

Clinical Standards Committee

Recommendations for Providing Six Month Reviews Post Stroke

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Introduction

A vital part for all stroke services is that they are subjected to rigorous quality improvement measures in order to attain clinical excellence and improve patient outcome and experience. This process requires development of applicable and meaningful standards so one can objectively assess how well a service is performing and allowing benchmarking of performance. Recording six month assessment data will have an important impact to both patients and professionals in identifying unmet need as well as measuring the impact of services are having on patients being treated for stroke. This current document developed by the British Association of Stroke Physicians (BASP) Clinical Standards Committee provides a framework to support clinicians in collaboration with commissioners to develop and deliver six month reviews to all applicable stroke survivors. It details the key drivers for change, the current organisation of services, the content of reviews, models of delivery, performance targets, recommendations and future research.

Drivers for Change

The English National Stroke Strategy recommends that stroke survivors should receive regular reviews of their health and social care status and secondary prevention needs, typically within six weeks of discharge home or to care home and again specifically six months after they have left hospital [1]. This is now supported by the NICE Quality Statement signifying that adults who have had a stroke should have a structured health and social care review six months and 1 year after stroke and then annually [2]. This is also endorsed by the Royal College of Physicians National Clinical Guidelines for Stroke recommending specialist referral, if new problems are identified at six months or if the person's physical or psychological condition or social environment has changed [3]. The Stroke Association has also listed this as one of its main priorities in its Strategy (2015-18) [4]. The aim of these reviews are to ensure that stroke survivors feel supported in the long term and provide access to further multidisciplinary specialist review, advice, information, support and rehabilitation where appropriate. However, the National Stroke Strategy offered no further detail with respect to the content of such a review, who it should be led by and how it should be delivered. This lack of clarity has meant that, in many parts of the UK, such six month reviews are not routinely offered or commissioned despite being embedded in the Clinical Commissioning Groups Outcome Indicator Set (CCG OIS) [5]. The CCG OIS sets out a requirement for all stroke survivors to receive a follow up assessment between four and eight months after initial admission to hospital following a stroke. There is also variation on how such data is recorded and submitted to the Sentinel Stroke National Audit Programme (SSNAP) with only a third of services carrying out

these reviews submitting six month data on to SSNAP [6]. SSNAP records information on mood, behaviour and cognition screening and whether support is required for this, current accommodation status, disability status, presence of atrial fibrillation, current secondary prevention therapy and evidence of stroke recurrence. It is therefore important to use this data to measure the impact of the quality of care delivered across the whole pathway in the longer term.

At present, there is not a strong evidence base regarding the benefits of stroke reviews in terms of patient outcomes, however anecdotal evidence from areas of good practice reveal a number of potential benefits including [7]:

- Avoidance of hospital admission (avoiding escalation of problems)
- Identification of secondary prevention needs (e.g. Undiagnosed atrial fibrillation, hypertension, medications management) and modification of risk factors
- Opportunities to reduce dependency by identifying further rehabilitation needs
- Improved quality of life
- Potential to improve access to voluntary sector support services (by highlighting areas where voluntary services can meet needs)
- 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's needs
- Reduced duplication between services and improved joint working across agencies
- Opportunities for improved data collection processes, audit, improving performance monitoring and inform service development needs

Current Organisation

From the SSNAP Organisational Audit Programme (2016) [6], only 68 out of 178 (38%) acute stroke services were commissioned to undertake six month reviews. 87 sites (50%) state that they performed such reviews, implying that many sites were carrying out reviews in the absence of any formal commissioning arrangements. Therefore, a significant proportion of the stroke population are still being denied an opportunity to undergo formal health and social structured assessments.

There was also variation in the delivery of six month reviews involving a number of different multiple providers across the pathway. These included community rehabilitation and early supported discharge teams, family and carer support services, outpatient clinics and stand alone 6 month stroke co-ordinator posts. Of these providers, 36% were undertaken by stroke co-ordinator posts, 10% by therapists, 7% by community nurses, 6% by voluntary service employees and 8% by secondary care clinicians [8]. In addition to this, there was wide variation in six month data input to SSNAP with 31% of family and carer support services and 75% of dedicated six month stroke co-ordinator services submitting data demonstrating inconsistency of quality data provision. In terms of the method of follow up characteristics, 83% and 17% of cases were performed in person and by post respectively. Electronic on-line services were not used. Without such a comprehensive review of six month data, many patients are missing out on vital assessments of their stroke secondary prevention, stroke recovery and disability management as well as any unmet clinical and social care needs.

What should a six month review consist of?

Typically services should be commissioned to provide six month review services to assess progress and needs to happen four to eight months after a patient's stroke. The review should be specifically tailored towards the individuals needs of the patients and initially consist of screening using the SSNAP minimum data set and then to proceed to use appropriate tools where necessary to identify key unmet post stroke needs across a number of domains. This will help to facilitate a clear pathway for specialist review where necessary for risk factor management, advice, information support and rehabilitation where required [9]. The five key domains include:

- **Medical** (*medicine management, compliance, risk factor management -blood pressure, anti-thrombotic therapy, weight control, nutrition, exercise, cholesterol, smoking, alcohol*)
- **Physical** (*on going therapy and rehabilitation needs-vision, hearing, communication, swallowing, mobility, falls, pain, continence*)
- **Cognitive and Emotional** (*mood, anxiety, emotionalism, fatigue, sleep, personality, sexual health*)
- **Leisure and Social** (*benefits and finance, driving, transport and travel, activities and hobbies, work, house and home*)
- **Needs of carer (s)**

There are a number of nationally recognised, standardised tools [10,11,12,13] as well as 'in house' tools [14] in operation with in-depth review and coverage of ongoing needs as described above. It is important that the reviews undertaken specifically cater for and are of relevance to the individual rather than applying an assessment tool universally for every patient. Services should be commissioned on the basis of the use of an assessment tool where necessary to ensure a quality review. It is important to acknowledge that patients with communication and cognitive deficits may require additional support to participate in the assessment and that the assessment process will need to be flexible to meet the needs of stroke survivors for who English is not their first language. Once these assessments have been undertaken, referral and signposting to other services such as stroke specialist rehabilitation, social care, peer support, befriending and voluntary sector support can be undertaken. Once the review has been undertaken, recommendations should be documented and sent to the patient's GP as well as including the patient with relevant contact details for further information. It is vital that six month review providers enter the relevant metrics onto the SSNAP minimum data set indicating also the date of review, discipline of the person conducting the review and whether the review was conducted by phone, person, online or post (Appendix 1).

Models of Delivery

When choosing a model of delivery to implement locally, it is important that commissioners appreciate how the model will be embedded within the entire stroke pathway and to ensure that data collected is then used in a patient centred approach according to individual need. Thus it is vital that the six month service review does not operate in isolation but collaboratively with secondary care, primary care, social care and voluntary services. (Appendix 2)

Identification of patients

Commissioners and providers should seek absolute clarity on how eligible patients (adults > 18 years, living in CCG area and registered with GP and are alive within six months of stroke) are referred including data sharing. Patients may be identified from the following referral routes such as discharge from hyper-acute stroke unit or stroke unit, early supported discharge team, community stroke team, care home and their own home (if they have not required hospital admission). In addition to this, some patients may have been treated in acute hospitals external to their responsible CCG. It is therefore important the discharging organisation (whether it acute, ESD or community rehabilitation teams) has developed a mechanism to ensure that six month review

providers are in receipt of the necessary discharge notification information including confirmed discharge date. This is to ensure that all eligible patients are referred accordingly and to enable the review provider to plan when to contact the patient. In addition to this, the patients GP can provide the reviewer with an updated medications list and current cardiovascular health information. Providers of six month review services must be registered to the SSNAP web tool to ensure review metrics are entered into the database. In the context of not being able to contact patients for a review, the provider and commissioner need to agree a pathway for escalation locally to maximise the notification process.

Location of Review

These can be undertaken in a number of settings including patient's home or usual residence (e.g. care home), outpatient clinics, general practice or other community settings. Commissioners will need to ensure there is flexibility with each model to ensure maximum uptake of reviews according to needs of patients. Factors driving location of assessment include patient choice, travel time for patients and reviewer, mobility, communication issues and costs. Advantages of home reviews include assessing patients in their own home and observing how well patients are coping. In many instances, face to face reviews should be offered as the preferred method however telephone reviews can also be offered depending on patient choice and accessibility. Benefits of face to face reviews include blood pressure measurements, ability to deal with language and cognitive deficits and assessments of carer's needs. However telephone reviews may be more time efficient and provide greater accessibility. Average time for assessments vary between 60-90 minutes for face to face and 30-45 minutes by telephone but may be shorter dependant on the individuals needs [14].

Process of 6 Month Review

Commissioners need to clarify the extent of the six month review service in exploring the following factors:

- Is there a requirement of the six month review provider to complete the assessment AND then facilitate onward referrals to other disciplines? The volume of such referrals will need to be monitored and the subsequent costs calculated.
- Whether the six month review provider has the necessary expertise to provide advice around stroke prevention, emotional support and exercise or whether longer appointments with more qualified reviewers are required and provide a better patient experience?

- Whether the six month review provider is expected to resolve any of the identified unmet need? In many areas such reviews are undertaken by either community stroke therapy teams or early supported discharge that may be well placed in assessing rehabilitation potential and facilitating onward referral. It should however be acknowledged that the review is regarded as an assessment process rather than a treatment session and that not ever single reviewer will have the expertise to deliver advice universally and as such having the skills to signpost and refer is of critical importance.

Training and Competence

It is important that the providers of the six month review service are embedded within a competent and skilled workforce and that commissioners are reassured that such providers are appropriately trained. Skills required include: assessing clinical needs of patients, trained in communication skills required to assess patients with aphasia or other communicative/cognitive difficulties, ability to recognise emotional and psychological issues, ability to liaise and collaborate with multidisciplinary stroke teams and signposting and referral to other services. The six month review provider must ensure that no patient is discriminated against on the basis of age, race, disability, income levels or sexual orientation.

Monitoring Performance

Providers of the six month review service should work collaboratively with commissioners in capturing data and monitor the following: types of unmet need, volume of unmet need, volume of referrals and sign posting. Reporting of such data will need to be mutually agreed and quality improvement plans need to be implemented in line with any new national guidance. Where national standards or targets exist, they should be met (Appendix 3). Methods of evaluation of the service may include user feedback, surveys and questionnaires, survey of providers, GP questionnaires and uptake of reviews from SSNAP.

Recommendations

1. All stroke survivors to be able to access a six month review, which could be in own home, community hospital, acute provider or by phone.
2. CCGs should commission six month reviews and report findings in accordance with CCG OIS. Commissioners should support developing a review service dependent upon local service configuration.
3. All stroke services should have mechanisms to identify patients for six month review eg SSNAP web tool
4. Six month review services should aim to assess in the first instance using the SSNAP minimum data set and then proceed to use appropriate tools where necessary.
5. The findings of the six month review should be communicated in writing to the stroke survivor and with their GP
6. There should be mechanisms of training and support of individuals with defined competencies who are six months review providers.
7. All six month review services should report performance and enter six month review minimum data onto SSNAP web tool to ensure accurate description of process and outcome at six months.

Areas of Development

1. Cost effective evaluation of different models of six month review services (including method of assessment, specific qualified reviewer type: stroke specific vs. generic and location) using routine data collection.
2. Examination of six month assessment tools in 'hard to reach groups' such as stroke survivors in care homes and those with cognitive and communication difficulties.
3. Evaluation of the impact of six month reviews on physical, psychological and social outcomes after stroke including quality of life

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<https://www.nottingham.ac.uk/emahsn/documents/summary-report---national-audit-of-6-month-reviews-after-strokefinal.pdf>

Appendix 1: SSNAP Minimum Data Set

SSNAP requires that data be collected and entered for the following metrics. The following data is also required: the date of the review, the discipline of the person conducting the review and whether the review was done by phone, in person, online or by post.

8.2 Was patient screened for mood, behaviour or cognition since discharge using a validated tool? Yes/no/no but

8.2.2 Was the patient identified as needing support? Yes/no

8.2.3 Has the patient received psychological support for mood, behaviour or cognition since discharge? Yes/no/no but

8.3 Where is the patient living? Home/care home/other

8.4 What is the patient's modified Rankin score?

8.5 Is the patient in persistent, permanent or paroxysmal atrial fibrillation? Yes/no/not known

8.6 Is the patient taking (yes/no/not known)

8.6.1 Antiplatelet

8.6.2 Anticoagulant

8.6.3 Lipid lowering

8.6.4 Antihypertensive

8.7 Since their initial stroke has the patient had (yes/no/not known):

8.7.1 Stroke

8.7.2 Myocardial infarction

8.7.3 Other illness requiring hospitalisation

Appendix 2: Examples of Differing Models of Service Provision

Provider	Review Method	Benefits / challenges	Provider Role	All stroke patients included	Tool used	Time per patient	GP information
Royal Hallamshire Hospital Sheffield	Face to Face (75%) Telephone (25%)	Benefits: Time efficient with telephone assessments in patients without cognitive and mobility problems. Majority of issues were addressed with signposting and advice	Community Stroke MDT member	All stroke patients recorded on SSNAP and registered with GP	GM-SAT	45 mins (telephone) 60 mins (face to face)	Letter
Stroke Association for Islington, Redbridge and Barnet CCG	Face to Face	Benefits: Needs of carers, Blood pressure assessments, deal with language and cognitive disorders. Challenges: Administrative and time and travel	Barnet-part time post Islington and Redbridge-6 week support and 6 month review	Barnet and Redbridge-excludes nursing home residents Islington: All	GM-SAT	60-90 mins	Letter or fax
Harrow CCG stroke coordinator	Telephone	Benefits: Time efficient, easy access. Challenges: difficulty with language and cognitive disorders	6 week, 6 month and 12 month reviews	All stroke patients	Flexible but used 'in house' tool including Barthel and Rankin score	30-45 mins	Letter

Appendix 3: Recommended Quality Metrics

Objective	Indicators	Frequency	Provided by
Ensure patients have equitable and appropriate access to treatment CCG OIS 2014/15 C3.8 (SSNAP Data)	<p>Title: People who have had a stroke who receive a follow up assessment between 4-8 months after initial admission (ASI 8/ SSNAP) (target = 100% at 6 months)</p> <p>Definition: The percentage of people who have a follow-up assessment between four and eight months after initial admission for stroke.</p> <p>Numerator: Of the denominator, the number of patients who had a follow-up assessment between four and eight months after initial admission for stroke</p> <p>Denominator: The number of stroke patients entered into SSNAP excluding:</p> <ul style="list-style-type: none"> patients who died within six months of initial admission for stroke patients who decline an appointment offered patients for whom an attempt is made to offer an appointment but are untraceable as they are not registered with a GP 	Quarterly	Service name
Improve patient experience	Local wording to be agreed between the Commissioner and provider	Quarterly	Service name
Informed patients	100% of patients and/or carers to receive a written copy of the outcomes of their 6-month review within 2 weeks of the review	Quarterly	Service name
Informed primary care	100% of GPs to receive a written copy of either: <ul style="list-style-type: none"> the outcomes of the review within 2 weeks of the review where patient consent has been given notification that the patient was uncontactable following the agreed escalation procedure notification that the patient did not attend the review within 4 weeks of the intended review date 	Quarterly	Service name
Complaints	Local wording to be agreed between the Commissioner and provider	Quarterly	Service name

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