A Dietician, with output response times within 48 hours.

The intensity of therapy will be 45 minutes per appropriate therapy area 5 times per week as per NICE Clinical Guidelines for Stroke Rehabilitation, with the exceptions also laid out in that Guideline.

The service provider will be expected to incorporate a measure of emotional wellbeing into its assessment which will use the same assessment tools as the acute setting and allow the detection of changes.

3.3 Population covered

- As per detailed in the referral criteria detailed in section 3.2, applicable to patients registered with a general practitioner in West Suffolk CCG or Ipswich and East Suffolk CCG

3.4 Any acceptance and exclusion criteria and thresholds

- As per detailed in the referral criteria detailed in section 3.2, applicable to patients registered with a general practitioner in West Suffolk CCG or Ipswich and East Suffolk CCG

3.5 Interdependence with other services/providers

Which other services or service providers will this service rely upon or be relied upon in order to function effectively.

- West Suffolk Hospital
- Ipswich Hospital
- Suffolk Community Healthcare
- Adult Social Services
- Voluntary Sector
- Mental Health Services
- Primary Care

The ESD will cover all patients from Ipswich and East Suffolk CCG and West Suffolk CCG. Where there is a patient who is registered with a General Practice at one of these CCGs, but is resident in a county other than Suffolk, the service provider is expected to co-operate fully with the patient's resident local authority.

The provider will be expected to have a good working knowledge of onward services and effect a seamless transfer to empower the patient to access those services, e.g. through discharge documentation.

4. Applicable service standards

4.1 Applicable national standards (e.g. NICE)

- National Institute of Health and Clinical Excellence (Quality Standards and Clinical Guidelines relating to Stroke and Stroke Rehabilitation)
- Royal College of Physicians - Sentinel Stroke National Audit Programme, and any equivalent successors

4.2 Applicable standards set out in guidance and / or issued by a competent body

The provider will be expected to fully collaborate with any service improvement project initiated by the

East of England Cardiovascular Strategic Clinical Network, and send a relevant health professional or manager to network meetings.

4.3 Applicable local standards

For onward referrals, the provider will be expected to adhere to the pathways set in place by Ipswich and East Suffolk CCG and West Suffolk CCG, as appropriate.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (see schedule 4, Parts A-D)

See the appropriate parts of the standard contract and insert into this section.

5.2 Applicable CQUIN goals (See schedule 4 Part E)

See the appropriate parts of the standard contract and insert into this section.

6. Location of Provider Premises

The Provider's premises are located at:

7. Individual Service User Placement

8. Information Requirements - Key Performance Indicators

8.1 General comments

As a new service within Ipswich and East Suffolk and West Suffolk, the Information Requirements have been constructed with the following aims.

a) A broad evaluation of the service, including service impact within the healthcare system (***see section 9: Information Requirements – Service Evaluation***)
b) Quality and performance of the service
c) Patient experience
d) Participation in SSNAP, an audit carried out nationally by the Royal College of Physicians

Where percentages are given as KPIs, the provider will be expected to provide both the numerator and denominator.

8.2 Key Performance Indicators relating to the quality and performance of the service:

Performance in indicators within this section measure whether the service is having the expected impact, and that the reasons for variation in these indicators are principally internal to the service.

#	Indicator	Denominator	Numerator	Threshold
1	Percentage of stroke survivors in receipt of early supported discharge who received a face-to-face specialist assessment[2] by the service within one day of discharge from the acute hospital[1]	Number of stroke survivors in receipt of early supported discharge	Number of stroke survivors in receipt of early supported discharge who received a specialist assessment[2] by the service within one day of discharge from the acute hospital[1]	100%

2	Percentage of patients who have recorded Modified Rankin Scale and Barthel scores on both entry to the service (this will be recorded on the discharge summary by the referrer) and on completion[3]	Number of stroke survivors in receipt of early supported discharge	Number of stroke survivors in receipt of early supported discharge who have recorded Modified Rankin Scale and Barthel scores on both entry to the service and on completion	100%
3	Percentage of patients supported to live in their own homes	Number of stroke survivors in receipt of early supported discharge who were discharged from acute hospital to their own home	Number of stroke survivors in receipt of early supported discharge who were discharged from the acute hospital to their own home and six weeks later were still in their own home on discharge from the early supported discharge service.	85%
4	Percentage of patients who withdraw their consent to participation in the service	Number of stroke survivors in receipt of early supported discharge	Number of stroke survivors in receipt of early supported discharge who withdraw their consent for participation prior to the end of treatment	<5%
5a	Percentage of patients in receipt of treatment intensities described in the NICE Clinical Guidelines for Stroke Rehabilitation – Physiotherapy[4]	Patients in receipt of early supported discharge	Patients in receipt of early supported discharge who receive 45 minutes of physiotherapy at least 5 times per week	70%
5b	Percentage of patients in receipt of treatment intensities described in the NICE Clinical Guidelines for Stroke Rehabilitation – occupational therapy[4]	Patients in receipt of early supported discharge	Patients in receipt of early supported discharge who receive 45 minutes of occupational therapy at least 5 times per week	67%
5c	Percentage of patients in receipt of treatment intensities described in the NICE Clinical Guidelines for Stroke Rehabilitation – speech and language therapy[4]	Patients in receipt of early supported discharge	Patients in receipt of early supported discharge who receive 45 minutes of speech and language therapy at least 5 times per week	37%

[1]For the purposes of these Key Performance Indicators, the acute trust will be expected to notify the service provider that there is a patient currently on the stroke unit who is likely to qualify for early supported discharge. The clock starts when a second contact is made from the stroke unit confirming that the patient is ready for discharge, and is at that point meeting all the eligibility criteria laid out in section 3.2.2.

[2] A specialist assessment is defined as being carried out by an assessor who has received specialist training in stroke rehabilitation

[3] For the purposes of this indicator, a Barthel and Modified Rankin Score taken on discharge from the acute hospital would qualify for the 'entry into service' component of the indicator.

[4] For the purposes of reporting this indicator, the provider is expected to deliver these **KPIs for all localities**, and to provide a breakdown by locality which can be identified from the patient's GP; for Ipswich and East Suffolk CCG localities consist of Ipswich, Suffolk Brett Stour, Commissioning Ideas Alliance and Deben Health. For West Suffolk CCG this consists of Bury St Edmunds, Blackbourne, Sudbury and Forest Heath.

8.3 Patient Experience

#	Indicator	Denominator	Numerator	Threshold
6	Percentage of service users who would be happy for friends or family to be cared for by early supported discharge service at the end of treatment by the service[1]	Number of stroke survivors in receipt of early supported discharge	Number of patients in receipt of the early supported discharge service who answer 'yes' to the question 'would you be happy for your friends or family to be cared for by early supported discharge service?'	The threshold will be the same agreed for Ipswich Hospital and West Suffolk Hospital for that contracting year.
7	Percentage of service users who were treated with respect[1] • Always • Mostly • Rarely • Never	Number of stroke survivors in receipt of early supported discharge	Number of patients in receipt of the early supported discharge service who at the end of treatment answered the question 'were you treated with respect and dignity?' as follows: • 'Always' • 'Mostly' • 'Rarely' • 'Never'	100% in combined category of 'always' or 'mostly'.
8	'Did you feel fully involved in setting goals for your treatment?'	Number who answered 'yes' to the question 'Did you feel fully involved in setting goals for your treatment?'	Number who answered the question 'Did you feel fully involved in setting goals for your treatment?'	100%
9	Patient Survey Completion	Number of stroke survivors in receipt of early supported discharge	Number who answered all 3 questions in relation to KPIs 6-8'	This value will be determined by response rates currently attained from other providers

[1]Exception reporting will be allowed where it is documented that neither the patient nor the carer is capable of answering this question, due to reasons of cognitive impairment or aphasia.

#	Open question to be collected from all patients
10	"How did you find the service?"

9. Information Requirements – Service Evaluation

9.1 Information collection

Performance in indicators within this section measure whether the service is having the expected impact, though the reasons for variation in these indicators are not necessarily internal to the service. The provider will be expected to collect this information.

#	Information for collection	Denominator	Numerator
E1	Percentage of appropriate accepted referrals for stroke survivors who are supported by a stroke skilled early supported discharge[1]	Number of patients with newly diagnosed stroke alive at discharge from the acute hospital	Number of patients newly diagnosed stroke alive at discharge from the acute hospital who appropriately receive early supported discharge
E2	Percentage of stroke patients in receipt of early supported discharge who required emergency inpatient readmission within 30 days[2]	Number of stroke survivors in receipt of early supported discharge	Number of stroke survivors in receipt of early supported discharge who were admitted to an acute hospital as an emergency inpatient admission within six weeks of their original discharge
E3	Feedback to the Commissioner on inappropriate referrals	Number of referrals to the early supported discharge service	Number of referrals to the early supported discharge service meeting eligibility criteria at point of transfer
E4	Mean length of inpatient stay for patients transferred into the early supported discharge service		
E5	Median length of treatment for patients in receipt of early supported discharge		
E6	Number of carers receiving a needs assessment using a validated tool (e.g. Caregivers Strain Index)		

It will be expected that the Provider will be fully engaged in any evaluation and audit process of the service with the Commissioner or the Referrer, including both health and social care.

9.2 Participation in SSNAP

The provider will be expected to participate in relevant sections SSNAP, an audit carried out nationally by the Royal College of Physicians, and equivalent successors.