Stroke Community Support Service Commissioning Review

Project Title	Stroke Community Support Service Commissioning Review		
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1. Executive summary

The purpose of this paper is to review Stroke Community Support provision in Buckinghamshire, using local patient and carer feedback and national best practice to inform commissioning intentions for 2016/17.

This review has been divided into the following sections: -

1. Executive summary
2. Background and reasons
3. What is a Stroke Community Support Service?
4. National context
5. Local context and service provision
6. Patient and carer engagement
7. Procurement, HR, Finance and Legal considerations
8. Key considerations for a new service
9. Options appraisal

The review, which commenced in September 2015, was delivered by a project team consisting of a Buckinghamshire County Council (BCC) and Clinical Commissioning Group (CCG) Commissioning Manager, BCC Project Officer, CCG Locality Manager and Independent GP Clinical Advisor.

The project team has strived to deliver a thorough and objective review which encompasses local patient and carer feedback, coupled with national guidance. The document will hopefully provide a starting point for Buckinghamshire Stroke Strategy Group to achieve its vision of co-created services.

Stroke Community Support Services in Buckinghamshire are currently delivered by Bucks Healthcare Trust (BHT) and Stroke Association (SA). BHT services are clinically led service and SA, non-clinically led.

CCG commission BHT as part of their annual block contract and BCC commission SA as part of a 4 year standalone contract which expires on 31st August 2016.

Services are configured as follows: -

	North Buckinghamshire	**South Buckinghamshire**
0-6 month service	SA	BHT
6 month plus service	SA	SA

Despite positive elements, locally there is duplication of resource, inequitable service delivery, arbitrary timelines and confusion for patients. There also appears to be some relationship and communication issues between the current commissioned providers.

Local contract and specifications are either no longer fit for purpose, or non-existent, making value for money and outcome measures difficult to demonstrate outside of SSNAP (Stroke Sentinel National Audit Programme) indicators.

Stroke Association service is funded through non-recurrent Better Care Fund monies (formerly S.256). The review has been unable to identify a meaningful comparable cost for the equivalent services delivered by BHT.

The literature review has collated the below summary findings: -

- Nationally, Stroke is an increasingly prevalent long-term condition, not just in older adults, but also in younger adults. Costs associated with supporting this are rising and the local picture in Buckinghamshire largely reflects the national picture.

- At a national level, services across the whole stroke pathway appear to be increasingly CCG commissioning led, as opposed to previous years when some longer term support was local authority led. In many areas services are funded via the Better Care Fund, with additional investment from health where required.

- There is national consensus that although great improvements have been made in acute stroke care since the 2007 National Stroke Strategy, the same progress has not been made in the provision of 'life after stroke' community support services. The evidence available would suggest that many other areas are only

now commissioning what Buckinghamshire already has in place through the existing Stroke Community Support Service contracts.

- There is no definitive description of a Stroke Community Support Service, only recommended components for incorporation. A variety of service models exist across the country, being either clinically or non-clinically led and there does not appear to be clear consensus which of these models has greater benefit.

- It is recognised that benefit can be gained from Stroke Community Support Services which are long term, condition specific and patient centred. These include:

    - Reduced number of contacts with statutory care services
    - Improved access to voluntary sector support services which can delay or reduce need to access other funded health or social care services
    - Increased ability to self-manage and reduce dependency
    - Earlier identification of carer needs
    - Reduced duplication between services and improved joint working across agencies

In addition to national guidance, the review has also incorporated patient and carer feedback. The project team have used a multi-channel approach in order to gain a broad range of views around current and potential future provision of Stroke Community Support in Buckinghamshire. We have also maintained a visible presence throughout the process with Buckinghamshire Stroke Strategy Group and Stroke Service User Group.

An option appraisal has been completed (Section 9) in order to inform a potential way forward for stroke provision in 16/17. The suggested option combination being:-

<u>Section A – Commissioning options</u>
Option 1: CCG to commission full stroke pathway, including Stroke Community Support Service and any associated budget

<u>Section B – Service Provision options</u>
Option 1: Integrated Stroke Community Support Service between clinical and non-clinical providers e.g. health and voluntary sector joint venture

<u>Considerations</u>
In respect of the above options, consideration also needs to be given to the following: -

- Is this a commissioning priority and for whom? Adam Willison to produce review and then end by March 2016.

- If so, where will the Stroke Association element of the service be funded from between 1st April and 31st August and then after 31st August 2016 given that the budget was one off money?

- Who will commission and how will any transition of service be managed, particularly given recent sensitivities?

2. Background and Reasons

In 2011, funding was made available to Buckinghamshire Primary Care Trust (PCT) to invest in joint service re-design developments with BCC. This was pump prime funding designed to initiate greater collaboration and preventative commissioning between the partners and support people with both health and social care needs in the community.

In 2012, it was agreed to apportion the funding in such as way as to support the implementation of the National Stroke Strategy (2007). Part of this implementation involved acting upon findings from a CQC review of local stroke support, the culmination of which had been critical of the level of support provided to patients in the community.

In response, the provision of a new Community Stroke Support Service aimed to:

- Maximise the independence of individuals and enable them to exercise choice and control in the way their care needs are met

- Maintain the health and well-being of individuals

- Ensure that individuals felt valued, had their cultural needs met, and remained part of the wider community

- Ensure that individuals felt safe and secure

- Enable individuals to enjoy life's risks associated with being independent and exercising personal choice

And the main objectives were:

1. To provide a **community support service** to new stroke survivors and their carers for the first 6 months from hospital discharge and those who require longer term support beyond 6 months, with a particular emphasis on provision for people from black and ethnic minority communities where the prevalence of stroke is higher.

2. To provide an **expert stroke programme** for stroke survivors and their carers.

3. To provide an **information resource** for stroke survivors, their carers and professionals. There would be a particular emphasis on improved information to those who had not received the patient portfolio, which is an information pack, to support stroke survivors and their carers upon hospital discharge.

A competitive tender process was undertaken, with Stroke Association (SA) securing the contract from 31st August 2012. Due to capacity issues in South Buckinghamshire, an agreement was reached at the same time with the emerging Clinical Commissioning Groups (CCG's) and Buckinghamshire Healthcare Trust (BHT) to provide extended services in this part of the county.

The Council's contract with the Stroke Association was for up to 4 years (2 years fixed and 2 years optional extension, although funding was only available for 3 years.) In advance of the 2 year fixed term date, a business case was agreed by the Adult Joint Executive Team (JET) to utilise the contract extension option for a further 1 year, with no further extension expected due to no further funding available. It was also agreed that alongside this extension, a short review be undertaken to look at an exit strategy for the service.

The initial outcome of the 2015 review concluded that future stroke support services should be commissioned and contracted by the Clinical Commissioning Groups (CCGs) via the existing contract with BHT.

The local Stroke Service User Support Group and SA challenged the rationale behind this decision and so the final twelve-month contract extension with the Stroke Association was exercised in order to allow time for a full commissioning review to be undertaken.

The Adult and Right Care JET both requested completion of a further commissioning review and options appraisal by 31st March 2016 in order to inform commissioning intentions for 2016/17.

3. What is a Stroke Community Support Service?

There is a lack of research-based evidence on the benefits and costs of clinically or non-clinically led support for long term stroke care.

The National Clinical Guidelines include more than 400 recommendations, but only 16 cover the care given to patients more than 6 months post stroke.[1] As a result, there is a lack of consensus nationally as to the function and form of a Stroke Community Support Service.

[1] National clinical guideline for stroke, Royal College of Physicians, 2012

Where long term support is commissioned, there appears to be a variety of services in place, delivered across health, social care and voluntary sector organisations. Broadly, however, it is possible to categorise these services as follows:

- A Stroke Coordinator/Navigator service
- A 6 month review service
- A long-term support service
- An information and advice service
- An Expert Stroke Programme
- A support network for Stroke Groups

The consistent features of these services are:

- Single point of contact
- Support throughout the stroke pathway
- Integrated, partnership working with other providers in the stroke pathway
- Long term psychosocial support
- A 6 month review
- Annual reviews dependent on ongoing need
- Support for carers and family/friends as required

What a Stroke Community Support Service is not

It is important to be able to segregate the service components from traditional clinical services provided within any stroke pathway. It appears that the key features of a Stroke Community Support Service can provide a wider health and social care support to survivors and their carers, not just purely clinical. Clinical services are provided by Stroke Specialists, normally from the acute sector and then General Practice in the community longer term.

In summary, a Stroke Community Support Service does not necessarily need to be clinically led. The review has based this assumption on the lack of evaluation of either type of service, a lack of consensus across commissioned services and expert opinion.

In order to achieve distinction, it should be made very clear within specifications and contracts that a Stroke Community Support Service is not duplicating, but rather, integrated or working closely in partnership with:-

- An emergency service
- A hyper acute stroke service
- An acute stroke service
- Inpatient stroke rehabilitation
- Early supported discharge
- Community based stroke/neuro-rehabilitation service

- Other information & advice providers
- Other support providers

4. National context

Stroke can be a devastating and life changing event for people. People suffer a stroke when an area of their brain is deprived of its blood supply, causing some brain cells to die.[2]

It is the forth-largest cause of death in England and is the biggest single cause of disability in adults. This is not only due to its direct impact on people's ability to move around, think and communicate, but also its wider impact on people's ability to work, take part in community activities or participate in everyday family life.

Stroke occurs approximately 152,000 times a year in the UK and, although stroke incidence rates fell 10% from 1990 to 2010, that is one stroke every 3 minutes and 27 seconds. Men are at a 25% higher risk of having a stroke and at a younger age to women and by the age of 75, 1 in 5 women and 1 in 6 men will have a stroke. In addition 46,000 people in the UK have a first incidence of transient ischaemic attack (TIA or "mini-stroke").[3]

There are more than 1.2 million people living in the UK[4] who have had a stroke, with over a third of survivors who live with moderate to severe disability as a result and are dependant on others. Approximately one third will die, another third recover within a month and the final group are likely to be left disabled and in need of long term rehabilitation.[5]

1 in 4 (26%) of those who experienced stroke will be under the age of sixty-five, with increasing prevalence in this group of adults.[6]

It is estimated that stroke costs Health and social care approximately £4.38 billion a year in direct care costs[7] and further £4.2 billion associated with loss of productivity, disability and informal care.[8]

Although healthcare services aim to prevent as many strokes as possible through rapid diagnosis and treatment, where strokes do occur, they aim alongside partners in social

[2] Supporting life after stroke, Care Quality Commission, 2011
[3] State of the Nation, Stroke Statistics January 2015, Stroke Association, 2015
[4] State of the Nation, Stroke Statistics January 2015, Stroke Association, 2015
[5] Supporting life after stroke, Care Quality Commission, 2011
[6] State of the Nation, Stroke Statistics January 2015, Stroke Association, 2015
[7] State of the Nation, Stroke Statistics January 2015, Stroke Association, 2015
[8] Progress in improving stroke care, National Audit Office, 2010

care, to deliver high quality, long term support to reduce mortality, life limiting disability and achieve optimum recovery.

The National Stroke Strategy 2007[9] characterised Life after Stroke with 7 quality markers addressing: -

1. Ongoing rehabilitation
2. End of life care
3. Seamless transfer of care
4. Long-term care and support
5. Assessment and review
6. Participation in community life
7. Return to work

The strategy defined this within the context of a Stoke Pathway, consisting of 20 Quality Markers:

[9] National Stroke Strategy, Department of Health, 2007

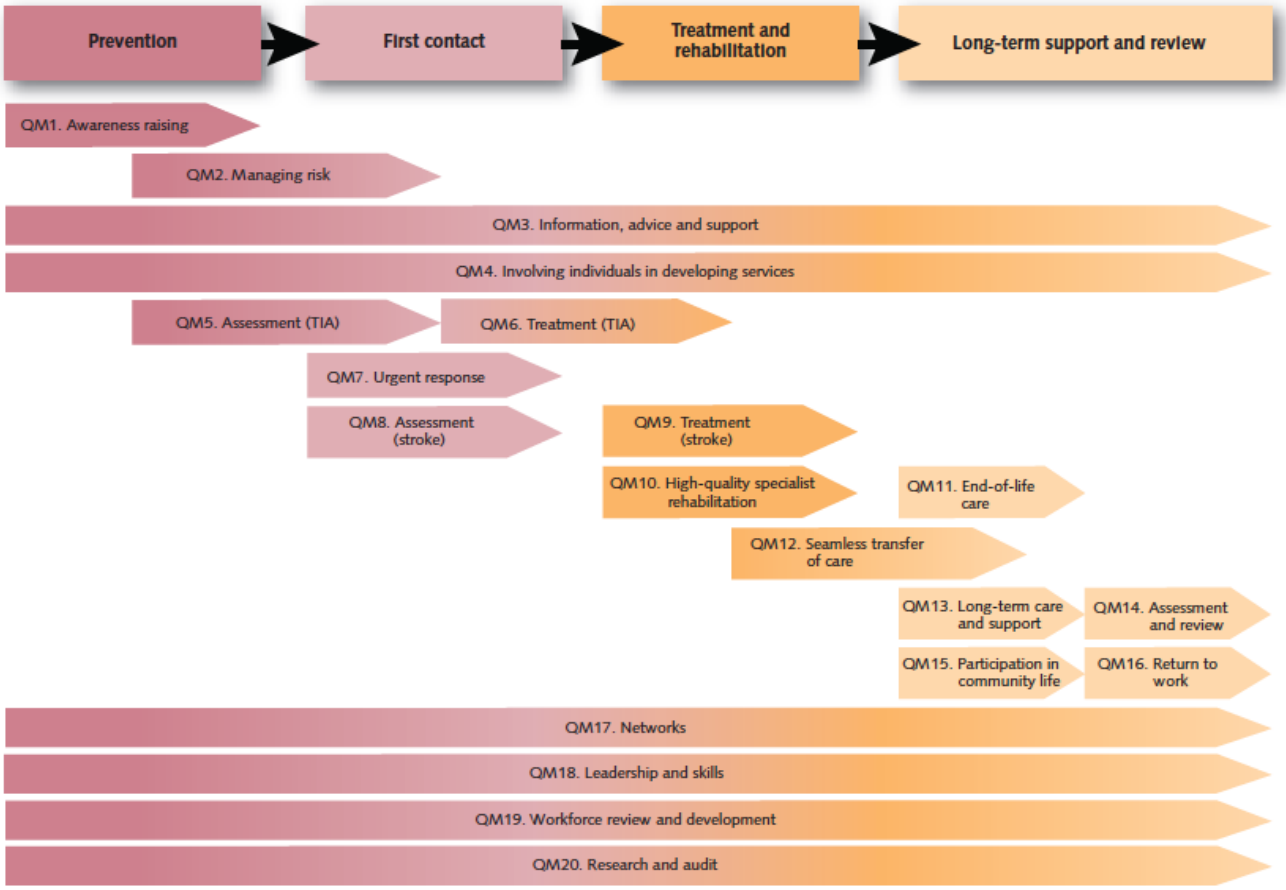

Figure 1 – Quality Marker Summary, National Stroke Strategy 2007[10]

In March 2013, the government launched a new Cardiovascular Disease Outcomes Strategy. In response to the problems that stroke survivors and carers often encounter when they leave hospital, the strategy also includes recommendations to help improve the longer term experience of people who have had a stroke. This includes making sure that people have their longer term needs assessed and reviewed and that they receive a written care plan. Particular areas of support such as emotional and psychological support are also addressed by the strategy. However, this new strategy does not supersede the National Stroke Strategy 2007 which is a 10 year programme and is still active.[11]

There has been significant national interest in stroke over the last 10 years following the National Audit Office (NAO) report, Reducing Brain Damage: Faster access to better stroke care (2005). The Stroke Sentinel National Audit Programme (SSNAP), run by the Royal College of Physicians, and the NAO's[12] follow-up report, have outlined significant

[10] National Stroke Strategy, department of Health, 2007
[11] Life After Stroke, Commissioning Pack for Clinical Commissioning Groups and Local Authority Commissioners, South East Coast Strategic Clinical Networks
[12] Progress in improving stroke care, National Audit Office, 2010

progress made in many aspects of hospital-based stroke care. There has also been an increase in the availability of Early Supported Discharge schemes (ESD), where people are able to leave hospital early and receive intense rehabilitation after they have returned home.

Despite an improving picture of stroke care in hospital and from supported discharge teams, many people report feeling abandoned by the health and social care system within a short time after returning home. There is evidence that services to support stroke survivors are variable and may be disjointed.

Since the publication of the National Stroke Strategy 2007, there has been considerable work undertaken to improve stroke care and services. Much of the effort has concentrated on prevention, emergency care and the acute care. Recent estimates indicate that about a third of stroke survivors are left with long-term residual disabilities and needs which can persist for many years following the stroke event. The term 'life after stroke' encompasses the multitude of services required to support people to recover from, and live with, the long-term effects of stroke.[13]

Although there are no specific figures in England to quantify numbers of stroke survivors and their needs, there is evidence of unmet need in nearly 50% of stroke survivors, between 1 and 5 years after stroke.[14] Surveys from the Stroke Association Needs Survey[15] and the Care Quality Commission (CQC)[16] confirm that stroke survivors and their carers experience unmet needs, particularly in terms of information, further assessment and access to community services. The CQC also found that even when services were available, access could be confusing and complicated.

It is possible that these deficiencies are, in part, a result of the many service guidelines, which focus on the early stages of care. For example, the Royal College of Physicians, National Institute for Clinical Excellence (NICE) and the National Service Frameworks all allude to longer-term needs, but their specific recommendations do not go beyond 6 week, 6 month and annual reviews post discharge from hospital.

It is clear from the evidence that any one group alone cannot adequately meet the needs of stroke survivors and their carers and there is a requirement for co-operation and complementary working across health services, social care and the third sector. The 'range of support' model recommended in the National Stroke Strategy 2007 demonstrates this:

[13] Life After Stroke, Commissioning Pack for Clinical Commissioning Groups and Local Authority Commissioners, South East Coast Strategic Clinical Networks
[14] Life After Stroke, Commissioning Pack for Clinical Commissioning Groups and Local Authority Commissioners, South East Coast Strategic Clinical Networks
[15] UK Stroke Survivors Needs Survey, The Stroke Association, 2010
[16] Supporting life after stroke, Care Quality Commission, 2011

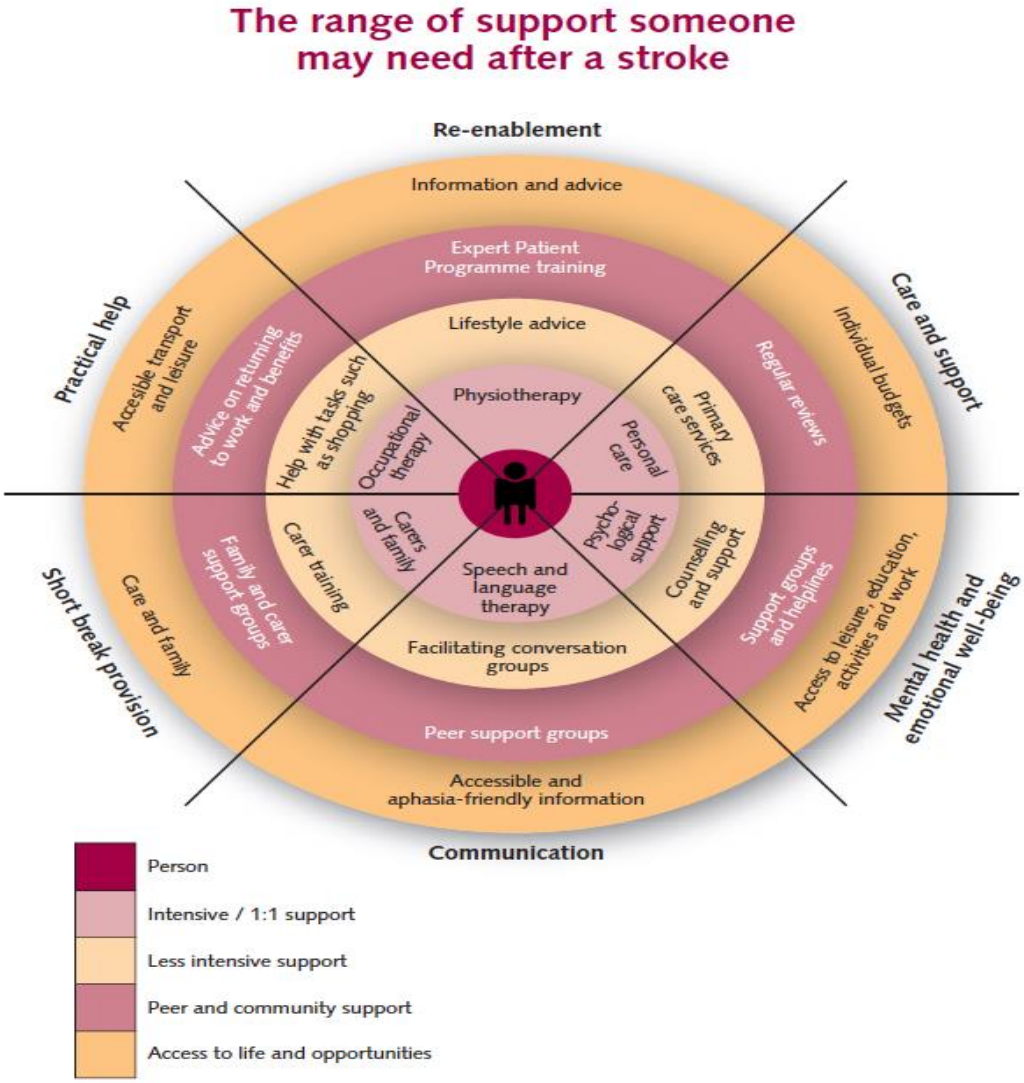

Figure 2 – The range of support someone may need after a stroke, National Stroke Strategy 2007[17]

Stroke patients may spend several days or weeks in hospital, but it is in the months and years after discharge that they, their families and carers experience the full impact of stroke.

A number of key drivers have established a clear steer for all stroke survivors to receive a review at 6 weeks, 6 months, twelve months and then annually thereafter. This facilitates a clear pathway back to provision of further specialist review, risk factor screening, advice, information, support and rehabilitation where required: -

[17] National Stroke Strategy, Department of Health, 2007

Table 1 – Driving National Standards[18]

Key Drivers	Descriptor/Standard
National Service Framework for Older People (2001) (5.27)	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 on-going 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 QM14 (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 a 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
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.
Royal College of Physicians (RCP) National Clinical Guidelines for Stroke (2012) Fourth Edition 7.1.1C and 7.4.1A	Any patient with residual impairment after the end of initial rehabilitation should be offered a formal review at least every 6 months, to consider whether further interventions are warranted, and should be referred for specialist assessment if: • new problems, not present when last seen by the specialist service, are present • the patient's physical state or social environment has changed Patients and their carers should have their individual practical and emotional support needs identified: • before they leave hospital • when rehabilitation ends or at their 6-month review • annually thereafter
NICE (CG162) Stroke rehabilitation guideline: Long term rehabilitation after stroke (2013)	Review the health and social care needs of people after stroke and the needs of their carers at 6 months and annually thereafter. These reviews should cover participation and community roles to ensure that people's goals are addressed.

There is a lack of research-based evidence on the benefits and costs of clinical and other support for long-term stroke care. The National Clinical Guidelines include more than 400 recommendations, but only 16 cover the care given to patients more than six months after the stroke.

The NAO 2005 report recommended that the Department should work more closely with the voluntary sector to improve long-term support and service provision. Many Local Authorities have now used their stroke grants to commission stroke support services from the voluntary sector. For example, Local Authorities had 268 contracts with the Stroke Association, to provide information, advice and support to stroke survivors,

[18] Stroke 6 Month Reviews, Commissioning Information Pack, South East Coast Strategic Clinical Networks, 2014

families and carers in 2009, compared with 164 in 2005.[19]

As many of the needs of stroke survivors are met by several organisations operating across health, social care, the third sector and others, the case for joint commissioning is made, with a strong track record of success in caring for people with long-term conditions. including stroke.

Commissioners should look, through their social and health care providers, to enable stroke survivors to re-engage in active citizenship, such as returning to work, establishing links with support groups or regaining autonomy, control and a positive sense of identity following a stroke. There are a cohort of people living with stroke, who despite having made considerable progress in their rehabilitation, never find themselves properly reintegrating with society and daily life.

6 Month Review

The National Audit Office's report ''Progress in Improving Stroke Care" (2010)[20] 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)[21] found that most Primary Care Trusts 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.

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:-

- Reduced GP and Stroke Consultant appointments
- Avoidance of hospital admission (avoiding escalation of problems)
- Identification of secondary prevention needs (e.g. undiagnosed atrial fibrillation, hypertension, medication 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

[19] Progress in improving stroke care, National Audit Office, 2010
[20] Progress in improving stroke care, National Audit Office, 2010
[21] Supporting life after stroke, Care Quality Commission, 2011

- 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 and Improved joint working across agencies
- Opportunities for improved data collection processes, audit, improving performance monitoring and inform service development needs

The National Stroke Strategy 2007[22] describes a good assessment process for someone who has just had a stroke as: - involving a multidisciplinary, person-centred assessment of the individual's needs and signposting to other services, e.g. housing or transport.

The same document further reminds us that it will be important to bear in mind that those who have had a stroke may have additional communication or cognitive support needs to be able to participate in the assessment. People for whom English is not their first language and those with literacy difficulties may also have different requirements and services need to be flexible enough to meet their needs.

A number of nationally recognised and standardised tools are available that ensure patients receive a suitably in-depth review. It is recommended in a number of documents that any new 6 month review consider using an assessment framework such as the Greater Manchester Stroke Assessment Tool (GM-SAT), to ensure a quality review.[23] GM-SAT is designed to cover the breadth of potential on-going or new needs the stroke survivor might have, including: -

Table 2 – Potential ongoing or new needs the stroke survivor might have[24]

Medicine Management	Exercise	Daily activities	Sleep pattern
Medicine Compliance	Vision	Mobility	Diabetes
Blood pressure	Hearing	Falls	Driving
Anti-thrombotic therapy	Communication	Mood	Transport & travel
Weight Management	Swallowing	Anxiety	Activities & hobbies
Memory & Concentration	Nutrition	Emotionalism	Work
Personality changes	Cholesterol	Alcohol	Money & benefits
Smoking	Pain	Sexual health	House and home
Healthy eating	Continence	Fatigue	Carers needs

[22] National Stroke Strategy, Department of Health, 2007
[23] Stroke 6 Month Reviews, Commissioning Information Pack, South East Coast Strategic Clinical Networks, 2014
[24] Stroke 6 Month Reviews, Commissioning Information Pack, South East Coast Strategic Clinical Networks, 2014

The GM-SAT was designed to be completed by professionals with stroke knowledge, but that are not necessarily registered clinicians. In order to maintain patient safety, the traditionally clinical based questions e.g. medication management, are designed to revert the stroke professional to refer those particular issues to a local clinician if necessary, such as the patients GP.

Other areas of the GM—SAT cover issues which may traditionally fall under social care responsibility e.g. activities and hobbies.

Local priorities tend to define what type of service will lead Stroke Community Support. In some areas, it is local authority commissioned and non-clinical providers deliver the support and reviews, well integrated with acute health services. Increasingly, however, areas are reverting to CCG led commissioning, but again, sometimes with non-clinical providers. This can be due to efficiency around one organisation providing commissioning of whole pathway, from acute through to long term support.[25]

The default position in some areas to commission support through acute services requires careful consideration as to the benefit of doing so. Invariably, acute providers do not necessarily have the correct skills base and resource in order to deliver long term stroke support in the community if local priorities, such as those identified by Buckinghamshire patients, focus more on areas such as improved befriending and stroke group peer support.

There is also the risk of commissioning a more expensive clinical provider, when a non-clinical provider may be able to deliver the service more cost effectively.

5. Local context and service provision

The Stroke Community Support Service in Buckinghamshire is an integral part of the overall stroke pathway. In reviewing this service it has been important to understand the wider context of stroke services within the county.

Buckinghamshire Healthcare Trust (BHT) delivers a safe and quality stroke service for its residents as evidenced by national figures in the Stroke Sentinel National Audit Programme (SSNAP) and by peer review both locally and nationally. In particular, the hyperacute/acute stroke service is recognised as an example of good practice across Thames Valley and beyond.

In addition to the hospital based services, BHT also delivers a number of longer term (post-acute) stroke services, including the Inpatient Neuro-rehabilitation service, the Early Supported Discharge service and the Community Neuro-rehabilitation and Community Head Injury services.

[25] Stroke 6 Month Reviews, Commissioning Information Pack, South East Coast Strategic Clinical Networks, 2014

BCC commissions a Stroke Community Support Service, provided by the Stroke Association (SA). However, historically, BHT has provided a 0-6 month service in south Bucks and this remains the case. Therefore in north Bucks (Aylesbury Vale CCG area) the SA provides support from 0-6 months and in south Bucks (Chiltern CCG area) BHT provides this support.

Both providers undertake 6 month reviews post hospital discharge in their respective areas. This is a key service, which meets a quality marker requirement for the National Stroke Strategy (quality marker no.14)[26] and CCG outcomes indicator set. The SSNAP (Stroke Sentinel National Audit Programme), a national clinical audit programme for stroke services provided under the NHS, also require the collection of data against post stroke reviews at 6 months.

The SA provides all other elements of community stroke support countywide from 6 months onwards. This includes information and advice, emotional support, practical support and the Expert Stroke Programme.

The review has revealed provider relationship issues between SA and BHT. Although much of this is anecdotal from both professional and patient, there is a feeling that relations between the providers are not that positive, particularly since last summer's complaint letters. In order for the current service configuration to work effectively, both organisations must have a good working relationship and be fully committed to integrated working. Without this, the quality of patient care is compromised.

The diagram below details the current service configuration and provision for a stroke survivor in North Buckinghamshire (broadly Aylesbury Vale CCG area) and South Buckinghamshire (broadly Chiltern CCG area): -

[26] National Stroke Strategy, Department of Health, 2007

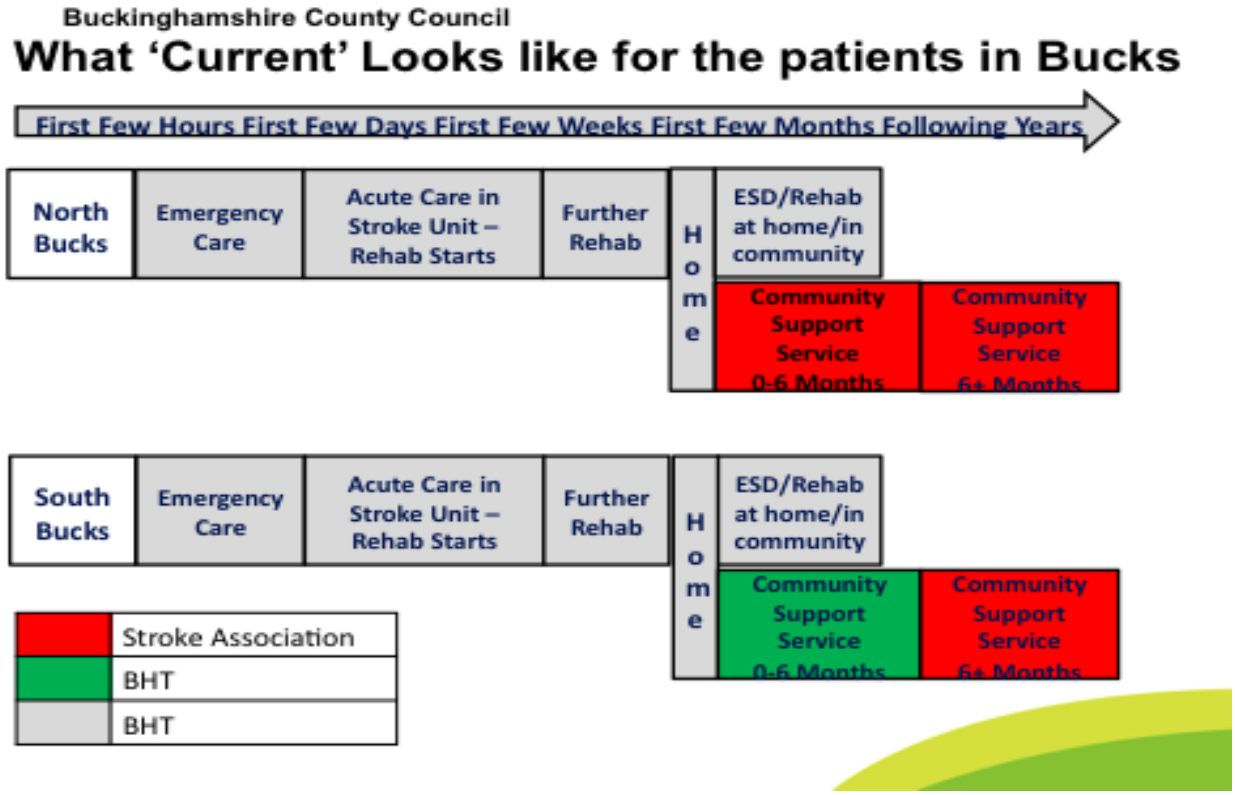

Figure 3 – Current stroke patient pathway in Buckinghamshire

The stroke pathway is supported by a good spread of local voluntary support groups that are focussed around some main areas of patient concentration.

These groups are supported either formally or informally by both current stroke support providers and vary in terms of attendance and frequency.

There is a question around whether local support groups are still the most effective way of meeting the needs of all stroke survivors and this may explain why attendance rates are sporadic and dependent on drive and enthusiasm of a small number of patients or carers.

The geographical spread of support groups in relation to stroke is fairly consistent, generally centring on the main areas of population in Buckinghamshire. The groups are predominantly voluntary sector led, receiving direct or indirect support from providers such as Stroke Association.

The previous business case for Stroke Community Support Services stated a vision by where the local voluntary groups would become self-sufficient and provide the necessary long term support and training for stroke survivors and carers. This has not been realised and the local groups are still fragmented and vary considerably in terms of attendance and support they are able to deliver to the local community. In addition,

younger stroke survivors are indicating a wish to access support in a different way e.g. via online means, as opposed to the traditional face to face group meetings. The current set up in Buckinghamshire is not able to meet this need.

The groups which are prevalent and very active in community support could potentially provide peer support to other areas, however, their success if very dependent on a small number of enthusiastic individuals. This has proven to not be sustainable and in other areas we have investigated as part of this review, a supporting partner e.g. SA in Berkshire, is still required in order to provide refresher training, updates on fundraising techniques and overall motivation in order to maintain group interest.

Stroke survivors are provided with support from other contracted services such as Carers Bucks and Prevention Matters. As Stroke care has many touch points for a patient, the role of the current stroke specific providers is to ensure that co-ordination and transfers of care between various providers occur smoothly. However, local feedback has been mixed and there are several cases bought to the attention of the review project group that highlight where referrals have not been made, or not followed up. There is also gaps in service that have been highlighted by patients such as; Prevention Matters cannot support stroke survivors in receipt of a social care package and are time limited and do not have stroke specialist knowledge.

Information analysis of Buckinghamshire service

In December 2015, the Sentinel Stroke National Audit Programme (SSNAP) published the first report[27] telling stroke survivors and their families about longer-term stroke services in England. SSNAP measures stroke services in hospital and services which provide longer term care. It does this to improve the quality of stroke services. The Royal College of Physicians (RCP) runs SSNAP and receives information from the services themselves. NHS England pay for SSNAP and a Stroke Working Party guides it. The findings for Buckinghamshire are summarised below and are taken directly from the SSNAP data reported: -

Table 3 – Summary of findings for Buckinghamshire: SSNAP long-term stroke service audit

Service in Bucks	**Self-management advice and useful information**	National % of services providing self-management advice	**6 Month review**	National % of services carrying out 6 Month Reviews
Inpatient rehab. (Buckinghamshire	Not reported	59	Does not carry	23

[27] Audit of loner term (post-acute) stroke service; Phase 2: Organisational audit of post-acute stroke service providers, Sentinel Stroke National Audit Programme (SSNAP), December 2015

Neurorehabilitation Unit) (BHT)	on		out	
Early Supported Discharge (Buckinghamshire ESD Team) (BHT)	Not reported on	77	Does not carry out	46
Buckinghamshire Community Neuro-Rehab. Service (BHT)	Not reported on	69	Does not carry out	39
Buckinghamshire Community Head Injury Service (BHT)	Provides	69	Does not carry out	39
Family and Carer Support Services (SA)	Provides	80	Carries out	17
6 Month Review only (BHT)	Not reported on	n/a	Carries out	n/a

The content of this table, taken from the national audit data, demonstrates that stroke survivors in Buckinghamshire are currently supported in self-management advice and useful information (and the 6-month review) by the 'Community Support Services' (Family and Carer Support Service and 6 Month Review Service). The assumption is therefore that, without this service, the existing services in Buckinghamshire are not currently set up to provide either.

Other findings of the SSNAP Audit that may be relevant and impact on the need for a Community Support Service in Buckinghamshire include:-

- Inpatient Rehabilitation
  - Stroke Survivors do not have access to a 'core' group of staff to ensure that they receive different types of therapy and support if they required (nationally, 98% of all inpatient rehabilitation services have this group)
- Early Supported Discharge
  - Meeting standard of review and treating stroke patients the next day or within 24 hours of discharge from hospital.
  - Has a 'core' staffing group.
  - Provides 6 days a week service.
  - Limit by time (months).
- Community Rehabilitation Services
  - Not meeting the standard for review (within 14 days) and start of treatment (within 90 days) of referral.
  - Has a 'core' staffing group.

  - Provides 5 days a week or less service.
  - No time limit.
- Family and Carer Support Services
  - Meeting standard for review (within 14 days) and support (within 90 days) of referral.
  - Provides 5 days a week or less service.
  - No time limit.

The SSNAP Audit[28] goes on to make key recommendations for post-acute stroke services, some of which are relevant to the current stroke pathway in Buckinghamshire and the review of the Stroke Community Support Service:-

1. All stroke patients should have a 6-month review. In England, this is in accordance with the National Stroke Strategy 2007 and all commissioners should be funding them. Currently this is achieved within Buckinghamshire.
2. We would encourage Commissioners to ensure that all stroke patients are receiving a 6 month review and this is entered onto SSNAP.
3. Information for stroke survivors and their carers, which will help stroke survivors deal with the effects of stroke, should be freely available in all longer term stroke services. Currently in Buckinghamshire this is provided for through the Community Support Service.
4. Non-stroke specialist services which are treating stroke patients should make sure that their staff, including rehabilitation assistants, receive regular training on how to care for stroke survivors.
5. People's access to psychological support should be as important as their access to physical support services.
6. Patient information that is relevant and accessible needs to be freely available in all post-acute care settings.
7. All stroke patients should have access to vocational rehabilitation where appropriate.
8. All services should have a clear re-referral pathway in order for patients to return to a service if needed.
9. All longer-term services should have clear policies on time limits and re-referral.

Both the SA and BHT provided data for the SSNAP Audit. This allows a comparison of the 0-6month services within Buckinghamshire (North – SA; South – BHT), as well as a comparison with other services across Thames Valley. This can be summarised as follows.

Table 4 - North Bucks Family Service (SA) v. other Family and Carer Support Services commissioned in Thames Valley region (7 in total)

[28] Audit of loner term (post-acute) stroke service; Phase 2: Organisational audit of post-acute stroke service providers, Sentinel Stroke National Audit Programme (SSNAP), December 2015

Service element	North Bucks Family Service (SA)	Other Thames valley Family and Carer Support Services
6 month review provided	Yes	5/6 services provide
Stroke specific service	Yes	Yes
Care settings	Variety, including patients home	Variety, including patients home
Median waiting time	3 days	3 days
Days/week available	5	5
Clinically led	No	No
Access to family/carer support services	Yes	Yes
WTE support workers per 100 patients referred	0.9	0.4-1.8
Referrals in 12 months	165	57-396
Information and training available to stroke survivos and carers	Yes	Yes
Participates in SSNAP clinical audit	Yes	Yes

Table 5 - South Bucks 0-6 month Service (BHT) v. other 6-month assessment only service in Thames Valley region (2 in total)

Service element	South Bucks 0-6m service (BHT)	Other service
Stroke Specific	Yes	Yes
Clinically led	Yes	No
Care settings	Community hospital / home	Home setting only
Median waiting time	9 days	123 days
Days/week available	5 days	5 days
WTE doctors per 100 stroke patients referred	1.5	n/a (nationally = 0.1-0.8)
WTE nurses per 100 stroke patients referred	0.2	n/a (nationally = 0.3)
Access to family/carer support services	No	No
Referrals in 12 months	269	280
Information and training available to stroke survivors and carers	Yes	Yes
Participates in SSNAP clinical audit	Yes	Yes

From these summary tables it is clear that the 2 services are different in a number of ways and the national and regional data suggests these discrepancies are not unique to Buckinghamshire. Neither does the data allow us to draw conclusions as to the preferred or best model for delivery. However the key differences can be listed:-

- The waiting time in North Bucks is 3 days compared to 9 days in South Bucks
- The South Bucks service is clinically led and contains a large number of clinical staff, compared to the non-clinically led North Bucks service
- The North Bucks service delivers 6 month reviews with 0.9WTE/100 support workers compared to the 0.2WTE/100 nurses in the South Bucks service
- Evaluated user outcomes are not available for either service making it difficult to compare

It has not been possible for the review to understand the extent of the difference in the delivery models between North and South Bucks. It is clear that the BHT South service is staffed with many of the same clinical services that are found in other existing stroke services also delivered by BHT (Inpatient rehab, ESD, Community rehab). It is not clear to the review what overlap exists and so raises the question of whether this is a true comparison between the services.

Performance Data

Accessing comparable data has been challenging for the review. The Stroke Association provide regular and detailed quarterly reports to BCC as well as an annual report. BHT is not commissioned by BCC but the review has been provided with a data report. It has been possible to compare the data in its very basic form but drawing conclusions has been less easy due to the differing service models.

The table below compares the north and south Bucks 0-6 month services on the data provided by the provider organisations. The data sets used are the most recent available at the time of writing the review.

Table 6 – Countywide performance data for 0-6month services between April and September 2015

	North Bucks (SA)	South Bucks (BHT)
Number of new referrals	74	123
Service declined by the client	0%	12%
Transfer to other service	0%	6%
Number of clients contacted within 2 days of referral	28%**	85%

Number of clients seen within 2 weeks of referral	23%***	95%
Caseload	115	278
Total number of home visits	111	269
Total number of 6 Month Reviews completed	60	118
Total number of review declined	13 (22%)	30 (25%)
Cases closed on completion of service	85%	84%

*34% were unable to be contacted
**SA uses 2 days from discharge and not from referral – many referrals not being made until >2 days after discharge
***A high number (62%) of patients declining visit or not responding to contact made

The discrepancies in the data sets make it difficult to compare the services. It is not unexpected that the number of referrals is higher in the South as it is a larger population area. The data for 'contact' and 'visit' is very different between providers. It may be possible to explain some of this by provider definition (contact from referral v contact from discharge) or even by staffing numbers of each service from the SSNAP audit data but the review is unable to make a definitive link. In is also impossible to comparing the financial envelope within which each service is delivered and so the review is unable to say what it may cost to provide a countywide 0-6 month service.

6 Month Plus Service & Expert Stroke Programme

The Stroke Association provides both these aspects of the Stroke Community Support Service across the whole county.

Reports provided regularly by the SA demonstrate a reasonable uptake of the Post 6 Months service with 198 referrals seen in the year ending March 2015. Subsequent referral numbers have dipped (84 over Q1-3 in 2015), although this may reflect the uncertainties in the ongoing viability of the contract over this period. Within these referral numbers there has been a large increase in health referrals in Q3 with 22 compared to only 8 in the previous 2 quarters. The review cannot say why this is but it may reflect an improved referral process between BHT and the SA. Table 5 shows the performance data for the Post 6 month service in Q1-3 of 2015/16.

Table 7 – Countywide performance data for 6 month+ service between April and December 2015 (SA only)

Number of new referrals	84 --- Self-referral – 28 Health – except GP - 30 Social Services – 1 Stroke Association – 20
Number of client contacted within 3 days of referral in %	85%
Service declined by the client	1
Transfer to other service	2
Caseload at end of Q3	24 (range 22-48)
Case closed due to completion of service (Improved outcome)	101

In addition to the patient, family and carer support offered in their 0-6 month service, the Post 6 Month service also gives patients access to the Life After Stroke (LAS) grants offered by the Stroke Association, as well as support for the Stroke Patient groups around the county (whether SA groups or not).

From the data available it is not possible to identify the number of patients who receive the 6 months plus service having part of the 0-6 month service. Nor is it possible to identify any specific differences in the needs of the patients seen in the 0-6month service compared to those in the 6 month + service.

The Expert Stroke Programme has been successful to those who have been able to benefit from it and the SA has provided quarterly data to support this. Feedback would suggest that the tightly defined structure of the programme and the face-to-face delivery often a long way from home has reduced uptake. Again uncertainty over the contract and ongoing funding has reduced the uptake in the last Q2 report. Table 6 shows some of the performance data presented by the SA for the Expert Stroke Programme.

Table 8 – Countywide performance data for Expert Stroke Programme (SA only) – Q2 2015/16

Number of courses completed	1 (4 sessions)
Number of people attended the course	17

Improved Well being reported	13
Reduction in care package	0 (most indicated that they are not in receipt of a care package)
Increased independence reported	12
Reduced GP visits reported	2

In Q3 (October to December 2015) it was agreed with the commissioner that the Expert Stroke Programme could not be delivered due to staffing issues and that a more streamline approach would be taken. As a consequence a 'Winter Wellness' session and a 'Stroke self-management' session were delivered to 13 stakeholders. For 2016 a series of sessions are being planned aimed at stroke survivors of working age and their specific needs. This more agile and responsive approach could replace the more rigid delivery of an Expert Stroke Programme in any future service specification.

Additional Information

Service user and carer feedback about services provided by the SA has been very positive. The SA have produced local case studies evidencing the positive difference their community support service and the Expert Stroke Programme have made, showing also where likely health or social care interventions (at high cost) have been avoided for individual stroke survivors. To put a financial return on this locally has not yet been attempted but the SA has drawn upon research studies to demonstrate the possible financial return on the funding of their contract as follows:

Table 9 – Possible financial return from the Stroke Association service[29]

Intervention by the SA	**Cost avoided**
Providing a stroke survivor and their family with support and guidance about reducing their risk of stroke by improving their diet and reducing alcohol intake	The health and social care costs of stroke £29,405 over 5 years
Supporting a stroke survivor to gain the confidence to access a peer support group and attend on a regular basis	The cost of local authority day care for older people is £36 per session

[29] Stroke Association quarterly contract data return, BCC

Sustaining families in their informal care arrangements by providing information, emotional support and respite opportunities and preserving the integrity of the family	The provision of median cost community care package at £445 per week
Providing the family of an aphasic stroke survivor with basic knowledge about communication difficulties after stroke, emotional support and ways of supporting conversation, reducing isolation and enhancing quality of life	Cost of treatment for depression by NHS is £340 per treatment

6. Patient and carer engagement

Since the outset of the review, one of the most important elements has been to proactively encourage stroke survivor and carer participation. Within the limited time and resources available, the project team has endeavoured to undertake collaborative working and gain as much feedback as possible.

Initially, an engagement plan was developed by the project team in partnership with BCC and CCG Communication Teams. In order to refine feedback, a 4 question survey was then formulated around patient experience in relation to Buckinghamshire Community Stroke Support and what people believed to be key service attributes.

As part of our onsite engagement, all known and emerging stroke groups were visited by a member of the project team. Paper surveys were hand delivered during these visits and followed up by e-mail distribution.

In addition, a number of stroke survivors and carers that did not attend a support group were visited and subsequently invited, if appropriate, to a facilitated focus group organised in conjunction with Carers Bucks.

Despite extensive engagement and some very useful insight via the onsite visits, remote feedback has been relatively low in number and some responses too ambiguous to utilise for the purposes of this review.

The table below outlines some of the patient engagement activity undertaken and response numbers: -

Table 10 – Patient engagement activities undertaken during review

Activity undertaken
7 x voluntary stroke groups visited
1 x Focus Groups – 4 carers attended
3 x individual Stroke Survivors met
4 x individual carers met
4 x joint assessments with providers
Consultation run on the Lets Talk Health Bucks Website
Chiltern Patient Participation Group attended – questionnaires emailed to the representatives
Age UK – 20 paper copies of survey provided
Questionnaire sent via BOPAG Newsletter (4,000+ circulation)
Intouch - 20 paper copies plus electronic copy sent
Buckingham Local Network group attended – 10 paper copies of the questionnaires left with organisations attending

Although overall patient and carer feedback has been varied, they have highlighted a number of common points:

- There is a great deal of confusion as to where stroke support comes from.
- The pathway seems far from smooth and there appears to be a lack of communication between departments and agencies.
- Those that received ESD support for 6 weeks felt that, although invaluable, are not provided for anywhere near long enough.
- The general consensus around acute services is that they are outstanding and that support provided in hospital is second to none
- Support received following discharge is inconsistent and there is a sudden “drop” in services. People reported feeling very isolated and unsupported, not knowing what is available or what they are entitled to.
- A long wait for community physiotherapy means that any progress made during the initial 6 week rehabilitation can be quickly lost.
- A number of patients appear to have fallen through the net, particularly if they suffered from other medical complications which required multi-disciplinary input. Stroke support seemed to be a lesser priority and forgotten.
- In many cases, the transition between the 0-6 month service and the 6 month plus service did not happen for the patient.
- There is a lack of emotional support and service navigation for patients and carers. People want someone with stroke knowledge that they can to talk to and to express their feelings to.

- Although the provision of the document is inconsistent, a more user friendly and tailored Stroke Patient Portfolio would have been welcomed.

Adjusting to this new way of life seemed to be the biggest challenge and, as a consequence, it seemed to have an impact on one's psychological wellbeing, as there seemed to be a lack of acceptance of the "new person" and all the emotional consequences that this brings. Patients, both who had benefitted from the stroke community support service and those who had not, reported feeling that there was not adequate support for this, nor did they feel able to talk to anybody about their new way of life. Some carers reported also a lack of motivation to do any exercises that might have speeded up the recovery of the stroke survivor, despite the fact that they were aware of the benefit of these.

Whilst varied, the general impression given by stroke survivors and carers is that a more holistic approach is required. Looking at stroke survivors' individual lives and what is important to each person would be more efficient in meeting people's needs.

Visits so far have indicated that the lack of communication between departments does not allow the pathway to recovery to be a smooth one. This leads to a lack of referrals to the various community support groups. Patients have indicated that they would like to have a single person that they could contact and that could support them by being signposted to relevant services and activities.

7. Procurement, HR, and Legal considerations

The SA contract with BCC is due to cease on 31st August 2016. There are no options to extend this contract and Procurement has confirmed this to be the case and that a courtesy notice period of 3 months could be provided to the current provider if a decision was made to terminate the contract.

Legal (Commissioning Support Unit, CSU) and Procurement (BCC + CSU) have also advised that although dependent on how the service is taken forward after August that TUPE is unlikely to apply.

Given the concerns received during the last attempted Procurement process, careful consideration will need to be given regarding any transfer of service or decommissioning process. This should also acknowledge the relatively short period of time available should a re-procurement exercise be undertaken.

It has not been possible to identify the exact cost of the BHT 0-6 months service for a variety of reasons e.g. lack of engagement early in the review process, no clearly defined contract or specification. However the assumed make up of the service from the

SSNAP audit data would suggest the cost would be higher compared with SA e.g. cost of the clinical components vs. non-clinical.

Benchmarking analysis

The SSNAP Audit only confirms what the review has found, which is a significant variation in the commissioning of stroke community support services, if they are commissioned at all. Where the service is commissioned the delivery models are different, as are the provider organisations used.

The review set out to look for an alternative delivery model used locally in an area with a similar demographic to Buckinghamshire. Berkshire's Stroke Recovery Service is one example model of a stroke community support service. It is delivered in partnership between the acute trust and the voluntary sector with links into the wider health and social care system.

To deliver the Stroke Recovery Service for up to 400 stroke survivors and their carers in Reading and Wokingham, the service costs £98,723 which includes salary, all costs, travel, administration, training, support and supervision, monitoring service delivery and signposting work. Excluding the Expert Stroke Programme it is therefore comparable with the 0-6months and post 6 months services delivered by the SA in Bucks.

Support begins following a stroke and continues on a needs led basis for an average of one year. Stroke survivors and carers are assessed on their level of need and given the appropriate amount of support based on that need. Following an initial assessment, their progress will be reviewed at six weeks, six months and at one year; at each stage their recovery plan and needs will be reviewed. Stroke Recovery Coordinators provide a range of support for stroke survivors, their families and carers.

The Berkshire West Reading and Wokingham Stroke Pathway is demonstrated below:

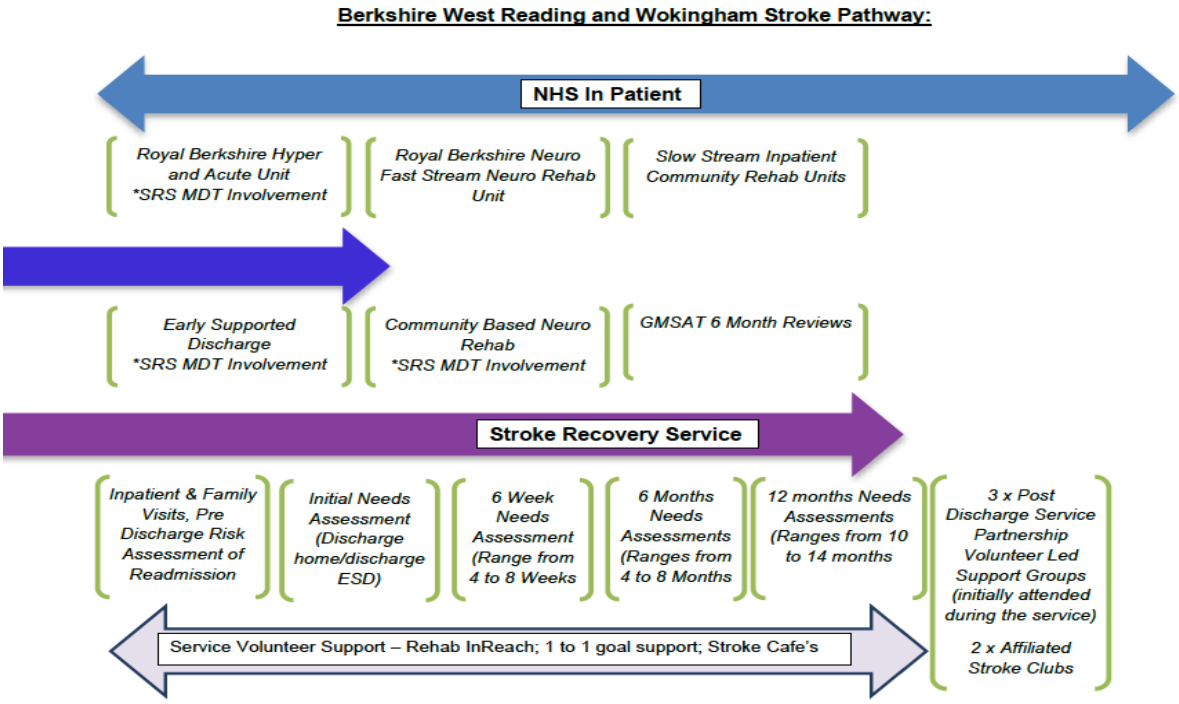

Figure 4 – Berkshire West Reading and Wokingham Stroke Pathway

The service offers:

- Assessment of risk of readmission prior to discharge for those going home without Early Supported Discharge
- More intensive support in place for those identified at highest risk of readmission
- Assessment of needs at earliest appropriate point following discharge
- Coordination and navigation of health and social care systems
- Personalised information and support
- Emotional support to improve psychological wellbeing by relieving the pressure stroke survivors and carers experience through the journey of recovery
- Stroke prevention advice and support to self-manage
- Practical advice and support, for example around managing hospital appointments, managing equipment and ways to live as independently as possible at home
- Support to make a recovery plan, set goals and achieve them
- Support to address social isolation
- Representation and advocacy

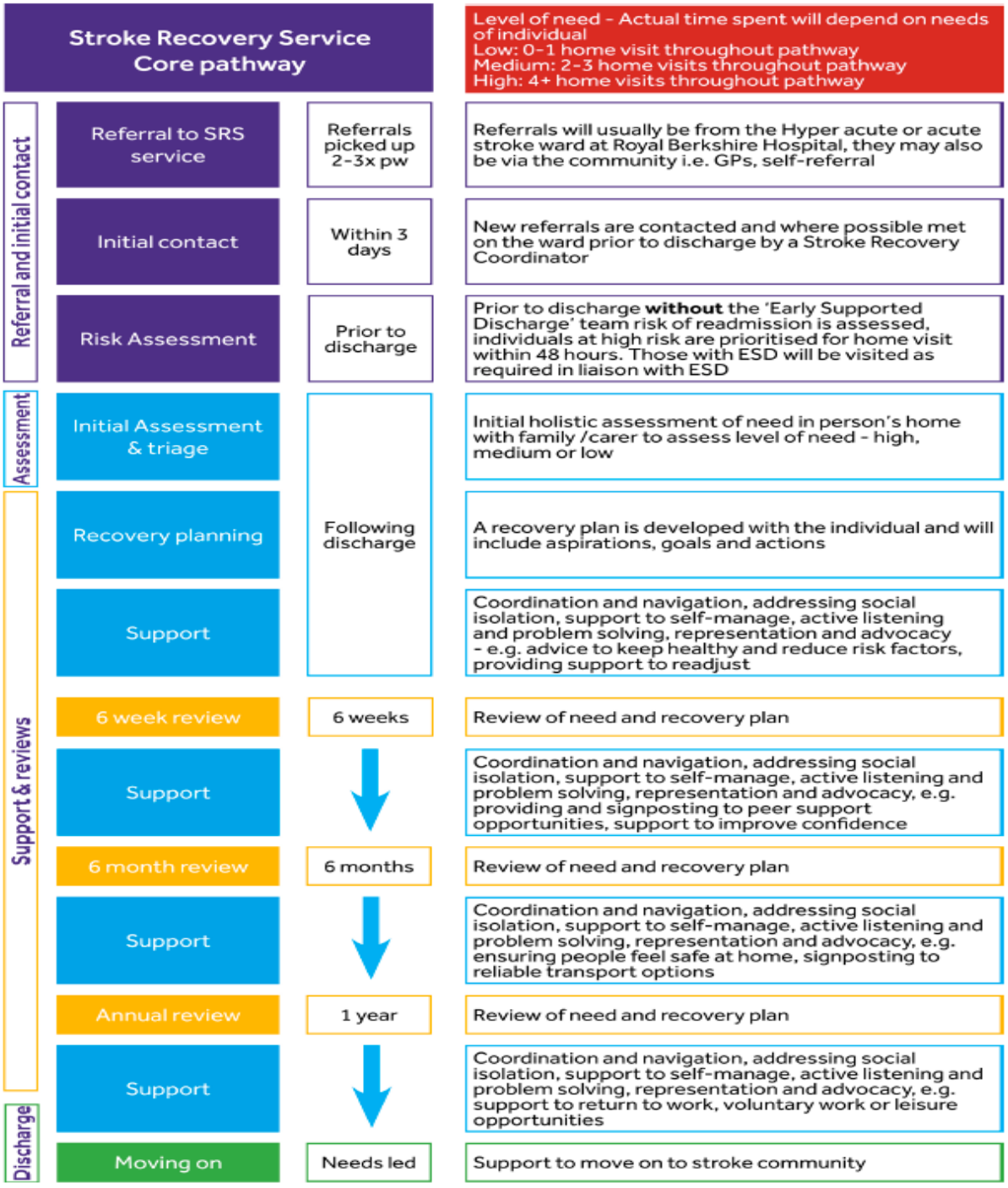

Figure 5 – The Berkshire West and Reading Stroke Recovery Service Core Pathway

Table 13 – Funding of the Berkshire West and Reading Stroke Recovery Service

Funder	Contribution	Stroke incidence

West Berkshire	£39,010	485 (across both)
Reading BC	£31,648	226 (53%)
Wokingham BC	£28,065	259 (47%)
Total	**£98,723**	**485**

This is a new service and the evaluation of its impact is, as yet, unknown. Anecdotal feedback from the service providers (Trust and SA) and the commissioners would suggest expected improvements in both impact on the system (admissions, prevention etc) and improved outcomes for users.

8. Key considerations for a new service

The National Stroke Strategy sets the scene for the development of stroke services and subsequent national documents have further stressed the importance of long term support of stroke survivors and their carers. Significant achievements have been made in Buckinghamshire during the last 5 years within the acute stroke services but the long term support remains an underutilised resource.

The review has identified a number of key considerations when looking to commission a Stroke Community Support Service into the future in Buckinghamshire:

- Long term community stroke support should remain a key part of the stroke pathway and this is supported by national guidance
- An equitable offering should exist for all stroke survivors in Bucks (north and south)
- There should be one provider of the stroke community support service across the county and this does not necessarily need to be the same provider as the other services in the stroke pathway
- An integrated pathway should exist, in partnership with other organisations, to allow for a smooth flow of patients and this should be built into the specification of all providers in the stroke pathway
- A holistic approach is required (health and social care)
- There should be consideration made as to the added value, beyond the commissioned service, brought to the service by a non-clinical provider, as demonstrated in other voluntary sector providers analysed as part of this review
- The service should be ‘Stroke Knowledgeable’ but not necessarily clinical and accessible from the point of admission
- The current division of the service (0-6 months; post 6 months) has no found basis and should be removed allowing for one ‘timeless’ service
- A comprehensive review at around the 6 months must be offered; this could be delivered separately to or as part of a long term support service
- In addition and in line with national guidance, all stroke survivors should be

offered a comprehensive annual review
- 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
- A 'stroke coordinator' or 'navigator' role is a valuable resource for stroke survivors and carers
- All stroke survivors should have access to a comprehensive emotional review and treatment and support regime
- Stroke survivors should be seen as a resource for other people with stroke through formal and informal peer support
- Stroke education, along with advice and support should be provided for families and professional and unpaid carers
- Carers and families should also have their needs assessed at regular intervals
- Carers and families should be provided with clear guidance on how to find help if problems develop
- Carers and families should have the opportunity to access long-term emotional and practical support through peer support groups facilitated by charitable or voluntary groups
- The Expert Stroke Programme may not demonstrate value for money as a defined service, compared with delivery by local stroke groups and peer support as part of, or in addition to, a Stroke Community Support Service

9. Options Appraisal

The following options are based on the assumption that the aforementioned key considerations are factored into any new specification.

Section A – Commissioning options

Table 14 – Commissioning options appraisal

Options	Description	Pros	Cons
1 (Suggested) **CCG to commission full stroke pathway, including Stroke Community Support**	This option would require a transfer of the remaining commissioning responsibility for Stroke Community Support Services from BCC to CCGs	-Removes complexity and duplication of resource of having 2 commissioning organisations - Aligns commissioning of Stroke Community Support Service with the rest of the stroke pathway and creates efficiencies around areas such as	- Risk of BCC attracting negative publicity if elements of current SA delivered services are lost as part of any transition or future model - Potential of reducing focus on social care benefits highlighted in

Service		contract management - Aligns with strategic direction of one commissioning organisation and other similar care pathways - Aligns with best practice examples encountered as part of this review, where commissioning responsibility is reverting from local authority to CCG - Opportunity to fully revise service specification and contract	this review
2 **Retaining current commissioning arrangements**	This option would maintain the current arrangement across BCC and CCGs	- Maintain commissioning and contracting expertise gained through 4 years of contract with SA - Maintain focus on social care benefits, with potential of improving	- No further funding allocated via BCC for extension beyond 16/17 - Maintains current commissioning and provision complexities highlighted in this review

Section B – Service Provision options

These options are based on the assumption that the suggested commissioning option is accepted.

Table 15 – Service Provision options appraisal

Option	Description	Pros	Cons
1 (Suggested) **Integrated Stroke Community Support Service between health and voluntary**	This option would require a new service specification taking into account the findings of this review	- A clearer and more integrated pathway for patient care - Maintaining long term stroke support as recommended by national guidance and local patient mandate - Patients receiving	- Potential that BHT and SA do not want to work together to deliver an integrated offer and BHT prefer to work alone, or with an alternative provider - Importance of good

sector	This includes maintaining the benefits seen from delivery of services by both acute and voluntary organisations and could be commissioned either separately as seen in West Berkshire, or in response a joint venture proposal	benefit of services delivered by both clinical and voluntary sector expertise - A more efficient use of resource - Opportunity to deliver new specification based on local patient need and demonstrate the benefits of multi-agency, multi-specialist delivery	inter-provider relations, currently not in place - Potential of ongoing issues around patient transfer of care even if time limited services are removed - Would require support of a subcontracting process within BHT - Relationships between BHT and the subcontracted provider would need to be monitored
2 **Transfer full service provision to BHT in line with SA contract expiry**	This option would see the contract with the SA expire on 31st August 2016 and countywide provision of all aspects of the Stroke Community Support Service pass to BHT.	- Resource to support a tender may not be required - Patients benefit from 1 provider through the whole stroke pathway - Maintains provision of a long term stroke support service	- BHT currently only deliver 0-6 month service in South Buckinghamshire and would require additional time and resource in order to provide countywide, long term support - It is not clear how much the service would cost given that BHT currently do not have a specification for the 0-6 month service - The cost of BHT delivering the full service is likely to exceed the current financial envelope - Arguably not as cost effective and less added value compared to that of a 3rd sector resource - Increased risks to the health and

			wellbeing of stroke survivors and carers if BHT cannot provide the long term and non-clinical elements of the service - May lose the multi-agency buy in gained to date
3 **Allow SA contract to expire, deliver countywide 6 month review service through BHT and long term support through other existing health and social care services & re-designed prevention matters programme**	This option would see the current service with SA expire, existing 0-6 month services being managed countywide by BHT and the provision of long term support via other existing health and social care services e.g. Prevention Matters, Carers Bucks, etc	- Tender process not required - Single, countywide provider of 0-6 month service - Short term financial savings as utilising other existing services to cover current 6 month+ service - Provision of stroke specific training to existing providers may enhance quality of current services	- Losing longer term, stroke specialist support and added value from voluntary sector - Not clear as to the financial resource required to extend 0-6 month service countywide through BHT - Potential for increased risks to the health and wellbeing to stroke survivors and their carers post 6 months - Increased risks of higher cost health & social care interventions due to lack of suitable services - Does not fully meet national and local good practice in relation to long term stroke support
4 **Do nothing**	This option would not be feasible as it would leave a gap in provision once SA contract expires and inequity of care across the county		

List of Resources Used in the Review

1. National Stroke Strategy, Department of Health, 2007

2. National Clinical Guideline for Stroke, Royal College of Physicians (Fourth Edition), 2012
3. Commissioning Concise Guide for Stroke, Royal College of Physicians, 2012
4. Improving Stroke Services: a guide for commissioners, Department of Health, 2006
5. Stroke rehabilitation guideline: Long term rehabilitation after stroke, NICE (CG162), 2013
6. Stroke in Adults, NICE, 2010
7. Audit of loner term (post-acute) stroke service; Phase 2: Organisational audit of post-acute stroke service providers, Sentinel Stroke National Audit Programme (SSNAP), December 2015
8. Life After Stroke, Commissioning Pack for Clinical Commissioning Groups and Local Authority Commissioners, South East Coast Strategic Clinical Networks, 2014
9. Stroke 6 Months Reviews, Commissioning Information Pack, South East Coast Strategic Clinical Networks, 2014
10. Progress in Improving Stroke Care, National Audit Office, 2010
11. Supporting life after stroke, A review of services for people who have had a stroke and their carers, Care Quality Commission, 2011
12. State of the Nation, Stroke Statistics January 2015, Stroke Association 2015
13. UK Stroke Survivor Needs Survey, Stroke Association, 2010
14. Improving Post-Stroke Management, National Institute for Health research, 2012
15. Post Stroke Review Pilot Project, The Evaluation Report, National Institute for Health Research, 2010
16. Implementing Evidence based Community Stroke Services, Collaboration for Leadership in applied Health Research and Care for Nottinghamshire, Derbyshire and Lincolnshire (CLAHRC NDL), 2012
17. Our health, our care, our say: a new direction for community services, Department of Health, 2006
18. Accelerating Stroke Improvement National Plan, NHS Improvement, 2010
19. Avoiding Hospital Admissions, What does the research evidence say? The Kings Fund, 2010
20. Survey to investigate the role of the community stroke care coordinator, Murray, Foster & Young, British Journal of Community Nursing, 2007