



East Midlands Cardiac and Stroke Network

PROJECT DOCUMENTATION

SERVICE SPECIFICATION

EARLY SUPPORTED DISCHARGE SERVICE

June 2010
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Approvals & Distribution

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1. Purpose

Purpose of Document

1.1 To document the recommendations for the given project based on the anticipated benefits to be gained

1.2 Background

Stroke is the third largest cause of death in the United Kingdom, and a third of people who have a stroke are left with long term disability, the effects of which can include aphasia, physical disability, loss of cognitive and communication skills, depression and other mental health problems. It affects between 174 and 216 people per 100,000 population in the UK each year (Mant *et al* 2004), and accounts for 11% of all deaths in England and Wales. The risk of recurrent stroke within five years of a first stroke is between 30% and 43% (Mant *et al* 2004).

Approximately a third of those having a stroke will die as a result, if not immediately, within 3 months. Recovery can continue for many years after an individual has had a stroke, so it is important that consideration is given on how to provide a seamless transfer of care and access to services over the long term. The most common transfer, and the most stressful to patients, is that from hospital inpatient care back to their home. *'Early supported discharge teams are effective both in terms of clinical benefit and resource use and yet only 22% of trusts have one. One of the common complaints of patients is that they feel abandoned when they leave hospital. The failure to provide specialist community stroke teams may be contributing to this perception'*, (National Sentinel Stroke Audit for 2006). Communication between services is often poor with inadequate information being delivered too late. Currently around half of stroke survivors receive rehabilitation to meet their needs during the first six months following discharge from hospital. This number falls to around a fifth in the following six months. However there is a need for quality and productivity improvements to be made not just within individual NHS organisations, but also at the interfaces between primary secondary and intermediate health care and social care, and with empowered stroke survivors. At the heart of this is the importance of transforming patient pathways, leading to the integration of services and in some cases, the integration of organisations. Where organisational change takes place, it is not necessarily one organisation taking over another, but creating new services with patients and their needs at the centre.

The National Stroke Strategy, published in 2007 by the Department of Health, pulls together the key evidence and outlines what needs to be done to create effective stroke services in England. The strategy sets a framework of Quality Markers (QM) for raising the quality of stroke prevention, treatment, care and support. QM 10 states that stroke services should *'Enable patients who have been admitted to hospital with a diagnosis of stroke to have early, fully supported specialist stroke care safely transferred and delivered within their normal home environment'*. The Royal College of Physicians Sentinel Audit, 2009, also highlighted the need for community based stroke services. Continuing on from work undertaken as part of the NHS Next Stage Review (NSR) into the Stroke Pathway, the East Midlands Cardiac and Stroke Network are reviewing the service provision which will enable patients to have specialist stroke care within their home environments. This will provide the means for QM10 to be achieved for all areas, and, within the timescales recently announced for the Accelerated Stroke Programme.

The chosen approach is to implement ESD teams for 40% of the stroke population (eligible patients) is to implement Early Supported Discharge (ESD) teams for each trust across the East Midlands. ESD services are provided by teams of nurses, therapists, doctors and social care staff, who, by working collaboratively, and with the patient and families, allow stroke patients to leave hospital earlier, receive intensive rehabilitation at home where appropriate, reduce the risk of re-admission into hospital for

stroke related problems, increase independence and quality of life for the patient, and support the carer and family.

The East Midlands Cardiac and Stroke Network will develop a model of care that will incorporate the needs of the region, in-line with national and international guidance. The Accelerated Stroke Programme has set a target date of April 2011 for implementation of the service, at which time 40% of eligible patients (i.e. 16% of the stroke population) having a Barthel score of greater than 9 will have access to ESD services. The following document sets out the specification for the model of care proposed, which ensures that all eligible stroke patients are identified in the acute stroke unit, with rehabilitation being delivered in the individuals place of discharge (e.g. own home, relatives home or residential care) to an agreed therapy plan with goal setting. This service model reflects the continued need for acute rehabilitation and the provision of ongoing stroke rehabilitation for as long as is needed where appropriate.

1.2 Aims and Objectives

- Eligible patients will have access to ESD to give the best possible outcomes for the patients and allow local NHS providers and commissioners to use resources effectively within the health economy.
- To ensure a whole system approach that raises standards across the whole stroke pathway by establishing a recommended model and limit point.
- To establish a recommended model for ESD services across the East Midlands to include specialist stroke multidisciplinary teams, who will support stroke patients on discharge from acute care to their place of residence in order to fulfil identified achievable measureable and agreed rehabilitation goals, and offer support and guidance to their carers and families. In most instances this will occur in a time limited framework. The team will signpost, or transfer to relevant NHS, Social Service and voluntary sector services for ongoing support.
- To show a reduction in length of hospital stay, thereby increase the proportion of patients spending at least 90% of their time on a stroke unit.
- To ensure timely discharge of all eligible stroke patients.
- To ensure equity of access to an ESD.
- To reduce hospital re-admission rates.
- To reduce premature admission into long term care.
- To provide 7 days a week service for eligible stroke patients.
- To ensure that people who have had a stroke achieve maximum independence.
- To include capacity for ongoing patient and carer evaluation of service.
- All transfers of care being managed in a person-centered and timely way.

1.3 Evidence Base, National Policy and Guidelines

- The National Stroke Strategy;
- The Cochrane Review of ESD;
- Royal College of Physicians Clinical Guidelines for Stroke 2008;
- The National Sentinel Stroke Audits;
- The National Service Framework for Older People Standard 5;
- The Accelerated Stroke Programme;
- Revised ESD Consensus Statement prepared by Prof. Marion Walker and Dr Rebecca Fisher of the Collaborative Leadership and Research in Health Care (CLAHRC), for NDLC;
- Evaluation tool to assess the implementation and effectiveness of ESD in practice in rural and mixed settings developed by Collaborative Leadership and Research in Health Care (CLAHRC), for NDLC;
- The East Midlands Public Health Observatory (EMPHO) previous and future demand modelling;

1.4 General Overview

Time is brain and the first 72 hours care is vital to ensure the optimum clinical outcome. This needs to be underpinned by an effective whole system pathway for assessment, transfer and repatriation to local stroke services, subsequent rehabilitation and longer term support. The purpose of the ESD team is to facilitate the safe, early discharge of eligible patients back into the community. Well organised discharge teams can ensure appropriate patients are transferred home from hospital, but maintaining improved death, disability and institutional outcomes as well as reduce hospital length of stay.

1.5 Benefits from utilisation of this document:

- A service that will be based on an international consensus developed by the CLAHRC NDL for local implementation;
- A service specification for a co-ordinated, specialised ESD team;
- The EMPHO previous and future demand modelling;
- The service will be sustainable and value for money;
- There will be equity of access and care standards;
- There will be a seamless pathway;

1.6 Outcomes from implementation of an ESD service

- Improved patient/carer satisfaction.
- Reduced readmission rates.
- Reduced length of stay in hospital following diagnosis of stroke.
- Improved scores in the relevant sections of the National Sentinel Audit for each individual service provider.
- Patients and/or carers to agree setting of patient centred goals.
- An increase in the proportion of patients spending at least 90% of their time on a stroke unit.
- Improve patient functional outcomes (e.g. Barthel) at discharge from ESD.
- 40% eligible patients with Barthel of > 9 by accepted into ESD services April 2011, 95% eligible patients with Barthel > 9 accepted into ESD services. by April 2012
- Reduction in long term use of Social Care.
- Reduction in stroke patient/carer depression.

2. Scope

2.1 Service Description

The ESD will:

- Only accept a patient to the service following discussion and agreement that the patient has a confirmed diagnosis of stroke;
- Referrals from acute stroke pathway will be accepted for all patients satisfying the eligibility criteria;
- Be delivered within place of residence;
- Be a 7 days a week service;
- Be time-limited dependent on local stroke service specification;
- Be free of charge to the service user;
- Provide a rapid same-day response where possible;
- Develop a proactive approach with timely case identification;
- Involve specialist assessment, active therapy, treatment, or opportunity for recovery, working to a structured individually tailored goal orientated treatment plan;
- Ensure effective treatment planning and co-ordination with seamless handover;

- Identify a key worker to liaise with the family and carers;
- Work to any agreed clinical governance policies that exist;
- Facilitate timely discharge from hospital through active intervention, and rehabilitation following a hospital stay;
- The ESD will develop a comprehensive multidisciplinary team (MDT) plan in liaison with acute health care providers at the time of discharge from acute care.
- To support partnership working with Local Authority, health and voluntary sector to support delivery of quality mainstream home care, domiciliary care or day care services.
- Ensure seamless transfer between services if a patient needs to move to an alternative provider;
- Information should be given to patients and carers on the contact information for named ESD Key Worker;
- Information on the Early Supported Discharge service and the disease process.

2.2 Equality Impact Assessment

Commissioners have a duty to work with Providers in the completion of Equality Impact Assessments.

2.3 Whole System Relationships

This service will form part of the overall pathway of care for patients who suffer a stroke.

- Early Supported Discharge services across the East Midlands provided on a network model of care.
- Successful delivery based on all professionals and organisations working together to achieve an excellent patient experience'
- The East Midlands Cardiac and Stroke Network Board will oversee the wider implementation of community stroke services in line with the NSR findings.

2.4 Interdependencies

The service model must align closely with the acute stroke unit from which patients are to be discharged, and with Community Stroke Rehabilitation services where they exist, or to whom they will be discharged to. To enhance this service, interdependency must be taken into account and there should be referral to, and close working with other agencies including:

- All trusts providing stroke services;
- Smoking Cessation Services where relevant;
- Community Services;
- Social Care;
- Voluntary services,
- Independent Sector;
- Orthotics;
- Primary Care;
- Home care service;
- Day care services;
- Community equipment;
- The Mobility Centre;
- Respite care;
- Night sitting service;
- Mental Health services;
- Psychology Services;
- Other rehabilitation services;
- Care Home Services;
- Lifestyle changes;

2.5 Relevant Networks

East Midlands Cardiac and Stroke Network
Neighbouring Networks

3. Service Delivery

3.1 Features of the Team

- Coordinated
- Stroke specialist
- Multidisciplinary
- Comprise as a minimum and based on consensus data – For 100 patients per year caseload:
 - Occupational Therapy (1.0);
 - Physiotherapy (1.0);
 - Speech And Language Therapy (0.4);
 - Physician (0.1);
 - Nurse (0-1.2);
 - Social worker (0-0.5);
- Will meet weekly as a minimum
- Set team and/or patient centred uni-professional goals
- Prevention, minimisation and management of complications
- Continual monitoring, re-assessment and treatment by stroke specialist team, to address continued impairments and limited activity, taking into account the patients psychological, emotional and cognitive needs.
- Commitment of the team for ongoing training and education.

3.2 Features of the Service

- Deliver stroke rehabilitation in the patients' place of residence.
- Time limited, being based on the existence and type of other community based stroke services operating in the area.
- The service will be provided for 7 days a week, promoting independence using intensive rehabilitation techniques when assisting with activities of daily living.
- Personalised comprehensive planning by MDT for transfer from ESD, to include assessment of social situation/support mechanisms, participating in home visits, equipment provision and review, relevant training for informal carers, psychological decisions support tools, leisure and occupational needs and referral to other agencies.
- Involvement and education of informal carers and support staff as to their individual needs. A Carers Assessment referral may need to be triggered.
- Access to refer to specialist services when the need is identified.
- Opportunity for individual teams to use their own therapy measures.

3.3 Ongoing Health Care

- Have strong links with secondary and primary care, specifically in relation to follow-up appointments 6 weeks, 6 months and annually after discharge dependent on local service specifications, and other specialist provider services.
- Align and interface with the Intermediate Care Services for physically frail and vulnerable older people.
- Link to local initiatives relating to long-term conditions.
- Link with local support groups and third sector providers.
- Lifestyle changes.
- Referral to the End of Life Care pathway where appropriate.

3.4 Ongoing Social Care

- Regular reviews of social care needs are to be undertaken at least 6 monthly and annually, in line with statutory guidance.
- Investigate and monitor all safeguarding concerns and issues identified to the service.
- Responsible for promoting self directed support to eligible stroke patients and carers
- Ensure that all carers have access to a formal Carers Assessment.
- Assess and provide a need based home care package
- Access to residential social and/or nursing care.
- Structured education programmes across the whole stroke pathway.

3.5 Ongoing Voluntary Sector

- Psychological well being of stroke survivors and carers.
- Self help and support groups.
- Carer information/education.
- Signposting to appropriate local stroke support organisations.

4. Referral, Access and Acceptance Criteria

4.1 Geographic coverage/boundaries

The East Midlands Cardiac and Stroke Network.

4.2 Location(s) of Service Delivery

Subject to local commissioning approval, the service will be delivered within the patient's place of residence.

4.3 Days/Hours of Operation

- The service will be open to service users seven days a week providing daily interventions dependant on patient needs
- All providers will be delivering a 7 day service for people discharged from the acute stroke unit.

4.4 Referral Criteria and Eligibility

- There will be a direct pathway of referral from the Stroke Units as outlined in the Stroke Strategy.
- Transfer dependency will be that patients can transfer safely from bed to chair i.e. can transfer with one, and able carer, or independently if living alone.
- Most patients eligible for ESD will have a Barthel of greater than 9.
- Within 24hrs of identification eligible patients will be referred to the ESD services.
- Rehabilitation goals must be identifiable.
- Referral is from an acute healthcare professional following comprehensive assessment.
- The patient must be medically stable with appropriate medical investigations completed.
- These patients must be able to safely transfer from bed to a chair (subject to Consensus).

Caveats

- The patient cannot be discharged until necessary care, equipment and transportation are in place. Responsibility for this must be clearly defined locally.
- Unsuitable home environment based on relevant clinical and/or social care assessment.

4.5 Referral Inclusion

- The patient/carers must give consent to ESD referral.
- For patients discharged alone to a private address they must be able to maintain their own safety independently.
- The ESD will inform the acute service and the patient/carer, of the rehabilitation and package of care they will be receiving when entering the service.

4.6 Readmission Strategy

There should be an agreed strategy between the ESD and the Acute Trust in the event of patient deterioration.

5. ESD Discharge Criteria & Planning

Planned discharge from the ESD should be initiated on ESD admission. This should be multidisciplinary and involve patient/carer decision.

5.1 Discharge Criteria

People are discharged from the service where they have reached the time limitation of service delivery of local service specifications.

- When their goals have been met or there is a plateau of improvement;
- The patient is not progressing in treatment;
- The patient is non compliant with treatment;

5.2 Discharge Procedure/Care Transfer

- The ESD will send a discharge summary to the GP and the stroke physician for information.
- At the point of discharge from ESD, the patients' medical care will be transferred to the GP.
- Responsibility for 6 month review needs to be in line with current provision and national guidance.
- Where further health care is required the relevant service should be identified
- Where further social care needs have been identified, the patient is transferred into Social Care services, which will assess and identify a person centered care plan.

6. Self-Care and Patient and Carer Information

- Patients will be given information at points of transfer/discharge regarding contact with appropriate local and statutory agencies.
- The needs of those who do not have English as their first language should be taken into account.
- The service will support patients to make choices about their care, including those with perceptual and cognitive difficulties, as well as those with speech impairments.
- Patient, family and carer education is an essential aspect of the service delivery to ensure long-term and sustained improvement.
- Signposting between appropriate services and partnership working is an integral aspect of the service delivery and will include driving advice, vocational training, health promotion and the voluntary sector.
- Employers' information and updates.

7. Quality and Performance Standards

Quality Performance Indicators	Threshold	Method of measurement	Consequence of breach
No. of patients assessed, and % on time within 24 hours of a hospital discharge	100% (and exception report for patients overdue)	Monthly monitoring. Sentinel Audit	
No. of discharges to rehab where the intention is for the person to go back home		Monthly monitoring	
Average waiting time for initial appointment/assessment & number of patients on a waiting list	<i>Provider must keep record of patients' date of referral & date of initial appointment</i>	Monthly monitoring	
No. (and %) of patients who have received a specialist assessment whilst in the service Carers receiving needs assessment or review and a specific carer's service, or advice and information	100% (and exception reporting)	Monthly monitoring NI 135	
Service User Experience Self reported experience of social care users Self reported measure of peoples overall health and wellbeing User reported measure of respect and dignity in their treatment	85% rate service good or better <i>All patients must be invited to feedback on or before discharge.</i>	NCH Quality panel, CQUIN Quarterly Patient Satisfaction Survey NI 127 NI 119 NI 128	Raised as a performance issue in Quarterly or 6-month review
Reduction in length of stay			
Number of patients spending 90% of their stay on a stroke unit			
Readmission status			
Relevant National Sentinel Audit Measures			

8. Activity

Activity Plan

Activity	Threshold	Method of Measurement	Consequence of Breach
No. of patients in caseload by (new and re-referrals) People with a long-term condition supported to be independent and in control of their condition	Actual figures	Monthly	Breach of Information Agreement (action required in DQIP) NI 124
No. of referrals and how appropriate were the referrals.	Actual figures	Monthly	Breach of Information Agreement (action required in DQIP)
No. of initial assessments delivered. Timeliness of social care assessment (all adults)	Actual figures	Monthly	Breach of Information Agreement (action required in DQIP) NI 132
No. of delayed referrals into the service and the reason Timeliness of social care packages following assessment Delays in transfer of care	Actual figures	Monthly	Breach of Information Agreement (action required in DQIP) NI 133 NI 131
No. of follow up Carers receiving needs assessment or review and a specific carer's service, or advice and information	Actual figures	Monthly	Breach of Information Agreement (action required in DQIP) NI 135
No. of patients discharged (removed from caseload) People supported to live independently through social services (all adults)	Actual figures	Monthly	Breach of Information Agreement (action required in DQIP) NI 136
No. of patients ready for discharge but not removed from caseload	Actual figures	Monthly	Breach of Information Agreement (action required in DQIP)
Average length of patient engagement in ESDT service (from referral to discharge)	Actual figures	Monthly	Breach of Information Agreement (action required in DQIP)
No. (and %) of patients in caseload reviewed at 91 days intervention, who are; i- at home, and have not been readmitted to hospital ii- have been re-admitted to hospital iii- in long-term care iv- deceased v- could not be traced	Actual figures	Monthly	Breach of Information Agreement (action required in DQIP)
No. (and %) of patient DNAs	Actual figures	Monthly	Breach of Information Agreement (action required in DQIP)

Additional Information Requirements

To produce, as a minimum, on an annual basis, a report to include:-

- Description of service;
- Team structure;
- Achievements in the last year;
- Summary of activity;
- Service developments for next year; and
- Reports on KPIs as detailed below:
 - Barthel score on admission, average score and range;
 - Barthel score on discharge, average score and range;
 - Average difference in score from admission to discharge and range;
 - Success in achieving personal goals;
 - Evidence of patient /carer information and education and involvement;
 - Report from patient satisfaction questionnaire and interviews; and
 - Number of complaints received;

9. Continual Service Improvement Plan

Redesigning health services which better meet the needs of patients has never been more critical to the long term success of the NHS. A core component of World Class Commissioning is to drive service innovation and improvement. It is therefore the responsibility of the Commissioners to ensure innovation, knowledge and best practice is applied to improve the quality and outcomes of its commissioned services. It will be the responsibility of the Provider to fully cooperate in reviewing and redesigning services at the request of the Commissioner.

Ongoing monitoring by the NSR Stroke Rehabilitation Group (sub group of the main NSR Stroke Board) Formal evaluation is being undertaken by CLARHC (Collaborative Leadership and Research in Health Care) from Nottingham University as part of their wider R&D programme on ESD schemes.

11. Prices & Costs

10.1 Price

Basis of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value
Block	Patient episode	£		£
Total		£		£

10.2 Cost of Service by commissioner

Total Cost of Service	Co-ordinating PCT Total	Associate PCT Total	Associate PCT Total	Associate PCT Total	Total Annual Expected Cost
£	£	£0	£0	£0	£

note: cost = full year effect, in year start will produce part year effect

References:

@AStroke

Collaborative Leadership and Research in Health Care (CLAHRC),
Department of Health, (2005), The National Service Framework for Long-term Conditions, London, DH
Department of Health (2007), National Stroke Strategy, London, DH.
Langhorne P, et al., (2005), 'Early supported discharge services for stroke patients: a meta-analysis of individual patients' data', *Lancet* 365, 501–6
National Clinical Guidelines for stroke. Intercollegiate Stroke Working Party (2002, revised 2004 and 2006)
National Initiatives for Local Authorities and Local Authority Partnerships
NHS Next Stage Review
Nottingham City Primary Care Trust Service Specification for Early Supported Discharge
NSF for Long-term Conditions
Our Health, Our Care, Our Say
Our NHS, Our Future
Sentinel Stroke Audit results available at: <http://www.rcplondon.ac.uk/pubs/books/strokeaudit>
The Accelerated Implementation Programme
The National Sentinel Stroke Audit
The National Service Framework for Older People
The National Stroke Strategy
The Royal College of Physicians' guidelines (2004)
The Stroke Association