# SCHEDULE 2 – THE SERVICES

1. **Service Specifications**

|  |  |
| --- | --- |
| Service Specification No. | **001** |
| Service | **Sandwell Stroke Recovery Service** |
| Commissioner Lead | **Sandwell and West Birmingham CCG** |
| Provider Lead |  |
| Period | **1st July 2021 – 30th June 2024** |
| Date of Review | **20th June 2021** |

|  |
| --- |
| **1. Population Needs** |
| * 1. **National/local context and evidence base**   **Stroke, a preventable disease, is the fourth single leading cause of death in the UK and the single largest cause of complex disability**. During hospital stay stroke survivors have access to on-call help and care; however, after discharge they have to adjust suddenly to the impact of stroke and changes to their life at home. Rebuilding a life after stroke, is a challenge over 100,000 people are faced with across the UK every year. Early access to rehabilitation can help restore movement, improve recovery, and reduce delayed discharges.  The impact of stroke varies hugely. A third of people develop depression and experience communications difficulties affecting long term recovery and achievement of personal goals and aspirations.  The National Stroke Strategy (2007) set our radical changes to stroke care which health economies have steadfastly met. The need to improve stroke services always continues and recent drivers include;   * NHS Long Term Plan – NHSE (2019)[[1]](#footnote-1) * Strategic Framework for Advancing Stroke Services – West Midlands Clinical Networks (2020)[[2]](#footnote-2) * Practical guidance supporting the 2019-20 Commissioning for Quality and Innovation (CQUIN): Six-month reviews for stroke survivors (2019)[[3]](#footnote-3)   Individuals who have had a stroke, and their relatives and carers, want to be kept informed, be included and have a clear, consistent point of contact throughout the pathway. Knowing how to access and receive support to navigate a range of services and support across health, social care, housing, transport, employment, education, leisure and the voluntary sector is key to the delivery of tailored services to meet individual, long-term needs and to achieve the desired goals. |

|  |
| --- |
| **2. Scope** |
| **2.1 Aims and objectives of service**  The purpose of the stroke recovery service is to improve patient outcomes following a stroke by providing people affected by stroke and their families/carers with high quality information, emotional support, practical advice and assistance. The aim of the service is to achieve a good quality of life for the individual and their carer by maximising independence, well-being, and choice.  The objectives of this service are: -   * To promote an optimum quality of life for patients and carers after a stroke; * Reduced impact of stroke on the individual and the stress felt by family and significant others in caring for the individual after a stroke * Support a smooth transition from hospital to home; * Ensure that service users and carers are systematically offered a 6-month review after the stroke to assess their needs. * Ensure the effective provision of information and emotional support available to stroke survivors, their families and carers in order to promote better physical and psychological health * Promote the individual who has had a stroke in their ability to manage the effects of stroke and to take more control and exercise more choice regarding their on-going care and support needs; * Promote the individual’s confidence and motivation to achieve their goals in all aspects of their lives; * Promote the carer’s confidence in effectively supporting the individual who has had a stroke * Support the individual who has had a stroke in their ability to understand the risk factors for stroke and support them to make healthier lifestyle choices and prevent further strokes / TIAs resulting in further hospital stays or a transfer to registered Residential / Nursing care; * Promote the individual and their carer in social contact with others, either one to one or in small groups (networks) for peer support; * Support the individual and carer to access facilities and services in their community and where appropriate to find, regain or remain in work and access other occupational and educational opportunities * Promote integrated services through Integrated Stroke Delivery Networks and seamless care and support for the individual who has had a stroke and their carers.   The service will also contribute to the achievement of the following health outcomes: -   * Reducing the number of people who smoke; * Reducing obesity and improving diet and nutrition; * Increasing physical activity; * Adopting sensible drinking habits; * Reducing high blood pressure; * Reducing mortality from stroke; * Reducing emergency re-admissions to hospital.   **2.2 Service description/care pathway**  Following discharge stroke patients must adjust suddenly to the impact of stroke and changes to their life at home. Early access to rehabilitation can restore movement, improve recovery and reduce delayed discharges.  Individuals who have had a stroke, and their relatives and carers, want to be kept informed, be included in decision making regarding their care, and have a clear, consistent point of contact throughout the pathway  The service will play a key role in stroke recovery, supporting smooth transition from hospital to home.  This service will be delivered in line with the Stroke Association’s ‘Life After Stroke’ service model which includes the following elements: -   * **Information -** through an initial standardised information pack followed by needs-led information, advice, explanation and signposting. Information will be provided, as needed, concerning all aspects of stroke including jargon-free explanations to ensure understanding. Also included will be information concerning local services, statutory, voluntary and paid, which will aid rehabilitation. * **Advice and support -** this will include emotional support, listening to families, working with them to find practical solutions to problems they face in daily life, and provide that vital on-going point of contact. Co-ordinators will be trained to look for signs of low mood and depression. They will refer on as appropriate and work with the families to find ways to build confidence and self esteem in the individual following a stroke. Other support includes advocacy with health and social care services and other statutory and non-governmental organisations and welfare advice where families will be advised and signposted to ensure their take-up of all available benefits. * **Stroke prevention -** primary and secondary prevention of stroke in supporting the individual and family to identify risk factors and promoting healthy choices. Contribute to awareness-raising days for the public, including stroke prevention awareness and improving knowledge of the FAST message * **Communication support -** whilst the service does not provide specific and targeted support for people with communication difficulties after stroke, their needs will be assessed and met as far as is possible. This will include referring and signposting, as well as facilitating peer support. * **Re-ablement and social inclusion –** to promote and support independence through self-care and management as far as possible, to maximise choices, health and well-being. Lessen the social isolation experienced by many stroke survivors and their families through reintegration into community life. Signposting to services such as housing, transport, employment, education, and leisure to meet individual goals * **Carer support –** promote psychological health among carers and provide re-assurance of ongoing support in practical advice, emotional support, signposting to other services and ad hoc requests for assistance. Where necessary the service will advocate on behalf of carers and their rights. * **6 month post stroke assessments –** undertake a systematic approach to offering assessments for stroke survivors 6 months after the stroke event in regard to biological, psychological and social issues using a validated assessment tool and address the identified needs with appropriate intervention, signposting or referral. This assessment is ideally done face to face or in some circumstances done via telephone.   The provider shall deliver these elements of service through suitably trained and skilled staff members in a coordinator role and using appropriately trained, supported, as well as appropriately vetted volunteers.  The provider shall ensure the coordinators have the necessary administration support for their roles to enable the service to operate efficiently and effectively.  The provider shall ensure that contact is made by the service to all stroke survivors and their families soon after the stroke event whether that is while they are still in hospital or in the community. Ongoing contact by visiting the individual’s home (if safe to do so and within COVID guidelines) and via telephone will be maintained according to patients’ needs and wishes up to a period of 12 months after the stroke event.  The provider shall ensure that stroke survivors and their families have a contact number for the support service and other useful contact telephone numbers in case of emergency. The service will aim to respond to ad hoc contact from stroke survivors or their families within 24 hrs.  The provider shall ensure they deliver this service in a culturally sensitive way that ensures all parts of the community are able to receive an equivalent service. All information will be available in various formats and in various languages.  To deliver a coordinated service model for stroke care in the community, these coordinator roles will be an integral member of the Sandwell Stroke Early Supported Discharge Service (ESD). The caseload for this service will not be limited to the ESD service but will cover all stroke survivors in Sandwell. The integration of this service with the ESD will enable improved joined up care for those patients that are receiving support for both those services.  The provider shall assess all referrals within 5 days of referral being received.  **2.3 Population covered**   * The individual must be registered with a Sandwell GP; * The individual must be 18 years or over; * The individual must have recently had a stroke; * The individual and their family / carer must wish to be referred to the Service.   **2.5 Interdependencies with other services**  As described above, the family and carer support service will be provided within the ESD service in an integrated way to the ESD caseload. As a part of this multi-disciplinary team the co-ordinators will contribute to the case discussions for the ESD patients and add their assessments and observations with the rest of the team.  The provider will be able to receive advice where necessary from colleagues within the ESD service as necessary and vice versa.  The provider shall ensure close liaison with other services within the stroke pathway by sharing information, working collaboratively, and operating in an open and inclusive way with other service providers. |
| **3. Applicable Service Standards** |
| **3.1 Applicable national standards**  The National Stroke Strategy sets out several quality markers (QM) needed for raising the quality of treatment and care and improving outcomes for stroke survivors and their carers. Markers of a quality service about information, advice and support, and long-term care and support are defined as: -   * QM3 – ‘People who have had a stroke, and their relatives and carers have access to practical advice, emotional support, advocacy and information throughout the care pathway and lifelong’. * QM10 – ‘People who have had strokes access high quality rehabilitation and, with their carer, receive support from stroke-skilled services as soon as possible after they have a stroke, available in hospital, immediately after transfer from hospital and for as long as they need it’. * QM13 – ‘A range of services are in place and easily accessible to support the individual long-term needs of individuals and their carers’.   **3.2 Applicable local standards** |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Quality requirement** | **Method of measurement** | **Period** | **Consequence of breach** | **Threshold** | | % of patients reporting they have a better understanding of stroke | d) Number of patients having an assessment  n) Number of patients reporting a better understanding of stroke | Quarterly | GC9 | 80% | | % of patients reporting they have a greater capacity to self-manage | d) Number of patients having an assessment  n) Number of patients reporting greater capacity to self-manage | Quarterly | GC9 | 80% | | % of patients who identified needs have been addressed | d) Number of patients having an assessment  n) number of patients whose needs have been met | Quarterly | GC9 | 80% | |

|  |
| --- |
| **4. Location of Provider Premises** |
|  |
| The Provider’s Regional Premises are located at: - |

1. <https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/better-care-for-major-health-conditions/stroke-care/> [↑](#footnote-ref-1)
2. <https://www.england.nhs.uk/midlands/wp-content/uploads/sites/46/2019/11/ACAI_9554_Regional-Stroke-Strategy-Publication_full_v10.pdf> [↑](#footnote-ref-2)
3. <https://www.england.nhs.uk/publication/practical-guidance-supporting-the-2019-20-cquin-six-month-reviews-for-stroke-survivors/> [↑](#footnote-ref-3)